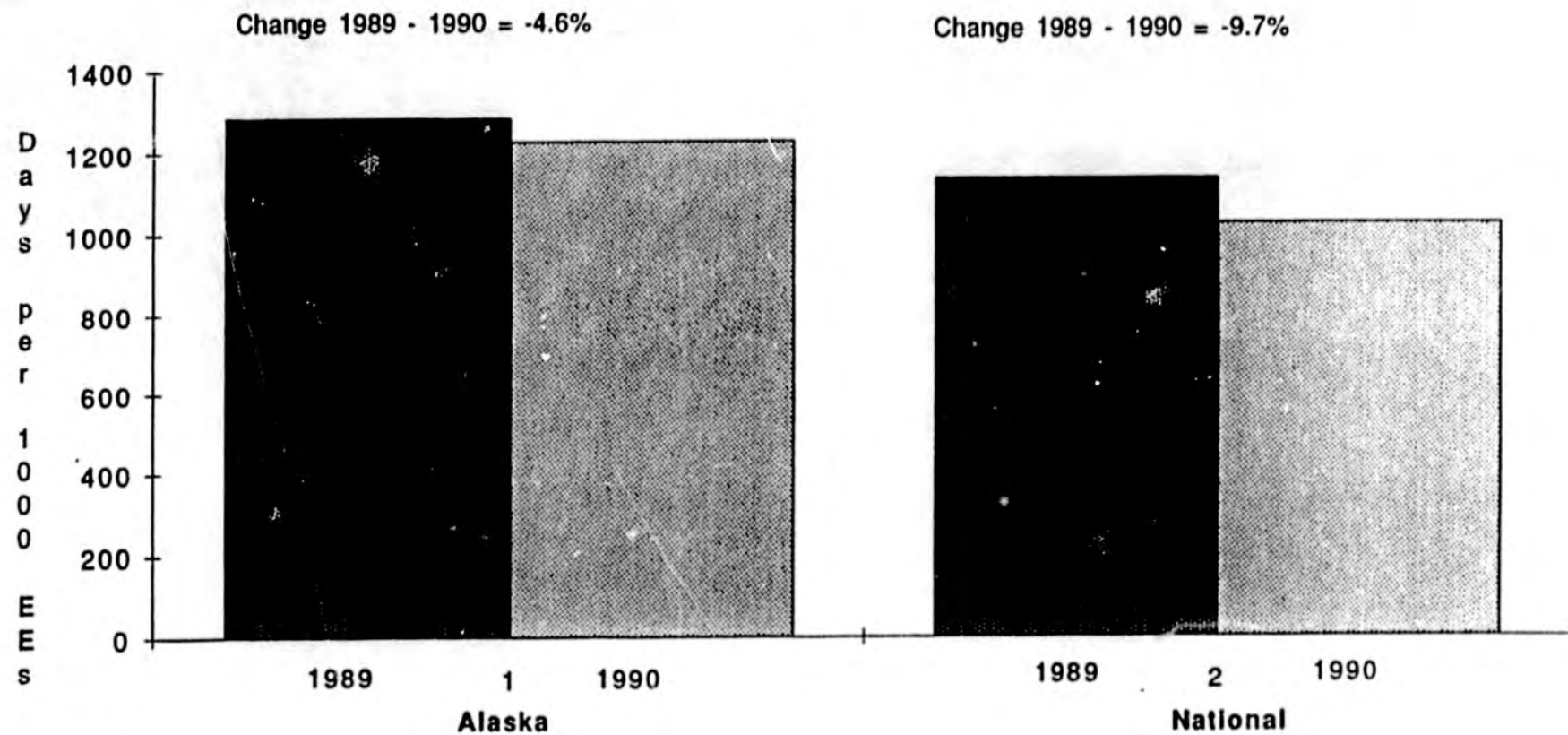


ALASKA LEGISLATURE SPECIAL COMMITTEE/SUBJECT FILE 8672
2192 SCOMM 86: HEALTH RESOURCES & ACCESS TASK FORCE, 1991-93

219

Inpatient Utilization

Ætna Alaska vs. Ætna National



NORMATIVE EXPERIENCE
AETNA ALASKA VS. AETNA NATIONAL
1990
AVERAGE PER DAY

MAJOR DIAGNOSTIC CATEGORY	SUBMITTED EXPENSE			COVERED EXPENSE		BENEFITS PAYABLE		LENGTH OF STAY	
	ALASKA	NAT'L	ALASKA PERCENT TO NATIONAL	ALASKA	NAT'L	ALASKA	NAT'L	ALASKA	NAT'L
NERVOUS SYSTEM	\$1,376	\$1,161	119%	\$1,310	\$1,103	\$1,185	\$8,098	8.2	8.5
EYE DISEASE	\$1,149	\$1,516	76%	\$1,113	\$1,441	\$1,001	\$3,583	2.6	2.9
EAR, NOSE AND THROAT	\$1,523	\$1,424	107%	\$1,442	\$1,344	\$1,358	\$3,165	3.0	2.7
RESPIRATORY	\$1,525	\$1,157	132%	\$1,505	\$1,097	\$1,383	\$5,556	4.8	5.9
CIRCULATORY	\$2,068	\$1,839	112%	\$2,025	\$1,749	\$1,842	\$7,911	4.8	5.2
DIGESTIVE	\$1,280	\$1,182	108%	\$1,208	\$1,123	\$1,109	\$4,685	4.2	4.8
HEPATOBIILIARY	\$1,366	\$1,386	99%	\$1,323	\$1,319	\$1,194	\$6,512	4.4	5.7
MUSCULOSKELETAL	\$1,638	\$1,354	121%	\$1,567	\$1,278	\$1,452	\$5,724	4.4	5.2
SKIN, BREAST	\$1,266	\$1,176	108%	\$1,244	\$1,114	\$1,135	\$4,419	4.0	4.6
ENDOCRINE	\$1,325	\$1,052	126%	\$1,297	\$999	\$1,185	\$4,365	4.9	5.1
KIDNEY	\$1,295	\$1,249	104%	\$1,280	\$1,188	\$1,170	\$4,251	3.5	4.1
MALE REPRODUCTIVE	\$1,599	\$1,305	123%	\$1,529	\$1,232	\$1,338	\$4,335	3.1	4.1
FEMALE REPRODUCTIVE	\$1,456	\$1,295	112%	\$1,434	\$1,213	\$1,325	\$4,195	3.8	4.0
PREGNANCY, CHILDBIRTH	\$1,311	\$1,083	121%	\$1,256	\$1,011	\$1,136	\$2,427	2.5	2.8
NEWBORNS	\$893	\$662	135%	\$868	\$635	\$770	\$1,783	3.3	3.4
BLOOD DISORDERS	\$1,597	\$1,337	119%	\$1,501	\$1,277	\$1,412	\$7,323	6.3	6.7
MYELOPROLIFERATIVE	\$1,212	\$1,532	79%	\$1,205	\$1,458	\$1,125	\$7,571	8.0	6.0
INFECTIOUS	\$1,628	\$1,183	138%	\$1,419	\$1,111	\$1,141	\$5,845	6.7	6.1
MENTAL DISORDERS	\$683	\$593	115%	\$670	\$583	\$614	\$10,169	14.9	20.4
SUBSTANCE ABUSE	\$459	\$442	104%	\$438	\$423	\$380	\$6,868	16.0	19.0
INJURY; POISONING	\$1,260	\$1,277	99%	\$1,236	\$1,215	\$1,157	\$4,513	4.7	4.3
BURNS	\$1,110	\$1,509	74%	\$1,107	\$1,490	\$1,076	\$11,997	6.1	9.3
SELECTED	\$670	\$882	76%	\$656	\$841	\$595	\$5,681	6.1	7.9
UNCLASSIFIED	\$1,354	\$1,415	96%	\$1,312	\$1,359	\$1,256	\$8,254	6.0	7.0
TOTAL	\$1,223	\$1,047	117%	\$1,181	\$997	\$1,074	\$4,944	4.7	5.8

* Major Diagnostic Categories are groupings of DRG's.

**Aetna Alaska Book of Business includes all health claims processed in 1990, for services incurred in 995, 997, 998, 999 Medical Expense Areas (M.A.'s).

G-7

**NORMATIVE EXPERIENCE
AETNA ALASKA VS. AETNA NATIONAL
1990
AVERAGE PER ADMISSION**

MAJOR DIAGNOSTIC CATEGORY	SUBMITTED EXPENSE			COVERED EXPENSE		BENEFITS PAYABLE		LENGTH OF STAY	
	ALASKA	NAT'L	ALASKA PERCENT TO NATIONAL	ALASKA	NAT'L	ALASKA	NAT'L	ALASKA	NAT'L
NERVOUS SYSTEM	\$11,325	\$9,887	115%	\$10,780	\$9,395	\$9,751	\$8,098	8.2	8.5
EYE DISEASE	\$2,930	\$4,393	67%	\$2,837	\$4,176	\$2,552	\$3,583	2.6	2.9
EAR, NOSE AND THROAT	\$4,603	\$3,887	118%	\$4,359	\$3,669	\$4,103	\$3,165	3.0	2.7
RESPIRATORY	\$7,363	\$6,784	109%	\$7,266	\$6,432	\$6,678	\$5,556	4.8	5.9
CIRCULATORY	\$10,028	\$9,601	104%	\$9,816	\$9,129	\$8,929	\$7,911	4.8	4.8
DIGESTIVE	\$5,375	\$5,717	94%	\$5,073	\$5,428	\$4,658	\$4,685	4.2	4.8
HEPATOBIILIARY	\$6,053	\$7,911	77%	\$5,864	\$7,528	\$5,293	\$6,512	4.4	5.7
MUSCULOSKELETAL	\$7,156	\$6,997	102%	\$6,844	\$6,605	\$6,342	\$5,724	4.4	5.2
SKIN, BREAST	\$5,112	\$5,411	94%	\$5,022	\$5,126	\$4,584	\$4,419	4.0	4.6
ENDOCRINE	\$6,479	\$5,328	122%	\$6,341	\$5,060	\$5,794	\$4,365	4.9	5.1
KIDNEY	\$4,546	\$5,180	88%	\$4,493	\$4,927	\$4,106	\$4,251	3.5	4.1
MALE REPRODUCTIVE	\$5,004	\$5,289	95%	\$4,786	\$4,994	\$4,188	\$4,335	3.1	4.1
FEMALE REPRODUCTIVE	\$5,547	\$5,200	107%	\$5,464	\$4,871	\$5,051	\$4,195	3.8	4.0
PREGNANCY, CHILDBIRTH	\$3,321	\$3,037	109%	\$3,182	\$2,834	\$2,876	\$2,427	2.5	2.8
NEWBORNS	\$2,930	\$2,237	131%	\$2,848	\$2,246	\$2,526	\$1,783	3.3	3.4
BLOOD DISORDERS	\$10,015	\$8,953	112%	\$9,415	\$8,548	\$8,855	\$7,323	6.3	6.7
MYELOPROLIFERATIVE	\$9,753	\$9,208	106%	\$9,693	\$8,763	\$9,054	\$7,571	8.0	6.0
INFECTIOUS	\$10,979	\$7,242	152%	\$9,568	\$6,799	\$7,698	\$5,845	6.7	6.1
MENTAL DISORDERS	\$10,192	\$12,077	84%	\$10,003	\$11,875	\$9,157	\$10,169	14.9	20.4
SUBSTANCE ABUSE	\$7,367	\$8,412	88%	\$7,021	\$8,051	\$6,100	\$6,868	16.0	19.0
INJURY, POISONING	\$5,866	\$5,482	107%	\$5,753	\$5,216	\$5,384	\$4,513	4.7	4.3
BURNS	\$6,800	\$13,957	49%	\$6,782	\$13,785	\$6,588	\$11,997	6.1	9.3
SELECTED	\$4,080	\$6,962	59%	\$3,999	\$6,636	\$3,624	\$5,681	6.1	7.9
UNCLASSIFIED	\$8,058	\$9,978	81%	\$7,807	\$9,579	\$7,474	\$8,254	6.0	7.0
TOTAL	\$5,758	\$6,036	95%	\$5,563	\$5,746	\$5,058	\$4,944	4.7	5.8

* Major Diagnostic Categories are groupings of DRG's.

**Aetna Alaska Book of Business includes all health claims processed in 1990, for services incurred in 995, 997, 998, 999 Medical Expense Areas (MLA's).

Alaska State Health Benefit Mandates

Alcoholism & Drug Abuse Treatment

Law: SB 363

Synopsis:

Coverage for treatment of alcoholism or drug abuse must include

(1) benefits of at least \$7,000 per two consecutive benefit years

(2) a lifetime maximum of at least \$14,000

No insurer may:

---impose a deductible or copay amount, pre-existing limitation, claim payment methodology, or precertification notification requirement different from that which applies to other covered expenses

---deny reimbursement for actual services rendered solely because the treatment was interrupted or not completed

cost impact:

Alcoholism/Drug Abuse expenses comprise 2-3% of a typical health plan's total medical benefit payments. Complete exclusion of coverage would potentially save an equivalent amount, not taking into account the potential increased claim costs for treatment of the medical complications of substance abuse and the potential increase in disability/time loss work benefits

Mammogram Screening

Law: HB 45

Synopsis:

Requires insurers to provide coverage for routine mammogram screening (i.e. in the absence of symptomatic evidence of the existence of a disease) under group medical policies; coverage must be provided on a basis no less favorable than for other radiological examinations covered under the policy. Minimum requirements are:

--one baseline mammogram between ages 35-40

--one mammogram every two years between ages 40-50

--annual mammograms thereafter

cost impact:

Depending on the composition of the employee group, the additional cost to a plan is approximately .7%-1.4%; however, since this is a preventive benefit, there would be assumed future long term savings to offset the cost of the procedure

Medical Coverage for Alaska's Children

- All plans underwritten or administered by Aetna in Alaska include coverage for dependent children
- Aetna's medical plans do not differentiate between employee and dependent coverage in terms of coverage and benefits (with one exception--not all plans include dependent child pregnancy benefits) Otherwise all plans, regardless of size, include some level of coverage for physician and nursing services, hospital care, laboratory expenses, prescription drugs, medical or surgical equipment, etc.
- dependents are covered from birth (and standardly including routine nursery charges) until age 19; and then beyond age 19 (standardly to age 23) if attending school on a regular basis and dependent on the insured employee for support
- coverage for a child with a developmental disability or physical handicap can be continued past the maximum age for as long as the person remains unable to earn his or her own living because of the handicap and remains chiefly dependent on the insured employee for support
- there is an increasing tendency for employers to require some employee contribution toward the cost of dependent coverage; the cost to employees ranges from a nominal \$10-20 monthly contribution to a 100% employee contribution obligation; cost-sharing with respect to dependent coverage is more prevalent among small employers
- preventative care benefits for children (such as immunizations and routine physical examinations) are an optional plan provision and standardly not included by Employers; a review of ten Aetna Alaska medical plans with 200+ employees found two employers that included a preventive care benefit for children; in our small employer product market we estimate that less than 10% of employers plan sponsors include any preventive care benefits

Aetna Small Group Market Information

Aetna supports reforms to the small group market to guarantee the availability of coverage to all small employers and to provide greater rate stability to these employers:

- All carriers writing coverage in this market should be required to provide both a basic benefit plan (free of state mandated benefits) and a standard benefit plan to any small employer that wants coverage, *regardless of the health status* of the employer or its employees
- All plans sold to small employers should be *guaranteed renewable*
- Carriers should be required to *accept whole groups*
- Rejecting high risk individuals from a group would be prohibited
- Pre-existing condition limitations should be *limited* to no more than 12 months
- *Continuity of coverage* should be provided by prohibiting re-application of pre-existing condition limitations for coverage that is continuous (i.e. to an employee switching jobs or an employer switching carriers)
- Two limitations should be placed on carriers use of experience rating in order to *make rates more predictable*: First, renewal rates should not increase by more than the increase in medical "trend" plus a maximum of 15%; Second, for groups with similar case characteristics, the initial and subsequent rates charged to these groups should not vary by more than a maximum of 50%
- A prospective *reinsurance mechanism* should be established to allow the carriers to spread the risk of the losses caused by high risk employer groups. Financing of the losses of this program should be done in two steps. First, all small group carriers should be assessed a charge of up to 4% of small group premium. If there are remaining losses, all carriers should be assessed for all insured employer groups

Small Group Market -- Response to Task Force Inquiries

- Aetna accepts or rejects whole groups, not individuals, as regards 10-200 employee groups; however, for groups of 2-9 employees we do ask for individual evidence of good health for entrants to the plan; Aetna does not accept groups but exclude certain conditions;
- For groups of 2-200 employees the percentage of administrative costs to total premium collected is 11% to 13.5%. This is a national average; we do not specifically differentiate among the states.
- As of the 1st quarter 1991, the average monthly premium charge per employee for 2-200 employee groups underwritten in Alaska was \$306.61
- All industries, business or professions are eligible for coverage; there are no blanket prohibitions or automatic Home Office rejections of any group based solely on occupational categories; we have broad representation of industries in our current book of business
- Pre-existing condition limitations are included in all size plans
If the group constitutes *transferred business* (i.e. employees insured on the Aetna plan effective date were previously insured under a prior insurance carrier) then the following limitations apply: For groups with fewer than 10 employees, expenses for preexisting conditions to a limit of \$2,000 will be covered during the first 365 days insured under an Aetna plan
For larger groups, Benefits for covered medical benefits will be paid to the extent the prior plan would have provided benefits. The benefit payable will be the lesser of the normal Aetna benefit in the absence of a pre-existing condition limitation and the unused portion of the maximum amount payable for that condition under the prior plan. In no event will Aetna pay less than the normal Aetna benefit payable on the first \$2,000 (groups of 10-49 employees) or \$4,000 (groups of more than 50 employees) of covered expense during the first 365 days insured under the Aetna plan.
If the group was *previously uninsured*, expenses for a preexisting condition will not be covered for the first 365 days insured under the new Aetna plan. However, for employee groups of 50 or more employees, up to \$4,000 of expenses incurred in connection with a preexisting condition will be considered a covered expense for which benefits are available.

UTILIZATION MANAGEMENT

Utilization Management (UM) involves reviewing inpatient, outpatient and selected specialist procedures, as well as special testing, before, during and after treatment. This helps assure that care is medically necessary and appropriate for a patient's clinical condition. It also helps direct members to cost-effective settings whenever possible.

BEFORE TREATMENT

- **Inpatient Precertification** reviews the medical necessity, appropriateness and setting for planned hospital, psychiatric and substance abuse treatment facilities, hospice and skilled nursing facility admissions. We establish optimal lengths of stay and identify opportunities for individual case management. Precertification involves the use of comprehensive guidelines developed by specialists in the appropriate fields regarding appropriateness and effectiveness of treatments and services for the entire range of medical conditions.

Precertification involves a review of the clinical information about the patient's condition, the proposed site of service, the length of stay, the health care resources required and the proposed procedure or treatment. Based on the information provided at the time of the review, we certify that the proposed site, service or treatment appears to meet the applicable health benefits plan's contract requirement that covered services be medically necessary and appropriate.

Review determinations are not directions to the provider to offer or refuse any course of treatment; they are rather assessments of the medical necessity or appropriateness of proposed care for the purpose of offering an advance indication concerning benefits. Utilization reviewers have no authority (and seek no such authority) to direct the provider of care or the patient to do or omit anything, and the provider and patient are always the final arbiters of any treatment plan. Utilization review denials simply indicate that the proposed treatment does not meet the medical necessity or appropriateness requirement in the absence of new information or changed circumstances; this is subject to rights of appeal at the certification and claim stages.

Last year our inpatient precertification programs cut our customers' overall claim costs by over \$150 per employee per year.

- **Outpatient Precertification** performs the same types of reviews for targeted high-cost or frequently utilized outpatient diagnostic tests and procedures. The development of Outpatient Precertification (OPP) was necessitated by the significant rise (15% to 20% annually) in both the utilization and cost of outpatient care. OPP integrates the most up-to-date computer technology with procedure-specific expert decision support in the form of clinical protocols to determine the medical necessity of certain outpatient tests and procedures.

For procedures to be included in our outpatient certification review process:

- adequate information and consensus opinion is needed from the medical literature on when these procedures should and should not be performed;
- the procedures must be of high enough cost and performed frequently enough so that review is cost effective;
- evidence is needed that the procedure is being performed for inappropriate reasons.

Following extensive literature research on each test/procedure, criteria are established and taken to a panel of expert clinical physicians for review. The result of this exhaustive process is a protocol consisting of algorithms which allows one to obtain needed clinical information from patients and physicians and, more importantly, to arrive at consistent decisions.

Physician reviewers assist in the precertification process, as necessary. Additionally, the nurses' decisions are audited, and ongoing monitoring is conducted via computer-generated traces.

In 1990, these programs reduced our customer's costs by reducing targeted procedures 15 percent.

- **Managed Second Opinion** identifies patients scheduled for targeted high-cost or frequently utilized surgical procedures who might benefit from a second opinion. Here, our medical managers use medical criteria developed by expert physician panels. This helps patients and their doctors determine the clinical appropriateness of the proposed treatment and evaluate alternatives.
- **Healthy Beginnings** identifies expectant mothers who may be at increased risk and provides them with prenatal education. The expectant mother is encouraged to visit an obstetrician and assisted in finding one, if necessary. When a potential high risk situation is identified, follow-up calls are made every two weeks until a doctor is identified and the doctor is notified of the woman's status. If necessary, follow-up calls are continued throughout the pregnancy, and rescreening is done at the end of the second trimester for all participants. Additional educational materials are distributed at each stage of pregnancy. In addition, an Aetna physician reviews high risk cases and contacts the attending physician, if necessary. Case management goes on throughout delivery and postnatal care. A subsequent call is made to the patient asking for help in evaluating the program. This innovative Aetna program is designed to reduce the chances of expensive neonatal care and to enhance overall quality.

The rate of low-birth-weight infants born to women enrolled in Healthy Beginnings is just 3.4 percent. This compares favorably with a national low birth-weight rate of 6 percent to 8 percent.

- **Computerized Medical Guidelines** help our nurse consultants determine whether to certify a proposed procedure - or refer it for medical director review. The guidelines also help our nurses avert the unnecessary use of health services, which improves quality and reduces costs. The guidelines are used in our inpatient and outpatient precertification, managed second opinion and prenatal health programs. They were developed after extensive research and with direct physician input.

- **Focused Psychiatric Review** precertifies and concurrently reviews psychiatric and substance abuse care. Master's level clinicians work with admitting physicians to promote the development of realistic treatment plans and identify alternative treatment methods. *Last year, this program saved our customers nearly \$6,000 - and reduced lengths of stay by 10 days - per confinement. Plans saving per employee can range from \$100 to \$300 per year.*
- **Institutes of Excellence** are leading institutions specializing in complicated, high cost, low frequency medical procedures such as transplants. These facilities have a demonstrated ability to achieve positive clinical outcomes. We negotiate preferential case rates with these facilities, and when appropriate, will direct members to them.
- **MEDIS (Medical Information System) Technology Data Base** provides our medical manager with the latest medical literature reviews and research information. This helps them make better precertification decisions and offer up-to-the minute information to plan members and providers.

DURING TREATMENT

- **On-Site Concurrent Review** monitors the patient's progress and the need for continued confinement. In selected locations, our nurses work on-site directly with the attending physician, the facility's staff, and if appropriate, the patient and the patient's family. In this way, Aetna nurses can help facilitate the discharge planning process. *This process saved our customers over \$300 per employee per year.*
- **Concurrent Quality Monitoring** is a process in which nurse consultants identify potential quality problems and report quality issues directly to our medical director, if appropriate, for immediate intervention. Nurses also flag issues such as unexpected returns to surgery.
- **Discharge Planning** involves identifying as early as possible any care that may be needed after discharge. The process identifies quality, cost-effective alternatives such as home health care. We also assist in making necessary arrangements prior to discharge. Through these efforts, patients can receive quality care and save money at the same time.
- **Individual Case Management** matches a patient's needs with available community resources in extremely complicated or lengthy cases, such as trauma, multiple sclerosis or cancer. Our extensive network of case management affiliates allows us to perform on-site assessments in many locations throughout the country. Nurse consultants monitor the appropriateness of the setting and treatment plan in the kinds of cases mentioned above. By seeking alternatives to traditional care and researching extra-contractual benefits. *Our nurses saved over \$68,000 per case for our customers.*

AFTER TREATMENT

We're refining existing methods and developing new methods to measure *actual* outcomes against outcome *standards*. After we collect this information, we look for ways to improve medical performance and clinical quality. We accomplish this through the following activities:

- **Provider Profiling and Trend Analysis** analyzes provider utilization and cost trends and identifies areas of overutilization and underutilization.
- **Retrospective Quality Reviews** are conducted and reviewed by Quality Assurance committees in accordance with national guidelines. These groups analyze specific cases and look for trends that may indicate problems.
- **Focuses Audits** examine the medical indication for certain common procedures with wide treatment variability, such as Caesarian delivery. Furthermore, they measure health care value by examining the type, quantity and cost of procedures used and the health outcome.

Network Management

Alternatives to traditional indemnity programs began to emerge in the 1970's. Encouraged by an Act of Congress in 1973, Health Maintenance Organizations (HMO's) were distinguished by their use of a closed network of providers, provider risk sharing, and tight control over delivery of care. In the 1980's, Preferred Provider Organizations (PPO's) were developed to provide both in and out-of-network benefits for a negotiated fee. Employers have accepted both HMO's and PPO's as viable means of delivering health care benefits.

Over the last decade there has been a dramatic shift from traditional indemnity plans to managed care programs. In 1980 only about 4% of all members covered by group health were enrolled in a managed care plan. Today, it is estimated that 30% of the group participate in HMO's and PPO's, and their numbers continue to grow each year. Health industry analysts project that 30% of health care enrollees could be participating in a PPO and 20% in an HMO by the year 2000. Aetna has provider networks in over 150 major metropolitan areas and more than 2.4 million members as of 1st quarter, 1990. *Aetna has approximately 1,000 hospitals and more than 75,000 physicians under contract. As a percentage of total claims PPO savings are 7-9%.*

State Of Alaska Employee Medical Plan

Analysis of Recent Cost Containment Activities

Plan Changes Introduced December 1989:

- Inclusion of a family of Aetna medical cost management programs, called "Healthline," designed to promote cost-effective and appropriate utilization of inpatient and outpatient medical services, and informed healthcare consumer behavior, including:
 - inpatient precertification, concurrent review, and discharge planning related to hospital care as well as psychiatric and substance abuse treatment facility care, including on-site nursing review at selected facilities
 - advance review of selected high cost or frequently utilized outpatient surgeries, diagnostic tests and procedures
 - a prenatal care information and advocacy service designed to reduce the risk of low birth weight babies
 - a general health care information service designed to promote health awareness, locate community healthcare resources and help individuals understand plan benefits and treatment alternatives
- Miscellaneous other changes including introduction of both vision care and pharmacy provider network plans, inclusion of optional mail order drug purchase plan, \$200 increase in annual employee out-of-pocket maximum

Plan Program Performance Results:

- One Study of the impact of Healthline Utilization Review concluded that the State Active Employee Plan's total inpatient care costs in 1990 were 14.4% lower than they would have been had the program not been in effect. Overall, inpatient days of confinement decreased 24%. Confinement days per 1000 employees decreased even more significantly--33.9%--for inpatient stays related to psychiatric and substance abuse disorders.
- Another evaluation of the State Employee Plan done to quantify the impact of the inclusion of precertification procedures determined that the program saved \$230.90 per employee per year. These savings translated into a return of \$10.24 for each dollar spent during the study period.

- Research done to study the impact of the On-Site Concurrent Review program administered in Anchorage concluded that in 1990 the program saved the State \$136 per employee. This saving translated into a 9% reduction in inpatient hospital costs for State employees with on-site nursing review compared to otherwise similar groups without the local review service.
- Two studies have been conducted to determine the cost saving impact of the Outpatient Procedure Precertification Programs implemented in December 1989. One analysis indicated that the per employee benefits paid for the tests and procedures encompassed by the program resulted in a 7.2 decrease in such expenses. Another evaluation concluded that decreases in utilization rates, compared to a control group without the program, resulted in total program savings of \$718, 908 in 1990.
- Preliminary review of the Healthy Beginnings prenatal care program has shown reduced cost per day for premature births and a reduced average of benefits paid for participants.

•

1990 Plan Utilization Cost Results:

- Total per employee benefits paid decreased 6% as compared to a 10% increase in Aetna's national Book of Business experience
- Had the State not implemented plan changes, a projection of expected utilization and expense inflation increases resulted in an estimated savings of 21%
- the overall "expense gap" between the State's plan costs and Aetna's national plan cost average decreased by 38% as a result of the the favorable State plan experience as contrasted to the deteriorating experience of comparison groups
- total inpatient hospital expenses decreased by 8.8% compared to an 8.7 increase for the rest of Aetna's Alaska customers
- the average hospital confinement length of stay decreased by 12%
- inpatient days of confinement decreased 24.1% (compared to a national comparison group decrease of 11.5%)
- the State paid portion of covered expense was 89% in 1990 compared to 91% in 1989; the employee paid portion of covered expenses increased from 9% to 11%

Price/Cost Analysis--Alaska vs. Lower 48

- analysis based on Aetna customer data as recorded in claim payment system
- data based on submitted charges and therefore not affected by plan design differences
- data *not* adjusted for impact of variables such as claimant demographics, intensity of illness, or case mix

• **Reasonable & Customary Charges--AK vs. National**
(analysis as of February 1990--comparison of submitted charges at the 85th percentile level)

--Alaska charge levels were higher than U.S. average in all 5 profiled expense areas -- range was +10% (radiology) to +42% (non-surgical physician services)

--Surgery charges were 23% above national average and laboratory charges were 18% above national average

• **Physician charges--Non-surgical services**
(based on review of 8 common medical services, including office and hospital visits and consultations -- data as of 8-31-91)

--On average Alaska charges are 33% higher than Washington State (range of +16- +48%)

--On average Alaska charges are 54% higher than U.S. national average (range of +37-- +114%)

• **Physician charges --Surgical Services**
(based on review of 15 frequently-performed surgical services-- data as of 8-31-91)

--Alaska charges higher than U.S. average national charge for 11 of 15 procedures

• **Hospital Costs -- Average Charge Per Day**
(based on 1990 calendar year data)

--average cost per day in Alaska is 17% higher than the National average cost per day of confinement; cost includes both room & board and ancillary costs

• **Hospital Utilization**

(based on 1990 calendar year data)

--both admissions per 1000 employees as well as days of confinement per 1000 employees are marginally higher in Alaska than in the lower 48; rates for both utilization indicators are decreasing in both Alaska and nationally, that at a lesser rate in Alaska compared to the lower 48

APPENDIX H

"Retention and Attraction of Practitioners in Rural Alaska"

presented to the Health Resources and Access Task Force

by Rodman Wilson, MD, Task Force member

November 18, 1991

Attraction and Retention of Practitioners in Rural Areas

Rural areas of America by and large have always been underserved medically. Small towns have difficulty in recruiting and retaining MDs and other health professionals.

In other states people as a rule can at least drive to a city for care and rural physicians often go 20-60 miles to a town with a hospital to attend their patients if there is no hospital where they practice. In many areas of Alaska neither patients or physicians can do this.

In addition, unlike in most other areas of USA, a dual system of care exists in Alaska: care for Alaska Natives and care for others. This creates special problems in rural areas where it is difficult and wasteful to provide two sets of facilities and personnel.

Table 1. Distribution of physicians in Alaska

~~Table 2. Numbers of physicians by specialty in Alaska~~

Table 2. Proportions of physicians by specialty in USA, Canada, and Alaska.

Table 3. Current needs for physicians in rural Alaska

A. Incentives to practice in small communities:

1. high stature in community
2. less likely to be sued
3. good place to rear children
4. good recreation
5. simpler life

B. Disincentives to practice in small communities:

- | | |
|---------------------------|---------------------------|
| 1. professional isolation | 7. spouse unhappy: |
| 2. on-call all the time | cultural aridity |
| 3. can't get away | few stores |
| 4. can't do OB because of | few jobs |
| exposure/liab ins cost | interpersonal dynamics |
| 5. no local CME | of small towns |
| 6. more no pay/low pay | 8. children disadvantaged |
| patients | if schools are poor |

C. How to improve recruitment and retention:

1. train more FPs and fewer specialists at universities
2. develop community-based family practice residencies (physicians tend to settle where they train)
3. scholarships or loan forgiveness for promise to locate in rural area
4. promote nurse practitioners and physician extenders (but this does not solve vacation coverage for MDs)
5. develop intrastate pool of practitioners for vacation and CME coverage
6. encourage communities to plan and develop realistic array of services & recruit personnel (Amundson)
7. subsidize liability insurance; immunity for selected health services; alter tort law otherwise
8. simplify billing (MDs often do this themselves in small communities to reduce overhead)
9. devise a system that pays for everyone's care (this alone would solve most of the problems above)

Table 1

PHYSICIAN DISTRIBUTION IN ALASKA

As of September 30, 1991

Town	Private Practice	Public Health	Military	Municipal State & Fed.	TOTAL
Adak			4		4
Anchor Point	1				1
Anchorage	359	68	54	15	496
Barrow		6			6
Bethel		17			17
Chugiak	2				2
Cordova	2				2
Craig	1				1
Delta Junction	1				1
Dillingham	1	5			6
Eagle River	10				10
Fairbanks	102	8	33	1	144
Glennallen	2				2
Haines	2				2
Homer	6				6
Juneau	36	5		2	43
Kenai	4				4
Ketchikan	18	4	1		23
Kodiak	13	2	1		16
Kotzebue		6			6
Metlakatla		1			1
Nome		7			7
Palmer	22				22
Petersburg	2				2
Seldovia	1				1
Seward	2				2
Sitka	9	11	1		21
Soldotna	21				21
Talkeetna	1				1
Tok	1				1
Valdez	2				2
Wasilla	11				11
Wrangell	1				1
TOTAL	633	140	94	18	885

Table 2

Proportions of Physicians by Specialty in USA, Canada, & AK

A. Percentage of Physicians in Family Practice USA & Canada

	1985*	1988+
USA	13.1 %	13.3
Canada	51.5	52.8

- * Clare FL, et al. Data watch: trends in health personnel. Health Affairs, Winter, 1987.
 + Canadian Health Insurance: Lessons for the United States. US General Accounting Office, June 1991

B. Numbers of Physicians Giving Patient Care by Specialties
USA 1990^o

primary care)	Family practice	66,418 (13.6%)	) 46%
	Medical specialties includes internal medicine & sub- specialties; pediatrics; OB-Gyn	157,934 (32.4)	
	Surgical specialties except OB-Gyn	128,552 (26.4)	
	Other specialties includes anesthesiology, neurology, psychiatry, radiology, pathology, public health, and others	134,892 (27.6)	
	Total	487,796 (100.0)	

^o American Medical Association

C. Physicians in Private Practice in Alaska by Specialty
Sept 30, 1991

(categories as above)

Family practice	158 (24.7)	) 50%
Medical specialties	161 (25.2)	
Surgical specialties	) 321 (50.1)	
Other specialties		
Total	640 (100.0)	

Alaska State Medical Association

D. USPHS & Native Health Corporation Physicians
Jan 1, 1991

FP/GP	73 (53.7)
Medical specialties	28 (20.6)
Surgical & other specialties	35 (25.7)
	136 100.0

Table ³/₄

Current Needs for Physicians in Rural Alaska
October 1991*

Indian Health Service/Alaska Native Health Corporations
need approx 20 new physicians annually in rural areas
because of rapid turnover.

Private family practice vacancies in Alaska towns:
(information incomplete)

Ketchikan	1	Petersburg	1
Wrangell	1	Haines	1
Craig	1	Juneau	2
Sitka	2	Valdez	1

Note: A group doing OB in Juneau recently stopped; they
were doing 25% of deliveries in Juneau.

* Sources: Thomas Nighswander, MD, USPHS, Anchorage
Thomas H. Wood, MD, Petersburg
Barbara J. Doty, MD, Wasilla

APPENDIX I

"Memo to the Alaska State Legislature,
Health Resources and Access Task Force"

From Jeff Gingold, Blue Cross of Washington and Alaska

January 1992

"Memo to Nancy Cornwell, Project Director,
Health Resources and Access Task Force"

From Phyllis Finn for Jeff Gingold

January 17, 1992



P O Box 327
Seattle, Washington 98111-0327

REPORT

DATE: January, 1992

TO: ALASKA STATE LEGISLATURE
HEALTH RESOURCES AND ACCESS TASK FORCE

FROM: Jeff Gingold
Vice President, General Counsel
BLUE CROSS OF WASHINGTON AND ALASKA

Blue Cross of Washington and Alaska is an independent, non-profit organization licensed as a prepaid health care services contractor in Washington and a hospital and medical services contractor in Alaska. As such, Blue Cross is one of the largest administrators of private and government health care programs in both states.

Committed to responding to the needs of Washington and Alaska residents, Blue Cross is recognized as a leader in the development of integrated and innovative products and services which provide access to quality, affordable health care and benefit programs.

ALASKANS COVERED BY BLUE CROSS OF WASHINGTON AND ALASKA

BCWA covered approximately 81,000 Alaska citizens, including Federal Employees, in 1990. This represented about 30% of the insured population and 20% of the total population.

COVERED ALASKANS
AS OF 12/31/91

(Not including Federal Employees)

<u>CATEGORY</u>	<u>GROUPS</u>	<u>SUBSCRIBERS (EMPLOYEES)</u>	<u>MEMBERS</u>
<u>Individual</u>	-	5,083	10,437
<u>Groups</u>			
5 to 24	245	2,857	5,418
25 to 99	68	3,453	6,002
100+	69	19,057	50,044
<u>GRAND TOTAL</u>	<u>382</u>	<u>30,450</u>	<u>71,901</u>

TRENDS

Source: Noble Lowndes

PRIMARY FACTORS:

- * Inflation - increased cost of medical services
- * Leveraging - reduced buying power of deductibles and coinsurance
- * Cost-shifting - reduced Medicaid and Medicare reimbursements
 - .. RBRVS - statewide versus geographic movement of services from office to institution
 - .. HCFA proposed not to fund hospital bonds
 - .. Federal versus state Medicaid - federal funding to decrease
 - .. HHS regulates referrals by providers to invested business' - increase non-Medicare/Medicaid referrals
- * Anti-Selection - shifting of employees to managed care
- * Technological Advances - increasing costs of equipment and services
- * Social Shifts - requirements to allocate funds for AIDS, psychiatric and substance abuse care
- * Utilization - increasing use of equipment and services

OUT-OF-STATE SERVICES

Alaskans covered by group plans received 22% of their services (measured by cost) out-of-state. Individual (non-group) enrollees received 29% of their care outside of Alaska. The combined total was 23%.

MEDICAL UNDERWRITING

BCWA declines approximately 10% of medically underwritten applications. However, this probably overstates the affects on overall access. Most enrollees are not medically underwritten. Of those who are, individuals declined by one carrier may apply to other carriers. Some will be accepted for coverage; others may be declined more than once and this would be inflate the percentage.

DEPENDENT COVERAGE
(Group Contracts)

On average, BCWA covered approximately 2.4 members (people) per contract (employee/subscriber) in Alaska compared to 1.8 members per contract in Washington. This equates to 1.4 dependents per subscriber.

The following are eligible to be enrolled as dependent children:

- . a natural child of the subscriber or spouse
- . an adopted child of the subscriber or spouse
- . a legally designated minor ward of the subscriber or spouse that meets BCWA's legal guardianship criteria
- . a child that has been physically placed with the subscriber, in accordance with state law, for the purpose of adoption.

Eligible children must also be under 23 years old, unmarried, and claimed as dependents on the subscriber's federal income tax return. However, if an otherwise eligible child does not qualify to be claimed as a dependent on the subscriber's federal income tax return, that child will be eligible if the subscriber or subscriber's eligible spouse is required by court order to provide health care coverage for that child. An optional eligibility provision for experience-rated groups covers dependent children until age 19 and then from age 19 to age 23 if the dependent child is a full-time student attending an accredited educational institution. Coverage may continue past the limiting age for an unmarried dependent child who cannot support himself or herself because of a developmental or physical disability, providing we are provided with proof of the child's disability and dependent status.

Any care connected with a dependent child's pregnancy is excluded except for care furnished in the direct treatment of a complication of pregnancy. Experience-rated groups have the option of providing obstetrical care benefits (pregnancy, childbirth, and related conditions) for dependent children.

Hospital nursery care at birth for a well baby will be covered, provided the mother is an inpatient and is receiving benefits for obstetrical delivery under the contract. Charges for nursery care for a well baby are combined with the mother's hospital charges and benefits are provided under the mother's coverage. The following physician services for well baby care during the initial hospital confinement of the newborn at birth are covered and provided under the enrolled baby's coverage:

- . The initial newborn examination and a second examination performed prior to discharge from the hospital.
- . Circumcision.

Hospital and physician nursery care for an ill baby is covered as any other medical condition under the enrolled baby's coverage.

Outpatient preventive care benefits for children are available to experience-rated groups as an optional provision.

ADVANTAGECARE

Synopsis:

AdvantageCare is a cost containment program designed to promote the most cost-effective setting for medically necessary care. The program consists of a combination of several interrelated Blue Cross services which include:

Preadmission Review: Initial call from a hospital, physician's office staff or enrollee when a nonemergent hospital admission is planned. During the call a determination is made regarding the medical necessity of the inpatient level of care.

Admission Review: Call initiated after an urgent or emergent admission has taken place. The inpatient admission is reviewed for medical necessity and appropriateness of the inpatient level of care.

Length of Stay Assignments: At the time of preadmission or admission review the AdvantageCare nurse assigns a target "length of stay", or number of inpatient days initially approved for the proposed treatment plan. Assignment of a length of stay is automated and is per the Professional Activity Study (PAS) 50th percentile, Western Region, with some modifications indicated by local Blue Cross experience.

Concurrent Review: Telephonic review with the hospital occurs when the enrollee remains in the hospital beyond the initial assigned length stay. Concurrent review is focused so that the process can be individualized depending on the cost saving mechanisms the hospital currently utilizes. Once the medical necessity of the enrollee's continued stay is established, another length of stay is assigned based on the information received regarding the plan of care. When appropriate, the case is referred to Individual Case Management.

Individual Case Management: AdvantageCare nurses identify case situations in which intervention may provide a more cost-effective and care-effective alternative. Any alternatives proposed are discussed further with the discharge planner, the enrollee, and their physician.

BESTBEGINNINGS

Synopsis:

BestBeginnings is a prenatal program designed to help reduce the high dollar costs and complications associated with low birth weight and premature infants by promoting education about prenatal care and encouraging women to adopt healthy life styles.

Enrolled expectant mothers are encouraged to call a BestBeginnings' registered nurse in the first trimester of pregnancy. The caller is interviewed to identify areas of potential problems during the pregnancy. A packet of educational and informational materials is sent to the participant. Follow-up calls are made two weeks after the materials are mailed to see if the information was received and whether there are any questions. The nurse will keep in touch with the expectant mothers throughout pregnancy to educate and support them.

All participants are encouraged to obtain regular maternity care. The BestBeginnings nurse will assist (as needed) the woman to clarify her provider's instructions and explanations. The nurse will support the provider's plan of care. When necessary, the nurse can initiate Individual Case Management through the patient's physician to coordinate needed services. The BestBeginnings program is included in all community-rated group programs as the groups renew and is available as an option for experience-rated groups.

ALASKA STATE MANDATED HEALTH BENEFITS
(Group Contracts)

ALCOHOLISM & DRUG ABUSE TREATMENT
Insurance Law: AS 21.42.365

Synopsis:

Coverage for treatment of alcoholism or drug abuse must provide:

- . benefits of at least \$7,000 over two consecutive benefit years; and lifetime benefits of at least \$14,000

The insurer may not:

- . impose a different deductible or copayment, claim payment methodology, or prenotification of treatment requirement than that used in determining the benefits for treating another covered illness;
- . limit coverage by provisions that are not applicable to other covered major illnesses;
- . limit treatment services to either an inpatient or outpatient service;
- . exclude from coverage the cost of medically necessary treatment received at an approved treatment facility;
- . or deny reimbursement for actual services rendered solely because treatment was interrupted or not completed.

Cost Impact:

Covered expenses for alcoholism/drug abuse treatment represent approximately 2%-3% of the average health care program's total medical benefit payments.

ALASKA STATE MANDATED HEALTH BENEFITS
(Group Contracts)
(Continued)

MAMMOGRAM SCREENING
Insurance Law: AS 21.42.375

Synopsis:

Coverage for low-dose mammography screening must be provided on a basis that is not less favorable than for other radiological examinations. The minimum coverage required includes:

- . a baseline mammogram for a person who is at least 35 years of age but less than 40 years of age;
- . one mammogram every two years for a person who is at least 40 years of age but less than 50 years of age;
- . an annual mammogram for a person who is at least 50 years of age;
- . a mammogram at any age for a person with a history of breast cancer or whose parent or sibling has a history of breast cancer, upon referral by physician.

Cost Impact:

Coverage of mammogram screening in our health care programs has resulted in an additional cost of .7% - 1.4%. It is assumed these costs will be partially offset long term by a medical claims savings resulting from this screening procedure.

ALASKA STATE MANDATED HEALTH BENEFITS
(Group Contracts)
(Continued)

COVERED PROVIDERS

Insurance Law: AS 21.36.090(d)

Synopsis:

Benefits must be provided without discrimination for services rendered within the scope of his-her occupational license by a state licensed physician (M.D.), dentist, osteopath, optometrist, chiropractor, nurse midwife, advanced nurse practitioner, naturopath, physical therapists, or occupational therapist.

Cost Impact:

Cost impact varies depending on which provider type is being analyzed. The following are examples of cost impact (as a percentage of medical expenses) for various provider types:

Chiropractor	2%-3%
Naturopath	.1%
Physical/Occupational Therapist	.5%
Physician (including osteopath & podiatrist)	28%
Psychologist/psychiatrist	1%-2%
Optometrist (including ophthalmologist for routine vision exams)	34%
Dentist	15%-16%

1990 AVERAGE CHARGE COMPARISON

Source: Blue Cross and Blue Shield Association

CPT4 CODES	ALASKA REGIONS				TOTAL ALASKA	TOTAL WASH	NATL	
	01	02	03	04				
PHYSICIAN OFFICE-NEW PATIENT								
90015	Intermediate	\$80	\$113	\$76	\$128	\$82	\$61	\$51
90020	Comprehensive	141	173	144	245	143	117	90
PHYSICIAN OFFICE-ESTABLISHED PATIENT								
90060	Intermediate	59	70	58	77	61	44	38
90080	Comprehensive	124	173	124	188	130	96	73
HOSPITAL MEDICAL SERVICES								
90220	Initial, Comprehen	189	202	202	275	195	140	124
90250	Subsequent Visit	64	63	59	80	64	46	52
CONSULTATIONS								
90620	Initial, Comprehen	181	198	180	375	183	147	134
PSYCHOTHERAPY								
90844	Individual 45-50 minutes	93	101	79	59	92	85	87

1990 AVERAGE CHARGE COMPARISON

Source: Blue Cross and Blue Shield Association

CPT4 CODES	ALASKA	WASHINGTON	NATIONAL
INTEGUMENTARY			
10060 Incision & Drainage Abscess	\$60	\$47	\$63
11100 Biopsy of Skin, One Lesion	83	61	68
19120 Excision Benign Breast Tumor	669	469	483
MUSCULOSKETETAL			
20610 Arthrocentesis, Major Joint	79	48	56
29881 Arthroscopy, w/Biopsy, Flexible	1,974	1,597	1,547
RESPIRATORY			
31625 Bronchoscopy, w/Biopsy, Flexib	593	492	465
CARDIOVASCULAR			
33513 Coronary, Artery Bypass, 4 Art	7,500	5,373	4,841
92982 Coronary Angioplasty	2,118	1,708	1,807
DIGESTIVE			
43235 Upper GI Endoscopy	435	379	415
44950 Appendectomy	1,276	888	799
45300 Proctosigmoidoscopy, Diagnosti	79	66	76
MALE GENITAL			
55700 Needle Biopsy of Prostate	373	161	232
FEMALE GENITAL			
58120 Dilation & Curettage	507	437	466
58150 Total Hysterectomy	2,112	1,882	1,554
MATERNITY			
59400 Normal Delivery w/Pre & Postna	1,492	1,884	1,588
OTHER			
72131 CT Scan - Spine	205	216	261
72141 MRI - Spine	453	630	574

Blue Cross of Washington and Alaska
Summary of Institutional Inpatient Admissions by Diagnosis Category
Alaska Subscribers
Incurred from 01/90 through 09/90

Diagnosis Category	Diagnosis Descriptions	Average Length of Stay	Eligible Charge per Admit	Eligible Charge per Day	Admits per 1000 Members	Days per 1000 Members	Elig Chrg per 1000 Members
001 - 139	Diseases - Infective/Parasitic	6.10	\$9,124	\$1,497	0.81	4.95	\$7,414
140 - 239	Neoplasms	5.58	\$9,138	\$1,639	2.36	13.16	\$21,563
240 - 279	Diseases - Endocrine, Nutritional, Metabolic	3.13	\$4,290	\$1,372	0.73	2.30	\$3,151
280 - 289	Diseases - Blood/Blood Organ	2.45	\$3,312	\$1,349	0.17	0.42	\$569
290 - 319	Mental Disorders	14.47	\$6,993	\$483	3.28	47.49	\$22,948
320 - 389	Diseases - Nervous Systems/Sense Organs	3.78	\$4,583	\$1,212	0.78	2.95	\$3,581
390 - 459	Diseases - Circulatory System	5.09	\$11,012	\$2,163	3.27	16.63	\$35,965
460 - 519	Diseases - Respiratory System	3.42	\$4,554	\$1,331	2.92	10.00	\$13,307
520 - 579	Diseases - Digestive System	4.17	\$6,237	\$1,494	3.84	16.05	\$23,976
580 - 629	Diseases - Genitourinary System	3.15	\$4,928	\$1,565	2.63	8.27	\$12,937
630 - 679	Delivery/Complications of Preg/Birth	3.31	\$3,858	\$1,166	10.58	34.99	\$40,811
680 - 709	Diseases - Skin/Subcutaneous Tissue	3.89	\$4,482	\$1,151	0.30	1.16	\$1,331
710 - 739	Diseases - Musculoskeletal System	3.98	\$6,494	\$1,632	2.27	9.02	\$14,715
740 - 759	Congenital Anomalies	2.65	\$5,878	\$2,215	0.41	1.08	\$2,388
760 - 779	Diseases Peculiar to Newborn Infants	10.26	\$18,682	\$1,822	0.67	6.89	\$12,554
780 - 799	Symptoms and Ill-defined Conditions	2.95	\$4,264	\$1,448	2.30	6.77	\$9,796
800 - 999	Injury and Adverse Effects	4.17	\$7,106	\$1,704	3.69	15.38	\$26,208
9--	Supplementary Classification	6.45	\$11,333	\$1,757	1.08	6.95	\$12,220
Total		4.86	\$6,307	\$1,298	42.08	204.45	\$265,434

SMALL GROUP MARKET

Blue Cross of Washington and Alaska Community rates groups of 5 to 99 employees.

Groups of 5 to 14 employees are medically underwritten (health statement required/proof of good health) on an accept/reject basis for the group. If the group is accepted, the individuals are allocated a risk code and two levels of rates are developed. The first set of rates provide coverage for all individuals. The second set of rates cover only those individuals with acceptable risk codes. The group elects which approach they wish to enroll on.

Groups of 15 to 99 employees are quoted on a guarantee issue basis.

Rates for Community groups are developed from base product rates which are adjusted for group demographics (size, age, sex, area, industry, contribution, participation, dependent content, medical conditions, etc.) trend, workplace smoking policy, HMO availability, duration of coverage, experience and expenses. Each group will have a unique rate under this rating approach.

January 17, 1992

VIA FACSIMILE

TO: Nancy Cornwell, Project Director
Health Resources and Access Task Force

FROM: Phyllis Finn
for Jeff Gingold

SUBJECT: RESPONSE TO YOUR QUESTIONS

Jeff Gingold asked that I get this response to you today by FAX as he had to be absent from the office and you would be expecting this response from BCWA.

1. The federal employees in the State of Alaska have approximately thirteen carriers from which to choose their medical coverage each year. Blue Cross Blue Shield Service Benefit Plan is one of the options. There are 18,763 federal employees in Alaska. Out of that number we have a total of 7,286 or 39% as of April 1991. Our Open Season gains have brought this number of enrolled up to 7,488 as of January 10, 1992.
2. For Alaskans covered by group plans that receive their services out-of-state, Blue Cross has no way of knowing whether the member happened to be out-of-state when a medical condition that needed attention came up or if a trip was made expressly to seek medical services out-of-state. Either way, all services would have to be "medically necessary" to be covered. We would have no way of determining if these out-of-state services were for acute care only---we would surmise many are covered students at out-of-state schools or working out-of-state. This would also encompass the Alaskan who lives in another state for part of each year or is traveling or on vacation. So, basically, the response would be that no, all out-of-state services are not for acute care only.
3. What size groups does BCWA use medical underwriting and how many in this group? BCWA medically underwrites groups size 5 - 14. There are 168 groups in this category; 1,403 subscribers (employees) or 2,695 members.
4. BCWA does not use DRGs in our claims payment. For this reason we would not be able to furnish you with any comparisons for Washington State. On the national level, if it would be helpful to you, we could check with other Blue Cross Blue Shield plans across the country and ask if any of them have any DRG charts available that could be used for a comparison. Please let us know if this would be useful for you to have.

5. In attempting to respond to your question on how Alaska compares to Alaska for overall charges, physician and hospital charges, etc., our data indicates that physician charges are generally higher in Alaska than in Washington.

It is more difficult to compare average hospital costs and lengths of stay because of differences in the way data is accumulated. Averages can be misleading because of variations in case mix (diagnoses of different complexity groups together, complications for specific diagnoses, and physician condition of patients), and variations in types of institutional providers between the two states.

Subject to these disclaimers, our data shows that institutional costs per day appear higher in Alaska, but length of stay appears longer in Washington.

pf

APPENDIX J

Health Care Legislation Under Consideration
By the Health Resources and Access Task Force

HOUSE CS FOR CS FOR SENATE BILL NO. 44 (STATE AFFAIRS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY THE HOUSE STATE AFFAIRS COMMITTEE

Offered: 5/17/91

Referred: Finance

Sponsor(s): SENATORS KERTTULA, Pourchot, Duncan

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to the establishment and operation of state veterans' home facilities; and
2 providing for an effective date."

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

4 * Section 1. PURPOSE. The purpose of this Act is to direct the Department of Military and
5 Veterans' Affairs to establish and operate state veterans' homes in a manner that would make them
6 eligible for the maximum amount of federal funds.

7 * Sec. 2. AS 18.07.111(9) is amended to read:

8 (9) "health care facility" means a private, municipal, state, or federal hospital,
9 psychiatric hospital, tuberculosis hospital, skilled nursing facility, kidney disease treatment center
10 (including freestanding hemodialysis units), intermediate care facility, and ambulatory surgical
11 facility; the term excludes

12 (A) an Alaska Pioneers' Home administered by the Department of
13 Administration under AS 44.21.020(10) and AS 47.55; [AND]

14 (B) the offices of private physicians or dentists whether in individual or

1 group practice; and

2 (C) a state veterans' home administered by the Department of

3 Military and Veterans' Affairs;

4 * Sec. 3. AS 44.35.020 is amended by adding a new subsection to read:

5 (c) The Department of Military and Veterans' Affairs shall apply for federal assistance
6 to establish and operate state veterans' home facilities. The department, within available funds,
7 shall establish and operate veterans' homes in the Matanuska-Susitna Valley area and at other
8 sites designated by the adjutant general.

9 * Sec. 4. This Act takes effect immediately under AS 01.10.070(c).

SENATE BILL NO. 45

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATOR KERTTULA

Introduced: 1/21/91

Referred: State Affairs and Finance

Funding Information: General Fund \$3,000,000

Other Funds -0-

\$3,000,000

A BILL

FOR AN ACT ENTITLED

1 "An Act making an appropriation to the Department of Administration for establishment
2 of a state veterans' home; and providing for an effective date."

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

4 * Section 1. The sum of \$3,000,000 is appropriated from the general fund to the Department of
5 Administration for the state share of the cost of applying for federal funds, conducting a feasibility study
6 for a state veterans' home, acquiring land for a state veterans' home, and planning, designing, and
7 constructing or otherwise acquiring a state veterans' home.

8 * Sec. 2. The appropriation made by this Act is for a capital project and is subject to lapse under
9 AS 37.25.020.

10 * Sec. 3. This Act takes effect on the effective date of an Act enacted by the Seventeenth Alaska
11 State Legislature directing the Department of Administration to establish and operate a state veterans'
12 home.

HOUSE CS FOR CS FOR SENATE BILL NO. 67 (FINANCE)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY THE HOUSE FINANCE COMMITTEE

Offered: 5/21/91

Referred: Rules

Sponsor(s): SENATORS JONES, Zharoff, Menard, Hoffman

REPRESENTATIVE Taylor

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to state aid for health facilities; and providing for an effective date."

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

3 * Section 1. AS 18.25 is amended by adding new sections to read:

4 Sec. 18.25.011. GRANT APPLICATIONS. (a) On or before June 15, a person,
5 including a municipality, may submit a grant application to the department for a health facility
6 construction grant.

7 (b) A project for which a certificate of need is required under AS 18.07.031 - 18.07.111
8 at the time of the grant application is not eligible for a grant under AS 18.25.011 - 18.25.035
9 unless a certificate has been issued to the health facility that is the subject of the application, and
10 the certificate is in effect at the time of the application.

11 (c) A project is not eligible for a grant under AS 18.25.011 - 18.25.035 unless the
12 applicant has submitted a five-year master plan for the construction of the health facility on or
13 before September 1 of the fiscal year in which the application is submitted; the master plan must
14 include a description of the applicant's fixed asset inventory system and preventive maintenance

1 program, a detailed scope of work, an estimated project budget, an operation, maintenance, and
2 financial feasibility study, and a documentation of the conditions justifying the project, including
3 a signed statement by an architect or engineer verifying any code violation documented in the
4 plan.

5 (d) The grant application must include

6 (1) evidence that the applicant has secured and will maintain adequate property
7 loss insurance for the replacement cost of the health facility or a program of insurance acceptable
8 to the department; and

9 (2) evidence acceptable to the department that the proposed project is a capital
10 construction project and not part of a preventive maintenance program or regular custodial care
11 program.

12 Sec. 18.25.013. HEALTH FACILITIES REVIEW BOARD ESTABLISHED. (a) There
13 is created in the Department of Health and Social Services the Health Facilities Review Board
14 composed of seven members consisting of the following persons appointed by the governor and
15 who serve at the pleasure of the governor:

16 (1) an architect licensed under AS 08.48;

17 (2) an engineer licensed under AS 08.48;

18 (3) a representative nominated by the Alaska Municipal League;

19 (4) a representative from the department;

20 (5) a representative of a health facility;

21 (6) a representative of the Alaska Area Native Health Service; and

22 (7) a representative of the office of management and budget in the Office of the

23 Governor.

24 (b) To the extent possible and except for the board members described under (a)(4) and
25 (7) of this section, the board members must be representative of all areas of the state.

26 (c) The members serve for staggered terms of three years.

27 (d) The members of the board shall elect a member of the board as chair.

28 (e) The board shall hold at least one meeting each year. The board may hold additional
29 meetings at the call of the chair or of a majority of the board members.

30 Sec. 18.25.015. BOARD DUTIES. (a) The board shall annually

31 (1) review the master plans submitted by applicants under AS 18.25.011;

(2) with regard to the plans reviewed under (1) of this subsection, establish and transmit to the department a revised and updated five-year construction grant schedule that establishes the priorities among the proposed health facility construction projects and serves the best interest of the state and the municipality or area in which the health facility is located.

(b) The primary criteria for establishing the priorities under (a) of this section are

(1) the degree of threat to the health or safety of facility occupants; and

(2) the degree of potential harm to building integrity as it affects the building's ability to support health care functions in a cost-effective manner.

(c) The board shall establish by regulation additional criteria for establishing the priorities under (a) of this section. The criteria must include at least the following factors:

(1) the ability of the project or project phase to be self-supporting;

(2) access to other sources of funding, including funding from the parent corporation of the health facility, if applicable;

(3) the overall capital requirements and operating cost efficiency over the lifetime of the facility;

(4) the community or area need for the facility as compared to alternative means for providing the care;

(5) the level of care required to provide basic cost effective and efficient health services;

(6) the effect of the grant award on the overall position of the applicant as compared to health facilities that are not eligible to receive grants under AS 18.25.011 - 18.25.035.

(d) The board may reject a grant application and omit it from the construction grant schedule if

(1) the applicant provides incomplete information or documentation on the project;

(2) the board determines that existing facilities can adequately serve the program requirements, or that an alternative project is in the best interests of the state; or

(3) the board determines that the project is not in the best interests of the state or the municipality or area in which the health facility is located.

Sec. 18.25.017. DEPARTMENT ACTION. (a) Before a grant application is submitted to the board, the department shall verify the amounts and reasons for the items in the budget for

1 each grant application.

2 (b) With regard to the construction grant schedule established by the board under
3 AS 18.25.015, the department shall transmit the construction grant schedule, including the
4 budgets verified under (a) of this section, to the governor by October 15 of each year and to the
5 legislature within the first 10 days of each regular legislative session.

6 Sec. 18.25.019. PUBLIC NOTICE AND HEARING. On or before July 15 of each year,
7 the department shall provide public notice of the grant applications made under AS 18.25.011
8 and the priorities established under AS 18.25.015. After public notice has been given, the
9 department shall, not later than August 15 of each year, hold a public hearing on the priorities
10 established under AS 18.25.015. In this section, "public notice" means notice published in a
11 newspaper of general circulation and notice to each person who has requested notice about the
12 grant requests from the department.

13 Sec. 18.25.021. AWARD. (a) The department shall award grants in the order of the
14 projects' priorities on the date the appropriation bill funding the health facility construction grant
15 fund becomes law, regardless of an administrative or judicial review pending under
16 AS 18.25.023. An administrative or judicial review pending under AS 18.25.023 at the time that
17 grants are awarded may not delay the funding of grants.

18 (b) If a project is assigned a new priority ranking under AS 18.25.023 after the date the
19 appropriation bill for the health facility construction grant fund becomes law, a grant shall be
20 awarded for the project in accordance with the new priority ranking at the next time that health
21 facility construction grants are awarded under AS 18.25.011 - 18.25.035.

22 Sec. 18.25.023. ADMINISTRATIVE AND JUDICIAL REVIEW. (a) An applicant
23 under AS 18.25.011 may not request reconsideration of a decision of the board unless the request
24 is based on reasonable issues of fact or law. The request must be in writing and include a
25 statement of the specific changes desired, and a summary of the evidence supporting the
26 applicant's claim that the board has erred in its review of the applicant's grant application. A
27 request for reconsideration must be submitted to the board by the first day of the public hearing
28 held under AS 18.25.019. The board shall review its decision on the basis of the request by the
29 applicant and determine whether its decision should be changed. The board shall issue its
30 determination in writing within 15 days after the last day of the public hearing held under
31 AS 18.25.019.

1 (b) An applicant under AS 18.25.011 may appeal an adverse decision of the board under
2 (a) of this section by filing a written notice of appeal with the commissioner within 15 days after
3 the date of the board's decision. The notice of appeal must state the legal and factual basis for
4 the appeal and the precise relief sought. The failure of the applicant to include an issue in a
5 notice of appeal constitutes a waiver of the right to have the issue considered. Not later than 10
6 days after receipt of a notice of appeal, the commissioner shall appoint a hearing officer who is
7 qualified under AS 44.62.350(c) to consider the appeal. If the hearing officer finds that the
8 notice of appeal does not raise a reasonable issue of fact or law, the hearing officer shall issue
9 a written decision denying the appeal. Denial of an appeal by a hearing officer is a final decision
10 that may be appealed under (d) of this section. If the hearing officer finds that the notice of
11 appeal raises a reasonable issue of fact or law, the hearing officer shall conduct a hearing on
12 those issues and recommend a decision to the commissioner. The hearing officer shall issue a
13 decision on the appeal not later than 60 days after being appointed. The commissioner shall
14 consider the recommended decision of the hearing officer within 10 days after receipt and may
15 adopt all, part, or none of the recommended decision or may remand the issue to the hearing
16 officer for further hearings. The commissioner shall issue a decision in writing within 10 days
17 after consideration of the hearing officer's decision.

18 (c) The hearing officer may consolidate appeals under (b) of this section if the notices
19 of appeal raise related issues of fact or law.

20 (d) An applicant under AS 18.25.011 may appeal an adverse decision of a hearing officer
21 or the commissioner under (b) of this section to the superior court in the manner provided by
22 AS 44.62.560 - 44.62.570 and the Alaska Rules of Appellate Procedure.

23 (e) The board shall adopt regulations governing procedures for the reconsideration and
24 appeal of decisions under (a) - (c) of this section. The regulations adopted under this subsection
25 are not required to conform to AS 44.62.330 - 44.62.630, but must be consistent with minimum
26 standards of due process.

27 (f) An applicant under AS 18.25.011 may not request reconsideration of or appeal a
28 priority determination on the grounds that a revised priority assigned to another project, due to
29 a reconsideration or appeal under this section, has resulted in a lower priority being accorded to
30 the applicant's project.

31 Sec. 18.25.025. GRANT AGREEMENT AND CONDITIONS. (a) The department shall

1 enter into a written agreement with the grantee before it distributes grant funds under
2 AS 18.25.011 - 18.25.035.

3 (b) The department shall require in the grant agreement that the grantee

4 (1) agree to construction of the health facility as described by the certificate of
5 need, if any, issued to the facility under AS 18.07.031 - 18.07.111;

6 (2) provide reasonable assurance by a means acceptable to the department that
7 the cost of the project will be uniform with the costs of the most current construction projects
8 in the area;

9 (3) agree to submit to the department for department approval a description and
10 justification of a cost overrun before the grantee agrees to pay for the overrun and before the
11 department distributes money to the grantee to pay for the overrun;

12 (4) agree to place the grant funds in an interest-bearing account and not to use
13 the interest or the grant funds for a purpose other than the project;

14 (5) agree to limit equipment purchases to that required for the facility operation;

15 (6) submit project budgets for department review and agree that the grant amount
16 may, at the discretion of the department, be reduced or increased by amounts equal to the
17 amounts by which contracts vary from the budget amounts approved by the department;

18 (7) submit to the department for approval, before advertising for bids for the
19 construction contract, a plan for construction that includes specifications, final construction
20 drawings, and proposed contract documents;

21 (8) submit for department review a tabulation of all bids received, a complete
22 copy of the lowest bid, a copy of the proposed notice to proceed with construction, and a copy
23 of the proposed construction contract;

24 (9) submit for department review and acceptance documentary evidence that the
25 project is being accomplished in accordance with all the assertions in the grantee's five-year
26 master plan and grant application;

27 (10) submit sufficient assurances that the project will be used for the stated
28 purposes of the grant for the expected useful lifetime of the facility;

29 (11) agree to conform to all applicable governmental codes and standards,
30 including the most recently adopted state statutes and regulations on building, health, mechanical,
31 electrical, fire, safety, and handicap accessibility, and those covering the planning, construction,

1 and operation of the health facility;

2 (12) agree to comply with

3 (A) the department's single audit requirements;

4 (B) AS 37.05.321, prohibiting the use of grant funds and earnings to
5 influence legislative action;

6 (C) the reporting requirements of AS 36.05 and AS 36.10; and

7 (D) 42 U.S.C. 2000a - 2000h-6 (Civil Rights Act of 1964), 29 U.S.C. 621-
8 634 (Age Discrimination in Employment Act of 1967), 7 U.S.C. 2027 (Food Stamp Act
9 of 1977), and the department's requirements for implementation of the federal statutes
10 listed in this subparagraph;

11 (13) identify anticipated operating costs and revenue and the sources of funding
12 that may be requested if costs exceed projected revenue;

13 (14) complete the project in a timely manner to a fully functional condition and
14 submit periodic status reports not less than every six months to the department detailing work
15 completed to date, a summary of expenditures compared with the approved budget, and an
16 explanation of any deviation from the approved work, schedule, or budget; and

17 (15) agree to comply with other requirements that the department, notwithstanding
18 AS 37.05.318, may reasonably impose on grantees and that are necessary to meet the intent of
19 the grant.

20 (c) Except as provided under (b) or (d) of this section, a cost of construction for a health
21 facility may be paid under a grant awarded under AS 18.25.021 without regard to whether the
22 cost was incurred before the

23 (1) award of the grant; or

24 (2) effective date of an appropriation to the health facility construction grant fund
25 for the year in which the grant is funded.

26 (d) The maximum percentage of the costs of planning and designing, including
27 engineering, that are incurred before awarding a grant and that may be paid under the grant may
28 not exceed 15 percent.

29 (e) The grantee may not satisfy more than five percent of the grantee's share of the total
30 cost of the health facility with items other than cash.

31 (f) Except as limited by (e) of this section, the fair market value of land acquisition and

1 site preparation may be included in the grantee's share of the total cost of the health facility.
2 The fair market value shall be determined as of the date when the grant application is submitted
3 under AS 18.25.011.

4 (g) The direct expenses of the grantee to administer the project may not exceed 10
5 percent of the grant.

6 Sec. 18.25.027. GRANT APPROPRIATIONS. Within the general appropriation bill
7 submitted to the legislature under AS 37.07.020, the governor shall include an appropriation for
8 health facility construction grants in the succeeding fiscal year as determined by the priority list
9 and budgets transmitted to the governor under AS 18.25.017.

10 Sec. 18.25.029. AMOUNT OF GRANTS. For each project included in a grant awarded
11 under AS 18.25.021, the state shall pay 75 percent of the total costs of construction incurred for
12 the project by the grantee during the fiscal year for which the grant is made.

13 Sec. 18.25.031. DISTRIBUTION OF GRANT. After the effective date of the agreement
14 for a grant under AS 18.25.011 - 18.25.035, the department shall advance 20 percent of the grant
15 to the grantee. The department shall base subsequent payments from the grant on payment
16 requests submitted by the grantee for the costs of construction incurred by the grantee for the
17 grant project. The department may not make a further payment under the grant until the grantee
18 has exhausted the advance.

19 Sec. 18.25.033. HEALTH FACILITY CONSTRUCTION GRANT FUND. The health
20 facility construction grant fund is created as an account in the general fund. The fund shall be
21 used to make grants under AS 18.25.011 - 18.25.035 for the costs of construction of health
22 facilities. Legislative appropriations under AS 18.25.011 - 18.25.035 for the costs of construction
23 of health facilities shall be deposited in the fund.

24 Sec. 18.25.035. DEFINITIONS. In AS 18.25.011 - 18.25.035,

25 (1) "board" means the Health Facilities Review Board;

26 (2) "costs of construction" means the cost of acquiring, constructing, enlarging,
27 repairing, remodeling, equipping, or furnishing health facilities and includes the total of all costs
28 of financing and carrying out the project, including

29 (A) the cost of necessary studies, surveys, plans and specifications,
30 architectural, engineering and other special services, the acquisition of real property, site
31 preparator. and development, and the acquisition of machinery and equipment necessary

- 1 for the project;
- 2 (B) the direct expenses of the grantee to administer the project;
- 3 (C) the cost of financing the project, including interest on bonds issued
- 4 to finance the project; and
- 5 (D) the cost of other items, including indemnity and surety bonds and
- 6 premiums on insurance, legal fees, fees and expenses of trustees, depositaries, financial
- 7 advisors, and paying agents for the bonds issued;
- 8 (3) "health facility" means a nursing home or a facility that provides
- 9 hospitalization for inpatient medical and surgical care of acute illness or injury or obstetric care,
- 10 but does not include a nursing home or facility that has more than 200 beds.
- 11 * Sec. 2. AS 18.25.035(3) is repealed and reenacted to read:
- 12 (3) "health facility" means a nursing home or a facility that provides
- 13 hospitalization for inpatient medical and surgical care of acute illness or injury or obstetric care.
- 14 * Sec. 3. AS 18.25.100 is repealed and reenacted to read:
- 15 Sec. 18.25.100. REGULATIONS. The department shall adopt regulations to implement
- 16 this chapter.
- 17 * Sec. 4. AS 46.11.900(7) is amended to read:
- 18 (7) "state financial assistance" means a loan, grant, guarantee, insurance, payment,
- 19 rebate, subsidy, or other form of state assistance other than aid under AS 05.35.010 - 05.35.070,
- 20 AS 14.11, AS 18.25.011 - 18.25.035, and AS 29.60, including the purchase by a state agency of
- 21 a loan to finance the construction or purchase of a residential building;
- 22 * Sec. 5. AS 18.25.010, 18.25.020, 18.25.030, 18.25.070, 18.25.080, 18.25.090, and 18.25.110 are
- 23 repealed.
- 24 * Sec. 6. Section 2 of this Act takes effect July 1, 1996.
- 25 * Sec. 7. Except as provided in sec. 6, this Act takes effect July 1, 1991.

CS FOR HOUSE BILL NO. 214 (HES)**IN THE LEGISLATURE OF THE STATE OF ALASKA****SEVENTEENTH LEGISLATURE - FIRST SESSION****BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE**

Offered: 4/5/91

Referred: Finance

Sponsor(s): REPRESENTATIVES DAVIDSON, Kubina, Koponen, C.Davis, Taylor, Gonzales

A BILL**FOR AN ACT ENTITLED**

1 "An Act relating to state aid for nonprofit health facilities; and providing for an effective
2 date."

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

4 * Section 1. AS 18.25 is amended by adding new sections to read:

5 Sec. 18.25.011. GRANT APPLICATIONS. (a) On or before June 15, a municipality
6 or a nonprofit organization may submit a grant application to the department for a nonprofit
7 health facility construction grant.

8 (b) A project for which a certificate of need is required under AS 18.07.031 - 18.07.111
9 at the time of the grant application is not eligible for a grant under AS 18.25.011 - 18.25.035
10 unless a certificate has been issued to the health facility that is the subject of the application, and
11 the certificate is in effect at the time of the application.

12 (c) A project is not eligible for a grant under AS 18.25.011 - 18.25.035 unless the
13 applicant has submitted a five-year master plan for the construction of the health facility on or
14 before September 1 of the fiscal year in which the application is submitted; the master plan must

1 include a description of the applicant's fixed asset inventory system and preventive maintenance
2 program, a detailed scope of work, an estimated project budget, an operation, maintenance, and
3 financial feasibility study, and a documentation of the conditions justifying the project, including
4 a signed statement by an architect or engineer verifying any code violation documented in the
5 plan.

6 (d) The grant application must include

7 (1) evidence that the applicant has secured and will maintain adequate property
8 loss insurance for the replacement cost of the health facility or a program of insurance acceptable
9 to the department; and

10 (2) evidence acceptable to the department that the proposed project is a capital
11 construction project and not part of a preventive maintenance program or regular custodial care
12 program.

13 Sec. 18.25.013. HEALTH FACILITIES REVIEW BOARD ESTABLISHED. (a) There
14 is created in the Department of Health and Social Services the Health Facilities Review Board
15 composed of seven members consisting of the following persons appointed by the governor and
16 who serve at the pleasure of the governor:

17 (1) an architect licensed under AS 08.48;

18 (2) an engineer licensed under AS 08.48;

19 (3) a representative nominated by the Alaska Municipal League;

20 (4) a representative from the department;

21 (5) a representative of a nonprofit health facility;

22 (6) a representative of the Alaska Area Native Health Service; and

23 (7) a member of the general public.

24 (b) The members serve for staggered terms of three years.

25 (c) The members of the board shall elect a member of the board as chair.

26 (d) The board shall hold at least one meeting each year. The board may hold additional
27 meetings at the call of the chair or of a majority of the board members.

28 Sec. 18.25.015. BOARD DUTIES. (a) The board shall annually

29 (1) review the master plans submitted by applicants under AS 18.25.011;

30 (2) with regard to the plans reviewed under (1) of this subsection, establish and
31 transmit to the department a revised and updated five-year construction grant schedule that

1 establishes the priorities among the proposed health facility construction projects and serves the
2 best interest of the state and the municipality or area in which the health facility is located.

3 (b) The board shall establish by regulation its criteria for establishing the priorities under
4 (a) of this section. The criteria must include at least the following factors:

- 5 (1) the degree of threat to the health or safety of facility occupants;
- 6 (2) the degree of potential harm to building integrity as it affects the building's
7 ability to support health care functions in a cost effective and efficient manner;
- 8 (3) the ability of the project or project phase to be self-supporting;
- 9 (4) access to other sources of funding;
- 10 (5) the overall capital requirements and operating cost efficiency over the lifetime
11 of the facility;
- 12 (6) the community or area need for the facility as compared to alternative means
13 for providing the care;
- 14 (7) the level of care required to provide basic cost effective and efficient health
15 services;
- 16 (8) the effect of the grant award on the overall position of the applicant as
17 compared to health facilities that are not eligible to receive grants under AS 18.25.011 -
18 18.25.035.

19 (c) The board may reject a grant application and omit it from the construction grant
20 schedule if

- 21 (1) the applicant provides incomplete information or documentation on the project;
- 22 (2) the board determines that existing facilities can adequately serve the program
23 requirements, or that an alternative project is in the best interests of the state; or
- 24 (3) the board determines that the project is not in the best interests of the state
25 or the municipality or area in which the health facility is located.

26 Sec. 18.25.017. DEPARTMENT ACTION. (a) Before a grant application is submitted
27 to the board, the department shall verify the amounts and reasons for the items in the budget for
28 each grant application.

29 (b) With regard to the construction grant schedule established by the board under
30 AS 18.25.015, the department shall transmit the construction grant schedule, including the
31 budgets verified under (a) of this section, to the governor by October 15 of each year and to the

1 legislature within the first 10 days of each regular legislative session.

2 Sec. 18.25.019. PUBLIC NOTICE AND HEARING. On or before July 15 of each year,
3 the department shall provide public notice of the grant applications made under AS 18.25.011
4 and the priorities established under AS 18.25.015. After public notice has been given, the
5 department shall, not later than August 15 of each year, hold a public hearing on the priorities
6 established under AS 18.25.015. In this section, "public notice" means notice published in a
7 newspaper of general circulation and notice to each person who has requested notice about the
8 grant requests from the department.

9 Sec. 18.25.021. AWARD. (a) The department shall award grants in the order of the
10 projects' priorities on the date the appropriation bill funding the nonprofit health facility
11 construction grant fund becomes law, regardless of an administrative or judicial review pending
12 under AS 18.25.023. An administrative or judicial review pending under AS 18.25.023 at the
13 time that grants are awarded may not delay the funding of grants.

14 (b) If a project is assigned a new priority ranking under AS 18.25.023 after the date the
15 appropriation bill for the nonprofit health facility construction grant fund becomes law, a grant
16 shall be awarded for the project in accordance with the new priority ranking at the next time that
17 nonprofit health facility construction grants are awarded under AS 18.25.011 - 18.25.035.

18 Sec. 18.25.023. ADMINISTRATIVE AND JUDICIAL REVIEW. (a) An applicant
19 under AS 18.25.011 may not request reconsideration of a decision of the board unless the request
20 is based on reasonable issues of fact or law. The request must be in writing and include a
21 statement of the specific changes desired, and a summary of the evidence supporting the
22 applicant's claim that the board has erred in its review of the applicant's grant application. A
23 request for reconsideration must be submitted to the board by the first day of the public hearing
24 held under AS 18.25.019. The board shall review its decision on the basis of the request by the
25 applicant and determine whether its decision should be changed. The board shall issue its
26 determination in writing within 15 days after the last day of the public hearing held under
27 AS 18.25.019.

28 (b) An applicant under AS 18.25.011 may appeal an adverse decision of the board under
29 (a) of this section by filing a written notice of appeal with the commissioner within 15 days after
30 the date of the board's decision. The notice of appeal must state the legal and factual basis for
31 the appeal and the precise relief sought. The failure of the applicant to include an issue in a

1 notice of appeal constitutes a waiver of the right to have the issue considered. Not later than 10
2 days after receipt of a notice of appeal, the commissioner shall appoint a hearing officer who is
3 qualified under AS 44.62.350(c) to consider the appeal. If the hearing officer finds that the
4 notice of appeal does not raise a reasonable issue of fact or law, the hearing officer shall issue
5 a written decision denying the appeal. Denial of an appeal by a hearing officer is a final decision
6 that may be appealed under (d) of this section. If the hearing officer finds that the notice of
7 appeal raises a reasonable issue of fact or law, the hearing officer shall conduct a hearing on
8 those issues and recommend a decision to the commissioner. The hearing officer shall issue a
9 decision on the appeal not later than 60 days after being appointed. The commissioner shall
10 consider the recommended decision of the hearing officer within 10 days after receipt and may
11 adopt all, part, or none recommended decision or may remand the issue to the hearing
12 officer for further hearings. The commissioner shall issue a decision in writing within 10 days
13 after consideration of the hearing officer's decision.

14 (c) The hearing officer may consolidate appeals under (b) of this section if the notices
15 of appeal raise related issues of fact or law.

16 (d) An applicant under AS 18.25.011 may appeal an adverse decision of a hearing officer
17 or the commissioner under (b) of this section to the superior court in the manner provided by
18 AS 44.62.560 - 44.62.570 and the Alaska Rules of Appellate Procedure.

19 (e) The board shall adopt regulations governing procedures for the reconsideration and
20 appeal of decisions under (a) - (c) of this section. The regulations adopted under this subsection
21 are not required to conform to AS 44.62.330 - 44.62.630, but must be consistent with minimum
22 standards of due process.

23 (f) An applicant under AS 18.25.011 may not request reconsideration of or appeal a
24 priority determination on the grounds that a revised priority assigned to another project, due to
25 a reconsideration or appeal under this section, has resulted in a lower priority being accorded to
26 the applicant's project.

27 Sec. 18.25.025. GRANT AGREEMENT AND CONDITIONS. (a) The department shall
28 enter into a written agreement with the grantee before it distributes grant funds under
29 AS 18.25.011 - 18.25.035.

30 (b) The department shall require in the grant agreement that the grantee

31 (1) agree to construction of the health facility as described by the certificate of

1 need, if any, issued to the facility under AS 18.07.031 - 18.07.111;

2 (2) provide reasonable assurance by a means acceptable to the department that
3 the cost of the project will be uniform with the costs of the most current construction projects
4 in the area;

5 (3) agree to submit to the department for department approval a description and
6 justification of a cost overrun before the grantee agrees to pay for the overrun and before the
7 department distributes money to the grantee to pay for the overrun;

8 (4) agree to place the grant funds in an interest-bearing account and not to use
9 the interest or the grant funds for a purpose other than the project;

10 (5) agree to limit equipment purchases to that required for the facility operation;

11 (6) submit project budgets for department review and agree that the grant amount
12 may, at the discretion of the department, be reduced or increased by amounts equal to the
13 amounts by which contracts vary from the budget amounts approved by the department;

14 (7) submit to the department for approval, before advertising for bids for the
15 construction contract, a plan for construction that includes specifications, final construction
16 drawings, and proposed contract documents;

17 (8) submit for department review a tabulation of all bids received, a complete
18 copy of the lowest bid, a copy of the proposed notice to proceed with construction, and a copy
19 of the proposed construction contract;

20 (9) submit for department review and acceptance documentary evidence that the
21 project is being accomplished in accordance with all the assertions in the grantee's five-year
22 master plan and grant application;

23 (10) submit sufficient assurances that the project will be used for the stated
24 purposes of the grant for the expected useful lifetime of the facility;

25 (11) agree to conform to all applicable governmental codes and standards,
26 including the most recently adopted state statutes and regulations on building, health, mechanical,
27 electrical, fire, safety, and handicap accessibility, and those covering the planning, construction,
28 and operation of the health facility;

29 (12) agree to comply with

30 (A) the department's single audit requirements;

31 (B) AS 37.05.321, prohibiting the use of grant funds and earnings to

1 influence legislative action;

2 (C) the reporting requirements of AS 36.05 and AS 36.10; and

3 (D) 42 U.S.C. 2000a - 2000h-6 (Civil Rights Act of 1964), 29 U.S.C. 621-
4 634 (Age Discrimination in Employment Act of 1967), 7 U.S.C. 2027 (Food Stamp Act
5 of 1977), and the department's requirements for implementation of the federal statutes
6 listed in this subparagraph;

7 (13) identify anticipated operating costs and revenue and the sources of funding
8 that may be requested if costs exceed projected revenue;

9 (14) complete the project in a timely manner to a fully functional condition and
10 submit periodic status reports not less than every six months to the department detailing work
11 completed to date, a summary of expenditures compared with the approved budget, and an
12 explanation of any deviation from the approved work, schedule, or budget; and

13 (15) agree to comply with other requirements that the department, notwithstanding
14 AS 37.05.318, may reasonably impose on grantees and that are necessary to meet the intent of
15 the grant.

16 (c) Except as provided under (b) or (d) of this section, a cost of construction for a health
17 facility may be paid under a grant awarded under AS 18.25.021 without regard to whether the
18 cost was incurred before the

19 (1) award of the grant; or

20 (2) effective date of an appropriation to the nonprofit health facility construction
21 grant fund for the year in which the grant is funded.

22 (d) The maximum percentage of the costs of planning and designing, including
23 engineering, that are incurred before awarding a grant and that may be paid under the grant may
24 not exceed 15 percent.

25 (e) The fair market value of land acquisition and site preparation may be included in the
26 grantee's share of the total cost of the health facility. The fair market value shall be determined
27 as of the date when the grant application is submitted under AS 18.25.011.

28 (f) The direct expenses of the grantee to administer the project may not exceed 10
29 percent of the grant.

30 Sec. 18.25.027. GRANT APPROPRIATIONS. Within the general appropriation bill
31 submitted to the legislature under AS 37.07.020, the governor shall include an appropriation for

1 nonprofit health facility construction grants in the succeeding fiscal year as determined by the
2 priority list and budgets transmitted to the governor under AS 18.25.017.

3 Sec. 18.25.029. AMOUNT OF GRANTS. For each project included in a grant awarded
4 under AS 18.25.021, the state shall pay up to 80 percent of the total costs of construction
5 incurred for the project by the grantee during the fiscal year for which the grant is made.

6 Sec. 18.25.031. DISTRIBUTION OF GRANT. After the effective date of the agreement
7 for a grant under AS 18.25.011 - 18.25.035, the department shall advance 20 percent of the grant
8 to the grantee. The department shall base subsequent payments from the grant on payment
9 requests submitted by the grantee for the costs of construction incurred by the grantee for the
10 grant project. The department may not make a further payment under the grant until the grantee
11 has exhausted the advance.

12 Sec. 18.25.033. NONPROFIT HEALTH FACILITY CONSTRUCTION GRANT FUND.
13 The nonprofit health facility construction grant fund is created as an account in the general fund.
14 The fund shall be used to make grants under AS 18.25.011 - 18.25.035 for the costs of
15 construction of nonprofit health facilities. Legislative appropriations under AS 18.25.011 -
16 18.25.035 for the costs of construction of nonprofit health facilities shall be deposited in the fund.

17 Sec. 18.25.035. DEFINITIONS. In AS 18.25.011 - 18.25.035,

18 (1) "board" means the Health Facilities Review Board;

19 (2) "costs of construction" means the cost of acquiring, constructing, enlarging,
20 repairing, remodeling, equipping, or furnishing nonprofit health facilities and includes the total
21 of all costs of financing and carrying out the project, including

22 (A) the cost of necessary studies, surveys, plans and specifications,
23 architectural, engineering and other special services, the acquisition of real property, site
24 preparation and development, and the acquisition of machinery and equipment necessary
25 for the project;

26 (B) the direct expenses of the grantee to administer the project;

27 (C) the cost of financing the project, including interest on bonds issued
28 to finance the project; and

29 (D) the cost of other items, including indemnity and surety bonds and
30 premiums on insurance, legal fees, fees and expenses of trustees, depositaries, financial
31 advisors, and paying agents for the bonds issued;

1 (3) "health facility" means a nursing home or a facility that provides
2 hospitalization for inpatient medical and surgical care of acute illness or injury or obstetric care;

3 (4) "nonprofit" means qualified for an exemption under 26 U.S.C. 501 from
4 federal income tax.

5 * Sec. 2. AS 18.25.100 is repealed and reenacted to read:

6 Sec. 18.25.100. REGULATIONS. The department shall adopt regulations to implement
7 this chapter.

8 * Sec. 3. AS 46.11.900(7) is amended to read:

9 (7) "state financial assistance" means a loan, grant, guarantee, insurance, payment,
10 rebate, subsidy, or other form of state assistance other than aid under AS 05.35.010 - 05.35.070,
11 AS 14.11, AS 18.25.011 - 18.25.035, and AS 29.60, including the purchase by a state agency of
12 a loan to finance the construction or purchase of a residential building;

13 * Sec. 4. AS 18.25.010, 18.25.020, 18.25.030, 18.25.070, 18.25.080, 18.25.090, and 18.25.110 are
14 repealed.

15 * Sec. 5. This Act takes effect July 1, 1991.

SENATE BILL NO. 73**IN THE LEGISLATURE OF THE STATE OF ALASKA****SEVENTEENTH LEGISLATURE - FIRST SESSION****BY SENATOR KERTTULA**

Introduced: 1/22/91
Referred: L&C and Finance

A BILL**FOR AN ACT ENTITLED**

1 "An Act relating to health insurance; and providing for an effective date."

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

3 * Section 1. LEGISLATIVE FINDINGS AND INTENT. (a) The legislature finds that

4 (1) access by residents to basic health care services is a natural, essential, and unalienable
5 right that is protected by art. VII, sec. 4, of the Constitution of the State of Alaska;

6 (2) many small employers in the state cannot afford to provide health insurance for their
7 employees;

8 (3) the state can improve the health care services available to employees and other
9 residents of the state who are uninsured or underinsured;

10 (4) many residents under 65 years of age lack access to basic health care services because
11 they are not able to purchase health care insurance at a reasonable price or because they are restricted
12 from purchasing health insurance by the practices of the insurance industry;

13 (5) lack of access to health care negatively affects the health status of the uninsured by
14 the delay or lack of medical treatment, thereby increasing the incidence of disease and illness in the

1 state;

2 (6) the cost of providing hospital care to the uninsured is a burden on all health care
3 consumers and certain businesses in the state.

4 (b) It is the intent of the legislature to promote the accessibility of health care services for all
5 of the state's citizens, a public purpose for which public money may be expended.

6 * Sec. 2. AS 21 is amended by adding a new chapter to read:

7 CHAPTER 55. STATE HEALTH INSURANCE.

8 ARTICLE 1. HEALTH INSURANCE AUTHORITY.

9 Sec. 21.55.010. CREATION AND PURPOSE. (a) The Health Insurance Authority is
10 established. The authority is a public corporation and an instrumentality of the state in the
11 Department of Commerce and Economic Development but has a legal existence independent of
12 and separate from the state.

13 (b) The purpose of the authority is to provide, on a basis calculated to reduce or contain
14 the costs of the program, a program of health insurance coverage for eligible residents of the state
15 who are not otherwise covered by a health insurance plan, a self-insurance health plan, a medical
16 assistance program, or another plan or program that provides for payment by a third-party payor
17 for health care services.

18 Sec. 21.55.020. BOARD OF DIRECTORS. (a) The authority is governed by a board
19 of seven directors. The directors are the commissioner of commerce and economic development,
20 the commissioner of health and social services, the director of the division of insurance, a rep-
21 resentative of the insurance industry, a representative of health care providers, and two
22 representatives of enrollees, appointed by the governor.

23 (b) Members of the board who represent the insurance industry, health care providers,
24 and enrollees serve staggered terms of four years. A vacancy in a directorship shall be filled for
25 the unexpired term in the same manner as the original appointment.

26 (c) The directors must be state residents and shall comply with the requirements of
27 AS 39.50 (Conflict of Interest). The directors of the authority serve without compensation, but
28 are entitled to travel and per diem expenses authorized by law for state boards and commissions
29 under AS 39.20.180.

30 Sec. 21.55.030. APPOINTMENT AND POWERS OF EXECUTIVE DIRECTOR. The
31 board shall appoint an executive director of the authority who serves at the pleasure of the board

1 and may be removed by the board at any time. The executive director must have educational
2 qualifications and administrative and other experience that the board determines to be necessary
3 for the performance of the duties of executive director. The executive director shall appoint and
4 may remove agents and subordinate officers that the executive director considers necessary and
5 may establish divisions and subdivisions within the authority. The position of executive director
6 is in the exempt service.

7 Sec. 21.55.040. DEPUTY EXECUTIVE DIRECTOR. The executive director shall
8 appoint a person to serve as deputy executive director of the authority. The deputy executive
9 director shall perform the duties that the executive director determines and shall, in the case of
10 a vacancy in the office of executive director and during the executive director's absence or
11 disability, exercise the powers and perform the duties of that office. The deputy executive
12 director must have educational qualifications and administrative and other experience that the
13 executive director determines to be necessary for the performance of the duties of deputy
14 executive director. The position of deputy executive director is in the exempt service.

15 Sec. 21.55.050. GENERAL POWERS. The authority may

16 (1) adopt regulations to implement this chapter;

17 (2) make contracts and execute all instruments necessary or convenient for
18 carrying out its business;

19 (3) acquire, own, hold, dispose of, and encumber personal property and lease real
20 property in the exercise of its powers;

21 (4) enter into agreements or transactions with a federal, state, or municipal
22 agency, or other public institution, or with a private individual, partnership, firm, corporation,
23 association, or other entity;

24 (5) procure insurance in connection with its duties in the amounts and from
25 insurers ~~as~~ may be necessary or desirable;

26 (6) provide a health insurance program through the purchase of health insurance
27 plans from the private sector, including managed health care plans; the financial assumptions
28 underlying these purchasing arrangements shall be made on an actuarially sound basis;

29 (7) design and revise a basic schedule of health care services that enrollees in the
30 health insurance program are entitled to receive, including those services that are typically
31 included in employer sponsored health benefit plans in the state; the authority may adopt

1 schedules of covered health care services that differ from the basic schedule and that apply to
2 specific classes of enrollees;

3 (8) provide a health insurance plan for individuals who are uninsured; the health
4 insurance shall emphasize preventative and primary care by requiring nominal copayments for
5 that coverage, and, shall deemphasize inpatient hospital care by requiring a large deductible and
6 copayment for that coverage;

7 (9) provide a group health insurance plan to employers who have at least one but
8 not more than 15 full-time employees and who have not offered a group health insurance plan
9 to their employees within the previous year;

10 (10) negotiate with hospitals in the state to obtain a discount on charges for
11 inpatient and outpatient care;

12 (11) maintain a prudent level of reserve funds to protect the solvency of the health
13 insurance fund established under AS 21.55.080; and

14 (12) conduct studies concerning the status of health care in the state, including
15 the effect on consumers and businesses of programs established under this chapter.

16 Sec. 21.55.060. TYPES OF INSURANCE PLANS. (a) The authority shall make
17 available health care insurance to all eligible residents who are not covered by a health insurance
18 plan, a self-insurance plan, or the medical assistance program under AS 47.07. The authority
19 may not operate as an insurance company but shall make health insurance plans available to
20 eligible residents of the state through the purchase of health insurance plans, including managed
21 health care plans, from private health insurance companies. The authority shall endeavor to
22 purchase health insurance plans in an economical manner and shall enroll individuals in managed
23 health care plans when practical.

24 (b) The authority shall make available group health insurance for employees and
25 dependents to an employer who has at least one but not more than 15 full-time employees, who
26 elects to participate, and whose employees have not participated in a group health insurance plan
27 in the previous year. Group health insurance shall be made available by the purchase of group
28 health insurance plans from private health insurers. The authority may require employers
29 participating in the group health insurance plan to contribute up to 50 percent of the premium
30 cost of the insurance. An employer who elects to participate must enroll at least 75 percent of
31 the full-time employees of the employer in the health insurance plan offered by the authority.

1 Sec. 21.55.070. PURCHASE OF INSURANCE. (a) The authority shall

2 (1) subject to appropriation, negotiate with and purchase, on the terms that it
3 considers to be in the best interest of the authority and its enrollees, from health insurance
4 companies licensed in this state, policies of group general or blanket insurance providing hospital,
5 surgical, medical, and other health insurance benefits covering all eligible residents and their
6 dependents not enrolled in a health insurance plan, self-insurance health plan, or the medical
7 assistance program;

8 (2) execute all agreements or contracts pertaining to the policies or amendments
9 to them for and on behalf and in the name of the authority; the authority may negotiate a contract
10 for a term not exceeding three years that it considers to be the most advantageous to the authority
11 and its enrollees;

12 (3) endeavor to contract with health insurance companies only for managed health
13 care plans or for health insurance plans that employ other methods to reduce costs of health care
14 services;

15 (4) offer an individual enrollee a choice of at least two plans providing health care
16 insurance benefits; not more than 30 percent of the enrollees may be enrolled in a health
17 insurance plan of a single health insurance company, unless the authority determines that it is in
18 the best interest of enrollees to enroll more than 30 percent of enrollees in a health insurance plan
19 of a single health insurance company;

20 (5) adopt regulations regarding eligibility criteria, enrollment, contribution, and
21 termination policies;

22 (6) establish procedures by which individuals who participate or are seeking to
23 participate in the health insurance program of the authority may appeal determinations of
24 noneligibility, enrollment, contribution, and termination;

25 (7) allow, on an annual basis, an opportunity for enrollees to transfer their
26 enrollments among participating health insurance plans;

27 (8) establish a schedule of premium contributions, copayments, deductibles, or
28 coinsurance amounts to be paid by individual enrollees and for group health insurance purchased
29 by the authority; the schedule must establish a sliding scale of payments for enrollees based on
30 family income and size and other factors determined to be appropriate by the authority; the
31 schedule must require enrollees to pay 100 percent of the premium contributions if their income

1 substantially exceeds the nonfarm poverty guidelines of the United States Office of Management
2 and Budget;

3 (9) in coordination with the Department of Revenue, allow an enrollee to annually
4 contribute the enrollee's permanent fund dividend towards the premium amount paid by the
5 individual enrollee; and

6 (10) require a health insurance company that provides health care benefits under
7 this chapter to establish grievance procedures that are approved by the authority.

8 (b) A health insurance plan provided by the authority to its enrollees through a contract
9 with a health insurance company shall provide a reasonable range of health care service, to
10 enrollees, access to an adequate range of health care providers, and at a minimum, the following
11 benefits:

- 12 (1) inpatient and outpatient acute hospital services;
13 (2) inpatient and outpatient physician services;
14 (3) diagnostic and screening tests;
15 (4) preventive care;
16 (5) prenatal and well-baby care; and
17 (6) medically necessary emergency health services.

18 Sec. 21.55.075. **PREMIUM SUBSIDY.** An employer who elects to participate in the
19 group health insurance offered by the authority and who in the previous calendar year had a net
20 business income of less than \$20,000 as verified by federal income tax returns, shall receive a
21 premium subsidy of the employer's contribution equal to the following:

- 22 (1) in the first year of participation, 50 percent of the employer's contribution;
23 (2) in the second year of participation, 25 percent of the employer's contribution.

24 Sec. 21.55.080. **HEALTH INSURANCE FUND.** The health insurance fund is established
25 as a separate account in the general fund. The fund shall be administered by the authority and
26 used to purchase insurance under AS 21.55.070. The fund consists of appropriations by the
27 legislature and private grants or contributions.

28 Sec. 21.55.250. **DEFINITIONS.** In this chapter,

- 29 (1) "authority" means the Health Insurance Authority created in AS 21.55.010;
30 (2) "eligible resident" means a resident who is less than 65 years of age and
31 whose gross family income at the time of enrollment is less than twice the nonfarm poverty

1 guidelines of the United States Office of Management and Budget;

2 (3) "enrollee" means a person who becomes a member of an insurance program
3 of the authority either individually or as a member of a family;

4 (4) "full-time employee" means an employee who works more than 30 hours in
5 a week;

6 (5) "health care services" means supplies, care, and services of medical, surgical,
7 optometric, dental, podiatric, chiropractic, psychiatric, therapeutic, diagnostic, preventive,
8 rehabilitative, supportive, or geriatric nature, including inpatient and outpatient acute hospital care
9 and services, and services provided by a community health center, or by a health maintenance
10 organization;

11 (6) "health insurance" means an individual or group contract or other plan
12 providing coverage of health care services that is issued by a health insurance company, a
13 hospital service corporation, a medical service corporation, or a health maintenance organization;
14 "health insurance" includes disability insurance under AS 21.12.050;

15 (7) "health insurance company" means a company that engages in the business
16 of health insurance;

17 (8) "health maintenance organization" means a company that provides or arranges
18 for the provision of health care services to enrolled members in exchange primarily for a prepaid
19 per capita or aggregate fixed sum;

20 (9) "hospital service corporation" has the meaning given in AS 21.87.330;

21 (10) "managed health care plan" means a health insurance plan that provides or
22 arranges for, supervises and coordinates health care services to enrolled participants, including
23 plans administered by health maintenance organizations and preferred provider organizations;

24 (11) "medical service corporation" has the meaning given in AS 21.87.330;

25 (12) "resident" means a person living in the state as defined by the authority by
26 regulation; it does not include a person who moved to the state for the sole purpose of securing
27 health insurance under this chapter; confinement of a person in a nursing home, hospital, or other
28 medical institution in the state is not by itself sufficient to qualify the person as a resident.

29 * Sec. 3. AS 36.30.015(e) is amended to read:

30 (e) The board of directors of the Alaska Railroad Corporation and the Health Insurance
31 Authority shall adopt procedures to govern the procurement of supplies, services, professional

1 services, and construction. The procedures must be substantially equivalent to the procedures
2 prescribed in this chapter and in regulations adopted under this chapter.

3 * Sec. 4. AS 36.30.850(b) is amended by adding a new paragraph to read:

4 (23) contracts of the Health Insurance Authority (AS 21.55).

5 * Sec. 5. AS 39.25.110 is amended by adding a new paragraph to read:

6 (30) the executive director, deputy executive director, and other staff of the Health
7 Insurance Authority.

8 * Sec. 6. AS 39.50.200(b) is amended by adding a new paragraph to read:

9 (52) Health Insurance Authority (AS 21.55)

10 * Sec. 7. PHASE-IN COVERAGE. (a) Notwithstanding AS 21.55.060, the Health Insurance
11 Authority shall, subject to appropriation, establish phase-in coverage for state health insurance required
12 by this Act on a regional, statewide, or population basis that is designed to test the relative advantages
13 and disadvantages of providing health insurance, particularly managed health care plans, to persons
14 lacking health insurance. Phase-in coverage shall be established through contracts with health insurance
15 companies, hospital service corporations, medical service corporations, or health maintenance
16 organizations. The authority shall use phase-in coverage as part of a plan to provide health insurance
17 to the uninsured on an orderly and gradual basis. Phase-in coverage shall be purchased for a period not
18 to exceed four years; coverage found by the authority to be an efficient and effective method of
19 providing health care services to the uninsured may be purchased by the authority on a permanent basis,
20 under the provisions of AS 21.55.

21 (b) The authority shall require that an insurer with which it contracts under this section submit
22 annually to the authority a report of the demographics and utilization patterns of the enrollees.

23 * Sec. 8. COMMISSION CREATED. (a) The Commission on Health Insurance Reform is
24 established to

25 (1) examine and determine what alternatives, if any, exist to provide citizens of the state
26 with an improved health care delivery and health care insurance system;

27 (2) recommend improvements to the competitive environment in the health insurance
28 system;

29 (3) review the affordability and availability of actuarially sound nongroup and Medicare
30 supplementary health insurance coverage; and

31 (4) study the implications of the provisions of this Act relative to preferred provider

1 arrangements and relative to the relationship between nonparticipating providers and hospital and medical
2 service corporations.

3 (b) The commission consists of a representative of a nonprofit hospital or medical service
4 corporation, a representative of the Department of Law, a representative of health care consumer groups,
5 a representative of health maintenance organizations, and a chair, to be appointed by the governor.

6 (c) The commission shall make its recommendations to the governor and the legislature before
7 October 1, 1992, and shall issue a final report before November 15, 1992.

8 * Sec. 9. TRANSITION. The initially appointed members of the board of the Health Insurance
9 Authority that are serving staggered terms, shall serve terms set by the governor under AS 39.05.055(2).

10 * Sec. 10. Section 8 of this Act is repealed January 1, 1993.

11 * Sec. 11. This Act takes effect July 1, 1991.

SENATE BILL NO. 74

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATOR KERTTULA

Introduced: 1/22/91

Referred: L&C and Finance

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to pooled health insurance for individuals who are uninsured or denied
2 adequate coverage; and providing for an effective date."

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

4 * Section 1. PURPOSE. It is the purpose of this Act to provide access to health insurance to all
5 residents of the state who are presently denied adequate health insurance or who are considered
6 uninsurable.

7 * Sec. 2. AS 21 is amended by adding a new chapter to read:

8 CHAPTER 55. STATE HEALTH INSURANCE.

9 ARTICLE 1. COMPREHENSIVE HEALTH INSURANCE ASSOCIATION.

10 Sec. 21.55.010. CREATION; MEMBERSHIP. There is established a nonprofit
11 incorporated legal entity to be known as the Comprehensive Health Insurance Association.
12 Membership consists of all licensed hospital or medical service corporations in the state that offer
13 subscriber contracts for major medical coverage and all insurers licensed to transact health
14 insurance in the state that offer policies for major medical coverage on an expense incurred basis.

1 All members shall maintain membership in the association as a condition of doing health
2 insurance business, or being able to offer subscriber contracts, in the state.

3 Sec. 21.55.020. BOARD OF DIRECTORS; ORGANIZATION. The board of directors
4 of the association shall be made up of seven individuals selected by participating members,
5 subject to approval by the director of the division of insurance. The director or the director's
6 designee shall serve as a nonvoting ex officio member of the board. In determining voting rights
7 at members' meetings, a member is entitled to vote in person or proxy. The vote shall be a
8 weighted vote based upon the member's premiums for health insurance for major medical
9 coverage on an expense incurred basis, or the member's subscriber fees, derived from or on
10 behalf of state residents in the previous calendar year, as determined by the director. In
11 approving members of the board, the director shall consider, among other things, whether all
12 types of participating members are fairly represented. Members of the board other than the
13 director or the director's designee may be reimbursed from the association for expenses incurred
14 by them as members, but may not otherwise be compensated by the association for their services.
15 The costs of conducting meetings of the association and its board of directors shall be borne by
16 members of the association.

17 Sec. 21.55.030. GENERAL POWERS. The association may

- 18 (1) exercise the powers granted to insurers under the laws of the state;
19 (2) sue or be sued;
20 (3) enter into contracts with insurers, similar associations in other states, or with
21 other persons for the performance of administrative functions;
22 (4) establish administrative and accounting procedures for the operation of the
23 association.

24 Sec. 21.55.040. PLAN OF OPERATION. (a) The association shall submit to the
25 director a plan of operation and amendments necessary or suitable to assure the fair, reasonable,
26 and equitable administration of the association. The plan of operation and amendments become
27 effective upon approval in writing by the director. If the association fails to submit a suitable
28 plan of operation by a date that is 180 days after the effective date of this Act, or if at subsequent
29 time the association fails to submit suitable amendments to the plan, the director may, after notice
30 and hearing, adopt reasonable regulations necessary or advisable to effectuate the provisions of
31 this chapter. These regulations shall continue in force until modified by the director or

1 superseded by a plan submitted by the association and approved by the director.

2 (b) All members of the association shall comply with the plan of operation.

3 (c) The plan of operation shall

4 (1) establish procedures whereby all the powers and duties of the association
5 under this chapter will be performed;

6 (2) establish procedures for handling assets of the association;

7 (3) establish the amount and method of reimbursing members of the board of
8 directors under AS 21.55.020;

9 (4) establish regular places and times for meetings of the board of directors;

10 (5) establish procedures for records to be kept of all financial transactions of the
11 association, its agents, and the board of directors;

12 (6) provide that a member insurer aggrieved by a final action or decision of the
13 association may appeal to the director within 30 days after the action or decision;

14 (7) establish procedures whereby selections for the board of directors will be
15 submitted to the director;

16 (8) contain additional provisions necessary or proper for the execution of the
17 powers and duties of the association.

18 Sec. 21.55.050. ADMINISTRATIVE PROCEDURE ACT. The association is exempt
19 from the Administrative Procedure Act (AS 44.62).

20 Sec. 21.55.060. TAX EXEMPTION. The association is exempt from the payment of fees
21 and taxes levied by the state or any of its political subdivisions except taxes levied on real or
22 personal property.

23 ARTICLE 2. STATE HEALTH INSURANCE PLANS.

24 Sec. 21.55.100. TYPES OF INSURANCE PLANS. (a) The association shall make
25 available to residents who are high risks an individual state plan of health insurance. The
26 association shall offer three alternatives related to deductibles as described in AS 21.55.120.

27 (b) The association shall make available to residents who are high risks and 65 years of
28 age or older a Medicare supplement plan that meets the minimum policy standards and minimum
29 benefit standards established by regulations adopted by the director under AS 21.89.060.

30 (c) The association may not deny coverage under a state plan to a resident who satisfies
31 the requirements of AS 21.55.300 - 21.55.310. The association shall determine whether a person

1 is a high risk in accordance with AS 21.55.500(9) and the director's regulations.

2 Sec. 21.55.110. MINIMUM BENEFITS OF STATE HEALTH INSURANCE PLAN.

3 Except as provided in AS 21.55.120 - 21.55.140, the minimum standard benefits of a health
4 insurance plan offered under AS 21.55.100(a) shall be benefits with a lifetime maximum of
5 \$1,000,000 per individual for usual, customary, reasonable, or prevailing charges or, when
6 applicable, the allowance agreed upon between a provider and the writing carrier for charges, for
7 the following medical services performed for an individual covered by the plan for the diagnosis
8 or treatment of nonoccupational disease or nonoccupational injury:

9 (1) hospital services;

10 (2) subject to the limitations of AS 21.36.090(d), professional services that are
11 rendered by a physician or by a registered nurse at the physician's direction, other than services
12 for mental or dental conditions;

13 (3) the diagnosis or treatment of mental conditions, as defined in regulations of
14 the director, rendered during the year on other than an inpatient basis, up to a yearly maximum
15 benefit of \$4,000;

16 (4) legend drugs requiring a physician's prescription;

17 (5) services of a skilled nursing facility for not more than 120 days in a policy
18 year;

19 (6) home health agency services up to a maximum of 270 visits in a calendar year
20 if the services commence within seven days following confinement in a hospital or skilled
21 nursing facility of at least three consecutive days for the same condition, except that in the case
22 of an individual diagnosed by a physician as terminally ill with a prognosis of six months or less
23 to live, the home health agency services may commence irrespective of whether the covered
24 person was previously confined or, if the covered person was confined, irrespective of the seven-
25 day period, and the yearly benefit for medical social services may not exceed \$200;

26 (7) hospice services for up to six months in a calendar year;

27 (8) use of radium or other radioactive materials;

28 (9) outpatient chemotherapy;

29 (10) oxygen;

30 (11) anesthetics;

31 (12) nondental prosthesis and maxillo-facial prosthesis used to replace any

1 anatomic structure lost during treatment for head and neck tumors or additional appliances
2 essential for the support of the prosthesis;

3 (13) rental, or purchase if purchase is more cost effective than rental, of durable
4 medical equipment that has no personal use in the absence of the condition for which it was
5 prescribed;

6 (14) diagnostic x-rays and laboratory tests;

7 (15) oral surgery for excision of partially or completely unerupted impacted teeth
8 or excision of a tooth root without the extraction of the entire tooth;

9 (16) services of a licensed physical therapist rendered under the direction of a
10 physician;

11 (17) transportation by a local ambulance operated by licensed or certified
12 personnel to the nearest health care institution for treatment of the illness or injury and round trip
13 transportation by air to the nearest health care institution for treatment of the illness or injury if
14 the treatment is not available locally; if the patient is a child under 12 years of age, the
15 transportation charges of a parent or legal guardian accompanying the child may be paid if the
16 attending physician certifies the need for the accompaniment;

17 (18) confinement in a licensed or certified facility established primarily for the
18 treatment of alcohol or drug abuse or in a part of a hospital used primarily for this treatment, for
19 a period of at least 45 days within any calendar year;

20 (19) alternatives to inpatient services as defined by the association in the state
21 plan benefits;

22 (20) second surgical opinions;

23 (21) other services that are medically necessary in the treatment or diagnosis of
24 an illness or injury as may be designated or approved by the director.

25 **Sec. 21.55.120. DEDUCTIBLES AND COPAYMENTS.** (a) A state plan other than a
26 Medicare supplement plan may require deductibles of \$200 a person, \$500 a person, or \$1,000
27 a person. The amount of the deductible may not be greater when a service is rendered on an
28 outpatient basis than when that service is offered on an inpatient basis. Expenses incurred during
29 the last three months of a calendar year and actually applied to an individual's deductible for that
30 year shall also be applied to that individual's deductible in the following calendar year. The
31 \$200 maximum, the \$500 maximum, and the \$1,000 maximum may be adjusted yearly to corre-

1 spond with the change in the medical care component of the Consumer Price Index, as adjusted
2 by the director. The base year for the computation shall be the first full calendar year of
3 operation of the association.

4 (b) A state plan other than a Medicare supplement plan shall require a maximum
5 copayment of 20 percent for charges for all types of health care in excess of the deductible and
6 50 percent for services described in AS 21.55.110(3) in excess of the deductible.

7 (c) The sum of the deductible and copayments required in any calendar year under a plan
8 may not exceed a maximum limit of \$2,000 per covered individual. Covered expenses incurred
9 after the applicable maximum limit has been reached shall be paid at the rate of 100 percent of
10 usual, customary, reasonable, or prevailing charges, except that expenses incurred for treatment
11 of mental and nervous conditions shall be paid at the rate of 50 percent. The \$2,000 maximum
12 shall be adjusted yearly to correspond with the change in the medical care component of the
13 Consumer Price Index as adjusted by the director.

14 (d) In this section, "Consumer Price Index" means the Consumer Price Index for all
15 urban consumers for the Anchorage Metropolitan Area compiled by the Bureau of Labor
16 Statistics, United States Department of Labor.

17 Sec. 21.55.130. PREEXISTING CONDITIONS. (a) A preexisting condition exclusion
18 in a state plan may not exclude coverage of a preexisting condition unless

19 (1) the condition first manifested itself within the period of three months
20 immediately before the effective date of coverage in a manner that would cause a reasonably
21 prudent person to seek diagnosis, care, or treatment; or

22 (2) medical advice or treatment was recommended or received within the period
23 of three months immediately before the effective date of coverage.

24 (b) A policy may not exclude coverage for a loss due to preexisting conditions for a
25 period greater than six months following the effective date of coverage.

26 (c) A state plan issued to a person whose previous subscriber contract, health policy, or
27 Medicare supplement policy was involuntarily terminated shall credit the time covered under the
28 previous contract or policy toward an exclusion for preexisting conditions under the state plan
29 if the previous contract or policy had a similar preexisting condition exclusion and the person
30 applies for a state plan within 31 days after termination of the previous contract or policy. If a
31 person covered by this subsection is accepted by the writing carrier and pays a specified premium

1 for retroactive coverage, the state plan is effective retroactively to the date that the person's
2 previous contract or policy terminated.

3 Sec. 21.55.140. CARE AND SERVICES NOT COVERED. A state plan may not
4 provide benefits for charges for the following:

5 (1) care for an injury or disease either

6 (A) arising out of and in the course of an employment subject to a
7 workers' compensation or similar law or where the benefit is required to be provided
8 under a workers' compensation policy to a sole proprietor, business partner, or
9 corporation officer; or

10 (B) to the extent benefits are payable without regard to fault under a
11 coverage statutorily required to be contained in a motor vehicle or other liability insurance
12 policy or equivalent self-insurance;

13 (2) treatment for cosmetic purposes other than surgery for the prompt repair of
14 an accidental injury sustained while covered or for replacement of an anatomic structure removed
15 during treatment of tumors;

16 (3) travel, other than transportation covered under AS 21.55.110(17);

17 (4) private room accommodations to the extent it is in excess of the institution's
18 most common charge for a semiprivate room;

19 (5) services or articles to the extent that the charge exceeds the reasonable charge
20 in the locality for the service;

21 (6) services or articles that are determined not to be medically necessary, except
22 for the fabrication or placement of the prosthesis as specified in AS 21.55.110(12) and (2) of this
23 section;

24 (7) services or articles that are not within the scope of the license or certificate
25 of the institution or individual rendering the services or articles;

26 (8) services or articles furnished, paid for or reimbursed directly by or under any
27 law of a government, except as otherwise provided in this chapter;

28 (9) services or articles for custodial care or designed primarily to assist an
29 individual in the activities of daily living;

30 (10) service charges that would not have been made if no insurance existed or that
31 the covered individual is not legally obligated to pay;

- 1 (11) eyeglasses, contact lenses, or hearing aids or the fitting of them;
2 (12) dental care not specifically covered by this chapter;
3 (13) services of a registered nurse who ordinarily resides in the covered
4 individual's home, or who is a member of the covered individual's family or the family of the
5 covered individual's spouse;
6 (14) experimental procedures; and
7 (15) services and supplies for which the patient was not charged.

8 Sec. 21.55.150. STATE PLAN PREMIUMS. (a) The association may not charge a rate
9 for coverage issued by or through the association that is excessive, inadequate, or unfairly
10 discriminatory.

11 (b) The association shall use separate scales of premium rates based on age and
12 geographic location of the insured.

13 (c) The five members of the association that insure, or have subscriber contracts with,
14 the largest number of individuals in the state under plans with benefits substantially equivalent
15 to the state plan benefits shall submit to the association an estimate of the rate that would be
16 actuarially sound for a person who is a standard risk for coverage substantially equivalent to the
17 state plan. The premium for a state plan may not exceed 125 percent of the average of those five
18 estimates.

19 ARTICLE 3. ADMINISTRATION OF PLANS.

20 Sec. 21.55.200. SELECTION OF WRITING CARRIERS. The association shall develop
21 bid specifications for members that wish to be selected as a writing carrier to administer a state
22 plan. The selection of the writing carrier shall be based upon criteria including the member's
23 proven ability to handle a large number of health insurance cases or subscriber contracts, efficient
24 claim paying capacity, and the estimate of total charges for administering the plan.

25 Sec. 21.55.210. DUTIES OF WRITING CARRIERS. (a) The writing carrier shall
26 perform the administrative and claims payment functions required by this section. The writing
27 carrier shall provide these services for a period of three years, unless a request to terminate is
28 approved by the director. The director shall approve or deny a request to terminate within 90
29 days of its receipt. A failure to make a final decision on a request to terminate within the
30 specified period shall be considered an approval. Six months before the expiration of each three-
31 year period, the association shall invite submissions of policy forms from members of the

1 association, including the writing carrier. The association shall follow the provisions of
2 AS 21.55.210 in selecting a writing carrier for the subsequent three-year period.

3 (b) The writing carrier shall provide to all eligible persons enrolled in a state plan an
4 individual policy or certificate, setting out a statement of the insurance protection to which the
5 person is entitled, with whom claims are to be filed, and to whom benefits are payable. The
6 policy or certificate must indicate that coverage was obtained through the association.

7 (c) The writing carrier shall submit to the association and the director on a quarterly basis
8 a report on the operation of the state plans. Specific information to be contained in the report
9 shall be determined by the association.

10 (d) Claims shall be paid by the writing carrier and shall indicate that the claim was paid
11 under a state plan. A claim payment shall include a telephone number that can be used for
12 inquiries regarding the claim.

13 (e) The writing carrier shall be reimbursed from the state plan premiums received for its
14 direct and indirect expenses for administering the plan. Direct and indirect expenses shall include
15 a pro rata reimbursement for that portion of the writing carrier's administrative, printing, claims
16 administration, management and building overhead expenses that are assignable to the
17 maintenance and administration of the state plans. The association shall approve cost accounting
18 methods to substantiate the writing carrier's cost reports consistent with generally accepted
19 accounting principles. Direct and indirect expenses may not include costs directly related to the
20 original submission of policy forms before selection as the writing carrier.

21 (f) The writing carrier shall at all times when carrying out its duties under this chapter
22 be considered an agent of the association.

23 Sec. 21.55.220. OPERATION OF THE PLAN. (a) Upon notification of eligibility under
24 AS 21.55.320, a person may enroll in a state plan by payment of the appropriate state plan
25 premium to the writing carrier.

26 (b) An employer that has in its employ one or more eligible persons enrolled in a state
27 plan may make all or a portion of a state plan premium payment directly to the writing carrier.

28 (c) Each member of the association shall share the losses due to claims expenses of the
29 state plans issued or approved for issuance by the association, and shall share in the operating
30 and administrative expenses incurred or estimated to be incurred by the association incident to
31 the conduct of its affairs. Claims expenses of the state plan that exceed the premium payments

1 allocated to the payment of benefits shall be the liability of the members. Each member shall
2 share in the claims expense of the state plans and operating and administrative expenses of the
3 association in an amount equal to the ratio of the member's total fees for subscriber contracts or
4 total health insurance premiums, received from or on behalf of state residents, as divided by the
5 total subscriber fees and health insurance premiums received by all members from or on behalf
6 of state residents, as determined by the director.

7 (d) The association shall make an annual determination of each member's liability, if any,
8 and may make an annual fiscal year end assessment if necessary. The association may also,
9 subject to the approval of the director, provide for interim assessments against the members as
10 may be necessary to assure the financial capability of the association in meeting the incurred or
11 estimated claims expenses of the state plans and operating and administrative expenses of the
12 association until the association's next annual fiscal year end assessment. Payment of an
13 assessment is due within 30 days of receipt by a member of written notice of a fiscal year end
14 or interim assessment. Failure by a member to tender to the association the assessment within
15 30 days shall be grounds for revocation of a member's certificate of authority. A member that
16 ceases to do health insurance business in the state, or ceases to offer subscriber contracts in the
17 state, due to revocation, suspension, or voluntary surrender of its certificate of authority remains
18 liable for assessments through the calendar year that the health insurance business ceased. The
19 association may decline to levy an assessment against a member if the assessment would not
20 exceed \$10. Assessments paid by a member are a general expense of the member.

21 (e) Net gains, if any, from the operation of the state plans shall be held at interest and
22 used by the association to offset future losses due to claims expenses of a state plan or allocated
23 to reduce state plan premiums.

24 ARTICLE 4. ENROLLMENT IN THE STATE HEALTH INSURANCE PLAN.

25 Sec. 21.55.300. ELIGIBILITY FOR STATE HEALTH INSURANCE. (a) Except as
26 provided in (b) of this section, a state resident who is a high risk is eligible to enroll in a state
27 plan described in AS 21.55.100.

28 (b) A person may not be covered by the state plan while covered by another health
29 insurance policy or subscriber contract. Upon ceasing to be a resident a person is not eligible
30 to purchase or renew coverage under a state plan, but previously purchased coverage remains in
31 effect for the period covered by payments made while a resident.

1 (c) Additional eligibility requirements may not be imposed by the director, the
2 association, or a writing carrier.

3 Sec. 21.55.310. ENROLLMENT BY AN ELIGIBLE PERSON. A person may enroll in
4 a state plan by applying to the writing carrier. The application must include the following:

- 5 (1) name, address, age, and length of residency of the applicant;
6 (2) a designation of the plan desired, including deductible option chosen;
7 (3) information relevant to whether the person is a high risk.

8 Sec. 21.55.320. WRITING CARRIER'S RESPONSE. Within 30 days after receiving the
9 certificate described in AS 21.55.310, the writing carrier shall either reject the application for
10 failing to comply with the requirements of AS 21.55.300 and 21.55.310 or forward the eligible
11 person a notice of acceptance and billing information.

12 Sec. 21.55.330. EFFECTIVE DATE OF POLICIES. (a) Except as provided in (b) of
13 this section and AS 21.55.130(c), insurance under a state plan is effective immediately upon
14 receipt of the first quarterly premium, and is retroactive to the date of the application, if the
15 applicant otherwise complies with the requirements of this chapter.

16 (b) Insurance under a state plan is effective retroactively to the date that the person's
17 previous contract or policy terminated if the person

18 (1) applies for a state plan within 60 days after the previous contract or policy
19 terminated;

20 (2) is accepted by the writing carrier; and

21 (3) pays a specified premium for the period of retroactive coverage.

22 Sec. 21.55.340. SOLICITATION OF ELIGIBLE PERSONS. (a) The association, under
23 a plan approved by the director, shall disseminate appropriate information to the residents of the
24 state regarding the existence of the state plans and the means of enrollment. Means of
25 communication may include use of the press, radio, and television, as well as publication in
26 appropriate state offices and publications.

27 (b) The association shall devise and implement means of maintaining public awareness
28 of the provisions of this chapter regarding the state plans and shall administer this chapter in a
29 manner that facilitates public participation in the state plans.

30 (c) Selling or marketing of qualified state plans is limited to licensed health insurance
31 agents.

1 (d) An insurer or hospital or medical service corporation that rejects or applies
2 underwriting restrictions to an applicant for a subscriber contract, a health insurance policy, or
3 a Medicare supplement plan in the state shall notify the applicant of the existence of the state
4 plans, the requirements for being accepted, and the procedure for applying.

5 ARTICLE 5. GENERAL PROVISIONS.

6 Sec. 21.55.400. DUTIES OF DIRECTOR. The director may

7 (1) approve the selection of the writing carrier by the association and approve the
8 association's contract with the writing carrier including the coverages and premiums to be
9 charged;

10 (2) contract with the federal government or another unit of government to ensure
11 coordination of the state plans with other governmental assistance programs;

12 (3) undertake directly or through contracts with other persons studies or
13 demonstration programs to develop awareness of the benefits of this chapter; and

14 (4) adopt regulations necessary to administer this chapter.

15 Sec. 21.55.410. STATE NOT LIABLE. The state is not liable for acts or omissions of
16 the association or a writing carrier under this chapter, nor is the state liable for payment of a
17 claim under a state plan issued by a writing carrier.

18 Sec. 21.55.500. DEFINITIONS. In this chapter

19 (1) "association" means the Comprehensive Health Insurance Association created
20 in AS 21.55.010;

21 (2) "copayment" means the portion of the eligible expenses, in excess of the
22 deductible, for which the insured is responsible;

23 (3) "deductible" means the portion of eligible expenses for which the insured is
24 responsible in each calendar year under AS 21.55.120(a);

25 (4) "health insurance" means an individual or group contract or other plan
26 providing coverage of health care services that is issued by a health insurance company, a
27 hospital service corporation, a medical service corporation, or a health maintenance organization;
28 "health insurance" includes disability insurance under AS 21.12.050;

29 (5) "home health agency services" means any of the following services provided
30 upon recommendation of a licensed physician as part of a treatment plan:

31 (A) intermittent or part-time nursing services of a registered professional

1 nurse or a licensed practical nurse, that are provided to a person under the continued
2 direction of the person's physician and within the limitation of the nurse's license;

3 (B) nursing services that are provided to a person at the person's
4 residence, including a residential care facility or adult boarding home; a hospital, skilled
5 nursing facility or intermediate care facility is not considered a residence;

6 (C) home health aide services that are prescribed by and under the
7 continued direction of a physician and supervised by a professional nurse;

8 (D) home health aide services that are provided to a person at the person's
9 residence, as described in (B) of this paragraph;

10 (E) physical and occupational therapy services, speech pathology, and
11 audiology services that are prescribed by a physician and provided to a person by or
12 under the supervision of a qualified practitioner; these services may be provided to a
13 person who is a patient in an intermediate care facility or skilled nursing facility;

14 (6) "hospice services" means services provided under a coordinated comprehensive
15 program of palliative and supportive care on a 24-hour, seven days per week basis for persons
16 who have been diagnosed as terminally ill and their families by an interdisciplinary team of
17 professionals or volunteers under an incorporated central administration that has a physician as
18 medical director;

19 (7) "major medical coverage" means a health insurance contract, or a subscriber
20 contract, that provides benefits for hospital and medical care with potential lifetime maximum
21 benefits per insured of at least \$10,000;

22 (8) "medical social services" means services rendered the patient under the
23 direction of a physician by a qualified social worker holding a master's degree from an accredited
24 school of social work, including assessment of the social, psychological and family problems
25 related to or arising out of the covered person's illness and treatment, appropriate action and
26 utilization of community resources to assist in resolving the problems, and participation in the
27 development of treatment for the covered person;

28 (9) "resident" means a person who is physically present in the state, has lived in
29 the state for at least the six consecutive months immediately preceding application for a state
30 plan, and intends to remain permanently in the state; "resident" also includes a person who is not
31 physically present in the state if the person lived in the state for at least six of the nine months

1 immediately preceding application for a state plan and the person's absence from the state is for
2 medical treatment or education; a person ceases to be a resident if the person is absent from the
3 state for more than 90 consecutive days for reasons other than for medical treatment or education;

4 (10) "residents who are high risks" means residents who

5 (A) have been rejected for medical reasons after applying for a subscriber
6 contract, a policy of health insurance, or a Medicare supplement policy by at least two
7 association members within the six months immediately preceding the date of application
8 for a state plan; or

9 (B) have had a restrictive rider placed on a subscriber contract, a health
10 insurance policy, or a Medicare supplement policy;

11 (11) "state plan" means a policy of insurance offered by the association through
12 a writing carrier;

13 (12) "usual, customary, reasonable, or prevailing charge" means the charge for
14 a medical care procedure, service, or supply item that is the lowest of the following amounts:

15 (A) the billed amount for the medical service provider's actual charge;

16 (B) the charge usually made by that provider for performing that procedure
17 or service or for providing the supply item; or

18 (C) the customary charge, based on a profile of charges made for the same
19 medical procedure, service, or supply item in the same geographical area by other
20 providers that have performed the same procedure or service or can provide the same
21 supply item;

22 (13) "writing carrier" means the insurer or insurers selected by the association and
23 approved by the director to administer a state plan.

24 * Sec. 3. The association established by sec. 2 of this Act shall make available to residents the plans
25 required by AS 21.55.100, enacted in sec. 2 of this Act, by January 1, 1992.

26 * Sec. 4. This Act takes effect immediately under AS 01.10.070(c).

CS FOR SENATE BILL NO. 83 (L&C)
IN THE LEGISLATURE OF THE STATE OF ALASKA
SEVENTEENTH LEGISLATURE - FIRST SESSION

BY THE SENATE LABOR AND COMMERCE COMMITTEE

Offered: 4/22/81
Referred: HES, Finance

Sponsor(s): SENATORS DUNCAN, Zharoff, Rodey

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to the Alaska State Health Resources Authority; relating to the delivery,
2 quality, and financing of health care for residents of the state, and to the issuance of
3 certificates of need; and providing for an effective date."

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

5 * Section 1. PURPOSE. The purpose of this Act is to

6 (1) by July 1, 1992, create and begin a phased implementation of geographic specific
7 health care provider reimbursement systems and utilization standards;

8 (2) after July 1, 1992, begin the procurement or provision of a comprehensive group
9 health insurance program for individuals, groups of individuals, or employers that the authority
10 determines do not have health insurance or for employers who elect to have the authority procure or
11 provide insurance on the employer's behalf; employer group health insurance may include coverage for
12 eligible employees and dependents;

13 (3) assure financial protection for participants and beneficiaries, provide equitable
14 payment to health care providers, and slow the increase in health care expenditures;

SB0083b

-1-

CSSB 83(L&C)

New Text Underlined (DELETED TEXT BRACKETED)

J-49

1 (4) expand the pool of subscribers and maximize the opportunities for health care cost
2 management and economies of scale when purchasing group health insurance;

3 (5) maintain efficient provider reimbursement systems to reduce the administrative cost
4 to providers who are serving employees of participants;

5 (6) maintain a statewide health care data base and utilization standards to control
6 inappropriate or improper utilization practices and to reduce the rate of inflation in the cost of health care
7 in the state;

8 (7) create the most comprehensive, cost-effective, and efficient method of providing a
9 variety of types of health care insurance necessary to meet the coverage requirements of a participant
10 resulting from negotiated employee contracts;

11 (8) realize the potential savings that will result if approximately 135,000 active and
12 retired state, municipal, and school district employees and their dependents participate in the
13 reimbursement systems and utilization standards offered by the authority; and

14 (9) continue to evaluate and where feasible offer a health insurance program for those
15 sectors of the state that remain uninsured or underinsured.

16 * Sec. 2. AS 18.07.035 is amended to read:

17 Sec. 18.07.035. APPLICATION AND FEES. Application for a certificate of need shall
18 be made to the department upon a form provided by the department and must contain the
19 information the department requires to reach a decision under AS 18.07.041 - 18.07.111. Each
20 application for a certificate of need must be accompanied by an application fee established by
21 the department by regulation. A copy of each application for a certificate of need, except an
22 application for a temporary or emergency certificate issued under AS 18.07.071, shall be
23 provided to the Alaska State Health Resources Authority.

24 * Sec. 3. AS 18.07.041 is amended to read:

25 Sec. 18.07.041. STANDARD OF REVIEW FOR APPLICATIONS FOR CERTIFICATES
26 OF NEED. The office shall grant a sponsor a certificate of need or modify a certificate of need
27 if the availability and quality of existing health care resources or the accessibility to those
28 resources is less than the current or projected requirement for health services required to maintain
29 the good health of Alaska citizens. A certificate of need may not be issued, except for a
30 temporary or emergency certificate under AS 18.07.071, unless the office has received a
31 determination from the Alaska State Health Resources Authority regarding the effect of the

1 certificate of need on the cost of group health insurance.

2 * Sec. 4. AS 24.20.206 is amended to read:

3 Sec. 24.20.206. DUTIES. The Legislative Budget and Audit Committee shall

4 (1) report to the legislature its recommendations relating to the confirmation of
5 appointees to the Board of Trustees of the Alaska Permanent Fund Corporation;

6 (2) annually review the long-range operating plans of all agencies of the state
7 which perform lending or investment functions;

8 (3) review periodic reports from all agencies of the state which perform lending
9 or investment functions;

10 (4) present a complete report of investment programs, plans, performance, and
11 policies of all agencies of the state which perform lending or investment functions to the
12 legislature within 30 days after the convening of each regular session;

13 (5) present to the legislature within 30 days after the convening of each regular
14 session a review of the report of the governor under AS 37.07.020(d) with recommendations for
15 needed legislation;

16 (6) in conjunction with the finance committee of each house recommend annually
17 to the legislature the investment policy for the general fund surplus and for the income from the
18 permanent fund;

19 (7) provide for an annual post audit and annual operational and performance
20 evaluation of the Alaska Permanent Fund Corporation investments and investment programs;

21 (8) provide for an annual operational and performance evaluation of the Alaska
22 Housing Finance Corporation and the Alaska Industrial Development and Export Authority; the
23 performance evaluation shall include, but is not limited to, a comparison of the effect on various
24 sectors of the economy by public and private lending, the effect on resident and nonresident
25 employment, the effect on real wages, and the effect on state and local operating and capital
26 budgets of the programs of the Alaska Housing Finance Corporation and the Alaska Industrial
27 Development and Export Authority;

28 (9) provide for an annual post audit and annual operational and performance
29 evaluation of the Alaska State Health Resources Authority.

30 * Sec. 5. AS 37.07.030 is amended to read:

31 Sec. 37.07.030. RESPONSIBILITIES OF THE LEGISLATURE. The legislature shall

- 1 (1) provide for a budget review function;
2 (2) analyze the comprehensive operating and capital improvements programs and
3 financial plans recommended by the governor;
4 (3) adopt legislation to authorize implementation of the governor's comprehensive
5 operating and capital improvements programs and financial plans or appropriate alternatives to
6 those plans;
7 (4) provide for a post-audit function to cover financial transactions, program
8 accomplishment, and compliance with legislative intent;
9 (5) adopt or revise the estimate of receipts required to balance the succeeding
10 fiscal year's budget in order that proposed expenditures do not exceed estimated receipts for that
11 fiscal year;
12 (6) adopt, revise, or initiate revenue measures in order to balance the succeeding
13 fiscal year's budget and the capital improvements section of the budget for the succeeding six
14 years;

15 **(7) appropriate funds for the operation of the Alaska State Health Resources**

16 **Authority.**

17 * Sec. 6. AS 39.25.110 is amended by adding a new paragraph to read:

18 (30) employees of the Alaska State Health Resources Authority.

19 * Sec. 7. AS 39.50.200(b) is amended by adding a new paragraph to read:

20 (52) Alaska State Health Resources Authority (AS 44.87).

21 * Sec. 8. AS 44 is amended by adding a new chapter to read:

22 **CHAPTER 87. STATE INSURANCE AUTHORITY.**

23 **Sec. 44.87.010. AUTHORITY CREATED; REQUIRED REIMBURSEMENT SYSTEMS**
24 **AND UTILIZATION STANDARDS. (a)** There is established within the Department of
25 **Administration a nonprofit incorporated legal entity known as the Alaska State Health Resources**
26 **Authority.**

27 **(b) The authority shall**

28 **(1)** by July 1, 1992, create and begin a phased implementation of geographic
29 specific health care provider reimbursement systems and utilization standards within the
30 boundaries of municipalities that have a population of 20,000 or more as reflected by the 1990
31 United States census; the health care provider reimbursement systems and utilization standards