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File No. 3

State of Rhode Island and Providence Plantations

JANUARY SESSION, 1974

CHAPTER 50.

AN ACT to Protect the Public Health of the People  
of the State of Rhode Island and Providence Plan-  
tations.

74-S 2239 A  
Approved  
Apr. 26, 1974.

PREAMBLE

Whereas, The state of Rhode Island has the right and the obligation to promote the public health, safety, morals and general welfare; and

Whereas, The high cost of health services can serve as a barrier to persons in need of health care, all to the detriment of the public health; and

Whereas, promotion of the public health, safety and welfare requires that all citizens have equal access to health services and a means to protect themselves against the extraordinary costs of serious illness or injury; and

Whereas, promotion of the public health, safety and welfare further requires that employers be encouraged to provide the best quality of health cov-

erage to their employees and their dependents, and that all other persons be encouraged to obtain the best quality of health coverage for themselves and their dependents; and

Whereas, Promotion of the public health, safety, and welfare further requires that persons or other entities which provide health services or which provide for the prepayment and insurance of health services, or which assist in the payment of health services; do so in furtherance of the public interest, now therefore,

It is enacted by the General Assembly as follows:

Section 1. Title 42 of the general laws entitled "State affairs and government" as amended is hereby further amended by adding thereto the following chapter:

## CHAPTER 62

### Catastrophic Health Insurance

42-62-1. **SHORT TITLE.**—This act shall be known and designated as the Rhode Island catastrophic health insurance plan ("CHIP") act.

42-62-2. **PURPOSES.**—The purposes of this chapter are to assure that each person residing in the state of Rhode Island shall have access to needed diagnostic, curative, and rehabilitative health services at reasonable costs and that each person shall have a reasonable means of protecting himself against the unusually high costs of receiving such health services. For these purposes the general assembly finds that promotion of the public health, safety and general welfare re-

quires that the conditions and responsibilities for the payment and provision of such health services be established.

**42-62-3. EXERCISE OF POLICE POWER.**—This chapter shall be deemed an exercise of the police power for the protection of the health, safety and general welfare of the people of the state.

**42-62-4. DEFINITIONS.**—

(a) The term "employer" means any person, partnership, association, trust, estate, corporation, whether foreign or domestic, or the legal representative, trustee in bankruptcy, receiver or trustee, thereof, or the legal representative of a deceased person, including the state of Rhode Island and each city and town therein, which has in its employ one or more individuals during any calendar year after the effective date of this chapter. For purposes of this section, the term "employer" shall refer only to an employer with persons employed within the state of Rhode Island.

(b) The term "employee" means any person who has entered into the employment of or works under contract of service or apprenticeship with any employer. It shall not include a person who has been employed for less than thirty days by his employer, nor shall it include a person who works less than an average of thirty hours per week. For purposes of this chapter, the term "employee" shall mean a person employed by an employer as defined in section 42-62-4 (a). Except as otherwise provided herein the terms "employee" and "employer" are to be defined according to the rules and regulations of the department of employment security.

(c) The term "insurer" shall include all persons, firms or corporations offering and/or insuring health services on a prepaid basis, including, but not limited to policies of accident and sickness insurance, as defined by chapter 18 of title 27, general laws of Rhode Island, 1956 as amended, nonprofit hospital or medical service plans, as defined by chapters 19 and 20 of title 27, general laws of Rhode Island, 1956 as amended, or any other entity whose primary function is to provide diagnostic, therapeutic or preventive services to a defined population on the basis of a periodic premium. It shall include all persons, firms, or corporations providing health benefits coverage for employees on a self-insurance basis without the intervention of other entities.

(d) The term "health maintenance organization" means an organized system of health care which accepts the responsibility to provide or otherwise assure the delivery of, an agreed upon set of comprehensive health maintenance and treatment services, for a voluntarily enrolled group of persons in a geographic area and is reimbursed through a pre-negotiated and fixed periodic payment made by or on behalf of each person or family unit enrolled in the plan.

(e) The term "health services" means those medical, professional, and paraprofessional services provided to a person to prevent disease, to maintain health, to detect disease and disability in early stages, to diagnose and treat illness, and to rehabilitate a person to his fullest capacities.

(f) The term "benefit" or "health benefit" means a health service financed for a person by a third party such as an insurer or the state.

(g) The term "allowable income" means the adjusted gross income as defined pursuant to section 44-30-12 of the Rhode Island general laws, 1956 as amended, minus any personal exemptions allowed pursuant to such chapter.

(h) The term "state" means the State of Rhode Island and Providence Plantations.

(i) The term "United States" means the government of the United States of America or any of its instrumentalities.

(j) The term, "departmental health advisory councils" means those councils which have been appointed to serve in an advisory capacity for various specific health matters which are a responsibility of the director of department of health or the director of the department of mental health, retardation, and hospitals.

(k) The term "maternity benefits" shall mean benefits rendered for normal obstetrical care. It shall include benefits for completion of obstetrics, prenatal care, care of the newborn infant, labor, delivery, and puerperium care. The term shall include benefits for normal deliveries or for any complications of pregnancy which do not result in delivery of a viable fetus.

(l) The term "medicare" means part A and part B of the United States social security act, title XVIII, as amended, 42 U.S.C. sections 1394, et seq.

(m) The term "physician" means any person duly licensed to practice surgery or medicine pursuant to the provisions of chapters 29, 31 of title 5 and chapters 36, and 37 of title 6 of the general laws of Rhode

Island, 1956 as amended (except dental hygienists), and comparable laws of other countries.

(n) The term "eligible person" means a person who has established permanent residency in the state for three months and who has the legal responsibility for the payment of eligible health costs incurred on his or her behalf or the behalf of persons for whom he or she is legally responsible. A person who has moved to the state for the primary purpose of receiving benefits provided pursuant to this chapter shall not be considered to be a permanent resident unless such residency has been established pursuant to a judicial order to be a permanent residency.

(o) The term "eligible health service" means a health service which would be covered within the type of qualified program an eligible person would be expected to have by the director of health in order to incur the smallest personal resource payment applicable under this chapter.

(p) The term "personal resource payment" means the money an eligible person is obligated to pay from his or her own wages, salary, income or assets for eligible health services which are not otherwise reimbursable under a health benefits plan unless such person is covered under provisions of section 42-62-9.

(q) The term "qualified program" means those health benefits plans which provide for the payment of health services by insurers through plans which have been certified as qualified by the director of the department of business regulation pursuant to this chapter.

(r) The term "health benefits plan" means any plan by which health benefits are paid by an insurer, the state, or the United States.

(s) The term "costs of eligible health service" means those usual and customary costs, or charges or rates of vendors at levels which have been approved in a qualified program by the director of business regulation, and which shall serve as the basis for the costs, rates or charges for which the state would be liable to pay pursuant to the provisions of this chapter.

## ARTICLE I

### Entitlement to Health Benefits Protection

42-62-5. ENTITLEMENT.—Each person residing in the state regardless of age, sex, race, religion, occupational status, or previously existing physical condition shall be entitled

(a) To receive financial protection from costs of health services under conditions and limitations established by this chapter.

(b) To have access to available diagnostic, curative and rehabilitative health services which are medically necessary; and

(c) To obtain through insurers financial protection against the costs of such health services provided by qualified programs.

### 42-62-6. DUTY OF THE STATE.—

(a) The state shall pay for the costs of eligible health services of an eligible person when such costs are determined to be catastrophic.

(b) The costs of eligible health services shall be determined to be catastrophic when an eligible person has incurred an obligation for payment in an amount of money determined pursuant to section 42-62-7.

(c) Any person who becomes eligible for payment for the costs of eligible health services determined to be catastrophic shall remain eligible for such coverage during the calendar year in which he becomes so entitled and during the following calendar year if such person incurs an obligation during such following calendar year for the payment of eligible health costs which are at least equal to twenty-five percent (25%) of the amount of what such person's personal resource payment would have otherwise been during the preceding year of catastrophic coverage. Said amount shall then be an eligible cost for catastrophic coverage during such following calendar year.

(d) Beginning at October 1, 1974, costs of eligible health services incurred on and after October 1 of any preceding year shall be construed as costs incurred in such following year.

(e) In the case of a dispute as to the eligibility of a type of health service for coverage as a catastrophic cost, the director of the department of health may determine, on the basis of an appeal by an eligible person and written comment by the appropriate insurer, whether or not such health service is an eligible health service.

(f) In the case of a dispute as to the eligibility of a person for coverage of catastrophic costs by the state, the director of the department of health shall determine said eligibility after an appeal by a person from a decision by an insurer.

#### 42-62-7. PERSONAL RESOURCE PAYMENTS.—

(a) To be eligible for payment by the state pursuant to section 42-62-6 of his or her health services

of a catastrophic nature, an eligible person must have incurred an obligation to make the applicable personal resource payment computed pursuant to this section. Such payment shall not be a cost payable by the state pursuant to subsections 42-62-6 (a) and (b).

(b) The applicable personal resource payment shall be determined on a calendar year basis and shall not include the payments made to meet the deductible of a major medical plan or the premium costs of a health benefits plan. It shall include the co-insurance payments made under a major medical plan.

(c) The applicable personal resource payment applies to the obligation for payment of health services that are not covered under any health benefit plan, except for health maintenance organization plans.

(d) The applicable personal resource payments shall be determined in relation to the extent of coverage for health benefits, if any, to which an eligible person is otherwise entitled according to the following categories:

(i) An eligible person

(A) Who has a qualified program must have incurred an obligation to pay an amount equal to five hundred dollars (\$500.00) or to ten percent (10%) of his or her allowable income, whichever amount is greater;

(B) Who has a program that would have otherwise been qualified, except for a qualified major medical health benefits plan, must have incurred an obligation to pay an amount equal to twelve hundred fifty dollars (\$1250.00) or to twenty-five percent (25%) of his or her allowable income, whichever amount is greater;

(C) Who has a plan or plans of health benefits which is not a qualified program must have incurred an obligation to pay an amount equal to (1) the difference between costs covered by his plan or plans of coverage and a qualified program, or (2) an amount which does not exceed five thousand dollars (\$5,000.00) or fifty percent (50%) of his or her allowable income, whichever is greater;

(ii) An eligible person who has medicare coverage and

(A) Who has a qualified supplemental program must have incurred an obligation to pay an amount equal to five hundred dollars (\$500.00);

(B) Who does not have a qualified supplemental program must have incurred an obligation to pay an amount equal to one thousand dollars (\$1000.00);

(iii) An eligible person who is not otherwise entitled to coverage under any other health benefits plan must have incurred an obligation to pay an amount equal to either five thousand dollars (\$5,000.00) or to fifty percent (50%) of his or her allowable income, whichever amount is greater.

**42-62-8. EXCLUSIONS.**—All services and charges within any of the following classifications are excluded from the financial protection provided pursuant to section 42-62-6 and shall not be included as applicable personal resource payments pursuant to section 42-62-7.

(a) Benefits provided pursuant to the laws of the United States including, but not limited to military service-connected disabilities, medical services pro-

vided for employees of the armed forces of the United States, medical services financed for the benefit of persons over the age of 65 years of age and for persons with insufficient income and assets to purchase benefits pursuant to the laws of the United States, and medical services which may be financed in the future on behalf of all citizens by the United States;

(b) Care which is primarily for custodial or domiciliary purpose and is not medically necessary;

(c) Cosmetic surgery unless provided as the result of an injury or medically necessary surgical procedure;

(d) Dentistry and optometry unless prescribed as medically necessary as the result of an injury or serious illness or disability;

(e) Chiropractic and psychological therapy and social counseling unless prescribed as medically necessary;

(f) Corrective appliances and artificial aids, such as hearing aids, corrective lenses and eyeglasses, unless such appliances and aids are medically necessary for the purpose of rehabilitation;

(g) Drugs and medication legally requiring prescriptions unless such items are medically necessary;

(h) Drugs and medication not legally requiring prescription;

(i) Outpatient psychiatric care in excess of fifty percent (50%) of the cost incurred of such eligible health services as may be incurred in a calendar year;

(j) Services delivered in facilities which have not been certified by the director of the department of health as qualified to provide such services.

**42-62-9. EMPLOYEES' HEALTH BENEFIT PLANS.—**

(a) Each employer shall, in accordance with regulations promulgated by the director of the department of business regulation in consultation with the director of the department of health, offer the opportunity for his employees to enroll in any available qualified health maintenance organization on the same absolute dollar cost sharing terms which may be provided for other health benefits plans made available for employee enrollment.

(b) The fair value of services rendered by a health maintenance organization to a subscriber after such subscriber has exhausted the services provided by the health maintenance organization's qualified program shall be recognized as eligible health care expenditures by the subscriber in computing his personal resource payment pursuant to section 42-62-7.

**42-62-10. QUALIFIED HEALTH PROGRAM.—**

(a) Upon application by an insurer for certification of a health insurance plan or plans as a qualified program for the purpose of this chapter, the director of business regulation, after consultation with the director of health, shall make a determination within ninety days (90) as to whether the applicant's plan or plans are qualified, and shall publish in the major newspapers of the state on a semi-annual basis thereafter a notice that such plan or plans are qualified.

(b) A program may be certified for a period of two years, if, at least,

(i) It meets the minimum standards of this chapter,

(ii) Its insurer meets the duties established by this chapter and the laws of the state,

(iii) It provides coverage for diagnostic, curative and rehabilitative health services for illness and for injuries for the subscriber and his dependents, which the director of the department of health, after consultation with the appropriate departmental health advisory councils, has recommended as being in the public interest.

(iv) It provides benefits which are approximately equal in scope and in actuarial value to the benefits described in subsection 42-62-10 (c).

(c) Any plan or combination of plans which provide the following benefits or their actuarial equivalent may be deemed to be a qualified program for purposes of the operation of this chapter:

(i) Hospital Services

1. One hundred twenty (120) days of inpatient care in short-term general hospitals, or forty-five (45) days in a specialized hospital, including the full cost of a semi-private room accommodation; meals and dietary services; general nursing care, and intensive care; use of the operating room; drugs and medications used in the hospital; medical and surgical supplies; diagnostic tests including laboratory examinations, pulmonary function, basal metabolism, electroencephalograms and electrocardiograms, insulin and shock therapy; diagnostic and therapeutic x-ray, radiotherapy and radioisotopic services; inhalation and oxygen therapy; blood derivatives, plasma, and charges for administration, typing and cross-matching (but not charges for whole blood); physical therapy, occupational therapy, speech and hearing therapy.

2. Coverage of all necessary services as defined in subsection (i) (1) for the inpatient maternity care, except that an insured or subscriber may be liable for the first one hundred dollars (\$100.00) of cost of such services, after which the qualified plan pays the balances.

3. The full cost of outpatient care from a hospital, if it is for an accidental injury occurring not more than seventy-two (72) hours after a poisoning or traumatic accident, and the use of an operating room for an operation involving (a) a cutting procedure; (b) use of general anesthesia; or (c) reduction of a fracture of dislocation.

4. The full cost of outpatient radiological services including diagnostic x-ray, radiotherapy and diagnostic and therapeutic radioisotopic services.

(ii) Physicians Services

Physicians' usual and customary charges for the following services:

1. Surgical services, consisting of operative and cutting procedures, including routine pre- and post-operative care, provided in a hospital, hospital outpatient department, physician's office, or the patient's home.

2. Services of an assisting physician in connection with such an operative procedure when the nature of such procedure is such that an assisting physician is medically necessary.

3. Services of a physician-anesthetist if anesthesia is administered by a physician other than the surgeon or assisting surgeon.

4. Diagnostic services as listed below, whether performed in a physician's office, approved and licensed medical laboratory or in a hospital, when required for the diagnosis of any condition due to illness or injury:

(a) Diagnostic x-ray and radioisotopic examinations;

(b) Electroencephalograms, basal metabolism tests and electrocardiograms;

(c) Laboratory tests, including pathological examinations;

(d) Radiation treatments by x-ray, radium, external radiation or radioactive isotopes.

5. Physicians' visits to care for a bed patient in a short-term general hospital up to 120 days per period of illness, or for 45 days per period of illness in specialized hospitals, except for routine pre-operative and post-operative physical examinations.

6. Consultation services, where medically necessary in the opinion of the attending physician, at one consultation per specialty per period of illness.

7. Obstetrical delivery services, including pre- and post-natal care, after the first fifty dollars (\$50.00) of charges, which shall be the liability of the patient.

8. Newborn baby care, when the examination and care is provided by a physician other than the physician making the delivery or administering anesthesia related to delivery.

9. Emergency accident services performed by a physician within 72 hours of a traumatic or poisoning accident are covered in full.

(iii) Major Medical Coverage

1. To supplement the protection provided by subsections (c) (i) and (c) (ii), the following additional coverages may be required as a condition for a program being certified as qualified:

(a) It provides up to ten thousand dollars (\$10,000.00) in coverage for payment of eligible health services;

(b) It provides such coverage for at least eighty percent (80%) of the usual and customary charges, or costs, as applicable, of health services described in subsection (c) (i) and (c) (ii) after an insured or subscriber has paid an annual deductible of one hundred dollars (\$100.00) per person or two (2) one hundred dollar (\$100.00) deductibles per family for covered services.

(c) Such covered service provided under subsection (b) shall include:

1. Physicians' services, including home and office visits.

2. Professional ambulance services locally to or from a hospital for inpatients, or to a hospital accident room following an accident.

3. Drugs and medications which by law require a written prescription.

4. Rental or purchase, whichever costs less, or wheelchairs and other durable equipment used for medical treatment exclusively.

5. Out-of-hospital speech therapy and physical therapy.

6. Multiphasic screening and other diagnostic screening examinations.

7. Orthopedic braces, prosthetic appliances, such as artificial limbs and eyes, including replacement, repair or adjustment.

8. Full time or visiting nurse services by a registered nurse or licensed practical nurse when ordered by an attending physician and when medically necessary, up to maximum charges of seven hundred fifty dollars (\$750.00) per year.

9. Services for diagnosis and treatment of mental and nervous disorders, provided, however, that an insured shall be required to make a fifty percent (50%) co-payment, and that the payment of the insurer shall in no event exceed one thousand dollars (\$1,000.00) in a case involving outpatient psychiatric treatment.

(d) Any plan or combination of plans which provides benefits to persons over the age of sixty-five years may be deemed to be a qualified supplemental program for purposes of this chapter after the effective date of this chapter if such plan or combination of plans is designed to supplement medicare and provide the following coverages:

1. The full cost of the hospital deductible and co-payment of part A of medicare as amended annually by actions of the secretary of the United States department of health, education and welfare;

2. The full cost of the physicians' deductible and co-payment amounts of part B of medicare;

3. Payments of amounts equivalent to parts A and B of medicare for services rendered outside the United States;

4. Hospital outpatient treatment for accidents and medical emergencies; and

5. X-ray and other diagnostic tests in the hospital's outpatient department and in the doctor's office.

**42-62-11. DUTIES OF PROVIDERS OF HEALTH SERVICES.—**

(a) Persons and other entities providing health services in the state have a duty to provide those services to any person in need of health services without regard to the person's race, sex, religion, age, or occupational status.

(b) On the basis of the duties required by this act and on the basis of existing legal requirements, the director of the department of health shall provide by regulations promulgated hereunder for the certification of providers and vendors of health services. Such persons or entities found to be not meeting the duty prescribed by subsection (a) may after a hearing, be denied by the director of health certification required for eligibility for reimbursements by insurers, for periods of not more than one (1) year for each determination.

**ARTICLE II**

**Minimum Standards Protection**

**42-62-12. MINIMUM STANDARDS.—**

(a) It shall be the duty of all corporations or other legal entities providing for payment for health services under any contract entered into with an employer, person, state or a political subdivision thereof, pursuant to the requirements of this chapter to comply with

minimum standards established by regulations promulgated by the director of business regulation. The director of business regulation shall promulgate such regulations within one year of the effective date hereof.

(b) Such minimum standards shall be designed to carry out the following purposes:

(i) The reasonable standardization and simplification of coverages to facilitate consumer understanding and comparisons;

(ii) The elimination of provisions which may be misleading or unreasonably confusing to the consumer in connection with the purchase of such coverages or with the settlement of claims;

(iii) The elimination of deceptive practices in connection with the sale of such coverages;

(iv) The elimination of provisions which may be contrary to the health needs of the public;

(v) The availability of qualified plans to persons residing in the state who apply therefor regardless of age, sex, race, occupational status or medical condition;

(vi) The promotion of efficient management of health services within the state;

(vii) The elimination of coverages which are so limited in scope as to be of no substantial economic value to the holders thereof;

(viii) The addition of coverages, the sale of which is required by the public interest to protect the health of persons residing in the state.

(c) Within sixty (60) days after promulgation of said minimum standard regulations by the director of business regulation, each insurer or other entity referred to in this section shall file with the director of business regulation a sample of each of said contracts which it proposes to use. A notice of a receipt of filing shall be delivered to the Rhode Island consumers' council. If requested by the Rhode Island consumers' council the director shall hold a hearing upon not less than ten days' written notice prior to said hearing. A notice of such hearing shall be sent to the filing party and to the Rhode Island consumers' council. The director shall issue a written decision as soon as is reasonably possible following completion of the hearing or at his review if there is no hearing. Said decisions may approve, disapprove or modify the contract offered by the filing party. Thereafter, all insurers or other entities referred to in this section 42-62-12 shall file any modifications of contracts which they propose to offer with the director of business regulation. The director shall thereupon follow the procedure prescribed by this section 42-62-12 (c).

42-62-13. RATES CHARGED.—The rates proposed to be charged or a rating formula proposed to be used by any insurer hereunder to employers, the state of Rhode Island or any political subdivision thereof or individuals shall be filed by such insurer at the office of the director of business regulation. Within thirty (30) days after receipt of such application, the director may hold a hearing upon not less than ten (10) days' written notice prior to the hearings. Said notice shall contain a description of the rates proposed to be charged and a copy of said notice shall be sent to the applicant and to the Rhode Island consumers' council.

At any hearing held hereunder, the applicant shall be required to establish that the rates proposed to be charged or the rating formula proposed to be used are consistent with the proper conduct of its business and with the interest of the public. Any documents presented in support of a filing of proposed rates hereunder shall be made available for public examination at such time and such place as the director may deem reasonable. The director upon such hearing may administer oaths, examine and cross-examine witnesses, receive oral and documentary evidence and shall have the power to subpoena witnesses, compel their attendance and require the production of all books, papers, records, correspondence, or other documents which he deems relevant. The director shall issue a decision as soon as is reasonably possible following completion of the hearing. Said decision may approve, disapprove or modify the rates proposed to be charged by the applicant. Insurers requesting changes in rates shall underwrite the reasonable expenses of the department of business regulation in connection with the aforesaid hearing including any costs related to advertisements, stenographic reporting, and expert witnesses fees.

**42-62-14. DUTIES OF REIMBURSEMENT AND SALE.—**

(a) It shall be the duty of insurers: (i) to offer to any person regardless of age, sex, race, occupational status or of physical condition any plan of health benefits it offers to other individual persons, and to offer to any employer regardless of age, sex, race, occupational status, physical condition, and number of persons employed, any plan of health benefits it offers to other employers; (ii) to promote efficient management; and (iii) to reimburse only vendors of

health services certified by the director of the department of health.

(b) It shall be the duty of vendors of eligible health services to provide those services to insurers and other persons at costs, charges, or rates which are equitable, non-discriminatory and in the public interest. In the event that the director of the department of business regulation shall determine that a vendor is discriminating unlawfully against any insurer with respect to costs, charges or rates, the director shall advise said vendor in writing to cease such discriminatory practices forthwith.

(c) At any hearing conducted pursuant to section 42-62-13, the director of the department of business regulation may disallow any payments made by an insurer to a vendor not certified by the department of health, or to a vendor which has failed to cease discriminatory practices against any insurer after having received a notice from the director of business regulation pursuant to section 42-62-14.

#### 42-62-15. FACILITY REINSURANCE POOL.—

(a) To be eligible to offer plans meeting minimum standards, insurers which are for profit entities or self insurers may enter an agreement to form a facility reinsurance pool within which losses are shared among the insurers on an annual basis in proportion to the number of persons insured pursuant to articles I and II of this chapter.

(b) Such agreements shall not be effective until approved by the director of the department of business regulation as being in the public interest and in con-

formance with regulations issued by the department of business regulation.

(c) If, after a sixty (60) day notice to all such insurers and after a public hearing, the director of the department of business regulation makes a finding that there is lack of fair competition among such insurers or that the public interest is not being served by existing agreements, or by a lack of an agreement, he may require such insurers as a condition of doing business within the state to participate in such facility reinsurance pool established under regulations issued pursuant to this chapter.

### ARTICLE III

#### Health Resources Development Fund

#### 42-62-16. HEALTH RESOURCES DEVELOPMENT FUND.—

(a) There is hereby established in the department of health the health resources development fund to be administered by the director of the department of health pursuant to the terms and for the purposes stated in section 42-62-16 and 42-62-17.

(b) Monies in such fund or for a project authorized pursuant to section 42-62-17 may be expended by contract, loan or grant, to maintain, to expand, and to improve health facilities, health services, and health education in the state of Rhode Island. Such purposes shall include the following: Construction or modernization of health facilities, the education or training of persons who would be qualified to provide professional health services, meeting the start-up costs of new forms of health delivery systems, such as health maintenance organizations, benefits for persons lacking adequate

insured coverage, and the development and implementation of experiments in lower costs or to improve the quality, availability, and accessibility of health services.

(c) Monies provided by loan shall be disbursed for periods not exceeding twenty-five (25) years and at an annual rate of interest not exceeding five percent (5%).

(d) Monies may be made available for scholarships to schools of medicine or dentistry on the condition that for each year of educational cost provided by the fund the recipient is required to serve as an employee of the department of health or the department of mental health, retardation, and hospitals for a period of two years.

(e) Monies disbursed from the fund or for projects authorized by section 42-62-17 shall be for purposes in conformance with state plans for comprehensive health, health services, manpower, and land use, as approved by the governor.

(f) The director of the department of health in consultation with the appropriate departmental advisory councils shall establish criteria for eligible capital projects and eligible education and training projects which are consistent with the comprehensive health, manpower and land use plans approved by the governor.

#### 42-62-17. AUTHORIZATIONS.—

(a) The director of health is authorized to expend from the health resources development fund such monies as may be appropriated by the general assembly or

received from insurers or other entities for the purposes of section 42-62-16.

(b) Notwithstanding any provision of their articles of incorporation, by-laws, or other enabling documents or laws to the contrary, an insurer is hereby authorized to allocate sums of money, derived from the collections of premiums, to the health resources development fund.

(c) Notwithstanding any provision of their articles of incorporation, by-laws, or other enabling documents or law to the contrary, an insurer is further authorized to expend on an annual basis a sum of monies equal to not more than five (5) percentum of its previous year's premium income for a project approved by the director of health, with the concurrence of the director of business regulation. The director of health is authorized to approve projects which are in conformance with purposes of section 42-62-16 and with the criteria further established pursuant to 42-62-16.

#### ARTICLE IV

##### ADMINISTRATION

##### 42-62-18. DESIGNATION OF RESPONSIBILITIES.—

(a) The director of the department of health shall have responsibility for the implementation of the duty of the state established pursuant to sections 42-62-6 and 42-62-7. The director is authorized to enter into contracts with insurers to carry out the duties of the state established by said sections. The director is further authorized to establish by regulation procedures for the collection of benefits to which a person becomes entitled pursuant to said sections, time for

filing claims, review of claims, and such other procedural matters as may be necessary to carry out the purposes of said sections.

(b) To the extent not otherwise designated in this chapter, the governor may designate a department as having responsibility for the implementation of a specific duty required by this chapter. The governor shall report such designation to the general assembly no later than the following year, and each house of the general assembly shall have thirty (30) days within which to disapprove any of the designated delegations and to substitute by passage of new legislation different delegations.

(c) To the extent that existing health related functions within departments or divisions need to be removed to another department for the purposes of more efficient administration, or to the extent that new divisions need to be established to meet the purposes of this chapter, the governor shall make such determinations shall include such determinations within his report to the general assembly.

42-62-19. IMPLEMENTATION OF CHAPTER.— The governor may delay the implementation of any provision of this chapter for one year after he makes a finding to be reported to the first subsequent session of the general assembly that such a section(s) of this chapter has been found to be unconstitutional or has been superseded or modified by an act of the United States.

42-62-20. INTERSTATE AGREEMENTS. — The governor is authorized to enter into agreements with

appropriate officials of a sister state or of the United States to carry out any of the duties of this chapter.

**42-62-21. HEALTH COST REPORT.**—The governor shall provide for a health cost to be made not later than December 31 to the general assembly on legislative and administrative steps required (i) to provide a more comprehensive protection against the costs of health services their provided pursuant to this chapter to persons without health insurance, (ii) to control the rising cost of health services, (iii) to provide for more efficient administration of health services by the state, (iv) to establish more efficient and uniform rate setting processes for the state's purchase of health services and goods, (v) to reduce out-of-pocket costs of health services to persons residing in the state, (vi) to establish a uniform reporting system for vendors for the costs of health services, and (vii) to respond to other changes in health finance, planning, and regulation that may be required in Rhode Island in the event of the passage of a national health insurance act.

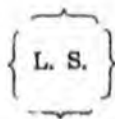
(b) Such report shall be made in consultation with the budget officer, the director of the department of health, the directors of the departments of mental health, retardation, and hospitals, social and rehabilitative services, and of business regulation, and the executive director of the consumers' council, and with representatives of insurers, of the Rhode Island Medical Society, of the Hospital Association of Rhode Island of employers' organizations and of employees' organizations.

42-62-22. ANNUAL REPORT ON THE HEALTH CONDITION OF THE STATE AND HEALTH EXPENDITURES.—The director of the department of health shall make an annual report to the governor and the members of the general assembly not later than January 30 of each year outlining in specific detail the health conditions of the people of the state, the level of health services available to the people of the state, the amount of funds spent in the previous year by public and private agencies and consumers for health services, and unmet health needs of the people of the state, the amounts of monies disbursement for the entitlements established under this act, and the amounts of monies which may be needed according to actuarial estimates to meet those entitlements in the following two years.

Sec. 2. Unless otherwise specified herein, this act shall take effect on January 1, 1975.

A true copy,

Attest:



*Robert V. F. Burns*

Secretary of State

THE FOLLOWING PAGES WERE TREATED AS  
A UNIT IN THE ORIGINAL FILE.

STATE OF ALASKA  
THE LEGISLATURE

POUCH Y STATE CAPITOL  
JUNEAU, ALASKA 99811  
907-465-3800

LEGISLATIVE AFFAIRS AGENCY

February 17, 1978

MEMORANDUM

SUBJECT: Comprehensive Health Insurance Legislation

TO: The Honorable Thelma Buchholdt

FROM: Sharman Haley  
Research Analyst 

Attached you will find the completed report on health care coverage in Alaska. This report is intended to outline for you the possible state approaches to comprehensive health coverage. It was conceived as a necessary step toward developing legislation on the subject of comprehensive health care for Alaska, as you requested last May.

This is the final report and contains the firmest cost estimates available at this time. Please destroy the draft copy I released to you earlier, as the figures the draft contains are less reliable and differ substantially.

Please indicate your wishes for the future handling of this report on the attached release form.

Attachments  
SH:dh

TO: The Honorable Thelma Buchholdt

FROM: Gregg K. Erickson  
Director of Research

Please indicate your directions concerning future handling of the attached information, which you requested under W0# 4206 (Subject: Health Care Assistance).

- I approved the release of this information to any requesting party.
- I do not approve the release of this information; maintain confidentiality
- I approve the release of this information under the following conditions:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

THIRD PARTY HEALTH COVERAGE IN ALASKA

## Table of Contents

	<u>Page</u>
Summary -----	i
I. Introduction -----	1
II. A Description of Health Coverage from Public Sources --	3
Alaska Area Native Health Service -----	3
U.S. Public Health Service -----	5
Uniformed Services Health Benefits Program -----	5
Medicare -----	6
Medicaid -----	7
General Relief Medical -----	9
Catastrophic Illness Committee -----	10
III. A Description of Health Coverage from Private Sources -	12
Private Health Insurance -----	12
Blue Cross -----	13
Health Maintenance Organizations -----	14
Teamsters -----	15
IV. An Analysis of the Extent of Health Coverage and Gaps in Coverage -----	17
The Covered Population -----	17
Services Covered -----	19
V. Possible Legislative Action to Extend Coverage -----	21
Universal Coverage -----	22
Coverage for the Uncovered -----	22
Coverage for Non-wage Earners and the marginally employed -----	22
Income Tax Credit -----	24
Medicaid Medically Needy Program -----	26
Mandatory Employer Coverage -----	28
High Risk Reinsurance Pools -----	29
Minimum Benefits Standards -----	30
VI. Conclusion -----	31
VII. Appendix -----	33

## SUMMARY

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

## I. INTRODUCTION

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

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

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

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

## II. A DESCRIPTION OF HEALTH COVERAGE FROM PUBLIC SOURCES

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

### Alaska Area Native Health Service

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

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

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

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

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

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

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

### U. S. Public Health Service

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

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

### Uniformed Services Health Benefits Program

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

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

### Medicare

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

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

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

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

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

### Medicaid

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

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

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

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

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

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

#### General Relief Medical

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

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

#### Catastrophic Illness Program

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

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

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

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

### III. A DESCRIPTION OF HEALTH COVERAGE FROM PRIVATE SOURCES

#### Private Health Insurance

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

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

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

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

### Blue Cross

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

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

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

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

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

#### Health Maintenance Organizations

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

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

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

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

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

#### Teamsters

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

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

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

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

##### The Covered Population

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

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

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

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

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

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

## Services Covered

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

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

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

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

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

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

<sup>1</sup> "National Health Expenditures, fiscal year 1976", Social Security Bulletin, April 1977, page 8.

## V. POSSIBLE LEGISLATIVE ACTION TO EXTEND COVERAGE

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

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

### Universal Coverage

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

### Coverage for the Uncovered

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

### Coverage for Non-Wage Earners and the Marginally Employed

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

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

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

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

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

#### Income Tax Credit

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

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

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

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

### Medicaid Medically Needy Program

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

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

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

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

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

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

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

#### Mandatory Employer Coverage

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

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

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

#### High Risk Reinsurance Pools

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

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

### Minimum Benefits Standards

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

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

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

## VI. CONCLUSION

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

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

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

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

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

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

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

VII APPENDIX

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

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

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

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

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

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

ESTIMATED ANNUAL PREMIUM \$86,800,000

TABLE III

ESTIMATED RANGE OF INITIAL<sup>1</sup> PREMIUM COSTS OF HEALTH  
COVERAGE FOR THE UNCOVERED POPULATION

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

- 
1. These costs would approach the cost of universal coverage over time, as private subscribers opt for state subsidized coverage.
  2. The estimated premium rate for state wide coverage, +50 to 75%. See Blue Cross memo which follows.

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

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

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

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

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

Blue Cross  
of Washington and Alaska



John M. Hopkins  
Vice President, Marketing

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

November 30, 1977

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

Dear Sharman:

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

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

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

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

Sincerely,

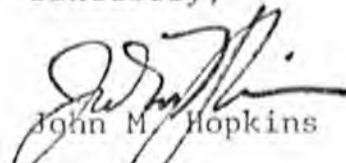
  
John M. Hopkins  
JM:lb

EXHIBIT 'A'

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

- I. A resident is a person whose primary residence has been within the State of Alaska for a continuous period of at least six months.
- II. An eligible resident is a resident not eligible for medical care benefits available through the following entities:
  - a. Federal Employee Health Programs
  - b. United States Armed Forces
  - c. CHAMPUS
  - d. Medicaid
  - e. United States Public Health Service
- III. Healthcare benefits would be provided as primary coverage, with the sole exception that the Program be coordinated as secondary coverage to Medicare. Any persons eligible for Medicare and not enrolling in the Medicare Program will receive the same coordinated benefits had they been covered under Medicare.
- IV. The State of Alaska would identify all eligible residents and submit necessary eligibility data to the Blue Cross Plan monthly on a computer tape in order that an updated eligibility file could be maintained for the Program. Administration and enforcement of eligibility rules would be the responsibility of the State of Alaska.
- V. The State of Alaska would remit, monthly, funds due the Plan based on the eligibility file and contract rates.
- VI. At the end of each contract year the Plan would provide a summary of Income, Incurred claims and administrative expenses under the Program. Any surpluses would be refunded to the State of Alaska. Any deficits would become due and payable to the Plan by the State of Alaska. The Plan would provide monthly reports to the State of Alaska during each contract year, itemizing year-to-date income and expense data.
- VII. During the initial years of the Program it is likely that abnormally high rates of inflation and increases in utilization of healthcare services will occur. In an attempt to control these anticipated trends and their effects on the cost of the Program, it would be desirable for the State of Alaska to enact legislation to control the expansion of healthcare facilities and to set reasonable limits on the rate of return healthcare providers may be allowed.

VIII. If the first contract year is from 7-1-78 through 6-30-79, one of the following options could be used in determining the monthly funds due to the Plan:

A. Rates by eligible resident-

1. Adult (age 19 and over) = \$34.10/month
2. Child (under age 19) = \$12.40/month

B. Rates by type of family unit-

1. Single Adult = \$34.10/month
2. Husband & Wife = \$68.20/month
3. Husband, Wife & one or more Children = \$96.70/month
4. Husband, or Wife and one or more Children = \$62.60/month

C. Rate for any Family Unit = \$71.40/month

Each family unit would coincide with one of the categories itemized in section VIII, B., above. Children must be unmarried and meet the IRS definition of a dependent to be considered an eligible member of any covered family unit.

The above rates assume all eligible residents will participate in the Program.

IX. To minimize the chance of duplicate coverage and benefit payments each eligible resident should be assigned a unique membership number under the Program. This procedure would also facilitate computerized surveillance of medical utilization under the Program. Surveillance programs could be used to detect abnormal utilization of benefits by covered members and abnormal patterns of service by healthcare providers.

X. The Program should provide coverage for services rendered within the State of Alaska. For services outside the state, coverage should be limited to emergencies and to referrals by Alaska physicians for conditions that, in the opinion of the attending physician, cannot be adequately treated in the State's healthcare facilities.

THE PRECEDING PAGES WERE TREATED AS  
A UNIT IN THE ORIGINAL FILE.



# LAWS OF ALASKA

1978

Source

SCS CSHB 409

Chapter No.

107

## AN ACT

Relating to catastrophic illness; and providing for an effective date.

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

\* Section 1. AS 47 is amended by adding a new chapter to read:

#### CHAPTER 8. CATASTROPHIC ILLNESS ASSISTANCE.

Sec. 47.08.010. REIMBURSEMENT OF PROVIDERS. According to the provisions of this chapter, the Department of Health and Social Services shall reimburse providers of medical care for unpaid costs incurred in the treatment of a person suffering an illness or accident which results in financial catastrophe to the person or his family.

Sec. 47.08.020. CATASTROPHIC ILLNESS COMMITTEE. There is created the Catastrophic Illness Committee, consisting of a medical review officer from the Department of Health and Social Services, a member appointed by the governor who has suffered a catastrophic illness, and a representative of the Department of Commerce and Economic Development appointed by the governor.

Sec. 47.08.030. NOTICE. The committee shall enlist the assistance of medical providers in making the public aware of the catastrophic illness assistance program.

Sec. 47.08.040. APPLICATIONS FOR ASSISTANCE. An application for financial assistance under this chapter may be filed by a person who has suffered catastrophic illness or by a parent, spouse, or legal guardian of that person, or by any other interested party with the written consent of the person who has suffered the catastrophic illness.

Sec. 47.08.050. SERVICES EXCLUDED FROM COVERAGE. Annually, the committee shall determine in light of appropriated funds and expected need the medical expenses reimbursable under this chapter, except that the following are not reimbursable:

- (1) dentistry and optometry unless prescribed by a licensed dentist or physician as medically necessary as the result of the injury or illness;
- (2) elective medical or surgical procedures;
- (3) drugs and medications not prescribed by a licensed physician;
- (4) services received as a result of a pregnancy or birth without unusual complications;
- (5) private psychological or psychiatric treatment or private alcoholism treatment, unless no, available from public agencies or programs;
- (6) chiropractic services;
- (7) services not of a medical nature;
- (8) medical services currently provided to persons in the custody of the division of corrections;
- (9) costs incurred before July 1976.

Sec. 47.08.060. CALCULATION OF APPLICANT'S SHARE.

(a) As frequently as necessary the committee shall adopt, in light of appropriated funds and expected need, a formula to be used in determining the applicant's share of total medical expenses incurred as a result of a catastrophic illness, based on the applicant's annual gross income, number of dependents, amount of assets, and forthcoming third-party payments, all considered in light of the requirement that the applicant's share will be paid to the provider on a payment schedule covering a period of at least three years.

(b) For the purposes of applying the formula to determine the applicant's share, multiple catastrophic illnesses occurring within a 12-month period to the applicant or other members of the applicant's family shall be treated as one catastrophic illness.

(c) In applying the formula to determine the applicant's share, the total gross income and the total assets of the family of the applicant may be taken into account, with the following exceptions:

- (1) the applicant's permanent place of abode;
- (2) one noncommercial vehicle;
- (3) tools, equipment, vehicles and other assets required in a trade or business;
- (4) ordinary household and personal effects;

(5) \$1,000 of liquid assets;

(6) all nonliquid assets unless such an exclusion would bring about an inequitable result; however, all income derived from such property shall be taken into consideration in determining the recipient's gross income;

(7) inalienable shares in a Native corporation created under the Alaska Native Claims Settlement Act, P.L. 92-203; 43 U.S.C. 1601 et seq., for the period of their inalienability as specified in the Act;

(8) Alaska longevity bonus payments;

(9) any other assets specifically restricted for the use of the recipient by state or federal law.

(d) Assets received by the applicant as a custodian, guardian, conservator, or trustee for another are not considered assets of the custodian, guardian, conservator, or trustee himself.

(e) The applicant's share shall be reduced in the amount of any premiums paid for disability insurance or a prepaid medical plan up to \$500 if incurred in the 12-month period beginning with the occurrence of the injury or the onset of the illness.

(f) Notwithstanding the provisions of this section, the committee may waive payment of an applicant's share when the catastrophic illness is the proximate result of an immunization required by law.

Sec. 47.08.070. STANDARDS FOR REIMBURSEMENT TO PROVIDERS. The amount that the committee reimburses providers for medical services rendered to a person who has suffered catastrophic illness may not be greater than 100 per cent of the total unpaid bills related to the catastrophic illness and shall be determined by the following standards:

(1) Only unpaid medical expenses for periods not to exceed 12 months, and related to catastrophic illness, may be considered. The initial 12-month period begins with the date of the first charges incurred because of the illness.

(2) The committee may not reimburse a provider if the applicant's total medical expenses related to the catastrophic illness are less than \$1,000 in any period not exceeding 12 months described in (1) of this section after all sources of third-party payment have been exhausted by the applicant or by someone acting on behalf of the applicant.

(3) The committee may not reimburse a provider for the applicant's share of the total medical expenses, moreover, a reimbursement to the provider shall be conditioned on the provider's agreement that the provider enter into a payment schedule with the applicant which will result in full liquidation of the applicant's share. Payment schedules may not be for a term of less than three years.

Sec. 47.08.080. RECONSIDERATION OF DECISION BY