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HHESS

STATE HEALTH INSURANCE (FILE NO. 2)

1911

STATE
HEALTH
INSURE.

2

Ken Moore
Director of Insurance
Not admitted
I was coming

TESTIMONY PREPARED
for
HOUSE OF REPRESENTATIVES
COMMITTEE ON HEALTH EDUCATION & SOCIAL SERVICES
ALASKA STATE LEGISLATURE

March 31, 1980

I apologize publicly to him for this breach of protocol

It is indeed a pleasure for me to appear before you today to discuss legislation which I believe will promote the health of residents of your great state and this great country. I am very pleased that a state legislature is seriously considering enactment of a bill which will guarantee citizens' access to third party payment for health care. It is also very comforting for Minnesotans who have championed this sort of legislation to know that Minnesota is not out of step in fighting for this enlightened program.

I have come a long way to be with you today. It is an awesome responsibility to represent the State of Minnesota, our Governor, Al Quie, and our Insurance Commissioner, Michael D. Markman. I also feel I represent the hundreds of people who toiled for many months before and after the enactment of our law. We had great cooperation from our local insurance people and although the insurance industry continues to be assaulted from many quarters, this is one area in which some of the industry can be justifiably proud.

What success our law has had in promoting access to comprehensive health care to Minnesotans lies in the willingness of the State and the insurance people within that state to join forces to effect the goal of the legislation.

Although I could not bring the experts who have made our program work smoothly with me, I did bring some of their work product which I shall leave with you with the hope that it will ease the implementation of the bill upon enactment.

My role here today as I see it is to share with you the experiences and knowledge gained in four years of working with our legislation which is similar to your proposed legislation. The provisions which are similar or nearly identical will of course, lend themselves to a recitation of historical fact. Those that are unique to your bill will require a forecast.

②

QUALIFIED MEDICARE SUPPLEMENT PLAN 21 50 040

STATE PLAN PREMIUM 21 50 050

125% of the 5 LARGEST
INSURELS FOR QUALIFIED PLANS

HMO ONLY - GEN ACCEPTED
ACTUARIAL PRINCIPLES.

DUTIES OF DIRECTOR 21 50 060

SAME AS MINN.

COMPREHENSIVE HEALTH ASSOCIATION 21 50 090

INSURELS
SELF INSURELS
FRATERNALS
HMO'S

BOARD (7) ELECTED BY
WEIGHTED VOTE

MANDATORY MEMBERSHIP AS A CONDITION OF
DOING BUSINESS.

ASSOCIATION MAY EXERCISE POWERS (SAME AS
MINN
INCLUDES PROVISION
FOR REINSURANCE SAME AS MINN

21 50 110

ENROLLMENT BY ELIGIBLE PERSON

NO PRESUMPTIVE CONDITIONS
6 MONTH WAITING PERIOD ON
90 DAY PRE EXISTING CONDITIONS

21 50 120

SOLICITATION OF ELIGIBLE PERSONS

DISSEMINATE INFO
PUBLIC AWARENESS
2500 REFINANCES
NOTIFICATION BY INSURER OF
EXISTANCE OF STATE PLAN UPON
REJECTION FOR COVERAGE

21 50 130

CONVERSION PRIVILEGES

POLICIES WRITTEN OR RENEWED IN
THIS STATE (NOT EXTRATERRITORIAL)
RIGHT TO CONVERT FOR ANY REASON
~~REQUIRE~~
INDIVIDUAL COVERAGE MUST BE
QUALIFIED PLAN. (NO CHOICE?)

PROVIDES FOR ENROLLMENT BY ELIGIBLE PERSON

EMPLOYER MAY PAY DIRECT TO W/C

8 1/2% MIN TO PAY CLAIMS

12% MAX TO W/C

MEMBERS SHARE LOSSES DUE TO CLAIMS EXPENSES.

ADMINISTRATION EXPENSES?

WHY CALL IT

REINSURANCE? PAYMENTS ASSESSED MAY BE OFFSET
PAYMENTS? BY INCOME TAX OR PREMIUM TAX

2150090 MINIMUM BENEFITS OF STATE PLAN

#1 #2 & QUALIFIED MED SUPPLEMENT

HMO WHERE AVAILABLE

(ACTUARIAL EQUIVALENT NOT OFFERED IN MINNESOTA)

2150100 ADMINISTRATION OF PLAN

PROPOSED PLANS MAY BE SUBMITTED
(PROTOTYPE OR AE)



Official Business

Alaska State Legislature

House of Representatives

Committee on Health, Education & Social Services

Pouch V
State Capitol
Juneau, Alaska 99811

21 March 1980

MAR 26 1980

To All Parties Interested in Health Care Coverage:

Hearings for legislation dealing with various health care issues are scheduled for March 31, April 1 and April 2 before the House Health, Education and Social Services Committee.

We are interested in your comments on this important piece of legislation which is presently in draft form. Therefore, we felt that it was necessary to prepare the following summary of the issues contained in the legislation to aid in the preparation of your testimony.

We expect that the legislation will be introduced in the House on March 25 or 26. The bill will be available at Legislative Information Offices throughout the state on the following day.

On March 31 and April 2, the Committee will be hearing testimony in Room 112 of the Capitol at 1:30 pm. On April 1 we will be holding teleconference hearings from Anchorage and Fairbanks from 7:00 - 9:00 pm Juneau time (5:00 - 7:00 pm Anchorage and Fairbanks time) and from all other sites from 1:30 - 3:00 pm Juneau time.

We regret that the bill is not available in its final form at this date. However, we would like to stress that all of the information necessary to formulate comments/testimony is included in the attached summary. Thank you for your cooperation.

Sincerely,

Thelma

Thelma Buchholdt
State Representative
Chair, House HESS Committee



Official Business

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Pouch V
State Capitol
Juneau, Alaska 99801

SUMMARY OF HEALTH CARE LEGISLATION

The first section of the bill requires employers to provide health coverage for their regular employees and to pay at least 50% of the premium cost of such coverage. The health coverage must meet or exceed the standards for a "number two qualified plan" as established in the second section of the bill, and must cover the employer's dependents as well. The employer may choose the type of health plan (insurance, self insurance, medicare service contract, etc.) and the carrier, provided that employers with 100 or more employees offer each employee a choice of an insurance type plan or a health maintenance organization contract, where a health maintenance organization exists. The employee's share of the premium is automatically withheld from his or her paycheck and may not exceed the amount the employee would have paid if the employer had chosen the most prevalent type of health care plan in the state. The employer is obligated to continue paying his or her share of the premium even if the employee is sick and unable to work, for up to three months or the period for which the employer must continue to pay wages, whichever is larger. Any employee who works for at least twenty hours per week on the average, and has been employed for at least four consecutive weeks, is to be covered. If the employee has health coverage from another source, such as another employer, a government program, or coverage as a dependent under someone else's health plan, the employer is not liable for health coverage for that employee. The bill specifically provides that employees retain the freedom to bargain collectively for health benefits which may differ from those provided under this legislation.

A small employer who can demonstrate undue financial hardship resulting from the mandatory health coverage is entitled to premium supplementation from the state. To qualify (1) the employer must employ fewer than eight employees, (2) the premium for which the employer is liable must exceed 1.5 percent of the total payroll, and (3) the amount that the employer's cost exceeds 1.5 percent of the payroll must exceed five percent of the employer's income from that business, before taxes. A qualifying employer is entitled to subsidy in the amount that his or her costs exceed these standards.

Employers who cover their Alaska employees in a group plan in which the majority of the covered employees are out-of-state and not covered by the act, are given, in section eight of the bill, an additional year to bring the coverage of their Alaska employees up to the standards mandated in the act.

The law mandating employer sponsored coverage would terminate when it is superseded by federal health insurance legislation.

Section two of the bill establishes state standards for "qualified" health insurance plans, and requires insurance carriers to offer qualified plans to all eligible applicants. The bill does not prohibit the offering or sale of unqualified plans. Qualified plans must include benefits for the following: hospital services, professional services rendered by a physician or at his or her direction, prescription drugs, nursing home services, home health agency services, radium, oxygen, anesthetics, prostheses, medical equipment, x-rays and laboratory tests, oral surgery, physical therapy services, medically necessary transportation, well baby care, routine physical exams, multiphasic screening, and other diagnostic testing. The plan must cover at least 80% of the usual and customary charges for covered services, must limit out-of-pocket expenses at least to \$3,000 per person annually, and may provide a limit on maximum lifetime benefit of not less than \$250,000. A number three qualified plan may have an annual deductible not exceeding \$150 per person or \$450 per family. A number two qualified plan may have an annual deductible not exceeding \$500 per person or \$1500 per family. A number three qualified plan may have an annual deductible not exceeding \$1,000 per person or \$3000 per family. A qualified Medicare supplement plan must provide coverage of at least 50% of the Medicare deductible and co-payment, provide at least 80% coverage of the services required in a qualified plan which are not covered by Medicare, limit out-of-pocket expenses to no more than \$1,000 per person per year, and provide for a maximum lifetime benefit of not less than \$100,000. The director has authority to upgrade minimum benefit standards by regulation.

The act also offers health insurance coverage to high risk "uninsurable" clients under the state plan. The state plan provides number one, number two, and Medicare supplement qualified plans at premium rates which may not exceed 125% of the average premium for a normal risk individual. To qualify, a person must present evidence that they have been refused coverage which is available to a person of standard risk by at least two carriers. The person is not covered for a preexisting condition during the first six months of coverage under the state plan if the person was diagnosed or treated for that condition during the 90 days preceding the filing of an application.

All health insurance carriers in the state are required to participate in a joint underwriting association to pool the risk of the state plan, to publicize the state plan, and to reinsure other coverage mandated by the act. Losses incurred by the association due to the state plan are to be covered through assessments on association members proportional to their volume of health insurance business in the state. Assessments on members may in turn offset the income tax or premium tax payable by that member to the state. Thus the state is ultimately liable for the losses incurred by the operation of the state plan. The association selects one carrier to act as its agent in writing and issuing each type of state plan insurance for a period of at least three years, and reimburses the carrier or carriers for their expenses.

The act requires that all group health insurance policies written in the state include the right to convert to an individual coverage qualified plan without the addition of underwriting restrictions, regardless of the reason for leaving the group. It also requires that individual policies include a provision that covered dependents may continue coverage following the death of the primary insured, under that or a different contract, without additional underwriting restrictions.

The remaining sections of the bill amend the state's medical assistance programs. The bill provides that the Department of Health and Social Services will purchase health care services for its clients through health insurance policies or through health care service contracts which provide some or all of the services covered by state medical assistance programs.

The bill authorizes the Department to pay a cash advance to providers who serve a large volume of state medical assistance clients. It also requires the state to pay interest on unpaid bills which have been presented by providers which satisfy program requirements for payment. If payment of the bill is delayed more than thirty days from the date it becomes payable, interest is charged at the rate of one percent per month. If payment of the bill is delayed more than six months from the date it becomes payable, interest is charged at the rate of two percent per month.

The bill expands Medicaid coverage to include prescription drugs, adult dental care, dentures, physical therapy, prosthetic devices, chiropractors' services, private duty nursing, podiatrists' services, and other optional services under the federal Medicaid program. Eligibility for Aid to Families with Dependent Children and Medicaid is expanded to cover unborn children.

The bill establishes a medically needy program under the state General Relief program. The monthly income threshold for eligibility is set at 150 percent of the poverty guidelines for Alaska, and includes a spend down provision such that a person who is over income qualifies when the amount of their excess income has been spent on medical bills.

Proofed 3-21

BY THE HEALTH, EDUCATION AND
SOCIAL SERVICES COMMITTEE

1 IN THE HOUSE

2 HOUSE BILL NO.

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 ELEVENTH LEGISLATURE - SECOND SESSION

5 A BILL

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

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

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

10 CHAPTER 12. PREPAID HEALTH CARE.

11 Sec. 18.12.010. COVERAGE OF REGULAR EMPLOYEES BY GROUP PREPAID
12 HEALTH CARE PLAN. (a) An employer who pays to a regular employee
13 monthly wages amounting to 86.67 times the minimum hourly wage estab-
14 lished in AS 23.10.065 shall provide coverage for the employee with a
15 prepaid group health care plan or combination of plans which have been
16 certified under AS 21.50.040 as a number two qualified plan including
17 coverage for dependents with a prepaid health care plan contractor in
18 accordance with this chapter.

19 (b) If the plan of health coverage does not meet the requirements
20 of AS 21.50.040 for a number two qualified plan, the employer shall make
21 available a supplemental plan of health benefits which, when combined
22 with the existing plan of health benefits, constitutes a number two
23 coverage plan.

24 Sec. 18.12.020. CHOICE OF PLAN TYPE AND OF CONTRACTOR. (a) An
25 employer required to provide coverage for his employees by a prepaid
26 group health care plan under this chapter shall determine whether
27 coverage is provided by

28 (1) a plan which obligates the prepaid health care plan
29 contractor to furnish the required health care benefits;

1 (2) a plan which obligates the prepaid health care plan
2 contractor to defray or reimburse the expenses of health care; *m*

3 (3) ^{plans under both (1) and (2) in compliance} ~~a plan which complies~~ with AS 18.12.030(2).

4 (b) The election made under (a) of this section is binding for one
5 year.

6 (c) Whether the employer elects a plan type described in (a)(1) or
7 (2) of this section, the employer may elect the particular contractor
8 but the employee is not obligated to contribute a greater amount to the
9 premium than he would have to contribute had the employer elected
10 coverage with the contractor providing the prevailing coverage of the
11 respective type in the state.

12 (d) The employer shall provide coverage with the prepaid health
13 care plan contractor selected under (c) of this section for all his
14 employees in the state electing the type of coverage who are covered by
15 the provisions of this chapter, except for employees covered by the
16 health care provisions of an applicable collective bargaining agreement
17 and except as provided in AS 18.12.110.

18 Sec. 18.12.030. DUAL OPTION. (a) An employer who employs 100 or
19 more persons in the state on the average during a calendar quarter other
20 than employees engaged in seasonal employment, shall, upon the next
21 renewal of the health benefits plan contract, offer his employees an
22 option to obtain health benefits through either an accident and health
23 insurance policy or a health maintenance organization contract if one is
24 available. An option need not be provided if fewer than 25 employees
25 select that option.

26 (b) An employer may make the offers through an insurer, a health
27 maintenance organization or on a self-insured basis. If an offer is
28 made on a self-insured basis, the accident and health insurance type of
29 coverage or health maintenance organization type of coverage shall meet

1 the requirements of the laws of the state as to the services covered or
2 benefits provided but is not required to be approved by the director.

3 (c) An insurer may not make acceptance of its offer to provide
4 insurance coverage contingent on acceptance by the employer of health
5 maintenance organization coverage by a particular health maintenance
6 organization. A health maintenance organization may not make acceptance
7 of its offer to provide health maintenance organization coverage con-
8 tingent on acceptance by the employer of insurance coverage by a par-
9 ticular insurer. An offer to provide the accident and health insurance
10 policy and the health maintenance organization contract may not combine
11 the two offers in a single price package.

12 Sec. 18.12.040. LIABILITY FOR PAYMENT OF PREMIUM AND FOR WITH-
13 HOLDING. (a) Unless an applicable collective bargaining agreement
14 provides otherwise, an employer shall contribute at least one-half of
15 the premium for the coverage required by this chapter and the employee
16 shall contribute the balance. The employee may not be required to
17 contribute more than 1.5 percent of his wages. If the amount of the
18 employee's contribution is less than one-half of the premium, the
19 employer is liable for the remaining portion of the premium.

20 (b) The employer shall withhold the employee's share from his
21 wages.

22 Sec. 18.12.050. COMMENCEMENT OF COVERAGE. The employer shall
23 provide the coverage required by this chapter for any regular employee
24 who has been in his employ for four consecutive weeks at the earliest
25 time after the fourth week at which coverage may be provided with the
26 prepaid health care plan contractor selected in accordance this chapter.

27 Sec. 18.12.060. CONTINUATION OF COVERAGE. If an employee is pre-
28 vented by sickness from working, the employer shall enable the employee
29 to continue his coverage by contributing to the premium the amount paid

1 by the employer toward the premium before the employee's sickness for
2 the period that the employee is prevented by sickness from working. The
3 obligation established by this section may not exceed a period of three
4 months following the month during which the employee became disabled
5 from working or the period for which the employer has paid regular wages
6 to the employee, whichever is longer.

7 Sec. 18.12.070. LIABILITY OF SECONDARY EMPLOYER. An employer who
8 has been notified by an employee on a form prescribed by the commis-
9 sioner that he is not the principal employer is relieved from the duty
10 to provide coverage required by this chapter until he is notified by the
11 employee under AS 18.12.090 that he has become the principal employer.
12 A secondary employer shall notify the commissioner on a form prescribed
13 by the commissioner that he is relieved from the duty of providing
14 coverage and of any change in that status.

15 Sec. 18.12.080. EXEMPTION OF CERTAIN EMPLOYEES. (a) In addition
16 to the exemption granted by AS 18.12.070, an employer is relieved of his
17 obligations under AS 18.12.010 to an employee who has notified him on a
18 form specified by the commissioner that the employee is

19 (1) protected by health insurance or a prepaid health care
20 plan established under a law of the United States;

21 (2) covered as a dependent under a prepaid health care plan,
22 entitling him to the health benefits required by this chapter;

23 (3) a recipient of public assistance or covered by a prepaid
24 health care plan established under the laws of the state governing
25 medical assistance.

26 (b) An employer receiving notice of a claim of exemption under
27 this section shall notify the commissioner of the claim on a form pre-
28 scribed by the commissioner.

29 Sec. 18.12.090. TERMINATION OF EXEMPTION. (a) If an exemption

1 claimed by an employee under AS 18.12.030 terminates. the employee shall
2 notify the principal employer promptly of the termination of the exemp-
3 tion and the employer shall provide coverage as required by this chap-
4 ter.

5 (b) If a principal employer becomes a secondary employer or a
6 secondary employer becomes the principal employer because of a change in
7 the employment situation of an employee or a redetermination by an
8 employee under AS 18.12.100, the employee shall promptly notify the
9 employers affected of the change and the new principal employer shall
10 provide coverage required by this chapter.

11 Sec. 18.12.100. PRINCIPAL AND SECONDARY EMPLOYERS. (a) If an
12 individual is concurrently a regular employee of two or more employers,
13 the principal employer is the employer who pays him the most wages. If
14 the employer who does not pay the most wages employs the regular em-
15 ployee for at least 35 hours per week, the employee shall determine
16 which of the employers is his principal employer and his other employers
17 are secondary employers. An employer designated as the principal
18 employer remains the principal employer for one year or until change of
19 employment, whichever occurs first.

20 (b) If an individual is concurrently a regular employee of a
21 public entity which is not an employer under this chapter and of an
22 employer under this chapter, the latter is a secondary employer.

23 (c) An employer who directly or indirectly interferes with or
24 coerces or attempts to coerce an employee in making a determination
25 under this section is guilty of a class B misdemeanor.

26 Sec. 18.12.110. FREEDOM OF COLLECTIVE BARGAINING. (a) This
27 chapter may not be construed to limit the freedom of employees to bar-
28 gain collectively for different prepaid health care plan coverage or for
29 a different allocation of the costs of the coverage. A collective

1 bargaining agreement may provide that the employer will provide the
2 health care specified in an agreement.

3 (b) If certain employees are not covered by the health care pro-
4 visions of an applicable collective bargaining agreement to which their
5 employer is a party, this chapter applies to them. An employer or group
6 of employers has complied with this chapter if the employer or group of
7 employers undertakes to provide health care services under a collective
8 bargaining agreement and the services are available to all employees not
9 covered by the agreement.

10 Sec. 18.12.120. INDIVIDUAL WAIVERS PROHIBITED. An employee as an
11 individual may not waive the required health care benefits or agree to
12 pay a greater share of the premium for the benefits than is required by
13 this chapter.

14 Sec. 18.12.130. JOINT PROVISION OF COVERAGE. For the purpose of
15 providing prepaid health care protection under this chapter for their
16 employees, employers may form associations with the contractors autho-
17 rized to provide coverage in the state.

18 Sec. 18.12.140. POWERS OF THE COMMISSIONER. The commissioner may
19 adopt regulations necessary for the administration and enforcement of
20 this chapter.

21 Sec. 18.12.150. PENALTIES. (a) An employer who fails to comply
22 with AS 18.12.010 - 18.12.040 shall pay a penalty of not less than \$25
23 or of \$1 for each employee for every day during which the failure con-
24 tinues, whichever is greater. The penalty shall be assessed under
25 regulations adopted by the commissioner under the Administrative Pro-
26 cedure Act (AS 44.62) and shall be collected by the commissioner and
27 paid into the general fund. The commissioner may, for good cause shown,
28 remit all or a part of the penalty.

29 (b) An employer, employee, or prepaid health care plan contractor

1 who wilfully fails to comply with this chapter or a regulation adopted
2 under it may be fined not more than \$200 for each violation.

3 Sec. 18.12.160. ENTITLEMENT TO PREMIUM SUPPLEMENTATION. (a) An
4 employer who employs less than eight employees entitled to coverage
5 under this chapter and who provides coverage to the employees under
6 AS 18.12.010 is entitled to premium supplementation if the employer's
7 share of the cost of providing the coverage as determined under
8 AS 18.12.040 and 18.12.060 exceeds 1.5 percent of the total wages
9 payable to the employees and if the amount of the excess is greater than
10 five percent of the employer's income before taxes directly attributable
11 to the business in which the employees are employed.

12 (b) The amount of the supplementation shall be that part of the
13 employer's share of the premium cost which exceeds the limits specified
14 in (a) of this section.

15 Sec. 18.12.170. CLAIM OF PREMIUM SUPPLEMENTATION. An employer
16 entitled to premium supplementation may file a claim in the manner
17 provided by regulation of the commissioner. The employer has the burden
18 of establishing his entitlement.

19 Sec. 18.12.180. EXISTING PLANS. This chapter may not be construed
20 to interfere with or diminish protection already provided under collec-
21 tive bargaining agreements or employer-sponsored plans more favorable to
22 the employees benefited by them than the protection provided by this
23 chapter.

24 Sec. 18.12.190. TERMINATION OF CHAPTER. This chapter terminates
25 on the effective date of federal legislation that provides for voluntary
26 prepaid health care for the people of this state in a manner at least as
27 favorable as the health care provided by this chapter or upon the
28 effective date of federal legislation that provides for mandatory pre-
29 paid health care for the people of this state.

1 commerce, performed for wages under a contract of hire, written or
2 oral, expressed or implied, with an employer, either inside or both
3 inside and outside the state if:

4 (i) the service is localized in the state; or

5 (ii) the service is not localized in any state but
6 some of the service is performed in the state and the individual's
7 base of operation, or, if there is no base operation, the place
8 from which the service is directed or controlled, is in the state;
9 or the individual's base of operation or place from which the
10 service is directed or controlled is not in any state in which some
11 part of the service is performed but the individual's residence is
12 in the state;

13 (B) does not mean service

14 (i) performed by an individual in the employ of an
15 employer who, under the laws of the United States, is re-
16 sponsible for care and cost in connection with the service;

17 (ii) performed by an individual in the employ of his
18 spouse, son, or daughter, and service performed by an
19 individual under the age of 21 in the employ of his father or
20 mother;

21 (iii) performed in the employ of a voluntary em-
22 ployee's beneficiary association providing for the payment of
23 life, sickness, accident, or other benefits to the members of
24 the association or their dependents or their designated bene-
25 ficiaries, if admission to membership in the association is
26 limited to individuals who are officers or employees of the
27 United States government, and no part of the net earnings of
28 the association inures (other than through such payments) to
29 the benefit of a private shareholder or individual;

1 (iv) performed by an individual for an employer as
2 an insurance agent or as an insurance solicitor, if all the
3 service performed by the individual for the employer is per-
4 formed for remuneration solely by way of commission;

5 (v) performed by an individual for an employer as a
6 real estate salesman or as a real estate broker, if all the
7 service performed by the individual for the employer is per-
8 formed for remuneration solely by way of commission;

9 (4) "income directly attributable to the business"

10 (A) means gross profits from the business less deduc-
11 tions for

12 (i) compensation of officers;

13 (ii) salaries and wages, except wages paid by an
14 individual proprietor to himself;

15 (iii) repairs;

16 (iv) taxes on business and business property;

17 (v) business advertising;

18 (vi) amounts contributed to employee benefit plans;

19 (vii) interest on business indebtedness;

20 (viii) rent on business property; and

21 (ix) other expenses necessary for the current con-
22 duct of business;

23 (B) does not mean

24 (i) bad debts;

25 (ii) contributions or gifts, other than those listed
26 under (A)(vi) of this paragraph;

27 (iii) amortization and depreciation; or

28 (iv) losses by fire, storm, casualty, or theft;

29 (5) "premium" means an amount payable to a prepaid health

1 care plan contractor as consideration for his obligations under a pre-
2 paid health care plan;

3 (6) "prepaid health care plan" means an agreement by which a
4 prepaid health care plan contractor undertakes in consideration of a
5 stipulated premium

6 (A) to furnish health care, including hospitalization,
7 surgery, medical or nursing care, drugs or other restorative
8 appliances, subject to, if at all, only a nominal per service
9 charge; or

10 (B) to defray or reimburse, in whole or in part, the
11 expenses of health care;

12 (7) "prepaid health care plan contractor" means

13 (A) a medical group or organization which undertakes
14 under a prepaid health care plan to provide health care;

15 (B) a nonprofit organization which undertakes under a
16 prepaid health care plan to defray or reimburse in whole or in part
17 the expenses of health care; or

18 (C) an insurer who undertakes under a prepaid health
19 care plan to defray or reimburse in whole or in part the expenses
20 of health care;

21 (8) "regular employee" means a person employed in the em-
22 ployment of any employer for at least 20 hours per week;

23 (9) "wages"

24 (A) means cash remuneration for services from whatever
25 source, including commissions, bonuses, and tips and gratuities
26 paid directly to an individual by a customer of the employer; if
27 the employee does not account to his employer for the tips and
28 gratuities received and is engaged in an occupation in which he
29 customarily and regularly receives more than \$200 a month in tips.

1 the combined amount received by him from his employer and from tips
2 is considered to be at least equal to the wage required by AS 23.-
3 10.065 or a greater sum as determined by regulation of the commis-
4 sioner;

5 (B) does not mean the amount of a payment

6 (i) specified in AS 23.20.530(b);

7 (ii) received for nonoccupational sickness or acci-
8 dent; or

9 (iii) received as workers' compensation.

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

11 CHAPTER 50. COMPREHENSIVE HEALTH INSURANCE.

12 Sec. 21.50.010. DUTIES OF INSURERS. (a) For each type of quali-
13 fied plan described in AS 21.50.030, an insurer or fraternal issuing
14 individual policies of accident and health insurance in the state other
15 than group conversion policies shall develop and file with the director
16 an individual policy which meets the minimum standards of that type of
17 qualified plan. An insurer or fraternal issuing individual policies of
18 accident and health insurance in the state shall offer each type of
19 qualified plan to each person who applies and is eligible for accident
20 and health insurance from that insurer or fraternal.

21 (b) An insurer or fraternal issuing Medicare supplement plans in
22 the state shall develop and file with the director a Medicare supplement
23 policy which meets the minimum standards of a qualified Medicare supple-
24 ment plan. An insurer or fraternal issuing Medicare supplement plans in
25 the state shall offer a qualified Medicare supplement plan to each
26 person who is eligible for coverage and who applies for a Medicare
27 supplement plan.

28 (c) For each type of qualified plan described in AS 21.50.040, an
29 insurer or fraternal issuing group policies of accident and health

1 insurance in the state shall develop and file with the director a group
2 policy which provides for each member of the group the minimum benefits
3 required by that type of qualified plan. An insurer or fraternal is-
4 suing group policies of accident and health insurance in the state shall
5 offer each type of qualified plan to each eligible applicant for group
6 accident and health insurance.

7 (d) Each insurer and fraternal shall include coverage of major
8 medical costs in every unqualified policy of accident and health in-
9 surance, unless the applicant for a new or renewal policy declines the
10 coverage in writing. The coverage shall provide that when a covered
11 individual incurs out-of-pocket expenses of \$5,000 or more in a calendar
12 year for services covered under AS 21.50.030(a), benefits shall be
13 payable, subject to any copayment authorized by the director, up to a
14 maximum lifetime limit of \$250,000.

15 (e) A policy of accident and health insurance may not be issued
16 renewed in the state after January 1, 1981, by an insurer or a fraternal
17 which has not complied with this section.

18 (f) An insurer or fraternal may fulfill its obligations under this
19 section by issuing the required coverages in its own name and reinsuring
20 the risk and administration of the coverages with the association in
21 accordance with AS 21.50.040(g)(5) and (6).

22 (g) This section does not require an insurer or fraternal to offer
23 or issue a policy to a person who does not meet the underwriting or
24 membership requirements of the insurer or fraternal.

25 Sec. 21.50.020. CERTIFICATION OF QUALIFIED PLANS. On application
26 by an insurer, fraternal, or employer for certification of a plan of
27 health coverage as a qualified plan or a qualified Medicare supplement
28 plan for the purposes of AS 21.50.010 - 21.50.130 the director shall
29 determine within 90 days whether the plan is qualified. Each plan of

1 health coverage shall be labeled as "qualified" or "nonqualified" on the
2 front of the policy or evidence of insurance. A qualified plan shall
3 indicate whether it is a number one, two, or three coverage plan.

4 Sec. 21.50.030. MINIMUM BENEFITS OF QUALIFIED PLAN. (a) A plan
5 of health coverage shall be certified as a number three qualified plan
6 whether or not the policy is issued in the state if it meets or exceeds
7 the following minimum standards:

8 (1) The minimum benefits for a covered individual shall,
9 subject to the other provisions of this subsection, be equal to at least
10 80 percent of the cost of covered services in excess of an annual de-
11 ductible which may not exceed \$150 per person.^{or \$450 per family} The coverage shall
12 include a limitation of \$3,000 per person on total annual out-of-pocket
13 expenses for services covered under this subsection. The coverage may
14 be subject to a maximum lifetime benefit of not less than \$250,000.
15 Covered expenses shall be the usual and customary charges for the fol-
16 lowing services and articles when prescribed by a physician:

17 (A) hospital services;

18 (B) professional services for the diagnosis or treatment
19 of injuries, illnesses, or conditions, other than outpatient mental
20 or dental, which are rendered by a physician or at his direction;

21 (C) drugs requiring a physician's prescription;

22 (D) services of a nursing home for not more than 120
23 days in a year if the services begin within 14 days following
24 confinement of at least three days in a hospital for the same
25 condition;

26 (E) service of a home health agency up to a maximum of
27 180 visits per year;

28 (F) use of radium or other radioactive materials;

29 (G) oxygen;

- 1 (H) anesthetics;
- 2 (I) prostheses;
- 3 (J) rental or purchase, as appropriate, of durable
- 4 medical equipment;
- 5 (K) diagnostic ^Xx-rays and laboratory tests;
- 6 (L) oral surgery for partially or completely unerupted
- 7 impacted teeth, a tooth root without the extraction of the entire
- 8 tooth, or the gums and tissues of the mouth when not performed in
- 9 connection with the extraction or repair of teeth;
- 10 (M) services of a physical therapist;
- 11 (N) medically necessary transportation.

12 (2) Covered expenses for the services and articles specified

13 in this subsection do not include the following:

14 (A) a charge for care for an injury or disease either

15 arising out of an injury in the course of employment and subject to

16 a worker's compensation law or for which benefits are payable under

17 another policy of accident and health insurance or Medicare;

18 (B) a charge for treatment for cosmetic purposes other

19 than surgery for the repair of an injury or birth defect;

20 (C) a charge for confinement in a private room to the

21 extent it is in excess of the institution's charge for its most

22 common semi-private room, unless a private room is prescribed as

23 medically necessary by a physician;

24 (D) that part of a charge for services or articles

25 rendered or prescribed by a physician, dentist, or other health

26 care personnel which exceeds the prevailing charge in the locality

27 where the service is provided;

28 (E) a charge for services or articles the provision of

29 which is not within the scope of authorized practice of the in-

stitution or individual rendering the services or articles.

(3) The minimum benefits for a qualified plan shall include, in addition to those benefits specified in (a)(1) of this section, benefits for the following services subject to applicable deductibles, coinsurance provisions, and maximum lifetime benefit limitations:

(A) well baby care;

(B) physicians' services for routine checkups and annual physicals when prescribed by a physician;

(C) multiphasic screening and other diagnostic testing.

(b) The director shall prescribe by regulation reasonable limits on the reimbursement required for the services specified in (a) of this section.

(c) A plan of health coverage shall be certified as a number two qualified plan if it meets the requirements established by the laws of the state and provides for payment of 80 percent of the covered expenses required by this section in excess of a deductible which does not exceed \$500 per person. *or \$1500 per family*

(d) A plan of health coverage shall be certified as a number one qualified plan if it meets the requirements established by the laws of the state and provides for payment of 80 percent of the covered expenses required by this section in excess of a deductible which does not exceed \$1,000 per person. *or \$3000 per family*

(e) A health maintenance organization which provides the services required by (a) of this section is providing a number three qualified plan.

Sec. 21.50.040. QUALIFIED MEDICARE SUPPLEMENT PLAN. A plan which provides benefits to persons over the age of 65 years may be certified as a qualified Medicare supplement plan if the plan is designed to supplement Medicare and provides coverage of 50 percent of the deduc-

1 tible and copayment required under Medicare and 80 percent of the
2 charges for covered services described in AS 21.50.030(a) which charges
3 are not paid by Medicare. The coverage shall include a limitation of
4 \$1,000 per person on total annual out-of-pocket expenses for the covered
5 services. The coverage may be subject to a maximum lifetime benefit of
6 not less than \$100,000.

7 Sec. 21.50.050. STATE PLAN PREMIUM. (a) The association shall
8 establish the following premiums to be charged for membership in the
9 state plan:

10 (1) The premium for the number one qualified plan may not
11 exceed 125 percent of the average of rates charged by the five insurers
12 with the largest number of individuals in a number one individual
13 qualified plan of insurance in force in the state.

14 (2) The premium for the number two qualified plan may not
15 exceed 125 percent of the average of rates charged by the five insurers
16 with the largest number of individuals in a number two individual
17 qualified plan of insurance in force in the state.

18 (3) The premium for a qualified Medicare supplement plan may
19 not exceed 125 percent of the average of rates charged by the five
20 insurers with the largest number of individuals enrolled in a qualified
21 Medicare supplement plan.

22 (4) The charge for health maintenance organization coverage
23 shall be based on generally accepted actuarial principles.

24 (b) The schedule of premiums for coverage under the state plan
25 shall be designed to be self-supporting and based on generally acc
26 actuarial principles.

27 Sec. 21.50.060. DUTIES OF DIRECTOR. The director may

28 (1) formulate general policies to advance the purposes of
29 AS 21.50.010 - 21.50.140 and may adopt regulations under the authority

1 tive Procedure Act (AS 44.62) to carry out AS 21.50.010 - 21.50.140.;

2 (2) adopt regulations revising minimum benefit standards
3 under AS 21.50.010 - 21.50.040 as may be appropriate due to inflation or
4 changes in prevailing industry standards;

5 (3) supervise the establishment of a comprehensive health
6 association within the limits described in AS 21.50.0~~50~~⁷;

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

10 (5) appoint advisory committees;

11 (6) conduct periodic audits to assure the general accuracy of
12 the financial data submitted by the writing carrier and the association;

13 (7) contract with the federal government or another unit of
14 government to ensure coordination of the state plan with other govern-
15 mental assistance programs;

16 (8) undertake directly or through contracts studies or demon-
17 stration programs to develop awareness of the benefits of AS 21.50.010 -
18 21.50.140, so that the residents of the state may avail themselves of
19 the health care benefits provided by these sections.

20 Sec. 21.50.070. COMPREHENSIVE HEALTH ASSOCIATION. (a) There is
21 established a comprehensive health association with membership con-
22 sisting of all insurers, self-insurers, fraternal, and health main-
23 tenance organizations licensed or authorized to do business in this
24 state.

25 (b) The board of directors of the association shall be made up of
26 seven individuals selected by participating members, subject to approval
27 by the director. To select the initial board of directors and to
28 initially organize the association, the director shall give notice to
29 all members of the time and place of the organizational meeting. In

1 determining voting rights at the organizational meeting, each member
2 shall be entitled to vote in person or by proxy. The vote shall be a
3 weighted vote based on the member's cost of self-insurance, accident and
4 health insurance premium, subscriber contract charges, or health main-
5 tenance contract payment derived from or on behalf of residents in the
6 previous calendar year, as determined by the director. If the board of
7 directors is not selected within 60 days after notice of the organiza-
8 tional meeting, the director may appoint the initial board. In ap-
9 proving or selecting members of the board, the director shall consider,
10 among other things, whether all types of members are fairly represented.
11 Members of the board may be reimbursed from the money of the association
12 for expenses incurred by them as members, but may not otherwise be
13 compensated by the association for their services. The costs of con-
14 ducting meetings of the association and its board of directors shall be
15 borne by members of the association.

16 (c) Members shall maintain their membership in the association as
17 a condition of doing business in the state. The association shall
18 submit bylaws and operating rules to the director for approval.

19 (d) Meetings of the association, its board, and committees of the
20 association shall comply with AS 44.62.310.

21 (e) Members shall enter into a contract with the association
22 according to terms specified in AS 21.50.080. The contract of re-
23 insurance shall be executed for a period of one year and may be renewed
24 annually. A company which ceases to do business in the state remains
25 liable under the contract for the reinsurance contracted for during that
26 calendar year.

27 (f) In the performance of their duties as members of the associa-
28 tion, the members are exempt from the provisions of AS 45.52.

29 (g) The association may

1 (1) exercise the powers granted to insurers under the laws of
2 the state;

3 (2) sue or be sued;

4 (3) enter into contracts with insurers, similar associations
5 in other states, or other persons for the performance of administrative
6 functions including the functions provided for in (5) and (6) of this
7 subsection;

8 (4) establish administrative and accounting procedures for
9 the operation of the association;

10 (5) provide under (h) of this section for the reinsuring of
11 risks incurred as a result of issuing the coverages required by
12 AS 21.50.010 and 21.50.120 by members of the association;

13 (6) provide under (i) of this section for the administration
14 by the association

15 of policies which are reinsured under (5) of this subsection.

16 (h) Each member which elects to reinsure its required risks under
17 (g)(5) of this section shall determine the categories of coverage it
18 elects to reinsure in the association. The categories of coverage are:
19 (1) individual qualified plans, excluding group conversions; (2) group
20 conversions; (3) group qualified plans with fewer than 50 employees or
21 members; and (4) major medical coverage. A separate election may be
22 made for each category of coverage. If a member elects to reinsure the
23 risks of a category of coverage, it must reinsure the risk of the cover-
24 age of every life covered under every policy issued in that category.
25 Members electing to administer the risks which are reinsured in the
26 association shall comply with the benefit determination guidelines and
27 accounting procedures established by the association. The fee charged
28 by the association for the reinsurance of risks may not be less than 11
29 percent of the total anticipated expenses incurred by the association

1 for the reinsurance.

2 (i) Each member electing to reinsure one or more categories of
3 coverage in the association under (g)(6) of this section may elect to
4 have the association administer the categories of coverage on the mem-
5 ber's behalf under (g)(6) of this section. If a member elects to have
6 the association administer the categories of coverage, it must do so for
7 every life covered under every policy issued in that category. The fee
8 for the administration shall not be less than 110 percent of the total
9 anticipated expenses incurred by the association for the administration.
10

11 Sec. 21.50.080. OPERATION OF STATE PLAN. (a) Upon certification
12 as an eligible person under AS 21.50.110, an eligible person may enroll
13 in the state plan by payment of the state plan premium to the writing
14 carrier.

15 (b) An employer which has in its employ one or more eligible
16 persons enrolled in the state plan may make all or a portion of the
17 state plan premium payment to the state plan directly to the writing
18 carrier.

19 (c) Not less than 87-1/2 percent of the state plan premium paid to
20 the writing carrier shall be used to pay claims and not more than
21 12-1/2 percent shall be used for the payment of agent referral fees
22 authorized in AS 21.50.120(c) and for payment of the writing carrier's
23 direct and indirect expenses, as specified in AS 21.50.100(g).

24 (d) Income in excess of the costs incurred by the association in
25 providing reinsurance or administrative services shall be held at in-
26 terest and used by the association to offset losses due to claims ex-
27 penses of the state plan or allocated to reduce state plan premiums.

28 (e) Each member of the association shall share the losses due to
29 claims expenses of the state plan according to the terms of the
individual reinsurance contracts executed by the association with each

1 member in accordance with AS 21.50.070(e). Deviations in the claim
2 experience of the state plan from the premium payments allocated to the
3 payment of benefits shall be the liability of the association members.
4 Association members shall share in the excess costs of the state plan in
5 an amount equal to the ratio of the member's total cost of self-
6 insurance, accident and health insurance premium, subscriber contract
7 charges, or health maintenance organization contract charges received
8 from or on behalf of state residents as divided into the total cost of
9 self-insurance, accident and health insurance premium, subscriber
10 contract charges, and health maintenance organization contract charges,
11 received by all association members from or on behalf of state
12 residents, as determined by the director. The reinsurance contract
13 shall provide for a retroactive determination of each member's liability
14 and payment due within 30 days after each renewal date of the re-
15 insurance contract. Failure by a member to tender to the association
16 the assessed reinsurance payment within 30 days of notification by the
17 association is grounds for termination of the member's membership. Net
18 gains from the operation of the state plan shall be held at interest and
19 used by the association to offset future losses due to claims expenses
20 of the state plan or allocated to reduce state plan premiums.

21 (f) The assessed reinsurance payment levied against a member may
22 be offset against the income tax or the premium tax payable under this
23 title by the member (payable under AS 43.20) for the year in which the
24 payment is assessed. The commissioner of revenue shall report not later
25 than the 10th day of a regular session to the legislature the total
26 amount of income tax or premium tax offset claimed by members during the
27 preceding calendar year.

28 Sec. 21.50.090. MINIMUM BENEFITS OF STATE PLAN. The association
29 through its state plan shall offer policies which provide the benefits

1 of a number one qualified plan, a number two qualified plan, and a
2 qualified Medicare supplement plan. It shall offer health maintenance
3 organization contracts in those areas of the state where a health
4 maintenance organization has agreed to make the coverage available and
5 has been selected as a writing carrier.

6 Sec. 21.50.100. ADMINISTRATION OF PLAN. (a) A member of the
7 association may submit to the director the policies of accident and
8 health insurance or the health maintenance organization contracts which
9 are being proposed to serve in the state plan. The time and manner of
10 the submission shall be prescribed by regulation of the director.

11 (b) On the director's approval of the policy forms and contracts
12 submitted under AS 21.50.070, the association shall select policies and
13 contracts submitted by a member or members of the association to be the
14 comprehensive health insurance plan. This selection shall be based on
15 criteria including the member's proven ability to handle large group
16 accident and health insurance cases, efficient claim paying capacity,
17 and the estimate of total charges for administering the plan. The
18 association may select separate writing carriers for the two types of
19 qualified plans, the qualified Medicare supplement plan, and the health
20 maintenance organization contract.

21 (c) The writing carrier shall perform all administrative and
22 claims payment functions required by this section. The writing carrier
23 shall provide these services for a period of three years, unless a
24 request to terminate is approved by the director. The director shall
25 approve or deny a request to terminate within 90 days of its receipt.
26 failure to approve or deny a request to terminate within 90 days of its
27 receipt constitutes an approval. Six months before the expiration of
28 each three-year period, the association shall invite submissions of
29 policy forms from members of the association, including the writing

1 carrier. The association shall select a writing carrier for the
2 following three-year period under (b) of this section.

3 (d) The writing carrier shall provide to all eligible persons
4 enrolled in the plan an individual certificate which contains a clear
5 and easily understandable statement as to the insurance protection to
6 which he is entitled, with whom claims are to be filed, and to whom
7 benefits are payable. The certificate shall indicate that coverage was
8 obtained through the association.

9 (e) The writing carrier shall submit to the association and the
10 commissioner on a monthly basis a report on the operation of the state
11 plan. Specific information to be contained in this report shall be
12 determined by the association before the effective date of the state
13 plan.

14 (f) All claims shall be paid by the writing carrier under the
15 provisions of AS 21.50.010 - 21.50.140 and shall indicate that the claim
16 was paid by the state plan. Each claim payment shall include infor-
17 mation specifying the procedure to be followed in the event of a dispute
18 over the amount of payment.

19 (g) The writing carrier shall be reimbursed from the state plan
20 premiums received for its direct and indirect expenses. Direct and
21 indirect expenses include but are not limited to a pro-rata reimburse-
22 ment for the portion of the writing carrier's administrative, printing,
23 claims administration, management and building overhead expenses which
24 are assignable to the maintenance and administration of the state plan.
25 The association shall approve cost accounting methods to substantiate
26 the writing carrier's cost reports consistent with generally accepted
27 accounting principles. Direct and indirect expenses may not include
28 costs directly related to the original submission of policy forms before
29 selection as the writing carrier.

1 (h) The writing carrier is an agent of the association and the
2 director with civil liability subject to the provisions of AS 09.50.250
3 09.50.300 when carrying out its duties under AS 21.50.010 - 21.50.140.

4 (i) Premiums received by the writing carrier for the state plan
5 are exempt from the requirements of AS 21.50.130(c).

6 Sec. 21.50.110. ENROLLMENT BY ELIGIBLE PERSON. (1) The state
7 plan is open for enrollment by eligible persons. An eligible person may
8 enroll by submission of a certificate of eligibility to the writing
9 carrier which provides:

10 (1) name, address, age, and length of time at residence of
11 the applicant;

12 (2) name, address, and age of spouse and children, if any, if
13 they are to be insured;

14 (3) evidence of rejection, or a requirement of restrictive
15 riders, or a preexisting conditions limitation on a qualified plan by at
16 least two association members within six months of the date of the
17 certificate, the effect of which is to reduce coverage substantially
18 from that received by a person considered a standard risk;

19 (4) a designation of the coverage desired.

20 (b) Within 30 days of receipt of the certificate described in (a)
21 of this section, the writing carrier shall either reject the application
22 for failing to comply with the requirements in (a) of this section or
23 forward the eligible person a notice of acceptance and billing infor-
24 mation. Insurance is effective immediately upon receipt of the first
25 month's state plan premium and shall be retroactive to the date of
26 application if the applicant otherwise complies with the requirements of
27 AS 21.50.010 - 21.50.140. An eligible person may not purchase more than
28 one policy from the state plan.

29 (c) A person who obtains coverage under this section is not

1 covered for a preexisting condition during the first six months of
2 coverage under the state plan if the person was diagnosed or treated for
3 that condition during the 90 days immediately preceding the filing of an
4 application.

5 Sec. 21.50.120. SOLICITATION OF ELIGIBLE PERSONS. (a) The asso-
6 ciation shall disseminate appropriate information to the residents of
7 the state under a plan approved by the director regarding the existence
8 of the state plan and the means of enrollment.

9 (b) The association shall maintain public awareness of the pro-
10 visions of AS 21.50.010 - 21.50.140 and shall administer this chapter in
11 a manner which encourages public participation in the state plan.

12 (c) The writing carrier shall pay an agent's referral fee of \$25
13 to each insurance agent who refers an applicant to the state plan if the
14 application is accepted. Selling or marketing of qualified state plans
15 may not be limited to the writing carrier or its agents. The referral
16 fees shall be paid by the writing carrier from money received as
17 premiums for the state plan.

18 (d) Every insurer which rejects or applies underwriting restric-
19 tions to an applicant for accident and health insurance shall notify the
20 applicant of the existence of the state plan, the requirements for
21 being accepted in it, and the procedure for applying to it.

22 Sec. 21 50.130. CONVERSION PRIVILEGES. (a) Each program of
23 self-insurance and each policy of group accident and health insurance or
24 contract of coverage by a health maintenance organization written or
25 renewed in the state shall include the right to convert to an individual
26 coverage qualified plan without the addition of underwriting restric-
27 tions regardless of the reason for leaving the group. A person leaving
28 the group may exercise his right to conversion within 30 days of leaving
29 the group.

1 (b) Plans of health coverage shall include a provision which, upon
2 the death of the individual in whose name the contract was issued,
3 permits an individual then covered under the contract to elect, within
4 the period specified in the contract, to continue coverage under the
5 same or a different contract without the addition of underwriting re-
6 strictions until he would have ceased to be entitled to coverage had the
7 individual in whose name the contract was issued lived.

8 Sec. 21.50.200. DEFINITIONS. In this chapter,

9 (1) "accident and health insurance policy" or "policy"

10 (A) means insurance or nonprofit health service plan
11 contracts providing benefits for hospital, surgical, and medical
12 care;

13 (B) does not mean coverage which is

14 (i) limited to disability or income protection
15 coverage,
16 (ii) automobile medical payment coverage,
17 (iii) supplemental to liability insurance,
18 (iv) sold by fraternal and provides payments on a
19 per diem, daily indemnity or nonexpense-incurred basis;

20 (2) "association" means a comprehensive health association
21 established under AS 21.50.070;

22 (3) "dependent" means a spouse or unmarried child under the
23 age of 18 years, a child who is a student under the age of 25 years and
24 financially dependent upon the parent, a dependent child of any age who
25 is disabled, or a household member~~x~~ who is financially dependent on the
26 primary insured;

27 (4) "director" means the director of insurance;

28 (5) "eligible person" means an individual who is a resident
29 of the state and meets the enrollment requirements of AS 21.50.110;

1 (6) "fraternal" means a corporation, society, order, or
2 voluntary association without capital stock which sells health and
3 accident insurance in accordance with AS 21.84;

4 (7) "gross income" means income under AS 43.20;

5 (8) "health benefits" means benefits offered to employees on
6 an indemnity or prepaid basis which pays the costs of or provide
7 medical, surgical, or hospital care;

8 (9) "health maintenance organization" means a nonprofit
9 corporation organized and operated under 42 U.S.C. sec. 300e;

10 (10) "insurer"

11 (A) means a company offering, selling, issuing or
12 renewing policies or contracts of accident and health insurance;

13 (B) does not mean health maintenance organization;

14 (11) "Medicare" means Part A and Part B of the United States
15 Social Security Act, Title XVIII, as amended, 42 U.S.C. sections 1394,
16 et seq;

17 (12) "Medicare supplement plan" means a plan of insurance
18 protection which provides benefits for the costs of medical, surgical,
19 or hospital care and which is marketed as providing benefits which
20 complement or supplement the benefits provided by Medicare;

21 (13) "plan of health coverage" means a plan or combination of
22 plans of coverage, including combinations of self-insurance, individual
23 accident and health insurance policies, group accident and health in-
24 surance policies, coverage under a nonprofit health service plan, or
25 coverage under a health maintenance organization subscriber contract;

26 (14) "qualified expense" means a charge incurred for a health
27 service which is included in the list of covered services described in
28 AS 21.50.040(a) and for which no third party is liable;

29 (15) "qualified Medicare supplement plan" means a health

1 benefit plan which has been certified by the director as providing the
2 minimum benefits required by AS 21.50.050 or the actuarial equivalent of
3 those benefits;

4 (16) "qualified plan" means those health benefit plans which
5 have been certified by the director as providing the minimum benefits
6 required by AS 21.50.040 or the actuarial equivalent of those benefits;

7 (17) "self-insurance" means a plan of health coverage offered
8 by a self-insurer;

9 (18) "self-insurer"

10 (A) means an employer who directly provides a plan of
11 health coverage to his employees and administers the plan of health
12 coverage himself or through an insurer;

13 (B) does not mean an employer engaged in the business of
14 providing health care services to the public who provides health
15 care services directly to his employees at no charge to them;

16 (19) "state plan" means policies of comprehensive health
17 insurance and contracts of health maintenance organization coverage
18 offered by the association through the writing carrier under this
19 chapter;

20 (20) "state plan premium" means a premium determined under
21 AS 21.50.060;

22 (21) "third party" means a person other than the eligible
23 person or his dependents;

24 (22) "writing carrier" means an insurer or insurers and a
25 hospital or medical service corporation or corporations selected by the
26 association and approved by the director to administer the comprehensive
27 health insurance plan.

28 * Sec. 3. AS 47.07 is amended by adding new sections to read:

29 ARTICLE 2. INSURANCE AND SERVICE CONTRACTS.

1 Sec. 47.07.100. MEDICAL ASSISTANCE BY INSURANCE OR SERVICE
2 CONTRACTS. (a) The commissioner shall use available medical assistance
3 funds to purchase and pay premiums on policies of insurance or pay the
4 expenses on health care service contracts or medical or hospital service
5 contracts that provide one or more of the medical and remedial care and
6 services available under medical assistance for the benefit of the
7 categorically or the medically needy.

8 (b) The policy of insurance or the contract must by its terms
9 guarantee

10 (1) to provide medical and remedial care and services of the
11 type and according to the standards prescribed under AS 47.07.030;

12 (2) to pay providers of medical and remedial care and
13 services the amount due, based on the number of days of care and the
14 fees, charges, and costs established under AS 47.04.030 except as to
15 medical or hospital service contracts issued by a hospital association
16 which employs a method of accounting or payment on other than a fee for
17 service basis;

18 (3) to provide medical and remedial care and services under
19 policies of insurance or contracts in compliance with applicable laws
20 and regulations;

21 (4) to provide the statistical data, records, and reports
22 relating to the provision, administration, and costs of providing
23 medical and remedial care and services as required by the commissioner.

24 Sec. 47.07.110. RATES ON INSURANCE OR SERVICE CONTRACTS. (a) The
25 commissioner shall establish uniform areawide rates for the payment on
26 policies of insurance or service contracts from available medical
27 assistance funds.

28 (b) The commissioner may not pay a premium or other periodic
29 charge on a policy of insurance, health care service contract, or

1 hospital service contract unless the insurer or contractor issuing the
2 policy or contract is authorized to do business in the state.

3 Sec. 47.07.120. CONTRACTS WITH DIRECT PROVIDERS OF CARE AND
4 SERVICE. (a) The commissioner may enter into nonexclusive contracts
5 under which funds available for medical assistance may be administered
6 and disbursed by the contractor to direct providers of medical and
7 remedial care and services available under medical assistance for
8 services rendered and supplies furnished by them under this chapter.
9 Payment shall be made under AS 47.07.030.

10 (b) A contract under this section shall

11 (1) oblige the contractor to make payments under the contract
12 promptly and not later than 30 days after receipt of the proper evidence
13 of the claim; and

14 (2) provide data, records, and reports ^T required by the com-
15 missioner.

Insert. Pick up Secs. 130 + 150 from page 32

16 * Sec. 4. AS 47.07.0~~30~~ is amended to read:

17 Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. Medical services
18 to be offered to eligible persons include inpatient hospital, outpatient
19 hospital, rural health clinic, outpatient surgical care centers,
20 laboratory and ~~X~~ray, refractions and eye examinations by
21 ophthalmologists or optometrists, eyeglasses prescribed by a physician
22 skilled in diseases of the eye or by an optometrist, podiatrist services
23 chiropractic services, private duty nursing, physical therapist services
24 occupational therapy services, dental services and dentures, personal
25 care services, prosthetic services, prescribed drugs, inpatient
26 psychiatric hospital, skilled nursing and intermediate care facility
27 services for persons age 65 or older and persons under age 21, skilled
28 and intermediate nursing home, physician, home health care services,
29 early periodic screening diagnosis and treatment of persons under 21

1 years of age, inpatient, skilled nursing, and intermediate care facility
 2 services for persons 65 years of age or older, clinic services,
 3 treatment of speech, hearing and language disorders, diagnostic,
 4 screening, prevention, and rehabilitation services and reasonable
 5 transportation to and from the point of medical care. No additional
 6 services may be provided unless approved by the legislature.

7 Sec. 47.07.130. IMPLEMENTATION. The commissioner shall implement
 8 the provisions of AS 47.07.100 - 47.07.130 when the commissioner
 9 determines that comparable benefits at equal or less cost than direct
 10 payments by the department to the providers of medical assistance.

11 Sec. 47.07.150. DEFINITIONS. In AS 47.07.100 - 47.07.150

12 (1) "commissioner" means the commissioner of health and
 13 social services;

14 (2) "department" means the Department of Health and Social
 15 Services.

*move to page 31
 sec. 3*

16 * Sec. 5. AS 47.07.070 is amended by adding a new subsection to read:

17 (b) In providing reimbursement to providers of services under (a)
 18 of this section, the state shall pay

19 (1) interest on unpaid ^{Medicaid} ~~medical~~ bills presented by providers
 20 at the rate of one percent per month when payment is delayed more than
 21 30 days after presentation of the billing; and

22 (2) interest on unpaid ^{Medicaid} ~~medical~~ bills presented by providers
 23 at the rate of two percent per month when payment is delayed more than
 24 six months after presentation of the billing.

25 * Sec. 6. AS 47.25.120 is amended to read:

26 Sec. 47.25.120. ELIGIBILITY FOR ASSISTANCE. Financial assistance
 27 may be given under AS 47.25.120 - 47.25.300 [, SO FAR AS PRACTICABLE
 28 UNDER THE CONDITIONS IN THIS STATE,] to

29 (1) a needy person who is eligible under the regulations of

1 the departmen' ; and

2 (2) a medically needy person who has incurred medical expenses
3 which equal or exceed the difference between the person's monthly income
4 and 150 percent of the current Federal Community Services Administration
5 poverty income guidelines for Alaska (45 C.F.R.,sec. 1060.2).

6 * Sec. 7. AS 47.25 is amended by adding a new section to read:

7 Sec. 47.25.175. INTEREST ON LATE PAYMENTS. In providing re-
8 imbursement to providers of medical services under AS 47.25.120 -
9 47.25.300, the state shall pay

10 (1) interest on unpaid medical bills presented by providers
11 at the rate of one percent per month when payment is delayed more than
12 30 days after presentation of the billing; and

13 (2) interest on unpaid medical bills presented by providers
14 at the rate of two percent per month when payment is delayed more than
15 six months after presentation of the billing.

16 * Sec. 8. ADJUSTMENT OF EMPLOYER-SPONSORED PLANS. When employees subject
17 to the requirements of AS 18.12 enacted in sec. 1 of this Act are included in
18 the coverage provisions of an employer-sponsored prepaid health care plan
19 covering similar employees employed outside the state and the majority of the
20 employees are not subject to the requirements of AS 18.12, the benefits
21 applicable to the employees covered by AS 18.12 shall be adjusted within one
22 year after the effective date of this Act so as to meet the requirements of
23 AS 18.12.

24 * Sec. 9. This Act takes effect January 1, 1981.
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**"CHAPTER
PREPAID HEALTH CARE ACT
PART I. SHORT TITLE; PURPOSE; DEFINITIONS**

Sec. -1 Short title. This chapter shall be known as the Hawaii Prepaid Health Care Act.

Sec. -2 Findings and purpose. The cost of medical care in case of sudden need may consume all or an excessive part of a person's resources. Prepaid health care plans offer a certain measure of protection against such emergencies. It is the purpose of this chapter in view of the spiraling cost of comprehensive medical care to provide this type of protection for the employees in this State. Although a large segment of the labor force in the State already enjoys coverage of this type either by virtue of collective bargaining agreements, employer-sponsored plans, or individual initiative, there is a need to extend that protection to workers who at present do not possess any or possess only inadequate prepayment coverage.

This chapter shall not be construed to interfere with or diminish any protection already provided pursuant to collective bargaining agreements or employer-sponsored plans that is more favorable to the employees benefited thereby than the protection provided by this chapter or at least equivalent thereto.

Sec. -3 Definitions generally. As used in this chapter, unless the context clearly requires otherwise:

- (1) "Department" means the department of labor and industrial relations.
- (2) "Director" means the director of labor and industrial relations.
- (3) "Employer" means any individual or type of organization, including any partnership, association, trust, estate, joint stock company, insurance company, or corporation, whether domestic or foreign, a debtor in possession or receiver or trustee in bankruptcy, or the legal representative of a deceased person, who has one or more regular employees in his employment. "Employer" does not include:
 - (A) The State, any of its political subdivisions, or any instrumentality of the State or its political subdivisions;
 - (B) The United States government or any instrumentality of the United States;
 - (C) Any other state or political subdivision thereof or instrumentality of such state or political subdivision.
 - (D) Any foreign government or instrumentality wholly owned by a foreign government, if (i) the service performed in its employ is of a character similar to that performed in foreign countries by employees of the United States government or of an instrumentality thereof, and (ii) the United States Secretary of State has certified or certifies to the United States Secretary of the Treasury that the foreign government, with respect to whose instrumentality exemption is claimed, grants an equivalent exemp-

n with respect to similar service performed in the foreign country by employees of the United States government and of instrumentalities thereof.

- (4) "Employment" means service, including service in interstate commerce, performed for wages under any contract of hire, written or oral, expressed or implied, with an employer, except as otherwise provided in sections 387-4 and 387-5.
- (5) "Premium" means the amount payable to a prepaid health care plan contractor as consideration for his obligations under a prepaid health care plan.
- (6) "Prepaid health care plan" means any agreement by which any prepaid health care plan contractor undertakes in consideration of a stipulated premium:
- (A) Either to furnish health care, including hospitalization, surgery, medical or nursing care, drugs or other restorative appliances, subject to, if at all, only a nominal per service charge; or
 - (B) To defray or reimburse, in whole or in part, the expenses of health care.
- (7) "Prepaid health care plan contractor" means:
- (A) Any medical group or organization which undertakes under a prepaid health care plan to provide health care; or
 - (B) Any nonprofit organization which undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care; or
 - (C) Any insurer who undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care.
- (8) "Regular employee" means a person employed in the employment of any one employer for at least twenty hours per week but does not include a person employed in seasonal employment. "Seasonal employment" for the purposes of this paragraph means employment in a seasonal pursuit as defined in section 387-1 by a seasonal employer during a seasonal period or seasonal periods for the employer in the seasonal pursuit or employment by an employer engaged in the cultivating, harvesting, processing, canning, and warehousing of pineapple during its seasonal periods. The director by rule and regulation may determine the kind of employment that constitutes seasonal employment.
- (9) "Wages" means all cash remuneration for services from whatever source, including commissions, bonuses, and tips and gratuities paid directly to any individual by a customer of his employer.

If the employee does not account to his employer for the tips and gratuities received and is engaged in an occupation in which he customarily and regularly receives more than \$20 a month in tips, the combined amount received by him from his employer and from tips shall be deemed to be at least equal to the wage required by chapter 387 or a greater sum as determined by regulation of the director.

"Wages" does not include the amount of any payment specified in section 383-11 or 392-22 or chapter 386.

Sec. -4 Place of performance. "Employment" includes an individual's entire service, performed within or both within and without this State if:

- (1) The service is localized in this State; or
- (2) The service is not localized in any state but some of the service is performed in this State and
 - (A) the individual's base of operation, or, if there is no base of operation, the place from which such service is directed or controlled, is in the State; or
 - (B) the individual's base of operation or place from which the service is directed or controlled is not in any state in which some part of the service is performed but the individual's residence is in this State.

Sec. -5 Excluded services. "Employment" as defined in section -3 does not include the following services:

- (1) Service performed by an individual in the employ of an employer who, by the laws of the United States, is responsible for care and cost in connection with such service.
- (2) Service performed by an individual in the employ of his spouse, son, or daughter, and service performed by an individual under the age of twenty-one in the employ of his father or mother.
- (3) Service performed in the employ of a voluntary employee's beneficiary association providing for the payment of life, sick, accident, or other benefits to the members of the association or their dependents or their designated beneficiaries, if
 - (A) admission to membership in the association is limited to individuals who are officers or employees of the United States government, and
 - (B) no part of the net earnings of the association inures (other than through such payments) to the benefits of any private shareholder or individual.
- (4) Service performed by an individual for an employer as an insurance agent or as an insurance solicitor, if all such service performed by the individual for the employer is performed for remuneration solely by way of commission.
- (5) Service performed by an individual for an employer as a real estate salesman or as a real estate broker, if all such service performed by the individual for the employer is performed for remuneration solely by way of commission.
- (6) Service performed by an individual who, pursuant to the Federal Economic Opportunity Act of 1964, is not subject to the provisions of law relating to federal employment, including unemployment compensation.

Sec. -6 Principal and secondary employer defined; coercion, interference, etc. prohibited. If an individual is concurrently a regular employee of two or more employers as defined in this chapter, the employee shall deter-

mine which of the employers shall be his principal employer. His other employers are secondary employers. The determination by the employee of his principal employer is binding for one year or until change of employment, whichever is earlier.

If an individual is concurrently is regular employee of a public entity which is not an employer as defined in section -3 and of an employer as defined in section -3 the latter shall be deemed to be a secondary employer.

An employer who, directly or indirectly, interferes with or coerces or attempts to coerce an employee in making a determination under this section shall be subject to the penalty provided under subsection -33(b).

Sec. -7 Required health care benefits. (a) A prepaid health care plan shall qualify as a plan providing the mandatory health care benefits required under this chapter if it provides for health care benefits equal to, or medically reasonably substitutable for, the benefits provided by prepaid health plans of the same type, as specified in section -12(a) (1) or (2), which have the largest numbers of subscribers in the State. This applies to the types and quantity of benefits as well as to limitations on reimbursability, including deductibles, and to required amounts of co-insurance.

The director, after advice by the prepaid health care advisory council, shall determine whether benefits provided in a plan, other than the plan of the respective type having the largest numbers of subscribers in the State, comply with the standards specified in this subsection.

(b) A prepaid group health care plan shall also qualify for the mandatory health care benefits required under this chapter if it is demonstrated by the health care plan contractor offering such coverage to the satisfaction of the director after advice by the prepaid health care advisory council that the plan provides for sound basic hospital, surgical, medical, and other health care benefits at a premium commensurate with the benefits included taking proper account of the limitations, co-insurance features, and deductibles specified in such plan. Coverage under a plan which provides aggregate benefits that are more limited than those provided by plans qualifying under subsection (a) shall be in compliance with section -11 only if the employer contributes at least half of the cost of the coverage of dependents under such plan.

(c) Subject to the provisions of subsections (a) and (b) without limiting the development of medically more desirable combinations and the inclusion of new types of benefits, a prepaid health care plan qualifying under this chapter shall include at least the following benefit types:

(1) Hospital benefits:

- (A) In-patient care for a period of at least one hundred twenty days of confinement in each calendar year covering:
 - (i) Room accommodations;
 - (ii) Regular and special diets;
 - (iii) General nursing services;
 - (iv) Use of operating room, surgical supplies, anesthesia services, and supplies;
 - (v) Drugs, dressings, oxygen, antibiotics, and blood transfusion services.

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(B) Out-patient care:

- (i) Covering use of out-patient hospital;
- (ii) Facilities for surgical procedures or medical care of an emergency and urgent nature.

(2) Surgical benefits:

- (A) Surgical services performed by a licensed physician, as determined by plans meeting the standards of subsections (a) and (b);
- (B) After-care visits for a reasonable period;
- (C) Anesthesiologist services.

(3) Medical benefits:

- (A) Necessary home, office, and hospital visits by a licensed physician;
- (B) Intensive medical care while hospitalized;
- (C) Medical or surgical consultations while confined.

(4) Diagnostic laboratory services, x-ray films, and radio-therapeutic services, necessary for diagnosis or treatment of injuries or diseases.

(5) Maternity benefits, at least if the employee has been covered by the prepaid health care plan for nine consecutive months prior to the delivery.

(d) The prepaid health care advisory council shall be appointed by the director and shall include representatives of the medical and public health professions, representatives of consumer interests, and persons experienced in prepaid health care protection. The membership of the council shall not exceed seven individuals.

PART II. MANDATORY COVERAGE

Sec. -11 Coverage of regular employees by group prepaid health care plan. Every employer who pays to a regular employee monthly wages in an amount of at least 86.67 times the minimum hourly wage, specified in chapter 387, as rounded off by regulation of the Director, shall provide coverage of such employee by a prepaid group health care plan qualifying under section -7 with a prepaid health care plan contractor in accordance with the provisions of this chapter.

Sec. -12 Choice of plan type and of contractor. (a) Every employer required to provide coverage for his employees by a prepaid group health care plan under this chapter shall elect whether coverage shall be provided by:

- (1) A plan which obligates the prepaid health care plan contractor to furnish the required health care benefits; or
- (2) A plan which obligates the prepaid health care plan contractor to defray or reimburse the expenses of health care.

His election is binding for one year.

(b) Whether the employer elects a plan type described in subsection (a) (1) or in subsection (a) (2), the employer may elect the particular contractor but the employee shall not be obligated to contribute a greater amount to the premium than he would have to contribute had the employer elected coverage with the contractor providing the prevailing coverage of the respective type in the State.

Subject to the provision of section -20, the employer shall provide coverage with the prepaid health care plan contractor selected pursuant to this subsection for all his employees in the State electing this type of coverage who are covered by the provisions of this chapter, except for employees covered by the health care provisions of an applicable collective bargaining agreement as provided in section -19(b) first sentence.

Sec. -13 Liability for payment of premium; withholding. Unless an applicable collective bargaining agreement specifies differently every employer shall contribute at least one-half of the premium for the coverage required by this chapter and the employee shall contribute the balance; provided that in no case shall the employee contribute more than 1.5 per cent of his wages; and provided that if the amount of the employee's contribution is less than one-half of the premium, the employer shall be liable for the whole remaining portion of the premium.

The employer shall withhold the employee's share from his wages with respect to pay periods as specified by the director.

Sec. -14 Commencement of coverage. The employer shall provide the coverage required by this chapter for any regular employee, who has been in his employ for four consecutive weeks, at the earliest time thereafter at which coverage may be provided with the prepaid health care plan contractor selected pursuant to this chapter.

Sec. -15 Continuation of coverage in case of inability to earn wages. If an employee is hospitalized or otherwise prevented by sickness from working, the employer shall enable the employee to continue his coverage by contributing to the premium the amounts paid by the employer toward such premium prior to the employee's sickness for the period that such employee is hospitalized or prevented by sickness from working. This obligation shall not exceed a period of three months following the month during which the employee became hospitalized or disabled from working, or the period for which the employer has undertaken the payment of his regular wages in such case, whichever is longer.

Sec. -16 Liability of secondary employer. An employer who has been notified by an employee, in the form prescribed by the director, that he is not the principal employer as defined in section -6 shall be relieved of the duty of providing the coverage required by this chapter until he is notified by the employee pursuant to section -18 that he has become the principal employer. He shall notify the director, in the form prescribed by the director, that he is relieved from the duty of providing coverage or of any change in that status.

Sec. -17 Exemption of certain employees. (a) In addition to the exemption specified in section -16, an employer shall be relieved of his duty under section -11 with respect to any employee who has notified him, in the form specified by the director, that the employee is:

- (1) Protected by health insurance or any prepaid health care plan established under any law of the United States;

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(2) Covered as a dependent under a prepaid health care plan, entitling him to the health benefits required by this chapter;

(3) A recipient of public assistance or covered by a prepaid health care plan established under the laws of the State governing medical assistance.

(b) Employers receiving notice of a claim of exemption under this section shall notify the director of such claim in the form prescribed by the director.

Sec. -18 Termination of exemption. (a) If an exemption which has been claimed by an employee pursuant to section -17 terminates because of any change in the circumstances entitling the employee to claim such exemption, the employee shall promptly notify the principal employer of the termination of the exemption and the employer thereupon shall provide coverage as required by this chapter.

(b) If because of a change in the employment situation of an employee or a redetermination by an employee as provided in section -6, a principal employer becomes a secondary employer or a secondary employer becomes the principal employer, the employee shall promptly notify the employers affected of such change and the new principal employer shall provide coverage as required by this chapter.

Sec. -19 Freedom of collective bargaining. (a) In addition to the policy stated in section -2, nothing in this chapter shall be construed to limit the freedom of employees to bargain collectively for different prepaid health care plan coverage or for a different allocation of the costs thereof. A collective bargaining agreement may provide that the employer himself undertakes to provide the health care specified in the agreement.

(b) If the employees rendering particular types of services are not covered by the health care provisions of the applicable collective bargaining agreements to which their employer is a party, the provisions of this chapter shall be applicable with respect to them. An employer or group of employers shall be deemed to have complied with the provisions of this chapter if they undertake to provide health care services pursuant to a collective bargaining agreement and the services are available to all other employees not covered by such agreement.

Sec. -20 Adjustment of employer-sponsored plans. Where employees subject to the coverage of this chapter are included in the coverage provisions of an employer-sponsored prepaid health care plan covering similar employees employed outside the State and the majority of such employees are not subject to this chapter, the benefits applicable to the employees covered by this chapter shall be adjusted within one year after the effective date of this chapter so as to meet the requirements of this chapter.

Sec. -21 Individual waivers prohibited; additional withholding for dependents. An employee may not waive individually all or part of the required health care benefits or agree to pay a greater share of the premium for such benefits than is required by this chapter.

Subject to section -7(b), an employee may consent to pay a greater

share of his wages and to a withholding of such share by the employer for the purpose of providing prepaid health care benefits of his dependents under the plan providing such benefits for himself.

Sec. -22 Exemption of followers of certain teachings or beliefs. This chapter shall not apply to any individual who pursuant to the teachings, faith, or belief of any group, depends for healing upon prayer or other spiritual means.

Sec. -23 Joint provision of coverage. Employers may form associations for the purpose of jointly providing prepaid health care protection under this chapter for their employees with the contractors authorized to provide such coverage in the State.

PART III. ADMINISTRATION AND ENFORCEMENT

Sec. -31 Enforcement by the director. Except as otherwise provided in section -7 the director shall administer and enforce this chapter. The director may appoint such assistants and such clerical, stenographic, and other help as may be necessary for the proper administration and enforcement of this chapter subject to any civil service act relating to state employees.

Sec. -32 Rule making and other powers of the director. The director may adopt, amend, or repeal, pursuant to chapter 91, such rules and regulations as he deems necessary or suitable for the proper administration and enforcement of this chapter.

The director may round off the amounts specified in this chapter for the purpose of eliminating payments from the premium supplementation fund in other than even dollar amounts or other purposes.

The director may prescribe the filing of reports by prepaid health care plan contractors and prescribe the form and content of requests by employers for premium supplementation and the period for the payment thereof.

Sec. -33 Penalties. (a) If an employer fails to comply with sections -1, -12, -13, or -15 he shall pay a penalty of not less than \$25 or of \$1 for each employee for every day during which such failure continues, whichever sum is greater. The penalty shall be assessed under rules and regulations promulgated pursuant to chapter 91 and shall be collected by the director and paid into the special fund for premium supplementation established by section -41. The director may, for good cause shown, remit all or any part of the penalty.

(b) Any employer, employee, or prepaid health care plan contractor who wilfully fails to comply with any other provision of this chapter or any rule or regulation thereunder may be fined not more than \$200 for each such violation.

PART IV. PREMIUM SUPPLEMENTATION

Sec. -41 Establishment of special premium supplementation fund. There is established in the treasury of the State, separate and apart from all public moneys or funds of the State, a special fund for premium supplementation which shall be administered exclusively for the purposes of this chapter. All premium supplementations payable under this part shall be paid from the

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fund. The fund shall consist of (1) all money appropriated by the State for the purposes of premium supplementation under this part and (2) all fines and penalties collected pursuant to this chapter.

Sec. -42 Management of the fund. The director of finance shall be the treasurer and custodian of the premium supplementation fund and shall administer the fund in accordance with the directions of the director of labor and industrial relations. All moneys in the fund shall be held in trust for the purposes of this part only and shall not be expended, released, or appropriated or otherwise disposed of for any other purpose. Moneys in the fund may be deposited in any depository bank in which general funds of the State may be deposited but such moneys shall not be commingled with other state funds and shall be maintained in separate accounts on the books of the depository bank. Such moneys shall be secured by the depository bank to the same extent and in the same manner as required by the general depository law of the State; and collateral pledged for this purpose shall be kept separate and distinct from any other collateral pledged to secure other funds of the State. The director of finance shall be liable for the performance of his duties under this section as provided in chapter 37.

Sec. -43 Disbursements from the fund. Expenditures of moneys in the premium supplementation fund shall not be subject to any provisions of law requiring specific appropriations or other formal release by the state officers of money in their custody. All payments from the fund shall be made upon warrants drawn upon the director of finance by the comptroller of the State supported by vouchers approved by the director.

Sec. -44 Investment of moneys. With the approval of the department the director of finance may, from time to time, invest such moneys in the premium supplementation fund as are in excess of the amount deemed necessary for the payment of benefits for a reasonable future period. Such moneys may be invested in bonds of any political or municipal corporation or subdivision of the State, or any of the outstanding bonds of the State, or invested in bonds or interest-bearing notes or obligations of the State (including state director of finance's warrant notes issued pursuant to chapter 40), or of the United States, or those for which the faith and credit of the United States are pledged for the payment of principal and interest, or in federal land bank bonds or joint stock farm loan bonds. The investments shall at all times be so made that all the assets of the fund shall always be readily convertible into cash when needed for the payment of benefits. The director of finance shall dispose of securities or other properties belonging to the fund only under the direction of the director of labor and industrial relations.

Sec. -45 Entitlement to premium supplementation. (a) An employer who employs less than eight employees entitled to coverage under this chapter and who provides coverage to such employees pursuant to section 7(a) shall be entitled to premium supplementation from the fund if the employer's share of the cost of providing such coverage as determined by sections 13 and 15 exceeds 1.5 per cent of the total wages payable to such employees and if the amount of such excess is greater than five per cent of the employer's

income before taxes directly attributable to the business in which such employees are employed.

(b) The amount of the supplementation shall be that part of the employer's share of the premium cost which exceeds the limits specified in subsection (a).

Sec. -46 Income directly attributable to the business. (a) "Income directly attributable to the business" means gross profits from the business minus deductions for:

- (1) Compensation of officers;
- (2) Salaries and wages, except wages paid by an individual proprietor to himself;
- (3) Repairs;
- (4) Taxes on business and business property;
- (5) Business advertising;
- (6) Amounts contributed to employee benefit plans;
- (7) Interest on business indebtedness;
- (8) Rent on business property; and
- (9) Other expenses necessary for the current conduct of business.

(b) Deductions shall not include:

- (1) Bad debts;
- (2) Contributions or gifts, other than those listed under subsection (a) (6);
- (3) Amortization and depreciation; or
- (4) Losses by fire, storm, casualty, or theft.

(c) The director may promulgate rules and regulations necessary to define income directly attributable to business for the purpose of section -45.

Sec. -47 Claim of premium supplementation. An employer entitled to premium supplementation shall file a claim therefor in the manner provided by regulation of the director. The employer shall have the burden of proof of establishing his entitlement."

SECTION 2. This Act shall take effect upon its approval, except that the coverage by group prepaid health care plans required by this Act and the payment of premiums for such coverage shall commence January 1, 1975; provided that this Act shall terminate upon the effective date of federal legislation that provides for voluntary prepaid health care for the people of Hawaii in a manner at least as favorable as the health care provided by this Act, or upon the effective date of federal legislation that provides for mandatory prepaid health care for the people of Hawaii.

(Approved June 12, 1974.)

ACT 51 Amend.

SLH 1975

ACT 50

rial is underscored. In printing this Act, the revisor of statutes need not include the brackets, the bracketed material, or the underscoring.*

SECTION 9. This Act shall take effect upon its approval.
(Approved May 6, 1975.)

ACT 51

H.B. NO. 419

A Bill for an Act Relating to Prepaid Health Care.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. Section 393-6, Hawaii Revised Statutes, is amended to read:

"Sec. 393-6 Principal and secondary employer defined; coercion, interference, etc. prohibited. If an individual is concurrently a regular employee of two or more employers as defined in this chapter, the principal employer shall be the employer who pays him the most wages; provided that if one of the employers, who does not pay the most wages, employs the regular employee for at least thirty-five hours per week, the employee shall determine which of the employers shall be his principal employer. His other employers are secondary employers. An employer so designated as the principal employer shall remain as such principal employer for one year or until change of employment, whichever is earlier.

If an individual is concurrently a regular employee of a public entity which is not an employer as defined in section 393-3 and of an employer as defined in section 393-3 the latter shall be deemed to be a secondary employer.

An employer who, directly or indirectly, interferes with or coerces or attempts to coerce an employee in making a determination under this section shall be subject to the penalty provided under subsection 393-33(b)."

SECTION 2. Statutory material to be repealed is bracketed. New material is underscored. In printing this Act, the revisor of statutes need not include the brackets, the bracketed material or the underscoring.*

SECTION 3. This Act shall take effect upon its approval.
(Approved May 6, 1975.)

ACT 52

H.B. NO. 442

A Bill for an Act Relating to Taxation of Banks and Other Financial Corporations.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. Section 241-4, Hawaii Revised Statutes, is amended by amending subsection (b) to read:

*Edited accordingly.

SLH 1976

ACT 25

ACT 25 Amend.

and may be leased by it as provided in chapter 171, Hawaii Revised Statutes, or may be retained for management by the department.

Any lease by the board of land and natural resources of Hawaiian home lands hereafter entered into shall contain a withdrawal clause, and the lands so leased shall be withdrawn by the board of land and natural resources, for the purpose of this Act, upon the department giving at its option, not less than one nor more than five years' notice of such withdrawal; provided, that the minimum withdrawal-notice period shall be specifically stated in such lease.

In the management of any retained available lands not required for leasing under section 207(a), the department may dispose of such lands to the public, including native Hawaiians, on the same terms, conditions, restrictions and uses applicable to the disposition of public lands as provided in chapter 171; provided, that the department may not sell or dispose of such lands in fee simple except as authorized under section 205 of this Act.

(3) The department shall not lease, use, nor dispose of more than twenty thousand (20,000) acres of the area of Hawaiian home lands, for settlement by native Hawaiians, in any calendar five-year period.

(4) The department may, with the approval of the governor and the Secretary of Interior, in order to consolidate its holdings or to better effectuate the purposes of this Act, exchange the title to available lands for land, publicly owned, of an equal value. All land so acquired by the department shall assume the status of available lands as though the same were originally designated as such under section 203 hereof, and all lands so conveyed by the department shall assume the status of the land for which it was exchanged. The limitations imposed by section 73(1) of the Hawaiian Organic Act and the land laws of Hawaii as to the area and value of land that may be conveyed by way of exchange shall not apply to exchanges made pursuant hereto. No such exchange shall be made without the approval of two-thirds of the members of the board of land and natural resources."

SECTION 2. Statutory material to be repealed is bracketed. New material is underscored. In printing this Act, the revisor of statutes need not include the brackets, the bracketed material, or the underscoring.*

SECTION 3. If any portion of this Act is declared invalid, the remaining portions of this Act shall not be affected thereby.

SECTION 4. This Act shall take effect upon its approval.

(Approved April 28, 1976.)

ACT 25

H.B. NO. 2194-76

A Bill for an Act Relating to Prepaid Health Care.

Be It Enacted by the Legislature of the State of Hawaii:

*Edited accordingly.

SECTION 1. The legislature finds that alcoholism and drug problems are the medical problems most disruptive of family life and employment, with alcoholism ranking, in addition, as the third highest medical cause of death in the United States today. Alcoholism and drug addiction are illnesses, and like other illnesses, their treatment should be uniformly covered by prepaid health care plans. The legislature further finds that such inclusion in prepaid health care plans will provide visibility to alcoholism and drug addiction benefits, and as a result, may encourage more accurate diagnosis of health problems related to alcoholism and drug addiction, because of health plan coverage. Moreover, employees may be encouraged to seek early diagnosis and treatment because of such coverage. Effective treatment will reduce substantially the great economic loss to employers. The purpose of this Act is to ensure adequate treatment for alcoholism and drug addiction by requiring its inclusion in prepaid health care plans, including coverage for appropriate detoxification and treatment facilities.

SECTION 2. Section 393-7, Hawaii Revised Statutes, is amended by amending subsection (c) to read as follows:

"(c) Subject to the provisions of subsections (a) and (b) without limiting the development of medically more desirable combinations and the inclusion of new types of benefits, a prepaid health care plan qualifying under this chapter shall include at least the following benefit types:

(1) Hospital benefits:

(A) In-patient care for a period of at least one hundred twenty days of confinement in each calendar year covering:

- (i) Room accommodations;
- (ii) Regular and special diets;
- (iii) General nursing services;
- (iv) Use of operating room, surgical supplies, anesthesia services, and supplies;
- (v) Drugs, dressing, oxygen, antibiotics, and blood transfusion services.

(B) Out-patient care:

- (i) Covering use of out-patient hospital;
- (ii) Facilities for surgical procedures or medical care of an emergency and urgent nature.

(2) Surgical benefits:

- (A) Surgical services performed by a licensed physician, as determined by plans meeting the standards of subsections (a) and (b);
- (B) After-care visits for a reasonable period;
- (C) Anesthesiologist services.

(3) Medical benefits:

- (A) Necessary home, office, and hospital visits by a licensed physician;
- (B) Intensive medical care while hospitalized;
- (C) Medical or surgical consultations while confined.

(4) Diagnostic laboratory services, x-ray films, and radio-therapeutic services, necessary for diagnosis or treatment of injuries or diseases.

(5) Maternity benefits, at least if the employee has been covered by the

prepaid health care plan for nine months prior to the delivery.

(6) Substance abuse benefits:

- (A) Alcoholism and drug addiction are illnesses and shall receive benefits as such. In-patient and out-patient benefits for the diagnosis and treatment of substance abuse, including but not limited to alcoholism and drug addiction, shall be specifically stated and shall not be less than the benefits for any other illness, except as provided in this subsection. Medical treatment of substance abuse shall not be limited or reduced by restricting coverage to the mental health or psychiatric benefits of a plan. However, any psychiatric services received as a result of the treatment of substance abuse may be limited to the psychiatric benefits of the plan.
- (B) Out-patient benefits provided by a physician, psychiatrist, or psychologist, without restriction as to place of service; provided that health plans of the type specified in section 393-12(a) shall retain for the contractor the option of:
 - (i) Providing the benefits in its own facility and utilizing its own staff, or
 - (ii) Contracting for the provision of these benefits, or
 - (iii) Authorizing the patient to utilize outside services and defraying or reimbursing the expenses at a rate not to exceed that for provision of services utilizing the health contractor's own facilities and staff.
- (C) Detoxification and acute care benefits in a hospital or any other public or private treatment facility, or portion thereof, providing services especially for the detoxification of intoxicated persons or drug addicts, which is appropriately licensed, certified, or approved by the department of health in accordance with the standards prescribed by the Joint Commission on Accreditation of Hospitals. In-patient benefits for detoxification and acute care shall be limited in the case of alcohol abuse to three admissions per calendar year, not to exceed seven days per admission, and shall be limited in the case of other substance abuse to three admissions per calendar year, not to exceed twenty-one days per admission.
- (D) Prepaid health plans shall not be required to make reimbursements for care furnished by government agencies and available at no cost to a patient, or for which no charge would have been made if there were no health plan coverage."

SECTION 3. New statutory material is underscored. In printing this Act, the revisor of statutes need not include the underscoring.*

SECTION 4. This Act shall take effect on July 1, 1976; provided that prepaid health care contracts due for renewal after July 1, 1976 may defer

*Edited accordingly.

ACT 27

inclusion of these substance abuse benefits until such renewal date, or January 1, 1977, whichever occurs earlier.

(Approved April 28, 1976.)

ACT 26

H.B. NO. 2533-76

A Bill for an Act Relating to Day Care Centers.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. Section 346-19, Hawaii Revised Statutes, is amended to read:

"Sec. 346-19 Day care centers defined. A "day care center" is defined as a place maintained by any individual, organization, or agency for the purpose of providing care for a child or children with or without charging a fee during any part of a twenty-four hour day. The term day care center includes any place where group care is provided for six or more children, and any family home providing care for two to five children.

Nothing in sections 346-18 to 346-25 shall be construed to include an individual person caring for a related child, a neighbor or friend caring for a child or children if the person does not regularly engage in such activity, a kindergarten or school conducted solely for educational purposes or specialized training, or an organization established to conduct athletic or social group functions."

SECTION 2. Statutory material to be repealed is bracketed. New material is underscored. In printing this Act, the revisor of statutes need not include the brackets, the bracketed material, or the underscoring.*

SECTION 3. This Act shall be effective July 1, 1976.

(Approved April 28, 1976.)

ACT 27

H.B. NO. 2880-76

A Bill for an Act Relating to the State Environmental Policy.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. The purpose of this Act is to propose an amendment to Section 344-4 of the Hawaii Revised Statutes to provide for guidelines relating to solid wastes.

SECTION 2. Section 344-4 (2) is amended to read as follows:

"(2) Land, water mineral, visual, air and other natural resources.

(A) Encourage management practices which conserve and fully utilize all natural resources;

*Edited accordingly.

SECTION 3. Statutory material to be repealed is bracketed. New material is underscored. In printing this Act, the revisor of statutes need not include the brackets, the bracketed material, or the underscoring.*

SECTION 4. This Act shall take effect upon its approval.

(Approved , 12, 1976.)

ACT 78

S.B. NO. 1820-76

A Bill for an Act Relating to the Prepaid Health Care Act.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. Section 393-3, Hawaii Revised Statutes, is amended by amending the definition of "Wages" to read:

"(9) "Wages" means all remuneration for services from whatever source, including commissions, bonuses, and tips and gratuities paid directly to any individual by a customer of his employer, and the cash value of all remuneration in any medium other than cash.

The director may issue regulations for the reasonable determination of the cash value of remuneration in any medium other than cash.

If the employee does not account to his employer for the tips and gratuities received and is engaged in an occupation in which he customarily and regularly receives more than \$20 a month in tips, the combined amount received by him from his employer and tips shall be deemed to be at least equal to the wage required by chapter 387 or a greater sum as determined by regulation of the director.

"Wages" does not include the amount of any payment specified in section 383-11 or 392-22 or chapter 386."

SECTION 2. Statutory material to be repealed is bracketed. New material is underscored. In printing this Act, the revisor of statutes need not include the brackets, the bracketed material or the underscoring.*

SECTION 3. This Act shall take effect upon its approval.

(Approved May 12, 1976.)

ACT 79

S.B. NO. 1832-76

A Bill for an Act Relating to Civil Service and Exemptions.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. Section 76-16, Hawaii Revised Statutes, is amended to read:

"Sec. 76-16 Civil service and exemptions. The civil service to which this part applies comprises all positions in the state service not existing or hereafter established and embraces all personnel services performed for the State, except the following:

*Edited accordingly

brackets, the bracketed material, or the underscoring.*

SECTION 10. This Act shall take effect upon its approval.

(Approved May 12, 1976.)

ACT 81

S.B. NO. 2225-76

A Bill for an Act Relating to Prepaid Health Care.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. Section 393-21, Hawaii Revised Statutes, is amended to read as follows:

"Sec. 393-21 Individual waivers; additional withholding for dependents.

(a) An employee may waive individually all of the required health care benefits pursuant to this chapter by:

- (1) Requesting the waiver by a writing submitted to the employer; and
- (2) Receiving approval of the waiver from the director upon the director determining that the employee has other coverage under a prepaid health care plan which provides benefits that meet the standards prescribed in section 393-7.

(b) The employer who receives from an employee a written request for a waiver under this section shall transmit to the director a copy of the waiver, on a form prescribed by the director, and a copy of the prepaid health care plan on the basis of which the waiver is requested.

(c) A waiver under this section is binding for one year and is renewable for subsequent one-year periods.

(d) An employer who, directly or indirectly, coerces or attempts to coerce an employee in making a waiver under this section shall be subject to the penalty provided under subsection 393-33(b).

(e) An employee may not agree to pay a greater share of the premium for such benefits than is required by this chapter.

(f) Subject to section 393-7(b), an employee may consent to pay a greater share of his wages and to a withholding of such share by the employer for the purpose of providing prepaid health care benefits of his dependents under the plan providing such benefits for himself."

SECTION 2. Statutory material to be repealed is bracketed. New material is underscored. In printing this Act, the revisor of statutes need not include the brackets, the bracketed material, or the underscoring.*

SECTION 3. This Act shall take effect upon its approval.

(Approved May 12, 1976.)

*Edited accordingly.

ACT 206

ACT 206 Amend.

brackets, the bracketed material, or the underscoring.*

SECTION 4. This Act shall take effect upon its approval.

(Approved June 7, 1976.)

ACT 206

S.B. NO. 1821-76

A Bill for an Act Relating to the Prepaid Health Care Act.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. Section 393-13, Hawaii Revised Statutes, is amended to read:

"Sec. 393-13 Liability for payment of premium; withholding; recovery of premium. Unless an applicable collective bargaining agreement specifies differently every employer shall contribute at least one-half of the premium for the coverage required by this chapter and the employee shall contribute the balance; provided that in no case shall the employee contribute more than 1.5 per cent of his wages; and provided that if the amount of the employee's contribution is less than one-half of the premium, the employer shall be liable for the whole remaining portion of the premium.

The employer shall withhold the employee's share from his wages with respect to pay periods as specified by the director.

If an employee separates from his employment after his employer has prepaid the employee's share of the cost of providing health care coverage, the employer may deduct an amount not to exceed one-half of the premium cost but without regard to the 1.5 per cent limitation, from the last salary or wages due the employee, or seek other appropriate means to recover the premium."

SECTION 2. Statutory material to be repealed is bracketed. New material is underscored. In printing this Act, the revisor of statutes need not include the brackets, the bracketed material or the underscoring.*

SECTION 3. This Act shall take effect upon its approval.

(Approved June 7, 1976.)

ACT 207

S.B. NO. 1899-76

A Bill for an Act Relating to the Establishment of an Office of Children and Youth.

Be It Enacted by the Legislature of the State of Hawaii:

SECTION 1. The legislature finds that securing the well-being of all of Hawaii's children should continue to be a policy concern of the highest order for state government. Hawaii has long been a leader among the states in the development of innovative undertakings in behalf of children and youth as evidenced, in part, by the enactment of Act 294, Session Laws of Hawaii 1949, which establish-

*Edited accordingly

**SOME ANSWERS
TO HAWAII
PREPAID
HEALTH CARE LAW**

**FOR EMPLOYERS
AND EMPLOYEES**



STATE OF HAWAII
Department of
Labor and Industrial Relations
DISABILITY COMPENSATION DIVISION
P.O. Box 3769
Honolulu, Hawaii 96812

INTRODUCTION

This leaflet has been prepared in question-and-answer format to help employers and employees understand the Hawaii Prepaid Health Care Law. The new law sets up a compulsory health insurance program for the workers of Hawaii. Since every employer has a major role in the program, it is hoped that the information contained herein will enable employers to implement the law with minimal difficulty. For detailed information of this new program, refer to the law.

WHAT IS THE HAWAII PREPAID HEALTH CARE LAW?

This landmark legislation (the first in the nation) requires Hawaii employers to provide health care services for their employees, thus assuring them of needed protection against the high costs of hospital and medical care.

WHEN WILL THIS NEW LAW TAKE EFFECT?

The law took effect on June 12, 1974, but the required coverage by group prepaid health care plans and the payment of premiums for such coverage will not commence until January 1, 1975.

WHEN DOES AN EMPLOYER BECOME SUBJECT TO THE LAW?

An employer becomes subject to the law when he has one or more regular employees. A regular employee is one who works twenty or more hours per week and is paid a monthly wage of at least 80-67 times the prevailing Hawaii minimum hourly wage. A regular employee does not include a person employed in seasonal employment (e.g., harvesting and canning of pineapples) or one who works less than twenty hours a week. The Federal, State and County governments are excluded from the law.

ARE THERE EMPLOYEES EXEMPT FROM COVERAGE?

Yes, besides employees working in seasonal employment, employers need not cover insurance and real estate salesmen or brokers paid solely on commission basis, parent working for son/daughter, wife/husband working for spouse, son/daughter under twenty-one years of age working for father/mother, and others specifically exempted by the law. Also exempt are employees who are covered as dependents under another health care plan.

CAN A REGULAR EMPLOYEE WORKING CONCURRENTLY FOR TWO OR MORE EMPLOYERS HAVE COVERAGE FROM ALL EMPLOYERS?

No.

WHO HAS TO PROVIDE COVERAGE IN ABOVE CASE?

The employee is required to name which of the two or more employers is the principal employer and which the secondary employer(s) on the employee notification form (HC-5). The principal employer is required to provide coverage. An employee's determination of principal employer is binding for one year or until change of employment occurs. A secondary employer can become the principal employer if the employee so chooses or if the employee no longer holds two or more jobs concurrently. The employer is prohibited from coercing, interfering or influencing an employee in making a determination.

WHEN IS AN EMPLOYER A PRINCIPAL OR SECONDARY EMPLOYER?

An employee is required to complete Form HC-5 for the purpose of naming his principal and secondary employers, or when ever he chooses to make a change with respect to the status of each employer. The employer and employee each retains a copy, with the original going to the Department of Labor.

MUST AN EMPLOYER COVER AN EMPLOYEE WHO IS ALREADY COVERED AS A DEPENDENT UNDER A HEALTH CARE PLAN?

No. Besides such dependents, others who are exempt are employees protected by health insurance or any prepaid health care plan established under any law of the United States, and recipients of public assistance or those covered by a State-legislated health care plan governing medical assistance.

WILL AN EMPLOYER BE NOTIFIED OF AN EMPLOYEE'S EXEMPT STATUS?

Yes. An exempt employee in any of the three categories mentioned above is required to complete Form HC-5 to notify the employer of the exemption, with a copy filed with the Department of Labor. Also, when the employee terminates exemption, the employer must be notified using the same form. When an employer receives notification that the employee has terminated exemption, the employee should be covered under the employer's health care plan.

WHAT PLANS ARE AVAILABLE FOR PROVIDING HEALTH CARE SERVICES?

There are two types of prepaid health care plans: (1) A plan by which a prepaid health care plan contractor would furnish health care, including hospitalization, surgery, medical or nursing care, drugs or other restorative appliances; and (2) a plan by which the contractor would delay or reimburse, in whole or in part, the expenses of health care.

WHAT IS MEANT BY PREPAID HEALTH CARE PLAN CONTRACTOR?

A prepaid health care plan contractor may fall in one of three groups: (1) Any medical group or organization which undertakes under a prepaid health care plan to provide health care benefits (e.g., Kaiser Medical Center); (2) any nonprofit organization which undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care (e.g., HMSA); or (3) any insurer who undertakes under a prepaid health care plan to defray or reimburse in whole or in part the expenses of health care (e.g., Aetna Life Insurance Company). Note: The names of contractors cited above do not constitute an endorsement. They are used strictly as illustrations.

WHO SELECTS THE PLAN TYPE AND CONTRACTOR FOR THE EMPLOYEES?

The employer selects the plan type and the contractor. The plan type may be either a plan which requires the prepaid health care plan contractor to furnish the required health care benefits, or a plan which requires the prepaid health care plan contractor to defray or reimburse the expenses of health care. This election is binding for one year.

IS SHARING OF PREMIUM COSTS PERMITTED?

While the employer has the option of paying the entire premium, an employee may be required to share the cost. The employer must pay at least one-half of the premium and the employee the balance. The employee's share, however, cannot exceed 15% of his wages. If the employee's share constitutes less than one-half of the premium, the employer must pay the entire remaining portion. The employer is permitted to withhold the employee's share from the employee's wages.

WHAT TYPES OF BENEFITS MUST BE PROVIDED IN A PREPAID HEALTH CARE PLAN?

An approved prepaid health care plan must include at least the following types: (1) hospital benefits, including inpatient care for at least 120 days of confinement in each calendar year; (2) surgical benefits; (3) medical benefits; (4) diagnostic benefits; and (5) maternity benefits if the employee has been covered by the prepaid health care plan for at least nine consecutive months prior to the delivery. Note: For detailed breakdown of above five types of benefits, see the law.

HOW SOON MUST AN EMPLOYER COVER AN EMPLOYEE?

Any regular employee who has been employed for four consecutive weeks by an employer must be covered at the earliest time thereafter.

WHAT HAPPENS TO AN EMPLOYEE'S COVERAGE IF THE EMPLOYEE IS UNABLE TO WORK BECAUSE OF DISABILITY?

If an employee is disabled and unable to work, the employer must continue the coverage by paying for the employer's share of the premium costs. The obligation is to continue the longer of the following periods: Three months following the month during which the employee became disabled, or following the period for which the employer has undertaken the payment of the employee's regular wages. An employee must keep up the employee's payments.

WHAT EFFECTS WILL THIS NEW LAW HAVE ON AN EXISTING PREPAID HEALTH CARE PLAN?

A prepaid health care plan shall qualify as a plan providing the required mandatory benefits (see above) if it provides health care benefits equal to, or medically reasonably substitutable for, the benefits provided by prepaid health care plans specified above, or if it provides sound basic hospital, surgical, medical and other health care benefits as determined by the director after advice by the prepaid health care advisory council.

WHO DETERMINES WHETHER OR NOT A PREPAID HEALTH CARE PLAN MEETS THE LAW'S REQUIREMENTS?

This determination is made by the Director of the State Department of Labor after advice by a seven member prepaid health care advisory council consisting of representatives of the medical and public health profession, representatives of consumer interests and persons experienced in prepaid health care protection.

WHAT EFFECTS WILL THIS NEW LAW HAVE ON COLLECTIVE BARGAINING?

(1) Employees will be free to bargain collectively for different prepaid health care coverage or for a different allocation of the costs thereof, or for the employer to provide the health care specified in the agreement. (2) An employer or group of employers will be deemed to be in compliance with the law if they provide health care services pursuant to a collective bargaining agreement and the services are available to all other employees not covered by such agreement. (3) An employer will be required to provide coverage for employees not covered by the health care provisions of the applicable collective bargaining agreement to which the employer is a party.

WHAT ABOUT EXISTING EMPLOYER-SPONSORED PLANS COVERING HAWAII-BASED EMPLOYEES?

Any out-of-state employer sponsored health care plan affecting employees of this state must be adjusted by June 11, 1975, so as to meet the law's requirements.

CAN AN EMPLOYEE'S RIGHT TO BE COVERED BY A HEALTH CARE PLAN BE WAIVED?

An employee may not waive individually all or part of the required health care services.

CAN AN EMPLOYEE AGREE TO PAY A GREATER SHARE OF THE PREMIUM COST?

An employee cannot agree to pay a greater share from wages except for the purpose of paying for the added cost of providing prepaid health care benefits for the employee's dependents under the same plan.

MUST AN EMPLOYEE BELONGING TO A FAITH-HEALING GROUP BE COVERED?

No.

CAN EMPLOYERS FORM ASSOCIATIONS FOR THE PURPOSE OF PROVIDING PREPAID HEALTH CARE PROTECTION?

Yes, as long as such health care protection is obtained from an authorized health care contractor.

ARE THERE PENALTIES FOR ANY INFRACTION OF THE LAW?

(1) An employer who fails without good cause to comply with the coverage provisions of the law shall be penalized not less than \$25 or \$1 for each employee for every day during which such failure continues, whichever sum is greater, and (2) an employer, employee or prepaid health care contractor who willfully fails to comply with any other provisions or any rules or regulations shall be fined not more than \$200 for each such violation.

WHAT IS THE PREMIUM SUPPLEMENTATION FUND?

This is a special fund financed and administered by the State for the purpose of assisting certain eligible employers in paying for the cost of providing the required health care benefits.

WHAT ARE THE ELIGIBILITY REQUIREMENTS FOR PREMIUM SUPPLEMENTATION?

An employer is entitled to premium supplementation if: (1) less than 8 workers are employed; (2) the employer's share of the cost of providing health care services exceeds 15% of the total wages payable to employees; and (3) the amount of such excess is greater than 5% of the employer's income before taxes directly attributable to the business (see below for definition).

HOW MUCH CAN AN EMPLOYER RECEIVE FROM THE PREMIUM SUPPLEMENTATION FUND?

The amount of premium supplementation shall be that part of the employer's share of the premium cost which exceeds the limits specified above.

HOW DOES AN EMPLOYER CLAIM PREMIUM SUPPLEMENTATION?

The employer must complete a prescribed claim form furnishing information that the employer's share of the premium cost exceeds the limits specified above.

WHAT IS MEANT BY INCOME DIRECTLY ATTRIBUTABLE TO THE BUSINESS?

Income directly attributable to the business means gross profits from the business minus deductions for: (1) compensation of officers; (2) salaries and wages, except wages paid by an individual proprietor to himself; (3) repairs; (4) taxes on business and business property; (5) business advertising; (6) amounts contributed to employee benefit plans; (7) interest on business indebtedness; (8) rent on business property; and (9) other expenses necessary for the current conduct of business.

WHAT DEDUCTIONS ARE EXCLUDED FROM INCOME DIRECTLY ATTRIBUTABLE TO THE BUSINESS?

These are: (1) bad debts; (2) contributions or gifts, other than those listed under 6 above; (3) amortization and depreciation; and (4) losses by fire, storm, casualty, etc.

WHAT AGENCY ADMINISTERS THE HAWAII PREPAID HEALTH CARE LAW?

The Disability Compensation Division of the Department of Labor and Industrial Relations administers the Hawaii Prepaid Health Care Law. If you need further information, please contact the following offices:

Address all inquiries to:

Dept. of Labor & Industrial Relations
Temporary Disability Insurance Division

Oahu P.O. Box 3769
825 Miliam Street, Room 201
Honolulu, Hawaii 96812
Phone 548-7821

Hawaii P.O. Box 671
State Office Building
75 Aupuni Street
Hilo, Hawaii 96720
Phone 961-7391

West Hawaii P.O. Box 97
Kealahou, Hawaii 96750
Phone 322-2775

Mauai P.O. Box 580
State Office Building
54 South High Street
Wailuku, Hawaii 96793
Phone 244-4322

Kauai P.O. Box 391
State Office Building
3060 Ewa Street
Lihue, Hawaii 96766
Phone 245-4351

19 March 1980

To: Representatives Buchholdt, McKinnon, Parker, Gardiner

From: Sharman Haley
Alaska Public Interest Research Group

Subject: Policy Options in Proposed Health Legislation

The health bill which is presently being drafted at Representative Buchholdt's request is largely modeled after Hawaii and Minnesota laws. These laws do not necessarily conform in detail to the situation in Alaska nor the interests of the Alaska sponsors. This memo calls to your attention various points in the model legislation which you may wish to consider modifying for Alaska. Certain policy considerations in the proposed Medicaid amendments and medically needy program are also discussed.

Health Insurance Minimum Standards and Risk Pooling

The Comprehensive Health Insurance Act adapted from Minnesota law and published in 1980 Suggested Legislation Vol. 39, by the Council of State Governments, is the model for the minimum benefits and risk pooling portions of the proposed legislation. One section in the model bill requires health insurance carriers to offer certain kinds of conversion privileges. For example, when an individual drops out of a group plan (such as with the termination of employment) the carrier must offer an individual plan to continue coverage without the addition of underwriting restrictions. Also, when the primary insured dies, the carrier must allow other individuals covered under the plan to continue coverage. This issue was not addressed in our drafting request. You may wish to consider including language on conversion privileges in the bill.

The model legislation also contains a provision known as "dual option" which requires major employers of 100 or more employees who offer health benefits to their employees, to offer both insurance or membership in a health maintenance organization where both are available. This in part is a policy to promote HMOs. This provision was not included in the drafting request. Since Anchorage may have an HMO in the near future, you may wish to consider a similar provision in the legislation for Alaska.

The model legislation sets out standards for three types of qualified plans. You should be aware that the legislation does not require that only qualified plans can be sold; it merely requires of all carriers that qualified plans be offered to each eligible customer.

The model legislation sets numerous specific dollar amounts. Presumably these amounts will have to be periodically updated for inflation or changes in standards. You may wish to consider adding the provision that the specified amounts are applicable for the first year and subsequently the commissioner may revise and update all the dollar amounts by regulation.

The model legislation initially sets premiums for the high risk coverage at the average premium level among the five largest carriers in the state for comparable standard risk coverage, and provides that in subsequent years the premiums are to be set such that the plan pays for itself according to actuarial principles. In Minnesota's experience however, the claims in the first 18 months were so high that they feared premiums would have to be raised 100% to cover the claims. To keep the premiums at an affordable level, the legislature amended the statute to limit the premiums to 125% of the standard risk premiums, and provided that assessments made against the carriers by the carriers association to cover the losses due to claims, could offset any income or premium taxes owed to the state by that carrier. Thus the state was made responsible for the losses incurred by the plan. You may wish to consider these amendments for the Alaska legislation as well.

The model act defines dependent as spouse, unmarried child under the age of 19, dependent child under the age of 25 who is a student and

is financially dependent on the parent, or a dependent child of any age who is disabled. You may wish to consider the addition of any household member who is financially dependent on the head of household, in order to include other relatives or non-relatives who may be members of that family unit.

The model legislation, in its itemization of minimum services covered and not covered, states that transportation costs other than ambulance are not covered. This is not well suited to Alaska, since medically necessary travel is frequent and expensive in most parts of the state.

The model legislation includes well baby care, routine physicals, and multi-phasic screening. It should be understood that since these are routine, predictable expenses, they do not fall within the central purpose of insurance -- that is, to insure against risk. Requiring coverage of basic medical care such as these in a consumer-paid plan does no service whatsoever to the consumer, since he or she will pay the full cost of routine care through higher premiums anyway. Requiring coverage of them in an employer-paid plan does offer an advantage to the consumer, of course, because it shifts the costs of these medical services from the consumer to the employer. Arguably there is a public purpose served in this requirement even for consumer-paid coverage -- namely to promote the utilization of these services in the interests of preventive medicine. Since the services have already been paid for, the consumer may as well utilize them. There are experts who claim, however, that routine physical exams, other than pap smears, blood pressure checks, or other procedures tailored to the health risks of the individual patient, are not cost effective; that overall they do not save more expense through the early detection of disease than they consume.*

Mandatory Employer Sponsored Coverage

The Hawaii Prepaid Health Care Act is the model for the mandatory employer sponsored coverage portions of the proposed legislation. The Hawaii

* One school of thought maintains that a more effective approach to preventive medicine would be promoting health education, self-awareness and self-responsibility for maintaining health among consumers. This would also promote early detection and reporting of symptoms when they do occur.

act excludes seasonal employees, in particular the pineapple pickers. The only explanation for this offered by the Hawaii program administrator was that the plantation owners had the political clout to get their employees exempted. Seasonal employees are a large component of Alaska's labor force, and often lack health coverage. You may wish to consider including seasonal employees in the Alaska legislation, or perhaps some form of hour bank for seasonal and temporary employees similar to the union health plans in the construction trades.

The model legislation mandates coverage of the employee only, and coverage of dependants is optional (unless the plan is of lower standard than the largest plan and is approved by the commissioner). You may wish to consider making coverage of dependents mandatory in employer-sponsored plans.

The Hawaii model sets up a separate fund for premium supplementation for qualifying employers. Several sections of the bill are devoted to defining the fund and how it is to be managed. Since the fund is not going to be self-supporting and will require annual appropriations anyway, there is little apparent advantage in terms of management or oversight in establishing a separate fund. You may wish to consider making premium supplementation part of the general fund.

The Hawaii model appears to make employee participation, including payment for the employee share of the premium, mandatory. The advantage in this is that more people will have coverage and employers cannot pressure employees to decline such coverage. The disadvantage is that employees may be required to contribute to the premium and have no choice whether or not to participate. You may wish to consider making participation voluntary on the part of the employee.

Linkage Between Hawaii and Minnesota Models

The Hawaii and the Minnesota models take two different approaches toward defining the minimum benefit standards for qualified health coverage plans. The Hawaii law is setting standards for mandatory employer coverage. In addition to meeting the very general benefit guidelines itemized in the

law, a qualified plan must meet one of two alternative benefit standards: (1) the benefits must meet or exceed the benefits of the largest plan in the state (in Alaska this would be either the Alaska State employees plan or possibly the Teamsters plan); or (2) the benefits must provide a level of coverage deemed satisfactory by the Commissioner. If these benefit plans are more limited than the largest plan, the employer must pay half the premium for dependents as well as the primary insured. The bill also establishes a prepaid health care council to advise the Commissioner on benefit levels. The law is administered by the Department of Labor.

The Minnesota law is setting standards for state qualified plans which all carriers are required to offer. The law specifies the scope of required benefits as well as minimum or maximum limits, copayments, and deductibles for three levels of qualified plans. The law is administered by the Division of Insurance.

While there is no direct conflict between these two laws which are proposed for Alaska, there is some duplication. Since the Alaska Department of Labor has no expertise in the arena of health insurance benefits, you may wish to consider centralizing all responsibility for benefit standards under the Division of Insurance, and leave only the employer compliance responsibilities with the Department of Labor. You should be aware that the Alaska Division of Insurance is already seeking authority to regulate minimum standards for insurance of all kinds in HB882 and SB513.

Consideration should also be given to the question of what standards employer coverage should meet and how they should be set. The Minnesota model specifies the standards for three levels of qualified coverage in law, and requires that employers who offer health coverage provide at least a number two qualified plan. The Hawaii model only provides general guidelines of minimum services to be covered, and leaves the other details up to the Commissioner, or else ties the standard to the benefits provided by the largest plan in the state. The state employees plan and the Teamsters plan are both more comprehensive than the minimum standards for the number two qualified plan, but of course would also be more expensive. The Minnesota approach is much simpler than the Hawaii approach and gives the legislature

greater control over the minimum standards. The standard required for employer plans does not necessarily have to be the same standard required for a qualified plan offered to individual consumers, particularly in the area of routine care for the reasons discussed in an earlier section.

Medicaid Medically Needy

Federal financial participation requirements in the Medicaid medically needy program set the maximum income threshold for medically needy program eligibility at 133% of the Aid to Families with Dependent Children income standard for a household of equivalent size. The minimum income threshold is set equal to the Adult Public Assistance standard or the AFDC standard, whichever is higher, for a household of equivalent size. Since in Alaska the AFDC standard is so much lower than the APA standard, \$350 for an AFDC family of two compared to \$608 for two APA eligibles, the federally mandated minimum medically needy income threshold for a family of two, \$608, is higher than the federally mandated maximum income threshold of \$466.55 ($\350×1.33). These are clearly impossible criteria. The federal policy manual appears to resolve the contradiction in favor of the lower standard. The result is that for adult eligibles the Medically needy income threshold is not much higher, and for a two person household is actually lower, than the income standard for the regular Adult Public Assistance program. (See attachment) This inconsistency could be left as is, or resolved in one of two ways: (1) the AFDC standard (which is lower than AFDC standards in many other states and a virtually impossible budget for a family in Alaska) could be raised; or (2) the medically needy income threshold could be set higher than 133% of the AFDC standard and the program could be financed entirely by the state.

Medicaid Optional Services

The Medicaid optional services included in the drafting request were the nine uncovered services most often requested by Medicaid clients and most recommended by social workers, as reported in OPTING: A Study of Medicaid Client Need. A copy of Table 2 from this report is attached. A complete listing of Medicaid optional services is attached should you wish to consider other optional services.



Alaska State Legislature
House of Representatives
Juneau, Alaska 99811

May 22, 1980

To: Representatives Gardiner, Meekins, McKinnon, Parker

From: Representative Thelma Buchholdt

Re: HCS CS SS SB 227 - Health Legislation

HCS CS SS SB 227, "An Act relating to the health of residents of the state," was passed out of the House HESS Committee on Wednesday, May 21. I am supplying you with a copy of the bill summary and the accompanying fiscal note. I am also enclosing a copy of the work draft that was passed out of Committee. I expect that the final version of the bill will be printed this afternoon.

Very briefly, Section 1 of the bill establishes a carrier reinsurance pool which would make health insurance available at a reasonable premium to every resident and every employer group in the state. This section of the bill is designed to pick up high-risk persons and other uninsurables in the state for whom health coverage is now unavailable.

Sections 4 through 7 of the bill comprise the original CS SS SB 227, sponsored by Senators Coletta, Hohman and Stimson, and require state employee health insurance to include coverage for alcoholism and drug dependence.

Section 8 of the bill requires the Commissioner of Health and Social Services to provide services under medical assistance programs through health insurance policies or health service contracts when cost effective. The bill authorizes the Department to make interim payments to providers who serve a large volume of state medical assistance clients. The bill also requires the state to pay interest to providers on overdue medical assistance bills.

Sections 9 and 10 of the bill expand the state's Medicaid program to include all services and eligibles qualifying for federal financial participation.

Finally, in Section 11, a medically needy program is established under the state General Relief program with an income standard set at 150% of the poverty guideline. Persons whose income exceeds the standard become eligible when they spend their excess income on medical bills.

The fiscal note for the bill includes approximately \$ 8 million from the state's General Funds, \$ 22,800 from other state funds and approximately \$ 8 million in federal funds.

HCS CSSS SB 227 (HESS)

BILL SUMMARY

(revised 5/21/80)

The basic concept of the first section of the bill is to establish a carrier reinsurance pool which would make health insurance available at a reasonable premium to every resident and every employer group in the state, regardless of underwriting risk. This section is modeled after Connecticut law.

AS21.50.010 Each carrier in the state which offers individual health coverage is required to make an individual comprehensive health care plan available to each resident of the state who is not eligible for Medicare. Each carrier in the state which offers group health coverage is required to make a group comprehensive health care plan available to every resident employer of three or more employees. The required coverage may be provided by a carrier or through the reinsurance association, but in the former case the premium charged may not exceed the applicable association premium. The bill does not preclude a carrier from carrying other kinds of health insurance nor does it require a carrier to provide coverage to a person or group who already has coverage.

AS21.50.020 The required comprehensive health plans must cover the services itemized. A choice of \$100, \$500, or \$1000 deductible is provided, and the maximum co-payment is set at 20%. The sum of co-payment and deductibles may not exceed \$1000 for an individual or \$2000 for a family before benefits

are paid at 100%. The maximum lifetime benefits limit may not be less than \$1,000,000. Pre-existing conditions may only be excluded if the condition was treated or medical advice was sought within six months prior to the effective date of coverage, but in any case may not be excluded from coverage for more than twelve months. The plans need not cover occupational injuries, cosmetic treatment, custodial care, services which are not medically necessary, services which are covered under an automobile liability policy, or other specified expenses. Group comprehensive health care plans must also cover dependents.

AS21.50.030 The Health Reinsurance Association is established consisting of all licensed health insurance carriers in the state. The board of governors and a plan of operation which addresses itemized issues are both subject to approval by the director. The authority to issue health insurance, to establish rates, to administer reinsurance, to pool risks, and other general powers are granted the association.

Each association member must designate the classes of risk which it elects to have written by or reinsured by the association. Individual lives may not be selected out of a group for reinsurance. Premium rates may not be excessive, inadequate, or unfairly discriminatory, nor may they exceed 125% of rates for standard risk groups. All rates are promulgated through the association by an actuarial committee.

Losses of the association are assessed to members. Members in turn may credit the assessed claims losses, but not

assessed administrative losses, against their premium or income tax. If the assessment exceeds their tax liability, the Commissioner of Revenue reimburses the carrier for the excess loss. Periodic audits are required.

AS21.50.040 Hospital or medical service corporations (such as Blue Cross) are given the option of participating in the Health Reinsurance Association or of setting up their own parallel residual market association under the same guidelines and standards.

AS21.50.050 The regulatory and oversight powers and administrative duties of the director of insurance are enumerated.

AS21.50.100 Definitions

Sections 2 and 3 are technical amendments to other chapters of the insurance code to bring them in conformity with Section 1.

Sections 4 through 7 of the bill amending AS39.30 comprise the original CSSSSB 227 and require state employee health insurance to include coverage alcoholism and drug dependence. Minimum benefits in the state employees plan are defined to include inpatient detoxification, inpatient treatment and outpatient treatment. Coverage may not exclude dependents or pre-existing alcoholism conditions.

Section 8 of the bill amending AS47.05 requires the Commissioner of Health and Social Services to provide services under medical assistance programs through health insurance policies or health service contracts when this would be cost effective. In a separate section, the department is authorized to make interim payments to providers who serve a large volume of state medical assistance clients. And finally, the bill requires the state to pay interest to providers on overdue medical assistance bills at the rate of one percent per month after 30 days and two percent per month after 90 days.

Sections 9 and 10 expand the state's Medicaid program to include all services and eligibles qualifying for federal financial participation.

Section 11 creates a medically needy program under the state General Relief program with an income standard at 150% of the poverty guideline. Persons whose income exceeds the standard become eligible when they spend their excess income on medical bills.

FISCAL SUMMARY

HCS CSSSSB 227 (HESS)

(in thousands of dollars)

<u>FY 81</u>	<u>General Funds</u>	<u>Federal Funds</u>	<u>Other</u>	<u>Total</u>
Sections 1-3: Health insurance pool	99.0			99.0
Sections 4-7: Alcoholism benefits	138.6	7.8	22.8	169.2
Sections 8-12: Medicaid & GR Med	<u>7,728.7</u>	<u>7,858.5</u>		<u>15,587.2</u>
TOTAL	7,966.3	7,866.3	22.8	15,855.4

FY 82

Sections 1-3: Health insurance pool	83.8		45.0	128.8
Sections 4-7: Alcoholism benefits	332.6	18.7	54.8	406.1
Sections 8-12: Medicaid & GR Med	<u>17,003.0</u>	<u>17,288.7</u>		<u>34,291.7</u>
TOTAL	17,419.4	17,307.4	99.8	34,826.6

Prepared by HESS staff 5/22/80

I. REQUEST

Bill/Resolution No. HCS CSSSSB 227 (HESS) SECTIONS 1-3
 Title An Act relating to the health of residents of the state
 Requested by Health Education and Social Services Comm. Date 5/20/80

II. FISCAL DETAIL

Agency Affected Division of Insurance
 Program Category Affected Public Protection
 BRU, Program, or Subprogram(s) Affected Division of Insurance
 (Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES		48.3	53.2	58.2		
200 TRAVEL		5.0	3.0	3.3		
300 CONTRACTUAL		40.9	26.8	29.4		
400 COMMODITIES		.8	.8	.9		
500 EQUIPMENT		4.0	--	--		
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
Reduct. of Unrestric. tax Rept. #019		--	45.0	99.0		
TOTAL		99.0	128.8	190.8		

FUNDING (Thousands of Dollars)

GENERAL FUND		99.0	83.8	91.8		
FEDERAL FUNDS						
OTHER (Specify Fund Source)						
Reduct. of Unrestric. tax Rept. #019		--	45.0	99.0		

POSITIONS

FULL TIME Market Analyst III		1	1	1		
PART TIME Clerk Typist III		1	1	1		
TEMPORARY						

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

This note assumes a half year of implementation and a half year of operation in FY81. It assumes 10% inflation for FY82 and FY83.

FISCAL NOTE

PERSONAL SERVICES

The law in Connecticut on which this bill is based was implemented with no additional staff. Most of the substantive work was performed by the industry. One new position with clerical support may be justified, however, for drafting the regulations, reviewing the organization of the Health reinsurance Association and approving the rates and policy forms developed by the carriers for the comprehensive health plan.

Market Analyst III	Range 18A	12 months	\$29,580
Clerk Typist III	Range 8A	half-time, 12 months	8,162
			<u>\$37,742</u>
	benefits (.1529)		5,771
	FICA		
	(.0665 x 8162 + 1985)		2,528
	health insurance		
	(127 x 1.5 x 12)		2,286
			<u>\$48,327</u>

TRAVEL

Travel to Connecticut and Minnesota and to Health Reinsurance Association board meetings	\$ 5,000
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CONTRACTUAL

Rent 2 positions x 150 sq. ft. x \$1.70 x 12 mo.	\$ 6,120
Phone (80 install + 600 local + 3,000 long distance)	3,680
Postage	1,000
Printing and Xerox	2,000
Equipment Rental (typewriter)	2,500
Consulting	25,000
Other	600
	<u>\$40,900</u>

<u>COMMODITIES</u> (1.5 x 500)	\$ 750
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EQUIPMENT

desks, chairs, bookcase, filing cabinet, caculator, etc.	\$ 4,000
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PREMIUM TAX OFFSET

Total Comprehensive Health Plan Premiums in Connecticut for 1979: \$2,785,367

Total FWA Assessment since April 1, 1976: \$ 80,000

Alaska population*/Connecticut population* = 395,000/2,746,000 = .144

Alaska rates/Connecticut rates: 1.35

Factor for change in deductions: 1.05

Factor for change in pregnancy benefits: 1.05

Factor for change in transportation benefits: fudgefactor: 1.20

Loss factor: (135% - 125%)/135% = .074

Inflation factor '79 - '81: 1.21

$\$2,785,367 \times .144 \times 1.35 \times 1.05 \times 1.05 \times 1.20 \times .074 \times 1.21 + (\$80,000/345) = 87,402$

This estimating procedure will tend to overestimate the costs. Nevertheless, there are many difference between Connecticut and Alaska which we cannot account for, and the margin for error is large. Rounding up to an even \$90,000 should produce a safe high estimate of the tax loss to the state in a full year of operation. Since FY '81 includes only a half year of operation, only half that amount would be claimed in FY '82.

* Civilian noninstitutionalized population under age 65.

FISCAL NOTE

I. REQUEST

Bill/Resolution No. HESS CS for SS Senate Bill 227 (HESS) SECTIONS 4-7
 Title Insurance for Alcoholism and Drug Dependence
 Requested by _____ Date _____

II. FISCAL DETAIL

Agency Affected Administration - Division of Retirement and Benefits
 Program Category Affected Retirement and Benefits (OTHER BENEFITS)
 BRU, Program, or Subprogram(s) Affected 02-96-8-01-02-00
 (Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 79	FY 80	FY 81	FY 82	FY 83	FY 84
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 TRS STATE MATCH						
100 BENEFITS		282.0	338.4	406.1	487.3	584.8
TOTAL		282.0	338.4	406.1	487.3	584.8

FUNDING (Thousands of Dollars)

GENERAL FUND		230.8	277.1	332.6	399.2	478.9
FEDERAL FUNDS		13.0	15.6	18.7	22.4	26.9
VETERAN'S FUND		0.6	0.7	0.8	1.0	1.2
FISH & GAME FUND		1.7	2.0	2.4	2.9	3.5
HIGHWAY FUND		3.7	4.4	5.3	6.3	7.5
AIRPORT FUND		8.2	9.8	11.8	14.1	17.0
CAPITAL FUND		24.0	28.8	34.5	41.4	49.7
PERS						
TRS						

POSITIONS

NONE

FULL TIME						
PART TIME						
TEMPORARY						

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

- Approximately 8,900 State employees are currently covered under the State Group Health Care Plan.
- The cost to implement the provisions of this bill will be \$2.64 per employee per month.
- Estimate that the cost to provide continued coverage will increase 20% each year for the immediate future. However, an effective alcoholism/drug dependency program should help to reduce overall health care claim experience in the future.
- Cost for coverage of political subdivisions (approximately 50 subdivisions) participating in group insurance not included; recommend that the Alaska Municipal League, 204 Franklin St., Juneau, AK 586-1325, be contacted for input.

IV. DATE 3/30/79 PREPARED BY Paul B. Arnoldt, Director
 AGENCY Division of Retirement & Benefits
 PHONE 465-4460

Original: Legislative Finance
 cc: Budget and Management
 Prime Sponsor (First Legislator Named) Senator Colletta & Senate HESS