

792 HESS STATE HEALTH INSURANCE (FILE NO. 2) 72

Summary Sheet

House CS for CS for Sponsor Substitute for Senate Bill No. 227
 (In thousands of dollars)

SECTIONS 8-12

	<u>Total</u>	<u>Federal</u>	<u>State</u>	<u>New Positions</u>
1. Addition of Medicaid Services and New Eligibles	\$24,194.5	\$15,717.0	\$ 8,477.5	17
2. Decrease of GR-Med. as Result of Adding Medicaid Svcs. and Eligible Groups	4,471.8	-0-	4,471.8	-0-
3. State Only Medically Needy	11,169.4	-0-	11,169.4	16
4. Interest Payment	<u>282.2</u>	<u>-0-</u>	<u>282.2</u>	<u>-0-</u>
TOTAL	\$31,174.3	\$15,717.0	\$15,457.3	33

[NOTE: THESE AMOUNTS PREPARED BY THE DEPARTMENT ARE FOR A FULL YEARS' OPERATION. THE SUMMARY SHEET PREPARED BY HESS STAFF ASSUMES A HALF YEAR OF OPERATION IN FY81 AND 10% INFLATION FOR FY82. --HESS STAFF]

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House CS for CS for Sponsor Substitute for Senate Bill No. 227
 Title An Act relating to the health of residents of the State.
 Requested by The Hess Committee Date May 2, 1980

II. FISCAL DETAIL

Department of Health and Social Services
 Agency Affected
 Program Category Affected Health/Social and Economic Assistance
 BRU, Program, or Subprogram(s) Affected Medicaid/Eligibility Determination/PAA
 (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		448.3				
200 TRAVEL		17.0				
300 CONTRACTUAL		175.5				
400 COMMODITIES		8.5				
500 EQUIPMENT		17.5				
600 LAND & STRUCTURES		-0-				
700 GRANTS, CLAIMS, ETC.		23,527.7				
TOTAL		24,194.5				

FUNDING (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
GENERAL FUND		8,477.5				
FEDERAL FUNDS		15,717.0				
OTHER (Specify Fund Source)		-0-				

POSITIONS

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
FULL TIME		17				
PART TIME		-0-				
TEMPORARY		-0-				

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

Medical benefits would be provided to approximately 3,065 new cases under the Medicaid program. Administration of program benefits would require 15 field staff positions and 2 central office positions, office space, and additional computer time to be divided between the Eligibility Determination and Public Assistance Administration BRUs. Funding is 50% federal except for the Indian Health Care program which is funded at 100% federal funds. Since the bill proposes to add new coverage groups and new categories of coverage to Medicaid, there will be a reduction in General Relief Medical program expenditures as indicated on page 2. Thus, the actual increase in state General fund revenues needed for this increased Medicaid coverage is $8,477.5 - 4,471.8 = 4,005.7$.

Original: Legislative Finance Prepared by: David M. Davidson Date: May 2, 1980
 cc: Budget and Management Division/Office: Public Assistance PH 465-3347
 Prime Sponsor (First Legislator Named) Department of Health & Social Services

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House CS for CS for Sponsor Substitute for Senate Bill No. 227
 Title An Act relating to the health of residents of the State.
 Requested by The Hess Committee Date May 2, 1980

II. FISCAL DETAIL

Department of Health and Social Services
 Agency Affected _____
 Program Category Affected Health
 BRU, Program, or Subprogram(s) Affected General Relief Medical
 (Note: If more than one budget component is affected, separate line-item amount 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						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		(4,471.8)				
TOTAL		(4,471.8)				

FUNDING (Thousands of Dollars)

GENERAL FUND	(4,471.8)				
FEDERAL FUNDS					
OTHER (Specify Fund Source)					

POSITIONS

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

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

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

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 cc: Budget and Management Division/Office: Public Assistance PH: 465-3347
 Prime Sponsor (First Legislator Named) Department of Health & Social Services

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House CS for CS for Sponsor Substitute for Senate Bill No. 227
 Title An Act relating to the health of residents of the State.
 Requested by The Hess Committee Date May 2, 1980

II. FISCAL DETAIL

Agency Affected Department of Health and Social Services
 Program Category Affected Health/Social and Economic Assistance
 BRU, Program, or Subprogram(s) Affected General Relief Medical/Eligibility Determination/PAA
 (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		423.3				
200 TRAVEL		16.0				
300 CONTRACTUAL		154.0				
400 COMMODITIES		8.0				
500 EQUIPMENT		16				
600 LAND & STRUCTURES		-0-				
700 GRANTS, CLAIMS, ETC.		10,551.6				
TOTAL		11,169.4				

FUNDING (Thousands of Dollars)

GENERAL FUND		11,169.4				
FEDERAL FUNDS		-0-				
OTHER (Specify Fund Source)		-0-				

POSITIONS

FULL TIME		16				
PART TIME		-0-				
TEMPORARY		-0-				

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

Medical benefits could be provided to approximately 2,821 new cases under a state-only medically needy program as part of the General Relief Medical program. Administration of program benefits would require 14 field staff positions and 2 central office positions, office space, and additional computer time to be divided between the Eligibility Determination and Public Assistance Administration BRUs. Funding is indicated as 100% state funds, but it may be possible to receive federal funding for certain individuals with income less than 133% of the state need standard for the particular eligibility categorical group to which they are related.

Original: Legislative Finance
 cc: Budget and Management
 Prime Sponsor (First Legislator Named)

Prepared by: David M. Davidson Date: May 2, 1980
 Division/Office: Public Assistance PH:465-3347
 Department of Health & Social Services

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House CS for CS for Sponsor Substitute for Senate Bill No. 227
 Title An Act relating to the health of the residents of the State.
 Requested by The Hess Committee Date May 2, 1980

II. FISCAL DETAIL

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

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL		282.2				
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		282.2				

FUNDING (Thousands of Dollars)

GENERAL FUND		282.2				
FEDERAL FUNDS		-0-				
OTHER (Specify Fund Source)						

POSITIONS

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

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

Funding necessary to make interest payments to providers for Medicaid and General Relief Medical clean claims not processed within 30 days of receipt by the Department. Federal law requires states to process 90% of Medicaid clean claims within 30 days of receipt, however no provision is made under federal law for funds to be used to make interest payments. Thus, all interest payments must be made using state funds only.

Original: Legislative Finance
 cc: Budget and Management
 Prime Sponsor (First Legislator Named)

Prepared by: David M. Davidson Date: May 2, 1980
 Division/Office: Public Assistance PII: 465-3347
 Department of Health & Social Services

HCS CSSS SB 227

BILL SUMMARY

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. Every self-insured employer group is required to make an individual comprehensive health care plan available as a conversion privilege to each group member. 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 was apparent and should have been diagnosed or treated 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.

AS21.50.030 Group comprehensive health care plans must also cover dependents and must include the privilege to continue coverage for a specified period of time upon leaving the group by reason of layoff, leave, termination, death or illness. Unmarried children remain eligible as dependents as long as they are under 19, under 23 and a full-time student, or disabled. Spouses and resident household members who are financially dependent on the employee are also covered as dependents up until they become eligible for Medicare. Group members must also be provided the privilege to convert to an individual plan immediately on the termination of group coverage.

AS21.50.040 Individual comprehensive health care plans must provide the privilege for dependents to continue coverage after the death of the primary insured until the coverage would have otherwise ceased.

AS21.50.050 The Health Reinsurance Association is established consisting of all licensed health insurance carriers in the state. The board of directors 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.

AS21.50.060 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.

AS21.50.070 The regulatory and oversight powers and administrative duties of the director of insurance are enumerated.

AS21.50.080 The conversion privileges required for group comprehensive health care plans under AS21.50.030 are also required for all group health policies issued in the state after January 1, 1981.

AS21.50.090. A voluntary health premium supplementation program is established for employers who choose to provide health benefits for their employees and meet certain financial hardship criteria. Premium supplementation is at the rate of 80% of the premium cost which exceeds 1.5% of the payroll plus 4% of the employer's income before taxes from that business. This section is modeled after Hawaii law.

AS21.50.200 Definitions.

Sections 2 through 5 of the bill amending AS39.30 comprise the original CSSSSB 227 and require group health insurance to include coverage for alcoholism and drug dependence. Minimum benefits are defined to include inpatient detoxification,

inpatient treatment and outpatient treatment. Coverage may not exclude dependents or pre-existing alcoholism conditions.

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Section 6 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.

Section 7 and 8 expand the state's Medicaid program to include all services qualifying for federal financial participation.

Section 9 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.

IMPACT ON INSURANCE CARRIERS

Minnesota Experience

The Minnesota Comprehensive Health Act took effect January 1, 1977. At year end, 1976, the following statistics were compiled:

Out of

751 carriers licensed to write health and accident insurance in the state,

42 carriers withdrew from the state rather than comply with the law. Of these,

25 never wrote any health insurance in the state anyway. The remaining

17 carriers that withdrew had a combined volume of

\$888,000 in health insurance premiums in Minnesota (less than 0.2% of the total) or an average of

\$52,200 in premiums per carrier. The largest carrier that withdrew reported a volume of

\$428,000 in accident and health premiums.

Since the time these statistics were compiled, other carriers have dropped their accident and health business in Minnesota, and some that originally withdrew have resumed their accident and health line of business in the state again.

Mr. Carroll Calloway, Assistant General Counsel for the Health Insurance Association of America, discussed several reasons that carriers might have preferred to stop doing accident and health business in Minnesota rather than comply with the Comprehensive Health Act.

The first objection was that many carriers specialize in a particular type of insurance and do not underwrite comprehensive policies. The law requires them to offer comprehensive plans, and does not allow them to refuse a client for reasons other than that the client is an uninsurable risk. Another objection was that the required conversion privileges obligates a carrier that specializes in group policies to also write individual conversion policies.

Mr. Calloway stated that the insurance carriers like the Connecticut comprehensive health act, because in Connecticut the underwriting burden for the mandated coverage is not placed on the individual carriers, but on the association. The association in Connecticut develops and underwrites the comprehensive health plan which the carriers are obligated to make available to their clients. The Minnesota law also provides for reinsurance and administration by the association of all required types of coverage and the association has the ability to develop prototype plans for use by any carrier which does not choose to develop and issue its own qualified plans. The Minnesota carriers association has refused, however, to reinsure lines of coverage mandated by the act, other than the state plan for high risk clients, according to Mr. Calloway. Thus it is not the provisions of the law which place an insurmountable burden on the carriers, but the practice of the association, which of course is run by the carriers themselves.

The third objection was the "major medical roll on" which requires carriers to offer major medical coverage to their client with unqualified plans. They regard this as an impairment of contract. This section to which the carriers strenuously object could easily be deleted without significantly weakening the bill, in light of the requirement that carriers must offer their client a comprehensive qualified plan with major medical coverage anyway.

The carriers which might find compliance with HB 977 most difficult perhaps are those who write only accident or illness indemnity policies with fixed reimbursement rates (for example, \$50 per day for every day in the hospital). These companies are not set up to handle claims based on expenses incurred as required of a qualified plan under HB 977. The largest carrier of this type in Alaska has a premium volume of \$723,000. It is not known how many other carriers of this type there are, nor what their premium volume might be. While it is perhaps undesirable to adversely affect any Alaska business with this legislation, it is notable that those for whom compliance with HB 977 would be most difficult are precisely those carriers who specialize in limited types of accident and health coverage which afford the least financial and medical protection to consumers.

POSITION PAPER
ON

HOUSE CS FOR CS FOR SPONSOR SUBSTITUTE FOR SENATE BILL NO. 227 (FINANCE)

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

1. Departmental Overview of House CS for CS for SS for SB 227 (Finance)

The Department of Health and Social Services will primarily reserve its comments to Sections 5-15 of the bill, as the earlier sections are concerned with health insurance. It is our understanding that these issues are planned to be addressed by the Division of Insurance in the Department of Commerce and Economic Development.

The Department, in general, believes that House CSCSSSSB 227 (Finance) takes a multi-faceted approach to a complex problem. It appears to move in too many directions and at too rapid a time frame, which could potentially jeopardize the accomplishment of the goals that the bill seeks to obtain. We recommend that all sections of the bill, except for Sections 5-8, be studied further during the interim to insure that the plan on which the insurance section of the bill is modeled is workable, affordable, and in the best interest of clients and the insurance industry. Sections 5-8 (pilot project for alcoholism insurance coverage for state and other participating government employees) which were the body of CSSSSB 227 (HESS) and the result of over a year's planning. That pilot project concept is supported by state government and the insurance companies that serve Alaska. We, therefore, recommend that the pilot project sections of the current committee substitute be addressed separately in their original piece of legislation. We are concerned that the fiscal impact of the expansion of the Medicaid program and the uncertainties of the health insurance section may outweigh serious consideration of the pilot project for alcohol insurance, which has been studied for a significant period of time.

The Department is also concerned about the massive increase to the Medicaid and General Relief-Medical programs, if House CSCSSSSB 227 (Finance) were to pass. The bill would increase the budgets of these programs by over 50% (if implemented for a full fiscal year) and would require a monumental effort on the part of our Division of Public Assistance to gear up for implementation by the January, 1981 effective date. We are concerned that the current Medicaid service program might suffer during the transition period as a result of such a significant increase. We would, therefore, recommend that if new options to Medicaid or General Relief-Medical were to be added that they be phased-in, rather than adding all remaining services and eligibility groups at a single time. Each service could be evaluated on its own merits, rather than in mass, to determine whether it is cost effective to do so at that time. If options are to be added, the Department is interested in exploring the coverage of the AFPC-unborn child under Medicaid and a limited medically needy program under General Relief-Medical. We are also interested in exploring the addition of prescription drugs to the list of covered Medicaid services, if it can be determined to be cost effective.

We also support in concept the purchase of health insurance policies or contracts for our current Medicaid or other state medical assistance clients when the Department determines that such a purchase would be cost effective. The purchase of such insurance or contracts would allow our clients to be integrated into the normal mainstream of the health delivery system, rather than be stigmatized by having to reveal his or her welfare status each time a medical assistance coupon is presented as payment in the medical provider's office.

II. Departmental Comments on Sections 5-8 (Mandatory State and Other Participating Government Employee Alcoholism and Drug Dependence Coverage)

Sections 5-8 of the bill are essentially the contents of CSCSSSB 227 (HESS) which passed from House HESS Committee on April 26, 1979. Sections 5-8 were the result of over a year's work involving insurance companies which serve Alaska, the Division of Insurance, and the Department's Office of Alcoholism and Drug Abuse. The sections authorize a limited pilot project to mandate health insurance coverage for the diagnosis and treatment of alcoholism and drug dependence for state and other participating government employees. The Department of Health and Social Services continues to support this concept. The Department of Administration in 1979 estimated the cost of such coverage for state employees to be \$338,400 for FY 81.

Authorization of such a pilot project would allow for the testing of the cost effectiveness and merits of mandatory employee alcoholism and drug dependence treatment coverage on a statewide basis. The project will test if coverage were available, would state employees in need of such services would seek them earlier in illness and thus potentially reduce costs for later medical care. The benefits to the employer through the early diagnosis and treatment of alcoholism or drug dependence could be increased employee productivity, reduced absenteeism, decreased sick leave utilization, fewer disability benefit payments, and reduced cost for hospitalization for injury- or disease-related problems.

We support Sections 5-8 of the bill.

III. Specific Department Comments on 9 Through 10 (Medical Assistance)

Section 9 - AS 47.05.070(a) - (Page 9, line 18)

The Department, as mentioned earlier in the position paper, is in favor of purchasing services through health insurance policies or contracts for medical assistance clients only if such purchase is more cost effective than traditional methods. The Department has no problem with the mandatory nature of the language in this section, but notes that there is currently no statutory prohibition against such purchase. Therefore, although these sections would facilitate the purchase of insurance for medical assistance clients, it is not absolutely essential to authorize it.

Section 9 - AS 47.05.110 - (Page 10, lines 24-29 and page 11, lines 1-4)

Under present Medicaid law, the Department is required to pay 90% of "clean claims" within 30 days of receipt, and 99% of "clean claims" within 90 days of receipt. The Department supports the idea that medical providers should not suffer financially because of payment delays after a reasonable period. We would though recommend that payment of interest commence at 60 days rather than 30 days after presentation of "clean claims." This is generally considered reasonable turnaround in Alaska by health providers for payments from private insurance carriers due to uncertainty of mail deliveries. Also, we have been informed by the federal Medicaid program that federal funds are not available for interest payments on late Medicaid claims.

Section 9 - AS 47.05.120 - (Page 11, lines 5-19)

Add definitions for "remedial care," "non-exclusive contract," and "health care service contracts."

Section 10 - AS 47.07.020(b) - (Page 11, lines 20-23) and Section 13 - (Page 12, line 13)

This section would amend Medicaid law to provide coverage for all optional groups not currently entitled to Medicaid benefits in Alaska, primarily the unborn child group, the unemployed fathers, and the medically needy group.

Also, Section 13 removes the requirement that future additions of optional eligible groups to Alaska's Medicaid program must be approved by the Alaska State Legislature. Therefore, when Congress authorizes a new Medicaid optional eligibility group in the future, Alaska statutes do not require revision in order for the State to be required to automatically begin covering the groups.

The Department recognizes the value of the addition of the unborn child group to Medicaid to assist in proper health and development of children to low income women through access to necessary pre-natal care. We believe the addition of this group to Medicaid will have little impact on the program's expenditures. We can see the need for health care coverage to the medically needy and to the unemployed fathers under Medicaid but the cost of these options would be substantial and would be covering a greatly expanded group of clients. The Department supports the concept of a limited medically needy program under General Relief-Medical including only the aged, blind, and disabled until such time that we can fully assess the monetary and administrative costs of more expanded coverage.

Section 11 - AS 47.07.030 - (Page 11, lines 24-28)

This section as amended would change Medicaid law to dramatically expand medical services offered under the Medicaid program. It also removes the requirement that future additions to Alaska's Medicaid services must be approved by the Alaska State Legislature. Therefore, when Congress authorizes a new Medicaid optional service in the future, the Alaska statutes need not be amended in order for the State to be required to automatically offer the service.

The Department recommends that each service addition should be evaluated on its own merit, perhaps adding only those services where it appears cost effective, in terms of saving general fund dollars to do so. Also, all services added in mass would cause administrative problems. A phase-in model would be more appropriate if the Legislature decides to pursue this section.

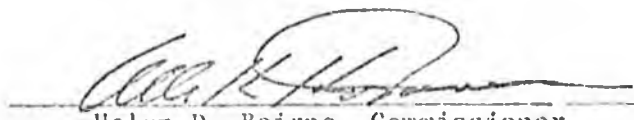
Section 12 - AS 47.25.120 - (Page 11, line 29 and Page 12, lines 1-12)

This section as amended would add broad medically needy coverage under the State General Relief-Medical program. The Department supports the concept of a more limited medically needy program including only the aged, blind, and disabled until we can gain some experience regarding monetary and administrative burdens.

Section 14 - (Page 12, lines 14-15 and Page 12, line 16)

Sections 10-12 would add all remaining optional eligibility groups and services to Medicaid and add a broad medically needy program to General Relief-Medical. The bill provides for an effective date of January 1, 1981 for these sections. In light of the size of these additions (over \$31 million for a full fiscal year), we would recommend a phase-in model over a period of years, beginning July 1, 1981, in order to administratively prepare for these changes with the minimum of adverse impact during the transition period to clients and providers.

Approved by:



Helen D. Beirne, Commissioner
Department of Health and Social Services

5/30/80
(DATE)

POSITION PAPER/Department of Health & Social Services

Medical
History
information

MEDICAID PROGRAM

in
ALASKA



Administered by:

STATE OF ALASKA
DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIVISION OF PUBLIC HEALTH

Jay S. Hammond, Governor

Helen D. Beirne, Commissioner

The Medicaid Program pays medical expenses for eligible, low-income people. Under agreement with the U.S. Department of Health, Education, and Welfare, the Alaska Division of Public Assistance runs the program through its local offices and fee agents. This booklet explains the rules, and tells you how to apply for and use Medicaid coupons. For more information, ask your local public assistance office or village fee agent.

1 FILE AN APPLICATION FORM

- * To be eligible for Medicaid you must usually be eligible for the:
 - Aid to Families with Dependent Children Program (AFDC)
 - OR
 - Adult Public Assistance Program (APA)
 - OR
 - Supplemental Security Income (SSI)
- * Certain people not eligible to receive benefits under the AFDC, APA, or SSI programs may still be eligible to receive Medicaid. This special group of people includes:
 1. Juveniles who are in the protective custody of the Department of Health & Social Services whose available financial resources do not exceed the AFDC need standard for a single person;
 2. Persons in health care facilities on an inpatient basis whose income does not exceed 300 percent of the current SSI payment standard;
 3. All individuals under age 21 who would be, except for age or attendance requirements, dependent children under the AFDC program;
 4. Certain families who become ineligible for AFDC payments due to increased earnings;
 5. Those reasonably classified individuals under age 21 who are in an intermediate care facility for the mentally retarded or persons with related conditions;
 6. Those reasonably classified individuals age 21 and under who are receiving active treatment in an inpatient psychiatric facility;
 7. Individuals under age 18 who meet the SSI eligibility requirements.
- * The public assistance office or village fee agent will give you an application for either AFDC or APA. Your local federal Social Security Administration office or their traveling representative will help you apply for SSI. Addresses for Social Security offices are listed in Section 13 of this booklet.
- * If you qualify for AFDC or APA, you will be mailed a check and Medicaid coupons within approximately 30 days from the date the office received your application.
- * If you qualify for SSI, you must still apply separately at the public assistance office for APA cash benefits and for Medicaid coverage.
- * You can apply for food stamps at the same time you apply for AFDC or APA and Medicaid.

2 AFDC, APA, AND SSI

- * Aid to Families with Dependent Children (AFDC) is a program which gives money for children of eligible low-income families who are deprived of one or both of their natural or adopted parents.
- * Adult Public Assistance (APA) is a program that includes three categories of eligibility (Old Age Assistance, Aid to the Blind, and Aid to the Disabled) and provides a supplemental payment to low-income adults whose income is not enough to provide for their own basic needs. All adults who qualify for APA must be either blind, OR 65 or older, OR physically or mentally disabled.
- * Supplemental Security Income (SSI) is a federal program for low-income adults who are either blind, OR 65 or older, OR physically or mentally disabled. It also provides cash assistance for low-income children who are either blind or disabled.

3 HAVE AN INTERVIEW

- * When you turn in your application, a worker will usually hold a confidential interview with you.
- * At the interview, the worker will explain the program rules and go over the information on your application. The worker will help you complete any of the application form you have not been able to fill out. Ask the worker to explain anything that you do not understand. It's important that you understand the rules.
- * Interviews are held at the public assistance office or at the fee agent's location. If no one in your household can go the interview, an adult friend or relative who knows your circumstances may go to be interviewed for you.
- * If you are disabled or are unable to go to the interview and no one can go for you, let the office know. It may be possible to arrange an interview at your home or by telephone.
- * If you live too far from an office or a fee agent, if you are ill, or if you do not have any transportation to an office, you won't have to have an interview.

4 MEET ELIGIBILITY RULES AND PROVIDE PROOF THAT YOU ARE ELIGIBLE

When you apply, you must show the Division of Public Assistance certain papers and give them information to prove you are eligible. Papers you need for proof may include birth certificates, paycheck stubs, fish tickets, recent income tax returns or other proof of your age, relationship, and income.

You should also be prepared to list your resources (property other than your home) such as cars, boats, savings accounts, and other valuables.

If you have trouble getting the documents or information you need, the division will help you. If the papers are not available, you may give the name of someone outside of your household and family, such as employer, who can confirm your statements.

Eligibility rules and proofs you may have to provide to support your application are different for each type of assistance. Your eligibility worker or fee agent will tell you what documents and information are necessary.

5 RECEIVE A NOTICE THAT THAT TELLS YOU IF YOU QUALIFY

- * After reviewing your application, the public assistance office will send you a Notice of Finding.
- * If you do not qualify, the Notice will explain why.
- * If you do qualify, the Notice will explain when your cash and Medicaid benefits will begin. It's possible that your bills from past months may also be paid by Medicaid.
- * If you think your application has been wrongly denied, you should tell the public assistance office. If they do not agree, you can ask for a fair hearing. For more information about fair hearings, see Section 10.

6 RECEIVE YOUR MEDICAID COUPONS

- * If the office finds that you are eligible, you will get your Medicaid coupons no later than 30 days from the date you first applied.
- * Medicaid coupons are either handwritten or printed by machine. Both types of coupons are equally valuable.
- * You will receive five Medicaid coupons. They will be printed with the names of everyone in your household who is eligible for Medicaid. Everyone listed can legally use the coupons.
- * Medicaid coupons are dated for one month and can only be used to pay for medical care received during that month.
- * If you need more Medicaid coupons, you can request them from the public assistance office.
- * Medicaid is a "last pay" program. This means that Medicaid will only pay your health provider for the part of his bill that isn't paid by your private or union health insurance, by Medicare, (see Section 13) or other insurance programs. When you apply for Medicaid, you must list any other sources of medical payments you have. You should also tell your doctor, hospital, etc. about them when you get service.
- * To use your Medicaid coupons you must give them to the doctor, hospital, or other health care provider when you receive medical care. It is very important to remember to give your Medicaid coupon to your health care provider. The coupon tells the doctor, clinic, etc. that you are eligible for that month for Medicaid benefits. Without the coupon, your bill cannot be correctly submitted for payment.

7 USE YOUR MEDICAID COUPONS

- * Most health care providers in Alaska participate in the Medicaid program. This means you can usually choose the doctor you would like to visit. If you are eligible for both Public Health Service and Medicaid, you also have the choice of going to the local Alaska Area Native Health Service (AANHS) or a private doctor.

If the medical treatment you need is not available in your area, payment for transportation may be provided to the nearest location where you can receive the necessary medical care.

When you are Medicaid-eligible and receive a Medicaid-covered service from a doctor or other health practitioner who is enrolled in the Medicaid program, he cannot ask you to pay for all or for any part of that service—even if Medicaid and any other health coverage you have doesn't pay all of his charges. If he bills the Division of Public Assistance, he must accept the Medicaid fee as the total payment for your bill.

Medicaid doesn't pay for every kind of medical and psychological care. If you want to be sure that Medicaid will pay for the services you want or need, your medical provider can tell you. The following list of services are paid by Medicaid:

1. hospital-inpatient and outpatient
2. skilled nursing facility
3. intermediate care facility
4. intermediate care facility for mentally retarded persons and persons with related conditions
5. laboratory and X-ray services
6. physician services
7. visual care services and dispensing
8. ophthalmic materials
9. medical transportation
10. speech, hearing, and language services
11. psychiatric facility services (if you are under 21 or over 65)
12. home health care services
13. community mental health clinics
14. family planning services
15. outpatient surgical care centers
16. rural health clinics
17. early periodic screening, diagnosis, and treatment (EPSDT) of individuals under 21 years of age

Payment of service is made directly to doctors, hospitals, and other providers of health care based on invoices submitted by the provider. Invoices must be accompanied by a coupon which you must surrender at the time service is provided.

8 SERVICES NOT COVERED BY MEDICAID

Most Medicaid-eligible people automatically qualify for coverage under the General Relief-Medical program (GRM). Payment is available through the GRM program for all Medicaid-eligible people for the medical services and supplies listed below when those services are not otherwise available under the Medicaid program :

- (1) dental care-limited to emergency treatment for relief of pain and acute infection;
- (2) family planning services;
- (3) pharmaceuticals and over-the-counter drugs;
- (4) physical and occupational therapy;
- (5) prosthetic devices and medical supplies.

More information about the GRM program is provided in Section 13 of this booklet.

- * It is your responsibility to pay for any medical treatment not covered by Medicaid or GRM.

The following services are NOT covered by Medicaid :

- (1) Any medical expense which is not reasonably necessary for the diagnosis and treatment of illness or injury or for the correction of an organic system;
- (2) Items and services not properly prescribed or determined necessary by a health care practitioner;
- (3) Expenses incurred for evaluative or periodic check-ups, examinations, or immunizations in connection with the participation, enrollment, attendance, or accomplishment of a program or activity not related to your physical or mental health or rehabilitation which does not meet the criteria of (1) above, is not provided as part of an EPSDT screening (see Section 12), or is not a physical examination required by the Division of Public Assistance for the purpose of determining eligibility :

- (4) Any expense which is for or in connection with cosmetic therapy or cosmetic surgery, except that Medicaid coverage is available when required for repair of accidental injury, for the improvement of the functioning of a malformed body member, or for the correction of a visible disfigurement which would materially affect your acceptance in society, and when performed within the normal course of treatment or otherwise beginning no later than one year after the event which caused the need for that corrective action;
- (5) Any expense which constitutes a non-medical charge imposed by a friend or relative, except when payment is made for medical transportation ;
- (6) Any medical expense which is for persons who are in the care and custody of federal, state, or local penal facilities, including juveniles in detention facilities.

* The services of the following practitioners are NOT covered under the Medicaid program in Alaska :

- (1) chiropractors ;
- (2) Christian Science practitioners or theological healers ;
- (3) naturopaths ;
- (4) podiatrists ;
- (5) private psychologists ;
- (6) any other licensed or unlicensed practitioners not enrolled in the Medicaid Program as providers.

9 YOU MUST REPORT CHANGES IN YOUR CIRCUMSTANCES

- * You must report changes promptly.
- * You can report changes by contacting the public assistance office or your fee agent. However, it is better to fill out the change report form included with your FDC or APA check and mail it to the office.

IT IS EXTREMELY IMPORTANT THAT YOU REPORT CHANGES, SO THAT YOUR HOUSEHOLD RECEIVES THE RIGHT AMOUNT OF BENEFITS.

Changes that you must report include :

- Changes in mailing or residence address;
- Movement of a related person into or out of the household;
- Increase, decrease, or change in source of income in the household;
- Any change in resources of the household;
- Any change in the costs of rent, mortgage payment, taxes or insurance;
- Change in eligibility status of any household member for other benefits;
- Death of a household member;
- Change in marital status of any household member;
- Change in school attendance of any household member;
- Placement of a child in the custody of the Department of Health & Social Services;
- Improvement in the condition of a blind or disabled person;
- Refusal to accept vocational rehabilitation services;
- Departure from the state, the United States, or both;
- Refusal to accept treatment, or discontinuing treatment for drug addiction or alcoholism; and
- Admission to or discharge from a public institution, hospital, or nursing home.

10 YOUR RIGHTS

YOU HAVE THE RIGHT TO.....

- * Apply for or request information about any assistance payments program or social service available from the Department of Health & Social Services including the following :
 - Family Planning
 - Child Protection
 - Alcoholic Rehabilitation
 - Family Counseling
 - Homemakers
 - Day Care
 - Information and Referral Supportive Services for Children.

(You are eligible for family planning services for three months from the date of your application for AFDC even if you are found ineligible.)

- * Receive courteous and fair treatment with no discrimination because of race, color, creed, religion, political belief, marital status, national origin, age, or sex.
- * Receive a prompt written decision of your eligibility.
- * Receive help from the department in obtaining child support for your children, if you are requesting assistance for children.
- * Receive free, regularly scheduled physical examinations, diagnosis, and treatment for most medical problems for all children and adults under 21 who are eligible for Medicaid, under a program called EPSDT.
- * Understand that information you give to the Division of Public Assistance will not be disclosed or used for purposes other than those connected with the administration of the public assistance laws of Alaska.
- * Request a hearing by a fair and impartial person if you are dissatisfied by a delay or with the decision on your eligibility or the amount of assistance provided to you.

At a fair hearing you can explain to a hearing official why you disagree with an action the public assistance office has taken on your case.

If the hearing official decides you are right, you will continue to receive, or will begin to receive, the correct amount of benefits. If the official decides the public assistance office is right, you will be asked to repay the value of any assistance you were not entitled to receive.

You can ask the public assistance office for a fair hearing in writing, in person, or over the phone.

You can ask a friend or a representative from Alaska Legal Services or anyone else to help you prepare for the hearing and to attend the hearing with you.

The hearing will be scheduled at a time and place that are reasonably convenient for you.

11 YOUR RESPONSIBILITIES

YOU HAVE A RESPONSIBILITY TO.....

- * Provide correct and complete information on your application and on all other forms related to your application and your eligibility for assistance.
- * Cooperate in providing information about absent parents who are responsible for the children in your care.
- * Accept any medical examinations necessary to determine your eligibility.
- * Cooperate with the Division of Public Assistance in verifying your situation and the information you provide.
- * Register for the Work Incentive Program when your youngest child reaches six years of age.
- * Never allow anyone to use your Medicaid coupons or ID card, unless the person is named on the card or coupon as an eligible recipient.
- * Apply for and make use of any benefits which you, or those for whom you want help, may be eligible, such as Unemployment Compensation, Social Security, Veteran's Benefits, etc.
- * Tell the Division of Public Assistance promptly as changes in your situation occur which may affect your eligibility or the amount of assistance you are paid.
- * Advise the Division of Public Assistance of any settlement in your favor as a result of an accident, and grant permission to the State of Alaska, Division of Public Assistance to file a claim against the settlement for medical bills paid in your behalf.

12 EARLY AND PERIODIC SCREENING, DIAGNOSIS & TREATMENT

EPSDT is part of the Medicaid Program and is mainly a preventive health program for children. The goal is to find children who have diseases or abnormalities and to prevent or correct handicaps by giving them medical treatment and rehabilitation as early as possible.

EPSDT services are available to all persons under 21 who are receiving, or are eligible to receive, Medicaid benefits.

EPSDT offers all the coverage available under Medicaid as well as the following special services :

1. physical exam and diagnosis
2. dental care
3. prosthetic devices (leg braces, wheel chairs, etc.) and medical supplies
4. physical therapy
5. immunizations
6. health and nutrition counseling.

13 OTHER MEDICAL PROGRAMS

GENERAL RELIEF-MEDICAL (GRM)

The General Relief-Medical Program (GRM), which is administered by the Division of Public Assistance, is a 100% state-funded program that provides for the payment of providers of medical and emergency dental care for eligible low-income Alaskans.

GRM is considered a "last resort" assistance program. AFDC and AFA recipients are automatically eligible for Medicaid and are therefore eligible for GRM benefits only for services not covered by Medicaid.

Applications for GRM are available at State Division of Public Assistance offices.

CATASTROPHIC ILLNESS PROGRAM

The Catastrophic Illness Program, which is administered by the Division of Public Assistance and a committee appointed by the Governor's Office, is a 100% state-funded program that pays providers of medical services.

The purpose of the program is to financially assist residents of Alaska who have suffered and received treatment for a catastrophic illness or injury. A catastrophic illness or injury is one which results in medical expenses of over \$1000 during a period of not more than 12 months—after all other sources of medical payment (insurance, etc.) have been used.

Applications for the Catastrophic Illness Program can be obtained at State Division of Public Assistance offices or by writing to:

Catastrophic Illness Program
Division of Public Assistance
Pouch H-07D
Juneau, Alaska 99801

Medicare is a federal health insurance program for certain kinds of individuals regardless of the amount of their income and resources :

- the aged (65 and older)
- the blind
- the disabled
- persons with certain permanent kidney failure

Although the name of the program "Medicare" is very similar to the name of the program "Medicaid" which is administered by the state Division of Public Assistance, Medicare is a completely separate and different program, administered by private health insurance companies.

Medicare is a two part program. Part A, available to all Medicare beneficiaries without charge, provides coverage for inpatient hospital services. Part B, which is available for a small monthly charge, provides coverage for outpatient and physician services. Detailed information about the Medicare program is available at any Social Security Administration office. In Alaska, Social Security offices are located at the following addresses :

Social Security Administration
P.O. Box 5837
Ketchikan, Alaska 99901

Social Security Administration
P.O. Box 1327
Juneau, Alaska 99802

Social Security Administration
P.O. Box 2600
Anchorage, Alaska 99510

Social Security Administration
P.O. Box 1449
Fairbanks, Alaska 99701

Information about Medicare can also be obtained by calling these toll-free numbers :

Juneau.....Zenith 5000

Anchorage.....Zenith 7777

Fairbanks.....Zenith 8888

14 DIVISION OF PUBLIC ASSISTANCE OFFICES

- ANCHORAGE 4th and Gambell
Anchorage, Alaska 99501
Phone: 274-6524
- ANIAK Box 63
Aniak, Alaska 99557
Phone: 675-4351 (Fee Agent)
- BETHEL Box 365
Bethel, Alaska 99559
Phone: 543-2686
- DILLINGHAM Box 221
Dillingham, Alaska 99576
Phone: 842-5961
- FAIRBANKS 675 7th Street, Section F
Fairbanks, Alaska 99701
Phone: 452-1637
- FORT YUKON Box 149
Fort Yukon, Alaska 99740
Phone: 662-2327
- GALENA Box 239
Galena, Alaska 99741
Phone: 656-1260
- JUNEAU 419 Sixth Street
Juneau, Alaska 99811
Phone: 465-3551
- KENAI Box 3613
Kenai, Alaska 99611
Phone: 283-3124
- KETCHIKAN 222 NBA Building
Ketchikan, Alaska 99901
Phone: 225-2135
- KODIAK Box 2515
Kodiak, Alaska 99615
Phone: 486-3783
- KOTZEBUE Box 41
Kotzebue, Alaska 99752
Phone: 442-3451

NOME. Box 221
Nome, Alaska 99762
Phone: 443-2237

PALMER. Box 901
Palmer, Alaska 99645
Phone: 745-4217

PETERSBURG. Box 1089
Petersburg, Alaska 99833
Phone: 772-3565

SITKA Box 1069
Sitka, Alaska 99835
Phone: 747-8234

UNALAKLEET Box 40
Unalakleet, Alaska 99684
Phone: 624-3601

VALDEZ. Box 750
Valdez, Alaska 99686
Phone: 835-2535

In rural communities where there isn't a district office, the Division of Public Assistance has paid volunteers, called fee agents, who can assist people to apply for Public Assistance Programs.

ABOUT THE COVER:

Antler was used for this spirit canoe in the shape of a sea lion. The seven figures represent people who were drowned when their boat was seized by an octopus. Among Salish groups, shamans performed a ceremony in which they paddled a spirit canoe to the land of the dead to bring back the soul of a person who had become ill because he had lost his soul.

Tlingit design. from the Museum of the American Indian, Heye Foundation. From THE ART OF THE NORTHWEST COAST INDIANS by Shirley Glubok

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DEPARTMENT OF HEALTH AND SOCIAL SERVICES
Division of Public Assistance
Pouch H-07
Juneau, Alaska 99811

Additional copies available on request

AK/DHSS/PA/80/02
Published: April 1980

Chapter 07. Medical Assistance for Needy Persons.

Section	Section
1. Purpose	60. Receipt of federal money
2. Eligible persons	70. Reimbursement for cost settled providers
3. Medical services to be provided	80. Definitions
4. State plan for provision of medical assistance	
5. Implementation of the medical assistance program	

Sec. 47.07.010. Purpose. It is declared as a matter of public concern that the needy persons of this state receive uniform and high quality medical care, regardless of race, age, national origin, or economic standing. Accordingly, this chapter authorizes the Department of Health and Social Services to apply for participation in the national medical assistance program as provided for under title XIX of the Federal Social Security Act. (§ 1 ch 182 SLA 1972)

Sec. 47.07.020. Eligible persons. (a) All residents of the state for whom the Social Security Act requires medicaid coverage are eligible to receive medical assistance under title XIX of that Act (42 U.S.C. 1396 et seq.).

(b) In addition to the persons specified in (a) of this section, the following optional groups of persons for whom the state may claim federal financial participation are eligible for medical assistance:

(1) persons eligible for but not receiving assistance under any plan of a state approved under part A of title IV (aid to families with dependent children), or title XVI (supplemental security income), of the Social Security Act;

(2) persons in a general hospital, skilled nursing facility or intermediate care facility, who, if they left the facility, would be eligible for assistance under one of the federal programs specified in (1) of this section;

(3) persons under 21 years of age under supervision of the department for whom maintenance is being paid in whole or in part from public funds and who are in foster homes or private child-care institutions; and

(4) aged, blind, or disabled persons, who, because they do not meet income and resources requirements, do not receive supplemental security income under title XVI of the Social Security Act, and who do not receive a mandatory state supplement, but who are eligible, or would be eligible if they were not in a general hospital or skilled nursing facility or intermediate care facility to receive an optional state supplementary payment;

(5) persons under 21 years of age in an institution designated as an intermediate care facility for the mentally retarded who are financially

* Sec. 10. AS 47.07.020(b) is repealed and re-enacted to read:

(b) Residents of the state for whom the Social Security Act provides optional medical coverage qualifying for federal financial participation are eligible for medical assistance.

(6) persons in a medical or intermediate care facility whose income while in the facility does not exceed 300 per cent of the supplemental security income benefit rate under title XVI of the Social Security Act but who would not be eligible for an optional state supplementary payment if they left the hospital or other facility.

(7) persons under 21 years of age receiving active treatment in a psychiatric hospital who are financially eligible as determined by the standards of part A of title IV (aid to families with dependent children) of the Social Security Act.

(c) Receipt of medical assistance under this chapter is considered to be an additional benefit to these individuals and does not affect other assistance payments, federal or state, for which the recipient is eligible.

(d) No additional groups may be added unless approved by the legislature. (§ 1 ch 182 SLA 1972; am § 1 ch 105 SLA 1974; am § 1 ch 117 SLA 1975; am § 1 ch 221 SLA 1976; am § 1 ch 11 SLA 1978)

Effect of amendments. — The 1975 amendment added paragraph (5) of subsection (b).

The 1976 amendment added paragraph (6) of subsection (b).

The 1978 amendment added paragraph (7) of subsection (b).

Legislative history report. — For report on ch. 182, SLA 1972 (FCCS HCS CSSB 56), see 1972 House Journal, p. 164. For report on ch. 105, SLA 1974 (CSB 175), see 1974 Senate Journal, p. 525 and 1974 House Journal, p. 763.

Sec. 47.07.030. Medical services to be provided. Medical services to be offered to eligible persons include inpatient hospital, outpatient hospital, rural health clinic, outpatient surgical care centers, laboratory and X-ray, refractions and eye examinations by ophthalmologists or optometrists, eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, inpatient psychiatric hospital for persons age 65 or older and persons under age 21, skilled and intermediate nursing home, physician, home health care services, early periodic screening diagnosis and treatment of persons under 21 years of age, clinic services, treatment of speech, hearing and language disorders, and reasonable transportation to and from the point of medical care. No additional services may be provided unless approved by the legislature. (§ 1 ch 182 SLA 1972; am § 1 ch 35 SLA 1973; am § 2 ch 105 SLA 1974; am § 1 ch 12 SLA 1976; am § 2 ch 221 SLA 1976; am § 1 ch 82 SLA 1978)

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

* Sec. 11. AS 47.07.030 is repealed and re-enacted to read:

Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. Medical services to be offered to eligible persons include services eligible for financial participation under Title XIX of the federal Social Security Act.

Selection of Medicaid Optional Services by States *

Top 10 States With Most Number
Of Optional Services

<u>States</u>	<u># of Optional Services Maximum = 32</u>
1. Wisconsin	32
2. Minnesota	31
3. California	29
4. Massachusetts	28
5. West Virginia	28
6. New Jersey	27
7. Kansas	26
8. Montana	26
9. Nebraska	26
10. Connecticut	24

Top 10 States with Least
Number of Optional Services

<u>States</u>	<u># of Optional Services Minimum = 0</u>
1. Wyoming	5
2. Delaware	9
3. Georgia	9
4. Mississippi	9
5. Alaska	10
6. Oklahoma	10
7. Rhode Island	10
8. Texas	10
9. Alabama	12
10. South Carolina	12

* Arizona currently does not participate in the Medicaid Program.

Most Selected Medicaid Optional Services
Not Included in Alaska's Medicaid Program

<u>Optional Service</u>	<u>No. of States, Terr., and Protectorates Selecting the Option. Maximum = 53</u>
1. Prescription drugs	51
2. Prosthetic devices	45
3. Podiatrist's services	38
4. Physical therapy	36
5. Dentures	33
6. Dental services	30
7. Other practioners' services	30
8. Private duty nursing	30
9. Mental treatment in ICF for person aged 65 or older	28
10. Occupational therapy	27
11. Rehabilitation service	27
12. Chiropractic services	26
13. TB treatment in inpatient hospital for persons aged 65 or older	26
14. Mental health treatment in SNF for persons aged 65 of older	25
15. Diagnostic services	23
16. Prevention services	20
17. Christian science sanitoria	18
18. Screening	14
19. Personal care	11
20. TB treatment in SNF for persons aged 65 or older	11
21. TB treatment in ICF for persons aged 65 or older	10
22. Christian science nursing	6

Services provided only for the Medicaid program or the State program for persons under 21 are not shown on this chart.

welfare offices and State Medicaid agencies.

Life - Support

Optional services in State Medicaid programs

STATE	SEE ABOVE	Pulmonologist Services	Optometric Services	Lithopneustic Services	Other Practitioner Services	Private Duty Nursing	Clinic Services	Dental Services	Physical Therapy	Occupational Therapy	Speech, Hearing, and Language Disorder	Prescribed Drugs	Dentures	Prosthetic Devices	Eyeglasses	Diagnostic Services	Screening Services	Preventive Services	Rehabilitative Services	Services for Age 65 or Older in Institutions			Intermediate Care Facility Services	Residential	Inpatient Psychiatric Services for Under Age 21	Christian Science Nurses	Christian Science Seminars	SNF for Under Age 21	Emergency Hospital Services	Personal Care Services	Total Available Services	
																				A. Inpatient Hospital Services	B. SNF Services	C. ICF Services										
1	Alabama																														12	
2	Alaska																														10	
3	Arizona																														20	
4	Arkansas																														20	
5	California																														14	
6	Colorado																														24	
7	Connecticut																														9	
8	Delaware																														13	
9	D.C.																														5	
10	Florida																														12	
11	Georgia																														9	
12	Hawaii																														20	
13	Idaho																														13	
14	Illinois																														15	
15	Indiana																														24	
16	Iowa																														18	
17	Kansas																														25	
18	Kentucky																														17	
19	Kentucky																														24	
20	Louisiana																														16	
21	Maine																														18	
22	Maryland																														16	
23	Massachusetts																														25	
24	Michigan																														22	
25	Minnesota																														11	
26	Mississippi																														8	
27	Missouri																														15	
28	Montana																														11	
29	Nebraska																														25	
30	Nevada																														20	
31	New Hampshire																														24	
32	New Jersey																														23	
33	New Mexico																														17	
34	New York																														19	
35	North Carolina																														13	
36	North Carolina																														24	
37	North Dakota																														20	
38	Ohio																														15	
39	Oklahoma																														15	
40	Oregon																														23	
41	Pennsylvania																														17	
42	Rhode Island																														10	
43	South Carolina																														14	
44	South Dakota																														13	
45	Tennessee																														14	
46	Texas																														17	
47	Utah																														13	
48	Vermont																														10	
49	Washington																														9	
50	Virginia																														15	
51	Washington																														23	
52	West Virginia																														23	
53	Wisconsin																														22	
54	Wyoming																														5	
55	Total	14	13	9	10	6	13	8	11	9	8	19	22	16	11	3	4	9	8	2	2	13	9	12	23	22	10	1	6	15	17	2
56	Total	24	22	17	20	14	23	22	25	18	21	32	11	25	25	18	11	16	15	9	8	27	16	16	26	25	22	5	12	24	23	9
57	Total	38	35	26	30	19	42	30	36	27	29	51	33	45	36	23	14	25	11	10	43	25	28	49	47	32	6	18	42	45	11	

MAP Federal Medical Assistance Percentage: Rate of Federal financial participation in a State's medical vendor payment expenditures on behalf of individuals and families eligible under Title XVI of the Social Security Act. Percentages, effective from October 1, 1977, through September 30, 1978, are rounded significantly freely. People receiving federally supported financial assistance. Medically Needy: People who are eligible for medical but not for financial assistance.

Health Care Legislation

HCS CS SS SB 227

HCS CS SS SB 227 "An Act relating to the health of residents of the state" is an omnibus health bill extending health coverage to several new groups of people and expanding the scope of coverage available.

* STATE HEALTH INSURANCE

The first three sections of the bill establish a state comprehensive health plan and a premium supplement program. The comprehensive health plan is a major medical insurance policy offered by a private carrier under contract with the state to any resident who does not have public or group health coverage. The premium program provides state premium supplements on a sliding scale basis to residents who purchase qualifying individual major medical insurance policies.

* ALCOHOLISM COVERAGE FOR STATE EMPLOYEES

Model benefits for coverage of alcoholism, including inpatient detoxification, inpatient treatment and outpatient treatment are added to the state employees health insurance plan. While the original bill mandated these benefits for all health insurance policies, the HESS Committee substitute bill would field test these new benefits on state employees.

* MEDICAID BY INSURANCE POLICIES OR HEALTH SERVICE CONTRACTS

Section eight of the bill directs the commissioner of Health and Social Services to provide Medicaid coverage through the purchase of private health insurance policies or health service contracts on behalf of Medicaid recipients, when this is found to be cost effective.

* RELIEF FOR MEDICAID PROVIDERS

The bill requires that the state pay interest at the rate of one percent per month to Medicaid providers on bills that are more than one month overdue, and two percent per month on bills that are more than three months overdue. It also allows the state to make an interim payment to large volume Medicaid providers prior to billing and processing of the claims.

* EXPANSION OF SERVICES AND ELIGIBLE PEOPLE COVERED UNDER MEDICAID

Sections nine and ten of the bill expand the state's Medicaid program to include all groups and all services for which federal funding is available. New additions include such eligible and services as unborn children, unemployed fathers, prescription drugs, adult dental care and physical therapy.

* COVERAGE FOR THE MEDICALLY NEEDED

Section eleven of the bill creates a new program of medical assistance for medically needy people under the state's General Relief-Medical program. The income threshold for eligibility is set at 150% of the poverty guideline for Alaska. People whose income exceeds that amount can still become eligible for assistance after they spend their "excess" income on medical bills.

* FISCAL IMPACT

The fiscal note for all these programs includes approximately \$8 million from the General fund and \$8 million in federal funds for FY81.

House HESS Committee Hearings on
State Health Insurance

Teleconference Witnesses

Bill Weimar, Anchorage
Nick Noll, Eye, Ear & Nose Clinic, Fairbanks
Donald Thieman, Fairbanks Medical Association
Chris Bearsly, Providence Hospital, Anchorage
David Mather, Tanana Chiefs Conference, Fairbanks
Margaret Wolfe, Anchorage
Angie Hague, National Association of Social Workers, Anchorage
Penny Hladna, Anchorage
Gordon DePew, Fairbanks Life Underwriters Assoriation
Bernie Barr, International Rehabilitation Association
Gil D'Innocente, Anchorage
Candice Berry, Welfare Rights Association, Anchorage
Pudge Kleinkoff, National Association of Social Workers, Anchorage
Frank Austin, Black Caucus Council for Economic Justice, Anchorage
Susan Johnson, Chris Billington, NJW, Anchorage
Nancy Lander, Women for Pclitics' Action, Anchorage
Rose Palmquist, Anchorage
Donna Hayes, Norton Sound Health Corporation, Nome
Herb Berkowitz, Anchorage
Mason Preston, Bethel
Rosy Porter, Bethel

Other Witnesses

Don Koch - Division of Insurance, Dept. of Commerce and Economic Development
Jim Jordan " " " " " " " " " "
Donald Ching- Dept. of Regulatory Agencies, State of Hawaii
John Ingrassia - Life and Health Section, Insurance Division, State of Mirmesota
Joan Gaurer - Director, Government Relations, Blue Cross of WA and AK
Dr. Helen Beirne - Commissioner, Dept. of Health and Social Services
Bob Ogden - Chief, Medical Assistance, Dept. of Health and Social Services

The House HESS Committee held a total of 12 hearings on HB977/SB227

**THELMA
BUCHHOLDT**

Alaska State Legislature
House of Representatives
Juneau, Alaska 99811

May 22, 1980

To: Representatives Gardiner, Meekins, McKinmon, 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.

Chapter 07. Medical Assistance for Needy Persons.

Section	Section
10. Purpose	60. Receipt of federal money
20. Eligible persons	70. Reimbursement for cost settled
30. Medical services to be provided	providers
40. State plan for provision of medical assistance	80. Definitions
50. Implementation of the medical assistance program	

Sec. 47.07.010. Purpose. It is declared as a matter of public concern that the needy persons of this state receive uniform and high quality medical care, regardless of race, age, national origin, or economic standing. Accordingly, this chapter authorizes the Department of Health and Social Services to apply for participation in the national medical assistance program as provided for under title XIX of the federal Social Security Act. (S 1 ch 182 SLA 1972)

Sec. 47.07.020. Eligible persons. (a) All residents of the state for whom the Social Security Act requires medicaid coverage are eligible to receive medical assistance under title XIX of that Act (42 U.S.C. 1396 et seq.).

(b) In addition to the persons specified in (a) of this section, the following optional groups of persons for whom the state may claim federal financial participation are eligible for medical assistance:

(1) persons eligible for but not receiving assistance under any plan of the state approved under part A of title IV (aid to families with dependent children), or title XVI (supplemental security income), of the Social Security Act;

(2) persons in a general hospital, skilled nursing facility or intermediate care facility, who, if they left the facility, would be eligible for assistance under one of the federal programs specified in (1) of this subsection;

(3) persons under 21 years of age under supervision of the department for whom maintenance is being paid in whole or in part from public funds and who are in foster homes or private child-care institutions; and

(4) aged, blind, or disabled persons, who, because they do not meet income and resources requirements, do not receive supplemental security income under title XVI of the Social Security Act, and who do not receive a mandatory state supplement, but who are eligible, or would be eligible if they were not in a general hospital or skilled nursing facility or intermediate care facility to receive an optional state supplementary payment;

(5) persons under 21 years of age in an institution designated as an intermediate care facility for the mentally retarded who are financially eligible as determined by the standards of the Federal Aid to Families with Dependent Children program;

* Sec. 10. AS 47.07.020(b) is repealed and re-enacted to read:

(b) Residents of the state for whom the Social Security Act allows optional medical coverage qualifying for federal financial participation are eligible for medical assistance.

(6) persons in a medical or intermediate care facility whose income while in the facility does not exceed 300 per cent of the supplemental security income benefit rate under title XVI of the Social Security Act but who would not be eligible for an optional state supplementary payment if they left the hospital or other facility.

(7) persons under 21 years of age receiving active treatment in a psychiatric hospital who are financially eligible as determined by the standards of part A of title IV (aid to families with dependent children) of the Social Security Act.

(c) Receipt of medical assistance under this chapter is considered to be an additional benefit to these individuals and does not affect other assistance payments, federal or state, for which the recipient is eligible.

(d) No additional groups may be added unless approved by the legislature. (§ 1 ch 182 SLA 1972; am § 1 ch 105 SLA 1974; am § 1 ch 117 SLA 1975; am § 1 ch 221 SLA 1976; am § 1 ch 11 SLA 1978)

Effect of amendments. — The 1975 amendment added paragraph (5) of subsection (b).

The 1976 amendment added paragraph (6) of subsection (b).

The 1978 amendment added paragraph (7) of subsection (b).

Legislative history reports. — For report on ch. 182, SLA 1972 (FCCS 1108 CS-B 56), see 1972 House Journal, p. 164. For report on ch. 105, SLA 1974 (CSSB 465), see 1974 Senate Journal, p. 525 and 1974 House Journal, p. 763.

Sec. 47.07.030. Medical services to be provided. Medical services to be offered to eligible persons include inpatient hospital, outpatient hospital, rural health clinic, outpatient surgical care centers, laboratory and X-ray, refractions and eye examinations by ophthalmologists or optometrists, eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, inpatient psychiatric hospital for persons age 65 or older and persons under age 21, skilled and intermediate nursing home, physician, home health care services, early periodic screening diagnosis and treatment of persons under 21 years of age, clinic services, treatment of speech, hearing and language disorders, and reasonable transportation to and from the point of medical care. No additional services may be provided unless approved by the legislature. (§ 1 ch 182 SLA 1972; am § 1 ch 35 SLA 1973; am § 2 ch 105 SLA 1974; am § 1 ch 12 SLA 1976; am § 2 ch 221 SLA 1976; am § 1 ch 82 SLA 1975)

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

* Sec. 11. AS 47.07.030 is repealed and re-enacted to read:

Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. Medical services to be offered to eligible persons include services eligible for federal financial participation under Title XIX of the federal Social Security Act.

Selection of Medicaid Optional Services by States *

Top 10 States With Most Number
Of Optional Services

<u>States</u>	<u># of Optional Services Maximum = 32</u>
1. Wisconsin	32
2. Minnesota	31
3. California	29
4. Massachusetts	28
5. West Virginia	28
6. New Jersey	27
7. Kansas	26
8. Montana	26
9. Nebraska	26
10. Connecticut	24

Top 10 States with Least
Number of Optional Services

<u>States</u>	<u># of Optional Services Minimum = 0</u>
1. Wyoming	5
2. Delaware	9
3. Georgia	9
4. Mississippi	9
5. Alaska	10
6. Oklahoma	10
7. Rhode Island	10
8. Texas	10
9. Alabama	12
10. South Carolina	12

* Arizona currently does not participate in the Medicaid Program.

Most Selected Medicaid Optional Services
Not Included in Alaska's Medicaid Program

<u>Optional Service</u>	<u>No. of States, Terr., and Protectorates Selecting the Option. Maximum = 53</u>
1. Prescription drugs	51
2. Prosthetic devices	45
3. Podiatrist's services	38
4. Physical therapy	36
5. Dentures	33
6. Dental services	30
7. Other practioners' services	30
8. Private duty nursing	30
9. Mental treatment in ICF for person aged 65 or older	28
10. Occupational therapy	27
11. Rehabilitation service	27
12. Chiropractic services	26
13. TB treatment in inpatient hospital for persons aged 65 or older	26
14. Mental health treatment in SNF for persons aged 65 of older	25
15. Diagnostic services	23
16. Prevention services	20
17. Christian science sanitoria	18
18. Screening	14
19. Personal care	11
20. TB treatment in SNF for persons aged 65 or older	11
21. TB treatment in ICF for persons aged 65 or older	10
22. Christian science nursing	6

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Optional services in State Medicaid programs

FMAP	State	Podiatrist Services	Optometrist Services	Chiropractor Services	Other Practitioner Services	Private Duty Nursing	Clinic Services	Dental Services	Physical Therapy	Occupational Therapy	Speech, Hearing, and Language Disorder	Prescribed Drugs	Dentures	Prosthetic Devices	Eyeglasses	Diagnostic Services	Screening Services	Preventive Services	Rehabilitative Services	Services for Age 65 or Older in ICF Institutions			Intermediate Care Facility Services	ICF for Mentally Retarded	Inpatient Psychiatric Service for Under Age 22	Christian Science Nurses	Christian Science Sanatoria	SNF for Under Age 21	Emergency Hospital Services	Personal Care Services	Total Additional Services				
																				A. Inpatient Hospital Services	B. SNF Services	C. ICF Services													
33	Alabama																														12				
10	Alaska																														10				
21	Arizona																														25				
72	Arkansas																														20				
50	California																														14				
14	Colorado																														24				
10	Connecticut																														9				
10	Delaware																														9				
3	D.C.																														9				
17	Florida																														9				
28	Georgia																														13				
3	Guam																														9				
50	Hawaii																														20				
14	Idaho																														10				
35	Illinois																														28				
58	Indiana																														24				
52	Iowa																														18				
13	Kansas																														25				
20	Kentucky																														17				
73	Louisiana																														18				
73	Maine																														22				
50	Maryland																														18				
52	Massachusetts																														28				
40	Michigan																														22				
35	Minnesota																														21				
14	Mississippi																														9				
1	Missouri																														15				
81	Montana																														27				
23	Nebraska																														26				
10	Nevada																														20				
83	New Hampshire																														24				
50	New Jersey																														27				
32	New Mexico																														17				
50	New York																														11				
82	North Carolina																														16				
81	North Dakota																														24				
18	Ohio																														22				
75	Oklahoma																														10				
57	Oregon																														23				
36	Pennsylvania																														31				
95	Puerto Rico																														13				
57	Rhode Island																														10				
37	South Carolina																														12				
54	South Dakota																														13				
73	Tennessee																														14				
61	Texas																														10				
76	Utah																														18				
64	Vermont																														10				
50	Virgin Islands																														9				
57	Virginia																														16				
52	Washington																														26				
70	West Virginia																														23				
53	Wisconsin																														22				
53	Wyoming																														5				
23		14	13	9	10	8	13	8	11	9	8	19	22	16	11	23	25	18	11	4	9	8	2	2	13	9	12	23	22	10	1	6	15	17	2
33		24	22	17	20	14	21	22	26	18	21	32	11	23	25	18	11	16	18	9	18	9	8	27	16	16	26	25	23	5	12	24	29	9	
53	Total	38	35	26	30	19	42	30	38	27	29	51	33	46	36	23	14	30	27	28	11	10	43	26	28	49	47	32	6	13	42	45	11		

FMAP Federal Medicaid Assistance Percentage: Rate of Federal financial participation in a State's medical vendor payment expenditures on behalf of individuals and families eligible under Title XIX of the Social Security Act. Percentages, effective from October 1, 1977, through September 30, 1979, are rounded.
 Financially Needy: People receiving federally supported financial assistance.
 Medically Needy: People who are eligible for medical but not for financial assistance.



**National
Conference
of State
Legislatures**

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President
George B. Roberts, Jr.
Speaker, New Hampshire
House of Representatives
Executive Director
Earl S. Mackey

January 28, 1980

Jan Sorice
House Committee on Health, Education
and Social Services
Pouch V
State Capitol
Juneau, Alaska 99801

Dear Ms. Sorice:

Enclosed, as you requested, is some information on state catastrophic health insurance programs.

Maine, Minnesota, Rhode Island, Connecticut, Hawaii and New York, in addition to Alaska, have enacted catastrophic health insurance legislation. Extensive analysis of these programs has not been performed, however.

Mr. Van Ellett at the Intergovernmental Health Policy Project is in the preliminary stages of preparing a background issue paper on catastrophic programs. He has indicated that he will be glad to offer further assistance in this area. Mr. Ellett can be contacted at:

The Intergovernmental Health Policy Project
Suite 505
1919 Pennsylvania Avenue, N.W.
Washington, D.C. 20006
(202)872-1445

I hope this information is useful. If I can be of further assistance, please feel free to call me.

Sincerely,

Russell W. Hereford
Project Director
Health Care Cost Containment

RWH/sep

enclosure

GR-MEDICALLY NEEDY PROGRAM

- * 50% of all tax returns in Alaska for individuals and families reported 1978 Adjusted Gross Incomes of less than \$20,000.
- * 30% reported incomes less than \$10,000; less than \$833 per month on the average for 1978.
- * Many more Alaskans do not file tax returns at all.

These statistics suggest that for a large number of Alaskans, medical care for age, illness or injury would be unaffordable without health insurance or medical assistance while some of these people may have group insurance or be eligible for Medicaid, Medicare, or Alaskan Native Health Service, many are not eligible for any third party health benefits. The medically needy program created by HCSCSSSB 227 would be an important medical resource for these people.

The income threshold for the medically needy program is set at 150% of the poverty guidelines for Alaska for 1979, the poverty guidelines were as follows:

Non-farm poverty income guidelines

<u>Family size</u>	<u>Annual</u>	<u>Monthly</u>	<u>150%</u>
1	\$4,270	356	534
2	5,640	470	705
3	7,010	584	876
4	8,380	698	1047
5	9,750	813	1219
6	11,120	927	1390

A person or family which is over income becomes eligible for medical assistance under this program if their income in excess of the threshold is spent on medical bills. Essentially, this provides a form of catastrophic coverage for all families, as well as a form of basic coverage for low-income families. The department estimates the new program would serve approximately 2,800 families and individuals.

ADJUSTED INCOME OF ALASKA TAXPAYERS FILING 1978 RETURNS

<u>annual income</u>	<u>average monthly income</u>	<u>percent of taxpayers earning this much or less</u>
\$5,000	\$ 416	16.5%
10,000	833	29.2
15,000	1,250	40.2
20,000	1,667	49.5
25,000	2,083	57.8
30,000	2,500	65.6

MEDICAID ELIGIBLES *

Currently Covered Eligibles

Child under 18 deprived of parental support or care

Parent or other caretaker relative

Child over 18 but under 21 who is school

All children in foster homes or institutions

All children in psychiatric hospitals

A child in an intermediate care facility for the mentally retarded

Aged, blind, or disabled persons

Eligibles added by HCSCSSSB 227

Child deprived of support of father due to unemployment

Spouse of disabled parent

Spouse of unemployed father

Pregnant woman and unborn child

All other financially eligible children

Caretaker relative of child over 18 but under 21 and not in school

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

Individuals who meet categorical criteria and whose incomes, less medical bills, are below 133% of the need standard (medically needy)

* In addition to these categorical criteria, persons must be financially needy.

Currently Covered Services

- Hospital-Inpatient & Outpatient
- Skilled Nursing Facility (SNF)
- Intermediate Care Facility (ICF)
- Intermediate Care Facility for Mentally Retarded persons and persons with related conditions (ICF/MR)
- Laboratory and X-ray Services
- Physician Services
- Visual Care Services, dispensing and ophthalmic materials
- Medical Transportation
- Psychiatric Facility Services
- Home Health Care Services
- Early Periodic Screening, Diagnosis, and Treatment of Individuals under 21 years of age (EPSDT)
 - a. dental services
 - b. prosthetic devices and medical supplies
 - c. physical therapy
- Community Mental Health Clinics
- Family Planning Services
- Outpatient Surgical Care Centers
- Rural Health Clinics

* Accessible through General Relief-Medical

Services Added By HCS CSSSSB 227

- Podiatrist Services
- Chiropractic Services
- Private Duty Nursing
- Personal Care Services
- * Physical Therapy
- * Occupational Therapy
- * Prescribed Drugs
- Dentures
- * Prosthetic Devices and Medical supplies
- Other Diagnostic, Screening, Preventive & Rehabilitative Services
- Services to Individuals over 65 year of age in Institutions for Mental Diseases
- Services to Individuals over 65 years of age in Institutions for tuberculosis
- Other Practitioner Services
 - a. private psychologist
 - b. nurse practitioner
 - c. physician assistant
- Clinic Services-other than Community Mental Health Clinics
- Services by Christian Science Nurses
- Services by Christian Science Sanatoria

House HESS Committee Hearings on
State Health Insurance

Teleconference Witnesses

Bill Weimar, Anchorage
Nick Noll, Eye, Ear & Nose Clinic, Fairbanks
Donald Thieman, Fairbanks Medical Association
Chris Bearsly, Providence Hospital, Anchorage
David Mather, Tanana Chiefs Conference, Fairbanks
Margaret Wolfe, Anchorage
Angie Hague, National Association of Social Workers, Anchorage
Penny Hladna, Anchorage
Gordon DePew, Fairbanks Life Underwriters Association
Bernie Barr, International Rehabilitation Association
Gil D'Innocente, Anchorage
Candice Berry, Welfare Rights Association, Anchorage
Pudge Kleinkoff, National Association of Social Workers, Anchorage
Frank Austin, Black Caucus Council for Economic Justice, Anchorage
Susan Johnson, Chris Billington, NOW, Anchorage
Nancy Lander, Women for Political Action, Anchorage
Rose Palmquist, Anchorage
Donna Hayes, Norton Sound Health Corporation, Nome
Herb Berkowitz, Anchorage
Mason Preston, Bethel
Rosy Porter, Bethel

Other Witnesses

Don Koch - Division of Insurance, Dept. of Commerce and Economic Development
Jim Jordan " " " " " " " " " "
Donald Ching- Dept. of Regulatory Agencies, State of Hawaii
John Ingrassia - Life and Health Section, Insurance Division, State of Minnesota
Joan Gaumer - Director, Government Relations, Blue Cross of WA and AK
Dr. Helen Beirne - Commissioner, Dept. of Health and Social Services
Bob Ogden - Chief, Medical Assistance, Dept. of Health and Social Services

The House HESS Committee held a total of 12 hearings on HB977/SB227

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

CHAPTER 27. STATE HEALTH INSURANCE.

Sec. 18.27.010. STATE COMPREHENSIVE HEALTH PLAN

- (a) The state comprehensive health plan shall be established by the Commissioner of Administration as provided in AS 18.27.030. The Commissioner shall provide for the underwriting and administration of the state plan through competitive bid. The state plan shall be made available to the public no later than July 1, 1981.
- (b) A resident of the state is entitled to enroll in the state plan if:
- (1) The resident is not eligible for Medicare or covered under a state or federal health program;
 - (2) The resident is not covered by a group health insurance plan.

Sec. 18.27.020. STATE HEALTH PREMIUM PLAN (a) A resident of the state is entitled to participate in the state health premium plan if:

- (1) The resident is enrolled in the state comprehensive health plan or an individual health insurance policy which is certified by the director of the division of insurance as meeting or exceeding the benefit standards of the state plan; and
 - (2) the resident is not enrolled in a group health insurance policy or covered under a state or federal health program;
 - (3) the resident qualifies for a supplement under the formula in subsection (b) of this section.
- (b) The amount of the supplement is equal to 80 percent of the monthly premium less 8 percent of the monthly premium for every \$100 of the insured's adjusted gross income, as defined in regulation, over \$1000 per month. The premium cost of the state plan is the maximum amount of monthly premium which may be used in the calculation of the supplement. The \$1000 per month of adjusted gross income used in the calculation shall be adjusted periodically by the commissioner by regulation to correspond with the change in the consumer price index.

Sec. 18.27.030. The commissioner shall:

- (a) hold statewide public hearings to determine the major medical insurance needs of Alaskans;
- (b) determine the number and characteristics of persons currently not covered by a group health plan or federal or state health program, and estimate the number of persons eligible to participate in the state health premium plan;

- (c) conduct an actuarial study to determine the cost of providing insurance covering the services in subsection (a), for the group in subsection (b);
- (d) present state health insurance plan to the legislature by January 1, 1981 including:
 - (1) services to be covered in the state health insurance plan;
 - (2) the cost of the services to be provided;
 - (3) the estimated number of Alaskans eligible to purchase the plan and the estimated number of Alaskans eligible to participate in the state health plan; and
 - (4) the estimated cost of the state health premium plan;
 - (5) a plan of operation for the state health premium plan which provides for:
 - (i) eligibility determination;
 - (ii) prompt payment of premium supplement entitlements to eligible residents or to their insurer;
 - (iii) reasonable protection against fraud; and
 - (iv) public awareness of the benefits provided under this chapter.
 - (6) recommendations for amendments of this chapter;

AS 13.27.040 DEFINITIONS. In this chapter

- (1) "commissioner" means the commissioner of administration;
- (2) "state plan" means the state comprehensive health plan established under AS18.27.010;

Health Care Survey: Doctors and Medicaid

A survey of 113 Anchorage doctors was conducted in order to determine the percentage of Anchorage physicians presently accepting Medicaid recipients as patients. The surveyors, posing as prospective patients, called each physician's office in an attempt to schedule an appointment. After it had been determined if the physician had any openings available, the method of payment was discussed. The conversation was specifically structured this way, in order to provide an indication of the extent to which the method of payment altered accessibility to health care.

The results of the survey are delineated in the accompanying chart. The percentage break-down is as follows: Pediatrics 40% of the doctors will accept Medicaid coupons, 60% will not; OB/GYN 6% will accept, 94% will not; Family Practice 27% will accept, 73% will not; internal 52% will accept, 48% will not; cardiology 100% will not accept; radiology 100% will accept. The chart clarifies the results, for example, cardiologists are not accepting Medicaid coupons, but they will accept as little as \$1.00 per month as payment.

The survey clearly shows the existence of a problem for Medicaid recipients seeking medical care. The brunt of the problem falls on women and children, not only because fewer pediatricians, obstetricians and gynecologists accept Medicaid patients, but also because most Medicaid patients are women and children. For example, in November 1979, 8,418 adults were eligible for Medicaid in Alaska; 6,193 of the total were women. The total number of Medicaid eligible children was 9,998.

There are no existing public facilities in Anchorage which provide prenatal care. There are no OB/GYN's in Anchorage who accept new Medicaid recipients needing gynecological care

as patients; only one Anchorage OB/GYN will accept new Medicaid patients for obstetrical care. It has been suggested that those women in need of, and without access to, OB and/or GYN care elicit the assistance of a family practitioner. Presently 73% of the family practitioners will not accept coupons as the method of payment.

It has further been suggested that poor people use the emergency room as a recourse to health care. This is a non-solution; the function of an emergency room is crisis-oriented, it is not designed to provide on-going care. At Providence Hospital, business personnel estimate that up to 30% of the patients using the emergency room are Medicaid recipients. Reportedly, the number of recipients using the emergency room has incrementally increased as the number of doctors willing to accept coupons has decreased.

Physicians who have elected to exclude patients from health care base their refusal on claims that they receive unsatisfactory payment for their services from Medicaid and that the reimbursements they do receive are untimely. It is also felt that the state requires an excessive amount of paperwork before reimbursements are approved. Doctors further claim that they owe no ethical obligation to the poor.

Although the state has encountered numerous difficulties in making timely Medicaid payments, the recent implementation of a new computer system has succeeded in processing the vast majority of all pending claims.

Poor people, still waiting in long lines at the welfare office to procure Medicaid coupons, continue to lack accessible health care. As one recipient complained to a staff person at the welfare office, coupons in hand, "What am I supposed to do with these, if no doctors in town will take them?"

Availability of Health Care to Medicaid Recipients: Jan./Feb. 1980 Telephone Survey

I	II	III	IV
Will accept all forms of payment including Medicaid	Will not accept new Medicaid patients/info on established caseload n/a	Will not accept new Medicaid patients; but carries an established Medicaid caseload	Not accepting any new patients

OB/GYN

Eastburn, Lydia	Gills, Raymond E. Nist, Richard Ekvall, David L. Ivy, William 1/ Ferucci, Leonard 1/ Newton, Burrit 1/ Orren, Jerry Wallner, Charles Stransky, George Curtis, Richard	Hanson, Hedric Erkman, John Renn, Claire Gibson, Sam	Compton, William
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PEDIATRICS

Keller, R. Tower, John C. Witt, Marian Zartman, Harvey P. Martin, Sarah	Lillibridge, Clinton Nesbitt, James Jr. Roberts, Dion Schriever, Gerry Hatton, Elizabeth Patterson, James Larson, William 1/	Kiehl, Phyllis Wallington, Joanne
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FAMILY PRACTICE

Agnew, Mark	Arbow, Donald	St. John, Charles
Myers, Robert C.	Jones, Leland	Bosveld, Robert
Sydnam, Nancy E. <u>2/</u>	Laufer, Kenneth	Foland, Mary Ann
Manwiller, Charles	Kiessling, Bruce	Wieland, Tyron
Jones, Warren <u>3/</u>	Taylor, Richard	
Billings, Robert	Cates, Vernon	
Feirtag, Mary	Romig, Howard C.	
Martin, Asa	Monlux, George	
Lindhal, James	Mosley, Charles	
Sutherland, Richard	Persons, Jean C.	
	Jackson, Marcell	
	Burgess, Joan	
	Bryan, Harold	
	Cormack, Allan	
	Nolan, Patrick	
	Smith, John	
	Colyar, A. B. <u>1/</u>	
	Morgan, Royce <u>1/</u>	
	Olsen, Harry <u>1/</u>	
	Lang, Thomas <u>1/</u>	

INTERNAL MEDICINE

Watson, III, James	Behymer, G. W.	Whaley, Robert	Buchanan, Richard
Webb, Dale <u>4/</u>	Steer, Paul		Schlosstein, Lee
Ames, John	Hall, Robert		Brownsberger, Keith <u>6/</u>
Henry, David	Peach, David		Witt, Richard <u>6/</u>
Fish, Winthrop	Morris, Ann		Wilson, Rodman <u>6/</u>
Burtis, Buffington	Morris, Gerald		
Sonneborn, David	Princiville, Thomas		
Armstrong, Michael	Blankinship, Gilbert <u>5/</u>		
Ragle, William			
Wilkins, Robert			
Archer, Gary			
Beechman, Sherman			
Austin, Stanley			
Stewart, George			

RADIOLOGY

Gibbons, John
 Hall, Rardolph
 Hendrics, Zeke
 Pister, James
 Coyle, Maurice J.
 Kottra, John
 Sterihagen, Charles

CARDIOLOGY

Baldauf, James 5/
 Bustad, Leo 5/

Footnotes:

- 1/ Cash only
- 2/ Limited amount
- 3/ Will not take coupons for O.B. care
- 4/ For cancer patients only
- 5/ Will not accept medicaid coupons; will accept minimal monthly cash payments (i.e.: \$1.00/mo.)
- 6/ Does have established medicaid caseload

Health Care Legislation

HCS CS SS SB 227

HCS CS SS SB 227 "An Act relating to the health of residents of the state" is an omnibus health bill extending health coverage to several new groups of people and expanding the scope of coverage available.

* HIGH RISK INSURANCE POOL

People who have high risk medical conditions often are considered "uninsurable" and cannot purchase comprehensive health insurance. Section one of the bill establishes a high risk insurance pool to be administered by the largest carrier in the state. Premiums would be limited to reasonable levels and the carrier would be allowed to pass excess claims losses from this coverage on to the state through the tax system.

* ALCOHOLISM COVERAGE FOR STATE EMPLOYEES

Model benefits for coverage of alcoholism, including inpatient detoxification, inpatient treatment and outpatient treatment are added to the state employees health insurance plan. While the original bill mandated these benefits for all health insurance policies, the HESS Committee substitute bill would field test these new benefits on state employees.

* MEDICAID BY INSURANCE POLICIES OR HEALTH SERVICE CONTRACTS

Section eight of the bill directs the commissioner of Health and Social Services to provide Medicaid coverage through the purchase of private health insurance policies or health service contracts on behalf of Medicaid recipients, when this is found to be cost effective.

* RELIEF FOR MEDICAID PROVIDERS

The bill requires that the state pay interest at the rate of one percent per month to Medicaid providers on bills that are more than one month overdue, and two percent per month on bills that are more than three months overdue. It also allows the state to make an interim payment to large volume Medicaid providers prior to billing and processing of the claims.

* EXPANSION OF SERVICES AND ELIGIBLE PEOPLE COVERED UNDER MEDICAID

Sections nine and ten of the bill expand the state's Medicaid program to include all groups and all services for which federal funding is available. New additions include such eligible and services as unborn children, unemployed fathers, prescription drugs, adult dental care and physical therapy.

* COVERAGE FOR THE MEDICALLY NEEDY

Section eleven of the bill creates a new program of medical assistance for medically needy people under the state's General Relief-Medical program. The income threshold for eligibility is set at 150% of the poverty guideline for Alaska. People whose income exceeds that amount can still become eligible for assistance after they spend their "excess" income on medical bills.

* FISCAL IMPACT

The fiscal note for all these programs includes approximately \$8 million from the General fund, \$23 thousand from other state funds and \$8 million in federal funds for FY81.

**THELMA
BUCHHOLDT**

Alaska State Legislature
House of Representatives
Juneau, Alaska 99811

May 22, 1980

To: Representatives Gardiner, Meekins, McKinmon, Parker

From: Representative Thelma Buchholdt

Re: HCS CS SS SB 227 - Health Legislation

HCS CS SS SR 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.

payments from public assistance, social security, unemployment and workmen's compensation, strike benefits from union funds, veterans benefits, training stipends, alimony, child support and military family allotments or other regular support from an absent family member or someone not living in the household; government employee pensions, private pensions and regular insurance or annuity payments; and income from dividends, interest, rents, royalties or income from estates and trusts. For eligibility purposes, income does not refer to the following money receipts: any assets drawn down as withdrawals from a bank, sale of property, house or car, tax refunds, gifts, one-time insurance payments or compensation for injury; also to be disregarded is non-cash income, such as the bonus value of food and fuel produced and consumed on farms and the imputed value of rent from owner-occupied farm or non-farm housing.

(2) *A Farm Residence*. Is defined as any dwelling on a place of 10 acres or more with \$50 or more annual sales of farm products raised there; or any place less than 10 acres having product sales of \$250 or more.

Poverty Income Guidelines for All States Except Alaska and Hawaii

Size of family unit	Non-farm family	Farm family
1	\$3,400	\$2,910
2	4,500	3,840
3	5,600	4,770
4	6,700	5,700
5	7,800	6,630
6	8,900	7,560

For family units with more than 6 members, add \$1,100 for each additional member in a non-farm family and \$930 for each additional member in a farm family.

Poverty Guidelines for Alaska

Size of family unit	Non-farm family	Farm family
1	\$4,270	\$3,650
2	5,140	4,510
3	7,010	6,370
4	8,360	7,130

Poverty Guidelines for Alaska—Continued

	Non-farm family	Farm family
5	9,750	8,290
6	11,120	9,450

For each family unit with more than 6 members, add \$1,370 for each additional member in a non-farm family and \$1,160 for each additional member in a farm family.

Poverty Guidelines for Hawaii

Size of family unit	Non-farm family	Farm family
1	\$2,930	\$2,350
2	5,190	4,420
3	6,450	5,490
4	7,710	6,560
5	8,970	7,630
6	10,230	8,700

For family units with more than 6 members, add \$1,250 for each additional member in a non-farm family and \$1,070 for each additional member in a farm family.

(44 FR 26476, May 7, 1979)

Subpart 1060.3—Limitation on Benefits to Those Voluntarily Poor (CSA Instruction 6004-2)

§ 1060.3-1 Applicability of this subpart

This subpart applies to all agencies receiving funds under Titles I-D, II and III-B of the Economic Opportunity Act for programs administered by OEO in which income criteria are used as admission standards (with the exception of Head Start and Upward Bound programs).

(Sec 602, 78 Stat. 503; 42 U.S.C. 2542) (34 FR 2419, Feb. 20, 1959)

§ 1060.3-2 Policy.

(a) Section 611 of the Economic Opportunity Act provides as follows:

The Director shall take such action as may be necessary to assure that, in determining a person's eligibility for benefits under this Act on account of his poverty such person will not be deemed to meet the poverty criteria if his lack of income results from his refusal, without good cause, to seek or accept employment commensurate with his health, age, education, and ability.

MEDICAID OPTIONAL SERVICES--INCLUDING THOSE

NOT CURRENTLY COVERED BY THE

ALASKA MEDICAID PROGRAM

The following is a list of all optional services under the Medicaid program. Optional services may be selected by the individual states for inclusion in their Medicaid program if a state decides to make those services available to all categories eligible for the basic Medicaid coverage. A brief description of each option is provided below followed by a comparison of optional services that are offered in Alaska, Idaho, Oregon and Washington, the four states comprising federal Region X. Those services covered in Alaska are indicated.

- (1) Podiatrist services. Manipulation of the feet and treatment of corns, bunions, callouses, etc., by a licensed podiatrist.
- x (2) Optometric services. Covered under Alaska Medicaid.
- (3) Chiropractic services. Treatment by a licensed chiropractor limited to manual manipulation of the spine.
- (4) Other practitioner services. Naturopaths, homeopaths, herbalists, faith healers.
- (5) Private duty nursing. Care by a registered nurse or licensed practical nurse under a physician's supervision in home, hospital or nursing facility when a person requires exceptional individual and continuous care.
- (6) Clinic services. Under the Alaska Medicaid program this is currently limited to state-operated and state-funded community mental health clinics. This option could also include such other services as health care clinics, alcoholism treatment centers, ambulatory surgical centers, and rural health care clinics. Rural health clinics are now a mandatory service pursuant to Public Law 95-210.

(7) Physical therapy. Physician-prescribed services provided by a licensed or certified physical therapist (depending upon state licensing procedures).

(8) Occupational therapy. Physician-prescribed services provided by a licensed or certified occupational therapist (depending upon state licensing procedures).

(9) Services for speech, hearing, and language disorders. Included under the Alaska Medicaid program.

(10) Prescribed drugs. Covered by state-only General Relief Medical. Alaska is one of only two states without Medicaid coverage for this option.

(11) Dentures. Replacement of a full or partial set of teeth.

(12) Prosthetic devices. Physician-prescribed replacement corrective or supportive devices that artificially replace a missing part of the body, to prevent deformity or malfunction, to support a weak or deformed portion of the body.

(13) Eyeglasses. Covered by Alaska Medicaid.

(14) Other diagnostic, screening, preventive and rehabilitative services. Identification of illness, injury or other health deviation; preventive and rehabilitative services to restore patient to functional level.

(15) Services to individuals over 65 years of age in institutions for tuberculosis. Facility providing services could be ICF, SNF or inpatient hospital.

(16) Services to individuals over 65 years of age in institutions for mental diseases. (a) Inpatient psychiatric care for persons over 65 is covered under the Alaska Medicaid program. (b) ICF and SNF care for persons over 65 with mental diseases is not covered in Alaska. Under this provision, it would be possible to provide nursing care for persons with mental disabilities who may not otherwise qualify for nursing care due to a lack of physical health problems requiring nursing home care.

(17) Intermediate care facilities (ICF). Covered under the Alaska Medicaid program.

(18) Inpatient psychiatric services for persons under 22 years of age. Covered by the Alaska Medicaid program.

(19) Transportation. Covered under the Alaska Medicaid program.

(20) Services by Christian Science nurses.

(21) Services by Christian Science Sanatoria.

(22) Skilled nursing facility care (SNF) for persons under 21 years of age. Covered by the Alaska Medicaid program.

(23) Emergency hospital services. Covered under the Alaska Medicaid program.

(24) Dental services. Adult dental services are not covered by Medicaid in Alaska.

(25) Personal care services. Physician-ordered services provided to a person in their home by a non-relative and supervised by a registered nurse.

(26) Intermediate care for the mentally retarded and persons with related conditions (ICF/MR). Covered under the Medicaid program in Alaska.

OPTIONAL SERVICES

<u>OPTIONAL SERVICES</u>	<u>ALASKA</u>	<u>IDAHO</u>	<u>OREGON</u>	<u>WASHINGTON</u>
Podiatrist Services	No	Yes	Yes	Yes
Optometric Services	Yes	Yes	Yes	Yes
Chiropractic Services	No	Yes	Yes	Yes
Other Practitioner Services	No	No	Yes	Yes
Private Duty Nursing	No	No	Yes	Yes
Clinic Services	Yes	Yes	Yes	Yes
Physical Therapy	No	Yes	Yes	Yes
Occupational Therapy	No	No	No	No
Services for Speech, Hearing & Language Disorders	Yes	No	No	Yes
Prescribed Drugs	No	Yes	Yes	Yes
Dentures	No	No	Yes	Yes
Prosthetic Devices	No	No	Yes	Yes
Eyeglasses	Yes	No	Yes	Yes
Other Services				
Diagnostic	No	No	Yes	Yes
Screening	No	No	No	Yes
Prevention	No	No	No	Yes
Rehabilitation	No	No	Yes	Yes
Services to Individuals Over 65 in Institutions for T.B.				
Inpatient	No	No	Yes	Yes
Skilled	No	No	Yes	Yes
ICF	No	No	Yes	Yes
Services to Individuals Over 65 in Institutions for Mental Diseases				
Inpatient	Yes	No	Yes	Yes
Skilled	No	No	Yes	Yes
ICF	No	Yes	Yes	Yes
Intermediate Care Facilities	Yes	Yes	Yes	Yes
Inpatient Psychiatric Services for Under 22	Yes	No	Yes	Yes
Transportation	Yes	Yes	Yes	Yes
Services for Christian Science Nurses	No	No	No	No
Services for Christian Science Sanitoria	No	No	Yes	No
SNF for Under 21	Yes	Yes	Yes	Yes
Emergency Hospital Services	Yes	Yes	Yes	Yes
Dental Services	No	No	Yes	Yes
Personal Care Services	No	No	No	No
ICF/MR	Yes	Yes	Yes	Yes

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

JAY S. HAMMOND GOVERNOR

POUCH H 01 - JUNEAU 96311

April 9, 1980

Ms. Thelma Buchholdt
Chairperson, House HESS Committee
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Document# 68-80

Dear Ms. Buchholdt:

At the recent teleconference on House Bill 977, your Committee requested further information regarding the definition of the "other diagnostic, preventative, and rehabilitative services" option to the Medicaid program. The definition included in federal Medicaid regulations for this option is as follows:

§440.130 Diagnostic, screening, preventive, and rehabilitative services.

(a) "Diagnostic services," except as otherwise provided under this subpart, includes any medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, to enable him to identify the existence, nature, or extent of illness, injury, or other health deviation in a recipient.

(b) "Screening services" means the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more particular diseases or health deviations; or to identify for more definitive studies individuals suspected of having certain diseases.

(c) "Preventive services" means services provided by a physician or other licensed practitioner of the healing arts within the scope of his practice under State law to--

- (1) Prevent disease, disability, and other health conditions or their progression;
- (2) Prolong life; and
- (3) Promote physical and mental health and efficiency.

(d) "Rehabilitative services," except as otherwise provided under this subpart, includes any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a recipient to his best possible functional level.

As you can see the federal definition is quite general. The Medicaid program allows state flexibility to define optional services for operational purposes. Seven states currently have selected to include this service option in their Medicaid programs. These states have defined this option as follows:

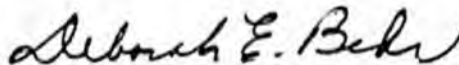
1. California - Rehabilitation center outpatient services. Included are physical, occupational, and speech therapy and audiology. One visit in a six-month period is allowed, without prior authorization, for evaluation purposes and preparation of an extended treatment plan. The treatment plan must be signed by a physician. Subsequent visits are subject to prior authorization. A maximum of 30 visits may be authorized at any one time. Authorizations are valid for up to 120 days.
2. Idaho - The following are the core medical rehabilitative services provided on a statewide basis through facilities comparable to adult/child development centers: medical/social and psychological evaluations, speech and hearing evaluations, psychological therapy, patient centered psychological consultation, speech therapy, and patient centered psychological consultation, speech therapy, and patient centered development deficiency services related to particular diseases or health deviations.
3. Nevada - Limited to inhalation therapy prescribed by a physician and provided by a Certified Respiratory Therapist subject to the same limits that apply for Medicare. Prior authorization by the Medical Care Section is required.
4. North Carolina - Limited to diagnostic, preventive, and rehabilitative services when provided by mental health centers.
5. Oklahoma - Limited to blood. For inpatients, payment is made to blood banks for blood and blood fractions when the cost of blood is not included in the hospital per diem cost. For outpatients, payment is made for blood and blood fractions on behalf of an eligible recipient who is suffering from a congenital or acquired disease of the blood which requires the use of blood or blood fractions. Specifically eliminated is gammaglobulin, both the pooled and specific types. Payment may be made to physicians, clinics, out-patient hospitals or blood banks. Blood claims are screened through the computer stream against eligibility files to assure that no payment is made beyond the scope of the program.

6. Wisconsin - Includes psychotherapy provided or supervised by a psychiatrist or psychologist in the provider's office, the outpatient office of a hospital, an outpatient facility, a nursing home, a licensed child-caring institution, a school, or the recipient's home or foster home. A diagnostic examination and a physician's written prescription for therapy must be furnished before therapy is begun (a prescription is not needed for emergency treatment but must be obtained within 48 hours). Prior authorization is required for all therapy.
7. Washington - Diagnostic services - covered as needed and approved. Preventive services - (a) Rabies shots; (b) Fluoride painting; and (c) Immunizations when not otherwise available. Rehabilitative services - (a) Physical medicine and rehabilitation as requested and approved; (b) Alcohol detoxification limited to 3 days in certified facilities which may be within the physical location of a general hospital - however, narcotic detoxification is not covered; (c) Chemotherapy and consultation for drug addiction are provided in clinics approved to provide to services; and (d) Adult Day Health Care as provided and periodically reviewed.

I hope this clarifies your concerns. Alaska, if it chooses to add this option, could define the option in a similar ways to those noted above, subject to federal approval in order to be eligible for federal financial participation.

If you have additional questions on this matter, please do not hesitate to contact the department at 465-3030.

Sincerely,



Deborah E. Behr
Special Assistant to
the Commissioner



Alaska State Legislature House

JUNEAU ALASKA

To: Representative Thelma Buchholdt
Chair, House HESS

From: Jan Sorice, A.A.

Re: CSSSSB 227

Section One of CSSSSB 227, which creates a Health Reinsurance Association of all carriers in the state, is based on Connecticut's Health Care Act of 1975. Travelers Insurance Company is the administering carrier for Connecticut's Health Reinsurance Association.

According to Tim Lyons of Travelers Insurance Company in Connecticut, the law serves a positive public purpose and does not impose an unreasonable

burden on the carriers. The law offers comprehensive health insurance coverage to any resident of the state and any employer group. In addition to providing coverage for high health risk people who are uninsurable under standard policies, the state comprehensive health care plan provides coverage to people who are temporarily lacking coverage, such as a person who is in between jobs and temporarily not eligible for group coverage, and provides many young, low-risk people an attractive health coverage plan at very modest premiums as well. Except for a

few carriers who choose to write their own comprehensive health insurance plans, the carriers act as agents to sell the comprehensive health plans written by the Health Reinsurance Association.

Mr. Lyons found no legal or administrative problems with the law, though he feels that it would be preferable to have all carriers in one residual market rather than one for insurance carriers and another for hospital/medical service corporations (Blue Cross and Blue Shield, predominately). He felt that one association would provide a more equitable sharing of the costs of high risk coverage among all carriers and would avoid duplication of administrative overhead.

Blue Cross of Connecticut does not participate in the Health Reinsurance Association, but instead chooses to operate a separate residual market mechanism and offer a competing comprehensive health plan as mandated by the law. Blue Cross' comprehensive health plan is offered at two-thirds the premium cost and has five times the enrollment of the comprehensive plan offered by the Health Reinsurance Association. Blue Cross prefers to operate a separate program because as a non-profit hospital/medical service corporation, they run their business a little differently than insurance companies do. Joe Kaluzynski, Director of Market Research and Product Development for Blue Cross, saw no administrative problems or other defects in the law.

Neither Mr. Kaluzynski nor Mr. Lyons saw any potential problems generated by the fact that most carriers operating in Alaska are not located here. Only one carrier in each association, the administering carrier, needs to have regular contact with the State or its residents.