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HHESS

STATE HEALTH INSURANCE (FILE NO. 2)

A COMPARISON OF BENEFITS UNDER HB 977
AND THREE OTHER COMPREHENSIVE HEALTH PLANS

Benefit	State Employees Blue Cross Plan	Alaska #2 Qualified Plan (HB 977)	Minnesota #2 Qualified Plan	Connecticut Middle Option Plan
deductible	\$50/person; \$150/family	\$500/person; \$1500/family	\$500/person	\$500/person
co-payment	10%	20%	20%	20%
out-of-pocket limit	\$2000	\$3000	\$3000	\$1000/person; \$2000/family
maximum lifetime benefit	\$250,000	\$250,000	\$250,000	\$1,000,000
pre-existing conditions limit	maximum benefit limited during 1st year of plan coverage to \$1000 for any pre-existing condition which was treated during the 3 months prior to enrollment in the plan	not specified	not specified	conditions manifested or treated in the 6 months prior to enrollment excluded from coverage for one year
fee basis	usual, customary and reasonable charges	usual and customary charges	usual and customary charges	may not exceed reasonable charges or rates approved by the commission on hospital and health care
COVERED SERVICES:				
hospital services	yes	yes	yes	yes
physician services	care rendered by M.D., osteopath, psychologist, chiropractor, podiatrist or Christian Science practitioner	care rendered by or at the direction of a physician	care rendered by or at the direction of a physician	professional services rendered by an M.D., osteopath, chiropractor, podiatrist, psychologist or naturopath
private duty nursing	RN services at the direction of a physician	professional services rendered at the direction of a physician	professional services rendered at the direction of a physician	professional services rendered by a registered nurse at the direction of a physician

Benefit	State Employees Blue Cross Plan	Alaska #2 Qualified Plan (HB 977)	Minnesota #2 Qualified Plan	Connecticut Middle Option Plan
Prescription drugs	yes	yes	yes	yes
radiation	yes	yes	yes	yes
x-ray & lab exams	yes	yes	yes	yes
oxygen	yes	yes	yes	yes
anesthetic	yes	yes	yes	yes
prostheses	yes	yes	yes	yes
medical supplies	bandages, crutches, wheel chairs, res- pirators, blood, hospital type beds, plasma	rental or purchase of durable medical equipment	rental or purchase of durable medical equipment	rental or purchase of durable medical equipment
pregnancy & childbirth	yes	yes	yes	\$250 limit except for complications
travel	ambulance or com- mercial airline to nearest facility	medically necessary transportation	ambulance to nearest facility & mileage rate to kidney dialysis treatment center	ambulance to nearest facility
alcoholism treatment	yes, on inpatient basis, except limited to \$1000 maximum if the facility does not have a contract with Blue Cross	yes	yes (required by law of all health in- surance policies)	yes
mental & nervous disorders	50% coverage up to \$2500 maximum per year when rendered by and M.D., D.O., or licensed psycholo- gist	_____	_____	50% coverage

Benefits	State Employees Blue Cross Plan	Alaska #2 Qualified Plan (HB 977)	Minnesota #2 Qualified Plan	Connecticut Middle Option Plan
Nursing home	—	120 days maximum if begun within 14 days of a hospital stay of at least 3 days	120 days maximum if it would qualify under Medicare	120 days maximum if begun within 14 days of a hospital stay of at least 3 days
home health care	—	up to 180 visits/year	if it would qualify under Medicare	up to 180 visits/year
oral surgery	yes	yes	yes	yes
physical therapist	—	yes	yes	yes
well baby care	—	yes, subject to de- ductibles, coinsurance and limits	effective July 1, 1980	—
physical exams	—	yes, subject to ap- plicable deductibles coinsurance and limits	effective July 1, 1982	—
multiphasic screening & other diagnosis	—	yes, subject to co- insurance, deductibles & limits	effective July 1, 1982	—
dental care	70 - 100% coverage up to a maximum of \$1000 per year	—	—	—
vision & optical	90% coverage for 1 exam and 1 set of lenses/year	—	—	—
audio	80% coverage up to \$400 over 3 years	—	—	—
medical social services	—	—	—	\$200 limit

Benefit	State Employees Blue Cross Plan	Alaska #2 Qualified Plan (HB 977)	Minnesota #2 Qualified Plan	Connecticut Middle Option Plan
conversion privileges	yes	yes	yes	yes
dependent coverage	spouse, dependent children under 23, disabled children of any age who are financially depen- dent	spouse, children under 18, children under 25 who are students and financially dependent, disabled children of any age who are financially dependent and dependant household members	spouse, children under 19, children under 25 who are students and financially dependent, children of any age who are disabled and depen- dent	not specified

BRIEF SUMMARY OF CSSSB 227

" AN ACT RELATING TO INSURANCE FOR ALCOHOLISM AND DRUG DEPENDENCE"

THIS BILL MAKES IT REQUIRED FOR GROUP INSURANCE POLICIES TO PROVIDE COVERAGE FOR ALCOHOLISM AND DRUG DEPENDENCE. THE MINIMUM REQUIREMENTS FOR THIS COVERAGE ARE DESCRIBED IN THE BILL AND INCLUDE:

1. 14 DAYS OF INPATIENT DETOXIFICATION CARE PER YEAR
2. 30 DAYS OF INPATIENT TREATMENT PER YEAR
3. 30 VISITS OF OUTPATIENT TREATMENT PER YEAR

ALL OF THE ABOVE MINIMUM REQUIREMENTS AS OUTLINED IN THE BILL ARE TO BE ADMINISTERED IN A/OF BY A

1. STATE APPROVED TREATMENT FACILITY
2. LICENSED HOSPITAL
3. LICENSED PHYSICIAN
4. STATE CERTIFIED PROFESSIONAL SUBSTANCE ABUSE COUNSELOR

THE INSURANCE AS REQUIRED BY THIS BILL WOULD INCLUDE BENEFITS FOR DEPENDENTS REGARDLESS OF AGE, SEX OR STATE OF ILLNESS.

HOSPITAL MEDICAL SERVICE CORPORATIONS IE. BLUE CROSS (THE LARGEST INSURANCE COMPANY WITH ALASKA) ARE REQUIRED BY THIS BILL TO INCLUDE ALCOHOLISM AND DRUG DEPENDENCE INSURANCE.

THIS BILL INSURES THAT ALL PERSONS COVERED BY A GROUP INSURANCE POLICY ARE COVERED FOR ALCOHOLISM AND DRUG DEPENDENCE WHETHER OR NOT SPECIFIED IN THE POLICY. (THE REASONING FOR THIS IS THAT SOME POLICIES ORIGINATE OUT OF STATE THEREFORE THE POLICY MIGHT NOT SPECIFY ALCOHOLISM AND DRUG DEPENDENCE COVERAGE, SO THIS WOULD CHANGE THE LAW MAKING IT AUTOMATIC FOR ALASKAN EMPLOYEES COVERED BY INSURANCE.)

CSSSSB 227 PROVIDES FOR AN EFFECTIVE DATE OF NOVEMBER 1, 1979 IN ORDER FOR INSURANCE COMPANIES TO COMPLY WITH THE NEW LEGISLATION.

Sec 1 AS 21.42

Requires that all group health insurance policies issued by insurance companies and all service or indemnity type contracts issued by non-profit corporations such as Blue Cross, provide as a minimum, specified coverages related to alcoholism and drug dependence.

COVERAGES are:

- A. not less than 14 days detoxification benefit at a rate equal to other benefits provided in the policy.
- B. not less than 30 days inpatient treatment benefit
- C. not less than 30 visits to specified outpatient treatment facilities.

Alcoholism and drug dependence coverage is to be provided for all persons covered under the group policy without regard to age, sex, state of illness, or pre-existing condition.

Section 1 also provides key definitions of alcoholism and drug dependence.

Section 2 Amends AS 21.87.347 to provide that Hospital Medical Service Corporations ie. Blue Cross, are also subject to the provisions of AS 21.42 as created by this bill.

Section 3 Specifies that coverage for alcoholism and drug dependence shall automatically apply to all persons covered by a group policy issued for delivery, delivered or renewed in this state after the effective date of the act; whether the policy wording specifically provides coverage or not.

Section 4 Provides for an effective date of November 1, 1979 in order for insurance companies to amend policies and adjust rates prior to the effective date.

Robertson, Monagle,

STATEMENT
of the
HEALTH INSURANCE ASSOCIATION OF AMERICA
CONCERNING PROPOSED
ALASKA COMPREHENSIVE HEALTH CARE PLAN
(House CS for CS for SS for S. B. 227)

The Health Insurance Association of America (HIAA) is a trade association of 311 insurance companies which write about 85% of the health insurance written by insurance companies in the United States.

Section 1 of the proposed House Committee Substitute for this bill, now being considered by the House Health, Education and Social Services Committee, would establish a comprehensive health care plan, and would require health insurers to participate in it. Our comments will be primarily directed to Section 1.

GENERAL PLAN OF SECTION 1

The basic idea of Section 1 is to establish a pool to make three specified plans of major medical insurance available to Alaska residents, under age 65, who are uninsurable or are otherwise high risks for such coverage when furnished by individual insurers. Pooling of high-risk insureds makes the financial resources of all health insurers available to cover the large claim payments that must be made.

Because major medical insurance, with its broad coverage and high maximum benefits, is costly anyway -- and even more so for high-risk insureds -- Section 1 also limits the premium rates that can be charged for the three major medical plans to amounts that are less than are needed to pay claims and administer the program, and the State eventually pays the difference by means of a tax offset. [A State subsidy is available to certain small employers to help them pay for one of the three plans of major medical insurance for their employees.]

All health insurers (including self-insurers) would be required to be members of the Association which operates the pooled business, and to share in the losses, with one exception. Blue Cross - Blue Shield could establish its own separate pool, or could provide the three plans without participating in a pool.

Section 1 is an altered version of an existing Connecticut law, and the subsidy for small employers is an idea adapted from an existing Hawaii law.

GENERAL COMMENTS

Going to the Connecticut law for guidance results in a much better plan than H. B. 977. The Connecticut law is unlike the Minnesota law on which it

is based, has not been a subject of great controversy or Constitutional challenge. It is, on the whole, a very workable law for that State. To be sure, it needs some alterations based on experience with it, and some additional ones if it is to be adapted for Alaska.

Before getting to that, it seems to us that the Alaska legislature should be asking, and getting answers to, some important questions:

- (1) Is there a need for such a program in Alaska?
- (2) How many Alaska residents can we expect to benefit from it?
- (3) How much will it cost?
- (4) Are the anticipated costs worth paying in view of the anticipated benefits?
- (5) Would such a program work in Alaska?

These same questions should be asked and answered about any proposed health insurance program, whether it be patterned after the Connecticut law or the Minnesota law, or whether it is something untried elsewhere.

What you need, we think, is to have a thorough study made by a firm of consulting actuaries that has sufficient knowledge about State health insurance plans and access to sufficient Alaska claims data. This would be advisable for any State contemplating a program, and particularly so for Alaska which is so different from other States. Among other things are Alaska's vast area, small population, comparatively younger (and probably healthier) residents, and a large proportion of residents already covered by government health care plans.

Lacking such a study, we can only make some guesses.

Let's go to question (2), and see what we can guess from experience elsewhere about how many Alaskans who are high risks for major medical insurance might become insured under such a program. The answer to this will have some bearing on the answers to questions (1) and (4).

In Connecticut, the two pools (one "pool" operated by Blue Cross - Blue Shield, the other by insurance companies) together cover 9,680 people, which is about 35 ten-thousandths (.0035) of the under-age-65, civilian, noninstitutionalized population of about 2,746,000 people. But a large majority of the people covered by the pools consists of standard risks, who could get coverage without the program. This is primarily because Blue Cross - Blue Shield puts all of its non-group insureds, both standard and high-risk individuals, into its pool. So the Connecticut figures are not much help to us.

In Minnesota, the Association (pool) has 1,465 policies in force for people under age 65. While the records do not indicate numbers of people covered, the great bulk of the policies cover only one person each. We estimate that the pool covers

1,758 people, which is about 5 ten-thousandths (.0005) of the under-age-65, civilian, noninstitutionalized population of about 3,493,000 people. This enrollment was achieved only after a major, intensive publicity effort participated in by the Association and hospitals and other health care providers. Unlike Connecticut, only high-risk individuals are included in this figure.

Applying these Minnesota results to the estimated 395,000 ~~under-age-65,~~² *rejection* civilian, noninstitutionalized Alaska population, we would expect an Alaska pool for high-risk individuals to cover somewhat under 200 Alaska residents. Some downward adjustment should be made for Alaska's comparatively younger and (at least partly for that reason) healthier population, and for the comparatively larger proportion of native Alaskans covered under government health care programs.

It should be kept in mind that a wide range of major medical insurance plans (including high-maximum plans) is already available from insurers to groups, and to standard and many substandard risk individuals, at premium rates that are lower than those to be charged by the pool. And Medicare, Medicaid, the Alaska catastrophic illness program, and other government programs provide coverage for many Alaskans.

The small number of people who can be expected to come into the pool is determined by a number of factors, including the small number of uninsurables, the inability of many to pay the costs of major medical insurance, the number of people already covered under major medical plans, and the number of people covered under other government programs.

COST OF PROGRAM

The Alaska Insurance Department has already given you an estimate of their anticipated costs, initially \$250,000 per year we understand.

In Section 1, proposed AS Sec. 21.50.090 provides for the State to aid small employers in paying premiums for health insurance coverage for employees and their dependents. We do not have any estimate of what this may cost the State, but think that the costs may be quite substantial.

In addition, there would be a cost to the State due to the tax offset (or payment by the State to the carrier) for losses due to costs of the program which exceed the premiums on business written by the pool. The Minnesota program lost \$1,000,000 in 1979, using the same limitation on premium rates that is in the proposed Alaska program. With only 10% or 11% as many insureds, but with considerable higher per person administrative costs, losses under the Alaska program might initially be \$200,000, perhaps somewhat less but possibly considerably more -- the latter if a home office type operation were established in Alaska, since no major health insurance writer has its home office in Alaska. Without a proper actuarial study, we cannot predict the range of this cost.

In addition, insurers will incur some costs for compliance with the law. The amount is unknown, but it will eventually be paid by Alaska policyholders and insureds.

COSTS TO EMPLOYERS

Proposed AS Sec. 21.50.080 would require all group "health policies" delivered or renewed in Alaska to contain the provisions called for in proposed AS Sec. 21.50.030(b). Those provisions deal principally with: (1) continuation of coverage under the group policy in specified circumstances for employees and/or dependents whose coverage would otherwise terminate; and (2) including a conversion to an individual policy, with benefits and terms at least as good as a comprehensive plan, when coverage under the group plan terminates.

Both proposed sections need careful redrafting in order not to interfere more than is intended with eligibility provisions of group policies, and to limit the conversion privilege so that it applies to the proper kinds of group policies and does not allow duplicate conversions.

After redrafting, the provisions should be considered in an actuarial study to determine the costs they will add to group plans, so that the Committee may consider whether it is advisable to add such cost burdens to employers who furnish health insurance coverage to employees under group policies or contracts.

PREMIUM RATES

An actuarial study is needed to determine the approximate premium rates that the pool will charge initially for coverage. This is essential if you are to make an informed, intelligent decision on the kinds of benefits and the amounts of benefits, including the deductibles, to be provided in the three plans. Section 1 of the proposed amendment already makes some changes in benefits from those provided under the Connecticut law. I do not know what reasons were involved in making the changes, but they have a significant effect on premium rates.

The decrease in the low option deductible to \$100 from \$200 will increase the premium rate for that plan by roughly 10%. The increase in the high option deductible to \$1,000 from \$750 will decrease the premium rate for that plan by roughly 7-1/2%. Removing Connecticut's \$250 limit (and applying no limit) to the normal maternity benefit will increase the premium rate of all three plans for women of child-bearing age, by roughly 5% to 10%.

It seems to me that we should be looking for ways to lower premium rates, by decreasing some benefits, rather than for ways to increase them. We do not want to price the plans so high that even fewer people will be able to afford them.

Health insurance premium rates are already higher for Alaska residents because of the higher health care costs in Alaska. And health care costs are rising at a rapid rate generally. We know, for example, that the insurance company pool in Connecticut is about to raise its rates by 20%. We know that health care costs in Anchorage are about 35% higher than in Hartford, Connecticut.

When a small sampling of Connecticut rates for just two age groups is roughly adjusted to account for the changes in the plans and to guess at what the pool rates might today be for Anchorage residents, and some of them indicate an annual rate, for one adult, of as much as \$1,100, \$1,300, or \$1,500, I worry. And whatever the rates are now, they may have to be 15% or more higher by the time the program can be put into effect.

After you have a proper actuarial study, you should consider what benefits the three plans should offer. *per year?*

OTHER CONSIDERATIONS

1. The size of Alaska, and the distribution of its population over so large an area, create some problems, but they can be dealt with. Costs of the program will be higher, and communications (including the enrolling of individuals and payment of claims) will take somewhat longer than would be the case with Minnesota or Connecticut.
2. Because, unlike Connecticut and Minnesota, Alaska does not have within its boundaries the home office of a large insurer capable of administering the program, the Committee should investigate the practicality of having the program administered from outside the State, and the availability of insurers willing to participate as administrator and as board members of the Association.
3. The small size of the anticipated enrollment in the program does not obviate the need for a pool. It does, however, make it impractical to have more than one pool, even at the beginning of the program. The two pools under the present Connecticut law is somewhat of an historical accident, and is not practical in the long run even with the larger enrollment in that State. The National Blue Cross-Blue Shield organization dropped its insistence on a separate pool about two years ago, and we think it is unlikely that another State will take a two pool approach.

Section 1 of the proposed amendment should be revised throughout to provide for one pool, all "health" insurers should be required to participate in it.

4. Section 1 of the proposed amendment should be amended to exempt the Association, and business written directly by insurers but reinsured in the Association, from the premium tax. This will help alleviate somewhat the higher premiums that Alaska residents will have to pay for the coverage (because of higher costs in Alaska) thus encouraging more people to participate in the plan. It will solve the problem of dealing with the premium tax differential between domestic and foreign insurance companies and service plans, and with the different manner in which the tax is computed for Blue Cross-Blue Shield business.

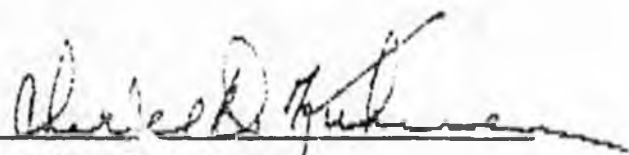
Because the program is certain to produce losses which the State will pay for (i.e., claims and other costs will exceed premiums), the State will wind up paying its own premium tax on this business anyway, so the premium tax exemption we suggest should not result in additional costs to the State.

5. Departures from the Connecticut law, other than those already mentioned, should be individually considered and, where appropriate, their effects on costs should be determined. Some examples are: applying the medical social services benefit to claims not involving terminal illness (proposed AS Sec. 21.50.020(a)(7)); addition of a coverage for transportation other than local ambulance transportation (proposed AS Sec. 21.50.020(c)(3)); omission of a coordination of benefits provision from group comprehensive plans (Conn. Ins. Law Sec. 38-374(c)); addition of household members other than spouse or child to persons who are to be covered as dependents (proposed AS Sec. 21.50.030 and .200) limiting the rate to be charged for coverage to 125% of small group rates, while Connecticut permits 125% (compare proposed AS Sec. 21.50.050(e)(4) with Connecticut insurance law Sec. 38-376(c)(3)).

6. A number of drafting corrections should be made. Examples: requiring all dependents to be covered under a group comprehensive plan, instead of just making them eligible for coverage (proposed AS Sec. 21.50.030(a)); clarifying the fact that insurers may also offer other group and individual comprehensive health insurance plans to cover Alaska residents; rewriting Section 5 of the proposed substitute bill so that it clearly does not apply to plans other than the State employees' plan.

CONCLUSIONS

The proposed committee substitute bill is not, particularly as to the provisions of Section 1, ready for final action by the Committee. An actuarial study should be made to determine costs and feasibility of the program for Alaska. After such a study, the Committee will have more of the information needed to decide whether to adopt such a program and, if so, what provisions should be included in it.


 Charles D. Muehlen
 Counsel

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 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.

AS21.50.200. 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 SSSSB 227 and require group health insurance to include coverage for 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.

Section 9 and 10 expand the state's Medicaid program to include all services 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.

Chapter 07. Medical Assistance for Needy Persons.

Section	Section
10 Purpose	60. Receipt of federal money
20 Eligible persons	70. Reimbursement for cost settled providers
30 Medical services to be provided	80. Definitions
40. State plan for provision of medical assistance	
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. (§ 1 ch 182 SLA 1972)

Sec. 47.07.020. Eligible persons. (a) All residents of the state for whom the Social Security Act requires medical 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. 7. 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 HCS CSSB 56; see 1972 House Journal, p. 1684. 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 1978)

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* Sec. 10. AS 47.07.020(d) is repealed.

* Sec. 8. 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 Services Act.



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May 7, 1980

Representative Thelma Buchholdt, Chairman
Health, Education & Social Services Committee
House of Representatives
Pouch V
Juneau, Alaska 99811

Dear *Thelma* Representative Buchholdt:

As I understand the House Committee substitute for the committee substitute for sponsor substitute for S.B. 227, the intent of this bill is to require an insurer or hospital/medical service corporation to make available in Alaska a health care plan with the comprehensive benefits outlined in this bill. An insurer would, however, be able to offer other contracts having different benefits to meet the requested coverages desired by employers and individuals in this state. This bill in no way mandates minimum coverages for all health care contracts.

In Section 21.50.020, I have several comments to make concerning some of the minimum benefits. Subsection (a)(3) concerns outpatient mental health benefits. I would hope that a maximum benefit level would be specified and that a maximum benefit would be described in this law for inpatient treatment for mental health as well. Both limits are needed to curb excessive utilization and high costs for the coverage.

Subsection (a)(6) includes home health benefits in the minimum benefits. In (6)(A) the number of visits per year is too high when you consider the limited availability of home health care in Alaska. A subscriber will be paying for a benefit which is usually not available in this state. Paragraph (6)(B) extends home health care to the terminally ill. This is usually defined as hospice services and is normally combined with the medical social services mentioned in (7). Hospice services are not available in Alaska to the best of my knowledge. This will add premium cost for services which may not be attainable.

Subsection (a)(7) adds medical social services, which are defined as being available to the patient or to his/her family. This creates a totally new category of care which may or may not be medically necessary. It is a benefit which is usually a part of home health care for the terminally ill. As a separate benefit it can be abused and can create unnecessary utilization. This benefit should be deleted.

Representative Thelma Buchholdt, Chairman

May 7, 1980

Subsection (a)(16) needs to be combined with subsection (c)(3) in order to detail a benefit for medically necessary transportation which requires pre-authorization for travel and other safeguards to eliminate abuse of this benefit. I would suggest that the contract language in your benefit booklet for coverage of state employees might serve as a model. (See enclosed booklet, pages 10-12.) The existing language would seem to approve payment of air ambulance rather than payment of commercial airline transportation.

Subsection (a)(17) must be deleted. This section allows changes in benefits which can adversely affect contracts in effect when these benefits are added. It is not necessary to the bill.

The minimum benefits section does not mention pregnancy benefits. While P.L. 95-555 controls the pregnancy benefits for groups of more than 15 employees, it does not govern smaller work forces or individual contracts. Our particular concern is in individual contracts since our experience shows that these contracts are usually purchased by persons past the age of childbirth and complete coverage of pregnancy like any other illness creates an increased premium for an unusable benefit.

On page 6, subsection (b)(5)(A) speaks of exclusion for a pre-existing condition which "first manifests itself within a period of six months immediately before the effective date of coverage." While I understand the reason for this language and approve of the intent, in actuality this creates endless hassle about what is a first manifestation and whether a person prudently sought care. It makes administration difficult. I suggest you should change the language to a limitation similar to that applying to coverage for state employees. (See enclosed booklet, page 7.)

In Section 21.50.030 the state requires that a person leaving a group will have a continuation of that same coverage for 39 weeks. That will negate the ability of an insurer to set minimum group sizes and to eliminate coverage for a group which gets to be too small. With nine months continuation, you negate the factor of size in small group business.

More important, the experience of the person on continuation coverage will have to be applied to the original group. If, for instance, John Smith quits work because his wife, a covered dependent, suffers a stroke, the claims paid for Mr. and Mrs. John Smith during the continuation coverage will be credited to Mr. Smith's previous employer. That experience will affect the rates which will be charged upon renewal of the group contract. Mr. Smith is no longer an employee, but the company incurs higher cost because of his medical bills and, in theory, subsidizes the continuation program. That is a cost that should not be borne by business, but with continuation coverage it is borne by each employer.

Representative Thelma Buchholdt, Chairman

May 7, 1980

The logistics of self-payments for continuation coverage from the terminated employee to the company and then to the insurer will also impact the administrative workload of the employer. Direct pay to the insurer cannot be handled because of the many different benefit plans which would be involved. Continuation coverage will be a big burden on businesses and an additional cost to them.

This bill specifies that all conversion insurance have the minimum comprehensive benefits outlined in this bill. That level of benefits is too extensive. It will intensify the adverse selection because only someone with a medical problem will purchase the conversion policy. The cost will be excessive and the healthy will "go bare" rather than pay a high premium.

In Sections 21.50.050 and 21.50.060 this bill recognizes the differences between commercial insurers and hospital/medical service corporations by providing an option for the latter in lieu of membership in the Health Reinsurance Association. The differences between for-profit and not-for-profit entities and the different methods used in claims payment, contractual agreements, and service to subscribers makes lumping the Blues and commercial insurers together unwise. This bill separates them while assuring that each provides his share of coverage to the poor risk market. This is a good feature of this piece of legislation.

However, in subsection (m) of Section 21.50.050 you allow a tax offset for those insurers who join the Health Reinsurance Association. The bill needs to be amended to add that offset in Section 21.50.060 (b) and (c) or the offset, of and in itself, destroys the viability of the option features of this bill.

Section 3 of this bill is the original committee's substitute for Senate Bill 227. The features of that alcoholism and drug dependence coverage differ from coverage provided under the minimum benefits for alcoholism and drug dependence. That difference may need to be resolved.

This bill will create additional requirements for insurers and for medical/hospital service corporations doing business in the state of Alaska. These requirements will increase costs.

This bill makes health care insurance available to any Alaskan. That insurance may not be affordable. The minimum benefits, patterned after Connecticut law, may be readily available in that state. Some of those benefits are not easily available in Alaska and the cost for them may be prohibitive. This bill could offer Alaskans a promise of help and, in reality, afford them no relief at all.

Sincerely,



Joan H. Gaumer, Director
Government Relations

JHG:eb
5B-10/11/12

Enclosure: State of Alaska Group Health Care & Life Insurance Benefits
(dated July 1, 1979)

cc: Wes Coyner

January 9, 1980

Thelma Buchholdt.
Pouch V
Juneau, Alaska 99811

Dear Thelma:

The following is an assessment of possible legislation in the area of state-subsidized health insurance. Two alternatives are discussed: the first calls for universal and comprehensive coverage, the second provides for a substantial improvement in health care services, but is not a comprehensive program. I would like to emphasize at the outset that the work done on this subject was done purely on my own time and does not, in any way, represent the opinions of the Alaska Public Interest Research Group.

Some form of state-subsidy in the area of health insurance has become necessary, in large part due to a nationwide problem with the availability of health care services. As medical costs spiral ever-upwards, more and more individuals are unable to procure adequate medical care. In Alaska, the problem is magnified by a limited number of physicians and substantially higher medical costs. In addition, numerous difficulties with Alaska's Medicaid system have limited the availability of health care even to those persons qualifying for state medical assistance.

Although various forms of government-subsidized health insurance have been proposed on a national level, cost considerations and intensive lobbying against such insurance by the medical and insurance communities have served to delay adoption of a national insurance plan. Subsidized health insurance on a state level was first proposed by you in 1977, however, at that time it was felt that the costs involved were prohibitive.

Since 1977, state oil revenues have accumulated in the treasury to the extent that the State of Alaska currently has a large amount of surplus revenue. Since the primary reason in the past for not funding some type of health insurance has been cost, and the state currently possesses the moneys to fund such a program, the time is now ripe to correct some of the glaring deficiencies in the area of health care.

The first approach to a solution of this problem involves universal and comprehensive state-subsidized health insurance. Adopting such coverage would be the most equitable manner of making health services available to Alaska's residents. However, this program would be extremely expensive (probably upwards of \$100 million), and could probably expect to meet with a great deal of resistance. The resistance would come not only from the extremely well-organized medical and insurance lobbies, but also from opponents of increased government services and proponents of income tax repeal. I doubt whether it is feasible to get a program of this type approved, however, you are much more aware of the political climate than am I.

The second approach, therefore, is a piecemeal solution to the health care problem. It addresses specific problems which exist in the area of health care services. It combines minimum standard benefits requirements, insurance availability to Medicaid-medically needy qualified individuals, mandatory employer sponsored coverage, and re-insurance pools.

Minimum standard benefits: There is no regulation of the levels of service covered by providers of health insurance in Alaska. Many policies are not adequate to protect those covered from financial hardship. Individuals purchasing insurance outside of a "group policy" are subject to broad exclusions for pre-existing conditions, even though such a condition may have occurred twenty years in the past (e.g. a previous back injury will give rise to an exclusion for any disease, defect or injury to the back even if totally unrelated). Many policies limit reimbursements to "reasonable charges" as defined by the insurance company, regardless of actual charges and the policy holder must pay the difference. This is especially a problem in Alaska where the "reasonable charge" determination is made in insurance company headquarters located outside the state.

In response to such problems, several states have adopted minimum standard benefits for health care plans. (see enclosed legislation). In addition, the National Association of Insurance Commissioners (NAIC) has developed model state health insurance legislation for minimum standard benefits (see 13 FORUM 680 (1978)). The standards set out the minimum acceptable level of service for health insurance policies in effect in the state.

Alaska should adopt minimum standard benefits requirements.

Insurance for Medicaid/medically needy: The Medicaid problem, in particular, must be addressed this session. Doctors are unhappy with the state's Medicaid program because they are not being paid. Recipients of state medical assistance are unhappy with the state's Medicaid program because doctors will not treat them because the doctors are not being paid. Both groups are clamoring for reform.

As an alternative to medical assistance by direct payments to providers, the state of Oregon has adopted a program (see enclosed legislation), where medical assistance funds are used to pay health insurance premiums. Thus, the state provides health insurance for defined groups of people (~~and the marginally employed~~) who have no practical access to private health care coverage.

At the same time, the state should opt in to the federal "medically needy" Medicaid program. This program would extend state medical assistance to those persons whose income exceeds the income standards of current assistance programs, but who have incurred medical expenses which equal or exceed the difference between the person's monthly income and the income standard applicable under the current program. In other words, the state would provide medical assistance to persons who otherwise would not have been eligible because they make too much money. The purpose of the "medically needy" program is to allow lower-middle-income person who can not afford to shoulder the full cost of medical care the opportunity to receive needed medical assistance. Under such a program, these individuals would "spend down" to the income limits, and the state would pick up the rest. This proposal is divisible from the rest of the insurance program discussed ~~here~~ and should be adopted even if no other aspect of my suggestions is appropriate for legislative action.

Alaska should utilize Medicaid funds to make health insurance available to qualified individuals:

Mandatory employer coverage: Hawaii has pioneered the area of requiring certain employers to carry health insurance on all employees. The specifics of their legislation ~~is~~ contained in Sharman Haley's report "Third Party Health Coverage in Alaska" and I therefore will not discuss the details here. Mandating employer sponsored coverage will close a large gap in Alaskan health care, will not involve a great deal of expense on the part of the state and will not substantially increase state bureaucracy.

Alaska should require employers to provide health insurance meeting minimum standard benefits to employees.

Reinsurance pools: At the present time in Alaska, high-risk individuals can not purchase health insurance at any price. To combat this problem and also to protect insurance companies from having to bear too great a burden in insuring such individuals, several states have developed mandatory reinsurance pools to ensure health care coverage ^{availability} for high-risk persons. (see enclosed legislation). This is a relatively inexpensive program to implement.

Alaska should require insurance companies to form reinsurance pools to protect high-risk individuals.

By combining the above four programs, the state would ensure that some form of health insurance is available to nearly all Alaskan citizens. The only ^{unemployed & the} persons left substantially unprotected are the self-employed. Although a provision could be made whereby these people could have optional health insurance with a state subsidy, this type of program would be extremely expensive. Self-employed and ^{self} self-insured persons benefit from the above described program through the minimum standard benefits requirement.

I hope my review ^{of} this issue has been of some use to you, it certainly has been of great interest to me. If there is anything further I can do, please let me know (preferably after February 28 and the traumas of the bar exam are over).

Enjoy the session!

Sincerely,

Laurie

Laurie Ctto

SUMMARY OF 1976 COMPREHENSIVE HEALTH INSURANCE ACT
Chapter 296, Minnesota Laws of 1976
Amended by Chapter 409, Minnesota Laws of 1977

Objectives

The 1976 law consists of three articles: Article I (a) establishes minimal standards for health insurance policies and (b) creates the Comprehensive Health Association which administers a "state insurance pool" for persons who are unable to buy insurance because of existing health problems. The objective of this article is to upgrade health insurance policies and to increase the availability of health insurance.

Article II establishes a hospital rate review system. This provision requires licensed hospitals to be subject to rate review by an approved voluntary, peer review organization. The Department of Health is authorized to "publicly review and comment" on the rates charged by hospitals. The objective of this article is to reduce rates charged by hospitals by monitoring those charges via a rate review system.

Article III provides financial assistance to persons who incur high medical expenses. The Catastrophic Health Expense Program is designed to protect households from being bankrupted by medical care expenses.

Summary

Article I - Minnesota Comprehensive Health Insurance Act of 1976

Part A - Minimum benefits for health insurance coverage

Duties of Insurance Companies

All health insurers doing business in the State of Minnesota are required to offer a "qualified" health policy to applicants for insurance. The article defines three levels of "qualified" plans-- number one (low), number two (standard), and number three (high). The minimum benefits of a number three plan "shall be equal to at least 80 percent of the cost of covered services in excess of an annual deductible which does not exceed \$150." The coverage shall also include a limitation of \$3000 per person on total annual out-of-pocket expenses for covered services. The maximum lifetime benefit cannot be less than \$250,000. The article also itemizes the services to be covered by the "qualified" plan. The three levels of "qualified" plans vary only in the amount of deductible required: number three - \$150; number two - \$500; and number one - \$1000. A health maintenance plan is defined as a number three qualified plan. Insurers are not prohibited from developing and selling an "unqualified" plan, however, the insurance companies must "affirmatively" offer coverage for major medical expenses to an applicant for a new "unqualified" plan. This major medical coverage shall be payable, subject to any copayment, up to a maximum lifetime limit of \$250,000 for out-of-pocket expenses incurred within a calendar year, exceeding \$5000.

Any insurance company issuing a Medicare supplement plan shall offer a "qualified" Medicare supplement plan to each eligible applicant. A plan is deemed "qualified" if it provides coverage of 50 percent of the deductible and copayment required under Medicare and 80 percent of the charges for "qualified plan" covered services which are not paid by Medicare. This plan includes a \$1000 per person limit on annual out-of-pocket expenses.

* Note: As of July 1, 1979, covered services must include a second opinion on surgical procedures expected to cost a total of \$500 or more.

Duties of Employers

Each employer who makes available to his employees a health insurance plan must offer at least a number two plan. The employer does not necessarily have to finance the qualified plan. It can be financed from funds contributed solely by the employer or solely by the employees; or a combination thereof. For the purposes of this article, an employer is defined as employing ten or more residents of the state. The employer may supplement the existing health plan in order to meet the number two plan requirement.

The penalty for noncompliance is the exclusion of the employer's costs for health benefits as a state income deduction. A non-profit employer would lose its tax exempt status if the requirement is not met.

Any employer with 100 or more employees must offer a dual option to obtain either an accident and health insurance policy or a health maintenance organization contract, if one is available.

Conversion Privileges

The law requires group accident and health insurance policies and health maintenance organization contracts to include the right to convert to an individual coverage "qualified" plan without the addition of underwriting restrictions. The person leaving the group has 30 days in which to exercise his right to convert.

Each health insurance plan must also include a provision allowing, upon the death of an insurance holder, other individuals covered under the plan to continue coverage.

Part B - Comprehensive Health Insurance Plan

Article I also creates the Comprehensive Health Association which must offer policies which provide the benefits of a number one qualified plan, a number two qualified plan, and a qualified Medicare supplement plan to individuals who cannot otherwise obtain standard insurance coverage because of health problems. The Association is comprised of all insurers, self insurers, fraternal, and health maintenance organizations doing business in Minnesota. These policies are referred to as the Comprehensive Health Insurance Plan or State Plan.

Comprehensive Health Insurance Plan

The Comprehensive Health Association is responsible for selecting a writing carrier to administer the Comprehensive Health Insurance Plan. The Association may select separate writing carriers for each type of "qualified" plan.

The state plan is open for enrollment at all times. An eligible person may apply to the Association or to the writing carrier. For the first 18 months of the plan's operation, premiums were determined by averaging the premium rates charged by the five largest insurers in each plan category. Subsequent premium determination will be based on actuarial experience. Not more than 12.5% of the premiums may be expended by the writing carrier for administration costs.

Each member of the Association is responsible for sharing the losses due to claim expenses of the state plan. Members shall share those costs on a pro-rated basis, determined as a ratio of premiums received by a member to the total amount of total premiums received by the Association members.

If there are any net gains from the operation of the state plan, it shall be used to offset future losses or reduce premiums.

Public Education

The Association is responsible for disseminating information to the public regarding the availability of the state plan.

Referral Fee

The writing carrier shall pay an agent's referral fee of \$25 to each agent who refers an applicant to the state plan. This fee is included in the 12.5% administration expense limit.

Pre-Existing Condition Clause

An enrollee of the state plan is not covered for any pre-existing condition during the first six months of coverage if the condition was diagnosed or treated within 90 days prior to the filing of an application.

Reinsurance

A member of the Association may elect to reinsure the risks involved with being required to offer (a) individual qualified plans, (b) group conversions, (c) group qualified plans with fewer than 50 members, or (d) major medical coverage. The member would be reinsured through the Association. The Association administers the policies that are reinsured by a member. Any income in excess of the costs incurred for providing the reinsurance service shall be used to offset losses in the state plan or reduce the premiums.

Article II - Hospital Administration Act

Article II establishes a system by which hospital rates are reviewed. A licensed hospital may agree to submit its financial reports and rate schedules to a voluntary, non-profit rate review organization

for review. If the hospital does not report to this rate review organization, it will be subject to review by the Department of Health, the administrative agency for this act.

The Department of Health shall prescribe standards for purposes of approving a rate review organization. The Department is authorized to collect financial information which includes (a) a balance sheet, (b) a statement of income and expenses, (c) a copy of the most recent Medicare cost report, and (d) a schedule of rates. The Department also has the right to inspect hospital records and audits. Any modifications to a hospital's rate schedule must be reported to the Department of Health 60 days in advance of their effective date. If a hospital is subject to review by the Department of Health, the Department may conduct a public hearing on any rate increases which they consider excessive and may publicly comment on any increase.

Insurance Rates

This article also requires actuarial justification of any premium increase for a nongroup policy at the time of filing the insurance plan with the Commissioner of Insurance.

Another provision directs the Commissioner of Insurance to disapprove a filed health plan "if the proposed premium rate is excessive because the insurer has failed to exercise reasonable cost control."

Article III - Catastrophic Health Expense Protection Act

This program offers financial relief to households which incur large medical expenses. The state will pay for 90% of "qualified" expenses, for which no third party is liable, in excess of a threshold figure which is calculated by an income-related formula. "Qualified" expenses are those charges for covered services itemized as minimum benefits in the Comprehensive Health Insurance Act (Article I).

The above mentioned formula is as follows: (a) calculate 40% of household income up to \$15,000, plus 50% of household income up to \$25,000, plus 60% of household income in excess of \$25,000; or, (b) \$2,500, whichever is greater. If, for example, the household income is \$10,000 the threshold figure is \$4000. In this case the state would pay 90% of "qualified" expenses in excess of \$4000.

Nursing Home Provision

The 1977 Legislature amended the Catastrophic Act to provide assistance to persons under the age of 65 who have resided in a nursing home for more than three years. The state will pay for all nursing home expenses which exceed 20% of household income.

Reasonableness of Rates

The Commissioner of Public Welfare is granted the authority to determine the reasonableness of provider charges. The Commissioner may also determine the "medical necessity" of a health service. In order to carry out that authority, the Commissioner may contract with a professional standard review organization to make these determinations.

Experience

Article I - Comprehensive Health Insurance Plan

The state plan went into effect on January 1, 1977. As of June 30, 1978, the plan had 1,074 policies in force. The total premiums earned for the first 18 months of the plan's operation was \$441,107.73. As indicated earlier, the premium rate for this time period was based on the average of premiums charged by the five largest insurers in each category. The total claims paid for this period is \$392,412.93. A reserve for incurred but not reported claims has been set at \$220,000.

The 1978 State Legislature appropriated \$200,000 to reimburse the Comprehensive Health Association for the first \$200,000 of claims expenses incurred after June 30, 1978 which are in excess of earned premiums. The premium will be determined by generally accepted actuarial principles subsequent to June 30, 1978 except that the new premium rate cannot exceed 125% of the average premium charged by the five largest insurers in each policy category. This premium limit was enacted by the 1978 Legislature.

Article II - Hospital Administration Act

All licensed hospitals have opted to be subject to review by a voluntary, non-profit rate review organization. This is the peer review organization of the Minnesota Hospital Association. It is estimated that if the hospitals comply to the proposed budgets developed through rate review the increase in hospital charges will be between 10% to 11% compared to an historical increase of nearly 14% per year.

Article III - Catastrophic Health Expense Protection Act

This Article went into effect July 1, 1977. Eighteen million dollars was appropriated for the biennium 1978-1979 for the medical care portion of the program. \$900,000 was appropriated for the nursing home section. To date there have been 148 approved applications for the medical care program for an expenditure of \$441,299. For fiscal year 1978, twelve applications were approved for the nursing home expense program, totaling \$55,323.65.

Georgetown University Health Policy Center
Seminar on State Health Insurance Plans
Mayflower Hotel, Washington, D.C.

September, 1977

THE POLITICAL PLANNING OF A STATE
HEALTH INSURANCE PROGRAM

By Senator Donald D. H. Ching
Majority Leader
Hawaii State Senate

The concept of prepaid health care based on mandatory employment-related coverage was a brand new idea when first introduced in the Hawaii Legislature in 1971. It became law three years later as Act 210 of the 1974 legislative session.

Enactment of our Prepaid Health Care Law climaxed several years of lively discussion in the Legislature, and for many of us who supported it, Act 210 marked yet another milestone in the growing body of progressive legislation placed in our statutes since our Islands became a sovereign state in 1959.

Measured against the national background, the law represented a significant achievement in terms of social progress. Yet, while there was much discussion between introduction and enactment, the proposal was not widely viewed as politically controversial by the public at large. As a matter of fact, in my nearly 20 years of experience in our Legislature, I have seen a lot more heat generated over issues of considerably lesser public import.

To be sure, there was resistance and opposition from the traditional opponents of so-called "social legislation." But there was not the hue and cry that one might expect, considering the novelty of the concept.

This is not to say that the spectrum of political thought in Hawaii does not cover any ground to the right of center. Let me assure you we do have traditional conservative views held by many in our State, and I, for one, believe this is a healthy condition. But to the credit of those who did not adhere to the concept, their opposition was not based on the emotionalism that too often attends and distorts vital public issues of the day.

I believe the law was generally accepted by the public because of the kind of political climate we have in Hawaii and because the law was viewed as a logical extension of the kinds of programs that were already in effect at the time.

Let me briefly describe our Prepaid Health Care Law, then attempt to present an account of its chronological place in the context of Hawaii's legislative history.

The Act requires virtually every employer in the State to provide regular employees a health insurance program and to contribute at least one-half the premium cost for the employees' coverage. The major categories of employees excluded are insurance and real estate salesmen paid entirely by commissions and individuals under 21 working under a parental relationship.

The employee's contribution is limited to no more than 1.5 per cent of his monthly salary. A "regular" employee is defined as one who works at least 20 hours a week, excepting seasonal hires in Hawaii's pineapple industry.

Health plans negotiated under collective bargaining agreements are exempt because such negotiated benefits are, for the most part, more liberal in coverage or employer contributions than required under the Act.

An employer can elect to provide a plan which obligates the insurer to either reimburse the expenses of health care or to directly furnish the required health care benefits. The level of benefits provided must be equal to or medically reasonably substitutable for those benefits provided by pre-paid health care plans of each type -- direct or reimbursed -- which has the largest number of subscribers in the State. In Hawaii, the standards are thus based on the Kaiser Health Foundation's Plan I, in the case of direct services, and the Hawaii Medical Service Association's (Blue Shield) Plan IV, in the case of reimbursed expenses. Both the Kaiser and HMSA plans are basic, comprehensive medical plans emphasizing ambulatory care.

Plans offered by other insurers may be provided, upon review and approval of a seven-member advisory council comprised of consumer, employer, medical profession, and health plan representatives.

What kind of coverage is required by our law? Every qualifying plan must include the following:

- 120 days of hospital benefits, plus outpatient services.
- surgical benefits, including anesthesiologist services.
- medical services, including home, office, hospital visits, and intensive medical care.
- laboratory, x-ray, and radio-therapeutic services necessary for diagnosis and treatment.
- maternity benefits, provided an employee has been covered for nine months prior to childbirth.
- and, under an amendment added last year, substance abuse benefits for alcoholism and drug addiction, including outpatient services and detoxification and acute care benefits.

The foregoing summarizes the basic provisions of our law.

How, then, did we come to enact what some may view as an extremely liberal mandatory health insurance program?

First, it should be noted that we have a substantial body of progressive and advanced social legislation in Hawaii. This is true of our labor laws, our educational system, our public welfare program, and in our judicial system. For instance, our minimum wage law, wage and hour law, workers' compensation, temporary disability insurance, and unemployment insurance programs all have standards comparable to the highest in the Nation. In addition, we also have a public defender program and a criminal injuries compensation law. We also have a no-fault insurance law and a medical malpractice law, the latter amended this year to remove the mandatory feature and to permit doctors the option of forming cooperative indemnity plans to protect themselves against liability judgments.

Our public assistance program is so liberal it is causing us severe financial strains -- but that's another story, and I won't digress into it, except to note that we eagerly look forward to federal reform initiatives promised by the Carter Administration.

The political foundation for eventual enactment of our prepaid health care law was further set during the mid-sixties in a program popularly labeled "The New Hawaii," adopted jointly by the legislative majorities and the Administration.

During this period, dramatic changes were advanced in terms of Hawaii's social, economic, and political conditions. Basically, the stated objective was to enact laws and programs to insure equal treatment and equal opportunities for all citizens. If this sounds simplistic, it should be borne in mind that Hawaii was pretty much the political domain of the sugar and pineapple plantation interests up until the end of World War II and that when, for the first time in our history, we elected a Democratic Governor and Democratic majorities in both houses of the State Legislature in 1962, there were not a few who thought the revolution was at hand.

But the changes we sought were achieved in orderly, not revolutionary, fashion. And there was early ferment for novel and innovative legislation to extend equal opportunity in basic human concerns to all segments of our society.

It appeared logical to move toward some form of mandatory prepaid health care law. The question then was how best to extend coverage to the uninsured working men and women

of Hawaii and thereby provide them "equal treatment" as a matter of social equity. Moreover, how could this be best achieved without any substantial added costs to the State, bearing in mind that our centralized system imposes unusually heavy financial burdens on the State?

To determine cost factors and the numbers and classes of employees in the uncovered "gap group," a study was commissioned through the Legislative Reference Bureau, the Legislature's principal research arm. Dr. Stefan A. Riesenfeld, former University of California law professor and a widely recognized authority on social legislation, now counsel to the U.S. State Department, was selected to do the research. Professor Riesenfeld had prepared an earlier report for the Legislature on temporary disability insurance, which study was extremely valuable to us in enacting our TDI law in 1969.

The Riesenfeld report, published in 1971, was a thorough and comprehensive study. Acknowledging the difficulty of precisely quantifying need, the report generally concluded that, among the State's employed, 11.7 per cent did not have hospital coverage, 13.5 per cent lacked surgical coverage, and 17.2 per cent did not have regular medical insurance.

The existence of a significant number of otherwise uncovered potential beneficiaries of the proposed legislation formed the primary policy consideration of the program. Other factors considered included the rising costs of health care and the need to assure the most practical method of ensuring the financial availability of health care for Hawaii's working men and women. Thus, the overall health of our population was the over-riding concern; without ensuring the

ready accessibility of health care, how could optimum health care be maintained?

Data compiled and analyzed in the report were very thorough. Sources outside the State included the Health Insurance Association of America, the Health Insurance Institute, the Bureau of Labor Statistics, the Social Security Administration, and the Bureau of the Census. Information from State agencies included data from the State Statistician and the Departments of Taxation, Planning and Economic Development, Social Services and Housing, and Labor and Industrial Relations. Data was also gathered from labor unions, the Hawaii Employers Council, the HMSA, Kaiser Foundation, and through questionnaires mailed to all employers covered by the Hawaii Employment Security Law.

Data used included statistics relative to the following:

-- Population by age levels, civilian and military.

The latter distinction was important because of the sizeable permanent military presence in Hawaii.

-- Labor force, public and private.

-- Population entitled to Medicare.

-- Extent of prepaid health plan coverage for hospital, surgical, and medical benefits, both for subscribers and dependents.

-- Size and type of business of private employers.

-- Medical assistance recipients and expenditures.

As indicated by the sources of data, the full range of interest groups became involved in the process, whether employer or employee oriented.

During our legislative committee hearings, testimony was presented by representatives of the insurance industry, the health professions, the University of Hawaii Schools of Public Health and Social Work, the Comprehensive Health Planning Council, and a wide range of individual citizens.

There was very little question as to whether the plan proposed would be comprehensive or catastrophic in its approach. The Riesenfeld report recommended the comprehensive coverage plan and specifically recommended the adoption of prevailing coverages in the State, which then became the legal minimum. This reflected the health care habits and patterns of the State and set a floor without unduly disrupting the existing schedules of coverage.

The decision to make coverage mandatory was central to the legislation proposed. Before enactment of Act 210, voluntary participation was, in effect, the public policy of the State.

As to the question of affordability, the only new cost factors imposed upon the State were founded upon the administrative requirements of the law and anticipated premium supplementation.

Administration of the new program proved to be quite easy, as it was smoothly meshed in as a responsibility of the Disability Compensation Division of the State's Department of Labor and Industrial Relations. Thus, three important employee benefits programs were placed under one umbrella: the well-established Worker's Compensation Law; the TDI law passed in 1969; and the 1974 Prepaid Health Care Act. (Incidentally,

you may have noticed that what used to be known as Workmen's Compensation is now referred to as Workers' Compensation in our State, reflecting the many similar amendments we have adopted consonant to our accepted policy on equal rights.)

Much to our pleasant surprise, the administrative expenses of Act 210 have been comparatively low. Initially, we authorized 11 new positions in the Disability Compensation Division, with an appropriation of \$250,000 in General Funds to cover salaries and other expenses. Much to the division's credit, Act 210 was implemented with substantially the existing staff. The first appropriation thus lapsed, and it was renewed this year at the same annual level on the expectation that additional personnel will be recruited during the next biennium.

A feature of Act 210 is a provision for premium supplementation financed by the State to cover employer premium requirements caused by limits imposed on employee contributions. This feature subsidizing employer contributions was included to provide a cost protection for marginal small businesses. Initially, \$375,000 was set aside in a trust fund for premium supplementation. Again, to our pleasant surprise, there has been little need to supplement premiums. It's estimated that, to date, only some \$20,000 to \$30,000 has been tapped from the trust fund in subsidies. Meanwhile, the fund is held in an interest-earning status.

What are the numbers that actually surfaced as a consequence of Act 210? The division reports that about 18,500 employers have thus far been registered. However, the extent

of newly covered workers has been difficult to establish because many of the registered employers had voluntary programs in effect before Act 210. Dr. Riesenfeld has estimated some 40,000 employees were not covered at the time he conducted his study. The Disability Compensation Division is of the opinion that actually more than 40,000 received new benefits because of the requirement that employers cover at least half of the premium costs.

Of the 18,500 employers, all but some 1,000 have elected plans offered by the State's two major insurers -- HMSA and Kaiser. The approximately 1,000 employers who have opted for plans offered by other insurers are the major source of additional workload upon the division. Each submittal in this category must be reviewed by the advisory council.

The advisory council provision serves another purpose. During the course of legislative hearings on the act, public health advocates had expressed concern that the required benefits might be too rigid and unresponsive to changes in health care over the years. The Prepaid Health Care Advisory Council provisions were thus added to establish an appropriate agent to review medical equivalency of benefits.

To conclude, in light of Hawaii's experience, I believe any national health insurance plan should take into consideration the course that we have opted for. I am confident the standards we have set would meet any that a federal law would impose. As a means of encouraging other states to follow suit, or to adopt a true state plan such as Rhode Island's,

I suggest federal legislation provide support grants to at least cover administrative costs and any necessary premium supplementation expenses.

Finally, let me summarize the conditions that led to the successful adoption and implementation of Hawaii's Prepaid Health Care Act:

1 -- A political climate sympathetic to social needs.

2 -- Timeliness in terms of progressive improvements to the general body of social legislation already on the books.

3 -- A comprehensive study of a state's needs, to arm proponents with the information necessary to justify the proposed legislation.

4 -- Open discussion involving all interested elements within the public.

5 -- The last may be an element not very common to other jurisdictions, but I believe it was an important consideration in our own deliberations. This is the fact, well established in our study, that the majority of employees insured under voluntary plans or through government-employee programs were covered under plans offered by two major insurers in the State. Having a clear pattern to follow in prevailing benefits, it was easier to overcome resistance against extending similar benefits to all the State's working men and women.

I hope our experience and the foregoing thoughts presented for your discussion prove helpful to you in your own endeavors to develop plans for extending health care benefits to all others who need such coverage in our Nation.

Mahalo.

#

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF DEPUTY COMMISSIONER

ROOM 214 MACKAY BUILDING
338 DENALI STREET
ANCHORAGE 99501

REPORT AND RECORD OF CONFERENCE

Region X - Department of Health, Education and Welfare
Federal Office Complex Seattle, Washington

Tuesday, October 30, 1979

Present: Mike Street; Ed Ross; Jim Van Hoomison; Boyd Kelley, Health Care Finance Administration; Bill Knestes, Indian Health Service; Mr. Moerlin, Health Research; Frederick McGinnis, Alaska Department of Health and Social Services.

Tentative agenda for the conference was distributed and accepted as the working program for the conference this date as follows:

Tentative Agenda

- I. Review developments to date on Model Health Plan for Alaska
- II. Review of discussions: Center for Health Services Research, University of Washington, on October 29, 1979. Discussion of report on that conference.
- III. Federal questions: Region X and Washington, D.C.
 - A. Waiver possibility: Title XIX, Medicaid funding, for Experimental Program in a State.
 - B. Technical Assistance Potential--
Region X
Washington, D.C.
 - C. Grant Fund Assistance: H.E.W.
- IV. Conferees: Recommended: H.E.W., Washington, D.C. Week of November 1 - 7, 1979.
- V. Other

Full discussions were held on a part of the outline of topics and points raised in the discussions of October 29, 1979, with representatives of the Center for Health Services Research, School of Public Health and Community Medicine, University of Washington, as follows:

A complete discussion transpired with regard to:

- Alaska Medicaid Program and costs;
- Alaska General Relief Medical Program and costs;
- Indian Health Service Delivery System in Alaska/
Medicaid Reimbursement policies;
- Alaska Catastrophic Illness Program;
- Alaska Military Health Programs;
- Private insurance coverages in Alaska;
- Other related topics bearing on current status
of Alaska health programs.

McGinnis indicated his views of some of the important next steps in developing the anticipated program:

- (1) Developing a Planning Task Force;
- (2) Providing an Advisory Body;
- (3) Creation of small staff and Director;
- (4) Developing of Data Gathering and Research Projects:

- *Survey/Gathering of published data from all sources bearing on related areas of concern;

- *Determination of current total costs in current plan of health services delivery:

- Department of Health & Social Services;
- Indian Health Services;
- Military forces;
- Veterans Administration;
- Native Health Corporations;
- Private insurance premiums and payments on plans;
- Labor insurance plans;
- Private insurance plans;
- Other identifiable costs;
- Federal Government/other.

- *Determination of gaps in data needed;

- *Provide for research needed to meet data needs on expenditures of health funds in Alaska;

*Provide for research to determine number of citizens without adequate health services; estimate costs of providing needed services under agreed-upon options available.

*Synthesis and interpretation of all data on hand and provided through special research tasks;

*Other research components determined necessary as planning gets underway and new needs develop.

(5) Determination of human/personnel and financial resources available from all sources to finance the project of planning:

*Within Health and Social Services Department/
State of Alaska;

1979 Fiscal Year:

Divisions related to health; State Health Planning Agency; Governor's Policy/ Planning Budget; Governor's Contingency Fund.

*Center for Health Services Research
University of Washington

*Institute of Social/Government Research
University of Alaska

*Possible Demonstration Grants/ Department of Health, Education and Welfare

*Alaska Legislative Appropriation

1980 Fiscal (Supplemental) Year
1981 Fiscal Year

*Private Foundation Grant(s) and other private sources

*Other sources

(6) Preparation of Budget identifying available manpower and funds for 1980 fiscal year and 1981 fiscal year.

(7) Other tasks to be developed and assigned as necessary as project develops.

- (8) Determination of technical assistance needs in economics, statistics, planning, accounting, legal and other assistance, and provision for securing needed assistance, including professional services contracts as deemed necessary.

The basic information shared with the Alaska State Health Coordinating Council and Governor Hammond in memoranda of August 3, 1978 and September 18, 1979 was discussed. The conferees had copies earlier of the information in the SHCC memorandum.

In general, the Region X conferees felt that the project was worthy of development and the following points were discussed:

1. The need to determine and state exactly the goals sought in the project. This will be especially important in presenting the project to H.E.W.
2. Recommendations were made to try to contact two officials of HEW in Washington on the forthcoming visit November 1 - 6, if possible; if not possible on this visit to Washington, then in the near future:

Mr. Ron Carlson, Park Law Building,
Rockville, Maryland,

and

Mr. Dale Serwer, Baltimore, Maryland.

Discussions with those men should include funding possibilities and also what they would like to see Alaska demonstrate.

3. Oregon has submitted a "Concept Paper" to Region X expressing the need and desire of that state to reorganize their health funding and programming. Mike Street will attempt to get a copy and will mail to McGinnis when received. (Note: If not received in two weeks, then Alaska should contact Oregon to secure a copy of the concept paper.)
4. It was generally agreed that assistance from the University of Washington Center for Health Services Research would likely be available through a contract with that Center for specific component(s) of the project. Desirability of competitive bidding of any contracts was discussed.

5. The working group formed for the project should give priority to writing of clear specifications of "scope of work" needed and such should be presented to all chosen to present proposals.
6. Mike Street indicated that Region X would determine the best single contact person to represent Region X in keeping in touch with progress on the project. A prospectus should be prepared on the exact services needed from contractors when that information is needed.

General summary comments were made as the conference adjourned with the understanding that the State and Region X would keep in contact on the project.

FMcG/mag

cc for information:

Commissioner Helen D. Beirne
Deputy Commissioner Allen K. Korhonen
Deputy Commissioner Catherine M. Lloyd
State Health Planning & Development Agency
Karen Cory, Governor's Office, Juneau
Fran Ulmer, Governor's Office, Juneau

TO: [The Honorable Terry Miller
Lieutenant Governor
State of Alaska

DATE: September 21, 1979

FILE NO:

TELEPHONE NO: 465-3030

FROM: *Helen D. Beirne*
Helen D. Beirne, Commissioner
Dept. Health & Social Services

SUBJECT: MODEL HEALTH DELIVERY
PROGRAM FOR ALASKA

You will recall that recently Deputy Commissioner McGinnis and I met with you in order to brief you as to developments to that time on the discussions regarding a model health delivery program for Alaska. We appreciate the time that you gave us to discuss the matter.

A memorandum was developed on September 18, 1979, from me to Governor Hammond. A copy of that summary memorandum is attached in order to share with you the latest developments in the Department's thinking regarding the proposed program.

At a meeting on September 19 in Governor Hammond's office, attended by Deputy Commissioner McGinnis, Jerry Reinwand, Karen Corey, Fran Ulmer and myself, the attached memorandum, having been read by the parties, was discussed.

At the conclusion of the conference, Governor Hammond did indicate to all of us that he had signed his approval to the recommendation made at the end of the memorandum. It will be the Department's plan to proceed with further exploration of the concept and we will plan to keep you informed, as well as others in the Governor's Office. Any comments or recommendations you may have with regard to this proposed program would be welcomed by the Department.


Attachment: Memo, 9/18/79, as indicated

TO: [Helen D. Beirne, Commissioner
Dept. Health & Social Services

DATE: November 5, 1979

FILE NO.

TELEPHONE NO.

FROM: Frederick McGinnis 
Deputy Commissioner
Dept. Health & Social Services

SUBJECT: Briefing Memorandum re Conference
in Washington, D.C. with Lt. Gov.
Terry Miller; Administrative
Assistant to the Lt. Gov. Pete
Rouse; and William Fullerton of
the Firm of Health Policies
Alternatives, Inc.

As you may remember, Lt. Gov. Terry Miller mentioned earlier his discussions in Washington, D.C. on a prior visit with Mr. William Fullerton of Health Policies Alternatives, Inc., with regard to Alaska's interest in developing a model health financing plan. You may recall also that Lt. Gov. Miller raised the question informally at a meeting with me and with Pete Rouse in the Governor's Office in Anchorage with regard to whether it might be possible to advance one part of our proposed programming for model programs to improve the catastrophic illness insurance program earlier.

In order to keep you abreast of later developments, at the request of Lt. Gov. Miller I met with him, Mr. Rouse and Mr. William Fullerton in Washington at the place of the Federal Health Policies Conference on Friday afternoon, November 2, at 2 PM. At that meeting, Alaska's plan to do a major study on alternatives in health financing programs was discussed.

No commitments were made to Mr. Fullerton and the following points were made by Lt. Gov. Miller.

1. The Lt. Gov. will discuss with Governor Hammond the possibility of a liberalized catastrophic illness program to assist people of middle to lower incomes who are above the poverty level income and therefore not eligible for relief programs (Medicaid, General Relief Medical).
2. Lt. Gov. Miller felt that the initiative for the short-range program, as well as the long-range program, should rest with the State Department of Health and Social Services.
3. Lt. Gov. Miller will brief Governor Hammond on his interest in improving the catastrophic illness assistance to a newly-defined group of Alaskans. It was understood that Deputy Commissioner McGinnis would brief Commissioner Beirne on these discussions in order that she may be fully aware at each step of the discussions.

November 5, 1979

4. Lt. Gov. Miller suggested that it might be well if the Governor's Office sponsored a small working party named by the Governor, including the Department of Health and Social Services as lead agency, the Department of Labor, the Department of Commerce (Insurance Division), and the Department of Law for legal counsel, to give guidance to developing some plan for the Governor to present to the Legislature at the forthcoming session.

Mr. McGinnis suggested that if the Fullerton firm should become involved in helping to do any of the research on the short-term or long-range project, it would be necessary for a Request for Proposal to be developed and that equal access to all information concerning Alaska's plan be made to at least three firms who may be interested in providing the professional assistance. It was also indicated that financial resources would have to be found for the additional research in order for either the short-term catastrophic illness program, as well as the longer range, fully innovated program anticipated.

It was indicated that Deputy Commissioner McGinnis would meet again with Mr. Fullerton on Monday afternoon, November 5, which conference did take place, and Mr. Fullerton made available certain materials from his firm as to their experience, which will be made available to you by mail.

Attached is a list of items that I believe the State Health Planning and Development Agency should begin assembling, with at least six copies of all the materials, as soon as possible in order that these materials may be made available to any firm considered as professional consultants to this short-range program, as well as the long-range problem.

I will be glad upon return to Alaska to comment further if you wish on the matters summarized ever so briefly in this briefing memorandum.

FMcG/mag
Attachment, as indicated above

ITEMS THAT THE STATE HEALTH PLANNING AND DEVELOPMENT AGENCY
SHOULD ASSEMBLE IN CONNECTION WITH MODEL HEALTH DELIVERY PROJECT

1. General demographic information on the Alaskan population-- income, age cohorts, cost of living, rates of inflation, family formation, birth rates, etc.
2. Medicaid Plan--plus all recent statistical data: eligibility, benefits by claim expenditures, administrative costs, etc.
3. Description of existing catastrophic plan, plus all recent statistical information on eligibles, payments and benefits.
4. Statistics on existing health insurance coverage--by plan, numbers of insured (any evidence of overlap?), government employee plan (federal, state and local), benefits covered, major medical or catastrophic provisions).
5. State Health Plan (under health planning law, plus statistical information on kinds, numbers and locations of all classes of health care providers.
6. Alaska Medicaid laws and regulations.
7. General Relief Medical laws and regulations.
8. Catastrophic Illness laws and regulations.
9. Department of Health and Social Services and Indian Health Services Memorandum of Agreement on Medicaid.
10. Any other related information deemed by SHPDA to be important to understand the clear status of health programs in Alaska today.

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF DEPUTY COMMISSIONER

ROOM 214 MacKAY BUILDING
338 DENALI STREET
ANCHORAGE 99501

REPORT AND RECORD OF CONFERENCE

Center for Health Services Research
School of Public Health and Community Medicine

University of Washington

Seattle

Monday, October 29, 1979

Present: Mr. Marc E. Provence, M.P.H. (HMO)
Ms. Shirley McEvoy, Research Assistant
Frederick McGinnis, Deputy Commissioner

The meeting between the above listed individuals began at 10:30 a.m. and concluded during early afternoon.

Mr. McGinnis outlined developments to date on the Alaska Model Health Program and reviewed earlier meetings with groups including the meeting with Dr. Stephen H. Shortell, Director of the Center, Ira Moscovic, Andy Dolan and Laura Beth Lawson last year, when the idea of a revised health plan for Alaska was first being discussed.

Copies of the Department memorandum dated August 2, 1978 to the Alaska State Health Coordinating Council and September 18, 1979 to Governor Jay S. Hammond were discussed as background papers to indicate the present thinking of Department leadership.

A complete discussion transpired with regard to:

- Alaska Medicaid Program and costs;
- Alaska General Relief Medical Program and costs;
- Indian Health Service Delivery System in Alaska/
Medicaid Reimbursement policies;
- Alaska Catastrophic Illness Program;
- Alaska Military Health Programs;
- Private insurance coverages in Alaska;
- Other related topics bearing on current
status of Alaska health programs.

McGinnis indicated his views of some of the important next steps in developing the anticipated program:

- (1) Developing a Planning Task Force;
- (2) Providing an Advisory Body;
- (3) Creation of small staff and Director;
- (4) Development of Data Gathering and Research Projects:

*Survey/Gathering of published data from all sources bearing on related areas of concern;

*Determination of current total costs in current Plan of health services delivery:

Department of Health & Social Services;
Indian Health Services;
Military forces;
Veterans Administration;
Native Health Corporations;
Private insurance premiums & payments on plans;
Labor insurance plans;
Private insurance plans;
Other identifiable costs;
Federal government/other.

*Determination of gaps in data needed;

*Provide for research needed to meet data needs on expenditures of health funds in Alaska;

*Provide for research to determine number of citizens without adequate health services; estimate costs of providing needed services under agreed upon options available;

*Synthesis and interpretation of all data on hand and provided through special research tasks;

*Other research components determined necessary as planning gets underway and new needs develop.

- (5) Determination of human/personnel and financial resources available from all sources to finance the project of planning:

*Within Health and Social Services Department/
State of Alaska;

1979 Fiscal Year:

Divisions related to health;
State Health Planning Agency;
Governor's Policy/Planning Budget;
Governor's Contingency Fund.

*Center for Health Services Research
University of Washington

*Institute of Social/Government Research
University of Alaska

*Possible Demonstration Grants/
Department of Health, Education & Welfare

*Alaska Legislative Appropriation
1980 Fiscal (Supplemental Year)
1981 Fiscal Year

*Private Foundation Grant(s) and other
private sources

*Other sources

- (6) Preparation of budget identifying available manpower and funds for 1980 fiscal year and 1981 fiscal year.
- (7) Other tasks to be developed and assigned as necessary as project develops.
- (8) Determination of technical assistance needs in economics, statistics, planning, accounting, legal and other assistance and provision for securing needed assistance, including professional services contracts as deemed necessary.

Earlier, Dr. Shortell had indicated to the State of Alaska that possible assistance which might be arranged through the Center for Health Research included:

Informal counsel and assistance;
Guidance reviews;
Contracts for defined components of work;
Assistance in planning evaluation;
Systems design, policy formulation.

Mr. Provence and Ms. McEvoy restated some of the above listed points during the meeting, emphasizing the possibility of specific contracts for specific components of the necessary work. It was indicated that beyond the expertise available in the Center for Health Services Research the Center has access to many sources of expertise within the University of Washington which could be called on for participation.

It was agreed at the conclusion of the meeting that:

- * Discussions would be held with Dr. Shortell, Director, on his return to Seattle and a report made of today's discussion.
- * A careful review of the two memoranda referred to herein earlier and the concepts contained therein would be discussed in staff.
- * Following the above steps they will prepare a letter to the Department with their observations and comments. Included in the comments will be a review and listings of the Center's potential involvement in the project and the bases (financial, personnel and otherwise) of such participation.

Following the outline of the conclusions and summaries listed above, the meeting was adjourned.

Frederick McGinnis
Deputy Commissioner

cc for information:

Commissioner Helen D. Beirne
Deputy Commissioner Allen K. Korhonen
Deputy Commissioner Catherine M. Lloyd
✓ State Health Planning & Development Agency
Karen Cory, Governor's Office, Juneau
Fran Ulmer, Governor's Office, Juneau

Karen Cory, Special Assistant
Office of the Governor
and
TO: Fran Ulmer, Director
Division of Policy Development
and Planning
Office of the Governor
DATE: November 5, 1979
FILE NO:
TELEPHONE NO: 465-3030

FROM: *Helen D. Beirne*
Helen D. Beirne, Commissioner
Dept. Health & Social Services
SUBJECT: Model Health Delivery
System for Alaska

As you will note from the enclosed material, the Department of Health and Social Services is moving rapidly ahead on a comprehensive study of a model health delivery system for Alaska. The Department's coordinator of this study is Deputy Commissioner Frederick McGinnis. As you are aware, Dr. McGinnis, who is at present located in Anchorage with a logistic responsibility for the Southcentral area, has had significant experience in the field of health and social services. His interest in the present topic dates back to when he served as the Commissioner of the Department of Health and Social Services for a period of four years. It could be stated that he has a greater depth of knowledge in this particular area than any other person in the state.

Deputy Commissioner McGinnis and I have met with Governor Hammond on two occasions and have received his concurrence that we should proceed on this matter as rapidly and thoroughly as possible with frequent informational and directional contacts with the Governor's Office.

In this packet you will find Dr. McGinnis' briefing memorandum regarding his conference in Washington, D.C., with Lieutenant Governor Terry Miller, which is their second meeting since the Governor's concurrence with the project. Also included are reports and records of the conferences he has recently attended to supplement our knowledge of model health delivery systems, to test the interest of those agencies with whom we must coordinate, and to determine from where assistance for such a program may come.

These reports, and those to follow, will express to you the Department's intense and dedicated interest in establishing a health delivery system for Alaska that will address the health and medical needs of all Alaskans in the most cost effective manner possible.

From this date on, and to expedite this study, Deputy Commissioner McGinnis will be copying you simultaneously with the Commissioner's Office as we move to a resolution of one of the state's most pressing problems in conjunction with the Governor's Office.

HDB/mag
Enclosures, as indicated above
cc: Governor Hammond
✓ Lieutenant Governor Miller

10. [Honorable Jay S. Hammond
Governor
State of Alaska

DATE: September 18, 1979

FILE NO:

TELEPHONE NO.

FROM: Helen D. Beirne, Commissioner
Dept. Health & Social Services

SUBJECT: Model Health Delivery Program
for Alaska

From time to time discussions have taken place within the Department and with others with regard to a "Model Health Delivery System" for the State of Alaska. For a number of years, delays have been encountered in active planning for an improved delivery system for Alaska because of the prospect of the National Health Insurance program being enacted by the Federal Congress. While numerous discussion continues to go forward with regard to a National Health Insurance program, it now appears that the enactment of and the implementation of such a plan are receding farther and farther into the future.

The question continues to be raised as to whether Alaska should consider the possibility of a Model Health Delivery System geared to the needs of our state. If such a system could be developed and become operative sometime before any National Health Insurance program is in place, it could serve as a prototype for the nation.

There are several reasons why Alaska should consider developing, as rapidly as good planning will permit, a Model Health Delivery Plan for all the citizens of our state. With our extremely small population and with the numerous extensive health delivery plans in place already, it would seem that Alaska could adjust its present program and add thereto in order to create a truly comprehensive and effective health delivery system. It will take bold, creative and extensive work to develop such a system for Alaska.

There are numerous parties at interest in such a proposed plan. In addition to the State of Alaska (executive and legislative branches), the Federal Department of Health, Education and Welfare and its several divisions have strong interests. The private physicians and hospitals of the state, which together become the strongest foundation stones of health delivery systems, would have substantial interests.

The Indian Health Service and the Alaska Native Health Corporations have strong interests, as would the insurance industry serving Alaska. Additional exploration will reveal other important interests to be considered, including the planning arm of our Department, the Office of Planning & Research of the Governor's Office, local, regional health planning agencies and the State Health Coordinating Council. As plans develop, all such segments with interest in such a program will need to be involved in the

planning, goal and objective setting, and implementation phases of any new program.

Apart from social and health policies concerned and apart from the different funding mechanisms and health providers, there is a national, as well as Alaskan, growing concern over the spiraling medical care costs. According to the U. S. Department of Labor, Bureau of Labor Statistics, the medical care costs in Anchorage, Alaska, in 1977 were 60% over the U. S. urban average costs. Los Angeles, California medical care costs were only 25% above the U. S. urban average costs.

A variety of studies has indicated that hospital charges and doctors' fees have been rising at higher rates throughout the nation than the Consumer Price Index has been accelerating.

Any new system planned should address (1) improved social policy, (2) improved health policy, (3) strong interest in prevention, (4) a more equitable access to health services, and (5) cost containment and cost effectiveness.

All of the above considerations, and others, have initiated certain discussions with regard to the prospects of the State of Alaska designing a new system and plan for the delivery of health services.

A careful analysis of a part of public spending for health in Alaska on the federal and state levels easily identifies approximately 183 million dollars being spent in FY 1980 for health programs (excluding capital expenditures) through our Department and the Indian Health Service alone. Other expenditures related to military personnel would be on top of that. In addition, special federal grants to the Native health corporations and other organizations in Alaska probably would bring the total into the 200 million annual range during FY 1980. Those figures exclude also the health care coverage of State, federal and local government employees covered under health insurance programs. Such costs represent an outlay of public funds on behalf of those employees of government at all levels in Alaska. Excluded also are industry, business and private insurance programs. In 1977, at least \$84,822,000 in health care and accident insurance premiums were paid.

A considerable amount of research will need to be done before Alaska can develop a definitive statement as to the total actual expenditures for health services in the State. Such research should be undertaken and facts developed as completely and as accurately as possible as to the status of spending at the present time. Any proposal for a revised program of health delivery in the state should be based upon sound statistical and fiscal data and should be able to demonstrate an improvement over the present

system. Any proposal would need to be acceptable to private providers.

The following contacts have been made and conferences on the concepts presented herein have been held as follows:

I. Washington, D.C.

Dr. George Lythcott of the Health Services Administration. Dr. Emory joined the discussions.

Mr. Isadore Seeman of the Office of Health, Policy, Research & Statistics of the U. S. Public Health Service

Mr. Ronald Carlson of the Health Care Finance Administration.

II. Seattle, Washington - Region X

Dr. David Johnson
Mr. Michael Street
Mr. David Hanson
Mr. Jim VanEomison
Deputy Commissioner Frederick McGinnis (DESS)
Ms. Sharon Osborn (DHSS)

III. Juneau, Alaska

Department of Commerce, Division of Risk Management:
John George
Richard Reiner
Office of Planning and Research
Virginia Stonkus
Chris Pohl
Governor's Office
Mike Harper
DESS
Commissioner Helen D. Beirne
Deputy Commissioner Frederick McGinnis
Special Assistant Janice Gates

IV. University of Washington - Seattle

Dr. Stephen M. Shortell, Director, Center for Health Services Research
Ira Moscovic, Rural Health Care and Manpower
Andy Dolan, Health Law, Regulation, Manpower
Laura Beth Lawson, Coordinator, Technical Assistance, Region X

V. State of Hawaii - Honolulu

Department of Labor
Department of Public Assistance
Department of Health

The purpose of this memorandum is to bring you up to date with the Department's present thinking and the explorations which have been going forward recently.

While your representatives at several meetings indicated that the concept should be explored further, the Department requests your formal approval to proceed further in development of the plan. Our plan would be to keep you advised at each phase and to seek your concurrence in any major commitments which would be needed as the study phase develops.

It is anticipated that the following steps will be taken in the near future by the Department, provided your approval to proceed is given at this time:

1. A survey of present planning and research funds available within the State of Alaska to assist in this planning effort. Included in the survey of financial resources will be the Office of Health Planning and Development of our Department, the budgets of the health divisions of our Department (Mental Health, Public Health, Alcoholism & Drug Abuse). Explorations may go forward with regard to resources which may be available from private foundations and the federal government.
2. A clarification of assistance that may be available through the University of Washington's Center for Health Services Research, Department of Health Services, under their contract with the federal government to assist states in Region X with health planning. In addition, explorations should be made with the University of Alaska's Institute of Social, Government and Economic Research as to any assistance they may be able to give the project.
3. If financial resources can be made available, the setting of criteria for and the naming of a project director for the plan. The project director and/or staff probably should be located within the Department's Office of Health Planning and Development, but given the specific task of working on this specific project.
4. Based on budget considerations and availability of funds, a small but competent staff should be identified

either to do the research or to contract for the research necessary to develop the data needed to carry forward the plan envisioned.

5. Preliminary conversations and/or discussions should be held with other parties at interest within Alaska, including:
 - Indian Health Service
 - Alaska Hospital Association
 - Alaska Medical Association
 - Alaska Legislature
 - Insurance industry
 - Governor's Planning Office
 - Consumer representatives
6. In due course, a broad-based advisory panel should be named to advise the project director and staff. Consideration will be given to whether or not the State Health Coordinating Council might serve as the advisory group to the project with possible provision for additional technical expertise if needed.
7. A proposed schedule of activities with time frames and objectives should be developed in order to plan realistically for the project.

Additional information will be provided to you if requests on any of the topics presented in this briefing memorandum.

RECOMMENDATION:

It is recommended that your approval be given to explore further the concept of a revised, improved and comprehensive health delivery system for Alaska with the goals of better services and cost efficiencies.

_____ Approved

_____ Not approved at this time

Jay S. Hammond, Governor

Fiscal
Information

SUMMARY SHEET

House CS for CS for Sponsor Substitute for Senate Bill No. 227 (HESS)
(In Thousands of Dollars)

For Full Fiscal Year 1981

	<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 for Full Fiscal Year	\$31,171.3	\$15,717.0	\$15,457.3	33

House CS for CS for Sponsor Substitute for Senate Bill No. 227 (Finance)
For 6 Months Implementation
FY 81

January 1, 1981 - June 30, 1981

	<u>Total</u>	<u>Federal</u>	<u>State</u>	<u>New Positions for 6 Months Only</u>
1. Addition of Medicaid Services and New Eligibles	\$12,097.3	\$7,858.5	\$4,238.8	17
2. Decrease of GR-Med. as Result of Adding Medicaid Svcs. and Eligibility Groups	(2,235.9)	-0-	(2,235.9)	-0-
3. State Only Medically Needy	5,584.7	-0-	5,584.7	16
4. Interest Payment	<u>282.2</u>	<u>-0-</u>	<u>282.2</u>	<u>-0-</u>
TOTAL for 6 Months	\$15,728.3	\$7,858.5	\$7,869.8	33

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House CS for CS for Sponsor Substitute for Senate Bill No. 227 (HESS)

Title An Act relating to the health of residents of the State.

Requested by The Hess Committee

Date May 2, 1980

For Full Fiscal Year

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 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
cc: Budget and Management
Prime Sponsor (Print Legislator Name)

Prepared by: David B. Davidson Date: May 2, 1980
Division: Office of Public Welfare
Department of Health & Social Services

33-101 (7-77) 91
By: 445-113-100

Approved: _____ Date: _____

FISCAL NOTE

I. REQUEST

Bill/Resolution No. Joint CS for CS for Sponsor Substitute for Senate Bill No. 227 (HBSS)

Title An Act relating to the health of residents of the State.

Requested by The Hess Committee

Date May 2, 1980

For Full Fiscal Year

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						
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.

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor of Act: Legislator David

Prepared by: David H. Davidson Date: May 2, 1980

Division/Office: Public Assistance PR: 408-647

Department of Health & Social Services

SS 001 (Rev. 1-79)

Printed by: [unclear]

Approval: [unclear] & [unclear]

Date:

FISCAL NOTE

I. REQUEST

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

For Full Fiscal Year

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		16.5				
600 LAND & STRUCTURES		-0-				
700 GRANTS, CLAIMS, ETC.		10,551.6				
TOTAL		11,169.4				

FUNDING (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
GENERAL FUND		11,169.4				
FEDERAL FUNDS		-0-				
OTHER (Specify Fund Source)		-0-				

POSITIONS

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
FULL TIME		16				
PART TIME		-0-				
TEMPORARY		-0-				

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

Medical benefits would 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
 Finance Sponsor (and Legislator Named) Prepared by: David H. Davidson Date: May 2, 1980
 Division/Office: Public Assistance File# 05-3316
 Department of Health & Social Services

33-001 (Rev. 12/79)
 33-1200-1178-01
 Approval: _____ Date: _____
 Page 3 of 4

FISCAL NOTE

I. REQUEST

Bill/Resolution No. House CS for CS for Sponsor Substitute for Senate Bill No. 227 (HESS)

Title An Act relating to the health of the residents of the State.

Requested by The Hess Committee

Date May 2, 1980

For Full Fiscal Year

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		232.2				
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
Budget and Management
Prime Legislative Auditor (Name)

Prepared by: David E. Davidson Date: May 2, 1980
Division: Public Assistance PH: dte-117
Department of Health & Social Services

Approved (Date)

Approved (Date) _____ Date: _____

METHOD USED TO DEVELOP FISCAL NOTE FOR HCS for CS for SSSB 227 (Fin)

SB 227* proposes to add new coverage and new eligible categories to the Medicaid and General Relief Medical (GRM) programs administered by the Department of Health & Social Services through the Division of Public Assistance. The bill would add services and eligible beneficiaries not presently covered by a medical assistance program administered by the Department. In order to attempt to gauge the effect of SB227, it was necessary to do some projections based on the present Alaska Medicaid and GRM programs and the Medicaid programs in other similar states. In developing a fiscal note for SB 320, the Department acquired financial reports from five western states having medically needy programs. The financial reports covered the federal fiscal years 1977 and 1978 for Hawaii, Montana, North Dakota, Utah, and Washington. This information also was used to develop the fiscal note for SB 227.

The fiscal note is divided into four pages to allow for separate considerations of adding new services and eligible groups to Medicaid on the GRM program by the effect that addition to Medicaid, the creation of a medically needy program, and the payment of interest on past due medical claims.

The first page of the fiscal note covers the addition of new eligible groups and service categories under the Medicaid program. The basic Medicaid request for FY 81 minus the 100% federally-funded Indian Health Care Improvement Act coverage (\$40,720,600) was used as a base. To that was added 17.1% additional funds for those new service categories that are not presently covered under the Alaska Medicaid program. This brings the total to \$47,683,800. The 17.1% figure is derived from the average percentage in the five other states for those categories of service that are not covered under the Alaska Medicaid program that would be added by this bill. This subtotal was then multiplied by 1.5, the factor by which I believe the overall cost of the Medicaid program would increase (\$71,525,700). Alaska has a lower percent of the total population participating in the Medicaid program than in other states, particularly in the groups of individuals under 21 and intact families.

To double check these perceptions, and to arrive at a more precise budget projection, the fiscal note was developed by budget components. It was projected that the Medicaid components would be affected in the following ways: hospital increase by 1.33, physicians increase by 1.33, other services increase by 1.33, EPSDT increase by 2.0, nursing homes remain constant, and Indian health increase by 2.0. The effect on the GRM budget, reflected by page two of the fiscal note, would be as follows: hospital reduced by .33, physicians reduced by .33, other services reduced by .50, and nursing homes and catastrophic illness remaining constant. These changes by specific component produced the total used for the fiscal note of \$71,487,900 for Medicaid in FY 81.

The high amount of federal funds shown in the fiscal note is the result of a large increase predicted in the Indian health component which is 100% federal funding. This increase would not be a function of people receiving new services but the result of a funding change--the Alaska Area Native Health Service (AANHS) would be able to receive more federal

* In all cases, Senate Bill 227 means House CS for CS for SSSB227

Medicaid money for services that they are already providing to persons eligible for AAHHS, but who are not Medicaid eligible now simply because Alaska's Medicaid program does not provide coverage for intact families.

The third page of the fiscal note covers the effect of adding a medically needy program in Alaska. It is based on the projections done in developing the fiscal note for the Senate Health Committee for SB 320. For purposes of SB 227, the amount in that fiscal note was doubled to reflect the fact that SB227 would require medically needy coverage for not only adult cases but also for families and individuals under age 21, and would establish a higher cut-off point for eligibility.

The fourth page provides an analysis of the costs of providing interest payments on past due clean claims submitted to the Department. While SB 227 does not say specifically that the provision would apply only to the Medicaid and GRM programs, that assumption has been made for purposes of the fiscal note. The amount projected is approximately one-half percent of the total Medicaid and GRM budgets, minus the Indian health component since that is merely a transfer of federal funds and not an actual payment for services rendered. The figure is based on the assumption that the Department will be able to continue to make improvements in its claims processing system, eventually obviating the need for any interest payments to be made. Of course, if the claims processing system would revert back to its previous condition, the amount of this fiscal note would be considerably greater.

The summary sheet totals the costs for the Department for SB 227. Since the fiscal notes were prepared based on the House version of the bill, the budgets reflect costs for a full fiscal year implementation. The current House Finance version begins implementation at a later date on January 1, 1981. Therefore, we have reduced the costs by 50% to reflect only 6 months implementation for that fiscal year.

DIVISION OF PUBLIC ASSISTANCE

BRU	FY79 ACTUAL TOTAL AS OF 11/27/79	FY80 FCC AUTHORIZATION	FY80 SUPPLE- MENTAL CURRENT REQUEST	FY80 PROJECTED TOTAL NEED	FY81 REQUEST
GEN. POP:					
DISCRETIONARY		(GF)		(GF)	(GF)
Elig. Det.	\$3718.3	4377.1	(2638.2)	4377.1	4695.9 (2331.0)
Staff Dev.	253.8	130.4	(40.8)	130.4	140.0 (69.1)
Quality Control	407.0	496.0	(248.5)	496.0	549.0 (274.5)
General Relief	707.1	650.0	(650.0)	650.0	650.0 (650.0)
TOTAL	<u>5086.2</u>	<u>5653.5</u>	<u>(3577.5)</u>	<u>5653.5</u> (3677.5)	<u>6034.9</u> (3324.6)
NON-DISCRETIONARY					
AFDC	21276.6	22734.5	(11367.2)	3447.9 26182.4 (13091.2)	31133.1 (15566.5)
AD	3130.2	3782.8	(3782.8)	202.7 3985.5 (3985.5)	4974.1 (4974.1)
AB	108.7	118.8	(118.8)	118.8 (118.8)	140.9 (140.9)
*OAA	2950.2	3141.4	(3141.4)	421.8 3563.2 (3563.2)	4344.9 (4344.9)
TOTAL	<u>27465.7</u>	<u>29777.5</u>	<u>(18410.2)</u>	<u>4072.4</u> 33849.9 (20758.7)	<u>40593.0</u> (25026.4)
* AGED COVER PROGRAM					
HEALTH:					
NON-DISCRETIONARY					
MEDICAID					
Hospitals	6047.9	5617.7	(1160.7)	1066.7 6634.4 (1694.0)	8923.7 (2451.9)
Physicians	2872.4	2819.2	(621.9)	1217.6 4036.8 (1230.7)	5381.1 (2690.6)
Other Services	899.9	735.1	(276.6)	435.8 1170.9 (494.5)	1563.1 (671.1)
EPSDT	1600.8	1711.5	(855.7)	480.0 2191.5 (1095.7)	2925.7 (1462.8)
Nursing Home	12947.8	15825.6	(967.4)	1716.0 17541.6 (858.0)	21927.0 (3553.5)
Indian Health	1458.7	6557.6	-0-	6557.6 -0-	7239.6 -0-
TOTAL	<u>25817.5</u>	<u>33266.7</u>	<u>(3882.3)</u>	<u>4916.1</u> 33182.8 (5372.9)	<u>47960.2</u> (10247.9)
GENERAL RELIEF MEDICAL					
Hospitals	4137.9	4147.9		1356.8 5504.7	7348.8 (7348.8)
Physicians	1443.4	1150.3		900.0 2050.3	2737.1 (2737.1)
Other	1338.0	1224.1		473.4 1697.5	2266.1 (2266.1)
Nursing Homes	328.8	683.9		231.7 915.6	1144.5 (1144.5)
Catastrophic Illness	801.8	754.2		-0- 754.2	977.3 (977.3)
Residential Nurse	-0-	166.4		-0- 166.4	166.4 (166.4)
TOTAL	<u>8049.9</u>	<u>8126.8</u>	<u>(8126.8)</u>	<u>2961.9</u> 11088.7 (11088.7)	<u>14640.2</u> (14640.2)
DISCRETIONARY					
PA Admin & Support	970.4	910.9	(529.2)	910.9 (529.2)	970.8 (594.8)
Collections	42.8	44.8	(44.8)	44.8 (44.8)	47.4 (28.4)
SUBTOTAL	67432.5	77780.2	34570.8	89730.6 (41471.8)	110225.5 (54964.3)
+FEDERAL FOOD STAMPS	10400.0	14976.0		14976.0	18637.0
+ENERGY ASSISTANCE PROGRAM	N/A	N/A		3636.7	unknown

FISCAL NOTE

Bill 4-5 mje

I. REQUEST
 Bill/Resolution No. CS for 55 Senate Bill 227
 Title Insurance for Alcoholism and Drug Dependence
 Requested by _____ Date _____

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

EXPENDITURES (Thousands of Dollars)

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

FUNDING (Thousands of Dollars)

GENERAL FUND		230.8	277.1	332.6	399.2	478.9
FEDERAL FUNDS		13.0	15.6	18.7	22.4	26.9
VETERAN'S FUND		0.6	0.7	0.8	1.0	1.2
FISH & GAME FUND		1.7	2.0	2.4	2.9	3.5
HIGHWAY FUND		3.7	4.4	5.3	6.3	7.6
AIRPORT FUND		8.2	9.8	11.8	14.1	17.0
CAPITAL FUND		24.0	28.8	34.5	41.4	49.7
PERS						
TRS						

POSITIONS

NONE

FULL TIME						
PART TIME						
TEMPORARY						

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

- Approximately 8,900 State employees are currently covered under the State Group Health Care Plan.
- The cost to implement the provisions of this bill will be \$2.64 per employee per month.
- Estimate that the cost to provide continued coverage will increase 20% each year for the immediate future. However, an effective alcoholism/drug dependency program should help to reduce overall health care claim experience in the future.
- Cost for coverage of political subdivisions (approximately 50 subdivisions) participating in group insurance not included; recommend that the Alaska Municipal League, 204 Franklin St., Juneau, AK 99801-1325, be contacted for input.

IV. DATE 3/30/79 PREPARED BY Paul P. Arnold, Director
 AGENCY Division of Retirement & Benefits
 PHONE 465-6663

Original Legislative Finance
 cc: Budget and Management
 Please specify what legislative committee/senator/councillor & Senate Bill
 number to be assigned to this expenditure

Paul P. Arnold

Original sponsors: Colletta, Stimson
and Hohman

IN THE SENATE

BY THE FINANCE COMMITTEE

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

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

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

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

* Section 1. AS 21 is amended by adding a new chapter to read:

CHAPTER 50. COMPREHENSIVE HEALTH CARE PLANS.

Sec. 21.50.010. RESIDUAL MARKET HEALTH INSURANCE POOL. (a) The carrier which writes the largest premium volume of health insurance in the state as determined by the director shall, as a condition of transacting health insurance, establish and operate a residual market health insurance pool. Individual, group, and Medicare supplemental comprehensive health care plans as described in AS 21.50.020 shall be available through the residual market health insurance pool to every eligible individual or employer resident in the state. Applicants shall have a choice of the low option, the middle option, or the high option deductible established under AS 21.50.020.

(b) The administering carrier shall submit to the director for approval a plan of operation for the residual market health insurance pool which assures the fair, reasonable, and equitable operation of the pool. The plan shall establish procedures for administration, accounting, record keeping, and reporting for the pool, amendment of the plan, and advertising of the coverage provided. If the carrier fails to submit a plan within six months after the effective date of regulations implementing this Act, the director may adopt a plan to carry out the provisions of this section.

(c) Rates for comprehensive health coverage issued through the residual market health insurance pool may not be excessive, inadequate, or unfairly discriminatory. The rate for a given classification or group in the pool may not be more than 125 percent of the rate for a classification or group of at least 25 persons with similar characteristics at standard risk, for equivalent coverage not written through the pool. All policy forms and rates shall be filed with the director and may be disapproved within 30 days from the filing.

(d) Following the close of a fiscal year, the administering carrier shall determine the net premiums, administrative expenses, and incurred losses for the year from the operation of the residual market health insurance pool. Net gains, if any, shall be held at interest to offset future pool losses or allocated to reduce future pool premiums. Net losses may be credited against the carrier's income tax payable under AS 43.20 or its premium tax payable under this title. If the administering carrier's total assessment exceeds its tax liability for the year, the commissioner of revenue shall directly reimburse the carrier in the amount of the excess.

Sec. 21.50.020. COMPREHENSIVE HEALTH CARE PLANS. (a) Each of the three types of comprehensive health care plans (individual, group, and Medicare supplemental) shall provide minimum standard major medical benefits required by regulation:

(b) A comprehensive health care plan shall provide for a choice of deductibles. The low option deductible is \$100 per person, the middle option deductible is \$500 per person, and the high option deductible is \$1,000 per person. The \$100 maximum, the \$500 maximum and the \$1,000 maximum established under this subsection shall be adjusted yearly by the director by regulation to correspond with the change in the medical care component of the consumer price index. The base year for the

computation is the first full year of operation of the plan.

(c) The sum of the deductible and copayments required in a calendar year under an option may not exceed a maximum limit of \$1,000 per covered individual or \$2,000 per covered family. The \$1,000 and \$2,000 maximums shall be adjusted yearly by the director to correspond with the change in the medical care component of the consumer price index.

(d) A comprehensive health care plan may limit lifetime benefits to a maximum of not less than \$1,000,000 per insured person.

(e) The director shall adopt regulations establishing subrogation rights and coordination of benefits.

Sec. 21.50.030. ELIGIBILITY. (a) An individual comprehensive health care plan is open to enrollment by a resident of the state who is under 65 and can provide evidence, with respect to major medical coverage, of rejection, requirement of restrictive riders, a rate up, or a preexisting conditions limitation by ^{two} a carrier^s within six months before the application for enrollment in an individual comprehensive health care plan, the effect of which is to substantially reduce coverage from that available to a person considered standard risk.

(b) A group comprehensive health care plan is available to a resident employer of three or more employees whom the employer seeks to enroll in a group plan, who can provide evidence, with respect to major medical coverage, of rejection, requirement of restrictive riders, a rate up, or a preexisting conditions limitation by ^{two} a carrier^s within six months before the application for a group comprehensive health care plan, the effect of which is to substantially reduce coverage from that available to a group considered standard risk or a group of 25 members.

(c) A Medicare supplemental comprehensive health care plan is open to enrollment by a resident of the state who is enrolled in Medicare Parts A and B and who can provide evidence, with respect to major medi-

cal coverage, of rejection, requirement of restrictive riders a rate up, or a preexisting conditions limitation by ^{two} a carrier^s within six months before the application for enrollment in an individual comprehensive health care plan, the effect of which is to substantially reduce coverage from that available to a person considered a standard risk.

(d) An individual may not purchase or renew coverage under a comprehensive health care plan established under this chapter after ceasing to be a resident of the state.

Sec. 21.50.040. ADDITIONAL CRITERIA FOR ELIGIBILITY. The director may adopt by regulation supplemental or alternative eligibility criteria which reflect the inability of an applicant to obtain coverage substantially similar to that which may be obtained by an applicant who is considered a standard risk or by a group with 25 members.

Sec. 21.50.050. POWERS OF DIRECTOR. The director may

(1) formulate general policies to advance the purposes of AS 21.50.010 - 21.50.040 and may adopt regulations under AS 21.06.090 to carry out the provisions of AS 21.50.010 - 21.50.040;

(2) adopt by regulation reasonable limits on administrative expenses of the administering carrier which may be paid from comprehensive health care plan premiums, and minimum standards for the proportion of comprehensive health care plan premiums to be paid out in claims;

(3) examine and investigate the operation of the residual market health insurance pool and shall have reasonable access to the books, records, files, papers, and documents of the administering carrier that relate to the operation of the pool;

(4) examine directors, officers, agents, brokers, or employees of the administering carrier for the purpose of determining if coverage is being adequately and fairly provided through the pool;

(5) contract with the federal government or with another unit