795 HHESS STATE HEALTH INSURANCE (FILE NO.3)

STATE HEALTH INSURE.

#3

GEORGE R. ARIYOSHI
GOVERNOR

TANY S. HONG
DIRECTOR
BANK EXAMINER
COMMISSIONER OF SECURITIES
INSURANCE COMMISSIONER

DONALD D. H. CHING
DEPUTY DIRECTOR

STATE OF HAWAII
OFFICE OF THE DIRECTOR
DEPARTMENT OF REGULATORY AGENCIES
1010 RICHARDS STREET
P. O. BOX 541
HONOLULU, HAWAII 96809

March 24, 1980

Representative Thelma Buchholdt
State Representative
District 9 (Spenard)
Chair, House HESS Committee
Alaska State Legislature
Pouch V, State Capitol
Juneau, Alaska 99811

Dear Representative Buchholdt:

This is to acknowledge receipt of your letter of March 18, 1980, inviting me to testify on proposed legislation similar to Hawaii's "Prepaid Health Care Act." Because the subject matter is not related at all with the state department which I am presently serving, I originally could not justify my going to Juneau as official State of Hawaii business. However, my Director and the Governor both feel that if my presence would assist Alaska in enacting progressive health care legislation, I would be given leave to go to Juneau with Hawaii's experience in this field.

I have spoken with Ms. Sorice of your office and am making plans to arrive in Juneau on Sunday, March 30, 1980, and will be available to testify on March 31 and April 1, 1980, if necessary.

I am looking forward to being of any assistance that I can possibly render in your efforts to enact such a bill. I think it has been of much benefit to the people of the State of Hawaii.

May I give you a short biographical sketch so that you may use this in further evaluation of my testimony next week:

1. Member of the Hawaii Legislature from 1959-1978 (8 years-House of Representatives; 12 years-Senate).

2. Attorney-at-Law.

3. Former Vice-President of the Bank of Hawaii (1963-1979).

4. Presently Deputy Director of the Dep rtment of Regulatory Agencies, State of Hawaii.

5. Member of the Board of Directors-Hawaii Medical Service Association (Blue Shield and Blue Cross Plan) (1965 to present), presently serving as its President.

I have never been to the great State of Alaska, and I am looking forward to my first visit.

Very truly yours,

Donald Ching

Donald D. H. Ching
Deputy Director

cc: Ms. Jan Sorice

by Tom Fink

THE ACME of legislation so far this session which interferes with our democratic way of life has been the introduction of House Bill 977. This bill is entitled "an act relating to the health of residents of the state". HB977 was introduced shortly before another similar bill was passed by the State House, Committee Substitute for House Bill 60.

The biggest trepidation many of us have in regard to the state's huge monetary wealth is that money will be used to interfere with our free and democratic society. It is for that reason that many of us suggested that the state use the surplus to pay off our debt and to build capital improvements which improve our economic viability and our conveniences of living.

We've all heard of national health insurance. The first part of HB 977 is state health insurance. The bill provides an employer must cover all employees with a certain type of insurance policy. An employee can only pay a limited amount for that policy so that the employer must pay the difference. Since the coverage is broad, the employer's cost is very substantial. Under certain circumstances an employer can obtain some reimbursement from the state.

IN THE NEXT section of the bill a state medical insurance corporation is set up in which all of the private carriers selling insurance in the state must become a part. Anyone who cannot buy standard coverage of the quality required may purchase insurance from this corporation. Any losses this corporation suffers must be paid for by the private carriers. The end result of this legislation is that the private carriers of medical insurance will be crowded out of the market and the state will be the sole insurer of health insurance. At that time the cost to the state treasury will be enormous.

CSHB60 is primarily a capital appropriations bill. Twenty pages of the 39-page bill and about $250 million is for the construction of all sorts of facilities throughout the state. Some of them are boondoggles, but by and large the facilities will contribute to the future economic viability of the state.

The other 18 pages of the bill, however, appropriates about $27 million for projects such as the following:

— $54,600 Anchorage current event society.

— $12,000 Anchorage Child Abuse Board for Advertising.

— $305,000 Anchorage operation of treatment alternative to street crime program.

— $87,000 Tyonek Village documentary film.

— $75,000 Alaska Federation for Community Self-Reliance grant.

— $180,000 Alaska Conservation Foundation.

— $35,000 Anchorage grant to task force on smoking and health.

— $453,000 Anchorage — Alaska Public Advocacy Corporation.

— $75,000 Alaska Public Interest Research Group.

— $48,000 Anchorage — Citizen Participation Project.

— $317,500 Anchorage — Alaska Center for Policy Studies.

These expenditures are the type that are only made when the state has money burning a hole in it's pocket. Many of these appropriations are to accomplish goals that are not proper for a government. Many of the appropriations are made to new organizations set up to employ friend of those in government. Many of them will result in substantial intrusions upon our democratic society.

IN ADDITION we have legislation pending to subsidize the cost of fuel and electricity so that there will be one price anywhere in the state regardless of the quantity used or the remoteness of the area from the product. We will have legislation also to establish one price for transportation of anyone or a commodity north of Seattle. Even if you happen to be in favor of this state subsidization, you must realize the result will be the state control of all those services and commodities. The legislature only pays the cost of a program for so long before it takes it over and establishes the manner of it's operation, the number of employees, the pay, and the profit margin.

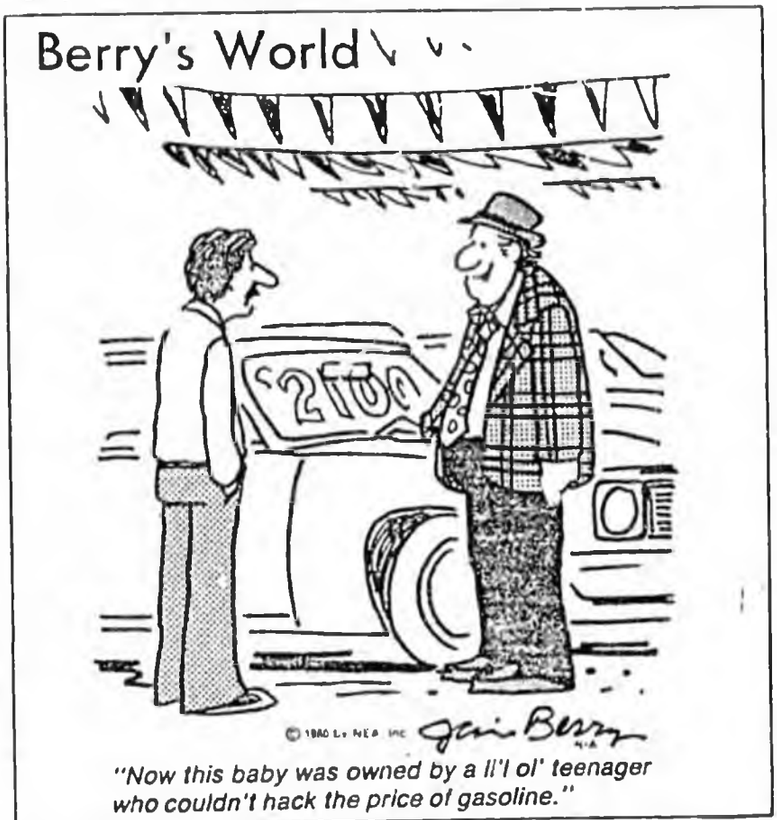
We already, of course, have set up a Renewable Resource Corporation with many millions of dollars and a Fish and Agricultural Bank which recently announced it is opening up six branches in the state. These institutions are totally state owned.

There really are only two answers to stop government expenditures for improper purposes this session. First of all the governor could and should veto by line item such expenditures. However, the probability is the governor will go to the Free Conference Committee and tell them if they add $50 million for his pet projects, he will agree not to veto any part of it.

THE SPEAKER of the House recently in a speech asked the public to quit putting pressure on the legislature to spend more money because they are unable to withstand the pressure. The Speaker knows or should know that this pressure will always exist as long as the government has a surplus. The Speaker is one of the people in the leadership who has to have the fortitude to say "no". It is the problem of which he complains that convinces most of us that we must spend the state's money on debt reduction and capital improvements so that the money isn't there for all these foolish operational programs.

Unless the leadership is going to assume the fortitude to say "no", I suggest the legislature gets about it's business and ends the sessions. Repeal taxes, make money available at reasonable rates for credit within the state, pass the operational budget, and adopt a large capital improvement budget.

The pressure to spend on all sorts of foolish programs will get stronger rather than weaker with every passing day.



"Now this baby was owned by a li'l ol' teenager who couldn't hack the price of gasoline."

generally prevailed.

Yet, always there is the hope of government for all. And so, on April 20, will try again. Five yea three general junta took President Oswaldo Lope was charged with takin bribe from United Brands United Fruit. The junta is tarily relinquishing powe the heady prospect of a open election with a mod curate vote count.

But it is difficult not to Nicaragua, where leftists ists combined to get Anastasio Somoza, now be sliding into Cuban-sty nism. Although the El Sa has ordered the expropr agricultural properties acres the radicals are and shooting continues. ago a cache of bodies ered in a Guatemala ca parent work of right squads.

Why can't Central make democracy work?

First, there is the self, mostly Indian, poli but gyrating between asms and black despair reach out and touch though they were angel dicious cynicism neces ble self-government.

Then, there is the n tral America's agricu coffee fincas may be re client, but sugar and best raised on large t land-owning companie been fair game for but either they or the tem of bickerin, coo necessities. Either wa men wielding machet their own masters.

But in recent ye arisen a more compel social chaos, and that ation of people due t ering of the death rat tries are due to doub tions in the next 18 like the Puerto Rica grate freely to the U the Mexicans who c the fence, these nat cape hatch.

IN 1968, HONDUR with El Salvador t squatters. The Mex thrown back Guatem from the south. With for arable land in t desperate people mo where they form lar increasingly restive

If the population off in this lovely spi two continents pros right, for technology But every advance new tide of babies.

And Marxism, one-time dividend and redistribution, song.

ALASKA LEGISLATIVE COUNCIL

LEGISLATIVE AFFAIRS AGENCY

REPORT OF THE

INTERIM COMMITTEE ON HEALTH CARE,

SOCIAL SERVICES AND

MENTAL HEALTH DELIVERY SYSTEMS

FEBRUARY 1974

The Health-Care Merry-Go-Round

by George Silver

The health insurance plan offered by Senator Long (left) has the best chance of getting through Congress this session.

FOR ALMOST 60 years now, a political event has unfolded each spring, a ritualized controversy over the value and scope of a national health program. While it is usually billed as "national health insurance," the underlying argument has little to do with health, and only a bit more to do with real insurance.

In the past 20 years, because the Democratic party has adopted national health insurance as a plank in its political platform, the spring ritual has become curiously formalized. The President issues a "health message" around February; White House aides and agency (usually HEW) experts prepare a legislative proposal that goes to the appropriate committee (or committees) in March or April. Then hearings are held, the witnesses for and against heard. The media join the fray with articles, learned discourse on local and national TV, and books. The administration announces the imminence of a legislative health program; Congress denounces the proposal and offers its own alternatives. In fact, a particularly novel aspect of this seasonal rite has been the lush proliferation of congressional counter-proposals, making the health insurance field look more like a war of all against all than an intra-party squabble. The rapid and uncontrollable escalation of the costs of medical care has convinced everyone that some sort of bill should be passed; but the profusion of bills has made consensus even harder to reach. Thus, after a great deal of noise about the need for sweeping reform, one bill cancels out another, and, in the end, only a small, tentative step is taken. And the 1978-80 congressional term looks like a textbook case of the usual formula.

While the ritual has remained more or less the same, the substance of the debate has grown ever more complicated. Seventy years ago national health insurance meant little more than being able to pay a doctor for care. Today we have solved the basic problems of acute and epidemic disease, infant mortality, and the like—except for minority groups and the poor—and we are more concerned with a *program* of care, a guarantee of *systematic* care. We have learned that our piecemeal system doesn't work, doesn't help the people it was presumably targeted for—the needy—and works against the others because it inflates and distorts, and deprives everyone when it doesn't work for the targeted population.

With this new element added, nobody can agree on exactly what national health care means. The variety of proposals is staggering and self-defeating. Once the principal obstacles to national health insurance were such antagonists as physicians, entrepreneurs in pharmacy manufacture or equipment, industry and insurance companies; now there is a plethora of protagonists with such conflicting proposals that the result is the same as if they were antagonists too. There are public and private advocates; professional anti-professionals recommending "health" insurance (as against medical-care insurance) with emphasis on preventive services, lifestyle change, and self-help; syndicalists with a platform of worker-management control; populists with a platform of community control.

The academic world has not been idle either, and there are contrasting economic recipes: tax revenue funding as against employer-employee funding; co-insurance and co-payment advocates as against those who argue for no payment at the time of service; and the anti-insurance cohorts who recommend a heavy personal financial commitment by the patient before *any* government support in order to check the heedless and prodigal use of, and demand for, medical services. Political scientists argue the benefits of a regulatory approach or a public utilities model, while management experts (the new mandarins) propose complex, computerized schemes for controls that would limit costs, adjust distribution, and assure quality.

Congress watchers point to the American Medical Association's multimillion-dollar political contributions and Washington "information office" as the chief villain and architect of the anti-national health program campaign. Certainly political contributions play an important role and have a strong impact on legislators and legislation. But it would be a mistake to give this factor too important a role in frustrating the legislative possibilities over the years. That block has been effective in over 10 administrations. Can the AMA be held solely and totally accountable? On the U.S. political scene representative government requires shifting minority allegiances to [illegible]

position by reciprocal trade-offs: Lesser issues buy votes on larger issues. Health insurance just may not represent a big enough issue for most congressmen to stake out a major position on the agenda.

In any case, it's not the AMA that's responsible for the bewildering variety of health bills now facing Congress; it would rather that none be promoted. Personal experience may shed some light on a more deserving culprit. From 1965 to 1968 I served as the deputy assistant secretary for Health. My boss was the first assistant secretary ever appointed to that job. Another first was the assistant secretary for planning and evaluation, brought over from the Department of Defense to introduce managerial skills and planning expertise into the hodgepodge of the HEW bureaucracy. Planning had one deputy also, for health program evaluation. All in all, there were about a dozen health professionals charged with the responsibility for developing programs agreed upon by the secretary of HEW and proposed by the President. There were also one or two assistants in the White House with such interest. At HEW, we occupied a few rooms on one side of the fifth floor of the old HEW building at Fourth and Constitution.

Congress was similarly endowed: The House and Senate each had one health staff member attached to the relevant committee. Wilbur Mills, then chairman of the House Ways and Means Committee, had a knowledgeable staff man, too, but he liked to keep a strong grip on health financing matters himself.

Today, nearly 250 people are preoccupied with the ramifications of health program development and health planning and evaluation in HEW. There is a huge new building down the street on Independence Avenue to house them. There are over 100 professional staff people in six congressional committees to deal with health legislation. Each congressman on a committee that touches health matters has a specialized staff assistant for health.

In the 1960s the dozen of us managed to get more than 40 health bills through the Congress: powerful instruments like Medicare, Medicaid, and a health manpower development act. Today's hosts have had to postpone even housekeeping measures like salary appropriations from one session to the next because they couldn't muster a majority vote on any health issue.

The problems of bureaucratic overkill and legislative free-for-all are not, of course, confined to health care; most social programs suffer from the same confused welter. The same may be said for the general American resistance to radical reform of any kind. Our taste for "creeping incrementalism" has led to a passion for tinkering and crude adjustment; whether in health care, the tax code, or welfare reform, reconstruction and systematic change have been neglected and delayed, so that social change proceeds at a snail's pace.

THE PRESENT congressional season features an apparent showdown in health-care legislation: Both President Carter and his nemesis, Senator Kennedy, have submitted major health-care bills. But the likelihood is that the prize will elude both. The best we can probably look forward to in this session of the Congress is Senator Russell Long's Catastrophic Health Insurance Protection Bill, possibly to be known as the National Health Insurance Act, even though it will not be, in scope or coverage, what the national health insurance struggle is about.

Kennedy's ambitious health care bill provides free medical care to everyone.

The Kennedy bill provides for everyone in the U.S. to have a credit card entitling him or her to medical care in the home, doctor's office, or hospital without added charge; old people would have their prescribed medicines paid for as well. There is no limit on use (except for psychiatric services) and preventive services are paid for. Funds will come from some employee contributions, larger employer contributions, tax funds for the poor, and contributions from the elderly (who will pay a part themselves as they do today under Medicare). The self-employed will pay, if they choose, a special health insurance premium geared to their income. The monies will go to privately controlled insurance funds, which will dole them out and monitor their use; the program will be planned and supervised by a variety of groups at the local, state, and national levels. There is a special fund set aside to develop and allocate resources (and redistribute them where necessary). And there is a ceiling, unfixed as yet, on expenditures. All this is to become operative in 1983.

The Carter plan is not so ambitious. It puts a ceiling on the total any person would have to spend for health care ("catastrophic" health insurance coverage); prescribes free care for pregnant women and infants under one year of age; recommends fee schedules for private health insurance for which the employer will pay at least three-quarters of the premium; and draws up fee schedules for public medical care to which doctors must adhere. Probably the largest jump in governmental responsibility is in federalizing medical care for the poor. Where now the states set income levels for Medicaid, the new law would set a new federal poverty level and immediately raise by more than 50 percent the number eligible. The Carter plan envisions phasing in of its objectives: After phase one has been implemented, there will be a review of the whole and consideration of what additional steps might be taken next.

Senator Kennedy's proposal, despite its grand intentions, is seriously defective. The surrender to the private insurance industry is curious, for Senator Kennedy has been the principal antagonist of the industry and has criticized it for stoking inflation in collaboration with health-care providers. While a ceiling on expenditures is proposed, and physician income may well be curtailed in this way, *non-physician* income is untouched. Since 60 percent of hospital costs are personnel costs and hospital costs are 40 percent of overall medical-care expenditures, there is a large loophole for sharply rising costs to escape the ceiling. What measures will be taken if institutions exceed budget? Will they file for bankruptcy? More serious is the vast increase in personnel proposed, layered on top of an existing regulatory bureaucracy. By now we must have learned that large bureaucracies cannot provide human services with efficiency.

President Carter's plan has highly visible flaws and no appeal to the articulate constituencies (like labor) that seek national health insurance legislation which will benefit *them*, immediately. It is *targeted* for specific groups, a shibboleth of his economic advisors, and offers little universal benefit. The failures of implementation of existing reform legislation bode ill for that part of the effort. It prescribes a reliance on unsupervised private insurance far greater than does Senator Kennedy's proposal. The whole effort is more pious and prayerful than useful. Costs would continue to mount, most of the poorly served would remain so, specialism would increase, and enrichment of the medical profession would continue to be guaranteed. No ceiling on expenditures means no ceiling on costs or income.

Sadly enough, in extending the Medicaid principle and reinforcing it, the Carter plan continues the "two-tier" sys-

tem of medical care that has been the curse of the present system: poor medical care for poor people, better medical care for the better off.

Senator Long's plan, the leading contender for passage in this Congress, if any bill is to pass, is relatively simple and ineffectual in altering the circumstances that contribute to present dissatisfactions. It will most certainly augment inflation. The plan advocates a catastrophic protection clause: After a family spends $2,000, government insurance would pay the remainder of any medical bills that year. It encourages hospital care and offers incentives to doctors and hospitals to raise fees ("get over that barrier" of $2,000 as quickly as possible to make the family eligible). President Carter's endorsement of this proposal as part of his phase one is equally inflationary.

But if history is our guide, Long's plan has the inside track. First of all, it will change nothing, a considerable advantage. Second, national legislation usually waits for state models to provide guidelines as well as to test the water of public acceptance. The states serve as "laboratories" for national experimentation, to use Brandeis's phrase. We have had state experiments in the health field before passage of other national health legislation; and in the past five years we have had state catastrophic health insurance laws (Rhode Island and Hawaii, for example). But we have never had a state compulsory health insurance law, despite some efforts on occasion in California, New York, Massachusetts, Michigan, and Pennsylvania. The generally successful experience with state catastrophic health insurance laws makes the probability of Long's plan becoming law more likely.

Political wisdom might dictate to Senator Kennedy (or Governor Brown, and other potential presidential candidates practicing in the bullpen) a powerful effort to obtain a model state program of compulsory health care. Who controls the politics of Massachusetts anyway?

TODAY'S PROPOSALS for national health insurance offer little cause for optimism that real change will take place in the system. The one thing that none of the plans promise—neither Carter's nor Kennedy's nor Long's—is equity. A concern with equity makes us ask the question: Do we want the poor and minorities to have the same medical care as the rich and the white? Do we want a health-care system that says that we are all entitled to care, as we need it, when we need it? Or one that says, if we can find it, or get it, an insurance company will pay for it?

It may be that, given the alignment of forces, this is the time to suggest a state health insurance program that undertakes radical reform, but in a smaller arena, say child health care, to test the feasibility, cost, and organizational considerations. We should seek equal access and high-quality cost control in this smaller arena by cooperative effort in which the federal government waives rigid regulations for the use of federal funds and the states incorporate these sums into a statewide health service financial budget. Applying such a program to child health care would naturally include an emphasis on preventive services, which are especially cheap for children: The most comprehensive program, instituted in Holland, costs roughly 9¢ per child per day. Since the Dutch standard of living and wage scale aren't too different from ours, it's likely that such a preventive system will cost no more here.

Carter's plan has visible flaws and is more pious and prayerful than useful.

If such a program worked for children, the lessons ultimately could be applied to adults and to the nation as a whole. There is already fairly widespread acceptance of the rough outline of an effective and economical national system. It will be prepaid; that is, people will pay little or nothing at the time of care to overcome costly and cumbersome bookkeeping, financial barriers to prompt use of services, and the quirky variations in charges that make budgeting impossible. Doctors will be part of a group organization, making all kinds of specialized care readily available to patients. The doctors will be salaried, eliminating the competitive aspects of present practice that encourage overuse of technology and referrals.

Primary care will be a team process, with family doctors and nurse practitioners or medical assistants liberally distributed in small clusters throughout the neighborhoods of the communities for easy access by patients. The teams will be part of groups, which in turn will be part of hospital units serving designated populations. Very complicated, delicate, and expensive hospital procedures will be restricted to a few regional hospitals, and effective transport and emergency vehicles will tie this network of care together.

From an organizational standpoint, regional commissions, possibly elected units like regional school boards, will deal with budgets, distributional problems, and manpower. Local committees, also possibly elected, will serve as channels of communication between the patients and the professionals: Grievances can be mediated this way, and local supervision can provide information on the operation of the groups and teams.

The entire program will be highly localized in order to keep huge bureaucracies from developing and becoming the self-serving megastructures that are the bane of modern life. If the regional commissions actually carry out their supervisory functions, this allocation of funds to local communities to plan imaginative and locally satisfactory approaches to medical care will ensure a useful national health program.

It will follow that while the monies for the service will be in the hands of local boards for disbursement, the source of the funds still will have to be federal and state taxes. The actual way in which the tax structure will have to be changed to accommodate a valid national health-care system remains unclear.

It's easy for someone outside the system to spin out an ideal plan, particularly if that someone won't have to take the responsibility for what happens if it should become operative. Nonetheless, the political possibilities are there and the potential examples abound. Ten million Americans belong to prepaid group practice systems. There are school systems with comprehensive preventive programs for children. Nearly 30 percent of the doctors in the United States are on salary now. Many neighborhood hospitals, like neighborhood schools, serve the local population exclusively. What is missing is a national commitment, national standards, assent to equity.

The agonizing over a national health program is only another example of the struggle Americans have had in this century to come to terms with the contradictions of their political heritage: individual responsibility and freedom to succeed and achieve, and to fail and suffer, on the one hand; on the other, government responsibility for the good and welfare of all. Our political tradition is cautious, too, not wanting to take too big a bite at one time. It makes sense to try the new remedy in a few states before you prescribe it for 215 million people. But you must try it, then, or be reconciled never to have a remedy at all!

Dr. Silver is a professor of public health at the Yale School of Medicine. His most recent book is Child Health: America's Future.

Health Boards

Board or Commission	Appointee	Term

BOARD OF NURSING
AS 08.68 - 7 members; 5 year term; removed only for neglect of duty or for unprofessional or dishonorable conduct after a fair and impartial hearing.

Norma J. Frank, R.N. — March 31, 1979
Box 4229
Mt. Edgecumbe, Alaska 99835
747-8244 (home)
966-8342 (work)

Eileen Montano, R.N. (chairman) — March 31, 1981
SR Box 10033
1.5 Mile Chena Ridge Road
Fairbanks, Alaska 99701
353-4227

Betty Irwin Hodo, R.N. — March 31, 1980
3812 Katmai Circle
Anchorage, Alaska 99503
274-3740 (home)
272-5522 Extention 140 (work)

Kandace Henry (public member/secretary) — March 31, 1980
1222 16th Avenue
Fairbanks, Alaska 99701
452-5310 (home)

Carol Ann Verga — March 31, 1982
Box 5138
Ketchikan, Alaska 99901
225-2620 (home)
225-6688 (work)

Erna Rasmussen (public member) — March 31, 1981
Box 2
Nome, Alaska 99762
443-2919 (home)
443-2798 (work)

Marion E. Bayless, R.N. — March 31, 1983
Chief, Area Nursing Services Branch
Alaska Area Native Health Service
Box 7-741
Anchorage, Alaska 99510
265-3121; 265-3122 work
333-5742

Board or Commission	Appointee	Term
STATE MEDICAL BOARD AS 08.64 - 7 members; 4 year term, serves until new member is appointed and qualified.		
	Jeffrey A. Partnow SR 3, Box 31473 Fairbanks, Alaska 99701 456-4724 (home) 452-4769 (work)	November 6, 1980
	Thomas J. Harrison, M.D. 3500 Lateuche, Suite 250 Anchorage, Alaska 99501 333-~~4513~~ (home) 4563 277-4151 (work)	July 8, 1980
	Thomas Stengl, M.D. Box 1059 Auke Bay, Alaska 99821 586-7466 or 586-6601 (work) 789-0805 (home)	January 12, 1980
	Hilbert J. Henrickson, M.D. (chairman) 3612 North Tongass Avenue Ketchikan, Alaska 99901 225-58[illegible] (home) 225-5146 (work)	April 21, 1982
	Winthrop Fish, M.D. 1249 Bannister Anchorage, Alaska 99504 279-8262 (home) 272-5733 (work)	April 21, 1981
	Janette P. Adasiak 1835 Crescent Drive Anchorage, Alaska 99504 279-4970	August 13, 1980
	Hugh Gellert Box 386 E. SRA Anchorage, Alaska 99507 344-3240 (home) 272-4922 (work)	January 19, 1981

Board or Commission	Appointee	Term

BOARD OF PHARMACY
AS 08.80 - 7 members, 5 year term; serves until the new member is appointed and qualified; Legislative co..firmation.

Eldon Ulmer (chairman) P.O. Box 1420 Anchorage, Alaska 99510 344-1260 (home) 277-2567 (work)	March 31, 1982
James L. Murphy 1114 Galena Street Fairbanks, Alaska 99701 456-4667 (home) 452-2328 (work)	March 31, 1981
Lester E. Elkins P.O. Box 409 Petersburg, Alaska 99833 772-3241 (work)	March 31, 1983
Charles R. Rush Box 3728 Anchorage, Alaska 99501 277-2701 (home) 272-6431 (work)	March 31, 1979
James H. McCorcle Box 450 Juneau, Alaska 99802 586-1025 (work) 586-2493 (home)	March 31, 1980
Fred Savok (public member) 8320 East 10th Anchorage, Alaska 99504 337-4965 (home)	March 31, 1981
Robert K. Snider (public member) P.O. Box 1620 Anchorage, Alaska 99510 277-5306 (home) 279-6471 (work)	March 31, 1980

Board or Commission	Appointee	Term

BOARD OF EXAMINERS IN OPTOMETRY
AS 08.72 - 5 members; 3 year term; serves until new member is appointed.

Timothy B. McLaughlin, O.D. (chairman) — June 15, 1979
P.O. Box 498
Sitka, Alaska 99835
747-6645 (work)
747-8449 (home)

John T. Shank, O.D. — June 15, 1980
P.O. Box 827
Kodiak, Alaska 99615
486-3859 (home)
486-5504 or 5592 (work)

Thomas Kinsella (public member) — June 15, 1981
SR Box 31071
Fairbanks, Alaska 99701
456-2617 (home)
452-1155 (work)

Carolyn J. Black — June 15, 1979
Box 24
Haines, Alaska 99827
766-2583 (home)
766-2576 (work)

Dr. Maynard Falconer — June 15, 1981
P.O. Box 919
Anchorage, Alaska 99501

Board or Commission	Appointee	Term

BOARD OF DISPENSING OPTICIANS
AS 08.71 - 7 members; serve at the pleasure of the Governor, 3 year term

George Tresnak — June 14, 1979
6051 East 22nd Avenue
Anchorage, Alaska 99504
333-9931 (home)
272-5715 (work)

Dick L. Kleinkopf (chairman) — June 14, 1981
P.O. Box 1660
Fairbanks, Alaska 99701
456-5316 (home)
452-5208 (work)

Philip A. Lampert — June 14, 1979
P.O. Box 4-2183
Anchorage, Alaska 99509
274-2273 (home)
274-9210 (work)

Edna M. Lyon — June 14, 1981
P.O. Box 92
Anchorage, Alaska 99510
272-6328 (home)
272-5715 (work)

Robert Sherwood (public member) — June 14, 1980
730 I Street
Anchorage, Alaska 99501
279-0422 (work)
276-4960 (home)

Harry J. Lang (public member) — June 14, 1979
1406 West 47th Avenue
Anchorage, Alaska 99503
279-5741 (work)

Larry E. Harper — June 14, 1980
404 K Street
Anchorage, Alaska 99501
349-4394 (home)
272-8632 (work)

Board or Commission	Appointee	Term

STATE PHYSICAL THERAPY BOARD
AS 08.84 - 5 members; 3 year term; shall serve until successors are appointed; appointed by the Governor.

Edward T. Heuston (secretary) Star Route, Box 6014 Eagle River, Alaska 99577 694-9761 (home) 274-3505 (work)	September 1, 1980
Gary W. McCarthy 1940 Patterson Anchorage, Alaska 99504	September 1, 1980
Donna Klokkevold, RPT (chairman) 3710 East 20th Avenue Anchorage, Alaska 99504 277-2219 (home) 272-0586 (work)	September 1, 1981
J. Michael James, M.D. 3710 East 20th Avenue Anchorage, Alaska 99504 277-1312 (work) 279-6094 (home)	September 1, 1980

Board or Commission	Appointee	Term

BOARD OF NURSING HOME ADMINISTRATORS
AS 08.70 - 5 members; 3 year term; serve at the pleasure of the Governor.

Leona Bowles 318 4th Street, Graehl Fairbanks, Alaska 99701 456-4586 (home) 452-1735 (work)	October 1, 1981
Roberley Reh Potter (administrator) Box 1176 Sitka, Alaska 99835 747-8250 (work)	October 1, 1979
Jane Hanna, R.N. (chairman) Route 3, Box 3738 Juneau, Alaska 99801 586-1529 (home)	October 1, 1980
Donna M. Stephens SR Box 50060 Fairbanks, Alaska 99701 479-4543 (home) 452-1921 (work)	October 1, 1980
Dove M. Kull 326 4th Street Mendenhall Apartments #1010 Juneau, Alaska 99801 586-2670 (home)	October 1, 1980

Board or Commission	Appointee	Term
BOARD OF CHIROPRACTIC EXAMINERS AS 08.20 - 5 members; 3 year term; serve at the pleasure of the Governor.		
	Keith Godfrey (chairman) 3800 Lake Otis Parkway Anchorage, Alaska 99504 272-0123 (work) 279-5838 (home)	July 15, 1979
	Adrian Barber (secretary) Klatt Station Box 10033 Anchorage, Alaska 99501 344-1501 (work) 344-7674 (home)	July 15, 1978
	Lee Q. Burger (vice president) 320 Bawden #306 Ketchikan, Alaska 99901 225-6815 (work) 225-2018 (home)	July 15, 1980
	Locke Jacobs (public member) 3540 Wingate Circle Anchorage, Alaska 99504 277-5682 (home) 277-1587 (work)	July 15, 1979
	Linnea Burmeister (public member) P.O. Box 1103 Nome, Alaska 99762 443-2958	July 15, 1981

Board or Commission	Appointee	Term

BOARD OF DENTAL EXAMINERS
AS 08.36 - 7 members; serves 5 year term, until new member is appointed and qualified

Wayne Putman, D.M.D. — February 1, 1983
Route 5, Box 5107
Juneau, Alaska 99803
789-6983 (work)
789-9045 (home)

Arthur Hansen (chairman) — February 1, 1982
3487 Airport Road
Fairbanks, Alaska 99701
479-2100 (work)
479-2101 (home)

Leonard Yuknis, D.D.S. — February 1, 1979
2601 Boniface Parkway
Anchorage, Alaska 99504
333-9591 (work)
344-5784 (home)

John R. Beard (public member) — February 1, 1981
425 G Street
Anchorage, Alaska 99501
277-3213 (work)

Jana M. Varrati, R.D.H. (dental hygienist) — February 1, 1981
7030 Foothill Drive
Anchorage, Alaska 99504
333-9591 or 272-7232 (work)
279-0268 (home)

Claude G. Rick, D.D.S. — February 1, 1981
3606 Rhone Circle
Anchorage, Alaska 99504
279-6235 (work)
272-0812 (home)

John Kobylarz, D.M.D. (secretary) — February 1, 1980
P.O. Box 830
Soldotna, Alaska 99669
262-4690 (work)
262-4942 (home)

Board or Commission	Appointee	Term

BOARD OF VETERINARY EXAMINERS
AS 08.98 - 3 members; 4 year term; serves at the pleasure of the Governor.

Berton A. Gore, D.V.M. (chairman) — July 31, 1980
P.O. Box 666
Palmer, Alaska 99645
745-3219 (work)
745-3345 (home)

Clifford D. Lobaugh, D.V.M. — January 31, 1981
RR#6 Box 3552
Juneau, Alaska 99803
789-9210 (home)
789-7551 (work)

David Howe, D.V.M.
2639 Boniface Parkway
Anchorage, Alaska 99504
337-1561 (work)
333-7207 (home)

Board or Commission	Appointee	Term

BOARD OF PSYCHOLOGISTS AND PSYCHOLOGICAL ASSOCIATE EXAMINERS
AS 08.86 - 5 members; 3 year terms; serves at the pleasure of the Governor.

Dorothy Whitmore, Ed.D. (chairman) — July 1, 1980
207 E. Northe Lights Blvd.
Suite 202
Anchorage, Alaska 99503
344-2078 (home)
276-2230 (work)

James C. Parsons — July 1, 1979
207 E. Northern Lights Blvd.
Suite 202
Anchorage, Alaska 99503
276-2230 (work)
279-3735 (home)

Robert D. Bowers — July 1, 1981
7744 Boundary Avenue
Anchorage, Alaska 99504
337-6256 (home)
279-9544 (work)

Dick L. Madson — July 1, 1980
Suite D, Nerland Building
543 Third Avenue
Fairbanks, Alaska 99701
456-7219 (home)
452-4215 or 452-4254 (work)

Pam Delys Raglien, Ph.D. — July 1, 1981
Kodiak/Aleutian Mental
Health Center
P.O. Box 712
Kodiak, Alaska 99615
486-5742 (work)

Official Business

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Pouch V
State Capitol
Juneau, Alaska 99811

March 28, 1980

To: Members of the House HESS Committee

From: Representative Thelma Buchholdt, Chair
House HESS Committee

Subject: HB977

Coming up for hearing in Committee on Monday, March 31 and Tuesday and Wednesday, April 1 and 2, will be a major bill to extend health coverage in this state. Enclosed is background material on the legislation. Briefly, it includes:

I. Summary of Proposed Health Legislation

This is a detailed explanation of the provisions of the bill. Section one requires employers to sponsor prepaid group health care plans for their employers. Section two requires insurance carriers to form a joint underwriting association and issue coverage for high risk "uninsurable" clients. It also establishes state standards for "qualified" health policies and requires carriers to offer qualified olicies to their clients. The remaining several sections expand s ate medical assistance programs and address provider payment problems.

II. An Analysis of the Extent of Health Care Coverage and Gaps in Coverage

This is an excerpt from Third Party Health Coverage in Alaska published by Legislative Affairs Agency Research Division in April, 1978. The author estimates that between 20 and 25 percent of the non-Native non-military population state-wide currently lack third party health coverage. An addendum h been included estimating that roughly 200 high risk clients uld enroll for the pooled risk coverage.

III. An Analysis of the Social Impact of the Proposed Health Legislation

This section considers the bill's impact on the public, on employers and employees, and on insurance carriers. It is estimated that the legislation would expand health coverage in the state to cover more than 95 percent of the population. Mandatory employer sponsored covera in which the premiums

are shared by the employer and the employee would raise labor costs to the employer and would lower the take-home pay of the employee. The premium cost of the required coverage is estimated at $30 to $50 per month for a single employee and $75 to $110 per month for an employee with dependents. The impact on insurance carriers would depend on how closely the bill's requirements match current practice and how large the volume of health insurance business the carrier has in Alaska.

IV. The Experience in Other States

This section includes two speeches presented at the "Health Care Financing Options for Colorado" conference, September, 1979. The first speech is by George Yuen, Director of Health, State of Hawaii, and describes the operation of Hawaii's Prepaid Health Care Act mandating employer sponsored coverage. The second speech is by Brian Oberg, Administrative Assistant to the Health and Welfare Committee, Minnesota House of Representatives. It describes the operation of Minnesota's Comprehensive Health Insurance Act which sets minimum standards for health insurance policies and establishes a mandatory assocaition of insurance carriers to underwrite health insurance for people who, because of existing health conditions, are unable to buy standard coverage. Both states have been very pleased with the results of their legislation and have experienced very few problems with it.

V. Legal Issues

A law suit has been brought against the Minnesota law challenging its constitutionality. While it is too early to predict the final outcome, the State of Minnesota is confident that the law will survive this test. This section includes a speech by John Igrassia, Supervisor of the Life and Health Section of the Minnesota Division of Insurance, discussing some of the legal issues in the case.

PROJECT HEALTH

The Multnomah County Medical Society supports the concept and goals of "Project Health" in principal, as they act to care for the medically indigent in our community. The Society encourages individual physicians to give consideration to participation in this project.

POSITION: Board of Trustees 2/27/74 - Executive Committee

PROJECT HEALTH I

The Multnomah County Medical Society recommends that, in the interest of quality patient care, physicians participating in the 'Project Health' pilot program should continue to bill their usual fees for professional services. When 'Project Health' funds are exhausted, the Multnomah County Medical Society urges its members to continue to provide care for these patients.

The Society also asks the 'Project Health' staff to provide an accounting of those patients who received care, showing the number of patients receiving care, the amounts billed, and the amounts paid.

POLICY: Board of Trustees 3/27/74 - Executive Committee

LA11 2313 11.28 JA01 0020 11.28 04/03/80

TO REP. BUCHHOLDT AND HER STAFF

BERNEICE BAR, 4220 B ST., SUITE 201, ANCHORAGE, AK 99503 WAS AT THE TELECONFERENCE ON HB 977 THE OTHER DAY, AND DURING THE COURSE OF THE CONFERENCE ASKED WHAT "REHABILITATIVE SERVICES" ON P. 33, LINE 8, ENTAILED. SHE SPOKE WITH SOMEONE FROM REP. BUCHHOLDT'S STAFF (COULDN'T REMEMBER THE NAME) WHO TOLD HER THAT SHE WOULD RESEARCH IT AND SEND HER INFORMATION. MS. BAR WORKS WITH REHABILITATION SERVICES AND THIS IS OF PARTICULAR INTEREST TO HER.

MS. BAR WAS EXPECTING THIS INFO TO BE TELECOPIED TO HER THROUGH OUR OFFICE.

WILL THE INFO BE FORTHCOMING? COULD I TELL HER WHEN TO EXPECT IT? THANKS. EFFIE (ANCHORAGE LEGISLATIVE INFORMATION OFFICE)

Jan 5

LA11 2390 14.02 JA01 0066 14.02 04/10/80

TO: JAN IN REP. BUCHHOLDT'S OFFICE
HOUSE MESS

FROM BERNEICE BAR, 4220 B. ST., SUITE 201, ANCHORAGE 99503
PHONE 279-9431

I HAVE NOT YET RECEIVED THE INFORMATION WHICH I REQUESTED ABOUT THE REHABILITATION SERVICES MENTIONED ON P. 33 LINE 8, OF HB 977. YOU MENTIONED WHEN I INQUIRED LAST WEEK THAT YOU WOULD BE MAILING IT.

Sent 4-11

YOUR PROMPT ATTENTION TO THIS MATTER WOULD REALLY BE APPRECIATED.
THANKS.

LIMITS ON EMPLOYEE SHARE OF PREMIUM COST

Hourly Wage	Gross Monthly Wage (172 hrs.)	Maximum employee share (HB 977) 1.5%	2%	3%
$3.60	$619	$9.29	12.38	18.57
4.00	688	10.32	13.76	20.64
6.00	1032	15.48	20.64	30.96
8.00	1376	20.64	27.52	41.28
10.00	1720	25.80	34.40	51.60
15.00	2580	38.70	51.60	77.40
20.00	3440	51.60	68.80	103.20

ESTIMATED PREMIUM COSTS FOR NUMBER TWO QUALIFIED PLANS[1]

Individual Plans - Employee Only	Minnesota Rate November 1979 (Quarterly)	Area Differential[2]	Est. Rate in Alaska (Quarterly)	Est. Rate in Alaska (Monthly)
low: Blue Cross/Blue Shield, Male age 20-24	$31.47	+12%	$35.25	$11.75
high: State Farm, Male or Female age 60-64	214.40	+ 7%	229.41	76.47
Average of 5 carriers[3], Male age 35-39	55.42	+11%	61.52	20.51
Average of 5 carriers[3], Female age 35-39	87.13	+11%	96.71	32.24
Individual Plans - Employee and Dependents				
low: Blue Cross/Blue Shield, M 20-24 + F 20-24 + children	$128.27	+13%	144.95	$48.32
high: State Farm, M 60-64 + F 60-64 + children	487.68	+ 7%	521.82	$173.94
Average of 5 carriers[3], M 35-39 + F 30-34 + children	185.80	+11%	206.24	$68.75

Group plan premiums are roughly 8% less than individual plan premiums.

1 The Minnesota minimum standards for a number two qualified plan are the same as those specified in HB 977 except that the requirements for coverage for well baby care, physical exams, and multi phasic screening have not yet taken effect in Minnesota, and Minnesota does not cover medically necessary transportation (other than an ambulance) or treatment for alcoholism or chemical dependence.

2 Derived from the area schedule of premiums of the CARE group insurance trust for all Alaska and for Anoka, Dakota, Hennepin, Ramsey, and Washington counties in Minnesota.

3 Blue Cross/Blue Shield, Prudential, State Farm, National Farmers Union, and Massachusetts Mutual. This is a straight average and not a weighted average. Since Blue Cross/Blue Shield has by far the lowest rates and covers 96% of the people covered by these five Minnesota carriers, the straight average used here is substantially higher than the weighted average would be.

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, respirators, 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 commercial 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 insurance policies	yes
mental & nervous disorders	50% coverage up to $2500 maximum per year when rendered by and M.D., D.O., or licensed psychologist	———	———	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 deductibles, coinsurance and limits	effective July 1, 1980	_____
physical exams	___	yes, subject to applicable deductibles coinsurance and limits	effective July 1, 1982	_____
multiphasic screening & other diagnosis	___	yes, subject to coinsurance, 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 dependent	spouse, children under 18, children under 25 who are students and financially dependent, disabled children of any age who are financially dependent and dependent household members	spouse, children under 19, children under 25 who are students and financially dependent, children of any age who are disabled and dependent	not specified

Section 18.12.040, on Page 3. This section discusses the commencement of coverage. It will mean a change in the usual probationary periods that have been set up by employers for their employees. The four week phase-in into the health care plan does not jibe with the usual two month, or sometimes three month, probation period for employees joining a company and may create a problem for an employer. We would need, here at Blue Cross, to adjust for our Alaskan employees the standard probationary period of our company. This would create a problem for our company as it would for any other company who has employees both in Alaska and in other states.

Section 18.12.070, Pages 4 and 5. This section of the legislation enables a person who has coverage as a dependent under some other health care plan to waive his coverage through his employer. That will create a complication in administration for employers. Looking at it from the point of view of insurance coverage, it will also create the possibility of selection of coverage, where the person knowing himself/herself to be in poor health will accept coverage under both types of employment and the healthy individual will not. That will result in the utilization being increased and therefore the cost to the employer for premium also will rise.

4B/11
js

Section 21.50.010(d) on Page 13. In this section of the bill an "unqualified policy" is used as terminology. There is no definition in this bill of an unqualified policy. This bill also uses the term "nonqualified plan" and there is confusion between "unqualified policy" and "nonqualified plan."

js
4B/12

Section 21.50.030(1), on Pages 14 and 15. The definition of minimum benefits needs some major corrections. All benefits offered in a state health plan should be determined to be medically necessary. A definition of medically necessary should be included in the definition section of this legislation. The reference throughout this subsection to services by varying health care practitioners never refers to them as licensed health care practitioners which I think should be inserted into the bill. The bill does not require that the service [redacted] be provided by a practitioner [redacted] within the scope of his practice. Tightening up the language will eliminate payment of claims for procedures that were provided by a practitioner whose scope of practice does not include that procedure and would eliminate payment for procedures which are not necessary to the life or health of the patient. In Subsection (D), services of a nursing home are included as a benefit. Nursing homes should be identified either as licensed or Medicare-approved.

Subsection (E) defines services of a home health agency. In the delineation of services by a home health agency I would urge you to list those services which will be covered for a patient served in his home. In other insurance contracts home health services often lists the practitioners whose services will be accepted as well as the paraprofessionals that will be included in this service. This bill, as it is now written, could result in a tremendous increase in home health costs and therefore an increase in premium price over a more restricted benefit.

Subsection (L) of this bill deals with oral surgery. While the root canal and oral surgery definitions are well worded, the wording of the language dealing with periodontal work would be very hard to administer. It would be difficult to explain to a patient that his periodontal services will be paid for if only periodontal work is done, but will not be paid for if, at the same time as having the periodontal surgery, there is some extraction or repair of teeth.

In subsection (N) the provision of payment for transportation must be more succinctly defined. As written,it is very broad and will be very expensive and administration will be difficult.

js
4B/13

Section 21.50.030(2) on Page 15. Subsection 2 deals with the exclusions for services or articles which will not be covered in the insurance. In (b) of that section, the phrase "birth defect" is used. I would suggest that a definition of birth defect be included in the definition section.

I would urge you to add a 5th exclusion to this section for services of custodial care. I would urge you to add a definition of custodial care which might read "Any portion of a service, procedure or supply rendered to manage a patient's illness, disease or injury after he or she has reached a point in recovery where such management, can no longer be expected to improve the condition."

Subsection (3) of this minimum benefit section lists benefits with specialized co-insurance, premium deductibles, and limitations. A definition of "well baby care" is needed. The inclusion of routine physicals and annual physicals should be limited more than the present language. Annual physicals, technically, are not prescribed by a physician. To control overutilization of this benefit, you may want to look at some of the recent changes announced by the American Cancer Society where they are recommending that cancer check-ups for persons between ages 20 and 40 be limited to one every three years. They are talking in terms of mammography for breast cancer detection yearly only for women over 50 and they are reducing the recommended number of chest x-rays as well as the recommended number of Pap smears from one a year to one every three years. This seems to be the trend in the detection of illness area and the language used in this bill should perhaps refer either to limitations of this sort or to dollar limitations in order to control utilization of a procedure that may not be cost effective.

Multiphasic screening should also be limited either by a dollar limitation or by a limitation on the number of procedures per year which will be paid for by the insurance.

All these changes have been suggested to eliminate the probability of excessive use, to eliminate inappropriate utilization, and to control costs to those necessary for the good health of Alaskans.

js
4B/14

Section 21.50.040 on Page 16. This section, which deals with Medicare Supplement Plans, does not seem to recognize that Medicare Supplement is also available to the disabled person under age 65 who is a Medicare recipient. The language of this section needs to take into account the fact that there are persons under 65 who are disabled who do purchase Medicare Supplement policies.

It is our concern that the benefits in this section for the Medicare Supplement Plan are so extensive that the costs will become too high for the average person to purchase a Medicare Supplement policy. The benefits which the State of Alaska would include in a Medicare Supplement Plan (which are not now included in Medicare-approved services) are prescription drugs, prostheses, durable medical equipment, oral surgery, and transportation. Two of the services, those of physical therapists and alcoholism treatment, are now limited by Medicare and an appreciable portion of the costs for services of this sort would then be born by the Supplement Plan. Since there is also a limitation of a $1,000 per person out-of-pocket for these covered services, it is expected that the utilization of these benefits would be extremely heavy and would therefore make the cost of the Medicare Supplement Program extremely high.

At the time that Congress was debating Medicare coverage, prescription drugs, transportation, and custodial care in nursing homes were all subjects which were debated and which were dropped out of Medicare coverage because the Federal Government did not feel that it had sufficient revenues to pay for these coverages. While the addition of these benefits would be of interest to many senior citizens in Alaska, the cost of providing these services may result in pricing the Medicare Supplement contract out of the reach of anyone on a retirement income.

js
4B/15

Section 21.50.080, Subsection 6(c), Page 21. This section specifies a 12-1/2 percent limit for retention costs and agent fees for the writing carrier of the State Plan. I know of no information which would indicate that this is a reasonable percentage. I would suggest that the Division of Insurance determine a reasonable limit and adopt it in regulations after sufficient experience indicates what that limitation should be.

In Section 6(e) the wording should be amended on lines 23 and 25 of Page 21 so that the losses which the members of the association will share will be losses due to administrative as well as claims expenses. I would suggest that on lines 23 and 25 that the words "and administrative" be inserted between the word "claims" and "expenses".

Section 21.50.080(6)(f) concerns the assessment of losses and they are offset either by income tax or premium tax payable in the State of Alaska. This offset will of course result in a loss of state revenue. It is the opinion of those persons at Blue Cross who have studied this legislation that the write-off should be eliminated and instead that rates for the state plan should be adjusted to assure revenue sufficient to refund the assessments paid by members of the association. This would eliminate the loss of revenue to the state and would place all members in an equal status regardless of whether they are accident and health insurers or nonprofit health service plans.

If an offset is included in this legislation then the second sentence of paragraph (f) should be amended in order to assure that the report to the legislature is placed within a workable time frame. It is my understanding that premium tax payments are made on a calendar year basis. They must be reported to the state during February of any year and are payable by March 31 of that year. A report concerning the losses from premium tax which is due before the end of January would not be feasible in my estimation.

js
4B/16

Section 21.50.100, Page 23. This section specifies the method by which the state plan is administered, however, there is no definition of a source of monies from which claims will be paid if those claims are in excess of the premium paid into the plan. There is no money available to continue payment of claims until the assessment against losses is paid as this legislation is now written.

Section 21.50.130, Pages 26 and 27. In this section a "individual coverage qualified plan" is referred to. I can find no definition of what an individual coverage qualified plan is.

Subsection (b) of this section is unclear. Blue Cross assumes that this subsection refers to a widow/widower of a person who has a conversion policy but we are not certain of this interpretation. If this section refers to the right of the widow/widower of a group member, then the language is obtuse and administration of that provision will be difficult.

js
14B/17

Section 21.50.200 on Pages 27 and 28. One of the definitions in this section is the definition of "dependent". You have specified that this includes "A household member who is financially dependent on the primary insured". That addition to the usual "family" dependents which can be identified by a legal action (marriage, divorce or adoption) or by birth will create administrative headaches and excessive additions or deletions on dependent lists. This definition of dependent would be open to abuse. It is conceivable that "dependents" could be changed readily creating administrative problems and claims payment problems and that dependents, in some cases, might be added solely for the ability to provide them with health care coverage through the policy being paid for by the primary insured's employer. That portion of the definition of dependent should be deleted from this bill.

js
4B/18

METHOD USED TO DEVELOP FISCAL NOTE FOR HB 977

House Bill 977 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 HB 977, 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 HB 977.

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

Medicaid money for services that they are already providing to persons eligible for AANHS, 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 HESS Committee for SB 320. For purposes of HB 977, the amount in that fiscal note was doubled to reflect the fact that HB 977 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 HB 977 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.

STATE OF ALASKA

Legislative Affairs Agency

THIRD PARTY HEALTH COVERAGE IN ALASKA

Prepared by

LEGISLATIVE AFFAIRS AGENCY

Research Division

April 1978

Foreword

This study was prepared by Sharman Haley of the Legislative Affairs Agency staff at the request of Representative Thelma Buchholdt. The issue of access to health care in Alaska is a matter of general concern to many other policymakers as well, and we are therefore making the report available, with Ms. Buchholdt's permission, in this more convenient format.

Interested readers are invited to share with us any comments they may have on the report or its subject matter.

Gregg K. Erickson
Director of Research
Legislative Affairs Agency

Juneau, Alaska
April 1978

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SUMMARY

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

I. INTRODUCTION

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

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

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

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

II. A DESCRIPTION OF HEALTH COVERAGE FROM PUBLIC SOURCES

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

Alaska Area Native Health Service

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

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

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

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

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

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

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

U. S. Public Health Service

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

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

Uniformed Services Health Benefits Program

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

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

Medicare

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

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

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

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

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

Medicaid

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

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

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

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

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

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

General Relief Medical

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

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

Catastrophic Illness Program

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

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

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

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

III. A DESCRIPTION OF HEALTH COVERAGE FROM PRIVATE SOURCES

Private Health Insurance

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

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

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

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

Blue Cross

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

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

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

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

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

Health Maintenance Organizations

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

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

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

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

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

Teamsters

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

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

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

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

The Covered Population

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

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

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

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

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

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

Services Covered

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

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

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

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

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

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

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

V. POSSIBLE LEGISLATIVE ACTION TO EXTEND COVERAGE

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

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

Universal Coverage

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

Coverage for the Uncovered

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

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

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

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

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

Income Tax Credit

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

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

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

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

Medicaid Medically Needy Program

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

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

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

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

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

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

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

Mandatory Employer Coverage

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

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

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

High Risk Reinsurance Pools

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

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

Minimum Benefits Standards

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

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

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

VI. CONCLUSION

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

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

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

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

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

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

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