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

PROFILE OF ALASKA CARRIERS 1978

Of the more than

300 carriers licensed to write accident and health insurance in Alaska, only

204 carriers reported any group or individual accident and health policy premium volume;

21 carriers reported over $500,000 in accident and health individaul and group premiums;

36 carriers reported $50,000 to $499,000 in accident and health individual and group premiums;

68 carriers reported 5000 to 49,000 in accident and health individual and group premiums; and

79 carriers reported less than $5,000 in accident and health individual and group premiums.

Hospital medical services corporations reported the following premium volumes:

Blue Cross of Washington and Alaska	$31,260,000
Deltal Dental Plan of Alaska	741,000
Physicians Services of Fairbanks	214,000
National Hospital Association	32,000

data from the 1979 Insurance Report by the Department of Commerce and Economic Development

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

April 14, 1980

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

Dear Representative Buchholdt:

It's been one full week since I have returned to my desk after my visit to Juneau and the "Lower 48". Our Legislature is in the midst of winding up for a possible adjournment this Friday. Therefore, I have been running from one conference committee meeting to another, especially since my Director is in Denver, Colorado, on official business.

I want to thank you and all of your associates for making my visit to Juneau very enjoyable and interesting. I have already discussed with Mrs. Ching plans to travel up the inland sea on a cruise, if not this summer, possibly next. I do not know whether the cruise will go as far north as Juneau, but I would like to show your capital to her.

I hope my visit was of some help to you and your proposed legislation I commend you for your efforts in trying to make Alaska a better community for Americans to live in. My best wishes to you and your associates in the successful conclusion of your efforts in regards to the Prepaid Health Care Insurance. Please call on me if I can be of any further assistance to you.

My best regards to all of your staff and associates.

Aloha,

Donald Ching

STATE OF MINNESOTA

Commissioner of Banks
(612) 296-2715
Commissioner of Insurance
(612) 296-2488

Commissioner of Securities
(612) 296-6848
Executive Secretary
(612) 296-2283

DEPARTMENT OF COMMERCE
500 Metro Square Building
St. Paul, Minnesota 55101

April 9, 1980

The Honorable Thelma Buchholdt
State Representative
Committee on Health, Education and Social Services
State of Alaska
State Capitol
Juneau, Alaska 99801

Dear Representative Buchholdt:

Thank you for the hospitality you and your staff extended to me during my recent visit to your beautiful state. It was a wonderful experience for me, one that I shall never forget.

I'm enclosing a copy of the statement I presented to the Pennsylvania House Insurance Committee last year. The presentation summarizes our experience and my thoughts on mandatory insurance coverage for treatment of drug and alcohol abuse.

I shall be happy to respond to any questions or to send you additional information on our insurance statutes or on the Minnesota Comprehensive Health Association.

Sincerely,

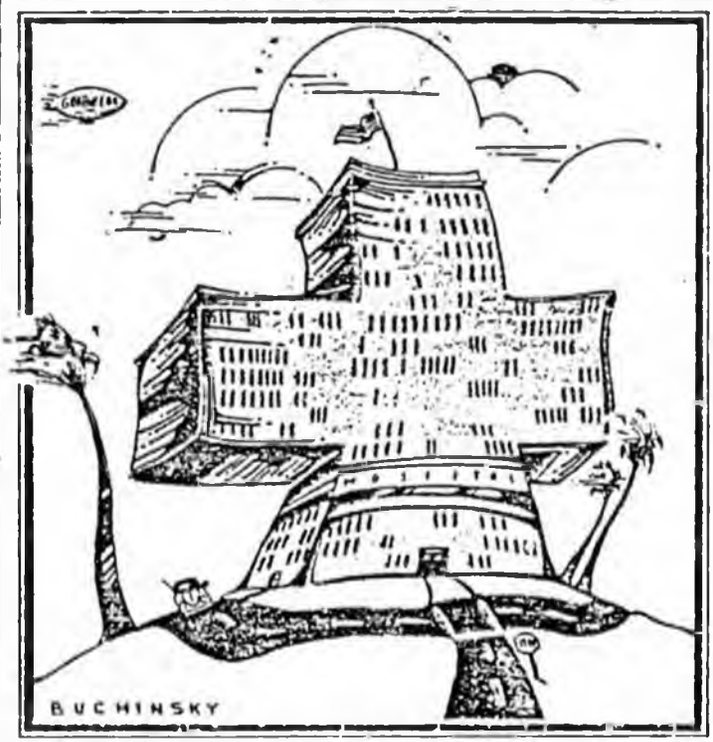
John T. Ingrassia
Supervisor
Life and Health Section
Insurance Division

mw
enclosure
0509

Mother's Healer

YOUR HEALTH AT TOO HIGH A PREMIUM

by Hugh Drummond, M.D.



SOME FORM OF national health insurance seems inevitable. It has been an almost sacred tenet of American liberalism since the New Deal. The Great American Center has shifted its hemorrhoidal bottom in this direction, and even organized medicine has begun to calculate the finger-lickin' goodies involved in a $60 billion-plus federal program.

Insurance is, of course, the American way of dealing with life's terror. No institution better describes a population trying to save its ass. It is a vestige of the medieval myth that moats and castle walls could keep out the plague. Insurance buildings are designed to convey immortality; steel and granite, sheathed in glass, they are meant to look like the executives who minister to them—vigorous, phallic, Apollonian. If God should break his contract with Noah, those buildings will endure the flood to pay the claims of a well-covered, if dead, constituency.

So it is inevitable that as we grow more anxious we will develop a form of universal health insurance, propped up by the federal government and its corporate underpinnings. About the only people left who are opposed to it are a few herbalists and that peculiar gaggle of paranoids on the Left and the Right, who cannot believe that anything compassionate or rational can emerge from the heart of this nation.

I have great respect for paranoia. So let me count myself among the crazies this time and suggest that, like the massive public housing projects that were another vision of American liberalism, national health insurance as currently conceived will someday be subjected to euthanasia.

Health insurance is really not health insurance at all, but sickness insurance. The major premise behind it is that we are all terrified by cancer and heart disease, which can be treated by such techniques as transplants, by-pass procedures and radiotherapy. These are enormously expensive technologies that the government will be expected to underwrite.

Overlooked are the pervasive diseases of the young and poor, such as lead poisoning, which affects a quarter of the kids in low-income neighborhoods, and malnutrition, which affects even more. Insurance doesn't touch these problems because their control has to do with social and environmental conditions. You can't fight hunger with pocketa-pocketa machines in medical centers.

In fact, when you get right down to it, you can't stop cancer and heart disease that way either. They are just as much social and environmental diseases as they are medical ones.

Since 1900, the ratio of cancer deaths to all deaths has increased five times; the same is true for heart disease. Together they will kill more than half of us. It is calculated by the American Heart Association and the Department of Health, Education and Welfare (HEW) that in a life of 65 years, we lose 1,300 days for being 25 per cent overweight, 1,800 days for living in a city and 3,300 days for smoking a pack a day. Yet we have virtually no information on the relative impact of bad housing, polluted air and water, Muzak and Twinkies. If we did, we would know we were losing the battle.

To really stop cancer we would need to control all industrial pollutants, such as asbestos, vinyl chloride and sulphur dioxide. The huge numbers of synthetic additives poured into our bodies every day would have to be eliminated. If we wanted to control heart disease we might have to do something about unemployment, which has been documented to increase nor-epinephrine and cholesterol excretion to murderous levels. We might also have to eat less, drink less, smoke less and drive less. If a serious effort were made in this country to prevent cancer, strokes and heart disease, the economy would collapse—a fact not lost on the pilots of the empire, many of them now supporting some form of national health insurance.

There have been amazingly few studies on the actual "outcome" of medical care in this country, but when they have been done the results are invariably depressing. A Johns Hopkins University doctor found that only 27 per cent of emergency room patients at Baltimore City Hospital received effective medical care. When the doctor's superiors insisted that the results would be radically different at a more "prestigious" hospital, namely Johns Hopkins, the doctor checked out the patients there who had gastrointestinal symptoms. He found that only 28 per cent of these Johns Hopkins patients received quality treatment. In other words, more insurance will help more people get lousy care.

With Medicaid and Medicare, the forerunners of national health insurance, the more we spent the less we got. In the first year of the programs, doctors' fees rose two and a half times as fast as the cost of living. In the last two years from September 1974 to September 1976, physicians' fees rose 23.3 per cent, while the Consumer Price Index increased by only 13.7 per cent. According to a report released in February by the Health Research Group, Medicare and Medicaid pay out more than $6 billion yearly in doctors' charges. Hospital costs have climbed even faster—a four-and-a-half-fold increase since the programs started. Where did all the extra money go?

Not to new services; there were hardly any of those. A lot of doctors got richer. There was expensive and "interesting" medical technology to utilize, such as the hyperbaric chamber at Mount Sinai, which is operated on an average of only once or twice a day. The money

it on buying and running it uld finance 20,000 outpatient isits a year, or a huge lead poisoning program in East Harlem. But that's not as much fun. Unfortunately, there is no assurance that similarly wasteful health care programs will not be funded by massive national health insurance.

Upper-level hospital personnel increased their salaries as the federal programs took hold. Hundreds of thousands of dollars were spent in efforts to prevent hospital employees from organizing unions. Much of the extra money went for outrageously expensive drugs and supplies. As long as the government was willing to underwrite the cost, the hospitals and doctors didn't care. Most of them welcomed the bucks the federal bonanza brought, no longer convinced that their salaries would decrease under the "socialized medicine" of Medicare and Medicaid.

And for the people the programs were supposed to serve? More people had access to bad health care. But one-third of Americans living below the poverty level remained untouched by Medicare and Medicaid. There was still no medical care for the poor. Enter national health insurance.

With national insurance, the $140 billion-a-year health industry could *really* rake it in. There would be the kind of guaranteed security the defense industry enjoyed during the height of the Cold War. Just think—no more people skipping out on their bills. The whole country as paying customers, and for each person, another prescription filled out, another piece of hardware needed, another disposable whatnot disposed of.

Under national health insurance, the poor still will not have quality medical attention. The health care system is not radically changed under the program, only subsidized fully. There will be no improved doctor-patient relationships, no health clinics that are community controlled. National health insurance does not mean better hospitals, with staffs responsive to the special problems of poor people. No fundamental change for the rich either. As usual, they will buy their way to priority.

We can also look forward to the government entering into some sort of alliance with private insurance companies, as it has with Medicare and Medicaid. Blue Cross is the leading contender for the job of administering a national health insurance system. That's the same Blue Cross that has allowed runaway hospital fees to multiply in the last ten years, while the average length of hospital stay has *decreased*. You might be interested in knowing that Blue Cross is controlled by the hospitals themselves. The hospitals created it during the Depression to ensure that their bills were paid, and you can be sure that with national insurance, hospital bills—no matter how ridiculously high—will be found "reasonable" by Blue Cross.

> "With national health insurance, the $140-billion-a-year health industry could really rake it in—as the defense industry did during the Cold War."

My real anxiety about national health insurance isn't only economic; it is philosophical. There is something wrong with a social policy that irrevocably consigns to a single profession something so subtle and profound as human health. For all the wonders of Western medical science, it has no understanding of and little interest in the meaning of health. It is possible that when you set out to "conquer disease," no less than when you set out to "conquer space," you can't win. Western medicine tries to throttle its patients into well-being. It relies on the military model of technology, the invention of hammers and the subsequent search for heads to bang with them. It has only given us a new ecology of disease with the smell of progress.

I am not suggesting that we dismantle all the cobalt units, computer assisted tomographs and heart-lung machines. But national health insurance will retard a more pluralistic approach to health, which might include self-help programs, herbal remedies and even faith healing. Is it antiscientific to permit the existence of activities that may have centuries of traditional practice and pure empiricism behind them? They may be conceptualized in less mechanistic terms than we have been trained to believe truthful. However, dying empires have always insisted that their vision of the truth is eternal when their artifacts barely survive.

Do I have the courage of my own convictions? Of course not. If I awake tonight with a right lower quadrant pain, shall I not call one of my surgical confreres rather than a Navajo healer? Would I deny that preference to anyone else? No. But neither would I deny the preference of someone for a Navajo healer. Yet with national health insurance, like all the other medical programs, Navajo healers will not be licensed to accept government money. National health insurance grants access to one kind of health care, and if a bill is passed, the "right" to medical care established will be a right to bad medicine.

Think of China for a moment. It has brought health to 800 million people, who were as mutilated, starved, infected and demoralized as any who have ever lived. And in that nation, where pragmatism is almost religious, where waste is murder, they brought health to the people with as much respect for the ancient and the traditional as for the modern and innovative.

Needless to say, there were other changes.

If you have any medical or psychiatric questions you'd like Dr. Hugh Drummond to address in this column, please write Mother's Healer, c/o Mother Jones, 607 Market Street, San Fran-

MEMO

TO: REP. TERRY GARDINER
FROM: JAMES LOVE
RE: HEALTH CARE
DATE: FEB. 20, 1980

A number of legislators have expressed an interest in health care legislation, but there is currently no program slated for consideration this year. What started out as a priority for 1980 has been pushed back a year, in the minds of several legislators.

While a year's delay is comforting for many reasons, there are equally compelling reasons for action this year. First, the legislature can accomplish a number of important objectives this year which will significantly expand health care services to many low-income and unemployed Abaskans, without attempting to design a comprehensive state insurance plan. The preliminary research on these proposals is in hand now. Specific proposals could be ready for introduction within two weeks, and floor action could be scheduled within four to six weeks.

This is an election year, and political consequences are important. But although some may see health care as a risky proposition, it has always recieved good marks from the public in opinion surveys. A state with a large supplus could do worse than spend some of it on the health of it's citizens.

Senate passage of any good legislation is always problematical, but we may have a few drawing cards. For example, the House and Senate are deadlocked on the State Medical Board, over the provision which requires doctors to treat Medicaid patients. The impact of this is twofold. The doctors are put in the position of arguing that health care for the poor is a government, rather than a private sector, responsibility. The doctors are also going to put pressure on the Senate for continuation of the Medical Board. The House can trade the Medicaid provision for movement on other health care bills.

Moreover, Hackney is pushing a health bill - something called "medic-alert" - which will provide for in-home care for the elderly. (this according to news reports). It may provide a vehicle for tacking on the House health package, which will include the elderly care, plus expanded care for many other Alaskans. This would get us to a vote on the Senate floor, in an election year, where Colletta, Bradley, Hackney, Sumner and others are running for re-election.

Several people are ready for action this year. Thelma is anxious to work on health care bills, willing to introduce a package through her committee, and willing to lend significant staff time to the effort. McKinnon is personally interested, and he chairs the Finance Subcommittee on health. Parker is interested and I imagine a number of other key House members would weigh in. Thelma and Joe, with some help from Parker, could provide the lead. In some ways both have held back, waiting for you to make your move.

AkPIRG will make health care a major priority this year if the pieces can be pulled together. We have one person already working full-time on the problems faced by Medicaid patients, and she could spend time lining up support for a health package.

The key consideration, in my thinking, concerns our ability to get solid back-up research for a legislative package - on a tight time table. Thelma will ask Jan to work on this, and Parker will ask Jim Erickson, but neither individual has prior experiance in the health care field. Duncan Read, who already has requests from Parker and others, has assigned Kreinheder to look at several of the proposals that should go this year, such as the Hawaii mandatory employer coverage. However, while Duncan's staff is certainly competent, they are also sorely overextended, and will not be able to provide the day by day, blow by blow, back-up needed to prepare a bill for passage within the short time frame needed for action this year.

According to Duncan, this could be remedied somewhat if he recieved requests from several legislators to work on health care problems. With enough interest, he could approach his governing council and ask that one staff be assigned full time to the health care area. Of course this would require that the other research topics be assigned a lower priority, and this by itself may not be desired.

The one person who knows more about this area than anyone else is Sharman. Her two memorandums to Thelma in 1977 and 1978 are still the basic research on the issue. She is working as a waitress for the federal cafeteria. She is interested in consulting on health care legislation. I imagine that she would need about two months work to justify quitting her present job. She would be available within five working days.

John Crandall tells me that the House will take up a supplemental this week or next which could provide funding for additional committee staff or consultants. Thelma, I am told, would prefer to have a contract with the Alaska Center for Policy Studies, or AkPIRG, than to expand her committee staff. This woild also solve the timing problem a bit, because either the Center, or AkPIRG could start work immediately on assurances from you or thelma that funding would be forthcomming.

The Alaska Center for Policy Studies, as I may have told you, is a non-profit corporation which undertakes public policy studies. It currently has two contracts with the legislature, including contracts with Rogers' Susitna Alternatives Committee and McKinnon's Leasing Policy Committee. The board of the Center includes Joe Josephson, Chairman, Vic Fischer, Vice-Chairman, and Hugh Fleischer, Sec/Treas. Other board members include Matt Berman, Pat Dobey, and Peter Gruenstein.

Assuming that we can agree to proceed, we could begin work on the following proposals:

1. Mandatory Employer Coverage. Hawaii now requires every employer to provide health insurance. This would expand coverage to many non-union workers, particularly those in low-paying service industries, who now lack coverage. Large employers, or those who have been organized by unions, should not be a source of opposition to this bill. Hawaii provides a special program for small employers which subsidizes the cost of insurance if it exceeds certain criteria.

2. Minimum Benefit Standards. The State would be given the authority to regulate the level of service covered by health insurance policies. Several states already do this, and in addition, the National Association of Insurance Commissioners (NAIC) has developed model state health insurance legislation for setting minimum health benefit standards.

3. Medicaid Medically Needy Program. This is an optional medicaid program which extends medicaid assistance to needy people who are a bit over current income guidlines. Twenty-nine states, two territories, and the District of Columbia participate in this program. Alaska does not.

4. Amend Medicaid Statutes. Provide Oregon option to use medicaid funds to purchase health insurance; provide for funding of interest payment penalties when the state is delinquent on its bills; and add additional services to the medicaid program, such as dental care.

5. Reinsurance Pools. Several states have developed mandatory reinsurance pools to ensure health care coverage availablity to high risk persons at reasonable rates. There will be little cost to the state to implement this.

6. Expand State Direct Service Programs. Additional funding could be made available to health clinics throughout Alaska to provide care to Alaskans on a sliding fee basis, according to income. The federal government already subsidizes physicians in areas like Juneau and Palmer, where the availability of services is a problem. This would also be a big help to communities that have doctors, if there was a problem of access, such as a refusal by doctors to accept medicaid coupons.

While these programs do not close all gaps, or address all health care issues, such as cost containment, they will extend services to many Alaskans, at a reasonable cost. Nothing is particularly novel, and experiance from other states is available. It can be pulled together as a House health package within the time frame detailed below.

Feb. 22 decision to proceed

29 detailed drafting request to LA legal

March 7 bills ready for introduction

17 hearings begin in HESS

31 legislation ready for floor action

With a combination of focus, coordination, and concentration, we can put together an excellent package this session. It would affect people's lives directly and immediately.

STATE OF ALASKA
THE LEGISLATURE
LEGISLATIVE AFFAIRS AGENCY

POUCH Y STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3600

MEMORANDUM

May 27, 1977

SUBJECT: State Health Insurance (W.O. #4206)

TO: The Honorable Thelma Buchholdt

FROM: Sharman Haley SH
Research Analyst

Carter's National Health Insurance Proposal

The Carter Administration has not developed a comprehensive health insurance proposal. An advisory committee was recently established to evaluate the alternative approaches to national health insurance, and they are currently taking testimony in several cities across the country.

During the campaign, Carter promised national health insurance with the following provisions:

1. universal and mandatory coverage, implemented in stages based on priorities of need and financial feasibility;
2. comprehensive and uniform benefits with emphasis on preventive medicine;
3. financing by payroll taxes and general tax revenues;
4. cost and quality controls, uniform standards and set rates;
5. maximum personal interrelationship between patient and physician consumer choice of provider, and basic concern for the dignity of the person, unrelated to wealth or income;
6. incentives for improved delivery of services, for increased productivity, for redistribution of health personnel, and

resources for the development of alternative delivery systems;

7. consumer representation in development and administration.

Carter estimated the cost of implementing this program at $10 billion of new federal expenditures. It is not clear what his reasoning was to arrive at such a low figure, since he has not proposed a plan that can be costed out. One comprehensive mandatory plan that has been cost estimated is the Health Security Act, and the estimate of new federal expenditures for that pla is $80 billion.

There were 23 different national health insurance proposals before Congress last year, but none are moving now.

State Approaches

Two national organizations have developed model state health insurance legislation. The Conference of Insurance Legislators proposes a comprehensive health care program with universal voluntary coverage, regulated by the state, but administered by private carriers and financed by consumers. The National Association of Insurance Commissioners proposes a catastrophic health care program financed by the state. We have requested copies of these two models.

There are five states that have passed and implemented state health insurance. In Rhode Island, Maine, and Minnesota, the state provides financial assistance for catastrophic health expenses. In Hawaii, Connecticut and Minnesota, again, the state regulates private comprehensive health coverage to insure quality and availability and to control costs. No state directly subsidizes comprehensive health insurance for its residents, because it appears to be prohibitively expensive.

Hawaii: Every employer in Hawaii is required to offer a qualified health care plan to his/her employees and to pay at least half the premium. Qualified plans must meet state minimum standards. Small employers with fewer than eight employees whose share of the premiums would exceed 1.5% of their payroll, when that excess is greater than 5% of the employer's income from the business are entitled to a state subsidy for the remainder of the premium. This statute took effect in 1975, and though several employers applied for state assistance, none were found to be eligible.

Connecticut: The Connecticut comprehensive health care plans statute insures the universal availability of comprehensive health care insurance contracts meeting state minimum standards, at standardized premiums. The Health Reinsurance Association is created with mandatory membership of all carriers in the state to pool risk for the mandated coverage. The premium rates vary by sex and age, and for group contracts by geographical area, as well. Sample quarterly premium rates are in Table I.

Table I - Sample Quarterly Premium Rates for Connecticut Comprehensive Health Care Plans

Individual/ /Group*	30-year old Female	60-year old Male
Deductible		
$200	$114.57/ /$103.11	$243.15/ /$218.82
$500	$ 85.92/ /$ 77.34	$182.37/ /$164.13
$750	$ 74.46/ /$ 67.02	$158.04/ /$142.23

* Rate for Hartford, New Haven and Fairfield region.

Minnesota: The Minnesota statute requires all health insurance carriers to offer health coverage which meets minimum state standards, and requires employee health benefits to meet minimum standards. It also established a state comprehensive health plan available to any resident who is rejected, restricted, or limited in their health coverage from the private sector. This state plan is offered by all carriers and reinsured by an association of carriers, in which membership is mandatory, to pool the profits and losses of high risk coverage.

This comprehensive health insurance statute in Minnesota took effect in January of this year. There are now 12 law suits pending challenging the law. Interstate employers complain that when Minnesota law requires a high standard of health benefits for employees, the employer must offer the same high benefits to its employees in other states. Thus, the law has impact beyond the borders of the state and may be unconstitutional.

Minnesota also has a Catastrophic Health Expense Protection Act under which the state pays 90 percent of a resident's health care expenses after the resident's out-of-pocket expenses exceed (a) 40 percent of his/her household income under $15,000, 50 percent of his/her household income between $15,000 and $25,000, plus 60 percent of his/her household income in excess of $25,000; or (b) $2,500; whichever is greater. This statute does not take effect until July 1 this year, so its fiscal impact is not known. On the basis of very crude estimates, it was budgeted for $18 million over the two year budget period, plus $50,000 for administration.

Rhode Island: Rhode Island's catastrophic health insurance statute has been in effect for three years. For the 85 percent of Rhode Island's residents who have private health coverage which meets minimum standards,

the state will pay costs of health care beyond the limits or coverage of the private insurance and above $500 or 10 percent of the resident's income. For the other 15 percent who do not have private insurance, the state will pay costs over $5,000 or 50 percent of the resident's income. The program is not well known yet. Of the 300 to 400 applications to the state for payment of health bills received each year, only half are found to be eligible. The annual state expenditure for the coverage is running $1,500,000 per year.

A health resources development fund is established not only to pay catastrophic costs but to make grants, loans, or contracts for the improvement of health facilities, services or education.

The statute also authorizes state regulation regarding consumer protection, quality of health coverage, universal availability, and rates.

Maine: The Maine catastrophic illness statute provides that the state will pay all remaining eligible health care expenses when the resident's out-of-pocket expenses reach 20 percent of the resident's net income, plus $1,000. For residents whose net worth exceeds $20,000 and such net worth includes cashable assets, 10 percent of such cashable assets are added to the out-of-pocket expenses threshold.

Considerations for Alaska

Although Alaska has a Catastrophic Illness Committee, it has not been given clear guidelines nor adequate funding.

The state approaches which have been tested elsewhere which you may want to consider for Alaska include:

1. state minimum standards for comprehensive health plans offered by private carriers;
2. mandatory availability of such plans to all state residents regardless of age or physical condition;
3. mandatory membership of all health insurance carriers in a reinsurance association to pool risk;
4. regulation of premium rates and provider reimbursements;
5. comprehensive health benefits mandated for all employees, with at least 50 percent of the premiums paid by employers;

All of the above provisions combined would still leave some people without comprehensive coverage. Self-employed, part-time or non-working people with adequate incomes would have a choice whether or not to purchase coverage, and some would choose not to. Self-employed, part-time, unemployed and non-working people with low incomes, however, could not afford to purchase private health insurance. People in this category might include farmers, homesteaders, miners, independent truckers, fishermen, small family business people, widows, retired people not eligible for Medicare, lots of low paid part-time workers (mostly women) and, of course, all their dependents. In addition, there are large numbers of seasonally employed people in Alaska who would only have coverage part of the year, such as loggers, cannery workers, and tourist industry employees. Public Health Services, Medicaid, and Medicare provide coverage for large sectors of low income Alaskans, plus General Relief-Medical and other state programs provide piecemeal health services for eligibles, but we are still far from comprehensive coverage for all.

The only way for the state to insure universal coverage is to subsidize it to the tune of millions of dollars.

Before we can proceed to draft a state comprehensive health insurance plan for Alaska, some policy decisions must be made:

1. Coverage - is enrollment voluntary or mandatory, and for whom is the coverage targeted?
2. Benefits - which expenses will be covered?
3. Financing - what portion will the state or employers pay? How much in premiums, deductibles, or co-payments must the consumer pay?
4. Cost and Quality Control - how will rates or standards of care be set?
5. Administration - what is the role of private carriers? What is the role of the state?

There will be a seminar on state health insurance plans on Friday, July 29, in Washington, D. C., sponsored by the Georgetown University Health Policy Center. There will be four forums: (1) political planning for enactment of state health insurance; (2) administrative aspects; (3) benefit coverage and eligibility; and (4) the cost of state health insurance, and looking ahead to national health insurance. Reservations or inquiries should be directed to: Jordan Braveman, Director of Policy Analysis, Georgetown University Health Policy Center, 3520 Prospect Street, N.W., Washington, D. C. 20057. He can also be reached by phone at (202) 625-3092.

We will be happy to meet with you at your earliest convenience to discuss these questions.

SH:jm

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 Department 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

19 March 1980

To: Representatives Buchholdt, McKinnon, Parker, Gardiner

From: Sharman Haley
Alaska Public Interest Research Group

Subject: Policy Options in Proposed Health Legislation

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

Health Insurance Minimum Standards and Risk Pooling

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

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

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

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

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

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

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

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

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

Mandatory Employer Sponsored Coverage

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

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

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

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

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

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

Linkage Between Hawaii and Minnesota Models

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

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

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

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

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

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

Medicaid Medically Needy

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

Medicaid Optional Services

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

HOUSE RESEARCH AGENCY
Pouch Y - State Capitol
Juneau, Alaska 99811
465-3991

MEMORANDUM

March 18, 1980

TO: Representative Bill Parker
Attn: Mr. Jim Erickson

FROM: Jack Kreinheder, Issues Analyst JK

RE: State Health Care Programs
Research Request No. 61

You have asked that we: (1) provide any available studies on Medicaid, state health insurance, and th State's health care program in general; and (2) determine whether the State could provide medical care for low-income groups in medically underserved areas of the state. The enclosed materials represent all the relevant materials we were able to locate, with the exception of past copies of the State Health Plan and the Medicaid Annual Status Report. These reports were not included because of their bulk and uncertain value to you; should you wish to review these documents, please let us know.

Our major findings with regard to direct State delivery of medical services are the following:

1. There appear to be no legal reasons why the State could not hire doctors to treat low-income groups or any other class of people; however, four major practical difficulties with such an approach were raised during the course of our research. The first problem is that everyone we contacted believed the medical community would oppose the competition which direct State participation in the delivery of medical services would represent. Secon., the State would need to purchase malpractice insurance for doctors in its employment, thus incurring substantial costs. Third, if the legislature approved funding for such a program, and later discontinued it, or if State physicians' services were to be provided on a temporary basis, the problem of "medical abandonment" could result in lawsuits against the State unless adequate arrangements were made for the further treatment of patients handled under the program. Fourth, it appears that medical services provided by State physicians would not be eligible for federal Medicaid funds

except on a temporary or special situation basis; therefore, the State would have to bear the full cost of the program unless State-provided services were demonstrated to qualify for a waiver from the usual federal Medicaid requirements.

2. Withdrawal from the Medicaid program is not, however, a prerequisite to the establishment of a State physician program. My understanding of the alternative health care system you are considering is that the State would not necessarily provide all the medical services now administered by private physicians under the Medicaid program, but would instead make State doctors available in areas which are medically under-served either because of the lack of physicians, the lack of specific medical services, or because of the refusal of available physicians to accept Medicaid patients. It is clear that the State could continue to receive federal Medicaid funds for medical services provided by private physicians; and, in addition, it appears that funds could also be received for State-provided services if a federal waiver from certain regulations could be obtained. The State currently receives over $22 million per year in federal Medicaid funds.

3. It may be possible to improve medical care for low-income persons by means other than, or in addition to, direct State health care delivery, and without opting out of the Medicaid program The principal problem with the Medicaid program, from the recipient's point of view, appears to be that many doctors in Alaska refuse to accept Medicaid patients. This reluctance to take Medicaid patients is, in turn, largely attributable to the extensive paper-work requirements and the extremely slow payment process of the current Medicaid system in Alaska. However, these problems are not inherent in the federal Medicaid system, and it appears that more rapid and efficient reimbursement of medical providers could substantially improve low-income access to medical care by encouraging more doctors to participate in the program. Of course, there may be other problems with the Medicaid program which might make withdrawal from the system desirable.

4. The expanded use of fiscal intermediaries may be one option for making more doctors available to low-income persons. Delta Dental Plan of Alaska is currently the only organization of this type in Alaska and handles only dental services, but all parties involved--the Department of Health and Social Services, the participating dentists, and the Medicaid recipients--seem to be very satisfied with the program. About 96 percent of the dentists in Alaska are members of Delta Dental and 95 percent of these participate in Medicaid. The fact that reimbursement to dentists by

Delta Dental for Medicaid cases usually occurs within two weeks, as compared to up to several months for other Medicaid claims handled by the State, is the main reason for the almost universal acceptance of Medicaid cases by Alaska dentists.

In an administrative review of the Alaska Medicaid program completed in 1979, HEW officials recommended that the Division of Public Assistance contract with a fiscal intermediary for Medicaid processing. The Division is planning to solicit within the next six months requests for proposals for the processing of all Medicaid claims by a fiscal intermediary, although H&SS may still elect to process claims in-house. Robert Ogden, Chief of Medical Assistance for the Division, stated that a fiscal intermediary handling all Medicaid claims could probably process claims as rapidly as Delta Dental currently does for dental claims, thus improving the prospects for physicians accepting Medicaid patients. However, the choice between the use of a fiscal intermediary and processing the Medicaid claims in-house will depend on administrative decisions made within the department.

Each of the four points summarized above will now be discussed in more detail.

State Medical Care

According to the sources we contacted, the basic answer to your second question is yes, the State could hire doctors to treat low-income groups. Eligibility could be determined in a number of ways and would not need to parallel the federal Medicaid system. Placement of the State-employed doctors throughout the state could be based on whatever criteria were deemed appropriate by the State.

The State already provides direct delivery of medical services to a limited degree. Nurses employed by the Division of Public Health administer the Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT) for children throughout the state. The program is small in comparison to other medical services, but it does provide a precedent on the State level for direct delivery of services.

Political resistance by the medical community was cited by several persons with whom we spoke as the greatest obstacle to the direct employment of doctors by the State. Our contacts believed that many doctors would view such an action as State competition with the private sector,

and as "socialization" of the medical profession. The apparent acceptance by the medical community of the EPSDT program suggests that opposition to the State physician approach would not be as strong if the approach were used only in a few selected areas or were clearly temporary in nature. For example, if the State adopted a procedure similar to that which was employed by the federal Department of Health, Education, and Welfare (HEW) to identify and designate the low-income population of Anchorage as a Critical Health Manpower Shortage Area (see Attachment A), doctors might be more willing to accept the State delivery approach than if it were part of a comprehensive, state-wide system.

Under the HEW system, which is authorized by section 332 of the Public Health Service Act, an area or population group of an area may be designated as a Health Manpower Shortage Area if the population-to-primary care physician ratio exceeds a certain level. An area is also given a degree-of-shortage classification based on this ratio. The population-to-physician ratio takes account of physician accessibility, rather than simply dividing the population by the number of physicians. For example, in Anchorage, the ratio of Medicaid eligible persons to all primary care practioners is estimated at 161:1, but when HEW adjusted for the fact that most of these physicians do not accept Medicaid patients, the final population-to-primary care physician ratio was determined to be 3,041:1.

This ratio qualified the low-income population of Anchorage as a degree-of-shortage group 4, which makes the area eligible to: (1) apply for placement of National Health Service Corps (NHSC) physicians; (2) be an eligible service area for purposes of repayment of health professions student loans and for the NHSC scholarship program; and (3) apply for grant funds under various sections of the Public Health Act.

A similar approach to improving medical care for medically underserved areas or population groups could be utilized by the State. Designation under the program might qualify an area for the placement of State-hired physicians, for grants to improve health care delivery, or perhaps for a special streamlined medicaid process which would encourage doctors to accept Medicaid patients. The latter option might be effective in a case like Anchorage's, in which the number of practicing physicians in an area is sufficient to meet the medical needs of the population, but the physicians will not accept Medicaid patients because of dissatisfaction with the reimbursement system.

Attachment B, which is a letter to Representative Martin from Commissioner Beirne, suggests other questions which should be considered if the State elects to provide medical care directly and/or withdraw from the Medicaid program. As Duncan Read indicated in his earlier memo, Dr. Frederick McGinnis, Deputy Commissioner of H&SS, has proposed a major study of health care financing options which would address questions relating to

State provision of health care, such as who would be eligible for the program, and what services should be provided. Dr. McGinnis has apparently expanded the scope of the proposed study and is attempting to obtain about $170,000 for the project. If the study is conducted, the results would be submitted to the 1981 legislature.

If the State physician health delivery system is to be pursued, the problems of malpractice insurance and medical abandonment must be considered. Neither of these problems would prevent the State from hiring doctors, but their cost and legal implications may have some bearing on the issue. The State currently carries a small amount of malpractice insurance for doctors employed in administrative capacities, apparently in the event that they are called upon in an emergency situation. To fully insure doctors employed by the State who regularly provided medical services would require a substantial expenditure. The magnitude of the insurance cost would depend on the number of doctors employed the service provided, and the scope of the program, but the cost could be significant.

Medical abandonment appears to be a relatively easy problem to avoid, but it could present legal problems if it is not considered in the design of any State-provided medical care program. Under state and federal law, physicians are responsible for arranging for continued medical care for their patients if, for any reason, they discontinue their treatment. A doctor not fulfilling this responsibility may be sued by a patient. The two ways in which the issue of medical abandonment could arise are: (1) if the legislature suddenly discontinued funding for the program, and (2) if the program were discontinued in an area because it was determined that the private physicians in the area could now adequately serve the population. In both instances, the problem of medical abandonment could be avoided by ensuring that adequate arrangements were made for the continuing treatment of patients after the State ceased providing service directly.

A final point to be considered regarding direct State delivery of medical care is the Medicaid funding question. I contacted officials with the Northwest regional office of the HEW Medicaid Bureau in Seattle to determine if federal Medicaid funding could be provided for medical services delivered by State-employed physicians. A firm answer could not be secured within the time frame of this project, but it appears that a waiver from certain federal regulations pertaining to reimbursement procedures and other matters would be required for federal funding to be given for State-provided services. The necessary conditions for such a waiver are also unclear at this time, but HEW officials indicated that the designation of an area or population group having a severe shortage of medical care might meet the waiver requirements.

You have indicated an interest in the possibility of the State withdrawing entirely from the Medicaid program, and the question of Medicaid support for State-provided services may therefore not be a major concern. However, the State currently receives over $22 million each year in federal Medicaid funds. It may, therefore, be desirable to retain these funds if a State medical care program could meet, or be exempted from, the necessary federal regulations without compromising the program. Please let us know if you would like a more concrete response to the Medicaid funding question. A written request to HEW would be required and their response could take two weeks or more, but we would be glad to pursue this issue if you would like.

Medicaid Issues

Although we were not asked to specifically address the Medicaid program in this memorandum, we obtained information on Medicaid during our research which may be of value to you in considering health care options. The greatest problem with the current Medicaid program in Alaska is that the claims processing system is inefficient, requires excessive paperwork, and results in long delays in provider reimbursement. It is the paperwork and the payment delays which have been the primary cause of Alaska physicians refusing to accept Medicaid patients. Attachments C and D provide a physician's perspective on the problems of the Medicaid system. In many cities, most notably Anchorage, the number of physicians seems to be adequate, but a Medicaid patient cannot see a doctor because the majority of physicians refuse to take Medicaid cases. It therefore appears that a more efficient and rapid claims processing system could do much to alleviate the difficulty of obtaining medical care for low-income Alaskans.

The current program of Medicaid dental services lends strong support to this premise. Medicaid claims for dental care do not go through the State system used for other medical services, but instead are handled by the Delta Dental Plan of Alaska, which acts as a fiscal intermediary between the providers and the State. The pertinent statistics regarding Medicaid participation by dentists were cited in the findings section, but the importance of Delta Dental in this discussion is that the vast majority of the state's dentists accept Medicaid patients. The two-week Medicaid reimbursement time which Delta Dental provides for dentists is the primary reason for the high degree of cooperation by Alaska dentists with the Medicaid program.

The obvious question, then, is if Delta Dental is so efficient, why doesn't the State use Delta or another fiscal intermediary to process all its Medicaid claims. There are a number of reasons why fiscal intermediaries do not represent an easy solution to the Medicaid and low-income health care problems.

The first is that Delta Dental does not appear eager, and may not have the capability to take on the processing of medical claims. Attachment D is a letter from the Pediatricians' Association to Representative Martin suggesting that the State contract with Delta Dental for payment of Medicaid claims for pediatric services. However, I spoke with Denise Knapp, Executive Director of Delta Dental, and she indicated that Delta has not agreed to process pediatric claims and is still only discussing the idea. Robert Ogden, Chief of Medical Assistance for H&SS, stated that while he has been very pleased with Delta's performance, he is not sure if Delta could handle the large volume of Medicaid claims for medical services, and knows of no other in-state firms who could.

A second possible problem with the expanded use of fiscal intermediaries is cost. Each claim processed by Delta Dental costs the State an average of more than $14, while the medical claims processed under the current system cost only about $1.45 each. However, Mr. Ogden was quick to point out that the current system does not meet federal requirements, and meeting these requirements is likely to increase the cost of processing claims whether a fiscal intermediary is used or not. In addition, Delta's cost is much higher than would be that of a fiscal intermediary handling all medical claims, because the fixed costs of the Delta claims processing system are spread over a relatively small number of claims (8,000 per year). A fiscal intermediary handling all Medicaid claims for medical services would process about 144,000 claims per year; cost per claim would therefore be much lower, perhaps in the $2.50 range, according to Mr. Ogden.

HEW has mandated that the Division of Public Assistance implement a new claims processing system by September, 1980. In an administrative review completed a year ago, HEW officials recommended that the Division contract with a fiscal intermediary for the processing of all Medicaid claims. (See Attachment E, Chapter 7, for more detail on this recommendation.) However, it is still uncertain whether this recommendation will be followed. The Division plans to solicit requests for proposals (RFP) for claims processing within the next six months. At least six to eight firms are expected to bid on the contract, but it appears that the decision to use a fiscal intermediary or to process Medicaid claims in-house will be more dependent on administrative decisions within H&SS than on the results of the RFP process.

We hope the information we have provided is useful to you. This memorandum is a brief treatment of a complex subject, so please let us know if you would like additional research, or if we may be of further assistance in any other way.

JK/dp

cc: Representative Terry Martin

Attachments:

A. HEW designation of Anchorage as a Health Manpower Shortage Area, from the Anchorage Neighborhood Health Center.

B. Letter from Commissioner Beirne to Representative Martin on Medicaid/State Health Care issues.

C. Letter from Dr. Lillibridge to HEW discussing Medicaid problems.

D. Letter from Dr. Lillibridge to Representative Martin on Medicaid problems and the Delta Dental program.

E. HEW administrative review of the Alaska Medicaid program.

F. H&SS task force recommendations on the Medicaid program.

G. Information supplied by Delta Dental on their program.

H. Alaska and National Health Insurance--report by Dr. McGinnis of H&SS.

I. Third Party Health Coverage in Alaska--1978 report by the former Legislative Affairs Research Division.

J. Opting-A Study of Medicaid Client Need--1977 report by the former Research Division.

K. H&SS 1977 Medicaid Annual Status Report.

L. January. 1980 State Health Plan.

STATE OF ALASKA

Legislative Affairs Agency

THIRD PARTY HEALTH COVERAGE IN ALASKA

Prepared by

LEGISLATIVE AFFAIRS AGENCY

Research Division

April 1978

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.

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

April 2, 1980

HEALTH INSURANCE BILL TO BE HEARD ON TELECONFERENCE NETWORK

The House Health, Education and Social Services Committee, chaired by Rep. Thelma Buchholdt, will hold three teleconferenced hearings on HB 977, " An Act relating to the health of residents of the state".

The first hearing will be teleconferenced to all sites on Tuesday, April 8th at 1:30 p.m., Juneau time, and will include testimony from all interested persons.

The second hearing, also on the 8th, will be held at 7:00 p.m., Juneau time. The committee will be taking testimony from insurance carriers and will include all teleconferencing sites.

The third hearing will be teleconferenced to all sites on Thursday, April 10th at 7:00 p.m..

Persons interested in testifying or observing at these hearings should contact the local Legislative Information Office in the following communities: Anchorage, Bethel, Fairbanks, Dillingham, Kotzebue, Nome, Kodiak, Soldotna, Ketchikan and Sitka. Further information may be obtained from the Committee Chair (465-3797) or the Teleconference Coordinator (465-4980)

OPTIONAL SERVICES

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

ALASKA PUBLIC INTEREST RESEARCH GROUP
Post Office Box 1093/Anchorage, Alaska 99510/(907) 278-3661

MEMO

To: Those interested in health care coverage
Re: Health care
Date: March 1980
From: Susan Johnson

Below is an outline of the legislation we discussed at the meeting held February 29, 1980 at the Federal Building, for you to review. The legislation is presently being drafted by Thelma Buchholdt's (hESS) Committee. The components are as follows:

1/ Mandatory Reinsurance: Several states have developed mandatory reinsurance pools to ensure health care coverage availability to high risk persons at reasonable rates. Many people are unable to purchase full health insurance coverage because existing health conditions make them a bad insurance risk. This component of the bill would mandate all health insurance carriers in each state 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 the risk is pooled among all carriers in the state.

2/ Minimum Benefits Standards: The state would be given the authority to regulate the level of service covered by health insurance policies. Several states have already implemented this and the National Association of Insurance Commissioners (NAIC) had developed model state health insurance legislation for setting minimum health benefit standards. This would address, for example, persons who are excluded from coverage because of pre-existing conditions.

3/ Amend Medicaid Statutes: This would provide the Oregon option to use Medicaid funds to purchase health insurance; provide for the funding of interest payment penalties when the state is delinquent on its bills, and to add additional services to the Medicaid program, such as prescription drugs, dental care, etc.

4/ Medicaid Medically Needy: This program would extend state medical assistance to those persons whose income exceeds the income standards of current assistance programs, but who have incurred medical expenses which equal or exceed the difference between the person's monthly income and the income standard applicable under the current program. In other words, the state would provide medical assistance to persons who otherwise would not have been eligible because they make too much money. The purpose of the "medically-needy" program is to allow lower-middle income persons who can not afford to shoulder the full cost of medical care the opportunity to receive needed medical assistance. Under such a program, these individuals would "spend down" to the income limits, and the state would pick up the rest.

5/ Mandatory Employer Coverage: Hawaii requires every employer to provide health insurance. This would expand coverage to many non-union workers, especially those in low-paying service industries, who now lack coverage. Hawaii offers this to employees who work a minimum of 20 hours. Small employers may apply for state subsidation, if the cost of insurance exceeds certain criteria.

Finally, AkPIRG supports appropriations for expended direct services by the state and local government and non-profit providers. For example, two GYN's will be added to the Neighborhood Health Center in Anchorage. Any suggestions are welcomed concerning other areas that could use additional funding.

I will contact you again when the bill has a number. Feel free to call should you have any questions.

Again, thank you for attending the meeting.

Sincerely,

To: Billy Berrier, Director
Legal Services Division
Legislative Affiars Agency

From: Representative Thelma Buchholdt
Health, Education and Social Services Committee Chair

Subject: Request for bill drafting

Please have one of your staff prepare for introduction one bill which will include the following elements:

Medicaid Amendments. This bill would add the Medically Needy program and several optional services to the state's participation in the federal Medicaid program. The bill would also allow the use of medicaid funds for the purchase of private health insurance as provided in Oregon law (ORS 414.115). The following Medicaid options would be included: prescription drugs, adult dental care, dentures, adult prosthetic devices, physical therapy and related services, chiropractors' services, podiatrists' services and private duty nursing.

Mandatory Employer-sponsored Health Insurance. This bill would require employers in the state to subsidize group health insurance plans for their employees. The bill would be modeled after the Hawaii Prepaid Health Care Act.

Health Insurance Regulation. This bill would give the state authority to regulate the level of service covered by health insurance policies sold in the state. The bill would also mandate coverage of high-risk clients and pooling of risk among all carriers. The bill would be modeled after relevant portions of the Comprehensive Health Insurance Act in 1980 Suggested State Legislation, Vol. 39, by The Council of State Governments.

TABLE 2

Average Ranking of Selected Medicaid Options by Type of Public Assistance Client

Rank	Recipients of Adult Public Assistance	Recipients of Aid to Families with Dependent Children
1st	Prescribed Drugs	Prescribed Drugs
2nd	Adult Dental Services	Adult Dental Services
3rd	Dentures	Physical Therapy and Related Services
4th	Physical Therapy and Related Services	Dentures
5th	Hearing Aids [1]	Chiropractor's Services
6th	Prosthetic Devices	Hearing Aids [1]
7th	Chiropractor's Services	Prosthetic Devices
8th	Private Duty Nursing	Private Duty Nursing
9th	Podiatrist's Services	Podiatrist's Services
10th	Care for Patients 65 or Over in Tuberculosis Institutions	Care for Patients 65 or Over in Tuberculosis Institutions

[1] *Hearing aids, at the time the survey was conducted, were not included in the coverage program offered to all Medicaid clients. An interpretation of Medicaid law and regulation by federal officials allowed hearing aids to be covered as part of the treatment of speech, hearing, and language disorders option. This policy change was implemented by the Division of Public Assistance in November.*

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Legal Services Division
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From: Representative Thelma Buchholdt
Health, Education and Social Services Committee Chair

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My assistant Jan Sorice will be in charge of this project and any further direction to the drafters will be provided by her. She may be reached at 465-3797.

This bill is to be introduced by the House Health, Education and Social Services Committee by request of Representative Thelma Buchholdt.

By federal statute, the maximum limit for income eligibility under Medicaid medically needy is 133 1/3% of the state AFDC standard for an equivalent family size (except that for a single person, the two-person family income standard is used). The following chart indicates what the Medicaid medically needy income limit would be for certain family sizes and types (where two income limits are listed, the difference is based on whether or not the adult-only household has rent, mortgage or other payments greater than $35 per month).

Household	AFDC	GRM	APA	MN (133 1/3%)
1 Person	$150	$235/ $300	$335/ $414	$466.55
2 Adults		$335/ $400	$502/ $608	$466.55
1 Adult, 1 Child	$350	$300		$466.55
1 Adult, 3 Children	$450	$400		$600

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MEDICAID OPTIONAL SERVICES--INCLUDING THOSE NOT CURRENTLY COVERED BY THE ALASKA MEDICAID PROGRAM

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

(1) Podiatrist services. Manipulation of the feet and treatment of corns, bunions, callouses, etc., by a licensed podiatrist.

(2) Optometric services. Covered under Alaska Medicaid.

(3) Chiropractic services. Treatment by a licensed chiropractor limited to manual manipulation of the spine.

(4) Other practitioner services. Naturopaths, homeopaths, herbalists, faith healers.

(5) Private duty nursing. Care by a registered nurse or licensed practical nurse under a physician's supervision in home, hospital or nursing facility when a person requires exceptional individual and continuous care.

(6) Clinic services. Under the Alaska Medicaid program this is currently limited to state-operated and state-funded community mental health clinics. This option could also include such other services as health care clinics, alcoholism treatment centers, ambulatory surgical centers, and rural health care clinics. Rural health clinics are now a mandatory service pursuant to Public Law 95-210.

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

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

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

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

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

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

(13) Eyeglasses. Covered by Alaska Medicaid.

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

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

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

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

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

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

(20) Services by Christian Science nurses.

(21) Services by Christian Science Sanatoria.

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

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

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

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

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

Alaska Native Health Board

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Reference #A79-1050

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10/26/79
pbm

ALEUTIAN PRIBILOF ISLAND ASSOC. INC.
BRISTOL BAY AREA HEALTH CORPORATION
COOK INLET NATIVE ASSOCIATION
COPPER RIVER NATIVE ASSOCIATION

KODIAK AREA NATIVE ASSOCIATION
MAUNELUK ASSOCIATION
THE NORTH PACIFIC RIM
NORTH SLOPE BOROUGH HEALTH CORP.

NORTON SOUND HEALTH CORPORATION
SOUTHEAST ALASKA REGIONAL HEALTH CORP.
TANANA CHIEFS CONFERENCE
YUKON-KUSKOKWIM HEALTH CORPORATION

OREGON

...th or tuberculosis not otherwise expressly ... posed or granted by law.
...556 §10]

...090 [1953 c.204 §6; renumbered 414.860 and ... 566.370]

414.095 Exemptions applicable to ... ments. Neither medical assistance nor ... ments payable to vendors out of public ... assistance funds are transferable or assigna... at law or in equity and none of the money ... ed or payable under the provisions of ORS ...435 and this chapter is subject to execu... levy, attachment, garnishment or other ... process.
...556 §11; 1967 c.502 §14]

414.105 Recovery of certain medical ... stances; certain transfers of property ...idable. (1) The Adult and Family Services ...sion may recover from any person the ... ...nts of medical assistance incorrectly paid ... behalf of such person.

(2) Medical assistance pursuant to ORS ...435 and this chapter paid on behalf of an ...idual who was 65 years of age or older ... he received such assistance may be ... ...ered from his estate, or if there be no ... the estate of the surviving spouse, if ..., shall be charged for such aid paid to ... or both; provided, however, that claim ... such medical assistance correctly paid to ... may be established against the estate, but ... shall be no adjustment or recovery ... until after the death of the surviving ..., if any, and only at a time when he has ... surviving child who is under 21 years of ... or is blind or permanently and totally ...bled. Transfers of real or personal prop... by recipients of such aid without ade... consideration are voidable and may be ... aside under subsection (2) of ORS 411.620.

(3) Except where there is a surviving ..., or a surviving child who is under 21 ... of age or is blind or permanently and ...ly disabled, the amount of any medical ... paid under this chapter is a claim ... the estate in any guardianship or ...servatorship proceedings and may be paid ...uant to ORS 126.353.
...556 §12; 1967 c.502 §15; 1969 c.507 §2; 1971 c.334 ... c.334 §1; part renumbered 416.280; 1975 c.386 ...

INSURANCE AND SERVICE CONTRACTS

414.115 Medical assistance by insurance or service contracts. In lieu of providing one or more of the medical and remedial care and services available under medical assistance by direct payments to providers thereof and in lieu of providing such medical and remedial care and services made available pursuant to ORS 414.065, the Adult and Family Services Division shall use available medical assistance funds to purchase and pay premiums on policies of insurance, or enter into and pay the expenses on health care service contracts, or medical or hospital service contracts that provide one or more of the medical and remedial care and services available under medical assistance for the benefit of the categorically needy or the medically needy, or both. The policy of insurance or the contract by its terms, or the insurer or contractor by written acknowledgment to the division must guarantee:

(1) To provide medical and remedial care and services of the type, to the extent and according to standards prescribed under ORS 414.065;

(2) To pay providers of medical and remedial care and services the amount due, based on the number of days of care and the fees, charges and costs established under ORS 414.065, except as to medical or hospital service contracts issued by a hospital association which employs a method of accounting or payment on other than a fee-for-service basis;

(3) To provide medical and remedial care and services under policies of insurance or contracts in compliance with all laws, rules and regulations applicable thereto; and

(4) To provide such statistical data, records and reports relating to the provision, administration and costs of providing medical and remedial care and services to the division as may be required by the division for its records, reports and audits.
[1967 c.502 §9; 1975 c.401 §1]

414.125 Rates on insurance or service contracts; requirements for insurer or contractor. (1) Any payment of available medical assistance funds for policies of insurance or service contracts shall be according to such uniform area-wide rates as the Adult and Family Services Division shall have established and which it may revise from time to time as may be necessary or practical, except that, in the case of a research and demonstra-

tion project entered into under ORS 411.135 special rates may be established.

(2) No premium or other periodic charge on any policy of insurance, health care service contract, or medical or hospital service contract shall be paid from available medical assistance funds unless the insurer or contractor issuing such policy or contract is by law authorized to transact business as an insurance company, health care service contractor or hospital association in this state.
[1967 c.502 §10; 1975 c.509 §6]

414.135 Contracts with direct providers of care and services. The Adult and Family Services Division may enter into nonexclusive contracts under which funds available for medical assistance may be administered and disbursed by the contractor to direct providers of medical and remedial care and services available under medical assistance in consideration of services rendered and supplies furnished by them in accordance with the provisions of this chapter. Payment shall be made according to the rules of the division pursuant to the number of days and the fees, charges and costs established under ORS 414.065. The contractor must guarantee the division by written acknowledgment:

(1) To make all payments under this chapter promptly but not later than 30 days after receipt of the proper evidence establishing the validity of the provider's claim.

(2) To provide such data, records and reports to the division as may be required by the division.
[1967 c.502 §11]

414.145 Implementation of ORS 414.115 to 414.135. The provisions of ORS 414.115, 414.125 or 414.135 shall be implemented [illegible] Department that such implementation will provide comparable benefits at equal or less cost than provision thereof by direct payments by the Adult and Family Services Division to the providers of medical assistance.
[1967 c.502 §11a; 1975 c.401 §3]

MEDICAL ADVISORY COMMITTEE

414.205 Medical advisory committee. (1) A medical advisory committee is established, consisting of not more than 15 members to be appointed by the Governor from among persons in the health professions, providers of medical and remedial care and services and the general public. In making his appointment, the Governor shall consult with appropriate professional and other interested organizations.

(2) Members shall serve at the pleasure of the Governor.

(3) Members of the advisory committee shall receive no compensation for their services, but subject to any applicable state law, shall be allowed actual and necessary travel expenses incurred in the performance of their duties from the Public Welfare Account.
[1967 c.502 §18]

414.210 [1957 c.692 §1; repealed by 1963 c.631 §2]

414.215 Duties of committee. The medical advisory committee shall advise the Adult and Family Services Division on:

(1) Health and medical care and services to be provided pursuant to this chapter.

(2) Matters referred to it for study by the division.
[1967 c.502 §19]

414.220 [1957 c.692 §2; repealed by 1963 c.631 §2]

414.225 Division to consult with and assist committee. (1) The Adult and Family Services Division shall consult with the medical advisory committee concerning the determinations required under ORS 414.065.

(2) The division shall provide secretarial services to the medical advisory committee.
[1967 c.502 §20]

414.230 [1957 c.692 §5; repealed by 1963 c.631 §2]

414.240 [1957 c.692 §3; repealed by 1963 c.631 §2]

414.250 [1957 c.692 §4; repealed by 1963 c.631 §2]

414.260 [1957 c.692 §6; repealed by 1963 c.631 §2]

414.270 [1957 c.692 §7(1); repealed by 1963 c.631 §2]

[illegible]

414.300 [1957 c.692 §5; repealed by 1963 c.631 §2]

MISCELLANEOUS

414.305 Payment of cost of medical care for institutionalized persons. (1) The Adult and Family Services Division is hereby authorized to pay the cost of care for patients within Mental Health Division institutions under the medical assistance program established by this chapter.

(2) All moneys received by the Mental Health Division from the Adult and Family

ALASKA PUBLIC INTEREST RESEARCH GROUP
Post Office Box 1093/Anchorage, Alaska 99510/(907) 278-3661

March 1980 NEWSLETTER Vol. 6, No. 2

New Date for Annual Meeting

The annual meeting will be held on *April 1, 1980* at the Pioneer Schoolhouse at 3rd and Eagle. The time of the meeting is set for 7:00 p.m. The primary business of the meeting will be the election of new members to the Board of Directors. Ballots and numbered envelopes are included in this newsletter; each number coincides with a member's name. Please return your ballot in the designated envelope so we can ensure that each member votes only once. Ballots will be counted the night of the meeting. If you can't attend the meeting to voice your concerns about the direction taken by AkPIRG during the past year, *mail your ballot* anyway. The election of an informed and dynamic Board of Directors is crucial to the well-being of AkPIRG.

Mike Ireton: Volunteer of the Year

Mike Ireton has been selected as Outstanding Volunteer for the year 1979 and will be honored at the University Affiliates Volunteer of the Year Award Presentation on March 21. Mike has put in an incredible number of hours working for AkPIRG and the entire staff and Board of Directors thank him warmly.

Thanks also to *all* AkPIRG volunteers for the generous donation of their time and energies. Volunteers are always needed and appreciated; if anyone is interested in participating as a volunteer, please call 278-3661.

The Alaska Public Interest Research Group newsletter is available to any AkPIRG member. The subscription price is included in the membership dues: $10 for individuals, $25 for institutions or businesses, and $5 for persons on limited incomes. The Alaska Public Interest Research Group is a non-profit citizens group, tax exempt under 501(c)(3) of the Internal Revenue Code.

AkPIRG offices are located at 513 West Seventh Avenue, Anchorage, Alaska. The mailing address is P.O. Box 1093, Anchorage, AK 99510. The phone number is 278-3661.

Comments on the newsletter, or any other aspect of AkPIRG activities are appreciated.

Editor: Laurie H. Otto.

Typography by Visible Inc., Anchorage, AK.

Oil Rig Discrimination

A legislative investigation of charges of discrimination against women in oil rig hiring practices was initiated March 5 by Speaker of the House Terry Gardiner. The need for an investigation was brought to light by OIL WATCH, a recently formed citizens-group which monitors all aspects of oil development in Alaska. The investigation will be conducted by the Commerce Committee, which is chaired by Fred Brown, D-Fairbanks.

In mid-November, Jim Bounds, member of Hotel, Restaurant, and Construction Camp Employees Union Local 878, came to OIL WATCH and told them that he had evidence that Amoco Production Company and Union Oil were responsible for discrimination against women. Bounds said that women in the culinary workers' union who had faithfully paid their union dues were waiting in the hiring halls, but not being dispatched for jobs for which they were qualified. Many of these women were on the union's "A" list, the top list of those waiting for jobs, while men lower on the lists or even outside the union were being dispatched instead, sometimes secretly.

The union is under contract to Universal Services Incorporated International (USI) to supply the labor promised by USI in its own contract with Amoco and Union Oil to do culinary work on their platforms in Cook Inlet. When Bounds asked officials in his union why no women were being dispatched, he was told that the contractor, USI, had warned the union not to send women out on dispatch on penalty of losing the USI contract. USI would apparently go with non-union labor if it had to, just to avoid sending women out to the platforms. The union officials explained that they had been told by USI people that a similar threat was in turn coming down on USI from Amoco and Union Oil. Apparently, the oil companies had told USI not to send women out to their platforms, or else USI would lose *its* contract with the companies. So, to hold onto its contract with Amoco and Union Oil, USI had decided to comply with these companies' requests not to send women out to the platforms in filling culinary jobs.

Mr. Bounds' evidence was primarily a series of taped telephone conversations between himself and officers of Amoco, Union Oil, and the field supervisor of their catering subcontractor, USI. An excerpt from the transcript of one of the tapes is presented below. The excerpt is from a conversation between Jim Bounds and Bob Gurnand, who is a field supervisor in the Kenai area for USI.

Jim Bounds: Here's what it boils down to: in other words, the oil companies come to the catering companies and say, "We don't want no women out there on them jobs," right?

Bob Gurnand: That's—well, more or less.

Jim Bounds: Then the catering companies go to the union and the catering companies tell the unions that, "We absolutely don't want no women out there on them jobs, and if you want

(continued on page 4)

Health Care Survey: Doctors and Medicaid

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

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

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

There are *no* existing public facilities in Anchorage which provide prenatal care. There are *no* OB/GYN's in Anchorage who accept new Medicaid recipients needing gynecological care as patients; only one Anchorage OB/GYN will accept new Medicaid patients for obstetrical care. It has been suggested that those women in need of, and without access to, OB and/or GYN care elicit the assistance of a family practitioner. Presently 73% of the family practitioners will not accept coupons as the method of payment.

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

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

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

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

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

I Will accept all forms of payment including medicaid	II Will *not* accept new medicaid patients/info on established caseload n/a	III Will *not* accept *new* medicaid patients; but carries an established medicaid caseload	IV Not accepting any new patients
OB/GYN			
Eastburn, Lydia	Gills, Raymond E. Nist, Richard Ekvall, David L. Ivy, William 1/ Ferucci, Leonard 1/ Newton, Burrit 1/ Orren, Jerry Wallner, Charles Stransky, George Curtis, Richard	Hanson, Hedric Erkman, John Renn, Claire Gibson, Sam	Compton, William
PEDIATRICS			
Keller, R. Tower, John C. Witt, Marian Zartman, Harvey P. Martin, Sarah	Lillibridge, Clinton Nesbitt, James Jr. Roberts, Dion Schriever, Gerry Hatton, Elizabeth Patterson, James Larson, William 1/	Kiehl, Phyllis Wallington, Joanne	

FAMILY PRACTICE

Agnew, Mark
Myers, Robert C.
Sydnam, Nancy E. 2/
Manwiller, Charles
Jones, Warren 3/
Billings, Robert
Feirtag, Mary
Martin, Asa
Lindhal, James
Sutherland, Richard

Arbow, Donald
Jones, Leland
Laufer, Kenneth
Kiessling, Bruce
Taylor, Richard
Cates, Vernon
Romig, Howard C.
Monlux, George
Mosley, Charles
Persons, Jean C.
Jackson, Marcell
Burgess, Joan
Bryan, Harold
Cormack, Allan
Nolan, Patrick
Smith, John
Colyar, A. B. 1/
Morgan, Royce 1/
Olsen, Harry 1/
Lang, Thomas 1/

St. John, Charles
Bosveld, Robert
Foland, Mary Ann
Wieland, Tyron

INTERNAL MEDICINE

Watson, III, James
Webb, Dale 4/
Ames, John
Hemry, David
Fish, Winthrop
Burtis, Buffington
Sonneborn, David
Armstrong, Michael
Ragle, William
Wilkins, Robert
Archer, Gary
Beechman, Sherman
Austin, Stanley
Stewart, George

Behymer, G. W.
Steer, Paul
Hall, Robert
Peach, David
Morris, Ann
Morris, Gerald
Princiville, Thomas
Blankinship, Gilbert 5/

Whaley, Robert

Buchanan, Richard
Schlosstein, Lee
Brownsberger, Keith 6/
Witt, Richard 6/
Wilson, Rodman 6/

RADIOLOGY

Gibbons, John
Hall, Randolph
Hendrics, Zeke
Pister, James
Coyle, Maurice J.
Kottra, John
Sternhagen, Charles

CARDIOLOGY

Baldauf, James 5/
Bustad, Leo 5/

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

Oil Rig *(cont. from page 1)*

the contract, you don't send no women out there," right?

Bob Gurnand: Well, that's just what the Union Oil Company man told me. He said if I send a woman out there, he's going to send her right back to us, and we lose the contract. And the union up there knows too, goddamnit.

After reviewing Jim Bounds' tapes, members of OIL WATCH interviewed and took sworn affidavits from other members of Local 878. One individual, Ruth Callan, gave particularly compelling testimony. Ms. Callan has lived in Alaska for thirty-three years and has been an officer of the Hotel, Restaurant and Construction Camp Employees Union, Local 878, since 1955. She served as a member of Local 878's Elective Board for ten years, including one term as President. For the past twenty years she has been a delegate to the Central Labor Council. She currently serves as Vice-President of the State Labor Council.

Ms. Callan has served as both head business agent and Secretary-Treasurer of Local 878. She stated in a sworn affidavit:

> While I was Secretary-Treasurer of Local #878, Bob Ryan, the head of USI in Alaska, told me that USI would lose its contract with the oil companies if women were sent out to the rigs. He said that one reason for this was the lack of "facilities" for women, meaning the lack of separate bunking and bathroom facilities.

It is interesting to note that both Bob Gurnand and Ruth Callan, in her affidavit, mentioned the dispatch of Dorothy Jackson, and the oil company's subsequent refusal to accept a woman dispatch on its rig. Ruth Callan stated:

> In May of 1979, USI called the Local for a bull cook which they needed by 5:00 p.m. I was told that if a woman answered the call that I should tell her that she would have to bunk and sleep with the men and use their same latrine facilities. This was intended to discourage a woman from accepting the dispatch. They didn't figure on Dorothy Jackson though. She said she didn't care, she was broke. I notified USI. Bob Ryan told me not to dispatch her because she was a woman. I replied that I was not going to refuse her a dispatch because she was a female. Bob Ryan told me that he would have to find some way to keep her off the rig. When Dorothy Jackson got to USI she was told that the dispatch was cancelled because the USI employee who had been scheduled to take R&R had changed his mind. Bob Ryan called me and said that I had cost some other union member his job because I had dispatched a woman. He told me that if the union dispatched women, the oil companies would end their USI contract and hire some non-union outfit that hired only men.

Bob Gurnand's version goes as follows:

> **Gurnand:** Well, I'll tell you here a while back I got into a situation with Union Oil Company, and I called Anchorage for a bull cook. So they put it on the open call in the union hall, and a woman took it. So they called me back and told me that a woman had taken the dispatch and I said "...Don't send her down there," I said, "...because they won't let her out there." So this was explained to the gal that took the dispatch, that there wasn't separate facilities and all this stuff for her, you know, and she was going to—she insisted on taking the dispatch and coming. So the Anchorage office called me back and they wanted me to call out there and explain the situation to the Union Oil Company people. I called out there, and you know what they told me?
>
> **Bounds:** No
>
> **Gurnand:** He said, "You send a woman out there, you lose the catering contract, and we'll go to a non-union contractor."

Union Oil Company dismissed Bounds' evidence by saying the whole thing was ridiculous. Union did confirm, however, that only one of the fourteen platforms in Cook Inlet had any women on it working in culinary positions. They asserted that women didn't want jobs on the platforms, since the conditions were "...awfully rough on a gal, and most gals prefer to work elsewhere."

Amoco has not responded to Bounds' charges; however, they also confirmed that only one of fourteen platforms has a woman currently working on it in a culinary position. Amoco asserted that to build separate facilities for women would be to discrimate against men.

The Alaska State Commission on Human Rights was asked to investigate this matter. The Director of the Commission, Neil Thomas, declined to initiate an investigation. Although Mr. Thomas acknowledes that this matter comes under the jurisdiction of the Commission, he has advised OIL WATCH that the Commission's present level of funding and its current caseload prevent him from investigating a matter which, under more favorable conditions, he would undertake.

The National Labor Relations Board was also asked to investigate, but the Board has the authorization to investigate only union matters—not oil companies or their sub-contractors.

The legislative investigation is expected to bring forward witnesses and victims of discrimination who have until now been unsure of where to go. OIL WATCH is continuing its independent investigation and will be aiding the committee in its legislative inquest.

Alaska Legislative Information

The following teleconferences have been scheduled to allow constituents the chance to discuss the issues with their legislators. For more information contact your local Legislative Affairs office. The phone number in Anchorage is 278-3668.

March 10: Anderson, Hohman at 7:00 p.m., Dillingham, 842-5319.

March 11: Interior Delegation at 7:00 p.m., Fairbanks 452-4448.

March 12: District 12 at 7:00 p.m., 1024 6th St. Anchorage.

March 13: District 10 at 7:00 p.m., 1024 6th St. Anchorage.

March 17: Hohman at 2:30 p.m., Bethel, 543-3541.

March 18: Interior Delegation at 7:00 p.m., Fairbanks, 452-4448.

March 19: Carney at 6:00 p.m., Mat-Su Office, 376-3704. Mulcahey, Zharoff at 7:00 p.m., Kodiak, 486-4881.

March 20: District 9 at 7:00 p.m., 1024 6th St. Anchorage.

March 24: District 13 at 7:00 p.m., Kenai, 264-9364.

March 25: Interior Delegation at 7:00 p.m., Fairbanks, 452-4448. District 8 at 8:00 p.m., Mt. View Library.

March 26: District 7 at 5:00 p.m., 1024 6th St. Anchorage. Munson at 7:30 p.m., 1024 6th St., Anchorage.

March 27: District 8 at 7:00 p.m., Eagle River Library.

Individual memberships play an important role in maintaining the vitality of AkPIRG. Membership renewals allow AkPIRG to continue its effective and responsive representation of the interests of Alaska's citizens. During this coming month AkPIRG will attempt to contact those persons whose memberships have lapsed. Please renew! For all members who have moved, please let us know your current address, so we can keep you informed of AkPIRG's ongoing activities.

Thursday March 20, 1980

TO: Reps. Buchholdt, McKinnon, and Parker

FROM: Sharman Haley
Alaska Public Interest Research Group

The proposed health legislation which is being prepared for introduction next week is scheduled for hearing in the House Health, Education and Social Services Committee the first week of April. A major portion of this bill is based on the Minnesota Comprehensive Health Insurance Act of 1976. In this act Minnesota pioneered the creation of a mandatory insurance carriers association to underwrite coverage for high risk "uninsurable" clients, as well as state regulation of minimum standards for health insurance policies. You may wish to bring someone from the State of Minnesota to testify on the proposed Alaska legislation from the perspective of the experience in Minnesota.

In the course of my research on the proposed legislation I have spoken at length with John Igrassia, Supervisor of the Life and Health Section of the Division of Insurance in Minnesota, and would recommend him as a good source of expert testimony on this subject. He has worked in his present capacity since the inception of the Minnesota legislation and is quite familiar with all its provisions, its administrative implementation, it's political fortune, and the legal challenges to it. Mr. Igrassia is proud of Minnesota's innovation in the area of health insurance and has testified in at least two other states who are considering similar legislation. He indicated that he would probably be able to come to Alaska in the time frame we are contemplating.

Travel and per diem expenses to bring Mr. Igrassia to Juneau would amount to less than $800. If you would like to extend an invitation to him to come, he may be reached at (612) 296-6929 in St Paul, Minnesota. I do not have a mailing address for him.

3/31/80
4/2/80

Intelligencer

E OF THE NORTHWEST SINCE 1863 L★

3/23/80

—P-I PHOTO BY CARY TOLMAN

turned Domingo from college and career bound to house bound.

Doctors vs. Medicaid

Thousands Caught In Crossfire

By Carol Perkins

Significant numbers of doctors, extremely unhappy with the state Medicaid program, are refusing to treat welfare patients, doctors told The Post-Intelligencer.

Some experts fear that a monumental health-care crisis is imminent because thousands of welfare patients are caught in a crossfire between doctors and the state Department of Social and Health Services over what are reasonable fees and necessary services.

Medicaid is the $350,000 joint federal and state health care program for the poor. Administered by the state, it serves 260,000 persons.

One such patient is Lenore Erdmann, who has a jaw and gum disease that is so excruciating that she goes for days without eating — sipping only a mixture of vinegar and honey to numb the pain.

A $4,000 operation could relieve the 55 - year - old Holly Park woman's agony. But her only income is a $253 monthly public assistance check.

But for nine years, the state has refused to pay for her requested oral surgery. And doctors are not lining up to perform the operation for free.

At the heart of the Medicaid issue is economics and professional dignity, doctors say. Under a new fee schedule, many are receiving less for treating welfare patients than they did last year.

The boycott of patients is scattered — but is growing in momentum. Many community health clinics report they are beginning to feel the crunch as more Medicaid patients are turned down by private physicians.

Some doctors are treating Medic-

Page A-12, Column 2

Coeds?

U.S. Looking At

Rights Restored To Kim

By Henry Scott Stokes
The New York Times

SEOUL, South Korea — The government's recent action in restoring civil rights to Kim Dae-jung transformed politics here at a stroke.

The action foreshadows a busy summer and autumn as Kim re-engages himself in a bid for the presidency, taking up where he left off in 1971. That year he took 45 percent of the poll in a contest with President Park Chung-hee.

Inevitably, people ask how the decision to let Kim re- enter the political arena was made when the army, the effective controller of South Korea under martial law, was known to detest the aspiring democrat, accusing him of supposed Marxist associations 30 years ago.

The decision was reached, according to reliable informants, through a long process of consultation led by Lt. Gen. Chon Doo-hwan, head of the Army Security Command, an army unit in Seoul, who along with a group of younger officers around him effectively controls the country.

On Dec. 12 these young officers displaced an older group led by the martial law commander, Chung Seung-hwa, in a midnight raid directed by Chon, who seized his commander and several other top generals and forced nearly 40 senior officers to step down. Chung was stripped of his four stars and has been convicted on charges of aiding Park's assassin, Kim Jae-kyu, former director of the Korean Central Intelligence Agency.

The supremacy of the 49-year-old Chon is therefore clear, and yet there are limits to his authority.

For instance, the economy, which was in dire trouble for a time after Chon's midnight action is run primarily by Deputy Prime Minister Lee Hahn-been. Lee visited the United States in February in an attempt to rebuild overseas bankers' trust in South Korea and its extraordinary economy, which since the early 1960's has been the most rapidly growing of its size in the world.

Above Lee, who is head of the central unit in the bureaucracy, the Economic Planning Board, is Prime Minister Shin Hyon-hwak,

Thousands of Patients Caught in Crossfire

From Page A-1

aid patients for emergencies only, while others are taking no new patients. Other doctors continue to treat Medicaid patients, but don't do the paperwork in hopes of putting economic pressure on the state, which receives matching funds from the federal government for the program.

"Everyone is a loser," says Dr. W. Maurice Lawson, Washington State Medical Association president. Because the state refuses to pay customary fees, the losses have to be absorbed by physicians, private pay patients and insurance companies.

The state medical association's judicial committee ruled that the boycott is not unethical unless doctors refuse to serve an entire class of patients.

However, many doctors feel they have a right to restrict the amount of charity work they do, and consider their Medicaid losses as charity.

Doctors are dissatisfied with Medicaid for many reasons:

- They contend fee schedules are grossly below customary fees, ranging from only 35 to 70 percent of their normal charges.
- Doctors maintain that Medicaid limits on types of service, prevent them from giving welfare patients adequate care. They note that preventive measures aren't usually covered.
- Doctors are angered by bureaucratic red tape. Washington Anesthesiologists' Association says that 14 percent of their patients are on Medicaid, but account for 40 percent of their office paperwork. Medical office managers report that it sometimes takes from two months to two years to be reimbursed for Medicaid claims.
- Doctors resent what they call "harrassment" by the state. They are angered because DSHS demands prior authorization for many medical procedures, and because the state audits their medical records, which they maintain violates their patients' rights to privacy.

Dr. Ted Haley, who is a Tacoma representative, says that a widespread Medicaid boycott by doctors next spring is a distinct possibility.

"We'll talk to DSHS, the legislature, the governor, but if we don't get relief, a boycott of the system — not the patient — may be the only alternative."

However, Sen. William "Big Daddy Day," senate social and health srvices chairman, who also is a Spokane chiropractor, asserts that doctors shold bite the bullet. "Hell, they've beenrecipients of state aid when they were in medical school, they can pay it back now by taking more charity cases."

This kind of response is what makes many doctors squeamish about stomping their feet too loudly in Olympia.

"Politically, doctors are the least able to defend themselves, " says Dr. Peter West, a Seattle family practioner. "They aren't seen as a group that is suffering a lot.

"The public is going to be quick to say, 'Those unfeeling bastards don't care about the poor.'"

"But doctors can't tell their secretaries and suppliers to accept 70 percent of usual wages and costs, but that is exactly what the state is doing to us," West says.

Entire clinics are refusing to accept Medicaid patients, except in emergency situations.

"It costs more for us to do the Medicaid paperwork than we get back from the state," says Roberto Robles, Swedish Hospital anesthesiologist.

All 17 of the anesthesiologists at Swedish Hospital are boycotting Medicaid, except in emergency cases, Robles says.

Bruce Ferguson, DSHS Medicaid director, acknowledges there are inequities in parts of the fee schedule and that the doctors have good reason to be upset. "We're working on the problem, but we've only got so much money, and as it is it looks like we're going to be overspent by $20 to $30 million dollars this bieninium."

He maintains that the extensive paperwork and audits "are necessary because we are spending public money."

Both physicians and patients are scrutinized for fraud violations. Last year ony only seven health care specialists were convicted of violations.

Jim Benz, regional federal Medicaid director, says Washington state does "a good job" policing the program, and says that "to my knowledge there are none of the Medicaid mills or kickbacks that are rampant in some areas of the country."

Dr. Fred Quarnstrom, who says he was one of the largest Medicaid dental providers in the state in 1978, no longer takes new welfare patients.

The Beacon Hill dentist says that he could no longer afford to keep up with the losses he was encountering. People think doctors get rich on Medicaid — I guess if you hired dozens of assistants and did hundreds of dentures a day you could make a living at it."

Dr. Larry Iversen, a Bremerton orthopedic surgeon, says, "If a doctor has a large welfare practice, he is scrutitinized and hassled by the state. If he doesn't take any Medicaid patients, he's accused of not being a humanitarian."

Elise Chayet of Evergreen Legal Services, reports a considerable increase in Medicaid clients who can't find doctors or are appealing state's refusal to put them on Medicaid or pay for certain medical expenses.

Community health care clinics are seeing an increase in Medicaid patients unable to get help from private doctors, and the increase is putting a strain on clinic budgets.

Caroline MacColl, King County Visiting Nurse Service director, says the agency stopped accepting new Medicaid patients for a two - month period in 1978. Even though the state finally raised the service's reimbursemnts, the agency will still lose $30,000 a year because of the "Medicaid gap," she says. Social workers are upset because patients are caught in the middle of the battle.

"It's an inhumane system," says Maria Crocker of Country Doctor clinic. "It's terrible when a sick person has to go through the yellow pages looking for a doctor and getting turned down time after time."

State Sen. James McDermott, a Seattle psychiatrist, says, "There is no final solution. All that can be done is to set a health care system in motion and keep adjusting it until it is humane and equitable."

DSHS chief Ferguson agrees, emphasizing that the issue is "cosmic in proportion."

But while health care experts hashes out the issue, patients like Lenore Erdmann continue to suffer

Erdmann, who has applied to Medicaid four times in the past nine years for oral surgery, says, "I don't understand why I have to wait so long when I'm in so much pain. I just keep praying, they'll take me this time."

Shacks Bare Endurance Of Yugoslav Guerrillas

Alaska State Legislature

House of Representatives

Committee on

Health, Education & Social Services

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

March 18, 1980

Donald D.H. Ching
Deputy Director
Department of Regulatory Agencies
P.O. Box 541
Honolulu, Hawaii 96809

Dear Mr. Ching:

The Alaska House of Representatives is currently considering legislation similar to Hawaii's "Prepaid Health Care Act." As you are an acknowledged expert on this legislation, your testimony would provide needed insight into the benefits of mandatory employment related health coverage.

I would therefore like to invite you to Alaska on March 31 and April 1 to testify on this bill. The legislation is presently being drafted, we will forward you a copy of the bill as soon as it is available. Please contact Jan Sorice of my office at 907-465-3777 if you need further information.

Sincerely,

Thelma

Thelma Buchholdt
State Representative
District 9 (Spenard);
Chair, House HESS Com[illegible]

Third-Party Health Coverage:

A third-party payer includes any organization, public or private, that pays or insures health or medical expenses on behalf of beneficiaries or recipients (e.g. Blue Cross and Shield, commercial insurance companies, Medicare and Medicaid). The individual generally pays a premium for such coverage in all private and some public programs. The organization then pays bills on his behalf; such payments are called third party payments and are distinguished by the separation between the individual receiving the service (the first party), the individual or institution providing it (the second party) and the organization paying for it (the third party).

It is difficult to identify the extent of third party coverage for Alaskans; to identify those that may not be protected by any program or those that may not have coverage adequate to fulfill their needs. Perhaps the most appropriate method of identifying those Alaskans without coverage or without adequate coverage are: 1) through a survey of individuals regarding health coverage, and/or 2) from a search of hospital and other health care billings that were paid "out of pocket" by the individual.

A random survey prepared in 1974/75 by Comprehensive Health Planning of Anchorage reported that 79.9% of the sample had third party coverage of some sort, and 20.1% had no such coverage. The same survey conducted through the Regional Medical Program among residents of the Kodiak Island Borough resulted in 92.6% of the respondents reporting that they had third party coverage, while 7.4% had none. These figures change significantly when applied to the non-Native, non-military population alone. In this perspective, over 25% of the Anchorage sample and over 20% of the Kodiak Island non-Native, non-military sample responded as having no health coverage. If these percentages (20%-25%) can be applied statewide, it would result in an estimate of 56,000 to 71,000 Alaskans lacking any third party health coverage.

A detailed search of hospital bills and other major medical bills that were paid "out of pocket" by the individual may result in significant information regarding not only those without coverage but also those finding that their coverage was not adequate to fulfill their needs. A general indication of the number of discharges from hospitals that result in payment by the individual can be obtained by information collected in the annual hospital survey. The percent of hospital bills paid by the individual varied considerably from one hospital to another. The Alaska Hospital and South Peninsula Hospital reported the highest percentages; 26% of the discharges making "out of pocket" payments. Further screening of this type of information is necessary.

DISCHARGES BY PRIMARY SOURCE OF PAYMENT

CY 1978

(Percent of all Discharges)

HOSPITAL	Workmen's Compensation	Medicare	Medicaid	CHAMPUS	IHS	Blue Cross	Other Commercial Insurance Co.	Prepaid Group Health Plan	Medical Foundation	Private Pay	No Charge	Other
SOUTHEAST												
Ketchikan General	4	10	6	2	21	13	32	-	-	8	-	6
Petersburg General	- not available -											
Wrangell General	-	13	4	-	-	-	-	-	-	-	-	83**
PHS-ANH Mt. Edgecumbe	- not available											
Sitka Community	7	9	3	-	-	43	22	-	-	9	-	5
Bartlett Memorial**	2	9	3	10	17	27	22	-	-	10	-	-
SOUTHCENTRAL												
Cordova Community	- not available -											
Valdez Community	- not available -											
Seward General	-	49	26	-	24	-	-	-	-	-	-	-
Faith	2	9	5	1	25	12	24	0	0	22	-	-
Central Peninsula	-	4	5	-	-	19	-	-	-	17	-	55***
South Peninsula	3	13	8	-	18	12	19	-	-	26	<1	-
Valley	1	10	13	-	-	13	55	-	-	25	-	4
Alaska Hospital and Medical Center	4	2	8	<1	-	11	25	24	-	26	-	-
Providence***	6	8	7	2	<1	15	39	-	-	7	2	13
PHS-ANH Alaska Native Medical Center	- not available -											
USAF Hospital, Elmendorf	- not available -											
Kodiak Island**	54	6	7	-	20	4	-	-	8	<1	-	1
Naval Regional Medical Center, Bremerton-Adak	- not available -											
PHS-ANH Kanakanak	-	-	-	-	100	-	-	-	-	-	-	-
PHS-ANH Bethel**	- not available -											
Norton Sound Regional **	2	6	11	1	65	11	4	0	0	1	0	0
NORTHERN												
PHS-ANH Kotzebue	- not available -											
PHS-ANH Barrow**	- not available -											
Fairbanks Memorial	1	3	10	1	10	14	29	-	-	25	1	-
PHS-ANH Tanana**	- not available -											
Bassett Army	- not available-											

**Includes all sources of payment except Medicare and Medicaid.

***Includes Workmen's Comp., CHAMPUS, Other Commercial Ins., Prepaid Group Health Plan, Medical Foundation and Other.

*Workmen's Compensation and Other.

**Reporting period is as follows: Bartlett Memorial: FY 1978; Kodiak Island: May 15 - Dec. 31, 1978; PHS-ANH Bethel, Barrow, and Tanana: FY 1977.

***Providence Hospital includes both outpatient and inpatient data.

Source: Office of Information Systems, Alaska Dept. of Health & Social Services, 1979 Annual Hospital Questionnaire.
AANHS, IHS, U.S. DHEW, Leading Health Problems of the Alaska Natives, FY 1977.

If the estimates of Alaskans protected by each type of third party coverage or non-fee services are added together, the total comes to 458,305 or more than the current estimate of the resident population (411,211 in 1977). This highlights the fact that there is considerable double coverage within the state such as individuals and their dependents covered by Blue Cross who are also eligible for the CHAMPUS program, Alaska Natives eligible for services by Alaska Area Native Health Services who are also covered by private health insurance, and families with more than one member subscribing to coverage that protects all dependents.

This is certainly NOT to say that all Alaskans are protected by some type of health coverage. Unfortunately, information regarding the number of persons covered by each program will not produce an estimate of who is without coverage. To accomplish this it would be necessary to identify all those with more than one type of coverage (both subscribers/enrollees and dependents).

ESTIMATED ALASKAN POPULATION
PROTECTED BY SPECIFIC HEALTH COVERAGE PROGRAMS

Private Health Insurance & Blue Cross	263,000
Teamster Employee Welfare Trust/Alaska Health Plan	25,200
Alaska Area Indian Health Services	
Alaska Natives	65,857
CHAMPUS & USHBP	
Active Military	24,984
Military Dependents & Retirees	55,000
Medicare Enrollees	9,818
Medicaid Participants (Not all eligibles)	11,815
General Relief Medical Program Participants	2,631
Catastrophic Relief Health Insurance Program	*
Veterans Administration	**

*Catastrophic Health Insurance Program is available to all Alaskans meeting criteria identified later in this chapter.

**The V.A. pays for health care that is related to prior military service.

Private Health Insurance: The major source of third party coverage is through private health insurance and the Blue Cross Plan. Although Blue Cross is considered a hospital/medical service corporation rather than a health insurance company, it is included in these discussions and in the data from the National Health Insurance Institute.

There is considerable variation in the services covered by different types of health insurance policies. Types of coverage include hospital expense, surgical expense, regular medical expense and major medical expense.

The National Health Insurance Institute estimates that 263,000 Alaskans under 65 years of age were covered by some type of health insurance as of December 31, 1976. The number by type of coverage is indicated below.

Figure V-32

PRIVATE HEALTH INSURANCE AND BLUE CROSS

NUMBER OF PERSONS IN ALASKA UNDER AGE 65 PROTECTED BY HOSPITAL SURGICAL, REGULAR MEDICAL AND MAJOR MEDICAL EXPENSE COVERAGE

December 31, 1976

Hospital Expense	263,000
Surgical Expense	246,000
Regular Medical Expense	248,000
Major Medical Expense	146,000

Note: The data refer to the net total of people protected, i.e. duplication among persons protected by more than one kind of insuring organization or more than one insurance company policy providing the same type of coverage has been eliminated. The estimated distribution by states reflects coverage by residence rather than employment. "Major Medical Expense" data refer to people covered by insurance companies only.

Sources: Health Insurance Association of America, Blue Cross Association, National Association of Blue Shield Plans, and the U.S. Department of Health, Education and Welfare.

The total dollar figure in premiums written for Alaskans was over $84 million during 1977. The amount of premiums written compared to losses incurred are summarized below. The total dollar figures of direct premiums written during 1977 by the twenty leading vendors in Alaska are identified in the following Figure V-34. These figures are accessed through the individual insurance companies' annual reports and aggregated by the Division of Insurance.

Figure V-33

TOTAL ACCIDENT & HEALTH INSURANCE
FINANCIAL DATA FOR ALASKA

1977

	Premiums Written	Losses Incurred
TOTAL	$84,822,000*	$63,158,343
Blue Cross	32,483,000*	29,380,307
Other Group	45,377,811	36,661,724
Credit	1,641,059	651,917
All Other	3,650,859	1,464,395
(Additional Figures)	1,669,000*	

*Some figures were rounded to the nearest thousand due to the information available.

Source: Alaska State Division of Insurance; from Annual Reports by each insurance company (Home Headquarters).

Figure V-34

HEALTH INSURANCE PREMIUMS WRITTEN IN ALASKA
Figures From Individual Company Annual Statements - 1977

TOP 20 VENDORS	PREMIUMS WRITTEN (In Thousands of Dollars)
Blue Cross of Washington & Alaska	$32,483.
Aetna Life Insurance Co.	10,082.
Bankers Life Co.	6,462.
Travelers Insurance Co., Life Dept.	4,782.
United Benefit Life Insurance Co.	4,226.
Continental Assurance Co.	2,638.
Metropolitan Life Insurance Co.	2,242.
Connecticut General Life Insurance Co.	1,903.
Equitable Life Assurance Co.	1,859.
New York Life Insurance Co.	1,488.
Pacific Mutual Life Insurance Co.	1,258.
Prudential Insurance Co. of America	1,038.
Western Life Insurance Co.	941.
Penn Mutual Life Insurance Co.	807.
Occidental Life Insurance Co. of Calif.	785.
First Farwest Life Insurance Co.	725.
Combined Insurance Co. of Americal	658.
Mutual of Omaha Insurance Co.	653.
Mutual Life Insurance Co. of New York	564.
Security Benefit Life Insurance Co.	438.
TOTAL PREMIUMS WRITTEN BY 301 COMPANIES:	$84,822.

Medicare: Medicare is a health insurance program administered by the federal government for the aged (Title 18 of the Social Security Act of 1965). Medicare coverage was extended in 1974 to also include disabled persons and persons with chronic kidney disease. Part A, Medicare coverage provides insurance for hospital care, post-hospital extended care and home health benefits. Part B, available on a voluntary basis with the payment of monthly premiums, provides medical insurance that covers not only care by physicians but also hospital outpatient services, physical therapy, diagnostic x-rays, ambulance services, etc.

By 1972, more than 95% of the U.S. population aged 65 and older was covered by Part A of Medicare. However, because of Medicare's deductibles and co-insurance provisions, and because of gaps in Medicare coverage, more than half of the Americans over 65 are buying private insurance to supplement Medicare. Medicare paid less than 35% of the total health bill to those over 65 during 1975.

Medicare expenditures for Alaska totaled over $7 million in 1976. Total Medicare expenditures rose by 54.9% between 1974 and 1976 for Alaska compared to 46.5% nationally. The Hospital Insurance Component (Part A) rose by 54.7% in Alaska and 45.1% nationally. The Supplementary Medical Insurance component (Part B) rose by a full 55.3% for Alaska compared to 50.1% nationally. During 1976, 9,818 Alaskans were enrolled in the Medicare program; including 8,653 persons age 65 and over, 1,165 disability beneficiaries, and 31 individuals with chronic kidney disease.

Figure V-35

MEDICARE ENROLLMENT (JULY 1) AND REIMBURSEMENT FOR HOSPITAL AND MEDICAL INSURANCE

ALASKA & U.S. CY 1976

	Hospital and/or medical insurance			Hospital insurance			Supplementary medical insurance		
	Number of persons enrolled	Amount reimbursed	Monthly average	Number of persons enrolled	Amount reimbursed	Monthly average	Number of persons enrolled	Amount reimbursed	Monthly average
All persons enrolled									
Alaska	9818	$7,161,870	$ 60.79	9750	$4,915,506	$ 42.01	8185	$2,246,364	$ 22.87
U.S.			$ 58.10			$ 42.79			$ 16.38
Persons age 65+									
Alaska	8653	$5,668,674	$ 54.59	8585	$4,101,190	$ 39.81	7174	$1,567,484	$ 18.21
U.S.			$ 56.80			$ 42.42			$ 15.41
Disability Beneficiaries									
Alaska	1165	$1,493,196	$ 106.81	1165	$ 814,316	$ 58.25	1011	$ 678,880	$ 55.96
U.S.			$ 70.82			$ 46.39			$ 26.44
Chronic Peral Disease									
Alaska	31	$ 651,374	$1,751.01	31	$ 189,239	$508.71	30	$ 462,135	$1,283.71
U.S.			$1,108.33			$305.26			$ 830.96

Medicaid and General Relief Medical: Persons eligible for the cash assistance payments (public assistance) under the categorical assistance programs (Old Age Assistance, Aid to the Blind, Aid to the Disabled, and Aid to Families with Dependent Children) are eligible for Medicaid coverage of health care costs. Additional eligibility criteria for Medicaid exists for persons in nursing facilities and children in foster care or juvenile care situations. Medicaid is a state administered medical assistance program funded by both federal and state sources.

General Relief Medical coverage is available for persons having no prior medical care resources and who meet financial eligibility requirements for the assistance programs listed above but do not meet other qualifications for Medicaid coverage (under 65, both parents in the home are physically able to work, not blind or disabled under federal definition). General Relief Medical (GRM) provides coverage for some medical services and supplies not covered under Medicaid such as prescription drugs, prosthetic devices and medical equipment. GRM is administered by the state and totally state funded.

During fiscal year 1977, 11,815 persons received Medicaid services in Alaska and 2,631 received services under the General Relief Medical program. The total funds expended and the services covered are identified in Figures V-36, V-37 and V-38.

Medicaid expenditures have grown tremendously as a result of population growth, inflation, increased availability of services, rising cost of services and increased utilization of federal revenues for medical programs. The following figures show that Medicaid expenditures have grown by over 300% between 1973 and 1977.

Figure V-36

FISCAL YEAR	MEDICAID EXPENDITURES	GR MED EXPENDITURES	ADMINISTRATION AND SUPPORT
1973	$ 4,447,219	$ 3,675,277	$ 481,890
1974	7,876,759	2,607,112	631,129
1975	9,309,702	2,358,080	722,778
1976	14,328,201	2,881,213	1,085,086
1977	18,608,568	3,743,128	1,253,002
1978 1/	25,915,719	6,213,100	1,346,800
1979 2/	38,611,695	6,769,100	1,423,950

1/ Projected expenditures
2/ Total of budget request including supplemental requests--includes $6,422,300 for Indian Health Care Improvement Act billings by ANHS; this is 100% federal funds.

SOURCE: Medicaid Annual Status Report FY 77, State of Alaska, Dept Health and Social Services, Division f Public Assistance.

Figure V-37

DISTRIBUTION OF MEDICAID PAYMENTS BY TYPE OF SERVICE

BY DATE OF SERVICE

FISCAL YEAR 1977

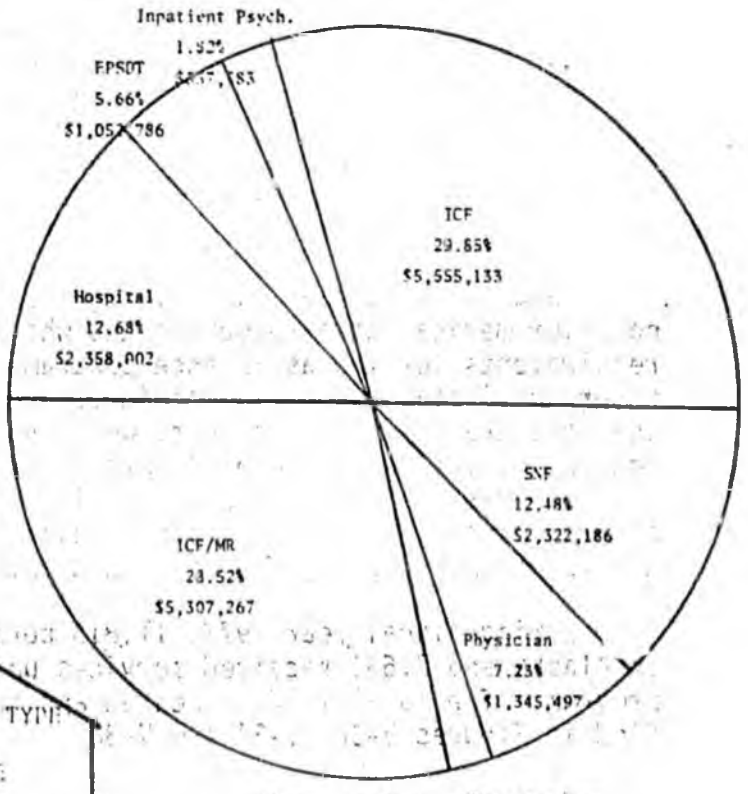
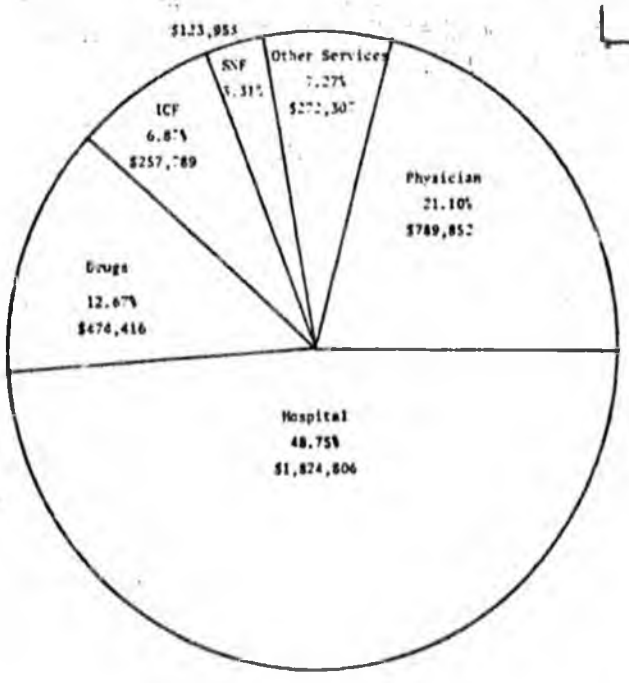


Figure V-38

DISTRIBUTION OF GR MED PAYMENTS BY TYPE OF SERVICE BY DATE OF SERVICE

FISCAL YEAR 1977



SOURCE: Medicaid Annual Status Report FY 77, State of Alaska, Dept Health and Social Services, Division of Public Assistance.

Catastrophic Illness Coverage: The State of Alaska initiated the Catastrophic Illness Program in July 1976 to assist individuals that have suffered an illness that results in high medical expenses. The program applies to medical bills related to catastrophic illnesses of more than $1,000 in a period not to exceed 12 months after all sources of third party payment has been exhausted. An applicant must be a resident of the state of Alaska at the time of the application and must have been a resident at the time of the catastrophic illness.

The Catastrophic Illness Committee, which administers the Program, determines the eligibility of applications and the amount of medical assistance to be awarded. The committee applies a formula for determining the amount of payment based upon family income and assets, and the amount of medical expenses incurred. The total budget for the Catastrophic Illness Program for FY 1979 is $514,000. The number of applications for catastrophic illness coverage which can be approved is therefore restricted by the appropriate budget. The program granted financial aid to over 80 persons during FY 78 and the number of applicants is increasing steadily.

Violent Crime Compensation: "Alaska Statute 18.67, establishing a Violent Crimes Compensation Board, was adopted by the State Legislature in 1972. Its purpose was to alleviate the financial hardships caused by crime related medical expenses or loss of income sustained by innocent victims of violent crimes in Alaska. Additionally, it provides for the payment of pecuniary loss to dependents of deceased victims to mitigate the loss of a loved one." The maximum award allowable per victim per incident is $25,000; except in the case of the death of a victim who has numerous eligible dependents, for which the maximum allowable is $40,000. The growth in the awareness of Violent Crimes Compensation has resulted in an increase in the number of applications received. The following chart documents the applications received and awards granted since 1973.

Figure V-39

APPLICATIONS AND AWARDS

	FY73	FY74	FY75	FY76	FY77	FY78
Applications Received	15	50	71	68	93	100
Applications Heard	-0-	37	51	82	81	99
Total Amount Awards Granted	-0-	36,025.60	125,266.20	272,948.29	120,968.07	285,672.63*
Pending Claims At End Of FY	13	38	41	8	28	33

*The Legislature approved a supplemental appropriation of $75,000.00 for awards for FY78. $94,379.30 of the F /78 award money was spent on prior year claims.

Administrative costs for Violent Crimes Compensation for FY 78 were as follows:

Staff salaries (2 persons) and benefits	$57,315.37
Travel includes board member travel and per diem	5,195.44
Attorney fees, office expenses, equipment, etc	11,372.97
Total Costs	$73,883.78

spouse and such children whose coverage under the policy terminates at the same time, or (ii.) to a child solely with respect to himself upon termination of his coverage by reason of ceasing to be a qualified family member under the group policy, if a conversion privilege is not otherwise provided above with respect to such termination.

(17) If the benefit levels required in paragraphs (10) and (11) exceed the benefit levels provided under the group policy, the conversion policy may offer benefits which are substantially similar to those provided under the group policy in lieu of those required in paragraphs (10) and (11).

(18) The insurer may elect to provide group insurance coverage in lieu of the issuance of a converted individual policy.

(19) A notification of the conversion privilege shall be included in each certificate of coverage.

(20) A converted policy which is delivered outside [state] must be on a form which could be delivered in such other jurisdiction as a converted policy had the group policy been issued in that jurisdiction.

Section 3. [*Severability.*] [Insert severability clause.]

Section 4. [*Repeal.*] [Insert repealer clause.]

Section 5. [*Effective Date.*] [Insert effective date.]

Comprehensive Health Insurance Act

This draft statute requires that employers in the state must include qualified catastrophic health insurance protection and minimum types of benefits for routine care in any policy provided to their employees pursuant to the individual's employment. This includes policies which are paid for partly or fully by the employee as well as those which are completely employer-paid. If only nonqualified plans are offered to employees, the employer may not deduct for tax purposes the cost of the insurance to him. In order to qualify, a plan must meet specified benefit levels and have no more than a maximum allowable deductible. This draft act also includes as Sections 18 and 19 a state catastrophic medical insurance plan under which the state will pay the medical expenses of those persons who incur uninsured medical expenses exceeding specified portions of their income.

This medical insurance plan is implemented by requiring in the statute that all insurers writing health insurance in the state must offer a qualified plan to their customers. A compulsory association of all insurers in the state is also to be formed under the act for the purpose of offering a qualified plan of insurance to those individuals whom the insurers have individually refused to insure. For those individuals who may be leaving employment at which they were enrolled in a qualified plan, the act provides mandatory conversion privileges enabling the individual to continue his insurance.

As the above indicates, this draft act is broad in scope and is directed toward multiple purposes. Among the related but separate purposes of the legislation are ensuring minimum standards for group health plans, creating an association of insurers as a resort for those individuals who could not otherwise obtain effective coverage, and providing catastrophic medical expense protection for all through employers and private insurers where possible and through the state welfare system where necessary.

This draft legislation is based on a 1976 Minnesota statute.

Suggested Legislation

(Title, enacting clause, etc.)

Section 1. [*Short Title.*] This act may be cited as the [state] Comprehensive Health Insurance Act.

Section 2. [*Definitions.*] As used in this act:

(1) "Employer" means any person, partnership, association, trust, estate, or corporation, which employs 10 or more individuals who are residents of this state.

(2) "Health maintenance organization" means a nonprofit corporation licensed and operated as provided in [appropriate state statute].

(3) "Qualified plan" means those health benefit plans which have been certified by the commissioner as providing the minimum benefits required by Section 6 of this act or the actuarial equivalent of those benefits.

(4) "Qualified Medicare supplement plan" means those health benefit plans which have been certified by the commissioner as providing the minimum benefits required by Section 7 of this act or the actuarial equivalent of those benefits.

(5) "Commissioner" means the [commissioner of insurance].

(6) "Dependent" means a spouse or unmarried child under the age of 19 years, a dependent child who is a student under the age of 25 and financially dependent upon the parent, or a dependent child of any age who is disabled.

(7) "Employee" means any [state] resident who has entered into the employment of or works under contract or service or apprenticeship with any employer. "Employee" does not include a person who has been employed for less than [30] days by his present employer, nor one who is employed less than an average of [30] hours per week by his present employer.

(8) "Plan of health coverage" means any plan or combination of plans of coverage, including combinations of self-insurance, individual accident and health insurance policies, group accident and health insurance policies, coverage under a nonprofit health service plan, or coverage under a health maintenance organization subscriber contract.

(9) "Insurer" means those companies operating pursuant to [appropriate state statute] and offering or selling policies or contracts of accident and health insurance. "Insurer" does not include health maintenance organizations.

(10) "Accident and health insurance policy" or "policy" means insurance or nonprofit health service plan contracts providing benefits for hospital, surgical, and medical care. "Policy" does not include coverage which is (i) limited to disability or income protection coverage, (ii) automobile medical payment coverage, (iii) supplemental to liability insurance, (iv) sold by fraternals and provides payments on a per diem, daily indemnity or nonexpense-incurred basis, or (v) credit accident and health insurance issued pursuant to [appropriate state statute].

(11) "Health benefits" means benefits offered to employees on an indemnity or prepaid basis which pay the costs of or provide medical, surgical, or hospital care.

(12) "Eligible person" means an individual who is a resident of [state] and meets the enrollment requirements of Section 14 of this act. For purposes of Sections 18, 19, and 20 only, "eligible person" means any person who while a resident of [state] has been found by the [commissioner of public welfare] to have incurred an obligation to pay qualified expenses for himself and any dependents in any [12] consecutive months exceeding (i) [40] percent of his household income up to $[15,000], plus [50] percent of his household income between $[15,000 and $25,000], plus [60] percent of his household income in excess of $[25,000], or (ii) $[2,500], whichever is greater.

(13) "Comprehensive health association" or "association" means the association created by Section 10 of this act.

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

(15) "Medicare supplement plan" means any plan of insurance protection which provides benefits for the costs of medical, surgical, or hospital care and which is marketed as providing benefits which complement or supplement the benefits provided by Medicare.

(16) "State plan premium" means the premium determined pursuant to Section 8 of this act.

(17) "Writing carrier" means the insurer or insurers and health maintenance organization or organizations selected by the association and approved by the commissioner to administer the comprehensive health insurance plan.

(18) "Fraternal beneficiary association" or "fraternal" means a corporation, society, order, or voluntary association without capital stock which sells health and accident insurance in accordance with [appropriate state statute].

(19) "Comprehensive health insurance plan" or "state plan" means policies of insurance and contracts of health maintenance organization coverage offered by the association through the writing carrier.

(20) "Self-insurer" means an employer who directly provides a plan of health coverage to his employees and administers the plan of health coverage himself or through an insurer. "Self-insurer" does not include an employer engaged in the business of providing health care services to the public who provide health care services directly to his employees at no charge to them.

(21) "Self-insurance" means a plan of health coverage offered by a self-insurer.

(22) "Qualified expense" means any charge incurred subsequent to [insert date] for a health service which is included in the list of covered services described in Section 6(a), and for which no third party is liable.

(23) "Household income" means the gross income of an eligible person and all his dependents for the calendar year preceding the year in which an application is filed pursuant to Section 18.

(24) "Gross income" means income as defined in [appropriate state tax statute].

(25) "Third party" means any person other than the eligible person or his dependents.

Section 3. [*Duties of Employer.*]

(a) Each employer who provides or makes available to his employees a plan of health coverage shall make available to his employees employed in this state a plan or combination of plans which have been certified by the commissioner as a number two qualified plan. If the plan of health coverage does not meet the requirements of Section 6 for a number two qualified plan, the employer shall make available a supplemental plan of health benefits which, when combined with the existing plan of health benefits, constitutes a number two coverage plan. The plan or combinations of plans may be financed from funds contributed solely by the employer or solely by the employees or any combination thereof. The plans may consist of self-insurance, health maintenance contracts, group policies, or individual policies or any combination thereof.

(b) In the event that an employer fails to make available at least a number two qualified plan health benefits to his employees employed in this state, none of the employer's costs for health benefits shall qualify as an income tax deduction pursuant to [appropriate state tax statute]. In the case of an employer who meets the requirements of [state statute defining tax exempt organizations], if the employer fails to make available at least a number two qualified plan to his employees, the employer shall lose his status as an exempt organization.

Section 4. [*Duties of Insurers.*]

(a) For each type of qualified plan described in Section 6, an insurer or fraternal issuing individual policies of accident and health insurance in this state, other than group conversion policies, shall develop and file with the commissioner an individual policy which meets the minimum standards of that type of qualified plan. An insurer or fraternal issuing individual policies of accident and health insurance in this state shall offer each type of qualified plan to each person who applies and is eligible for accident and health insurance from that insurer or fraternal.

(b) An insurer or fraternal issuing Medicare supplement plans in this state shall develop and file with the commissioner a Medicare supplement policy which meets the minimum standards of a qualified Medicare supplement plan. An insurer or fraternal issuing Medicare supplement plans in this state shall offer a qualified Medicare supplement plan to each person who is eligible for coverage and who applies for a Medicare supplement plan.

(c) For each type of qualified plan described in Section 6, an insurer or fraternal issuing group policies of accident and health insurance in this state shall develop and file with the commissioner a group policy which provides for each member of the group the minimum benefits required by that type of qualified plan. An insurer or fraternal issuing group policies of accident and health insurance in this state shall offer each type of qualified plan to each eligible applicant for group accident and health insurance.

(d) Each insurer and fraternal shall include coverage of major medical costs in every unqualified policy of accident and health insurance, unless the applicant for a new or renewal policy declines the coverage in writing. The coverage shall provide that when a covered individual incurs out-of-pocket expenses of $[5,000] or more within a calendar year for services covered in Section 6(a), benefits shall be payable, subject to any copayment authorized by the commissioner, up to a maximum lifetime limit of $[250,000].

(e) No policy of accident and health insurance may be issued or renewed in this state [180] days after [insert date] by an insurer or a fraternal which has not complied with the requirements of this section.

(f) An insurer or fraternal may fulfill its obligations under this section by issuing the required coverages in their own name and reinsuring the risk and administration of the coverages with the association in accordance with paragraphs (5) and (6) of Section 10(g).

(g) Nothing in this section shall require an insurer or fraternal to offer or issue a policy to any person who does not meet the underwriting or membership requirements of the insurer or fraternal.

Section 5. [*Certification of Qualified Plans.*] Upon application by an insurer, fraternal, or employer for certification of a plan of health coverage as a qualified plan or a qualified Medicare supplement plan for the purposes of Sections 1 to 17, the commissioner shall make a determination within [90] days as to whether the plan is qualified. All plans of health coverage shall be labeled as "qualified" or "nonqualified" on the front of the policy or evidence of insurance. All qualified plans shall indicate whether they are number one, two, or three coverage plans.

Section 6. [*Minimum Benefits of Qualified Plan.*]

(a) A plan of health coverage shall be certified as a number three qualified plan if it otherwise meets the requirements established by [appropriate state statute] and the other laws of this state and whether or not the policy is issued in this state and meets or exceeds the following minimum standards:

(1) The minimum benefits for a covered individual shall, subject to the other provisions of this subsection, be equal to at least [80] percent of the cost of covered services in excess of an annual deductible which does not exceed $[150] per person. The coverage shall include a limitation of $[3,000] per person on total annual out-of-pocket expenses for services covered under this subsection. The coverage may be subject to a maximum lifetime benefit of not less than $[250,000]. Covered expenses shall be the usual and customary charges for the following services and articles when prescribed by a physician:

(i) Hospital services.

(ii) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than outpatient mental or dental, which are rendered by a physician or at his direction.

(iii) Drugs requiring a physician's prescription.

(iv) Services of a nursing home for not more than [120] days in a year if the services commence within [14] days following confinement of at least

[three] days in a hospital for the same condition.

(v) Service of a home health agency up to a maximum of [180] visits per year.

(vi) Use of radium or other radioactive materials.

(vii) Oxygen.

(viii) Anesthetics.

(ix) Prostheses.

(x) Rental or purchase, as appropriate, of durable medical equipment.

(xi) Diagnostic X-rays and laboratory tests.

(xii) Oral surgery for partially or completely unerupted impacted teeth, a tooth root without the extraction of the entire tooth, or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth.

(xiii) Services of a physical therapist.

(2) Covered expenses for the services and articles specified in this subsection do not include the following:

(i) Any charge for any care for any injury or disease either arising out of an injury in the course of employment and subject to a worker's compensation or similar law, for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle or other liability insurance policy or equivalent self-insurance, or for which benefits are payable under another policy of accident and health insurance or Medicare.

(ii) Any charge for treatment for cosmetic purposes other than surgery for the repair of an injury or birth defect.

(iii) Any charge for travel other than travel by ambulance to the nearest health care institution qualified to treat the illness or injury.

(iv) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semi-private room, unless a private room is prescribed as medically necessary by a physician.

(v) That part of any charge for services or articles rendered or prescribed by a physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality where the service is provided.

(vi) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual rendering the services or article.

(3) Effective [insert date], the minimum benefits for a qualified plan shall include, in addition to those benefits specified in subsection (a)(1), benefits for the following services subject to applicable deductibles, coinsurance provisions, and maximum lifetime benefit limitations:

(i) Well baby care.

(ii) Physicians' services for routine checkups and annual physicals when prescribed by a physician.

(iii) Multiphasic screening and other diagnostic testing. The commissioner by rule shall prescribe reasonable limits on the reimbursement required for these services.

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

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

(d) A health maintenance organization which provides the services required by [appropriate state statute] shall be deemed to be providing a number three qualified plan.

Section 7. [*Qualified Medicare Supplement Plan.*] Any plan which provides benefits to persons over the age of 65 years may be certified as a qualified Medicare supplement plan if the plan is designed to supplement Medicare and provides coverage of [50] percent of the deductible and copayment required under Medicare and [80] percent of the charges for covered services described in Section 6(a), which charges are not paid by Medicare. The coverage shall include a limitation of $[1,000] per person on total annual out-of-pocket expenses for the covered services. The coverage may be subject to a maximum lifetime benefit of not less than $[100,000].

Section 8. [*State Plan Premium.*]

(a) For the first year of operation of the comprehensive health insurance plan, the association shall establish the following premiums to be charged for membership in the comprehensive health insurance plan:

(1) The premium for the number one qualified plan shall be the average of rates charged by the [five] insurers with the largest number of individuals in a number one individual qualified plan of insurance in force in the state.

(2) The premium for the number two qualified plan shall be the average of rates charged by the [five] insurers with the largest number of individuals in a number two individual qualified plan of insurance in force in the state.

(3) The premium for a qualified Medicare supplement plan shall be the average of rates charged by the [five] insurers with the largest number of individuals enrolled in a qualified Medicare supplement plan.

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

(b) For the second and subsequent years, the schedule of premiums for membership in the comprehensive health insurance plan shall be designed to be self-supporting and based on generally accepted actuarial principles.

Section 9. [*Duties of Commissioner.*] The commissioner may: