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(1) Formulate general policies to advance the purposes of Sections 1 to 17; the commissioner may also adopt, promulgate, repeal, and amend rules pursuant to the rulemaking provisions of [state administrative procedure act] to carry out the provisions of Sections 1 to 17.

(2) Supervise the creation of a comprehensive health association within the limits described in Section 10.

(3) Approve the selection of the writing carrier by the association and approve the association's contract with the writing carrier including the state plan coverage and premiums to be charged.

(4) Appoint advisory committees.

(5) Conduct periodic audits to assure the general accuracy of the financial data submitted by the writing carrier and the association.

(6) Contract with the federal government or any other unit of government to ensure coordination of the state plan with other governmental assistance programs.

(7) Undertake directly or through contracts with other persons studies or demonstration programs to develop awareness of the benefits of Sections 1 to 17, so that the residents of this state may best avail themselves of the health care benefits provided by these sections.

(8) Contract with insurers and others for administrative services.

Section 10. [*Comprehensive Health Association.*]

(a) There is established a comprehensive health association with membership consisting of all insurers, self-insurers, fraternals, and health maintenance organizations licensed or authorized to do business in this state.

(b) The board of directors of the association shall be made up of [seven] individuals selected by participating members, subject to approval by the commissioner. To select the initial board of directors, and to initially organize the association, the commissioner shall give notice to all members of the time and place of the organizational meeting. In determining voting rights at the organizational meeting, each member shall be entitled to vote in person or by proxy. The vote shall be a weighted vote based upon the member's cost of self-insurance, accident and health insurance premium, subscriber contract charges, or health maintenance contract payment derived from or on behalf of residents in the previous calendar year, as determined by the commissioner. If the board of directors is not selected within [60] days after notice of the organizational meeting, the commissioner may appoint the initial board. In approving or selecting members of the board, the commissioner shall consider, among other things, whether all types of members are fairly represented. Members of the board may be reimbursed from the moneys of the association for expenses incurred by them as members, but shall not otherwise be compensated by the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by members of the association.

(c) All members shall maintain their membership in the association as a condition of doing business in this state. The association shall submit bylaws and operating rules to the commissioner for approval.

(d) All meetings of the association, its board, and any committees of the association shall comply with the provisions of [state open meetings act].

(e) All members shall enter into a contract with the association according to terms specified in Section 11. The contract of reinsurance shall be executed for a period of one year and shall be renewed annually thereafter. A company which ceases to do business within the state shall remain liable under the contract for the reinsurance contracted for during that calendar year.

(f) In the performance of their duties as members of the association, the members shall be exempt from the provisions of [state antitrust statute].

(g) The association may:

(1) Exercise the powers granted to insurers under the laws of this state.

(2) Sue or be sued.

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

(4) Establish administrative and accounting procedures for the operation of the association.

(5) Provide for the reinsuring of risks incurred as a result of issuing the coverages required by Sections 4 and 16 by members of the association. Each member which elects to reinsure its required risks shall determine the categories of coverage it elects to reinsure in the association. The categories of coverage are: (i) individual qualified plans, excluding group conversions; (ii) group conversions; (iii) group qualified plans with fewer than [50] employees or members; and (iv) major medical coverage. A separate election may be made for each category of coverage. If a member elects to reinsure the risks of a category of coverage, it must reinsure the risk of the coverage of every life covered under every policy issued in that category. Members electing to administer the risks which are reinsured in the association shall comply with the benefit determination guidelines and accounting procedures established by the association. The fee charged by the association for the reinsurance of risks shall not be less than [110] percent of the total anticipated expenses incurred by the association for the reinsurance.

(6) Provide for the administration by the association of policies which are reinsured pursuant to paragraph 5 of this subsection. Each member electing to reinsure one or more categories of coverage in the association may elect to have the association administer the categories of coverage on the member's behalf. If a member elects to have the association administer the categories of coverage, it must do so for every life covered under every policy issued in that category. The fee for the administration shall not be less than [110] percent of the total anticipated expenses incurred by the association for the administration.

(a) Upon certification as an eligible person in the manner provided by Section 14, an eligible person may enroll in the comprehensive health insurance plan by payment of the state plan premium to the writing carrier.

(b) Any employer which has in its employ one or more eligible persons enrolled in the comprehensive health insurance plan may make all or any portion of the state plan premium payment to the state plan directly to the writing carrier.

(c) Not less than [87½] percent of the state plan premium paid to the writing carrier shall be used to pay claims, and not more than [12½] percent shall be used for the payment of agent referral fees as authorized in Section 15(c) and for payment of the writing carrier's direct and indirect expenses, as specified in Section 13(g).

(d) Any income in excess of the costs incurred by the association in providing reinsurance or administrative services shall be held at interest and used by the association to offset losses due to claims expenses of the state plan or allocated to reduce state plan premiums.

(e) Each member of the association shall share the losses due to claims expenses of the comprehensive health insurance plan pursuant to the terms of the individual reinsurance contracts executed by the association with each member in accordance with Section 10(e). Deviations in the claim experience of the state plan from the premium payments allocated to the payment of benefits shall be the liability of the association members. Association members shall share in the excess costs of the state plan in an amount equal to the ratio of the member's total cost of self-insurance, accident and health insurance premium, subscriber contract charges, or health maintenance organization contract charges received from or on behalf of [state] residents as divided into the total cost of self-insurance, accident and health insurance premium, subscriber contract charges, and health maintenance organization contract charges received by all association members from or on behalf of [state] residents, as determined by the commissioner. The reinsurance contract shall provide for a retroactive determination of each member's liability and payment due within [30] days after each renewal date of the reinsurance contract. Failure by a member to tender to the association the assessed reinsurance payment within [30] days of notification by the association shall be grounds for termination of the member's membership. Net gains, if any, from the operation of the state plan shall be held at interest and used by the association to offset future losses due to claims expenses of the state plan or allocated to reduce state plan premiums.

Section 12. [*Minimum Benefits of Comprehensive Health Insurance Plan.*] The association through its comprehensive health insurance plan shall offer policies which provide the benefits of a number one qualified plan, a number two qualified plan, and a qualified Medicare supplement plan. They shall offer health maintenance organization contracts in those areas of the state where a health maintenance organization has agreed to make the coverage available and has been selected as a writing carrier.

Section 13. [*Administration of Plan.*]

(a) Any member of the association may submit to the commissioner the policies of accident and health insurance or the health maintenance organization contracts which are being proposed to serve in the comprehensive health insurance plan. The time and manner of the submission shall be prescribed by rule of the commissioner.

(b) Upon the commissioner's approval of the policy forms and contracts submitted pursuant to Section 10, the association shall select policies and contracts submitted by a member or members of the association to be the comprehensive health insurance plan. This selection shall be based upon criteria including the member's proven ability to handle large group accident and health insurance cases, efficient claim paying capacity, and the estimate of total charges for administering the plan. The association may select separate writing carriers for the two types of qualified plans, the qualified Medicare supplement plan, and the health maintenance organization contract.

(c) The writing carrier shall perform all administrative and claims payment functions required by this section. The writing carrier shall provide these services for a period of [three] years, unless a request to terminate is approved by the commissioner. The commissioner shall approve or deny a request to terminate within [90] days of its receipt. A failure to make a final decision on a request to terminate within the specified period shall be deemed to be an approval. [Six] months prior to the expiration of each [three]-year period, the association shall invite submissions of policy forms from members of the association, including the writing carrier. The association shall follow the provisions of subsection (b) in selecting a writing carrier for the subsequent three-year period.

(d) The writing carrier shall provide to all eligible persons enrolled in the plan an individual certificate, setting forth a statement as to the insurance protection to which he is entitled, with whom claims are to be filed and to whom benefits are payable. The certificate shall indicate that coverage was obtained through the association.

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

(f) All claims shall be paid by the writing carrier pursuant to the provisions of Sections 1 to 17 and shall indicate that the claim was paid by the state plan. Each claim payment shall include information specifying the procedure to be followed in the event of a dispute over the amount of payment.

(g) The writing carrier shall be reimbursed from the state plan premiums received for its direct and indirect expenses. Direct and indirect expenses

shall include, but need not be limited to, a pro rata reimbursement for that portion of the writing carrier's administrative, printing, claims administration, management and building overhead expenses which are assignable to the maintenance and administration of the state plan. The association shall approve cost accounting methods to substantiate the writing carrier's cost reports consistent with generally accepted accounting principles. Direct and indirect expenses shall not include costs directly related to the original submission of policy forms prior to selection as the writing carrier.

(h) The writing carrier shall at all times when carrying out its duties under Sections 1 to 17 be considered an agent of the association and the commissioner with civil liability subject to the provisions of [appropriate state tort liability statute].

(i) Premiums received by the writing carrier for the comprehensive health insurance plan are specifically exempted from the provisions of Section 15.

Section 14. [*Enrollment by Eligible Person.*]

(a) The comprehensive health insurance plan shall be open for enrollment by eligible persons. An eligible person may enroll by submission of a certificate of eligibility to the writing carrier. The certificate shall provide the following:

(1) Name, address, age, and length of time at residence of the applicant.

(2) Name, address, and age of spouse and children, if any, if they are to be insured.

(3) Evidence of rejection, or a requirement of restrictive riders, or a preexisting conditions limitation on a qualified plan, the effect of which is to substantially reduce coverage from that received by a person considered a standard risk, by at least [two] association members within [six] months of the date of the certificate.

(4) A designation of the coverage desired.

(b) Within [30] days of receipt of the certificate described in Section 14(a), the writing carrier shall either reject the application for failing to comply with the requirements in Section 14(a) or forward the eligible person a notice of acceptance and billing information. Insurance shall be effective immediately upon receipt of the first month's state plan premium, and shall be retroactive to the date of application, if the applicant otherwise complies with the requirements of Sections 1 to 17. An eligible person may not purchase more than one policy from the state plan.

(c) No person who obtains coverage pursuant to this section shall be covered for any preexisting condition during the first [six] months of coverage under the state plan if the person was diagnosed or treated for that condition during the [90] days immediately preceding the filing of an application.

Section 15. [*Solicitation of Eligible Persons.*]

(a) The association pursuant to a plan approved by the commissioner shall disseminate appropriate information to the residents of this state regarding the existence of the comprehensive health insurance plan and the means of enrollment. Means of communication may include use of the press, radio, and television, as well as publication in appropriate state offices and publications.

(b) The association shall devise and implement means of maintaining public awareness of the provisions of Sections 1 to 17 and shall administer these sections in a manner which facilitates public participation in the state plan.

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

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

Section 16. [*Conversion Privileges.*] Every program of self-insurance, policy of group accident and health insurance or contract of coverage by a health maintenance organization written or renewed in this state shall include the right to convert to an individual coverage qualified plan without the addition of underwriting restrictions regardless of the reason for leaving the group. The person leaving the group may exercise his right to conversion within [30] days of leaving the group. Plans of health coverage shall also include a provision which, upon the death of the individual in whose name the contract was issued, permits every other individual then covered under the contract to elect, within the period specified in the contract, to continue his coverage under the same or a different contract without the addition of underwriting restrictions until he would have ceased to have been entitled to coverage had the individual in whose name the contract was issued lived.

Section 17. [*Dual Option.*]

(a) An employer who employs in this state, on the average during a calendar quarter, [100] employees or more, other than employees engaged in seasonal employment, and who offers a health benefits plan to employees, whether purchased from an insurer or a health maintenance organization, or provided on a self-insured basis, shall, upon the next renewal of the health benefits plan contract, offer his employees a dual option to obtain health benefits through either an accident and health insurance policy or a health maintenance organization contract if one is available. An option need not be provided if fewer than [25] employees select that option.

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

health maintenance organization type of coverage shall meet the requirements of the laws of this state as to the services covered or benefits provided, but need not otherwise be approved by the commissioner or the board of health.

(c) No insurer shall make acceptance of its offer to provide insurance coverage contingent on acceptance by the employer of health maintenance organization coverage by a particular health maintenance organization. No health maintenance organization shall make acceptance of its offer to provide health maintenance organization coverage contingent on acceptance by the employer of insurance coverage by a particular insurer. No offer to provide the accident and health insurance policy and the health maintenance organization contract shall combine the two in a single price package.

(d) The [board of health], in consultation with the commissioner, shall adopt rules to implement the provisions of this section.

Section 18. [*Application for Assistance.*]

(a) Any person who believes that they are or will become an eligible person may submit an application for state assistance to the [commissioner of public welfare]. The application shall include a listing of expenses incurred prior to the date of the application and shall designate the date on which the [12]-month period for computing expenses began.

(b) If the [commissioner of public welfare] determines that an applicant is an eligible person, he shall pay [90] percent of all qualified expenses of the eligible person and his dependents in excess of: (1) [40] percent of his household income under $[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 (2) $[2,500], whichever is greater for the [12]-month period in which the applicant becomes an eligible person. If the [commissioner of public welfare] determines that the charge for a health service is excessive, he may limit his payment to the usual and customary charge for that service. If the [commissioner of public welfare] determines that a health service provided to an eligible person was not medically necessary, he may refuse to pay for the service. To the extent feasible, the [commissioner of public welfare] shall contract with a review organization in making any determinations as to whether or not a charge is excessive. To the extent feasible, the [commissioner of public welfare] shall contract with a review organization in making any determination as to whether or not a service was medically necessary. If the [commissioner of public welfare], in accordance with this section, refuses to pay all or a part of the charge for a health service, the unpaid portion of the charge shall be deemed to be an unconscionable fee, against the public policy of this state, and unenforceable in any action brought for the recovery of moneys owed.

Section 19. [*Duties of Commissioner.*]

(a) The [commissioner of public welfare] shall:

(1) Promulgate reasonable rules to implement Sections 18 to 20.

(2) Establish application forms and procedures for the use of persons seeking to be declared eligible persons.

(3) Investigate applications to determine whether or not the applicant is a qualified person and investigate claims from providers of health services to determine whether or not to pay them.

(b) The [commissioner of public welfare] may:

(1) Enter into contracts with the United States or any state agency, instrumentality or political subdivision for the purpose of coordinating the program established by this act, with other programs which provide or pay for the delivery of health services.

(2) Enter into contracts with third parties to perform some or all of the duties imposed on the [commissioner of public welfare] by Sections 18 and 19.

Section 20. [*Appeals.*] The final decision of the [commissioner of public welfare] in denying an application for status as an eligible person or denying all or part of the charges for a health service may be appealed by any interested party pursuant to [state administrative procedure act].

Section 21. [*Severability.*] [Insert severability clause.]

Section 22. [*Repeal.*] [Insert repealer clause.]

Section 23. [*Effective Date.*] [Insert effective date.]

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Legislative Affairs Agency

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A Study of Medicaid Client Need

February 1977

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A Study of Medicaid Client Need

PREPARED BY

LEGISLATIVE AFFAIRS AGENCY
DIVISION OF RESEARCH

FEBRUARY, 1977

Foreword

In the fall of 1972, Alaska entered the national Medicaid program, providing certain of its citizens thereby a limited spectrum of medical care services.

Since this modest beginning, the legislature has increased Medicaid coverage by the addition of a few services above those which the state is required to cover in order to participate in the federal program. These optional services allowed the state to earn addition "matching" federal funds, some of which were a direct one-for-one offset to medical care expenditures that the state itself had been previously paying for in their entirety. Other program additions resulted in increased state expenditures, but provided a more complete medical coverage package.

In order to maximize the benefits from the additional expenditures, optional service additions must undergo careful scrutiny to insure that the options chosen return the greatest level of benefits in terms of meeting the health needs of the approximately seven percent of Alaska's population served by the Medicaid program. During 1976, a number of legislators indicated their desire to have better information upon which to base their decisions concerning the addition (or deletion) of various possible optional services. In order to meet this need, Miss Deborah Behr of the Research Division staff began, in June of 1976, an extensive effort directed at reviewing public assistance eligibility supervisors' perceptions of client requirements, analyzing written denials of additional client service requests, and obtaining information from various states regarding their experience with selected options. The present study is the result of this effort.

Gregg K. Erickson
Director of Research
Legislative Affairs Agency

Juneau, Alaska
February, 1977

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O P T I N G

A Study of Medicaid Client Need

PART I. OVERVIEW OF THE MEDICAID PROGRAM

INTRODUCTION TO THE PROGRAM

Medicaid is a program funded jointly by the federal and state governments which aids certain needy Alaskans in providing payments for them to receive medical services. It helps assure that medical services are available to those needy eligible persons when they are ill or injured. It also assists in guaranteeing that the highest quality care of the kind required by the patient's condition is available, by mandating certain medical reviews of patient care and treatment. Medicaid also attempts to make services available by utilizing the present system of private practitioners, facilities, and institutions to provide the care required at the lowest possible cost to the taxpayer.

STATE PLAN FOR MEDICAID

The Medicaid program in Alaska is administered by a single state agency, the Department of Health and Social Services, which is required to submit a state plan to the Secretary of the federal Department of Health, Education, and Welfare for his review and approval.

The state plan is essentially a contract between the state department and the federal Department of Health, Education, and Welfare specifying conditions to be met in order to qualify for federal financial participation. Some topics included in it are:

1. eligibility determination
2. recipient eligibility
3. eligibility verification
4. medical services
5. health care
6. quality control
7. fair hearings
8. methods of administration
9. utilization review
10. fraud

Many of these items are required be included in the plan (mandatory), but others the state may decide whether or not to include (optional). The optional portions allow the state to shape a medical assistance program to the needs and financial resources of its citizens.

DIFFERENCES BETWEEN MEDICAID AND MEDICARE

Medicaid is often confused with the Medicare program in the state. Medicaid is a medical assistance program for certain needy low-income people. In Alaska, Medicaid is administered by the Division of Public Assistance, an agency of the Alaska Department of Health and Social Services. It is authorized under Title XIX of the federal Social Security Act and AS 47.07.010-.080 of the Alaska statutes. States can design their own programs within set federal guidelines to meet the needs and resources of its citizens. Medicaid programs can and do vary from state to state.

In comparison, Medicare is a medical insurance program for those people, rich or poor, covered by Social Security. It is administered by the Social Security Administration of the federal government. The program is the same in all fifty states. Almost everyone over 65 and some younger persons who have been receiving Social Security disability payments for at least two years qualify for the program.

BRIEF HISTORY OF MEDICAID PROGRAM IN ALASKA

On July 6, 1972, Alaska became the 49th state to provide the Medicaid program for its residents. The state had, since the mid-60's, provided for such services under the General Relief - Medical program. Costs had risen from $1.8 million to $8.7 million in FY 72. This dramatic increase was due to many factors, the major ones being:

1. The number of eligibles had increased, but the rate of expenditure was increasing at even a faster pace.

2. The scope of the program had been liberalized and expanded with a related increase in utilization of services.

3. Medical care costs were rising at a rate disproportionate to that of other costs of living.

In light of this situation, the administration and the legislature came to basic conclusions that the General Relief - Medical program, which was supported 100% with state monies, had need of administrative controls to review services and, hopefully, reduce health care expenditures. There was a general consensus that either the General Relief - Medical program had to be upgraded or research should be done to investigate the possibility of the implementation of the Medicaid program. In April, 1972, the Department of Health and Social Services contracted with Touche Ross and Company, a public accounting firm, to develop a cost benefit study of the Medicaid program. Budgets were developed and testimony was made to the legislature that session. On June 17, 1972, the enabling bill for the Medicaid program passed the legislature and was later signed into law with an effective date of July 6, 1972. (The history of the program can be traced on Table 1: Medicaid History Timeline.)

TABLE 1

State of Alaska
Medicaid History Timeline

Date	Occurrence
April 10, 19[illegible]2	Touche Ross & Company begin Medicaid System Design
April 18-June 9, 1972	Departmental Presentation to Legislature
May 10, 1972	Department of Health and Social Services' Steering Committee Established
June 17, 1972	Enabling Bill Passes Legislature
July 6, 1972	Medicaid Becomes Law
September 1, 1972	Medicaid Implemented
September 28, 1972	State Plan Submitted to Federal Department of Health, Education and Welfare
April 4, 1973	Effective date of Intermediate Nursing Home Care Option
May 16, 1974	Effective date of Inpatient Psychiatric Hospital Option for Eligible Persons 65 or Over and Under 22
May 16, 1974	Effective Date of Miscellaneous Minor Eligibility Groups (Primarily needy children under 21 in foster care under supervision by Department of Health and Social Services)
July 13, 1974	Effective date of 60 day limit on filing Medicaid claims
April 15, 1975	New Division of Public Assistance Formed
September 2, 1975	Effective date of Intermediate Nursing Home Care for Mentally Retarded Under 21 who Meet AFDC Need Standards Option
March 12, 1976	Effective date of Eye Glasses and Optometrist Service Options
June 21, 1976	Effective Date of New Nursing Home Group of Eligibles
July 1, 1976	Effective Date of Limited Clinic Services Option (Primarily Community Mental Health Centers and State Operated Mental Centers)
July 1, 1976	Effective date of Treatment of Speech, Hearing, and Language Disorders Option

The Department of Health and Social Services worked during the interim period to provide the necessary procedures and organization to make Medicaid an administrative reality in Alaska. A new Division of Medical Assistance in the Department of Health and Social Services was formed to administer the new program, as well as the remnants of the General Relief - Medical program. On September 1, 1972, the Medicaid program was actually implemented. (The Division continued to administer the program until April, 1975, when the new Division of Public Assistance was formed. This new division combined the eligibility determination, income maintenance, and medical assistance functions into one organizational grouping in the state.) Later that month, the official state plan was submitted to the federal Department of Health, Education and Welfare for its approval.

With the approval of the state plan, Alaska realized the benefits due to implementation of the Medicaid program:

1. Federal matching funds for medical expenditures became 50%, thereby allowing the continuation of the level of medical services without further increase in state general fund expenditure.

2. Federal match for categorical assistance programs under the Social Security Act increased from 30% to 50%.

3. Administrative controls, seen as necessary, were implemented to fulfill Medicaid requirements in order to receive federal financial participation.

When the legislature approved the Medicaid program, it included a restriction in statute mandating that all new services or eligibility group additions must receive its approval. At time of passage, the enabling legislation included those services and eligibility groups mandated by the federal government in order to receive federal financial participation. Since that time, the legislature has added few additional services or eligible groups.

The legislature added the first additional service option in 1973. At that time, intermediate nursing home care was selected. This option permitted the coverage of a lower and less expensive level of nursing home care. This addition allowed many Medicaid recipients in skilled nursing, who did not require that level of treatment, to be properly placed in intermediate nursing care thus "saving" state general fund dollars.

In 1974, the inpatient psychiatric hospital services option was added for eligible persons 65 years of age or over and 21 or under. This allowed the state to claim federal reimbursement for some persons at Alaska Psychiatric Institute, who were eligible for Medicaid coverage and were at that time receiving their care 100% from state monies. Also, other small groups of new eligibles were added at that time. Primarily they consisted of certain needy foster care children under 21 supervised by the Department of Health and Social Services. Prior to

that time these children had, in most cases, received coverage for their health care through the General Relief-Medical program. Also, legislation was passed requiring that medical assistance claims be submitted promptly, no later than six months afte date of service or third party payment was received. This permitted more administrative control of expenditures and allowed for greater accuracy in budget projections.

The option to include a new group of needy eligibles under 21 who were in intermediate nursing homes for the mentally retarded became effective in 1975. This permitted a group of children at Harborview Memorial Hospital, Alaska Psychiatric Institute, and Hope Park to receive Medicaid coverage and, hence, additional federal dollars could be earned for their care.

In 1976 the legislature chose to add four new items to the program. A new group of needy persons became eligible for Medicaid coverage for their nursing home care due to an addition of an option. Also, that session, prescription eyeglasses and optometrist's services were added to the program. The legislature also approved the addition of limited clinic services which allowed state operated mental health centers and state approved community outpatient mental health centers receiving grants under A.S. 47.30.520 - 47.30.620 to be covered. This permitted federal funds to be earned in these state general fund supported projects. Also, at that time, the coverage of treatment of speech, hearing, and language disorders was added to the Medicaid program.

The legislature has shown interest in examining and evaluating the available Medicaid options, as seen by the recent history of the program in the state. Many of these options, especially in the case of coverage of nursing home care for certain needy eligible persons, actually "saved" state money. By adding them to the Medicaid program, federal funds could be realized for some of those services, which were being paid at that time 100% from state general funds. Also, by increasing the scope of the service package, a more consistent medical treatment program could be offered to these needy persons. For example, prior to the 1976 addition, eyeglasses were not generally available to all Medicaid eligibles who needed them. Only Medicaid eligible children who had been seen in early screening programs and referred for eyeglasses could be reasonably assured of coverage under the program for their lenses. Needy adults, such as those in nursing homes, had no such guarantee.

Alaska was one of the last states to join the Medicaid program and has been cautious in increasing the scope of the program in the state. In comparison with many other states in the program, Alaska's program is limited, with few service and eligibility group options beyond those basic services and groups required to maintain compliance with the program. This paper will later examine the current scope of the program and the options available under it that the legislature may be called upon to evaluate in 1977 and thereafter.

PART II. CURRENT STATUS OF MEDICAID PROGRAM IN ALASKA

ELIGIBILITY OF CLIENTS

The Alaska Medicaid program provides coverage for certain needy persons receiving or eligible to receive public assistance under:

Federal Supplemental Security Income (SSI),

Alaska Old Age Assistance (OAA),

Alaska Aid to the Blind (AB),

Alaska Aid to the Disabled for Persons who Meet Federal Criteria for Disability (AD), or

Aid to Families with Dependent Children (AFDC),

and certain others (mostly children)

Alaska does not cover the medically needy under its Medicaid program.

In general to be eligible for Medicaid in Alaska, an individual must:

(1) Be physically present in Alaska at time of application and citizen of U.S. or lawfully admitted alien;

(2) Not be in a public institution such as a jail (a person may however be in chronic disease facility such as a nursing home);

(3) Not have more than $1,500 in non-exempt personal property; this excludes a home (there is no lien requirement), personal belongings, in certain cases, a necessary automobile and some types of income producing property;.

(4) Not have transferred property to qualify for assistance;

(5) Meet program requirements such as blind, disabled, aged over 65, or dependent child

The Division of Public Assistance examines the financial and living situation to determine if a person is eligible. As a basic rule, if a family of four meets general program requirements, has monthly net income of no more than $400 earned (excluding reasonable work related expenses) and unearned income, the family would qualify for assistance under Aid to Families With Dependent Children program. There is no geographical differential on the total amounts allowed. The amounts vary for the adult programs (OAA, AB, AD) but generally, if household expenses (excluding fuel) are over $35 a month and the net income is no more than $334 a month of earned (excluding reasonable work-related expenses) and unearned income, a single person family would qualify if other program requirements are met. The $334 figure can vary annually

in accordance with cost of living adjustments required in AS 47.25.640; 47.25.430; 47.25.810. Eligibility for categorical assistance programs automatically makes one eligible for Medicaid.

SERVICES COVERED UNDER MEDICAID

The State of Alaska covers basically two types of services: mandatory, which the states are required to provide, and optional, which the state may provide and receive federal reimbursement. Alaska provides all mandatory services, but optional services are limited.

Mandatory Services

Alaska must provide the following services: 1) inpatient hospital services; 2) outpatient hospital services; 3) physician's services; 4) x-ray and laboratory services; 5) skilled nursing home services; 6) home health services; 7) early and periodic screening, diagnosis, and treatment of children under 21; and 8) family planning services. Alaska also is required to cover transportation necessary to receive medical service, if unavailable from any other source, but it is not listed as a federal requirement.

Optional Services

In addition to the mandatory services, Alaska provides and receives federal reimbursement for the following services:

(1) Inpatient psychiatric hospital services for individuals age 65 or older or under age 22
(2) Intermediate care facility services
(3) Skilled nursing for those persons under 21 years of age
(4) Emergency hospital services
(5) Eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist
(6) Services for individuals with speech, hearing, and language disorders
(7) Services through state approved out-patient community mental health clinics which receive grants under AS 47.30.520-47.30.620 and state-operated mental health clinics
(8) Optometrist's services and limited dental and prosthetic devices as required under EPSDT regulations

Other services that the state could choose to provide for certain of its needy individuals, but which has not yet opted for, include:

(1) Prescribed drugs
(2) Dental Services (for persons over 21 not covered under the early screening program)
(3) Dentures
(4) Prosthetic devices (for persons over 21 not covered under the early screening program)

(5) Private duty nursing
(6) Physical therapy and related services
(7) Chiropractor's services and other practitioners
(8) Podiatrist's services
(9) Care for patients aged 65 or older in Institutions for Tuberculosis
(10) Other diagnostic services, screening, preventive services, rehabilitative services

Parts III through V of this report deal later with these optional services in more depth, examining the need and aspects to consider in the evaluation of these alternatives to the program.

FINANCIAL PARTICIPATION BY FEDERAL GOVERNMENT

The federal government financially participates in the Medicaid program by means of matching state dollars for allowable administrative and medical expenditures. Services to eligible clients receive 50% reimbursement, except for family planning supplies and services which are matched at 90% level. Administrative costs are generally matched at 50%. Professional medical review staff are reimbursed at 75% level. (Certain other administrative services receive special match rates, such as 100% for certification and survey of nursing homes. These special rates are itemized in federal law and regulation.)

At the present time there is no "ceiling" or set limit for Alaska on the amount of federal funds available for reimbursement. There has, in recent years, been much discussion on the federal level to restrict such reimbursement, as was indicated in President Ford's budget address in January, 1976. At that time, he mentioned the possibility of placing the Medicaid program in a block grant package with other federally assisted health care programs. By this method, a dollar limit would have been set on the available federal funds for those purposes. Generally, though, the prospects for major funding modifications in the Medicaid program appear slim, although tighter management and administrative mechanisms to control fraud and quality of services seems to be a continued interest.

NEW DEVELOPMENTS IN MEDICAID

In the fall of 1976 the federal government placed additional responsibilities on the Medicaid program, through the passage of Public Law 94-437. That bill, known as the Indian Health Care Improvement Act, mandated closer coordination of Medicaid and Indian health services and required that all services for Medicaid eligible Alaska Natives in Indian health facilities be billed to Medicaid. The federal government would then reimburse the state's Medicaid program at 100% for such services. Additional administrative functions would receive normal federal reimbursement rates. The services eligible for reimbursement under Public Law 94-437 are only those included in the approved Medicaid state plan and provided to Medicaid eligible Alaskan Natives.

Total ramifications of the bill are yet unknown. Federal officials report though that Alaska is far ahead of other affected states in implementing the new law. For example, seven of Alaska's nine Indian Health Service hospitals currently meet statutory requirements for participation in Medicaid without further action. State officials note though that unless there is a major shift in procedures for handling people covered under Indian Health Improvement Act, field office work will increase greatly (e.g., issuing medical coupons, arranging necessary transportation, answering client and provider questions). These state officials voiced concern that estimates of the number of new Alaska Native clients attracted to apply for Medicaid coverage are unknown. The attachment of a dollar figure to the cost of medical services for these persons would be just a rough estimation.

PART III. GENERAL INFORMATION REGARDING OPTIONAL SERVICES

CONTROLS THAT STATES MAY IMPOSE ON MEDICAID OPTIONAL SERVICES

Since the addition of optional services is at the discretion of the state, the federal government allows great flexibility for states to determine the scope of the option that they wish to provide for their Medicaid clients. Generally, federal law and regulation define the basic objectives and requirements of the options, all of which must be met in order to obtain federal financial participation. Some of the requirements address equal offering of services to all eligibles, the qualifications of persons providing the services, and degree of supervision required for paraprofessionals. Within those broad parameters states can shape optional services to fit their unique needs and resources.

Alaska can limit optional services by (1) qualifying coverage, (2) requiring prior authorization, (3) limiting usage frequency, (4) requiring clients to share in cost of services, or (5) limiting the amount of provider reimbursement:

(1) *Qualifying Coverage*

Medicaid law and regulation permit the limiting of coverage of optional services. For example, dentures can be selected as a separate service without having to cover other prosthetic devices such as hearing aids, crutches, etc, or without having to cover other dental services. The Medicaid program does require that the option limitations be applied equally to all eligible clients. (There are certain exceptions to this policy. Some options are defined in federal law to include only specific age groups such as persons under 21 or over 65.) The state, for example, cannot as a general rule limit eligibility for optional service to only those persons receiving aid under a particular program such as Old Age Assistance. If a state chooses an optional service, it must be covered for all groups (except as noted in federal law or regulation) or federal reimbursement will be jeopardized.

(2) *Requiring Prior Authorization*

States can control inappropriate overutilization of optional services by requiring the client to receive approval from the Medicaid agency prior to obtaining certain medical care. Preauthorization is usually based on medical need for services and appropriateness of the care requested to the condition being treated. The Division of Public Assistance has, since the beginning of Medicaid, required preauthorization of all nursing home placements. This mechanism serves to reduce unnecessary placements, place clients at appropriate levels of care, and suggest alternative, and usually cheaper, methods of treatment.

(3) *Limiting Usage Frequency*

Optional services can also be limited by restricting client use. This is generally done by limiting the number of treatments or services paid by Medicaid in a specific time period. For example, Maryland limits adults to one eye examination and one pair of eyeglasses every two years. Arkansas limits Medicaid clients to three prescriptions per month. These restrictions must be applied though uniformly to all clients receiving assistance. Limitations of the amount of services should take into account unusual emergency situations. States cannot impose barriers to needed <u>minimum</u> levels of health care, or risk federal sanction.

(4) *Requiring Clients to Share in Cost of Services*

Some states require Medicaid clients to participate in sharing the costs of certain optional services. Federal regulation sets certain maximum allowable limits on the amount of payment that clients can be required to cover. Those regulations also specify the mechanisms that states can use to allow clients to share in the cost of certain services. Fees are generally limited to small amounts such as $.50 per prescription drug and $2.00 per pair of eyeglasses. Originally, this procedure was instituted to control overutilization of services and not to generate funds. California, along with some other states which elected this option, has found that the cost of administration of this mechanism generally did not offset the revenues gained. The charges did not significantly affect client use of services, and the states found that the collecting and controlling of such small fees were bothersome to both client and provider.

(5) *Limiting the Amount of Provider Reimbursement*

Costs of optional services can also be reduced by limiting the amount of provider reimbursement. Often this comes in the form of reducing reimbursement by a set percentage or by "freezing" payment levels at the current standar s. (Medicaid pays "reasonable" rates to its providers. The costs allowable under its definitions often differ greatly from those accepted by Blue Cross and other insurance companies. Fees paid under Medicaid are often lower than fees paid by the general public for the same services.) The state of Michigan, for example, recently implemented an 11% reduction in normal fees paid to practitioners, dentists, laboratories, and other providers. Often such changes receive strong provider reaction and sometimes jeopardize the continued participation of those providers in the program. Federal officials also note the potential use of low bid health providers. For example, the state could solicit bids for a contract to supply Medicaid clients with specific services, such as eyeglasses. The state could select the most advantageous bid and award the contract without jeopardizing federal reimbursement.

OTHER ISSUES TO CONSIDER IN EVALUATING MEDICAID OPTIONAL SERVICES

Although this study focuses primarily on client need, there are other factors that must be considered in evaluating the merits of any given Medicaid option. Three of these major considerations are: availability of funds, costs versus benefits of options, and ease of administration.

The availability of funds plays a major role in the scope of services that a state believes it can provide for its citizens. The high cost of medical care demands an in-depth analysis of cost before any new service is added. Although this study does not discuss this financial issue, it is a major part of any decision to modify the program. Legislators who have a well defined proposal for additional option(s) may request the Research Division of the Legislative Affairs Agency to prepare an analysis of its costs, both direct and administrative.

The costs versus benefits of an option can be an important consideration in deciding whether or not the state should participate in it. For example, certain Medicaid options sometimes "save" state money, if that service is currently paid entirely from state funds or if it allows a client to receive less specialized and less expensive type of service that are more appropriate to this medical condition or problem. In 1976, the Alaska State Legislature added coverage of new limited group of needy eligibles who currently reside in nursing homes. The care for those persons at that time was paid for 100% from state general funds through the General Relief-Medical program. By adding that option, the state was able to claim 50% federal reimbursement for their care. Also, in 1973, the state added the intermediate nursing home care option. By covering this lower and less expensive level of nursing home care, many Medicaid recipients in skilled nursing, who did not require that level of treatment, could be placed in intermediate nursing care. The cost per day for each patient was reduced considerably.

The ease of administration is important also in evaluating the merits of certain options. The drug option, for example, requires that strict payment procedures regarding maximum allowable charges be in place. These are spelled out in some detail in the federal regulations, and the state must meet those requirements or risk loss of federal participation. Federal officials note that many of these cost containment mechanisms would normally be in place in any efficiently administered pharmaceuticals program, regardless of source of funding for it. The transfer of a program from state-only funding to federal assistance should cause minimal additional administrative expenses if adequate cost containment measures are in place in the existing program.

IV. MEDICAID CLIENT NEEDS

QUESTIONNAIRE OF PUBLIC ASSISTANCE SUPERVISORS

In Fall, 1976, a questionnaire was prepared to poll public assistance supervisors (eligibility work supervisors) on their estimation of client need for certain services based on their actual experience in the field. The questionnaire, prior to mailing, was reviewed by both the Division of Public Assistance and Department of Health and Social Services Commissioner's Office. The questionnaires were mailed to nineteen supervisors, many of whom had worked with public assistance clients for a significant period of time. (That sample of supervisors was chosen under the guidance of the Division of Public Assistance's Chief of Field Operations.) Approximately one month after mailing, a follow-up questionnaire was sent.

Fourteen, or 75%, of the supervisors polled responded to the questionnaire. All areas of the State were represented, including Anchorage, Fairbanks, Fort Yukon, Juneau, Kenai, Ketchikan, Nome, and Sitka. Each supervisor was asked specific questions concerning his or her evaluations of client need for Medicaid options not yet selected by the State.

QUESTION #1: In your experience, what optional services currently not covered under Medicaid do you feel your Medicaid eligible clients need most?

Table 2 shows the rank order obtained from the supervisor's responses to question #1. Interestingly, the top four items for each category (Adult Public Assistance and Aid to Families with Dependent Children program recipients) were the same. The ranking for dentures option differed slightly, being seen more necessary for older persons receiving Adult Public Assistance than the younger Aid to Families with Dependent Children recipients.

Since the Medicaid program requires that services included in the State Plan be offered equally to all eligible persons (except for certain specialized programs such as early childhood screening) the similar ranking of need options for both Adult Public Assistance and Aid to Families with Dependent Children Program is particularly meaningful. If it were called upon to evaluate new options, the legislature could be reasonably sure that any of the top four options (prescribed drugs, adult dental services, dentures, and physical therapy and related services) would be "needed" by both categories of clients.

QUESTION #2: On the average, how many Medicaid clients a month ask you if they can receive certain services?

Table 3 shows the responses by the supervisors concerning the requests of Medicaid eligibles for additional services. The responses to question #2 did not match the pattern formed from the supervisor's responses

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 hange was implemented by the Division of Public Assistance in November.*

to question #1. For example, the Medicaid prescribed drug option which was ranked as needed first for both program categories, received less than 50% of the requests made for adult dental services, which was ranked as needed second by the supervisors. This could be anticipated for Medicaid clients who do not have prior health resources equal or better in coverage to General Relief-Medical automatically receive their drugs through GRM. One Juneau public assistance supervisor noted that for these persons, eligibility for prescription drugs under GRM is automatically determined at the time that Medicaid eligibility is confirmed. Therefore, few Medicaid clients would ask for prescription drugs, since coverage is established at the time they enter the Medicaid program.

Aid to Families with Dependent Children recipients requested fewer services than did the Adult Public Assistance recipients. This was expected, for the recipients of AFDC tend to be young and thus often have less need for diverse health services. Also, many AFDC recipients are eligible for a wider range of treatment service through the Early Periodic, Diagnosis and Treatment Program (EPSDT), a child check-up program. For example, dental care is available to public assistance recipients under 21 as a referral through EPSDT, but currently persons over 21 who are mostly on Adult Public Assistance programs cannot routinely receive preventative dental care under any of the state medical assistance programs.

Many of the Medicaid options available under the federal program do not match with Alaska's availability of services. In rural Alaska, it would be difficult to obtain chiropractor's or podiatrist's services close to home. Also, the option of care for patients 65 or over in tuberculosis institutions is not really relevant to Alaska, since there are no tuberculosis sanatoriums in the State. Care for such conditions would have to be provided in nursing homes, hospitals, and physicians' offices, all of which are currently covered under Medicaid.

The low number of requests in all categories may be due to lack of client awareness that these additional services sometimes can be covered under the state funded medical assistance program, General Relief-Medical. Because of limited funds under that program, the Division of Public Assistance has not actively conducted an outreach program to inform clients of eligibility requirements and services covered. Also, many clients may be reluctant to ask for services, which they feel they stand a likelihood of being rejected. Dentures are a good example of this. Because of funding limitations, dentures can only be covered in extreme hardship situations. Clients often are informed of this policy from their dentists, public health nurses, or social workers, before a formal request is made to the Division of Public Assistance.

SURVEY OF "DENIALS" OF SERVICE RECORDS

The needs of clients were also analyzed through a survey of all denials of requests for additional services for Medicaid clients. Medicaid clients sometimes require services that are not included in the Medicaid

TABLE 3

Total Average Number of Medicaid-Eligibles Requesting
Optional Services Monthly by Program Category

Option	Recipients of Adult Public Assistance	Recipients of Aid to Families with Dependent Children	Total
Adult Dental Services	81.5	88.0	169.5
Dentures	60.5	21.0	81.5
Prescribed Drugs	38.0	39.0	77.0
Physical Therapy and Related Services	20.5	23.0	43.5
Hearing Aids [1]	27.0	16.0	43.0
Prosthetic Devices	25.5	12.0	37.5
Chiropractor's Services	15.5	15.0	30.5
Private Duty Nursing	13.5	5.5	19.0
Podiatrist's Services	4.0	1 5	5.5
Care for Patients 65 or Over in Tuberculosis Institutions	1.0	0.0	1.0
Total	287.0	221.0	508.0

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

TABLE 4

Denials of Optional Services for Medicaid-Eligibles
(September 1, 1972 to July 31, 1976) [1]

1.	Dental Services	140 [2]
2.	Therapy	63
3.	Dentures	44 [2]
4.	Prosthetic Devices	37
5.	Prescription Drugs	28
6.	Hearing Aids	15 [3]
7.	Chiropractor's Services	3
8.	Podiatrist's Services	2
9.	Private Duty Nursing	1
10.	Tuberculosis Institution for 65 or Over	0

[1] *The figure includes only denials of requests submitted in writing to the Division of Public Assistance, Central Office. That Division also handles numbers of informal telephone requests, which are not included in these figures.*

[2] *The figure excludes Delta Dental Corporation denials. Delta Dental Corporation currently reviews and evaluates all public assistance clients requests for care. These records were not readily available in Juneau for the study period. In FY76, Delta Dental denied 454 Medicaid adults for dental services and 20 Medicaid adults for dentures.*

[3] *Hearing aids were added to the Medicaid program as of November, 1976. An interpretation by federal officials of the treatment of speech, hearing, and language disorders option added last session allowed hearing aids to be covered as part of the treatment plan.*

program. If the client has no other prior health care resource equal or better in coverage to that of General Relief-Medical (GRM) Program, that client may be able to receive those services through GRM. Since GRM is funded entirely by state general funds, monies are strictly controlled and extremely limited. In order to insure the equitable use of the funds, many services require pre-authorization by the Central Office of the Division of Public Assistance before they can be provided and paid for by the General Relief-Medical Program.

Requests for service can come in two forms: letters and phone calls. The Division of Public Assistance maintains files of only written requests for service. During the month of July, 1976, a tabulation of those records was performed. Table 4 shows the number of denials of optional services which were requested by Medicaid clients during the period September 1, 1972 to July 31, 1976.

Note that the top four options that eligibility work supervisors felt their clients needed appeared within the top five items requested for those clients. Thus, the public assistance supervisors confirm the client perceived need for dental services, therapy, dentures, and prescription drugs. The survey also revealed a client perceived need for prosthetic devices (such as artificial limbs, crutches, canes, etc.).

These tabulations of requests for service represent only written requests. Because of the "emergency" nature of some services and the ease of telephoning for approval, many denials of services are not represented in the written files. Also, many clients will not request a service which they know is unavailable or which they stand a likelihood of being denied. Clearly, then, these figures substantially under-represent client need.

RESULTS OF STUDY

1. Basically State of Alaska eligibility work supervisors feel that their Medicaid-eligible clients most need:

1. Prescription Drugs
2. Adult Dental Services
3. Dentures*
4. Physical Therapy and Related Services*

* *The rank order of these services varies by program which client is receiving aid. The adult public assistance clients are seen to need dentures much more frequently than do clients of Aid to Families with Dependent Children.*

2. The top four services that eligibility work supervisors feel that their Medicaid-eligible clients ask for most frequently are:

1. Adult Dental Services
2. Dentures
3. Prescription Drugs
4. Physical Therapy and Related Services

3. Records of "denials" of requests for services to be provided from the General Relief-Medical Program to Medicaid recipients indicate that the following services are requested and denied most frequently:

1. Dental Services
2. Therapy
3. Dentures
4. Prosthetic Devices

4. The records for the number of client requests generally underestimate client need because only written records are available and because many public assistance clients will not request a service which they know is unavailable or which they stand a likelihood of being denied.

PART V. ANALYSIS OF OTHER STATES' EXPERIENCE WITH SELECTED OPTIONS

OVERVIEW OF STATES PARTICIPATING IN SELECTED OPTIONS

The survey of denials of requests for services and tabulation of the responses to the questionnaire sent to the public assistance supervisors point to four service options which clients are perceived as needing most. These are: prescription drugs, adult dental services, dentures, and physical therapy and related services.

These optional services have been elected by many other states. For example--

- 96% of all states and United States protectorates have Prescription Drug Option *

- 64% of all states and United States protectorates have Dental Services Option *

- 60% of all states and United States protectorates have Physical Therapy and Related Services Option *

**Only states participating in Medicaid program are included in total figures. Data are as of June 1, 1976 and were obtained from United States Department of Health, Education and Welfare. (Data are unavailable on the number of states offering denture service to their eligibles.)*

Many states added these services in the mid-1960's when Medicaid first began. However, it was found that some states eliminated or restricted some of these options during the period January 1, 1975 to July 1, 1976. With the skyrocketing cost of medical care and the increasing demand upon state dollars, we decided to review the options that were selected as needed by public assistance supervisors and contact those states that had recently modified them.

QUESTIONNAIRE OF STATES MODIFYING SERVICES

In early December, the Research Division of the Legislative Affairs Agency prepared a questionnaire to ask the views of state Medicaid program administrators regarding the options they had recently restricted. Fourteen states that had recently modified optional services included in this survey were contacted. Eleven states (or 79%) responded to the questionnaire. Since existing federal reports do not pinpoint the number of states modifying their denture coverage, that option was not included in the discussion.

State Experience With Prescription Drug Option

Of the 51 states providing prescription drugs, 11 states (or 22%) reduced their coverage during the period of January 1, 1975 - July 1, 1976. Seven of those states responded to the questionnaire. The majority of those states reduced coverage of drugs in order to reduce expenditure of state dollars. They noted that it created a hardship, but most clients felt coverage of only certain drugs was better than no coverage at all of them. Basically, controls were maintained by limiting the number of monthly prescriptions any one client could obtain and by limiting the types of drugs covered.

It is interesting to note that one state, Oklahoma, added the drug option during this period. In responding to the questionnaire, the director of the Oklahoma program stated that the option was added at the direction of their legislature. Certain administrative restrictions were imposed when the option was added. Prescriptions were limited to three per client per month and the different categories of drugs were also restricted. The director noted that public reaction to the addition of services has been generally favorable.

State Experience With Dental Services Option

13% of the states which chose the dental services option eliminated it during the period January 1, 1975 to July 1, 1976. (Recently two states, Massachusetts and New Jersey, have reinstated coverage of this option). Five of the seven states eliminating this option responded to the survey.

Generally, these five states found that the adult dental services option was needed by clients and was easy to administer. Restrictions on the option were basically due to lack of state funds. In one instance, New Hampshire, the legislature set a priority list of services that were to be provided. Since adult dental services received a low priority and funds were limited, the option was dropped. The dropping of the option generated considerable negative client reaction, as evidenced primarily by an increased number of client administrative appeals on this issue.

State Experience With Physical Therapy and Related Services Option

Michigan was the only one of 32 states which included physical therapy and related services in their programs and chose to modify that option during the period January 1, 1975 to July 1, 1976. The Michigan Medicaid program responded to the questionnaire and noted its experience with the option. The respondent found that the option was needed by clients; however, the cut, an elimination of physical therapy in long term care institutions, was made in response to lack of sufficient funding. To date, this change in the program has not been rescinded.

RESULTS

1. At least 60% of all states participating in the Medicaid program also cover some form of prescription drugs, dental services, and physical therapy and related services options for their clients. These services were among the top four requested by Alaska public assistance clients and seen as needed most for them according to a survey of Alaska public assistance supervisors. (Nationwide data on the numbers of states covering dentures in their programs are not available.)

2. Two of the top four services seen as needed for public assistance clients, prescription drugs and dental services, were also the top two services restricted or eliminated by other states during the period January 1, 1975 - July 1, 1976. (See Part IV for survey results.)

3. Most states modified the options to reduce expenditure of state funds. They did not drop or restrict them because of lack of client need or complexities in administration.

4. Restrictions of service options were generally done in four ways: limiting coverage of service, limiting client access, reducing provider fee payments, and charging clients small fees.

5. Reduction of fees generally brought strong reaction by the provider sector.

6. The states believe that limiting coverage to certain number of services allowable per month and restricting coverage of type of service allowable under the option was generally more acceptable than totally eliminating it.

7. In most cases, states modifying these options chose to restrict prescription drug coverage but they chose to eliminate dental services (except as was required under the early screening program).

8. In some cases states reinstated changes in options a short time after they were made. This was generally due to the strong reaction received from the groups affected.

PART VI. CONCLUSIONS TO THE STUDY

From the responses to the questionnaire sent to public assistance supervisors concerning client need, the survey of denial records of requests for additional services, and the responses from other states regarding their experience with the program, the following conclusions can be drawn:

1. Of Medicaid optional services available that Alaska does not currently provide under its program, public assistance clients appear to need most(in descending order of need):

   (1) Prescription Drugs
   (2) Dental Services
   (3) Dentures*
   (4) Physical Therapy and Related Services*

   * *The rank order of these services varies by program under which client is receiving aid. The adult public assistance clients are seen to need dentures as a higher priority than do clients of Aid to Families with Dependent Children.*

2. Three of the optional services listed in Item #1 are included by over 60% of the states participating in Medicaid. Prescription drugs, for example, are included in 95% of all state programs. (Data on coverage of dentures are generally unavailable on nationwide basis.)

3. Two of the options that clients "need" most--prescription drugs and dental services--topped the list of options that states reduced or eliminated during the period January 1, 1975 - July 1, 1976. These modifications were done as cost containment measures and not as a response to lack of client need or to complexities of administering the options.

4. Alaska could be reasonably assured that services listed in Item #1 would be needed and used by clients. The choice to include them appears to be a decision based primarily on the state's availability of state funds. The state could choose to cover an option, but restrict that option in many ways to meet funding limitations.

GLOSSARY OF TERMS

AB - See Aid to the Blind.

AD - See Aid to Disabled.

ADC - See Aid to Families with Dependent Children.

AFDC - See Aid to Families with Dependent Children.

APA - See Adult Public Assistance.

APD - See Aid to Disabled. Stands for Aid to Permanently Disabled.

Adult Public Assistance - A cash supplemental program administered by the state in cooperation with the U.S. Department of Health, Education, and Welfare. Designed to provide a state-legislated level of cash assistance to aged, blind, and disabled persons who meet certain income and resource requirements, and who are predominately eligible for Supplemental Security Income (SSI) payments. State administrative costs as well as actual cost payments are 100% state only costs.

Aid to the Blind - A cash supplemental program administered by the state in cooperation with the U.S. Department of Health, Education, and Welfare. Designed to provide a state legislated level of cash assistance to those eligible blind persons who meet certain income and resource requirements, and who are predominately eligible for SSI payments. It is considered an "Adult Public Assistance" program.

Aid to Disabled - A cash supplemental program administered by the state in cooperation with the U.S. Department of Health, Education and Welfare. Designed to provide a state legislated level of cash assistance to those eligible disabled persons who meet certain income and resource requirements and who are predominately eligible for SSI payments. It is considered an "Adult Public Assistance" program.

Aid to Families with Dependent Children - A federal program administered by the state through an approved state plan filed with the U.S. Department of Health, Education, and Welfare. Designed to provide a state-legislated level of cash assistance to dependent children who have been deprived of one or both parents, and who meet certain income and resource requirements. Both administration costs and the actual cash payments provided to recipients are shared equally (50%) by the state and federal government.

Categorical Assistance - Aid, in form of income maintenance, to certain needy persons who receive assistance under Old Age Assistance, Aid to the Blind, Aid to the Disabled, Supplemental Security Income, and Aid to Families of Dependent Children programs.

Compliance - In a federal program, the act of performing certain set program functions in accordance with those requirements outlined in the state plan, federal law, and regulation. Generally, meeting all federal program requirements is necessary to receive federal financial participation in the program.

DHSS - See Department of Health and Social Services.

Department of Health and Social Services - A department of the executive branch designated to be single state agency to administer the Medicaid program for the state of Alaska.

EPSDT - See Early and Periodic Screening, Diagnosis and Treatment.

Early and Periodic Screening, Diagnosis and Treatment - A mandatory service under Medicaid which provides for special check-ups at set intervals for certain needy children, in order to find and treat health problems before they become serious. Coverage includes only those Medicaid eligibles under 21 years of age.

Eligible - A person qualified to receive assistance funded under particular program. Eligibility criteria can vary, so that eligibility must be established on program by program basis.

FFP - See Federal Financial Participation.

Federal Financial Participation - The means by which the federal government asssists in supporting certain specific program. The federal government generally provides aid by two methods: 1) matching dollars by set percentage or 2) formula money grants.

GRM - See General Relief-Medical.

General Relief-Medical - A state emergency medical program designed to respond to immediate medical needs of Alaskan families in time of extreme financial crisis. All assistance rendered under this program is in the form of vendor payments to medical providers. State administrative costs as well as actual cash payments to vendors are 100% state-only costs.

Intermediate Nursing Care - An optional service available to be provided under Medicaid program. Denotes a less intensive and less expensive level of around-the-clock nursing care, in comparison to skilled nursing.

Mandatory Coverage - A portion of the Medicaid program that is required to be covered by each and every state in the program, in order for the state to be entitled to federal financial participation. Mandatory coverage items concern persons eligible to receive services and the services provided to those persons. States can still administratively "control" mandatory services and not jeopardize federal financial participation by controlling the amount of service available to client, amount of financial participation (deductible required to be paid by client) in order for the client to receive such services, and other mechanisms.

Medicaid - A federal assistance program established by Title XIX of the Social Security Act and administered by the state through an approved state plan filed with U.S. Department of Health, Education, and Welfare. Designed to provide medical coverage for recipients of Aid to Families With Dependent Children; Supplemental Security Income, elderly and blind recipients of Adult Public Assistance and those disabled persons who meet federal definitions of disability; and certain other groups. State administrative costs are shared equally (50%) by the state and federal governments, except for professional medical support personnel who are funded at 75% federal reimbursement. Actual medical vendor payments are shared equally (50%) by the state and federal government, except for family planning which is funded at 90% federal reimbursement.

Medically Needy - An optional group of eligibles for whom federal reimbursement for necessary medical care may be covered under the Medicaid program. Generally includes individuals who have insufficient income and resources to meet the costs of necessary medical or remedial care and services. Presently Alaska does not include the medically needy under its Medicaid program.

Medicare - An insurance program administered solely by the federal government to provide payments for necessary medical care for those people, rich or poor, who receive Social Security payments.

OAA - See Old Age Assistance.

Old Age Assistance - A cash supplemental program administered by the state in cooperation with the U.S. Department of Health, Education, and Welfare. Designed to provide a state legislated level of cash assistance to those eligible persons 65 and over who meet certain income and resource requirements and who are predominately eligible for Supplemental Security Income payments. It is considered an "Adult Public Assistance" program.

Option - A portion of the Medicaid program that is discretionary on the part of the state. Options generally deal with persons eligible for coverage or medical services available for those eligible persons. Options are set out in federal law and regulations and are generally eligible for federal financial participation. Since the choice of options is up to each state, options can generally be designed to fit the state's unique needs and available resources, but each option chosen must meet certain broad federal program requirements.

Public Assistance - A division of Department of Health and Social Services, responsible for administration of the Medicaid, General Relief-Medical, and Income Maintenance programs. This division determines the eligibility of state's residents for such services by carefully reviewing the person's income, resources, and other factors according to state and federal standards.

Quality Control - An office of the Department of Health and Social Services which is assigned the responsibility to verify that

randomly selected cases are eligible to receive services in month that service was rendered. The verification consists of check of files, client contact, and collateral sources.

Recipient - A person receiving income maintenance or assistance services funded under a particular program.

SSA - See Social Security Administration.

SSI - See Supplemental Security Income.

Skilled Nursing Care - A mandatory service required to be provided under the Medicaid program. Denotes highly professional round-the-clock nursing care and monitoring. Generally more expensive and more specialized care than intermediate care.

Social Security Administration - An agency of the federal Department of Health, Education and Welfare assigned the responsibility to administer Social Security, Medicare, and Supplemental Security Income programs.

State Plan - A contract between the single state agency to administer the Medicaid program and the federal Department of Health, Education and Welfare, specifying conditions to be met in order to be eligible for federal financial participation.

Supplemental Security Income - An assistance program funded and administered by federal government which provides payments to certain needy persons who are aged, blind, or disabled and meet program and financial requirements. Payments are uniform nationwide and are based on need.

Title XIX - A portion of the federal Social Security Act which outlines the Medicaid program.

Title XVIII - A portion of federal Social Security Act which outlines the Medicare program.

Utilization Review - Random records check of sample institutional Medicaid billing to insure that services rendered match with those billed to the program. Verifies that institutional records are complete, accurate, and up-to-date. Examines for overuse or misuse of treatment and professional resources and the patient's duration of stay relating to those resources.

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THE POLITICAL PLANNING OF A STATE HEALTH INSURANCE PROGRAM

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

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

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

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

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

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

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

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

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

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

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

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

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

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

-- 120 days of hospital benefits, plus outpatient services.

-- surgical benefits, including anesthesiologist services.

-- medical services, including home, office, hospital visits, and intensive medical care.

-- laboratory, x-ray, and radio-therapeutic services necessary for diagnosis and treatment.

-- maternity benefits, provided an employee has been covered for nine months prior to childbirth.

-- and, under an amendment added last year, substance abuse benefits for alcoholism and drug addiction, including outpatient services and detoxification and acute care benefits.

The foregoing summarizes the basic provisions of our law.

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

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

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

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

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

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

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

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

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

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

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

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

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

Data used included statistics relative to the following:

-- Population by age levels, civilian and military. The latter distinction was important because of the sizeable permanent military presence in Hawaii.

-- Labor force, public and private.

-- Population entited to Medicare.

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

-- Size and type of business of private employers.

-- Medical assistance recipients and expenditures.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 -- A political climate sympathetic to social needs.

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

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

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

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

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

Mahalo.

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