

ALASKA LEGISLATURE COMMITTEE FILES 1981-1982 8672

1569 SHESS HB 41

Distribution of Income. Income tax data for Alaska residents filing for 1979 were used to derive distributions around the median income levels described above. Residents who itemized and filed jointly were used to represent families of three and four. Residents taking the standard deduction were used to represent families of one and two. In both cases, inflation was taken into account by assuming an even distribution of income within each tax bracket and moving the top quarter of filers in each bracket into the next higher bracket. This approximates the impact of 33 percent (7.5 percent per year) inflation from 1979 to 1983.

The distribution would provide subsidies to about 70 percent of one and two person families and about 51 percent of three and four person families. Table 4 provides greater detail on subsidies. Families with income greater than 125 percent of median income for that family size receive no subsidies, families with income between 45 and 125 percent of median income are on the subsidy schedule and are eligible for subsidies of less than 100 percent of costs, and families earning less than 45 percent of median income are fully subsidized.

Table 4
Distribution of Alaskans by Eligibility
for Subsidy Under HB 41

<u>Family Size</u>	<u>Percent with No Subsidy</u>	<u>Percent with Partial Subsidy</u>	<u>Percent with Full Subsidy</u>
1 and 2	30	38	32
3 and 4	49	40	11

Source: House Research Agency 2/82

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Amount of Subsidy. Given the data described above, the amount of State funds to be spent on subsidies under HB 41 can be calculated for various situations. Table 5 presents estimates of the average amount of subsidy which would be paid to those with incomes of less than 125 percent of the median income. The figures are based on the subsidy schedule presented in Table 4 and assume premiums of \$130 and co-payments of \$500.

Table 5
Estimated Subsidy per Household Under HB 41

	<u>Families of 1 and 2</u>	<u>Families of 3 and 4</u>
Premium	\$1,237	\$ 976
Co-payment	271	222
TOTAL	\$1,509	\$1,198

Source: House Research Agency 2/82

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Cost of Plan. Cost calculations were performed for four major groups. The groups and assumptions used in computing costs are described below.

Not Presently Covered

- Assumptions:
- 44,000 individuals (14,667 households) have no health insurance (Battelle estimate)
 - half (7,333) these households are 1- and 2-person families and half are 3- and 4-person families
 - price elasticity of demand is .65 (Battelle Estimate)

- Conclusions:
- 45% of 1- and 2-person families elect coverage
 - 23% of 3- and 4-person families elect coverage
 - subsidy to this group (those not presently covered by health insurance) is \$14.9 million

Private Individual Coverage

- Assumptions:
- 25,000 individuals (8,333 households) have private individual health insurance coverage (Battelle estimate)

- half of these households (4,167) are 1- and 2-person families and half are 3- and 4-person families
- the State subsidizes costs whether these households retain private coverage or switch to the State plan

Conclusion: • subsidy to this group is \$7 million

Covered by Employee Plans

- Assumptions:
- 194,000 individuals (64,667 households) are presently covered by health insurance through their places of employment (Battelle estimate)
 - half (32,333) of these households are 1- and 2-person families and half are 3- and 4-person families
 - 40% would not switch because their employer pays all costs of their present plan (Battelle, Table X-4)
 - 25% of those with partial payment plans would switch to the State plan (Battelle, Table X-5)

- Conclusions:
- subsidy to this group is \$8.1 million
 - if "side deals" between covered persons and their employers resulted in all presently covered employees converting to the State plan, the subsidy to this group would increase to \$32.4 million (note: side deals were not included in the cost calculations shown in Table 1)

High Risk Individuals

As explained in the Battelle study, data on this group are limited. The cost of providing coverage to this group is included in Table 1, but the figures are rough estimates based on work performed by Battelle. The Battelle study uses a premium of 125 percent of the

Representative Buchholdt
March 12, 1982
Page 8

standard premium for the high risk group. That figure was combined with data from Battelle's Table X-9 and Table 5 of this memorandum to produce an estimate of \$.8 million for premium subsidy and \$.2 million for subsidization of co-payments.

Native Population

We have no data on the distribution of income among Natives. Based on the results of the Battelle study, inclusion of Alaskan Natives would roughly double the cost of the plan. This approximation was used to develop the numbers in Table 2 of this memorandum.

* * *

Although we have attempted to present the above information in a non-technical manner, we realize that mathematical data can be confusing. If you or your staff have any questions about the source of numbers or what calculations were performed, please call and we will try to help. We will be pleased to perform additional work on this project if the provisions of HB 41 change. Please do not hesitate to call if we can be of further service.

POSITION PAPER
COMMITTEE SUBSTITUTE FOR
CS FOR SPONSOR SUBSTITUTE
HOUSE BILL NO. 41 (FINANCE)

DRAFT

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

I. DEPARTMENTAL OVERVIEW OF CS FOR SPONSOR SUBSTITUTE HOUSE BILL NO. 41 (FINANCE)

Committee Substitute for CS for Sponsor Substitute to House Bill No. 41 (Finance) is composed primarily of four parts:

- a. Sections 1, 2, 3 and 4 provide for a state comprehensive health plan available to all residents of the State which will pay all or a part of the coverage for low income persons.
- b. Sections 5, 6, 7 and 8 expand the insurance statutes to require that certain Group insurance plans include coverage for alcoholism and drug dependence.
- c. Section 9 directs the Commissioner of Health and Social Services to contract for medical services through insurance companies or health care services organizations for beneficiaries of the Department's medical programs once contracting is determined cost competitive. (Medicaid, General Relief Medical, Catastrophic Illness, Crippled Children's, and Maternal and Child Health Programs).
- d. Sections 10 and 11 expand the Medicaid program by adding new beneficiaries and services respectively.
- e. Section 12 is a definition section.
- f. Section 13 mandates that the Legislative Council shall study and make recommendations to improve coverage of Medicare and Indian Health Service.

II. GENERAL DEPARTMENTAL COMMENTS/RECOMMENDATIONS

The major portions of this bill pertain to the provisions and development of a state comprehensive health plan. The Governor has, as prescribed and funded by the 1980 Legislature, requested the Department for a "Comprehensive Health Care and Financing Study" for Alaska. That study is now completed. The study examined the present health care delivery and financing systems in Alaska, identifying existing and potential funding sources, examining improvements to the present systems and a discussion of alternative methods of providing for health care and cost distribution in Alaska.

The Department of Health and Social Services will primarily reserve its comments to Sections 5 through 11 of the bill as the earlier sections are concerning insurance, and it is our understanding that the Department of Administration and Department of Commerce and Economic Development will address that aspect of the bill. The Department's general comments regarding Sections 5 through 11 are as follows:

1. Sections 5 - 8. We support the requirement of alcohol and drug abuse treatment coverage under health insurance benefit package for state employees with an optional provision available to employees of other governmental units.

We believe such benefits have the potential to be cost-saving for the State, in such areas as sick leave utilization, absenteeism, lost production time and other factors.

2. Section 9. We support the concept of purchasing health care services for our medical assistance beneficiaries through health insurance policies or other contracts when judged by the Commissioner of the Department of Health and Social Services to be cost effective.
3. Section 10 as written would require DHSS to provide Medicaid coverage to all optional groups, except medically needy, not just those that currently exist under state statutes. A clearer picture of the federal plan for Medicaid has not materialized in the last 9 months. In fact, even greater confusion surrounds this issue than before.
4. Section 11 would require DHSS to provide Medicaid coverage for all services permitted under federal law rather than limit the program to those services presently listed in state statutes. Again, a clearer picture of the federal plan for Medicaid does not exist at the present time.

III. SPECIFIC DEPARTMENTAL DISCUSSIONS OF SECTIONS (5 - 8) - ALCOHOL AND DRUG ABUSE TREATMENT

Insurance Coverage for State Employees:

Sections 5 - 8 of the bill mandate additional coverage for alcoholism and drug dependence under the state employee health benefits package and make such coverage optional to employees of other governmental units. Its intent is to consider the treatment of alcohol and drug dependence as similar to other medical conditions and is consistent with legislation that has recently been enacted in twenty-nine other states.

We believe that such coverage would be beneficial in that it would encourage people to avail themselves of needed alcoholism and drug abuse treatment services. To the extent that they do so, lost production, absenteeism, sick leave utilization, disability benefit payments and hospitalization for accidental injury and related diseases should diminish. Evidence from public and private organizations around the country (Kennecott Copper, Kemper Insurance, State of California, as examples) indicate that utilization of these benefits actually cuts costs to individuals and firms for acute medical care for accidental injury and numerous illnesses.

Additionally, the provision of these benefits is an encouragement for hospitals in Alaska to begin to provide structure Alcoholism/Drug Abuse Treatment services, and for physicians to begin to state diagnosis of alcoholism and/or prescription drug addiction on their claims to insurance companies, instead of utilizing inappropriate euphemistic diagnoses for claiming benefits, as many now admittedly do in apparently somewhat massive numbers.

The effect of proper physician diagnosis and structured treatment will be to upgrade both the quality and appropriateness of care throughout the State.

The need for sections 5-8 of this bill was formally identified in several statewide hearings conducted by the Senate Select Committee on Alcohol Abuse in 1977, and initially was introduced to the Senate as SB 545 in March, 1978. Although not acted upon that session, an interim committee of legislators, insurance industry, and state personnel were appointed to further evaluate the issue resulting in the introduction of SB 227 in March, 1979, which passed the Senate that year. Late in the 1980 session the House HESS Committee substantially amended SB 227 to include the ideas contained in Sections 1-4 and 9-11 of the current HB 41, which passed the House in 1981.

Since the provisions contained in sections 5-8 of HB 41 did pass the Senate in 1979 and the House in 1981, consideration might be given to separating these sections from HB 41 for passage this session.

IV. SPECIFIC DEPARTMENTAL CONCERNS IN SECTIONS 9, 10 and 11 (MEDICAL ASSISTANCE)

Section 9 - Line 22 on Page 7 Through Line 14 on Page 9:

AS 47.05.070 - Directs the Commissioner of DHSS to select either the option of purchasing and paying premiums on policies of insurance, or paying the expenses of health care service contracts when judged cost-effective by the Commissioner. The Department supports this concept so long as there is a determination of program wide cost-effectiveness rather than on a service-by-service basis. It should be pointed out that the Department already has the ability to purchase insurance or health care service contracts under existing federal law. This change would simply make it mandatory for the Department to do so.

AS 47.05.100 - We support the general public policy intended by this portion of the bill, however, we would like to offer an amendment as follows:

INTEREST ON LATE PAYMENTS. When presented by a provider of medical services with a clean claim, the State shall pay:

- (1) interest at the rate of one percent per penalty month when payment is delayed more than 45 days after presentation of the clean claim. A "penalty month" starts on the 46th day and consists of 30 day increments thereafter until the claim is paid.

- (2) no change
- (3) the interest for a full month if the overdue claim is not paid by the 15th day of any penalty (calendar) month.

Section 10 - Line 15 on Page 9 Through Line 20 on Page 9:

AS 47.07.020 - This Section would amend state law to provide coverage for all optional groups not currently entitled to Medicaid benefits, except the medically needy. This includes the unborn child group, the unemployed parent group, caretaker relatives and certain individuals under 21.

As stated earlier the Department would recommend phasing selected eligible groups into the programs instead of adding all remaining groups simultaneously.

By staging the categorical groups a number of benefits would result:

- (1) The Department may have received official notice of how President Reagan's administration is going to change the methods of distributing federal funds for Medicaid programs.
- (2) The Department's permanent medical claims payment system will be implemented by September 1982 and the added bill processing burden will be eased.
- (3) The Department would be prepared in advance with regulations and additional staff to handle the new coverage groups.

Section 11 - Lines 21 Through 25 on Page 9:

AS 47.07.030 - This section as amended would change state law to dramatically expand medical services offered under the Medicaid program. It is suggested the following services be specifically listed in CSSSHB41 (Finance) rather than the current blanket provision adding all services:

- (1) Physical Therapy
- (2) Occupational Therapy
- (3) Prescribed Drugs
- (4) Prosthetic Devices and Medical Supplies
- (5) Other Practitioner Services
 - a. private psychologist
 - b. nurse practitioners
 - c. physician assistants

- (6) All Clinic Services
- (7) Other Diagnostic, Screening, Preventative and Rehabilitative Services
- (8) Personal Care Services
- (9) Dentures and Routine Dental Services

This change would add some new areas of coverage and federal funds for certain services that are currently being provided to Medicaid beneficiaries using state-only funds from the GRM program could be claimed.

Creation of a comprehensive health plan as contained in Section 1 would allow the transfer of major portions of the GRM program to the comprehensive health plan. GRM would remain to provide coverage for long term care services, residential care, and emergency coverage for those individuals not enrolled in the comprehensive health plan. The coordination of benefits under the comprehensive health plan and the residual coverage under GRM needs to be clarified. Also, the relationship between the comprehensive health plan under CSSHB 41 (Finance) and the present catastrophic illness program should be clarified. Most payments made under the catastrophic illness program are for major medical types of coverage that may also be covered under the comprehensive health plan.

V. DEPARTMENTAL POSITION

- (1) The department offers no position on the Statewide comprehensive health plan presented in Sections 1-4 of this bill.
- (2) The department supports passage of the alcohol provisions of this bill (Sections 5-8).
- (3) The department supports passage of Section 9 which requires purchase of medical services under the Department's programs through health insurance contracts when judged cost-effective by the Commissioner.
- (4) Adding all new beneficiaries and services (Sections 10 and 11) under Medicaid as proposed in this bill in view of the unclear federal financial picture and the State's own forecasts for smaller revenues due to the worsening oil market should be carefully considered. It appears that some new benefits could be added at little or no additional cost to the State.

POSITION PAPER/Department of Health & Social Services

Recommended by:

Rod Betit
Rod Betit, Director
Division of Public
Assistance

Date:

2/25/82

Robert L. Cole by Leo Spaulding
Robert Cole, Coordinator
Office of Alcoholism and
Drug Abuse

Date:

Approved by:

Helen D. Beirne
Commissioner

Date:

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. CSSSHB 41
Title An Act relating to the health of residents of the state
Requested by Senate HESS Committee Date 2/25/82

II. FISCAL DETAIL

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

EXPENDITURES (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.	0	(5311.9)	(6108.6)	(7024.9)	(8078.7)	(9290.5)
TOTAL	0	(5311.9)	(6108.6)	(7024.9)	(8078.7)	(9290.5)

FUNDING (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
GENERAL FUND	0	(5311.9)	(6108.6)	(7024.9)	(8078.7)	(9290.5)
FEDERAL FUNDS						
OTHER (Specify Source)						

POSITIONS

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
FULL TIME	0	0	0	0	0	0
PART TIME						
TEMPORARY						

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

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

IV. DATE 2/25/82 PREPARED BY David M. Davidson
AGENCY Division of Public Assistance
Original: Legislative Finance PHONE 465-3347
cc: Budget and Management
Prime Sponsor (First Legislator Named)
33-001 (Rev. 12/81)

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. CSSSHB 41
 Title An Act relating to the health of residents of the state.
 Requested by Senate HESS Committee Date 2/25/82

II. FISCAL DETAIL

Agency Affected Department of Health and Social Services
 Program Category Affected Health/Social and Economic Assistance
 BRU, Program, Or Subprogram(s) Affected Medicaid/Eliq. Deter./PA Admin.
 (Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES	0	389.3	428.2	471.0	518.1	569.9
200 TRAVEL	0	14.2	15.6	17.2	18.9	20.8
300 CONTRACTUAL	0	147.2	161.9	178.1	195.9	215.5
400 COMMODITIES	0	7.2	7.9	8.7	9.5	10.4
500 EQUIPMENT	0	14.6	0	0	0	0
600 LAND & STRUCTURES	0	0	0	0	0	0
700 GRANTS, CLAIMS, ETC.	0	20576.9	23663.5	27213.0	31295.0	35989.2
TOTAL	0	21149.4	24277.1	27888.0	32037.0	36805.8

FUNDING (Thousands of Dollars)

GENERAL FUND	0	8100.6	9296.4	10679.1	12267.8	14096.6
FEDERAL FUNDS	0	13048.8	14980.7	17208.9	19769.2	22709.2
OTHER (Specify Source)						

POSITIONS

FULL TIME	0	12	12	12	12	12
PART TIME						
TEMPORARY						

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

Medical benefits would be provided to approximately 2145 new cases under the Medicaid program. Administration of program benefits would require 11 field positions and 1 central office position, office space, and additional computer time to be divided between the Eligibility Determination and Public Assistance Administration BRUs. Funding is 48% federal except for the Indian Health care program which is funded at 100% federal funds.

IV. DATE 2/25/82 PREPARED BY David M. Davidson
 AGENCY Division of Public Assistance
 Original: Legislative Finance PHONE 465-3347
 cc: Budget and Management
 Prime Sponsor (First Legislator Named)
 33-001 (Rev. 12/81)

MEDICAID SERVICES

Currently Covered Services

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

Services Added by CSSSHB-41(Finance)

Podiatrist services
Chiropractic Services
Private Duty Nursing
Personal Care Services
* Physical Therapy
* Occupational Therapy
* Prescribed Drugs
Dentures and Routine Dental Services
* Prosthetic Devices and Medical Supplies
Other Diagnostic, Screening Preventative & Rehabilitative Services
Services to Individuals Over 65 Years of Age in ICF Institutions for Mental Diseases
Services to Individuals Over 65 Years of Age in Institutions for Tuberculosis
Other Practitioner Services
 a. private psychologist
 b. nurse practitioner
 c. Physician assistant
Clinic Services - other than Community Mental Health Clinics
Services by Christian Science Practitioner
Services by Christian Science Sanatoria

* Currently accessible through General Relief Medical

BACKGROUND INFORMATION FOR FY 83
FISCAL NOTES ON CSSHB 41--
GENERAL RELIEF MEDICAL

<u>COMPONENT</u>	<u>FY 83 REQUEST</u>	<u>FISCAL NOTE</u>	<u>TOTAL REMAINING</u>
Hospital	\$ 4,548.0	\$(2,695.5)	\$ 1,852.5
Physician	2,031.5	(1,121.2)	910.3
Other Services	2,757.9	(1,495.2)	1,262.7
Nursing Homes	501.1	0	501.1
Catastrophic Ill.	2,158.4	0	2,158.4
Residential Care	181.4	0	181.4
TOTAL	\$12,178.3	\$(5,311.9)	\$ 6,866.4

BACKGROUND INFORMATION FOR FY 83
FISCAL NOTES ON CSSHB 41--
MEDICAID

COMPONENT/NEW SERVICE GROUPS	FY 83 REQUEST	NEW CATEGORICALLY NEEDY COVERAGE	TOTAL WITH CATEGORICALLY NEEDY
Hospital	\$12,327.8	\$ 3,007.1	\$15,334.9
Physician	7,858.1	1,631.2	9,489.3
Other Services	1,695.5	447.5	2,143.0
EPSDT	2,751.9	2,662.5	5,414.4
Nursing Homes	21,831.3		21,831.3
SUBTOTAL	\$45,109.4	\$ 7,748.3	\$52,857.7
Indian Health	5,450.0	5,577.7	11,027.7
SUBTOTAL	\$50,559.4	\$13,326.0	\$63,885.4
New Other Services		2,671.4	2,671.4
New Dental Services		2,120.1	2,120.1
New Drug Services		2,459.4	2,459.4
TOTAL	\$50,559.4	\$20,576.9	\$71,136.3

SUMMARY OF FY 83 BUDGET FOR CSSSHB 41

	<u>TOTAL</u>	<u>FEDERAL</u>	<u>STATE</u>	<u>POSITIONS</u>
(1) ADDITION OF MEDICAID SERVICES & NEW OPTIONAL CATEGORICAL GROUPS	\$21,149.4	\$13,048.8	\$ 8,100.6	12
(2) DECREASE OF GRM DUE TO TRANSFER OF SERVICES & ELIGIBLES TO MEDICAID	(5,311.9)	---	(5,311.9)	---
	_____	_____	_____	_____
TOTAL	\$15,837.5	\$13,048.8	\$ 2,788.7	12

CASELOAD ESTIMATES FOR FY 83
FISCAL NOTES ON CSSHB 41

PROGRAM CATEGORY	CURRENT CASELOAD	GRM REDUCTION	CATEGORICALLY NEEDY	TOTAL WITH CATEGORICALLY NEEDY
AFDC	5595		3752	9347
OAA	2272			2272
AB/AD	2185			2185
GRM	4218	(1607)		2611
TOTAL	14,270	(1607)	3752	16,415



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3991

March 19, 1982

MEMORANDUM

TO: Representative Thelma Buchholdt

FROM: David Teal *Teal*
Research Staff

RE: Fiscal Note for Health Insurance (HB 41)
Supplementary Information: Research Request Number 82-72

Research request number 82-72 was transmitted to you on March 12, 1982. It contained estimates of costs related to HB 41, a bill which would implement a statewide health insurance plan. Louann Cutler, of your staff, responded to that memorandum with a request for additional information. Specifically, she asked that 1) a fourth option--a combination of a 90 day restriction on joining the plan and a provision excluding those presently covered by private individual health insurance coverage--be added to the options presented in memorandum 82-72; 2) individuals covered by general relief medical (GRM) and medicaid be omitted from the non-covered population under the "premium subsidy only" options; and 3) regional cost differences be explored.

As discussed with Louann, an expanded version of memorandum number 82-72 may have greater clarity than a memorandum containing only the supplemental information. Accordingly, memorandum 82-72 has been revised and appears as an attachment to this memorandum.

Attachment



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3991

March 19, 1982

MEMORANDUM

TO: Representative Thelma Buchholdt

FROM: David Teal, *Teal* Jon Sherwood, *J.S.* and Leslie Longenbaugh *LL*
Research Staff

RE: Fiscal Note for Health Insurance (HB 41)
Research Request Number 82-72

This revised version of a memorandum transmitted to you on March 12, 1982 incorporates the additional information described in the cover document to this memorandum.

This agency was asked to estimate costs related to HB 41, a bill which would implement a statewide health insurance plan. Your office also requested an analysis of several options which are not currently included in HB 41. We have estimated the costs of a health insurance plan under these options, but, as instructed, have not considered any language changes that may be required to adopt the options.

Estimated Costs of HB 41

Table 1 presents estimates of cost under assumptions described in this memorandum. Although we believe we used the best data available to us, we have some questions about the reliability of data used to produce cost estimates and are therefore somewhat uncomfortable about the range of potential error of the estimates.

Table 1 shows that the estimated cost of implementing HB 41 is \$31 million, with about half of that cost directed toward those who currently have no health insurance coverage. The estimates in Table 1 do not include 1) administrative costs; 2) adjustments for regional cost differences which were specified in the bill; 3) costs of providing insurance coverage to the Native population; or 4) costs of providing insurance coverage to employees who are currently covered by employer-provided plans and who would find it financially advantageous to switch to the State plan only if "side deals" were made with their employers. A brief discussion of assumptions and of the process used to derive the estimates in Table 1 appears later in this memorandum.

Table 1
Estimated Costs of HB 41

<u>Group</u>	<u>Estimated Cost</u> <u>(\$ millions)</u>
Not Covered by Health Insurance	\$14.9
Covered by Private Insurance Plans	7.0
Covered by Employer Insurance Plans	8.1
High Risk Group	<u>1.0</u>
TOTAL	\$31.0

Source: House Research Agency 3/82

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Regional Cost Adjustments. Although HB 41 allows regional adjustments to be made to median income, section 18.27.030 does not specify a formula for making such adjustments. We would be willing to do additional work on this subject if you wish, but can do little with the limited information currently available. As you may be aware, small villages tend to have both higher living costs and lower levels of median income than urban areas of Alaska. This fact allows a very broad range of subsidy adjustments to be made. Perhaps a verbal discussion of the intent of adjustments would be useful if more work on this topic is desired.

Table 2 gives estimates of the cost of implementing several health insurance options. The cost estimate presented in Table 1 is the basis for the estimates in Table 2, with alternative plans increasing or decreasing costs from the starting point of \$31 million. The effects of various options on the estimated cost of the health insurance plan are discussed below.

Table 2
 Estimated Cost of HB 41 Under Various Options
 (in millions of dollars)

Option	Non-Natives		All Residents	
	Subsidy for:		Subsidy for:	
	Premiums and Co-Payment	Premiums Only	Premiums and Co-Payment	Premiums Only
HB 41 (per Table 1)	\$31.0	\$17.8	\$55.8	\$32.0
Private Individual Plans Excluded	24.0	12.1	48.8	26.4
90-Day Restriction on Cost Sharing	20.8	9.4	41.6	20.4
Private Individual Plans Excluded and 90-Day Restriction on Cost Sharing	19.1	8.0	39.9	19.0

Source: House Research Agency 3/82

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All Residents. Based on results of the Battelle study, coverage of Natives would increase costs of the basic insurance plan by about 80 percent. This factor was used to obtain a cost of \$55.8 million if the present form of HB 41 were available to all residents of Alaska. This \$55.8 million cost was used as a starting point for plans which would extend coverage to all residents. Cost savings under the various alternatives were subtracted from this figure.

We have no data on the distribution of income among the Native population and have no good indication of the number of Natives that would adopt the various health insurance options presented in Table 2. The figures in Table 2 are therefore rough estimates of program costs.

Premium Subsidy Only. In its present form, HB 41 would subsidize both premiums and out-of-pocket expenses for those below certain income levels. If out-of-pocket--or co-payment--expenses were not subsidized and the same number of people were covered by the plan, the cost of all options of the plan would fall by about 18 percent. However,

program costs can be expected to decline due to lower participation rates among those currently eligible for general relief medical (GRM) and medicaid. Because no patient co-payments or deductibles are required under GRM or medicaid, the 5,000 non-Native families eligible for those programs are assumed to forego coverage under the "premium subsidy only" options of the health insurance plan.

Although those eligible for GRM or medicaid constitute only about one-third of non-Native Alaskans without health insurance coverage, they would be the most heavily subsidized group and their exclusion would reduce costs by over \$9 million. The effect of excluding those eligible for GRM or medicaid plus the effect of subsidizing only premiums for the remainder of participants would be to lower costs of the program to about \$17.8 for non-Natives and to about \$32 million for all residents.

Private Individual Plans. If the bill were revised in a way that prevented those currently covered by private individual plans from switching to the State plan, program costs under the "premium and co-payment subsidy" option would decline by about \$7 million. The Battelle study assumes that no Natives have private individual coverage, so the estimated costs under this option show the same \$7 million decline for both "non-Native" and "all residents" options. Under the "premium subsidy only" options, costs would be reduced to about \$12.1 million and \$26.4 million for the non-Natives and all residents, respectively.

Restricted Eligibility for Cost Sharing. A provision restricting the cost-sharing features of HB 41 to those who had not had health insurance coverage during the 90 days preceding membership in the State plan could have a significant impact on program costs. If such a provision prevented 50 percent of those covered by employer plans, 75 percent of those covered by private individual plans, and 90 percent of those in the high risk group from switching to the State plan, costs of providing health insurance coverage under the State plan would decline by approximately \$10.2 million for the non-Native group. Expected cost reduction for coverage to all residents would decline by about \$14.2 million.

The above percentages were used as examples; we have no way of predicting the actual effect of a 90-day restriction. If the same percentages are applied to the "premium subsidy only" options, estimated costs are reduced to \$9.4 million for non-Natives and to \$20.4 for all residents.

Permanent Fund Dividends. There was some discussion with your staff on the potential for using Permanent Fund dividends to partially offset the costs associated with HB 41. Unless residents were required to use their dividends to pay a portion of the State's costs, the dividends would reduce the cost to the individual but would not decrease costs to the State.

Due to the uncertainty surrounding the status of Permanent Fund dividends, no accurate assessment of the effect of dividends on HB 41 can be made at this time. Permanent Fund dividends may indirectly reduce costs to the State by increasing the income of individuals and so reducing the level of subsidy for which they qualify. Unless dividends exceed several hundred dollars, this factor should not be significant.

Discussion of Assumptions and Methodology

The following discussion applies to estimated cost of a health insurance plan under the current language of HB 41. As noted earlier in this memorandum, costs under various alternatives were derived by computing the effect of changes to the current version.

Premium Amount. The estimates in Table 1 of this memorandum are based on monthly premiums of \$130 per household. Although \$130 may be the average health insurance premium in Alaska, it is possibly higher than the current premium that might be expected to apply to a plan such as that described in HB 41. According to Kurt Fortney, of Blue Cross, the average group premium (including vision and dental care) for Alaska's private sector is \$106 per month. Higher deductions and deletion of provisions for vision and dental care can be expected to result in lower premiums, but we do not have an estimate of premiums that may be required for the plan specified in HB 41. Based on premium increases experienced in the last few years, the \$130 figure appears to be a reasonable estimate of costs of insurance coverage in 1983 under HB 41.

Co-payments. In all cases, \$200 was used as the deductible and \$300 as the average individual's share of medical expenses once the deductible is surpassed.

Subsidies. Subsidies were calculated according to the schedule below.

Table 3
Subsidies for Health Insurance under HB 41

<u>Family Income as a percent of Median Family Income</u>	<u>Premium Subsidy (percent)</u>	<u>Co-Payment Subsidy (percent)</u>
125	0	0
120	10	0
115	20	0
110	30	0
105	40	0
100	50	0
95	60	9
90	70	18
85	80	27
80	90	36
75	100	45
70	100	55
65	100	64
60	100	73
55	100	82
50	100	91
45	100	100

Source: Louann Cutler, Representative Buchholdt's office

=====

Median Income. Based on information provided by the Alaska Department of Labor, the estimated median income for families of three and four persons was calculated as \$28,555 for 1982. The same information was used to calculate a 1982 median income of \$18,625 for one and two person families. Because we were unable to discover distributions of income according to family size, we used only two groups instead of four separate levels of median income.

Distribution of Income. Income tax data for Alaska residents filing for 1979 were used to derive distributions around the median income levels described above. Residents who itemized and filed jointly were used to represent families of three and four. Residents taking the standard deduction were used to represent families of one and two. In both cases, inflation was taken into account by assuming an even

distribution of income within each tax bracket and moving the top quarter of filers in each bracket into the next higher bracket. This approximates the impact of 33 percent (7.5 percent per year) inflation from 1979 to 1983.

The distribution would provide subsidies to about 70 percent of one and two person families and about 51 percent of three and four person families. Table 4 provides greater detail on estimated subsidies payable under current language of HB 41. Families with income greater than 125 percent of median income for that family size receive no subsidies, families with income between 45 and 125 percent of median income are on the subsidy schedule and are eligible for subsidies of less than 100 percent of costs, and families earning less than 45 percent of median income are fully subsidized.

Table 4
 Distribution of Alaskans by Eligibility
 for Subsidy Under HB 41

<u>Family Size</u>	<u>Percent with No Subsidy</u>	<u>Percent with Partial Subsidy</u>	<u>Percent with Full Subsidy</u>
1 and 2	30	38	32
3 and 4	49	40	11

Source: House Research Agency 2/82

=====

Amount of Subsidy. Given the data described above, the amount of State funds to be spent on subsidies under the current version of HB 41 can be calculated. Table 5 presents estimates of the average amount of subsidy which would be paid to those with incomes of less than 125 percent of the median income. The figures are based on the subsidy schedule presented in Table 4 and assume premiums of \$130 and co-payments of \$500.

Table 5
Estimated Subsidy per Household Under HB 41

	<u>Families of 1 and 2</u>	<u>Families of 3 and 4</u>
Premium	\$1,237	\$ 976
Co-payment	271	222
TOTAL	\$1,509	\$1,198

Source: House Research Agency 2/82

=====

Cost of Plan. Cost calculations were performed for four major groups. The groups and assumptions used in computing costs under the current version of HB 41 are described below.

Not Presently Covered

- Assumptions:
- 44,000 individuals (14,667 households) have no health insurance (Battelle estimate)
 - half (7,333) these households are 1- and 2-person families and half are 3- and 4-person families
 - price elasticity of demand is .65 (Battelle Estimate)

- Conclusions:
- 45% of 1- and 2-person families elect coverage
 - 23% of 3- and 4-person families elect coverage
 - subsidy to this group (those not presently covered by health insurance) is \$14.9 million

Private Individual Coverage

- Assumptions:
- 25,000 individuals (8,333 households) have private individual health insurance coverage (Battelle estimate)

- half of these households (4,167) are 1- and 2-person families and half are 3- and 4-person families
- the State subsidizes costs whether these households retain private coverage or switch to the State plan

Conclusion: • subsidy to this group is \$7 million

Covered by Employee Plans

- Assumptions:
- 194,000 individuals (64,667 households) are presently covered by health insurance through their places of employment (Battelle estimate)
 - half (32,333) of these households are 1- and 2-person families and half are 3- and 4-person families
 - 40% would not switch because their employer pays all costs of their present plan (Battelle, Table X-4)
 - 25% of those with partial payment plans would switch to the State plan (Battelle, Table X-5)

- Conclusions:
- subsidy to this group is \$8.1 million
 - if "side deals" between covered persons and their employers resulted in all presently covered employees converting to the State plan, the subsidy to this group would increase to \$32.4 million (Note: Side deals were not included in the cost calculations shown in Table 1 or Table 2.)

High Risk Individuals

As explained in the Battelle study, data on this group are limited. The cost of providing coverage to this group is included in Table 1, but the figures are rough estimates based on work performed by Battelle. The Battelle study uses a premium of 125 percent of the standard premium for the high risk group. That figure was combined

Representative Buchholdt
March 19, 1982
Page 10

with data from Battelle's Table X-9 and Table 5 of this memorandum to produce an estimate of \$.8 million for premium subsidy and \$.2 million for subsidization of co-payments.

* * *

Although we have attempted to present the above information in a non-technical manner, we realize that mathematical data can be confusing. If you or your staff have any questions about the source of numbers or what calculations were performed, please call and we will try to help. We will be pleased to perform additional work on this project if the provisions of HB 41 change. Please do not hesitate to call if we can be of further service.

Relationship Between Insurance
and Health Care Costs

The total U. S. expenditures for health care increased 1,400 percent during the period 1950-1978. This represents an increase in actual dollars of 170.3 billion dollars. The percentage of the Gross National Product consumed by health care went from 4.5% in 1950 to 9.1% in 1978; and it is felt that unchecked, health care will be consuming approximately 13.1% of the GNP by 1990. Several factors has contributed to the increased cost of health care. These factors included:

1. increased medical care prices,
2. population growth, and
3. increased demand for medical care.

The Center for Health Services Research and Development has indicated that increase in medical care prices account for 59.3% of the increase in personal health expenditures in the U.S. for the period 1950-1978. Clearly, then the increase in medical care prices is a major factor. What has contributed to the increase in medical care cost? While it is true that inflation is an important attributable factor, evidence indicates that the cost of health care goods and services generally increased more rapidly than the overall measure of the price of consumer goods. The President's Council on Wage and Price Stabilization reported that in 1978 the rate of inflation of physician's fees had consistently outpaced "the overall inflation except during the 1971-74 period of wage price control."

Physician and Hospital Reimbursement have come under increasing scrutiny as an important factor in the rapid rise in the cost of medical care. Two recent studies of the effect of current physicians reimbursement policies on charges to Medicaid and Medicare were examined in detail. Both studies concluded that the current policy of reimbursing "the customary, prevailing and reasonable charge" tends to be inflationary.

The dominant practice in insurance today is to pay the physician's charges or "the customary, prevailing and reasonable charge," whichever is less. While the maximum charge for any given service is supposed to be secret, it is easy for a physician to discover the charge. All she/he has to do is to charge a high fee and see if it gets paid. If the entire charge is accepted then she/he is at or below the customary level. In addition, charges that are above the customary level, but less than twice the customary level, are used in the pool of charges that determines the charges in subsequent allowances.

In a study of customary allowance for selected procedures covered under Blue Shield in Washington, D.C. during the period 1975-1978, the increase in the customary allowance for physician fees ranged from 29% to 75%.

In fact, one surgical group of two physicians who performed 68.9% of coronary artery by-pass operations in the state was primarily responsible for a 75% increase in the customary allowance for the operations.

Martin Feldstein of Harvard has argued that increases in hospital costs have been induced primarily by increases in insurance coverage and rising incomes. As growing insurance coverage reduces the net price of out-of-pocket cost of hospital/physician care, individuals demand more services, higher quality care, and more amenities. Since increasing insurance coverage allows hospitals to charge higher prices without any reduction in capacity utilization, hospitals use additional revenues to introduce more expensive technology, employ additional staff, etc.

The potential increase in hospital prices induced by insurance coverage is quite high. For example: suppose that in the absence of hospitalization insurance a hospital could charge \$100 per hospital stay and maintain a given level of capacity. A change to insurance coverage which reduces out-of-pocket costs to 20% of hospital charges permits the hospital to charge \$500 per stay without any increase in the out-of-pocket cost to the individuals. By increasing insurance coverage, the hospital can greatly increase the cost of hospital care without increasing the direct financial burden on the patients.

Third-party insurance (including Medicare/Medicaid) which are based on reasonable charge methodology has resulted in an enormous rise in the cost of health care. Before the advent of reasonable and customary charge reimbursement, both the patient, the physician, and the hospital were necessarily concerned with the patient's ability and willingness to pay for various options. With ever more comprehensive health care insurance coverage, patients can not only afford more health care, but have little incentive to seek care in the most economical manner. The cost doesn't concern the hospital or the physician since they can pass them on to the third party payors and the third parties aren't worried about the cost since they can pass them on in higher premiums.

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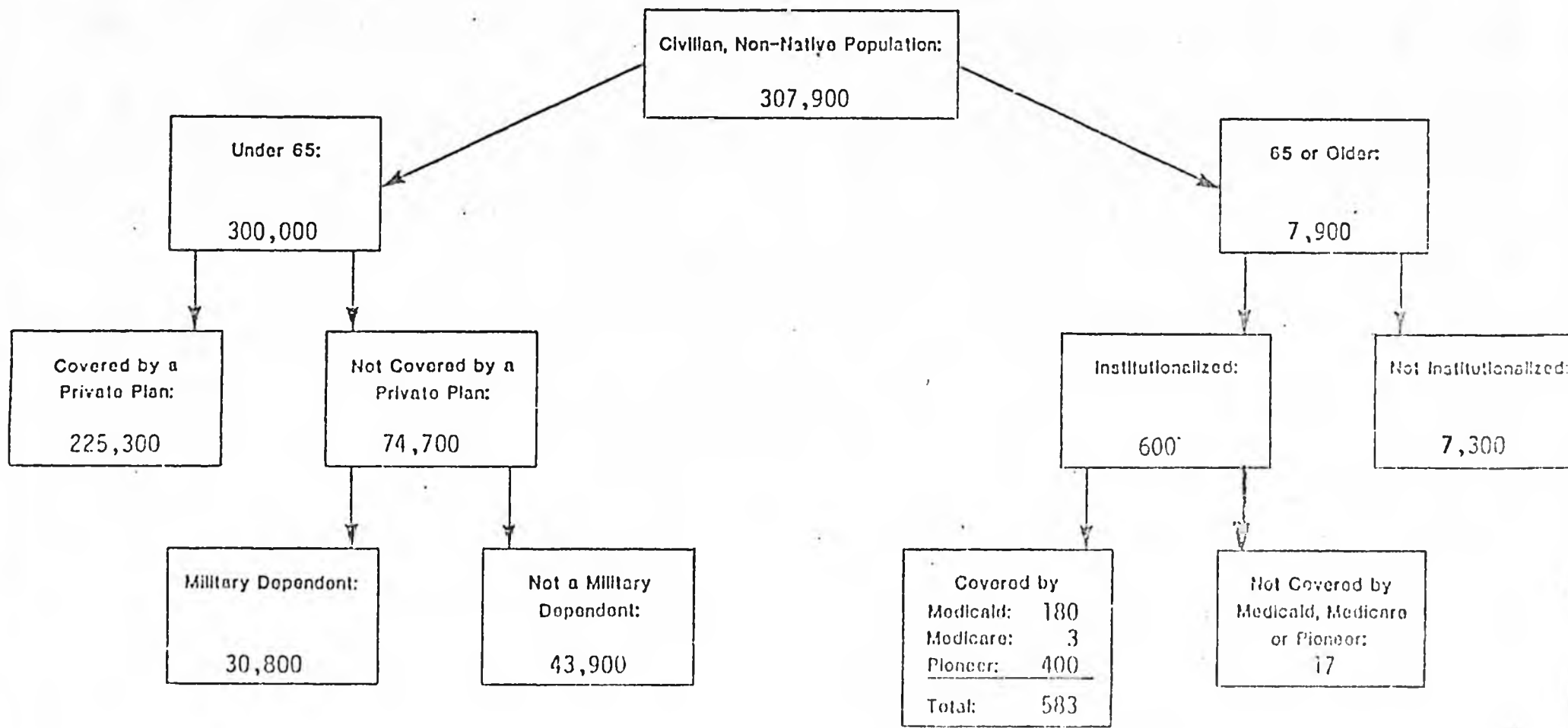
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American Journal of Medicine, vol. 68, March 1980, p. 319-321

U. S. Department of Health, Education, and Welfare, Trends Affecting the U. S. Health Care System, p. 195-199

CIVILIAN NON-NATIVE POPULATION: THIRD-PARTY COVERAGE



Source: Battelle Research Center



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3991

April 8, 1980

MEMORANDUM

TO: Representative Hugh Malone

ATTN: Paul Quensnel

FROM: Christine Johnson *Johnson*
Research Staff

SUBJECT: Research Request No. 81-60
State Health Care Coverage

Some time ago Paul Quesnel of your staff asked us to find out whether or not the State is paying for health care coverage for both husbands and wives when both work for the State. Since the State's health plan fully covers the spouses and dependents of State employees, it seems as though the State would only need to pay for coverage once when both husband and wife are State workers.

As we have indicated to Mr. Quesnel, when both husband and wife work for the State, the state is paying for medical coverage for each. The current monthly cost of this coverage is \$123.71 per person. This may increase next year to approximately \$150.00.

Apparently, this topic has been discussed extensively. According to the State Division of Retirement and Benefits, the State is providing coverage for each spouse at the insistence of the collective bargaining units, as under this policy the couple's medical coverage is improved. The regular health care plan which each employee receives at no cost, covers only 90% of the hospital and doctor costs incurred by the employee and his or her dependents. Furthermore, the coverage does not extend to certain services such as routine physicals. Employees who would like more comprehensive coverage must purchase supplemental coverage. Individuals who are covered both as employees and as the dependents of employees have the equivalent of two health care insurance plans, and receive 100% coverage without paying for supplemental benefits. In addition, their maximum coverage increases from \$250,000 to \$500,000.

CJ

NORTH SLOPE BOROUGH

Anchorage Liaison Office
3201 "C" Street, Suite #602
Anchorage, Alaska 99503
Telephone: (907) 276-4374
Telex Number: 26522

March 25, 1981

Charles Parr, Chairman
Health and Social Services Committee
Pouch V
Juneau, Alaska 99811

Dear sir:

The North Slope Borough Health and Social Service Agency would like to lend its support to the passage of H.B. 41, an act relating to health care for state residents. In so doing, however, the following points need to be made:

I.A. The act as now written excludes consideration for Alaska Natives, both rural and urban, unless they are employed;

B. A detailed study is needed of the impact this exclusiary clause will have;

C. There are misconceptions regarding the type and depth of coverage, as well as access to that coverage by Alaska Natives;

D. There are misconceptions regarding the access to that same level of care through Indian Health Service in rural areas by non-natives, non-IHS beneficiaries. Currently, non-beneficiaries enjoy access to and through IHS to identical levels of care at the Service Unit Hospitals, and at a cost that would not meet or exceed deductibles of an insurance policy. The only exceptions may be hospitalization by referral, or specialist care not locally available.

E. Access, particularly for those in the villages is predicated on having the money to pay for air fares to and from the Service Unit. This aspect has been one of the largest stumbling blocks to adequate preventive and early treatment of illness for village residents.

II. The expansion of Medical/Medicare is a vital need for all

Alaskans, and its expansion into a fully functional program would be a great step forward for the population who are often at greatest risk, and whose health is key to taking advantage of increased opportunities in other life spheres. Also, the contracting of this program to a private carrier has advantages in administration that are superior.

III. Inclusion of alcoholism and drug addiction services in the benefits package is another positive step in providing better access to care that is needed. Specific coverage for mental health, including services of psychologists, psychiatrists, and hospital facilities should be included under the same aegis.

IV. There are many small scale employers in the state. Full costs of such coverage could be a significant deterrent to financial success of these businesses. Consideration should be given to applying a sliding fee for cost of coverage based upon factors including the following:

- net receipts on an annual basis
- number of employees
- location of business
- length of operation

Such consideration would benefit not only the myriad small businesses, but their many employees.

It is recognized that coverage such as that would increase costs associated with expansion of services, but the services are badly needed throughout our state and are, in our judgement, a justified expenditure which will have immediate and lasting benefit for all Alaskans.

We reiterate the need for and value of a study regarding Alaska Native inclusion within the provisions of this act.

Sincerely yours,

Elise Patkotak

Elise Patkotak, Director
Health and Social Service Agency
North Slope Borough

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and Health Care Costs

The total U. S. expenditures for health care increased 1,400 percent during the period 1950-1978. This represents an increase in actual dollars of 170.3 billion dollars. The percentage of the Gross National Product consumed by health care went from 4.5% in 1950 to 9.1% in 1978; and it is felt that unchecked, health care will be consuming approximately 13.1% of the GNP by 1990. Several factors has contributed to the increased cost of health care. These factors included:

1. increased medical care prices,
2. population growth, and
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The Center for Health Services Research and Development has indicated that increase in medical care prices account for 59.3% of the increase in personal health expenditures in the U.S. for the period 1950-1978. Clearly, then the increase in medical care prices is a major factor. What has contributed to the increase in medical care cost? While it is true that inflation is an important attributable factor, evidence indicates that the cost of health care goods and services generally increased more rapidly than the overall measure of the price of consumer goods. The President's Council on Wage and Price Stabilization reported that in 1978 the rate of inflation of physician's fees had consistently outpaced "the overall inflation except during the 1971-74 period of wage price control."

Physician and Hospital Reimbursement have come under increasing scrutiny as an important factor in the rapid rise in the cost of medical care. Two recent studies of the effect of current physicians reimbursement policies on charges to Medicaid and Medicare were examined in detail. Both studies concluded that the current policy of reimbursing "the customary, prevailing and reasonable charge" tends to be inflationary.

The dominant practice in insurance today is to pay the physician's charges or "the customary, prevailing and reasonable charge," whichever is less. While the maximum charge for any given service is supposed to be secret, it is easy for a physician to discover the charge. All she/he has to do is to charge a high fee and see if it gets paid. If the entire charge is accepted then she/he is at or below the customary level. In addition, charges that are above the customary level, but less than twice the customary level, are used in the pool of charges that determines the charges in subsequent allowances.

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Martin Feldstein of Harvard has argued that increases in hospital costs have been induced primarily by increases in insurance coverage and rising incomes. As growing insurance coverage reduces the net price of out-of-pocket cost of hospital/physician care, individuals demand more services, higher quality care, and more amenities. Since increasing insurance coverage allows hospitals to charge higher prices without any reduction in capacity utilization, hospitals use additional revenues to introduce more expensive technology, employ additional staff, etc.

The potential increase in hospital prices induced by insurance coverage is quite high. For example: suppose that in the absence of hospitalization insurance a hospital could charge \$100 per hospital stay and maintain a given level of capacity. A change to insurance coverage which reduces out-of-pocket costs to 20% of hospital charges permits the hospital to charge \$500 per stay without any increase in the out-of-pocket cost to the individuals. By increasing insurance coverage, the hospital can greatly increase the cost of hospital care without increasing the direct financial burden on the patients.

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THE FOLLOWING DOCUMENT(S) MAY NOT FILM
LEGIBLY BECAUSE OF POOR QUALITY OF THE
ORIGINAL.

INDICATORSHOUSE BILL 41BATTELLE
STATE SUBSIDIZED EMPLOYMENT
BASED PROGRAMBATTELLE
STATE SPONSORED HEALTH
INSURANCE PLAN

Key Factors

A health insurance program for Alaska residents and dependents whose total adjusted gross income is at or below 75% of the base income.

Under this option, the state would subsidize certain employers who offered a group health insurance plan to their workers. The key features of this program are:

- * An eligibility criteria designed to target the program at employers least likely to offer group plans, i.e. small employers with low income, part-time and temporary workers; and to minimize the number of employers which already offer group health from qualifying for the subsidy. This could be done by including an employer payroll limit of 5 or 10 times the average wage and salary income in Alaska.

- * The amount of subsidy would vary across across employers and be determined based on the employer's total premium costs and end total payroll. No employer would receive a subsidy of 100% of 100% of the premium cost under this scheme. The amount of subsidy would equal the difference between employers total premium cost and 5% or 10% of his total payroll, subject to a maximum.

- * Participation by employers who satisfy the eligibility criteria would be voluntary - they could collect a state subsidy by offering a group health plan to all their workers provided the employer pays at least 50% of the unsubsidized share of the premium.

*Open for enrollment to all residents of Alaska.

*A graduated premium subsidy for low income participants based on annual family income.

*A state subsidy for the high risk population based on charging high risk population premium rates below the true cost of their health insurance coverage.

*Premium rates for participants who do not qualify for subsidy based on their expected levels of utilization.

Number of New Family
Coverages

Not Stated

2,050 to 4,600

4,600

Number of Total Coverages

Not Stated

6,300 to 11,100

22,600 to 30,800

<u>INDICATORS</u>	<u>HOUSE BILL 41</u>	<u>BATTELLE</u> <u>STATE SUBSIDIZED EMPLOYMENT</u> <u>BASED PROGRAM</u>	<u>BATTELLE</u> <u>STATE SPONSORED HEALTH</u> <u>INSURANCE PLAN</u>
Total Premium Costs to State	\$31 Million (Non-Native Only)	\$3,530,000 to \$12,890,000	\$45,900,000 to \$51,580,000
Premium Cost Per Household	\$130 Per Month \$1198 to \$1509 Per Year	\$130 Per Month * \$1560 Per Year	\$1600 to \$2100 Per Year
Basic Program Structure	<p>Commissioner of the Department of Administration shall:</p> <ul style="list-style-type: none"> * establish a health insurance program for residents * establish minimum program benefits * May contract for administration of program by competitive bid and for a three year period. * The program shall provide for co-payments, deductibles that have annual limits. 	<ul style="list-style-type: none"> * Legislature shall establish by law and regulation * Employers participating would choose benefits package up to a minimum based on market premium cost of a standard group health benefit plan (state defined). 	<ul style="list-style-type: none"> *Program to be administered by private insurance carrier via contract awarded by competitive bid *Typical major medical plan of somewhat higher than usual deductibles and co-insurance rates.

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LEGIBLY BECAUSE OF POOR QUALITY OF THE
ORIGINAL.

FISCAL NOTE

I. REQUEST
 Bill/Resolution No. Sponsor Substitute House Bill 41 (partial)
 Title State Comprehensive Health Plan
 Requested by House HESS Date _____

II. FISCAL DETAIL
 Agency Affected Department of Administration, Division of Retirement & Benefits
 Program Category Affected Public Health
 BRU, Program, or Subprogram(s) Affected Retirement & Benefits
 (Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)
EXPENDITURES (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
100 PERSONAL SERVICES		144.8	591.1	650.2	715.2	786.7
200 TRAVEL		3.0	3.0	3.3	3.6	4.0
300 CONTRACTUAL		862.6	353.3	388.6	427.5	470.3
400 COMMODITIES		1.0	3.2	3.5	3.9	4.3
500 EQUIPMENT		12.0	5.0	2.0	2.0	2.0
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL	-0-	1,023.4	955.6	1,047.6	1,152.2	1,267.3

FUNDING (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
GENERAL FUND		1,023.4	955.6	1,047.6	1,152.2	1,267.3
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
FULL TIME		12	16	16	16	16
PART TIME						
TEMPORARY						

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

Assumption:

- 30 thousand accounts first year with 75,000 covered individuals.
- Field offices in Anchorage, Fairbanks, Nome and Juneau.
- Staff costs increase by 10% after FY 83.
- Does not include benefit costs under the cost sharing program or the costs under Sections 5-8.

This fiscal note addresses only the estimated costs of administering the state comprehensive health plan and state health insurance cost sharing program and producing the report called for in Sec. 2 of the bill.

IV. DATE February 26, 1981 PREPARED BY Ken Humphreys, Deputy Director
 AGENCY Division of Retirement & Benefits
 PHONE 465-4462

Original: Legislative Finance
 cc: Budget and Management
 Prime Sponsor (First Legislator Named) Buchholdt
 Office of the Governor (Keith Specking)

FISCAL NOTE

I. REQUEST

Bill/Resolution No. SSHB41
 Title An ACT relating to the Health of Residents of the State
 Requested by HOUSE HESS Committee Date 2/26/81

II. FISCAL DETAIL

Agency Affected Department of Health and Social Services
 Program Category Affected Health/Social and Economic Assistance
 BRU, Program, or Subprogram(s) Affected Medicaid/Eligibility Deter/Pub. Assistance Admin.
 (Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
100 PERSONAL SERVICES		147.4				
200 TRAVEL		5.4				
300 CONTRACTUAL		55.7				
400 COMMODITIES		2.7				
500 EQUIPMENT		5.6				
600 LAND & STRUCTURES		0				
700 GRANTS, CLAIMS, ETC.		8812.9				
TOTAL		9029.7				

FUNDING (Thousands of Dollars)

GENERAL FUND		3320.4				
FEDERAL FUNDS		5709.3				
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		5				
PART TIME						
TEMPORARY						

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

Medical benefits would be provided to approximately 920 new cases under the Medicaid program. Administration of program benefits would require 4 field staff positions and 1 central office positions, office space, and additional computer time to be divided between the Eligibility Determination and Public Assistance Administration BRUs. Funding is 50% federal except for the Indian Health Care Program which is funded at 100% federal funds.

IV. DATE 2/26/81 PREPARED BY David M. Davidson
 AGENCY Division of Public Assistance

Original: Legislative Finance
 cc: Budget and Management
 Prime Sponsor (First Legislator Named) M&B Approval David M. Davidson Date 2/26/81
 PHONE 465-3347

POSITION PAPER

WORK DRAFT OF SENATE COMMITTEE SUBSTITUTE FOR
COMMITTEE SUBSTITUTE FOR SPONSOR SUBSTITUTE FOR
HOUSE BILL NO. 41 (HESS)

I. BACKGROUND

The work draft for Senate HESS committee substitute for House Bill No. 41 would create a state-sponsored health insurance program. Previous versions of HB 41 have included proposals to make changes in the Medicaid and General Relief Medical (GRM) programs, create an employer-based health insurance subsidy program, and create a high-risk health insurance program. While the HB 41 work draft would establish the health insurance program in the Department of Administration, the subject matter of the bill does involve the Department of Health and Social Services. During the last eighteen months, the Battelle Institute has been studying health care financing in Alaska under a contract with the Department of Health and Social Services, and the results of that study are now available.

Several factors emerge from that study which bear mentioning as they relate to legislation proposing to establish a state-sponsored health insurance program:

1. There are approximately 30,000 Alaskans who have no public or private health insurance or health care coverage and:
 - a. almost all are civilian non-Natives under age 65;
 - b. approximately 12,000 are dependent children;
 - c. of the approximately 18,000 adults in this group, 14,500 are employed at least part of the year;
 - d. approximately 6000 of the 18,000 adults are childless single individuals or couples.
2. The Medicaid program could be expanded to provide coverage to many of the individuals who would be eligible for the state-sponsored health insurance program and thereby result in federal funds being used rather than state funds.
3. The scope of benefits under a state-sponsored health insurance program, the extent of state subsidy, the extent of crossover from existing employee plans, and the amount of the deductible will have a major impact on the cost of the program.

II. EFFECT OF THE HB 41 WORK DRAFT

Battelle Institute has estimated that the cost of implementing a state-sponsored health insurance program of the type proposed by the HB 41 work draft would cost the State of Alaska between \$23 and \$52

million for benefits and between \$1.5 and \$3.6 million for program administration. In addition, program administration will involve between 60 and 90 employees.

Given the present fiscal problems experienced by the State of Alaska due to the decline in the world price of oil, the development of a state-sponsored health insurance program could take place only if new state revenues were found or if funds were diverted from presently funded programs or projects. While this does not appear likely to happen this year, it is still important to discuss some concerns that the Department has about the HB 41 work draft.

1. The HB 41 work draft does not specify what categories of service would be covered under the state-sponsored health insurance plan, leaving this responsibility to the Commissioner of the Department of Administration. The nature, cost, and desirability of the program will vary greatly depending on the services covered.

2. No mention is made of coverage for preventive health care. Under Medicaid, the Early and Periodic Screening, Diagnosis and Treatment program provides preventive health screening and treatment services for all Medicaid-eligible children, including routine dental care. Without preventive coverage, the state-sponsored program will merely be providing illness insurance.

3. Since the HB 41 work draft lacks detail on what the program would entail, there is no information as to what the period of eligibility will be for state subsidy of premiums and deductibles. Under Medicaid and GRM, individuals must report as frequently as monthly or lose eligibility. If longer periods of time are used for the state subsidy, will there be adjustments for seasonal variations in income. Also, no mention is made of how personal assets will be considered in determining eligibility. Under the Catastrophic Illness program, a percentage of personal assets above a maximum level are considered available to meet the applicant's medical needs.

4. Expansion of the Medicaid program could provide the same type of health insurance coverage as would be created under the state-sponsored health insurance program for those individuals who will likely receive full state subsidies. The primary difference is that by expanding the Medicaid program, the State of Alaska would be able to take advantage of federal funds to make up 48% of the benefit and administrative costs.

5. Nothing in the HB 41 work draft indicates the basis upon which payment will be made to health care providers. Some of the alternatives are: usual and customary charges; usual, customary, and reasonable schedule of maximum allowances; percentage of charges; lower of costs or charges; flat rate; interim rates with retrospective cost settlement; per capita payments. Whatever the payment method used, several studies have shown that fee-for-service health insurance programs are not the most cost-effective method of providing health care coverage. A state-sponsored health insurance program may be more efficiently administered through the development of health maintenance organizations or other prepaid health plans that operate on a per capita basis rather than a fee-for-service basis.

6. A major factor in the delivery of health care in Alaska is access to health care providers. The availability of health insurance is of little value if an individual does not have access to services. Under the Medicaid program, necessary, medically-related transportation is a program benefit. Consideration should be given to assuring that necessary medically-related transportation is included in a state-sponsored health insurance program.


7. The HB 41 work draft would preclude state subsidy for individuals who already receive government subsidized health insurance or health care services. However, such an exclusion should apply only when the individual's other subsidized program provides equal or better coverage than available under the state-sponsored health insurance program.

8. Federally-operated health care facilities providing services at no cost to beneficiaries are not eligible to receive payment for them under almost all health insurance programs. Whether or not this will be the case under a state-sponsored health insurance program depends partly on the willingness of federally-operated facilities to provide health care to non-beneficiaries, and the cost-effectiveness of providing transportation to private health care providers more distant from their homes than federally-operated facilities.

III. POSITION OF THE DEPARTMENT

Given a more promising financial picture for the State of Alaska, we believe that a state-sponsored health insurance program that has taken into consideration the factors raised in part II could be a worthwhile expenditure of state revenues and contribute to the overall productive of the people of the state of Alaska. However, in the present fiscal reality, we believe that the creation of a state-sponsored health insurance program would require a major redirection of state spending priorities which the Department believes cannot be undertaken at this late date in the 1982 legislative session. As an alternative, the Department would like to suggest that the contents of CSSB 817 be considered as a Senate HESS committee substitute for HB 41. CSSB 817 would transfer funds between the GRM and Medicaid programs to take advantage of federal Medicaid funds that are available without increasing the state budget. Under CSSB 817, the Department would provide health care coverage, including preventive health care services, to over 4000 children not presently eligible for Medicaid, and provide prenatal care to almost 400 pregnant women not currently eligible for Medicaid. Passage of CSSB 817 would not cost the state any money, but would provide health care services to a portion of the population targeted for coverage under the state-sponsored health insurance program in the HB 41 work draft.

Approved by:


Helen D. Beirne, Commissioner

Dated:

4-7-82

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. SCS CSSSHB 41 (work draft)
 Title An Act establishing a state health insurance program
 Requested by Senate HESS Committee Date 3/30/82

II. FISCAL DETAIL

Agency Affected Department of Health and Social Services
 Program Category Affected None
 BRU, Program, Or Subprogram(s) Affected None
 (Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL	0	0	0	0	0	0

FUNDING (Thousands of Dollars)

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS						
OTHER (Specify Source)						

POSITIONS

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
FULL TIME	0	0	0	0	0	0
PART TIME						
TEMPORARY						

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

The HB 41 work draft proposes to create a state-sponsored health insurance program in the Department of Administration and would therefore have no effect on the Department of Health and Social Services.

IV. DATE 4/7/82 PREPARED BY David M. Davidson
 AGENCY Division of Public Assistance
 Original: Legislative Finance PHONE 465-3347
 cc: Budget and Management
 Prime Sponsor (First Legislator Named)
 33-001 (Rev. 12/81)

Jcc

CHARLIE PARR - FIVE
HEALTH & SOCIAL
PUL

A-PFB
PDS
outgo
#1/81

Tanana Chiefs Conference, Inc.
201 First Avenue
Fairbanks, Alaska 99701

March 25, 1981

Senator John Sackett
Pouch V
Juneau, Alaska 99801

Dear Senator Sackett,

This is to request your assistance in resolving a current problem with Medicaid reimbursement to ANHS for outpatient services at three health centers in the State. At stake in the Interior Service unit is approximately \$280,000 for FY81 alone.

According to the Division of Public Assistance, payment cannot be made on billings from these health centers because State statutes disallow their eligibility, in conflict with the intent of P.L.94-437.

It is our understanding that language to resolve the problem is included in SB41; given the likely delays in action on this bill, a more expeditious solution would be to modify Statute 47.07.030 (Welfare, Social Services, Institutions) Definitions section, to repeal the clause in Section 4 defining clinic services.

If this amendment could be processed in this session, these revenues to ANHS could be released resulting in greatly improved patient care in our region.

Please advise us concerning the necessary actions in this matter. We are prepared to provide additional information necessary to allow this action to be taken.

Sincerely,
TANANA CHIEFS CONFERENCE, INC.

Paul Sherry
Paul Sherry
Director, Health Authority

G H IVEY
(JERRY)
DIRECTOR

- cc: Dave Mather, Regional Health Development
- William C. Williams, President
- Dr. Ron Gould Patient Care Services
- Tanana Chiefs Regional Health Board

ALASKA AREA
NATIVE HEALTH
SERVICE

750,000 + would be able to give back
health corps or provide more health
services. 265-3153

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

JAY S. HAMMOND, GOVERNOR

POUCH H 01
JUNEAU, ALASKA 99811
PHONE: 465-3030

June 2, 1981

Document# 154-81

The Honorable Don Clocksin
Chairman
House HESS Committee
Alaska State Legislature
State of Alaska
Pouch V
Juneau, AK 99811

Dear Mr. Clocksin:

Your staff requested language to allow the three major Alaska Area Native Health Service satellite clinics in Ketchikan, Juneau, and Fairbanks to bill for Medicaid eligible services and the State to receive 100% federal reimbursement. We would recommend the amendment of AS 47.07.080(4) as follows to accomplish this:

(4) "clinic services" means services provided by [WHICH ARE RESTRICTED TO] state approved outpatient community mental health services which receive grants under AS 47.30.520 - 47.30.620, [AND] state-operated community mental health clinics, and physician clinics.

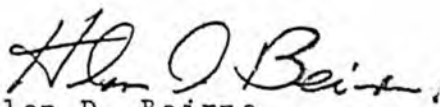
This action would require the addition of \$750,000 to \$1,000,000 in the first fiscal year of operation, with that amount of federal receipts being added to the state's Medicaid budget.

We must caution that adding any new services to Medicaid at this time must be done with the consideration that Congress is currently reviewing proposals to place a "cap" on federal Medicaid reimbursement. If a "cap" were to be placed by Congress on Medicaid federal reimbursement, the addition of AANHS clinics to the Alaska Medicaid program at this time may be done without assurance that 100% federal receipts will be realized.

We also have concerns regarding increasing possible state responsibility for services traditionally provided by federal agencies, such as AANHS. Such a move has the possibility of setting an undesirable precedent which may confuse the lines in the future of who is responsible for these medical care costs in the state for eligible Alaska Natives. This will especially be true when additional federal health care dollars for Medicaid services have a possibility of being significantly limited.

We appreciate your interest in this matter.

Sincerely,


Helen D. Beirne
Commissioner

POSITION PAPER
COMMITTEE SUBSTITUTE FOR
CS FOR SPONSOR SUBSTITUTE
HOUSE BILL NO. 41 (FINANCE)

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

I. DEPARTMENTAL OVERVIEW OF CS FOR SPONSOR SUBSTITUTE HOUSE BILL NO. 41 (FINANCE)

Committee Substitute for CS for Sponsor Substitute to House Bill No. 41 (Finance) is composed primarily of four parts:

- a. Sections 1, 2, 3 and 4 provide for a state comprehensive health plan available to all residents of the State will pay all or a part of the coverage for low income persons.
- b. Sections 5, 6, 7 and 8 expand the insurance statutes to require that certain Group insurance plans include coverage for alcoholism and drug dependence.
- c. Section 9 directs the Commissioner of Health and Social Services to contract for medical services through insurance companies or health care services organizations for beneficiaries of the Department's medical programs once contracting is determined cost competitive. (Medicaid, General Relief Medical, Catastrophic Illness, Crippled Children's, and Maternal and Child Health Programs).
- d. Sections 10 and 11 expand the Medicaid program by adding new beneficiaries and services respectively.
- e. Section 12 is a definition section
- f. Section 13 mandates that the Legislative Council shall study and make recommendations to improve coverage of Medicare and Indian Health Service.

II. GENERAL DEPARTMENTAL COMMENTS/RECOMMENDATIONS

The major portions of this bill pertain to the provisions and development of a state comprehensive health plan. The Governor has, as prescribed and funded by the 1980 Legislature, embarked upon a "Comprehensive Health Care and Financing Study" for the development of a comprehensive health care and cost distribution plan for Alaska. That study is now at mid-point. The study is examining the present health care delivery and financing systems in Alaska, identifying existing and potential funding

sources, examining improvements to the present systems and a discussion of alternative methods of providing for health care and cost distribution in Alaska, and designing legislative and administrative proposals for the implementation of potential new systems or methods.

At present the Governor's study is to be completed by December 15, 1981. This presents tight timing for the Department of Administration to consider the information in the Governor's study and report by the 30th day of the 1982 legislative session.

Since the Reagan Administration and Congress are reviewing alternative approaches to funding and administration of the Medicaid program, it is not advisable for Alaska to immediately to adopt all eligible groups, except for medically needy, and all 16 outstanding optional services at this time. Absent a clearer picture of the financial and administrative ramifications involved, the potential long term consequence could be funding of this program expansion with all state general funds.

As early as January, 1982, the Department and the Alaska Legislature will have a clearer picture of the effects of the various proposals in Congress concerning Medicaid and will have the benefit of the information included in the "Comprehensive Health Care Study".

For the above reasons, therefore, the Department of Health and Social Services cannot support CSSSHB-41 at this time.

The Department of Health and Social Services will primarily reserve its comments to Sections 5 through 11 of the bill as the earlier sections are concerning insurance, and it is our understanding that the Department of Administration and Department of Commerce and Economic Development will address that aspect of the bill. The Department's general comments regarding Sections 5 through 11 are as follows:

1. Sections 5 - 8, we support the requirement of alcohol and drug abuse treatment coverage under health insurance benefit package for state employees with an optional provision available to employees of other governmental units.

We believe such benefits have the potential to be cost-saving for the state, in such areas as sick leave utilization, absenteeism, lost production time and other factors.

2. Section 9. We support the concept of purchasing health care services for our medical assistance beneficiaries through health insurance policies or other contracts when judged by the Commissioner of the Department of Health and Social Services to be cost effective.
3. Section 10 as written would require DHSS to provide Medicaid coverage to all optional groups, except medically needy, not just those that have been added piecemeal to the state statutes. We would prefer that such major changes be delayed until we have a clearer picture of the federal budget impacts and the benefit of the results of the comprehensive health study. If the legislature wishes to pursue this, we would recommend phasing additional eligible groups into the program rather than adding all remaining groups at a single time.
4. Section 11 would require DHSS to provide Medicaid coverage for all services permitted under federal law rather than limit the program to those services presently listed in state statutes. We would prefer that such major changes be delayed until we have a clearer picture of the federal budget impacts and the benefit of the results of the comprehensive health study. Again, we would recommend phasing additional services into the program rather than adding all 16 outstanding optional services at a single time.

III. SPECIFIC DEPARTMENTAL DISCUSSIONS OF SECTIONS (5 - 8) -
ALCOHOL AND DRUG ABUSE TREATMENT

Insurance Coverage for State Employees:

Sections 5 - 8 of the bill mandate additional coverage for alcoholism and drug dependence under the state employees health benefits package and make such coverage optional to employees of other governmental units. Its intent is to consider the treatment of alcohol and drug dependence as similar to other medical conditions and is consistent with legislation that has recently been enacted in twenty-nine other states.

We believe that such coverage would be beneficial in that it would encourage people to avail themselves of needed alcoholism and drug abuse treatment services. To the extent that they do so, lost production, absenteeism, sick leave utilization, disability benefit payments and hospitalization for accidental injury and related diseases should diminish. Evidence from public and private organi-

zations around the country (Kennecott Copper, Kemper Insurance, State of California, as examples) indicate that utilization of these benefits actually cuts costs to individuals and firms for acute medical care for accidental injury and numerous illnesses.

Additionally, the provision of these benefits is an encouragement for hospitals in Alaska to begin to provide structured Alcoholism/Drug Abuse Treatment services, and for physicians to begin to state diagnosis of alcoholism and/or prescription drug addiction on their claims to insurance companies, instead of utilizing inappropriate euphemistic diagnoses for claiming benefits, as they now admittedly do in apparently somewhat massive numbers.

The effect of proper physician diagnosis and structured treatment will be to upgrade both the quality and appropriateness of care throughout the State.

IV. SPECIFIC DEPARTMENTAL CONCERNS IN SECTIONS 9, 10 and 11 (MEDICAL ASSISTANCE)

Section 9 - Line 22 on Page 7 Through Line 14 on Page 9:

AS 47.05.070 - Directs the Commissioner of DHSS to select either the option of purchasing and paying premiums on policies of insurance, or paying the expenses of health care service contracts when judged cost-effective by the Commissioner. The Department supports this concept so long as this determination of cost-effectiveness is accomplished looking at the entire program rather than on a service-by-service basis. It should be pointed out that the Department already has the ability to purchase insurance or health care service contracts under existing federal law. This change would simply make it mandatory for the Department to do so.

AS 47.05.100 - We support the general public policy intended by this portion of the bill, however, we would like to offer an amendment as follows:

INTEREST ON LATE PAYMENTS. When presented by a provider of medical services with a clean claim, the state shall pay:

- (1) interest at the rate of one percent per penalty month when payment is delayed more than 45 days after pre-

sentation of the clean claim. A "penalty month" starts on the 46th day and consists of 30 day increments thereafter until the claim is paid.

- (2) no change
- (3) the interest for a full month if the overdue claim is not paid by the 15th day of any penalty (calendar) month.

Section 10 - Line 15 on Page 9 Through Line 20 on Page 9:

AS 47.07.020 - This Section would amend state law to provide coverage for all optional groups not currently entitled to Medicaid benefits, except the medically needy. This includes the unborn child group, the unemployed parent group, caretaker relatives and certain individuals under 21.

As stated earlier the Department would recommend phasing additional eligible groups into the programs instead of adding all remaining groups simultaneously. We would suggest that categorical groups be added in the following timeframes:

- (1) July 1982: Unborn Child Group
Caretaker Relatives
Individuals Under 21
- (2) July 1983: Unemployed Father Group

By staging the categorical groups in this manner a number of benefits would result:

- (1) The Department will have received official notice of how President Reagan's administration is going to change the methods of distributing federal funds for Medicaid programs.
- (2) The Department's permanent medical claims payment system will be implemented and the added bill processing burden will be eased.
- (3) The Department would be prepared in advance with regulations and staff to handle the new coverage groups representing approximately 2,000 additional families.

Section 11 - Lines 21 Through 25 on Page 9:

AS 47.07.030 - This section as amended would change state law to dramatically expand medical services offered under

the Medicaid program. We would prefer that such major changes be delayed until we have a clearer picture of the federal budget impacts and the benefit of the results of the comprehensive health study. If the legislature wishes to pursue this, we would recommend phasing additional services into the program rather than adding all 16 outstanding optional services at this time. It is suggested the following services be specifically listed in CSSSHB41 (Finance) rather than the current blanket provision adding all services:

- (1) Physical Therapy
- (2) Occupational Therapy
- (3) Prescribed Drugs
- (4) Prosthetic Devices and Medical Supplies
- (5) Other Practitioner Services

- a. private psychologist
- b. nurse practitioners
- c. physician assistants

- (6) All Clinic Services
- (7) Other Diagnostic, Screening, Preventative and Rehabilitative Services
- (8) Personal Care Services
- (9) Dentures and Routine Dental Services

This change would add some new areas of coverage and would permit DHSS to claim federal funds for other services that are currently being provided to Medicaid beneficiaries using state-only funds from the GRM program.

Creation of a comprehensive health plan as contained in Section 1 would permit the transfer of major portions of the GRM program to the comprehensive health plan. GRM would remain to provide coverage for long term care services, residential care, and emergency coverage for those individuals not enrolled in the comprehensive health plan. The coordination of benefits under the comprehensive health plan and the residual coverage under GRM needs to be clarified. One method of doing this would be to limit GRM coverage to one episode during any 12 month period. Finally, the relationship between the comprehensive health plan under CSSSHB 41 (Finance) and the present catastrophic illness program should be clarified. Most payments made under the catastrophic illness program are for major medical types of coverage that may also be covered under the comprehensive health plan.

Recommended by:

Rod Betit
Rod Betit, Director
Division of Public
Assistance

Date:

May 5, 1981

RLC by George Mendell
Robert Cole, Coordinator
Office of Alcoholism and
Drug Abuse

Date:

May 5, 1981

Approved by:

Helen D. Beirne
Helen D. Beirne
Commissioner

Date:

5-11-81

MEDICAID SERVICES

Currently Covered Services

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

Services Added by CSSSHB-41(Finance)

Podiatrist services
Chiropractic Services
Private Duty Nursing
Personal Care Services
* Physical Therapy
* Occupational Therapy
* Prescribed Drugs
Dentures and Routine Dental Services
* Prosthetic Devices and Medical Supplies
Other Diagnostic, Screening Preventative & Rehabilitative Services
Services to Individuals Over 65 Years of Age in Institutions for Mental Diseases
Services to Individuals Over 65 Years of Age in Institutions for Tuberculosis
Other Practitioner Services
 a. private psychologist
 b. nurse practitioner
 c. Physician assistant
Clinic Services - other than Community Mental Health Clinics
Services by Christian Science News
Services by Christian Science Sanatoria

* Currently accessible through General Relief Medical

BACKGROUND INFORMATION FOR FISCAL NOTES
ON SPONSOR SUBSTITUTE FOR CSSSHB41 (FINANCE)

MEDICAID

Component/New Service Groups	FY 82 Request	New Categorically	Total with Categori- cally Needy
Hospital	11,826.7	2,614.9	14,441.6
Physician	6,415.2	1,418.4	7,833.6
Other Services	1,759.6	389.1	2,148.7
EPSDT	3,455.5	2,315.2	5,770.7
Nursing Homes	21,521.0		21,521.0
Subtotal	44,978.0	6,737.6	51,715.6
Indian Health	7,239.1	4,850.2	12,089.3
Subtotal	52,217.1	11,587.8	63,804.9
New Other Serv.		2,323.0	2,323.0
New Dental Serv.		1,843.6	1,843.6
New Drug Serv.		2,138.6	2,138.6
Total	52,217.1	17,893.0	70,110.1

BACKGROUND INFORMATION FOR FISCAL NOTES
ON SPONSOR SUBSTITUTE FOR CSSSHB41 (FINANCE)

GENERAL RELIEF MEDICAL

<u>Component</u>	<u>FY 82 Request</u>	<u>Fiscal Note</u>	<u>Total Remaining</u>
Hospital	7,102.7	(2,343.9)	4,758.8
Physician	2,954.6	(975.0)	1,979.6
Other Services	2,600.4	(1,300.2)	1,300.2
Nursing Homes	305.9		305.9
Catastrophic	980.2		980.2
Residential	189.7		189.7
Total	14,133.5	(4,619.1)	9,514.4

CASELOAD ESTIMATES FOR FISCAL NOTES
ON SPONSOR SUBSTITUTE FOR CSSH41 (FINANCE)

Program Category	Current Caseload	GRM Reduction	Categorically Needy	Total with Categorically Needy
AFDC	6665		3752	10,417
OAA	2421			2,421
AB/AD	2398			2,398
GRM	4664	(1607)		2,857
Total	15,948	(1607)	3752	18,093

SUMMARY OF BUDGET FOR CS...341 (FINANCE)

	<u>TOTAL</u>	<u>FEDERAL</u>	<u>STATE</u>	<u>POSITIONS</u>
(1) ADDITION OF MEDICAID SERVICES & NEW OPTIONAL CATEGORICAL GROUPS	18,413.4	11,631.8	6781.6	12
(2) DECREASE OF GRM DUE TO TRANSFER OF SERVICES & ELIGIBLES TO MEDICAID	(4,619.1)	-	(4619.1)	-
	-----	-----	-----	-----
TOTAL	13,794.3	11,631.8	2162.5	12

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. CSSSHB 41 (Finance)
 Title An ACT Relating to the Health of Residents of the State
 Requested by Senate HESS Committee Date May 5, 1981

II. FISCAL DETAIL

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

EXPENDITURES (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		(4,619.1)	(5311.9)	(6108.6)	(7024.9)	(8078.7)
TOTAL		(4,619.1)	(5311.9)	(6108.6)	(7024.9)	(8078.7)

FUNDING (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
GENERAL FUND		(4,619.1)	(5311.9)	(6108.6)	(8024.9)	(8078.7)
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
FULL TIME						
PART TIME						
TEMPORARY						

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

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

IV. DATE May 5, 1981 PREPARED BY David M. Davidson
 AGENCY Public Assistance
 PHONE 465--3347
 Original: Legislative Finance
 cc: Budget and Management
 Prime Sponsor (First Legislator Named) M&B Approval 11/4/81 @ 6:00 PM Date May 5, 1981

THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. CSSSHB 41 (Finance)
 Title An ACT Relating to the Health and Residents of the State
 Requested by Senate HESS Date May 5, 1981

II. FISCAL DETAIL

Agency Affected Department of Health and Social Services
 Program Category Affected Health/Social and Economic Assistance
 BRU, Program, or Subprogram(s) Affected Medicaid/Eligibility Deter./Public Assist. Admin.
 (Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
100 PERSONAL SERVICES		353.9	389.3	428.2	471.0	518.1
200 TRAVEL		12.9	14.2	15.6	17.2	18.9
300 CONTRACTUAL		133.8	147.2	161.9	178.1	195.9
400 COMMODITIES		6.5	7.2	7.9	8.7	9.5
500 EQUIPMENT		13.3	-0-	-0-	-0-	-0-
600 LAND & STRUCTURES		-0-	-0-	-0-	-0-	-0-
700 GRANTS, CLAIMS, ETC.		17893.0	20576.9	23663.5	27213.0	31295.0
TOTAL		18413.4	21135.4	24277.1	27888.0	32037.0

FUNDING (Thousands of Dollars)

GENERAL FUND		6781.6	7782.0	8938.8	10268.4	11796.0
FEDERAL FUNDS		11631.8	13353.4	15338.3	17619.6	20241.0
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		12	12	12	12	12
PART TIME						
TEMPORARY						

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

Medical benefits would be provided to approximately 2145 new cases under the Medicaid program. Administration of program benefits would require 11 field staff positions and 1 central office position, office space, and additional computer time to be divided between the Eligibility Determination and Public Assistance Administration BRUs. Funding is 50% federal except for the Indian Health Care Program which is funded at 100% federal funds.

IV. DATE May 5, 1981 PREPARED BY David M. Davidson
 AGENCY Division of Public Assistance
 Original: Legislative Finance PHONE 465-3347
 cc: Budget and Management
 Prime Sponsor (First Legislator Named) M&B Approval Date May 5, 1981

HB 41 file

**THELMA
BUCHHOLDT**

Alaska State Legislature
House of Representatives
Juneau, Alaska 99811

April 30, 1981

Honorable Charlie Parr
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Charlie:

As you know, HB 41 has now passed the House and has been referred to your Committee for its consideration. As you also know, I would very much appreciate your scheduling HB 41 for a hearing before your Committee when it fits your schedule.

Thanks alot.

Sincerely,

Thelma
Thelma Buchholdt
State Representative
District 9 (Spennard)

Alaska State Legislature



Senate

SENATOR MIKE COLLETTA

May 11, 1981

MEMORANDUM

TO: Senator Charles Parr
Chairman, HESS

FROM: Senator Mike Colletta

Mike Colletta

SUBJ: Recommended Committee Change - CSHB 41

It has been brought to my attention that Sec. 11 of this bill, relating to the definition of services covered, does not provide for chiropractic treatment coverage.

I would appreciate the Committee's consideration of including chiropractic care in this bill, as well as a review of other normal, necessary, and desirable services which may have been excluded in Title XIX of the federal Social Security Act, which serves as the definitional base for services covered under this measure.

Thank you.

POSITION PAPER
SPONSOR SUBSTITUTE
HOUSE BILL NO. 41
DEPARTMENT OF HEALTH AND SOCIAL SERVICES

POSITION PAPER

SPONSOR SUBSTITUTE

HOUSE BILL NO. 41

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

I. DEPARTMENTAL OVERVIEW OF SPONSOR SUBSTITUTE HOUSE BILL NO. 41

Sponsor Substitute House Bill No. 41 is composed primarily of four parts:

- a. Sections 1, 2, 3 and 4 provide for a state comprehensive health plan to provide health insurance benefits for all Alaskans who are otherwise not covered under a private or public health plan and includes a cost-share program wherein the State may share in paying for insurance of low income persons.
- b. Sections 5, 6, 7 and 8 expand the insurance statutes to require that CERTAIN Group insurance plans include coverage for alcoholism and drug dependence.
- c. Section 9 allows the Commissioner of Health and Social Services to contract for medical services through insurance companies and other health organizations for the payment and/or delivery of medical services to Department beneficiaries.
- d. Sections 10 and 11 expand the Medicaid program by adding new services and beneficiaries.

II. GENERAL DEPARTMENTAL COMMENTS/RECOMMENDATIONS

The major portions of this bill pertain to the provisions and development of a state comprehensive health plan. The Department is supportive of the provision or development of this method of health care financing. However, the Governor has, as prescribed and funded by the 1980 Legislature, embarked upon a "Comprehensive Health Financing Study" for the purpose of informing all Alaskans of various alternatives to coordinating existing health resources, identifying and filling gaps where health resources currently do not exist and methods of financing services in a comprehensive and coordinated way.

With this study in mind the Department is concerned that the report required in Section 2 of SSNB-41 have the benefit of the comprehensive data and recommendations that will be included in the Governor's study. At present the Governor's study is to be completed by December 15, 1981. This timing does not provide the opportunity to the Department of Administration to consider the information in the Governor's study and report by the 10th day of the 1982 legislative session. Therefore, the Department recommends that line 13, page 3 be amended to read as follows:

"The Commissioner of Administration shall report by the (10th) 90th day of the Second Session of the Twelfth State Legislature on:"

The Department of Health and Social Services will primarily reserve its comments to Sections 5 through 11 of the bill as the earlier sections are concerning insurance, and it is our understanding that the Department of Administration and Department of Commerce and Economic Development will address that aspect of the bill. The Department's general comments regarding Sections 5 through 11 are as follows:

1. Sections 5 - 8, we support the requirement of alcohol and drug abuse treatment coverage under health insurance benefit package for state employees with an optional provision available to employees of other government units.

We believe such benefits have the potential to be cost-saving for the state, in such areas as sick leave utilization, absenteeism, lost production time and other factors.

2. Section 9 we support the concept of purchasing health care services for our medical assistance beneficiaries through health insurance policies or other contracts when judged by the Commissioner of the Department of Health and Social Services to be cost effective.
3. Section 10 as written would require DHSS to provide Medicaid coverage to all optional groups, not just those that have been added piecemeal to the state statutes. We would rather see additional eligible groups phased into the program than all remaining groups being added at a single time. Each group should be evaluated on its own merits, rather than in mass to determine whether it is necessary to include them and what the cost of each might be.
4. Section 11 would require DHSS to provide Medicaid coverage for all services permitted under federal law rather than limit the program to those services presently listed in state statutes. Again, we would rather phase into additional services than add all services at a single time.

III. SPECIFIC DEPARTMENTAL DISCUSSIONS OF SECTIONS (5 - 8) - ALCOHOL AND DRUG ABUSE TREATMENT

Insurance Coverage for State Employees

Sections 5 - 8 of the bill mandate additional coverage for alcoholism and drug dependence under the state employees health benefits package and make such coverage optional to employees of governmental units. Its intent is to consider the treatment of alcohol and drug dependence as similar to other medical conditions and is consistent with legislation that has recently been enacted in twenty-nine other states.

We believe that such coverage would be beneficial in that it would encourage people to avail themselves of need alcoholism and drug abuse treatment services. To the extent that they do so, lost production, absenteeism, sick leave utilization, disability benefit payments and hospitalization for accidental injury and related diseases should diminish. Evidence from public and private organizations around the country (Kennebeck Coppin, Kemper Insurance, State of California, as examples) indicate that utilization of these benefits actually cuts costs to individuals and firms for acute medical care for accidental injury and numerous illnesses.

Additionally, the provision of these benefits is an encouragement for hospitals in Alaska to begin to provide structural Alcoholism/Drug Abuse Treatment services, and for physicians to begin to state diagnosis of alcoholism and/or prescription drug addiction on their claims to insurance companies, instead of utilizing inappropriate euphmistic diagnoses for claiming benefits, as they now admittedly do in apparently somewhat massive numbers. The effect of proper physician diagnosis and structured treatment will be to upgrade both the quality and appropriateness of care throughout the State.

IV. SPECIFIC DEPARTMENTAL DISCUSSION OF SECTIONS 9, 10 AND 11 (MEDICAL ASSISTANCE)

Section 9 - Line 25 on Page 6 Through Line 27 on Page 8:

AS 47.05.070 - Provides the Commissioner of DHSS the option of purchasing and paying premiums on policies of insurance or paying the expenses of health maintenance organizations service contracts or medical or hospital service contracts. As indicated we support this concept and would only suggest that "health maintenance organizations" be defined.

AS 47.05.080 - Recommend deletion of this section entirely. Current federal laws and regulations adequately cover the methods of contracting for health, medical and remedial services, and supplies. Also Alaska's current statutes and regulations concerning uniform purchasing (AS 37.050.220 - 330) provide contracting authority and obligate contractors to make payments promptly as provided in contract. If this portion is left in the bill, the term "remedial care" should be defined.

AS 47.05.100 - We support the intent of this portion of the bill, however, we would like to offer an amendment as follows:

INTEREST ON LATE PAYMENTS. When presented by a provider of medical services with a clean claim, the state shall pay:

- (1) interest at the rate of two percent per penalty month when payment is delayed more than 60 days after presentation of the clean claim. A "penalty month" starts on the 61st day and consists of 30 day increments thereafter until the claim is paid.
- (2) Providers should receive a full month's interest entitlement if the bill is paid after the 15th day of any penalty month.

This change accomplishes the intent of the bill, however, provides less administrative problems and costs for providers and the state in accounting for interest owed and received.

AS 47.04.120 - Add definition of "health maintenance organization", "non-exclusive contract", "medical or hospital service contracts", and "remedial care".

Section 10 - Line 28 on Page 8 through Line 2 on Page 9:

AS 47.07.020 - This Section would amend state law to provide coverage for all optional groups not currently entitled to Medicaid benefits, primarily the unborn child group, the unemployed father, caretaker relatives, individuals under 21 and the medically needy group.

POSITION PAPER/Department of Health and Social Services

As stated earlier the Department would rather see additional eligible groups phased into the programs instead of all remaining groups being added at a single time. We would suggest the categorical groups be added in the following timeframes:

- (1) July 1982: Unborn Child Group
Caretaker Relatives
Individuals Under 21
- (2) July 1983: Unemployed Father Group

By phasing in the categorical groups in this manner a number of benefits would result:

- (1) The Department will have received official notice of how President Reagan's administration is going to change the methods of distributing federal funds for Medicaid programs.
- (2) The Department's permanent medical claims payment system will be implemented and the added administrative burden will be eased.
- (3) The Department would be prepared in advance with regulations and staff to handle the added recipient volume.

The Department recommends that the medically needy group not be added under Medicaid but instead be included under the state comprehensive health plan portion of SSHB-41.

Medicaid eligibility is broken down into two types: categorically needy and medically needy. Categorically needy includes those individuals whose eligibility is based on their income being below an amount based on cash assistance payments (under the AFDC, APA, and SSI programs). Medically needy goes beyond categorically needy to provide coverage to those individuals who meet the categorical eligibility requirements of the cash assistance programs (age, disability or deprivation of parental support), but who are not eligible for cash payments because their income is too high. Under medically needy they would be permitted to spend a portion of their income on their medical needs and thus become eligible for Medicaid to pay the remaining cost of the covered services. To a certain extent, medically needy coverage under Medicaid would duplicate coverage under the comprehensive health plan and the cost-sharing program, but would permit the State to receive federal funds to provide part of those services. However, at the income levels permitted under the Medicaid medically needy program, individuals who would receive health coverage at no expense under this bill would be required to pay part of their income for health care under a medically needy program.

Section 11 - Lines 3 Through 7 on Page 9:

AS 47.07.030 - This section as amended would change state law to dramatically expand medical services offered under the Medicaid program. The Department recommends that each service be evaluated on its own merits, adding only those services that are important to maintaining the general health of Medicaid recipients. It is suggested the following services be specified listed in SSHB-41 rather than the current blanket provisions:

- (1) Physical Therapy
- (2) Occupational Therapy
- (3) Prescribed Drugs
- (4) Prosthetic Devices and Medical Supplies
- (5) Other Practitioner Services
 - a. private psychologist
 - b. nurse practitioners
 - c. physician assistants
- (6) All Clinic Services
- (7) Other Diagnostic, Screening, Preventative and Rehabilitative Services
- (8) Personal Care Services
- (9) Dentures and Routine Dental Services

This change would add some new areas of coverage and would permit DHSS to claim federal funds for other services that are currently being provided to Medicaid beneficiaries using state-only funds from the GRM program. It should be emphasized that while a broad category of service under Medicaid permits DHSS to make payment for services, DHSS is required to establish the conditions under which payment will be made. For each category of service, DHSS creates controls to assure that only medically appropriate treatment receives reimbursement.

The creation of a comprehensive health plan with a cost-sharing program as contained in section 1 would permit the transfer of major portions of the GRM program to the comprehensive health plan. GRM would remain to provide coverage for long term care services, residential care, and emergency coverage for those individuals not enrolled in the comprehensive health plan. The coordination of benefits under the comprehensive health plan and the residual coverage under GRM needs to be clarified to assure that GRM is not a disincentive to participation in the comprehensive health plan. One method of doing this would be to limit GRM coverage to one episode during any 12 month period.

The relationship between the comprehensive health plan with the cost-sharing program and the present catastrophic illness program should be clarified. The cost-sharing program requires that beneficiaries of the comprehensive health plan incur some portion of the expenses of the program based on their ability to pay. If the deductible requirements under the catastrophic illness program are nearly as low as or lower than those under the cost-sharing program, there will be little incentive for anyone to participate in the comprehensive health plan, in part defeating the intent of the bill. Since most payments made under the catastrophic illness program are for major medical types of coverage that may be covered under the comprehensive health plan, there is potential for overlap.

SUMMARY OF BUDGET FOR SSHB41

	<u>TOTAL</u>	<u>FEDERAL</u>	<u>STATE</u>	<u>POSITIONS</u>
(1) ADDITION OF MEDICAID SERVICES & NEW OPTIONAL CATEGORICAL GROUPS	18,413.4	11,631.8	6781.6	12
(2) ADDITION OF MEDICAID MEDICALLY NEEDY GROUPS	9,029.7	5,709.3	3320.4	5
(3) DECREASE OF GRM DUE TO TRANSFER OF SERVICES & ELIGIBLES TO MEDICAID	(4,619.1)	-	(4619.1)	-
(4) INTEREST PAYMENTS	<u>667.2</u>	<u> </u>	<u>667.2</u>	<u>-</u>
TOTAL	23,491.1	17,341.1	6150.1	17
TOTAL WITHOUT MEDICALLY NEEDY	14,461.5	11,631.8	2829.7	12
TOTAL WITHOUT INTEREST PAYMENTS	13,794.3	11,631.8	2162.5	

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF DEPUTY COMMISSIONER

ROOM 214 MacKAY BUILDING
333 DENALI STREET
ANCHORAGE 99501

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ADVISORY COMMITTEE FOR ALASKA COMPREHENSIVE HEALTH CARE AND FINANCING STUDY

Page Three

Darryl Trigg
Alaska Native Health Board
P.O. Box 966
Nome, Alaska 99762

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

JAY S. HAMMOND, GOVERNOR

POUCH H 01
JUNEAU, ALASKA 99811

PHONE:

465-3030(MA)

Budget Response #19

May 6, 1981

The Honorable Thelma Bucholdt
Pouch V, State Capitol
Juneau, Alaska 99811

Dear Representative Bucholdt:

The Budget Breakdown proposal for the Phase II of the Alaska Comprehensive Health Care and Financing Study is as follows:

200	Travel	\$ 27,000
300	Contractual	123,000
	TOTAL	<u>\$150,000</u>

The 200 line item for travel includes:

1. The travel necessary for the project director.
2. Travel and per diem for up to 17 persons directly and/or indirectly related to the statewide Advisory Committee. (No travel or per diem costs have been involved for representatives of the Governor's Office, the Lt. Governor's Office, the Insurance Industry, or Region X representative. Included however are provisions for travel and per diem for members representing the Alaska State Medical Association and the Alaska State Hospital Association which may or may not continue to cover travel and per diem expenses as has been the case in the past.)
3. Travel and per diem for one member of the Committee, the Director of the State Health Planning and Development Agency, assuming that the agency's budget will not be sufficient to cover the expenses.
4. Expenses for two possible necessary trips to Washington, D.C. by two Battelle representatives with regard to negotiations for waivers relating to the Medicaid program, if developments make this necessary.
5. The assumption that airline fares may go up beyond the 15% currently being discussed in the next few months and providing an inflation factor of 30% for airline travel during the conclusion of the study phase and a few months into the 1982 calendar year for the implementation period.
6. A figure of approximately \$1,000 to allow for any possible increase in per diem payments or other unexpected travel claims for the project.

7. Travel and per diem provisions assuming that one meeting of the Committee may be held in Fairbanks and one in Juneau.
8. Provision for travel and per diem relating to necessary Advisory Committee and project staff relating to Public Hearings called for in the contract for the project.

The 300 line items in contractual include contract funds which may be required for research and data gathering not included in the contract with the Battelle Institute as provided for in Phase I of the study.

Sec. 2.4 PHASE I - - INITIAL PLANNING DOCUMENT. Subsection 1 e requires the contractor as a part of the work under Phase I to provide....

" A description of the types of data not available at present but needed to decide which alternative health care provision and financing approaches would be desirable and feasible for the State of Alaska to pursue, and the cost of obtaining those data. "

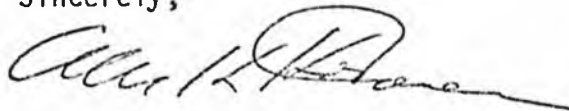
The contractor has submitted topics related to collection of primary data not included in the original scope which the study needs to address but has not yet addressed. Examples of this include:

1. Collection and refining of certain data related to the private sector insurance coverage. Additional knowledge of existing coverage levels for different types of benefits is necessary for final options to be considered. Profile information generated to date relies upon data from principal insurers and certain national level data. Information needed could be derived through scientific sample surveys of coverage offered by employers in the state. Within that data additional advantages develop.
2. Any new program doubtless will address private coverage and/or state funded coverage of alcoholism coverage. Exploration and data gathering are needed with regard to such questions as return on current investment in alcoholism care, etc..
3. Research as to the impact of the growing size of Alaska's elderly population following the Bureau of the Census projection of 125-210% increase in the next 20 years. Implications for state policy making and funding in the presence of a possible ceiling on Medicaid funds should be addressed. Certain other relevant data with regard to the elderly population is needed.
4. Physician distribution in rural areas with regard to access to services as relates to physical availability as well as the non-physician provider relating to recent trends and expectations for the future.

5. Present status of native non-profit health corporation assumption of responsibility for health care from federal government and from state government; current or potential capacity for assumption of more local control; and financial implications present and future.
6. Impact of federal fund reductions on state options.
7. Limited additional sets of data and exploration are needed such as disease patterns in the rural population and their impact on health care needs; hospital costs and utilization and alternatives for cost containment; implications of any new program structure on the demand on health care resources; cost to the state; and incentives for changes in private sector behavior under any new health care plan and financing development.

Up to \$110,000 is allocated for planning purposes for potential expenditures to complete the research and data gathering. The additional \$13,000 is allocated to other contract expense activities such as extra copies of the Battelle reports for distribution within the state, potential added expenses incurred with the public hearing process, telephone, telegraph and mailing charges, and additional copying expenses associated with the project.

Sincerely,



Helen D. Beirne
Commissioner

cc: Senate Finance Committee
House Finance Committee
Health, Education & Social Services Committee

THE UNCOVERED POPULATION

43,917 Alaskans currently have no health care coverage. Of these 43,917, about 40% are children, 25% are parents, 35% are single individuals. 60% are employed. Of the 60% employed, 29.7% are in business services; 24.7% are in wholesale or retail trade; 18.8% are in construction; 15.3% are in manufacturing, transportation, and utilities; 7.1% are in personal services; 2.7% are in agriculture, forestry and fishing (this figure does not take into account all the fishermen that will be without coverage in October, when PHS no longer plans to provide coverage to seamen with documented vessels); and 1.1% are in mining. About 5% of the 43,917 are categorized as "high risk". (There are about 4,000 high risk individuals in the state; some have private insurance but all would probably be interested in joining the plan created by this legislation because rates may be less expensive for high risk individuals than rates currently available in the market.)

Source: Survey of Income and Education (US Bureau of the Census):
John Wills, Battelle Research Center

19,000
43,917
16,000

(LC: 3/30/81)

How the Health Plan and the cost sharing program would work

The State Comprehensive Health Plan envisioned in section 1 (hereafter referred to as "the Health Plan") would be most attractive to those who have no coverage now, or those who have coverage that provides fewer benefits than the Health Plan would provide. The first group is comprised largely of those with high risk health conditions that make them ineligible for most individual health insurance policies; non-union or seasonal workers such as fishermen, cannery workers, construction workers, and legislative employees; and self-employed individuals. The latter group consists largely of those with individual health insurance plans.

The State Health Insurance Cost Sharing Program in section 1 (hereafter referred to as "the cost sharing program") would be attractive to many Alaskan individuals and families whose income is less than 125% of the median adjusted gross income figure for each family size. As long as a resident is enrolled in the Health Plan or a plan with comparable or better benefits for which no cost sharing is available from an employer or another source, the resident would be eligible for cost sharing under the program. The cost sharing program would also be an incentive to carriers who currently offer nonsubsidized policies with less than comparable benefits to upgrade their policies so that they will be competitive with the Health Plan.

The Department of Administration will report back to the legislature at the beginning of next session on various aspects of the Health Plan and the cost sharing program. After the legislature approves the Department's plans, the Department will engage in extensive advertising of the Health Plan and the cost sharing program, and coverage and cost sharing will commence on July 1, 1982. The advertising is necessary to ensure that as many people as possible know of the Health Plan and the cost sharing program so that they can enroll immediately in July if they wish to.

It is important to recognize the distinction between the Health Plan and the cost sharing program. Although cost sharing under the program is available to all enrolled in the Health Plan who meet the income and other requirements of the program, cost sharing is also available to residents enrolled in individual private plans that are certified as equivalent to the Health Plan. Cost sharing is not available to those enrolled in another form of subsidized health care plan, such as an employer or union sponsored plan, or a federal health program. Thus, the Health Plan offers coverage to anyone and especially to those who are currently without it, and the cost sharing program helps the Health Plan's participants and others defray the costs of health care financing.

The cost sharing program is based on incomes of family units; it helps single individuals and families with incomes less than 125% of median income figures. The subsidy schedule distinguishes between premium cost sharing and out-of-pocket cost sharing. Cost sharing for premium payments is available to all those with income less than 125% of the median income

because a family will automatically incur this cost in order to have insurance without ever getting sick. However, cost sharing for out-of-pocket expenses-----which represent the state's share of the consumer's costs when actually seeking health care-----is only available for those who could not afford to meet such expenses without the state's help. The philosophy behind the cost sharing distinction is that the consumer should be encouraged to seek health care only when necessary, and that the best incentive to achieve this policy objective is to insure that the consumer who can afford it, pays for the bulk of his health care expenses.

Eligibility and determination of the level of cost sharing will be performed by the Department in accordance with statute. An individual wishing to join the Health Plan would present proof of eligibility and proof of his level of cost sharing authorized under the cost sharing program to the insurance carrier, who would enroll the resident in the Health Plan. Every participant then, regardless of their income and subsidy levels, would sign up for the Health Plan in the same manner. They would also present their insurance card or other proof of insurance to a provider of care just as any other insured person would do. Claims payment would also be similar to other health insurance policies. Depending on the provider's usual arrangement, the individual would either pay his share of the bill directly to the provider or be billed for his share by the carrier. This would also be the arrangement for those enrolled in the cost sharing program and not in the Health Plan, when provider visits are necessary.

Provider reimbursement under the Health Plan would be the responsibility of the carrier. The carrier would make reimbursement payments directly to a provider and there would be no need for the state to serve as an intermediary in the performance of this function although some monitoring of the carrier's claims payment procedures would be necessary. The state would establish a running account from which the carrier could make claims payments. Claims data and other fiscal information would be compiled by the carrier and be available for the Department's use. The Department would have to keep records on participant's eligibility and subsidy status and perform certain other administrative functions. However, the private carrier will perform the bulk of administrative tasks in the form of claims payment.

Sponsors' Suggested Amendments to SS HB 41

page 1:

line 20--- "amount of copayments and deductibles for each enrolled resident and the resident's covered dependents for"

page 2:

line 7---"plan or covered under a [state or] federal health program and"

page 7:

line 1---"hospital or dental service contracts that provide one or more of the medical"

line 12---"Sec. 47.05.080. CONTRACTS WITH [DIRECT PROVIDERS OF CARE AND SERVICE.] FISCAL INTERMEDIARIES."

page 9:

line 2---"participation, not including residents eligible under the medically needy option, are eligible for medical assistance."

line 7---" [Services] Security Act."

line 8---new section 12 to read as follows: " * Sec. 12. AS 42.07.080 is amended by adding a new subsection (5) to read as follows:
(5) "medically needy" means a person who meets the categorical requirements of eligibility for medical assistance, but whose income exceeds the income standard for categorical assistance and is less than the medically needy income standard." Renumber remaining sections appropriately.

line 10---"* Sec. 14. Sections 5-8 [and 10-12] of this Act take effect January 1,"

line 13---"* Sec. 16. Sections 2, and 3, and 10-12 of this Act take effect immediately in"

CSSSHB 41 (HESS): How it would effect Medicaid in Alaska

To get federal funding for Medicaid services, a state must offer certain mandatory services to certain mandatory groups of eligibles. In addition, it can choose to offer other optional services to other optional groups of eligibles.

Alaska currently offers all mandatory services to all mandatory groups of eligibles. In addition, it offers some optional services to some optional groups of eligibles. CSSSHB 41 (HESS) would require the state to offer all services, mandatory and optional, to all groups of eligibles, mandatory and optional, for which federal funding is available on March 1, 1981, except for those considered "medically needy". The bill does not require the state to pick up the medically needy option because these individuals would be covered under the Plan established in section 1 of the bill; anyone with an income less than 150% of the poverty guideline would receive 100% state subsidy for the cost of the Plan.

This summary describes which services and eligibles are currently provided for in Alaska and which would be added if CSSSHB 41 (HESS) is enacted.

The question of how much will be cut from the federal budget allocation to Alaska for Medicaid is not an easy one to answer. We will not know for sure until Congress acts, since several different ideas are currently being considered. Staff has more information on the different proposals if members are interested.

(LC, using H&SS Medicaid coverage information: 4/2/81)

MEDICAID ELIGIBLES*

Currently Covered Eligibles

Child under 18 deprived of parental support or care

Parent of AFDC child or other specified relative

Child between 18 and 21 who is a dependent of an AFDC household

All children in psychiatric hospitals

A child in an intermediate care facility for the mentally retarded

Aged, blind, or disabled persons

All children in foster homes or private child-caring institutions

Eligibles added by SS HB 41

Child deprived of support of parent due to unemployment

Spouse of disabled parent

Spouse of unemployed parent

Pregnant woman and unborn child

All other financially eligible children

Caretaker relative of child over 18 but under 21 and not a dependent in an AFDC household

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

* In addition to these categorical criteria, a person must also be financially needy

MEDICAID SERVICES

Currently Covered Services

Hospital---inpatient and outpatient
 Skilled nursing facility (SNF)
 Intermediate Care Facility (ICF)
 ICF for mentally retarded persons
 and persons with related conditions (ICF/MR)
 Laboratory and x-ray services
 Physician services
 Visual care services, dispensing and
 ophthalmic materials
 Medical transportation
 Speech, hearing, and language services
 Psychiatric facility services
 Home health care services
 Early periodic screening, diagnosis,
 and treatment of individuals under 21 (EPSDT)
 a. dental services
 b. prosthetic devices and medical supplies
 c. physical therapy
 Community mental health clinics
 Family planning services
 Patient surgical care centers
 Rural health clinics

Services Added by SS HB 41

Podiatrist services
 Chiropractic services
 Private duty nursing
 Personal care services
 *Physical therapy
 *Occupational therapy
 *Prescribed drugs
 Adult dentures and routine dental services
 *Adult emergency dental services
 *Prosthetic devices and medical supplies
 Other diagnostic, screening, preventive & rehab. servic
 Services to those over 65 in mental institutions
 Services to those over 65 in tuberculosis institutions
 Other practitioner services
 a. private psychologist
 b. nurse practitioner
 c. physician assistant
 Clinic services---other than comm. mental health clinic
 Services by Christian Science nurses
 Services by Christian Science sanatoria
 * Currently available through General Relief Medical