ALASKA LEGISLATURE COMMITTEE FILES 1981-1982 8672

1570 SHESS HB 41

1570

Health, Education and Social Services Committee

Charlie Parr, Chairman
Terry Stimson, Vice-Chairman
Vic Fischer
Tim Kelly
Mike Colletta

Official Business

Alaska State Legislature

Senate

Pouch V
State Capitol
Juneau, Alaska 99811
465-4907
465-4908

MEMORANDUM

TO: Charlie Parr

FROM: Rocky Plotnick Weller

DATE: April 30, 1981

RE: The Alaska Comprehensive Health Care Financing Study

You have asked for the current status of the Alaska Comprehensive Health Care Financing Study. I have outlined the study's purpose and schedule below:

I. The study's purpose is to explore health care financing in Alaska, explore alternative means of expanding health care coverage, and improve physical and financial access to health care services.

II. Phase I of the study was completed by Battelle on March 30, 1981. It describes the present methods of public and private health care delivery, access, coverage and financing in Alaska. Also, it presents alternative approaches to reshape health care coverage and financing, and to a lesser extent, delivery and access.

III. The Advisory Committee will meet May 7, 1981 to consider the alternative approaches addressed in Phase I and decide which approaches Battelle should develop.

IV. Phase II will provide a complete plan for implementing and financing each of the alternative approaches selected. The deadline for the

draft is September, 1981.

V. The final document should be completed and submitted to the Department of Health & Social Services, the Governor and the Legislature by December 11, 1981.

AMENDMENT TO CS SS HB 41 (HESS)

Offered by Rep. Buchholdt

Page 2, lines 8-18: Delete sec. 18.27.020(b). Change section numbers and references to sections accordingly.

Page 4, line 28: Add a new section 5, and renumber remaining sections accordingly.

* Sec. 5. JOINT INTERIM COMMITTEE ESTABLISHED. (a) There is established a Joint Interim Committee on Indian Health Service and Medicare of the Twelfth Legislature, composed as follows:

(1) one member of the finance committee of the senate appointed by the chairmen of the finance committee of the senate;

(2) one member of the finance committee of the house appointed by the chairman of the finance committee of the house;

(3) the director of the Division of Retirement and Benefits, Department of Administration, or his representative;

(4) the coordinator of the Division of Adult and Aging Services, Department of Health and Social Services, or his representative;

(5) the area director of Indian Health Service in Alaska, or his representative;

(6) one representative of the Alaska insurance industry;

(7) the executive director of one of the native health corporations, or his representative;

(8) the president of the Alaska Federation of Natives, or his representative; and

(9) the director of the Older Persons Action Group, or his representative.

(b) The committee established under (a) of this section shall by the 30th day of the Second Session of the Twelfth State Legislature

(1) determine and report to the legislature how the Indian Health Service delivery system can be improved;

(2) determine and report to the legislature what role the state should play to complement federal funding of the Indian Health Service;

(3) determine and report to the legislature what role the state should play to complement services available to Alaska's senior citizens under Medicare; and

(4) obtain the assistance of a private attorney skilled in health care financing law, for the purposes of (1) - (3) of this section.

(LC: 4/1/81)

Fiscal note for amendment offered by Rep. Buchholdt

Personal Services (Direct staff support: one a.a., one sec.)	$ 25,000
Travel (Transportation, per diem for public hearings and other committee business)	$ 50,000
Contractual (Professional staff: lawyer, health care consultant, computer time-- $75,000; office space, telephone and equipment rental, supplies-- $10,000)	$ 85,000
TOTAL	$ 160,000

(LC: 4/1/81)

THELMA BUCHHOLDT
Alaska State Legislature
House of Representatives
Juneau, Alaska 99811

March 6, 1981

TO: Rep. Jack Fuller, Chair
Members of the Bush Caucus

FROM: Rep. Thelma Buchholdt

SUBJECT: SS HB 41 and Indian Health Service

Bill Summary

SS HB 41 does the following: (1) provides for a health plan that any resident can join; (2) provides for cost sharing from the state for those enrolled in the plan (or a comparable plan that has the same or better benefits) who do not presently have a subsidized health care financing plan or policy; (3) provides for alcohol and drug dependency treatment coverage for state employees; (4) attempts to resolve problems associated with Medicaid reimbursement; and (5) expands Medicaid coverage to the maximum extent allowed under federal law. The bill will ensure that all residents have some level of health care. The health plan and cost sharing program will be most attractive to those who do not have care now, i.e. seasonal workers such as fishermen, construction workers, cannery workers, legislative employees and the like; high risk uninsurables; and those who are presently covered by an expensive individual private plan. The bill also improves health care coverage for the Alaskan poor by expanding Medicaid and by allowing free coverage under the health plan for all residents with income less than 150% of the poverty guideline who meet the criteria of the cost sharing program. Further, it provides alcoholism and drug dependency coverage to a stable group of the insured, so that the costs of such coverage can be determined, with the intent of providing such coverage for all Alaskans eventually. Finally, it attempts to clear up the problems caused by the Medicaid bureaucracy so that doctors and hospitals will not refuse to provide care to Medicaid recipients. The bill does not attempt to solve all the problems related to health care financing in Alaska. Rather, it provides some solutions that are workable and carefully constructed, to insure that everyone has at least some level of coverage provided to them, in legislation that both the legislature and the Governor can accept.

Indian Health Service (IHS)

One issue that the bill does not address is the level and quality of services provided by IHS. The reason this issue is left out is not

because I do not feel that it needs to be addressed, but rather because I feel that it is a very complex, serious problem that needs a great deal of study before any action can be taken. Briefly stated, there are two major areas of concern with IHS: (1) not all services are available everywhere in the state, and (2) quality of care is not as good as it should be in many IHS facilities. Regarding the first issue, though this is certainly true, it is also true that every facility, according to Jerry Ivey and James Armbrust, provides major medical, out patient and emergency dental services. As regards the second issue, according to the personal experiences that I have heard about on many occasions, it is also true. However, SS HB 41 is not the vehicle to attack these problems. It has been suggested that some form of secondary or primary coverage for IHS recipients be included in the bill. I think the first suggestion is misleading and the second suggestion is not well thought out and does not take into account the serious ramifications involved.

Secondary Coverage

The secondary coverage "solution" is political double talk. As mentioned earlier, every IHS facility provides major medical, out patient and emergency dental services. The health plan called for in my bill will cover such services. However, I do not know what other services it will cover. It will certainly not be the "cadillac" health insurance that state employees currently enjoy because the health and employment profile of the residents that are likely to enroll would preclude totally comprehensive care because of the enormous cost of such a program for such people. It will not be a truly comprehensive health plan and there will be many types of health care services that it will not cover. Moreover, the three types of services (which are the crucial services that must be offered to ordinarily healthy individuals) that will definitely be provided are the same as those provided by IHS; and an IHS recipient would have to utilize IHS facilities and doctors for those services because IHS would be their primary source of health care and the health plan would only be their secondary source of health care. Thus, secondary coverage is, for IHS recipients, in reality, a myth. It will not benefit the average IHS recipient with a medical problem because he will still be bound to an IHS facility, an IHS doctor, and other IHS services for the health care that really counts, and the health care that is most likely to be needed. Secondary coverage is likely not to provide more benefits to IHS recipients than are currently available even when one recognizes the variability of services provided in different parts of the state, and will definitely not address the issue of quality of care of IHS services.

Primary Coverage

The primary coverage issue is one that we simply do not know enough about at this point in time. If we allow IHS recipients to choose between the plan and IHS, we are inviting--in fact, encouraging the federal government to renege upon its responsibility to provide health care to Native Alaskans. (One could also argue that secondary coverage is this type of encouragement as well.) Is this what we want? Do we want to "take over IHS"? Are we prepared to take over a federal program of this magnitude? I don't think that this solution gets at the real

issues that plague IHS or provides a viable solution to the problem.

It won't be long before the people figure out the myth of secondary coverage or the large and very expensive state bureaucracy that will be needed to run a state-controlled IHS. We need to look at the problems of IHS much more carefully, talk with those who are familiar with health care coverage in the bush, and then decide what the state's role should be in the provision of IHS services. It could be that there's a need to create an interim committee that would look into this issue and report back to the next session on solutions to the problem. In sum, SS HB 41 is not the proper mechanism to clean up IHS. We don't have enough information to know what the proper solution is, but we can obtain that information. We should think before acting, instead of reacting.

FY 82 FISCAL SUMMARY FOR SSHB 41 (with amendments)

	TOTAL	FEDERAL	STATE	POSITIONS	Effective Date
Department of Health and Social Services					
(1) Addition of Medicaid Services and New Optional Categorical Groups	18,413.4	11,631.8	6781.6	12	July 1, 1981
(2) Decrease in GRM due to Transfer of Services and Eligibles to Medicaid	(4,619.1)	-	(4619.1)	-	July 1, 1981
(3) Decrease of GRM due to Transfer of Eligibles to Comprehensive Plan	0	-	0	0	July 1, 1982
(4) Interest Payments	667.2	-	667.2	-	
Department of Commerce and Economic Development					
(5) Certification of Insurance Policies as Comparable to Health Plan	38.1	-	38.1	1	July 1, 1982
Department of Administration					
(6) Alcoholism Benefits half year	180.0	-	180.0	-	Jan 1, 1982
(7) Administrative Costs for Studying and Implementing the Comprehensive Plan	1,023.4	-	1023.4	12	immediate
(8) Benefit Costs under Cost Sharing Program	0	-	0	-	
					July 1, 1982
TOTAL	15,703.0	11,631.8	4071.2	25	

highest of enrollees

(2/27/81 SH)

MEMORANDUM State of Alaska

TO: Robert G. Ogden
Chief of Medical Assistance
Division of Public Assistance

DATE: 20 January 1981

FILE NO:

TELEPHONE NO:

FROM: David M. Davidson 3347
Medical Assistance Program Officer
Division of Public Assistance

SUBJECT: Briefing Memo on HB 41--Comprehensive Health Plan and Medicaid Amendments

House Bill 41 is composed of three major parts. A state comprehensive health plan would be created providing for state premium supplement, group insurance plans would be required to include coverage for alcoholism and drug dependence, and changes would be made to the Medicaid and General Relief Medical (GRM) programs by adding new services and beneficiaries. This briefing memo discusses the bill (except for the alcohol and drug provisions), what would be the effect of the proposed changes to existing programs, and proposes some alternatives to the bill that might be considered.

Before discussing sections of the bill, some consideration should be given to recommending that the bill be split into two separate bills. The portions dealing with a comprehensive health plan and alcoholism and drug dependency coverage would add new programs for the general population; the Medicaid and GRM amendments would add benefits to existing welfare programs. It would appear that there may be a conflict in purpose between these two interests that would warrant dividing HB 41 into two separate bills.

Section 1. Beginning with line 4 on page 2, the section discusses the cost sharing and income standards using 80% state payment as the base level of participation. It is not clear whether the reference to $1000 per month adjusted gross income refers to an individual or a family. Federal figures indicate that the median income for a family of four in Alaska is slightly higher than $31,000 per year. Thus, if the $1000 per month adjusted gross income is for a family, it would result in lower middle income families being excluded from participation in the program.

There is a question regarding the relationship between the comprehensive health plan and the catastrophic illness program. The comprehensive health plan in this bill requires some cost sharing. If the scope of catastrophic illness program is expanded by the Governor, and the cost-sharing requirements greatly reduced or eliminated, what incentive is there for anyone to participate in a comprehensive health program where they will have to pay some or all of the cost of their care, versus a catastrophic illness program with little or no cost sharing.

A. Mandatory categorically needy groups. Without discussing all the variety of minor limitations and requirements, the following is a list of the mandatory categorically needy groups presently eligible for Medicaid in Alaska:

1. Individuals with income and resources low enough to be eligible for cash assistance under the AFDC program; that is, households with dependent children under the age of 18 deprived of parental support because of the absence or incapacity of one or more parents.

2. Individuals with income and resources low enough to be eligible for a cash assistance payment under the federal SSI program; individuals must be aged (age 65 or older), blind, or disabled.

3. Individuals under age 21 not eligible for AFDC simply because they are age 18 or older; these are individuals still dependent on their families for financial support.

B. Optional categorically needy groups. Without discussing minor limitations and requirements, the following is a list of the optional categorically needy groups presently eligible for Medicaid in Alaska:

1. Individuals eligible for cash assistance but not receiving cash payments for whatever reason.

2. Individuals eligible for cash assistance except that they are in an institution and no cash payment is being made.

3. Individuals under age 21 with income and resources low enough to be eligible for AFDC but do not qualify as dependent children; limited to individuals in the protective custody of DHSS, individuals in inpatient psychiatric facilities, and individuals in intermediate care facilities for the mentally retarded (ICF/MR).

4. Individuals who are aged, blind, or disabled, whose income exceeds the SSI limits, but are receiving an optional state supplement payment under the Adult Public Assistance (APA) program.

5. Individuals in institutions who meet the income, resource, and categorical requirements for the AFDC, SSI, or APA programs, but are in institutions (hospitals or long term care facilities); eligibility is limited to those individuals whose income does not exceed three times (300% of) the income standard for a single individual under the SSI program.

2. Individuals who meet the medically needy income and resource criteria and meet all other eligibility criteria for the aged, blind, or disabled for the following groups: A.2. and B.4.

The addition of these groups would increase Medicaid participation, but would also decrease the number of GRM cases. Presently state funds are used to provide GRM coverage for services provided to some individuals who could be covered under an expanded Medicaid program, thus causing Alaska to lose the 50% federal funds that are available for those services. Medically needy coverage would provide 50% federal funding for services provided to individuals who are either not receiving the services presently or are receiving the services but are having difficulty paying for them. These individuals could be covered under the comprehensive health plan (as could all individuals presently eligible for Medicaid) but Alaska would not receive federal funding for coverage under the comprehensive health plan if the premium costs exceed the cost of providing services if Alaska continued to pay the claims directly.

There are some distinct disadvantages to individuals who might be included under the optional medically needy coverage if it was added to Medicaid and if the comprehensive health plan becomes law. Under medically needy, an individual having income above the eligibility limit may still be eligible for Medicaid coverage for a portion of their medical expenses. However, the individual would be required to pay for all medical expenses incurred until the amount of their expenses equaled the difference between their income and the medically needy income standard. Medicaid would then pay for the remaining costs. As an example, if an individual had income of $750 per month and the medically needy income standard was $500 per month, the individual would have to incur $250 in medical expenses before they would be eligible for Medicaid coverage for any remaining expenses. Therefore, the comprehensive health plan, with an expanded sliding scale would be a more equitable method of providing coverage for individuals in moderately low income brackets under a revised version of the bill.

Section 8. This section would require DHSS to provide Medicaid coverage for all categories of service permitted under federal law rather than be limited to those services listed in the present statute. This change would add some new areas of coverage not presently paid for by DHSS. It would also allow DHSS to claim 50% federal funds for certain services that are presently provided for Medicaid beneficiaries in Alaska using 100% state funds. Listed below are those broad categories of service that are funded by Medicaid, those that are funded for Medicaid beneficiaries using state funds which would be converted to Medicaid coverage under this bill, and those services that would be new areas of coverage under Medicaid.

B. State-funded services for Medicaid beneficiaries. The following are categories of service that are presently covered using 100% state funds for Medicaid beneficiaries in Alaska and would become Medicaid reimbursed services eligible for 50% federal funds under this bill:

1. dental care--limited to emergency treatment for relief of pain and acute infection (for individuals 21 and over),

2. family planning services,

3. pharmaceuticals and over-the-counter drugs,

4. physical and occupational therapy,

5. prosthetic devices and medical supplies.

C. New Medicaid coverage. The following categories of service are not covered by the present Medicaid program in Alaska but would be added by this bill:

1. clinic services--not limited to community mental health clinics, but covering native health service clinics (100% federal funding), well-child clinics, and other types of health care clinics,

2. dental services--not limited to relief of pain and acute infection, but providing routine dental care including dentures, bridges, examinations, and cleaning,

3. private duty nursing--nursing care in the home for individuals who would otherwise have to remain in a hospital,

4. other diagnostic, screening, preventive, and rehabilitative services--immunizations, adult preventive health programs, adult day care, and other services not covered elsewhere,

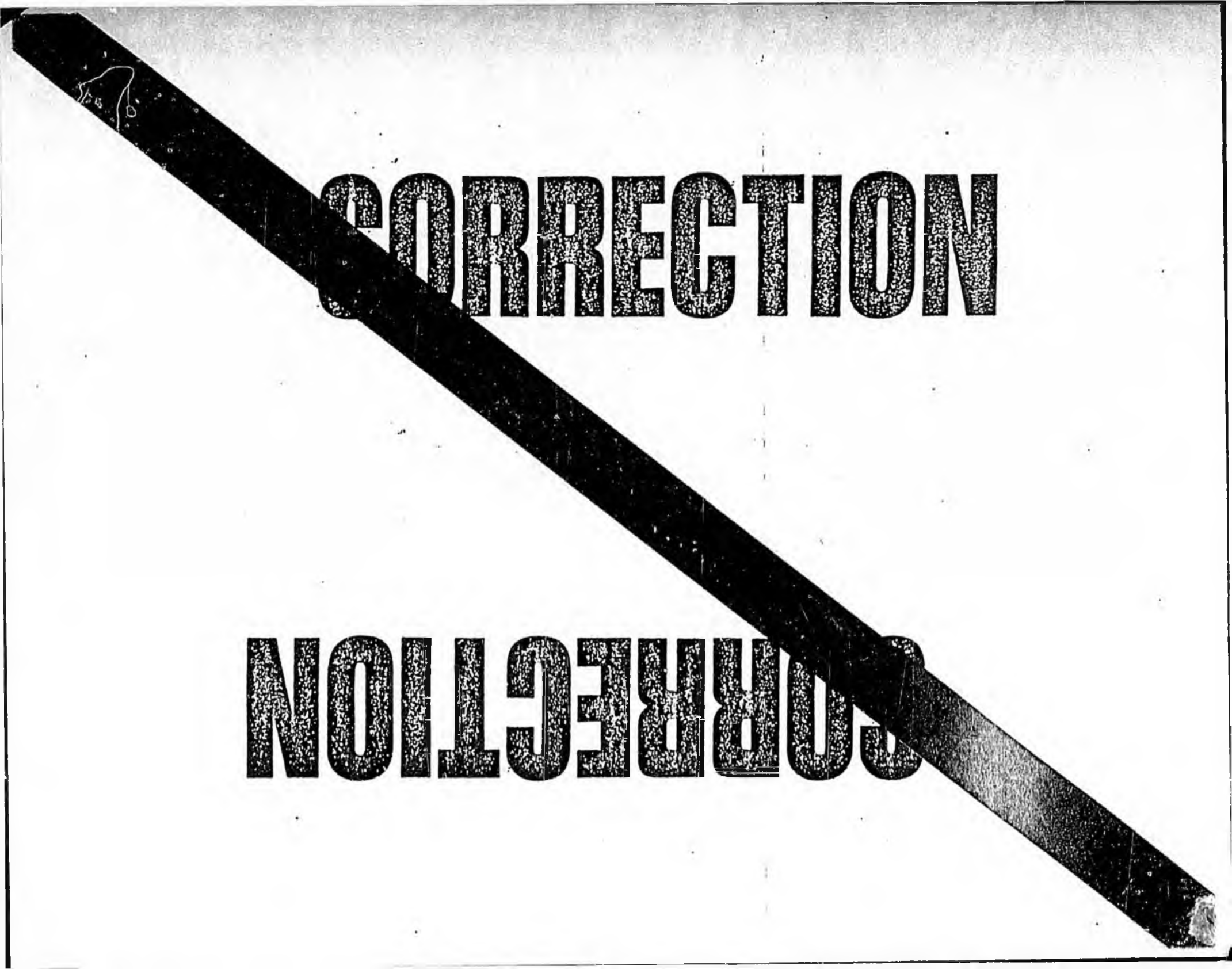
5. podiatrists' services,

6. chiropractors' services,

7. personal care services--similar to homemaker services,

8. other practitioners--including private psychologists, nurse practitioners, nurse midwives, and physicians' assistants,

9. other miscellaneous coverages--services for individuals age 65 and over in tuberculosis institutions, services by Christian Science nurses, and Christian Science sanatoria.


CORRECTION
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MEMORANDUM State of Alaska

TO: Robert G. Ogden
Chief of Medical Assistance
Division of Public Assistance

DATE: 20 January 1981

FILE NO:

TELEPHONE NO:

FROM: David M. Davidson 3347
Medical Assistance Program Officer
Division of Public Assistance

SUBJECT: Briefing Memo on HB 41--Comprehensive Health Plan and Medicaid Amendments

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Before discussing sections of the bill, some consideration should be given to recommending that the bill be split into two separate bills. The portions dealing with a comprehensive health plan and alcoholism and drug dependency coverage would add new programs for the general population; the Medicaid and GRM amendments would add benefits to existing welfare programs. It would appear that there may be a conflict in purpose between these two interests that would warrant dividing HB 41 into two separate bills.

Section 1. Beginning with line 4 on page 2, the section discusses the cost sharing and income standards using 80% state payment as the base level of participation. It is not clear whether the reference to $1000 per month adjusted gross income refers to an individual or a family. Federal figures indicate that the median income for a family of four in Alaska is slightly higher than $31,000 per year. Thus, if the $1000 per month adjusted gross income is for a family, it would result in lower middle income families being excluded from participation in the program.

There is a question regarding the relationship between the comprehensive health plan and the catastrophic illness program. The comprehensive health plan in this bill requires some cost sharing. If the scope of catastrophic illness program is expanded by the Governor, and the cost-sharing requirements greatly reduced or eliminated, what incentive is there for anyone to participate in a comprehensive health program where they will have to pay some or all of the cost of their care, versus a catastrop' ic illness program with little or no cost sharing.

Some consideration might be given to eliminating Section 9 of the bill, which proposes to create a medically needy program under the state-funded GRM program. Rather than creating a new welfare program, why not change the income criteria under Section 1 so that individuals with income below $1000 per month (or some other more precisely determined amount) would be able to participate in the comprehensive health plan with the State paying a greater portion of the premium costs up to 100%. This would avoid adding more work to already busy welfare offices. In fact, consideration should be given to eliminating much of the GRM program by transferring the bulk of the GRM caseload to the comprehensive health plan.

There are four types of cases that receive coverage under GRM: a) family units where both parents are in the home and able to work, b) low-income single individuals or childless couples, c) individuals not eligible for Medicaid who suffer some major accident or injury, and d) disabled or elderly individuals needing expensive long term care with income or resources that exceed the standard of the Medicaid program. Other sections of the bill, discussed below, would deal with health insurance coverage for people in category a). The Governor's proposed expansion of the catastrophic illness program, and the proposed amendments to this bill, would take care of categories c) and d). The remaining persons fall into category b) and could be included in a revised version of Section 1 that would include a state share extending up to 100% based on income.

The revision mentioned above regarding to individuals in category c) could be added to the bill in the form of intent that the comprehensive health plan have some limit of liability at a fairly low amount, with medical expenses over that amount being the responsibility of the catastrophic illness program. By setting the liability limit at a low level under the comprehensive health plan, premium amounts are reduced, keeping down the cost of participation and placing all catastrophic coverage in a single program.

Section 7. As written, this section would require DHSS to provide Medicaid eligibility to all optional groups, not just those that have been added piecemeal to the statute. Medicaid eligibility is broken down into two types: categorically needy and medically needy. Alaska presently has only categorically needy coverage for some but not all groups. Categorically needy includes those individuals whose eligibility is based on their income being below a limit based on cash payments made under the AFDC, APA, and SSI programs.

A. Mandatory categorically needy groups. Without discussing all the variety of minor limitations and requirements, the following is a list of the mandatory categorically needy groups presently eligible for Medicaid in Alaska:

1. Individuals with income and resources low enough to be eligible for cash assistance under the AFDC program; that is, households with dependent children under the age of 18 deprived of parental support because of the absence or incapacity of one or more parents.

2. Individuals with income and resources low enough to be eligible for a cash assistance payment under the federal SSI program; individuals must be aged (age 65 or older), blind, or disabled.

3. Individuals under age 21 not eligible for AFDC simply because they are age 18 or older; these are individuals still dependent on their families for financial support.

B. Optional categorically needy groups. Without discussing minor limitations and requirements, the following is a list of the optional categorically needy groups presently eligible for Medicaid in Alaska:

1. Individuals eligible for cash assistance but not receiving cash payments for whatever reason.

2. Individuals eligible for cash assistance except that they are in an institution and no cash payment is being made.

3. Individuals under age 21 with income and resources low enough to be eligible for AFDC but do not qualify as dependent children; limited to individuals in the protective custody of DHSS, individuals in inpatient psychiatric facilities, and individuals in intermediate care facilities for the mentally retarded (ICF/MR).

4. Individuals who are aged, blind, or disabled, whose income exceeds the SSI limits, but are receiving an optional state supplement payment under the Adult Public Assistance (APA) program.

5. Individuals in institutions who meet the income, resource, and categorical requirements for the AFDC, SSI, or APA programs, but are in institutions (hospitals or long term care facilities); eligibility is limited to those individuals whose income does not exceed three times (300% of) the income standard for a single individual under the SSI program.

C. New optional categorically needy groups. The following are optional categorically needy groups not covered under the present Alaska Medicaid program that would be added by this bill:

1. Individuals under age 21 with income and resources low enough to be eligible for AFDC but do not qualify as dependent children, and are not in the custody of DHSS, not in an inpatient psychiatric facility, and not in an ICF/MR.

2. Expectant mothers with income and resources low enough be eligible for AFDC but do not qualify because they do not have any dependent children yet.

3. Individuals in households with income and resources low enough to be eligible for AFDC but do not qualify because the Alaska AFDC program does not provide cash assistance to families where both parents are in the household and able to work; this group overlaps to a certain extent with that in C.1. because it is possible under C.1. to cover children in these households without covering the parents medical needs.

4. Caretaker relatives with income and resources low enough to be eligible for AFDC if the children for whom they are caring were their own children; caretaker relatives (aunts, uncles, grandparents, sisters, and brothers) are not parents and therefore do not meet the categorical requirements for AFDC coverage even though they receive AFDC payments on behalf of the children.

5. Individuals with income and resources low enough to be eligible for AFDC except that they receive free work-related child care and therefore lack an allowable expense that would permit them to remain eligible for Medicaid.

D. New optional medically needy groups. In addition to the categorically needy optional groups, the optional medically needy groups listed below would be covered under this bill. Medically needy income and resource limits may be set by the state, but the income limit may not exceed 133% of the AFDC income standard for a comparable family. Under medically needy, individuals are permitted to deduct actual and accrued medical expenses to reduce their countable income to the 133% limit. At that point, Medicaid would provide coverage for all eligible services at Medicaid reimbursement rates. The following are the optional medically needy groups that would be added to the Medicaid program:

1. Individuals who meet the medically needy income and resource criteria and who meet all other eligibility criteria for families and children from the following groups: A.1., A.3., and C.1.to C.4.

2. Individuals who meet the medically needy income and resource criteria and meet all other eligibility criteria for the aged, blind, or disabled for the following groups: A.2. and B.4.

The addition of these groups would increase Medicaid participation, but would also decrease the number of GRM cases. Presently state funds are used to provide GRM coverage for services provided to some individuals who could be covered under an expanded Medicaid program, thus causing Alaska to lose the 50% federal funds that are available for those services. Medically needy coverage would provide 50% federal funding for services provided to individuals who are either not receiving the services presently or are receiving the services but are having difficulty paying for them. These individuals could be covered under the comprehensive health plan (as could all individuals presently eligible for Medicaid) but Alaska would not receive federal funding for coverage under the comprehensive health plan if the premium costs exceed the cost of providing services if Alaska continued to pay the claims directly.

There are some distinct disadvantages to individuals who might be included under the optional medically needy coverage if it was added to Medicaid and if the comprehensive health plan becomes law. Under medically needy, an individual having income above the eligibility limit may still be eligible for Medicaid coverage for a portion of their medical expenses. However, the individual would be required to pay for all medical expenses incurred until the amount of their expenses equaled the difference between their income and the medically needy income standard. Medicaid would then pay for the remaining costs. As an example, if an individual had income of $750 per month and the medically needy income standard was $500 per month, the individual would have to incur $250 in medical expenses before they would be eligible for Medicaid coverage for any remaining expenses. Therefore, the comprehensive health plan, with an expanded sliding scale would be a more equitable method of providing coverage for individuals in moderately low income brackets under a revised version of the bill.

Section 8. This section would require DHSS to provide Medicaid coverage for all categories of service permitted under federal law rather than be limited to those services listed in the present statute. This change would add some new areas of coverage not presently paid for by DHSS. It would also allow DHSS to claim 50% federal funds for certain services that are presently provided for Medicaid beneficiaries in Alaska using 100% state funds. Listed below are those broad categories of service that are funded by Medicaid, those that are funded for Medicaid beneficiaries using state funds which would be converted to Medicaid coverage under this bill, and those services that would be new areas of coverage under Medicaid.

A. Existing Medicaid coverage. The following are categories of service that are presently covered using 50% federal funds for Medicaid beneficiaries in Alaska:

1. hospital--inpatient and outpatient,

2. skilled nursing facility (SNF),

3. intermediate care facility (ICF),

4. intermediate care facility for the mentally retarded and persons with related conditions (ICF/MR),

5. laboratory and X-ray services,

6. physician services,

7. visual care services, dispensing, and opthalmic materials,

8. medical transportation,

9. speech, hearing, and language services,

10. psychiatric facility services,

11. home health care services,

12. early periodic screening, diagnosis, and treatment of individuals under 21 (EPSDT), which includes the following services limited to persons eligible under this category:

    a. dental services,

    b. prosthetic devices and medical supplies,

    c. physical therapy,

13. clinic services--limited to community mental health clinics and state-operated mental health clinics,

14. family planning services,

15. outpatient surgical care centers,

16. rural health clinics.

B. State-funded services for Medicaid beneficiaries. The following are categories of service that are presently covered using 100% state funds for Medicaid beneficiaries in Alaska and would become Medicaid reimbursed services eligible for 50% federal funds under this bill:

1. dental care--limited to emergency treatment for relief of pain and acute infection (for individuals 21 and over),

2. family planning services,

3. pharmaceuticals and over-the-counter drugs,

4. physical and occupational therapy,

5. prosthetic devices and medical supplies.

C. New Medicaid coverage. The following categories of service are not covered by the present Medicaid program in Alaska but would be added by this bill:

1. clinic services--not limited to community mental health clinics, but covering native health service clinics (100% federal funding), well-child clinics, and other types of health care clinics,

2. dental services--not limited to relief of pain and acute infection, but providing routine dental care including dentures, bridges, examinations, and cleaning,

3. private duty nursing--nursing care in the home for individuals who would otherwise have to remain in a hospital,

4. other diagnostic, screening, preventive, and rehabilitative services--immunizations, adult preventive health programs, adult day care, and other services not covered elsewhere,

5. podiatrists' services,

6. chiropractors' services,

7. personal care services--similar to homemaker services,

8. other practitioners--including private psychologists, nurse practitioners, nurse midwives, and physicians' assistants,

9. other miscellaneous coverages--services for individuals age 65 and over in tuberculosis institutions, services by Christian Science nurses, and Christian Science sanatoria.

It should be emphasized that while a broad category of service permits DPA to make payments to certains types of health care providers, DPA has the responsibility to establish the conditions under which payment will be made. Physical and occupational therapy are categories of service that are covered presently, but the scope of services are limited, the number of visits are limited without special justification, and the services must be requested by a physician. Similar controls would be imposed by DPA on any new categories of service so that payment would be made only for medically-appropriate treatment. Several new categories of service would be infrequently used while others, such as private psychologists, nurse practitioners, chiropractors, and podiatrists, are often requested. While unlimited coverage of the services of these providers would certainly be inappropriate, they do fit within the overall scope of health care that should be provided. There is little question that the adult dental services presently provided are totally inadequate.

Section 9. As discussed under Section 1., this section could be deleted and the coverage incorporated in the comprehensive health plan. In its place would be legislation to delete the GRM program. Some GRM funds would be transferred to Medicaid to partially fund the new services to be added by Section 8., some GRM funds would be retained for the catastrophic illness program, and the remaining GRM funds would be transferred to the comprehensive health plan.

Summary. Under a revised version of HB 41, the following would occur:

1. Medicaid would be expanded to include the optional categorically needy groups not already covered; it would be expanded to permit the remaining optional service categories to be covered with the conditions of participation and limits of coverage to be defined by DPA in regulations; medically needy would not be added.

2. The GRM program would be eliminated.

3. The catastrophic illness program would be expanded to provide greater coverage, including payment for services that have largely been excluded in the past, such as long term care; coverage would be available as a supplement to the comprehensive health plan; the deductible amount and income criteria would be changed to conform to coverage under the comprehensive health plan.

4. A comprehensive health plan would be created. Eligibility would be open to all individuals of the state meeting the income and resource criteria established for the program. Individuals having full-service health care coverage (such as Alaska Native Health Service or the military)

would receive coverage for those services not covered under the full-service program. Individuals with other health insurance coverage would be entitled to participate, but the comprehensive health plan would be a last-pay program. As an example of how state participation would be determined, individuals having income below a certain level, say 150% of the poverty guidelines, would be entitled to 100% state funding of the premium costs and 100% funding of all coinsurance and deductible amounts. Individuals with income above 150% of the poverty guidelines but below 200% of the poverty guidelines would be entitled to 100% funding of the premium costs but would be responsible for all coinsurance and deductible costs. Individuals with income over 200% of the poverty guidelines would be entitled to state payment of the premium costs on a decreasing scale with state participation becoming zero at 115% of the median income amount.

J. Fairgrail

Battelle
Human Affairs Research Centers
4000 N.E. 41st Street
P.O. Box C-5395
Seattle, Washington 98105
Telephone: (206) 525-3130
CABLE: HARCSEA

January 20, 1981

Dr. Frederick McGinnis
Deputy Commissioner
Department of Health
and Social Services
Mackay Bldg., Room 214
338 Denali Street
Anchorage, AK 99501

RE: First Monthly Progress Report on
Alaska Health Care Financing Project
Contract No. 064563
(Project No. P24187)

Dear Dr. McGinnis:

The first month of work on this project has been devoted to establishing contact with the Advisory Committee and defining the outlines of the first two reports, and to data collection and background discussions with a number of individuals knowledgeable about health care in Alaska.

We are proceeding to prepare the first two reports for this project according to the outline we presented at the Advisory Committee meeting on January 5. We have met with Andrew Dolan, the legal consultant for this project, and have begun to outline the nature of his contribution to the report on State Options for Action.

Data collection from the public sector has been proceeding on schedule. We have contacted a number of public sector officials in our data collection thus far, including representatives of the State Division of Insurance, Center for Health Statistics, Department of Public Assistance, Office of Management and Budget, and Department of Labor; the Federal Health Care Financing Administration (Medicare), Department of Defense, Indian Health Service, and Bureau of the Census; and the South Central Health Systems Agency. All have been cooperative, and collection of data from the public sector appears to pose no difficulties.

We have also begun data collection activities in the private sector: commercial insurers, Blue Cross/Blue Shield, and the Teamsters. As expected, this activity is more difficult and time consuming than data collection in the public sector. We are slightly behind our schedule for collecting these data, but this has not

impeded progress and we do not believe it will affect our ability to deliver the first two reports as scheduled.

I have put Mr. Fargnoli in touch with Charles Kuhnen of the Health Insurance Association of America, and they are in the process of identifying a representative of the commercial insurance sector for the Advisory Committee. It is important to identify such an individual promptly, since we believe that this will enhance the cooperation of the commercial insurance sector with our efforts.

Work during the next month will be devoted to further data collection and to drafting the first two reports. As we discussed at the January meeting, we will return to Anchorage on February 23 to give a progress report to the Advisory Committee and have a working session on the development of options for state action. We are planning on a one-day meeting, and hope that we can devote the bulk of it to a working session on the state's options.

This early Advisory Committee input on options is important since the range of issues to be dealt with is broad and time is tight. As examples of areas in which the state might intervene to improve the health care system, we could consider the following:

1) The state could act to broaden coverage. This might be through regulation which mandated that employers offer health plans to workers, through promotion of voluntary efforts via taxes and subsidies to employers or consumers, through regulation to "assign" high risk individuals to private insurance pools, or through direct state provision of a health insurance plan.

2) The state could act to promote minimum benefit packages in private insurance. This again could be through regulation or market incentives. In addition to minimum benefit packages, the state might use the same mechanisms to encourage other features in health insurance plans (such as cost sharing features or elegibility criteria).

3) The state could act to promote efficient behavior by providers. Examples of this would be the elimination of cost reimbursement in public programs in favor of other reimbursement methods or discouraging "usual, customary, and reasonable" pricing provisions in health insurance contracts. The attractiveness of these options depends upon how strongly the committee feels that cost containment is a key objective. The state might also attempt to influence where providers choose to practice by various subsidy schemes.

4) The state could act to promote healthy and efficient behavior by consumers. Examples of this would be to mandate or promote provisions in insurance contracts which encouraged preventive care, to reward consumers who can demonstrate healthy behavior with lower insurance premiums or subsidies, or to promote insurance features which reward the individual financially for staying healthy.

We hope to discuss these and other options at the February meeting. Indeed, it might be valuable to circulate this letter to the Advisory Committee in order to give an "advance preview" of that meeting.

The project is currently proceeding on schedule.

Sincerely,

John Wills

John Wills, Ph.D.
Research Scientist

JW:kd

cc: Suresh Malhotra
Andrew Dolan
Jack Fargnoli
William Sanford

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

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

April 27, 1981

The Honorable Charles H. Parr
Alaska State Senate
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Senator Parr:

As the 1980 legislature envisioned, by an appropriation to the Department of Health and Social Services for a health care study project, the department proceeded immediately to implement the "Alaska Comprehensive Health Care and Financing Study." The Battelle Human Affairs Research Institute was the successful bidder and has proceeded on schedule to conduct the study.

In December 1980, we furnished you with a then-current "Status Report" on developments to that date. By way of keeping you informed as to continuing progress on the study we are pleased to furnish you herewith: Interim Report No. 1: "A Survey of Health Care Resources and Financing in Alaska"; and Interim Report No. 2: "Options for State Action."

The Advisory Committee for the study (list enclosed) continues to meet regularly to confer with the Battelle scientists and departmental representatives. The Committee will meet next on May 7, 1981 to complete work on recommendations for two or three alternative approaches or options for Battelle to develop with all necessary details for consideration by the Department, the Governor, and the Legislature as to potential future state policies and programs in health care and financing.

The work of Battelle, the Department, and the Advisory Committee will continue throughout 1981. Certain additional data, not now available, will need to be secured and evaluated. The final study report is due in December of 1981.

The continued support and interest by the legislators are appreciated very much. Please let us know if we can furnish you any other information regarding this project between now and December when the final report will be completed. It is anticipated that recommendations for legislative considerations and actions will be available not later than the first month of 1982.

Sincerely,

Helen D. Beirne

Helen D. Beirne
Commissioner

06-F38LH Enclosures: Advisory Committee List, Interim Report No. 1 and Interim Report No. 2.

BRIEFING PACKET

State of Alaska
Comprehensive Health Care Financing Study

CONTENTS

From: Office of the Lieutenant Governor

State of Alaska
Comprehensive Health Care Financing Study

OVERVIEW

The Comprehensive Health Care Financing Study emerged in 1980 as part of this administration's emphasis on human resources in its long term investment strategy. The rationale was that, if an acceptable approach could be found, the state's currently favorable financial position might be used to establish a structure for providing increased health benefits to Alaskans well into the indefinite future. Accordingly, this study was initiated to explore, from a variety of viewpoints, a full range of broad and innovative approaches to the entire question of health care financing in Alaska. Now under way, the study also seeks to explore alternative means of expanding personal health care coverage, and improving both physical and financial access to health care services.

The first phase of the study will conclude on March 30, 1981, at which time policy makers will have their first look at the menu of possible health care financing approaches available. During the study's second phase, which will conclude on December 11, 1981, two or three overall approaches will be selected for detailed study, public review, and the work-up of alternative implementation plans.

Naturally, an undertaking on this scale cannot be accomplished overnight or without the participation of the public and numerous interested parties. The project's organization, therefore, has been designed to maximize the input available from all sectors. A thirteen-member advisory committee has been appointed for the project, representing the public and directly affected parties, and an outreach effort has been initiated to interface with other interested groups, individuals and the Legislature.

* * *

06-F1LH

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF DEPUTY COMMISSIONER

ROOM 214 MacKAY BUILDING
538 DENALI STREET
ANCHORAGE 99501

STATUS REPORT: DECEMBER 18, 1980

ALASKA COMPREHENSIVE HEALTH CARE AND FINANCING STUDY PROJECT

BACKGROUND

For about three years, discussions developed within the Department of Health and Social Services, the Office of the Governor, State Health Coordinating Council and other parties at interest in Alaska. In addition, several conferences were held with U.S. Department of Health, Education and Welfare in Seattle (Region X) and Washington, D.C. Discussions centered on health care and financing.

Several issues were faced in those consultations:

1. For a number of years, delays were encountered in active planning for an improved delivery and financing system for Alaska because of the prospect of the National Health Insurance program being enacted by the Federal Congress. While numerous discussion continues to go forward with regard to a National Health Insurance program, it continues to appear that the enactment of and the implementation of such a plan are receding farther and farther into the future.

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

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

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

The Indian Health Service, the Alaska Native Health Corporations and the insurance industry serving Alaska have strong interests. Other important interests to be considered exist: the planning arm of our department, S.H.P.D.A., the Office of Planning and Research of the Governor's Office, local, regional health planning agencies and the State Health Coordinating Council. As plans develop, all such segments with interest in such a program will be involved in the planning, goal and objective setting, and implementation phases of any new program.

5. Apart from social and health policies concerned and apart from the different funding mechanisms and health providers, there is a national, as well as Alaskan, growing concern over the spiraling medical care costs.

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

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

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

7. A careful analysis of a part of public spending for health in Alaska on the federal and state levels easily identifies approximately $212,361,000 budgeted for FY-81 for health programs (excluding capital expenditures) through our Department and the Indian Health Service alone. Other expenditures related to military personnel (active and retired) would be on top of that and would be substantial. In addition, special federal grants to the Native health corporations and other organizations in Alaska

probably would bring the total into the $225,000,000 annual range during FY-81. Those figures exclude also the health care coverage of State, federal and local government employees covered under health insurance programs. Such costs represent an outlay of public funds on behalf of those employees of government at all levels in Alaska. Excluded also are industry, business and private insurance programs. In 1977, at least $84,822,000 in health care and accident insurance premiums were paid.

8. Considerable amount of research was deemed necessary before Alaska could develop a definitive statement as to the total actual expenditures for health program services in the state. Such research was planned so that facts could be developed as completely and as accurately as possible as to the status of spending at the present time. Current "health status" of Alaskans would need to be determined. Any proposal for a revised program of health delivery in the state should be based upon sound statistical and fiscal data and should be able to demonstrate an improvement over the present system. Any proposal for change would need to be acceptable to private medical care providers.

9. Alaska's Senator Ted Stevens, in 1979, surveyed certain attitudes of Alaskans with regard to national health assistance programs and published the following summary based on 15,000 participants:

"Question 10:
Health assistance is currently available thorugh Medicare and Medicaid to the indigent and the elderly at a cost to the taxpayers of about $46 billion annually. Proposals before Congress to expand national health assistance range fron Senator Kennedy's proposed comprehensive national health insurance plan costing another $40 billion, to a limited catastrophic health insurance plan to cover expenses of long term, high cost illnesses, at an additional cost of $3.5 billion. Which of the following best summarizes your views on our national health assistance programs?

36.0% - Favor an additional limited health insurance program to cover catastrophic illness costs only.

23.2% - Favor a reduction in the current Medicare/Medicaid system.

19.5% - Favor a comprehensive national health insurance plan.

15.1% - Favor the current Medicare/Medicaid system.

5.8% - No opinion/other."

10. Alaska's total health care systems and financing plans, public and private, although not perfect have enormous strengths and generous provisions.

Fundamental and residual concerns include:

(1) Continuing rise in health care costs
(2) Effects of spiraling costs on all segments of society - consumers, employees, employers and government
(3) Although voluntary efforts by health care industry to control costs have met with limited success expenditures will continue to increase until more adequate solutions are found
(4) Since Congressional National Health Insurance proposals pending do not commend themselves as being beneficial for Alaska; a unique, bold and creative plan is called for to serve Alaskans in a better way than at present.

11. It is possible that one option resulting from the study could include replacement of stringent government regulatory controls with application of "free-market" oriented principles designed to:

(1) Foster competition among alternative health care plans, including financing mechanisms;
(2) Replace the government retroactive cost-plus reimbursement systems with fixed-premium financing that reflects competitive pricing in the market-place;
(3) Provide consumer participation, cost-sharing and informed choice, and
(4) Rechannel financial resources saved into improved access for medically needy citizens not now covered.

The Planning and Design Consultant will develop several alternative proposals for consideration.

PRELIMINARY CONSULTATIONS, BRIEFINGS AND DEVELOPMENTS

1. Preliminary consultations and briefings were developed with:

State of Alaska:

Department of Health and Social Services' officials, Office of the Governor and Lieutenant Governor, State Health Planning and Development Agency, State Health

Coordinating Council, Department of Commerce/
Risk Management, Governor's Office of Policy Planning
and Development

U.S. Department of Health, Education and Welfare:
Region X (Seattle):
Health Services Administration
Health Care Finance Administration
Regional Directors Office

Washington, D.C.:
Health Services Administration
Indian Health Service (U.S. Public Health Service)
Health Policy, Research and Statistics
Health Care Finance Administration

Other:
State of Hawaii, Departments of Labor,
Public Assistance and Health;

Center for Health Services Research,
University of Washington, Seattle

2. On September 19, 1979, Governor Jay Hammond gave formal approval to the project and authorized the Department to take necessary steps to implement the project. The Governor subsequently, formally, delegated the Lt. Governor to represent the Office of the Governor in matters related to the project.

3. The Alaska Legislature appropriated $170,000 for the Health Care Study project at the session closing June 6, 1980. The Department took necessary steps to initiate the study following the approval of the funds.

4. The Request for Proposals were developed, advertised widely and released on October 15, 1980. Over 125 firms nationwide have requested the proposal. Offers to perform the work proposed will be opened on November 17, 1980. It is planned to award the contract for the work mid-December 1980.

RATIONALE FOR STUDY

The State of Alaska is conerned with the cost and availability of adequate health care for all Alaskans. Health care is a complex mix of government and private coverage financing and delivery systems and programs. Financing of coverages and access to services exists with little or no coordination or cohesion. Since the entry of the federal government into the mainstream of health care with the initiation of the Medicare and Medicaid programs, the cost of health care has increased at an alarming rate. While the proposals

and debates in Washington, D.C. continue through the years over whether there should be a national health care program, state and local governments, industry, labor and private citizens wrestle with the effects of uncontrolled costs and access to services.

Some states have considered the question and decided that the cost of assuring the availability of mainstream health care to all individuals, regardless of ability to pay, is unrealistic and unaffordable. Other states, faced with increasing Medicaid caseloads and declining state revenues, have sought to eliminate fraud and abuse in the programs, reduce payment levels and reduce the amount of services provided. These attempts have met with varying degrees of success and failure. The overall problems of inefficiency, improper utilization, and the inequities of the health care delivery and financing systems have not been solved.

With Alaska's relatively small population and a high percentage of people covered under one or more health care systems or plans, it would appear that Alaska could adjust its present approaches, policies, and programs to create a comprehensive, cost-effective, and efficient health care coverage and financing system, characterized by improved access to health care services to individuals.

TIME SCHEDULE FOR STUDY

1. Selection of advisory committee - September 25, 1980.
2. Release of RFP - October 15, 1980.
3. Final date for submittal of proposals - November 17, 1980.
4. Evaluation of proposals and recommendations - November 21, 1980.
5. Awarding of consultant contract - December 1, 1980.
6. Approval of contract and signing; begin Phase I - December 12, 1980.
7. Completion of Phase I document - March 30, 1981.
8. Evaluation by DHSS and the advisory committee, selection of alternative approaches; begin Phase II - May 15, 1981.
9. Completion of Phase II document; submittal of preliminary final draft to advisory committee for evaluation and comments - September 18, 1981.
10. Completion of public meetings and evaluation by DHSS and the advisory committee - October 30, 1981.
11. Completion of final document and submittal to DHSS, the Governor, and if deemed necessary, the Legislature - December 11, 1981.

CONTRACT ACTIVITIES

The contractor selected will be required to perform the following major tasks during the two phases of the overall study:

Phase I

1. Prepare an initial planning document which describes the present modes of public and private health care delivery, access, coverage and financing in Alaska, and which presents in conceptual terms major alternative approaches that the State of Alaska might pursue to reconfigure such modes (particularly as regards access, coverage, and financing), either wholly or in part.

Phase II

2. Prepare a final planning document which assesses in detail the feasibility, including financing of, and outlines an implementation plan for, two or three of the alternative approaches identified in Phase I, above, as selected by the Governor, DHSS and the Advisory Committee for further consideration.

It is recognized that the State does not, except in very few instances, directly provide health care services or "service delivery". The focus of the study is therefore primarily on identifying alternative methods of health care coverage and financing, and of improving access to and coverage for health care services. The broad scope of this search for alternatives does necessarily involve scrutiny of the existing services delivery systems, but only insofar as knowledge of those systems is essential for improving coverage, financing and access. References to analyzing or reconfiguring the existing health care delivery system in Alaska, therefore, pertain chiefly to those services currently provided directly by the State of Alaska. While no identified alternative approach, including approaches to services delivery, is beyond the compass of this study, the improvement of health care coverage, access and financing constitute the study's primary goals.

The contractor also will be responsible for presenting these two documents, at specified times and in the manner specified to the Governor, DHSS, the Advisory Committee and the interested public.

PHASE I: INITIAL PLANNING DOCUMENT:

The contractor selected will be responsible for preparing an initial planning document for presentation to the Governor, DHSS and the Advisory Committee not later than March 30, 1981.

The initial planning document will comprise two separate but related reports:

1. A report which describes analytically and separately, for both the public and private sectors, the present modes of health care delivery, coverage and financing in Alaska, as well as the present demographics of access to health care services and coverage. This report will essentially serve as

the data base for formulation and subsequent evaluation of the alternative health care coverage and financing approaches. As such, it should contain the following as a minimum:

a. A survey of all relevant data describing the providing and cost of health care services in Alaska, both public and private (including but not limited to the State of Alaska, the federal government and the Indian Health Service, military and veterans' health care, and private providers), and a summarized but thorough description of these services and costs;

b. A survey of all relevant data describing the present systems of health care coverage and financing in Alaska, including the costs involved as well as gaps or duplications in coverage, and a summarized but thorough description of these systems, costs, gaps and duplications;

c. A determination of the total cost of health care in Alaska under the present systems, with projections for the next five to ten years;

d. A determination of the number and types of individuals in Alaska with inadequate or no health care coverage (and the cost of providing that care or coverage), duplicate forms of coverage, coverage by no access to health care services, and coverage and access but insufficient financial resources to meet deductible requirements in coverage; and,

e. 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.

Besides serving as a data base for the alternative health care access, coverage and financing approaches, this report is intended to identify gaps, duplications, problems and cost inefficiencies in the present statewide health care coverage and financing system. It is also intended to provide DHSS and the Advisory Committee with information necessary to assess the direction being taken by the contractor, and to provide input into the final Phase 2 product.

2. A report which presents in conceptual terms major alternative approaches that the State of Alaska might pursue to reconfigure present modes of health care delivery, access, coverage and financing in the State either wholly or in part. The report should necessarily emphasize reconfiguration of those elements of the statewide health services system which it is in the interest of the State of Alaska to change, (access, coverage, and financing, as well as those health services directly provided by the State), but also should not exclude necessarily the possibility of more comprehensive reconfigurations.

A broad spectrum of possible involvement by the State of Alaska should be considered in this report, including at least the following potential roles (or combination thereof) which the State might play: (1) as a subsidizer of private health coverage programs: (2) as an intervenor in health care coverage or financing through statutory or regulatory reform: and, (3) as a direct provider and financer in limited cases (as at present) of health care services.

As such, the following possible approaches should be considered, along with preliminary indications of their impact and feasibility, as a minimum:

a. the possibility of an insurance subsidy program with an established minimum benefits package available from private insurers, with State payment of premiums, based on a sliding fee scale determined by individuals' ability to pay, for individuals for whom the State bears financial responsibility for health care;

b. the possibility of conventional and high-risk health insurance coverage for wage earners, including part-time employees, through the use of income tax credits and/or employer tax credits in lieu of direct payments;

c. the possibility of increasing access to medical services and extending health care coverage to individuals currently not covered or inadequately covered;

d. the possibility of improved alternatives for health care access, coverage and financing for rural areas of the State;

Because of the interrelationship of State, federal and private health care and financing sources, any new approaches to health care delivery and financing suggested in this report should be based on at least the following:

a. a review of State and federal laws and regulations which could affect an alternative approach to health care delivery and financing in Alaska;

b. a review of the level of direct health care services provided by the federal government in Alaska for U.S. Civil Service employees and their dependents, active and retired military employees and their dependents, veterans and members of the Merchant Seaman Service, including their expected level of utilization of the private health care delivery system in Alaska in the next five to ten years;

c. a review of the level of Indian Health Service funding to tribal organizations and non-profit organizations under the federal Indian Health Care Improvement Act, and the effect of that funding on the future delivery of health care services in rural Alaska;

d. a consideration of the anticipated future levels of federal planning and funding for health maintenance operations and prepaid health plans in Alaska;

e. a consideration of the relative effectiveness and efficiency of State versus federal versus municipal versus private initiative in planning for health care access, coverage, financing and administration; and,

f. a review and analysis of available results of studies completed on "cost sharing" by patients; applicability of "cost sharing" for current Alaska State programs and any proposed revised programs and financial impact of implementation of "cost sharing" by patients at selected levels of payments by the patients.

PHASE 2: FINAL PLANNING DOCUMENT

The contractor selected as a result of this RFP will be responsible for preparing a final planning document of preliminary presentation to DHSS, the Advisory Committee and the interested public not later than September 18, 1981.

The final planning document will provide a complete plan for implementing and financing each of the two or three alternative approaches to health care coverage and financing which have been selected by DHSS and the Advisory Committee in Phase I of the overall study.

The final planning document shall be as specific as possible as regards the implementation and financing steps to be taken by the State of Alaska, including at a minimum the following: time-frames; policy and administrative decisions to be made; explanation and uses of the methodologies employed to develop financing costs; feasibility, impact and purposes of approaches developed; sources of conflict and identified competing interests; statutory and regulatory changes necessary; funding sources and fiscal mechanisms to be utilized; and other relevant information necessary to select and implement the health care coverage and financing approaches under study. Options related to each alternative approach developed shall be presented with cost differentials for each option so identified.

On the cost side, the alternatives should be evaluated in each phase as to the potential cost implications of implementing that phase - as it would affect state, local, and federal government, the private health care industry, non-profit health care organizations, consumers and health insuring organiations.

A preliminary draft of the final planning document will be submitted to DHSS and the advisory committee by September 18, 1981. DHSS and the advisory committee will review the material and prepare written comments, criticisms, and recommendations. The final planning document, including substantive public comments and the advisory committee report, will be prepared by the contractor and submitted to DHSS and the advisory committee not later than December 11, 1981. The final planning document will be presented to the Governor and the Legislature

by DHSS with the participation of the contractor.

DHSS PROJECT ORGANIZATION

The following is a general description of the functions of the advisory committee, the steering committee, and the project coordinator.

1. Advisory committee - the advisory committee will act as the sounding board for the DHSS and the contractor. The advisory committee will not be the decision-making body for the contract. The advisory committee will be responsible for assuring that the contractor is progressing toward the goal of the project and to assure that all facets of the present delivery and financing systems are taken into consideration. The contractor should be prepared to meet with the advisory committee at least bi-monthly over the life of the project.

2. Steering committee - the steering committee will be the decision-making body for the life of the contract. The steering committee will be responsible for assuring that all deliverables are produced on schedule and that they fulfill the requirements of the contract. The steering committee will make modifications to the contract if necessary and will provide the contractor with any entree necessary to secure information from the State to complete the contract.

3. Project coordinator - the project coordinator will be the focal point of all contact between the contractor and the steering committee and advisory committee. The project coordinator will meet regularly with the contractor and will be responsible for assuring that deadlines are not delayed because of scheduling problems with committee members or difficulty in securing needed information from departmental sources. All communications by the contractor should be addressed to the project coordinator.

ATTACHMENTS:

No. 1 : Evaluation Committee Members and Agenda : Criteria

No. 2 : Advisory Committee Members and Agenda

STATE
of ALASKA

MEMORANDUM

RECEIVED
DEC 22 1980
LT. GOV'S OFFICE

TO: Lt. Governor Terry Miller
Attn; Jack Fargnoli

DATE : December 17, 1980

FROM:

Frederick McGinnis
Deputy Commissioner
Health and Social Services

SUBJECT:

Copy of letter and attachments mailed today: For Information: Alaska Health Care and Financing Project

Attached herewith for your information and files you will find a copy of a letter one of which was mailed to each legislator today along with the attachment indicated on the letter.

This transmittal is made to you in order to keep you informed as to this particular development related to the project.

Copies of the Memorandum to:

Commissioner Beirne
Deputy Commissioner Korhonen
Deputy Commissioner Tirador
Special Assistant Deborah Behr

Governor Jay Hammond : Attn: Carole Burger
Lt. Governor Terry Miller: Attn: Pete Rouse
Attn: Jack Fargnoli
Mr. Keith Specking: Legislative Assistant

STATE OF ALASKA
DEPT. OF HEALTH AND SOCIAL SERVICES
OFFICE OF THE COMMISSIONER

JAY S. HAMMOND, GOVERNOR
POUCH H 01 – JUNEAU 99811

December 17, 1980

Senator Arliss Sturgulewski
2957 Sheldon Jackson Street
Anchorage, Alaska 99504

Dear Senator Sturgulewski:

The 1980 legislature appropriated $170,000 for the Department of Health and Social Services to provide for a "Health Care Study". The funds for the study were recommended by the Department with the strong support of the Governor and interested legislators.

This letter is sent to all legislators to express appreciation for legislative support and provisions for the study and to furnish you with the enclosed "Status Report" on the project to date. Your review of the Status Report is invited. We believe the study results will provide the needed data and policy options for possible state actions during the 1982 session of the legislature.

You will be interested to know that the Request for Proposals to conduct the study was requested by over one hundred twenty firms. Nine organizations submitted offers to conduct the study. A special nine person Evaluation Committee (see attachment No. 1 to Status Report) reviewed and ranked the offers and recommended award of contract to Battelle Human Affairs Research Center of Seattle provided all the Department's contract terms could be met. The contract should be executed fully within a few days.

The Advisory Committee (see attachment No. 2 to Status Report) has had it's first meeting and will meet next the first week in January.

The Phase I of the contractor's work described in the Status Report will be completed March 30, 1981. Phase II is scheduled for completion and submittal December 11, 1981.

The Departmental Project Coordinator for the study project is Deputy Commissioner Frederick McGinnis, 214 MacKay Building, 338 Denali Street, Anchorage, 99501. Your comments, recommendations and questions would be welcomed and should be sent to the Project Coordinator at the address indicated.

Your interest in and continued support of the study project are appreciated very much.

Sincerly,

Helen D. Beirne

Helen D. Beirne
Commissioner

Enclosure: Status Report

05-F1LH

STATE OF ALASKA

ATTACHMENT NO. 2

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF DEPUTY COMMISSIONER

ROOM 214 MacKAY BUILDING
332 DENALI STREET
ANCHORAGE 99501

ADVISORY COMMITTEE FOR COMPREHENSIVE HEALTH CARE AND FINANCING STUDY

JANUARY 5, 1981

COMMITTEE MEMBERS:

James M. Armbrust
Statewide Health Coordinating Council
c/o Alaska Area Native Health Service
Box 7-741
Anchorage, Alaska

Tom Mingen
Alaska State Hospital Association
c/o Fairbanks Memorial Hospital
1650 Cowles Street
Fairbanks, Alaska 99701

Tom Morehouse
Insitute of Government Research
700 A Street
Anchorage, Alaska 99501

Jack Fargnoli
Office of the Lieutenant Governor
State of Alaska
Pouch AA
Juneau, Alaska 99811

Carole Burger
Office of the Governor
State of Alaska
Pouch A
Juneau, Alaska 99811

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

David E. Johnson
Alaska State Medical Association
3612 Tongass Avenue
Ketchikan, Alaska 99901

COMMITTEE MEMBERS (cont.):

Leslie Goss → Sharman Haley
Alaska Public Interest Research Group
P.O. Box 1093
Anchorage, AK 99501

Glenn Hackney (Public Interest Member)
1136 Sunset Drive
Fairbanks, AK 99701

(NOTE: It is anticipated that several additional appointments may be made to the committee - additional Public Interest Member; Region X, Department of Health & Human Services; Insurance Industry; Department of Health & Social Services.)

PROJECT DIRECTOR:

Frederick McGinnis
Deputy Commissioner
Department of Health & Social Services
214 McKay Building
338 Denali Street
Anchorage, AK 99501

STEERING COMMITTEE:

Carole Burger, Special Assistant
Office of the Governor

Jack Fargnoli, Special Assistant
Office of the Lieutenant Governor

Frederick McGinnis, Deputy Commissioner
Department of Health & Social Services

06-F,1 LH

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF DEPUTY COMMISSIONER
ROOM 214 MacKAY BUILDING
338 DENALI STREET
ANCHORAGE 99501

EVALUATION COMMITTEE
FOR AN
ALASKA COMPREHENSIVE HEALTH CARE AND FINANCING STUDY
PLANNING AND DESIGN CONSULTANT

November 24-26, 1980
State Office Building
Department of Commerce
9th Floor
Juneau, Alaska

1. Dr. Robert Day, Dean
   School of Public Health
   Center for Health Services Research
   University of Washington
   Seattle, Washington 98195
   (206) 543-8683

2. Lee Gorsuch (or Designee)
   Director
   Institute of Social and Economic Research
   University of Alaska
   707 A Street Room 206
   Anchorage, Alaska 99504
   (907) 278-4621

3. Janice Rae Cole
   Division of Policy Development and Planning
   Office of the Governor
   State of Alaska
   Pouch AD
   Juneau, Alaska 99811
   (907) 465-3577

--Continued--

4. Fred Mueller
Deputy Commissioner
Department of Administration
Pouch C.
Juneau, Alaska 99811
(907) 465-2200

5. Robert A. Hall (or Designee)
Director
Municipality of Anchorage
Department of Health and Environmental Protection
825 L Street
Anchorage, Alaska 99501
(907) 264-4621

6. Phoebe Lindsey, Director
State Health Planning and Development Agency
Department of Health and Social Services
Pouch H-01A
Juneau, Alaska 99811
(907) 465-3038

7. Carole Burger
Office of the Governor
Pouch A
Juneau, Alaska 99811
(907) 465-3500

8. Jack Fargnoli
Office of the Lieutenant Governor
Pouch AA
Juneau, Alaska 99811
(907) 465-3520

9. Frederick McGinnis
Deputy Commissioner
Resource Individual for Information/Project Coordinator
Department of Health and Social Services
214 MacKay Building
338 Denali Street
Anchorage, Alaska 99501
(907) 278-4668

EVALUATION OF THE PROPOSAL

5-1 EVALUATION COMMITTEE

A committee composed of representatives of government and interested groups will be appointed to evaluate the proposals. The criteria listed below will be used to evaluate the proposals for the purpose of ranking them in relative position based on how fully each proposal meets the requirements of this RFP. Particular emphasis will be placed on the offeror's description of how the activities will be performed.

5-2 OBJECTIVE

The objective of the State in soliciting and evaluating proposals is to ensure the selection of a firm that will produce the best possible results for the expended funds.

5-3 MINIMUM REQUIREMENTS

All proposals will be evaluated first to ensure that they meet the minimum requirements of the RFP. Proposals that fail to address all of the requirements will receive no further consideration.

5-4 EVALUATION METHOD

Percent

25% a. Technical Credibility - Demonstrated understanding of the end product requirements; soundness of technical approach to satisfy these requirements including demonstrated ability to develop a final report.

25% b. Management Credibility - Soundness of the management plan for accomplishing objectives in light of technical approach, schedule factors, project control methods, as well as interface with DHSS, reporting, and related relationships.

25% c. Technical Resources to be Provided - Quality of expertise that will specifically be brought to bear on this project. This includes evaluation of the experience and qualifications of individuals that will be assigned to the project.

25% d. Related Experience - References that demonstrate a capability in performing work similar to the specific objectives in the statement of work of this RFP.

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

EVALUATION COMMITTEE - PRELIMINARY AGENDA
ALASKA COMPREHENSIVE HEALTH CARE AND FINANCING STUDY PROJECT

NOVEMBER 24-26, 1980
CONFERENCE ROOM, DEPARTMENT OF COMMERCE, JUNEAU, ALASKA

1. Introduction of Members and Welcome
2. Review and Revision of Agenda
3. Summary Briefing on Project
4. Selection of Chairperson and Recorder for Committee
5. Opening and Logging of Proposals Received
6. Development of Committee Procedures
7. Development of Standards/Criteria for Evaluation of Proposals
   Review PART V 5-1 through 5-4 of the RFP (Attached)
8. Oral Presentations by Offerors (Schedule Attached)
9. Review of Proposals for Evaluations
10. Development of Recommendation to Department
11. Other Considerations as Determined by Committee
12. Future Meetings Discussions and Adjournment

(7)

COST PROPOSAL

ALASKA COMPREHENSIVE HEALTH CARE AND FINANCING STUDY

In response to

a request for proposals from the
Department of Health and Social Services
State of Alaska

November 1980

Battelle Proposal No.: P24187

Battelle Memorial Institute
Human Affairs Research Centers
4000 N.E. 41st Street
Seattle, Washington 98105

Appendix B-2
Cost/Pricing

Estimated Budget

	Task 1		Task 2		Task 3		Task 4	
	Hours	Amount	Hours	Amount	Hours	Amount	Hours	Amount
Personnel								
S Malhotra	50	$1,362	-0-	$ -0-	50	$ 1,362	-0-	$ -0-
E Perrin	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
K McCaffree	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-
J Wills	100	2,183	50	1,091	60	1,309	25	545
C Hart	150	1,303	50	434	-0-	-0-	-0-	-0-
Secretary	66	552	-0-	-0-	67	561	-0-	-0-
Total Personnel		$5,400		$1,525		$ 3,232		$ 545
Travel								
Seattle/Anchorage/Juneau/Seattle 5 trips, 1 person, 2 days								
Airfare	$1,141				$ 570			
Subsistence	248				124			
Ground Transportation	248				124			
Seattle/Anchorage/Juneau/Fairbanks/Seattle								
Airfare								
Subsistence								
Ground Transportation								
Total Travel		1,637				818		
Consultant								
15 days @ $250/day						1,562		
Data Processing		500		500				
Subcontract								
Management and Planning Services/Alaska (see Schedule A for detail)		17,251		1,375		5,130		-0-
Other Direct Costs								
Telephone	$ 345		$90		$165		$30	
Duplicating	173		45		304		15	
Word Processing	179		47		550		16	
Materials and Supplies	40		10		20		5	
Total Other Direct Costs		737		192		1,039		66
Total Direct Costs		$25,525		$3,592		$11,781		$ 611
Staff Time Overhead								
36% of Direct Labor		1,944		549		1,164		196
General & Administrative Costs								
42% of Direct Costs and Staff Time Overhead excluding the amount over $25,000 on any subcontract.		11,537		1,740		5,437		339
Total Cost		$39,006		$5,881		$18,382		$1,146
Fixed Fee		3,511		529		1,654		103
Total Cost + Fee		$42,517		$6,410		$20,036		$1,249

Estimated Budget

	Task 5		Task 6		Task 7		Task 8		Total Project	
	Hours	Amount	Hours	Amount	Hours	Amount	Hours	Amount	Hours	Amount
Personnel										
S Malhotra	100	$ 2,723	-0-	$ -0-	50	$ 1,362	-0-	$ -0-	250	$ 6,809
E Perrin	40	1,535	-0-	-0-	-0-	-0-	-0-	-0-	40	1,535
K McCaffree	40	1,356	-0-	-0-	-0-	-0-	-0-	-0-	40	1,356
J Wills	75	1,636	40	873	-0-	-0-	50	1,091	400	8,728
G Hart	100	868	-0-	-0-	-0-	-0-	-0-	-0-	300	2,605
Secretary	67	561	-0-	-0-	-0-	-0-	100	837	300	2,511
Total Personnel		$ 8,679		$ 873		$ 1,362		$1,928		$ 23,544
Travel										
Seattle/Anchorage/Juneau/Seattle 5 trips, 1 person, 2 days										
Airfare	$570				$571				$2,852	
Subsistence	124				124				620	
Ground Transportation	124				124				620	
Seattle/Anchorage/Juneau/Fairbanks Seattle 1 trip, 1 person, 3 days										
Airfare					656				656	
Subsistence					211				211	
Ground Transportation					161				161	
Total Travel		818				1,847				5,120
Consultant										
15 days @ $250/day		2,188								3,750
Data Processing		500								1,500
Subcontract										
Management and Planning Services/Alaska (see Schedule A for detail)		12,456		13,855		7,880		2,200		60,147
Other Direct Costs										
Telephone	$ 405		$45		$45		$135		$1,260	
Duplicating	203		22		22		508		1,292	
Word Processing	211		23		23		998		2,047	
Materials and Supplies	45		5		5		16		146	
Total Other Direct Costs		864		95		95		1,657		4,745
Total Direct Costs		$25,305		$14,823		$11,184		$5,785		$98,806
Staff Time Overhead										
36% of Direct Labor		3,125		314		490		694		8,476
General and Administrative Costs										
42% of Direct Costs and Staff Time Overhead, excluding the amount over $25,000 on any subcontract		7,315		538		1,593		1,797		30,396
Total Cost		$35,945		$15,675		$13,267		$8,276		$137,678
Fixed Fee		3,235		1,411		1,194		745		12,391
Total Cost + Fee		$39,180		$17,086		$14,461		$9,021		$150,069

TECHNICAL PROPOSAL

ALASKA COMPREHENSIVE HEALTH CARE AND FINANCING STUDY

In response to

a request for proposals from the
Department of Health and Social Services
State of Alaska

November 1980

Battelle Proposal No.: P24187

Battelle Memorial Institute
Human Affairs Research Centers
4000 N.E. 41st Street
Seattle, Washington 98105

Appendix B-1 Performance of Services and Statement of Work
Pages 1 through 47

III. TECHNICAL APPROACH

A. Objectives

The specific objectives of the proposed study are to:

- identify systemic and financial barriers to access to health care in Alaska;
- identify problems of inefficiency caused by duplication of coverage or other features implicit in the health care financing system;
- propose a set of specific actions which the state could take to address the problems identified;
- evaluate the feasibility of several selected alternatives, as well as their impact on the population and on state and local governments; and
- prepare an implementation plan for each of the selected alternatives.

We propose a work plan which will meet these objectives by carrying out eight major tasks, described below.

B. Specific Tasks

The specific tasks and subtasks to be carried out in the course of this study are listed below. Immediately following this list is a description of each task.

Task 1: Identify inadequacies in coverage and access to care in Alaska.

- Subtask 1-A: Collect data necessary for description of coverage, access, and costs.
- Subtask 1-B: Identify who is and is not covered by a health insurance or health care plan.
- Subtask 1-C: Identify population with coverage but without access to health care, and evaluate the importance of deductibles and copayments as barriers to access.

Task 2: Estimate current and forecast future cost of health care system in Alaska.

- Subtask 2-A: Estimate current total cost of health care in Alaska.
- Subtask 2-B: Project the total cost of care under the current system into the future

Task 3: Identify alternative options for achieving comprehensive health care coverage and eliminating barriers to access.

Subtask 3-A: Identify specific problems to be addressed by the State, both in the short and long run.

Subtask 3-B: Examine the salient features of the legal system which define the State's scope for intervention.

Subtask 3-C: Survey approaches used in other states, as well as other innovations which may apply to Alaska.

Subtask 3-D: Delineate a set of options for presentation to the advisory committee.

Task 4: Identify any further data requirement for evaluation of options.

Task 5: Conduct feasibility study of options selected by advisory committee.

Subtask 5-A: Specify new financing mechanisms required to implement the selected options.

Subtask 5-B: Collect any further data required for analysis.

Subtask 5-C: Evaluate the legal and regulatory options.

Subtask 5-D: Estimate fiscal impact on state and local governments.

Subtask 5-E: Identify social/political barriers to implementation.

Task 6: Prepare implementation plans for selected options.

Task 7: Present options to public meetings of interested parties.

Task 8: Incorporate suggested revisions into final planning document.

January 5, 1981

DRAFT OUTLINE OF REPORTS #1 AND #2
STATE OF ALASKA HEALTH CARE FINANCING PROJECT

REPORT #1:
HEALTH CARE IN ALASKA: FINANCING, COVERAGE, SERVICES, AND COSTS

I. Executive Summary

II. Introduction and Overview

III. Who Pays for Health Services In Alaska?

- A. Third Party Reimbursement
  - 1. Private Sector
    - a. Commercial insurers
    - b. Blue Cross/Blue Shield
    - c. Self-insured trust funds
  - 2. Public Sector
    - a. Medicare
    - b. Medicaid
    - c. General Relief Medical
    - d. Veteran's Administration
- B. Direct Service Provision
  - 1. AANHS
  - 2. Native Corporations
  - 3. State of Alaska
  - 4. Military
- C. Consumer Out-of-Pocket Expenditures
  - 1. Due to lack of coverage
  - 2. Due to cost-sharing by covered individuals
- D. Who finances the third party reimbursers and direct service providers?
  - 1. Beneficiary premiums
  - 2. Employer premiums
  - 3. General tax revenue
  - 4. Other revenue sources
- E. Summary

The health care costs of society are always ultimately borne by one or another segment of the general public. In the summary, we will draw out of this chapter:

- a snapshot of the pattern of health service financing as it exists now,
- a discussion of the implicit transfers among groups in the society, and
- an indication of problem areas in health service financing.

IV. Who is covered, and for what benefits?

A. Coverage

1. Who are the uncovered?
2. How is coverage affected by economic conditions?

B. Benefits

1. Among the covered population, what benefits are provided? What gaps in services exist?

C. Summary: Identification of problem areas

V. Health Services and Access to Care in Alaska

A. Service delivery in Alaska: How well does it meet Alaska's special needs?

B. Non-financial barriers to access

1. Geographic
2. Administrative
3. Social/Cultural

C. Summary: How can financing or administrative arrangements lower the barriers to access identified in this chapter? (Some barriers will not be affected by financial or administrative arrangements, and so are beyond the scope of this study.)

VI. Current and Projected Health Care Costs in Alaska

A. Current Costs: Two general measures

1. Provider revenues
2. Payer expenditures

B. Projected costs at current service levels

1. Price trends
2. Utilization trends
3. Population trends

VII. Alaska's Health Care Financing Needs

Draws out of the previous chapters a summary of the problems, together with identification of potential problems which cannot currently be verified for lack of data.

Appendix: Backup Data Tables

REPORT #2

OPTIONS FOR STATE ACTION

I. Executive Summary

II. Introduction and Overview

III. Survey of Alaska's Financing Needs

- A. Review of problems (from Report #1)
- B. General principles of effective financing mechanisms
  1. Insurance vs. income transfers
  2. Efficiency vs. equity
  3. Social insurance vs. public assistance
  4. Actuarial tests
  5. Cost containment vs. barriers to access

IV. The State's Options

V. Review of Legal Issues

- A. Brief general review
- B. Specific issues suggested by the proposed options

VI. Future Developments Which Bear on the State's Choice of Options

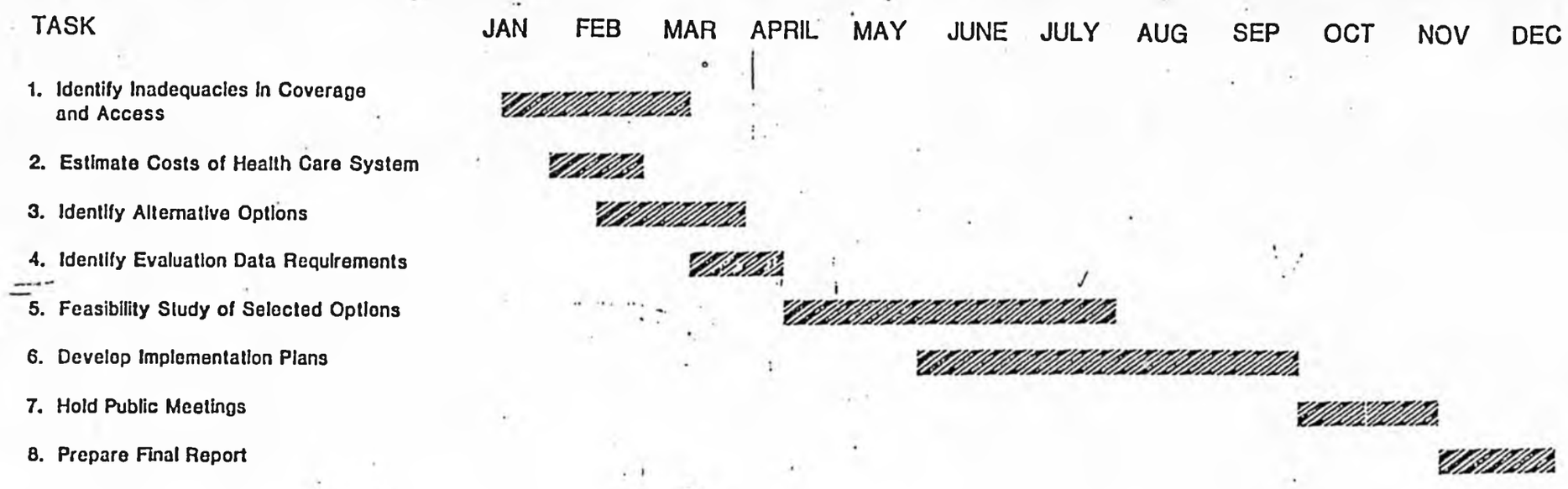
- A. Growth of health maintenance organizations
- B. National Health Insurance
- C. Trends in Medicare and Medicaid
- D. A changing federal/state relationship

VII. Further Data Requirements

What additional data, if any, are required to analyze each of the various options?

(9)

Alaska Comprehensive Health Care and Financing Study
Project Schedule



REPORTS

Interim Report No. 1 — ▲ March 30, 1981

Interim Report No. 2 — ▲ March 30, 1981

Interim Report No. 3 — ▲ September 18, 1981

Final Report — December 11, 1981 △

MILESTONE MEETINGS/PRESENTATIONS

Initial Advisory Committee Meeting — ● January 6, 1981

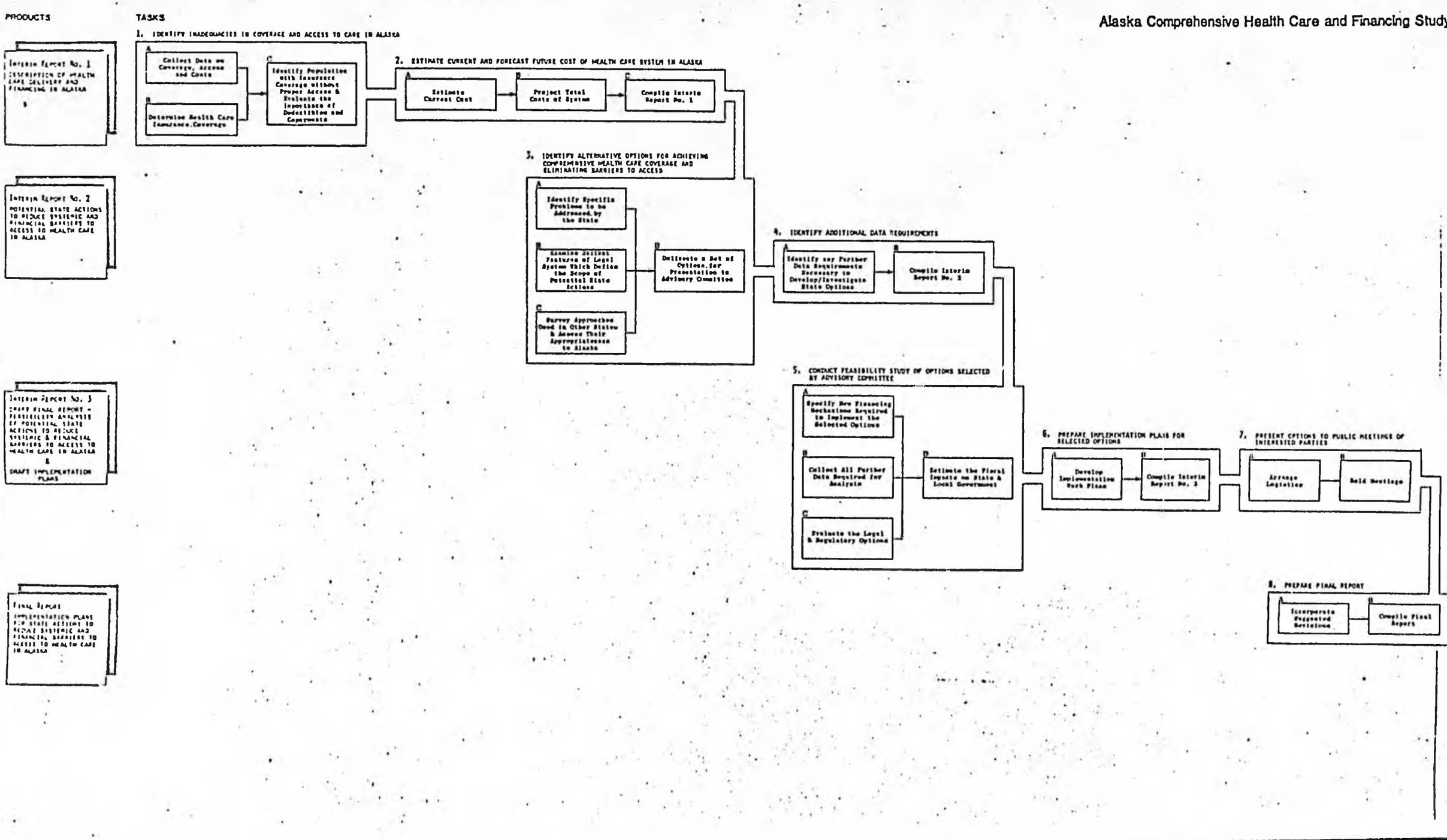
Interim Reports 1 & 2 — ● March 30, 1981

Midpoint Review Interim Report No. 3 — ● July 15, 1981

Public Meetings — ●●● October 1981

Final Report — December 11, 1981 ○

ATTACHMENT NO. 6



ATTACHMENT NO. 5

Minutes of Meeting
Advisory Committee
Alaska Comprehensive Health Care and Financing Study Project
Conference Room, Department of Health And Social Services
December 1, 1980
Juneau, Alaska
8:00 AM

1. Members of the meeting were introduced.

Darryl Trigg Designee	Alaska Native Health Boards, Inc.
David E. Johnson President	Alaska State Medical Association
Leslie Goss Executive Director	Alaska Public Interest Research Group
Tim Mingin President-Elect	Alaska State Hospital Association
James M. Armbrust Chairperson	State Health Coordinating Council
Jack Fargnoli	Office of the Lieutenant Governor
Carole Burger	Office of the Governor
Frederick McGinnis Coordinator	Deputy Commissioner, Department of Health and Social Services

2. Roll Call of Members was held.

3. Jack Fargnoli was named convenor and temporary chairperson.

4. Summary Briefing for members was given by Deputy Commissioner Frederick McGinnis:

   Developments leading to RFP
   RFP Process and RFP Highlights
   Evaluation Committee, Membership, Agenda
   Questions and Answers on RFP, Status Report

Ms. Burger departed the meeting at 10:00 a.m.

5. Discussion was held on whether to open the committee to members of the public. (i.e. additional public interest members)

   After formal discussion it was moved by Mr. Johnson, seconded by Mr. Mingen and voted by the majority of committee membership that:

   > "A formal request be addressed to the Lieutenant Governor's office requesting that no more than three but no less than two members of the general public be added to the membership of the Advisory Committee"

6. Mr. Trigg requested comments on a request that alternates be approved to attend for the permanent members of the committee.

   After formal discussion it was agreed that alternates would be welcome, with the stipulation that the permanent members brief their alternatives before the next meeting.

   Members also discussed the possibility that a member would not be able to attend the majority of the meetings. If that was the case they were asked to notify the committee and a new member would be appointed.

7. A central contact for committee members was decided on. Dr. McGinnis will be the central contact for all committee members for the time being.

   Fredrick McGinnis
   Deputy Commissioner
   Department of Health and Social Services
   Room 214 MacKay Building
   338 Denali Street
   Anchorage, Alaska 99501
   278-4668 (contact phone)

8. Discussion was made on the formal procedures of the meetings. It was decided that the procedures would be made as the meetings progressed. A schedule of procedures would be made available to the members with each Minute of the Meeting notice.

9. Discussion was held on the possibility of keeping all committee members informed ahead of time on what will be discussed at the next meeting. Dr. McGinnis stated that he will send all items of interest to the committee members. He will also note whether the items should be brought to the next meeting. Also, an agenda will be sent prior to the next meeting.

10. Dr. McGinnis brought to the attention of the committee members the following correspondence:

1. Memo from Mark S. Johnson, Emergency Medical Services Section
TO: Dr. Frederick McGinnis
RE: Health Care Financing Study.

"Would like the committee to address the problems of payment for air transport of emergency patients from bush and rural areas to hospitals, and the problems of getting medical equipment back to communities after it is sent with emergency patients."

2. Memo from Michael Cushing, Div. of State Health Planning & Dev.
TO: Reed Schonfeldt, SCHSS, Office of Information
RE: Health Cost/Expenditure Project

Question 1: What are the health expenditures in Alaska for the major categories of service (Promotion/Prevention, Information/Referral, Diagnosis & Treatment, Rehabilitation, Maintenance, State, Private, Other)?

Question 2: What are the health expenditures, by service attributed to heart disease & Hypertension in the state of Alaska.

3. Memo from Dean F. Tirador, Deputy Commissioner, Dept. of Health & Social Services
TO: Liz Muktarian, Director, Div. of Adult & Aging Services
RE: Financing of Health Care for the Elderly

"Medicare does not cover dental care, hearing aids, pharmaceuticals or routine refractions or eye glasses in most cases."

"Problems in health care for the elderly include:

'lack of coverage for dental care;
'lack of coverage under Medicare for costs of drugs and medications
'a tendency on the part of people with marginal incomes to delay seeking of health care to the point that when they finally do, they wind up with truly tremendous bills
' lack of alternatives to institutionalization'"

4. Letter form Helen D. Beirne, Commissioner
TO: Marlene Johnson, Alaska Native Health Board
RE: Acknowledgement of receipt of Resolution Number 81-17 passed at the October 22, 1980, Alaska Native Health Board Meeting.

11. Dr. McGinnis handed out papers titled:

    1. "Medicaid and the Mainstream: Reassessment in the Context of the Taxpayer Revolt"

    2. "Department of Health & Social Services, Division of Public Assistance, Request for Proposals for Systems Planning and Design Consultant"

12. A request was made by Mr. Johnson that a list of committee member names and addresses be made available to all committee members. A list was passed around and a copy is attached to these minutes.

13. Dr. McGinnis suggested that agenda item number 11 on this meeting agenda list be an on-going item. He recommended that the word "Recommendation" be put in the plural form of "Recommendations".

14. Discussion was held on the selection of the contractor. Dr. McGinnis indicated that the final choice would probably be made today in Seattle. All members, on request, would get copies of the contractor's proposals and costs.

15. A suggestion by Mr. Johnson was made to include the University of Alaska's Economics Division as a member of the committee. Discussion was held on this and it was noted that this membership should not be one of the two or three seats made available to the public.

16. A request for reimbursement, from the State of Alaska, was handed to all committee members who would like to be reimbursed for their travel costs.

17. A Motion was made by Mr. Johnson, seconded by Mr. Trigg and approved by committee vote that the next meeting be held in Anchorage, on January 5, 1981, starting at 8:30 a.m., in Dr. McGinnis's offices at the above mentioned address, unless notified otherwise.

    This Motion is subject to change by the majority of committee members by a telephone conference call.

The meeting was adjourned at 12:22 p.m.

Attachment No. 1 Names and addresses of current committee members.

Attachment No. 2 Preleminary Agenda for December 1, 1980 meeting.

ATTACHMENT No. 2

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

ADVISORY COMMITTEE - PRELIMINARY AGENDA
ALASKA COMPREHENSIVE HEALTH CARE AND FINANCING STUDY PROJECT

DECEMBER 1, 1980
CONFERENCE ROOM, DEPARTMENT OF HEALTH AND SOCIAL SERVICES
JUNEAU, ALASKA
8:30 AM

1. Introduction of Members and Welcome
2. Review and Revision of Agenda
3. Summary Briefing on Project
4. Selection of Chairperson and Recorder for Committee
5. Review of Evaluation Committee Membership, Agenda and Criteria
6. Report on Evaluation Committee Actions
7. Related Studies:
   Health Insurance Option: Division of Public Assistance
   Health Cost Expenditure Project: Region X, Department of Health & Human Services
8. Role of Advisory Committee: DHSS Contract Organization
9. Development of Advisory Committee Procedures
10. Communications and Referred Matters
11. Development of Preliminary Recommendation to Department and Contractor
12. Other Considerations as Determined by Committee:
    Future Meetings, Discussions and Other Matters

Minutes of Meeting
Advisory Committee
Alaska Comprehensive Health Care and Financing Study Project
January 5, 1981
Anchorage, Alaska
8:00 AM

1. Members Present: David Johnson, Darryl Trigg, Jack Fargnoli, Carole Burger, Tom Morehouse, Tom Mingen, James Armbrust, Leslie Goss, Frederick McGinnis.

2. Additional Persons in Attendance: John Wills, Daniel Malick, Richard Wells, Jay Cushman, Dean Tirador, Elizabeth Tower.

3. Jack Fargnoli convened the committee as temporary chairperson.

4. Frederick McGinnis distributed the following materials:
   A. "Cost Proposal" from Battelle dated November 1980.
   B. "Technical Proposal" from Battelle dated November 1980.
   C. Copy of the contract for the study between Battelle Human Affairs Research Center and the Alaska Department of Health and Social Services.

5. There was discussion of membership status.
   1 ISER Member - named - Morehouse
   2 Public Interest Members - to be named
   Insurance Industry to be named

6. Frederick McGinnis defined the roles of the Evaluation Committee, Advisory Committee, Steering Committee, Project Coordinator, and the Department of Health and Social Services.

7. Frederick McGinnis distributed copies of a letter text sent to all legislators and a letter sent to twenty five organizations and firms inviting and requesting the cooperation of those agencies in assisting the contractor in securing needed information, data, etc.

8. Darryl Trigg raised a question with Mr. Wills as to what mechanisms, programs will be used to be sure that the needs of rural Alaska will be met and this matter was discussed with Mr. Wills and some other members of the committee

9. Dr. Johnson indicated we must deal with what has happened before within Health Systems Agencies to help to gather information on needs of bush Alaska and we must rely on what is being done.

10. Additional sources of information on rural medical needs and problems were suggested as follows:
    Health Systems Agencies
    Indian Health Service
    Alaska Area Native Health Boards
    Aleution - Pribiloff Islands Statements of Need Conference Report
    Alaska Federation of Natives
    Alaska Health Foundation
    Alaska Native Health Corporations (Yukon Kuskokwim - Norton Sound)

11. Leslie Goss indicated she will submit a list of other persons recommended to be included in receiving notices of meetings and minutes of meetings.

12. John Wills reviewed his technical background for leading this study and referred to studies and projects in which he had been engaged previously. He referred to more extensive materials regarding his background in the technical proposal.

13. Mr. Cushman reviewed the experience of his firm, Management and Planning Services Alaska, in the field of management studies.

14. Mr. Wills discussed two reports to be prepared next as called for in the contract, as follows:

    Report I: Health Care in Alaska: Financing, Coverage, Services, and Costs

    Report II: Options for State Action

    (See Attachment #1 to these minutes for a breakdown of the topics to be covered in these reports)

    Mr. Wills presented two charts and discussed them at length as follows:

    Chart #1

    A. Products include interim reports, numbers one, two and three and a final report.

    B. Tasks to be accomplished in relation to the products.

    Chart #2

    Projects scheduled including schedules relating to tasks, reports, meetings, and presentations to the State.

    (NOTE: Copies of charts are a part of the record of this meeting.)

15. John Wills emphasized the need for an insurance representative on the committee, both for input purposes as well as for assisting the contractor in obtaining necessary data from selected insurance carriers. Wills indicated that he would contact the Lieutenant Governor's Office and Martin Tirador of Blue Cross by letter regarding the specific types of data needed.

16. In response to a query from Tom Mingen, John Wills indicated that, because Blue Cross plus 4-5 major private insurance carriers write approximately 70% of all health insurance in Alaska, analysis of that group of insurers seemed an adequate cut-off point for purposes of the study. The committee expressed conceptual approval of that approach as practical.

17. John Wills clarified for the committee the role which Management Planning Services, the study subcontractor, would play in conduct of the project. That role will include: analysis of the fiscal impacts of identified financing options; development of implementation plans for identified options; systems description; and review and collaboration with the major contractor on other aspects of the study.

18. A general discussion was held by the committee with the contractor regarding whether any particular options might be excluded from the study's purview because of unacceptability to specific parties at interest. John Wills indicated that his understanding of the contractor's responsibility was that the contractor would identify any and all potentially feasible operations, and that it would be the business of the advisory committee alone to select specific options for further study in Phase 2 of the project. Wills noted that this probably would be the main business of the committee during the March 30-May 15, 1981 hiatus. Jack Fargnoli noted that one of the specific provisions of the RFP and the study contract is that the contractor will identify interested parties affected by any option, and that in fact a major purpose for the committee itself was to identify and consider any such effects prior to selection of any option or options for possible implementation.

19. Tom Mingen expressed his impression that the scope and purposes of the study may not be well understood by the public. That feeling was echoed by Richard Wells, who noted that the public image of the project may be important to its success.

20. Jack Fargnoli inquired whether the contractor's view of the scope of options to be investigated included such possibilities as modifications of state catastrophic illness coverage and expansion of health care coverage for the elderly. John Wills replied that the contractor would try to stratify the data collected so as to allow identification of such groups and their inclusion within the options eventually presented; however, he said, much of this will be determined by the nature of the data available from private carriers and from the state.

21. A tentative schedule for two future meetings of the committee was adopted, as follows:

February 23, 1981 (Monday)	Anchorage	Meeting with contractor; Preliminary discussion of options identified.
March 9, 1981 (Monday)		Draft Phase 1 reports to be mailed to committee members for review.
March 16, 1981 (Monday)	Anchorage	Meeting with contractor; discussion of draft reports.

22. The meeting was adjourned at approximately 3:00 PM.

Attachments:

No. 1 Draft Outline of Reports #1 and 2: Battelle
No. 2 Current Membership List: Advisory Committee
No. 3 List of Additional Persons in Attendance/Interested Parties
No. 4 Agenda and Meeting Notice for January 5, 1981 Meeting.
No. 5 Products, Interim Reports and Tasks Chart: Battelle
No. 6 Project Schedule Chart: Battelle

06-F1LH

STATE OF ALASKA

ATTACHMENT NO. 4

JAY S. HAMMOND, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF DEPUTY COMMISSIONER
ROOM 214 MacKAY BUILDING
338 DENALI STREET
ANCHORAGE 99501

December 18, 1980

To: Members of Advisory Committee
Alaska Comprehensive Health Care
and Financing Study Project

From: Frederick McGinnis, Project Coordinator

Re: Meeting of Committee

The next meeting of the Advisory Committee for the Health Care Study Project was decided by the committee as follows:

Date: January 5, 1981 Monday

Time: 8:30 A. M.

Place: Room 426 McKay Building
338 Denali Street, Anchorage

We will look forward to seeing you at the meeting.

Preliminary Agenda

1. Call to Order : Introductions
2. Discussion of Membership Status
3 Review of Minutes: December 1, 1980
4. Determination of Agenda: This meeting
5. Review of Advisory Committee Role
6. Advisory Committee Procedures
7. Communications
8. Status of Contract Award
9. Review of Contract Provisions
10. Review of Accepted Proposal
11. Discussions with Contractor Representative
12. Recommendations to Department and Contractor
13. Other Business and Deferred Matters
14. Date and Place: Next Meeting
15. Adjournment

Enclosure: Minutes, Agenda, Membership List From meeting on December 1, 1980

AMENDED TITLE: CSSSHB 41(FIN)(EFD FAILED)
AN ACT RELATING TO THE HEALTH OF RESIDENTS OF THE STATE;
AND PROVIDING FOR AN EFFECTIVE DATE

GENERAL DOLLARS: $2,162,500 (F. NOTE)

PRIME SPONSOR: BUCHHOLDT.

OTHER DOLLARS: $11,631,800

CO-SPONSORS: CATO, GARDINER, CLOCKSIN, ROGERS, FULLER, ZHAROFF, ADAMS, VASKA.
CURRENT STATUS: 4/30/81 IN (S) HESS REFERRAL: FINANCE

DATE	SEQ	PAGE	LEGISLATIVE ACTION
02/19/81	01	0296	FIRST READING -- COMMITTEE REPORTS
03/31/81	02	0754	HESS -- CS04, NR01
04/16/81	03	0963	FIN -- DNP02, CS08
04/16/81	04	0963	FIN FISCAL SUMMARY HSE SUPPL #28
04/24/81	05	1065	SECOND READING
04/24/81	06	1066	FIN CS ADOPTED BY UNAN CONSENT
04/24/81	07	1066	ADVANCED TO 3RD READING BY UNAN CONSENT
04/24/81	08	1066	THIRD READING
04/24/81	09	1066	PASSED BY DIV 21-14-05
04/24/81	10	1067	EFFECTIVE DATE FAILED BY DIV 22-13-05
04/24/81	11	1067	NOTICE OF RECONSIDERATION GIVEN
04/27/81	12	1093	FAILD TO RETN 2ND READNG BY DIV 19-20-01
04/27/81	13	1094	POSTPONED UNTIL 04/29/81 BY DIV 21-18-01
04/29/81	14	1135	FAILD TO RETN 2ND READNG BY DIV 14-21-05
04/29/81	15	1136	FAILD TO RETN 2ND READNG BY DIV 14-20-06
04/29/81	16	1137	FAILD TO RETN 2ND READNG BY DIV 14-21-05
04/29/81	17	1140	PASSED ON RECONSIDERATN BY DIV 22-14-04
04/29/81	18	1140	EFFECTIVE DATE FAILED BY DIV 23-13-04
****	**	**	*** *** ***

DATE	SEQ	PAGE	LEGISLATIVE ACTION
04/30/81	19	0912	FIRST READING -- COMMITTEE REPORTS
			HESS
			FINANCE
			RULES
****	**	**	*** *** ***

Would affect 44,000

House OKs health care

By MICHAEL MULNIX
Empire Staff Reporter

A major health-care bill which would provide state insurance to an estimated 44,000 Alaskans now without coverage or with inadequate health protection passed the House on a 21-14 vote today.

The state would pick up part of an individual's insurance tab as long as he is not enrolled in a group or federal health plan and does not make enough money to pay for complete protection.

According to the Batelle Research Center, of the 44,000 residents currently uncovered, 40 percent are children. The uncovered adult population includes primarily construction, cannery, firefighting and other seasonal workers, as well as fishermen, farmers, miners and employees of small businesses.

A cost-sharing program has been established for state plan participants and others currently without coverage an employer or the federal government helps to finance. The amount of cost sharing available depends on income, family size and the region of the state in which the insured person lives. The program would be targeted toward people not currently covered and not needy enough to qualify for federal assistance.

Initially, Natives were excluded from the program because they are covered under the Indian Health Service program. Rural lawmakers, however, said the IHS program is inadequate. The bill was therefore amended in committee to require the state to study the IHS and come up with ideas for improvements.

The entire program is estimated to cost about $3.8 million in fiscal 1982 and $13.2 million in fiscal 1983, skyrocketing to $69.5 million by fiscal 1986.

Rep. Terry Martin, R-Anchorage, argued against the bill (CSSHB41), saying more study is needed.

"I know I'm shooting down motherhood and apple pie here, but I take this whole bill to be a cannon shooting down a mosquito," Martin said.

Martin said state officials should concentrate on reducing "duplication and triplication" and bureaucracy in state insurance programs before instituting yet another one.

Rep. Thelma Buchholdt, D-Anchorage, prime sponsor of the bill, said money spent to formulate the vast insurance program is "a very good way to invest in the people of the state."

"I would go so far as to make health care an inherent right of the people," she said. "We should take care of them."

The health plan would provide alcohol and drug dependency coverage, expand the state's Medicaid program to provide all services allowed by federal law and provide for a study of federal medical programs in the state.

Buchholdt stressed the plan is not a "give-away" program, but is based on an individual's ability to pay. She said the reason for the large, yearly increases in costs for the program would result from people becoming aware the plan was being offered.

The state now spends between $440-488 million on health insurance yearly, Martin said. He said the new bill "promises nothing but more high expenditures."

Rep. Don Clocksin, D-Anchorage, chairman of the Health,

Continued on Page 2

Juneau Empire
April 24, 1981

Health care...

Continued from Page 1

Education and Social Services Committee, argued that since the state now spends billions of dollars on other programs, it should be willing to spend some money on residents.

"We can have no better expenditure of money than to improve our health. There is no more important issue before the Legislature than the health of its people," Clocksin said. "We have existing programs, I agree. We have gaps in those programs, I agree. This bill will fill those in all of those gaps."

Rep. Terry Gardiner, D-Ketchikan, related the health plan to bills which allocate state money for housing, mining, fishing or other special interest groups.

"There's not a lot of equity in it (the insurance bill), but it's better than doing nothing," he said. "It doesn't mean it's wrong just because every citizen doesn't benefit from the program."

Suggested amendments for HB 41

page 1, lines 15-18:

(c) The commissioner may contract for the underwriting [of the program] and [may contract for the] administration of the program. A contract entered into under this subsection shall be for a maximum of three years [period] and shall be based on competitive bids.

conversations with representatives in the insurance industry indicate that there may be some hesitancy to underwrite a "social" group whose characteristics are unknown, and that the state may need to underwrite the risk for the initial period of the program until risk factors are proven.
Similarly, there may be some difficulty finding a company to sign a three year contract.

page 1. lines 19-23:

(d) The program shall provide for copayments and deductibles, and shall provide for an annual deductible payment for each member and a maximum deductible payment for each family unit.

(e) The program shall provide for the payment of reimburseable institutional and professional charges incurred by a member or covered dependent to a maximum level as determined by regulation. After such level is reached, the program shall provide for 100% of reimburseable charges.

the intent of (d), in addition to guaranteeing the use of copayments and deductibles in the plan, was to insure a type of "catastrophic" coverage to the plan with a limit on the out-of-pocket expenses in any given year to an individual and dependents.

page 3, line 4"

(9) "subsidized medical care" means medical care provided at reduced charge or no charge to an individual and their eligible dependents.

intent is to acknowledge that all types of subsidized care available is not necessarily free of charge.

median income figures for AC:

family of 4	$ 31,037
family of 3	$ 26,071
family of 2	$ 21,105
single indiv.	$ 16,139

direct costs. Catalog of Federal Domestic Assistance Number is 13.242, Mental Health Research Grants, and support is authorized under the Public Health Service Act, Section 301(c); Pub. L. 78–410 as amended, (42 U.S.C. 241, 242a). OMB Circular A–95 State and local clearinghouse review is not required for this program.

The purpose of this cooperative agreement is to support the development of appropriate data analytic methods for assessing patients' behavioral states and traits which have been measured by the different instruments used in these ongoing studies. More specifically, this will involve constructing and developing appropriate approaches to the analysis of behavioral data associated with subtypes of depression, and examining available data in order to develop reliable measures of outcome in the treatment of depression with tricyclic antidepressants.

Criteria used in the review of applications received in response to this announcement are as follows:

(1) Adequacy of resources;

(2) Experience with the different live and video assessment techniques utilized;

(3) Ability to work with the various collaborating centers;

(4) Publication history in this area of research.

Availability of Additional Information

The NIMH encourages persons interested in applying for this award to contact Dr. Stephen Koslow, Project Director for this program, (whose address and phone number are given above) for a statement of guidelines for preparing the application. Because this project is intended to assist in the analysis of behavioral data obtained from the current collaborative program on depression, the NIMH believes that information about the program up to now is essential in order to prepare an application.

Application kits (PHS 398) can be obtained from the Grants Operation Section, NIMH, Room 7C–05, Parklawn Building, 5600 Fishers Lane, Rockville, Maryland 20857. All applications should be submitted to Division of Research Grants, NIH, Westwood Building, 5333 Westbard Avenue, Bethesda, Maryland 20205.

Robert L. Trachtenberg,

Deputy Administrator, Alcohol, Drug Abuse, and Mental Health Administration.

[FR Doc. 80-36486 Filed 11-21-80; 8:45 am]

BILLING CODE 4110-88-M

Office of Human Development Services

Family Median Income by State; Eligibility for Social Services

Under the provision of sections 2002(a)(5)(B), 2002(a)(6) (A) and (B), and 2002(a)(14)(A) of title XX of the Social Security Act, promulgation is made of the median income of a family of four for each State, the District of Columbia, and the States as a whole applicable to the period October 1, 1981 through September 30, 1982. For those States whose 1982 fiscal year begins before or after October 1, 1981, this promulgation is also applicable. The purpose of the promulgation is to determine the extent of Federal financial participation (FFP) in State expenditures under title XX. The above listed sections impose certain limitations with respect to the avilability of FFP based upon the relationship of the income of the family of a service recipient to the median income of a family of four in the State.

Estimates of the median income of four-person families for each State and the District of Columbia were developed by the Bureau of the Census. In developing the median income scales, the Bureau of the Census used the following three sources of data:

(1) The March 1980 Current Population Survey; (2) the 1970 Census of Population; and (3) per capita personal income estimates from the Bureau of Economic Analysis. The methodology for adjusting median income for families of different sizes is specified in 45 CFR 1396.60.

The median income for a family of four, by State for fiscal year 1982 with calculation at the 80, 90, and 115 percent levels, is set forth below for use by States in establishing income ceilings and fee schedules under title XX of the Social Security Act:

Median Income for Families of Four for Fiscal Year 1982

State	Median income [1]	80 percent of median income	90 percent of median income	115 percent of median income
Alabama	$18,613	$14,890	$16,752	$21,405
Alaska	31,037	24,830	27,933	35,693
Arizona	23,000	18,400	20,700	26,450
Arkansas	18,493	14,794	16,644	21,267
California	25,109	20,087	22,598	28,875
Colorado	25,228	20,182	22,705	29,012
Connecticut	24,410	19,528	21,969	28,072
Delaware	21,184	16,947	19,066	24,362
District of Columbia	21,310	17,048	19,179	24,507
Florida	20,757	16,606	18,681	23,871
Georgia	21,578	17,262	19,420	24,815
Hawaii	24,582	19,666	22,124	28,269
Idaho	20,429	16,343	18,386	23,493
Illinois	24,265	19,412	21,839	27,905
Indiana	22,614	18,091	20,353	26,008
Iowa	22,567	18,054	20,310	25,952
Kansas	22,048	16,278	20,563	26,275
Kentucky	19,138	15,310	17,224	22,009
Louisiana	20,166	16,133	18,149	23,191
Maine	18,074	14,459	16,267	20,785
Maryland	24,686	19,749	22,217	28,389
Massachusetts	23,788	19,029	21,407	27,354
Michigan	24,422	19,538	21,980	28,085
Minnesota	24,409	19,527	21,968	28,070
Mississippi	17,672	14,138	15,905	20,323
Missouri	21,294	17,035	19,165	24,488
Montana	20,051	16,041	18,046	23,059
Nebraska	20,749	16,599	18,674	23,861
Nevada	25,457	20,366	22,911	29,278
New Hampshire	22,335	17,868	20,102	25,685
New Jersey	24,640	19,712	22,176	28,336
New Mexico	21,032	16,826	18,929	24,187
New York	21,082	16,866	18,974	24,244
North Carolina	19,648	15,718	17,683	22,595
North Dakota	19,520	15,616	17,568	22,448
Ohio	22,528	18,022	20,275	25,907
Oklahoma	20,852	16,682	18,767	23,980
Oregon	24,031	19,225	21,628	27,636
Pennsylvania	22,314	17,851	20,083	25,661
Rhode Island	21,638	17,309	19,472	24,881
South Carolina	20,154	16,123	18,139	23,177
South Dakota	19,209	15,367	17,288	22,090
Tennessee	19,437	15,550	17,493	22,353
Texas	23,416	18,733	21,074	26,928
Utah	21,250	17,000	19,125	24,438
Vermont	19,314	15,451	17,383	22,211
Virginia	22,976	18,381	20,678	26,422
Washington	24,410	19,528	21,969	28,072
West Virginia	18,876	15,101	16,988	21,707
Wisconsin	23,518	18,814	21,166	27,046
Wyoming	22,673	18,138	20,406	26,074

[1] Median income based on 1979 data.

NOTE.—The median income for a family of four in the 50 States and the District of Columbia, applicable to the period October 1, 1981 through September 30, 1982 is $22,395.

(Catalog of Federal Domestic Assistance Program No. 13.771 Social Services for Low Income and Public Assistance Recipients)

Dated: November 18, 1980.

Cesar A. Perales,

Assistant Secretary for Human Development Services.

[FR Doc. 80-36528 Filed 11-21-80; 8:45 am]

BILLING CODE 4110-92-M

White House Conference on Aging; Technical Committee Meeting

The White House Conference on Aging Technical Committee was established to provide scientific and technical advice and recommendations to the National Advisory Committee on the 1981 White House Conference on Aging and to the Executive Director of the 1981 White House Conference on Aging in developing issues to be considered and to produce technical documents to be used by the Conference.

Notice is hereby given pursuant to the Federal Advisory Committee Act, (Pub. L. 92–463, 5 U.S.C. App. 1, sec. 10, 1976) that the Technical Committee on Older Americans as a Growing National Resource will hold their final meeting on Wednesday, December 17, 1980 from 9:30 a.m. until 3:30 p.m. in Room 5542 at

(2) Donated funds from private sources must:

(i) be transferred to the State agency and under its adminstrative control;

(ii) be donated to the State agency, without restrictions as to use, except that the donor may specify either or both of the following—

(A) the services, administration, or training for which the funds are to be used, if the donor is not a sponsor or operator of a program to provide such services, adiministration, or training,

(B) the geographic area in which the serivces are to be provided

(iii) not be used to purchase services from the donor unless the donor is a nonprofit organization and it is an independent decision of the State agency to purchase services from the donor.

(b) For purposes of this Part, a voluntary federated fund-raising organization is not considered to be a sponsor or operator of a service facility, and member agencies are considered separate autonomous entities so long as control by interlocking board membership or other means does not exist.

(c) In-kind contributions from public agencies, which do not meet the definition of third-party public agency in § 1396.53(d), must be valued in accordance with the cost principles specified in Subpart Q of 45 CFR Part 74.

(d) Under this Part a third-party public agency means any public entity (including Indian tribes) except—

(1) Units of the State government; and

(2) Units adminstering local governments in a State whose title XX program is State supervised and locally administered.

(e) The effective date of paragraph (c) of this section is October 1, 1980.

§ 1396.54 [Reserved]

§ 1396.55 [Reserved]

§ 1396.56 Fifty Percent Rule.

(a) If one-half of the Federal funds to which the State is otherwise entitled is greater than the amount of the aggregate expenditures (combined State and Federal) made under the program for individuals identified in this paragraph, such Federal funds will be adjusted so the total Federal reimbursement does not exceed twice the amount of the total expenditures in behalf of those individuals:

(1) Who are receiving aid and under the plan of the State approved under part A of title IV or who are eligible to receive such aid; or

(2) Whose needs are taken into account in determining the needs of an individual who is receiving aid under the plan of the State approved under part A of title IV, or who are eligible to have their needs taken into account in determining the needs of an individual who is receiving or is eligible to receive such aid; or

(3) With respect to whom supplementary security income benefits under title XVI or State supplementary payments, are being paid, or who are eligible to have such benefits or payments paid with respect to them; or

(4) Whose income and resources are taken into account in determining the amount of supplemental security income benefits or State supplementary payments being paid with respect to an individual, or whose income and resources would be taken into account in determining the amount of such benefits or payments to be paid with respect to an individual who is eligible to have such benefits or payments paid with respect to him; or

(5) Who are eligible for medical assistance under the plan of the State approved under title XIX.

(b) In accounting for costs for services to meet the requirements of paragraph (a) of this section:

(1) In lieu of accounting for the status of each person receiving a service on the basis of group determination of eligibility, States may use generally accepted statistical sampling procedures.

(2) Regarding services to persons who receive services without regard to income (family planning services, services to prevent or remedy abuse, neglect or exploitation of children and adults, and information and referral services), States may use any appropriate method, including generally accepted sampling procedures or allocation of costs to the services provided these persons in the same ratio as the known cost of all other services distributed for the 50 percent rule.

Subpart F—Limitations: Individuals Served, Eligibility and Fees

§ 1396.60 Persons eligible and access to services.

(a) *Conditions for FFP.* FFP is available in expenditures for services to individuals provided that:

(1) The service is included in the State's services plan;

(2) The individual who receives the service is a member of one of the categories covered by the State's services plan; and

(3) Such individual was eligible under the provisions of this section and those of § 1396.61 at the time of receipt of the service.

(b) *Categories of individuals who may receive services—*

(1) *Income maintenance status.* The following individuals are eligible on the basis of income maintenance status:

(i) Recipients of AFDC;

(ii) Those persons whose needs were taken into account in determining the needs of AFDC recipients; and

(iii) Recipients of SSI benefits or State supplementary payments.

(2) *Income status.* Individuals other than those described in paragraph (b)(1) of this section, are eligible if the family's monthly gross income is less than 115 percent (or, at State option, a lower percentage) of the median income of a family of four in the State adjusted for size of family, subject to the limitations set forth in § 1396.62. Income status individuals include those whose eligibility is determined on a group basis.

(3) *Without regard to income.* Individuals may be provided family planning services under § 1396.63, information or referral services under § 1396.64, or services to prevent or remedy neglect, abuse, or exploitation of children or adults under § 1396.65, without regard to income at State option if the State so provides in its services plan.

(c) *Median income.* (1) On or before December 1 of each year, beginning with calendar year 1975, the Secretary will promulgate the median income for a family of four for each State and for the 50 States and the District of Columbia. This promulgation shall be used for purposes of determining eligibility and establishing fees in the following Federal or State fiscal year.

(d) *Income levels as baselines for fee imposition.*

(1) Except for individuals whose eligibility is determined on a group basis, individuals whose eligibility is based on income status shall be subject to imposition of a fee for service (in accordance with § 1396.62) if their family's monthly gross income exceeds 80 percent of the median income of a family of four in the State or the median income of a family of four in all States, whichever is less, and does not exceed 115 percent of the median income of a family of four in the State, adjusted for family size.

(2) The median incomes (at 80 percent and 115 percent) as calculated in paragraph (d)(1) of this section for a family of four, shall be adjusted for family size according to the following percentages:

(i) One person—52 percent.

(ii) Two person family—68 percent.

(iii) Three person family—84 percent.

(iv) Four person family—100 percent.

COMMENTS

The Division of Insurance is limiting its comments to Section 1 of the bill which adds a new chapter to AS 18. The new chapter primarily impacts the Department of Administration but also affects the Division of Insurance.

The new chapter creates a State Comprehensive Health Plan (SCHP) with benefit standards to be establisehd by the Commissioner of Administration. Eligible persons for SCHP are residents of the State.

SCHP also provides for a cost sharing program for persons with certain adjusted gross income levels. The program is available for SCHP coverage or certified individual policies.

There is one area in the proposed chapter which affects our program. It is the sole cause of the fiscal impact noted. On page 2, lines 1-5 and 28, there is a reference to certification of individual health insurance policies used to provide coverage under the proposal. This approach would put the Division of Insurance into a paper shuffle that we are trying to avoid in favor of a more effective approach. If the approach is pursued, changes in AS 21.42 would be necessary to give the Director of Insurance authority to adopt the necessary regulations to implement the certification procedure. When an insurer elects to be active in a particular marketplace, it is a voluntary decision. The proposed approach tends to put procedural roadblocks in front of the insurer and tends to delay the time frame between the decision to provide a market and the date they can actually provide a market.

The amendments we have suggested do several things. It takes the fiscal burden off the division thus reducing the fiscal note to zero. It dramatically reduces the time frame between decision to provide a market and the date it can actually be provided. It is a more efficient approach since certification by the director can still result in error thus allowing a policy not meeting the standard to be used in the program. The amendment requires that the insurance company certify that its policy meets the minimum standard under the SCHP. Having done that, the policy provides at least the minimum standard coverage whether the language of the contract specifically provides the standard or not. This new approach would place responsibility for contract content with the insurer and eliminate the need for further paper shuffling by the State.

In addition, to the direct program impacts, we have several observations that may require a clarification of intent or reaction by the Legislature.

1. There is no definition of resident.

2. There is no limitation of coverage for preexisting medical conditions.

3. Adjusted gross income is not defined.

4. Section is silent concerning the mechanics of cost sharing program including timing and proof. Potential fraud in the system needs to be considered so that State supplements will indeed be used for the purpose intended.

April 2, 1982

HB 411

Senator Charles Parr
Alaska State Legislature
Pouch V (MS 3100)
Juneau, Alaska 99811

Dear Senator Parr:

We would like to commend you on your efforts to maintain a fiscally responsible budget. In line with this thinking, we would like to reaffirm our opposition to HB 41 and SB 417 relating to health insurance for residents in the state.

We know that you recognize that with the recent changes in Federal social programs, this legislation will be of primary focus in the ensuing months. Last year the GFWC FREE Committee drafted position papers on both of these bills which you have in your possession. In light of the recently completed Battelle Study and its inconclusive results, we maintain our opposition to the entire concept of socialized medicine.

Sincerley yours,

Pauline Martens

Pauline Martens, Chairman
GFWC FREE Committee

P.O. Box 4-2955 • Anchorage, Alaska 99509
A committee of the GFWC Anchorage Woman's Club

CHARLIE PARR

ALASKA LEGISLATURE

S.R. Box 50599
Fairbanks, Alaska 99701
(907) 456-5029

Pouch V
Juneau, Alaska 99811
(907) 465-4907

May 18, 1981

Ms. Ann Croswell
P. O. Box 571
Kodiak, Alaska 99615

Dear Ms. Croswell:

Thank you for your letter of May 14.

I am not aware of the contents of the various studies you refer to. If what you say is accurate, the Battelle Study is unnecessary.

I was not a member of the Health, Education and Social Services Committee in the previous legislature, and do not know what went into the decision to fund that study. Since it is ongoing, however, it does seem advisable to wait until we have the results before taking action of the scale required by HB 41.

Sincerely,

Charles H. Parr

CHP:vc

May 14, 1981

Senator Charles Parr
Alaska State Legislature
Pouch V
Juneau, Ak. 99811

Dear Senator Parr:

Thank you for responding to my letter regarding H.B. 41. I recently had the opportunity of speaking to both Representative Zharoff and Senator Mulcahy regarding several bills I have been following. Both Representative Zharoff and Senator Mulcahy informed me that H.B. 41 probably will not be passed during this legislative session. It seems that there is concern that the Battelle study be completed before the State Health Insurance Plan be implemented. My concern is that first, my health might not hold out and that second, a similar study has already been done by the Legislative Affairs Agency in 1978. In this study, much of the research and information regarding the gaps and barriers in health care in Alaska has been gleaned. As an employee of the Kodiak Area Native Association from 1978 to 1980, I assisted in writing the KANA Five Year Health Plan. It was a comprehensive document containing much information regarding health care on Kodiak Island. To my knowledge, all the Native Non-Profits in Alaska completed similar health plans.

It would seem to me that there are many valuable documents available containing the exact information the Battelle study would show. It does exasperate me to think that duplication takes precedence over a desperately needed health insurance plan.

I urge your continued support of H.B. 41. Thank you.

Sincerely,

Ann Croswell

Ann Croswell

cc: Alaska Health Care Advocates

CHARLIE PARR

ALASKA LEGISLATURE

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Fairbanks, Alaska 99701
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Juneau, Alaska 99811
(907) 465-4907

May 21, 1981

Mr. Ronald L. Bliss
Secretary
Health Alaska, Inc.
P. O. Box 1239
Anchorage, Alaska 99510

Dear Mr. Bliss:

Senator Fahrenkamp has kindly forwarded me a copy of your letter of May 5 regarding the Individual Practice Association.

The Health, Education and Social Services Committee plans to do a great deal of work during the interim on the Health Care System of the State. Your suggestion will certainly be considered along with others. We will look forward to your assistance as we search for a better way to provide and pay for our health care.

Sincerely,

Charles H. Parr

CHP:vc

Alaska State Legislature Senator Parr

SENATOR BETTYE FAHRENKAMP
CHAIRMAN, RESOURCES COMMITTEE

4016 EVERGREEN
FAIRBANKS ALASKA 99701

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Senate

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907-465-3834
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May 18, 1981

Ronald L. Bliss
Secretary
Health Alaska, Inc.
P.O. Box 1239
Anchorage, Alaska 99510

Dear Ron:

Thank you for your letter with reference to health care services and the attached draft legislation. I think it is always a good idea to use existing services.

By a copy of this letter I am forwarding your letter and enclosure on to Senator Par who is chairman of the HESS Committee.

Sincerely,

Bettye Fahrenkamp
Alaska State Senator

BF/ab

cc: Senator Parr w/encl.

Health Alaska, INC.
P.O. Box 1239 Anchorage, Alaska 99510

May 5, 1981

Senator Bettye Fahrenkamp
Pouch V
Juneau, Alaska 99811

Dear Senator Fahrenkamp:

We represent a diverse community group united for the purpose of arresting the alarming rise in health care costs.

The rate of inflation for health costs is approximately double that of the general rate of inflation. Each and every hour the cost of providing health care services in this country rises by approximately one million dollars. These increases are unfortunately not due to providing substantially greater amounts of health care; rather they reflect higher costs for approximately the same level of service.

These staggering figures assume an even more ominous nature when considered in light of the fact that health care cost impacts all sectors of the economy. Public budgets are being eroded to an increasing degree by health care expenditure. Private businesses are forced to pass along higher health related personnel costs in higher prices. Consumers must commit a greater portion of their inflation ravaged income to the purchase of health care.

Health Alaska, Incorporated, a non-profit Alaskan corporation, was formed for the purpose of establishing a health care delivery system possessing the twin attributes of cost efficiency and quality care. We propose to create a prepaid group health plan based on an Individual Practice Association (I.P.A.). Simply stated, under this system a group of consumers prepay a certain fixed amount for a comprehensive health care package. The health services are then rendered by individual health providers who belong to the I.P.A. and practice in their own offices or facilities.

There is no need to develop a complex, costly and cumbersome bureaucratic organization to deliver health care services under this system. We propose to utilize the already existent institutions, facilities and insurance mechanisms which can easily adapt themselves to participate in an I.P.A.