

ALASKA LEGISLATURE COMMITTEE FILES 1981-1982 8672

1571 SHESS HB 41 1571

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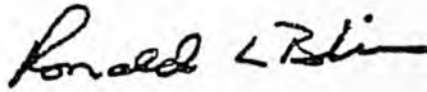
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All of the Board members are at your disposal to discuss this subject further. We recognize the current press of legislation and the demands on your time. We would greatly appreciate any assistance you could offer in securing passage of our proposed

legislation.

Thank you for your time.

Sincerely yours,

A handwritten signature in cursive script that reads "Ronald L. Bliss". The signature is written in dark ink and is positioned above the typed name.

Ronald L. Bliss, Secretary

RLB:bj
enc

DRAFT LEGISLATION
FOR STATE PARTICIPATION IN THE DEVELOPMENT
OF A PREPAID HEALTH PLAN

A BILL

For an Act entitled: "An Act relating to the health of residents of the state; and providing for developmental funding."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA

Section 1. DEFINITIONS. In this chapter

- (1) "Prepaid health plan" is an organization which, for a predetermined monthly fee, provides a comprehensive range of health services to its enrollment.
- (2) "Developmental period" is the time frame within which all organizational and contractual elements are developed and put into place.
- (3) "Benefit package" is the range of services to be provided by the prepaid health plan.
- (4) "Individual practice association" is a form of prepaid health plan which provides physician services to its enrollment through private practitioners located in their existing offices.

Section 2. DEVELOPMENTAL PERIOD.

- (1) Health Alaska, Inc. is a non-profit, locally sponsored Alaskan corporation, chartered to provide quality, cost effective health care services to its enrollment on a prepaid basis using the individual practice association model.
- (2) A feasibility study has been completed which clearly demonstrates market and financial feasibility within the Municipality of Anchorage.
- (3) The prepaid health plan concept has demonstrated that it can have a retarding effect on the rate of increase in the cost of health care. It will provide a benefit package which is at least the equivalent of existing indemnity coverage.

- (4) Developmental support funding is required to:
 - (a) Hire full time professional staff;
 - (b) Put into place the appropriate organizational and contractual documents;
 - (c) Cover other costs such as consultants, office space, and travel.

Section 3. DEVELOPMENTAL FUNDING.

- (1) The sum of Three Hundred Thousand Dollars (\$300,000) is appropriated to support the cost of bringing Health Alaska, Inc. to the point of beginning operations.

Section 4. EXPANSION TO OTHER PARTS OF ALASKA.

- (1) At appropriate points in time, Health Alaska, Inc. will expand its operations to other population centers within the state.

HealthAlaska, Inc. - 1981

Chairman

Bruce Eliassen, Controller
Hickel Enterprises
The Hotel Captain Cook
P.O. Box 2280
Anchorage, Alaska 99510
(907) 276-7400

Treasurer

Terrence H. Hayden, Vice President
Commercial Loan Review
Corporate Headquarters
National Bank of Alaska
P.O. Box 600
Anchorage, Alaska 99510
(907) 276-1132

Member

Stan Howitt, General Counsel
Alaska Electrical Trust Funds
Denali Towers, Suite 200
Anchorage, Alaska 99503
(907) 276-1246

Member

Larry Buchholtz
Worker's Compensation
3301 Eagle
Anchorage, Alaska 99503
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Member

Beverly J. Dubie Michaels
c/o Central Alaska Broadcasting Co.
(KIMO 13)
2700 Tudor Road
Anchorage, Alaska 99507
(907) 276-1313 H 349-7167

Vice Chairman

Ronald A. Pavellas, Administrator
The Alaska Hospital & Medical
Center, Inc.
2801 DeBarr Road
Pouch 8-AH
Anchorage, Alaska 99508
(907) 276-1131, Ext. 703

Secretary

Ronald L. Bliss
Bradbury, Bliss & Riordan, Inc.
431 West 7th Avenue, Suite 201
Anchorage, Alaska 99501
(907) 278-4511
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Member

Bob Baer
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Anchorage, Alaska 99501
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Member

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2702 Denali Street
Anchorage, Alaska 99503
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Pouch 8-AG
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(907) 276-4334



ALASKA HEALTH CARE ADVOCATES

P.O. BOX 1037 D.T. ANCHORAGE, ALASKA 99510 272-8734

February 24, 1981

Dear Friend,

As you know, the cost of health care in Alaska continues to skyrocket. According to U.S. Labor Dept. figures medical care costs in Fairbanks rose by more than 14% last year, while the cost of medical care in Anchorage rose at a 15.3% rate. Both of these figures are well above the 11.1% average inflation rate among U.S. cities.

Particular hard hit by these inflationary trends is Alaska's large low-moderate income population. The Alaska Department of Revenue reports that for 1978, 68% of the state's residents had annual incomes of under \$25,000.00.

Yet, there are glaring deficiencies in the state's health care financing programs. The number of uncovered or inadequately covered persons numbers in the thousands. Enclosed is a copy and section by section analysis of House Bill 41, a comprehensive health care financing bill in the current session of the State Legislature designed to make health care more available and affordable.

The bill would establish minimum benefits standards for a comprehensive insurance plan open to all residents who choose to enroll, and are eligible. The state would subsidize, on a sliding fee scale, the insurance premiums and deductibles for moderate income residents who aren't covered under an existing plan, and choose to enroll in the state plan.

The bill would also:

- Require state employee health insurance to include coverage and benefits for drug and alcohol dependency. This would be a pilot program to see if it might be feasible to expand such coverage to other groups;
- Mandate the purchase of private insurance for those who are presently covered under Medicaid, if and when the state decides this is cost effective;
- Authorize interim payments to doctors and hospitals who have a large volume of medical assistance clients. The state would also be required to pay an interest on overdue Medicaid bills of 1% per month after 30 days and 2% per month after 90 days.
- Expand Medicaid services and eligibles in Alaska to include physical therapy adult dental care, coverage for unemployed fathers and caretaker relatives of a child over 18 and under 21, among others

- * BUT TO INSURE PASSAGE OF LONG-OVERDUE REFORMS, WE NEED YOUR HELP.
PLEASE SUBMIT WRITTEN TESTIMONY TO YOUR LOCAL REPRESENTATIVE AND GOV. HAMMOND
- * PLEASE TESTIFY AT THE TELECONFERENCE, MARCH 2, at 3 p.m. (Juneau Time), 1:00 p.m. Anchorage time.
- * If you have any questions or comments regarding this, please do not hesitate to contact us at 272-8734. We look forward to hearing from you.

For Health Care Advocates

David Pierce

Susan Johnson



ALASKA HEALTH CARE ADVOCATES

P.O. BOX 1037 D.T. ANCHORAGE, ALASKA 99510

272-8734

A LARGE PROPORTION OF THE PEOPLE WHO WOULD BE AFFECTED BY HB41 ARE WOMEN. THE MEDICAID PROVISIONS WOULD IMPACT WOMEN AS WOULD THE SECTION WHICH WOULD ALLOW THE STATE TO USE MEDICAID FUNDS TO PURCHASE PRIVATE INSURANCE PREMIUMS FOR MEDICAID ELIGIBLES. WHY ?

According to Randy Moore of the State Dept. of Health and Social Services, the number of Medicaid eligibles last December was the highest in four years. This was the last month for which Medicaid statistics were available.

December, 1980

AFDC— Total Medicaid eligible: 15,889 people. That is 5,049 adults and 10,840 children.

March, 1979

The figures for March 1979 are applicable to the 1980 Medicaid population.

93.7% female
4.5% male
1.8% not stated

Children in the AFDC group included:
49.3% female
50.7% male

Open door - limited svcs.
Neighborhood Health - has 1 nurse
practitioner in pre-natal
takes medicaid but seeks
to serve ^{lower-} middle income
people.

Health Alaska, INC.

P.O. Box 1239 Anchorage, Alaska 99510

May 4, 1981

Senator Charles Parr, Chairman
Health, Education & Social Services
State Capitol
Pouch V
Juneau, Alaska 99811

Dear Senator Parr:

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.

The cost containment advantages of an I.P.A. are based on the unusual nature of the health care market. In the health care market, the supplier, or provider also determines the level of demand by the amount of care they prescribe. Under the current fee for service system, there are no incentives to limit the services, and thus the fees. With an I.P.A., the provider must render all services for a fixed sum of money; this instills the necessary incentive to avoid over-treatment and become more cost efficient.

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How the Health Plan and the cost sharing program would work

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

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

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

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

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

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

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

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

Sponsors' Suggested Amendments to SS HB 41

page 1:

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

page 2:

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

page 7:

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

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

page 9:

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

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

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

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

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

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

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

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

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

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

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

MEDICAID ELIGIBLES*

Currently Covered Eligibles

Child under 18 deprived of parental support or care

Parent of AFDC child or other specified relative

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

All children in psychiatric hospitals

A child in an intermediate care facility for the mentally retarded

Aged, blind, or disabled persons

All children in foster homes or private child-caring institutions

Eligibles added by SS HB 41

Child deprived of support of parent due to unemployment

Spouse of disabled parent

Spouse of unemployed parent

Pregnant woman and unborn child

All other financially eligible children

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

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

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

Currently Covered Services

Hospital---inpatient and outpatient

Skilled nursing facility (SNF)

Intermediate Care Facility (ICF)

ICF for mentally retarded persons
and persons with related conditions (ICF/MR)

Laboratory and x-ray services

Physician services

Visual care services, dispensing and
ophthalmic materials

Medical transportation

Speech, hearing, and language services

Psychiatric facility services

Home health care services

Early periodic screening, diagnosis,
and treatment of individuals under 21 (EPSDT)

- a. dental services
- b. prosthetic devices and medical supplies
- c. physical therapy

Community mental health clinics

Family planning services

Patient surgical care centers

Rural health clinics

Services Added by SS HB 41

Podiatrist services

Chiropractic services

Private duty nursing

Personal care services

*Physical therapy

*Occupational therapy

*Prescribed drugs

Adult dentures and routine dental services

*Adult emergency dental services

*Prosthetic devices and medical supplies

Other diagnostic, screening, preventive & rehab. services

Services to those over 65 in mental institutions

Services to those over 65 in tuberculosis institutions

Other practitioner services

- a. private psychologist
- b. nurse practitioner
- c. physician assistant

Clinic services---other than comm. mental health clinic

Services by Christian Science nurses

Services by Christian Science sanatoria

* Currently available through General Relief Medical

HB 41 file

OF COUNSEL
M. E. MONAGLE

ROBERTSON, MONAGLE, EASTAUGH & BRADLEY

ROBERT B. BAKER
LEROY J. BARKER
L. G. BERRY
C. R. RICH
CARL W. WINNER

R. E. ROBERTSON 11885-19811
F. O. EASTAUGH
J. B. BRADLEY
WILLIAM G. RUDDY
L. B. JACOBSON
MICHAEL T. THOMAS
JAMES F. CLARK
PAUL M. HOFFMAN
J. P. TANGEN
D. ELIZABETH CUADRA
HAROLD E. SNOW, JR.
PAMELA L. FINLEY

A PROFESSIONAL CORPORATION
ATTORNEYS AT LAW
POST OFFICE BOX 1211
JUNEAU, ALASKA 99802

ANCHORAGE OFFICE
601 WEST FIFTH, SUITE 510
ALASKA MUTUAL BANK BLDG.
POST OFFICE BOX 679
ANCHORAGE, ALASKA 99510
PHONE (907) 271-6693
CABLE: ROMEA
TELEX: 090-26-486

JUNEAU OFFICE
210 FERRY WAY, 7TH FLOOR
POST OFFICE BOX 1211
JUNEAU, ALASKA 99802
PHONE (907) 586-3340
CABLE: ROMEA
TELEX: 099-45-376

May 14, 1981

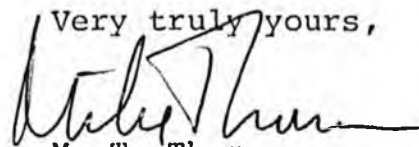
The Honorable Charles Parr
Chairman, Health, Education &
Social Services
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Re: House Bill 41 and Senate Bill 417

Dear Senator Parr:

The Health Insurance Association of America and the American Council of Life Insurance are interested in the above bills. This letter is to request that someone in your Committee notify my office when the above-referenced bills are to be heard.

Thank you for your courtesy.

Very truly yours,

M. T. Thomas

POSITION PAPER/Department of Health and Social Services

POSITION PAPER

SPONSOR SUBSTITUTE

HOUSE BILL NO. 41

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

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

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

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

II. GENERAL DEPARTMENTAL COMMENTS/RECOMMENDATIONS

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

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

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

FOOTNOTES ON PAPER/Department of Health and Social Services

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

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

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

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

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

Insurance Coverage for State Employees:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Section 11 - Lines 3 Through 7 on Page 9:

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

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

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

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

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

SUMMARY OF BUDGET FOR SSB41

	<u>TOTAL</u>	<u>FEDERAL</u>	<u>STATE</u>	<u>POSITIONS</u>
(1) ADDITION OF MEDICAID SERVICES & NEW OPTIONAL CATEGORICAL GROUPS	18,413.4	11,631.8	6781.6	12
(2) ADDITION OF MEDICAID MEDICALLY NEEDY GROUPS	9,029.7	5,709.3	3320.4	5
(3) DECREASE OF GRM DUE TO TRANSFER OF SERVICES & ELIGIBLES TO MEDICAID	(4,619.1)	-	(4619.1)	-
(4) INTEREST PAYMENTS	<u>667.2</u>	<u> </u>	<u>657.2</u>	<u>-</u>
TOTAL	23,491.1	17,341.1	6150.1	17
TOTAL WITHOUT MEDICALLY NEEDY	14,461.5	11,631.8	2829.7	12
TOTAL WITHOUT INTEREST PAYMENTS	13,794.3	11,631.8	2162.5	

Terry Gardiner

Box 6092, Ketchikan, Alaska 99901 Pouch V, Juneau, Alaska 99811

June 6, 1979

Dr. James Wilson
P. O. Box 8678
Ketchikan, Alaska 99901

Dear Dr. Wilson:

Sorry for the delay in responding to your letter on HB 412.
It got caught in the mail transfer with the end of the session.

This bill was introduced by Rep. McKinnon of Anchorage. It
was passed out of the House HESS Committee and was amended.
The bill has been referred to the House Judiciary committee
chaired by Rep. Charles Parr. I'm forwarding a copy of your
letter to Rep. Parr.

This bill doesn't seem to consider the problems of small
hospitals like so many of the bills introduced by our legislators
from Anchorage. I would oppose this bill unless there were
assurances it would not adversely impact small hospitals like
ours.

Sincerely,

Terry Gardiner
Speaker

cc: Rep. Parr, House Judiciary ←

DRS. WILSON AND WILSON, P.C.
ARTHUR N. WILSON, M.D.
JAMES A. WILSON, M.D., F.A.C.S.
ARTHUR N. WILSON, JR. M.D.
TY A. SALNESS, M.D.
P.O. BOX 8678
KETCHIKAN, ALASKA 99901

May 10, 1979

Mr. Terry Gardiner
The House of Representatives
P.O. Box 6092
Ketchikan, Alaska 99901

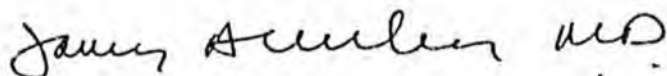
Dear Terry:

I am writing about House Bill No. 412, an act providing for minimum standards for hospital care. I realize I am writing very late but this bill has just come to my attention. Briefly, we think this is a rather awful punitive bill and is going to create considerable troubles for hospitals such as ours which has 44 beds and is being required to have a physician in the near vicinity of the hospital at all times. Very frankly, we were dropping our active care beds as you may remember, down to 39, so we are falling into this group where the attendant medical physician who is required to be on duty or on call can actually be out of the hospital rather than in the hospital.

Terry, we have looked into the cost of having emergency room coverage with an in-hospital physician on call at all times. The physician services groups that provide this kind of service are currently asking for \$45,000 a month up front, i.e., paid ahead of time before they would consider a contract. This is about the only way we would be able to have in-house coverage that would fall within the minimum standards of care required by this bill.


When I was an intern and a resident at a 500 bed hospital in Portland we had quarters and had a medical resident and a surgical resident and several interns sleeping in quarters adjacent to the hospital. This was part of our training program. When we try to apply this kind of thinking to small isolated hospitals with short staffs of perhaps 7 or 8 physicians such as Ketchikan, this type of bill would present a real hardship and would be fought most bitterly by the various medical staffs. I sincerely hope that this bill somehow gets sidetracked.

Sincerely,



James A. Wilson, M.D., F.A.C.S.

JAW/mc



Federation's Role in our Enterprise Economy

April 28, 1981

POSITION PAPER

TO: Legislators of the State of Alaska

FROM: FREE Committee of the Anchorage Women's Club

RE: Senate Bill No. 417 "An Act relating to health insurance for residents of the state; and providing for an effective date."

The FREE Committee of the Anchorage Women's Club opposes SB 417 for the following reasons:

1. This bill places the State Commissioner of Administration as both the underwriter and the payor.
2. Presentation at this time is ill-advised due to the incomplete report outstanding by the Battelle Human Affairs Research Center. The State of Alaska has contracted with Battelle for an indepth study at a cost of \$170,000. The interim report was submitted March 30, 1981, with the final report due December 11, 1981.
3. No specifications are outlined in this bill. Eligibility needs to be spelled out with reference to definition of the phrase "resident of the state". Will this be thirty days, one year, two years, etc.? This question is particularly pertinent in view of the pending suit by Mr. & Mrs. Zobel. Also, the problem of transients in Alaska for periods of six months or more should be addressed.
4. The cost factor involved in providing such a health program would be exorbitant. Given that we currently have ample funds in Alaska, this coverage may be possible at this time. However, such wealth is not guaranteed forever. Oil revenues are subject to environmental factors which could substantially change their presence in Alaska.

P.O. Box 4-2955 • Anchorage, Alaska 99509

A committee of the GFWC Anchorage Woman's Club



FREE

Federation's Role in our Enterprise Economy

5. Section 1, subparagraph (c) states that "the Commissioner shall pay the premiums of a resident ... if the resident is not enrolled in a group health insurance plan." This would effectively permit and/or encourage employers to terminate such coverage thus allowing employees to be covered under the state plan. This paragraph would also allow those persons who have voluntarily chosen to utilize their available premium dollars for other reasons to be eligible for the state program.
6. This bill does not specify what types of medical care would be covered. It does state that dental care, eye glasses, hearing aids, prescriptions or fitting of hearing aids and eye glasses are not covered. The range of other less vital and unnecessary treatments is at question.
7. SB 417 would encourage social irresponsibility of the individual as regarding normal preventative health care. It provides no incentive to maintain a healthful living routine and environment. Abuses of such broad coverage could easily encompass treatment of negligible scrapes, scratches, bruises, etc.
8. The insurance industry in Alaska has been effectively and competently providing health care coverage to residents. A bill such as this could effectively alter one of our fundamental free enterprise systems.
9. The \$2,500.00 deductible/coinsurance out-of-pocket limit could be too high for the truly needy resident. This deductible should be carefully evaluated.
10. No public meetings have been held for open discussion of such a massive undertaking. Input from all sectors must be obtained and considered. A thirteen member advisory committee known as the Alaska Comprehensive Health Care Financing Study Advisory Committee is currently working with the Battelle group regarding Alaska's health care needs. Public education and opinion must be obtained prior to this bill being signed into law.

P.O. Box 4-2955 • Anchorage, Alaska 99509

A committee of the GFWC Anchorage Woman's Club



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Federation's Role in our Enterprise Economy

11. SB 417 does not address interest in prevention, equitable access of health services, or cost containment and cost effectiveness.
12. Evaluation by other states has resulted in their decision not to implement this type of health insurance due to cost. Yet to be solved are the problems of inefficiency, improper utilization, inequities of delivery and financing systems.
13. Health care costs have risen dramatically since the federal government entered into health care with Medicare and Medicaid programs and with excessive costs on an administrative level.
14. The present Social Security system is practically bankrupt. The unending "red tape" and ineffective administration is well known. How will SB 417 differ?
15. Medicaid currently fosters family instability, i.e. more dollar coverage is available with the desertion of the supporting male member. The \$300.00 deductible per family or \$100.00 deductible per person could easily be abused by large families via separation of the members.
16. How will this bill help reduce spiraling costs of health care? Sen. Edward Kennedy estimated the first year's cost of Medicare as \$70 million; the actual cost was approximately \$140 million. The normal cost formulas did not work. This bill offers no cost containment provisions.
17. This bill does not address itself to payment to the medical industry. Payments under Medicare/Medicaid are frequently +90 days overdue to hospitals, physicians, nursing homes, physical and occupational therapists, pharmacies, etc. Such delinquent payment for services and prescriptions could effectively force small businesses into bankruptcy and/or force refusal to honor such patients. A detailed method of repayment needs to be outlined.



FREE

Federation's Role in our Enterprise Economy

18. A 1979 survey of 15,000 Alaskans by Sen. Ted Stevens regarding national health assistance, indicated that 36% favor additional insurance to cover catastrophic illness costs only; 23.2% favored a reduction of Medicare and Medicaid; 19.5% favored a comprehensive national health insurance plan; 15.1% favor current Medicare and Medicaid programs; and 5.8% were of no opinion or other. The people of Alaska deserve the right to voice their opinion and preference regarding this proposed program.
19. This bill is another form of standardization in which everyone lives in the same house, wears the same uniform, has the same insurance plan. This deprives the individual of his/her free choice.
20. An increase in the bureaucracy to administer this program will be necessary.
21. This bill furthers the direction of socialized medicine. A bill of this type could end up being the prototype to the nation for a national health care program.
22. The General Federation of Women's Clubs opposes all forms of socialized medicine.

We feel that SB 417 is entirely too broad for realistic or practical application. The bill raises more questions than it answers. It does not address many key issues and is premature in view of the outstanding final document of the Battelle Study.

CHARLIE PARR

ALASKA LEGISLATURE

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

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

May 22, 1981

Adrian G. Barber, D.C.
Alaska Chiropractic Society
C Street Plaza Building
Suite 102
1577 C Street
Anchorage, Alaska 99501

Dear Dr. Barber:

I do not expect to act on CSHB 41 this session.
The Committee will do a great deal of interim
work, and will take the bill up in January.

I would appreciate receiving information from
you during the interim or next session.

Sincerely,

Charles H. Parr

CHP:vc



alaska chiropractic society

ADRIAN G. BARBER, D.C.
President
C Street Plaza Bldg., Suite 102
1577 C Street
Anchorage, Alaska 99501
278-6481

GENE A. KREMER, D.C.
Vice President
2 Plaza
3222 Minnesota Drive
Anchorage, Alaska 99503
278-2522

MYRON D. SCHWENERT, D.C.
Secretary
C Street Plaza Bldg., Suite 102
1577 C Street
Anchorage, Alaska 99501
278-6481

BOBBY A. LUCAS, D.C.
Treasurer
P.O. Box 1481
Wasilla, Alaska 99687
278-2478

May 15, 1981

Senator Charles Parr
Pouch V
Juneau, Alaska 99811

RE: CSHB 41

Dear Senator Parr:

Section 11 of CSHB 41 does not provide for Chiropractic coverage.

It is imperative that Alaskans have the opportunity to choose Chiropractic care if they wish.

I or a representative of the Society would be happy to testify before your committee on the necessity of Chiropractic inclusion.

Thank you for your consideration.

Sincerely,

Adrian G. Barber, D.C.

AGB:mas



Alaska State Legislature

House of Representatives

Pouch V
State Capitol
Juneau, Alaska 99811

Official Business

May 18, 1981

TO THE EDITOR:

We are writing in response to the May 11, 1981, Times editorial, "Socialized medicine". Since the term is so often abused, and since we weren't sure what exactly you intended by the phrase, we consulted the dictionary on the matter:

Socialized medicine. The provision of medical and hospital care for the people at nominal cost by means of government regulation of health services and subsidies derived from taxation.

The insurance plan in HB 41 would not provide for medical and hospital care at a nominal cost. It would provide affordable care for those who are presently without it. Under the plan, a family of four with an annual income between \$14,000 and \$39,000 would pay from 10 to 90% of their health insurance costs. So, the state would not pay the full cost of care for those covered. It would only help participants meet the cost of their insurance coverage.

The bill does not provide for any government regulation of the private health care industry. Also, the money used by the state to help participants meet their insurance costs will come from Prudhoe Bay, not from taxation. Certainly, our oil dollars are everyone's dollars, and we should all share in them equally. But the health bill is no different from any other proposal that targets a specific group of Alaskans. Low interest agricultural loans benefit farmers, low interest home loans benefit home buyers, low interest business loans benefit businesses, hydroelectric projects benefit electricity users in the middle and southern portions of the state, property tax relief benefits property owners, and so on. When viewed as a whole, these programs do benefit all of us equally by making Alaska a more prosperous state. This does not mean, however, that each program separately provides direct and equal benefit to each and every Alaskan.

HB 41 does not meet the dictionary definition of "socialized medicine". Another important aspect of the insurance portion of the bill is not socialistic. The money appropriated by the legislature to help meet insurance costs, plus the money collected from participants for their portion of the cost of the plan would be kept in a fund which could be

PAGE TWO.

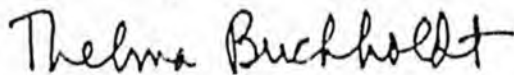
invested just like other investment funds (permanent fund, state employee pension and benefit funds, the general fund surplus) that the state currently maintains. The interest earned on the state's investment of the fund would be used to help cover expenses of the insurance plan and conceivably, the plan could eventually be self-supporting. A venture of this type is usually associated with capitalism, not with socialism.

The state's investment of the fund would help keep costs down. Additionally, your assumption that the plan would provide "nothing short of everything" so that the "cost would be horrendous" is untrue. We envision the plan providing a basic package of services that will ensure a decent standard of health care for all Alaskans. The plan will not pay for unnecessary medical and hospital care, but instead, will provide comprehensively for basic health care needs.

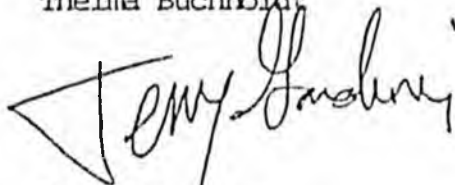
So much attention has been focused on the insurance portion that we wonder if people know that the bill includes funding for alcoholism treatment of state employees, an attempt to improve the provider reimbursement system for government health care programs, expansion of Medicaid coverage, and a study of how the state can complement Public Health Service and Medicare. All of these services are greatly needed to provide more and better health care to Alaskans.

HB 41 does not attempt to take care of every health need of every Alaskan with 100% state money. We are attempting instead to assure that 40,000 Alaskans who currently have no health care financing plan are able to afford health crises and provide for their basic health care needs; that more attention be paid to our obvious and collective alcoholism; that comprehensive health care be available to those who are least able to afford it; and that the state consider partial funding of the health needs of rural Alaskans and older Alaskans. Funding for these services is vital and would be an excellent investment in Alaska's future.

Sincerely,



Thelma Buchholdt



Terry Gardiner



Don Clocksin

Prime sponsors of HB 41

Health care legislation answers diverse range of needs

Alaska Health Care Advocates

Health Care Advocates welcomes the position expressed in your editorial calling for health care as a priority for this state. However, we do not agree with your conclusion that action on health legislation should wait for the results of the Battelle study, currently under way, on health care and financing. We will confine our remarks to three points in support of our position.

(1) House Bill 41 contains much more than just the state health plan referred to in your editorial; it also addresses long overdue Medicaid amendments and alcoholism benefits, each of which are important legislation in their own right.

(2) HB 41 is not a hasty, ill-conceived, unresearched concoction, but the product of three years of research and legislative work.

(3) There is no conflict between HB 41 and the Battelle study; they are in fact complementary.

Let us review the full scope of the bill. To begin with, the bill would expand Medicaid eligibility and coverage to include all optional groups and services qualifying for federal financial participation. It would extend Medicaid coverage to approximately 5600 Alaskans, specifi-

cally low-income women who are pregnant, children deprived of parental support due to unemployment, and certain other members of AFDC (Aid to Families with Dependent Children) households who currently are not covered by Medicaid. Newly covered services would include physical therapy, occupational therapy, prescription drugs, adult dental care, prosthetic devices, nurse practitioners and physician assistants.

Delays in claims processing and payments to providers reached crisis proportions in Alaska's Medicaid program in recent years. The bill addresses this problem by allowing interim or advance payments to large-volume Medicaid providers, and by instituting interest penalties payable by the state on overdue payment of claims. The state could get out of claims processing altogether if it is found to be cost-effective. The bill allows Medicaid funds to be used to pay health insurance premiums or subscriber fees for prepaid health service contracts on behalf of Medicaid eligibles.

Alcohol abuse is Alaska's biggest health problem. It precipitates other illnesses and injuries which require medical treatment. The bill provides

compass

*points of view
from our
community*



benefits to state employees for alcohol and drug abuse treatment as a demonstration project.

The state health plan is actually two separate programs. One is an unsubsidized group insurance plan open to all state residents, including high-risk individuals for whom individual insurance coverage is not available in the private market.

The second program is a cost-sharing program which would help pay for health insurance for Alaskans who have no subsidy from another source, such as private employers or federal programs. The subsidies are graduated by income, reaching 100 percent for needy low-income people not qualifying for Medicaid. Cost sharing may be applied toward either the state plan or a private

insurance plan that is of comparable quality.

The development of this legislation reaches back to 1977, before the Battelle study had been considered, when Rep. Thelma Buchholdt requested that the legislative research agency study third-party health coverage, gaps in coverage and options for state action. The results of the study were published in April 1978. In 1980 major health legislation was introduced a direct ancestor of HB 41.

While the Medicaid portions of the bill have remained very much the same through all subsequent versions of the bill, the health plan has gone through major revisions and refinements. The state health plans of Hawaii, Minnesota, and Connecticut each were

used as models for the Alaska legislation. Each version was drafted, debated, revised, debated and finally rejected in favor of the uniquely Alaskan approach embodied in the current bill. The bill has undergone exhaustive scrutiny by the insurance industry and administrative agencies as well as consumer representatives.

While the framework of a state health plan has been constructed, much more research and preparation is needed to implement the programs. HB 41 directs the Department of Administration to develop and cost out a benefit package, to draw up implementation plans for the two programs, and to recommend any amendments needed to facilitate the smooth implementation of the program.

The bill also calls for a study by the Legislative Council addressing issues surrounding the state's role in providing health coverage for Alaska Native people in light of federal responsibilities in that area. The results of both studies will be delivered to the legislature next session in time for further legislative action before start-up of the plan.

The Battelle study meshes with this timetable perfectly. The first phase of the study,

consisting of an analysis of the existing health care and financing system and identification of gaps and problems, has been completed. While the scope is broader and the research more thorough, the conclusions of the Battelle study with respect to health coverage are not substantially different from the earlier study by the legislative research.

In the second phase of the Battelle study, implications will be more thoroughly analyzed and implementation plans developed in detail for two or three specific options for state action.

One of the options selected for further study by the advisory committee is the coordination of Native and non-Native health services. A second option selected is a state health plan along the lines embodied in HB 41. The results of these two studies will be completed and a draft available for public comment in September 1981. Thus there is plenty of time to incorporate the results of the Battelle study into the implementation plans for HB 41.

To stall passage of health legislation by awaiting the study's results is pointless and would likely delay implementation for at least two years.

Why should Alaskans wait?

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

MEMORANDUM

February 20, 1980

TO: Representative Bill Parker
FROM: Duncan L. Read *D L R*
RE: State Health Care Programs
Research Request No. 61

Although Jack Kreinheder has been assigned to work on your research request, I have just completed some cursory research related to alternative State health care financing systems in response to another request and thought it appropriate to share the resulting findings that are pertinent to your interests. Mr. Kreinheder will commence work on your request within the near future, as soon as he completes projects assigned to him that preceded yours.

First, you requested any available studies or reports regarding medicaid, State health insurance, and the State's health care program. We have requested a copy of the new State Health Care Plan, which should be available from the Department of Health and Social Services within the next two weeks. After seeing the attached news article, we have also requested from the Anchorage Neighborhood Center a copy of a recent federal Bureau of Health Manpower study. That report should contain information that addresses your second question concerning direct delivery of services by government or government payment for services provided by private, non-profit corporations to medically underserved populations.

While Mr. Kreinheder will address your second question in greater depth, it does appear that there are precedents for direct delivery of, or payment for services by, the government. The attached news article clearly shows the federal government can assume direct responsibility for health care in certain circumstances, as it already has in many Alaska communities through local sponsors. Arizona, as you know from research provided you last year, does not participate in the medicaid program and county governments provide medical assistance, often directly by medical personnel in the county's employment. One municipality in Alaska, Anchorage, has assumed full health powers, though it has not elected to provide the broad range of services that are provided by local governments elsewhere.

Representative Bill Parker
February 20, 1980
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You have indicated that you are interested in options to continuing State participation in the federal medicaid program. Dr. Fred McGinnis, Deputy Commissioner of the Department of Health and Social Services, has a long-standing interest in health care financing options and has recently attempted to find monies (\$20-30,000) with which to conduct a small, in-house study. Yesterday, Representatives Martin and Hayes had introduced a resolution and accompanying appropriations measure (\$200,000) with Representative Beirne providing for a more comprehensive study to be conducted by the legislature. Representative Martin had earlier indicated a willingness to share information compiled for him with you (although we did not reveal your identity).

Two factors may have to be addressed in direct delivery of services by the State:

- medical malpractice insurance for State-employed doctors
- the implied contractual relationship between providers and patients and the related concept of medical abandonment, which might pose difficulties for the state if it chose to provide services on a limited-term basis.

Mr. Kreinheder will explore these in more detail.

Finally, you may be interested in a mandatory health insurance program recently instituted by the state of Hawaii. The statutory provisions are attached. While Hawaii has not withdrawn from the medicaid program, it is my understanding that they are currently experimenting with a control group who will receive coverage only from their health insurance programs and then will compare costs to those also covered by Medicaid.

This summarizes our information to date. More details will be forthcoming.

DLR/dp

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

MEMORANDUM

March 18, 1980

TO: Representative Bill Parker
Attn: Mr. Jim Erickson

FROM: Jack Kreinheder, Issues Analyst

RE: State Health Care Programs
Research Request No. 61

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

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

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

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

2. Withdrawal from the Medicaid program is not, however, a prerequisite to the establishment of a State physician program. My understanding of the alternative health care system you are considering is that the State would not necessarily provide all the medical services now administered by private physicians under the Medicaid program, but would instead make State doctors available in areas which are medically under-served either because of the lack of physicians, the lack of specific medical services, or because of the refusal of available physicians to accept Medicaid patients. It is clear that the State could continue to receive federal Medicaid funds for medical services provided by private physicians; and, in addition, it appears that funds could also be received for State-provided services if a federal waiver from certain regulations could be obtained. The State currently receives over \$22 million per year in federal Medicaid funds.
3. It may be possible to improve medical care for low-income persons by means other than, or in addition to, direct State health care delivery, and without opting out of the Medicaid program. The principal problem with the Medicaid program, from the recipient's point of view, appears to be that many doctors in Alaska refuse to accept Medicaid patients. This reluctance to take Medicaid patients is, in turn, largely attributable to the extensive paperwork requirements and the extremely slow payment process of the current Medicaid system in Alaska. However, these problems are not inherent in the federal Medicaid system, and it appears that more rapid and efficient reimbursement of medical providers could substantially improve low-income access to medical care by encouraging more doctors to participate in the program. Of course, there may be other problems with the Medicaid program which might make withdrawal from the system desirable.
4. The expanded use of fiscal intermediaries may be one option for making more doctors available to low-income persons. Delta Dental Plan of Alaska is currently the only organization of this type in Alaska and handles only dental services, but all parties involved--the Department of Health and Social Services, the participating dentists, and the Medicaid recipients--seem to be very satisfied with the program. About 96 percent of the dentists in Alaska are members of Delta Dental and 95 percent of these participate in Medicaid. The fact that reimbursement to dentists by

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

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

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

State Medical Care

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

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

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

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

Under the HEW system, which is authorized by section 532 of the Public Health Service Act, an area or population group of an area may be designated as a Health Manpower Shortage Area if the population-to-primary care physician ratio exceeds a certain level. An area is also given a degree-of-shortage classification based on this ratio. The population-to-physician ratio takes account of physician accessibility, rather than simply dividing the population by the number of physicians. For example, in Anchorage, the ratio of Medicaid eligible persons to all primary care practitioners is estimated at 161:1, but when HEW adjusted for the fact that most of these physicians do not accept Medicaid patients, the final population-to-primary care physician ratio was determined to be 3,041:1.

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

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

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

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

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

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

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

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

Medicaid Issues

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

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

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

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

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

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

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

JK/dp

cc: Representative Terry Martin

Attachments:

- A. HEW designation of Anchorage as a Health Manpower Shortage Area, from the Anchorage Neighborhood Health Center.
- B. Letter from Commissioner Beirne to Representative Martin on Medicaid/State Health Care issues.
- C. Letter from Dr. Lillibridge to HEW discussing Medicaid problems.
- D. Letter from Dr. Lillibridge to Representative Martin on Medicaid problems and the Delta Dental program.
- E. HEW administrative review of the Alaska Medicaid program.
- F. H&SS task force recommendations on the Medicaid program.
- G. Information supplied by Delta Dental on their program.
- H. Alaska and National Health Insurance---report by Dr. McGinnis of H&SS.
- I. Third Party Health Coverage in Alaska---1978 report by the former Legislative Affairs Research Division.
- J. Opting-A Study of Medicaid Client Need--1977 report by the former Research Division.
- K. H&SS 1977 Medicaid Annual Status Report.
- L. January, 1980 State Health Plan.

PLEASE NOTE: THE FOLLOWING PAGES WERE TREATED
AS A UNIT IN THE ORIGINAL DOCUMENT

Nancy:

I decided to write you a note, since we often cannot get together.

Aside, from minor drafting considerations, I only have three comments:

- (1) the regional median income figures may be a better way to deal with regional cost differences, as we discussed.
- (2) The language in our bill regarding copayments and deductibles may be better because it will encourage competition among bids if you don't specify what the rates have to be. (Similar to the argument against specifying benefits in the bill, but leaving them up to regs after competitive bid process has taken place.) Also, the lower the deductible, the higher monthly premiums will be, as we discussed.
- (3) You and Charlie may want to consider including the section in our bill about underwriting and admin. Our bill says, "The commissioner shall contract for the administration and may contract for the underwriting. . ." The purpose of this is to be sure that they contract out the administration part of it. We felt that Retirement & Benefits can barely handle the state employees program and that they do not need the million and one field offices, employees, etc. that they claim they need to do the program, even if they don't contract it out. We thought it would be better to have Blue Cross do that and open field offices if they like. Of course, Retirement & Benefits disagrees with us on this point. The "may contract for the underwriting" language was to allow the state to underwrite the plan itself if this turns out to be a better deal for us. We can eventually use the interest money in the fund to pay for administration, or a part of it, if all goes well with investing the fund.
You may feel that your language in proposed 18.27.010(c) takes care of all problems. This is fine, unless you feel that the admin. part should be contracted out, as we do.
- (4) Well, I'm going to make one more pitch for the 90-day limitation. At least half the cost of the present bill is covering people who already have coverage and who may switch because they think they'll get a better deal (the side deal scenario). Anything we can do to discourage this switching--since many think it will occur--- is beneficial to the bill, I think, because it makes it more politically palatable because it will cost less money. However, if you are not into this kind of a time limitation, maybe we could be more creative and come up with something else?

I appreciate the opportunity for input, on behalf of Thelma. I would be happy to discuss any of these or other issues with you further, if you like.

- Louann

Hein ✓✓



Original sponsors: Buchholdt, Cato,
Gardiner, et al

1 IN THE HOUSE

BY THE HEALTH, EDUCATION AND
SOCIAL SERVICES COMMITTEE

2 SENATE CS FOR CS FOR SPONSOR SUBSTITUTE FOR HOUSE BILL NO. 41 (HESS)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 TWELFTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act relating to the health of residents of the
7 state."

8 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

9 * Section 1. AS 18 is amended by adding a new chapter to read:

10 CHAPTER 27. STATE HEALTH INSURANCE.

11 Sec. 18.27.010. STATE ~~COMPREHENSIVE~~ HEALTH PLAN. (a) The com-
12 missioner shall establish minimum benefit standards for the state
13 ~~comprehensive~~ health plan and shall provide for the underwriting and
14 administration of the state ~~comprehensive~~ health plan.

15 (b) A resident of the state is entitled to enroll in the state
16 ~~comprehensive~~ health plan.

17 (c) The state ~~comprehensive~~ health plan shall provide for copay-
18 ments and deductibles, and shall provide an annual limit on the total
19 amount of copayments and deductibles for each enrolled resident and the
20 covered dependents of the resident for each year. The annual limit
21 shall be the same regardless of family size.

22 (d) The commissioner shall ~~contract for the administration and~~
23 may contract for the underwriting of the state comprehensive health
24 plan. A contract entered into under this subsection shall be based on
25 competitive bids and shall be for a three-year period.

26 (e) Notwithstanding the provisions of (c) of this section and
27 AS 18.27.020(c), a resident who is enrolled in the state comprehensive
28 health plan or in a health insurance plan certified under AS 18.27.020-

29 (a)(1)(B); and who is eligible for a permanent fund dividend under

1 AS 43.23.010 may direct the commissioner of revenue to use as much of
2 the permanent fund dividend as is necessary to pay a cost incurred by
3 the resident arising from participation in the state comprehensive
4 health plan or in a health insurance plan certified under AS 18.27.020-
5 (a)(1)(B).

6 Sec. 18.27.020. STATE HEALTH INSURANCE COST SHARING PROGRAM. (a)
7 Cost sharing under the state health insurance cost sharing program may
8 be provided to a resident who

9 (1) is enrolled in

10 (A) the state ~~comprehensive~~ health plan established
11 under this chapter; or

12 *ask*
13 *Ed*
14 (B) a nonsubsidized health insurance plan that the
15 insurer has certified to the commissioner as equivalent to or
16 exceeding the benefit standards of the state comprehensive health
17 plan established by the commissioner under AS 18.27.010(a); and

18 (2) qualifies for cost sharing under (c) of this section.

19 (b) Cost sharing may not be provided if, and to the extent that,
20 subsidized medical care or subsidized health insurance (other than the
21 state ~~comprehensive~~ health plan established under this chapter) is, or
22 during the 90 days preceding enrollment in the state ~~comprehensive~~
23 health plan has been, available and accessible to the resident or
24 would be or would have been available and accessible upon application
25 by the resident.

26 (c) The commissioner shall pay the state share of the costs of
27 health insurance incurred by a resident of the state and his covered
28 dependents qualifying for cost sharing under the following formula:

29 (1) if the total adjusted gross income of the resident and
his dependents is at or below 75 percent of the base income, 100 per-
cent of the premium cost of health insurance;

1 (2) if the total adjusted gross income of the resident and
2 his dependents is between 75 percent of the base income and 125 percent
3 of the base income, a graduated percentage of the premium cost of
4 health insurance between 100 percent and zero percent;

5 (3) if the total adjusted gross income of the resident and
6 his dependents is at or below 45 percent of the base income, 100 per-
7 cent of copayments and deductibles;

8 (4) if the total adjusted gross income of the resident and
9 his dependents is between 45 percent of the base income and 95 percent
10 of the base income, a graduated percentage of the copayments and de-
11 ductibles from 100 percent and zero percent;

12 (5) if a resident is enrolled in a health insurance plan
13 certified to the commissioner under (a)(1)(B) of this section, the
14 state share of the cost of health insurance for the resident is limited
15 to the amount that the state's share would have been if the resident
16 had been enrolled in the state comprehensive health plan.

17 *Def. part?* (d) The commissioner shall adopt minimum benefit standards and
18 guidelines by which an insurer shall compare its health insurance plan
19 with the state comprehensive health plan for the certification of a
20 plan under (a)(1)(B) of this section.

21 (e) Notwithstanding the provisions of a health insurance plan,
22 an insurer shall provide the benefits that under (a)(1)(B) of this
23 section the insurer has certified are included in the plan.

24 Sec. 18.27.030. DEFINITIONS. In this chapter

25 (1) "adjusted gross income" means the (adjusted gross income)
26 of the resident determined under the regulations of the commissioner;

27 (2) "base income" means

28 (A) family median income for Alaska determined by the
29 United States Bureau of the Census; and

1 (B) regional adjustments established by the commis-
2 sioner to the family median income for Alaska determined by the
3 United States Bureau of the Census, that are based on relative
4 costs of living in the state;

5 (3) "commissioner" means the commissioner of administration;

6 (4) "copayment" means the portion of covered expenses pay-
7 able by the resident after the deductible has been met;

8 (5) "insurance" means prepaid plans or indemnity plans;

9 (6) "resident" means a person who for 12 consecutive months
10 immediately preceding enrollment in the state comprehensive health plan
11 under this chapter has maintained a permanent place of abode in the
12 state and during that time period has continually maintained his voting
13 residence in the state;

14 (7) "subsidized health insurance" means health insurance all
15 or part of the premiums of which are paid by an employer^{or institution} of the insured;

16 (8) "subsidized medical care" means medical care provided
17 free of charge.

18 * Sec. 2. AS 21.54.060 is amended by adding a new paragraph to read:

19 (7) under a policy issued to the state to insure residents
20 of the state under AS 18.27.

21 * Sec. 3. AS 39.30.090(1) is amended to read:

22 (1) A group insurance policy shall provide one or more of
23 the following benefits: life insurance, accidental death and dismem-
24 berment insurance, weekly indemnity insurance, hospital expense insur-
25 ance, surgical expense insurance, dental expense insurance, audio-
26 visual insurance, alcoholism and drug dependency insurance, or other
27 medical care insurance.

28 * Sec. 4. AS 39.30 is amended by adding a new section to read:

29 Sec. 39.30.092. COVERAGE FOR ALCOHOLISM AND DRUG DEPENDENCE. (a)

1 The group insurance policy under AS 39.30.090(1)

2 (1) shall provide coverage for alcoholism and drug depen-
3 dence to include

4 (A) inpatient detoxification benefits for not less than
5 14 days of benefit each calendar year in a state-approved treat-
6 ment facility or licensed hospital; payment of institutional and
7 professional benefits shall be equal to and payable as any other
8 covered condition, except a covered condition which, by the terms
9 of the policy, has an internal restriction;

10 (B) inpatient treatment coverage benefits for not less
11 than 30 days of benefit each calendar year in a state-approved
12 treatment program; payment of institutional and professional bene-
13 fits shall be at the same level as any other covered condition,
14 except a covered condition which, by the terms of the policy, has
15 an internal restriction; and

16 (C) outpatient treatment coverage benefits of not less
17 than 30 visits each calendar year if treatment is provided by a
18 licensed physician, state-approved treatment program, or state-
19 certified professional substance abuse counselor; coverage shall
20 include individual, family or group therapy; benefits shall be
21 paid at not less than 75 percent of the usual, customary and
22 reasonable charge for a medical procedure, treatment or service in
23 the geographic area;

24 (2) may not exclude dependents otherwise covered and may not
25 limit coverage for alcoholism or drug dependence because of age, sex or
26 state of illness;

27 (3) may not apply preexisting or named condition exclusions
28 to deny coverage for alcoholism or drug dependence; and

29 (4) may require a physician's certification of necessity as

1 a condition of payment for alcoholism or drug dependence treatment.

2 (b) The provisions of this section apply to group health insur-
3 ance contracts and group service or indemnity type contracts issued to
4 provide coverage for employees of the state and may apply to contracts
5 for the benefit of employees of other participating governmental units
6 only if the governing body of the governmental unit elects to have the
7 provisions apply.

8 (c) In (a) of this section,

9 (1) "alcoholism" means an illness or condition characterized
10 by the habitual lack of self control in the use of alcoholic beverages,
11 or use of alcoholic beverages to the extent that health is substantial-
12 ly impaired or endangered, or social or economic function is substan-
13 tially disrupted;

14 (2) "drug dependence" means the condition of being physi-
15 cally or psychologically addicted to an opiate, opiate derivative,
16 tranquilizer, amphetamine, barbiturate, or similar substance, but
17 excluding nicotine, caffeine and alcohol;

18 (3) "state" means any state in the United States and in-
19 cludes the District of Columbia.

20 * Sec. 5. AS 39.30.100 is amended to read:

21 Sec. 39.30.100. DEFINITIONS. In AS 39.30.090 - 39.30.100 [AS 39.-
22 30.090]

23 (1) "eligible employee" means

24 (A) an employee who has served in permanent full-time
25 or part-time employment with the same governmental unit for 30
26 days or more, except an emergency or temporary employee, and

27 (B) an elected or appointed official of a governmental
28 unit, effective upon taking the oath of office;

29 (2) "governmental unit" means the state, a borough, muni-

1 cipal corporation, or other political subdivision of the state, and the
2 North Pacific Fishery Management Council;

3 (3) "insurance", "insurance carrier" and "insurance policy"
4 include health care services, health care service contractors and con-
5 tracts.

6 * Sec. 6. AS 47.05 is amended by adding new sections to read:

7 Sec. 47.05.070. MEDICAL ASSISTANCE BY INSURANCE OR SERVICE CON-
8 TRACTS. (a) The commissioner shall use medical assistance funds to
9 purchase and pay premiums on policies of insurance or pay the expenses
10 of health care service contracts that provide one or more of the ser-
11 vices available under state medical assistance programs.

12 (b) The policy of insurance or the contract financed under this
13 section must guarantee to

14 (1) provide services and supplies under policies of insur-
15 ance or contracts under AS 21;

16 (2) provide the statistical data, records, and reports
17 relating to the provision, administration, and costs of providing
18 services and supplies as required by the commissioner.

19 Sec. 47.05.080. IMPLEMENTATION. The commissioner shall implement
20 the provisions of AS 47.05.070 when he determines that comparable
21 benefits are available at equal or less cost than direct payments by
22 the department to the providers of services and supplies.

23 Sec. 47.05.090. INTERIM PAYMENT. The commissioner may make an
24 interim payment to a provider of medical services before he receives a
25 bill for the services.

26 Sec. 47.05.100. INTEREST ON LATE PAYMENTS. When presented by a
27 provider of medical services with a clean claim, the commissioner shall
28 pay

29 (1) interest at the rate of one percent per month when

1 payment is delayed more than 45 days after presentation of the clean
2 claim;

3 (2) interest at the rate of two percent per month when
4 payment is delayed more than 90 days after presentation of the clean
5 claim; and

6 (3) the interest for a full month if the overdue clean claim
7 is not paid by the 15th day of a calendar month.

8 Sec. 47.05.110. DEFINITIONS. In AS 47.05.070 - 47.05.110

9 (1) "clean claim" means a claim for payment which can be
10 processed without obtaining additional information from the provider of
11 the service or from a third party; it includes a claim with errors
12 originating in the department's claims processing system, but does not
13 include claims from a provider who is under investigation for fraud or
14 abuse, or a claim under review for medical necessity;

15 (2) "commissioner" means the commissioner of health and
16 social services;

17 (3) "department" means the Department of Health and Social
18 Services;

19 (4) "health care service contract" means a contract with a
20 nonprofit corporation which accepts prepayment for health care services
21 and is sponsored by or associated with a group of physicians or a group
22 of hospitals or both or by a health maintenance organization recognized
23 under federal law;

24 (5) "medical assistance" means Medicaid (AS 47.07), general
25 relief medical (AS 47.25.120), catastrophic illness (AS 47.08), and
26 crippled children's and maternal and child health programs (AS 18.05.-
27 010).

28 * Sec. 7. AS 47.07.020(b) is repealed and reenacted to read:

29 (b) A resident of the state for whom the provisions of the Social

1 Security Act in effect on March 1, 1981, allow optional medical cover-
2 age that qualifies for federal financial participation is eligible for
3 medical assistance. A resident of the state qualifying as medically
4 needy under AS 47.07.080(5) is not eligible for medical assistance.

5 * Sec. 8. AS 47.07.030 is repealed and reenacted to read:

6 Sec. 47.07.030. MEDICAL SERVICES TO BE PROVIDED. Medical ser-
7 vices to be offered to eligible persons include those services eligible
8 for federal financial participation under the provisions of Title XIX
9 of the federal Social Security Act in effect on March 1, 1981..

10 * Sec. 9. AS 47.07.080 is amended by adding new paragraphs to read:

11 (5) "medically needy" means a person who meets the categori-
12 cal requirements of eligibility for medical assistance but whose income

13 (A) exceeds the income standard for categorical assist-
14 ance; and

15 (B) is less than the medically needy income standard
16 after the deduction of allowable medical expenses;

17 (6) "categorical requirements of eligibility" means the
18 standards established under 42 C.F.R., secs. 435.500 - 435.541;

19 (7) "medically needy income standard" means the standards
20 established under 42 C.F.R., secs. 435.800 - 435.816.

21 * Sec. 10. AS 47.07.020(d) is repealed.

22 * Sec. 11. By the 30th day of the First Session of the Thirteenth Legis-
23 ture the commissioner of administration shall submit to the legislature a
24 report on

25 (1) proposed minimum benefit standards and estimated actuarial
26 costs of the state comprehensive health plan (AS 18.27);

27 (2) the anticipated number and characteristics of participants in
28 the state health insurance cost sharing program (AS 18.27.020) and the
29 projected cost to the state;

1 (3) a proposed plan for

2 (A) implementation of AS 18.27;

3 (B) eligibility determinations under AS 18.27;

4 (C) payment of the state share of premium costs and copay-
5 ment and deductibles incurred under AS 18.27; and

6 (D) informing the public of benefits under AS 18.27;

7 (4) recommendations for amendments to AS 18.27.

8 * Sec. 12. Coverage under the state ~~comprehensive~~ health plan (AS 18.27.-
9 010) and the state health insurance cost sharing program under AS 18.27.020
10 begins on July 1, 1983.

11 * Sec. 13. The provisions of secs. 3 - 5 of this Act apply to group
12 policies or contracts which provide coverage under AS 39.30.090 - 39.30.100
13 and which are delivered, issued for delivery, or renewed in this state after
14 the effective date of this Act. A policy or contract providing coverage for
15 eligible employees in this state under AS 39.30.090 - 39.30.100 delivered,
16 issued for delivery, or renewed after the effective date of this Act provides
17 the minimum coverage required by this Act even if the language of the policy
18 or contract does not specifically so provide.

19 * Sec. 14. (a) By the 30th day of the First Session of the Thirteenth
20 Legislature the Legislative Council shall study and make recommendations to
21 the legislature

22 (1) for federal improvements in the Indian Health Service delivery
23 system;

24 (2) on the alternatives available to the state to complement the
25 funding of the Indian Health Service;

26 (3) on the alternatives available to the state to complement
27 services available to the senior citizens of the state under Medicare.

28 (b) The Legislative Council shall seek participation in the study by

29 (1) the health, education, and social services committees of the

1 legislature;

2 (2) the Alaska Native Health Board;

3 (3) regional health organizations;

4 (4) other providers and consumers of health care;

5 (5) the Department of Health and Social Services;

6 (6) the Alaska Area Native Health Service, United States Public

7 Health Service.

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PLEASE NOTE: THE PRECEDING PAGES WERE TREATED
AS A UNIT IN THE ORIGINAL DOCUMENT.

80% of Median Income

INCOME LIMITS FOR SECTION S - LOW INCOME AND SECTION 236
IN ALASKA BY CENSUS DIVISION

Handwritten notes:
Nancy
10/1/81
10/1/81

As of October 1, 1981



CENSUS DIVISION	NUMBER OF PERSONS IN HOUSEHOLD							
	1	2	3	4	5	6	7	8+
	15,012							
Aleutian Islands	\$12,050	\$13,750	\$15,500	\$17,200	\$18,300	\$19,350	\$20,450	\$21,500
Anchorage	16,350	18,700	21,000	23,350	24,800	26,300	27,750	29,200
Angoon	10,450	11,900	13,400	14,900	15,850	16,750	17,700	18,650
Barrow	12,050	13,750	15,500	17,200	18,300	19,350	20,450	21,500
Bethel	10,450	11,900	13,400	14,900	15,850	16,750	17,700	18,650
Bristol Bay Borough	14,550	16,650	18,700	20,800	22,100	23,400	24,700	26,000
Bristol Bay	10,450	11,900	13,400	14,900	15,850	16,750	17,700	18,650
Cordova-McCarthy	14,050	16,050	18,050	20,100	21,350	22,600	23,850	25,100
Fairbanks	14,500	16,600	18,650	20,700	22,000	23,300	24,600	25,900
Haines	15,600	17,850	20,100	22,300	23,700	25,100	26,500	27,900
Juneau	18,850	21,550	24,250	26,950	28,650	30,350	32,000	33,700
Kenai-Cook Inlet	15,250	17,400	19,600	21,750	23,100	24,500	25,850	27,200
Ketchikan	15,050	17,200	19,350	21,500	22,850	24,200	25,550	26,900
Kobuk	10,450	11,900	13,400	14,900	15,850	16,750	17,700	18,650
Kodiak	13,600	15,500	17,450	19,400	20,600	21,850	23,050	24,250
Kuskokwim	10,450	11,900	13,400	14,900	15,850	16,750	17,700	18,650
Matanuska-Susitna	13,600	15,500	17,450	19,400	20,600	21,850	23,050	24,250
Nome	10,450	11,900	13,400	14,900	15,850	16,750	17,700	18,650
Outer Ketchikan	13,100	14,950	16,850	18,700	19,850	21,050	22,200	23,400
Prince of Wales	14,000	16,000	18,000	20,000	21,250	22,500	23,750	25,000
Seward	13,600	15,500	17,450	19,400	20,600	21,850	23,050	24,250
Sitka	16,600	18,950	21,300	23,700	23,150	26,650	23,100	29,600
Skagway-Yakutat	13,600	15,500	17,450	19,400	20,600	21,850	23,050	24,250
Southeast Fairbanks	13,350	15,300	17,200	19,100	20,300	21,500	22,700	23,900
Upper Yukon	10,450	11,900	13,400	14,900	15,850	16,750	17,700	18,650
Valdez-Chitna-Whittier	14,450	16,500	18,600	20,650	21,950	23,200	24,500	25,800
Wade Hampton	10,450	11,900	13,400	14,900	15,850	16,750	17,700	18,650
Wrangell Petersburg	13,600	15,500	17,450	19,400	20,600	21,850	23,050	24,250
Yukon-Koyukuk	15,350	17,550	19,750	21,900	23,300	24,650	26,050	27,400

Nancy; To get 100% of median income: ~~multiply~~ divide all figures by .8. Then you can factor back higher + lower percentages.

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

DATE: February 22, 1982

TO: Fred McGinnis

FROM: John Willis *JW*

SUBJ: Coverage Estimates and HB-41

Per your request I have gathered together some information from our report which might be useful to you in your hearings this week. The information basically pertains to two items

- clarification and justification of our estimates of the size of the uncovered population in Alaska.
- conclusions from our analysis of a state sponsored health insurance plan which also bear on House Bill 41.

I. Clarification of Coverage Estimates

It seems to me there are four questions that are relevant here:

- What do we estimate to be the size of the uncovered population in Alaska?
- How did we derive this estimate?
- Are there potential problems with the data we used to make the estimates?
- If so, are these problems severe enough to warrant rejecting the estimates?

I will answer each in turn.

- A. What do we estimate to be the size of the uncovered population in Alaska?

We estimate that there are approximately 44,000 persons in Alaska who do not have at least one of the following:

- a private health insurance plan (group or individual policy)
- access to the military health care system
- access to the Indian Health Service Medicare coverage
- other PHS or VA coverage.

Of these 44,000 without private coverage, approximately 15,000 are eligible (not recipients) for either Medicaid or GRH. This leaves approximately 29,000 persons with no source of coverage, including public assistance.

These 29,000 persons are civilian, non-Natives under the age of 65. (We have assumed all Natives to have coverage by virtue of the IHS, and almost all non-Native Alaskans over 65 have Medicare coverage.) Among these 29,000 uncovered persons about 43% are children. Of the adults, about 83% are employed, typically for small firms which do not offer health insurance, or on less than a full-time permanent basis. About 90% are healthy, while about 10% have a health impairment of one sort or another. (For other characteristics of the uncovered, please see pages 75-83 of the Advance Final Report.)

The precise number uncovered fluctuates over the course of a year because of seasonality of employment, being highest in the late winter and lowest in the late summer. Our estimates are for the spring months, which are neither the peak nor the trough of coverage.

B. How were these estimates derived?

Our estimates were derived from data contained in the Survey of Income and Education (SIE), conducted by the U.S. Bureau of the Census in Alaska in 1976. We obtained the raw data tapes from the Bureau of the Census and generated the estimates on our own computers.

The Survey of Income and Education was a lengthy personal interview, covering 7378 Alaskans in 2722 families drawn from 17 of the state's 29 census districts. The survey was designed by the Bureau to generate accurate state level estimates of a number of variables for Alaska and every other state; it has been and continues to be used by the federal government in a number of programs that require state level estimates. It is the only statewide data source in existence which links data on insurance coverage, race, income, and other personal and family characteristics.

Since the size of Alaska's population changed between 1976 and 1980, we used the SIE to estimate two proportions:

- What proportion of civilian, non-Natives under age 65 are covered by one or more coverage source other than military care or public assistance?
- Of these, what proportion are dependents of active duty servicemen or women, or otherwise eligible for military related care?
(Note that this does not include all military care related eligibles, since some were included in the first cut.)

We then applied these proportions to the 1980 census figures for Alaska to arrive at the 44,000 figure. The 29,000 figure was derived from this by subtracting estimates of Medicaid and GRM eligible (not recipients) under the age of 65.

C. Are there potential problems with these estimates?

Yes. Any estimate has a degree of uncertainty attached to it, if only because it is based on a sample and not a census. More important, however, are fears

that the procedures used by the Bureau of the Census may have led to systematic bias in the results. It has been alleged that the SIE underrepresents Natives. However, these estimates pertain only to the non-native population, and so even if the allegation is correct it does not bias our estimate.

Finally, the proportions we estimated were those in 1976, the year of the survey. To the extent that these changed significantly between 1976 and 1980 the estimates could differ. At the national level there has been very little change in coverage proportions over the past five years. Obviously, we have no direct evidence supporting or rejecting that this is also the case in Alaska, but it would be surprising for dramatic changes to occur in these proportions over so short a period as five years. It would be our guess that the true number lies within $\pm 10\%$ of the estimate, i.e., between 39,000 to 49,000 persons.

D. Do the problems warrant rejecting the estimates?

In my opinion, no. I base this on three factors. First, every large scale survey can be subjected to criticism. I have worked with many, and find that the SIE to be better designed, documented, and carried out than most. The Bureau of the Census is the premier sampling and surveying organization in the country, probably the world, and this reputation is a factor in my judgment.

Second, the numbers appear to be reasonable. They show that coverage among non-native Alaskans is reasonably close to--perhaps slightly better than--the figures for the U.S. as a whole.

Finally, if one rejects the SIE then there is no other data source to take its place. I am aware of other efforts to estimate coverage in Alaska, but none that I know of are equally rigorous in method or design, or are as well documented, or permit linking insurance coverage to the other important variables necessary for policy analysis.

II. Implications of Our Study for HB-41

There are two general areas where our study generates information which bears on HB-41.

The first has to do with the implications of the Medicaid aspects of that bill. Our estimates of AFDC-Unemployed Parent coverage and coverage of the so-called Ribicoff children would bear on a part of HB-41. At this time we are working with the Division of Public Assistance to try to reconcile our estimates with them. The details of this are excruciatingly difficult to establish, and at this time we have not decided whether or not, or to what extent, our estimates need revising. Therefore, I cannot comment on this aspect.

The second aspect of HB-41 for which our report has some relevance is the part dealing with a state sponsored health insurance plan. In our report we analyzed a plan similar but not identical to this part of HB-41.

Important points to note from our report in evaluating HB-41 are:

- Unlike HB-41 the proposed state insurance plan retains GRM program--costs and coverage estimates therefore do not include the GRM eligible population (reminder--like HB-41 Medicare population is also excluded from the state plan). Thus, to compare our costs to HB-41's gross costs (before GRM savings are subtracted) you should add the GRM budget to our plan estimate.
- Our premium subsidy schedule is more stringent than that of HB-41--thus our cost and coverage estimates would be relatively lower. (Note--a higher subsidy implies that a higher proportion of potential participants (both uncovered and already covered) would join the state plan).
- Our cost estimates are in 1981 dollars and do not include costs of administering the program or loss of premium tax revenue to the state.
- Our cost estimates are based on per capita premiums of \$130 per month for the subsidized group. This premium is based on:
 - 50% of the potential participants being single individuals, i.e., not seeking family coverage
 - the benefit package described on pages 90-91 of the Advance Final Report, which is less extensive than HB-41 benefit package. This also implies that our plan would be less costly than HB-41.
- Our coverage estimates are for family coverages and should be multiplied by average family size in ^{the target population (approximately 2.1)} ~~Alaska (3.26, Source: SIF)~~ to obtain total number of individual coverages.
- Separate cost and coverage estimates are provided for all Alaskans and non-Natives. Note that assumptions regarding participation levels used to obtain Native and non-Native estimates were the same for both groups. However, we also pointed out that Natives who were eligible only for a partial premium subsidy might elect not to participate, since they already have access to the IHS, and that if this were the case then approximately 1350 fewer Native families would participate and annual costs would be \$1.2 million lower.
- Our plan did not permit persons to obtain state subsidized private individual coverage.
- As we discussed, graduated premiums based on age (or other characteristics) are important for avoiding adverse selection into the plan by high utilizers of health service. HB-41 is silent on this issue.

- Our plan, unlike HB-41, did not subsidize the patient cost sharing portion of reimbursement, which would have increased the cost to the state.
- Finally, we estimated that our plan would result in about 5000 new subsidized family coverages (~~2,500~~ individuals) in the non-Native population, and 11,000 new subsidized family coverages (27,500 individuals) in the Native population.

However, the total number of subsidized coverages would be much larger, because of switchover from the private sector. In order to generate one new family coverage, the state would have to subsidize a total of 2.3 to 3.9 families. In other words, between 57% and 75% of the subsidy dollars would go to persons already covered. One could expect a similar but not the same levels of switchover in HB-41 plan. This target inefficiency is a frustrating but unavoidable part of any such plan. We have found no way to avoid it, and believe that it must simply be accepted as a necessary part of the cost of providing insurance under such a plan.

And, finally, we would like to emphasize that our plan is significantly different in detail from the HB-41 plan. As such it is not possible to apply any of our estimates directly to the HB-41 plan.

/sbs

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MEDICARE BUY-IN: COST BENEFIT TO ALASKA

1.	Number of potential buy-in enrollees	1,468
2.	Number of potential enrollees who will receive Medicare services 1/	1,101
3.	Potential payment by Medicare for services 2/	\$220,200
4.	Total number of potential enrollees receiving DPA cash payments 3/	1,298
5.	Total number of potential enrollees receiving medical coverage only--no cash payment 3/	170
6.	Cost to Alaska for 4. above, assuming a 50% FFP rate 1,298 X \$11.00 (Medicare premium for FY 82) X 12 months X 50% FFP	\$ 85,668
7.	Cost to Alaska for 5. above, 170 X \$11.00 X 12	\$ 22,440
8.	Total cost to Alaska: 6. plus 7.	\$108,108
9.	Estimated savings for Alaska as a result of buy-in	\$220,200 -108,108 \$112,092

(Medicaid eligibles only)

*85,668
22,440

108,108*

- 1/ Based on Washington and Idaho utilization figures for 1979 as compiled by HCFA Region X
- 2/ Based on one-half of the average Medicare cost per buy-in user in Washington and Idaho during 1979 as compiled by HCFA Region X
- 3/ Based on actual DPA case counts for June 1981 adjusted for anticipated participation based on the GAO 1979 buy-in study: OAA--2,558 X 56.1%, AD--2,350 X 1.4%

Total on OAA and on AD - then by formula determine a percentage who would use service = 1298

STATE OF ALASKA
THE LEGISLATURE

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

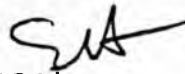
LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM

February 23, 1982

SUBJECT: Health of residents of the state
(SCS CSHB 41 (HESS))

TO: Representative Thelma Buchholdt

FROM: Edward H. Hein 
Legislative Counsel

Enclosed is a draft the changes to HB 41 requested by Louann Cutler. I have made several changes to the bill as explained below.

On page 1, lines 26 - 29 and page 2, lines 1 - 5, I have revised this subsection for purposes of clarity, but have not changed the substance of the subsection.

On page 2, lines 6 - 23, I have added new subsections (a) and (b), in accordance with my memorandum of October 26, 1981. The current subsections (b), (c) and (d) have been relettered (c), (d) and (e) respectively and references to those subsections have been changed throughout the bill.

On page 2, lines 17 - 23, I have revised the language of subsection (b) for purposes of clarity. Thus, the language differs somewhat from the language I proposed in the October 26, 1981 memorandum. I have added a 90-day waiting period as an anti-switch over provision.

On page 3, lines 17 - 23, I have revised the language for purposes of clarity.

On page 3, line 29 and page 4, line 3, I have inserted "Bureau of the Census" in place of "federal office of human development service".

On page 4, lines 9 - 16, I have added new definitions for resident subsidized health insurance and subsidized medical care.

On page 7, lines 22 - 24, I have revised this section for purposes of clarity.

On page 8, lines 16 - 17, I have added a definition for department.

On page 9, line 1, I have changed the word "qualifying" to "that qualifies" for purposes of clarity.

On page 9, line 3, after the word "needy", I have inserted the phrase "under AS 47.07.080(5)".

On page 9, lines 21 - 22, I have added language to clarify that the commissioner is to make his report to the legislature.

Louann Cutler also had asked me to insert provisions to discourage switch-over from private insurance plans to the state plan by high risk persons. I have not included that provision in the bill draft because it has not been determined who will constitute high risk persons. If that provision is to be added to the bill, I suggest that the following changes be made:

A new section of the bill should be added containing at least three subsections. The first subsection would provide that the cost of a premium under the state comprehensive health insurance plan established under this chapter for a person in a high risk category is 125 percent of the cost of the standard premium under the state comprehensive health plan. A second subsection would describe the high risk categories according to the persons you want to define as high risk. A third subsection should be included to provide that a person in a high risk category who is otherwise eligible to participate in the state comprehensive health plan may not be excluded from the plan because he is in a high risk category. Another subsection should be added to AS 18.27.020, the cost sharing section. The additional subsection should provide that for purposes of the cost sharing program the commissioner shall pay the state's share of costs of health insurance incurred by a resident in a high risk category under (the section number designated for the new section on high risk categories) in the same dollar amount as for a person who is not in a high risk category. Finally, on page 2, line 24, subsection (c) should be

• Representative Thelma Buchholdt
Page 3
February 23, 1982

amended to provide that except as provided in the additional subsection we add to AS 18.27.020, the commissioner shall pay, etc.

EHH:ljb

Enclosure

SECTION 1: Sets up a state health plan (hereafter referred to as "the Plan") and a state health insurance cost sharing program, by adding a new chapter to Title 18 (Health and Safety) of state law.

Sec. 18.27.010. State Comprehensive Health Plan. Provides for the establishment of the Plan in the ~~Department of Administration~~. The Commissioner is directed to establish ~~minimum benefit standards~~ for the Plan, and provide for underwriting and administration of the Plan. A contract for the underwriting and administration of the Plan shall be for ~~three years~~. A Plan participant may direct that their permanent fund dividend be used to cover their portion of the cost of the Plan.

Sec. 18.27.020. State Health Insurance Cost Sharing Program. A resident enrolled in the Plan, or a private individual health insurance policy with benefits that meet or exceed the Plan's benefits, is entitled to a subsidy to help defray the cost of health care. Residents that are not enrolled in a federal health plan or a private group health insurance policy are eligible for a state subsidy if they meet the income criteria of the cost sharing program.

The subsidy schedule of the cost sharing program is geared to family units, and a distinction is made between the amount of subsidy available for premium and out-of-pocket (copayment and deductible) expenses. The intent of the distinction is to keep down the cost of insurance by requiring those with higher incomes to pay a greater percentage of the cost of actual services rendered (copayment and deductible) than they pay for the cost of being insured before seeking health care (premium). A higher subsidy may be available for a Barrow family than for an Anchorage family due to the higher cost of living in Barrow.

The subsidy schedule can be summarized as follows:

<u>monthly income</u>	<u>family pays</u>	<u>state pays</u>
below 45% of median adj. gross income for Ak. (150% of poverty guideline)	0%	100%
45-75% of median	0% premium, portion of out-of-pocket	100% premium, portion of out-of-pocket
75-100% of median	portion of premium and out-of-pocket	portion of premium and out-of-pocket
100-125% of median income	portion of premium, 100% out-of-pocket	portion of premium and 0% out-of-pocket

By paying 100% of costs for families below 45% of median income, the state will transfer most of the existing Public Assistance General Relief Medical (GRM) program to the Plan. Most of the services currently offered through GRM would then be provided through an insurance model instead of through a welfare model.

A residual GRM program would still exist to pay for certain one-time expenses that would not be covered through the Plan and to pay for such services as long term care that are too expensive to cover through an insurance model.

The state subsidy available for a certified individual private policy is limited to the amount the state would have paid had the resident been enrolled in the Plan.

SECTION 2: Report to the legislature.

The Commissioner shall report back to the legislature at the beginning of the next session on the following items: (1) proposed minimum benefits for the Plan and the actuarial costs anticipated; (2) the number and characteristics of people who are expected to enroll in the cost sharing program and how much it will cost the state; (3) a proposal to implement the Plan and the cost sharing program, to determine eligibility, to pay the state's share of the costs of the Plan and the cost sharing program, and to advertise the availability of the Plan and the cost sharing program; and (4) recommendations for amendments to AS 18.27.

SECTION 3: Effective date for AS 18.27.

Coverage under the Plan and subsidies under the cost sharing program must be available on July 1, 1982.

SECTION 4: Technical amendment to present law.

SECTION 5-8: Alcoholism and drug dependency coverage.

Requires state employee health insurance coverage to include coverage for treatment of alcoholism and drug dependency.

SECTION 9: Provides differing mechanisms for provider reimbursement under federal and state medical assistance programs.

Sec. 47.05.070. Medical Assistance By Insurance or Service Contracts. If the Commissioner (of Health and Social Services) determines that it would be more cost effective to pay for medical assistance services through means other than the current fee-for-service payment mechanism, she may do so. Payment of health insurance policy premiums or expenses of health maintenance organization, medical or hospital service contracts are authorized in this section.

Sec. 47.05.080. Implementation. Requires the Commissioner to implement 47.05.070 only if it would be cost effective to do so. In other words, these mechanisms would be used only if it would cost the same or less than the current fee-for-service arrangement.

Sec. 47.05.090. Interim Payment. The Department of Health and Social Services may make an interim payment to a provider of a large volume of services under state medical assistance programs.

Sec. 47.05.100. Interest on Late Payments. Requires the Department to pay 1% interest on provider claims for services rendered under medical assistance programs that are not paid within 45 days of receipt of a clean claim. The interest rate goes up to 2% for claims that are outstanding after 90 days.

SECTION 10: Requires the state to offer Medicaid to all categories of eligibles for whom services may be provided under federal law as of March 1, 1981.

Alaska currently provides Medicaid services to all categories of people that federal law requires, and additional categories that are considered optional under federal law. This section would require the Department to provide Medicaid services to other categories of people that Medicaid considers optional. The state would then be offering services to all categories of people for which federal match funding is available, except for those considered "medically needy". There is no need for the state to pick up the medically needy option because these individuals would be covered under the Plan established in section 1, since anyone with an income less than 45% of median income will receive 100% state subsidy for the cost of the Plan.

Some of the categories considered optional under Medicaid are presently offered by the state through GRM. The effect of transferring these categories to Medicaid would be to collect 50% of the cost of providing service to certain people from the federal government. In other words, the state would be paying half of the present cost of providing certain services to these categories of Medicaid eligible people.

SECTION 11: Requires the state to offer all Medicaid services allowable under federal law, as of March 1, 1981.

Alaska currently provides all of the services required by federal law, and some that are considered optional. This section would require the Department to pick up the rest of the services that are considered optional. It would then be offering all services available for Medicaid matching funds. The GRM transfer effect described under section 10 would apply to certain of these services as well.

SECTION 12: Definitions.

SECTION 13: Study of federal programs.

This section requires the Legislative Council to make recommendations to the legislature, by next session, about how the state can complement federal provision of services through Indian Health Service and Medicare. The council would consult with various private and state agencies that have knowledge of the Indian Health Service and Medicare programs in compiling its recommendations.

SECTION 14: Deletes section of law that requires the Department to ask the legislature's permission to add any new Medicaid service or eligible categories.

This section of law would no longer be needed since all available categories would be offered or provided for through other means.

SECTIONS 15-18: Effective dates.

Sec. 1-4: 7/1/82

Sec. 5-8: 1/1/82

Sec. 9: 7/1/81

Sec. 2-3, 10-14: immediately.

(LC: 5/3/81)

COST SHARING AVAILABLE FOR HEALTH INSURANCE UNDER HB 41

<u>Percent of median*</u>	<u>Premium subsidy</u>	<u>Out-of-pocket subsidy</u>
125	0%	0%
120	10%	0%
115	20%	0%
110	30%	0%
105	40%	0%
100	50%	0%
95	60%	9%
90	70%	18%
85	80%	27%
80	90%	36%
75	100%	45%
70	100%	55%
65	100%	64%
60	100%	73%
55	100%	82%
50	100%	91%
45	100%	100%

* Refers to percentage of median income for each family size

THE UNCOVERED POPULATION

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

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

(LC: 3/30/81)

CS SS HB 41 (Finance)
Health Care Financing Legislation

Six components of the bill:

- (1) Creation of a state health plan open to all residents but designed primarily to cover the 44,000 Alaskans who are presently without coverage. 40% of the 44,000 are children. The uncovered adult population consists of construction, cannery, firefighting and other seasonal workers; fishermen, farmers and miners; those who work in retail and wholesale trade, manufacturing, transportation, utilities, and personal services industries; many employees of small businesses and many of the self-employed. ¹
- (2) Creation of a cost sharing program for state plan participants and others currently without coverage that an employer or the federal government helps to finance. The amount of cost sharing available depends on income, family size and what region of the state the insured lives in.
- (3) Provision of alcohol and drug dependency health insurance coverage for state employees.
- (4) Enables the state to use alternative methods to reimburse providers of medical services offered through federal and state medical assistance programs.
- (5) Expands Alaska's medicaid program to provide all services to all eligibles allowed by federal law.
- (6) Provides for a comprehensive study of federal medical programs in the state. The study would result in recommendations to the legislature regarding solutions to problems of funding and provision of services through these programs.

Fiscal impact (general fund dollars): ^{*}

FY 82: \$ 3,768,900
FY 83: \$ 13,247,700
FY 84: \$ 28,959,400
FY 85: \$ 57,084,300
FY 86: \$ 69,514,300

¹ This information is from the Batelle Research Center.
* The FY '83-'86 figures are rough estimates.

FISCAL SUMMARY FOR CSSSHB 41 (Finance)

	<u>FY '82</u>	<u>FY '83</u>	<u>FY '84</u>	<u>FY '85</u>	<u>FY '86</u>
Federal funds:					
1. Medicaid match	11631.8	13353.4	15338.3	17619.6	20241.0
General fund:					
DHSS					
1. Medicaid	6781.6	7782.0	8938.8	10268.4	11796.0
2. GRM transfer to 50% federal match	(4619.1)	(5311.9)	(6108.6)	(7024.9)	(8078.9)
ADMIN.					
1. Alcoholism	180.0	414.0	476.1	547.5	629.6
2. Benefits/cost sharing	0.0	8800.0	23950.0	51420.0	63107.0
3. Administration	1426.4	1563.6	1703.1	1873.3	2060.6
REVENUE					
1. Rogers amendment	0.0	0.0	0.0	0.0	0.0
<u>TOTAL GENERAL FUND</u>	<u>3768.9</u>	<u>13247.7</u>	<u>28959.4</u>	<u>57084.3</u>	<u>69514.3</u>
Total of g.f. and fed. funds	15400.7	26601.1	44297.7	74703.9	89755.3

(LC: 4/14/81)

FISCAL NOTE

I. REQUEST

Bill/Resolution No. Proposed CSSHB 41 (Finance)

Title An Act Relating to the Health and Residents of the State

Requested by HOUSE FINANCE COMMITTEE Date 4/9/81

II. FISCAL DETAIL

Agency Affected Department of Health and Social Services

Program Category Affected Health/Social and Economic Assistance

BRU, Program, or Subprogram(s) Affected Medicaid/Eligibility Deter./Public Assist. Admin.

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
100 PERSONAL SERVICES		353.9	389.3	428.2	471.0	518.1
200 TRAVEL		12.9	14.2	15.6	17.2	18.9
300 CONTRACTUAL		133.8	147.2	161.9	178.1	195.9
400 COMMODITIES		6.5	7.2	7.9	8.7	9.5
500 EQUIPMENT		15.3	-0-	-0-	-0-	-0-
600 LAND & STRUCTURES		0	-0-	-0-	-0-	-0-
700 GRANTS, CLAIMS, ETC.		17893.0	20576.9	23663.5	27213.0	31295.0
TOTAL		18413.4	21135.4	24277.1	28880.0	32037.0

FUNDING (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
GENERAL FUND		6781.6	7782.0	8938.8	10268.4	11796.0
FEDERAL FUNDS		11,651.8	13353.4	15338.3	17619.6	20241.0
OTHER (Specify Fund Source)						

POSITIONS

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

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

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

IV. DATE 4/9/81

PREPARED BY David M. Davidson

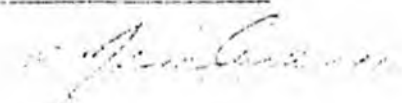
AGENCY Division of Public Assistance

PHONE 405-5317

Original: Legislative Finance

and Management

Legislative Finance Committee



THE LEGISLATURE OF THE STATE OF ALASKA
TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill Resolution No. Proposed CSSSHB 41 (Finance)
 Title An ACT Relating to the Health of Residents of the State
 Requested by HOUSE FINANCE COMMITTEE Date 4/9/81

II. FISCAL DETAIL

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

EXPENDITURES (Thousands of Dollars)

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

FUNDING (Thousands of Dollars)

	FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
GENERAL FUND		(4,619.1)	(5311.9)	(6108.6)	(7024.9)	(8078.7)
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

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

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

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

IV. DATE 4/9/81 PREPARED BY David M. Davidson
 AGENCY HOUSE FINANCE COMMITTEE
 PHONE 333-2201