ALASKA LEGISLATURE COMMITTEE FILES 1981-1982 8672

1572 SHESS HB 41

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF PUBLIC ASSISTANCE

JAY S. HAMMOND, GOVERNOR

POUCH H-07
JUNEAU, ALASKA 99811
PHONE: (907) 465-3355

April 9, 1981

Document# 98-81

The Honorable Samuel Cotten
House of Representatives
Alaska State Legislature
Pouch V
Juneau, Alaska 99811

Dear Representative Cotten:

This letter is intended to confirm the Department's estimate of increased Medicaid costs in FY82 based on CSSSHB-41 as amended by Representatives Buchholdt, Adams and Rogers on April 8, 1981.

HB-41 as originally introduced presented $23,491.1 in additional costs as follows. (See position paper dated 2/27/81).

		TOTAL	FED	STATE	POS.
(1)	Addition of all Medicaid Services & New Optional Categorical Groups.	$18,413.4	11,631.8	6,781.6	12
(2)	Decrease of GR Medical	(4,619.1)		(4,619.1)	
(3)	Addition of Medically Needy to Medicaid	$ 9,029.7	5,709.3	3,320.4	5
(4)	Interest Payments	667.2		667.2	
	TOTAL	$23,491.1	17,341.1	6,150.1	17

However, as a result of testimony offered by the Department and others, CSSSHB-41 was modified to delete medically needy coverage (item #3 above) and to resolve the Department's concerns with the interest payments provisions (item #4 above). As a result, only these costs associated with items #1 and #2 above remain at this time, representing an increase of $13,794.3 as follows. (See position paper dated 4/3/81).

		TOTAL	FED	STATE	POS.
(1)	Addition of all Medicaid Services & New Optional Categorical Groups.	$18,413.4	11,631.8	6,781.6	12
(2)	Decrease of GR Medical	(4,619.1)		(4,619.1)	
	TOTAL	$13,794.3	11,631.8	2,162.5	12

Two final comments are in order:

* President Reagan's proposed CAP on Medicaid makes it very uncertain whether the State will receive the expected $11,631.8 in additional federal funds. The State could find itself in the position of paying the entire $13,794.3 out of the State general fund.

* These estimates do not include the costs associated with implementation of Sections 1-8 of CSSSHB-41. These costs would be in addition to the $13,794.3 increase in Medicaid.

Please let me know if I may provide any additional information.

Sincerely,

Rod Betit

Rod Betit
Director

I. REQUEST

Bill/Resolution No. Sponsor Substitute House Bill 41 (Sections 5-8)

Title Insurance for Alcoholism and Drug Dependence

Requested by _____ Date _____

II. FISCAL DETAIL

Agency Affected Administration - Division of Retirement & Benefits

Program Category Affected Labor Services

BRU, Program, or Subprogram(s) Affected 02-96-8-01-02-00 (OTHER BENEFITS)

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

EXPENDITURES (Thousands of Dollars)

		FY 81	FY 82	FY 83	FY 84	FY 85	FY 86
100	PERSONAL SERVICES						
200	TRAVEL						
300	CONTRACTUAL						
400	COMMODITIES						
500	EQUIPMENT						
600	LAND & STRUCTURES						
700	STATE TRS MATCHING						
100	BENEFITS		180.0	414.0	476.1	547.5	629.6
	TOTAL		180.0	414.0	476.1	547.5	629.6

FUNDING (Thousands of Dollars)

GENERAL FUND		147.4	339.1	389.9	448.4	515.6
FEDERAL FUNDS		8.3	19.0	21.9	25.2	29.0
VETERAN'S FUND		0.4	.8	1.0	1.1	1.3
FISH & GAME FUND		1.1	2.5	2.9	3.3	3.8
HIGHWAY FUND		2.3	5.4	6.2	7.1	8.2
AIRPORT FUND		5.2	12.0	13.8	15.9	18.2
CAPITAL FUND		15.3	35.2	40.4	46.5	53.5
PERS						
TRS						

POSITIONS

FULL TIME						
PART TIME						
TEMPORARY						

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

1. Approximately 10,275 State employees are currently covered under the State Group Health Plan.

2. The cost to implement provisions of this bill will be $2.92 per employee per month.

3. Estimate that the cost to provide continued coverage will increase 15% each year for the immediate future. However, an effective Alcoholism/Drug dependency program should help to reduce overall health care claim experience in the future.

IV. DATE February 26, 1981 PREPARED BY Ken Humphreys, for Paul B. Arnoldt, Director

AGENCY Division of Retirement & Benefits

PHONE 465-4460

Orig. to: Legislative Finance

cc: Budget and Management

Prime Sponsor (First Legislator Named)

Office of the Governor (Policy Director)

ESTIMATION OF FISCAL IMPACT FOR STATE
COST-SHARING UNDER CSSSHB 41 (Finance)

44,000	individuals with no health coverage (Battelle study)
25,000	individuals with individual private coverage (est. by Battelle)
+ 31,000	assumed migration from small group plans (fudge factor)
100,000	individuals eligible for cost sharing (round estimate)
÷ 3.03	average people per household (1980 est. by state demographer)
33,000	households eligible for cost sharing (round estimate)
x $1,620	average plan cost per household ($1,320 premium + $300 out of pocket)
$53,465	total plan cost (in thousands)
x .564	average subsidy level (analysis of SIE data)
$30,179	benefit costs of cost sharing program (FY81 dollars)
x 1.166	two years' inflation factor at 8%
$35,200	cost of full enrollment, FY83 dollars

$35,200 x .25 = $ 8,800 est. FY83 benefit costs (assumes 50% of eligibles enroll by end of FY83-- 25% ann. ave.)

$35,200 x 1.08 x .63 = $23,950 est. FY84 benefit costs (assumes 75% of eligibles enroll by end of FY84)

$35,200 x 1.166 x .88 = $51,420 est. FY85 benefit costs (assumes 100% of eligibles enroll by end of FY85)

$35,200 x 1.793 x 1.0 = $63,107 est. FY86 benefit costs (assumes 100% enrollment all year)

SF 4/9/81

TWELFTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. CS SS HB 41 (Finance) (partial)

Title State Comprehensive Health Plan

Requested by House Finance Date

II. FISCAL DETAIL

Agency Affected Administration - Division of Retirement & Benefits

Program Category Affected General Government

BRU, Program, or Subprogram(s) Affected Retirement & Benefits and Administrative Services

(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		329.7	965.5	1051.1	1156.2	1271.8
200	TRAVEL		6.0	6.0	6.6	7.3	8.0
300	CONTRACTUAL		1001.0	572.6	629.9	692.8	762.1
400	COMMODITIES		3.5	9.5	10.5	11.5	12.6
500	EQUIPMENT		86.0	10.0	5.0	5.5	6.1
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.						
	TOTAL		1426.4	1563.6	1703.1	1873.3	2060.6

FUNDING (Thousands of Dollars)

GENERAL FUND		1426.4	1563.6	1703.1	1873.3	2060.6
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		25	29	29	29	29
PART TIME						
TEMPORARY			4			

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

Assumption:

1. 35 thousand accounts first year with 85,000 covered individuals.
2. Field offices in Anchorage, Fairbanks, Nome and Juneau.
3 Staff costs increase by 10% after FY83.
4. Does not include benefit costs under the cost sharing program or the cost under Sections 5-8.
5. Eligibility for resident status and co-payments determined by Division of Retirement & Benefits.

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

IV. DATE PREPARED BY Ken Humphreys, Deputy Director

AGENCY Division of Retirement & Benefits

PHONE 465-4462

Original: Legislative Finance

cc: Budget and Management

Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/80)

HEALTH INSURANCE SUBSIDIES FOR A FAMILY OF 3

PERCENT OF MEDIAN	ANNUAL INCOME	MONTHLY INCOME	PREMIUM SUBSIDY	OUT-OF-POCKET SUBSIDY
125	$32,588	$2,716	0%	0%
120	$31,284	$2,607	10%	0%
115	$29,981	$2,498	20%	0%
110	$28,677	$2,390	30%	0%
105	$27,374	$2,281	40%	0%
100	$26,070	$2,173	50%	0%
95	$24,767	$2,064	60%	9%
90	$23,463	$1,955	70%	18%
85	$22,160	$1,847	80%	27%
80	$20,856	$1,738	90%	36%
75	$19,553	$1,629	100%	45%
70	$18,249	$1,521	100%	55%
65	$16,946	$1,412	100%	64%
60	$15,642	$1,304	100%	73%
55	$14,339	$1,195	100%	82%
50	$13,035	$1,086	100%	91%
45	$11,732	$978	100%	100%

HEALTH INSURANCE SUBSIDIES FOR A FAMILY OF 4

PERCENT OF MEDIAN	ANNUAL INCOME	MONTHLY INCOME	PREMIUM SUBSIDY	OUT-OF-POCKET SUBSIDY
125	$38,800	$3,233	0%	0%
120	$37,248	$3,104	10%	0%
115	$35,696	$2,975	20%	0%
110	$34,144	$2,845	30%	0%
105	$32,592	$2,716	40%	0%
100	$31,040	$2,587	50%	0%
95	$29,488	$2,457	60%	9%
90	$27,936	$2,328	70%	18%
85	$26,384	$2,199	80%	27%
80	$24,832	$2,069	90%	36%
75	$23,280	$1,940	100%	45%
70	$21,728	$1,811	100%	55%
65	$20,176	$1,681	100%	64%
60	$18,624	$1,552	100%	73%
55	$17,072	$1,423	100%	82%
50	$15,520	$1,293	100%	91%
45	$13,968	$1,164	100%	100%

HEALTH INSURANCE SUBSIDIES FOR A FAMILY OF 1

PERCENT OF MEDIAN	ANNUAL INCOME	MONTHLY INCOME	PREMIUM SUBSIDY	OUT-OF-POCKET SUBSIDY
125	$20,175	$1,681	0%	0%
120	$19,368	$1,614	10%	0%
115	$18,561	$1,547	20%	0%
110	$17,754	$1,480	30%	0%
105	$16,947	$1,412	40%	0%
100	$16,140	$1,345	50%	0%
95	$15,333	$1,278	60%	9%
90	$14,526	$1,211	70%	18%
85	$13,719	$1,143	80%	27%
80	$12,912	$1,076	90%	36%
75	$12,105	$1,009	100%	45%
70	$11,298	$942	100%	55%
65	$10,491	$874	100%	64%
60	$9,684	$807	100%	73%
55	$8,877	$740	100%	82%
50	$8,070	$673	100%	91%
45	$7,263	$605	100%	100%

HEALTH INSURANCE SUBSIDIES FOR A FAMILY OF 2

PERCENT OF MEDIAN	ANNUAL INCOME	MONTHLY INCOME	PREMIUM SUBSIDY	OUT-OF-POCKET SUBSIDY
125	$26,388	$2,199	0%	0%
120	$25,332	$2,111	10%	0%
115	$24,277	$2,023	20%	0%
110	$23,221	$1,935	30%	0%
105	$22,166	$1,847	40%	0%
100	$21,110	$1,759	50%	0%
95	$20,055	$1,671	60%	9%
90	$18,999	$1,583	70%	18%
85	$17,944	$1,495	80%	27%
80	$16,888	$1,407	90%	36%
75	$15,833	$1,319	100%	45%
70	$14,777	$1,231	100%	55%
65	$13,722	$1,143	100%	64%
60	$12,666	$1,056	100%	73%
55	$11,611	$968	100%	82%
50	$10,555	$880	100%	91%
45	$9,500	$792	100%	100%

GLOSSARY

(1) premium--- monthly payment by insured person to insurance carrier for insurance policy

(2) deductible--- the amount of covered health expenses that the insured must pay in full, before carrier begins to assist with payment of expenses

(3) copayment--- the percentage of covered health expenses that the insured person is expected to pay in addition to the deductible payment

(4) out-of-pocket---deductible and copayments

(5) benefits--- two common meanings: (a) the types of medical services that a health insurance plan covers, i.e. hospital stay, doctor visit, x-rays, ambulance service, etc. (b) the portion of covered expenses that the insurance carrier pays

(6) maximum lifetime benefit--- the maximum dollar amount of health insurance benefits that a carrier will pay to a participant in a health insurance plan

Example using (1),(2),(3),(4b),(5),and (6): A plan costs $50/month (premium). A participant must pay the first $200 of covered expenses each year (deductible) in addition to the monthly premium payment. The participant must also pay 20% of covered expenses (copayment) up to $2000, in addition to deductible and premium payments. After the participant has incurred $2000 in copayments and deductible payments (out-of-pocket expenses), the insurance carrier will pay 100% of future expenses (benefits) up to $250,000 (maximum lifetime benefit).

(7) provider--- One who furnishes medical services, i.e. a doctor, dentist, chiropractor, hospital, etc.

(8) Medicaid--- A program that pays for medical care for public assistance recipients and certain other needy persons, jointly funded by the state and federal governments. It is important not to confuse Medicaid with Medicare which is a federal health insurance program primarily for the elderly.

(9) GRM--- General Relief Medical is a wholely state funded program that pays for medical care that is not provided under Medicaid to Medicaid recipients and to certain other needy persons.

(10) prepaid health plan--- This is a generic term that refers to an insurance plan, a hospital or medical service contract, or a health maintenance organization service contract.

(11) hospital or medical service contracts--- Prepaid health plans that provide subscribers with hospital or medical services under contract with the provider. Blue Cross and Blue Shield are the major examples.

(12) HMO--- A health maintenance organization is a prepaid health plan in which the carrier is also the direct provider of covered health services. Group Health in Seattle and the Kaiser Permanente Plans in Oregon, California, Hawaii and elsewhere are the major examples.

(13) insurance--- While insurance technically refers to indemnity coverage, for purposes of this bill it is defined to include prepaid plans as well.

(14) poverty guideline--- The income figure for each family size for Alaska that is intended to approximate the minimum income needed to provide the basic necessities of living. It is the income guideline used in certain federal programs.

(15) median income--- The middle adjusted gross income figure for each family size for Alaska used by certain federal programs. While the formula by which it is calculated does approximate the real median income, it is not a true statistical median.

(16) medical assistance programs--- Medicaid, GRH and other state programs that help needy people meet their medical expenses.

(17) high-risk uninsurable--- This term refers to a person who has difficulty obtaining insurance. He is considered a "high risk" because he has had a serious accident or medical condition in the past that requires continuous monitoring, in the form of expensive and on-going health services. Most carriers do not want to provide insurance for such individuals at the same rate as healthier people, and some do not wish to cover them at all.

(LC: 2/81)

Alaska State Legislature

Senate

JUNEAU, ALASKA

Comprehensive health care proposed in bill

By The Associated Press

Rocky Plotnick Weller did not invest in health insurance when her benefits an an administrative assistant ended with the legislative session in 1979. "I couldn't afford it. I was young. I never thought I'd get sick," she said.

But she was wrong. Ms. Weller had to spend three days in the hospital that fall. The bill: $4,200. It took all of her savings and help from her parents to pay off the debt.

Doug Jordan has cancer. His illness caused him to lose his job, and with it his health insurance. Now, he said, no one will sell him a policy. "I'd cost them too much," he said.

Michael Thomas was installing a set of cabinets when he fell off a ladder and broke his wrist. He owned his own carpentry business and did not have health insurance to foot his sizable hospital bill.

Ms. Weller, Jordan and Thomas are among an estimated 43,000 Alaskans who do not have health insurance. Mo. of the uninsured have jobs at least part of the year, many are self-employed, and some are considered high insurance risks and cannot get policies.

In a plan targeting those who are not needy enough to qualify for present state or federal health insurance policies, Reps. Thelma Buchholdt, D-Anchorage, and Terry Gardiner, D-Ketchikan, have introduced a bill (SHB41) to set up a comprehensive health insurance program bankrolled by the state.

"Everybody has a wild scheme for throwing money away, but health care is a basic need like education," Gardiner said.

The bill had its first hearing today in the House Health, Education and Social Services Committee. Chairman Don Clocksin, D-Anchorage, said state health insurace is a priority this session.

Under the bill, residents could sign-up for the state-funded health insurance if they are not already covered by a group, state or federal policy. Because they are already covered by a federal program, natives would not be eligible.

According to the proposal, the state would pay for part or all of the individual's premium payments and medical bills, based on income. For example, an individual making up to $7,263 a year or a family of four with an annual income of $13,968 would be fully covered. Half of the monthly premium and no additional expenses would be paid for individuals earning $16,140 a year and families making $31,040.

The insurance plan would be purchased by the state from a private carrier. The state would also subsidize residents' private policies if the benefits provided are at least as good as those available under the state plan.

It is not known how many people would be eligible for the program.

The bill would extend the health insurance are now provided state employees to cover alcohol and drug addiction. Mrs. Buchholdt said those benefits are being partially extended as a pilot program.

Mrs. Buchholdt said the need for a state insurance is great — especially among residents with moderate incomes because they earn too much to qualify for state and federal health insurance programs, but not enough to pay for a private policy.

Juneau Empire 2-27-81

Health program hit as premature

By KARIN DAVIES
The Associated Press

JUNEAU — Amid charges that lawmakers are acting too quickly, the House voted 21-14 Friday in favor of legislation intended to make health care affordable to all Alaskans.

Rep. Terry Martin, R-Anchorage, said lawmakers should wait until an ongoing health care study is finished in December, and should give the state bureaucracy time to straighten out existing health care programs.

In a speech from the House floor, Martin urged lawmakers to "be patient. Let's see what that $250,000 study it going to bring." Martin said the health program hammered out by Rep. Thelma Buchholdt, D-Anchorage, promises nothing but a $70 million expense to the state by 1986.

But Ms. Buchholdt said, "Health care is almost a basic necessity . . . and a very good way to invest in the people of this state." She added that adequate health care should be an inherent personal right.

Republicans and Libertarians voted against the measure. Rep. Dick Randolph, L-Fairbanks, gave notice of reconsideration on his vote, which means the legislation may come up for another vote on Monday.

Randolph charged that lawmakers are guilty of "developing in Alaska an absolutely socialistic society" by approving the health care program.

Ms. Buchholdt disagreed. "Isn't it ironic," she asked, "that whenever we talk about education or health care" charges of socialism are leveled, but not when low-interest loans are discussed.

Rep. Terry Gardiner, D-Ketchikan, said the bill simply guarantees a badly needed minimum level of health care service for all residents.

The measure is expected to gain some support in the Senate, although a streamlined plan introduced by Senate President Jalmar Kerttula, D-Palmer, is preferred.

Under Ms. Buchholdt's bill, the state would underwrite a comprehensive health insurance program targeting those not covered by an employer or an existing federal policy.

Alaska Natives would be excluded from the program, which has evoked criticism from many rural lawmakers who said the federal Indian Health Service program for natives is inadequate. As a result, the bill was amended in committee to require the state to study the Indian Health Service program, and suggest ways for the state to complement its funding.

The state would spend an estimated $3.8 million next year for start-up costs of the health care program, which would take effect in July, 1982. An estimated $13 million would be required during 1983; the program would cost $69 million a year by 1986.

An estimated 43,000 Alaskans do not have health insurance, according to studies done for the state. Most have jobs at least part of the year, many are self-employed, and some are considered high insurance risks and cannot buy policies.

Anch. D. Vans Sat. April 25, 1981

(1)

5-2-81 NCSL Workshop

Sandy Golden

IHS

I. Clinical

hosp. & clinic

M.H.

alcohol

maintenance & repair

dental

contract health care ($ to reg. hosp. & clinic)

II. preventative

sanitation

p.h. nurse

health education

CHR program (community health rep.)

III. Urban Health Projects

IV. Indian Health Manpower

V. Tribal Management

VI. Program Management

(2)

Bill Penn

Is IHS a "plan"? (Penn says no.)
(as used in HB 41)

Alaska Natives
64,047 1980 pop. estimate census
74,611

@ 20% Ak. Natives served by Ak. Natives
Native Regional Health corps., except Ketchikan,
are assuming responsibility
community health aides / @ 70% health care
usually low paid & mostly women
@ 35% turnover a year
to qualify for medicare, the tribal entities
must accept all persons in their region, not
just Ak. Natives –
Regional corps getting alcohol & M.H. state $
to get IHS $, entire board must be Native
☆ Deficiencies: patient travel - patient pays 1st 1/2
& M.H. providers – lack of says 450+ more un-
paid – no long term care no hearing aid – no
eye glasses –
dental is maintenance which means no
corrective part does not include dentures, crowns
etc

Dann continued —

(3) Reagan's Budget —

94 million 81 - all.

cuts: H_2O/waste

supplies

contract

monitoring (inflation, fuel, etc.)

travel

re HB411: establish objectives

insurance scheme? } and not always guarantees the other

access?

healthcare - ?

pre-pay - costs lower } medical costs

reimburse - costs higher

lose competitive/co-payment plan (30% pay)

266 dent.
297 doc
795,000 "Indian" people (1970 census)

(4)

Sherman -
Battelle study -
minimum disruption

44,000 alaskans w/out health ins. coverage

1) state health comp. insurance plan

2) preventive care

3) high risk individuals (?)

4) reform of Med & medicare

IHS has no defined benefits
very ambiguous

(5)

Russ Hereford
H & SS → states
reduce Fed. mgs.

Kathy — call David Harrison

Fed cut @ 200,000 for Alaska's share in permanent battle $

"Catastrophic" health insurance— a misguided prescription?

CHRISTOPHER J. ZOOK, FRANCIS D. MOORE
RICHARD J. ZECKHAUSER

WHEN the economy was sound and medical care more affordable, comprehensive national health insurance was a top priority measure on the liberal political agenda. The straitened circumstances and escalated medical costs of recent years, however, have compelled analysts and officials to lower their sights. Seeking something short of national health insurance that would nevertheless insure people against the crippling costs of severe accidents and illnesses and long-term hospitalization, they have hit upon the simple idea of "catastrophic health insurance." Such coverage, it is believed, would provide Americans appropriate care for unavoidable high-cost illness at a fraction of the cost of any comprehensive care program. But is this the case?

Proposals for catastrophic health insurance characteristically have a simple benefit structure whereby medical expenditures above some annual dollar threshold would be fully paid for all illnesses and conditions. This approach is justified by the assumptions that high-cost illness strikes individuals at random and accounts for a small share of total resources, and that a large portion of its costs cannot be controlled by either the patient or the institution delivering care.

These perceptions are often influenced by first-hand knowledge of a small group of tragic cases. For example, during the 1978 Kennedy hearings on national health insurance, the stories of 68 high-cost users attracted the spotlight. Similarly, personal testimony had a major impact on the Kidney Disease Amendments of 1971, after hearings during which patients were actually dialyzed in front of Congressional committees. However compelling these scenes may be they simply do not adequately represent what might now be called, and under national health insurance surely would be considered, "catastrophic" illnesses.

Study of the available evidence has convinced us that many common perceptions of the nature of high-cost illness and the characteristics of patients are either too simple or plainly wrong. First, the costs of treating high-cost illness account for a much larger part of all health costs than is generally believed. Second, its characteristics and financial implications vary widely across patient groups. Third, it is more often long-term and repetitive than short-term and acute. Fourth, some costs of care appear to be, in part, controllable with appropriate incentives. This new evidence requires a new and more complex understanding of the nature of medical "catastrophes." On that basis, proposals for insurance should be reformulated to protect people from financial ruin while maintaining incentives to contain the cost of medical care. Comprehensive national health insurance is considered too expensive and as giving the wrong incentives. Catastrophic health insurance will be little better if the nature of high-cost illness is not properly diagnosed and understood.

Diagnosing the nature of high-cost illness

Case-by-case review of patient medical records in selected hospitals in California and Massachusetts have been conducted recently by Zook and Moore, and Schroeder. These studies, together with the work of Birnbaum, provide the principal sources of detailed information on the identity of high-cost patients.[1] They reveal important and sometimes surprising facts about five facets of high-cost illness: its total cost, its typical time span, the role of medical technology, the importance of unexpected medical complications, and the frequency of potentially harmful personal habits among some expensive patients.

[1] Christopher J. Zook and Francis D. Moore, "The High Cost Users of Medical Care," *New England Journal of Medicine*, 302, 1980, pp. 996-1002; Stephen Schroeder, *et al.*, "Frequency and Clinical Description of High Cost Patients in 17 Acute Care Hospitals," *New England Journal of Medicine*, 300, 1979, pp. 1306-1309; and Howard Birnbaum, *Catastrophic Illness in the United States* (Boston: Lexington Press), 1978.

1. *Medical expenditures are highly concentrated.* National medical care expenditures are concentrated in a small fraction of patients. In any given year, about half of the resources in a typical hospital are consumed by only 13 percent of the patients. The most expensive one-fifth of patients accounts for nearly 70 percent of total resources. Since one person in ten is hospitalized each year, this implies that 1.3 percent of the nation's population may account for half of all charges in short-stay hospitals. This skewness is not primarily a function of patient age. Though the aged account for nearly 40 percent of high-cost patients, there is a similar pattern of concentration within each age cohort. (In fact, some of the most expensive patients begin their "careers" at birth with non-lethal congenital abnormalities.)

Of all patients in the five hospitals in the Zook-Moore study, the high-cost 10 percent had direct hospital charges in 1976 averaging $30,000.[2] All of the high-cost patients had expenses above $15,000. Inclusion of charges for professional services, outpatient care, home care, drugs, and institutional services would further increase these amounts. Though there was considerable variation across hospitals in the average level of expenses, the distribution of medical resources was highly skewed in every hospital.

Though our data are derived from short-stay hospitals, there is evidence that a substantial additional portion (one study suggests half) of high-cost patients are in nursing homes, special disease hospitals, terminal illness facilities, or mental institutions. Each year, 1.6 million people spend some time in an institution of this sort. Together, they represented a total institutional care budget of over $17 billion in 1976, implying an average expense per capita of over $15,000, with some patients consuming many times this quantity of medical resources. Including both long- and short-stay institutions, approximately 2 percent of the United States population accounts for over 60 percent of all hospital and institutional care resources in a given year. If high-cost "institutional" (e.g., chronic domiciliary) users disproportionately overlap with high-cost users of a short-stay hospital, as they surely must, the concentration is even greater.

This significant concentration of medical resources appears to be increasing over time. One study has shown that the average medical expenses for the high-cost 1 percent of persons in the population in a year are growing at a rate that is 5 percent greater

[2] All figures are inflated to 1980 dollars.

than those of the least costly 25 percent of persons. Thus, the most expensive patients are becoming both absolutely and relatively more expensive to treat.

2. *High-cost illness is seldom a single episode.* Discussion of catastrophic health insurance often depicts patients in intensive care or "brain death" as typical of high-cost illness. In contrast, we find that high-cost illness is most often longitudinal in nature, comprising a series of treatments and hospital episodes over time rather than one medical emergency. In the Zook-Moore study of six populations in five hospitals of varied nature, the highest-cost 10 percent of the illnesses treated in a year were classified into several categories: single cost-intensive illness ("intensive care"), single prolonged hospitalization, repeated hospitalization for the same disease, and combinations of these categories. Repeated hospitalization for the same disease was by far the largest of these groups, accounting for 50 to 90 percent of high-cost patients in the different populations.

A large proportion of high-cost illnesses are not imminently terminal, but rather extend over many months or years. The recidivists in the high-cost group were 15 years younger on average than other high-cost patients with cost-intensive or prolonged hospitalizations and frequently suffered from a degenerative or irreversible long-term illness, such as advanced coronary artery disease or cirrhosis of the liver. Only 12 percent of the recidivists died in the hospital or were judged to be imminently terminal at discharge. The one-year hospital charges of the recidivists averaged $15,800.

In contrast, half of the patients with single cost-intensive hospitalizations died in the hospital or were judged terminal at discharge. The average cost (excluding physician fees) of this type of stay was $15,000. Twenty-two percent of patients with a single prolonged hospitalization died or were terminally ill, and the average cost of their stay was $18,700. Previous studies of intensive care have shown even higher in-hospital fatality rates and expenses. There is no doubt that these illnesses have a tremendous financial impact on the hospital and they have understandably drawn a great deal of public attention. However, neither intensive care nor prolonged hospitalization was the most frequent type of high-cost utilization over periods of a year or longer, that distinction belonging to patients who underwent repeated hospitalizations for the same disease.

3. *Medical technology is not the primary source of rising costs.*

Technological advances are often thought to be the principal cause of the high costs of individual "catastrophic" illnesses. (Coronary artery bypass grafting, kidney dialysis, and hyperalimentation are commonly cited examples.) Yet there is evidence to suggest that high daily hospital charges and high costs per illness typically reflect the use of a large total volume of standard resources—often fairly simple—rather than the application of a new technology.

Among the high-cost patients in the Zook-Moore study, a major procedure or treatment seldom accounted for a large share of total costs. Only 1 percent of this group had a cardiac pacemaker, 4 percent had a recent coronary artery bypass graft, 6 percent were on dialysis, 1 percent had open heart surgery, less than 1 percent required hyperalimentation, 2 percent required radiotherapy, and 2 percent required care in a neonatal intensive-care unit. (Since two of the hospitals studied had large kidney disease services, the incidence of dialysis may be higher than in the population overall.) These figures resemble the results of a study of 17 California hospitals which concluded that high-cost patients differed from their low-cost counterparts more in the amount than in the kind of care received.

Therefore, for high-cost patients (as for others) most days spent in the hospital do not include major tests or procedures, let alone intensive care. Though high-cost patients have more complex days somewhat more often than low-cost patients, the difference was much less than one might expect. The Zook-Moore study classified hospital days into four categories, depending upon their complexity. Briefly, the categories were: (1) routine dwelling days; (2) days of minor testing, blood work, physician consultation, and special intravenous medications; (3) days of major diagnostic testing, minor operations, or special precautions; and (4) intensive care, operations over three hours, emergency admission for major trauma, or life-support services. So-called "intensive care" days were more than twice as common for high-cost patients than for other patients, but they still accounted for only one day in eight for this highest-cost category. Routine dwelling days represented a quarter of the time spent in the hospital by the highest-cost group as compared to 40 percent of the time spent by the lowest-cost group. Thus, for many high-cost illnesses, treatment does not consist predominantly of intensive bursts of the most high-technology care. Patients suffering from alcoholism, diabetes, obesity, certain neurological disorders (e.g., multiple sclerosis), mental disease and stroke for instance, incur high costs primarily by consuming large

quantities of hospital days and many hours of professional services. They may never reach the operating room, nor be assessed by a CAT scanner.

4. *Complications during treatment raise costs.* Hospitals are complex institutions where hundreds of difficult judgments are made, orders are interpreted, and technical procedures are undertaken every hour. In such an intricate environment, many forms of accident, error, and unforeseen health events may arise to prolong or increase the costs of treatment. Some complications during treatment are simply bad outcomes of well-informed gambles (prosthesis failure or digitalis toxicity in heart disease are some natural but unforeseen progressions of disease; others are due to misapplication of diagnostic equipment; some are drug reactions; others are due to infections acquired in the hospital, still others are due to errors by physicians and other care providers. In any case, unexpected complications during treatment are an important cause of high-cost illness.

Unexpected complications, which other studies have shown to strike one patient in five, are most common among high-cost patients—both per day and per hospitalization. The Zook-Moore study identified 22 forms of unexpected complication during hospitalization in the five hospital populations. On average, 1.8 such events occurred during each cost-intensive hospitalization, 1.3 during each prolonged hospitalization, and 3.2 during stays that were both prolonged and cost-intensive, but only .2 in other types of hospitalization. By virtue of their illness, high-cost patients seem particularly susceptible to medical complications which further raise costs.

5. *Harmful habits lead to high costs.* Persons with a potentially harmful habit are hospitalized substantially more than are others. (This is not to imply inevitable causality. In any particular case, the condition requiring hospitalization may have developed independently of a harmful habit.) The high prevalence of alcoholism among patients in general hospitals illustrates the link between habits and hospital costs. Though 4 to 5 percent of the overall adult population is alcoholic, it has been estimated that 9 to 14 percent of the general hospital population (15 to 29 percent of males in that group) is alcoholic. Our data confirm these high levels of alcoholism in the general hospital population and the overwhelming recidivist tendencies of these patients. When hospitalized, patients with unhealthy habits like alcoholism are more expensive to treat and become high-cost patients. In the Zook-Moore study, poten-

tially harmful habits were noted in the records of high-cost patients more than 40 percent more often than in the records of other patients.

The picture of high-cost illness that emerges from consideration of the factors discussed above is not entirely consistent with the "catastrophic" stereotype of life maintenance in intensive care, problems of when to declare brain death, or advanced high-technology treatment. Rather, high-cost illness is usually long term and often mundane or recurrent, embodying costs due, in part, to unexpected complications during treatment or to persistent unhealthy personal habits. Though random medical tragedies are an important component of the high-cost patient group, they are isolated elements representing only a small part of the picture. Unfortunately, proposals for catastrophic health insurance are based primarily on this rather simple notion of the source of high medical costs.

Problems with the current plans

From this profile of the high-cost users of medical care emerge three important considerations for the design of health insurance programs. First, high-cost illnesses differ widely in terms of clinical options, controllability of resource utilization, and predictability (the repeaters). Insurance schemes should reflect those differences. Identical insurance structures for the very different illnesses described above may make no more sense than identical plans for fire and life insurance. In fact, the potential for identifying chronic repeaters suggests a form of prospective reimbursement to a specialist institution (e.g., in spinal cord injury) for some patients.

Second, the data suggest that "catastrophic health insurance" is unlikely to be as economical as is often asserted. In fact, the high-cost 10 percent of patients accounted for 40 to 50 percent of hospital charges in one year and cost over $13,700 apiece. Methods are still needed to instil cost efficiencies while insuring against genuine cases of financial hardship.

Third, some utilization by the high-cost users may be more "optional" or elastic than is generally thought; this possibility is suggested by the surprising prominence of harmful habits, of treatment complications, of "routine," low-intensity care, and of repeated hospitalization (as opposed to emergency intensive care).

These three themes—marked patient differences, surprisingly high costs (often predictable over several years), and the potential for controllability of some cost components—put current proposals for

health insurance in a new light and point towards new and more workable policy approaches to health insurance.

The front-running alternatives for national health insurance are built upon the premise of relieving the financial burden of high-cost illness for all Americans. The Catastrophic Health Insurance Bill that has received tentative approval from the Senate Finance Committee, employing what is called the Long-Dole approach, provides federal payment of all medical expense for a person beyond a $3,500 annual threshold. (The threshold is lower for poor people.) Consumer Choice Health Plan, a leading pro-competitive option put forward by Alain Enthoven, would require any private plan approved for federal support to include "catastrophic coverage." Major-risk health insurance is also central to a plan put forth in *The Public Interest* in 1971 by Martin Feldstein. This scheme would use public loans to patients as well as co-insurance and deductibles to hold down costs from "first dollar" coverage while relieving some of the fiscal burden imposed on the individual by high-cost illness. Proposals by Senator Edward Kennedy for a comprehensive national health insurance plan under the Health Care for All Americans Act were presented in a series of 1978 hearings where experiences of patients with high-cost illness dominated the testimony. The Carter Administration proposal, National Health Plan, also included retrospective payment for high-cost illness, with uniform reimbursement provisions across all providers and diagnoses.

The findings described above suggest that major improvements are needed in the catastrophic coverage provisions of these plans. Though few proposals contain incentives for providers to develop long-term care programs to reduce readmissions, repeated hospitalization for the same disease is the most frequent utilization mode defining high-cost illness. In addition, no plan contains incentive provisions to reduce the frequency of potentially harmful habits, such as higher premiums for the heavy smoker, the obese overeater, or the noncomplying clinic "no-show." No plan considers how patients at high risk of complication may reach the most efficient providers. Patient profiles are very different, but no plan considers how we can overcome repeated treatment failures in hospitals, an important source of high medical costs and poor medical outcomes.

High-cost illnesses for the most part are not random "bolts from the blue," yet many proposals for catastrophic health insurance are based on this misconception. They fail to confront key cost components of high-cost illness and neglect important differences across categories of patients.

There is no reason why insurance plans cannot address separately the different segments of high-cost users, identified above, in more carefully tailored ways. The terminal cancer patient, the non-complying diabetic, the repeatedly hospitalized alcoholic, the paraplegic, and the elderly widow with severe peripheral vascular disease are similar in their status as high-cost users of medical care, but dramatically different in their care requirements, their financial needs, and the lower-cost treatment alternatives that are available. Health insurance proposals should and can take these differences into account if they are to meet the patients' needs within reasonable costs. Since catastrophic health insurance, as embodied in present proposals, does not recognize differences it is unlikely to be inexpensive or fully equitable, nor will it offer a "quick fix" to the most pressing health problems.

For example, the Long-Dole bill features full federal reimbursement for in-patient, post-hospital, physician, and home health services after a deductible ($3,500 in the present version) is exceeded during a calendar year. Payments would be open-ended and determined retrospectively on the basis of hospital charges. Such a plan unfortunately perpetuates the sort of program design that has raised current health costs to such a high level. By tempting hospitals to get the patient's bill up to $3,500 whenever possible (to reach a range in which there is full federal payment) it may exert a further inflationary impact on medical costs.

Financial rewards or penalties applied at the appropriate leverage point can greatly affect the behavior of patients, doctors, and hospitals, and could reduce total costs. One recent study of California Medicaid experience, for instance, found that the institution of a one-dollar charge per physician office visit decreased demand for those visits and increased demand for hospital services (which remained "free" to the consumer). Patterns of charges and payments have also been shown to be influential for dental care and other out-patient services. When the dollar amounts are large, both consumer and provider behavior may be modified dramatically. The treatment of kidney disease provides a particularly graphic example. Federal legislation enacted in 1972 provided 100 percent coverage for dialysis treatment and associated physicians' fees. This discouraged kidney transplantation, and favored dialysis in centers over dialysis at home. In the next five years, private firms steadily entered the market for dialysis services. As a result, by 1978, 37,000 patients were being dialyzed—up from roughly 10,000 in 1974—with a 50 percent increase in this number predicted by the mid-1980's.

Moreover, the share of patients on home dialysis declined from 40 percent to 13 percent in the 1972-1976 period. In cases such as renal dialysis, where there are therapeutically-competitive alternatives, financial and service-support incentives to employ lower-cost methods are especially promising.

By misunderstanding the nature of high-cost illness, the one-year deductible proposed by catastrophic insurance plans is terribly inequitable. Approximately 20 percent of all patients in the Zook-Moore study had been hospitalized at least four times in the previous five years for the same disease; many had recurrent illnesses over much longer periods. A longer-term benefit structure could reflect more adequately the extremely high year-after-year costs of illnesses such as vascular disease, certain congenital defects, some cancers, cirrhosis of the liver, intractable anemia, diabetes, or major stroke. It is possible to account for costs over a series of years, with appropriately tailored co-insurance and deductible provisions. The single, short, cost-intensive episode, so well covered by a one-year, open-ended insurance plan, is neither the most frequent type of high-cost illness, the most socially disruptive or financially ruinous, nor the case that needs greatest societal attention. A newborn with certain congenital anomalies might never "qualify" in one year, yet from birth to age 15 might require 10-20 hospital admissions. This would have a greater long-term impact on the family budget than would most serious accidents or severe burn incidents, misfortunes which would be adequately covered under current proposals for catastrophic insurance coverage.

A reassessment of high-cost illness also makes it clear that catastrophic plans seldom give appropriate incentives to hospitals and insurers to control costs. Insurance provisions that pay for all patients' expenses once they exceed a threshold (e.g., $3,500) will affect the way that hospitals decide to price their services. In fact, it may become advantageous to hospitals to reverse the present practice of subsidizing high-cost days by low-cost days and to charge higher prices for intensive care and complex forms of care. This would make the expensive appear even more expensive and would also magnify the total bill for high-cost illness. Open-ended reimbursement after a one-year deductible also gives providers and insurers little financial incentive to develop preventive programs or long-term management services. Major-risk insurance a now conceived will be able to forestall financial ruin for a smau percentage of patients, but will do little to promote a more cost-effective organization of medical treatment which would benefit everyone.

Considering new remedies

Recent surveys of high-cost patients allow a more sophisticated understanding of the potential impact of catastrophic health insurance. We have found that high-cost illnesses differ widely but are mainly concentrated among a small number of long-term patients, that insurance will not be as economical as some have imagined, and that some components of high costs can be controlled. Our assessment suggests several improvements for catastrophic health insurance.

1. *Different groups need different plans.* Study of the high-cost users revealed several categories of patient, each with different needs, treatment alternatives, and behaviors. For instance, nearly 50 percent of childhood high-cost illnesses were traceable to a congenital defect; about 40 percent of the high-cost adult users had a potentially harmful habit noted in the record; over 20 percent of high-cost users were over 70 years of age; and nearly 10 percent had cancer. Patients defined by clinical parameters such as these would have very different incentives to use medical services. Just as physicians would counsel these groups differently as to their care, insurance plans should guide them differently into the most appropriate pattern of health services utilization.

Alcoholism and mental disease were both important among high-cost patients. In the institutions studied, these patients were confined to the hospital for many days. A much lower-intensity setting (i.e., not a hospital), if reimbursed in appropriate fashion, might prove to be equally effective and less costly. The treatment of diabetes mellitus provides another example of the possibility of developing a more cost-effective approach to a single diagnosis. One study at Stanford has shown that appropriate education and substitution of ambulatory services can reduce re-admissions of diabetics by as much as 56 percent. This approach has apparently succeeded in reducing costs while maintaining or increasing quality of care.

There are currently few financial incentives in the insurance plans to employ the most cost-effective modes of care for these illnesses. By insuring against hospitalization—the highest-cost setting—we lower its relative cost and make it a more attractive mode of care to the patient. Proposals for undifferentiated catastrophic illness coverage could worsen this problem. Distinctive modes of reimbursement for particular high-cost use groups, by contrast, may foster the growth of geographically clustered services for similar diagnoses, thereby making possible significant economies of scale. Attempts to regionalize heart surgery [illegible] tential economies. One study found that unit costs were related strongly to the number of procedures done per year, suggesting large savings may be realized through "learning by doing." Another study estimated that if 50 operations were performed a year, the cost per patient would be $21,500, but with a tenfold increase in scale, the cost per patient would drop to $8,700.

2. *Prospective reimbursement can control costs.* A shift from current patterns of reimbursement for providers also offers possibilities for considerable savings. Control over the costs of care is possible only when the provider or patient is a primary decision maker and has a direct stake in the conservation of scarce medical resources. Under cost-based reimbursement after the fact, neither consumer nor provider has an incentive to control cost in a single episode or to foster the most cost-effective modes of long-term care (e.g., early use of ambulatory services to forestall the need for later emergency hospital admission).

Planning for long-term care is especially important, since almost two-thirds of the high-cost 20 percent of patients in our study experienced repeated hospitalization for the same disease (often predictable) in a single year, and many repeat visits in earlier (and later) years. Early interventions to lower the probability of future hospitalizations could provide major cost savings. For example, giving known hypertensives effective rewards for compliance and careful follow-up after screening can reduce later rates of hospitalization. The medical care system has an important opportunity to design similar cost-effective programs for other illnesses.

One way to provide incentives for cost-effective care of the high-cost patient group might be through "prospective reimbursement." Under such a system, certain institutions would be promised a predetermined annual payment to assume responsibility for the care of a patient with a long-term, high-cost illness. (Short-term illnesses with potentially high-cost consequences could be handled differently.) The magnitude of the payment would depend on the illness diagnosed, and might change over time for a given patient. A spinal cord injury center, for example, might be granted a fixed payment on the first of the year for each paraplegic whose care it assumed. Appropriate medical centers would be given similar payments for each child with cystic fibrosis, hemophilia, or other severe, predictable and repetitive illness. The same approach (perhaps with additional categorization of patient condition) could be undertaken for mental disease, renal failure, or even alcoholism.

The value of this system is that the health care provider assumes responsibility for costs above the expected level. At the same time, if costs can be held below the expected level, the provider retains the cost savings. Thus incentives to conserve resources are built into a system which at the same time guarantees the provider a level of reimbursement that, across the range of patients treated, should adequately cover the costs of appropriate care. Such a program would shift responsibility for designing and implementing cost reductions from the regulators of medical care to its deliverers. Physicians would retain control over detailed clinical decisions. This is in contrast to command and control methods of cost containment imposed by outside public agencies, which operate through regulation of capital investment and, in some cases, as with Professional Standards Review Organizations, with assessments of patient care on a case-by-case basis. Widespread prospective reimbursement would probably also give rise to new forms of provider organizations, and group practices specializing in certain types of patients or illnesses. Their success would depend on their ability to deliver care less expensively than do existing institutions.

Quality assurance must be a continuing concern in any system for financing medical care. For certain classes of high-cost users this problem might be particularly acute. Strong, readily implementable sanctions should be available to maintain acceptable quality of care, thereby avoiding the exploitation of possibly helpless groups such as the mentally ill, the senile, and the very sick. Financial penalties for inadequate care might well be linked directly to the reimbursement system. Because of the cost-quality tradeoff, there is also a danger in placing unduly strong cost-reducing incentives on physicians. The objective should be to create a climate or ethos of cost reduction, and of more fervent inquiry into "how much is enough." This sort of indirect encouragement to improve performance is often cited as a principal benefit of profit-sharing plans for workers in private companies. Something similar could perhaps be achieved in health services. (The proponents of health maintenance organizations claim that it already has been.)

The most important feature of prospective reimbursement in the context of the high-cost users is that it provides a strong incentive to deliver health care on a cost-effective basis over the long term. Attention to costs on an episode-by-episode basis is hardly sufficient (it may even be counterproductive in circumstances where rehabilitation or prevention is a possibility), especially when all the evidence suggests that those who use medical resources most extensively utilize them on a continuing basis over a period of years.

3. *There must be incentives for prevention.* We have seen that high-cost users are more likely than other patients to have potentially unhealthy habits. Persons with a documented adverse lifestyle were found to be more often in the hospital, more costly to treat per illness, and more repetitive in hospital utilization than others. Any public program to finance care of high-cost illness must inevitably confront this problem. Given the interdependence created by any system of health insurance, if individuals are to have sufficient incentive to take care of themselves—to reduce their levels of risk and thereby their expected medical expense—they must be "penalized" in some way for engaging in unhealthy behavior.

There have been relatively few documented attempts made on a significant scale to modify risk factors. Where the attempt has been made it has often met with success, especially in reducing risk factors related to coronary disease: smoking, obesity, and certain dietary habits. The Stanford Heart Disease Project, for instance, sponsored a highly successful voluntary campaign of education and counseling for those most at risk in three California communities. National trends also show that risk factors can be modified and that they can make a difference in personal health. The rate of coronary death in the population for males aged 45 to 54 has declined by 20 percent since 1970, possibly due to improvements in smoking habits and diet within this group. The North Karelia project in Finland also focused on providing information and counseling with regard to cardiovascular risk factors. In four years it achieved substantial reductions in smoking, cholesterol levels, blood pressure, and hypertensive drug noncompliance rates at a modest cost.

Programs in the workplace have also shown some success. In fact, 30 percent of major United States companies now conduct some form of non-smoking program, and 3 percent of these businesses pay their employees not to smoke. Though few reliable statistics are available at present, early results suggest that even small rewards for, or assistance in, smoking or weight reduction can affect behavior and health outcomes. If voluntary community campaigns and relatively small programs in the workplace can reduce unhealthy behaviors, it seems likely that more vigorous approaches, including direct financial incentives for low risk-factor levels, may do even better.

The prevalence of potentially harmful habits noted in the medical records examined by the Zook-Moore study underscores the potential importance of preventive measures, promoted in part by

educational programs, but encouraged strongly by insurance-plan design. Thus a high-cost patient who fails to control the habit of alcoholism or smoking might be required to pay a higher premium until his physician testifies the problem has been solved. The incentive need not be applied at the time of the high-cost illness. The fearful lifestyle consequences of many high-cost illnesses are a far more powerful deterrent to risk-taking behavior than the possibility of high medical costs. Charging after the illness sets in offers little in the way of additional incentive, yet subjects a class of individuals to a significant financial risk, assuming that only a small fraction of people with bad habits get "caught." Moreover, in many instances, it might prove infeasible to charge after the high-cost illness has set in. If we wish to charge individuals for taking increased risks of incurring high-cost illness, and sensible policy would suggest that we should, the most propitious time to do so is while they are taking the risk, before they enter the high-cost user statistics. Severe penalties for speeding and substantial taxes on cigarettes are more appropriate, and probably more feasible, than an actuarially based charge on paraplegics and lung cancer victims for their illnesses.

Problems that could yield to preventive measures are found in their most extreme forms in the most costly illnesses. This is the finding that most forcefully dispels the common misperception of high-cost illness as a random catastrophe. At a minimum, any major-risk health insurance plan should consider: (1) greater taxation of tobacco (perhaps at varying rates dependent on the characteristics of the cigarette) and alcohol, with the proceeds helping to finance the insurance program, (2) insurance premium incentives to lose weight, to stop smoking and drinking, and to adhere to medical regimens, (3) development of new approaches to chronic repeaters especially those with lifestyle-disease involvements, (4) incentives to channel certain categories of patients to hospitals where rates of unexpected complications for their particular problem are lower, and (5) more widespread use of successful community education programs such as the Stanford Heart Project.

Treating the "high-cost" users

While discussions of catastrophic illness conjure up images of unforseen accidents and disease, insurance proposals currently before Congress would really cover all forms of very expensive medical care. Relief for its citizens from the financial burden of high-cost illness is a [illegible] little doubt that high-cost patients often need and merit financial assistance and large quantities of medical resources. Many of the tragedies that befall the high-cost users are precisely the types of events for which organized insurance can provide its greatest benefits. But there are numerous ways to insure and many ways to aid those in need. If high-cost illness in all its forms is really the concern, Congress and the new Administration must understand the nature of the problem, its causes, and the treatments to which it might yield. Any program to cover high-cost illness should not only achieve the primary function of insurance (the spreading of risk), but should also build incentives into the health-care system for the most competent care by doctors, adherence to life-preserving lifestyles by patients, and cost-effectiveness by those who provide care.

Major mistakes are not uncommon in health-care programs partly because the health-care system works in mysterious ways. A broad-based insurance program to cover high-cost illness should not be mandated until we develop a deeper understanding of the problem. Observing its responses to policies in place can often change our conceptions dramatically, and convince us that quite different policies would be desirable. For instance, the "doctor shortage" of ten years ago is seen now, by many, as a "doctor surplus." Actions are now being taken to reverse this trend. Hospital reimbursement provides another example. During the 1970's the state of New York penalized hospitals financially for excess bed capacity. Yet it was recently decided that this did not hold down costs and that payment incentives will now need to be given to hospitals to encourage empty beds, precisely the opposite policy.

Reversal is likely to prove much more difficult, however desirable in concept, where coverage for high-cost illness is concerned. Entitlements are always difficult to reduce, especially when the target group appeals to our sympathies. Moreover, health-care delivery institutions adapt themselves to any new reimbursement mechanism and tend to become dependent upon it. Should policy in this area prove to be more expensive than estimated, or merely poorly designed, we might repent at leisure.

copy to Haney

ALASKA HEALTH CARE ADVOCATES
P.O. BOX 1037 D.T. ANCHORAGE, ALASKA 99510
907-272-8734;272-6652

Senator Charlie Parr
Pouch V
Juneau, Alaska 99811

May 19, 1981

Dear Senator Parr:

Rocky tells me you are concerned by HB41 because of the research presently underway by the Battelle group. It seems there has been a great deal of misconception regarding the goals of the Battelle study and HB41. The two are, in fact, complimentary.

Enclosed please find an article which explains the goal of the Battelle study and HB41, and how they interface. I think you will find several of the major items in HB41 entirely consistent with your campaign theme of representing the disenfranchised.

I will be in Juneau the last week in May, and hope to talk to you about the importance of the passage of HB41 for the low-moderate income consumer. Thank you for your time and attention; I look forward to seeing you at the end of May.

Sincerely,

Susan Johnson

Susan Johnson
Executive Director

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

MEMORANDUM

April 18, 1980

TO: Representative Joe McKinnon

FROM: Jack Kreinheder, Betty Barton
Issues Analysts

RE: Cost of Statewide Health Insurance
Research Request No. 128

You have requested that we: 1) estimate the cost to the State of providing universal health insurance equivalent to the current Blue Cross State employee health plan for all residents of the state, regardless of other federal or private insurance coverage; and 2) determine the probably savings to the State which might result from reduced expenditures for Medicaid, catastrophic illness, general relief medical, and other State health programs. Your second question is still being investigated, and will be addressed in a separate memo as soon as we complete our research.

We have estimated that if the State were able to extend its current State employee insurance coverage at the current premium rate ($100.16 per month for each family unit) to all residents of the state, the total additional cost would be about $175 million per year. However, Blue Cross personnel stressed that the premiums for such extended coverage could be substantially higher and cannot be predicted with confidence at the present time. A number of undetermined factors were cited which preclude the accurate estimation of premium costs for statewide health insurance coverage, including family size, risk characteristics of the total Alaska population, and transportation costs for medical treatment in rural areas of the State.

Our contacts at Blue Cross were not able to provide even a maximum probable premium cost for universal coverage, but indicated that the premiums could be 50% higher than for the current State employee program. Thus, the total cost to the State for universal coverage could be $263 million or more, depending on the factors cited above, and others.

It is important to note that the total cost of statewide health coverage could be substantially lower if residents eligible for various federal health programs were excluded from the program. Nearly one-third of the state's population is estimated to be eligible for health care coverage under the U.S. Public Health Service and CHAMPUS programs. Costs for statewide health coverage might therefore be reduced by roughly one-third if persons already eligible for these federal programs were not included in the State program.

We regret that we could not provide a more precise cost estimate for statewide health insurance, but we hope our "ballpark" figures are of some use to you. Our research on your second question, pertaining to cost savings from statewide health coverage, will be transmitted shortly, hopefully later this afternoon. Please let us know if we may be of further assistance.

JK:BB/dp

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

MEMORANDUM April 23, 1980

TO: Representative Joe McKinnon

FROM: Jack Kreinheder/Betty Barton

RE: Costs of Statewide Health Insurance
Research Request No. 128

This memorandum responds to your request concerning the reduction of State health care expenditures which might be realized from the provision of statewide health insurance. To accomplish this, we first determined which State programs currently are providing payment for health care services rendered. We then examined the types of health care services eligible for reimbursement under these programs and compared them against allowed health care under the State's Comprehensive Medical Plan for employees of the State of Alaska. To determine the amount of State money that would be saved through statewide health insurance, we reviewed the Division of Public Assistance budget and subtracted program and related overhead costs for administrative and space expenditures for health care services that probably would be available through a statewide plan. Our figures do not include indirect costs such as overhead costs for administrative and space expenditures that may be charged by the Departments of Health and Social Services and Administration for management of these programs. We have included for your review budgetary allocations for those Medicaid and General Relief Medical services that we feel would be unaffected by statewide health insurance.

Summary

Our research indicates that $21.5 million State dollars are committed for expenditure to purchase health care services in FY 80. This figure includes $12 million from the State's general fund and $9.47 million from the State's federal revenue sharing entitlement. If statewide health insurance were provided, it appears that $11.5 million of these expenditures could be saved and that $10.0 million would remain for payment of services most likely not covered in an insurance program.

Please bear in mind that our calculations are estimates derived in part from hypothetical constructions, and so, should be judged with a degree of caution. The basis for our conclusions is detailed below:

Medicaid

This State-administered program is funded federally with a 50 percent match requirement of State dollars (in recent years, the State has combined State general fund dollars with a portion of its federal revenue sharing entitlement, which may be used as such, to meet its contribution requirement). Medicaid is a program of "final resort;" payments are made to providers for health care services delivered to eligible clients only after all other funding sources, such as Workman's Compensation and the Fisherman's Fund, are exhausted. The State reimburses providers for "reasonable costs" incurred in hospital, physician, and nursing home care. Cost determinations are made based on the findings of the federal government's fiscal intermediary (Blue Cross) and the State's Medicaid auditors. Medicaid payments are also made for the Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT) as well as for other services, such as the Anchorage Home Health Care Program. As we will discuss later, Medicaid also reimburses for services provided at Harborview and the Alaska Psychiatric Institute, which we have not included in our computations.

As is detailed in the attached charts, it appears that the effect of statewide health insurance on the Medicaid program would be a savings of $4.95 million. This finding assumes that the insurance plan would provide the same payment to participating hospitals and physicians currently provided by Medicaid. It further assumes that Medicaid's other services would be considered allowed costs (excluding $63,500 expended on home health care). A statewide insurance plan probably would provide payment for a portion of EPSDT but would regard screening as a nonreimbursable service. A major health category that would not be covered by statewide insurance is nursing home care. The State's Comprehensive Medical Plan does not provide coverage for long-term care provided by an intermediate or skilled nursing facility, which means that the $7.9 million in State funds used to reimburse nursing home providers probably would remain as an expenditure.

General Relief Medical

This program is funded solely through the State's general fund. The program provides medical assistance to financially needy individuals having specific medical problems and lacking the resources, including insurance, to provide themselves with adequate care. Obviously, this

program would be impacted significantly by a statewide insurance program. However, also included under this program, albeit with less stringent eligibility requirements, is the Catastrophic Illness Program. This program provides assistance to individuals after their third party coverage is exhausted and after no less than $1,000 in health expenses in a twelve-month period have been accrued. Because of the program's special function, we have treated it as an expenditure which would remain unchanged by the provision of statewide health insurance. In fact, whether it would appear as a savings or an unchanged cost depends on the number of uninsured individuals utilizing the program. Unfortunately, there is no available data that categorizes Catastrophic Illness beneficiaries.

It appears that the impact of statewide health insurance on General Relief Medical would be a reduction of $6.5 million in State expenditures, primarily the result of savings in hospital, physicians', and other service costs. As with Medicaid, service expenditures remaining unchanged include those for nursing home care. In addition, a relatively small program entitled Residential Nursing probably would be ineligible under statewide insurance coverage.

Problems/Limitations

As noted earlier in this memorandum, Medicaid also generally provides coverage to Harborview and API. Services at Harborview for FY 81 are projected to cost the State $4.1 million for the care of its patients. The facility is licensed for 96 beds and 97 percent of the beds are occupied by Medicaid beneficiaries. Medicaid rates (based on the facility's occupancy rates and cost of care) currently have been set at $153.75 per day, or $56,118 per patient annually. Under the State's Comprehensive Medical Plan, only limited coverage is extended for treatment of mental or emotional disorders. Insurance is restricted to short-term, treatable illness, defined as neurosis, psychoneurosis, mental or emotional disorders, or psycopathy. No coverage is provided for adolescent behavioral disorders; learning disabilities, or marital, family, sexual, or other counseling. (Apparently, some consideration is occasionally given in favor of short-term, one-on-one counseling.) Custodial care also is excluded from coverage under the State's plan. It is doubtful then that statewide health insurance, under the current State policy's design, could supplant State expenditures at Harborview.

Some insurance coverage could be extended to eligible patients at API, although probably not on the level of reimbursement provided by Medicaid. Physician's services for mental and nervous disorders are covered, in part, with 50 percent of a patient's eligible expenses reimbursed in an amount not to exceed $2,500 for each covered member per benefit year. The Medicaid program reimburses services provided to eligible patients "reasonably classified" aged 21 years or younger "who are receiving treatment in an inpatient psychiatric facility." The current Medicaid rate for API is $196.00 per day. However, the amount of Medicaid projected for receipt by the institution for FY 80 is unknown.

The eligibility determination for Medicaid reimbursement at API was recently the subject of a federal audit; and, consequently, staff at the Department of Health and Social Services are uncertain of the amount of Medicaid billings which will be approved. The State has authorized $7.58 million for API in FY 80; however, included within this figure are unrestricted federal receipts (for Medicaid and third party payments. As a result, it currently is not possible to derive an estimate of the effects of statewide health insurance on State health care expenditures in this program.

We have limited our scope of research in this memorandum to services eligible for reimbursement by Medicaid and General Relief Medical. Following transmittal of this information to your office, we will explore the effects, if any, of statewide health insurance on other State programs offering health care services similar in nature to those provided through the State's insurance plan, e.g., alcoholism treatment.

We apologize for the delay in preparing this memorandum for you. Compiling the data was more problematic than we had originally anticipated. We hope the information contained herein is suited to your needs.

JK:BB/dp

Attachments

PROJECTED COST SAVINGS OF STATE HEALTH CARE EXPENDITURES
RESULTING FROM A STATEWIDE HEALTH INSURANCE PROGRAM*

	*Savings of State Funds (in thousands) by Source		
	General Fund	Federal Revenue Sharing	Total
Medicaid			
Hospitals	$1,160.7	$1,648.9	
Physicians	621.9	787.7	
Other Services	213.1	90.95	
EPSDT	427.9	-0-	
	$2,423.6	$2,527.55	$4,951.15
General Relief Medical			
Hospitals	$4,147.9		
Physicians	1,150.3		
Other Services	1,224.1		
	$6,552.3	-0-	$6,522.3
Administrative Overhead			
Medicaid	$22.8		
General Relief Medical	22.8		
	$45.6	-0-	$ 45.6
		TOTAL SAVINGS	$11,519.05

* Based on FY 80 Authorized Budget

HEALTH CARE EXPENDITURES NOT ANTICIPATED TO BE DIMINISHED BY STATEWIDE HEALTH INSURANCE COVERAGE*

	State Funds (in thousands) by Source		
	General Fund	Federal Revenue Sharing	Total
Medicaid			
Nursing Homes	$ 967.4	$6,945.4	
Other services	63.5	-0-	
EPSDT	427.9	-0-	
	$1,458.8	$6,945.5	$8,404.2
General Relief Medical			
Nursing Homes	$ 683.9		
Residential Nursing	166.4		
Catastrophic Illness	754.2		
	$1,604.5	-0-	$1,604.5
Administrative Overhead			
Medicaid	$ 22.8		
General Relief Medical	22.8		
	$ 45.6	-0-	$ 45.6
		TOTAL EXPENDITURES	$10,054.3

* Based on FY 80 Authorized Budget

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

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

MEMORANDUM May 22, 1980

TO: Representative Joe McKinnon

FROM: Betty Barton BB

RE: Costs of Statewide Healthwide Insurance: Addendum to Research Request No. 128

In an earlier memorandum to you, we determined the probable savings to the State that could occur from reduced expenditures for Medicaid and General Relief Medical were statewide health insurance made available. At that time, we speculated that there could be added, less apparent savings realized in other health programs, such as those administered by the State Office of Alcoholism and Drug Abuse. We stated that we would conduct additional research in this area and notify you of our findings. Our research indicates that no reductions in cost, beyond those already submitted to you, would be realized through the provision of statewide health insurance. Other programs are not structured to purchase health services provided to beneficiaries by health care providers, as are Medicaid and Genearl Relief Medical, and so, would not be affected by payments of third party carriers.

We apologize for the delay in transmitting this information to your office.

BB/dp

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

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

February 13, 1981

MEMORANDUM

TO: Representative Charles Anderson

FROM: Peter B. Froehlich PBF

RE: Hawaii No-Fault Insurance Statute
Research Request 81-16

You have asked for information concerning the Hawaii no-fault insurance statute. In response to your request, we have assembled the following materials which are attached to this memorandum:

- a copy of the Hawaii no-fault insurance statute, Chapter 294 Motor Vehicle Accident Reparations. (For your convenience, we combined the chapter as it existed after the 1976 session of the Hawaii legislature with the amendments enacted in 1977, 1978, and 1979 sessions.)
- a copy of the digest summary of the eight amendments to the chapter enacted by the 1980 session;
- copies of two companion sections of the Hawaii statutes updated to the present (Sections 286-116 and 806-13); and
- a copy of an information pamphlet for Hawaii drivers which was published in the fall of 1978, and despite subsequent amendments to the act, is still in use.

In addition, we have contacted the Hawaii Assistant Commissioner of Insurance, David T. Ishikawa who has headed the no-fault section of the insurance division since 1974, shortly after the no-fault law was enacted.

Mr. Ishikawa stated that after many amendments had been made to the Hawaii no-fault statute over the past seven years, it was generally felt that all major problems had been eliminated. Only one or two minor housekeeping amendments are anticipated this year. He stated that a primary reason for the success of the Hawaii statute is the threshold of $2,500 damages or death or permanent disability, above which a tort suit is permitted. This threshold has kept 90% of those injured in car accidents within the no-fault system and out of court.

The only real problem Hawaii's system is experiencing is the rapidly rising premium costs of coverage. However, this is a problem which

arises not from the system itself, but from inflation and the increasing number and severity of accidents.

According to Mr. Ishikawa, the most controversial aspect of the Hawaii statute is the coverage provided by the state, free of charge, to welfare recipients. He stated that some people object, on philosophical grounds, to subsidizing low-income drivers, but that others feel that the poor will drive regardless, and the state-funded coverage protects the public in the case of accidents involving an indigent driver. No proposed changes are expected to this part of the Hawaii law.

In response to your question concerning the potential difficulty of drivers obtaining proof of insurance and then cancelling their coverage, Mr. Ishikawa stated that it was something which could only be minimized, never eliminated. In Hawaii, it is minimized in two ways: numerous "checkpoints" and severe penalties. Every time a driver and/or vehicle owner has any contact with a government employee, agent or officer, he must show a no-fault insurance identification card. This includes renewal of driver's licenses, renewal of vehicle registration and license plates, annual safety inspections and so on. The penalties for not having a card, which is issued on purchase of insurance, or for using a false card, are strikingly severe. They include all of the following:

1) suspension or revocaton of driver's license;

2) suspension or revocation of vehicle registration or license plates;

3) impoundment of vehicle;

4) up to 30 days imprisonment;

5) mandatory fine of at least $100 and up to $1,000.

While these checkpoints and penalties have not resulted in 100% compliance, they have been effective, according to the Assistant Commissioner.

In addition to the information included in this memorandum, we have requested copies of the regulations which have been adopted to implement the Hawaii statute and the 1981 report to the legislature on its implementaton. We will forward these and other general materials we have requested from the National Conference of State Legislatures immediately upon receipt.

If we can provide any further information concerning the no-fault insurance system in Hawaii or any other state, please do not hesitate to contact us.

PBF/dp

DIGEST of 1980 AMENDMENTS TO HAWAII NO-FAULT INSURANCE STATUTE (CHAP. 294)

ACT 5
(SB 1115, SD 2, HD 2)

PUBLICATION OF INSURERS AND PREMIUMS CHARGED FOR MOTOR VEHICLE INSURANCE. Requires the state commissioner of motor vehicle insurance to publish annually in a newspaper of general circulation a list of all insurers with representative annual premiums for motor vehicle insurance. (SSCR 350, 481; HSCR 8-80, 424-80)
Effective April 9, 1980.

ACT 6
(HB 1802)

MILITIA, SERVICE BY GOVERNMENT EMPLOYEES. Amends law providing for the reporting of government employees to military service by deleting limitation to "male" employees and eliminating specific male gender reference to the governor. (HSCR 70-80; SSCR 822-80)
Effective April 9, 1980.

ACT 7
(HB 1803)

HAWAII STATE GUARD, COMPOSITION OF. Provides the military forces of the State be composed of all able-bodied citizens instead of only able-bodied male citizens who volunteer for service and supplemented, if necessary, by members, rather than men, of the unorganized militia. (HSCR 78-80; SSCR 823-80)
Effective April 9, 1980.

ACT 8
(HB 1826)

EMPLOYEES' RETIREMENT SYSTEM APPLICABILITY TO MEMBERS' SURVIVING SPOUSES. Amends law which makes other state or county pension or retirement laws inapplicable to members covered by the employees'retirement system of the State to include a member's surviving spouse of either sex, not just widows. (HSCR 606-80; SSCR 816-80)
Effective April 9, 1980.

ACT 9
(HB 1957)

CERTIFICATION OF ADDITIONAL ELIGIBLES WHEN MORE THAN 1 VACANT CIVIL SERVICE POSITION IN A CLASS. Allows the director of personnel services to certify an

ACT 44
(SB 2007, HD 1)

VENDING FROM STATE HIGHWAYS; PROHIBITED; PENALTY. Provides that any vehicle or structure parked or placed wholly or partly within the right-of-way of any state highway for the purpose of selling the vehicle or structure or things therefrom, creates a hazardous condition or is a public nuisance, and the department of transportation may remove or require the immediate removal of the vehicle or structure from the highway.

Provides that any person violating this provision is guilty of a misdemeanor. (SSCR 94-80; HSCR 806-80)
Effective April 25, 1980.

ACT 45
(SB 2070, HD 1)

NO-FAULT INSURANCE; ELIGIBILITY FOR JOINT UNDERWRITING PLAN AMENDED. Amends eligibility provisions of joint underwriting plan in Hawaii no-fault law by providing automatic no-fault insurance coverage to all bona fide public assistance recipients upon the issuance of joint underwriting plan certificates by the department of social services and housing. Deems certificate a policy for purposes of insurance law upon the issuance of a valid no-fault insurance identification card. (SSCR 105-80, 551-80; HSCR 804-80)
Effective April 25, 1980.

ACT 46
(SB 2081, SD 1, HD 1)

HAWAII INSURANCE LAW; LIFE INSURANCE POLICY LOANS. Amends life insurance policy loan provision in Hawaii Insurance Law by raising from 6 to 8 per cent the maximum rate of interest that life insurance carriers may charge on policy loans.

Provides insurance commissioner with authority to require life insurance carriers to raise dividends or lower premiums to policyholders when holder's policy provides a rate of return exceeding 6 per cent a year. (SSCR 133-80; HSCR 784-80, 833-80)
Effective June 1, 1980.

ACT 71
(HB 2698, HD 1, SD 1)

UNIVERSITY OF HAWAII'S OVERSEAS OPERATIONS AND ASIAN STUDIES PROGRAMS; REPEALED. Repeals statutory provisions relating to the University of Hawaii's overseas operations and Asian studies programs. (HSCR 459-80; SSCR 854-80)
Effective May 17, 1980.

ACT 72
(HB 2703, HD 1, SD 1)

COLLEGE OF EDUCATION; CLARIFICATION OF LANGUAGE. Amends provision of University of Hawaii law by replacing the term "teachers college" with "college of education". Provides that in the matter of the curriculum, the university authorities may, instead of being required to, obtain the approval of the department of education. Repeals the section giving recognition to normal school students and section regarding the status of teachers employed on 9/1/31. (HSCR 463-80; SSCR 855-80)
Effective May 17, 1980.

ACT 73
(HB 2789, SD 1)

NO-FAULT INSURANCE, CUSTOMER'S POLICY PRIMARY OVER REPAIRER'S POLICY. Clarifies that if a temporary substitute vehicle is made available to a customer by a repair shop or a motor vehicle dealer repairing or servicing the customer's insured vehicle, the no-fault policy on the customer's insured vehicle shall be primary over the policy on the temporary substitute vehicle whether or not a charge is made by deleting no charge requirement. (HSCR 590-80; SSCR 989-80)
Effective May 17, 1980.

ACT 74
(HB 2842, HD 1, SD 1)

ANIMAL SPECIES ADVISORY COMMISSION; INCREASE MEMBERSHIP AND AMEND DUTIES. Includes the recommendation of the forestry division of the department of land and natural resources, in addition to the department's fish and game division as presently required, prior to authorization by rule of the deliberate introduction of a species of animal by the department of land and natural resources into any habitat within the State, whether the introduction is from without the State into the State or from 1 area in the State into another area in the State.

ACT 85
(SB 2197, SD 1)

PURCHASE OF GOODS PRODUCED BY INMATE LABOR BY STATE AGENCIES AND POLITICAL SUBDIVISION; REPEAL OF CERTAIN REQUIREMENTS. Deletes requirement that purchases of all articles or products manufactured by the department of social services and housing, by inmate labor, by state agencies or its political subdivisions shall be made through the department of accounting and general services.

Abolishes the requirement that exceptions to the purchase of such products be made by a board consisting of the director of social services, the state comptroller, and the director of finance. Provides instead that all such exceptions shall be made by the director of social services. (SSCR 117-80; HSCR 749-80, 919-80)
Effective May 21, 1980.

ACT 86
(SB 2214, SD 1)

INSURANCE; COMMISSIONER, APPOINTMENT OF ASSISTANT COMMISSIONER, ESTABLISHMENT OF INSURANCE DIVISION, SALARY. Amends no-fault motor vehicle insurance law by amending the definition of "commissioner" from the state commissioner of motor vehicle insurance to the insurance commissioner provided for by the Hawaii Insurance Law.

Amends the Hawaii Insurance Law by establishing an insurance division within the department of regulatory agencies under the supervision and control of the assistant insurance commissioner. Requires director of regulatory agencies to appoint, with approval of the governor, an assistant insurance commissioner to serve at director's pleasure, who shall supervise the performance of the duties of the division.

Repeals provisions establishing office of, providing for appointment of, and granting of powers and duties to, the commissioner of motor vehicle insurance.

Amends salary provisions for motor vehicle insurance commissioner and making them applicable instead to the assistant insurance commissioner and providing that the director of regulatory agencies instead of the insurance commissioner has the authority to set such salary, and provides the salary shall not be more than $37,500. Deletes reference setting salary ceiling for motor vehicle insurance commissioner as of 7/1/75 and 7/1/76.

Provides that the incumbent commissioner of motor vehicle insurance on effective date of Act shall serve as the assistant insurance commissioner until termination of incumbent's term and requires director of regulatory agencies to thereafter appoint assistant insurance commissioner pursuant to this Act. (SSCR 134-80; HSCR 721-80, 924-80)
Effective May 21, 1980.

abetting or entering into a contract with unlicensed persons or contractors to be fined $200 for the first offense, $600 for the second offense, and not less than $800 or more than $1,000 for any subsequent offense. (SSCR 560-80; HSCR 832-80)
Effective May 22, 1980; except that penalties incurred and proceedings initiated before May 22, 1980 are not affected.

ACT 103
(SB 2676, SD 1)

MOTOR VEHICLE INSURANCE; PERMISSION FOR USE OF CAR. Clarifies that under a no-fault policy, coverage of an operator of the insured motor vehicle means one using such vehicle with the express or implied permission of the named insured. (SSCR 506-80; HSCR 879-80)
Effective May 22, 1980.

ACT 104
(SB 2770, SD 1, HD 1)

HAWAII VISITORS BUREAU EXECUTIVE BOARD MEMBERSHIP; PROHIBITION AGAINST STATE OR COUNTY OFFICER OR EMPLOYEE SERVING; REPEALED. Repeals law prohibiting an employee or officer of the State or its political subdivisions or any member of a county advisory committee created under the law relating to county advisory committees to the department of planning and economic development from serving as a member of the Hawaii Visitors Bureau executive board or committee. Prohibits instead only employees or officers of the department of planning and economic development from serving as members of the Hawaii Visitors Bureau executive board. (SSCR 589-80; HSCR 844-80)
Effective May 22, 1980.

ACT 105
(SB 2870, SD 1, HD 1)

ARREST WITHOUT A WARRANT. Authorizes a police officer or other officer of justice to arrest a person without a warrant, and detain for examination when there is probable cause for the arresting officer to believe, instead of having reasonable suspicion, the person arrested has committed an offense in the officer's presence or has committed a felony or misdemeanor whether in the officer's presence or otherwise. Deletes reference to seaport or town and to cases where it is not certain an offense has not been committed. Deletes reference to intention to commit an offense.

Provides an arresting officer has probable cause when the facts and circumstances within the officer's knowledge and of which the officer has reasonably trustworthy information are sufficient in themselves to warrant a

ACT 143
(SB 209, SD 2, HD 2)

NO-FAULT INSURANCE FOR PUBLIC ASSISTANCE RECIPIENTS. Adds provision to no-fault law providing insurance for public assistance recipients to provide that only one vehicle per public assistance unit will be insured unless extra vehicles are approved by the department of social services and housing as being needed for medical or employment purposes. (SSCR 344, 464; HSCR 9-80, 815-80)
Effective May 28, 1980.

ACT 144
(SB 1370, SD 2)

JUDICIARY PERSONNEL; COMPENSATION. Adds provision to employee compensation law that no position shall be classified and paid in salary ranges SC-1, SC-2, and SC-3 in the judiciary unless recommended by the administrative director of the courts and approved by the chief justice. Provides further that not more than one position shall be classified and paid in these ranges in the judiciary.

Requires the administrative director of the courts to report annually to the legislature as to the manner in which the positions assigned to these ranges are being used. (SSCR 43, 47-80; HSCR 700-80, 1040-80)
Effective May 28, 1980.

ACT 145
(SB 1838, SD 3, HD 1, CD 1)

HAWAII CRIME COMMISSION; DUTIES; POWERS; COMPOSITION. Provides that the presently existing Hawaii crime commission shall remain in existence instead of ending on 6/30/80 as established in the office of the lieutenant governor from 7/1/80 to 6/30/81. Provides that commencing 7/1/81, there is established within the office of the lieutenant governor for administrative purposes only the Hawaii crime commission and that this commission shall have its existence terminated, if not renewed by the legislature on 1/30/84.

Provides that the commission shall be composed of 9, instead of 12, members appointed by the governor with the advice and consent of the senate. Deletes exception for chairperson from appointment provisions, deletes reference to the 7/1/77 to 6/30/80 term, and deletes provisions that the members shall be representative of the State's population and provisions for appointment of chairperson by legislature and filling of vacancies. Provides that the term of each member shall be from 7/1/81 to 1/30/84. Requires the governor to appoint a chairperson and fill all vacancies for the unexpired term with the advice and consent of the senate. Provides that a vacancy for chairperson shall be filled the same as for initial appointments. Provides that the

dynamite or other explosives, blasting caps, bombs, or bombshells, by changing the penalty from a 2 to 5 year term of imprisonment without probation to a class C felony and imprisonment for 5 years without probation.

Amends provisions on issuance of licenses to carry firearms, prohibitions on such licensing, and the carrying of pistols or revolvers, by changing the penalty for violating such provisions from imprisonment for 2 to 5 years without probation to a class C felony.

Amends provisions which prohibit the wilful alteration, removal, or obliteration of the name of the make, model, manufacturer's number, or other mark of identity of any firearm or ammunition by changing the penalty from imprisonment for a term of 1 to 2 years without probation to a misdemeanor. (HSCR 315-80; SSCR 964-80; HC 28-80; SC 30-80)
Effective June 7, 1980.

ACT 234
(HB 1986, SD 1, CD 1)

MOTOR VEHICLE ACCIDENT REPARATIONS; NO-FAULT. Amends definition of no-fault benefits in Motor Vehicle Accident Reparations law to include only the monthly earnings loss equal to the lesser of (1) $800 a month, or (2) the monthly earnings for the period during which the accidental harm results in the inability to engage in available and appropriate gainful activity, deleting existing 3rd option of a monthly amount equal to the amount by which the lesser of (1) or (2) above exceeds any lower monthly earnings at the time the injured person resumes gainful activity.

Deletes commencement date of 9/1/74 in provision requiring the motor vehicle insurance commissioner to accumulate experience data on a yearly basis. Deletes specific reference to claims filed and tort claims filed, settled, or litigated in provision requiring tabulation of amounts of benefits paid and adds requirement of tabulation of benefit amounts reserved. Requires the commissioner to perform such actuarial evaluations of these data necessary (instead of arranging the claims made by dollar value from maximum to zero) in determining annually the specific dollar value figure below which 90 per cent of all, non-zero (added), medical rehabilitative claims, arising from motor vehicle accidents occurring during the next no-fault policy term year are expected to fall (instead of claims made or paid during the year). Provides that this specific figure shall be used annually as the medical rehabilitative limit for all accidents occurring during the next no-fault policy term year for the purpose of the exception to abolition of tort liability provision. Deletes prior reference applying limit to 3rd and succeeding years and deletes provision that for 9/1/74 to 8/31/76 the medical rehabilitative limit shall be $1,500. Adjusts the period that the commissioner shall make the tabulation to compute the medical rehabilitation limit from 7/1 to 6/30 to 4/1 to 3/31 preceding the 9/1 start of the no-fault policy term year.

Clarifies that each violation of the Motor Vehicle Accident Reparations law by the operator, owner, or registrant of a motor vehicle shall be deemed a

separate offense and subject to a fine of not less than $100 nor more than $1,000 and such fine shall not be suspended irrespective of the Hawaii Penal Code and deletes the alternative penalties of 30 days in jail, suspension of driver's license, or forfeiture of vehicle registration, or any combination of penalties. Adds provision that in the case of multiple violations, the court shall in addition to any other penalty impose:

(1) Imprisonment of not more than 30 days;

(2) Suspension or revocation of driver's license of the driver and the registered owner;

(3) Suspension or revocation of the vehicle's registration plates;

(4) Impoundment or impoundment and sale of the motor vehicle for storage costs and other charges incident to seizure of the vehicle or other costs involved pursuant to the required policy coverage provision; or

(5) Any combination of penalties.

Amends criminal procedure law on motor vehicle insurance violations to clearly provide for multiple violations and to add to the penalties the court shall impose, the penalty of imprisonment of not more than 30 days.

Adds new section to no-fault law that if an insurer or self-insurer elects to deny a claim for no-fault or optional additional insurance benefits in whole or in part, it shall within 5 business days thereafter notify the claimant in writing of the denial and reasons therefor. Provides that if the claimant objects to the denial, the claimant shall file with the motor vehicle insurance commissioner 2 copies of the denial, a written request for review and a statement of specific reasons for the claimant's objections, filed within 60 days after denial. Provides that the commissioner shall not review any denial in which the disputed amount is less than $5,000.

Requires the commissioner to conduct a hearing to review the denial under the Administrative Procedure Act with the hearing powers under the law conferring that power on boards to conduct hearings. Provides that after granting an opportunity for hearing to the insurer and claimant, the commissioner shall affirm or reject the denial and order the payment of benefits as the facts may warrant. Provides that the commissioner may assess the hearing cost upon either or both of the parties. Provides that the commissioner's final order may be appealed under the Administrative Procedure Act. (HSCR 123-80; SSCR 983-80; HC 5-80; SC 6-80)
Effective June 7, 1980.

least one general partner. (HSCR 443-80; SSCR 767-80, 1008-80; HC 36-80; SC 46-80)
Effective June 13, 1980.

ACT 271
(SB 1960, SD 1, HD 1, CD 1)

NO-FAULT INSURANCE; PREMIUM DISCOUNTS, SURCHARGES, AND DRIVER EDUCATION FEES FOR MOTORCYCLES, MOTOR SCOOTERS, AND RELATED VEHICLES. Amends insurance rates provision in no-fault motor vehicle insurance law by requiring all insurers of motorcycles, motor scooters, or vehicles with less than 4 wheels, notwithstanding existing law requiring each insurer to establish own rate schedule, to provide a 10 per cent discounted premium to operators who successfully complete a safe driving course approved by state director of transportation.

Permits any insurer of such vehicles to provide a 10 per cent or less discounted premium to operators who submit affidavits stating intent to wear approved safety helmet during operation of vehicle. Adds proviso permitting insurers providing discounts to levy a surcharge, equal to discount, on premiums of operators failing to submit affidavits. Prohibits any insured operator with discounted premium from operating such vehicle unless operator wears approved safety helmet.

Adds proviso to law requiring 1/2 of all driver education underwriter fees collected to be expended for a driver retraining program and 1/2 to support a high school driver education program to provide that all such fees collected from insurers of motorcycles, motor scooters, or related vehicles shall be expended for educating operators of such vehicles. (SSCR 636-80; HSCR 828-80; SC 51-80; HC 41-80)
Effective June 16, 1980.

ACT 272
(SB 2927, SD 2, HD 1, CD 1)

MENTAL HEALTH PATIENTS; INFORMED CONSENT AND RIGHTS. Requires informed consent, as required by the medical torts law and as defined by the board of medical examiners, to be obtained from a patient, or the patient's guardian, if the patient is not competent to give informed consent, before any non-emergency treatment for mental illness can commence. Requires a signed consent form reflecting the proceeding to be obtained and maintained as part of the patient's record.

Affords any patient in a licensed psychiatric facility the following rights, as provided by the institution. Qualifies all such rights of in-patients by reasonableness, in view of the circumstances and the availability of resources. Includes, but is not limited to, the following: (1) access to written rules and regulations with which the patient is expected to comply;

NO-FAULT INSURANCE
FALL 1978

THE LAW

On September 1, 1974, a new system of automobile insurance was established in Hawaii which affected anyone who owned a car or who might be injured in an automobile accident. It is a law which provides prompt payment of medical bills, loss of wages and any other appropriate economic losses resulting from injuries in an auto accident *regardless of whose fault it is.* This law is known as the *Hawaii No-Fault Law.*

WHAT IS NO-FAULT?

First of all, when we speak of "no-fault", we are talking about *injuries as a result of an auto accident* — and not damages to cars or property. Before Hawaii's no-fault law came into effect, we operated completely under a *tort* or *fault system* of insurance.

For example, if you were involved in an accident and were injured, you had to worry about whose fault it was and whether your insurance company or the other person's insurance company was going to pay you. If the other driver was at fault, then you may have had to either hire a lawyer or appear in court before getting any money from the other driver or his insurance company.

Under today's no-fault law, your insurance company pays you *directly* for your losses as a result of injuries in the accident and regardless of fault. Similarly, the other driver collects the losses for his injuries from his insurance company without his company having to determine who was at fault.

Thus, no-fault is a system of insurance which provides fast and adequate payment of claims for injuries and financial losses resulting from accidents *without the need to resort to lawsuits.*

DOES NO-FAULT COVER ALL YOUR LOSSES?

The Hawaii No-Fault Law was primarily designed to take care of first things first — to make sure that protection through insurance is provided for *personal injuries* since this is where most major problems occur.

The basic no-fault automobile insurance policy will at least provide you with the minimum protection required by law. This coverage includes *no-fault benefits* (or personal injury protection) up to $15,000 per person, *residual bodily liability* of $25,000 per person, and *property damage liability* of $10,000 for each occurrence.

These basic requirements must be offered and purchased in a package form, but of course, you still have the option to add other coverages based on your individual needs.

To better understand the protection no-fault insurance offers, you

need to know a little about the kind of losses people normally claim after an accident.

First, there are losses that you can measure, the kind that actually cost you money, such as doctor and hospital bills, x-rays and therapy, lost wages, nursing and housekeeping care, funeral and child care expenses.

Then there are other losses hard to measure which do not really cost you any money but which you feel you should be compensated for. Examples of these are inconvenience, pain and suffering, disability, disfigurement and death.

With no-fault insurance, *except* for losses you cannot measure accurately — primarily the "pain and suffering" you may have due to an accident — *almost all of your out-of-pocket losses* would be covered up to the limits of your policy regardless of fault.

DOES NO-FAULT TAKE AWAY THE RIGHT TO SUE?

Although having a no-fault policy ensures payment by your insurance company for all losses arising from injuries received in an auto accident *regardless of fault,* this does not mean that your right to sue the wrongdoer has been completely eliminated under the law. The law recognizes that some people will experience pain and suffering after an accident, and because of this, your right to sue has simply been *restricted.*

This means that you can sue or be sued *but only under certain conditions.*

Since Hawaii's no-fault law does not completely eliminate a person's right to sue, the possibility of your being sued is very real in the event you are the driver at fault in an accident which causes serious injury to others. You still need protection from suits and part of your basic no-fault policy will give you this protection.

REQUIRED AUTOMOBILE INSURANCE COVERAGES

No-Fault Benefits or Personal Injury Protection Coverage

The basic no-fault benefit coverage will pay you, your relative, or any other person riding in your car up to *$15,000* per person for injury *regardless of fault.*

The following are the types of benefits you can get if injured in an auto accident:

medical expense benefits — all reasonable charges for medical, hospital, surgical, professional nursing, dental, optometric, ambulance, prosthetic services, x-rays and religious remedial care and treatment;

rehabilitation expenses benefits — includes charges for psychiatric, physical and occupational therapy and rehabilitation;

work loss benefits — includes loss of wages up to *$800* a month due to injury;

substitute service expense benefits — all reasonable charges up to *$800* a month for necessary services, such as caring of children, housekeeping or yardwork, which would have been performed by you had you not been injured;

funeral expense benefit — all reasonable charges up to *$1,500* for funeral services including burial and cremation expenses;

survivors' loss benefits — payment to your surviving spouse or dependents up to *$15,000;*

attorney's fees and cost benefits — reasonable sum for attorney's fees and costs you are entitled to unless the court determines otherwise;

other reasonable and appropriate costs.

Residual Bodily Injury Liability Coverage

Although most of the injury claims will be taken care of under the no-fault benefits coverage, there will be situations when you can be sued. The *residual bodily injury liability coverage* will protect you, your family and anyone else driving your car with your permission in the event that you may be sued because of injury caused to others.

What are the situations under which you can be sued? You can be sued by the person you injured under any of the following conditions:

if his medical bills exceed *$1,500* (the current limit set by the Automobile Insurance Commissioner);

if his total no-fault bills exceed *$15,000;*

if his injury consists of permanent and serious disfigurement which causes that person's mental and emotional suffering;

if his injury results in permanent loss of use of part of his body;

if his injury results in death.

Property Damage Liability Coverage

This coverage protects you or any driver of your car for damages to the property of others. Remember, the no-fault law applies only to injuries and does not affect the "fault system" for accidents involving property damage, such as damage to a fire hydrant, a guardrail, a traffic lightpost, a fence or even a house. If you are at fault in such an accident, you will be held liable and can be sued for these losses.

Furthermore, this particular coverage does not pay for damage to *your* car. You must buy a separate "collision coverage" to take care of this.

YOUR POLICY

Your no-fault auto insurance policy is a contract. It is written so that your rights and responsibilities as well as that of the insurance company are stated clearly.

A no-fault auto policy usually consists of the following:

declarations — the declarations sheet, usually the first page of the policy contract, shows your name, address, policy number, the date and time your policy begins and expires, the coverages and the limits you selected, the description of your vehicle, the cost of each coverage and the total premium or cost you pay for the coverages involved;

Insurance agreement — this is what your insurance company promises to pay and what losses it agrees to cover;

definitions — these basically explain who is covered and the meaning of words used in your policy contract;

exclusions — this part explains the situations under which the policy will not cover you or your car;

conditions — this section explains how and under what conditions the company can cancel your policy; how you can cancel your policy; your duties in reporting to the company in the event of an accident;

endorsements — these are forms attached to your policy which are used to change certain terms of your policy, to increase or decrease your existing coverage or to add new coverage to your policy. For example, if you purchase a new car and sell the other, you can make this change simply by an endorsement without buying a new policy.

HOW MUCH INSURANCE DO YOU NEED?

The Hawaii No-Fault Law requires you to buy the *basic no-fault auto policy* which contains the minimum limits of no-fault benefits, bodily injury liability and property damage liability damage coverages. But, *you have the right to seek and obtain additional coverage to suit your needs.*

All insurance companies are required to offer higher limits of protection, but the decision to buy higher protection is up to each individual buyer. For instance, you may wish to purchase higher no-fault benefits coverage if your income is more than $800 a month, which the basic no-fault benefits pays you. Or, you may want higher limits for bodily injury or property damage liability coverages for protection against lawsuits.

Higher limits over the basic limits can be bought for an additional cost as follows:

	Basic	Higher Limits
No-Fault Benefits Coverage	15,000	30,000; 50,000
Residual Bodily Injury Liability Coverage	25,000	50,000; 75,000
Property Damage Liability Coverage	10,000	15,000; 20,000

No-Fault Benefits Coverage — Deductibles

In addition to offer higher limits of protection, all insurance companies must give you a choice of selecting a deductible amount on your no-fault benefits coverage. The deductible amounts which you can select — *$100, $300* or *$500* — will be the amount which will reduce the no-fault benefits payable to you for your injuries. Of course, your premium for this coverage will be correspondingly reduced if you choose a deductible.

The optional coverages including the required basic no-fault coverages are shown below:

Physical Damage Insurance

Although Hawaii's no-fault law does *not* require you to purchase insurance protection to cover losses to your car, all insurance companies *must* offer you physical damage insurance if you want it.

This type of insurance is important to have when your car is new, or while you are still paying a note for it. Suppose your new car is totally wrecked in an accident. Without such insurance, you could be left with a big bill to pay — and no car.

Physical damage insurance covers two kinds of losses, collision and comprehensive:

Collision Coverage

This coverage pays for damages to your car when it is involved in any type of collision. Your own insurance company pays for such damages, regardless of who is at fault. You can still sue the other driver at fault, but it may be easier to let your company fix your car under your collision coverage and let them collect the amount they paid you from the other driver or his insurance company.

Deductible Collision

When buying collision coverage, your insurance company will offer you a choice of deductibles of *$50, $100* or *$250*. The deductible amount you select is the amount you agree to pay first from your own pocket toward the damage to your car. Your company will then pay the rest. Of course, the higher collision deductible you choose, the cheaper your premium for this coverage will be.

Comprehensive Coverage

Comprehensive insurance pays for losses like theft of your car, and damages by fire, windstorm, vandalism, flood and falling objects. It pays for almost all unusual damages to your auto *other* than collision damage. For example, it would pay for the cost of repair or replacing your car if a tree falls on it. If you are an owner of a new or expensive car, comprehensive insurance would be an important coverage to have.

Uninsured Motorists Insurance

This additional coverage is for protection against uninsured motorists up to a minimum of *$25,000* per person. This insurance will cover your own injuries or those of occupants in your car when you are involved with an uninsured car or a hit-and-run driver. The same applies to you and your family if struck and injured as a pedestrian in a crosswalk or sidewalk by an uninsured car or hit-and-run driver. *This coverage is for injury only and does not pay for damage to your car.*

Keep in mind that your own *no-fault benefits* for medical expenses will apply first to any injuries in a car accident. To qualify for uninsured motorists coverage benefits, the condition stated earlier under which you can sue must still be met.

This particular coverage is an insurance required by law, but you may reject it in writing. Nevertheless, it is highly recommended that it is purchased as part of your no-fault auto insurance package.

HOW YOUR POLICY WORKS

Now that you are familiar with the requirements of the Hawaii No-Fault Law, let's see how your policy works. Examples of typical accidents are given to illustrate how the various coverages would apply.

Example: While driving, you hit a traffic lightpole and knock it down, causing damage to your car. Since you were at fault, your *property damage liability coverage* pays for damage to the pole. Damage to your car can be taken care of under your *collision coverage,* if you had purchased it. You pay the deductible amount and your company pays the rest.

Example: In the second accident above, you were also injured and treated for minor cuts and bruises. You incur a $100 bill and remain at home from work for two days. Under your *no-fault benefits coverage,* your insurance company pays the doctor bill, including any x-ray or surgical costs, and for two days' loss of wages.

Example: A car in front of you stops suddenly at a stop sign. Following too closely, you rear-end that car. The driver of that car endures minor cuts and bruises, four days of lost work and damage to his car. Your car was also damaged, and you and your spouse suffer minor cuts and bruises.

In this situation, the other driver will be reimbursed for his medical expenses and lost wages by *his* insurance company under *his* no-fault benefits coverage, even though you were clearly at fault. But *your* property damage liability coverage pays for his car damage.

You and your spouse's medical bills will be paid from *your* no-fault benefits coverage. Your car damages will also be paid under your own collision coverage, with your company paying over the deductible you had selected. For instance, if the damage costs $400 and you have a $100 deductible collision coverage, your company will pay $300 towards the repair after you put up the first $100.

Example: While driving through an intersection, you are hit by a driver running the red light. You are taken to the hospital by ambulance, suffering a broken arm and a facial laceration which requires stitches that result in permanent scarring.

Your no-fault benefits coverage will cover your medical, surgical, hospital, nursing and ambulance bills, and up to $800 a month in lost wages for the time you are unable to work. Remember, your company will pay up to *$15,000* for all the benefits provided under this basic coverage.

You can also sue the other driver for your injuries, including pain and suffering due to the permanent scar which caused your mental and emotional distress. And payment for your car damage will come from the other driver's insurance company under his property damage liability coverage.

Example: You are hit by an oncoming car while crossing the street and sustain serious injuries. As a pedestrian, you are entitled to all no-fault benefits in each of the following situations.

First, the insurance company of the car that struck you must pay for all no-fault benefits you claim. But if that car carried no insurance, then *your* company will pay you under *your* no-fault benefits coverage, providing you own a car and have a basic auto insurance policy.

On the other hand, if you do not own a car, then you can get paid under a relative's no-fault benefits coverage, providing he owns a car and is a resident of your household.

Finally, if none of the above situations apply and no benefits are readily available to you, you can file a claim with the Hawaii Joint Underwriting Plan Assigned Claims Program through the State Motor Vehicle Insurance Division. Your claim will then be assigned to an auto insurance company and handled just as if you had a no-fault policy with that particular company.

In conclusion, buying the kinds and amounts of insurance you need is difficult because you cannot predict the future. You do not know if, or when, you will be involved in an accident or the amount of damages or injuries you might cause. Therefore, it is important that you consider the following guidelines when buying insurance:

The more you have to protect, the more insurance you may need. It

you own a home and earn good wages, consider buying more insurance than the minimum coverages required by law.

Buying insurance to cover your own smaller losses may be wasteful. You may save money if you take a higher collision deductible or do not buy collision coverage on an older car. The key to this guideline is to decide what amount of money you could pay if your car is damaged in case of an accident without causing yourself financial hardship.

Always discuss your insurance needs with your agent or company representative. It is the job of this person to help you select the types and amounts of insurance coverage you need.

BUYING A POLICY

In passing the no-fault law, the Hawaii State Legislature determined that competition among insurance companies would be the best way to minimize and stabilize auto insurance rates. Thus, each insurance company is required to set its *own* rates, based on its *own* auto experience. This is called *open-rating.*

Open-rating makes for *open competition* among the companies and this means each company will charge you its own price for your business. Because of competition, you will notice differences in rates when you shop around for insurance.

THE COST OF YOUR AUTO INSURANCE

When you buy no-fault auto insurance, you should know what things are considered by insurance companies in arriving at your premium. The process of pricing insurance is called *rating* and the factors generally considered by companies in rating are:

Where You Live
Most companies use the four-territory system: Honolulu, Maui (Lanai and Molokai included), Kauai and Hawaii counties. Rates within each territory are based on the losses involving autos garaged within that area.

How Your Car is Used
If your car is used for pleasure purposes only, you will pay the lower rate offered by your insurance company. If you drive to and from work or use your car for business, your rate will be higher. Some companies will also consider the annual mileage as a rating factor.

Accidents and Violations
Your driving record and those of the members in your household who drive are important considerations. Many companies use a surcharge system based on the number of accidents and traffic violations occuring in the most recent three-year driving period. So the poorer the driving record, the higher the premium.

Your Car Type
The year, make, model and engine size of your car are also important factors. Rates are usually higher if you own a high performance or sports car. The value of your car is also significant; the less it costs to repair or replace your car, the lower the cost of your premiums for comprehensive and collision coverages.

Coverages, Limits and Deductibles
If you purchase higher limits of protection and more coverages, your premiums will be higher. Purchasing a low deductible on your collision coverage and no deductible on your comprehensive coverage also results in higher premiums.

Discounts
Most companies have various discounts as part of their rating plan. Some types of discount offered are: two or more cars discount if insured with the same company; driver education course discount; carpools discount; bumper discount on later model cars which have improved bumpers; student discount, and senior citizen discount.

HOW TO SAVE MONEY ON YOUR AUTO INSURANCE

The best way to save money on your auto insurance is to *drive safely.* The cost of medical expenses, legal settlements and auto repairs all influence the cost of auto insurance. Therefore, driving safely is the key to keeping your premiums down.

Here are some other suggestions which may help lower your costs:

Think twice before buying a high performance, high-powered, expensive or sporty car. Cars with smaller engines cost less to insure.

Don't buy unnecessary physical damage insurance. For instance, the premium for collision coverage on an older car may cost more than the car is worth.

Increase the amount of your deductible when purchasing collision coverage. Higher deductibles will reduce your premium, so decide how much of a loss you can pay and then buy the deductible for it.

Buy comprehensive coverage with a deductible instead of full coverage. This will also reduce your premium.

Have every teenaged driver in your household complete a driver education course approved by the State Department of Education. Most high schools offer such courses. Some companies give a discount for driver training, but more importantly, your teenager will be a safer driver.

If you own two or more cars, insure them with one company. You may be entitled to a multi-car discount.

Notify your insurance company promptly if you sell a car or if a driver leaves your household. It could lower your premium.

Pay the whole premium at once, if you can afford it. Most companies have installment payment plans or a plan to finance your premium. You may have to pay extra charges when you pay through these plans.

Above all, maintain a good driving record. No accidents and a clean driving record will mean lower rates for you.

SHOPPING FOR AUTO INSURANCE

Since the Hawaii No-Fault Law calls for an open competition rating system, remember that rates will be different among companies. However, although price is important, it should *not* be the only consideration. The *quality* and *service* you get from the company and agent are all part of what you will be buying. Therefore, it is important that you shop around.

Where to Shop

Many insurance companies and agents advertise. Check the newspapers and yellow pages of your telephone directory for companies and agents in your area. Contact your relatives, neighbors and friends for recommendations or information about the price, quality and service of their company or agent. Ask what kind of claim services they are getting.

Price Quotations

When asking for premium quotations, be sure you provide the *same information* to each company or agent. The company or agent will usually request: a description of your vehicle, its use, drivers license numbers and records of all drivers in your household and the limits of the coverages you want. Save time and effort by having this information ready when you begin to shop.

Quotations by telephone may not be as accurate as when you personally visit the company or agent. And, remember, most companies or agents *do not guarantee* quotations by telephone.

When calling agents for quotations, also inquire how many companies that agent represents. Many agents represent several companies and may be able to provide you several quotes. Other agents represent a company belonging to a group of companies going under one name, and they too can provide quotes of all the companies in that group. In this manner, you can make easy price quotations.

Why You Need a Good Agent

Even though you think you have chosen a good insurance company, you still have to depend on an agent for service. A good agent is one who will be able to serve you in many ways. He will be able to answer your questions on insurance, assist you in processing your claim with

the company, and help you determine how much insurance is needed. It would be worth your while to look around for a good agent, one whom you can always depend on.

SETTLING YOUR CLAIM

A prime reason for passing the Hawaii No-Fault Law was to speed up payment of claims to injured persons of auto accidents regardless of fault. With this in mind, all insurance companies are mandated by law to pay no-fault benefits within 30 days after you supply proof of loss.

In filing your claim, give your company details regarding the accident — specifically, your injuries, the treatment and care you are receiving, your income, your doctor's name and the hospital.

Once your company verifies the treatment with your hospital and doctor, and the loss of time from your job with your employer, it must pay you the benefits you are entitled to within 30 days. A 1.5 percent interest is also required on all amounts not paid to you within this period.

WHAT TO DO IN CASE OF AN ACCIDENT

At the Scene

The first thing to do is help the injured [illegible]ering first aid if qualified and calling an ambulance.

Second, notify the police. To the police and the other drivers involved, identify yourself. Give your name, address, driver's license number and name of your insurance company.

Be sure you also get the names and addresses of the owners or drivers and passengers of the other cars, as well as the names of their insurance companies.

Just as important is obtaining names and addresses of witnesses who may be valuable in settling your claim.

In the instance of damaging a parked car or someone's property, you are responsible for locating the owner and identifying yourself. If this is not possible, you should attach a note to the property giving your name, address and telephone number.

After the Accident

Contact your insurance company immediately and give as many details as possible. It is important that you do not delay. Witnesses may disappear, evidence may be destroyed, memories may fade and injured parties may exaggerate their injuries. Give your *complete cooperation* to your insurance company and the agent assigned to your case for full protection and prompt payment of all entitled benefits.

YOUR RIGHTS

The Hawaii No-Fault Law requires every owner of a car, bus, truck or motorcycle to have insurance. Without insurance, vehicle registration papers and license plates must immediately be surrendered to the county director of finance.

Any uninsured owner may be fined $1,000 for each violation of driving without insurance and receives no compensation if involved in an accident. Furthermore, he runs the risk of being sued.

As a policyholder of no-fault insurance, it is good to know your legal rights and where you stand with your insurance company and agent.

No insurance company can refuse to sell you a no-fault insurance policy if you are an owner, unless the principal driver of your car does not have a valid driver's license or unless you do not pay the premium.

No company can refuse to renew your policy unless the principal driver of your car does not have a valid driver's license or unless you do not pay the premium.

No company can cancel your policy, once issued, unless you do not pay your premium or your driver's license has been suspended or revoked. Furthermore, *your company must give proper notice of its intent to cancel your policy.*

No company can refuse the benefits you are entitled to should you become involved in an accident.

FILING A COMPLAINT

If you believe that any of your rights have been violated or that you were treated unfairly, or that a claim with your company was not handled properly, you have a right to file a complaint with the State Motor Vehicle Insurance Division.

However, your first step should be to contact your agent or company representative since many complaints are simply a result of a mistake or misunderstanding that can be corrected upon polite inquiry.

Complaints to the State *must be in writing.* Request standard complaint forms by calling 548-5450. Completed forms should then be mailed to:

Motor Vehicle Insurance Division
State Department of Regulatory Agencies
P. O. Box 2399
Honolulu, Hawaii 96804

Coverages:
- $15,000 Basic Personal Injury Protection
- $25,000 Bodily Injury Liability
- $10,000 Property Damage Liability
- $25,000 Uninsured Motorists Coverage

Actual Cash Value
- Comprehensive
- $ 100 Deductible Collision } 1977 Plymouth Volare, V-8

Approximate Annual Premiums for the Above Coverages for Rates in Effect as of July 1, 1978

Company (alphabetical order)	Terr. / Use	OAHU		MAUI		KAUAI		HAWAII	
		Pleasure	To/From Work	Pleasure	To/From Work	Pleasure	To/From Work	Pleasure	To/From Work
CLEAR RECORD									
Aetna Casualty & Surety Co.		242	277	168	192	165	189	194	222
Aetna Fire Underwriters Ins. Co.		237	273	167	192	165	189	195	224
Aetna Insurance Co.		237	273	167	192	165	189	195	224
Allstate Indemnity Co.		742	847	585	673	559	642	622	716
Allstate Insurance Co.		462	527	367	421	348	400	388	446
American Automobile Ins. Co. (FAP)		362	417	264	303	291	334	291	334

Company	Terr.	OAHU		MAUI		KAUAI		HAWAII	
	Use	Pleasure	To/From Work	Pleasure	To/From Work	Pleasure	To/From Work	Pleasure	To/From Work
American Automobile Ins. Co. (SAP)		266	306	180	207	214	246	212	243
American Casualty Co.		229	263	160	183	159	181	203	232
American Employers' Ins. Co.		331	381	251	289	246	283	299	344
American & Foreign Ins. Co. (FAP)		396	455	351	403	305	350	351	403
American & Foreign Ins. Co. (SAP)		362	416	322	371	282	324	322	371
American Home Assurance Co.		251	289	160	183	159	181	188	215
American Manufacturers Mutual Ins. Co.		334	383	291	335	256	294	294	338
American Motorists Ins. Co.		334	383	291	335	256	294	294	338
American Mutual Liability Ins. Co.		358	411	241	277	241	277	266	306
American National Fire Ins. Co.		225	259	147	169	146	167	171	196
American Star Ins. Co.		232	267	161	184	161	184	187	214
Amica Mutual Ins. Co.		229	263	160	183	159	181	187	214
Argonaut Ins. Co.		368	423	317	364	280	322	321	369
Argonaut-Midwest Ins. Co.		368	423	317	364	280	322	321	369
Associated Indemnity Corp. (FAP)		362	417	264	303	291	344	291	334
Associated Indemnity Corp. (SAP)		266	306	180	207	214	246	212	243
Assurance Company of America		384	441	268	308	266	306	322	371
Carriers Ins. Co.		288	331	202	232	200	230	249	286
Centennial Ins. Co.		229	263	160	183	159	181	187	214
Charter Oak Fire Ins. Co.		554	638	401	460	395	454	471	540
City Ins. Co.		360	414	311	356	275	316	315	362
Colonial Penn Ins. Co.		149	193	97	126	97	125	115	149
Commercial Ins. Co. of Newark, N.J.		384	442	267	307	264	304	318	365

Company	Terr.	OAHU		MAUI		KAUAI		HAWAII	
	Use	Pleasure	To/From Work	Pleasure	To/From Work	Pleasure	To/From Work	Pleasure	To/From Work
Commercial Union Ins. Co.		331	381	251	289	246	283	299	344
Continental Casualty Co.		229	263	160	183	159	181	203	232
Continental Ins. Co.		384	442	267	307	264	304	318	365
Criterion Ins. Co.		358	372	268	276	265	274	280	290
Cumis Insurance Society, Inc. (FAP)		189	217	133	153	132	152	155	178
Cumis Insurance Society, Inc. (SAP)		146	168	108	124	108	124	128	147
Employers' Fire Ins. Co.		331	381	251	289	246	283	299	344
Employers Mutual Liability Ins. Co.		401	461	288	331	282	324	342	393
Federal Ins. Co.		211	242	131	150	131	150	155	177
Fidelity & Casualty Co. of New York		384	442	267	307	264	304	318	365
Financial Security Life Ins. Co. (FAP)		261	300	180	207	178	205	208	239
Financial Security Life Ins. Co. (SAP)		260	300	180	207	180	207	216	248
Fireman's Fund Ins. Co. (FAP)		362	417	264	303	291	334	291	334
Fireman's Fund Ins. Co. (SAP)		266	306	180	207	214	246	212	243
Fireman's Ins. Co. of Newark, N.J.		384	442	267	307	264	304	318	365
First Ins. Co.		370	426	253	291	250	288	301	346
General Accident Fire & Life Assurance		263	302	190	218	188	215	224	257
Glen Falls Ins. Co.		384	442	267	307	264	304	318	365
Globe Indemnity Co. (FAP)		396	455	351	403	305	350	351	403
Globe Indemnity Co. (SAP)		362	416	322	371	282	324	322	371
Government Employees Ins. Co.		303	330	227	247	223	243	271	296
Grain Dealers Mutual Ins. Co.		414	476	284	326	278	319	345	397
Great American Ins. Co.		225	259	147	169	146	167	171	196

HAWAII NO-FAULT AUTOMOBILE INSURANCE QUOTATION WORKSHEET

MINIMUM RATING INFORMATION REQUIRED:

A. List All Drivers in Household:

Driver No. Name	Within Last 3 Years	
	No. of Accidents (at fault only)	No. of Moving Violations
1.		
2.		
3.		
4.		

B. Automobiles to be Insured:

	Make	Model & Year	Uses: Car Most (Driver No.)	Car Used For: (P) Pleasure (T&F) To & From Work (B) Business	Annual Mileage
Car 1					
Car 2					

C. Cost of your Insurance:

Coverages Required by Law:	Select Limits or Deductible	ANNUAL PREMIUMS Company A	Company B	Company C	Company D
1. NO-FAULT BENEFITS (Personal Injury Protection) (Required Min. - $15,000)	____per pers.				
2. BODILY INJURY LIABILITY (Required Min. - $25,000)	____per pers.				
3. PROPERTY DAMAGE LIABILITY (Required Min. - $10,000)	____per acc.				
4. UNINSURED MOTORISTS (Required Min. - $25,000)	____per pers.				
Additional Optional Coverages: 5. Comprehensive	Deduct. ____per acc.				
6. Collision	Deduct. ____per acc.				
7. Other Coverages					
TOTAL ANNUAL PREMIUM					
8. Company membership fee (if any)					
9. Service Fee or Finance Charges					
TOTAL ANNUAL COST OF INSURANCE					

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3591

February 13, 1981

MEMORANDUM

TO: Representative Charles Anderson

FROM: Betty Barton, Issues Analyst

RE: Auto Insurance
Research Request No. 81-16

As a component of your request on liability insurance for motor vehicles, you have asked that we compile proposed legislation, introduced in past legislative sessions, that is pertinent to the subject. An additional request made by your office for information regarding Hawaii's statutory provisions on compulsory liability insurance is addressed in a separate memorandum.

For this project, we have collected bills introduced from the Ninth Legislature, convening in 1975, through the current session of the Twelfth Legislature. These bills are attached to this memorandum; a listing of their titles, sponsors, and final status follows:

NINTH LEGISLATURE

Number	Abbreviated Title	Sponsor	Final Status
HB 38	Motor Vehicle Insurance	Urion	In (H) Judiciary
HB 44	Motor Vehicle Insurance	Swanson	In (H) Commerce
SB 657	Motor Vehicle Insurance	Croft	In (H) Commerce

TENTH LEGISLATURE

Number	Abbreviated Title	Sponsor	Final Status
HB 217	Motor Safety Responsibility Act	Urion	In (H) Commerce
HB 594	Motor Vehicle Insurance	Commerce	In (H) Judiciary

Number	Abbreviated Title	Sponsor	Final Status
HB 614	Motor Vehicle Insurance Policies	Rules	In (H) Commerce

ELEVENTH LEGISLATURE

Number	Abbreviated Title	Sponsor	Final Status
HB 402	Re/Motor Vehicle Insurance, E.D.	McKinnon	In (H) Commerce
SB 274	Re/Motor Vehicle Safety Responsibility Act, E.D.	Commerce	In (S) Commerce
SB 280	Re/Motor Vehicle Insurance	Commerce	In (S) Commerce
SB 460	Authorizing Municipalities to Establish Requirements for Motor Vehicle Security Deposits	Bradley	In (S) Judiciary
SB 461	Tax Credit for Auto Insurance Premiums	Bradley & Stimson	In (S) State Affairs
SB 542	Financial Responsibility Regarding Motor Vehicles	Commerce	In (S) Judiciary

TWELFTH LEGISLATURE

Number	Abbreviated Title	Sponsor	Final Status
SB 70	Authorizing Municipalities to Establish Requirements for Motor Vehicle Security Deposits	Stimson & Bradley	In (S) Community & Regional Affairs

As you will note, SB 70, cosponsored by Senators Stimson and Bradley, is the only bill which has been introduced this session thus far related to the financial responsibilities of owners and operators of motor vehicles. A similar bill, SB 460, sponsored by Senator Bradley, was introduced in the Eleventh Legislature. If we can provide you with additional information regarding the enclosed materials, please do not hesitate to contact us.

BB/bf

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

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

March 4, 1981

MEMORANDUM

TO: Representative Charles Anderson

FROM: Betty B Barton
Research Staff

RE: Auto Insurance
Research Requst No. 81-16 (Additional Material)

We have received additional materials concerning Hawaii's program for compulsory no-fault/liability insurance. We have enclosed the following for your review:

Rules and Regulations of the Motor Vehicle Insurance Division, State of Hawaii

Annual Report to the Legislature, Motor Vehicle Insurance Division, State of Hawaii, July 1, 1979-June 30, 1980

Annual Report to the Legislature, Motor Vehicle Insurance Division, State of Hawaii, July 1, 1978-June 30, 1979

In addition, we have enclosed materials, which you may find helpful, compiled for us by the National Conference of State Legislatures. These materials outline the key components of auto insurance programs in other states.

If you have any questions regarding these materials or other aspects of auto insurance, please do not hesitate to contact us.

BB/bf
Encls.

STATE OF ALASKA

Legislative Affairs Agency

THIRD PARTY HEALTH COVERAGE IN ALASKA

Prepared by

LEGISLATIVE AFFAIRS AGENCY

Research Division

April 1978

Foreword

This study was prepared by Sharman Haley of the Legislative Affairs Agency staff at the request of Representative Thelma Buchholdt. The issue of access to health care in Alaska is a matter of general concern to many other policymakers as well, and we are therefore making the report available, with Ms. Buchholdt's permission, in this more convenient format.

Interested readers are invited to share with us any comments they may have on the report or its subject matter.

Gregg K. Erickson
Director of Research
Legislative Affairs Agency

Juneau, Alaska
April 1978

Table of Contents

SUMMARY

With the costs of health care continuing to rise, third party health coverage is becoming increasingly crucial for the protection of people's health and financial security. A variety of state and federal health programs and private health insurance policies provide piecemeal third party coverage for Alaska's civilian population. It is estimated that 20 to 25 percent of Alaska's non-Native, non-military-dependent civilian population are without third party health coverage of any kind. The comprehensiveness of coverage or level of coverage provided the covered population is not known; in some cases the coverage may be inadequate to protect people from financial hardship or inappropriate levels of medical care. There are a variety of approaches the legislature may consider to improve or extend third party health coverage in Alaska. These options include: state subsidized health insurance, state mandated employer subsidized health insurance, state regulation of health insurance carriers, and expansion of the state's Medicaid program. While plugging these coverage gaps would not cure all the ills of the health care system, it would be a step.

I. INTRODUCTION

With the dramatic increases in health care costs in the last decade or two, routine medical care has become for many an unaffordable luxury. A serious illness or accident for them would be a financial catastrophy. More and more people are relying on health insurance and other kinds of third party health coverage to finance the major part of their unpredictable health expenses. To an ever growing extent people are demanding third party coverage for routine health expenses as well. Third party health coverage has become an integral and crucial part of the health care system.

Because public and private third party payers foot the bill for two-thirds of the nation's personal health care expenditures, their policies profoundly affect the nature and terms of the health care itself. For example, many insurance policies will pay for hospital care, but not nursing care; so patients are hospitalized in many cases where nursing care would be sufficient, and less costly. Similarly, many people will not see a doctor until health conditions become acute, because preventive care is not customarily covered. The policies of third party payers also affect providers in terms of the rates they charge, the quality of care they provide, and the services they can afford to develop.

As third party health financing becomes paramount to ensure financial access to health care, the gaps in third party coverage become more glaring. The following chapters of this report address themselves to

these gaps in third party coverage. Sections II and III describe all the major public programs and private plans which currently provide third party health coverage in Alaska. Section IV analyzes available data on the extent of existing coverage and identifies some of the gaps both in terms of the covered population and services covered. Section V outlines a smorgasbord of legislative remedies to plug some of these gaps. The concluding chapter indicates other areas which may be of concern to the legislature.

II. A DESCRIPTION OF HEALTH COVERAGE FROM PUBLIC SOURCES

As this report is concerned primarily with comprehensive health care, only the public programs which cover a broad range of health services and serve a significant portion of the population are described here. There are a number of programs which cover only specific health services, such as family planning or treatment of occupational injuries, or serve only a narrowly defined segment of the population, such as crippled children, which are not described here.

Alaska Area Native Health Service

The Alaska Area Native Health Service (AANHS) is a regional administrative unit of the Indian Health Service, which is a branch of the U. S. Public Health Service. It serves an estimated 65,000 eligible Alaska Natives, spouses, and dependents.

Primary care is provided in villages by 216 community health aides, each selected by the village council and paid under contract with AANHS. These aides are responsible for giving first aid in emergencies, examining the ill, reporting their symptoms to the physician, carrying out the treatment recommended, instructing the family in giving nursing care, and conducting on-going health education in the villages. Routine primary care is also delivered in the villages by itinerant doctors, nurses, dentists, and other health professionals.

If the injury or illness is serious enough to require inpatient care or more specialized diagnosis and treatment, the patient is referred to the nearest of the seven field hospitals. This secondary level of

care includes routine hospital admissions for common illnesses or injuries, for minor surgical conditions, or for pregnancy. The field hospital staff also provides primary care for their immediate community.

Serious or life-threatening illnesses or injuries are referred to Alaska Native Medical Center in Anchorage for treatment under the immediate direction of a specialist. Major surgery and complex diagnostic procedures are performed at the Medical Center. The Alaska Native Medical Center also provides primary health care for the Anchorage area AANHS eligibles and secondary health care for the Anchorage Service Unit.

In areas where direct health care by AANHS is not available, or for services which AANHS is unable to provide, health care is purchased under contract from private physicians, dentists, optometrists, hospitals, and pharmacies by AANHS on behalf of Native patients. Highly specialized treatments, such as heart surgery or kidney transplants, are referred out-of-state. In areas of the state where private health services exist, contractual care is an important component of the AANHS delivery system.

Despite the comprehensive design, there are gaps in this delivery system. Budgeted funds for contractual services are limited, and frequently become depleted long before the next allocation. If it is not an emergency condition, the patient must wait, or else pay for the treatment himself. If it is an emergency condition, transportation is usually arranged to another delivery point.

U. S. Public Health Service

The Bureau of Medical Services, a division of the U. S. Public Health Service akin to Indian Health Services, provides direct comprehensive health care for the Coast Guard and merchant seamen, and provides occupational health care and safety services for all federal employees. Federal health care responsibility for seamen derives from a 1798 act of Congress providing for the "relief of sick and disabled seamen".

In Alaska this care is delivered by the Alaska Area Native Health Service under contract with the BMS. In addition to an estimated 24,000 Coast Guard personnel and dependents, and bonafide merchant seamen, many fishermen are eligible for Public Health Services. Fishermen and other boaters qualify if they are owners or principal operators of a documented vessel. A documented vessel is a seaworthy power boat registered with the Coast Guard which could be utilized by the Coast Guard in case of a national emergency. There are an estimated 3,750 documented vessels in Alaska, including fishing boats and pleasure boats. There may be more than one principal operator of a boat. Dependents are not covered.

Uniformed Services Health Benefits Program

The military provides comprehensive health care to enlisted personnel through military medical facilities and staff. They also provide comprehensive health care to retirees and military dependents through the Uniformed Services Health Benefits Program (USHBP). USHBP provides health services to military dependents in two ways: through military medical facilities and staff on a space-available basis, and through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) when necessary medical services are not available through

military facilities. CHAMPUS is a supplementary health insurance plan purchased from a private carrier. CHAMPUS will reimburse 75 - 80 percent of allowable charges for necessary medical care. A $50 deductible is also collected on outpatient services. The CHAMPUS carrier in 1975 estimated that 55,000 dependents and retirees were covered in Alaska.

Medicare

Medicare is a federal health insurance program for people 65 and over, and certain disabled people under 65. It is financed by a combination of employee contributions, employer contributions, monthly premiums and federal funds, and is administered by the Social Security Administration.

Part A of Medicare is hospital insurance which is provided at no premium charge to those who have worked long enough under social security, and provided to others over 65 for a monthly premium of $54. Medicare Part A only helps pay for medically necessary covered services up to a specified number of inpatient days or home health visits. The Medicare patient must pay a deductible and a scheduled percentage of the covered costs, as well as the costs of uncovered services and services beyond the limits of Medicare coverage. The Part A hospital insurance helps pay for inpatient hospital care, inpatient care in a skilled nursing facility when it is medically necessary following a hospital stay, and certain prescribed services from a home health agency following a hospital stay. Medicare does not pay for custodial or long-term care.

Part B of Medicare is medical insurance. Anyone eligible for Part A hospital insurance is eligible for Part B medical insurance at a monthly premium of $7.70. Medicare medical insurance can help pay for doctors' services, outpatient hospital care, outpatient physical therapy

and speech pathology, and many other health services and supplies which are not covered by Part A hospital insurance. The medical insurance enrollee must pay the first $60 worth of covered services each year. After that the medical insurance pays 80 percent of "reasonable charges" for covered services and supplies. "Reasonable charges" are computed each year by Aetna (the Medicare carrier in Alaska) based on billings the previous year. The actual charges by the provider may exceed the "reasonable charges" covered by Medicare, and the patient must pay the difference, as well as paying the uncovered 20 percent of the "reasonable charges". Among the services not covered by Part B medical insurance are: routine physical exams, prescription drugs, eye glasses, hearing aids, dentures, dental care, and chiropractic services.

Though people over 65 must have accumulated sufficient work under the social security system to automatically be eligible for hospital insurance, the 1966 law "grandfathered in" all the social security ineligibles at that time. It is estimated that now 99 percent of the non-Native population in Alaska over 65 are enrolled in Medicare.

Medicaid

Medicaid is a medical assistance program funded jointly by the state and federal governments. In Alaska it is open to public assistance clients and eligibles, and certain other needy people in nursing homes, or inpatient psychiatric hospitals. Medicaid clients receive care from participating private providers, who then bill the Medicaid program. Alaska's Medicaid program covers all the federally mandated services: inpatient and outpatient hospital services, physicians services, x-ray and lab services, skilled nursing home services, home health

services, family planning services, transportation, and early and periodic screening, diagnosis and treatment (EPSDT) for eligible people under the age of 21. In addition, the state program covers a few optional services: inpatient psychiatric care for those over 65 or under 22, intermediate nursing home care, eye glasses, treatment for speech, hearing and language disorders, and approved outpatient mental health care. The state Medicaid program does not cover the following services for which federal match is available: prescription drugs, dental care or dentures for those over 21, prosthetic devices for those over 21, physical therapy, chiropractor's services, or preventive care for those over 21.

In FY 1976, 22,952 Alaskans, or 5 percent of the civilian population, were enrolled in the categorical public assistance programs (Old Age Assistance, Aid to the Blind, Aid to the Disabled, Aid to Families with Dependent Children, and Supplemental Security Income) and eligible for Medicaid.

To be eligible for public assistance, and therefore Medicaid, a person must not only meet income criteria, but categorical criteria of need, such as over 65, blindness, mental or physical disability, under 18 and deprived of the care of one or both parents, or a person related to and caring for eligible dependent children. Many Alaskans, such as low income families with both parents present, meet the income criteria for public assistance but do not meet the categorical criteria, and are therefore not eligible for Medicaid.

Because Natives receive much of their medical care from the U. S. Public Health Service, Native eligibles account for only one-third of Medicaid expenditures even though nearly two-thirds of the Medicaid

eligibles are Native. This may change with the implementation of the Indian Health Care Improvement Act of 1976. This federal law requires that medical care provided to Native Medicaid eligibles by the U. S. Public Health Service be billed to the state Medicaid program, with the state receiving 100 percent reimbursement from the federal government for Medicaid expenditures in behalf of Natives. This new billing procedure has not yet been implemented in Alaska.

General Relief Medical

The state-funded General Relief Medical program covers needy people and services not covered under Medicaid, as funding permits. People who meet the income criteria for Medicaid but do not meet the program criteria and have no prior health resource (such as Indian Health or health insurance) are eligible for all General Relief Medical covered services. Any Medicaid eligible is also eligible for those General Relief Medical services not covered under Medicaid. The GRM program covers the same services as Medicaid (inpatient and outpatient hospital care, physicans services, x-ray and laboratory services, nursing home care, home health care, mental health care, eyeglasses, treatment for speech, hearing, and language disorders, and transportation) plus many more not covered by Medicaid, such as drugs, physical therapy, prosthetic devices, hearing aids, chiropractors, podiatrists, emergency dental care, wheelchairs and other equipment. Nearly all services except hospital and physican care must be pre-authorized by the state program administration, and most services are subject to strict limitations. Medically justified services will be refused when funds are not available. The budget is established by the legislature.

The General Relief Medical program ensures that all Alaskans under the income limits for public assistance have some health care resource. For a single adult paying over $35 rent per month, that income limit is $334 per month; for a couple it is $490. For a family the formula is based on adjusted net income; the first $30 of earned income, one-third of every dollar of earned income after that, and reasonable work-related expenses are deducted from the net income to maintain an incentive for cash assistance recipients to work. Therefore, there is no simple dollar figure for General Relief Medical eligibility for a family. While the estimated 22,950* Alaskans below the federal poverty level might meet the income criteria for General Relief Medical, it should be noted that many of these are Alaska Natives or Medicaid eligibles, and so have a prior health resource. In FY 77, $3.7 million was expended in the GRM program, and $4 million was budgeted for FY 78.

Catastrophic Illness Program

The state Catastrophic Illness Committee administers a program that provides financial aid for persons of all income levels who have suffered a catastrophic illness--an illness that incurs high medical expenses. Total medical bills related to the illness must exceed $1000 in a 12 month period after all sources of third party payment, such as state and federal medical assistance programs, private and military health insurance, and awards in legal actions, have been exhausted. The Committee

---

* U. S. Department of Commerce, 1976 Survey of Income and Education Preliminary Results.

meets twice a month to determine the eligibility of applicants and the amount of medical assistance to be awarded, using a formula based on annual income, number of dependents, amount of assets, and the assumption that the applicant's share will be paid to the provider on a payment schedule covering a period of at least three years.

In its second year of operation, the program has granted aid to over 80 persons with the number of applicants steadily increasing as the program becomes better known. The largest portion of applicants are those in lower income brackets who do not qualify for other forms of aid. While applicants would have to be refused aid if funds were depleted, it is anticipated that the $450,000 appropriation for FY 78 will be adequate to meet this year's needs.

III. A DESCRIPTION OF HEALTH COVERAGE FROM PRIVATE SOURCES

Private Health Insurance

Health insurance pays benefits on an indemnity basis. When covered health expenses are incurred, the subscriber submits a claim to the insurance carrier. Benefits are normally paid to the subscriber. Normally, benefits are calculated on the basis of "reasonable charges" for each service or a schedule of maximum fees, rather than actual charges, and the subscriber must pay the difference if actual charges are higher.

Hospital expense coverage is the core of health insurance, because hospital care is the largest single medical expense. Hospital costs have risen faster in the last ten years than any other item in the consumer price index, and they continue to rise. Similarly, surgery has become a highly technological and expensive component of medical care, and the expansion of surgical expense coverage has followed closely the expansion of hospital expense coverage. Regular medical expense coverage is the third component of what is known as "Basic Protection", and covers physicians' services, and other medical services such as x-rays and lab tests. Basic protection policies are designed to cover one or more of these key medical services and the bulk of unpredictable medical expenses. Basic protection policies typically have limits on the number of days, dollars or visits covered, as well as a schedule of maximum benefits for services.

Major medical is the other main category of health insurance, and is designed to protect the subscriber from very large, unpredictable

medical expenses. It covers virtually any kind of health care prescribed by a physician. The maximum benefits under major medical is characteristically high, and the subscriber is typically required to pay a deductible and co-insurance as a disincentive for unnecessary utilization of medical care. Major medical insurance can either be designed to supplement a basic protection policy, or to incorporate basic protection and provide comprehensive coverage.

Blue Cross

Blue Cross is not an insurance company, but a hospital/medical service corporation, along with Fairbanks Physicians' Service and Delta Dental. As well as being non-profit, a hospital/medical service corporation differs from an insurance company in that it contracts with health care providers to deliver services to subscribers. The providers bill the corporation directly for the services provided, according to a fee schedule established in the contract. The subscribers pay a flat monthly premium for the coverage.

Blue Cross is specifically a hospital service corporation and maintains contracts with all the general hospitals in the state (not military or PHS hospitals). Fairbanks Physicians' Service is a medical service corporation and contracts with local physicians for services. Delta Dental is a dental service corporation and contracts with local dentists.

Blue Cross, however, covers more than just hospital expenses. Blue Cross provides major medical coverage, and subscribers are required to pay deductibles and co-payments, just like an insurance policy. Covered

expenditures delivered by providers not under contract with the service corporation are handled like insurance claims, on an indemnity basis. Benefits are based on "reasonable charges" and the subscribers must pay the difference if actual charges exceed "reasonable charges".

Pre-paid hospital/medical service plans are typically less expensive than health insurance through private carriers for several reasons: 1) they are non profit corporations, and any money in excess of their benefit payments and operating expenses usually goes toward equipment purchases for participating providers; 2) through their contracts with providers they are able to exert some cost and quality control pressure on providers, however, the effectiveness of this is mitigated by the extensive use of cost-plus contracts; and 3) though they do advertise, they do not deal through insurance agents and do not pay commissions. The end result is that an estimated 90 percent of subscriber premiums to an established hospital medical service plan are paid out in benefits, while only 50 to 80 percent of subscriber premiums to a private insurance carrier are paid out in benefits.*

Health Maintenance Organizations

Health maintenance organizations (HMOs) provide a full range of health care services to enrollees either directly through plan-owned facilities and plan-employed providers, or by contract with private facilities and providers. Enrollees pay a flat monthly rate for compre-

---

* Source: Don Koch, Alaska Department of Commerce and Economic Development, Division of Insurance.

hensive health care, with no deductibles or co-payments. HMOs have proven to be the most cost effective form of comprehensive health care services, because they are the only form of health care delivery which has built-in cost controls and an orientation toward preventive health care. HMOs have demonstrated significantly lower hospital utilization rates than any other kind of health care plan. Hospitalization continues to be the largest and fastest growing component of health care expenses nationwide.

The federal government has taken a great deal of interest in HMOs. There is a federal loan program for planning and establishing qualified HMOs, there is a federal law requiring large employers in HMO service areas to offer HMO coverage as an alternative to health insurance benefits, and DHEW is currently organizing a conference of labor and industry leaders to promote the HMO concept.

Alaska has one HMO in the planning stage, the Greater Anchorage Health Plan.

Teamsters

In most union health plans, employer contributions for health benefits are paid into a trust fund, and the trustees of the fund purchase group insurance for eligible union members. The Alaska Teamster-Employer Welfare Trust is unlike other union health trusts in that it is a self-insurer. In other words, the Teamster trustees do not purchase health coverage from a private health insurance carrier; they are their own carrier, and pay health insurance benefits to qualifying Teamsters directly from their own trust fund. In addition to a health insurance plan, the Alaska Teamster-Employer Welfare Trust offers an alternate

HMO-type plan called the Alaska Health Plan. The Alaska Health Plan is not officially an HMO under federal law because it does not offer open enrollment and does not provide the full range of services required of a qualified HMO. However, its operation is similar to an HMO. The Alaska Health Plan contracts with the Alaska Clinic and the Alaska Hospital and Medical Center to provide preventive, curative, and rehabilitative health services to plan members. The relationship between the Teamsters and the Alaska Hospital is more than just contractual, however, as Teamsters financed the hospital and serve on the board. The Teamster Alaska Dental Plan is also on an HMO model, but it differs from the health plan in that the Alaska Dental Clinic is directly owned and the dentists are directly employed by the Teamsters.

There are an estimated 28,000 Teamsters Local 959 members in Alaska, though they are not all eligible for health benefits. Eligibility is determined by the number of hours worked, and with the high post-pipeline unemployment, some Teamsters have exhausted their health benefits.

IV. AN ANALYSIS OF THE EXTENT OF HEALTH CARE COVERAGE AND GAPS IN COVERAGE

The Covered Population

Nationally, 178 million people - more than 8 out of 10 persons in the civilian non-institutional population - had some form of private health insurance in 1975, according to the Health Insurance Institute. The same survey reported 250 thousand people in Alaska, (two thirds of the civilian population) had private coverage.

The major public programs, U.S. Public Health Service, Medicaid and Medicare, provide health coverage to an estimated 20% of Alaska's civilian population. It is not known to what extent public coverage duplicates private coverage state-wide. However, random sample surveys were conducted in 1974-75 in both Anchorage and Kodiak Island Borough with questions regarding health coverage. The Anchorage survey reported that 79.9% of the sample had third party health coverage of some sort, and 20.1% had none. In Kodiak Island Borough 92.6% of the respondents reported third party health coverage, while only 7.4% reported none. This high percentage of health coverage in Kodiak Island is largely due to the high proportions of Indian Health Service eligibles (over 40%) and military personnel and dependents (over 25%). Those 7.4% without coverage constituted over 20% of the non-Native non-military or military dependent population.

The 20.1% of the Anchorage sample without health coverage constituted over 25% of the non-Native non-military or military dependent population in Anchorage.

If we can assume that a similar percentage (20-25%) of the non-Native non-military population state-wide currently are without third party health coverage from any source, 56 to 71 thousand Alaskans totally lack third party health coverage.

The biggest hole in this coverage patchwork is moderate and low income people who are self-employed or marginally employed, or non-union employees of an employer who doesn't provide health benefits. These people are above the income eligibility standards for Medicaid or General Relief Medical, yet their cash income is not adequate to afford either the expense of private health insurance, nor the expense of many medical services on a fee-for-service basis. This group includes farmers, shop owners, small contractors, temporary and part-time employees, casual laborers, subsistence providers and the unemployed. It also includes a large number of non-union workers, particularly those working for small employers, such as child care workers, waitresses, clerks, clerical workers, delivery truck drivers, gas station attendants and construction workers in home building. And of course the dependents of these bread-winners normally lack coverage as well.

In Alaska there are many seasonally employed people as well who have health coverage only part of the year while they are employed, such as loggers and cannery workers. Most construction workers (outside of home building) are unionized and have "hour banks" for health benefits such that if they work enough hours over the summers their accrued health benefits will last through to the next season. However, when there is not enough work to go around, many people are not able to accumulate enough health coverage to last the winter.

Services Covered

Health plans vary widely in the services covered and the levels of coverage provided. The foregoing analysis distinguished between people who have any sort of third party health coverage, and those who have no coverage at all. We have not yet considered whether those with some coverage have coverage that is adequate to protect them from financial hardship. Some policies, for instance, are specialized and cover only hospital expenses, or only surgical expenses. Many policies do not cover particular services such as prescription drugs, office visits, or nursing care outside of a hospital.

In the Anchorage survey, while 20% of the respondents lacked hospital coverage, 24% of the respondents lacked surgical coverage, 46% lacked coverage for visits to the doctor's office, 60% lacked dental coverage, and 70% lacked mental health coverage.

Many policies have limits on coverage that are exhausted by severe illnesses, or require co-payments which can add up to substantial sums. Many policies limit their payments to "reasonable charges" as defined by the insurance company, regardless of the actual charges, and the consumer must pay the difference.

It is not difficult for a consumer even with some health insurance to incur heavy financial losses due to health care expenditures. The following statistics suggest that insurance companies in fact are not paying the bulk of health care expenses.

While the private health insurance industry claims to serve over 80% of the nation's civilian non-institutionalized population, in 1976 they paid only 26% of personal health care expenditures nationally.

Government programs paid another 40%, and consumers paid 32% directly. The remaining 1% of personal health care expenditures was paid by philanthropic organizations.[1]

[1] "National Health Expenditures, fiscal year 1976", Social Security Bulletin, April 1977, page 8.

V. POSSIBLE LEGISLATIVE ACTION TO EXTEND COVERAGE

There are several measures which have been conceived to fill some of the gaps in health care coverage. Maine, Connecticut, Rhode Island, Minnesota, and Alaska have all enacted some form of state assistance for catastrophic illnesses. Connecticut and Minnesota have also made some cautious steps toward more comprehensive coverage with legislation that regulates health insurance carriers, mandating minimum benefit standards, controlling premium rates, and mandating pooled coverage for high risk subscribers. Hawaii has taken the boldest step toward expanding health coverage by mandating that all employers subsidize health coverage for their employees. These states are pioneers. Their state health insurance programs are new, and are being watched with interest by other states.

No state has instituted a universal or a state subsidized comprehensive health insurance program. While universal coverage is the goal for proponents of government sponsored health coverage, no one has been able to develop an acceptable scheme of financing universal coverage, either at the state or national level. If universal coverage is not yet a viable option for states, we are left with a patchwork approach to health coverage, covering only the holes we can reach. The following is an inventory of some of the "patches" available to state legislatures, in order of decreasing cost to the state.