ALASKA LEGISLATURE COMMITTEE FILES, 1989-1990 8672
5698 HOUSE HEALTH, EDUCATION & SOCIAL SERVICES 122

frustration and was feeling overwhelmed by the problems they faced as they attempted to sustain health services for community residents.

The University of Washington team recognized that the number and range of problems facing a typical community such as Seward, in today's threatening environment, could only be addressed successfully if a more comprehensive strategy was developed. The underlying tenet of the Community Health Services Development strategy is that substantial change in failing rural health services can only be accomplished by mobilizing broad community health leadership and public support for these changes.

Four objectives of the Community Health Services Development strategy are:

1. To design a community health system to meet the individual community's needs.

   A major proposition of the CHSD strategy is that the community rural health system should be constructed to meet the needs of the population it serves, including the large segments of rural communities that lack access to basic health care services because of financial, cultural and geographic barriers. In order

to accomplish this objective, we work with the community to determine the health needs of the local population and to develop a mix of services to meet those needs. This often means expanding the range of services available, since they have often atrophied for unnecessary and idiosyncratic reasons.

2. To improve the financial stability of local health institutions.

A major intervention is to provide thorough financial and managerial review of rural hospitals, nursing homes and clinics, and make specific recommendations on how to improve financial management and general administrative leadership.

3. To increase community utilization of and satisfaction with local health services.

A common problem in many rural communities is that the population is ambivalent about the quality of services provided locally. Local services are often perceived as unavailable or inferior, and a substantial portion of the population seeks health care outside the local area. This has the perverse effect of becoming a self-fulfilling prophecy when a shrinking market share and

falling utilization undermine the ability of health care personnel and institutions to sustain services that are in place.

4. To enhance local community leadership and effectiveness.

A common denominator in many rural communities is inadequate or dysfunctional community leadership. Too often communities have no mechanism for identifying, energizing and engaging local health and community leaders an effort to improve local health care capacity and quality. Rural hospital boards are often weak, and unaware of their need to serve as a conduit for community participation in shaping local health care systems. Many important components of rural communities are uninvolved or disaffected, and communication and teamwork among community leaders, hospital leadership, local physicians and other health providers is often more fractious than functional.

The Community Health Services Development Process:

Once a community agrees to participate in the CHSD process, there are three major phases:

1. Community Analysis:

The issues discussed above regarding Seward were identified through an extensive and careful analysis of the community health services. This analysis includes: a community market survey, mailed to each household in the service area to document satisfaction and utilization by local citizens; an exhaustive analysis of the financial, management, and organizational systems of institutions (hospital, nursing home, etc.); a needs assessment documenting health care strengths and weaknesses from interviewing 30 to 40 leaders in each community; and a demographic profile of each community.

From this thorough and objective study, the primary strengths and problems in the community health care system are clearly identified. This includes not only financial, personnel, and market share problems but also quality, performance, teamwork and leadership issues. In most communities, this is the first time these issues have been both comprehensively and honestly documented and described.

2. Hospital and community-wide health services planning: The above information becomes the raw material for a strategic planning process which usually involves both the

hospital (first) and the entire spectrum of community health services. This planning process necessitates broad community participation. The plan should reflect the optimal menu of health services that the community needs, and the steps to address the problems that have been identified.

It is instructive here to illustrate some of the major goals that were part of Seward's initial strategic plan. They included:

- To achieve a financial position for the community hospital that will insure long-term stability and enable the hospital to meet the challenges of a dynamic health care environment.

- To maintain and improve the market position of Seward General Hospital throughout the east Kenai peninsula.

- To demonstrate leadership, through the hospital trustees and administration, to provide, integrate, and coordinate human services in the east Kenai peninsula.

- To maintain an environment in which individual

employees and others associated with Seward General Hospital can achieve maximum equality.

- To develop maximum integration and collaboration among the major health care providers in the community including the physicians, hospital, nursing home and mental health services.

- To develop a community health insurance plan to retain maximum health care dollars and patient services within the community.

- To improve the quality of pharmacy and mental health services.

These goals included many sub-tasks to effectively address the problems outlined earlier in this document.

3. Implementation:

Every effort is made by health care and community leaders, in collaboration with University of Washington/AHEC staff, to aggressively implement the changes reflected in the strategic plan. This requires clear delineation of responsibilities, diffusion of responsibility to a wider range of community participants and leaders, clearly

delineated timelines, and commitment to an ongoing planning cycle each year for both the hospital and other community health services.

Major outcomes of the CHSD strategy:

A rigorous two-year evaluation of the six initial communities, including Seward, is currently underway. This evaluation involves repeating most parts of the community analysis. Quantitative information regarding changes in market share, public satisfaction levels, etc. is not yet available.

However, in hospital financial status, a number of changes have already been documented as a result of the CHSD model. The more important outcomes include:

1. A commitment by hospital board and administration, as well as all community providers, to a rigorous, goal-oriented, problem-solving strategic planning process, to be re-examined annually. This is a major accomplishment for hospitals and communities that have never before accepted the need to plan in order to insure efficient use of scare resources and to direct aggressive attention to threats and problems.

2. An improvement in the financial "bottom line" for Seward General Hospital.

3. The development of a community problem-solving organization, the "expanded core group", which includes representation from every element of health and human services in Seward. This group has developed more effective problem-solving approaches by providers in the community, improved teamwork, and is insuring better cooperation among the health care providers.

4. Hospital governance (by board and administration) is markedly improved. Changes have included a commitment by the board to a planning process, dramatically increased board confidence and competence, a board recruitment and development program, streamlined decision making and meetings, annual planning retreats, and the enlistment of new community members for specific expertise. As in other communities, this has been one of the most dramatic outcomes of enhanced community health leadership.

5. A hospital marketing plan has been developed to aggressively address the reasons many residents were leaving the community for health services. Prenatal and obstetrical services have been expanded, anesthesia

coverage has been improved and limited surgical services are now provided at the hospital. The image of the community hospital has improved through attention to the buildings, equipment, and their appearance. Programs to improve the interpersonal skills, personal appearance, sensitivity, and nurturing attitudes of personnel have been carried out. The importance of these efforts cannot be overemphasized when the reasons for citizen out-migration are understood.

6. New community technology including ultrasound and fetal monitoring equipment has been purchased.

7. A new hospital management information system has been instituted, and numerous management and financial systems changes have been implemented.

8. A more coordinated and functional physician recruitment strategy has been developed by the community, with excellent cooperation between the medical staff and the hospital.

9. An expanded range of physician specialists is now coming to the community to provide services locally.

10. Improved cooperation between the hospital and nursing home has been achieved, and an effective nursing home administrator recruited.

11. The community is exploring the development of a community health insurance plan to maximize the use of local dollars and develop incentives for local utilization of health services.

The above accomplishments are impressive. They represent constructive changes across the entire spectrum of community health services, and they also reflect a rate of change that certainly exceeds that which existed before the CHSD strategy was implemented.

In summary, general outcomes from the CHSD strategy in all participating communities include the following:

a. A systematic, comprehensive approach to strengthening health care which includes system-wide planning, change on multiple fronts, more openness to outside facilitation and assistance, and greater peer group accountability.

b. Improved system performance including enhanced community and health care leadership, improved teamwork, improved morale and optimism, and an

expansion of the scope of health services available locally.

c. A structure for the future which insures continuing planning and problem-solving, a future-oriented attitude, and a willingness to continue to use outside resources to augment community skills and leadership.

In summary, Seward's experience has mirrored our experience in approximately 20 communities to date. Although some health care problems in rural communities will continue to be vexing due to the small population size and limited resources, the overall perspective of the CHSD strategy is that only with a community-driven approach involving broad health care and community leadership can many communities hope to sustain, let alone expand, the health services available to their residents. We believe at this time, even without the data from the Rural Hospital Project evaluation, that this process is far more effective than the crisis oriented, fragmented responsess that many rural communities have historically utilized.

The partnering of community leaders with outside facilitators and consultants has proved to be a powerful team to address the complex issues facing rural communities. At a very modest cost per community (considering the overall

expenditure of health care dollars annually in a community), we believe that our experience with the CHSD strategy has shown that rural communities themselves are the most effective resources to stablilize their health services, rather than rely primarily on external saviors and solutions.

1219ch.doc

ALASKA STATE LEGISLATURE

While in Ketchikan
352 Front Street
Ketchikan, AK 99901
907-225-9675

While in Juneau
P.O. Box V
Juneau, AK 99811
907-465-3743

Senator Lloyd Jones

April 29, 1990

MEMORANDUM

To: Representative Johnny Ellis, Chair
House Health, Education and Social Services Committee

From: Senator Lloyd Jones LJ

Subj: SB 326 - Health Planning Grants

Thank you for hearing Senate Bill 326.

SB 326 establishes a health planning grant program in the Department of Health and Social Services for community health care planning. The bill is based on a model grant program established by Dr. Bruce Amundson of the University of Washington. Dr. Amundson was also instrumental in establishing a health planning grant for the City of Seward. Attached is a position paper written by Dr. Amundson, which gives background on the model program. Also included for backup are:

- Revised fiscal note and analysis
- Summary of the bill
- Written testimony and letter of support
- Case study

As you know from our work with the Governor's Interim Commission on Health Care, one of the Commission's serious concerns was the state's inability to put together either a long or short term health care policy. As state revenues dwindle, so will state support for much needed health care facilities and programs. This bill allows local decision making regarding the future of health care programs and facilities at the community level.

I hope you will support this bill and join me in cross-sponsorship. If you have any questions regarding this bill, please feel free to call me or Glenda Carino of my staff.

SCHOOL OF MEDICINE

February 16, 1990

TO: Alaska State Senate Finance Committee

FROM: Peter J. House PH
Associate Director (Acting)
Office of Rural Health
University of Washington

RE: Senate Bill 326

I am writing this memo to you as follow-up to my testimony before the Senate Finance Committee on February 1, 1990. As you know from my remarks of a few weeks ago, the purpose of the Office of Rural Health at the University of Washington is to help rural communities stabilize their health care systems. We believe that Senate Bill 326 is consistent with our purpose, and for that reason we would like to reiterate our support for this legislation.

First let me answer the question concerning the need for community-based planning. One of the central findings of our work (starting in 1984 with the Rural Hospital Project and continuing today with the Community Health Services Development Program), is that the fundamental factor destabilizing rural health care systems is the fact that significant portions of local populations seek health care services outside their community when those services are available in the local community. This out-migration damages the financial viability (and ultimately the availability) of local health care services. A corollary finding is that the communities themselves hold the key to stemming this outflow of patients.

Senate Bill 326, we believe, adopts (and sets aside funds for) a process that will empower communities to develop strategies to stabilize their rural health care systems. Our experience, working with communities utilizing an approach like that supported by Senate Bill 326, shows a history of communities progressing from desperate circumstances to well ordered strategies leading to amazing improvements of the health care resources in their communities.

SCHOOL OF MEDICINE, OFFICE OF

98195 (206) 543-6020 (206) 545-2491

Another aspect of the need for planning concerns the necessity of state financing of the work. Most rural communities lack the resources to get a project like this started. In communities with hospitals, nursing homes, or other health and social services organizations, chances are that the administrators or the boards simply don't have the time to undertake the comprehensive approach as outlined in Senate Bill 326. In communities without such organizations, there is a near certainty that there is no one in town with the skills and the time to lead such an effort. We have found well organized projects (led by the state and utilizing consultants), as envisioned in Senate Bill 326, to be an effective and efficient approach to the problem.

Assigning resources to community-based planning can avoid the expenditure of funds on more expensive strategies. Hasty, underfunded planning projects are the kind that produce simplistic yet, all to often, expensive solutions to health care problems. In our experience with applying this approach to over 20 communities since 1984, only rarely have community groups come up with initiatives that bore large capital price tags. The more elegant and effective strategies have often been inexpensive. So, for that reason, spending money on some solid planning now can save wasted capital dollars later.

I understand that certain portions of my testimony on February 1 were difficult to hear and I accept that as a hazard of testifying by telephone. My hope is that by placing my comments in this written format I will be able to strengthen the testimony I have already made to you. We at the University of Washington, are "true believers" in the community-based approach to stabilizing local health care systems and we urge you to move forward with the enactment of this important legislation.

Thank you, and please call me or my associates if we can be of further assistance in providing testimony or documentation to support Senate Bill 326.

PJH:sb
2-16ala.mem

TONASKET, WASHINGTON
A CASE STUDY

Demographic Profile

Population - Community	1,000
Population - Service Area	9,000
Hospital Size	22 Beds
Providers	4 M.D.s 2 Mid-Levels
Distance to Nearest Hospital	23 Miles
Economic Base	Agriculture Timber

CASE STUDY OF A RURAL WAMI COMMUNITY

HEALTH CARE PROBLEMS	INTERVENTIONS AND RESULTS
Persistent primary care physician shortage.	Successful recruitment of two additional family physicians
Fragile hospital financial status (including $650,000 in warrants).	Dramatic change in hospital financial status.
	Establishment of hospital district and tax levy.
	Construction of new 70-bed nursing home.
Weak hospital board.	Restructured, educated, effective board.
Substantial outmigration for most health services	Increased utilization data (i.e., hospital occupancy).
	Additional medical specialty consultants coming to community.
	Addition of new technology (US and shared CT).
	Marketing program targeted at weakest utilizers.
Substantial weaknesses in hospital management & financial systems (i.e., massive AR, no management information system).	New computer-based MIS.
	Contract for financial expertise.
	Revamped billing and collection policies.
Lack of community awareness of fragility of hospital and health system.	Creation of a community health care foundation.
	Weekly series of article on health issues in local newspaper.
Lack of teamwork among major providers.	Explicit help with conflict resolution and development of consensual goals.
Highest percentages of uncompensated care of any state hospital.	
Timber-dependent, economically depressed environment.	

NORTH VALLEY HOSPITAL

Financial Status Before and After
Rural Hospital Project

	1983	1986	1987	1988
Income From Operations[1]	(210,004)	6,711	414,165	35,743
Net Gain/Loss[2]	(169,774) (plus 650,000 in short-term debt)	238,538	555,253	113,995

---

[1] Income (loss) from operations

[2] Operating Margin plus non-operating revenue

THE TWO COMPONENTS TO DEVELOP A DURABLE COMMUNITY-BASED HEALTH PLAN:

COMMUNITY PREPARATION & ORGANIZATION	+	HEALTH PLAN DEVELOPMENT

STAGE I: COMMUNITY PREPARATION

FACILITATOR: COMMUNITY CONSULTANT (UNIV. OF WA/ALASKA)

- o IDENTIFY AND CONVENE HEALTH AND COMMUNITY STAKEHOLDERS
- o DISCUSS CONCEPT, BENEFITS TO COMMUNITY AND ORGANIZATION
- o PERFORM SURVEY OF EMPLOYERS (# EMPLOYEES, INSURANCE COVERAGE, LEVEL OF INTEREST)
- o CONDUCT ANALYSIS OF HEALTH SERVICES IF DATA NEEDED (I.E., MARKET SURVEY; NEEDS ASSESSMENT)

STAGE II: COMMUNITY BODY - COMMUNITY CONSULTANT/ LEGAL COUNSEL

- o ESTABLISH A COMMUNITY CORPORATION AND BOARD (EMPLOYERS, HOSPITAL, PHYSICIANS, OTHER PROVIDER GROUPS, ETC.)

STAGE III: HEALTH PLAN DEVELOPMENT

FACILITATOR: COMMUNITY CONSULTANT/ BOARD/HEALTH CARRIER

- o ESTABLISH AND CLARIFY CONTRACTING AUTHORITY OF CORPORATION TO:
  - MANAGE PLAN
  - CONTRACT WITH PRIVATE AND PUBLIC EMPLOYERS
  - BEAR RISK
- o OBTAIN LEGAL AND REGULATORY APPROVAL
- o DEVELOP BENEFIT PLAN(S)

STAGE IV: MANAGE THE HEALTH PLAN OVER TIME

FACILITATOR: BOARD/CONSULTANT/ HEALTH CARRIER

- MARKET THE PLAN
- CLAIMS TRANSACTIONS
- MANAGEMENT INFORMATION TO BOARD FOR UR AND QA
- MANAGEMENT DECISION
  - BENEFITS
  - UTILIZATION

The Department of Health and Social Services is authorized to contract with an appropriate agency, educational institution or organization to carry out the purpose of this legislation. An appropriate contracting entity would be one with experience and demonstrated success in community health services development, in rural Alaska. [This entity would have responsibility for community selection and allocating monies to carry out the work program.]

University of Washington Correspondence

INTERDEPARTMENTAL

SCHOOL OF MEDICINE
OFFICE OF THE DEAN
REGIONAL AFFAIRS, XF-01

April 18, 1989

TO: Attendees, House Health, Education and Social Services Committee Conference on Financing Health Care for Alaska's Uninsured and Underinsured

FROM: Bruce Amundson, M.D.
AHEC Associate Director for Community Health Systems

SUBJECT: A PROGRAM TO MAINTAIN RURAL HEALTH CARE DOLLARS IN COMMUNITIES THROUGH THE DEVELOPMENT OF COMMUNITY-BASED HEALTH PLANS

A large proportion of rural communities in the United States are experiencing threatened or actual deterioration of their health services. The rural hospital, traditionally the core of the rural health care system, is currently the weakest link in the elements that comprise that system in many communities. However, a broad and vexing array of other problems are simultaneously confronting communities. These issues have been carefully documented by recent studies and community-based intervention efforts at the School of Medicine at the University of Washington.

The belief is widely held among state and national policy makers and some rural leaders that many or most rural communities cannot afford to sustain any but the most rudimentary health services. Our research, however, does not support this pessimistic assumption. Through studying a sample of communities we have demonstrated for the first time that more money is already being spent for health services in each community than is required to support the entire existing health care system. The following 1985 data illustrates this finding:

	Community A	Community B	Community C
Money expended for health care by or on behalf of all service area residents (i.e. private insurance, Medicare, Medicaid, etc.)	$18,715,268	$8,906,050	$8,130,605
Revenue needed to support basic health services (i.e. hospital, home health, mental health budgets, gross M.D. revenue)	$ 9,791,327	$4,635,539	$5,268,737
Available "surplus"	$ 8,923,941	$4,270,511	$2,861,868

The conclusion is obvious: rural communities appear to have more than enough money to sustain their services if that money can be kept in the communities. Community insurance plans (i.e., PPOs) can provide incentives and organizational frameworks to keep care local and manage patients that leave to obtain services not provided in the community.

The Situation in Alaska

Current developments in Alaska regarding health care costs have created special concern. While health care costs are spiraling across the country, the increase in insurance rates in Alaska has been particularly high, forcing insurers to increase premiums as much as 40% or decrease benefits. It appears that unless we are able to control health care costs, health insurance and health care will become unaffordable for many more people in the state.

Experience with Community PPOs i our Region

Substantial interest has developed in the northwest region in the idea of community-based insurance plans. First, they are a way to keep insurance premium expenditures and out-of-pocket payments in the community, supporting the very important primary care system. Second, the development of community boards with broad representation including hospitals, physicians, community leaders, and major employers, provides a structure wherein the predominant goal of maintaining and strengthening community health services can be supported by all interested parties. Third, this community non-profit corporate structure provides an unprecedented vehicle for communities to regain control and ownership of their health system, including the dollars. Fourth, there is preliminary, but fascinating, evidence that utilization

may be more effectively controlled from within the community (because people know each other and this network can be effectively utilized for utilization, monitoring and review), than any other utilization process to date.

At least four community-based health plans are operational in the WAMI region. With the assistance of the Rural Hospital Project at the University of Washington and Blue Cross of Washington and Alaska, the Seward community is currently developing such a plan.

BA:dm
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SB

332

STATE OF ALASKA
THE LEGISLATURE

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

LEGISLATIVE AFFAIRS AGENCY

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Copies of minutes listed below were originally included in this file. The minutes are available on the STAIRS database CMPR. In order to save space copies of minutes have not been left in the files.

Mary Van Nimwegen

SB 332

H HESS 4/19/90

H HESS 4/24/90

HOUSE COMMITTEE REPORT

(7)
Date Referred: March 23, 1990 FURTHER REFERRALS:

FINANCE

Date of Committee Action: 4/24/90

The HESS Committee considered: CSSB 332(SA)am

CS SENATE BILL NO. 332 (SA) am FLAGGING RECORDS OF MISSING CHILDREN

"An Act relating to records of missing children; and to records of certain children transferred as students."

RECOMMENDATIONS:
[ ] be replaced with _____ [ ] the same title [ ] a new title
[ ] have attached amendment(s)
[X] do pass
[ ] do not pass
[ ] no recommendation
[ ] individual recommendations
[ ] additional referral to the _____ Committee

ADOPTS: _____ letter of intent

ATTACHES NEW FISCAL NOTE(s): (Dept)
[ ] fiscal impact _____
[ ] zero fiscal note _____
[ ] zero with analysis _____

APPROVES PREVIOUS: (Date/Dept)
[ ] fiscal note(s) _____
2[X] zero fiscal note(s) 3/14/90/DIRS/DRS
[ ] zero fn/analysis _____

SIGNING DO PASS:

SIGNING: (Check approp. column)

	Do Not Pass	No Rec	Amend

Chairman's Signature

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: CSSB 332 (SA) (b)
PUBLISH DATE: 3/14/90

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: Flagging Records of Missing Children
Sponsor: Sentator Uehling, etc.
Requestor: Senate HESS

Agency Affected: Public Safety
BRU: Alaska State Troopers
Component: Detachment & C.I.B.

EXPENDITURES/REVENUES: (Thousands of Dollars) (Inflation not included)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
REVENUE	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of Dollars)

GENERAL FUND	-0-	-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS						
OTHER/PROG RCPT						
TOTAL .	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

ANALYSIS: (Attach a separate page if necessary)

No significant fiscal impact upon the Department of Public Safety is anticipated.

JAR 3/1/90

Prepared by: Francis C. Allan
Division: Alaska State Troopers
Phone: 269-5691
Date: 03/01/90

Approved by Commissioner: Arthur English
Agency: Department of Public Safety
Date: 3-1-90

Page 1 of 1

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: CSSB 332 (SA)(a)
PUBLISH DATE: 3/14/90

FISCAL NOTE

REQUEST:

Revision Date:
Title: Relating to records of missing children

Agency Affected: Health & Social Services
BRU:

Sponsor: Senator Uehling
Requestor:

Components:

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY92	FY93	FY94	Y 95	FY 96
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

FY90 is "0".

Prepared by: Katherine Kelley, Director
Division: Public Health
Phone: 465-3090
Date: 2/27/90

Approved by: Commissioner: Myra M. Munson
Agency: Department of Health and Social Services
Date:

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

Senator Rick Uehling

Downtown, Elmendorf, Northeast Anchorage

Co-Chairman, Senate Finance Committee
International Trade & Tourism Committee
State Affairs Committee

Memorandum

March 26, 1990

To: Representative Johnny Ellis
Chairman, House Health Education
and Social Services Committee

From: Senator Rick Uehling
Co-Chairman, Senate Finance Committee

Subject: CSSB 332 (State Affairs), an act relating to records of missing children; and to records of certain children enrolled or transferred as students.

I would appreciate your assistance in scheduling SB 332, an act relating to records of missing children, and to records of certain children enrolled or transferred as students, for a hearing before the House Health Education and Social Services Committee at the earliest convenient date.

This bill represents an effort to aid law enforcement agencies trying to locate missing children and reunite them with their families. This legislation will insure that the records of missing children are flagged at their schools and the Bureau of Vital Statistics so that any effort to gain copies of the records will alert law enforcement agencies. The measures mandated by this bill are not costly and will generally assist public and private agencies looking for children that have been separated from their families.

SB 332 has been endorsed by two major national organizations working on the missing children problem, Child Find of America, Inc. and the National Center for Missing and Exploited Children. Letters from these organizations are included for your files.

P.O. BOX V, JUNEAU, AK 99811 (907) 465-4821 • 3111 ST. #515, ANCHORAGE, AK 99503 (907) 561-7613

In response to recommendations from the Departments of Public Safety and Health and Social Services I proposed, and the Senate State Affairs Committee adopted, a Committee Substitute for SB 332. I believe the changes made in the proposed CS are positive and add to the effectiveness of this legislation. The changes tighten up the bill and prevent unproductive paper shuffling between the Department of Public Safety, the Bureau of Vital Statistics and Alaska schools.

Please do not hesitate to call on Mike Abbott of my staff if there is additional information that would be of assistance to you.

Backup materials for SB 332, Missing Kids

1) December 1, 1989 letter from Child Find of America, Inc endorsing SB 332

2) January 23, 1990 letter from National Center for Missing and Exploited Children endorsing SB 332

CHILD FIND OF AMERICA INC.®

7 INNIS AVENUE / PO BOX 277 / NEW PALTZ, NY 12561-9277
914-255-1848 FAX 914-255-5706

DEC 15 1989

December 1, 1989

Senator Rick Uehling
PO Box V
Juneau, AK 99811

Dear Senator Uehling:

I am pleased to offer my support for your senate bill to provide for the flagging of school records of missing children.

Because most abducted children eventually are put in school, tracking the movement of school records is a proven tool in the search for missing children. Your bill requiring notification of the Department of Public Safety when the transfer of school records is requested would be an expeditious way to make even better use of this tool.

Thanks for your efforts on behalf of this important issue. If we can be of further assistance in support of your bill please do not hesitate to call on us.

Sincerely,

Carolyn Zogg

Carolyn Zogg
Executive Director

CZ/jrm

cc: State Senator Charles D. Cook, R-40
Assemblyman Maurice D. Hinchey, Jr., D-101

JAN 2 9 1990

2101 Wilson Boulevard • Suite 550 • Arlington, VA 22201
703/235-3900

NATIONAL CENTER FOR MISSING & EXPLOITED CHILDREN

The Honorable Rick Uehling
Alaska State Legislature
P.O. Box V
Juneau, AK 99811

January 23, 1990

Dear Senator Uehling:

The National Center has recently received a copy of S.B. 332, entitled "An Act relating to records of missing children; and to records of certain children enrolled or transferred as students." This office was pleased to assist you in the development of this legislation. The National Center for Missing and Exploited C hildren strongly supports this type of legislation.

If we can be of any further assistance, please do not hesitate to call on us.

Sincerely,

Paulette L. Stevens

Paulette L. Stevens
Legislative Specialist

SB

334

STATE OF ALASKA
THE LEGISLATURE

POUCH Y · STATE CAPITOL
JUNEAU, ALASKA 99811
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Mary Van Nimwegen

SB 334

H. HESS 2/21/90

H. HESS 3/7/90

HOUSE COMMITTEE REPORT

3/8

(7)
Date Referred: January 26, 1990 FURTHER REFERRALS: FINANCE

Date of Committee Action: 3/7/90

The HESS Committee considered: SB 334(efd am)

SENATE BILL NO. 334(efd am) MEDICAID WAIVERS FOR HOME-BASED SERVICES

"An Act directing the Department of Health and Social Services to seek permission to use options and receive waivers under the Medicaid program for the cost of home or community-based services for developmentally delayed children, developmentally disabled persons, disabled adults, and older Alaskans; directing other agencies to assist in that process; and providing for an effective date."

RECOMMENDATIONS:

[ ] be replaced with _____ [ ] the same title [ ] a new title

[ ] have attached amendment(s)

[X] do pass

[ ] do not pass

[ ] no recommendation

[ ] individual recommendations

[ ] additional referral to the _____ Committee

ADOPTS: House HESS letter of intent

ATTACHES NEW FISCAL NOTE(s): (Dept)

[ ] fiscal impact _____

[ ] zero fiscal note _____

[ ] zero with analysis _____

APPROVES PREVIOUS: (Date/Dept)

[X] fiscal note(s) 1/22/90 DHSS

[ ] zero fiscal note(s) _____

[ ] zero fn/analysis _____

SIGNING DO PASS:

J Ellis

M Hoffman

Rita Fan

Chris Davis

SIGNING: (Check approp. column)

	Do Not Pass	No Rec	Amend
W Furnas		X	

J Ellis
Chairman's Signature

Alaska State Legislature

SENATE

Official Business

P.O. Box V
State Capitol
Juneau, Alaska 99811

R - bill file

M E M O R A N D U M

TO: Representative Johnny Ellis

FROM: Senator Jay Kerttula

SUBJ: Senate Bill 335 --
Health Maintenance Organizations

DATE: April 17, 1990

Senate Bill 335 is based on the National Association of Insurance Commissioners' Model Act for Health Maintenance Organizations. Alaska is one of two states which have not enacted the NAIC model act or similar or related legislation.

Senate Bill 335 would provide a specific licensing, incorporation, and regulatory scheme for health maintenance organizations. HMOs provide for basic health care services on a prepaid basis and have characteristics of both an insurer and a health care provider. Thus, membership in an HMO can be purchased by either an individual or an employer as a form of health care insurance, or health care in an HMO can be paid for by a traditional insurance policy such as Blue Cross or Aetna. The lack of an Alaska statute which regulates HMOs is a barrier to the development of HMOs in Alaska. State regulation is also necessary in order to ensure the protection of Alaska residents from insolvent HMOs. There are no HMOs in Alaska at this time, although there have been HMOs in Alaska in the past.

Medical costs are soaring -- health care now takes up 11 percent of the gross national product and it is anticipated to rise to 18 percent of the GNP by the year 2,000. HMOs provide both good medical options in terms of preventative medicine and a mechanism for containing costs. As an example of perceived costs savings resulting from HMOs -- the federal administration has proposed reducing medicaid premiums by $60 per month for beneficiaries who join an HMO.

Attached is information on Senate Bill 335, relating to Health Maintenance Organizations. SB 335 is currently in the House Rules Committee. I think this bill is needed. It has the dual benefit of encouraging preventative health care and containing costs. The bill is supported by the administration and has "0" fiscal note.

I urge your support of Senate Bill 335.

JK:kh

CONTENTS

SENATE BILL 335 PACKET

PROVIDED BY SENATOR KERTTULA

DESCRIPTION OF THE MAJOR PROVISIONS OF

CS SSSB 335 (FINANCE)

1. Requirements for Certificate of Authority: Senate Bill 335 requires that a list of conditions be met -- including demonstration of financial solvency -- prior to issuance of a certificate of authority. The bill also lists specific items of information that must be included within an application, and allows the department to acquire any other information that may be found necessary in the future.

2. Coordination with the Department of Health and Social Services: The nature of an HMO is that it is both an insurer and a health care provider. Therefore, both the Department of Commerce and the Department of Health and Social Services have an interest in the quality of an HMOs' operation. Senate Bill 335 requires that a copy of the application be forwarded by the Director of Insurance to the Department of Health and Social Services within 10 days after its receipt. Within 60 days after the Commissioner of Health and Social Services receives a copy of the application, he or she makes a recommendation; and within 30 days after that recommendation, the Department of Commerce either "issues or denies" a certificate of authority.

3. Solvency and Limits on Investments: CS SSSB 335 (Finance) would require a deposit of the greater of 10 percent of an HMOs' estimated expenditures for health care services for its first year of operation, twice its estimated average monthly uncovered expenditures for its first year of operation, or $250,000. The model act would have required a deposit of the greater of 5 percent of an HMOs' estimated expenditures for health care services for its first year of operation, twice its estimated average monthly uncovered expenditures for its first year of operation, or $100,000. The larger deposit which would be required under the CS is viewed as necessary to ensure that Alaska consumers will be protected from insolvent HMOs. The larger deposit is not viewed as an insurmountable barrier to the development of HMOs, since the deposit is only increased for the first year of operation -- after that the deposit requirements under the CS mirror the requirements under the model act (two percent

for the second fiscal year, three percent for the third fiscal year, four percent for the fourth fiscal year, and four percent thereafter.) The deposit requirements do not apply if the HMO has a net worth of $1 million without buildings, or $5 million with buildings, or some alternative formulas are met which demonstrate similar financial stability. Finally, the HMO must have and maintain a "capital account of at least $100,000" in addition to any of the deposit requirements.

4. Governing Body: Senate Bill 335 requires that the governing body of an HMO be made up of at least one-third "consumers who are substantially representative of the participants." The sponsor substitute also requires that the HMO establish advisory panels so that enrollees would have an opportunity to participate in matters of policy and operation.

5. Dual Choice: Senate Bill 335 requires that each employer in the state, whether public or private, having 25 employees or more "shall make available to its employees or members the option to enroll" in an HMO. Mandatory dual choice is viewed as necessary to make an HMO financially viable in Alaska. In addition, federal medicaid regulations require that there be an dual choice requirement before they will provide medicaid reimbursement to an HMO. Under Senate Bill 335, an employer is not required to pay more for employee health benefits than he or she would have been required to pay if not covered by the bill.

Senate Bill 335 also mandates, that the option of enrollment in an HMO should first be submitted to a bargaining unit, if the employees are members of a collective bargaining unit. If the option is approved by the bargaining representative, the option of enrollment shall then be made to each represented employee. This language mirrors the federal regulations.

6. Form Filing and Rate Approval: Senate Bill 335 includes a mechanism for the approval of "an evidence of coverage." The bill provides that the HMO file the form with the Division of Insurance 30 days before it is to be used. The form is considered approved unless the director has affirmatively approved or disapproved the form within the 30 day period.

7. Complaint System : Senate Bill 335 contains a detailed section requiring that the HMO establish and maintain a complaint system.

8. Powers of an HMO: Senate Bill 335 has a section listing the powers of an HMO, and lists prohibited practices. The bill also limits the amount of money that can be recovered from an HMO from a participant who was not entitled to receive certain services to the actual cost of providing the health care service. Senate Bill 335 also provides a window of 10 days in which a participant who has just signed up with an HMO can return the agreement and demand a refund.

9. Taxation: Senate Bill 335 provides that an HMO is to be taxed and shall file reports as an authorized insurer.

10. Other Provisions: Senate Bill 335 contains a section imposing fiduciary obligations in the handling of money by an HMO. The bill also provides that health care services must be provided by appropriately licensed health care providers.

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: CSSSSB 335 (L+C)
PUBLISH DATE: 2/28/90

FISCAL NOTE

REQUEST:

Revision Date:
Title: An Act relating to Health Maintenance Organizations
Sponsor: Sen. Kerttula
Requestor: Senate Labor & Commerce

Agency Affected: Commerce & Econ. Dev.
BRU: Insurance
Components: Operations

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	0	0	0	0	0	0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary) No fiscal impact in FY 90.

No fiscal impact on the division.

Prepared by: Joan Brown, Administrative Officer
Division: Insurance
Phone: 465-2597
Date: February 7, 1990

Approved by Commissioner: Larry Merculieff
Agency: Department of Commerce & Economic Development
Date: 2/7/90

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

Changes in CSSSSB335 (L+C) have no fiscal impact. This fiscal note is appropriate. Projections of no fiscal impact would continue through 1996.

3712D-2/011990b

Model Health Maintenance Organization Act

Table of Contents.

Section 1. Short Title.

This Act may be cited as the Health Maintenance Organization Act of (insert year).

Introductory Comment.

The rising cost of health services in recent years has led government agencies, private organizations, and legislative bodies to seek alternatives to the traditional medical delivery system which will provide improved health care at a lower cost. The health maintenance organization is a concept which has received much attention as one means through which an improvement in delivery might be achieved.

Shortcomings of Existing Health Care Delivery System

The health care delivery system as it is now constituted presents several problems. First, many people are unable to obtain health care when they need it and in the form they need it. This problem can be divided into three subareas: (a) In many areas of the country, the availability of health care in terms of the quantity of manpower and facilities is inadequate; (b) Even where physicians, nurses, clinics, and hospitals do exist, they may lack accessibility due to poor location, poor management, lack of transportation, language or racial barriers, inconvenient hours, etc; and (c) Even if health care is available and accessible, it may not be continuous: that is, a single patient may not be treated as a person with a continuing or a variety of problems but rather as a single isolated health care problem incident. The problems of availability, accessibility, and continuity, at least in part, have been attributed to the lack of responsibility vested in one person, group, or organization to assure the delivery of health care.

Medical Care Foundations

A variation of the HMO concept is seen in some medical care foundations. Although individual foundations differ greatly in detail, a foundation for medical care is usually sponsored and organized by a county or state medical society. The membership consists of physicians who apply to and are accepted by the foundation.

Those medical care foundations which can be considered as a variant of the HMO concept, often contract with an insurer or other prepayment plan (e.g., hospital or medical service corporations) to provide coverage meeting certain minimum criteria consistent with the delivery of quality medical care. The insurer collects the premiums, promotes, markets, and underwrites the program. The enrollee may seek physician services from any member of the foundation who then bills either the insurer or the foundation, not the enrollee. Although such billings are on a fee-for-service basis, the amount charged the enrollee is fixed and prepaid without regard to the number or type of services used. The foundation establishes some form of peer review to monitor not only the level of charges but also the type and quality of care rendered. Since the amount of income does not vary with the number or type of services provided, incentives exist to maintain costs at as low a level as possible. However, unlike the HMO concept described above, even though physician services are prepaid from the patients' viewpoint, from the physicians' viewpoint, the fee-for-service practice is maintained. Under the federal HMO Act, this type of organization is called an Individual Practice Association Type HMO.

The Need for State Authorizing and Regulatory Legislation

From 1970 to 1973, the administration and committees in both houses of Congress spent much time analyzing the health maintenance organization alternative in connection with national health insurance and federal assistance bills for HMO's. This analysis resulted in the enactment of the federal HMO Act in 1973. Since then, the number of health maintenance organizations and the number of HMO enrollees has grown rapidly. Prior to 1972, however, few states had a statutory framework tailored to the supervision of health maintenance organizations. Chartering, licensing, contract and rate regulation, and other supervision was being carried out under general insurance laws, hospital and medical service corporation statutes, other special statues, or not at all. Because the HMO is a unique type of organization, many provisions of such state laws were inapplicable, highly restrictive or prohibitive to the formation and operation of an HMO. Therefore, in 1972 the NAIC adopted the Model Health Maintenance Organization Act which accommodates the unique features of HMO's.

Purpose of a State Model Bill

The model bill clearly authorizes the establishment and operation of HMO's. Restrictive provisions in other laws which are inappropriate to HMO's are rendered inapplicable. Appropriate grants of authority are established to enable the HMO's to fulfill the function envisioned for them. At the same time, however, the public has a vital interest in the fiscally sound, efficient, and ethical operation of HMO's. As is the case with insurance and hospital and medical service corporations, HMO's are "affected with the public interest." Regulatory safeguards dovetailed to the unique nature of HMO's are essential. Thus, the purpose of this model bill is twofold.

First, it attempts to provide a legal framework enabling the organization and functioning of HMO's of a wide variety including those based upon the medical care foundation or individual practice association concept. The legal environment is designed to permit a high degree of flexibility. No one form of organization or one type of modus operandi is required. Instead the HMO concept can be refined and subjected to further experimentation. Second, the model bill attempts to provide a regulatory monitoring system not only to prevent or remedy abuse, but also to assist in the future improvement and development of this alternative form of a health care delivery system.

Of course, it is also possible that the statutes of a given State are presently broad enough to allow operation of at least certain types of HMO's and provide the commissioners with appropriate authority to regulate them. In those states, a bill such as this may be desirable in order to consolidate and define more clearly the authority for and manner of regulation of an HMO. However, it may be possible to form HMO's under existing laws in some states before passage of this model legislation and it is anticipated that such programs can develop concurrently with any legislative activity.

Comment. Subsection (6) defines an HMO to be any person that undertakes to provide or arrange for at least basic health care services on a prepaid basis. This can achieved either (a) by providing the services directly through physician or other providers actually employed by the HMO and through hospitals or facilities owned or directly operated by the HMO, or (b) by contracting or arranging with physicians, hospitals or other facilities to provide such services. The term "arrange" does not contemplate those traditional arrangements which hospital or medical service corporations make in conjunction with their prepayment service plans pursuant to hospital or medical service corporation laws. If it were otherwise, the traditional hospital and medical service corporation prepayment service plan, by itself, would be an HMO.

Subsection (2) defines basic health care services. This definition, combined with the requirement that an HMO provide for basic health care services in Sections 4(2)(c) and 18(1)(c), establishes a minimum package of health care services which an HMO must provide or arrange for. This is intended to assure that the enrollees obtain at least a sufficiently broad range of services to meet a reasonable amount of their health care needs. At the same time, however, the definition should not be so broad as to be financially prohibitive to a substantial number of enrollees. Services for mental illness and alcohol and drug abuse are not included because they are often not covered by insurance or hospital or medical service plans and their inclusion would create a competitive disadvantage of HMO's. If a state believes that such services, or others, should be included as basic health care services, all carriers in the state should be required to offer or cover them.

Since no HMO may function without either a certificate of authority (see Section 3(1)) and since an HMO must furnish basic health care services (see Section 4(2)(c)), no health care services may be provided or arranged for on a prepaid basis without the minimum package of basic health care benefits. This serves two purposes: (a) it requires the provision of adequate protection and (b) it prevents the avoidance of the applicability of the Act by the mere expediency of failing to meet the minimum package requirements.

In addition, the HMO may furnish additional services, certain limited indemnity benefits and more comprehensive indemnity benefits. (See Section 5(1)(f).) These additional services and benefits can be put together in any one of a variety of ways. The indemnity or service benefits might cover such situations as out-of-area emergency services, out-of-area benefits for dependents away at college, or services which the affiliated providers lack the capacity to make available. This flexibility in piecing together the package of coverage through direct and indirect services and indemnity benefits enables an HMO type operation to meet health care needs in a wide variety of circumstances.

The definition of an HMO affords wide latitude for different arrangements. This highly flexible approach seems best suited to our diverse and pluralistic society with problems varying from locality to locality. Flexibility will allow continued innovation and experimentation with different organizational structures. It may be easier to recruit health personnel if a number of alternative approaches are available. Consistent with this philosophy is the absence of any requirement of a minimum number of employees or of a mandate as to whether or not the HMO should be a profit or non-profit organization. Permitting both profit and non-profit organizations will broaden the financial and managerial resources which can be drawn upon in developing the HMO concept.

Subsection (9) defines uncovered expenditures for use in Section 13. These are expenditures for health care services for which the HMO is at risk. They will vary in type and amount, depending on the arrangements of the HMO. They may include out-of-area services, referral services and hospital services. They do not include expenditures for services when a provider has agreed not to bill the enrollee even though the provider is not paid by the HMO, or for services that are guaranteed, insured or assumed by a person or organization other than the health maintenance organization.

(k) A description of the complaint procedures to be utilized as required under Section 11;

(l) A description of the procedures and programs to be implemented to meet the quality of health care requirements in Section 4(1)(b);

(m) A description of the mechanism by which enrollees will be afforded an opportunity to participate in matters of policy and operation under Section 6(2);

(n) Such other information as the commissioner (director, superintendent) may require to make the determinations required in Section 4.

(4) (a) An applicant or a health maintenance organization holding a certificate of authority granted hereunder shall, unless otherwise provided for in this Act, file a notice describing any material modification of the operation set out in the information required by Subsection (3). Such notice shall be filed with the commissioner (director, superintendent) prior to the modification. If the commissioner (director, superintendent) does not disapprove within (insert number) days of filing, such modification shall be deemed approved.

(b) The commissioner (director, superintendent) may promulgate rules and regulations exempting from the filing requirements of Paragraph (a) those items he deems unnecessary;

(5) An applicant or a health maintenance organization holding a certificate of authority granted hereunder shall file all contracts of reinsurance. Any agreement between the organization and an insurer shall be subject to the laws of this state regarding reinsurance. All reinsurance agreements and any modifications thereto must be filed and approved. Reinsurance agreements shall remain in full force and effect for at least ninety (90) days following written notice by registered mail of cancellation by either party to the commissioner (director, superintendent).

Comment. Section 3 requires the licensing of an HMO in order to provide health care services on a prepaid basis. The legal entity, in which the responsibilities imposed by this Act are vested, serves as the focus of regulatory attention to assure that the consuming public is well served.

Subsection (1) is intended to provide a general override to existing state laws which restrict or prevent the formation or operation of health maintenance organizations. Among other restrictions, existing state laws may:

(1) require approval of a health maintenance organization by a medical society;

(2) require that physicians constitute all or a majority of the governing body of a health maintenance organization;

(3) require that all physicians or a percentage of physicians in the local medical society be permitted to participate in rendering the services of the organization;

(4) require that such organization submit to regulation as an insurer of health care services;

(5) require that only unincorporated individuals or associations or partnerships may provide health care services;

(6) prohibit advertising by a professional group for recruitment of enrollees.

In addition to the general override provided in Subsection (1), Section 25 specifically provides that the insurance law, the hospital and medical service corporation law and certain other provisions do not apply to HMO's. Furthermore, Section 6 specifically provides that any persons, whether or not providers of health care services, may serve on the governing body. There is no statutory requirement as to the appropriate composition of the membership of the governing body.

(c) The health maintenance organization will effectively provide or arrange for the provision of basic health care services on a prepaid basis, through insurance or otherwise, except to the extent of reasonable requirements for co-payments;

(d) The health maintenance organization is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner (director, superintendent) may consider:

(i) The financial soundness of the arrangements for health care services and the schedule of charges used in connection therewith;

(ii) The adequacy of working capital;

(iii) Any agreement with an insurer, a (hospital or medical service corporation), a government, or any other organization for insuring the payment of the cost of health care services or the provision for automatic applicability of an alternative coverage in the event of discontinuance of the health maintenance organization;

(iv) Any agreement with providers for the provision of health care services; and

(v) Any deposit of cash or securities submitted in accordance with Section 13.

(e) The enrollees will be afforded an opportunity to participate in matters of policy and operation pursuant to Section 6;

(f) Nothing in the proposed method of operation, as shown by the information submitted pursuant to Section 3 or by independent investigation, is contrary to the public interest; and

(g) Any deficiencies identified by the (commissioner of public health) have been corrected.

(3) A certificate of authority shall be denied only after compliance with the requirements of Section 21.

Comment. A health maintenance organization combines several characteristics of an insurance operation (including the need for financial responsibility, the assumption of risk and similarity in marketing activities) with the characteristics of a health care delivery system. Section 4 provides for the authorization and regulation of health maintenance organizations to be carried out through existing state agencies. The creation of a new agency specifically for health maintenance organizations would unnecessarily duplicate existing functions in the state insurance and health departments. It is felt that the expertise of the state insurance department on fiscal and other regulatory matters and the familiarity of the state health department with regard to health matters should both be utilized in the regulation of health maintenance organizations. To minimize administrative problems, the prime responsibility for administration is vested in one agency—the insurance department. However, to the extent possible, the responsibilities of the two agencies are clearly defined with the insurance commissioner obligated to rely on the health department with respect to the latter's sphere of expertise.

Subsection (1)(b) empowers the commissioner of public health to establish and apply standards of quality concerning health care. Among the arguments raised against quality control are: (1) they may limit the number of HMO's which will get started, (2) quality assurance procedures will prove to be expensive and (3) such controls will engender opposition from certain providers. On the other hand, existing methods for quality control are said to be fragmented and inadequate. If the states are to authorize and encourage HMO's by this legislation, they have an obligation to assure that the health care services provided are of reasonable quality. This is particularly true because of the built-in incentive for an HMO to restrict the utilization of services due to the incentives to stay within a fixed budget.

(2) (a) A health maintenance organization shall file notice, with adequate supporting information, with the commissioner (director, superintendent) prior to the exercise of any power granted in Subsections (1)(a), (b) or (d). The commissioner (director, superintendent) shall disapprove such exercise of power only if in his opinion it would substantially and adversely affect the financial soundness of the health maintenance organization and endanger its ability to meet its obligations. If the commissioner (director, superintendent) does not disapprove within (insert number) days of the filing, it shall be deemed approved.

(b) The commissioner (director, superintendent) may promulgate rules and regulations exempting from the filing requirement of Paragraph (a) those activities having a de minimis effect.

Comment: The exercise of authority granted in Subsections (1)(a), (1)(b) and (1)(d) shall be subject to disapproval by the commissioner within (insert number) days of a filing by a health maintenance organization. The commissioner may promulgate rules and regulations exempting certain contracts from the filing requirement where exercise of the authority granted in the section would have little or no effect on the financial condition and ability to meet obligations of the organization.

Section 6. Governing Body.

(1) The governing body of any health maintenance organization may include providers, or other individuals, or both.

(2) Such governing body shall establish a mechanism to afford the enrollees an opportunity to participate in matters of policy and operation through the establishment of advisory panels, by the use of advisory referenda on major policy decisions, or through the use of other mechanisms.

Comment: While Section 3(1) should adequately override restrictive laws related to membership of a governing body, Section 6(1) makes explicit the permissible membership of such a group. The model bill does not, however, require that a health maintenance organization be consumer controlled. It is expected that HMO's controlled in a variety of ways will be organized. Where organizations are not consumer controlled, it is believed that some means for enrollee participation should be provided. For example, such matters as availability, accessibility and continuity of health care services are factors which directly confront the consumers and in which they have a particular interest. The disclosure of information under other sections is also designed to assist the consumers.

Arguments against a role for the consumer include: (1) such participation is unnecessary and perhaps even harmful to the efficient and professional delivery of health care services, (2) a consumer role will impede the initiation of an HMO since more people must be involved and (3) consumers can always seek alternative health care. The arguments for a consumer role seem more persuasive. These include (1) consumer participation results in a more responsive organization, and (2) consumer participation is not the same as lay control over the rendering of professional service.

Section 7. Fiduciary Responsibilities.

(1) Any director, officer, employee or partner of a health maintenance organization who receives, collects, disburses, or invests funds in connection with the activities of such organization shall be responsible for such funds in a fiduciary relationship to the organization.

(2) A health maintenance organization shall maintain in force a fidelity bond on employees and officers in an amount not less than $100,000 or such other sum as may be prescribed by the commissioner (director, superintendent). All such bonds shall be written with at least a one-year discovery period and if written with less than a three-year discovery period shall contain a provision that no cancellation or termination of the bond, whether by or at the request of the insured or by the underwriter, shall take effect prior to the expiration of 90 days after written notice of such cancellation or termination has been filed with the commissioner (director, superintendent) unless an earlier date of such cancellation or termination is approved by the commissioner (director, superintendent).

(b) Such charges may be established in accordance with actuarial principles for various categories of enrollees, provided that charges applicable to an enrollee shall not be individually determined based on the status of his health. However, the charges shall not be excessive, inadequate, or unfairly discriminatory. A certification, by a qualified actuary or other qualified person acceptable to the commissioner (director, superintendent), to the appropriateness of the use of the charges, based on reasonable assumptions, shall accompany the filing along with adequate supporting information.

(3) The commissioner (director, superintendent) shall within a reasonable period, approve any form if the requirements of Subsection (1) are met and any schedule of charges if the requirements of Subsection (2) are met. It shall be unlawful to issue such form or to use such schedule or charges until approved. If the commissioner (director, superintendent) disapproves such filing, he shall notify the filer. In the notice, the commissioner (director, superintendent) shall specify the reasons for his disapproval. A hearing will be granted within (insert number) days after a request in writing by the person filing. If the commissioner (director, superintendent) does not approve any form or schedule of charges within (insert number) days of the filing of such forms or charges, they shall be deemed approved.

(4) The commissioner (director, superintendent) may require the submission of whatever relevant information he deems necessary in determining whether to approve or disapprove a filing made pursuant to this Section.

Comment: Subsection (1)(a) requires that every enrollee be provided with evidence of coverage and allocates the responsibility for providing that evidence. Paragraph (c) establishes requirements which such evidence of coverage must meet. The group contracts to be filed pursuant to Section 3(3)(f) are not subject to the standards and filing requirements of Section 8, since such group contracts are not issued to enrollees. Paragraph (d) clarifies the relationship between filing requirements under this Section and under the state insurance or hospital or medical service corporation law. Filing is required under Paragraph (b) unless the form is already subject to filing requirements under existing state law. However, where existing state law does not apply standards as strict as those contained in Paragraph (c), such standards are, in effect, read into the existing law. Where the filing under state insurance or medical or hospital service corporation law is required to meet standards as strict as those in Paragraph (c), the former would be applicable. A state may want Paragraph (d) to be revised to make specific reference to existing state laws.

Subsection (2)(a) provides for the filing of charges for health care services, i.e., that part of the benefit package which is provided in the form of service vis-a-vis indemnity or service benefits. Those parts of the package providing benefits under agreement with an insurance company or hospital or medical service corporation will be subject to regulation in accordance with existing laws.

Paragraph (b) neither requires nor prohibits community rating. Reasonable underwriting classifications are permitted for the purpose of establishing the charges. Different charges may be imposed on different groups of enrollees. Such a rigid requirement as community rating would appear to be inappropriate when the competing financing mechanisms are not subject to such a constraint. The competitive disadvantage which such requirement might impose could impede the development of HMO's.

Because of its somewhat different nature, an HMO is not required by this Act to meet reserve requirements similar to those imposed on insurance companies. Thus it is important that the charges be set at an adequate level. The requirement for certification by an actuary or other qualified person along with supporting information is intended to assist the commissioner in determining adequacy. In applying the standard of excessive, inadequate, or unfairly discriminatory, it is contemplated that the commissioner may consider the amount necessary to assure a reasonable return on the initial and subsequent capital invested and an amount needed to accumulate adequate funds to stabilize the level of charges against fluctuation due to inflation, changes in medical technology and related causes.

Comment: Every health maintenance organization is required to establish a complaint system to provide reasonable procedures for the disposition of complaints. The organizations may be expected to receive two types of complaints. One type is related to the basic health care services or additional services furnished by it. The other type is related to that portion of the coverage in addition to basic health care services which is provided by insurance, hospital or medical service corporations, or some means other than being furnished by the organization. For complaints arising from health care services, the administrative procedure to handle complaints should provide the mechanism through which enrollees receive a fair and proper opportunity to have their cases heard, including the use of binding arbitration as a means of resolving claims concerning coverage. For complaints regarding benefits over which the health maintenance organization has no direct control such as those portions of the benefit package which are covered by insurance, the health maintenance organization is responsible only for maintaining statistical information and transmitting the complaints to the persons responsible.

In establishing the format for records and reports pursuant to this Section, the commissioner may want to require disclosure similar to that provided for under the NAIC Model Unfair Trade Practices Act. Section 4(10) of that Act requires, among other data, a record of total number of complaints since the last examination, the nature of each complaint, the disposition of the complaint, and the time it took to process each complaint. (See 1972 NAIC Proceedings I 443).

Section 12. Investments.

With the exception of investments made in accordance with Section 5(1)(a) and (b) and Section 5(2), the funds of a health maintenance organization shall be invested only in securities or other investments permitted by the laws of this State for the investment of assets constituting the legal reserves of life insurance companies or such other securities or investments as the commissioner (director, superintendent) may permit.

Comment: Life and health insurers are subject to statutory investment requirements designed to assure conservatism and liquidity in the handling of the insurer's funds. Sound financial management is an important element in the variable operation of an HMO. Furthermore, it is contrary to the intent of this bill to foster conditions which would enable an HMO to be used as a "front" for a speculative investment operation. At the same time, however, it is recognized that for an HMO to fulfill its expected functions, it may be both desirable and necessary for the HMO to invest a portion of its capital funds in facilities and services to better enable it to meet its obligations. Such investments may not conform to the traditional insurance law investment limitations. Consequently, this section excepts this type of investment when approved by the commissioner in accordance with the standards set out in Section 5(2).

Section 13. Protection Against Insolvency.

(1) Unless otherwise provided below, each health maintenance organization shall deposit with the commissioner (director, superintendent) or with any organization or trustee acceptable to him through which a custodial or controlled account is utilized, cash, securities, or any combination of these or other measures that is acceptable to him in the amount set forth in this section.

(2) The amount for an organization that is beginning operation shall be the greater of: (a) five percent (5%) of its estimated expenditures for health care services for its first year of operation, (b) twice its estimated average monthly uncovered expenditures for its first year of operation or (c) $100,000.

At the beginning of each succeeding year, unless not applicable, the organization shall deposit with the commissioner (director, superintendent) or organization or trustee, cash, securities, or any combination of these or other measures acceptable to the commissioner (director, superintendent), in an amount equal to four percent (4%) of its estimated annual uncovered expenditures for that year.

(3) Unless not applicable, an organization that is in operation on the effective date of this section shall make a deposit equal to the larger of: (a) one percent (1%) of the preceding 12 months uncovered expenditures, or (b) $100,000 on the first day of the fiscal year beginning six (6) months or more after the effective date of this section.

Comment. Even though very serious problems can arise if a health maintenance organization defaults on its contracts, fiscal control of health maintenance organizations in a manner comparable to that applied to insurance companies appears inappropriate in view of the service nature of such organizations. The best protection for enrollees is a financially sound organization that generates net income. However, beginning health maintenance organizations are often small businesses with limited financial resources that will sustain operating losses in their early years. Unreasonably high starting capital or reserve requirements may prevent some organization from starting or may unreasonably tie up the capital of those that do. Therefore, this Section provides for a structured but flexible approach to protecting against insolvency. It requires the maintenance of a minimum capital account, a deposit of cash or securities in a minimum account, and the organization's generation of additional amounts annually as a source of funds to meet its contractual obligations to the enrollees in the event of insolvency. The commissioner may waive all or part of these requirements when satisfied that the organization has sufficient net worth or an adequate history of generating net income to assure its viability. The requirements may also be waived if the health maintenance organization's performance is guaranteed by another financially strong organization.

The section relates the deposit requirements to the amount of the health maintenance organization's uncovered expenditures. This amount will vary depending upon the type of organization and the nature of its arrangements with providers. For example, the physicians of the staff of the organization or a contracting medical group or individual practice association may agree to look only to the organization for payment of services provided to the organization's enrollees and agree not to bill them in the event of insolvency.* An organization could have insurance for all or part of its hospitalization expense or another organization could agree to guarantee that the liabilities of the health maintenance organization are met.

In all such cases, it is recommended that the contractual provision require the provider or guarantor to notify the commissioner if the provision or insurance is modified or no longer in effect or if payment on the contract or policy has not been made in a reasonable period of time. (Section 3(5) requires prior notification of cancellation of any reinsurance.) This can provide an early warning of possible adverse changes in the health maintenance organization's financial position. In addition, the status of such provisions or policies should be covered in annual interrogatories to the organization.

The requirement in Subsection (8) for a capital account only applies to organizations licensed after the effective date of the subsection. Thus, the capital account requirement would have to be taken into consideration by persons starting a new HMO. If a state wishes to apply the requirement to existing HMO's, it should allow for an appropriate phase-in period.

It is believed that these provisions and the related provisions of Section 4(2)(d), including possible insurance backup arrangements, provide adequate assurances. The failure to provide assurances as required would subject the health maintenance organization to suspension or revocation of its certificate of authority under Section 18.

Section 14. Prohibited Practices.

(1) No health maintenance organization, or representative thereof, may cause or knowingly permit the use of advertising which is untrue or misleading, solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For purposes of this act:

(a) A statement or item of information shall be deemed to be untrue if it does not conform to fact in any respect which is or may be significant to an enrollee of, or person considering enrollment with a health maintenance organization;

*A Provision to accomplish this might read:

(2) The commissioner (director, superintendent) may by rule exempt certain classes of persons from the requirement of obtaining a license:

(a) If the functions they perform do not require special competence, trustworthiness or the regulatory surveillance made possible by licensing; or

(b) If other existing safeguards make regulation unnecessary.

Section 16. Powers of Insurers and (Hospital and Medical Service Corporations).

(1) An insurance company licensed in this state, or a (hospital or medical service corporation) authorized to do business in this State, may either directly or through a subsidiary or affiliate organize and operate a health maintenance organization under the provisions of this act. Notwithstanding any other law which may be inconsistent herewith, any two or more such insurance companies, (hospitals or medical service corporations), or subsidiaries or affiliates thereof, may jointly organize and operate a health maintenance organization. The business of insurance is deemed to include the providing of health care by a health maintenance organization owned or operated by an insurer or a subsidiary thereof.

(2) Notwithstanding any provision of insurance and (hospital or medical service corporation) laws (citations), an insurer or a (hospital or medical service corporation) may contract with a health maintenance organization to provide insurance or similar protection against the cost of care provided through health maintenance organizations and to provide coverage in the event of the failure of the health maintenance organization to meet its obligations.

The enrollees of a health maintenance organization constitute a permissible group under such laws. Among other things, under such contracts, the insurer or (hospital or medical service corporation) may make benefit payments to health maintenance organizations for health care services rendered by providers.

Comment: Subsection (2) overrides the group laws to permit an insurer or a hospital or medical service corporation to provide coverage protecting enrollees of an HMO. This authority is intended to permit insurers and the service corporations to write coverage (1) to fill the gaps which the providers of health care services do not provide, (2) to provide coverage in excess of the services provided, (3) to cover catastrophe situations, (4) to provide protection to the enrollees in the event the HMO becomes insolvent, and (5) to provide coverage against the cost of health care services as the health maintenance organization deems necessary. This section might also be redrafted to make specific reference to the relevant Section of existing law.

Section 17. Examination.

(1) The commissioner (director, superintendent) may make an examination of the affairs of any health maintenance organization and providers with whom such organization has contracts, agreements, or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this State but not less frequently than once every three years.

(2) The (commissioner of public health) may make an examination concerning the quality of health care service of any health maintenance organization and providers with whom such organization has contracts, agreements, or other arrangements as often as is reasonably necessary for the protection of the interests of the people of this State but not less frequently than once every three years.

(3) Every health maintenance organization and provider shall submit its relevant books and records for such examinations and in every way facilitate them. For the purpose of examinations, the commissioner (director, superintendent) and the (commissioner of public health) may administer oaths to, and examine the officers and agents of the health maintenance organization and the principals of such providers concerning their business.

(2) A certificate of authority shall be suspended or revoked only after compliance with the requirements of Section 21.

(3) When the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of such suspension, enroll any additional enrollees except newborn children or other newly acquired dependents of existing enrollees, and shall not engage in any advertising or solicitation whatsoever.

(4) When the certificate of authority of a health maintenance organization is revoked, such organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs, and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of such organization. It shall engage in no further advertising or solicitation whatsoever. The commissioner (director, superintendent) may, by written order, permit such further operation of the organization as he may find to be in the best interest of enrollees, to the end that enrollees will be afforded the greatest practical opportunity to obtain continuing health care coverage.

Section 19. Rehabilitation, Liquidation, or Conservation of a Health Maintenance Organization.

(1) Any rehabilitation, liquidation or conservation of a health maintenance organization shall be deemed to be the rehabilitation, liquidation, or conservation of an insurance company and shall be conducted under the supervision of the commissioner (director, superintendent) pursuant to the law governing the rehabilitation, liquidation, or conservation of insurance companies. The commissioner (director, superintendent) may apply for an order directing him to rehabilitate, liquidate, or conserve a health maintenance organization upon any one or more grounds set out in (cite sections of state rehabilitation law), or when in his opinion the continued operation of the health maintenance organization would be hazardous either to the enrollees or to the people of this state. Enrollees shall have the same priority in the event of liquidation or rehabilitation as the law provides to policyholders of an insurer.

(2) A claim by a health care provider for an uncovered expenditure has the same priority as an enrollee, provided such provider of services agrees not to assert such claim against any enrollee of the health maintenance organization.

Comment. Section 19 provides for the rehabilitation, liquidation, or conservation of health maintenance organizations to be carried out by the Commissioner under state laws applicable to insurance companies. Inasmuch as all states have existing authority, it is felt that the use of such statutes would be appropriate and would avoid the necessity of developing new administrative procedures applicable only to health maintenance organizations. Subsection (2) is designed to provide the maximum protection for enrollees by paying those providers that can bill the enrollee before those that have agreed not to. However, in order to obtain this priority, the provider must agree that the payment fully discharges the obligation of the enrollee. Incidentally, the NAIC has recommended the adoption of a model liquidation and rehabilitation act (See 1968 NAIC Proceedings I 214).

Section 20. Regulations.

The commissioner (director, superintendent) may, after notice and hearing, promulgate reasonable rules and regulations, as are necessary or proper to carry out the provisions of this Act. Such rules and regulations shall be subject to review in accordance with (insert section number providing for review of administrative orders).

Section 21. Administrative Procedures.

(1) When the commissioner (director, superintendent) has cause to believe that grounds for the denial of an application for a certificate of authority exist, or that grounds for the suspension or revocation of a certificate of authority exist, he shall notify the health maintenance organization and the (commissioner of public health) in writing specifically stating the grounds for denial, suspension, or revocation and fixing a time of at least (insert number) days thereafter for a hearing on the matter.

Section 23. Penalties and Enforcement.

(1) The commissioner (director, superintendent) may, in lieu of suspension or revocation of a certificate of authority under Section 18, levy an administrative penalty in an amount not less than (insert amount) dollars nor more than (insert amount) dollars, if reasonable notice in writing is given of the intent to levy the penalty and the health maintenance organization has a reasonable time within which to remedy the defect in its operations which gave rise to the penalty citation. The commissioner (director, superintendent) may augment this penalty by an amount equal to the sum that he calculates to be the damages suffered by enrollees or other members of the public.

(2) (a) If the commissioner (director, superintendent) or the (commissioner of public health) shall for any reason have cause to believe that any violation of this act has occurred or is threatened, the commissioner (director, superintendent) or (commissioner of public health) may give notice to the health maintenance organization and to the representatives, or other persons who appear to be involved in such suspected violation, to arrange a conference with the alleged violators or their authorized representatives for the purpose of attempting to ascertain the facts relating to such suspected violation, and, in the event it appears that any violation has occurred or is threatened, to arrive at an adequate and effective means of correcting or preventing such violation.

(b) Proceedings under this subsection shall not be governed by any formal procedural requirements, and may be conducted in such manner as the commissioner (director, superintendent) or the (commissioner of public health) may deem appropriate under the circumstances. However, unless consented to by the health maintenance organization, no rule or order may result from a conference until the requirements of this section or Section 21 of this act are satisfied.

(3) (a) The commissioner (director, superintendent) may issue an order directing a health maintenance organization or a representative of a health maintenance organization to cease and desist from engaging in any act or practice in violation of the provisions of this act.

(b) Within (insert number) of days after service of the cease and desist order, the respondent may request a hearing on the question of whether acts or practices in violation of this Act have occurred. Such hearings shall be conducted pursuant to (cite Sections of State Administrative Procedure Act), and judicial review shall be available as provided by (cite sections of State Administrative Procedure Act).

(4) In the case of any violation of the provisions of this act, if the commissioner (director, superintendent) elects not to issue a cease and desist order, or in the event of noncompliance with a cease and desist order issued pursuant to Subsection [illegible] commissioner (director, superintendent) may institute a proceeding to obtain injunctive or other appropriate relief in the (name of court of primary jurisdiction for actions of this nature).

Comment: Sections 23(3) and 23(4) authorize the commissioner to issue a cease and desist order and to apply for injunctive relief. When the commissioner is not granted such statutory powers, the language should be modified to provide for the legal steps to be taken by the attorney general or other appropriate state official.

Section 24. Statutory Construction and Relationship to Other Laws.

(1) Except as otherwise provided in this act, provisions of the insurance law and provisions of (hospital or medical service corporation) laws shall not be applicable to any health maintenance organization granted a certificate of authority under this act. This provision shall not apply to an insurer or (hospital or medical service corporation) licensed and regulated pursuant to the insurance law or the (hospital or medical service corporation) laws of this State except with respect to its health maintenance organization activities authorized and regulated pursuant to this act.

Section 29. Dual Choice.

Each employer, public or private, in this state which offers its employees a health benefit plan and employs not less than twenty-five employees, and each employee benefit fund in this state which offers its members any form of health benefit, shall make available to and inform its employees or members of the option to enroll in at least one health maintenance organization holding a valid certificate of authority which provides health care services in the geographic areas in which a substantial number of such employees or members reside. Where there is a prevailing collective bargaining agreement, the selection of the health maintenance organization(s) to be made available to the employees shall be made under the agreement.

No employer in this state shall be required to pay more for health benefits as a result of the application of this section than would otherwise be required by any prevailing collective bargaining agreement or other contract for the provision of health benefits to its employees, provided that the employer or benefits fund shall pay to the health maintenance organization chosen by each employee or member an amount equal to the lesser of (a) the amount paid on behalf of its other employees or members for health benefits or (b) the health maintenance organization's charge for coverage approved by the commissioner (director, superintendent) pursuant to Section 8 of this act.

Comment: This Section is similar to Section 1310 of the federal HMO Act, but extends the dual choice requirement to state licensed HMO's. The licensing requirements of this act are less stringent than the federal requirements, so this provision will assist in the development and growth of state licensed HMO's.

Section 30. Severability.

If any section, term, or provision of this act shall be adjudged invalid for any reason, such judgment shall not affect, impair, or invalidate any other section, term, or provision of this act, but the remaining sections, terms and provisions shall be and remain in full force and effect.

Legislative History (all references are to the Proceedings of the NAIC)

1973 Proc. I 9, 11, 141, 192, 202-222 (adopted).
1973 Proc. II 139 (synopsis of model).
1974 Proc. I 12, 14, 405, 413 (amended).
1982 Proc. I 19, 28, 431, 498-499, 530-554 (revised and reprinted).

MODEL HEALTH MAINTENANCE ORGANIZATION ACT

The date in parentheses is the effective date of the legislation or regulation, with latest amendments.

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Alabama	ALA. CODE §§ 27-21A-1 TO 27-21A-32 (1986).	
Alaska	NO ACTION TO DATE	
Arizona		ARIZ. REV. STAT. ANN. §§ 20-1051 to 20-1069 (1973/1985) "Health Care Service Organizations".
Arkansas	ARK. STAT. ANN. §§ 66-5201 to 66-5228 (1975/1987).	
California		CAL. HEALTH & SAFETY CODE §§ 134 to 1399.64 (1979/1986) ("Knox-Keene Health Care Services Plan").
Colorado	COLO. REV. STAT. §§ 10-17-101 to 10-17-115 (1963/1986).	
Connecticut		CONN. GEN. STAT. §§ 33-179a to 33-179t (1971/1987) "Health Care Centers".
Delaware	HB 99 Model pending (1987).	DEL. CODE ANN. tit. 16 §§ 9101 to 9118 (1982). See also tit. 18 §§ 6401 to 6406 (1987).
D.C.	NO ACTION TO DATE	
Florida		FLA. STAT. §§ 641.17 to 641.33 (1985/1987).
Georgia	GA. CODE ANN. §§ 33-21-1 to 33-22-28 (1979/1986).	
Guam	NO ACTION TO DATE	
Hawaii	NO ACTION TO DATE	
Idaho		IDAHO CODE §§ 41-3501 to 41-3934 (1974/1985).

MODEL HEALTH MAINTENANCE ORGANIZATION ACT

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Illinois	ILL. REV. STAT. ch. 111 1/2 §§ 1401 to 1417 (1974/1987).	
Indiana		IND. CODE §§ 27-8-7-1 to 27-8-7-18 (1979/1987) ("Proposed Health Care Delivery Plans").
Iowa	IOWA CODE §§ 514B.1 to 514B.32 (1973).	
Kansas	KAN. STAT. ANN. §§ 40-3201 to 40-3227 (1974/1987).	
Kentucky		KY. REV. STAT. §§ 304.38-010 to 304.38-210 (1982/1986);
Louisiana	LA. REV. STAT. ANN §§ 22:2001 to 22:2025 (1986).	
Maine	ME. REV. STAT. ANN. tit. 24-A §§ 4201 to 4226 (1975/1986).	
Maryland		MD. ANN. CODE art 19 §§ 701 to 734 (1982/1987).
Massachusetts		MASS. GEN LAWS ch. 176G §§ 1 to 17 (1976/1986).
Michigan		MICH. COMP. LAWS. §§ 333.21001 to 333.21098 (1982/1986).
Minnesota	MINN. STAT. §§ 62D.01 to 62D.30 (1973/1986).	
Mississippi	MISS. CODE ANN. § 41-7-401 et seq. (1986).	
Missouri	MO. REV. STAT. §§ 354.400 to 354.550 (1983).	
Montana	MONT. CODE ANN. §§ 33-31-101 to 33-31-405 (1987).	

MODEL HEALTH MAINTENANCE ORGANIZATION ACT

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
Nebraska	NEB. REV. STAT §§ 44-3201 to 44-3291 (1978/1985).	
Nevada		NEV. REV. STAT. §§ 695C.010 to 695C.350 (1973/1987).
New Hampshire		N.H. REV. STAT. ANN. §§ 420-B:1 to 420-B:22 (1977/1985).
New Jersey	N.J. REV. STAT. §§ 26:2J-1 to 26:2J-30 (1973).	
New Mexico	N.M. STAT. ANN. §§ 59A-46-1 to 59A-46-31 (1985/1986).	
New York		N.Y. PUB. HEALTH LAW §§ 4400 to 4413 (1976).
North Carolina	N.C. GEN. STAT. §§ 57B-1 to 57B-25 (1979).	
North Dakota	N.D. CENT. CODE §§ 26.1-18-01 to 26.1-18-35 (1983).	
Ohio	OHIO REV. CODE ANN. §§ 1742.01 to 1742.36 (1976).	
Oklahoma		OKLA. STAT. tit. 63 §§ 2501 to 2510 (1975).
Oregon		OR. REV. STAT. §§ 750.003 to 750.075 (1985).
Pennsylvania		PA. STAT. ANN. tit. 40 §§ 83-101 to 83-119 (1981).
Puerto Rico		P.R. LAWS ANN. tit. 26 §§ 1901 to 1927
Rhode Island	R.I. GEN. LAWS §§ 27-41-1 to 27-41-29 (1983/1987).	

MODEL HEALTH MAINTENANCE ORGANIZATION ACT

NAIC MEMBER	MODEL/SIMILAR LEGIS.	RELATED LEGIS./REGS.
South Carolina	S.C. CODE ANN. §§ 38-25-10 et seq. (1987).	
South Dakota		S.D CODIFIED LAWS ANN. §§58-41-1 to 58-41-97 (1974).
Tennessee	TENN. CODE ANN. §§ 56-32-201 to 56-32-225 (1986/1987).	
Texas	TEX. INS. CODE ANN. art. 20A.01 to 20A.35 (1975/1987).	
Utah		UTAH CODE ANN. §§ 31A-8-101 to 31A-8-406 (1986/1987).
Vermont	VT. STAT. ANN. tit. 8 §§ 5101 to 5113 (1979) (Most of model.)	
Virgin Islands	NO ACTION TO DATE	
Virginia	VA. CODE §§ 38.2-4300 to 38.2-4321 (1986).	
Washington		WASH. REV. CODE ANN. §§ 48.46.010 to 48.46.920 (1975/1986) (Parts of model).
West Virginia	W.VA. CODE §§ 33-25A-1 to 33-25A-28 (1977).	
Wisconsin		See WIS. STAT. § 628-36 (2m) providing that Commissioner may make rules for HMOs. See also ch. 609 (1985) on joint ventures.
Wyoming	WYO. STAT. §§ 26-34-101 to 25-34-128 (1986).	

HMO Dominance Seen In '90s

National Health Care Expected In Next Century

BY RICHARD DONAHUE

CHICAGO—Health maintenance organizations will become the dominant financier of private health care in the U.S. before year 2000, a business-forecasting consultant predicts.

Sometime after that, the nation will adopt a Canadian-like national health insurance system, according to Roy Amara, president of the Institute of the Future, Menlo Park, Calif.

Mr. Amara sees an increased use of HMOs in the 1990s as a way to check rapidly increasing health costs. "I mean use of the real HMOs," he said, "the kind that puts the health-care providers at financial risk, the kind that employs salaried physicians and the kind that puts emphasis on wellness and preventive care."

Preferred provider organizations and managed fee-for-service plans are not substitutes for HMOs, he told attendees at a health-care symposium sponsored by Society of Actuaries of Schaumburg, Ill. and the American Hospital Association, Chicago.

Rather, he said, they represent "palatable steps" to HMOs, which were at first a "bridge too far" for many people.

The HMO population in the U.S. will grow from the approximately 30 million persons which now use them to 60 million by 1995, and then up to 60 percent or 70 percent of all privately insured persons by the year 2000, according to Mr. Amara. (Currently, the entire privately-insured population is 170 million, according to the Health Insurance Association of America, headquartered in Washington, D.C.)

"In HMOs, patients will lose their freedom to pick their own physicians, and physicians will lose much of their clinical and economic autonomy as they watch their incomes shrink," Mr. Amara said.

He said the percentage of physicians who are salaried will increase from about eight percent in 1985 to about 35 percent in 2000.

Mr. Amara said Americans are not prepared for the dramatic changes coming in health care.

"The American public is not ready to accept rationing or restrictions in health care because health-care costs still don't bite deeply into the average household income," he said. "Only 5 percent of income goes for health expenditure now."

This will change, he said, as employers are forced to shift more of the burden of health-care cost to employees. Employers, who now pay more than 40 percent of the nation's health-care bill, will demand a bigger say in how the money is spent, he said.

Health-care costs, now at more than 11 percent of GNP, will, according to government predictions, be between 15 and 18 percent of GNP by the end of the century, he said.

Cont'd on Page 22

Dominance Of HMOs Seen By The 1990s

Cont'd from Page 21

But employers and the government—which pays about half of health-care costs—cannot tolerate such a level, he said, predicting that health costs will level off at 13.5 percent of GNP by the end of the century.

He said a national health-care system, when it comes, will be similar but not identical to the system in Canada "where government is the insurer and taxes finance the cost."

State governments and private health insurers undoubtedly will play a more significant role in a U.S. system than do the provinces and insurers under the Canadian system, he said.

A U.S. national health system will mean there will be fewer, but larger, health insurers, he said, some of which may be employed to administer the national plan. □

Medical Benefits

Volume 6, Number 15 August 15, 1989

HEALTH CARE COSTS

Marion Managed Care Digest
HMO Edition 1989

Marion Laboratories, Inc., July 1989

"For the year ended Dec. 31, 1988, 659 HMOs were in operation. Another seven were under development.'

Operating HMOs reported total enrollments up 8.7% to 33 million in 1988, compared with 1987 when 707 operating HMOs reported more than 31 million enrollees.

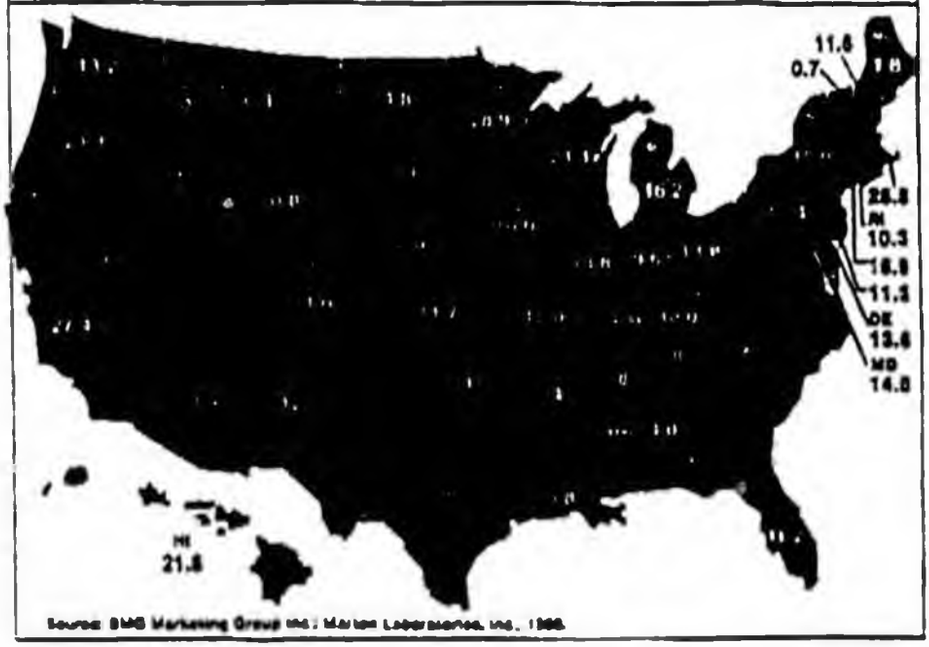
The number of operating HMOs fell 6.8% in 1988, compared with a 12% increase in 1987. An industry shakeout had been predicted for several years. The industry is likely to continue its consolidation through 1993 as the number of HMOs falls gradually each year.

HMOs are increasing their market penetration nationwide. Plans in 28 states reported enrolling 10% or more of their state's residents in 1988 (Figure 1), up from 24 states in 1987 and 20 a year earlier.

HMOs also successfully reduced the number of days that their enrollees spent in hospitals in 1988. Average annual hospital days per

Continued page 2

Figure 1. HMO market penetration (percent) by state, 1988.



Source: SMG Marketing Group Inc.; Marion Laboratories, Inc., 1989.

INSIDE

Marion Managed Care Digest
(continued from page 1)

1,000 non-Medicare members dropped to 364 from 377.2 a year earlier (Table 1).

Nearly 16% of HMOs operating at year-end 1988 offered an open-ended option, the newest and fastest growing HMO product. An open-ended plan offers enrollees the right to choose at point of service whether they want to seek care within the HMO or to go outside to the physician or hospital of their choice.

HMOs with open-ended options expected to have nearly 2 million enrollees in these plans by year-end 1989, an increase of 17.3% from year-end 1988. Enrollment in open-ended plans rose 53% to 1.6 million in 1988 from a year earlier. Enrollees in open-ended plans accounted for 4.8% of all HMO enrollees.

Non-Medicare enrollees averaged 3.7 ambulatory visits each to their HMOs in 1988, according to 167 reporting plans. HMOs averaged 3.7 physician encounters and visits per non-Medicare enrollee in 1988, according to 233 reporting plans.

The average family premium charge for all HMOs rose 11.8% in 1988 to $242.50 per month from $216.82 in 1987 (Table 1).*

*Editor's note: The source for data used in this report was SMG Marketing Group Inc. See *MB*, 2/20/89, p. 8, for a report based on the same data base.

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Table 1. Selected HMO utilization and premium averages by state, 1988.

State	Hospital days per 1,000 non-Medicare members	Physician encounters per member	Amb. visits per member	Premiums	
				Family	Individual
Alabama	380.7	3.0	4.8	$228.81	$87.14
Arizona	292.0	3.7	3.9	250.44	84.82
Arkansas	461.4	4.9	1.5	226.55	82.50
California	318.4	3.3	8.5	251.76	95.35
Colorado	275.6	3.5	2.0	228.90	84.93
Connecticut	402.8	3.9	3.1	282.40	112.96
Delaware	360.0	0.2	0.4	229.88	89.99
D.C.	382.7	2.9	3.3	236.32	89.80
Florida	385.9	3.3	2.6	220.67	83.42
Georgia	385.0	4.6	3.5	237.86	90.29
Hawaii	308.7	4.3	4.6	221.01	77.00
Idaho	212.0	—	—	227.50	93.50
Illinois	369.2	4.2	2.8	227.20	86.47
Indiana	363.9	4.5	2.9	237.21	81.68
Iowa	310.0	3.6	—	215.25	80.42
Kansas	441.0	3.3	2.1	248.80	94.79
Kentucky	370.0	—	—	236.99	85.44
Louisiana	406.0	3.7	0.2	235.46	85.66
Maine	343.3	—	—	248.33	96.67
Maryland	328.4	3.7	3.4	255.38	88.78
Massachusetts	389.1	3.5	4.2	292.27	109.89
Michigan	368.6	3.7	5.1	243.91	95.82
Minnesota	362.4	4.0	4.6	229.62	86.53
Missouri	394.3	2.8	1.4	250.50	90.45
Montana	375.0	4.4	3.1	205.00	80.00
Nebraska	329.9	2.6	—	253.75	94.50
Nevada	—	—	—	300.00	115.00
New Hampshire	384.0	4.9	3.5	281.50	100.50
New Jersey	416.2	3.0	3.7	222.79	88.52
New Mexico	365.0	3.5	—	272.27	104.66
New York	374.6	3.7	2.3	216.21	86.12
North Carolina	332.8	3.6	2.0	235.63	86.34
North Dakota	359.0	6.9	2.7	250.24	106.29
Ohio	404.2	3.6	3.2	251.35	93.46
Oklahoma	300.0	3.9	9.9	253.17	87.00
Oregon	298.1	2.6	2.3	213.16	78.93
Pennsylvania	376.5	3.5	2.4	221.64	83.59
Rhode Island	356.5	4.5	—	242.50	101.50
South Carolina	386.7	3.1	0.7	186.87	72.33
South Dakota	578.8	4.4	4.4	280.54	91.30
Tennessee	432.6	4.0	2.1	246.38	98.76
Texas	356.9	4.0	3.0	254.40	90.48
Utah	288.7	2.7	4.2	278.40	89.25
Vermont	—	—	—	206.00	82.00
Virginia	392.1	3.6	3.0	282.89	106.44
Washington	320.1	4.2	3.3	242.99	84.54
Wisconsin	383.2	4.7	3.7	253.51	96.57
Wyoming	560.0	4.0	1.7	220.00	90.00
Total U.S.	364.0	3.7	3.7	242.49	90.90

Alaska, Mississippi and West Virginia had no operating HMOs in 1988.

Source: SMG Marketing Group Inc., Marion Laboratories, Inc., 1989

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How Cost-Effective Is Your Health Plan?

Benefits, July 1989

"To determine your plan's rating, add up the points indicated for each answer, then compare your total with those illustrated on the plan evaluation chart at the end. If your plan's cost-effectiveness rating is less than 'excellent,' you should consider incorporating some cost-effective features your score shows are missing from your plan."

1. Does your plan have first-dollar coverage for hospitalization?
   - ___A) (+20) No/Do have hospital pre-certification
   - ___B) (−5) No/No hospital pre-certification
   - ___C) (−15) Yes/Do have hospital pre-certification
   - ___D) (−30) Yes/No hospital pre-certification

2. Does your plan have first-dollar coverage for medical/surgical services?
   - ___A) (+10) No/Do have pre-certification
   - ___B) (0) No/No pre-certification
   - ___C) (−5) Yes/Do have pre-certification
   - ___D) (−15) Yes/No pre-certification

3. Your group plan's major medical deductible is:
   - ___A) (+10) $300 per calendar year or more
   - ___B) (0) More than $100/less than $300 per calendar year
   - ___C) (−20) $100 per calendar year or less

4. Is your major medical deductible indexed to your company's employees' earnings?
   - ___A) (+10) Yes/Also indexed to trend increases
   - ___B) (+5) Yes
   - ___C) (0) No

5. Your major medical co-insurance out-of-pocket limit is:
   - ___A) (+10) More than $1,000 per employee per year
   - ___B) (0) More than $500/up to $1,000 per employee per year
   - ___C) (−10) $500 or less per employee per year

6. Is your major medical co-insurance limit indexed to the employees' earnings?
   - ___A) (−10) Yes/Also indexed to trend increases
   - ___B) (+5) Yes
   - ___C) (0) No

7. Does your plan include a large claims management review/assistance service?
   - ___A) (+15) Yes/Also includes psychiatric claim review
   - ___B) (+10) Yes
   - ___C) (−10) No

8. Does your plan include a limit, or a review service, for chiropractic and/or podiatric care?
   - ___A) (+5) Yes/Chiropractic and podiatric care review
   - ___B) (0) Yes/Chiropractic or podiatric care review
   - ___C) (−5) No

9. Does your plan include a hospital bill audit service?
   - ___A) (+5) Yes
   - ___B) (−5) No

10. Does your plan have a pre-existing conditions limitation for new hires?
    - ___A) (+10) Yes
    - ___B) (−10) No

11. Do you require employee contributions for dependent coverage?
    - ___A) (+10) Yes/Dependents only
    - ___B) (0) No

12. Do you have an employee assistance program (EAP)?
    - ___A) (+5) Yes
    - ___B) (0) No

13. Do you provide a wellness program or incentives for a healthier lifestyle?
    - ___A) (+5) Yes
    - ___B) (0) No

14. Does your plan include a mail-order or prescription drug program?
    - ___A) (+5) Yes
    - ___B) (0) No

15. Does your plan include a preferred provider organization (PPO)?
    - ___A) (+15) Yes/PPO pays less than 100% of charges
    - ___B) (+5) Yes/PPO pays 100% of eligible charges
    - ___C) (−10) No

16. Do you provide employees with an HMO option?
    - ___A) (+15) Yes/HMO experience is integrated with primary plan's experience
    - ___B) (+5) Yes/HMO is a stand-alone service—less than 20% of employees participate
    - ___C) (−5) Yes/HMO is a stand-alone service—more than 20% of employees participate
    - ___D) (0) No

17. Do you actively police the coordination of benefits provision of your program?
    - ___A) (+10) Yes
    - ___B) (−10) No

18. Is your waiting period for new entrants long enough to avoid providing coverage during the initial 'heavy turnover' period?
    - ___A) (+5) Yes
    - ___B) (−5) No

19. Do you have an in-house COBRA compliance system or use an outside service?
    - ___A) (+10) Yes/Includes notification of new hires, qualifying event notification, monitoring of eligibility period, monthly bill processing and management
    - ___B) (0) Yes/But doesn't include all of the above
    - ___C) (−10) No

20. Do you provide retiree health coverage?
    - ___A) (+10) No
    - ___B) (−10) Yes/Contributory
    - ___C) (−15) Yes/Non-contributory

Plan evaluation

Total points	Plan rating	Anticipated rate increase
170 - 195	Excellent	0%-10%
130 - 170	Good	10%-20%
100 - 130	Fair	30%-40%
80 - 100	Poor	40%-50%
under 80	Disastrous	50% +

HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES

P.O. BOX V, JUNEAU 99811
(907) 465-3759

LETTER OF INTENT
to SB 334 (efd Am)

It is the intent of this legislation that the Department of Health and Social Services will study the "TEFRA Option" as part of the home and community based services package. A "TEFRA Option" allows the same income deeming standards that apply to an institutionalized child to apply to a similarly disabled child living at home.

Rep. Johnny Ellis, Chair

ALASKA MENTAL HEALTH BOARD

STEVE COWPER, GOVERNOR
STATE OF ALASKA

ST. ANN'S CENTER
419 6th STREET, SUITE 124
JUNEAU, ALASKA 99801
907-465-3071

February 27, 1990

Representative Johnny Ellis
Room 104, Capitol
P.O. Box "V"
Juneau, Alaska 99811

Honorable Representative Ellis,

The Alaska Mental Health Board (AMHB) expresses support for SB334, legislation dealing with options and waivers under Medicaid. At the AMHB meeting February 24-25, the Board, by unanimous vote, supported SB334.

The AMHB has discussed the purposes and benefits of SB334 with representatives of the Older Alaskans Commission, the Governor's Council for the Handicapped and gifted and the Department of Health and Social Services. The planning process enabled by the legislation can come to benefit many persons with disabilities. At the same time, Alaska may come to realize an enhancement of home and community based care, an often preferred type of care that is also less costly.

The AMHB hopes SB334 is reported favorably out of House HESS.

Sincerely,

Dennis M. Scholl, Ph.D.
Executive Director

cc. Thelma Langdon
Senator Uehling
OAC
GCH&G
DHSS

TIMELINE FOR IMPLEMENTATION OF SB 334

FY 91							FY 92		
07/01/90			09/01/90			06/01/91	07/01/91	01/15/92	05/92
OAC and CCHG hire staff	Interagency Policy Team meet--set-up work plan	OAC and CCHG start to gather information	DH&SS hire staff	All staff visit "model" states	Public conference for potential consumers and providers of Medicaid Community Care	OAC and CCHG issue report and recommend-actions		DH&SS submit cost study and recom-mendations on effect of options and waivers	Legislative input/decisions regarding options and waivers. Legislature amend AS 47.30 to add options. DH&SS begin to prepare option/ waiver applications.

FY 93					FY 94		
07/01/92	07/15	09/15	01/01/93		07/01/93	12/15/93	01/01/04
	DH&SS give copies of applications to OAC and CCHG	DH&SS apply for chosen options or waivers	Some new service options programmed in MMIS and available (tentative)	DH&SS negotiate waivers and complex options with HCFA	Waiver Approval from HCFA should be received staff hired and trained (tentative)	Waiver system programmed in MMIS; waiver (tentative)	Waiver services available (tentative)

KEY: DH&SS = Department of Health and Social Services
CCHG = Governor's Council for the Handicapped and Gifted
OAC = Older Alaskans Commission
HCFA = Federal Health Care Financial Adminsitration (Medicaid)

Prepared by: Older Alaskans Commission

4/15D1/022107-0

The Missed Opportunities of Medicaid

Chris Koyanagi

Dr. Sharfstein's Introduction: The federal-state mental health care program is a major payer for mental health care. Medicaid could finance additional community services needed by adults and children with severe mental illness, but it is both underutilized and inappropriately utilized in most states. The National Mental Health Association has published Operation Help: An Advocate's Guide to Medicaid, which provides detailed descriptions of how states have used Medicaid options to cover community mental health care and how they might better use these monies to improve planning and service delivery for the severely mentally ill. This month's column by the author of Operation Help recognizes the potential of Medicaid and the need to revise state Medicaid plans to reflect appropriate public health objectives.

Medicaid is a federal-state program that pays medical bills for certain low-income people who can't afford the costs of care. In 1987, a total of 23.2 million people received Medicaid benefits, and the program now spends more than $66.9 billion annually (1). Yet despite its size, many low-income people are not covered by Medicaid, resulting in a problem of access to health care that is becoming more and more acute. The percentage of those with incomes below the federal poverty level who have Medicaid coverage has declined from 65 percent ten years ago to less than 40 percent (2).

Medicaid is not a single program but a collection of 53 separate state and territorial programs with different target populations and various packages of services. Although the federal government prescribes basic requirements and describes options, each state and territory has its own version of the program. The federal and state governments share the cost of Medicaid expenditures, with the federal share varying from 50 percent to 78 percent, depending on the state's per capita income. Federal funds pay more than half of all Medicaid costs ($37.4 billion in 1990). States pay between 22 percent and 50 percent of costs ($29.5 billion in 1990), and in some states local governments contribute to the state share of Medicaid expenditures.

As a result of state decisions on who to cover and which services to reimburse, Medicaid spending varies widely between the states. In 1984 Medicaid per capita spending averaged $148 but ranged from $382 in New York to $52 in Wyoming (3).

Access to Medicaid is also influenced by the number of providers who are participating. For example, the Health Care Financing Administration reports that 25 percent of the nation's physicians do not now participate in Medicaid and will not take Medicaid patients (4). Reasons include low payment scales, burdensome paperwork, and long delays in receiving reimbursement.

The history of the Medicaid program explains, in part, why federal and state Medicaid policymakers have been reluctant to entertain proposals to expand mental health services. At its inception, Medicaid was viewed as providing the "deserving poor" (those who were eligible for other federal cash-assistance programs) with health care coverage similar to that provided to working people through insurance. Although the program has since been moving away from this model, it still primarily covers individuals receiving cash assistance, and it still emphasizes basic medical services.

In its early years, the costs of Medicaid rose much faster than predicted, but despite this fact major expansions were made both in eligibility (covering those who are disabled and receive Supplemental Security Income benefits) and in services (such as covering care provided in intermediate care facilities for the mentally retarded [ICF-MR]). These changes increased costs still further, ensuring that cost control, more than program expansion, would be the overriding concern of Medicaid policymakers.

Thus, although the percentage of poor people covered by Medicaid has been dropping in recent years, the costs have increased substantially, in large part because of expenditures for ICF-MR coverage and for long-term care in nursing facilities. Medicaid is now the principal payer for long-term care in this country. Fifty-seven percent of nursing home expenditures are paid by public funds, and in 1979 about 87 percent of public funding for nursing home care came from Medicaid (5).

In addition to escalating costs, in the 1970s Medicaid was also faced with a series of scandals concerning fraud and abuse that brought the program under close scrutiny.

Because of these experiences, Medicaid planners have become extremely wary of services that may be costly, uncontrollable, or subject to abuse. They are also concerned about the substantial costs expended for long-term care and about services that are less medical in nature. To Medicaid agencies, mental health services seem to fit into all these categories. And since Medicaid is run by state Medicaid agencies and not

Ms. Koyanagi is director of federal relations for the National Mental Health Association, 1021 Prince Street, Alexandria, Virginia 22314. Steven S. Sharfstein, M.D., is editor of this column.

by the state mental health authorities, state Medicaid agency views have tended to prevail as state policymakers decide on what services should be covered under Medicaid.

Ensuring the availability of an appropriate array of mental health services is further complicated by the extraordinarily complex set of rules that govern the Medicaid program. There are federal laws, regulations, and guidelines, as well as state plans, rules and regulations, and reimbursement policies. The result is considerable confusion about what Medicaid really allows, a situation that benefits Medicaid agency officials whose objective is to control and limit their program's expenditures. Since they are the only ones who know the rules, they can control the game.

A first step to improving a state Medicaid plan for the benefit of those who need mental health care is to understand who uses Medicaid mental health services and what services they most need. It is also important to consider Medicaid policies that may impact on how mental health care can be delivered (for example, institutional versus community care coverage). Then one can compare what federal Medicaid law permits with a package of appropriate community care services as described by the mental health system.

Characteristics of Medicaid mental health patients

Recent studies have found that users of Medicaid mental health services seem to fall into three broad categories (6):

- Heavy users of services (discussed more fully below).
- Episodic users who make up to six to ten visits to providers (normally outpatient visits).
- Persistent users who receive a large number of less expensive services, such as outpatient or partial hospitalization, but little inpatient care. Although they may not receive many services, they maintain ongoing contact with the system over a long period.
- Both heavy and persistent users who tend to have diagnoses of schizophrenia, affective disorders, or other long-term mental illnesses. The episodic users have a variety of diagnoses.

The heavy users are primarily young adults who use Medicaid inpatient hospital services at a disproportionately high rate. They are frequently treated in community hospitals for a short time and then released, often to be readmitted within weeks. In Philadelphia, they make repeated use of emergency services; although they constitute only 20 percent of the case load, they represent 55 percent of admissions and use 70 percent of service hours (7). These individuals are also heavy users of partial hospitalization and other day treatment services and outpatient services. In New York, 29 percent of Medicaid reimbursement for psychiatric inpatient care is for 5.1 percent of patients, and long inpatient stays (an average length of stay is 105 days) often occur because alternative community placements are not available (8).

Clearly, the services utilized by these heavy users are, for the most part, not well suited to their needs. Their special needs do not fit into the traditional brief therapy model of outpatient care, nor are they well served by expensive emergency care and general hospital inpatient care. Yet these are the only services available to many young people with mental illnesses. Because more suitable services are lacking, readmission rates are significant (7).

Similar problems are evident in child and adolescent care, where those who are Medicaid eligible have higher use of emergency mental health services (7).

Hospital inpatient bias

Another problem in providing appropriate care to the Medicaid population is the program's general bias toward inpatient care. Several factors contribute to this bias. For example, certain eligibility criteria make it easier to cover individuals when they are in institutions. Medicaid has also helped fuel the enormous growth in the last 15 years in general hospital psychiatric care and now pays $2 billion a year nationally for general hospital mental health care (6). Some states have caused a further imbalance in mental health coverage by offering unlimited inpatient care coverage but restricting access to community-based services.

Coverage of mental health services

Under federal law, certain services must be available to Medicaid-eligible individuals, and other services may be covered at the state's option. However, the special needs of persons with mental illness are not well served by Medicaid. For example, under federal law only persons age 65 and over or under age 22 are entitled to Medicaid-funded care in psychiatric hospitals. Persons with mental illnesses may obtain nursing facility services under Medicaid, but only in institutions that are not required to provide (and often do not provide) appropriate mental health care. There is no category to cover the costs of care for people with mental illnesses in small residential facilities such as halfway houses, group homes, and adult foster homes, although there is such coverage for persons with mental retardation.

In addition to specific prohibitions related to age and treatment sites, the Medicaid law presents states with another barrier to covering mental health services. Because it contains no statements about specific mandatory services for mental health care and few statements about specific optional services, there is no straightforward way for states to develop a package of adequate community-based mental health services under Medicaid. The most explicit statements in the law concerning mental health care are those that exclude coverage. As a result, most mental health services must be provided through other service options, such as clinic services, physician services, or rehabilitative services. Some of these service categories currently have regulatory requirements inappropriate to community mental health care.

But the picture is not nearly as bleak as this quick summary sug-

gests. While mandatory Medicaid benefits do not provide comprehensive coverage for community mental health services, combining the mandatory services with certain optional services allows a state to cover a very comprehensive package of services. Moreover, many of the restrictions facing community mental health providers are state restrictions, not federal policy, and thus are subject to change at the state level.

Once a state elects to cover a Medicaid service, it can define the exact meaning of each service within broad federal guidelines. The states, not the federal government, determine who may provide the service and under what conditions, for how long (or for how many visits) coverage is available, whether preadmission screening and other reviews of appropriateness of care are required, and the reimbursement rate that will be paid to providers for services. Under federal law, states must have a uniform benefit package for all Medicaid recipients and cannot set limits solely on the basis of diagnosis or type of illness or condition. However, states are allowed so much flexibility that they have been able, in fact, to restrict mental health care far more than care for other illnesses.

The Community Support Program of the National Institute of Mental Health has identified 12 essential services for adults with long-term mental illnesses (9). Medicaid, while it is not relevant for financing all of these various services, can provide substantial support for six of the 12—case management, rehabilitation, mental health treatment, crisis response services, health and dental care, and transportation. If a state wanted to maximize Medicaid reimbursement for community support services, it should add to the mandatory services of general hospital inpatient and outpatient care and physician services the following optional Medicaid services:

Targeted case management. This is defined by Medicaid as services that help eligible individuals gain access to needed medical, social, educational and other services, such as housing, vocational services, and financial assistance. States can target these services to certain populations, such as individuals with long-term mental illnesses.

Rehabilitation. Medicaid's definition of rehabilitation is very broad. It covers any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under state law, for maximum reduction of physical or mental disability and restoration of a recipient to the best possible functional level. Services may be provided in any setting, including the client's residence or work place. States are just beginning to use this option to cover the services of psychosocial rehabilitation and similar community day programs, where social skills training, medication management, and other supportive services are provided.

Clinic services. Traditionally, states have used the clinic services option to cover the services provided in community mental health centers. The widespread use of this option has resulted in detailed federal requirements, some of which are not conducive to good patient care. Clinic services must, for example, always be furnished in the clinic (except for services to homeless people), and mental health professionals may not provide clinic services in the client's home. The clinic services option includes both outpatient therapy visits and partial hospitalization programming.

Prescription drugs. Prescription drug coverage is now nearly universal under Medicaid, although often there are limits on the numbers of prescriptions allowed or the frequency of refills.

Personal care services. Under this option, direct patient care and services related to activities of daily living can be provided in the recipient's home. Services must be provided or supervised by a registered nurse and prescribed by a physician in accordance with the patient's plan of care. Personal care services can include assistance with grocery shopping and household services. Clients must require direct patient care services to be eligible for other services.

Care provided by other practitioners. Medicaid can cover the services of other mental health practitioners, and a number of states now cover psychologists under this option and a few also include psychiatric social workers.

Inpatient psychiatric hospital care for those age 65 and over. This option allows states to finance psychiatric hospital care for older individuals.

Similarly, for children and adolescents, Medicaid can contribute resources to many of the services identified by NIMH as essential components of a community system of care. As for adults, Medicaid can finance case management, day treatment services, early identification, assessment and intervention services, outpatient assessment and treatment, emergency and crisis management, crisis residential hospital services, intensive care services, health care, and transportation for children (9).

In addition to the services described above for adults, for children federal Medicaid law also requires states to furnish early and periodic screening and diagnostic services to identify physical or mental problems. Treatment to correct or ameliorate "any defects or chronic conditions" discovered must also be furnished (10). This provision requires a comprehensive assessment of a child's overall health, development, and nutritional status, including an assessment of mental health factors. However, screening and diagnostic assessments are not aggressively pursued. Only 3 million Medicaid-eligible children and adolescents received these exams in 1987, even though studies show that those who do receive such services have lower health care costs as a result (11).

Other important service options for children are targeted case management, rehabilitation, clinic services, prescription drugs, and services of other mental health professionals. Case management is a particularly important service for children and adolescents who normally receive services from many community agencies. The rehabilitation option can provide for family-

based in-home services and services to young people in foster care or therapeutic group homes as well as for day treatment.

State Medicaid plans should also include the one optional service targeted specifically to children in need of mental health care: inpatient psychiatric hospital services for individuals under age 22. Although this option covers only certain facilities (many residential treatment centers cannot qualify), it is an important option to have available for children who need inpatient care.

Unfortunately, it is impossible to find a single state with a Medicaid services package that provides comprehensive coverage as described above either for adults or children.

Proposed action

Mental health advocates should focus far more attention on Medicaid. After several years of control and retrenchment, Medicaid is now growing. The federal government has been expanding eligibility for low-income pregnant women and children and in the process has broken the tie between Medicaid and welfare, so that Medicaid is moving toward becoming a program of health care for all low-income people. Although the prospects for further federal expansions are not good at this time, states have also begun to expand both program eligibility options and services coverage. State mental health agencies in most states are now paying greater attention to the Medicaid system, and many states have recently expanded community mental health coverage.

Although some problems remain with federal law and regulations, most of the current barriers to providing adequate mental health coverage for Medicaid recipients stem from state policies. Changing this situation should be a high priority for those who want to improve access to appropriate mental health care for low-income people.

References

1. Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means, 1989 ed. Washington, DC, Committee on Ways and Means, US House of Representatives, 1989
2. Medicaid: a safety net riddled with holes. Congressional Quarterly 1668:566, Feb 10, 1988
3. Holahan JF, Cohen JW: Medicaid: The Trade-Off Between Cost Containment and Access to Care. Washington, DC, Urban Institute, 1986
4. Health Care Financing Administration Program Statistics: Analysis of State Medicaid Program Characteristics, 1984. HCFA pub 03204. Washington, DC, Aug 1985
5. Fox PD, Clauser SB: Trends in nursing home expenditures: implications for aging policy. Health Care Financing Review 1:65–70, fall 1980
6. Hadley T, in Medicaid Funding Issues and Strategies for Community-Based Mental Health Service System Improvement. Proceedings of a colloquium held by the Division of Education and Service System Liaison, National Institute of Mental Health, Rockville, Md, Mar 11, 1988
7. Surles R: Testimony at hearings on the federal role in providing services to the mentally ill. Washington, DC, Human Resources and Intergovernmental Relations Subcommittee, Committee on Government Operations, US House of Representatives, May 19, 1987
8. Report to New York Legislature by the Commission on Quality of Care for the Mentally Disabled. Albany, NY, 1988
9. Toward a Model Plan for a Comprehensive Community-Based Mental Health System. Rockville, Md, Division of Education and Service System Liaison, National Institute of Mental Health, 1987
10. Section 1905(a)(4)(B)), Title 19, Social Security Act. 42 US Code of Federal Regulations, 440.40(b)
11. Opportunities for Success: Cost-Effective Programs for Children, Update 1988. Report of the Select Committee on Children, Youth, and Families, US House of Representatives, Washington, DC, US Government Printing Office, 1988

1990 H&CP Institute

The 42nd Institute on Hospital and Community Psychiatry will be held October 7-11 at the Marriott City Center in Denver. James T. Barter, M.D., of Chicago is chairman of the program committee. A preliminary program will be published in the June issue.

The institute is one of two national meetings sponsored annually by the American Psychiatric Association. Last fall's institute in Boston drew almost 1,800 mental health professionals.

Senator Rick Uehling

Downtown, Elmendorf, Northeast Anchorage

Co-Chairman, Senate Finance Committee
International Trade & Tourism Committee
State Affairs Committee

MEMORANDUM

TO: Representative Johnny Ellis
Chair, House HESS Committee

FROM: Senator Rick Uehling

DATE: January 26, 1990

RE: **The Home Care Initiative,**

SB ~~344~~ 334: "An Act directing the Department of Health and Social Services to seek permission to use options and receive waivers under the Medicaid program for the cost of home or community-based services for developmentally delayed children, developmentally disabled persons, disabled adults, and older Alaskans; directing other agencies to assist in that process; and providing for an effective date."

I have asked staff to provide the following background and analysis to SB 334, which has been referred to the HESS Committee. At this time, I respectfully request that this bill be scheduled for a HESS Committee hearing as soon as possible.

Senate Bill 334 directs the Department of Health and Social Services to apply for federal approval to modify Alaska's medicaid program to allow for home care services for certain medicaid eligible Alaskans.

I know that through your work with the disabled and elderly people in this state, you understand the importance of this legislation. Thank you for your consideration.

Attachment

P.O. BOX V, JUNEAU, AK 99811 (907) 465-4821 • 3111 ST. #515, ANCHORAGE, AK 99503 (907) 561-7613

Senator Rick Uehling

Downtown, Elmendorf, Northeast Anchorage

Co-Chairman, Senate Finance Committee
International Trade & Tourism Committee
State Affairs Committee

BILL SUMMARY

SB 334

"AN ACT DIRECTING THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES ... TO SEEK ... WAIVERS UNDER THE MEDICAID PROGRAM"

This bill directs DHSS to apply for federal approval to modify Alaska's medicaid program to allow for home care in place of institutional care.

Alaska's current medicaid program does not provide home care benefits for those patients who qualify for institutional care. This program if adopted will allow Alaskans who qualify for medicaid to choose home care rather than institutional care.

Home care can provide many benefits. The federal program caps the cost of home care so that it cannot exceed the cost of institutional care. In many cases the home care alternative will save the state money. In addition, for certain patients the recovery process is more rapid when the patient is in a home environment, supported by family.

The bill works by requiring DHSS, the Older Alaskans Commission, and the Governor's Council for the Handicapped and Gifted to survey client needs and to coordinate the list of potential home care services. DHSS will then serve as the lead agency to prepare an application to the federal government to modify Alaska's medicaid program to include home care services.

Alaskans who benefit from this legislation include senior citizens, parents of disabled children, disabled adults, and Alaskans experiencing a developmental disability.

P.O. BOX V, JUNEAU, AK 99811 (907) 465-4821 • 3111 ST. #515, ANCHORAGE, AK 99503 (907) 561-7613

Senator Rick Uehling

Downtown, Elmendorf, Northeast Anchorage

Co-Chairman, Senate Finance Committee
International Trade & Tourism Committee
State Affairs Committee

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Amended: 1/25/90
Introduced: 1/8/90
Referred: Health, Education and Social Services and Finance

6-1564J

BY SEN. UEHLING, Fahrenkamp, Duncan, Sturgulewski, Faiks, Halford, Rodey, Jones, Eliason, Zharoff, Pourchot

IN THE SENATE

SENATE BILL NO. 334(efd am)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act directing the Department of Health and Social Services to seek permission to use options and receive waivers under the Medicaid program for the cost of home or community-based services for developmentally delayed children, developmentally disabled persons, disabled adults, and older Alaskans; directing other agencies to assist in that process; and providing for an effective date."

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

* Section 1. FINDINGS; INTENT. (a) The legislature finds that children and adults who are experiencing disabling conditions have individual and changing needs that can be best addressed by having available to them a mix of services, including home and community-based services and institutional care. The historical focus of the Medicaid program has been on providing services in institutional settings for adults who need outside assistance in daily living and for children who need developmental help. Therefore, some persons whose needs could be met outside of institutions have, nevertheless, become institutionalized so that they could receive services through the Medicaid program. Other persons in need have received no services until their conditions deteriorated to the point where they met the Medicaid criteria for institutionalization. Nursing facilities, hospitals, and intermediate care facilities for the mentally retarded should remain readily available for those whose needs require that kind of setting, but the availability of home and community-based services should also

be expanded so that, when possible, persons could be deinstitutionalized, avoid institutionalization, or avoid becoming at risk of institutionalization and be assisted to live on their own, with their families, or in group settings that allow semi-independent living in their own communities. Furthermore, home and community-based services can help persons whose disabling conditions might never require institutional care, but whose lives could be more comfortable and more productive if the services were provided.

(b) It is the legislature's intent in enacting this Act to require the Department of Health and Social Services to seek approval from the federal government to use some Medicaid program money to broaden the range of home and community-based services that are available for appropriate groups of developmentally delayed children, developmentally disabled persons, disabled adults, and older Alaskans, who could benefit from them, especially those who would otherwise require Medicaid program money for more costly institutionalization. The choice of which waivers and options would be applied for and which population groups should be served would be made by the department after priorities are recommended by the Governor's Council for the Handicapped and Gifted and the Older Alaskans Commission. Through budget oversight, legislative hearings, and other legislative action, the legislature would give specific budgetary authority and policy directives to the department to guide it when it applies for the options and waivers.

* Sec. 2. PRELIMINARY RESEARCH. (a) The Governor's Council for the Handicapped and Gifted and the Older Alaskans Commission shall, in consultation with other appropriate public and private agencies, conduct research, compile statistics, and prepare information and documents that would be useful to the Department of Health and Social Services in determining necessary services, optimal service delivery areas and methods, and

the appropriate groups of developmentally delayed children, developmentally disabled persons, disabled adults, and older Alaskans, for which the department may apply for home and community-based options and waivers under 42 U.S.C. 1396n and other federal laws relating to the Medicaid program.

(b) By June 1, 1991, the Governor's Council for the Handicapped and Gifted and the Older Alaskans Commission shall submit written reports to the legislature and the Department of Health and Social Services documenting their recommendations for the scope and substance of the options and waivers that the department may apply for under this Act, including their recommended priorities for which specific populations should be served.

* Sec. 3. PRELIMINARY DETERMINATIONS; FISCAL ANALYSIS OF PROPOSED PROGRAM CHANGES. (a) Based on the written reports, including the priority designations, received under sec. 2(b) of this Act, the Department of Health and Social Services shall make a preliminary determination of which options and waivers it plans to apply for. The department shall, by January 15, 1992, submit to the legislature a report estimating the fiscal effect of implementing the particular options and waivers for which it plans to seek approval from the federal government under this Act. The report must include for each population group for which approval for an option or waiver will be sought

(1) a description of the group and its geographical distribution, including the number of persons to be served in each geographical area;

(2) the specific types of services to be provided under the option or waiver;

(3) the cost to the state of implementing the option or waiver, including administrative costs, the cost of services to be provided under the options or waivers, and other affected Medicaid program costs; the report must specifically address whether use of the option or waiver will

result in the provision of services to a newly eligible population not previously receiving Medicaid services; and

(4) the cost to the state of serving the group and other affected Medicaid program costs if the option or waiver is not approved and implemented, including administrative costs and the costs of services that would be provided in the existing health care delivery system without using the option or waiver.

(b) During the process of developing the applications that would be submitted to the federal government for its approval under this Act, reliable information should become available to substantiate the costs of implementing home and community-based options and waivers. The legislature acknowledges that reliable information on this subject is not currently available, although long-term cost avoidance is likely because home and community-based services will help slow the rate of growth in the need for construction of additional nursing home beds and help persons avoid institutionalization. Therefore, it is the legislature's intent that fiscal notes prepared for this Act should reflect only the costs of researching, writing, negotiating, and obtaining approval of the applications to the federal government and the costs of preparing the fiscal analysis required under (a) of this section. Estimates of program implementation costs, including the costs of services, should be made only after comprehensive data is available.

* Sec. 4. FINAL DETERMINATION; APPLICATIONS FOR OPTIONS AND WAIVERS. (a) After legislative review during the Second Session of the Seventeenth Alaska State Legislature, and before September 15, 1992, the Department of Health and Social Services shall apply to the Secretary of Health and Human Services for permission to use home and community-based options and waivers that may be approved under 42 U.S.C. 1396n(c) - (d) and other federal laws for developmentally delayed children, developmentally disabled persons,

disabled adults, and older Alaskans, especially those for whom the department determines that but for the provision of the services the persons would require the level of care provided in a hospital, nursing facility, or intermediate care facility for the mentally retarded, the cost of which could be reimbursed under the federal Medicaid program. When determining which options and waivers it will apply for under this subsection, the department shall consider the priorities recommended by the Governor's Council for the Handicapped and Gifted and the Older Alaskans Commission and the specific budgetary authority and policy directives set by the legislature.

(b) In its process of seeking permission to use options and receive waivers under (a) of this section, the Department of Health and Social Services may seek to provide all appropriate services allowed by federal law that are consistent with the needs of the population groups for which the department intends to provide services under the options and waivers.

(c) While preparing applications required under (a) of this section, the Department of Health and Social Services shall consult with the Governor's Council for the Handicapped and Gifted and the Older Alaskans Commission. In addition, 60 days before submitting applications to the Secretary of Health and Human Services, the department shall deliver a copy of the proposed applications to the council and the commission for their review and comment. The department shall consider comments made by the council and commission and amend the applications as considered appropriate by the department before submitting them to the Secretary of Health and Human Services.

(d) The Department of Health and Social Services may submit more than one application under this section if more than one group of persons could be effectively served by home or community-based options or waivers consistent with (a) of this section and the requirements of 42 U.S.C. 1396n(c) -

(d) and other federal laws.

* Sec. 5. INTERAGENCY COORDINATION. The Governor's Council for the Handicapped and Gifted, the Older Alaskans Commission, and the Department of Health and Social Services shall enter into an interagency agreement for carrying out this Act. The agreement must provide that

(1) the Department of Health and Social Services is recognized as the lead agency responsible for applying to the federal government for the use of options and waivers described in this Act; and

(2) all three agencies will cooperate with each other in providing requested nonconfidential information that would assist the agencies in fulfilling their duties under this Act.

* Sec. 6. DEFINITIONS. In this Act

(1) "developmentally delayed children" means children who are eligible for Medicaid under federal regulations and need early intervention services because they

(A) are experiencing developmental delays, as measured by appropriate diagnostic instruments and procedures, in cognitive development; physical development, including vision and hearing; language and speech development; psychosocial development; or self-help skills;

(B) have a diagnosed physical or mental condition that is likely to result in developmental delay described in (A) of this paragraph; or

(C) are at risk of having substantial developmental delays as described in (A) of this paragraph if early intervention services are not provided;

(2) "developmentally disabled person" means a person who is eligible for Medicaid under federal regulations and has a severe, chronic disability that

(A) is attributable to a mental or physical impairment or

combination of mental and physical impairments;

(B) is manifested before the person attains age 22;

(C) is likely to continue indefinitely;

(D) results in substantial functional limitations in three or more of the following areas of major life activity: self-care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic self-sufficiency; and

(E) reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are of lifelong or extended duration and are individually planned and coordinated;

(3) "disabled adult" means a person 18 years of age or older who is eligible for Medicaid under federal regulations and is unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of at least 12 months;

(4) "older Alaskans" has the meaning given in AS 47.65.060, except that it includes only older Alaskans who are eligible for Medicaid under federal regulations.

* Sec. 7. This Act takes effect immediately under AS 01.10.070(c).

STATE OF ALASKA
1990 LEGISLATIVE SESSION

PUBLISH DATE: _____

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: An Act Relating to directing the Department of Health and...
Sponsor: Uehling, Fahrenkamp, Duncan
Requestor: Uehling

Agency Affected: Health and Social Services
BRU: Medical Assistance Administration
Components: Central Administration

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	148.8	203.7	210.4			
TRAVEL	10.6	4.9	4.7			
CONTRACTUAL	278.6	217.4	218.9			
SUPPLIES	6.0	6.5	6.5			
EQUIPMENT	22.0	-0-	-0-			
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	466.0	432.5	440.5			
CAPITAL	-0-	-0-	-0-			
REVENUE	-0-	-0-	-0-			

FUNDING: (Thousands of Dollars)

GENERAL FUND	233.0	216.2	220.3			
FEDERAL FUNDS	233.0	216.3	220.2			
OTHER						
TOTAL	466.0	432.5	440.5			

POSITIONS:

FULL-TIME	5	5	5			
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

FY90 Impact-None.
This is the TOTAL Fiscal Note for SB 334; including RSA's with The Older Alaskans Commission and The Governor's Council on the Handicapped and Gifted for their activites. Funding is 50% federal financial participation and 50% state general fund match.

Prepared by: For: Kim Busch
Division: Medical Assistance
Phone: 465-3355
Date: January 22, 1990

Approved by Commissioner: Myra M. Munson
Agency: Department of Health and Social Services
Date: 1/22/90

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