

ALASKA LEGISLATURE COMMITTEE FILES 1993-1994 8672

7777 HOUSE HEALTH EDUCATION & SOCIAL SERVICES

H B

2 2

# FISCAL NOTE

STATE OF ALASKA  
1993 LEGISLATIVE SESSION

BILL NO. HB 22

Revision Date: March 19, 1993 Dept. Affected: Administration  
 Title: An Act establishing the Alaska Children's Health Corporation and the Alaska Healthy Start Program, relating to insurance RU: Children's Health Corporation  
 Sponsor: Nordlund  
 Requestor: \_\_\_\_\_ COMPONENT SERIAL NO. \_\_\_\_\_

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99
PERSONAL SERVICES	151.3	294.8	294.8	294.8	294.8	294.8
TRAVEL	24.2	15.4	15.4	15.4	15.4	15.4
CONTRACTUAL	101.4	151.4	151.4	151.4	151.4	151.4
SUPPLIES	4.8	4.8	4.8	4.8	4.8	4.8
EQUIPMENT	79.7	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
<b>TOTAL OPERATING</b>	<b>361.4</b>	<b>466.4</b>	<b>466.4</b>	<b>466.4</b>	<b>466.4</b>	<b>466.4</b>
<b>CAPITAL</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>
<b>REVENUE FUND SOURCE:</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

FUNDING:

1002 Federal Receipts	0	0	0	0	0	0
1003 GF Match	0	0	0	0	0	0
1004 GF	361.4	466.4	466.4	466.4	466.4	466.4
1005 GF/Program Receipts	0	0	0	0	0	0
1006 GF/MHTIA	0	0	0	0	0	0
Other	0	0	0	0	0	0
<b>TOTAL</b>	<b>361.4</b>	<b>466.4</b>	<b>466.4</b>	<b>466.4</b>	<b>466.4</b>	<b>466.4</b>

POSITIONS

FULL-TIME	4	4	4	4	4	4
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year (FY93) impact: \$ zero

**ANALYSIS:** (attach a separate page if necessary.) This analysis only examines the operating expenses of the corporation. We have insufficient data at this time to make assumptions on enrollments, resulting copayments and eventual State subsidy.

Prepared By: Robert F. Stalnaker *Robert Stalnaker* Phone: 465-4470  
 Division: Retirement and Benefits Date: March 19, 1993

Approved by Commissioner: Nancy Bear Usura *NBCU* Date: 3/22/93  
 Agency: Department of Administration

PREPARER TO PROVIDE ALL DISTRIBUTION COPIES TO GOVERNOR'S LEGISLATIVE OFFICE  
 For further distribution information call the Governor's Legislative Office

House Bill 22  
 Analysis of Financial Impact  
 Prepared by the Division of Retirement and Benefits  
 Department of Administration  
 Revised March 19, 1993

Analysis: This bill creates the Alaska Children's Health Corporation and the Alaska Healthy Start Program in the Department of Administration. This independent agency, governed by a 7 member board of directors, would purchase and administer a specific health plan for certain children and pregnant women. The corporation would also manage a health fund that would consist of donations and appropriations.

Employing an Executive Director and additional staff as necessary, the corporation would:

- Accept applications for health care
- adopt regulations outlining additional coverage
- establish copay. nt levels for applicants
- solicit private donations
- procure insurance coverage

The Alaska Children's Health Fund is also created in this bill and placed within the corporation. The fund would consist of money from donations and appropriations. The fund would also be used to pay premiums and board expenses. Copayments would be deposited in the general fund and accounted for separately by the Department of Administration.

During FY 94 it is assumed that only the executive director will be on board for a full year. The administrative assistant, clerk typist and R&B technician are assumed to work for six months. The accounting technician and accounting clerk are assumed to begin in FY 95.

	FY94	FY95
<b>PERSONAL SERVICES</b>		
	(full year cost)	
Executive Director (12 months)	\$90.8	
Administrative Assistant II (6 months)	45.3	
Clerk Typist III (6 months)	33.6	
Retirement/Benefit Technician (6 months)	42.0	
Accounting Technician II (begin FY95)	45.3	
Accounting Clerk III (begin FY95)	<u>37.8</u>	
Total Personal Services.....	\$151.3	\$294.8
 <b>TRAVEL</b>		
Assume 4 board meetings for FY 94 and 3 each year thereafter	19.6	
Administrative travel for Director:		
Board meetings	2.8	
Organizational meetings	<u>1.8</u>	
Total Travel	\$24.2	15.4

House Bill 22  
 Analysis of Financial Impact  
 Prepared by the Division of Retirement and Benefits  
 Department of Administration  
 Revised March 19, 1993

CONTRACTUAL

Office space -- 800 sq. ft. @ \$2.25 X 12 months	\$21.6		
Telephone -- \$500 X 12 months	6.0		
Copier -- \$400 X 12 months	4.8		
Courier services -- \$220 X 12 months	2.4		
Postage -- \$550 X 12 months	6.6		
Printing, binding and mailing services	10.0		
Professional services contract(s) such as :			
Health consulting serves (begin FY 95)	50.0		
marketing representative	<u>50.0</u>		
Total Contractual		\$101.4	151.4

SUPPLIES

Office supplies	1.8		
Software	<u>3.0</u>		
Total Supplies		\$4.8	4.8

EQUIPMENT

6 Personal computers, server, printer	\$45.0		
Phones (1100/unit)	6.6		
Fax machine	2.6		
Office furniture:			
1 management unit	4.0		
5 support workstations	15.0		
6 chairs	2.4		
7 side chairs	2.1		
2 file cabinets	.9		
bookcase	.5		
storage cabinet	<u>.6</u>		
Total Equipment		<u>\$79.7</u>	<u>0</u>
 TOTAL projected operating cost		 <u>\$361.4</u>	 <u>\$466.4</u>

This fiscal note only addresses potential administrative costs. It does not attempt to address the appropriations that would be needed to cover the cost of providing the health insurance program. That appropriation would depend on the coverage to be provided, the cost of the premium to be borne by participants and the total number of participants.

3111 C STREET  
ANCHORAGE, ALASKA 99503-3957  
561-7007

WHILE IN SESSION:  
ALASKA STATE CAPITOL  
JUNEAU, ALASKA 99801-1182  
465-4968

# Alaska State Legislature

## House of Representatives



DISTRICT 11:  
SAND LAKE  
SPENARD  
TAKU-CAMPBELL

### Representative Jim Nordlund

#### HB 22 -- The Alaska Healthy Start Program

##### Sponsor Statement

Alaska has been blessed with many resources. The most precious of these is our children. House Bill 22 directly addresses the well-being of Alaska's children by providing an affordable health insurance program for all those who are uninsured, as well as for uninsured pregnant women. The target population consists of those citizens who are not "poor" enough to qualify for Medicaid, yet who do not have access to health insurance coverage.

There are two aspects of the health insurance program which are significant. First, the emphasis will be on "bang for the buck"--preventive and emergency services for children and prenatal care for pregnant women. Second, the yearly cost of the package of health services is proposed to be affordable to middle- and lower-income families. This affordable, effective insurance program will be offered through private insurance companies and will be administered by the Alaska Children's Health Corporation, a public corporation legally separate from the state which will be governed by a board of directors.

Except for first-year start-up costs, the program has been designed to require no state funding; all medical services as well as administrative costs will be paid for entirely by premiums which the board will establish.

In its final report to the governor and legislature in January of this year, the Health Resources and Access Task Force recommended that affordable health insurance be made available to uninsured low-income pregnant women and children. HB 22 does exactly that.

*Sponsor Statement*

CSHB 22 -- The Alaska Healthy Start Program

Sectional Analysis

SECTION 1.

Establishes the Healthy Start Program as a new Chapter 55 under Title 21 (Insurance). The Healthy Start Program is administered by the Alaska Children's Health Corporation.

Article 1 of Chapter 55 establishes the Alaska Children's Health Corporation. The Corporation's purpose is to:

- 1) administer the Alaska Children's Health Care Plan,
- 2) purchase health insurance for eligible participants,
- and 3) manage the Alaska Children's Health Fund.

The Board of Directors for the Corporation is made up of seven members, including the Commissioners of the Departments of Commerce and Economic Development and Health and Social Services and five other individuals with experience in providing health care, managing large funds, providing health insurance, and promoting child welfare. The Board is allowed to hire staff.

Article 2 creates the Alaska Children's Health Care Plan.

Medical services for children which must be provided under the plan are:

- 1) routine examinations,
- 2) diagnostic and screening services,
- 3) immunizations and preventive services,
- 4) laboratory and x-ray services,
- 5) outpatient physician services,
- 6) outpatient surgery,
- 7) emergency room services, and
- 8) prescription drugs.

Maternity care is also included for women during pregnancy and for a period immediately following childbirth.

The Board is authorized to adopt regulations to determine the scope of these services and to add additional services. They are also authorized to set deductibles, limits, and other such mechanisms to control the utilization and cost of the plan. (Decisions on level and scope of services would be driven by the desired level of premiums.)

Eligible participants in the plan include:

- 1) children under the age of 19 or pregnant women
- 2) who have been Alaskan residents for at least one year and
- 3) who are not covered under another public or private health insurance plan, or by Medicaid.

Application for coverage under the plan can be made directly to the Corporation or by filling out a relevant section of the child's or woman's Permanent Fund dividend application.

Administration of the plan by the Board includes:

- 1) soliciting private funds to cover premiums,
- 2) purchasing insurance to cover eligible participants,
- 3) marketing the plan to encourage participation, and
- 4) determining premium requirements of participants.

Premiums may be reduced for lower-income children and pregnant women if private funds are sufficient, or if the Legislature specifically appropriates funds to do so.

Article 3 establishes the Alaska Children's Health Fund as part of the Corporation. Sources for the Fund are:

- 1) the premiums paid by the insured,
- 2) money donated from private sources, and
- 3) appropriations by the legislature.

The Fund is used to pay the insurance premiums for women and children covered by the plan and for expenses incurred by the Corporation.

#### SECTION 2.

Places any staff employed by the Corporation into exempt (from provisions of the State Personnel Act) service.

#### SECTION 3.

Requires any insurer bidding for the provision of coverage under the Alaska Employee Group Insurance Plan to also bid on the Alaska Children's Health Care Plan (the Healthy Start Program).

#### SECTION 4.

Requires the Department of Revenue to include on the child's PFD application questions asking whether the child's parent or guardian wishes to apply for coverage under the Healthy Start Program. This section also requires the

Department to adopt regulations to determine how PFD deductions will be made and premium payments paid on behalf of the child.

SECTION 5.

Sets up staggered terms for the members of the Board of Directors of the Corporation.

SECTION 6.

Establishes an immediate effective date for Sections 1, 2, and 5.

SECTION 7.

Delays the effective date for Sections 3 and 4 until July 1, 1994.

HOUSE BILL 22  
FREQUENTLY ASKED QUESTIONS

**QUESTION:** What does HB 22 do?

**ANSWER:** This bill provides health insurance for children and pregnant women from families who have no other form of health coverage. This bill fits into a systematic, phase-in approach, endorsed by the Health Resources and Access Task Force, to control costs and ensure that all Alaskans have access to health care.

**QUESTION:** Why is HB 22 necessary?

**ANSWER:** Children do not have the ability to provide for their own health coverage. In many cases parents do not have a workplace plan that will cover their children and cannot afford the private plans that are available.

**QUESTION:** Will this bill save money in the long run?

**ANSWER:** Yes. Most of the time uncovered kids and pregnant women receive only the medical care they absolutely need. These costs are passed onto everyone else in the form of higher insurance premiums. Under the program of preventive care in this bill, health problems can be prevented or detected early, saving money for everyone while helping many Alaskans avoid the misery of illness.

**QUESTION:** How many children would be covered under the bill?

**ANSWER:** There are an estimated 21,000 Alaskan children without health insurance or any other form of health coverage. It is difficult to determine at this time how many families will take advantage of the program.

**QUESTION:** What medical services are covered?

**ANSWER:** The plan includes preventive services, emergency services, outpatient services, and prescription drugs for children, and maternal care for women.

**QUESTION:** Who pays for the coverage?

**ANSWER:** The families of eligible women and children will pay the premiums. The Corporation may also receive contributions from private sources and special appropriations from the legislature to lessen the burden of premiums on low-income families.

**QUESTION:** How much would it cost to cover one child?

**ANSWER:** Based on the services listed in HB 22, and given the advantages of pooling, a preliminary analysis shows the yearly premium for a child to be about \$600. Children are the least costly group of uninsured to cover.

*Most commonly asked questions - HB 22*

ALASKA STATE

# HOSPITAL & NURSING HOME

ASSOCIATION

March 1, 1993

Representative Cynthia Toohey  
Co-Chair  
Committee on Health, Education  
and Social Services  
State House of Representatives  
Capitol Building Re: HB 22, Healthy Start  
Juneau, AK 99801 Program

Dear Representative Toohey:

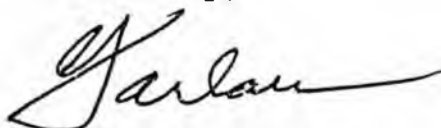
ASHNHA, representing community hospitals and nursing homes urges House Health Committee support of HB 22, establishing the Alaska Children's Health Corporation and the Alaska Healthy Start Program.

We note this legislation is incorporated into SB 114, the Health Resource & Access Task Force recommendations for health reform.

If the Legislature can move this year on an overall health reform program, we support the inclusion of HB 22, as it deals directly with making health insurance available for children.

If it is necessary to wait for 1994, then we would encourage serious consideration of HB 22 and HB 12, small employer health insurance this year as both bills improve access to health care. This is not to forego the importance of the Legislature considering legislation to control health costs as well.

Sincerely,



Harlan R. Knudson  
President/CEO

cc: Representative Jim Nordlund



ALASKA CHAPTER  
NATIONAL ASSOCIATION OF  
SOCIAL WORKERS

8923 Tanis Drive  
Juneau, Alaska 99801  
(907) 789-7099  
FAX (907) 790-2209

Executive Director  
William Diebels, LCSW

BOARD OF DIRECTORS

PRESIDENT  
Eileen Lally, LCSW  
Anchorage

IMMEDIATE PAST PRESIDENT  
Nina Kinney, LCSW  
Juneau

VICE-PRESIDENT  
Colleen Patrick-Riley, LCSW  
Anchorage

SECRETARY  
Melanie Modawell, MSW  
Anchorage

TREASURER  
Susan LaBelle, ACBSW  
Anchorage

NORTHERN REPRESENTATIVE  
John Waters, LCSW  
Fairbanks

SOUTHCENTRAL REGION  
Patrick Cunningham, DSW  
Anchorage

SOUTHCENTRAL REGION  
Angela Salerno, MSW  
Anchorage

SOUTHCENTRAL REGION  
Jack Thomas, LCSW  
Ketchikan

WESTERN REGION  
Lola Mallette, LCSW  
Bethel

AT LARGE REPRESENTATIVE  
Cecelia Esparza, ACSW  
Kodiak

STUDENT REPRESENTATIVE  
Maesha Champion  
Anchorage

March 23, 1993

Representative Jim Nordlund  
Alaska House of Representatives  
P.O. Box V  
Juneau, Alaska 99811

Dear Representative Nordlund,

The Alaska Chapter of the National Association of Social Workers (NASW) supports House Bill 22, an act establishing the Alaska Children's Health Corporation and the Alaska Healthy Start Program. The NASW recognizes the urgency of providing health coverage to the 20,000 or more Alaskan children who have no access to health care.

NASW is committed to meaningful health care reform efforts that increases access for traditionally underserved populations. Also, failure to provide coverage for screening and routine health care guarantees the need to pay for more expensive, avoidable emergency procedures.

No parent should have to choose between work and affordable health care for their children. The absence of an insurance program for low income working families forces this choice. The Healthy Start Program would eliminate this family crisis. There is no better investment our state can make than assuring access to health care for our children.

Respectfully,

Theresa Tanoury, LCSW  
Social Action Committee Chair

# Health Care

## A top priority for the legislature

Legislators may be tempted to not do anything about health-care reform this year, what with President-elect Bill Clinton promising to unveil a plan for national reform in his first 100 days. But it would be a mistake to wait.

Even if Mr. Clinton issues his package promptly, it is likely to be tied up for months, if not years, in Congress. In the meantime, medical costs will continue to soar as more and more people will go without adequate health care.

Any state that is able to put even incremental reforms in place will be ahead of the game. Should

Congress decide to support pilot projects — such a bill was introduced last session — a state with a plan would be the first in line.

And Alaska has a plan — if the legislature will take it up.

The state's Health Resources and Access Task Force is issuing its final report this week, to be presented formally to Gov. Wally Illickel and the legislature during the last week in January.

But first, the problem. In Anchorage, while

consumer prices for all goods and services grew 28.9 percent during the 1980s, medical costs grew by 81.5 percent. And Alaska's per-capita health-care spending was already 27 percent above the age-adjusted national average.

Yet despite all the money spent on health care, not everyone has coverage. Over 76,000 Alaskans have neither insurance nor are eligible for Medicaid. They are not deadbeats; almost 90 percent of them hold jobs or are the dependents of workers whose jobs do not provide insurance coverage. Over 21,000 Alaska children are uninsured.

People without insurance tend to delay medical care. Their health is often poorer as a result, and when they do ask for help, the care is likelier to be more intensive and more expensive.

Who pays? Hospitals and doctors swallow some of the losses. Other costs are shifted to people who do have insurance. So premiums go up. Employers ask their employees to pay a larger share of the premiums or drop coverage altogether. Then more people are without insurance, and more costs are shifted.

Unless you are a millionaire, you are one step away from a medical disaster. You could lose your job or even just change jobs, and lose your insurance. You could get sick or have an accident and see your coverage canceled or your premiums skyrocket.

Moreover, the tight link between health care and jobs is part of the problem with the economy. Businesses are burdened with high premiums, and the legendary mobility of the American work force is hampered because workers don't dare leave their jobs and strike out to be entrepreneurs.

So what's the solution?

The task force report calls for fundamental change. Its most radical recommendation is for Alaska to establish a single-payer system, similar to what Canada has, where health care would be available to all Alaskans.

But the task force knows this is going to be a tough sell. So it also has come up with a series of interim steps that can be taken immediately to hold down costs and increase access.

The task force recommends establishing a health-care authority to set a statewide health-care budget, work with providers to set mutually acceptable reimbursement rates and develop uniform billing and common claim forms.

It recommends insurance reform measures to guarantee renewability, eliminate multiple waiting periods for pre-existing conditions, restrict premium rates and require insurers to disclose rating practices.

It recommends establishing pooling arrangements for individuals and businesses to purchase health-care coverage. And it recommends state subsidies to cover high-priority populations, starting with low-income pregnant women and children.

What will this cost? The state will need a tax — a payroll tax, an income tax. But the tax is a matter of redistributing, rather than increasing, spending. Remember, we are paying now, through cost shifting, administrative waste, high premiums, delayed care.

The task force has come up with concrete recommendations for change. We will be examining these recommendations further as the legislature convenes. If you would like a copy of the task force's report, call the Health Resources and Access Task Force at 465-2933.

---

Over 76,000 Alaskans have neither insurance nor are eligible for Medicaid. They are not deadbeats; almost 90 percent of them hold jobs or are the dependents of workers whose jobs do not provide insurance coverage. Over 21,000 Alaska children are uninsured.

---

ALASKA 1988-91  
TOTAL POPULATION EXCLUDING NATIVE AMERICANS/ALASKANS

TABLE OF ANYINS BY AGE2

ANYINS	AGE2					Total
	<18	18-24	25-49	50-64	65+	
Uninsured	21301	11330	36669	6760.9	575.8	76627
	5.17	2.76	8.89	1.64	0.14	18.59
	27.80	14.79	47.05	8.81	0.75	
	17.62	27.14	19.41	13.78	2.90	
Insured	100259	30409	162225	33483	19266	33631
	24.82	7.38	36.92	8.12	4.67	81.41
	29.87	9.06	45.35	8.98	6.74	
	82.45	72.86	80.59	83.22	97.10	
Total	121560	41739.7	189994	40233.9	19831.8	412258
	29.49	10.12	45.82	9.76	4.61	100.00

TABLE 1 OF ANYINS BY POVERTY  
CONTROLLING FOR AGE2<18

ANYINS	POVERTY				Total
	<=100% P ov	101-200%	201-300%	>300% P v	
Uninsured	3877.2	4481.3	6214	6728.5	21301
	3.10	3.69	5.11	5.54	17.52
	18.20	21.04	29.17	31.59	
	31.42	21.72	28.42	10.08	
Insured	8483.3	16163	15648	59994	100259
	6.96	13.29	12.67	49.35	82.48
	8.44	16.11	15.81	59.84	
	68.58	78.26	71.58	89.92	
Total	12340.5	20694.7	21862.4	87222.4	121560
	10.16	16.97	17.98	64.89	100.00

Jim - (under 18)  
# of children 300%  
of poverty or below:  
3877  
4481  
+ 6214  

---

14,572

CHECKS - Uninsured - Insured - Poverty Levels - Health Systems Co.

**ESTIMATES OF ENROLLEES AND COSTS UNDER  
SUBSIDIZED INSURANCE PROGRAM FOR LOWER INCOME  
ADULTS AND CHILDREN NOT ELIGIBLE FOR MEDICAID OR IHS COVERAGE**

<u>Income</u>		<u>Number of Eligible Uninsureds</u>
Under Poverty		
	Adults	9,290
	Children	426
	Total	<u>9,716</u>
100-200% Poverty		
	Adults	11,935
	Children	3,631
	Total	<u>15,566</u>
200-250% Poverty		
	Adults	5,857
	Children	3,469
	Total	<u>9,326</u>
All Incomes		
	Adults	27,082
	Children	7,526
		<u>34,608</u>
<b>TOTAL</b>		<b>34,608</b>

SOURCE: Health Systems Research, Inc.

Blue Cross  
of Washington and Alaska



March 25, 1993

P. O. Box 327  
Seattle, Washington 98111-0327

The Honorable Jim Nordlund  
Alaska State Representative  
Alaska State Capitol  
Juneau, Alaska 99801-1182

Subject: HB 22 - Healthy Start Program  
Alaska Children's Health Corporation

Dear Representative Nordlund:

In our fax to you March 9, 1993 we listed the 1994 annual expected claims costs for each of the covered services itemized in the above referenced bill. With the exception of vision hardware, the services were reimbursable at 100% of allowed charges. Allowed charges are those determined reasonable and customary by the insurer.

The targeted premium looked at was \$900 or less per year. This target amount was to cover not only the claims costs but also the administrative costs to pay the claims.

Each covered service was detailed so one could determine which services were the most expensive and also which could be viewed as elective and less emergent in nature. It should be emphasized these costs represent expected claim payments only; expenses for claims processing and customer service would need to be added to these costs and then compared to the target. Lower premiums could be achieved by placing co-pays, coinsurances and annual maximums on these services.

It is our belief this program will, in the long run, help lower overall health care costs in the State of Alaska provided residents purchase the coverage for their children. It accomplishes this by covering preventive type services where the obvious benefit is early detection of serious medical conditions and the resulting corrective treatments. Undetected these conditions could result in higher medical treatment costs down the line. From this position Blue Cross of Washington and Alaska supports your legislation on children's health.

Sincerely,

John Gabriel  
Assistant Actuary

Blue Cross - 1994 annual expected claims costs

AK93KIDS.XLS

3/7/93 12:08 PM

## HB 22 EXPECTED CLAIMS COSTS FOR 1994

## COVERAGE FOR CHILDREN UNDER AGE 19

	EXPECTED ANNUAL CLAIM COST PER CHILD
PHYSICIAN SERVICES, Rx, & VISION	
PHYSICIAN OFFICE - DIAGNOSTIC SCREENING & MISCELLANEOUS SERVIC	\$299.08
PHYSICIAN O-P ER VISITS	\$32.16
RADIOLOGY ( PROF & TECH IN OFFICE ONLY)	\$19.26
PATHOLOGY (PROF & TECH IN OFFICE ONLY)	\$20.72
PHYSICIAN O-P SURGERY	\$65.17
PRESCRIPTION DRUGS - O-P PHARMACY	\$68.35
VISION HARDWARE ( LENSES/ FRAMES )	\$17.41
PREVENTIVE SERVICES:	
WELL BABY	\$27.48
HEARING EXAM	\$3.45
PHYSICAL EXAMS	\$13.09
VISION EXAMS	\$12.54
SPEECH EXAMS	\$0.18
IMMUNIZATIONS	\$27.63
DENTAL	\$366.02
	TOTAL \$972.54
ADULT FEMALE *	
PHYSICIAN PRENATAL VISITS ONLY	\$723.79
PHYSICIAN DELIVERY ( INCLUDES PRE & POST NATAL VISITS)	\$3,424.51

\* only pregnant women or women expecting maternity care will purchase this benefit.

\* Per page 4, HB 22, LINE 24 & 25 . Premium portion to be determined by the board.

0:30 No.001 P.02

MAR 09 '95

ID:206-670-4900

BC WA&AK

AK93KIDS.XLS

PHYSICIAN SERVICES, Rx & VISION SUPPLIES

DESCRIPTION:

PHYSICIAN O-P ER VISITS

VISITS TO EMERGENCY AREA IN O-P HOSP BY PRIMARY PHYSICIAN OR HOSP STAFF PHYSICIAN (CPT4: 90500-90590,99062-99065)

RADIOLOGY ( PROF &TECH IN OFFICE ONLY)

PROFESSIONAL & TECHNICAL COMPONENT OF RADIOLOGY SERVICES BILLED TOGETHER WHEN X-RAY PERFORMED IN CLINIC OR OFFICE SETTING (CPT4: 70010-79999)

PATHOLOGY (PROF & TEC H IN OFFICE ONLY)

PROFESSIONAL & TECHNICAL COMPONENT OF PATHOLOGY SERVICES WHEN BILLED TOGETHER & PERFORMED IN CLINIC OR OFFICE SETTING (CPT4 : 80002-89399)

PHYSICIAN 'O-P SURGERY

PHYSICIAN SURGERY IN O-P HOSP ,OR FREE STANDING SURG FACILITY, OFFICE ' & ANESTHESIA. INCLUDES PRE & POST SURGICAL ENCOUNTERS W/ 'SURGEON '(CPT4: 10000-58999,59525,60000-69979,00100-01999) EXCLUDES [00842,,00855,'00946,99100-99140 OR OTHER OB PROCEDURES] OR 10000-58999,60000-69979 'WITH ANESTHESIA MODIFIER)

PRESCRIPTION DRUGS - O-P PHARMACY  
VISION HARDWARE ( LENSES/ FRAMES )

INCLUDES DISPENSING FEE. DRUGS ORDER BY ATTENDING PHYSICIAN LENSES & CONTACTS BUT NOT BOTH ,1 /YEAR @ \$200 MAX. FRAMES . @ \$75 '(CPT4: 92390-92396)

PHYSICIAN OFFICE - DIAGNOSTIC  
SCREENING & MISCELLANEOUS SERVICES

PHYSICIAN OFFICE & HOME VISITS, INCLUDES THERAPEUTIC INJECTIONS, ALLERGY TESTING & ALLERGY IMMUNOTHERAPY, DIAGNOSTIC TESTING , & OTHER MISC PROF SERVICES AS ( BIOFEEDBACK, PULMONARY, NEUROLOGY,, 'CHEMOTHERAPY, DERMATOLOGY, NON-INVASIVE VASCULAR DIAGNOSTIC STUDIES. 'VESTIBULAR FUNCTION TESTS, GASTRO-ENTEROLOGY & OTORHINOLOGY SERVICES.

INCLUDED BECAUSE THEY ARE RELATED TO DIAGNOSTIC TESTING. (CPT4: 90000-90080,90699,90900-98922,99000-99758,99070,90100-90400-90470,'90780-90790170,,99,95000-95105,95115-95190,90900-90915,'95805-95999,'96400-96594010-94799,49,98900-96999,93850-93960,92531-92547,91000-91299, 92502-92504,92511-92520

AK93KIDS.XLS

WELL BABY

HEARING EXAM  
PHYSICAL EXAMS

VISION EXAMS

SPEECH EXAMS  
IMMUNIZATIONS

NORMAL PERIODIC EXAMS OF WELL KIDS UNDER AGE 2 (CPT4 90753-90757,90763-90764,90778)  
HEARING EXAMS ( CPT4 92506-92508,92551-92599)  
ROUTINE EXAMS FOR CHILDREN OVER 2 YRS . INCLUDES ASSOCIATED X-RAYS & LAB (CPT4 90750-90753,90760-90763,90774)  
1 EYE EXAM /YEAR FOR OPHTHALMOLOGIST OR OPTOMETRIST ( CPT4 92002,92371,92499)  
SPEECH EXAMS ( CPT4 92506-92508)  
PROF SVCS & MATERIALS WITH ADMIN IMMUIZATIONS (CPT4: 90701-90749)

2/26/93 4:18 PM

AK93KIDS

ALASKA CHILDREN PROGRAM:

PER 2-19-93 MEMO FROM :

M&amp;R HGC ADJUSTED TO ALASKA

SERVICES	MONTHLY CLAIM COST	ALASKA ADJUSTMENT	PER CHILD ANNUAL CLAIM COST (NO ADMINISTRATIVE COSTS FIGURED IN HERE)
WELL BABY	\$1.28	\$1.59	\$19.06
HEARING EXAM	\$0.21	\$0.22	\$2.65
PHYSICAL EXAMS	\$1.42	\$1.49	\$17.88
VISION EXAMS	\$0.74	\$0.78	\$9.32
SPEECH EXAMS	\$0.02	\$0.02	\$0.25
IMMUNIZATIONS	\$1.53	\$1.61	\$19.28
TOTAL	\$5.18	\$5.70	\$68.44
	SELECTION LOAD		\$10.27
	CALENDAR YEAR 1994:		\$78.71

SERVICES	DESCRIPTION OF SERVICES
WELL BABY	NORMAL PERIODIC EXAMS OF WELL KIDS UNDER AGE 2 (CPT4 90753-90757,90763-90764,90778)
HEARING EXAM	HEARING EXAMS ( CPT4 92506-92508,92551-92599)
PHYSICAL EXAMS	ROUTINE EXAMS FOR CHILDREN AGE 2 & OVEWR. INCLUDES ASSOCIATED X-RAYS & LAB (CPT4 90750-90753,90760-90763,90774)
VISION EXAMS	1 EYE EXAM /YEAR FOR OPTHTHALMOLOGIST OR OPTOMETRIST ( CPT4 92002-92371,92499)
SPEECH EXAMS	SPEECH EXAMS ( CPT4 92506-92508)
IMMUNIZATIONS	PROF SVCS & MATERIALS WITH ADMIN IMMUIZATIONS ( CPT4 90701-90749)



Aetna Health Plans  
Suite 1600 Century Square  
1501 Fourth Avenue  
Seattle, WA 98101  
Mail: P.O. Box 91032 (98111-9132)

Steven M. LaBrun  
Account Manager  
(206) 467-2803  
Fax: (206) 467-2087

March 29, 1993

The Honorable Jim Nordlund  
Alaska State Legislature  
State Capitol  
Juneau, Alaska 99811

Dear Representative Nordlund:

Attached is an exhibit outlining expected 1st year (1994) claim cost for coverage made available under the terms of HB22. I have itemized several levels of coverage, beginning with a program of strictly preventive care, and expanded to separate claim estimates for vision, dental and basic medical coverage.

The attached estimates are based on typical charges for services in the Anchorage area. The exhibit includes both a broad description of benefits as well as any payment limits, restrictions, or cost-sharing features that might apply.

Included in the claim cost is a add-on to reflect the possibilities of "adverse selection." This term relates to the design of an insurance program and the extent to which individuals are able to elect the plan only because they have known or expected medical costs. To use vision care as an example, if only those persons with vision problems were allowed to elect coverage, then the true insurance nature of the coverage and the spreading of risk would be compromised. Since this program is entirely voluntary one can expect a higher per participant claim cost than would otherwise be found under a typical employer insurance program, which includes safeguards to minimize adverse selection.

While not included in the exhibit, I did research typical claim costs for maternity and prenatal care. This data is based on a special survey of Alaska physicians performed January 1993

- prenatal care--\$600
  - delivery-only fees--vaginal \$1950; C-section \$2,400
  - global charge (includes delivery and pre/post natal care--vaginal \$2,550; C-section \$3100
- Impact of adverse selection would be most severe for this coverage since only expectant mothers would choose the coverage, thereby essentially negating the insurance aspect of the benefit.

The claim cost estimates do not include cost of insurance administration. There are many variable that would need to be better defined before an estimate could be made. These include the specific plan design offered, the service to be provided, the degree of involvement of the Corporation in assuming administrative functions, the projected number of enrollees. However, it should be noted that as a percentage of claim payments, administration costs will be much higher than under a typical insurance plan, in part due to the fixed cost of processing claims of relatively small dollar value. In fact if a minimal benefit program is offered, it is entirely likely that costs of administration will exceed claim costs.

I hope this information is useful; please contact me if I can provide any further assistance.

Regards,

Steve LaBrun

## HB 22--Alaska Children's Program Plan Claim Costs

### Assumptions:

- coverage available to children under age 19
- 12 month residency
- not otherwise covered under other public/private insurance plan
- no pre-existing limitations/exclusions
- open rules of entry into and exit from plan

### Benefits/Claim Cost Estimates for 1994 (per child/per month)

#### Preventive/wellness routine care--\$4.30

coverage includes immunizations and well baby/routine physical exams

benefits provided for physician office charges as well as diagnostic lab work ordered at time of visit

six visits covered in 1st year of life, two in second year, once per year thereafter

benefit paid at 100% of reasonable and customary (R&C) charge, no deductible

#### Vision exams--\$1.60

one exam covered every 24 months

paid at 100% R&C, no deductible

#### Vision Eyewear--\$2.00

one purchase every 24 months if required due to change in prescription

frames paid at 100% R&C up to \$50 maximum payment; lenses at 100% R&C

03/30/93

16:00

003

### Dental Coverage--\$20.00

covers preventive and basic services

includes exams, x-rays, cleanings, fluoride, fillings, extractions, periodontal and endodontic treatment; orthodontia not covered

benefits paid at 80% of R&C, no deductible, up to \$1,000 per calendar year

### Ambulatory Medical Coverage--\$54.00

covers the following services:

- outpatient physician charges--office visits and surgery
- diagnostic lab and x-ray expenses
- medically necessary physical and speech therapy
- drugs that require a prescription (excludes contraceptives and over-the-counter medications)
- rental or purchase of durable medical supplies
- hospital emergency room expenses

The following expenses are excluded:

inpatient hospital expenses, inpatient surgical expenses, inpatient/outpatient psychiatric and substance abuse treatment expenses, ambulance charges, home health care, private duty nursing

benefits paid at 80% after a \$100 calendar year deductible;  
\$1,000 calendar year out-of-pocket limit

8-LS0198E ✓  
Lauterbach  
3/15/93

CS FOR HOUSE BILL NO. 22( )  
IN THE LEGISLATURE OF THE STATE OF ALASKA  
EIGHTEENTH LEGISLATURE - FIRST SESSION

BY

Offered:  
Referred:

Sponsor(s): REPRESENTATIVES NORDLUND, Brown, B.Davis, Ulmer, Sitton, Finkelstein, Brice

A BILL

FOR AN ACT ENTITLED

1 "An Act establishing the Alaska Children's Health Corporation and the Alaska  
2 Healthy Start Program; relating to insurance; and providing for an effective  
3 date."

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

5 \* Section 1. AS 21 is amended by adding a new chapter to read:

6 CHAPTER 56. HEALTHY START PROGRAM.

7 ARTICLE 1. ALASKA CHILDREN'S HEALTH CORPORATION.

8 Sec. 21.56.010. CREATION OF CORPORATION. The Alaska Children's  
9 Health Corporation is created as a public corporation. The corporation is an  
10 instrumentality of the state within the Department of Administration, but it has a legal  
11 existence independent of and separate from the state.

12 Sec. 21.56.020. PURPOSE OF THE CORPORATION. (a) The corporation's  
13 purpose is to

14 (1) administer the Alaska children's health care plan as described in

1 this chapter;

2 (2) purchase health insurance coverage for children and pregnant  
3 women who are eligible for the plan under AS 21.56.110; and

4 (3) manage the Alaska children's health fund created under  
5 AS 21.56.200.

6 (b) The corporation is not considered an insurer. The directors and employees  
7 of the corporation are not considered to be agents of an insurer. Neither the  
8 corporation nor a director or employee of the corporation is subject to the licensing  
9 requirements of this title. However, the division of insurance may require that a  
10 marketing representative used and compensated by the corporation be appointed as a  
11 representative of the insurers with which the corporation contracts.

12 Sec. 21.56.030. BOARD OF DIRECTORS. (a) The corporation is governed  
13 by a board of directors consisting of the commissioner of administration, the  
14 commissioner of health and social services, and five other members appointed by the  
15 governor. The five appointed members must include persons who are experienced in  
16 providing health care, managing large funds, providing health insurance, and promoting  
17 child welfare. At least one member must be a person who resides in a rural area of  
18 the state or is familiar with health care delivery in rural areas of the state.

19 (b) Board members shall serve staggered terms of four years.

20 (c) The board members shall select from among themselves a chair and a vice-  
21 chair.

22 (d) Members of the board receive no compensation for their services but are  
23 entitled to per diem and travel allowances authorized by law for other boards and  
24 commissions under AS 39.20.180.

25 (e) The board shall meet at least twice a year at times and locations  
26 determined by the chair. Four members of the board constitute a quorum.

27 (f) The board may hire an executive director to assist it in carrying out its  
28 duties. The executive director may hire other necessary staff. The executive director  
29 and other employees of the board serve at the pleasure of the board and are in the  
30 exempt service under AS 39.25.110.

31 ARTICLE 2. ALASKA CHILDREN'S HEALTH CARE PLAN.

1           Sec. 21.56.100. CONTENTS OF PLAN. (a) The Alaska children's health  
2 care plan consists of the following medical services for children who are eligible under  
3 AS 21.56.110:

- 4           (1) routine examinations;
- 5           (2) diagnostic and screening services;
- 6           (3) immunizations and preventive services;
- 7           (4) laboratory and x-ray services;
- 8           (5) outpatient physician services;
- 9           (6) outpatient surgery;
- 10          (7) emergency room services;
- 11          (8) prescription lenses, eyeglass frames, and vision care;
- 12          (9) prescription drugs; and
- 13          (10) other services, as approved by the board under (b) of this section.

14           (b) The board may, by regulations adopted under AS 44.62 (Administrative  
15 Procedure Act), determine the scope of the services listed in (a) of this section and add  
16 other categories of services for children that will be covered under the plan. A new  
17 category of service is not covered under the plan until an insurer agrees to cover it.

18           (c) The plan also includes prenatal services and at least three months of  
19 postnatal services for pregnant women. The board may, by regulations adopted under  
20 AS 44.62 (Administrative Procedure Act), determine the scope of services covered  
21 under this subsection, including the duration of postnatal services beyond the minimum  
22 set under this subsection. The board may also add delivery services for pregnant  
23 women to the plan.

24           (d) In addition to the premium required under AS 21.56.140, the board may  
25 require a copayment for a service, establish deductibles, set duration and usage limits,  
26 develop and implement procedures related to utilization review, and establish other  
27 reasonable conditions relating to the provision of services under (a) - (c) of this section  
28 to limit the cost of the plan's operation and to ensure the efficiency and efficacy of the  
29 services provided under the plan.

30           (e) When determining the scope of services or adding services under (b) of this  
31 section or establishing conditions relating to the provision of services under (d) of this

1 section, the board shall give priority to the provision of preventive services with the  
2 fewest conditions practicable.

3 Sec. 21.56.110. ELIGIBILITY FOR THE PLAN. (a) A child is eligible for  
4 coverage under AS 21.56.100(a) and (b) if

5 (1) the child is under the age of 19 and has been a resident of the state  
6 for the 12 months immediately preceding application for plan coverage or, if the child  
7 is less than one year old, at least one of the child's parents has been a resident of the  
8 state for the 12 months immediately preceding application for plan coverage;

9 (2) the child does not have health care coverage under another public  
10 or private health insurance plan;

11 (3) the child is not eligible for medical coverage under AS 47.07  
12 (Medicaid); and

13 (4) the premium for plan coverage is paid on behalf of the child, as  
14 determined by the board under AS 21.56.140.

15 (b) A pregnant woman is eligible for coverage under AS 21.56.100(c) if

16 (1) the woman has been a resident of the state for the 12 months  
17 immediately preceding the woman's application for plan coverage;

18 (2) the woman does not have coverage for similar services under  
19 another public or private health insurance plan;

20 (3) the woman is not eligible for medical coverage under AS 47.07  
21 (Medicaid); and

22 (4) the premium for plan coverage is paid on behalf of the woman, as  
23 determined by the board under AS 21.56.140.

24 Sec. 21.56.120. APPLICATION PROCESS. (a) A pregnant woman or the  
25 parent or guardian of a child may request an application packet for plan coverage by  
26 notifying the board directly or by completing the relevant section of the woman's or  
27 child's permanent fund dividend application form as provided under AS 43.23.017.

28 (b) Upon direct notification by an interested person or upon notification from  
29 the Department of Revenue of the name and mailing address of a person who has  
30 requested an application packet for the plan under (a) of this section, the board shall  
31 send an application packet to the person requesting it.

1 (c) An application packet sent under (b) of this section must include

2 (1) a description of the health care coverage available under the plan;

3 (2) a copy of the schedule used by the board to determine the premium  
4 responsibility and a description of deductibles and copayment requirements the board  
5 has established under AS 21.56.100(d);

6 (3) an explanation of the eligibility requirements for the plan;

7 (4) a form to be returned to the board requesting whether the applicant  
8 wishes to pay the plan premium by deduction from the person's permanent fund  
9 dividend if the person is found to be eligible for the plan; and

10 (5) an application form to be returned to the board if the person wants  
11 to apply for coverage personally or on behalf of an eligible child.

12 (d) Within 30 days after receiving a completed application for plan coverage,  
13 the board shall either notify the applicant about whether the plan coverage is approved  
14 or request additional information necessary to determine the eligibility. If the board  
15 determines that a pregnant woman or a child is eligible for the plan, the notification  
16 of eligibility sent under this subsection must include a determination of amount of the  
17 premium required under AS 21.56.140.

18 (e) Plan coverage begins on the day the required premium is received by the  
19 board except that for a person who indicated with the application form that the  
20 premium could be paid by reduction of a permanent fund dividend, plan coverage  
21 begins on the date plan coverage is approved for the person. If the board subsequently  
22 determines that the person's permanent fund dividend is unavailable or insufficient to  
23 cover the plan's premium, the board shall suspend the person's coverage until  
24 additional payment is received.

25 (f) The board's denial or withdrawal of plan coverage may be appealed to the  
26 superior court.

27 Sec. 21.56.130. ADMINISTRATION OF PLAN. (a) The board shall  
28 administer the Alaska children's health care plan by

29 (1) soliciting and accepting funds from private sources for use under  
30 AS 21.56.140(d); the board may also accept donations of services, supplies, personnel,  
31 and other in-kind donations;

1 (2) soliciting and evaluating bids and purchasing insurance from one  
2 or more insurers to provide plan coverage;

3 (3) marketing the plan in a manner designed to make its existence  
4 known to pregnant women and the parents and guardians of children who may be  
5 eligible for the plan;

6 (4) evaluating applications for plan coverage and determining eligibility  
7 for plan coverage;

8 (5) determining the premium that is required under AS 21.56.140.

9 (b) The board shall adopt regulations under AS 44.62 (Administrative  
10 Procedure Act) to implement this chapter.

11 Sec. 21.56.140. PREMIUMS. (a) The board shall adopt a schedule of  
12 premiums that includes a premium for a child's coverage, a premium for a woman's  
13 coverage that includes delivery services if the board chooses under AS 21.56.100(c)  
14 to offer that coverage, and a premium for a woman's coverage that does not include  
15 delivery services.

16 (b) The board, in cooperation with the Department of Revenue, shall adopt  
17 regulations under which a pregnant woman or a parent or guardian may request that  
18 a permanent fund dividend to which the woman is entitled be reduced by the  
19 Department of Revenue to provide the premium payment for the woman's or child's  
20 plan coverage.

21 (c) The board shall deposit premiums received under this section into the  
22 general fund. The department of administration shall separately account for premiums  
23 deposited into the general account by the board. The estimated annual balance in the  
24 account may be used by the legislature to make appropriations to the fund established  
25 under AS 21.56.200.

26 (d) To the extent that the board receives private funds under  
27 AS 21.56.130(a)(1) or an appropriation made specifically for the purposes of this  
28 subsection, the board shall reduce the premium levels determined under (a) of this  
29 section for pregnant women and children whose household incomes are below 300  
30 percent of the income level established under AS 47.25.310 - 47.25.420 for eligibility  
31 for aid to families with dependent children.

1           Sec. 21.56.150. CONFIDENTIALITY OF RECORDS. (a) Information  
2 received by the board in an application for plan coverage is confidential and is not  
3 subject to public inspection and copying under AS 09.25.110 - 09.25.120.

4           (b) A board member or employee of the corporation who divulges information  
5 in violation of (a) of this section is guilty of a class B misdemeanor.

#### 6           ARTICLE 3. ALASKA CHILDREN'S HEALTH FUND.

7           Sec. 21.56.200. CREATION OF FUND. The Alaska children's health fund  
8 is created in the corporation. It consists of money donated to the corporation from  
9 private sources and appropriations made to the fund.

10          Sec. 21.56.210. USE OF THE FUND. The board may use money in the fund

11           (1) to pay insurance premiums for the Alaska children's health care  
12 plan; and

13           (2) for the board's expenses incurred in administration of the plan and  
14 the fund.

#### 15          ARTICLE 4. GENERAL PROVISIONS.

16          Sec. 21.56.290. DEFINITIONS. In this chapter,

17           (1) "board" means the board of directors of the Alaska Children's  
18 Health Corporation established under AS 21.56.010;

19           (2) "corporation" means the Alaska Children's Health Corporation  
20 established under AS 21.56.010;

21           (3) "fund" means the Alaska children's health fund established under  
22 AS 21.56.200;

23           (4) "plan" means the Alaska children's health care plan described under  
24 AS 21.56.100.

25          Sec. 21.56.299. SHORT TITLE. This chapter may be cited as the Healthy  
26 Start Program.

27 \* Sec. 2. AS 39.25.110 is amended by adding a new paragraph to read:

28           (30) the executive director and other employees of the Alaska  
29 Children's Health Corporation (AS 21.56).

30 \* Sec. 3. AS 39.30 is amended by adding a new section to read:

31          Sec. 39.30.092. BIDDER REQUIREMENT. An insurer may not submit a bid

1 under AS 39.30.090 for a type of medical care coverage that is included in the Alaska  
2 children's health care plan under AS 21.56 unless the insurer also submits a bid to the  
3 Alaska Children's Health Corporation to cover that type of medical care under  
4 AS 21.56.

5 \* Sec. 4. AS 43.23 is amended by adding a new section to read:

6 Sec. 43.23.017. ALASKA CHILDREN'S HEALTH PLAN. (a) The  
7 department shall include on the permanent fund dividend application form a question  
8 requesting whether the applicant wishes to apply for coverage of a child or pregnant  
9 woman under the Alaska children's health care plan established under AS 21.56.

10 (b) Within 30 days after receiving an application form that indicates interest  
11 in the Alaska children's health plan, the department shall notify the Alaska Children's  
12 Health Corporation of the names and mailing addresses of persons who have indicated  
13 on a permanent fund dividend form that they would like to apply for coverage under  
14 the Alaska children's health care plan.

15 (c) The department, in cooperation with the Alaska Children's Health  
16 Corporation, shall adopt regulations governing how it will honor a request that a  
17 permanent fund dividend be reduced by the department to provide the premium  
18 payment for coverage under the Alaska children's health care plan.

19 \* Sec. 5. TRANSITIONAL PROVISION. Notwithstanding AS 21.56.030(b), enacted by  
20 sec. 1 of this Act, the governor shall set the terms of the first five appointed members of the  
21 board of directors of the Alaska Children's Health Corporation so that one of the appointed  
22 members serves a two-year term, two members serve three-year terms, and two members serve  
23 four-year terms.

24 \* Sec. 6. AS 21.56.010 - 21.56.030, 21.56.130(a)(1), and 21.56.200 - 21.56.299, enacted  
25 by sec. 1 of this Act, and secs. 2 and 5 of this Act take effect immediately under  
26 AS 01.10.070(c).

27 \* Sec. 7. Except as provided in sec. 6 of this Act, this Act takes effect July 1, 1994.

# The Role of Private Health Insurance in Children's Health Care

John F. Sheils  
Patrice R. Wolfe

## Abstract

Private health insurance is the primary means of financing health care for America's children and pregnant women. Most coverage is provided under employer plans. Access to private health care coverage, however, is threatened by the increasing cost of health care, cost shifting by providers, and insurance marketing practices that tend to deny coverage to high-risk individuals. These pressures have already led to an increase in the number of uninsured children and pregnant women.

This paper provides an overview of the private health insurance market with a focus on recent trends. The effects of self-funding arrangements by employers and of various cost control arrangements—including managed care plans, patient cost-sharing provisions, and employee premium contributions—are examined for their potential impact on children and pregnant women. Policies that might expand health insurance coverage for children, including a universal health insurance plan, and health insurance market reforms, are explored. Alternative strategies for enhancing universal health insurance coverage for children include mandatory employer-based insurance programs, a program of tax credits to underwrite individual insurance plans, and a single-payer government program financed through the tax system. The authors conclude that efforts should be made to preserve the current private health insurance system by reducing cost shifting from public programs, guaranteeing the availability of coverage to all groups, and controlling costs by means of competition, managed care, and perhaps global spending limits. Such comprehensive reforms might be necessary merely to preserve private insurance coverage for a majority of America's children and pregnant women.

Private insurance is the primary source of funding for health care for children and pregnant women in the United States. The March 1990 Current Population Survey (CPS) reports that about 63% of all children are covered as dependents under employer health insurance plans and another 10% are covered under individually purchased non-group insurance. About 60% of pregnant women are covered under employer plans, either as employees or as dependent spouses, and about 6% have non-group coverage.<sup>1</sup>

The extent of private insurance coverage for children declined during the 1980s largely because of an increase in health care costs, a

*John F. Sheils, M.P.P., is vice president of Lewin-ICF, a research and consulting firm which specializes in health and environmental matters.*

*Patrice R. Wolfe, M.P.P.M., is manager in the Systemetrics division of MED-STAT Systems, Inc. At the time this paper was written, she was senior associate at Lewin-ICF.*

The purpose of health insurance is to minimize the risk of financial catastrophe that often results from unexpectedly large losses or expenditures by pooling the experiences of a large number of people. In general, large employer groups can predict with reasonable accuracy what their health care expenses will be during a particular year. Although it may be difficult to predict precisely how many people will incur large expenses and how much each person's illness will cost, a group can spread the resulting expenses among a large number of people, thereby creating an average expense that varies far less than an individual's expense. This concept, known as risk pooling, allows a large employer to estimate fairly accurately the cost of offering health care insurance to its employees.<sup>5</sup> Similarly, insurance companies pool the risk of numerous small groups and individuals to predict their overall expenses.

#### Fully Insured Arrangements

Traditional private health insurance is based on a contractual arrangement between a purchaser (either an employer or an individual) and an insurer where the purchaser agrees to pay the insurer a predetermined amount (the premium) per covered member per time period (typically a month) in return for full assurance that all approved expenditures will be paid by the insurer.<sup>6</sup> In other words, the purchaser is not at risk if expenses exceed the total premium amount. In 1989, American employers and employees spent \$36.9 billion on fully insured group health insurance premiums.<sup>7</sup>

Under plans of this type, the insurer is fully responsible for all covered health care expenditures. The insurer's goal, therefore, is to set premiums so that they cover the expected claims payout for the covered population plus a margin for profit, overhead expenses, and reserves to cover unexpectedly large claims.

#### Self-funding Arrangements

Although insurance companies traditionally performed the risk pooling function for employers and individuals, employers have in recent years increasingly pursued self-funding as an alternative method for financing their health care plans. The percent of medium and large employers who self-funded grew from 19% in 1979 to 66% in 1988.<sup>8</sup> In self-funded plans, the employer assumes all risk for health expendi-



tures and contracts with a third-party administrator or insurer to handle claims processing and other administrative functions related to the plan.

Self-funding has many advantages for the employer. First, the Employee Retirement Income Security Act (ERISA) of 1974 preempts states from regulating self-insured plans. Thus, employers who opt for self-funded plans can avoid paying for those state-mandated benefits that they do not want to cover. Second, employers can avoid insurance premium taxes. Third, for an employer that perceives its employees to be healthier, on average, than other comparable employers, self-funding provides the opportunity to pay for health care based on the group's own experience, rather than paying an insurance premium that reflects the experience of a larger and sicker employer community. The primary drawback to self-funding is the increased risk of large losses as a result of unexpectedly high medical claims.

Employers can reduce their exposure to this hazard by purchasing insurance specifically to cover extraordinarily large expenditures. For example, in a minimum premium plan, the purchaser assumes full responsibility for health care expenditures up to a certain threshold. Beyond that threshold, an insurance company takes over or shares in the payment of all additional claims. Minimum premium plans are often good options for employers that find it economical to self-fund but do not have the financial resources to pay for unexpected high-dollar cases such as low birth weight infants with multiple complications.

ganizations and even with traditional indemnity insurance plans. Under case management, a case manager coordinates health care from a variety of providers for individuals with complex and lengthy or chronic illnesses. Case management can be used to facilitate cost-effective care which integrates health care with the total needs (developmental, educational, and environmental) of a child or a pregnant woman. It can facilitate home placement and reduce overall costs. As advocates for an insurer, however, case managers can also be used to deter utilization of expensive services.

The effectiveness of managed care programs in reducing costs varies with the type of managed care plan. A Rand Corporation study of prepaid health plans indicates that expenditures in an HMO can be as much as 25% lower than in conventional health plans.<sup>9</sup> The more loosely arranged plans such as PPOs show little, if any, overall savings because of their organizational structure. An A. Foster Higgins survey indicates that some utilization review programs save up to 4% on total medical plan costs.<sup>10</sup> Some studies of selected programs indicate that every dollar spent on utilization management results in a reduction in claims of \$4 to \$9; however, other studies indicate that these programs are barely cost-effective.<sup>11</sup>

While empirical evidence is limited, it is widely believed that managed care is most effective in modifying medical practice when network providers serve exclusively those covered under the plan (as happens in the HMO staff model) and when patients obtain their care exclusively through the network. There is some expectation that the potential for cost savings under managed care will grow as medical effectiveness and outcomes research are further developed to yield cost-effective practice guidelines which can be disseminated through managed care networks.

### Cost Sharing Arrangements

Insurance products also vary greatly in how they require employees and their families to share health care costs with the employer. Employee cost sharing takes many forms, including premium contributions, deductibles, and coinsurance. While employee cost sharing traditionally has not been a central feature in most employer-financed insurance plans (especially those that are union-negotiated), it

is becoming more popular, in part because of increasing pressure to control health expenditures.

About 45% of employees contribute to the cost of their health insurance premiums.<sup>12</sup> For health insurance plans that require a premium contribution, employees typically pay, on a pretax basis, a percentage of the monthly premium amount. The average employee contribution is 21% of the monthly premium.<sup>13</sup> Under some plans the contribution rate varies by type of policy and may be less for an individual than for a family. Premium contributions are more common for HMOs, in which 54% of enrollees pay a contribution, than they are for non-HMO plans, in which 41% of enrollees pay a contribution.<sup>14</sup>

Deductibles are common features in non-HMO insurance plans, but vary enormously in how they are structured. In 97% of fully insured plans, the insured individual must satisfy an aggregate annual deductible amount for medical expenses. Common deductibles for individual coverage are \$100 and \$200; for family coverage typical deductibles are \$300 or \$400 per family per year.<sup>15</sup> Once the insured person or family has incurred and paid for health care expenses equal to the deductible amount, the insurer assumes responsibility for the majority of health expenditures.

---

*Case management can be used to facilitate cost-effective care which integrates health care with the total needs (developmental, educational, and environmental) of a child or a pregnant woman.*

---

Some managed care plans attempt to use the deductible to direct covered individuals to hospitals and physicians with whom the managed care plan has a financial arrangement. For example, many PPOs, EPOs, and point-of-service plans have two sets of deductible rates, one for in-network providers with whom the plan has a contractual agreement and one for out-of-network providers. Typically, these plans use out-of-network deductibles that are much higher than the in-network deductibles in an effort to persuade beneficiaries to use providers who are part of the network.

**Table 1. Percentage of Health Insurance Plans Covering Well-child Care and Preventive Diagnostic Services in 1989**

Services	Traditional Indemnity Plans	Preferred Provider Organizations	IPA Model Health Maintenance Organizations	Staff Model Health Maintenance Organizations
Well-child care	50	62	98	99
Preventive diagnostics	67	71	94	100

Source: Health Insurance Association of America. *Source Book of Health Insurance Data, 1990*. Washington, DC: HIAA, 1990, p. 33.

factors influence the cost of a private health insurance plan, including the comprehensiveness of the benefits package and the degree to which cost containment programs are used. From the insurer's perspective, a major factor influencing the cost of insurance is the "riskiness" of the group or individual to be covered. Many insurers attempt to exclude high-cost groups and individuals from coverage or design policies to protect the insurer from the consequences of high-cost illness.

Preexisting condition limitations are frequently used to protect the insurer from high-cost illnesses by excluding from coverage for a specified period (often 6 to 12 months) medical care required to treat a condition that was diagnosed and/or treated prior to the commencement of coverage. By covering only new conditions, the insurer can reduce costs and offer a lower premium. These limitations have serious implications for pregnant women and infants. Because pregnancy is typically considered to be a preexisting condition, women who become insured after they have become pregnant or during a waiting period before their insurance becomes effective may find it difficult to obtain reimbursement for the costs of the pregnancy.

### Trends in Private Insurance Coverage for Children

Although private health insurance remains the primary source of health insurance for children and pregnant women in the United States, the percentage of children with private coverage declined throughout the 1980s. The erosion in coverage can be traced to the rising cost of health insurance and the growth in insurer risk selection practices that

severely restrict the availability of insurance to persons with a history of medical conditions. Moreover, the rising cost of health care has caused many employers to reduce the range of benefits provided and to require additional employee cost sharing in the form of increased deductibles and premium contributions. These trends in private insurance coverage are discussed below.

#### Trends in Coverage

The March 1990 Current Population Survey (CPS) data indicate that about 74% of all children have private insurance coverage. Nearly two thirds of all children (63%) are covered as dependents under a working parent's employer health plan (table 2). Another 11% of all children are covered under individually purchased non-group insurance plans. In addition, about 27% of all pregnant women are covered as employees under an employer health plan. About 33% are covered as dependents under their spouses' employer health plans, and another 6% are covered under individually purchased non-group insurance plans. Overall, about 60% of pregnant women have employer-sponsored coverage.

The percentage of children with employer health insurance declined from 66% in 1980 to 62% in 1986; however, the percentage with employer insurance increased to 63% by 1990. Although there are differences in the way insurance coverage is measured across surveys, these trends are generally consistent with other survey data.<sup>18</sup> For example, in this journal issue Monheit and Cunningham report that the percentage of children with private health insurance coverage throughout the year declined from 71% in 1977 to 63% in 1987.

The decline in the percentage of children covered under employer plans

shifting may be causing increases in uncompensated and undercompensated care by further reducing the affordability of private insurance.

In response to rising health care costs, many employers have attempted to control spending through a variety of managed care strategies. Industry data show that HMO enrollment has grown steadily during the past decade.<sup>20</sup> In 1988, about 19% of persons insured by benefit plans of firms with 100 or more employees were enrolled in HMOs and approximately 7% were enrolled in selective contracting plans (PPOs and EPOs).<sup>21</sup> In addition, 91% of employer plans surveyed by A. Foster Higgins have some form of utilization review program.<sup>22</sup> For example, 73% of insurers require precertification for selective hospital admissions, and about half require concurrent review of hospital admissions. Despite these efforts to contain costs, however, many employers have found it necessary to reassess the level of coverage provided.

#### Covered Services

The traditional role of private insurance was to cover costs associated with acute illnesses, not costs associated with services designed to prevent illness. Rapidly rising health care costs have led many employers to broaden that focus. Pregnant women have been a popular target of managed care programs because expenses related to childbirth are the largest single component of a typical employee group's health care costs and may range from 10% to 49% of total expenditures.<sup>23</sup> Employers and insurers now offer services that were rarely covered under traditional insurance plans, including free obstetrical visits, behavior modification classes for smoking cessation and weight loss, preconception health risk appraisals, and extensive prenatal and postpartum educational materials and classes.<sup>24</sup> One employer estimates that its pregnancy health benefits management program saved almost \$500,000 in its first year by reducing the frequency of low birth weight babies.<sup>23</sup>

Young children are also a popular target for specialized programs such as case management. For example, a midwestern HMO is implementing a case management program designed to help children with chronic asthma. The program was designed in response to the fact that asthma was the number one reason for school absenteeism in the area and a



© Kathy Scamba 1992

major source of HMO expenditures. In concert with the school nurse, primary care physician, a social worker, the parents, and a combination of other professionals, the pediatric asthma case manager works with the child to help him or her accept the responsibilities associated with asthma treatment. The goal is to keep the child in school and out of the emergency room or hospital inpatient setting.<sup>25</sup>

Another increasingly popular program involves using so-called Centers of Excellence. Centers of Excellence are facilities identified by insurers as high quality, cost-effective providers of specialty care. For example, children's hospitals are often designated as Centers of Excellence for the provision of specialized pediatric care. All cases for specific types of care are then sent to the Center of Excellence for treatment. Currently, the most popular types of Centers of Excellence are those specializing in organ transplants and rehabilitation services.

While many of the trends in children's coverage are positive, coverage for certain services of particular importance to children has declined in recent years. An annual survey of medium and large firms conducted by the Bureau of Labor Statistics (BLS) indicates that the percentage of persons with dental coverage declined from 77% in 1984 to 66% in 1989.<sup>26</sup> The BLS data also indicate that the percentage of participants in plans with limitations on the number of days of inpatient coverage increased from 43% in 1982 to 77% in 1989. In

dependent by another family member (34.3% in 1979 to 31.4% in 1986).<sup>32</sup>

#### Insurance Rating and Availability

Perhaps the most disconcerting trend in our health care financing system has been the erosion of insurance as a means of pooling risk. In effect, we are rapidly moving to an insurance system that is willing to insure only healthy individuals. In the early days of the health insurance industry, all individuals paid a uniform community-rated premium. Community rating pools the cost of all health services provided in a given region across all community members and sets a single uniform premium for all insured individuals. Under a community-rated system, people who use lesser amounts of health care effectively subsidize the cost of care provided to sicker individuals who use more services. However, if one takes the long view, community rating assures that when healthy individuals become ill they will receive needed health services while paying no greater premium than other members of the community.

Community rating was brought to an end by competition among insurance companies. The typical marketing strategy for an insurer is to attract business by offering competitive premiums to only the healthiest groups and limiting the insurer's exposure by refusing to cover health conditions that were present before the policy was issued. Renewal premiums are adjusted based upon experience so that premiums increase if the health status of the group declines. In today's system, most individuals pay a premium that reflects their health status and typical expenditure patterns rather than the overall average cost of health care in their community.

Furthermore, insurers often engage in a practice known as medical underwriting which analyzes health characteristics of individual group members to identify potentially high-risk individuals. Underwriting occurs primarily in the small group and individual insurance markets with the result that selected people are denied coverage through this process. To date, medical underwriting has been used infrequently by larger employers who are typically self-funded and/or can effectively pool risk to reduce their exposure to large losses.

The demise of community rating has worked to the benefit of some and to the detriment of others. Healthier individuals

benefit from this change because they pay a premium that is often substantially lower than what they would have paid under a community-rated system. However, medical underwriting has greatly increased premiums for sicker individuals and, in many instances, has left uninsured those most in need of health coverage. Moreover, as healthier people become sick, they often face dramatic increases in premiums and may ultimately find themselves uninsured.

Insurer risk selection practices can have a dramatic impact on families with chronically ill children. Many parents find that they cannot change jobs without losing coverage for these children because of preexisting condition limitations. In some small groups, the presence of a single chronically ill child can so increase premiums that the employer may terminate coverage. Moreover, as these chronically ill children reach adulthood, they are no longer eligible for coverage as dependents under their parents' employer plans and may not be able to obtain insurance on their own.

### The Impact of Benefit Packages on Costs and on Children's Health Status

Using deductibles and coinsurance to increase patient cost sharing is an effective means of reducing employer health plan costs. Cost sharing reduces health benefits costs to the employer in two ways. First, it reduces the share of an individual's total health spending which is paid for by the plan. Second, cost sharing creates an in-



time. Specifically, the data do not reflect the general trend toward reduced inpatient utilization and increased use of outpatient treatments. Moreover, the HIE reflects the impact of overall family deductibles as well as individual deductibles. Thus, the utilization response under child-only health policies could differ from the HIE experience.

### Impact on Health Status

Analysis of the HIE data indicates that the lower utilization associated with cost-sharing plans had no measurable impact on health status.<sup>37</sup> The health status of children in the various cost-sharing plans was compared on the basis of two measures: objective physical examinations administered under the HIE and subjective health status reports provided by the individual. Little difference in health status was observed across the various types of cost-sharing plans under either health status measure.

The results of the HIE study must be treated with caution because the data do not include a sufficiently large sample to measure the impact of cost sharing on at-risk children.<sup>38</sup> For example, the study indicated that poor children with cost sharing were more than twice as likely to suffer from anemia than poor children with free care. This suggests that cost sharing may have a detrimental impact on health status for children in low-income families.

These results are generally consistent with the results obtained in other studies of service utilization and health status. These studies provide little evidence that additional medical services result in improved health status for children, except for the poor. However, a study by Dutton and Silber of alternative ambulatory care settings with different cost-sharing requirements indicated that small improvements in health status were observed among children that do not face cost sharing.<sup>39</sup>

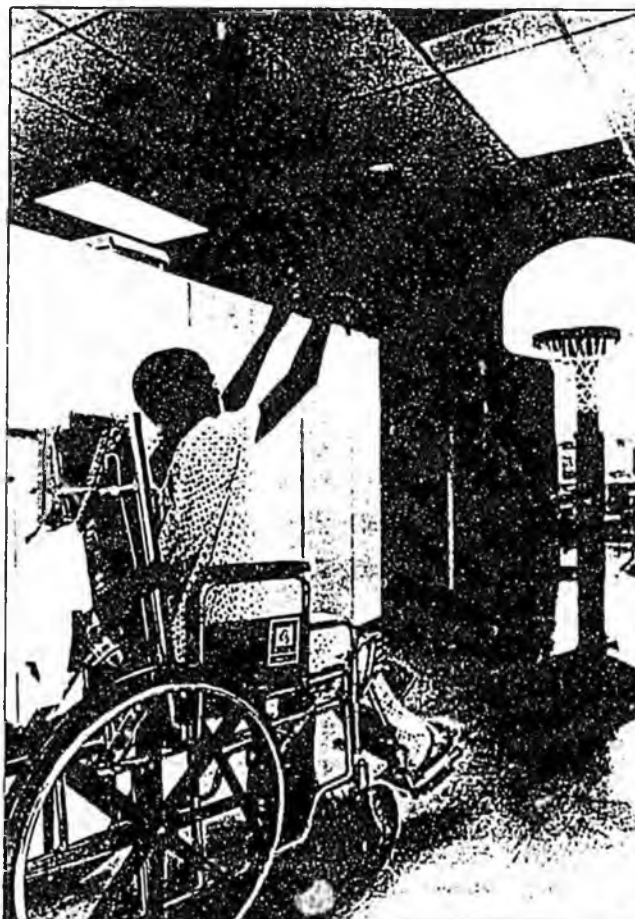
### Policy Issues Concerning Private Health Coverage for Children

More than 30 health care reform bills have been introduced in Congress. Several other proposals have been developed by insurers, provider groups, and business associations. While some of these proposals would eliminate private insurance and

cover all persons under a single government program, most of these proposals would build upon the existing private insurance system. Nearly all of the proposals that build upon the existing private insurance system would regulate insurance marketing practices so that coverage is available to all regardless of health status. Some plans would provide incentives for employers and/or individuals to purchase private insurance while others would require that all individuals obtain insurance. These proposals typically emphasize access to insurance for children and pregnant women and often stress prenatal and well-child care.

### Universal Coverage for Children

The American Academy of Pediatrics (AAP) has proposed to require insurance coverage for all pregnant women and children through the age of 21. The AAP plan would provide a comprehensive benefits package covering preventive services, inpatient care, prescription drugs, developmental disabilities, substance abuse treatment, nutritional supplements, and counseling services related to parental education and child abuse.<sup>40</sup> The plan also would require physician-directed case



© Melny Soane 1992

duces administrative costs. In fact, average costs could actually increase as high-risk individuals who do not now have insurance obtain coverage and enter the broader private insurance risk pool. Although the pooling of risk implied by these reforms can be expected to reduce premiums for high-risk individuals who now purchase insurance, risk pooling will inevitably result in premium increases for lower-risk individuals who now enjoy favorable premium rates. Thus, a restoration of risk pooling in our insurance system will move us back toward a system where lower-risk individuals subsidize health costs for high-risk cases and may actually increase the overall average cost of health insurance and health care.

### Toward Universal Coverage

Most health reform plans are intended to extend coverage to all uninsured persons regardless of age. Although plans vary in significant ways, they can be classified into three basic approaches: (1) mandated employer responsibility; (2) tax incentive programs; and (3) single payer approaches. Although these plans would extend coverage to all children, the benefits provided under these proposals are typically less well tailored to the special needs of children than are child-only plans such as the one proposed by AAP.

#### Employer Responsibility

In 1988, Sen. Edward Kennedy (D-MA) and Rep. Henry Waxman (D-CA) jointly introduced a bill that would require all employers to cover their workers and their dependents.<sup>42</sup> Since that time, the authors of the bill have shifted their support to the pay-or-play approach, which gives employers the option of paying a tax and having their workers covered under a public plan in lieu of providing employees with private insurance. However, both the employer mandate and the pay-or-play approach establish that employers are responsible for covering their workers. The pay-or-play approach is now embodied in the Health America Act currently under consideration by Congress.

The Health America Act (S. 1227) specifies a minimum standard benefits package to be provided to all individuals which includes well-child care, prenatal care, and substance abuse treatment. The bill also includes insurance market reforms that are designed to extend coverage to all individuals while substantially restricting variations in premiums resulting from

changes in health status. Indeed, an employer mandate could not be effective unless accompanied by regulations making insurance available to all individuals.

#### Tax Credit Program

The Heritage Foundation has developed a program that would replace our existing system of employer-based coverage with a requirement that all individuals purchase insurance.<sup>43</sup> Employers would be required to convert their current contributions to wages, which would then become taxable to the employee. The increase in tax revenues would be used to finance a tax credit to individuals, which would vary with income and the cost of insurance. This proposal also includes insurance market reforms designed to assure the availability of insurance coverage and limit the variation in premiums by health status.

The purpose of the Heritage Foundation proposal is to make individuals more conscious of the cost of care they consume by requiring that they purchase insurance out of their income. The plan does not specify a minimum benefits package so that individuals would be permitted to delete coverage for selected benefits. This may result in reductions in coverage for important child health services such as preventive care.

#### Single Payer

Several bills have been introduced which would eliminate private insurance and cover all Americans under Medicare<sup>44</sup> or cover all Americans under a single government program modeled on the Canadian system.<sup>45</sup> However, a publicly financed national health insurance plan does not necessarily mean the end of private insurance. For example, the Health USA Act introduced by Sen. J. Robert Kerrey of Nebraska would establish a publicly financed national health insurance program in which individuals choose among insurers competing on the basis of price and quality.<sup>34</sup>

#### Cost Containment

The share of our gross national product devoted to health care increased from 9.1% in 1980 to 12.2% by 1990. Yet, despite this dramatic increase in the share of our national wealth devoted to the health sector, the number of persons without health insurance increased by 9 million during this same period.<sup>46</sup> As costs have risen, fewer and fewer employers and families have been able to afford insurance coverage. Indeed, controlling costs is widely

### Global Budgeting

Global budgeting is the process whereby some portion of total health expenditures is paid according to a prospectively determined (typically negotiated) annual budget. Global budgets are commonly implemented in countries with national health insurance, particularly in the hospital sector, where operating budgets are used also for planning purposes. It is harder to impose budget ceilings on physician services, although West Germany has successfully done so for many years. A recent study by the General Accounting Office (GAO) estimated that global budgets reduced health care spending in real terms by 9% in the hospital sector in France and by 17% in the physician sector in West Germany.<sup>49</sup>

While global budgets appear to be effective in controlling health care costs, there is some evidence that they may lead to non-price rationing of services and shifting of costs from the payers (for example, the federal and regional governments) to the citizens, primarily in the form of the long waits associated with access to many services. Queuing is most common for nonemergency services such as diagnostic tests and elective surgeries. There is little evidence, however, that children are adversely affected by queuing. In fact, infant mortality rates in other developed countries using global budgeting tend to be far lower than those in the United States.<sup>50</sup>

## Conclusions

Private health insurance is the primary source of coverage for America's chil-

dren and pregnant women. Access to private health coverage is threatened by the spiraling cost of health care, cost shifting, and insurance marketing practices which tend to deny coverage to high-risk individuals. These pressures threaten to increase the number of uninsured persons and reduce the level of coverage for persons who remain insured. These changes will ultimately result in increased pressure on government programs to care for our nation's uninsured children.

Efforts should be taken to preserve the stability of our private insurance system. Reimbursement under public programs should be sufficient to reduce the cost shifting that is compounding the growth in private insurance costs. Insurance marketing practices should be reformed to guarantee the availability of coverage to all groups by restoring insurance as a means of pooling risk. Aggressive cost containment efforts should also be initiated involving competition, managed care, and possibly global spending limits.

The rising cost of health services threatens to transform health care into a luxury good affordable only by higher-income Americans. This will represent a particular hardship for America's children, a disproportionate share of whom are living below the poverty line. Though typically thought of as a means of expanding insurance coverage, extensive reforms of the health care system may be needed just to preserve the existing level of private insurance coverage.

1. Lewin-ICF analysis of the March 1990 Current Population Survey (CPS) Data.
2. Kronick, R. Health insurance, 1978-1989: The frayed connection between employment and insurance. *Inquiry* (Winter 1991) 28:318-32.
3. American Academy of Pediatrics. *Children first: A legislative proposal*. Washington, DC, 1990.
4. Health Insurance Association of America. *Source Book of Health Insurance Data, 1990*. Washington, DC: HIAA, 1990, pp. 29-30.
5. Although risk pooling minimizes a large group's need to insure against large unanticipated expenditures, most employers choose to pass on some or all of the risk associated with unexpected costs to an insurer that can reduce risk even further by pooling the experiences of many large groups.
6. Approved services are those that are (1) considered covered by the policy guidelines (for example, most policies do *not* cover experimental procedures) and (2) determined to be medically necessary or appropriate (for example, cosmetic surgery is considered medically necessary only in specific situations). In some managed care arrangements, services must be performed by a select group of providers to be approved for payment.
7. See note no. 4, HIAA, p. 29.

36. Leibowitz, A., et al. Effect of cost-sharing on the use of medical services by children: Interim results from a randomized controlled trial. *Pediatrics* (May 1985) 75,5:942-50.
37. Burciaga Valdez, R.O. *The effects of cost sharing on the health of children*. RAND Corporation, March 1986. Prepared for the U.S. Department of Health and Human Services.
38. Another reason the HIE may not be useful in assessing the impact of cost sharing on poor children is that the experimental insurance package had annual expenditure ceilings that were fixed as a proportion of family income. This diluted the effects of cost sharing on poor families, who reached the expenditure ceilings more quickly than higher income families and then were eligible for free care the rest of the year. Most real-world insurance plans have expenditure ceilings nominally fixed for all beneficiaries regardless of family income. As a result poor families could face substantial cost-sharing requirements for most of a year which might serve as a more substantial deterrent to utilization than modeled in the HIE. Starfield, B., and Dutton, D. Care, costs, and health: Reactions to and re-interpretation of the Rand findings. *Pediatrics* (October 1985) 76,4:614-21.
39. Dutton, D.M., and R.S. Silber. Children's health outcomes in six different ambulatory care delivery systems. *Medical Care* (1980) 18,7:693-713.
40. American Academy of Pediatrics. *Children first: A legislative proposal*. Washington, DC: AAP, 1990.
41. Executive Office of the President. *The President's comprehensive health reform program*. Washington, DC., February 6, 1992.
42. The Basic Health Benefits for All Americans Act, S. 768 (1988) introduced by Sen. Edward Kennedy (D-MA) and Rep. Henry A. Waxman (D-CA).
43. Butler, S.M. *Assuring affordable health care for all Americans*. Washington, DC: The Heritage Foundation, 1991.
44. The Medplan Act of 1991, H.R. 650 (1991) introduced by Rep. Pete (Fortney) Stark (D-CA).
45. The Universal Health Care Act, H.R. 1300 (1991) introduced by Rep. Marty Russo (D-IL).
46. Sheils, J. The impact of the Health America Act on health spending. Testimony before the Senate Finance Subcommittee on Health for Families and the Uninsured, September 23, 1991.
47. The health care delivery system of the Department of Veterans' Affairs is probably the only exception to this rule. Its sole source of revenue is the federal government, which determines a global budget for the VA system prospectively.
48. Moran, D. W., and Wolfe, P.R. Can managed care really control costs? *Health Affairs* (Winter 1991) pp. 120-28.
49. General Accounting Office, *Health care spending control: The experience of France, Germany, and Japan*. Gaithersburg: GAO, November 1991, pp. 46-47.
50. Aaron, H. *Serious and unstable condition*. Washington, DC: The Brookings Institution, 1991, p. 79.

**THE STATE OF ALASKA  
HEALTH RESOURCES AND ACCESS TASK FORCE**

**FINAL REPORT**

to

**the Governor and Legislature**

**January 1993**

**Alaska State Legislature  
Health Resources and Access Task Force  
State Capitol  
Juneau, Alaska 99801-1182**

*Portions of Health Resources + Access Task Force 1/93*

***Finding #4: In spite of significant spending on health care, many Alaskans lack coverage for even the most basic health care services.***

While \$1.6 billion (the estimated total health care spending in Alaska in 1991) seems like it should be sufficient to provide a basic level of care to all Alaskans, the Task Force observed that:

- In the late 1980s, over 76,000 non-elderly Alaskans had no health care coverage.

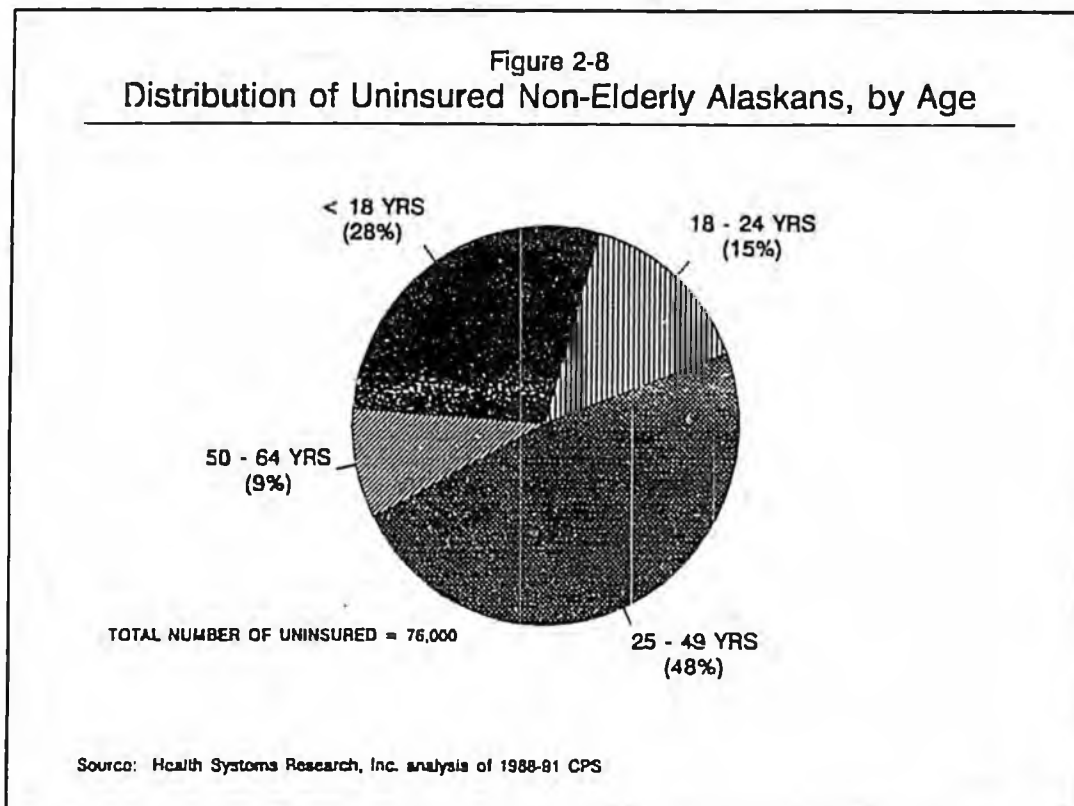
An analysis of Alaska-specific data from the 1988 through 1991 Current Population Surveys revealed that approximately 76,000 non-elderly Alaskans had no health care coverage. That means that they had no coverage for any service, whether it be private insurance, Medicaid, Medicare, Indian Health Service coverage, or any other type of third-party health care coverage.<sup>6</sup>

---

<sup>6</sup> The Current Population Survey is a national survey conducted each year by the U.S. Bureau of the Census. While the number of persons included in the CPS from states with relatively low populations (such as Alaska) is small, most states nonetheless rely on CPS data to provide rough estimates of the number of uninsured because better estimates are expensive and difficult to generate. One technique used to compensate for the small sample size is to analyze survey results over a several year period. This approach was used in the analyses conducted for the Task Force. We would also note that in the Task Force's Interim Report (January 11, 1992), 90,000 Alaskans were reported as being uninsured. This number included a certain number of Alaska Natives who responded in the survey that they had no health care coverage, despite the fact that they are eligible to receive care through the AANHS/IHS system. Dr. Bartlett of Health Systems Research, Inc., in response to the Task Force's request to develop an estimate using the "assumption that all Alaska Natives have health care coverage through the Indian Health Service system," removed the Alaska Native respondents from the sample and reanalyzed the data. This reduced the estimate of the number of uninsured Alaskans from 90,000 to 76,000. For complete results of Dr. Bartlett's analyses, see Appendix D.

- Over 21,000, more than one in every four, uninsured Alaskans are under the age of 18.<sup>7</sup>

Figure 2-8 presented below displays the distribution of Alaska's non-elderly uninsured population by age. Because of the nearly universal coverage provided by Medicare to the elderly population, our analysis focuses on the characteristics of the non-elderly uninsured population. As can be seen from this chart, over a quarter (28 percent) of uninsured persons in the state are children, while another 15 percent are young adults aged 18 - 24. The remainder of the state's uninsured population are adults aged 25 - 49 (48 percent) and older adults aged 50 - 64 (9 percent).



- In the late 1980s, many uninsured Alaskans did not have sufficient income to purchase health care coverage on their own.

A 1989 study by the National Health Care Campaign found that, in most states, it is only when families earn more than 250 percent of the poverty level that they begin to accumulate the disposable income required to contribute toward a portion of

<sup>7</sup> In the Task Force's *Interim Report*, we reported that there were 28,000 uninsured children. When Dr. Bartlett removed Alaska Native respondents from the CPS sample, the estimate of the number of uninsured children was reduced to 21,000. See Appendix D.

premium costs (Appendix D). When the Task Force compared this finding to its analysis of the incomes of uninsured Alaskans, it discovered that a significant portion of the state's uninsured population could not afford to purchase coverage on their own. For example, the Task Force realized that even though the federal and State governments together spent over \$214 million in 1991 in Alaska for the Medicaid program, more than 13,500 uninsured Alaskans lived in households in the late 1980s with incomes below the federal poverty level.<sup>8</sup> An additional 16,000 uninsured Alaskans lived in households with incomes between 100 and 200 percent of poverty (with incomes between \$15,120 and \$30,240 for a family of four).

#### PERSONAL STORIES . . .

*"When my daughter and son-in-law were expecting their first child, my daughter was unable to work . . . Our son-in-law was making just enough to pay for essentials. The state welfare system declined their request for medical coverage claiming our son-in-law's income was too high, wasn't making more than \$6 per hour . . . I was informed that (a particular) hospital would help. The hospital charged according to income. They paid all of the hospital bill."*

— Anchorage Resident

Of particular concern to the Task Force was the fact that so many thousands of low income children were without basic health care coverage. We found that of the more than 21,000 uninsured Alaskan children, about 3,900 lived in households with incomes below the federal poverty level, while another 4,500 were in families with incomes between one and two times the poverty level.

Given the financial risks of being uninsured, the Task Force also found it disturbing that nearly 30,000 uninsured Alaskans were in families with incomes in excess of 300 percent of poverty. Of these, roughly 18,000 were employed full-time for the entire year. The Task Force concluded that, under the current system, there may be a number of reasons why persons with adequate incomes are without coverage. Some may be uninsured because they wish to avoid the expense or consider themselves to be "immortal." Others have significant health care needs and cannot find an insurer who will offer them a policy at an affordable price. The Task Force further recognized that as long as some Alaskans remain uninsured and continue to incur health care expenses which they cannot afford, providers will continue to shift the costs of caring for the uninsured and underinsured to employers who provide health care benefits to their employees.

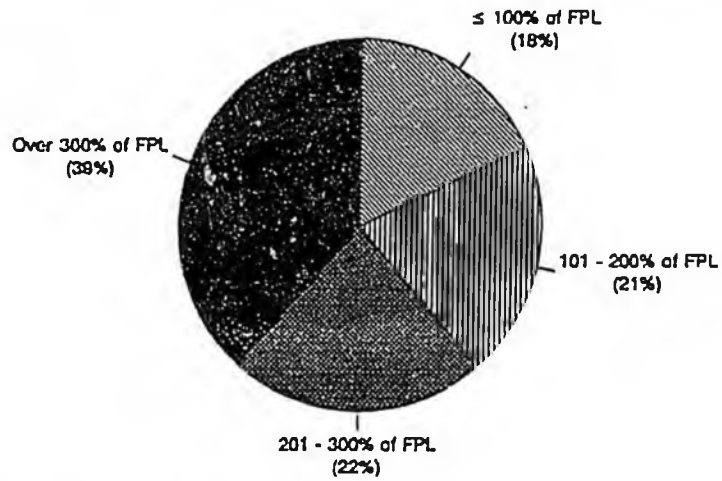
#### PERSONAL STORIES . . .

*"I can't get health insurance because I have been diagnosed recently with MS. I was working in a full-time position (for a large employer), I was pregnant at the time I was diagnosed. Unfortunately, the employer is here in the state and felt a need to lay me off, when I was pregnant and recently diagnosed. I have contacted several health insurance companies in the private sector and to my disbelief, people with tuberculosis, any form of cancer within the last ten years, diabetes, overweight, MS, AIDS, or even having open heart surgery cannot obtain health insurance in the private sector, even though we are willing to pay the premium, we are unable to get health insurance."*

— Anchorage Resident

<sup>8</sup> The 1989 federal poverty level for a family of four in Alaska was \$15,120.

Figure 2-9  
Distribution of Uninsured Non-Elderly Alaskans,  
by Poverty Status



TOTAL NUMBER OF UNINSURED = 76,000

Source: Health Systems Research, Inc. analysis of 1988-91 CPS

**Table 2-3**  
**Breakdown of Insurance Company Administrative Expenses**  
 (Percentage of Incurred Claims)

Number of Employees			General*	Profit & Risk	Commission	Total
1	to	4	23.1	8.5	8.4	40.0
5	to	9	21.0	8.0	6.0	35.0
10	to	19	17.5	7.5	5.0	30.0
20	to	49	14.9	6.8	3.3	25.0
50	to	99	10.0	6.0	2.0	18.0
100	to	499	8.9	5.5	1.6	16.0
500	to	2,499	7.8	3.5	0.1	12.0
2,500	to	9,999	5.9	1.8	0.3	8.0
10,000	or	more	4.3	1.1	0.1	5.5

\* Includes claims administration, general administration, interest credit, and premium taxes.

Source: Congressional Research Service

**RECOMMENDATION # 6:**

***The Task Force recommends the establishment of State-sponsored health insurance pooling arrangements.***

During its deliberations, the Task Force reviewed information indicating that nationwide as much as 40 percent of premiums charged to very small businesses may be attributable to administrative costs. While the small group market reform provisions included in earlier recommendations are expected to reduce the administrative costs associated with providing coverage to small businesses, the Task Force also considered it appropriate for the State, through the newly established Health Care Authority, to establish one or more pooling arrangements through which both individuals and businesses, small and large, could purchase health care coverage. It is anticipated that certain additional efficiencies and economies could accrue to the members of these pool arrangements that would further reduce their premium costs. In designing these pools, the Task Force noted the importance of considering their medical underwriting and premium setting practices in relation to those of other insurers governed by the small market reform proposals to ensure that these State-sponsored pools are not damaged by the adverse selection that would result from other insurers subtly "dumping" undesirable risks into these pools.

**RECOMMENDATION # 7:**

***The Task Force recommends the passage of legislation providing for publicly-subsidized coverage of uninsured low-income pregnant women and children who are not eligible for Medicaid.***

Even with the recommendations concerning cost containment, market reform, and pooling measures in place, the Task Force recognizes that it would be necessary to provide some level of public subsidy to certain low-income uninsured persons if they are to be able to afford health care coverage (see Finding #4).

The Task Force determined that the populations to be given highest priority for receiving subsidized coverage should be low income pregnant women and children in families with incomes too high to be eligible for Medicaid but too low to be able to

purchase private health insurance on their own.<sup>8</sup> Priority was given to these groups because of the documented improvements in birth outcomes and the cost savings associated with the receipt of prenatal care by pregnant women and the positive lifelong benefits associated with providing adequate primary and preventive care to children. The Task Force also determined that the positive health improvements resulting from public health care subsidies for these populations could be maximized by providing coverage of comprehensive services (e.g., prenatal and other preventive services, plus other ambulatory and inpatient care) for low income pregnant women and ambulatory care services for low income children.

Given these priorities, the Task Force recommends that legislation be enacted to establish a program providing State-subsidized insurance coverage for low-income children who are not eligible for Medicaid or Indian Health Service coverage and who are in families with incomes below 300% of the federal poverty level. In order to make the program more affordable at the outset, coverage would be provided for primary and preventive and/or ambulatory care services, but not for inpatient care.

Experience in other states has shown similar programs to be more attractive to families if they were perceived to foster self-sufficiency and were similar to private insurance in design. Therefore, the Task Force recommends that the program be given an identity apart from Medicaid, particularly the eligibility system. This would not preclude the Medicaid agency from administering the program if it proves most cost-effective, however serious consideration should be given to having a private insurer administer the program under contract to the State. The Task Force was heartened by expressions of interest from two major carriers in Alaska in being involved in such a program.

While coverage would be substantially subsidized by the State, premium sharing requirements in the range of \$50 - \$300 per year per child should be established on an income-related sliding scale basis. This premium sharing will not only reduce the required level of State subsidy, but also will give parents of enrolled children a sense of involvement and participation in contributing to coverage for their children.

As illustrated in Table 4-2 on the following page, approximately 14,600 uninsured Alaskan children would be eligible for coverage under this program. The Task Force estimates that roughly 8,200 children would actually enroll in the program, with nearly 90 percent of these children having no previous health care coverage. The remaining enrollees are expected to be children with private insurance that provides inadequate coverage of primary and preventive care. The annual cost of the program is estimated to be \$6.1 million, of which \$4.2 million would be financed by State subsidies. The remaining \$1.9 million would be paid by families in the form of premium contributions.

---

<sup>8</sup> It should be noted that the Task Force identified high-risk individuals as another high priority population and in our interim recommendations we endorsed the establishment of a statewide high-risk insurance pool for this population. Legislation establishing such a pool was enacted last year by the Alaska State Legislature.

Table 4-2  
**ESTIMATES OF ENROLLEES AND COSTS UNDER  
 SUBSIDIZED AMBULATORY CARE PROGRAM FOR LOWER INCOME  
 ALASKAN CHILDREN NOT ELIGIBLE FOR MEDICAID OR IHS COVERAGE**

<u>Income</u>	<u>Number of Uninsured Children</u>	<u>Number of Enrollees</u>	<u>Costs (in millions of \$)</u>		
			<u>State</u>	<u>Family</u>	<u>TOTAL</u>
Under Poverty	3,900	300	\$0.2	\$0.0	\$0.2
100-200% Poverty	4,500	2,900	\$1.8	\$0.4	\$2.2
200-300% Poverty	6,200	5,000	\$2.2	\$1.5	\$3.7
<b>TOTAL</b>	<b>14,600</b>	<b>8,200</b>	<b>\$4.2</b>	<b>\$1.9</b>	<b>\$6.1</b>

Source: Health Systems Research, Inc.

With respect to the coverage of low income pregnant women, the Task Force recognizes that, while federal laws enable the State of Alaska to extend Medicaid eligibility to pregnant women and infants in families with incomes up to 185% of poverty, the State currently has elected to provide coverage only to pregnant women and infants in families with incomes below 133% of poverty. The Task Force recommends that the State expand its Medicaid coverage for pregnant women and infants up to 185% of poverty. The FY 1994 cost of this expansion to the State is estimated to be \$3.8 million, which will be matched by an equal amount from the federal government. For uninsured women with incomes above this income level but below 300% of poverty, the Task Force recommends the establishment of a publicly-subsidized private insurance program providing comprehensive services.



Alaska State Legislature  
House of Representatives  
COMMITTEE ON HEALTH, EDUCATION  
AND SOCIAL SERVICES

DATE: MARCH 31, 1993

PLACE: Capitol Room 106

SUBJECT OF MEETING:  
CONFIRMATION HEARINGS - AK BOARD OF EDUCATION  
STOWELL JOHNSTONE  
\*HB 195: AUTHORIZING YOUTH COURTS  
\*HB 22: AK HEALTHY START PROGRAM  
(\*HB195 AND \*HB 22 TO BE TELECONFERENCE)

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?	WHAT SUBJECT/ WHICH BILL?
Valerie M. Johnson	Fairbanks	779 8th St. Borough Fairbanks	99701	456-8113	452-6194	(Y) N	HB 195
Ken Sykes	IDS/Trade	503 9th				Y (N)	HB 22
Bob Sims	" "	503 9th				Y N	HB 22
Caren Robinson	League of Women				586-1107	(Y) N	HB 195
Patty Merut		4581 Drake St. FBKS	99709	479-0700	474-0841	Y N	
Randall Hines	DHSS	Box 110630 Juneau	99811		465-3187	(Y) N	HB 195
						Y N	
						Y N	
						Y N	
						Y N	
						Y N	

3/31/93

LTN1100-R01  
04/01/93

LEGISLATIVE TELECONFERENCE NETWORK

PAGE 01  
18:24:24

TCN: 30412 DATE & TIME: 03/31/93 15:00 TO 16:00 STATUS: 7 STATS. IN

\*\*\*\* ORDER SUMMARY \*\*\*\*

SPONSOR: HHES HOUSE HEALTH, EDUCATION AND SOCIAL SERVI CHAIRS: TOOHEY  
PURPOSE: PUB PUBLIC HEARING BUNDE  
CONTACT: LYNNE SMITH TEL#: (907)465-6825  
CHAIRING SITE: JUNEAU CAPITOL CAP106

SPONSOR REMARKS(PUB): TESTIMONY: Y ALLOWED 5 MINUTE LIMIT  
TCN REQUESTED ON 03/31/93 AND HAS 8 UPDATES

\*\*\*\* AGENDA \*\*\*\*

- 1 HB 195 AUTHORIZING YOUTH COURTS
- 2 HB 22 ALASKA HEALTHY START PROGRAM

\*\*\*\* PARTICIPATING LIDS \*\*\*\*

ANC ANCHORAGE	3111 C STREET	LOCATION STAFF
BAR BARROW	COURTHOUSE #305	LOCATION STAFF
FBX FAIRBANKS	119 N CUSHMAN ST	LOCATION STAFF
* JNU JUNEAU	CAPITOL CAP106	LOCATION STAFF

\*\*\*\* VOLUNTEER & OFFNET SITES \*\*\*\*

ZZZ OF1 OFFNET 1	SEATTLE	STEVE LEBRUN	(206)467-2803
ZZZ OF2 OFFNET 2	HOONAH	MAXINE SANLAND	(907)945-3668

PARTICIPANTS IN ANCHORAGE ANC

ID	NAME	ADDRESS	CITY	ROLE	CONTACT
1	MARY MCGINNIS	1000 MULCHATNA	ANCHORAGE	OBSV. HB 22	AK 99654 (907)373-7569
2	BRYAN CLARK	1981 COMMODORE	ANCHORAGE	ANCH YOUTH CRT TSFY. HB 195	AK 99507 (907)344-4486
3	JESSE KICHL	6301 TRAPPER TRACT	ANCHORAGE	ANCH YOUTH CRT TSFY. HB 195	AK 99516 (907)345-3394
4	ROBERT BUTTCANE	2600 PROVIDENCE DR.	ANCHORAGE	ANCH YOUTH CRT TSFY. HB 195	AK 99508 (907)562-2285
5	THELMA LANGDON	2363 CAPT. COOK DRIVE	ANCHORAGE	ACTION OF CHILD TSFY. HB 22	AK 99517 (907)248-0834
6	SHARON LEON	5205 STRAWBERRY RD	ANCHORAGE	ANCH YOUTH CRT TSFY. HB 195	AK 99502 (907)274-5986
7	BLYTHE MARSTON	3001 MC COLLIE AVE	ANCHORAGE	TSFY. HB 195	AK 99517 (907)248-7739
8	JON EALY	5245 E. 147TH	ANCHORAGE	AYC ANCH BAR TSFY. HB 195	AK 99516 (907)345-7119
9	MARY BRISTOL	3305 GLENN DON DR.	ANCHORAGE	ANCH SCHOOL TSFY. HB 195	AK 99504 (907)333-6725
10	CAROLE CLARK	1981 COMMODORE DR.	ANCHORAGE	ASD TEACHER OBSV. HB 195	AK 99507 (907)344-4486
11	ROBERT OWENS	PO BOX 105035	ANCHORAGE	ANCH BAR TSFY. HB 195	AK 99510 (907)274-5152
12	JOSHUA WALTON	PO BOX 221166	ANCHORAGE	ANCH YOUTH CRT TSFY. HB 195	AK 99522 (907)248-1323
13	JUSTIN WALTON	PO BOX 221166	ANCHORAGE	ANCH YOUTH CRT TSFY. HB 195	AK 99522 (907)248-1323
14	BRYAN MERRELL	17613 RACHEL CIRCLE	EAGLE RIVER	ANCH BAR-YNG LAW TSFY. HB 195	AK 99577 (907)272-6474
15	MARIGH HUGHES	509 W 3RD	ANCHORAGE	AK BAR FND TSFY. HB 195	AK 99501 (907)263-8359

PARTICIPANTS IN: ANCHORAGE ANC

16	ROYH PO BOX 213-649	HENDERSON	JUV DIVERSION ANCHORAGE	TSFY. HB 195 AK 99521 (907)338-5548
17	STEVEN 715 L ST	PRADILL	ANCHORAGE	TSFY. HB 195 AK 99501 (907)279-4529
18	SCOTT 3951 FURROW CRK RD	ANDREWS	ANCHORAGE	OBSV. HB 195 AK 99516 (907)345-3601
19	DID NOT	SIGN IN		OBSV. HB 195 AK (907)000-0000
20	DID NOT	SIGN IN		OBSV. HB 195 AK (907)000-0000

PARTICIPANTS IN: FAIRBANKS FBX

1 MS.	KAREN 204 FRONT ST.	PERDUE	FAIRBANKS	TSFY. HB 22 AK 99707 (907)000-0000
2 MS.	JANE	DEMERT	FNA FAIRBANKS	TSFY. HB 195 AK (907)000-0000
3 MS.	ELLEN	GANLEY		OBSV. HB 195 AK (907)000-0000
4 MR.	MARK	BOYER	FAIRBANKS	OBSV. HB 195 AK (907)000-0000

PARTICIPANTS IN: JUNEAU JNU

1 REP.	CON	BUNDE		TSFY. HB 195 AK (907)000-0000
2 REP.	CYNTHIA	TOOHEY		TSFY. HB 195 AK (907)000-0000
3 REP.	PETE	KOTT		TSFY. HB 195 AK (907)000-0000
4 REP.	AL	VEZEY		TSFY. HB 195 AK (907)000-0000
5 REP.	GARY	DAVIS		TSFY. HB 195 AK (907)000-0000
6 REP.	HARLEY	OLBERG		TSFY. HB 195 AK (907)000-0000
7 REP.	BETTYE	DAVIS		TSFY. HB 195 AK (907)000-0000
8 REP.	IRENE	NICHOLIA		TSFY. HB 195 AK (907)000-0000
9 REP.	TOM	BRICE		TSFY. HB 195 AK (907)000-0000
10 REP.	JOE	SITTON		TSFY. HB 195 AK (907)000-0000
11 REP.	JIM	NORDLUND		TSFY. HB 195 AK (907)000-0000
12	TESTIFIER	1		TSFY. HB 195 AK (907)000-0000
13	TESTIFIER	2		TSFY. HB 195 AK (907)000-0000
14	TESTIFIER	3		TSFY. HB 195 AK (907)000-0000

15 \* SHERRIE GOLL T

AK (907)000-0000  
TSFY. HB 195  
AK (907)000-0000  
TSFY. HB 195

16 \* \* \* TESTIFIER 5

LTM1100-R01  
04/01/93

LEGISLATIVE TELECONFERENCE NETWORK

PAGE 03  
18:24:24

TCN: 30412 DATE & TIME: 03/31/93 15:00 TO 16:00 STATUS: 7 STATS. IN

PARTICIPANTS IN: JUNEAU

JNU

17	TESTIFIER	6	AK	(907)000-0000 TSFY. HB 195
18	TESTIFIER	7	AK	(907)000-0000 TSFY. HB 195
19	OBSERVER	1	AK	(907)000-0000 OBSV. HB 195
20	OBSERVER	2	AK	(907)000-0000 OBSV. HB 195
21	OBSERVER	3	AK	(907)000-0000 OBSV. HB 195
22	OBSERVER	4	AK	(907)000-0000 OBSV. HB 195
23	OBSERVER	5	AK	(907)000-0000 OBSV. HB 195
24	OBSERVER	6	AK	(907)000-0000 OBSV. HB 195
25	OBSERVER	7	AK	(907)000-0000 OBSV. HB 195
26	OBSERVER	8	AK	(907)000-0000 OBSV. HB 195
27	OBSERVER	9	AK	(907)000-0000 OBSV. HB 195
28	OBSERVER	10	AK	(907)000-0000 OBSV. HB 195
29	OBSERVER	11	AK	(907)000-0000 OBSV. HB 195
30	OBSERVER	12	AK	(907)000-0000 OBSV. HB 195
31	OBSERVER	13	AK	(907)000-0000 OBSV. HB 195
32	OBSERVER	14	AK	(907)000-0000 OBSV. HB 195

PARTICIPANTS IN: OFFNET 1

ZZZ OF 1

1 STEVE LEBRUN

AK (907)000-0000  
TSFY. HB 195  
AK (907)000-0000

H B

2 8

# FISCAL NOTE

**STATE OF ALASKA**  
**1993 LEGISLATIVE SESSION**

**BILL NO.** HB 28

Revision Date: \_\_\_\_\_ Dept. Affected: Department of Corrections  
 Title: "An Act relating to increasing the BRU: Statewide Programs  
penalty for providing alcoholic beverages to a minor Component: \_\_\_\_\_  
 Sponsor: Rep. Williams  
 Requestor: Rep. Williams COMPONENT SERIAL NO. 1858

**Expenditures/Revenues:** (Thousands of Dollars)

OPERATING	FY94	FY95	FY96	FY97	FY98	FY99
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL	600.	600.	600.	600.	600.	600.
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
<b>TOTAL OPERATING</b>	<b>600</b>	<b>600.</b>	<b>600.</b>	<b>600.</b>	<b>600.</b>	<b>600.</b>

<b>CAPITAL</b>						
----------------	--	--	--	--	--	--

<b>REVENUE FUND SOURCE:</b>						
-----------------------------	--	--	--	--	--	--

**FUNDING:** (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF	600.	600.	600.	600.	600.	600.
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
<b>TOTAL</b>	<b>600.</b>	<b>600.</b>	<b>600.</b>	<b>600.</b>	<b>600.</b>	<b>600.</b>

**POSITIONS:**

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year (FY93) impact:                     -0-                    

**ANALYSIS:** (Attach a separate page if necessary)

See attached page

Prepared by: Dana LaTour Phone: 465-3376  
 Division: Commissioner's Office Date: 2-12-93  
 Approved by Commissioner: Lloyd G. Rupp Date: 2-12-93  
 Agency: Department of Corrections

**PREPARED TO PROVIDE ALL DISTRIBUTION COPIES TO GOVERNOR'S LEGISLATIVE OFFICE**  
 For further distribution information call the Governor's Legislative Office

Fiscal Note

HB 28: An Act relating to the penalty for providing beverages to a person under the age of 21;..."

Page 2

This bill amends AS 04.16.051 and AS 04.16.180(a) to raise the penalty for furnishing alcoholic beverages to a person under the age of 21 from a class A misdemeanor to a class C felony.

The Department of Law has estimated that approximately 200 complaints involving furnishing alcoholic beverages to minors are referred to their department for prosecution each year. About 100 of those complaints will include sufficient evidence to bring a felony prosecution.

For the purpose of this fiscal note it is assumed that the lowest mean sentence for a class C felony of this type is 7.5 months or 225 bed-days. The average mean sentence length for the class A misdemeanor of providing alcoholic beverages to a minor is 1.5 months or 45 bed-days. Thus it is assumed that raising the offense from a class A misdemeanor to a class C felony would result in an increase in sentence of 180 bed-days. Subtracting one-third of the sentence for statutory good time results in an increase of 120 bed-days per offense. It is assumed that these offenders could be placed in contract community residential center beds at an average cost of \$50 per day.

The following calculation is used to compute the fiscal impact to the Department of Corrections:

100 convictions per year x 120 additional bed days x \$50 =  
\$600,000 per year

**FISCAL NOTE**

**STATE OF ALASKA**  
**1993 LEGISLATIVE SESSION**

**BILL NO. HB 28**

Revision Date: \_\_\_\_\_  
 Title: "An Act relating to the penalty for providing  
alcoholic beverages to a person under 21."  
 Sponsor: Reps. Williams, Phillips, Davis, Nicholia  
 Requestor: \_\_\_\_\_

Department Affected: Administration  
 BRU: Public Defender Agency  
 Component: Public Defender Agency  
 COMPONENT SERIAL NO. 1631

**EXPENDITURES/REVENUES:**

OPERATING	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99
PERSONAL SERVICES	67.3	69.3	71.4	73.5	75.7	78.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	4.0	4.1	4.2	4.3	4.4	4.5
SUPPLIES	2.0	2.0	2.0	2.0	2.0	2.0
EQUIPMENT	4.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	0.0	0.0	0.0	0.0	0.0	0.0
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
<b>TOTAL OPERATING</b>	<b>77.3</b>	<b>75.4</b>	<b>77.6</b>	<b>79.8</b>	<b>82.1</b>	<b>84.5</b>

CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
---------	-----	-----	-----	-----	-----	-----

REVENUE FUND SOURCE:	0.0	0.0	0.0	0.0	0.0	0.0
----------------------	-----	-----	-----	-----	-----	-----

**FUNDING:**

1002 Federal Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1003 GF Match	0.0	0.0	0.0	0.0	0.0	0.0
1004 GF	77.3	75.4	77.6	79.8	82.1	84.5
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1006 GF/MHTIA	0.0	0.0	0.0	0.0	0.0	0.0
OTHER	0.0	0.0	0.0	0.0	0.0	0.0
<b>TOTAL</b>	<b>77.3</b>	<b>75.4</b>	<b>77.6</b>	<b>79.8</b>	<b>82.1</b>	<b>84.5</b>

**POSITIONS:**

FULL-TIME	0.0	0.0	0.0	0.0	0.0	0.0
PART-TIME	2.0	2.0	2.0	2.0	2.0	2.0
TEMPORARY	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of current year (FY93) impact: \_\_\_\_\_

ANALYSIS: (Attach a separate page if necessary.)  
 See attached.

Prepared by: John Salemi, Public Defender  
 Division: Public Defender Agency

Phone: 279-7541  
 Date: \_\_\_\_\_

Approved by Commissioner: Nancy Bear Usura  
 Agency: Administration

Date: 2/12/93

PREPARER TO PROVIDE ALL DISTRIBUTION COPIES TO GOVERNOR'S LEGISLATIVE OFFICE  
 For further distribution information call the Governor's Legislative Office

## CONTINUATION of FISCAL NOTE ANALYSIS

For Bill/Resolution No. HB 28

This bill amends Title 4 (A.S. 04.16.051 and A.S. 04.16.180) as a means of enhancing the penalty for furnishing alcohol to an individual under the age of 21 years. The actual penalty increase is significant; from a class A misdemeanor, a crime carrying a maximum sentence of one year in jail and a \$5,000 fine, to a class C felony, a category of crime with a jail sentence of up to five years in prison and a fine of up to \$50,000.

The Department of Law has indicated in their fiscal analysis that 200 complaints per year are processed involving furnishing alcoholic beverages to minors. They estimate that 100 of these "will include evidence sufficient enough to permit (the District Attorney's office) to bring a felony prosecution." Assuming that the Public Defender would eventually take on representation of the vast majority of these felony cases a significant fiscal impact will be realized.

The National Advisory Commission on Criminal Justice Standards, established by the administrator of the Law Enforcement Assistance Administration, has established national caseload standards applicable to Public Defender agencies. With respect to felony cases, the standards indicate that the felony caseload of a Public Defender attorney should not exceed that of 150 cases per year. Using this standard of measurement the anticipated impact on this agency if this proposal becomes law will be the equivalent of one half-time attorney position (75 new felony cases per year). Some support staffing is also necessary to absorb a significant felony caseload increase. Therefore a half-time paralegal position would also be necessary. (It should be noted that in 1992 the Public Defender Agency submitted an indeterminate fiscal note with respect to a similar legislative proposal. That fiscal note was prepared without the benefit of the Department of Law's estimates with respect to felony prosecutions that would be initiated if this bill were to become law).

CONTINUATION of FISCAL NOTE ANALYSIS

For Bill/Resolution No. HB 28

BUDGET ANALYSIS

100	Personal Services		
	1/2 Attorney IV	41.5	
	1/2 Paralegal Assistant II	25.8	
			67.3
200	Travel		-0-
300	Contractual		4.0
400	Supplies		2.0
500	Equipment (one time)		<u>4.0</u>
		TOTAL	77.3



Position Title Paralegal Assistant II		No. of Positions 1	Range / Step 16/A	Barg. Unit GGU
Time Status PPT	Staff Months 6.0	Location Anchorage		Election District 7
<b>TYPE OF EXPENDITURE</b>		<b>Amount</b>		
Salary		18,222		
Benefits		7,535		
Premium Pay				
Other				
Total Personal Services		25,757		
Travel		-0-		
Contractual		-0-		
Commodities		1.0		
Equipment		2.0		
Other				
Total Cost		28,757		
<b>FUNDING SOURCE FOR TOTAL COST</b>				
Federal Receipts 1002				
G.F. Match 1003				
General Fund 1004		28,757		
I-A Receipts 1007				
CIP Receipts 1061				
Other				
<b>Justification</b>  This bill, HB 28, amends Title 4 (A.S. 04.16.051 and A.S. 04.16.180) as a means of enhancing the penalty for furnishing alcohol to an individual under the age of 21 years. The actual penalty increase is significant; from a class A misdemeanor, a crime carrying a maximum sentence of one year in jail and a \$5,000 fine, to a class C felony, a category of crime with a jail sentence of up to five years in prison and a fine of up to \$50,000.  The anticipated impact on this agency if this proposal becomes law will be the equivalent of one half-time attorney position (75 new felony cases per year). Some support staffing is also necessary to absorb a significant felony caseload increase. Therefore a half-time paralegal position would also be necessary.				

**Request For  
New Position**

AGENCY Administration  
BRU Public Defender Agency  
COMPONENT Public Defender Agency

**FY** \_\_\_\_\_

Page 5 of 5  
Revised Date: \_\_\_\_\_

FISCAL NOTE

STATE OF ALASKA  
1993 LEGISLATIVE SESSION

BILL NO. HB 28

Revision Date: January 28, 1993  
Title: \*...penalty for providing alcoholic beverages to a person under the age of 21...  
Sponsor: Representative Williams  
Requestor: Representative Williams

Department Affected: Department of Law  
BRU: Prosecution  
Component: All  
COMPONENT SERIAL NO. 0085 through 0090

EXPENDITURES/REVENUES:

OPERATING	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-

CAPITAL						
---------	--	--	--	--	--	--

REVENUE FUND SOURCE:						
----------------------	--	--	--	--	--	--

FUNDING:

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
OTHER						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

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

Estimate of current year (FY93) impact: -0-

ANALYSIS: (Attach a separate page if necessary.)

Please see the attached analysis.

Prepared by: Richard I. Peques, Director  
Division: Administrative Services Division  
Approved by Commissioner: Charles E. Cole, Attorney General  
Agency: Department of Law

Phone: 465-3672  
Date: January 28, 1993  
Date: January 28, 1993

PREPARER TO PROVIDE ALL DISTRIBUTION COPIES TO GOVERNOR'S LEGISLATIVE OFFICE  
For further distribution information call the Governor's Legislative Office

*Fiscal Note - Law - Prosecution*

FISCAL NOTE

STATE OF ALASKA  
1993 LEGISLATIVE SESSION

BILL NO. HB 28

ANALYSIS (Continued):

This bill amends AS 04.16.051 and AS 04.16.180(a) to raise the penalty for furnishing an alcoholic beverage to a person under the age of 21 years from a class A misdemeanor to a class C felony.

About 2,000 misdemeanor liquor violations are referred to the Department of Law for prosecution each year. Most of these are minor consuming complaints and about 10 percent, or 200 of these complaints, involve furnishing alcoholic beverages to minors. About one-half of this latter number of complaints, or 100, will include evidence sufficient enough to permit us to bring a felony prosecution.

Although bringing a felony prosecution is somewhat more time-consuming and costly than bringing a misdemeanor prosecution, when the work that will be caused by this bill is spread throughout the entire criminal division we cannot show a significant fiscal impact at any particular location. However, in a time of substantially diminishing resources, such as now, we strongly caution against creating additional workload for our prosecutors. Any new workload can only be handled at the expense of decreasing prosecutorial efforts in other areas, such as violent crimes and drug trafficking.

# FISCAL NOTE

STATE OF ALASKA  
1993 LEGISLATIVE SESSION

BILL NO: HB 28

Revision Date: \_\_\_\_\_ Dept. Affected: Public Safety  
 Title: "An act relating to the penalty for providing alcoholic beverages to a person under 21." BRU: Alaska State Troopers  
 Component: Detachments  
 Sponsor: Representative Williams  
 Requestor: Representative Williams COMPONENT SERIAL NO. 799

**EXPENDITURES/REVENUES: (Thousands of Dollars) (inflation not included)**

OPERATING	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
<b>TOTAL OPERATING</b>	-0-	-0-	-0-	-0-	-0-	-0-
<b>CAPITAL</b>	-0-	-0-	-0-	-0-	-0-	-0-
<b>REVENUE FUND SOURCE:</b>	-0-	-0-	-0-	-0-	-0-	-0-

**FUNDING: (Thousands of Dollars)**

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
<b>TOTAL</b>	-0-	-0-	-0-	-0-	-0-	-0-

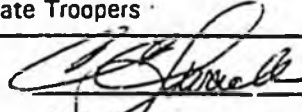
**POSITIONS:**

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

Estimate of current year (FY 93) impact: \$ \_\_\_\_\_

**ANALYSIS: (Attach a separate page if necessary.)**

No fiscal impact upon the Alaska State Troopers is anticipated.

Prepared By: Francis C. Allan Phone: 269-5691  
 Division: Alaska State Troopers Date: 1/29/93  
 Approved by Commissioner:  Date: 2/10/93  
 Agency: Richard A. Burton, Dept. of Public Safety

**PREPARER TO PROVIDE ALL DISTRIBUTION COPIES TO GOVERNOR'S LEGISLATIVE OFFICE**

For further distribution information call the Governor's Legislative Office

*Fiscal Note - Public Safety - Troopers*

FISCAL NOTE

STATE OF ALASKA  
1993 LEGISLATIVE SESSION

BILL NO. HB 28

Revision Date: \_\_\_\_\_  
Title: 'An Act relating to the penalty for providing alcoholic beverages . . .'  
Sponsor: Representatives Williams, Phillips, et al.  
Requestor: House HESS

Department Affected: Administration  
BRU: Office of Public Advocacy  
Component: Office of Public Advocacy  
COMPONENT SERIAL NO. 43

EXPENDITURES/REVENUES:

OPERATING	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	0	0	0	0	0

CAPITAL	0	0	0	0	0	0
---------	---	---	---	---	---	---

REVENUE FUND SOURCE:	0	0	0	0	0	0
----------------------	---	---	---	---	---	---

FUNDING:

1002 Federal Receipts	0	0	0	0	0	0
1003 GF Match	0	0	0	0	0	0
1004 GF	0	0	0	0	0	0
1005 GF/Program Receipts	0	0	0	0	0	0
1006 GF/MHTIA	0	0	0	0	0	0
OTHER	0	0	0	0	0	0
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

Estimate of current year (FY93) impact: None

ANALYSIS: (Attach a separate page if necessary.)

Prepared by: Brant McGee, Public Advocate  
Division: Office of Public Advocacy

Phone: 274-1684  
Date: \_\_\_\_\_

Approved by Commissioner: Nancy Bear Usher  
Agency: Administration

Date: 2/12/93

PREPARER TO PROVIDE ALL DISTRIBUTION COPIES TO GOVERNOR'S LEGISLATIVE OFFICE  
For further distribution information call the Governor's Legislative Office

# Alaska State Legislature



During Session:  
State Capitol  
Juneau, AK 99801-1182  
(907) 465-3424  
Fax (907) 465-2793

In Ketchikan:  
352 Front Street  
Ketchikan, AK 99901  
(907) 247-4672  
Fax (907) 225-8546

Committees:  
House Resources,  
Chairman  
Community &  
Regional Affairs  
Labor & Commerce

Representative William K. Williams

## SPONSOR STATEMENT HB 28

Honorable Co-Chairs and members of the committee thank you for hearing this bill today.

House Bill 28 is legislation first introduced in the 1992 Legislature by former Representative Cheri Davis in response to the tragic alcohol related deaths of two youths in our community. The purpose of this legislation is to change the penalty for providing alcoholic beverages to a person under the age of 21.

Currently, Furnishing alcohol to a minor is a misdemeanor with a maximum penalty of one year in prison and a \$5,000 fine.

House Bill 28 would make furnishing a minor with alcohol a class "C" felony with a maximum penalty of five years in prison and a \$50,000 fine.

By creating stiffer penalties for providing alcoholic beverages to minors, House Bill 28 will strengthen the deterrent effect of the present laws and enforcement efforts.

Thanks again for hearing this bill today. I'd be glad to try to answer any questions you may have in regard to HB 28.

**BILL NO:** HB 28

**DATE:** February 10, 1993

**TITLE:** "An Act relating to the penalty for providing alcohol to a minor"

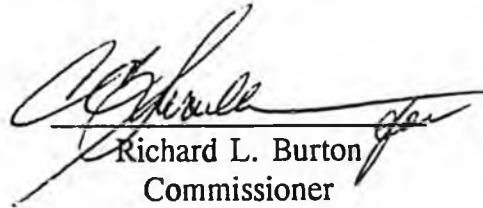
**CONTACT:** C.E. Swackhammer  
Deputy Commissioner  
465-4322

**POSITION PAPER - Department of Public Safety**

HB 28 amends AS 04.16.051 - Furnishing Alcoholic Beverages to Persons under 21 - by making this offence a Class C felony.

This proposed legislation will affect anyone who furnishes or delivers (not just sells) alcohol to a person under the age of 21 years.

Creating a felony for this offense will require presentation before a Grand Jury to review each case. Additional time will be necessary for Grand Jury preparation, witness coordination and transportation, and Trooper testimony.



Richard L. Burton  
Commissioner

Position Paper - Public Safety

(b) A person receiving compensation for transporting alcoholic beverages may not knowingly deliver alcoholic beverages to a drunken person. (§ 3 ch 131 SLA 1980; am § 6 ch 156 SLA 1988)

**Effect of amendments.** — The 1988 amendment added subsection (b).

**Legislative history reports.** — For Senate letter of intent relating to the en-

actment of (b) of this section by sec. 6, ch. 156, SLA 1988 (HCS CSSB 371 (Jud) am H), see 1988 Senate Journal 2939.

NOTES TO DECISIONS

**Effect of AS 04.21.020.** — Section 04.21.020, which provides conditions for the civil liability of persons providing alcoholic beverages, does not immunize vendors who violate this section. *Williford v. L.J. Carr Invs., Inc.*, 783 P.2d 235 (Alaska 1989).

Recognition of bystander's right to

recover damages for negligent infliction of emotional distress caused by injury to another. — See *Tommy's Elbow Room, Inc. v. Kavorkian*, 727 P.2d 1038 (Alaska 1986).

Applied in *Lord v. Fogcutter Bar & Stacy Cap*, 813 P.2d 660 (Alaska 1991).

**Sec. 04.16.050. Possession or consumption by persons under the age of 21.**

NOTES TO DECISIONS

**Comparative negligence.** — A licensee who violates this section is not entitled to assert the comparative fault of the minor/consumer, in an action for damages resulting from the unlawful sale of intoxicating liquor. *Loeb v. Rasmussen*, 822 P.2d 914 (Alaska 1991).

Stated in *Shamberg v. State*, 762 P.2d 488 (Alaska Ct. App. 1988).

Cited in *Alfred v. State*, 758 P.2d 130 (Alaska Ct. App. 1988).

**Sec. 04.16.051. Furnishing or delivery of alcoholic beverages to persons under the age of 21.** (a) A person may not furnish or deliver an alcoholic beverage to a person under the age of 21 years.

(b) This section does not prohibit the furnishing or delivery of an alcoholic beverage

(1) by a parent to the parent's child, by a guardian to the guardian's ward, or by a person to the legal spouse of that person if the furnishing or delivery occurs off licensed premises; or

(2) by a licensed physician or nurse to a patient in the course of administering medical treatment.

(c) Acts unlawful under AS 11.51.130 are not made legal by (b) of this section. (§ 3 ch 131 SLA 1980; am § 9 ch 109 SLA 1983; am §§ 7, 8 ch 156 SLA 1988; am § 1 ch 50 SLA 1989)

**Effect of amendments.** — The 1988 amendment inserted references to delivery in the catchline and in subsections (a) and (b).

The 1989 amendment, effective May 27, 1989, inserted "or delivery" in paragraph (b)(1).

**Legislative history reports.** — For Senate letter of intent relating to the amendments to (a) and (b) of this section by secs. 7 and 8, ch. 156, SLA 1988 (HCS CSSB 371 (Jud) am H), see 1988 Senate Journal 2939.

**Sec. 04.16.150. Licensee responsible for violations.****NOTES TO DECISIONS**

Stated in *Tommy's Elbow Room, Inc. v. Kavorkian*, 727 P.2d 1038 (Alaska 1986).

**Article 2. Penalties and Forfeitures.****Section**

180. Penalties for violation  
200. Unlicensed persons

**Sec. 04.16.180. Penalties for violation.** (a) Except as provided in AS 04.11.015, AS 04.16.200 — 04.16.210, and AS 04.21.065, a person who violates a provision of this title or a regulation adopted by the board is guilty, upon conviction, of a class A misdemeanor. Each violation is a separate offense.

(b) A suspension or revocation of a license ordered by the board under AS 04.11.370(4) and (5) shall be as follows:

(1) On first conviction: the license of the premises involved may not be revoked, but may be suspended for not more than 45 days.

(2) On second conviction: the license of the premises involved may not be revoked, but may be suspended for not more than 90 days.

(3) On third conviction: the license of the premises involved may be suspended or revoked.

(c) In this section, the terms "second conviction" and "third conviction" include only convictions for violations that occur within five years of the first conviction. The terms refer to the cumulative number of convictions of a licensee of any combination of violations of the provisions of this title, regulations adopted under this title, or ordinances adopted under AS 04.21.010. The terms "second conviction" and "third conviction" include a conviction of the agent or employee of a licensee of a violation of a law, regulation, or ordinance if the conviction constitutes a ground for suspension or revocation under AS 04.11.370(5).

(d) This section does not affect the authority of the board to suspend or revoke a license when the board determines that continuance of activities under a license would not be in the best interests of the public. (§ 3 ch 131 SLA 1980; am § 10 ch 156 SLA 1988; am § 1 ch 81 SLA 1989)

**Effect of amendments.** — The 1988 amendment inserted "AS 04.11.015 and" in the first sentence in subsection (a). The 1989 amendment, effective August 30, 1989, inserted a reference to AS 04.21.065 in the first sentence of subsection (a) and made related grammatical changes.



LTN1100-R01  
03/04/93

LEGISLATIVE TELECONFERENCE NETWORK

PAGE 01  
16:23:08

TCN: 30299 DATE &amp; TIME: 03/04/93 15:00 TO 16:00 STATUS: 6 ADJOURNED

## \*\*\*\* ORDER SUMMARY \*\*\*\*

SPONSOR: HHES HOUSE HEALTH, EDUCATION AND SOCIAL SERVI CHAIRS: TOOHEY  
 PURPOSE: PUB PUBLIC HEARING BUNDE  
 CONTACT: LYNN SMITH TEL#: (907)465-6825  
 CHAIRING SITE: JUNEAU CAPITOL CAP106

SPONSOR REMARKS(PUB): TESTIMONY:Y ALLOWED 3 MINUTE LIMIT  
 PUBLIC TESTIMONY ON HB 28  
 TCN REQUESTED ON 03/04/93 AND HAS 2 UPDATES

## \*\*\*\* AGENDA \*\*\*\*

1 HB 28 PENALTY FOR PROVIDING ALCOHOL TO A MINOR

## \*\*\*\* PARTICIPATING LIOS \*\*\*\*

BAR BARROW	COURTHOUSE #305	LOCATION STAFF
* JNU JUNEAU	CAPITOL CAP106	LOCATION STAFF
KTN KETCHIKAN	352 FRONT STREET	LOCATION STAFF

## PARTICIPANTS IN: KETCHIKAN

KTN

1 MS	CHERI DAVIS	KETCHIKAN	TSFY. HB 28
	BOX 5723		AK 99901 (907)225-6304
2 MS	SUE HENRY	KETCHIKAN	TSFY. HB 28
	433 JACKSON ST.		AK 99901 (907)225-5501
3 MR.	PETER JENSEN	KETCHIKAN	TSFY. HB 28
	BOX 7032		AK 99901 (907)225-2277
4 MS	JEANNEANE HENRY	KETCHIKAN	TSFY. HB 28
	2428 DUNTON ST.		AK 99901 (907)225-2428
5 MS	LYNDA ADAMS	KETCHIKAN	TSFY. HB 28
	BOX 7171		AK 99901 (907)225-6227
6 MS	GIGI PILCHER	W.I.S.H.	TSFY. HB 28
	BOX 6552	KETCHIKAN	AK 99901 (907)225-0202
7 MS	FRAN YOUNG	KETCHIKAN	TSFY. HB 28
	537 TOWER RD.		AK 99901 (907)225-3528
8 MR.	GERRET KOEPPING	KTN DAILY NEWS	OBSV. HB 28
	501 DOCK ST.	KETCHIKAN	AK 99901 (907)225-3157
9 MR.	HALL ANDERSON	KTN DAILY NEWS	OBSV. HB 28
	501 DOCK ST.	KETCHIKAN	AK 99901 (907)225-3157



# Alaska State Legislature

## House of Representatives

COMMITTEE ON HEALTH, EDUCATION  
AND SOCIAL SERVICES

DATE: MARCH 4, 1993

PLACE: Capitol Room 106

### SUBJECT OF MEETING:

\*HB 28: PENALTY FOR PROVIDING ALCOHOL  
TO A MINOR

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?	WHAT SUBJECT/ WHICH BILL?
John Salemi	Public Defender					(Y) N	HB 28
Randall O. Madigan	Self	P.O. Box 2051 Nome	99762	443-5123		(Y) N	HB 28
Thea Smolcer	Adventure Prohibitory	401 E. Fireweed	99503	249-1212	276-2700	(Y) N	HB 28
						Y N	
						Y N	
						Y N	
						Y N	
						Y N	
						Y N	
						Y N	