

ALASKA LEGISLATURE COMMITTEE FILES 1993-1994 8672

7814 HOUSE HEALTH EDUCATION & SOCIAL SERVICES

ADMINISTRATIVE AMENDMENT # 1
(A.1)

A M E N D M E N T

In: House (Hes)

To: HB 414 "An Act Creating the Alaska Health Commission;....., and providing for an effective date."

Page 1, line 8 after "health care" add and maintenance of the public's health [IS] are vital to the public's interest.

Page 1, line 11 after "insurance" delete [, AND]

Page 1, line 12 after "malpractice" add and the lack of coordination of population based public health services.

Page 2, line 14 after "relating to" add the individual and public health care needs

Page 5, after line 6 add a new section (6) as follows:

- (6) Establish a Public Health Advisory Committee which
(A) consists of at least one member of the commission and other individuals with significant public health expertise appointed by the commission; and -
(B) Advises the commission on public health matters and the integration of public health services under AS 44.19.621.

AMENDMENT

ADMINISTRATIVE
AMENDMENT #2
(A.2)

IN: House (HES)
TO: HB 414 "An Act Creating the Alaska Health Commission;....; and providing for an effective date.

Page 2, line 23 after "proposals;" add "including a proposal which is based on a single payor strategy."

Page 8, after line 9 add a new section (9) as follows:

(9) "single payer strategy" means a method of financing health services so that every resident would receive at a minimum a uniform set of benefits and payment for services would be made primarily through a single entity.

Post-It™ brand fax transmittal memo 7671 # of pages > 1

To: ERIEN PLATE	From: JAY LIVERI
Co.: "IRG"	Gov: " "
Dept.:	Phone: "
Fax #: 2135	Fax #: 3068

CORRECTION

**THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY**

AMENDMENT

ADMINISTRATIVE
AMENDMENT # 2
'A.2'

IN: House (HES)
TO: HB 414 "An Act Creating the Alaska Health Commission;....; and providing for an effective date.

Page 2, line 23 after "proposals;" add "including a proposal which is based on a single payer strategy."

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Post-It™ brand fax transmittal memo 7671 # of pages 1

To	ERGEN PLATE	From	JAY LIVERY
Co.	"URGENT"	Phone #	
Dept.		Fax #	3068
Fax #	2135		

ADMINISTRATIVE
AMENDMENT # 3
(A.3)

AMENDMENT

IN: House (HES)
TO: HB 414 "An Act Creating the Alaska Health Commission;...; and
providing for an effective date.

Page 5, after line 6 add a new section (6) as follows:

(6) Pursue necessary federal waivers from applicable federal law or other federal health care payers to the extent necessary to maximize the collection and analysis of health care data.

FEB-25-94 FRI 9:25
FEB-25-94 FRI 9:33

ALASKA ATTORNEY GENERAL
ANCHORAGE AGO

FAX NO. 9074656735
FAX NO. 2763897

P. 02
P. 02/02

ADMINISTRATIVE AMENDMENT # 4
(A.4)

773-94-0024
8-GH2024.A
4/24/94

AMENDMENT

OFFERED IN THE HOUSE/SENATE

TO: HB 414/SB 270

Page 2, line 20:

Following "pools":

Insert ", including pools for the primary benefit of children,"

Page 13, line 5:

Following "pools":

Insert ", including pools for the primary benefit of children,"

Page 14, line 6

Following "pools":

Insert ", including pools for the primary benefit of children,"

Page 15, line 12:

Following "pools":

Insert ", including pools for the primary benefit of children,"

ADMINISTRATIVE AMENDMENT
(15)

5

3/1/94

A M E N D M E N T

FOR CHARGE DISCLOSURE BY HEALTH PROVIDER
OFFERED IN THE HOUSE/SENATE

TO: HB 414
SB 270

Page 2, line 18:

Following "health":

Delete "insurance"

Insert "care"

Page 2, line 19:

Following "insurers":

Insert "and disclosure of charges by health providers"

Page 7, following line 22:

Insert a new section to read:

"Sec. 44.19.635. DISCLOSURE OF PROVIDER CHARGES; FINE FOR NONDISCLOSURE. (a) At least annually, a provider shall compile a list of charges for the 20 health care services most commonly provided by that provider. Charges for hospital services may be prepared on the basis of diagnosis related groups. Upon request of a person who is considering obtaining services from a provider, that provider shall provide the list of charges to the person for use in comparing charges among providers.

(b) Upon the request of a patient and before the commencement of a medical procedure, the provider shall disclose to that patient the estimated charge for that procedure. The estimated charge must be made in good faith and must be based on the provider's history of charges for that procedure. Nothing in this subsection requires a provider to make a charge estimate if the provider does not agree to perform the procedure.

(c) A provider shall place the following statement either on a form to be signed by the patient or in a conspicuous location on an easily readable sign: "You are entitled to a charge estimate for a medical procedure before the procedure is performed by your health provider."

(d) If the commission, after investigation of a complaint by a patient, determines that a provider has not complied with (a) of this section, has not provided a charge estimate as required by (b) of this section, or has failed to comply with (c) of this section, the commission may assess a fine of up to \$500 against the provider. The commission may assess only one fine under this section against a provider in a calendar year. A provider's violation of this section does not preclude the provider from collecting payment for services provided.

(e) A provider aggrieved by a decision of the commission under this section may appeal the decision to the superior court under procedures provided by court rule."

Post-It™ brand fax transmittal memo 7671		# of pages ▶ 1
To FIFTEEN PLATE	From JAY LILEY	
Co.	Co.	
Dept.	Phone #	
Fax # 2135	Fax # 3068	

FISCAL IMPACT OF PROPOSED AMENDMENTS TO SB 270/HB 414

Amendment 1: Public Health Committee

Assumptions:

Committee has six members
 Assume staff work done by either Health Commission staff or
 Division of Public Health employees
 Committee meets 3 times per year in person (2 in FY 95)
 Committee has 4 additional teleconference meetings per year

	FY 95	FY 96 - FY 00
TRAVEL COST:	\$ 4,800	\$ 10,500 (each year)
CONTRACTUAL (Public Notice):	1,000	3,500 (each year)

Amendment 2: Single Payor Analysis

No Cost; Already assumed in original fiscal note

Amendment 3: Erisa Waiver:

Assumptions: Costs to be split between personnel and contracting line items. Requires one staff person to prepare application and possible contractual funds specialized assistance:

	FY 95	FY 96 - FY00
\$	100,000	100,000 →

Amendment 4: Pooling

No additional cost anticipated

Amendment 5: Disclosure of Prices

Assumptions: One research analyst is required to monitor compliance; travel included

	FY 95 (6 months)	FY 96 - FY00
Personnel	\$30,000	\$ 59,000 (inflate 5%)
Travel	1500	3000 ANNUALLY
Supplies	500	1000
Contractual	3.4	6.8
Equipment	12.1	0

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Co. "URGENT"	Phone #
Dept.	Fax #
Fax # 2135	Fax # 3068

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LTN1100-R01
03/11/94

LEGISLATIVE TELECONFERENCE NETWORK

PAGE 01
13:14:20

TCN: 40393 DATE & TIME: 03/04/94 15:00 TO 17:00 STATUS:7 STATS. IN

**** ORDER SUMMARY ****

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

SPONSOR REMARKS(PUB): TESTIMONY:Y ALLOWED 3 MINUTE LIMIT
TCN REQUESTED ON 03/04/94 AND HAS 4 UPDATES

**** AGENDA ****

1 HB 414 COMPREHENSIVE HEALTH CARE

**** PARTICIPATING LIOS ****

ANC ANCHORAGE	716 W 4TH, #200	LOCATION STAFF
FBX FAIRBANKS	119 N CUSHMAN ST	LOCATION STAFF
* JNU JUNEAU	CAPITOL CAP106	LOCATION STAFF
NAT MATSU	165 E PARKS HWY.	LOCATION STAFF
SIT SITKA	210 LAKE STREET	LOCATION STAFF

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

ZZZ OFF OFFNET 1 SEATTLE JIM HICKEY (206)467-2802

PARTICIPANTS IN: ANCHORAGE

ANC

1	JACKIE PFLAUM	REP DARYL YOUNG	TSFY. HB 414
	601 W 10TH AVE	ANCHORAGE	AK 99501 (907)786-1250
2	DENNY DEGROSS		TSFY. HB 414
	2348 LEANDER CIRCLE	ANCHORAGE	AK 99515 (907)344-8824
3	BRUCE MOIRE		TSFY. HB 414
	3261 AMBER BAY LOOP	ANCHORAGE	AK 99515 (907)279-9952
4	DAVID FRAZIER		TSFY. HB 414
	2636 SHEPHERDIA DR	ANCHORAGE	AK 99508 (907)274-2869
5	BONNIE NELSON	AKPIRG	TSFY. HB 414
	20615 WHITE BIRCH RD	CHUGIAK	AK 99567 (907)688-3017
6	BRUCE GALE		ORSV. HB 414
	2600 DENALI ST. STE 501	ANCHORAGE	AK 99515 (907)344-8824
7	ROBERT GOUSHNOUR	MOA	ORSV. HB 414
	PO BOX 196650	ANCHORAGE	AK 99519 (907)343-4517
8	THEDA PITTMAN		ORSV. HB 414
	4720 EAGLE. NO 1	ANCHORAGE	AK 99503 (907)561-0515
9	ERIC DEEG		ORSV. HB 414
	1031 W 4TH. STE 400	ANCHORAGE	AK 99501 (907)276-5617
10	PETER NAKAMURA	DEPT HEALTH	ORSV. HB 414
			AK (907)000-0000
11	ONE	OBSERVER	ORSV. HB 414
			AK (907)000-0000
12	TWO	OBSERVER	ORSV. HB 414
			AK (907)000-0000

PARTICIPANTS IN: FAIRBANKS

FBX

1 MS.	MARLENE LEAK		TSFY. HB 414
	771 8TH AVE.	FAIRBANKS	AK 99701 (907)452-1015
2 MS.	KATHLEEN DOVE		TSFY. HB 414

3 NS.

P.O. BOX 74048
ELAINE LONDON

FAIRBANKS
TCC

AK 99707 (907)458-8000
OBSV. HR 414

LTN1100-R04
03/11/94

LEGISLATIVE TELECONFERENCE NETWORK

PAGE 02
13:14:20

TCN: 40393 DATE & TIME: 03/04/94 15:00 TO 17:00 STATUS:7 STATS. IN

PARTICIPANTS IN: FAIRBANKS

FRX

	122 1ST. AVE.		FAIRBANKS	AK 99701 (907)452-8251
4 NS.	MARY	HAJDUKOVICH	FLUMFIELD	OBSV. HB 414
	323 6TH AVE.		FAIRBANKS	AK 99707 (907)452-2619

PARTICIPANTS IN: JUNEAU

JNU

1 REP	CYNTHIA	TOONEY		TSFY. HB 414
				AK (907)000-0000
2 REP	CON	BUNDE		TSFY. HB 414
				AK (907)000-0000
3 REP	AL	VEZEY		TSFY. HB 414
				AK (907)000-0000
4 REP	HARLEY	OLBERG		TSFY. HB 414
				AK (907)000-0000
5 REP	PETE	KOTT		TSFY. HB 414
				AK (907)000-0000
6 REP	TOM	BRICE		TSFY. HB 414
				AK (907)000-0000
7 REP	GARY	DAVIS		TSFY. HB 414
				AK (907)000-0000
8 REP	IRENE	NICHOLIA		TSFY. HB 414
				AK (907)000-0000

9	TO	OBSERVE		OBSV. ALL ITEMS
10	TO	OBSERVE		OBSV. ALL ITEMS
11	TO	OBSERVE		OBSV. ALL ITEMS
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14	TO	OBSERVE		OBSV. ALL ITEMS
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37 TO OBSERVE
40 TO OBSERVE

OBSV. ALL ITEMS
OBSV. ALL ITEMS

LYN1199-R01 LEGISLATIVE TELECONFERENCE NETWORK PAGE 63
03/11/94 13:14:20
TON: 40593 DATE & TIME: 03/04/94 15:00 TO 17:00 STATUS:7 STAT: IN

PARTICIPANTS IN: DUNEAO

ONU

41 TO TESTIFY TESTIFY ALL ITEMS
42 TO TESTIFY TESTIFY ALL ITEMS
43 TO TESTIFY TESTIFY ALL ITEMS

PARTICIPANTS IN: SITKA

SIT

1 JOHN SHAFFER AARP - SLC TESTIFY, HB 414
303 KIMSHAM SITKA AK 99835 (907)747-8167
2 JAMES O. BURRIS AARP OBSV. ALL ITEMS
115 GRANITE CREEK RD. SITKA AK 99835 (907)747-8425

PARTICIPANTS IN: OFFNER 1

ZZZ OF1

1 MR JIM HICKEY SEATTLE OBSV. HB 414
(907)000-0000 AK
2 MR STEVE LEBRUNN OBSV. HB 414
(907)000-0000 AK

37 TO OBSERVE
40 TO OBSERVE

OBSV. ALL ITEMS
OBSV. ALL ITEMS

LTN1100-R01
03/11/94

LEGISLATIVE TELECONFERENCE NETWORK

PAGE 03
13:14:20

TCN: 40393 DATE & TIME: 03/04/94 15:00 TO 17:00 STATUS:7 STATS. IN

PARTICIPANTS IN: JUNEAU

JNU

41	TO	TESTIFY	TSFY. ALL ITEMS
42	TO	TESTIFY	TSFY. ALL ITEMS
43	TO	TESTIFY	TSFY. ALL ITEMS

PARTICIPANTS IN: SITKA

SIT

1	JOHN	SHAFFER	AARF - SLC	TSFY. HB 414
	303 KINSHAM		SITKA	AK 99835 (907)747-8167
2	JAMES O.	BURRIS	AARF	OBSV. ALL ITEMS
	115 GRANITE CREEK RD.		SITKA	AK 99835 (907)747-8425

PARTICIPANTS IN: OFFNET 1

ZZZ OF1

1	MR	JIM	HICKEY	SEATTLE	AK	OBSV. HB 414 (907)000-0000
2	MR	STEVE	LEBRUNN		AK	OBSV. HB 414 (907)000-0000



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

SUBJECT OF MEETING:
 HB 414: COMPREHENSIVE HEALTH CARE

DATE: 3/4/94

PLACE: Capitol Room 106

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
✓ Donald Novotney	Alaska Nurses Assn.	1120 Timbalin Ct Juneau AK 99801	99801	7804300	5868413	<input checked="" type="radio"/> Y	<input type="radio"/> N	HB 414
✓ Marie Darlin	NARFE	Bx 21283 Juneau	99802	6-3637		<input checked="" type="radio"/> Y	<input type="radio"/> N	HB 414
						<input type="radio"/> Y	<input type="radio"/> N	
						<input type="radio"/> Y	<input type="radio"/> N	
						<input type="radio"/> Y	<input type="radio"/> N	
						<input type="radio"/> Y	<input type="radio"/> N	
						<input type="radio"/> Y	<input type="radio"/> N	
						<input type="radio"/> Y	<input type="radio"/> N	
						<input type="radio"/> Y	<input type="radio"/> N	
						<input type="radio"/> Y	<input type="radio"/> N	
						<input type="radio"/> Y	<input type="radio"/> N	

3/4/94

NATIONAL ASSOCIATION OF RETIRED FEDERAL EMPLOYEES

ALASKA FEDERATION



My name is Marie Darlin and I am President of the National Association of Retired Federal Employees of Alaska.

Our Association is concerned that Alaska have a state health plan in effect by 1-1-98 when our Federal Employee Health Benefits Program is due to end. AT that time federal retirees and employees are to be folded into the state plans. Our organization has over 1000 members from a total of about 5300 federal civilian annuitants and surviving spouses.

In a recent survey of annuitants, two of the recommendations to the Legislature were:

To provide long term care and health care facilities planning to meet current and future needs.

To provide more community based health services to allow retirees to remain in their homes as long as possible.

Our survey showed 65% of the retirees are married -- equaling 8,745 persons.

57% are over 65, indicating that 4,968 persons are under Medicare as first payer.

8% (or 424) plus their spouses are over 80 years of age & need or will need community based services and/or long term care.

This information is available in the report "As It Really Is" provided to each legislator at the beginning of the last session.

A comprehensive Health Care Plan for Alaska will help keep retirees here. This amounts to monthly annuities of over seven million, and as of January 1994 amounted to 97,000,000 per year for just the civilian federal annuitants.

In addition, there are over 5,000 military retirees in Alaska, plus the VA and the Indian Health Service, all of which have a federal health plan that will no doubt be folded into state plans also. Information we have received says all three programs will require their clientele to choose between their current plan or a state plan.

And now I would like to comment on HB 414 and concerns with this legislation.

The deadlines of January 1, 1996 for continued work and study seem to be postponing further any specific action on work that has already been done over the past 4-5 years. Sec. 44.19.622 concerning the Commission lists Qualifications in the Title and yet I do not see anything listing qualifications for these three members. Item (e) does refer to statutes when checked turned out to be a listing of conflicts of interest — which would indicate that anyone with ties to the medical, hospital, or provider community could not be a member. And there is no indication that consumers would be represented on the Commission.

Page 4 Line 25 is confusing - does it mean the commission will be providing and charging for services? What services -- collecting data, monitoring costs, etc. Unless it means those services provided by a Health Plan.

Page 7 Line 28 has "Health care services" defined as in another Statute which does not speak to many issues to be addressed in a health plan. -- i.e. long term care, community based services, medications, etc. plus mental health concerns.

P. 8 line 11 addresses in statute issues of mandatory arbitration, which it would seem could be better addressed in regulations.

Thank you for the opportunity to make this presentation., and to indicate we do not endorse this bill, ^{USW} but would prefer action on SB 284 and your House Bill 1451.

Marie Darlin, Box 2-1283, Juneau, AK 99802
586-3637

Presentation to House HESS Committee on HB 414 3/4/94



UNIVERSITY OF ALASKA ANCHORAGE

3211 Providence Drive
Anchorage, Alaska 99508-8175

STUDENT HEALTH CENTER
(907) 786-4040

March 4, 1994

Dear Representative Toohy:

Re: Health Care Reform

I am a family nurse practitioner and the manager of the University of Alaska Anchorage Student Health Center.

The University of Alaska Anchorage - Student Health Center is an outpatient facility that provides diagnosis and treatment of episodic illnesses, health education and promotion, physical examination, family planning, mental health services, dispenses medications and provides other health related services.

The role of the Student Health Center is to empower students to make educated decisions regarding their health care needs and health status. The proactive position of health care advocacy, low cost-high quality health care, and accessibility promote a health-oriented lifestyle for students.

Health is viewed as a supporting and facilitating resource through which the welfare of individuals can be enhanced. An individual's health status has a profound effect on his/her ability to function at work, home, school, and in the community.

The Student Health Center is currently staffed by two family nurse practitioners, a mental health nurse practitioner, and two office support personnel. On an average we provide health care services to 60 individuals daily. The vast majority of these individuals do not have health insurance or financial resources to secure necessary health care services. Frequently students do not have money to pay for lab work, diagnostic procedures or prescription drugs. I perceive this to be a health care crisis.

The vast majority of students are in school to improve their lives. Frequently students are single parents who hope to become more financially secure, others are suddenly single people who desire to reclaim their lives or start anew and again hope to improve their life, earning potential and well-being. These individuals are in need of health care that meets their variable needs. This health care must be financially attainable and accessible.

Representative Toohey
March 4, 1994
Page 2

Students taking 6 or more credits on the Anchorage campus currently pay a \$12.00 Health Center fee each semester. This entitles them to health care services that includes: diagnosis and treatment of illnesses, family planning, treatment of sexually transmitted diseases, health screening, immunizations, psychiatric-mental health therapy and health education. These services are provided at minimal cost.

Although the Student Health Center is currently understaffed to meet the demand for services, health care is provided in a prompt and comprehensive manner while maintaining a high quality of health care delivery. A fee increase has been proposed in order to increase the staffing of the Health Center to meet the increased demand for services.

Frequently students come to the Health Center who have not had health care for 5 - 10 years because they have been unable to afford it. For example, we see women who have not had a Pap Test for 10 years. This simple test can detect cancer of the cervix which is treatable before becoming a life threatening disease. An advanced cervical or uterine cancer will cost a tremendous amount of money to maintain a reasonable quality of life for the "victim" of a detectable and treatable disease can cause. Other students have chronic illnesses and have not been able to be monitored and treated to improve their quality of life because of the expense of health services.

When students are asked where they would have been treated for the illness they present with, the answer is frequently, "I would have toughed it out until I needed to go to the emergency room." This is the wrong answer. This is a very expensive way to treat many illnesses. Bronchitis, pneumonia, and many other illness can be treated on an outpatient basis in a cost effective and efficient manner saving a great deal of money.

As you consider "Health Care Reform" keep in mind that preventive care is a way to reduce cost. The old adage, "An ounce of prevention is worth a pound of cure," is true for health care. Prompt, efficient, and cost effective health care is essential.

Health care is both a right and a privilege. As you consider the issue of "HEALTH CARE REFORM," keep your focus on the issue of optimal health care for every individual.

Representative Toohey
March 4, 1994
Page 3

As you continue to map a future for health care delivery in the State of Alaska, do not neglect the important contribution of nurse practitioners. Nurse practitioners and nurses have had a positive impact on the health of Alaska for many years. Often nurse practitioners provide health care in locations where physicians choose not to reside. The services provided help individuals maintain their optimal health.

Although I am sure you are aware of the role of nurse practitioner I would like to include the definition as set forth in the State of Alaska Statute:

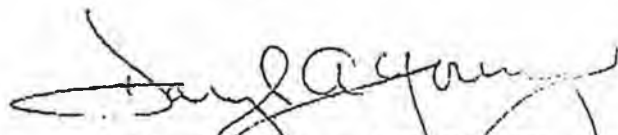
An advance nurse practitioner is a registered nurse authorized to practice in the State, who, because of specialized education and experience, is certified to perform acts of medical diagnosis and the prescription of medical, therapeutic, or corrective measures under regulations adopted by the Board of Nursing. AS08.68.910(1)

Nurse practitioners are primary "health" care providers. They provide health care to individuals, families and communities. The key words are **HEALTH CARE**. "Medicine" or "medical care" is really health care. Health care is provided by nurse practitioners and nurses and is not restricted to physicians. As you the plan for the future of health care delivery in Alaska please remember the important contribution of nurse practitioners.

I believe that health is the individual's obligation to preserve to the best of their ability with the assistance of health care professionals and not something that is surrendered to a physician or other health care provider. There is a health care crisis and it will take a collaborative effort on the part of all health care providers to relieve this crisis.

I appreciate your involvement in health care reform. If I can be of further assistance, please contact me at (907)786-4040.

Sincerely,



Daryl A. Young, MS, RN, CS, ANP
Family Nurse Practitioner

A M E N D M E N T

OFFERED IN THE HOUSE
TO: HB 414

BY REPRESENTATIVE BRICE

Page 2, line 5, after "services,":

Insert "the creation of a public health improvement plan,"

Page 2, line 21:

Delete "and"

Page 3, line 16, following "1997":

Delete "."

Insert "; and

(6) establishing a public health improvement plan advisory committee
and developing a public health improvement plan as required under AS 44.19.636."

Page 5, line 6, after "AS 44.19.629":

Insert ";

(6) establish a public health improvement plan advisory committee to
develop a public health improvement plan as required under AS 44.19.636."

Page 7, after line 22:

Insert a new section to read:

"Sec. 44.19.636. PUBLIC HEALTH IMPROVEMENT ADVISORY
COMMITTEE. (a) The commission shall establish and appoint the members of an
advisory committee for the purpose of developing a public health improvement plan.
The committee must include at least one member of the commission. In appointing
other members of the committee, the commission shall consider public and private
health care professionals, labor organizations, businesses, the education system, the

Alaska Public Health Association, the Alaska Mental Health Board, the Alaska Native Health Board, as well as the need for geographic, ethnic, and cultural diversity on the committee.

- (b) The plan developed by the committee under (a) of this section must
 - (1) recognize the need for
 - (A) community involvement in health care planning and delivery;
 - (B) attention to local needs that may vary from place to place;
 - (C) accountability for the use of public funds;
 - (D) equity and stability in the distribution of public funds;
 - (E) shared responsibility of all levels of government for administering and financing public health care delivery; and
 - (F) coordination of basic public health services; and
 - (2) include
 - (A) an analysis of the health status of the residents of the state;
 - (B) an assessment of the most appropriate role for various levels of government to play in addressing the health care needs of the residents of the state;
 - (C) a delineation of the standards that should be used in performing assessment, policy development, and quality assurance in the delivery of public health services;
 - (D) documentation of the extent to which the current public health system implements or achieves the standards identified under (C) of this paragraph;
 - (E) identification of interjurisdictional issues involved in health care access and delivery;
 - (F) recommendations, including recommendations for specific legislative action when necessary, pertaining to the following:
 - (i) strategies, time lines, financial needs, and specific sources of stable revenue for bringing the state public health care system up to standards identified by the committee;
 - (ii) appropriate sharing of the responsibility of local,

regional, state, and federal government entities to deliver public health care services efficiently and effectively, including recommendations for organization within state government;

(iii) integration of the public health care system with state and national health care reform efforts;

(iv) the committee's estimate of the optimal share that public health should represent in the total health care delivery system of the state, expressed in terms of a percentage of health care dollars spent or in terms of public dollars per state resident."

Page 17, after line 12:

Insert a new bill section to read:

"* Sec. 22. TRANSITION. Notwithstanding AS 44.19.621(a)(6), enacted in sec. 3 of this Act, the Alaska Health Commission shall develop a public health improvement plan as described under AS 44.19.636 by January 1, 1996."

Renumber the following bill sections accordingly.

Page 17, line 16:

Delete "and 21"

Insert "21, and 22"

FEB 18 1994

**Anchorage Chamber of Commerce
Resolution On Health Care Reform
93/94-7**

WHEREAS quality, access, and the costs of health care are all critical to Alaskans; and

WHEREAS the cost of health care is being born by the state, the federal government, public and private sector employers and individuals collectively; and

WHEREAS certain legislation is pending which could significantly alter health care and the allocation of costs to pay for health care for Alaskans.

BE IT RESOLVED that the Anchorage Chamber of Commerce urges Alaska Legislators and the Governor to:

1. To clearly identify the cost implications (to the state, residents, public & private sector employers) of health care reform;
2. Avoid a single payor system;
3. Increase access to coverage for small employers through insurance company reform;
4. Address coverage for non-residents employed in seasonal industries in the state;
5. Thoroughly review entitlement to benefits if provided through taxes, assessments or premiums through employment;
6. Allow freedom of choice of employers to participate or not participate in any state mandated health care plan;
7. Address in advance how school districts, municipalities, boroughs or other public sector employers would have to increase budgets to cover any costs increase associated with health care reform;
8. Address how premiums will be paid by unemployed individuals and if premiums are not paid, who shares the burden of health care costs for those individuals;
9. Adopt a level of benefits which establishes the base benefit payment for all health care providers and allows residents to seek care from any provider in the state recognizing how ever, some providers will charge an amount greater than allowed by the plan which must be paid by the resident;
10. Address the number of employees/persons covered;
11. Address impact on collective bargaining agreements;
12. Address impact on national employers doing business in Alaska;
13. Address plan sponsors who currently give retiree welfare benefits to non-residents.

Be it further resolved that health care reform and the payment of health care costs should address all of the above areas and town meetings should be held to discuss the ramification of any proposed amendments or changes prior to voting on reform; and

While the current health care system may need to be fine tuned and some changes made, it does not need to be dismantled.

George Wuerch
Chairman 1993-94

Carol Heyman
President

February 18, 1994



Alaska State Legislature

House of Representatives
 COMMITTEE ON HEALTH, EDUCATION
 AND SOCIAL SERVICES

DATE: 2/15/94

PLACE: Capitol Room 106

SUBJECT OF MEETING:
 * HB 414: COMPREHENSIVE HEALTH CARE

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?	WHAT SUBJECT/ WHICH BILL?
William Craig	AK. NATIVE ALIEN 32 AK. IND. ALIEN INTERIM RES.	613 Degraff St Sitka, AK	99835	747-5917	747-5917	Y N	
						Y N	
	AARTD					Y N	
						Y N	
						Y N	
						Y N	
						Y N	
						Y N	
						Y N	
						Y N	



ALASKA NURSES ASSOCIATION

237 E. 3rd Avenue #3 Anchorage, AK 99501-2523
(907) 274-0827 FAX: (907) 272-0292

March 4, 1994

Representative Cynthia Toohey, Co-Chair
House of Representatives HESS Committee
Room 104-C
Capitol Building
Juneau, Alaska 99801-1182

Dear Representative Toohey:

On behalf of the Alaska Nurses Association (AaNA), I thank you for the opportunity to testify today on HB 414, an act creating the Alaska Health Commission. The AaNA commends governor Hickel in his recognition of the need for health care reform and his efforts to solve what is perhaps the largest long-term problem facing Alaskans.

The Alaska Nurses Association believes that there already has been a great deal of data collected and debate conducted related to the issues of universal coverage, access to care and mix of providers, data collection, cost control and utilization, a public health improvement plan, tort reform and health insurance reform which have occurred in officially sponsored functions of the legislature. Although there may be some disagreement about some of the data that has been collected, there is more than ample information with which to move forward with a specific plan for health care reform.

The Alaska Nurses Association strongly supports universal health care coverage for all Alaskans. We believe this is the single most important aspect of health care reform. The Association, knowing the value of guaranteed coverage to primary care services, supports a single payer approach to ensuring a basic set of benefits for every citizen in this state.

We believe that HB 414 should be amended to require the Alaska Health Commission to develop a plan of universal coverage for all Alaskans within the same time line outlined in the bill for recommendations from the Commission to the Governor and Legislature. The Commission should be specifically directed to present a preferred plan, and alternatives if it deems advisable, which guarantees universal health care under a single payer system. This plan(s) should detail the benefits package of coverage, costs, financing mechanism(s), cost containment measures, and other features which the Commission believes necessary.

Representative Cynthia Toohey

March 4, 1994

Page 2

The Alaska Nurses Association is committed to the belief that a strong consumer presence needs to be an inherent component of the Alaska Health Commission. We are convinced that it is only by empowering more consumers that the system will become more responsive to the concerns of those directly impacted by that system. We believe there needs to be significant consumer representation on the Commission itself and urge you to consider a larger number of commissioners which more broadly represents the concerns of the health care consumer.

As an organization that has long advocated the principles of disease prevention and health promotion we are disturbed that there is not a plan to provide for a strong public health structure within HB414. We strongly recommend that the aspects of HB332 which outline the need for a strong public health component in health care reform be incorporated into HB 414. Further, we believe that health promotion and disease prevention strategies must be recognized as appropriate strategies to address the goals of cost containment and improved health outcomes.

We strongly support Section 7 "Review and Approval of Rates and Rating Factors". We believe that the health insurance industry should receive the same public scrutiny as that enjoyed by other insurance providers in the state. We believe that such public review will aid in the forthcoming deliberations. We are encouraged by the health insurance industry's endorsement of the Governor's proposed legislation, including this particular aspect.

Overall, the Alaska Nurses Association is pleased that the Governor and legislature is addressing the issue of health care reform. However, we do not believe HB 414 in its present form goes far enough to move us forward. We recommend that the committee work to incorporate our suggestions in order to pass legislation which will be effective. Thank you.

Sincerely yours,



Jackie Pflaum
Legislative Chair

FEB 18 1994

**Anchorage Chamber of Commerce
Resolution On Health Care Reform
93/94-7**

WHEREAS quality, access, and the costs of health care are all critical to Alaskans; and

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4. Address coverage for non-residents employed in seasonal industries in the state;
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6. Allow freedom of choice of employers to participate or not participate in any state mandated health care plan;
7. Address in advance how school districts, municipalities, boroughs or other public sector employers would have to increase budgets to cover any costs increase associated with health care reform;
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9. Adopt a level of benefits which establishes the base benefit payment for all health care providers and allows residents to seek care from any provider in the state recognizing however, some providers will charge an amount greater than allowed by the plan which must be paid by the resident;
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Be it further resolved that health care reform and the payment of health care costs should address all of the above areas and town meetings should be held to discuss the ramification of any proposed amendments or changes prior to voting on reform; and

While the current health care system may need to be fine tuned and some changes made, it does not need to be dismantled.

George Wuerch
Chairman 1993-94

Carol Heyman
President

February 18, 1994

FISCAL NOTE

STATE OF ALASKA
1994 LEGISLATIVE SESSION

BILL NO. CS HB 414 (HESS)

Revision Date: _____

Department Affected: Office of the Governor

Title: "An Act creating the Alaska Health Commission..."

BRU: Commissions and Special Offices

Sponsor: House Rules Committee

Component: Alaska Health Commission

Requestor: Governor

COMPONENT SERIAL NO. _____

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
PERSONAL SERVICES	640.2	734.3	749.9	706.6	783.3	801.3
TRAVEL	23.3	30.5	30.5	30.5	30.5	30.5
CONTRACTUAL	330.7	336.6	336.6	336.6	336.6	336.6
SUPPLIES	8.5	9.0	9.0	9.0	9.0	9.0
EQUIPMENT	78.5	.5	.5	.5	.5	.5
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	1081.2	1110.9	1126.5	1143.2	1159.9	1177.9

CAPITAL EXPENDITURES						
----------------------	--	--	--	--	--	--

CHANGE IN REVENUES ()						
------------------------	--	--	--	--	--	--

FUND SOURCE

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts	1081.2	1110.9	1126.5	1143.2	1159.9	1177.9
1006 GF/MHTIA						
OTHER						
TOTAL	1081.2	1110.9	1126.5	1143.2	1159.9	1177.9

POSITIONS

FULL-TIME	11	11	11	11	11	11
PART-TIME						
TEMPORARY						

Estimate of any current year (FY94) cost: 0

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

Prepared by: Michael A. Nizich, Director
Division: Division of Administrative Services

Phone: 465-3876
Date: 3/11/94

Approved by Commissioner: Patrick P. Ryan, Chief of Staff
Agency: Office of the Governor

Date: 3/11/94

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

Fiscal impact of proposed amendments to HB414:

Amendment 1: Public Health Committee

Assumptions:

Committee has six members
 Assume staff work done by Health Commission staff and Division of
 Public Health employees
 Committee meets 3 times per year in person (2 in FY95)
 Committee has 4 additional teleconference meetings per year

	FY95	FY96 - 00
Personal Services:		
1 Research Analyst	30,000 (6 mos.)	59,000 (inflate 5% annually)
Travel:	4,800	10,500
Contractual:		
Public Notices	1,000	3,500
Equipment:	12,100	-0-

Amendment 2: Single Payor Analysis

No cost - already assumed in original fiscal note

Amendment 3: Erisa Waiver:

Assumptions: contracting for specialized assistance

	FY95	FY96 - 00
Contractual:	100,000	100,000 (each year)

Amendment 4: Pooling

No additional cost anticipated

Amendment 5: Disclosure of Prices

Assumptions: One research analyst is required to monitor
 compliance; travel included

	FY95	FY96 - 00
Personal Services:		
1 Research Analyst	30,000 (6 mos.)	59,000 (inflate 5% annually)
Travel:	1,500	3,000
Supplies:	500	1,000
Contractual:	3,400	6,800
Equipment:	12,100	-0-

PERSONAL SERVICES

580.2

Fiscal note assumes Commissioners appointments on 7/1/94 and provides for 11 months of staff within first year. Subsequent years include merit increases for staff.

3	Commissioners	Rg. 26C	290.7
1	Special Assistant	Rg. 23A	70.9
3	Research Analysts	Rg. 18A	155.9
1	Secretary I	Rg. 10A/B	32.9
1	Clerk Typist III	Rg. 08A/B	29.8

TRAVEL

17.0

Travel costs and per diem associated with Commission activities -- research, investigation, public hearings

CONTRACTUAL

226.3

Professional Services:

technical/legal assistance contracts	150.0
--------------------------------------	-------

Communication:

Telephone (toll costs, base/local fixed costs, fax postage) 900/mo x 12	10.8
---	------

Advertising, Printing:

Public hearing advertising, report printing	5.0
---	-----

Transportation:

Freight and express charges 75/mo x 12	.9
--	----

Minor Repair, Maintenance:	.8
----------------------------	----

Equipment rental:

Photocopier 600/mo x 12	7.2
-------------------------	-----

Rental for space:

1433 sq. ft. x \$3.00/ft x 12 mos.	<u>51.6</u>
	226.3

SUPPLIES

8.0

Data processing and office supplies

EQUIPMENT

54.3

Communication:

Phone system	4.0
Fax Machine	2.8
Mailing equipment	3.0

Data Processing Equipment:

PCs, system printer, software for 9 work stations	26.0
--	------

Furniture/Office equipment:

9 offices/work stations file cabinets, bookcases and miscellaneous office equipment	<u>18.5</u> 54.3
--	---------------------

#1
AMENDMENT

HB 414

Page 1, line 8

After "health care",

Delete "is a vital public interest."

Insert "and maintenance of the public's health are vital to the public's interest."

Page 1, line 11

After "insurance",

Delete "and"

Page 1, line 12

After "malpractice",

Insert "and the lack of population based public health services"

Page 2, line 14

After "relating to",

Insert "the individual and public"

Page 5, after line 6,

Add a new section

(6) establish a Public Health Advisory Committee which
(A) consists of at least one member of the commission and other individuals with significant public health expertise appointed by the commission; and
(B) advises the commission on public health matters and the integration of public health services under AS 44.19.621.

#2

8-GH2024\A.1
Ford
2/15/94

A M E N D M E N T

OFFERED IN THE HOUSE

BY REPRESENTATIVE BRICE

TO: HB 414

Page 2, line 5, after "services.":

Insert "the creation of a public health improvement plan."

Page 2, line 21:

Delete "and"

Page 3, line 16, following "1997":

Delete "."

Insert "; and

(6) establishing a public health improvement plan advisory committee and developing a public health improvement plan as required under AS 44.19.636."

Page 5, line 6, after "AS 44.19.629":

Insert ";

(6) establish a public health improvement plan advisory committee to develop a public health improvement plan as required under AS 44.19.636."

Page 7, after line 22:

Insert a new section to read:

"Sec. 44.19.636. PUBLIC HEALTH IMPROVEMENT ADVISORY COMMITTEE. (a) The commission shall establish and appoint the members of an advisory committee for the purpose of developing a public health improvement plan. The committee must include at least one member of the commission. In appointing other members of the committee, the commission shall consider public and private health care professionals, labor organizations, businesses, the education system, the

Alaska Public Health Association, the Alaska Mental Health Board, the Alaska Native Health Board, as well as the need for geographic, ethnic, and cultural diversity on the committee.

- (b) The plan developed by the committee under (a) of this section must
 - (1) recognize the need for
 - (A) community involvement in health care planning and delivery;
 - (B) attention to local needs that may vary from place to place;
 - (C) accountability for the use of public funds;
 - (D) equity and stability in the distribution of public funds;
 - (E) shared responsibility of all levels of government for administering and financing public health care delivery; and
 - (F) coordination of basic public health services; and
 - (2) include
 - (A) an analysis of the health status of the residents of the state;
 - (B) an assessment of the most appropriate role for various levels of government to play in addressing the health care needs of the residents of the state;
 - (C) a delineation of the standards that should be used in performing assessment, policy development, and quality assurance in the delivery of public health services;
 - (D) documentation of the extent to which the current public health system implements or achieves the standards identified under (C) of this paragraph;
 - (E) identification of interjurisdictional issues involved in health care access and delivery;
 - (F) recommendations, including recommendations for specific legislative action when necessary, pertaining to the following:
 - (i) strategies, time lines, financial needs, and specific sources of stable revenue for bringing the state public health care system up to standards identified by the committee;
 - (ii) appropriate sharing of the responsibility of local,

regional, state, and federal government entities to deliver public health care services efficiently and effectively, including recommendations for organization within state government;

(iii) integration of the public health care system with state and national health care reform efforts;

(iv) the committee's estimate of the optimal share that public health should represent in the total health care delivery system of the state, expressed in terms of a percentage of health care dollars spent or in terms of public dollars per state resident."

Page 17, after line 12:

Insert a new bill section to read:

"* Sec. 22. TRANSITION. Notwithstanding AS 44.19.621(a)(6), enacted in sec. 3 of this Act, the Alaska Health Commission shall develop a public health improvement plan as described under AS 44.19.636 by January 1, 1996."

Renumber the following bill sections accordingly.

Page 17, line 16:

Delete "and 21"

Insert "21, and 22"

3

A M E N D M E N T

OFFERED IN THE HOUSE
TO: HB 414

BY REPRESENTATIVE TOOHEY

Page 7, after line 22:

Insert a new section to read:

"Sec. 44.19.636. REQUIRED AVAILABILITY OF PRICE LIST. (a) A health care provider shall prepare a list of the provider's prices for common health care services that includes the time period in which the prices apply. The price list shall be made available by posting the price list in a conspicuous location in the health care provider's office. The commission shall determine by regulation the health care services that must be disclosed and the contents of the price list required under this section.

(b) If a health care provider charges a price for a health care service that differs from the posted price, the health care provider shall provide an explanation of the deviation to the person receiving the health care service.

(c) At least annually, a health care provider shall submit to the commission copies of the provider's current price list. The commission shall specify by regulation the date for submitting the price lists."

4

8-GH2024A.3 ✓
Ford
3/9/94

A M E N D M E N T

OFFERED IN THE HOUSE
TO: HB 414

BY REPRESENTATIVE TOOHEY

Page 7, after line 22:

Insert a new section to read:

"Sec. 44.19.635. PROHIBITED PRICE INCREASES. A health care provider may not increase the provider's prices for health care services more than once in a calendar year. The commission shall adopt regulations to implement this section."



Alaska State Legislature

Please enter into the record my testimony to the House H.E.S.S.
committee name

committee on HB 414, dated MARCH 4, 1994.
bill/subject

Attached please find a copy of the current Health Care Financing Administration - 1500 medical services billing form (dated 12/90, in lower right corner). This standardized form is one of the things your proposed legislation would mandate. I thought you might like to know that one already exists. Also attached is the previous H.C.F.A.-1500 form (dated 1/84) which was replaced by the current version. I no longer have any copies of the H.C.F.A.-1500 designed in the 1970's.

The preceding is but one example from HB 414 showing that the bills were not researched well. Also note the attached copy of a page from Time Magazine: The graph shows the cost of U.S. medical care began increasing dramatically in 1987. The article (see underlined paragraph) never noted that in 1986 Congress enacted C.O.B.R.A., which forced hospital emergency rooms to treat all patients whether or not they paid. This is one of those "unfunded liabilities" that governments impose on lesser governments and the private sector.

However, notice on the graph that in 1990 the medical care inflation started to decrease dramatically. This was prior to the Clinton campaign's cry of "health care crisis". There was no great increase in HMO's that year that turned things around. The graph after 1990 shows the resourcefulness and responsiveness of the private sector: Medicine took a hit from Congress and still found a way to cut costs and maintain quality of care in only 3 years. And all this without a huge bureaucracy telling Medicine what to do! Has government ever cut costs and improved services at the same time?

Signed:

Marlene M. Leak
Testifier

MARLENE M. LEAK

SELF

Representing (Optional)

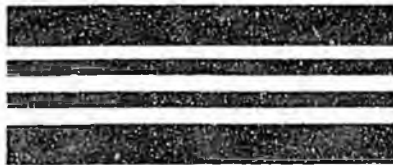
771 8th AVE. FAIRBANKS 99701

Address

452-1015

Phone No.

PLEASE DO NOT
STAPLE IN
THIS AREA



HEALTH INSURANCE CLAIM FORM

FORM APPROVED OMB NO. 0938-0008
READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM (CHECK APPLICABLE PROGRAM BLOCK BELOW)

MEDICARE (MEDICARE NO.)
 MEDICAID (MEDICAID NO.)
 CHAMPUS (SPONSOR'S SSN)
 CHAMPVA (VA FILE NO.)
 FECA BLACK LUNG (SSN)
 OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)		2. PATIENT'S DATE OF BIRTH		3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)	
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)		5. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		6. INSURED'S ID NO. (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS)	
TELEPHONE NO.		7. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>		8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)	
		<input type="checkbox"/> INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN		11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)	
9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)		10. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/>		TELEPHONE NO.	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT BELOW.		11A. CHAMPUS SPONSOR'S STATUS: <input type="checkbox"/> ACTIVE DUTY <input type="checkbox"/> DECEASED <input type="checkbox"/> RETIRED		BRANCH OF SERVICE	
SIGNED _____ DATE _____		13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.		SIGNED (INSURED OR AUTHORIZED PERSON) _____	

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF: _____	ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP) _____	15. DATE FIRST CONSULTED YOU FOR THIS CONDITION _____	16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES _____	16A. IF EMERGENCY CHECK HERE <input type="checkbox"/>
17. DATE PATIENT ABLE TO RETURN TO WORK _____	18. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____	DATES OF PARTIAL DISABILITY FROM _____ THROUGH _____		
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (E.G., PUBLIC HEALTH AGENCY) _____		20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____		
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN OFFICE) _____		22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES _____		

23A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY; RELATE DIAGNOSIS TO PROCEDURE IN COL. D BY REFERENCE NOS. 1, 2, 3, ETC. OR DX CODE B.

1. _____	EPSDT YES <input type="checkbox"/> NO <input type="checkbox"/>
2. _____	FAMILY PLANNING YES <input type="checkbox"/> NO <input type="checkbox"/>
3. _____	
4. _____	

PRIOR AUTHORIZATION NO. _____

24. A. DATE OF SERVICE FROM TO	B.* PLACE OF SERVICE	C. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE IDENTIFY: _____ (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	D. DIAGNOSIS CODE	E. CHARGES	F. DAYS OR UNITS	G.* T.O.S.	H. LEAVE BLANK

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE(S) OR CREDENTIALS). IF CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF.) DATE _____		26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES <input type="checkbox"/> NO <input type="checkbox"/>		27. TOTAL CHARGE _____		28. AMOUNT PAID _____		29. BALANCE DUE _____	
32. YOUR PATIENT'S ACCOUNT NO. _____		30. YOUR SOCIAL SECURITY NO. _____		31. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO. _____ ID NO. _____					
33. YOUR EMPLOYER ID NO. _____									

*PLACE OF SERVICE AND TYPE OF SERVICE (T.O.S.) CODES ON BACK
REMARKS:

APPROVED BY AMA COUNCIL
ON MEDICAL SERVICE 8/83

FORM HCFA-1500 (1-84) FORM OWCP-1500
FORM CHAMPUS-501 (1-84) FORM RRB-1800
APPROVED BY THE HEALTH CARE FINANCING ADMINISTRATION & CHAMPUS

FORM JUBO COWELL SYSTEMS INC CHAMPAIGN IL

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 is completed, the patient's signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge

submitted. CHAMPUS is not a health insurance program and renders payment for health benefits provided through membership and affiliation with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned "Insured", i.e. items 3, 6, 7, 8, 9, and 11.

BLACK LUNG AND FECA CLAIMS: The provided agrees to accept the amount paid by the Government as payment in full. See Black Lung FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally rendered by me or were rendered incident to my professional service by my employee under immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For services to be considered an "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral,

For CHAMPUS claims, I further certify that neither I nor any employee who rendered the services are employees or members of the Uniformed Services (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422.510).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION

We are authorized by HCFA, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and BLACK LUNG programs. Authority to collect information is in section 205 (a), 1872 and 1875 of the Social Security Act as amended and 44 USC 3101, 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq.

Federal agencies as necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

With the one exception discussed below, there are no penalties under these Programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards and other organizations or

It is mandatory that you tell us if you are being treated for a work related injury so we can determine whether workers' compensation will pay for treatment. Section 1877 (a) (3) of the Social Security Act provides criminal penalties for withholding this information.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request. I further agree to accept, as payment in full the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductibles and coinsurance.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally rendered by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete.

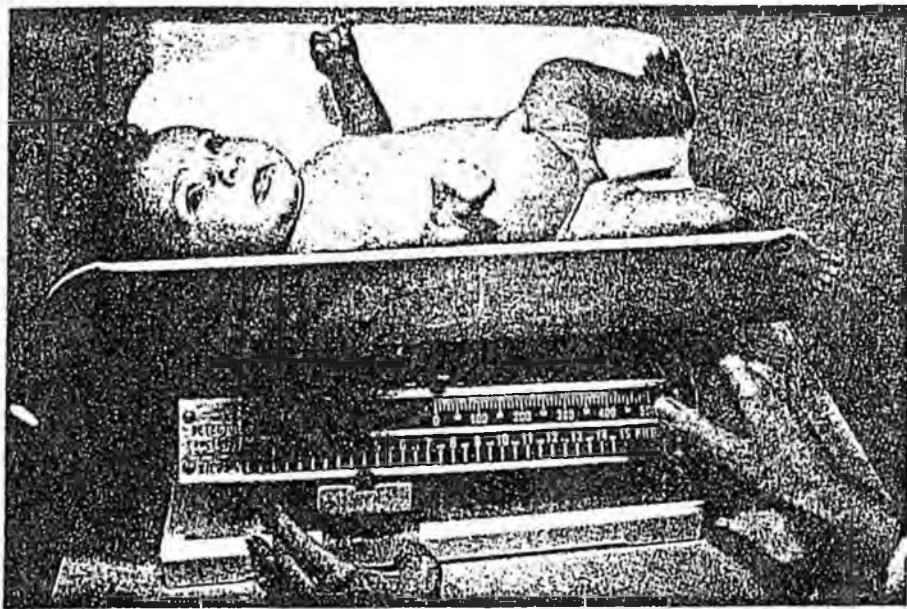
I understand that payment and satisfaction of this claim will be from Federal and/or State funds, and that any false claims, statements, or documents or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

PLACE OF SERVICE CODES:

- 1 - (IH) - Inpatient Hospital
- 2 - (OH) - Outpatient Hospital
- 3 - (O) - Doctor's Office
- 4 - (H) - Patient's Home
- 5 - - Day Care Facility (PSY)
- 6 - - Night Care Facility (PSY)
- 7 - (NH) - Nursing Home
- 8 - (SNF) - Skilled Nursing Facility
- 9 - - Ambulance
- 0 - (OL) - Other Locations
- A - (IL) - Independent Laboratory
- B - (ASC) - Ambulatory Surgical Center
- C - (RTC) - Residential Treatment Center
- D - (STF) - Specialized Treatment Facility
- E - (COR) - Comprehensive Outpatient Rehabilitation Facility
- F - (KDC) - Independent Kidney Disease Treatment Center

TYPE OF SERVICE CODES:

- 1 - Medical Care
- 2 - Surgery
- 3 - Consultation
- 4 - Diagnostic X-Ray
- 5 - Diagnostic Laboratory
- 6 - Radiation Therapy
- 7 - Anesthesia
- 8 - Assistance at Surgery
- 9 - Other Medical Service
- 0 - Blood or Packed Red Cells
- A - Used DME
- F - Ambulatory Surgical Center
- H - Hospice
- L - Renal Supplies in the Home
- M - Alternate Payment for Maintenance Dialysis
- N - Kidney Donor
- V - Pneumococcal Vaccina
- Y - Second Opinion on Elective Surgery
- Z - Third Opinion on Elective Surgery



This infant's HMO in California helps keep a lid on medical-cost inflation

■ HEALTH CARE

Crisis? What Crisis?

As medical inflation eases, so does the sense of urgency that Clinton needs to push his revolutionary plan

By ADAM ZAGORIN WASHINGTON

THE LATEST ASSAULT ON BILL CLINTON'S top domestic goal began with 10 words on a Sunday-morning talk show last week. "We do not have a health-care crisis in America," declared Daniel Patrick Moynihan, the Senate Finance Committee chairman. His words sent shivers through the White House, where creating a national sense of urgency about health care is regarded as critical to propelling the President's reforms through Congress. As the week progressed, things only got worse. The American Medical Association, it was disclosed, is preparing a plan to lobby for 37 significant changes in Clinton's plan, including the elimination of proposed limits on doctors' fees. Then came a letter, signed by 565 economists, warning about fallout from the price controls contained in the Clinton proposal.

Administration officials quickly tried to dampen the rising rebellion. Senior economic advisers led a hushed but urgent campaign to prevent the influential Business Roundtable from endorsing a more modest alternative to the President's 1,300-page plan. White House economics chief Robert Rubin and Deputy Treasury Secretary Roger Altman telephoned insurance-company CEOs at Prudential, Chubb, American International Group

and GNA to urge them not to endorse the rival plan, backed by Representative Jim Cooper of Tennessee and Senator John Breaux of Louisiana. But the Administration's pre-emptive strike met with resistance. Late Friday an informal straw poll of the Roundtable's policy committee turned up broad support for Cooper-Breaux.

On his return from Europe this week, Clinton aims to launch an all-out campaign for passage with his Jan. 25 State of the Union speech. But attitudes about health-care reform have shifted in the months since Clinton unveiled his plan in September. The economy has rebounded smartly, and a growing number of legislators have been denying the existence of a national medical emergency. Certainly one aspect of the crisis, the skyrocketing cost of care, has abated. Medical inflation fell from an annual rate of 6.3% in the first half of last year to 4.4% in the second half, according to the consumer price index. New projections indicate that the Federal Government will spend \$120 billion less on Medicare and Medicaid through 1998 than was estimated only a year ago.

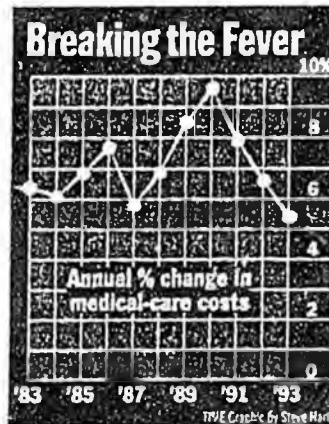
Behind the slowdown lie aggressive steps by several states including Maryland, Oregon and Florida to contain medical costs. Many private companies are taking their own measures. Typical is Intel, the microchip manufacturer, which suffered 20% annual increases in health-insurance premiums until the introduction of a managed-care program in 1990 that covers 20,000 U.S. employees. Now costs are edging up only 5% a year.

Another ingredient of medical-cost containment involves the decision by many hospitals, pharmaceutical companies and other providers to stabilize or lower their prices, perhaps in hopes of heading off congressional action on health-care reform. This, at least, is the argument advanced by Administration experts who caution that decelerating costs could prove illusory and that only a full-scale, Clinton-style reform with mandatory price restraints can tackle the job in the long run. "Medical inflation slowed in the late 1970s just in time to defeat a previous effort at cost containment," recalls Laura Tyson, chairman of the Council of Economic Advisers. "Later on, prices resumed their former upward spiral."

Moreover, advocates of reform argue, inflation is only one of many health-care problems that need fixing, most notable among them the lack of coverage for 37 million Americans, which the Clinton plan is designed to remedy. Warns Paul Begala, a senior Clinton political adviser: "The American people believe something serious must be done in a country where any one of us could lose our medical insurance tomorrow."

The sentiment among critics of Clinton's plan leans toward proposals that are more incremental, with less ambitious financing and lower costs. The one claiming the most support so far is the Cooper-Breaux plan, also known as "Clinton Lite." The proposal matches many features of the President's proposal but does not put limits on insurance premiums and will not yield universal coverage.

Several Republican legislators have developed their own, mostly incremental plans, hoping to avoid the awkward choice between opposing reform altogether and voting for some variation of the Clinton plan, for which the President will get most of the political credit. But, as the saying goes, you can't beat something with nothing. And the Republicans have yet to agree on an alternative that isn't Democratic in design. —With reporting by Michael Duffy and Dick Thompson/Washington



A M E N D M E N T

OFFERED IN THE HOUSE
TO: HB 414

BY REPRESENTATIVE KOTT
#2

13 20 "state;"
Page 2, line 27, after "1996,"

Insert "a benefit package may not limit the covered health care services on the basis of a preexisting condition;"



STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

January 28, 1994

*The Honorable Ramona Barnes
Speaker of the House
Alaska State Legislature
State Capitol
Juneau, AK 99801-1182*

Dear Speaker Barnes:

Under the authority of art. III, sec. 18, of the Alaska Constitution, I am transmitting a bill relating to health care reform.

Alaskans' access to quality, affordable health care is a vital public interest. This bill addresses improvements to the delivery, quality, access, cost, and financing of health care services. The bill is not intended to be viewed as a comprehensive reform proposal. Rather, it is a measured, responsible step forward to set the stage for comprehensive reform.

At the same time, however, the bill makes immediate improvements to the current health care system. As importantly, it creates a process that will provide the governor, the legislature, and the public with the information necessary to make rational health care reform decisions. The bill does not foreclose any reform options, including those presently being considered by Congress and by the state legislature.

Immediate steps taken through this bill to close gaps in the health care system include: the adoption and implementation of a uniform claim form, the use of mandatory non-binding arbitration as an alternative to litigation in resolving certain health system disputes, facilitating the creation of pools for sharing risks or purchasing insurance relating to health care services, and requiring health insurers and related entities to obtain approval for certain rates or fees charged to consumers.

The creation of the Alaska Health Commission, together with the duties imposed upon it, constitutes a major part of the bill. Along with being given authority to approve

The Honorable Ramona Barnes
January 28, 1994
Page 2

health insurer rates and other filings, the commission is charged with collecting and analyzing health care information and data. This information will serve as the basis for formulating, for the governor's and legislature's consideration, proposals on the primary mechanisms needed to effect meaningful comprehensive health care reform.

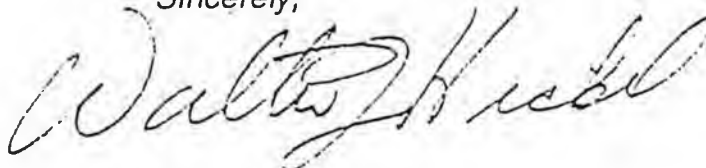
This proposal allows a deliberate process for determining how Alaskans will reform their health care system. The proposal focuses on collecting Alaska health care data, and it allows for analysis of what other states have done in the area. It also provides time to synchronize state efforts with those of impending federal health care reform.

This bill requires that its objectives be completed within established time frames. The analysis to be provided by the commission, particularly with regard to the cost, financing, and implementation of health care reform, is critical given the current fiscal circumstances facing the state. It is essential that the fiscal impact of health care reform be fully considered before further action is taken.

Please contact my staff if you need a detailed section-by-section description or additional explanation of the bill.

I urge your favorable action on this important bill.

Sincerely,

A handwritten signature in cursive script, appearing to read "Walter J. Hickel". The signature is written in dark ink and is positioned above the printed name.

Walter J. Hickel
Governor

January 31, 1994

SECTIONAL SUMMARY OF
GOVERNOR'S HEALTH COMMISSION BILL
(HB 414/SB 270)

Prepared by: Alaska Department of Law

Note: The bill itself is the best statement of its contents. A sectional summary of a bill is not an authoritative interpretation of the bill.

Section 1. FINDINGS. This section sets out legislative findings regarding access to health care, increases in health care costs, and the need for reform of the health care system in Alaska.

Section 2. INTENT. This section sets out legislative intent concerning the promotion of access to affordable, quality health care for Alaskans.

Section 3. COMMISSION. This section creates the Alaska Health Commission (commission); sets forth the purposes of the commission; establishes the composition, qualifications, terms, removal, and designation of its chairperson; authorizes the commission to hire staff; sets compensation for the members of the commission; establishes requirements for meetings; sets the powers and duties of the commission; and establishes duties of the commissioner to report to the governor, legislature, and the public on commission activities at the request of the governor.

Section 3 also requires the director of insurance to establish uniform forms and procedures for health claims no later than July 31, 1996; requires a health insurer to file with the commission (and the division of insurance) its rates and related data, and changes to the rates; authorizes the commission to review and approve the filings; gives appeal rights to a health insurer aggrieved by commission decision concerning that insurer's filing; sets parameters for reporting and disclosure of information; makes certain patient health records confidential; makes unlawful disclosure or use of commission information a class B misdemeanor; provides immunity from civil damages for commission members and others specified in AS 44.19.632 for negligent acts or omissions; allows the commission to give oaths and issue subpoenas; authorizes the court to issue orders to show cause for failure to comply with lawful subpoenas of the commission; allows the legislature to appropriate a portion of the proceeds of the tax on insurance premiums collected under AS 21.09.210 for commission operating costs; and establishes definitions for certain terms used in AS 44.19.620 - 44.19.639.

Section 4. MANDATORY ARBITRATION. This section mandates that a

person who files a suit for damages for medical malpractice must also submit the claim to the court for mandatory arbitration. The decision of the arbitrator is nonbinding; if it is rejected by either party, the action may then proceed in court. In existing AS 09.55.535, which is repealed and reenacted by this section, arbitration was voluntary only and was conducted by a multimember board, rather than a single arbitrator. This section corresponds with language in sec. 3 of SB 123 (1993), and it is designed to facilitate early resolution of claims before costly legal proceedings are pursued.

Section 5. EXPERT ADVISOR. This section amends AS 09.55.536 to authorize the court to appoint a single expert medical advisor rather than a three-person expert advisory panel as is currently required. The expert medical advisor would make written reports in court cases for medical malpractice claims. Except for minor technical changes, this section corresponds with sec. 4 of SB 123 (1993). This section is designed to reduce costs of obtaining expert advice in medical malpractice cases and facilitate early resolution of claims before costly court actions are pursued.

Section 6. PROCEDURE FOR CERTAIN CLAIMS AGAINST A HEALTH INSURER. This section is similar to sec. 4, except that, unless that practice is preempted by federal law that provides otherwise, it requires a health insurance claimant who files certain court actions against a health insurer to submit the claim to the court for mandatory arbitration. Again, the arbitrator's decision is nonbinding but should facilitate early resolution of claims before costly legal proceedings are pursued.

Section 7. REVIEW AND APPROVAL OF RATES AND RATING FACTORS (TRADITIONAL HEALTH INSURANCE). This section acknowledges the sec. 3 requirement that disability insurers ("health insurers" under AS 44.19.620 - 44.19.639) must file disability insurance rates or rating factors with the commission for approval. The director of insurance makes recommendations to the commission to approve or disapprove the filings.

PURCHASING POOLS. This section requires the director of insurance to adopt regulations to facilitate the creation of pools to share risk or purchase disability insurance. Before adopting regulations, the director must consult with and consider recommendations of the commission.

Section 8. CONFORMING AMENDMENT. This section makes a technical amendment to reflect the repeal of AS 21.86.070(e). The two changes together delete references to the authority of the director of insurance to require additional information concerning, and approve filing of, rates for health maintenance organizations. Under sec. 3 of the bill, the commission will perform that function.

Section 9. REVIEW AND APPROVAL OF RATES AND CHARGES (HMO). This

section establishes the procedure for filing, review, and approval by the commission of health maintenance organizations' rates and charges. The director of insurance must make recommendations to the commission on the approval or disapproval of the rates. This section is similar to sec. 7, but relates to health maintenance organizations.

Section 10. PURCHASING POOLS. This section requires the director of insurance to adopt regulations to allow the creation of pools for the purpose of sharing risks or purchasing insurance relating to health maintenance organizations. This section is similar to sec. 7, but relates to health maintenance organizations.

Section 11. REVIEW AND APPROVAL OF RATES AND CHARGES (SERVICE CORPORATIONS). This section establishes procedures for filing, review, and approval by the commission, of rates, fees, and payments by hospital and medical service corporations. The director of insurance must make a written recommendation to the commission on the approval or disapproval of these items. This section is similar to secs. 7 and 9 but relates to service corporations.

Section 12. PURCHASING POOLS. This section requires the director of insurance to adopt regulations to allow for the creation of pools to share risk or purchase insurance related to service corporations. This section is similar to secs. 7 and 10, but relates to hospital and medical service corporations.

Sections 13 and 14. COMMISSION PROCUREMENT PROCEDURES. These sections together exempt the commission from the state procurement code, but require the commission to adopt its own procurement regulations. The regulations must be consistent with the competitive procurement principles of the procurement code. The exemption is considered necessary to allow the commission to meet the relatively short deadlines for reports and recommendations set by AS 44.19.621.

Section 15. EXEMPT SERVICE. This section places the commission staff in the exempt state service. Commission members also would be in the exempt service under existing AS 39.25.110(10).

Section 16. OPEN MEETINGS ACT LIMITATION. This section would require that commission meetings related to the adoption of regulations or to actions on rate filings fall under the requirements of the Open Meetings Act. Other commission meetings would be exempted from those requirements. This would allow the commission members to conduct day-to-day administrative activities without first issuing a public notice and convening a public meeting.

Section 17. SUNSET PROVISION. This section establishes a sunset date for the commission of June 30, 1999. This would allow for

routine review and evaluation of the effectiveness of the commission.

Section 18. REPEALERS. This section repeals portions of existing statutes, due to changes contained in this bill. AS 09.55.560(2), defining "board" for the purpose of arbitration under AS 09.55.535, is repealed because AS 09.55.535 has been changed to provide for a single arbitrator instead of an arbitration board. AS 09.55.560(3), defining "panel" to mean an expert advisory panel established under AS 09.55.536, is repealed because AS 09.55.536 has been amended to use a single expert instead of a three-person expert advisory panel. In existing insurance statutes regulating health maintenance organizations, AS 21.86.070(e) and (f), dealing with filing of HMO enrollee changes, are repealed because of the new provisions at AS 21.86.075 addressing review and approval of rates and charges by the commission.

Section 19. COURT RULE REPEAL. This section repeals Alaska Rule of Civil Procedure 72.1 in accordance with art. IV, sec. 15, of the Alaska Constitution. The rule, addressing expert advisory panels, is no longer necessary because of the change in AS 09.55.536 replacing the panel with a single expert advisor.

Section 20. APPLICABILITY. This section specifies that the changes made by secs. 4, 5, and 6 of the bill, concerning mandatory arbitration and medical experts, apply only to causes of action accruing on or after the bill's effective date, which sec. 23 designates as July 1, 1994.

Section 21. INITIAL APPOINTMENT OF COMMISSION MEMBERS; REAPPOINTMENT OF INITIAL APPOINTEES. This section requires that the terms of persons initially appointed to the commission must be set in accordance with AS 39.05.055, which addresses requirements for staggering initial terms of commission members. The initial appointees have one-, two-, or three-year terms respectively. This section also allows for initial appointees to be able to be reappointed for one additional six-year term.

Section 22. COURT RULE REQUIREMENT. This section provides that sec. 19 -- repealing Civil Rule 72.1 -- takes effect July 1, 1994 only if sec. 19 receives a two-thirds majority vote of each house as required by art. IV, sec. 15, Alaska Constitution.

Section 23. EFFECTIVE DATE. This section establishes July 1, 1994 as the effective date for all sections of the bill, except sec. 19 on the court rule change.

GOVERNOR'S ALASKA HEALTH COMMISSION LEGISLATION (SB 270 & HB 414)

Governor Hickel has introduced legislation to provide a mechanism for focusing on health care in Alaska. This legislation will promote access to affordable health care and provide a means to analyze health care proposals that address the needs of Alaskans.

The Governor's legislation establishes a commission that will analyze state and federal health care systems, implement changes to the present system, and make recommendations for long-term reform. The commission will be comprised of three full-time, paid commissioners appointed by the Governor and confirmed by the Legislature. They will hold staggered, six-year terms. This legislation specifies deadlines by which the commission will complete tasks and report to the Governor and the Legislature. The Commission's budget for the first year is \$885,800 from insurance premium tax receipts. (This amount includes staff appropriate for the commission's functions.)

The commission will identify and implement insurance pools and implement a universal claim form to facilitate data collection and analysis, and to lower administrative costs. They will analyze and collect health care data specific to Alaska on which to base future health care policy decisions and recommendations. Non-binding arbitration will be instituted as an alternative to litigation in resolving malpractice and claim disputes between insurance companies and beneficiaries. Upon review and recommendation by the Division of Insurance the commission can approve changes to health insurance premiums.

The commission will define a potential benefit package for universal coverage and determine the cost of comprehensive reform proposals. They will investigate the use of standard practices to reduce medical tort liability and devise administrative structure to implement reforms. Specific recommendations will be developed and submitted to the Governor for consideration and transmittal to the Legislature.

The commission will conduct public meetings regarding health care issues and commission activities.

GOVERNOR'S ALASKA HEALTH COMMISSION LEGISLATION

PURPOSE

To provide a mechanism for focusing on Alaska's health care system and needs; to promote access to affordable health care; to analyze health care proposals that address the needs of Alaskans; and to make health care recommendations to the Governor and Legislature.

STRATEGY

Establish a commission to analyze state and federal health care systems; implement changes to the present system; and make recommendations for long-term reform.

- * *Membership:* The commission will be comprised of three full-time, paid commissioners appointed by the Governor and confirmed by the Legislature. Staggered, six-year terms. Sunset on the commission for continuation after five years. Governor appoints chair. Members can be removed for cause.
- * *Time frames:* Legislation specifies deadlines by which the commission will complete tasks and report to the Governor and the Legislature.
- * *Cost:* Commission's budget for the first year is \$885,800 from insurance premium tax receipts. Includes staff appropriate for commission's functions.

COMMISSION RESPONSIBILITIES

Authority to implement changes to current health care system:

- * Identify and implement insurance pools.
- * Implement universal claim form to facilitate data collection and analysis and lower administrative costs.
- * Collect health care data specific to Alaska on which to base future health care policy decisions and recommendations.

- * Implement non-binding arbitration as an alternative to litigation in resolving malpractice disputes and claim disputes between insurance companies and beneficiaries.
- * Upon review and recommendation by the Division of Insurance, approve changes to health insurance premiums.
- * Conduct public meetings regarding health care issues and commission activities.

Conduct health care system analysis:

- * Analyze Alaska health care data.
- * Define potential benefit package for universal coverage.
- * Determine cost of comprehensive reform proposals.
- * Investigate the use of standard practices to reduce medical tort liability.
- * Devise administrative structure to implement reforms.

Develop policy recommendations:

- * Develop and submit specific recommendations to the Governor for consideration and transmittal to the Legislature.

WALTER J. HICKEL
GOVERNOR



P. O. Box 110001
Juneau, Alaska 99811-0001
(907) 455-3500

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

January 28, 1994

*The Honorable Ramona Barnes
Speaker of the House
Alaska State Legislature
State Capitol
Juneau, AK 99801-1182*

Dear Speaker Barnes:

Under the authority of art. III, sec. 18, of the Alaska Constitution, I am transmitting a bill relating to health care reform.

Alaskans' access to quality, affordable health care is a vital public interest. This bill addresses improvements to the delivery, quality, access, cost, and financing of health care services. The bill is not intended to be viewed as a comprehensive reform proposal. Rather, it is a measured, responsible step forward to set the stage for comprehensive reform.

At the same time, however, the bill makes immediate improvements to the current health care system. As importantly, it creates a process that will provide the governor, the legislature, and the public with the information necessary to make rational health care reform decisions. The bill does not foreclose any reform options, including those presently being considered by Congress and by the state legislature.

Immediate steps taken through this bill to close gaps in the health care system include: the adoption and implementation of a uniform claim form, the use of mandatory non-binding arbitration as an alternative to litigation in resolving certain health system disputes, facilitating the creation of pools for sharing risks or purchasing insurance relating to health care services, and requiring health insurers and related entities to obtain approval for certain rates or fees charged to consumers.

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The Honorable Ramona Barnes
January 28, 1994
Page 2

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This bill requires that its objectives be completed within established time frames. The analysis to be provided by the commission, particularly with regard to the cost, financing, and implementation of health care reform, is critical given the current fiscal circumstances facing the state. It is essential that the fiscal impact of health care reform be fully considered before further action is taken.

Please contact my staff if you need a detailed section-by-section description or additional explanation of the bill.

I urge your favorable action on this important bill.

Sincerely,

A handwritten signature in cursive script, reading "Walter J. Hickel". The signature is written in dark ink and is positioned above the printed name and title.

Walter J. Hickel
Governor

January 31, 1994

SECTIONAL SUMMARY OF
GOVERNOR'S HEALTH COMMISSION BILL
(HB 414/SB 270)

Prepared by: Alaska Department of Law

Note: The bill itself is the best statement of its contents. A sectional summary of a bill is not an authoritative interpretation of the bill.

Section 1. FINDINGS. This section sets out legislative findings regarding access to health care, increases in health care costs, and the need for reform of the health care system in Alaska.

Section 2. INTENT. This section sets out legislative intent concerning the promotion of access to affordable, quality health care for Alaskans.

Section 3. COMMISSION. This section creates the Alaska Health Commission (commission); sets forth the purposes of the commission; establishes the composition, qualifications, terms, removal, and designation of its chairperson; authorizes the commission to hire staff; sets compensation for the members of the commission; establishes requirements for meetings; sets the powers and duties of the commission; and establishes duties of the commissioner to report to the governor, legislature, and the public on commission activities at the request of the governor.

Section 3 also requires the director of insurance to establish uniform forms and procedures for health claims no later than July 31, 1996; requires a health insurer to file with the commission (and the division of insurance) its rates and related data, and changes to the rates; authorizes the commission to review and approve the filings; gives appeal rights to a health insurer aggrieved by commission decision concerning that insurer's filing; sets parameters for reporting and disclosure of information; makes certain patient health records confidential; makes unlawful disclosure or use of commission information a class B misdemeanor; provides immunity from civil damages for commission members and others specified in AS 44.19.632 for negligent acts or omissions; allows the commission to give oaths and issue subpoenas; authorizes the court to issue orders to show cause for failure to comply with lawful subpoenas of the commission; allows the legislature to appropriate a portion of the proceeds of the tax on insurance premiums collected under AS 21.09.210 for commission operating costs; and establishes definitions for certain terms used in AS 44.19.620 - 44.19.639.

Section 4. MANDATORY ARBITRATION. This section mandates that a

person who files a suit for damages for medical malpractice must also submit the claim to the court for mandatory arbitration. The decision of the arbitrator is nonbinding; if it is rejected by either party, the action may then proceed in court. In existing AS 09.55.535, which is repealed and reenacted by this section, arbitration was voluntary only and was conducted by a multimember board, rather than a single arbitrator. This section corresponds with language in sec. 3 of SB 123 (1993), and it is designed to facilitate early resolution of claims before costly legal proceedings are pursued.

Section 5. EXPERT ADVISOR. This section amends AS 09.55.536 to authorize the court to appoint a single expert medical advisor rather than a three-person expert advisory panel as is currently required. The expert medical advisor would make written reports in court cases for medical malpractice claims. Except for minor technical changes, this section corresponds with sec. 4 of SB 123 (1993). This section is designed to reduce costs of obtaining expert advice in medical malpractice cases and facilitate early resolution of claims before costly court actions are pursued.

Section 6. PROCEDURE FOR CERTAIN CLAIMS AGAINST A HEALTH INSURER. This section is similar to sec. 4, except that, unless that practice is preempted by federal law that provides otherwise, it requires a health insurance claimant who files certain court actions against a health insurer to submit the claim to the court for mandatory arbitration. Again, the arbitrator's decision is nonbinding but should facilitate early resolution of claims before costly legal proceedings are pursued.

Section 7. REVIEW AND APPROVAL OF RATES AND RATING FACTORS (TRADITIONAL HEALTH INSURANCE). This section acknowledges the sec. 3 requirement that disability insurers ("health insurers" under AS 44.19.620 - 44.19.639) must file disability insurance rates or rating factors with the commission for approval. The director of insurance makes recommendations to the commission to approve or disapprove the filings.

PURCHASING POOLS. This section requires the director of insurance to adopt regulations to facilitate the creation of pools to share risk or purchase disability insurance. Before adopting regulations, the director must consult with and consider recommendations of the commission.

Section 8. CONFORMING AMENDMENT. This section makes a technical amendment to reflect the repeal of AS 21.86.070(e). The two changes together delete references to the authority of the director of insurance to require additional information concerning, and approve filing of, rates for health maintenance organizations. Under sec. 3 of the bill, the commission will perform that function.

Section 9. REVIEW AND APPROVAL OF RATES AND CHARGES (HMO). This

section establishes the procedure for filing, review, and approval by the commission of health maintenance organizations' rates and charges. The director of insurance must make recommendations to the commission on the approval or disapproval of the rates. This section is similar to sec. 7, but relates to health maintenance organizations.

Section 10. PURCHASING POOLS. This section requires the director of insurance to adopt regulations to allow the creation of pools for the purpose of sharing risks or purchasing insurance relating to health maintenance organizations. This section is similar to sec. 7, but relates to health maintenance organizations.

Section 11. REVIEW AND APPROVAL OF RATES AND CHARGES (SERVICE CORPORATIONS). This section establishes procedures for filing, review, and approval by the commission, of rates, fees, and payments by hospital and medical service corporations. The director of insurance must make a written recommendation to the commission on the approval or disapproval of these items. This section is similar to secs. 7 and 9 but relates to service corporations.

Section 12. PURCHASING POOLS. This section requires the director of insurance to adopt regulations to allow for the creation of pools to share risk or purchase insurance related to service corporations. This section is similar to secs. 7 and 10, but relates to hospital and medical service corporations.

Sections 13 and 14. COMMISSION PROCUREMENT PROCEDURES. These sections together exempt the commission from the state procurement code, but require the commission to adopt its own procurement regulations. The regulations must be consistent with the competitive procurement principles of the procurement code. The exemption is considered necessary to allow the commission to meet the relatively short deadlines for reports and recommendations set by AS 44.19.621.

Section 15. EXEMPT SERVICE. This section places the commission staff in the exempt state service. Commission members also would be in the exempt service under existing AS 39.25.110(10).

Section 16. OPEN MEETINGS ACT LIMITATION. This section would require that commission meetings related to the adoption of regulations or to actions on rate filings fall under the requirements of the Open Meetings Act. Other commission meetings would be exempted from those requirements. This would allow the commission members to conduct day-to-day administrative activities without first issuing a public notice and convening a public meeting.

Section 17. SUNSET PROVISION. This section establishes a sunset date for the commission of June 30, 1999. This would allow for

routine review and evaluation of the effectiveness of the commission.

Section 18. REPEALERS. This section repeals portions of existing statutes, due to changes contained in this bill. AS 09.55.560(2), defining "board" for the purpose of arbitration under AS 09.55.535, is repealed because AS 09.55.535 has been changed to provide for a single arbitrator instead of an arbitration board. AS 09.55.560(3), defining "panel" to mean an expert advisory panel established under AS 09.55.536, is repealed because AS 09.55.536 has been amended to use a single expert instead of a three-person expert advisory panel. In existing insurance statutes regulating health maintenance organizations, AS 21.86.070(e) and (f), dealing with filing of HMO enrollee changes, are repealed because of the new provisions at AS 21.86.075 addressing review and approval of rates and charges by the commission.

Section 19. COURT RULE REPEAL. This section repeals Alaska Rule of Civil Procedure 72.1 in accordance with art. IV, sec. 15, of the Alaska Constitution. The rule, addressing expert advisory panels, is no longer necessary because of the change in AS 09.55.536 replacing the panel with a single expert advisor.

Section 20. APPLICABILITY. This section specifies that the changes made by secs. 4, 5, and 6 of the bill, concerning mandatory arbitration and medical experts, apply only to causes of action accruing on or after the bill's effective date, which sec. 23 designates as July 1, 1994.

Section 21. INITIAL APPOINTMENT OF COMMISSION MEMBERS; REAPPOINTMENT OF INITIAL APPOINTEES. This section requires that the terms of persons initially appointed to the commission must be set in accordance with AS 39.05.055, which addresses requirements for staggering initial terms of commission members. The initial appointees have one-, two-, or three-year terms respectively. This section also allows for initial appointees to be able to be reappointed for one additional six-year term.

Section 22. COURT RULE REQUIREMENT. This section provides that sec. 19 -- repealing Civil Rule 72.1 -- takes effect July 1, 1994 only if sec. 19 receives a two-thirds majority vote of each house as required by art. IV, sec. 15, Alaska Constitution.

Section 23. EFFECTIVE DATE. This section establishes July 1, 1994 as the effective date for all sections of the bill, except sec. 19 on the court rule change.

**GOVERNOR'S
ALASKA HEALTH COMMISSION
LEGISLATION
(SB 270 & HB 414)**

Governor Hickel has introduced legislation to provide a mechanism for focusing on health care in Alaska. This legislation will promote access to affordable health care and provide a means to analyze health care proposals that address the needs of Alaskans.

The Governor's legislation establishes a commission that will analyze state and federal health care systems, implement changes to the present system, and make recommendations for long-term reform. The commission will be comprised of three full-time, paid commissioners appointed by the Governor and confirmed by the Legislature. They will hold staggered, six-year terms. This legislation specifies deadlines by which the commission will complete tasks and report to the Governor and the Legislature. The Commission's budget for the first year is \$885,800 from insurance premium tax receipts. (This amount includes staff appropriate for the commission's functions.)

The commission will identify and implement insurance pools and implement a universal claim form to facilitate data collection and analysis, and to lower administrative costs. They will analyze and collect health care data specific to Alaska on which to base future health care policy decisions and recommendations. Non-binding arbitration will be instituted as an alternative to litigation in resolving malpractice and claim disputes between insurance companies and beneficiaries. Upon review and recommendation by the Division of Insurance the commission can approve changes to health insurance premiums.

The commission will define a potential benefit package for universal coverage and determine the cost of comprehensive reform proposals. They will investigate the use of standard practices to reduce medical tort liability and devise administrative structure to implement reforms. Specific recommendations will be developed and submitted to the Governor for consideration and transmittal to the Legislature.

The commission will conduct public meetings regarding health care issues and commission activities.

GOVERNOR'S ALASKA HEALTH COMMISSION LEGISLATION

PURPOSE

To provide a mechanism for focusing on Alaska's health care system and needs; to promote access to affordable health care; to analyze health care proposals that address the needs of Alaskans; and to make health care recommendations to the Governor and Legislature.

STRATEGY

Establish a commission to analyze state and federal health care systems; implement changes to the present system; and make recommendations for long-term reform.

- * *Membership:* The commission will be comprised of three full-time, paid commissioners appointed by the Governor and confirmed by the Legislature. Staggered, six-year terms. Sunset on the commission for continuation after five years. Governor appoints chair. Members can be removed for cause.
- * *Time frames:* Legislation specifies deadlines by which the commission will complete tasks and report to the Governor and the Legislature.
- * *Cost:* Commission's budget for the first year is \$885,800 from insurance premium tax receipts. Includes staff appropriate for commission's functions.

COMMISSION RESPONSIBILITIES

Authority to implement changes to current health care system:

- * Identify and implement insurance pools.
- * Implement universal claim form to facilitate data collection and analysis and lower administrative costs.
- * Collect health care data specific to Alaska on which to base future health care policy decisions and recommendations.

- * Implement non-binding arbitration as an alternative to litigation in resolving malpractice disputes and claim disputes between insurance companies and beneficiaries.
- * Upon review and recommendation by the Division of Insurance, approve changes to health insurance premiums.
- * Conduct public meetings regarding health care issues and commission activities.

Conduct health care system analysis:

- * Analyze Alaska health care data.
- * Define potential benefit package for universal coverage.
- * Determine cost of comprehensive reform proposals.
- * Investigate the use of standard practices to reduce medical tort liability.
- * Devise administrative structure to implement reforms.

Develop policy recommendations:

- * Develop and submit specific recommendations to the Governor for consideration and transmittal to the Legislature.

5

PROPOSED AMENDMENT TO HB 414

Delete Sections 7, 9, and 11

Section 7 establishes health insurance rate regulation of private insurers as a power and duty of the new Alaska Health Commission .

Section 9 gives the same power and duty for Health Maintenance Organizations

Section 11 gives the same power and duty for service corporations (ie Blue Cross).

HEALTH INSURANCE RATE FILING REQUIREMENTS IN THE STATES

<u>State:</u>	<u>Citation:</u>	<u>Filing Requirement:</u>	<u>Applies to:</u>
Alabama	No provision		
Alaska	No provision		
Arizona	Reg.4-14-607	File and use	Individual health
Arkansas	§23-79-109	Prior approval (30 day deemer provision)	Individual health
California	§10290 tit.10 Reg.2213	File and use (30 days)	Individual health
Colorado	§10-16-107	File and use (30 days)	All health
Connecticut	§38a-481	File and use (30 days)	All health
Delaware	tit.18§§3333, 2504	File and use (90 days)	All health including Med Supp and BC/BS
District of Columbia	§35-517	File and use (30 days)	All health
Florida	Reg.4-58	File and use	All health
Georgia	§33-20-20	Prior approval	All health
Hawaii	No provision		
Idaho	§41-2136	File and use	Individual health
Illinois	I.C. §355	File and use	All health
Indiana	§27-8-5-1	File and use	All health
Iowa	Reg.191-36.9	File and use	All health including Med Supp
Kansas	§40-2215	File and use (30 days)	Individual health
Kentucky	§§304.17-380 to 304.17-383	Prior approval	Individual policies unless contain loss ratio guarantee
Louisiana	R.S.22:211	File and use	All health
Maine	24-A§2736	File and use (60 days)	Individual health Med Supp, LTC

Maryland	Reg. 9:30:44.02	File and use (90 days)	All health
Massachusetts	Ch. 175§10B	File and use (30 days)	All health
Michigan	§500.3474	File and use	Individual health
Minnesota	§62A.02	File and use (60 days)	All policies
Mississippi	Reg. L&GH 73-4	File and use	All health
Missouri	No provision		
Montana	No provision		
Nebraska	§44-710	File and use	All health
Nevada	§689A.360	File and use	Individual health
New Hampshire	§415:1	File and use (30 days)	All health
New Jersey	Reg. 11:4-18.1	File and use	Individual health
New Mexico	§59A-18-13	Prior approval	All health
New York	§3216	File and use	Individual health
North Carolina	§58-51-95 §50-51-85	File and use (90 days) File and use	All health Group health
North Dakota	§26.1-30-19	Prior approval (60 day deemer)	All health
Ohio	§3923.021	File and use (30 days)	All health
Oklahoma	tit. 36§4402	File and use	Individual health
Oregon	No provision		
Pennsylvania	§40-39-101	Prior approval	All health
Rhode Island	Reg. XXIII, Part XI	prior approval	All health
South Carolina	§38-71-310	Prior approval (90 day deemer)	Individual health
South Dakota	No provision		
Tennessee	§56-26-102	Prior approval (30 day deemer)	All health except experience rated groups
Texas	Art. 3.42	File and use	Individual health

Utah	Reg.R540-85	File and use	Individual health
Vermont	Title 8 §4062	File and use (30 days)	All health
Virginia	§38.2-316	File and use	All health
Washington	No provision		
West Virginia	§33-16B-1	Prior approval (60 day deemer)	All health
Wisconsin	§625.13	Use and file (30 days)	Individual health
Wyoming	§26-18-135	File and use	Individual health

Information supplied by NAIC Chart 7/92

+56-

any benefit plan design written, issued, or administered by the carrier at the time of application for a new health benefit plan, or at the time of renewal of a health benefit plan.

(f) The availability, upon request, of a listing of all the carrier's benefit plan designs, including the rates for each benefit plan design.

10717. (a) No carrier shall provide or renew coverage subject to this chapter until it has done all of the following:

(1) A statement has been filed with the commissioner listing all of the carrier's benefit plan designs currently in force that are offered or proposed to be offered for sale in this state, identified by form number, and, if previously approved by the commissioner, the date approved by the commissioner as well as the standard employee risk rate for each risk category for each benefit plan design and the highest and lowest risk adjustment factors that the carrier intends to use in determining rates for each benefit plan design. When filing a new benefit plan design pursuant to Section 10705, carriers may submit both the policy form and the standard employee risk rates for each risk category at the same time.

(2) Either:

(A) Thirty days expires after that statement is filed without written notice from the commissioner specifying the reasons for his or her opinion that the carrier's risk categories or risk adjustment factors do not comply with the requirements of this chapter.

(B) Prior to that time the commissioner gives the carrier written notice that the carrier's risk categories and risk adjustment factors as filed comply with the requirements of this chapter.

(b) No carrier shall issue, deliver, renew, or revise a benefit plan design lawfully provided pursuant to subdivision (a), and no carrier shall change the risk categories, risk adjustment factors, or standard employee risk rates for any benefit plan design until all of the following requirements are met:

(1) The carrier files with the commissioner a statement of the specific changes which the carrier proposes in the risk categories, risk adjustment factors, or standard employee risk rates.

(2) Either:

(A) Thirty days expires after such statement is filed without written notice from the commissioner specifying the reasons for his or her opinion that the carrier's risk categories or risk adjustment factors do not comply with the requirements of this chapter.

(B) Prior to that time the commissioner gives the carrier written notice that the carrier's risk categories and risk adjustment factors as filed comply with the requirements of this chapter.

(c) Notwithstanding any provision to the contrary, when a carrier is changing the standard employee risk rates of a benefit plan design lawfully provided under (a) or (b) above but is not changing the risk categories or risk adjustment factors which have been previously authorized, the carrier need not comply with the requirements of paragraph (2) of subdivision (b), but instead shall submit the revised

To: Reed Stoops | From: Charlie Hunt
Co./Dept. | Co./Dept. Actna

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standard employee risk rates for the benefit plan design prior to offering or renewing the benefit plan design.

(d) When submitting filings under subdivision (a), (b), or (c), a carrier may also file with the commissioner at the time of the filings a statement of the standard employee risk rate for each risk category the carrier intends to use for each month in the 12 months subsequent to the date of the filing. Once the requirements of the applicable subdivision (a), (b), or (c), have been met, these rates shall be used by the carrier for the 12-month period unless the carrier is otherwise informed by the commissioner in his or her response to the filings submitted under subdivision (a), (b), or (c), provided that any subsequent change in the standard employee risk rates charged by the carrier which differ from those previously filed with the commissioner must be newly filed in accordance with this subdivision and provided that the carrier does not change the risk categories or risk adjustment factors for the benefit plan design.

(e) If the commissioner notifies the carrier, in writing, that the carrier's risk categories or risk adjustment factors do not comply with the requirements of this chapter, specifying the reasons for his or her opinion, it is unlawful for the carrier, at any time after the receipt of such notice, to utilize the noncomplying health benefit plan, benefit plan design, risk categories, or risk adjustment factors in conjunction with the health benefit plans or benefit plan designs for which the filing was made.

(f) Each carrier shall maintain at its principal place of business copies of all information required to be filed with the commissioner pursuant to this section.

(g) Each carrier shall make the information and documentation described in this section available to the commissioner upon request.

(h) Nothing in this section shall be construed to permit the commissioner to establish or approve the rates charged to policyholders for health benefit plans.

10718. (a) In addition to any other remedy permitted by law, the commissioner shall have the administrative authority to assess penalties against carriers, insurance producers, and other entities engaged in the business of insurance or other persons or entities for violations of this chapter.

(b) Upon a showing of a violation of this chapter in any civil action, a court may also assess the penalties described in this chapter, in addition to any other remedies provided by law.

(c) Any production agent or other person or entity engaged in the business of insurance, other than a carrier, that violates this chapter is liable for administrative penalties of not more than two hundred fifty dollars (\$250) for the first violation.

(d) Any production agent or other person or entity engaged in the business of insurance, other than a carrier, that engages in practices prohibited by this chapter a second or subsequent time, or who commits a knowing violation of this chapter, is liable for

homeowners. It is the first of its kind in the country.

California Insurance Commissioner John Garamendi, along with the Association of California Insurance Companies and the Consumers Union, has asked the Legislature to repeal the earthquake plan. Garamendi, who originally backed the program when he was a state senator, now is concerned about the financial stability of the plan. If the law is repealed, any surcharges collected will be returned.

■ Rate Suppression Found to Affect Health Insurance Availability

A major study of insurance organizations suggests that overly aggressive regulation in some states has contributed to the increase in the number of Americans without medical insurance. The report by Milliman & Robertson, an actuarial firm, found fewer companies writing individual health insurance policies in states with the strongest regulatory climates. As a result, medical coverage was less available in those jurisdictions.

"States with authority to regulate rates generally had the largest growth in the number of uninsured," said Mark Litow, a co-author of the study. "Heavy regulation appears to reduce competition which, in turn, can harm the consumer."

The study surveyed insurance companies, Blue Cross/Blue Shield organizations, HMOs and state risk pools that provided health care coverage for individuals under age 65.

Findings of the 50-state study which covered the period from 1988 through early 1990 indicate:

- The number of uninsureds grew more than twice as fast in states with the authority to regulate rates compared to states that did not have such authority;
- States with the authority to regulate premium rate levels tend to be less competi-

tive than states without such authority; and

- Nationally, one and a half times more companies left the individual major medical insurance market than entered it.

Copies of the study are available from Mark E. Litow, Milliman & Robertson, at 414-784-2250.

■ Maryland Insurance Division to Probe Insurance Fraud

Maryland's Insurance Division has announced the formation of a panel to investigate insurance fraud. Joseph T. Kelly, an assistant state insurance commissioner, who is also a former state police officer with experience in fighting fraud, will head the panel.

Expected to complete its work within 12 months, the panel will include insurance executives, doctors, lawyers, criminal investigators and consumer advocates, among others. Issues under consideration include the creation of a fraud bureau and changes in state law to assist anti-fraud efforts.

■ Texas Regulators to Guide Employers Casualty Co.

Dallas-based Employers Casualty Co., which could be insolvent by as much as \$52.7 million, consented to an order from the Texas regulators on Feb. 10, under which they agreed to stop writing all new policies and renewals. The company also agreed to continue servicing all existing policies until they expire.

State Insurance Commissioner Georgia Flint said, "Immediate action was necessary to assure that this company's \$650 million in assets is managed in the most efficient possible way to protect its policyholders and the taxpayers of Texas."

The company reported a net loss for 1991 of \$39.2 million due to a \$57.2 million shortfall in reserves set aside to cover claims.

**Public Policy Survey
Individual Medical Insurance Market**

AN INDUSTRY STUDY



Milliman & Robertson, Inc.
Actuaries and Consultants

**PUBLIC POLICY SURVEY
INDIVIDUAL MEDICAL
INSURANCE MARKET**

An Industry Study

January 27, 1992

MILLIMAN & ROBERTSON, INC.

Public Policy Survey
Individual Medical Insurance Market

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The views expressed in this report are not necessarily those of Milliman & Robertson, Inc., nor of the sponsors of this report.

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Public Policy Survey
Individual Medical Insurance Market

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Public Policy Survey
Individual Medical Insurance Market

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INTRODUCTION

The Public Policy Survey for the Individual Medical Insurance Market was designed to determine the availability of medical insurance during 1988, 1989 and early 1990, to individuals who were not covered by Medicare or an employer group medical insurance program. Additionally, the survey was designed to provide insight into the impact of state regulation on the individual medical insurance market.

Specific areas addressed by the survey are:

- The number of companies actively writing individual medical insurance by state.
- The market share for insurance companies, Blue Cross/Blue Shield organizations, HMOs and state risk pools by state.
- The use of association/franchise products and one-life group products in the individual insurance market.
- The extent of difficulties encountered in compliance with state regulations, and the impact on the marketplace.

Throughout this study, the term medical insurance means insurance which provides significant medical care benefits to persons under age 65. Medicare supplement, long term care, hospital indemnity, group conversions and specialty coverage, such as cancer, are excluded. The total individual medical insurance market consists of three submarkets or products: individual, association/franchise and one-life group. The individual product includes policies that are sold directly to an individual or family using an individual insurance contract or certificate. The association/franchise product includes policies sold to an individual or family, rather than a group, through an association or franchise. The one-life group product includes policies sold to an individual or family under a multiple-employer trust or similar arrangement, where the group size is one.

SURVEY PROCEDURE

The Public Policy Survey form was mailed to approximately 1,000 companies, including insurance companies, Blue Cross/Blue Shield organizations and state risk pools. This form can be found in Appendix A. Since HMOs typically use different terminology than other companies and few HMOs are marketing individual coverage in a substantial manner, InterStudy, an HMO research organization, was asked to add a question to their annual enrollment survey.

Because a very high response rate was needed to determine items such as the approximate number of companies offering individual medical insurance, a professional telephone survey service was engaged to make follow-up phone calls to those who did not return the Public Policy Survey. As expected, the large majority of those phoned said they had never sold individual medical insurance.

Those companies which did not respond by mail and could not be eliminated by the telephone service were studied further if the company had more than \$1 million of earned accident and health premiums that might be individual medical insurance. Milliman & Robertson, Inc. used Annual Statement materials and follow-up phone calls to estimate the individual medical insurance inforce for the significant non-responding companies. Further details on these procedures and the response rates can be found in Appendix B.

GENERAL CONCLUSIONS

The main conclusions of the study are:

- From 1988 to 1989 policies inforce increased by 3.6% and policies issued increased by 14.2%. While the inforce and issue counts in the Survey increased, it appears the actual change in the number of people insured from 1988 to 1989 was quite small, and may be a decrease.
- At the end of 1989, 64% of the policies inforce were from insurance companies, 32% from Blues organizations, 3% from HMOs, and 1% from state risk pools. Approximately 152 HMOs, 116 insurance companies, 61 (virtually all) Blue Cross/Blue Shield organizations, and 14 state risk pools were issuing policies in 1989. However, no state had more than 30 companies (including Blues organizations) issuing 250 or more policies per year (roughly one issue per working day), and only 3 states had 20 or more companies issuing 500 or more policies per year. By contrast, there were 19 states that had fewer than 10 companies issuing 250 or more policies and 24 states that had fewer than 10 companies selling 500 or more policies. These and other results indicate that the market does not appear to be competitive in certain states while other states appear to be competitive. The least competitive states appear to be Hawaii, Rhode Island, Idaho, District of Columbia, New York and Delaware; the most competitive states appear to be Nebraska, Colorado, Iowa, South Dakota, Kansas and Louisiana.
- In terms of the types of coverage, individual products had 78% of the inforce at year end 1989, association/franchise had 15% and one-life groups 7%. In 1988, comparable numbers were 80% for individual products, 13% for association/franchise and 7% for one-life groups. These results indicate that issues of new policies are shifting to association/franchise and one-life group products. This shift circumvents regulation, which is much greater for individual products than for association/franchise or one-life group products.

For the period of 1987 through 1989, the individual medical insurance market experienced a net loss in that 1.5 times as many companies left the market as entered it.

Within the segments of the market, departures from the individual marketplace were most severe, with 2.1 times as many companies leaving as entering. While some of the individual marketplace departures represented a move to another product form, such as one-life group, the market has suffered a net loss in the number of companies.

The most frequent reasons given for a company ceasing to issue individual major medical policies were lack of profitability and mandated benefit regulation.

Rate regulation and the difficulty experienced by companies in getting rate approval appears to affect the market situation state by state. Observations include:

- Rate regulation and timeliness of rate increase approvals were the most frequent comments by Survey respondents about difficulties with state regulation. States with the authority to regulate rates had more company comments in total and per company than those that lacked such authority;
- States with the authority to regulate rates had relatively low growth in insureds and high growth in uninsureds;
- Of the six most competitive states, none have authority to regulate rates; of the six least competitive states, four have such authority. Of the 25 most competitive states, 17 do not have the authority to regulate premium rate levels, while of the 26 least competitive states, 13 do have such authority and two additional states review rate filings as though they have such authority.
- Two-thirds of the states with the authority to regulate rates have fewer than 10 companies issuing 500 or more policies per year, compared to two-thirds of the

states that lack the authority to regulate rates having 10 or more companies issuing 500 or more policies per year;

In summary, the Survey findings lead to a serious concern over the direction of the marketplace, in regard to its ability to attract competitors and be profitable. This direction has resulted in virtually no market growth and caused companies to withdraw entirely from the market. Of particular concern in today's environment of increasing costs is the current trend toward increasing rate regulation and companies trying to circumvent this regulation. This trend is resulting in problems with companies receiving timely rate increases, which often leads to larger aggregate rate increases, larger total lapses and more uninsureds. Also, the real value of regulation--to facilitate the availability of reasonably priced coverage and provide adequate oversight to avoid company insolvencies--may be eroding.

8-GH2024E ✓

Ford

3/14/94

CS FOR HOUSE BILL NO. 414(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

EIGHTEENTH LEGISLATURE - SECOND SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:

Referred:

Sponsor(s): **HOUSE RULES COMMITTEE BY REQUEST OF THE GOVERNOR**

A BILL

FOR AN ACT ENTITLED

1 "An Act creating the Alaska Health Commission; relating to the delivery, quality,
 2 access, and financing of health care; relating to review and approval of rates and
 3 charges of health insurers; relating to certain civil actions against health care
 4 providers and health insurers; amending Alaska Rules of Civil Procedure 26 and
 5 27 and Alaska Rules of Evidence 802, 803, and 804; repealing Alaska Rule of
 6 Civil Procedure 72.1; and providing for an effective date."

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

8 * **Section 1. FINDINGS AND INTENT.** (a) The legislature finds that the access to
 9 quality and affordable health care and maintenance of the public's health are vital to the public
 10 interest. The legislature further finds that health care costs have grown at a rate far in excess
 11 of the overall inflation rate in the economy due to several factors, including variations in
 12 treatment practices of providers, cost shifting by health care providers, administrative costs
 13 of insurance claims practices, unavailability of affordable insurance, costs of increasing claims

1 and liability for medical malpractice, and lack of coordination of population based public
2 health services. The legislature therefore finds a present need for long-term reform of the
3 health care system in the state.

4 (b) It is the intent of the legislature to promote access to affordable, quality health
5 care for Alaskans by establishing a mechanism for the review of health insurance rate filings,
6 the implementation of health care reform measures, the stabilization of health care service
7 costs, the collection and analysis of information and data concerning health care services, and
8 the making of recommendations based on that data to the governor and the legislature.

9 * Sec. 2. AS 08.64.326 is amended to read:

10 Sec. 08.64.326. GROUNDS FOR IMPOSITION OF DISCIPLINARY
11 SANCTIONS. (a) The board may impose a sanction if the board finds after a hearing
12 that a licensee

13 (1) secured a license through deceit, fraud, or intentional
14 misrepresentation;

15 (2) engaged in deceit, fraud, or intentional misrepresentation while
16 providing professional services or engaging in professional activities;

17 (3) advertised professional services in a false or misleading manner;

18 (4) has been convicted, including conviction based on a guilty plea or
19 plea of nolo contendere, of

20 (A) a felony or other crime if the felony or other crime is
21 substantially related to the qualifications, functions, or duties of the licensee;
22 or

23 (B) a crime involving the unlawful procurement, sale,
24 prescription, or dispensing of drugs;

25 (5) has procured, sold, prescribed, or dispensed drugs in violation of
26 a law, regardless of whether there has been a criminal action;

27 (6) intentionally or negligently permitted the performance of patient
28 care by persons under the licensee's supervision that does not conform to minimum
29 professional standards even if the patient was not injured;

30 (7) failed to comply with this chapter, a regulation adopted under this
31 chapter, or an order of the board;