26-LS0141\R
Mischel
3/25/10

**CS FOR HOUSE BILL NO. 25( )**

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - SECOND SESSION

**BY**

**Offered:**
**Referred:**

**Sponsor(s): REPRESENTATIVE HAWKER**

**A BILL**

**FOR AN ACT ENTITLED**

**"An Act establishing the Alaska Health Care Commission in the Department of Health and Social Services; and providing for an effective date."**

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

*** Section 1.** AS 18.05.010(b) is amended to read:

(b) In performing its duties under this chapter**, AS 18.09,** and AS 18.15.355 - 18.15.395, the department may

(1) flexibly use the broad range of powers set out in this title assigned to the department to protect and promote the public health;

(2) provide public health information programs or messages to the public that promote healthy behaviors or lifestyles or educate individuals about health issues;

(3) promote efforts among public and private sector partners to develop and finance programs or initiatives that identify and ameliorate health problems;

(4) establish, finance, provide, or endorse performance management standards for the public health system;

(5) develop, adopt, and implement

**(A) a statewide health plan under AS 18.09 based on recommendations of the Alaska Health Care Commission established in AS 18.09.010; and**

**(B)** public health plans and formal policies through regulations adopted under AS 44.62 or collaborative recommendations that guide or support individual and community public health efforts;

(6) establish formal or informal relationships with public or private sector partners within the public health system;

(7) identify, assess, prevent, and ameliorate conditions of public health importance through surveillance; epidemiological tracking, program evaluation, and monitoring; testing and screening programs; treatment; administrative inspections; or other techniques;

(8) promote the availability and accessibility of quality health care services through health care facilities or providers;

(9) promote availability of and access to preventive and primary health care when not otherwise available through the private sector, including acute and episodic care, prenatal and postpartum care, child health, family planning, school health, chronic disease prevention, child and adult immunization, testing and screening services, dental health, nutrition, and health education and promotion services;

(10) systematically and regularly review the public health system and recommend modifications in its structure or other features to improve public health outcomes; and

(11) collaborate with public and private sector partners, including municipalities, Alaska Native organizations, health care providers, and health insurers, within the public health system to achieve the mission of public health.

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

**Chapter 09. Statewide Health Care.**

**Article 1. Alaska Health Care Commission.**

**Sec. 18.09.010. Alaska Health Care Commission.** The Alaska Health Care Commission is established in the Department of Health and Social Services. The purpose of the commission is to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state.

**Sec. 18.09.020. Composition; chair.** The commission consists of 12 members as follows:

(1) nine voting members appointed by the governor as follows:

(A) the state officer assigned the duties of medical director for the department, who shall serve as chair;

(B) one member who represents the tribal health community in the state;

(C) one member who represents a statewide chamber of commerce who is not financially associated with the health care industry;

(D) one member who represents the Alaska State Hospital and Nursing Home Association;

(E) one member who is a health care provider and

(i) engaged in the active practice of the health care provider's profession in the state;

(ii) licensed to practice in the state;

(iii) not affiliated with the Alaska State Hospital and Nursing Home Association;

(F) one member who represents the health care industry in the state;

(G) one member who is a

(i) health care consumer;

(ii) resident of the state; and

(iii) not employed by and does not have a business interest in the health care industry;

(H) one member who is a licensed primary care physician in the state and who is in the active practice of family medicine, primary care

internal medicine, or pediatric medicine;

(I) one member who represents the Alaska Mental Health Trust Authority; and

(2) three nonvoting members appointed as follows:

(A) one ex officio member from the house of representatives, appointed by the speaker of the house of representatives;

(B) one ex officio member from the senate, appointed by the president of the senate;

(C) an ex officio member representing the Office of the Governor.

**Sec. 18.09.030. Public members' terms of office.** (a) Public members of the commission serve for staggered terms of three years or until a successor is appointed.

(b) If a vacancy occurs in a public member's seat on the commission, the governor shall make an appointment for the unexpired portion of that member's term.

(c) A public member may serve not more than two consecutive terms.

(d) In this section, "public member" means those members appointed under AS 18.09.020(1)(B) - (I).

**Sec. 18.09.040. Executive director.** The commission shall employ an executive director, who may not be a member of the commission. The executive director serves at the pleasure of the commission. The commission shall establish the duties of the executive director. The executive director is in the partially exempt service under AS 39.25 (State Personnel Act).

**Sec. 18.09.050. Staff.** The department may assign employees of the department to serve as staff to the commission. The commission shall prescribe the duties of the commission staff.

**Sec. 18.09.060. Bylaws.** The commission, on approval of a majority of its membership and consistent with state law, shall adopt and amend bylaws governing proceedings and other activities, including provisions concerning

(1) a quorum to transact commission business and other aspects of procedure;

(2) frequency and location of meetings;

(3) establishment, functions, and membership of committees; and

(4) conflicts of interest that require

(A) a member to declare a substantial financial interest in an official action and to request to be excused from voting in that instance;

(B) a ruling by the chair on a request by a member to be excused from voting;

(C) an opportunity to override a ruling by the chair on a majority vote;

(D) filing of a written disclosure form with the department that lists all potential conflicts of interest of a member valued at more than $5,000 annually if the interest is related to health care system income affecting the member or a member of the member's immediate family.

**Sec. 18.09.070. Duties of the commission.** (a) The commission shall serve as the state health planning and coordinating body. Consistent with state and federal law, the commission shall provide recommendations for and foster the development of a statewide health plan containing the following:

(1) a comprehensive statewide health care policy;

(2) a strategy for improving the health of all residents of the state that

(A) encourages personal responsibility for disease prevention, healthy living, and acquisition of health insurance;

(B) reduces health care costs by using savings from

(i) enhanced market forces;

(ii) fraud reduction;

(iii) health information technology;

(iv) management efficiency;

(v) preventative medicine;

(vi) successful innovations identified by other states; and

(vii) other cost-saving measures;

(C) eliminates known health risks, including unsafe water and wastewater systems;

(D) develops a sustainable health care workforce;

(E) improves access to quality health care; and

(F) increases the number of insurance options for health care services.

(b) The commission may hold public hearings to gather information and opinions from health care consumers on matters before the commission. Hearings shall be conducted under AS 44.62.210, except that the commission shall provide public notice of hearings not less than 15 days before the conduct of the hearing and include not fewer than three notices published in the statewide news media.

(c) The commission shall submit to the governor and the legislature by January 15 of each year an annual report regarding the commission's recommendations and activities. The report shall include voting records, copies of financial disclosures, and conflicts of interest statements.

**Sec. 18.09.080. Compensation, per diem, and expenses.** A member appointed to the commission under AS 18.09.020(1) is entitled to per diem, reimbursement for travel, and other expenses authorized by law for boards and commissions under AS 39.20.180.

**Article 2. General Provisions.**

**Sec. 18.09.900. Regulations.** The department may adopt regulations under AS 44.62 (Administrative Procedure Act) to carry out the purposes of this chapter.

**Sec. 18.09.990. Definitions.** In this chapter,

(1) "commission" means the Alaska Health Care Commission established in AS 18.09.010;

(2) "department" means the Department of Health and Social Services.

* **Sec. 3.** AS 39.25.120(c)(7) is amended to read:

(7) the principal executive officer of the following boards, councils, or commissions:

(A) Alaska Public Broadcasting Commission;

(B) Professional Teaching Practices Commission;

(C) Parole Board;

(D) Board of Nursing;

(E) Real Estate Commission;

(F) Alaska Royalty Oil and Gas Development Advisory Board;

(G) Alaska State Council on the Arts;

(H) Alaska Police Standards Council;

(I) Alaska Commission on Aging;

(J) Alaska Mental Health Board;

(K) State Medical Board;

(L) Governor's Council on Disabilities and Special Education;

(M) Advisory Board on Alcoholism and Drug Abuse;

(N) Statewide Suicide Prevention Council;

(O) the State Board of Registration for Architect, Engineers, and Land Surveyors;

**(P) Alaska Health Care Commission;**

* **Sec. 4.** AS 44.66.010(a) is amended to read:

(a) Boards and commissions listed in this subsection expire on the date set out after each:

(1) Alcoholic Beverage Control Board (AS 04.06.010) - June 30, 2010;

(2) Board of Parole (AS 33.16.020) - June 30, 2016;

(3) Regulatory Commission of Alaska (AS 42.04.010) - June 30, 2011;

(4) Alaska Commission on Aging (AS 47.45.200) - June 30, 2016;

(5) Council on Domestic Violence and Sexual Assault (AS 18.66.010) - June 30, 2014;

(6) special education service agency (AS 14.30.600) - June 30, 2013;

(7) [REPEALED

(8)] Statewide Suicide Prevention Council (AS 44.29.300) - June 30, 2013;

**(8)** [(9)] Alaska Seismic Hazards Safety Commission (AS 44.37.065) - June 30, 2012;

**(9) Alaska Health Care Commission (AS 18.09.010) - June 30, 2014**.

* **Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to

read:

TRANSITION: REGULATIONS. The Department of Health and Social Services may proceed to adopt regulations necessary to implement the changes made by this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory change.

*** Sec. 6.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: ALASKA HEALTH CARE COMMISSION. The members appointed to the Alaska Health Care Commission, established by Administrative Order No. 246 dated December 4, 2008, shall serve as the voting members of the Alaska Health Care Commission under AS 18.09.010, enacted by sec. 2 of this Act, for one-year to three-year staggered terms as determined by the governor according to AS 39.05.055.

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

# FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HB025
() Publish Date:

Identifier (file name): HB025-DHSS-PHA-03-29-10
Dept. Affected: Health & Social Services

Title: Health Reform Policy Commission
RDU: Public Health
Component: Public Health Administration

Sponsor: Hawker

Requester: House HSS
Component Number: 292

**Expenditures/Revenue** (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

| | Appropriation Required | Information | | | | | |
|---|---|---|---|---|---|---|---|
| **OPERATING EXPENDITU** | **FY 2011** | **FY 2011** | **FY 2012** | **FY 2013** | **FY 2014** | **FY 2015** | **FY 2016** |
| Personal Services | 134.5 | | 134.5 | 134.5 | 134.5 | 134.5 | |
| Travel | 35.0 | | 35.0 | 35.0 | 35.0 | 35.0 | |
| Contractual | 300.0 | | 320.5 | 320.5 | 320.5 | 320.5 | |
| Supplies | 20.5 | | 10.0 | 10.0 | 10.0 | 10.0 | |
| Equipment | 10.0 | | 0.0 | 0.0 | 0.0 | 0.0 | |
| Land & Structures | | | | | | | |
| Grants & Claims | | | | | | | |
| Miscellaneous | | | | | | | |
| **TOTAL OPERATING** | **500.0** | **0.0** | **500.0** | **500.0** | **500.0** | **500.0** | **0.0** |
| **CAPITAL EXPENDITURE** | | | | | | | |
| **CHANGE IN REVENUES** | | | | | | | |

**FUND SOURCE** (Thousands of Dollars)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1002 Federal Receipts | | | | | | | |
| 1003 GF Match | | | | | | | |
| 1004 GF | 500.0 | | 500.0 | 500.0 | 500.0 | 500.0 | |
| 1005 GF/Program Receipt | | | | | | | |
| 1037 GF/Mental Health | | | | | | | |
| Other Interagency Receipt | | | | | | | |
| **TOTAL** | **500.0** | **0.0** | **500.0** | **500.0** | **500.0** | **500.0** | **0.0** |

**Estimate of any current year (FY2010) cost**

**POSITIONS**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Full-time | 1 | | 1 | 1 | 1 | 1 | |
| Part-time | | | | | | | |
| Temporary | | | | | | | |

**ANALYSIS:** *(Attach a separate page if necessar*

This bill establishes the Alaska Health Reform Policy Commission in DHSS to develop specific policy recommendations for the Legislature and Executive Branch to consider regarding health care issues. The Commission would be composed of 16 members and chaired by the Commissioner of DHSS or a designee. The Commission would meet regularly in person or via teleconference. Under this legislation, the Commission will sunset on July 1, 2015.

**71000 Personal Services:** The bill states that an Executive Director would staff the Commission; administrative support would be provided by existing DHSS staff. Personal Services costs of $134.5 is Range 23, Step F.

(continued on P. 2)

Prepared by: Ward B. Hurlburt, MD, MPH, Chief Medical Officer/Director
Division: Division of Public Health
Phone: 269-8126
Date/Time: 12/28/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services
Date: 3/29/2010

FISCAL NOTE

STATE OF ALASKA

2010 LEGISLATIVE SESSION

BILL NO. HB025

**ANALYSIS CONTINUATION**

**72000 Travel** Travel and per diem for Commission staff and for 12 Commission members to conduct quarterly face-to-face public meetings. The four other members are legislators and would have per diem and travel covered.

**73000 Contractual** Professional services contracts will be needed to supplement staff research, and core service RSAs will be required to provide lease space, telecommunications, mainframe connectivity, postage, etc.

**74000 Supplies**
In addition to day-to-day office supplies, FY11 includes start-up costs such as computers, office furniture, reconfiguring leased space, wiring needs for connectivity, printers, fax, and photocopier.

**75000 Equipment**
FY11 includes purchase of a server; in subsequent fiscal years, technology upgrades and maintenance will be covered through the contractual line.

The bill becomes effective immediately upon the Governor's signature. This means there may be some limited costs in FY10 that will have to be absorbed by the Department of Health & Social Services.

# Representative Mike Hawker
## Alaska State Legislature

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*Bird*
*Girdwood*
*Portage*
*Whittier*
*Sunrise*
*Hope*

## House Bill 25
## Sponsor Statement

**"An Act establishing the Alaska Health Reform Policy Commission in the Department of Health and Social Services; and providing for an effective date."**

House Bill 25 establishes the Alaska Health Reform Policy Commission in the Department of Health and Social Services for the purpose of developing comprehensive policy to address current and long-range healthcare needs in the state. The commission will consider the entire spectrum of health care related issues in the state and formulate specific policy recommendations to be considered by the legislature and the executive branch.

The commission integrates executive management from the Department of Health and Social Services, professionals in their fields of expertise and ex-officio nonvoting advisory members from the legislative and executive branches.

The commission is structured to facilitate objective and innovative thinking. All members must have demonstrated leadership and accomplishment in specialized disciplines or enterprises and possess unquestioned ability to directly influence policy direction within the appointee's area of expertise.

The commission is established for a period of five years. It is required to submit an annual report to the legislature and governor by January 15 of each year. The initial report must include a five-year strategic plan with prioritized, targeted, and defined objectives as well as an evaluation of the strengths, weaknesses, and relative performance of health care services and conditions in Alaska.

# HB 25
# Sectional Analysis

Prepared by Representative Mike Hawker's Office

**Section 1:** Findings and intent section.

**Section 2:** Establishes the Alaska Health Reform Policy Commission. Sets out composition, appointment process, meeting procedures, duties and staff. Also requires an annual report and specifies the deadline and required contents of the report.

**Section 3:** Adds the executive director of the Commission to AS 39.25.120, which lists state employees who are classified as partially exempt under the State Personnel Act.

**Section 4:** Repeals the Commission on July 1, 2015.

**Section 5:** Immediate effective date.

# HOUSE BILL NO. 25

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - FIRST SESSION

**BY REPRESENTATIVE HAWKER**

**Introduced: 1/20/09**
**Referred: Health and Social Services, Finance**

## A BILL

## FOR AN ACT ENTITLED

**"An Act establishing the Alaska Health Reform Policy Commission in the Department of Health and Social Services, and establishing the position of the executive director of that commission in the partially exempt service; and providing for an effective date."**

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

* **Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

LEGISLATIVE FINDINGS AND INTENT. (a) The Alaska Legislature finds that

(1) the Constitution of the State of Alaska requires the legislature to promote and protect the public health;

(2) health policy issues present some of the greatest challenges faced by the state;

(3) the health status of Alaskans is directly tied to the long-term success of the state's economy and well being; and

(4) the increasing cost of health care is threatening employer-sponsored health

care and making companies less competitive in the global economy.

(b) The legislature intends to mandate under this Act an evaluation of the state's health care needs, propose reforms, and improve health care in Alaska by establishing the Alaska Health Reform Policy Commission to include all public and private stakeholders for the purpose of developing a comprehensive policy that better meets the current and long-range health care needs in the state.

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

**Chapter 09. Statewide Health Care.**

**Article 1. Alaska Health Reform Policy Commission.**

**Sec. 18.09.010. Alaska Health Reform Policy Commission.** The Alaska Health Reform Policy Commission is established in the Department of Health and Social Services. The purpose of the commission is to consider the entire spectrum of health care related issues in the state and formulate targeted and specific policy recommendations to be considered by the legislature and by the executive branch.

**Sec. 18.09.020. Composition; chair; meetings.** (a) The commission consists of 16 members, including

(1) 11 members appointed by the governor as follows:

(A) the commissioner of health and social services or the commissioner's designee, who shall serve as chair;

(B) 10 members who have specialized training or experience and are recognized leaders in the members' fields and who are either a health care consumers or health care providers of services as follows:

(i) three members representing private health care interests;

(ii) three members representing organizations that provide health care coverage, including an employer that provides an employer-sponsored health insurance plan, a union that has a union health care trust, and a third-party insurance provider;

(iii) two members representing health care consumers;

(iv) one member representing non-Native federal health care services;

(v) one member representing tribal health care services; and

(2) five nonvoting advisory members appointed as follows:

(A) two members from the senate, appointed by the president of the senate;

(B) two members from the house of representatives, appointed by the speaker of the house of representatives;

(C) one member appointed by the governor.

(b) The commission shall meet regularly in person or by teleconference. All meetings shall be open to the public and shall be held on reasonable notice. A quorum is a majority of the voting members of the commission. The votes of the members of the commission shall be recorded, and effective action requires the affirmative vote of a majority of the voting members of the commission present. A member may not be recused from voting solely based on a conflict of interest.

(c) A public member appointed to the commission is not entitled to a salary, but is entitled to per diem, reimbursement for travel, and other expenses authorized for boards and commissions under AS 39.20.180.

(d) A member serves at the pleasure of the member's appointing authority for a five-year term. A vacancy may be filled for the remainder of a member's term. At the direction of the appointment authority, a member appointed by the president of the senate or speaker of the house of representatives may remain on the commission even if that member does not remain in the legislature for the full five-year term.

**Sec. 18.09.030. Duties.** The duties of the commission established under AS 18.09.010 include

(1) providing a public forum for the consideration and discussion of health policy alternatives;

(2) developing, coordinating, and recommending to the legislature and to the governor health policy reform initiatives;

(3) coordinating policy development with state, federal, and private sector interests that finance, provide, or regulate the delivery of health care;

(4) coordinating health policy development among relevant state

agencies;

(5) developing policy recommendations to

(A) improve individual access to health insurance and health care services;

(B) promote healthful life choices made by individuals;

(C) contain health care costs;

(D) enhance diversity of health care options;

(E) improve quality of health care;

(F) inform consumers;

(G) meet current and future workforce needs in the health care industry; and

(6) developing viable financing proposals to support the commission's recommendations.

**Sec. 18.09.040. Executive director.** The commission shall employ an executive director who may not be a member of the commission. The executive director shall serve at the pleasure of the commission. The commission shall establish the duties of the executive director. The executive director is in the partially exempt service under AS 39.25 (State Personnel Act).

**Sec. 18.09.050. Reports.** The commission shall submit an annual report to the legislature and the governor by January 15 of each year. The report must summarize significant work, findings, and recommendations of the commission. The first report of the commission must include a five-year strategic plan with prioritized, targeted, and defined objectives as well as an evaluation of the strengths, weaknesses, and relative performance of health care services and conditions in the state. Subsequent reports must include revisions, if any, to the strategic plan, along with a report on the progress of the commission in meeting the objectives of the plan.

**Sec. 18.09.095. Definition.** In this chapter, "commission" means the Alaska Health Reform Policy Commission.

* **Sec. 3.** AS 39.25.120(c)(7) is amended to read:

(7) the principal executive officer of the following boards, councils, or commissions:

(A) Alaska Public Broadcasting Commission;

(B) Professional Teaching Practices Commission;

(C) Parole Board;

(D) Board of Nursing;

(E) Real Estate Commission;

(F) Alaska Royalty Oil and Gas Development Advisory Board;

(G) Alaska State Council on the Arts;

(H) Alaska Police Standards Council;

(I) Alaska Commission on Aging;

(J) Alaska Mental Health Board;

(K) State Medical Board;

(L) Governor's Council on Disabilities and Special Education;

(M) Advisory Board on Alcoholism and Drug Abuse;

(N) Statewide Suicide Prevention Council;

(O) the State Board of Registration for Architect, Engineers, and Land Surveyors;

**(P) Alaska Health Reform Policy Commission;**

* **Sec. 4.** AS 18.09.010, 18.09.020, 18.09.030, 18.09.040, 18.09.050, 18.09.095; and AS 39.25.120(c)(7)(P) are repealed July 1, 2015.

* **Sec. 5.** This Act takes effect immediately under AS 01.10.070(c).

# ALASKA STATE LEGISLATURE


## SENATOR DONALD C. OLSON

CAPITOL BUILDING
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## Senate Bill 172 Alaska Health Care Commission

26-LS0790\A

### SPONSOR STATEMENT

Alaska is currently facing serious healthcare cost, access and quality issues. Between 1991 and 2005, health care expenditures in our state more than tripled from $1.6 billion to $5.3 billion. Costs are expected to double again by 2013 to over $10 billion. All levels of government – state, local, and federal – are affected, and Alaska's economy cannot sustain this inflationary growth. The purpose of SB 172 is to establish in statute the Alaska Health Care Commission to address the need for health care reform in our state. This issue is complex and broad in scope, and cannot be dealt with adequately unless we have a permanent body to plan and follow through for long range comprehensive health care reform.

The two most recent groups to work on the issue of health care reform in Alaska, the Alaska Health Care Roundtable (2005) and the Alaska Health Care Strategies Planning Council (2007), both recommended that a permanent body be established to address the problem of health care reform. The Roundtable (which met for 2 years) and the Planning Council (which met for 6 months) recognized that the problem is too great to be effectively addressed through a short-term, ad-hoc body.

The Alaska Health Care Commission would be established in the Department of Health And Social Services, and would consist of a ten member body including public officials and private citizens. Representatives from both the executive and legislative branches of state government are included, as well as citizens representing the private business sector, the health care community, and consumers. Three members are to be ex officio appointees from the legislature and the governor's office.

The composition and small size would enable efficient and effective teamwork and decision-making, while bring a balance of viewpoints and perspectives.

The commission would provide its recommendations and support the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the State. A plan for reform will be based on education, sustainability, management efficiency, health care effectiveness, private-public partnerships, research, personal responsibility and individual choice.

Alaska's need for healthcare reform is pressing and must be dealt with thoroughly and efficiently, with a long range view towards meaningful and lasting change. The Alaska Health Care Commission would play an important role in this process, and it is essential that we make it a permanent component of the Department of Health and Social Services, so that present as well as future issues with Alaska's healthcare systems can be better anticipated, understood and addressed.

# Sectional analysis: Alaska Health Care Commission Bill

## Section 1

**AS 18.05.010(b)**- Establishes the Alaska Health Care Commission in the Department of Health and Social Services that will work toward recommendations for a statewide health plan under AS 18.09.

## Statewide Health Care
## Section 2

**Sec 18.09.010**-This section is the basic language to establish the Commission and outline the commission's primary objectives.

**Sec 18.09.020**-Creates a 10 member Commission made up of Health Professionals and the public including three ex officio appointees from the legislature and the governors office.

**Sec. 18.09.030**- Members will serve three year staggered terms. Should an opening occur prior to the completion of the term the governor shall appoint a replacement.

**Sec. 18.09.040**- Creates the position of executive director as a partially exempt position appointed by the commission.

**Sec. 18.09.050**- Permits the Department to assign employees to work with the Commission as support staff.

**Sec. 18.09.060**- The commission shall submit internally by-laws for consideration by the full Commission. By laws will establish quorum requirements, time and locations for meetings, etc. The section also defines conflicts of interests when voting and annual reporting requirements

**Sec. 18.09.070**- This section defines the duties of the Commission, to include goals and language for input from the public through the public hearing process.

**Sec. 18.09.080**- Standard language that allows members to receive per diem and travel but no salary for serving on the commission.

**Sec. 18.09.900**- Authorizes the Department to promulgate the necessary regulations to maintain the commission

**Sec 18.09.990**- Defines the use of the words commission and department.

## Section 3

**AS 39.25.120 (c)(7)**- adds the commissions executive director position to the list of existing executive directors serving other boards and commissions.

**Section 4**

**AS 44.66.010 (a)-** Sunset- the commission expires unless renewed by the legislature on June 30, 2014

**Section 5**

**Uncodified language-** Permits the department to begin the regulatory process which can not take effect until this bill is singed into law.

**Section 6**

**Uncodified language-** The members already serving on the commission shall continue in their positions based on the staggering of their terms.

**Section 7**

**Effective date-** Immediate effective date clause.

**CS FOR SENATE BILL NO. 172(HSS)**

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - SECOND SESSION

**BY THE SENATE HEALTH AND SOCIAL SERVICES COMMITTEE**

**Offered: 3/18/10**
**Referred: Finance**

**Sponsor(s): SENATOR OLSON**

**A BILL**

**FOR AN ACT ENTITLED**

**"An Act establishing the Alaska Health Care Commission in the Department of Health and Social Services; and providing for an effective date."**

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

*** Section 1.** AS 18.05.010(b) is amended to read:

(b) In performing its duties under this chapter, **AS 18.09,** and AS 18.15.355 - 18.15.395, the department may

(1) flexibly use the broad range of powers set out in this title assigned to the department to protect and promote the public health;

(2) provide public health information programs or messages to the public that promote healthy behaviors or lifestyles or educate individuals about health issues;

(3) promote efforts among public and private sector partners to develop and finance programs or initiatives that identify and ameliorate health problems;

(4) establish, finance, provide, or endorse performance management standards for the public health system;

(5) develop, adopt, and implement

**(A) a statewide health plan under AS 18.09 based on recommendations of the Alaska Health Care Commission established in AS 18.09.010; and**

**(B)** public health plans and formal policies through regulations adopted under AS 44.62 or collaborative recommendations that guide or support individual and community public health efforts;

(6) establish formal or informal relationships with public or private sector partners within the public health system;

(7) identify, assess, prevent, and ameliorate conditions of public health importance through surveillance; epidemiological tracking, program evaluation, and monitoring; testing and screening programs; treatment; administrative inspections; or other techniques;

(8) promote the availability and accessibility of quality health care services through health care facilities or providers;

(9) promote availability of and access to preventive and primary health care when not otherwise available through the private sector, including acute and episodic care, prenatal and postpartum care, child health, family planning, school health, chronic disease prevention, child and adult immunization, testing and screening services, dental health, nutrition, and health education and promotion services;

(10) systematically and regularly review the public health system and recommend modifications in its structure or other features to improve public health outcomes; and

(11) collaborate with public and private sector partners, including municipalities, Alaska Native organizations, health care providers, and health insurers, within the public health system to achieve the mission of public health.

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

**Chapter 09. Statewide Health Care.**

**Article 1. Alaska Health Care Commission.**

**Sec. 18.09.010. Alaska Health Care Commission.** The Alaska Health Care Commission is established in the Department of Health and Social Services. The purpose of the commission is to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state.

**Sec. 18.09.020. Composition; chair.** The commission consists of 12 members as follows:

(1) nine voting members appointed by the governor as follows:

(A) the state officer assigned the duties of medical director for the department, who shall serve as chair;

(B) one member who represents the tribal health community in the state;

(C) one member who represents a statewide chamber of commerce who is not financially associated with the health care industry;

(D) one member who represents the Alaska State Hospital and Nursing Home Association;

(E) one member who is a health care provider and

(i) engaged in the active practice of the health care provider's profession in the state;

(ii) licensed to practice in the state;

(iii) not affiliated with the Alaska State Hospital and Nursing Home Association;

(F) one member who represents the health care industry in the state;

(G) one member who is a

(i) health care consumer;

(ii) resident of the state; and

(iii) not employed by and does not have a business interest in the health care industry;

(H) one member who is a licensed primary care physician in the state and who is in the active practice of family medicine, primary care

internal medicine, or pediatric medicine;

(I) one member who represents the Alaska Mental Health Trust Authority; and

(2) three nonvoting members appointed as follows:

(A) one ex officio member from the house of representatives, appointed by the speaker of the house of representatives;

(B) one ex officio member from the senate, appointed by the president of the senate;

(C) an ex officio member representing the Office of the Governor.

**Sec. 18.09.030. Public members' terms of office.** (a) Public members of the commission serve for staggered terms of three years or until a successor is appointed.

(b) If a vacancy occurs in a public member's seat on the commission, the governor shall make an appointment for the unexpired portion of that member's term.

(c) A public member may serve not more than two consecutive terms.

(d) In this section, "public member" means those members appointed under AS 18.09.020(1)(B) - (I).

**Sec. 18.09.040. Executive director.** The commission shall employ an executive director, who may not be a member of the commission. The executive director serves at the pleasure of the commission. The commission shall establish the duties of the executive director. The executive director is in the partially exempt service under AS 39.25 (State Personnel Act).

**Sec. 18.09.050. Staff.** The department may assign employees of the department to serve as staff to the commission. The commission shall prescribe the duties of the commission staff.

**Sec. 18.09.060. Bylaws.** The commission, on approval of a majority of its membership and consistent with state law, shall adopt and amend bylaws governing proceedings and other activities, including provisions concerning

(1) a quorum to transact commission business and other aspects of procedure;

(2) frequency and location of meetings;

(3) establishment, functions, and membership of committees; and

(4) conflicts of interest that require

(A) a member to declare a substantial financial interest in an official action and to request to be excused from voting in that instance;

(B) a ruling by the chair on a request by a member to be excused from voting;

(C) an opportunity to override a ruling by the chair on a majority vote;

(D) filing of a written disclosure form with the department that lists all potential conflicts of interest of a member valued at more than $5,000 annually if the interest is related to health care system income affecting the member or a member of the member's immediate family.

**Sec. 18.09.070. Duties of the commission.** (a) The commission shall serve as the state health planning and coordinating body. Consistent with state and federal law, the commission shall provide recommendations for and foster the development of a statewide health plan containing the following:

(1) a comprehensive statewide health care policy;

(2) a strategy for improving the health of all residents of the state that

(A) encourages personal responsibility for disease prevention, healthy living, and acquisition of health insurance;

(B) reduces health care costs by using savings from

(i) enhanced market forces;

(ii) fraud reduction;

(iii) health information technology;

(iv) management efficiency;

(v) preventative medicine;

(vi) successful innovations identified by other states; and

(vii) other cost-saving measures;

(C) eliminates known health risks, including unsafe water and wastewater systems;

(D) develops a sustainable health care workforce;

(E) improves access to quality health care; and

(F) increases the number of insurance options for health care services.

(b) The commission may hold public hearings to gather information and opinions from health care consumers on matters before the commission. Hearings shall be conducted under AS 44.62.210, except that the commission shall provide public notice of hearings not less than 15 days before the conduct of the hearing and include not fewer than three notices published in the statewide news media.

(c) The commission shall submit to the governor and the legislature by January 15 of each year an annual report regarding the commission's recommendations and activities. The report shall include voting records, copies of financial disclosures, and conflicts of interest statements.

**Sec. 18.09.080. Compensation, per diem, and expenses.** A member appointed to the commission under AS 18.09.020(1) is entitled to per diem, reimbursement for travel, and other expenses authorized by law for boards and commissions under AS 39.20.180.

**Article 2. General Provisions.**

**Sec. 18.09.900. Regulations.** The department may adopt regulations under AS 44.62 (Administrative Procedure Act) to carry out the purposes of this chapter.

**Sec. 18.09.990. Definitions.** In this chapter,

(1) "commission" means the Alaska Health Care Commission established in AS 18.09.010;

(2) "department" means the Department of Health and Social Services.

* **Sec. 3.** AS 39.25.120(c)(7) is amended to read:

(7) the principal executive officer of the following boards, councils, or commissions:

(A) Alaska Public Broadcasting Commission;

(B) Professional Teaching Practices Commission;

(C) Parole Board;

(D) Board of Nursing;

(E) Real Estate Commission;

(F) Alaska Royalty Oil and Gas Development Advisory Board;

(G) Alaska State Council on the Arts;

(H) Alaska Police Standards Council;

(I) Alaska Commission on Aging;

(J) Alaska Mental Health Board;

(K) State Medical Board;

(L) Governor's Council on Disabilities and Special Education;

(M) Advisory Board on Alcoholism and Drug Abuse;

(N) Statewide Suicide Prevention Council;

(O) the State Board of Registration for Architect, Engineers, and Land Surveyors;

**(P) Alaska Health Care Commission;**

* **Sec. 4.** AS 44.66.010(a) is amended to read:

(a) Boards and commissions listed in this subsection expire on the date set out after each:

(1) Alcoholic Beverage Control Board (AS 04.06.010) - June 30, 2010;

(2) Board of Parole (AS 33.16.020) - June 30, 2016;

(3) Regulatory Commission of Alaska (AS 42.04.010) - June 30, 2011;

(4) Alaska Commission on Aging (AS 47.45.200) - June 30, 2016;

(5) Council on Domestic Violence and Sexual Assault (AS 18.66.010) - June 30, 2014;

(6) special education service agency (AS 14.30.600) - June 30, 2013;

(7) [REPEALED

(8)] Statewide Suicide Prevention Council (AS 44.29.300) - June 30, 2013;

**(8)** [(9)] Alaska Seismic Hazards Safety Commission (AS 44.37.065) - June 30, 2012;

**(9) Alaska Health Care Commission (AS 18.09.010) - June 30, 2014.**

* **Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to

read:

TRANSITION: REGULATIONS. The Department of Health and Social Services may proceed to adopt regulations necessary to implement the changes made by this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory change.

*** Sec. 6.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: ALASKA HEALTH CARE COMMISSION. The members appointed to the Alaska Health Care Commission, established by Administrative Order No. 246 dated December 4, 2008, shall serve as the voting members of the Alaska Health Care Commission under AS 18.09.010, enacted by sec. 2 of this Act, for one-year to three-year staggered terms as determined by the governor according to AS 39.05.055.

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

# FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number
Bill Version: SB172
() Publish Date

Identifier (file name): SB172-DHSS-PHA-02-01-10
Dept Affected: Health & Social Services
Title: Alaska Health Care Commission
RDU: Public Health
Component: Public Health Administration
Sponsor: Olson
Requester: Senate HSS
Component Number: 292

**Expenditures/Revenue** (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below

| | Appropriation Required | Information | | | | | |
|---|---|---|---|---|---|---|---|
| **OPERATING EXPENDITU** | **FY 2011** | **FY 2011** | **FY 2012** | **FY 2013** | **FY 2014** | **FY 2015** | **FY 2016** |
| Personal Services | 134.5 | | 134.5 | 134.5 | 134.5 | 134.5 | 134.5 |
| Travel | 35.0 | | 35.0 | 35.0 | 35.0 | 35.0 | 35.0 |
| Contractual | 300.0 | | 320.5 | 320.5 | 320.5 | 320.5 | 320.5 |
| Supplies | 20.5 | | 10.0 | 10.0 | 10.0 | 10.0 | 10.0 |
| Equipment | 10.0 | | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |
| Land & Structures | | | | | | | |
| Grants & Claims | | | | | | | |
| Miscellaneous | | | | | | | |
| **TOTAL OPERATING** | **500.0** | **0.0** | **500.0** | **500.0** | **500.0** | **500.0** | **500.0** |
| **CAPITAL EXPENDITURE** | | | | | | | |
| **CHANGE IN REVENUES** | | | | | | | |

**FUND SOURCE** (Thousands of Dollars)

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1002 Federal Receipts | | | | | | | |
| 1003 GF Match | | | | | | | |
| 1004 GF | 500.0 | | 500.0 | 500.0 | 500.0 | 500.0 | 500.0 |
| 1005 GF/Program Receip | | | | | | | |
| 1037 GF/Mental Health | | | | | | | |
| Other Interagency Receip | | | | | | | |
| **TOTAL** | **500.0** | **0.0** | **500.0** | **500.0** | **500.0** | **500.0** | **500.0** |

**Estimate of any current year (FY2010) c** 500.0

**POSITIONS**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Full-time | **1.0** | | 1 | 1 | 1 | 1 | 1 |
| Part-time | | | | | | | |
| Temporary | | | | | | | |

**ANALYSIS:** *(Attach a separate page if nece:*

SB 172 establishes the Alaska Health Care Commission in DHSS to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state. The commission would be composed of 10 members. SB 172 closely parallels Administrative Order #246 of December 2008 establishing a health care commission to address Alaska's health care challenges.

The current Alaska Health Care Commission recently adopted a formal policy recommendation to establish a permanent health care commission in statute to address the need for health care reform in Alaska. The

(continued on page 2)

Prepared by: Ward B. Hurlburt, MD, MPH, Chief Medical Officer/Director
Phone: 269-8126
Division: Public Health
Date/Time: 12/28/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date: 2/1/2010
DHSS Finance & Management Services

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

BILL NO. SB172

ANALYSIS CONTINUATION

(Continued from Page 1)
The commission based this recommendation on the finding that the need for a plan to address health care cost, access and quality issues is greater than ever before. Health care expenditures in Alaska more than tripled between 1991 and 2005 from $1.6 billion to $5.3 billion. Costs are expected to double again, to over $10 billion, by 2013. The Alaska economy cannot sustain this inflationary growth, and government (all levels - local, state, and fed) carries 64% of this cost burden between the cost for government health care programs and provision of health care insurance for government employees. *(Data cited from "Alaska's $5 Billion Health Care Bill - Who's Paying?" UA Research summary No. 6, Institute of Social and Economic Research, University of Alaska, March 2006.)*

The two most recent groups to work on the issue of health care reform in Alaska, the Alaska Health Care Roundtable (2005) and the Alaska Health Care Strategies Planning Council (2007), both recommended that a permanent body be established to address the problem of health care reform. The problem is too great in scope and too complex to be able to plan and follow-through in just one or two years time through an ad-hoc body.

$500.0 in state general funds is required for operations of the health care commission, as follows:

**71000 Personal Services:** The bill states that an Executive Director would staff the Commission; administrative support would be provided by existing DHSS staff. Personal services costs of $134.5 is Range 23, Step F.

**72000 Travel** Travel and per diem for Commission staff and for 8 Commission members to conduct quarterly face-to-face public meetings. The two other members are legislators and would have per diem and travel covered.

**73000 Contractual** Professional services contracts will be needed to supplement staff research, and core service RSAs will be required to provide lease space, telecommunications, mainframe connectivity, postage, etc.

**74000 Supplies**
In addition to day-to-day office supplies, FY11 includes start-up costs such as computers, office furniture, reconfiguring leased space, wiring needs for connectivity, printers, fax, and photocopier.

**75000 Equipment**
FY11 includes purchase of a server; in subsequent fiscal years provide technology upgrades and maintenance will be covered through the contractual line.

The bill becomes effective immediately upon the Governor's signature. This means there may be some limited costs in FY10 that will have to be absorbed by the Department of Health & Social Services.

# Alaska's $5 Billion Health Care Bill—Who's Paying?

By Mark Foster and Scott Goldsmith

March 2006
UA Research Summary No. 6
Institute of Social and Economic Research • University of Alaska Anchorage

**Figure 1. Growth in Alaska Health-Care Spending, 1991-2005**


Source: Authors' estimates

Spending for health care in Alaska topped $5 billion in 2005. Just how big is $5 billion? It is, for perspective, one-third the value of North Slope oil exports in 2005—a year of high oil prices. It's nearly one-sixth the value of everything Alaska's economy produced last year.

In 1991, health-care spending in Alaska was about $1.6 billion. Even after we take population growth into account, spending for health care increased 176% per Alaskan in 15 years. These soaring costs are taking a growing share of family and government budgets, increasing labor costs, and putting businesses at a competitive disadvantage.

The $5.3 billion in spending in 2005 was all for the 665,000 people who live in Alaska, but individuals didn't pay all the bills. They paid nearly 20% out of their pockets and through payroll deductions. Businesses (including non-profits) and governments paid about 80%. Of course, individual Alaskans and other Americans indirectly pay all these costs, because they buy goods and services, own businesses, and pay taxes.

What does health-care spending buy? Stays in the hospital, visits to doctors and dentists, prescription drugs, and more, as well as program administration and public health programs. Our estimates don't include capital expenditures.[1]

Who pays the bills, and how has that burden shifted as spending increased?

• *Private and government employers spent about $2 billion for employee health-care coverage in 2005.* For comparison, they paid $11.8 billion in wages in 2005. With rising costs, businesses and governments have become increasingly likely to pay health-care bills themselves—"self-insure"—rather than pay through insurance premiums.

• *Alaska households spent just over $1 billion for health care in 2005, up from $361 million in 1991.* That includes everything individual Alaskans spent—not only their out-of-pocket costs, but also what was deducted from their paychecks to help pay for health coverage through their employers.

• *Governments spent $2.2 billion for health care programs in 2005, up from $736 million in 1991.* Medicaid spending was almost $1 billion.

Health-care spending could double again by 2013, if current trends continue. Why are costs of medical care so high, and why are they increasing faster than everything else? Why have health-care costs in Alaska stayed higher than U.S. averages, even as other costs moved closer to national levels? Are we getting better care now? Who can't afford care?

We're starting to assemble data to help answer those questions. Alaskans face some hard choices about how to control costs but still have a health-care system that provides good care and is accessible to everyone. We hope to provide some useful insights.

This publication is the first step in ISER's research on the health-care industry. It starts with our new estimates of spending and of changes since 1991, when we last looked at health-care spending.[2] But cost alone is only one part of the complicated health-care story, and here we also begin looking at:

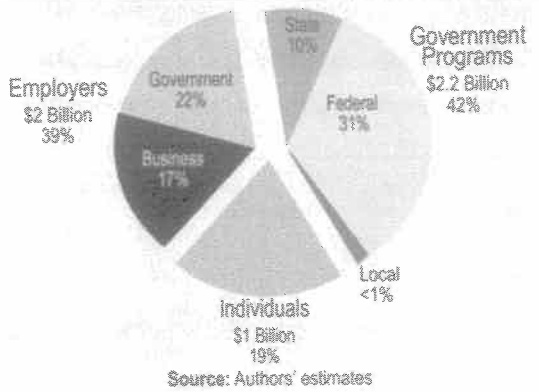
• Who are the most expensive patients? Our analysis of national data shows that the average "high-cost" patients aren't as expensive as you might think.

• Who is more likely to have health insurance provided through their jobs at a reasonable cost? Single people working for big companies.

• How does use of the health care system in the U.S. compare with use in other countries? Canadians and Australians seem to use their systems about as much.

• What is driving costs? Despite what many people think, there are no simple explanations: it's a puzzle with many pieces.

**Figure 2. Who Pays The Bills?**
(Total 2005 Spending: $5.3 Billion)




Source: Authors' estimates

Understanding Alaska (UA) is a special series of ISER research studies examining Alaska economic development issues. The studies are paid for by the University of Alaska Foundation. UA reports are available from ISER's offices and at: www.alaskaneconomy.uaa.alaska.edu

## Organization of Summary

We first describe what health-care dollars buy—what shares go to doctors, hospitals, drugs, and other expenses. Then we look in more detail at our estimates of health-care spending in 2005 and the changes since 1991. We think our estimates are a good effort to update our previous work. But the health-care industry is complex, and tracking all the spending is difficult.

After we talk about spending, we give readers a glimpse of related health-care issues. In some cases we have no Alaska data and rely on national figures, which are still useful in illustrating important issues.

Pages 4, 5, and 6 discuss access to, use of, and benefits from the health-care system: who is uninsured; who has health-care coverage and how that coverage is provided; which patients get the costliest care; how Americans' use of medical care compares with use by people in other industrialized countries; and whether we've gotten healthier in exchange for more spending.

Page 7 summarizes what we know about how medical costs in Alaska differ from the U.S. average, and page 8 concludes with a discussion about the many things that may be driving health-care costs.

Keep in mind that population growth and general inflation account for part of the increase in health-care spending since 1991. Alaska's population increased from about 570,000 in 1991 to 665,000 by 2005. Also, prices for everything Americans buy also went up, by about 43% nationwide and 39% in Anchorage. But prices of medical care nearly doubled (Figure 3).

## What Are We Buying?

Figure 4 shows that as of 2000, more than 70% of Alaska's health-care spending was for hospital care and visits to doctors. Prescription drugs accounted for about 9% and dental care 7%. The "other" category includes medical products, health care provided on the job and in schools, and Medicaid payments for in-home care.

Nursing home and home health care made up only 2% of health-care spending in 2000, far short of the U.S. average of 11%—and that share actually dropped between 1990 and 2000, despite fast growth in the number of Alaskans over 65. There has been a shift in how long-term care is provided in Alaska. A change in Medicaid allowed payment for in-home and assisted-living care for people who would otherwise have been cared for in nursing homes.

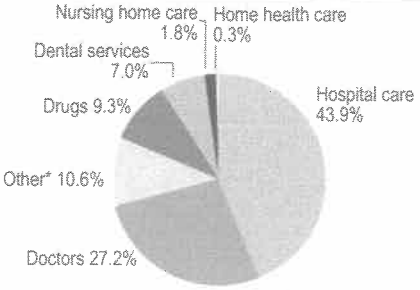
All types of health-care spending grew rapidly since 1990, but the fastest growth was in prescription drugs and the "other" category (described in the footnote to Figure 4).

## How Has Spending Changed?

Table 1 details who paid for health-care in 2005. Figures 5 and 6 show changes in levels and shares of spending from 1991 to 2005.

• Growth in government spending wasn't uniform. The federal government's share of spending increased (Figure 5). Costs for Medicare and Medicaid more than quadrupled and costs for the Indian Health Service doubled.

**Figure 4. What Are We Buying?**
(Alaska Health Care Spending, 2000)




*Includes, among other things, durable and non-durable medical products, direct services employers provide employees, government expenditures in schools, and Medicaid payments that allow people to be cared for at home instead of in institutions.

**Source**: Center for Medicare and Medicaid Services

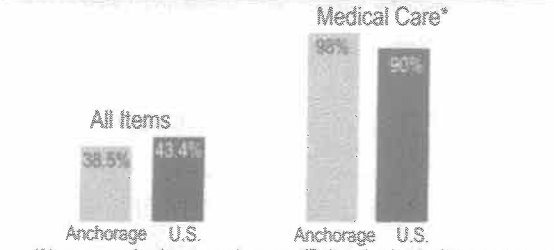
• State government's share dropped, partly because the federal government paid a bigger share of Medicaid costs in 2005 than in 1991.[3]

• Local government is the smallest government spender, but the local share of spending increased, mostly because of growing costs for employee health coverage.

• Employers saw the fastest growth. Combined spending by private and government employers increased about 290% (Figure 6).

• Spending by individual Alaskans didn't go up as much—184%—but the $1 billion they spent in 2005 was still more than the $922 million businesses spent.

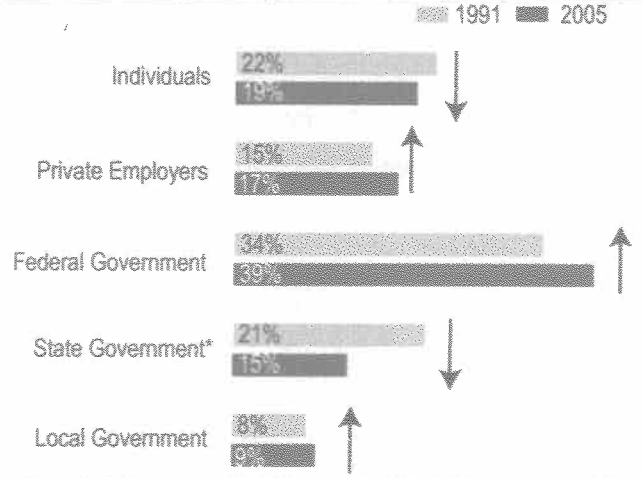
**Figure 3. Increase in Consumer Price Index Anchorage and U.S., 1991-2005**




*Measures price increases in a specific "market basket" that includes hospital care, visits to doctors and dentists, nursing home care, and medical supplies; also indirectly measures increases in health insurance premiums.

**Source**: U.S. Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers, Anchorage and U.S. City Average

**Figure 5. How Did Shares of Spending Change From 1991 to 2005, Among Those Who Buy Health Care?**




*See endnote 3, page 8. Note: Totals may not add to 100% because of rounding.

**Source:** Authors' estimates

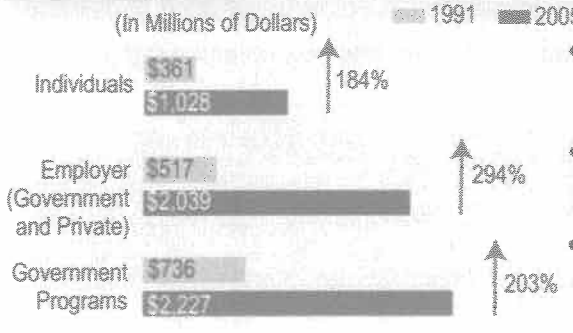
## Table 1. Health-Care Spending in Alaska, Fiscal Year 2005
(Total Spending: $5.3 Billion)

| Who Provides the Coverage? | Who Buys the Care? (In Million of Dollars) | | | | | |
|---|---|---|---|---|---|---|
| | Individuals | Businesses | Local Government | State Government | Federal Government | Total |
| **Individuals** | $1,028 | | | | | $1,028 |
| Out-of-pocket costs | $431 | | | | | |
| Individual policies | $276 | | | | | |
| Payments for employer-based insurance | $320 | | | | | |
| **Employers** (Including retiree coverage) | | $922 | $454 | $252 | $411 | $2,039 |
| Insurance Premiums | | $303 | $103 | $72 | $75 | |
| Self-Insured Costs[a] | | $485 | $352 | $180 | $115 | |
| Military Medical Costs | | | | | $221 | |
| Worker's Compensation (medical benefits) | | $134 | | | | |
| **Government Health Programs** | | | $38 | $535 | $1,654 | $2,227 |
| Medicare | | | | | $419 | |
| Medicaid | | | | $303 | $667 | |
| Other Public Programs | | | | | | |
| Federal | | | | | | |
| Indian Health Service Contracts | | | | | $401 | |
| Veterans' Affairs | | | | | $105 | |
| Community Health Centers | | | | | $29 | |
| State | | | | | | |
| Grant to local governments, private groups | | | | $116 | | |
| API, Pioneers' Homes | | | | $55 | | |
| Other State-Administered | | | | $31 | | |
| Elementary and Secondary Schools | | | $3 | $8 | $33 | |
| WAMI Medical Education | | | | $2 | | |
| Department of Corrections | | | | $21 | | |
| Local | | | | | | |
| Health and hospital spending | | | $35 | | | |
| **Total Spending** | $1,028 | $922 | $492 | $787 | $1,950 | $5,294 |

[a] Many organizations that self-insure—that is, they pay some of their bills themselves—also still carry some insurance to help cover extraordinary risks.

**Source:** Authors' estimates Note: Totals may not sum because of rounding.

## Figure 6. How Did Spending Change From 1991 to 2005, Among Those Who Provide Coverage?




**Source:** Authors' estimates

### Biggest Kinds of Changes

- Individual Alaskans have seen big increases not only in costs they notice most—how much they have to pay out of their own pockets—but also in less obvious costs: deductions from their paychecks to pay their share of employer-based insurance.
- Both private and government employers became much more likely to self-insure. Self-insurance costs made up about two-thirds of combined employer spending for insurance premiums and self-insurance in 2005, up from about one-third in 1991.
- Spending for Medicaid more than quadrupled (from $215 million to $970 million), so that in 2005 it alone made up nearly $1 in every $5 of health-care spending. Analysts attribute the fast growth of Medicaid nationwide to growing numbers of eligible Americans, including low-paid workers whose employers don't provide coverage and low-income seniors; to program expansion; to increasing prices of medical care; and to treatment of medical conditions at lower thresholds.

## Health-Care Coverage

Most Alaskans—an estimated 87%—have some form of health-care coverage, either through private insurance or government programs.[4] Some people have more than one kind of coverage, so the percentages in Figure 7 add to more than 100%.

Around 64% of Alaskans are covered by private insurance, 38% by government programs, and nearly 13% have no coverage. Nationwide, 68% of people are covered by private insurance, 30% by government programs, and close to 16% have no coverage.

Alaskans are more likely to have coverage through the military (reflecting the state's large number of active-duty and retired military); the Indian Health Service (because Alaska Natives make up 20% of the population); and Medicaid (the joint federal-state program mainly for low-income and disabled people). Fewer Alaskans are covered by Medicare, because fewer are over 65.

We don't know characteristics of the 13% of Alaskans with no health-care coverage, but we know that nationwide the uninsured are most likely to be young adults and to have annual incomes below $25,000 (Figure 8 ).

Children in Alaska are more likely to have coverage than both adults in Alaska and children nationwide. Figure 9 shows that about 8% of children in Alaska had no coverage in 2003, compared with the U.S. average of nearly 12%.[5] The smaller share of uninsured children in Alaska is probably due to the fact that Alaska Native children are eligible for care through the Indian Health Service, and also to the Denali KidCare program, an extension of Medicaid that provides coverage for low-income children without other coverage.

It's outside the scope of this summary to describe all the ways that families, communities, and governments are affected because millions of Americans lack health insurance. But a recent report by the National Academy of Sciences broadly summarized those effects. It found that the uninsured are in worse health; that uninsured children are more likely to have development delays; that the direct costs of caring for uninsured Americans fall heavily on local communities; and that governments pay hospitals large public subsidies to offset their costs for uncompensated care.[6]

The 64% of Alaskans with private insurance either pay for that coverage themselves (through individual policies) or are covered through their jobs and share the costs with their employers. Figures 10, 11, and 12 show how the rising costs of medical care have affected health-insurance coverage for Alaskans working for private industry.

**Figure 7. Health-Care Coverage, Alaska and U.S., 2004**

| | Private Insurance | Medicaid | Medicare | Military | IHS only* | None |
|---|---|---|---|---|---|---|
| Alaska | 63.5% | 15.3% | 7.3% | 11.6% | 4.2% | 12.8% |
| U.S. | 68.1% | 12.9% | 13.7% | 3.7% | N/A | 15.7% |

*Authors' adjustment. See endnote 4, page 8.

Note: Totals are more than 100% because some people have more than one coverage.
**Source**: U.S. Census Bureau, Current Population Survey, 2004

• Health insurance in Alaska was already more expensive in the 1990s and still is. In 2003, insurance premiums for family coverage at private firms were about $10,500 in Alaska and $9,200 nationwide. By 2005, those premiums had jumped to an average of $11,268 nationally (Figure 10).

**Figure 8. Who Is Most Likely To Be Uninsured in U.S.?**

| By Age | Percent Uninsured |
|---|---|
| 18-24 | 31% |
| 65+ | 1% |
| **By Annual Income** | |
| Less than $25,000 | 24% |
| $75,000+ | 8.4% |

**Source**: U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the U.S.*, 2004

• Premiums are higher in Alaska, but workers here pay a smaller share, as Figure 11 shows. As of 2003, employees at private firms in Alaska paid 11% of the premiums for single-person coverage and 17% for family coverage, compared with 17% for single-person coverage and 25% for family coverage nationwide. But employers, especially at small firms, have been shifting more insurance costs to workers. The 2005 UBA-Ingenix Health Plan Survey found that employees of businesses nationwide paid 43% of the premiums for family coverage.

**Figure 9. Health-Care Coverage for Children (18 and Under), Average 2001-2003**


**Source:** American Academy of Pediatrics, adjusted U.S. Census data; see endnote 5, page 8.

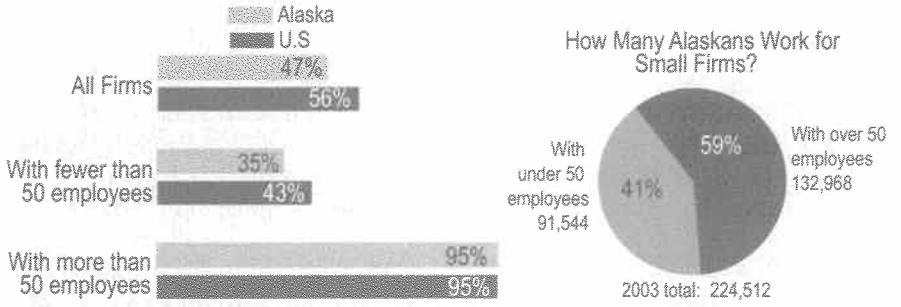
**Figure 10. Health Insurance Premiums For Family Coverage[a], Private Firms**


[a]Total costs shared by employer and employee. [b] Alaska figures for 2005 not available.
**Sources**: Medical Expenditure Panel Survey, U.S. Agency For Health Care Research and Quality, 2003; 2005 UBA/Ingenix *Health Plan Survey*

**Figure 11. Share of Health Insurance Premiums Employees Pay**
(At Private Firms Offering Health Insurance)


[a]Reported in Medical Expenditure Panel Survey, 2003
[b]Alaska 2005 figures not available; national figures from 2005 UBA/Ingenix *Health Plan Survey*

## Figure 12. Private Firms Offering Health Insurance,* Alaska and U.S., 2003




* Not all workers at firms that offer insurance carry that insurance. **Source**: Medical Expenditure Panel Survey, 2003

• Small Alaska businesses are less likely to offer insurance coverage. Only about a third of those with fewer than 50 employees offer coverage, compared with 43% nationwide (Figure 12).

A lot of Alaskans work for small businesses. In 2003, about 91,500 of the state's 224,500 private-industry employees worked for businesses with fewer than 50 employees. That's more than 40% of all those with jobs in private industry.

### Who Costs the Most and the Least?

We've talked about the costs of health care and of health-care coverage. Now we turn to the other side of the equation: who's getting the benefits of the spending?

Health-care spending in Alaska was close to $8,000 per person in 2005. But not everyone is average. The cost of care for a few is significantly higher than average, but for many it's only a few hundred dollars a year.

As a first step toward understanding who gets the benefits of health-care spending, ISER analyzed national data on the characteristics of high- and low-cost patients. That data is from a federal panel survey—that is, a survey that follows households over time.

As Figure 13 shows, just 5% of patients nationwide account for almost half of all health-care spending in any given year, while at the other extreme 50% of patients account for just 3% of spending in a year.

A lot of Americans tend to think that the most expensive patients are probably very old, or suffering from some catastrophic illness or injury, and are possibly uninsured.

The high-cost patients are older; health-care costs do go up as people age.[7] But their average age is 57, and fewer than 40% are over 65. The average bill for high-cost patients in 2002, under $20,000, doesn't reflect major illnesses or end-of-life care. Rather, it's for a few days in the hospital for surgery, several visits to doctors, and significant spending for prescription drugs. Few of the high-cost patients—2%—are uninsured.

The low-cost patients are mostly young, averaging 28 years old. They may see a doctor or a dentist once a year, and they pay almost half their modest medicals bills out of their pockets.

Many of the low-cost group—nearly 20%—are uninsured. The share of uninsured patients in this group tracks with what the National Academy of Sciences has reported: that the uninsured often don't have any medical costs at all in a year, and among those who do, their expenses are less than half the average for people under 65.[8]

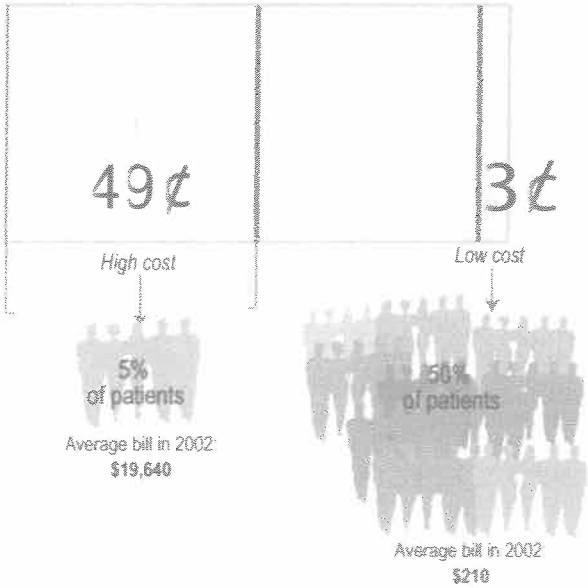
Keep in mind that it's easy to go from being a low-cost patient in one year to a much costlier one the next—a car accident, the sudden onset of an illness, or a hundred other unpredictable events can push anyone into the ranks of the high-cost patients.

## Figure 13. Who Are the High-Cost and the Low-Cost Patients in the U.S.?

Distribution of Health-Care Spending on Patients, 2002

**Who Are the High-Cost Patients?**

- Mostly middle-aged people (average age 57), who are hospitalized for a few days, see doctors several times a year, and spend considerable money (average $3,000) on prescription drugs.
- About 40% are over 65
- They are from all income levels. A third have high incomes (family income over $80,000), and about a fifth are poor (family income under $18,000).
- Only 2% are uninsured. More than two-thirds have private insurance, and nearly a third are covered by government health programs, the most common being Medicare.
- They pay about 12% (average $2,400) of their bills out-of-pocket.




**Who Are the Low-Cost Patients?**

- Mostly young (average age 28), healthy people, who are likely to see a doctor and a dentist once a year and spend little (average $44) for prescription drugs.
- About 3% are over 65
- They are from all income levels, with almost the same breakdown as among high spenders: nearly a third have high incomes and about a fifth are poor.
- Nearly 20% are uninsured. About 17% are covered by government programs, most commonly Medicaid. The majority have private insurance.
- They pay about 40% (average $84) of their bills out-of-pocket.

**Sources**: *MEPS Statistical Brief No. 81, May 2005 and analysis of MEPS data by Stephanie Martin of ISER*

## Do We Use More Medical Care?

Americans spend more on health care than anybody else. Do Americans increase health-care costs by getting more medical care than people in other developed countries? Or conversely, do countries with national health-care systems hold down costs by rationing care?

Figure 14 compares Americans with the British, Canadians, New Zealanders, and Australians on use of, access to, and satisfaction with their health-care systems. The comparison countries all have some form of national health-care system.

Overall, the comparisons show that residents of all four countries are almost equally likely to see doctors and have diagnostic tests, and that Americans are slightly more likely to take prescription drugs.

Americans are, however, more likely to skip medical tests because of cost and less likely to get appointments the same day they call. They also seem to be somewhat less satisfied with care they get from their doctors and in the emergency room.

**Figure 14. Use of Medical Care, U.S. and Selected Countries, 2004**
(Percent of Survey Respondents)

| | U.S. | Great Britain | New Zealand | Canada | Australia |
|---|---|---|---|---|---|
| Saw at least one doctor in previous 2 years | **97%** | 95% | 97% | 95% | 98% |
| Regularly take prescription drugs | **46%** | 44% | 39% | 43% | 39% |
| Had blood tests, x-rays, or other diagnostic tests in past 2 years | **84%** | 71% | 82% | 84% | 83% |
| Able to get doctor's appointment same day when sick | **33%** | 41% | 60% | 27% | 54% |
| Skipped medical tests, treatment or follow-up because of cost | **27%** | 2% | 20% | 8% | 18% |
| Rate regular doctor's care excellent or very good | **61%** | 64% | 74% | 68% | 71% |
| Among those who used emergency room, share who rate emergency services fair or poor | **34%** | 23% | 27% | 27% | 23% |

**Source**: Commonwealth Fund International Health Policy Survey, 2004

## Are We Healthier?

Another important aspect of the health-care story is what we're getting in return for the high spending. Are Alaskans healthier than in 1990?

The answer seems mixed. In 2005 the United Health Foundation ranked Alaska as among the most improved states in health outcomes since 1990. Despite that improvement, the foundation still ranks Alaska somewhere in the mid-range of states on health measures—because 15 years ago Alaska was ranked toward the bottom.[9] Figure 15 illustrates some of the improvements Alaska has made since 1990.

Rates of infectious disease (which include hepatitis, tuberculosis, and many more) went from far above the U.S. average in 1990 to significantly below by 2005. Infant mortality dropped in Alaska and throughout the country.

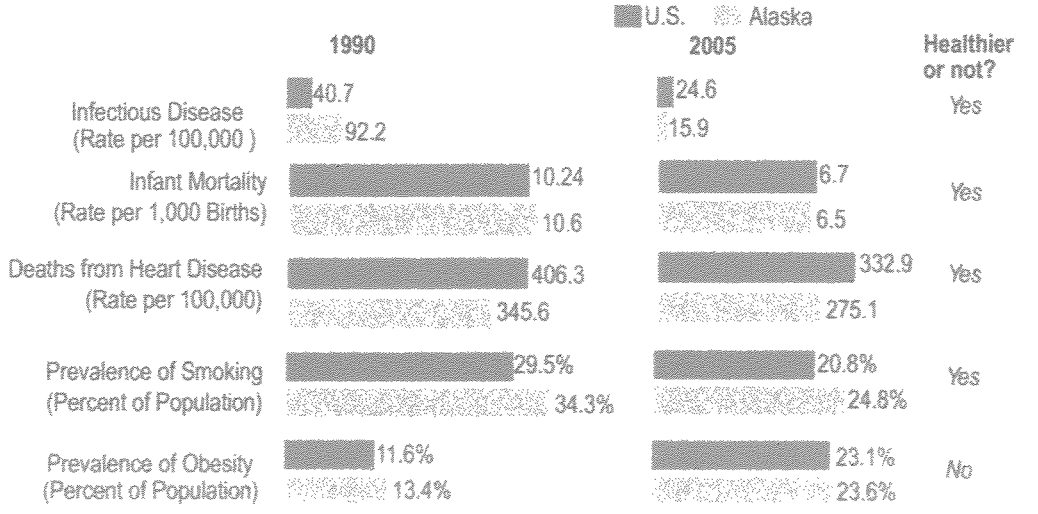
Declines in infectious disease and infant deaths in Alaska can be traced partly to public-health spending for immunizations, as well as for safe water and sewer systems, new housing, and better access to medical care in remote villages.[10] In Alaska and nationwide, advances in treatment and technology have also reduced infant deaths.

With improved treatments for heart disease, the rate of death from heart disease declined by 20% in Alaska since 1990, dropping slightly faster than the national rate.

Rates of smoking among Alaskans fell also, but Alaskans are still more likely to smoke than other Americans. Again, public-health campaigns to fight smoking likely contributed to the decline.

On the down side, Alaskans and other Americans are far more likely to be obese now than in 1990—and obese people are more likely to require treatment for diabetes and high blood pressure.

**Figure 15. Are Alaskans Healthier Now Than in 1990?**




**Source**: United Health Foundation, *America's Health Rankings 2005*

## Alaska and U.S. Costs

Years ago, everything cost more in Alaska, and costs still remain high in remote areas. But in Anchorage and other urban places, the historically high costs of many things have moved closer to U.S. averages in recent times, as the population grew, local markets got bigger, and infrastructure and transportation improved.

But costs of medical care haven't declined relative to U.S. averages. Overall medical costs are probably somewhere in the range of 25% higher in Alaska, but that cost difference varies quite a bit among services and procedures, and prices don't always reflect cost.

Alaska has fewer practicing doctors per capita than the nation as a whole, but somewhat more dentists—so how the supply of medical professionals may affect costs is not clear (Figure 16).

Figures 17 through 20 show some examples of cost differences, but it isn't a comprehensive picture.

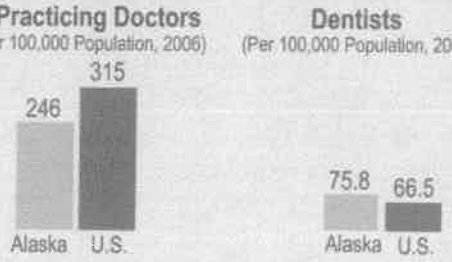
• Overall costs of medical and surgical procedures in Alaska were about 18% above the U.S. average in 2001 and dental procedures 37% more (Figure 17).

• Average costs of a visit to a doctor's office were 30% higher in Alaska in 2001. But the average is a mix of private insurance and government payments. A private insurer in Anchorage and Fairbanks paid nearly twice as much as Medicare for an office visit in 2001, as Figure 18 shows.

• Alaskans don't use as many prescription drugs as other Americans—mostly because there are fewer Alaskans over 65—but we pay more. In 2003, the average price of retail prescriptions was 25% higher in Alaska.

• Costs of hospital care went up faster in Alaska than nationwide from 2000 to 2003—so in 2003 average expenses for a day in an Alaska hospital were 42% above the U.S. average, compared with 30% in 2000.

**Figure 16. How Do Numbers of Alaska Doctors and Dentists Compare with U.S. Averages?**



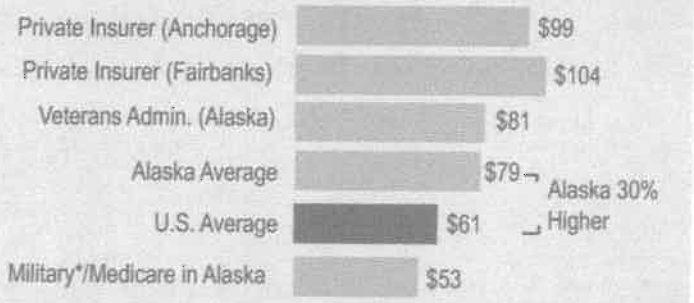

Note: Figures updated and corrected March 2007; see endnote 11.
**Sources:** American Medical Association; American Dental Association; U.S. Census Bureau

**Figure 17. How Much Higher are Medical Costs in Alaska?**
(Costs Paid by Private Insurer, 2000)

| | Percent Above U.S. Average |
|---|---|
| Medical/Surgical Procedures | 18.1% |
| Dental Procedures | 37.7% |

**Source:** Ingenix data base; cited in Alaska Division of Medical Assistance, HealthCare Cost Analysis, 2001

**Figure 18. Costs of An Office Visit, Alaska and U.S., 2001**
(Established Patient, 15 minutes)




*Insurance coverage for active-duty and retired military personnel for medical care not available from military facilities.
**Source:** GAO Report GAO-01-620, May 2001

**Figure 19. Prescription Use and Cost, Alaska and U.S., 2003**

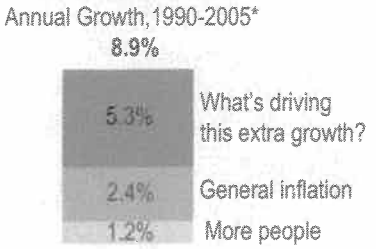
| | Prescriptions Per Capita | Average Price of Retail Prescriptions | Average Cost Per Capita |
|---|---|---|---|
| United States | 10.7 | $52.97 | $566.78 |
| Alaska | 6.3 | $66.89 | $421.41 |

**Source:** Kaiser Family Foundation, based on data from Verispan, LLC; Special Data Request, 2004; and U.S. Census Bureau, State Population Datasets for six Race Groups

**Figure 20. Hospital Costs, Alaska and U.S. , 2000 and 2003**
(Expenses per In-Patient Day)


**Source:** 2003 American Hospital Association, Annual Survey

**Figure 21. What's Driving Health-Care Spending In Alaska?**




*Authors' estimate

## What's Driving Costs? It's a Puzzle

Spending for health care in Alaska increased an average of nearly 9% a year from 1990 to 2005—and that figure doesn't reflect the big capital costs for building hospitals and clinics in the state since 1990.

More people and general inflation together account for only about 40% of that growth. So what's driving the rest?

Just about everybody has an opinion about what's pushing up medical costs, here and nationwide. Alaska has some special conditions—mostly small markets and high costs in rural areas—but other possible contributors to high costs are common to Alaska and the rest of the country.

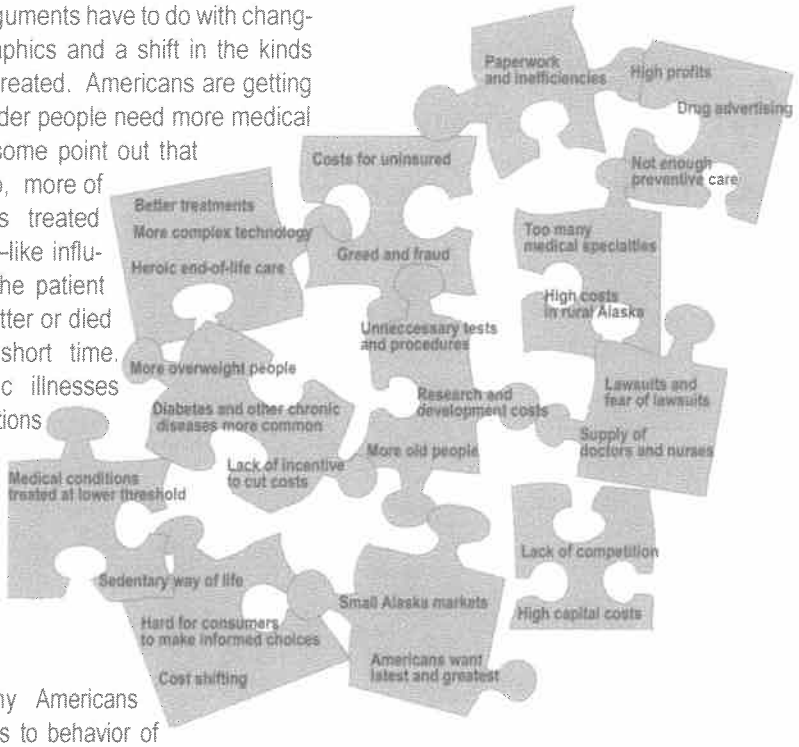
Some people think the big factors have to do with our system of delivering health care. Those include market forces—like lack of competition, for instance, and lack of incentives in many parts of the system to control costs—as well as inefficiencies created by the complexity of the U.S. system.

Other arguments related to the delivery system are that Americans get more medical care than they need, because most of the bills are still paid by health insurance. Others believe, by contrast, that costs of caring for uninsured people are responsible.

Others blame environmental factors, especially Americans eating too much and not exercising—leading to the spread of diabetes and other conditions requiring more care.

Still others say the growth has to do with changes in treatments and technology—treating conditions at lower thresholds (like the recent drop in the cholesterol level at which doctors recommend treatment); more effective but costlier treatments and prescription drugs; and more complex technology.

Other arguments have to do with changing demographics and a shift in the kinds of illnesses treated. Americans are getting older, and older people need more medical care. Also, some point out that decades ago, more of the illnesses treated were acute—like influenza—and the patient either got better or died in a fairly short time. Now, chronic illnesses and conditions—like high blood pressure—are common and require long-term treatment.




And many Americans link high costs to behavior of drug companies, the insurance industry, the medical and legal professions, and individual Americans. Such behavior would include, for instance, insurance and drug companies making high profits; doctors overbilling government programs; and patients filing lawsuits—causing doctors to practice "defensive medicine."

Probably there are other opinions we haven't discussed here. We're not endorsing any of them, but merely pointing out that many things could be contributing to rising costs—and it's a puzzle how all the pieces fit together. We will learn more as we study Alaska's health-care system. But for now, we want to emphasize that the answer to what is driving health-care costs is not simple, and finding solutions won't be simple either.

## Endnotes

1. Our estimates are based on the Center for Medicare and Medicaid Services' definitions of personal health care spending. See http://www.cms.hhs.gov/NationalHealthExpendData/01_Overview.asp#TopOfPage. We have also included insurance costs, to capture the expenses paid by employers and employees.

2. ISER *Research Summary* No. 53, "The Cost of Health Care in Alaska," December 1992

3. The decline in state share is expected to ameliorate somewhat beginning in FY 2006, due to a decision by the 9th District Appellate Court to disallow the Fair Share program that enabled tribal hospitals to receive a higher reimbursement than non-tribal hospitals for uncompensated care.

4. U.S. Census Bureau figures from the Current Population Survey classify Alaskans with coverage only through the Indian Health Service as "uninsured." We have adjusted those figures, separating those with IHS-only coverage from the uninsured. The adjustment is based on methods of the University of Minnesota's School of Medicine, State Health Access Data Center.

5. American Academy of Pediatrics figures for uninsured Alaska children are adjusted U.S. Census figures, separating children with IHS-coverage only from the "uninsured" category.

6. National Academy of Sciences, *Hidden Costs, Value Lost: Uninsurance in America*. Available at: http://www.nap.edu/catalog/10719.html. Public subsidies for uncompensated care are illustrated in the State of Alaska's FY 2007 budget request, which includes $27 million to help Alaska hospitals pay for uncompensated care.

7. In 1999, for example, health-care spending for Americans 75 to 84 was seven times higher than for those 18 and under.

8. See note 6.

9. United Health Foundation, *America's Health Rankings*, 2005 edition.

10. See Chapter 3 in ISER report, *Status of Alaska Natives 2004*, May 2005.

11. Our original figure for number of dentists per 100,000 in Alaska was incorrect. We thank researchers at Health Planning and Systems Development in the Alaska Department of Social Services for helping us identify that error. A separate addendum, *Dentists in Alaska*, prepared in March 2007, provides more information about the source of the error and the correction. See: http://www.iser.uaa.alaska.edu/Publications/researchsumm/UA_RS6_addendum03_07.pdf

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**Editor**—Linda Leask **Graphic Artist**—Clemencia Merrill

# Principles, Elements and Specific Steps

Draft 8 August 29, 2007

Proposal by the Alaska Health Care Roundtable to help the Council achieve the goals it identified at its first meeting:

## Health Care Strategies Planning Council Mission Statement (Approved at the June 11, 2007 meeting)

Develop strategies, including performance measures, to provide health care access for all Alaskans by 2014 with the goal of making Alaskans the healthiest population in the nation.

The definition of "access" includes: coverage, affordability, timely service, quality of care, prevention, managing chronic conditions, workforce issues and cost.

*Roundtable recommendations are as follows:*

## Principles of reform — Guidelines for creating effective specific action steps

- Creating healthier people who consume less medical services is the only major sustainable strategy to slow growth of health care costs.

- Plans, programs and policies must encourage and support the principle of individual responsibility to maintain and protect each person's health.

- Dramatically improve value for every health care dollar.
    - Health services that effectively educate and motivate individuals underpin an effective, efficient health care system. Prevention and timely appropriate levels of care earn strong return on investment (ROI) for both employer and public programs. Examples are immunization programs, hypertension or HIV screening, promoting prenatal care, etc.
    - Organizational wellness programs, government or private, are starting to prove that improving employee health is a win/win for both employees and employers.

- Financially support carefully planned experimentation with different types of health delivery models and payment models. Alaska is a highly diverse state. The wide variety of community sizes, many in remote areas, with differing access to care and different prevailing payment systems argues towards creating a variety of solutions from which to choose. Employers are particularly concerned about quality.

- All Alaskans need quality, affordable health care that provides:
  - Physical access
  - Financial access
  - Information access

- Facilitate universal participation in the most appropriate fashion for each individual. Forms of coverage or care include:
  - Employer-based
  - Individual-based
  - Federal programs
  - Military programs
  - Alaska Native programs

- Rely on and develop the private insurance market in sectors where it is currently working and other sectors where it can be logically employed. Avoid creating costly state bureaucracies that duplicate private sector capabilities.

- "Grow our own" health care practitioners at all levels as much as possible.
  - In-state education and clinical training increases the likelihood of keeping graduates in Alaska.
  - In-state education stems the flow of education dollars Outside and helps generate a sustainable economy.
  - Create specialized programs to meet the needs of rural Alaska.

- Collaboration and cooperation is essential. The problem is larger than any one part of the system can solve. Areas to address are financing and insurance, workforce development, facilities and citizen education. Private, state, federal and Native resources will need to be coordinated so all can contribute to the solution.

- Generate sufficient information and research, both in Alaska and from best practices Outside, to support sound fact-based decision making.

- Provide sufficient and appropriate facilities where necessary around the state. Emphasize regional planning, coordination, cooperation and efficiency.

- Develop a statewide electronic health record network that is secure and interoperable with existing systems to improve quality of care and reduce waste by providing necessary medical information to providers.

## Elements of reform — Building blocks for a better system

- The problem is huge and complex. Businesses, individuals and governments all must contribute to managing and financing a new Alaskan health care system for it to be sustainable.

- We must stem erosion of employer-sponsored insurance. Keep what works and reshape or fill in as necessary. Reform plans should build on and improve existing parts of the system that work without harming those who are already well served.

- Information to evaluate costs and alternatives before and after treatment is an essential building block of individual financial responsibility. Information access and transparency seems like a basic need, but is elusive. Technology and disclosure requirements will help.

- Encourage adequate federal Medicare reimbursement of provider's costs, but cobble together work-arounds until that happens. This can include creative use of Medicare and Medicaid waivers. Keep track of the changing federal health care environment to uncover opportunities and influence needed change.

- Electronic health records are the cornerstone to modernizing Alaska's health care. Build on existing private and state-level initiatives.

- Develop navigation aids and fail-safe systems to help people gain access to and deal with complexities of the system. Navigation aids must take into account the human, as well as the technological networks, which build healthy lives.

- Alaska has information gaps that need to be filled to chart an optimum path to progress. Fundamental research will enable policy-makers to make sound decisions based on facts: 1. Quantify and identify the source of Alaska cost differentials vs. Outside. 2. Understand who is not covered or insufficiently covered. 3. Continue to define work force development challenges across the full job spectrum.

- Build on the many Alaskan programs that have proven effective or show promise in the areas of quality, access and cost control.

- Monitor and learn from other state's experience in coverage and cost control.

- Alaska will need an ongoing official state-wide group to monitor the ever-changing health care scene and find appropriate synergies.

## Specific immediate steps to consider

- Establish an ongoing Alaska health care council/commission/board to coordinate public policy.
- Support and coordinate Alaska research and monitor national research and developments.
- Develop a variety of Alaska health care reform plans based on research to be able to compare and contrast their benefits, costs and impacts.
- Support the next step in development of Alaska electronic health records.
- Develop and monitor quantifiable health care goals for Alaska.
- Support workforce development capable of filling current and anticipated needs.
- Encourage primary care capability based on the "Medical Home" model which provides an ongoing health care point of contact. Examples are family physicians or community health centers.
- Monitor and improve liability and tort laws to help reduce malpractice insurance costs, encourage quality improvements and make Alaska a more attractive place to practice medicine.
- Encourage schools at all levels to foster healthy life styles and offer sports and exercise programs that build life long healthy habits.
- Work with the federal delegation and authorities to maximize federal support of Alaska projects and programs and to support national health care reform efforts that will benefit Alaskans.
    - E.g. Develop stand-alone Medicare clinics in major Alaska hubs via an open RFP process
- Identify pseudo-reform "myths"—things to avoid.

## Pseudo-reform "myths" — Things to avoid

- Continued employer transfer of health care costs to employees.

- Assuming that "market forces" alone will make health care better and more efficient. Health Savings Accounts (HSAs) may be part of a total solution, but not the only solution. Even enlightened health care consumers do not have access to information they need to "shop around" for best value.

- Freezing or reducing state funding. The State of Alaska will need to make additional financial and programmatic investments as a full partner in a comprehensive solution.

- Reliance on the federal government to solve the problem. National solutions are necessary and hopefully will be forthcoming. However, in the interim, Alaska needs to do what it can to help itself.

- Assuming, hoping or praying that the problem will solve itself and go away. Effective, creative coordination of every tool available within Alaska is the only chance for success. An ongoing, adequately resourced council, commission or board will need to continue the work of the Alaska Health Care Strategies Planning Council.

## Why we need to act now

- As a small state with significant resources, Alaska has the elements it needs to improve the health of its citizens in the long-term.
- Guiding principles will focus the creativity and coordination needed to achieve this lofty, but basic human goal.
- Unchecked, current health trends will create the first generation in 100 years that can expect a shorter life span than their parents.
- Insufficient federal reimbursements are transferring a huge financial burden to the private sector which in turn is passing costs on to employees.
- A mandatory rational system based on the strongest elements already in place can provide basic care for all Alaskans enabling a shift of emphasis towards prevention.
- Investing in prevention and individual responsibility offer high "bang for the buck." Healthy people feel better and place less financial demands on the system.
- The aging population will increase per capita costs of health. These increases can be mitigated by effective primary prevention and health promotion.
- Everyone and all parts of society need to be part of the solution—businesses, individuals and all levels of government.
- The health care system is not a goal in and of itself. The real goal is healthy Alaskans who know they will be properly cared for if they do get sick.

## Background — An unsustainable deteriorating situation

- Many thanks to the Alaska Health Care Strategies Planning Council and key legislators for beginning a formal state dialogue.
- Businesses face annual double-digit increases in health care costs. This necessitates:
  - Cutting back coverage
  - Increasing employee financial contributions
  - Educating and empowering employees to develop healthier lifestyles
- The situation is bad and getting worse.
  - According to a July 2007 Commonwealth Fund report comparing states, Alaska ranks 26th overall, 36th for access and 49th in quality.
  - Medicare and Medicaid do not reimburse providers for their cost of doing business. This "pinch" is being passed on to businesses and insurers, creating an ever-escalating financial burden on them. Health care costs for businesses are a financial ball and chain not shared by international competitors.
  - Many Alaskans are without any health care coverage, or have inadequate coverage.
    - Over 90,000 Alaskans have no health care coverage—if living together, they would be the second largest city in Alaska.
    - Many more are under-insured.
  - Everyone has nominal access to some form of health care at the emergency room, but it is after-the-fact and expensive.
  - Many people in need do not know where to turn because of:
    - Lack of knowledge
    - Lack of money
    - Linguistic and cultural barriers
    - Crushing work and family schedules
  - Alaska is short 300 doctors today, with more needed to replace an aging work force. Similar shortages exist for nurses and other health practitioners.
  - Potential gas pipeline construction will further strain an already challenged Alaska health care system.

- The unhappy net result:
  - Alaska has the highest per capita state expenditures on health care in America ($8,000 per person).
  - America has the highest per capital health care expenditures in the world ($7,000 per person).
  - Alaska and America have poor health compared to other industrialized nations despite having greater expenditures on health care.
  - Alaskan and American businesses are becoming less competitive compared to international businesses in countries with public health care systems.

- A caring, humane and financially efficient society cannot continue this downward spiral. Serious national conversations and major state-level reform efforts are under way. Fortunately, Alaska has potential building blocks for a better system and guidelines to help use them.