ALASKA STATE LEGISLATURE

SENATE HEALTH, EDUCATION & SOCIAL SERVICES COMMITTEE

November 9, 2001

9:05 a.m.

MEMBERS PRESENT

Senator Lyda Green, Chair
Senator Loren Leman, Vice Chair
Senator Gary Wilken
Senator Bettye Davis

MEMBERS ABSENT

Senator Jerry Ward

OTHER LEGISLATORS PRESENT

Representative Fred Dyson
Representative Sharon Cissna

COMMITTEE CALENDAR

Subcommittee on Health Care and Welfare

PREVIOUS COMMITTEE ACTION

See Senate HESS minutes dated 11/8/01.

WITNESS REGISTER

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ACTION NARRATIVE

TAPE 01-51, SIDE A

CHAIRWOMAN LYDA GREEN called the Senate Health, Education & Social Services Committee meeting to order at 9:05 a.m. She announced the committee would discuss welfare reform and the impact that welfare reform has had on Medicaid.

MS. SANDY HOBACK, a consultant under contract with the American Institute for Full Employment, explained that she did an assessment of Alaska's welfare reform effort. She was unable to do an in-depth assessment but believes she hit most of the high points of Alaska's welfare reform efforts during her trip to Alaska this past summer.

REPRESENTATIVE DYSON informed the committee that Mr. Nordlund concurred with a significant portion of the recommendations made in the consultant's report and that he has asked that the recommendations be sorted into three categories: those that require legislative action; those that involve DHSS policy direction; and those that would be good practice. He asked that Ms. Hoback explain the recommendations and that Mr. Nordlund describe DHSS's take on those recommendations.

MS. HOBACK said the first recommendation is to amend Alaska statute to allow Alaska to give full flexibility allowed under federal law to extend benefits to some long-term recipients. Alaska law is currently more restrictive than the federal law regarding the percentage of people who can receive an exemption from the five-year time limit. That restriction unnecessarily puts the state at risk of federal penalties. She recommends using very narrow criteria to exempt people rather than an arbitrary percentage cap. Creating a legislative review process would assure that the program is not being abused or overly used.

MR. JIM NORDLUND, Director of the Division of Public Assistance, Department of Health and Social Services (DHSS), mentioned that the first recommendation is in legislation introduced last year. It removes the strict 20 percent cap on the number of individuals exempted from the five-year limit from state law. The Institute recommends, and DHSS advocates, the use of criteria instead to determine who is exempt from the five-year limit.

REPRESENTATIVE DYSON said that after the review of each recommendation, the committee would like to know whether the Administration plans to introduce legislation to address it.

MR. NORDLUND explained that the Governor introduced two bills last year to address the first recommendation. The House bill passed without that provision. The Senate bill is still in the

Senate HESS Committee.

CHAIRWOMAN GREEN asked if the Senate bill will need to be changed.

MR. NORDLUND said it might.

SENATOR TAYLOR asked how the cap can be repealed if it is a federal requirement.

MR. NORDLUND clarified the federal requirement applies to federal money. States are required to spend a certain amount to participate in this program, but the federal law contains a liberal interpretation of how states can spend the money. The state share of the money can be used to provide benefits for families that go over the 20 percent cap.

SENATOR TAYLOR said he understands that the state does not have to comply with the federal law if it wants to pay the full cost and that federal participation only applies to families that qualify under the federal law.

MR. NORDLUND replied that if the number of exempted recipients is over 20 percent and the state wants to be able to provide benefits beyond that, it has to set up a separate state program that uses state money only. He said it all comes "out in the wash" because a greater share of federal money is applied to the 20 percent.

CHAIRWOMAN GREEN called a brief at-ease.

MS. HOBACK agreed that this matter is essentially a bookkeeping issue because the states' maintenance of effort (MOE) is required. More of the federal dollars can be shifted to the families under the five-year time limit and the state dollars can be used for what is called a state open program.

CHAIRWOMAN GREEN asked if the state's MOE may not pay enough in future years.

MS. HOBACK said a number of states disagree that they should have to maintain such a high MOE.

CHAIRWOMAN GREEN said her concern is that this approach may only work for a few years. She asked if the MOE is a fixed amount every year.

MR. NORDLUND explained the federal law says that the state must

spend at least 75 to 80 percent of the amount of money it spent in 1994, when it was running the Aid to Families with Dependent Children (AFDC) program. The federal block grant, for the current six-year authorization period, is based on the amount of money spent on the AFDC program in 1994.

CHAIRWOMAN GREEN asked if that number can always be calculated so that what happened last year has no effect.

MR. NORDLUND said that is correct.

MS. HOBACK pointed out that in 2003, the federal program will be reauthorized so that issue will be addressed at that time. At the very least, Congress will draw a different line and not hold states to 1994 levels.

SENATOR TAYLOR commented that under that federal law, no state has been able to achieve a savings greater than 25 percent of the 1994 base. He asked:

> Is that why some states have now branched out and are utilizing some of those funds as opposed to welfare payments? They are now showing up in the form of education grants and opportunities for welfare to work programs and that kind of stuff. Is that what's happening in those other states?

MR. NORDLUND said essentially yes, but there are strict limits on what TANF dollars can be spent on. Some states have gone beyond what has traditionally been the AFDC program. He explained that in Alaska, the savings from fewer benefit dollars have been used to replace general fund dollars used for childcare. Those federal funds have to be used for programs related to TANF.

CHAIRWOMAN GREEN asked if the legislature should do anything to prepare for the federal reauthorization in 2003.

MR. NORDLUND said no one knows what the federal reauthorization will look like. He believes the best thing to do is advocate with Alaska's congressional delegation. Most states are asking that federal funds not be cut because even though the amount of benefit money has decreased, states are using those funds to make general fund savings elsewhere. States are also asking for continued flexibility. He believes one of the reasons welfare reform has been successful is that states were freed from the shackles of federal rules.

CHAIRWOMAN GREEN asked DHSS for a model of how the state and federal funds saved by welfare reform have been redirected in

Alaska, where the state has flexibility, and the consequences of different actions the state might take.

MR. NORDLUND noted that he prepared a handout for committee members that shows how funds were spent before and after welfare reform.

SENATOR TAYLOR noted Ms. Hoback found that DHSS has no formal process in place to provide additional staffing to ensure that as few families as possible reach the five-year limit. She recommended an additional statutory change to create a separate state program. He asked if that statutory change is in the bill before the Senate HESS Committee.

MR. NORDLUND said DHSS is in the process of figuring out whether statutory authority is required to create a separate state program.

SENATOR TAYLOR asked if DHSS supports a separate state program so that the state can avoid federal penalties.

MR. NORDLUND said it does and he offered to follow-up with the committee on the need for a statutory change.

MS. HOBACK said the second recommendation is to develop a progressive sanction system for clients who are not cooperating. Alaska's sanction policy is to remove the adult needs from the grant, which results in a 40 percent reduction. No penalty is associated with the first sanction. The second sanction lasts for six months and the third and subsequent sanctions are for 12 months. 37 other states use a different strategy: the first sanction results in a very small grant reduction of $50; the second sanction results in the removal of the adult needs; the third sanction can result in full closure of that grant. However, any of the sanctions can be "cured" with cooperation so that prolonged penalties do not have to occur. She feels that prolonged penalties work as a disincentive to cooperation. As long as individuals are on prolonged sanctions, the time clock continues to tick. She said it is more effective to close the grant if a person will not cooperate and reopen it when he or she wants to cooperate. She noted that in almost every state that imposes full family sanctions, sanction rates have been reduced because there is a great deal of incentive to cooperate when the alternative is to lose all benefits.

MR. NORDLUND acknowledged that DHSS is reviewing its sanction policies as they have not worked very well. He pointed out that a person who is sanctioned and then immediately tries to comply

may not be eligible for six months. The reward for compliance is so delayed, it is not much of an incentive. DHSS has not decided whether it wants to implement full family sanctions and would like to discuss that matter with the legislature.

CHAIRWOMAN GREEN asked whether DHSS will have a position on that issue before the legislative session.

MR. NORDLUND said it could but he felt DHSS should have an interactive discussion with the legislature on this issue because there are different ways to design the sanctions. He pointed out that if a full family sanction regime is used, DHSS would want to implement another level of scrutiny so that no mistakes are made.

MS. HOBACK said the next recommendation is in regard to the diversion program, which is an upfront process to get people employed before they sign up for cash assistance. Clients could get up to two months worth of assistance in exchange for not applying for full cash assistance. During interviews across the state, she found very few clients took advantage of it because the amount of money was not enough to allow people to be self-sufficient. She suggested the diversion program needs closer review and, at a minimum, pay at least three months of cash assistance to entice people to use it. She also believes there is room for improvement in the process of engaging applicants when they come through the door. People should immediately understand that the entire process is about becoming employed versus becoming eligible for benefits. She pointed out that effective programs in other states are able to divert a significant percentage of applicants into employment.

MR. NORDLUND agreed the program has too much of an eligibility focus rather than a self-sufficiency focus and stated a statutory change would be the simplest because the program needs to be "operationalized" in a different way.

REPRESENTATIVE DYSON felt the mindset of the staff will have to change.

MR. NORDLUND said he believes the mindset of staff has changed but the bigger problem is the process, which has an eligibility focus.

REPRESENTATIVE DYSON asked if DHSS needs legislative help to change the process.

MR. NORDLUND said it does not and that most of the recommendations in the report are management priorities. He

pointed out DHSS is not asking for statutory or financial help since the recommendations require operational changes.

MS. HOBACK said the final legislative recommendation is to authorize a more complete wage subsidy. The State of Oregon has a very successful private sector wage subsidy program that cashes both the food stamp and cash grant benefits out to use as reimbursement to private sector employers who are willing to work with TANF recipients and provide them actual training opportunities for up to six months. This has been a very successful tool to get people engaged in the private sector, especially in the more rural parts of Oregon where it became an economic development tool. It allows businesses to explore expansion of their businesses when they otherwise would not have sufficient capital. Oregon purposely puts its more barrier-prone clients into those opportunities so it ends up being a very cost-effective tool for the state and a good economic development tool for employers. She noted that many people believe the new on-the-job training approach used in Alaska will not provide sufficient incentive to get many employers involved.

MR. NORDLUND said DHSS definitely wants to look into this recommendation and believes it can be implemented with policy changes.

REPRESENTATIVE DYSON said he is surprised that TANF funds can be given to an employer instead of a recipient and he would be surprised if DHSS has the flexibility to do that. He commented that the recommendations will require a complete change that he does not think can be done incrementally.

MR. NORDLUND said he believes the concept is valid. One reason DHSS has not employed it is that the economy has been very good. However, two factors are now coming into play, one being that the people who were easiest to get employed are and second, the economy is starting to turn around. Looking at greater incentives for employers to hire people is something that DHSS needs to address at this time.

SENATOR TAYLOR asked Mr. Nordlund to suggest statutory changes if he discovers they are necessary to implement the recommendations.

MR. NORDLUND said he would but pointed out that Senator Green's welfare reform bill that passed several years ago contained broad language that pertained to work supplementation. He believes that language provides the statutory authority to run this program the way it is envisioned.

REPRESENTATIVE DYSON said the legislature could also revisit DHSS's missions and measures statement.

CHAIRWOMAN GREEN asked Ms. Hoback to review welfare reform policy priorities.

MS. HOBACK said the first recommendation is to change the childcare co-pay schedule to avoid the "cliff" effect. The current co-pay schedule is stair-stepped, similar to the tax code, so that a small increase in income can create a large increase in the co-pay amount. Consequently, a person could get a raise but take home less pay.

TAPE 01-51, SIDE B

YVONNE CHASE, Deputy Commissioner of the Department of Education and Early Development, said Ms. Hoback's description of the "cliff" effect is very accurate. It is a problem that many states have grappled with. Oregon is one state that moved to eliminate those cliffs. A working group has been reviewing the problem and expects to eliminate the "cliff" effect in Alaska by next July. The working group is facing a couple of challenges: it is trying to make sure that it can be accomplished for the individuals with the lowest income while maintaining cost neutrality. She believes the working group has designed a system to accomplish that and will take regulations to the state board at the end of this month for public comment. Right now, a low-income person may pay 3 percent of childcare costs while the state pays a 97 percent subsidy. A 50-cent per hour raise may change the equation so that the state subsidy drops to 85 percent. The State of Oregon implemented a system where the person is given a couple of months of extra assistance when he or she moves from public assistance to get on their feet. In addition, a sliding scale with a curve is used. At the same time, the top end of the scale needs to be reviewed to determine at what point a person's income is sufficient to move out of the program. DOEED looked at a broad overview of the caseload in the Palmer-Wasilla area and found that public assistance clients needed a lower subsidy as their wages increased.

CHAIRWOMAN GREEN said in some cases, it would not be worth accepting a salary increase so she thinks the changes will be great. She reaffirmed that this change will require no legislation.

REPRESENTATIVE DYSON said it is his desire that whatever tracking system is used to qualify a person for benefits be used to qualify a person for other programs so that the person doesn't

have to go on a pilgrimage from department to department. He said he would like to see departments transmit electronically and plans to follow up on that issue.

CHAIRWOMAN GREEN said she believes creating a seamless process for state program eligibility will be a priority over the next few years.

DEPUTY COMMISSIONER CHASE agreed that it is something DOEED needs to look at and, in discussing the issue with Mr. Nordlund, she believes they have a solution that will not only be seamless but will drastically reduce the need for the client to appear in person. She explained that as the parent moves from being a client of public assistance toward self-sufficiency they would move into a different childcare subsidy system, if it is still needed. An interagency process could take place without the client seeing much of that movement.

CHAIRWOMAN GREEN asked Ms. Hoback to continue discussing the Institute's recommendations.

MS. HOBACK said the next recommendation is to revise the policy and practices for treating individuals limited by incapacity from full participation in work activities and require mental health and substance abuse treatment when needed. She believes the agency is working to change this policy. The Institute recommends that if a doctor says a person is incapacitated, the exemption be to the level of capacity so that, for example, the person might still be capable to work part-time. People with mental health, drug or alcohol issues should be required to undergo treatment as a part of that plan.

SENATOR TAYLOR noted that the way the regulations are now written, an exemption is provided so that substance abusers do not have to comply. He said that is one of the most backward policies he has ever heard of.

MR. NORDLUND said the confusion stems from the fact that when the regulations were adopted, DHSS didn't want to require substance abusers to participate in work activity because they would not be good employees. However, the regulations did not require participation in a treatment program; that is the change that will be made.

SENATOR TAYLOR asked if that regulatory change is being made now.

MR. NORDLUND said it is.

MS. HOBACK continued and explained the next recommendation requires clients who claim a disability to file for federal disability benefits. The Supplemental Security Income (SSI) program is federally funded. If, in fact, a person is too disabled to participate in a work program, that person should be required to file for those benefits.

MR. NORDLUND indicated that policy is being changed. He added that the SSI benefits are a little more generous than ATAP benefits and not time limited.

SENATOR TAYLOR asked if ATAP benefits will be cutoff if the client does not apply for SSI disability status.

MR. NORDLUND said it will probably be an element of their family self-sufficiency plan so that anyone who does not comply with that plan could get sanctioned. He cautioned that these are truly the neediest of clients so DHSS would want to make sure they do not fall through the cracks.

SENATOR TAYLOR expressed concern that 65 to 70 percent of SSI applicants will be denied because the federal government has stringent standards for that program. He cautioned that requirement may not provide any significant help to them or to the state.

CHAIRWOMAN GREEN said the fact they are denied SSI payments would not disqualify them for state benefits.

MR. NORDLUND said that is correct and added that many people who are denied are accepted on appeal. DHSS would just want to make sure they go through the application process.

MS. HOBACK said the last recommendation is to reduce the 12-month exemption period for parents of infants to 16 weeks. The parental leave law in Alaska allows up to 16 weeks of leave. It is inconsistent that ATAP clients are not required to do anything for 12 months. Most states have reduced the exemption period to the amount provided in their parental leave laws.

MR. NORDLUND said DHSS is pursuing that change in regulation as well. He pointed out that change will create an increased need for childcare, which is not easily available for infants.

DEPUTY COMMISSIONER CHASE stated the difficulty of finding infant care and childcare during non-traditional hours will have to be remedied. That remedy might require providing incentives for providers.

CHAIRWOMAN GREEN acknowledged that dilemma in the Mat-Su Valley.

DEPUTY COMMISSIONER CHASE said she believes that most of the providers who are not licensed could be licensed fairly easily. DOEED has also been working to reduce the amount of paperwork involved.

SENATOR TAYLOR said childcare is a critical component of welfare reform, which is why he is very concerned about current policy. His district has actually lost daycare providers because of that policy. He is seeing fewer children placed in daycare while DOEED's policy is to enhance and increase daycare facilities.

DEPUTY COMMISSIONER CHASE offered to review the specifics of Senator Taylor's district but noted that slight modifications were made to the staffing ratios. DOEED did go back and make some adjustments so she believes the final regulations that were adopted did not contain the numbers that Senator Taylor expressed concern about. DOEED also provided incentives and increases for licensed providers who care for infants and toddlers.

CHAIRWOMAN GREEN asked if they need to mold something a little different for the childcare piece since it is not K-12.

DEPUTY COMMISSIONER CHASE replied that they are working through that in the department and are looking at readiness and safety for children.

MR. NORDLUND said they are in the process of doing intensive staffing as the first families to hit the 60-month limit will do so next July. Each client needs a case manager, eligibility technician and a social worker.

SENATOR TAYLOR asked about the geographic factor. He asked if DHSS assumes clients don't have to find work because there just isn't any work out there. He had the feeling that the only people who would be cut off of welfare are folks in Wrangell, Petersburg and Ketchikan and that a lot of people out in the villages wouldn't be cut off.

MR. NORDLUND replied that the geographic distinction is in federal law and says that Indian reservations and Alaska Native villages with effective unemployment rates over 50 percent and families living in those villages, Native or not, are exempt from the five-year limit. They are still required to pursue self-sufficiency activities, like some community work experience. There is limited effectiveness in how well they apply that

policy.

SENATOR TAYLOR asked how to get classified as a Native village, because that's what his district needs.

MR. NORDLUND replied that they are the villages listed under ANCSA.

SENATOR TAYLOR commented on the disproportionate aspects of ANCSA.

MR. NORDLUND said this administration played virtually no role in that. It was a federal decision driven more by reservations in the Lower 48. Our congressional delegation made sure Alaskan villages were included. It is recognized by many people in the Native community as a double-edged sword. He added there is a lot more they could do to get folks in the villages to contribute to the community, by using the school districts for instance.

An unidentified male speaker said with that in mind, he favors performance standards for staff and performance based contracting so that employees are rewarded for the number of job contracts rather than the number of cases they handle.

MR. NORLUND said they take those things to heart and those are the things they are most enthusiastic about in this report. They plan to hire a consultant to help improve their case management system. One of the key issues is to establish true performance measures that work with associated penalties and bonuses.

MS. HOBACK said these issues really have to do with accountability and Mr. Nordlund has been very receptive. She thought they could increase the utilization of [indisc] training in the villages and more community service things. She thought they should merge the food stamp program into the DPH policy unit because there is a difference in philosophies in the two departments around the importance of employment. The easiest way to have a common philosophy would be to merge those units.

CHAIRWOMAN GREEN asked if any state distributes welfare benefits in the form of no-interest loans versus grants.

MR. NORDLUND said he didn't know of anything like that. Ms. Hoback said she didn't either, but some states offer low-interest housing loans as incentives to people as opposed to the cash grant program.

SENATOR TAYLOR thanked Ms. Hoback and the American Institute for

Full Employment for everything they had done and Mr. Nordlund and his staff. He believed they have made a conscientious and professional effort to figure out a way around some of these problems.

9:19 a.m.

MS. KAREN PEARSON, Director, Division of Public Health, DHSS, introduced Dr. Beth Funk, physician and manager of Infectious Disease Control, and Dr. Lynn Lucher, Ph.D, who does lab tests on all specimens that have come to the DHSS lab. She thanked the legislature for helping DHSS get a new lab. Without it, their specimens would have been sent to another state and put in line when they were trying to figure out how to let communities know what to do in case of a bio-terrorism attack.

TAPE 01-52, SIDE A
9:49 a.m.

MS. PEARSON said local communities don’t have to know who all of the players are. They support the 24/7 operation of the Emergency Coordinating Center because it is a central point of contact any time of the day or night. However, in the process of dealing with the bio-terrorism threat, the legislature needs to make sure that it doesn't "drop the ball" on other diseases. They need to discuss what sort of minimum capacity needs to be maintained in Fairbanks, so that if the Anchorage lab went down, another would be available.

She said the public perception of the public health system has been changing with the events of 9/11. The system in Alaska has been stretched very thin since then and DHSS has a 50 percent vacancy rate in staff positions. The job is getting done, but discussions are needed.

CHAIRWOMAN GREEN asked her if the vacancy rate is due to attrition.

MS. PEARSON answered it's because of the lag in salaries; 50 percent means seven positions - laboratory RNs, a tech and microbiologists 1, 2, and 3. She explained that to deal with the situation, DHSS has gone into an emergency mode and created exempt temporary positions. It can raise salaries a bit, do some serious recruiting and not "burn out" and lose the staff it has.

CHAIRWOMAN GREEN asked if staff is on contract.

MS. PEARSON replied that they are temporary positions.

CHAIRWOMAN GREEN asked what the typical salary is.

MS. PEARSON replied range 14 - 16 with 18 being the top. Those are pretty low ranges when the low range has a Ph.D.

CHAIRWOMAN GREEN asked if they have requested a salary study be done.

MS. PEARSON replied that DHSS just requested one from the administration and hopes to have it done within a year.

CHAIRWOMAN GREEN asked if it would be a statewide employee review.

MS. PEARSON replied that the request came from DHSS, but she understands that it would look at every department with people in that classification.

CHAIRWOMAN GREEN commented that a legislator’s salary equates to a range 8.

MS. PEARSON responded, "Well then, we'll all work on this together."

CHAIRWOMAN GREEN said her concern is that bio-terrorism could happen, but it might not. In the meantime, TB and other infectious diseases, which could be the equivalent of bio-terrorism - especially in Alaska where some populations are in third-world conditions, are on the increase. She asked how to make sure the state is at least staying even with those.

MS. PEARSON said that is a good question. DHSS tried to address that last year because it does not believe it has the basic capacity to respond to all the infectious disease in Alaska or to do testing and checking to prevent outbreaks. She said DHSS would be asking for this funding and terrorist funding at the same time.

SENATOR TAYLOR said that for the past 20 years, Alaska has had emergency response teams and a tremendous amount of bureaucracy to make sure that every token individual within a community that might have any level of authority would be included within the plan, which was generated by the Exxon Valdez incident. He thought that they should be able to apply information from that process, like communication systems. He asked if she had thought about using systems already in place.

MS. PEARSON replied that everyone is at the table with this issue. The EMS people have been a part of the bio-terrorism planning team. A lot of things are in place, but people need new and additional training to be able to respond to something different.

SENATOR TAYLOR said his other concern is if an unforeseen event occurs, Alaskans are so dependent on air travel, i.e., the hospital in Ketchikan gets medications delivered every other day by airplane. His staff found that no one coordinates transportation of blood and other medical supplies in Southeast.

DR. FUNK said they are working on those kinds of things now. She works with one program within the section of epidemiology with the infectious disease program, which includes TB and other diseases like gastrointestinal flu borne illness outbreaks or hepatitis. They have worked for the last two years with other sections in the Division of Public Health, other partners throughout the state and other systems, Anchorage in particular, to start setting up an infrastructure for responding to bio-terrorism. Everyone was caught by surprise.

The Division of Public Health has found that the relationships they have been working on are really paying off. At the State Emergency Coordination Center (SECC) she helped complete a survey and write up to send into the Department of Justice about the infrastructure for emergency and public health response in communities statewide. As a result, they will receive $1.2 million from the Department of Justice for communications and other emergency equipment.

SENATOR TAYLOR asked if anyone is assessing private industry.

DR. FUNK said to her understanding, not many private contractors have level B suits needed to go into a chemically contaminated area. Those are issues they will have to focus on.

An unidentified male said the question is why would Alaska be attacked. He answered it is because of the oil pipeline and our military capacity. He said we have to ask what will make us safer and what will work best with Alaska’s cool temperatures and wind patterns.

DR. FUNK said that every climate has some of those issues, but even if Alaska isn't a target, we have to "be in the game" because of the mobility of the population. A biological agent has an incubation period of a few days to several weeks.

DR. LUCHER said her job has been to make sure the state laboratory is prepared to do the testing necessary to confirm the presence of bacteria distributed by CDC as being those of greatest concern for intentional release in bio-terrorism. Every state lab has a CDC trainee to do tests, but it's up to her office to train other key personnel to test as well. They also must to get the word out to hospital laboratories because, in the case of a covert release, they would do the initial patient

specimen work. This new focus has increased and improved their relationship with other clinical laboratories in the state.

One problem, from a disease surveillance standpoint, occurs when specimens or bacteria isolated from specimens get sent out of state to another reference lab, it is difficult to capture important information. This is a problem in some parts of the state more than others. If DHSS builds on the terrorist initiative to improve its working relationship with clinical laboratories, they will hopefully get more specimens that should be coming to them anyway and allow DHSS to keep better track of disease incidents in the state.

SENATOR TAYLOR asked if there isn't a practical difficulty in achieving that since Southeast has historically shipped its specimens south because it's cheaper.

MS. LUCHER said that is true, and if they can't improve increased specimen flow to the state lab, they want to at least make sure the information comes to them or epidemiology, especially regarding certain types of food borne diseases like e. coli 0157h7. One other thing she helped work on at the state lab is molecular subtyping of bacteria because it's important to know if five cases are really caused by the same organism or not. Getting key bacteria would definitely improve disease surveillance.

CHAIRWOMAN GREEN asked what kind of networks are available to communicate with the private sector in an emergency.

MS. LUCHER answered that the best example to illustrate that concept is the way they are working to engage hospital laboratories in looking for bio-terrorism agents. Hospital labs can take cultures, reduce the choices, and then send it to the DHSS lab where the bacteria can be identified.

CHAIRWOMAN GREEN asked how many hospital labs are in Alaska.

MS. LUCHER replied there are about 26 distributed across the state.

SENATOR TAYLOR remarked that everything they are talking about today is dependent upon an airplane transportation system that is working. He assumed they had some sort of protocol set up.

MS. LUCHER replied they do with the military.

CHAIRWOMAN GREEN said they are doing a wonderful job and encouraged them to keep up the good work.

11:36 a.m.

MR. DAVID PIERCE, Health Planner, said he is also known as the CON (CON) Coordinator and that the CON office has been active since 1976. Most states established CON offices in the 1970s; 74 percent of states still have CON programs.

CHAIRWOMAN GREEN interrupted him to say the reason they are talking about it at all today is because it's tied in to Medicaid.

MR. PIERCE explained that some of the big issues CON deals with are rational development of health care, quality of care, access, decreasing unnecessary duplication and cost containment. It also has a public involvement component where people who are involved in the projects have input into the process. Most projects are approved, but over the past 20 years about 500 nursing home beds were proposed and not built. If all those beds had been built, it would save about $60 million per year.

Other states like Texas and California contract for certain numbers of beds rather than review projects as they come in. Other states have also put moratoriums on construction to limit growth. CON programs vary by state depending on the need. One of the key issues to think about in Alaska is that the small populations are served.

CHAIRWOMAN GREEN asked him to explain that further.

MR. PIERCE replied that some types of care will only be accessible in the larger communities. Alaska doesn't have a CAT scanner, a type of radiology that detects cancer.

TAPE 02-52, SIDE B

There must be a certain level of use to be able to support a piece of equipment financially. Also, certain types of services, like open-heart surgery, need to be used enough to maintain the skill level of the physicians or there will be more complications with those surgeries.

MR. PIERCE said that approximately 86 percent of the nursing home bed care is Medicaid related. The average cost of a day in a nursing home statewide is $306. So, basically, every 10 nursing home beds is going to cost $1 million to Medicaid.

CHAIRWOMAN GREEN asked for an example of [indisc] versus long-term care.

MR. PIERCE replied the Mary Conrad Center has 90 beds and they are all full.

CHAIRWOMAN GREEN asked if anyone who walks through the door and

qualifies for Medicaid can stay in that bed.

MR. PIERCE replied no. There are two kinds of payments. The other 14 percent of people are private pay or Veterans Administration.

CHAIRWOMAN GREEN asked if they are not in the CON process and Mary Conrad needed 10 more beds, Medicaid would have the ability to say the beds weren't approved therefore they wouldn't pay.

MR. PIERCE said no, because once a place is licensed as a Medicaid provider, it is able to take patients.

CHAIRWOMAN GREEN asked why they would then need a CON.

MS. JANET CLARKE, Department of Health and Social Services, said Mr. Pierce was talking about licensing, which comes after the CON process, which comes prior to construction. Long-term care has been the concern of the Alaskan legislature, which declared a moratorium on it for a number of years. "When David says that once you're licensed, if someone comes in they are eligible for that is correct, but the CON process is where the review happens."

Typically, a person needing skilled long-term nursing care is not eligible right away because they have to spend down some of their assets.

SENATOR TAYLOR commented that we have to bankrupt them first.

MS. CLARKE said that was right.

CHAIRWOMAN GREEN said she didn't want to be protected by the government all the time and she finds it strange that someone in an office in Juneau can determine how many CAT scanners can be in the state of Alaska. A hospital should be able to go out and buy one - and go broke if that's what happens.

MS. CLARKE replied that a few years ago the legislature passed amendments to the CON law making care more stringent requirements for long-term care - because the legislature was concerned about the implications for Medicaid.

CHAIRWOMAN GREEN said there had been three major attempts to revise the process.

MS. CLARKE said she understands what the Senator is getting at, but:

> What I was trying to get at is that the CON program as far as considering cost implications to Medicaid - based on the law - can only do that for long-term care.

> For the other parts, acute care or CAT scans, they can't consider the implications for Medicaid or cost. It's based on need and access, etc. The way the legislature has structured the law, there are two different review standards, and I think, because of the implications for Medicaid.

MR. PIERCE said one important thing to remember is that there's only one market in the state, Anchorage, where there's competition between hospitals. In most of the other communities there is one facility. In these cases, if someone goes bankrupt, you end up with people not having anything.

SENATOR TAYLOR said he wanted to get away from the Medicaid aspects of this.

> Why should anyone have to go through the process if economically they believe it's a good investment for them to put in an MRI or should they tell all patients in Ketchikan you can't have an MRI here. You need to buy a $350 - $400 airplane ticket and fly up to Juneau and use Juneau's machine, which, by the way, hasn't been approved yet, either.

CHAIRWOMAN GREEN asked if he knew of any case where people had been denied access to Providence.

MR. PIERCE replied that he didn't know of any circumstance like that.

MS. CLARKE reminded everyone that CON applies to capital construction of over $1 million; it's not for operating costs.

MR. PIERCE said a lot of health care is moving from the in-patient to the out-patient areas. He said, "Hospitals do a variety of things that some of them get more money than what they pay out in costs for the service."

CHAIRWOMAN GREEN asked for an example.

MR. PIERCE replied a critical care unit or an ICU or maybe in-patient services.

CHAIRWOMAN GREEN commented that this was more discouraging to her than encouraging.

MR. RICK JOHNSON, Valley Hospital Operating Board of Directors, said he thought what Mr. Pierce was trying to say is that there is a concern about "cherry picking." He said:

> If you open up an out-patient surgery center and are in direct competition with Valley Hospital where we have to accept a reduced rate for Medicaid and Medicare, then all those services are going to go elsewhere where we make some money to be able to support our community hospital - that's going to be gone.

CHAIRWOMAN GREEN said everyone understands that. She was concerned that hospitals operate under a different set of rules when it comes time to make their reports to the federal government and when they pay taxes.

MR. JOHNSON said that was correct.

CHAIRWOMAN GREEN said she was perfectly willing to have his Board make decisions and not have an office telling them what they can and can't do.

MR. JOHNSON asked what happens when they don't have a CON process and someone opens up a shop "out here" and takes everything away from Valley Hospital that makes money.

> I'm not saying that we shouldn't be efficient and being able to compete, but we need to be able to do that - but they take everything else away from Valley Hospital and we don't have an opportunity, because we have to take everybody that walks through the door. We have to take Medicare and Medicaid patients at a lower reimbursement level and the only way that we can support ourselves is through profit centers. These other folks that open up a facility out here, they don't have to take Medicaid or Medicare.

CHAIRWOMAN GREEN asked:

> Who's to say that they don't want to take low pay, co-pay private - just like the whole raft of assortment that you ... Are you saying that because the law doesn't require them to do that?

MR. JOHNSON said that was correct.

CHAIRWOMAN GREEN said maybe that is the point they need to address. She found it strange that he would turn over his decision-making ability to an agency in state government.

MR. JOHNSON agreed and said it is a strange paradox.

12:25

SENATOR TAYLOR expressed concern about the different rates charged for the same service. He noted:

> Because they have a ticket to play, they are the only game in town and that CON becomes how do we protect our monopoly to make certain that nobody else does come in and cherry pick. There's never been a level playing field; there's not going to be one.

MR. JOHNSON responded:

> But, we have requirements, but how do we correct those federal requirements, the state requirements that we have…We only get x amount of reimbursement on those particular things and we have to accept everybody who walks through the door and somebody can go down the street and open up a shop and they don't have to take them.

SENATOR TAYLOR said, "You have my complete sympathy; I understand. I was just trying to clarify the reality of where we are at today."

CHAIRWOMAN GREEN said she thought they could set aside the federal requirements. She doesn't have any delusion about making any substantive change in the CON process.

MR. JOHNSON said he is just looking for a level playing field.

CHAIRWOMAN GREEN said the problem is how to get there.

MR. JOHNSON said their strategic plan is to build a new facility to double their capacity and he doesn't want to have to go through the CON process. He is concerned that other people can build a facility and not have the same requirements that his hospital does.

MR. PIERCE said they are trying to educate administrators on how to get up to speed on the CON process.

SENATOR DAVIS asked if 74 percent of the states use the CON. Mr. Johnson said that is correct.

SENATOR DAVIS asked if he knew what the other states did who did not use that process and what kind of problems did they have.

MR. JOHNSON said he could get her some information.

SENATOR DAVIS said information on things that are working in other states might help the situation in Alaska.

MS. CLARKE said some other states might contract for a certain number of beds and that's all Medicaid will pay for.

SENATOR DAVIS responded:

> Are we going to address the Medicaid issue here or are we going to address the CON issue. The Medicaid is something we can fix ourselves, because it's the state…. The CON has to do with the hospitals building new buildings or not allowing someone else to buy a piece of equipment. That's where the problem is.

MS. CLARKE responded that the CON program was developed in the ‘70s to look at health planning and that's still the construct of the state statute. "It's a health planning process and actually some communities find it helpful..."

She said they could give the committee information on what is working in other states, but they didn't have it with them today.

REPRESENTATIVE DYSON said he talked to some doctors who said if they are given tax free status, they would be glad to take all clients.

SENATOR TAYLOR said the federal government provides a system of public health and a system of veterans health and native health centers. Each of those is a form of socialized medicine with the doctors working on a salary. The private enterprise system starts to get involved with the CON process. He asked if the CON application had been approved for the Sitka hospital.

MS. CLARKE said they are always looking for ways to improve the system.

SENATOR DAVIS said she would like to see some recommendations from her Department.

MS. CLARKE replied that she didn't have recommendations because they are in the midst of implementing regulations from the last major change to the long-term care part of the CON statute from 1999. She said they received a lot of comments and they would be renoticing those regulations. She would be interested in talking about the rest of the program, however.

CHAIRWOMAN GREEN said she really appreciated everyone's comments and asked people to send her their opinions and suggestions on this issue.

MR. ROB GOULD, Fairbanks Memorial Hospital, said:

The cherry picking is what really concerns the facilities. The fact of the matter is, I understand we are talking about Medicaid, but most facilities or most people who want to put in a surgery center or an MRI, they aren't doing it to target Medicare and Medicaid, because those payers do not pay costs. They want private insurance where they can negotiate and bill what they think is reasonable and get a reimbursement that either makes a profit or at least pays costs. So, one of the big issues is that for health care facilities and I'll just take out a hospital, for example, and an MRI. Let's say it was open and realistically for around $1 million you can get an MRI, give or take $100,000. If there was not a CON required for over $1 million and there were five in this community, we would not be able to have an MRI at this facility. The others are not going to be open 24 hours a day.

We are required to take patients 24 hours a day; we are required to take every patient regardless of their ability to pay and that's where the playing field is not fair. It's not an Alaskan issue; it's a societal issue of how are you going to level the playing field. Nobody would do long-term care beds; nobody would do in-patient beds, because they don't pay for themselves. The overhead is too great; you have to have other services to complement them. The problem is that there are very few industries in the United States where the government can dictate what they're going to pay you. If you're going to buy 100 trucks, you don't go to Ford and say we're going to pay you $50 per truck; they go to Ford and GM and five others and do a bidding process; but this is such a large portion of our population that the government is paying for that they can't do that - especially in small rural communities of which a majority of Alaska is. They don't have that ability and you loose some critical services in these rural communities when you let people start cherry picking.

CHAIRWOMAN GREEN asked him for an example of a small community.

MR. GOULD replied that Fairbanks is considered urban, but they don't have the volume for cardiac services. They do not have enough heart cases for a cardiac surgeon to remain proficient. His hospital is open 24 hours a day and staffed to accept a patient at any time. Surgery centers shut their doors at 5:00 and

patients with complications from a surgery would end up on his doorstep.

TAPE 01-53, SIDE A

MR. GOULD said if they go through the CON process, it's because they want the Medicaid dollars. But they really want the private insurance companies that pay the majority of the costs, because government only pays about 80 percent of costs. Private insurance companies pay about 125 percent of costs. He stated:

> So, any of us that are insured by insurance are subsidizing anybody that is on the government system, whether it be Medicaid or Medicare, because of the fact it has become so expensive it is very difficult to pay costs when you are such a large payer. We're lucky. We have a young healthy population compared to many states and our Medicare population is very low… But it is difficult in those kind of communities to operate where you are only getting Medicare reimbursement.

MR. GOULD said he is having trouble staffing his own rooms right now. If another place opens, they have to find the staff for it. He guesses that they will try to pay higher wages and take from Fairbanks Memorial Hospital. He thought they needed most help in work force development.

CHAIRWOMAN GREEN said she expected a letter from him, but didn't expect to get letters from patients who signed the form on the counter at his hospital.

MR. GOULD said he was not aware of that.

CHAIRWOMAN GREEN said she wondered whether the hospital associations chose to provide services that are actually functions of the social service arm of the State of Alaska or of the community. She didn't want them to use that as ammunition against someone else providing competition.

MR. GOULD said, "We don't even have an HMO in Alaska, because there is no way to have a profitable HMO in this state…. We don't have a large enough population to spread the risk."

CHAIRWOMAN GREEN asked if HMOs are forbidden by law in Alaska.

MR. GOULD replied no. He understood that two companies had asked for the license package, but haven't responded. Experts say that it takes between a half million and one million people in an HMO plan for it to be financially viable.

MR. RICK JOHNSON said he is also an insurance agent and that HMOs are not prohibited, but there isn't enough population.

12:36 - 1:36 p.m. LUNCH BREAK

CHAIRWOMAN GREEN recapped that they are trying to see how Medicaid works within the greater scheme of lots of things that impact costs of doing business in Alaska. One thing that continues to come up is access to insurance for the general population. Policy makers often have to mandate coverage. They tried to find a private plan for Kid Care, but weren't able to do that. Currently, there is legislation at the federal level that may increase that program which again increases Medicaid and reduces our pool in the State of Alaska. If Congress decides at some point they don't want to pay, who picks up that difference, she asked. She said the State of Alaska already has the ACIA and wondered if the definition of ACIA could be expanded.

MR. CECIL BYKERK, Executive Vice President and Chief Actuary, Mutual of Omaha, said he is also Chairman of ACIA and has been with it since 1992. He said that ACIA had been reasonably successful at providing coverage for a modest number of individuals who had been unable to get insurance. They began issuing policies in 1993, grew to 175 people in the middle of 1995 and grew at a very slow rate after that. Beginning in late 1998, they began to grow more rapidly and in late 2000, they started almost jumping. They are not completely sure of all the factors that impact them.

> However, more carriers are getting out of the individual market, not just in Alaska, but nation-wide. Healthcare costs and, as a result of that, premiums are going up dramatically across the country and in Alaska as well. We're routinely seeing in the individual market premium increases of 20 - 25 and in some cases 30 percent a year on a premium that was already fairly hefty. We have that sort of market environment that is out there. Alaska has obviously many unique characteristics. I think that the individual private insurance market place in Alaska is probably for the most part somewhat [indisc] of what's going on around the country.
>
> ACIA is the mechanism by which the state met the federal law that's commonly called HIPA, which attempts to provide affordability to individuals who had employer coverage or church coverage or government coverage and were loosing that coverage for one reason or another. Those individuals can come in to ACIA without being a high risk individual as a result of

that approach in that legislation. We have some people coming in under that arrangement.

MR. BYKERK said they have an annual board meeting at which people testify and it is rewarding when they can provide coverage. Even though the individuals are paying a premium for their coverage, the intent is not to compete with the private market, but to add on to it with people who are otherwise uninsurable.

However, besides paying that premium, there's a shortfall, which is picked up by assessing all of the insurance companies that provide major medical insurance in the state. That assessment base is limited to insured plans. Employers that use self-funded plans do not contribute to the assessment. We are only allowed to actually assess on the basis of the actual insurance premiums. We currently in Alaska are assessing the carriers around 1.5 percent of the premium. While on the surface this is 1.5 percent that the insurance carriers have to pay out, in essence it's 1.5 percent of additional premium that the insureds will end up paying - because they have to in effect pay the bill. So, we have the phenomenon that the healthier insured people are to some degree footing the bill for the uninsured. That's the way our high risk pools work across the country and that's how their intended.

However, the fact that Alaska has reached 1.5 percent in the premium assessment is of concern to the Board. Typically, insurance carriers across the country feel that they are well to have assessments get to about one percent. They really feel that above that they're really starting to add on additional premium to their customers, which the customers are already paying enough. That is one area of concern for us. There are mechanisms that perhaps we can address. As all of you know, ARISA prevents us from assessing self insured ARISA plans, but there are some mechanisms that two or three other states have used that have gotten around that so that those states have a broader assessment base. In a different time we would be happy to expand on how some of that is structured.

With respect to managing the association, we are making every attempt to provide good coverage, but at the same time trying to manage that coverage. We've had a couple of law changes over the years - the most recent one which was to allow us to negotiate discounts in some cases for a preferred provider. Networks - we

implemented that and we're trying to use that to further reduce our overall expenditures or costs of reimbursement for the services that are provided to our policyholders. So, the Board is fully aware of all of the costs.

Just to go on for a second further, I might add to how high risk pools might be used to address some of the other issues mentioned in the introduction. Some states have subsidies for individuals who can't afford the premium, but it still allows some of those individuals with some subsidization to at least be an insured person rather than being an uninsured person and a responsibility of the state.

I'm involved with the Board in Montana that has passed a law that allows the Board to seek funds other than state funds to try and support low-income subsidies. We have made some inroads with the federal government that are now questionable because of all the other things that are going on whether we're going to get some seed money for that. I think there are possibilities there. Of course, it still comes back to the comments if you are dependent on federal money, it can always be pulled out from under you…

CHAIRWOMAN GREEN asked what ACIA means.

MR.BYKERK said it is the Alaska Comprehensive Insurance Association. He said it was originally an Act.

CHAIRWOMAN GREEN asked if it could be expanded to become more of a high-risk pool with the ability to combine with private sector insurance to cover people who might otherwise need additional Medicaid.

MR. BYKERK answered that ACIA could be expanded to cover a number of segments of the population. Typically uninsured people are that way for two reasons - one is that they're uninsurable and the other is that they can't afford the premium. ACIA is a place for them to be enrolled which could be done by a subsidization process. If they are healthy enough to get insurance from the private sector but don't have the money to pay for it, he suggests that they be subsidized to buy in the private market, not by ACIA. It is set up to manage people who are unhealthy. To the extent they would subsidize someone who is healthy through ACIA, they would be competing with the private market. The private market wants to sell them insurance, but at some point if a person becomes unhealthy enough that they are uninsurable, that's when ACIA should have a role. There is a small number of

uninsureds who just aren't interested.

REPRESENTATIVE DYSON said a number of non-profit writers who contract with the state to provide services are having trouble attracting and keeping qualified staff and the issue is not being able to provide health insurance for the non-profits. He, Karen Perdue and Commissioner Duncan wanted to find a way to qualify like-state employees. He thought it was a good idea, but he didn't know if there was a downside from the private industry point of view.

MR. BYKERK said he might not be the right person to comment, but if there's no other vehicle to provide them coverage, one would have to think of that.

MR. JOHNSON said he is on the Board of Health Underwriters as well as the Valley Hospital in Wasilla. As far as ACIA goes, he asked if they have access only by high-risk personnel.

MR. BYKERK replied except by those people who would be coming in as HIPA eligible or federally eligible individuals. This basically means if they are with an employer for 18 months, they could come in to ACIA whether they are uninsurable or not.

MR. JOHNSON asked if essentially everybody has access to health care in the State of Alaska via insurance, ACIA, or presenting to the emergency room.

MR. BYKERK responded that in general that's true.

MR. JOHNSON said there was some discussion about competition and that Alaska is loosing insurance carriers and asked what could help that.

MR. BYKERK replied that the Division of Insurance has created a good environment and that's not what is driving it away. He thought it was because a number of carriers in the United States are getting out of the business completely. Others might be withdrawing because they can't get enough business to provide the overhead to stay here.

MR. JOHNSON said it is the perception of his over 1,500 clients that health insurers are gouging consumers and asked what kind of income they are making from health insurance products in Alaska.

MR. BYKERK said he couldn't limit himself to the state of Alaska, but his company lost over $25 million on individual major medical business. Not every company is in that boat, but almost no one is making much of a profit. "Insurance companies aren't gouging people, but the fact is that health care costs are just skyrocketing everywhere ..."

Their profit margin is 1 - 3 percent of gross premium. He said they weren't getting that and he didn't think very many carriers were. One of the companies in the midst of withdrawing from Alaska lost $50 million last year in the individual market.

REPRESENTATIVE DYSON asked if people were getting medical care that they might not elect to get if they were spending their own money and asked what the legislature could do to help.

MR. BYKERK replied that there were more and more sophisticated things. Last year the pharmaceuticals increased considerably. He explained that in the year 2000, ACIA had 395 policy holders; 89 of which had a $5,000 deductible; 25 had a $10,000 deductible; 107 had $1,500 deductible; and their lowest deductible of $500 was held by 31 people. He thought that people were trying to carry their weight. He said they are losing the litigation on denial of services and certifications to do certain things to the point where companies are gun-shy to deny a service because they're afraid they're going to get sued whether they're at fault of not. Doctors and hospitals are in the same boat. If they don't prescribe every possible drug and try every technique or service, they are potentially at risk for not doing their job.

REPRESENTATIVE DYSON asked if the tort reform legislation they passed several years ago helped at all.

MR. BYKERK said he didn't know.

REPRESENTATIVE DYSON again asked what the legislature could do to help.

MR. BYKERK said he really didn't know the particulars on the state of Alaska.

TAPE 01-53, SIDE B
2:17 p.m.

In his company he is trying to encourage a greater presence because he thinks there is opportunity, but if ACIA could get a broader base of assessment that would help keep down the price of insurance premium in the state.

MR. JOHNSON said that ACIA appeals to him a little bit. He said that it is not a state funded program; its mandated by law and is funded by the insurance carriers here. This is reflected in premiums. The committee needs to know that every time there is a state mandate requiring insurance companies to provide a certain service, there is an attendant cost to everybody along the road.

Estimates for mental health parity are about 1 percent and that

is way off base. It should be purchased by people who want that service and not be passed to everyone.

CHAIRWOMAN GREEN asked how other states get around the ARISA restrictions of creating sources of premium dollars.

CHAIRWOMAN GREEN said they have time constraints and will get back to him on this issue. She also wanted to discuss what worked in other states and if there was another mechanism to provide health care to the 20,000 children in Denali Kid Care.

MR. JOHNSON said he understood that federal funding for Denali Kid Care would be diminishing and asked if the State of Alaska would pick up that share.

CHAIRWOMAN GREEN indicated she didn't think they would.

MR. JOHNSON said his inclination was to have a needs based program that some folks could pursue at the state level to provide funding for private insurance for those folks who are working, but can't quite afford health insurance coverage - at least a safety net program.

CHAIRWOMAN GREEN asked if that could be made into something that worked for not only children, but for young couples.

MR. JOHNSON replied that he thought it could, but they have hard and steadfast rules right now with regard to Medicaid and income levels. "Either you're in or you're out." He said he would be happy to work with them on this.

MS. NICOLE SALINAS, Aetna Accounts Executive, said they have looking at forming associations of small groups to let them band together to access more affordable health care.

CHAIRWOMAN GREEN said she is very concerned about resolving these issues.

MR. BYKERK said that he would be available to help.

MR. JOHNSON said he has concerns about the competition in the state of Alaska.

REPRESENTATIVE DYSON asked what they could do.

MR. JOHNSON replied that they could get rid of the state mandates or at least make them optional. Those people who have the need can pay the extra cost.

REPRESENTATIVE DYSON asked if more tort reform was needed.

MR. JOHNSON answered yes.

REPRESENTATIVE DYSON asked what he thought about people getting care that they really didn't need if they were paying for it themselves.

CHAIRWOMAN GREEN asked about a co-pay option.

MR. JOHNSON said he thought that would be great and he thought a co-pay on Medicaid would be great, higher than we have now.

> This again is my personal opinion. You've got people standing in line for a carton of cigarettes and they only have to pay a $5 co-pay when they go to the doctor’s office and they're the same people. If they can afford to pay for that, they can afford to pay a higher co-pay on Medicaid.

CHAIRWOMAN GREEN said she appreciated their efforts and announced that finished the presentations and she would not take questions.

MR. BOB LOHR, Division of Insurance, said he wanted to know if they got the one-page fact sheet, which incorporates the division's result from the 2000 survey on health insurance. In this survey there is one insurer, Blue Cross, that provides almost 90 percent of the individual health insurance in Alaska. Mutual of Omaha is next with about 9 percent. "The market is highly concentrated."

In the small employer market, there are three insurers that provide more than 85 percent of the insurance - Blue Cross, Aetna and Principal. He said there are barriers to writing health insurance in Alaska because basically it's a small remote population and administrative costs are very high. It's a wide-spread population and less than two-tenths of one percent of the indemnity market in the United States. It's hard to establish relationships and contracts with health care providers. He said that SB 37, that would allow collective negotiation by doctors, is emphatically not part of the solution; it would make things much worse not better.

MR. LOHR attempted to explain the barriers to Alaskans for purchasing health insurance. ACIA coverage for the uninsurable is an extremely successful program and he wanted to thank Mr. Bykerk for his involvement in it.

There are two insurers in the standard market and many are not able to afford the premiums. According to the most recent census data, although it's not totally reliable, approximately 19 percent of Alaskans in 2000 were uninsured and that number has grown from previous years. Lack of affordability is the key

reason why that's the case. He said there's no free lunch with health insurance. Direct or indirect premium subsidies or other assistance programs are essential and he thought the private insurance market is the best way to provide those. Programs that reinforce the market are preferable to government run programs. Mr. Bykerk touched on a couple of specific ACIA type mechanisms that could assist. The premium assessment rising to 1.5 percent of total health insurance premiums that are subject to that assessment is a serious concern.

> Having the cost of the uninsurable paid by the healthy is kind of a death spiral. When you get to the 1.5 percent level, you're seriously influencing the cost of health care for everyone, which drives companies out of the market. It's not being avoided; it's simply being paid by a very limited sector of the market. If there isn't some way to broaden the base of that assessment, and there are a number of models out there that have proven very successful in other states and I believe it would be well worth the committee's time to examine those and we would cooperate with any kind of effort to explore alternative mechanisms to the direct assessment on individual health insurers.

CHAIRWOMAN GREEN thanked him and said the committee would work to resolve these issues.

REPRESENTATIVE DYSON said that President Bush is talking about tax credits for people who are making contributions to health insurance and urged the committee to consider that.

CHAIRWOMAN GREEN replied that he was looking at the wrong person. Expanding Kid Care to include families is the opposite of what would bring about any long-term solution in the state. "I think we could invest our money to assist people locally in requiring involvement locally and do something that gets people into private coverage versus Medicaid…"

MR. LOHR said the Denali Commission indicated its mandate had been amended to focus on health facilities funding. If their charge was further amended to add the next step of going to health program funding and dealing with some of the intractable problems they have just discussed, there would be funding from the federal government with an Alaskan specific solution being developed.

CHAIRWOMAN GREEN said they should have their staff get together and work on language for that.

MS. MARJORIE LINDER said she is representing herself and tomorrow

is her 57th birthday. She received a birthday present from her health insurance company - a notice saying that December 15 she would be paying $830.88 per month in premiums for a policy with a $2,500 deductible. This is an increase in rates since May 2000 of $293.57.

REPRESENTATIVE DYSON said he assumed there was no change in her coverage.

MS. LINDER said it was not related to that. She added that this is more than her daughter pays for rent and second only to her mortgage and twice as high as her food costs. After she has paid her premiums and $2,500 deductible, she has paid $12,470.56 annually. "I have been contributing to the state since 1978 as a self-employed person and I have faithfully paid all my bills to Mutual of Omaha and I am in really a tough situation…"

She said she cannot afford to pay for additional health care. Last year she had shoulder surgery and they declined to pay 40 percent of the bill. Mutual of Omaha "suckered me into a particular pool at a reasonable rate in 1993." In May of 1996 she only paid $188.13 per month; in April of 1997 she paid $226 and they closed the pool. She said it was important to realize that pools are time sensitive and they get closed and decrease in size. The insurance industry is defining the small pools; she is not electing to get into a small pool. In 5.5 years, her premiums have gone up 441 percent.

MS. LINDER had an article from Alaska Economic Trends, June 2001, that showed the percent of change from the previous year for medical care. It shows that in a year in which the percent of medical care costs changed 2 percent in Alaska, her premium was driven up 30 percent. In a year in which the change was 4.3 percent, her premium went up 41 percent from the previous year.

> I'm really trying to say there is something rotten in [indisc.]. There is some problem we have in this particular state that makes this really unfair, unaffordable. As hard as I try and as hard as I work, there is not much of a way that I can afford to keep going.

She said she is turning to ACIA, which has become the dumping ground for folks like her. There really is no open market in Alaska. She said she has to wait six months for her preexisting conditions to be covered by ACIA. She wanted them to consider a way they can have bigger pools of people like herself that are not time sensitive and are not age related.

An insurance agent spoke up and said the insurance concept is spreading of risk. In his office alone in health insurance, he

has had a $1.2 million claim, and an $800,000 claim in the last ten years. That has to be spread out amongst everybody else. These claims were for unborn premature deliveries.

MS. LINDER said she didn't have maternity insurance. She wanted a bigger group that wasn't time or age sensitive.

CHAIRWOMAN GREEN thanked her for her testimony.

MR. RODMAN WILSON said he is a retired internist in Anchorage and ran the Health Department in the ‘80s and it's a shame that the United States hasn't figured out how to take care of its health care. Most of the other industrialized nations have done so. It's a shame that Alaska doesn't figure out a way to take care of everybody's health care.

TAPE 01-54, SIDE A
3:06 p.m.

He said that lawmakers should devise a system that theoretically would be universal.

> You wouldn't have to join it, but it would be there for everybody. It would be a single payer system where all medical bills went to a central clearinghouse and they would turn around and within two weeks or less and pay the bill. It would be a system that would allow full free choice of who you want to go to and the hospital and etc. It is a system that would be governed overall by a budget. You've got to have a ceiling on things. If you start to exceed the ceiling quarter by quarter as these things are monitored, you cut back on the payments to the provider until you get back in line.
>
> One thing that might be used as a very important feature of this would be to say, 'Okay, if you want to surrender your Permanent Fund dividend and that of all your family, strictly voluntary, we'll give you health care. If it's a family, that's approaching $8,000. That might just do family.
>
> I think you need a committee to design a system and cost a system. The committee would have to have staff enough to ferret out all the numbers. I used to have the numbers, but they're out of date and see what it would cost. It might turn out that it cost too much; it might be that it costs $10,000 per person and that's $1 billion and that's too much. It's more than that; it's $6 billion for 600,000 folks. It might be that by

spreading the risk again and by taking care of everybody in the universal system, the cost would only be $4,000 per person. I think if you could simplify the administration and stop the wrangle over who pays what part of the bill, you could provide care universally to Alaskans.

Administrative costs across the country because of all the country, because of all the different players, amounts to 25 percent of the health care dollar. If you reduce that down to 10 percent, you could take care of most of the folks that don't get taken care of.

MS. RENEE MASON said she has lived in Alaska since 1975 and has raised seven children. Currently she is helping a friend who is 77 years old who is involved with the Medicaid and Medicare system and living at Providence Horizon House, an assisted living center. She would like to see Medicaid as it is come to an end. She is intrigued by the possibilities. She wanted to call their attention to approximately 20 young adults who are homeless and because they have no address or phone number, they can't get jobs. Some of them are still under age and not eligible for services. She stated:

The young men end up stealing and dealing drugs; the young women end up getting pregnant in order to have services available to themselves, because when you have a child, you qualify. Some families have just enough income to not qualify for services and yet not enough income to provide the services for themselves. The persons who are in need are quite often those people least able to help themselves. They are ill and if you've ever been ill for any length of time or in the hospital, you know you just do not feel up to dealing with bureaucracy and the paperwork and the confusion that comes with Medicaid and Medicare. These people are often elderly. My friend in the last three years has ended up in the hospital three times with heart attacks because of concerns over her financial situation - part of that is Medicaid and Medicare problems. The other group that falls into this category are the uneducated, often the poor. The reason they are uneducated is partially because they are poor. The reason they're poor is because they're uneducated. It becomes a vicious cycle and generation after generation these people are the ones who are vulnerable to abuse and misuse of the system. They do not understand the statutes and regulations and are intimidated by the bureaucracy that goes with it.

I was intrigued by the suggestion of a one large door type of agency where one caseworker handles a family and is therefore able to coordinate all of the services that are available.

MS. MASON pointed out that sometimes people have no idea what services are available to them. She liked the housing waiver for the elderly as it helped her friend do as much as she is capable of doing. She thought it might be worthwhile to look at a similar kind of housing waiver for young adults who need counseling, job training, day care and minimal health care that might get them into the work force, off of welfare and hopefully out of the Medicaid system in the future.

MS. MASON said she believes that money spent on intervention and preventive care will be a long-term cost saver.

MS. KAREN NUGEN-LOGAN, Executive Director, Nugen's Ranch, said they offer health insurance to their employees. They are a small non-profit organization that contracts with the state. In October they were told their premiums were going to go up by $346 per employee, a 52 percent increase from last year. The facility is now paying $999.01 for each employee on the plan. They were told the premium increased because she hired older people and that her group had more health problems. This is devastating to employees who are contributing to part of the increase, but she is still on the verge of losing full coverage for everybody because she can't afford it. Affordable insurance is very important to the employees.

CHAIRWOMAN GREEN asked what her annual premium was.

MR. LOGAN replied that before October it was $652.85 per employee and she had 15 at that time. The company is Aetna and it is the only company that would take the group in 1996. Her company only covers the employee, not their families.

MR. JERRY NEAR said he is a long-time insurance agent and a student of this issue for a long time. He thought mandated costs and mental health parity are issues. He believes that on the Kenai, more than 20 percent of the people are uninsured. He put out a web page at aktelecare.org that outlines Mr. Rodman's testimony. One concern has been the escalating cost of state participation in Medicaid. The cost of health insurance is so high that many people can't handle it any more and the Medicaid program is picking up the slack. The state might soon have to carry the cost of the Denali Kid Care program and he's not sure how it will do that.

REPRESENTATIVE DYSON thanked him for his advice and efforts.

MS. MARY GRISCO, All Alaska Pediatric Partnership, said that the Partnership is a unique collaborative effort among the medical group at Fort Richardson, the Alaska Native Tribal Health Consortium and Children's Hospital at Providence, the Municipality of Anchorage, the Department of Social Services, and Valley Hospital at Fairbanks Memorial. They are encouraged by Denali Kid Care. It gives children of working parents a medical home, a term the American Academy of Pediatrics Policy says is a place where comprehensive continuously accessible family centered coordinated and affordable care is available for [indisc] by qualified children's health specialists. This means that people don't doctor-hop, which means that expenses go down for clinics and emergency rooms. It means that parents have accessibility to care for primary health needs like shots.

Health insurance for a lot of working parents simply isn't there. Either employers do not provide it, because they figure the employee can find it somewhere else, or the employee sponsored private care has gaps in the benefits or high cost sharing obligations. A parent who has a medical home for their child has less stress and will therefore be a better worker on the job. The Partnership appreciates concerns about fraud and is interested in streamlining accountability without increasing operating costs.

MS. MARILYN KASPER, Alaska Primary Care Association, said she wanted to talk to them about the Community Health Center Program, which is playing an increasingly important role in the state. In 1995, Alaska had a single Ph.D. in Anchorage and that number has grown to 9 non-tribal and tribal organizations with 29 sites statewide. All of these places see people who would not otherwise have access to basic primary health care. President Bush has shown his commitment to the program with his plan to double the number of health centers in the country and double the number of people they serve. She thought they would see a $175 million increase in appropriations for the program. Senators Stevens and Murkowski have also recognized the importance of health centers and are working hard to strengthen the program here. Statistics from 1999 indicate that Alaska has five community health center organizations and clinics in 13 communities. The program has doubled since then. In 1999, on average, 37 percent of the patients at the centers were uninsured and some centers exceeded 50 percent. Thirty-four of the people were insured by Medicaid, Denali Kid Care or Medicare (5 percent) and 29 percent had private insurance. Now that the health centers are serving people in 29 communities it's too early to tell what the numbers are, but they have become a major source of care for people in the state. This is important since the cost of medical service in Alaska is 60 percent more than it is nationally and the cost of providing medical care has risen nearly 200 percent in the last 20 years. Financial barriers to obtaining health care coverage

are considerable, even if someone has insurance.

She pointed out that health centers save the system money and by providing that ounce of prevention, they are saving pounds of cure later. The impacts are significant in terms of lower hospital admission rates, shorter lengths of stay, lessen appropriate use of the emergency rooms and significantly lower infant mortality and morbidity rates. Studies over the last decade have found nationally that Medicaid patients who use health centers receive care of greater quality that costs less than those who use the private primary care providers, such as hospitals, outpatient units and private physicians. These findings are consistent with dozens of studies on the cost effectiveness and quality of care.

MS. KASPER said the cost of technology is a major driver in the rapidly escalating cost of health care. The reasonable reimbursement system for Medicaid patients is changing to a system that will start costing health centers money to see the patients that they are serving. She urged the legislature to continue to support health centers.

REPRESENTATIVE DYSON asked if the big hospitals belong to her group.

MS. KASPER replied no and that the Hospital and Nursing Home Association represents them. Health centers are private not-for-profit agencies.

REPRESENTATIVE DYSON asked if they get some of their revenue from fees for service.

MS. KASPER’s answer was indiscernible.

REPRESENTATIVE DYSON asked if they are a trade association or a lobby group.

MS. KASPER replied they are a membership association of people in the health care field, but they are not a lobbying organization in the traditional sense. She said, "Our mission is to promote access to health care for people who don't have it."

REPRESENTATIVE DYSON asked if it is just for the members of her association.

MS. KASPER replied no; it is for people who live in the state of Alaska.

REPRESENTATIVE DYSON asked who pays for her services.

MS. KASPER replied they get some federal funding and membership

dues and they provide services like grant writing and conference formation, etc.

REPRESENTATIVE DYSON asked who pays the dues.

MS. KASPER replied that for the membership organizations - the community health centers, the rural health clinics, community clinics and some institutional members - the dues are not significant. Dues are $200 - $400 for an organizational member; $100 for an institutional member; $10 for a student and $50 for an individual member. They also have a sliding scale policy for dues.

MS. SUSAN MASON, Sunshine Community Health Center, said Sunshine is a non-profit family qualified health center located in Talkeetna. It is a critical safety net provider for the northern region of the Mat-Su Valley. Statistics from 1999 indicate that 35 percent of individuals in Willow and 26 percent in Trapper Creek live below 200 percent of the poverty level. Analysis of patient data indicates that 40 - 50 percent of their patient population has no medical insurance. They also have an increasing number of underinsured patients who mostly have catastrophic insurance coverage or their deductibles are so high that they are virtually without insurance. They have a difficult time getting providers in her area and this is a critical and growing problem for rural Alaska. Community health centers play a crucial role in providing overall health care for Alaskans. She applauded the committee's commitment to ensure careful and comprehensive planning for our state's Medicaid plans and urged them to consider the negative impacts on some of the safety net providers.

MS. SARAH JACKSON, manager, St. Francis House, said they provide basic emergency services to economically struggling families in Anchorage. Many people they work with have medical problems that contribute to their poverty. Also, a lot of people who are working can't take care of their families. In addition, they answer the statewide 24-hour information and referral hotline. She is a member of the Anchorage Access to Health Care Coalition because she believes, based on her experiences, there is a high correlation between inadequate access to health care and poverty. She is concerned that Denali Kid Care is going to be compromised and asked them to do everything in their power to protect the minimal health programs they have in place. She stated:

> As it is, these programs are woefully inadequate and there are thousands of working Alaskans who do not have access to affordable health insurance and only receive health care in times of an emergency... Many of these people who are treated in this way have no means to fill the prescriptions they receive. This is an

ineffective way to deal with health care needs.

MS. ANGELA GONZALEZ, consumer member of the Medical Care Advisory Committee, said they advise the Commissioner on all aspects of the medical industry. Her three children have been on the Denali Kid Care system since it started and she is a believer in preventive care. Before Denali Kid Care they had to go to the emergency room quite a bit. She had comments from mothers who had children with health issues or had prenatal care through Denali Kid Care who are very grateful. A lot of the children were born healthy and a lot of them who had medical problems were covered, which made it possible for them to become healthy.

3:45 - 3:52 p.m. BREAK

CHAIRWOMAN GREEN said this committee is a jumping off place for this issue and welcomed comments or suggestions. She thanked everyone for attending and adjourned the meeting at 3:55 p.m.