Health Care Costs Containment

HOUSE HESS COMMITTEE

1) CALL MEETING TO ORDER

2) NOTE MONTH/DAY/YEAR Monday, March 20, 1989

3) NOTE TIME:

4) NOTE MEMBERS PRESENT AND EXCUSED

(For the record, note any late arrivals to the meeting)

5) REMIND PARTICIPANTS TO SIGN WITNESS REGISTER

6) COMMITTEE CALENDAR:

SB 166: Medicaid Payments to Health Facilities

Containing the Costs of Health Care in Alaska

7) INTRODUCE WITNESSES

For the record, ask witnesses to state their name, title and the name of the firm or agency they represent.

Ask witnesses with written testimony to submit it to the committee secretary.

8) UPCOMING COMMITTEE MEETING SCHEDULE: See attached

9) ANNOUNCE TIME OF ADJOURNMENT

Presentors for the Health Association of Alaska:

Jim Gingerich (Fairbanks Memorial Hospital) - acute care

Dennis Murray (Heritage Place -a nursing home in Soldotna) - long term care

HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES

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

HOUSE HESS COMMITTEE

Committee Schedule
March 20 - March 24, 1989

(*indicates first public hearing)

HOUSE HESS	Capitol Rm. 106 465-3759 or 60	8:30 a.m. T - W - Th - F

~~Monday, March 20, 1989 8:00 a.m.~~

~~SB 166: Medicaid payments to health facilities~~

~~Containing the Costs of Health Care in Alaska~~

Tuesday, March 21, 1989

Containing the Costs of Health Care in Alaska (Cont'd)

Wednesday, February 22, 1989

Yukon Legislative Assembly Presentation

Report on Disease Outbreaks in Rural Alaska

HB 126: Anabolic steroids as controlled substance

Thursday, March 23, 1989

NO MEETING

Friday, March 24, 1989

NO MEETING

Blue Cross pullout hits home for Redwood City employees

By Shannon Rasmussen
Times Tribune staff

Now that the news has sunk in that Blue Cross of California is canceling its health insurance coverage, Redwood City employees are scrambling to find a comparable plan.

With only about two months before the cancellation becomes effective, city union representatives already have suggested one plan they believe would provide a stable and long-term benefit.

"To us it's extremely serious that Blue Cross is canceling," said Joe Brenner, who represents Local 715 of the Service Employees International Union. "We're absolutely committed to find the best alternative."

Last week, the City Council's Personnel Commission began to look at the request of various city union representatives to contract with the Public Employees Retirement System plan, which offers about 15 different health coverage plans under its umbrella.

However, at issue with the PERS plan is the cost that the city may incur. The plan would require the city to contribute as much money to its retirees' health plans as to its active employees' plans, according to officials.

Currently, retirees who were hired before 1983 and who participate in the city's health coverage plans receive $270 per month toward health coverage — equal to the city's monthly contribution to plans for active employees.

But the city does not pick up insurance costs for employees hired after 1983 who retire.

In some cases, such as the city's Kaiser plan, the $270 buys the maximum coverage of $232.91 per month for an employee with two or more dependents.

Another consideration is that PERS may raise its monthly premium rate to more than $400 for a family, said Jim Irizarry, director of human resources.

"We're trying to work with our employee organizations," Irizarry said. "We're sympathetic to this crisis."

Employees currently may choose to join health plans under Bay Pacific, Kaiser and the Association of Bay Area Governments.

For city employee Molly Spore-Alhadef, PERS would be an answer to the problems she faces.

Her husband sees a number of specialists, many who aren't covered under her current Association of Bay Area Governments health plan.

She was with Blue Cross for 10 years, until a year ago when the rates became too costly.

Alhadef recently had considered returning to Blue Cross, but now does not have that choice. Now she says PERS is her best bet.

"We are stuck," she said. "For those of us affected this is a big crisis. Health care is such a personal thing."

When Blue Cross could not get 50 percent of the city's employees to participate in its plans, it notified the city it would withdraw effective May 1.

Christine Sullivan, public relations specialist with Blue Cross, said it is standard practice within the insurance industr 'o cancel when membership falls below 50 percent. The reason, she said, is that a larger client pool spreads the risk and ensures a balance between premium costs and claims costs.

Several Peninsula cities and

Please see PULLOUT, A-4

PULLOUT

Continued from A-3

school districts who have Blue Cross coverage reported they have received no indication they may face a similar situation.

In Menlo Park, however, a city official said the city did not renew its coverage with Blue Cross last year because of the increase in premiums and because not enough people were participating.

Sandy Salerno, finance director in Belmont, said in July the city joined the PERS plan rather than stick with Blue Cross partly because of imposed rate increases.

Redwood City's cancellation followed an initial notice that the company would raise its rates between 52 percent and 57 percent for its Fee for Service and Prudent Buyer plans.

The increase would have resulted in a monthly charge to the city's Blue Cross customers of between $392 to $502 per month, depending on the type of coverage.

As of last month, 108 of the city's 456 employees were enrolled in Blue Cross. Of 172 retirees, 66 were enrolled in the plan.

On the Peninsula and across the nation, municipalities have been hit with rate increases as the cost of health care escalates, said Armand Bengle, vice president of Alexander & Alexander Consulting Group, an employee benefits consulting firm in San Francisco.

Many municipalities, such as Redwood City, contribute a set amount per month toward employees' premiums, which also may affect which plan an employee chooses, Bengle explained.

If a company cannot get 50 percent participation, the costs are spread among a smaller number of people and at a greater risk to the company, Bengle said.

Based on other reports and trends, health care officials speculate that health insurance premiums will continue to jump nationwide.

Redwood City anticipates that its overall health insurance costs could double in the next five years, causing officials to be extra cautious.

That increase could mean spending $3.4 million per year for employees and another $700,000 per year for retirees in Redwood City.

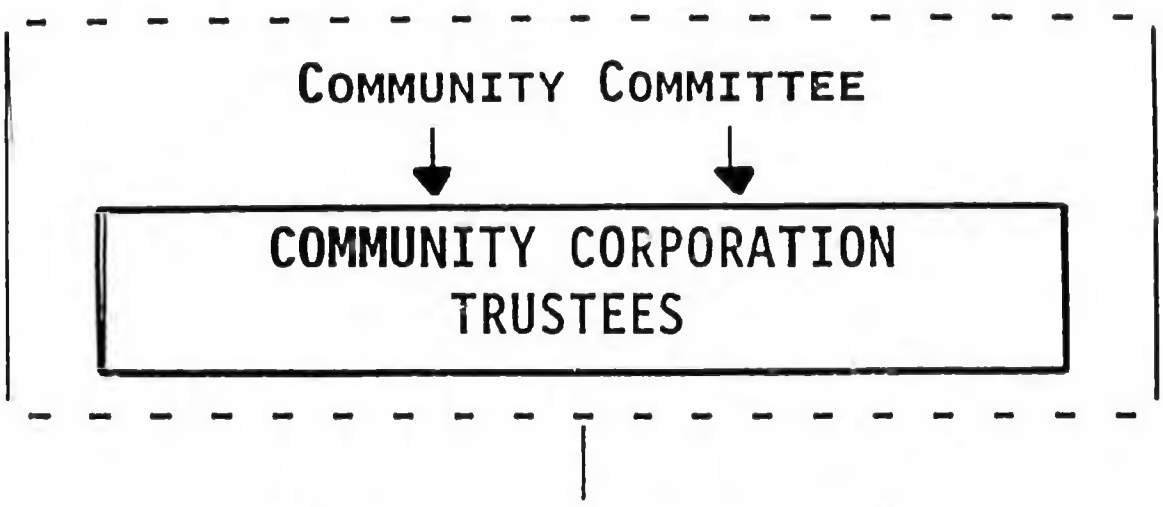
Prior to the cancellation, Blue Cross had presented a proposal to Redwood City requiring the city to replace its Bay Pacific health plan with Blue Cross' California Care Health Maintenance Organization.

But city employee representatives were not interested in that proposal, and the city cannot require employees to join one plan over another, Irizarry said.

CRITICAL OBJECTIVES
FACING 1989 ALASKA LEGISLATURE

OBJECTIVE	ACTION
1. MODERATE COST EXPANSION OF STATE EMPLOYEE BENEFIT PROGRAM.	
2. PROVIDE FINANCIAL ACCESS TO SERVICES TO PEOPLE WHO CAN NO LONGER AFFORD HEALTH INSURANCE.	
3. PAY FAIR AND REASONABLE PRICES FOR MEDICAID SERVICES.	
4. KEEP AND BUILD A STRONGER LOCAL HEALTH CARE STRUCTURE IN EACH ALASKAN COMMUNITY.	
5. CREATE A LOCALLY OWNED STRUCTURE TO MANAGE AND GOVERN HEALTH CARE APPROPRIATE TO ALASKA.	

COMMUNITY CORPORATION



PRIVATE (YEARS 1 - 3)

SMALL EMPLOYERS

LARGE EMPLOYERS

- SCHOOLS
- BOROUGH
- HOSPITAL
- CHAMPUS/ FEDERAL EMPLOYEES

INDIVIDUALS

- INDIVIDUAL POLICY
- BASIC CARE POLICY

PUBLIC (YEARS 2 - 5)

MEDICARE

MEDICAID

LABOR & INDUSTRIES

HIGH RISK

UNCOMPENSATED ASSISTANCE

OTHER

LONG-TERM CARE

DENTAL

PUBLIC HEALTH ISSUES

STATE OF ALASKA

WHAT CAN BE DONE TO KEEP BENEFITS AND REDUCE COSTS?

YEAR 1

- IMPLEMENT UTILIZATION REVIEW, INCLUDING DEDUCTIBLE FOR PREAUTHORIZATION
- FOCUS ON INPATIENT AND ALCOHOL, SUBSTANCE AND MENTAL HEALTH
- ANALYZE DATA TO TARGET REVIEW
- DEVELOP EMPLOYEE ASSISTANCE PROGRAM
- EDUCATE EMPLOYEE - NEWSLETTER
- PILOT - OPTIONAL INSURANCE PROGRAM

YEAR 2

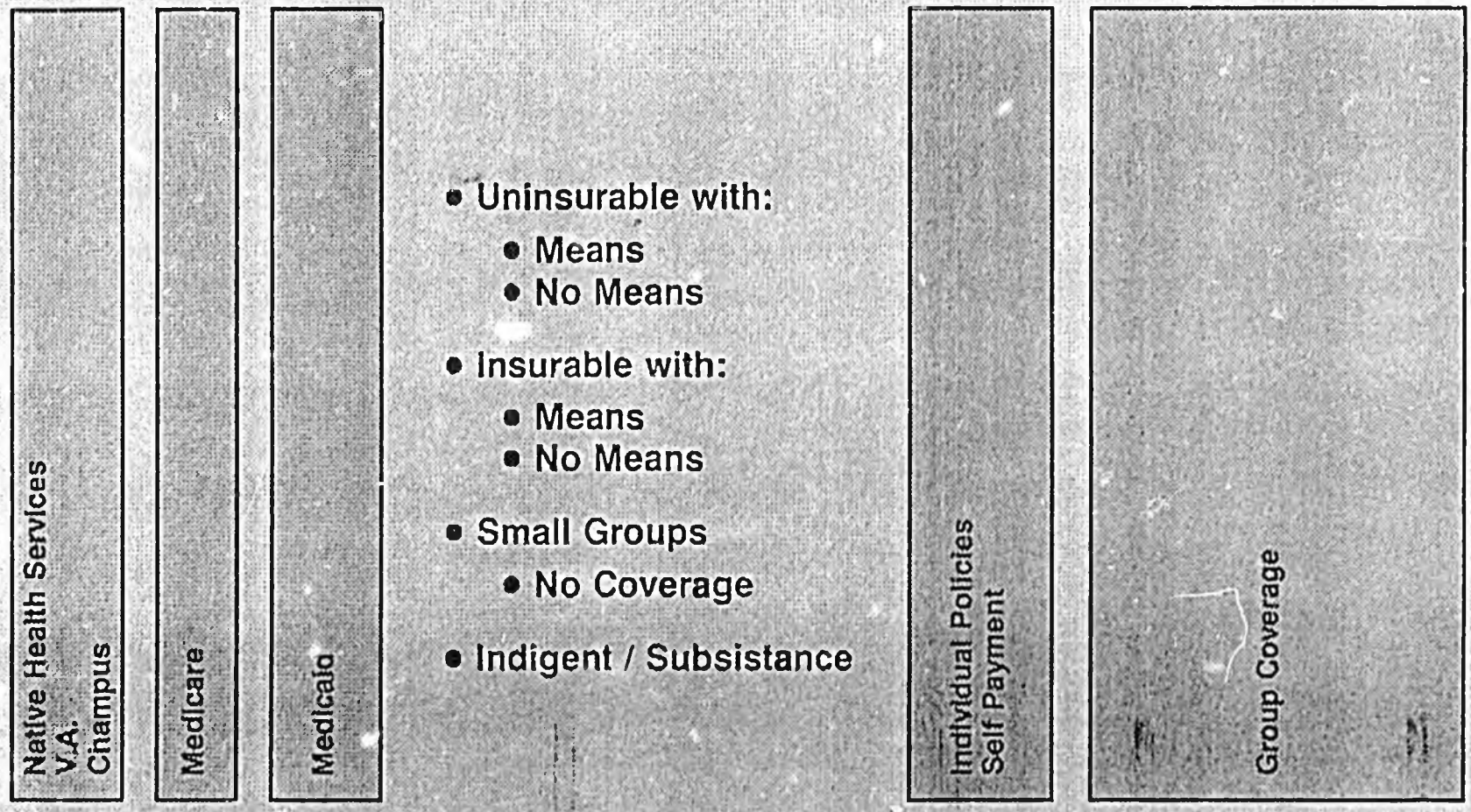
- GENERAL BENEFIT MODIFICATIONS
- NEW BASIC PLAN OFFERED AS AN OPTION
- BUY CARE FROM LESS COSTLY PROVIDERS
- FEE SCHEDULE FOR DENTISTS/PHYSICIANS

PRINCIPLES

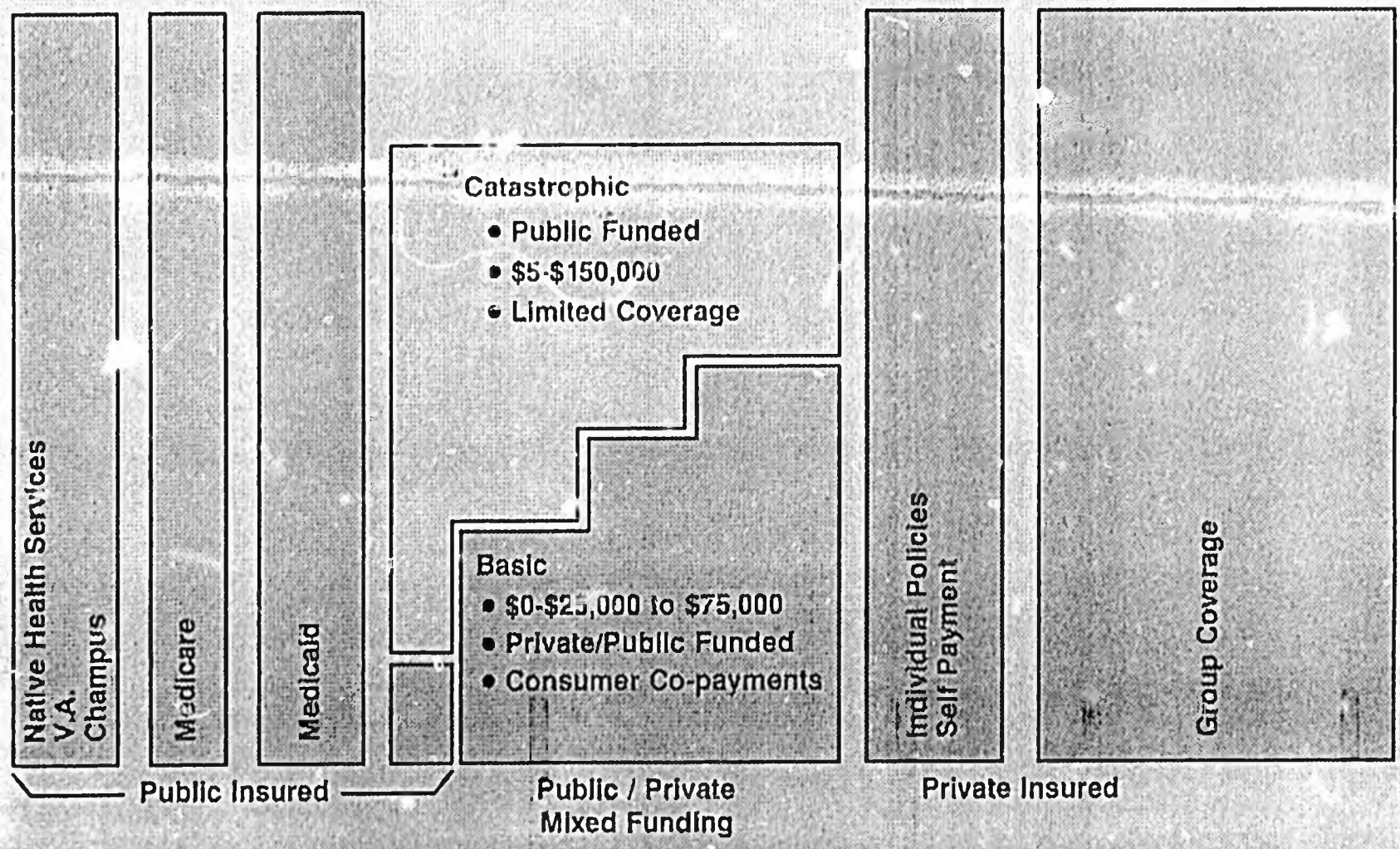
- Start immediately with the possible
- Understand your data and develop short-term and long-term plan
- Move incrementally
- Offer choices and reward employees for prudent decisions
- Buy strategically - not year to year

Health Care Funding

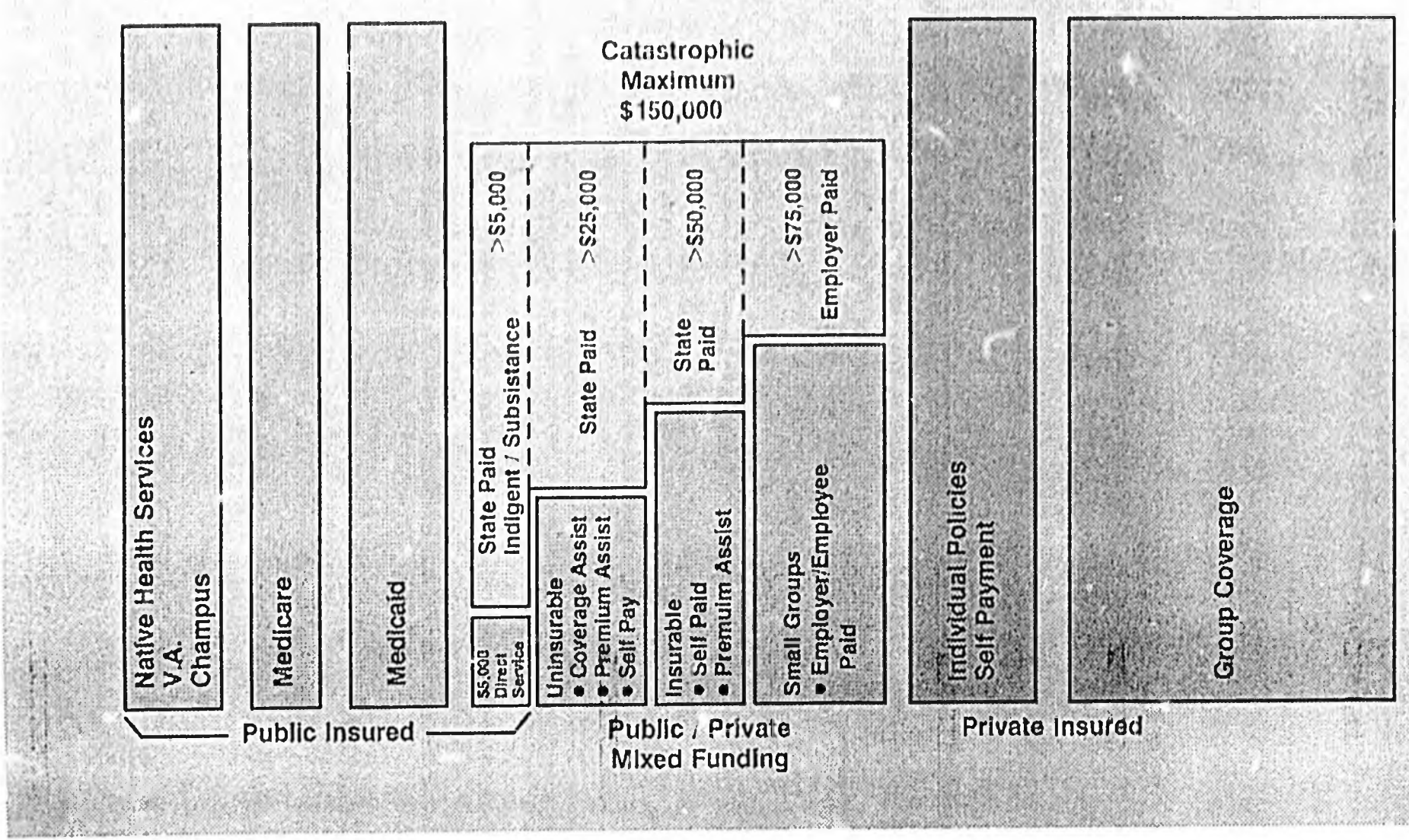
The Problem



Health Care Funding
Joint Public/Private Solution



Health Care Funding



March 20, 1989

TESTIMONY TO

ALASKA STATE LEGISLATURE

Bruce Amundson, M.D.
University of Washington, School of Medicine
Area Health Education Center
Associate Director of Community Health Systems

SUMMARY OF OBSERVATIONS
ON RURAL HEALTH CARE

- Many rural communities are in crisis, often confronted simultaneously with multiple problems in their health care systems.

- In spite of this, research at the University of Washington demonstrates that rural communities can successfully stabilize and strengthen their health delivery systems (see attachments).

- Aggressive attention to delivery system problems within the community has been shown to be the most effective use of community resources and energy.

- Our studies show there are enough health care dollars already being spent by most rural communities to support the local health care system, provided that quality services are provided.

- Health care ideally should be managed at the community level to both ensure support for primary health care services and to give communities control of their health care dollars.

- Successful rural community-based health insurance programs have been developed in the northwest.

11.1% of GNP
to health care

sufficient resources

SAMPLE OF ACCOMPLISHMENTS AND PROGRAMS IMPLEMENTED
IN
SIX RURAL COMMUNITIES

1. New Nursing Homes in Two Communities
2. Successful Nurse Recruitment Programs in Two Communities
3. Two Community Health Care Foundations Established
4. Improved Emergency Medical Systems
5. Hospital Financial Status Improved in Five of Six Sites
6. Four Communities Added Primary Care Physicians
7. Strategic Planning Cycle Completed in All Communities
8. Five New Management Information Systems in Hospitals
9. New Technology added - Mammography, Ultrasound, Etc.
10. Wide Community Leader Participation in Health System Decisions
11. Two Community PPO's Initiated
12. Increased Scope of Health Services in Several Communities
13. Successful Conflict Resolution in Three Communities
14. Improved Mental Health and Pharmacy Services
15. Nursing Home and Hospital Trustee Skills Greatly Increased
16. Direct Intervention with Impaired Professionals

Background -- Statement
Jim Gingerich, Chairman
Health Assn of Alaska

Before House HES Committee
March 20, 1989

Mr. Gingerich is
Administrator, Fairbanks
Memorial Hospital

COST OF LIVING

MEDICAL COSTS

"If you have your health you have it all," is more true than ever. For those less fortunate, medical costs can result in catastrophic financial burdens for themselves and their families; even employers, insurance firms, and government assistance programs are reeling under the burden. Locally, the State of Alaska must periodically ask for additional appropriations to cover health insurance overruns and tries to prepare for a pending crisis as the State's young population grows older and requires more medical services.

Advances in modern medicine have promoted a longer and fuller life, but not without a price. Health care costs have long been outpacing the overall rate of inflation. Since 1980, the cost of medical care nationally has risen twice as fast as the overall inflation rate. The situation has been more severe in Alaska. In Anchorage, for example, medical care cost increases are three times the inflation rate. Although comparable inflation information is not available for Fairbanks, surveys show our medical costs to be nearly twice the national average and on par with both Juneau and Anchorage.

There are no easy solutions to the high cost of health care, but it important to understand the history and ramifications of the problem.

RISING MEDICAL COSTS

Before discussing medical costs, the distinction between costs and prices must be made clear. Costs take into account both usage and price. Health care involves not only medical services but also insurance payments, employee health benefits, and government assistance programs. Increased demands with even stable prices result in higher expenditures which must ultimately be paid for by the consumer.

Only five times since 1951 have annual increases in medical costs for the U.S. City Average of the Consumer Price Index for All Urban Consumers (CPI-U) been below the overall national rate of inflation. The increase of medical costs relative to the overall inflation rate is shown clearly in Figure 31. During the 1970's, inflation rates for medical costs versus all items were roughly similar, although medical costs maintained a consistently higher increase. By the 1980's, any similarity between the rise in medical costs to the overall inflation rate was lost. While the overall rate of inflation has moderated in recent years, medical care costs have continued at the high pace established in the mid-1970's.

By December 1987, expenditures toward medical care caused it to be given a weight of 5.8% of the CPI-U, a full percentage point higher than in 1979. This is a further indication of the growing contribution of medical costs toward overall inflation.

This extreme picture is mirrored closer to home in the inflation data for Anchorage (Figure 32). The all items component, which measures overall inflation, has risen 43.6% nationally and 27.0% in Anchorage between 1980 and 1988. In contrast, medical care costs have escalated 85% for both the U.S. City Average and Anchorage during the same period (Table 44). However, due to the higher cost of living in Alaska, the 85% increase in medical costs in Anchorage involves a much larger dollar figure.

In 1988, medical care costs rose 6.4% in Anchorage and 6.5% nationwide. During the same period the all items index rose 4.1% for the U.S. City Average and only 0.4% in Anchorage. The picture is somewhat distorted in Anchorage because of sharply decreasing shelter costs. If the current anti-inflationary effect of the housing crisis in Anchorage is eliminated through the use of the All Items Less Shelter component, medical costs there increased at more than twice the adjusted inflation rate.

ALASKAN MEDICAL PRICES

Is the situation in Fairbanks as serious as that in Anchorage? Before responding to this question, it is necessary to understand that there are no similar CPI data available for Fairbanks. However, it is possible to look at various other surveys of health care to compare Anchorage and Fairbanks prices.

The first documentation of comparative medical costs resulted from the Community Research Center's participation in the American Chamber of Commerce Researchers Association (ACCRA) inter-city cost of living survey. The first ACCRA health care index for Fairbanks (determined from a survey conducted in the second quarter of 1986) was 232.9 compared to an average of 100 for the 249 participating communities. Anchorage had an index of 188.9 for health care in the same quarter.

The first quarter of 1988 is the last time that Anchorage participated in the survey and is thus the most recent period in which costs for Fairbanks and Anchorage can be compared. In that quarter, the composite index for Fairbanks was 130.9 for all 59 items and the health care index was 191.4. Anchorage had an overall index of 129.5 and a health care index of 188.4. Decreases in the health care index for both communities from the 1986 values quoted earlier were due more changes in data collection specifications than changes in relative costs between Alaska and Outside. The ACCRA data suggest that health care costs in both cities are not only quite comparable but also absolutely higher than the national average. Only Juneau, with a health care index of 196.4, nearly twice the national average, had a higher index among the 256 participating cities.

The health care component of the ACCRA survey is based on only four items: a semi-private hospital room, an office visit to a general practitioner, a dental exam and cleaning, and a bottle of aspirin. These items are not meant to provide comprehensive health care cost information, rather they were chosen to be indicative of the full range of medical care costs. Their choice for the ACCRA survey resulted from their uniformity and ease in data collection, not that hospital room rates and medical visits convey the true cost of health care. Taken individually, however, it is clear how their costs in Fairbanks compare to other communities (Table 45).

In January 1988, Fairbanksans paid an average of $305 for the hospital room, $49.33 for a standard physician office call, $85.22 for the dental work, and $3.37 for the aspirin. Among the 256 communities nationwide participating in the survey, the average hospital room cost $216.42, the general practitioner office call $26.30, the dental exam and cleaning $34.19, and the aspirin $3.43.

Prices in Fairbanks were not uniformly the highest in the nation. Thirteen other communities including Anchorage and Juneau paid more for the hospital room and residents of Washington, DC, paid more for the doctor visit. No one, however, paid more for the dental exam and cleaning. The high expenses for professional medical services found in the ACCRA data for Alaska are supported by insurance company reimbursements. Blue Cross of Washington and Alaska determined that prices in Alaska are higher than

those in Washington by 46% in medicine, 28% in surgery, 72% in laboratory, and 35% in radiology fields.

HOSPITAL COSTS

To describe their costs, it is necessary to understand the structure of the hospitals, the type of care provided, and their profit motivation. Fairbanks Memorial Hospital (FMH) is a 138-bed institution owned by the Greater Fairbanks Community Hospital Foundation. The hospital is leased to the Lutheran Hospitals and Homes Society (LHHS), a not-for-profit management corporation. Although not intended to return a profit, the corporation must meet its expenses and provide for the replacement of equipment and facility upgrades. Any excess revenues beyond expenses are put back into the hospital rather than being distributed among share holders. Substantial donations by community individuals and businesses to FMH result in readily accessible, low cost health care for Interior residents.

In contrast to the situation in Fairbanks, over half of the non-government hospital beds in Anchorage are in privately owned institutions. These profit oriented hospitals are Humana Hospital-Alaska with 238 beds, Charter North Hospital with 80 beds, and the Horizon Recovery Center with 34 beds. Only Providence Hospital with 337 beds is a not-for-profit establishment. Unlike FMH, however, Providence Hospital is wholly church owned.

The health care services which the Anchorage facilities provide also differ from FMH. Providence Hospital provides the most extensive services in the state. On the other hand, Humana Hospital, while almost twice are large as FMH, provides a mix of services very similar to FMH. Because Charter North Hospital and the Horizon Recovery Center specialize in resolving alcoholism or chemical dependency and providing psychiatric services as opposed to the acute care, they are not suitable for comparison with FMH. Thus only Providence and Humana will be considered in any comparisons made to Anchorage in determining whether the hospital situation in Fairbanks is as serious as in Alaska's largest city.

One of the most common medical procedures is child birth. Blue Cross of Washington and Alaska found the average maternity charge in Alaska to be $3,500 while in Washington state it was only $2,600. At FMH, the average charge for normal obstetrical care with a well baby was $2,237.41 (Table 46). By way of comparison, the average charge in Anchorage was $2,646.52 at Providence Hospital and $3,398.03 at Humana Hospital-Alaska. A caesarian section with a well baby was $4,748.95 locally, $4,870.64 at Providence, and $8,249.85 at Humana. This procedure averaged $5,745 in Alaska and $4,070 in Washington. While some medical costs in Fairbanks are high, local hospital rates appear to compare favorably with Washington.

The following are some of the underlying reasons for the price differences. Increased severity of illnesses treated and the greater the number of services provided result in a higher rate being charged by the hospital to cover the more extensive overhead in facilities and equipment. Both Anch[illegible]spitals offer a wider range of medical care than FMH, especially Providence Hosp[illegible].h acts as a hub for Alaskan medical care. In order to make these capabilities a[illegible], every patient using Providence pays a premium rate. Records indicate that FM[illegible] treating sicker Medicare patients than Humana but less severe than Providence. Humana Hospital, on the other hand, has three factors which contribute to its higher costs: (1) it must show a profit, (2) it provides a broader range of acute care than FMH, and (3) it has a lower occupancy rate and must therefore charge more to cover its capital investment.

CAUSES OF MEDICAL CARE COST INCREASES

What has prompted the rise in medical costs? Insurance companies, hospitals, and the medical profession have each presented the reasons from their perspective. A recent *New York Times*' article presented the recurring themes in order of increasing importance as: (1) malpractice, (2) catastrophic cases, (3) technological advances, (4) increased utilization, (5) cost shifting, and (6) a seemingly redundant factor called medical inflation. In discussing the meaning of each of these causes, examples will be given from Fairbanks Memorial Hospital.

Insurance premiums for medical malpractice have escalated dramatically. At the same time hospital administrative legal fees have soared; at FMH they rose 240% between 1985 and 1987 and are quickly approaching one million dollars annually. Also, to avoid the threat of malpractice, physicians may practice "defensive" medicine and use expensive tests and procedures which might not otherwise be warranted.

The cost of catastrophic cases is the next inflationary factor. Modern medicine can now overcome conditions that were fatal only a few years ago, but the intensive nature of this intervention does not come cheaply. At FMH it is not the heroic procedures themselves which result in large medical bills but rather long term health care of patients with special problems such as burns. The accumulated costs can easily exceed full financial resources of the patient and thus must be spread out by the hospital over the prices charged for all its other services.

Technological innovations themselves, while enhancing the health and well being of individuals, add enormo · costs. New diagnostic devices, such as ultra-sound, which can look within the body w· ·ut the use of surgery, have become basic medical equipment. When not sufficiently uti· :d, however, the cost of these devices must be covered by increased fees for all patients whether they use them or not. FMH has a diagnostic radioisotope facility, a neonatal intensive care unit, and a computer tomographic (CT) scanner. Fairbanks does not have an intensive cardiac care unit, an open heart surgery facility, a burn unit, a cardiac catherization laboratory, a full range of radiation therapy, magnetic resonance imaging, or hemodialysis. These are found at Providence Hospital, which serves specialized needs for the entire state.

Greater usage of medical care has resulted from its increased accessibility and public awareness of the scope of service·s available. Increasing demand affects not only health care providers, but also insurance companies and assistance programs. Usually economies of scale recognized by the health care industry do not make up for the additional expenditures by corporate, government, or individual payers and total costs continue to increase.

Then, once hospital rooms and equipment are in place, reduced demands can even result in higher fees necessary to cover high fixed costs. In 1988, FMH had the fewest admissions in ten years and shorter average length of stay (Table 68). Combined with more emergency and outpatient visits, this pattern contributed to large increases in the average charge per hospital day. Despite cutbacks the hospital has made in the number of staff in response to decreases in hospital usage, the average charge per day has increased from $690 in 1983 when patient days peaked at 42,718 to $1,182 in 1988 (Table 69).

Another factor contributing to rising costs has been the cost shifting done by hospitals to maintain revenue levels. There has been a rise in uncompensated care resulting from charity, bad debt, or governmental and insurance program reimbursement policies (Table 47). For example, as a result of a recent rate hearing for FMH, Medicaid reimbursement was recently set at only a fraction of charges. In 1988, FMH provided nearly

$5.2 million in uncompensated care. Bad debt was accounted for 33% of the uncompensated care while unusual circumstances resulted in medicaid being responsible for 29%. Medicare accounted for 17%. Health care providers have effectively shifted these unreimbursed costs to individual and private sector payers.

The largest factor in rising health care costs, however, is simply medical inflation. These are direct costs which the health care providers must pay for increases in supply prices and wages.

Finally, according to Mike Powers, Chief Financial Officer of FMH, some of the recent prices changes among Alaskan hospitals are not the result of inflation as much as a more accurate accounting of true costs. This can be seen in the 15% rise in the medical care index for Anchorage in 1986. Strict accounting of service and supply usage that year resulted in apparent medical care inflation twice the normal rate for the CPI-U in the community. A similar result can be seen in the rise in the average charge per hospital day when similar procedures were introduced at FMH in 1987. Regardless of the appropriateness of the new accounting practices, the result is inflation of medical costs from the perspective of users and rate payers.

COST CONTAINMENT

What can be done to keep medical price increases in line? A recent report by the Governor's Interim Commission on Health Care entitled *The Best of Care* discussed the challenges of providing affordable health care to Alaskans. The commission suggested some regulations to contain health costs and recommended the development and funding of home- and community-based care systems for persons in need of long term care as an alternative to more expensive institutional care. However, because a long term solution to the overall problem of increasing health care costs was not found, the report urged continued effort to resolve the many issues involved.

Alaska is in a unique situation. The youthful nature of the state's population results in a lower percentage of expenditures for health care, only 3% in Anchorage according to a 1982-83 survey, than the national average of 4%. However, by age 65 expenditures typically increase to above 10%. As the Alaskan population ages, local health needs will naturally increase and this demand could fuel even higher medical costs if appropriate measures are not in place.

For the moment the fact remains: medical care costs in Fairbanks are high. Individuals can immediately respond by becoming intelligent consumers. Fairbanks is fortunate to have the services of a large number of physicians in a broad range of specialties among whom to chose (e.g., see Table 70). Patients in consultation with their physicians can also explore alternative modes of health care in an effort to contain costs while meeting medical needs.

The Fairbanks Memorial Hospital has internally sought to contain prices by reducing staff, freezing salaries, and obtaining economies through aggregating services and purchases. Being a community owned hospital, individuals can provide input to its management through participation in the Greater Fairbanks Community Hospital Foundation.

It is up to all participants in the health care triangle–the using public, the health care providers, and the government and private underwriters–to seek innovative ways to contain costs. There is an impending crisis if the cost of health care continues to increase at its

present rate. It will take community involvement to insure that Fairbanks maintains its excellent medical facilities and staffs at affordable rates.

health
association
of alaska

319 Seward St., Juneau, Alaska 99801 • (907) 586-1790
REPRESENTING ACUTE, LONG TERM AND OUTPATIENT FACILITIES

Monday
March 20, 1989

Health Association of Alaska - Testimony
Cost of Health Care -- House HES Committee

Harlan Knudson, Executive Director (Brief Overview)

Jim Gingerich, Administrator, Fairbanks Memorial Hospital
and Dennis Murray, Administrator Heritage Place Nursing Home,
Soldotna - Review hospital/nursing home costs.

Dr. Bruce Amundson - University of Washington School of Medicine
- Area Health Education Center. Dr. Amundson is
is Associate Director of Community Health Systems.
His topic -- A proposal to strengthen community health
systems.

Many Thanks.....

OVERVIEW OF STATE AND LOCAL PROGRAMS FOR THE MEDICALLY INDIGENT

I. INTRODUCTION

II. CHARACTERISTICS OF STATE AND LOCAL MI PROGRAMS

III. PROGRAMMATIC MODELS

IV. NEW APPROACHES

V. SURVEY STATE'S PROGRAM

TRADITIONAL PROGRAMMATIC MODELS

- PATIENT-FOCUSED
  - STATE-ONLY MEDICAID
  - GENERAL ASSISTANCE (GA) MEDICAL
  - .CATEGORICAL
  - CATASTROPHIC
  - REGULATORY

    INSURANCE CONTINUATION & CONVERSION

    RISK POOLS FOR "UNINSURABLES"

EXPANDING PRIVATE COVERAGE FOR PERSONS NOT LINKED TO WORKPLACE:

RISK POOLS FOR MEDICALLY UNINSURABLES

- 1 - 2 MILLION UNINSURABLES ESTIMATED (AIDS MAY INCREASE)

- CURRENTLY IN 15 STATES:

CONNECTICUT
FLORIDA
ILLINOIS
INDIANA
IOWA
MAINE
MINNESOTA
MONTANA
NEBRASKA
NEW MEXICO
NORTH DAKOTA
OREGON
TENNESSEE
WASHINGTON
WISCONSIN

FEATURES OF RISK POOLS FOR MEDICALLY UNINSURABLES

- PERSONS REJECTED BY 1 OR MORE INSURERS DUE TO HEALTH STATUS

- PREMIUMS ARE CAPPED AT 125% - 400% OF INDIVIDUAL AGE/SEX-RATED RATE

  (WI SUBSIDIZES PREMIUMS FOR POOR)

- TYPICAL INDEMNITY BENEFITS

- OFTEN PRE-EXISTING CONDITION EXCLUSIONS AND WAITING PERIOD

- ALL INSURERS IN STATE MUST PARTICIPATE (NOT SELF-INSURED EMPLOYERS DUE TO ERISA)

- MOST STATES OFFER TAX CREDITS TO INSURERS FOR LOSSES

- CAN BE PART OF A SMALL EMPLOYER INSURANCE STRATEGY

GAO STUDY OF RISK POOL LAWS

- RISK POOLS REACH A SMALL NUMBER OF PEOPLE

- SINCE PREMIUMS ARE CAPPED, THEY ALL OPERATE AT A LOSS (EVEN IN STATES WITHOUT CREDIT, LOSSES ARE UNDER 1% OF PREMIUM INCOMES FOR CARRIERS)

- STILL NOT AFFORDABLE FOR MANY PEOPLE

- USERS MOST LIKELY TO BE 40-64 YEARS OLD

- MORE COSTLY USERS: 30% MORE EXPENSIVE PER CAPITA THAN US AVERAGE

TRADITIONAL PROGRAMMATIC MODELS

- INSTITUTION-FOCUSED
  - OWNING HOSPITALS OR CLINICS
  - PAYMENTS TO PRIVATE HOSPITALS OR CLINICS
  - REGULATORY
    - RATE-SETTING
    - CON
    - LICENSURE
    - ANTI-DUMPING
    - TAX EXEMPTION AUTHORITY

NEW APPROACHES TO FINANCING AND DELIVERING INDIGENT HEALTH CARE

- COMPREHENSIVE STATE HEALTH INSURANCE
- NEW FINANCING SOURCES
- "COUNTY RELIEF" LAWS
- COST-EFFECTIVE DELIVERY APPROACHES
  - MANAGED CARE (HMO, PPO)
  - INTEGRATED PUBLIC HOSPITAL SYSTEMS

APPROACHES TO EXPAND PRIVATE SECTOR COVERAGE

OUTLINE

- REASONS TO SEEK EXPANDED PRIVATE SECTOR COVERAGE
- OBSTACLES TO EXPANDING PRIVATE SECTOR COVERAGE
- TARGET POPULATIONS
- EXPANDING COVERAGE FOR UNINSURED WORKERS AND/OR DEPENDENTS
- EXPANDING COVERAGE FOR RECENTLY UNEMPLOYED WORKERS AND DEPENDENTS
- EXPANDING PRIVATE INSURANCE COVERAGE FOR PERSONS NOT LINKED TO WORKPLACE

REASONS TO SEEK EXPANDED PRIVATE SECTOR INSURANCE

- STRONG TRADITION OF HEALTH INSURANCE THROUGH THE WORKPLACE
- CAN BE SEEN AS BASIC RESPONSIBILITY OF ALL EMPLOYERS
- NON-INSURING EMPLOYERS CAN BE SEEN AS UNFAIR COMPETITORS
- PLURALISTIC APPROACH TO ADDRESSING THE UNINSURED
- KEEPS COSTS OFF PUBLIC BUDGETS
- AS EMPLOYERS' PRICE DEMANDS LIMIT COST SHIFTING, UNINSURED ACCESS PROBLEMS ARE RELATED IN PART TO EMPLOYER POLICIES

OBSTACLES TO EXPANDING PRIVATE SECTOR COVERAGE

- RESISTANCE TO GOVERNMENT INTERVENTION (ESPECIALLY MANDATES)

- EMPLOYER CONCERNS ABOUT COSTS AND ADMINISTRATION

- POSSIBLE EFFECTS UPON EMPLOYERS:

  - DISEMPLOYMENT

  - BUSINESS CLOSURES

  - LOSS OF BUSINESS FROM ONE STATE TO ANOTHER

  - LOSS OF COMPETITIVENESS ACROSS STATE OR NATIONAL LINES

TARGET POPULATIONS

- PERSONS LINKED TO WORKPLACE
  - WORKERS AND DEPENDENTS
  - RECENTLY UNEMPLOYED WORKERS

- PERSONS NOT LINKED TO WORKPLACE
  - HIGH RISK, UNINSURABLES
  - OTHER UNEMPLOYED PERSONS

WHO ARE THE WORKING UNINSURED?

- OVER HALF (55%) OF THE UNINSURED ARE WORKERS
  2/3 FULL-TIME AND 1/3 PART-TIME

- ANOTHER 22% ARE THEIR DEPENDENTS

- ANOTHER 12% ARE DEPENDENTS OF INSURED WORKERS

- PRIMARILY LOWER WAGE WORKERS
  35% EARN LESS THAN MINIMUM WAGE

OPTIONS FOR EXPANDING PRIVATE SECTOR COVERAGE TO WORKERS

- VOLUNTARY PRIVATE SECTOR OPTIONS

- PUBLIC SECTOR POLICIES

  - MANDATES

    EMPLOYERS

    INSURERS

  - INCENTIVES

    SUBSIDIES

    ADMINISTRATIVE SUPPORT

    TAX INCENTIVES

INTRODUCTION

RWJ HEALTH CARE FOR THE UNINSURED PROGRAM

- PURPOSE IS TO DEMONSTRATE NEW PUBLIC AND/OR PRIVATE SECTOR FINANCING AND/OR DELIVERY APPROACHES FOR CARING FOR THE UNINSURED

- 15 PROPOSALS FUNDED IN 1986 AND 1987 ($16 MILLION)

- GRANT RECIPIENTS ALL FOCUS PRIMARILY ON THE WORKING UNINSURED

- TRYING TO DEVELOP AFFORDABLE INSURANCE PRODUCTS FOR WORKERS IN SMALL FIRMS

STRATEGIES FOR AFFORDABLE INSURANCE

- PROVIDER DISCOUNTS (PPO OR EPO) APPROACH)

  - NEGOTIATE DISCOUNTED FEES WITH HOSPITALS AND/OR PHYSICIANS (IF SUBSCRIBERS USE OTHERS, THEY WILL PAY MORE)

  - GRANTEES

    MAINE DEPARTMENT OF HUMAN SERVICES

    DENVER HEALTH AND HOSPITALS ("SCOPE")

    FLORIDA DEPARTMENT OF HEALTH AND REHABILITATION SERVICES

    TENNESSEE ASSOCIATION OF PRIMARY HEALTH CENTERS

    INTERMOUNTAIN HEALTH CARE (UTAH) (LIMITS HOSPITAL DAYS)

- LIMITING BENEFITS

  - INSURANCE PREMIUMS ARE LOWER IF COSTLY BENEFITS (SUCH AS HOSPITAL CARE) CAN BE LIMITED

  - GRANTEES:

    UNIVERSITY OF ALABAMA (LIMITS HOSPITAL DAYS AND OUTPATIENT VISITS, BUT INCLUDES DRUG PRESCRIPTIONS WITH COPAYMENT)

STRATEGIES FOR AFFORDABLE INSURANCE

- PROVIDER RISK SHARING (CAPITATION)

  - WHEN PROVIDERS SHARE IN RISK OF HEALTH CARE COSTS, THEY CAN CURB HEALTH CARE USE AND LOWER PREMIUMS (HMO'S SAVE 10% TO 40% OF COSTS COMPARED TO FEE-FOR-SERVICE PLANS BY LOWERING HOSPITAL USE)

  - GRANTEES:

    TENNESSEE ASSOCIATION OF PRIMARY HEALTH CENTERS

    UNIVERSITY OF ALABAMA

    ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM (AHCCCS)

    WASHINGTON BASIC HEALTH PLAN

- CASE MANAGEMENT (WITHOUT CAPITATION)

  - REQUIRING ENROLLEES TO GO THROUGH ONE PROVIDER FOR REFERRAL TO CARE IS BELIEVED TO SAVE MONEY

  - GRANTEES

    INTERMOUNTAIN HEALTH CARE

    MAINE DEPARTMENT OF HUMAN SERVICES

STRATEGIES FOR AFFORDABLE INSURANCE

- POOLING TO FORM LARGE GROUPS (MULTIPLE EMPLOYER OR EMPLOYEE TRUSTS)

  - INSURANCE POOLING ARRANGEMENTS AGGREGATE MANY SMALL GROUPS INTO LARGE ONES TO SAVE ADMINISTRATIVE AND MARKETING COSTS AND POOL RISKS

  - GRANTEES:

    FLORIDA DEPARTMENT OF HEALTH AND REHABILITATION SERVICES (MET)

    SOUTH COVE COMMUNITY HEALTH CENTER (EMPLOYEE POOL)

    WEST VIRGINIA PUBLIC EMPLOYEES INSURANCE AGENCY (USING PUBLIC EMPLOYEE MET MODEL FOR SMALL EMPLOYERS)

- HIGH COST SHARING (LARGE DEDUCTIBLES OR COPAYMENTS)

  - TRADITIONAL WAY TO LOWER INSURANCE PREMIUMS (BY BOTH SUBSCRIBER PAYMENT FOR CARE AND REDUCING USE)

  - GRANTEE: DENVER HEALTH AND HOSPITALS

STRATEGIES FOR AFFORDABLE INSURANCE

- EXPLICIT STATE PREMIUM SUBSIDIES
  - SINCE OTHER APPROACHES MAY NOT LOWER PREMIUMS ENOUGH
  - GRANTEES:
    - MICHIGAN LEAGUE FOR HUMAN SERVICES (TARGETING INSURANCE PLANS TO POST-AFDC NEW EMPLOYEES TO KEEP THEM OFF WELFARE

      WASHINGTON'S BASIC HEALTH PLAN

      MAINE DEPARTMENT OF HUMAN SERVICES

- TRADITIONAL INSURANCE APPROACHES TO LOWERING PREMIUMS
  - MEDICAL UNDERWRITING (FL, TN, DENVER)
  - MINIMUM EMPLOYEE PARTICIPATION (AL, FL)
  - MINIMUM EMPLOYER CONTRIBUTION (AL, FL)
  - PRE-EXISTING CONDITION EXCLUSIONS AND/OR WAITING PERIODS (TN, UT, AZ, AL)
  - MINIMUM FIRM LIFE (FL)
  - MINIMUM EMPLOYEE TENURE (AL)

EMPLOYEE INCENTIVES

- SUBSIDIES (WA)
- EMPLOYEE POOLS (SOUTH COVE)
- TAX INCENTIVES
- ADVERSE SELECTION PROBLEM

OPTIONS FOR EXPANDING COVERAGE TO RECENTLY UNEMPLOYED WORKERS

- INSURANCE REGULATION
  - CONTINUATION REQUIREMENTS
  - CONVERSION REQUIREMENTS
  - COBRA

- MAY STILL BE UNAFFORDABLE FOR THE UNEMPLOYED

- ADVERSE SELECTION ISSUES

Comprehensive Health Care for

Alaska--Alternative Paths

Financing models:

Comprehensive health program

- Canadian model
- universal private insurance model

"Massachusetts plan"

- expanded private insurance plus public pool

Statewide health insurance pool

- pool existing public groups and enroll others into pool plan

Targeted programs for special populations

- workers/dependents, unemployed, mothers, children, uninsurable

Provider availability issues

Canadian Model

Tax-based, publicly funded universal coverage

- government pays providers directly
- controls costs by setting hospital & MD payments

Issues:

- benefits to cover?
- cost sharing?
- exclude elderly?
- expenditures and tax base needed?
- effectively eliminates most private insurance

State-Financed Insurance

Tax-based program where state purchases private insurance

- would cover all residents
- uses private insurance industry

Issues:

- benefits to cover?
- cost sharing?
- exclude elderly?
- expenditures and tax base needed?
- less cost control by using private insurance plans

"Massachusetts Plan"

Expanding private insurance through payroll tax and credits

Pool for all uninsured and others that wish to join

- to purchase private insurance plan(s) through state
- subsidies for low income persons
- include Medicaid if it purchases private insurance

Issues:

- benefits to cover?
- cost sharing?
- how to assure dependent coverage in all plans?
- size of employers to tax?
- rate of employer payroll tax?
- if Medicaid included, what about non-covered benefits?
- size of public expenditure and tax base needed?
- underwriting and adverse selection issues

State Insurance Pool

Create pool of existing insured public employees

- permit all insured and uninsured persons to enroll
- state-chosen plan(s)
- subsidies for low income persons
- include Medicaid if it purchases private insurance

Issues:

- benefits to cover?
- cost sharing?
- how to assure dependent coverage in all plans?
- if Medicaid included, what about uncovered benefits?
- size of public expenditure and tax base needed?
- financial viability of public insurance pools?
- underwriting and adverse selection issues

Targeted Programs

Special Populations

Workers and Dependents

- private employer incentives
- public subsidies
- Medicaid "buy in"

Unemployed

- COBRA extensions and subsidies
- special public/private programs

Children, Pregnant Women

- Medicaid expansions
- Medicaid "buy in"
- enhanced private insurance/regulation
- categorical programs

Medically High Risk Uninsurable persons

- risk pools
- Medicaid "buy in"

Non-Financial Access Barriers

Medically Underserved Areas

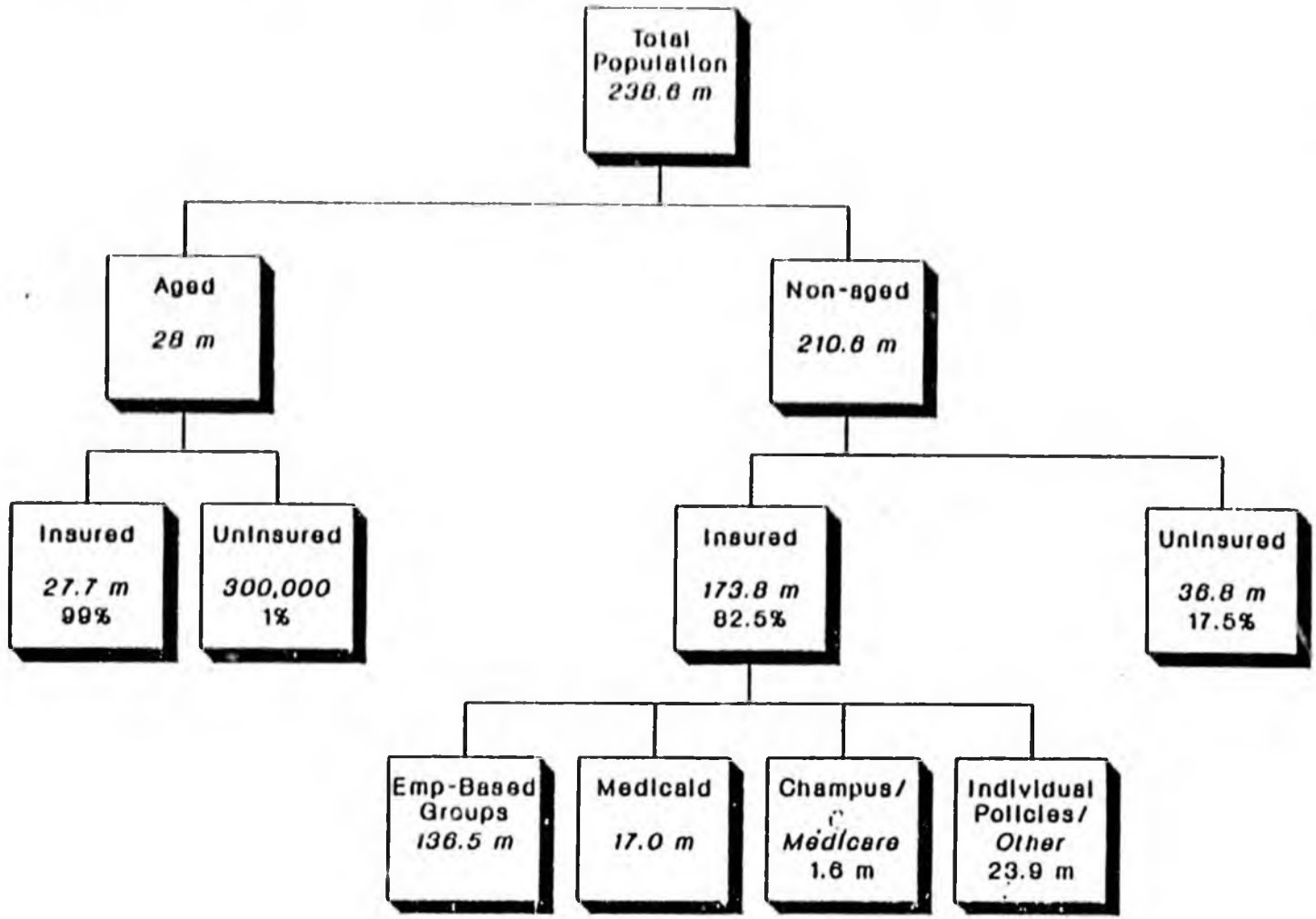
Provider availability

grants and loans to providers
direct payments to support hospitals and clinics
assistance with malpractice and other special costs

Delivery system issues

contracts with IHS providers to serve non-Native Americans

INSURANCE STATUS OF US POPULATION: 1986



Source: CRS Analysis of March 1987 CPS