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HEALTH CARE REFORM FINAL RECOMMENDATIONS

**TO THE
GOVERNOR**

**AND THE
SEVENTEENTH ALASKA STATE LEGISLATURE
ADOPTED MARCH 14, 1992**

**ALASKA STATE LEGISLATURE
HEALTH RESOURCES AND ACCESS TASK FORCE**

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INTRODUCTION

As promised in its January 1992 Interim Report to the Governor and Legislature, the Health Resources and Access Task Force has been pursuing the development of a comprehensive health reform package. Included in this document are the task force's interim recommendations which were formally adopted on March 14, 1992. These recommendations represent the task force's final recommendations to the Governor and the Seventeenth Alaska State Legislature.

The task force agreed that these recommendations would reflect the group's support for concepts rather than specific legislative bills. All recommendations described in this document are recommended for immediate consideration by the legislature unless otherwise noted and should be considered by the legislature as a package.

The task force will continue to pursue its charge to recommend to the governor and legislature a health care program covering all Alaskans and a strategy to contain health care costs. The task force will make its final recommendations to the governor and Eighteenth Alaska State Legislature when it ends on February 1, 1993.



SUMMARY OF RECOMMENDATIONS FOR COMPREHENSIVE HEALTH CARE REFORM

The Health Resources and Access Task Force recommends a **comprehensive** health reform package which will:

- Establish a single entity to oversee the cost containment, access, and pooling initiatives recommended by the task force;
- Control health care costs by establishing a global spending limit for all health care expenditures in Alaska and a reimbursement system for all health care payors;
- Increase access by reforming the small group insurance market, creating pools, and providing subsidies to certain uninsured individuals;
- Reduce medical malpractice costs; and,
- Reduce the 'excess capacity' in Alaska's health care facilities by strengthening the Certificate of Need process.

AN ENTITY TO OVERSEE COST CONTAINMENT, ACCESS, AND POOLING INITIATIVES SUPPORTED BY THE TASK FORCE

A single entity referred to as an authority or commission would oversee the cost containment, access, and pooling initiatives recommended by the task force. The task force supported the concept that the state structure the entity so that it functions in the most efficient manner possible and not duplicate functions in other entities. This entity should be established immediately after enactment of enabling legislation.



COST CONTAINMENT

The task force divided its recommendations on cost containment into three areas:

- A.** Global budgeting including global spending limits, reimbursement schedules, data collection/analysis, common claims forms, utilization standards, and time frames for claims payments;
- B.** Regulation of utilization review agents; and,
- C.** Authority to review rates filed by health insurers.

A. Global budgeting

A global spending limit or goal for all health care expenditures in Alaska will be established by a health care authority or commission.

The global spending goal will limit the annual rate of increase in health care expenditures to increases in the Consumer Price Index (CPI). The base for the goal is overall spending in a given prior year. The annual targets established in this manner can be adjusted by the authority/commission to reflect the following factors:

- Changes in the size and/or demographic characteristics (e.g., age distribution) of the state's population that may affect the need/demand or health care in the future;
- Changes in technology and health care delivery that may increase or decrease health care costs;
- The identification and reduction of the provision of unnecessary health care;

- Desired changes in some segments of the population (e.g., the uninsured's) access to adequate health care services;
- Increases or decreases in the costs associated with medical malpractice premiums and awards as appropriate;
- Reductions in administrative costs; and,
- Other such factors as the state authority/commission may determine to be appropriate (i.e., epidemics and disasters).

The overall limit or goal for health care expenditures will be subdivided, establishing limits or sub-goals for hospital care expenditures, physician services expenditures, etc.

All health care providers will comply with the payment or reimbursement schedules established by the authority/commission. Rates of reimbursement will be established as well as sanctions for non-compliance.

- For health care facilities (and the reimbursement levels for individual facilities), the base for the expenditure goal will be actual costs in a prior year.
- For hospitals, the unit of payment will be on a DRG-specific per discharge basis. Price or charge levels will be increased above cost levels to account for uncompensated care and/or Medicare rates that are not sufficient to cover costs.
- For physician services, the reimbursement schedules will utilize resource-based relative-value scale (RBRVS).
- For other services, the authority/commission will develop the specific reimbursement schedules.

Data collection is an essential element of global budgeting. The authority/commission will have the authority and capacity to collect and analyze all health care data necessary to do global budgeting.

The authority/commission will develop a uniform billing and common claims form which all payors (including self-pay) and providers will be required to use.

The authority/commission will develop utilization standards.

The authority/commission will establish requirements for the timely payment of claims by all payors. A target is 15 working days from the receipt of a clean claim.

The task force recognizes "global budgeting" will take several years to implement representing several phases. The first year following the creation of the authority/commission will be used to establish the data system and begin collecting data. In year two, data (from year zero and year one) will be analyzed and a global spending limit or goal, sub-goals, and a reimbursement system and rates will be established. In year three, global budgeting will be in place and as well as a new reimbursement system utilized.

B. Regulation of utilization review agents

The task force supported the concept of regulating utilization review agents which should be implemented in year one after enactment of enabling legislation.

C. Authority to review rates filed by health insurers

The task force supported the concept of providing the state director of insurance the authority to review and approve or disapprove rates filed by all health insurers, both non-profit and commercial, proposing to sell group and/or individual insurance in Alaska.



ACCESS

The task force divided its recommendations on access into seven areas:

- A.** Small group market reform
- B.** State high-risk pool enacted by law
- C.** Community rating/minimizing medical underwriting
- D.** Pools created by the authority/commission
- E.** State incentives
- F.** "Pay-or-play" approach
- G.** Retention and attraction of health care professionals

A. Small group market reform

Having recognized the problems facing small groups in their interim report, the task force supported the concept of small group market reform. Improvements in the availability of private coverage for small employers can be accomplished through insurance regulation reform and the creation of a reinsurance association. A model recommended by the National Association of Insurance Commissioners is designed to:

- promote the availability of health insurance to small employers regardless of their health status or claims experience;
- prevent abusive rating practices;
- require disclosure of rating practices to purchasers;
- establish rules regarding the renewability of coverage;
- establish limitations on the use of preexisting condition exclusions;
- provide for development of "basic" and "standard" health benefit plans to be offered to small employers;
- provide for the establishment of a reinsurance program; and,
- improve the overall fairness and efficiency of the small group insurance market.

Small group market reforms could be operational within 12 months following the creation of a reinsurance association.

The task force recognized that in order for pools created by the authority/commission to avoid attracting a disproportionate share of high-risk individuals and thereby decreasing their viability, such pools must employ the same rating and underwriting practices used by private insurers. Therefore, these small group market reforms are an essential first ingredient to establishing such pools.

B. State high-risk pool enacted by law

The task force supported the concept of establishing a high-risk pool. In doing so, the task force chose not to endorse either an assessment level on insurers or a particular level of state subsidy typically used to finance such a pool, or a specific premium cap for enrollees. The task force recognized that the need for a high-risk pool would diminish as insurers moved closer to community rating and away from medical underwriting.

C. Community rating/minimizing medical underwriting

In addition to the above-mentioned Insurance Industry reforms, the task force supported the concept of 'community rating'. They recommended the authority/commission identify the effects of mandating community rating (for all private groups as well as any pools created by the authority/commission) and report to the legislature its findings and recommendations within one year of the creation of the commission/authority.

The task force also supported the concept of 'minimizing medical underwriting'. They recommended an appropriate administrative entity identify the effects of restricting the degree to which private insurers (for private groups) and the authority/commission (for pools created by the authority/commission) can practice medical underwriting and report to the legislature its findings and recommendations within one year of the creation of the commission/authority.

D. Pools created by the authority/commission

An authority/commission created by the state would have the authority to establish pools.

The task force supported the concept that both individuals and groups would be eligible to join pools created by the authority/commission.

Any pool created by the authority/commission would take 12 to 15 months to become operational once the decision was made to do so.

E. State incentives

The task force, recognizing that it is often necessary to provide incentives to groups and individuals to become insured, established the following order of priority for state subsidies (1 = highest, 4 = lowest):

1. low income pregnant women and children;
2. low income adults and children (not included under "1" above);
3. high-risk individuals; and,
4. small businesses.

The task force supported the concept that the highest priority benefits for low-income pregnant women and low-income children (their highest priority group for a state subsidy), is 'comprehensive services' (preventive, ambulatory, and inpatient services) for low-income pregnant women and 'ambulatory services only' for low-income children.

F. "Pay-or-play" approach

The task force did not recommend any immediate action regarding the "pay-or-play" approach but agreed they would consider it further at their June 1992 meeting.

G. Retention and attraction of health care professionals

The task force recommended the implementation of incentives which will help to attract and retain qualified health care professionals in medically underserved areas of the state.



MEDICAL MALPRACTICE

The task force recommended using "clear and convincing" as the standard of proof in lawsuits arising from the delivery of a baby.

The task force recommended changing the statute of limitation from the current law (2 years from event or knowledge of event but tolled until age 19) to 8th birthday for a child under age 6.



HEALTH PLANNING/CERTIFICATE OF NEED

The task force supported the concept of strengthening the Certificate of Need process including the recommendation directing the Department of Health and Social Services to promulgate standards in regulation establishing "need" and determining whether a Certificate of Need will be awarded. The task force recommended that Certificate of Need apply to all health facilities including Pioneers' Homes, Veterans Homes, and doctors' offices for expensive medical equipment. The task force recommends that federal facilities voluntarily comply with Certificate of Need and file impact statements with the Department of Health and Social Services. It will take the Department approximately 12 months to develop standards once given the authority to do so.