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STATE OF ALASKA

**HEALTH RESOURCES AND ACCESS
TASK FORCE**

Interim Report to the Governor and Legislature

Adopted, January 11, 1992

THE STATE OF ALASKA
HEALTH RESOURCES AND ACCESS TASK FORCE

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to the
Governor
and
Legislature

Adopted, January 11, 1992

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EXECUTIVE SUMMARY

The United States spends more on health care than most other industrial countries. In the 1980s, employers began to pay a dramatically larger percentage of their after-tax profits and households a larger share of their after-tax income on health care.

U.S. health care spending grew at nearly twice the rate of general inflation in the 1980s. Total health spending in Alaska was \$1.5 billion in 1990, up from \$481 million in 1979. This dramatic rise in the cost of health care generated significant concern for those who finance health care, primarily employers. It raised questions about what they are paying for and why costs are rising.

Concerns about higher costs influenced insurers to become increasingly defensive and selective. Their practices have affected all employers but particularly small employers. These groups more frequently experience high and unanticipated rate increases and a larger share of their premium goes toward administrative costs. Small group insurance practices have directly excluded some groups and individuals with pre-existing conditions, health needs, and those that work in certain industries. Higher premiums have influenced employers to share more of the costs with their employees, to drop dependent coverage, and even health care as a benefit. As a result, an increasing proportion of the Alaskan population is without health care coverage. Approximately 90,000 Alaskans are uninsured. Eighty-five percent of the uninsured Alaskan adults have some link to the work force and of those that work, 55 percent work for small businesses. Trends also suggest a growing percentage of insured Alaskans have inadequate coverage.

The uninsured and individuals with inadequate coverage generate significant unpaid medical bills. In addition, some payors reimburse providers below what it cost them to provide the services. All costs incurred by providers for services which are underpaid or not paid are shifted to other payors, most notably, employers who provide health insurance for their workers and taxpayers. As costs are shifted, premiums for the insured increase and the pressure increases on employers to control costs, ask employees to pay more of their premiums, and reduce and even drop coverage.

Some aspects of Alaska's health care access and cost problems are unique. The task force was able to obtain information on only some of those aspects. For example, charge levels for health care services in Alaska are generally higher than the national average. Occupancy rates at our community hospitals have historically been below the national average. It is estimated that Alaska has 229 surplus beds in our hospitals which cost Alaska's health care payors between \$5.8 and \$11.6 million per year. In 1990, 10 acute

care community hospitals shifted \$16.8 million of actual costs to other payors to cover costs associated with charity care, bad debt, and Hill Burton free care. Alaskans living in rural and remote areas of the state defer treatment because of the travel or costs required. Alaskans have to travel to Anchorage or another state to access the majority of high-tech medical services. And some Alaskan communities have a shortage of family practice physicians.

These problems have existed in Alaska for a long time. However, these problems have grown so significantly in the 1980s that more Alaskans are at risk of becoming uninsured or underinsured. Employers, taxpayers, policymakers, health care providers, labor organizations, consumers, and insurers recognize that changes must be made in the way we finance and utilize health care services.

The Health Resources and Access Task Force has brought the major health care interests together. Their charge is to design a program that will provide access to a basic level of health care services for all Alaskans and a strategy to contain health care costs. This report contains their interim findings. It also lists the policy options under their consideration. The task force expects to recommend specific legislation to the governor and legislature by March 16, 1992.

SUMMARY OF FINDINGS

HEALTH CARE ACCESS PROBLEM-UNDERSTANDING TO DATE

The Size and Characteristics of the Uninsured Population in Alaska

- In 1989, approximately 90,000 Alaskans had no health care coverage.
- In 1989, approximately 28,000 Alaskan children were uninsured.
- In 1989, twenty-thousand uninsured Alaskans had incomes below the federal poverty level and another 20,000 had incomes one and two times the poverty level. Thirty-one thousand uninsured Alaskans had incomes greater than three times the poverty level.
- In 1989, of the 61,000 nonelderly uninsured adult Alaskans, 51,000 had some link to the work force.
- In 1989, of the 51,000 uninsured Alaskan workers, 28,000 were employed by small businesses with fewer than 25 employees.

Why Some Employers do Not Provide Health Insurance Benefits

- According to a 1989 HIAA survey, 75 percent of employers when asked the reasons for not offering health insurance, said it was too expensive.

Problems Facing Small Groups

- Small groups seeking health care coverage more frequently experience practices which directly exclude groups or individuals or coverage for certain pre-existing medical conditions.
- "Select and ultimate" rating approaches used in conjunction with pre-existing condition limitations can result in high and unanticipated rate increases which often motivates groups to change insurance carriers.
- Tiered rating structures used by the small group insurers result in very high rates for groups with health needs. These rates frequently drive these groups out of the market.
- Manual rating used by small group insurers result in higher premiums for older employees and women, regardless of their health status.
- Some small businesses in certain industries cannot find insurers that will write policies for their employees.

- For comparable benefit packages, health plan costs are 10 to 40 percent higher for small employers. Small business owners overwhelmingly cite the cost of coverage as the most important reason for not offering health insurance coverage.
- The administrative expenses of insurers, reflected in premiums offered, are significantly higher for small groups than large groups.
- Only a handful of insurers sell to small groups in Alaska.

The Consequences of Having an Uninsured Population

- A larger share of the uninsured report having a lower health status than the insured.
- The uninsured use fewer services overall than the insured. However, when they do use services, it is more likely to be late in the course of a disease and in costly institutional settings such as emergency rooms.
- The uninsured (and underinsured) generate significant unpaid medical bills which ultimately are paid by employers who offer health insurance for their workers, taxpayers, and health care providers who absorb costs not paid by other sources.

Other Indicators of the Health Care Access Problem in Alaska

- If the national estimate "that one-quarter of the privately-insured under 65 population is underinsured" is accurate in Alaska, then it can be estimated that about 60,000 nonelderly Alaskans are underinsured.
- Some Alaskans who are covered by Medicaid and Medicare may have difficulty finding a provider that will treat them.
- Some Alaskans defer medical treatment because of the travel required to see a health care provider or costs associated with travel.

HEALTH CARE COST PROBLEM-UNDERSTANDING TO DATE

Indicators of the Health Care Cost Problem

- Health care spending in the United States is increasing much faster than general inflation.
- Total health care spending in Alaska in 1990 was estimated to be \$1.523 billion, up from \$481.25 million in 1979.
- In Alaska, per capita health care spending increased 111 percent from \$1,197 in 1979 to \$2,524 in 1989.

- In 1987, per capita health care spending for the elderly in the U.S. was four times greater than for children under 19 years of age. Population trends suggest the elderly will consume an even larger share of total health care spending in future years.
- Alaska's 1990 per capita health care spending was 36 percent above the age-adjusted national average.

Who Pays the Health Care Bill in Alaska and What Services are They Paying For

- The federal, state, and local governments pay a larger proportion of the health care bill in Alaska as compared to the U.S. as a whole.
- In 1990, 38.4 percent of all U.S. health care spending went for hospital care, 18.9 percent for physician services, 8.2 percent for drugs and nondurables, 7.9 percent for nursing home care, and 12.1 percent for nonpersonal services.

The Consequences of High Health Care Expenditures

- Health care spending represents an increasing share of the GNP in the United States.
- The United States spends more on health care than most other industrial countries.
- Employers are spending a higher percentage of their corporate after-tax profits on health insurance.
- Households are spending a larger percent of their after-tax income on health care.
- During the 1980s, out-of-pocket expenditures increased faster than medical care prices due in part to increased employee cost-sharing. Both the percentage of plans requiring premium cost-sharing and the dollar amounts contributed by employees have increased in the 1980s.
- In 1989, nearly two-thirds of 43 major labor walkouts in the United States were disputes over health benefits.
- A larger percentage of Alaskans are becoming uninsured.

Factors Contributing to the Increase in Health Care Expenditures

- Between 1975 and 1987, general price inflation accounted for 51.3 percent of the increase in personal health expenditures in the U.S. while medical price inflation contributed 19.5 percent. Population growth accounted for another 8.8 percent of the increase and all other factors including changes in utilization, the intensity of the services used, and the aging of the population together contributed 20.4 percent of the growth in expenditures.
- In the United States, between 1975 and 1988, population growth was a fairly constant contributor to the growth in health care spending. General inflation, medical inflation, and all other factors varied as contributors over the same period.
- Population growth, one factor known to contribute to the increase in health care expenditures, increased at a 3.2 percent average annual rate in Alaska in the 1980s as compared to 1.1 percent for the U.S. as a whole.
- Medical price inflation in Anchorage has increased at approximately the same rate as the U.S. average.

FACTORS WHICH CONTRIBUTE TO HEALTH CARE ACCESS AND COST PROBLEMS IN ALASKA

Charges/Prices for Health Services in Alaska

- Charge levels for health care services in Alaska are generally higher than the national average.
- Between 1972 and 1989, the average expenses per adjusted patient day in Alaska's acute care community hospitals ranged from 60 to 100 percent above the national average.
- Between 1972 and 1989, the average annual payroll per employee in Alaska's acute care community hospitals was 37 to 72 percent above the national average.
- Alaska's Medicaid reimbursement rate for nursing home beds is three times the U.S. average net patient revenue for nursing home care.

Patient Utilization Patterns in Alaska

- Occupancy rates in Alaska's acute care community facilities have historically been below the national average for comparably-sized hospitals except during the economic boom of the 1980s. In 1989, the Alaska average occupancy rate was 45 percent compared to the U.S. average of 57 percent for similar-sized facilities.

- On an average per capita basis, Alaskans have historically spent considerably fewer days in Alaska's acute care community hospitals than the U.S. population as a whole spent in U.S. hospitals. In addition, once admitted, Alaskans on the average have shorter lengths of stay as compared to the U.S. population as a whole.
- Outpatient utilization at Alaska's acute care community hospitals has historically been below the national average.

Excess Capacity in Alaska's Acute Care Community Hospitals

- Using the national average as the bench mark, 12 of Alaska's 16 acute care community hospitals have excess capacity or beds. At the U.S. average occupancy rate, 229 of the 1,027 acute care beds in Alaska are surplus. Eighty percent of the surplus beds are in Anchorage and Fairbanks. Only 15 excess beds are in co-located facilities (both acute care and nursing home beds).
- The total annual cost to Alaskans in 1989 to pay for surplus beds has been estimated to range from \$5.8 to \$11.6 million or 2 to 4 percent of the total annual acute care facility costs.
- Using a more rigorous standard for occupancy, 75 percent, and a fixed cost assumption of 20 percent, the annual cost of excess capacity in Alaska's acute care facilities would be as high as \$20.8 million.

High-Tech Medical Equipment and Services in Alaska

- Alaskans must travel to Anchorage or other states to access the majority of high-tech medical services. Some high-tech services are available in Fairbanks and a few are available in Juneau, Palmer, and Ketchikan.
- Alaska's demand for high-tech medical equipment and services is reduced.
- Alaska does not presently have excessive amounts of high-tech equipment and units. The equipment and units increase health care expenditures in Alaska but are not a major influence at this time.
- Increased access to high-tech medical equipment, particularly in smaller communities, may result in higher health care expenditures, increased use, and diminished quality of care.

Mandated Benefits in Alaska

- Alaska has only two significant mandated benefits. Together they have a minor cost impact on individual insurance premiums.

Uncompensated Care/Cost-Shifting to Public and Private Payors

- In 1990, ten hospitals, representing 86 percent of the acute care community hospital beds in Alaska, shifted \$16.8 million of actual costs to other payors to cover costs associated with charity care, bad debt, and Hill Burton free care. This traditional method of financial hospital care provided to the uninsured (and underinsured) and other shortfalls from government health care financing programs can result in significant increases in prices that most Alaska hospitals charge privately insured persons.

Distribution of Physicians in Alaska

- Some Alaskan communities, particularly in Southeast, have insufficient numbers of family practice physicians.

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CHAPTER ONE INTRODUCTION

During the 1991 legislative session, the Alaska State Legislature passed Legislative Resolve 45 which created the Health Resources and Access Task Force. The primary purposes of the task force are:

- (1) to design a cost-efficient program that allows access to a basic level of health care services for all state residents;
- (2) to continue the work of the Health Care Cost Containment Task Force in seeking ways to achieve savings in the cost of health care in the state; and,
- (3) to define a strategy for implementing a health care program covering all Alaskans and a strategy to contain the costs of health care in the state.

(The resolution creating the task force includes 14 specific tasks related to these primary purposes. Appendix A contains the resolution.)

The Health Resources and Access Task Force was created as a result of an agreement between legislative and executive branch leaders that a single unified task force would continue the work of the Health Care Cost Containment Task Force and begin the work of the Universal Health Care Task Force.

The Health Resources and Access Task Force consists of 17 members including three members of the Senate, three members of the House, three members representing the executive branch, and eight public members representing the medically indigent, employers, health care providers, health insurers, nonprofit organizations, consumers, and labor organizations.

The task force, created in May of 1991, ends on February 1, 1993. The legislative and executive branch members met in June and August 1991 to organize and appoint the public members. The full task force met in September, October, November 1991 and January 1992. During those meetings, the task force developed an understanding of the health care access and cost problems facing Alaska and reviewed approaches implemented by other states in resolving similar problems. In addition, they drafted guiding principles and began the development of options aimed at resolving some of the health care problems facing Alaska.

Numerous individuals participated in task force meetings and presented information including Steve LeBrun with Aetna Life Insurance Company; Bruce Amundson, M.D.; Harlan Knudson and Garrey

Peska representing the Alaska State Hospital and Nursing Home Association; Jeffrey Duzenbery and Jeff Gingold with Blue Cross of Washington and Alaska; Jennifer Christian, M.D., (President of the Alaska State Medical Association) and David Hennigan representing the Health Access and Cost Containment Council; Jay Livey, Kim Busch, Jack Nielsen, Gordan Landes, Larry Streuber and Bradley Whistler with the Alaska Department of Health and Social Services; and, Dave Walsh and Chris Ulmann with the Alaska Division of Insurance. Numerous presentations were also made by Larry Bartlett, Ph.D., Director of Health Systems Research, Inc. and Scott Goldsmith, Ph.D., with the Institute of Social and Economic Research. In addition to the seventeen task force members, a number of individuals also participated as designees of members including Kim Busch, James Gingerich, Jay Livey, Pat Smutz, Dave Walsh, and Roberley Waldron.

Legislative Resolve 45 requires the task force to report its findings and recommendations to the governor and legislature by February 1, 1992 and February 1, 1993. This report represent their interim findings and lists the options under their consideration. It also contains much of the information presented at their meetings to date.

Chapter Two contains guiding principles drafted by the task force to be used to develop and evaluate public policy options.

Chapter Three describes several indicators of the extent to which Alaskans do not have access to appropriate, affordable health care. It also describes the difficult problems facing those who are at the greatest risk of not having insurance and the consequences of their not having access. Several indicators of the high cost of health care in Alaska are also described as well as the consequences of and the factors which contribute to high costs. This chapter also contains information on factors which the task force suspect contribute to the health care access and cost problems in the state and for which they were able to obtain Alaska-specific information.

Chapter Four lists the options which are under consideration by the task force.

CHAPTER TWO GUIDING PRINCIPLES

At its September meeting, the Health Resources and Access Task Force drafted the following principles to be used to guide the development of public policy. These principles will assist the task force in evaluating options under their consideration.

PREAMBLE

The Constitution provides that the State of Alaska is responsible for the public health. However, each Alaskan bears individual responsibility to maintain a healthful lifestyle.

Health care costs can best be contained by an educated public, committed to wellness. The state must take an aggressive role in working with all Alaskans on health and safety education and the prevention of illness.

Access

1. All Alaskans should have access to adequate, effective, appropriate, and quality health care services without regard to financial means or status.
2. A basic level of health care will be defined by the task force to which everyone has access, with priority on effective, appropriate, and quality care, especially preventive and primary care, early diagnosis and treatment, and incentives for healthful lifestyles.

Financing

3. All Alaskans share a responsibility to obtain and pay for adequate health care for themselves and their dependents, but the government should participate in financing care for those unable to pay.
4. Responsibility for the financing of options should be equitably distributed among payers.
5. Options for improving access should minimize the negative impacts on businesses and on current employer health benefit plans and should not be an incentive for providers to reduce or drop coverage. Employers are encouraged to participate with their employees to meet the responsibility regarding care for their own health needs.

Cost Containment

6. Health care expenditure controls should be essential elements of approaches to expand access to care for the uninsured and to ensure continued adequate coverage for those currently insured.
7. Use of cost sharing may be considered to control excessive utilization but should take into account ability to pay.
8. Approaches should include incentives to seek and provide care in the most efficient and cost effective manner and location, including contractual arrangements for patient management and utilization controls.
9. Providers should be reimbursed at reasonable levels. These and other health care policies should promote efficient service delivery and availability and constrain unnecessary expenditures.
10. Individuals should have an informed and reasonable choice in selecting health care providers although they may be restricted to certain providers in cases where these arrangements significantly increase the cost-effectiveness of this care.

General

11. Approaches to expand access to care for the uninsured should be as simple to administer as possible and avoid duplication of resources. Special attention should be given to minimizing the administrative burden on small businesses, providers and consumers.
12. Program policy design should be sensitive to the culture and problems of provider availability and accessibility, especially in rural areas.

CHAPTER THREE
HEALTH CARE ACCESS AND COST PROBLEMS
STUDIED BY TASK FORCE

The Health Resources and Access Task Force developed an understanding of the access and cost problems facing Alaska by reviewing national and state data. In many cases, their review was limited by the lack of comprehensive data and their understanding based on problems for which they could obtain data.

Many Alaskans do not have access to appropriate, affordable and timely health care. One significant indicator of the "access problem" is the size of the uninsured population. Section (A) of this chapter describes:

- the size and characteristics of the uninsured population in Alaska;
- some of the reasons employers do not provide health insurance benefits;
- the problems facing small groups (who are at the highest risk of being uninsured or becoming uninsured);
- the consequences of having an uninsured population; and,
- some other indicators of the access problem in Alaska.

The high cost of health care is overwhelmingly cited by employers as the most important reason for not offering health care coverage. Section (B) of this chapter describes:

- indicators of the magnitude of the health care "cost problem" in Alaska including who pays the health care bill in Alaska and what they are paying for;
- the consequences of high expenditures; and,
- factors that contribute to rising expenditures.

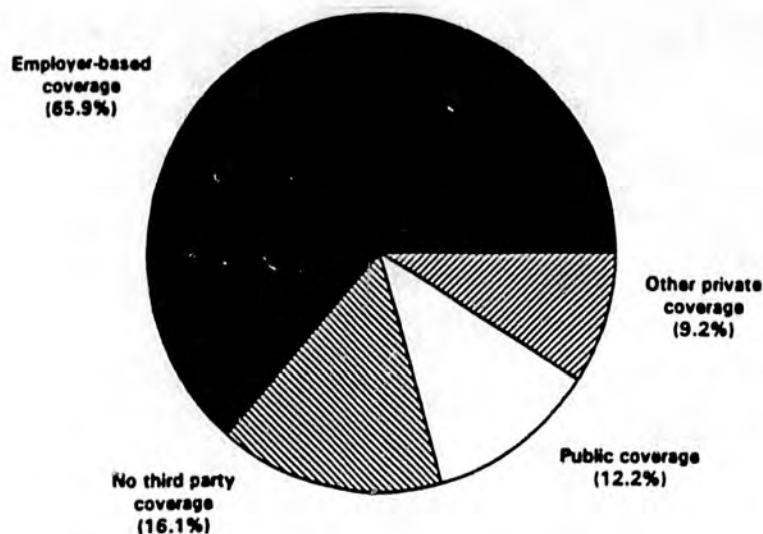
Section (C) of this chapter includes Alaska-specific information on factors which the task force suspects contribute to the health care access and cost problems in the state. As the task force discovered, some of these factors are more significant than others. The factors include:

- charges or prices for health services in Alaska;
- patient utilization patterns in Alaska;
- excess capacity in Alaska's acute care community hospitals;
- the extent of high-tech medical equipment and units in Alaska;
- mandated benefits in Alaska;
- uncompensated care in Alaska's acute care community hospitals and cost-shifting to public and private payors; and,
- the distribution of physicians in Alaska.

A. HEALTH CARE ACCESS PROBLEM-UNDERSTANDING TO DATE

Unlike many industrial countries, the United States relies primarily on employers to finance health care. In 1989, 65.9 percent of the nonelderly U.S. population had employer-based coverage, 9.2 percent had other private coverage, 12.2 percent had public coverage including Medicare, Medicaid, and Champus, and 16.1 percent had no third party coverage.¹ One significant indicator of the access problem is the size of the uninsured population.

Figure 1. Nonelderly Population with Selected Sources of Health Care Coverage in the United States, 1989



Source: Employee Benefit Research Institute analysis of March 1990 CPS data.

The Size and Characteristics of the Uninsured Population in Alaska

The task force reviewed data on the characteristics of the uninsured population in Alaska. Of the uninsured, some have tried to obtain health care coverage but have not been able to find an willing insurer. Others have been offered rates that are unaffordable. Still other uninsured Alaskans have not attempted to obtain coverage.

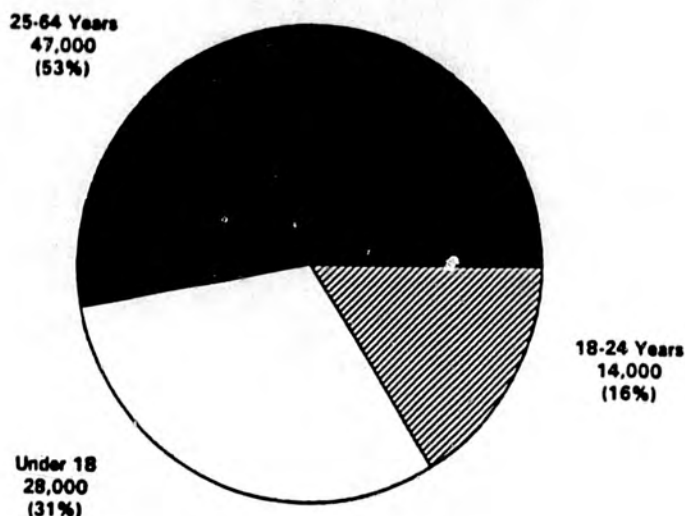
- In 1989, approximately 90,000 Alaskans had no health care coverage.

An analysis of data from the Alaska portion of the 1988 and 1989 Current Population Survey (CPS) revealed that in 1989 approximately 90,000 Alaskans had no health care coverage such as private

insurance, Medicaid, or Medicare, and lack any other third-party health care coverage. This represented 18.8 percent of the state's population. The 90 percent confidence range for this 1989 estimate of uninsured Alaskans is 90,000 plus or minus 23,000 individuals or between 67,000 and 113,000 Alaskans.² Another analysis indicates the number of uninsured Alaskans grew at a faster rate between 1980 and 1988 than the national average.³

- In 1989,⁴ approximately 28,000 Alaskan children were uninsured.

Figure 2. Uninsured Alaskans by Age, 1989

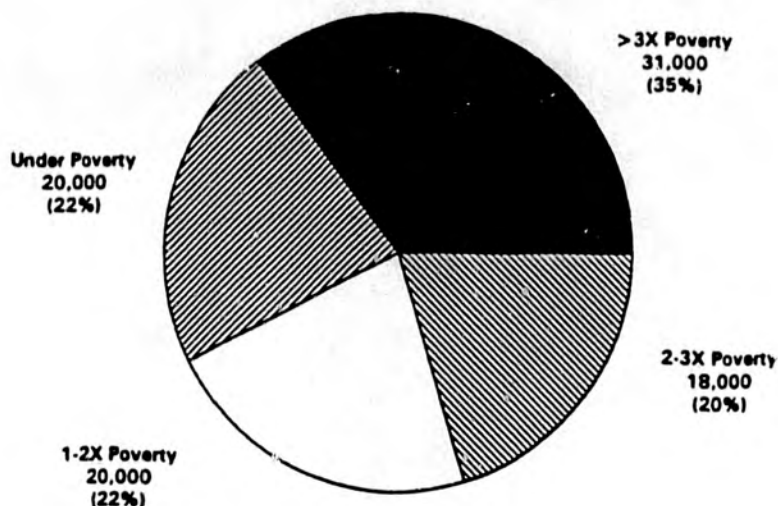


Source: Health Systems Research Inc., analysis of March 1988 and 1989 CPS.

- In 1989, twenty-thousand uninsured Alaskans had incomes below the federal poverty level and another 20,000 had incomes one and two times the poverty level. Thirty-one thousand uninsured Alaskans had incomes greater than three times the poverty level.⁵

The 1989 Alaska federal poverty level income for a family of 4 was \$15,120.⁶

Figure 3. Uninsured Alaskans by Poverty Status, 1989

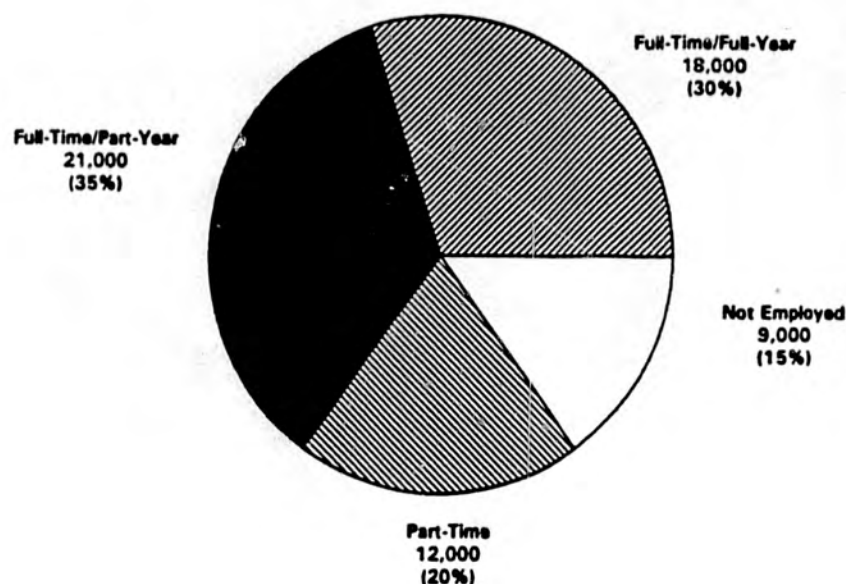


Source: Health Systems Research, Inc., analysis of March 1988 and 1989 CPS.

- In 1989, of the 61,000 nonelderly uninsured adult Alaskans, 51,000 had some link to the work force.

The CPS analysis revealed 85 percent of the uninsured nonelderly adults (ages 18-64) were employed for at least some portion of the year in which they were uninsured. Only 15 percent were unemployed the entire year.

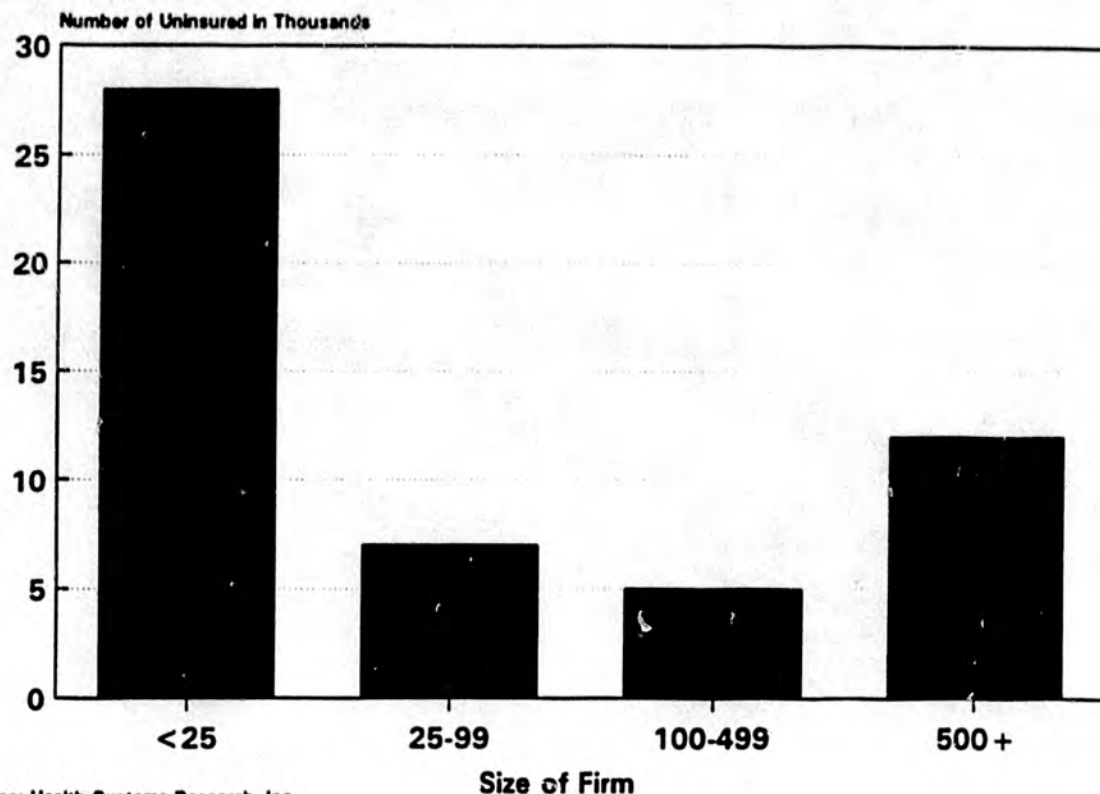
Figure 4. Employment Status of Uninsured Alaskans, 1989
Ages 18-64



Source: Health Systems Research, Inc., analysis of
March 1988 and 1989 CPS.

- In 1989, of the 51,000 uninsured Alaskan workers, 28,000 were employed by small businesses with fewer than 25 employees.⁸

Figure 5. Uninsured Workers in Alaska by Size of Firm, 1989



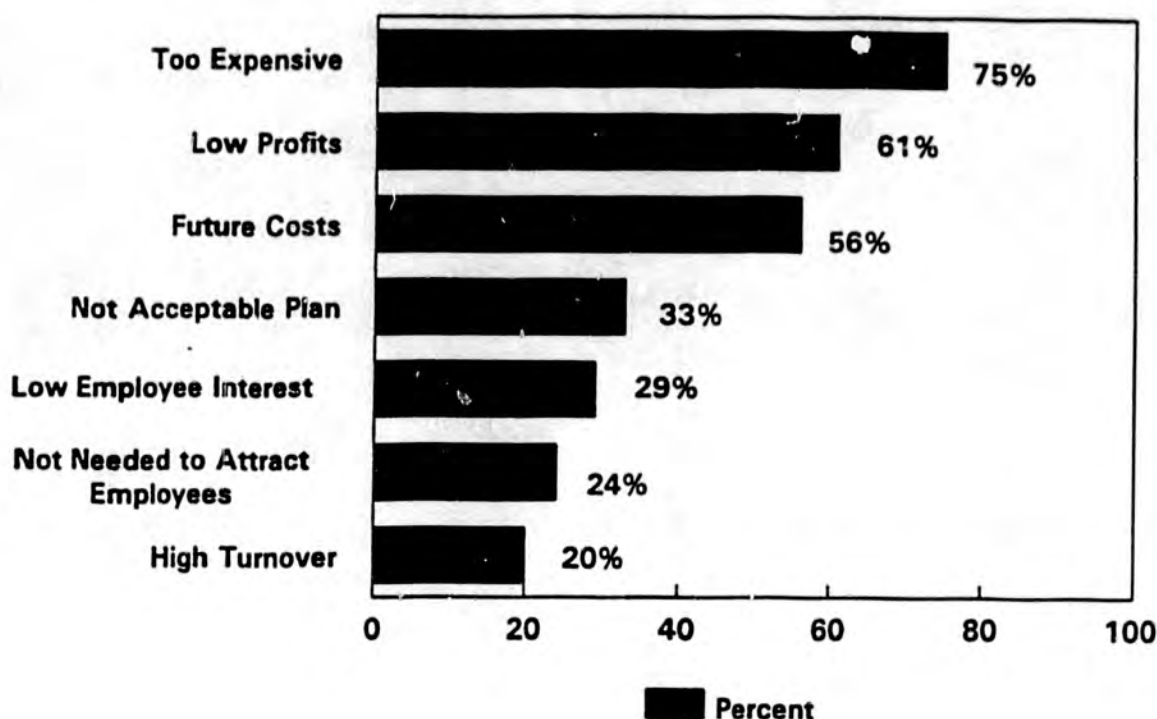
Source: Health Systems Research, Inc., analysis of March 1988 and 1989 CPS.

Why Some Employers Do Not Provide Health Insurance Benefits

- According to a 1989 HIAA survey, 75 percent of employers when asked the reasons for not offering health insurance, said it was too expensive.

In the same survey, employers identified other reasons for not providing coverage.

Figure 6. Percent of Firms Citing Particular Reasons as a Very Important Reason for Not Offering Health Insurance



Source: HIAA 1989 Employer Survey.

Problems Facing Small Groups

Small groups with fewer than 25 employees are the highest risk of being uninsured or becoming uninsured. A description of the problems these groups face in securing and retaining insurance coverage is described below.

The nature of small businesses has historically contributed to the difficulty in providing adequate and continuous coverage to employees at an affordable cost. New businesses start up and fail at a rapid rate. Employee turnover in small businesses is higher and they employ more part-time workers. High fluctuations in monthly cash flows and seasonality of work may also contribute to the difficulty in providing coverage.

The small group insurance market experienced serious problems during the 1980s when prices rose disproportionately and some insurers experienced significant losses. Many insurers left this

market and those that remain adopted increasingly defensive practices.

- Small groups seeking health care coverage more frequently experience practices which directly exclude groups or individuals or coverage for certain pre-existing medical conditions.

Some insurers in the small group market are requiring extensive medical histories and/or medical exams before agreeing to provide coverage to a group. Medical underwriting practices, typically not required for larger groups, help the insurer identify high risk individuals. Insurers may attempt to avoid a loss by refusing to cover a particular individual or a pre-existing health condition. They may adjust their proposed premium to cover the anticipated exposure due to the high risk condition, or they may refuse the entire group. Pre-existing condition limitations, which usually last between 12 and 36 months, preclude coverage for care related to a medical condition which pre-dated the purchase of the policy.¹⁰

- "Select and ultimate" rating approaches used in conjunction with pre-existing condition limitations can result in high and unanticipated rate increases which often motivates groups to change insurance carriers.

Small group insurers frequently use a "select and ultimate" rating approach where an initial rate is given to a group for a period during which certain pre-existing limitation exclusions are in effect. A subsequent and frequently higher rate is offered as coverage for treatment of the previously excluded medical conditions becomes effective. Faced with large increases in rates, businesses may seek coverage from a different carrier which often results in employees with chronic health problems facing another waiting period.¹¹

- Tiered rating structures used by the small group insurers result in very high rates for groups with health needs. These rates frequently drive these groups out of the market.

Small group insurers divide or segment pools based on claims experience and projected risk in attempt to provide lower rates for low use groups. Each segment receives a corresponding rate. The result is high rates for small groups with health needs.¹²

- Manual rating used by small group insurers result in higher premiums for older employees and women, regardless of their health status.

Insurers frequently "manually rate" small groups offering premiums based on the age, sex, and area of those seeking coverage. The

insurance industry practice is to "avoid cross-subsidization" by charging premiums for each subscriber based on what that person is expected to use. The result is that premiums for young, single individuals, particularly men are low in comparison to premiums for older employees and or businesses with predominately a female work force.¹³

- Some small businesses in certain industries cannot find insurers that will write policies for their employees.

Some small businesses whose employees may have greater exposure to certain hazards on-the-job such as small aviation firms and heavy equipment operators cannot find insurers that will write policies for their employees. Health care providers sometimes experience these problems because they are suspected of being high users. Other groups who are considered financially unstable including those that are predominately seasonal are sometimes excluded from coverage without regard to health status or their ability to pay.¹⁴

- For comparable benefit packages, health plan costs are 10 to 40 percent higher for small employers. Small business owners overwhelmingly cite the cost of coverage as the most important reason for not offering health insurance coverage.^{15, 16, 17}

A 1987 study prepared for the Small Business Administration found that health plan costs, with comparable plans and benefits, were 10 to 40 percent higher for small businesses than for larger businesses.¹⁸

- The administrative expenses of insurers, reflected in premium⁹⁴ offered, are significantly higher for small groups than large⁹⁵ groups.

A 1990 Congressional Research Service study which examined the administrative expenses of insurers as a percentage of claims paid. Administrative expenses were defined as expenses for claims and general administration, interest credit, premium taxes, profit and risk, and commission. Although individual policies may vary, this study found that the smallest groups may pay as much as 40 percent of their incurred claims toward administrative costs and the largest groups as little as 5.5 percent.¹⁹

Figure 7. Breakdown of Insurance Company Administrative Expenses
(Percentage of Incurred Claims)

<u>Number of Employees</u>	<u>General*</u>	<u>Profit & Risk</u>	<u>Commission</u>	<u>Total</u>
1 to 4	23.1	8.5	8.4	40.0
5 to 9	21.0	8.0	6.0	35.0
10 to 19	17.5	7.5	5.0	30.0
20 to 49	14.9	6.8	3.3	25.0
50 to 99	10.0	6.0	2.0	18.0
100 to 499	8.9	5.5	1.6	16.0
500 to 2,499	7.8	3.5	0.7	12.0
2,500 to 9,999	5.9	1.8	0.3	8.0
10,000 or more	4.3	1.1	0.1	5.5

Source: Congressional Research Service

* Includes claims administration, general administration, interest credit, and premium taxes.

The Health Insurance Association of America also reports administrative expenses. Their data reflects a similar distribution in the types of administrative expenses but a smaller range (25 percent of incurred claims for groups with fewer than 25 employees and 6 percent for groups of 2,500 or more employees).²⁰

- Only a handful of insurers sell to small groups in Alaska.

According to the Division of Insurance, at this time only nine insurers sell to the small groups in Alaska.²¹

Thirty-nine percent of private employees work in firms with fewer than 20 employees or about 53,000 Alaskans. These workers are primarily employed in the trade and services sectors but include all industries.²²

The Consequences of Having An Uninsured Population

Both the uninsured individual and other health care payors bear the consequences of having an uninsured population.

- A larger share of the uninsured report having a lower health status than the insured.²³
- The uninsured use fewer services overall than the insured. However, when they do use services, it is more likely to be late in the course of a disease and in costly institutional settings such as emergency rooms.

A 1986 Health Interview Survey found the uninsured see a physician two-thirds as often as the insured and spend three-fourths as many days in the hospital. They are more likely to rely on emergency rooms for routine services.^{24, 25}

- The uninsured (and underinsured) generate significant unpaid medical bills which ultimately are paid by employers who offer health insurance for their workers, taxpayers, and health care providers who absorb costs not paid by other sources.

Uncompensated care or unpaid medical bills are generated by the uninsured when they are unable to pay for their medical care. Health care providers must shift or absorb the costs of services to the uninsured to other health care payors ultimately increasing the cost of health care for the insured. (Uncompensated care and cost-shifting will be discussed in Section (C) of this chapter.)

Other Indicators of the Health Care Access Problem in Alaska

Other indicators of the access problem are described below.

- If the national estimate "that one-quarter of the privately-insured under 65 population is underinsured" is accurate in Alaska, then it can be estimated that about 60,000 nonelderly Alaskans are underinsured.

The underinsured have health care coverage but it does not adequately cover necessary care. Although, the underinsured have not been sufficiently identified, one study which relied on national data, estimated that "more than one quarter of the privately-insured under 65 (population) have no protection against expensive hospital stays".²⁶ The 1989 Current Population Analysis reported 239,000 nonelderly Alaskans had private health care coverage.²⁷ Assuming the national estimate of the size of the underinsured population is accurate in Alaska, it can be estimated that about 60,000 nonelderly Alaskans are underinsured.

Since this study was completed, the number of individuals who are underinsured has probably grown given the trend toward increased employee cost-sharing. Trends in recent years show more health care plans are requiring employees to share the cost of premiums. In addition, employees contributions for deductibles and co-payments are increasing. Both trends suggest the financial

barriers to health care in the United States are increasing, even for the insured. In the 1980s this has resulted in aggregate out-of-pocket expenses growing faster than medical prices.²⁸

- Some Alaskans who are covered by Medicaid may have difficulty finding a provider that will treat them.

Although this problem appears to be much less prevalent in Alaska than in some other states, a few providers may be reluctant to accept lower payments, the extra paperwork, or other problems associated with serving the Medicaid populations.²⁹

- Some Alaskans defer medical treatment because of the travel required to see a health care provider or costs associated with travel.

Alaskans living in remote and rural areas of the state often travel great distances and at significant costs to obtain health care. The Alaska Native Health Board recently reported the unmet need for patient travel was \$4.9 million in Fiscal Year 1990. Forty percent of all their patients who need to travel for medical care defer treatment because they lack money for airfare.³⁰

B. HEALTH CARE COST PROBLEM-UNDERSTANDING TO DATE

The cost of health care and health insurance in the United States is so high that employers and individuals are finding it increasingly unaffordable. Two indicators of the magnitude of the health care cost problem, the rate of spending and per capita spending, are described below.

Indicators of the Health Care Cost Problem

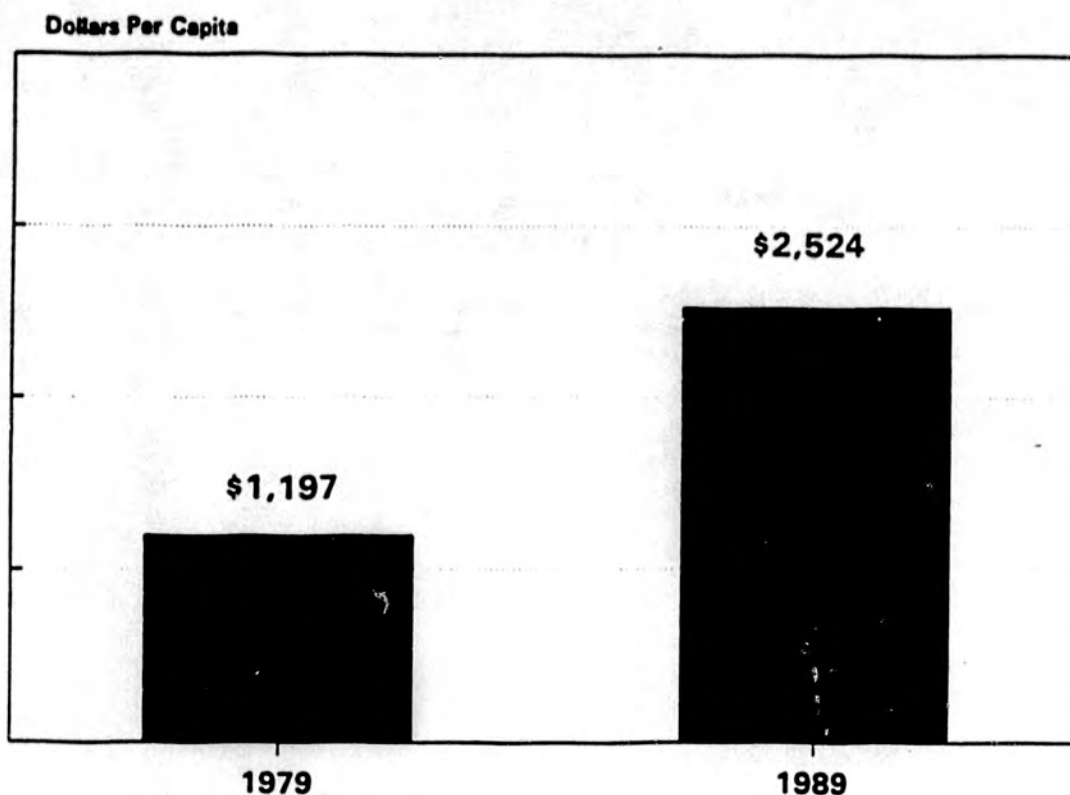
- Health care spending in the United States is increasing much faster than general inflation.

Total U.S. spending for health care climbed 167 percent from \$249 billion in 1980 to \$666 billion in 1990. General inflation accounted for roughly half the increase.³¹

- Total health care spending in Alaska in 1990 was estimated to be \$1.523 billion, up from \$481.25 million in 1979.³²

- In Alaska, per capita health care spending increased 111 percent from \$1,197 in 1979 to \$2,524 in 1989.³³

Figure 8. Estimated Alaska Per Capita Health Care Spending
1979 and 1989

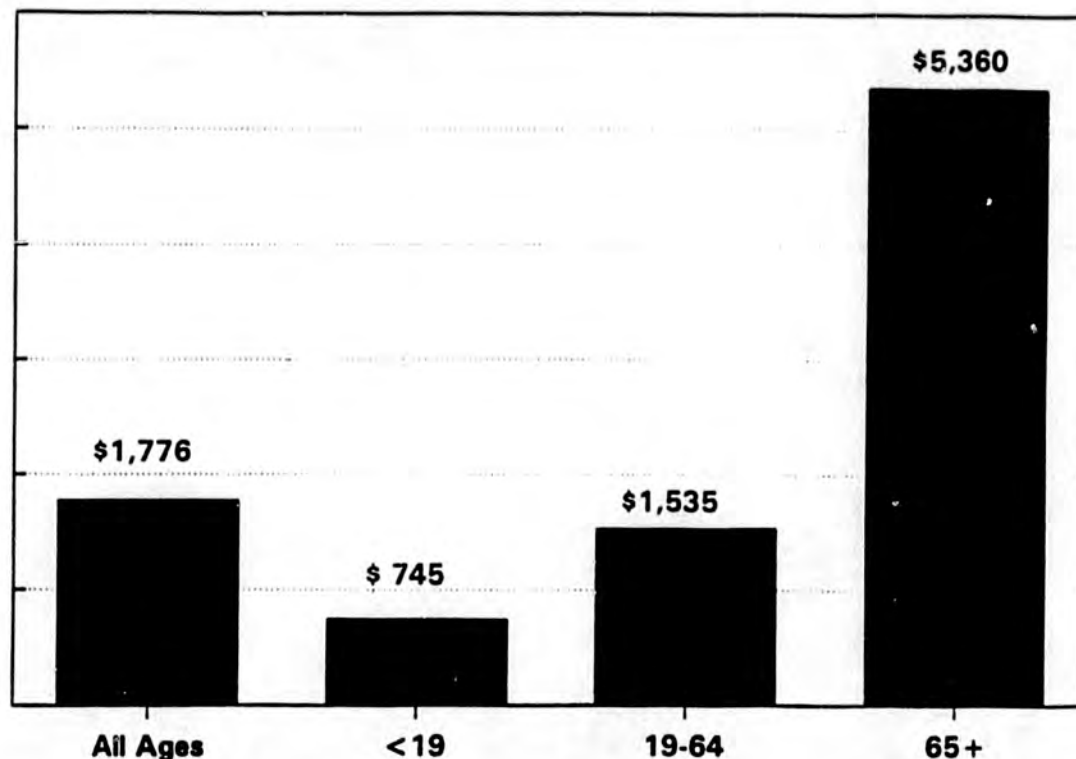


Source: Alaska Health Care Cost Containment Task Force.

- In 1987, per capita health care spending for the elderly in the U.S. was four times greater than for children under 19 years of age. Population trends suggest the elderly will consume an even larger share of total health care spending in future years.

In 1987, health expenditures for the people over age 65 averaged \$5,360 per capita as compared to \$1,535 for adults between the ages of 19 and 64 and \$745 for children under 19 years of age. The elderly consume a disproportionate share of both hospital and nursing home services.³⁴

Figure 9. Estimated U.S. Per Capita Health Care Spending
By Age Group, 1987



Source: Health Care Financing Administration.

The proportion of health care spending on the elderly in the United States is likely to grow given that the elderly currently represent about 12 percent of the U.S. population and are expected to increase to 21 percent by 2030. In Alaska, the 1990 elderly population was 4.1 percent of the total population. However, Alaska's elderly population is growing at a faster rate than U.S. elderly population. In the 1980s, the over 65 population in Alaska grew at an average annual rate of 6.8 percent in contrast to the U.S. elderly population which grew at average annual rate of only

2.1 percent.³⁵

The growth rate of the elderly population is expected to have significant effects on public sector health spending since the services for the elderly are financed disproportionately by the public sector.³⁶

- Alaska's 1990 per capita health care spending was 36 percent above the age-adjusted national average.

Alaska's relatively young population results in lower per capita health care spending. The federal study cited above estimated that in 1987, per capita health care spending for individuals under 19 years was approximately 48.5 percent of per capita spending for persons 19-64, while per capita spending for those 65 and over was nearly three and a half times that for the 19-64 year old population. Using these ratios, the effect of Alaska's younger population on per capita expenditure levels can be estimated as follows. If the U.S. were assumed to have the same age distribution as Alaska, it is estimated that 1990 national per capita health care spending would have been only \$2,039. By comparison, Alaska's 1990 per capita health care spending was \$2,769, or 36 percent above the national age-adjusted average.³⁷

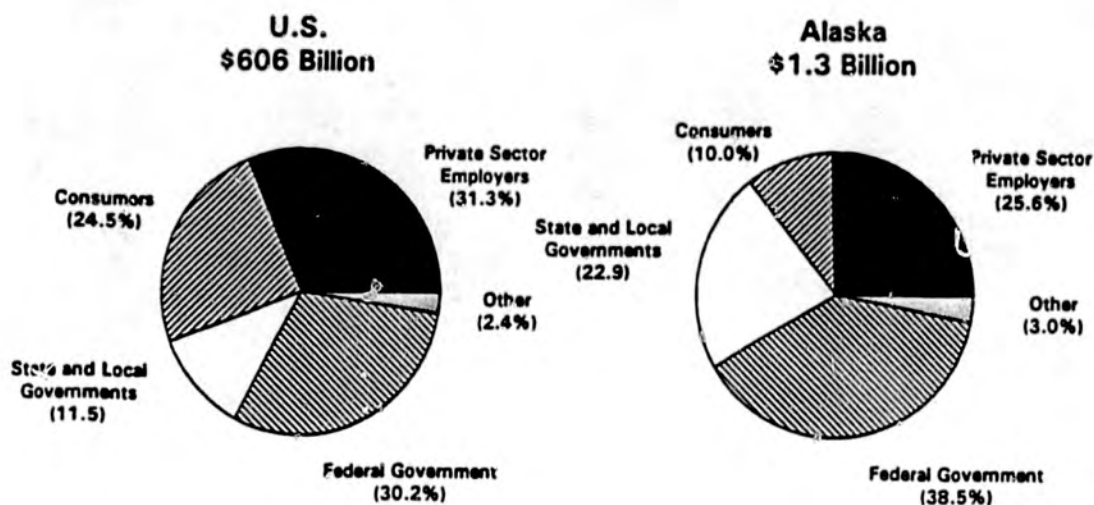
Who Pays the Health Care Bill in Alaska and What Services are They Paying For

All health care payors absorbed these tremendous increases in spending. Who is paying and the services they are paying for are described below.

- The federal, state, and local governments pay a larger proportion of the health care bill in Alaska as compared to the U.S. as a whole.³⁸

While total health spending in Alaska was estimated to be \$1.523 billion in 1990, the sources of payment in Alaska are available for 1989 as reported below.³⁹

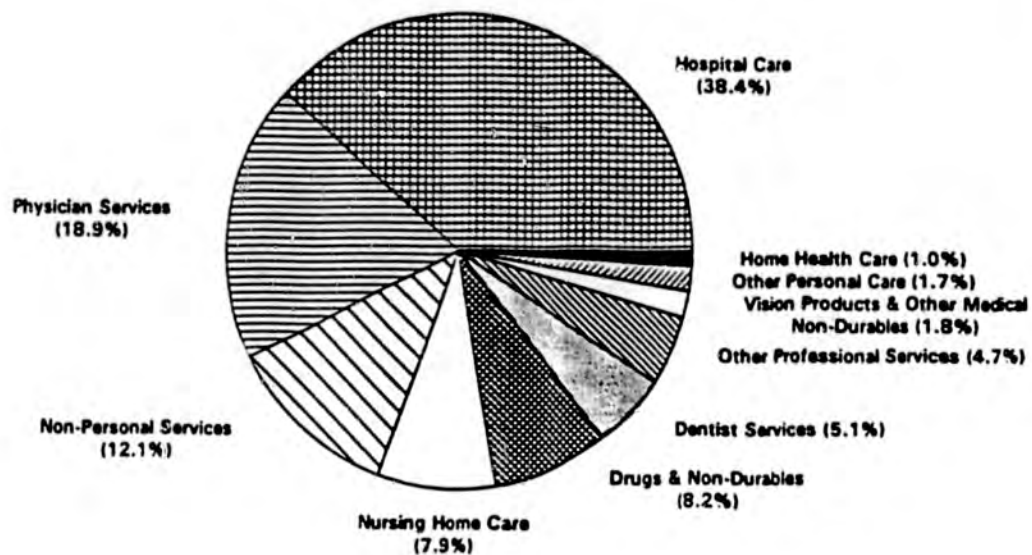
Figure 10. Sources of Payment for Health Care Expenditures, U.S. and Alaska, 1989



Source: Alaska Health Care Cost Containment Task Force.

- In 1990, 38.4 percent of all U.S. health care spending went for hospital care, 18.9 percent for physician services, 8.2 percent for drugs and nondurables, 7.9 percent for nursing home care, and 12.1 percent for nonpersonal services.⁴⁰

Figure 11. U.S. Health Care Expenditures
by Type of Expenditure, 1990



Source: Health Care Financing Administration.

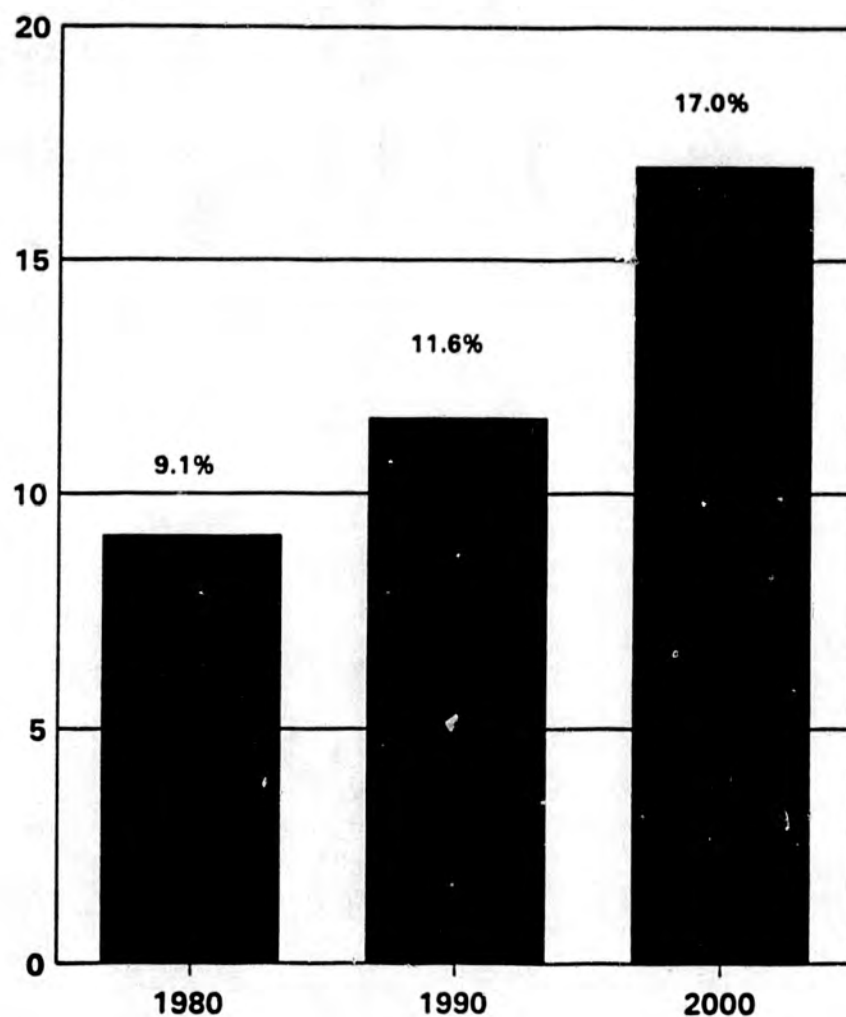
Between 1980 and 1989, spending for physician services grew at an average annual rate of 12.2 percent while spending for nursing home services grew at a slower 10.2 average annual rate. Spending for hospital services grew at the slowest rate of the three with an average annual rate of 9.6 percent. These growth rates are due in part to the change in hospital use patterns. In the 1980s, hospitals began providing more outpatient settings and the number of inpatients days and the number of admissions declined. The growth in physician services can also be attributed to the common fee-for-service reimbursement system which creates incentives for the physician to increase the number of services they provide, the supply of physicians particularly specialists who tend to be better compensated than primary care physicians, and the use of new medical technologies and services.⁴¹

The Consequences of High Health Care Expenditures

Described below are indicators of the consequences of high health care expenditures on the economy, business, and employees.

- Health care spending represents an increasing share of the GNP in the United States.⁴²

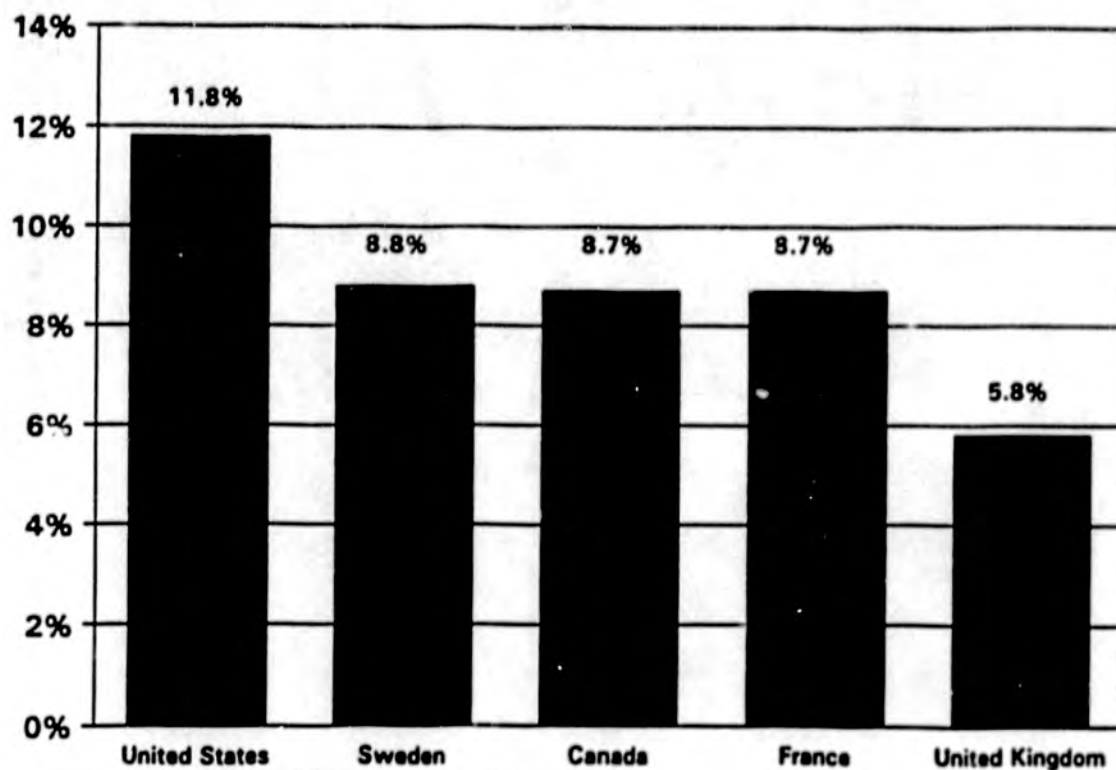
Figure 12. U.S. Health Care Spending as a Percent of Gross National Product, Selected Years



Source: Congressional Research Service

- The United States spends more on health care than most other industrial countries.⁴³

Figure 13. Health Spending as a Percent of Gross Domestic Product, Selected Countries, 1989

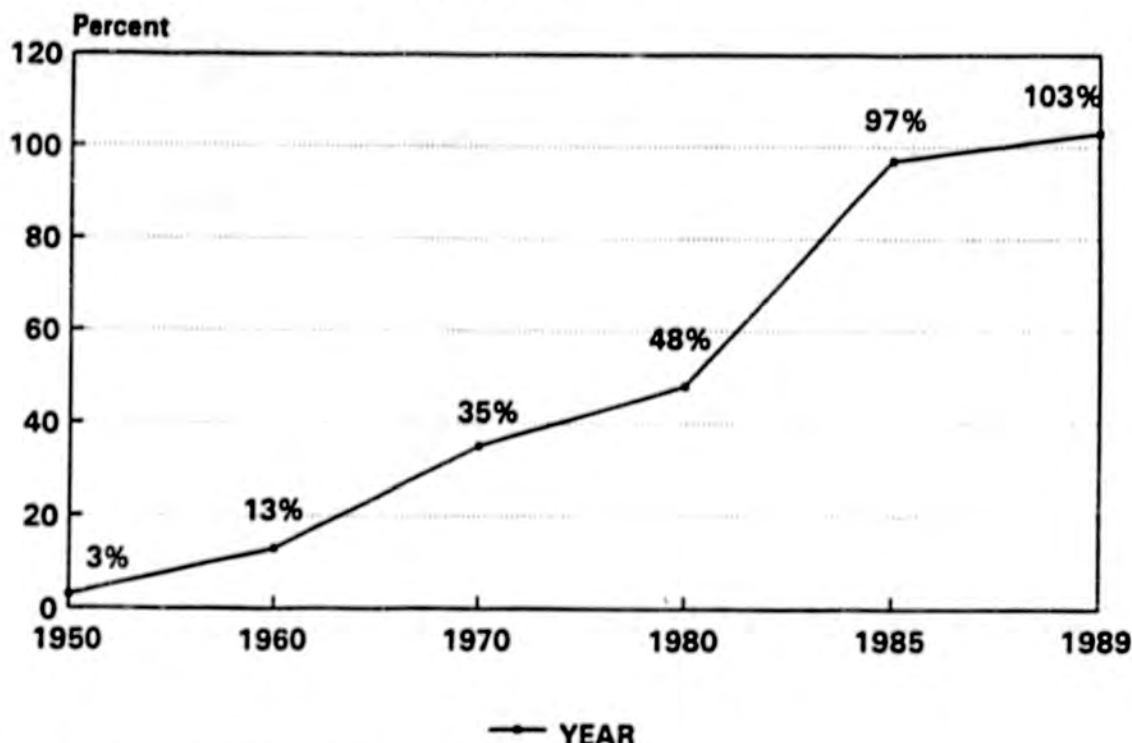


Source: Schleber, George and Jean-Pierre Poller, Int'l Health Spending Issues and Trends, "Health Affairs", Spring 1991.

- Employers are spending a higher percentage of their corporate after-tax profits on health insurance.

According to the Employee Benefits Research Institute, health insurance was only 35 percent of corporate after-tax profits in 1970. By 1980, it had increased to 48 percent and had grown to 103 percent by 1989.⁴⁴

Figure 14. Employer Spending on Health Insurance as a Percentage of Corporate After-Tax Profits, Selected Years



Source: Employee Benefit Research Institute tabulations of U.S. Dept. of Commerce data.

- Households are spending a larger percent of their after-tax income on health care.

In 1982-83, households on the average spent 4.1 percent of their incomes on health care. By 1982-83, it had increased to 5.0 percent.⁴⁵

- During the 1980s, out-of-pocket expenditures increased faster than medical care prices due in part to increased employee cost-sharing. Both the percentage of plans requiring premium cost-sharing and the dollar amounts contributed by employees have increased in the 1980s.

According to the U.S. Bureau of Labor Statistics, the proportion of workers required to pay part of their individual coverage increased from 21 percent to 46 percent between 1982 and 1988 and from 51 percent to 65 percent for family coverage. In addition, the average per employee premium costs for workers with individual coverage increased from \$31 to \$72 over the same period and from \$171 to \$320 for family coverage.⁴⁶

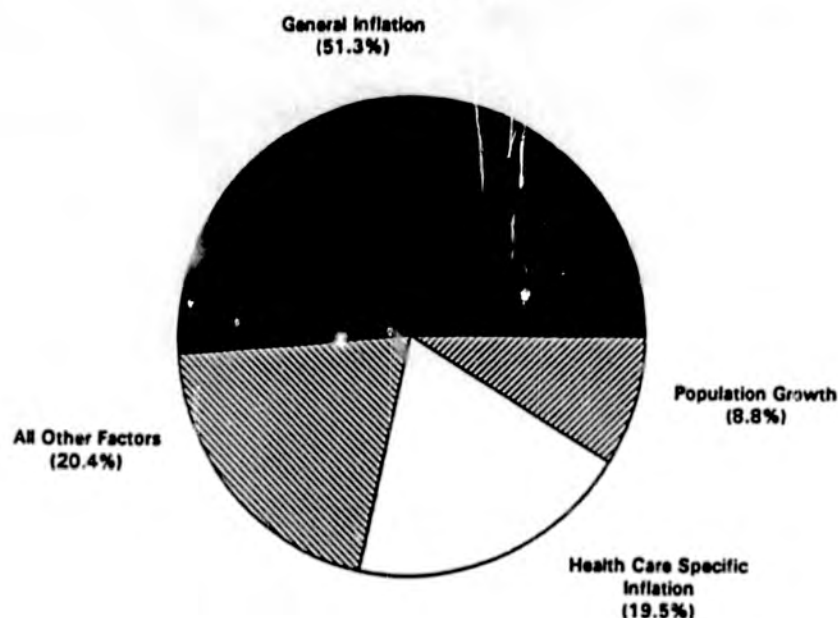
- In 1989, nearly two-thirds of 43 major labor walkouts in the United States were disputes over health benefits.⁴⁷
- A larger percentage of Alaskans are becoming uninsured.⁴⁸

Factors Contributing to the Increase in Health Care Expenditures

Health care expenditures are affected by complex and interrelated factors. Three factors which can be measured directly are the change in population, general price inflation, and medical price inflation. Other factors, more difficult to measure, include the introduction of new medical technologies, the change in the mix of services consumed, and the increase in the use of medical services.

- Between 1975 and 1987, general price inflation accounted for 51.3 percent of the increase in personal health expenditures in the U.S. while medical price inflation contributed 19.5 percent. Population growth accounted for another 8.8 percent of the increase and all other factors including changes in utilization, the intensity of the services used, and the aging of the population together contributed 20.4 percent of the growth in expenditures.⁴⁹

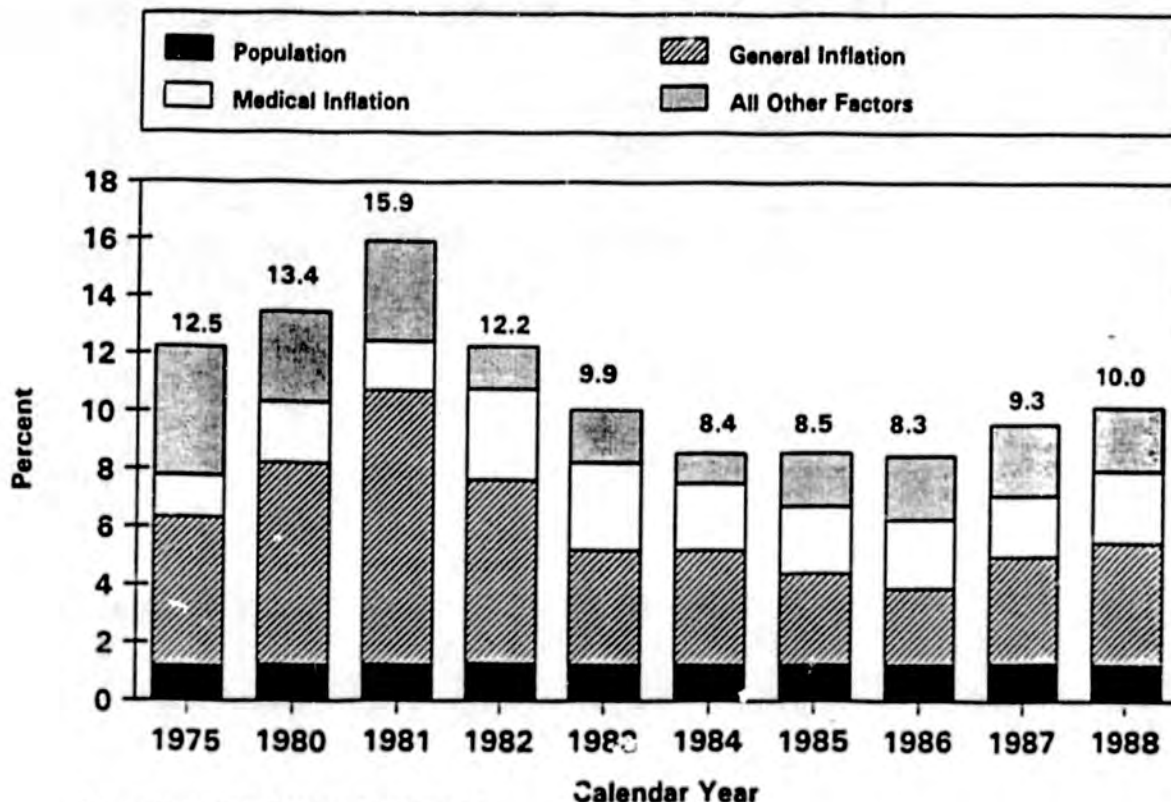
Figure 15. Factors Affecting Changes in
U.S. Personal Health Expenditures,
1975-1987



Source: National Committee for Quality Health Care.

- In the United States, between 1975 and 1988, population growth was a fairly constant contributor to the growth in health care spending. General inflation, medical inflation, and all other factors varied as contributors over the same period.⁵⁰

Figure 16. Factors Accounting for Average Annual Growth in U.S. Personal Health Care Expenditures: Selected Calendar Years, 1975-1988



Source: Health Care Financing Administration

- Population growth, one factor known to contribute to the increase in health care expenditures, increased at a 3.2 percent average annual rate in Alaska in the 1980s as compared to 1.1 percent for the U.S. as a whole.⁵¹
- Medical price inflation in Anchorage has increased at approximately the same rate as the U.S. average.

Between 1975 and 1990, the medical component of the Anchorage Consumer Price Index increased at approximately the same rate as the medical component for the U.S. CPI. Medical price differentials for other Alaska locations are not available.⁵²

C. FACTORS WHICH CONTRIBUTE TO THE HEALTH CARE ACCESS AND COST PROBLEMS IN ALASKA

The task force identified a number of additional factors they suspect contribute to the health care access and cost problems in Alaska. Of those the task force identified, they obtained Alaska-specific information on the following: charges/prices for health services, patient utilization patterns, excess capacity in Alaska's acute care community hospitals, the use of high tech medical equipment and units in Alaska, mandated benefits, uncompensated care resulting in the shifting of costs to private payors, and the distribution of physicians in Alaska.

Charges/Prices for Health Services in Alaska

Described below is data and findings on charges or prices for health services in Alaska. It was provided to the task force by Aetna Life Insurance Company, Blue Cross of Washington and Alaska, the University of Alaska's Institute of Social and Economic Research (ISER), and the Alaska Department of Health and Social Services. Aetna and Blue Cross information comes from their customer data as recorded in their claims payment systems. Data reported by ISER was obtained from the American Hospital Association and represents the sixteen acute care community hospitals in Alaska. (See Appendices D, E, G, and I for background information.)

- Charge levels for health care services in Alaska are generally higher than the national average.

An Aetna comparison of submitted charges in February 1990 identified that Alaska charge levels were higher than the U.S. average in five profiled expense areas.⁵³

Aetna reviewed eight common non-surgical medical services including office and hospital visits and consultations in 1991. On the average, Alaska charges were 54 percent higher than the national average and 33 percent higher than Washington state.⁵⁴ Data provided by Blue Cross on the same non-surgical medical services substantiates this finding.⁵⁵

A review of physician charges for surgical services for Aetna's customers revealed 1991 Alaska charges were higher than the U.S. average for 11 of the 15 frequently-performed services.⁵⁶

The 1990 average charge per day for hospital care in Alaska for Aetna's customers was 17 percent higher than the national average. Data from Blue Cross also confirmed that the average per day hospital charges are higher in Alaska.⁵⁷

Aetna reviewed 24 major diagnostic categories and found that its

average charge for hospital care for these categories was 17 percent higher in Alaska than the national average in 1990.⁵⁸

- Between 1972 and 1989, the average expenses per adjusted patient day in Alaska's acute care community hospitals ranged from 60 to 100 percent above the national average.

ISER examined data from the American Hospital Association between 1972 and 1989 and compared the average expenses per adjusted patient day. For that period, the average annual growth rate in Alaska for this measure was 13.8 percent. In 1989, Alaska's average was 76 percent above the national average.⁵⁹

- Between 1972 and 1989, the average annual payroll per employee in Alaska's acute care community hospitals was 37 to 72 percent above the national average.

ISER examined average payroll as a contributor to costs for health care in Alaska. Again using data provided by the American Hospital Association from 1972 - 1989, they compared average annual payroll in Alaska and U.S. hospitals. Historically, the average annual growth for this measure in Alaska has been 9.8 percent. In 1989, average payroll per employee in Alaska's acute care community hospitals was 55 percent above the national average.⁶⁰

- Alaska's Medicaid reimbursement rate for nursing home beds is three times the U.S. average net patient revenue for nursing home care.

In 1989, the average Medicaid reimbursement rate for nursing care beds in Alaska was \$202 per day as compared to the 1988 U.S. average net patient revenue for nursing care of \$51.27 per day. Hawaii comes closest to Alaska with a 1988 average net patient revenue for nursing home care of \$88.69 per day.⁶¹

Patient Utilization Patterns in Alaska

There is considerably more utilization data available on Alaska's hospitals and nursing homes than on outpatient services. As a result, most of the information reviewed by the Task Force focused on inpatient uses. This should not be interpreted that outpatient utilization patterns are less important to the Task Force.

The University of Alaska's Institute of Social and Economic Research (ISER) compiled and analyzed data from the Medicaid Rate Advisory Commission and the American Hospital Association and presented the following findings, as well as a report included in Appendix D.

- Occupancy rates in Alaska's acute care community facilities have historically been below the national average for comparably-sized hospitals except during the economic boom of the 1980s. In 1989, the Alaska average occupancy rate was 45 percent compared to the U.S. average of 57 percent for similar-sized facilities.

Occupancy rates are the best overall measure of inpatient utilization of hospitals.⁶² ISER examined occupancy rates in Alaska and U.S. hospitals between 1972 and 1989 and found both have fallen since the mid-1980s. Although many factors have contributed to lower occupancy rates, changes in federal and state inpatient reimbursement systems are widely accepted as having provided incentives for shorter lengths of stay and fewer hospital admissions.⁶³

The occupancy rate in Alaska's sixteen acute care community hospitals averaged 45 percent in 1989. The rates ranged from 11 to 61 percent. The average occupancy rate was higher in Anchorage and Fairbanks, at 50 percent, than in the remainder of the state at 35 percent. The average was even lower in co-located facilities (those including both acute care and nursing home beds) at 32 percent than for facilities with only acute care beds which averaged 46 percent. Four of Alaska's acute care community hospitals had occupancy rates above the national average for similar-sized facilities in 1989.⁶⁴

- On an average per capita basis, Alaskans have historically spent considerably fewer days in Alaska's acute care community hospitals than the U.S. population as a whole spent in U.S. hospitals. In addition, once admitted, Alaskans on the average have shorter lengths of stay as compared to the U.S. population as a whole.

ISER examined inpatient days per capita and length of stay data between 1972 and 1989 for Alaska's acute care community hospitals and U.S. hospitals.⁶⁵ In 1989, they found the number of inpatient days per capita in Alaska's acute care community hospitals was 0.53 days as compared with the national average of 0.92 days. The average length of stay in Alaska's acute care community hospitals was 5.9 days in 1989 as compared to the national average of 6.9 days. The young average age of Alaska's population and the selection of out-of-state hospital care by some Alaskans contribute to these utilization patterns in Alaska's hospitals.⁶⁶ Blue Cross confirmed that length of stays for their Alaska customers in Alaska's hospitals are shorter than in Washington's hospitals.⁶⁷

- Outpatient utilization at Alaska's acute care community hospitals has historically been below the national average.

ISER examined outpatient utilization at Alaska's acute care

community hospitals and U.S. hospitals between 1972 and 1989.⁶⁸ They calculated the number of outpatient visits per capita and found an average of 0.99 visits per capita in 1989 in Alaska's acute care community hospitals as compared with 1.17 visits in U.S. hospitals.⁶⁹

Excess Capacity in Alaska's Acute Care Community Hospitals

There has been a lack of direction from the State of Alaska regarding standards for hospital size. In the mid-1980s, the State significantly reduced its health planning efforts and has not issued a state health plan since 1984. The Certificate of Need process continues in Alaska but without the goals and standards that a state health plan could provide. Capital grants continue to be provided to individual communities for facility construction without a clear policy from the State.

The task force observed that Alaska's acute care community hospitals on the average are much smaller than U.S. hospitals as a whole and that they tend to have more beds than necessary to meet current demand. The Institute of Social and Economic Research (ISER) analyzed the costs associated with excess capacity in Alaska's sixteen acute care community hospitals. Three approaches were used to characterize the costs which result because these hospitals have more beds than required to serve current needs. The analyses were done in aggregate using cost and utilization data covering only 1989. The data was provided by the Medicaid Rate Advisory Commission and the American Hospital Association. ISER's results are intended to serve as general indicators of the costs of excess capacity and are not intended as comprehensive analyses of individual facilities or the need for these services in individual communities.

ISER's primary comparison of excess capacity in Alaska's acute care community hospitals was based on a comparison of Alaska occupancy rates in 1989 with occupancy rates for acute care facilities of similar size in U.S. hospitals for the same period. The complete analysis is in Appendix D.

- Using the national average as the bench mark, 12 of Alaska's 16 acute care community hospitals have excess capacity or beds. At the U.S. average occupancy rate, 229 of the 1,027 acute care beds in Alaska are surplus. Eighty percent of the surplus beds are in Anchorage and Fairbanks. Only 15 excess beds are in co-located facilities (both acute care and nursing home beds).⁷⁰
- The total annual cost to Alaskans in 1989 to pay for surplus beds has been estimated to range from \$5.8 to \$11.6 million or 2 to 4 percent of the total annual acute care facility costs.

ISER calculated the range of costs using the assumption that 10 percent (lower limit) to 20 percent (upper limit) of the total acute care facility costs were fixed. Costs were calculated based on actual occupancy rates in 1989 and then compared to costs for Alaska's acute care community hospitals assuming the occupancy rates were equal to hospitals of similar size in the entire U.S. during the same period.⁷¹

- Using a more rigorous standard for occupancy, 75 percent, and a fixed cost assumption of 20 percent, the annual cost of excess capacity in Alaska's acute care facilities would be as high as \$20.8 million.

The use of national occupancy rates is not necessarily a desirable benchmark. For comparison purposes, ISER also calculated the cost of excess capacity using the assumption of an occupancy rate of 75 percent as a standard. The high costs of acute care beds argues for the most efficient use of those beds. Nationally in the 1970s,⁷² the occupancy rate for mid-sized hospitals approached 75 percent. In addition, Alaska's 1984 State Health Plan established occupancy rate goals of 80 percent for Level IV communities (population between 40,000 and 750,000) and 65 percent for Level III communities (populations between 1,500 and 60,000).⁷³

High-Tech Medical Equipment and Services in Alaska

Data and findings on the cost and accessibility of high-tech medical equipment and services was provided to the Task Force by the Planning Section of the Alaska Department of Health and Social Services and is described below. (See Appendix F.)

It is widely recognized that the increased use of high-tech medical equipment and services has improved the quality of health care in the United States, as well as contributed to the rise in health care expenditures. MRIs (magnetic resonance imaging), CT scans (computerized tomography), cardiac catheterization labs, neonatal intensive care units, and open heart surgery units are examples of the more expensive equipment and services which have improved the quality of health care.

- Alaskans must travel to Anchorage or other states to access the majority of high-tech medical services. Some high-tech services are available in Fairbanks and a few are available in Juneau, Palmer, and Ketchikan.⁷⁴
- Alaska's demand for high-tech medical equipment and services is reduced.

Alaska's relatively young population and lower rates of death for certain chronic diseases has the effect of reducing the demand for

many high-tech medical services. Alaska's death rates for heart disease, cancer, cerebrovascular and chronic obstructive pulmonary disease are below the national average. Many high-tech medical services are commonly used to detect and treat these diseases.⁷⁵

- Alaska does not presently have excessive amounts of high-tech equipment and units. The equipment and units increase health care expenditures in Alaska but are not a major influence at this time.

The amount of high-tech medical equipment and units is due in part to lower demand and the fact that Alaska's many small hospitals can not afford them or do not have the medical personnel to use them. The Department concluded high-tech medical equipment is not contributing excessively to rising health care expenditures at this time.⁷⁶

- Increased access to high-tech medical equipment, particularly in smaller communities, may result in higher health care expenditures, increased use, and diminished quality of care.

Pressures on smaller hospitals (particularly those with low occupancy rates) to increase revenues and retain patients are likely to increase the desire to make available high-tech medical services in their communities. Once in place, the tendency is to use it. More specialized personnel needed to operate the equipment and the equipment itself will tend to increase expenditures. More importantly, "medical research has demonstrated specifically with high-tech medical services that quantity (of services provided) correlates with (improved) patient outcomes".⁷⁷

Mandated Benefits in Alaska

Proponents of mandated benefits argue that they provide needed access to services and to certain individuals or groups. Opponents argue that they invariably drive up the cost of coverage. AS 21.36.090(d) requires that employers must offer benefits for the following state licensed providers types: chiropractor, naturopath, physical/occupational therapist, physician (including osteopath and podiatrist), psychologist and psychiatrist, optometrist, and dentist. However, the costs of providing these benefits can be limited by capping the maximum benefits paid.⁷⁸

- Alaska has only two significant mandated benefits. Together they have a minor cost impact on individual insurance premiums.

AS 21.45.365 requires an employer with 20 or more employees to provide at least \$7,000 (over two consecutive years) in alcoholism and drug abuse treatment benefits (with a maximum lifetime benefit of \$14,000). AS 21.42.375 requires coverage for routine mammogram

screening according to a schedule. Both Aetna Life Insurance Company and Blue Cross of Washington and Alaska recently estimated the cost impacts of the alcoholism/drug abuse treatment benefit were between 2 to 3 percent of a typical health care plan's total medical benefit payment and between 0.7 and 1.4 percent for the mammogram screening.⁷⁹

Uncompensated Care in Alaska's Acute Care Community Hospitals and Cost-Shifting to Public and Private Payors

Persons who receive health services but either cannot or do not pay for them generate substantial uncompensated health care costs each year. In addition, some payors reimburse providers below their full-charge level. Costs incurred by providers for services which are underpaid or not paid must be shifted to other payors including employers who provide health insurance to their workers and taxpayers.

- In 1990, ten hospitals, representing 86 percent of the acute care community hospital beds in Alaska, shifted \$16.8 million of actual costs to other payors to cover costs associated with charity care, bad debt, and Hill Burton free care. This traditional method of financial hospital care provided to the uninsured and underinsured and other shortfalls from government health care financing programs can result in significant increases in prices that most Alaska hospitals charge privately insured persons.

Data provided by the Alaska State Hospital and Nursing Home Association was used to calculate the actual costs associated with charity care, bad debt, and Hill Burton free care. These costs may have been offset by the \$3.7 million in revenues from state and local governments. The \$16.8 million figure may significantly understate the magnitude of cost-shifting at Alaska's acute care community hospitals. Industry representative have stated that public payors such as Medicare and Medicaid do not cover the cost of delivering services to those clients. If this is the case, then costs associated with the delivery of services to Medicare and Medicaid patients are shifted to private payors. The task force will continue to work to determine the magnitude of the cost-shifting in Alaska.⁸⁰

Data on cost-shifting for physician services is nearly impossible to obtain although of no less interest to the task force.

Distribution of Physicians in Alaska

An insufficient supply of family practice physicians in Alaska may contribute to both the health care cost and access problems.

- Some Alaskan communities, particularly in Southeast, have insufficient numbers of family practice physicians.

An October 1991 estimate suggested the Alaska Area Native Health Service and health corporations need about 20 new physicians annually in rural Alaska due to high turnover. In addition, 10 family practice physicians are currently needed in seven communities in Southeast Alaska and Valdez.⁸¹

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CHAPTER FOUR

OPTIONS UNDER CONSIDERATION BY THE TASK FORCE

Many states have faced the similar complex health care problems and experimented with innovative approaches in order to assure appropriate and affordable health care to their citizens. The task force reviewed all the major approaches implemented in other states. They have relied on presentations made by Lawrence Bartlett, Ph.D., Director of Health Systems Research, Inc. for much of this information. Two documents have also served as references, the National Academy for State Health Policy's Access and the Uninsured: A Guide for States (April 1991) and the Congressional Research Service's report on Controlling Health Care Costs (January 1990). Listed below are the options under consideration by the Task Force.

At their October meeting, the Task Force identified the following set of options which they were to study over their next several meetings.

- Examine regulatory, reimbursement, and demonstration/ pilot project approaches (i.e. alternative facility models) to address the excess capacity problem.
- Expand access for kids (including medically needy option for women and children).
- (Some form of) Regulatory reform in small group market.
- (Options for uninsured: explore such things as) Hour banks for seasonal/part-time workers.
- Data gathering (including providers rates (charges) review, insurer rate review, making data available to consumers, flow of medical expenditures outside the state, reinstatement of health planning function).
- Strengthening Certificate of Need process.
- Retention and attraction of primary care health workers to medically under-served areas.
- Utilization review standards.
- Pooling concept.
- Malpractice reform.
- Alternate dispute resolution for malpractice cases.
- Identify non-efficacious procedures.
- High-risk pool/comprehensive health insurance association.
- Expand local access available at the community.
- Universal access/coverage.
- Single-payor/all-payor.
- Philosophy: micro vs. macro management.
- Development of reimbursement schedules and utilization standards.

At their November and January meetings, the task force had lengthy discussions about these options and numerous pieces of legislation.

Also at the January meeting, they reviewed and compared two comprehensive health reform proposals, Senate Bill No. 83 and the Health Access and Cost Containment Council's "Comprehensive Health Insurance Payment and Reform Act" (CHIPRA). (Senate Bill No. 83 as well as all other legislation currently under consideration by the task force is contained in Appendix J. The CHIPRA proposal can be found in Appendix K.) The task force decided to pursue the development of a comprehensive health reform package with the hope of introducing it during the 1992 legislative session. In order to accomplish this goal, they scheduled three work sessions in February and a regular meeting in March at which they will adopt their recommendations. The task force expects to recommend specific legislation to the governor and legislature by March 16, 1992.

(LIST OF) APPENDICES
(Appendices are published in a separate document.)

Appendix A: Legislative Resolve 45, Establishing A Health Resources and Access Task Force

Appendix B: Background Information on Health Care Access Issues, Prepared for the Alaska Health Resources and Access Task Force by Lawrence Bartlett, Ph.D., Health Systems Research, Inc., Washington, D.C., September 18, 1991.

Appendix C: Background Information on Health Care Cost Issues, Prepared for the Alaska Health Resources and Access Task Force by Lawrence Bartlett, Ph.D., Health Systems Research, Inc., Washington, D.C., September 18, 1991.

Appendix D: "Report to the Health Resources and Access Task Force, January 1992", by Oliver Scott Goldsmith, Ph.D., University of Alaska, Institute of Social and Economic Research.

Appendix E: "Memo to Nancy Cornwell regarding Summary of Utilization Rates for the 1990 Alaska Hospital Survey and comparison to U.S. Averages", from Bradley J. Whistler, Planning Section, Alaska Department of Health and Social Services, October 9, 1991.

Appendix F: "Memo to the Health Resources and Access Task Force", from Bradley J. Whistler, Planning Section, Alaska Department of Health and Social Services, October 21, 1991.

Appendix G: (Untitled) Data and Information Presented to the Health Resources and Access Task Force, November 18, 1991, by Steve LeBrun, Aetna Life Insurance Company.

Appendix H: "Retention and Attraction of Practitioners in Rural Alaska", presented to the Health Resources and Access Task Force by Rodman Wilson, MD, Task Force member, November 18, 1991.

Appendix I: "Memo to the Alaska State Legislature, Health Resources and Access Task Force", from Jeff Gingold, Blue Cross of Washington and Alaska, January 1992. "Memo to Nancy Cornwell, Project Director, Health Resources and Access Task Force", from Phyllis Finn for Jeff Gingold, January 17, 1992.

Appendix J: Health Care Legislation Under Consideration by the Health Resources and Access Task Force.

Continued, Appendices

Appendix K: "The Comprehensive Health Insurance and Payment Reform Act of 1992 (CHIPRA), An Outline for Model Health Care Reform Legislation", draft, by the Health Access and Cost Containment Council, January 21, 1992.

Appendix L: "Letter to Senator Jim Duncan, Co-Chair, Alaska State Health Resources and Access Task Force, regarding Health Care Expenditures Report Retrospective Review", from Jeff Malek, Noble Lowndes, January 7, 1992.

Appendix M: "Memo to Nancy Cornwell", from Larry Bartlett, Health Systems Research, Inc., January 23, 1992.

Appendix N: "Worksheet: Computations of Actual Costs which were Shifted to Other Payors to Cover Charity Care, Bad Debt, and Hill Burton Free Care at Alaska's Acute Care Community Hospitals, 1990", by Nancy Cornwell, Health Resources and Access Task Force Project Director, January 26, 1992. "Letter to Nancy Cornwell", from Garrey Peska, Alaska State Hospital and Nursing Home Association, January 13, 1992. "Letter to Senator Jim Duncan and Representative Johnny Ellis, Co-Chairmen, Health Resources and Access Task Force", from Garrey Peska, Alaska State Hospital and Nursing Home Association, January 10, 1992.

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62. Occupancy rate is defined as the number of inpatient days (excluding newborns) divided by total beds multiplied by 365 days (excluding newborn bassinets).

63. Goldsmith.

64. Goldsmith.

65. ISER assumed the Alaska Native and military populations are primarily served by federal hospitals and therefore subtracted out these populations when computing these indicators.

66. Goldsmith.

67. Gingold.

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