SCR 10

SENATE FINANCE COMMITTEE REPORT

DATE: 3/6/91 FURTHER:

DATE TURNED INTO OFFICE: 3/11/91

The Finance Committee considered SENATE CONCURRENT RESOLUTION NO. 10

Establishing a Health Resources and Access Task Force.

and recommended:

[ ] replace with _____ CS _____ [✓] same title
[✓] or adopt _____ CS SCR 10 (HES) [ ] new title
[ ] technical title change (HB only)

[ ] attached amendment(s)
[ ] _____ letter of intent adopted

[✓] do pass

[ ] do not pass

[ ] no recommendation

[ ] individual recommendations

[ ] further referral to _____

ATTACHES NEW FISCAL NOTE(S):

Dept/Date:

[ ] fiscal note(s) _____

[ ] zero fiscal note(s) _____

[ ] appropriation-no fiscal note

APPROVES PREVIOUS:

Dept/Date:

[✓] fiscal note(s) LAA 182.9 2/26/91

[ ] zero fiscal note(s) _____

SIGNING DO PASS:

1. _____ 2. _____

Co-Chairs: Signatures and Recommendations

OTHER RECOMMENDATIONS:

FISCAL NOTE

No. 1

(H) Version: SCR 10

(S) Publish Date: 3/6/91

STATE OF ALASKA
1991 LEGISLATIVE SESSION

Revision Date:

Title: Establishing a Health Resources and Access Task Force.

Sponsor: Senator Duncan

Requestor: Senator Duncan

Department Affected: Legislative Affairs Agency

BRU: Legislative Council

Component: Council & Subcommittees
Session Expenses, Legis. Oper Budget

COMPONENT SERIAL NO: 783

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES	68.4	42.0	0	0	0	0
TRAVEL	22.5	11.0	0	0	0	0
CONTRACTUAL	92.0	46.0	0	0	0	0
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	182.9	99.0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	182.9	99.0	0	0	0	0
FEDERAL FUNDS						
OTHER						
TOTAL	182.9	99.0	0	0	0	0

POSITIONS:

FULL-TIME	1	0	0	0	0	0
PART-TIME	0	1	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year impact:

ANALYSIS: (Attach a separate page if necessary)

SCR 10 establishes a Health Resources and Access Task Force within the Legislative Branch. The following is requested to adequately support the task force:

Changes in S SCR 10 (HSS) reflect NO FISCAL CHANGE from the original fiscal note. This fiscal note is appropriate.

03/6/91 date — MAF Comte Aide (initial)

Prepared By: Pamela A. Stoops, Director — Phone: 465-3850

Division: Administrative Services — Date: 2/26/91

Approved By: Warren W. Endicott, Executive Director

Agency: Legislative Affairs Agency — Date: 2/26/91

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impacted Agency(ies).

PERSONAL SERVICES

Staff is requested as follows to assist the Health Resources & Access Task Force.

Legislative Assistant - Range 21A
$4,155 x 12 months = $49,860
$49,860 x 37% benefits = $68,427 68.4

Funding for FY 93 is for seven months. The task force is terminated February 1, 1993.

TRAVEL

It is anticipated there will be 3 meetings of the Health Resources & Access Task Force.

3 meetings x 12 members = 36 airfares
36 airfares x $436 = $15,696
2 days per diem x 36 = 72
72 days x $95 = $6,840 22.5

It is assumed that the travel costs for the two Executive Branch members will be absorbed within their existing budgets.

CONTRACTUAL

Professional services funding to carry out the task force duties--$90,000. 90.0

Advertising - advertising of public notice of meetings--$2,000. 2.0

SUPPLIES

Supplies for the task force will be absorbed within the Session Expenses and Legislative Operating Budgets.

EQUIPMENT

Equipment for the task force will be absorbed within the Session Expenses and Legislative Operating Budgets.

CS FOR SENATE CONCURRENT RESOLUTION NO. 10 (HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered: 3/6/91
Referred: Finance

Sponsor(s): SENATORS DUNCAN, Kerttula, Pourchot, Menard

A RESOLUTION

Establishing a Health Resources and Access Task Force.

BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:

WHEREAS estimated annual expenditures for health care in Alaska have risen by 300 percent in the last 10 years from $480 million to over $1.5 billion; and

WHEREAS an estimated 90,000 residents of the state cannot afford to pay their medical bills, are not covered by a group health insurance plan, do not qualify for public assistance programs, and cannot afford to pay individual health insurance premiums; and

WHEREAS, if current trends continue, it is estimated that expenditures for health care in the state could increase to at least $10 billion by the year 2000 and over 25 percent of the state's residents may be uninsured; and

WHEREAS the legislature, aided by the Health Care Cost Containment Task Force, has achieved savings in the costs of health care to the state totaling over $20 million in fiscal years 1990 and 1991; and

WHEREAS every resident should have access to a basic level of health care regardless of income and should not become financially destitute before obtaining health care; and

WHEREAS the legislature recognizes that there is a continuing need to develop and evaluate

ways to manage health care expenditures in the state;

BE IT RESOLVED by the Alaska State Legislature that the Health Resources and Access Task Force is established with the following primary purposes:

(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 for continuing to contain the costs of health care in the state; and be it

FURTHER RESOLVED that the task force shall

(1) solicit advice and information from the medically indigent, health care consumer groups, the insurance industry, health care providers, labor organizations, emergency services personnel, large and small businesses, the Medical Care Advisory Committee, the Alaska Native Health Service, actuaries, the public, and others;

(2) investigate and gather data relating to health care quality, access, delivery, payment systems, and financing in the state, especially in rural areas;

(3) ascertain and review successful health care protection methods in other states, territories, and countries and other health care alternatives, including ways of providing health care for persons without insurance or with limited health care protection;

(4) continue to update an accurate estimate of the number of people who are unable to receive necessary health care services in the state, which patients are generating unpaid medical bills, which state residents are uninsured or lack adequate insurance, which health care providers are providing uncompensated care, who is paying for the cost of uncompensated care, and the total cost of uncompensated care in the state;

(5) identify those health care services necessary to achieve an acceptable minimum level of health care for all state residents and to examine those health care services that provide the most care for the most people at the least cost, including prevention services;

(6) monitor and evaluate experience under the state employee and retiree health plans;

(7) evaluate the potential benefits of health education, wellness plans, and prevention plans for all residents;

(8) develop strategies to support health care professions training and the retention of health care professionals in the state;

(9) recommend ways to coordinate services among nonprofit health care providers, profit making health care providers, the state division of public health, the United States Department of Veterans Affairs, the United States Department of Defense, and the Alaska Native Health Service in order to achieve a more efficient and effective health care delivery system;

(10) review ways to maximize the use of federal funds for health care programs in the state;

(11) investigate ways to reduce costs associated with malpractice insurance coverage, including its effect on the cost of health care in the state;

(12) consider the feasibility of redistributing funds currently spent by the state on health care in order to provide residents with affordable and equitable care;

(13) provide advice and assistance to other public agencies involved in health care programs; and

(14) pursue other sources of funding for the expenses of the task force; and be it

FURTHER RESOLVED that the task force shall consist of 17 members as follows:

(1) three members of the Senate appointed by the President of the Senate;

(2) three members of the House of Representatives appointed by the Speaker of the House;

(3) three persons representing the executive branch, appointed by the Governor;

(4) eight members chosen by the members appointed under paragraphs (1) - (3) as follows: one individual representing the medically indigent, one individual representing private employers who are not health care providers, two individuals representing health care providers, one individual representing the health insurance industry, one individual representing nonprofit organizations, one consumer of health services who is not an employer or health care provider, and one individual representing labor organizations; and be it

FURTHER RESOLVED that the members of the task force shall elect from among themselves a chair and a vice-chair and that the conduct of the task force meetings shall be in sessions open to the public where all interested parties may provide information; and be it

FURTHER RESOLVED that, within funds made available for the purpose, the task force may hire staff and contract for services to perform its duties; and be it

FURTHER RESOLVED that the task force shall report its findings and recommendations to the Governor and the legislature by February 1, 1992, and February 1, 1993; and be it

FURTHER RESOLVED that the task force is terminated at 11:59 p.m. on February 1, 1993.

R/O HFC 4-5-91

FISCAL NOTE

STATE OF ALASKA
1991 LEGISLATIVE SESSION

BILL NO: HCSCSSCR 10(Fin)

Revision Date:
Title: Establishing a Health Resources and Access Task Force.
Sponsor: Senator Duncan
Requestor: House Finance

Department Affected: Legislative Affairs Agency
BRU: Legislative Council
Component: Council & Subcommittees
Session Expenses, Legis. Oper Budget
COMPONENT SERIAL NO:

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES	128.9	75.2	0	0	0	0
TRAVEL	61.8	30.9	0	0	0	0
CONTRACTUAL	92.0	53.5	0	0	0	0
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	282.7	159.6	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	282.7	159.6	0	0	0	0
FEDERAL FUNDS						
OTHER						
TOTAL	282.7	159.6	0	0	0	0

POSITIONS:

FULL-TIME	2	0	0	0	0	0
PART-TIME	0	2	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year impact:

ANALYSIS: (Attach a separate page if necessary)

HCSCSSCR 10(Fin) establishes a Health Resources and Access Task Force within the Legislative Branch. The following is requested to adequately support the task force:

Prepared By: Pamela A. Stoops, Director — Phone: 465-3800
Division: Administrative Services — Date: 4/2/91

Approved By: Warren W. Endicott, Executive Director
Agency: Legislative Affairs Agency — Date: 4/2/91

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impacted Agency(ies).

PERSONAL SERVICES

Staff is requested as follows to assist the Health Resources & Access Task Force.

Legislative Assistant - Range 21A
$4,155 x 12 months = $49,860
$49,860 x 37% benefits = $68,427 — 68.4

Administrative Assistant - Range 19A
$3,637 x 12 months = $43,644
$43,644 x 39% benefits = $60,528 — 60.5

Funding for FY 93 is for seven months. The task force is terminated February 1, 1993.

TRAVEL

It is anticipated there will be 6 meetings of the Health Resources & Access Task Force.

6 meetings x 14 members = 84 airfares
84 airfares x $436 = $36,624
Per diem - $18,976 — 55.6

It is assumed that the travel costs for the three Executive Branch members will be absorbed within their existing budgets.

Staff travel - to attend task force meetings - $6,200. — 6.2

CONTRACTUAL

Professional services funding to contract with State Health Care policy expert --$90,000. — 90.0

Advertising - advertising of public notice of meetings--$2,000. — 2.0

SUPPLIES

Supplies for the task force will be absorbed within the Session Expenses and Legislative Operating Budgets.

EQUIPMENT

Equipment for the task force will be absorbed within the Session Expenses and Legislative Operating Budgets.

FISCAL NOTE

STATE OF ALASKA **BILL NO. SCR 10**

1991 LEGISLATIVE SESSION

Revision Date: _____

Title: Resolution establishing a Health Resource and Access Task Force.

Sponsor: Duncan

Requestor: _____

Department Affected: Administration

BRU: Labor Relations

Component: Labor Relations

COMPONENT SERIAL NO. 0 0 5 8

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year impact: _____

ANALYSIS: (Attach a separate page if necessary.)

With the exception of possible participation in task force proceedings, there is no direct cost to agencies. Task force funding will be sought via sponsor fiscal note (attached).

Prepared by: Bruce Cummings Phone: 465-4404

Division: Labor Relations Date: 2/28/91

Approved by Commissioner: Millett Keller

Agency: Administration Date: 3/4/91

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impacted Agency(ies).

Rev 10/90

8/8/LEG/0581751C.KP/1

SFC 3/11/91 am

CHANGES FROM SCR 10 to CSSCR 10 (HES)

PAGE 1 LINE 5
delete [over] insert an estimated

PAGE 1 LINE 9
delete [will] insert could

PAGE 1 LINE 10
delete [will] insert may be

PAGE 3 LINE 14
delete [14] insert 17
delete [and two alternates]

PAGE 3 LINE 16
delete [, on to whom shall be designated as an alternate]

PAGE 3 LINE 19
delete [, on to whom shall be designated as an alternate]

PAGE 3 LINE 20
delete [two] insert three

PAGE 3 LINE 22
delete [two] insert one

PAGE 3 LINE 23

after
"two individuals representing health care providers,"

insert
one individual representing the health insurance industry.

SFC 3/11/91 am

SENATE CONCURRENT RESOLUTION NO.10
BY SENATOR JIM DUNCAN

Senate Concurrent Resolution 10 was introduced to continue the work of the Health Care Cost Containment Task Force and to build on the findings, recommendations and successes achieved by that group over the last two years.

Task Force members recommended the adoption of a concurrent resolution creating a HEALTH RESOURCES and ACCESS TASK FORCE to continue the study of this issue and forward recommendations regarding access to affordable, quality health care for all Alaskans.

The intent is to take the expertise developed with the Health Care Cost Containment Task Force and combine the expectations for the Universal Health Care Task Force as proposed by Ch.179, SLA 1990. This will create a new Task Force to work on the management of health care expenditures in Alaska and at the same time seek ways to improve access to quality health care for Alaskans.

It is envisioned that the work plan and resources of the new Task Force would have the depth to investigate all facets of health care access and financing of Alaska health care programs.

The new Task Force membership should include individuals representing:

The Legislative Branch;
The Executive Branch;
The Private Sector Employers;
Non Profit Organizations;
Health Care Consumer;
Health Care Providers;
The Medically Indigent;
Labor Organizations; and
The Health Insurance Industry.

The HEALTH RESOURCES and ACCESS TASK FORCE proposed in SCR 10 will be responsible for designing a cost efficient program that allows access to a basic level of health care services for all state residents; 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 to define a strategy for implementing a health care program covering all Alaskans and a strategy for continuing to contain the costs of health care in Alaska.

SFC 3/11/91 am

STATE OF ALASKA

HEALTH CARE COST CONTAINMENT

TASK FORCE REPORT

TO

THE SEVENTEENTH LEGISLATURE

RELATING TO THE ACCESS, QUALITY, DELIVERY AND

FINANCING OF

HEALTH CARE FOR ALL ALASKA RESIDENTS

WITH
SUMMARY OF FINDINGS AND RECOMMENDATIONS

FEBRUARY 1991

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT
TASK FORCE

MEMBERSHIP

SENATOR JIM DUNCAN, CHAIRMAN

REPRESENTATIVE MIKE NAVARRE,VICE CHAIRMAN

SENATOR DRUE PEARCE

REPRESENTATIVE MARK BOYER

MS. MICHELLE CASTANEDO

MR. BRUCE CUMMINGS

MR. DON HITCHCOCK

MS. BARBARA HUFF

MS. KAREN PERDUE

MR. GREG O'CLARAY

MR. JEFFREY MALEK, CONSULTANT

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE

REPORT TO THE SEVENTEENTH LEGISLATURE

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EXECUTIVE SUMMARY

The purpose of this section of this report is to give an overall perspective of the problems facing Alaska with rapidly rising health care costs and illustrate Task Force recommendations that provide solutions to assure affordable quality health care access to all Alaska residents.

OVERVIEW

Health care costs in Alaska are rising at a pace two and three times the inflation rate for all other goods and services. **In 1990, total Alaska health care expenditures are estimated to be in excess of $1.5 billion up from $480 million in 1979. Without a plan for a long term health care delivery system, quality assurance, and financing management, total health care expenditures in Alaska will exceed $10.0 billion by the year 2000 of which the state governments portion will be $3.0 billion.** (see exhibit one on page 10)

Health care expenditures in Alaska have been rising at a rate of over 20% each of the last five years. These trends are not unique to Alaska alone. Health care expenditures in the U.S. exceeded $606 billion in 1989 and consumed twelve percent of our Gross National Product. Nationally, the Federal Government and virtually all other states are seeking ways to reduce these expenditures or slow the health care inflation rate to be in line with the market basket Consumer Price Index.

These rapidly rising costs further exacerbate the uninsured population in Alaska, **recent estimates indicate that more than 90,000 Alaska residents are uninsured. At this rate twenty-five percent of Alaskas' population will be uninsured by the year 2000**[1] (see exhibit two on page 11). These increase in costs have substantially driven up health insurance premiums for all employers, making it very difficult if not impossible, to continue to provide or offer coverage.

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[1] Families U.S.A. Foundation

The Health Care Cost Containment Task Force initially was charged with the task of investigating, analyzing and recommending ways to reduce or stabilize the health insurance costs for State of Alaska employees, retirees and their dependents

With these recommendations implemented, the monthly premium cost was reduced and stabilized at $385.00 until January 31, 1992, **resulting in net savings in excess of $20 million for FY 90 & 91[2].**

The Task Forces' charge was expanded early last session to include reviewing the delivery, quality, access and financing of health care for all Alaska residents.

The Task Force, in its expanded role, has investigated the problem of rapidly increasing health care costs in Alaska through public testimony, surveys, research (statewide and nationally) and a detailed analysis of potential solutions.

During this review the Task Force has identified not a sole culprit but numerous contributing factors that must be reviewed in an all encompassing manner to provide the best long term solutions. The contributing factors identified by the Task Force include:

* Inefficient Medical Care Delivery Systems
* Overbuilt Health Care Facilities
* Cost of New Medical Technology and Facilities
* Malpractice Insurance and Protective Measure costs
* Limited Competition For Providers / Insurers
* Health Care Delivery System Waste, Overhead And Administrative Costs
* Limited Wellness Promotion And Resources
* Large Population of Under / Uninsured Residents
* Cost Shifting Between Health Plans and Programs
* Life Style Diseases and Injuries
* Mandated Benefit Coverage
* Limited Access to Private Health Plans

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[2] 1990 Health Care Cost Containment Task Force Report

* No Managed Care Delivery Systems in Place
* Lack of End User Involvement and Education

Although a long and far reaching list each contributing area must be comprehensively addressed to achieve the stated goal of stabilized medical costs in Alaska and basic health care access for all Alaskans'.

SPECIFIC FINDINGS

The Health Care Cost Containment Task Force has been reviewing the causes for the rapidly rising costs in the State of Alaska not only for State sponsored plans, but health care costs statewide.

1. Health care expenditures in Alaska have *increased 300% over the last 10 years, the second highest in the nation*

2. The health care expenditures portion of the *State of Alaska budget is the fastest growing component of the whole budget, 385.5 Million in FY 90, and at this pace will exceed 3.0 Billion in FY 2000 (see exhibit one on page 10).*

3. The number of *uninsured residents in Alaska* has increased at an alarming rate to an *estimated 90,000* uninsured residents, representing *16.5% of the total population in Alaska. At this rate twenty five percent of Alaskas' population will be uninsured by the year 2000 (see exhibit two on page 11).*

4. The cost of providing health coverage for *State employees and their dependents* has been reduced and *stabilized at $385.00 (per month, per employee) for FY 90 and 91.* This compares favorably with the most recent Survey of State's health care plans that showed *only one other state (Arizona) where premiums were reduced*, and only three other State's premiums were held at the 1989 level[3]. It is important to note that while these were important short term measures, a long term solution to this problem must be implemented soon to avoid further large rate increases.

5. One area that has come to light, and is significant in its impact on health care expenses, is cost or liability shifting between programs. It is an item of significant impact. When a health program either reduces benefits or payments the natural reaction by health care providers is to shift those costs to other payors.

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[3] 1990 Martin A. Segal Company Summary of State Health Plans

SURVEY RESULTS

The survey done by the Task Force was designed to give greater insight to health insurance plans offered by Alaska employers, the costs for these plans, who is covered by health insurance, along with additional data and perspectives from health care providers.

Over 300 surveys were mailed to various groups in Alaska including, municipalities, school districts, health care providers and private sector employers.

The survey questions were tailored to gather specific information relative to each category of respondent.

Questions ranged from those eligible / ineligible for employer health plans, number of employees, plan design, employee / employer contributions, cost containment measures implemented, premium costs, ideas to help reduce ever increasing health care costs and the reasons for these increasing costs. The questionnaires sent to health care providers had additional questions to determine their specific perspective about rising health care costs and certain contributing factors *ie.*; bad debt, malpractice insurance costs and others.

The survey results gave us information that previously was not available such as, range of employer sponsored health plan designs, eligibility, associated premium costs, cost containment strategies employed, respondents perspective, and impressions about the health care delivery system in Alaska.

In comparison to the State of Alaska active employee health plan, the survey results showed that the state no longer had either the most expensive health plan (64% of respondents plans premium or premium equivalent was in excess of the states $385. per month) and no longer was the States plan the best in coverage (54% of respondents provide similar or better benefits).

Surprisingly 94% of the respondents do offer some form of health insurance to their full-time employees while none of the respondents provide coverage for part-time, seasonal, or occasional employees.

The majority of respondents have implemented ways to reduce their health plan costs. Seventy one percent of respondents have implemented at least two cost containment measures. Sixty percent have also made benefit changes in the last two years.

In addition respondents also are implementing alternate financing of health insurance. Thirty one percent of the respondents have self insured their plans.

The survey confirmed earlier information that the majority of health insurance in Alaska is underwritten by three carriers, Aetna, Blue Cross and Great West insurance companies.

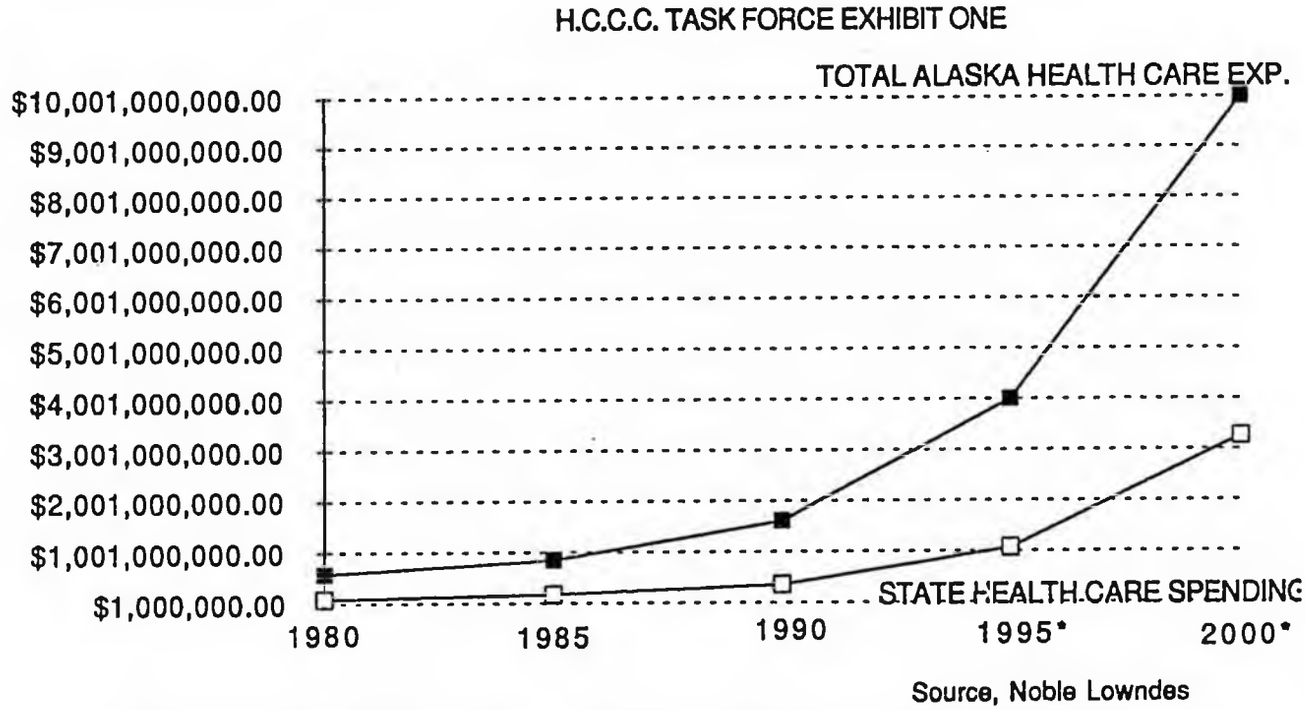
THE FUTURE

The State of Alaska Health Care Cost Containment Task Force has reviewed and recommended ways to reduce health care costs in the short term, but in order to assure quality affordable health care protection for all Alaskans a long term strategy such as the Alaska State Health Resources Authority (ASHRA) outlined in the legislative recommendations, section 8, of this report must be implemented.

In addition, because of the size and scope of the health care related problems facing the state of Alaska the Task Force recommends that a group comprised of a cross section of Alaska employers, health care providers, legislature, Executive branch, nonprofit, uninsureds and consumers continue the work of the Health Care Cost Containment Task Force to continue towards the goal of assuring quality affordable health care for all Alaskans.

EXHIBIT : ONE

Exhibit one demonstrates the rise in health care spending in Alaska from 1980 through the year 2000.



Illustrates total health care expenditures in Alaska

1980=$576. million, 1985=$852. million, 1990=$1.608 billion
1995=$4.0 billion*, 2000=$10.0 billion*

Illustrates health care spending by the State .

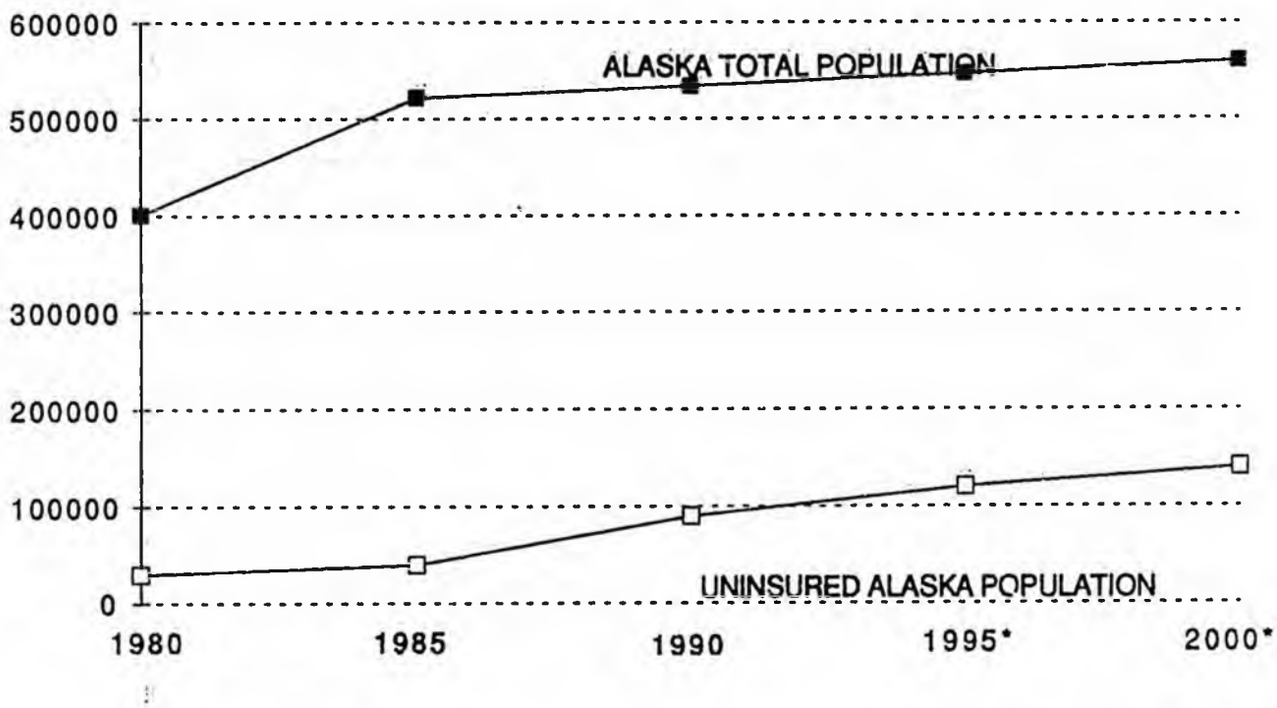
1980=$75. million, 1985=$175. million, 1990=$350. million
1995=$1.068 billion*, 2000=$3.26 billion*

* estimate

EXHIBIT : TWO

Exhibit two illustrates Alaskas total population and the population of residents without health insurance (uninsured).

H.C.C.C. TASK FORCE EXHIBIT TWO - COMPARISON OF ALASKAS UNINSURED TO TOTAL POPULATION



Source, Noble Lowndes

Illustrates total Alaska population.

1980= 401,000, 1985= 522,000, 1990= 534,000
1995= 547,000, 2000= 560,000

Illustrates the uninsured population in Alaska.

1980= 30,000, 1985= 40,000, 1990= 90,000
1995= 120,000*, 2000= 140,000*

* estimates

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE
REPORT

SECTION ONE

TASK FORCE WORK PLAN AND OBJECTIVES

WORK PLAN AND OBJECTIVES

One of the major realizations of the previous year's work was that the health cost experience and expectations of any one particular group, such as state employees, cannot be viewed in isolation. Influences from the cost of service to all other health care consumers and correlated systemic factors contribute a significant portion to any one group's eventual cost, regardless of use.

Last session the work plan for the Task Force was redesigned to address unresolved health care cost issues identified in the February, 1990 report to the legislature. These issues included concerns about such long term and destabilizing effects as cost shifting, uncompensated care, and health delivery system inefficiencies. Other issues were identified that in a preliminary way held promise for some measure of control or alleviation of the health care cost spiral. In addition to this work, the Task Force would monitor closely the effects of cost containment measures established for state employee health plans and seek appropriate containment measures for retired public employees.

The main objectives of the plan were to understand, in as complete a manner possible, the financial nature of Alaskans' health care and health care delivery system. Secondly, the Task Force sought a broad spectrum of opinions about what could be done to preserve or improve access to quality affordable health care for all Alaskans in the context of financial trends and constraints.

These objectives were served by analyses of all health care funding and expenditures in the state, and informational surveys of municipalities, school districts, health care providers, and health care facilities. Information on the Alaskan perspective was additionally obtained from three public hearings and other meetings with the following groups:

* Alaska School Board Association
* Alaska Municipal League
* Alaska Municipal Finance Officers' Association
* Alaska Hospital and Nursing Home Association
* Alaska State Medical Association
* Alaska Chiropractic Society
* Anchorage Medical Society
* Alaskan private sector employer group
* National Education Association of Alaska
* Alaska State Employees Association
* Public Employees Retirement System Advisory Board
* Teachers Retirement System Advisory Board

The Task Force recognized that the health care problems it was addressing were also being discussed in other states, public forums, and by research groups throughout the nation. Indeed, the issue has attracted considerable attention in professional journals and other print media. An appreciation for the larger context of health care cost and access, viable solutions were gained through meetings and discussions with the following:

* National Governors' Association Conference on Affordable Health Care
* American Federation of State, County and Municipal Employees, Washington, D.C.
* Families USA Foundation (Senior citizen advocacy group)

* National Leadership Commission on Health Care
* Physicians Payment Review Commission (Congressional)
* State of Maryland, Health Services Cost Review Commission
* State of Washington
* State of Hawaii
* State of Minnesota
* State of Wisconsin
* State of Arizona
* State of New Mexico
* State of Massachusetts
* State of Oregon
* State of Oklahoma
* State of Utah
* State of Kansas
* State of South Carolina
* State of Louisiana
* State of California
* State of Colorado
* State Alliance for Universal Health Care

The health care funding and expenditure analyses were based in part on all federal, state, and local government expenditures for different categories of health care and groups of people. State data included, in addition to employee and retiree costs, the health costs of prisoners, medicaid, Pioneer Homes, Alaska Psychiatric Institute, and rural health aides, among others. Similarly, federal data included military and military dependents' expenditures, Indian Health Service, veterans, and medicare. In all categories the number of Alaskans benefitted were determined or estimated. Alaska Department of Labor statistics were used for the private sector labor force to estimate the private sector's contribution. Two recent studies, the 1990 Health Care Cost Containment Task Force Report and the Families USA Foundation gave new estimates of the

number of Alaskans who are without health insurance or any other type of medical care. In contrast to the funding and expenditure side, revenue reports of all major health care institutions were obtained and consolidated.

Municipalities and school districts were target groups for the informational survey because they are large employee groups whose health care cost increases most directly affect state budgetary considerations. The survey sought specific information on their health plan cost increases over the last ten years, the nature of the benefit, and cost containment features employed. The survey also had questions on the effectiveness of cost containment measures and solicited opinions on what could done to slow medical inflation.

Survey forms sent to health care facilities and health care providers were to determine the nature of their employees' health care coverage and cost experience. Additional information requested concerned the nature of their business as providers. This information included percentages of practice devoted to different categories of payors (medicare, medicaid, state employee, et. al.), the amount of uncompensated services, its increase, and the amount of fee and rate increases over the last ten years.

The expenditure and funding analyses and the survey information provided a useful foundation for meetings with the Alaskan groups listed above. They illustrated the overall nature of the issue and brought focus to the discussions. In addition to the information gained, the meetings with the second group listed above underscored the gravity with which other health care professionals, public officials, labor and management organizations view the health care cost and accessibility issue. It gave the Task Force a sense of commonality in its search for a solution.

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE
REPORT

SECTION TWO

STATE EMPLOYEE AND RETIREE PLAN UPDATE & RESULTS

STATE OF ALASKA
EMPLOYEE AND RETIREE HEALTH PLAN UPDATE

The Health Care Cost Containment Task Force continued to review and monitor the health plans for actives and retirees during the last year.

ACTIVE EMPLOYEE HEALTH PLAN

This work resulted in the continued moratorium on premium increases for the active employees plan. This resulted in the monthly premiums being held at the $ 385.00 level until January 31, 1992 allowing state agencies substantial relief from increasing costs associated with health insurance. This resulted in savings in excess of $20 million for FY90, 91.

The Task Force strongly encourages the State to continue to review the possibility of self or alternate funding the plan to improve the plans financial position and overall management. In addition, the State should during the Request For Proposal process for the state plan request proposals for both an all inclusive and unbundled basis. That is, major components (cost containment, utilization review, etc.) should be bid collectively and separately to determine the most advantageous end result.

RETIREES HEALTH PLAN

The Task Force reviewed and recommended cost management techniques that could be utilized by the retirees heath plan to improve the plans financial experience, without compromising the current level of benefits.

These recommended cost management techniques were ratified by the Public Employees Retirement System and the Teachers Retirement System boards and are currently being implemented. These changes will not only reduce the premium requirements but also may improve the funds future.

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE
REPORT

SECTION THREE

HEALTH CARE EXPENDITURES IN ALASKA

AND

THE UNITED STATES

HEALTH CARE EXPENDITURES IN THE UNITED STATES

The amount **spent on health care in the United States exceeded $606 billion in 1989, which is approximately twelve percent of our gross national product.** Health care expenditures in the U.S. are increasing at the rate of approximately twenty percent per year each of the last five years

The **U.S. spends $1.152 million per minute on health care and is increasing $230,000. per minute.**

The U.S. spends 12 % of our GNP on health care more than any of our allied neighbors (Canada=7.5%, Japan=8%, Great Britain=7%). These expenditures have a substantial negative effect on our ability to remain competitive in the world market place.

Health care expenses consumed 11.6% of U.S. residents disposable income in 1989 and impacts every purchase decision made today. For example it is estimated that $700.00 of the purchase price for each new Chrysler automobile goes to pay for employee health care, as compared to foreign models at about $300.00. This demonstrates the additional financial burden of this sizable expense on our ability as a nation to compete in world markets for products and services.

Americans spent more for health care in 1989 than we did for food stuffs.

Of substantial additional concern is that while as a nation we spend more on heath care than any other nation (12% of GNP), fewer have access to health care protection, it is estimated that 38 million U.S. residents are without health insurance.

ALASKA HEALTH CARE EXPENDITURES

The amount spent on health care in Alaska exceeded $1.5 billion in 1990 up from $480 million in 1979. Alaska health care expenditures are increasing at the second fastest pace of the fifty states.

Alaska spends approximately $2850.00 per minute on health care and is increasing by $534.00 every minute. At the current rate of growth, and without health care reform, the total health care expenditures in Alaska will exceed $10 billion by the year 2000.

Even though Alaska continues to spend more on health care there are fewer residents covered by health insurance. The Task Force estimates show that 90,000 Alaska residents are uninsured and without change 25% Alaskas' population will be uninsured by the year 2000.

With the increasing economic burden of health care expenditures, and the increasing number of residents without health care protection, Alaska is at a greater disadvantage than other states and nations to further its economy.

EXHIBITS THREE THRU SEVEN (On the following pages)

SOURCE: NOBLE LOWNDES 1991

Exhibit Three illustrates 1989 U.S. health care expenditures by source of payment, private sector employers, federal programs, state and local government programs, consumers and all others.

Exhibit Four illustrates 1989 Alaska health care expenditures by source of payment, private sector employers, federal programs, state and local government programs, consumers and all others.

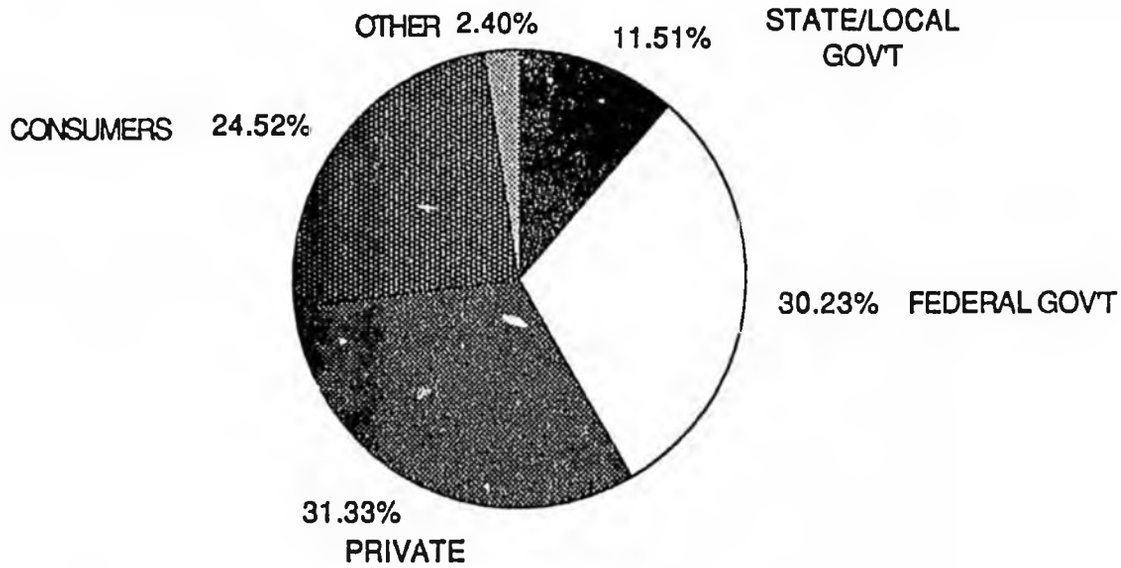
Exhibit Five illustrates Alaska health care expenditures from 1979 to 1989 and breaks down by payor (private sector, federal programs and state programs)

Exhibit Six illustrates Alaska state spending for 1989 categorized by program, medicaid, employees, retirees, municipal and political subdivisions, workers compensation, and other state funded health programs.

Exhibit Seven illustrates total Alaska health care expenditures as compared to total population to determine per capita expenses for health care.

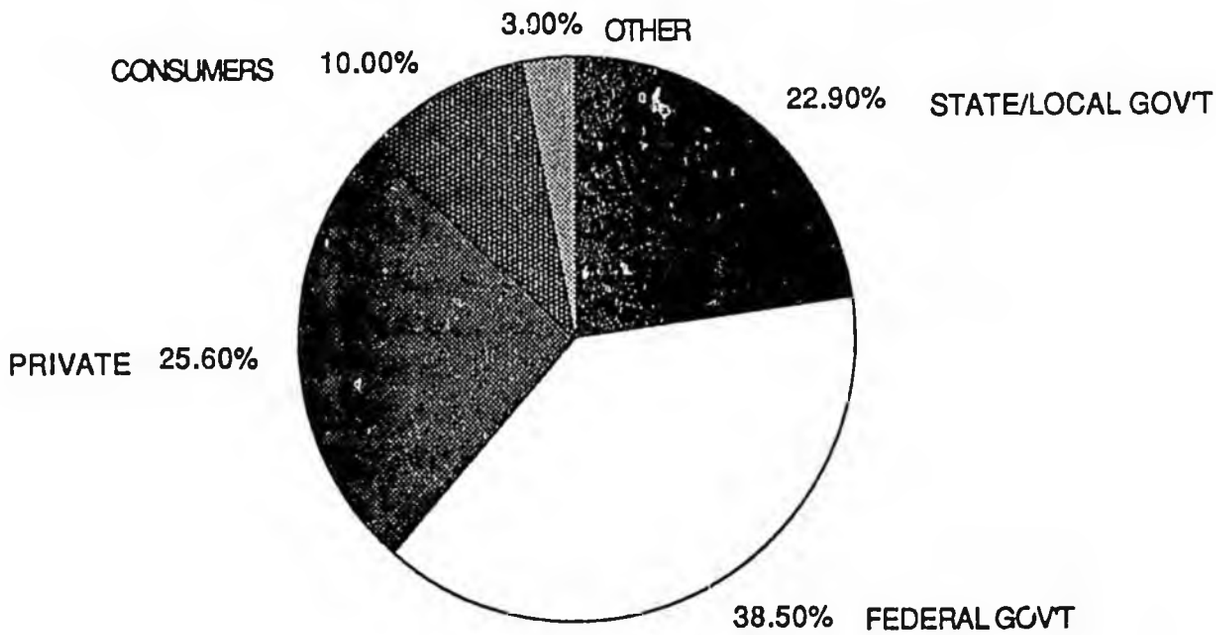
HCCC-TF EXHIBIT THREE

PERCENT OF U.S. HEALTH CARE EXP. BY SOURCE OF PAYOR



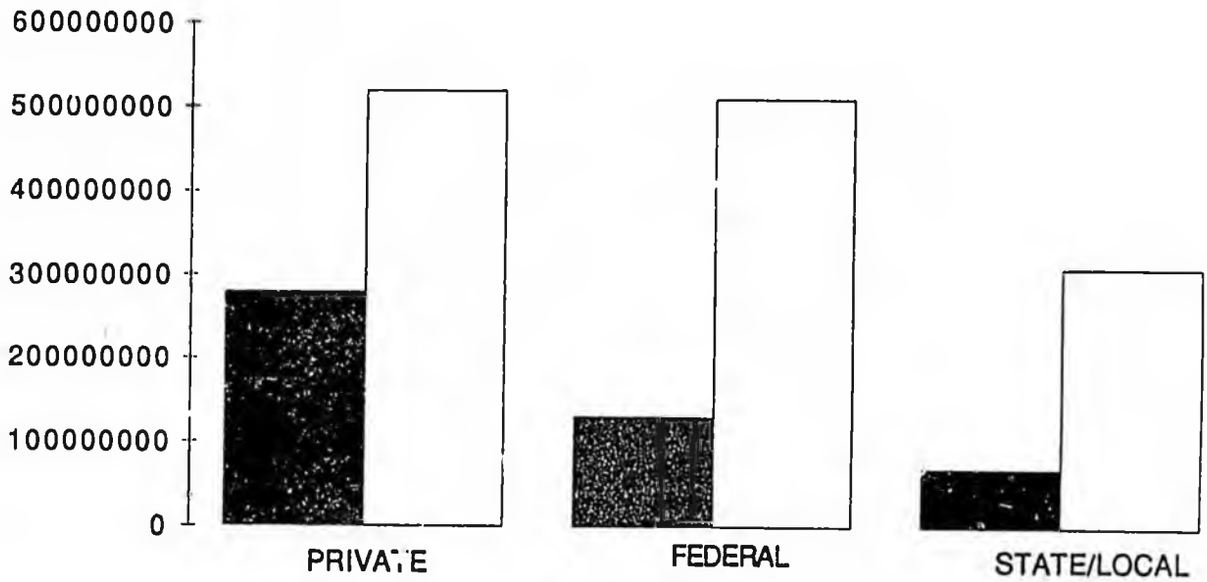
HCCC-TF EXHIBIT FOUR

PERCENT OF ALASKA HEALTH CARE EXP. BY SOURCE OF PAYOR



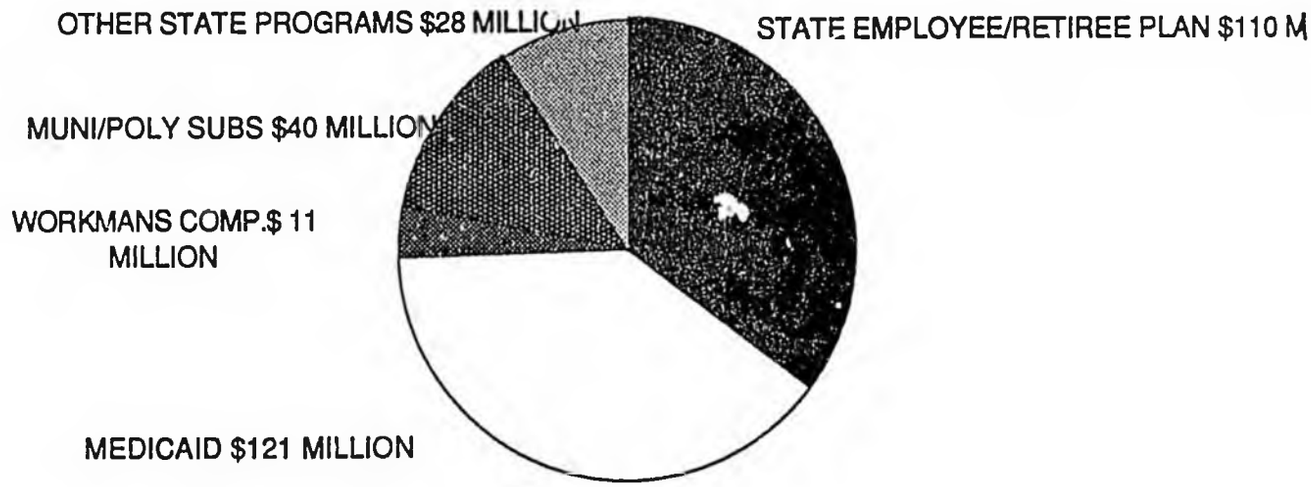
HCCC-TF EXHIBIT FIVE

STATE OF ALASKA HEALTH CARE EXPENDITURES 1979 VS 1989



HCCC-TF EXHIBIT SIX

1989 STATE OF ALASKA HEALTH CARE EXPENDITURES BY STATE PROGRAM



HCCC-TF EXHIBIT SEVEN

STATE OF ALASKA
PER CAPITA HEALTH CARE EXPENDITURE ANALYSIS
1979-1989

	1979	1984	1989
POPULATION	401,000	522,000	534,000
HEALTH CARE EXP.	$480. MILLION	$710. MILLION	$1.34 BILLION
PER CAPITA HEALTH CARE EXP.	$1197.00	$1360.00	$2524.00

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE
REPORT

SECTION FOUR

CAUSES OF RISING HEALTH CARE COSTS IN ALASKA

CAUSES OF RISING HEALTH CARE COSTS IN ALASKA

The Task Force in its expanded role, has investigated the problems and causes of rapidly rising health care expenditures in Alaska. The Task Force used public testimony, surveys, research (statewide & nationally) along with a detailed analysis of the delivery and financing of health care in Alaska in its investigation.

During this review the Task Force has identified not a sole culprit but numerous contributing factors that must be dealt with in an all encompassing manner to provide long term relief and health care expenditure management.

LIFE STYLE RELATED

Alaska residents like those in the lower 49 have seen increasing health care treatments due to life style injuries and diseases. These include alcohol and drug abuse, sports related injuries, cancer, AIDS and heart disease as the major expenditure causes in Alaska.

COST SHIFTING FROM OTHER HEALTH PROGRAMS

Alaska has to recognize the impact of cost shifting on the total cost of health care. When other programs either cut back or reimburse providers at lower levels these liabilities are directly transferred to other payors.

In addition, when programs make either enhancements or reductions in benefit levels these add additional costs or program burdens.

UNINSURED / UNDERINSURED ALASKA RESIDENTS

It is estimated that there are 90,000 Alaska residents that are with out health care protection, in addition there are a substantial number that do not have adequate coverage.

These residents are prevented from regular preventative care that would eliminate more serious and costly future health care needs. Also compounding the health care cost problem is when the uninsured / underinsured residents receive treatment they cannot afford. This is recognized by the health care provider as uncompensated care, but this cost is generally spread out among the other payors.

NEED FOR PREVENTATIVE CARE, WELLNESS INCENTIVES AND HEALTH CARE EDUCATION

More and more evidence points out the significant value in promoting wellness and preventative medicine. Through health education and programs that cover and promote preventative medicine Alaskans could improve their overall health and help reduce unnecessary expenditures.

Health care education and preventative medicine programs must be designed with up to date information and continually adjusted to changing medical trends, findings and advancements. These programs must also continually educate the public and recognize changes in lifestyle, surroundings and perception of health.

One example of a heath promotion, education and prevention program is the "Healthy Beginnings Program" recommended by the Health Care Cost Containment Task Force and instituted by the State for the employee health insurance plan in early 1990.

The "Healthy Beginnings Program" is a program for women and their babies starting with the first trimester, with screening for potential moderate or high risk pregnancies to determine steps necessary to eliminate or reduce the risk of a premature or unhealthy delivery.

The program centers around early intervention, education and wellness along with continued communication with the mother throughout her pregnancy.

Since the inception of the "New Beginnings Program" mothers who have participated in the program are reducing the number of low birth weight deliveries. The program has also saved the State Employee health plan millions of dollars.

Promoting health education, wellness and prevention is a cost effective way to help assure Alaska residents are receiving health care at the appropriate time and level of treatment necessary.

HIGH COST OF MEDICAL TECHNOLOGY AND WASTE

During the last five years two new facets of medical inflation have come to light. These are new technology and waste in the medical delivery system.

In recent years new technology in the form of equipment, procedures, treatments and medicines has greatly improved our ability as a nation to prolong life. While this has had a substantial effect on being able to keep people alive it has also come with substantial additional health care expenditures.

Alaska has also participated in this race for the newest and best medical technology. While we too have been able to improve the longevity of our residents the cost has been significant.

A method must be developed to assure that the technology is available to residents without duplication or undue cost to the health care delivery system. In addition we must weigh the benefits and cost of any new technology that has a substantial effect on the Alaska health care delivery system.

DIRECT AND INDIRECT MALPRACTICE INSURANCE COSTS

Malpractice insurance premiums and the associated costs continue to be a significant component of health care expenditures in Alaska. While many attempts have been made to improve and or reform the system no significant in roads have been made to reduce the overall costs.

Malpractice premiums paid to insurance companies are only one part of the equation. Of equal importance and much more difficult to measure is the practice of defensive medicine by health care providers attempting to avoid a "claim".

The problem is not only one of cost but of those providers who go without coverage or inadequate protection. It is estimated that approximately 25% of physicians and 50% of obstetric / gynecologic practitioners in Alaska are uninsured for malpractice.

The malpractice problem must be dealt with in any comprehensive strategy to manage health care expenditures in Alaska, it should be done on a systemic approach, including loss prevention, education, financing of protection and the ability to project and limit losses.

HEALTH INSURANCE CARRIERS ROLE

Health insurance carriers play an important role in the delivery and financing of health insurance in Alaska. In Alaska their are only seven insurance companies with any volume selling health insurance policies. Three nonresident companies have control of approximately 90% of the market place.

Alaska health insurance carriers have made constrictions in their underwriting standards and at the same time generally set premiums based on cost of claims plus overhead expenses & profit and instituted cost containment programs.

This limited the risk for carriers but placed additional burdens on access to health insurance adding to the population of those underinsured / uninsured.

It is recognized that writing and servicing health insurance policies in Alaska may be some what more expensive than in the other 49 states. However, Alaska is a large and growing marketplace that needs affordable health protection.

GROWTH OF NEW MANDATED COVERAGES AND HEALTH CARE SPECIALTIES

Alaska like most other states has passed a number of measures (sixteen since 1985) that mandate additional coverages for health care services in health insurance policies. This proliferation of mandated coverages adds to overall heath care expenditures in Alaska.

Although many of these measures can be justified, in the future all measures that expand the mandated coverage list should be evaluated by the legislature for total long term impact on the health care delivery system in Alaska.

New health care specialties have become an important component in the Alaska health care delivery system however, the trade off is a reduction in primary care providers especially in the rural areas.

HEALTH CARE PROFESSIONAL TRAINING AND RETENTION

The future of the health care delivery system in Alaska revolves around the ability to train and retain quality health care professionals in Alaska. The programs in place today must be revisited and revised to keep up with the primary and emergency care needs of Alaska especially in rural Alaska.

GENERAL OBSERVATIONS

Alaska has no central authority to provide health care planning, review of delivery, quality, access, and financing of health care protection. Alaska needs to have, in place, as the Health Care Cost Containment Task Force recommended, long term strategies to assure the medical delivery system remains accessible and affordable.

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE
REPORT

SECTION FIVE

HEALTH CARE DELIVERY SYSTEM

FINDINGS AND SURVEY RESULTS

ALASKA HEALTH CARE DELIVERY SYSTEM FINDINGS

The Task Force in its expanded duties reviewed the health care delivery system in Alaska and its important role in managing health care expenditures in Alaska.

During this review the Task Force recognized the importance in continuing the work already done in building a health care delivery system of which we can be proud. But in order to continue to expand and improve the system certain long range plans and controls must be implemented.

ALASKA LARGE GEOGRAPHIC AREA AND RURAL POPULATION

Alaska has an enormous land area and residents in largely rural areas that require health care. Alaska does have a good rural health care delivery system, but it is not immune from the problems such as long distance travel for care, limited health care services in some areas, difficulty in attracting and retaining health care professionals in rural areas and small facilities with limited services.

However only about 20% of the health care expenditures in Alaska are expended in the areas outside of the cities of Anchorage, Fairbanks and Juneau.

URBAN ALASKA HEALTH CARE DELIVERY SYSTEMS

Alaska expends about 80% of its health care dollars in it's three largest cities (Anchorage, Fairbanks, Juneau) creating another set of complexities in delivering heath care to Alaska residents.

Because the urban areas have larger populations and many rural residents receive health care in these cities, they are able to generally support more health care facilities and providers normally found in cities of like size.

The isolation from neighboring states also creates the need for self supporting health care delivery systems.

OUT OF STATE HEALTH CARE DELIVERY SYSTEMS

Alaska's health care delivery system relies on the systems of other states for certain treatments and as an alternate choice for residents.

Many Alaska residents choose to receive treatment or hospitalization in other states for a variety of reasons. These include the lack of available care in state or simply as a matter of convenience or comfort.

It is difficult to determine the amount of health care that is provided to residents by out of state providers. However, the out of state delivery system provides an important alternate delivery system and an equally important safety valve.

This system of receiving care must be continually monitored to assure that it provides care with out detracting or escalating health care costs for Alaska.

OTHER HEALTH CARE DELIVERY SYSTEMS IN ALASKA

Alaska has a number of other programs providing health care to residents. These include, Indian Health Service (I.H.S.), Civilian Health And Medical Programs for Uniformed Services (CHAMPUS), Veterans Administration (VA), Medicare, Medicaid and Public Health Systems.

In order assure and maintain an efficient health care delivery system in Alaska all systems must, when feasible, coordinate and share information to prevent duplication, gaps in service and fueling medical inflation.

SURVEY RESULTS

The survey done by the Task Force was designed to give greater insight to health insurance plans offered by Alaska employers, the costs for these plans, who is covered by health insurance, and additional data and perspectives from health care providers.

Over 300 surveys were mailed to various groups in Alaska including, municipalities, school districts, health care providers and private sector employers.

The survey questions were tailored to gather specific information relative to each category of respondent.

Questions ranged from those eligible / ineligible for employer health plans, number of employees, plan design, employee/employer contributions, cost containment measures implemented, premium costs, ideas to help reduce ever increasing health care costs and the reasons for these increasing costs.

Questionnaires sent to health care providers had additional questions to determine their specific perspective about rising health care costs and certain contributing factors *ie.*; bad debt, malpractice insurance costs and others.

The survey results gave us information that previously was not available. These includethe range of employer sponsored health plan designs, eligibility, associated premium costs, cost containment strategies employed, and respondents perspective, and impressions about the health care delivery system in Alaska.

In comparison to the State of Alaska active employee health plan, the survey results showed:

(1) the state no longer had either the most expensive health plan (64% of respondent's plans premium or premium equivalent was in excess of the states $385. per month) and,

(2) no longer was the State's plan the best in coverage (54% of respondents provide similar or better benefits).

With respect to the number of respondents offering health insurance;
(1) surprisingly 94% do offer some form of health insurance to their full-time employees while,
(2) none of the respondents provide coverage for part-time, seasonal, or occasional employees.

The majority of respondents have implemented ways to reduce their health plan costs;
(1) seventy one percent have implemented at least two cost containment measures, and
(2) sixty percent have also made benefit changes in the last two years.

In addition respondents also are implementing alternate financing of health insurance. Thirty one percent have self insured their plans.

The survey confirmed earlier information that the majority of health insurance in Alaska is underwritten by three carriers: Aetna, Blue Cross and Great West.

The survey asked specific questions about respondent's opinions relating to cost containment techniques that have worked for them and those that did not. Results showed that 55% of respondents felt that second surgical opinions and preferred provider organizations did not demonstrate significant savings. Seventy percent felt that utilization review, large case management and self insurance had positive results.

Respondents offered the following ways to control health care cost (shown with the percent of respondents offering each).

Statewide plan.....67%
Malpractice reform.....55%
Regulate provider rates.....53%
Provide insurance for uninsured..50%

In addition, the survey asked respondents their views of the major contributors to rising cost of health care in Alaska (shown with the percent of respondents for each).

Health care providers.....67%
Malpractice insurance.....64%
Overbuilt facilities.....59%
Insurance carriers.....55%
Plan members.....48%
New technology.....46%

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE
REPORT

SECTION SIX

TASK FORCE RECOMMENDATIONS

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE

RECOMMENDATIONS

The Health Care Cost Containment Task Force has over the last twenty-two months reviewed the rapidly increasing costs of health care in Alaska and have identified not one sole culprit but many contributing factors that collectively drive the health care economy in Alaska.

The Task Force has identified the following main components that should be focused on as a minimum starting point to bring health care expenditures in control for Alaska.

* Cost shifting from other programs
* Federal program cost shifting
* Improve health care delivery and financing systems
* Uninsured / underinsured Alaska State residents
* Accessibility of care
* Mandated coverage costs
* Improve the involvement and education for end users
* Collect current and meaningful health care data
* Institute preventative medicine programs

The Health Care Cost Containment Task Force makes the following recommendations which are designed to provide affordable quality health care access for all Alaska residents.

A. Create an authority that would establish and maintain health care provider payment and utilization schedules taking into consideration geographic location, actual provider cost, availability, and medical necessity (potentially using an established system as a foundation). The schedules will be used by all public sector employers and available to private sector as well.

And:

Would establish a voluntary health care protection procurement and financing pool to maximize purchasing power for;

i. State, local government and political subdivisions.
ii. Underinsured / uninsured for State residents.
iii. Public / small employers plan.

This authority would be governed by a board and would assure that access to quality affordable was available to all Alaskans.

B. Collection and analysis of state health care utilization andcost data, to recognize trends and recommend solutions to the appropriate entity.

C. Expanded monitoring and certifying of facilities expansion and substantial equipment technological purchases to assure need and eliminate duplication or unnecessary expense. This would require revision of the C.O.N. statutes currently in place.

D. Promote health awareness, preventative medicine and quality health care for all state residents.

E. Provide quality affordable health care access for Alaska residents who are underinsured / uninsured.

F. Continue to evaluate the effect of Federal program changes and maximize the use of Federal Funds.

G. Promote health care professional training and retention in Alaska.

H. Develop a way for the sole proprietor and small employer to provide health coverage to employees and their dependents.

I. Continue to evaluate alternate and self funding as an option for the state employees and retirees plans. Include in the next Request For Proposal a request for bids on a comprehensive and unbundled basis.

J. Form a cross section focus task force to continue to study and make recommendations to assure quality, affordable, health care access for all Alaskans.

TASK FORCE RECOMMENDATIONS FOR LEGISLATION

The Task Force recognizes the need for specific legislation to provide for a comprehensive approach to produce cost effective quality health care access to all Alaska residents.

Two separate but interrelated pieces of legislation are being recommended and endorsed by the task force. These are:

ALASKA STATE HEALTH RESOURCES AUTHORITY (ASHRA)

Creation of the Alaska State Health Resources Authority (ASHRA) SB 83, HB 71 which once enacted would be empowered to manage the access, delivery, quality, planning and financing of health care in Alaska.

The authority would be implemented in two phases:

PHASE ONE

By July 1, 1992 create and begin implementation of a statewide health care provider reimbursement schedules and utilization standards, which shall be used by all Alaska public employers and available for use by all other Alaska employers by application to the authority.

This provision requires the authority to create a system or method that streamlines or results in cost efficient payments to providers, and includes schedules of maximum allowable reimbursement for health care related services. These schedules would be based on actual provider cost, geographic regions, and availability of care. In addition, this provision creates the statewide utilization standards system to monitor, track and validate patterns of treatment by health care providers. This assures that cost efficient and cost

effective care is provided with out compromising the quality of care for participants in the authority.

The authority would also be required to issue an impact statement on all certificate of need applications within 60 days of notice. this will allow the authority to determine the cost implication of these proposed certificates or changes to existing certificates.

IMPACT

The goal of this phase is to reduce the rise in medical inflation for participants in the authority to at or about Consumer Price Index from its current level of about 20% per year. Another goal is to minimize cost shifting to other health care programs. With out this phase, health care expenditures in Alaska would top $10 billion by the year 2000. The State of Alaska's portion of this increase would exceed 3.0 billion. At the same time the ranks of uninsured residents would total 25% of our population. (exhibits one, and two)

PHASE TWO (optional procurement of insurance)

Beginning after July 1, 1992, the Authority is directed to procure or provide comprehensive group health insurance for Alaska public employers and other employers in the state who elect to participate.

This would expand the pool of subscribers and maximize the opportunities for health care cost management and should realize significant additional savings for those participating in the authority.

In addition to creating the most comprehensive, cost effective, and efficient method of providing a variety of types of health care plans, the Authority must meet the coverage requirements resulting from negotiated agreements.

The authority is also required to review and where feasible provide health insurance protection for the uninsured and underinsured Alaska residents.

No later than January 1, 1993 the authority would develop and offer a health insurance protection plan for the sole / small Alaskan employer.

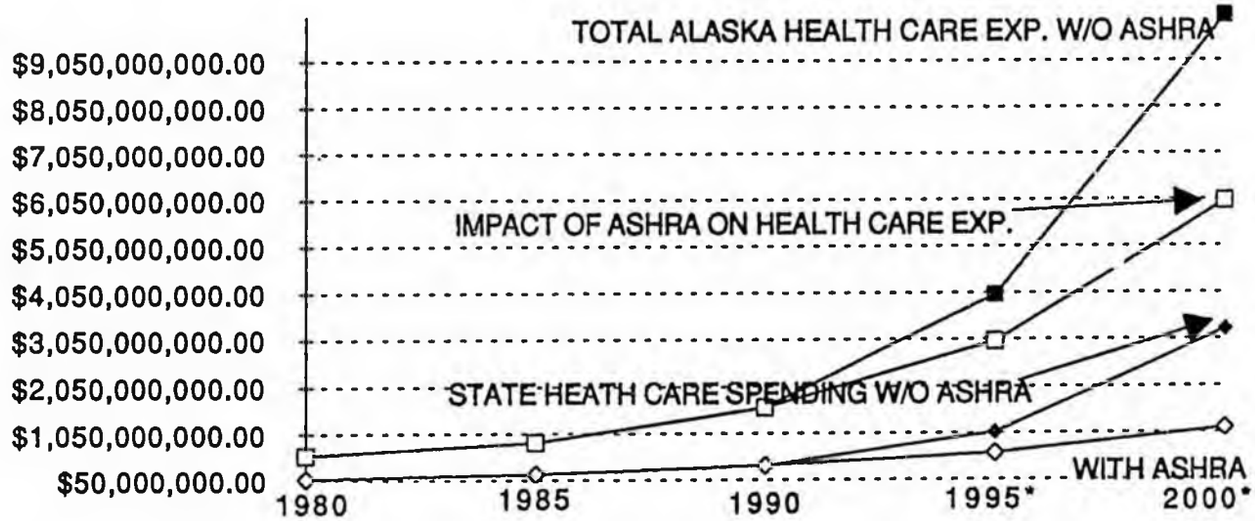
IMPACT

Phase two would bring together the provider reimbursement and utilization management components with the delivery and financing of health care in Alaska. This will enable the state, through the authority, to provide access to quality cost effective health care for all Alaska residents.

ASHRA EXHIBIT ONE; illustrates the estimated impact on total and the states portion of health care expenditures as compared without the effect of ASHRA. Total health care expentitures would be reduced in the year 2000 from $10 billion to under $6.0 billion and the states portion would be reduced from $3.28 billion to $2.0 billion. For a total estimated cost of health care savings of $4.0 billion in the year 2000.

ASHRA EXHIBIT ONE

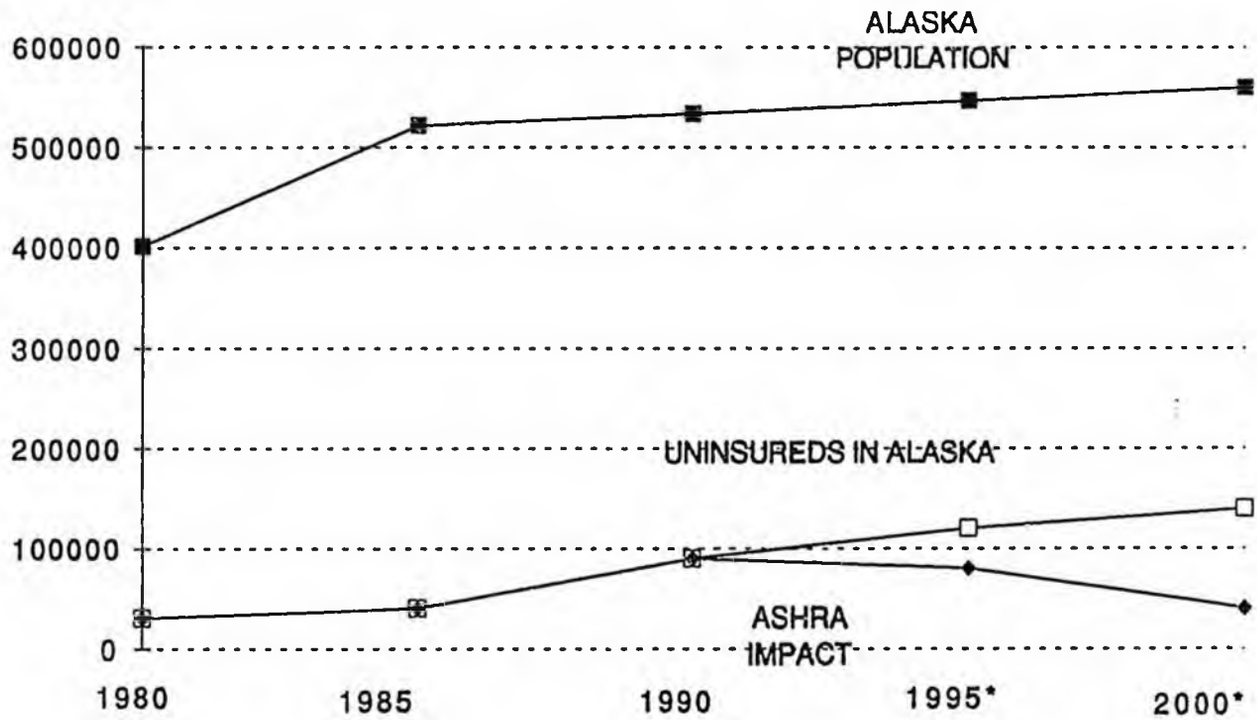
ESTIMATED IMPACT OF ASHRA ON HEALTH CARE EXPENDITURES IN ALASKA



ASHRA EXHIBIT TWO; illustrates the estimated impact of ASHRA on the uninsured population in Alaska. ASHRA would reduce by the year 2000 the number of Alaska residents without health insurance to about 40,000 from the 120,000 projected without ASHRA.

ASHRA EXHIBIT TWO

ESTIMATED IMPACT OF ASHRA ON THE UNINSURED POPULATION IN ALASKA



COMPANION LEGISLATION

THE CERTIFICATE OF NEED PROGRAM (C.O.N.), SB 84, HB 69

Proposed legislation would amend AS 18.07 to create a rational frame work for the planning and development of all health care services in the state to ensure promotion and protection of public health, the providing of equitable access to health services, and the avoidance of unnecessary increases in health care costs.

By amending AS 18.07 the Certificate Of Need program would regain an important role in the approval process for health care facilities, technology, modification, expansion or change of purpose. This change would not only provide the system an early warning device but a way to accurately measure the initial and future cost impact to the total health care delivery system.

The task force has identified that the cost of facilities and technology has a direct impact on the total cost of health care and, therefore, should be prospectively managed.

PROPOSED RESOLUTION

THE HEALTH RESOURCES AND ACCESS TASK FORCE

The task force recommends the adoption of a concurrent resolution creating a HEALTH RESOURCES AND ACCESS TASK FORCE to continue the study of this issue study forward recommendations regarding access to affordable, quality health care for all Alaskans.

The foundation of knowledge, education and demonstrated success of the Health Care Cost Containment Task Force must be built upon in order to see implementation of long term solutions to the health care crisis in Alaska.

The ideal approach is to take the expertise developed in the Health Care Cost Containment Task Force and combine the ambitions of the

Universal Task Force (ch.179, SLA 1990) to create a hybrid focus group to simultaneously work on the management of health care expenditures in Alaska while improving access to quality health care.

It is envisioned that the work plan and resources of the group would have the depth to investigate all facets of health care access and financing in Alaska as compared to alternate solutions implemented by other countries, provinces, states and other health care programs.

This focus group membership should include:

- Legislative Branch
- Executive Branch
- Private Sector Employers
- Non Profit Sector
- Health Care Consumer
- Health Care Providers
- Medically Indigent
- Labor Organization

It is important to have further work done in this area, and to provide information and input to the Alaska State Health Resources Authority.

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE
REPORT

SECTION SEVEN

OPEN / UNRESOLVED ALASKA HEALTH CARE DELIVERY ISSUES

OPEN / UNRESOLVED ALASKA HEALTH CARE DELIVERY ISSUES

The Health Care Cost Containment Task Force has, in its effort to find the cause of the rapidly increasing cost of health care in Alaska, found several contributing factors that need further investigation.

DELIVERY AND ACCESS

Delivery of health care in Alaska has been found to be one of the greatest contributors to the increasing cost of health care. Traditional approaches to delivering health care when applied to the large geographic area of Alaska has created a hodge podge of service which is often inadequate, underutilized and thus more costly than what can be offered through a coordinated statewide system of delivery. In addition, the increasing population of underinsured and uninsured receiving uncompensated care causes additional strain on urban, as well as, rural facilities and providers.

Included within the problems of delivery and access to health care in Alaska are answers to some of the increased cost of health care. Some of these are overbuilt facilities, new technology which is often underutilized, a lack of prevention programs, the need for statewide planning, and inadequate financing of health care for all Alaskans.

UNINSURED / UNDERINSURED

The health of small businesses in Alaska is often dependent upon a limited number of individuals each of whom is very important to the operation of an organization which has no insurance for its employees or must pay an unreasonable price for limited coverage.

As the cost of health care increases, many of these sole proprietorships and small businesses and their employees are forced to join the ranks of the underinsured or uninsured.

HIDDEN COSTS

Malpractice insurance coverage is a continuing problem not only adding to the cost of some medical procedures but increasing health care cost in general. Many health care providers believe it is necessary to practice defensive medicine as a means to lessen potential liability. This induced caution is reflected in additional laboratory test, unnecessary use of technology, exploratory surgery, increased inpatient time, and other practices that increase the cost of health care for everyone.

MANAGING THE SYSTEM

Oversight will be necessary in any effort to coordinate access to federal state and local delivery systems. Attempts to merge or attract additional sources of financing and coordinate the use of facilities for persons needing health care in Alaska will require guidance. Even the operation and activities of the Alaska State Health Resources Authority the creation of which is supported by this Task Force as recommended in section 8 will require at least periodic oversight.

These issues represent some of the more obvious areas causing the cost of health care to increase and indicate a need to continue the work that has been started. While the work of the Health Care Cost Containment Task Force has brought to light some areas where millions of dollars in cost savings have already been achieved much more remains to be done. To establish realistic, reliable and efficient controls on the cost of health care and provide access to all Alaskans will require a great deal more work than has been completed to date

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE
REPORT

SECTION EIGHT

ATTACHMENTS

NEA-ALASKA

AFFILIATED WITH THE NATIONAL EDUCATION ASSOCIATION

ANCHORAGE REGIONAL OFFICE
1411 W. 33RD AVENUE
ANCHORAGE, ALASKA 99503
(907) 274-0536

JUNEAU OFFICE
105 MUNICIPAL WAY, SUITE 302
JUNEAU, ALASKA 99801
(907) 586-3090

FAIRBANKS REGIONAL OFFICE
2118 CUSHMAN STREET
FAIRBANKS, ALASKA 99701
(907) 456-4435

February 11, 1991

To: **Senator Pearce, Chair**
Members, Senate Labor and Commerce Committee

Re: **SB 83;** ***"An Act relating to the Alaska State Health Resources Authority; relating to the delivery, quality, and financing of health care for residents of the state, and to the issuance of certificates of need; and providing for an effective date."***

NEA-Alaska supports and encourages your favorable consideration of SB 83. It represents a sound and viable alternative to the cost, quality, and utilization of health care services, especially as it may pertain to public school district employees.

Currently, school district employees are covered by a variety of health care plans with a broad range of benefits at differing levels of premium costs.

Many districts are disadvantaged in their ability to maximize benefit coverages at reasonable costs and have seen these costs increase at alarming rates in recent years.

Access to utilization standards, more efficient administrative and provider reimbursement systems, and the opportunity for reducing premium costs and for improving benefits through participation in expanded group pools represents substantial opportunity for employers and employees alike.

Implementation of the provisions in SB 83 is a critical step if we are to effectively deal with health care costs in Alaska.

Thank you for your consideration of our recommendation.

Respectfully submitted,

Bob Manners
Executive Director

Don Oberg
President

cc: **Senator Duncan**

ALASKA STATE EMPLOYEES ASSOCIATION

AFSCME Local 52, AFL-CIO

February 11, 1991

Hon. Jim Duncan, State Senator
Pouch V
Juneau, Alaska 99811

Dear Senator Duncan:

On behalf of the Alaska State Employees Association and its 9,000 members statewide, I want to thank you for introducing Senate Bill 83, which seeks to establish an Alaska State Health Resources Authority to help cap the state's increasing health care costs.

As you know from your experience with the Alaska Health Care Cost Containment Task Force, health care costs to Alaskans exceeded $1.5 billion in 1989 and have been rising at a rate of more than 20% each of the past five years. These cost increases have concommittantly increased the costs of health insurance premiums for all Alaskan employers, including the State of Alaska, making it more and more difficult for them to continue health care coverage for their employees.

Clearly, something needs to be done to bring down or, at the very least, check Alaska's spiraling health care costs and SB 83 takes the right approach.

For its part, ASEA/AFSCME Local 52 has agreed to a defined contribution to health care costs in its collective bargaining agreement with the state, but this is only a step in what should be a comprehensive attept to contain costs throughout Alaska.

Furthermore, SB 83 makes inherently good public policy. Such an approach benefits union's, such as ASEA, by mitigating their health care costs; it benefits the State by lowering its operating costs; and it benefits private sector employers by reducing their cost of doing business with the state.

Again, my thanks to you and your colleagues on the Health Care Cost Containment Task Force for tackling a complex, difficult and controversial subject.

Respectfully yours,

Buddy Maupin

Buddy Maupin, Business Manager
ASEA/AFSCME Local 52, AFL-CIO

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NFIB Alaska

National Federation of
Independent Business

February 11, 1991

The Honorable Jim Duncan
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Duncan:

The legislative agenda of NFIB/Alaska is determined by our ballot. The ballot is our annual poll of our membership on a series of issues deemed critical to small business. A majority vote, of the members in response to the poll, sets our policy and position on legislative issues.

I have previously shared the results of the entire poll with your office. Now that you have introduced SB 83 - Alaska State Health Resource Authority - the objective of this letter is to share with you some thoughts on the bill.

The idea of a voluntary health insurance program appears to be a viable means of providing health insurance to the uninsured population in Alaska. Small businesses are willing to provide health insurance to employees, as long as the cost is not prohibitive. A voluntary pooling approach is a more acceptable alternative than a legislative mandate that all employers must provide health insurance coverage for their employees.

The key elements to NFIB/Alaska members support of the concept of pooling are: the program would be voluntary, administered by private insurance companies and affordable.

For your records the following are the results of the 1991 NFIB/Alaska ballot questions regarding health insurance:

State Office
9159 Skywood Lane
Juneau, AK 99801
(907) 789-4278

Should legislation be passed in order to create a voluntary health insurance plan which would be administered by private insurance companies and which would pool small businesses together so they could purchase employee health insurance at group rates?

Yes 72.2% No 17.0% Undecided 10.8%

a. If this pooling of employers in order to purchase health insurance was available, would you participate?

Yes 50.2% No 19.3% Undecided 30.5%

b. Should employers be allowed the option of having their employees pay part of the premium cost of health insurance purchased through the above pooling plan?

Yes 90.0% No 5.2% Undecided 4.8%

NFIB/Alaska hopes this information regarding the views of small business owners on this issues will be useful to you. If you have any questions regarding this information, please do not hesitate to contact me.

I look forward to working with you on SB 83 and other issues of importance to the small business members of NFIB/Alaska.

Sincerely,

Resa Jerrel

Resa Jerrel
NFIB/Alaska
State Director

RESOLUTION

BE IT RESOLVED BY THE JUNEAU FORUM ON THE 1991 ALASKA CONFERENCE ON AGING:

WHEREAS health care expenditures in Alaska have risen from $480 million in 1979 to over $1.5 billion in 1989, a per capita increase of $1327.00 per person per year; and

WHEREAS the number of uninsured or underinsured Alaskans is now estimated at over 90,000 persons; and

WHEREAS a large number of the uninsured and underinsured are senior citizens; and

WHEREAS the Alaska State Health Care Cost Containment Task Force was created early in 1989 to find ways to control the ever increasing cost of health care in Alaska; and

WHEREAS the Alaska State Health Care Cost Containment Task Force has as a result of its research and investigation identified ways to control the rising cost of health care in Alaska; and

WHEREAS the Task Force has endorsed Senate Bill 83 and the changes proposed therein necessary to rising health care cost; and

WHEREAS the Juneau Forum of the 1991 Alaska Conference on Aging has reviewed the findings and recommendations of the Alaska State Health Care Cost Containment Task Force;

BE IT RESOLVED by the Juneau Forum of the 1991 Alaska Conference on Aging that the rising cost of health care is a serious problem for senior citizens; and be it

FURTHER RESOLVED that the Juneau Forum of the 1991 Alaska Conference on Aging strongly supports the cost containment measures proposed in Senate Bill 83; and be it

FURTHER RESOLVED that the Juneau Forum of the 1991 Alaska Conference on Aging strongly supports the Legislatures passage Senate Bill 83, creating the Alaska State Health Resources Authority.

Adopted:

JUNEAU FORUM
1991 ALASKA CONFERENCE ON AGING

By: Juneau Comm. on Aging

Chairperson: Lauris S. Parker

Lauris S. Parker

AASB

ASSOCIATION OF ALASKA SCHOOL BOARDS

1990 CORE RESOLUTIONS

passed by the membership
1990 ANNUAL STATEWIDE CONFERENCE
ASSOCIATION OF ALASKA SCHOOL BOARDS
TUESDAY, NOVEMBER 13, 1990

SUBJECT: ADMINISTRATION
90-36
HEALTH INSURANCE

WHEREAS, the Alaska Legislature through the work of the Health Care Cost Containment Task Force is looking at measures to control the rate of increase in the cost of health care for all Alaskans; and

WHEREAS, the cost of health insurance has increased sharply in recent years and shows no signs of stabilizing; and,

WHEREAS, school districts are required to operate within a fixed budget and need to stabilize costs as much as possible to allow for reasonable planning for a sound educational program; and,

WHEREAS, the increasing cost of providing health insurance to school employees has a significant impact on the operating budget of school districts in Alaska; and,

WHEREAS, Alaska school districts have demonstrated that insurance pooling has been an effective means of stabilizing insurance costs for their types of coverage;

NOW THEREFORE BE IT RESOLVED that the Association of Alaska School Boards aggressively investigate the feasibility of pooling for school district employee health insurance as a viable alternative for providing cost containment on a significant budget item.

MEDICAL INDIGENCY ProjectNotes

National Conference of State Legislatures Vol. 1, No. 1 December 1989

RIGHT OR PRIVILEGE:
SHOULD EVERYONE HAVE ACCESS TO BASIC HEALTH CARE?

"In a civilized society, every member of society should have access to a basic package of health services." Uwe Reinhardt, a Princeton economist and member of the National Leadership Commission on Health Care, has likened this to the guarantee of universal access to public education. Yet, the United States and South Africa are the only major industrialized powers that fail to guarantee access to health care.

Americans struggle with the issue of whether health care is a right or a privilege. In a country that has the best health care technology in the world, nearly 37 million of its citizens do not have health insurance. Those who cannot afford to pay, often called the "medically indigent," face major access barriers to health care services.

In the absence of a national health policy, the health care access and rights debate is centered in state legislative chambers. Medical indigency and uncompensated health care costs were identified as top priority issues for the 1989 legislative sessions, and will continue to demand attention in the 1990s. The three primary concerns identified by legislators are ensuring access to health care, paying for it, and expanding the availability of insurance to uninsured persons. Health care analysts have suggested that while in past years state legislatures proceeded slowly, states are now taking a leadership position on these issues. Access, cost, and quality issues continue to headline the policy concerns of consumers, providers, and payers.

Financing health care for people who do not have private insurance or who are not eligible for government programs is a major problem for state legislatures. Medical indigency has taken on greater urgency in recent years because of changes in the health care system. In the past, health care providers used a portion of their profits from paying patients to subsidize the costs of care to this nonpaying group. Recent efforts by insurers, the business community, and government to reduce their health care costs have made it increasingly difficult for providers to continue this practice. The focus of this article is universal access to health care and state efforts to ensure availability.

Who are the medically indigent?

The term "medically indigent" usually applies to low-income uninsured people who are unable to pay for their medical care. Others may also be included in a state's definition, including insured persons who cannot afford to pay for services not covered by their policies, or for high insurance deductibles or co-payments. Even middle-class individuals may be considered medically indigent if they cannot pay for the costs of a catastrophic illness or accident. The following items reveal information about uninsured and medically indigent people that may be of interest to state lawmakers:

- Although Medicaid eligibility criteria vary widely among states, on the average, an American with two children may earn no more than $6,036 annually to qualify for Medicaid. In *Alabama*, a family of three can earn no more that $1,418 per year to be eligible for Medicaid, in *California*, the threshold is $10,704.
- One in three Americans is without adequate insurance coverage and millions go without basic health care services.
- Nearly one-third of Hispanic Americans are uninsured.
- More than one in five African Americans do not have health insurance.
- One-third of the uninsured are children, including some five million adolescents aged 10 to 18. Uninsured children receive 40 percent less physician care than insured children, according to the National Association of Children's Hospitals & Related Institutions (NACHRI).
- Forty-four percent of uninsured children live in families with incomes below the federal poverty level.
- Almost 20 percent of uninsured children live with an adult who is insured through the workplace.
- The incidence of uninsured residents is almost twice as high in the Western and Southern states than in the North Central and Northeastern states.
- Persons without health insurance "self ration" by seeing a doctor about 65 percent as frequently as those with coverage or by not even seeking medical care.
- Millions of persons who do receive health care services, but either cannot pay or do not pay for them, generate billions of dollars of uncompensated health care costs each year.

"Establishing priorities in health care is a necessary step toward defining adequate health care." Sen. John Kitzhaber, MD, President, Oregon State Senate

Should the health system be restructured ?

The last several years have witnessed a shift in public policy approaches to meeting the needs of the medically indigent. The health care system is seeing a change in the "Robin Hood" ethic of compliance with the expectation that providers are somehow obliged to serve patients regardless of their ability to pay. Public debate is brewing about how much health care is "adequate" for those who cannot pay for it. As this debate continues, several factors point to a health care system with growing problems:

- Health care costs continue to skyrocket. In 1988, national health expenditures were 11.3 percent of the gross national product (GNP), the broadest measure of U.S. economic activity. By 1993, health care spending will grow to an estimated 13 percent of the GNP.
- The gap between the medical "haves" and "have nots" is widening.
- Millions of Americans report financial barriers to receiving adequate health care.
- The U.S. has one of the highest infant mortality rates in the industrialized world, exceeding that of 16 other developed nations.
- Our nation's safety net is fraying. Public hospitals are endangered and no longer have the resources to serve as health providers of last resort.
- The ability of hospitals to absorb uncompensated care costs has diminished as their ability to shift costs has declined and as the uninsured population has grown.
- Physicians report that the aged, poor, and uninsured utilize emergency rooms as a primary source of health care and that overcrowding is severely limiting the public's right to timely and good quality care.
- Access to emergency medical and trauma services is threatened by the continuing problems of health care financing and because so many emergency room patients are uninsured. Emergency room closures present access problems even for those who are fully insured.
- U.S. hospitals and emergency rooms with too many patients and too few beds are in a widespread and growing crisis, according to the American College of Emergency Physicians (ACEP).
- In some quarters, Medicare and Medicaid are equated with charity care because reimbursements under these programs sometimes are far below costs.
- Medicaid eligibility has been eroded over the past decade, government reimbursement levels and "red tape" inhibit physicians from treating the poor, and emergency rooms have been labeled as the "opening through which debts blow."

These and other problems fuel the national health care debate. State legislators find themselves in the middle of the fray.

Can change be expected?

The overriding problem will not be solved right away, and the issues raised as a result will set the agenda for change. Inequities in the distribution and provision of care will require change at many levels. The need for change is apparent, but there is no consensus as to what form the change will take in light of expectations versus economic realities.

Can improvement at the state and local level resolve the increasing financial burden of providing care on the national level? Department of Health and Human Services Secretary Louis Sullivan, MD has declared that state and local government and private employers must share in the solution to the problem. Scholars suggest that total resources be determined in the context of federal and state budgets.

Rationing has been proposed as one possible solution to the current crisis of cost in health care. Advocates believe the allocation of resources makes funding decisions more rational.

> *"In an era of federal budget deficits and tight state budgets, how to assist the medically indigent has become a question of what is the most efficient allocation of limited dollars."*
> Katherine Swartz and Debra Lipson, *Strategies for Assisting the Medically Uninsured*

Rationing also has been criticized as an unhealthy "stopgap" measure that denies care to the most deserving segments of the medically indigent population. Proponents argue that a two-tier system is developed, offering "second class" medicine in a top quality environment.

Over the past five years, the states have taken the lead in developing legislation to address the growing problem of paying for and ensuring access to medical services for the medically indigent. States have experimented with a number of different programs for the indigent. The majority of state legislatures have enacted or considered bills to expand access to and finance health care for medically indigent persons.

Conclusion

The answer to the question of whether access to basic health care for all is a right or a privilege is both political and policy oriented. The U.S. Supreme Court has determined that there is no *constitutional* right to medical care, even to medical care that is lifesaving. Future solutions will come from Congress and the individual state legislatures. Changes to the current health care system will require an examination of the following:

1. Community interdependency – the inevitable conclusion that no one group can do it alone.
2. Voluntary action – the acceptance of short-term and intermediate strategies to develop an equitable and affordable long-term solution.
3. Decision making process – the promise of specific benefits or the rationing of health care services.

FYI

For further information on project activities, contact:

Shelda L. Harden
Policy Specialist
Health Services Program
Human Services Department
1050 Seventeenth Street,
Suite 2100
Denver, Colorado 80265
(303) 623-7800

STATE ACTIVITY

Hawaii

"Hawaii did it first," said State Representative Jim Shon, chair of Hawaii's Health Committee in the House of Representatives, referring to the state's 1989 Universal Health Care Insurance Act. "By guaranteeing health care insurance for all of Hawaii's people, we have taken another step toward national leadership in health care."

The new law focuses on basic coverage for preventive primary care, prenatal care, childhood immunizations, mammograms, pap smears, and all aspects of outpatient care. Also included are an expansion of Medicaid services and specially targeted health services for gap groups that have difficulty obtaining conventional insurance, such as the homeless. Fifty thousand uninsured Hawaiians will gain health insurance coverage under the new law. The state Department of Health will administer the program and purchase health care coverage for specific services from private health insurance contractors for individuals who qualify for, and choose to purchase the bargain coverage on a sliding-fee-scale basis. These are primarily low-income individuals who cannot participate in existing programs and do not have the means to purchase private health care insurance coverage.

Massachusetts

The Health Security Act of 1988 created one of the most comprehensive health insurance plans in the nation. The law guarantees the gradual introduction, over four years, of coverage for all residents. The legislation was designed to expand the number of businesses providing insurance to their employees. Other uninsured persons are to receive insurance through a state program administered by the new Department of Medical Security. By 1992, businesses with more than five employees will be required to pay a surcharge of 12 percent of each full-time employee's first $14,000 in wages into a health insurance trust fund, up to a maximum of $1,680 per employee.

Employers who provide health insurance can deduct those costs from the surcharge, resulting in major new costs only to employers who do not provide insurance. Although this approach is designed to comply with the federal Employee Retirement Income Security Act (ERISA) provisions, it is unclear whether it would survive a court challenge. The law also provides positive incentives for small businesses to provide insurance before the 1992 deadline. A number of insurers are in the implementation phase of the health insurance program and some 15,000 residents have gained insurance coverage from the state; most are disabled unemployed adults, disabled children, pregnant women, and people who have left welfare to take a job without insurance. However, Massachusetts is currently in the midst of a serious economic crisis that is likely to affect the universal health law. Critics worry that the state will not carry its share of the costs.

California

In the last 10 years California's uninsured population has risen approximately 60 percent to 5.2 million people. Two-thirds of the uninsured residents are either employed or dependents of someone who is employed. Two bills signed into law this fall are designed to ensure coverage to all working residents by 1992:

A task force authorized under Chapter 829 (AB 350) will report to the legislature March 1, 1990 on the statutory responsibility of employers to provide employees with insurance and changes in insurance rate-setting practices to ensure that coverage is both available and affordable.

Chapter 797 (SB 1207) expands eligibility for small business tax credits for employer-sponsored health coverage. A tax credit of up to $25 a month per employee (or 25 percent of the cost paid or incurred during a tax year by an employer to provide coverage) to firms that provide benefits equal to or better than those in the basic program. Eligible firms are those that employ 25 or fewer workers and employers will be required to pay at least 75 percent of the premiums. The tax credit will take effect in January 1992.

Oregon

In Oregon, over 400,000 people -- one out of every five living in the state -- have no health coverage. In the absence of a federally approved national health policy, Oregon arrived at the following prescription to provide access to health care for everybody:

Of the 300,000 Oregonians living below the Federal Poverty Level (FPL), only 160,000 are being served by the state Medicaid program. Chapter 836 (SB 27) revises the current state Medicaid program to expand eligibility and redesign the health care package. Eligibility would expand by allowing all residents under 100 percent FPL to have access to Medicaid benefits. Currently, eligibles include families under 58 percent FPL, pregnant women with young children up to 100 percent FPL, medically needy, and aged, blind, and disabled.

The benefit package would be redesigned by the Health Service Commission appointed to review all health services, as generally prescribed by the act, and rank them in order of most important to least important. The commission will present its recommendations to the Joint Legislative Committee on Health Care, which will make recommendations to the Emergency Board. The Emergency Board and subsequent Ways and Means Committees will appropriate funds on a per capita rate, which will determine the quality of the health care package. Revenue shortfalls will not result in reduction in eligibles or provider rates, but by reduction in the benefit package.

A tax credit program was established in 1988 to encourage small businesses, who have not previously offered health care benefits, to provide such benefits. In return, the employer receives an affordable benefit package and a tax credit of up to $25 per employee per month for as long as the employer provides the benefit. Chapter 381 (SB 935) attempts to provide access to health care for uninsured working Oregonians by expanding the existing tax credit program administered by the Insurance Pool Governing Board and creating incentives and rewards to employers who provide health benefits.

Chapter 838 (SB 534) addresses the problem of providing health care services to the uninsured and uninsurable and the need to spread the cost to as broad a base as possible. The measure establishes the Oregon Medical Insurance Pool Board as a state agency to supervise a medical insurance risk pool. It also appropriates $1 in million general funds to the Oregon Medical Insurance Pool Account.

Other

In New York, state health commissioner David Axelrod, MD, proposed a universal insurance coverage plan, with elements of cost control, in September of this year. The UNY*Care plan is expected to be introduced in the 1990 legislative session. In Pennsylvania, state representative Donald W. Dorr introduced a package of bills to increase the availability of health insurance and health services.

MEDICAL INDIGENCY PROJECT

The National Conference of State Legislatures (NCSL) has a strong commitment to assisting state legislatures with a variety of medical indigency issues. NCSL is assembling a consortium of funders to address the problems of medical indigency. The Colorado Trust and American College of Emergency Physicians are the first to support the Medical Indigency Project. NCSL received a two-year grant from the Colorado Trust to assist state legislators in developing policies on health care for the medically indigent. The Colorado Trust is a private foundation established in 1985. Its primary mission is to promote and enhance the health and well-being of all people, particularly the citizens of Colorado. The American College of Emergency Physicians strives to provide a unifying direction of purpose in the field of emergency medicine. The college provides information regarding the practice of emergency medicine and encourages training of emergency physicians, with the aim of improving emergency room care.

The project conducts on-site technical assistance, publishes periodic reports, and maintains an information clearinghouse on innovative state programs of care for the medically indigent. The project also will produce three newsletters on issues concerning the medically indigent. ProjectNotes is the first in a series of reports on access to care, financing, and the quality of health care for the medically indigent.

TECHNICAL ASSISTANCE

Technical assistance services offer legislatures programs tailored specifically to their state's situation. Assistance in the past has included special workshops, assistance with drafting legislation, and special testimony.

A number of states have expressed an interest in technical assistance for 1989 - 1990 on a variety of topics related to the issue of medical indigency. Requests for technical assistance come from states with large medically indigent populations and states that have experienced a recent increase in this group. States chosen to receive technical assistance are determined according to state need, issue area, potential impact on the legislative process, and legislative interest. If your state legislature is interested in more information on technical assistance programs concerning issues affecting the medically indigent, please contact project staff.

PUBLICATIONS

The Medical Indigency Project has produced a variety of publications and other information resources on major medical indigency health policy issues. One copy of each publication is provided upon request at no cost to state legislators, legislative staff, and state legislative libraries. Please contact NCSL's Book Order Department at the number listed in the FYI section.

INFORMATION CLEARINGHOUSE

The Medical Indigency Project and other health projects have developed an extensive information clearinghouse on a variety of health topics. The information clearinghouse guarantees legislators and legislative staff a quick, reliable, and knowledgeable source of information when research reports and legislation are being formulated. NCSL's Health Services Program fields over 1,000 information requests a year from legislative offices, health departments, other health care professionals, and the media.

Requests cover a broad range of medical indigency topics, including: uncompensated care, Medicaid eligibility and expansion, funding sources, health insurance regulation, risk pools, mandated health benefits, and state programs for the medically indigent. The resources of the Medical Indigency Project information clearinghouse may be accessed by contacting project staff.

MEETINGS AND SEMINARS

NCSL's Annual Meeting and other seminars and conferences provide an opportunity to reach a large number of interested legislators. Health issues are always among the most important sessions at these meetings and draw large audiences. Information on upcoming workshops will be included in future editions of ProjectNotes.

National Conference
of State Legislatures
1050 17th Street, Suite 2100
Denver, Colorado 80265

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MEDICAL INDIGENCY ProjectNotes

National Conference of State Legislatures Vol. 1, No. 2 February 1990

HEALTH CARE FOR THOSE WHO CANNOT ALWAYS AFFORD CARE

The headlines of the nation's newspapers and periodicals mark the absence of a national health care assurance policy: "US Must Cure Health Care Ills;" "State Health Care Funding Criticized;" "Can You Afford to Get Sick?: The Battle Over Health Benefits;" "US Rations Health Care;"and "Deciding What Medical Care the Poor Can Have: Lists Are Drawn Up." State and federal efforts to better the health care system are fragmented and often work at cross purposes. The lack of agreement on a solution begs the unanswered question: who is responsible?

Health care expenditures have escalated astronomically in the last 25 years. Health care costs consumed 5.9 percent of the Gross National Product (GNP) in 1965. The U.S. Department of Commerce has reported that the nation's health care tab was $600 billion in 1989, or 11.5 percent of the GNP. Those billions, up 10 percent from 1988 total health care expenditures, translate into approximately $2,400 per person. 1990 health spending is expected to reach $661 billion. At the same time, the number of uninsured has grown substantially.

Medical indigency and health insurance are top priority issues for the 1990 legislative sessions. Health insurance issues are explicitly tied to medical indigency policy. Improving access to health care is of concern to medical indigency policymakers as millions of uninsured people report financial barriers to receiving needed care. Mandating health insurance benefits, establishing financial incentives for employer-paid coverage, and creating state-sponsored insurance plans are a few of the key issues facing state lawmakers today.

INSURANCE STATUS

Recent efforts to help solve the problems of medical indigency and uncompensated care focus on the "insurance status" of the population. Lack of insurance leads to an abundance of problems for individuals and health care providers alike. If they can't afford to pay cash or the insurance deductible, the 37 million Americans without health insurance must rely on the goodwill of hospitals, doctors, and other providers. Lack of health insurance or insufficient insurance coverage is not an exclusive problem of the unemployed, the elderly, or persons living in rural areas.

- A decade ago, approximately 25 million Americans under age 65 did not have health insurance. Today, 37 million Americans, approximately 16 percent of the nation's population, have no health insurance coverage at all, more people than the combined populations of New York, New Jersey, and Illinois.
- Of the uninsured and increasingly underinsured Americans, the majority have ties to the workplace. Twenty-three million "working poor" have jobs or are dependents of workers.
- Almost one third of uninsured employees work for employers who do not offer insurance. More than one-third of uninsured workers do not participate in their employer's health insurance plan even if they are eligible. Approximately one-third of uninsured workers do not qualify for their employer's health plans.[1]
- Underinsured people are those who cannot pay for their share of insurance deductibles or copayments or for medical care not covered by their insurance policies. Fifty million Americans are covered only part of the year, and millions more are covered by inadequate plans for catastrophic illness or accident. Nearly every health care consumer has the potential of facing medical expenses for which he or she cannot pay because insurance policies generally have a cap on expenditures.
- The uninsurable or "high risk" population consists of an estimated one to two million people with high health risks, such as heart disease, diabetes, or acquired immunodeficiency syndrome (AIDS). Many are refused health insurance coverage and others cannot afford to purchase an individual policy, which usually is offered for a much higher premium.
- Researchers believe that the uninsurable population is growing and attribute the increase to the following factors: insurers are adopting more restrictive health insurance standards due to an increasingly competitive insurance market; not as many employers are providing health insurance benefits because of escalating costs; and advances in technology enable insurers to identify people who have potentially costly illnesses.
- Others presumably can pay for their care but do not. For example, some people who have insurance do not pay their deductible or copayment amount. It is unclear how many insured people have difficulty paying these costs.

- Seventeen percent, representing 9.5 million women of child-bearing age (15 to 44), have no private or public health insurance.[2] Researchers have concluded that 9 percent of women who have private insurance have policies that provide inadequate coverage for maternity care.[3]
- Between the ages of 15 and 44, women's need for health services is substantially higher than men's because of reproductive health needs, including perinatal care and contraception. Furthermore, the reproductive years are the time period when women's health most affects society as a whole, by determining the health of the next generation.
- Burdens of inadequate and incomplete insurance coverage weigh heavily on minority women. A disproportionate burden of illness falls on ethnic minorities, especially African-American women, giving rise to a greater need for health care.

Among the factors contributing to the growth in the uninsured population are the following: a smaller percentage of poor people are covered by Medicaid, because states have limited eligibility over the years to help control costs; most new jobs in the past 10 years are in the service sector, where employees are less likely to be covered by health insurance; and work-based dependent coverage appears to be declining. For this reason many state initiatives focus on expanding work-based insurance coverage, either by giving employers incentives or by requiring them to make insurance available.

[1] Irene Fraser, *Promoting Health Insurance in the Workplace: State and Local Initiatives to Increase Private Coverage* (Chicago: American Hospital Association, 1988).

[2] Kay Johnson, Director, Health Division, Children's Defense Fund, quoted in Hunger Action Forum, Vol. 2, No. 8, August 1989.

[3] Paula Braveman, MD, et al., *"Women Without Health Insurance: Links Between Access, Poverty, Ethnicity, and Health," The Western Journal of Medicine,* 1988 December: 149: 708-11.

FINANCING INSURANCE COVERAGE

"A major reason why so many people lack health insurance is that state government regulations are increasing the costs of insurance and pricing millions of people out of the market for insurance. Freedom of choice in health insurance means being able to buy a health insurance policy tailored to individual and family needs. This is a freedom that is rapidly vanishing from the health insurance marketplace." John C. Goodman and Gerald L. Musgrave, Freedom of Choice in Health Insurance, National Center for Policy Analysis

All 50 states have mandated benefit laws which typically require employers that offer group health plans to include specific benefits. During the past 20 years, states across the U.S. have imposed nearly 700 of these mandates. This approach has become increasingly more controversial when employers are mandated to provide insurance coverage. The National Center for Policy Analysis estimated that in 1986, between 14 percent and 25 percent, or 5.2 million to 9.3 million of the people without health insurance, had no insurance because state governments imposed special interest regulations that mandated expensive coverage.

States are struggling with the financial realities of health care mandates. States are not always in a financial position to respond to urgent health care needs. The vagaries of funding a multitude of state programs sometimes require states to mandate employer-based expansions of health care services. Financing programs at times is simply beyond the capabilities of current state budgets. However, employer-based mandates are not the only alternative available, a variety of state approaches are presented below:

- One approach to insuring the employed uninsured population is to expand the number of employers who offer health benefits.
- Another approach is to develop mechanisms that enable employees who cannot afford their share of the premium for work-based insurance, especially for dependents, to purchase insurance at affordable rates.
- Unemployed uninsured people also may benefit from programs that enable more workers to purchase insurance, if they are allowed to participate.
- The problems facing the underinsured may require insurance policies to provide coverage for more services, such as mental health benefits, mammography screenings, and maternity care.
- Another approach is to exempt certain covered services from cost-sharing requirements.

In 1990 many states will consider these approaches as well as state risk pools for the one to two million Americans deemed uninsurable.

- At least 15 states have insurance risk share pools to help provide access to insurance for high risk individuals who otherwise would have trouble obtaining coverage.
- The costs to risk pool participants are usually 25 to 50 percent higher than premiums paid by persons with private insurance.
- Even with the high contributions paid by covered people, risk pool programs must be subsidized to cover their costs.

State legislatures and the federal government are considering a variety of other financing mechanisms. Alternatives include using funds from general revenues, changing the estate and gift tax laws, increasing tobacco and alcohol taxes, creating tax incentives for expanding health coverage, enacting state risk pool arrangements, mandating benefits, and Medicaid expansions.

WHOSE RESPONSIBILITY?

STATE

State governments are faced with increasing health care costs for the medically indigent and are under pressure to find more adequate and equitable means to finance health care. The following state examples illustrate the innovative ways in which states address these issues:

COLORADO

The Colorado Health Care Access Act (**HB 1034**) was introduced by Representative Carol Taylor-Little and Senator Sally Hopper in January of this year. The legislation, patterned after the 1989 Oregon Basic Services package, proposes to address the access problem in two ways: first, by guaranteeing basic health coverage for everyone with incomes under the federal poverty line and committing not to reduce eligibility or provider payment due to budget constraints; and second, by giving small employers a tax incentive to provide health insurance for their employees, a strategy intended to help the working poor. The act would add as many as 170,000 Coloradans with incomes below the federal poverty line to the expanded Medicaid program, many of whom would be children. Up to 245,000 Colorado workers and their families in thousands of small firms also are expected to benefit.

Under the proposal, an independent, objective commission comprised of health care providers, consumers, and experts in health care financing, delivery, and ethics would develop a list of health care services in order of priority, according to the benefits and costs of each service. The proposal requires the commission to consult with the Joint Review Committee for the Medically Indigent, the Joint Budget Committee, and the House and Senate health committees.

Sponsors of the legislation hope to benefit business in three ways: by giving small employers access to low-cost health insurance through a state pool; by providing a tax credit to small employers who purchase insurance through the pool; and by giving all employers valuable information on the effectiveness and appropriateness of services prioritized by the commission, which employers can use in designing more cost-effective benefit packages, thus helping them to control costs.

GEORGIA

In 1989 Representative E.M. Childers, chair of the House Health and Ecology Committee, authored a resolution in the Georgia General Assembly creating the Access to Health Care Commission (**1989 Georgia Laws, p. 1749, HR 162**). The commission is charged with studying factors that limit access to health care in Georgia and making recommendations concerning programs and policies to improve access in the state. The commission is composed of 30 members: six representing the state General Assembly (health, insurance, and appropriations committees); health providers (hospitals physicians, nurses, and health centers); health consumers; business; insurers; and state organizations.

A comprehensive solution to the problem of medical indigence is the goal. Georgia has one of the highest infant mortality rates in the United States. Eighteen percent of the population under age 65 is uninsured, including 55 percent of families with income between 50 and 100 percent of the federal poverty level. Of particular concern are the following rural health issues: 40 percent of the state's population are located in rural areas; 50 percent of the population aged 65 and above are located in rural areas; and problems exist with the financial instability of the state's rural hospitals.

INDIANA

Legislation enacted in 1989 (**1989 Indiana Acts, P.L. 327, SEA 385**) established a Commission on State Health Policy. The commission is intended to improve the effectiveness of programs financed by the state and the effectiveness and delivery of health care services in the state. A study and recommendations are to include research on access to health care, the cost of health care and its underlying factors, preventive health care, and the role of healthy lifestyles. The act also creates a State Health Policy Advisory Committee to provide information and assist the commission in the performance of its duties. The commission is to submit an interim report to the governor and the General Assembly before November 1, 1990, and a final report before November 1, 1991.

The Steering Committee on Health Care for the Medically Underserved, a coalition of health care providers, business, government, and consumer representatives, issued a report calling for state-supported demonstration projects to test private financing mechanisms for uninsured and underinsured residents. The projects are intended to help the state develop an overall policy for financing the delivery of health care services to the working poor. The committee recommended that the state expand its Medicaid program to cover more women, children, and infants who cannot afford health care. It also recommended that the state study ways to develop other public programs to increase health coverage for the indigent.

MISSOURI

In December 1989, Representative Gail L. Chatfield proposed sweeping legislation to create the Missouri Universal Health Assurance Plan (**HB 1127**). The sponsor emphasized that the intent of the legislation is to provide increased health care coverage to citizens who are currently uninsured by restructuring the state's financing mechanisms so that individuals, businesses, and providers of health care may all benefit. The proposed legislation would cover a range of options, including: mandatory employer coverage, direct state subsidies of individual premiums, and expansions of Medicaid. The basic premise behind the bill is to establish a Canadian style comprehensive health program with three guiding principles: universal access, cost containment, and quality assurance.

The Canadian system mentioned above is perceived to have one of the best health care systems in the developed world. The model is best described as a single-payer public system providing affordable, universal coverage. Each province has its own system, although all provinces conform to basic rules of universality and accessibility.

The Missouri plan is intended to replace the patchwork of private and public insurance with a single state insurance program for which everyone is eligible and within which every resident will have access to a basic package of health care services. The proposed plan would consolidate all of the money presently being paid by private companies and individuals, as well as the state, federal, and local governments into a single fund. Finally, the plan contains quality assurance provisions for constant monitoring and improvement of the quality of care.

OTHER

Nearly 1.8 million residents of **North Carolina** either have no health insurance or inadequate coverage. A task force of the North Carolina Institute of Medicine has proposed creation of a comprehensive health-benefits plan that would represent the minimum level of insurance coverage to which all citizens would have access. The plan would include comprehensive coverage for primary care, particularly preventive services, but would provide for only 10 days of inpatient care in order for the coverage to remain affordable. The gross cost of the plan would be $1.4 billion, but institute officials contend that the net cost would be much lower -- about $700 million -- because of savings resulting from reductions in cost shifting and out-of-pocket expenditures by the medically indigent.

In **Washington** state, a bill introduced late in 1989 would create the Universal Health Access Program, based on the Canadian health care system. Nearly 700,000 people -- 15 percent of the population -- remain uninsured and unable to afford health services. Representative Dennis Braddock hopes that a universal health system will enable the state to combine and streamline the various health care programs currently operated by the state with a price tag of $3 billion a year.

FEDERAL

Federal proposals also have addressed the issue of how to better protect uninsured, underinsured, and uninsurable Americans.

The Pepper Commission, created by the now-repealed Medicare Catastrophic Coverage Act of 1988, is currently formulating recommendations on how to deal with the insurance crisis, curb costs, and widen access to care. Among the issues being discussed are the following: implementation of employer-paid health insurance for workers and dependents coupled with a new payroll tax to buy coverage for those lacking insurance; creation of a single government agency empowered to set rates for Medicaid and Medicare; and expansion of Medicaid. The "play or pay" option already has been embraced or proposed in some states, e.g., Massachusetts, Colorado, Oregon, and Washington. However, critics fear it would hurt small firms and trigger unemployment.

The Social Security Advisory Council, a private sector panel studying the system, has until July 1990 to draft a report, with a final report on the health care system due to the Department of Health and Human Services by January 1991. The Council, unlike the Pepper Commission, has no congressional mandate, and no major changes or restructuring are expected to be suggested.

Congress has passed several initiatives to expand Medicaid coverage. The current trend is to expand Medicaid whereby states are able to address the health care needs of pregnant women, infants, and children in low-income families. Forty-one states have raised Medicaid income eligibility to at least the full federal poverty level. Of these, nine have increased their eligibility levels to the maximum allowed -- 185 percent of federal poverty.

LABOR/BUSINESS

The U.S. Chamber of Commerce, the National Association of Manufacturers, and other business groups are pushing for government action. Business representatives maintain that they "have done all we can do" to manage health care costs. Employers realize that if they do not insure workers they pay dearly. They subsidize the cost of care provided to workers whose employers do not provide health care. The issue of health care costs is one of the most bitterly fought at the bargaining table, e.g, "Baby Bell" contract, Pittston Coal Company strike.

Unions have played a major role in developing employer-based health care coverage for working families. Until recently, such coverage provided access to care for most working Americans and their families. But the health insurance system has evolved during the past decade because of the shifting economy. Over the years, organized labor has fought to protect workers from increased health care costs. However, only 29 percent of employers today offer 100 percent reimbursement for health care, compared with 53 percent just five years ago. A growing number of workers are no longer provided family coverage or cannot afford high monthly premium contributions to insure spouses and children. Working families are now paying more for their health care, if they can afford to pay for it all.

In order to control skyrocketing costs, an AFL-CIO grassroots campaign seeks to develop a five-point national health care program that would: place a cap on all health care expenditures, assure all Americans access to basic health care services, invest in technology assessment, develop guides for physicians to consult in treating various conditions, and inform consumers about cost and quality of health care services by making materials available to all consumers. Federation President Lane Kirkland has stressed that the AFL-CIO's objectives are to launch a "combined federal-state program that will control health care inflation, require all businesses to do their fair share in providing health care protection to employees, provide coverage for the poor and unemployed, effectively monitor the quality of health care,

and eliminate unnecessary procedures."

"Results of the 1987 National Medical Expenditure Survey indicate that many employees would prefer alternatives to costly, high-option traditional insurance, although many employers do no offer them. Furthermore, employees seem willing to trade some reductions in deductibles and copayments for additional protection against catastrophic medical expenses. But the appeal of more traditional high-option benefits, such as first-dollar coverage for hospital stays, will lead many employees to choose the high-option plans, no matter how financial incentives are changed to favor low-option plans and HMOs." **Pamela Farley Short and Amy K. Taylor, National Center for Health Services Research.**

More Americans are paying more for their own health costs, according to the Employee Benefit Research Institute. Of 1,000 Americans surveyed, about 43 percent paid higher monthly premiums in the last two years; another 32 percent paid more for deductibles; and about 40 percent paid more copayments and dependent-coverage costs. Critics argue that what we do not need are programs that are little more than "band-aids," stop-gap measures that moderate the inequities individuals now experience in the distribution and provision of medical care in our nation.

The question remains, where will responsibility lie? Policymakers at both the state and federal level continue to struggle with these issues. Is a national legislative solution the answer? Some argue that only a federal solution is equitable. On the other hand, federal proposals are often characterized as preemptive of state authority. States are wary of federal interventions that strip state flexibility and displace state plans to deal with the problem. Are individual state solutions the answer? States are in varying degrees of fiscal health. Many contend that piecemeal state solutions will further hamper efforts at "universality." The debate continues, and states retain the authority to address their own needs and develop service systems designed to best respond to their unique circumstances.

FYI

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COMING IN APRIL

ALTERNATIVE FUNDING SOURCES FOR CARE OF THE MEDICALLY INDIGENT

Medical indigency issues continue to dominate health care agendas across the nation. Legislators feel pressure from a variety of sources to address the problem, including health care advocates, business leaders, physicians, and hospitals, most notably public hospitals. The last few years have witnessed a shift in public policy approaches to meeting the needs of the medically indigent. The goal of presenting state information in ProjectNotes has been to inform state legislators of these approaches.

A variety of approaches have been proposed and implemented to help solve the problem and legislators are keenly aware that what works for one state may not be acceptable or feasible in another. Proven and promising strategies states have used to control health care costs while seeking alternative revenue sources to fund care for the medically indigent are highlighted in the April edition of ProjectNotes.

TECHNICAL ASSISTANCE UPDATE

The Medical Indigency Project has sponsored state technical assistance programs in **Alaska, Colorado, Kansas, Nevada, Oklahoma, South Carolina,** and **Wisconsin.** The April edition of ProjectNotes recaps these programs and tracks legislative activity surrounding the issue of medical indigency in the state since the program presentation.

1989 HEALTH CARE LEGISLATION REVIEW

The Health Services Program is currently compiling the seventh in a series of NCSL publications summarizing significant health care laws passed by the 50 states, commonwealths, and territories in 1989. The section on Medical Indigency will be previewed in the April edition of ProjectNotes.

MEDICAL INDIGENCY ProjectNotes

MEDICAL INDIGENCY PROJECT

The National Conference of State Legislatures (NCSL) has a strong commitment to assisting state legislatures with a variety of medical indigency issues. NCSL is assembling a consortium of funders to address the problems of medical indigency. The Colorado Trust and American College of Emergency Physicians are the first to support the Medical Indigency Project. NCSL received a two-year grant from the Colorado Trust to assist state legislators in developing policies on health care for the medically indigent. The Colorado Trust is a private foundation established in 1985. Its primary mission is to promote and enhance the health and well-being of all people, particularly the citizens of Colorado. The American College of Emergency Physicians strives to provide a unifying direction of purpose in the field of emergency medicine. The college provides information regarding the practice of emergency medicine and encourages training of emergency physicians, with the aim of improving emergency room care.

The project conducts on-site technical assistance, publishes periodic reports, and maintains an information clearinghouse on innovative state programs of care for the medically indigent. The project also will produce three newsletters on issues concerning the medically indigent. ProjectNotes is the first in a series of reports on access to care, financing, and the quality of health care for the medically indigent.

TECHNICAL ASSISTANCE

Technical assistance services offer legislatures programs tailored specifically to their state's situation. Assistance in the past has included special workshops, assistance with drafting legislation, and special testimony.

A number of states have expressed an interest in technical assistance for 1989 - 1990 on a variety of topics related to the issue of medical indigency. Requests for technical assistance come from states with large medically indigent populations and states that have experienced a recent increase in this group. States chosen to receive technical assistance are determined according to state need, issue area, potential impact on the legislative process, and legislative interest. If your state legislature is interested in more information on technical assistance programs concerning issues affecting the medically indigent, please contact project staff.

PUBLICATIONS

The Medical Indigency Project has produced a variety of publications and other information resources on major medical indigency health policy issues. One copy of each publication is provided upon request at no cost to state legislators, legislative staff, and state legislative libraries. Please contact NCSL's Book Order Department at the number listed in the FYI section.

INFORMATION CLEARINGHOUSE

The Medical Indigency Project and other health projects have developed an extensive information clearinghouse on a variety of health topics. The information clearinghouse guarantees legislators and legislative staff a quick, reliable, and knowledgeable source of information when research reports and legislation are being formulated. NCSL's Health Services Program fields over 1,000 information requests a year from legislative offices, health departments, other health care professionals, and the media.

Requests cover a broad range of medical indigency topics, including: uncompensated care, Medicaid eligibility and expansion, funding sources, health insurance regulation, risk pools, mandated health benefits, and state programs for the medically indigent. The resources of the Medical Indigency Project information clearinghouse may be accessed by contacting project staff.

MEETINGS AND SEMINARS

NCSL's Annual Meeting and other seminars and conferences provide an opportunity to reach a large number of interested legislators. Health issues are always among the most important sessions at these meetings and draw large audiences. Information on upcoming workshops will be included in future editions of ProjectNotes.

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StateSide

Discussions with Health Policymakers

by Linda Demkovich

Intergovernmental Health Policy Project

January 1991

Alliance Strives for Universal Coverage

In 1988, after a legislative effort that would have allowed all Minnesota residents to buy into a basic "Chevrolet" insurance plan to cover health care costs fell apart in a dispute over financing, Rep. Paul Anders Ogren decided it was time to do what has become known in the political world as "networking."

The themes sounded again during the debate over the Minnesota insurance plan, Ogren said, "was that it will become a magnet for people who are ill, that it will put [the state] at an economic disadvantage relative to its neighbors, that the problem has to be solved by federal action, because of the sheer complexity and the cost."

Looking around, however, Ogren realized that many other states were also trying to address the problems of the uninsured and that a few – most notably Massachusetts and Oregon – had actually succeeded in enacting substantive reforms. The problem, in his view, was that they were doing so in isolation, with no means for sharing information and learning how to avoid each other's mistakes. "There was no resource network for progressive legislators pushing for universal health care at a state level," he observed.

That's when the Minnesota Democrat hit on the idea of launching the State Alliance for Universal Health Care – "as sort of a signal to legislators across the country that we can be a damned sight bolder than we've been thus far."

In mid-December, in concert with the Health Committee of the National Conference of State Legislatures (NCSL), the Alliance co-sponsored a special two-day seminar on the theme "Expanding Access to Health Care." The session, a follow-up to the Alliance's first formal meeting, which was held in August 1990 in Nashville, took place just before the NCSL's regular state-federal assembly in Washington, D.C., and attracted 60 attendees. Among the featured speakers were Sen. Edward M. Kennedy (D-MA) and maverick Senator-elect Paul Wellstone (D-MN).

In separate interviews after the seminar, State Health Notes talked about the Alliance and the prospects for enactment of a universal health care system with both Ogren and Ohio Rep. Robert F. Hagan (D), who is member of the Alliance's board of directors.

"A Dollar is A Dollar"

The immediate aim of the Alliance is to build "a coalition of legislative leaders... committed to the guarantee of universal health care in each of our states." Longer term, according to the mission statement drafted in April 1990, "our collective efforts must and will culminate in a national resolution, through the Congress and President" in support of universal care.

At present, neither Ogren nor Hagan sees signs that federal policymakers are close to achieving that goal or that they are committed to helping the states achieve it by eliminating some of the barriers that Congress has, over the years, thrown in the states' way.

"The reason for the proliferation of organizations like the Alliance," said Hagan, the chief sponsor of the Universal Health Insurance for Ohio (UHIO) plan, which is modeled on Canada's national health system, "is the realization that the federal government cannot do it." Problems – ranging from the failure of the savings and loan industry and the burgeoning budget deficit at home to the threatening situation in the Persian Gulf – will continue to divert Washington policymakers from the health system crisis, the Ohio lawmaker said.

At the same time, Hagan said, the federal government has thrown up roadblocks – things such as ERISA, the federal pension law that bars states from requiring companies that self-insure to comply with mandated health insurance benefits and risk-pool laws, and a cumbersome waiver process that discourages the states from experimenting with Medicaid reforms. "I would like to see a waiver granted that would allow one state to implement a single-payer system and work it out over a period of five to ten years," he said.

The concept underlying the UHIO plan is not a new one, after all, Hagan continued. "This is something that has been implemented in Canada. At some point, we have to admit that someone had a better idea." Like Canada, which sold its system province to province, "we have to go state to state until we convince [the federal government] of the need for a national plan." Until that happens, "we'll have to take responsibility for our own problems. What I've realized is that when they are viewed from that perspective, the problems are not nearly as big."

Part of the problem, Ogren says, is that liberal congressional leaders like Kennedy have been unwilling to admit

that their dream of a national health plan is unlikely to be realized any time soon. He likens the struggle to an old religious tradition: "I'm half Jewish and at Passover, we always say, 'Next year in Jerusalem.' The problem is, we've been saying it for 2000 years, and it's never quite next year." At the seminar, he said that he told Kennedy, "Just in case you don't get there next year, how about loosening the reins on the states so that we can make modest progress at our parochial level while the grand plan is forged here in Washington?" The response? "Next year in Jerusalem," he laughed.

Despite the lack of flexibility, Ogren said he is convinced that the states can, on their own, make a significant difference in solving the problems of the uninsured. "Those states that throw up their hands and say 'We can't afford it, Washington has to do it,' are dreamers. A dollar is a dollar, whether it's raised by the states or the federal government," he asserted.

Interim Steps

There are "some short-term benefits coming out of the scrutiny of the insurance sector," Ogren noted. While states may not be able to regulate companies that choose to self-insure, "they can certainly institute community rating and eliminate discrimination on the basis of age, sex and preexisting conditions, and really take health insurance back to where it was 20 years ago, when the young and the old, men and women, the healthy and the ill, were blended into a single comprehensive pool.

"I don't know if it will go as far as full-fledged community rating," the lawmaker said, "but we're going to come closer to the roots of what insurance is presumably all about."

A problem with what most states are now doing, he continued, "is that there is little pretense of health care reform. There is quite a bit of insurance reform, but as [states] pick their enemies, they're looking at only half of the equation. They're looking almost exclusively at the administrative cost component, and I don't think it's as simple as that."

Short of moving to a single-payer system, the states can also set for themselves the goal of coordinating various health programs. On average, Ogren said, "the states administer about a half dozen different health care programs, often in a half dozen different agencies, with a half dozen different reimbursement mechanisms. If they can streamline all of those programs, wrap them into a single state-administered program that incorporates the uninsured ... the program would also be a competitor in the marketplace." It would encompass not only the poor enrolled in Medicaid and the uninsured but also would attract people who are now buying insurance individually and would give it up gladly because of preposterous rates."

A principal aim of the Alliance is to coordinate independent state efforts. "There are lots of mistakes that won't have to be replicated because we'll have the chance to see what works and what doesn't. Now, state legislators largely work in a consummate vacuum."

A parallel aim is "to see what our collective voice can mean here in Washington." NCSL has "a very diffused voice. It cannot advocate for a specific position because it must encompass all positions."

Outside Reaction

Since it was formed, the Alliance has attracted a small cadre of legislators who share Ogren's belief. IAlso on the board are Sens. John Kitzhaber (OR), Paula Hollinger (MD) and Stanley C. Walker (VA) and Reps. James Shon (HI), Dennis Braddock (WA), John Timmer (SD), John McDonough (MA), Gene Davis (UT) and Gail Chatfield (MO). All but Timmer are Democrats.

Clearly not all legislators embrace the Alliance's mission statement. Delaware Rep. Jane Maroney (R), a self-described "states' rights person" – said she believes that states can and should solve their own problems, "so I have an argument conceptually" with the need for federal intervention. Even so, Maroney said, "there is no reason not to debate a system such as the one in place in Canada. We need dialogue. The chemistry of good will takes time to develop."

Not even those who agree with the goal of universal care are necessarily convinced that the Alliance is an ideal vehicle for reaching it. Ogren and his board are "senior, credible people," but they are appealing only to a subset of legislators. They are committed to specific, fundamental change, but there is no evidence that they have swayed some of their more mainstream colleagues," an attendee at the December seminar noted. "They don't seem to feel that they have to market their position. Their audience seems to be people who are already committed to the goal and who need information to translate it into program changes."

Ogren reiterated that the Alliance -- which he termed "truly political, not at all policy-oriented" -- was not created to dictate a common tool or model program for achieving universal access but rather to facilitate the exchange of information among the states.

The Alliance, Hagan asserted, does have room for other viewpoints, provided potential members are committed to three major principles: universality of coverage; cost containment; and a belief that health care is a right.

SENATE BILL NO. 83

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATORS DUNCAN, Zharoff, Rodey

Introduced: 1/23/91
Referred: L&C, HES and Finance

A BILL

FOR AN ACT ENTITLED

"An Act relating to the Alaska State Health Resources Authority; relating to the delivery, quality, and financing of health care for residents of the state, and to the issuance of certificates of need; and providing for an effective date."

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

* **Section 1.** PURPOSE. The purpose of this Act is to

(1) by July 1, 1992, create and begin implementation of a statewide health care provider reimbursement system and utilization standards;

(2) after July 1, 1992, provide comprehensive group health insurance for the state, municipalities, school districts, other employers in the state who elect to participate, and all eligible employees of the state, a municipality, a school district, or other employer in the state who elect to participate in the group insurance offered by the Alaska State Health Resources Authority;

(3) expand the pool of subscribers and maximize the opportunities for health care cost management and economies of scale when purchasing group health insurance;

(4) maintain an efficient provider reimbursement system to reduce the administrative cost

to providers who are serving employees of participants;

(5) maintain a statewide health care data base and utilization standards to control inappropriate or improper utilization practices and to reduce the rate of inflation in the cost of health care in the state;

(6) create the most comprehensive, cost-effective, and efficient method of providing a variety of types of health care insurance necessary to meet the coverage requirements of a participant resulting from negotiated employee contracts;

(7) realize the potential savings that will result if approximately 135,000 active and retired state, municipal, and school district employees and their dependents participate in the group health insurance program offered by the authority;

(8) evaluate the need for mandatory participation in the group health insurance offered by the authority; and

(9) evaluate the need for group health insurance for residents of the state who are uninsured or underinsured.

* **Sec. 2.** AS 18.07.035 is amended to read:

Sec. 18.07.035. APPLICATION AND FEES. Application for a certificate of need shall be made to the department upon a form provided by the department and must contain the information the department requires to reach a decision under AS 18.07.041 - 18.07.111. Each application for a certificate of need must be accompanied by an application fee established by the department by regulation. **A copy of each application for a certificate of need, except an application for a temporary or emergency certificate issued under AS 18.07.071, shall be provided to the Alaska State Health Resources Authority.**

* **Sec. 3.** AS 18.07.041 is amended to read:

Sec. 18.07.041. STANDARD OF REVIEW FOR APPLICATIONS FOR CERTIFICATES OF NEED. The office shall grant a sponsor a certificate of need or modify a certificate of need if the availability and quality of existing health care resources or the accessibility to those resources is less than the current or projected requirement for health services required to maintain the good health of Alaska citizens. **A certificate of need may not be issued, except for a temporary or emergency certificate under AS 18.07.071, unless the office has received a determination from the Alaska State Health Resources Authority regarding the effect of the certificate of need on the cost of group health insurance.**

* Sec. 4. AS 21 is amended by adding a new chapter to read:

CHAPTER 77. STATE INSURANCE.

Sec. 21.77.010. AUTHORITY CREATED; REQUIRED REIMBURSEMENT SYSTEM AND UTILIZATION STANDARDS. (a) There is established within the Department of Administration a nonprofit incorporated legal entity known as the Alaska State Health Resources Authority.

(b) The authority shall, by July 1, 1992, establish and begin implementation of a health care provider reimbursement system and utilization standards. The state, a municipality, or a school district shall use the health care provider reimbursement system and utilization standards established by the authority for eligible employees of the state, a municipality, or a school district. With the approval of the authority, other employers in the state may use the health care provider reimbursement system and utilization standards established by the authority.

(c) The authority shall, no earlier than July 1, 1992, establish a group health insurance pool or pools of eligible employees of the state, a municipality, or a school district if the employer has elected to participate in the group health insurance obtained by the authority and may provide group health insurance to employees of other groups that elect to participate in the group health insurance pool provided by the authority. Employees of other groups that elect to participate shall use the reimbursement system and utilization standards established by the authority.

(d) Upon application by an eligible state program, the authority may, beginning July 1, 1992, allow the eligible state program to participate in the group health insurance pool provided by the authority.

Sec. 21.77.015. REQUIRED COOPERATION BY STATE AGENCIES. An agency of the state that provides health care or that provides funds to purchase health care shall, to the maximum extent possible, cooperate in the development of the use of the health care provider reimbursement system and utilization standards established by the authority, including sharing relevant information.

Sec. 21.77.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The authority shall be managed by a board of directors composed of nine members appointed by the governor. The governor shall appoint at least one but not more than two members as representatives from each of the following:

(1) the executive branch;

(2) labor organizations;

(3) school districts;

(4) municipalities;

(5) private sector employers;

(6) health care providers.

(b) Members of the board serve staggered terms of four years. The board shall elect from its membership a president, vice-president, and secretary. Members of the board serve without compensation but are entitled to receive per diem and travel expenses authorized for boards and commissions under AS 39.20.180. Members of the board are subject to AS 39.50.

Sec. 21.77.030. GENERAL POWERS. The authority may

(1) beginning July 1, 1992, exercise the powers granted to insurers under the laws of the state; if the authority acts as an insurer, the authority shall comply with the requirements applicable to insurers under this title;

(2) sue or be sued;

(3) enter into contracts or agreements;

(4) establish administrative or accounting procedures;

(5) collect, invest, and disburse funds;

(6) charge fees for providing administrative services;

(7) establish appropriate levels of reserves to cover the expenses of the authority;

(8) adopt necessary regulations and procedures for implementation of this chapter.

Sec. 21.77.040. DUTIES OF BOARD; ANNUAL REPORT. The board shall

(1) in providing group health insurance required under this chapter, provide comprehensive coverage at the lowest possible cost per eligible employee;

(2) provide to the governor and to the legislature an annual report covering the previous fiscal year's activities of the authority;

(3) review each application for a certificate of need under AS 18.07.041 and within 60 days after receiving a copy of the application determine the effect of issuing the certificate on the cost of the group health insurance required under this chapter; a copy of the determination shall be provided to the office of planning and research in the Department of Health and Social Services;

(4) every third fiscal year, include in the annual report a cost and benefit analysis of the activities of the authority.

Sec. 21.77.050. STAFF AND PROFESSIONAL SERVICES CONTRACTS. The authority shall employ an executive director who serves at the pleasure of the authority as its chief administrative officer. The executive director may, with the approval of the authority, select and employ additional staff as necessary. Employees of the authority are in the exempt service under AS 39.25.110. In addition to its staff of regular employees, the authority may contract for the services of consultants and professional, technical, and financial advisors the authority considers necessary for the purpose of developing information, conducting hearings, studies, investigations, or other proceedings, or otherwise exercising its powers.

Sec. 21.77.060. PROCUREMENT OF INSURANCE. (a) The authority shall, after July 1, 1992, obtain a policy or policies of group health insurance covering eligible employees of an employer that has elected to participate, from an insurer authorized to transact business in the state under AS 21.09, or act as a self-insurer if the authority determines that self-insurance can provide the desired insurance coverage and benefits at a lower cost per eligible employee.

(b) Except when acting as a self-insurer, the authority shall obtain group health insurance in compliance with the provisions of AS 36.30 and shall make available bid specifications for desired group health insurance benefits to all insurance carriers licensed in the state and qualified to provide the desired benefits. The specifications shall be made available at least once every five years.

Sec. 21.77.070. ALASKA STATE HEALTH RESOURCES FUND. The Alaska state health resources fund is created in the general fund. The fund consists of money appropriated by the legislature. The fund shall be managed and invested by the board. The board may expend money from the fund to carry out the provisions of this chapter.

Sec. 21.77.080. INSURANCE PREMIUMS. The authority shall provide that sufficient funds are collected to provide authorized benefits, reserves, and to pay the expenses of the authority. Reserves remaining at the termination of an insurance contract shall be invested by the authority in the same manner as retirement funds are invested under AS 14.25.180.

Sec. 21.77.090. PARTICIPATION; WAIVER. (a) The state, a municipality, a district, or other employer in the state may participate in the group insurance coverage provided by the authority. If the state, municipality, district, or other employer elects to participate, the state,

municipality, district, or other employer shall continue to participate unless a waiver is granted by the board.

(b) In determining whether a waiver should be granted, the board shall establish minimum benefit and financial standards for the desired group health insurance coverage. The minimum benefit and financial standards and the proposed time schedule for responsive offers shall be sent to all participants at the time the request for proposal for the desired group health insurance coverage is issued. A participant seeking a waiver of coverage shall match the minimum benefit and financial standards set out in the request for proposal for the desired group health insurance coverage. Participants shall submit documentation of their insurance coverage matching the board's minimum benefit and financial requirements before the deadline established by the board. The board may approve or disapprove a waiver of participation based on the documentation submitted by the participant regarding the benefit and financial standards established by the board.

(c) A participant may separately provide for health insurance coverage additional to that offered by the authority.

Sec. 21.77.100. DEFINITIONS. In this chapter,

(1) "authority" means the Alaska State Health Resources Authority;

(2) "board" means the board of directors of the Alaska State Health Resources Authority;

(3) "district" has the meaning given in AS 14.17.250;

(4) "eligible employee" means an employee of a participant who qualifies for group health benefits as determined by the participant;

(5) "eligible state program" means a program in which an agency of the state provides health care or provides funds to purchase health care for persons who are not employees of the state;

(6) "employer" means the state, a municipality, a district, a collective bargaining unit, the board of a public corporation of the state created within a principal executive department, a self-employed person, or a person employing one or more persons in a business or industry;

(7) "fund" means the Alaska state health resources fund;

(8) "group health insurance" means coverage that may include life insurance,

accidental death and dismemberment, medical care and treatment, dental care, eye care, and other group health coverage as determined by the authority;

(9) "municipality" includes a public corporation established by a municipality;

(10) "participant" means the state, a municipality, a district, or other employer in the state;

(11) "reimbursement system" means a system or method that streamlines or results in cost efficient payments to health care providers, and includes schedules of maximum allowable reimbursement for health care related services based on geographic regions, actual provider costs, and availability of services;

(12) "state" means the executive, legislative, and judicial branches of state government, and includes the University of Alaska and a public corporation of the state created within a principal executive department;

(13) "utilization standards" means a system to monitor, track, and verify patterns of treatment by health care providers that assures that cost efficient and cost effective care is provided within accepted medical standards without reducing the quality of care.

* **Sec. 5.** AS 37.07.030 is amended to read:

Sec. 37.07.030. RESPONSIBILITIES OF THE LEGISLATURE. The legislature shall

(1) provide for a budget review function;

(2) analyze the comprehensive operating and capital improvements programs and financial plans recommended by the governor;

(3) adopt legislation to authorize implementation of the governor's comprehensive operating and capital improvements programs and financial plans or appropriate alternatives to those plans;

(4) provide for a post-audit function to cover financial transactions, program accomplishment, and compliance with legislative intent;

(5) adopt or revise the estimate of receipts required to balance the succeeding fiscal year's budget in order that proposed expenditures do not exceed estimated receipts for that fiscal year;

(6) adopt, revise, or initiate revenue measures in order to balance the succeeding fiscal year's budget and the capital improvements section of the budget for the succeeding six years;

(7) **appropriate funds for the operation of the Alaska State Health Resources Authority**.

* **Sec. 6.** AS 39.25.110 is amended by adding a new paragraph to read:

(30) employees of the Alaska State Health Resources Authority.

* **Sec. 7.** AS 39.50.200(b) is amended by adding a new paragraph to read:

(52) Alaska State Health Resources Authority (AS 21.77).

* **Sec. 8.** REPORT. The Alaska State Health Resources Authority shall report to the Alaska State Legislature by March 1, 1992, on the progress made by the authority in establishing a health care provider reimbursement system and utilization standards.

* **Sec. 9.** This Act takes effect immediately under AS 01.10.070(c).

SENATE BILL NO. 84

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATOR DUNCAN

Introduced: 1/23/91
Referred: HESS and Finance

A BILL

FOR AN ACT ENTITLED

"An Act relating to state coordination of health planning and development; abolishing the Statewide Health Coordinating Council; and providing for an effective date."

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

*** Section 1.** AS 18.07 is amended by adding a new section to read:

Sec. 18.07.005. LEGISLATIVE PURPOSE. It is the purpose of this chapter to create a rational framework for the planning and development of all health care services in the state to ensure promotion and protection of public health, provide equitable access to health services, and avoid unnecessary increases in health care costs.

*** Sec. 2.** AS 18.07.021 is amended to read:

Sec. 18.07.021. STATE HEALTH PLANNING AND DEVELOPMENT [AGENCY]. The [OFFICE OF PLANNING AND RESEARCH IN THE] department is **responsible for** [THE] state health planning and development, [AGENCY DESIGNATED UNDER 42 U.S.C. 300m(b)(3). THE OFFICE] shall [PERFORM THE FUNCTIONS ENUMERATED UNDER 42 U.S.C. 300m-2,] administer the certificate of need program outlined in **AS 18.07.031 - 18.07.111**

[AS 18.07.041 - 18.07.111], and **shall perform** other functions prescribed in this chapter.

* **Sec. 3.** AS 18.07.031 is repealed and reenacted to read:

Sec. 18.07.031. CERTIFICATE OF NEED REQUIRED. (a) Unless authorized under the terms of a certificate of need issued by the department, a person may not

(1) make a capital expenditure of $1,000,000 or more for construction of a health care facility;

(2) convert a building, in whole or in part, for use as a health care facility if the fair market value of the converted part of the building is greater than $500,000 and the sum of the fair market value plus additional capital expenditures made to facilitate the conversion equals or exceeds $1,000,000;

(3) alter or redistribute the bed capacity of a health care facility by more than 10 beds or 10 percent of the number of beds in the facility, whichever is fewer;

(4) add or eliminate a category of health services to or from those provided by the health care facility; or

(5) acquire a health care facility at a cost of $1,000,000 or more.

(b) The dollar thresholds in (a) of this section apply to total anticipated costs. Costs of constructing or acquiring a health care facility may not be artificially divided, fragmented, or structured to circumvent the requirements of this section.

* **Sec. 4.** AS 18.07.035 is amended to read:

Sec. 18.07.035. APPLICATION AND FEES. Application for a certificate of need shall be made to the department upon a form provided by the department and must contain the information the department requires to reach a decision under **AS 18.07.031 - 18.07.111** [AS 18.07.041 - 18.07.111]. Each application for a certificate of need must be accompanied by an application fee established by the department by regulation.

* **Sec. 5.** AS 18.07.051 is amended by adding a new subsection to read:

(b) A certificate of need is valid only for the defined scope, physical location, and person stated in the certificate.

* **Sec. 6.** AS 18.07.061 is amended to read:

Sec. 18.07.061. MODIFICATION AND TERMINATION OF ACTIVITIES. The certificate holder shall apply to the **department** [OFFICE] for a modification of the certificate [BEFORE TERMINATING PART OF THE ACTIVITIES AUTHORIZED BY THE TERMS OF

ISSUANCE, BUT THE CERTIFICATE HOLDER IS NOT REQUIRED TO OBTAIN THE ACQUIESCENCE OF THE OFFICE] before **transferring the certificate or modifying or** terminating all **or part of** the activities authorized by the certificate. If a certificate holder **intends to terminate** [TERMINATES] all of the activities authorized by a certificate, the certificate holder is required to **apply to** [NOTIFY] the **department** [OFFICE] 60 days before termination and to surrender the certificate to the **department** [OFFICE] within 30 days **after** [OF] termination.

* **Sec. 7.** AS 18.07.061 is amended by adding new subsections to read:

(b) An application for transfer of a certificate shall be made on forms provided by the department and must contain

(1) evidence, of the type the department may require by regulation, that the transferee is able to assume ownership or operation of the health care facility and to provide the appropriate health services;

(2) evidence that the transferee is acquiring the health care facility at no more than its current fair market value; and

(3) other information that the department may require.

(c) Transfer of a certificate is subject to conditions the department considers necessary.

* **Sec. 8.** AS 18.07.071 is repealed and reenacted to read:

Sec. 18.07.071. EMERGENCY CERTIFICATES. (a) The department shall expedite review of an application for a certificate of need under AS 18.07.031(a)(1) that is required to

(1) eliminate or prevent imminent safety hazards as defined by a federal, state, or local fire, building, or life safety code or regulation;

(2) comply with state licensure standards; or

(3) comply with accreditation standards, compliance with which is required to receive federal reimbursement.

(b) An application approved under (a) of this section may be approved only to the extent that the capital expenditure is required to eliminate or prevent the hazards or to comply with the standards described in (a) of this section.

* **Sec. 9.** AS 18.07 is amended by adding a new section to read:

Sec. 18.07.079. FINAL DECISION. (a) Within 150 days after it determines that it has received a complete application, the department shall take one or more of the following actions:

(1) approve part or all of the application and issue a certificate of need that includes conditions that the department considers appropriate; the conditions must be directly related to the activities for which the application was made;

(2) deny a certificate of need;

(3) recommend modifications to the application; if the applicant agrees to modify the application, the department may defer a final decision on the application for 30 days after receiving the modified application and all additional information to support the modifications; deferral for more than 30 days under this paragraph may be made by the department only after written findings that there is good cause for deferring the decision and that deferral is in the public interest.

(b) The department shall send the final written findings and decision to the applicant and to other persons who request a copy of the findings and decision. If the final decision is to approve an application, the department shall issue a certificate of need to the applicant.

* **Sec. 10.** AS 18.07.081(a) is amended to read:

(a) The **department** [OFFICE], a member of the public who is substantially affected by activities authorized by the certificate, [OR] another applicant for a certificate of need**, or a health care facility that either provides services similar to the proposed activity or has indicated to the department in writing within the year preceding the decision to grant the certificate an intention to provide similar services to a health service population that includes all or part of the health service population served under the certificate of need** may **request** [INITIATE] a hearing to obtain modification, suspension or revocation of an existing certificate of need by filing an accusation with the **department** [COMMISSIONER] as prescribed under AS 44.62.360. A revocation, modification, or suspension of an outstanding certificate may not be undertaken unless it is in accordance with AS 44.62.330 - 44.62.630.

* **Sec. 11.** AS 18.07.081(c) is amended to read:

(c) A certificate of need shall be suspended if an accusation is filed before the commencement of activities authorized under **AS 18.07.079** [AS 18.07.041] that charges that factors upon which the certificate of need was issued have changed [,] or new factors have been discovered that significantly alter the need for the activity authorized. [A SUSPENSION OF A CERTIFICATE MAY NOT EXCEED 60 DAYS. AT THE END OF THIS PERIOD OR SOONER, THE OFFICE SHALL REVOKE OR REINSTATE THE CERTIFICATE].

* **Sec. 12.** AS 18.07.081(d) is amended to read:

(d) A certificate of need may be revoked if

(1) the **certificate holder** [SPONSOR] has not shown continuing progress toward commencement of the activities authorized under **AS 18.07.079 within one year after** [AS 18.07.041 AFTER SIX MONTHS OF] issuance;

(2) the **certificate holder** [APPLICANT] fails, without good cause, to complete activities authorized by the certificate;

(3) the **certificate holder** [SPONSOR] fails to comply with the provisions of this chapter or regulations adopted under this chapter;

(4) the **certificate holder** [SPONSOR] knowingly misrepresents a material fact in obtaining the certificate;

(5) the facts charged in an accusation filed under (c) of this section are established; or

(6) the **certificate holder** [SPONSOR] fails to provide services authorized by the terms of the certificate.

* **Sec. 13.** AS 18.07.081(e) is amended to read:

(e) A person **who files** [MAY NOT FILE] an accusation seeking suspension or revocation of a certificate of need under this section, knowing that the charges stated in the accusation are untrue or that the charges do not constitute grounds for revocation or suspension under this chapter**, is guilty of a class B misdemeanor**.

* **Sec. 14.** AS 18.07.091 is repealed and reenacted to read:

Sec. 18.07.091. REPORTING REQUIREMENTS, PENALTIES, AND INJUNCTION. (a) The department shall require all health care facilities operating in the state to periodically file reports required by the department by regulation.

(b) The department shall require a certificate holder to file with the department, periodically during the development stage and annually after that until completion of the activity authorized under AS 18.07.031, a report demonstrating that the activity is in compliance with all provisions of the certificate of need.

(c) If the department finds that a person has substantially failed or refused to comply with AS 18.07.031 - 18.07.111 or a regulation adopted under those sections, the department may take one or more of the following actions:

(1) issue an order directing the person to stop the questioned activity;

(2) deny, suspend, revoke, or modify a construction license required under AS 18.20.020 as related to the questioned activity;

(3) suspend a payment to be made by the department to the person for capital and operating expenses relating to the questioned activity;

(4) deny, suspend, revoke, or modify a certificate of need; or

(5) issue an order against a person who violates a provision of AS 18.07.031 - 18.07.111 or a regulation adopted under those sections imposing a civil penalty of not more than $20,000.

(d) Before imposing a sanction listed in (c) of this section, the department shall give reasonable notice of and an opportunity for a hearing.

(e) Notwithstanding AS 44.62.330 - 44.62.630, if the department finds that there will be a significant and adverse effect upon the public interest caused by substantial failure or refusal of a person to comply with AS 18.07.031 - 18.07.111 or a regulation adopted under those sections, the department may issue an order that does one or more of the following:

(1) directs the person to stop the questioned activity;

(2) suspends a construction license required under AS 18.20.020 as related to the questioned activity; or

(3) suspends a payment to be made by the department to the person for capital and operating expenses relating to the questioned activity.

(f) Notwithstanding AS 44.62.330 - 44.62.630, an order under (e) of this section takes effect immediately upon service by the department and remains in effect pending the decision after any hearing that may have been requested unless the person served can demonstrate to the department's satisfaction that the questioned activity is not subject to the application and review requirements of AS 18.07.031 - 18.07.111, or that the person would likely prevail on the merits and that allowing the activity to continue is in the public interest.

(g) Injunctive relief against a violation of AS 18.07.031 - 18.07.111 or a regulation adopted under those sections may be obtained from a court of competent jurisdiction by the department, a certificate holder who is adversely affected by the violation, or a member of the public substantially and adversely affected by the violation.

* **Sec. 15.** AS 18.07.101 is amended to read:

Sec. 18.07.101. REGULATIONS. The **department** [COMMISSIONER] shall adopt, in accordance with the Administrative Procedure Act (AS 44.62), regulations that establish procedures under which **a person** [SPONSORS] may **apply** [MAKE APPLICATION] for **a certificate** [CERTIFICATES] of need required by this chapter**, establish the amount of variation that may occur in an activity authorized by a certificate of need without requiring a modification of the certificate,** [AND THAT] govern the review of those applications by the **department** [OFFICE], establish requirements for a uniform statewide system of reporting financial and other operating data, **establish reasonable fees for applications and other services,** and otherwise carry out the purposes of this chapter.

*** Sec. 16.** AS 18.07.111 is repealed and reenacted to read:

Sec. 18.07.111. DEFINITIONS. In this chapter

(1) "category of health services" means a service that is recognized as a distinct service for the purposes of health care facility licensure and certification under regulations adopted under AS 18.20.010 - 18.20.130, except that "service" does not include the lawful practice of a profession or vocation conducted independently of a health care facility and in accordance with applicable licensing laws of the state;

(2) "certificate" means a certificate of need;

(3) "certificate of need" means a written order of the department that sets out the affirmative findings that a proposed activity sufficiently satisfies the plans and criteria prescribed for such an activity by this chapter and by department regulations and that permits the certificate holder to proceed with the activity;

(4) "commencement of activities" means, with the intent to continue until it is completed,

(A) the visible commencement of actual operations, on the ground, which is readily recognizable as such, for the construction of a building, the alteration of the bed capacity of a health care facility, or the provision for or deletion of an existing category of health services to consumers; or

(B) a significant step toward acquisition of a health care facility;

(5) "complete activities" means the substantial performance of the work required to comply with the terms of issuance of the certificate of need that all parties participating in those activities have obligated themselves to perform;

(6) "construction" means excavation, erection, alteration, modification, reconstruction, modernization, improvement, extension, or other development by or on behalf of a health care facility and includes the lease or purchase of equipment;

(7) "department" means the Department of Health and Social Services;

(8) "health care facility" means an institutional health service provider licensed in whole or in part by the state under AS 18.20.010 - 18.20.130, whether public or private, whether a partnership or corporation, whether organized for profit or not, and includes a hospital, psychiatric hospital, substance abuse hospital, tuberculosis hospital, skilled nursing facility, kidney disease treatment center (including freestanding hemodialysis units), intermediate care facility, ambulatory surgical facility, freestanding emergency care facility, osteopathic facility, independent diagnostic laboratory, and central service facility; "health care facility" does not include

(A) an Alaska Pioneers' Home administered by the Department of Administration under AS 44.21.020(10) and AS 47.55;

(B) the offices of private physicians or dentists, whether in individual or group practice, occupied on a regular basis to perform the range of diagnostic and treatment services usually performed by physicians and dentists on an outpatient basis;

(C) office buildings built or leased by or on behalf of a health care facility for the exclusive use of physicians, dentists, and other practitioners of the healing arts, or other investments made by or on behalf of a health care facility, unless capital expenditures or operating expenses will be charged or reimbursed in the future as costs for providing patient services offered by the health care facility; and

(9) "person" means an individual, corporation, company, partnership, firm, association, organization, business trust, estate, or government entity, and includes a health care facility.

* Sec. 17. AS 18.20.050 is amended to read:

Sec. 18.20.050. DENIAL, SUSPENSION, OR REVOCATION OF LICENSE. The department may deny, suspend, or revoke a license in a case in which it finds that there has been a substantial failure to comply with the requirements established under AS 08.64.336, <u>AS 18.07.031 - 18.07.111,</u> or AS 18.20.060 - 18.20.080. The license of a nursing facility, as defined in AS 18.20.390, also may be suspended or revoked by the department under

AS 18.20.310(a)(5).

* **Sec. 18.** AS 44.29.100 is amended to read:

Sec. 44.29.100. ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE. There is established in the Department of Health and Social Services an advisory board on alcoholism and drug abuse. [THE BOARD SHALL FUNCTION AS A STANDING COMMITTEE OF THE STATEWIDE HEALTH COORDINATING COUNCIL ESTABLISHED UNDER AS 18.07.011.]

* **Sec. 19.** AS 47.30.475(b) is amended to read:

(b) Money available under this section shall be awarded by the department to applicants on the basis of community need, but only if the award is consistent with the annual implementation plan developed under 42 U.S.C. 300l-2(b)(2) (National Health Resources Planning and Development Act of 1974) by the health systems agency for the health system area in which the applicant is located [AND THE STATE HEALTH PLAN DEVELOPED BY THE STATEWIDE HEALTH COORDINATING COUNCIL UNDER 42 U.S.C. 300m-3(c)(2)(A),] and only after consideration of comment and advice of the Advisory Board on Alcoholism and Drug Abuse. In awarding grants, the department shall further consider the amount of money that is available for all applications and whether an application would contribute to the wise development of a comprehensive program of alcoholic and drug abuse rehabilitation and prevention.

* **Sec. 20.** AS 18.07.011, 18.07.041, 18.07.081(b); AS 18.08.020(2), 18.08.090(11); and AS 18.26.030(a)(4)(B) are repealed.

* **Sec. 21.** This Act takes effect immediately under AS 01.10.070(c).

SENATE CONCURRENT RESOLUTION NO. 10

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATORS DUNCAN, Kerttula, Pourchot, Menard

Introduced: 2/13/91
Referred: HESS and Finance

A RESOLUTION

Establishing a Health Resources and Access Task Force.

BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:

WHEREAS estimated annual expenditures for health care in Alaska have risen by 300 percent in the last 10 years from $480 million to over $1.5 billion; and

WHEREAS over 90,000 residents of the state cannot afford to pay their medical bills, are not covered by a group health insurance plan, do not qualify for public assistance programs, and cannot afford to pay individual health insurance premiums; and

WHEREAS, if current trends continue, it is estimated that expenditures for health care in the state will increase to at least $10 billion by the year 2000 and over 25 percent of the state's residents will be uninsured; and

WHEREAS the legislature, aided by the Health Care Cost Containment Task Force, has achieved savings in the costs of health care in the state totaling over $20 million in fiscal years 1990 and 1991; and

WHEREAS every resident should have access to a basic level of health care regardless of income and should not become financially destitute before obtaining health care; and

WHEREAS the legislature recognizes that there is a continuing need to develop and evaluate

ways to manage health care expenditures in the state;

BE IT RESOLVED by the Alaska State Legislature that the Health Resources and Access Task Force is established with the following primary purposes:

(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 for continuing to contain the costs of health care in the state; and be it

FURTHER RESOLVED that the task force shall

(1) solicit advice and information from the medically indigent, health care consumer groups, the insurance industry, health care providers, labor organizations, emergency services personnel, large and small businesses, the Medical Care Advisory Committee, the Alaska Native Health Service, actuaries, the public, and others;

(2) investigate and gather data relating to health care quality, access, delivery, payment systems, and financing in the state, especially in rural areas;

(3) ascertain and review successful health care protection methods in other states, territories, and countries and other health care alternatives, including ways of providing health care for persons without insurance or with limited health care protection;

(4) continue to update an accurate estimate of the number of people who are unable to receive necessary health care services in the state, which patients are generating unpaid medical bills, which state residents are uninsured or lack adequate insurance, which health care providers are providing uncompensated care, who is paying for the cost of uncompensated care, and the total cost of uncompensated care in the state;

(5) identify those health care services necessary to achieve an acceptable minimum level of health care for all state residents and to examine those health care services that provide the most care for the most people at the least cost, including prevention services;

(6) monitor and evaluate experience under the state employee and retiree health plans;

(7) evaluate the potential benefits of health education, wellness plans, and prevention plans for all residents;

(8) develop strategies to support health care professions training and the retention of health care professionals in the state;

(9) recommend ways to coordinate services among nonprofit health care providers, profit making health care providers, the state division of public health, the United States Department of Veterans Affairs, the United States Department of Defense, and the Alaska Native Health Service in order to achieve a more efficient and effective health care delivery system;

(10) review ways to maximize the use of federal funds for health care programs in the state;

(11) investigate ways to reduce costs associated with malpractice insurance coverage, including its effect on the cost of health care in the state;

(12) consider the feasibility of redistributing funds currently spent by the state on health care in order to provide residents with affordable and equitable care;

(13) provide advice and assistance to other public agencies involved in health care programs; and

(14) pursue other sources of funding for the expenses of the task force; and be it

FURTHER RESOLVED that the task force shall consist of 14 members and two alternates as follows:

(1) three members of the Senate appointed by the President of the Senate, one of whom shall be designated as an alternate;

(2) three members of the House of Representatives appointed by the Speaker of the House, one of whom shall be designated as an alternate;

(3) two persons representing the executive branch, appointed by the Governor;

(4) eight members chosen by the members appointed under paragraphs (1) - (3) as follows: one individual representing the medically indigent, two individuals representing private employers who are not health care providers, two individuals representing health care providers, one individual representing nonprofit organizations, one consumer of health services who is not an employer or health care provider, and one individual representing labor organizations; and be it

FURTHER RESOLVED that the members of the task force shall elect from among themselves a chair and a vice-chair and that the conduct of the task force meetings shall be in sessions open to the public where all interested parties may provide information; and be it

FURTHER RESOLVED that, within funds made available for the purpose, the task force may hire staff and contract for services to perform its duties; and be it

FURTHER RESOLVED that the task force shall report its findings and recommendations to the Governor and the legislature by February 1, 1992, and February 1, 1993; and be it

FURTHER RESOLVED that the task force is terminated at 11:59 p.m. on February 1, 1993.

HOUSE BILL NO. 69

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVES BOYER, Navarre

Introduced: 1/23/91
Referred: Health, Education and Social Services, Judiciary, Finance

A BILL

FOR AN ACT ENTITLED

"An Act relating to state coordination of health planning and development; abolishing the Statewide Health Coordinating Council; and providing for an effective date."

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

*** Section 1.** AS 18.07 is amended by adding a new section to read:

Sec. 18.07.005. LEGISLATIVE PURPOSE. It is the purpose of this chapter to create a rational framework for the planning and development of all health care services in the state to ensure promotion and protection of public health, provide equitable access to health services, and avoid unnecessary increases in health care costs.

*** Sec. 2.** AS 18.07.021 is amended to read:

Sec. 18.07.021. STATE HEALTH PLANNING AND DEVELOPMENT [AGENCY]. The [OFFICE OF PLANNING AND RESEARCH IN THE] department is **responsible for** [THE] state health planning and development, [AGENCY DESIGNATED UNDER 42 U.S.C. 300m(b)(3). THE OFFICE] shall [PERFORM THE FUNCTIONS ENUMERATED UNDER 42 U.S.C. 300m-2,] administer the certificate of need program outlined in **AS 18.07.031 - 18.07.111**

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[AS 18.07.041 - 18.07.111], and **shall perform** other functions prescribed in this chapter.

* **Sec. 3.** AS 18.07.031 is repealed and reenacted to read:

Sec. 18.07.031. CERTIFICATE OF NEED REQUIRED. (a) Unless authorized under the terms of a certificate of need issued by the department, a person may not

(1) make a capital expenditure of $1,000,000 or more for construction of a health care facility;

(2) convert a building, in whole or in part, for use as a health care facility if the fair market value of the converted part of the building is greater than $500,000 and the sum of the fair market value plus additional capital expenditures made to facilitate the conversion equals or exceeds $1,000,000;

(3) alter or redistribute the bed capacity of a health care facility by more than 10 beds or 10 percent of the number of beds in the facility, whichever is fewer;

(4) add or eliminate a category of health services to or from those provided by the health care facility; or

(5) acquire a health care facility at a cost of $1,000,000 or more.

(b) The dollar thresholds in (a) of this section apply to total anticipated costs. Costs of constructing or acquiring a health care facility may not be artificially divided, fragmented, or structured to circumvent the requirements of this section.

* **Sec. 4.** AS 18.07.035 is amended to read:

Sec. 18.07.035. APPLICATION AND FEES. Application for a certificate of need shall be made to the department upon a form provided by the department and must contain the information the department requires to reach a decision under **AS 18.07.031 - 18.07.111** [AS 18.07.041 - 18.07.111]. Each application for a certificate of need must be accompanied by an application fee established by the department by regulation.

* **Sec. 5.** AS 18.07.051 is amended by adding a new subsection to read:

(b) A certificate of need is valid only for the defined scope, physical location, and person stated in the certificate.

* **Sec. 6.** AS 18.07.061 is amended to read:

Sec. 18.07.061. MODIFICATION AND TERMINATION OF ACTIVITIES. The certificate holder shall apply to the **department** [OFFICE] for a modification of the certificate [BEFORE TERMINATING PART OF THE ACTIVITIES AUTHORIZED BY THE TERMS OF

ISSUANCE, BUT THE CERTIFICATE HOLDER IS NOT REQUIRED TO OBTAIN THE ACQUIESCENCE OF THE OFFICE] before **transferring the certificate or modifying or** terminating all **or part of** the activities authorized by the certificate. If a certificate holder **intends to terminate** [TERMINATES] all of the activities authorized by a certificate, the certificate holder is required to **apply to** [NOTIFY] the **department** [OFFICE] 60 days before termination and to surrender the certificate to the **department** [OFFICE] within 30 days **after** [OF] termination.

*** Sec. 7.** AS 18.07.061 is amended by adding new subsections to read:

(b) An application for transfer of a certificate shall be made on forms provided by the department and must contain

(1) evidence, of the type the department may require by regulation, that the transferee is able to assume ownership or operation of the health care facility and to provide the appropriate health services;

(2) evidence that the transferee is acquiring the health care facility at no more than its current fair market value; and

(3) other information that the department may require.

(c) Transfer of a certificate is subject to conditions the department considers necessary.

*** Sec. 8.** AS 18.07.071 is repealed and reenacted to read:

Sec. 18.07.071. EMERGENCY CERTIFICATES. (a) The department shall expedite review of an application for a certificate of need under AS 18.07.031(a)(1) that is required to

(1) eliminate or prevent imminent safety hazards as defined by a federal, state, or local fire, building, or life safety code or regulation;

(2) comply with state licensure standards; or

(3) comply with accreditation standards, compliance with which is required to receive federal reimbursement.

(b) An application approved under (a) of this section may be approved only to the extent that the capital expenditure is required to eliminate or prevent the hazards or to comply with the standards described in (a) of this section.

*** Sec. 9.** AS 18.07 is amended by adding a new section to read:

Sec. 18.07.079. FINAL DECISION. (a) Within 150 days after it determines that it has received a complete application, the department shall take one or more of the following actions:

(1) approve part or all of the application and issue a certificate of need that includes conditions that the department considers appropriate; the conditions must be directly related to the activities for which the application was made;

(2) deny a certificate of need;

(3) recommend modifications to the application; if the applicant agrees to modify the application, the department may defer a final decision on the application for 30 days after receiving the modified application and all additional information to support the modifications; deferral for more than 30 days under this paragraph may be made by the department only after written findings that there is good cause for deferring the decision and that deferral is in the public interest.

(b) The department shall send the final written findings and decision to the applicant and to other persons who request a copy of the findings and decision. If the final decision is to approve an application, the department shall issue a certificate of need to the applicant.

*** Sec. 10.** AS 18.07.081(a) is amended to read:

(a) The **department** [OFFICE], a member of the public who is substantially affected by activities authorized by the certificate, [OR] another applicant for a certificate of need**, or a health care facility that either provides services similar to the proposed activity or has indicated to the department in writing within the year preceding the decision to grant the certificate an intention to provide similar services to a health service population that includes all or part of the health service population served under the certificate of need** may **request** [INITIATE] a hearing to obtain modification, suspension or revocation of an existing certificate of need by filing an accusation with the **department** [COMMISSIONER] as prescribed under AS 44.62.360. A revocation, modification, or suspension of an outstanding certificate may not be undertaken unless it is in accordance with AS 44.62.330 - 44.62.630.

*** Sec. 11.** AS 18.07.081(c) is amended to read:

(c) A certificate of need shall be suspended if an accusation is filed before the commencement of activities authorized under **AS 18.07.079** [AS 18.07.041] that charges that factors upon which the certificate of need was issued have changed [,] or new factors have been discovered that significantly alter the need for the activity authorized. [A SUSPENSION OF A CERTIFICATE MAY NOT EXCEED 60 DAYS. AT THE END OF THIS PERIOD OR SOONER, THE OFFICE SHALL REVOKE OR REINSTATE THE CERTIFICATE].

* **Sec. 12.** AS 18.07.081(d) is amended to read:

(d) A certificate of need may be revoked if

(1) the **certificate holder** [SPONSOR] has not shown continuing progress toward commencement of the activities authorized under **AS 18.07.079 within one year after** [AS 18.07.041 AFTER SIX MONTHS OF] issuance;

(2) the **certificate holder** [APPLICANT] fails, without good cause, to complete activities authorized by the certificate;

(3) the **certificate holder** [SPONSOR] fails to comply with the provisions of this chapter or regulations adopted under this chapter;

(4) the **certificate holder** [SPONSOR] knowingly misrepresents a material fact in obtaining the certificate;

(5) the facts charged in an accusation filed under (c) of this section are established; or

(6) the **certificate holder** [SPONSOR] fails to provide services authorized by the terms of the certificate.

* **Sec. 13.** AS 18.07.081(e) is amended to read:

(e) A person **who files** [MAY NOT FILE] an accusation seeking suspension or revocation of a certificate of need under this section, knowing that the charges stated in the accusation are untrue or that the charges do not constitute grounds for revocation or suspension under this chapter**, is guilty of a class B misdemeanor**.

* **Sec. 14.** AS 18.07.091 is repealed and reenacted to read:

Sec. 18.07.091. REPORTING REQUIREMENTS, PENALTIES, AND INJUNCTION. (a) The department shall require all health care facilities operating in the state to periodically file reports required by the department by regulation.

(b) The department shall require a certificate holder to file with the department, periodically during the development stage and annually after that until completion of the activity authorized under AS 18.07.031, a report demonstrating that the activity is in compliance with all provisions of the certificate of need.

(c) If the department finds that a person has substantially failed or refused to comply with AS 18.07.031 - 18.07.111 or a regulation adopted under those sections, the department may take one or more of the following actions:

(1) issue an order directing the person to stop the questioned activity;

(2) deny, suspend, revoke, or modify a construction license required under AS 18.20.020 as related to the questioned activity;

(3) suspend a payment to be made by the department to the person for capital and operating expenses relating to the questioned activity;

(4) deny, suspend, revoke, or modify a certificate of need; or

(5) issue an order against a person who violates a provision of AS 18.07.031 - 18.07.111 or a regulation adopted under those sections imposing a civil penalty of not more than $20,000.

(d) Before imposing a sanction listed in (c) of this section, the department shall give reasonable notice of and an opportunity for a hearing.

(e) Notwithstanding AS 44.62.330 - 44.62.630, if the department finds that there will be a significant and adverse effect upon the public interest caused by substantial failure or refusal of a person to comply with AS 18.07.031 - 18.07.111 or a regulation adopted under those sections, the department may issue an order that does one or more of the following:

(1) directs the person to stop the questioned activity;

(2) suspends a construction license required under AS 18.20.020 as related to the questioned activity; or

(3) suspends a payment to be made by the department to the person for capital and operating expenses relating to the questioned activity.

(f) Notwithstanding AS 44.62.330 - 44.62.630, an order under (e) of this section takes effect immediately upon service by the department and remains in effect pending the decision after any hearing that may have been requested unless the person served can demonstrate to the department's satisfaction that the questioned activity is not subject to the application and review requirements of AS 18.07.031 - 18.07.111, or that the person would likely prevail on the merits and that allowing the activity to continue is in the public interest.

(g) Injunctive relief against a violation of AS 18.07.031 - 18.07.111 or a regulation adopted under those sections may be obtained from a court of competent jurisdiction by the department, a certificate holder who is adversely affected by the violation, or a member of the public substantially and adversely affected by the violation.

* Sec. 15. AS 18.07.101 is amended to read:

Sec. 18.07.101. REGULATIONS. The **department** [COMMISSIONER] shall adopt, in accordance with the Administrative Procedure Act (AS 44.62), regulations that establish procedures under which **a person** [SPONSORS] may **apply** [MAKE APPLICATION] for **a certificate** [CERTIFICATES] of need required by this chapter**, establish the amount of variation that may occur in an activity authorized by a certificate of need without requiring a modification of the certificate,** [AND THAT] govern the review of those applications by the **department** [OFFICE], establish requirements for a uniform statewide system of reporting financial and other operating data, **establish reasonable fees for applications and other services,** and otherwise carry out the purposes of this chapter.

*** Sec. 16.** AS 18.07.111 is repealed and reenacted to read:

Sec. 18.07.111. DEFINITIONS. In this chapter

(1) "category of health services" means a service that is recognized as a distinct service for the purposes of health care facility licensure and certification under regulations adopted under AS 18.20.010 - 18.20.130, except that "service" does not include the lawful practice of a profession or vocation conducted independently of a health care facility and in accordance with applicable licensing laws of the state;

(2) "certificate" means a certificate of need;

(3) "certificate of need" means a written order of the department that sets out the affirmative findings that a proposed activity sufficiently satisfies the plans and criteria prescribed for such an activity by this chapter and by department regulations and that permits the certificate holder to proceed with the activity;

(4) "commencement of activities" means, with the intent to continue until it is completed,

(A) the visible commencement of actual operations, on the ground, which is readily recognizable as such, for the construction of a building, the alteration of the bed capacity of a health care facility, or the provision for or deletion of an existing category of health services to consumers; or

(B) a significant step toward acquisition of a health care facility;

(5) "complete activities" means the substantial performance of the work required to comply with the terms of issuance of the certificate of need that all parties participating in those activities have obligated themselves to perform;

(6) "construction" means excavation, erection, alteration, modification, reconstruction, modernization, improvement, extension, or other development by or on behalf of a health care facility and includes the lease or purchase of equipment;

(7) "department" means the Department of Health and Social Services;

(8) "health care facility" means an institutional health service provider licensed in whole or in part by the state under AS 18.20.010 - 18.20.130, whether public or private, whether a partnership or corporation, whether organized for profit or not, and includes a hospital, psychiatric hospital, substance abuse hospital, tuberculosis hospital, skilled nursing facility, kidney disease treatment center (including freestanding hemodialysis units), intermediate care facility, ambulatory surgical facility, freestanding emergency care facility, osteopathic facility, independent diagnostic laboratory, and central service facility; "health care facility" does not include

(A) an Alaska Pioneers' Home administered by the Department of Administration under AS 44.21.020(10) and AS 47.55;

(B) the offices of private physicians or dentists, whether in individual or group practice, occupied on a regular basis to perform the range of diagnostic and treatment services usually performed by physicians and dentists on an outpatient basis;

(C) office buildings built or leased by or on behalf of a health care facility for the exclusive use of physicians, dentists, and other practitioners of the healing arts, or other investments made by or on behalf of a health care facility, unless capital expenditures or operating expenses will be charged or reimbursed in the future as costs for providing patient services offered by the health care facility; and

(9) "person" means an individual, corporation, company, partnership, firm, association, organization, business trust, estate, or government entity, and includes a health care facility.

* **Sec. 17.** AS 18.20.050 is amended to read:

Sec. 18.20.050. DENIAL, SUSPENSION, OR REVOCATION OF LICENSE. The department may deny, suspend, or revoke a license in a case in which it finds that there has been a substantial failure to comply with the requirements established under AS 08.64.336, **AS 18.07.031 - 18.07.111,** or AS 18.20.060 - 18.20.080. The license of a nursing facility, as defined in AS 18.20.390, also may be suspended or revoked by the department under

AS 18.20.310(a)(5).

* **Sec. 18.** AS 44.29.100 is amended to read:

Sec. 44.29.100. ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE. There is established in the Department of Health and Social Services an advisory board on alcoholism and drug abuse. [THE BOARD SHALL FUNCTION AS A STANDING COMMITTEE OF THE STATEWIDE HEALTH COORDINATING COUNCIL ESTABLISHED UNDER AS 18.07.011.]

* **Sec. 19.** AS 47.30.475(b) is amended to read:

(b) Money available under this section shall be awarded by the department to applicants on the basis of community need, but only if the award is consistent with the annual implementation plan developed under 42 U.S.C. 300l-2(b)(2) (National Health Resources Planning and Development Act of 1974) by the health systems agency for the health system area in which the applicant is located [AND THE STATE HEALTH PLAN DEVELOPED BY THE STATEWIDE HEALTH COORDINATING COUNCIL UNDER 42 U.S.C. 300m-3(c)(2)(A),] and only after consideration of comment and advice of the Advisory Board on Alcoholism and Drug Abuse. In awarding grants, the department shall further consider the amount of money that is available for all applications and whether an application would contribute to the wise development of a comprehensive program of alcoholic and drug abuse rehabilitation and prevention.

* **Sec. 20.** AS 18.07.011, 18.07.041, 18.07.081(b); AS 18.08.020(2), 18.08.090(11); and AS 18.26.030(a)(4)(B) are repealed.

* **Sec. 21.** This Act takes effect immediately under AS 01.10.070(c).

HOUSE BILL NO. 71

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVES BOYER, Navarre

Introduced: 1/24/91
Referred: Labor and Commerce, Health, Education and Social Services, Finance

A BILL

FOR AN ACT ENTITLED

"An Act relating to the Alaska State Health Resources Authority; relating to the delivery, quality, and financing of health care for residents of the state, and to the issuance of certificates of need; and providing for an effective date."

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

*** Section 1.** PURPOSE. The purpose of this Act is to

(1) by July 1, 1992, create and begin implementation of a statewide health care provider reimbursement system and utilization standards;

(2) after July 1, 1992, provide comprehensive group health insurance for the state, municipalities, school districts, other employers in the state who elect to participate, and all eligible employees of the state, a municipality, a school district, or other employer in the state who elect to participate in the group insurance offered by the Alaska State Health Resources Authority;

(3) expand the pool of subscribers and maximize the opportunities for health care cost management and economies of scale when purchasing group health insurance;

(4) maintain an efficient provider reimbursement system to reduce the administrative cost

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to providers who are serving employees of participants;

(5) maintain a statewide health care data base and utilization standards to control inappropriate or improper utilization practices and to reduce the rate of inflation in the cost of health care in the state;

(6) create the most comprehensive, cost-effective, and efficient method of providing a variety of types of health care insurance necessary to meet the coverage requirements of a participant resulting from negotiated employee contracts;

(7) realize the potential savings that will result if approximately 135,000 active and retired state, municipal, and school district employees and their dependents participate in the group health insurance program offered by the authority;

(8) evaluate the need for mandatory participation in the group health insurance offered by the authority; and

(9) evaluate the need for group health insurance for residents of the state who are uninsured or underinsured.

*** Sec. 2.** AS 18.07.035 is amended to read:

Sec. 18.07.035. APPLICATION AND FEES. Application for a certificate of need shall be made to the department upon a form provided by the department and must contain the information the department requires to reach a decision under AS 18.07.041 - 18.07.111. Each application for a certificate of need must be accompanied by an application fee established by the department by regulation. **A copy of each application for a certificate of need, except an application for a temporary or emergency certificate issued under AS 18.07.071, shall be provided to the Alaska State Health Resources Authority.**

*** Sec. 3.** AS 18.07.041 is amended to read:

Sec. 18.07.041. STANDARD OF REVIEW FOR APPLICATIONS FOR CERTIFICATES OF NEED. The office shall grant a sponsor a certificate of need or modify a certificate of need if the availability and quality of existing health care resources or the accessibility to those resources is less than the current or projected requirement for health services required to maintain the good health of Alaska citizens. **A certificate of need may not be issued, except for a temporary or emergency certificate under AS 18.07.071, unless the office has received a determination from the Alaska State Health Resources Authority regarding the effect of the certificate of need on the cost of group health insurance.**

* **Sec. 4.** AS 21 is amended by adding a new chapter to read:

CHAPTER 77. STATE INSURANCE.

Sec. 21.77.010. AUTHORITY CREATED; REQUIRED REIMBURSEMENT SYSTEM AND UTILIZATION STANDARDS. (a) There is established within the Department of Administration a nonprofit incorporated legal entity known as the Alaska State Health Resources Authority.

(b) The authority shall, by July 1, 1992, establish and begin implementation of a health care provider reimbursement system and utilization standards. The state, a municipality, or a school district shall use the health care provider reimbursement system and utilization standards established by the authority for eligible employees of the state, a municipality, or a school district. With the approval of the authority, other employers in the state may use the health care provider reimbursement system and utilization standards established by the authority.

(c) The authority shall, no earlier than July 1, 1992, establish a group health insurance pool or pools of eligible employees of the state, a municipality, or a school district if the employer has elected to participate in the group health insurance obtained by the authority and may provide group health insurance to employees of other groups that elect to participate in the group health insurance pool provided by the authority. Employees of other groups that elect to participate shall use the reimbursement system and utilization standards established by the authority.

(d) Upon application by an eligible state program, the authority may, beginning July 1, 1992, allow the eligible state program to participate in the group health insurance pool provided by the authority.

Sec. 21.77.015. REQUIRED COOPERATION BY STATE AGENCIES. An agency of the state that provides health care or that provides funds to purchase health care shall, to the maximum extent possible, cooperate in the development of the use of the health care provider reimbursement system and utilization standards established by the authority, including sharing relevant information.

Sec. 21.77.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The authority shall be managed by a board of directors composed of nine members appointed by the governor. The governor shall appoint at least one but not more than two members as representatives from each of the following:

(1) the executive branch;

(2) labor organizations;

(3) school districts;

(4) municipalities;

(5) private sector employers;

(6) health care providers.

(b) Members of the board serve staggered terms of four years. The board shall elect from its membership a president, vice-president, and secretary. Members of the board serve without compensation but are entitled to receive per diem and travel expenses authorized for boards and commissions under AS 39.20.180. Members of the board are subject to AS 39.50.

Sec. 21.77.030. GENERAL POWERS. The authority may

(1) beginning July 1, 1992, exercise the powers granted to insurers under the laws of the state; if the authority acts as an insurer, the authority shall comply with the requirements applicable to insurers under this title;

(2) sue or be sued;

(3) enter into contracts or agreements;

(4) establish administrative or accounting procedures;

(5) collect, invest, and disburse funds;

(6) charge fees for providing administrative services;

(7) establish appropriate levels of reserves to cover the expenses of the authority;

(8) adopt necessary regulations and procedures for implementation of this chapter.

Sec. 21.77.040. DUTIES OF BOARD; ANNUAL REPORT. The board shall

(1) in providing group health insurance required under this chapter, provide comprehensive coverage at the lowest possible cost per eligible employee;

(2) provide to the governor and to the legislature an annual report covering the previous fiscal year's activities of the authority;

(3) review each application for a certificate of need under AS 18.07.041 and within 60 days after receiving a copy of the application determine the effect of issuing the certificate on the cost of the group health insurance required under this chapter; a copy of the determination shall be provided to the office of planning and research in the Department of Health and Social Services;

(4) every third fiscal year, include in the annual report a cost and benefit analysis of the activities of the authority.

Sec. 21.77.050. STAFF AND PROFESSIONAL SERVICES CONTRACTS. The authority shall employ an executive director who serves at the pleasure of the authority as its chief administrative officer. The executive director may, with the approval of the authority, select and employ additional staff as necessary. Employees of the authority are in the exempt service under AS 39.25.110. In addition to its staff of regular employees, the authority may contract for the services of consultants and professional, technical, and financial advisors the authority considers necessary for the purpose of developing information, conducting hearings, studies, investigations, or other proceedings, or otherwise exercising its powers.

Sec. 21.77.060. PROCUREMENT OF INSURANCE. (a) The authority shall, after July 1, 1992, obtain a policy or policies of group health insurance covering eligible employees of an employer that has elected to participate, from an insurer authorized to transact business in the state under AS 21.09, or act as a self-insurer if the authority determines that self-insurance can provide the desired insurance coverage and benefits at a lower cost per eligible employee.

(b) Except when acting as a self-insurer, the authority shall obtain group health insurance in compliance with the provisions of AS 36.30 and shall make available bid specifications for desired group health insurance benefits to all insurance carriers licensed in the state and qualified to provide the desired benefits. The specifications shall be made available at least once every five years.

Sec. 21.77.070. ALASKA STATE HEALTH RESOURCES FUND. The Alaska state health resources fund is created in the general fund. The fund consists of money appropriated by the legislature. The fund shall be managed and invested by the board. The board may expend money from the fund to carry out the provisions of this chapter.

Sec. 21.77.080. INSURANCE PREMIUMS. The authority shall provide that sufficient funds are collected to provide authorized benefits, reserves, and to pay the expenses of the authority. Reserves remaining at the termination of an insurance contract shall be invested by the authority in the same manner as retirement funds are invested under AS 14.25.180.

Sec. 21.77.090. PARTICIPATION; WAIVER. (a) The state, a municipality, a district, or other employer in the state may participate in the group insurance coverage provided by the authority. If the state, municipality, district, or other employer elects to participate, the state,

municipality, district, or other employer shall continue to participate unless a waiver is granted by the board.

(b) In determining whether a waiver should be granted, the board shall establish minimum benefit and financial standards for the desired group health insurance coverage. The minimum benefit and financial standards and the proposed time schedule for responsive offers shall be sent to all participants at the time the request for proposal for the desired group health insurance coverage is issued. A participant seeking a waiver of coverage shall match the minimum benefit and financial standards set out in the request for proposal for the desired group health insurance coverage. Participants shall submit documentation of their insurance coverage matching the board's minimum benefit and financial requirements before the deadline established by the board. The board may approve or disapprove a waiver of participation based on the documentation submitted by the participant regarding the benefit and financial standards established by the board.

(c) A participant may separately provide for health insurance coverage additional to that offered by the authority.

Sec. 21.77.100. DEFINITIONS. In this chapter,

(1) "authority" means the Alaska State Health Resources Authority;

(2) "board" means the board of directors of the Alaska State Health Resources Authority;

(3) "district" has the meaning given in AS 14.17.250;

(4) "eligible employee" means an employee of a participant who qualifies for group health benefits as determined by the participant;

(5) "eligible state program" means a program in which an agency of the state provides health care or provides funds to purchase health care for persons who are not employees of the state;

(6) "employer" means the state, a municipality, a district, a collective bargaining unit, the board of a public corporation of the state created within a principal executive department, a self-employed person, or a person employing one or more persons in a business or industry;

(7) "fund" means the Alaska state health resources fund;

(8) "group health insurance" means coverage that may include life insurance,

accidental death and dismemberment, medical care and treatment, dental care, eye care, and other group health coverage as determined by the authority;

(9) "municipality" includes a public corporation established by a municipality;

(10) "participant" means the state, a municipality, a district, or other employer in the state;

(11) "reimbursement system" means a system or method that streamlines or results in cost efficient payments to health care providers, and includes schedules of maximum allowable reimbursement for health care related services based on geographic regions, actual provider costs, and availability of services;

(12) "state" means the executive, legislative, and judicial branches of state government, and includes the University of Alaska and a public corporation of the state created within a principal executive department;

(13) "utilization standards" means a system to monitor, track, and verify patterns of treatment by health care providers that assures that cost efficient and cost effective care is provided within accepted medical standards without reducing the quality of care.

* Sec. 5. AS 37.07.030 is amended to read:

Sec. 37.07.030. RESPONSIBILITIES OF THE LEGISLATURE. The legislature shall

(1) provide for a budget review function;

(2) analyze the comprehensive operating and capital improvements programs and financial plans recommended by the governor;

(3) adopt legislation to authorize implementation of the governor's comprehensive operating and capital improvements programs and financial plans or appropriate alternatives to those plans;

(4) provide for a post-audit function to cover financial transactions, program accomplishment, and compliance with legislative intent;

(5) adopt or revise the estimate of receipts required to balance the succeeding fiscal year's budget in order that proposed expenditures do not exceed estimated receipts for that fiscal year;

(6) adopt, revise, or initiate revenue measures in order to balance the succeeding fiscal year's budget and the capital improvements section of the budget for the succeeding six years;

(7) appropriate funds for the operation of the Alaska State Health Resources Authority.

* **Sec. 6.** AS 39.25.110 is amended by adding a new paragraph to read:

(30) employees of the Alaska State Health Resources Authority.

* **Sec. 7.** AS 39.50.200(b) is amended by adding a new paragraph to read:

(52) Alaska State Health Resources Authority (AS 21.77).

* **Sec. 8.** REPORT. The Alaska State Health Resources Authority shall report to the Alaska State Legislature by March 1, 1992, on the progress made by the authority in establishing a health care provider reimbursement system and utilization standards.

* **Sec. 9.** This Act takes effect immediately under AS 01.10.070(c).

HOUSE CONCURRENT RESOLUTION NO. 5

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVES ELLIS, Boyer, Navarre, Koponen, Ulmer

Introduced: 2/13/91
Referred: Health, Education and Social Services, Finance

A RESOLUTION

Establishing a Health Resources and Access Task Force.

BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:

WHEREAS estimated annual expenditures for health care in Alaska have risen by 300 percent in the last 10 years from $480 million to over $1.5 billion; and

WHEREAS over 90,000 residents of the state cannot afford to pay their medical bills, are not covered by a group health insurance plan, do not qualify for public assistance programs, and cannot afford to pay individual health insurance premiums; and

WHEREAS, if current trends continue, it is estimated that expenditures for health care in the state will increase to at least $10 billion by the year 2000 and over 25 percent of the state's residents will be uninsured; and

WHEREAS the legislature, aided by the Health Care Cost Containment Task Force, has achieved savings in the costs of health care in the state totaling over $20 million in fiscal years 1990 and 1991; and

WHEREAS every resident should have access to a basic level of health care regardless of income and should not become financially destitute before obtaining health care; and

WHEREAS the legislature recognizes that there is a continuing need to develop and evaluate

ways to manage health care expenditures in the state;

BE IT RESOLVED by the Alaska State Legislature that the Health Resources and Access Task Force is established with the following primary purposes:

(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 for continuing to contain the costs of health care in the state; and be it

FURTHER RESOLVED that the task force shall

(1) solicit advice and information from the medically indigent, health care consumer groups, the insurance industry, health care providers, labor organizations, emergency services personnel, large and small businesses, the Medical Care Advisory Committee, the Alaska Native Health Service, actuaries, the public, and others;

(2) investigate and gather data relating to health care quality, access, delivery, payment systems, and financing in the state, especially in rural areas;

(3) ascertain and review successful health care protection methods in other states, territories, and countries and other health care alternatives, including ways of providing health care for persons without insurance or with limited health care protection;

(4) continue to update an accurate estimate of the number of people who are unable to receive necessary health care services in the state, which patients are generating unpaid medical bills, which state residents are uninsured or lack adequate insurance, which health care providers are providing uncompensated care, who is paying for the cost of uncompensated care, and the total cost of uncompensated care in the state;

(5) identify those health care services necessary to achieve an acceptable minimum level of health care for all state residents and to examine those health care services that provide the most care for the most people at the least cost, including prevention services;

(6) monitor and evaluate experience under the state employee and retiree health plans;

(7) evaluate the potential benefits of health education, wellness plans, and prevention plans for all residents;

(8) develop strategies to support health care professions training and the retention of health care professionals in the state;

(9) recommend ways to coordinate services among nonprofit health care providers, profit making health care providers, the state division of public health, the United States Department of Veterans Affairs, the United States Department of Defense, and the Alaska Native Health Service in order to achieve a more efficient and effective health care delivery system;

(10) review ways to maximize the use of federal funds for health care programs in the state;

(11) investigate ways to reduce costs associated with malpractice insurance coverage, including its effect on the cost of health care in the state;

(12) consider the feasibility of redistributing funds currently spent by the state on health care in order to provide residents with affordable and equitable care;

(13) provide advice and assistance to other public agencies involved in health care programs; and

(14) pursue other sources of funding for the expenses of the task force; and be it

FURTHER RESOLVED that the task force shall consist of 14 members and two alternates as follows:

(1) three members of the Senate appointed by the President of the Senate, one of whom shall be designated as an alternate;

(2) three members of the House of Representatives appointed by the Speaker of the House, one of whom shall be designated as an alternate;

(3) two persons representing the executive branch, appointed by the Governor;

(4) eight members chosen by the members appointed under paragraphs (1) - (3) as follows: one individual representing the medically indigent, two individuals representing private employers who are not health care providers, two individuals representing health care providers, one individual representing nonprofit organizations, one consumer of health services who is not an employer or health care provider, and one individual representing labor organizations; and be it

FURTHER RESOLVED that the members of the task force shall elect from among themselves a chair and a vice-chair and that the conduct of the task force meetings shall be in sessions open to the public where all interested parties may provide information; and be it

FURTHER RESOLVED that, within funds made available for the purpose, the task force may hire staff and contract for services to perform its duties; and be it

FURTHER RESOLVED that the task force shall report its findings and recommendations to the Governor and the legislature by February 1, 1992, and February 1, 1993; and be it

FURTHER RESOLVED that the task force is terminated at 11:59 p.m. on February 1, 1993.

THE FOLLOWING DOCUMENT HAS NOT BEEN FILMED BUT IS AVAILABLE IN THE ORIGINAL FILE.

SFC 2/11/91 a:

STATE OF ALASKA

HEALTH CARE COST CONTAINMENT

TASK FORCE REPORT

TO

THE SEVENTEENTH LEGISLATURE

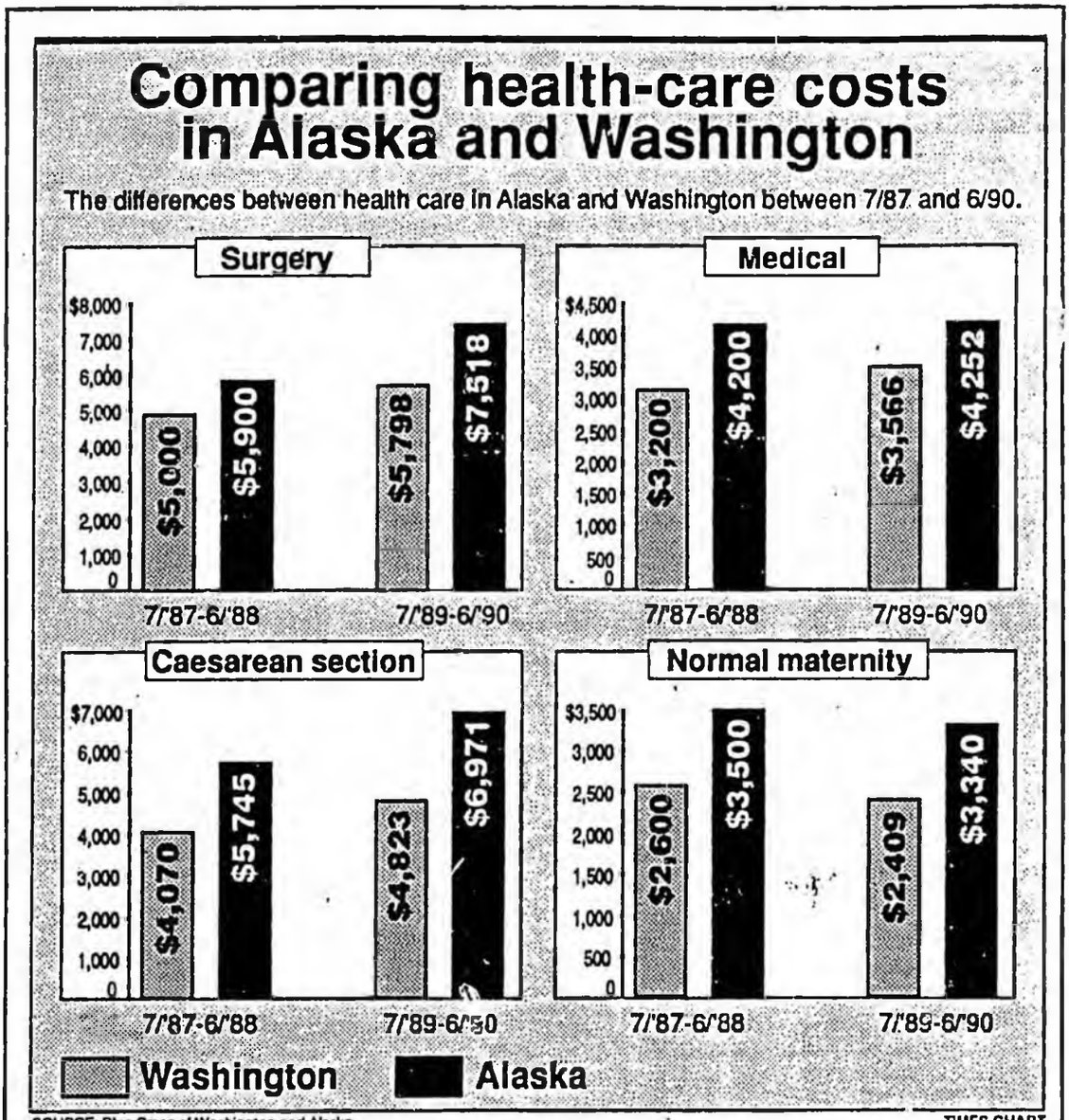
RELATING TO THE ACCESS, QUALITY, DELIVERY AND

FINANCING OF

HEALTH CARE FOR ALL ALASKA RESIDENTS

WITH
SUMMARY OF FINDINGS AND RECOMMENDATIONS

FEBRUARY 1991



New insurance plan puts lid on physician charges

New insurance plan puts lid on physician charges

By PATRICIA SOLOVEICHIK

TIMES BUSINESS WRITER 3-1-91

Alaska health care providers took another step toward controlling skyrocketing medical costs this year with the creation of a Blue Cross participating provider agreement that limits physician fees, said Eric Rohlman, vice president for group marketing at Blue Cross.

The program gives patients the option of choosing among 94 participating doctors. These physicians are not allowed to charge fees higher than what Blue Cross is willing to pay for medical services.

Patients who choose a Blue Cross physician in the program, which is called "Participating Provider Network," would avoid "balance billing," Rohlman said. Balance billing occurs when a doctor charges a fee higher than the insurance company has agreed to pay and the patient has to pay the difference, above and beyond the percentage of fees patients already pay.

The program also requires participating physicians to handle the insurance company's paperwork in billing their services.

Although the new physicians network is not expected to reduce costs dramatically, Rohlman said over time it will slow down inflation in medical costs and make Alaska consumers more accountable.

Blue Cross currently provides 81,547 enrollees, or 23 percent of Alaska residents, with health care coverage.

Anchorage Blue Cross customers say the program will help in controlling the rise in group health-care premiums.

"It's a convenience to our employees," said Kathy Steckman, personnel manager for National Bank of Alaska. "This will help because physicians will charge only reasonable and customary costs. That should help hold down costs."

NBA's Blue Cross health insurance is self-funded, which means employee premiums are placed in a trust fund, along with NBA contributions and claims are paid from that fund.

Warren DeVorak, personnel administrator with the Anchorage School District, said he has known about Blue Cross' efforts for some time and has supported it as a way to hold down costs.

"We've had insurance premium increases of 12 to 15 percent a year. This program won't exactly stem that, but it will hold it down significantly in the future," he said. "And it's a win-win situation for employees."

Chris Ulmann, a market analyst for the state Division of Insurance in Anchorage who oversees the Blue Cross arrangements, said "it took quite some time to sign up the participating doctors in the program."

"Signing up 94 physicians is a true success. Doctors are more independent here than they are in other states," Ulmann said.

He said some physicians had charged that

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Blue Cross coerced physicians into signing on with the program by threatening to write out checks to patients instead of sending payment directly to the non-participating doctor.

Under a new Alaska law, non-participating physicians risk having claim payments made directly to their patients. Physicians participating in the new program, however, would be paid directly, Rohlman said.

He said the program offered advantages to doctors, such as improved cash flow and reduced credit risks.

Dr. Charles Aarons, a family practice physician in Anchorage, said his clinic signed up for the program because the clinic's fees were actually lower than the Blue Cross fee schedule.

"But I'm still vehemently opposed to it. They gradually tighten the screws after they suck you in," Aarons said. "I will be interested to see what happens when we try to drop out."

He said fee freezes or minimal inflationary compensation is the rule with such programs in the Lower 48, and he expects similar conditions in Alaska.

"Price controls in a free economy don't work because they eventually lead to rationing," Aarons said.

Rohlman said Blue Cross has not asked physicians to scale down fees and predicts that few will have to do so to participate.

"The vast majority (of physicians fees) are reasonable, but a few set reimbursements by codes that are extremely unreasonable. Our goal is not to come in and reduce reasonable charges," but to identify those doctors who will not gouge patients, he said.

"We shouldn't have to pay the high end, and certainly not three times the average," he said.

However, he said insurers are willing to recognize Alaska's unique situation has given rise to costs 40 percent higher than those in Washington state.

A small, isolated population, boom and bust economy, higher labor and supply costs and a fragmented health-care system contribute to the extraordinary medical inflation in Alaska, according to Blue Cross.

A limited office visit is 40 percent more costly in Alaska than in Washington. A hysterectomy is 32 percent higher, while a mammography costs about the same, Rohlman said.

"We cannot look to the hospitals and doctors as the solutions. As consumers, we have to be part of it," he said.

Jack Lindsey → Oct 11 – New Eng. Journal of Medicine

For the Health of a Nation

by Henry Simmons, M.D., from the Report of the National Leadership Commission on Health Care

The National Leadership Commission on Health Care identified four major problems in our health care system and proposed a major restructuring of the nation's health care system to resolve them. The commission's proposal provides universal access to a basic level of health services; it controls escalating costs through use of economic leverage in the purchase of care, financing and systems reforms, economic incentives including cost sharing, and practice guidelines to encourage appropriate care and eliminate unnecessary care. The commission believes that reducing unnecessary procedures will help contain costs and improve the quality of health care. Its malpractice reform recommendations will also help contain costs and improve quality.

The commission agreed on a vision of a better health care system in the twenty-first century, one that promotes preventive care and healthy lifestyles, and established an innovative, efficient health care system. The system would encourage personal responsibility for choosing good health and appropriate treatment, support a strong doctor-patient relationship, and establish and utilize a public-private partnership to control costs, assure universal access, and improve the quality of care.

Problems with the Current Health Care System

America's health care system is in crisis. Costs are out of control, millions of Americans face difficulty gaining access to needed care, there is a malpractice crisis, and there are serious problems in the quality and appropriateness of much of the medical care being rendered. These problems are interrelated, systemic, and growing worse. It seems clear that they cannot be solved without a long-term, comprehensive strategy. Awareness of these problems has led to a strong shift in public attitudes to broad dissatisfaction with our health care system.

The rate of health care cost escalation is of major concern to both government and the private sector. Unless we act soon to change America's health care system, by the year 2000 the United States could be spending a quarter of the GNP—$2.5 trillion—on health care. That number is more than double the federal government's entire budget for 1990. It is also $1 trillion more than recent estimates for U.S. spending on health care at the turn of the century. National health care spending of $2.5 trillion translates to almost $10,000 per year for every man, woman, and child in this country.

Government is concerned because it is increasingly clear that the federal deficit and rising health care costs are inextricably intertwined. Business and labor are concerned because rising health care costs are now considered a major threat to industry's economic viability and its ability to compete and to provide jobs. The American people are concerned because more and more of the costs are borne directly by individuals, and there is no end in sight.

A systemic problem of this magnitude cannot be solved with a piecemeal strategy. Nor can it be solved by any one segment of society, including government, alone. We all share some of the blame for this complex societal problem, and therefore we share the responsibility for resolving the problem. Costs must be contained, quality and access must be assured, the malpractice problem must be resolved, and, to the extent possible, the American system of freedom of choice, "pluralism," and competition must be preserved. But this will not be possible without comprehensive, long-term structural reform. Such reforms will require creation of a new public-private partnership and a coordinated effort of business, labor, government, providers, insurers, and consumers. Otherwise, costs and problems will only be shifted, and our situation will grow more severe, to the detriment of all.

The growing seriousness of the problems and public concerns have combined to create a new opportunity and need for effecting major change in our health care system. There is now a clear and compelling case for comprehensive reform.

Summary of the Commission's Proposal

The National Leadership Commission on Health Care's final report, *For the Health of a Nation: A Shared Responsibility*, proposes a major restructuring of the nation's health care system. The central feature of the commission's proposal is the notion that none of the problems besetting the nation's health care system—lack of access for millions, poor quality, inefficiency, soaring costs, and a malpractice insurance crisis—can be solved in isolation. The problems are interconnected; the solution must also be. The plan is based on seven fundamental principles and has four interrelated parts—a universal access proposal, a national quality improvement initiative, a cost containment strategy, and a malpractice reform package.

Fundamental Principles of the Commission's Proposal

The commission's proposal is based on seven fundamental principles.

1. *Principle of Universal Access.* There should be no financial barrier separating Americans in need of health care from access to care.
2. *Principle of Fair Compensation.* Every provider of health services in America should be adequately compensated for services rendered to patients.
3. *Principle of Clinical and Economic Freedom.* To the maximum extent possible, without unduly compromising other important principles, health policy ought to restore clinical freedom in rendering health services and economic freedom in financing these services, within the context of adequate countervailing market power from those who ultimately pay for health care in America.
4. *Principle of Shared Responsibility.* Financial responsibility for health care for those too poor to afford it should be shared by government, individuals, and employers.
5. *Principle of Individual Responsibility.* To help achieve the goal of universal access to health care, the individual has a duty to have adequate insurance coverage for himself or herself and dependents.
6. *Principle of Basic Benefits Guarantee.* The design of a basic package of health service benefits to which all Americans should have reliable access is ultimately a federal responsibility.
7. *Principle of a Strong Doctor-Patient Relationship.* Any health care system should foster the goal of protecting the integrity of the doctor-patient relationship.

In light of the federal deficit, the commission proposes building upon the American tradition of providing private health insurance through the workplace. The proposal is designed to encourage continued extensive reliance on that approach, without mandating that employers provide such coverage. The commission also noted that universal access could be funded out of general revenues.

The Commission's Proposal

The Universal Access (UNAC) Plan. UNAC would provide universal access to basic health care for all Americans without insurance. Medicaid recipients would become part of this program. There would be an incentive for more employers to offer health insurance to employees, since both would pay a fee to UNAC if employees were not offered insurance. Financing for this public program would be paid for through a health insurance premium of 0.6 percent of income up to the social security maximum, paid by everyone with incomes over 150 percent of the federal poverty level and their employers, with special provisions for new and small businesses and part-time workers. The funds would be collected nationally; the UNAC program would be administered in a decentralized fashion by the states.

A National Quality Improvement Initiative. This provision would improve the quality, appropriateness, and efficiency of care by establishing a national program of increased technology assessment and outcomes research that would result in national practice guidelines for all the major procedures. Since seventy major procedures account for about half of our total national health expenditures, this is an important way to eliminate unnecessary care. Up to $500 million a year from the UNAC funds would support this ongoing program, designed to assess technology, develop guidelines and standards, and compare new procedures, as they become available, with those already in use.

A Cost Containment Strategy. The elimination of much unnecessary care could potentially cut back up to 20 percent to 30 percent of all procedures performed today. UNAC will have economic leverage, because it will negotiate payment rates for 60 million to 70 million people. Under UNAC, cost shifting of charity care will end and there will be greater inter-employer equity. UNAC will also encourage intervention. The new ability through research and guidelines to make more informed purchasing decisions, combined with cost sharing, will increase individual responsibility. The commission called for increased use of organized systems of care, such as PPOs, by private employers and for physician payment reform with expenditure targets.

A Malpractice Reform Package. This six-part proposal, based on successful programs in some states, calls for strict criteria for expert witnesses; strengthened standards of negligence; punitive damages limited to a grave dereliction of professional responsibility with damages going to the state; limited contingency fees; a fast track through the court system for malpractice cases; and increased use of arbitration. If the states do not move expeditiously to make these changes, there should be consideration of federal preemption of state malpractice laws.

PLEASE MICROFILM TOP PAGE ONLY

DOCUMENTS WHICH HAVE NOT BEEN FILMED BUT ARE AVAILABLE IN THE ORIGINAL FILE INCLUDE:

→ Article by Consumer Reports Aug. 1990
"The Crisis in Health Insurance."
→ Article by National Governor's Association
"Health Care Reform: Rx For a Healthy America"
→ Article by Families USA Foundation
"To the Rescue Toward Solving America's Health Care Crisis"
"Rising Health Costs in America 1980-1990-2000"