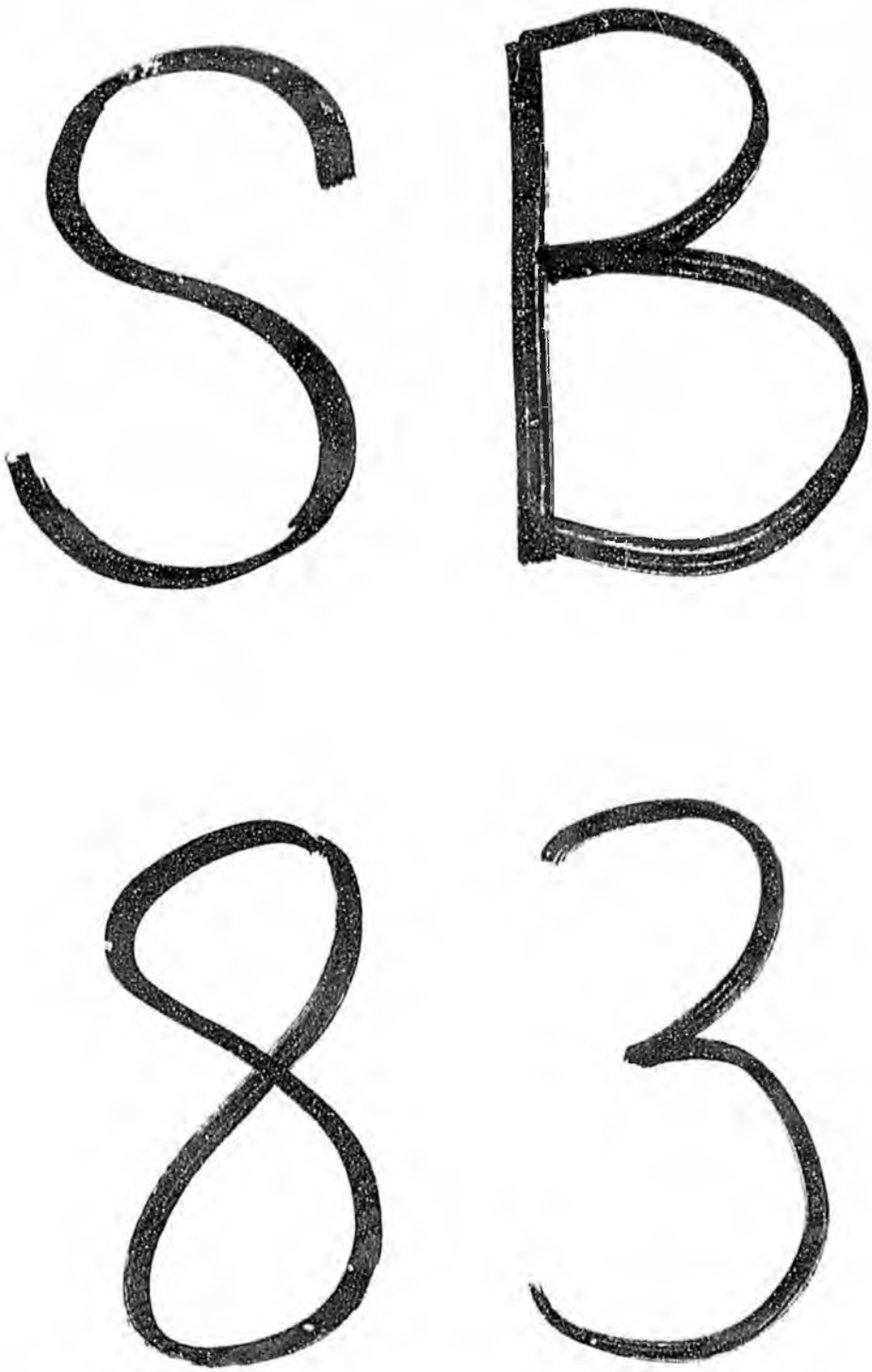


STATE OF ALASKA
1990 LEGISLATURE

BILL VERSION SB 83
PUBLISH DATE

FISCAL NOTE

REQUEST:
Revision Date: 3-18-91
Title: Alaska State Health Resources Authority
Sponsor: Senator Duncan

Affected Agency:
BRU:
Components:

EXPENDITURES/REVENUES: (THOUSANDS OF DOLLARS)

OPERATING		FY 91	FY 92	FY93	FY 94	FY 95	FY 96
Personal Services			112.7	112.7			
Travel			40.4	40.4			
Contractual			145.3	145.3			
Supplies			3.5	3.5			
Equipment			21.0	1.0			
Land & Structures							
Grants, Claims							
Miscellaneous							
TOTAL OPERATING			322.9	302.9	*	*	*
CAPITAL							
REVENUE				122,723.	318,573.	642,677.	1,614,954.0

FUNDING: (THOUSANDS OF DOLLARS)

General Fund			322.9	302.9	*	*	*
Federal Fund							
Other							
TOTAL			322.9	302.9	*	*	*

POSITIONS:

Full-Time			2	2			
Part-Time							
Temporary							

ANALYSIS: (ATTACH A SEPARATE PAGE IF NECESSARY) See pages 2 and 3 for budget detai

*After July 1, 1992, the Authority shall provide that sufficient premiums are collected to provide the required insurance coverage and to pay the expenses of the Authority.

Prepared By: Dale Staley for Senator Jim Duncan Phone: 465-4766
Division: Date: 3-1-91

Approved By:
Agency: Date:

DISTRIBUTION (BY PREPARER)
LEGISLATIVE FINANCE
LEGISLATIVE SPONSOR

REQUESTOR
OFFICE OF MANAGEMENT & BUDGET
AGENCY(IES)

CONTINUATION OF FISCAL NOTE:

Senate Bill 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."

Personal Services:

Executive Director Range 24A
$5084 x 12 months = $60,008
$60,008 x 37% benefits = $22,573
Subtotal $82,581

Clerk Typist III Range 8B $1830
$1830 x 12 months = $21,960
$21960 x 37% benefits = $8,125
Subtotal $30,085

Total Personal Services $112,666

Travel:

It is anticipated there will be 6 meetings of the Health Care Resources Authority.
6 meetings x 9 members = 54 airfares
54 airfares x $436 = $23,544
2 days per diem x 54 = 108
108 days x $95 = $10,260
Subtotal $30,804

Travel for Executive Director
10 board meetings x $436 = $4,360
2 meetings x 12 months x $436 = $5,232
Subtotal $ 9,592

Total Travel $ 40,396

CONTINUATION OF FISCAL NOTE:

SB 83

Contractual:

Office Space 500 sq. ft. x $1.75 = $875		
$875 x 12 months	$ 10,500	
Telephone $200 x 12 months	$ 2,400	
Postage $200 x 12 months	$ 2,400	
Advertising and printing	$ 5,000	
Professional Services Contract(s)	$125,000	
which may include:		
Rate Studies		
Utilization Research		
Financial Systems Analysis		
Total Contractional		$145,300

Supplies:

$1,000 per employee	$ 2,000	
Software	$ 1,500	
Total Supplies		$ 3,500

Equipment:

2 Desk top computers and a printer	$ 11,000	
Bookcases and file cabinets	$ 1,200	
Desk and chairs	$ 4,000	
Photocopier	$ 2,000	
Phone system	$ 800	
Miscellaneous	$ 2,000	
Total Equipment		$ 21,000

TOTAL OPERATING $322,862

REVENUE ASSUMPTIONS FOR SB 83

The revenue assumptions are based on the estimated 20% per year increase in the costs of medical care.

Understanding that this 20% per year figure may not be constant over a long period of time it is the target that SB 83 is aiming to reduce. This figure has been used in the following table to demonstrate the costs savings in Alaska resulting from the phased implementation of SB 83. Savings achieved by this phased implementation are calculated by the application of the formula in column B.

	A Health Care Expenditure w/o ASHRA	B FORMULA	C Health Care Expenditure With ASHRA	ANNUAL SAVINGS .
FY 91	$1,929,000.0		NO ASHRA	00.0
FY 92	$2,315,520.0		NO ASHRA	00.0
FY 93	$2,778,624.0	20%@CPI, 80%@17%	$2,655,901.0	$ 122,723.0
FY 94	$3,334,348.0	30%@CPI, 70%@15%	$3,015,775.0	$ 318,573.0
FY 95	$4,001,218.0	40%@CPI, 60%@15%	$3,358,541.0	$ 642,677.0
FY 96	$4,801,462.0	40%@CPI, 60%@15%	$3,729,137.0	$ 1,072,325.0
FY 97	$5,761,754.0	40%@CPI, 60%@15%	$4,146,800.0	$ 1,614,954.0
FY 98	$6,914,105.0	50%@CPI, 50%@15%	$4,571,847.0	$ 2,342,258.0
FY 99	$8,296,926.0	50%@CPI, 50%@15%	$5,040,461.0	$ 3,256,465.0
FY 2000	$9,955,312,.0	50%@CPI, 50%@15%	$5,557,108.0	$ 4,398,204.0

NOTES:

A = FULL 20% ANNUAL MEDICAL INFLATION

B = EFFECTS OF ASHRA, CPI ESTIMATED AT 5% PER YEAR, REDUCED INFLATION AT 17% PER YEAR UNTIL 1994, 15% THEREAFTER.

C = TOTAL HEALTH CARE EXPENDITURE IN ALASKA AFTER ASHRA.

FISCAL NOTE

BILL NO. CSSB 83
Ford 3/23/92

STATE OF ALASKA
1992 LEGISLATIVE SESSION

Revision Date: March 27, 1992
Title: An Act establishing the Alaska State Health Resources Authority

Department Affected: Administration
BRU: Retirement and Benefits

Component: Retirement and Benefits

Sponsor: Duncan
Requestor: Senate HESS Committee

COMPONENT SERIAL NO. 64

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
PERSONAL SERVICES	138.4	163.3	171.4	180.0	189.0	198.5
TRAVEL	63.3	49.7	49.7	49.7	49.7	49.7
CONTRACTUAL	139.0	139.0	139.0	139.0	139.0	0139.0
SUPPLIES	3.3	3.3	3.3	3.3	3.3	3.3
EQUIPMENT	33.3	1.0	1.0	1.0	1.0	1.0
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	377.3	356.3	364.4	373.0	382.0	391.5
CAPITAL	0	0	0	0	0	0
REVENUE FUND SOURCE:	0	0	400.8	410.3	420.2	430.7

FUNDING: (Thousands of dollars)

GENERAL FUND	377.3	356.3	0	0	0	0
FEDERAL FUNDS		0	0	0	0	0
OTHER FUND SOURCE	0	0	364.4	373.0	382.0	391.5
TOTAL	377.3	356.3	364.4	373.0	382.0	391.5

POSITIONS

FULL-TIME:	3	3	3	3	3	3
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.)

See attached

Prepared By: Gary Bader
Division: Retirement and Benefits
Phone: 465-4470
Date: March 27,1992

Approved by Commissioner: Nancy Bear Usera
Agency: Department of Administration
Date: 3/30/92

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

Analysis: This bill creates the Alaska State Health Resources Authority in the Department of Administration. This independent agency would have specific duties and powers as outlined including regulatory powers and authority to charge fees and establish reserves to cover the expenses of the Authority. The Authority shall be managed by a nine member board of directors appointed by the Governor.

Employing an Executive Director and additional staff as necessary, the Authority shall:

** issue determinations on the effect of certificates of need on the cost of group health insurance under AS 18.07.071;

** by July 1, 1993, collect all data to develop the data system of health expenditures described in section AS 44.87.060.

** by July 1, 1994, complete development of budget and expenditure limits for the state.

**by July 1, 1995, implement expenditure limits, mandatory reimbursement schedules and utilization standards.

The bill requires representatives from different classes of healthy care providers to annually negotiate the reimbursement scedules to be mandated. The bill would allow procurement of group health insurance for employers or residents.

It is expected that this bill would decrease the cost of health insurance through the expenditure cap.

For purposes of this fiscal analysis, it is assumed that participation in the plan will be adequate to allow the Authority to charge sufficient administrative fees to support the entire operating costs of the Authority beginning in FY 95. These fees are shown as revenue on

the fiscal note form and it is assumed that the amount collected will be 10% higher than the operating costs for the first five years in order to establish a reserve to cover continuing expenses. It is also assumed that staff salaries will increase 5% annually.

Personal Services

Executive Director (Range 26A, 12 mos.)	87.1	
Administrative Assistant II (14A, 9 mos.)	29.9	
Clerk Typist III (8B, 9 mos.)	21.4	
Total Personal Services		138.4

Travel

Assume 12 Board Meetings for FY 92 and 9 each year thereafter at an average cost of $400 per member per trip:

$475 X 9 members X 12 trips =	51.3	

Administrative travel for Director:

Board Meetings	$400 X 12 =	4.8	
Organizational Meetings	$600 X 12 =	7.2	
Total Travel			63.3

Contractual

Office space--500 sq. ft. @ $2.00 X 12 mos.=	12.0
Telephone--$300 X 12 mos.=	3.6
Courier Services--$220 X 12 mos.=	2.4
Postage--$500 X 12 mos.=	6.0
Printing, binding, transcription services=	15.0

Professional Services Contract (s) which could include services such as:

- carrier surveys and analysis;
- provider data collection;
- provider meetings;
- financial and investment consulting;

self vs fully insured analyses; and/or plan design and development=		100.0	
Total Contractual			139.0

Supplies

$500 per employee		1.5	
Software		1.8	
Total Supplies			3.3

Equipment

3 PCs and printer		15.0	
Phone system		2.6	
Photocopier		1.3	
Fax machine		1.8	
Office furniture:			
1 management unit	4.0		
2 support workstations	5.0		
3 chairs	1.2		
3 side chairs	.8		
2 file cabinets	.9		
bookcase	.1		
storage cabinet	.6		
Total Equipment			33.3

FISCAL NOTE

BILL NO. CSSB 83

STATE OF ALASKA
1991 LEGISLATIVE SESSION

Revision Date: April 3, 1990
Title: An Act relating to the Alaska State Health Resources Authority

Department Affected: Administration
BRU: Health Resources Authority

Component: Health Resources Authority

Sponsor: Duncan
Requestor:

COMPONENT SERIAL NO. 6.4

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES	155.5	163.3	171.4	180.0	189.0	198.5
TRAVEL	62.5	49.7	49.7	49.7	49.7	49.7
CONTRACTUAL	319.0	239.0	239.0	239.0	239.0	239.0
SUPPLIES	3.3	3.3	3.3	3.3	3.3	3.3
EQUIPMENT	33.3	1.0	1.0	1.0	1.0	1.0
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	573.6	456.3	464.4	473.0	482.0	491.5
CAPITAL	0	0	0	0	0	0
REVENUE	0	547.6	557.3	567.7	578.4	589.8

FUNDING: (Thousands of dollars)

GENERAL FUND	573.6	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	456.3	464.4	473.0	482.0	491.5
TOTAL	0	0	0	0	0	0

POSITIONS

FULL-TIME:	3	3	3	3	3	3
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.)

See attached analysis

Prepared By: Gary Bader
Division: Retirement and Benefits
Approved by Commissioner: Millett Keller
Agency: Department of Administration

Phone: 465-4460
Date: 4/2/91
Date: 4/3/91

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

Rev 10/90

Analysis: This bill creates the Alaska Health Resources Authority in the Department of Administration. This independent agency would have specific duties and powers as outlined including regulatory powers and authority to charge fees and establish reserves to cover the expenses of the Authority. The Authority shall be managed by a nine member board of directors appointed by the Governor.

Employing an Executive Director and additional staff as necessary, the Authority shall:

** issue recommendations on the effect of certificates of need under AS 18.07.071 effective immediately;

** by July 1, 1992, create provider reimbursement systems and utilization standards mandatory within the boundaries of municipalities with a population of 20,000 or more. Implementation must be complete by 12/31/93;

** after July 1, 1992, procure or provide through self insurance group health insurance pool for certain individuals, groups or employers; and

**after February 15, 1993, procure or provide through self insurance group health insurance for employers with 50 or fewer emplyees and who have been refused coverage by two carriers and have not provided insurance to its employees for a year.

The bill allows voluntary participation in the Authority's group plan that would be available after 7/1/92. It is assumed that the State would participate in this plan if the coverage could be provided less expensively than through the normal marketplace. It is expected that this bill will decrease the cost of health insurance since that is the charge to the Authority. Upon participation, a public entity or other employer would be required to continue participation unless granted a waiver by the Authority.

For purposes of this fiscal analysis, we have assumed that participation in the plan will be adequate to allow the Authority to charge sufficient administrative fees to support the entire operating costs of the Authority beginning in FY 93. These fees are shown as revenue on the fiscal note form and it is assumed that the amount collected will be 20% higher than the operating costs for the first five years in order to establish a reserve to cover continuing expenses. It is also assumed that staff salaries will increase 5% annually.

At the same time the fees are taken from insurance premiums paid by participating employers, it is assumed for purposes of this analysis, that there is a decrease in the overall health care expenditure in the state due to the cost containing influences of the Health Resource Authority. This decrease in expenditures resulting in annual savings has been estimated by other sources to be $132,723 in FY 93 and increasing to $1,066,318 by FY 96.

Personal Services

Executive Director (Range 26A, 12 mos.)	87.1	
Administrative Assistant II (14A, 12 mos.)	39.9	
Clerk Typist III (8B, 12 mos.)	28.5	
Total Personal Services		155.5

Travel

Assume 12 Board Meetings for FY 92 and 9 each year thereafter at an average cost of $400 per member per trip:

$475 X 9 members X 12 trips =	51.3	

Administrative travel for Director:

Board Meetings	$400 X 12 =	4.8	
Organizational Meetings	$600 X 12 =	7.2	
Total Travel			63.3

Contractual

Office space--500 sq. ft. @ $2.00 X 12 mos.=	12.0	
Telephone--$300 X 12 mos.=	3.6	
Courier Services--$220 X 12 mos.=	2.4	
Postage--$500 X 12 mos.=	6.0	
Printing, binding, transcription services=	15.0	
Professional Services Contract (s) which could include services such as: carrier surveys and analysis; provider data collection; provider meetings; financial and investment consulting; self vs fully insured analyses; and/or plan design and development=	280.0	
Total Contractual		319.0

Supplies

$500 per employee	1.5	
Software	1.8	
Total Supplies		3.3

Equipment

3 PCs and printer		15.0	
Phone system		2.6	
Photocopier		1.3	
Fax machine		1.8	
Office furniture:			
1 management unit	4.0		
2 support workstations	5.0		
3 chairs	1.2		
3 side chairs	.8		
2 file cabinets	.9		
bookcase	.1		
storage cabinet	.6		
Total Equipment			33.3

No. 3

FISCAL NOTE

Bill Version: CSSB 83 (S+C)

(S) Publish Date: 4/22/91

STATE OF ALASKA
1991 LEGISLATIVE SESSION

Revision Date: April 3, 1990
Title: An Act relating to the Alaska State Health Resources Authority

Department Affected: Administration
BRU: Health Resources Authority

Component: Health Resources Authority

Sponsor: Duncan
Requestor:

COMPONENT SERIAL NO. 6 4

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES	155.5	163.3	171.4	180.0	189.0	198.5
TRAVEL	62.5	49.7	49.7	49.7	49.7	49.7
CONTRACTUAL	319.0	239.0	239.0	239.0	239.0	239.0
SUPPLIES	3.3	3.3	3.3	3.3	3.3	3.3
EQUIPMENT	33.3	1.0	1.0	1.0	1.0	1.0
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	573.6	456.3	464.4	473.0	482.0	491.5
CAPITAL	0	0	0	0	0	0
REVENUE	0	547.6	557.3	567.7	578.4	589.8

FUNDING: (Thousands of dollars)

GENERAL FUND	573.6	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	456.3	464.4	473.0	482.0	491.5
TOTAL	0	0	0	0	0	0

POSITIONS

FULL-TIME:	3	3	3	3	3	3
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.)

See attached analysis

Prepared By: Gary Bader Gary M Bader
Division: Retirement and Benefits
Approved by Commissioner: Millett Keller
Agency: Department of Administration

Phone: 465-4460
Date: 4/2/91
Date: 4/2/91

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

Rev 10/90

CSSB 83
Analysis of Financial Impact
Prepared by the Division of Retirement and Benefits
Department of Administration
April 2, 1991

Analysis: This bill creates the Alaska Health Resources Authority in the Department of Administration. This independent agency would have specific duties and powers as outlined including regulatory powers and authority to charge fees and establish reserves to cover the expenses of the Authority. The Authority shall be managed by a nine member board of directors appointed by the Governor.

Employing an Executive Director and additional staff as necessary, the Authority shall:

** issue recommendations on the effect of certificates of need under AS 18.07.071 effective immediately;

** by July 1, 1992, create provider reimbursement systems and utilization standards mandatory within the boundaries of municipalities with a population of 20,000 or more. Implementation must be complete by 12/31/93;

** after July 1, 1992, procure or provide through self insurance group health insurance pool for certain individuals, groups or employers; and

**after February 15, 1993, procure or provide through self insurance group health insurance for employers with 50 or fewer emplyees and who have been refused coverage by two carriers and have not provided insurance to its employees for a year.

The bill allows voluntary participation in the Authority's group plan that would be available after 7/1/92. It is assumed that the State would participate in this plan if the coverage could be provided less expensively than through the normal marketplace. It is expected that this bill will decrease the cost of health insurance since that is the charge to the Authority. Upon participation, a public entity or other employer would be required to continue participation unless granted a waiver by the Authority.

274

For purposes of this fiscal analysis, we have assumed that participation in the plan will be adequate to allow the Authority to charge sufficient administrative fees to support the entire operating costs of the Authority beginning in FY 93. These fees are shown as revenue on the fiscal note form and it is assumed that the amount collected will be 20% higher than the operating costs for the first five years in order to establish a reserve to cover continuing expenses. It is also assumed that staff salaries will increase 5% annually.

At the same time the fees are taken from insurance premiums paid by participating employers, it is assumed for purposes of this analysis, that there is a decrease in the overall health care expenditure in the state due to the cost containing influences of the Health Resource Authority. This decrease in expenditures resulting in annual savings has been estimated by other sources to be $132,723 in FY 93 and increasing to $1,066,318 by FY 96.

Personal Services

Executive Director (Range 26A, 12 mos.)		87.1
Administrative Assistant II (14A, 12 mos.)		39.9
Clerk Typist III (8B, 12 mos.)		28.5
Total Personal Services		155.5

Travel

Assume 12 Board Meetings for FY 92 and 9 each year thereafter at an average cost of $400 per member per trip:

$475 X 9 members X 12 trips =		51.3

Administrative travel for Director:

Board Meetings	$400 X 12 =	4.8
Organizational Meetings	$600 X 12 =	7.2
Total Travel		63.3

Contractual

Office space--500 sq. ft. @ $2.00 X 12 mos.=		12.0
Telephone--$300 X 12 mos.=		3.6
Courier Services--$220 X 12 mos.=		2.4
Postage--$500 X 12 mos.=		6.0
Printing, binding, transcription services=		15.0
Professional Services Contract (s) which could include services such as:		
carrier surveys and analysis;		
provider data collection;		
provider meetings;		
financial and investment consulting;		
self vs fully insured analyses; and/or		
plan design and development=		280.0
Total Contractual		319.0

Supplies

$500 per employee		1.5
Software		1.8
Total Supplies		3.3

Equipment

3 PCs and printer		15.0
Phone system		2.6
Photocopier		1.3
Fax machine		1.8
Office furniture:		
1 management unit	4.0	
2 support workstations	5.0	
3 chairs	1.2	
3 side chairs	.8	
2 file cabinets	.9	
bookcase	.1	
storage cabinet	.6	
Total Equipment		33.3

4084

FISCAL NOTE No. 1

Bill Version: SB 83

(S) Publish Date: 4/22/91

STATE OF ALASKA
1991 LEGISLATIVE SESSION

Revision Date:

Title: An Act relating to the Alaska State Health Resources Authority

Department Affected: Administration

BRU: Retirement and Benefits

Component: Retirement and Benefits

Sponsor: Duncan

Requestor:

COMPONENT SERIAL NO. 64

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.)

Prepared By: Gary Bader Phone: 465-4460

Division: Retirement and Benefits Date:

Approved by Commissioner: Millett Keller Date: 2/17/91

Agency: Department of Administration

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

Rev 10/90

STATE OF ALASKA
1991 LEGISLATIVE SE..ION

Bill Versio
Publish Da

No. 2

Bill Version: SB 83

(S) Publish Date: 4/22/91

REQUEST: FISCAL NOTE

Revision Date:

Agency Affect: Health & Social Serivces

Title: Relating to the delivery, quality, and financing of health care

BRU: State Health Serivces

Sponsor: Duncan, Zharoff

Components: none

Requester: Labor and Commerce

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants, Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
REVENUE	0.0	0.0	0.0	0.0	0.0	0.0

FUNDING: (Thousands of Dollars)

General Funds	0.0	0.0	0.0	0.0	0.0	0.0
Federal Funds						
Other						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS

Full-Time		0	
Part-Time		0	
Temporary		0	

Changes in CSSB 23 (HC) have no fiscal impact. This fiscal note is appropriate.

4-19-91 date

RAM Comte Aide (initial)

ANALYSIS: (attach a separate page if necessary)

No fiscal impact will occur in the immediate future. At the time that the Authority requires services from Division of Public Health, the Division will assess the Authority for those services

Prepared By: Alfred G. Zangri

Phone: 465-3090

Division: PUBLIC HEALTH

Date: 02/13/91

Approved By Commissioner: Theodore Mala, M.D., MPH

Date: 3/12/91

Agency: HEALTH & SOCIAL SERVICES

Distribution (by preparer):
Legislative Finance, Legislative Sponsor, Requestor,
Office of Management & Budget, Impacted Agency(ies)

Alaska State Legislature

SENATOR JIM DUNCAN

P. O. BOX V JUNEAU, ALASKA 99811-3100

(907) 465-4766

COMMITTEES:
FINANCE
VICE CHAIR – HEALTH EDUCATION & SOCIAL SERVICES
BUDGET & AUDIT
BANKING & ECONOMIC DEVELOPMENT

EXECUTIVE SUMMARY

Senate Bill 83, legislation creating the Alaska State Health Resources Authority (ASHRA), introduced by Senator Jim Duncan and endorsed by the State of Alaska Health Care Cost Containment Task Force.

BACKGROUND

Health care expenditures in Alaska have risen from $480 million in 1979 to over $1.5 billion in 1989, a per capita rise in expenditures from $1197.00 in 1979 to over $2524.00 in 1989.

These staggering increases and the substantial rise in the uninsured and underinsured population (estimated at over 90,000) prompted the Legislature to create the Alaska State Health Care Cost Containment Task Force in 1989.

Since early in 1989 the Task Force has been investigating the causes for these rampant rises in health care expenditures and costs. After twenty two months of hearings, surveys, investigations and critical reviews around the State and Nationally the Task Force will be issuing its findings, recommendations and report to tne Seventeenth Alaska Legislature in mid February 1991.

The Task Force report will show that there is no one culprit to blame for these rapidly rising costs, but that the only credible long term solution is a comprehensive approach that manages health care delivery at all levels to assure affordable, quality health care access for all Alaskans.

The comprehensive approach recommended by the Task Force is provided for in the legislation creating the Alaska State Health Resources Authority (ASHRA).

THE LEGISLATION

The legislation will create the Alaska State Health Resources Authority (ASHRA). ASHRA will be empowered to manage the delivery, quality and financing of health care in Alaska. The powers of the Authority will be implemented in two phases.

PHASE ONE

By July 1, 1992 the Authority will have created and will begin implementation of statewide health care provider reimbursement schedules and utilization standards. which shall be used bv all Alaska public emplovers 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 health care providers and includes schedules of maximum allowable reimbursement for health care related services. These schedules will be based on geographic regions, actual provider costs, and availability of care. The Authority will also create a statewide utilization standards system to monitor, track and verify patterns of treatment by health care providers to assure that cost efficient and cost effective care is provided without reducing the quality of medical care available to participants in the Authority.

The Authority will also be required to issue an impact statement on all Certificate Of Need (CON) applications within 60 days of notice. This will allow the Authority to determine the cost implications of the proposed certificates or changes to certificates of need.

IMPACT

The goal of this phase is to reduce the rate of inflation in the cost of medical care for participants in the Authority to or near the C.P.I. from its current level of about 20% per year. Also to minimize the cost shift to other health care programs.

PHASE TWO (procurement of insurance)

Beginning after July 1, 1992 the Authority is authorized to provide comprehensive group health insurance for Alaska public employers and other employers in the state who elect to participate in the Alaska State Health Resources Authority.

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

Creating the most comprehensive, cost effective, and efficient method of providing a variety of types of health care insurance necessary to meet the coverage requirements resulting from negotiated agreements. The Authority will also be charged with reviewing, and where feasible, providing coverage to the uninsured and underinsured residents of Alaska. Additionally the Authority could also devise a health insurance protection plan for the sole proprietor or small Alaskan employer.

IMPACT

This phase will bring together the provider reimbursement and utilization management with the delivery and financing of health care in Alaska, which will enable the state through the Authority to provide quality, cost effective health care to all Alaska residents.

Alaska State Legislature

SENATOR JIM DUNCAN

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COMMITTEES:
VICE CHAIR – FINANCE
VICE CHAIR – STATE AFFAIRS
RULES
BUDGET & AUDIT
ETHICS REFORM

PROVIDING ACCESS TO AFFORDABLE HEALTH CARE FOR ALL ALASKANS

POSITION PAPER

from

SENATOR JIM DUNCAN

Background

The rising costs of health care and health insurance in our state is one of the most critical problems facing all Alaskans. Total health care expenditures in Alaska during 1990 are estimated at $1.5 Billion, up 300% from the $480 Million expended in 1979. It is estimated that 90,000 Alaskans are either uninsured or underinsured. If the current inflationary trend continues unchecked, it is estimated that by the year 2000 health care expenditures will increase to at least $10 Billion with over 25% of the state's population uninsured or underinsured.

In addition to inflationary pressures pushing the cost of health care and health premiums upward there are a number of other contributing factors. These included overbuilt facilities, new technology, a lack of prevention programs, the need for statewide planning, the absence of a health care financing system, and uncompensated costs incurred by providers. As the cost of health care increases the cost of health insurance premiums also go up forcing more and more Alaskans, both employed and unemployed, to join the ranks of the uninsured and underinsured.

Statement of Problems

Providing access to affordable health care must begin by slowing down the rate of increase in the costs of health care. By simply spending millions of dollars to provide health care for those who are uninsured or underinsured or to pay providers for uncompensated care can only offer temporary relief to patients and providers. This will undoubtedly add to the inflationary increase in health care cost, and result in increasing the number of uninsured Alaskans.

The Solution

The establishment of fee schedules and utilization standards to be used by providers for services delivered to all Alaskans is a necessary step to slow the rate of increase in the cost of health care. This approach will work !

-over-

The State of Maryland established reimbursement schedules for hospitals in 1974. Hospital rates in Maryland have been reduced from 25% above the national average in 1974 to 8% below the national average today. The National Governor's Association, in a February 2, 1991 press release, indicated its Task Force on Health will suggest a "State Level All-Payer System" in which an association of purchasers come together to negotiate with an association of providers. In addition, the Families USA Foundation in a November 1990 report recommends a similar approach.

Legislative Action

Controlling rate increases and utilization as done in Maryland, and establishing an "all payer's system" as referred to in the press release by the National Governor's Association and the Families USA Foundation is exactly what the Alaska State Health Resources Authority as created by Senate Bill 83 is designed to do.

Senate Bill 83 is designed to develop ways to provide affordable quality health care for all Alaskans by the creation of a Health Resources Authority. Initially the authority is required to create and begin to implement a system that results in cost efficient payments to health care providers. This system includes schedules of maximum allowable reimbursement for health care related services based on actual provider costs, geographic regions and availability of care. The authority is also directed to create a statewide utilization standards system to monitor, track and verify patterns of treatment by health care providers to assure that cost efficient and cost effective care is delivered without reducing the quality of medical care available to participants or affecting the design of their health care plan. The fee schedules and utilization standards will be used by providers for services delivered to all public employees and private sector employers may elect to use the schedules. Allowing all employers to use the schedules will prohibit cost shifting. This does not affect plan design and is a positive step in controlling costs.

The authority is directed to design and procure or provide a basic health care plan for the small employer who elects to participate. This plan will be designed to address the problem of the uninsured and underinsured who do not presently have access to health care.

Conclusion

We need affordable, quality health care for all Alaskans. Senate Bill 83 is designed to maintain quality care, slow the inflationary rise in health care cost, and reduce the number of uninsured and underinsured Alaskans.

HEALTH CARE COST CONTAINMENT INFORMATION PACKET

-Paper from Senator Duncan concerning access to affordable health care for all Alaskans.

-Minutes from Senate Labor & Commerce hearing on SB 83 on April 15, 1991.

-Press releases with background information from the State of Maryland's Health Services Cost Review Commission on the successful implementation of hospital rates which have cut costs dramatically. These figures are highlighted on the first page of the release.

-A press release from the National Governor's Association announcing that a report on controlling health care costs will be issued later this year by its' Task Force on Health Care. The report will include an approach similar to the approach in Senator Duncan's legislation which is highlighted on the bottom of page 3.

-A report by the Families USA Foundation entitled, "To the Rescue: Toward Solving America's Health Cost Crisis" which outlines a goal of holding health care expenses to an inflation rate of 6.6% annually and recommends establishment of system wide rate controls for providers. This information is highlighted on pages 5 and 6 of the report.

-Another report by the Families USA Foundation entitled, "Emergency: Rising Health Costs in America", which outlines the dramatic increase in the ranks of the uninsured. Pertinent information is highlighted on pages 2 through 5. Table 4 in the back of the report estimates Alaska's uninsured population at about 86,000 in 1988.

-A report by AETNA which estimates a 20% increase to the State of Alaska in the cost of health care per year.

-An article in the March 1, 1991, edition of the Anchorage Times regarding the efforts by Blue Cross in Alaska to control health care costs through a participating provider agreement that limits physician's fees.

-Editorials by the Anchorage Daily News and the Alaska Journal of Commerce in support of Senator Duncan's legislation. Journal of Commerce article on issue is also attached.

-An editorial by the Anchorage Times in opposition to Senator Duncan's legislation and Senator Duncan's response. Printed with Senator Duncan's response were the views of Mr. Harlan Knudson, President of the Alaska State Hospital and Nursing Home Association and Dr. Raymond Schalow, Executive Director of the Alaska State Medical Association.

-A May 1991 SENIOR VOICE article concerning necessary changes in our health care system.

-A report on the uninsured population submitted to the American Association of Retired Persons.

-A report by Dr. Henry Simmons of the National Leadership Commission on Health Care.

-A column by Lou Cannon of the Washington Post on Hawaii's health care system.

-A series of articles in the Alaska press on SB 83.

-Copies of various endorsements of the concepts proposed in SB 83.

-The final report of the Alaska Health Care Cost Containment Task Force to the Legislature.

DIVISION OF LEGAL SERVICES

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MEMORANDUM March 30, 1992

SUBJECT: Sectional analysis - (CSSB 83( ))

TO: Senator Jim Duncan

FROM: Michael F. Ford
Legislative Counsel

The following is a sectional analysis of CSSB 83( ), dated March 27, 1992:

Section 1 - Purpose.

Section 2 - Requires a copy of certain certificate of need applications be provided to the Alaska Health Resources Authority.

Section 3 - Prohibits certain certificates of need from being issued until a cost determination is received from the Alaska Health Resources Authority.

Section 4 - Requires the Legislative Budget and Audit Committee to provide for an annual audit and performance evaluation of the Alaska Health Resources Authority.

Section 5 - Requires the legislature to appropriate funds for the operation of the Alaska Health Resources Authority.

Section 6 - Places the executive director of the authority in the exempt service.

Section 7 - Subjects the employees of the authority to the conflict of interest chapter AS 39.50.

Section 8 -

Sec. 44.87.010 - Creates the authority as a public corporation in the Department of Administration. Describes the purpose of the authority.

Sec. 44.87.020 - Establishes the board of directors and provides for organization of board.

Sec. 44.87.030 - Establishes the general powers of the authority.

Sec. 44.87.040 - Establishes the duties of the board, including requiring an annual report.

Sec. 44.87.050 - Provides for certain staff of the authority and for professional service contracts.

Sec. 44.87.060 - Requires the authority to develop and periodically update a statewide health care data system. Specifies the data system has a base year of 1991 and requires certain specific expenditures be included in the data system.

Sec. 44.87.070 - Requires the authority to develop statewide health care budget and expenditure limits. Establishes the base year as 1991 and requires that the limits be adjusted for inflation and for certain factor specified under subsection (c).

Sec. 44.87.080 - Requires the board to convene representatives from each class of health care provider to negotiate recommendations for required reimbursement schedules. Requires the board to adopt a good faith negotiating process and specifies that each class have a three-person negotiating team. Allows the board to appoint a negotiating team for a class of health care providers who fail to select a negotiating team. Provides that if the negotiating process fails to result in a recommended reimbursement schedule, the board shall establish the required schedule by regulation.

Sec. 44.87.090 - Requires that the authority establish reimbursement schedules, that the schedules use a base year of 1991, and that the schedules be adjusted as provided under AS 44.87.070(b) and (c). Requires that the schedules incorporate certain specified criteria for hospitals, physicians and other health care services. Requires the schedules include recommendations resulting from health care provider negotiations under AS 44.87.080.

Sec. 44.87.100 - Requires that health care providers must comply with the expenditure limits and reimbursement schedules established by the board. Prohibits submission of a charge for health care services that fails to comply with limits or schedules established by the authority and provides that a person receiving a charge that violates the limits or schedules established by the authority may not be required to pay the charge.

Sec. 44.87.110. - Requires a health care provider, insurer, or agency of the state to provide certain information if requested by the authority.

Sec. 44.87.120 - Allows the authority to procure or offer group health insurance to a resident or an employer without coverage or for whom the authority can provide more cost effective insurance. Allows the authority to establish pools for purposes of group health insurance. Requires that insurance be obtained from licensed insurers, except when acting as a self-insurer. Requires the authority to solicit proposals for required coverage and obtain approval from the legislature, before acting as a self-insurer.

Sec. 44.87.130 - Creates a fund for the authority to expend to carry out duties imposed under AS 44.87.

Sec. 44.87.140 - Provides for the collection and investment of insurance premiums by the authority.

Sec. 44.87.150 - Provides that certain public records statutes apply to the authority, except for certain medical records. Provides that the authority is subject to the Administrative Procedure Act.

Sec. 44.87.900 - Definitions.

Section 9 - Required report from the authority to the legislature.

Section 10 - Establishes a phased transition period under which the provisions of AS 44.87 would be implemented.

Section 11 - Delayed effective date for health care provider negotiation process.

Section 12 - Delayed effective date for mandatory health care provider compliance with expenditure limits and reimbursement schedules.

Section 13 - Effective date.

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Mail Stop 3101

MEMORANDUM May 7, 1991

SUBJECT: Sectional analysis - CSSB 83(L&C)

TO: Senator Jim Duncan

FROM: Michael F. Ford
Legislative Counsel

The following is a section by section analysis of CSSB 83(L&C):

Section 1 - Purpose.

Section 2 - Requires certificate of need applications, except for temporary or emergency applications, to be provided to the authority.

Section 3 - Provides that certificates of need, except for temporary or emergency certificates, may not be issued until the authority makes a determination regarding the effect of the certificate on group health insurance.

Section 4 - Requires the Legislative Budget and Audit Committee to perform an annual audit of the authority.

Section 5 - Requires the legislature to appropriate funds for the operation of the authority.

Section 6 - This provision places employees of the authority in the exempt service.

Section 7 - This provision subjects the employees of the authority to the conflict of interest chapter AS 39.30.

Section 8 -

Sec. 44.87.010 - Creates the authority and requires the creation and phased implementation of reimbursement systems and utilization standards established by the authority, within municipalities that have a population of 20,000 or more by July 1,

1992, and in municipalities with less than 20,000 in population, by July 1, 1995. Also, all reimbursement systems and utilization standards created within a municipality that has a population of 20,000 or more must be operational by December 31, 1993 or by July 1, 1995, if the municipality has less than 20,000 in population. Also, a requirement is imposed under subsection (c), that all health care providers or persons submitting a claim for services provided to a public employer or public employee, must use the reimbursement systems or utilization standards if established by the authority. Other employers may elect to use the reimbursement systems and utilization standards, if the use is approved by the authority. Also establishes reimbursement components under (a)(3). Beginning July 1, 1992, the authority is required to design a new health insurance program for certain employers who elect to participate, under subsections (e), (f) and (g). The authority is required to provide public notice and accept public comments under subsection (h).

Sec. 44.87.015 - Requires cooperation by state agencies.

Sec. 44.87.020 - Establishes the board and its organization.

Sec. 44.87.030 - Establishes the general powers of the authority.

Sec. 44.87.040 - Establishes the duties of the board, including requiring an annual report.

Sec. 44.87.050 - Provides for certain staff of the authority and for service contracts.

Sec. 44.87.060 - Allows the authority, after July 1, 1992, to procure insurance for an individual or employer without insurance or with insurance that is more costly than could be provided by the authority. Allows the authority to establish group insurance pools for employees who elect to participate, requires coverage for eligible employees and dependents, and requires employees who elect to participate to use the reimbursement systems and utilization standards established by the authority. This section also imposes restrictions on when the authority can act as a self-insurer, in subsection (c) and (d), and allows creation of pools or subpools to track insurance costs, in subsection (e).

Sec. 44.87.070 - Creates a fund for the authority to expend to carry out duties imposed by this chapter.

Sec. 44.87.080 - Provides for the collection and investment of insurance premiums.

Sec. 44.87.090 - Allows participation by the state, a municipality or a school district in the group insurance provided by the authority. Requires participation after initial entry into the system, unless a waiver is granted. Sets out criteria for granting a waiver.

Sec. 44.87.100 - Definitions.

Section 9 - Report.

Section 10 - Effective date.

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91-087.mai

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MEMORANDUM March 21, 1991

SUBJECT: Sectional analysis - CSSB 83(L&C) and CSSB 83( )

TO: Senator Drue Pearce

FROM: Michael F. Ford
Legislative Counsel

The following is a section by section analysis of CSSB 83(L&C), with a comparison to CSSB 83( ) that reflects the changes made in the blank substitute:

Section 1 - Purpose.

The blank CS contains minor changes in paragraphs (1), (2) and (9), adds new paragraph (3), and deletes paragraph (8).

Section 2 - Requires certain certificate of need applications to be provided to the authority.

No change.

Section 3 - Provides that certain certificates of need may not be issued until the authority makes a determination regarding the effect of the certificate on group health insurance.

No change.

Section 4 - Requires the legislature to appropriate funds for the authority.

This section is now section 5 in the blank CS. Section 4 is a provision requiring an annual audit by the Legislative Budget and Audit Committee.

Section 5 - This provision places employees of the authority in the exempt service.

No change.

Section 6 - This provision subject the employees of the authority to the conflict of interest chapter AS 39.30.

No change.

Section 7 -

Sec. 44.87.010 - Creates the authority and requires establishment of a reimbursement system and utilization standards. Requires the state, a municipality, or a school district to use the reimbursement system and utilization standards. Allows other employers to participate with approval of the authority. Limits the authority's ability to establish group health insurance pools, to not earlier than July 1, 1992. Allows participation by an eligible state program.

The blank CS requires, by July 1, 1992, the creation and phased implementation of reimbursement systems and utilization standards established by the authority, within municipalities that have a population of 20,000 or more. Also, all reimbursement systems and utilization standards created within a municipality that has a population of 20,000 or more must be operational by December 31, 1993. Also, a requirement is imposed under subsection (c), that all health care providers or persons submitting a claim for services provided to a public employer or public employee, must use the reimbursement systems or utilization standards if established by the authority. Other employers may elect to use the reimbursement systems and utilization standards, if the use is approved by the authority. The blank CS also imposes new deadlines on the authority in (a)(1), requires new reimbursement components under (a)(2) and (3), and inserted paragraphs (a)(4) and (5). The blank CS also requires the authority to design a new health insurance program for certain employers who elect to participate, in subsections (e), (f) and (g). The authority is required to provide public notice and accept public comments under subsection (h).

Sec. 44.87.015 - Requires cooperation by state agencies.

No change.

Sec. 44.87.020 - Establishes the board and its organization.

No change.

Sec. 44.87.030 - Establishes the general powers of the authority.

No change.

Sec. 44.87.040 - Establishes the duties of the board, including requiring an annual report.

The blank CS adds paragraphs (5) - (9), that impose new duties on the board.

Sec. 44.87.050 - Provides for certain staff of the authority and for service contracts.

No change.

Sec. 44.87.060 - Gives the authority the power to procure insurance or to act as a self-insurer. Imposes certain requirements on the insurance obtained by the authority.

The blank CS rewrites subsection (a) to limit the authority to providing insurance for an individual or employer without insurance or with insurance that is more costly than could be provided by the authority. This section also adds a new subsection (b) that allows the authority to establish group insurance pools for employees who elect to participate, requires coverage for eligible employees and dependents, and requires employees who elect to participate to use the reimbursement systems and utilization standards established by the authority. This section also imposes new restrictions on when the authority can act as a self-insurer, in subsection (c) and (d), and allows creation of pools or subpools to track insurance costs, in subsection (e).

Sec. 44.87.070 - Creates a fund for the authority to expend to carry out duties imposed by this chapter.

No change.

Sec. 44.87.080 - Provides for the collection and investment of insurance premiums.

No change.

Sec. 44.87.090 - Allows participation by the state, a municipality or a school district in the group insurance provided by the authority. Requires participation after initial entry into the system, unless a waiver is granted. Sets out criteria for granting a waiver.

No change.

Sec. 44.87.100 - Definitions.

The blank CS contains two new definitions, of "full-time employee" and "public employer" and made minor changes in the definition of "reimbursement system".

Section 8 - Report.

No change.

Section 9 - Effective date.

No change.

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91-198.plm

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Ford
4/27/92

CS FOR SENATE BILL NO. 83 ( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATORS DUNCAN, Zharoff, Rodey

A BILL

FOR AN ACT ENTITLED

"An Act relating to Alaska State Health Resources Authority; and providing for an effective date."

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

* Section 1. PURPOSE AND INTENT. (a) The purpose of this Act is to collect data necessary for the

(1) development of recommended statewide health care expenditure limits, and access and quality goals;

(2) development of recommended reimbursement schedules, utilization standards, and other measures that may include increased utilization of managed care, increased utilization of alternatives to institutionalization, and procedures for the allocation and limitation of capital investment necessary to achieve health care budget goals, while maintaining quality, and improving accessibility to health care;

(3) performance of studies, issuance of reports, and gathering of data to contribute to the objective of providing access to high quality affordable health care; and

(4) performance of any other activities determined to be necessary to further the goal of making available affordable, accessible, high quality health care in the state.

(b) It is the intent of this Act to require the legislature to amend this Act before the Alaska State Health Resources Authority implements statewide health care expenditure limits, reimbursement schedules, or utilization standards.

* Sec. 2. AS 24.20.206 is amended to read:

Sec. 24.20.206. DUTIES. The Legislative Budget and Audit Committee shall

(1) report to the legislature its recommendations relating to the confirmation of appointees to the Board of Trustees of the Alaska Permanent Fund Corporation;

(2) annually review the long-range operating plans of all agencies of the state which perform lending or investment functions;

(3) review periodic reports from all agencies of the state which perform lending or investment functions;

(4) present a complete report of investment programs, plans, performance, and policies of all agencies of the state which perform lending or investment functions to the legislature within 30 days after the convening of each regular session;

(5) present to the legislature within 30 days after the convening of each regular session a review of the report of the governor under AS 37.07.020(d) with recommendations for needed legislation;

(6) in conjunction with the finance committee of each house recommend annually to the legislature the investment policy for the general fund surplus and for the income from the permanent fund;

(7) provide for an annual post audit and annual operational and performance evaluation of the Alaska Permanent Fund Corporation investments and investment programs;

(8) provide for an annual operational and performance evaluation of the Alaska Housing Finance Corporation and the Alaska Industrial Development and Export Authority; the performance evaluation shall include, but is not limited to, a comparison of the effect on various sectors of the economy by public and private lending, the effect on resident and nonresident employment, the effect on real wages, and the effect on state and local operating and capital budgets of the programs of the Alaska Housing Finance Corporation and the Alaska Industrial Development and Export Authority;

(9) provide for an annual post audit and annual operational and performance evaluation of the Alaska State Health Resources Authority.

* Sec. 3. 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. 4. AS 39.25.110 is amended by adding a new paragraph to read:

(30) the executive director of the Alaska State Health Resources Authority.

* Sec. 5. AS 39.50.200(b) is amended by adding a new paragraph to read:

(54) Alaska State Health Resources Authority (AS 44.87).

* Sec. 6. AS 44 is amended by adding a new chapter to read:

CHAPTER 87. ALASKA STATE HEALTH RESOURCES AUTHORITY.

Sec. 44.87.010. AUTHORITY CREATED; PURPOSE. (a) The Alaska State Health Resources Authority is established. The authority is a public corporation and an instrumentality of the state within the Department of Administration but has a legal existence independent of and separate from the state.

(b) The purpose of the authority is to collect data necessary to recommend

(1) statewide health care expenditure limits, and access and quality goals;

(2) reimbursement schedules, and utilization standards;

(3) a program to provide access to health care insurance or services for all residents of the state; and

(4) where possible, coordination of the delivery, quality, access, and financing of health care in the state.

(c) The authority may not implement statewide health care expenditure limits, reimbursement schedules, or utilization standards until authorized by the legislature after January 31, 1994.

Sec. 44.87.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The authority shall be managed by a board of directors composed of five members appointed by the governor. In appointing members to the board, the governor shall ensure that

(1) the interests of health care providers and purchasers are fairly represented; and

(2) a majority of the board are experts in health care issues and fairly represent the interests of the general public in having access to quality and affordable health care.

(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. 44.87.030. GENERAL POWERS. The authority may

(1) sue or be sued;

(2) enter into contracts or agreements;

(3) establish administrative or accounting procedures;

(4) collect, invest, and disburse funds;

(5) charge fees for providing administrative services;

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

Sec. 44.87.040. DUTIES OF BOARD; ANNUAL REPORT. The board shall

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

(2) analyze the health care needs of the state population that is uninsured or underinsured;

(3) provide recommendations to the legislature for a systematic approach or plan with alternatives including financing alternatives that may be considered to assure access to affordable quality health care for all state residents; the recommendations must be updated each year.

Sec. 44.87.050. 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. The executive director is in the exempt service under AS 39.25.110. Employees of the authority other than the executive director are in the classified service under AS 39.25.100. 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. 44.87.060. STATEWIDE HEALTH CARE DATA SYSTEM. (a) The authority shall develop and periodically update a data system that indicates the total amount expended on health care for residents of the state. To the extent practicable, the data system base year for health care expenditures shall be 1991 and must contain a separate expenditure breakdown for

(1) hospital services;

(2) physician services;

(3) laboratory services;

(4) pharmaceutical products;

(5) durable medical equipment; and

(6) other health services that the authority determines appropriate.

(b) In addition to the data collected under (a) of this section, the authority shall collect data on the following:

(1) the aging of the population and other factors that may affect the demand for health care in the future;

(2) general inflation factors and the costs related to inflation in labor and other inputs used to produce health services;

(3) technological advances that may increase or decrease health care costs;

(4) appropriate improvements in health care productivity;

(5) feasible reductions in unnecessary health care;

(6) the need to assure that all sectors of the population have adequate access to health care services;

(7) the effect and availability of statewide expenditure goals on the quality of health care; and

(8) other factors that the authority determines appropriate.

Sec. 44.87.070. STATEWIDE HEALTH CARE EXPENDITURE LIMITS. (a) The authority shall recommend a statewide health care budget and expenditure limits, based on the data obtained under AS 44.87.060. To the extent practicable, the base year for the statewide health care budget and expenditure limits shall be 1991.

(b) The authority shall annually adjust the recommended health care expenditure limits developed under this section to reflect changes in the Consumer Price Index for all urban consumers for all items complied by the Bureau of Labor Statistics, United States Department of Labor, for the preceding calendar year. The annual index for 1991 is the reference base index.

(c) In developing recommended expenditure limits applicable in a current year the authority shall adjust the expenditure limits for the following factors if these factors would affect the expenditure limits:

(1) changes in the size or demographic characteristics of the population of the state;

(2) changes in technology and health care delivery that may increase or decrease health care costs;

(3) reduction in unnecessary health care;

(4) access to adequate health care services;

(5) costs of medical malpractice insurance;

(6) administrative cost reduction; and

(7) other factors determined appropriate by the authority.

(d) Health care expenditure limits recommended under this section must, to the extent practicable,

(1) include a separate expenditure limit for each health care service described under AS 44.87.060(a) and may include limits for other subcategories of health care services that the authority determines appropriate;

(2) be based on the following criteria as adjusted under (b) and (c) of this section:

(A) for hospitals and health care facilities, the limit must be based on actual costs in the base year;

(B) for health care providers other than hospitals and health care facilities, the limit must be based on the actual expenditures or payments in the base year;

(C) for other health care services not described in (A) or (B) of this paragraph, limits shall be developed as determined by the authority.

Sec. 44.87.080. ESTABLISHMENT OF REIMBURSEMENT SCHEDULES. Reimbursement schedules recommended by the authority shall use a base year of 1991 to the extent practicable, and incorporate the following criteria as adjusted by factors described in AS 44.87.070(b) and (c):

(1) for hospitals, the schedule shall be established to allow payment on a per discharge basis and utilize diagnosis related groups as the classification system; the schedule must reflect uncompensated care or payments received from public programs that are not sufficient to cover costs;

(2) for health care facilities other than hospitals, the schedule shall be based on the actual cost of the service in the base year;

(3) for physician services, the schedule must include a resource based relative value scale;

(4) for other health care services not described in (1) - (3) of this subsection, schedules shall be developed as determined by the authority.

Sec. 44.87.090. REQUIRED COOPERATION IN EXPENDITURE LIMIT AND GOAL DEVELOPMENT. When requested by the authority, a health care provider, insurer, or an agency of the state shall collect and provide information possessed by the health care provider, insurer, or agency, necessary to the development and revision of the health care expenditure, access, and quality goals established by the authority.

Sec. 44.87.100. PUBLIC RECORDS; PROCEDURES. The provisions of AS 09.25.110 - 09.25.120 apply to records of the authority, except for medical records that identify an individual. The Administrative Procedure Act (AS 44.62) applies to the authority.

Sec. 44.87.900. 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) "health care provider" means an acupuncturist licensed under AS 08.06; a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.72; a pharmacist licensed under AS 08.80; a physical therapist or occupational therapist licensed under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate licensed under AS 08.86; and a hospital as defined in AS 18.20.130, including a governmentally owned or operated hospital; and an employee of a health care provider acting within the course and scope of employment;

(4) "health care services" means services for medical or dental care or hospitalization, furnished for the purpose of alleviating, curing, or healing human illness, injury, or physical disability;

(5) "hospital" has the meaning given in AS 18.20.130;

(6) "insurer" has the meaning given in AS 21.90.900;

(7) "reimbursement schedules" means a schedule or system that streamlines or results in cost efficient payments to health care providers, and includes a schedule of maximum allowable reimbursement for health care services;

(8) "resident" means a person who is eligible for a permanent fund dividend under AS 43.23.005;

(9) "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;

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

* Sec. 7. REPORT. The Alaska State Health Resources Authority shall report to the Alaska State Legislature by

(1) March 1, 1993, on the progress made by the authority in establishing recommended health care provider reimbursement systems and utilization standards; and

(2) January 31, 1994, with final recommendations for statewide health care expenditure limits, reimbursement systems, and utilization standards.

* Sec. 8. This Act takes effect immediately under AS 01.10.070(c).

7-LS0305\P
Ford
3/27/92

CS FOR SENATE BILL NO. 83 ( )

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - SECOND SESSION

BY

Offered:
Referred:

Sponsor(s): SENATORS DUNCAN, Zharoff, Rodey

A BILL

FOR AN ACT ENTITLED

"An Act establishing the Alaska State Health Resources Authority; relating to the delivery, quality, access, and financing of health care; requiring the establishment of health care expenditure limits; relating 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 provide for the

(1) development of statewide health care expenditure limits, and access and quality goals;

(2) development of reimbursement schedules, utilization standards, and performance of other activities necessary to achieve expenditure limits developed under (1) of this section;

(3) establishment of reimbursement schedules, utilization standards, and other measures that may include increased utilization of managed care, increased utilization of alternatives to institutionalization, and procedures for the allocation and limitation of capital investment necessary to achieve the health care budget goals, while maintaining quality, and improving accessibility to health care;

New Text Underlined [DELETED TEXT BRACKETED]

(4) preparation and submission to the legislature, and to the general public, of an annual report concerning the success in achieving the limits and goals established under (1) of this section, together with recommendations the authority considers appropriate to further the objectives of providing access to affordable, quality health care for all Alaskans;

(5) establishment of uniform billing and claim forms and mandatory reporting requirements to

(A) measure the success in meeting the limits and goals established under (1) of this section;

(B) permit the authority, to the extent practicable, to analyze data acquired under reporting requirements to assist purchasers and consumers in evaluating the quality and cost of care offered by different providers; and

(C) reduce the administrative cost of the health care system;

(6) recommendation of reimbursement schedules, and other measures as appropriate and consistent with expenditure limits developed by the authority to ensure access to quality affordable health care under health insurance programs and programs under which the state provides or enters into contracts for the delivery of health care and to minimize cost-shifting;

(7) performance of studies, issuance of reports, and gathering of data to contribute to the objective of providing access to high quality affordable health care; and

(8) performance of any other activities determined to be necessary to further the goal of making available affordable, accessible, high quality health care in the state.

* **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 citizens of this state. **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 24.20.206 is amended to read:

Sec. 24.20.206. DUTIES. The Legislative Budget and Audit Committee shall

(1) report to the legislature its recommendations relating to the confirmation of appointees to the Board of Trustees of the Alaska Permanent Fund Corporation;

(2) annually review the long-range operating plans of all agencies of the state which perform lending or investment functions;

(3) review periodic reports from all agencies of the state which perform lending or investment functions;

(4) present a complete report of investment programs, plans, performance, and policies of all agencies of the state which perform lending or investment functions to the legislature within 30 days after the convening of each regular session;

(5) present to the legislature within 30 days after the convening of each regular session a review of the report of the governor under AS 37.07.020(d) with recommendations for needed legislation;

(6) in conjunction with the finance committee of each house recommend annually to the legislature the investment policy for the general fund surplus and for the income from the permanent fund;

(7) provide for an annual post audit and annual operational and performance evaluation of the Alaska Permanent Fund Corporation investments and investment programs;

(8) provide for an annual operational and performance evaluation of the Alaska Housing Finance Corporation and the Alaska Industrial Development and Export Authority; the performance evaluation shall include, but is not limited to, a comparison of the effect on various sectors of the economy by public and private lending, the effect on resident and nonresident employment, the effect on real wages, and the effect on state and local operating and capital budgets of the programs of the Alaska Housing Finance Corporation and the Alaska Industrial

Development and Export Authority;

(9) provide for an annual post audit and annual operational and performance evaluation of the Alaska State Health Resources Authority.

*** 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) the executive director of the Alaska State Health Resources Authority.

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

(54) Alaska State Health Resources Authority (AS 44.87).

*** Sec. 8.** AS 44 is amended by adding a new chapter to read:

CHAPTER 87. ALASKA STATE HEALTH RESOURCES AUTHORITY.

Sec. 44.87.010. AUTHORITY CREATED; PURPOSE. (a) The Alaska State Health Resources Authority is established. The authority is a public corporation and an instrumentality of the state within the Department of Administration but has a legal existence independent of and separate from the state.

(b) The purpose of the authority is to

(1) develop statewide health care expenditure limits, and access and quality goals;

(2) implement statewide health care expenditure limits through reimbursement schedules and utilization standards;

(3) develop a program to provide access to health care insurance or services for all residents of the state; and

(4) where possible, coordinate the delivery, quality, access, and financing of health care in the state.

Sec. 44.87.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The authority shall be managed by a board of directors composed of nine members appointed by the governor. In appointing members to the board, the governor shall ensure that

(1) the interests of health care providers and purchasers are fairly represented; and

(2) a majority of the board are experts in health care issues and fairly represent the interests of the general public in having access to quality and affordable health care.

(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. 44.87.030. GENERAL POWERS. The authority may

(1) 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 AS 21;

(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. 44.87.040. DUTIES OF BOARD; ANNUAL REPORT. The board shall

(1) establish reimbursement schedules and utilization standards necessary to

implement this chapter;

(2) develop uniform billing and common claims forms for health care providers and patients;

(3) in procuring or providing group health insurance allowed under this chapter, procure or provide comprehensive coverage at the lowest possible cost per participant;

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

(5) 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;

(6) establish a grievance procedure to resolve disputes between the authority and health care providers or participants;

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

(8) analyze the health care needs of the state population that is uninsured or underinsured;

(9) provide recommendations to the legislature for a systematic approach or plan with alternatives including liabilities and financing alternatives that may be considered to assure access to affordable quality health care for all state residents; the recommendations must be updated each year.

Sec. 44.87.050. 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. The executive director is in the exempt service under AS 39.25.110. Employees of the authority other than the executive director are in the classified service under AS 39.25.100. 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. 44.87.060. STATEWIDE HEALTH CARE DATA SYSTEM. (a) The authority shall develop and periodically update a data system that indicates the total amount expended on health care for residents of the state. To the extent practicable, the data system base year for health care expenditures shall be 1991 and must contain a separate expenditure breakdown for

(1) hospital services;

(2) physician services;

(3) laboratory services;

(4) pharmaceutical products;

(5) durable medical equipment; and

(6) other health services that the authority determines appropriate.

(b) In addition to the data collected under (a) of this section, the authority shall collect data on the following:

(1) the aging of the population and other factors that may affect the demand for health care in the future;

(2) general inflation factors and the costs related to inflation in labor and other inputs used to produce health services;

(3) technological advances that may increase or decrease health care costs;

(4) appropriate improvements in health care productivity;

(5) feasible reductions in unnecessary health care;

(6) the need to assure that all sectors of the population have adequate access to health care services;

(7) the effect and availability of statewide expenditure goals on the quality of health care; and

(8) other factors that the authority determines appropriate.

Sec. 44.87.070. STATEWIDE HEALTH CARE EXPENDITURE LIMITS. (a) The authority shall develop statewide health care budget and expenditure limits, based on the data obtained under AS 44.87.060. To the extent practicable, the base year for the statewide health care budget and expenditure limits shall be 1991.

(b) The authority shall annually adjust the health care expenditure limits developed under this section to reflect changes in the Consumer Price Index for all urban consumers for all items complied by the Bureau of Labor Statistics, United States Department of Labor, for the preceding

calendar year. The annual index for 1991 is the reference base index.

(c) In developing expenditure limits applicable in a current year the authority shall adjust the expenditure limits for the following factors if these factors would affect the expenditure limits:

(1) changes in the size or demographic characteristics of the population of the state;

(2) changes in technology and health care delivery that may increase or decrease health care costs;

(3) reduction in unnecessary health care;

(4) access to adequate health care services;

(5) costs of medical malpractice insurance;

(6) administrative cost reduction; and

(7) other factors determined appropriate by the authority.

(d) Health care expenditure limits developed under this section must, to the extent practicable,

(1) include a separate expenditure limit for each health care service described under AS 44.87.060(a) and may include limits for other subcategories of health care services that the authority determines appropriate;

(2) be based on the following criteria as adjusted under (b) and (c) of this section:

(A) for hospitals and health care facilities, the limit must be based on actual costs in the base year;

(B) for health care providers other than hospitals and health care facilities, the limit must be based on the actual expenditures or payments in the base year;

(C) for other health care services not described in (A) or (B) of this paragraph, limits shall be developed as determined by the authority.

Sec. 44.87.080. REQUIRED HEALTH CARE PROVIDER NEGOTIATION. (a) The board shall convene representatives from each class of health care providers to negotiate recommendations for the reimbursement schedules required under AS 44.87.090. A recommendation may not be submitted to the board unless it meets the expenditure limits established under AS 44.87.070. The board shall adopt regulations to establish a good faith negotiating process.

(b) Negotiations required under (a) of this section

(1) shall be conducted annually, shall commence on or before January 1, and shall be completed on or before March 31 unless the board extends the time for completing the negotiation process;

(2) must include an attempt to agree on recommendations to be submitted to the board for reimbursement schedules required under AS 44.87.090;

(3) shall endeavor to recommend reimbursement schedules that, if implemented, will result in the achievement of the expenditure limits established under AS 44.87.070.

(c) Each health care provider class shall be responsible for providing a three-person negotiating team to represent that class in negotiations required under this section. A negotiating team may not represent a class of health care providers unless the team presents a petition to the authority indicating that at least 50 percent of the health care providers in that class have consented to representation by that negotiating team. A petition required under this subsection shall be submitted annually on or before January 1.

(d) If a class of health care providers fails to select a negotiating team as required by this section, the board shall appoint a three-person negotiating team to represent health care providers in that class.

(e) A reimbursement schedule to which a majority of the negotiators agree shall be adopted by the board as provided under AS 44.87.090(b). If a majority of the negotiators fail to agree on a recommended reimbursement schedule, the board shall adopt regulations establishing reimbursement schedules required under AS 44.87.090.

Sec. 44.87.090. ESTABLISHMENT OF REIMBURSEMENT SCHEDULES. (a) Reimbursement schedules established by the authority shall use a base year of 1991 to the extent practicable, and incorporate the following criteria as adjusted by factors described in AS 44.87.070(b) and (c):

(1) for hospitals, the schedule shall be established to allow payment on a per discharge basis and utilize diagnosis related groups as the classification system; the schedule must reflect uncompensated care or payments received from public programs that are not sufficient to cover costs;

(2) for health care facilities other than hospitals, the schedule shall be based on the actual cost of the service in the base year;

(3) for physician services, the schedule must include a resource based relative value scale;

(4) for other health care services not described in (1) - (3) of this subsection, schedules shall be developed as determined by the authority.

(b) A reimbursement schedule established by the board must include the recommendations resulting from the negotiation process under AS 44.87.080, unless the negotiation process fails to result in recommendations or the authority determines that the recommendations would result in the violation of an expenditure limit established under AS 44.87.070.

Sec. 44.87.100. MANDATORY HEALTH CARE PROVIDER COMPLIANCE. (a) All health care providers in the state shall comply with the expenditure limits established by the authority under AS 44.87.070 and the reimbursement schedules established by the board.

(b) A health care provider may not submit a charge for health care services that fails to comply with this section. A person receiving a charge that does not comply with (a) of this section may not be required to pay that portion of the charge that exceeds the reimbursement schedules established under AS 44.87.090.

Sec. 44.87.110. REQUIRED COOPERATION IN EXPENDITURE LIMIT AND GOAL DEVELOPMENT. When requested by the authority, a health care provider, insurer, or an agency of the state shall collect and provide information possessed by the health care provider, insurer, or agency, necessary to the development and revision of the health care expenditure, access, and quality goals established by the authority.

Sec. 44.87.120. PROCUREMENT OF INSURANCE. (a) The authority may procure and offer a policy or policies of comprehensive group health insurance to a resident or an employer that the authority determines does not have health insurance or for whom health insurance could be more cost effective if procured by the authority. Group health insurance may include coverage for eligible employees and dependents. The authority shall procure the insurance from an insurer authorized to transact business in the state under AS 21.09, or the authority may elect to act as a self-insurer if approved by the legislature and the authority complies with (d) of this section.

(b) The authority may establish a group health insurance pool or pools of eligible residents or employers that elect to participate in the group health insurance procured or provided

by the authority. Coverage provided under this subsection must include eligible dependents of residents and employees.

(c) Except when acting as a self-insurer, the authority shall procure or provide 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.

(d) Before the authority elects to act as a self-insurer, the authority shall solicit proposals for the required coverage from insurers licensed in this state to offer health insurance. If after the proposal process has been completed, the authority determines that the desired coverage or benefits are not available from insurers licensed in this state or the authority can provide the desired coverage and benefits at a lower cost per eligible person, the authority may submit a plan of the intended self-insurance coverage and benefits to the legislature. The authority may not begin acting as a self-insurer until the legislature has approved the self-insurance plan submitted by the authority.

Sec. 44.87.130. 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. 44.87.140. 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. 44.87.150. PUBLIC RECORDS; PROCEDURES. The provisions of AS 09.25.110 - 09.25.120 apply to records of the authority, except for medical records that identify an individual. The Administrative Procedure Act (AS 44.62) applies to the authority.

Sec. 44.87.900. 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) "class" means a group of health care providers who are practicing the same

occupation or profession;

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

(5) "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;

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

(7) "group health insurance" means coverage that may include medical care and treatment, dental care, eye care, and other group health coverage as determined by the authority;

(8) "health care provider" means an acupuncturist licensed under AS 08.06; a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.72; a pharmacist licensed under AS 08.80; a physical therapist or occupational therapist licensed under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate licensed under AS 08.86; and a hospital as defined in AS 18.20.130, including a governmentally owned or operated hospital; and an employee of a health care provider acting within the course and scope of employment;

(9) "health care services" means services for medical or dental care or hospitalization, furnished for the purpose of alleviating, curing, or healing human illness, injury, or physical disability;

(10) "hospital" has the meaning given in AS 18.20.130;

(11) "insurer" has the meaning given in AS 21.90.900;

(12) "participant" means a person who participates in the group health insurance procured or provided by the authority;

(13) "reimbursement schedules" means a schedule or system that streamlines or results in cost efficient payments to health care providers, and includes a schedule of maximum allowable reimbursement for health care services;

(14) "resident" means a person who is eligible for a permanent fund dividend under AS 43.23.005;

(15) "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;

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

* **Sec. 9.** REPORT. The Alaska State Health Resources Authority shall report to the Alaska State Legislature by March 1, 1993, on the progress made by the authority in establishing a health care provider reimbursement systems and utilization standards.

* **Sec. 10.** PHASED TRANSITION PERIOD. Notwithstanding the provisions of AS 44.87, the Alaska State Health Resources Authority shall implement the provisions of AS 44.87 on an orderly and gradual basis as follows:

(1) by July 1, 1993, the authority shall finish collecting data required under AS 44.87.060;

(2) by July 1, 1994, the authority shall complete the statewide health care expenditure budget and reimbursement schedules described in AS 44.87.070 and 44.87.090;

(3) by January 1, 1995, the authority shall implement the expenditure limits established under AS 44.87.070, and the reimbursement schedules and utilization standards required under AS 44.87.040(1) and the uniform billing and common claims forms required under AS 44.87.040(2) shall be in operation.

* **Sec. 11.** AS 44.87.080, enacted in sec. 8 of this Act, takes effect January 1, 1994.

* **Sec. 12.** AS 44.87.100, enacted in sec. 8 of this Act, takes effect January 1, 1995.

* **Sec. 13.** Except as provided in secs. 11 and 12 of this Act, this Act takes effect immediately under AS 01.10.070(c).

1991 LEGISLATION
POSITION PAPER
DEPARTMENT OF ADMINISTRATION

Division Labor Relations **Bill Number** CSSB 83

Bill Title Act relating to the Alaska State Health Resources Authority

Position Statement: Explain briefly what bill does, its impacts and Department's position, i.e., a) support, b) do not support, c) neutral or d) oppose.

We oppose this legislation for budgetary reasons.

This bill would establish the Alaska State Health Resources Authority as a nonprofit incorporated legal entity, within the Department of Administration; the authority is to be managed by nine (9) uncompensated directors appointed by the Governor.

The Alaska State Health Resources Authority would be charged with three (3) primary responsibilities:

1. Issuing recommendations on the effect of certificates of need (AS 18.07.071) on group insurance costs, effective immediately.

2. By July 1, 1992, implement a health care provider reimbursement system and utilization standards; these are mandatory for all public employers and may be voluntarily utilized by other employers.

3. By July 1, 1992, establish a voluntary health insurance pool designed to purchase or provide affordable health insurance.

State agencies involved in health care/health insurance are to cooperate in developing the reimbursement system and utilization standards, through the sharing of information. The authority is to report its progress to the legislature by March 1, 1992, and annually thereafter.

While we support the objectives proposed in this legislation, we must oppose the bill's proposed effective dates because immediate implementation will increase our FY 92 operating budget beyond the level we believe appropriate. The bill is otherwise meritorious. We believe the bill should be given budgetary support in FY 93, along with a cost reduction justification offset.

APPROVED:

Director Bruce Cummings **Division** Labor Relations

Signature Bruce Cummings **Date** 4/1/91

Commissioner Millett Keller

Signature Millett Keller **Date** 4/3/91

(For more information, call Barbara Pritchett 465-2200) Rev. 01/28/91

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MEMORANDUM

State of Alaska

TO: Senator Drue Pearce
Chairperson
Senate Labor & Commerce Committee
Alaska State Senate

DATE: March 1, 1991

FILE NO.:

THRU:

TELEPHONE NO.: (907) 465-2515

SUBJECT: CSSB 83

FROM: Dave Walsh
Director
Division of Insurance
Department of Commerce
and Economic Development

We have reviewed the following documents and they appear to respond to the points and concerns noted in the February 22, 1991 Position Paper from the Department of Commerce and Economic Development attached. The reviewed documents are:

CS for Senate Bill No. 83 (L&C)	Work Draft 7-LS0305\G, Ford, 2/28/91
Amendment to CSSB 83 (L&C)	Work Draft 7-LS0305\G.1, Ford, 2/28/91
Amendment to CSSB 83 (L&C)	Work Draft 7-LS0305\G.2, Ford, 2/28/91
Amendment to CSSB 83 (L&C)	Work Draft 7-LS0305\G.3, Ford, 2/28/91
Amendment to CSSB 83 (L&C)	Work Draft 7-LS0305\G.4, Ford, 2/28/91
Amendment to CSSB 83 (L&C)	Work Draft Page 5 Line 29, Ford, no date

Dep tment of Commerce & Economic Development / POSITION PAPER

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."

This department is in favor of this legislation with the changes noted below.

SB 83 would create a Health Resources Authority in the Department of Administration which would become the purchasing entity or may become the provider of health insurance coverage for state employees, municipal employees, school district employees and other groups electing to participate.

The department recommends the following changes to SB 83.

1. Move Section 4 of the bill from Title 21 to another title.

   This would avoid conflict with the content and purpose of Title 21. Title 21 is designed for the regulation of the business of insurance. Section 4, on the other hand, is designed for the purchase or provision of coverage. These two roles tend to be in conflict with each other. Further, Title 21 is administered and regulated within the Department of Commerce and Economic Development while Section 4 is an authority administered under the Department of Administration.

2. Eliminate regulatory oversight of the authority by the Division of Insurance.

   The regulation of one agency in the executive branch by another agency in the executive branch is not workable. The potential for interagency squabbles is substantially increased and other conditions beyond the regulatory scheme may control and prevail. This arises if the authority elects to become a direct provider of coverage. To a large extent, that should be part of the responsibility of the authority Board of Directors.

3. Provide for legislative oversight of any move to provider status.

   If the authority elects to become a direct provider of coverage, it basically enters an area that has been a subject for private enterprise. Such a move must, therefore, be subject to a process that assures that conditions warrant such a move. This should be done only after appropriate hearings on the specific move and the Legislature has had an opportunity to review the proposal.

4. Expand the report required in page 4 to include complaints against the authority as an element for review.

   The fiscal activities of the authority are a reasonable measure of the financial activities and rate activities of the authority. An equally important activity is one that deals with how the authority treats those it serves. Complaints are one measure of a firm's success in its relations with the public. It should also serve to let the authority and the Legislature know how the public perceives the authority and the coverage it provides.

5. Change the cost-benefit analysis to biannual rather than triannual.

   A greater frequency of cost-benefit analysis is desirable. A two-year period would assure that each Legislature has an opportunity to see and review such information. The three-year approach would skip every other Legislature.

Exec. Asst. II

Glenn A. Olds, Commissioner

Date: 2-22-91

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STATE OF ALASKA

FEB 2 5 1991

WALTER J. HICKEL, GOVERNOR

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

OFFICE OF THE COMMISSIONER

P. O. BOX D
JUNEAU, ALASKA 99811-0800
PHONE: (907) 465-2500

February 25, 1991

Honorable Drue Pearce
Alaska State Senate
P.O. Box V
Juneau, AK 99811

Dear Senator Pearce:

Please accept this letter as a formal retraction of the position paper on SB 83 dated 2/19/91. The most current position paper, dated 2/22/91, is attached.

The original bill analysis was not affected.

Please excuse our ignorance on this procedure. If the Department of Commerce and Economic Development can be of any assistance to you in the future, please do not hesitate to ask.

Sincerely,

Larry Galloway
Special Assistant

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Enclosure
cc: Senator Jim Duncan

08-H2LH

Department of Commerce & Economic Development / POSITION PAPER

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."

This department is not in favor of this legislation as presently written.

SB 83 would create a Health Resources Authority in the Department of Administration which would become the purchasing entity or may become the provider of health insurance coverage for state employees, municipal employees, school district employees and other groups electing to participate.

We believe that this legislation effectively puts the state in the insurance business as either an agent or as an insurer. It will adversely impact competition, and tends to create a monopoly either way. If the authority further concentrates insurance coverage in a single insurer as an agent or elects to become an insurer itself, other private insurers will be unable to continue to provide coverage at a reasonable expense level, thus resulting in higher costs of coverage. The remaining market will be too small to support more than a very few insurers, thus limiting choice and competition. It is unlikely they will be able to compete with the state.

The legislation will adversely impact insurance agents currently making a living at selling health insurance. No data is available to quantify this impact.

- Move AS 21 provisions to another title.
- Expand the report required in page 4 to include complaints as an element for review.
- Change the cost-benefit analysis to biannual rather than triannual.
- Provide for legislative oversight of any move to provider status.
- Eliminate regulatory oversight of the Authority by the Division of Insurance.

Spec. Asst II

Glenn A. Olds, Commissioner

Date: 2-19-91

GAO/DK/dgl8929D
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Health Access & Cost Containment Council

POSITION PAPER
in re: SB 83
by
Joint Health Access and Cost Containment Council
Alaska Hospital & Nursing Home Association
Alaska Hospital Council
Alaska State Medical Association

We do not support Senate Bill 83, and would like to lay out the reasons for our opposition in a joint response by our three organizations, representing Alaska's hospitals, nursing homes and physicians. Our comments concern both the Health Care Cost Containment Task Force Report (or, HCCC Report) to the 17th Legislature, and its outgrowth legislation, SB 83.

We share a deep concern about the crisis of the uninsured and the increasing costs of health care. We have formed a working group to deal with the issues, the Joint Health Access and Cost Containment Council. Health care providers represented by this Council are committed to help solve the problem of ensuring access to health care for all Alaskans; we are equally committed to help find ways to contain health care costs and maximize effectiveness of health care dollars. In our judgment, SB 83 does not adequately address either of these broad commitments.

Before we comment on Senate Bill 83, we must first review the Health Care Cost Containment Task Force Report of February 1991 on which SB 83 is based. The report's major contentions are that Alaska health care costs are skyrocketing, and will be almost $10 billion by the year 2000; and that, the cause of this inflation is provider charges. SB 83 consequently proposes a reduction of those charges as the primary method of controlling health care expenditures. It also proposes, without saying how, to establish utilization standards to reduce the volume of services.

The HCCC Report is so poorly done that it is difficult to critique without redoing all the work. Throughout the report, statements are made without adequate data, sources are not referenced, the method selected for multiple data "adjustments" is not specified, the questionnaires used and the response rates are not shown. The report has an obvious slant, driven by alarmist costs for the year 2000, extrapolated from scanty data using unstated statistical methodology. *Since these projections are central to the HCCC Report's conclusions, it is imperative that the methodology used by fully revealed and completely justified.*

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The projections seem to have been made by taking the rate of increase from a single year --1979-80-- and projecting forward for 20 years of compounded increases. However, the rate of increase on which the projections are based is in marked disagreement with the health care cost inflation rate given by the U.S. Bureau of Labor Statistics in the Consumer Price Index (CPI) for 1985-89. (See attached). These CPI figures actually show that the rate of increase in Anchorage is approximately one-half that shown in the Task Force's Report. It also shows that Alaska's rate is in line with the rate of medical inflation nationwide. *In fact, as the CPI shows, Alaska's rates in the recent past have increased more slowly than U.S. rates.*

The report fails to address other Alaska-specific factors impinging on cost increases. For example, during the 1970's and 1980's Alaska medicine was intent on catching up with the rest of the country in order to create the medical and technological infrastructure already in place elsewhere in the United States. In response to strong public demand, the health care community built coronary and intensive care units, developed an adequate emergency medical services and transport system, built newborn and pediatric intensive care units, acquired CT scanners and so on. Further the state greatly expanded the Pioneer Home system, nursing homes and schools, public health nursing and village aide programs; and thereby created increased expectations in rural and bush Alaska for high quality local services. These represented huge capital outlays and have clearly driven the costs of medical care upwards in Alaska.

Had these expenditures not been made, Alaskans would now be complaining loudly that our medical system is backward and inadequate, and that we need to spend the money immediately to improve it. *The money was spent, and it should have been spent--Alaska was a medically underdeveloped territory. These expenditures severely skew the Alaska cost increase curve.* The skewing is not automatically bad--it's just a reality of what it costs to cease being a medical backwater of Seattle. As the CPI figures show, now that we have made our initial investment, our rate of cost increases has slowed to keep step with the rest of the nation.

One of the most significant developments in health care insurance costs in Alaska is almost completely ignored by the HCCC Report: namely, that $20 million was saved in 1990-91 for state employee health insurance expenditures without any legislation at all and without the development of a huge state bureaucracy. During this period, some common modes of controlling costs were instituted: pre-admission review, effective case management and some increase in employee financial participation. Yet the report fails to take this decrease into account in making its alarmist extrapolations about state employee health costs in the year 2000. In fact, if we use the report's simplistic projection model, and take the very latest percentage change in rates, then project it linearly forward to 2000, we find predicted health care costs for 2000 *lower* than those of 1990! *An unlikely event, but the result of simplistic statistical modeling.*

The HCCC Report only gives lip service to other factors impinging on health care cost increases, even though these overshadow by far the effect of provider charges. Some of these other factors include: ever-growing social expectations -- and patient demands -- for the full use of every resource on every problem, coupled with capital-intensive technological breakthroughs; professional liability and defensive medicine issues; the huge resources spent to preserve life born too soon and to put off death for the mortally ill; and the unanticipated and massive health care expenditures resulting from the AIDS, violence and cocaine epidemics. These are all given only perfunctory attention, even though we providers see these as the real drivers of health care costs increases.

Purported to be a response to the problems identified in the HCCC Report, SB 83 does not meaningfully address the problem the Task Force identified as highest priority: the paramount question of access to care for the uninsured and underinsured. This is surprising, since the HCCC Report claims growth in this group from 40,000 to 90,000 in the last few years. And furthermore, publicity about SB 83 implies that the bill addresses this problem. In fact, SB 83 specifies neither how nor when this group will have health insurance, only that the problem will be addressed after July 1, 1992.

Despite the report's stated interest in reducing cost shifting, SB 83 will actually exacerbate the problem. It will further erode access and quality of care by further jeopardizing the economic viability of Alaska's rural hospitals. Already, many of these hospitals are serving a small number of patients, and barely make ends meet. Rural physicians depend on the existence of rural hospitals and nursing homes for a substantial part of their practice activity. Every patient without insurance generates costs for the hospitals and physicians, which are either included in charges to other patients who can pay, or are taken as losses by the hospitals and physicians.

The pool of employees covered under SB 83's Health Resources Authority (HRA) would be the last major group which can help bear the costs of care for the uninsured. *Medicaid and Medicare reimbursement already is at or below real cost.* If the HRA lowers the rate it pays for care of its beneficiaries, the costs for taking care of the uninsured cannot be passed along to others, nor made to vanish. The costs will be there, and will increase the losses taken by the hospitals, and by the physicians. The losses will reduce the margin of free care which health care providers will be able to provide to those with no resources, or even tip the fragile balance of financial viability of small hospitals and their physicians. These obviously make the problem of access even worse.

The HCCC Report's reference to the importance of controlling the costs of defensive medicine is ignored in SB 83. There is nothing in the way of tort reform, or any other solution. Some individual physicians are paying more than $100,000 a year for professional liability insurance. A family practitioner who agrees to deliver babies may pay more than $1000 per baby delivered for the obstetrical portion of his/her malpractice insurance. Some authorities estimate that the cost of medical care is inflated by as much as one-third by defensive medicine, which is further encouraged with each huge judgement or settlement. And the spiral of medical costs continues upwards.

The heart of SB 83 is fixing provider charges and establishing "utilization standards." Careful historical analysis of the establishment of fee schedules reveals almost nothing but failures. The establishment of fee ceilings invariably results in further inflationary pressures, as the ceiling automatically becomes the new "floor" which all providers will automatically charge, even those whose charges were originally lower than the ceiling. *We have cited source articles in our bibliography.* The establishment, maintenance and periodic revision of a fee schedule is a complex and costly undertaking, requiring a sizeable bureaucracy.

Our experience with fee schedules has been unpleasant. Fee schedules under other programs, which at first appeared fair, and based on fair market rates, increasingly have become provider's-cost-based, and then payor's-budget-based, and so paper-laden, complicated and slow that no payment is sometimes better than the costs of collection. Fee schedules exacerbate access to care because some providers choose not to participate.

What would the establishment and implementation of utilization standards really mean? First, there currently *are* no generally accepted standards -- medicine is not an exact science. Some work has begun in this area, but it is early and largely untested. Second, assuming that such standards can be developed, then a bureaucracy must be established and hired to implement and enforce them. Due process for beneficiaries and providers must be developed and maintained. A large professional and paralegal bureaucracy will have to be established, which will likely cost more to sustain than whatever minimal savings may be realized

Finally, SB 83 creates a government-run insurance bureau, whether or not the state actually gets into the direct insurance business of receiving premiums, reviewing claims, and making payments.

In short, SB 83 certainly will create a large bureaucracy and in our opinion is unlikely to reduce the cost of medical care in Alaska at all.

Health care providers in Alaska oppose SB 83. So what do we support?

* First, and foremost, we support and pledge to continue our participation in the establishment of a coherent health policy for Alaska. This must address access to health care as one of the basics. It must set goals for health status and spell out the skeleton of a health care system to which federal, state, and local government programs, as well as private health care providers can contribute. How can we know whether we have succeeded if we don't know where we are trying to go?

* Secondly, we support a high quality analysis of the Alaska health care system, using standardized methodology and uniform medical data. The discrepancies between the HCCC Task Force Report and our analysis must be resolved prior to the adoption of any legislation enacting changes.

* Third, we support watchful analysis and thoughtful observation of other state and federal proposed solutions to the problem of providing health care to all Americans at reasonable cost. We are a small state and can ill-afford to be out "on point" when larger states with more resources have been unable as yet to demonstrate a successful solution.

* Fourth, we support continued implementation of those cost-saving measures which have been demonstrated to reduce cost *without* increased regulation or the creation of state bureaucracies -- measures such as those which have already reduced the increase in health care insurance costs for state employees by $20 million in FY 1990 and frozen them in place for FY 1991.

* Fifth, we support immediate and concrete measures to deal with Alaska's uninsured that could include the establishment of basic medical benefits packages, mandated risk pooling for currently uninsurable individuals, and state subsidies of premiums for certain individuals.

* And finally, we support a mechanism that provides a forum for cooperation, dialogue and consensus among all levels of government, business, the uninsured, providers, Natives, and the generai public.

For all of the reasons cited in previous pages, the Joint Health Access and Cost Containment Council and its constituent organizations representing Alaska's hospitals, nursing homes and physicians, respectfully request that the legislature not pass Senate Bill 83. We stand willing and ready to assist in whatever way we can with a thoughtful, careful analysis of Alaska's health needs and its current health system. We believe that the broadest base of agreement possible is the place to start, and that sound public policy will more certainly follow if we agree where we are trying to go.

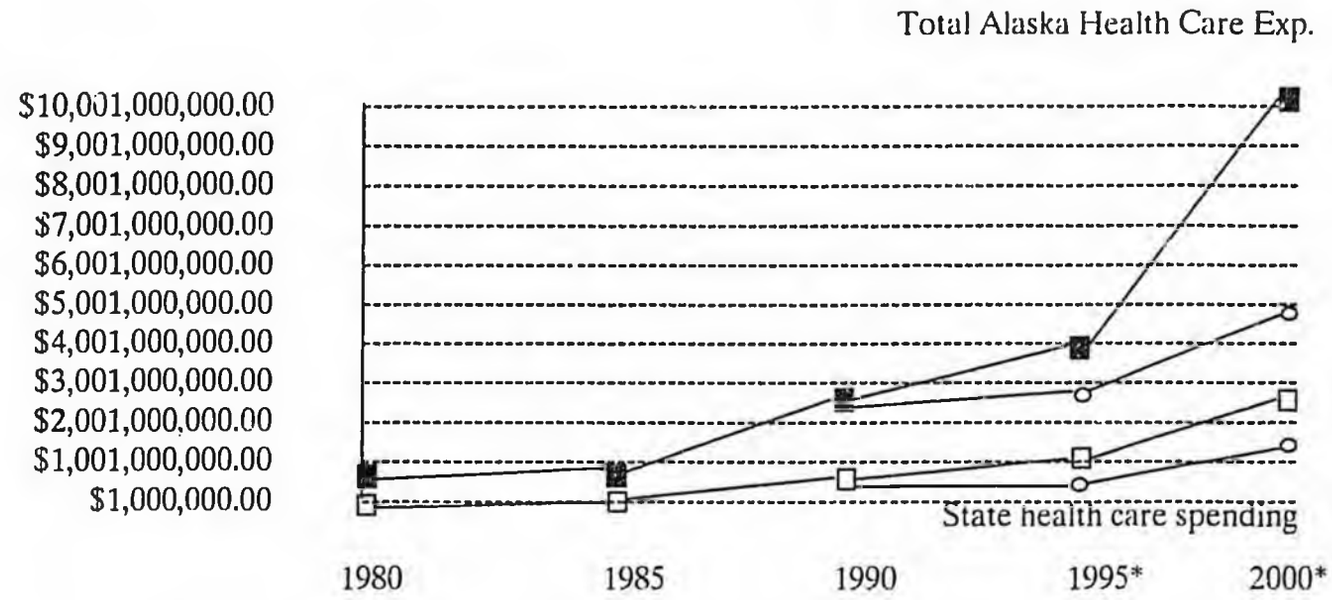
Respectfully submitted on behalf of the Joint Health Access and Cost Containment Council,

April 12, 1991

Health Cost Containment Task Force Exhibit

Source - Noble Lowndes

This exhibit 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*

○ Revised to reflect corrected rate of increase

* estimate

Table 1

Consumer Price Index – Urban Consumers
All Items and Selected Components
U.S. & Alaska

Year	All Items				All Items Less Shelter				Housing		Medical		Food & Beverage	
	U.S. annual average	Percent change	Anchorage annual average	Percent change	U.S. annual average	Percent change	Anchorage annual average	Percent change	U.S. annual average	Anchorage annual average	U.S. annual average	Anchorage annual average	U.S. annual average	Anchorage annual average
1960	29.6		34.4											
1965	31.5	6.4%	35.3	2.6%										
1970	38.8	23.2	41.1	16.4										
1975	53.8	38.7	57.1	38.9										
1980	82.4	53.2	86.5	49.7	82.9		84.7		81.1	85.9	74.9	76.5	88.7	89.7
1981	90.9	10.3	92.4	8.1	91.0	9.8%	92.0	8.6%	90.4	92.5	82.8	86.9	93.5	94.3
1982	96.5	6.2	97.4	5.4	96.2	5.7	96.3	4.7	96.9	98.2	92.5	94.8	97.3	97.2
1983	99.6	3.2	99.2	1.8	99.8	3.7	99.9	3.7	99.5	98.3	100.6	99.7	99.5	99.7
1984	103.9	4.3	103.3	4.1	103.9	4.1	103.6	3.9	103.6	102.7	106.8	106.6	103.2	103.2
1985	107.6	3.6	105.8	2.4	107.0	3.0	107.5	3.8	107.7	103.0	113.5	110.9	105.8	106.2
1986	109.6	1.9	107.6	1.8	108.0	0.9	111.2	3.4	110.9	102.6	122.0	127.6	109.1	110.6
1987	113.6	3.6	108.2	0.5	112.6	3.3	115.1	3.5	114.2	97.5	130.1	137.0	113.5	113.1
1988	118.3	4.1	108.6	0.4	115.9	3.9	117.8	2.3	118.5	95.4	138.6	145.0	118.2	118.9
1989	124.0	4.8	111.7	2.9	121.6	4.9	122.3	3.8	123.0	98.3	149.3	7.0 154.1	7.6 124.9	127.2
1st half 1988	116.8		108.4		114.4		117.0		117.2	95.8	136.5	143.0	116.5	118.5
1st half 1989	122.7	5.1	110.9	2.3	120.4	5.2	121.4	3.8	121.7	95.8	146.3	9.8 / 152.1	10.1 123.6	116.4
1st half 1990	128.7	4.9	116.9	5.4 ←	126.2	4.8	126.5	4.2	128.6	102.2	159.1	12.8 160.1	7.0 131.0	122.5

Notes: The most current Consumer Price Index data available for Alaska is for the first half of 1990.
For comparability, data for the first half of 1988 and 1989 are given to show the percentage change over the year.

Source: U.S. Department of Labor, Bureau of Labor Statistics.

TESTIMONY ON SB83
OLIVER M. KORSHIN, M.D.
APRIL 10, 1992

Senator Sturgelewski and committee members, thank you very much for the opportunity to testify on SB83 on behalf of the Alaska State Medical Association. My name is Oliver Korshin. I am board certified in both preventive medicine and ophthalmology. I spent a career in the federal government administering various health programs before entering private practice here in Anchorage in 1985. I am a member of the doctors' and hospitals' joint council that has developed CHIPRA, a truly comprehensive health care reform bill, on which you have already heard testimony.

It is my organization's firm position that the enormous complexity of the health care crisis demands sweeping reform, such as CHIPRA, and not quick fixes, like SB83. SB83 caters to the resentment and frustration everyone feels about the costs of health care, but it contains radical, one-dimensional solutions which are untested. If it is enacted, it will only exacerbate the problem.

Senator Duncan persists in referring to SB83 as comprehensive, but it is no such thing. Purely and simply, it is a price control bill that would fix prices for an entire free-market segment of Alaska's economy without addressing other, crucial aspects of the health care crisis. Read SB83 carefully and note: nothing in SB83 is mandated except price controls, data collection and the establishment of expenditure limits. These portions of the bill are to be implemented according to a timetable, but the procurement of insurance for those 90,000 Alaskans outside the health care system is optional, and will very likely never come to pass. Controlling

the health care crisis by addressing only reimbursements to providers is like solving a housing crisis by legislating that new homes shall sell for only 1/3 of their current prices. Few homes would be built after enactment of such a law. The housing crisis would no doubt deepen.

Senator Duncan represents SB83 as the embodiment of the legislative Task Force's "final recommendations," but this is not true. Although I think the task force failed to grapple with several critical health care issues, [personal responsibility, preventive care] its report was thorough. Its recommendations indeed included the concepts of global budgeting and establishment of provider reimbursement schedules, and these are dutifully written into SB83, but it also had strong recommendations in the areas of general health insurance reform, small group health insurance market reform, malpractice reform, and access. These are all basic elements in any meaningful health care reform. But where are these concepts in SB83? They are either absent or optional.

And, incidentally, I am puzzled by use of the word "final" as in "final recommendations." I'm under the impression that the Task Force has not yet finished its work and will be meeting again in June.

Not only does this bill fail to address the real causes of increasing health care costs, but its centerpiece, global budgeting, is seriously flawed in its proposed implementation.

First, let me talk about global budgeting in the abstract. If you enact SB83, Alaska will be the first to try it in this country. No other state has global budgeting of health care or has set expenditure limits for the totality

of health services delivered within its borders, nor is any state contemplating it. There are several good reasons for this.

Global budgeting is a meaningful concept only where the authority making the budget and setting the limits also pays all the costs. Thus, a single program, such as Medicare, can set a global budget (it hasn't yet). So can a socialized medical system, such as the Canadian one, where the government is the sole payor.

In a pluralistic system like ours, even just identifying the totality of expenditures in the health sector is almost impossible. And, if you've really identified it, how do you pick a limit? 5% more than last year? 20% less? Who makes that decision? After all, what gets paid for and how much is paid will have profound effects on the practice of medicine in the state, on the availability of providers and technology, etc.

Under SB83 the health resources authority decides, and so must bear all responsibility for the consequences, since the future success or failure, or growth or shrinkage, of health care services and costs will no longer be a market phenomenon, but a result of the authority's central planning and control of the entire health care system. We all know the fate of centrally planned economies... The greatest experiment in centralized planning in the history of the planent collapsed under its own weight last year, and the republics of the former Soviet Union are struggling to reintroduce market forces and privatization into their society, including into their sclerotic, low quality, inefficient (but inexpensive) health care system even as the Alaska legislature debates doing just the opposite.

Besides, global budgeting cannot work fairly when the entity making the budget does not pay *all* the costs of the system, or pays only a small portion. SB83 calls for control of *all* health expenditures in the state of Alaska. How can it control the costs of the substantial federal health programs in the state, such as Medicare, the VA, the military, and Native Health Service, over which it has no jurisdiction? It cannot. It does not even propose seeking waivers from the fedewral government to do so. How can it control the costs of out-of-state care delivered to, and paid for by Alaskans? It cannot. These sources of care cumulatively account for at least a quarter of total annual health expenditures in Alaska.

And SB83 must receive a failing grade for its global accounting because it ignores substantial expenditures in adding up the state's total health care tab. The Authority confines itself principally to Senator Duncan's real targets: hospitals and physicians. Just for starters, the bill omits the following important categories of health expenditures:

- First and foremost, the costs of the gargantuan Alaska State Health Resources Authority, but you will be obligated to appropriate funds for it every year.
- The profits and overhead expenses of health insurance companies.
- All public health programs.
- Land acquisition, facilities construction and mortgage costs or their equivalent for federal and state facilities. For example, the $120 million that will be spent for a new Native Medical Center will not

appear in their annual operating budget, ever. But private sector cost figures *do* include these big-ticket items.

- Reimbursements (at the outset) to dentists, dental hygienists, chiropractors, naturopaths, physical therapists, occupational therapists, psychologists, private-duty nurses, nurse practitioners, nurse midwives, physicians assistants, podiatrists, optometrists, opticians, acupuncturists, naturopaths, homeopaths, etc. If you don't include them at the outset, it's not global; if you do include them, it's a bureaucratic nightmare to implement what the bill demands.

Now for the moment, let's assume that the health resources authority by some miracle identifies these costs and sets expenditure limits in each category. It still treats the private sector unfairly compared to the public sector. SB83 would regulate the incomes of only those providers in the private sector, and would do nothing to regulate the cost of the public sector doctors or hospitals. For global budgeting to have any meaning, *all* providers must have their reimbursements subject to the same degree of control, whether by restricting fees, reducing salaries or eliminating positions. To single out only reimbursements for fee-based private-sector providers and ignore the public sector is not only denying the former equal protection of the law, but effectively scuttles the whole global budgeting concept. The private sector would be held hostage to the inefficiencies and spending habits of the public sector, since the target expenditure limits are based on the total of both sectors.

How about the rate-setting portion of SB83? What has been the experience with rate-setting elsewhere in the country, or within programs

such as Medicare? What have been its effects on the availability of providers and access to care? I mean much simpler rate-setting, not tied to a global expenditure ceiling as in SB83.

In New York, the physical plants and capital equipment of hospitals have been eroded; the level of care they provide is being jeopardized. In Massachusetts, while costs have been kept down, access has become a problem as physicians have left the state or have retired early rather than deal with the constraints placed on medical practice by the state. Many say they can no longer afford to practice because of unrealistic reimbursement levels and a physician shortage now exists. In Connecticut, proposed rate setting precipitated a vigorous hospital lobbying campaign that resulted in a hefty rate *increase*. Wisconsin tried hospital rate setting starting in 1983, but abolished its commission in 1987, because it was ineffective and because individual legislators were constantly introducing exceptions for hospitals in their own districts! And Washington state, having experimented with hospital rate-setting in the early 1980's, abolished its rate-setting commission in 1987, also because it was ineffective.

In Alaska, which already has difficulty attracting and retaining physicians, rate-setting will probably cause many early retirements and discourage the recruitment of new physicians. This will be particularly crippling outside of Anchorage and Fairbanks. Community hospitals now on the brink will have to close their doors.

Why are physicians so vigorously opposed to Alaska's government, or any government, for that matter, becoming involved in setting our fees? Well, it has to do with a shared experience we all have had with Medicare,

the ultimate health care Big Brother in this country. It had made us profoundly distrustful of any government's ability or willingness or promise to regulate fees equitably. We have seen how a program driven only by budgetary considerations has adversely affected the practice of medicine.

This is a very hot topic in our profession right now, and I'd like to give you some history so you can understand where physicians are coming from on this issue and why. Beginning in 1986, Harvard Medical School, under a grant from Medicare, developed a new methodology for reimbursing physicians for their services, called the resource based relative value system or RBRVS, which also happens to be the methodology SB83 proposes. For the last 40 years physicians were paid on the so-called usual, customary and reasonable system, or UCR, based on historical charges in geographic localities. The UCR system favored procedure-based, surgically-oriented practices. Under UCR Medicare was paying, on the average, about 40¢ on the dollar through 1991.

RBRVS seeks to make payment for services more fair by considering the work, overhead and malpractice components that go into producing each service. The various components add up to a total relative value unit figure for a service, which is multiplied by a standard dollar value per unit. So, for example, if a service adds up to 1.5 RVU's and the conversion unit for the system is $80.00, the charge works out to 1.5 x $80.00, or $120.00.

At any rate, RBRVS held out the promise of more equitable reimbursements for physicians, by paying more for services that used "brains," (so-called "cognitive" services) and by paying less for those that used

"brawn" (i.e., surgical procedures). RBRVS split the profession along a medicine-surgery fault line, since RBRVS would augment the earnings of family practitioners, internists and other non-surgical specialties, while surgeons would be economically hurt. Nonetheless, after Harvard developed RBRVS, the AMA formally endorsed and supported it along with a number of physician specialty groups. They worked closely with Medicare in developing new procedure codes for the system.

But in June, 1991, six months before RBRVS was to go into effect, Medicare published its rules in the Federal Register. It had added so many new variables, caveats, exemptions, disclaimers and exceptions that were not part of the Harvard study, and had not even been discussed, and had also set the dollar conversion factor so low, that those who had predicted they would be paid a little less were paid *much* less, and those who thought they'd be paid more, and who had ardently supported RBRVS, were *also* paid less. Everyone lost. Physician specialties which had been previously split united in a firestorm of protest over what they all saw as a betrayal, generating 95,000 letters to Congress in a 60-day period.

Medicare backed down a bit, but when RBRVS took effect on January 1 of this year, physicians found reimbursement levels for some Medicare services were set so low under RBRVS that they literally do not meet the costs of providing the service. That might be OK, if Medicare were a program for the indigent, but it is not: it covers the poor and millionaires alike, and physicians cannot charge more than the Medicare rates to any beneficiary—by law. And *now* Medicare reimbursement rates average only about 34¢ on the dollar. That is what providers mean when they say that Medicare is not paying its share.

What is RBRVS à la Medicare or à la SB83 going to do for access to services? For one thing, several large internal medicine practices in Anchorage have already stopped taking new Medicare patients. In my own specialty, Medicare will reimburse me $57.20 for spending half an hour inserting a pair of tiny silicone plugs into the tear drains of people with very dry eyes. The plugs alone cost me $87.50 a pair from the sole manufacturer of the product. So, when I seen this Medicare patient I effectively get paid nothing for my time and have to spend $30 on top of it!

An internist told me the other day that he would have to pay more for a plumber to make a simple repair than he would get paid for admitting a sick, old lady in the middle of the night. Well, like welfare Cadillac stories, I wondered about this one. So I checked it out. I called a few plumbers, and asked what it would cost to replace the circulating pump on my furnace on a Saturday night. The answer: $90.00 an hour, two hours minimum, counting time to and from the shop, plus $77.50 for the pump: $257.50. Then I consulted the RBRVS manual, looked up the code that would apply to spending four hours admitting an old, dehydrated person with pneumonia at 2AM, not counting time to and from home, a total of, say, five hours of doctor time in the middle of the night. I would collect $121.18, no night time differential, and, if I see the patient one or two more times the next day, that's included in the $121.18 as well.

As long as Medicare is the only program paying below its share of costs, providers can still manage to see their elderly Medicare patients because they can still charge their other patients more than Medicare's 34 cents on the dollar: that's called cost-shifting. But if *all* services were reimbursed at Medicare rates, as proposed in a Congressional Budget Office

document, (and this is private medicine's worst nightmare), many, many physicians would have to close their offices because their revenues would fall below their expenses.

This is real, not a threat or a joke. Doctors don't work out of the front room of their houses any more as they did when we were kids. They pay rents, staff salaries, malpractice insurance, business liability insurance, unemployment insurance, phone bills, fax bills, office supply expenses, accounting expenses, computer costs, business property taxes, just like everyone else. No doctor could survive seeing 100% Medicare patients unless he ran them through his office at the rate of one every three minutes, which is no certainly no way to practice medicine. And in states where Medicaid pays even less than Medicare, notorious "medicaid mills" have been in existence for years, which *do* practice like that.

This rather lengthy explanation reveals why doctors are so incredibly wary of government price controls and government promises to "trust us." Once burned, twice shy. That's why, in our CHIPRA proposal, we employ market-based mechanisms to control rising costs.

Overall, the opinion of most health economists clearly indicates that rate-setting cannot be used as the sole method of cost containment and health system reform. Doing so will lead to profound and sometimes unanticipated dysfunctions elsewhere in the system. Yet this is precisely what SB83 is designed to do.

As far as I can see, the principal virtue of SB83 is that it caters to the resentments and frustrations that most people have about the high costs of health care; it bashes doctors and hospitals, (two favorite targets); it

sounds simple; and it's easy to find people to testify for it, just as it would be easy to find people to testify in support of a bill that cuts in half plumbers' fees, or lawyers' fees or the cost of automobile repairs. Its main defects are that it is a quick fix, it's not adequately tied to any other reform measures, and it will make the entire health care system much, much worse for Alaska's patients and providers alike. ASMA requests that you don't give it your support.

HIAA

Health Insurance Association of America

STATEMENT OF HIAA

ON

SENATE BILL 83

PRESENTED BY:

JAN ANDREA MEISELS

LEGISLATIVE DIRECTOR

BEFORE THE

ALASKA SENATE COMMITTEE ON HEALTH, EDUCATION AND SOCIAL SERVICES

APRIL 10, 1992

2214 Clarendon Street Suite 226
Woodland Hills, CA 91367-6324
818-704-9274

Madame Chairwoman, Members of the Committee, I am Jan Andrea Meisels, Legislative Director of the Legal/State Affairs Department for the Health Insurance Association of America (HIAA), a trade association of the nation's leading commercial insurance carriers that provide health insurance for approximately 95 million Americans. HIAA is opposed to SB83.

SB83 is an attempt to control health care costs by having the state institute a new bureaucracy to set provider rates through expenditure targets, utilization standards, as the procurer or insurer to provide that health insurance and/or coverage to Alaskans. SB83, if enacted would eventually place the state in the role of single payer in the state, eliminating the private insurance market.

Based on the experience with other government programs, i.e. Medicare, Medicaid, the government set reimbursement rates are inadequate to cover provider costs -- which result in a lesser quality of care, denied access and shifting of utilization and costs to others. These government payer "attributes" are a major factor resulting in increasing costs to the private sector. Both Medicare and Medicaid have resulted in broken promises, budget deficits and with Medicaid, it has fostered arbitrary reductions in eligibility to the poor and payment to providers for services that they are expected to render at inadequate reimbursement rates with the result that many providers will no longer accept Medicaid patients due to the reimbursement rates. Due to its rural nature, Alaska is a state that can ill afford to have

providers so disenfranchised, that they may migrate to "the lower 48". The state is currently experiencing revenue shortfalls, so it is questionable how the state can assure reimbursement levels will not be affected by state budget woes, when the proposal calls for the state to eventually become the single payer for health care for all Alaskans.

The single payer concept subtly embraced by SB83 can be analagized to the Canadian health care system. The Canadian style of health insurance is fraught with negative features -- insurance is rationed by politicians and not by medical necessity, there are long-waiting lists for surgeries denied "as being elective" by government boards -- patients have died while awaiting "elective" surgeries and Canadian citizens benefit from the proximity of the United States medical system which serves as a pressure valve for the government-run system "north of the border". Although most forms of health insurance are illegal in Canada, private spending to enhance an austere government plan still accounts for more than one fourth of all health expenditures.

Advocates of the "single payer" system indicate -- erroneously -- that there will be "savings to the system" because of doing away with numbers of insurance companies and their operating expenses. While the cost may appear to be less, we assert that it is not less costly in the long run. At least three types of insurer operating expenses within the "claims

processing" function result in direct benefits to the consumer. Two of these go directly to reduce the overall expense of the health care system. When claims are filed, insurers verify not only the eligibility of the claimant for benefits; we also verify that the type of services provided and the individual or institution providing them are eligible for reimbursement under the benefit plan. A related "investment" by insurers is the detection of deliberate attempts to defraud insurers -- and thereby to defraud honest plan participants. Maintaining a pluralistic system, enhances competition which serves the public well. Among the advantages of this competition is that it encourages positive technological innovation -- encouragement which is lacking in a single-payer system. In fact, other countries, including Canada, currently rely on and benefit from technological development in the United States. Health insurers also compete vigorously in the area of customer service. This results in several positive developments, including systems innovation and quality service and claims handling.

Perhaps most importantly, competition encourages efficient quality care. Employers and employees demand the allocation of resources to effectively administer the system, including implementing managed care programs. This ensures that care is appropriate and of high quality, and that reimbursement is made only when consistent with terms of the plan. Through these functions, the private sector collectively is working to control increases in health care costs. In contrast, what is being

advocated is to place a cap on expenditures without changing the way medical services are rendered.

One of the most important investments the private insurance system has made is the implementation of managed care features of a benefit plan. Managed care has as its primary objective the delivery of effective, appropriate medical care. When experts agree that 25 to perhaps 40 percent of medical services provided yields no significant medical benefit, and in some cases are actually harmful, it is clear that we need to focus on administrative resources on making sure that the medical care received by our insureds is appropriate and of good quality. By working with patient and provider, managed care plans improve the delivery of health care, by among other things, by reducing instances of unnecessary testing and procedures, and closely coordinating the delivery of care with the needs and desires of the patients.

SB83 advocates the Authority to develop and administer utilization standards. However, government-run systems are notoriously poor at this kind of individual judgement. The Professional Review Organizations (PROs) and their predecessors have been at best marginally effective; and legal requirements make it impossible, for all practical purposes, for government to develop effective managed care systems based on selection of efficient physicians and hospitals, as private insurers are aggressively undertaking to do. Thus, government health

insurance programs in most other countries, such as Canada, typically address cost control by simply limiting physician fees and putting a cap on hospital expenditures without changing the way medical services are rendered. Moreover, while Canadians may claim that their single-payer system is not "socialized medicine", because providers are not directly employed by the government, there is little doubt that the allocation of health care resources is centrally planned, just as it would be in a socialist state: In Canada, all major hospital decisions to invest in new technology or services must be approved by the provincial governments.

It is quite clear that new, high-tech services simply are not adequately available in Canada, and therefore, patients who need them have to wait in line. This "rationing by queue" is the inevitable result of government attempts to control costs by restricting health care budgets while publicly espousing a commitment to universal access. Because anything new represents an additional cost, a bureaucratic budgetary approach to cost control discourages innovation, perpetuates existing inefficiencies, and leads to creeping obsolescence. This is an outcome we must strive to avoid as we seek a uniquely American solution to our cost and access problems.

A pluralistic, private system gives the customer a range of options to choose from -- and trade offs to make. If a customer is unhappy, he can switch his coverage to another insurer.

Choice stimulates competitors to provide good, high quality care and service. Private insurers have the ability and incentive to mold benefit packages to meet the needs of the beneficiaries. These preferences reflect the make up the employer's work force, budget size, competition, regional variations and the need for employers to retain their work force.

Attached to this statement are several articles from Springfield, Illinois which talk about problems Illinois is having with their state employees program -- which is self-insured and self-administered. Due to the state's fiscal problems, the state employee health insurance plan is being adversely affected due to under funding by $135-150 million in this fiscal year which is resulting in excessive delays in claims payment. The time lag for claim payments effect not only the health care providers, but also the insureds -- the residents of Illinois -- the state employees. Basically, how would Alaskans feel if this happened to them -- considering that this may occur with a single payer -- government controlled -- health care financing system. Excessive delays in claims payments, with the citizens of Alaska potentially facing fiscal adversity due to the state's fiscal problems.

The fiscal note on SB83 has been estimated at $377,000. HIAA believes this is substantially understated. The cost for administering the program will be expensive because the expenditure targets will eventually have to be related to the

individual health care provider -- physician, hospital, pharmacist, laboratory service and other providers. For example, the Maryland Health Care Service Cost Review Commission which approves budgets and rates for 52 acute care hospitals, six psychiatric hospitals and four chronic facilities has a budget in FY 1993 of $2.1 million. We recognize, that Alaska has 24 hospitals and nursing homes -- slightly less than half the number of facilities in Maryland. However, SB83 grants the Authority expenditure target responsibility and the ultimate rate determination for physicians, pharmacists, laboratory services and other health care providers which are not controlled by the Maryland Health Care Service Cost Review Commission. Therefore, we believe the total cost of administering this program, let alone the provision of self insuring for the residents of Alaska will be considerably higher than the $377,000 fiscal note. In addition, calculated into the equation for the cost of the state, should be the loss of premium tax revenues the state generates from insurance companies. With the enactment of SB83, the state would lose the premium tax revenues that commercial health insurance companies pay as the state determines to procure insurance from a single insurer or self insurers and administers and eliminates all private insurers.

Included in SB83 is the requirement that three provider representatives be selected by their constituents to negotiate expenditure targets with the Authority. It may be questionable whether providers may be permitted to do this type of negotiation

without some sort of federal anti-trust clearance. The Committee may wish to obtain a legal opinion as to the legality of the requirement for providers to negotiate rates by themselves so that it does not violate Federal Trade Commission anti-trust requirements.

The proposal for expenditure targets and the resultant individual provider rate setting implications are reminiscent of the current federal Medicare reimbursement system where the rates are reduced, but not the number of services or the eligibility to services. While the proposed Alaska Health Resources Authority is charged with developing expenditure targets for the entire state, a large percentage of that population is covered outside the state's jurisdiction -- people covered by Medicare, Medicaid, CHAMPUS, the military, the Bureau of Indian Affairs, employees under the Federal Employees Health Benefit Act -- to name but a few. The reimbursement, benefit level and eligibility are all decided by the federal government and therefore will not be influenced by the state bureaucracy of the Alaska Health Resources Authority. Therefore, the alleged controls espoused by SB83 is a result of a partial expenditure target i.e. "a house with missing walls", so that there really is no "control". If the proposed expenditure target takes into effect the federal government program revenues, it will result with the remaining non-federal government covered citizens having the "privilege" of subsidizing these underfunded government programs by further

inappropriate and inadequate rates which will result in a negative effect on the health care of all Alaskan residents.

There is a definite need for Alaska to address both access and costs. The insurance industry is strongly committed to successfully addressing both of these issues. SB242 greatly enhances access to the groups that are most in need -- small employers -- as 90 percent of Alaska's employers have 25 employees or less. Further, we strongly believe that the managed care programs which ensure only medically necessary care provided in the most cost efficient setting, by quality health care providers is the way to address health care costs. Private insurance companies have a substantial investment in the development and promotion of effective managed care programs. Private insurance managed programs are not a governmental bureaucratic centralized autocracy such as being advocated in SB83 -- but rather they examine the needs of the individual patient, working with the patient's physician to determine what is most appropriate. Managed care is working both by enhancing health care quality and controlling medical expenditures. We therefore respectfully request that the Senate HESS Committee not approve SB83.

STATE OF MARYLAND

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EXECUTIVE DIRECTOR

HEALTH SERVICES COST REVIEW COMMISSION
4201 PATTERSON AVENUE — 2ND FLOOR — BALTIMORE, MARYLAND 21215
AREA CODE 410-764-2605
FAX-410-764-6987

April 9, 1992

Ms. Jan Andrea Meisels
Legislative Director
Health Insurance Association of America
22144 Clarendon Street
Suite 220
Woodland Hills, California 91367-6324

Dear Jan:

Enclosed is a copy of the FY93 budget allowance for the Health Services Cost Review Commission (HSCRC). You will note the total expenditure is $2.1 million. Other than salary and fringe benefits, the largest single component is for contractual services which incorporates several contracts for processing the HSCRC data. The total budget is financed through a user fee assessed on hospital patients and included in the rates set by the HSCRC. The industry we regulate includes 52 acute hospitals, six private psychiatric hospitals and four chronic facilities. According to the annual disclosure report for FY91 total revenue is approximately $4 billion. According to AHA statistics for 1990, the state of Alaska had 16 community hospitals with total expenses of only $318 million. Although there are certain fixed costs associated with operating a Commission, I can well imagine a substantially lower budget for accomplishing the same purposes as the HSCRC in a state with one quarter of the hospitals and one tenth of the revenue as in Maryland.

Should you require any additional information, please feel free to contact me.

Sincerely,

John M. Colmers
Executive Director

[illegible]eneral\mcisels.409

TDD for the Disabled
Baltimore Area 383-7555

FROM:CENTRAL SERVICES TO: 8187041053 APR 9, 1992 9:04AM P.0

Dept of Budget & Fiscal Planning — BUDGET ESTIMATES — 32160202
Budget Form No. DBFP-DA-3 — FISCAL YEAR 1993

Reg atory Services
Health Services Cost Review Commission
Health Services Cost Review Commission
Health Services Cost Review Commission

Appropriation Statement:

		1991 Actual	1992 Appropriation	1993 Request	1993 Allowance
	Number of Authorized Positions	28.00	28.00	28.00	28.00
01	Salaries Wages and Fringe Benefits	1,305,389	1,269,706	1,354,136	1,343,655
02	Technical and Special Fees	8,100	13,284	13,284	13,294
03	Communication	39,880	25,332	40,955	40,955
04	Travel	3,544	4,577	3,446	3,446
07	Motor Vehicle Operation & Maintenance	78	483	725	725
08	Contractual Services	487,892	555,991	547,608	687,608
09	Supplies and Materials	8,060	10,512	9,330	9,330
11	Equipment - Additional				
13	Fixed Charges	3,240	3,674	4,203	4,203
	Total Operating Expenses	542,502	600,569	606,267	746,267
	Total Expenditure	1,916,291	1,883,559	1,973,687	2,103,216
	Original General Fund Appropriation	1,874,420	1,883,559		
	Transfer of General Fund Appropriation	41,871			
	Total General Fund Appropriation	1,916,291	1,883,559		
	Less: General Fund Reversion/Reduction				
	Net General Fund Expenditure	1,916,291	1,883,559	1,973,687	2,103,216
Add:	Special Fund Expenditure				
	Federal Fund Expenditure				
	Reimbursable Fund Expenditure				
	Unrestricted Fund Expenditure				
	Restricted Fund Expenditure				
	Total Expenditure	1,916,291	1,883,559	1,973,687	2,103,216
	Direct Local (Unappropriated)				
	Total Expenditure	1,916,291	1,883,559	1,973,687	2,103,216



State Journal-Register/Rich Saal

This sign outside Clarkston Court in Springfield admonishes the state for being so far behind on paying its bills.

Between a doc and a hard place

Late medical insurance payments are a problem for state employees, too

By DOUG FINKE
STAFF WRITER

For Jack and Diane, two state employees, state government's credit rating isn't the issue. Their own is.

The General Assembly will convene in Springfield Wednesday to hear Gov. Jim Edgar's plan for filling at least a $350 million hole in the state's budget.

When Edgar is finished, lawmakers will debate the wisdom of tax hikes, budget cuts, borrowing and other ideas (both those that are politically expedient and those that are not) for mending the budget hole.

Jack and Diane — a husband and wife who asked that their real names not be used — have little interest in whether Edgar or the legislature, Republicans or Democrats, come out ahead politically when the budget dust settles.

They're wondering how they're going to keep up with the medical bills when their first child is born this spring.

"The baby is due about a month after the state is projected to stop paying its bills," said Jack. "The doctors have been fine so far. (But) we've had indications the hospital may insist on a payment plan. It's going to be very, very difficult times for us."

Like most other bills owed by the state, payments for state employee health insurance claims are far behind the normal 60-day schedule. Lynn Calame, benefits manager for the Department of Central Management Services, said the state is current for medical bills through Oct. 9, meaning some bills nearly three months old haven't been paid.

Three months isn't the longest backlog in the state's portfolio, but the impact of late medical insurance payments is just as acute for employees as late payments are for hospitals, nursing homes and pharmacies.

Calame said there is just about an even split be-

See LATE on page 4

LATE

From page 1

tween medical providers who will wait for payments from the state health insurance program and those who are demanding that patients pay upfront.

When a physician requires a payment at the time a service is delivered, it's the employee who, in effect, is carrying the state until money is available to pay the claim.

Compounding the problem for state employees, though, is that Edgar and the legislature underfunded this year's health insurance program by an estimated $100 million. Projections now are that the state will simply run out of money for state workers' health insurance claims in late February or March — perhaps four months before the end of the fiscal year.

That's what has Jack and his wife extremely worried right now. He estimates he faces $1,000 in out-of-pocket medical expenses if the state doesn't accelerate payments.

"When we decided to start the family, we didn't expect to pick up the (entire) cost of the doctors and the hospital," Jack said.

On top of the medical outlay, Jack's wife will not have a state paycheck during most of her maternity leave. Add to that the possibility that state employees may be asked to take furloughs to help balance the budget and the couple's financial squeeze draws tighter.

"We both sat down and looked at the private sector," Jack said. "We looked at whether we can afford to stay on with the state."

Late payment of medical bills is doing nothing for already low state employee morale. That's particularly true since most state employees began making contributions to their health insurance plan this month, for the first time ever.

The provision was part of the contract negotiated with the American Federation of State, County and Municipal Employees. In return, the state this month began to assume employee pension contributions. That provides more take-home pay without a traditional pay raise.

The state sought the employee contribution to health insurance costs in hopes that, if employees bore part of the medical care burden, they would be more careful to seek medical help only when needed.

"I had a $4,000 medical bill in October that the state hasn't paid a dime on," responded one disgruntled secretary of state's employee. "If that was a regular insurance company not paying bills, the state would shut them down. They're taking money for a product I'm not getting. I'm getting hounded by creditors."

> *"We both sat down and looked at the private sector. We looked at whether we can afford to stay on with the state."*
>
> **Jack**
> State worker

Calame said the employee contributions should generate about $1.8 million a month for medical, dental and dependent charges. That will provide a little relief for the cash-strapped program, but those contributions will make up only a minuscule portion of the $100 million shortfall in the health insurance program.

Many medical providers are working with their state employee patients to come up with suitable payment plans until state checks arrive.

"We're trying to be as understanding with our patients as we can," said Jill Guinan, business office director for Springfield Clinic. "We encourage them to make monthly payments."

Those monthly payments sometimes include expenses covered by insurance, in which case the client reimburses the patient once the state pays up.

The clinic does "a significant portion of our business" with state employees, Guinan said.

While Edgar is expected to address the state's overall budget mess on Wednesday, he is not expected to single out employee health insurance claims for special consideration. However, a group of House Democrats is preparing its own solution to the budget problem, which will address health insurance.

Rep. Mike Curran, D-Springfield, said about a dozen Democrats have hatched a plan "that we feel is a very good solution," although he declined to outline it prior to Edgar's budget speech.

Curran said it is clear that something must be done about the underfunded health care program.

"These are people who are paying for their own health insurance," Curran said. "I'm hearing a lot of frustration from them. State government isn't (the legislature), it's the employees."

FY92

~~Budget threatens~~ for county health efforts

By Joan Latz Griffin
Public health writer

Anthony Frye, 29, has tuberculosis. He needs to take medication regularly for at least a year. Otherwise, not only will he get sick but he will become infectious and able to pass the disease on to others.

Frye receives his medical care from Freedom Center, a satellite clinic of Cook County Hospital at 1515 W. Monroe St. Cook County is reimbursed for part of the cost of Frye's care through the Illinois Department of Public Aid's General Assistance program.

But that reimbursement will stop if the cuts proposed in Gov. Jim Edgar's budget are approved by the General Assembly.

The Senate Appropriations Committee will hold hearings on the cuts at 11 a.m. Monday at Illinois Masonic Hospital, 836 W. Wellington Ave.

Medical benefits for people receiving General Assistance, usually single adults, along with many health benefits for the working poor and dental and eye care for women and children, will be dropped. Extra funds paid to hospitals that treat large numbers of poor will be reduced.

City and county clinics like Freedom Center could become overwhelmed, public health providers say, and private hospitals that continue to treat the poor will lose millions of dollars.

"Reductions in the medical benefits of the General Assistance program would hurt all of us," said Dr. Richard Bick, medical director for the Chicago Department of Health.

"In treating tuberculosis, for example, it's not the medication that is expensive, but the staff to make sure that all the patients take their medication. Also we have to test all the people they have had close contact with."

Because Frye is homeless and spends his days at drop-in centers and his nights in shelters, he routinely comes in contact with hundreds of other poor people. Allowing him to again become infectious would be likely to cost much more than continuing to treat his tuberculosis.

Refusing to pay to treat Frye's tuberculosis is just one example of the kind of cost-shifting and "penny-wise and pound-foolish" proposals that public welfare activists abound in the budget cuts.

"If the medical benefits for GA are eliminated, sure the men can go to Cook County Hospital," said Doug Dohmeyer, executive director of the Public Welfare Coalition. "But County will already be losing money on the GA patients it already serves, and now it will have more of them and they will probably be sicker when they get there."

County Hospital projects it will lose $19 million if the budget cuts go through. Other West Side hospitals and their projected losses are Loretto, $3 million; Bethany, $3.5 million; Mt. Sinai, $8 million; and St. Anthony, $1 million, said Jackie Reed, head of the West Side Health Authority.

"Our community cannot afford to lose these hospitals, and if these cuts go through, it will be just that much harder for them to stay open," she said.

Tribune 4/15/91

March 5, 1992 - Sun-Times

Unions: State slow to pay worker health-care claims

By Charles N. Wheeler III
Chief, Springfield Bureau
Chicago Sun-Times

SPRINGFIELD—Two unions filed contract grievances with the state Wednesday, contending health care for 7,000 state workers they represent is being curtailed by long delays for insurance claim payments.

Union officials said the move was intended to pressure Gov. Edgar and the Legislature to plug a $160 million shortfall in funding for the state's health insurance program.

Because of the shortfall, the state has fallen months behind in paying medical bills for its workers, with claims dating back to last fall just now being paid, according to state officials.

Legislation pending in the House would appropriate the needed funds for the program, but the proposal has had a cool reception from Edgar.

"The governor continues to be concerned about delays in paying medical bills of state employees," said Mike Lawrence, his press secretary. "However, we're in a very tough budget situation. The options would be to either raise taxes or borrow money without having a plan to repay the money. Both of these options are unacceptable to the governor."

But officials of the unions—the Illinois Federation of Teachers and the Teamsters—argued that the payment delays are causing grave harm.

Many state employees must pay immediately for medical services by doctors, pharmacies, hospitals and other providers tired of waiting months for benefit checks, said Gary Leach of the Illinois Federation of Teachers.

"We are certain some members are in the early stages of serious illness but will not be able to verify this because they are forced to cancel doctor's visits," he said.

Some workers are being hounded by collection agencies while others have been sued by providers seeking payment, Leach said.

The grievances by state employee locals of the teachers federation and the Teamsters were similar to ones lodged by Council 31 of the American Federation of State, County and Municipal Employees, the state's largest employee union.

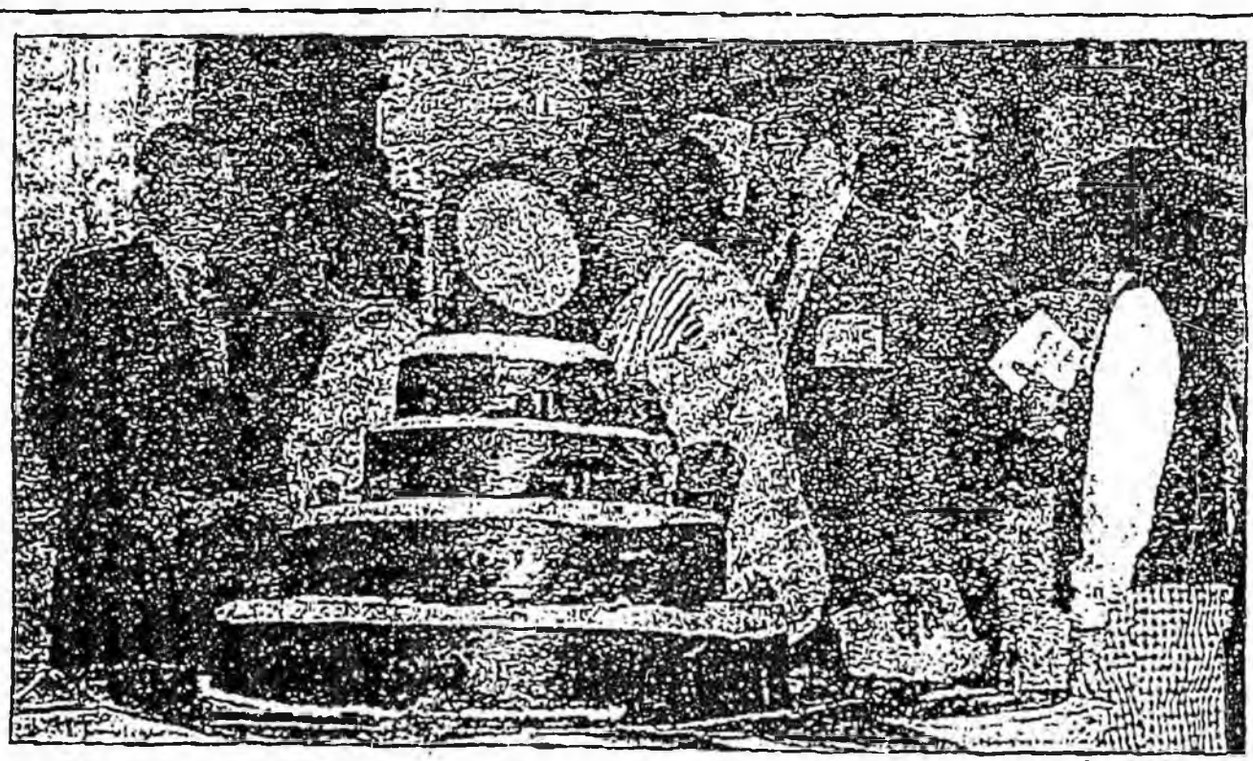
The latest reminder of the state's budget woes, the complaints came on the heels of a bleak report from state Comptroller Dawn Clark Netsch, who said revenues remained "dead in the water" through February.

Most ominously, the comptroller said, sales tax receipts in February totaled $253 million, $57 million less than the $310 million collected in February, 1990.

"If there has been an economic turnaround, it's not showing up in our revenues to date," said Netsch.

Through the first seven months of the 1992 fiscal year, income and sales tax receipts have been "essentially flat," she said, causing her to lower her office's estimates of revenue for the fiscal year by about $100 million.

As a result of the cash crunch, Netsch said, the state faced a near $600 million backlog of unpaid bills at the end of February.



SUN-TIMES/Jon Bell

Sharing Chicago's birthday

People born on March 4 line up Wednesday—Chicago's 155th anniversary—to shake hands with Mayor Daley at the Cultural Center, Washington and Michigan. The city celebrated with a chocolate cake created by pastry chef Eric Burkey of the Sheraton Chicago Hotel & Tower

1992 Legislation
FY 92 budget

MARKETPLACE INSIDE
For the record/page 12
Police beat/page 12
Obituaries/page 12

CITY/STATE

FRIDAY
FEBRUARY 21, 1992
THE STATE
JOURNAL-REGISTER
SPRINGFIELD, ILLINOIS
PAGE 12

AFSCME to call for health insurance measure

Curran, union join to ask money for cash-strapped fund

By DOUG FINKE
STAFF WRITER

Rep. Mike Curran and the largest state employee union will join forces today to call for more money for the cash-strapped state employee health insurance fund.

The Edgar administration Thursday said it will support tapping various specialized funds for $15 million to help pay employee health-insurance claims. However, the administration so far is not proposing additional funding for the employee health insurance fund.

Curran, a Springfield Democrat, and the American Federation of State, County and Municipal Employees union will hold a news conference this morning calling for a $150 million supplemental appropriation for state employee health insurance.

Curran said he wants the state to borrow the money, just as it did to pay bills owed to nursing homes and Medicaid providers.

"We were willing to borrow for that," Curran said. "Now employees have to borrow to pay the state's bills. We're still a deadbeat, only now with a different group of people."

The employee health insurance fund is underfunded by $135 million to $150 million this fiscal year, meaning some medical bills will be left unpaid for months. On Feb. 1, the state began setting priorities on health-care bills — and simply stopped paying some of them.

As a result, some state employees are being hounded by creditors seeking payment for medical expenses. Others have had to postpone treatment.

"We've been told of signs in some medical offices saying employees have to pay up front," said AFSCME spokesman Steve Trossman. "Our members can't afford that."

Mike Lawrence, a spokesman for Gov. Jim Edgar, said the administration is willing to replenish about $15 million of the health insurance fund by tapping other state accounts. That will cover $15 million cut from health insurance funding as part of the January budget-cutting agreement.

"There was an agreement with the (legislative) leaders at that time to take money from other funds," Lawrence said.

"We are not ready to propose any more supplementals, but we have not ruled out that possibility," he added.

Lawrence said the administration remains reluctant to borrow additional funds unless a repayment plan is part of the deal, as was the case when the state borrowed $500 million to speed up payments to Medicaid providers.

Rick Davis, a spokesman for Comptroller Dawn Clark Netsch, said the state's contribution to employee health insurance effectively ran out Feb. 1. The only money left in the fund comes from employee payroll deductions for their own and dependent coverage. Davis said that comes to about $13 million a month. If fully funded, the insurance fund would have about $30 million available per month.

"This will drastically slow down (payments), because funding is relying solely on employee contributions," Davis said. "The bills will be paid as (funds) trickle in."

HIAA

Health Insurance Association of America

10A
File 1 SB83

March 4, 1991

Senator Arliss Sturgulewski
Chairperson
Senate Health, Education and Social Services Committee
Alaska State Legislature
P. O. Box V
Juneau, AK 99811

Dear Senator Sturgulewski:

Thank you very much for meeting with me during my recent visit to Juneau and discussing SB83 and its companion bill HB71 as well as HIAA's alternative for affordable, available and cost-effective health insurance, "Financing Health Care for All Americans." If you have any further questions regarding HIAA's opposition to SB83/HB71 or our alternative approach, please do not hesitate to contact me or Gordon Evans.

Sincerely,

Jan Andrea Meisels

Jan Andrea Meisels
State Affairs Associate

JAM:mlp

cc: Gordon Evans

6052 Hackers Lane Agoura Hills, CA 91301-1410 818/991-6817 Telecopier 818/991-0722

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

April 15, 1992

MEMO TO: CHAIR & MEMBERS
SENATE HESS COMMITTEE

FROM: Harlan R. Knudson, President/CEO
Alaska State Hospital & Nursing Home Assn.

SUBJECT: Opposition - SB 83, Health Care Authority

Community hospital and nursing home members of this Association had the opportunity to review SB 83 at a meeting here in Juneau on April 6.

These facilities, who must work everyday with commercial insurance companies, Medicaid, Medicare, CHAMPUS and the Veterans Administration are unanimously opposed to SB 83.

We recommend that SB 83 and CHIPRA, the Comprehensive Health Insurance and Payment Reform Act be referred to the citizens of Alaska for thorough public debate and that the Legislature make "comprehensive" health care reform a number one priority for 1993.

Our opposition to SB 83 is based on:

1. Sections 1-8, Pages 1 to 4
   - refers issue of health care limits, access to care, quality controls, utilization controls rather than spell out in legislation how this is done.
   - adds another level of administration to CON process
   - places Health Resource Authority in Department of Administration when experienced personnel are in Department of Health & Social Services.
2. Page 7, Sec. 44.87.060, Line 1 -- Duplicates data program of Department of Health & Social Services
3. Page 7, Sec. 44.87.070 - develop a statewide healthcare budget and expenditure limit. There is serious question if this can even be done, but it is certain the cost to do this will be very expensive.
4. Page 8, Sec. 44.87.080, health care providor negotiations. Besides the very serious anti-trust question of having all health providors join together to negotiate fees, the negotiation process appears unworkable.
5. Page 9, Section 44.87.090 reimbursement schedules. The fiscal note ignores the cost of appeals and litigation. With all providors, easily several millions of dollars a year.
6. Page 10, Section 44.87.100, We understand compliance with reimbursement schedules but have no comprehension of how you comply with expenditure limits.

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(More)

7. Page 10, Section 44.87.110. Mandate providor provide information. Who pays for gathering the information?

8. Page 10, Section 44.87.120, Procurement of Insurance. If the state should self insurer, there needs to be an answer as to federal tax liability.

9. Page 11, Section 44.87.130. We have heard that the Authority will eventually be budget neutral, but have not found where they are authorized to tax or charge fees.

In conclusion we consider SB 83, a costly administrative nightmare that will do little to insure all Alaskans access to cost effective, affordable health care.

#####

ALASKA HOSPITAL COUNCIL

P. O. Box 34035 • Juneau, AK 99803-4035

April 9, 1992

Senator Arliss Sturgulewski, Chair
Senate Health , Education, & Social Services Committee
Alaska State Legislature
Room 427, Capital Building
P. O. Box V
Juneau, AK 99811

Subject: Senate Bill 83, "An Act establishing the Alaska State Health Resources Authority; . . ."

Dear Senator Sturgulewski:

We have reviewed the significant changes in the latest version of Senate Bill 83. While we recognize the tremendous amount of effort involved in the preparation and attempts to address and resolve such complex issues, we have several comments and questions on this particular legislation.

Rate Controls

The bill relies heavily on rate controls. Whether called "expenditure limits" or "reimbursement schedules" this reliance on rate controls is likely to add to the complexity, frustration, and inefficiency than is present in the existing system. Much has been written about the problems and hazards of government imposition of rate controls. Rate controls which favor too heavily the buyer or payor tend to either lower the supply of the service or cause a decline in the quality of the service. If rate controls favor the seller or provider too much, they can lead to inefficiency. In either case the potential exists to create a system which neglects the needs and desires of the consumer or patient.

Rate controls create under-investment in capital expenditures and a lack of ongoing expenditures for repairs and maintenance. With the rapid expansion of technology in the medical field, a system that relies only on rate controls has the potential of not offering

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the technology needed and desired by patients. Again, a system that is not responsive to the consumer or patient.

Please consider the following quote: "Some States have tried rate controls on hospitals for more than a decade. A recent study comparing hospital expenditures...revealed that expenditures in the regulated states rose an average of 9.5 percent from 1986-1989, compared with 7.1 percent in the competitive states. Increases in the regulated states exceeded the national average of 8.5 percent". (Lewin/ICF, April 1991).

We need to carefully weigh the impact on providers, payors, and patients of a system that would rely so heavily on rate controls and expenditure controls. It appears to contain many hazards.

Certificate of Need

In 1982 the Federal Government removed its CON requirements. This left states free to abolish their CON laws. Attached is a map showing the large number of states that have repealed CON laws. In addition, a number of states have scheduled CON laws to sunset. Why are so many states eliminating CON requirements?

In March of 1988 the Federal Trade Commission commented on "... the overall effectiveness of the Certificate of Need process...". Below are all of the headings and subheadings of these FTC "comments". They point out many of the problems with CON laws:

> "I. Interest and Experience of the Federal Trade Commission.
>
> II. CON Regulation is Ineffective and Possibly Counterproductive in Promoting Efficiency in Health Care Markets
>
> A. CON Regulation is Unnecessary to Remedy Deficiencies in Health Care Reimbursement
>
> B. CON Regulation is Ineffective as a Cost-Containment Mechanism
>
> C. CON Regulation Interferes with Competition in Health Care Markets.
>
> D. CON Regulation is not a good Mechanism for Addressing Concerns Related to Access for Indigent Patients.

III. If the CON Process is Retained, the Thresholds should be Raised and the Scope of Coverage should be Restricted in order to Reduce the Negative Effects of CON on the Competitive Process."

Since the goal is to improve many if not all of the features of the system (including access, quality, and costs) it seems from this information that an easing or even elimination of CON restrictions is the best way to achieve of this common goal.

Effect of CON on the Cost of Group Health Insurance

There is a provision of the bill which states that: "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" (Page 3, Line 3). Frankly, this provision is difficult to understand but it appears to involve a task tremendously complicated and time consuming.

Creation of additional Bureaucracy (Alaska State Health Resources Authority)

In assessing the potential addition of a new bureaucracy to State Government to control and limit rates, we can only draw on our existing/previous experience for guidance. There is already in the state a mechanism for setting facility (Hospital and Nursing Home) payment rates. It is known as the Medicaid Rate Advisory Commission. All, including the State, who are associated with this system are frustrated and are working to replace it with something less cumbersome. It should be understandable then that there is concern at the proposed addition of another rate setting body. The rates established by the current MRAC seem to result in an increasing number of appeals and litigation. This means that issues from a given Fiscal Year wait many months, even years, to be resolved. The addition of ASHRA would likely add more forms, more time and the potential for more appeals and litigation. Providers are already needing to expend an increasing proportion of scarce resources on activities to satisfy rate setting bodies. SB 83 creates another one.

Bureaucracies such as that proposed here are expensive to set up and maintain. The FY 1993 budget request for the Medicaid Rate Advisory Commission is $622,600. In addition, there is a separate budget request of $687,000 for the unit that conduct audits of Hospitals and Nursing Homes. The total annual cost of these two functions is in excess of $1.3 million. Since the Alaska State Health Resources Authority would be setting rates for all providers of Health Care not only Hospitals and Nursing Homes it would appear

that the total budget to operate ASHRA would need to be several times larger than the $1.3 million needed to establish and monitor Medicaid rates.

ASHRA is directed in the legislation to develop state-wide health care budget and expenditure limits. There appears to be no mechanism to assist providers in managing ever increasing costs with which they must deal.

The proposals presented in SB 83 only generally and briefly, if at all, reference other key factors impacting the increasing cost of health care. The impact of ever increasing Medical Liability insurance costs and the need for Malpractice reform to slow the growth in these costs is not addressed. The importance of providing access to care for the uninsured and under-insured is briefly mentioned but no specific proposals are brought forward. No one in need of medical care is refused treatment, but the costs associated with the provision of care to those who are in need, but who are unable to pay, has a major impact on the health care system and remains to be addressed.

We appreciate the opportunity to comment.

Sincerely,

The Alaska Hospital Council

STATES WITHOUT HOSPITAL CON PROGRAMS



Repealed Hospital CON Programs

CON Sunset Dates

CON Programs in Operation

ALASKA STATE
HOSPITAL & NURSING HOME
ASSOCIATION

February 25, 1991
Alaska State Hospitals & Nursing Homes
Contact: Harlan Knudson, President, 586-1790, Juneau

FACT SHEET FOR RESPONSE TO:
*** The State of Alaska's Health Care Cost Containment Task Force Report**
and
*** Senate Bill No. 83 (HB No. 71), a bill creating the Alaska State Health Resources Authority.**

Introduction:

The Health Care Cost Containment Task Force Report was released this February. The task force was formed originally to consider ways to cut the cost to the state of providing health insurance for its employees. Its duties were extended last year to cover all uninsured and under-insured Alaskans.

The report's major recommendation is creation of the Alaska State Health Resources Authority, as described by legislation sponsored by Sen. Jim Duncan (D-Juneau). The authority would set up a rate and reimbursement payment schedule for health care providers in Alaska, and dictate that schedule be followed by all public employers. It would also allow establishment of insurance pools by groups of smaller employers in search of available and affordable health insurance.

Hospital concerns with the task force and its recommended legislation:

* The task force's view of health care was extremely limited -- there was no representation from the business community, health providers or consumers on the task force. **All its members, but one union representative, were state employees or legislators.**

* There is little hard data to back up the task force report's findings. For example, it cites "overbuilt health care facilities" as one reason for the increasing cost of health care, but fails to indentify one facility that it considers overbuilt.

* Much of the hard data is does provide is questionable at best. **There is no analysis of its statement that Alaska health care costs have been increasing at 20 percent for the last five years.** Even if correct, this figure is influenced by such factors as the increase in health care provided in the state, instead of outside the state, and an increase in the number of people eligible for Medicaid because of new federal guidelines.

* The U.S. Dept. of Labor, in fact, has released data on the Anchorage consumer price index showing medical care to have among the smallest increases of any cost-of-living component between the

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second half of 1989 and the second half of 1990. (Medical care showed a 4.2 percent increase; motor fuel was 21 percent, food was 5.9 percent and the consumer price increase overall was 7 percent.)

* There is no analysis of the report's conclusion that there are 90,000 uninsured and underinsured, or that that number will increase to 25 percent of Alaska's population by the year 2000. While we recognize there is an increase in the number of uninsured and underinsured, it is essential that that figure be as accurate as possible before it is used to drive changes to the health care delivery system.

* There is no acknowledgement given of the vast improvement in medical care and delivery in Alaska in recent years, or of cost-saving measures taken by hospitals. These include flexible staff scheduling, group purchasing of supplies and a marked emphasis on outpatient, versus inpatient care.

* There is no acknowlegement of the costs hospitals can't control, but must deal with. These include the cost of fuel oil, wages driven by staff shortages and renovation and maintainence of facilities.

Why we like Senate Concurrent Resolution No. 10 and House Concurrent Resolution No. 5, legislation also introduced by task force members.

* They acknowledge and address the problem of the uninsured and underinsured, an issue all health care providers in Alaska struggle with daily.

* They recommend collecting the information needed to deal with this problem including uniform medical data from health care providers and opens the door to addressing the individual responsibility of every citizen to help control health costs.

* While the basis (the whereas portion) of the legislation is bassed on unsubstantiated data, the resolutions would, for the first time, provide Alaska policy makers with the necessary information to establish a fair and equitable program or programs to control health costs while assuring all Alaskans have access to health care.

* They recommend creation of a Health Resources and Access Task Force -- a group drawn from a broad representation of interests that would delve more thoroughly into the issue of health care costs and access.
* They bring a cross-section of Alaskans, including legislators, members of the administration, health consumers, private employers, health care providers and organized labor to the table to resolve a major issue facing every state in the nation -- controlling costs while assuring all citizens access to care.

# # #

FEB 2 5 1991

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

February 22, 1991

Senator Drue Pearce
Chair, Labor & Commerce Committee
P. O. Box V
Juneau, AK 99811

RE: SB 83

Dear Senator Pearce:

The Alaska State Hospital & Nursing Home Association would like to recommend that the report of the Health Care Cost Containment Task Force, along with SB 83, recommended by that Task Force be referred to the proposed Health Resources and Access Task Force. (SCR 10)

SB 83 is opposed in its current form because it creates yet another untried, undefined payment system for hospitals, and physicians. Simply telling hospitals and doctors what you will pay for their services will escalate shifting the costs of health care to other payors (if there are any left) and do nothing to improve access to care or control the overall cost of care.

The Task Force on Cost Containment was a public employee task force that did a good job in addressing state employee health costs and controlling those costs. It also opened the door to the serious problem of those who do not have health insurance. But, any long range solutions must be developed by a cross section of our provider, legislative, consumer community. This is done under SCR 1[illegible]

Sincerely,

Harlan R. Knudson
President/CEO

HRK/ma

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April 2, 1992

VIA TELECOPIER--ORIGINAL TO FOLLOW

Harlan R. Knudson, Executive Director
Alaska State Hospital & Nursing Home Association
319 Seward Street, Suite 11
Juneau, Alaska 99801

Re: Senate Bill 83

Dear Harlan:

You have asked me to review the new version of Senate Bill 83 (Work Draft, Ford, 3/23/92). My review has revealed at least two potential legal problems with the bill.

1. Potential federal income tax liability: The bill authorizes the new Alaska State Health Resources Authority to exercise the powers of an insurer. (Page 5, line 20; page 10, line 20) If the Authority did operate as an insurer, it would be required to pay federal income taxes. There may be an assumption that, since the Authority will be "non-profit," it will be eligible for an exemption from federal income taxes. There is, however, no such exemption for insurers. The Internal Revenue Service is quite sensitive about efforts by states to perform functions of private business. The Medical Indemnity Corporation of Alaska encountered this problem with the Internal Revenue Service, and it led to the sale and dissolution of MICA. It is my understanding that the Internal Revenue Service may have raised a similar issue about other Alaska public corporations. The Alaska Railroad is exempt from federal income taxes only because the federal legislation that authorized the sale of the Railroad to the state includes an express exemption specifically for the Railroad. (Dave Walsh, the Director of Insurance, was involved in the Railroad purchase and with MICA and is familiar with the issue.)

Liability for federal income taxes clearly could affect the financial situation of the Authority. Even more seriously, however, attempts to avoid such liability, through litigation or otherwise,

could result in needless expenditures of funds. On the other hand, if the Authority were to concede that it had an obligation to pay federal income taxes, it could establish a dangerous precedent for other public corporations that may have similar exposure.

2. Potential antitrust issues: The bill requires groups of health care providers to "negotiate" recommendations for reimbursement schedules. (Page 9, line 12) On its face, such "negotiations" raise questions about potential violations of the antitrust laws. Specifically, it might be alleged that such "negotiations" were a conspiracy in restraint of trade. Such allegations may be subject to the "state action" defense, since the "negotiations" would be required by state law. Without conducting legal research on this issue, I cannot evaluate how the federal antitrust laws might apply to this situation. The issue requires clarification, however, because, if there is any possibility of exposure to federal antitrust liability, including the provision for treble damages, it is unlikely that any health care providers would be willing to serve on the negotiating teams.

I hope these comments are helpful I will be out of the State until Wednesday, April 8, but my office can reach me if you have any questions before then.

Very truly yours,

ATKINSON, CONWAY & GAGNON

By Susan Wright Mason
Susan Wright Mason

SWM
LTR0492:27/5951.3

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PHONE (907) 562-2211

SISTERS OF PROVIDENCE
SERVING IN THE WEST SINCE 1856

April 14, 1992

Senator Arlis Sturgulewski, Chair
Senate HESS Committee
Members of Senate HESS Committee

Dear Senator Sturgulewski and Committee Members:

Thank you for the opportunity to present CHIPRA at the April 7, 1992, Committee Meeting. We healthcare providers are grateful.

I would entreat you to continue to work with us to develop a total healthcare reform approach for our State. Providers are concerned about healthcare costs. That is why we have come forward with the CHIPRA proposal. We have identified very specific cost containment mechanisms: prices and fees not exceeding the CPI, a base set at 1991 Medicaid charges, publication of prices and fees.

However, we know that in order to make a difference, the pieces of reform should be implemented as a package. If this is not possible, the first steps need to assist providers in keeping their costs down and relieving cost shifting to uncompensated care. This can be done by insurance reform and medical liability reform. To implement cost controls such as SB83 will not solve the problem.

The CHIPRA proposal requires all participate in a solution to healthcare reform. It is the only way that we can truly change the situation. Attachment I describes the areas of participation.

These sacrifices from all will result in a system that provides access to a basic health plan for Alaskans.

Thank you for your interest and leadership in this key issue.

Sincerely,

Sister Dona Taylor
Administrator

SDT:lp.0834D
cc: Harlan Knudson

OPPORTUNITIES TO ESTABLISH HEALTH CARE ACCESS AND COST CONTAINMENT

HEALTH CARE FACILITIES

1. Provide Commission/Health Board with prescribed data.
2. Hospitals of over 45 beds to establish in-house utilization and outcome monitoring system.
3. Hospitals to be at risk financially for prescribed utilization standards and prohibited from balance billing for defined excess utilization.
4. Must establish a uniform charge schedule for all patients unless separate schedules required by law or established with an entity (not individual or family) contracting for health care for a population group.
5. Must post understandable charge schedules for the public.
6. Must accept fee schedule assignment.
7. Must submit to annual rate information if rates exceed CPI.
8. Federal and state facilities must comply with same regulations as private sector (licensure and Certificate of Need).

OPPORTUNITIES TO ESTABLISH HEALTH CARE ACCESS AND COST CONTAINMENT

PHYSICIANS

1. Reimbursement schedules based on 1991 charge schedule provided for Medicaid reimbursement available to patients upon request.

2. Stay within CPI or limitations will be set.

3. Participate in expedited Medical Malpractice Settlements and Alternative Disputes Resolution Procedures.

4. Must comply with same licensure and Certificate of Need guidelines as other providers.

OPPORTUNITIES TO ESTABLISH HEALTH CARE ACCESS AND COST CONTAINMENT

INSURANCE COMPANIES

1. Provide purchaser with packages which include incentives for wellness.
   - Incentives for use of primary care physician, disincentives for inappropriate use of specialists and emergency rooms
2. Participate in, and fund, single claims clearing house, universal standard claim form.
3. Establish rates utilizing community rating.

JO/0163b

OPPORTUNITIES TO ESTABLISH HEALTH CARE ACCESS AND COST CONTAINMENT

INDIVIDUAL CONSUMER

1. Must provide proof of health care coverage in order to qualify for Permanent Fund Dividend.

2. Purchase/participate in CHIPRA if no other plan available, utilizing PFD to purchase (on sliding fee scale) if no other options available.

3. Commitment to healthier lifestyles:

   - Utilize insurance coverage for wellness approaches (following national recommendations age/sex physicals, and screenings).

   - Select and utilize personal primary care physicians for all family members (to avoid unnecessary use of specialists and emergency room care).

   - Follow easily available guidelines for better health. Appropriate weight, exercise, eating habits, use of seat belts and other safety equipment, no smoking, etc.

OPPORTUNITIES TO ESTABLISH HEALTH CARE COST ACCESS AND COST CONTAINMENT

STATE GOVERNMENT

1. Set up a reimbursement and benefits review commission to:

   - establish a Basic Health Plan (CHIPRA)
   - establish insurance pool and negotiate discounts.
   - establish centralized claims clearing house.
   - manage the provider data reporting system.
   - make public provider fee schedules for standard procedures.

2. Assure adequate and appropriate capitalization of the health care delivery system.

3. Establish medical liability reform as part of CHIPRA.

CHIPRA HIGHLIGHTS

1. All Alaskans must have at least basic health coverage. If they have no other resource and don't qualify for Medicaid, they use their Permanent Fund -- on a sliding fee scale – to apply towards the purchase of a CHIPRA Policy.

2. All Alaskans must provide proof of health coverage to obtain PF Dividend. ("Coverage" includes programs such as Indian Health Systems, Medicare, VA, etc.)

3. Preventive care covered 100% in CHIPRA. This offsets high deductibles of $1,000 individual, $5,000 family. (Benefit plan is not finalized.)

4. All CHIPRA members and all public employees in same insurance pool. Latter would continue to maintain and negotiate "CHIPRA PLUS" benefits (keeping current levels such as lower deductibles, expanded coverage etc. in place) Other CHIPRA participants could also select "PLUS" benefits, if they were willing to pay the extra cost.

5. Insurance rate would be Community, not Group rated.

6. Insurance premium and hospital/physician price control tied to CPI and rate review by authority.

7. Sets a System (Reimbursement and Benefits Review Commission or Health Board) and Standards in place, then allows market to drive the process.

8. Streamlines the system:

   - Single claim form and clearing house for all insurance companies doing business in the state.

9. Reforms medical liability process.

10. Establishes funding mechanisms for universal access by asking all parties to assume some responsibility. (Providers, large and small business, insurors, government, legal community, individuals.)

0160b

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SISTERS OF PROVIDENCE
SERVING IN THE WEST SINCE 1856

Fax to 8/5/83

March 22,1991

Dear Senator Sturgulewski,

Since Providence Hospital falls within your district, I wish to note that I am opposed to Senate Bill 83 which would create the Alaska Health Care Authority and Reimbursement System. My colleagues in health care and I truly wish to work with Senator Duncan in resolving the state's health care needs. We recognize and accept that all parties must be willing to make concessions and compromises for the good of all our citizens.

Basically, our concerns are not with the concepts of SB83 but with the prioritization - or order - in which it proposes change. The bill essentially places the problem of the uninsured on the back burner. I believe, however, that unless this issue is addressed it will be the Achilles heel in all other attempts to solve the puzzles of the health care delivery system.

Historic attempts at health care reform in the U.S. indicate the dilemma cannot be solved a piece at at time. All aspects must be addressed simultaneously.

SCR10 calls for a task force which would include all the players in the delivery system - Legislature/Business/Insurance and Providers. I would support this legislation. It provides an opportunity for all concerned to develop a solution.

I would be happy to talk with you further on these issues.

Sincerely,

Sister Dona Taylor
Administrator

HIAA

Health Insurance Association of America

STATEMENT OF HIAA

STATEMENT

of the

HEALTH INSURANCE ASSOCIATION OF AMERICA

on

HEALTH CARE FINANCING FOR ALL AMERICANS

and

SENATE BILL 83

Presented by

JAN ANDREA MEISELS

State Affairs Associate

Before the

ALASKA SENATE COMMITTEE ON LABOR AND COMMERCE

FEBRUARY 28, 1991

5072 Hackers Lane
Agoura, California 91301
818-991-0057

I am Jan Andrea Meisels, State Affairs Associate, Health Insurance Association of America. HIAA is a trade association of 300 private health insurance companies which provide health insurance for 95 million Americans.

The escalating spiral of health care costs continues to plague our society. The members of this committee are familiar with the effects on the Medicaid and Medicare programs. The private health insurance market has been no less immune to its deleterious effects.

The small employer market provides one of the most vivid examples of how health care cost inflation continues to afflict our financing system. Faced with unrelenting demands to hold health care costs down, insurers and employers have intensified the search for ways to moderate premium increases. Leaving high-risk individuals out of group coverage has been one such response. The "excessive employer churning" that newspaper accounts often bring to our attention is largely a function of employers seeking the lowest available rate. We, too, constantly hear the charge by small employers that the presence of a high-risk individual in their group has made it impossible to obtain coverage at any price.

This dynamic is complicated further by the tumultuous labor market of the small employer. Small employers are far more likely than larger organizations to go in and out of business. Our own annual employer survey suggests that employees of small firms also are more likely to change jobs. Employee turnover among small, insured firms is about 23 percent annually and is twice that level for small employers without coverage. These factors contribute to the reluctance of such employers to offer coverage as well as the difficulties of serving the market.

As the complexities of the small employer market have grown and the likelihood of individuals' being separated from the financing system has increased, there is a growing perception that even if they have coverage, they stand a reasonable chance of losing it if they change employers, or if they have poor claims experience.

Madam Chairperson, we have now reached the point where substantial small employer market changes are needed if we are to serve the longer-term interests of small employers and meet the concerns of policy makers. Last year the HIAA Board adopted a comprehensive set of recommendations that we believe can be achieved in the context of a viable private marketplace. Last week the HIAA Board overwhelmingly approved the final details of this proposal. The essence of our proposal is to make certain changes in the market so that it provides substantially more predictability and protection to the purchasers of coverage. Let me emphasize that, to work, these changes will have to apply to all players in the small employer market. All competing entities in the small employer market, including non-insured benefit plans, would have to be bound by the same rules in order to prevent any company or segment of the market from being placed at a disadvantage.

The small employer market precepts we recommend are:

1. GUARANTEED AVAILABILITY

All small employer groups would be able to obtain private health insurance regardless of the health risk they present.

2. COVERAGE OF WHOLE GROUPS

If a carrier chooses to cover an employer group, it would be required to accept the whole group. Individuals could not be excluded from coverage within the group for health reasons.

3. RENEWABILITY OF COVERAGE

At renewal time, employer groups and/or individuals within these groups would be assured that their coverage would not be canceled because their health had deteriorated.

4. CONTINUITY OF COVERAGE

Given the frequency with which small employers change carriers and employees in this market change jobs, individuals should have greater protection when making such moves. Therefore, when individuals are covered in the system, they would not have to face new preexisting condition restrictions, once those requirements have been fulfilled, in the event that they change jobs or their employer changes carriers.

5. PREMIUM PRICING LIMITS

There should be meaningful limits on how much an insurance carrier's rates could vary for employer groups of similar composition (similar demography, geography, benefit design and industry). This also would involve limits on how much a carrier could raise its rates for a specific group above and beyond general increases in trend factors.

Insurance carriers would retain the right to medically underwrite for purposes of assessing risk and setting rates but not to exclude individuals from coverage in a group plan.

6. VIABILITY OF A PRIVATE MARKETPLACE

Finally, a major objective of these reforms should be to ensure a viable private marketplace over the long term.

These precepts were adopted by the Board with the understanding that they will exact some pain for the industry in the short term, but are critical for coverage of the small employer over the longer term. They represent our industry's

commitment to meeting the needs of the small employer community by providing a responsive insurance marketplace.

To give effect to these proposals, government must authorize a private not-for-profit reinsurance organization. Otherwise, these reforms are not achievable. This organization would allow carriers to pay a premium in exchange for having the reinsurer bear the risk for reinsured individuals. Consistent with the small employer market changes, the proposal does not envision breaking up groups for purposes of reinsurance. Rather, insurers would treat all individuals in a group the same way; all members would have the same benefits. The reinsurer would stand behind the carrier and simply reimburse for claims associated with reinsured individuals. This will allow us to assure that high risks are spread, broadly through the private market rather than concentrated in one small employer group.

The reinsurance mechanism naturally would sustain financial losses or shortfalls, since carriers would reinsure only persons whose claims are expected to exceed the price of reinsurance. The intent of the proposal is that losses be financed privately. Losses first would be spread across carriers in the small employer market up to four percent of premium. If losses were not absorbed fully by the small employer market, a second tier of losses would be spread across health benefit plans of small and large employers, up to one percent of premium and premium equivalent.

These proposals will assure that no small employer, and no employee of a small employer, will be turned down for health insurance because of poor health. They will restore the concept of pooling risk across large groups, greatly limiting how much of the cost of poor health must be borne by the individual employer. Further they will moderate significantly the sometimes dramatic premium increases now experienced by small employers at renewal time and thereby reduce the incentive to change carriers frequently.

With our recommended market changes in place, the small employer will stand to benefit greatly from our rapidly evolving cost management capacity. These reforms will encourage competition based on efficiency rather than just selection. Competitors would no longer be allowed to draw business away from more efficient health benefit plans by offering temporarily low prices that skyrocket once an employee gets sick. Insurers that reduce inefficient administrative costs and that offer cost-effective financing systems and delivery networks will gain a larger share of what is an extremely price-sensitive market.

Another factor affecting high insurance costs for insured employers is the amount of mandated benefits and services the legislatures have required insured plans to include. Collectively across the United States the state legislatures have required 800 different mandates to be included in the insured product. While many of the mandates may have merits on their own it is the

cumulative effect of the mandates that increase the cost of insurance. The effect of the mandated benefits result in making the employer chose between a "cadillac plan" and no plan at all. A study by a respected health economist at the University of Illinois estimates that as many as 16 percent of uninsured small employers fail to offer coverage because of the added cost of state mandates.

It is ironic that the federal tax code forces employers to incorporate in order to get a 100 percent deduction for their health insurance plan. Self-employed individuals who also provide protection to their employees are only allowed to deduct a 25 percent deduction for their health plan. We have testified before Congress several times requesting the tax deduction for these individuals be increased and extended as the 25 percent deduction ends this year.

These small employers are the groups with the most working uninsured -- yet they are given the burden of mandated benefits and a reduced tax benefit to provide coverage to their employee. U.S. Department of Human Services Current Population Survey has indicated that nationally 66 percent of the uninsured are employed full-time work for businesses with 25 or fewer employees -- 46 percent work for employers with 10 or less employees.

The government has an important role to play in addressing affordable and available coverage to those who are at or below poverty level. While we are very pleased that in 1990 Congress adopted many of the HIAA recommendations expanding Medicaid coverage, we still believe there is more to be accomplished -- expanding Medicaid to all people who are at or below poverty level.

I want to emphasize that it is definitely not business as usual in the insurance industry. Besides the small group market insurance reforms which I have already discussed, the nation's insurers are moving on their own against what we know to be the root cause of so many of our problems, the ever spiralling cost of health care. There is a sea change under way in how insurers do business. Our companies are making, and have already made, major investments in managed care. They are no longer solely in the role of risk-spreading and claims processing. They are actively taking on the role of health care managers, devoting major efforts to the goal of getting better value for the health care dollar. The information technology that becomes more sophisticated each day increases our ability to make sound health care judgments on value, on quality, on under utilization as well as over utilization, on efficacy and outcomes. This role is a very different one from that of the traditional health insurer our companies previously fulfilled.

We recognize that there is no magic bullet to solve the egregious problem of unacceptable health care cost escalation. However, we in the private sector recognize that there is a substantial problem and have developed a very effective private sector tool which is just beginning to be used.

Escalating health care costs are not due to a single factor, but a multitude of factors: cost-shifting from government programs, such as Medicare and Medicaid and the uninsured; an aging population; new technology; increased consumer demand; proliferation of health care providers; and inappropriate services. Some of these factors are beyond anyone's control, i.e. the aging of the population. Other factors can be and are being addressed aggressively by the insurance industry. Eliminating inappropriate services which may account for 25 percent or more of medical expenditures is a critical objective, both as a way of reducing costs and improving quality of care. Managed care is increasingly recognized as the best mechanism for carrying our such improvements.

The key objective of managed care is to assure that patients receive appropriate care, that is of high quality care, efficiently provided in the least costly setting. Will it work? Our nation's business leaders think so. According to a survey of Fortune 1000 senior executives conducted by the Roper Organization, Inc., more than two-thirds (68 percent) believe that managing health costs through networks such as health maintenance organizations and preferred provider organizations is, or could be, effective; 89 percent of the executives polled have made changes in their corporate health plans, targeted at containing costs; and an overwhelming 94 percent oppose national health insurance as a solution for the escalating health financing crisis. The vast majority clearly think the private sector should take responsibility for solving their health care financing crisis.

SB 83

Much of the premise of SB 83 is based on the belief that expanding upon the Maryland Health Cost Services Commission model to all Alaskan health care providers will affect reductions in the overall rate of increase in health care costs. The Maryland Commission is a hospital rate setting commission. However, Maryland has a unique aspect -- which no other state currently enjoys, nor will another state enjoy -- a Medicare waiver. This waiver granted by the Health Care Financing Administration (HCFA) allows the state program to determine what rate Medicare will pay hospitals, rather than HCFA. This phenomenon has basically eliminated cost-shifting from the governmental payers, a very critical aspect as to why health care costs continue to spiral in other states, especially in the private market.

Other eastern states have hospital rate setting commissions, but do not have Medicare waivers. New Jersey which lost their Medicare waiver several years ago is currently undergoing a severe crisis, as the uncompensated care trust fund has not been renewed and if it was renewed 24 percent of each hospital bill would have been added as for uncompensated care. Currently some hospitals with high levels of uncompensated care are adding 60 percent of the bill to the New Jersey Commission approved

hospital rate to account for the uncompensated care. Clearly Medicare's under reimbursement is accounting for at least one-third of this add on, with Medicaid and the uninsured uncompensated costs making up the difference.

New York's hospital rate setting program has caused the hospitals $1 billion in operational losses. New York also had a waiver from 1983-1985. New York's uncompensated care is 40-45 percent of hospital bills.

Maryland, New York and New Jersey hospitals still are fighting the battle of uncompensated care as many people are uninsured and when they become ill and seek treatment, their unreimbursed costs become a factor in the rates of people with insurance.

Attached to this statement is a copy of a letter from John Colmers, executive director of the Maryland Health Services Cost Review Commission, indicating the budget of the commission for FY 1992 -- $1.885 million. This is the cost for only the operation of the commission's rate setting for 52 acute care hospitals, and six psychiatric facilities. Alaska would have to spend considerably more for the administration of such a Commission as the intent of SB 83 is to set maximum allowable rates for all health care providers -- individual and institutional.

The Maryland system does not address the issue of accessibility to health care, affordability of health insurance or health care nor does the system address appropriateness of care or quality of providers. Hospitals in a protected regulated environment lose incentives to be more cost effective. The HIAA program of Financing Health Care for All Americans, including managed care does effectively address all these issues, and therefore, the HIAA program will be more effective in assisting individual Alaskans, Alaskan employers and labor organizations to increase affordability of health insurance and health care, increase accessibility to those without insurance and foster cost effective, quality health care.

Phase II of SB 83 would essentially eliminate the private insurance market and develop a state health insurance program. We strongly believe that the private insurance market is a much more viable and effective entity than a government administered program. Both Medicare and Medicaid are government programs that have resulted in broken promises, budget deficits and both arbitrary reductions in eligibility to the poor and payments to providers for services they are expected to render at inadequate reimbursement rates resulting in many providers who will not accept Medicaid patients.

For all the reasons expressed above, we believe the HIAA proposal does more for containing costs, increased accessibility and effectiveness of health delivery systems.

STATE OF MARYLAND

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SUSAN R. GUARNIERI, M.D.
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JOHN M. COLMERS
EXECUTIVE DIRECTOR
KURT F. PRICE
DEPUTY DIRECTOR

HEALTH SERVICES COST REVIEW COMMISSION
4201 PATTERSON AVENUE—2ND FLOOR—BALTIMORE, MARYLAND 21215
AREA CODE 301-764-2605
FAX-301-764-5987

February 15, 1991

Ms. Jan Meisels
HIAA
6052 Hackers Lane
Agoura Hills, California 91301

Dear Jan:

Enclosed, as requested, is a copy of the Annual Disclosure Report released by the Commission at its February 6, 1991 public meeting. You have also asked for information regarding the budget of the Commission. The proposed FY92 budget for the Commission is $1,885,385. Health General Article Section 19-207.1 authorizes the Commission to include two-thirds of this budget amount in the rates approved by the Commission. Hospitals collect this money from the payors and reimburse the state annually.

Should you have any additional questions, please feel free to contact me.

Sincerely,

John M. Colmers
Executive Director

enc.

general\meisels

TTY for The Deaf
Baltimore Area 383-7555
D.C. Metro Area 565-0451

NEA-ALASKA

AFFILIATED WITH THE NATIONAL EDUCATION ASSOCIATION

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FAIRBANKS REGIONAL OFFICE
2118 CUSHMAN STREET
FAIRBANKS, ALASKA 99701
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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 AFL-CIO

2501 Commercial Dr
Anchorage, Alaska 99501
(907) 258-6284

319 1st Ave
Fairbanks, Alaska 99701
(907) 456-2030

MANO FREY
Executive President

February 27, 1991

Senator Jim Duncan
P.O. Box V
Juneau, AK. 99811

Dear Senator Duncan:

On Thursday, February 21, the Executive Board of the Alaska AFL-CIO voted its unanimous support for SB-83, a measure introduced to decelerate the cost spiral of health care for Alaskans.

The unchecked increases in health care costs is of grave concern to all Alaskans. It has priced insurance right out of the market for many small businesses, resulting in a drastic increase in the percentage of uninsured/ underinsured citizens. This in turn has dumped a greater proportion of the costs on those of us who are fortunate enough to enjoy comprehensive insurance coverage. Alaskans can no longer afford to leave this problem unresolved.

SB-83 is the most comprehensive, reasonable, and effective legislation we have ever seen introduced in this area. It would provide a long-term policy rather than a short-term fix.

With regard to health care cost containment and access questions, all too often public officials are quick to agree that someone else should do something about it. The Alaska AFL-CIO applauds your leadership in the field of health care quality and access through your introduction of SB-83 and urges its passage.

Yours in Progress,

Mano Frey
President

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.

Health Consumers Of Alaska, Inc.
P.O. Box 91539
Anchorage, Ak. 99509
(907) 277-6219

Senator Jim Duncan
AK. State Legislature
Pouch V
Juneau, Ak. 99801

3-18-91

Testimony SB 83+84

Dear Senator Duncan,

This letter is a follow up on The Public opinion message of support sent to you last week. I also talked directly with your staff and offered to provide testimony by members as well as by myself.

Truly your efforts to help control the ever escalating prices of Health care services are sincerely appreciated. The present condition is unacceptable to the Public and to the health consumers.

We all recognize I'm sure that there is no single cause for the rapid price increases; on the other hand, some of the causes are more outstanding than others and need to be dealt with now. The providers are simply not entitled to raise prices without adequate justification, and this would be the responsability of a price review board or authority. The consumer would not be required to pay for errors by the management of the provider organization.

While we may all agree that we have many fine providers in Alaska, and in my opinion we certainly do, none the less we should not hesitate to express concern about high prices and their causes. A check and balance system is absolutely necessary in our opinion.

We want to expressly thank you for having the courage to confront the problem, for demanding a solution, and then for offering a realistic solution.

We have reviewed your Bills. We have heard " the tree fall in the forest" We stand ready to work with you in any way we can.

Sincerely,

Dr. Mike Beirne, M.D.
President

The Health Consumers Of Alaska is an Alaskan non-profit corporation organized in 1987. An informed consumer is our goal.

NORTH SLOPE BOROUGH

OFFICE OF THE MAYOR

P.O. Box 69
Barrow, Alaska 99723

Phone: 907-852-2611

Jeslie Kaleak, Sr., Mayor

April 10, 1991

Senator Sturgulewski
Chairperson, Health, Ed. & Social Services Committee
P.O. Box V
Juneau, Alaska 99811-3100

Dear Senator Sturgulewski,

I recently received a letter from Senator Duncan, along with its enclosures of the Alaska State Health Care Cost Containment Task Force Report and the drafts of the associated House and Senate Bills, requesting my support for certain pieces of legislation he is sponsoring. More specifically, the bills are SB 83 & 84. I want to commend the members of the Task Force for their hard work in attempting to find solutions to the overwhelming problem of health care cost containment.

After lengthy review by myself and my staff, I feel it is necessary to draw your attention to some of our primary concerns regarding the proposed legislation. The specific areas of concern include, but are not limited to, 1) Procurement of Coverage, 2) Administration of Coverage, 3) Pricing of Coverage and Cost of the Program, 4) Provider Rate Setting, 5) Eligibility Criteria, 6) Definition of Group Health Insurance, 7) Certificates of Need, and, 8) Evaluation of need for mandatory participation. Until these concerns are specifically addressed, the North Slope Borough cannot support the proposed legislation. In fact, we find the bills both unacceptable and unnecessary.

1) **Procurement of Coverage:** It is unclear in the legislation as to the Alaska State Health Resources Authority's actual ability to contract with insurers, the number of insurers or consultants it would contract with, and how the costs of such services would be distributed to the participants. We are curious as to who will do, and when will, a cost-benefit analysis be completed with respect to the costs of procuring and maintaining a state-sponsored healthcare authority?

2) **Administration of Coverage:** The legislation is also unclear with regard to who would administer insurance claims. It appears to give the Health Resources Authority the power to administer claims but it is unlikely this would occur, even if the state elects to self-insure. The state of Alaska has seen several private insurance carriers attempt to maintain local claims processing office. Economics has proved this venture to be a

costly undertaking. The metropolitan areas of Anchorage, Fairbanks and Juneau cannot seem to maintain a large enough, or skilled enough, pool of labor to efficiently process a large number of claim transactions. We offer as examples Aetna and Travelers who both found it not cost effective to maintain local claims adjudication offices.

In addition, we understand that the Health Authority would have the power to administer the plan eligibility and implementation, and utilization standards, but, the Health Authority does not possess the information to do so. The three insurance carriers who do most of the business in the state have spent several years establishing their databases. Utilization standards are often considered proprietary information, not for sale or outside use. How would the Health Authority overcome this problem?

3) **Pricing of Coverage and Cost of the Program:** The bills are not clear with respect to how exactly coverage would be priced for the participants. Under the proposed bills, SB 83 and HB 71, the Health Authority would establish a pool or pools of eligible employees, for the purposes of providing health coverage. It is not stated whether this eligibility definition would involve the use of community rating for the group or groups, or, whether groups would be specifically established based upon risk categories.

If Alaska's state pool becomes solely high risk health insurance, the costs associated with this program will be extremely high. As rates increase due to poor risks, the pool will be left only with the least healthy of the population as they must accept all applicants in the absence of pre-existing exclusions. High losses associated with this will be paid by the carrier(s) or, in the worst case, by the state if the Authority elects to self insure. Without a reinsurance mechanism, carriers will leave, or never participate in, this market because they cannot afford these types of expected high losses.

Also, even without high losses, the establishment and administration of the program will be costly for the state. Current budget projections for Alaska predict deficits in future years. In addition, the Alaska economy is an unstable one which cannot count on a consistent level of income from year to year.

4) **Provider Rate Setting:** Experience in six states which utilize a statewide hospital rate setting system (CT, MA, NY, NJ, MD, WA) has shown that between 1980 and 1989, states with rate setting arrangements have no clear cost advantage over states without rate setting. In fact, in recent years, some rate setting states have experienced growth rates for hospital costs in excess of the national average. For example, in 1988, five out of six rate setting states had growth rates for costs per admission above the national growth rate; in 1989 three of the six states had growth rates 2-6 percent above the national average.

The rate setting system used in Maryland is often cited as one which has been successful at consistently controlling hospital costs. Between 1980 and 1989, Maryland was the only one of the six rate setting states which had a cost per admission growth rate below

the national average for every year. However, the spread between Maryland's rate of growth and that for the nation has significantly narrowed in recent years. More importantly, on a per capita basis, in 1988 Maryland had a higher percentage increase in its costs than the average for either the five other regulated states or the national average.

Alaska, which is not currently a regulated state, has had a rate of growth for hospital costs which is not out of line with that for the regulated states over the past ten years. In 1989, Alaska's per admission hospital costs rose almost five percent less than the national average, and were between 2 and 11 percent lower than any of the six regulated states, including Maryland. The North Slope Borough has experienced per hospital admission costs between 4 and 9 percent below those of the six regulated states.

5) **Eligibility Criteria:** The proposed legislation is not clear in the area of defining who is eligible for the state's coverage or what criteria would be used to determine eligibility. If current eligibility language from either employers or insurers is used, the problems of "uninsured", "underinsured", and "uninsurable" individuals remain unaddressed. These people will continue to fall outside of the affordable health care providing arena. All public employers appear to be eligible (along with all employees of this group); other (i.e., private) employers (or their employees) can elect to join the pool (or use only the rate setting and utilization standards), yet no more specific criteria (i.e., pre-existing conditions language) is given.

Because of the vagueness of the definition of "eligible", we are prone to believe that ***adverse selection*** will occur. If the state allows all employer groups or any of their employees to join the pool, only the high risk individuals or groups will elect this coverage. The ramifications of this language will create a pool with a similar demographic cross section to that of COBRA participants. Small employers will act in their own best interest and sign up their unhealthy (i.e., high risk) employees for the pool when they need coverage and then withdraw them (take them out of the pool, back to their own plan) when they get healthy. Even if coverage is not community rated, this would be a problem since there are no pre-existing exclusions included in this Bill, thus, all could sign up.

If the plan is community rated, adverse selection poses a more severe problem. State employees pose no selection problems since all will join, not just the high risk cases. Under pure community rating, state employees will face much higher rates since the bad risks from the private employers will drive up rates for all. If coverage is not community rated, rates will still need to be higher since the good risks will need to subsidize the bad.

6) **Definition of Group Health Insurance:** Senate Bill 83 and House Bill 71 define group health insurance as including " life insurance, accidental death and dismemberment, medical care and treatment, dental care, eye care, and other group health coverage as determined by the authority". We are very concerned that these bills do not address life insurance and accidental death and dismemberment coverages when

discussing rate setting and administration. The North Slope Borough has better-than-average life and AD&D experience and would undoubtedly see additional benefit cost increases.

7) **Certificates of Need:** With respect to the requirement of Certificates of Need, Sec. 3, SB 84, and the definition of a "health care facility" in, Sec. 16, SB 84, we will need some additional clarification. As you may know, the North Slope Borough and several of the other rural Borough's have municipal powers in the Health area.

We have a Health Department that has satellite health aide facilities in each of our eight villages and the two primary urban centers, Fairbanks and Anchorage. The definitions of a health care facility and the requirements for Certificates of Need could greatly affect the services this department provides to our entirely rural population. In fact, the requirement of Need Certificates justifying an addition of services in the rural areas could be very restrictive. Such a requirement will also affect our only hospital, the Barrow Public Health Service Hospital. Adding services in an area that has few or no services currently can only save us money in the short and long run.

8) **Evaluation of need for <u>mandatory</u> participation:** Requiring participation of public entities in the group health insurance offerings of the Alaska State Health Resources Authority would cost the North Slope Borough a great deal of money in both the long- and short-term.

If group insurance costs were mandated at the rate the state currently spends for health care, the North Slope Borough would immediately find its health care costs increase approximately 35%, or, $1,000,000 per year. If coverage is not mandated, but remains voluntary, and since all public and private employers and employees are permitted to use the rate setting agreement, those who choose not to would have costs shifted onto them. (This scenario is unlikely unless the state allows only those in the pool (or puts some other condition on the use of the rate setting) to use the rate setting arrangement.) It appears that either way costs will increase for us, but, they will increase the least with a completely voluntary participation clause for public entities.

Also, given that all providers would have the state set rates for them, hospitals would lose a substantial amount of revenue, thus reducing the dollars available to purchase new equipment, hire skilled physicians, etc. Between the services the Borough currently provides, those services that PHS provides, and our exempt status under the IHC Act, we could only see cost increases through mandated participation.

Senator Stugulewski, we do realize that health care cost containment is one of the primary issues that both the public and private sectors must work together on for solutions. We again acknowledge the hard work the Task Force has put into their report and thank you for including us in your informational search. Please feel free to contact

my office if you need clarification of any of our concerns, or have any comments regarding our information.

Sincerely,

Jeslie Kaleak, Sr.
Mayor

cc: Rep. Eileen MacLean
Sen. Al Adams
Sen. Fischer, Vice-Chairman, HES
Sen. Cotten
Sen. Hoffman
Sen. Menard

AVCP

Association of Village Council Presidents

Pouch 219 • Bethel, Alaska 99559

(907) 543-3521

April 6, 1992

Senator Lyman Hoffman
Pouch V
Juneau, Alaska 99811

RE: S.B. 83, Alaska State Health Resources Authority

Dear Senator Hoffman:

Thank you for the opportunity to comment on S.B. 83. As Mike Smith pointed out in our telephone conversation last week, I had written last year in opposition to the bill. However, after I read the latest (3-27-92) version (which your office faxed to me), I have learned that this is a very different bill.

After having discussed S.B. 83 with Senator Duncan's office (Dale Staley) and with Dave Mather (Health Resources and Access Task Force), as well as others who oppose the bill, I am ready to urge your support of the bill. It may not be perfect, but I believe it is worthy of support.

As I understand the latest version, the rate setting is designed to limit health care expenditures for all state residents and will not only apply to those whose insurance is procured through the Authority. Therefore, there is no opportunity for cost-shifting, such as occurs with medicare.

Other features of the bill, such as the data-gathering elements, should provide useful information in order that future decisions can be made based on accurate and comprehensive information.

There is probably some degree of risk of "quality-flight" and access reduction (i.e., the best health care providers leaving the state) with this bill. Ideally, for this reason, I would probably rather support a national solution, such as a Canadian-style single-payer system. However, no such national solution appears imminent and I believe it is necessary for Alaska to do what it can to help its citizens deal with sky-rocketing health care costs and not wait for the Federal government. Other states are moving forward, thus limiting the risks of health care shortages in Alaska that could be caused if "looser" requirements exist in many other states. Hopefully, the negotiation aspects of the bill will also prevent this from being a serious problem.

I realize my support of this legislation puts me at odds with the stated position of the TIPSA trust, of which AVCP is a member and I am a trustee. However, as I stated above, this version of S.B. 83 is a very different piece of legislation than what was originally introduced.

Sincerely,

ASSOCIATION OF VILLAGE COUNCIL PRESIDENTS
Myron Naneng, President

Lee Olson, Vice President of Finance

cc: Senator Jim Duncan
Senator Al Adams
Senator Fred Zharoff
Representative Ivan M. Ivan
Representative Richard Foster
Representative Georgiana Lincoln
Representative Jerry Mackie

4421 E. Huffman Road
Anchorage, AK 99516
March 27, 1991

Senator Arliss Sturgulewski
Alaska State Legislature
P.O. Box V (MS 3100)
Juneau, AK 99811

Dear Senator Sturgulewski:

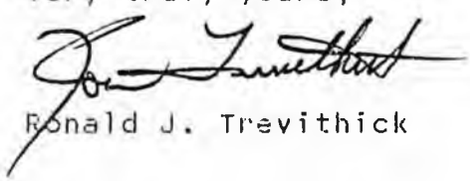
I'm deeply concerned that Alaska Senate Bill 83, sponsored by Juneau Senator Jim Duncan, is the wrong approach for solving the problems of access and rising cost of health care. These problems are complex and require careful study before we embark upon a set of solutions that could bring even greater turmoil to our already troubled health care system.

For example, the Duncan proposal would impose price controls on services. Providers would be limited to what they could charge. On the surface, this may sound like a good idea, but over a period of time, the quality of services will surely decline and many health care professionals will relocate to places where their earnings potential is not controlled by government. Since the program is voluntary for private employers, the bill does nothing to improve access for the thousands of individuals who cannot afford health insurance.

The proposal also calls for creation of a state government agency to administer a government authorized insurance program. Not only does the insurance pool arrangement described in the bill have several financial and underwriting difficulties, it will mean additional cost for taxpayers of the state.

I believe a better option would be to improve upon our existing public/private system rather than creating an expansive government bureaucracy. Yes, we all would like to stop the rapid escalation of health care cost, but Duncan's approach won't work!

Very truly yours,



Ronald J. Trevithick

Alaska State Legislature

Please enter into the record my testimony to the Senate H.E.S.S. committee name

committee on Health Task Force bill/subject, dated 3/25/92.

March 25, 1992

TO: Senate H.E.S.S. Committee

FROM: Rose Palmquist 376-2274
president, O.P.A.G.
POB 870294
Wasilla, 99687

RE: COMPREHENSIVE HEALTH COVERAGE AND COSTS

Dear Chairman of Health Task Force,

Your testimony on 3-25-92 was very impressive and acceptable as a beginning towards health care for all.

The task Force obviously addressed the concerns.

Signed: _____

Name	Rose Palmquist	Phone (H)	376-2274
Title	Pres OPAG	Phone (O)	
Address	Box 870294- Wasilla AK	ZIP	99687

Address

Phone No.

1/14/92

Dear Senator,

I understand that Senate Bill 83 (Jim Duncan) deals with some form of state health insurance.

I am totally and unequivocally AGAINST a state (and a national) health care insurance system. Let's keep it in the FREE enterprise system that gives us the world's best health care. Government participation will not improve the situation but exacerbate it.

I hope you'll vote AGAINST S.B. 83.

Sincerely,
Jim Dore

J. DORE
11301 PYRAMID DR. #21
ANCHORAGE, AK 99516

344-1761

UNINSURED ALASKA POPULATION

Total Uninsured Population
(Excluding Native Population) **76,627**

Uninsured earning less than 300% of poverty level: 61.47% (47,106)
Uninsured earning more than 300% of poverty level: 38.53% (29,521)

Uninsured Children Under Age 19 **15,694** **(20.48%)**
(300% of Federal Poverty Level and below)

less than 100% of poverty level: 4,284 children
100 - 200% of poverty level: 4,888 children
200 - 300% of poverty level: 6,522 children

Uninsured Small Business Family Members **16,025** **(20.91%)**
- Firms with 25 employees
- Include full-time/full-year workers
- Does *not* include full time/part-year workers

Medically Uninsurable **4,000** **(5.22%)**
(i.e. "high risk" individuals)

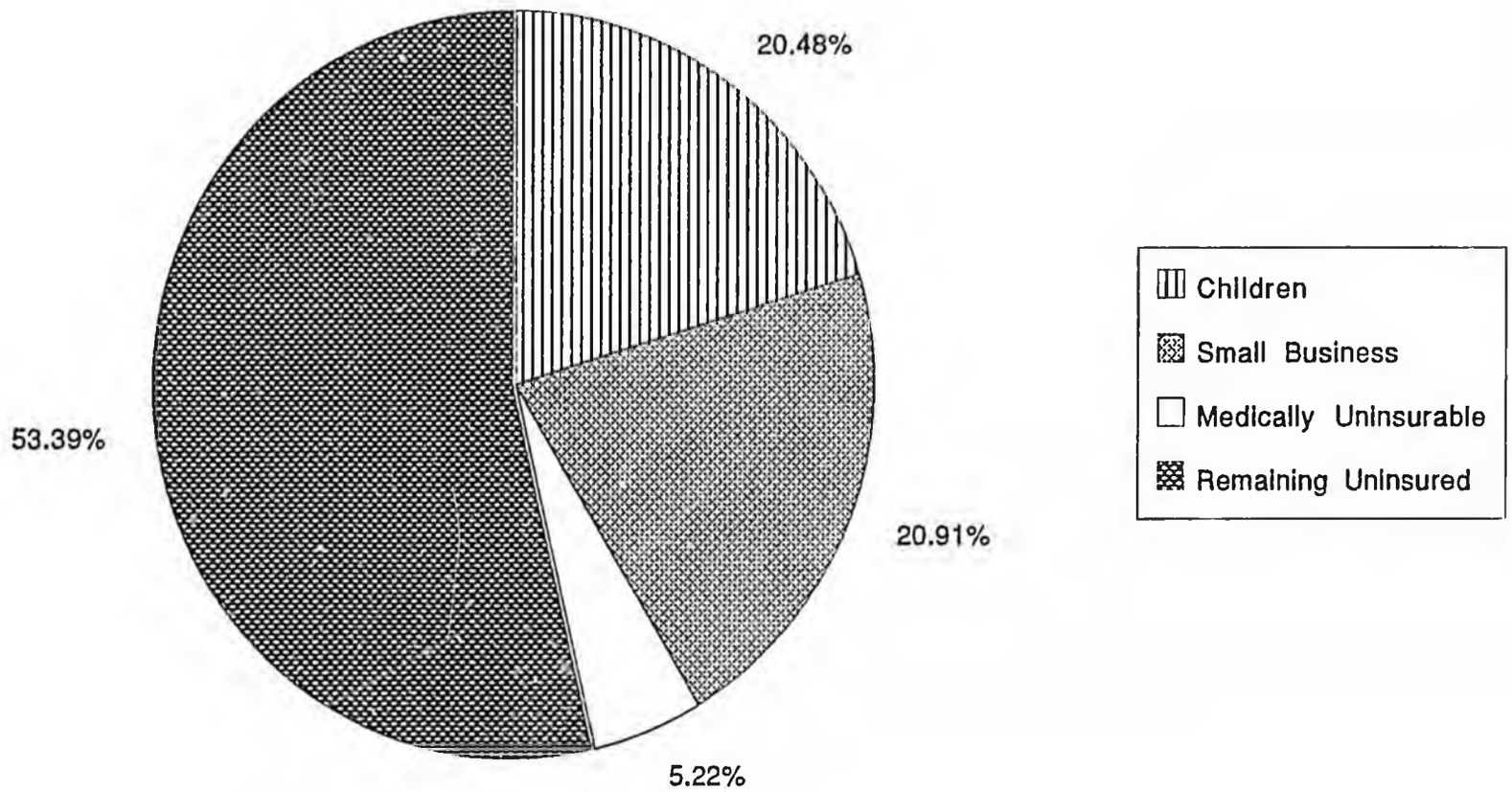
Above figures represent potential size of enrollee participant group for coverage provided under the terms of SB 74, SB 242 and SB 290. Actual enrollment will depend on specific benefit levels offered, participant premium/contribution levels, and participant cost-sharing provisions.

1992 Poverty Guidelines for Alaska

Size of family Unit	*Poverty Guideline (100%)*
1	$8500
2	$11,480
3	$14,460
4	$17,440
5 and above	extra $2,980 per member

Data Sources: Health Systems Research, Inc. February 7, 1992 report; Aetna estimates

UNINSURED ALASKAN POPULATION



COMPARISON OF SELECTED HEALTH REFORM PROPOSALS[1]

FEATURES	PROPOSAL												
	AHA	Pepper	Kennedy	AMA	Stark	NGA	USCC	BRT	HLC	NAM	ACP	AFL-CIO	NLC
OVERVIEW OF PLAN													
Approach													
pluralistic	X	X	X	X		X	X	X	X	X			X
unitary					X[2]						X[3]	X	
Access Assured													
universal	X	X	X	X	X	X		X[4]			X	X	X
not universal							X[5]		X	X			
PRIVATE PROGRAM													
Individual Mandates	X	X	X										X
Employer Mandates	X	X	X	X								X	X
phase-in	X	X	X	X									X
small employers permanently exempt													
minimum % of premium paid for full-time employees	50	80	80										75
minimum % of premium paid for dependents	50	80	80										
premium participation for part-time	X	X	X										X
Subsidies/Tax Incentives	X	X	X	X			X	X	X	X			
employer	X	X	X	X			X	X	X	X			
individual	X	X	X	X			X	X	X				
Cap on Tax Deductible Premium				X[6]									

AHA = American Hospital Association
Pepper = Pepper Commission
Kennedy = Kennedy's Basic Health Benefits for All Americans Act
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COMPARISON OF SELECTED HEALTH REFORM PROPOSALS (cont.)

FEATURES	PROPOSAL												
	AHA	Pepper	Kennedy	AMA	Stark	NGA	USCC	BRT	HLC	NAM	ACP	AFL-CIO	NLC
Insurance Market Reform	X	X		X		X	X	X	X	X		X	
reinsurance mechs./pools	X	X		X			X	X	X				
elim. pre-existing condition clauses	X	X	X	X			X						
required community rating		X	X[7]										
PUBLIC PROGRAM(S)													
Organization													
single program	X										X	X	
separate for different populations		X	X	X	X	X	X	X	X	X			X
Eligibility/Basic													
everyone					X						X	X	
poor	X	X	X	X			X	X	X	X			X
elderly/disabled	X		X[8]	X			X[8]	X[8]	X[8]	X[8]			X[8]
others on buy-in	X	X	X				X	X		X			X
Eligibility/Catastrophic													
everyone	X												
public program enrollees only		X			X[9]								
Funding													
federal	X	X	X	X	X	X	X	X	X	X	X		X
state		X	X	X	X	X	X	X	X	X	X		X
premiums	X	X	X		X	X				X	X		X
individual income-related	X	X	X		X	X				X	X		X
service specific	X[10]												

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COMPARISON OF SELECTED HEALTH REFORM PROPOSALS (cont.)

FEATURES	PROPOSAL												
	AHA	Pepper	Kennedy	AMA	Stark	NGA	USCC	BRT	HLC	NAM	ACP	AFL-CIO	NLC
employer	X	X			X								X
Administration													
federal	X	X			X							X	
federal/state		X[11]	X	X			X	X	X	X			X
private as TPA	X	X[11]		X	X		X	X	X	X			
private as underwriters				X									
BENEFITS													
Federal Definition Of Minimum Benefit	X	X	X	X	X	X[12]			X	X	X	X	X
applies to public plan	X	X[13]	X	X[13]	X	X			X	X	X	X	X
applies to private plans	X	X	X	X		X						X	X
Preemption or elim. of state mandates	X	X	X	X			X	X[14]	X[15]	X[16]			
Scope													
basic	X	X	X	X	X	X			X	X	X	X	X
catastrophic	X	X	X		X[17]								
preventive	X	X			X	X				X	X		X
long-term care	X	X[18]		X[19]	X	X							
Limits													
quantitative limits on services		X			X[17]					X			
dollar limits													
marginal services excluded	X												
medically necessary & reasonable	X	X	X		X						X		
high front-end deduct. and copays	X	X			X[20]								

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COMPARISON OF SELECTED HEALTH REFORM PROPOSALS (cont.)

FEATURES	PROPOSAL												
	AHA	Pepper	Kennedy	AMA	Stark	NGA	USCC	BRT	HLC	NAM	ACP	AFL-CIO	NLC
IMPROVED AFFORDABILITY													
Federally-Administered Controls on Prices or Total Expenditures					X							X	
State-Administered Controls on Provider Prices or Total Expenditures						X							
Optional Use Of Public Program Rates By Private Insurers													X
Incentives Operating Among Purchasers, Providers, And Consumers With Negotiated Payment	X								X	X			
Required Management Of Care	X	X								X			
all care	X												
only selected services (e.g., long-term care) or selected populations		X			X					X			
Promotes Management of Care		X						X	X				
Disclosure Of Provider Cost And Quality Data	X	X						X	X	X		X	X
Guidelines On Technology And Special Services	X	X				X		X				X	
Use Of Medical Practice Parameters	X	X		X		X	X	X				X	X
Tort Reform	X	X		X		X	X	X	X	X	X	X	X
Anti-trust and Other Legal Reforms to Promote Cost Containment	X									X			
Promotion Of Living Wills And Advance Directives	X												

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Endnotes

1. Some of the proposals are at the "principles" stage and may change significantly. Please refer to the attached summaries for the source and status of the information reflected in this chart.
2. Rep. Stark's proposal calls for public program coverage of all Americans for basic coverage, but it also mandates that employers supplement basic coverage with private coverage if they currently provide more than MediPlan's benefit package. Consequently, this "maintenance of effort" provision takes on some of the character of a pluralistic system. MediPlan LTC is completely public.
3. ACP's position paper presents a national universal financing plan as its long-term goal, but concedes that the immediacy of current access problems may make it necessary to suppport incremental expansions in insurance coverage through Medicaid expansions and, perhaps, an employer mandate. The recommendations presented in their paper are limited to the long-term goal.
4. While BRT's principles call for universal access, the program elements reflected in the principles would not provide for universal access.
5. The USCC adopted a long-term goal of universal access through a pluralistic system, but its proposal is limited to an expanded Medicaid program and a series of provisions designed to improve access to affordable private insurance.
6. Also includes tax-exempt rebates to employees selecting insurance plans with premiums less than those of employer's other plans.
7. Community rating would be required only for the system of regional insurers who would provide insurance to small businesses.
8. Does not propose any alterations of the Medicare program.
9. Catastrophic protection provided only for low-income enrollees.
10. Premiums would be service specific only for expanded benefits to current Medicare beneficiaries whose premium and cost-sharing levels for current services would be grandfathered under the new public program.
11. Presented as one of several options.
12. NGA splits this responsibility between federal and state governments: the federal government would establish guidelines for minimum benefits, while state governments would be responsible for establishing a process to develop, determine, and define the specific benefit package.
13. Enriched package under public plan.
14. BRT would eliminate any federal or state mandated benefit laws.
15. Exemption from state mandated benefit laws would appear to apply only to small employers.
16. Provides exemption from state mandated benefit laws only for basic catastrophic plans.
17. Quantitative limits for hospital care benefits and cost-sharing are eliminated for low-income individuals, thereby providing for some catastrophic coverage for the poor.
18. Means-tested.
19. Asset protection plan.
20. High front-end deductibles and copayments would apply only to long-term care coverage.

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AB 83 L+C

Mary,

AP.
AB 84 HCS
C.A. comm.

Plz hold for
bill file
(will prob.
be introduced
Mon
or
Tues

Alaska State Legislature

SENATOR JIM DUNCAN

P. O. BOX V JUNEAU, ALASKA 99811-3100

(907) 465-4766

COMMITTEES:
FINANCE
VICE CHAIR – HEALTH EDUCATION & SOCIAL SERVICES
BUDGET & AUDIT
BANKING & ECONOMIC DEVELOPMENT

January 17, 1991

MEMORANDUM

To: All members
Health Care Cost Containment
Task Force

From: D. Gray, Staff

Re: Task Force meeting Friday, January 18.

Note that the Task Force meeting place has been changed to the Governor's Conference Room on the third floor of the Capitol building.

Attached is the meeting agenda and material relating to the agenda. The draft report is yet to be completed. Two legislative proposals are included for your review. One relates to the certificate of need process and the other establishes the Alaska State Health Resources Authority.

NOBLE LOWNDES
Consultants & Actuaries

JEFF MALEK

MEETING AGENDA

HEALTH CARE COST CONTAINMENT TASK FORCE

January 18, 1991

Governor's Conference Room

10:00 a.m.

1. Review of interim activities.
2. Recent developments.
3. Status of Task Force report.
4. Proposed legislation.
5. Other business.

HEALTH CARE COST CONTAINMENT

TASK FORCE

Interim activities of the Task Force

1. Public hearings in Fairbanks, Juneau, and Anchorage (teleconferenced to all other sites).

2. Information surveys of municipalities, school districts, health facilities, and health care providers.

3. Alaska health care funding and expenditures analysis.

4. Additional meetings and communications:

   A. Alaska School Board Association.
   B. Alaska Municipal League.
   C. Alaska Municipal Finance Officers Association.
   D. Alaska Hospital and Nursing Home Association.
   E. Alaska State Medical Association.
   F. Anchorage Medical Association.
   G. Alaska business group.
   H. NEA Alaska.
   I. Alaska State Employees Association.
   J. National Governors' Association.
   K. AFSCME Washington, D.C.
   L. Families USA (Senior citizen advocacy group).
   M. National Leadership Commission on Health Care.
   N. Physicians Payment Review Commission.
   O. State of Maryland.
   P. State of Washington.
   Q. State of Louisiana.
   R. State Alliance for Universal Health Care.

HEALTH CARE COST CONTAINMENT

TASK FORCE

REPORT TO THE LEGISLATURE

Draft Outline

I. Introduction

A. History of Task Force.
1. Beginnings
2. Purpose
3. Accomplishments

B. Extension.
1. Finish investigation of long range solutions.
2. Effects of uninsured/underinsured residents' health care.

II. Investigation and work plan.

A. Determine the nature and extent of rising health care costs in Alaska

B. Work Plan
1. Research.
2. Surveys.
3. Public hearings.

III. Findings: Nature of health care in Alaska.

A. Funding sources (Fed., State, local govt., and private).
B. Alaska population health care payment and accessibility demographics
C. Health care provider demographics.

IV. Findings: Sources of health care cost increases.

A. Previous capital expenditures
B. Labor availability and cost.
C. Technology.
D. Uncompensated care.
E. Costs associated with litigation.
F. Inefficient delivery and reimbursement systems
G. Cost shifting from other programs
H. Federal program changes.
I. Health care market place competition issues

V. Long term cost containment proposals.

VII. Recommendations

VIII. Future considerations for Health care in Alaska

STATE OF ALASKA

HEALTH CARE COST CONTAINMENT

TASK FORCE REPORT

TO

THE SEVENTEENTH LEGISLATURE

SUMMARY OF FINDINGS AND RECOMMENDATIONS

DISCUSSION DRAFT -I

CONFIDENTIAL . FOR TASK FORCE MEMBERS USE ONLY

FEBRUARY 1991

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE
REPORT TO THE SEVENTEENTH LEGISLATURE

INDEX

SECTION

EXECUTIVE SUMMARY.....i

OVERVIEW.....1

TASK FORCE WORK PLAN AND OBJECTIVES.....2

STATE EMPLOYEE AND RETIREE HEALTH PLAN UPDATE / RESULTS....3

HEALTH CARE EXPENDITURES IN ALASKA & U.S. 4

CAUSES OF RISING HEALTH CARE COSTS IN ALASKA 5

HEALTH CARE DELIVERY SYSTEM FINDINGS AND SURVEY RESULTS....6

POTENTIAL SOLUTIONS TO SLOW MEDICAL INFLATION.....7

TASK FORCE RECOMMENDATIONS 8

TASK FORCE LEGISLATIVE CONSIDERATIONS 9

OPEN/UNRESOLVED ALASKA HEALTH CARE DELIVERY ISSUES 10

APPENDICES 11

EXECUTIVE SUMMARY

The purpose of this section of the report is to give an overall perspective of the problems facing Alaska with rapidly rising health care costs and propose solutions to stem this problem.

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 1989, total Alaska health care expenditures are estimated to be in excess of 1.5 billion dollars up from 250 million in 1979, with no substantial change in the states population.

Health care expenditures have been rising at a rate of over 20% each of the last five years in Alaska. These trends are not unique to Alaska alone. 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 CPI.

These rapidly rising costs further exacerbate the uninsured population in Alaska, which recent estimates indicate that more than 90,000 Alaska residents are uninsured. This increase in costs have substantially driven up health insurance premiums for all employers , making it very difficult if not impossible, to continue coverage.

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 this work completed and showing favorable results, the Task Forces' charge was expanded during the last session to include reviewing the health care costs 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 options available to the state.

During this review the Task Force has identified not a sole culprit but numerous contributing factors that must be reviewed in a 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
* Malpractice Insurance Costs and Protective Measures
* 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 Public and Private Health Plans
* Life Style diseases and injuries
* Mandated Benefit Coverage
* Limited Access to Private Health Plans
* No Managed Care Delivery Systems IN Place

Although a long and far reaching list each item must be comprehensively addressed to achieve the stated goal of stabilized medical costs in Alaska and basic Health coverage for all Alaskans'.

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 157.2% over the last 10 years, the second highest in the nation[1][2]

1

2 Families USA Foundation Report Nov.1990

FINDINGS CONT.

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 2.0 Billion in FY 95.

3. The number of uninsured residents in Alaska has increased at an alarming rate to a estimated 90,000 uninsured residents, representing 16.5% of the total population in Alaska.

4. The cost of providing health coverage for State employees and their dependents has been reduced and stabilized at $385.00 for FY 90 and 91. This compares favorably with the most recent survey of State's health care premiums that showed only one other state (Arizona) premiums were reduced, and three other State's premiums were held at the 1989 level[3].

5. The survey done by the Task Force revealed :

[3]Survey of State employee health benefit plans 1990 Martin E Segal Company

DISCUSSION DRAFT

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE

RECOMMENDATIONS

The Health Care Cost Containment Task Force has over the last nineteen 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 contributing factors that should be focused on as a minimum starting point to bring health care expenditures in control for Alaska.

*Low occupancy rates at facilities
*Cost shifting from other programs
*Federal program cost shifting
*Inefficient delivery systems
*Uninsured / underinsured Alaska State residents
*Accessibility of care
*Mandated coverage costs
*Lack of involvement and education for end users
*Lack of current and meaningful data

After evaluating the many contributing factors , the following recommendations are designed to provide long term health care cost management for Alaska.

1.Establish a State Health Insurance Authority that would be responsible for:

A. Establishing and maintaining health care provider payment and utilization schedules taking into consideration geographic,availability, medical necessity and overall cost effectiveness (potentially using an established system as a foundation);

B. Establish a health care procurement and financing pool to maximize purchasing power for;

i State , local gov't and political subdivisions (Voluntary)

ii. Underinsured/uninsured for State residents

iii.Small employers plan

These Pools would be governed by a board and would provide health insurance on the most cost efficient basis.

C Collection and analysis of state health care utilization/cost data, to recognize trends and recommend solutions to the appropriate entity.

.2 Continued monitoring and certifying of facilities.expansion and substantial equipment purchases to assure need and eliminate duplication or unnecessary expense.

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

4. Provide health care for the underinsured/uninsured at an affordable premiums.

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

EXHIBIT I

H.C.C.C. TASK FORCE CHART 1

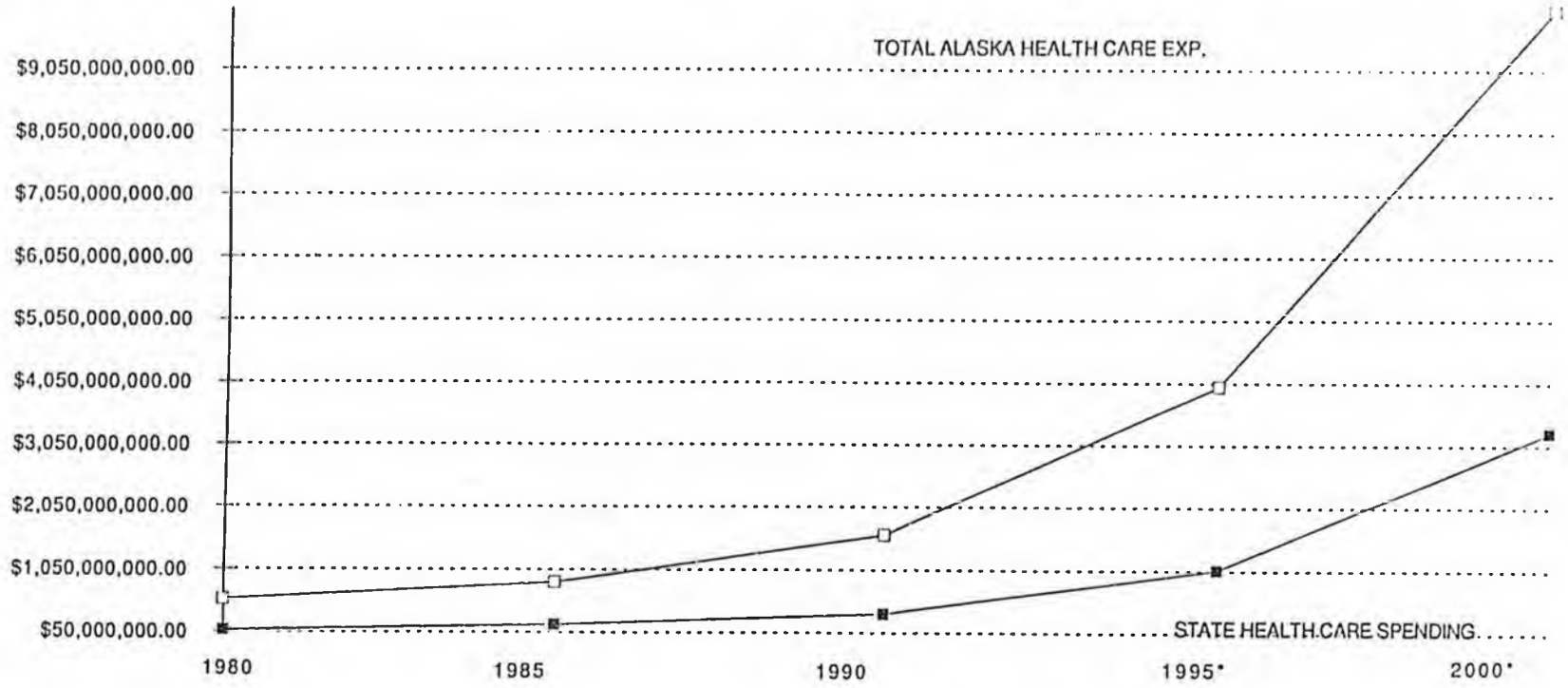
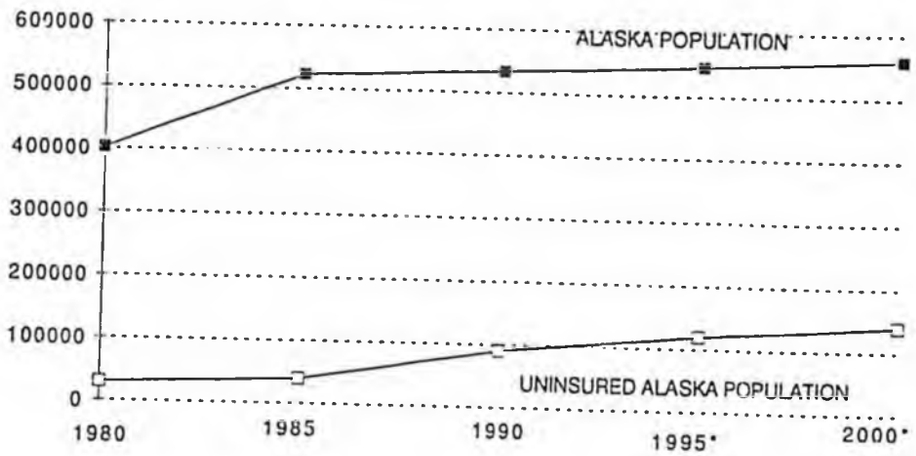
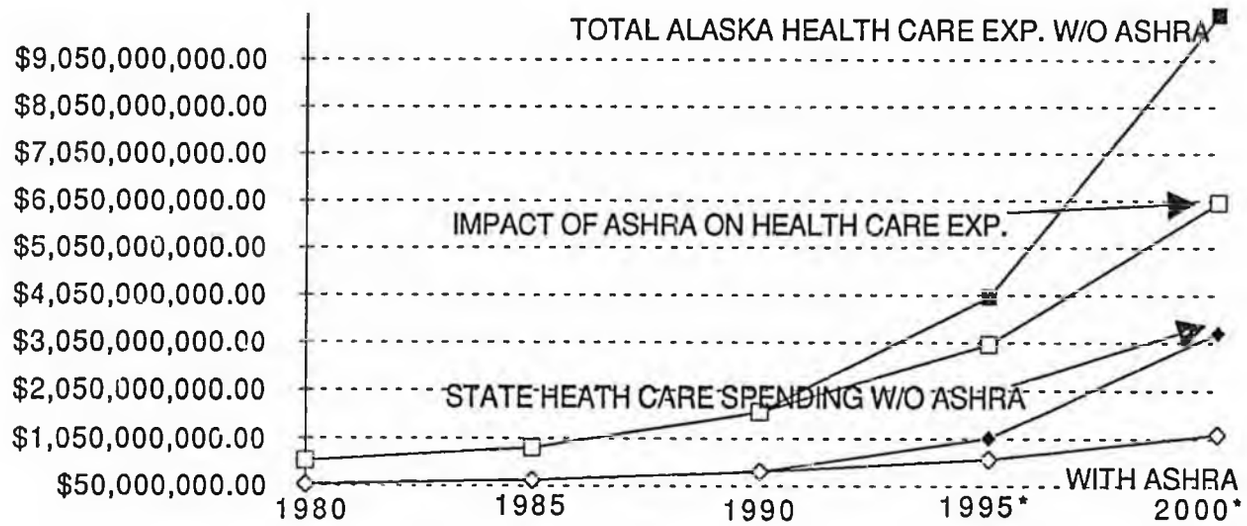


EXHIBIT II

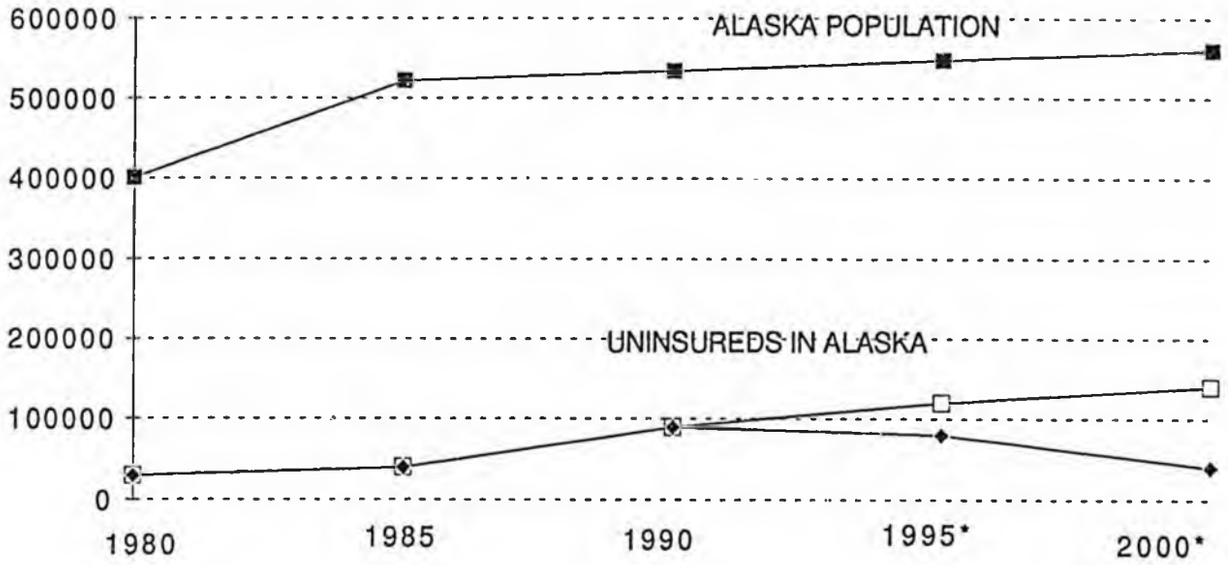
H.C.C.C. TASK FORCE CHART 2



ESTIMATED IMPACT OF ASHRA ON HEALTH CARE EXPENDITURES IN ALASKA

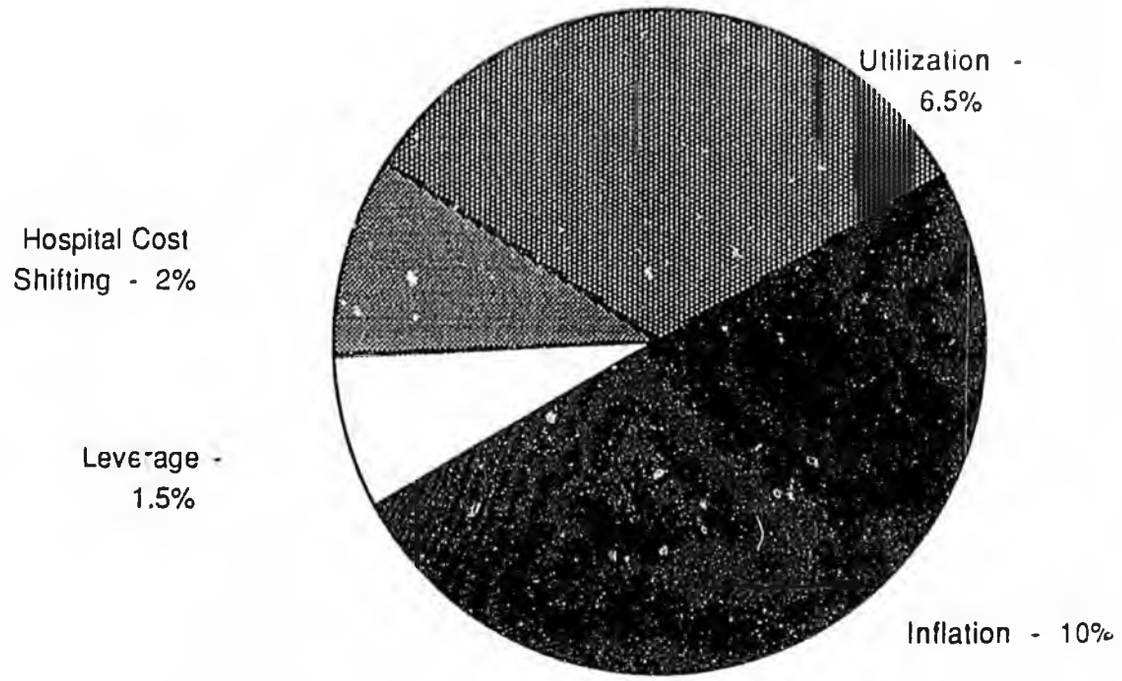


ESTIMATED IMPACT OF ASHRA ON THE UNINSURED IN ALASKA



AETNA

Indemnity Plan - With Healthline
Trend Components
(20% Annual)



Inflation:	Anticipated price increase for established medical services and commodities.
Hospital Cost Shifting:	Additional nonprice related increase in hospital charges to compensate for inadequate Government reimbursement for Medicare/Medicaid patients, lower negotiated rates for PPO's and HMO's, and no payment from the indigent.
Leverage:	Increased portion of medical costs paid by the employer due to the fixed nature of employee copayments.
Utilization:	Projected increase in utilization of services and commodities including the shift to new and more expensive methods of treatment.

9/21/90

Exhibit J

STATE OF ALASKA

1991 TREND CALCULATION

I. MIDPOINT CALCULATION

Trend

Experience Period		Billing Period	
Sep-89	Sep-90	Feb-91	Feb-92

17 Months

II. ANNUAL TREND FACTORS

Coverage	Per Annum Trend %
Comprehensive Medical	20.0%
Comprehensive Dental	11.0%
Prescription Drug	30.0%
Basic Vision	3.0%

III. WEIGHTED TREND COMPONENTS

Actives & SBS I	Per Annum %	Claim %	Weighted Trend
Comprehensive Medical	20.0%	82.9%	16.6%
Comprehensive Dental	11.0%	13.9%	1.5%
Prescription Drug	30.0%	3.2%	1.0%
TOTAL WEIGHTED TREND			19.1%
Retiree D/V/A			
Comprehensive Dental	11.0%	76.8%	8.4%
Basic Vision	3.0%	23.2%	0.7%
TOTAL WEIGHTED TREND			9.1%

IV. ADJUSTED TREND COMPONENTS

	Weighted Trend	X	Period	X	Loss Ratio	=	Adjusted Trend
Actives & SBS I	19.1%		17/12		75.5%		20.4%
SBS Option II	20.0%		17/12		61.3%		17.4%
Retiree Medical	20.0%		17/12		73.5%		20.8%
Retiree D/V/A	9.1%		17/12		77.0%		10.0%

9/21/90

Exhibit K

STATE OF ALASKA

SUMMARY OF RATES

	CURRENT RATES	EFFECTIVE February 1, 1991
I. ACTIVES		
Medical/Dental	$371.84	$371.84
Vision Service Plan	$12.70	To Be Determined 1/9 91
TOTAL	$384.54	
Employee Supplemental	$18.62	$18.62
Employee & Dependent Supplemental	$50.64	$50.64
II. SUPPLEMENTAL BENEFITS OPTION II		
Employee	$79.38	$79.38
Employee & Family	$194.40	$194.40
III. RETIREE MEDICAL		
Employee & Dependent	$243.98	$243.98
IV. RETIREE DENTAL/VISION /AUDIO		
Retiree	$27.65	$27.65
Retiree & Spouse	$55.30	$55.30
Retiree, Spouse & Child	$77.30	$77.30
Retiree & Child	$49.70	$49.70

LABOR AND COMMERCE
APRIL 15, 1991
SB 83
Prepared by Senator Duncan's Office

PRESENT
Senator Pearce, Chairman Labor and Commerce
Senator Duncan, Prime sponsor of SB 83
Staff from Senator Halford's office

Testimony on Line
Dr. Robert Critteden, Special Assistant to Governor Gardener State of Washington
Mr. John Colmers,Director of the Health Service Cost Review Commission, State of Maryland

Presentation by Dr. Critteden:

Today I would like to comment on three things. One is a little bit about the problems that we face in all states not just in Alaska or Washington. Second is to talk about the experience the State of Washington and lastly I would like to speak briefly to the special framework of SB 83.

Briefly I think all states are having to face the same crisis with the health care system that you are. There is obviously a real cost crisis. We have major barriers to coverage, access, availability of different services, on the state side cost levels are major problems for state government as you know these include employee health care, medicaid, workman's compensation costs. In fact in our state health care costs are eroding a lot of other state priorities.

On the business side interestingly a lot of our businesses are finding erosion in their bottom line. For the large businesses it's now a minor to moderate issue. For our small businesses they are in a crisis as far as I can tell. They have come to us complaining and describing some fairly bad problems. Our labor sector folks and our employed people are extremely

affected at the present time the health benefits are being cut and in fact health benefits are cutting away any wage increases. As you might have heard the National Governor's Association has made health the number one issue this year and that's because this issue is pervasive throughout the country.

In Washington State I would like to comment really on the issue of cost and access. Beginning in about 1987 we took the access issue as our prime issue in the health arena. We put through a thing called the basic health plan which is a state subsidized health insurance program for low income working people. At that time we also put through a program that expands medicaid to cover women and children including special services. We call that our first steps program. Our second step was covering all children below poverty which we paid for with state only money.

After we finished putting all of those together we actually looked at the number of uninsured that we had and we found that in fact the number had increased. In fact our access problems were worse and we were no further ahead and in fact probably were further behind than when we started. The reason for this was the small businesses primarily the ones who are affected by the high cost of health care were slowly but surely decreasing their coverage of their own employees and particularly dependents because of health insurance.

Since that point we have changed our focus dramatically in the state and we still think that access is in the long run what we want to get out of the health care system. Actually what we really want out of the system is group health but access is one way to do that. But we also realize that to achieve that goal we need to create a system that can bring stability back to our health care system that can in fact control the costs that are right now making it unstable and eroding other state priorities. We believe also that we need to have the affected people sitting at the table when we do have some type of goal setting at the table and we feel that people have to make the trade off between what they want vs what they can pay for.

The problem with our current health care system is that we don't have a system and I think that the intent on our part is to move that way. We have put together a number of proposals in the last couple of years to move in that direction. One is we've taken our employee health and formed an authority which now is getting much more aggressive with its purchasing of health care. We have broadened that out to reforming all health care purchasing in the state and we have a proposal which is now in both the House and Senate budgets funding it and we will be moving forward very aggressively in reforming health care purchasing in our state. The third thing we have going on is we have a commission that is looking more broadly at ways we can develop a comprehensive system reform.

SB 83 is similar to a mechanism that has been discussed broadly by a number of people, having to do with bringing the purchasing power and the different elements together to form one integrated purchaser. After reading SB 83 I think it has a lot of similarities to other people's suggestions, it has elements to it that make a lot of sense. There are obviously concerns by a lot of people about whether or not you have some powerful control which would take away from the provider's availability to survive or they would be so disadvantaged. In fact in discussions in our own state with our different provider groups the issue is not whether something like this is going to happen but when.

I think in the long run with health care cost management there will be more and more concentration on ways of becoming better purchasers. The issue is whether the providers themselves can in fact join together on the other side and negotiate as a whole with a very strong entity and I think that that is the only fair thing to do. But I think that eventually we need to have a place where we can rationally allocate resources. I think that there are a lot of elements to this that make some sense.

I will say from my Governor's point of view we certainly take no position on your bill. I think that we are looking at something similar to this as well as other things so it's really a matter of us commenting on the fact that this is a proposal to answer some of the questions and one we are discussing in some general terms in our own state.

I would like to conclude with a couple of quick comments. One is that as far as developing a system up here every other country in this world has done it and I think that from our own broad perspectus we need to start looking at ways of creating a system of care as s opposed to a hodge podge which we have. Of interest to all other countries that have actually done it have better health status, they have helped their workers and are much more competitive than we are. This is an issue that we really have to face. Second issue is the constituencies in health care have changed. In the past we have always been on the advocates and the industry being the insurers and the providers to direct politically the health care policy and I think that now things are changing rapidly and we are finding that the labor, business and public purchaser's are becoming much more interested in health policy and having a larger role. I think they ought to be a central part in any solution that we put forth. That concludes my comments and I look forward to your resolution of this particular bill.

Senator Duncan

Regarding the basic health plan that you folks put together in the State of Washington and your expansion of medicaid etc. That is a subsidized program you have as far as your basic health plan?

Dr. Critteden:

Yes. It is definitely subsidized. The individual pays a premium but the total amount of the premium is about 17% of the total cost of the program so I think it is 83% subsidized.

Sen. Duncan:

Is that available to all individuals in the State, how do people access that plan?

Dr. Critteden:

It is not a statewide program but rather a demonstration program. We have it limited to 25,000 people and in about 6 or 7 communities. The demand far exceeds the supply. And in fact the providers are also very interested in providing when we have more supply available. But it is still preliminary.

Senator Duncan

After this was done and even after you provided access to 25,000 individuals you have still seen the number of uninsured residents of Washington increasing is that correct?

Dr. Critteden:

I would like to say that there is even more than that. We have covered the maximum medicaid expansions available and we have put in our own childrens only program in and after both of those we still found the number of uninsured increasing.

Sen Duncan:

The reason I understood you to say today on the teleconference here was because those who were being covered were dropping off dependents and others, why because of the rising cost or the increasing cost?

Dr. Critteden:

Yes. As far as we can tell that is what the small business people report as the reason they cannot continue coverage.

Sen Duncan:

You mentioned you have a purchasing authority that is being proposed or being put together is that correct?

Dr. Critteden:

It actually is in effect but it is limited to public employees, state employees at the present time. It is there and in fact a central part of our purchasing activity. But it is still limited only to state employees at the present time.

Sen Duncan:

This authority actually goes out and solicits and puts together a plan and solicits coverage from the insurance carriers in the state is that how that works?

Dr. Critteden:

It does it two ways. In the self insurer part half the public employees are covered by our own self insurer which we then have an internal management as well as contract outside for the rest subcontracting, P.P.O. arrangements and pharmacy issues. Half of the patients are covered through contracts with managed care providers, primarily health maintenance organizations.

Sen Duncan:

One final question. It kind of goes with what we have proposed in SB 83 you talked about how you think controlling cost is important and that there seems to be a direction a lot of folks are considering to move to bring purchasers together in one large group. You talked about the question about whether the providers can join together and negotiate for those rates and I think that's an important concept. Have you had any thought or suggestion as to how that might be structured? We have looked at that as we have discussed SB 83 and I think it's important that you have all parties at the table. The difficulty is to find who you should negotiate with for the providers, for the hospitals the doctors. Do you have any suggestions about how that might be structured?

Dr. Critteden:

I think it's a couple of issues. One is whether they can do it, there are those that are concerned with anti trust. Our lawyers are telling us that as long as it is for public good in other words it's stated in state statute that this is something that is for the public good that this is allowed then I don't think it's a problem. The second thing is who should represent them. I think that has to be determined by the providers themselves. The physicians have to determine whatever mechanism they want to and I think that has to be a mutually agreed upon thing. I guess I would probably go to the medical associations say and see if they could do a poll see if they can represent them if they can't legitimately represent then would have to think of another way of forming an organization. I would tend to think that your associations would be the place to start.

Sen Duncan

I have a copy of a news release from the National Governor's Association that was made in February of this year and one of the things they talked about NGA was coming out with their report in August of this year. The news release came out February 2nd 1991 from the office of public affairs of the NGA it says and I quote "the report will describe a series of incremental and discrete cost control strategies such as expanded use of managed care programs, administrative reform, and medical tort reform. It will also suggest bold and innovative strategies such as a state level all payor system and global budgeting for the control of capital expansion." What we are talking about in SB 83 is trying to get to a state level all payor system. Do you have any further update on where NGA is on that thinking and is there any other information you can provide us at this time?

Dr. Critteden:

I think that I can tell you it sounds like the Governor's are going to be very pressured for putting together some sort of strong cost containment. I think there's some division exactly what the exact mechanism should look like. I'll say the majority are leaning toward the element you are talking about. There are a fair number of people who want to try a little more competitive model but also there is nobody who wants free competition..

Yes, I think we are moving ahead I think there will be recommendations with it. NGA comes out my bets are they are going to say this is the way, these are ways they can and one of the models will be similar to SB 83 an all payor sort of model. What we are asking for at this point is to have state's take a lead and start putting something in place so that we can derive our federal policy from that from the real experience. I think that's important. The second thing that the states are very clear about is that we can't wait for the federal government to act. I think we have to act now; I think we know what to do. In Washington we are going to have real problems in our next bi-annual budget we are squeaking by in this one with a fairly large cut in both education and in human services and particularly in health just because of the health budget. In the next two years from now we are going to be facing the worst problems. So we are not going to wait we are going to have to go ahead.

John Colmers, Director of Health Service Cost Review Commission in Maryland - Presentation

Asked specifically to testify on SB 83 and my comments are focused exclusively on describing the rate setting system in Maryland and how that system has functioned over the years. We have found ourselves the subject of considerably greater interest in the last 18 months or so than we have had in many years and I think the cycle that naturally occurs in political thought is swinging back in the direction of a more regulated approach to health care costs.

In Maryland our focus has been in the area of hospital expenses and the state recognized back in 1971 the importance of getting a handle on that element of health care expenditures. Hospitals represent roughly 40% of all personal health expenditures in the country and those figures are roughly equivalent in Maryland as well. In 1971 the cost for admission in a Maryland hospital was some 25-30% above the national average. By 1990 the cost for admission in a Maryland hospital was 8.1% below the national average. This has been accomplished by not in any one particular year achieving significant savings but by achieving savings of anywhere between 1% and 3 % each year. When you achieve results like that over a period of

time the savings can be quite substantial and there have been estimates made of what the cost in Maryland would have been if we had gone up at the national average since 1976 that reach into the multiple billions of dollars and almost a billion dollars in 1990 dollars alone in that one particular year alone.

Now the rate setting system itself is fairly complex and although occasionally we hear complaints about its complexity the nature of the business that we regulate is complicated and the statute that we operate under has provided the rate setting system considerable flexibility in establishing the rates. It has been important over the years that in establishing those rates that considerable difference be made to the unique circumstances of individual hospitals. There are no flat formulas that are used to the exclusion of considering individual circumstances. There are substantial appeal rights available to providers. The rate setting commission decisions are appealable directly to the courts. There is no administrative appeal which has been a critical element of our system which has removed it from both the perception of and the actual fact of political influence. The decisions are appealable directly to the courts. We have not gone to court of appeals in Maryland which is the highest court in the state since 1985 so it has been relatively infrequent. The early years of the commission certainly we were in court more frequently with a number of test cases.

A critical feature of our rate setting system of course is the fact that it is an all payor system. We are the only all payor system in existence. The all payor system is brought about by the existence of what's known as the medicare waiver. A waiver is continued under provisions of the social security act section 18.14. b There are other sections in the social security act under which other states could apply for waiver status. That would be under section 18.86. c of the social security act.

The waiver is important for several reasons. First of all the waiver is what allow[illegible] our system to be equitable. All payors are paying on the basis of the same rates there is no legitimized cost shifting that occurs within our rate setting system. The charges that are allocated to individual centers

ultimately are charged to patients are reflective of their costs. Do not include hidden costs or taxes in the form of cross subsidization that occurs in other jurisdictions.

The waiver is also important because it allows for our system to finance uncompensated care. In 1990 Maryland hospitals provided 275 million dollars in uncompensated care but that's the majority of which was recovered by hospitals through the rate setting system. Because of the waiver the medicare program is contributed to financing that uncompensated care.

The waiver is also important because it allows for a local control to hospital cost increases and that adds two important aspects. First of all, for institutions, it means that there is a single source that they can go to to address the financial means of their institutions. And unlike other institutions there are not the multiple payors you have to deal with; the federal medicare program, the state medicaid program, there is a single source to deal with issues associated with finance. And from the payors perspective that is also true. They do not have to deal with the 53 acute general hospitals within the state individually as much as they can deal on finance on broader financial issues with the committee, with that single agency. The payors are protected against the cross cost shifting that occurs as I mentioned earlier in other jurisdictions. I think the local control is also important from the sense that as I noted earlier there is considerable deference given to individual hospital requirements and if there is one thing that I have learned in the years that I have been at the Maryland system is that every hospital believes themselves to be unique and as a result it is important to be able to consider those characteristics. By having individuals who have a tie to the community, have a direct understanding of the conditions within the state; it's more likely to develop an equitable system than one that is developed on a national scale. It certainly will come as no surprise to you that we are very strong believers in state sponsored solutions to dealing with the problems with health care costs in particular hospital care. The role of the federal government is important in establishing general goals and guidelines and performance standards. Performance standards which we must meet in order to keep our waiver I

mights add. But by having that local control you can design the system to meet the unique characteristics of your institutions. I would be more than happy to spend more time talking about the nuts and bolts of the rate setting system. Let me pause right here and see if there are any questions on what I have just said so far.

Sen Duncan

First of all do you have a system? When you're setting the rates with the hospitals is that a negotiating system? How does that system work? Do you negotiate with them or do you just evaluate their cost based on certain criteria, certain components and set the rates and then they have the chance to appeal and that process works. Could you explain that?

Mr. Colmers

In essence there are two approaches that can be taken. One which is known as a full rate review and the other which is known as inflation adjustment system. The full rate review is a process by which a hospital's rates are set initially. All hospitals in Maryland have undergone at least one full rate review. That is a very complicated process that involves comparing the costs of the hospital under study with a peer group of institutions. There are formula's that are established but it is a matter that goes before the commission often involves considerable amount of negotiation in developing those rates. We conduct on average four or five full rate reviews a year. Some years we conduct none, some years we conduct more than four or five. Most hospitals have their rates set by a system that is known as the inflation adjustment system that is how they get their rates updated each year. That is much more formulistic and having less lee way involved. It has been developed as an accommodation to hospitals even though it is far less cumbersome and time consuming than a full rate application. It is also less risky for hospitals than a full rate application. Because under a full rate review the entire cost base of the institution is available for scrutiny. So the short answer is there really both methods, one that involves considerably more discussions and negotiations and lee way of course we are guided by precedent on how we do the full rate

reviews. The second is the inflation adjustment system which is much more formula driven. Neither of those systems are described in the statue itself but are contained in either regulatory language or in guidelines that have been developed by the commission.

Sen Duncan

My understanding or assumption then, each hospital has their own rates I assume, so when you are doing the full rate review it kind of involves negotiating you are dealing with one provider one hospital is that correct?

Mr. Colmers

We work one hospital at a time and we're comparing that hospital to peers, to similar institutions that's generally the standard of reasonableness. If someone else can do it for that cost the presumption is that you ought to be able to.

Sen Duncan

How does expansion and renovation work in your state, do you have a certificate of need process or does the rate setting process really replace certificate of need and that you determine whether or not the need is there and whether or not you will build increased expansion or renovation into the rates, is that how that works?

Mr. Colmers

There is a separate C.O.N. process here in Maryland and it is still in place for many projects. However, since 1989 there has been a change in statute here in Maryland that exempts any certificate of need project, regardless of the cost if the hospital agrees that they will take no more than a million and a half dollar in their rate over the life of the project in order to implement it. So that would mean that a major renovation project for example that had has an expected life of 30 years a million and a half dollars over 30 years is hardly anything at all and as a result many hospitals have decided to take

that route even though it means substantially no more money than they would have expected otherwise under the rate system they are willing to take that pledge rather than to go through the burdensome process of the C.O.N. Even if a hospital were to receive a certificate of need however that does not automatically guarantee that the hospital will be provided all the additional revenues that they requested they still have to deal with the rate setting commission separately.

Sen Duncan

Since this has begun in 1971 when you started rate setting have their been hospitals that have not been able to survive to operate under it do you prop up rates for certain hospitals so that they can continue if it's determined that there's a real need in that area of the state? How does that work?

Mr. Colmers:

I believe that there has been no hospital has failed in the Maryland system as a result of having inadequate rates. In terms of propping up institutions certainly there are hospitals within the state of Maryland that have greater needs than others. Whether it be because of their serving a very large poor population, whether it is because they have substantial amount of uncompensated care, whether the labor expenses in their area particularly higher than the norm. There is the possibility in our system for hospitals to make those cases so I don't believe a hospital has failed in Maryland because of the rate system.

There have been hospitals however who have either entered into bankruptcy or closed. There is an example of a hospital back in 1985 that filed for bankruptcy after it had been found to have overcharged as a result of a rate proceeding some 18 million dollars. The hospital filed in federal bankruptcy court right after the commission's decision in that rate case was upheld by court of appeals and the federal bankruptcy judge threw the hospital out of court saying that you can't go into bankruptcy to avoid the state rate setting function. As it turns out that hospital was sold to a national chain and it's part of the sales agreement there was a provision

established for the repayment of that 18 million dollars over a six year period and that's 3 million dollars a year. There is another hospital that is currently in bankruptcy in the state of Maryland located in western Maryland it is a result of a poor management decision. The hospital sold the facility to an entrepreneur and leased it back from that entrepreneur they still retained the license. They leased it back from the entrepreneur at an effective interest rate of 21%. The rate setting commission when the hospital came in for a full rate review said that type of arrangement is unreasonable and included in rates which we presume to be reasonable capital costs based on a reasonable assumption of interest and equity contribution over the life of the project. The difference between what was in rates and what the hospital received was close to a half a million dollars a year. Because of that management decision the hospital found that they had income that was not sufficient to cover expenses and they have called for protection under Chapter 11 of the federal bankruptcy code. Finally we have had hospitals that have merged or consolidated perhaps unlike the situation in Alaska.

There are many multiple hospital jurisdictions here in Maryland and we do have certainly excess hospital capacity. The rate setting system is structured to provide maximum encouragement to institutions to merge and consolidate and to remove that excess capacity.

So I would say that in summary we have not had to propp up hospitals. The legislation requires the commission to be concerned about the financial status of hospitals. The procedures that have been in place permit us to consider unique and individual circumstances. I don't think that we've ever had a case where a hospital has gone out of business because of the rates that have been set by the commission but we have had hospitals that have closed or have filed for protection under the bankruptcy laws.

Sen Pearce

First of all if you began this in 1971 how long did it take to get all of your hospitals on line and do the full rate reviews for all of them?

Mr. Colmers:

Statue was passed in 1971 and one of the most important features certainly back then was to get the commission a period of time before we actually had to go about setting rate. We began setting rates in 1974 and 1975. So it was about a three year period for start up. Now I would suspect that one would not need that long of period today. Much of the technology of how to go about setting rates has been dealt with by us and others but clearly you need some period of time to develop reporting mechanisms and the various rate setting systems for that particular jurisdiction.

Sen Pearce:

You spoke of under both the full rate review but also your inflation adjustment system that you actually negotiate with the hospitals, do you have a team that goes into an individual hospital in both cases and brings information back to a central place and provides some sort of a decision that goes then to the full commission for their decision who actually does the negotiating at what level does it happen?

Mr. Colmers

First of all if I gave the impression that the inflation adjustment system involved negotiation let me correct that. There is virtually no lee way in the inflation adjustment system at all it is all formula driven. A hospital either accepts what the inflation adjustment system provides or they can follow full rate review. They are protected by having that administrative route so that they can be denied the I.A.S. they don't have to take the I.A.S. and they still have the opportunity to follow full review.

In terms of negotiations the staff of the commission, we have 28 people, are budget is about 1.8 million dollars a year. We regulate an industry that's 3 and a half billion dollars in size in terms of gross revenue. When a hospital follows a full rate review there are generally two or three rate analysts on the staff who work in analyzing the information that has been submitted by the hospital and to conduct the standard comparisons that are used as part

of the review process. Once an initial recommendation has been prepared by that group I will review the material we will prepare a written recommendation that will go to the commission that will contain recommendations on each component of the hospitals application as well as a final revenue figure at the set of rates. If the hospital is in agreement with that fine, generally it involves a substantial amount of negotiation subsequent the hospital will go back and review our work papers, they will ask for a special consideration in one area or another.

There are probably two levels of negotiations that the team that I spoke of will handle much of the technical negotiation. Was this particular schedule filled out properly, were these the actual costs of the comparison group of hospitals, were they priced well within the proper manner. Questions of that nature will be handled by that group. The final negotiations generally involve myself or my deputy director. If we are unable to reach a conclusion, reach a negotiated settlement, obviously we go to the commission. That develops as a contested case in which the commission will establish a hearing process to review the testimony of the hospital and ultimately the record in that proceeding would be available to go to court for appeal by the hospital going forward.

Let me also say that in all since these involved contested cases and we have a single staff we do have assigned a staff member who does not attend staff meetings does not become part of a process of reviewing the rates of a particular hospital. To set up what is called a chinese wall between that member of the staff and one of the A.G.'s that has been assigned to us so that they can represent the commission in a public hearing on a contested case and the balance of the staff and the other A.G. assigned to us will represent the commission staff before the commission.

Sen Pearce

You said that most of your court tests happened early on what were the points that there was most contention on that you fought out in court?

Mr. Colmers

First and foremost was the first test cases had to do with testing the law itself whether we had the authority to do it, whether it was appropriate, what was meant by the terms peppered throughout the law. Are the terms reasonable, what is meant by reasonable, does it mean for example if there are competing quote reasonable rates for a hospital which one would prevail. And the courts decided that the commission could select among competing reasonable rates and if there was an adequate justification for their selection. It would be the commission's view that would prevail. Just because a hospital doesn't believe it's a reasonable rate doesn't mean that the commission wanted to accept that method. Some of the later court cases that tested this specific method that we have employed, how we are going about comparing hospitals, what are the criteria that are established to select hospitals that are comprable, how do you go about doing labor market adjustments, how do you account for differences in the types of cases that a hospital treats and so forth.

Finally there were a series of court cases that involved our jurisdiction over physician services. We had believed that in the initial years of the rate setting commission we have authority over setting rates for hospital based physicians. We went to the court of appeals twice on it, the first time we won, well partially won and it was remanded back to the commission. The next time we went to the court of appeals we lost jurisdiction over most of these hospital based physicians and that has been the case ever since. So there was a fair amount of activity that was involved in that.

But since 1985 the last case that went to the court of appeals in 1985 was a full rate application. It was in fact the full rate review of a hospital that I had mentioned earlier that filed for bankruptcy to try to escape the 18 million dollar over charging by the facility and that case tested virtually all of the rate setting methods that we have in place and the court of appeals came down in support of all of those procedures on point each and every one.

Sen Pearce

One of the things there's been a lot of comments about in the draft version of SB 83 are the kind of elusive components that the reimbursement systems and utilization standards components would be looked at in the setting views, you've got a list that says must include but are not limited to, do you have in your system for the full rate reviews, I know your inflation adjustment system is pretty much formula driven but for the full rate review do you have a list of things that you always take into account and then use kind of an open ended other things as necessary that the different hospitals can bring to you because they think they are unique?

Mr. Colmers

Well, again SB 83 as I read it, first of all in concept is quite different than the all payors system, but at least in the section that discusses reimbursement systems our statutes does not describe the procedures that we're supposed to take into account or in fact what are the characteristics we're supposed to be taking into account. Our statute in the section that talks about full authority for setting hospital rates is in fact very simple but does include language that ultimately has been tested in the court of appeals. The language which is there at section 19-216 of the health care article of Maryland requires that in reviewing the rates and in making any investigation that the commission considers necessary.

For purchasers first, that the total cost of all hospital services offered by or through a facility are reasonable. Two, that the aggregate rates of the facility are reasonably related to the aggregate costs of the facility and three that the rates are set equitably among all purchasers or costs of the purchasers without undo discrimination or preference. The commission is further given authority to be concerned with the financial condition of Maryland's hospitals that we permit a non profit facility to charge reasonable rates that will permit the facility to provide on a solvent basis efficient and effective services in the public interest. So throughout the year you have language that is balancing the needs of the facility with the needs of the payors and is mitigated by language such as reasonable and efficient and effective. It is not overly postscriptive in describing the rate setting mechanisms that are to be employed. And as I said at the outset these rate

setting mechanisms are extraordinarily complicated as I believe they need be. But it has been the language in the statute is the guide against which all of the rate setting mechanisms are ultimately tested in the courts. It was the courts view for example that the procedures that we use in the full rate review system were reasonable in evaluating the hospitals total costs that the rates that were produced would allow a hospital to operate efficiently and effectively on a solvent basis. So these balancing characteristics I think are critical in the statute and I did not see that in my review of the draft of SB 83 in terms of the balancing of those provisions. I think each one of the ones that I've talked about independently are important and I think collectively they work quite well together to balance the interests of both the purchasers and the providers.

Sen Pearce

I believe I understood you to say that there was a court case in which the commission lost the right to set rates for hospital based physicians and has there since that, obviously something made the commission feel that they had that right at the beginning is there, has there been discussion within the legislature or by the commission or by any group in Maryland of expanding to private physicians the cost setting?

Mr. Colmers

Yes, as a matter of fact for the last two legislative sessions there have been bills introduced in the general assembly to grant the commission authority over the rates of hospital paid physicians. Both years those bills have not received favorable report. Our commission certainly is in favor of looking at this issue. We think that for hospital based physicians given the nature of the work that they do given that individuals generally do not have any choice in selecting which hospital based physician that there ought to be at least an investigation to determine whether we ought to set the rates to that. That was a bill that was before the general assembly this year. Our commission supported that but for a variety of reasons not the least of which was the fiscal note attached to doing --- setting the bill did not

receive a favorable report. Maryland as many other states in the lower 48's are operating in a pretty tight budget.

DRAFT

State-Specific Estimates of the Size and Characteristics of the Uninsured Population

Submitted to:

The American Association for Retired Persons

Prepared by:

Lawrence Bartlett
and
Kerry Carroll

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1001 Connecticut Avenue, N.W., Suite 719
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August, 1990

TABLE OF CONTENTS

List of Tables i

Attached

Chapter One: Background and Purpose of this Document 1

Chapter Two: Technical Issues Associated with Using CPS Data to Estimate States' Uninsured Populations 5

A. The Current Population Survey 5

B. The Reliability and Accuracy of CPS Estimate 7

Chapter Three: Estimates of the Size and Characteristics of States' Uninsured Populations 10

A. Health Care Coverage and the Size of the Uninsured Population in Individual States 10

B. Age Distribution of the Uninsured 24

C. Poverty Status of the Uninsured 30

D. Employment-Related Characteristics of the Uninsured 35

List of Tables

Table 1	Insurance Status of State Populations, 1988 (In Thousands)	12
Table 2	Insurance Status of State Populations, 1988 (Percent Distribution)	14
Table 3	Insurance Status of the Under 65 Population, 1988 (In Thousands)	18
Table 4	Insurance Status of the Under 65 Population, 1988 (Percent Distribution)	20
Table 5	Estimated Size of the States' Uninsured Population, 1987 and 1988 (In Thousands)	22
Table 6	States' Uninsured Populations, by Age, 1988 or 1987/1988 (In Thousands)	26
Table 7	States' Uninsured Populations, by Age 1988 or 1987/1988 (Percent Distribution)	28
Table 8	States' Uninsured Populations, by Poverty Status 1988 or 1987/1988 (in Thousands)	31
Table 9	States' Uninsured Populations, by Poverty Status 1988 or 1987/1988 (Percent Distributions)	33
Table 10	Uninsured Adults, 18-64, by Employment Status 1988 or 1987/1988 (In Thousands)	36
Table 11	Uninsured Adults, 18-64, by Employment Status 1988 or 1987/1988 (Percent Distribution)	38
Table 12	Uninsured Adults and Children, by Employment Status of the Head of Household 1988 or 1988/1987 (In Thousands)	41
Table 13	Uninsured Adults and Children, by Employment Status of the Head of Household 1988 or 1988/1987 (Percent Distribution)	43
Table 14	Distribution of Uninsured Workers by Industry Classification, U.S., 1988	46
Table 15	Uninsured workers by Major Industry Classification, 1988 (In Thousands)	47
Table 16	Uninsured Nonelderly Adults 18-64 by Firm Size, 1988 or 1988/1987 (In Thousands)	50
Table 17	Uninsured Nonelderly Adults 18-64 by Firm Size, 1988 or 1988/1987 (Percent Distribution)	52

Attached

CHAPTER ONE:
Background and Purpose of this Document

In recent years, increased public attention has focused on the problems this nation's uninsured population often face in obtaining access to needed health care services. At the federal level, this increased recognition of the problem has heightened the debate about the need for a national solution. However, it is at the state government level that many of the most significant public policy measures have been taken to address the problems of the uninsured.

One of the factors that has prompted state policymakers to act is the sheer size of the problem. Indeed, until recently, the estimate that 37 million Americans, or about 15% of the population, are without health insurance has been cited as evidence of the access problems that exist within our health care financing/delivery system.

This estimate of the number of uninsured persons was based upon data from the Current Population Survey (CPS), a national survey conducted each year by the U.S. Bureau of the Census. Data from the CPS had shown an increase in the number of uninsured nationwide from 1979 to 1984, with that number remaining fairly constant at approximately 37 million from 1984 to 1986. However, a recently published analysis of preliminary data from the 1988 CPS showed a significant drop in the estimated number of uninsured persons, from 37.4 million to 31.1 million, a decline of nearly 17%.

As will be discussed later in this document, a significant portion of this recent decline is likely to be due to changes in the way the CPS asked about health care coverage and in the manner in which the survey data are analyzed. For example, in addition to revisions of both the content and the sequence of questions used in earlier

surveys, several new coverage-related questions have been added to the new version of the CPS.

Such technical issues may explain much of the difference between the estimates of 37 million and 31 million uninsured nationwide. However, until these and other reasons for such differences are more widely understood, in many states the net effect of the new national CPS estimates will be, at best, to create considerable confusion and, at worst, to result in complete paralysis of access-related policy development. Such responses are likely to occur because many states that have developed proposals to expand coverage of the uninsured have based their analyses on state-specific estimates of the number of uninsured derived from pre-1988 CPS survey results.

This report seeks to reduce the confusion that may exist within many states and therefore enable policymakers to move forward in developing appropriate programs and policies that address the access problems that exist within their states. More specifically, the purposes of this study are the following:

- To reduce the confusion caused by the release of significantly different national estimates of the size and characteristics of the uninsured by explaining in easy-to-understand terms the possible reasons for such variations.

- To educate the target audience about the statistical reliability of estimates derived from surveys such as the CPS so that they will be better able to understand both current and future state-specific estimates of the uninsured that are derived from the CPS or similar survey.

- To provide persons at the state level--including state legislators and executive branch officials, AARP volunteers, and other concerned parties

with information on the size and characteristics of each state's uninsured population.

- To enable concerned parties from individual states to compare the size and characteristics of their uninsured populations with those of other states.

The material presented in this document can be divided into two major categories. In Chapter Two, the reader will find information about the general nature of the Current Population Survey, the questions in the survey that deal with health care coverage, and statistical issues concerning the accuracy and reliability of estimates derived from the CPS. While we have attempted to present this information in as simple a manner as possible, it is nonetheless somewhat technical in nature. Readers not immediately interested in this level of detail may wish to skip much of this material, although they should review the section dealing with the accuracy and reliability of estimates so that they will be aware of the limitations of certain state-specific estimates and understand the rationale behind certain of our analytic methods (e.g. combining two years of survey data for smaller states).

Chapter Three provides a narrative overview that discusses the national estimates of the size and characteristics of the uninsured population based upon data from the 1989 and 1988 CPS and highlights the extent of the variation that exists across states with respect to their uninsured populations. Information that should be of significant use to readers interested in learning more about the uninsured in their own state is contained in a series of tables that provide detailed information on the estimated number of uninsured people in each state and the age, poverty status, and employment characteristics of these persons. The tables are structured to allow easy comparisons both between national and state data and across states.

While it is beyond the scope of this document to provide a detailed state-by-state analysis of the demographic, economic, and public policy factors that result in a state having a relatively large or small uninsured population, what will become clear from the information presented in this report is the relationships that exist between age, poverty, and employment and being uninsured. The figures presented in this document may differ from figures that some states are now using to measure the size of their uninsured populations. Our hope is that such differences will prompt interested groups to assess the relative strengths and weaknesses of these estimates--including the methods used to collect the information and the time period to which the information applies--and to determine which set of figures best measures the situation in their state. Indeed, the overriding goal of this study is to generate greater interest among state policymakers and other individual parties in understanding the specific factors affecting the size of their state's uninsured population. It is hoped that the result of this enhanced understanding will be the development of more effective and appropriate strategies to address the access problem.

TABLE 3
INSURANCE STATUS OF THE UNDER 65 POPULATION, 1988
(In Thousands)

STATE	TOTAL POPULATION	PRIVATE GROUP	PRIVATE NON-GROUP	MEDICAID	OTHER	UNINSURED	UNINSURED AS % OF UNDER 65 POPULATION
U.S. TOTAL	214,660	134,072	15,984	16,958	10,619	34,112	15.9
ALABAMA	3,478	2,069	202	311	134	695	20.0
ALASKA	453	212	27	63	58	90	19.7
ARIZONA	3,053	1,837	191	142	179	662	21.7
ARKANSAS	2,146	1,160	148	204	120	484	22.5
CALIFORNIA	24,907	13,740	1,780	2,615	1,399	5,080	20.4
COLORADO	2,802	1,731	231	183	202	428	15.3
CONNECTICUT	2,794	2,109	211	89	58	294	10.5
DELAWARE	589	409	29	42	40	64	10.9
DIST. OF COL.	507	294	36	47	18	101	20.0
FLORIDA	10,420	5,674	904	574	782	2,336	22.4
GEORGIA	5,564	3,286	395	421	316	1,049	18.9
HAWAII	920	549	60	47	145	111	12.1
IDAHO	879	511	114	47	39	159	18.1
ILLINOIS	10,094	6,838	695	891	313	1,219	12.1
INDIANA	4,849	3,404	373	190	211	617	12.7
IOWA	2,416	1,603	412	117	52	219	9.1
KANSAS	2,072	1,419	217	77	102	232	11.2
KENTUCKY	3,116	1,894	173	255	174	573	18.4
LOUISIANA	3,847	1,839	256	482	204	1,012	26.3
MAINE	1,038	669	82	100	50	121	11.6
MARYLAND	4,152	2,857	193	276	338	440	10.6
MASSACHUSETTS	5,164	3,651	377	388	178	510	9.9
MICHIGAN	8,205	5,532	553	948	316	719	8.8
MINNESOTA	3,908	2,498	523	349	66	451	11.5
MISSISSIPPI	2,282	1,126	186	273	138	516	22.6

TABLE 3
INSURANCE STATUS OF THE UNDER 65 POPULATION, 1988
(In Thousands)

STATE	TOTAL POPULATION	PRIVATE GROUP	PRIVATE NON-GROUP	MEDICAID	OTHER	UNINSURED	UNINSURED AS % OF UNDER 65 POPULATION
MISSOURI	4,518	2,926	421	340	159	617	13.6
MONTANA	706	373	97	59	48	122	17.2
NEBRASKA	1,375	817	187	77	104	174	12.7
NEVADA	983	591	51	28	78	230	23.4
NEW HAMPSHIRE	968	716	63	17	38	126	13.0
NEW JERSEY	6,633	4,885	480	336	132	725	10.9
NEW MEXICO	1,331	588	111	134	123	361	27.2
NEW YORK	15,367	9,844	966	1,893	417	1,948	12.7
NORTH CAROLINA	5,576	3,594	406	266	350	843	15.1
NORTH DAKOTA	573	321	119	22	44	63	11.0
OHIO	9,717	6,777	590	884	313	995	10.2
OKLAHOMA	2,744	1,442	229	182	214	644	23.5
OREGON	2,427	1,601	142	152	87	425	17.5
PENNSYLVANIA	10,405	7,466	690	727	309	1,023	9.8
RHODE ISLAND	877	609	72	71	39	75	8.6
SOUTH CAROLINA	2,970	1,918	159	201	194	449	15.1
SOUTH DAKOTA	620	326	114	34	41	100	16.1
TENNESSEE	4,303	2,481	376	468	212	678	15.8
TEXAS	15,221	8,188	1,043	876	919	4,067	26.7
UTAH	1,519	1,058	117	79	54	203	13.3
VERMONT	480	318	48	31	18	60	12.6
VIRGINIA	5,312	3,309	348	283	552	737	13.9
WASHINGTON	4,193	2,709	311	262	356	522	12.4
WEST VIRGINIA	1,631	1,007	91	187	48	264	16.2
WISCONSIN	4,140	3,033	345	202	109	414	10.0
WYOMING	417	263	40	18	29	65	15.7

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

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For further information call: * For release 1:30 p.m.

John M. Colmers * February 6, 1991

PRESS RELEASE

For the fifteenth consecutive year, the cost of a hospital admission in Maryland rose at a rate below the national average, according to Charles O. Fisher, Sr., Chairman of the Health Services Cost Review Commission, the state agency that regulates hospital rates.

The Commission's Annual Disclosure revealed that cost per admission rose 8.70% in Maryland last year, while the national average was 8.96%. Based on these figures, Marylanders saved an estimated $5.3 million in hospital costs in 1990.

Chairman Fisher noted that in 1976 the cost of an admission to a Maryland hospital was more than 25% above the national average, and that in 1990 it was 8.11% below the national average. (See Chart 1). Since the cost per admission in Maryland has not risen at the national rate since 1976, the increased cost to Marylanders would have been approximately 34% or $1.1 billion in 1990 alone.

While hospital costs per admission rose 8.7%, hospital charges per admission rose 10.04%. Hospitals' uncompensated care rose in 1990 from approximately $246 million or 7.8% of revenue to $271.9 million or 7.7% of revenue. (See Chart 2).

TTY for The Deaf
Baltimore Area 383-7555
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Hospital profits decreased from $78.3 million in 1989 to $67.0 million in 1990. (See Chart 3). Nineteen hospitals (Memorial at Cumberland, Key Medical Center, Franklin Square, Frederick, GBMC, Good Samaritan, Harbor Medical Center, Holy Cross, Johns Hopkins, Johns Hopkins Oncology, Peninsula General, Physician Memorial, Sacred Heart, St. Agnes, St. Joseph's, Sinai, Suburban, University and Washington Adventist) had profits exceeding $2,000,000, while two hospitals (Homewood Medical Center and AMI Doctors Hospital) had losses exceeding $2 million. In total, 42 acute hospitals showed profits while 12 hospitals posted losses.

Mr. Fisher noted the Commission's continued monitoring of the financial condition of Maryland hospitals. Hospital profits fell slightly despite an increase in revenue per admission of 10.04% compared to an 8.24% increase in revenue per admission the previous year. Simultaneous with the release of this disclosure statement, the Commission released the second annual report measuring hospital financial and operating characteristics relative to industry-wide standards. This report was developed through a cooperative effort of the Commission, the hospitals, third party payers, and the business community. Mr. Fisher renewed the commitment on the part of the Commission to continue to adjust the rate setting system as circumstances warrant. The Commission modified the rate system last year by tying continued growth to the ability of the system to match the rate of growth in hospital costs nationally. Mr. Fisher, an attorney from Westminster said, "The success of hospital rate setting in Maryland is the result of the continued commitment on the part of all the participants to the goals of cost containment, stability, and financial access. Our ability to continue this program will depend on the joint response of the Commission, the hospitals, and the payers to respond to the challenges of continued cost containment, particularly for

Medicare cases."

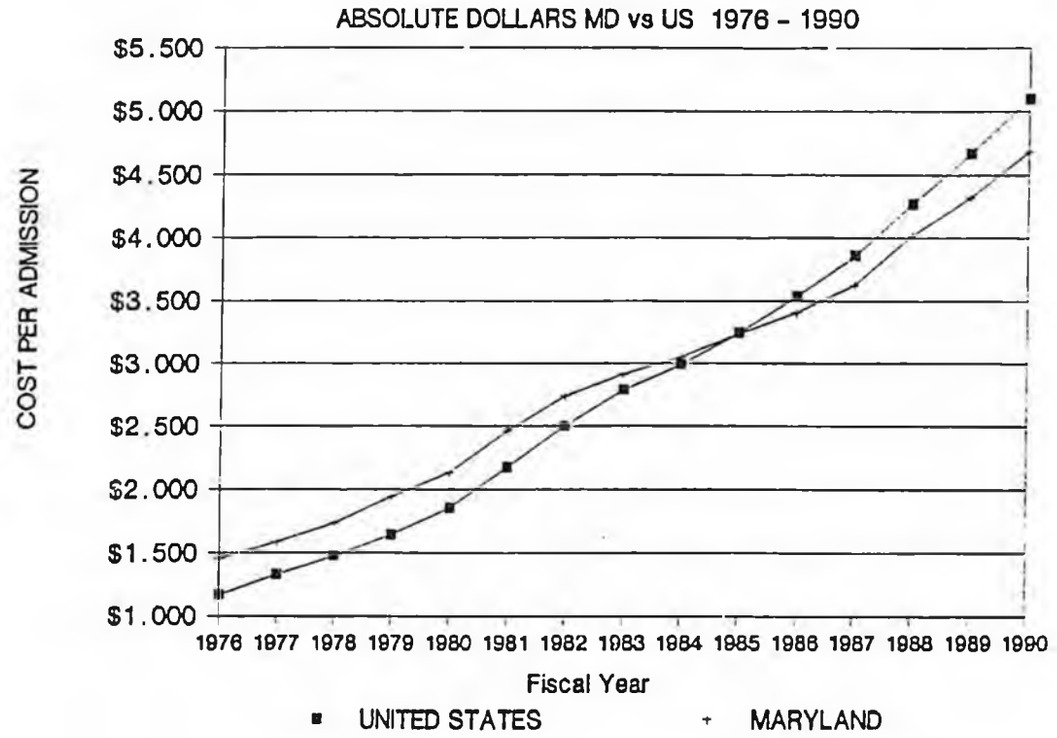
Net patient revenue increased by 11.53% as the combined result of a 1.00% increase in the number of admissions, the increase in the charge per admission, the change in case mix, and a growth in outpatient activity. There was also a slight increase in equivalent patient days of 84,695 or 1.8%.

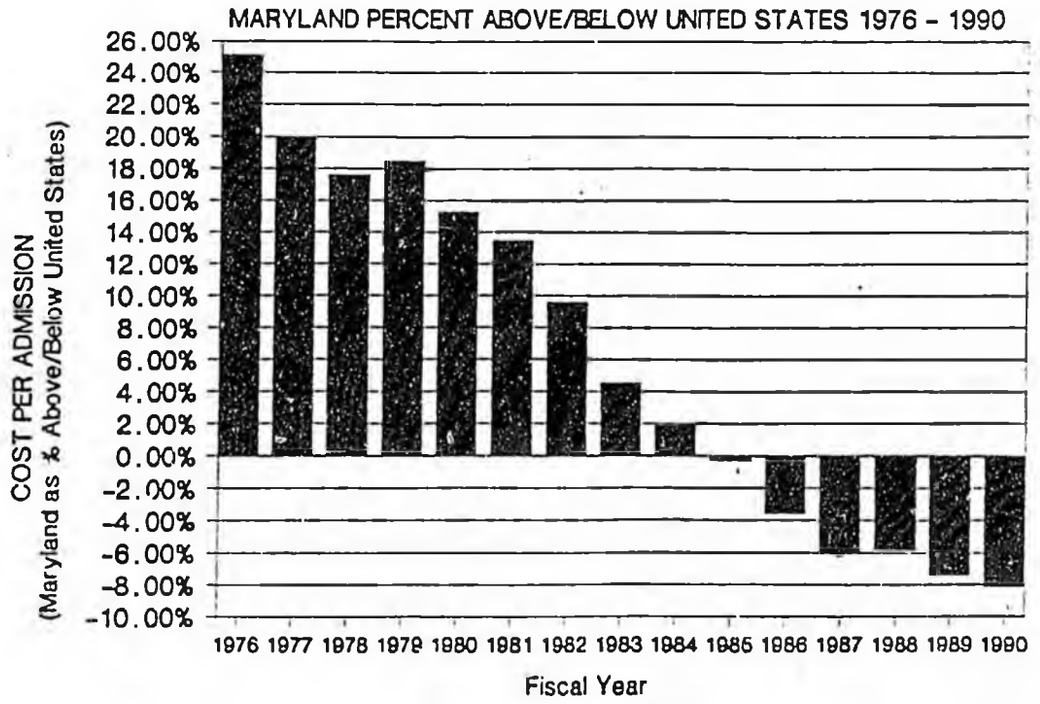
Hospital uncompensated care increased in absolute terms but decreased in relative terms in FY 1990. Total hospital uncompensated care rose to $271.9 million, an increase of 10.51% over the previous year. This represents 7.72% of gross patient revenue, a slight decrease from the 7.79% experienced the previous year.

Mr. Fisher concluded by noting that while Maryland's cost per admission has fallen from 25% above the national average to 8.11% below the national average, there is no reason to be complacent. Hospitals are facing increasing pressures that lead to increased costs. These can only be controlled by the continuation of the cooperative effort associated with Maryland's hospital regulatory structure coupled with increased involvement by business and labor, the ultimate payers.

The Commission expects to face continued challenges as it attempts to balance the legitimate needs of Maryland hospitals with the actions necessary to maintain the all payer system and its inherent equity and financial access.

CHART 1
COMPARISON - COST PER ADMISSION

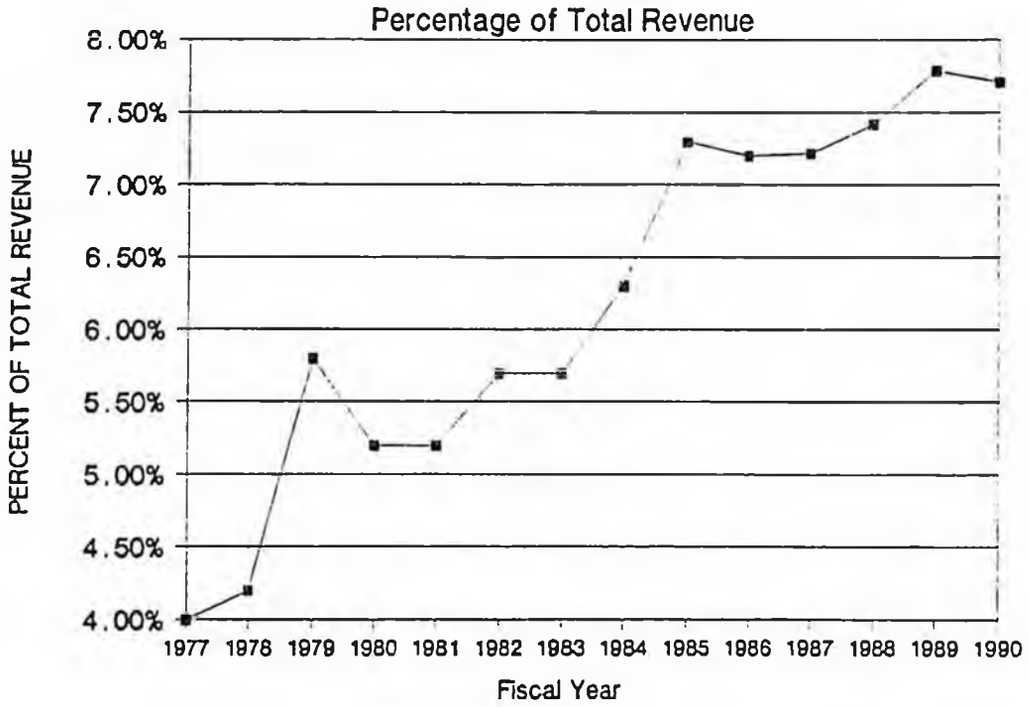


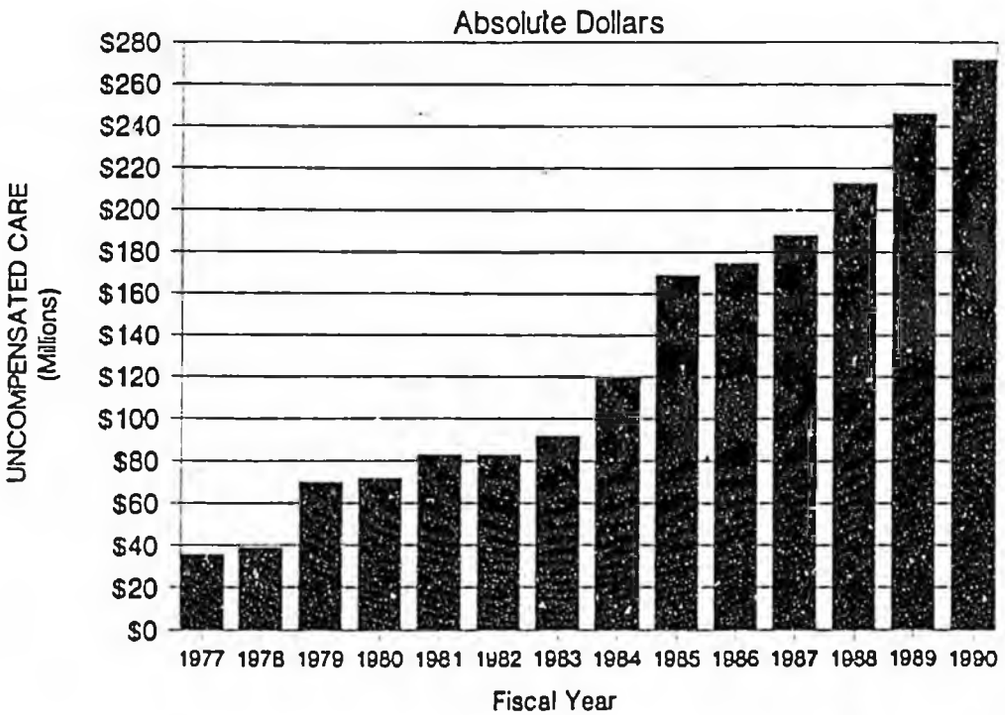


Source: HSCRC Annual Disclosure Reports

CHART 2

UNCOMPENSATED CARE
MARYLAND HOSPITALS 1977 - 1990

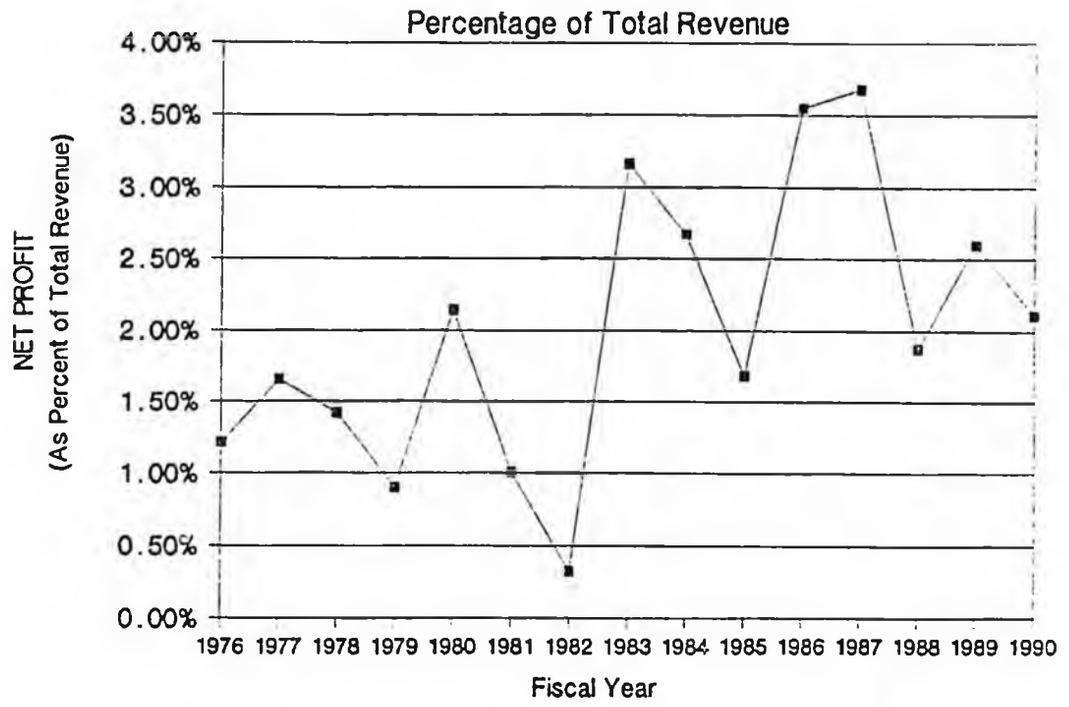


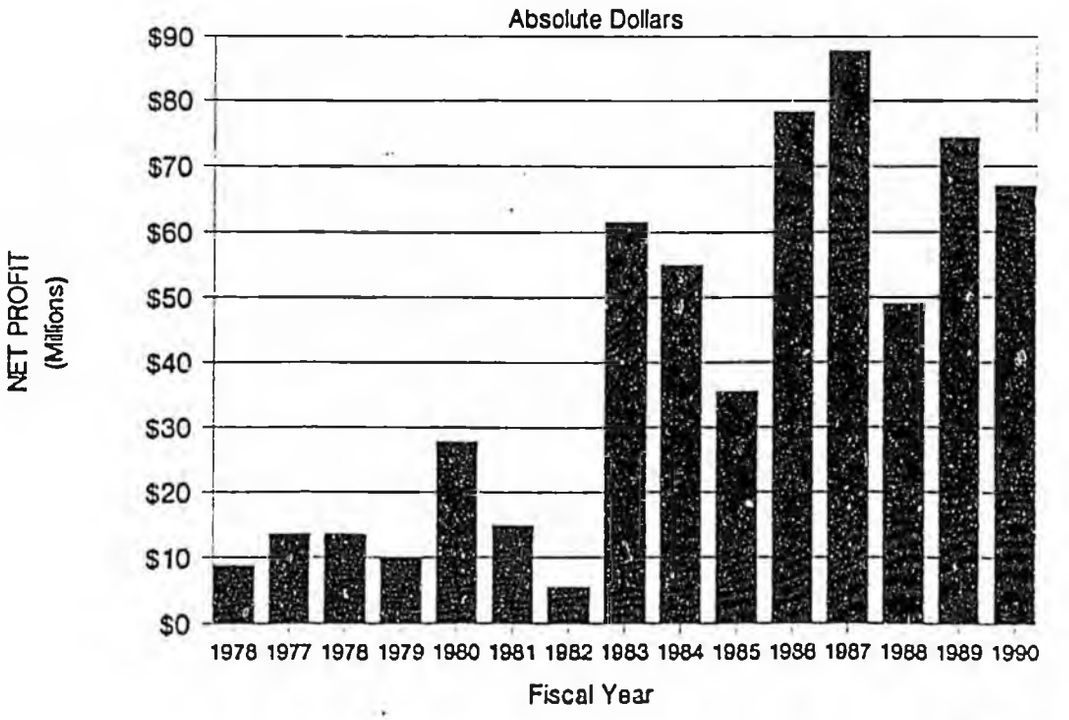


Source: HSCRC Annual Disclosure Reports

CHART 3

NET PROFITS
MARYLAND HOSPITALS 1976 - 1990





Source: HSCRC Annual Disclosure Reports

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*

For further information call: * For release 1:30 p.m.

John M. Colmers * February 6, 1991

* * * * * * * * * * * * *

DISCLOSURE OF

HOSPITAL FINANCIAL AND STATISTICAL DATA

Charles O. Fisher, Sr., Chairman of the Maryland Health Services Cost Review Commission (HSCRC), today released annual figures showing Maryland hospitals' performance during their last fiscal year.

In its annual disclosure of hospital costs, the Health Services Cost Review Commission revealed hospitals in Maryland held the increase in cost per equivalent admission (EIPA) to 8.7%. The estimated national rate of increase in 1990, according to statistics produced by the American Hospital Association, was 8.96%. Viewed from this perspective, this comparatively good performance yielded savings totalling $5.3 million.

This is the fifteenth year in a row that the Health Services Cost Review Commission's disclosure report has demonstrated that the percentage increase in hospital costs in Maryland has been lower than the rest of the nation. Last year's disclosure report indicated that the hospital cost increase per admission in Maryland was approximately one and two thirds percentage points less than the national average.

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The Health Services Cost Review Commission was the first hospital rate review agency in the United States established to regulate rates for all those who purchase hospital care. The Commission began regulating hospitals in 1974 and has since assisted Maryland hospitals in remaining well below the national level of hospital cost increases. Had cost per admission since Fiscal Year 1975 risen at the national rate, Fiscal Year 1990 expenditures would have been $4,250,241,000 or $1.1 billion more in 1990 alone. This is a cumulative savings of approximately 34%.

Equivalent Inpatient Admissions (EIPA) is a statistic formulated by the Health Services Cost Review Commission which equals inpatient admissions plus an adjustment to include outpatient visits. Equivalent Inpatient Days (EIPD) makes a similar adjustment in a per day basis.

An examination of the new financial disclosure reveals the following for Maryland acute hospitals:

1) The average cost per EIPA (equivalent admission) increased 8.7% from $4,115 in 1989 to $4,473 in 1990.

2) The average cost per EIPD in Maryland increased 8.97% from $618 in 1989 to $673 in 1990.

3) The average charge per admission increased 10.04% from $4,587 in 1989 to $5,048 in 1990.

4) Total net profits in decreased 14% from $78,323,400 in 1989 to $67,012,300 in 1990.

5) Total net patient revenue rose from $2,765,000,000 in 1989 to $3,083,861,800 in 1990 an increase of 11.53%.

Another unique feature of the Maryland hospital payment system is the coverage of the reasonable cost of providing care to those who can not pay -- i.e., uncompensated care. In 1990, Maryland hospitals incurred approximately 7.7 cents of uncompensated care for every dollar of total operating cost. More than 88% of the statewide uncompensated care expenditure of $272 million originated in the state's metropolitan areas.

The Maryland Health Services Cost Review Commission (HSCRC) was established by the General Assembly in 1971. It is an independent Commission functioning within the Department of Health and Mental Hygiene. It consists of seven members interested in health care problems and appointed by the Governor. The Commission's rate review authority includes assuring the public that (a) a hospital's total costs are reasonable; (b) a hospital's aggregate rates are reasonably related to its aggregate costs, and (c) rates are set equitably among all purchasers of care.

STATE OF MARYLAND

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HEALTH SERVICES COST REVIEW COMMISSION
4201 PATTERSON AVENUE — 2ND FLOOR · BALTIMORE, MARYLAND 21215
AREA CODE 301-764-2605

For further information call: * For release 1:30 p.m.

John M. Colmers * February 7, 1990

PRESS RELEASE

For the fourteenth consecutive year, the cost of a hospital admission in Maryland rose at a rate below the national average, according to Charles O. Fisher, Sr., Chairman of the Health Services Cost Review Commission, the state agency that regulates hospital rates.

The Commission's Annual Disclosure revealed that cost per admission rose 7.44% in Maryland last year, while the national average was 9.29%. Based on these figures, Marylanders saved an estimated $49 million in hospital costs in 1989. Mr. Fisher congratulated Maryland's hospitals for this excellent relative performance in holding down the rate of increase in the cost of hospital care.

Chairman Fisher noted that in 1976 the cost of an admission to a Maryland hospital was more than 25% above the national average, and that in 1989 it was 7.37% below the national average. (See Chart 1). Since the cost per admission in Maryland has not risen at the national rate since 1976, the increased cost to Marylanders would have been approximately 34% or $976 million in 1989 alone.

TTY for The Deaf
Baltimore Area 383-7555
D.C. Metro Area 565-0451

While hospital costs per admission rose 7.44%, hospital charges per admission rose 8.24%. Hospitals' uncompensated care rose in 1989 from approximately $213.6 million or 7.4% of revenue to $246.0 million or 7.8% of revenue. (See Chart 2).

Hospital profits increased from $49 million in 1988 to $74.4 million in 1989. (See Chart 3). Sixteen hospitals (Anne Arundel, Key Medical Center, Franklin Square, Frederick, Good Samaritan, Harbor Medical Center, Johns Hopkins, Liberty Medical Center, Mercy, North Arundel, Sacred Heart, St. Joseph's, Suburban, Union Memorial, University and Washington County) had profits exceeding $2,000,000, while five hospitals, (Bon Secours, AMI Doctors, Prince George's General, St. Agnes and University - MIEMSS) had losses exceeding $2 million. In total, 45 acute hospitals showed profits while 10 hospitals posted losses.

Mr. Fisher noted the Commission's continued monitoring of the financial condition of Maryland hospitals. Overall hospital profits increased during the past year while, at the same time, hospital costs in Maryland continued to increase at levels below that of hospitals nationally. Simultaneous with the release of this disclosure statement, the Commission released the first report measuring hospital financial and operating characteristics relative to industry-wide standards. This report was developed through a cooperative effort of the Commission, the hospitals, third party payers, and the business community. Mr. Fisher congratulated hospitals on their performance and renewed the commitment on the part of the Commission to continue to adjust the rate setting system as circumstances warrant. Mr. Fisher, an attorney from Westminster said, "The success of hospital rate setting in Maryland is the result of the continued commitment on the part of all the participants to the goals of cost containment, stability, and financial access."

Net patient revenue increased by 9.20% as the combined result of a 1.29% increase in the number of admissions, the increase in the charge per admission, the change in case mix, and a growth in outpatient activity. There was also a slight increase in equivalent patient days of 30,315 or .7%.

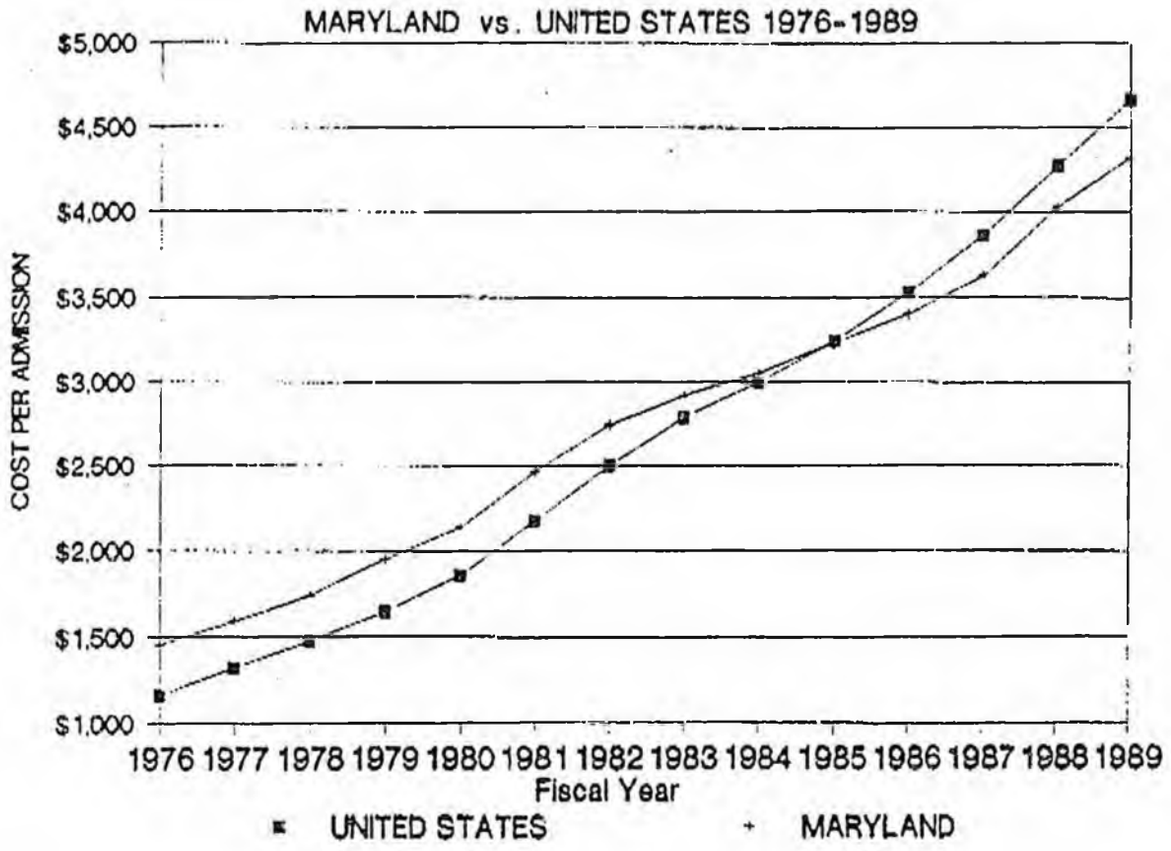
Hospital uncompensated care increased both in relative and absolute terms in FY 1989. Total hospital uncompensated care rose to $246 million, an increase of 13.61% over the previous year. This represents 7.79% of gross patient revenue, an increase from the 7.42% experienced the previous year, thereby continuing the increase in the percent of uncompensated care reported last year.

Mr. Fisher concluded by noting that while Maryland's cost per admission has fallen from 25% above the national average to 7.37% below the national average, there is no reason to be complacent. Hospitals are facing increasing pressures that lead to increased costs. These can only be controlled by the continuation of the cooperative effort associated with Maryland's hospital regulatory structure coupled with increased involvement by business and labor, the ultimate payers.

The Commission expects to face continued challenges as it attempts to balance the legitimate needs of Maryland hospitals with the actions necessary to maintain the all payer system and its inherent equity and financial access.

CHART 1

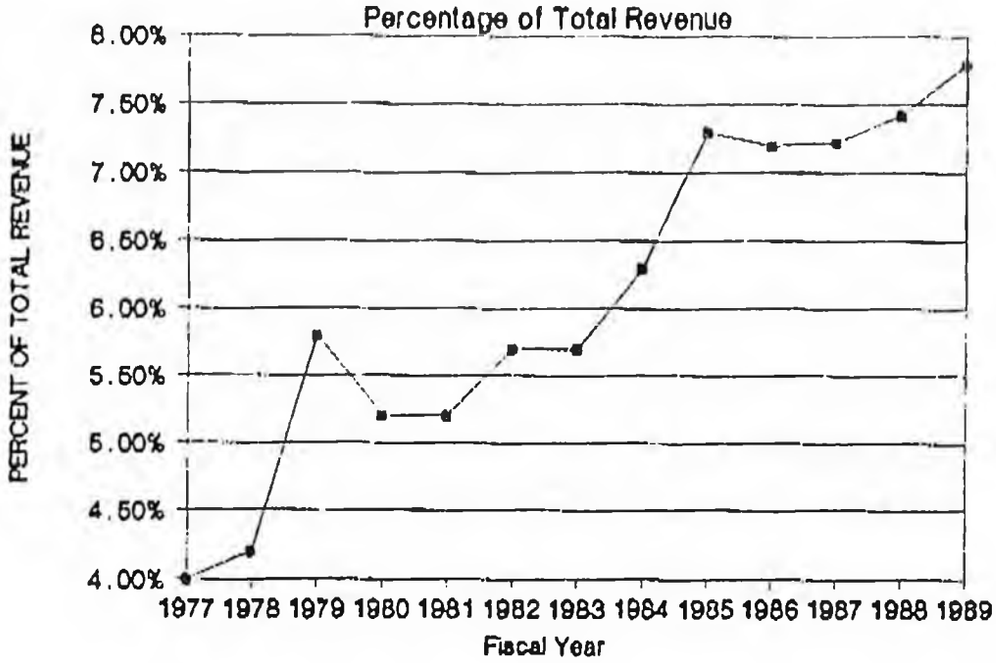
COMPARISON - COST PER ADMISSION

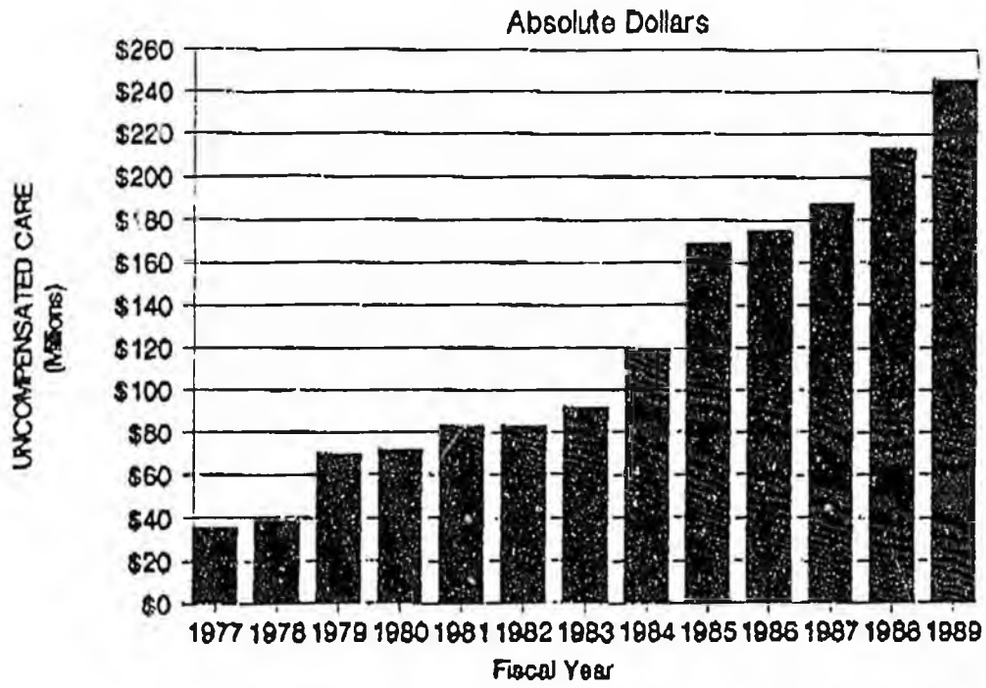


Source: HSCRC Annual Disclosure Reports

CHART 2

UNCOMPENSATED CARE
MARYLAND HOSPITALS 1977 - 1989

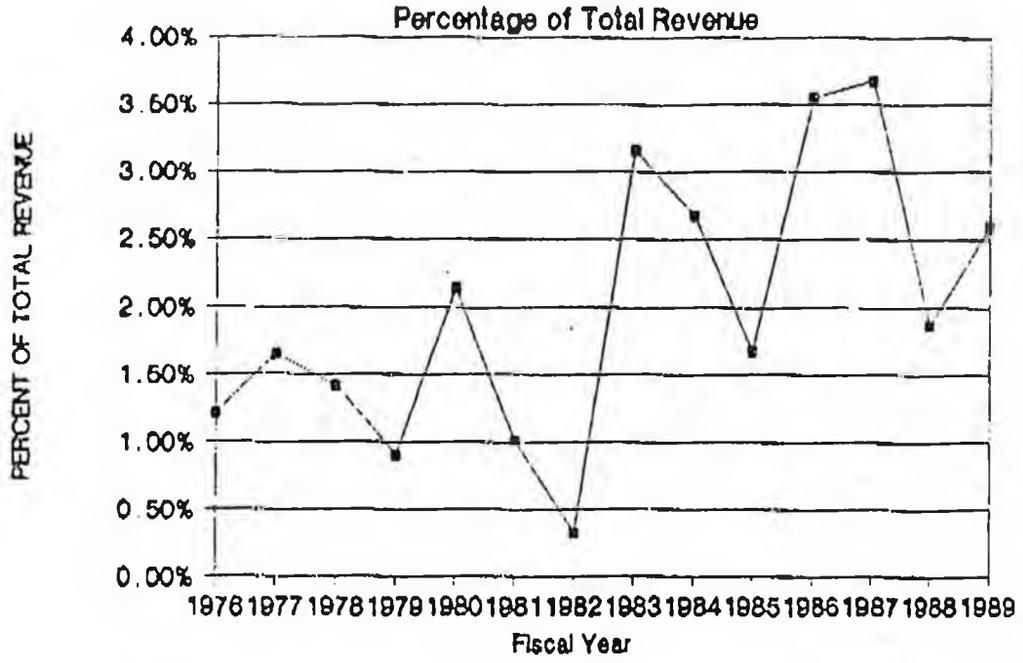


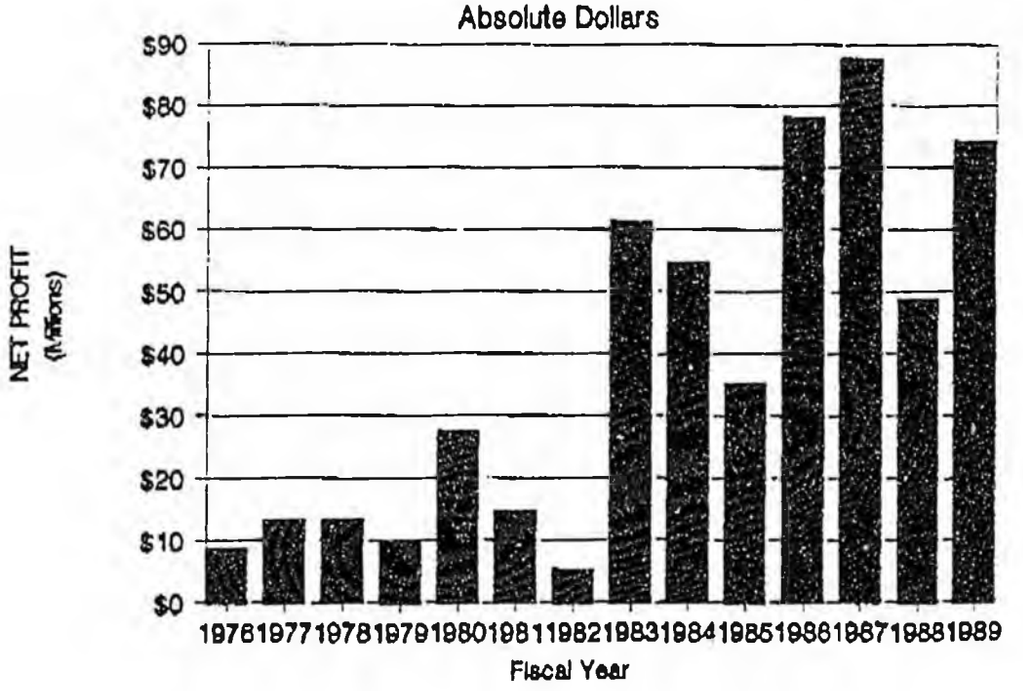


Source: HSCRC Annual Disclosure Reports

CHART 3

NET PROFITS
MARYLAND HOSPITALS 1976 - 1989





Source: HSCRC Annual Disclosure Reports

HEALTH SERVICES COST REVIEW COMMISSION

I. BACKGROUND

In 1971, the Maryland General Assembly reacted to the skyrocketing increase in hospital costs by creating the Health Services Cost Review Commission (the "HSCRC"), the first hospital rate setting agency in the country. Before 1971, hospitals in Maryland were reimbursed on the basis of "reasonable costs" incurred. This open ended financing system guaranteed funds for hospitals, but imposed no constraints on efficiency. With the creation of the HSCRC, hospitals were to be reimbursed based on the reasonableness of the relationship between costs and services, as determined by the HSCRC. HSCRC's rate setting methodology establishes standards of reasonableness that promote efficient use of resources.

In 1974, after three years of development, the HSCRC began performing rate reviews. At the same time, the HSCRC began negotiating with the Department of Health and Human Services for a demonstration project grant which would include a "waiver" of Medicare and Medicaid reimbursement principles in favor of HSCRC rate setting methodology. The waiver was considered essential in order to achieve the goal of equitable pricing for all payor groups. Finally, after three years of negotiations, the waiver was granted effective July 1, 1977. As a result, Maryland became one of the first two states to establish an all-payor system. Today, Maryland stands alone as the one state in the country that maintains the equity in pricing attributable to an all-payor system.

This equity in pricing has achieved dramatic results. In February of 1991, the HSCRC released its annual Disclosure Statement revealing that for the fifteenth consecutive year, the cost of a hospital admission in Maryland rose at a rate below the national average. Specifically, the cost per admission in Maryland rose 8.70%, while the national average was 8.96%. It is noteworthy that in 1976, the cost of an admission to a Maryland hospital was

more than 25% above the national average. As a result of hospitals responding to the incentives of the Maryland rate setting system, the cost per admission to a Maryland hospital in 1990 was 8.11% below the national average.

II. RATE REVIEW METHODOLOGY

The Maryland rate setting system uses a quasi-public utility approach to hospital rate regulation, in which rates are set and then adjusted for such items as inflation, volume changes, and pass-through costs. Hospital rate setting in Maryland currently consists of four systems: (a) Rate Review; (b) Inflation Adjustment; (c) the Guaranteed Inpatient Review System; and (d) the Screening System.

A. Rate Review

In reviewing a hospital's request for permanent rates, the HSCRC applies a standard of reasonableness based on the experience of similar hospitals. A rate review system is used to develop an initial set of rates approved for units of service in the various revenue producing departments. Under this system, all hospitals are required to annually submit data on base and budgeted years, using a uniform accounting and reporting system. The total approved revenues are based on four component parts: direct and allocated indirect departmental expenses, other financial considerations (inclusion of provisions for reasonable uncompensated care and working capital), a payor differential, and a capital facilities allowance for buildings and equipment. All in all, Maryland's rate review system provides an equity among classes of patients that far surpasses the pluralistic payment approach of non-regulated states.

B. Inflation Adjustment

The Inflation Adjustment System was instituted to allow hospitals reasonable rate increases while avoiding the administrative burden of full rate review. It considers inflation adjustments, volume adjustments, changes in payor and case mixes, and certain limited pass-

through costs.

Inflation adjustments are made for: 1) salaries and fringe benefits and 2) food, supplies, utilities, and other expenses. The inflation adjustment compensates the hospital for the past year if actual inflation was greater than the projected rate. (Conversely, if the actual rate is lower than the projected rate, then a deduction will be made in the budget year rate.) Second, if a correction needs to be made, a price leveling adjustment brings the rates to the level where they would have been if the inflation rate had been projected accurately. Finally, the provision for future inflation is established at a level equal to the most recent changes in inflation.

Volume for the budget year is established at a level equal to the actual volume for the current year. Different fixed-variable cost proportions have been established for the routine and ancillary areas as well as for different magnitudes of volume changes.

Pass-through costs are limited to: 1) changes in the Federal minimum wage law to the extent that they exceed wage and salary allowances, 2) actuarially-supported pension cost increases (only to the extent that such increases were above the allowed increase for inflation), and 3) incremental costs resulting from compliance with requirements mandated by the Commission.

C. Guaranteed Inpatient Review System

The Commission instituted the Guaranteed Inpatient Revenue (GIR) System because of concern that the original system, based on rates per units of service, was leading to increased volume and overuse of hospital services. The GIR system seeks to control the volume of ancillaries and lengths of stay. It guarantees payment for each case treated by the hospital. The GIR system determines the average charge for each diagnosis for each type of payor. The average charge is adjusted for inflation and a minimum 1 percent factor for growth and technology. The total GIR payment is the product of discharges (by diagnosis

and payor) and adjusted charges. At year end, the GIR payment is compared to the revenue from the Commission-approved rates charged by the hospital during the year. If the revenue from rates is less than the GIR payment, the hospital will receive the fixed cost portion of the savings. However, if the revenues exceed the GIR payment, the Commission will recoup the additional funds from the hospital in the following year.

D. Screening System

The Screening System is based on a comparison of hospitals' average charge per admission after a series of adjustments for cost factors which are either beyond management control (such as labor market differences) or which the Commission chooses to finance (such as bad debt and charity expenses). This system, introduced in 1982, was designed to identify those hospitals appropriate for targeting for HSCRC rate review efforts. The Screening System also identifies those hospitals eligible for the Inflation Adjustment System. Until 1986, the comparison of hospitals' average charge per admission was done within five groups, and the cutoff point was mean plus twice the inflation factor for the particular year. Then a statewide comparison was adopted with additional regression analysis-based adjustments to each hospital's charge per admission for indirect teaching costs and the presumed cost of treating low income patients. These regression-based adjustments are similar to those used for the Medicare Prospective Payment System.

III. UNCOMPENSATED CARE METHODOLOGY

The Uncompensated Care Methodology has been developed in order for hospitals to recover their reasonable full financial requirements. As with all other components of the Commission's rate setting system, the uncompensated care provision is subject to a reasonableness standard. Since 1983, the reasonableness standard has been based upon a regression analysis conducted annually by the Commission. This regression analysis produces

a predicted level of uncompensated care which serves as the upper limit in the provision of rates. For each year since 1983, one of the variables that has been used in the analysis has been the percentage of revenue attributed to Medicaid patients. The actual level of uncompensated care included in rates is based upon an analysis of the predicted amount, the actual amount incurred by the hospital, and the amount in rates, as well as the relative profits of the institution and its relative standing in charge per admission. The most recent update to the policy was adopted by the Commission at its June, 1990 public meeting. This particular regression analysis found that the variables significant in explaining the variation in uncompensated care among the hospitals in the State included: the percentage of Medicaid and SSI revenue; the percentage of inpatient revenue from commercial insurance patients; the percentage of revenue from patients residing in either Baltimore City or the District of Columbia; and, the percentage of revenue from non-Medicare patients admitted through the emergency room.

IV. CONCLUSION

Despite its longstanding success, the HSCRC is well aware that hospitals are facing increasing pressures that lead to increased costs. Therefore, the HSCRC is committed to continuation of the cooperative effort associated with Maryland's hospital regulatory structure coupled with increased involvement by business and labor, the ultimate payors. The Commission is also committed to continuation of the cooperative spirit that has existed between the agency and the State and Federal governments, which has made it possible for Maryland to consistently take the lead on health care cost containment issues.

NATIONAL GOVERNORS' ASSOCIATION

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Background

OFFICE OF PUBLIC AFFAIRS
February 2, 1991 (12-91)
Contact: Rae Young Bond, 202/624-5330

HEALTH CARE REFORM: Rx FOR A HEALTHY AMERICA

WASHINGTON, D.C. -- The nation's Governors have made health care reform their number one priority this year for several reasons:

- Health care costs have risen so dramatically that states -- who finance health care for the needy, directly provide services through public health and other programs, and pay for health benefits as employers -- find it increasingly difficult to fund other critical state priorities.

- Despite the expenditure of ever-increasing amounts of money, access to health care services is limited and may become increasingly limited.

- The shifting of costs and responsibilities from one payor to another in the system is exacerbating the problems of both cost and access and is contributing to an inefficient system.

- The current health care system is not structured to encourage the delivery of preventive health care services, which Governors increasingly understand is critical to a healthy and productive citizenry.

Health care in the United States is nearing a state of crisis. In 1983, the United States spent $357 billion, or 10.5 percent of the gross national product (GNP) on health care. By 1989, those figures had climbed to more than $599 billion, or 11.5 percent of GNP -- that's $2,400 for every man, woman, and child in the country. Left unchecked, health care costs are projected to rise to $1.5 trillion, or 15 percent of the GNP, by the year 2000.

Yet, millions of Americans have limited or no access to the health care services they need. Based on insurance statistics alone, the figures are appalling. Approximately 31 million people are uninsured annually, and 37 million are uninsured in any given month. Governors, who are responsible for the health and welfare of their citizens, understand clearly that having health insurance or Medicaid coverage does not ensure access to services, particularly for poor and rural citizens.

-more-

Because there are so many other factors that make a difference in whether people actually have access to health care services, Governors must address the following kinds of issues: adequately funding public health efforts; meeting the transportation needs of poor and rural citizens; coordinating the outreach efforts that result in people using health care services more effectively; and screening and licensing health care personnel and facilities.

Employers, the traditional source of insurance coverage for workers and their families, are experiencing double-digit increases in their employee health insurance premiums. Their responses have ranged from dropping coverage for their workers' dependents to decreasing coverage for their employees. For most small businesses, increasingly expensive health insurance is simply beyond their financial reach.

Governors are employers too. In fact, in some states, government is the largest single employer. And as employers, Governors suffer the same premium increases and face the same draconian choices as any other employer.

Where Does Medicaid Fit?

While the Governors are taking an expansive view of health care reform in their initiative, "Rx for a Healthy America," it is clear that the genesis of their interest is their concern and frustration with the current direction of the Medicaid program.

Since its inception in 1965 as a program designed to provide health care services to women and children eligible for Aid to Families with Dependent Children (AFDC) and to the aged, blind, and disabled covered by federal Supplemental Security Income (SSI), Medicaid has grown to include a wide variety of special populations and services. This growth has created problems both in the states' ability to fund and effectively administer the program.

For instance, in 1980, Medicaid spending accounted for 9 percent of a state's budget; in 1990, it accounted for nearly 14 percent of all state spending. Further, the rapid expansion of mandated populations and federal micro-management of services has created an administrative nightmare.

The NGA Task Force on Health will consider and discuss a variety of conceptual options for restructuring the Medicaid program when it meets in Washington, D.C., on February 3, 1991. Although Medicaid is but one piece of a larger puzzle, it is a very large piece.

Wide-reaching and thoughtful discussion about Medicaid could lead to the creative use of its resources.

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What Are the Governors Doing?

To provide the larger context for Medicaid and the other critical and interlocking issues in health care, National Governors' Association Chairman Booth Gardner of Washington established the Task Force on Health. The task force is working on two products that will be completed by August 1991: a report on state options in health care reform and a policy on health care.

Task Force Report. The task force report will detail state options to both increase access to health care and control costs throughout the health care system. The options in the report will both identify incremental steps states have already taken successfully and describe comprehensive ways states can restructure their health care financing and delivery.

The report will guide states in reorienting their health care systems to emphasize preventive and primary care. It also will discuss how to overcome the barriers to the provision of preventive and primary care; barriers that riddle the current structure of the health care system.

The report will outline steps Governors can take to help the working uninsured. Constructive guidance will be offered to Governors interested in working with their business community to help small businesses obtain affordable health insurance for their employees. It will offer suggestions to help stabilize the insurance situation for businesses that now provide health insurance coverage but are finding it increasingly difficult to do so.

A variety of options for expanding access to health care for the non-working population will also be covered. The options will range from expanded use of Medicaid and Medicare to the development of a totally new publicly funded health insurance program for non-working people.

Because the Governors know that without significant new cost controls, the goal of increasing access to care will never be realized, the report will contain a wide range of options for cost containment.

The report will describe a series of incremental and discrete cost control strategies, such as the expanded use of managed care programs, administrative reform, and medical tort reform. It will also suggest bold and innovative strategies, such as a state-level all-payor system and global budgeting for the control of capital expansion.*

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* All-Payor System: A system in which association of purchasers come together to negotiate payment with an association of providers.

Global Budgeting: The idea of defining limits on the total amount of health care expenditures. Allocations are then made within that amount.

Managed Care: The concept of managing the access to health care, the utilization of services, and the cost of care.

Finally, although the focus of the report will clearly be on state action, the report will contain suggestions for federal action that would help the states implement the strategies.

Policy on the Federal Role. To complement the report, the task force will develop a policy for consideration during their annual meeting in August 1991. The policy will focus on the key issues that would require federal action to restructure the health care system. The policy will focus on recommendations on the future of the Medicaid program, changes in insurance practices, and small market reforms to enhance increased access to health insurance.

How Are the Governors Reaching Out?

The Governors began the process of reaching out to a wide variety of people when they hosted a national conference on health care reform in September 1990. During the two-day conference, some of the best health policy analysts and experts in the country participated in roundtable discussions. The participants and Governors explored issues ranging from ensuring the delivery of quality care to helping business find affordable, stable insurance policies; from insurance practice reforms to the individual's responsibility for health care. That conference gave the task force valuable information and insight with which to begin its work.

As the report is developed, Governors will seek extensive feedback and "reality-testing" from the wider community. This spring, Governors will hold a series of regional meetings to elicit comments on drafts of the report from business, labor, the insurance industry, and the provider community.

Further, the Governors will host a working meeting of state health policy analysts and health and human service executives to invite review and comment on the report as it moves to its final form. By involving the widest variety of interested people, Governors believe the strategies in the report will be tested for "workability" and will have benefitted from the best thinking of those involved in the health care system.

What Happens Beyond the Task Force?

Although the formal work of the task force will conclude in August 1991, the issue of health care reform will remain a high priority for the nation's Governors. As the Governors begin to implement the recommendations contained in the report, policymakers at all levels of government will have the opportunity to learn more about what works and what does not.

The Governors want to have the participation and cooperation of their federal partners in fashioning innovative approaches to health care reform. As the Governors and their federal partners evaluate these approaches, there will be opportunities to develop an informed national consensus about how best to move the nation's health care system toward a day when access to health care can be ensured for everyone at prices all can afford.

-30-

To The Rescue

Toward Solving America's Health Cost Crisis

A report by
Families USA Foundation

in cooperation with
Citizen Action

November 1990

Families USA Foundation
1334 G Street, NW
Washington, DC 20005
(202) 628-3030

EXECUTIVE SUMMARY

Absent fundamental change in our health care system, families, businesses, and government can expect to pay a $1.5 trillion health care bill in the year 2000. This is a bill none of us can afford. The United States health care system can be rescued from the damaging spiral of out-of-control health costs and declining access and quality.

By taking action now to control provider rates, reduce unnecessary procedures, and eliminate insurance administrative waste, the United States could reduce the health care bill by $274 billion in the year 2000 -- and still guarantee universal access to health care.

The data in this report demonstrates that both universal access and cost containment are achievable goals. Three specific and straight-forward steps would produce the following savings and benefits:

- *Insurance administrative savings of $52.8 billion can be achieved in 2000 by eliminating the high cost of private insurance administration. This does not include additional savings that physicians and hospitals may realize under a simplified insurance administration system.*

- *By holding health expenditures to a 6.6% annual rate of growth (still above general inflation, but 2% below projected health care inflation), $245.7 billion can be saved in 2000. The Medicare program is already committed to achieving this level of savings through rate and volume controls. It is time to make a national commitment to apply the 2% solution system-wide.*

- *The cost in 2000 of expanding access to the currently uninsured and underinsured is $24.3 billion. This cost is far less than the savings described above.*

Tables at the end of this report present the savings that can be achieved with the above reforms, nationally and within each state, in 1990 and the year 2000.

Absent fundamental change in our health care system, families, businesses, and government can expect to pay a $1.5 trillion health care bill by the year 2000. This is a bill none of us can afford to pay without seriously jeopardizing our standard of living, access to care and our economy. The United States health care system needs to be rescued from the damaging spiral of out-of-control health costs and declining access and quality.

This report presents data, on a state-by-state and national basis, about specific steps this country could take to achieve lower health care costs, universal access and improved quality of care for all Americans. By taking action now to control provider rates and reduce insurance administrative waste, the United States could reduce this bill by $274 billion in the year 2000 -- and still guarantee universal access to health care.

In the face of rising health costs and declining access, public dissatisfaction with the American health care system has been increasing. Most Americans (89%) see the need for fundamental change in the direction and structure of the U.S. health care system. Only 10% agree with the statement that "on the whole, the health care system works pretty well." Americans are significantly less satisfied with their health care system and physician care than either the Canadians or British.[1]

Economist Uwe Reinhardt has observed that this public disenchantment with the health care system reflects serious misgivings over the way American health care is financed. The American health insurance system lacks the security, portability and administrative simplicity desired by American citizens.[2] The approaches to health care reform described in this report address the sources of this public dissatisfaction.

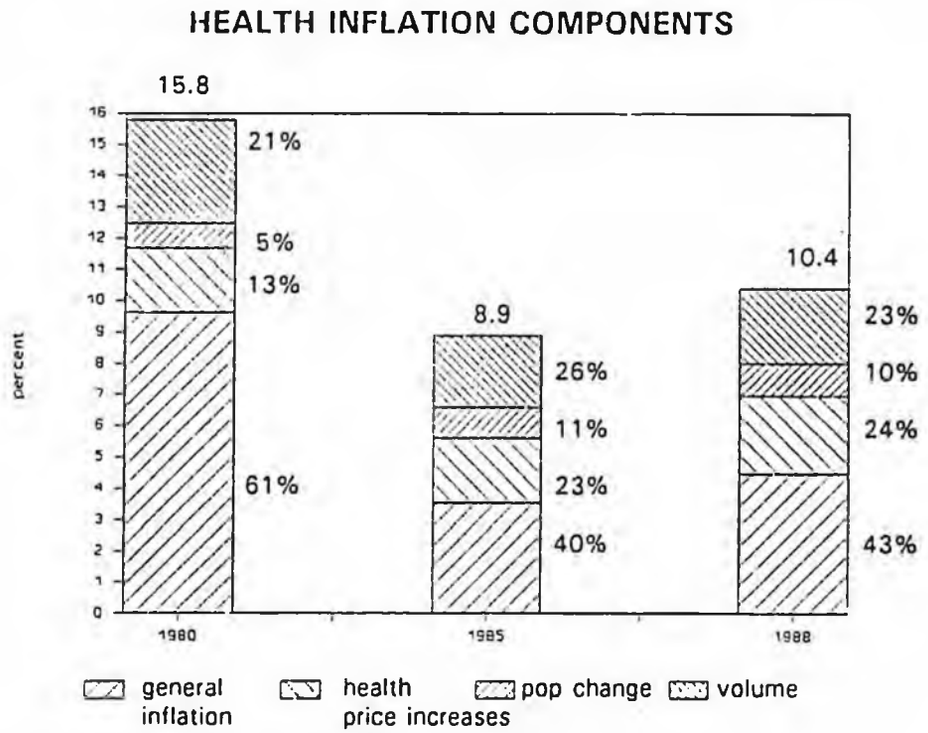
CAUSES OF EXCESSIVE HEALTH CARE INFLATION

Health care spending has increased at more than twice the rate of general inflation during the last decade and, absent reform, this trend is expected to continue during the 1990s. An analysis of the components of health care inflation reveals areas that can be controlled without affecting quality.

Health care inflation is usually broken down into four components: general price inflation; medical price inflation; population changes; and intensity, or the volume of services provided. Although the United States has an aging population, changing demographics account for a relatively minor portion of increased health care spending -- 1% of the 11.7% annual compound rate of growth between 1975-87.[3] The fact that as Americans grow older they need more health care is <u>not</u> the major contributor to spiraling health costs. This factor accounts for one-tenth of rising costs.

A major factor driving up health care costs is the amount health care prices have increased <u>above</u> the general rate of inflation -- that is, the amount that health care providers have increased their prices for services by more than the rate of general inflation. These excess

price increases accounted for 2.2% of the 11.7% rate of growth between 1975-87.[4] These excessive health care price increases account for one-fifth of rising health costs. Such price increases are encouraged by the fee-for-service reimbursement system that is prevalent in the United States. Under many insurance plans, providers are paid more the more they increase their fees. The last decade has been marked by sustained increases in real net physician income. Physician incomes have increased an average of 7.1% from 1981-88 compared to average earnings increases of 4.1%.[5] Health care chief executives were the nation's highest paid CEOs in 1989.[6]



Source: Health Care Financing Administration

The American fee-for-service system rewards physicians more for performing surgery and other procedures, than for time spent counseling, diagnosing and examining patients. The financial incentives inherent in this type of payment system contribute to the second major factor which drives up health care spending -- the increasing quantity, or volume and intensity, of services provided to each person. Volume and intensity growth accounted for 2.3% of the 11.7% growth rate, or one-fifth of health care inflation.[7]

This increase in the amount and type of medical procedures is especially worrisome since there is overwhelming evidence that a significant proportion of the American health care dollar is spent on unnecessary tests and procedures, endangering health and quality of care. Recent research has found that 32% of carotid endarterectomies, 17% of coronary angiographies, and 17% of upper gastrointestinal endoscopies are inappropriate. The General

Accounting Office found that inappropriate use of surgical procedures ranged from 14% to 32%. Many common procedures, such as Caesarean section deliveries and coronary artery bypass surgery, are often used without producing any medical benefit for the patient.[8]

The cost-containment strategies described below are designed to reduce the size of the two most troublesome components of health care inflation: excess health price increases and increases in the volume and intensity of health care services provided. The other two components -- economy-wide inflation and increases in the population -- are determined outside of the health care system.

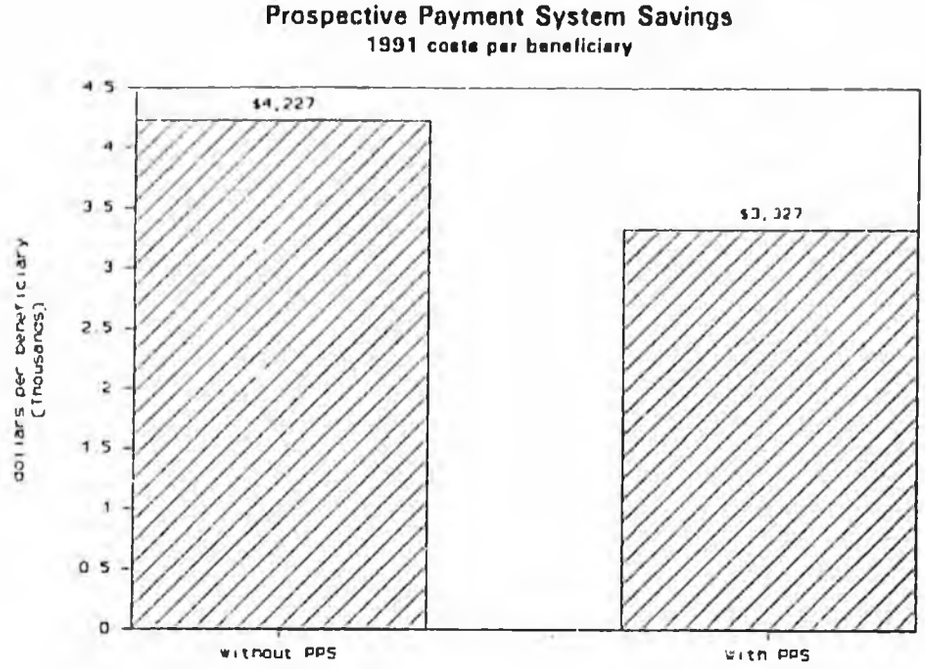
Although both public and private health care plans have initiated a variety of cost containment efforts in the last decade, these piecemeal approaches have failed to control costs system-wide. The fragmented nature of our multiple-payer approach has been a major barrier to effective cost containment. All too often one payer's success at controlling use and charges has resulted in another payer's loss, as providers just shift costs to those with less bargaining power in the health care marketplace. Private employers are paying an estimated $31 billion, or 27% of their health care costs, for uninsurance, underinsurance or underpayments by other sectors of our society.[9] The lack of uniform cost and quality data and standards is also an impediment to controlling system-wide costs.

CONTROLLING HEALTH CARE EXPENDITURES

THE 2% SOLUTION -- MAKING A NATIONAL COMMITMENT

The Medicare program, which accounts for almost one-fifth of our national health spending, has developed successful methodologies for holding down costs. These methodologies would have a far greater impact if they could be applied system-wide. Without mechanisms for controlling costs system-wide, providers have the ability to shift costs to other payers. Other industrialized countries and some states have also adopted strategies that have held down costs.

The Medicare program is putting into place a new system for paying physicians. This new system addresses many of the problems identified above. A new physician fee schedule will increase reimbursement for primary care services and reduce fees for over-valued procedures. At the same time, Medicare will use a volume performance standard, or VPS, to protect Medicare against physicians performing more services to make up for any fee reductions. The new legislation assumes that Medicare physician costs will be reduced 2% annually beginning in 1993, below what they would have been without any volume controls. The VPS is modelled after the concept of expenditure targets used in several Canadian provinces.

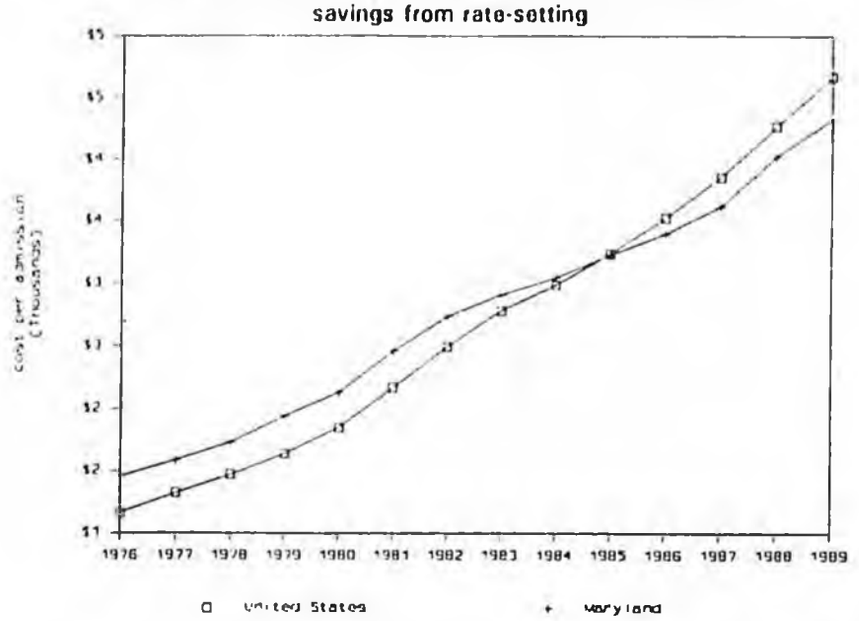


Source: Committee on Ways & Means, *1990 Green Book*, p. 238

Since 1984, Medicare has been paying hospitals a set dollar amount per admission based on diagnosis and adjusted for geographic variations in labor costs. This prospective payment system (PPS) will save Medicare $30 billion in 1991 alone. As the graph illustrates, Medicare's prospective payment system for hospitals has saved the program 21% on hospital costs per beneficiary.[10] The Health Care Financing Administration has estimated that increases in hospital costs could be reduced 2% nationally through practice pattern changes (primarily reduced length of stay).[11]

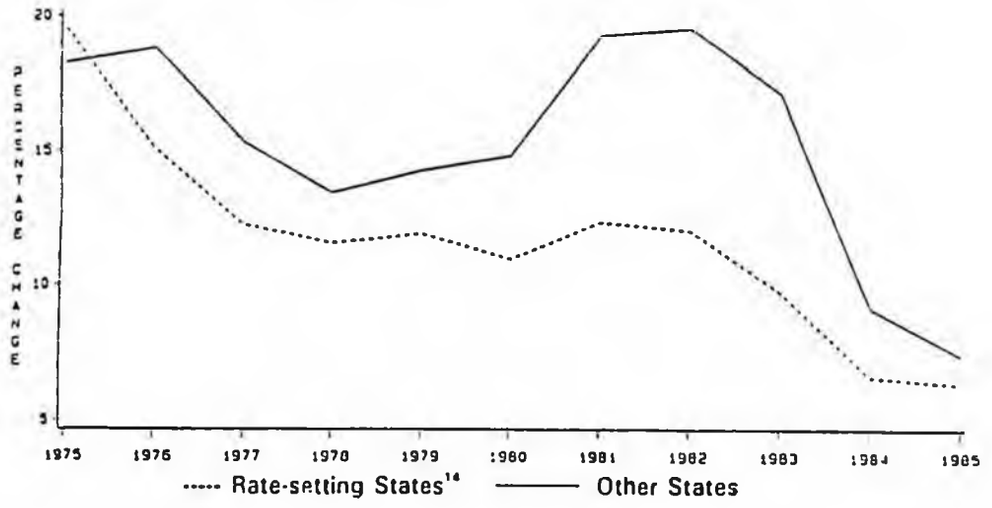
Several states have controlled hospital costs by establishing rates for all payers, public and private, large and small. The rate of increase in individual hospital expenses was reduced 4% in these states. Hospital charges per admission were 3.8% lower in the experimental states compared to other states.[12] As of 1988, Maryland's cost per admission rose 7.5%, as compared with a national rate of increase of 9.1%. This difference saved residents of Maryland $38 million in 1988 alone. If costs per admission in Maryland had risen at the national rate since 1976, when Maryland began its rate-setting system, Marylanders would have paid an additional $845 million for hospital costs between 1976 and 1988.[13]

Maryland vs. United States 1976-1988
savings from rate-setting



Source: Maryland Health Services Cost Review Commission, FY 1989 Report

Rate-Setting States vs. United States
Change in Gross Inpatient Revenue per Admission



Source: Johns Hopkins Center for Hospital Finance and Management

The development by the Medicare program of new methodologies to set physician fees fairly and to control the volume of physician services means that states now have the tools to control all health expenditures within the state.

Reducing health expenditures by 2% annually is a realistic and modest goal. Using rate control authority to reduce anticipated medical inflation by just 2% per year would produce

enormous savings by the year 2000. This expenditure control approach would still allow an annual medical inflation rate of 6.6%, well above projected general inflation of just over 4%, and produce savings of $245.7 billion in 2000.

Establishment of system-wide rate controls for providers would go far to get at the two causes of health care inflation identified above -- excess price and volume increases -- and would effectively contain costs. Unified payment rates would also eliminate the destructive cost-shifting and high administrative burden imposed by our current fragmented health care system. Such an approach would draw on the proven cost containment successes of otner countries and on our own Medicare and state-based approaches.

ACHIEVING TIIE SAVINGS

There are a wide variety of ways this nation can achieve this annual 2% savings without reducing quality of care. Holding down the rates of increase in providers' income is one way. Other ways involve using our national resources in a more rational manner.

The development and use of **practice guidelines** for care is one way to reduce unnecessary care and the high costs associated with it. Studies consistently find striking variations in practice patterns in different geographic regions. These variations are not explained by differences in the population. Rather, practice styles of physicians account for the differences, not patient needs or superior care. Research has shown that once physicians do learn about the results of appropriateness studies and variations in use of procedures, their practice patterns change. The elimination of unnecessary procedures not only saves money, but improves quality of care for all Americans. The National Leadership Commission on Health Care estimated that practice pattern changes could reduce health expenditures by up to $22 billion annually.[15]

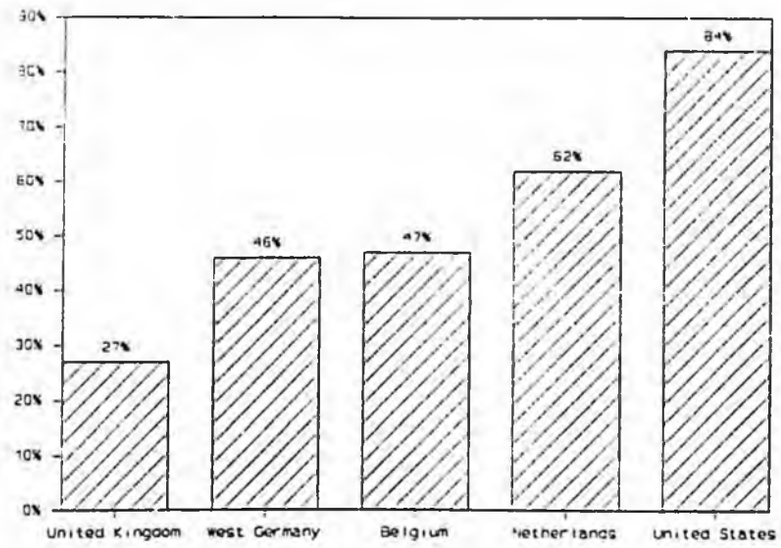
Technology assessment and capital planning also offer a means to reduce cost without jeopardizing quality. Our knowledge about effective care has not kept pace with expanding technologies. High technology equipment is often disseminated prior to any research about its application and likely outcomes. Technology assessment could both save costs and improve quality. Similarly, capital spending review and budgets for both inpatient and outpatient services would eliminate incentives for wasteful and duplicative capital spending. Excess hospital beds are costing the United States at least $3.1 billion in 1990.[16] Furthermore, quality is improved when providers perform procedures frequently. Studies have found that a greater concentration of surgery in fewer hospitals tended to lower mortality rates.[17]

Other countries, including Canada, have used their rate-setting and budget authority to directly address the tough questions of a **fair net income for physicians and the appropriate supply of physicians.** In Canada physician incomes are four to five times the average industrial wage, as compared with five to six times the average industrial wage in the United States. In contrast to the United States, income differentials between primary care

and specialties are relatively small in Canada.[18] In the United States, the number of primary care physicians is decreasing relative to other physicians. In Canada, primary care physicians account for 52.5% of all physicians.[19]

Other Western countries have successfully increased the percentage of primary care physicians relative to specialists. As of 1980, the percentage of active physicians who were specialists varied among industrialized countries as follows: United Kingdom - 27%; West Germany - 46%; Belgium - 47%; Netherlands - 62%; United States - 84%.[20]

Specialists by Country
percent of physicians, 1980



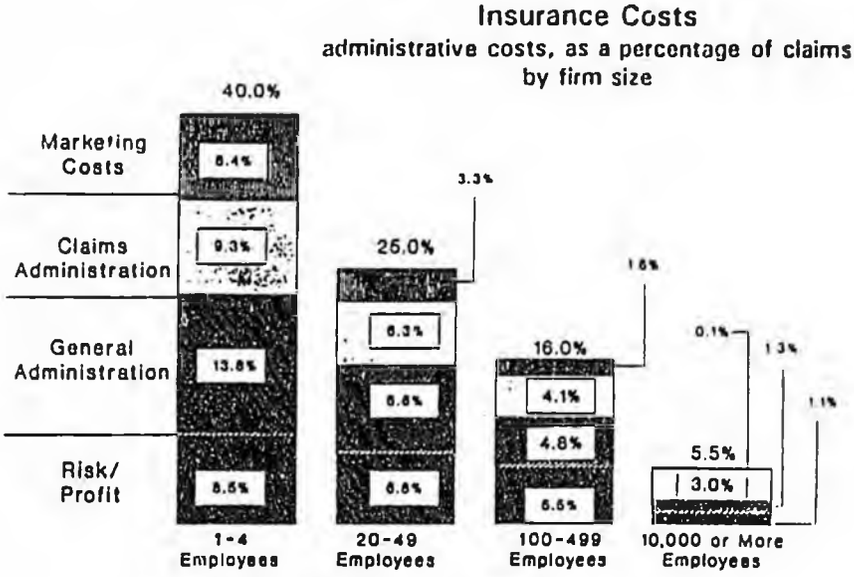
Source: *Journal of the American Medical Association*

INSURANCE ADMINISTRATIVE SAVINGS

The United States health care system has the highest proportion of administrative costs in the world. Our pluralistic health insurance system, with over 1,500 different insurance companies and several public programs, spawns diverse and duplicative payment rules, differing rates, dozens of separate utilization review systems, complex and costly eligibility determinations, high marketing costs and profits. Americans, in effect, pay what one economist has described as a "plurality tax" on all health services.[21]

The high administrative costs of the private insurance industry are disproportionately borne by small business and individuals who must purchase coverage on their own. The costs of marketing, insurance company profits, medical underwriting, and commissions fall most heavily on those groups with the least market power. For every dollar of health care costs paid by groups of 1-4 individuals, 40 cents goes for administrative costs under our private

insurance system. Groups of 20-49 incur 25 cents in administrative costs for every dollar spent. Even groups of 100-500 pay administrative costs of 16 cents for every dollar spent.[22]



Source: Hay/Huggins, Inc.

By 2000 the United States could save $52.8 billion annually in insurance administration costs by eliminating this plurality tax and utilizing a single, public administrative system. These savings are calculated by reducing health insurance administrative costs to those of the Medicare and Medicaid programs (2.7%).

Simplifying insurance administration in the U.S. may also allow physicians and hospitals to save on overhead costs associated with billing. Such savings are not included in the above estimates. The **provider administrative and billing overhead costs** associated with the American multiple-payer system are higher than any other country. In the United States, 18% of hospital spending is for administration and billing and 45% of gross physician income is for professional expenses, much of it for billing. Under Canada's single-payor system, only 8% of hospital costs are for administration and billing, and 36% of physician costs for professional expenses. According to one estimate, adopting a Canadian-style, single-payor health insurance system in the United States could have saved $22.5 billion in hospital, physician and nursing home expenses in 1983.[23] Reducing these costs incurred by American hospitals, doctors and other providers is another way to reduce provider rates without reducing provider income or quality of care. Administrative simplification would also address the dissatisfaction with complex and overlapping bureaucracy increasingly expressed by patients and providers.

UNIVERSAL COVERAGE

Savings from either of the reforms presented in this report -- 2% rate reductions and/or 12% administrative savings -- are more than enough to fund coverage for the uninsured.

A fundamental aspect of any health care reform must be the provision of universal access. Without universal access, Americans will continue to incur unnecessary costs due to delayed care, lack of cost-effective preventive care for children and pre-natal care for women, and untreated chronic illnesses which become more serious and costly. If everyone is insured, the risks can be spread evenly across the population.

Universal access will also help to ensure an adequate supply and distribution of health care providers. The financial burden of hospital uncompensated care is forcing hospitals to eliminate services that attract uninsured patients -- such as emergency and trauma centers. This curtails access for insured patients and forces everyone to travel further for emergency care. In geographic areas with large proportions of uninsured people, providers find that losses from uninsured patients cannot be recovered from the shrinking base of insured people and that continued provision of service to the entire community is not financially viable.[24]

The costs of providing coverage for the uninsured in the year 2000 will be $24.3 billion. This cost is based on a basic benefit package of hospital, physician services, diagnostic tests, limited mental health preventive services and prescription drug coverage. Since the uninsured use approximately one-third less health care than insured persons, this estimate shows the cost of the increase in the use of services. This estimate does not include any savings that would be generated by ensuring cost-effective preventive care and on-going treatment of chronic illnesses.

CONCLUSION

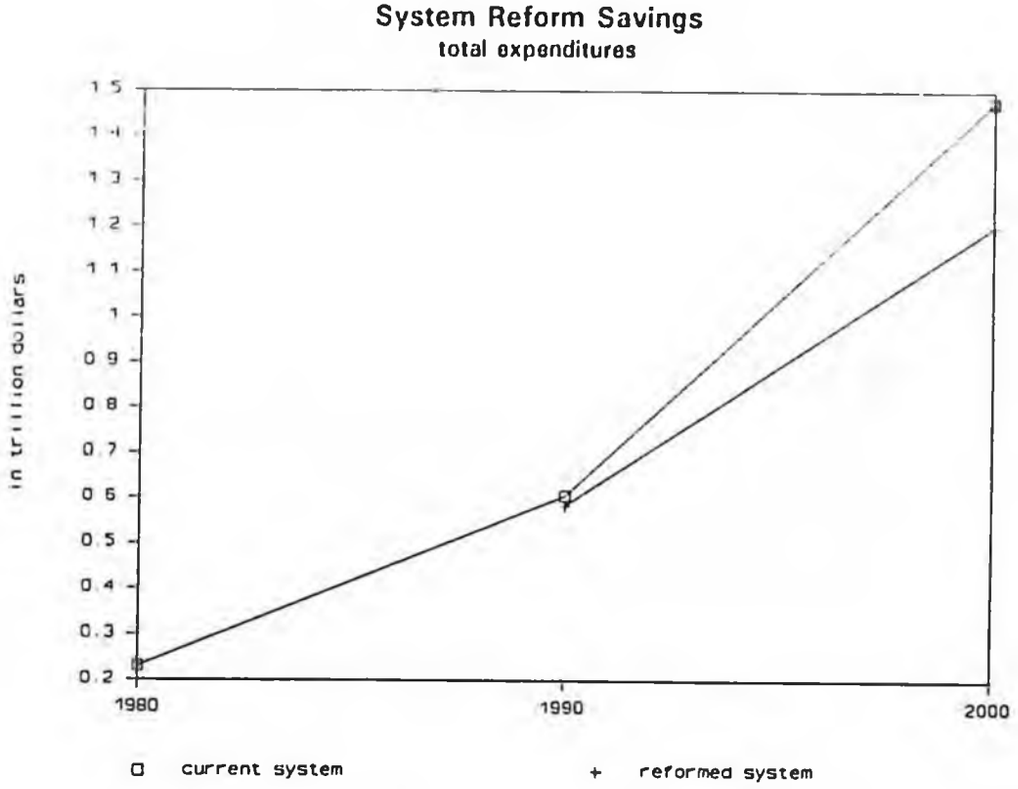
The data in this report demonstrate that both universal access and cost containment are achievable goals in the United States. By acting now on the three specific reforms presented in this report, the United States could save $274 billion in the year 2000:

- The cost in 2000 of expanding access to the currently uninsured and underinsured is $24.3 billion.

- By holding provider fees and rates to a 6.6% annual rate of per capita growth (about one and one-half times general inflation) $245.7 billion can be saved by the year 2000. This can be accomplished by expanding reforms in the Medicare program to our entire health care system.

- Administrative savings of $52.8 billion can be achieved in 2000 by eliminating the high costs of private insurance administration. Additional savings may be possible from reduced provider overhead costs associated with billing.

The following tables present the savings that can be achieved with the above reforms, nationally and within each state, in 1990 and the year 2000.



ENDNOTES

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4. Ibid.

5. American Medical Association, Socioeconomic Characteristics of Medical Practices, as cited by Committee on Ways and Means, U.S. House of Representatives, **1990 Green Book**, pp. 281-282, and pp. 1211-1212.

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7. George J. Schieber and Jean-Pierre Pouiller, op. cit.

8. The Pepper Commission, U.S. Bipartisan Commission on Comprehensive Health Care, A Call for Action, September 1990, p. 40.

9. Lewin/ICF estimate using the Health Benefits Simulation Model.

10. Committee on Ways and Means, op. cit., p. 238.

11. National Leadership Commission on Health Care, **For the Health of a Nation**, Washington, D.C., January 1989, p. T.A. III-2.

12. Johns Hopkins Center for Hospital Finance and Management, **A Study of the Cost Effectiveness of Medicare Waivers and Efficiency of State All-Payer Hospital Payment Systems, 1987.** Maryland, Massachusetts, New Jersey and New York have had all-payer hospital rate-setting systems. Maryland is the only state that currently has such a system. In the other states, hospitals preferred to be paid under Medicare's DRG system; other payers are still subject to rate-setting.

13. Maryland Health Services Cost Review Commission, Fiscal Year 1989 Report.

14. Maryland data is included from 1974 to 1985. New Jersey data is included from 1980 to 1985. Massachusetts and New York are included from 1982 to 1985.

15. National Leadership Commission on Health Care, op. cit.

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17. Robert G. Hughes, Sandra S. Hunt, Harold S. Luft, "Effects of Surgeon Volume and Hospital Volume on Quality of Care in Hospitals", **Medical Care**, Vol. 25, No. 6, June 1987, pp. 489-503 and Joyce V. Kelly and Fred J. Hellinger, "Physician and Hospital Factors Associated with Mortality of Surgical Patients," **Medical Care**, Vol. 24, No. 9, Sept. 1986, pp. 785-800.

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19. John K. Ingiehart, "Canada's Health Care System Faces Its Problems," **New England Journal of Medicine**, February 22, 1990, p. 567.

20. Steven A. Schroeder, "Western European Response to Physician Oversupply: Lessons for the United States," **Journal of the America Medical Association**, July 20, 1984, pp. 373 - 384.

21. Kenneth E. Thorpe, **Single Payor/Universal Health Care: Design and Implementation Issues**, Harvard School of Public Health, unpublished paper for National Leadership Coalition on Health Care Reform, 1990.

22. Hay/Huggins, Inc., as provided by Lewin/ICF.

23. Steffie Woolhandler and David Himmelstein, "A National Health Program: Northern Light at the End of the Tunnel," **Journal of the American Medical Association**, October 20, 1989, Vol. 262, No. 15, pp. 2136-2137 and David Himmelstein and Steffie Woolhandler, "Cost Without Benefit, Administrative Waste in U.S. Health Care," **New England Journal of Medicine**, Vol. 314, No. 7, February 13, 1986, pp. 441-5.

24. The Pepper Commission, op. cit., pp. 37, 43.

COMPARISON OF TOTAL PROJECTED HEALTH CARE EXPENDITURES
BY STATE UNDER ALTERNATIVE POLICIES IN 2000
(In Thousands)

STATE	Current Law	Universal Access	Rate Control (2%) Savings a/	Insurance Administrative Savings a/	Total Universal Access & Rate Controls & Administration	Change From Current Law
ALABAMA	22,667,039	389,069	(3,805,249)	(629,995)	18,620,864	(4,046,175)
ALASKA	3,228,864	52,890	(534,023)	(134,503)	2,613,223	(615,640)
ARIZONA	23,306,882	313,035	(3,866,096)	(835,211)	18,918,612	(4,388,270)
ARKANSAS	11,097,073	193,713	(1,867,838)	(282,744)	9,140,204	(1,956,868)
CALIFORNIA	223,595,772	3,283,773	(37,113,065)	(8,154,865)	181,611,615	(41,984,157)
COLORADO	18,819,641	328,250	(3,119,607)	(762,585)	15,265,699	(3,553,942)
CONNECTICUT	20,996,403	354,138	(3,463,197)	(940,296)	16,947,048	(4,049,355)
DELAWARE	4,138,620	60,393	(691,154)	(125,720)	3,382,140	(756,480)
DISTRICT OF COLUMBIA	3,500,076	67,223	(593,286)	(70,790)	2,903,224	(596,852)
FLORIDA	90,060,126	1,210,959	(15,089,001)	(2,344,533)	73,837,551	(16,222,576)
GEORGIA	37,733,919	538,227	(6,309,527)	(1,087,148)	30,875,471	(6,858,448)
HAWAII	7,653,634	109,434	(1,262,304)	(323,721)	6,177,043	(1,476,590)
IDAHO	3,959,138	71,591	(659,214)	(145,671)	3,225,845	(733,294)
ILLINOIS	69,779,254	1,240,749	(11,547,728)	(2,963,833)	56,508,442	(13,270,812)
INDIANA	28,504,460	497,770	(4,717,173)	(1,201,718)	23,083,339	(5,421,122)
IOWA	13,620,316	271,924	(2,257,420)	(588,209)	11,046,611	(2,573,704)
KANSAS	14,677,643	257,370	(2,425,163)	(642,393)	11,867,457	(2,810,186)
KENTUCKY	15,737,895	291,848	(2,649,529)	(414,825)	12,965,388	(2,772,507)
LOUISIANA	20,590,574	410,813	(3,475,688)	(517,528)	17,008,171	(3,582,403)
MAINE	6,645,638	105,620	(1,099,393)	(272,017)	5,379,847	(1,265,790)
MARYLAND	31,074,629	458,792	(5,196,582)	(907,527)	25,429,311	(5,645,318)
MASSACHUSETTS	42,436,773	725,588	(7,030,106)	(1,730,655)	34,401,601	(8,035,173)
MICHIGAN	54,691,321	967,289	(9,055,599)	(2,289,721)	44,313,290	(10,378,031)
MINNESOTA	25,755,773	429,535	(4,239,365)	(1,200,744)	20,745,199	(5,010,574)
MISSISSIPPI	11,044,767	193,386	(1,860,928)	(270,833)	9,106,391	(1,938,375)
MISSOURI	31,946,064	536,740	(5,284,951)	(1,336,112)	25,861,740	(6,084,324)
MONTANA	3,486,657	69,350	(583,844)	(115,140)	2,857,023	(629,634)
NEBRASKA	8,580,707	159,869	(1,417,323)	(387,626)	6,935,627	(1,645,080)
NEVADA	8,837,119	112,469	(1,458,356)	(354,811)	7,136,421	(1,700,698)
NEW HAMPSHIRE	6,351,711	85,896	(1,045,852)	(273,909)	5,117,846	(1,233,865)
NEW JERSEY	42,383,428	701,136	(7,014,626)	(1,744,086)	34,325,852	(8,057,576)
NEW MEXICO	7,076,082	112,592	(1,179,766)	(235,763)	5,773,146	(1,302,936)
NEW YORK	115,121,894	2,064,813	(19,206,482)	(3,993,908)	93,986,317	(21,135,578)
NORTH CAROLINA	32,183,511	489,202	(5,377,481)	(980,695)	26,314,536	(5,868,975)
NORTH DAKOTA	3,606,280	73,636	(599,931)	(144,244)	2,935,741	(670,539)
OHIO	61,941,308	1,100,776	(10,267,317)	(2,531,973)	50,242,794	(11,698,514)
OKLAHOMA	14,232,334	293,934	(2,400,143)	(381,102)	11,745,023	(2,487,311)
OREGON	15,269,405	258,617	(2,537,250)	(574,818)	12,415,954	(2,853,451)
PENNSYLVANIA	69,555,852	1,237,755	(11,558,415)	(2,674,454)	56,560,738	(12,995,113)
RHODE ISLAND	6,448,659	109,254	(1,070,219)	(250,613)	5,237,081	(1,211,578)
SOUTH CAROLINA	15,222,478	239,954	(2,544,917)	(464,043)	12,453,472	(2,769,006)
SOUTH DAKOTA	3,773,731	67,320	(625,132)	(156,856)	3,059,063	(714,667)
TENNESSEE	27,908,735	456,767	(4,683,096)	(765,810)	22,916,594	(4,992,141)
TEXAS	88,910,873	1,544,835	(14,903,974)	(2,620,198)	72,931,636	(15,979,237)
UTAH	7,493,528	123,948	(1,238,664)	(317,448)	6,061,362	(1,432,164)
VERMONT	2,753,403	43,861	(454,743)	(117,254)	2,225,268	(528,135)
VIRGINIA	34,364,026	507,109	(5,735,435)	(1,069,528)	28,066,172	(6,297,854)
WASHINGTON	27,295,859	429,823	(4,533,675)	(1,006,614)	22,185,394	(5,110,465)
WEST VIRGINIA	7,844,814	165,857	(1,325,762)	(197,336)	6,487,573	(1,357,240)
WISCONSIN	26,967,967	480,209	(4,460,714)	(1,159,098)	21,828,364	(5,139,603)
WYOMING	1,634,546	36,516	(272,443)	(65,427)	1,333,192	(301,354)
TOTAL	$1,478,507,197	$24,325,619	($245,708,644)	($52,756,656)	$1,202,367,516	(274,139,681)

a/ Savings computed on the basis of total health spending under Universal Access
SOURCE: Lewin/ICF estimates

COMPARISON OF TOTAL PROJECTED HEALTH CARE EXPENDITURES
BY STATE UNDER ALTERNATIVE POLICIES IN 1992
(In Thousands)

STATE	Current Law	Universal Access	Rate Control (2%) Savings a/	Insurance Administrative Savings a/	Total Universal Access & Rate Controls & Administration	Change From Current Law
ALABAMA	9,522,402	194,638	(178,794)	(267,894)	9,270,352	(252,050)
ALASKA	1,242,929	26,459	(23,357)	(50,932)	1,195,100	(47,830)
ARIZONA	8,105,810	156,601	(152,028)	(291,921)	7,818,461	(287,348)
ARKANSAS	4,706,750	96,908	(88,387)	(121,620)	4,593,652	(113,099)
CALIFORNIA	84,754,469	1,642,760	(1,589,709)	(3,117,188)	81,690,332	(3,064,137)
COLORADO	8,045,268	164,212	(151,054)	(325,362)	7,733,064	(312,204)
CONNECTICUT	8,815,608	177,163	(165,471)	(405,325)	8,422,175	(393,433)
DELAWARE	1,547,100	30,213	(29,023)	(47,620)	1,500,670	(46,430)
DISTRICT OF COLUMBIA	1,559,131	33,630	(29,307)	(31,931)	1,531,523	(27,608)
FLORIDA	31,411,102	605,802	(589,111)	(840,263)	30,587,530	(823,572)
GEORGIA	13,669,245	269,257	(256,468)	(395,572)	13,286,461	(382,784)
HAWAII	2,797,343	54,746	(52,478)	(117,620)	2,681,991	(115,352)
IDAHO	1,748,435	35,815	(32,830)	(64,245)	1,687,175	(61,260)
ILLINOIS	30,597,883	620,704	(574,422)	(1,343,072)	29,301,094	(1,296,789)
INDIANA	12,362,662	249,017	(232,055)	(532,810)	11,846,815	(515,847)
IOWA	6,615,476	136,034	(124,228)	(294,609)	6,332,683	(282,794)
KANSAS	6,426,779	128,754	(120,622)	(289,497)	6,145,414	(281,365)
KENTUCKY	7,021,825	146,002	(131,888)	(185,001)	6,849,938	(171,888)
LOUISIANA	9,545,115	205,516	(179,412)	(240,437)	9,330,783	(214,332)
MAINE	2,687,926	52,838	(50,430)	(112,449)	2,577,885	(110,041)
MARYLAND	11,627,792	229,518	(218,175)	(342,905)	11,296,230	(331,562)
MASSACHUSETTS	17,947,477	362,987	(336,913)	(753,437)	17,220,115	(727,362)
MICHIGAN	23,874,781	483,902	(448,200)	(1,031,175)	22,879,307	(995,473)
MINNESOTA	10,857,061	214,882	(203,724)	(514,127)	10,354,092	(502,969)
MISSISSIPPI	4,638,528	96,744	(87,129)	(114,055)	4,534,088	(104,439)
MISSOURI	13,373,361	268,513	(251,010)	(578,860)	12,812,003	(561,358)
MONTANA	1,641,223	34,694	(30,837)	(53,992)	1,591,087	(50,136)
NEBRASKA	3,933,640	79,977	(73,851)	(181,791)	3,757,975	(175,664)
NEVADA	3,115,213	56,264	(56,355)	(125,858)	2,987,264	(127,949)
NEW HAMPSHIRE	2,258,658	42,971	(42,350)	(99,597)	2,159,682	(98,976)
NEW JERSEY	17,368,763	350,755	(326,039)	(735,990)	16,657,489	(711,274)
NEW MEXICO	2,757,688	56,326	(51,778)	(91,096)	2,671,140	(86,547)
NEW YORK	50,354,750	1,032,956	(945,534)	(1,792,954)	48,649,219	(1,705,532)
NORTH CAROLINA	12,259,381	244,731	(230,076)	(376,230)	11,897,807	(361,574)
NORTH DAKOTA	1,751,185	36,838	(32,900)	(71,797)	1,683,326	(67,859)
OHIO	27,193,403	550,681	(510,491)	(1,146,344)	26,087,249	(1,106,154)
OKLAHOMA	6,824,669	147,045	(128,280)	(184,441)	6,658,993	(165,676)
OREGON	6,523,595	129,377	(122,415)	(246,256)	6,284,301	(239,294)
PENNSYLVANIA	30,541,650	619,207	(573,360)	(1,221,936)	29,365,561	(1,176,089)
RHODE ISLAND	2,701,187	54,656	(50,708)	(107,859)	2,597,276	(103,911)
SOUTH CAROLINA	6,011,186	120,041	(112,815)	(183,631)	5,834,781	(176,405)
SOUTH DAKOTA	1,662,251	33,678	(31,205)	(70,916)	1,593,808	(68,443)
TENNESSEE	11,328,956	228,505	(212,657)	(314,445)	11,030,359	(298,597)
TEXAS	37,380,724	772,828	(702,025)	(1,111,317)	36,340,210	(1,040,514)
UTAH	3,085,385	62,007	(57,912)	(129,926)	2,959,554	(125,831)
VERMONT	1,117,014	21,942	(20,957)	(48,544)	1,069,456	(47,558)
VIRGINIA	12,931,845	253,690	(242,614)	(404,510)	12,538,410	(393,434)
WASHINGTON	11,084,596	215,026	(207,913)	(408,369)	10,683,339	(401,257)
WEST VIRGINIA	3,846,712	82,973	(72,306)	(97,342)	3,760,037	(86,675)
WISCONSIN	11,980,357	240,232	(224,859)	(528,175)	11,467,555	(512,802)
WYOMING	821,858	18,268	(15,458)	(32,805)	791,862	(29,996)
TOTAL	605,978,347	12,169,281	(11,373,916)	(22,177,039)	584,596,673	(21,381,674)

a/ Savings computed on the basis of total health spending under Universal Access
SOURCE: Lewin/ICF estimates

TECHNICAL APPENDIX

Methodology Used to Project State Health Expenditures in 2000

In this analysis we developed estimates of total health expenditures in each state by source of payment in 1980 and 1987. We also developed projections of future health expenditures by state in selected years under current policy and alternative health care financing scenarios. This appendix describes the methods used to develop these estimates.

A. HEALTH EXPENDITURES BY STATE

We developed estimates of health expenditures by source of payment for the 50 states and the District of Columbia in 1980 and 1987 using available data. For both years we presented estimates of the following categories of personal health care expenditures:

- Direct payments by households.
- Employer health insurance payments.
- Payments by other private sources.
- Medicare payments.
- State Medicaid expenditures.
- Federal Medicaid expenditures.
- Payments by other public sources.

State-level data on Medicare and Medicaid spending were obtained from the Health Care Financing Administration (HCFA). However, information on other health care expenditures by state and local governments is largely unavailable from existing data sources. Data on health spending by households and employers are also unavailable at the state level.

Due to the lack of state-level health expenditures data, we estimated state spending using techniques that reflect the unique socio-economic composition of the population in each state. We developed these estimates for 1980 and 1987 using the following three steps:

- **Develop First Stage estimates.** We estimated total expenditures by source of payment based upon the socio-economic composition of the population in each state. The Lewin/ICF Health Benefits Simulation Model (HBSM) was used to estimate per-capita health spending for each source of payment by age, income, geographic region, and health insurance status. Using these per capita health spending estimates, we estimated total health spending in each state based upon state-level data on the distribution of persons by age, income, and insured status as reported in the Current Population Survey (CPS) for 1980 and 1987.

- **Adjust First Stage Estimates to Replicate Known Totals By State.** We then adjusted the first stage estimates to reflect the following known control totals for 1980 and 1987:

  -- Medicare spending by state.
  -- Federal Medicaid spending by state.
  -- State Medicaid spending.

  In addition, we adjusted total health spending to reflect HCFA estimates of relative differences in per-capita health spending by state in 1982.

- **Adjust Second Stage Estimates to Replicate HCFA Estimates of National Health Spending by Source of Payment.** The state-level health spending estimates developed in the second stage were adjusted to replicate HCFA estimates of national health spending by source of payment.

B. PROJECTIONS OF HEALTH SPENDING IN FUTURE YEARS UNDER ALTERNATIVE SCENARIOS

In the second task we developed projections of total health spending in each state under alternative health care financing strategies. Projections of total health spending in each state were developed for each year between 1988 and 2000 assuming current policy continues throughout this period. These projections are based upon census projections of population growth by state and HCFA projections of national health expenditures through 2000.

We then developed estimates of total health spending by state under three policy scenarios. These policy scenarios are described below.

Scenario #1

In the first scenario we developed estimates of national health spending under a universal health plan that emphasized a pluralistic health insurance system. We assumed

that, under this scenario, all individuals would be covered under a benefits package similar to that recommended by the Pepper Commission with the exception that prescription drugs would be covered.

Under this scenario, we estimate that there will be an initial increase in health spending in 1990 as previously uninsured persons become covered under a health plan. The increase in health spending was allocated across states in proportion to the number of uninsured in each state. (Estimates of uninsured persons by state are also provided as part of this study.) For purposes of estimating the administrative costs of insurance under this scenario, we assumed that 1) all workers and dependents would become covered under private employer health insurance where administrative costs average about 15 percent of benefit payments, and 2) all non-workers would become covered under a public plan where administrative costs average about three percent of benefit payments.

Scenario #2

In the second scenario we assumed that all persons in the United States would become covered under a unitary payer system. We assumed that the unitary plan would have patient cost sharing similar to that under the Pepper Commission proposal ($250 deductible for a single person, $500 per family, 20% copayments for hospital, physician and lab services, with an out-of-pocket limit of $3,000 per individual or family). Under this scenario, we estimated the savings due to reduced insurance administrative overhead charges under a unitary payer system.

We assumed that the shift to the unitary payer would result in substantial savings in administrative costs due to the elimination of insurer profits and marketing costs and the simplification of claims processing and other general administrative functions. We estimated these administrative savings by assuming that persons who were privately insured in Scenario #1 would be shifted to a unitary payer where administrative overhead

charges are assumed to be the same as in the current Medicare program. For privately insured persons we assumed that this would reduce administrative charges from 15 percent of benefit payments to less than 3 percent.

Scenario #3

We also estimated total health spending in 1990 and 2000 assuming cost controls were implemented. HCFA estimates that per capita health spending will increase by about 8.6 percent per year through 2000. To illustrate the potential impact of cost controls, we estimated health expenditures in 2000 assuming the growth in spending is reduced to 6.6 percent annually.

The purpose of these estimates is to show the potential savings that could be achieved by slowing the projected rate of growth in health spending. These estimates are intended to be illustrative and should not be interpreted as estimates of the savings arising under any particular cost containment program.

EMERGENCY!

Rising Health Costs in America
1980 - 1990 - 2000

A Families USA Foundation Report

in Cooperation with

Citizen Action

Families USA Foundation
1334 G Street, NW
Washington, DC 20005
(202) 628-3030

October 1990

Health care costs in the United States have risen dramatically, far outpacing economic growth, general inflation, and families' incomes. These spiraling health costs are creating an emergency -- a crisis of affordability for consumers, government, labor, and business. Families are paying more in premiums, deductibles and co-payments while often seeing their benefits shrink. Employers faced with double digit premium increases now find that health care costs consume nearly 94% of net profits.[1] Rising costs have also resulted in a growing number of Americans without adequate health coverage, or none at all.

This report examines the magnitude of the health care cost crisis by providing data on health spending and the uninsured during the 1980s and projections of what the United States will be spending by the end of the 1990s should the status quo continue in our health care system. Information on health care costs and numbers of uninsured are provided on a state-by-state and national basis. This is the first time state-based data on health care expenditures has been available since 1982, when the Health Care Financing Administration stopped providing it.

The magnitude of health care cost increases over the 1980s indicates why there is serious interest in health care reform. This interest has been increasing among both state and federal legislators.

THE 1980s: RISING COSTS

During the last decade, health care costs have risen at rates far exceeding the consumer price index. Between 1980 and 1989 the average annual increase in the consumer price index was 4.7%. Health care spending increases averaged 10.4% during this same period. An increasing portion of every family budget has been going to pay for health care since skyrocketing health costs have dwarfed wage increases. Annual earnings increased 4% per year, on average, since 1980.

National health care spending more than doubled between 1980 and 1990, jumping from $230 billion to $606 billion. American consumers pay directly for over 25% of this huge health care bill through out-of-pocket payments. Although many public and private health plans have responded to these cost increases with a variety of cost control initiatives, these efforts have been piecemeal and have not succeeded in holding down system-wide costs.

- Per capita spending increased 139% from 1980 to 1990, rising from $1,016 to $2,425 per person in 1990.

- From 1980 to 1990 overall health care spending in the United States more than doubled, increasing by 163%, from $230 billion to $606 billion.

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. Also 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.

StateSide ... Discussions with Health Policymakers is a periodic feature of State Health Notes, Published by the Intergovernmental Health Policy Project. The views expressed in StateSide belong to those who are interviewed.

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

New Text Underlined [DELETED TEXT BRACKETED]

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. 2. 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, **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).

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**

[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. 3001-2(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

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 de red 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 same health-care mess, but two opposing solutions

Controlling costs is the key



Sen. Jim Duncan

By SEN. JIM DUNCAN

Alaska's health-care system is seriously ill.

The cure is comprehensive reform with three necessary components: Increased access to services, cost containment and quality care. Health-care spending in Alaska has increased over 300 percent since 1979. About 90,000 Alaskans, or 16 percent of our population, have no health-care coverage. Without reform, costs will soar from the $1.5 billion we spend now to $10 billion by the year 2000 and our uninsured will grow to 25 percent of the population.

Recommendations by the Health Care and Access Task Force, that I co-chair, provide an opportunity to enact meaningful health-care reform.

The plan's initial goals are to help people who can afford to help themselves but who aren't presently being served by the insurance industry, make health-care available to low-income pregnant women and children, and slow down increasing costs.

The ultimate goal is universal health care all Alaskans can afford.

Please see Page F-6, **DUNCAN**

Alaska's health-care system is breaking down as costs soar and insurance premiums move ever higher. More and more employers are cutting back on health-care benefits or dropping coverage altogether. As many as 90,000 Alaskans have no insurance, and a heart attack, stroke or other serious illness can wipe out a lifetime of savings.



A new Alaska consensus has emerged for changing the system. But the reform movement has split on how to fix the system.

In one corner, we have a coalition of doctors, hospitals and nursing homes with their proposed Comprehensive Health Insurance and Payment Reform Act. It stresses now programs to make insurance more affordable.

In the other corner is Sen. Jim Duncan, a Juneau Democrat whose pending bill emphasizes limiting health costs through government regulation.

Everyone gives up something

By DR. OLIVER M. KORSHIN



Dr. Oliver M. Korshin

Alaska's physicians and hospitals recently released a plan for comprehensive health reform. Its premise is that the players in the health-care arena — providers, hospitals, patients, insurance companies, employers, malpractice attorneys — share responsibility for the health-care crisis and must each give up something to achieve a solution.

The plan proposes:

- Health insurance for everyone who wants it.
- Expanding health-insurance benefits so that patients don't have to pay for routine physicals, prenatal care and other services that keep people healthy.
- Returning health insurance to its original purpose of spreading risks throughout a community instead of excluding people needing it most —the sick.
- Pegging increases in the cost of medical services, as well as health-insurance premiums, to the average rise in the inflation rate.
- Requiring physicians and hospitals to discount services

Please see Page F-6, **KORSHIN**

DUNCAN: Cost containment is key

Continued from Page F-1

The task force made a number of recommendations to provide the protection of health insurance to more Alaskans. These access recommendations include:

- A National Association of Insurance Commissioners' reform plan. The result should be improvement in the availability of insurance coverage for small employers.
- Establishment of a state high-risk pool. This involves making insurance available at a higher rate than normal to people who previously were rejected from obtaining insurance coverage for medical reasons.
- A program to ensure low-income pregnant women and children have availability to health care.
- Establishing a state authority, with members appointed by the governor, that can pool together individuals or groups into purchasing groups to procure or provide insurance at lower prices.

In the area of cost containment, the task force embraced a bold and innovative method. It recommended a global spending limit — which would set the allowable total health-care spending in Alaska — to slow down the annual increase in expenditures.

The $1.5 billion expended in Alaska on health care last year is identified as the base year for this spending limit. The limit is subject to adjustment to reflect the annual rate of inflation and other factors.

Provider groups — including dentists, doctors, hospitals and laboratories — each would have a recognized target budget. Representatives from each group negotiate with the authority to establish reimbursement schedules and acceptable standards of service to provide quality care but guard against unnecessary care. This method will work to contain costs. If we can slow down the inflationary spiral 1 to 2 percent a year, we will be successful in reducing health-care costs while greatly increasing access.

"This method will work to contain costs. If we can slow down the inflationary spiral 1 to 2 percent a year, we will be successful in reducing health-care costs while greatly increasing access."

Providers representatives on the task force voted for this approach. It is disappointing now to examine a new proposal from the provider community that only addresses access. They want to use your permanent fund dividend and large state appropriations, and mandate employers to pay for health insurance.

Their proposal won't work because it ignores cost containment. In 1974, Hawaii enacted a program for universal access to insurance without cost controls. Major problems with their system still exist; most notably uncontrolled costs.

☐ Sen. Jim Duncan, D-Juneau, is co-chairman of a state task force exploring ways to change Alaska's health-care system.

KORSHIN: Let players share responsibility

Continued from Page F-1

for those insured through the new program.

• Reforming malpractice laws to reduce costly medical services that doctors and hospitals use to help bolster their defense if sued. This cost is estimated at $225 million in Alaska in 1990.

Yes, our plan requires every Alaskan who receives a permanent fund dividend to have health insurance or coverage through a program like Medicare, Medicaid or the Native Health Service. Those who don't now have coverage would use their dividend to buy basic health insurance provided by the program. Those less well off would pay less for their policies.

Yes, our plan requires employers pay 50 percent of a basic insurance plan for employees. But this makes insurance an affordable benefit.

These features are controversial, but you can't provide services to 90,000 uninsured Alaskans without spending more money. With no income tax and an annual dividend, Alaska is uniquely positioned to solve its health-care crisis.

This crisis is more complex than most social and economic problems. Its solution must be comprehensive. A quick fix that addresses only part of the equation will make it worse.

Sen. Jim Duncan's bill, SB83, to solve the crisis is one-dimensional, mandating government price controls for physicians and hospitals under a "global budget" approach that's never been tried. That's the whole plan. The rest of the bill's plan is merely vague options. In contrast, all of our plan's components are mandated. Our plan is *not* slick election-year salesmanship.

Proposing price controls on doctors and hospitals caters to widespread resentment about the high costs of health care. But, as a sole reform measure, it will drive physicians from Alaska, particularly from rural areas. Hospitals on the brink will close.

The senator says his bill adopts the recommendations of a state-funded task force. Incorrect.

None of the task force recommendations about insurance reform, improved access to health care, and malpractice reforms are mandated in the bill.

The senator claims other bills before the legislature complement his bill and comprise a comprehensive reform package. Also incorrect. Taken together they still don't approach comprehensive reform because they don't adequately address health insurance reform, access for the uninsured or malpractice reform. Besides, none of these bills are linked. Any one could pass in a piecemeal fashion.

SB83 was totally revised shortly after publication of the Duncan task force's report, whereas our plan has evolved through a series of a dozen drafts over the last year. If a radically altered, "all new" SB83 can be introduced this late in the legislative session, our plan can, too. We challenge the legislature to introduce the plan so it can be openly debated.

□ Dr. Oliver M. Korshin is an Anchorage ophthalmologist. He worked in the federal government administering various health programs before entering private practice in 1985.

OPINION

TWO VIEWS

Alaska's health care system needs fixing, but question is how

Global spending limit needed

By JIM DUNCAN


Duncan

The health care system in Alaska is seriously ill. The cure is comprehensive reform that includes three necessary components: increased access, cost containment and quality care.

Health care expenditures in Alaska have increased over 300 percent since 1979. Approximately 90,000 Alaskans have no health care coverage. Small and large businesses have seen insurance premiums increasing by 20 percent to 30 percent a year.

Alaskans have filed for bankruptcy because they became ill and could not pay their medical costs. No one should become too comfortable because those of us who enjoy the protection of health insurance today may be without it tomorrow.

It was clear to the Alaska Health Resources and Access Task Force, which I co-chaired, that we invite a complete collapse of our health care delivery system without comprehensive reform. Task force recommendations call for an innovative and comprehensive approach that I am confident will work.

To increase access, the Task Force recommended the following action:

- Passage of legislation recommended by the National Association of Insurance Commissioners to bring about insurance regulation reform. The result should be improvement in the availability of private coverage for small employers.
- Establishment of a state high-risk pool.
- Immediately provide incentives to ensure low-income pregnant women and children have access to preventive care.
- Establishment of an authority with an ability to pool together individuals or groups into pools to procure or provide insurance.

In the area of cost containment, the task force embraced a bold and innovative method. It recommended a global spending limit to slow down the annual inflationary increase in total health care expenditures in Alaska.

The $1.5 billion expended in Alaska on health care in 1991 is identified as the base for the spending limit.

The limit will be adjusted to reflect annual Consumer Price Index increases and other factors that may increase or decrease health care costs such as changes in population and medical technology.

Subgroups of providers, including hospitals, physicians, dentists and others are recognized with their own budget targets. Each group will appoint representatives to negotiate with the authority to establish reimbursement systems and utilization standards to maintain total expenditures under the global limit and to ensure quality care. This method will work to contain costs.

If we can slow down the inflationary spiral 1 percent to 2 percent a year, we will have taken giant steps in reducing health care costs while greatly increasing access.

There is not any one culprit we can blame for our sick health care system. Medical providers, the insurance industry and consumers all share in the responsibility and all must share in the solution. This is why the task force was composed of a cross section of Alaskans. Membership included lawmakers, administration officials, consumers, a representative of the insurance industry and two medical providers.

I find it surprising that medical providers are now flatly rejecting the task force recommendations on cost containment after voting for the recommendations as members of the task force. Instead, the providers have submitted a proposal that will do little to slow down the approximate 20-percent annual increase in health care costs.

The providers' proposal wants to use your Permanent Fund dividend. It also requires large state appropriations and mandates employers to offer and pay at least 50 percent of insurance premiums. Under the providers' proposal, everyone participates in the solution except providers.

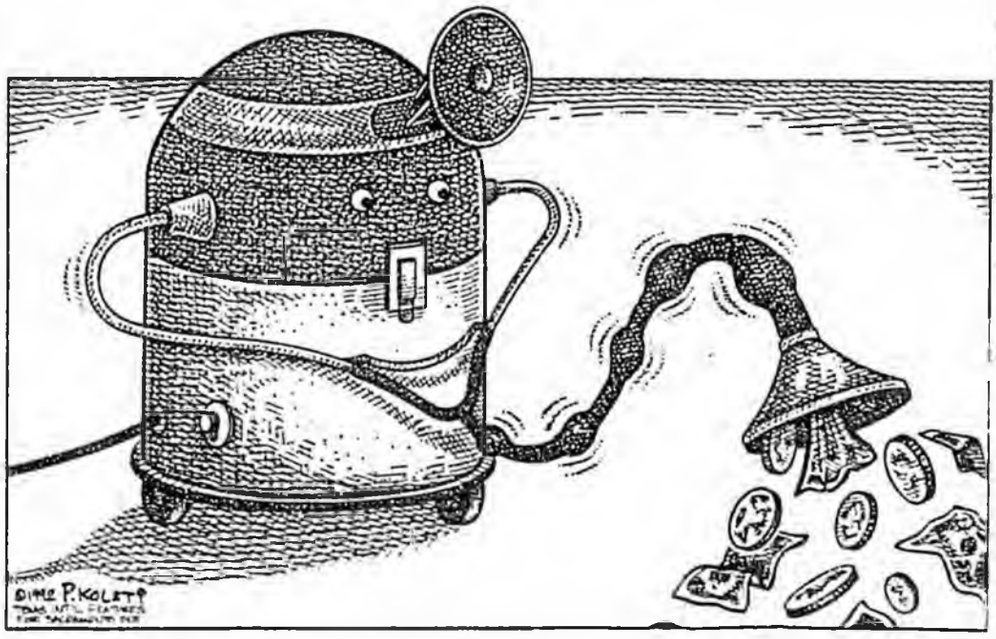
Simply providing access as the providers recommend and ignoring the need to contain costs does not work. Hawaii in 1974 enacted a program for universal access without cost controls. Hawaii officials indicate that major problems with their system still exists; most notably uncontrolled costs growing between 10 percent and 20 percent a year.

Combining access with cost controls, as recommended by the task force, provides an opportunity to bring about meaningful health care reform. The initial goal is to provide access to Alaskans who can help themselves, access to low income pregnant women and children, and to slow down increasing costs.

The ultimate goal is universal access and health care all Alaskans can afford.

We should enact the prescribed medicine and put our health care system on the road to recover. The Task Force has provided a workable solution, so let's proceed with the business of health care reform. Alaskans can't afford to wait any longer. We need to implement comprehensive care reform now.

Jim Duncan represents Juneau in the state Senate.



Universal access for Alaskans

By OLIVER M. KORSHIN


Korshin

The health care crisis in Alaska, as elsewhere in the United States, is multifaceted, more complex than most social and economic problems. Its solution must be comprehensive, including, at a minimum, improved access and cost reduction.

It cannot be cured with a quick fix that addresses only part of the equation. Such a "solution" will likely worsen the crisis.

Alaska's physicians and hospitals have spent over a year developing a plan for comprehensive health care reform, called CHIPRA (Comprehensive Health Insurance and Payment Reform Act of 1992).

One premise of CHIPRA is that the players in the health care arena — providers, hospitals, patients, insurance companies, employers, malpractice attorneys — need to acknowledge their share of responsibility for the health care crisis and give up something to achieve a workable solution.

Many physicians would accept reduction in their practice incomes in exchange for less government intrusion between them and their patients, timely payment, less paperwork and reduced fears of being sued.

CHIPRA proposes the following:

- Universal access to basic health insurance for all Alaskans.
- Preventive care free of deductibles and co-payments.
- Return health insurance to its original purpose of spreading risks throughout a community instead of excluding people from coverage precisely because they need it!
- Peg fee increases for doctors and hospitals, as well as increases in health insurance premiums, to the Consumer Price Index.
- Physicians and hospitals must discount their services for CHIPRA enrollees.
- Reform malpractice statutes to reduce or eliminate costly defensive medicine.
- Administrative simplification by requiring a central claims clearing house and a single claims form.

Yes, CHIPRA does require Alaskans to have health insurance or coverage through a program such as the Veterans Administration, Medicare or the Native Health Service in order to receive a Permanent Fund dividend. But CHIPRA mandates sliding-scale premiums, so that everyone pays a fair share of the cost of coverage.

Yes, CHIPRA does require employers pay 50 percent of the cost of basic insurance for employees. That's the contribution employers must make to solve the crisis. It permits insurance to become an affordable benefit.

We're not attempting to conceal these controversial features of CHIPRA. After all, if we really care about Alaska's uninsured, we have to face the fact that bringing them into the system is going to cost money.

And, with no state income tax and an annual dividend besides, Alaska is in a unique position to fix its own health care crisis.

Sen. Duncan's plan, SB83, offers a one-dimensional solution for this complex problem. SB83 mandates that state government manage the costs of all doctors and hospitals — private, state, federal — under a "global health budget."

Global budgeting for all health services is an untested approach that's never been tried in any state.

But the only tool SB83 gives the state under this global budget scheme is price controls on private sector doctors and hospitals. No insurance reform. No malpractice reform. No improved access for the uninsured.

Placing price controls on private doctors and community hospitals caters to widespread popular resentment and frustration about the high cost of health care, but, if enacted, SB83 will drive physicians from Alaska and make recruitment difficult. Community hospitals will be driven closer to the brink or have to close their doors.

Sen. Duncan says that SB83 incorporates the recommendations of his task force, but that's not accurate.

The senator's task force made some important recommendations — about true insurance reform, access for the uninsured, malpractice reform and administrative simplification, but only price controls got into the mandated language of SB83. The rest of the task force's recommendations are missing or optional.

Sen. Duncan claims other bills before the Legislature complement SB83, and together make a comprehensive reform "package." Also inaccurate.

We support the concepts in several of them, but all these bills taken together still don't constitute comprehensive reform. In particular, there is no bill that gives coverage to the uninsured or that broadly reforms either health or malpractice insurance.

Besides, all these bills are independent, none are linked legislatively. Passage of one is not contingent on passage of all. This is not a health system reform package.

SB83 underwent a hasty, total revision within two days after publication of the Duncan Task Force's report, whereas CHIPRA has painstakingly evolved through a series of about a dozen drafts over more than a year.

If the "all new" SB83 can be re-introduced in its radically altered form this late in the session, there's no compelling reason CHIPRA cannot be introduced, too.

We challenge Sen. Duncan to allow introduction of CHIPRA so it can be debated before all Alaskans.

Oliver M. Korshin, M.D., is in private practice in ophthalmology in Anchorage.

HEALTH CARE: ROUND 2

A continuing dilemma

ON THE OPPOSITE page are two views on proposed changes needed in Alaska's health care system. Both cases are well stated — though poles apart.

Sen. Jim Duncan, D-Juneau, is one of the few members of the Legislature with the grit to tackle this tangled issue head-on. He writes about his bill, originally introduced last year, and now revised, which is currently being discussed in the Legislature.

Dr. Oliver Korshin, an Anchorage ophthalmologist, writes about a health care reform proposal called the Comprehensive Health Insurance and Payment Reform Act of 1992 (CHIPRA). This monumental piece of draft legislation resulted from a team of Alaska physicians and providers meeting for over a year.

Both sides agree there is a problem, but neither so far has presented a plan that is workable.

HERE ARE some of the many reasons why we feel this way. Sen. Duncan's bill creates a board that would regulate fees charged by physicians and hospitals. To practitioners, that sounds a lot like government price controls, which they understandably fear. In fact it *is* price controls. It also sets up a bureaucracy, and who needs another one of those during these days of budget deficits?

The CHIPRA plan, however, also errs on the side of mandates. Among other things, it orders all employers to provide health insurance coverage (a "basic benefits policy"), and says employers must pay at least 50 percent of the premium. This version of "pay or play" has been widely criticized nationwide (as other states grapple with soaring health care costs) as unworkable and yet another burden on already over-burdened businesses.

The CHIPRA plan also mandates that everyone in the state who gets a Permanent Fund dividend carry health insurance. Premiums would be paid for from individual's dividends if they had no other insurance. In a land of fiercely independent souls, who want to make their own decisions on how to spend their dividend, this suggestion will be as popular as, well, as doing away with the dividend altogether.

ONE OF the most appealing aspects of Sen. Duncan's approach is its bold (perhaps too bold) attempt to contain costs. The CHIPRA proposal addresses the troubling area of malpractice in an attempt to curtail "defensive" medicine, with the implication being that doing so would also contain costs now passed on to the patient. Both have positive and negative aspects that need more evaluation.

The important thing is both agree that change is needed. And both agree that the best system would enable Alaskans to have access to basic health care in a way that doesn't break the bank.

A start has been made, thanks to Sen. Duncan and the folks who worked so hard on CHIPRA. The task now is to take the best of both and combine into a workable plan that's fair to all.

5/10/91 ALL ALASKA WEEKLY

Fairbanks dental costs among highest in nation

BY SCOTT J. MCCREA
ALL- ALASKA WEEKLY

According to statistics recently released by the American Chamber of Commerce Researcher's Association, the price of dental care in Fairbanks is 63 percent higher than the national average.

The latest ACCRA index, which surveys the cost of living in 293 participating cities nationwide, lists the average price of an oral examination and teeth cleaning in Fairbanks at $104.28. The price makes Fairbanks as being the second highest in the nation, with Juneau and Kodiak taking top honors at the price of $113. According to the survey, the average cost of the same dental work nationwide is $41.15.

"It's (the index) a price survey," said Leslye Korvola, manager of the borough's Community Research Center. "It does not reflect consumption or expenditures."

Still, said Korvola, the controversy over the cost of dental care in Fairbanks has been a "very sensitive" issue.

"A lot of dentists feel they are providing a service that is more than just dollars and cents," said Korvola.

Korvola said that even though the cost of dental care is higher than the national average, what people end up paying is actually much less.

"The expenditures are much lower because we don't pay out of our own pocket," said Korvola. "Many people are covered by health care insurance or receive government benefits."

The survey has created an uproar in the past among dentists who felt that the

See page 20: DENTAL CARE

DENTAL CARE

From page 1

research was not accurately done. Fairbank's dentists argued that the random sampling of only five dentists was not adequate enough information with which to determine an average cost on. Korvola said that while the research center surveys on the average of five dentists each time the index is compiled, it is a different five dentists each time. This year, she said, the center surveyed nine dentists.

Another past controversy surrounding the survey was that Fairbanks' dentists were not pricing the same services as dentists in the Lower 48 were. The survey used to ask for a cost on a visual examination and simple cleaning. However, the critics argued, what exactly entails a visual examination might differ from dentist to dentist.

Korvola said that as a result, the survey now specifically asks for a price quote on cited code numbers for procedures used by the American Dental Association. The new survey began in 1987, and since then the cost of dental work has fluctuated from $113.60 in 1986 to $93 in 1988 to the latest figures of $104.28. But despite the reduction in cost from the first survey in 1986, the current statistics still show Fairbanks as being more than twice as high as the average cost.

Dr. Eric Buetow, a North Pole dentist who is the president of the Alaskan Northern Central District Dental Society, said that that one of the main reasons the price of dental care isso high is that "it's an incredibly expensive business to run."

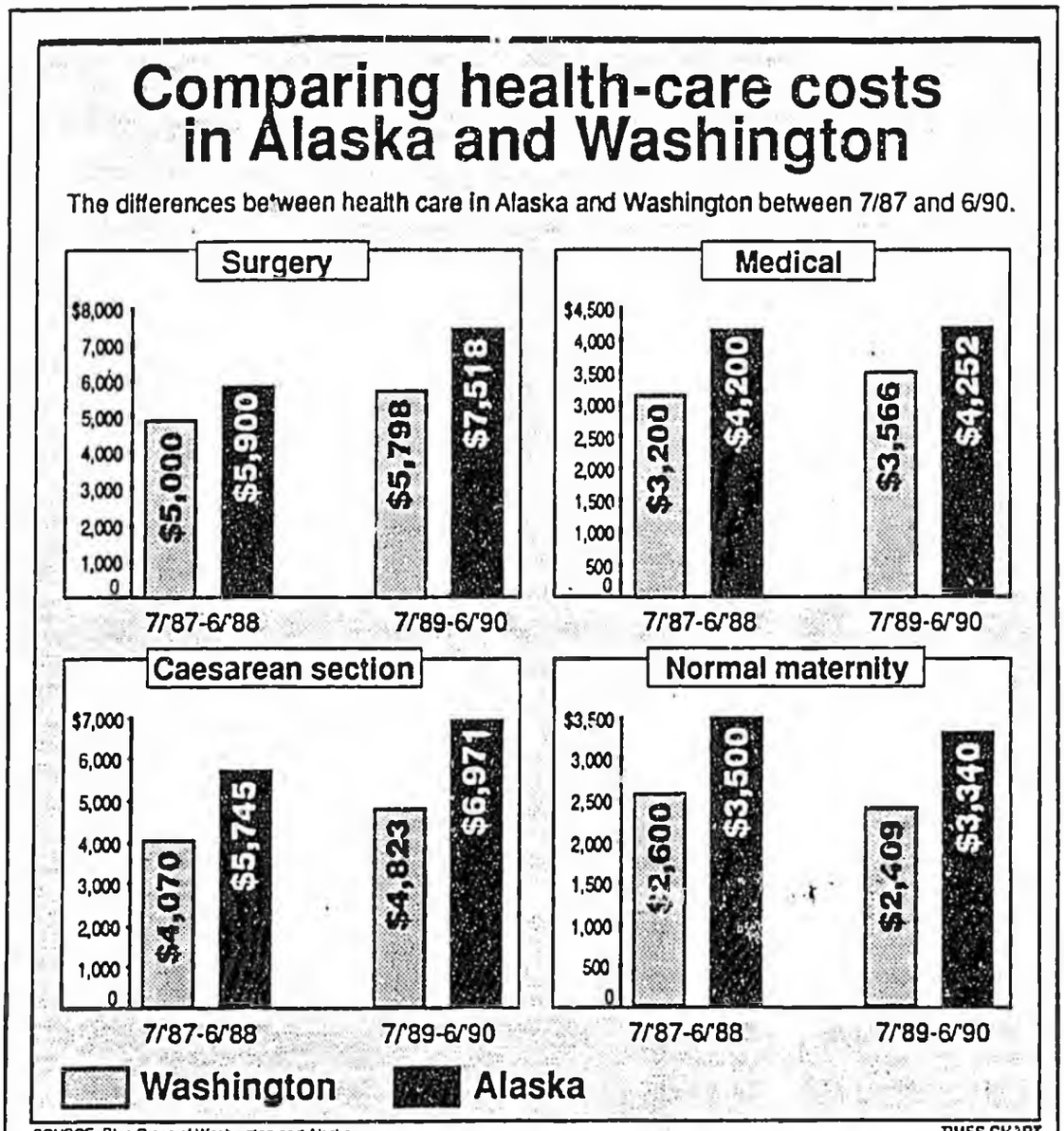
"I have to make a lot of money before I can put a dollar in my pocket," said Buetow, who runs his own business. The cost of supplies for Fairbanks' dentists is high because they often have to order them out of the Lower 48.

"I would guess you would see more of a fluctuation in prices between here and the Lower 48," said Buetow. "I'm sure they will be high, but I'm darn sure in some places on the East Coast you'll find similar fees for the same service."

"It's a tough competition out there," said Buetow. He added that in many metropolitan areas in the Lower 48 there are a larger number of dentists per capita.

"It's tougher to get people in the door out there (Lower 48)," he said. Many dentists often turn to advertising and often turn to free examinations to lure prospective customers, Buetow said.

"Fairbanks has been free and clear of that problem," he added. "No dentists have been forced to leave due to a lack of business."



SOURCE: Blue Cross of Washington and Alaska

TIMES CHART

3-1-91

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

See Health, page C5

Health

Continued from page C1

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.

Anchorage Daily News
3-18-91

Health-care woes

Sen. Duncan offers a timely cure

Anyone who thinks Alaska's health-care system is healthy hasn't been paying attention. For those fortunate enough to have health care, costs are spiraling out of control. And those escalating costs are putting health care beyond the reach of more and more Alaskans.

Perhaps as many as 90,000 state residents have no health insurance or government medical aid, according to a recent legislative study. Because the uninsured must pay out of their own pockets, they skimp on routine care that helps prevent costly illnesses. When they do fall sick, treatment for major conditions can easily push them into poverty or bankruptcy.

For more than a decade, the Alaska Legislature has been happy to confine its concern about health care to mere talk. Despite a decade of oil-boom affluence, the state did almost nothing to control costs to patients or help those without insurance.

At long last, though, there's fresh hope the legislature may do something meaningful. Proposals pushed by Juneau Sen. Jim Duncan may not be perfect, but they give the legislature a good place to start.

Sen. Duncan's package involves two major initiatives. First, it aims to slow the endless cost escalation for health insurance and medical care. Second, it offers tens of tnousands of uninsured Alaskans hope of obtaining health insurance.

On the cost control front, Sen. Duncan's idea has been attacked as a recipe for counterproductive government meddling. In reality, though, it's an exercise in common-sense economics.

State government is one of the largest buyers of medical care in Alaska. When you buy in bulk, you have the power to negotiate a better price. Sen. Duncan would take advantage of that buying power to try to hold down both the cost of care and the cost of health insurance. The idea is similar to the cost-control initiative recently begun by one of the state's largest insurers, Blue Cross.

Sen. Duncan would go a step further and have the state more closely watch investments in costly medical facilities. Overbuilding hospital capacity can drive up overhead costs for all patients. So can instances where numerous facilities each obtain their own expensive but rarely used equipment, instead of agreeing to share.

To expand health-insurance coverage, Sen. Duncan would also capitalize on the state's buying power. Employers would be invited to join with the state in a single health-insurance pool. The larger pool would offer a way to help cut both the cost of insurance and the cost of medical care.

In the longer term, Sen. Duncan would have the state look at creating a pool for those who don't have or aren't wealthy enough to buy their own insurance.

Sen. Duncan's cost-control proposals have given the state's medical establishment apoplexy. Their resistance makes it unlikely that anything resembling his package will pass this year. Instead, the legislature will probably resort to that tried and true time-buying technique, the task force.

Taken seriously, the task force can be a useful way to build consensus. But if the legislature substitutes a task force for legislation, the burden will be on those who reject Sen. Duncan's approach to offer an alternative that better serves the same worthy goals.

Editorial

HEALTH INSURANCE: TIME FOR ACTION

It's time to stop talking and do something about the crisis in health insurance and costs of medical care. Alaska health delivery costs have soared 20 percent annually over the last five years, the second highest rate of any state. The costs of health insurance has become so burdensome that many businesses are having to skinny down on employee coverage.

Many Alaskans are simply slipping out of the safety net, and today are uninsured. This compounds the problem, because their emergencies, if uncollectable by hospitals and doctors, wind up being paid by all of us in higher rates, which further aggravates insurance premiums.

State Sen. Jim Duncan has an ambitious approach, a state medical authority that will negotiate pre-approved rates with health providers and, pooling all public employees with private employers who wish to join, negotiate bulk insurance packages. Alternatively, there is Sen. Jay Kerttula's more modest proposal to offer a kind of safety-net coverage for Alaskans too high-risk to get insurance.

The medical establishment is lobbying hard against Duncan's bill in Juneau. We don't know whether his approach is best, but it's urgent that we do something, not just appoint another task force to study the problem.

HEALTH-CARE COSTS TOO HIGH, ALL AGREE

By Margaret Bauman
Alaska Journal of Commerce

Everyone agrees that Alaska's major health problem is cost, but the cure — that's another matter.

The only thing various factions agree on is something has to be done about the cost, which has left thousands of residents unable to afford health insurance.

"The unchecked increases in health care costs is of grave concern to all Alaskans," said Mano Frey, president of the Alaska State AFL-CIO, in a letter to Sen. Jim Duncan, D-Juneau. "It has priced insurance right out of the market for many small businesses, resulting in a drastic increase in the percentage of uninsured/underinsured citizens."

Duncan is the author of a proposal for a state health authority that would set rates for medical services and seek group coverage for some 135,000 state and local public employees.

Legislators hope to slow rising medical costs which they say now run at 20 percent annually, while making health insurance more affordable for public institutions and eventually businesses and Alaskans now without adequate medical coverage.

According to Frey, Duncan's Senate Bill 83 "is the most comprehensive, reasonable, and effective legislation we have ever seen introduced in this area. It would provide a long term policy rather than a short term fix."

Frey said the national AFL-CIO is interested in the legislation as well. "They really are positive about this legislation. It could very well develop, if it works, into something other states and the United States in general could adopt," he said.

Frey said he would think individual physicians would be supportive of the plan too, because potentially it could expand the numbers of people that should get some primary car instead of just catastrophic. "People wait until they are seriously ill before they seek help and that's not right," he said.

Ray Schalow, executive director of the Alaska State Medical Association, also voices concern over the current cost of health care. "Our biggest complaint is nobody seems to care about the uninsured," he said.

"You have to deal with all these issues at the same time. We need to sit down at the table and address the total issue.

"I don't question where Duncan's heart is. We've looked at his task force report," Schalow said. But Schalow said physicians and hospitals are already working together, through a cost containment council, to address the issue of costs.

Schalow said he also is concerned that Duncan's proposal would add another layer to the administrative costs that already eat up 20 percent of the cost of health care today.

But the state medical society does want good health care for all residents, he said. "There are enough dollars that flow into Alaska to take care of every man, woman and child in the state."

Schalow also points to a report from

Continued on Page 20

Stratton

Continued from Page 6

allow for denying projects in areas where other resources are far more valuable than gold.

And third, where mines are permitted to go ahead, there must be stronger environmental protections. Reclamation must be a condition of the initial permit and bonds must be secured to ensure that reclamation is a reality. Recent water quality laws have cleaned up a lot of dirty water discharge, but these laws need much stronger enforcement. Without the threat of traffic cops, we'd all become speeders. Without strong enforcement of environmental laws, miners do little or nothing to protect the environment.

The conference taught me a lot about the mining industry. I hope the mining industry participants learned a thing or two about us. As more citizens learn the ecological impacts of mining and understand the archaic controls which guide mine development, the more pressure there will be to change the status quo. Miners cannot continue to live in the 19th century as we prepare for the 21st. They can kick and scream and quote their interpretation of the Constitution all the way to defeat, which will happen, or they can accept that the world has changed since 1872. They may even learn to like cornbread and beans.

Jim Stratton is a leader in the Alaska environmental movement.

If you're optimistic about the economy, buy a Kenworth. If you're pessimistic, buy two.

Industry

Continued from Page 19

Eastern United States hardwood in lumber, log and recently chip form, has stepped into this change to become a major supplier to Pacific rim users during the 1980s.

These developments present new opportunities for the interior forest of Alaska which has a large percentage of hardwood in the timber mix. In the past, that hardwood had been a significant liability, hindering development of the forest products industry in the mixed stands of the Alaska boreal forest (of Southcentral and Interior Alaska,) and significantly in the Mat-Su area. That birch, and to a lesser degree cottonwood, that was a drag on the potential for harvesting the white spruce in the Susitna forest ten years ago now has a market opportunity in the Pacific rim and the west coast of the U.S.

The major national markets for Mat-Su forest products are Japan and other growth countries on the Pacific rim. The west coast furniture and flooring markets of the U.S. could also use interior Alaska hardwood lumber products. The most significant competitors for this potential industry are British Columbia, Washington, Oregon, and Siberian Russia. Mat-Su cannot compete in volume for them, but they do have products in meeting market niche requirements if Alaska processors play smart in the new market-driven forest products industry. Twenty seven people in three groups of high level buyers of Alaska forest products viewed the Interior forests in 1985 and 1986 and indicated that commercial value appeared to be present.

Due to market developments the past few years, Alaska birch should be able to realize a long-term future market niche if it is developed in reasonable volume and as a dependable supply for the users.

In the next decade, many of the Pacific rim countries besides Japan will become not only major importers of Alaska forest products, but also substantial users of value-added forest products that Alaska is, or is capable of, producing.

Opportunities for development of a resource does not mean income to resource owners. It is the offering and the prudent development of the resource in a timely manner than turns opportunity into jobs and income.

Frank Seymour is timber marketing specialist for the Division of Business Development, Alaska Department of Commerce and Economic Development.

Health

Continued from Page 10

the Alaska State Hospital & Nursing Home Association which concludes the task force out of which Duncan's legislation emerged had an extremely limited view of health care. The report was issued Feb. 25.

"There was no representation from the business community, health providers or consumers on the task force," the report said.

"All its members, but one union representative, were state employees or legislators."

The association also challenges cost figures cited by the task force. "There is no analysis of its statement that Alaska health care costs have been increasing at 20 percent for the last five years," the association said. "Even if correct, this figure is influenced by such factors as the increase in health care provided in the state, instead of outside the state, and an increase in the number of people eligible for Medicaid because of new federal guidelines.

"There is no analysis of the report's conclusion that there are 90,000 uninsured and underinsured, or that

Continued on Page 21

Loggers Buying GUIDE

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Health

Continued from Page 10

that number will increase to 25 percent of Alaska's population by the year 2000," the association said. "While we recognize there is an increase in the number of uninsured and underinsured, it is essential that that figure be as accurate as possible before it is used to drive changes to the health care delivery system."

The association favors Senate Concurrent Resolution no. 10 and House Concurrent Resolution No. 5, legislation also introduced by task force members.

"They acknowledge and address the problem of the uninsured and underinsured, an issue all health care providers in Alaska struggle with daily," the association said. "They recommend collecting the information needed to deal with this problem, including uniform medical data from health care providers and opens the door to addressing the individual responsibility of every citizen to help control health costs."

Individual citizen responsibility is a point also raised by the insurance industry.

"It is the responsibility of the consumer to get involved, to ask how much a procedure will cost and why," said Mick Brogan, a veteran insurance broker.

"Until the consumer gets involved, that equalization of costs is only half complete. A higher priority right now is the uninsured and uninsurables. We are giving them risks they have no business handling all by themselves."

Brogan feels the state would be better off taking care of the underinsured and uninsurables before coming up with a "grand master plan to rewrite basic insurance. They are talking about results. If you are going to control costs you have to go to the consumer and the provider," Brogan said. "Those are the only two that can really control the cost. The point is, with respect to co-insurance, that you can't engage the consumers in participation unless you have them paying part of the bill.

"Unless consumer are participating in the costs, you really don't have much hope that costs will be held down. There is no reason for utilization to be reduced," he said.

Not content to wait until legislators decide what they want to do, Blue Cross of Washington and Alaska has been promoting a participating provider agreement that puts a ceiling on physician fees.

So far, the program has signed up 95 physicians in Alaska, said Eric Rohlman, vice president of group marketing for Blue Cross.

Blue Cross of Washington and Alaska has over 35,000 subscribers in Alaska, through individual and group policies, with more than double that number of residents actually covered through the policies.

That group represents about 22 percent of all physicians with $1 million or more in malpractice insurance, Rohlman said.

A participating physician is one who agrees to accept the Blue Cross payment as the payment in full. "In return, Blue Cross directly pays the physician and improves the physician's cash flow," Rohlman said. "Under this plan, the subscriber does not have to pay anything up front."

"This should be a win-win situation," Rohlman said. "If someone doesn't want to go to a participating doctor, they don't have to, but there is a benefit of not having to pay up front and you will not be balance billed," he said.

"We have collected bills for over 40 years in Alaska, so we think we ought to know what average charges are," Rohlman said. Blue Cross is finding well over 75 percent of charges are at or below the ceiling set by Blue Cross, he added.

One physician who chose not to participate said he wrote to Blue Cross several months ago to ask if the ceiling on charges would be kept in pace with the physician's rising expenses.

He said he is still waiting for a reply.

Blue Cross is optimistic that more physicians will sign up as participants. "Recruiting will continue," he said. "We are in for the long term."

"Blue Cross benefits because they can tell perspective customers they can offer lower rates," Brogan said. "The physician benefits because theoretically he would be a preferred provider for Blue Cross participants. Participants would theoretically pay less in the short run, but that cost advantage can only be passed on to the consumer until the providers figure out basically in their billing practices how to bill around it."

While physicians are signing up for the participating physician plan, they aren't necessarily content with it.

"Our clinic has signed up for it," said Dr. Charles Aarons.

"Our clinic actually will get more for this plan than we have been charging previously. I"ll be making more money from Blue Cross for a while, so my opinions are not tainted by financial self-interest at the moment.

"But Blue Cross because of its position in the market can act as a monoposony. The typical behavior of Blue Cross is they get doctors signed up, then start tightening down.

"They won't actually cut, but in a short period of time they get the cost increases down where they want," Aarons said.

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MISSES MARK

2.26.91

Unhealthy health plan

Tues

A LEGISLATIVE task force on health care costs last week estimated that 90,000 Alaskans are in need of affordable, adequate health insurance. There is no reason to dispute the finding of the task force, which is the pet project of Sen. Jim Duncan of Juneau. But there is reason to question the senator's recommendations on how to solve the problem.

His solution is to ensure that all government employees receive good health benefits at low cost by placing additional limits on the fees that health care providers can charge government employees.

Unfortunately, it's a proposal that will exacerbate, not relieve, the health cost crisis.

According to Mr. Duncan, the state should create a new state agency, a health resources authority, that would control rates for medical services charged by doctors, hospitals, pharmacists and other care providers who wish to do business with the state.

With an estimated 135,000 Alaskans covered under state, local or school district union contracts for guaranteed health care, Sen. Duncan intends to leverage their business to get doctors and hospitals to participate in the state price control scheme. He intends to later extend the system to cover private sector employees as well.

THE THOUGHT of yet another government bureaucracy spending millions of more public dollars is frightening enough, but the proposal is much more serious than just creating more government.

The approach ignores the complexity of the health care cost problem itself.

For doctors there's malpractice insurance approaching rates of $100,000 per year. For hospitals there's uncompensated care — those thousands of Alaskans who come in for care and can't pay for it.

Then there's federal government programs like Medicare, Veterans Administration and Champus that reimburse providers according to a set formula, which nets health providers barely 60 cents on the dollar for the cost of care.

THE PROVIDER is expected to just eat the unreimbursed costs, which means to stay in business raising rates for private payers. Sen. Duncan's proposal will only produce additional losses for the health care industry in Alaska.

While there is nothing wrong with wanting to provide good health benefits for government employees, the Legislature should be looking at the total system to develop a health plan that addresses all citizens' needs.

That plan should consider issues like uncompensated care, availability and access to new technology, society's expectations for care, and major health problems like AIDS. A public debate should cover questions like whether we want to ration medical care — as is done in Canada and other countries that have a form of socialized medicine.

The Legislature should work closely with providers and consumers to improve and pay for health care in Alaska. The goal should be to provide the greatest good for the greatest number.

Mr. Duncan's aim misses that mark.

DEEDLE DUMB

2.26.91

Tues

Half-time Legislature

THE NEWS report from Juneau last week said the Legislature has scheduled floor sessions to take place only every other day. One day off, one day on, deedle, deedle dumpling my son John.

Perhaps lawmakers want to rest up for the final two days of the session when all the work takes place.

More likely, they're on a part-time schedule because there just isn't very much going on, and it would be a little boring to just sit around in the House or Senate chamber looking at each other. So they take off half the time.

It didn't used to be that way. During the first 10 years of statehood, the people's representatives could gather in Juneau, do all they had to do, and get back home in two or three months' time. Legislative sessions lasted between 60 and 90 days during the 1960s.

Then came the Prudhoe Bay lease sale, and $900 million to light up the eyes of lawmakers who couldn't count the many ways to spend it. Sessions began dragging on in length beginning in 1970. By 1984 they were lasting almost a half-year. That's when the public said "no more."

A constitutional amendment that year limited the legislature to three-month sessions.

But the 121-day limitation isn't sufficient, as the current half-time Juneau schedule shows. It should be trimmed back even further. Gov. Hickel's proposed 75-day session limit would be a good start. A 60-day limit, with exceptions for emergencies, would make better sense.

Rather than part-time schedules, legislators should put in a full week's work, get the job done, and come back home to live with the people who elect them to be their representative. That's the way the system is designed to work.

THREE PERSPECTIVES

Finding ways to limit healtl

One solution from Legislature to control costs



Sen. Jim Duncan

A tree falls in the forest. There is no one there to hear it fall. Is there a sound? I draw this analogy to The Anchorage Times editorial of Feb. 26 regarding legislation I introduced to help control the inflationary spiral of health care costs in Alaska.

Prior to the publication of the editorial, I had an in-depth discussion with The Anchorage Times editorial board to explain this legislative proposal. After reading the editorial, I had to wonder if I was making a sound when I spoke, or if there was no one around to hear. The editorial missed the mark and the facts entirely.

No one can deny the existence of a problem with rapidly increasing health care cost. However, a notable deficiency in The Anchorage Times editorial was the absence of an alternative solution. The attitude seems to be that there are no solutions. It is the same attitude I've encountered from some health care providers in the state.

The Anchorage Times editorial leaves you with the impression that my proposal is directed solely at public employees. It isn't! It invites and encourages participation from the private sector on a voluntary basis. It can serve as a viable vehicle that will offer all Alaskans affordable quality health care.

The rising cost of health care in our state is one of the most critical problems facing all Alaskans. Total health expenditures in Alaska during 1990 are estimated at $1.5 billion, up 300 percent from the $480 million expended in 1979. It is estimated 80,000 Alaskans are either uninsured or underinsured. If the current inflationary trend continues unchecked, it is estimated health care expenditures will increase to at least $10 billion with over 25 percent of the state's population uninsured by the year 2000.

The problem is not restricted to Alaska. The federal government and virtually all states are grappling with ways to control health care costs. The National Governors Association, AFL-CIO, American Association of Retired Persons and other national groups have identified it as a principal issue of concern. Seventeen states, including Alaska, have established approaches to containing costs and report encouraging results. The Alaska Health Care Cost Containment Task Force, which I chaired, investigated this serious problem for two years and determined it is time for our state to act.

Our private employers want a solution. The Task Force met with a number of Alaska's largest private employers and found many are paying higher premiums for less benefits than the state. Other private employers have found it difficult, if not impossible, to continue coverage thus adding to the ranks of uninsured and underinsured Alaskans.

Increases in health care are also attributed to uncompensated costs incurred by providers. The Anchorage Times asserts the legislation would simply increase uncompensated care losses. On the contrary, losses can be reduced by cutting down on uncompensated claims by providing all Alaskans with the protection of health insurance.

Senate Bill 83 creates a Health Resources Authority. It is charged with establishing a system that results in cost efficient payments to providers.

This system includes schedules of maximum allowable reimbursement for services based on actual provider costs, geographic regions and availability of care. It is also directed to create a statewide utilization standards system to monitor, track and verify patterns of treatment by providers to assure cost effective care is delivered without reducing the quality of medical care. The reimbursement schedules and utilization standards will be used by all public employers and be available for use by all private employers.

After July 1, 1992, the authority may procure or provide a comprehensive group plan to all private and public employers who elect to participate. This will expand the pool of subscribers, maximize the opportunities for cost management, and should realize significant savings.

While editorials need not be objective and impartial, they should be based on fact. I'm assuming The Times provides health insurance coverage for its employees. It should investigate the increase in premiums it pays, the reduction in benefits offered in its policy, or costs it has shifted to employees over the years. It should conduct exhaustive conversations with private and public employers. This may prove to be an ear opener.

I encourage all Alaskans, especially The Anchorage Times, to listen for falling trees. I hear the trees falling as 11 more Alaskans become uninsured on a daily basis as our private employers struggle to keep up with ever increasing health care costs. This legislation recognizes the problem and puts forth a solution. In this regard, it does not miss the mark. It is absolutely right on target!

Jim Duncan represents Juneau in the Alaska state Senate. Opinions expressed in this column do not necessarily reflect the editorial policy of The Anchorage Times. 3-10-91

Patients without insurance create burden for hospitals

Fixing health costs for state employees won't solve problem



Harlan Knudson

Next time you see a young motorcyclist driving down the road at 80 miles an hour without a helmet, you should know that if he ends up in the hospital with thousands of dollars worth of injuries, you're probably going to be the one paying the bill.

The problem of the thousands of uninsured and underinsured Alaskans is not a simple one, and won't be solved easily.

There are a lot of reasons many Alaskans don't have adequate health insurance. They include our lifestyle, especially substance abuse, hazardous jobs and recreation activities; the increasing cost of health insurance; employment that doesn't offer insurance at all; and the lack of blanket supplemental coverage for those with partial insurance.

Sen. Jim Duncan, D-Juneau, is making an admirable attempt to address this compelling problem with legislation he has introduced to establish a health authority.

But his approach has some problems.

The two major components of Duncan's bill are the creation of a rate schedule for health providers that public employers would use, and a provision for creation of insurance pools for groups of private employers.

Duncan's legislation grew out of recommendations by the Health Care Cost Containment Task Force. The task force was originally formed to consider ways to cut down on the amount the state was paying to insure its own employees. Last year, its duties were extended to look into health care cost containment for all Alaskans.

We believe this is no way to go about looking at what is probably the largest health care problem facing Alaska — affordable care for all.

All but one of the task force members were state employees or legislators — there was one union representative. There were no representatives of health providers, consumers or the business community.

In addition, the information the task force relied upon in making its recommendations, specifically the rate of increase in health care costs and the number of Alaskans needing more insurance, is open to question.

While it's one thing to contain the cost of health care by controlling a population insured by a single company — state employees — it is quite another to contain the cost of health care for all Alaskans.

In reducing the cost of health insurance for state employees, the state as purchaser of the insurance and employer of its beneficiaries could dictate or negotiate some cost-cutting measures.

That approach quite obviously will not work on the entire population; a population with health coverage from dozens of different sources or no coverage at all.

The Alaska State Hospital & Nursing Home Association would rather the patients — uninsured and underinsured Alaskans — be diagnosed before treatment by a health authority or any other means.

That diagnosis should be based on adequate information from the state's health providers and consumers, as well as on thoughtful discussion about what the state can and should provide all its citizens when it comes to basic health care.

We believe another bill Duncan has introduced, Senate Concurrent Resolution No. 10 (HCR No. 5 has been introduced in the House by Rep. Johnny Ellis, D-Anchorage) will go a long way toward that diagnosis.

This bill would establish a task force — one that would include providers, consumers and legislators. This task force would be directed to look at the issue of cost containment, the number of uninsured and underinsured Alaskans and health service coordination, among other tasks. It would make recommendations to the legislature in 1992 and 1993.

Those reports, when added to the information already gathered, should tell us the right treatment to cure the ill of too many Alaskans who can't afford adequate health care.

Harlan Knudson is president of the Alaska State Hospital and Nursing Home Association. Opinions in this column do not necessarily reflect the editorial policy of The Anchorage Times 3-10-91

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Physicians have bills too



Raymond Schalow

Why does medical care cost so darn much?

That's a question we ask our physicians, our hospitals, our friends, and our politicians. Everyone will tell you it's a complicated question, and it is. But let me give you two tragic examples that illustrate some of the causes that contribute to rising costs and their effect on our urban and rural communities.

The Anchorage Neighborhood Health Center is the only health facility in Alaska that provides care to those who can least afford it. Its mission statement declares, "ANHC is to be responsive to the needs of the community, especially those who most likely lack access to services because of financial barriers, language barriers, lifestyle barriers, health status barriers, or cultural barriers."

In 1984 ANHC used to do that! In 1990, however, they could only treat 25 percent of the over 48,000 low income persons in Anchorage.

Beginning in 1984, the quantity of service delivered to the Anchorage community began to rapidly decrease. In fact, by 1988 ANHC delivered $275,000 less in services than it did in 1984. Incredible as it sounds, this loss of health care had absolutely nothing to do with state and federal budget cutting.

It's called malpractice insurance! Even though the ANHC physicians were salaried and had never been sued, the cost of their malpractice insurance increased from $16,350 in 1984 to $287,775 in 1988, and rose even higher in 1989, while their primary income (government funding) remained constant.

In other words, $275,000 that could have been spent on hiring additional physicians, purchasing better equipment, or maintaining dental care services had to be used to pay malpractice insurance premiums.

That simply means that members of the community who can least afford medical care now receive $275,000 less than they received in 1984.

This ANHC story is tragic, but it's not the only tragic story that adds to our high cost of health care. Let's take rural Alaska.

Dr. Stanley Jones is a family [illegible] who provided care for the citizens of Haines, Alaska, for more than 26 years. But in 1989 he packed his bag and quit!

Haines is a rural community with no hospital and only one medical office. In addition to Haines, Dr. Jones provided care for Skagway at a personal cost of $100 or more for each round trip ticket.

For all of those 26 years, these two communities had a physician on call 24 hours a day, 365 days a year. Because there was no hospital, Dr. Jones had to have an inventory of drugs, supplies and equipment that exceeded $130,000.

Nurses and administrative staff were also on call 24 hours a day, and their wages had to be guaranteed. Due to the freeze of Medicare and Medicaid payment schedules, Dr. Jones' fees were reimbursed at a substantially lower rate than the cost of his service. Although Dr. Jones had never been sued, his malpractice insurance jumped from $1,000 in 1984 to $69,500 in 1987.

Finally, he was forced to cease the delivery of babies because he could no longer cover the cost of his insurance. Expecting mothers had to travel to Juneau two or three weeks prior to their expected delivery date. Soon thereafter, Dr. Jones retired from active practice entirely.

In a 1989 Senate hearing, Dr. Jones in emotional testimony stated that he could no longer earn a reasonable living in the community he called home. To illustrate his plight, he submitted his 1988 tax return that detailed a personal income loss of $10,000.

The high cost of health care is a complicated issue, and some of the best minds in the country are struggling with the problem. We must provide health care for every one of our citizens, and as the cost of charitable care continues to grow, it is shifted to those who can afford to pay. However, if a large segment of our society cannot, or will not contribute its fair share, then costs will continue to soar.

Some members of society want to ratchet down on health care providers as though they are the problem. But this only adds to the confusion, and ... yes, to the cost. This is a serious social problem that can only be solved when physicians, hospitals, government, large and small businesses, and the public itself finally decide to sit down together, as equal partners and discuss the issues.

Band-Aids are only temporary. What we need is reconstructive surgery.

Raymond Schalow is executive director of the Alaska State Medical Association. Opinions expressed in this column do not necessarily reflect the editorial policy of The Anchorage Times. 3-10-4



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WASHINGTON REPORT

Labor unions back national health care reforms

The AFL-CIO Executive Council has unanimously adopted a resolution to push for universal access to health care, significant cost containment, quality care and progressive financing, according to a report in International Teamsters Retiree News.

The group called on all affiliated unions to mobilize their 14.2 million members in a grass-roots campaign and an all-out lobbying effort to win national reforms for the health care industry, said the Teamster newsletter.

There has been "a major underlying climactic change in our society in terms of the perceptions of this issue and its sense of urgency," AFL-CIO president Lane Kirkland said. He cited employers facing "extraordinary uncontrolled costs and the extraordinary shifts with the American Medical Association now recognizing access to health care as a basic human right."

The urgency of the health problem lead the labor group to "support measures that can be enacted," the newsletter said. Among those measures are bills introduced by Sen. Edward M. Kennedy (D-Massachusetts) and Rep. Henry Waxman (D-California) to extend insurance coverage to 37 million Americans lacking insurance.

Other legislation labor will support, according to the newsletter, would:

- Guarantee all Americans the right to health care by establishing a national social insurance program to include workers, the unemployed and others not in the work force. The program would incorporate Medicare and Medicaid.
- Continue labor's goal of a social insurance national health care program "while recognizing that reform may come about in stages."
- Create a national cost containment program that includes a cap on health spending, a capital budget to manage the currently uncontrolled duplication of technology, and a better allocation of resources. A federal authority that negotiates uniform reimbursement rates with hospitals and doctors would be used by all payers.
- Create a national commission of consumers, labor, management, government and providers to run the program.
- Guarantee a core package of benefits, which could be supplemented voluntarily or by collective bargaining.
- Contain progressive financing that requires all employers to contribute.
- Overhaul the existing structure by standardizing claim forms, improving care delivery and assuring that "no individual will be denied coverage regardless of age, income, job status, or health history."
- Reduce job-based retiree health costs by lowering Medicare eligibility to age 60, thus putting the program in line with the average retirement age.
- Improve quality through "practice guidelines" for physicians, create a system for technology assessment, and build a national data base on cost and quality.
- Encourage physicians to avoid unnecessary tests and procedures, while developing a better system to handle malpractice disputes.

Devise a strategy to provide all Americans access to long-term care and to make home care available for the chronically ill.

The group called on all affiliated unions to mobilize their 14.2 million members in a grass-roots campaign to win national reforms for the health care industry.

Jack Lindberg →
Oct 11 – New Eng. Journal of Medicine

For the Health of a Nation

by Henry Simmons, M.D., from the Report of the National [redacted]

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.

NATIONAL LEADERSHIP COALITION FOR HEALTH CARE REFORM

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American Academy of Pediatrics
American Association of Retired Persons
American College of Physicians
American Federation of State, County, and Municipal Employees
American Federation of Teachers
American Nurses' Association, Inc.
Ameritech
Association of Academic Health Centers
Association of Minority Health Professional Schools
Bell Atlantic
BellSouth
Bethlehem Steel
Chrysler Motors Corporation
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DuPont
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International Association of Machinists and Aerospace Workers
International Brotherhood of Electrical Workers
International Union of Electrical Workers
Lincoln Telephone & Telegraph Co.
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September 21, 1990

From: Beverly Long / Alex

Hawaii an innovator in public health care

HONOLULU — Dr. John Lewin is a spare-time marathon runner with a long distance vision of a nation in which everyone receives prepaid health care.

"I think basic health care is a fundamental human right," says Lewin, the state director of health in Hawaii.

But this former family physician and health officer for the Navajos is convinced this right can best be realized not through a Canadian-style government health service but by vigorous American style competition among health care providers. What Lewin wants the government to do is provide the incentives — or the mandates — that will require this kind of competition.

Hawaii has long been an example in the art of providing health care for working people at a price even the smallest employer can afford. Since 1974 it has been the first (and only) state requiring employers to provide health insurance to all their full-time employees. While businesses can require employees to pay half the cost of this insurance and coverage of dependents is optional, the coverage is mandatory for full-time workers. In practice, most dependents are covered by some health insurance plan.



LOU CANNON

The results of this experiment have been significant. Life expectancy in Hawaii has increased by nearly five years to 78. Infant mortality, which had the high rate of 16 per 1,000 in 1974, is now down to 8.4 — one of the best rates in the nation. And while the rates of cancer and heart disease are similar in Hawaii to those of other states, the death rates from these diseases are lower in Hawaii. Because of its law requiring health coverage for workers, Hawaii has by far the nation's lowest "gap group" -- the term applied to those insufficiently old for Medicare, insufficiently poor for Medicaid and unfortunate to work for an employer who lacks an insurance program.

And last April, at the urging of Lewin and the state's progressive Democratic Gov. John Waihee, Hawaii passed another first-of-its-kind law extending health insurance to the 35,000 persons (a little more than 3 percent of the population) who formed its gap group: the self-employed, part-time and seasonal workers, homeless unemployed and some dependent children. When this State Health Insurance Program (SHIP) was passed, some insurers argued it would be prohibitively expensive. Lewin took the view that the group as a whole (the homeless were an exception) would be healthy and that insurers would find it worthwhile to compete for their business. The results so far suggest Lewin was right.

In comparison with other visionary health programs, notably one in Massachusetts, the emphasis in Hawaii has been on prevention through regular physical examinations, mammograms and prenatal care. The result has been not only a healthier population but low costs that have prompted competitive bids from insurance companies.

Hawaii's health care has become nearly universal at a time when most of the country is heading in the opposite direction. The number of Americans who lack any health insurance is increasing. By and large, these are people who rely on hospital emergency rooms for their medical care.

According to some estimates, as many as 40 million Americans, nearly 20 percent of the population, are lost in this health-coverage gap. The numbers are particularly high in states such as California, which have a high percentage of young workers, immigrants and service industries that tend not to extend health care to employees.

Both in human and economic terms, America pays a tremendous cost for the health-care gap. In inner cities throughout the nation, hospitals and trauma centers are closing down or limiting care because of the high cost of providing uncompensated care in an emergency room. Uninsured Americans tend to wait until a health problem is life threatening — and perhaps incurable — before they seek medical care.

In 1974, Hawaii overcame the reservations of small business men about health-insurance costs by establishing a "community rating." This meant that all the small employers in the state were treated as one risk pool, enabling them to obtain the rate breaks routinely available to big business.

Larger states have balked at such community ratings, although the idea is a way of enticing competitive bids from insurers that would keep costs down and improve long-range health care.

Hawaii's example ought to prove particularly tempting to governors such as Pete Wilson of California, a farsighted Republican who wants to improve preventive health care. Wilson ought to talk to Waihee and especially to Lewin. It is time to provide health care for everyone.

[ ] Lou Cannon is a Washington Post columnist and reporter.

Falling through the net

90,000 Alaskans lack means to pay huge medical bills

By HAL BERNTON
Daily News reporter

Emmett Walton's lung collapsed on a nightmarish flight from Anchorage to Ketchikan. One minute, the 56-year-old Anchorage security guard was relaxing with his wife, Margaret, in the seat of an Alaska Airlines jet, the next he was gasping for precious oxygen through a collapsing lung rapidly filling with fluid. The date was June 16, 1989, a day that for the Waltons marked a turning point in struggles against both a severe physical disability and a crippling financial burden.

Walton was rushed to Ketchikan Memorial, then Providence Hospital in Anchorage for a difficult recovery period in which he slipped in and out of consciousness. Walton, a career Army veteran, fell back on a military benefits program to pick up more than 70 percent of the medical bills from more than two dozen creditors.

But Walton didn't have any supplementary insurance. And his life savings of $2,000 wasn't enough to pay his share of the bills and still keep current on an old batch of medical bills resulting from his wife's stay in a Las Vegas hospital.

At an age when many couples are busying planning their retirements, the Waltons sold their trailer, moved in with Margaret's mother in Mountain View and filed for protection from creditors. The bankruptcy petition filed earlier this year lists assets of $3,639 and debts — almost all of them medical — of $22,944.

"We get phone call after phone call from the hospitals," said Margaret Walton. "Naturally, they want their money. I can't blame them for that. But we just don't have it."

The Waltons are part of an increasing



PAUL SOUDERS / Anchorage Daily News

A collapsed lung and no supplementary insurance put Emmett and Margaret Walton in Bankruptcy Court.

The Waltons are part of an increasing number of Alaskans who run the risk of financial ruin if they get seriously sick or injured. They are among the unfortunates in an Alaska health-care system that is out of control.

For more than a decade, the costs of state medical care have leaped ahead at rates frequently exceeding 20 percent a year. Today, Alaska health care carries an annual price tag of more than $1.5 billion, according to one state study.

Insurers have been raising their rates to match the medical costs. That has made it harder and harder for employers to offer — or self-employed people to purchase — good medical coverage. Today, an estimated 90,000 Alaskans — nearly double the number of a decade ago — lack adequate medical insurance or don't have any insurance at all, according to a state legislative task force study.

"There's a huge gaping hole" in the medical safety net, said Heidi Thomas, a counselor for homeless women at the Clare House in Anchorage. For the women who seek refuge at the Clare House, just getting in the front door of a doctor's office can be a challenge. "The homeless have medical needs but often no insurance to cover them," Thomas said.

Doctors and hospital officials say they try not to turn away those who can't pay. As proof, they point to bad debt that continues to mount even as the economy improves.

Providence Hospital, for example, recorded $4 million in bad debt in 1987, near the height of a severe recession. In 1990, a red-hot year for the state economy, bad debt increased to $9.1 million.

The more bad debt increases, the more the hospital raises prices to help compensate for the costs of the unpaid care, said Dave Hennigan, a Providence Hospital financial officer.

Doctors often do the same, and many have been able to keep earning more money each year.

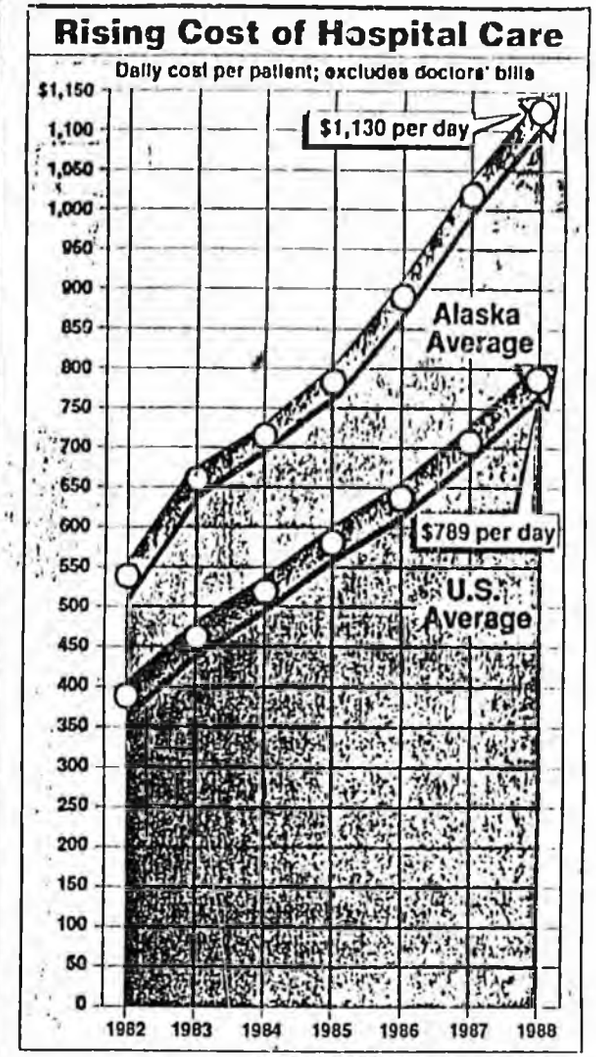
Anchorage doctors' incomes have risen at roughly the same 6 percent annual rate noted in a national survey by the American Medical Association, according to Ray Schalow, executive director of the Alaska State Medical Association.

PAUL SOUDERS / Anchorage Daily News

A collapsed lung and no supplementary insurance put Emmett and Margaret Walton in Bankruptcy Court.



FRAN DURNER / Anchorage Daily News



RON ENGSTROM / Anchorage Daily News

Sonja Javier, who had no insurance from her seasonal job, sought and eventually found help to fix a painful infection of her teeth. "I can't believe I live in a state that has so much money it pays you to live here but none for my teeth," said Javier. Others without insurance depend on a patchwork of state aid and charity.

The national survey reported that the average U.S. physician's net income before taxes rose from $104,100 in 1983 to $144,700 in 1988, the last year in which statistics were available.

Schalow said Anchorage doctors are willing to tighten their belts to help keep costs under control.

"I can tell you we are willing to come to the table and take our hits like anybody else," said Schalow.

But there is no consensus about how to address the twin problems of rising numbers of uninsured patients and skyrocketing costs.

Doctors and hospitals want to attack the mounting bad debt by creating some sort of universal health insurance — possibly through a state-subsidized insurance pool — that would be available to all Alaskans. They are forming a private task force to develop draft legislation.

Meanwhile, insurer and and employers are pressing proposals to help limit costs. One bill introduced by Sen. Jim Duncan, D-Juneau, would attempt to clamp down on medical costs with a rate-setting board roughly akin to the public utilities commission.

That bill — in its present form — is certain to be fought by the health care industry officials.

"It's fair to say they're not real pleased with this," Duncan said.

□

Alaska's health-care problems are part of a national crisis that has triggered a soul-searching debate — in Congress, the health-care industry and academia — about the costs of medicine and who should bear it.

In Alaska, those costs have soared higher and often faster than those of almost any other state.

Spend a day in an Anchorage private hospital, and your bill will average more than $1,500, according to Medicaid statistics. That's more than double the daily cost of 1983.

That's also over 25 percent higher than the national average, according to American Hospital Association statistics.

Visit an Anchorage doctor for a checkup, and you'll pay an average of $46.17 compared to the national average of $34.76, according to Runzheimer International, a Wisconsin-based consulting firm.

Drop by an Anchorage dentist for teeth cleaning and you'll pay an average of $64.50, about 31 percent more than the national average, according to the Runzheimer survey.

Last year, more than $340 million of the health-care spending came straight out of the state budget. That spending included $263 million for Medicaid and other entitlement programs and $78 million for child health, mental health and other services.

On a per capita basis, state health-care spending topped $2,800 in 1990 and if left unchecked would exceed $18,000 per capita by the year 2000, according to Jeff Malek, a San Francisco-based health consultant who has been studying Alaska health costs for a state task force.

Please see Page F-4, **BILLS**

BILLS: Insurers, doctors ha

Continued from Page F-1

What forces push up the cost of Alaska health care?

Hospitals and doctors point to the state's higher-than-average wage costs in an extremely labor-intensive health-care industry. Much of the labor is highly skilled and often in short supply.

"I could go down to Kentucky and get a dental assistant for $5 an hour," said Ken Wynne, an Anchorage dentist. In Alaska, such help is hard to find and "makes anywhere from $9 to $15 an hour," Wynne said.

Doctors also cite malpractice insurance costs that for some specialties have more than tripled since 1986.

An Alaska obstetrician, for example, may pay $70,000 for a year's malpractice insurance, nearly 90 percent higher than in California, according to Ron Neupauer, underwriting manager for the Medical Insurance Exchange of California, which writes policies in Alaska.

"It's not that there are so many claims in Alaska," Neupauer said. "But my goodness, when there is one it's in the multimillion-dollar range, and there's not that many obstetricians to spread the risk around," he said.

The state task force, in a draft report, cited other reasons for rising costs of Alaska health care.

Alaska doctors, for example, lack the competition from health maintenance organizations and other discount health-care systems common in the Lower 48. Such systems may offer a 25 percent savings from traditional fee-for-service care, according to a Rand Corp., study in Seattle.

The state task force also pointed to the overexpansion by hospitals in the 1980s. That has pushed up operating expenses and might force administrators to charge more for services, Malek said.

Humana Hospital-Alaska, for example, opened a $23.5 million wing in 1986. The new tower increased Humana's capacity from 199 beds to 238, according to the American Hospital Association.

But Humana has had a hard time bringing in patients to help pay off the expansion. In 1989, the hospital association reported Humana had a 37 percent occupancy. That's substantially below the 70 percent national average.

Despite the low occupancy rate, Humana reported a 1989 profit of $4.5 million on revenues of $61 million.

Lyn Whitley, a Humana spokeswoman, said the expansion is a long-range project and the beds will be needed. In the meantime, the hospital has cut costs by staffing less than 160 of the hospital's beds.

The upward spiral of health care has left both insurers and employers scrambling to find ways to keep costs under control.

One major push has been aimed at people who are insured.

The state, for example, has offered one of

"It's fair to say (health care officials) are not real pleased with this."

— Sen. Jim Duncan
on his attempt to start a rate-setting board



Alaska's most comprehensive health-insurance packages. But the cost jumped from $218 a month in 1984 to $425 a month in fiscal year 1989.

Then, in May 1989, the state signed an agreement with the employees' union calling for precertification of surgery, auditing of medical bills, modest reductions in certain coverage limits and other cost-cutting steps. The new policy booklet developed from that agreement also advised — much to the dismay of Alaska hospital officials — for subscribers to shop around and check rates of Lower 48 hospitals.

Since the new plan went into effect, the cost of insuring state workers has declined to $385 a month.

But policy restrictions aren't always painless to employees. Some businesses make their workers pay much larger shares of monthly premiums and much higher deductibles. And sometimes the policies don't cover the really big bills the employee desperately needs paid.

Rolinda Standridge, for example, has a

ıve different ideas on costs

Veterans Administration job that comes with a family health-insurance package that promises to pay 85 percent of all bills, once a deductible is met. But it won't cover pre-existing medical conditions. And that means the insurance won't pay a penny to help treat the heart ailment of Ron Standridge, her husband of one year.

Ron is a self-employed jeweler who hasn't been able to afford his own insurance. He has had several serious heart operations and may need more surgery.

But the couple can't pay off Ron's old medical bills, much less take on any new ones, according to Rolinda. Earlier this year, the couple filed for bankruptcy, listing debts to hospitals and doctors of more than $20,000.

"I'm not sure what will happen," Rolinda said. "We'll be going to our first meeting of creditors soon."

Other workers, struggling to survive on part-time or seasonal employment, find they can't work enough hours to qualify for insurance benefits.

Sonja Javier is a 41-year-old Anchorage woman who has worked in the housekeeping division of the Anchorage Holiday Inn. She had steady hours during the summer tourist season but said she was asked to come into work only a few times in the lean fall and winter months.

Javier said she didn't have enough time on the job to qualify for health insurance offered through her local union.

She wanted that coverage to help finance treatment of rotting teeth that were infecting her body.

"The infection has really been spreading. At one point last June I had blue streaks traveling all the way up my neck," said Javier.

Javier has less than half or her original 32 teeth, and the survivors perch unsteadily on the soft flesh of the sickly gums.

"Right now, it embarrasses me to even to go out and look for another job. When I keep my mouth closed, I'm OK. But when I open my mouth, forget it. When I talk, I start foaming at the mouth."

The pain had been building for more than a year.

Javier first sought help from the Anchorage Neighborhood Health Center, the only center set up to aid low-income people. She said she couldn't secure an appointment from the dental clinic, which later shut down due lack of funds.

Then she sought help from several dentists but says she was refused treatment because she had no money to pay for the costly job of pu''ing her teeth, treating the gums and fitting dentures.

"I wasn't asking for something unreasonable. I said, 'Give me a payment plan.' " Javier said. "If that's crazy, I'm sorry. But I can't believe I live in a state that has so much money it pays you to live here but none for my teeth."

The infection kept getting worse, and Javier resorted to begging antibiotics from friends to help keep the pain in check. Two weeks ago, after a trip to the Providence Emergency Room and several telephone calls to the Southcentral Dental Society, Javier finally found Wynne, the Anchorage dentist.

"She had three badly abscessed teeth that were really terrible," Wynne said. "She was in real pain."

Wynne pulled the three infected teeth on Feb. 7 and has agreed to see Javier for follow-up treatment and worry about the billings later. He said most Anchorage dentists attempt to do at least some charity work, and many participate in a rotating weekly on-call roster. Those signed on to the roster agree to treat emergencies, no matter what the patient's ability to pay.

But for the first six months of this year, no dentists have signed up for the on-call roster. So Wynne found himself unexpectedly drafted to treat Javier. "It's a highly unusual situation. We'll have to do something about the roster at the next dental society meeting," Wynne said.

□

Employees aren't the only ones feeling the bite of cost-control efforts.

Insurers and others who pay medical bills also are targeting hospitals, doctors and others who provide medical services.

The strongest thrust so far has come from the federal government, which has developed programs to help finance the care of the elderly, disabled and poor. In recent years, the government, sometimes working with the state, has set tough new limits on reimbursements. Due largely to these restrictions, Providence Hospital has seen its unreimbursed costs for contract care skyrocket from $8.1 million in 1987 to $30 million in 1990.

Providence, in turn, increases its rates to help compensate for the loss of federal payments, Hennigan said.

Thus the hospital — despite the rising tide of bad debt and payment shortfalls — was able to earn a net income of $8.2 million from revenues of $119.3 million, according to a hospital financial statement.

But Alaska insurers don't want to get stuck with subsidizing the government care. They are attempting to curb their medical costs with contract agreements in which hospitals and doctors agree to limit fees to amounts approved by the companies.

The most aggressive, has been launched by Blue Cross of Washington and Alaska, which this month announced a new "participating provider" network of 94 state doctors.

The doctors won't charge more than what Blue Cross considers "customary and reasonable." The program is designed in part to eliminate any surprises subscribers get when their medical costs are higher than the norm.

Doctors have long fought such price-control efforts, and so far, only 22 percent of the state's eligible doctors have opted to join the new network. "Once they get a hold, they'll ratchet down, or try to freeze rates," said Doug G. Smith, an

Please see Page F-6, BILLS

BILLS: Insurers, doctors have different ideas on cutting costs

Continued from Page F-1

orthopedic surgeon who refused to join the network. "These programs have happened all the time in the Lower 48 but we're a little more independent up here and resistant to being herded around."

Doctors, as well as hospitals, also are preparing to fight Duncan's bill to set up a much more wide-ranging price-control system.

Duncan's bill would establish a nine-member board composed of public, labor and private sector representatives including at least one person from the health-care industry. The board would set maximum rates that doctors, hospitals and pharmacists could charge for their services. Those charges would vary from region to region and could increase only when approved by the authority.

Doctors might not like those rates, but the proposed legislation would forbid them from trying to collect more money by billing subscribers for a balance due.

The rate schedule would initially cover the 135,000 Alaskans insured by state municipal and school district insurance plans. But Duncan hopes many state businesses would choose to join the program to help keep down employee health-insurance costs.

The legislation includes several other provisions, including one measure that would create insurance pools that small employers could join to try and get better rates.

"With this bill, Alaska would come out of the dark ages and to the forefront of national cost-control efforts," said Malek, the California consultant who helped draft the legislation.

But doctors and hospital officials think the legislation unfairly singles their operations out as the cause of the state's health-care crisis.

"We cannot support any legislation that has, as its primary method of health-care cost controls, regulating reimbursements to physicians and hospitals," said Harlan Knudson, executive director of the Alaska State Hospital & Nursing Home Association.

"It's crazy, unless we address the whole damn (health care) problem," said Schalow, of the state medical association.

Health-care industry officials, in a recent policy paper, declare the need for a comprehensive state health plan. Some technologies, they say, may have to be rationed because there's just not enough money to pay for their routine use.

They also seek universal health insurance so more of their patients could pay for treatment.

Such a plan may be developed by a state health-care task force, then submitted to the legislature. But Schalow said the doctors don't have enough representation on the task force, and will develop their own plan.

Doctors and hospitals also are seeking further reforms of state liability laws to help curb the cost of malpractice insurance.

"Liability insurance premiums for malpractice have reached levels that physicians can no longer afford nor can their patients afford through increased fees," the policy paper stated.

Duncan said he knows his legislation may face a tough fight from the health-care industry. But he hopes for allies among major state employers hurt by the rising cost of health-care insurance.

"Our goal is not to reduce the quality of health care, or put people out of business. We just want to make this whole system work," Duncan said.

Uninsured Alaskans, health costs on increase, says state task force

Saying that health care costs are out of control at the same time the number of people who can't afford health care is growing by leaps and bounds, Sen. Jim Duncan (D-Juneau) has introduced a bill that would dramatically change the way care is paid for.

Duncan, who chaired the state's Health Care Cost Containment Task Force, presented the report to the legislature in February, along with his bill aimed at reforming health care.

The task force was created last year. Its original job had been to find ways to cut back on the cost of health care insurance paid by the state for its employees. Members include legislators Duncan, who chaired the task force;

"Without substantial reform or an organization that can focus on the problem and bring these pieces together, we will never affect a solution."

Rep. Mike Navarre (D-Soldotna), vice chairman; Sen. Drue Pearce (R-Anchorage); and representatives of state departments and labor organizations.

The task force's report bases most of its recommendations on its findings that health care expenditures are the fastest growing component of the whole budget, $385.5 million in fiscal year 1990, and that the number of uninsured and under-insured Alaskans is 16.5 percent of the population, or 90,000.

Much of the task force's findings are based on some 300 surveys it sent out to groups in Alaska, including public employers, health care providers and private sector employers.

It also examined health care plans in other states and held three public hearings.

In addition, the report describes the results of its earlier task -- to control the cost of health insurance paid by the state for is employees.

Jeffrey Malek; the consultant who worked on the report, and Duncan described the task force's findings and Duncan's consequent legislation to legislative committees in February.



Photo by Mark Kelley

At left, Sen. Jim Duncan (D-Juneau) testifies on health legislation he is introducing before the House Labor and Commerce Committee. Rep. Mark Boyer (D-Fairbanks), who introduced similar legislation in the House, is at right.

Malek said the number of uninsured, new medical technology, malpractice costs and cost shifting are behind much of the increase in health care costs. The factor most responsible for the rise in costs is the increasing number of people who can't afford health care, forcing hospitals and providers to shift the cost of paying for their care to others, he said.

"Without substantial reform or an organization that can focus on the problem and bring these pieces together, we will never affect a solution," Malek told the Senate Labor and Resources Committee.

Under the legislation introduced by Duncan, Senate Bill No. 83 (It's been introduced in the House by Rep. Mark Boyer), would create an Alaska State Health Resources Authority.

The authority, composed of nine volunteers, would include representatives of the executive branch, labor organizations, school districts, municipalities, private sector employers and health care providers.

It would perform a number of tasks, including reviewing all certificate of need requests, but its most controversial task would be to set rate reimbursement schedules for Alaska health care providers, said Duncan.

Those schedules would be followed by public employers and any private employers who choose to do so, said Duncan. The authority would also allow the creation of insurance pools by private employers. This proposal is especially aimed at employers, such as fishermen, who may have difficulty obtaining commercial insurance on their own.

"I believe if we're going to address health care costs in the state and do it comprehensively, this is the vehicle," said Duncan.

Duncan told the Senate Labor and

Continued on next page

Task force report ...

Continued from page 3

Resources Committee that the reimbursement schedule would take into account the actual costs felt by providers, saying the point of the legislation is to "control the inflationary rise" of health care, not cut the current cost.

Response from committee members to the legislation was mixed. Sen. Richard Eliason (D-Sitka), questioned the amount of money the task force says is being spent on health care. The task force says Alaskans spend $2,850 a minute on health care, and that figure is increasing by $534 a minute.

Sen. Virginia Collins (R-Anchorage) expressed concern about subsidizing health care, as long as the number of people who can't buy their own health care increases.

"As long as we continue to subsidize health care, we're going to continue to increase the cost of health care, and not necessarily increase the quality of health care," she said.

This bill by Duncan is not the only piece of legislation associated with the task force's report.

Also introduced in both House and Senate is a resolution that would establish a Health Resources and Access Task Force.

This task force would perform some of the same duties performed by the task force chaired by Duncan -- namely, it would examine the cost of health care and access to health care.

Its responsibilities, however, would extend to much more information gathering than was undertaken by the Health Care Cost Containment Task Force.

It would seek data on these issues from the medically indigent, health care consumer groups, the insurance industry, health care providers, labor organizations, emergency service workers, businesses, the Medical Care Advisory Committee, the Alaska Native Health Service and the public.

Its membership would also be different from the earlier task force. Members would include six legislators, two representatives of the executive branch and eight representatives of the medically indigent, private employers, health care providers, nonprofit organizations, health consumers and labor organizations.

This task force would make two reports to the governor and legislature, in 1992 and 1993.

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Calendar

March	
	National Nutrition Month
	Mental Retardation Month
	National Social Workers Month
18-24	**National Poison Prevention Week**
21-22	**American Hospital Association Region 9 Policy Board Meeting, Carmel, Calif.**
26-27	**American Health Care Association Board of Directors, Washington, D.C.**
30	**Doctor's Day**
April	
	National Alcohol Awareness Month
	National Child Abuse Prevention Month
	National Sexually Transmitted Diseases (STDs) Education and Awareness Month
	National Occupational Therapy Month
	Cancer Control Month
7-9	**Alaska State Hospital & Nursing Home Association Mid-year Legislative Conference, Juneau**
21-23	**Healthcare Forum 61st Annual Meeting -- Breakthrough Leadership; Building High Performance Organizations, San Francisco**
22-25	**Conference on Aging, Anchorage**
May	
	National Arthritis Month
	National Mental Health Month
	National High Blood Pressure Month
6-12	**National Nurses Week**
12-18	**National Hospital Week**
	National Nursing Home Week
19-22	**14th Annual National Rural Health Association Conference, Seattle**
June	
9-12	**American Health Care Association Congressional Conference, Washington, D.C.**
17-18	**American Hospital Association Region 9 Policy Board Meeting, Seattle**

A legislative viewpoint

Basic health services top lawmakers' lists

Health care issues are continuing to gather supporters among the Alaska State Legislature, although this session the focus may be more on fending off cuts to health care budgets, rather than creating new programs, say some key legislators.

"What I'm hearing from legislators this session is that basic health care is one of the priorities," said Rep. Georgianna Lincoln, co-chair with Rep. Pat Carney of the House Health, Education and Social Services Committee.

Lincoln, a freshman Republican representative from Rampart, said she has been struck by the high number of Alaskans without basic health care coverage, and the high cost of health care.

Lincoln, however, said she thinks the legislature is going to be reluctant to spend much new money on the problem of health care, a view shared by Sen. Arliss Sturgulewski (R-Anchorage) chair of the Senate Health, Education and Social Services Committee.

Sturgulewski said she thinks her committee will have to spend a lot of time trying to find funding for programs cut under the governor's budget. These include the homemaker service and portions of the childcare budget.



Rep. Georgianna Lincoln

"Most of us are in a state of shock right now because of program cuts ... and a lack of funding," said Sturgulewski.

Sturgulewski also mentioned concern about comments by Health and Social Services Commissioner Ted Mala regarding cuts to or elimination of Medicaid.

"I see no way the state could possibly move into coverage of these programs," said Sturgulewski. Medicaid is funded in equal parts by the state and federal governments.

There is a bright side to the budget cuts, said Lincoln. "I think what it's [the cuts] doing is to analyze what we've got and how we can make that better."

"The state should be able to deliver the health care much better than it is, but I don't think it will cost any more," she said.

Drawing from her background in resource development, Sturgulewski sees the settlement of the mental health lands dispute as a major issue to be tackled by her committee.

Once settled, the mental health lands dispute has the potential of giving more than $1 billion in funds for health programs serving the mentally ill.

Sturgulewski, a 13-year legislator who has not before chaired the HE&SS Committee, said there has so far been little leadership from the new administration on major health issues. With the lack of leadership from the governor's office, the legislature has stepped in, she said.

"We do have to take a very close look at how we're providing health care and how we're delivering it because of the tremendous cost involved," she said.

She complimented Sen. Jim Duncan (D-Juneau) on his attempt to address the problem of Alaska's under-insured and uninsured with a health authority.

"I think the approach and leadership Sen. Duncan is taking is excellent ... but it too won't go very far if the administration doesn't buy into it," she said.

Both legislators hedged on the question of capital dollars for health facility renovation and construction. Sturgulewski said it's too early to tell what will happen, while Lincoln said she gets the feeling anything not considered a "basic service" will have trouble getting funded.

Sturgulewski and Lincoln said they see a need for a statewide health policy, but expressed doubt about finding a lot of money for such a plan.

"We have been studied and studied and studied to death. Now we need to dust off all these studies that have been done and see what we can use," said Lincoln.



Sen. Arliss Sturgulewski

Sturgulewski said the key to a statewide health policy is coordination between the administration and the legislature.

"We're still serving [health care] out of little boxes, a mental health box, a social services box ..." said Sturgulewski.

Lincoln said she is particularly concerned about coordinating health care for Alaska's rural areas.

"When you ask me about health, it's difficult for me to talk just about health. I want to talk to you about no jobs in the village, that is health. I want to talk to you about children who are dropping out of school, that is health," said Lincoln. "If any one of those things don't click in your life, it affects your health, whether that's mental or physical health."

From KETCHIKAN Daily News
4/30/91

Health insurance

The United States' system of paying for health care is breaking down. Fixing it is one of the most formidable challenges of the 1990s. With no federal leadership on this issue, the states will have to blaze the trail.

Few people actually pay for health care directly. Insurance, mainly provided by employers or the government, pays most doctor and hospital bills. Thus the cost of periodic illnesses or emergencies is spread widely. But the cost has grown so high — 11.6 percent of the nation's output goes to pay for health care — that it's painful to bear even when it's distributed through insurance.

Rising costs push more employers to limit or suspend health insurance benefits and force the government to restrict coverage. Caring for the growing number of uninsured people — 32 million nationwide — forces doctors and hospitals to shift more costs onto the shoulders of those who can pay. ...

People will not continue to accept a system that leaves so many without any protection at all.

— The Register-Guard, Eugene, Ore., April 18

Title
SB 83

3-8-91

Bill upsets insurers, medical industry

Law would put lid on medical fees charged state employees

By PATRICIA SOLOVEICHIK
TIMES BUSINESS WRITER

A proposal introduced in the state Legislature last month that would require the state of Alaska to set fees that doctors and other health-care providers charge patients has insurers, the medical community and some businesses in an uproar.

Sen. Jim Duncan, D-Juneau, author of the proposal, said Senate Bill 83 and companion legislation would create the Alaska State Health Resources Authority. If enacted, it would establish by July 1992 reimbursement rates and treatment standards that insurers must use in paying health-care providers who serve state employees.

After July 1992, ASHRA would offer comprehensive group health insurance to public employees and to businesses in Alaska that want to participate.

The legislation requires all health-care providers hoping to do business with the state's 135,000 public employees could not charge fees higher than those established by the state and would be required to meet state guidelines for treating patients, Duncan said.

Duncan said his legislation is the result of two years of study by the state Health Care Cost Containment Task Force, of which the senator was chairman.

Duncan said he hopes the state's private employers would join the program using participating physicians and medical facilities, particularly small businesses that would be provided group coverage for their employees.

"We met with large corporate employers in December to discuss this legislation, and they indicated that without this legislation they would need to either reduce benefits or ask employees to pay more," Duncan said.

"The business community is very interested in a solution, but they have not made a definitive statement on S.B. 83," he said.

Several large local employers testified before the task force about their concerns, including

See Insure, page C3

Insure

Continued from page C1

BP Exploration (Alaska) Inc. BP Exploration officials could not be reached for comment late Thursday.

Resa Jerrell, state director of the National Federation of Independent Businesses, said she favors the legislation as a "viable means of providing health insurance to the uninsured population in Alaska."

She said a voluntary pooling is a more acceptable alternative than a legislative mandate that all employers must provide health insurance coverage for their employees.

But she said NFIB members are adamant that the program be voluntary and administered by private insurance companies. Duncan has said Alaska would self-insure those without coverage if insurance companies could not meet state cost expectations.

Insurers in Alaska are not pleased with state regulatory intervention. They say they would prefer to take care of the problem through the free enterprise system.

"Sen. Duncan is able, through state government, to bring a much larger solution faster," said Eric Rohlman, vice president of group marketing for Blue Cross of Washington and Alaska.

"But I think its better to look to private enterprise. We hope we can be part of the solution and still believe in competition," Rohlman said.

"The disappointing part of S.B. 83 is that many feel we haven't moved fast enough," Rohlman said.

Duncan believes Alaskans do not have the time to wait for private enterprise solutions.

"If the system goes unchecked, it's in danger of collapse. As costs continue to rise, more people will drop out of insurance coverage. Those people will still go to hospitals, but the cost will be picked up by those who are able to pay.

"As the number of uninsured people rises, so will the cost of health care, which will cause more people to drop out. It's a circle that continues until at some point it collapses on us," Duncan said.

Harlan Knudson, chairman of the Alaska State Hospital and Nursing Home Association, agreed that the cost-shifting would occur, but he pointed the finger at Duncan's bill as the issue that is most disconcerting.

"The state will push down the reimbursement that hospitals now get for state employment and public employee insurance. That cost will be shifted to other buyers of health care," Knudson said.

He also charged that the program will become a "tremendously expensive undertaking."

And he said he is concerned that this bill will get the go-ahead because of public pressure on the Legislature to take some strong action on health-care costs.

In Resolution No. 5, which Knudson said he supports, Duncan said the imposition of fee schedules is necessary to get a handle on the 200 percent rise over the last 10 years in Alaska's annual expenditures for health care. The outlays have gone from $680 million to more than $1.6 billion.

And the state's uninsured have reached 90,000 people, or 18 percent of the total population. Duncan said a continuation of current trends would mean 25 percent of the state's residents will be unable to get insurance.

Under S.B. 83, ASHRA would be managed by a board of directors composed of nine members appointed by the governor from the executive branch, organized labor, school districts, municipalities, private sector employers and health-care providers.

The Associated Press

JUNEAU — The House approved a $606 million spending plan for education on Tuesday, but the governor's chief budget official says he intends to fight the bill in the Senate.

Representatives passed House Bill 5 by a 38-2 vote. The plan would spend almost $54 million more than proposed by Gov. Walter Hickel on pupil transportation, student lunch programs and the state's contribution toward school operating costs.

The House measure would fund the state's share of operating costs at last year's



level. The governor has asked for a 7.3 percent cut.

"The House definitely intends to send a message to the governor," said House Speaker Ben Grussendorf, D-Sitka. "Our commitment is to education."

Anchorage Republican Reps. Terry Martin and Loren Leman cast the only votes against the bill.

Shelby Stastny, director of Hickel's Office of Management and Budget, last week called the House bill irresponsible and said the governor would likely veto it.

Stastny said he was not surprised by the wide margin of Tuesday's vote.

"We still have the Senate to go through," he said. "The Senate's indicated they're going to be more deliberate. We hope that the Senate will slow down and allow us to look at it a little bit."

The House passed the education spending bill in just two weeks. Legislators normally take most of the 19-week session to iron out state spending plans.

The bill now goes to the Senate, where it likely will take the place of a nearly identical bill introduced by Sen. Paul Fischer, R-Soldotna. Fischer said he would support the House bill and would like to see quick approval.

Sen. Pat Pourchot, D-Anchorage, has said the measure would move slower in the Senate, but the group would not miss "the strategic deadline" for overriding a Hickel veto.

It would be easier for the legislature to pass a bill and then face a possible gubernatorial veto while still in session. If the measure passes at the end, lawmakers would have to call a special session to consider a veto override.

Missing from the House bill is almost $129 million to help offset school construction costs.

Lawmakers wanted the bond debt money taken out so it could be lumped in with the rest of the state construction budget later during the session.

Health cost Rx

A ray of hope for controlling costs

Alaskans pride themselves on being first in many national comparisons, but one top ranking is a first-class pain in the pocketbook. Hands down, Alaska has the highest medical costs in the country.

According to statistics from the Anchorage planning department, the city's 1989 medical cost index was 28 percent higher than Boston, the highest Outside city cited. Anchorage topped New York by 35 percent and Los Angeles by 46 percent. And within Alaska, Anchorage is a low-budget location. Costs in Fairbanks, Ketchikan and Juneau are even higher.

Fortunately, a large number of Alaskans may soon enjoy at least a small measure of relief from these high costs. The giant health insurance firm Blue Cross is starting to use its clout to hold down doctors' fees. The insurer has persuaded some 22 percent of Alaska's eligible doctors to charge only what Blue Cross considers reasonable. Some doctors have been charging more, leaving Blue Cross patients to pay whatever exceeds the firm's cost cap, on top of the usual co-payments and deductibles.

Blue Cross' arrangement is good news for the 80,000 Alaskans it insures. The deal should exert powerful pressure to limit ever-increasing doctors' fees. Unlike some cost-control measures that force patients to use certain doctors, however, Blue Cross clients remain free to see the physician of their choice.

Alaska doctors are less enamored of the change — even though the arrangement is common in the Lower 48. For them, health insurance becomes more of a mixed blessing. Until now, insurance has enabled them to charge prices with little regard for how they affect most patients. Now, they're being asked to make some price concessions in return for the good financial fortune insurance allows them to enjoy.

Sounds like a fair trade to us.

LIMITS: 94 doctors agree to Blue Cross health insurance plan to set rates

Continued from Page A-1

ka doctors have agreed to work for fees set by private insurers, according to state and industry officials. Such cost-containment efforts are common in the Lower 48, but Alaska doctors have often viewed these programs with distrust and outright hostility.

So far, Blue Cross has signed up about 22 percent of Alaska doctors who had enough malpractice insurance to meet insurer requirements. In Anchorage, the program includes 50 doctors, about 14 percent of qualifying area physicians. The Anchorage network includes more than 15 family practitioners, nine psychiatrists, two obstetrician-gynecologists and six podiatrists.

Blue Cross officials hope the network will rapidly expand, but some doctors — even some who joined the program — are angered by what they view as Blue Cross's strong-arm recruiting tactics.

Blue Cross told doctors that if they declined to join the network, the insurer would stop sending them direct payment of medical bills, according to a copy of an Oct. 12 letter Blue Cross sent to state doctors. Instead the check would be made out to both the doctor and the subscriber, then sent to the subscriber, who would be responsible for forwarding it on to the doctor. Doctors fear that would slow an already cumbersome collection process.

But as long as the subscriber approves direct payment to the doctor, Blue Cross appears to have no legal authority to deny those payments, according to Dave Walsh, director of the state Division of Insurance.

"We have asked Blue Cross for additional information as to why they think they ought to do this," Walsh said.

Ford, in an interview Friday, said the company has decided to hold off on imposing the new payment system. "We decided the time was not right."

In the meantime, some doctors say they will fight the Blue Cross program.

"We don't appreciate having someone come in with heavy-handed scare tactics," said Doug G. Smith, an orthopedic surgeon who refused to join the program. "Once they get a hold, they'll ratchet down, or try to freeze rates. These programs have happened all the time in the Lower 48 but we're a little more independent up here and resistant to being herded around."

And one doctor who joined the program isn't sure how long he'll stay in.

"They agreed upon our fee schedule and did not try to discount us, but I do not have any illusions about their long-term objective," said Bruce Klessling, an Anchorage family practitioner. "We will withdraw from the program if they don't allow for the normal cost increases we have to incur to keep our office open."

Blue Cross officials say about 75 percent of Alaska's doctors charge acceptable rates. The rest charge anywhere from 5 percent to roughly 20 percent more.

Doctors who participate in the network will be free to raise their rates. But if those increases exceed what Blue Cross considers reasonable, they may be kicked out of the network, Rohlman said.

94 doctors agree to limit fees to what Blue Cross says is fair

By HAL BERNTON
Daily News reporter

Blue Cross, the giant health insurer, has created a network of 94 Alaska doctors who will limit subscriber fees to amounts approved by the company.

Officials of Blue Cross view the network as a "milestone agreement." They say it can put an end to their subscribers' getting stuck with surprise bills because doctors charge more than the insurer allows for a given service.

Alaska subscribers will have no obligation to use doctors on the insurer's new list. But if they do, they may save on medical bills.

"It will be a consumer choice," said Dave Ford, a Blue Cross vice president. "If he goes to the doctor who has signed up, then he will have the protection."

Once a deductible is met, Blue Cross policies typically pay from 80 percent to 100 percent of a subscriber's medical bills, as long as the doctor's fee doesn't exceed rates Blue Cross considers reasonable. But in recent years, doctors' fees have risen faster than the Blue Cross rates, saddling subscribers with a growing share of medical costs.

"As carriers have reduced their payments to doctors, doctors, in many instances, have simply recouped that from the consumer," said Eric Rohlman, a Blue Cross vice president. "This (network) addresses that problem."

Seattle-based Blue Cross of Washington and Alaska is one of the state's largest insurers, with policies covering nearly 80,000 Alaskans.

"I hope it works," said Bill Purrington, an Anchorage health insurance broker. "The problem is there's been such a huge increase in the cost of health care in the last 10 years."

The new network appears to mark the first time Alas-

Please see Back Page, LIMITS

- Spending for employer-based health insurance premiums increased 164% in the past decade, from $66 billion to $174 billion.

- An increasing portion of every family's budget is going to pay for health care as shown by the 157% rise in out-of-pocket spending from 1980 to 1990 (excluding the cost of employee premium contributions), from $63 billion to $162 billion.

- State government spending for Medicaid increased 156% between 1980 and 1990, from $10.7 billion to $27.4 billion.

- Massachusetts ($3,031), California ($2,894), New York ($2,818), Nevada ($2,757) and Rhode Island ($2,707) have the highest levels of per capita health spending in 1990. South Carolina ($1,689), Idaho ($1,726), Mississippi ($1,751), Wyoming ($1,756) and Utah ($1,784) have the lowest levels of per capita health spending in 1990.

- In Arizona (160.7%), Alaska (157.2%), Florida (152.3%), New Mexico (152.2%) and Maine (150%) per capita health expenditures increased at least 150% from 1980 to 1990.

Although all states experienced health care spending increases well above the consumer price index, there is high variation in spending among states. This variation is generally explained by the following kinds of factors: demographics (especially the proportion of a state's population that is either women of child-bearing age, or older men and women); the numbers of uninsured persons in a state (uninsured persons consume about one-third less health care than insured persons); the environmental conditions in a state (these can cause deteriorating health); the number and type of health care facilities and providers in a state (this will cause individuals to travel into or out of a state to get health care); the practice patterns of providers in state (the use of hospital inpatient care and surgical procedures varies greatly among geographic areas), and historical levels of spending in a state.

THE 1980s: DECLINING ACCESS

Dramatic increases in health care spending have not resulted in more Americans having access to better care. Despite the high price tag of our health care system, millions of Americans are without any health insurance, public or private. The number of uninsured Americans has grown during the 1980s.[2] State-by-state data on

numbers of uninsured persons show variation in the growth or decline of uninsured persons. Reasons for this state variation are diverse. In some instances, an aging population means that a growing portion of the state's residents have become eligible for Medicare. The composition of a state's economy can also influence the number of uninsured, as particular industries are more or less likely to offer employer coverage. Other factors, such as a state's Medicaid eligibility level, income levels, and economic well-being, also influence the number of uninsured.

- Over 13% of Americans, almost 32 million, were uninsured on any given day in 1988.

- The number of uninsured Americans has increased 30%, from 24.5 million persons in 1980 to 31.8 million persons in 1988 (the most recent year for which published statistics are available).

- 28% of U.S. residents, 63 million people, lacked health insurance for at least a month during the 28 month period ending May 1987, according to the Census Bureau.

- New Mexico (22.8%), Arkansas (2[illegible]8%), Texas (21.4%), Florida (18.4%), Oklahoma (18%), Mississippi (17.9%), Arizona (17.7%), Nevada (17.3%), Louisiana (17.3%) and California (17.2%) had the highest percentages of uninsured persons as of 1988.

- Nevada (86.7%), Kentucky (68.9%), Florida (62%), Texas (59.5%) California (57.7%), Alaska (57.2%), and Oregon (52.6%) all saw the number of uninsured persons in the state increase by more than 50% from 1980 to 1988.

Who are these uninsured persons? Young adults are the most likely to lack insurance. Twenty-seven percent of persons 18-24 lack insurance.[3] These are individuals who are likely to be in entry-level jobs and to be too old to qualify as dependents of other family members. Twenty-eight percent of the uninsured are children. Forty-two percent of the nation's uninsured live in the South.

Five out of eight uninsured persons are employed or are dependents of employed persons. Just over half of uninsured workers are employed by firms with less than 25 employees.

Why has the number of uninsured persons increased? One of the major reasons is a reduction in the number of individuals and their families covered by employment-

related insurance. In recent years there has been an increase in the number of persons employed in businesses that don't offer health insurance, or offer inadequate or unaffordable insurance.[4]

Health care inflation and competition in the small group insurance market have combined to make health insurance increasingly unaffordable for small businesses, their employees and their dependents. In order to hold premiums and benefit payments down and attract customers, insurers have been engaging in a number of practices that have had the effect of increasing the number of uninsured, or underinsured persons, who work in small businesses or are dependents of these workers. These practices include: denying coverage to certain, high-risk individuals within small groups; denying coverage to entire small groups considered to be high risk; and denying coverage for pre-existing conditions, such as diabetes or asthma.[5]

Analysis of the nonelderly population shows that an additional 13 percent of the nonelderly, 20 million persons, are underinsured -- at risk of spending more than 10 percent of their income on health care.[6] Since the elderly spend an estimated 18% of their incomes on health care on average, including the elderly would add many millions to the number of underinsured.[7]

When small businesses do get insurance, the insurance companies establish the premiums based on "experience-rating" -- the practice of basing premiums solely on the experience of the specific group, rather than establishing a "community-rating" for the larger community as a whole. Premiums set on the basis of experience-rating, rather than community rating, are more unstable and rise quickly.

One of the ways employers have responded to escalating premiums is by charging employees a greater share of the premiums. The percentage of employees paying $100 or more a month for family health insurance rose from 5 percent in 1986 to 16 percent in 1988. Average employee payments for individual coverage rose 32 percent between 1988 and 1989.[8] These increased cost demands on employees result in employees, especially low-wage employees, declining health insurance because it is unaffordable.

A vicious cycle of higher costs and declining access was set in motion during the 1980s. Uninsured persons often forego cost effective preventive care and, when they seek care, do so at costly hospital emergency rooms instead of physicians' offices. To cover the cost of treating the uninsured, hospitals raise their rates to privately-insured patients and insurance premiums go up. Cost-shifting due to uncompensated care and the lack of insurance offered by some employers accounts for approximately

27% of employer health care costs. In the face of rising premiums, more employers chose not to offer coverage at all, ultimately increasing the costs of coverage for those who remain insured.

THE 1990s: A $1.5 TRILLION ANNUAL HEALTH CARE BILL

The huge increase in outlays for health care during the 1980s pales in comparison to what this country will spend by the year 2000 should the status quo continue with our health care system. Absent fundamental change, consumers, employers and governments can expect a $1.47 trillion annual health care bill by the year 2000.

- By 2000, health care spending will rise to $5,515 per person, an increase of 443% from 1980.
- From 1980 to 2000, overall health care spending will be six and one-half times higher.
- Employers and employees will have to absorb a 529% increase from 1980 to 2000, from $66 billion to $412 billion for employer-based health coverage.
- Families will experience a 512% increase in out-of-pocket health care costs between 1980 and 2000, from $63 billion to $386 billion, not counting the employee share of health insurance premiums.
- By the year 2000, state governments can expect to see a 480% increase in Medicaid expenditures, from 1980 spending levels of $11 billion to $62 billion in 2000.
- In the 1980-2000 period, per capita spending will increase fastest in Arizona (493%), Alaska (485%), New Mexico (473.9%), Florida (473.7%), Maine (468.5%), North Dakota (467.6%) and Washington (466%).

Clearly, health care spending of the magnitude described above presents a crisis of affordability for every family, for the American economy, and for government. The data in this report illustrates the need for fundamental reform of our health care system. Unless the United States takes bold action now, all Americans will suffer a declining standard of health care and a declining standard of living as a result of the increasing burden of health care costs.

ENDNOTES

1. Katherine R. Levit, Mark S. Freeland and Daniel Waldo, "Health spending and ability to pay: Business, individuals and government," **Health Care Financing Review**, Spring 1989, p. 9.

2. The estimates in this report are based on the most recent data from the Census Bureau. These estimates, 31.8 million persons nationally, are lower than previous estimates of approximately 37 million uninsured persons because the Census Bureau now asks if uninsured persons are covered by insurance form someone not living in the household, e.g. a noncustodial parent.

3. Unless otherwise noted, data are the results of analysis by Lewin/ICF, Inc.

4. See **A Call for Action**, The Pepper Commission, The U.S. Bipartisan Commission on Comprehensive Health Care, Final Report, September 1990, p. 23-6.

5. These practices are described in "The Crisis in Health Insurance," **Consumer Reports**, August 1990, p. 533-7.

6. Jack Needleman, Judith Arnold, John Sheils and Lawrence S. Lewin, "The Health Care Financing System and the Uninsured," submitted to the Office of Research, Health Care Financing Administration, Department of Health and Human Services, April 4, 1990. The Joint Economic Committee estimates the number of the underinsured at 70 million. See **Medical Alert**, a staff report of the Subcommittee on Education and Health of the Joint Economic Committee, October 1989.

7. Committee Analysis, Select Committee on Aging, U.S. House of Representatives, October 26, 1988.

8. United States Department of Labor, Bureau of Labor Statistics, **News**, (Washington, D.C., USDL 90-160, March 30, 1990).

Table 1

PER CAPITA HEALTH SPENDING
1980 - 2000

STATE	1980	1990	% Change 1980-1990	% Change Rank	2000	% Change 1980-2000
ALABAMA	924	2,286	147.4%	13	5,201	462.8%
ALASKA	921	2,367	157.2%	2	5,390	485.5%
ARIZONA	848	2,211	160.7%	1	5,031	493.0%
ARKANSAS	844	1,944	130.4%	46	4,423	424.1%
CALIFORNIA	1,186	2,894	143.9%	17	6,584	454.9%
COLORADO	996	2,415	142.5%	20	5,496	451.8%
CONNECTICUT	1,148	2,699	135.2%	39	6,136	434.7%
DELAWARE	960	2,268	136.3%	36	5,160	437.6%
DISTRICT OF COLUMBIA	1,241	2,586	108.4%	51	5,882	374.1%
FLORIDA	962	2,427	152.3%	3	5,520	473.7%
GEORGIA	883	2,072	134.7%	40	4,714	434.0%
HAWAII	993	2,469	148.5%	9	5,619	465.6%
IDAHO	708	1,726	143.9%	18	3,928	455.0%
ILLINOIS	1,093	2,619	139.6%	29	5,953	444.6%
INDIANA	919	2,201	139.4%	30	5,004	444.3%
IOWA	993	2,351	136.6%	35	5,343	437.9%
KANSAS	1,057	2,548	141.1%	22	5,792	448.0%
KENTUCKY	806	1,875	132.5%	43	4,266	429.1%
LOUISIANA	940	2,185	132.4%	44	4,972	428.9%
MAINE	870	2,175	150.0%	5	4,945	468.5%
MARYLAND	1,041	2,436	134.1%	42	5,541	432.5%
MASSACHUSETTS	1,284	3,031	136.0%	38	6,890	436.5%
MICHIGAN	1,097	2,569	134.3%	41	5,840	432.5%
MINNESOTA	1,110	2,480	123.4%	49	5,641	408.1%
MISSISSIPPI	759	1,751	130.6%	45	3,984	424.6%
MISSOURI	1,033	2,568	148.6%	8	5,837	465.1%
MONTANA	859	2,059	139.7%	27	4,686	445.6%
NEBRASKA	1,016	2,452	141.4%	21	5,576	448.8%
NEVADA	1,109	2,757	148.5%	10	6,272	465.3%
NEW HAMPSHIRE	813	1,981	143.6%	19	4,505	453.8%
NEW JERSEY	930	2,224	139.2%	32	5,056	443.8%
NEW MEXICO	711	1,792	152.2%	4	4,078	473.9%
NEW YORK	1,257	2,818	124.2%	48	6,408	409.8%
NORTH CAROLINA	773	1,833	137.1%	34	4,170	439.5%
NORTH DAKOTA	1,066	2,661	149.7%	6	6,051	467.6%
OHIO	1,039	2,493	140.0%	26	5,667	445.6%
OKLAHOMA	906	2,139	136.2%	37	4,867	437.3%
OREGON	940	2,312	146.0%	15	5,260	459.8%
PENNSYLVANIA	1,021	2,536	148.3%	11	5,763	464.2%
RHODE ISLAND	1,184	2,707	128.6%	47	6,153	419.7%
SOUTH CAROLINA	706	1,689	139.2%	31	3,842	444.4%
SOUTH DAKOTA	952	2,322	144.0%	16	5,278	454.7%
TENNESSEE	952	2,262	137.7%	33	5,145	440.8%
TEXAS	915	2,192	139.7%	28	4,987	445.3%
UTAH	741	1,784	140.8%	23	4,062	448.0%
VERMONT	815	1,956	140.1%	25	4,448	445.9%
VIRGINIA	863	2,076	140.5%	24	4,724	447.2%
WASHINGTON	929	2,311	148.7%	7	5,258	466.0%
WEST VIRGINIA	843	2,088	147.6%	12	4,752	463.4%
WISCONSIN	1,097	2,449	123.2%	50	5,567	407.3%
WYOMING	714	1,756	146.1%	14	3,998	460.0%
TOTAL	$1,016	$2,425	138.7%		$5,515	442.8%

SOURCE: Lewin/ICF estimates

Table 2

TOTAL HEALTH SPENDING
1980 - 2000
(in thousands of dollars)

STATE	1980	1990	% Change 1980-1990	Rank	2000	% Change 1980-2000
ALABAMA	3,598,838	9,522,402	164.6%	21	22,667,039	529.8%
ALASKA	370,082	1,242,929	235.9%	3	3,228,864	772.5%
ARIZONA	2,305,619	8,105,810	251.6%	1	23,306,832	910.9%
ARKANSAS	1,929,340	4,706,750	144.0%	37	11,097,073	475.2%
CALIFORNIA	28,080,581	84,754,469	201.8%	5	223,595,772	696.3%
COLORADO	2,878,913	8,045,268	179.5%	14	18,819,641	553.7%
CONNECTICUT	3,566,669	8,815,808	147.2%	32	20,996,403	488.7%
DELAWARE	570,197	1,547,100	171.3%	17	4,138,620	625.8%
DISTRICT OF COLUMBIA	791,551	1,559,131	97.0%	51	3,500,076	342.2%
FLORIDA	9,376,859	31,411,102	235.0%	4	90,060,126	860.5%
GEORGIA	4,822,254	13,669,245	183.5%	12	37,733,919	682.5%
HAWAII	958,674	2,797,343	191.8%	8	7,653,634	698.4%
IDAHO	668,050	1,748,435	161.7%	24	3,959,138	492.6%
ILLINOIS	12,489,958	30,597,883	145.0%	35	69,779,254	458.7%
INDIANA	5,047,369	12,362,662	144.9%	36	28,504,460	464.7%
IOWA	2,894,898	6,615,476	128.5%	49	13,620,316	370.5%
KANSAS	2,498,938	6,426,779	157.2%	26	14,677,643	487.4%
KENTUCKY	2,951,766	7,021,825	137.9%	45	15,737,895	433.2%
LOUISIANA	3,954,402	9,545,115	141.4%	42	20,590,574	420.7%
MAINE	978,536	2,687,926	174.7%	15	6,645,638	579.1%
MARYLAND	4,388,016	11,627,792	165.0%	20	31,074,629	608.2%
MASSACHUSETTS	7,367,870	17,947,477	143.6%	38	42,436,773	476.0%
MICHIGAN	10,158,071	23,874,781	135.0%	46	54,691,321	438.4%
MINNESOTA	4,525,259	10,857,061	139.9%	44	25,755,773	469.2%
MISSISSIPPI	1,914,580	4,638,528	142.3%	41	11,044,767	476.9%
MISSOURI	5,079,283	13,373,361	163.3%	23	31,946,064	528.9%
MONTANA	676,015	1,641,223	142.8%	39	3,486,657	415.8%
NEBRASKA	1,595,143	3,933,640	146.6%	33	8,580,707	437.9%
NEVADA	887,542	3,115,213	251.0%	2	8,837,119	895.7%
NEW HAMPSHIRE	749,188	2,258,658	201.5%	6	6,351,711	747.8%
NEW JERSEY	6,848,103	17,368,763	153.6%	27	42,383,428	518.9%
NEW MEXICO	925,932	2,757,688	197.8%	7	7,076,082	664.2%
NEW YORK	22,066,936	50,354,750	128.2%	50	115,121,894	421.7%
NORTH CAROLINA	4,546,873	12,259,381	169.6%	18	32,183,511	607.8%
NORTH DAKOTA	696,115	1,751,185	151.6%	30	3,606,280	418.1%
OHIO	11,215,407	27,193,403	142.5%	40	61,941,308	452.3%
OKLAHOMA	2,740,188	6,824,669	149.1%	31	14,232,334	419.4%
OREGON	2,474,037	6,523,595	163.7%	22	15,269,405	517.2%
PENNSYLVANIA	12,117,790	30,541,650	152.0%	29	69,555,852	474.0%
RHODE ISLAND	1,121,337	2,701,187	140.9%	43	6,448,659	475.1%
SOUTH CAROLINA	2,203,405	6,011,186	172.8%	16	15,222,478	590.9%
SOUTH DAKOTA	657,535	1,662,251	152.8%	28	3,773,731	473.9%
TENNESSEE	4,368,396	11,328,956	159.3%	25	27,908,735	538.9%
TEXAS	13,012,429	37,380,724	187.3%	10	88,910,873	583.3%
UTAH	1,082,735	3,085,385	185.0%	11	7,493,526	592.1%
VERMONT	416,395	1,117,014	168.3%	19	2,753,403	561.2%
VIRGINIA	4,615,580	12,931,845	180.2%	13	34,364,026	644.5%
WASHINGTON	3,838,548	11,084,596	188.8%	9	27,295,859	611.1%
WEST VIRGINIA	1,644,557	3,846,712	133.9%	47	7,844,814	377.0%
WISCONSIN	5,164,568	11,980,357	132.0%	48	26,967,967	422.2%
WYOMING	335,414	821,858	145.0%	34	1,634,546	387.3%
TOTAL	$230,166,741	$605,978,347	163.3%		$1,476,507,197	541.5%

SOURCE: Levin/ICF estimates

Table 3a

ESTIMATED SOURCES OF PAYMENT FOR PERSONAL HEALTH EXPENDITURES IN THE YEAR 1980 a/
(Dollars in thousands)

STATE	OUT OF POCKET b/	EMPLOYER SPONSORED	NON GROUP	OTHER PRIVATE	MEDICAID STATE	MEDICAID FEDERAL	MEDICARE	OTHER PUBLIC	TOTAL	PER CAPITA COST
ALABAMA	1,137,579	756,469	186,631	44,044	77,669	193,143	551,719	651,587	3,598,838	924
ALASKA	88,948	121,467	7,286	6,155	13,720	13,720	17,773	101,013	370,082	921
ARIZONA	582,995	698,587	72,743	30,635	NA	NA	328,804	585,855	2,305,619	848
ARKANSAS	582,892	369,379	86,083	23,012	65,441	175,772	300,720	325,184	1,929,340	844
CALIFORNIA	6,111,415	7,281,598	710,178	370,271	1,401,953	1,401,953	4,164,002	6,639,211	28,080,581	1,100
COLORADO	695,272	933,532	74,085	43,390	87,470	99,272	302,454	642,838	2,878,913	996
CONNECTICUT	1,026,949	1,228,813	238,910	43,629	179,702	179,702	611,034	57,729	3,566,669	1,148
DELAWARE	168,160	130,750	28,466	5,787	23,279	23,279	87,529	99,949	570,197	960
DISTRICT OF COLUMBIA	168,707	123,705	20,275	6,661	86,588	86,588	148,818	142,410	791,551	1,241
FLORIDA	2,814,989	1,778,037	476,882	86,060	185,429	237,458	2,153,010	1,051,597	9,378,859	962
GEORGIA	1,499,191	1,132,191	233,268	54,378	157,967	317,264	614,894	813,100	4,822,254	883
HAWAII	217,089	277,774	24,639	12,659	49,435	49,435	92,413	234,429	958,674	993
IDAHO	157,700	192,082	18,680	9,178	18,331	35,112	83,920	172,443	888,050	708
ILLINOIS	3,400,015	4,201,372	906,180	222,739	612,487	612,487	2,339,686	194,382	12,489,958	1,093
INDIANA	1,497,890	1,805,812	411,938	97,491	155,513	208,516	754,790	115,418	5,047,369	919
IOWA	817,145	979,140	238,551	51,420	102,750	133,038	466,426	85,821	2,894,898	993
KANSAS	674,088	796,112	204,462	42,970	88,309	111,000	443,405	130,491	2,498,938	1,057
KENTUCKY	945,732	738,292	181,140	31,508	87,004	208,798	397,782	373,522	2,951,788	800
LOUISIANA	1,198,552	880,116	196,340	40,451	133,052	293,670	470,671	741,550	3,954,402	940
MAINE	284,843	280,438	77,439	13,382	41,417	93,826	179,001	8,389	978,536	870
MARYLAND	1,286,977	1,149,042	211,012	48,508	164,234	164,234	698,873	667,138	4,388,018	1,041
MASSACHUSETTS	1,961,518	2,207,911	437,648	88,910	500,501	538,607	1,529,777	104,000	7,367,870	1,284
MICHIGAN	2,648,028	3,441,020	718,157	159,462	550,719	550,719	1,771,878	317,690	10,158,071	1,097
MINNESOTA	1,243,101	1,498,322	361,196	63,258	269,169	337,814	704,635	27,881	4,525,259	1,110
MISSISSIPPI	619,332	410,989	0	23,320	46,684	168,171	281,274	262,078	1,914,580	759
MISSOURI	1,402,558	1,652,437	436,857	98,288	120,224	183,065	1,006,024	99,831	5,079,283	1,033
MONTANA	158,707	182,422	19,008	9,501	22,871	41,158	73,442	168,847	676,015	859
NEBRASKA	469,733	532,375	134,464	30,893	47,309	64,430	260,572	55,207	1,595,143	1,016
NEVADA	202,680	261,305	22,759	12,294	23,073	23,073	112,798	229,561	887,542	1,109
NEW HAMPSHIRE	227,069	280,811	53,749	9,806	28,738	45,157	107,870	16,078	749,188	813
NEW JERSEY	1,907,217	2,381,168	458,158	85,935	388,438	388,438	1,146,073	92,675	6,848,103	930
NEW MEXICO	228,563	248,079	25,581	14,431	22,378	49,875	91,184	247,833	925,032	711
NEW YORK	5,502,085	6,045,460	1,304,282	248,347	2,334,327	2,334,327	4,012,129	285,980	22,066,936	1,257
NORTH CAROLINA	1,443,006	1,108,169	227,200	52,418	133,398	276,833	578,692	729,155	4,548,873	773
NORTH DAKOTA	199,350	223,808	59,960	13,989	18,626	29,670	120,945	29,759	696,115	1,066
OHIO	3,218,538	4,009,617	854,293	190,723	373,505	458,355	1,818,967	191,410	11,215,407	1,039
OKLAHOMA	840,211	581,953	139,726	28,583	89,177	173,587	433,308	443,842	2,740,188	906
OREGON	550,453	705,573	68,503	33,498	81,525	102,339	319,288	604,859	2,474,037	940
PENNSYLVANIA	3,486,617	3,967,694	860,052	181,365	487,881	589,683	2,385,775	168,722	12,117,790	1,021
RHODE ISLAND	291,138	358,994	72,062	12,411	89,551	95,300	204,278	17,604	1,121,337	1,184
SOUTH CAROLINA	883,690	437,942	95,613	25,117	77,334	189,059	230,513	484,138	2,203,405	706
SOUTH DAKOTA	202,638	199,249	58,778	15,537	17,015	38,808	99,529	25,381	657,535	952
TENNESSEE	1,377,091	1,038,889	226,380	45,904	119,232	270,798	629,940	662,156	4,368,396	952
TEXAS	4,244,744	3,070,355	632,707	159,455	418,882	588,238	1,870,299	2,018,750	13,012,429	915
UTAH	261,640	347,150	28,870	14,937	26,122	55,687	78,516	268,814	1,082,735	741
VERMONT	119,592	133,426	29,474	5,360	18,259	41,687	63,594	4,002	416,395	815
VIRGINIA	1,402,784	1,123,900	234,835	46,855	160,351	208,611	593,161	845,275	4,615,580	863
WASHINGTON	852,112	1,071,822	99,177	52,104	169,065	169,065	400,188	1,025,015	3,838,548	929
WEST VIRGINIA	551,141	396,291	89,965	18,220	34,764	71,711	252,528	229,937	1,644,557	843
WISCONSIN	1,349,249	1,765,318	391,282	78,756	298,468	408,568	822,555	52,372	5,164,568	1,097
WYOMING	78,091	108,783	9,364	4,878	7,400	7,400	32,597	87,905	335,414	714
TOTAL	$63,149,984	$65,626,952	$12,946,686	$3,123,818	$10,697,198	$13,147,308	$37,248,701	$24,228,100	$230,166,741	$1,016

a/ Includes personal health expenditures and administrative costs
b/ Does not include employee share of premiums for employer sponsored insurance. These payments are included in the 'Employer Sponsored' column.

SOURCE: Lewin/ICF estimates

Table 3b

ESTIMATED SOURCES OF PAYMENT FOR PERSONAL HEALTH EXPENDITURES IN THE YEAR 1990 a/

(Dollars in thousands)

STATE	OUT OF POCKET b/	EMPLOYER-SPONSORED	NON-GROUP	OTHER PRIVATE	MEDICAID STATE	MEDICAID FEDERAL	MEDICARE	OTHER PUBLIC	TOTAL	PER CAPITA COST
ALABAMA	2,814,760	2,012,389	416,532	101,765	163,013	425,482	1,932,643	1,655,817	9,522,402	2,286
ALASKA	329,687	427,212	29,864	24,057	60,300	60,360	231,034	1,242,929	2,307	
ARIZONA	1,972,363	2,379,617	240,868	137,174	222,869	367,652	1,367,192	1,416,276	8,105,810	2,211
ARKANSAS	1,449,372	892,449	108,921	57,525	103,707	292,630	990,607	721,250	4,706,750	1,944
CALIFORNIA	20,379,570	25,840,378	2,335,173	1,471,282	3,574,078	3,574,078	14,653,732	12,926,177	84,754,469	2,694
COLORADO	2,097,807	2,670,571	283,730	139,260	304,439	304,439	969,270	1,295,747	8,045,268	2,415
CONNECTICUT	2,278,555	3,303,221	412,925	92,600	514,939	514,939	1,578,600	89,760	8,815,608	2,680
DELAWARE	454,368	365,183	70,128	14,539	66,056	66,056	291,765	218,999	1,547,100	2,268
DISTRICT OF COLUMBIA	318,981	240,188	50,202	11,101	182,516	182,516	344,880	228,817	1,559,131	2,586
FLORIDA	9,375,203	6,218,478	1,398,700	322,380	878,583	1,125,484	8,083,607	4,010,566	31,411,102	2,427
GEORGIA	3,964,313	3,041,590	570,838	124,588	489,424	852,179	2,224,539	2,301,978	13,669,245	2,072
HAWAII	697,628	966,101	96,984		102,084	108,251	295,352	484,921	2,797,343	2,469
IDAHO	440,614	525,464	53,198		46,179	109,063	238,416	305,267	1,748,435	1,726
ILLINOIS	8,208,698	10,348,102	1,808,653		1,231,633	1,231,633	6,719,023	519,434	30,597,883	2,619
INDIANA	3,382,637	3,988,394	810,531	2[illegible]	481,451	813,468	2,204,733	447,133	12,382,682	2,201
IOWA	1,634,062	2,210,041	448,818	115,314	247,022	355,295	1,345,939	49,288	6,815,478	2,351
KANSAS	1,772,719	2,218,335	415,790	100,840	220,378	220,379	1,287,846	190,689	6,426,779	2,548
KENTUCKY	1,947,743	1,418,857	270,882	67,343	254,106	599,458	1,233,765	1,229,672	7,021,825	1,875
LOUISIANA	2,547,782	1,822,033	352,995	98,280	345,188	608,634	1,741,608	2,030,597	9,545,115	2,185
MAINE	689,728	882,374	149,985	29,998	128,835	284,450	480,731	62,124	2,687,926	2,175
MARYLAND	3,169,204	2,674,955	404,581	99,774	541,404	541,404	2,176,431	1,958,060	11,627,792	2,436
MASSACHUSETTS	4,443,792	6,173,324	740,668	185,223	1,239,474	1,239,474	3,627,313	280,008	17,947,477	3,031
MICHIGAN	6,005,418	7,977,976	1,391,031	372,097	1,001,668	1,318,780	5,159,240	570,371	23,874,781	2,569
MINNESOTA	3,032,352	4,004,588	872,128	180,038	859,001	756,225	1,408,019	144,050	10,857,081	2,480
MISSISSIPPI	1,319,923	849,242	177,033	51,154	111,948	408,809	827,081	895,339	4,638,528	1,751
MISSOURI	3,643,381	4,398,101	845,312	224,843	355,821	547,736	3,055,506	302,658	13,373,381	2,568
MONTANA	383,483	438,540	46,226	25,273	57,205	112,946	241,279	336,263	1,641,223	2,059
NEBRASKA	1,132,690	1,361,739	285,541	70,028	128,525	171,137	668,770	115,011	3,933,640	2,452
NEVADA	807,751	1,033,508	98,602	58,825	71,592	71,592	488,338	487,008	3,115,213	2,757
NEW HAMPSHIRE	681,915	799,660	107,811	33,381	97,629	118,939	370,959	48,364	2,258,658	1,981
NEW JERSEY	4,545,827	6,011,019	741,459	200,122	1,042,327	1,042,327	3,501,694	283,989	17,368,763	2,224
NEW MEXICO	705,691	728,428	82,220	49,898	87,401	193,993	344,985	564,873	2,757,688	1,792
NEW YORK	11,740,681	14,348,785	2,020,635	569,890	5,288,300	5,288,300	10,274,890	625,078	50,354,750	2,818
NORTH CAROLINA	3,808,151	2,855,434	587,968	130,692	378,718	850,088	1,957,921	1,712,411	12,259,381	1,833
NORTH DAKOTA	442,609	540,478	111,059	28,698	66,987	108,809	350,419	85,946	1,751,185	2,661
OHIO	6,966,974	8,754,357	1,645,671	429,028	1,244,280	1,730,605	5,855,967	557,522	27,193,403	2,493
OKLAHOMA	2,028,546	1,379,606	286,712	78,027	294,947	400,683	1,278,850	1,081,298	6,824,669	2,139
OREGON	1,657,140	2,007,536	207,895	110,855	171,045	274,849	986,819	1,106,956	6,523,595	2,312
PENNSYLVANIA	7,993,087	9,580,155	1,597,413	385,577	1,248,011	1,835,583	7,748,007	375,638	30,541,650	2,536
RHODE ISLAND	704,349	853,513	135,007	30,385	173,508	223,809	531,829	48,987	2,701,187	2,707
SOUTH CAROLINA	1,809,718	1,401,609	269,561	63,523	100,020	426,154	889,166	891,426	6,011,186	1,689
SOUTH DAKOTA	469,323	532,487	106,769	30,642	51,119	107,733	320,442	43,718	1,662,251	2,322
TENNESSEE	3,284,049	2,365,882	493,952	110,504	341,451	804,357	2,185,966	1,742,697	11,328,958	2,282
TEXAS	11,992,115	8,477,215	1,555,824	465,330	1,145,085	1,320,848	6,584,259	5,840,450	37,380,724	2,192
UTAH	777,209	1,085,590	80,021	51,752	65,019	172,449	318,184	525,161	3,085,385	1,784
VERMONT	323,043	381,043	64,238	13,292	47,488	96,873	172,612	18,629	1,117,014	1,956
VIRGINIA	3,886,531	3,123,031	569,665	128,546	469,473	532,390	2,061,361	2,160,846	12,931,845	2,076
WASHINGTON	2,613,828	3,348,969	321,777	186,957	587,419	588,783	1,550,885	1,918,178	11,084,598	2,311
WEST VIRGINIA	1,098,107	714,758	170,355	34,438	103,791	280,771	720,922	743,573	3,846,712	2,088
WISCONSIN	3,112,443	4,068,108	754,732	166,823	526,448	713,420	2,256,989	378,584	11,980,357	2,449
WYOMING	206,156	269,578	26,328	13,994	19,865	19,865	107,370	158,705	821,856	1,758
TOTAL	$161,818,653	$174,125,101	$27,063,851	$6,308,703	$27,397,885	$34,258,738	$118,277,024	$56,730,394	$805,978,347	$2,425

a/ Includes personal health expenditures and administrative costs.

b/ Does not include employee share of premiums for employer-sponsored insurance. These payments are included in the "Employer-Sponsored" column

SOURCE: Lewin/ICF estimates

Table 3c

ESTIMATED SOURCES OF PAYMENT FOR PERSONAL HEALTH EXPENDITURES IN THE YEAR 2000 a/

(Dollars in thousands)

STATE	OUT OF POCKET b/	EMPLOYER-SPONSORED	NON-GROUP	OTHER PRIVATE	MEDICAID: STATE	MEDICAID: FEDERAL	MEDICARE	OTHER PUBLIC	TOTAL	PER CAPITA COST
ALABAMA	6,587,653	4,708,531	676,603	267,806	367,825	980,063	5,375,234	3,424,954	22,667,039	5,201
ALASKA	865,699	1,121,008	78,581	71,054	152,806	152,806	250,751	536,159	3,228,864	5,390
ARIZONA	5,810,602	8,764,398	686,598	438,907	610,678	1,008,299	4,621,770	3,565,631	25,306,882	5,031
ARKANSAS	3,349,188	2,080,831	460,622	149,517	231,248	652,384	2,720,302	1,472,984	11,097,073	4,423
CALIFORNIA	53,007,530	66,844,841	8,086,483	4,304,439	8,982,640	8,982,640	45,912,680	29,714,318	223,595,772	6,584
COLORADO	4,091,263	6,222,417	616,198	365,225	684,360	684,360	2,685,710	2,670,108	18,819,641	5,496
CONNECTICUT	5,271,870	7,637,346	1,003,744	241,508	1,148,656	1,148,656	4,340,830	203,993	20,996,403	6,136
DELAWARE	1,195,017	959,790	184,820	43,011	107,503	107,503	611,917	509,052	4,130,620	5,160
DISTRICT OF COLUMBIA	704,046	529,771	111,169	27,784	388,391	388,391	804,558	445,985	3,500,076	5,882
FLORIDA	20,031,662	17,254,594	3,886,487	1,008,793	2,351,978	3,012,935	26,673,673	9,842,004	90,060,126	5,520
GEORGIA	10,652,590	8,320,611	1,565,419	383,629	1,281,755	2,513,120	7,237,055	5,569,541	37,733,819	4,714
HAWAII	1,910,550	2,643,972	266,159	147,929	269,540	280,542	961,238	1,173,704	7,653,634	6,619
IDAHO	993,703	1,184,244	120,221	71,628	104,758	237,141	636,985	608,459	3,959,138	3,928
ILLINOIS	18,024,960	22,707,029	3,975,387	1,315,734	2,607,418	2,607,418	17,533,255	1,008,052	69,779,254	5,953
INDIANA	7,587,956	8,940,608	1,035,468	576,081	1,041,239	1,759,298	5,877,353	666,461	28,504,460	5,004
IOWA	3,643,891	4,405,316	893,561	257,698	474,894	686,568	3,177,848	86,542	13,620,318	5,343
KANSAS	3,916,623	4,897,773	920,556	250,103	469,432	469,432	3,381,372	372,350	14,677,643	5,792
KENTUCKY	4,324,250	3,147,873	602,648	160,169	543,908	1,283,120	3,255,128	2,412,801	15,737,895	4,288
LOUISIANA	5,456,366	3,899,393	757,556	231,930	712,733	1,256,667	4,432,467	3,643,422	20,590,574	4,972
MAINE	1,663,097	2,126,142	362,405	81,089	299,039	661,265	1,320,211	132,350	6,645,638	4,945
MARYLAND	6,357,706	7,049,413	1,227,079	295,958	1,376,536	1,376,536	6,827,112	4,563,688	31,074,829	5,541
MASSACHUSETTS	10,176,490	14,127,420	1,718,516	502,868	2,736,599	2,736,599	9,871,559	566,719	42,436,773	6,890
MICHIGAN	13,452,128	17,623,526	3,081,357	925,109	2,135,251	2,606,316	13,553,224	1,114,322	54,691,321	5,640
MINNESOTA	7,051,420	9,305,816	1,566,223	470,911	1,478,030	1,695,420	3,891,005	296,049	25,755,773	5,841
MISSISSIPPI	3,116,442	2,003,742	418,660	135,852	254,833	920,041	2,320,879	1,868,319	11,044,767	3,984
MISSOURI	6,368,592	10,095,144	1,945,872	580,908	787,988	1,212,966	6,340,413	614,402	31,946,004	5,837
MONTANA	813,087	929,192	98,218	60,273	116,938	230,866	607,947	830,119	3,486,657	4,686
NEBRASKA	2,403,866	2,887,401	607,149	167,136	282,930	350,103	1,886,381	215,663	8,580,707	5,578
NEVADA	2,264,610	2,895,540	277,018	179,189	193,513	193,513	1,627,012	1,206,717	8,837,119	6,272
NEW HAMPSHIRE	1,867,766	2,188,757	295,910	102,842	257,810	314,084	1,207,467	117,076	6,351,711	4,505
NEW JERSEY	10,737,775	14,186,913	1,755,005	531,709	2,373,749	2,373,749	9,828,803	592,886	42,383,428	5,056
NEW MEXICO	1,814,472	1,871,107	211,785	144,264	216,800	480,760	1,053,827	1,283,288	7,076,082	4,078
NEW YORK	26,052,821	31,813,339	4,493,114	1,422,407	11,313,586	11,313,586	27,094,850	1,618,092	115,121,894	6,408
NORTH CAROLINA	9,678,126	7,405,800	1,477,120	381,519	947,619	2,127,070	6,036,653	3,927,803	32,183,511	4,170
NORTH DAKOTA	865,467	1,080,024	222,543	60,052	167,663	205,918	832,722	151,892	3,586,280	6,051
OHIO	15,316,195	19,232,288	3,625,387	1,060,889	2,637,207	3,667,115	15,298,854	1,083,233	61,941,308	5,667
OKLAHOMA	4,165,518	2,833,786	590,559	175,778	584,502	794,040	3,123,636	1,964,314	14,232,334	4,667
OREGON	3,848,838	4,657,015	483,608	289,452	384,153	814,885	2,722,582	2,271,082	15,269,405	5,260
PENNSYLVANIA	17,430,559	20,877,036	3,490,750	898,713	2,823,883	3,438,693	20,075,366	724,354	69,555,852	5,763
RHODE ISLAND	1,630,994	1,975,031	313,274	79,140	387,360	499,056	1,462,841	100,253	6,446,659	6,153
SOUTH CAROLINA	4,553,474	3,524,182	679,663	178,781	388,200	1,033,779	2,656,713	2,204,678	15,222,478	3,842
SOUTH DAKOTA	1,032,399	1,170,535	235,401	75,618	166,414	226,484	837,667	84,893	3,773,731	5,276
TENNESSEE	7,962,737	5,732,759	1,200,168	301,376	708,197	1,680,317	6,288,723	3,734,459	27,908,735	5,145
TEXAS	28,125,731	19,868,305	3,058,095	1,227,572	2,589,258	2,988,233	18,351,490	12,106,189	88,910,873	4,987
UTAH	1,889,913	2,682,268	194,991	141,549	152,431	404,292	819,416	1,128,663	7,493,526	4,082
VERMONT	777,694	916,691	154,985	35,992	110,215	224,378	493,830	39,637	2,753,403	4,448
VIRGINIA	10,235,657	8,219,198	1,503,410	380,799	1,192,047	1,351,801	6,451,550	5,029,568	34,364,028	4,724
WASHINGTON	6,496,052	8,197,810	790,328	520,941	1,340,650	1,344,072	4,540,641	4,155,168	27,295,859	5,258
WEST VIRGINIA	2,216,108	1,441,469	344,513	78,170	201,945	507,382	1,728,884	1,326,244	7,844,814	4,752
WISCONSIN	6,803,691	8,886,593	1,653,258	409,690	1,109,502	1,503,550	5,868,345	733,339	29,967,967	5,587
WYOMING	409,029	534,489	52,348	31,230	37,999	37,999	253,161	278,293	1,934,548	3,998
TOTAL	$385,931,868	$412,369,109	$63,755,912	$22,246,107	$62,147,543	$77,766,646	$328,079,858	$124,210,355	$1,476,507,197	$5,515

a/ Includes personal health expenditures and administrative costs.

b/ Does not include employee share of premiums for employer-sponsored insurance. These payments are included in the "Employer-Sponsored" column.

SOURCE: Lewin/ICF estimates

Table 4

ESTIMATED NUMBER OF UNINSURED PERSONS

STATE	1980 NUMBER a/	1980 % OF STATE POP	1980 RANK b/	1988 NUMBER c/	1988 % OF STATE POP	1988 RANK b/	PERCENT CHANGE
ALABAMA	560,052	14.4%	9	615,680	15.1%	15	9.9%
ALASKA	54,655	13.6%	11	85,903	15.8%	13	57.2%
ARIZONA	449,151	16.5%	2	608,444	17.7%	7	35.5%
ARKANSAS	372,852	16.3%	3	519,163	21.6%	2	39.2%
CALIFORNIA	3,004,160	12.7%	14	4,737,675	17.2%	10	57.7%
COLORADO	371,701	12.9%	13	428,555	13.0%	22	15.3%
CONNECTICUT	193,401	6.2%	50	186,011	5.8%	51	-3.8%
DELAWARE	53,621	9.0%	36	65,178	10.2%	34	21.6%
DISTRICT OF COLUMBIA	97,916	15.3%	6	97,659	15.7%	14	-0.3%
FLORIDA	1,358,123	13.9%	10	2,199,960	18.4%	4	62.0%
GEORGIA	672,080	12.3%	17	788,513	12.6%	25	17.3%
HAWAII	78,539	8.1%	43	87,669	8.1%	42	11.6%
IDAHO	115,174	12.2%	18	165,419	16.4%	11	43.6%
ILLINOIS	1,078,105	9.4%	32	1,164,471	10.1%	35	8.0%
INDIANA	538,413	9.8%	30	751,116	13.6%	21	39.5%
IOWA	244,302	8.4%	41	222,017	7.9%	44	-9.1%
KANSAS	172,575	7.3%	48	257,374	10.4%	33	49.1%
KENTUCKY	328,638	9.0%	37	555,113	14.9%	16	68.9%
LOUISIANA	522,790	12.4%	16	778,919	17.3%	9	49.0%
MAINE	127,156	11.3%	22	92,123	7.8%	45	-27.6%
MARYLAND	382,164	9.1%	35	430,254	9.5%	38	12.6%
MASSACHUSETTS	493,906	8.6%	39	424,868	7.3%	48	-14.0%
MICHIGAN	604,488	6.5%	49	756,414	8.2%	41	25.1%
MINNESOTA	350,485	8.6%	40	282,003	6.6%	50	-19.5%
MISSISSIPPI	378,740	15.0%	8	472,365	17.9%	6	24.7%
MISSOURI	511,424	10.4%	26	533,342	10.5%	32	4.3%
MONTANA	120,046	15.3%	7	129,258	15.9%	12	7.7%
NEBRASKA	147,733	9.4%	33	168,268	10.5%	31	13.9%
NEVADA	92,188	11.5%	20	172,097	17.3%	8	86.7%
NEW HAMPSHIRE	70,854	7.7%	46	105,203	9.9%	36	48.5%
NEW JERSEY	688,699	9.4%	34	638,403	8.3%	40	-7.3%
NEW MEXICO	245,114	18.8%	1	345,509	22.8%	1	41.0%
NEW YORK	1,656,634	9.4%	31	2,049,755	11.5%	28	23.7%
NORTH CAROLINA	668,728	11.4%	21	883,308	13.8%	20	32.1%
NORTH DAKOTA	52,615	8.1%	45	50,447	7.5%	47	-4.1%
OHIO	872,119	8.1%	44	1,031,230	9.6%	37	18.2%
OKLAHOMA	399,994	13.2%	12	592,995	18.0%	5	48.3%
OREGON	260,217	9.9%	29	397,160	14.6%	18	52.6%
PENNSYLVANIA	981,113	8.3%	42	949,608	8.0%	43	-3.2%
RHODE ISLAND	72,422	7.6%	47	71,051	7.2%	49	-1.9%
SOUTH CAROLINA	493,006	15.8%	5	406,552	11.9%	26	-17.5%
SOUTH DAKOTA	86,842	12.6%	15	104,051	14.7%	17	19.8%
TENNESSEE	536,142	11.7%	19	687,400	14.2%	19	28.2%
TEXAS	2,270,337	16.0%	4	3,621,720	21.4%	3	59.5%
UTAH	146,561	10.0%	28	198,706	11.7%	27	35.6%
VERMONT	52,373	10.2%	27	50,256	9.2%	39	-4.0%
VIRGINIA	473,667	8.9%	38	637,029	10.8%	30	34.5%
WASHINGTON	457,440	11.1%	24	579,781	12.8%	24	26.7%
WEST VIRGINIA	217,640	11.2%	23	245,160	12.9%	23	12.6%
WISCONSIN	273,431	5.8%	51	361,781	7.6%	46	32.3%
WYOMING	50,687	10.8%	25	54,968	10.9%	29	8.4%
TOTAL	24,501,212	10.8%		31,837,904	13.1%		29.9%

a/ Based upon March 1980 Current Population Surveys (CPS) estimates adjusted to reflect changes in survey design implemented in the March 1988 CPS.

b/ Based upon percent uninsured.

c/ Based upon March 1988 CPS data.

SOURCE: Lewin/ICF estimates.

TECHNICAL APPENDIX

Methodology Used to Project State Health Expenditures in 2000

By:

Lewin/ICF
a division of Health & Sciences International, Inc.

TECHNICAL APPENDIX

Methodology Used to Project State Health Expenditures in 2000

In this analysis we developed estimates of total health expenditures in each state by source of payment in 1980 and 1987. We also developed projections of future health expenditures by state in selected years under current policy and alternative health care financing scenarios. This appendix describes the methods used to develop these estimates.

A. HEALTH EXPENDITURES BY STATE

We developed estimates of health expenditures by source of payment for the 50 states and the District of Columbia in 1980 and 1986 using available data. For both years we presented estimates of the following categories of personal health care expenditures:

- Direct payments by households.
- Employer health insurance payments.
- Payments by other private sources.
- Medicare payments.
- State Medicaid expenditures.
- Federal Medicaid expenditures.
- Payments by other public sources.

State-level data on Medicare and Medicaid spending were obtained from the Health Care Financing Administration (HCFA). However, information on other health care expenditures by state and local governments in largely unavailable from existing data sources. Data on health spending by households and employers are also unavailable at the state level.

Due to the lack of state-level health expenditures data, we estimated state spending using techniques that reflect the unique socio-economic composition of the population in each state. We developed these estimates for 1980 and 1987 using the following three steps:

- **Develop First Stage estimates.** We estimated total expenditures by source of payment based upon the socio-economic composition of the population in each state. The Lewin/ICF Health Benefits Simulation Model (HBSM) was used to estimate per-capita health spending for each source of payment by age, income, geographic region, and health insurance status. Using these per capita health spending estimates, we estimated total health spending in each state based upon state-level data on the distribution of persons by age, income, and insured status as reported in the Current Population Survey (CPS) for 1980 and 1987.

- **Adjust First Stage Estimates to Replicate Known Totals By State.** We then adjusted the first stage estimates to reflect the following known control totals for 1980 and 1987:

  -- Medicare spending by state.
  -- Federal Medicaid spending by state.
  -- State Medicaid spending.

  In addition, we adjusted total health spending to reflect HCFA estimates of relative differences in per-capita health spending by state in 1982.

- **Adjust Second Stage Estimates to Replicate HCFA Estimates of National Health Spending by Source of Payment.** The state-level health spending estimates developed in the second stage were adjusted to replicate HCFA estimates of national health spending by source of payment.

These steps were performed separately to develop estimates for 1980 and 1987.

Projections of total health spending in each state were developed for each year between 1988 and 2000 assuming current policy continues throughout this period. These projections are based upon census projections of population growth by state and HCFA projections of national health expenditures through 2000.

ADDITIONAL TABLES

Sources of Payment for Personal Health Expenditures 1980, 1990, 2000

Percentage Distribution

ESTIMATED SOURCES OF PAYMENT FOR PERSONAL HEALTH EXPENDITURES IN THE YEAR 1980 a/

STATE	OUT OF POCKET b/	EMPLOYER SPONSORED	NON-GROUP	OTHER PRIVATE	MEDICAID STATE	MEDICAID FEDERAL	MEDICARE	OTHER PUBLIC	TOTAL
ALABAMA	31.0 %	21.0 %	5.2 %	1.2 %	2.2 %	5.4 %	15.3 %	18.1 %	100.0 %
ALASKA	24.0	32.8	2.0	1.7	3.7	3.7	4.8	27.3	100.0
ARIZONA	25.3	30.3	3.2	1.6	0.0	0.0	14.3	25.4	100.0
ARKANSAS	30.2	19.1	4.5	1.2	3.4	9.1	15.6	16.9	100.0
CALIFORNIA	21.8	25.9	2.5	1.3	5.0	5.0	14.6	23.8	100.0
COLORADO	24.2	32.4	2.6	1.5	3.0	3.4	10.5	22.3	100.0
CONNECTICUT	26.8	34.5	6.7	1.2	5.0	5.0	17.1	1.6	100.0
DELAWARE	28.5	24.0	5.0	1.0	4.1	4.1	15.4	17.0	100.0
DISTRICT OF COLUMBIA	21.3	15.8	3.6	0.6	10.0	10.9	18.6	16.0	100.0
FLORIDA	30.0	10.0	5.1	1.0	1.6	2.5	23.0	17.6	100.0
GEORGIA	31.1	23.5	4.6	1.1	3.3	6.6	12.6	16.9	100.0
HAWAII	22.7	20.0	2.6	1.3	5.2	5.2	9.6	24.5	100.0
IDAHO	23.6	28.6	2.6	1.4	2.7	5.3	9.6	25.6	100.0
ILLINOIS	27.2	33.6	7.3	1.6	4.9	4.9	16.7	1.6	100.0
INDIANA	20.7	35.6	6.2	1.9	3.1	4.1	15.0	2.3	100.0
IOWA	28.2	33.6	6.2	1.6	3.5	4.6	16.6	3.0	100.0
KANSAS	27.0	31.9	6.2	1.7	3.9	4.4	17.7	5.2	100.0
KENTUCKY	32.0	25.0	5.5	1.1	3.3	7.0	13.5	12.7	100.0
LOUISIANA	30.3	22.3	5.0	1.0	3.4	7.4	11.9	18.6	100.0
MAINE	29.1	26.7	7.8	1.4	4.2	9.6	16.3	0.9	100.0
MARYLAND	29.3	26.2	4.6	1.1	3.7	3.7	15.9	15.2	100.0
MASSACHUSETTS	26.6	30.0	5.9	1.2	6.6	7.3	20.6	1.4	100.0
MICHIGAN	26.1	33.9	7.1	1.6	5.4	5.4	17.4	3.1	100.0
MINNESOTA	27.5	33.1	6.0	1.6	5.9	7.5	15.6	0.6	100.0
MISSISSIPPI	32.3	21.5	0.0	1.2	2.5	6.6	14.7	13.7	100.0
MISSOURI	29.2	32.5	6.6	1.9	2.4	3.6	19.6	2.0	100.0
MONTANA	23.5	27.0	2.6	1.4	3.4	6.1	10.9	25.0	100.0
NEBRASKA	29.4	33.4	6.4	1.8	3.0	4.0	16.3	3.5	100.0
NEVADA	22.6	29.4	2.6	1.4	2.6	2.6	12.7	25.9	100.0
NEW HAMPSHIRE	30.3	34.6	7.2	1.3	3.6	6.0	14.4	2.1	100.0
NEW JERSEY	27.8	34.6	6.7	1.3	5.7	5.7	16.7	1.4	100.0
NEW MEXICO	24.7	26.6	2.6	1.6	2.4	5.4	9.6	26.6	100.0
NEW YORK	24.9	27.4	5.9	1.1	10.6	10.6	16.2	1.3	100.0
NORTH CAROLINA	31.7	24.3	5.0	1.2	2.9	6.1	12.7	16.0	100.0
NORTH DAKOTA	26.6	32.2	6.6	2.0	2.7	4.3	17.4	4.3	100.0
OHIO	26.7	35.6	6.5	1.7	3.3	4.1	16.2	1.7	100.0
OKLAHOMA	30.7	21.2	5.1	1.0	3.6	6.3	15.6	16.2	100.0
OREGON	22.6	26.5	2.6	1.4	3.3	4.1	12.9	24.4	100.0
PENNSYLVANIA	26.6	32.7	7.1	1.3	4.0	4.9	19.7	1.4	100.0
RHODE ISLAND	26.0	32.0	6.4	1.1	6.2	6.5	16.2	1.6	100.0
SOUTH CAROLINA	30.1	19.9	4.3	1.1	3.5	6.6	10.5	22.0	100.0
SOUTH DAKOTA	30.6	30.3	6.9	2.4	2.7	5.9	15.1	3.9	100.0
TENNESSEE	31.5	23.7	5.2	1.1	2.7	6.2	14.4	15.2	100.0
TEXAS	32.6	23.6	4.9	1.2	3.2	4.5	14.4	15.5	100.0
UTAH	24.2	32.1	2.7	1.4	2.4	5.1	7.3	24.8	100.0
VERMONT	26.7	32.0	7.1	1.3	4.6	10.0	15.3	1.0	100.0
VIRGINIA	30.4	24.4	5.1	1.0	3.5	4.5	12.9	18.3	100.0
WASHINGTON	22.2	27.9	2.6	1.4	4.4	4.4	10.4	26.7	100.0
WEST VIRGINIA	33.5	24.1	5.5	1.1	2.1	4.4	15.4	14.0	100.0
WISCONSIN	26.1	34.2	7.6	1.5	5.7	7.9	15.9	1.0	100.0
WYOMING	23.3	32.4	2.5	1.5	2.2	2.2	9.7	26.2	100.0
TOTAL	27.4 %	28.5 %	5.6 %	1.4 %	4.6 %	5.7 %	18.2 %	10.5 %	100.0%

a/ Includes personal health expenditures and administrative costs.

b/ Does not include employee share of premiums for employer-sponsored insurance. These payments are included in the "Employer-Sponsored" column.

SOURCE: Lewin/ICF estimates.

ESTIMATED SOURCES OF PAYMENT FOR PERSONAL HEALTH EXPENDITURES IN THE YEAR 1990 a/

STATE	OUT OF POCKET b/	EMPLOYER-SPONSORED	NON-GROUP	OTHER PRIVATE	MEDICAID STATE	MEDICAID FEDERAL	MEDICARE	OTHER PUBLIC	TOTAL
ALABAMA	29.6 %	21.1 %	4.4 %	1.1 %	1.7 %	4.5 %	20.3 %	17.4 %	100.0%
ALASKA	26.5	34.4	2.4	1.9	4.9	4.9	6.5	18.6	100.0
ARIZONA	24.3	29.4	3.0	1.7	2.7	4.5	16.9	17.5	100.0
ARKANSAS	30.6	19.0	4.2	1.2	2.2	6.2	21.0	15.3	100.0
CALIFORNIA	24.0	30.3	2.8	1.7	4.2	4.2	17.5	15.3	100.0
COLORADO	26.1	33.2	3.3	1.7	3.6	3.9	12.0	16.1	100.0
CONNECTICUT	25.6	37.5	4.9	1.1	5.6	5.6	17.9	1.1	100.0
DELAWARE	29.4	23.6	4.5	0.9	4.3	4.3	16.9	14.2	100.0
DISTRICT OF COLUMBIA	20.5	15.4	3.2	0.7	11.7	11.7	22.1	14.7	100.0
FLORIDA	20.8	19.6	4.4	1.0	2.8	3.6	25.7	12.6	100.0
GEORGIA	29.0	22.3	4.2	0.9	3.6	7.0	16.3	10.6	100.0
HAWAII	24.9	34.5	3.5	1.7	3.6	3.6	10.6	17.3	100.0
IDAHO	25.2	30.1	3.0	1.6	2.6	6.2	13.6	17.5	100.0
ILLINOIS	26.6	33.6	5.9	1.7	4.0	4.0	22.0	1.7	100.0
INDIANA	27.4	32.3	6.6	1.6	3.9	6.6	17.6	3.6	100.0
IOWA	27.7	33.5	6.6	1.7	3.7	5.4	20.3	0.7	100.0
KANSAS	27.6	34.5	6.5	1.6	3.4	3.4	20.0	3.0	100.0
KENTUCKY	27.7	20.2	3.9	1.0	3.6	6.5	17.6	17.5	100.0
LOUISIANA	26.7	19.1	3.7	1.0	3.6	6.4	18.2	21.3	100.0
MAINE	25.7	32.6	5.6	1.1	4.6	10.6	17.1	2.3	100.0
MARYLAND	27.3	23.0	4.0	0.9	4.7	4.7	16.7	15.6	100.0
MASSACHUSETTS	24.0	34.4	4.2	1.1	6.9	6.9	20.2	1.6	100.0
MICHIGAN	25.5	33.4	5.6	1.6	4.2	5.5	21.6	2.4	100.0
MINNESOTA	27.9	36.9	6.2	1.7	6.1	7.0	13.0	1.3	100.0
MISSISSIPPI	26.5	16.3	3.6	1.1	2.4	6.6	17.6	19.3	100.0
MISSOURI	27.2	32.9	6.3	1.7	2.7	4.1	22.6	2.3	100.0
MONTANA	23.3	26.7	2.6	1.5	2.5	6.9	14.7	20.5	100.0
NEBRASKA	26.6	34.6	7.3	1.6	3.3	4.4	17.0	2.9	100.0
NEVADA	25.9	33.2	3.2	1.6	2.3	2.3	15.7	15.6	100.0
NEW HAMPSHIRE	30.2	35.4	4.6	1.5	4.3	5.3	16.4	2.1	100.0
NEW JERSEY	26.2	34.6	4.3	1.2	6.0	6.0	20.2	1.6	100.0
NEW MEXICO	25.6	26.4	3.0	1.6	3.2	7.0	12.5	20.5	100.0
NEW YORK	23.3	26.5	4.0	1.1	10.5	10.5	20.4	1.6	100.0
NORTH CAROLINA	31.0	23.3	4.6	1.1	3.1	6.9	16.0	14.0	100.0
NORTH DAKOTA	25.3	30.9	6.3	1.5	5.0	6.1	20.0	4.9	100.0
OHIO	25.6	32.2	6.1	1.6	4.6	6.4	21.5	2.1	100.0
OKLAHOMA	29.7	20.2	4.2	1.1	4.3	5.9	16.7	15.6	100.0
OREGON	25.4	30.6	3.2	1.7	2.6	4.2	15.1	17.0	100.0
PENNSYLVANIA	26.2	31.4	5.2	1.2	4.1	5.4	25.4	1.2	100.0
RHODE ISLAND	26.1	31.6	5.0	1.1	6.4	6.3	19.7	1.6	100.0
SOUTH CAROLINA	30.1	23.3	4.5	1.1	2.7	7.1	14.6	16.5	100.0
SOUTH DAKOTA	26.2	32.0	6.4	1.6	3.1	6.5	19.3	2.6	100.0
TENNESSEE	29.0	20.9	4.4	1.0	3.0	7.1	19.3	15.4	100.0
TEXAS	32.1	22.7	4.2	1.2	3.1	3.5	17.6	15.6	100.0
UTAH	25.2	35.5	2.6	1.7	2.1	5.6	10.3	17.0	100.0
VERMONT	26.9	34.1	5.6	1.2	4.3	6.7	15.5	1.7	100.0
VIRGINIA	30.1	24.1	4.4	1.0	3.6	4.1	15.9	16.7	100.0
WASHINGTON	23.6	30.2	2.9	1.7	5.1	5.1	14.1	17.3	100.0
WEST VIRGINIA	26.5	16.6	4.4	0.9	2.7	6.6	18.7	19.3	100.0
WISCONSIN	26.0	34.0	6.3	1.4	4.4	6.0	18.9	3.2	100.0
WYOMING	25.1	32.6	3.2	1.7	2.4	2.4	13.1	19.3	100.0
TOTAL	26.7 %	26.7 %	4.5 %	1.4 %	4.5 %	5.7 %	19.2 %	9.4 %	100.0%

a/ Includes personal health expenditures and administrative costs.

b/ Does not include employee share of premiums for employer-sponsored insurance. These payments are included in the 'Employer-Sponsored' column.

SOURCE: Lewin/ICF estimates.

ESTIMATED SOURCES OF PAYMENT FOR PERSONAL HEALTH EXPENDITURES IN THE YEAR 2000 a/

STATE	OUT OF POCKET b/	EMPLOYER-SPONSORED	NON-GROUP	OTHER PRIVATE	MEDICAID STATE	MEDICAID FEDERAL	MEDICARE	OTHER PUBLIC	TOTAL
ALABAMA	20.1 %	20.6 %	4.3 %	1.2 %	1.6 %	4.2 %	23.7 %	15.1 %	100.0%
ALASKA	28.6	34.7	2.4	2.2	4.7	4.7	7.6	16.6	100.0
ARIZONA	24.1	29.0	2.9	1.9	2.6	4.3	19.8	15.3	100.0
ARKANSAS	30.2	18.6	4.2	1.3	2.1	5.9	24.5	13.3	100.0
CALIFORNIA	23.7	29.6	2.7	1.9	4.0	4.0	20.5	13.3	100.0
COLORADO	20.0	33.1	3.3	1.9	3.6	3.6	14.3	14.2	100.0
CONNECTICUT	25.1	30.4	4.6	1.2	5.5	5.5	20.7	1.0	100.0
DELAWARE	26.9	23.2	4.5	1.0	4.0	4.0	22.0	12.3	100.0
DISTRICT OF COLUMBIA	20.1	15.1	3.2	0.6	11.1	11.1	25.6	12.7	100.0
FLORIDA	26.9	19.2	4.3	1.1	2.6	3.3	29.6	10.9	100.0
GEORGIA	26.6	22.1	4.1	1.0	3.4	6.7	19.2	14.6	100.0
HAWAII	25.0	34.5	3.5	1.9	3.5	3.7	12.6	15.3	100.0
IDAHO	25.1	29.9	3.0	1.6	2.6	6.0	18.1	15.4	100.0
ILLINOIS	25.6	32.5	5.7	1.9	3.7	3.7	25.1	1.4	100.0
INDIANA	26.6	31.4	6.4	2.0	3.7	6.2	20.6	3.1	100.0
IOWA	20.6	32.3	6.6	1.9	3.5	5.0	23.3	0.6	100.0
KANSAS	26.7	33.4	6.3	1.7	3.2	3.2	23.0	2.5	100.0
KENTUCKY	27.5	20.0	3.6	1.1	3.5	6.2	20.7	15.3	100.0
LOUISIANA	26.5	16.9	3.7	1.1	3.5	6.1	21.5	18.7	100.0
MAINE	25.0	32.0	5.5	1.2	4.5	10.0	19.9	2.0	100.0
MARYLAND	26.9	22.7	4.0	1.0	4.4	4.4	22.0	14.7	100.0
MASSACHUSETTS	24.0	33.3	4.0	1.2	6.4	6.4	23.3	1.3	100.0
MICHIGAN	24.6	32.2	5.6	1.7	3.0	5.1	24.8	2.0	100.0
MINNESOTA	27.4	36.1	6.1	1.6	5.7	6.6	15.1	1.1	100.0
MISSISSIPPI	26.2	16.1	3.6	1.2	2.3	6.4	21.0	16.9	100.0
MISSOURI	26.2	31.6	6.1	1.6	2.5	3.6	26.1	1.9	100.0
MONTANA	23.3	26.6	2.6	1.7	3.4	6.6	17.4	18.1	100.0
NEBRASKA	26.0	33.7	7.1	1.6	3.1	4.1	19.7	2.5	100.0
NEVADA	25.6	32.6	3.1	2.0	2.2	2.2	18.4	13.7	100.0
NEW HAMPSHIRE	29.4	34.5	4.7	1.6	4.1	4.9	19.0	1.6	100.0
NEW JERSEY	25.3	33.5	4.1	1.3	5.6	5.6	23.2	1.4	100.0
NEW MEXICO	25.6	26.4	3.0	2.0	3.1	6.6	10.9	16.1	100.0
NEW YORK	22.6	27.6	3.9	1.2	9.6	9.6	23.5	1.4	100.0
NORTH CAROLINA	30.7	23.0	4.6	1.2	2.9	6.6	18.6	12.2	100.0
NORTH DAKOTA	24.6	29.9	6.2	1.7	4.6	5.7	23.1	4.2	100.0
OHIO	24.7	31.0	5.9	1.7	4.3	6.0	24.7	1.7	100.0
OKLAHOMA	29.3	18.9	4.1	1.2	4.1	5.6	21.9	13.8	100.0
OREGON	25.2	30.5	3.2	1.8	2.5	4.0	17.6	14.8	100.0
PENNSYLVANIA	25.1	30.0	5.0	1.3	3.6	4.9	28.9	1.0	100.0
RHODE ISLAND	25.3	30.6	4.9	1.2	6.0	7.7	22.7	1.6	100.0
SOUTH CAROLINA	29.9	23.2	4.5	1.2	2.6	6.6	17.5	14.5	100.0
SOUTH DAKOTA	27.4	31.0	6.2	2.0	2.9	6.1	22.2	2.3	100.0
TENNESSEE	26.5	20.5	4.3	1.1	2.9	6.7	22.6	13.4	100.0
TEXAS	31.6	22.3	4.1	1.4	2.9	3.4	20.6	13.6	100.0
UTAH	25.2	35.5	2.6	1.8	2.0	5.4	12.3	15.1	100.0
VERMONT	28.2	33.3	5.6	1.3	4.0	6.1	17.9	1.4	100.0
VIRGINIA	29.8	23.9	4.4	1.1	3.5	3.9	18.6	14.6	100.0
WASHINGTON	23.5	30.0	2.9	1.9	4.9	4.9	16.6	15.2	100.0
WEST VIRGINIA	28.2	18.4	4.4	1.0	2.0	6.5	22.0	16.9	100.0
WISCONSIN	25.2	33.0	6.1	1.5	4.1	5.6	21.6	2.7	100.0
WYOMING	25.0	32.7	3.2	1.9	2.3	2.3	15.5	17.0	100.0
TOTAL	26.1 %	27.0 %	4.3 %	1.5 %	4.2 %	5.3 %	22.2 %	8.4 %	100.0%

a/ Includes personal health expenditures and administrative costs

b/ Does not include employee share of premiums for employer-sponsored insurance. These payments are included in the "Employer-Sponsored" column.

SOURCE: Lewin/ICF estimates.



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

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STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE

REPORT TO THE SEVENTEENTH LEGISLATURE

INDEX

SECTION

EXECUTIVE SUMMARY.....i

TASK FORCE WORK PLAN & OBJECTIVES.....1

STATE EMPLOYEE AND RETIREE HEALTH PLAN UPDATE / RESULTS.....2

HEALTH CARE EXPENDITURES IN ALASKA & U.S. 3

CAUSES OF RISING HEALTH CARE COSTS IN ALASKA 4

HEALTH CARE DELIVERY SYSTEM FINDINGS AND SURVEY RESULTS.....5

TASK FORCE RECOMMENDATIONS 6

OPEN / UNRESOLVED ALASKA HEALTH CARE DELIVERY ISSUES.....7

ATTACHMENTS.....8

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.

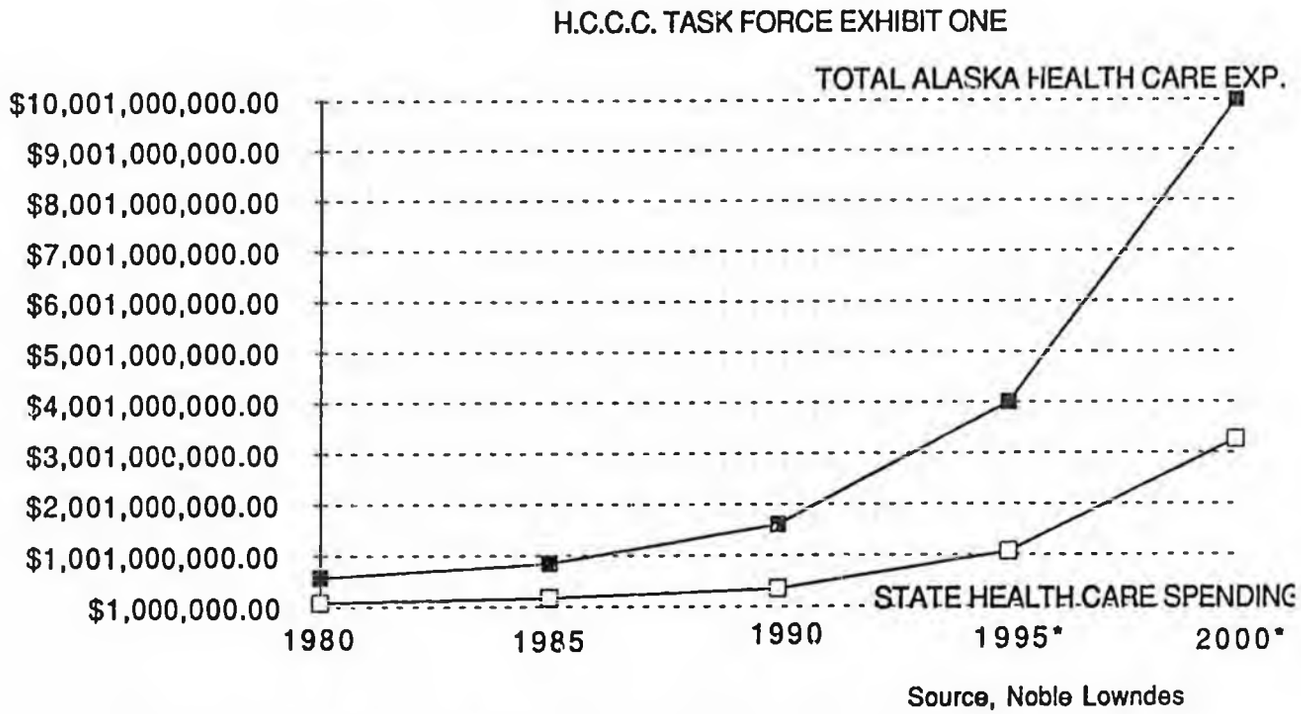
THE FUTURE

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.



Source, Noble Lowndes

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 .

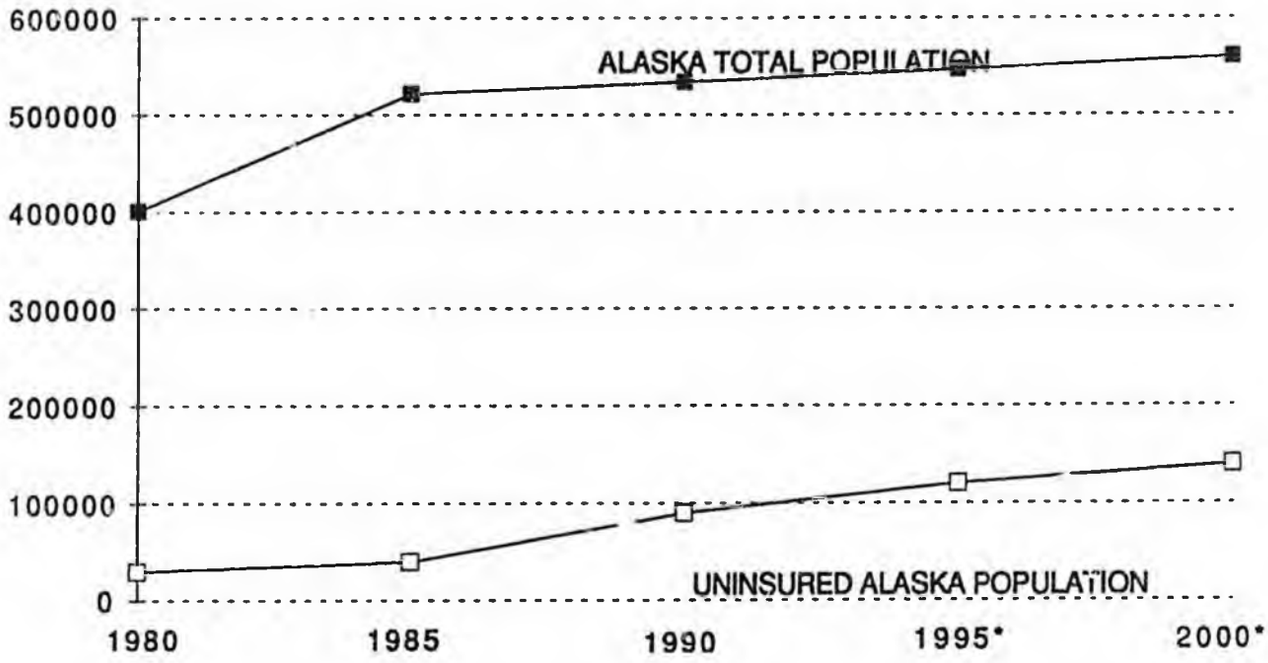
1980=$75. million, 1985=$175. million, 1990=$350. million
1995=$1.068 billion*, 2000=$3.26 billion*

* 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 heaith 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.

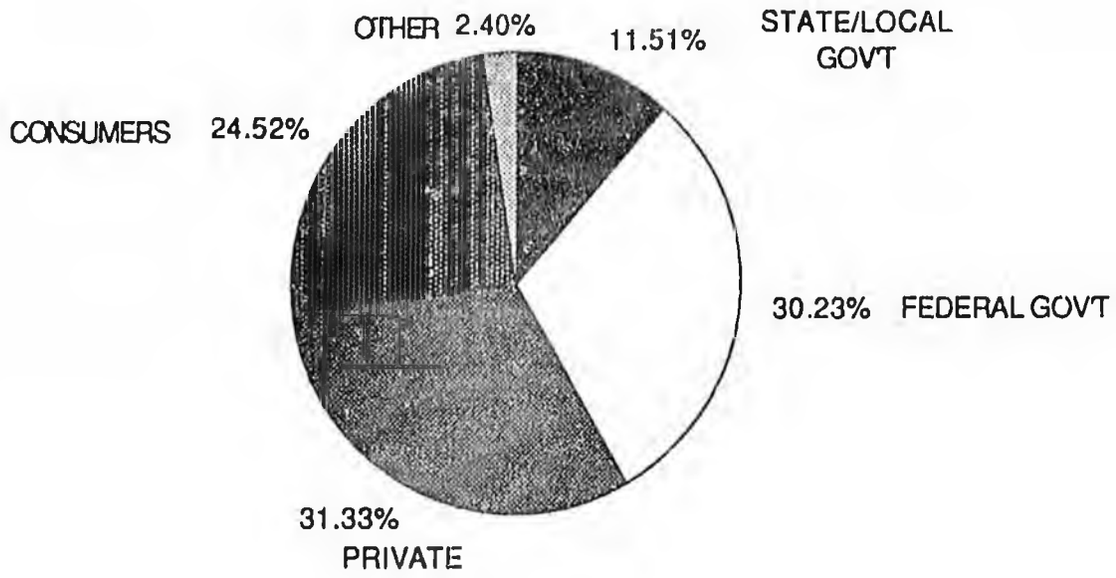
Exhibit Five illustrates Alaska health care expenditures from 1979 to 1989 and breaks down by payor (private sector, federal programs and state programs)

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.

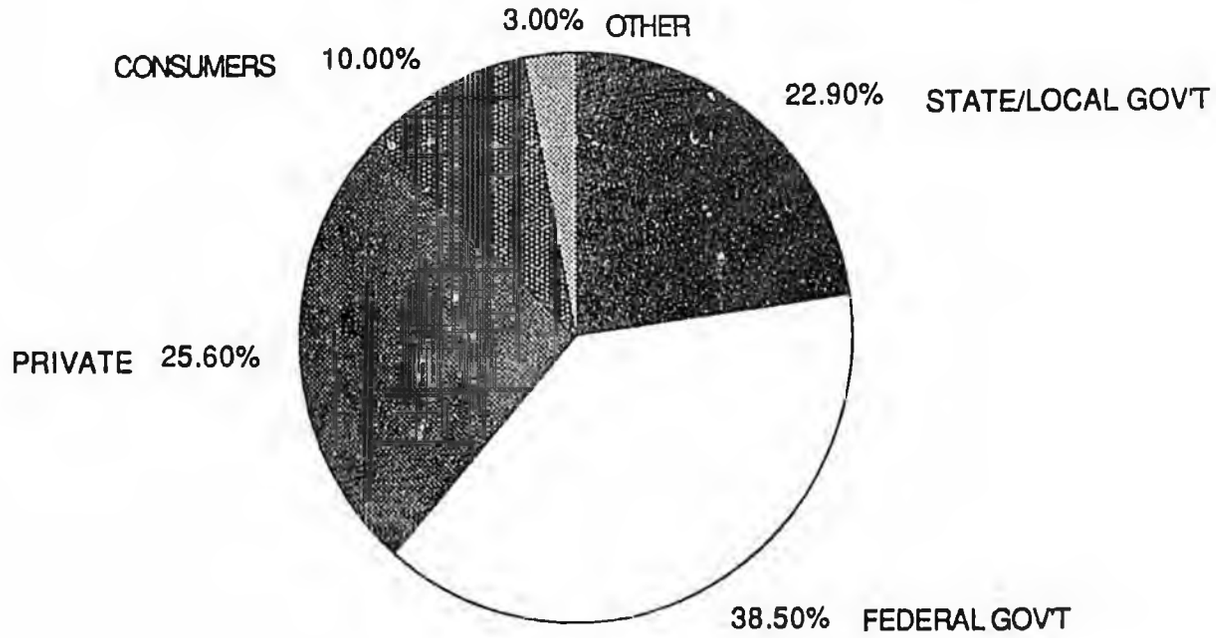
HCCC-TF EXHIBIT THREE

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



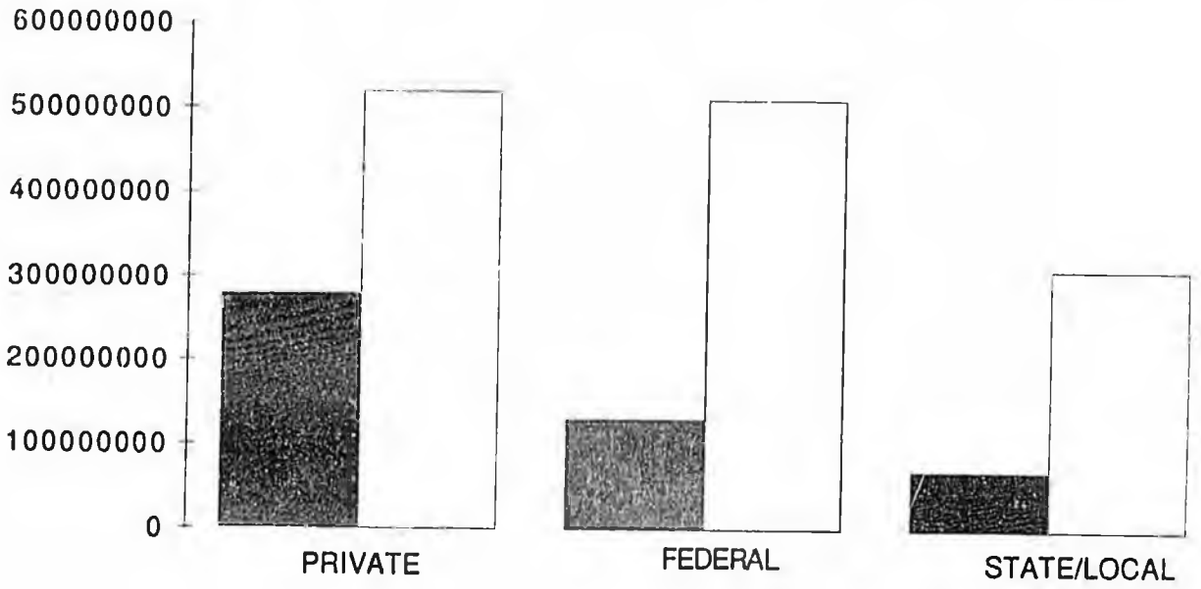
HCCC-TF EXHIBIT FOUR

PERCENT OF ALASKA HEALTH CARE EXP. BY SOURCE OF PAYOR



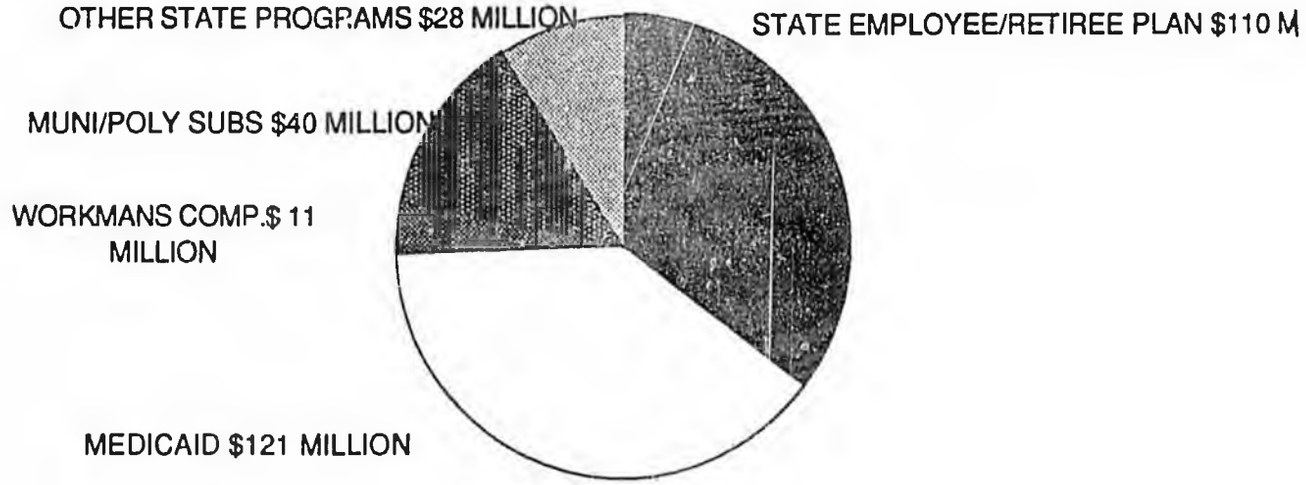
HCCC-TF EXHIBIT FIVE

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.

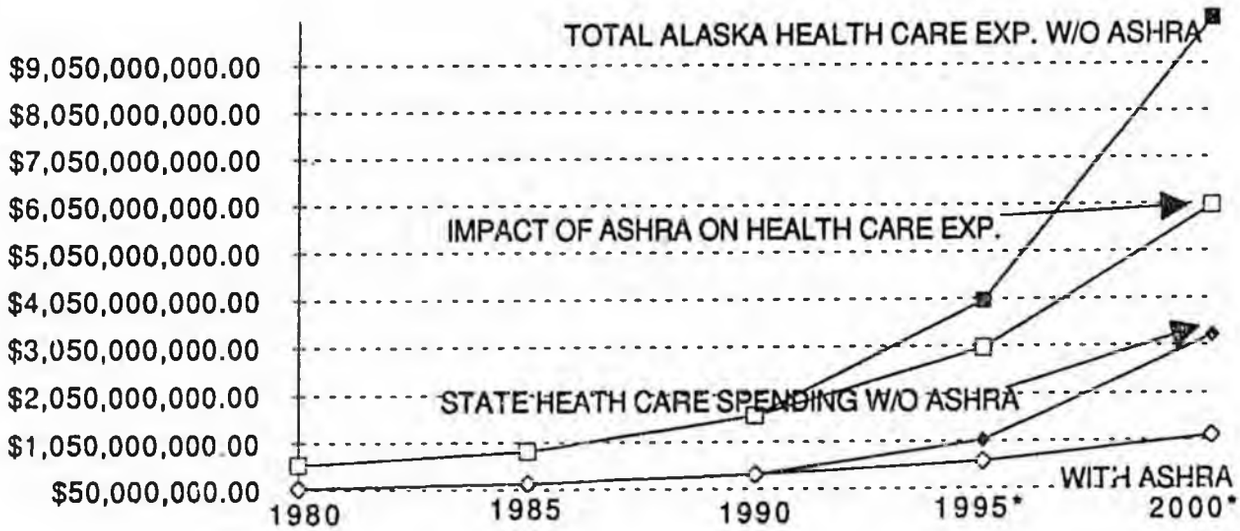
IMPACT

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 $8.0 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

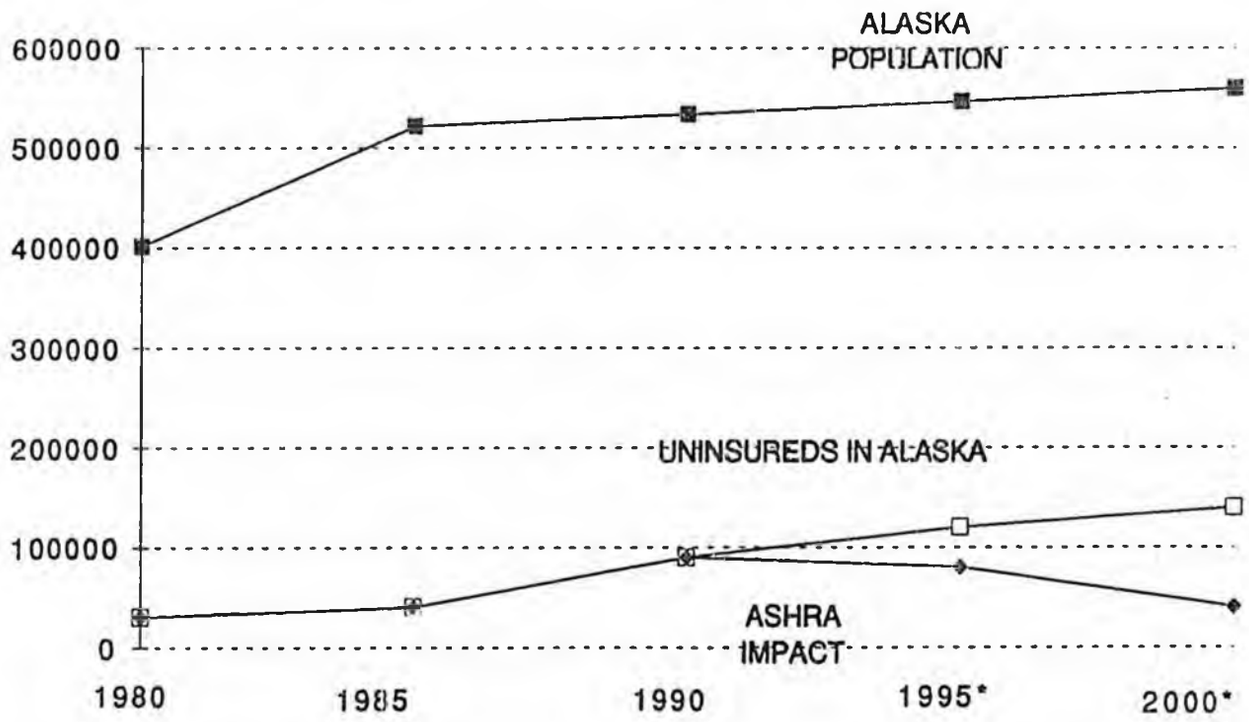
ESTIMATED IMPACT OF ASHRA ON HEALTH CARE EXPENDITURES IN ALASKA



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%

The Guardian of
Small Business

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:

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Policy Specialist
Health Services Program
Human Services Department
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Suite 2100
Denver, Colorado 80265
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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.

- o 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.
- o 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.
- o 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]
- o 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.
- o 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.
- o 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.
- o 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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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.

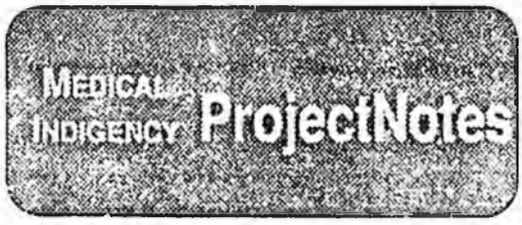
A variety of approaches have been proposed and implemented to help solve the problem and legislators are keenly aware that what works for one state may not be acceptable or feasible in another. Proven and promising strategies states have used to control health care costs while seeking alternative revenue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