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FISCAL NOTE

STATE OF ALASKA
1991 LEGISLATIVE SESSION

BILL NO. 8B84

Revision Date: _____ Dept. Affected: Health and Social Services
 Title: An Act relating to state coordination of health planning and development BRU: Administrative Services
 Component: Planning and Development
 Sponsor: Duncan
 Requestor: by the HESS Committee COMPONENT SERIAL NO. 0323

Expenditures/revenues: (Thousands of Dollars)

OPERATING	FY92	FY93	FY94	FY95	FY96	FY97
PERSONAL SERVICES	59.4	62.2	62.2	62.2	62.2	62.2
TRAVEL	3.2	3.3	3.3	3.3	3.3	3.3
CONTRACTUAL	20.4	20.4	20.4	20.4	20.4	20.4
SUPPLIES	0.5	0.5	0.5	0.5	0.5	0.5
EQUIPMENT	10.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	93.5	86.4	86.4	86.4	86.4	86.4
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	93.5	86.4	86.4	86.4	86.4	86.4
FEDERAL FUNDS	0.0	0.0	0.0	0.0	0.0	0.0
OTHER	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	93.5	86.4	86.4	86.4	86.4	86.4

POSITIONS:

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

Estimate of current year impact: **No FY91 fiscal impact.**


ANALYSIS: (Attach a separate page if necessary)

During 1991, the department completed six Certificate of Need reviews requiring the full time efforts of a Health and Social Services Planner II (R 19). If Senate Bill 84 is passed, which gives the department much broader and stricter review powers, the department estimates that Certificate of Need (CON) reviews will increase by another six to eight projects. Therefore, the department estimates that a Health and Social Services Planner II will be required to keep up with the increased workload. Duties of this position include: writing appropriate regulations; reviewing letters of intent to deter-

(Continued)

Prepared by: Janet Clarke, Director
 Division: Division of Administrative Services

Phone: 465-3082
 Date: 02/11/91

Approved by Commissioner: 
 Theodore A. Mala, MD, MPH
 Agency: Department of Health and Social Services

Date: 2/11/91

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

ANALYSIS (cont.):

mine whether a CON is required; assisting applicants through pre-application conferences in CON preparation; reviewing all data elements in CON application for completeness; preparing and submitting all advertising related to CON; holding CON public meetings; completing major CON review reports which determine whether or not a CON application is approved or disapproved; and acting as expert witness at all appeals/litigation related to CON.

DESCRIPTION	COMMENT #	FY92	FY93
Line 100 - Personal Services			
H&SS Planner II, PFT, 12 months, (R 19)-Juneau	(1)	59,438	62,172
Line 200 - Travel			
Staff Travel for Public Meetings:			
a) 3 CON Public Meetings x 1 staff x 2 days = 6 days	(2)		
b) 6 days x \$115 per diem		690	690
c) 1 staff x \$475 avg. airfare x 3 Public Meetings	(3)	1,425	1,500
d) 1 staff x \$35 misc. expense x 3 Public Meetings		105	105
Staff Travel for Hearing Appeals:			
a) 1 Hearing Appeal x 1 staff x 4 days = 4 days	(4)		
b) 4 days x \$115 per diem		460	480
c) 1 staff x \$475 airfare x 1 Hearing		475	500
d) 1 staff x \$35 misc. expense x 1 Hearing		35	35
TOTAL TRAVEL		<u>3,190</u>	<u>3,290</u>
Line 300 - Contractual Services			
a) Advertising of 6 CON reviews @ \$400 each		2,400	2,400
b) Hearing Officer, assume 1 appeal @ \$5,000		5,000	5,000
c) Attorney time and all costs related to litigation	(5)	6,000	6,000
d) Office space rental for staff		3,000	3,000
e) Communications including local, long distance, fax and postage		4,000	4,000
TOTAL CONTRACTUAL		<u>20,400</u>	<u>20,400</u>
Line 400 - Supplies			
a) Paper, office supplies, etc.		500	500
TOTAL SUPPLIES		<u>500</u>	<u>500</u>
Line 500 - Equipment			
a) Personal computer, software, printer, etc.		7,500	0
b) Desk, chair, file cabinets, calculator, etc.		2,500	0
TOTAL EQUIPMENT		<u>10,000</u>	<u>0</u>
TOTAL FOR PROJECT		<u>93,526</u>	<u>86,362</u>

- (1) The staff costs for FY93 assumes a 5% cost of living increase
- (2) This assumes that out of 6-8 additional CON reviews, that 3 will require Public Meetings
- (3) For FY93, it is assumed that average travel costs will increase from \$475 to \$500 per trip.
- (4) This assumes that Hearing Appeals will increase to one per year from the present of one every 2 or 3 years.
- (5) The \$6,000 figure was provided by the Department of Law as what they would charge to handle all costs related to litigation for 1 Hearing.

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

SECTIONAL ANALYSIS

SENATE BILL NO. 84

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

Section 1. The legislative purpose for chapter 18.07 is to provide a rationale for the planning and development of health care services that promotes the health of the public and avoids unnecessary increases in health care costs.

Section 2. The specific designation of the Office of Planning and Research as administrator of the certificate of need program is deleted.

Section 3. A certificate of need is required for construction, conversion, or acquisition of a health care facility whose value is in excess of \$1,000,000. A certificate is also required for changes in the bed capacity of a facility or change in categories of health care services provided by a facility.

Section 4. Technical change.

Section 5. Activities authorized by the certificate are valid only for the defined scope, physical location, and person stated in the certificate.

Section 6. A certificate holder is required to apply to the department before transferring, modifying, or terminating activities authorized by the certificate.

Section 7. An application to transfer a certificate must contain information about the nature of the transfer and evidence that the transferee is able to operate the facility. The department may impose conditions on the transfer.

Section 8. Provided are the emergency conditions under which the department shall expedite review of applications for a certificate of need.

Section 9. The department shall make a final decision on a certificate of need application within 150 days. Deferral of decision beyond this limit may be made under certain conditions.

Sections 10, 11, 12, and 13. Accusatory proceedings for modification, suspension, and revocation of an existing certificate of need are amended. A competing health care facility may request a hearing for modification, suspension, or revocation. Untrue accusation charges, knowingly stated, is a class B misdemeanor.

Section 14. This section rewrites existing law and details reporting requirements of certified health care facilities, penalties for non-compliance, and adds an injunctive relief provision. Generally, it increases sanctions against non-compliance.

Section 15. Regulation authority of the department is expanded to establish variation of activity thresholds which will be permitted without requiring a modification of certificates of need.

Section 16. Definition section. Excluded from the definition of health care facility are the Alaska Pioneers' Home facilities, outpatient clinics and offices of private physicians or dentists, and office buildings used exclusively by health care providers.

Section 17. Technical change.

Section 18 and 19. The Statewide Health Coordinating Council is abolished.

Section 20. Repealer section, mostly pertaining to the Statewide Health Coordinating Council.

Section. 21. Effective date clause.

DIVISION OF LEGAL SERVICES

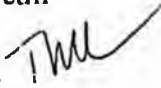
**LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA**

P.O. Box Y, Juneau, Alaska 99811
(907) 465-3867 or 465-2450
FAX (907) 465-2029

Deliveries to: 240 Main Street
Court Plaza, Room 500
Mail Stop 3101

MEMORANDUM

January 10, 1991

SUBJECT: Certificate of Need Program (7LS0407A)
TO: Senator Jim Duncan
FROM: Terri Lauterbach 
Legislative Counsel

Enclosed is a new draft relating to the certificate of need program.

You had asked that the bill be redrafted to ensure that (1) a CON was required for equipment purchases costing \$1,000,000 or more and (2) cost limits used in the bill referred to total project costs so that a large project could not escape CON review by being split into smaller projects.

This bill has not been changed with respect to the first item requested. Equipment purchases are already covered by the definition of "construction" in AS 18.07.111, both in current law and as amended in this draft. It includes "the lease or purchase of equipment." Joanne Clark at DHSS confirmed for me that the department has already done CON reviews for equipment like the MRI's you mentioned. The only issue left in this area is not whether equipment is covered (it is), but whose acquisition of it is covered. That is, CON only covers health care facilities, so that if someone other than a health care facility acquires an MRI or other expensive equipment, a CON is not required under current law. Of course, the department looks closely at whatever relationship there might be between a neighboring health care facility and the non-health care facility to determine if, in fact, a CON is needed; in some instances, the relationship might be close enough that the department would consider the equipment to have been leased or purchased by the health care facility itself. It appears to me that the rewritten definition of "health care facility" in section 16 of the draft addresses this issue. For instance, the new definition covers "freestanding emergency care facilit[ies] and independent diagnostic laborator[ies]." These are not covered in current law.

In response to your second request, I have added a new subsection (b) in bill section 3. It is modeled after language in AS 36.30.305(c) (state procurement code).

Senator Jim Duncan
January 10, 1991
Page 2

I have enclosed for your information a 1985 Attorney General Opinion that relates to the issue of whether a CON is required when a non-health care facility acquires expensive equipment.

I hope you find the opinion and this memo helpful. Please let me know if I can be of further assistance.

TML:gc
91-012.glc

Enclosure

MEMORANDUM

State of Alaska

TO: John R. Pugh, Commissioner
Dept. of Health & Social Services

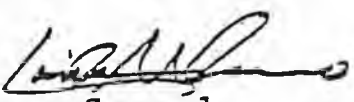
DATE: February 11, 1985

FILE NO: 366-274-85

TELEPHONE NO: 465-3603

FROM: Norman C. Gorsuch
Attorney General

SUBJECT: Does doctor group
leasing hospital
land for MRI need
CON?

By: Linda M. Cerro 
Assistant Attorney General
Human Services-Juneau

You have asked whether Diagnostic Imaging of Alaska (DIA), a 25-physician investment group, which intends to purchase and operate a magnetic resonance imaging mobile unit (MRI) at a cost of \$1.9 million, to locate on land leased from Humana Hospital-Alaska (Humana), is subject to certificate of need review. It is understood that DIA will lease space from Humana which is adjacent to but separate from the hospital facility. It is further understood that Humana is not involved in the purchase of the MRI, nor is it leasing the MRI from DIA. Humana patients requiring MRI diagnostic services will independently contract with DIA and not with Humana.

Under the facts presented, neither DIA's purchase and operation of a magnetic resonance imaging mobile unit, nor Humana's lease of land to DIA for that purpose, is subject to certificate of need review.

AS 18.07.031, which sets forth those activities requiring review, provides in pertinent part:

Certificate of Need Required. No person may make an expenditure of \$1,000,000 or more for any of the following unless authorized under the terms of a certificate of need issued by the office:

- (1) construction of a health care facility;
- (3) addition or elimination of a category of health services provided by a health care facility.

The term "health care facility" is defined at AS 18.07.111 as:

- (7) "health care facility" means a private, municipal, state or federal hospital, psychiatric hospital, tuberculosis hospital, skilled nursing facility, kidney disease treatment center (including freestanding hemodialysis units), intermediate

care facility, and ambulatory surgical facility;
the term excludes

(B) the offices of private physicians or
dentists whether in individual or group practice;

The term "category of health services" is defined as:

(8) "category of health services" means a
major type, program, unit, division, or department
of care provided through a health care facility
whether inpatient or outpatient, including an
outpatient department, psychiatric wing, kidney
dialysis program, radiotherapy, burn unit, or new-
born intensive care unit, except that "service"
does not include the lawful practice of a pro-
fession or vocation conducted independently of a
health care facility and in accordance with
applicable licensing laws of the state;

You are correct that DIA is not a "group practice" of
"private physicians" as intended by the Alaska Legislature when
it exempted the offices of private physicians from the definition
of health care facility. That exemption was intended for the ty-
pical physician's office through which a physician regularly sees
outpatients for the diagnosis and treatment of illness. However,
neither does DIA, a 25-physician investment group, fall within
the term of "health care facility", as it is restrictively de-
fined at AS 18.07.111(7). To encompass DIA's purchase of an MRI,
the definition of health care facility would have to include a
facility engaged principally in providing services for the
diagnosis of human disease. 1/

1/ In *Medcor, Inc. v. Finley*, No. A-3677-79A (N.J. Super. Ct.
App. Div., May 22, 1981), a mobile multiphasic health testing
service which offered automated testing using mobile vans
carrying medical screening equipment, brought an action seeking
judicial review of a state agency determination that it was
subject to certificate of need regulation. The state statutes
subjected "health care facilities" providing "health care
services" to CON regulation. The court held that the mobile
testing service was subject to regulation because: (1) it was
within the statutory definition of a health care facility ("a
facility or institution ... engaged principally in providing
services for ... diagnosis or treatment of human disease ...");
(footnote continued)

John R. Pugh, Commissioner
Dept. of Health and Social Services
366-274-85

February 11, 1985
Page 3

Since enactment of the National Health Planning and Resources Development Act of 1974 (NHPRDA), major medical equipment has been placed in doctor's offices, medical office buildings and in space leased from hospitals in order to circumvent review. As a result, Congress, in enacting P.L. 96-79, the 79 amendments to the NHPRDA, required state certificate of need program coverage of all major medical equipment, wherever located, if its cost exceeded the stated threshold. Until AS 18.07 is amended to more fully conform with the NHPRDA, however, DIA's \$1.9 million purchase of an MRI is outside the scope of state CON review.

Nor is the purchase and operation of an MRI by DIA a "category of health services provided by a health care facility". Aside from the fact that the physician investment group is not a health care facility, the definition of "category of health services" specifically excepts "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".

Finally, while the definition of "construction" at AS 18.07.111(3) includes the purchase or lease of equipment, it is understood that any lease agreement between DIA and Humana is simply for the lease of the land upon which DIA plans to operate its MRI, and is not a lease of the equipment itself.

LMC:gmw

cc: Pat Alexander
Dave Williams

(footnote continued)
and (2) the state CON regulations included mobile multiphasic health testing services in their list of standard categories of health care services.

Position Paper
Senate Bill 84

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

The Department of Health and Social Services supports Senate Bill 84.

Senate Bill 84 makes substantial changes to Alaska's Certificate of Need program (AS 18.07). Senate Bill 84 significantly broadens and strengthens program coverage of hospital and nursing home development in Alaska. Senate Bill 84 would require many more types of hospital and nursing home development to come under Certificate of Need review and approval from the Department.

In the present Certificate of Need law (AS 18.07) there are "gaps" that exist that allow certain types of major hospital and nursing home developmental activities to go into effect without any Certificate of Need review. Even though no Certificate of Need review is presently required on many activities, these activities have fiscal impacts on the Medicaid budget. The Department feels that the types of activities that are presently exempted from coverage should come under Certificate of Need review. The Department feels that by strengthening the Certificate of Need program, as is done in Senate Bill 84, more containment of medicaid costs will be achieved. Therefore, the Department supports Senate Bill 84.

Recommended by: J. Clarke
Janet Clarke
Director
Division of Administrative
Services

Date: 2/14/91

Approved by: Theodore A. Mala
Theodore A. Mala, MD, MPH
Commissioner
Department of Health and
Social Services

Date: 2/25/91

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

April 23, 1991

Senator Arliss Sturgulewski, Chair
Senate Health, Education & Social
Services Committee
Capitol Room 427
Juneau, AK 99801

Re: SB 84, Certificate of Need
Proposed Amendments

Dear Senator Sturgulewski:

The Association would like to offer the following amendments to SB 84, sponsored by Senator Duncan, amending the state "certificate of need" law.

#1 - Page 2, line 7 -- Delete subsection (2) of AS 18.07.031 entirely.

An alternative to deleting this section, that relates to the "conversion of a building for health services" would be the attached "alternate No. 1" amendment that provides amendatory language which clarifies that the cost of converting an existing building must be \$1 million or more before requiring a certificate of need.

#2 - Page 9, line 19 delete reference to "18.07.041". This would have repealed that part of the current statute which describes the standard for determining whether to issue a certificate of need.

By copy of this letter, we will alert Senator Duncan and the Department of our interest in working with them on SB 84.

Sincerely,



Harlan R. Knudson
President/CEO

Encl: (1)

cc: Senator Duncan
Tom Bergstrom, DHSS
ASHNHA Executive Committee

ALTERNATE NO. 1

ALASKA STATE HOSPITAL AND NURSING HOME ASSOCIATION

PROPOSED CHANGES TO SENATE BILL 84

March 6, 1991

1. Page 2, line 3: The Association proposes that AS 18.07.031(a), as it appears in Senate Bill 84, be revised as follows:

Sec. 18.07.031. CERTIFICATE OF NEED
REQUIRED. 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) make a capital expenditure of
\$1,000,000 or more to convert an existing
building or part of a building to a health care
facility [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, within two
years of the most recent alteration or
redistribution of bed capacity;

(4) make a capital expenditure of \$1,000,000 or more to add or eliminate a category of health services to or from those provided by the health care facility; or

(5) make a capital expenditure of \$1,000,000 or more to acquire a health care facility [AT A COST OF \$1,000,000 OR MORE].

2. Page 2, line 16: The Association proposes that AS 18.07.031(b) be amended as follows:

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

3. Page 8, line 1: The Association proposes that AS 18.07.111(6) be revised as follows:

(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 except when the lease or purchase of equipment is for the routine replacement of existing equipment;

PSA91:30/5951.3

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

February 11, 1991

Senator Arliss Sturgulewski, Chair
Senate Health, Education & Social
Services Committee
Capitol Room 427
Juneau, AK 99801

RE: SB 84 Certificate of Need

Dear Senator Sturgulewski:

The Alaska State Hospital & Nursing Home Association would like to request that no vote be taken to move the bill out of committee during the hearing on SB 84, amending the state certificate of need law Tuesday, February 12.

Unfortunately I must be in Anchorage that day. Hospitals and nursing homes have had little time to review SB 84, though it appears to be very similar to CSHB 399, rejected by the Legislature in 1990.

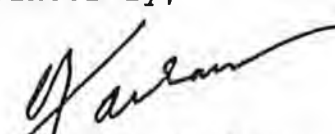
The Association believes that the "technical" amendments could be done by a cooperative effort between the Department and the Association. Any legislative changes in the certificate of need process should wait until there is state policy that clarifies the need and funding of federal/state health facilities as well as community facilities.

As you know, state and federal facilities do not need a certificate of need, nor do state outpatient programs such as in the area of mental, even though they compete and duplicate services already provided by a community hospital and nursing home.

We think the soon to be appointed Task Force on Universal Health Care (HB 581, 1990) or the Alaska State Health Resources Authority as proposed in SB 83, authored by Senator Duncan this session should be charged with recommending a health policy for this state that will maximize the use of our federal/state/community facilities and programs, and prevent unnecessary duplication and competition.

Thank you for your consideration.

Sincerely,



Harlan R. Knudson
President/CEO

HRK/ma
cc: Members, Senate HESS

Bill upsets insurers, medical industry

3-8-91

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 C5

Insure

Continued from page C1

BP Exploration (Alaska) Inc. BP Exploration officials could not be reached for comment late Thursday.

Rosa 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 NFIIB 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 it's 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 health care. 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 \$980 million to more than \$1.5 billion.

And the state's uninsured have reached 80,000 people, or 18 percent of the total population. Duncan said a continuation of current trends would mean 23 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.

FORUM

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 pro-



LOU CANNON

vide 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.

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 increas-

ing. 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.

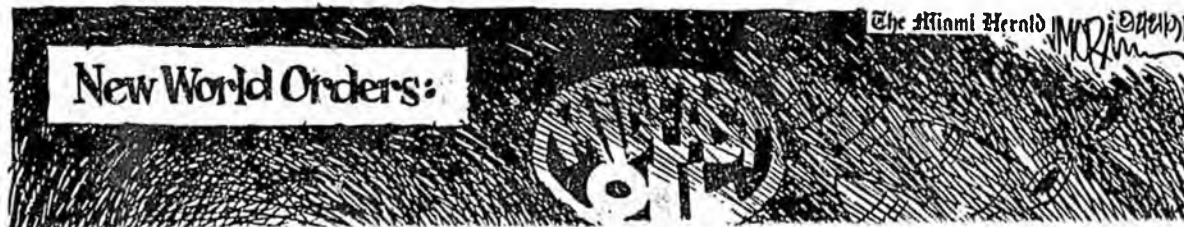
Hawaii's example ought to prove particularly tempting to governors such as Pete Wilson of California, a farsighted Republican who wants to improve preventive health care. Wilson ought to talk to Waihee and especially to Lewin. It is time to provide health care for everyone.

Lou Cannon is a Washington Post columnist and reporter.

Tax-free activism

I wish that the members of the Anchorage Baptist Temple and their ilk would obey the commandment "Thou shalt not steal" and quit taking my money to support their political agenda. Because the Anchorage Baptist Temple is a tax-free organization, some part of my taxes goes to support

New World Orders:



Who is he to question the values of the women who serve on the commission, which is devoted to promoting women's and children's interests? After reflection, I realize he is not a mean man, so the only explanation for his actions is ignorance.

I will forgive Walter Hickel and I will pray for Walter Hickel's enlightenment.

FORUM

Alaska can cure health-care problems with some imagination

By RODMAN WILSON, M.D.

The legislature may soon create a Health Resources and Access Task Force to tackle the vexing problem of providing basic health care to all Alaskans at a price that we can bear.

Such appointed bodies generally conclude by recommending minor modifications to the status quo. This is the way we tend to change things in America. Let's hope that this group is more imaginative than that.

In 1965, Congress created Medicare to provide acute medical care for the elderly. It would have been better for the nation if Congress had set in place a system to finance health care for children. Children were provided for under Medicaid, also enacted in 1965, but only if poor. Medicaid, however, currently serves only 45 percent of the poor.

The first piece, then, of any plan that the new task



force fashions should be a way to pay for care of all children through at least age 18. Except for prematurity, medical care of infants and children is by and large "low-tech" and therefore relatively inexpensive. Much of it is to prevent disease and detect disorders early.

Hand in hand with financing care for children should come reproductive care for women. This includes prevention, detection and management of pregnancy and full care of a mother for a time after birth. Reproductive care is likewise mostly low-tech.

Next could come long-term care (LTC) for the elderly and totally disabled adults younger than 65. Medicare provides only limited LTC. Most employer

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plans do not cover it.

LTC either at home or in an institution is expensive because it is labor intensive, but it generally does not involve sophisticated equipment or complex treatment regimens.

One way to finance LTC would be to require beneficiaries of Alaska's longevity bonus program to use \$100 of their \$250 monthly stipend to purchase LTC insurance. Then when one needed home care or placement in a nursing or Pioneers home, there

would be money to pay for it.

The income stream from the Mental Health Lands Trust Fund (once it is un-snarled) could underwrite almost all psychiatric care, other counseling and most of the special needs of the mentally retarded.

We should be careful not to use the trust fund just to care for the irremediable. Much of the money should go to prevent, attenuate and cure mental and emotional disorders.

Among groups decreed eli-

gible for care by Judge Meg Greene are "chronic alcoholics suffering from psychosis" and "senile people ... who suffer from major mental illness." This quasi-medical language is confusing, for few alcoholics are psychotic and all senile people have major mental defects.

All of this needs modern definition and sharp delineation. The Mental Health Trust Coalition and others are doing this.

Illnesses and injuries afflicting adults between ages 19 and 64 remain. These are often complex to treat and costly. They constitute the biggest challenge to the Health Resources and Access Task Force.

It ought to decide early whether to base a plan or plans on employer insurance programs. Aside from governmental employees, Alaska does not have many big employee groups. There are many small businesses,

many self-employed individuals and many seasonal workers. Health insurance for these is hard to find and expensive.

It might make more sense in Alaska to craft a system based on a health tax. This would eliminate much of the cost shifting that currently abounds and should cost less overall than current overlapping mechanisms of paying for health care.

It could also lead to appealing trade-offs with employers. Money from federal medical programs would, of course, continue to be claimed to offset some of the costs.

Medical care will remain expensive no matter how we pay for it. But there are ways to save money. That's a story for another day.

□ Dr. Rodman Wilson served as public health director for the municipality from 1982-1987.

Anthropologist a great scholar

I'm disappointed with the articles criticizing Dr. Hrdlicka of the Smithsonian Institution, who collected anthropological evidence from the Aleuts.

Dr. Hrdlicka was a great scholar. He founded the American Journal of Physical Anthropology and the American Association of Physical Anthropologists.



the world. We might as well allow mining on Mount McKinley, or private industry to develop our parks. If there is money to be made, what is there to stand in the way? In pursuit of the almighty dollar, man has unnecessarily destroyed many of our national treasures. Why do you think Alaska is called "The Last Frontier"?

If we allow the encroachment of the