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Alaska State Legislature

House of Representatives
 COMMITTEE ON HEALTH, EDUCATION
 AND SOCIAL SERVICES

DATE: 2/23/94

PLACE: Capitol Room 106

SUBJECT OF MEETING:

HB 139: ASSISTIVE TECHNOLOGY LOAN GUARANTEES
 *HB 451: COMPREHENSIVE HEALTH INSURANCE ACT

*INDICATES FIRST PUBLIC HEARING

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?	WHAT SUBJECT/ WHICH BILL?
Stan RIDGEMAN	DUIZ				✓ 405-6932	(Y) N	HB 139
Rupe ANDREWS	AARP				✓ 789-7422	(Y) N	HB 139
Nancy CORNWELL	Health System Reform Work Group	2411 West 69th Ave Anchorage AK	99502		243-8326	(Y) N	HB 451
						Y N	
						Y N	
						Y N	
						Y N	
						Y N	
						Y N	
						Y N	

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TO: House Hess

ATTN: _____ FAX: 465-2137 PHONE: _____

FROM: Carol Humlin Fauré PHONE: _____

INSTRUCTIONS: Testimony for 3/2 teleconference on
SB270/SB284

SENT: Date _____ Time _____

DISPOSAL OF ORIGINAL: Discard _____ Hold for Pickup _____

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TRANSMITTED BY: AG

3/2/94

My name is Carol Hamlin Faure, and I appreciate having the chance to testify today. I am a social work student at UAA, and I am currently working as a student intern for the Governor's Council on Disabilities and Special Education. I have spent a large part of my internship following health care reform efforts in Alaska for the Council's Health Committee. Although I do not speak for the Council, my work there has increased my awareness of health care issues that impact people with disabilities and their families. I'd like to address some of these issues today.

The first issue is consumer representation on any commission or corporation that is set up to address health care. This is important for two reasons. Representation will help to ensure that the health care concerns of consumers are considered and acted upon. Secondly, consumer representation will contribute to the feeling of ownership in the resulting health care reform measures. I'm pleased to see consumer representation included in SB 284.

Universal health care coverage is essential to people with disabilities, who want and need quality, affordable health care. Also, because people with disabilities often have complex, sometimes specialized medical needs, issues of provider choice and full coverage for services are very important.

A major issue is a benefits package that addresses the needs of people with disabilities. Some important benefits are durable medical equipment, travel costs, personal assistance services, daily therapies and other regular treatments that are necessary to maintain daily health, and long term care. I'm pleased to see that SB 284 specifically requires the development of a long term care plan.

Public involvement in the health care reform process is critical, not just for people with disabilities, but for all Alaskans. You are all aware of the importance of a feeling of ownership on the part of Alaskans. Without that ownership, reforming our health care system is nearly impossible. For people with disabilities, having input into the process of defining a benefits package is absolutely necessary if we are to fill the gaps in service that presently exist in our system. I like the process for public involvement that is included in SB 284.

If you would like more information about the health care concerns of people with disabilities, I encourage you to contact Kathy Fitzgerald, who is the chair of the Governor's Council on Disabilities and Special Education's Health Committee. Thank you again for the opportunity to testify today.



NEA-ALASKA

Affiliated with the National Education Association

NEA-ALASKA POSITION STATEMENT

SB 284 AND HB 451

Alaskans will benefit by our elected state leaders establishing a universal health care plan prior to the adoption of any national plan. SB 284 and HB 451 provide for a health care plan developed by the Health Resources and Access Task Force and the community of providers responsible for health care in Alaska.

NEA-Alaska is committed to a comprehensive health care single-payer system that guarantees universal access regardless of pre-existing conditions or economic circumstances. The plan must address the specific problems unique to our state -- health care delivery system, transportation problems, incentives to providers to locate in areas of Alaska that are not served or are currently underserved.

Any program should support existing collective bargaining agreements as well as the concept of collective bargaining itself. Employees must expect that the rights and benefits they have achieved through collective bargaining will be protected.

The plan should require simplification of forms and reduce unnecessary paperwork.

Health care costs must be controlled through reduction of administrative costs and increased budget discipline on health care providers and insurance companies.

Emphasis on preventive care must be an important component of any program.

Goal #1 on the National Education Goals states "by the year 2000 all children in America will start school ready to learn". If we are to achieve that goal, health care must be made universally available to every family and child. Healthy children make healthy schools.

NEA-Alaska supports SB 284 and HB 451 and commends those who possess the vision to take early action to propose development of an affordable and accessible health care plan for Alaska and her families.

2/23/94

2/8/94

Report of the
Health System Reform Work Group

PURPOSE AND MEMBERSHIP OF THE
HEALTH SYSTEM REFORM WORK GROUP

At the suggestion of several legislators, sponsors of Senate Bill 114 and representatives of the Health Access and Cost Containment Council, who authored Senate Bill 205, began meeting during the legislative interim. It was recognized that there were a number of areas of agreement in the two pieces of legislation.

Members of the work group included legislators, physicians, hospital and nursing home administrators, representatives of the insurance industry, the Administration, and the Alaska Native Health Board.

In addition, many other individuals representing a wide range of interests participated in the meetings. The group met bimonthly through December 1993. This documents reports areas of agreement among all but a few members of the work group. It also suggests a time line for implementation.

The report does not attempt to describe the extent of health care problems facing Alaska nor does it analyze the feasibility or cost of implementing proposed reforms.

This report presents the work group's areas of agreement in the following sequence:

- I. creation of a corporation
- II. cost control and utilization
- III. universal coverage
- IV. financing universal coverage
- V. access to care and mix of providers
- VI. data collection

- VII. a public health improvement plan
- VIII. tort reform
- IX. health insurance reform

I. CREATION OF A CORPORATION

Successful health care reform demands ongoing coordination, integration, and monitoring of the various elements of any comprehensive reform package. The work group agreed that a single administrative and policy-making entity is best suited to coordinate, integrate, and monitor the various elements of their reform proposal.

Areas of Agreement

Section A: Creation of a corporation. A health care corporation will be created to provide a health plan for all Alaskan residents and to monitor and control all health care expenditures in the state.

The corporation will be within a department of the state government but will operate as independently as possible.

Section B: Board of Directors. The operations of the corporation will be directed by a board of directors whose responsibilities are defined below.

Section C: Corporation's responsibilities. The corporation's board of directors will:

- (1) hire an executive director who serves at the pleasure of the board; the executive director hires other staff as necessary;
- (2) design a public involvement process for the purpose of gathering public input on the benefit package, options for financing, cost-sharing, and plan administration;
- (3) establish a comprehensive health care data system and begin collecting and analyzing health care expenditure data, demographic data, clinical information, billing and payment data, and health status, vital statistics, and other public health data;
- (4) design and adopt uniform claims forms and implement their use;

- (5) develop a public health improvement plan for the state of Alaska;
- (6) create a claims clearinghouse in Alaska to process all claims made to the corporation;
- (7) define the benefit package and eligibility requirements;
- (8) establish a voluntary cost control system including:
 - (a) establish and adopt a voluntary state-wide health care expenditure target;
 - (b) annually monitor health care expenditures and determine whether they have exceeded the voluntary expenditure target, how expenditures and patterns of utilization have changed, what factors have contributed to any charges, and report to the legislature and governor;
 - (c) prospectively collect and publish descriptions of provider types and lists of provider prices for frequently billed services and procedures;
 - (d) establish appropriate cost-sharing requirements for all residents under the corporation's health care plan;
 - (e) contract with an agency or agencies of Alaskan providers to perform peer volume, quality and appropriateness control;
- (9) present options to the governor and legislature on how to finance a health plan for all Alaskans;
- (10) with funds appropriated by the legislature, provide or purchase health care coverage (a health plan) for all Alaskan residents through a market-based single-payer system;
- (11) pursue waivers from the Employee Retirement Income Security Act and federal health care payers in order to capture both their claims data and revenue streams;
- (12) develop incentives to attract, train and retain a broad array of health care providers in underserved areas of the state;
- (13) through the claims clearinghouse, pay claims submitted by licensed providers for services that are in the benefit package;
- (14) at any time beginning three years after the voluntary expenditure target has been in effect, if the corporation concludes that voluntary compliance has failed substantially to achieve the adopted voluntary expenditure target:
 - (a) the corporation may, by regulation, impose a mandatory expenditure budget or limit;
 - (b) the corporation may, by regulation, impose mandatory expenditure budget or limits on one, some, or all subcategories of the budget;

(c) the corporation may, by regulation, directly assume some or all previously contracted cost control functions;

(d) the corporation may, by regulation, establish new price, volume and quality control guidelines;

In addition, the corporation will continue to:

(e) annually monitor health care expenditures and determine if they exceeded the mandatory budget, how expenditures and patterns of utilization have changed, what factors contribute to those changes, and report to the legislature and governor;

(f) establish appropriate cost-sharing requirements for all residents under the corporation's plan.

(15) establish committees of experts and others as needed to make recommendations regarding preventive measures, efficacy of health care modalities, provider mix within the state, and other matters; and.

(16) hold public meetings and make annual reports to beneficiaries, the governor, and the legislature.

Section D: Composition and appointment of board of directors. The board of directors will not exceed nine members. They will be appointed to staggered terms by the governor and confirmed by the legislature. A member will serve until replaced by the governor.

A majority of the board will be experts in health issues and fairly represent the interests of the general public in having access to quality and affordable health care. Interests of health care providers and purchasers will be fairly represented on the board. All directors will be residents of the state of Alaska. Their sex and geographical representation will approximate that of the state's population.

Section E: Board compensation, meetings, and staff. Directors will be compensated for the time they serve. This is expected to be part-time. The board will meet at least quarterly and will be supported by professional staff.

II. COST CONTROL AND UTILIZATION

Historical experience with utilization controls, managed care, and hospital rate setting have resulted in little, if any, significant decline in the rate of growth of health care spending. Market-oriented competitive strategies, for which there is almost no experience in Alaska, are unlikely to be effective at controlling costs in many areas because of chronic provider shortages and sparse population.

Areas of Agreement

The work group agrees that health care expenditures will for at least three years be controlled using a voluntary cost-control system as outlined in sections (A) through (E) below:

Section A: Establishing and adopting a voluntary state-wide health care expenditure target. The work group agrees that the management of limited health care resources in Alaska will best be accomplished by annually establishing and adopting a voluntary state-wide health care expenditure target. The corporation will establish the expenditure target from a base year of historical expenditures (the year prior to enactment of enabling legislation) and adjust it in future years, as appropriate by the following factors:

-changes in the general Consumer Price Index (for Alaska) plus a factor as follows:

- in the first year, CPI plus 1.5 percent;
- in the second year, CPI plus 1.0 percent;
- in the third year, CPI plus 0.5 percent; and,
- in the fourth year and years thereafter,
CPI with no additional factor;

-changes in the size and other demographic characteristics in the population such as aging;

-changes in the burden of disease resulting from epidemics, disasters, and reduction or elimination of diseases;

-elimination of unnecessary care;

- changes in technology;
- increases or decreases in the costs associated with medical malpractice premiums and awards;
- changes in administrative costs;
- changes aimed at improving access to care; and,
- changes in the patterns of utilization.

In designing the expenditure target, the corporation will take into consideration and, where possible, include all current sources of payment for health care services in Alaska including:

- all public and private employers and other groups that provide insurance or self-insured plans;
- individual plans and out-of-pocket expenses;
- federal, state, and local government sources, such as Medicare, the military, CHAMPUS, the Department of Veterans Affairs, the Indian Health Service, federal employee plans, Medicaid, General Relief Medical, grants to other governments and non-profit organizations, and other state and local government direct-service health programs;
- transportation costs associated with getting to and from health services; and,
- capital costs of health care facilities.

Section B. Monitoring the expenditure target. The corporation will monitor and make an annual report to the legislature and governor on:

(1) changes in total expenditures, (2) whether expenditures have exceeded the expenditure target, (3) how expenditures and patterns of utilization have changed, and (4) what factors have contributed to those changes.

Section C. Publish Provider Prices. Providers will post or make their price lists available upon request at their place of business. They will list their most frequently billed services.

Annually and prospectively, providers will submit a list of their prices to the corporation. The corporation will publish a description of types of providers licensed to provide services in the benefit package as well as comparative lists of provider prices for frequently billed services.

Section D. Cost-sharing with consumers. After seeking input from the public, the corporation will establish levels of deductibles and copayments.

Section E. Peer volume and quality control. The corporation will contract with an agency or agencies of Alaskan providers to perform peer volume, quality, and appropriateness control. This agency will establish peer specialty groups whose charge will be to control excesses within their discipline by reducing volume of care or by other mechanisms.

Peer specialty groups may also recommend through the agency expected or desired changes in the types and intensity of services or the types of providers best suited to furnish them. The agency may laterally organize various peer groups as a way of consolidating information from the groups. The agency may make this information and other recommendations available to the corporation. Recommendations developed by this agency will focus on developing incentives rather than controlling patterns of care.

Specific state action to require one or more cost control agencies will be necessary in order to forestall Federal Trade Commission antitrust action against providers.

Section F: The possibility of a mandatory cost control system. By the end of the third year of a voluntary cost control system, the corporation will determine if total health care expenditures have exceeded the expenditure target. If the corporation concludes that voluntary compliance has failed substantially to achieve the adopted voluntary expenditure target, the corporation may establish a mandatory state-wide health care expenditure budget. The corporation will not have to seek approval from the governor or legislature in order to implement a mandatory budget. The corporation may also establish new price, volume, and quality controls and guidelines.

The corporation may also annually establish mandatory sub-budgets as a means of controlling costs and making desired changes in the service delivery system.

The corporation may assume some or all of the previously contracted cost control functions or decide to contract with appropriate agencies for some cost control functions.

The corporation will continue to monitor expenditures and patterns of utilization.

III. UNIVERSAL COVERAGE

Areas of Agreement

Section A: Universal Coverage for all Alaskan Residents. The work group agrees on the goal of universal health care coverage for all Alaskans. They further agree that the corporation will be required by law to provide or purchase a health plan for all Alaskan residents.

IV. FINANCING UNIVERSAL COVERAGE

Areas of Agreement

Section A. A market-based single-payer system. The work group agrees that the corporation will provide or purchase health plans for all residents of the state. The corporation will design a system which utilizes market forces to encourage consumers to make more informed and appropriate purchasing decisions. Employers, unions, and individuals may purchase health benefit plans which cover services not included in the corporation's benefit package.

Section B. Market forces/appropriate utilization. The corporation will rely on market forces to control inappropriate utilization. Patterns of utilization will be influenced through appropriate deductibles and copayments and through incentives aimed at appropriate care. The corporation will publish comparative lists of provider prices. Each provider will post or provide upon request their prices at his or her place of business.

Section C. Health Fund. The corporation will undertake an extensive public involvement process for the purpose of gathering public input on the benefit package, options for financing, cost-sharing, and plan administration.

By January 1, 1997, the corporation will present options for financing the health plan for all Alaskans to the legislature. The legislature will decide, from among a variety of revenue sources, which should be used to finance the health plans for Alaskan residents. Potential revenue sources include: payroll taxes, income taxes, sales taxes, excise taxes, permanent fund earnings and dividends, and contributions to premiums. The legislature will appropriate funds to the corporation to pay for the health plan for Alaskans. As federal waivers are granted, existing federal and state revenue streams will be allocated to the corporation's fund.

IV. ACCESS TO CARE AND MIX OF PROVIDERS

In addition to access problems associated with inadequate health care coverage, the current distribution of health care resources in the state impedes some Alaskans from physically getting to health care services.

Areas of Agreement

Section A. Transportation costs. Transportation costs associated with receiving appropriate health care, particularly in a state like Alaska with few roads, must be considered a legitimate health care expense. In addition, reasonable changes in the distribution of health care providers and other resources must be made in the current system in order to alleviate some of the physical access problems. Therefore, valid transportation expenses should be included in the expenditure target.

Section B. Incentives to change the provider mix. The corporation will develop incentives to attract, train and retain health care providers in underserved areas. Incentives may include creating a student loan forgiveness program, supporting the development of an Alaska-based family residency program, developing and maintaining Alaska-based training and rotations for mid-level practitioners, and continuing efforts to analyze specific recruitment and retention problems in the state.

Section C. Scope of practice and reimbursement for services. Allied health professionals, like physicians, will be reimbursed by the claims clearinghouse for services rendered which are in the corporation's benefit package. For services within the benefit package, the corporation shall not restrict reimbursements for a particular provider and a particular service without making similar restrictions for all providers. That is, the corporation may not control health care expenditures by reimbursing only certain providers for a particular service. If the corporation chooses to control health care expenditures by reducing the benefit package, the elimination of certain services in the benefit package must be for all classes of providers.

To help attract and retain primary care providers to the state and in particular to underserved areas, the corporation may vary the rates of reimbursement to providers.

Section D. Allied health professionals. Allied health professionals ask to be included in the same type of peer volume and quality control activities as physicians and health care facilities. The work group agrees that they should be involved in these activities as long as they make the same commitment physicians and health care facilities have made to: (a) provide their fee schedules to the corporation, and (b) limit increases in prices to the CPI plus factors defined in Section II.

V. DATA COLLECTION

Areas of Agreement

Section A. Data collection. The corporation will establish a comprehensive health care data system to collect and analyze the following health care data elements:

- (a) health care expenditures including capital expenditures and transportation expenditures associated with receiving care;
- (b) demographic data;
- (c) clinical information including diagnoses, use of services (provider type, type of services and procedures, location of care, length of care, and referral patterns), quality of care, and health outcomes;
- (d) billing and payment data; and,
- (e) health status, vital statistics, and other public health data.

The above data elements are essential to the corporation's ability to carry out its functions.

The best source of information for most of these data elements is claims data collected by third-party payers. Additional expenditure data will need to be collected from health care agencies such as the Indian Health Service, the Department of Veterans Affairs, and the military, which do not provide indemnity (insurance) plans but rather provide health services directly.

Sources of data on health status, health outcomes, quality of care, and transportation costs, are more difficult to identify. The corporation will have to develop these data bases.

Section B. Uniform claims forms and single claims clearinghouse. The corporation must take two important additional steps in order to develop a comprehensive data system. They are: (1) design and adoption of uniform claims forms for use by all providers and payers, and (2) establishment of a claims clearinghouse in Alaska to process all claims submitted to the corporation.

These steps are necessary even as we transform from our multiple-payer system to a market-based single-payer system.

Another step in the development of a comprehensive data system is to pursue a federal waiver from the Employee Retirement Income Security Act. Without it, the state will not be able to compel self-insured employer plans to provide their claims data to the corporation.

VII. A PUBLIC HEALTH IMPROVEMENT PLAN

Areas of Agreement

The work group discussed Representative Joe Sitton's proposal to create a public health commission with the charge of developing a public health improvement plan. The work group agrees that such a plan is essential and that all public health providers in the state should participate in its development.

Section A. A public health improvement plan. The corporation shall direct the development of a public health improvement plan for the state of Alaska. The plan will identify core public health services and the roles and responsibilities of each federal, state, regional and local public health agency. The work group recognizes that a sound public health infrastructure is

essential to maintaining and improving the health of Alaskans and to controlling the growth in personal health care spending.

VIII. TORT REFORM

Areas of Agreement

The work group agrees that the following tort reform changes are warranted.

Section A. Statute of limitation at age 8 for injury before age 6. The current statute of limitations will be reduced from age 23 so that an action based on alleged professional negligence may not be brought against a health care provider on behalf of a person less than six years of age unless it is brought before the eighth birthday. Exceptions include fraud, intentional concealment of facts, or an undiscovered inappropriate foreign body within the person.

Section B. Floating or pre-judgment interest rates. Pre-judgment interest on medical malpractice claims should be linked to the federal discount rate in effect on January 1 of the year in which judgment or decree is entered.

Section C. Mandatory non-binding arbitration of all lawsuits. As specified in both Senate Bills 123 and 204, all lawsuits alleging medical malpractice will be submitted to non-binding arbitration. The state's three person pre-trial screening process will be replaced with one neutral expert. The arbitration process, including discovery, will be completed within 6 months. The arbitrator's written decision is admissible in court.

Section D. Limitation on recoverable damages. The work group agrees that a limitation on the amount of recoverable damages should be established either through a cap on non-economic damages or through a proposal made by the trial lawyers.

The work group was unable to decide between a cap of \$250,000 on non-economic damages as included in Senate Bill 204 and a new system proposed

by the trial lawyers that would replace the existing way in which medical malpractice lawsuits are adjudicated in Alaska.

Under the trial lawyers' proposal, a (state) authority will issue each health care provider a standardized liability package with a \$5 million limit on coverage. Every provider will be required to purchase professional liability insurance from the corporation. Premiums will reflect type and location of practice, and in the case of financial hardship, income. A risk pool may be established. The corporation will be the only named defendant in a medical malpractice action.

All cases asking compensatory damages of less than \$200,000 will be arbitrated with the cost of arbitration borne equally by both sides and limited to no more than one medical expert for each side. The arbitration hearing will be concluded within two days' time. If a case proceeds to a jury trial, the arbitrator will be the first witness as a friend of the court. The witness fee of the arbitrator will be borne by the party bringing the appeal.

The work group was intrigued by the trial lawyers' proposal but were unable to reach agreement.

Pending Issues

The work group was unable to reach agreement on changing the collateral source rule as presented in Senate Bill 204.

IX. HEALTH INSURANCE REFORM

Interim reform of the health insurance market was not of great interest to the work group, presumably because these potential access improvements are known to be marginal. The work group found some similarities between Senate Bills 114 and 205.

Since these bills were introduced in the legislature, Senate Bill 173 was enacted. It provides for some improvements in the small group insurance market. Insurers can no longer use claims experience, health status, and

length of coverage to set premium rates. It also requires that at least a basic plan be offered if an insurer has been denied coverage on the basis of health status or claims experience.

Under the work group's proposal, a health plan uniformly providing benefits to all Alaskan residents would eliminate the need to further regulate the health insurance industry. However, until the corporation begins providing a health plan to all residents, significant concerns remain.

Areas of agreement

Section A. Rating Practices. Senate Bill 114 and 205 both require insurers or a state pool to set their premium rates based on a quasi-community rate and to issue and renew plans to all groups that make such a request. Insurers may deny coverage for pre-existing conditions for only a limited period of time (one year in SB 114; corporation determines by regulation in SB 205). In all cases, however, insurers or the state pool must offer a basic plan to all who apply.

Section B. Rate review authority. The work group agrees that rate changes filed by all health insurers that sell group or individual insurance policies in Alaska will be subject to review and approval by the state director of insurance. The director must be given appropriate actuarial staff to perform this new function.

Pending Issues

The work group agrees and both bills require that insurers use a quasi-community rate. Both bills allow rates to vary by age and family composition/status. Senate Bill 114 also allows rates to vary by occupation and industry but requires that all rates fall within an established range or band. Insurers may not vary rates among similar businesses within a given geographical regional. Senate Bill 205 allows rates to vary by sex and other "generic factors". Rates must be set on a state-wide basis.

Suggested Timetable

(assumes enactment in 1994 and adequate staffing)

Functions of Corporation

	<u>Begin Date</u>
(1) Create corporation	July 1994
(3) Design public involvement system/begin process	Dec. 1994
(2) Establish data system and begin collecting data	Dec. 1994
(4) Design claims forms	June 1995
implement their use	Dec. 1995
(5) Develop a public health improvement plan	Dec. 1994
(6) Create clearinghouse	Dec. 1995
(7) Establish benefit package and eligibility requirements	1995
(8) Establish voluntary cost control system	Dec. 1996*
Establish Year One expenditure target	1997
(Year Three expenditure target)	1999
Monitor expenditures/patterns of utilization	1995
Collect and publish fees	Dec. 1995
Establish cost-sharing	Jan. 1997
Contract w/peer volume/control agency	Jan. 1996
(9) Present options to the legislature and governor on how to finance the health plans for all Alaskans	Jan. 1997
(10) Legislature begins funding health plans for all Alaskans (date received by corporation)	Jan. 1998
(11) Pursue federal waivers	Dec. 1994
(12) Initiatives to attract, train, and retain providers	Dec. 1994
(13) Claims clearinghouse begins paying claims	Dec. 1996

*If voluntary cost controls are successful at keeping expenditures within the expenditure target, this function will continue.

Continued. Suggested Timetable

Functions of Corporation

Begin Date

If the voluntary cost control system does not succeed in keeping expenditures within the expenditure target, at the end of the third year, the corporation may:

- | | |
|--|-----------|
| (14) Establish a mandatory cost control system | 2000 |
| Establish a mandatory budget | 2000 |
| May assume all or some cost control functions | 2000 |
| Establish new price, volume, and quality controls | 2000 |
| Establish mandatory sub-budgets | 2000 |
| (15) Establish committees of experts | As needed |
| (16) Hold public hearings/report to legislature and governor | Annually |

**HEALTH SYSTEM REFORM WORK GROUP
ALASKA PROPOSAL**

SB 284/HB 451

February 9, 1994

Provided by Senator Jim Duncan

ISSUE	WORK GROUP PROPOSAL SB 284/ HB 451
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1. Universal Coverage/Access

The corporation is required by law to purchase and/or directly provide a health plan for all Alaska residents.

2. Financing Universal Coverage

The corporation either contracts or directly pays for the health plans through a "market-driven single-payer system." The system would use market forces to insure appropriate consumption (i.e., published fees, appropriate copayments and deductibles, and incentives to use preventive services).

The legislature would decide from among a variety of revenue sources which should be used to finance the health plans.

Federal contributions added to fund.

3. Cost Containment

Cost containment is necessary.

There will be a set target budget.

There is a base year set for the global/target budget.

The corporation will set both the "target" budget and sub-budgets.

Total expenditures would be under voluntary control (peer review/sanctions). If not successful in a three year period of time, mandatory control would be put in place, and corporation assumes cost control functions.
(See also Provider Mix)

4. Data Collection

Single claim form through single entity.

All claims data + IHS, VA, CHAMPUS (non-fee-for-service) expenditures.

Other health data (which data still to be resolved)

Confidentiality protected.

Annual/periodic reports.

5. **Establish Alaska Health Insurance Corporation**

General

The group would be as independent as possible from politics. It would be housed in a state agency as a public corporation with a board of directors.

It would be a policy making entity, compensated (but not full time employment), have regularly scheduled meetings and a professional staff. The Directors must be residents of Alaska.

The Directors would have staggered terms, longer than four years such that no single governor would be able to appoint all members. (However, given the constitution, a governor can remove directors.) There should be no vacancies.

Members confirmed by the Legislature.

Advisory groups to report to corporation.

Functions

Responsible for implementation of policy as well as development of future policy/alternatives. This includes such items as setting the benefit package, developing and establishing an expenditure target, getting federal waivers, etc.

5. **Establish Alaska Health Insurance Corporation (continued)**

Membership Criteria

Fair geographical representation of the directors.
Uncertain how to assure this feature.

Gender balance.

General categories of membership with fair representation of consumers and providers. If physicians on board of directors, allied health professionals should also be represented.

6. **Provider Mix**

Expenditure data used to establish current provider mix, used by corporation in future years to adjust mix.

Allied health professionals included in same type of peer review/cost control activities as physicians.

Allied health professionals allowed to practice full range of what they are licenses to practice and not constrained by reimbursement mechanisms (as long as such services are included in the benefit package).

Allied health professionals involved in making recommendations to corporation on desired or expected changes in types/intensity of services, increase/decrease in numbers of providers. Recommendations from various peer groups consolidated at structural level between corporation and peer groups. This lateral integration of peer groups will focus on developing "incentives" rather than controls in making recommendations to the corporation.

6. **Provider Mix (continued)** Incentives to attract/retain health care professionals in medically underserved areas...student loan forgiveness. Alaska based family residency program, training for mid-level practitioners, RAHEC to analyze retention and recruitment.
7. **Utilization** Utilization needs to be controlled.
- Utilization is a factor to be examined and factored into establishing targets. Specialty groups will examine utilization and make recommendations to the corporation. If corporation "target" is not met and utilization's target has been determined to be inappropriate, corporation will examine other means of controlling utilization.
- Specialty groups given the opportunity to deal with excesses by imposing across-the-board cuts before corporation imposes mandatory sub-budgets.
- Quality of care is another factor that must be factored into budget/sub-budgets.
8. **Access to Care (both coverage and physical access).** Appropriate transportation costs must be included in expenditure target budget, plus a factor for adjusting the target. Data collected should include transportation costs.
- Authority responsible for analyzing current service delivery system and recommending changes to the system as a means of improving access.

9. Health Insurance Reform

Community rating.

Coverage of pre-existing conditions.

Guaranteed renewal.

Insurers must offer basic plan.

Single claims form/electronic claims system.

Claims clearinghouse.

Minimum benefit package.

Director of Division of Insurance should have corporation to review and approve or disapprove health insurance rates; will need adequate staff including actuaries.

10. Tort Reform

Statute of limitation at age 8 for injury before age 6.

Prejudgement interest floats with federal discount rate.

Universal coverage assures future medical care for the negligently injured.

Mandatory non-binding arbitration of **all** lawsuits; one neutral expert.

Arbitration of all small claims; threshold of \$100,000-\$200,000; if appealed, losing party would have to pay 100% of all costs; eliminate panel, one medical expert per side; limit on attorney fees, both sides; arbitrator is a friend of the court; Rule 11 strengthened.