

SB

284

FISCAL NOTE

**STATE OF ALASKA
1994 LEGISLATIVE SESSION**

BILL NO. SB 284

Revision Date: 3/22/94
 Title: Comprehensive Health Insurance Act
 Sponsor: Senate HESS
 Requester: _____

Department Affected: Commerce and Economic Development
 BRU: Insurance
 Component: Operations
 COMPONENT SERIAL NO. 0354

Expenditures/Revenues:

OPERATING EXPENDITURES	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
PERSONAL SERVICES	199.8	199.8	199.8	199.8		
TRAVEL	3.6	3.6	3.6	3.6		
CONTRACTUAL	42.4	42.4	42.4	142.4		
SUPPLIES	4.0	4.0	4.0	4.0		
EQUIPMENT	48.4	4.0	4.0	4.0		
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	298.2	253.8	253.8	353.8		

CAPITAL EXPENDITURES						
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CHANGE IN REVENUES ()						
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FUND SOURCE

1002 Federal Receipts						
1003 GF Match						
1004 GF	298.2	253.8	253.8	353.8		
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	298.2	253.8	253.8	353.8		

Estimate of current year (FY 94) cost: \$ _____

POSITIONS

FULL-TIME	4.0	4.0	4.0	4.0		
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary.)
 See attached.

Prepared by: David J. Walsh
 Division: Insurance

Phone: 465-2515
 Date: 3/22/94

Approved by Commissioner: Paul Fuhs
 Agency: Commerce and Economic Development

Date: _____

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SB 284 Division of Insurance Fiscal Note for the Alaska Health Insurance Corporation				
	FY95	FY96	FY97	FY98
Rate Approval				
Insurance Analyst III R-18@\$58.2	58.2	58.2	58.2	58.2
2 Consumer Complaint Specialists R-14 @\$45.2	90.4	90.4	90.4	90.4
Travel: Instate	3.6	3.6	3.6	3.6
Contractual: 3 position X \$10.6	31.8	31.8	31.8	31.8
Office space per position- 12 mths/\$1.80/sq ft/175 sq ft = \$3.8				
Miscellaneous contractual- \$6.8				
Contract w/consulting actuary	0.0	0.0	0.0	100
Supplies: \$1.0/position	3.0	3.0	3.0	3.0
Equipment: \$12.1/position 1st yr, \$1.0 after	36.3	36.3	36.3	36.3
Support for Division Liaison				
Administrative Asst III, R-16 @51.2	51.2	51.2	51.2	51.2
Contractual: 2 position X \$10.6	10.6	10.6	10.6	10.6
Office space per position- 12 mths/\$1.80/sq ft/175 sq ft = \$3.8				
Miscellaneous contractual- \$6.8				
Supplies: \$1.0/position	1.0	1.0	1.0	1.0
Equipment: \$12.1/position	12.1	1.0	1.0	1.0
Total Costs:	298.2	287.1	287.1	387.1

FISCAL NOTE

STATE OF ALASKA
1994 LEGISLATIVE SESSION

BILL NO. SB 284

Revision Date: 3/22/94
 Title: Comprehensive Health Insurance Act
 Sponsor: Senate HESS
 Requestor: _____

Department Affected: Commerce and Economic Development
 BRU: Alaska Health Insurance Corporation
 Component: _____
COMPONENT SERIAL NO. _____

Expenditures/Revenues:

OPERATING EXPENDITURES	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
PERSONAL SERVICES	2,654.5	3,641.7	5,502.7	18,581.7		
TRAVEL	579.6	372.4	398.8	431.8		
CONTRACTUAL	1,896.5	1,308.2	1,755.3	4,985.4		
SUPPLIES	75.0	95.0	128.0	437.0		
EQUIPMENT	886.3	338.5	562.1	4,400.1		
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	6,091.9	5,755.8	8,346.9	28,836.0		

CAPITAL EXPENDITURES	12,000.0	2,500.0	2,500.0	2,675.9		
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CHANGE IN REVENUES ()						
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FUND SOURCE

1002 Federal Receipts						
1003 GF Match						
1004 GF	18,091.9	8,255.8	10,846.9	31,511.9		
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	18,091.9	8,255.8	10,846.9	31,511.9		

Estimate of current year (FY 94) cost: \$ _____

POSITIONS

FULL-TIME	55.0	75.0	108.0	499.0		
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary.)
 Please see attached.

Prepared by: David J. Walsh
 Division: Insurance

Phone: 465-2515
 Date: 3/22/94

Approved by Commissioner: Paul Fuhse
 Agency: Commerce and Economic Development

Date: _____

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					FY 95	FY 96	FY 97	FY 98
SB 284 Fiscal Note for the Alaska Health Insurance Corporation								
Board of Directors: (See Attached Charts)								
	7 members	\$400/day honorarium			280.0	123.2	117.6	98.0
		FY95 100 days	\$280.0					
		FY96 44 days	\$123.2					
		FY97 42 days	117.6					
		FY98 35 days	98.0					
	Travel				204.6	134.2	156.2	118.8
Staff:								
# positions								
1	Executive Director	PX R-28			95.6	95.6	95.6	95.6
1	Deputy Director	R-23			79.3	79.3	79.3	79.3
1	Administrative Officer III	R-21			70.5	70.5	70.5	70.5
1	Secretary	R-10			36.9	36.9	36.9	36.9
2	2 Clerk-Typist III	R-8 @\$33.3			66.6	66.6	66.6	66.6
1	Accounting Clerk III	R-10			36.9	36.9	36.9	36.9
1	Information Officer	R-17			54.5	54.5	54.5	54.5
1	Paralegal Assistant II	R-16			51.2	51.2	51.2	51.2
1	Accounting Tech III	R-16 @\$51.2			51.2	51.2	51.2	51.2
1	Administrative Asst III	R-16 @\$51.2			51.2	51.2	51.2	51.2
1	Publication Specialist II	R-16 @\$51.2			51.2	51.2	51.2	51.2
1	Accountant IV	R-20 @\$65.8			65.8	65.8	65.8	65.8
1	Acct Supervisor I	R-16 @\$51.2			51.2	51.2	51.2	51.2
2	Acct Tech I	R-12 @\$41.0			82.0	82.0	82.0	82.0
1	Acct Clerk III	R-10 @36.9			36.9	36.9	36.9	36.9
1	Personnel Officer I	R-18 @\$58.2			58.2	58.2	58.2	58.2
1	Supply Officer II	R-16 @\$51.2			51.2	51.2	51.2	51.2
2	Mail Clerk Carrier II	R-9 @\$35.1			70.2	70.2	70.2	70.2
21				Total:	1,060.6	1,060.6	1,060.6	1,060.6
	Travel:				50.0	50.0	50.0	50.0
	Contractual costs per person:	10.6			222.6	222.6	222.6	222.6
		12 mths/\$1.80/sq ft/175 sq ft = \$3.8						
		Miscellaneous contractual- \$6.8						
	Contract w/Dept. of Law for legal support services (1 AAG & 1 secretary)				140.0	140.0	140.0	140.0
	Supplies: 1.0/position				21.0	21.0	21.0	21.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after				254.1	21.0	21.0	21.0

HEALTH1A.XLS

	FY 95	FY 96	FY 97	FY 98
Public Involvement Process:				
Advertising (2 time newspaper ads Juneau, Anchorage, Fairbanks, & Ketchikan) \$1.0/hearing 45 hearings (FY95) 24 hearings (FY96) 36 hearings (FY97) 11 hearings (FY98)	45.0	24.0	36.0	11.0
Teleconference hearings via LIO sites Full service set-up for 4-8 hr mtg. \$25/hr/LIO site plus toll costs. LIC has 22 sites, \$4,400 plus toll costs of \$2,600 per 8 hr conference. \$7,000/8hr 45 hearings/3 days = 135 days (FY95) 24 hearings/1 day = 24 days (FY96) 36 hearings/1 day = 36 days (FY97) 11 hearings/1 day = 11 days (FY98) This assumes no transcription of hearings or minutes.	945.0	168.0	252.0	77.0
Printing handouts for hearings/meetings 7000 copies of 2 back-to-back pages = \$650 \$650/7000 = \$.093/item rounded to \$.10 Assuming 50,000 copies x \$.10 = \$5,000 (FY95) 24/45 = 53% \$5,000 x 53% = \$2,666 or \$2.7 (FY96) 36/45 = 80% \$5,000 x 80% = \$4,000 or \$4.0 (FY97) 11/45 = 24% \$5,000 x 24% = \$1,222 or \$1.2 (FY98)	5.0	2.7	4.0	1.2

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					FY 95	FY 96	FY 97	FY 98
Data Collection:								
Capital Expenditure:								
	Computer equipment				10,000.0	2,000.0	2,000.0	2,000.0
(Estimated based on the current value of the equipment owned by Blue Cross of WA and AK)								
	Software Development (contracted out)*				2,000.0	500.0	500.0	500.0
*This assumes waiver of procurement process and that contractor is able to modify existing system to the corporation's use. The Division of Insurance is not aware of any off-the-shelf software available. Software cannot be finalized until regulations are adopted which specify the data to be collected.								
Per discussions with representatives of the Department of Health and Social Services (DHSS), the \$10 million computer equipment expenditure may not be required in FY 95, but rather the corporation may choose to contract for the use of computer resources.								
The comprehensive computer system envisioned by this legislation has never been established before in any state. Because of the time deadlines in the bill, the Corporation's system cannot use the Medicaid Management Information System (MMIS) as the "core" as there is not enough time to modify MMIS to meet the added requirements of this legislation.								
DHSS spent \$2,446.9 to develop the MMIS in FY 87. A key difference between MMIS development and the system envisioned by the bill is that DHSS had in place a computerized eligibility system and a known benefit package. DHSS is currently looking at upgrading MMIS and anticipates the software cost to be \$6.5 million. This system services roughly 100,000 Alaskans, a much smaller population than this legislation would cover.								
Therefore, while there is uncertainty about the cost split among computer hardware, software, and contracts, DHSS feels that our total cost estimate is reasonable.								
	1	Chief R-22 @ \$74.5			74.5	74.5	74.5	74.5
	1	Analyst/Programmer IV R-19 @\$61.9			61.9	61.9	61.9	61.9
	1	Analyst/Programmer III R-17 @\$54.5			54.5	54.5	54.5	54.5
	1	Secretary R-10 @\$36.9			36.9	36.9	36.9	36.9
Fees and Premiums Section								
	1	Economist II R-20 @ \$65.8			65.8	65.8	65.8	65.8
	2	Research Analyst III R-18 @ \$58.2			116.4	116.4	116.4	116.4
	2	Research Analyst II R-16 @ \$51.2			102.4	102.4	102.4	102.4
	3	Statistical Tech I R-12 @ \$41.0			123.0	123.0	123.0	123.0
	3	Statistical Tech II R-14 @ \$45.2			135.6	135.6	135.6	135.6
	1	Statistical Clerk R-10 @ \$36.9			36.9	36.9	36.9	36.9

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					FY 95	FY 96	FY 97	FY 98
	Operational Expense Section (start in FY 1996)							
1	Economist II R-20 @ \$65.8					65.8	65.8	65.8
4	Statistical Tech I R-12 @ \$41.0					164.0	164.0	164.0
3	Statistical Tech II R-14 @ \$45.2					135.6	135.6	135.6
2	Statistical Clerk R-10 @ \$36.9					73.8	73.8	73.8
3	Research Analyst II R-16 @ \$51.2					153.6	153.6	153.6
3	Research Analyst III R-18 @ \$58.2					174.6	174.6	174.6
32				Total:	807.9	1,575.3	1,575.3	1,575.3
	Note: (This unit is comparable to the Research and Analysis section in the department of Labor with 38 positions)							
	Contractual- \$10.6 per position				169.6	339.2	339.2	339.2
	Office space per position-							
	12 mths/\$1.80/sq ft/175 sq ft = \$3.8							
	Miscellaneous contractual- \$6.8							
	Supplies: \$1.0/position				16.0	32.0	32.0	32.0
	Equipment: 12.1/position 1st yr, 1.0/pos. alter				193.6	209.6	32.0	32.0

HEALTH1A.XLS

					FY 95	FY 96	FY 97	FY 98
	Claims Clearinghouse:							
1	Director R-26*				0.0	0.0	90.0	90.0
1	Claims Administrator R-21*				0.0	0.0	70.5	70.5
1	Data Processing Manager II R-22*				0.0	0.0	74.5	74.5
2	Analyst Programmer V R-21 @\$70.5*				0.0	0.0	141.0	141.0
4	Analyst Programmer IV R-19 @\$61.9*				0.0	0.0	247.6	247.6
4	Analyst Programmer IV R-19 @\$61.9				0.0	0.0		247.6
4	Analyst Programmer III R-17 @\$54.5				0.0	0.0		218.0
1	Analyst Programmer II R-15 @\$48.0				0.0	0.0		48.0
1	Physician Assistant R-20*				0.0	0.0	65.8	65.8
1	Investigator IV R-20 @\$65.8*				0.0	0.0	65.8	65.8
4	Nurse IV R-18 @\$58.2				0.0	0.0		232.8
3	Nurse III R-16 @\$51.2				0.0	0.0		153.6
4	Investigator III R-18 @\$58.2				0.0	0.0		232.8
3	Investigator II R-16 @\$51.2				0.0	0.0		153.6
6	Eligibility & Qual Ctrl Tech II R-18 @\$58.2*				0.0	0.0	349.2	349.2
24	Eligibility Tech IV R-16 @\$51.2				0.0	0.0		1,228.8
12	Eligibility Tech IV R-16 @\$51.2*				0.0	0.0	614.4	614.4
48	Eligibility Tech III R-14 @\$45.2				0.0	0.0		2,169.6
108	Eligibility Tech II R-12 @\$41.0				0.0	0.0		4,428.0
22	Data Processing Clerk III R-10 @\$36.9				0.0	0.0		811.8
3	Mail Clerk Carrier II R-9 @\$35.1*				0.0	0.0	105.3	105.3
2	Mail Clerk Carrier I R-7 @\$31.8				0.0	0.0		63.6
1	Secretary R-10 @\$36.9*				0.0	0.0	36.9	36.9
260				Total:	0.0	0.0	1,861.0	11,849.2
	* Means that this person starts in FY 97, everyone else starts in FY 98							
	Staffing in this unit is based on the staffing currently in Aetna's claims office							
	Travel:				0.0	0.0	10.0	100.0
	Contractual- \$10.6 per position				0.0	0.0	349.8	2,756.0
	Office space per position-							
	12 mths/\$1.80/sq ft/175 sq ft = \$3.8							
	Miscellaneous contractual- \$6.8							
	Supplies: \$1.0/position				0.0	0.0	33.0	260.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after				0.0	0.0	399.3	2,779.7
	Note: The utilization review unit does not include physicians or other medical specialists.							
	This may result in some friction with affected disciplines.							
	Note: The bill requires that the claims clearinghouse be established by 12/31/95.							
	We understand from the author of the bill this means that the claims clearinghouse would be organized by that date but will not be doing any work before 7/1/97. The cost of organizing the section would be part of the data collection set-up.							

HEALTH1A.XLS

					FY 95	FY 96	FY 97	FY 98
	Fee Reporting							
8	Document Processing Clerk III R-10 @\$36.9				295.2	295.2	295.2	295.2
3	3 Clerk III R-8 @\$33.3				99.9	99.9	99.9	99.9
1	Investigator III R-18 @\$58.2				58.2	58.2	58.2	58.2
2	Investigator II R-16 @\$51.2				102.4	102.4	102.4	102.4
1	Publication Specialist II R-16 @\$51.2				51.2	51.2	51.2	51.2
1	Analyst/Programmer III R-17 @\$54.5				54.5	54.5	54.5	54.5
16				Total:	661.4	661.4	661.4	661.4
	Travel:				25.0	25.0	25.0	25.0
	Contractual- \$10.6 per position				169.6	169.6	169.6	169.6
	Office space per position- 12 mths/\$1.80/sq ft/175 sq ft = \$3.8							
	Miscellaneous contractual- \$6.8							
	Supplies: \$1.0/position				16.0	16.0	16.0	16.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after				193.6	16.0	16.0	16.0
	Printing Annual Provider Price List (assuming \$.5 per copy, 30 copies printed)				15.0	15.0	15.0	15.0
	Public Health Improvement Plan							
1	Health & Soc Ser Planner III R-21 @\$70.1				70.1	70.1	70.1	70.1
1	Health & Soc Ser Planner I R-17 @\$54.5				54.5	54.5	54.5	54.5
0	Clerk-Typist III R-8 @\$33.3				0.0	0.0	0.0	0.0
2				Total:	124.6	124.6	124.6	124.6
	Travel:				20.0	20.0	20.0	20.0
	Contractual- \$10.6 per position				21.2	21.2	21.2	21.2
	Office space per position- 12 mths/\$1.80/sq ft/175 sq ft = \$3.8							
	Miscellaneous contractual- \$6.8							
	Supplies: \$1.0/position				2.0	2.0	2.0	2.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after				24.2	2.0	2.0	2.0
	Contract Funds:				63.5	63.5	63.5	63.5

HEALTH1A.XLS

					FY 95	FY 96	FY 97	FY 98
Federal Medicaid Waiver								
Contract w/Dept. of Law for representation in Washington D.C.					100.0	100.0	100.0	100.0
NOTE: These figures are estimates. The actual number could be significantly higher.								
Develop Incentives to Attract Health Care Providers								
Forgiveness of Student loans: A loan forgiveness program would require legislation in order to be enacted, so no expense amounts for this are included in this fiscal note. As an estimate, a 1992 bill, CSHB 442 (HES) carried a fiscal note with costs ranging from \$26.7 in the second year to \$347.5 in the sixth.								
Enrollment								
2	Chief, R-22 @\$74.5				0.0	0.0	0.0	149.0
2	Eligibility & Qual Ctrl Tech II R-18 @\$58.2				0.0	0.0	0.0	116.4
2	Eligibility Tech IV R-16 @\$51.2				0.0	0.0	0.0	102.4
14	Eligibility Tech II R-12 @\$41.0				0.0	0.0	0.0	574.0
1	Analyst Programmer V R-21				0.0	0.0	0.0	70.5
1	Analyst Programmer IV R-19 @\$61.9				0.0	0.0	0.0	61.9
2	Investigator III R-18 @\$58.2				0.0	0.0	0.0	116.4
1	Acct Tech II, R-14 @\$45.2				0.0	0.0	0.0	45.2
1	Data Entry Center Supervisor, R 14 @\$45.2				0.0	0.0	0.0	45.2
1	Document Processor IV, R-12 @\$41.0				0.0	0.0	0.0	41.0
2	Document Processor III, R-10 @\$36.9				0.0	0.0	0.0	73.8
1	Document Processor II, R-8 @\$33.3				0.0	0.0	0.0	33.3
49	Document Processor I, R-7 @\$31.8				0.0	0.0	0.0	1,558.2
1	Accounting Clerk III, R-10 @\$36.9				0.0	0.0	0.0	36.9
2	Clerk Typist III, R-8 @\$33.3				0.0	0.0	0.0	66.6
82				Total:	0.0	0.0	0.0	3090.8
Travel					0.0	0.0	0.0	0.0
Contractual: \$10.6/position					0.0	0.0	0.0	869.2
Office space per position- 12 mths/\$1.80/sq ft/175 sq ft = \$3.8								
Miscellaneous contractual- \$6.8								
Enrollment booklet 350,000 copies/\$450/1000 copies								157.5
Supplies: \$1.0/position					0.0	0.0	0.0	82.0
Equipment: 12.1/position 1st yr, 1.0/pos. after					0.0	0.0	0.0	992.2
Capital Expenditure:								
Microfilm Equipment								175.9
(This unit is designed to be very comparable to the PFD division)								--

STATE OF ALASKA
1994 LEGISLATIVE SESSION

BILL NO. SB 284

Revision Date: 3/22/94
Title: Comprehensive Health Insurance Act

Department Affected: Commerce and Economic Development
BRU: Alaska Health Insurance Corporation
Component: _____

Sponsor: Senate HESS
Requestor: _____

COMPONENT SERIAL NO. _____

Expenditures/Revenues:

OPERATING EXPENDITURES	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
PERSONAL SERVICES	2,306.7	3,293.9	3,293.9	6,384.7		
TRAVEL	579.6	372.4	388.8	331.8		
CONTRACTUAL	1,811.7	1,223.4	1,320.7	2,144.6		
SUPPLIES	67.0	87.0	87.0	169.0		
EQUIPMENT	779.1	330.5	111.9	1,317.3		
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	5,544.1	5,307.2	5,202.3	10,347.4		

CAPITAL EXPENDITURES	*500.0	*500.0	*500.0	*11,332.9		
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CHANGE IN REVENUES ()						
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FUND SOURCE

1002 Federal Receipts						
1003 GF Match						
1004 GF	6,044.1	5,807.2	5,702.3	21,680.3		
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	6,044.1	5,807.2	5,702.3	21,680.3		

Estimate of current year (FY 94) cost: \$ _____

POSITIONS

FULL-TIME	47.0	67.0	67.0	231.0		
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary.)

Please see attached.

*The capital costs are based upon information provided by the Department of Health and Social Services.

Prepared by: David J. Walsh
Division: Insurance

Phone: 465-2515
Date: 3/22/94

Approved by Commissioner: Paul Fuhs
Agency: Commerce and Economic Development

Date: _____

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For further distribution information call the Governor's Legislative Office

DRAFT

					FY 95	FY 96	FY 97	FY 98
SB 284 Fiscal Note for the Alaska Health Insurance Corporation								
Board of Directors: (See Attached Charts)								
	7 members \$400/day honorarium				280.0	123.2	117.6	98.0
	FY95 100 days \$280.0							
	FY96 44 days \$123.2							
	FY97 42 days 117.6							
	FY98 35 days 98.0							
	Travel				204.6	134.2	156.2	118.8
	Staff:							
# positions								
1	Executive Director PX R-28				95.6	95.6	95.6	95.6
1	Deputy Director R-23				79.3	79.3	79.3	79.3
1	Administrative Officer III R-21				70.5	70.5	70.5	70.5
1	Secretary R-10				36.9	36.9	36.9	36.9
2	2 Clerk-Typist III R-1 @ \$33.3				66.6	66.6	66.6	66.6
1	Accounting Clerk III R-10				36.9	36.9	36.9	36.9
1	Information Officer R-17				54.5	54.5	54.5	54.5
1	Paralegal Assistant II R-16				51.2	51.2	51.2	51.2
1	Administrative Asst III R-16 @\$51.2				51.2	51.2	51.2	51.2
1	Publication Specialist II R-16 @\$51.2				51.2	51.2	51.2	51.2
1	Acct Tech I R-12 @\$41.0				82.0	82.0	82.0	82.0
1	Acct Clerk III R-10 @36.9				36.9	36.9	36.9	36.9
13				Total:	712.8	712.8	712.8	712.8
	Travel:				50.0	50.0	50.0	50.0
	Contractual costs per person:	10.6			137.8	137.8	137.8	137.8
	12 mths/\$1.80/sq ft/175 sq ft = \$3.8							
	Miscellaneous contractual- \$6.8							
	Contract w/Dept. of Law for legal support services (1 AAG & 1 secretary)				140.0	140.0	140.0	140.0
	Supplies: 1.0/position				13.0	13.0	13.0	13.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after				157.3	13.0	13.0	13.0

					FY 95	FY 96	FY 97	FY 98
Public Involvement Process:								
	Advertising (2 time newspaper ads Juneau, Anchorage, Fairbanks, & Ketchikan) \$1.0/hearing 45 hearings (FY95) 24 hearings (FY96) 36 hearings (FY97) 11 hearings (FY98)				45.0	24.0	36.0	11.0
	Teleconference hearings via LIO sites Full service set-up for 4-8 hr mtg. \$25/hr/LIO site plus toll costs. LIO has 22 sites, \$4,400 plus toll costs of \$2,600 per 8 hr conference. \$7,000/8hr 45 hearings/3 days = 135 days (FY95) 24 hearings/1 day = 24 days (FY96) 36 hearings/1 day = 36 days (FY97) 11 hearings/1 day = 11 days (FY98) This assumes no transcription of hearings or minutes.				945.0	168.0	252.0	77.0
	Printing handouts for hearings/meetings 7000 copies of 2 back-to-back pages = \$650 \$650/7000 = \$.093/item rounded to \$.10 Assuming 50,000 copies x \$.10 = \$5,000 (FY95) 24/45 = 53% \$5,000 x 53% = \$2,666 or \$2.7 (FY96) 36/45 = 80% \$5,000 x 80% = \$4,000 or \$4.0 (FY97) 11/45 = 24% \$5,000 x 24% = \$1,222 or \$1.2 (FY98)				5.0	2.7	4.0	1.2
Data Collection/Analysis and Claims:								
1	Chief R-22 @ \$74.5				74.5	74.5	74.5	74.5
1	Analyst/Programmer IV R-19 @\$61.9				61.9	61.9	61.9	61.9
1	Analyst/Programmer III R-17 @\$54.5				54.5	54.5	54.5	54.5
1	Secretary R-10 @\$36.9				36.9	36.9	36.9	36.9
Fees and premiums Section								
1	Economist II R-20 @ \$65.8				65.8	65.8	65.8	65.8
2	Research Analyst III R-18 @ \$58.2				116.4	116.4	116.4	116.4
2	Research Analyst II R-16 @ \$51.2				102.4	102.4	102.4	102.4
3	Statistical Tech I R-12 @ \$41.0				123.0	123.0	123.0	123.0
3	Statistical Tech II R-14 @ \$45.2				135.6	135.6	135.6	135.6
1	Statistical Clerk R-10 @ \$36.9				36.9	36.9	36.9	36.9

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					FY 95	FY 96	FY 97	FY 98
	Operational Expense Section (start in FY 1996)							
1	Economist II R-20 @ \$65.8					65.8	65.8	65.8
4	Statistical Tech I R-12 @ \$41.0					164.0	164.0	164.0
3	Statistical Tech II R-14 @ \$45.2					135.6	135.6	135.6
2	Statistical Clerk R-10 @ \$36.9					73.8	73.8	73.8
3	Research Analyst II R-16 @ \$51.2					153.6	153.6	153.6
3	Research Analyst III R-18 @ \$58.2					174.6	174.6	174.6
32				Total:	807.9	1,575.3	1,575.3	1,575.3
	Note: (This unit is comparable to the Research and Analysis section in the department of Labor with 38 positions)							
	Contractual- \$10.6 per position				169.6	339.2	339.2	339.2
	Office space per position- 12 mths/\$1.80/sq ft/175 sq ft = \$3.8							
	Miscellaneous contractual- \$6.8							
	Supplies: \$1.0/position				16.0	32.0	32.0	32.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after				193.6	209.6	32.0	32.0
	Capital Expenditure:							
	Contractual Claims Handling/Data Collection costs:				500.0	500.0	500.0	11,157.0
	The amounts for '95 to '97 assume that data is downloaded from computer files maintained by hospitals, insurers, etc. Not all of the data required by the bill will be included in these computer files. This amount also assumes that data from IHS, self-insurers, etc will not be included until the appropriate waivers can be obtained.							
	The '98 amount assumes a decreasing per claim rate equal to what Medicaid is currently paying.							
	Claims volume (,000):	Cost per claim						
	up to 650	\$6.23						
	650 to 675	\$4.75						
	675 to 700	\$3.50						
	over 700	\$2.25						
	4.712 claims per person/ 500,000 non-medicaid people in Alaska = 2.356 million claims per year. Plus 1.411 million claims from medicaid people = 3.767 million total claims.							
	While it is likely that the cost per claim would decrease with the additional number of claims, the required data collection system would be expanded from what is currently in use for Medicaid. We assumed that the increases and decreases will cancel out.							

					FY 95	FY 96	FY 97	FY 98
	Fee Reporting							
8	Document Processing Clerk III R-10 @\$36.9				295.2	295.2	295.2	295.2
3	3 Clerk III R-8 @\$33.3				99.9	99.9	99.9	99.9
1	Investigator III R-18 @\$58.2				58.2	58.2	58.2	58.2
2	Investigator II R-16 @\$51.2				102.4	102.4	102.4	102.4
1	Publication Specialist II R-16 @\$51.2				51.2	51.2	51.2	51.2
1	Analyst/Programmer III R-17 @\$54.5				54.5	54.5	54.5	54.5
16				Total:	661.4	661.4	661.4	661.4
	Travel:				25.0	25.0	25.0	25.0
	Contractual- \$10.6 per position				169.6	169.6	169.6	169.6
	Office space per position-							
	12 mths/\$1.80/sq ft/175 sq ft = \$3.8							
	Miscellaneous contractual- \$6.8							
	Supplies: \$1.0/position				16.0	16.0	16.0	16.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after				193.6	16.0	16.0	16.0
	Printing Annual Provider Price List				15.0	15.0	15.0	15.0
	(assuming \$.5 per copy, 30 copies printed)							
	Public Health Improvement Plan							
1	Health & Soc Ser Planner III R-21 @\$70.1				70.1	70.1	70.1	70.1
1	Health & Soc Ser Planner I R-17 @\$54.5				54.5	54.5	54.5	54.5
0	Clerk-Typist III R-8 @\$33.3				0.0	0.0	0.0	0.0
2				Total:	124.6	124.6	124.6	124.6
	Travel:				20.0	20.0	20.0	20.0
	Contractual- \$10.6 per position				21.2	21.2	21.2	21.2
	Office space per position-							
	12 mths/\$1.80/sq ft/175 sq ft = \$3.8							
	Miscellaneous contractual- \$6.8							
	Supplies: \$1.0/position				2.0	2.0	2.0	2.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after				24.2	2.0	2.0	2.0
	Contract Funds:				63.5	63.5	63.5	63.5
	Federal Waivers for Medicaid etc							
	Contract w/Dept. of Law for representation in Washington D.C.				100.0	100.0	100.0	100.0
	NOTE: These figures are estimates. The actual number could be significantly higher.							

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					FY 95	FY 96	FY 97	FY 98
	Develop Long-Term Health Care Plan							
1	Health & Soc Serv Planner III R-21 @\$70.1					70.1	70.1	70.1
1	Health & Soc Serv Planner II R-19 @\$61.9					61.9	61.9	61.9
1	Health & Soc Serv Planner I R-17 @\$54.5					54.5	54.5	54.5
1	Clerk-Typist III R-8 @\$33.3					33.3	33.3	33.3
4					0.0	219.8	219.8	219.8
	Travel:					20.0	20.0	20.0
	Contract Funds:				0.0	????	????	????
	Contractual- \$10.6 per position				0.0	42.4	42.4	42.4
	Office space per position-							
	12 mths/\$1.80/sq ft/175 sq ft = \$3.8							
	Miscellaneous contractual- \$6.8							
	Supplies: \$1.0/position				0.0	4.0	4.0	4.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after				0.0	48.4	48.4	48.4
	Miscellaneous supplies:				20.0	20.0	20.0	20.0
	General office equipment:							
	Recording equipment \$.2				0.2	0.0	0.0	0.0
	3 Fax @ \$3.0 = \$9.0				9.0	0.0	0.0	0.0
	Conference Table \$4.0				4.0	0.0	0.0	0.0
	Conference chairs 25 @ \$220				5.5	0.0	0.0	0.0
	Storage cabinets 10 @ \$.3				3.0	0.0	0.0	0.0
	File cabinets 50 @ \$.6				15.0	15.0	0.0	0.0
	Telephone system @\$1.3/position				61.1	26.0	0.0	213.2
	Photocopier @\$90.0				90.0	0.0	0.0	0.0
	Photocopier mid size 2 @ 7.0				14.0	0.0	0.0	0.0
	Photocopier desktop 2 @\$1.2				2.4	0.0	0.0	0.0
	Typewriters 10 @\$1.5				5.0	0.0	0.0	0.0
	Reception chairs 3 @\$220 =				0.7	0.0	0.0	0.0
	Mailing equipment \$.5				0.5	0.5	0.5	0.5
	Total Number of Positions:				47.0	67.0	67.0	231.0
	Total Salary Cost:				2,306.7	3,293.9	3,293.9	6,384.7
	Total Cost other than Salary:				3,737.4	2,513.3	2,408.4	15,295.6
	Grand Total:				6,044.1	5,807.2	5,702.3	21,680.3
	4 year total:				39,233.9			
NOTE: These estimates do not take into account 1) any costs to the workers' compensation system resulting from the merger of occupational and non-occupational health care, nor 2) the impact of this plan on premium tax receipts by the general fund.								

Alaska State Legislature

Legislative Research Agency



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February 25, 1994

MEMORANDUM

TO: Senator Jim Duncan

FROM: Maureen Weeks^{MW}
Legislative Analyst

RE: **Comparison of Senate Bill 284 and Senate Bill 270**
Research Request 94.157

You asked us to compare two health care reform bills before the legislature this year, Senate Bill 284/House Bill 451 and Senate Bill 270/House Bill 414. The comparison is attached.

We chose our questions from the topics covered in side-by-side comparisons of health care reform plans by the American Association of Retired Persons and the Intergovernmental Health Policy Project at the George Washington University. For your convenience, here is a table of contents.

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I hope this is useful for your purposes. If you have any questions would like additional information, please call.

Attachment

Summary Statement

SB 284/HB 451	SB 270/HB 414
Comprehensive reform using a market-based single-payer system with health care coverage for every legal Alaska resident	Commission analyzes health care reform proposals, makes changes in current health care systems, and recommends long-term reform

Definition:

"Market based single payer system" means a system in which a single entity provides health insurance to all residents of the state and the insurance is based on market forces, including provider defined fees, defined patient copayments, sliding scale copayments for the indigent, provider fees that are posted or made otherwise available at the point of services, published or disseminated fees in comparative lists that allow fee comparison by consumers, voluntary expenditure targets, provider peer review and control of volume, utilization, and quality of health services, and a regularly published description of the various types of providers licensed to provide services in the benefit package." (Sec. 21.58.400(9))

Market Forces:

A "market-based" system uses market forces to make consumers more aware of the actual costs of health services and provides consumers with information enabling them to make more informed purchasing decisions. (Sec. 1 (b)(2)).

Analysis of Cost-Benefits:

The commission is "not intended to be viewed as a comprehensive reform proposal." Instead, it would analyze cost-benefit of elements of reform proposals (Governor's transmittal letter, p. 1; and N. Usera, personal communication)

Does the Plan Describe a Benefits Package?

SB 284/HB 451	SB 270/HB 414
No. the corporation is to develop a package by December 31, 1995	No. the commission is to analyze and make recommendations on "defining a range of potential benefit packages" by January 1, 1996

Mandate to Develop Benefits Package:

The Alaska Health Insurance Corporation "shall" develop a "benefits package of health care services that enrollees in the state health insurance plan are entitled to receive" (21.58.110) "The corporation shall adopt regulations specifying the health care services required to be covered by the state health insurance plan . . ." (21.58.170(a))

"By December 31, 1995, the corporation shall determine the health care services required under AS 21.58.170 . . ." (Sec. 12(3))

Public Participation:

The Alaska Health Corporation shall allow the public an "ongoing opportunity" to participate in decisions made by the board of directors about health care services residents want included in the benefit package. (Sec. 21.58.320)

Annual Review:

"The corporation shall . . . at least annually, review the health care benefits package and revise it as determined by the corporation, taking into consideration the health needs of the state, available funding, and other relevant factors as determined by the corporation . . ." (21.58.100(10))

Defining a Range of Potential Benefit Packages:

The Alaska Health Commission is to analyze health care reform proposals; recommend proposals to the governor and the legislature; and make recommendations on "defining a range of potential benefit packages for universal health care coverage for Alaskans -- on or before January 1, 1996" (Sec. 44.19.621(a)(5)(A)) The commission would analyze plans placed before it, including universal coverage plans (N. Usera, personal communication).

Does the Bill Offer a Financing Plan?

SB 284/HB 451	SB 270/HB 414
<p>No, the corporation is to present financing options to the governor and legislature by January 1, 1997</p>	<p>No, the commission is to analyze and make recommendations on "determining financing plans for recommended proposals" by January 1, 1996</p>

Financing Options:

"[B]y January 1, 1997, the corporation shall . . . present options to the governor and the legislature on how to finance a state health insurance plan under a market based single payer system." Sec. 12 (6)

Public Participation in Decisions:

The Alaska Health Insurance Corporation "shall" give the public "an ongoing opportunity" to participate in the corporation's board of directors' decisions regarding financing options and revenue sources that should be used to finance the health plan. (Sec. 21.58.320)

Determining Financing Plans:

The Alaska Health Commission is to analyze health care reform proposals; recommend proposals to the governor and the legislature; and make recommendations on "determining financing plans for recommended proposals -- on or before January 1, 1996." 44.19.620(a)(5)(D)

Summary Statement

SB 284/HB 451	SP 270/HB 414
Comprehensive reform using a market-based single-payer system with health care coverage for every legal Alaska resident	Commission analyzes health care reform proposals, makes changes in current health care systems, and recommends long-term reform

Definition:

"'Market based single payer system' means a system in which a single entity provides health insurance to all residents of the state and the insurance is based on market forces, including provider defined fees, defined patient copayments, sliding scale copayments for the indigent, provider fees that are posted or made otherwise available at the point of services, published or disseminated fees in comparative lists that allow fee comparison by consumers, voluntary expenditure targets, provider peer review and control of volume, utilization, and quality of health services, and a regularly published description of the various types of providers licensed to provide services in the benefit package.' (Sec. 21.58.400(9))

Market Forces:

A "market-based" system uses market forces to make consumers more aware of the actual costs of health services and provides consumers with information enabling them to make more informed purchasing decisions. (Sec. 1 (b)(2).

Analysis of Cost-Benefits:

The commission is "not intended to be viewed as a comprehensive reform proposal." Instead, it would analyze cost-benefit of elements of reform proposals (Governor's transmittal letter, p. 1; and N. Usera, personal communication)

Does the Plan Provide for Universal Coverage?

SB 284/HB 451	SB 270/HB 414
Yes, by Jan. 1, 1998	No, it promotes access to affordable care

Universal Coverage:

"The purpose of this Act is to . . . create a market based single payer state health insurance system that provides health insurance to all residents of the state . . ." (Sec. 1(b)(2))

"By January 1, 1998, the corporation shall . . . begin to provide health insurance coverage for state residents . . ." (Sec. 12(7))

Access to Affordable Care:

"It is the intent of the legislature to promote access to affordable, quality health care for Alaskans . . ." (Sec. 2).

Governor's transmittal letter states, "This bill addresses improvements to the delivery, quality, access, cost and financing of health care services. The bill is not intended to be viewed as a comprehensive reform proposal." (1/28/94, p. 2)

Does the Plan Describe a Benefits Package?

SB 284/HB 451	SB 270/HB 414
<p>No, the corporation is to develop a package by December 31, 1995</p>	<p>No, the commission is to analyze and make recommendations on "defining a range of potential benefit packages" by January 1, 1996</p>

Mandate to Develop Benefits Package:

The Alaska Health Insurance Corporation "shall" develop a "benefits package of health care services that enrollees in the state health insurance plan are entitled to receive" (21.58.110) "The corporation shall adopt regulations specifying the health care services required to be covered by the state health insurance plan . . ." (21.58.170(a))

"By December 31, 1995, the corporation shall . . . determine the health care services required under AS 21.58.170 . . ." (Sec. 12(3))

Public Participation:

The Alaska Health Corporation shall allow the public an "ongoing opportunity" to participate in decisions made by the board of directors about health care services residents want included in the benefit package. (Sec. 21.58.320)

Annual Review:

"The corporation shall . . . at least annually, review the health care benefits package and revise it as determined by the corporation, taking into consideration the health needs of the state, available funding, and other relevant factors as determined by the corporation . . ." (21.58.100(10))

Defining a Range of Potential Benefit Packages:

The Alaska Health Commission is to analyze health care reform proposals; recommend proposals to the governor and the legislature; and make recommendations on "defining a range of potential benefit packages for universal health care coverage for Alaskans -- on or before January 1, 1996" (Sec. 44.19.621(a)(5)(A)) The commission would analyze plans placed before it, including universal coverage plans (N. Usera, personal communication).

How is the Plan to be Administered?

SB 284/HB 451	SB 270/hb 414
<p>By the Alaska Health Insurance Corporation</p> <p>Membership: 7 directors appointed by the governor to 4-year terms</p> <p>Meetings: at least quarterly</p> <p>Compensation: \$400 per meeting day plus travel and per diem</p>	<p>By the Alaska Health Commission</p> <p>Membership: 3 members appointed by the governor to six-year terms</p> <p>Meetings: at least quarterly</p> <p>Compensation: Range 26C</p>

Make-up of the Board:

The majority of directors are to be expert in health care issues; consumers and providers are to be "fairly represented"; geographic and gender composition are to approximate that of the state.

Committees of Experts:

The commission "shall" establish committees of experts to make recommendations.

Comparison to Permanent Fund Board:

In testimony before the legislature, the bill's authors compare it to "arm's length" entities such as the Alaska Permanent Fund Board.

Advisory Committees:

The commission "may" establish advisory committees to conduct research or investigation (committees must include at least one commission member) and "may" adopt regulations establishing fees for services provided by the commission.

Comparison to Public Utilities Commission:

In testimony before the legislature, the Governor's representative compared the commission to a public utilities commission.

Does the Bill Offer a Financing Plan?

SB 284/HB 451	SB 270/HB 414
No, the corporation is to present financing options to the governor and legislature by January 1, 1997	No, the commission is to analyze and make recommendations on "determining financing plans for recommended proposals" by January 1, 1996

Financing Options:

"[B]y January 1, 1997, the corporation shall . . . present options to the governor and the legislature on how to finance a state health insurance plan under a market based single payer system." Sec. 12 (6)

Public Participation in Decisions:

The Alaska Health Insurance Corporation "shall" give the public "an ongoing opportunity" to participate in the corporation's board of directors' decisions regarding financing options and revenue sources that should be used to finance the health plan. (Sec. 21.58.320)

Determining Financing Plans:

The Alaska Health Commission is to analyze health care reform proposals; recommend proposals to the governor and the legislature; and make recommendations on "determining financing plans for recommended proposals -- on or before January 1, 1996." 44.19.620(a)(5)(D)

How Does the Plan Control Costs?

SB 284/HB 451	SB 270/HB 414
Sets health care expenditure target, with annual review	Simplifies administration with uniform procedures
Uses a monitoring system: physicians voluntarily regulate health care costs (followed by mandatory regulation if necessary)	Requires state approval for rates charged by insurers
Posts and publishes provider prices for consumer comparison shopping	Sets up pools to share risks
Requires providers to provide health care data	Establishes mandatory non-binding arbitration in medical malpractice suits, with arbitrator's decision admissible in court
Uses copayments to encourage shopping	Considers altering hospital licensing to lower use of expensive acute care
Simplifies administration with uniform claims forms and claims clearinghouse	
Uses preventive and wellness programs	
Promoting effective medical treatments	
Identifying the best provider mix and encouraging effective medical treatments	

How Does the Plan Control Costs? (Continued)

SB 284/HB 451

SB 270/HB 414

General Statement:

"The purpose of this Act is to . . . increase access to health care by containing the rate of increase of health care expenditures . . ." (Sec. 1(b)(1))

Expenditure Target:

"The corporation shall prescribe by regulation a statewide health care expenditure target . . . [T]he base year . . . shall be calendar year 1993 . . . The corporation annually shall adjust the . . . target . . . to reflect changes in the Consumer Price Index" as well as changes in demographics, medical technology, access to services, the burden of disease, elimination of unnecessary care, liability insurance costs, administrative costs and utilization patterns. (Sec. 21.58.270(a) and (b))

Voluntary Physician Compliance with Target:

The expenditure target adopted by the corporation [is] a recommended target for expenditures within each specified category or subcategory of health care services or products . . . [P]roviders may voluntarily comply with the expenditure target and may take all appropriate steps not prohibited by law to attempt to ensure that annual expenditures for health care in the state do not exceed the expenditure target . . ." (Sec. 21.58.280)

General Statement

"The analysis to be provided by the commission, particularly with regard to the cost, financing and implementation of health care reform, is critical, given the current fiscal circumstances facing the state. It is essential that the fiscal impact of health care reform be fully considered before further action is taken." (Governor's transmittal letter, 1/28/94, p. 2.)

Uniform Procedures:

No later than July 31, 1996, the director of the division of insurance, after considering the advice of the commission, shall adopt by regulation uniform claims forms, uniform standards and uniform procedures for the processing of data relating to billing for and payment of health care services provided to Alaskans." (44.19.628(a))

Rate Approval:

Health insurance "rates, fees and payments . . . may not be excessive, inadequate or unfairly discriminatory" and "rates [paid] to providers . . . must be fair and reasonable." (Sec. 21.87.190(a))

A health insurer or health maintenance organization "shall" file rates or fees with the commission and the division of insurance (including changes). The division "shall" review the filing within 45 days and recommend approval or disapproval to the commission in writing. The commission shall hold a public hearing for comment on the filing." (Sec. 44.19.625 and 21.51.350 and 21.86.075)

How Does the Plan Control Costs? (Continued)

SB 284/HB 451

SB 270/HB 414

Mandatory Physician Compliance:

The corporation "shall" monitor the success of voluntary compliance. If the corporation determines (after three years) that voluntary compliance has "failed substantially" to meet the target, the corporation "shall" impose a mandatory expenditure limit, by regulation. (Sec. 21.58.300)

The corporation "may" regulate compliance by: imposing a mandatory limit on one or more subcategories or on specific items; establishing mandatory price and utilization controls; monitoring expenditures; and establishing cost-sharing recommendations. It may also directly assume all or part of cost-control functions (deductibles and copayments, information on provider fees, and the expenditure target). (Sec. 21.58.300(b))

Copayments:

After seeking input from the public, the corporation shall establish deductible and copayment amounts. (Sec. 21.58.170 and 21.58.180) In testimony before the legislature, the bill's authors have characterized the copayments as "substantial" and said the purpose would be to encourage consumers to "shop" for the best price.

Uniform Claims:

By June 31 (sic), 1995, the corporation "shall" complete and implement a uniform claims form (Sec. 21.58.110(4) and Sec. 12(2))

Pools:

The purpose of the commission is to [promote] the creation of pools for the purpose of sharing risks or purchasing insurance for health care services . . ." (Sec. 44.19.621(a)(4))

After consulting with the Alaska Health Commission, the director "shall" adopt regulation to create pools "for the purpose of sharing risks or purchasing insurance." (Sec. 21.87.285 and 21.86.320 and 21.87.285)

Mandatory Arbitration:

A person who files an action against a health insurer or a medical malpractice action against a health care provider shall submit the claim to the court for arbitration. Either party may reject the arbitrator's decision. The decision is admissible in court. (Sec. 09.55.535(a)-(e) and Sec. 09.55.565)

Hospital Licensing:

The commission is to analyze and make recommendations to the governor and legislature on "investigating alternatives to existing hospital licensing requirements to allow for less use of [expensive] acute care facilities." Deadline: January 1, 1997. (Sec. 44.19.622(a)(5)(H))

How Does the Plan Control Costs? (Continued)

SB 284/HB 414	SB 270/HB 414
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Claims Clearinghouse:

By December 31, 1995, the corporation "shall" establish a claims clearinghouse. A provider "shall" submit all claims for payment under the state health insurance plan to the claims clearinghouse. Subject to appropriation, the claims clearinghouse shall pay claims approved for payment by the corporation. (Sec. 21.58.220(a) and (b) and Sec. 12(3))

Prevention and Wellness:

The purpose of the Act is to . . . [use] preventive and wellness programs to reduce health care costs (Sec. 1(b)(3)(B)).

Effective Treatments. Provider Mix:

The corporation "shall" establish committees of experts to recommend how to control health care costs. The recommendations are to include: a greater emphasis on healthful lifestyles, prevention of disease and injury, promoting effective medical treatments, and identifying the optimal provider mix within the state. (Sec. 21.58.110(18))

Does the Plan Allow Public Participation?

SB 284/HB 414	SB 270/HB 414
<p>The Alaska Health Insurance Corporation sets up an "extensive" public involvement process allowing Alaskans to participate in decisions made by the board of directors</p>	<p>The Alaska Health Commission collects and analyzes data from public hearings. Except when adopting regulations or acting on rate filings, the Alaska Health Commission is exempt from the Open Meetings Act</p>

Public Involvement Process:

"The corporation shall design, implement and maintain an extensive community based public involvement process (to allow) residents . . . to participate in decisions made by the corporation's board of directors regarding: health care services residents want included in the benefit package; financing options; revenue sources that should be used to finance the health plan; cost-sharing options; and administration of the health care plan." (Sec. 21.58.320)

"The [Alaska Health Insurance] Corporation shall . . . create and implement the formal public involvement process . . . for the purpose of gathering broad input on the state health insurance plan, options for financing the cost of coverage, cost-sharing of the health insurance plan, and the cost of the plan . . ." (Sec. 21.58.110(2))

"The corporation shall conduct a comprehensive public involvement process designed to solicit information and opinions regarding [health care services] required to be covered . . ." (Sec. 21.58.170(b))

Public Participation:

"The commission shall . . . collect and analyze data and information from public, private or other sources relating to the cost, delivery, or financing of health care services provided to Alaskans." The term "public" here refers to public hearings (N. Usara, personal communication)

Open Meetings Exemption:

"[M]eetings of the Alaska Health Commission, except for meetings concerning the adoption of regulations or actions on filings," are exempt from AS 44.62.310 (the Open Meetings Act). (Sec. 44.62.310(d)(6))

Rate and Filings Public Hearings:

"The commission shall hold a public hearing for comment on [rate] filing[s] and for verifying the basis for the filing[s]." (Sec. 44.19.629(b)(3))

Does the Plan Allow Public Participation? (Continued)

SB 284/HB 414

SB 270/HB 414

Regulations Take Public Requests Into Account:

"The corporation shall adopt regulations specifying the health care services required to be covered by the state health insurance plan, taking into consideration the services requested by the public . . ." (Sec. 21.58.170(a))

Does the Plan Include Data Collection?

SB 284/HB 451	SB 270/HB 414
<p>Yes. plan sets up a health care data system to begin collecting data by December 31, 1994; invalidates licenses of providers who do not comply</p>	<p>Yes. plan sets up a system to collect and analyze health care data; providers and insurers must submit that data.</p>

Comprehensive Data Collection:

"The corporation shall . . . establish [a] comprehensive health care data system . . ." Sec. 21.58.110(3)

The corporation "shall . . . establish the [health care data] system . . . and begin collecting data by December 31, 1994." (Sec. 12(1).

List of Data to be Collected:

"The corporation shall develop and periodically update a health care data system [based on] calendar year 1993 and [including] health care expenditures, including [the following]: capital expenditures associated with receiving health care; demographic data; clinical information, including patient diagnosis, type of provider, type of service, location and length of care, referral patterns, quality of care, and result of care; billing and payment data; and public health data, including vital statistics and health status. (Sec. 21.58.260(a))

Providers Must Submit Data . . .

Providers "shall" comply with requirements to submit claims data for the health care data system, including regulations adopted by the Alaska Health Insurance Corporation. (Sec. 21.58.260(b) and Sec. 08.02.025)

Commission Shall Collect Data:

"The purpose of the commission is to [establish and implement] a system for collecting and analyzing information and data relating to health care needs of and services provided to Alaskans." (Sec. 44.19.621(a)(1))

"The commission shall . . . collect and analyze data and information from public, private, or other sources relating to the cost, delivery, or financing of health care services provided to Alaskans." (Sec. 44.19.625(b)(2))

Providers and Insurers Must Provide Data:

"All persons and entities providing or insuring health care services to Alaskans shall provide, upon request or order of the commission, reports, data, health information, insurance schedules, statistics, and other information, as determined necessary by the commission, by regulation . . ." (Sec. 44.19.631(a))

Mechanism to Collect and Analyze Data:

"It is the intent of the legislature to [establish] a mechanism for the . . . collection and analysis of information and data concerning health care services and the making of recommendations based on that data . . ." (Sec. 2)

Does the Plan Include Data Collection? (Continued)

SB 284/HB 451	SB 270/HB 414
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... Or Invalidate Their Licenses

A provider's license "is not valid" unless the health care provider submits required data. (Sec. 08.02.025)

Federal Waivers:

The corporation "shall" apply for federal waivers to "incorporate . . . claims data . . . into the corporation's data system . . ." (Sec. 21.58.110(14))

Data Used to Monitor Voluntary Compliance:

Based on the data compiled through the health care data system, the corporation "shall" monitor the success of voluntary provider compliance with the health care expenditure target (Sec. 21.58.270(a))

Does the Plan Include Preventive Care?

SB 284/HB 451	SB 270/HB 414
Yes, one goal of the corporation is to prevent illness and promote wellness	The bill does not mention prevention or wellness

Preventive and Wellness Programs:

"The purpose of the Act is to . . . provide a structure for addressing the health care needs of the state, including . . . use of preventive and wellness programs to reduce health care costs" (Sec. 1(b)(3)(B))

Commission Does Not Endorse Particular Approach:

The commission performs a "market analysis" on health care reform proposals (or elements of those proposals) brought to it by the governor or by others; it does not endorse a particular approach. (N. Usara, personal communication)

Benefits Include Prevention and Wellness Goal:

"The corporation shall adopt regulations specifying the health care services required to be covered by the state health insurance plan, taking into consideration . . . the goal of prevention of illness and promotion of wellness . . ." (Sec. 21.58.170(a))

Expert Committees Consider Health and Prevention:

The corporation shall . . . establish committees of experts . . . to make recommendations to the corporation regarding how to contain the cost of health care, including incorporating a greater emphasis on healthful lifestyles [and] prevention of disease and injury . . ." (Sec. 21.58.110(18))

Does the Plan Include Public Health?

SB 284/HB 451	SB 270/HB 414
<p>The corporation establishes a public health improvement plan and requires recommendations for specific legislative action for that plan</p>	<p>Public health is not included in the bill</p>

Need to Focus on Public Health:

"The legislature finds that . . . there is a compelling need for a strong, clear focus on public health issues" (Sec. 1(5))

Intent to Include Public Health Issues:

The authors of the bill intend to amend the bill to include public health issues (N. Usera, personal communication)

Public Health Improvement Plan:

"The corporation shall . . . develop and update (a) public health improvement plan for the state" (Sec. 21.58.110(3) and 21.58.310(a))

Plan Includes:

The plan required under this section must include: an analysis of health status in Alaska; an assessment of appropriate government roles; standards for assessment, development and quality assurance; documentation of the extent to which the current public health system implements or achieves these standards; identification of interjurisdictional issues involved in health care access and delivery; [and] recommendations . . ." (Sec. 21.58.310(b))

Required recommendations for specific legislative action include: strategies, time lines, financial needs and specific sources of stable revenue . . . ; local, regional, state and federal [sharing of responsibility] to deliver public health care services . . . ; integration of the public health care system with state and national health care reform efforts; the corporation's estimate of the optimal share [expressed as a percent] that public health should represent in the total health care delivery system of the state." (Sec. 21.58.310(b)(6))

Does the Plan Include Long-Term Care?

SB 284/HB 451	SB 270/HB 414
<p>Yes, the Alaska Health Insurance Corporation must develop a long-term care plan by January 1, 1997</p>	<p>No, the plan does not include long-term care</p>

Developing Long-Term Care Plan:

"The purpose of this Act is to . . . provide a structure for addressing the health care needs of the state, including . . . developing a comprehensive long-term care plan that integrates support services and that promotes human dignity." (Sec. 1(b)(3)(A))

By January 1, 1997, the corporation shall develop a long-term care plan that comprehensively addresses the needs of Alaska residents. (Sec. 21.58.110(19) and Sec. 12(6))

Long-Term Care Is Public Health Component:

The bill's authors consider long-term care as one component of the continuum of care that must be considered in addressing public health (N. Usher, personal communication)

Does the Plan Consider Primary Care?

SB 284/HB 451	SB 270/HB 414
Yes. the corporation must give incentives to primary care physicians to practice in Alaska, especially in rural areas	No. the plan does not discuss primary care

Design an Incentive Program:

The corporation "shall" design a program to give incentives to primary care providers to practice in Alaska, "especially in rural and under-served areas of the state. (Sec. 21.58.110(16))

Incentives:

Incentives "may" include "added premiums" on prices for primary care providers; student loan forgiveness, in-state family practice residency, and training and "rotations" for "midlevel practitioners." (Sec. 21.58.110(16))

Commission Does Not Endorse a Particular Approach:

The commission performs a "market analysis" on health care reform proposals (or elements of those proposals) brought to it by the governor or by others; it does not endorse a particular approach. (N. Usara, personal communication)

What is the Federal Role in the Plan?

SB 284/HB 451	SB 270/HB 414
<p>The state must apply for waivers from federal laws before it can require claims data and redirect revenue</p> <p>The bill does not mention the need to study the effects of federal health care reform laws on Alaska</p>	<p>The commission is to analyze the effects on Alaska of new federal health care reform laws</p> <p>The plan does not mention the possible need to apply waivers to federal laws (such as ERISA)</p>

Federal Waivers:

By December 31, 1994, the corporation shall determine the federal waivers necessary to set up the Alaska Health Insurance Corporation. (Sec. 12(1))

The corporation shall . . . pursue necessary federal waivers from applicable federal law or other federal health care payers in order to incorporate both claims data and revenue streams into the corporation's data system and additional revenue into the state health insurance fund. (Sec. 21.58.110(14))

New Federal Laws?

The bill does not mention how the plan would "dovetail" with new federal health care reform laws.

Requirements Imposed by New Federal Laws:

The Alaska Health Commission is to analyze health care reform proposals; recommend proposals to the governor and the legislature; and make recommendations about "requirements imposed on [Alaska] by [health care reform] measures passed by Congress." (Sec. 44.19.621(a)(5)(B))

ERISA Waiver?

The plan requires all providers and insurers of health care to Alaskans -- including self-insurers -- to submit "reports, data, health information, insurance schedules, statistics and other information." The state may need a waiver from the federal Employee Retirement Income Security Act (ERISA) before it can force self-insurers to comply.

Does the Plan Discuss Medical Malpractice Liability?

SB 284/HB 451	SB 270/HB 414
No. it suggests separate legislation	Yes. the plan requires non-binding arbitration of medical malpractice claims, with the arbitrator's decision admissible in court
<p><u>Separate Legislation:</u></p> <p>"Because the state constitution's single subject rule precludes the consideration of comprehensive tort reform in the same legislative enactment as health care reform, tort reform should be addressed in a separate legislative enactment." (Sec. 118)</p>	<p><u>Arbitration Required:</u></p> <p>"A person who files an action for damages against a health care provider resulting from medical malpractice shall also submit the claim to the court for arbitration." (Sec. 09.55.535(a))</p> <p><u>Arbitrator's Decision Not Binding:</u></p> <p>"The decision of the arbitrator may be rejected by a party." (Sec. 09.55.535(d))</p> <p><u>Arbitrator's Decision Admissible in Court:</u></p> <p>"If the decision . . . is rejected . . . the action may proceed in . . . court. The arbitrator's decision is admissible evidence in that action . . ." (Sec. 09.55.535(e))</p> <p>Action against a health insurer (including a health maintenance organization) must also go to non-binding arbitration and the arbitrator's decision is admissible in court (Sec. 09.55.565)</p>

**Anchorage Chamber of Commerce
Resolution On Health Care Reform
93/94-7**

WHEREAS quality, access, and the costs of health care are all critical to Alaskans; and

WHEREAS the cost of health care is being born by the state, the federal government, public and private sector employers and individuals collectively; and

WHEREAS certain legislation is pending which could significantly alter health care and the allocation of costs to pay for health care for Alaskans.

BE IT RESOLVED that the Anchorage Chamber of Commerce urges Alaska Legislators and the Governor to:

1. To clearly identify the cost implications (to the state, residents, public & private sector employers) of health care reform;
2. Avoid a single payor system;
3. Increase access to coverage for small employers through insurance company reform;
4. Address coverage for non-residents employed in seasonal industries in the state;
5. Thoroughly review entitlement to benefits if provided through taxes, assessments or premiums through employment;
6. Allow freedom of choice of employers to participate or not participate in any state mandated health care plan;
7. Address in advance how school districts, municipalities, boroughs or other public sector employers would have to increase budgets to cover any costs increase associated with health care reform;
8. Address how premiums will be paid by unemployed individuals and if premiums are not paid, who shares the burden of health care costs for those individuals;
9. Adopt a level of benefits which establishes the base benefit payment for all health care providers and allows residents to seek care from any provider in the state recognizing however, some providers will charge an amount greater than allowed by the plan which must be paid by the resident;
10. Address the number of employees/persons covered;
11. Address impact on collective bargaining agreements;
12. Address impact on national employers doing business in Alaska;
13. Address plan sponsors who currently give retiree welfare benefits to non-residents.

Be it further resolved that health care reform and the payment of health care costs should address all of the above areas and town meetings should be held to discuss the ramification of any proposed amendments or changes prior to voting on reform; and

While the current health care system may need to be fine tuned and some changes made, it does not need to be dismantled.

George Wuerch
Chairman 1993-94

Carol Heyman
President

February 18, 1994

**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.

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 changes, 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 |

2 FROM DONALD FRITZ

7120 Henderson Loop
Anchorage AK 99507
349-8034

to: Senator Jim Duncan
attn: Rolanne Stewart
State Capital, Juneau, Alaska
99601-1152

Dear Senator,

Thank You for your time and attention, I will be brief. On January 12 1994 at about 7P.M. I had an accident at my home which resulted in a deep cut on the bridge of my nose; actually, a flap of skin and underlying tissue was cut loose (and flapping), and there was profuse bleeding. I was taken by a friend to my girl friend's home where we first tried to figure out where to go that could clean and stitch the wound and hopefully not charge too much, since I have no insurance. We finally settled on Providence Emergency Room, since it was after normal business hours.

At the hospital we waited for about an hour, filling in forms and relaxing. A very pleasant and efficient doctor then cleaned and stitched the flap down and prescribed antibiotics. This took about an hour. I remained in the emergency room another hour receiving intravenous antibiotics and resting up from the general trauma of the event. Then I went home.

The next day I called the hospital and asked about the bill for services rendered, and they told me that they had no idea what the charges were, and they would not begin to guess. How much does a dozen stitches on the nose cost?

Well, Sirs, 2 hours in the emergency room costs \$350.00 (that's for the real estate), and 1 hour of the doctor's time cost \$727.00. Add a few miscellaneous items and you're up to \$1200.

Anybody that has received a minor medical bill like that recently, has a very good idea why we have a health care crisis: THE AVERAGE GUY CAN'T AFFORD IT.

We can't get sick. We can't get hurt.

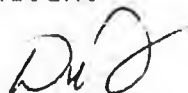
When your assembled body considers health care reform, asking Alaskans to collect together somehow to secure health care, please carefully consider your opening option of calling for an independent audit to rollback the cost of non-elective health care at such facilities as present themselves as general to-the-public health care providers. The time to control non-elective health care costs is RIGHT NOW, before we all sign on the dotted line.

I modestly suggest a commission such as the Public Utilities Commission to govern basic rates at the basic care givers.

As an alternative, perhaps the State might organize and fund basic care facilities to compete in a no-frills way with the higher priced services presently being offered (in a market too small to cause competition to function as a greed control).

Thank You for your attention and good luck in your earnest search for a much needed solution.

Sincerely,



Donald Fritz

HGI # A
 CYCLE 01/17/94
 OUTP.

PROVIDENCE HOSPITAL
 PO BOX 196604
 ANCHORAGE, AK
 907 261-3005
 FEI # 920016429N

PAGE NO. 1
 99519-6604
 BIRTH-DATE 02/20/49
 HOSP NO. 061

8	E	PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS
		FRITZ, DONALD E.	52177656	M		01/12/94		

GUARANTOR NAME AND ADDRESS	DONALD E. FRITZ 7120 HENDERSON LP ANCHORAGE, AK 99507	C.U.B.	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
		1	SELF PAY	S01#	
MERCHANT MD CLIFFORD					

PLEASE RETURN THIS PORTION WITH YOUR PAYMENT.

AMOUNT OF PAYMENT \$

DATE OF SERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS. CO. NO. 1	EST. COVERAGE INS. CO. NO. 2	EST. COVERAGE INS. CO. NO. 3	EST. COVERAGE INS. CO. NO. 4	PATIENT AMOUNT
DETAIL OF CURRENT CHARGES, PAYMENTS AND ADJUSTMENTS								
1/12	001 CATH-INTRA	0861375	6.00					6.00
1/12	002 SUTURE EXTRA	0865370	22.60					22.60
1/12	001 TRAY-SUTURE/P	0865425	45.50					45.50
1/12	002 DRESSING PACK	0866462	11.40					11.40
1/12	001 IV START PACK	0866502	5.70					5.70
1/12	002 MEDICATION I	0866300	4.60					4.60
1/12	004 MEDICATION I	0866300	9.20					9.20
1/12	001 MEDICATION II	0866301	12.60					12.60
1/12	001 COMPREHENSIV	0862427	350.00					350.00
1/12	001 BARD INFUSOR	0863900	5.25					5.25
1/12	001 LAC/RED/COMP/	0891225	727.00					727.00
SUMMARY OF CURRENT CHARGES								
	MED-SUR SUPPLIES		91.20					91.20
	PHARMACY		26.40					26.40
	ER PHY FEE		727.00					727.00
	EMERGENCY ROOM		355.25					355.25
SUB-TOTAL OF CURR. CHARGES			1199.85					1199.85

PAYMENT IS DUE WITHIN 15 DAYS

Outpatient services are on a cash basis only. If you are unable to pay account in full within 15 days, please contact the Patient Account Department for payment arrangements.

CYNTHIA BAXON - no pay til Resolved 1/21/94

Thank you.
 261-3005-3.

PH 8532-6 (1/91) NS

IT IS OUR PLEASURE TO SERVE YOU
 THANK YOU FOR SELECTING PROVIDENCE

T O T A L S	1199.85							1199.85
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PATIENT NUMBER 52177656
 PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS BILL WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNT SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

PAY THIS AMOUNT 1199.85

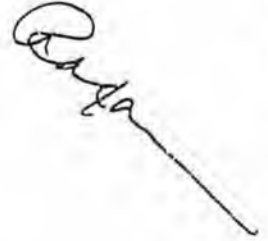
PROVIDENCE HOSPITAL
 ANCHORAGE, AK



PHOTO OF TOM FROZE showing
wound on face (nose and eye)
TAKEN 1/29/74

• Kurt Kristensen • HCO # 1 • Box 945 • Kenai • Alaska • 99611 •
Phone • 907-776-8591 • Fax • 907-776-8594

January 7, 1994



Honorable Senator Jim Duncan
Alaska State Senate
Juneau, Alaska 99801-1182

Dear Mr. Duncan & Staff:

Thank you for your courteous and prompt correspondence on the health insurance compromise efforts you have sponsored so capably.

I have reviewed the action document and have a few comments:

1. The document is very sketchy and I would appreciate follow-up documents as this evolves into a bill during this session.
2. I support a completely insurance company free concept; even in Hawaii the monopoly insurance carriers are managing a 35% profit margin. The only acceptable level of involvement would be as a super-risk carrier for excess costs for catastrophic illness (but here too it should be a non-patient contact role)
3. I hope cost containment will be accompanied by real preventative health provisions; options as well as penalties (taxes and higher deductibles).
4. I hope members of the council could possibly be appointed from existing borough committees (local health committees).
5. I am concerned that chiropractors, naturopaths and like health professionals be allowed to operate unrestricted by current medical establishment.
6. Utilization limits and allocation should be (first) considered by local health committees.
7. I am really leery about a "minimum coverage plan" and allowing the insurance companies to continue to limit and harass patients:

• Kurt Kristensen • HCO # 1 • Box 945 • Kenai • Alaska • 99611 •
Phone • 907-776-8591 • Fax • 907-776-8594

continued-page 2

and doctors; if unavoidable, let the Authority provide several additional options for families to choose, cafeteria style, what they need. With full coverage available for no more than the amount of the permanent dividend amount per person, per year. Should you need additional revenues it should, in my opinion, come from general revenues raised through an income tax/employment tax-with employees paying 2% of gross income and employers paying 4% of gross payroll.

8. Finally I would like to make a case for abandoning the separate system of paying for injured workers' medical treatment under the Alaska Workers' Compensation coverage:

As I indicated to you, in our discussion in Kenai, in my own injury resolution, the treatment and limitations given to me has been far worse than the actual injury.

For every doctor my primary physician would send me to (that would confirm original diagnosis and treatment plan) the workers' compensation carrier would find a physician that would say the opposite. In my opinion they have spent more money fighting treatment than they would have needed to spend had they listened to my primary physician.

I propose that you consider rolling all medical care for injured workers into the new universal care plan and leave the rehabilitation to a new arbitration authority consisting of a hearing officer and the first two doctors that treat the injured worker.

I believe savings in workers compensation rates will drop in such a no-fault system.

In conclusion, Mr. Duncan, my proposal (# 8) may contain the silver lining that will convince employers to participate in a constructive single-payer universal health-care plan. In return for the employee contribution to the universal plan and the employer retaining current immunity to employee law suits it would be possible to consider covering non-employment coverage of rehabilitation and retraining.

I believe that is a win-win-situation.

• Kurt Kristensen • HCO # 1 • Box 945 • Kenai • Alaska • 99611 •
Phone • 907-776-8591 • Fax • 907-776-8594

continued-page 3

Should you consider this idea, please go one step further and confer with Mr Kerttula and Mr. Navarre about my proposal for a Governor's Council on Safety and Workers' Compensation.

I am taking the liberty of including a copy of my letter to Senator Kerttula regarding the Governor's Council concept.

Sincerely,

A handwritten signature in cursive script, appearing to read "Kurt".

LEGISLATIVE PROPOSAL FOR 1994 SESSION

PROPOSAL

FOR

A GOVERNOR'S COUNCIL ON WORKERS' COMPENSATION AND SAFETY

Whereas Alaska has the Nation's highest commercial injury rates, and

Whereas the Alaska Workers Compensation Division opens approximately
30,000 cases each year, and

Whereas Alaska private industry lost 133,050 workdays in 1990 a 21% increase
over 1989, and

Whereas injured workers are denied a fair and timely resolution of their claims, and

Whereas commercial carriers have become the primary deliverers of services to injured
workers, and are unable to separate their employer/profit relationship from their
care and obligation to secure equitable resolution for injured workers, and

Whereas in recent years the average of settlements for injured workers have fallen
below \$ 20,000, and

Whereas a need exists to link the Alaskan Workers' right to a safe and healthy work
environment with an equitable and no-fault system for returning injured workers to
a level of competence and income potential not less than 2/3 of pre-injury
income and benefits, and

Whereas events have proven that the system cannot be allowed to become politicized, be it herewith known that an impartial committee of well-intentioned individuals from all areas and aspects of the process should be created as a Permanent Commission with a basic staff, budget and mission to hold public deliberations on these issues and advise the Governor and the Legislature on effective and fair ways of insuring a safe workers' environment in Alaska and an equitable and efficient manner of rehabilitating injured workers in a cost-effective and no-fault fashion.

Whereas the credibility of this Council is paramount, be it resolved that the Council shall have 17 members, and that an impartial State Hearing Officer shall be assigned as the presiding officer of all meetings.

Be it resolved that the members shall hold 5 year terms and that 3 members shall be replaced each year, and

Be it resolved that the members shall be appointed in the following manner:

- 4 injured workers--selected by attorney groups for injured workers
- 1 attorney for injured worker--selected by trade group
- 1 attorney for employer--selected by trade group
- 1 Rehabilitation Provider--selected by trade group
- 1 Social Case Worker for injured workers--selected by trade group
- 1 employee physician--selected by trade group
- 1 employer physician--selected by trade group
- 1 private union representative--selected by trade group
- 1 public union representative--selected by trade group
- 1 legislative House member or staff--Republican
- 1 legislative Senate member or staff--Democrat
- 1 state OSHA Division Chief
- 1 state Workers Compensation Division Chief
- 1 governor's representative



AFSCME/Alaska Office P.O. Box 93830 Anchorage, AK 99509-8330
 (907) 277-5218 AK Toll Free 1-(800) 478-5215 FAX (907) 277-5208

Senator Steven Rieger
 Health, Education, and Social Services Committee Chair
 State Capital
 Juneau, Ak. 99801

2/17/94

Dear Senator Rieger,

I would like to express my support for Senate Bill 284 (health care reform). The bill features many concepts which the American Federation of State, County, and Municipal Employees supports. The concept of universal coverage is necessary and fair, and the single payer system appears to be the best of the available options. As a representative of public employees, I have seen the numerous problems our current health system has created for our members, and I welcome health care reform.

S.B. 284 is desirable now because it allows Alaska to create a system tailored to our specific needs, before we find ourselves under a federal mandate which might not work here.

I support S.B. 284 and the Senate's effort at reforming Alaska health care. I particularly commend Senator Duncan's tireless efforts on this important issue. The time for health care reform is now.

Sincerely,

Steven Larsen

International Union Representative
 American Federation of State County and Municipal Employees

cc Senators Sharp; Leman; Miller; Duncan; Ellis; Salo

Post It™ brand fax transmittal memo 7671

of pages ▶ 1

To: Senator Steve Rieger From: Steve Larsen



Alaska State Legislature

Please enter into the record my testimony to the SEN. HESS
 committee name
 committee on SB 284, dated 2/17/94
 bill/subject

I represent the Christian Science Churches in Alaska. I would like to take this opportunity to share with you a need we feel is very important. As you may know, Christian Science includes as a part of the religion, the practice of spiritual healing. The treatment of disease and illness in Christian Science is done solely through the means of prayer. Alaska's constitution protects the right of the individual to practice his religion. Alaska state statutes currently recognize and accommodate treatment solely by spiritual means, through prayer, in accordance with the tenets and practices of a recognized church or religious denomination by an accredited practitioner of the church or denomination. See AS 11.51.120(b), AS 47.10.080(k), AS 47.10.085, AS 47.17.020(d), AS 47.17.290(13).

In some instances it may become necessary for a Christian Scientist to enter a Christian Science sanatorium while receiving Christian Science treatment. Christian Science sanatoriums are already providers as "hospitals" in the Medicare law, and most probably would be included in a federal national health program as providers in a federal law. Most major insurance companies accept claims for stays in Christian Science sanatoriums. Therefore, I would like to offer the following suggestion as an amendment. It would be to the definition of "health care provider" on page 18 line 29. Please add at the end of line 29:

"and a sanatorium as included in the definition of 'hospital' in title XVIII of the federal Social Security Act and treatment and care compatible with such services."

I feel that this is a very reasonable and important amendment, and one that is necessary, if you are to achieve your stated intent to "preserve the individual's choice of health care provider" (p. 2).

Signed: Donald A. Mangeldorf
 Testifier

CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR ALASKA

Representing (Optional)

P.O. Box 873452 WASILLA, AK 99687

Address

376-7413

Phone No.

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

February 18, 1994

Senator Steve Reiger, Chair
Senate Health, Education & Social
Services Committee
Capitol Building
Juneau AK 99801

Re: SB 284, Health Reform

Dear Senator Reiger:

ASHNHA, representing community hospitals and nursing homes from across the state supports SB 284, drafted by the Health System Reform Work Group, as a "work in progress" towards health reform.

By "work in progress" we mean that individual hospitals and nursing home members and their trustees are in the process of reading and responding to the final version of SB 284 as introduced on February 9.

SB 270, the Governor's health reform proposal is under similar review.

Community hospitals were represented with the other organizations, professions and agencies in the drafting of SB 284 by the Work Group. They now stand ready to work with the Legislature and Administration in building on SB 284 and SB 270 to assure all Alaskans access to cost effective, quality health care.

Sincerely,



Harlan R. Knudson
President/CEO



AKPIRG

ALASKA PUBLIC INTEREST RESEARCH GROUP

Post Office B
(907) 2

Post-It™ brand fax transmittal memo 7671 # of pages 2

To	SENATOR RICHARD S. COMA	From	
Co.	FOR YOUR	Co.	AKPIRG
Dept.	COMMITTEE	Phone #	2785661
Fax #	4652069	Fax #	2789300

Quality and affordable health care is an inalienable right of all Alaskans and the promotion and protection of that right is a responsibility of the state.

All pre-existing conditions result in discrimination, inequality, prevent "portability," and must be abolished.

Consumer involvement and consumer control are of vital public interest in health policy reform. Because of the complexity and potential impact of health reform, no one with a vested interest should be appointed to any new Board / Commission / Authority / Corporation.

Mandatory utilization review (volume control) and enforcement of the rates and fees of insurers and health providers is a responsibility of the state.

Mandatory review and enforcement of minimum/appropriate standards of care are a responsibility of the state.

The U.S. Public Interest Research Group as well as the Congressional Budget Office have reported that on the national level the single payer financing proposal has been the only proposal that can result in equitable universal health care as well as reduce costs.

There can be no free riders. There has to be a shared sacrifice. Women, children, the elderly and people with disabilities want to pay their fair share; but that fair share should not be more than what is paid by hospital administrators, legislators or President Clinton. Mandatory coverage at an affordable premium rate will be necessary in order to assure low deductibles and co-payments. The sick, injured and persons with disabilities must have affordable benefit packages to independently participate in a world where they can work or own their own business.

There must be an application of waivers from federal regulations so that Alaska can implement a comprehensive benefit package as good or better than what the citizens of Canada or any other country have, and to assure that Alaska dollars stay in Alaska and federal dollars committed to Alaska health programs continue to come to Alaska.

THE
FOLLOWING
DOCUMENTS
ARE
POOR
ORIGINAL
COPIES

There must be a state plan to coordinate both private and public facilities and programs so as to assure more efficient delivery of services.

A 1992 Legislative Report demonstrated that malpractice is a problem in Alaska, but there has been no proof that reducing benefits to those injured due to negligence would in fact reduce costs to taxpayers. AKSIAO's research instead shows that current proposals for tort reform protect wrong doers at the expense of civil rights to citizens especially women, children, the elderly, people with disabilities and subsistence users.

By Bonnie Nelson
Consumer Advocate



AKPIRG
ALASKA PUBLIC I
 Post Office Box 10-1093/A

Post-It™ brand fax transmittal memo 7671		# of pages	5
To	SENATOR RIEDEL	From	S CONVI
Co	FOR YOUR	Co	AKPIRG
Dept.	COMMITTEE	Phone #	2785661
Fax #	4652069	Fax #	2789300

Prepared Testimony for Presentation to the Health Resources and Access Task Force by Alaska Public Interest Research Group.
 September 25, 1992

Task Force Members:

Alaska Public Interest Research Group, a 6,000 member non-profit research and consumer advocacy group has been asked to address "what recommendations AkPIRG has for reforming the health care system" and "how the current health care system creates problems for our organization's interests."

We have decided to focus on our comments directly on the Health Care Reform Final Recommendations to the Governor and the Legislature, adopted March 14, 1992.

AkPIRG applauds the decision to endorse a single payor system by the Health Resources and Access Task Force. It is in that spirit of appreciation that we hope you will examine these comments and distribute them to all interested parties. They are intended to spark renewed debate and begin a process of serious public examination of this important subject.

A. Global budgeting in the sense that it is commonly used, as in Canada, can only work if there is a single payor system. The most efficient single payor system is operated by the public sector. Nowhere in the final recommendations does it state categorically that Alaska will become the single health insurer, and that private health insurance will be abolished. If private health insurance is simply to be funneled through a new state agency, this is really no better than the current system in terms of wasted private insurance overhead and administrative costs.

In Canada physicians with negotiated fees simply do the procedures to amass the income they desire. What will prevent that under this system?

A key issue is WHO will be on the authority/commission that regulates rates and other important features of Alaska's health care system? It should not be a hegemony of health care providers and others with a financial interest in the health care system. Consumers and others from grass roots organizations must have a very significant and central role in this all important regulatory body, and all of their work must be public and open to public scrutiny and review.

If medical care prices are not frozen the first year, or rolled back to the previous year immediately after this legislation is enacted, health care entrepreneurs will massively increase prices.

in anticipation of regulation years down the road. Additional data collection will be important and useful.

E. Regulation of Utilization Review Agents is extremely important since they are totally unregulated nationally. Health care consumers should be a central part of the board or other mechanism established to regulate UR agents.

C. Authority to review rates filed by health insurers. We understand that legislation to do this was killed by a massive lobbying effort of the health insurance industry. This legislation would be a very important step. This demonstrated political power will certainly be used to kill other key aspects of the Task Force recommendations without work to organize grassroots support for this legislation.

D. Small Group Market Reform has generally been a failure across the country as a means of expanding access. State initiatives along these same lines have been ignored by the targeted small businesses.

E. State High-Risk Pool Enacted by Law. While such pools have been implemented in many states across the country, they have been of very limited effectiveness because either the premiums are too high to help all but the wealthy, or the state rapidly runs out of funds to subsidize pool insurance.

F. Community rating/minimizing medical underwriting. If you contemplate a private health insurance system, then the concepts of community rating and the minimization of medical underwriting are laudable goals. The point, of course, is to abolish private health insurance and eliminate the need altogether for medical underwriting and individual payment for coverage.

G. State incentives. These are only necessary if premiums are paid by all to private health insurers, guaranteeing inequality of access. In the case of a single public payor financed by progressive taxation, there is obviously no need to offer "state incentives."

H. Pay-or-play approach is a very bad idea for a number of reasons. It builds upon the flawed historical approach of providing health care at the place of employment. It knocks out small business and favors big business. It short changes retired people, the unemployed and all those not associated with a workplace. It is administratively far more difficult than progressive taxation to finance a single payor. It keeps the private insurance industry and guarantees its stranglehold on the inequities of health care.

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I. Medical malpractice insurance. There is little empirical evidence that the Task Force's approach on this issue will in any way result in the lowering of medical malpractice payments, but it is very likely to take away the civil liberties of a class of people. Furthermore, it will encourage those physicians who apparently engage in malpractice to continue doing so. If we are to encourage reform in this area, we must abolish the old boy peer review networks enjoyed by physicians and their licensing boards and replace them with predominantly consumer review boards. Since the malpractice premiums would need to be rigidly controlled and companies forced to follow actuarial and not cash flow accounting, a better idea might be to have the state take over malpractice insurance.

J. Health Planning/Certificate of Need. While this is an excellent idea, once again there must be a predominance of people on the regulating board who are not health care providers, and who otherwise have no conflict of interest. Furthermore, the regulating body must have the legal teeth to implement what they recommend.

Further commentary:

Health care reform in Alaska will confront problems that are not yet seriously acknowledged, problems that will challenge the state under any implemented system.

The future of the Indian Health Care System, even as an inadequate, ultimate safety net for indigenous peoples, both rural and urban, who do not otherwise qualify for medical care will be seriously challenged, both by falling Federal support for Indian health programs and, ironically, by the state's persistent legal challenge to the legal concept of tribal sovereignty. This irrational attack on the proposition that underlies continual Congressional support of a Federal program for native peoples in Alaska will also seriously impact programs delivered by regional nonprofit health organizations who depend on this same source of funds.

As to unmet needs which will generate massive health problems in the future, one need look no further than the just completed newspaper series on water and sewage problems in Alaska native villages to anticipate epidemics that will flow from the bush to urban Alaska. Finally, the persistent failure of Federal agencies to disclose historical contamination of Alaska lands and wildlife has been coupled with the serious misinterpretation of health data that has concealed generational afflictions caused, not by life styles, but by environmental poisoning of the lands, water and wildlife. The recent rediscovery of a radioactive dump is but the first indication of this vile legacy long buried in IRS data and

long misinterpreted or ignored because the victims are predominantly native people served by the IHS.

Although its charge may be otherwise, the Health Resources and Access Task Force should look carefully at these "time bombs" and direct its considered expertise to remediation that will force Federal acknowledgement of this serious problem and redirect state energy to consumer protection and not to attacks on the legal proposition of tribalism that now requires Federal support of a supplementary managed health system. That system of Indian health care must be seriously expanded and improved.

Thank you for this opportunity to begin what is hoped will be public discussion and debate on health care reform.

Stephen Conn
Executive Director

Dr. Lawrence D. Weiss, AkPIRG Health Reform Volunteer Consultant

ALASKA NATIVE HEALTH BOARD
STATE LEGISLATIVE PRIORITIES FOR FISCAL YEAR 1995

I. *PUBLIC POLICY LEGISLATION PRIORITIES*

- A. State health care reform
- B. Public health services enhancement
- C. Mandatory school health education
- D. An increase in tobacco taxes
- E. Loan forgiveness for health professionals

II. *CAPITAL PROJECT APPROPRIATIONS PRIORITIES*

- A. Rural village water and sanitation facilities
- B. Village clinic construction and replacement

III. *HEALTH PROGRAM PRIORITIES*

- A. Home and community based services
- B. Health promotion and disease prevention
- C. Mental health and substance abuse services
- D. Support for physician assistant training and compensation
- E. UAA Masters in Social Work degree

SUMMARY OF RECOMMENDATIONS
ALASKA NATIVE HEALTH BOARD
STATE LEGISLATIVE PRIORITIES FOR FISCAL YEAR 1995

I. PUBLIC POLICY LEGISLATION PRIORITIES

A. State health care reform

It is essential that the State of Alaska enact legislation in 1994 to establish the framework for health care reform in Alaska. Alaska has the opportunity to provide for universal coverage and cost containment in a manner that will fit Alaska's unique health care system and needs. The Alaska Native Health Board supports the authorization in 1994 of an "Alaska Health Authority" to be charged with developing a plan of action for the state. This plan should be based on a single-payer system. It should leave intact the Indian Health Service system for the provision of health services to Alaska Natives, while involving the Alaska Native health community in the design of the state's overall health system.

B. Public health services enhancement

The Alaska Native Health Board endorses the legislation introduced by Representative Joe Sitton (H.B.332) and its companion bill (S.B.259) to describe in statute the public health responsibilities of the state of Alaska, to create a public health commission, and to develop a comprehensive plan for providing public health services for the residents of Alaska.

C. Mandatory school health education curriculum

The 1993 legislature was successful in securing passage of legislation urging all school districts in the state to implement a comprehensive school health education curriculum. Despite the Governor's veto, the need remains to ensure that all school-age children in the state receive the basic information essential to maintain personal hygiene, respond to emergency medical conditions, prevent disease, and develop healthy lifestyles. Failure to implement such a curriculum on a mandatory basis will be more costly over the long run than the expense of providing this effort. The Alaska Native Health Board supports passage of H.B.320.

D. Supporting an increase in state tobacco taxes

Alaska has the sixth highest smoking rate in the United States, and the highest level of use of smokeless tobacco. Cancer has outstripped heart disease as the top killer of Alaskans. Raising tobacco taxes has the double benefit of raising revenues for the state while reducing the demand for tobacco, especially among younger Alaskans. The Alaska Native Health Board endorses the Governor's initiative, but recommends that the tax be increased to \$1.00 per pack of cigarettes.

E. Loan forgiveness for health professionals

Alaska continues to experience a serious need to recruit and maintain an adequate number of health care professionals statewide. Special needs exist in rural Alaska, where recruitment and retention are more difficult and the need for Alaska Native health professionals is well-demonstrated. We support Senator Ellis' bill (S.B.235) authorizing the forgiveness of state loans to health professionals in exchange for service in the state.

II. CAPITAL PROJECT APPROPRIATIONS PRIORITIES

A. Rural village water and sanitation facilities

For the third year in a row, the Alaska Native Health Board considers the construction and rehabilitation of village water and sanitation systems to be the highest priority for capital projects legislation. In 1993 significant progress was made in improving coordination with federal and state agencies and securing a long-term commitment of funding from both sources to address rural Alaska's \$1 billion unmet need. The Alaska Native Health Board endorses the recommendation of the Department of Environmental Conservation to maintain an annual commitment of at least \$25 million for construction projects in rural Alaskan villages.

B. Village clinic construction and replacement

The Alaska Native Health Board maintains the vision that all villages in Alaska will have adequate community health clinics. We endorse appropriations in response to needs identified by individual rural communities for clinic construction and rehabilitation as an overall capital improvement budget priority. Renewal of a special \$500,000 appropriation to the Department of Environmental Conservation will ensure that all village clinics will have piped water and sewer service before the year 2000.

III. HEALTH PROGRAM OPERATIONS PRIORITIES

A. Home and community-based services

In 1993 the Department of Health and Social Services was successful in securing federal waivers to allow the use of Medicaid funds for providing home and community based services in Alaska. Unfortunately, Medicaid funding limitations have delayed the implementation of these new authorities. The Alaska Native Health Board recognizes that, in the long run, home and community based care will reduce the need for institutional services and result in dramatic cost savings for the state. We urge the legislature to provide the Medical Assistance funding necessary for the enhancement of these services in FY1995, and to support the Governor's bill (S.B.249 and H.B. 377) for assisted living services.

B. Health promotion and disease prevention

While health promotion and disease prevention initiatives are responsible for less than one percent of health expenditures in the state, they hold the greatest promise for long-term reduction of mortality, illness, and injury for Alaskans. Through such efforts as passage of the public health legislation and school health education legislation identified above, and through the maintenance and enhancement of funding for current Department of Health and Social Services initiatives, the legislature will provide a strong foundation for long-term health status improvement and medical care cost containment.

C. Mental health and substance abuse services

The State of Alaska made great strides in the late 1980s to develop a comprehensive array of community mental health and substance abuse facilities and services throughout Alaska. It is essential to continue efforts to resolve the Mental Health Lands Trust so that sustained state funding remains available for the services currently provided. Of particular concern is the provision of adequate resources to reduce dependency on the Alaska Psychiatric Institute by allowing rural hospitals to provide inpatient psychiatric services without financial risk.

D. Physician assistant training and compensation

Alaska has become increasingly reliant on physician assistants for providing comprehensive ambulatory care services, especially in many rural communities which lack physician services. The Alaska Native Health Board endorses legislation (S.B.231

and H.B. 341) which will allow and enhance reimbursement for physician assistant services.

Over the past two years the Southeast Alaska Regional Health Corporation has been successful in establishing the first program for training physician assistants in Alaska in conjunction with the University of Washington. The Alaska Native Health Board urges the legislature to provide the financial support necessary to maintain this effort.

E. Masters in Social Work degree at University of Alaska

The University of Alaska Anchorage has been successful in securing support for beginning a Masters in Social Work degree program in Anchorage. The Alaska Native Health Board endorses approval by the legislature of \$260,000 for implementing this program in FY1995.

BRIEFING PAPER: ALASKA HEALTH CARE REFORM

Alaska needs to join the growing number of states undertaking the reform of their health care systems. Alaska's health care costs are increasing at staggering rates, and over 75,000 Alaskans have no source of health care coverage.

While most Alaska Natives are included in the benefits system of the Indian Health Service, there are many health services that the Indian Health Service does not provide (such as long-term care) or does not adequately cover. The facilities operated by the regional Alaska Native non-profit health organizations are impacted by service demands of non-insured Alaskans in rural areas, and our resources for purchase of specialized care in the private sector cannot keep up with the increasing costs of such services.

Consequently, the Alaska Native Health Board has been an active participant throughout 1993 in the discussions designed to develop an Alaska-specific solution to our health care crisis.

We concur with both the findings of the ad-hoc committee and the governor that Alaska must put in place its own system of health care reform before a federal mandate is imposed. We urge the Alaska State Legislature to act this session to establish an "Alaska Health Authority" empowered to develop the specifics of a reformed system for consideration in the 1995 legislative session.

We support the concept of a single-payer system which recognizes the need to retain the separate federal medical programs of the Veterans Administration, CHAMPUS, and the Indian Health Service.

The Alaska Native health community is prepared to actively participate with the new Health Authority to ensure that the Alaska Native health system is efficiently and effectively coordinated with the system designed by the state in conjunction with the private sector medical community, the insurance industry, business, and labor.

The Alaska Native Health Board will be submitting specific recommendations concerning the bills which come before the legislature as the session progresses.

BRIEFING PAPER: ENHANCING PUBLIC HEALTH SERVICES

The Alaska Native Health Board was actively involved in a series of meetings in 1993 devoted to the promotion and protection of public health services in Alaska. These included the public health policy conference at the University of Alaska-Fairbanks, the Alaska Health Summit at the Egan Center in Anchorage, and several follow-up meetings with the State of Alaska and other public health agencies.

We share the concern of Representative Joe Sitton that, although the Alaska State Constitution mandates the protection of the health of the public, there has never been formal action to address this protection through state statutes. Furthermore, the essential public health services required by Alaskans should be clearly defined and well-coordinated through a long-term services plan.

The Alaska Native Health Board supports the concept of the formation of a permanent state board or commission to oversee this planning process and address coordination of services. Public health services in Alaska are provided through multiple agencies including the State Department of Health and Social Services, the Indian Health Service, borough and city health departments, and the regional Alaska Native health organizations. The efficiency of these services will be enhanced through proper oversight and coordination.

The reform of the health care system in Alaska must provide for the maintenance of essential public health services.

The Alaska Native Health Board endorses passage of S.B. 259 and H.B. 332 during this legislative session, and is prepared to actively participate in the formation of the commission and the development of a long-term public health services plan.

BRIEFING PAPER: MANDATORY COMPREHENSIVE SCHOOL HEALTH EDUCATION

Health services in Alaska are based to a large extent on crisis intervention and the medical model, which waits until problems become serious before resources are committed. The result is unnecessary suffering, a huge financial burden on individuals and society, and self-destructive patterns of behavior that are resistant to change.

Alaska's primary health problems are behavior-based. They include substance abuse, mental health disorders, suicide, tobacco use, sexually transmitted diseases, unintentional injury, drownings, child abuse, domestic violence, and increasingly HIV.

Whereas we have greatly expanded the availability of clinical services throughout Alaska, medical personnel alone cannot reverse the trends of these diseases and conditions. The Alaska Native Health Board believes in the old adage that "an ounce of prevention is worth a pound of cure."

One important key to success in addressing behavioral problems in our society lies in the education system. Positive behaviors learned at an early age will have life-long benefits. While a health education emphasis is applied in Headstart programs in Alaska, our elementary and high schools generally fail to provide comprehensive education for our youth regarding personal and family health.

School districts complain that the resources are not adequate and that other curricula must be prioritized, yet our school spending levels outstrip any other state. While conservative parents argue that sex education should not be taught in schools, our STD and teen pregnancy rates are among the highest in the country.

Health education focuses on many non-controversial areas, including personal hygiene, personal safety and injury prevention, knowledge of diseases, first aid and CPR. Sex education can be modified to meet parental concerns in each school district.

Health education is inexpensive relative to many other curricula, and will save millions of dollars in long-term medical care and other societal costs if implemented. School districts will not institute more than cursory programs unless mandated by the State of Alaska. Your mandate is requested.

BRIEFING PAPER: SUPPORTING AN INCREASE IN TOBACCO TAXES

An Anchorage Daily News headline in October, 1993 delivered a chilling message that has become all too common throughout the United States of America: "Cancer top killer in state: Officials blame tobacco for rise." This should come as no surprise in Alaska, with the sixth highest smoking rate in the U.S. The previous "top killer" in Alaska was heart disease, which is often attributable to smoking as well. Rates of smokeless tobacco use in Alaska are the highest in the United States, leading to early nicotine addiction among hundreds of youth each year and placing users at high risk for cancer of the mouth and other disease.

The good news about tobacco-related death and disease is that they are entirely preventable. In addition, lawmakers have at their disposal a powerful tool to significantly reduce demand for tobacco while actually raising revenues: that is, raising tobacco taxes.

Governor Hickel is to be commended for his recent proposal to raise Alaska's cigarette tax by 14 cents a pack (to 42 cents). However, consideration of the magnitude of the problem, the effectiveness of taxation, and levels of taxation in Alaska as compared to other states and countries quickly reveals that a 14 cent increase is not nearly enough. Consider the facts:

- Smoking claims more lives in the U.S. each year than alcohol, cocaine, heroin, auto accidents, homicide, and suicide combined.
- Smoking is seldom an informed choice. Almost all new users are children and teens who are most susceptible to advertising. Most adults smoke not by choice but from addiction.
- Tobacco is the only consumer product that kills when used exactly as prescribed.
- More Americans will die from second-hand smoke this year than from AIDS. Children whose parents smoke are at high risk of asthma, bronchitis, pneumonia, otitis media, and sudden infant death syndrome.
- Smoking causes approximately one out of every six deaths in Alaska. Alaska's health care costs attributable to smoking in 1989 were estimated at \$34.1 million for persons 35 and older. Alaskans spend over \$105 million each year on tobacco.

- Alaska Natives have one of the highest smoking rates in the nation, averaging nearly 50% among both men and women.
- Rates of smokeless tobacco use in Alaska are also highest among Alaska Natives.
- Alaska Natives have the highest cancer death rate of any Native group in the country. The most common cancer is lung cancer.

Since Canada raised its cigarette taxes in the late 1980s from an average of 46 cents per pack to \$3.27 per pack, teen smoking has been reduced by two-thirds and total cigarette consumption has fallen faster than anywhere in the world.

A recent Gallup poll revealed that most smokers want to quit, and 86 percent said they would try to quit if cigarette prices rose to \$5.00 per pack.

-- - With our current tax of 29 cents per pack, Alaska ranks 23rd out of the 50 states in taxation levels, while the United States ranks last among 18 developed nations in cigarette taxes.

The Alaska Native Health Board strongly urges the legislature to raise Alaska's cigarette tax to \$1.00 per pack or higher. We also urge the state to use a portion of the revenues to fund a permanent Office of Tobacco Control within the Division of Public Health.

BRIEFING PAPER: LOAN FORGIVENESS FOR HEALTH PROFESSIONALS

The regional Alaska Native health organizations currently constitute a \$150,000,000 industry in rural Alaska. These organizations are responsible for the operation and management of six hospitals, numerous health centers, and a wide spectrum of community health programs.

The success of these organizations is critically dependent on their ability to attract and retain qualified health care professionals, including physicians, mid-level practitioners, dentists, nurses, pharmacists, radiology and laboratory technicians, and sanitarians. Many of the individuals currently employed were recruited from outside of the state and have a tenure of two years or less.

Alaska Natives currently represent less than 10 percent of the health care professionals serving with these organizations. While this number is increasing, one of the most significant barriers to successful placement of Alaska Natives in health professions is the high cost of medical education.

Often Alaska Natives who successfully complete courses of study in the lower 48 states end up practicing outside of Alaska or in urban areas because of the need to generate an adequate income to repay student loans.

The Alaska Native Health Board believes that more Alaskans will pursue the health professions, and that more Alaskan health professionals will return to serve in rural Alaska if the onus of repayment is relieved.

Passage of the legislation submitted by Senator Johnny Ellis, S.B.235, will provide the relief that is needed. This will ensure that Alaska's investment in health professional education is rewarded by attracting and retaining Alaskans in service to essential health programs throughout the state.

BRIEFING PAPER: RURAL VILLAGE WATER AND SANITATION FACILITIES

1994 marks the third year that the Alaska Native Health Board has placed village water and sanitation facilities at the top of its priority list for capital appropriations by the Alaska State Legislature.

We commend the legislature for the landmark actions of the 1993 session in approving nearly \$44 million for construction and rehabilitation of facilities in rural communities.

We believe that substantial progress was made administratively in 1993 in addressing the \$1 billion unmet need in these areas. The Departments of Environmental Conservation and Community and Natural Resources participated in a year-long joint effort with federal agencies to clearly substantiate the needs, improve coordination on construction prioritization and implementation, improve protocols for working with city and tribal governments, provide training for community system operators, and address such difficult issues as the need for subsidizing operational costs.

The Alaska Native Health Board in turn has taken the lead in organizing a Rural Alaska Sanitation Coalition, which will bring together rural health agency representatives and community government representatives to work cooperatively with state and federal agency personnel to continue this work in 1994 and 1995. We will be co-sponsoring a sanitation summit meeting in conjunction with the Alaska State Rural Development Council in Anchorage March 14-18, 1994, and urge attendance by legislators.

The most important ingredient in the long-range solution is a commitment by the State of Alaska to a ten-year schedule of construction equally matched by federal funds. The Department of Environmental Conservation is recommending an FY1995 capital appropriation of \$25 million to address the needs in the communities highest on its priority listing. While a ten-year schedule will require a commitment of \$50 million per year, we applaud DEC's initiative and urge the legislature's support.

Over 100 communities in rural Alaska still use honeybuckets for their waste management. Many sewage lagoons and community solid waste sites are out of compliance with federal and state standards. Rural Alaska will continue to face sanitation-related diseases such as Hepatitis A and meningitis until piped water and sewer are available in these communities.

BRIEFING PAPER: VILLAGE CLINIC CONSTRUCTION AND REPLACEMENT

Over 400 Community Health Aides serve as the backbone of rural Alaska's health care program. Substantial improvements in the numbers, compensation, and training levels of Community Health Aides have been accomplished in the past three years as the result of increased program support by the Indian Health Service. However, many community clinics continue to be substandard, lacking adequate equipment, heating sources, handicapped access, adequate lighting, storage space, and, most importantly, access to safe water and sanitation.

Most community health clinics in rural Alaska are owned and operated by local governments through leases with the Indian Health Service. The only source of financing for replacing or upgrading these facilities is through DCRA grant sources or designated capital appropriations.

The Alaska Native Health Board ~~applauds the~~ Alaska State Legislature for the appropriations made in 1993 for the upgrade of many facilities. Community governments which prioritize the safety and adequacy of their community health clinics deserve the continuing support of the legislature in meeting these needs.

The Alaska Native Health Board also requests the continuation of the annual appropriation of \$500,000 begun two years ago to address the need to provide for piped water and sewer service to all village health clinics. Over the past two years this allocation has met approximately one-half of the needs identified by the state and the Indian Health Service. We need to fulfill the objective of safe water supply in all rural clinics by the year 2000.

BRIEFING PAPER: HOME AND COMMUNITY BASED SERVICES

Last year the Alaska Native Health Board urged the State of Alaska to secure waivers from the U.S. Department of Health and Human Services to implement Project CHOICE. We are pleased that these waivers have been granted and that the program is now underway. The costs of institutional care for elderly and disabled Alaskans are the highest in the United States. Alaska's elderly population will continue to grow at an accelerating rate (94 percent in the last decade). It is essential that the State of Alaska undertake every effort to seek means for providing for the health and social needs of our elderly and disabled through non-institutional approaches in the coming years.

The technology for de-institutionalization is rapidly improving through the investments being made in home health care in the lower 48 states. This technology must be replicated in Alaska, and special efforts must be made to make it available in rural areas. Many of the regional Alaska Native health organizations are investing in the identification and training for home health aides and personal care providers and are seeking to convert available facilities for extended care services. Many rural Alaska communities are proposing low-cost alternatives through the offering of such programs as home-delivered or group meal programs, respite care, personal care/chore services, adult day care and group homes, case management, and assisted living services.

Investments by the State of Alaska in programs such as these will ensure that elderly and disabled rural Alaskans can stay in their home communities where their quality of life is better and their longevity will be enhanced. Such an investment will reduce the demand for the construction of higher-cost facilities in both urban and rural Alaska, and reduce the burden on Medicaid, GRM, and private insurance resources for financing these services.

It should be the goal of state policy makers to ensure a full continuum of care to meet the needs of all Alaskans, regardless of income or Medicaid eligibility. We encourage close scrutiny of the September 1993 reports released by the Older Alaskans Commission, entitled "A Blueprint for Home-Based Long-Term Care for the Elderly in Alaska" and "Long-Term Care Alternatives for Alaska's Elderly: 1993 and Beyond." The Alaska Native Health Board urges full funding for the Division of Medical Assistance appropriation for these services, and support the Governor's bill for assisted living (S.B.249 and H.B. 377). We urge the Legislature to work with the Older Alaskans Commission and regional Alaska Native health organizations to help close the large gaps in services to rural and Alaska Native elders. Such efforts will ultimately benefit not only our elders, but all Alaskans.

BRIEFING PAPER: HEALTH PROMOTION AND DISEASE PREVENTION

A dramatic shift in causes of death among Alaska Natives has been seen in the last 50 years. In 1950, almost 46 percent of Alaska Native deaths were from infections, while 11.3 percent were due to suicides, homicides, and unintentional injuries. Today, infections account for only 1.2 percent of deaths while suicides, homicides, and unintentional injuries (including drownings, aircraft and motor vehicle accidents, fires, and injuries related to alcohol and other drugs) now account for almost one-third of all Native deaths. Deaths from heart disease and cancer have increased from 12.4 percent of the total in 1950 to 31.8 percent today. Like suicide, homicide, and injury, cancer and heart disease are largely preventable through healthy lifestyle choices.

The 1993 report of the Alaska Health Resources and Access Task Force is unequivocal in its call for greater State investment in health promotion and disease prevention to address these behavioral health issues. This report cited the American Public Health Association's ranking of Alaska as 44th among the states in healthy behaviors.

The Department of Health and Social Services initiated an Office of Prevention under the Cowper administration; unfortunately this initiative was cancelled by Dr. Ted Mala. This administration has also reduced the number of public health nurses located in rural Alaska. The few programs that are currently in place need to be maintained and strengthened, including the BRU grant awards to the regional non-profit Alaska Native health organizations.

The Alaska Native Health Board strongly endorses the community health promotion grant program administered by the Division of Public Health using the federal Preventive Health and Health Services block grant. Programs such as the Rural Human Services Project and the Community Suicide Prevention grant program are essential to turning around rural Alaska's behavioral health problems. Programs which provide family counseling, alcohol-free community activities, aftercare services from persons returning from treatment, FAS and AIDS education and prevention, parenting skills training, smoking cessation services, and nutrition education are in critical need in most rural Alaska communities.

The resources of the Indian Health Service alone are not adequate to provide these programs. Continued support from the State of Alaska will ensure that future generations of Alaskans will be healthier and more productive citizens.

BRIEFING PAPER: MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

The investment made by the State of Alaska over the past ten years in the establishment and growth of comprehensive mental health and substance abuse treatment facilities and services is finally paying off.

The Alaska Native Health Board believes that sustained education efforts regarding these problems, combined with an increased commitment on behalf of the Alaska Native leadership, is resulting in a growing desire to address these problems by families and communities to seek assistance and change in their lives.

Rural and Alaska Native organizations have invested more of our available resources to establish the types of programs which are proving successful, including recovery camps, halfway houses, and youth treatment programs. Alaska Natives have increasingly become committed to receiving the training necessary to provide these services for ourselves in our communities: —

Now that the state revenue crisis is intensifying, the pressures to reduce funding for these programs will increase. Because of the nature of the problems they address, the need to sustain these programs over a ten to 20-year time frame is essential. If Alaska is to reduce the long-term demand for corrections facilities and programs, for psychiatric institutions, and for inpatient medical facilities, community-based prevention and treatment programs must be sustained.

The revenue stream required for their support is available through the Mental Health Lands Trust settlement. We urge the Alaska State Legislature to undertake all necessary actions to ensure the conclusion of this settlement in 1994. We further recommend close consideration of the recommendations of the Alaska Mental Health Board and the new strategic plan of the Division of Alcoholism and Drug Abuse for other approaches to resolving these difficult issues.

The Alaska Native Health Board requests that these community mental health and substance abuse programs be maintained at current levels in FY1995, and allowed to become successful in achieving our objectives of sobriety and wellness in the Alaska Native community.

BRIEFING PAPER: SUPPORT FOR PHYSICIAN ASSISTANT TRAINING AND COMPENSATION

In 1992 the Alaska Native Health Board endorsed the proposal by the Southeast Alaska Regional Health Corporation to initiate an in-state training program for physician assistants. In 1993 this program became a reality, and has helped increase the availability of Alaska-trained mid-level practitioners.

Physician assistants are in increasing demand throughout Alaska and are becoming an essential feature of the rural Alaska health care system.

Physician assistants meet the need for outpatient services in communities which are too large to be served by Community Health Aides but are too small to attract physicians as local health care providers. Under the preceptorship of urban-based physicians, they can provide a more comprehensive array of pharmaceuticals, coordinate medical evacuations, diagnose and refer more complex medical cases, and provide clinical support for Community Health Aides in surrounding communities. It is also substantially less expensive for rural communities to support physician assistants than physicians.

The University of Washington and the WAMI Medical Education Program have demonstrated that physician assistants who are trained in Alaska are more likely to return to practice in Alaska. In addition, the in-state training offered in Sitka is generally preferred by Alaska Natives over lower-48 based training.

State funding for continuation of the SEARHC physician assistant training program at Sitka is essential to maintain this program in future years of operation.

The Alaska Native Health Board also endorses legislation extending Medicaid reimbursement for more of the services provided by physician assistants in rural Alaska (S.B.231 and H.B. 341). Such reimbursement will increase the viability of subregional health centers operated by local governments and reduce the demand on Medicaid for payment of travel costs for referral to treatment in urban facilities.

BRIEFING PAPER: SUPPORTING THE MASTERS IN SOCIAL WORK PROGRAM AT THE UNIVERSITY OF ALASKA-ANCHORAGE

Last year the Alaska Native Health Board encouraged the Alaska State Legislature to support the development of a Masters in Social Work Degree Program at the University of Alaska in Anchorage. This program has now been authorized and has enrolled 30 students.

There is a high demand for social workers throughout the state. Our regional health and social services organizations require MSW degree social workers to be in compliance with federal and state regulations for program operations. Other agencies demanding qualified MSW candidates include the Division of Family and Youth Services and community mental health centers.

The availability of an Alaska-based program increases the ability of Alaska Natives to secure this degree both in terms of affordability and access. Eleven percent of the University of Alaska's Bachelors in Social Work graduates are Alaska Natives, and many seek to achieve a masters degree.

The program increases the tuition revenues of the University of Alaska system, capturing resources that would otherwise go to outside educational institutions.

The program includes the requirement for students to provide 14,800 hours per year of voluntary placement in Alaska health and social service agencies, enhancing the services of these agencies and increasing the familiarization of the students with Alaska's unique program demands.

The UAA Masters In Social Work degree program needs a second year commitment of \$260,000 from the Alaska State Legislature to maintain its operations. The Alaska Native Health Board strongly endorses this investment.



Alaska State Legislature

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

committee on SB 270 & 284, dated MARCH 2, 1994
bill/subject

Attached please find a copy of the current Health Care Financing Administration - 1500 medical services billing form (dated 12/90, in lower right corner). This standardized form is one of the things your proposed legislation would mandate. I thought you might like to know that one already exists. Also attached is the previous H.C.F.A.-1500 form (dated 1/84) which was replaced by the current version. I no longer have any copies of the H.C.F.A.-1500 designed in the 1970's.

The preceding is but one example from SB 270 and 284 showing that the bills were not researched well. Also not the attached copy of a page from Time Magazine: The graph shows the cost of U.S. medical care began increasing dramatically in 1987. The article (see underlined paragraph) never noted that in 1986 Congress enacted C.O.B.R.A., which forced hospital emergency rooms to treat all patients whether or not they paid. This is one of those "unfunded liabilities" that governments imposes on lesser governments and the private sector.

However, notice on the graph that in 1990 the medical care inflation started to decrease dramatically. This was prior to the Clinton campaign's cry of "health care crisis". There was no great increase in HMO's that year that turned things around. The graph after 1990 shows the resourcefulness and responsiveness of the private sector: Medicine took a hit from Congress and still found a way to cut costs and maintain quality of care in only 3 years. And all this without a huge bureaucracy telling Medicine what to do! Has government ever cut costs and improved services at the same time?

Signed: *Marlene M. Leak* MARLENE M. LEAK
Testifier

SELF
Representing (Optional)
771 8th AVE. FAIRBANKS 99701
Address
452-1015
Phone No.

PLEASE DO NOT STAPLE IN THIS AREA



HEALTH INSURANCE CLAIM FORM

1 MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (20% or ID) <input type="checkbox"/> FICA - E.R. LUNG (SSA) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID)				13 INSURED'S ID NUMBER (FOR PROGRAM IN ITEM 1)	
2 PATIENT'S NAME (Last, First, Middle Initial)				3 PATIENT'S BIRTH DATE (MM DD YY) SEX (M <input type="checkbox"/> F <input type="checkbox"/>	
4 PATIENT'S ADDRESS (No. Street)				5 PATIENT RELATIONSHIP TO INSURED (Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
6 PATIENT'S CITY STATE		7 PATIENT STATUS (Single <input type="checkbox"/> Married <input type="checkbox"/> Other <input type="checkbox"/>		8 INSURED'S ADDRESS (No. Street)	
9 OTHER INSURED'S NAME (Last, First, Middle Initial)		10 IS PATIENT'S CONDITION RELATED TO EMPLOYMENT (CURRENT OR PREVIOUS) YES <input type="checkbox"/> NO <input type="checkbox"/>		11 INSURED'S POLICY (GROUP OR PLAN) NUMBER	
12 PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Authorized this release of any medical or other information necessary to process this claim. Also required payment of government benefits either to myself or to the party who pretests equipment before.)		13 AUTO ACCIDENT? (State) YES <input type="checkbox"/> NO <input type="checkbox"/>		14 INSURED'S DATE OF BIRTH (MM DD YY) SEX (M <input type="checkbox"/> F <input type="checkbox"/>	
15 EMPLOYER'S NAME OR SCHOOL NAME		16 OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		15 EMPLOYER'S NAME OR SCHOOL'S NAME	
16 INSURANCE PLAN NAME OR PROGRAM NAME		17 IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> (If yes, refer to and complete item 8 & d)		16 INSURANCE PLAN NAME OR PROGRAM NAME	
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.				17 INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (authorize payment of medical benefits to the undersigned and/or supplier to services described below)	
14 DATE OF CURRENT ILLNESS (First symptom or injury (accident or pregnancy) MP) (MM DD YY)		15 PATIENT HAS HAD SAME OR SIMILAR ILLNESS (GIVE FIRST DATE) (MM DD YY)		18 DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION (FROM MM DD YY TO MM DD YY)	
17 NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		18 NUMBER OF REFERRING PHYSICIAN		19 HOSPITALIZATION DATES RELATED TO CURRENT SERVICE (FROM MM DD YY TO MM DD YY)	
19 RESERVED FOR LOCAL USE		20 OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES		20 MEDICAID REIMBURSEMENT COOP. ORIGINAL Ref. No.	
21 DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (APPROPRIATE ITEMS TO BE FOLLOWS BY LINE)				21 PRIOR AUTHORIZATION NUMBER	
24 DATE(S) OF SERVICE (FROM MM DD YY TO MM DD YY)		25 PROCEDURES, SERVICES, OR SUPPLIES (Specify drug(s), procedure(s), or modifier)		22 CHARGES (DATE, ICD-9-CM, ICD-9-CM, ICD-9-CM)	
25 FEDERAL TAX ID NUMBER SSN EIN		26 PATIENT'S ACCOUNT NO.		27 AGENT ASSIGNMENT? (For gov't claims, see back) YES <input type="checkbox"/> NO <input type="checkbox"/>	
28 SIGNATURE OF PHYSICIAN OR SUPPLIER (including degrees or credentials) (copy to front of statements on the reverse) (copy to this bill only if made & paid the bill)		29 NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than date of office)		28 TOTAL CHARGE \$	
SIGNED DATE		SIGNED DATE		29 AMOUNT PAID \$	
APPROVED BY AREA CHIEF (ON MEDICAL SERVICE BILL)		PLEASE PRINT OR TYPE		30 PHYSICIAN'S SUPPLIER'S BILLING NAME ADDRESS ZIP CODE & PHONE #	
APPROVED BY AREA CHIEF (ON MEDICAL SERVICE BILL)		PLEASE PRINT OR TYPE		30 BALANCE DUE \$	

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION

EASE DO NOT STAPLE IN THIS AREA



HEALTH INSURANCE CLAIM FORM

FORM APPROVED DMB NO. 0838-0008
CHECK APPLICABLE PROGRAM AT BOX BELOW

MEDICARE (MEDICARE NO.)
 MEDICAID (MEDICAID NO.)
 CHAMPUS (SPONSOR'S SSN)
 CHAMPVA (VA FILE NO.)
 FECA BLACK LUNG (SSN)
 OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)		2. PATIENT'S DATE OF BIRTH		3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)	
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)		4. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		6. INSURED'S ID NO. (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS)	
7. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>		8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)		<input type="checkbox"/> INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN	
9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)		10. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/>		11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT (IF) OW.		13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.		11A. CHAMPUS SPONSOR'S STATUS ACTIVE DUTY <input type="checkbox"/> DECEASED <input type="checkbox"/> RETIRED <input type="checkbox"/> BRANCH OF SERVICE	
SIGNED _____ DATE _____		SIGNED _____		SIGNED (INSURED OR AUTHORIZED PERSON)	

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THE CONDITION	16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES	16A. IF EMERGENCY CHECK HERE <input type="checkbox"/>
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____	19. DATES OF PARTIAL DISABILITY FROM _____ THROUGH _____	
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (E.G., PUBLIC HEALTH AGENCY)		20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____	
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN OFFICE)		22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES	

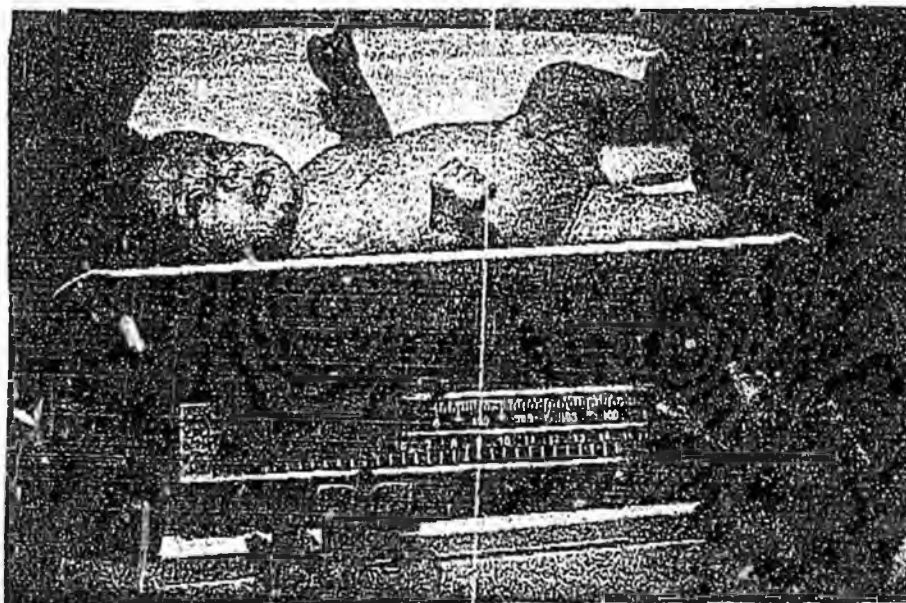
23A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: RELATE DIAGNOSIS TO PROCEDURE IN COL. D BY REFERENCE NOS. 1, 2, 3, ETC. OR ICD CODE: B.

1.	EPSONI YES <input type="checkbox"/> NO <input type="checkbox"/>
2.	FAMILY PLANNING YES <input type="checkbox"/> NO <input type="checkbox"/>
3.	
4.	

24. DATE OF SERVICE FROM TO	25. PLACE OF SERVICE	26. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY) (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	27. DIAGNOSIS CODE	28. PRIOR AUTHORIZATION NO.			
				29. CHARGES	30. DAYS OR UNITS	31. T.O.S.	32. LEAVE BLANK

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE) ON CREDENTIALS. (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF.)	26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES <input type="checkbox"/> NO <input type="checkbox"/>	27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE
30. YOUR SOCIAL SECURITY NO.	31. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.			
32. YOUR PATIENT'S ACCOUNT NO.	33. YOUR EMPLOYER ID NO.	ID NO.		

FORM BUBBLED WITH CHAMPUS



This infant's HMO in California helps keep a lid on medical-cost inflation

■ HEALTH CARE

Crisis? What Crisis?

As medical inflation eases, so does the sense of urgency that Clinton needs to push his revolutionary plan

By ADAM ZAGORIN WASHINGTON

THE LATEST ASSAULT ON BILL CLINTON'S top domestic goal began with 10 words on a Sunday-morning talk show last week. "We do not have a health-care crisis in America," declared Daniel Patrick Moynihan, the Senate Finance Committee chairman. His words sent shivers through the White House, where creating a national sense of urgency about health care is regarded as critical to propelling the President's reforms through Congress. As the week progressed, things only got worse. The American Medical Association, it was disclosed, is preparing a plan to lobby for 37 significant changes in Clinton's plan, including the elimination of proposed limits on doctors' fees. Then came a letter, signed by 565 economists, warning about fallout from the price controls contained in the Clinton proposal.

Administration officials quickly tried to dampen the rising rebellion. Senior economic advisers led a hushed but urgent campaign to prevent the influential Business Roundtable from endorsing a more modest alternative to the President's 1,300-page plan. White House economics chief Robert Rubin and Deputy Treasury Secretary Roger Altman telephoned insurance-company CEOs at Prudential, Chubb, American International Group

and CNA to urge them not to endorse the rival plan, backed by Representative Jim Cooper of Tennessee and Senator John Breaux of Louisiana. But the Administration's pre-emptive strike met with resistance. Late Friday an informal straw poll of the Roundtable's policy committee turned up broad support for Cooper-Breaux.

On his return from Europe this week, Clinton aims to launch an all-out campaign for passage with his Jan. 25 State of the Union speech. But attitudes about health-care reform have shifted in the months since Clinton unveiled his plan in September. The economy has rebounded smartly, and a growing number of legislators have been denying the existence of a national medical emergency. Certainly one aspect of the crisis: the skyrocketing cost of care, has abated. Medical inflation fell from an annual rate of 6.3% in the first half of last year to 4.4% in the second half, according to the consumer price index. New projections indicate that the Federal Government will spend \$120 billion less on Medicare and Medicaid through 1998 than was estimated only a year ago.

Behind the slowdown lie aggressive steps by several states including Maryland, Oregon and Florida to contain medical costs. Many private companies are taking their own measures. Typical is Intel, the microchip manufacturer, which suffered 20% annual increases in health-insurance premiums until the introduction of a managed-care program in 1990 that covers 20,000 U.S. employees. Now costs are edging up only 5% a year.

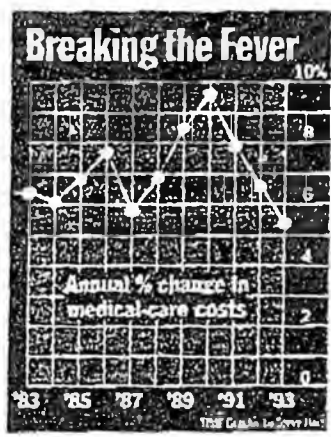
Another ingredient of medical-cost containment involves the decision by many hospitals, pharmaceutical companies and other providers to stabilize or lower their prices, perhaps in hopes of heading off congressional action on health-care reform.

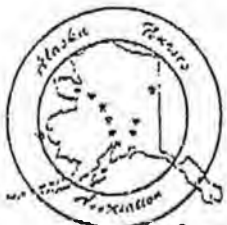
This, at least, is the argument advanced by Administration experts who caution that decelerating costs could prove illusory and that only a full-scale, Clinton-style reform with mandatory price restraints can tackle the job in the long run. "Medical inflation slowed in the late 1970s just in time to defeat a previous effort at cost containment," recalls Laura Tyson, chairman of the Council of Economic Advisers. "Later on, prices resumed their former upward spiral."

Moreover, advocates of reform argue, inflation is only one of many health-care problems that need fixing, most notable among them the lack of coverage for 37 million Americans, which the Clinton plan is designed to remedy. Warns Paul Begala, a senior Clinton political adviser: "The American people believe something serious must be done in a country where any one of us could lose our medical insurance tomorrow."

The sentiment among critics of Clinton's plan leans toward proposals that are more incremental, with less ambitious financing and lower costs. The one claiming the most support so far is the Cooper-Breaux plan, also known as "Clinton Lite." The proposal matches many features of the President's proposal but does not put limits on insurance premiums and will not yield universal coverage.

Several Republican legislators have developed their own, mostly incremental plans, hoping to avoid the awkward choice between opposing reform altogether and voting for some variation of the Clinton plan, for which the President will get most of the political credit. But, as the saying goes, you can't beat something with nothing. And the Republicans have yet to agree on an alternative that isn't Democratic in design. —With reporting by Michael Duffy and Dick Thompson/Washington





ALASKA NURSES ASSOCIATION

237 E. 3rd Avenue #3 Anchorage, AK 99501-2523
(907) 274-0827 FAX: (907) 272 0292

March 2, 1994

Senator Steve Rieger
Room 516-C
Capitol Building
Juneau, Alaska 99801-1182

Dear Senator Rieger:

On behalf of the Alaska Nurses Association (ANA) I thank you for the opportunity to testify on today SB 284, an act establishing the Alaska Health Insurance Corporation. The Alaska Nurses Association commends the legislature for the leadership demonstrated on this issue.

The Alaska Nurses Association strongly supports universal coverage for all Alaskans. We believe this is the single most important aspect of health care reform. The Association, knowing the value of guaranteed coverage to primary care services, would support a single payer approach to ensuring a basic set of benefits for every citizen of this state.

Under SB284, we salute the development of a corporation which will control costs, increase coverage, and provide a structure for addressing the health care needs of the state. We applaud the bill's recognition for a strong public health care system. As an organization that has long advocated the principles of disease prevention and health promotion, we are gratified to see that wellness and prevention have been recognized as appropriate strategies to achieve the goals of cost containment and improved health outcomes.

We are concerned that the bill as written does not clearly prevent the exclusion of coverage for any reason, particularly pre-existing conditions, employment, family situations or other reasons now often used as reasons to exclude coverage. We ask your careful consideration and any necessary amendments to assure universal and comprehensive coverage.

The Alaska Nurses Association applauds your efforts to include all appropriate providers in the cost reimbursement mechanisms which will occur in the reformed health care system. We strongly support the incentives for primary care providers which have been suggested. The inclusion of all primary care providers will significantly impact the accessibility of rural populations to access primary care.

The Association is committed to the belief that strong consumer presence needs to be an inherent component of the Alaska Health Insurance Corporation. While we recognize the need for expert representation on the Corporation Board, we also are convinced that it is only by empowering more consumers that the system will become more responsive to the concerns of those directly impacted by that system. You have addressed the need for required public involvement in Sec 21.58.320. However, we believe there needs to be significant consumer representation on the Board of Directors itself and urge you to add language to the bill which will demonstrate a commitment to greater consumer representation.

The Alaska Nurses Association endorses SB284 and looks forward to continuing opportunity to provide input and engage in dialogue about health care reform in the State of Alaska. Thank you.

Sincerely yours,

Jackie Pflaum
Legislative Chair

TASKTIME.

State of Alaska Division of Insurance Senate Bill 284 House Bill 451 Pert Chart of Implementation Tasks and Times		Effective date: July 1, 1994												1997	1998	1999	2000
AS 21 58 Reference	Footnotes	30-Sep 1994	31-Dec 1994	31-Mar 1995	30-Jun 1995	30-Sep 1995	31-Dec 1995	31-Mar 1996	30-Jun 1996	30-Sep 1996	31-Dec 1996						
AS 21 58 010	Appoint Alaska Health Ins Corp Board, 7 Members	.....														
AS 21 58 060	Determine duties of Chair, Vice Chair by Reg (1)																
	Write Job description for Executive Director (2)																
AS 36 30.015	Appoint Executive Director	.....														
	Adopt procedures for procurement of supplies, services, prof svcs, construction																
	Write job description for Administrative officer and other classified staff members (2)																
	Hire administrative Officer	.....														
	Hire clerical	.....														
	RSA with Dept of Law for legal services																
	Cost:																
	Office Space																
	Office furniture, equipment																
	Travel Expense																
	Expense for preparation of regulation																
	• RSA																
AS 21 58 320	Implement public involvement process	.....	.....												
AS 21 58 110(2)	Develop extensive community based public involvement process																
	Public Hearing - Teleconference - 5 days/hearing (3)	1 per mo	1 per mo	1 per mo	1 per mo	1 per mo	1 per mo										
	Publications, advertising																
	Write job description for information officer (classified)																
	Hire information officer																
	Cost:																
	Information Officer																
	Public Hearing space rental																

DRAFT

		TASKTIME													
		30-Sep	31-Dec	31-Mar	30-Jun	30-Sep	31-Dec	31-Mar	30-Jun	30-Sep	31-Dec	1997	1998	1999	2000
		1994	1994	1995	1995	1995	1995	1996	1996	1996	1996				
	Printing, mailing, advertisement cost Travel Expense for Board Teleconference														
AS 21.58.260	Establish data system, begin collecting data	.....	.....	(4)											
AS 21.58.110(3)	Select computer equipment, obtain Hire computer specialists, programmers														
AS 21.58.260(a)	Determine process for obtaining summary data from claim system, population stats, public health														
AS 21.58.260(b)	Adopt regulations for system of obtaining claims info from providers paid by others outside of claim clearinghouse/until clearinghouse on line														
	Cost: Office Space Office furniture equipment Computer hardware Computer software-programming Contract funds														
AS 21.58.310	Begin first public health improvement plan Hold public hearings for input into plan Construct plan Hold public hearings for comment on plan written Determine information sources Develop recommendations for legislative action	.....	.....	(4)											
As 21.59.110(5)	Annually update plan Write job description for planners (classified emp) Hire specialist/expert planner for health care Hire assistant planner for health care														
	Cost: Hearing space Advertising Publication of proposed plan Teleconference Salaries														
AS 21.58.110(6)	Determine federal waivers necessary to implement	.....	.....	(4)											

10/13/94

Footnotes	TASKTIME											1998	1999	2000
	30-Sep 1994	31-Dec 1994	31-Mar 1995	30-Jun 1995	30-Sep 1995	31-Dec 1995	31-Mar 1996	30-Jun 1996	30-Sep 1996	31-Dec 1996	1997			
AS 21.58 110(14)	Research info needed for waivers Determine, obtain legal assistance Prepare plan for requesting waive RSA to Dept of Law for Wash, DC representation Cost: Legal fees (research and representation) Travel to Washington DC Printing cost RSA													
AS 21.58 110(16)	Develop incentives to attract health care providers Determine options available - rural Public Hearings for comment - teleconference Test incentives, make adjustments Write job description for 1/2 time staff (classified) 1/2 time staff - hearings, reporting Cost Public Hearing Space Cost of plan, subsidy (student loan forgiveness, clinics, housing, staff, location, etc) Teleconference													
AS 21.58 110(4)	Complete uniform claims form Initial public hearing for input- teleconference Determine necessary info on form Determine codes needed to gather info from forms Coordinate with others (Feds, states) Determine users (providers, insureds) of forms Determine data capture needs (equip, staff) Final public hearing on form - teleconference Write job description for Dept of Ins staff (classified) One Dept of Ins staff, support person (1 year) Computer facilities Cost Printing Distribution Education of user (pamphlets, advertising, etc)													

DRAFT

		TASKTIME														
		Footnotes	30-Sep 1994	31-Dec 1994	31-Mar 1995	30-Jun 1995	30-Sep 1995	31-Dec 1995	31-Mar 1996	30-Jun 1996	30-Sep 1996	31-Dec 1996	1997	1998	1999	2000
	Travel for coordination with other jurisdictions Computer Salaries															
AS 21.58.220	Establish claims clearinghouse				.....										
AS 21.58.110(1)	Develop regulations on system for paying claims Determine data system needed Write job descriptions for staff (classified) Determine and hire staff to input data Determine and hire staff to review data, test check data Determine and hire staff to investigate fraud Determine legal staff to prosecute fraud/RSA Determine review, complaint procedure Determine system for payment of health care outside of Alaska															
AS 21.58.110(9)	Reg to define acceptable reasons for denial of claims Cost: Computer system Office and computer space Office equipment, phone system Salaries (Legal, Computer, Clerical) Adoption of regulations (hearings, pub notice) File space RSA															
AS 21.58.170	Determine health care services required	(5) (6) (7)			.....										
AS 21.58.110(7)	for health care plan benefits package Develop list of minimum services based on need, cost, funds available Public Hearing to get comment on list Adopt regulations giving minimum services						1 per mo	1 per mo	1 per mo	1 per mo						
AS 21.58.110(10)	Determine impact on waiver from Feds Review list annually Write job description for staff person (classified) Hire staff person for initial list and annual review RSA to Dept of Law for legal assistance Cost:															

DRAFT

TASKTIME

		Footnotes	30-Sep 1994	31-Dec 1994	31-Mar 1995	30-Jun 1995	30-Sep 1995	31-Dec 1995	31-Mar 1996	30-Jun 1996	30-Sep 1996	31-Dec 1996	1997	1998	1999	2000
		Research assistance														
		Adoption of regulations (hearings, publication)														
		Office space														
		Office furniture, equipment														
		Salary														
		RSA														
AS 21	58.230	Begin monitoring health care expenditures, utilization patterns, begin collecting fee information (8)			.....	.....	.....	.....				
		Develop monitoring interval, end product														
		Develop summary reports from claims system														
AS 08	02.025	Develop system for collecting fee info from providers														
		- develop codes, common names for procedures														
		- determine system for summarizing, computer needs, publication needs														
		- develop system for requiring participation by providers in submitting fee information														
		- develop review, complain handling system														
		Develop summary reports for utilization data														
		Adopt regulations														
		Write job description of staff (classified)														
		Determine and hire necessary staff (prof. clerical)														
		Determine computer needs, obtain equipment														
AS 21	58.240	Annual publication of types of providers & prices														
AS 21	58.250	Annual comparative list of common services, prices based on claims														
		Cost:														
		Salaries														
		Office space														
		Office furniture, equipment														
		Adoption of Regulations (hearing, publication)														
		Computer														
		Printing, Distribution														
AS 21	58.330	Implement peer review system for utilization, c u i. (8)			.....	.....	.....	.....				
		Develop peer specialty groups to control utilization														
		Determine system for evaluating quality of peer reviewers														

		TASKTIME														
		Footnotes	30-Sep-1994	31-Dec-1994	31-Mar-1995	30-Jun-1995	30-Sep-1995	31-Dec-1995	31-Mar-1996	30-Jun-1996	30-Sep-1996	31-Dec-1996	1997	1998	1999	2000
	Determine documentation needed to support peer review conclusions Determine system for review, complaints Determine publication of peer review info Cost: Travel Printing Public Hearing															
AS 21.58.110(7)	Adopt regulations to establish eligibility criteria for enrollment, define resident Determine criteria based on AK law and judgments Determine enrollment information needed, form Determine enrollment period, sign up			.....	.....	.....	.....	.....			
AS 21.58.110(8)	Determine premium and sliding scale based on ability to pay, annually															
AS 21.58.190	Develop process for determining ability to pay Develop process for collecting fees Develop process for cancelling coverage Determine review, complaint process Determine system for detecting fraud Determine system for prosecuting fraud/RSA															
AS 21.58.140	Adopt regulations for processes and procedures															
As 21.58.160	Determine disclosure procedure for medical, financial data															
AS 21.58.210	Disseminate info regarding plan and enrollment Write job descriptions for staff (classified) Determine and hire necessary staff (professional, clerical, investigators) Cost: Salaries Printing, distribution of forms Advertising - education RSA File space (secure)															
AS 21.58.280	Voluntary cost control system										.....	.....	.....	.....	.....	.....

TASKTIME

Footnotes	TASKTIME												1998	1999	2000
	30-Sep 1994	31-Dec 1994	31-Mar 1995	30-Jun 1995	30-Sep 1995	31-Dec 1995	31-Mar 1996	30-Jun 1996	30-Sep 1996	31-Dec 1996	1997				
AS 21.58.110(11)	Determine system for reviewing provider charges Determine summary info from data system (claims.etc) Determine summary info from provider fee lists Determine interval of review of costs Compare infra to expenditure target by category Determine when voluntary system is not working														
AS 21.58.110(17)	Adopt regulations for mandatory system if voluntary system fails to achieve target expenditures Determine system for enforcing mandatory cost Determine recommendations on containing cost of health care Write job description of staff (classified) Determine and hire necessary staff for review														
AS 21.58.110(18)	Develop committees of experts to review Costs: Salaries Office space Office furniture and equipment Compensation to experts Adopt regulations (hearings, publication)														
AS 21.58.110(19)	Develop long-term health care plan Determine needs of AK residents Determine system of attaching costs to needs Costs: Public Hearing Space														
AS 21.58.180	Establish deductible, copayment amounts Determine costs, premiums Costs: Advertising Public Hearing														
AS 21.58.110(12)	Present options to governor, legislature. - how to finance state health ins plan under market based single payer system														

	Footnotes	TASKTIME										1997	1998	1999	2000		
		30-Sep 1994	31-Dec 1994	31-Mar 1995	30-Jun 1995	30-Sep 1995	31-Dec 1995	31-Mar 1996	30-Jun 1996	30-Sep 1996	31-Dec 1996						
AS 21.58.110(13)	Determine if Corp is insurer or coverage procured from one or more companies (9)																
AS 21.58.270	Establish statewide health care expenditure target Determine change in demographics, medical tech access to health care, catastrophe, elimination of unnecessary care, chg in cost of liability ins, chg in admin cost, chg in utilization Annually adjust expenditure target													*****/			
AS 21.58.110(15)	Begin to provide health ins coverage for state residents													*****/			
AS 21.58.110(20)	Annually report to enrollees, governor, legislature Hold public meetings Cost: Teleconference Printing, distribution Travel																
AS 24.20.206	Legislative Budget and Audit provide annual post audit and operational and performance evaluation of Corp																

FOOTNOTES

All time lines are based on best case scenerios or specific times for implementation included in legislation.

(1) It has not been determined who will write regulations for determining duties of the chair and vice chair of the corporation board.

(2) It is unclear who will be preparing job descriptions prior to Executive Director coming on board.

(3) Assumes public hearing will not be transcribed.

(4) We do not anticipate that this time line can be met.

(5) The providers list in the bill at AS 21.58.400 does not match the provider list in As 21.36.090.

(6) The affect this bill may have on workers compensation coverages, disability coverages has not been taken into consideration.

(7) The affect of this bill on the total amount of premium taxes collected from insurers writing accident and health insurance has not been taken into consideration.

(8) The complete evaluation of this requirement is beyond the expertise of the staff of the Division of Insurance.

(9) If Corporation becomes the insurance company additional staff and costs will be undertaken such as an insurance company would incur.

Responsibilities of Board of Directors of Health Insurance Corporation

Section	Working hours for each board member	Due by:	3Q 94	4Q 94	1Q 95	2Q 95	3Q 95	4Q 95	1Q 96	2Q 96	3Q 96	4Q 96	1Q 97	2Q 97	3Q 97	4Q 97	98
See hearing worksheet	Attending hearings (assume 8 hours each day, member attends half the hearings hearings in FY 95 are 3 days each, hearings thereafter are one day each)	varies	180	156	96	120	52	8	8	28	60	20	32	32	44	0	0
See hearing worksheet	Prepare for and summarize hearings (2 hour. for each hearing)	varies	30	26	16	20	26	4	4	14	30	10	16	16	22	0	0
AS 21.58.060	Determine duties of chair and vice chair & elect them	ASAP	4														
AS 21.58.070	Meet quarterly (assume 1 day each quarter)	quarterly	8	8	8	8	8	8	8	8	8	8	8	8	8	8	32
AS 21.58.090	Prepare job description for executive director; advertise	ASAP	2														
AS 21.58.090	Interview four candidates for executive director	ASAP	8														
AS 21.58.090	Meet to select executive director	ASAP	4														
AS 21.58.100(12)	Present options to legislature for financing of plan	Annually ?				2				2				2			2
AS 21.58.100(16)	Meet with universities, doctors, etc to encourage primary care physicians (assume 4 hours a week for 12 weeks)	12/31/94		48													
AS 21.58.100(18)	Establish and work with committees of experts regarding cost containment, etc (assume 2 hours per month)	7/1/94 and ongoing	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
AS 21.58.100(20)	Hold public meetings to report to enrollees, governor, & legislature	Annually after 1998															2
AS 21.58.130	Review proposals from insurers to provide health insurance to Alaskans (two week's work, assuming that background work done by staff)	1/1/97 ? and every three years								80							
AS 21.58.130	Select insurer to provide coverage, or decide to form own insurer	1/1/1997 and every three years								8							
AS 21.58.280	Work with providers in meeting voluntary expenditure target (assume 1day per month)	1998 and ongoing															96
AS 21.58.290	Report to the governor and legislature on health care expenditures, etc	Annually				2				2				2			2
AS 21.58.320	Assist in the "extensive community based public involvement process" (assume 2 hours per month)	12/31/94 and ongoing	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
AS 21.58.330	Set up peer review of quality (assume 2 hours per month)	1/1/96 and ongoing					6	6	6	6	6	6	6	6	6	6	6
AS 24.20.206	Meet with the Legislative Budget and Audit Committee following their annual audit (one day meeting)	12/31/94			8				8				8				8
Total Hours Worked in Fiscal Year:			802				348				332				278		
Total Days worked in Fiscal Year (rounded):			100				44				42				35		

This worksheet calculates the total number of hours that A SINGLE BOARD MEMBER will spend doing various tasks.

NOTE: These numbers do not consider any time spent in the event that the board decides to form their own insurer. Such a decision will greatly increase the participation required by the board.

Hearings required to implement The Alaska Health Insurance Corporation

Section	Hearings (some for regs, some not)	Due by:	Hearings to be held in:															
			3Q 94	4Q 94	1Q 95	2Q 95	3Q 95	4Q 95	1Q 96	2Q 96	3Q 96	4Q 96	1Q 97	2Q 97	3Q 97	4Q 97	98	
AS 21.54. 25	Set out criteria for insurers' claims grievance procedures	7/1/94	2															
AS 21.58. 060	Prescribe duties for director's chair and vice-chair	7/1/94	1															
AS 21.58. 110(4)	Develop a uniform claims form	7/1/95			2	2												
AS 21.58. 110(7)	Develop eligibility requirements for enrollees	1/1/96			3	3	3											
AS 21.58. 110(9)	List acceptable reasons for denying claims	7/1/97 ?										3	3					
AS 21.58. 110(16)	Create program to encourage primary care physicians	12/31/94	2	2														
AS 21.58. 110(19)	Develop long term care plan	1/1/97							2	2	3							
AS 21.58. 170(a)	Specifying the health benefits to be included	12/31/95			3	3	3											
AS 21.58. 110(10)	Review the health benefits in plan	Annually after 1995										2				2		
AS 21.58. 160	Establish standards for confidentiality of medical and financial information on enrollees	12/31/94 ?	3	3														
AS 21.58. 180	Setting the deductibles and copayments	1/1/97								2	2							
AS 21.58. 190 & 110(8)	Establishing the premiums and enrollee fees	7/1/97 ?									3	3	3					
AS 21.58. 190	Set out method for enrollees to submit financial info	7/1/97 ?										2	2					
AS 21.58. 220	Require providers to submit claims to clearinghouse	1/1/98 ?														2		
AS 21.58. 220	Set out clearinghouse's claims grievance procedures	1/1/98 ?											2	2				
AS 21.58. 230(a)	Set out contents of provider price list	12/31/95					2	2										
AS 21.58. 230(b)	Set date for providers to submit price list	12/31/95					1											
AS 21.58. 260(a)	Set out types of data to be collected in data system	12/31/94	3	3														
AS 21.58. 260(b)	Require providers to submit claims data to data system	12/31/94		1														
AS 21.58. 270(a)	Prescribe initial statewide health care expenditure target	1/1/98												3	3			
AS 21.58. 270(b)	Adjust statewide health care expenditure target	Annually after 1998																
AS 21.58. 280	Establish voluntary cost control system and method for evaluation	12/31/96								3	3							
AS 21.58. 300(b)	Impose a mandatory expenditure limit (if voluntary fails)	Optional after 2001																
AS 21.58. 300(b)	Establish mandatory price guidelines	Optional after 2001																
AS 21.58. 300(b)	Establish cost sharing recommendations relevant to expenditure limit	Optional after 2001																
AS 21.58. 300(d)	Establish procedures for monitoring compliance with cost control provisions	Optional after 2001																
AS 21.58. 300(d)	Establish procedures for providing notice to overcharged person	Optional after 2001																
AS 21.58. 310	Develop initial public health improvement plan	12/31/94	3	3														
AS 21.58. 310	Update public health improvement plan	Annually after 1994					2				2				2			
AS 21.58. 320	Design community based public involvement process	12/31/94		1														
AS 21.58. 330	Set up peer review system for quality controls	1/1/96				2	2											
AS 36.30 015(e)	Adopt procedures to govern procurement	12/31/94	1															
Total Hearings in the quarter:			15	13	8	10	13	2	2	7	15	5	8	8	11	0	0	
Total Hearings in FY:			45				24				36				11			

This sheet calculates the number of hearings that will need to be held to implement the programs in the bill
Assume that hearings in FY 95 each last 3 days, hearings in later FYs average one day each

Number of Trips Taken by Directors of Alaska Health Insurance Corporation

Section	Purpose of Trip	Due by:	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q	3Q	4Q	
			94	94	95	95	95	95	96	96	96	96	97	97	97	97	98
See hearing worksheet	Attending hearings (assume 8 hours each hearing, member attends half the hearings)	varies	30	26	16	20	26	4	4	14	30	10	16	16	22	0	0
See hearing worksheet	Prepare for and summarize hearings (2 hours for each hearing)	varies	30	26	16	20	26	4	4	14	30	10	16	16	22	0	0
AS 21.58.060	Determine duties of chair and vice chair & elect them	ASAP	4														
AS 21.58.070	Meet quarterly (assume 1 day each quarter)	quarterly	4	4	4	4	4	4	4	4	4	4	4	4	4	4	16
AS 21.58.090	Prepare job description for executive director; advertise	ASAP	4														
AS 21.58.090	Interview four candidates for executive director	ASAP	4														
AS 21.58.090	Meet to select executive director	ASAP	4														
AS 21.58.100(12)	Present options to legislature for financing of plan	Annually ?				4				4				4			4
AS 21.58.100(16)	Meet with universities, doctors, etc to encourage primary care physicians (assume 4 hours a week for 12 weeks)	12/31/94		48													
AS 21.58.100(18)	Establish and work with committees of experts regarding cost containment, etc (assume 2 hours per month)	7/1/94 and ongoing	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12
AS 21.58.100(20)	Hold public meetings to report to enrollees, governor, & legislature	Annually after 1998															4
AS 21.58.130	Review proposals from insurers to provide health insurance to Alaskans (two week's work, assuming that background work done by staff)	1/1/97 ? and every three years								4							
AS 21.58.130	Select insurer to provide coverage, or decide to form own insurer	1/1/1997 and every three years								4							
AS 21.58.280	Work with providers in meeting voluntary expenditure target (assume 1 day per month)	1998 and ongoing															48
AS 21.58.290	Report to the governor and legislature on health care expenditures, etc	Annually				4				4				4			4
AS 21.58.320	Assist in the "extensive community based public involvement process" (assume 2 hours per month)	12/31/94 and ongoing	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12
AS 21.58.330	Set up peer review of quality (assume 2 hours per month)	1/1/96 and ongoing					4	4	4	4	4	4	4	4	4	4	4
AS 24.20.206	Meet with the Legislative Budget and Audit Committee following their annual audit (one day meeting)	12/31/94			4				4				4				4
Total Number of Trips in FY:			372				244				284				216		
Total Travel Cost in FY:			\$204,600				\$134,200				\$156,200				\$118,800		
Number of Directors who must travel each time:			4														
Plane fare per trip:			400														
average 1 1/2 nights per trip at \$100 per night:			150														
Average cost per trip:			550														

This worksheet calculates the total number of trips to be taken by directors for various reasons. It assumes that 4/7 of the members must travel for any given meeting/hearing/etc.

FISCAL NOTE

STATE OF ALASKA
1994 LEGISLATIVE SESSION

BILL NO. SB 284

Revision Date: _____
 Title: Comprehensive Health Insurance Act
 Sponsor: Senate HESS
 Requestor: _____

Department Affected: Commerce and Economic Development
 BRU: Alaska Health Insurance Corporation
 Component: _____
 COMPONENT SERIAL NO. _____

Expenditures/Revenues:

OPERATING EXPENDITURES	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
PERSONAL SERVICES	3,402.5	4,389.7	6,250.7	19,329.7		
TRAVEL	684.6	557.4	583.8	616.8		
CONTRACTUAL	2,037.0	1,448.7	1,546.0	5,125.9		
SUPPLIES	90.0	110.0	143.0	452.0		
EQUIPMENT	1,087.3	353.5	577.1	4,415.1		
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	7,301.4	6,859.3	9,100.6	29,939.5		

CAPITAL EXPENDITURES	12,000.0	2,500.0	2,500.0	2,675.9		
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CHANGE IN REVENUES ()						
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FUND SOURCE

1002 Federal Receipts						
1003 GF Match						
1004 GF	19,301.4	9,359.3	11,600.6	32,615.4		
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	19,301.4	9,359.3	11,600.6	32,615.4		

Estimate of current year (FY 94) cost: \$ -0-

POSITIONS

FULL-TIME	70.0	90.0	123.0	514.0		
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary.)

Please see attachments.

Prepared by: David J. Walsh, Director
 Division: Insurance

Phone: 465-2515
 Date: 2/28/94

Approved by Commissioner: Paul Fuhs
 Agency: Commerce and Economic Development

Date: _____

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					FY 95	FY 96	FY 97	FY 98
SB 284 Fiscal Note for the Alaska Health Insurance Corporation								
Board of Directors: (See Attached Charts)								
	7 members	\$400/day honorarium			280.0	123.2	117.6	98.0
		FY95 100 days	\$280.0					
		FY96 44 days	\$123.2					
		FY97 42 days	117.6					
		FY98 35 days	98.0					
	Travel				204.6	134.2	156.2	118.8
Staff:								
# positions								
1	Executive Director	PX R-28			95.6	95.6	95.6	95.6
1	Deputy Director	R-23			79.3	79.3	79.3	79.3
1	Administrative Officer III	R-21			70.5	70.5	70.5	70.5
1	Secretary	R-10			36.9	36.9	36.9	36.9
2	2 Clerk-Typist III	R-8 @ \$33.3			66.6	66.6	66.6	66.6
1	Accounting Clerk III	R-10			36.9	36.9	36.9	36.9
1	Information Officer	R-17			54.5	54.5	54.5	54.5
1	Paralegal Assistant II	R-16			51.2	51.2	51.2	51.2
1	Accounting Tech III	R-16 @ \$51.2			51.2	51.2	51.2	51.2
1	Administrative Asst III	R-16 @ \$51.2			51.2	51.2	51.2	51.2
1	Publication Specialist II	R-16 @ \$51.2			51.2	51.2	51.2	51.2
1	Accountant IV	R-20 @ \$65.8			65.8	65.8	65.8	65.8
1	Acct Supervisor I	R-16 @ \$51.2			51.2	51.2	51.2	51.2
2	Acct Tech I	R-12 @ \$41.0			82.0	82.0	82.0	82.0
1	Acct Clerk III	R-10 @ \$36.9			36.9	36.9	36.9	36.9
1	Personnel Officer I	R-18 @ \$58.2			58.2	58.2	58.2	58.2
1	Supply Officer II	R-16 @ \$51.2			51.2	51.2	51.2	51.2
2	Mail Clerk Carrier II	R-9 @ \$35.1			70.2	70.2	70.2	70.2
21				Total:	1,060.6	1,060.6	1,060.6	1,060.6
	Travel:				50.0	50.0	50.0	50.0
	Contractual costs per person:	10.6			222.6	222.6	222.6	222.6
	12 mths/\$1.80/sq ft/175 sq ft =	\$3.8						
	Miscellaneous contractual-	\$6.8						
	Contract w/Dept. of Law for legal support services (1 AAG & 1 secretary)				140.0	140.0	140.0	140.0
	Supplies: 1.0/position				21.0	21.0	21.0	21.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after				254.1	21.0	21.0	21.0

					FY 95	FY 96	FY 97	FY 98
Public Involvement Process:								
Advertising (2 time newspaper ads Juneau, Anchorage, Fairbanks, & Ketchikan)					45.0	24.0	36.0	11.0
\$1.0/hearing 45 hearings (FY95)								
24 hearings (FY96)								
36 hearings (FY97)								
11 hearings (FY98)								
Teleconference hearings via LIO sites					945.0	168.0	252.0	77.0
Full service set-up for 4-8 hr mtg.								
\$25/hr/LIO site plus toll costs.								
LIO has 22 sites, \$4,400 plus toll costs of \$2,600 per 8 hr conference.								
\$7,000/8hr 45 hearings/3 days = 135 days (FY95)								
24 hearings/1 day = 24 days (FY96)								
36 hearings/1 day = 36 days (FY97)								
11 hearings/1 day = 11 days (FY98)								
This assumes no transcription of hearings or minutes.								
Printing handouts for hearings/meetings					5.0	2.7	4.0	1.2
7000 copies of 2 back-to-back pages = \$650								
\$650/7000 = \$.093/item rounded to \$.10								
Assuming 50,000 copies x \$.10 = \$5,000 (FY95)								
24/45 = 53% \$5,000 x 53% = \$2,666 or \$2.7 (FY96)								
36/45 = 80% \$5,000 x 80% = \$4,000 or \$4.0 (FY97)								
11/45 = 24% \$5,000 x 24% = \$1,222 or \$1.2 (FY98)								
Data Collection:								
Computer equipment					10,000.0	2,000.0	2,000.0	2,000.0
(Estimated based on the current value of the equipment owned by Blue Cross of WA and AK)								
Software Development (contracted out)*					2,000.0	500.0	500.0	500.0
*This assumes waiver of procurement process and that contractor is able to modify existing system to the corporation's use. The Division of Insurance is not aware of any off-the-shelf software available. Software cannot be finalized until regulations are adopted which specify the data to be collected.								
1	Chief R-22 @ \$74.5				74.5	74.5	74.5	74.5
1	Analyst/Programmer IV R-19 @\$61.9				61.9	61.9	61.9	61.9
1	Analyst/Programmer III R-17 @\$54.5				54.5	54.5	54.5	54.5
1	Actuary R-27 @\$92.8				92.9	92.9	92.9	92.9
1	Secretary R-10 @\$36.9				36.9	36.9	36.9	36.9

					FY 95	FY 96	FY 97	FY 98
	Fees and Charges Section							
1	Economist II R-20 @ \$65.8				65.8	65.8	65.8	65.8
2	Research Analyst III R-18 @ \$58.2				116.4	116.4	116.4	116.4
2	Research Analyst II R-16 @ \$51.2				102.4	102.4	102.4	102.4
3	Statistical Tech I R-12 @ \$41.0				123.0	123.0	123.0	123.0
3	Statistical Tech II R-14 @ \$45.2				135.6	135.6	135.6	135.6
1	Statistical Clerk R-10 @ \$36.9				36.9	36.9	36.9	36.9
	Demographics Section							
1	Economist II R-20 @ \$65.8				65.8	65.8	65.8	65.8
2	Research Analyst II R-16 @ \$51.2				102.4	102.4	102.4	102.4
1	Research Analyst III R-18 @ \$58.2				58.2	58.2	58.2	58.2
3	Statistical Tech I R-12 @ \$41.0				123.0	123.0	123.0	123.0
2	Statistical Tech II R-14 @ \$45.2				90.4	90.4	90.4	90.4
1	Statistical Clerk R-10 @ \$36.9				36.9	36.9	36.9	36.9
	Operational Expense Section (start in FY 1996)							
1	Economist II R-20 @ \$65.8					65.8	65.8	65.8
4	Statistical Tech I R-12 @ \$41.0					164.0	164.0	164.0
3	Statistical Tech II R-14 @ \$45.2					135.6	135.6	135.6
2	Statistical Clerk R-10 @ \$36.9					73.8	73.8	73.8
3	Research Analyst II R-16 @ \$51.2					153.6	153.6	153.6
3	Research Analyst III R-18 @ \$58.2					174.6	174.6	174.6
43				Total:	1,377.5	2,144.9	2,144.9	2,144.9
	Note: (This unit is comparable to the Research and Analysis section in the department of Labor with 38 positions)							
	Contractual- \$10.6 per position				286.2	455.8	455.8	455.8
	Office space per position- 12 mths/\$1.80/sq ft/175 sq ft = \$3.8							
	Miscellaneous contractual- \$6.8							
	Supplies: \$1.0/position				27.0	43.0	43.0	43.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after				326.7	220.6	43.0	43.0

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					FY 95	FY 96	FY 97	FY 98
	Claims Clearinghouse:							
1	Director R-26*				0.0	0.0	90.0	90.0
1	Claims Administrator R-21*				0.0	0.0	70.5	70.5
1	Data Processing Manager II R-22 *				0.0	0.0	74.5	74.5
2	Analyst Programmer V R-21 @\$70.5*				0.0	0.0	141.0	141.0
4	Analyst Programmer IV R-19 @\$61.9*				0.0	0.0	247.6	247.6
4	Analyst Programmer IV R-19 @\$61.9				0.0	0.0		247.6
4	Analyst Programmer III R-17 @\$54.5				0.0	0.0		218.0
1	Analyst Programmer II R-15 @\$48.0				0.0	0.0		48.0
1	Physician Assistant R-20*				0.0	0.0	65.8	65.8
1	Investigator IV R-20 @\$65.8*				0.0	0.0	65.8	65.8
4	Nurse IV R-18 @\$58.2				0.0	0.0		232.8
3	Nurse III R-16 @\$51.2				0.0	0.0		153.6
4	Investigator III R-18 @\$58.2				0.0	0.0		232.8
3	Investigator II R-16 @\$51.2				0.0	0.0		153.6
6	Eligibility & Qual Ctrl Tech II R-18 @\$58.2*				0.0	0.0	349.2	349.2
24	Eligibility Tech IV R-16 @\$51.2				0.0	0.0		1,228.8
12	Eligibility Tech IV R-16 @\$51.2*				0.0	0.0	614.4	614.4
48	Eligibility Tech III R-14 @\$45.2				0.0	0.0		2,169.6
108	Eligibility Tech II R-12 @\$41.0				0.0	0.0		4,428.0
22	Data Processing Clerk III R-10 @\$36.9				0.0	0.0		811.8
3	Mail Clerk Carrier II R-9 @\$35.1*				0.0	0.0	105.3	105.3
2	Mail Clerk Carrier I R-7 @\$31.8				0.0	0.0		63.6
1	Secretary R-10 @\$36.9*				0.0	0.0	36.9	36.9
260				Total:	0.0	0.0	1,861.0	11,849.2
	* Means that this person starts in FY 97, everyone else starts in FY 98							
	Staffing in this unit is based on the staffing currently in Aetna's claims office							
	Travel:				0.0	0.0	10.0	100.0
	Contractual- \$10.6 per position				0.0	0.0	0.0	2,756.0
	Office space per position-							
	12 mths/\$1.80/sq ft/175 sq ft = \$3.8							
	Miscellaneous contractual- \$6.8							
	Supplies: \$1.0/position				0.0	0.0	33.0	260.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after				0.0	0.0	399.3	2,779.7
	Note: The utilization review unit does not include physicians or other medical specialists. This may result in some friction with affected disciplines.							
	Note: The bill requires that the claims clearinghouse be established by 12/31/95.							
	We understand from the author of the bill this means that the claims clearinghouse would be organized by that date but will not be doing any work before 7/1/97. The cost of organizing the section would be part of the data collection set-up.							

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				FY 95	FY 96	FY 97	FY 98
	Fee Reporting						
2	Research Analyst III R-16 @\$51.2			102.4	102.4	102.4	102.4
8	Document Processing Clerk III R-10 @\$36.9			295.2	295.2	295.2	295.2
3	3 Clerk III R-8 @\$33.3			99.9	99.9	99.9	99.9
1	Investigator III R-18 @\$58.2			58.2	58.2	58.2	58.2
2	Investigator II R-16 @\$51.2			102.4	102.4	102.4	102.4
1	Publication Specialist I R-13 @\$42.7			42.7	42.7	42.7	42.7
1	Publication Specialist II R-16 @\$51.2			51.2	51.2	51.2	51.2
1	Analyst/Programmer III R-17 @\$54.5			54.5	54.5	54.5	54.5
19			Total:	806.5	806.5	806.5	806.5
	Travel:			50.0	50.0	50.0	50.0
	Contractual- \$10.6 per position			201.4	201.4	201.4	201.4
	Office space per position-						
	12 mths/\$1.80/sq ft/175 sq ft = \$3.8						
	Miscellaneous contractual- \$6.8						
	Supplies: \$1.0/position			19.0	19.0	19.0	19.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after			229.9	19.0	19.0	19.0
	Printing Annual Provider Price List			15.0	15.0	15.0	15.0
	(assuming \$.5 per copy, 30 copies printed)						
	Public Health Improvement Plan						
1	Health & Soc Ser Planner III R-21 @\$70.1			70.1	70.1	70.1	70.1
1	Health & Soc Ser Planner I R-17 @\$54.5			54.5	54.5	54.5	54.5
1	Clerk-Typist III R-8 @\$33.3			33.3	33.3	33.3	33.3
3			Total:	157.9	157.9	157.9	157.9
	Travel:			100.0	100.0	100.0	100.0
	Contractual- \$10.6 per position			31.8	31.8	31.8	31.8
	Office space per position-						
	12 mths/\$1.80/sq ft/175 sq ft = \$3.8						
	Miscellaneous contractual- \$6.8						
	Supplies: \$1.0/position			3.0	3.0	3.0	3.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after			36.3	3.0	3.0	3.0
	Contract Funds:			45.0	45.0	45.0	45.0

DRAFT

HEALTH1.XLS

					FY 95	FY 96	FY 97	FY 98
	Federal Waiver							
	Contract w/Dept. of Law for representation in Washington D.C.				100.0	100.0	100.0	100.0
	NOTE: These figures are estimates. The actual number could be significantly higher.							
	Develop Incentives to Attract Health Care Providers				????	????	????	????
	Enrollment							
2	Chief, R-22 @\$74.5				0.0	0.0	0.0	149.0
2	Eligibility & Qual Ctrl Tech II R-18 @\$58.2				0.0	0.0	0.0	116.4
2	Eligibility Tech IV R-16 @\$51.2				0.0	0.0	0.0	102.4
14	Eligibility Tech II R-12 @\$41.0				0.0	0.0	0.0	574.0
1	Analyst Programmer V R-21				0.0	0.0	0.0	70.5
1	Analyst Programmer IV R-19 @\$61.9				0.0	0.0	0.0	61.9
2	Investigator III R-18 @\$58.2				0.0	0.0	0.0	116.4
1	Acct Tech II, R-14 @\$45.2				0.0	0.0	0.0	45.2
1	Data Entry Center Supervisor, R 14 @\$45.2				0.0	0.0	0.0	45.2
1	Document Processor IV, R-12 @\$41.0				0.0	0.0	0.0	41.0
2	Document Processor III, R-10 @\$36.9				0.0	0.0	0.0	73.8
1	Document Processor II, R-8 @\$33.3				0.0	0.0	0.0	33.3
49	Document Processor I, R-7 @\$31.8				0.0	0.0	0.0	1,558.2
1	Accounting Clerk III, R-10 @\$36.9				0.0	0.0	0.0	36.9
2	Clerk Typist III, R-8 @\$33.3				0.0	0.0	0.0	66.6
82				Total:	0.0	0.0	0.0	3090.8
	Travel				0.0	0.0	0.0	0.0
	Contractual: \$10.6/position				0.0	0.0	0.0	869.2
	Office space per position- 12 mths/\$1.80/sq ft/175 sq ft = \$3.8							
	Miscellaneous contractual- \$6.8							
	Enrollment booklet 350,000 copies/\$450/1000 copies							157.5
	Supplies: \$1.0/position				0.0	0.0	0.0	82.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after				0.0	0.0	0.0	992.2
	Microfilm Equipment							175.9
	(This unit is designed to be very comparable to the PFD division)							

HEALTH1.XLS

				FY 95	FY 96	FY 97	FY 98
	Develop Long-Term Health Care Plan						
1	Health & Soc Serv Planner III R-21 @ \$70.1				70.1	70.1	70.1
1	Health & Soc Serv Planner II R-19 @ \$61.9				61.9	61.9	61.9
1	Health & Soc Serv Planner I R-17 @ \$54.5				54.5	54.5	54.5
1	Clerk-Typist III R-8 @ \$33.3				33.3	33.3	33.3
4				0.0	219.8	219.8	219.8
	Travel:				100.0	100.0	100.0
	Contract Funds:			0.0	????	????	????
	Contractual- \$10.6 per position			0.0	42.4	42.4	42.4
	Office space per position-						
	12 mths/\$1.80/sq ft/175 sq ft = \$3.8						
	Miscellaneous contractual- \$6.8						
	Supplies: \$1.0/position			0.0	4.0	4.0	4.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after			0.0	48.4	48.4	48.4
	Miscellaneous supplies:			20.0	20.0	20.0	20.0
	General office equipment:						
	Recording equipment \$.2			0.2	0.0	0.0	0.0
	3 Fax @ \$3.0 = \$9.0			9.0	0.0	0.0	0.0
	Conference Table \$4.0			4.0	0.0	0.0	0.0
	Conference chairs 25 @ \$220			5.5	0.0	0.0	0.0
	Storage cabinets 10 @ \$.3			3.0	0.0	0.0	0.0
	File cabinets 50 @ \$.6			15.0	15.0	0.0	0.0
	Telephone system @\$1.3/position			91.0	26.0	42.9	508.3
	Photocopier @\$90.0			90.0	0.0	0.0	0.0
	Photocopier mid size 2 @ 7.0			14.0	0.0	0.0	0.0
	Photocopier desktop 2 @\$1.2			2.4	0.0	0.0	0.0
	Typewriters 10 @\$.5			5.0	0.0	0.0	0.0
	Reception chairs 3 @\$220 =			0.7	0.0	0.0	0.0
	Mailing equipment \$.5			0.5	0.5	0.5	0.5
	Total Number of Positions:			70.0	90.0	123.0	514.0
	Total Salary Cost:			3,402.5	4,389.7	6,250.7	19,329.7
	Total Cost other than Salary:			15,898.9	4,969.6	5,349.9	13,285.7
			Grand Total:	19,301.4	9,359.3	11,600.6	32,615.4
			4 year total:	72,876.7			
	NOTE: These estimates do not take into account 1) any costs to the workers' compensation system resulting from the merger of occupational and non-occupational health care, nor 2) the impact of this plan on premium tax receipts by the general fund.						

FISCAL NOTE

STATE OF ALASKA
1994 LEGISLATIVE SESSION

BILL NO. SB 284

Revision Date: _____
 Title: Comprehensive Health Insurance Act

 Sponsor: Senate HESS
 Requestor: _____

Department Affected: Commerce and Economic Development
 BRU: Insurance
 Component: Operations

COMPONENT SERIAL NO. 354

Expenditures/Revenues:

OPERATING EXPENDITURES	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
PERSONAL SERVICES	351.1	292.9	292.9	292.9		
TRAVEL	55.0	25.0	25.0	25.0		
CONTRACTUAL	74.2	63.6	63.6	163.6		
SUPPLIES	7.0	6.0	6.0	6.0		
EQUIPMENT	84.7	6.0	6.0	6.0		
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	572.0	393.5	393.5	493.5		

CAPITAL EXPENDITURES						
-----------------------------	--	--	--	--	--	--

CHANGE IN REVENUES ()						
-------------------------------	--	--	--	--	--	--

FUND SOURCE

1002 Federal Receipts						
1003 GF Match						
1004 GF	572.0	393.5	393.5	493.5		
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL						

Estimate of current year (FY 94) cost: \$ -0-

POSITIONS

FULL-TIME	7.0	6.0	6.0	6.0		
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary.)

Please see attachments.

Prepared by: David J. Walsh, Director
 Division: Insurance

Phone: 465-2515
 Date: 2/28/94

Approved by Commissioner: Paul Fuhs
 Agency: Commerce and Economic Development

Date: _____

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SB 284 Division of Insurance Fiscal Note for the Alaska				
Health Insurance Corporation				
	FY95	FY96	FY97	FY98
Develop Uniform Claim Form by 6/30/95				
Insurance Analyst III R-18 @\$58.2	58.2	0.0	0.0	0.0
Travel: For instate meetings and to Washington, DC to interface with Health Care Financing Administration (HCFA) which is working on a national uniform claim form.	30.0	0.0	0.0	0.0
Contractual: 1 position X \$10.6	10.6	0.0	0.0	0.0
Office space per position- 12 mths/\$1.80/sq ft/175 sq ft = \$3.8				
Miscellaneous contractual- \$6.8				
Supplies: \$1.0/position	1.0	0.0	0.0	0.0
Equipment: \$12.1/position 1st yr, \$1.0 after	12.1	0.0	0.0	0.0
Rate Approval				
Insurance Analyst III R-18@\$58.2	58.2	58.2	58.2	58.2
3 Consumer Complaint Specialists R-14 @\$45.2	135.6	135.6	135.6	135.6
Travel: Instate	5.0	5.0	5.0	5.0
Contractual: 4 position X \$10.6	42.4	42.4	42.4	42.4
Office space per position- 12 mths/\$1.80/sq ft/175 sq ft = \$3.8				
Miscellaneous contractual- \$6.8				
Contract w/consulting actuary	0.0	0.0	0.0	100.0
Supplies: \$1.0/position	4.0	4.0	4.0	4.0
Equipment: \$12.1/position 1st yr, \$1.0 after	48.4	4.0	4.0	4.0

Division Liaison				
Program Coordinator R-20 @\$65.8	65.8	65.8	65.8	65.8
Clerk-Typist III R-8 @\$33.3	33.3	33.3	33.3	33.3
Travel:	20.0	20.0	20.0	20.0
Contractual: 2 position X \$10.6	21.2	21.2	21.2	21.2
Office space per position- 12 mths/\$1.80/sq ft/175 sq ft = \$3.8				
Miscellaneous contractual- \$6.8				
Supplies: \$1.0/position	2.0	2.0	2.0	2.0
Equipment: \$12.1/position	24.2	2.0	2.0	2.0
Total Costs:	572.0	393.5	393.5	493.5

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C:SB2481
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Memo to: Dave Walsh, Director

Date: February 24, 1993

From: Gene Furman CPA AFE
Insurance Financial Examiner

Subject: Structure of a health
insurer and manning thereof

When the fiscal note working group gets to the point of costing out the structure of the Alaska Health Insurance Corporation ("AHIC") it is likely that the appropriate model to use for this costing process will be the to elect the option to have the AHIC act as a health insurance provider. This option is most attractive in terms of job creation in that a significant number of jobs will be moved from outside to inside the state. Further, AHIC thus has the potential to become an incubator for a new alaskan industries. Spin off jobs such as training required employees at University of Alaska and increased bush employment when direct medical service providers are created are important examples of the indirect benefits of AHIC.

We need to review the organizational structure of a life and health insurer to be certain that we have an accurate picture of the costs required. Accordingly, I have outlined below organizational elements which the fiscal note working group should consider. It can be utilized as a checklist to determine that we have considered all AHIC costs.

Health Insurer Organization

A) Levels of authority

- 1) Board of Directors - Covered in AS 21.58.020 to .080 (*)
The Board should be divided into at least the following committees:
 - a) Executive committee -
 - 1) Executive Director, Senior Deputy Executive and various Directors
 - 2) Deal with matters which bear a vital relation to the general business policy of AHIC. (*)
 - b) Insurance committee -
 - 1) Various Deputy or Assistant Executive Directors and Directors
 - 2) Deals with decisions under
 - AS 21.58.310 - public health improvement plan
 - AS 21.58.110 - federal waivers (*)
 - AS 21.58.110 - incentives for bush health care providers (*)
 - AS 21.58.220 - claims clearing house (*)
 - AS 21.58.110 - acceptable reasons for denial of claims (*)
 - AS 21.58.170 - determine health care services required (*)

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AS 21.58.110 - annual review (*)

AS 21.58.230 - monitoring health care
expenditures utilization (*)

- c) Compensation committee - deals with matters of employee compensation and benefits
 - d) Audit committee - receives and follows up on the reports of the internal audit department and the independent auditors
 - e) Government relations - liasons with the state legislature and federal government
- 2) Executive Officers - An Executive Director and Deputy or Assistant Executive Directors are provided for in AS 21.58.090. (*)
- 3) Managerial Officers - Directors and Deputy or Assistant Directors will be needed to be responsible for the day to day functions of departments. These subordinate officers will be engaged in the following relationships
- a) line,
 - b) staff, or
 - c) functional.

B) Departmentalization

- 1) Actuarial department - establishes the company's premium rates, reserve liabilities and generally handles all the mathematical operations of the company, designs new policies and forms, files rates and forms with regulator for approval, preforms frequency and cost studies.
- 2) Marketing department - responsible for placing new coverage, service to policyholders, supervises the activities of agents, preforms market analysis, trains agents and controls sign up costs.
- 3) Accounting department - responsible for company's accounting procedures and report preparation including the company's annual report to its regulators.
- 4) Auditing department - establishes and supervises the company's auditing function.
- 5) Investment department - handles the company's investment program under policies laid down by the board of directors, collects the interest and dividends on the company's investments and reinvestment of same.
- 6) Treasury department - manages the company's cash flow and banking relationships.
- 7) Legal department - handles the conduct of court cases

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growing out of contested claims, sufficiency and correctness of policy forms, agency contracts and analysis and interpretation for the benefit of the company of both state and federal statutory and court law governing health insurance.

- 8) Underwriting department - responsible for establishing standards of selection and for passing judgment on applicants for health insurance.
- 9) Medical department - supervises the company's medical examiners and the final authority on services and procedures to be covered.
- 10) Administration department - issues new coverage certificates, premium and commission accounting, policy changes, claims and similar functions of policyholder service; personnel administration, official company correspondence, minutes of meetings, corporate governance, government relations and planning.

C) Functionalization - as multiple health insurance products are developed costs from each function will be required to implement and service the product.

(*) These costs exist in both the independent procurement and the acting as an insurer options.

Source: Life Insurance, Black & Skipper, eleventh edition, Prentice Hall, 1987.

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DRAFT FOOTNOTE REGARDING COST CONTROL PROGRAMS

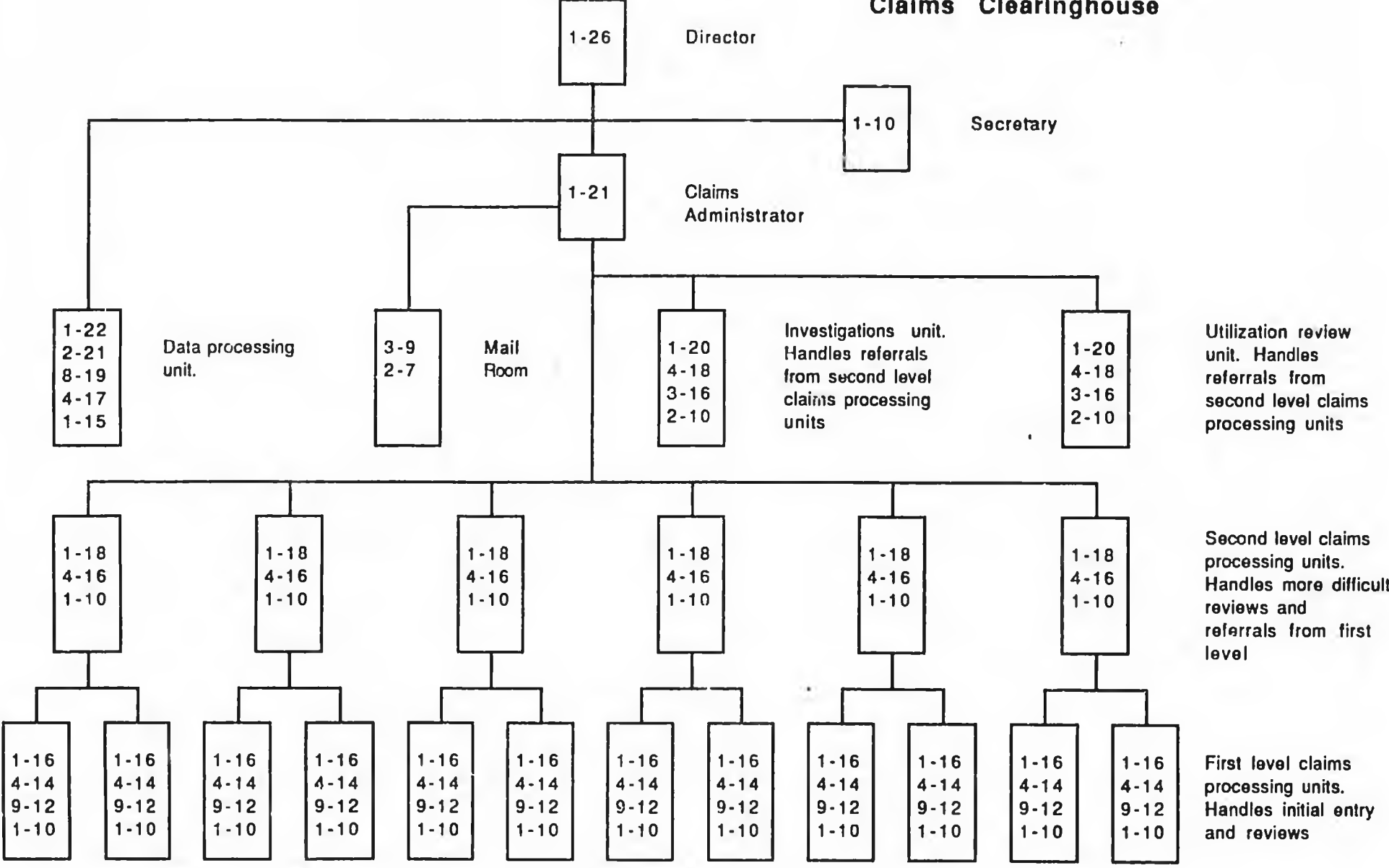
AS 21.58.260 requires the collection of health care data from which the corporation shall, under .270, prescribe by regulation a statewide health care expenditure target which shall, under .280, constitute a recommended target for expenditures within each specified category or subcategory of health care services or products. AS 21.58.290 and .300 require the monitoring of the voluntary health care provider compliance program of .280, the reporting of this effort to the legislature and the imposition by regulation of mandatory expenditure limits on one or more subcategories should voluntary compliance not produce the desired affect.

We can and have provided costs for adopting a regulation and a section of people to monitor and report to the legislature. What we have not included are costs of enforcement for the mandatory compliance of cost controls. Cost and product controls have been adopted at various times in our country's history. Examples would be the price controls of the second world war, Prohibition in which the sale of alcohol was banned and President Carter's recent attempt at price controls to bring the inflation of the seventies under control. Each ended in a country worse off than before the remedy. Accordingly, we are unable to identify a successful model after which to pattern a system of effective price or product controls which would not result in black market activities or a refusal of medical service providers to provide a product at the mandated price. Examples of this pattern of behavior would be the government controlled health care systems of Canada, Germany and India.

Also, we have no information regarding the political will of the legislature to enforce the mandatory cost control program. Without enforcement there will be no cost or product control programs. Judges, prosecutors, state troopers, investigators, paralegal and clerical support personnel therefore are some of the most expensive employees in state government. Enforcement quickly becomes expensive. An identification of the willingness of the legislature to accept the political backlash which even moderate enforcement will produce will be required before it is possible to calculate a cost.

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Claims Clearinghouse



DRAFT

LIST OF CONTACTS RELATING TO THE
FISCAL NOTE FOR SB 284

Becky, Juneau.....Legislative Information Office

Madeline Kellyhouse.....PFD
Tom Williams.....PFD
Mike McGee.....PFD
Randy Moore.....PFD

Larry Kemp.....Dept. of Commerce & Economic Dev.
Judy Weske.....Dept. of Commerce & Economic Dev.
Occupational Licensing

Brad Whister.....Dept. of Health & Soc. Serv.

Phyllis.....Blue Cross
Lorraine Manger.....Blue Cross

Chuck Caldwell.....Dept. of Labor/Research & Analysis

Jim Coates.....Dept. of Labor/Unemployment Ins.

Barbara Saunders.....Aetna

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mailed to
Bonnie by
me 3/1/94



Betty -
I spoke w/
Bonnie right
after the mtg
& I was sure
she told me.
4 people came
to this mtg
only 4

LEGISLATIVE TELECONFERENCE NETWORK SIGN-IN SHEET

UNIVERSITY OF ALASKA
CHUGACH/EAGLE
RIVER
CAMPUS

SPONSOR: SENATOR HESS
SUBJECT: Health Reform
START/END TIME: 1:30 DATE: 02/18/94

PLEASE

	Name/Representing	Address	Zip	Phone No.	Testify	Observe	Bill No.
1.	Bonnie Nelson	20615 White Birch Rd	99567	688-3012	✓		
2.	Daryl Nelson	" " "	"	"	✓		
3.	Janet Oates	HC 85 9291 Heland Rd. ER	99577	696-2345	✓		
4.	RUTH CALLAN	22424 71. Birchwood	99567	688-9047	✓		
5.	JESSIE YEARSLEY	22424 N Birchwood Ln	99567	688-5446	✓		
6.	Wole PARSON	3677 College Rd	99709	479-3800		✓	
7.	Kim Adams	P.O. Box 2425, Palmer, AK	99645	746-6202			
8.	Julie Oates	9151 W Pkwy Terr Ln AK	99577	696-3779			
9.	Karin Williams	Box 878901 Wasilla, AK 99687	99687	696-3279		✓	
10.							
11.							
12.							
13.							
14.							
15.							

mailed to Jana
by Bonnie Nelson
re 3/1/94



LEGISLATIVE TELECONFERENCE NETWORK

SIGN-IN SHEET

UAA CHUGACH/EAGLE
RIVER
CAMPUS

SPONSOR: SENATE HESS

SUBJECT: Health Reform

START/END TIME: 1130 DATE: 02/14/94

PLEASE PRINT

	Name/Representing	Address	Zip	Phone No.	Testify	Observe	Bill No.
1.	Bills Johnston	Box 770334 Eagle River AK	99577	694-9766			284
2.	Ruth Callan	22424 N Birchwood	99567	688-9047			284
3.	Daryl Nelson	20619 White Birch	99567	699-3017			284
4.	Bonnie Nelson	LL	LL	LL			284
5.							
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TESTIMONY ON HEALTH CARE REFORM LEGISLATION

BEFORE THE

ALASKA SENATE COMMITTEE ON

HEALTH, EDUCATION AND SOCIAL SERVICES

February 28, 1994

My name is Gordon Evans and I represent the Health Insurance Association of America ("HIAA"), which is a trade association of the nation's leading commercial health insurance companies which provide health insurance for approximately 55 million Americans.

I am here today to present HIAA's view on the issue of "health care reform". HIAA supports enactment of Senate Bill 270 with some modification as the best way to approach the problems in our health care system.

HIAA wholeheartedly embraces many of the building blocks upon which comprehensive health care is based: measurable quality and outcomes standards, physician choice, and administrative simplification. Reform must include a shift in emphasis away from sickness and repair, and toward health and wellness.

However, we disagree with the sponsors of Senate Bill 284 that the government is the most appropriate mechanism for delivering health coverage to all Alaskans. HIAA advocates that government should be an "enabler" not a "doer."

The system must be streamlined and be made more "user friendly." Our health care system is awash in a sea of paperwork. HIAA supports standard guidelines for electronic data processing and a nationally uniform claim form to achieve an efficient and paperless system. Collecting and disseminating appropriate outcomes data and practice guidelines should be a component of any health care reform package.

HIAA also believes that all Alaskans, indeed all Americans, are entitled to health care coverage. To achieve this goal, we should build on the employer-based system to create a consumer-responsive, prevention-focused, affordable, and cost effective health system. We do not believe that a government-run, single-payer type system would provide the service or access to technology that most Americans expect and deserve.

All of us -- including the insurance industry -- are concerned about the more than 37 million Americans, including an estimated 76 thousand Alaskans, who do not have health care coverage. However, adopting Canadian-style, single-payor public health insurance -- everybody is covered and it appears to be cheaper -- unfortunately is not the magic solution.

For one thing, it's not that simple. There is no free lunch, as the economists like to say. If you try to provide free health care to everybody on a fixed government budget, eventually something's got to give -- and the consequences are very clear from the Canadian experience.

Everybody has access in Canada, the advocates say. Well, yes, but access to what? Can every Canadian get to see a doctor when they have the flu or their child has an earache? Does every Canadian have prompt access to medically necessary care?

Studies by the Vancouver-based Fraser Institute estimate that, across Canada, more than 177,000 people are waiting for surgery. Average waiting times vary by type of surgery and by province for certain kinds of medical care. For example:

- * On average, it takes almost seven weeks to see a gynecologist in New Brunswick.
- * Patients in British Columbia wait up to a year for routine procedures such as prostatectomies, hip replacements, and surgery for hemorrhoids and varicose veins.
- * In Ontario, patients wait up to six months for a CAT scan, up to a year for eye surgery and orthopedic surgery, up to a year and four months for an MRI scan, and up to two years for other treatment.
- * All over Canada, patients wait for coronary bypass surgery.
- * On average, it takes about five weeks to see a specialist in all 10 Canadian provinces.

Is this the type of access we want?

As the waiting lines grow for virtually every type of treatment in every Canadian province, America serves as Canada's safety valve. In increasing numbers, Canadians are crossing the U.S. border to get care they cannot get at home.

Health care budgets have gotten particularly tight in the Canadian provinces in the last few years. Health spending now consumes about a third of provincial budgets. The government in Ottawa has frozen its per capita contribution at the 1989-90 level for the foreseeable future. The result has been turmoil at the provincial level as the provinces struggle to keep health spending from breaking the budget.

The essence of the American health care system is its ability to adapt quickly to changing needs and to develop and rapidly employ new and better ways of treating illness and maintaining health. Such responsiveness is clearly not possible when all major resource allocation decisions are made by the government.

One of the major rationales given by advocates for a government-run health insurance system for their claim that such a publicly run system will be cheaper than our current system is that administrative costs are lower. This may appear to be the case on the surface, but there is no reason to assume that the government will show the needed fiscal restraint in health care when it has failed to restrain other government programs.

In closing, let me emphasize that it has not been HIAA's intent to defend the current U.S. health care financing system as perfect, nor to portray the Canadian system as inept. Clearly, we must develop and adopt improvements that will extend affordable health care coverage to all Alaskans and all Americans.

The question is not whether we should address the problem. We should. Rather, the question is whether we should pursue a solution that builds upon what is good about America's health care financing and delivery system, or adopt an approach that would abruptly sweep away ~~our~~^{our} present structure and substitute a radically different approach.

HIAA appreciates the opportunity to appear today and we would be happy to work with the committee and the Legislature to seek a resolution of this problem.

Public Opinion Message

Title First Name Middle Name Last Name Suffix

 Mailing Address Zip

 Home Address Zip

 Telephone Affiliation City

House Members		
Barnes*	Hoffman*	Olbergs
Bride*	Hudson	Parnell*
Brown*	James*	Phillips
Bunde*	<input checked="" type="checkbox"/> Kott*	Porter*
Carney*	Larson*	Sanders*
Davidson	Mackles	Sitton*
Davis*	MacLean*	Therrell*
Davis, B*	Martin*	Toohy <input checked="" type="checkbox"/>
Davis G	Menard*	Ulmer
Finkelstein*	Moses*	Vezey*
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Duncan	Miller*
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Frank*	Phillips*
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Anchorage Caucus*
Fairbanks Caucus*
Mat-Sui Caucus*
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Committees
C&RA
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HESS <input checked="" type="checkbox"/>
Judiciary
Labor & Comm
Rules
State Affairs
Trans

Bill #
 Support Oppose Amend
 Not Related

Subject
Alaska Health Insurance Corporation

50 Word Maximum Message

1	2 oppose	3 these	4 bills	5 because
6 they	7 will	8 eliminate	9 personal	10 choice
11 by	12 creating	13 a	14 state	15 run
16 health	17 care	18 monopoly,	19 These	20 bills
21 also	22 have	23 to	24 cost	25 estimate
26 nor	27 any	28 provision	29 for	30 financing
31 the	32 cost	33 of	34 health	35 care.
36 Please	37 do	38 not	39 support	40 SB-284
41 or	42 HB-451.	43	44	45
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Post-It brand fax transmittal number 7671 of pages 1
 465-2069

**PUBLIC OPINION TELECONFERENCE ON SENATE
BILL #284-MARCH 2, 1994**

1. THE FINDINGS AND THE PURPOSES OF SENATE BILL 284 REFLECT THE BELIEF THAT THERE ARE A GROWING NUMBER OF CITIZENS WHO ARE UNABLE TO OBTAIN HEALTH INSURANCE OR PAY FOR THE NEEDED CARE.
 - A. I CANNOT HELP BUT WONDER WHETHER THE SOLUTION PROPOSED FOR THOSE WITHOUT MEDICAL COVERAGE IS SIGNIFICANTLY LARGER THAN THE PROBLEM???
 - B. DO WE REALLY HAVE ANY MEANS OF DETERMINING HOW MANY PEOPLE IN FACT DO NOT HAVE AFFORDABLE ACCESS TO HEALTH CARE COVERAGE?? THE INFORMATION AVAILABLE DOES NOT APPEAR TO TRULY ANSWER THAT QUESTION. PERHAPS A SERIES OF QUESTIONS ON THE PERMANENT FUND APPLICATION DETAILING THE REASONS PEOPLE DO NOT HAVE COVERAGE WOULD GIVE US A MORE ACCURATE FIGURE.
2. THE FINDINGS AND PURPOSES OF SENATE BILL 284 STATE THAT HEALTH CARE SERVICES AND HEALTH INSURANCE IN THE STATE ARE BECOMING PROHIBITIVELY COSTLY.
 - A. I QUESTION WHETHER OR NOT THE PROPOSED ALASKA HEALTH INSURANCE CORPORATION WOULD BE ABLE TO PROVIDE COVERAGE AT A MORE REASONABLE RATE IN LIGHT OF THE FACT THAT THERE DOES NOT APPEAR TO BE ANY ESTIMATE OR PLAN FOR ESTIMATION BEFORE ENACTMENT.
3. SENATE BILL 284 DOES NOT OFFER A PLAN OR AN ESTIMATE FOR FUNDING THE INSURANCE CORPORATION UNTIL "AFTER" CLAIMS HAVE BEGUN TO BE PAID. THE POLICY OF PASSING A BILL AND FIGURING OUT HOW TO FUND IT LATER IS IRRESPONSIBLE.
4. OF MAJOR CONCERN IS THE FACT THAT THE CORPORATION DOES NOT REQUIRE PUBLIC INPUT VIA THE VOTING PROCESS TO CHANGE MANY OF THE SIGNIFICANT AREAS OF ITS OWN OPERATION AS WELL AS THE FUNDING OF SUCH. THE POWERS OVER PROVIDERS OPERATING IN OUR STATE ARE TOTALLY OFEN ENDED AS WELL.

NEWS

American Medical Association

FEBRUARY 28, 1994

Surgeons back single payer

ACS says national plan would protect patients' choice of doctor

By Sharon McIlrath
AMNEWS STAFF

WASHINGTON — Sending shock waves through the health world, the American College of Surgeons has become the first major medical organization to back a single-payer health plan in the United States.

The position was adopted by the college's board of regents Feb. 4 and revealed to the world six days later at a congressional hearing.

ACS Chairman David Murray, MD, said the 60,000-member group acted out of frustration with insurer-run managed care plans and a desire to bring about reforms that permit "patients to select the physician or surgeon of their choice." He emphasized that the college had not endorsed any of the single-payer bills introduced in Congress to date, and had a number of quarrels with a leading contender introduced by Rep. Jim McDermott, MD (D, Wash.), and Sen. Paul Wellstone (D, Minn.).

The single-payer endorsement came at a fairly low-key hearing of a House Education and Labor subcommittee and had not been included in a written statement delivered to the commit-

tee earlier. It caught committee members as well as other medical groups completely off guard and caused some grumbling among surgical subspecialties, which now must decide whether to follow the ACS or break ranks.

For the moment, the National Medical Assn. and the American Medical Women's Assn. are the ACS's only medical company in the single-payer camp. Other major physician groups say there are pockets of support for a Canadian-type plan among their colleagues as well, and some surgical groups are reserving judgment until they've held further discussions with ACS.

But experience with Medicare and Medicaid has left many doctors wary of a plan that AMA President-elect and Maine surgeon Robert McAfee, MD, said would take "medical decisions out of the hands of doctors and patients and give it to faceless government bureaucrats." Also, as Dr. Murray told reporters at the hearing, the ACS board has not polled its members, and there may be some dissension with the single-payer endorsement within the college's ranks.

The ACS endorsement came on the heels of a visit from Dr. McDermott, who also traveled at his own expense to plead his case before the AMA and the American College of Physicians. Despite the ACS's reservations about his proposal, the Washington psychiatrist was plainly elated with their decision and said he'd willingly make some changes to meet ACS objections and bring other medical groups aboard.

"These groups are all fractured," he said. "But with the surgeons going, you might be surprised what happens. . . . The importance of what they've said is that managed competition takes away from decisions between doctors and patients and puts it in the hands of insurance companies. . . . Differences between us are easily bridgeable."

One of ACS's chief complaints about the McDermott-Wellstone proposal is its reliance on states to administer the program, Dr. Murray said. Surgeons fear that would be a "replay of Medicaid," which varies from state-to-state but is widely regarded as poorly administered and underfinanced.

Dr. McDermott said his plan, which requires the same benefits and pay structure in all states, avoids Medicaid mistakes. But he said Ways and Means health subcommittee Chairman Rep. Pete Stark has introduced another plan that extends Medicare to all Americans and suggests that this might be the basis for a compromise with surgeons.

Inside: more on reform

CBO: Mixed marks
for Clinton plan
budget [1]

ACP exec, a vocal
reform advocate,
resigns [2]

AMA to Congress:
No retreat on
coverage [3]

Update: Reform
in the states . . . [4]

Flash points:
abortion, mam-
mography [5]

MAR 1 9 1994 MED 13:34 PK HOSP & NURSING HOME BOT 46305515 P. 10

Moreover, he said, if surgeons and other doctors want assurances that they'll have a place at the bargaining table, he'd have "no problem" with adding "a guaranteed mechanism for negotiation" to his bill.

Although the White House did not return repeated phone calls, several medical leaders said they thought that rather than boosting the chances of a single-payer plan, the new ACS position might improve the prospects for the Clinton bill instead.

That proposal — which creates regional purchasing alliances, requires employers to pay for worker health benefits and caps annual increases — has been depicted by opponents as bureaucratic, expensive and radical. But with ACS supporting a single-payer plan, the president's plan may seem more "moderate," postulated American Society of Internal Medicine Executive Vice President Alan Nelson, MD.

"McDermott's got some company now," added American Academy of Family Physicians Executive Robert Graham, MD. He can say that besides 90 co-sponsors, he's also got "this very learned physicians group, which says this is not a bad way to do it." This "makes the president look more moderate" and shows that he's positioned his plan "midstream" in the debate.

'No' to single payer

While AAFP is backing the president's plan as a "starting point," ASIM has said only that it likes some elements of the plan and disapproves of others. But like the AMA's Dr. McAfee, Drs. Graham and Nelson are firmly opposed to the single-payer concept.

To a large degree, all three men say the government itself is to blame. "The history of government-run medical programs does not inspire confidence that our patients' medical needs will be the government's top priority," observed Dr. McAfee.

"Our members have had 30 years experience with a single payer called HCFA, and it really hasn't been all that satisfactory," Dr. Graham agreed.

"When you have a single payer with the ability to impose price controls, the viability of the system rests on government's intention to deal in good faith," and the track record with Medicare and Medicaid "isn't reassuring," added Dr. Nelson.

Nor is Dr. McAfee the only surgeon unhappy with the ACS's new position. Durham, N.C., surgeon and former AMA President James E. Davis, MD, recently founded the American Society of General Surgery, which unlike the ACS will make policy chiefly through a house of delegates. He predicts that ACS's action will prove "very troubling to many, many surgeons throughout the country" and may "make democratically-based organizations such as ours more attractive."

That doesn't keep the medical profession's single-payer backers from hoping. Representatives of the Physicians for a National Health Program, which backs a Canadian-style plan, were overjoyed at the latest turn of events. "It's a highly important and dramatic breakthrough," said Quentin Young, MD, PNHP past president.

"We've seen an increasing physician awareness that the only reform that preserves patient choice and physician autonomy is single payer," the Chicago internist continued. "We didn't think the ACS would be the first major break out of the kennel. But I think this is a harbinger of what we can expect from other places in the house of medicine."

Secret support

Privately, representatives of most physician organizations say they've seen some upturn in the number of members who see a single-payer plan as preferable to those that hasten the

drive to managed care.

One medical executive was shocked when the Canadian approach beat out managed competition and incremental reforms in a straw vote among Oregon members. A family physician in Wisconsin says it no longer takes several drinks to get physicians in that state to speculate that a single-payer plan might not be any worse than managed care.

But primary care representatives say they think single payer support is concentrated mainly among surgeons and medical subspecialists, who fear managed care will put them out of business.

It boils down to economics, said AAFP's Dr. Graham. For family physicians, managed care does create some frustrations but their specialty's in short supply, so "there's no threat to their livelihood."

In a community with 50 cardiologists and three big managed care organizations using 10 cardiologists each, however, 20 cardiologists are going to be left with nothing to do, he added. And in that scenario, "I've heard an increasing number of people say I'd rather have single payer."

Whether its economics or autonomy that drives them, many subspecialists would prefer to practice in a system where patients don't need a primary care gatekeeper's or insurers' permission to seek treatment from a specialist. And, Dr. Murray told the House subcommittee, many do find a Medicare-type system preferable.

"We can take care of a Medicare patient as we see fit," he told the panel. "But we take care of our other patients

the way the insurance company sees fit. . . . These conditions are becoming increasingly onerous and in some cases are affecting quality of care."

But while they're inclined to agree with Dr. Murray's assessment of managed care, some surgical subspecialties are dubious about the ACS strategy. The American Academy of Orthopaedic Surgeons wants to meet with ACS regents to "decipher their reasons" before deciding whether to jump on the single-payer bandwagon, said AAOS President Bernard Rineberg, MD.

"Managed care is moving ahead at its own rate of speed," he noted, however. It already is being pushed for Medicare and is likely to be "layered on" whatever health plan is eventually enacted by Congress, including those that have only one payer.

RECEIVED FEB 22 1994

John J. Shaffer
303 Kimsham Street
Sitka Alaska 99835-7124

February 18, 1994

Senator Steve Rieger, Chair
Senate HESS Committee
Alaska State Legislature
State Capitol (MS 3100)
Juneau AK 99801-1182

Dear Senator Rieger:

Thank you for giving me a few personal minutes yesterday to let you know about my concern for the passage of a good bill focusing on Health Care Reform.

As you may have noticed today, the power went out in Sitka just after I gave my name for the record at the teleconference. Some of my Sitka friends teased me about that situation. Hope it didn't cause too much confusion on your end.

Please let members of your committee know the essence of my testimony, which would have been similar to this:

"My name is John J. Shaffer of Sitka and I am speaking on behalf of the State Legislative Committee of the American Association of Retired Persons.

For several years, we have placed the area of health care as the number one priority in our legislative program. This priority has been consistently endorsed by members of our organization, which relates to more than 42,839 individuals in the State of Alaska.

Our concern is not just for Senior Citizens, but for everyone in our state: children, youth and adults. We are concerned for those who are insured and for those who are not insured. Increased health care costs affects all of us.

The State Legislative Committee has just endorsed the concepts of Health Care Reform which are contained in Senate Bill No. 284.

Now that the Legislature and the Governor have received the Final Report of the Health Resources and Access Task Force, much of the ground work for this issue has been done.

It is not the time for more study, it is the time for action."

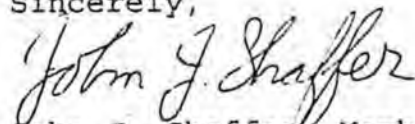
Setting up a Corporation with a board of directors that would be "compensated, but with less than full time employment", would be a positive step in the direction of action.

Senator Rieger, you are to be commended for holding hearings on this promptly and I hope you are able to move the bill on to the next committee quickly.

When you have additional hearings, perhaps the power source in Sitka will be more cooperative.

I think it would be exciting for Alaska to be ahead of the curve on health care reform, making us "in charge" of the changes that may be coming from the federal level, rather than just being reactive.

Sincerely,



John J. Shaffer, Member
State Legislative Committee
American Association of Retired Persons

cc: Mary Lou Meiners, Chair
AARP State Legislative Committee

Raven Causes Power Outage

By SHANNON HAUGLAND
Sentinel Staff Writer

All of Sitka lost power for about an hour this afternoon when a raven electrocuted itself in some high-voltage conductors at the Marine Street substation.

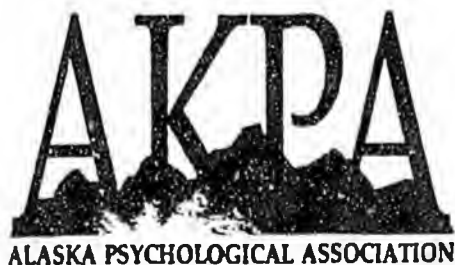
City Electrical Superintendent Dick Wilson said it was "an easy fix" and there was no damage to the system.

He said it appeared that the raven was sitting on one of the buses — a high voltage conductor — and then touched another bus that crossed overhead with its head or beak. The resulting short circuit opened protective breakers and shut down power to the distribution network.

He said the bird's insides "exploded" outside its body all over the immediate area, leaving only feathers and a skeleton.

"It was so instantaneous, he probably never knew what hit him," said Wilson.

Sentinel
2/18/94



TESTIMONY GIVEN TO THE ALASKA SENATE HEALTH, EDUCATION & SOCIAL SERVICE COMMITTEE
2/18/94

My name is Dr. Sally Schliesmann, and I am a licensed psychologist in private practice in Anchorage. I am also President of the Alaska Psychological Association. I am here today to talk about the importance of including psychological services in state health care reform.

Last fall, I had the opportunity to participate in the Health Care Reform Work group meetings crafting a joint health care proposal. Today there are several issues I want to bring to your attention, the first of which is access to service. Many people who seek therapy use insurance to cover some of the expense, BUT not all insurance packages include payment for therapy. Most people cannot afford to pay out-of-pocket. In my own business, 50% of my clients use insurance, 50% do not. 10% are on a sliding scale, which means I offer them service at a reduced fee. Many people drop out of therapy due to financial struggles. I do my best, ethically and reasonably, to accommodate this. I estimate that I get 5-10 calls a month from people who want to make an appointment and then discover they can't afford it. Most of these people will probably not get help. One alternative for them is Southcentral Counseling Center, a state-funded mental health center, which currently has a five-week waiting list.

I see this as a health care crisis. I am one practitioner. In our state, there are 170 licensed psychologists and psychological associates available to provide services to those in need. There are many in need who aren't able to afford to get the help they need.

The next issue of importance is early intervention. What does this mean? It means getting to the problems when they're small so they don't get worse, and before they cause deeper emotional problems and greater financial setbacks. A young married couple recently came to see me for marriage counseling. They sought help when their problems were new, and with hard work, came to some resolutions in six weeks and now feel stronger in their marriage and more able to face future problems. A young college student recently came to see me to get help with bulimia. She had bulimic symptoms for six months. She sought help early enough and her prognosis is good because of this. It doesn't take much to imagine the worse-case scenario of either of these examples: the psychological and financial costs will be high if problems go untreated.

Page 2
Senate HESS Testimony
Dr. Schliesmann
2/18/94

National health reform has emphasized the importance of primary and preventive health care in contrast to specialized treatment. I encourage you to consider, and as the health care reform debates continue, to think of psychological services as primary care and preventive service. Mental health is an essential component of total health care.

Did you know that

- personal and family problems are the number one workplace threat?
- 30-60% of physician visits are made by patients with no diagnosable physical illness. Anxiety and depression are among the six most common conditions seen in family medical practice.
- alcohol treatment for one family member subsequently reduces the health care costs of the whole family
- psychological intervention enables surgery and heart attack patients to recover more quickly

There is an accumulating body of research showing the significance of behavior and psychology on the body's immune system. In addition, psychologists provide interventions to help with hypertension, cancer, and gastrointestinal disorders, to name a few health concerns.

The more access to and availability of psychological services that people have, the more mentally healthy people are, the better individuals will be, communities will be and, as a whole, both individuals and communities will spend less on overall health services.

I have more information and statistics on these and many other issues of concern to psychologists. I am happy to provide you with more information at your request. I look forward to offering you more input regarding state health care reform.

Thank you.

02/19/74
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LEGISLATIVE TELECONFERENCE NETWORK SYSTEM
PARTICIPANT LIST (TESTIFIERS ONLY)
TELE-0307 SCHEDULED FOR 02/19/74 12:30 TO 1:30
PUBLIC HEARING SENATE HEALTH, EDUCATION & SOCIAL SERVICE

LTN1150
BY JNU
FOR JNU

LEGISLATION JURISDICTION

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LEGISLATIVE TELECONFERENCE NETWORK SYSTEM
MESSAGE FROM LIGGERS IN JUNEAU

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AND

RE: COM: 403AW SCHEDULED FOR 02/18/94 13:30 TO 14:30

MONITOR SENATE HEALTH, EDUCATION & SOCIAL SERV PURPOSE: PUBLIC HEARING

MESSAGE TEXT: ~~ONE SOMEONE WOULD ALSO LIKE TO TEST.~~

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02/18/94 13:20:30 LEGISLATIVE TELECONFERENCE NETWORK SYSTEM
MESSAGE FROM LIOCELM IN HOMER LTC

LTN1150
AND

RE TCU 48569 SCHEDULED FOR 02/18/94 13:30 TO 15:30
SPONSOR: SENATE HEALTH, EDUCATION & SOCIAL SERVICES PUBLIC HEARING

MESSAGE TEXT: HOMER STANDING BY. NO PARTICIPANTS YET THRU.

02/18/94
13:23:43

LEGISLATIVE TELECONFERENCE NETWORK SYSTEM
PARTICIPANT LIST (ALL PARTICIPANTS)

LTN1150
BY:JIT
FOR:JIT

TCU 48569 SCHEDULED FOR 02/18/94 13:30 TO 15:30
PUBLIC HEARING SENATE HEALTH, EDUCATION & SOCIAL SERVICES

LOCATION: SITE A
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10/11/94~~

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10/11/94~~

TESTIFY
TESTIFY

02/18/94
3:34:42

LEGISLATIVE TELECONFERENCE NETWORK SYSTEM
PARTICIPANT LIST (ALL PARTICIPANTS)

LINE 154
BY FBI
FOR FBI

TCN 40509 SCHEDULED FOR 02/18/94 13:30 TO 15:30
PUBLIC HEARING SENATE HEALTH, EDUCATION & SOCIAL SERVICE

LOCATION FAIRBANKS
35 284

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02/18/94
15:34:55

LEGISLATIVE TELECONFERENCE NETWORK SYSTEM
PARTICIPANT LIST (TESTIFIERS ONLY)

LINE 155
BY MAT
FOR MAT

TCN 40509 SCHEDULED FOR 02/18/94 13:30 TO 15:30
PUBLIC HEARING SENATE HEALTH, EDUCATION & SOCIAL SERVICE

LOCATION MATSU
58 284

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TESTIFY

02/18/94
13:30:57

LEGISLATIVE TELECONFERENCE NETWORK SYSTEM
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LTN1150
BY SOL
FOR: SOL

TCN 40309 SCHEDULED FOR: 02/18/94 13:30 TO 15:30
PUBLIC HEARING SENATE HEALTH, EDUCATION & SOCIAL SERVICES

LOCATION: KEN STE
20 797

MR

MIKE

LOCKWOOD

CPG

TESTIFY

02/18/94 13:40:11 LEGISLATIVE TELECONFERENCE NETWORK SYSTEM
MESSAGE FROM: LIGCERT IN JUNEAU

LTN1120
AND

RE TCN: 40309 SCHEDULED FOR: 02/18/94 13:30 TO 15:30
SPONSOR: SENATE HEALTH, EDUCATION & SOCIAL SER/PURPOSE: PUBLIC HEARING

MESSAGE TEXT: ZENS, DUNCAN, ELLIS, SAID ARE 1/2 JOU

Additional people in Eagle River

- 1) Ruth ~~Call~~ Allen
- 2) ~~Jessie Ayrault~~
- 3) ~~Cole Carson~~
- 4) Kim ~~Allen~~ Ayrault

Sitka has
power outage
and will call
back as soon
as they have
power again.

258/1241



LEGISLATIVE TELECONFERENCE NETWORK SIGN-IN SHEET

SPONSOR: Senate Mess
SUBJECT: SB 270 & SB 274
START/END TIME: 1:30 DATE: 2/12/94

PLEASE PRINT

	Name/Representing	Address	Zip	Phone No.	Testify	Observe	BTI No.
1.	Thelma Langdon Elder Persons Action Group	2363 Surf. Cook Dr Anchorage	99517	347-0134	✓		
2.	DAVID MALTMAN Gov Control	3601 C ST # 740		563-5355		✓	
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Govmans Council Office 3601 C ST # 740

Offsets

Governor's Council on Disabilities

~~1) Thelma Langdon to testify~~

2 observers

Eagle River —

Testify

~~1) Janet Oates~~

~~2) Daryl Nelson~~

~~3) Bonnie Nelson~~

Cordova

Jarman

Kelchkin

Sitka

Tair

Mat

Soldatna



Testimony
3 min limit

LEGISLATIVE TELECONFERENCE NETWORK SIGN-IN SHEET

40309

pg 2

SPONSOR: Senate HESS
SUBJECT: SB 270 Health Care SB 284. Nevada Jones Act
START/END TIME: 1:30 DATE: 2-17

PLEASE PRINT

	Name/Representing	Address	Zip	Phone No.	Testify	Observe	Bill No.
1.	Mary Ellen Goodland	2616 Newberry Anchorage AK	99507	522-1466	<input checked="" type="checkbox"/>		SB 284
2.	MARS FSC AIRTEL CO	2501 COMMERCIAL DR	99501	272-4571	<input checked="" type="checkbox"/>		
3.	Richard Lee & Associates (Tombstone)	PO Box 107072	99511	214-4722	<input type="checkbox"/>		
4.	Ken [unclear]	MCA/IDHITS/CO + AOVIA	99519	343-4623	<input checked="" type="checkbox"/>		
5.	William C. [unclear]	MCA/IDHITS/PC Box 156156 Anch. AK	99519	343-4622		<input checked="" type="checkbox"/>	
6.	Michael A. Brogan Had to leave	1435 'N' ST.	99501	257-5260	<input checked="" type="checkbox"/>		
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*Testimony
3 min time
limit*

LEGISLATIVE TELECONFERENCE NETWORK SIGN-IN SHEET

40309

SPONSOR: Sen. HESS

SUBJECT: SB 276 - Hunter Care SB 284 - Hunter Ins Act

START/END TIME: 1:30 DATE: 2-17

PLEASE PRINT

	Name/Representing	Address	Zip	Phone No.	Testify	Observe	Bill No.
1.	William ASMA	1200 Airport Hts #310	99508	276-8878	✓		
2.	STEPHAN CONN	AK FIRE P.O. BOX 101093	99509	276-3661	✓		284
3.	DR SALLY SCHLIESMANN	2100 DENALI SUITE 701 Anchorage	99503	275-1200	✓		
4.	Barbara Wingo	11411 Lone Tree Dr. Anch. AK	99514	503-4308 346-1525	✓		284
5.	Ed BURMAN	9960 WINE TREE DR	99512	346-1001	✓		284
6.	Ken Taylor - highway committee	4116 W. 11th St Anchorage	99506	563-1000	✓		
7.	David Wachtore / Spirit House		99501	277-0782		✓	284
8.	Charles E. McKee	1505 W 43rd #7	99504		✓		284
9.	Theba Pittman	4720 Eagle #1 Anch	99503	561-0515		✓	
10.	Martie C. Leonard	1032 W. 11th Anch	99501	272-9152		✓	284
11.	DAVID G ALEXANDER MD	9601 PROSPECT DR	99516	346-2444	✓		
12.	Roni Zobel	3431 ILLIAMNA	99517	248-4544	✓		
13.	MARTORIE T. LINDER	P.O. Box 230029	99523	346-3611	✓		284
14.	JAMES DELROSS	2348 Leander Cir - Anch	99515	374-8524	✓		284 270
15.							



Aleutian/Pribilof Islands Association, Inc.

401 E. Fireweed Lane, Suite 201
Anchorage, Alaska 99503-2111
Phone (907) 276-2700

April 22, 1994

HD-379-94

Alaska State Senate
The Honorable Senator
Steve Rieger, Chairman
Health, Education & Social Services Committee
MS 3100
Juneau, Alaska 99811

Dear Chairman Rieger:

The Aleutian/Pribilof Islands Association, Inc. urges your support for the preservation of two vital rural health manpower development programs that Alaska is about to lose: The Alaska Center for Rural Health and the Alaska Physician Assistant Training Project.

The Alaska Center for Rural Health (formerly know as RAHEC) is a non-profit corporation which has been working furiously to ensure adequate health manpower for Alaska. As you know, we have a very hard time recruiting and retaining adequate health manpower to the more remote areas of our state. The Center, through its ability to establish communications between the far-flung parts of our rural health system and sources of training and health center development, has begun to mobilize us towards growing our own health profession's resources.

They have also conducted systematic study of our health manpower problems and provides timely connection to educational resources. By doing so, it has begun to show us ways to achieve health career development. Further, the Center has been designated as Alaska's Office of Rural Health by the Governor, and has over the past two years been assisting rural communities to more effectively plan for the health services. The Center requires \$250,000 to maintain its core operations. If historical success is any indication, the Center should be able to nearly double that amount each year in obtaining federal funds for our state.

The Alaska PA Project, three years in the making under a federal demonstration grant, is now graduating twelve Alaska-trained physician's assistants per year. The Center has taken on the

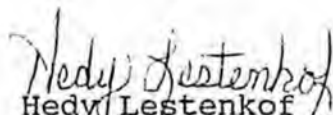
HD-379-94
April 22, 1994
Steve Rieger, Chairman

responsibility for administering the PA project without asking for administrative expenses since it represents an important part of its mission. Therefore, the \$500,000 that is needed to support the PA Project will go totally to the training of students.

We strongly urge that you appropriate the amount of \$750,000 to the Center to provide core funding for these two programs.

Thank you for your interest and assistance in improving the delivery of health services in Alaska.

Sincerely,


Hedy Lestenkof
Health Director

cc: Bert M. Sharp, Vice-Chairman
Loren Lemman, Committee Member
Mike Miller, Committee Member
Jim Duncan, Committee Member
Johnny Ellis, Committee Member
Judy Salo, Committee Member
Alaska Center for Rural Health