HEALTH CARE, 10/6/05

Callers:

Becky Rooney
Bev Wooley
Cindy Standard
Dennis Murray
Fairbanks LIO
Gayle/Sen Dyson's office
Greg Scandlen
Homer LIO
Jim Frogue
Jordan Marshall
Juneau LIO
Kathy Erickson
KBBI
Kelly Donally
Kodiak LIO
Laura Truman
Laurie Herman
Linda Fink
Lisa Weisner
Mary Sutton
Matsu LIO
Pat Jackson
Rep Coghill
Rep Guttenberg
Rep Wilson
Richard Benavides
Sen Hoffman's office
Sheila Peterson
Wendy Chamberlain
Sitka LIO

SENATOR FRED DYSON
REPRESENTATIVE PEGGY WILSON

JOINT HEALTH, EDUCATION, & SOCIAL SERVICES COMMITTEES
Thursday, October 6, 2005
Anchorage Legislative Information Office, Room 220
10:00 am –1:00 pm

AGENDA

- Health Savings Accounts
  - Jim Frogue, Center for Health Transformation
  - Greg Scandlen, Consumers for Health Care Choices
  - Laura Trueman, Coalition for Affordable Health Coverage
- Hospital Billing
  - Senator Fred Dyson, Alaska State Legislature
  - Rod Betit, President—Alaska State Hospital & Nursing Home Association
- Commonwealth North Health Care Task Force
  - Duane Heyman
  - Thomas Nighswander, M.D.
- Division of Public Health: Concepts for a Web-Based Health Tool Kit
  - Tammy Green, Section Chief—Chronic Disease Prevention and Health Promotion

During Session (January - May): Alaska State Capitol • Juneau, Alaska 99801 • (800) 342-2199 • (907) 465-2199 • (907) 465-4587 (fax)
During Interim (June-December): 10928 Eagle River Road, Suite 238 • Eagle River, Alaska 99577 • (907) 694-6683 • (907) 694-1015 (fax)
senator.fred.dyson@legis.state.ak.us • www.akrepublicans.org

GUEST BIOGRAPHIES

JIM FROGUE

Center for Health Transformation http://www.healthtransformation.net/home/

Jim Frogue joined the Center for Health Transformation as the State Project Director. He serves as the Center's chief liaison to state policy projects. His primary areas of focus are Medicaid and Health Savings Accounts. Prior to joining the Center, Mr. Frogue was for three years Director of the Health and Human Services Task Force at the American Legislative Exchange Council. There, he coordinated the development and dissemination of market-oriented health policies among state legislator representatives from 45 states. Mr. Frogue has also worked for three Members of Congress, most recently as Legislative Director for Rep. Kay Granger of Texas. He also worked for two years as the health care policy analyst at the Heritage Foundation.

Mr. Frogue has testified to state legislatures in Florida, Texas, Ohio, Kansas, Colorado, and Alaska as well as to the U.S. Department of Health and Human Services Importation Task Force. He was also appointed by Speaker William J. Howell to the Virginia Council on Human Resources and will serve until 2008.

Mr. Frogue's op-eds have appeared in the Atlanta Journal Constitution, Chicago Sun Times, the Washington Times, and Health Care News. He has also appeared on CNBC's *Bullseye*, NPR's *The Diane Rehm* show and *All Things Considered*, and the Kaiser Network's "Ask the Experts" webcast.

Jim holds a Master of Philosophy degree from Cambridge University and a Bachelor of Arts with honors from the University of Southern California. He lives in Arlington, Virginia.

Information-Rich Health Savings Accounts:
http://www.healthtransformation.net/projects/Health_Savings_Accounts/

GREG SCANDLEN
Director, Consumers for Health Care Choices
Health Savings Accounts: http://www.regence.com/hsa/101/galenInstituteWhitePaper.pdf

DUANE HEYMAN, Commonwealth North
THOMAS NIGHSWANDER, M.D., Task Force Co-Chair
http://www.commonwealthnorth.org/reports2/05updatedhealthcare.pdf

LAURA CLAY TRUEMAN
Executive Director, Coalition for Affordable Health Coverage
http://www.healthtaxcredits.org/

Laura Clay Trueman leads the Coalition for Affordable Health Coverage, a broad-based assortment of more than 20 individual companies and national associations focused on advocating market-based solutions to reduce the number of uninsured. Since becoming Executive Director of CAHC in 2003, Trueman has worked to raise the profile of the uninsured issue and has led members in educating Senators, Representatives and their staff about the value of making private coverage available to more Americans through the enactment of health care tax credits, Health Savings Accounts, and other consumer-oriented approaches.

Trueman's professional background includes six years in the Senate covering health, education, and other social issues as Legislative Assistant and then Legislative Director to Oklahoma Senator Don Nickles. She worked with the Senate Health Education Labor and Pension Committee where she developed expertise on a range of health, education, and welfare issues. In addition, Trueman served in politically appointed positions at the U.S. Department of Health and Human Services during the Reagan and Bush Administrations, working in the areas of adolescent pregnancy and AIDS public education and information.

Ms. Trueman has been awarded fellowships for study at Emory University and by the American Hospital Supply Corporation. She has a Masters Degree in Writing from Johns Hopkins University and has been published in trade magazines and the Washington Post.

Coalition for Affordable Health Coverage Members include: AdvaMed, Aetna, America's Health Insurance Plans, American College of Cardiology, American Medical Association, American Osteopathic Association, Assurant Health, American Legislative Exchange Council, Bayer, Communicating for Agriculture, Federation of American Hospitals, FMC Corporation, GlaxoSmithKline, Healthcare Leadership Council, National Association of Health Underwriters, National Association of Manufacturers, National Association for the Self-Employed, Pharmaceutical Research and Manufacturers Association, UnitedHealth, US Chamber of Commerce, Women Impacting Public Policy, and Wyeth.

HSAs Spread Quickly, Surprise Critics: http://heartland.org/Article.cfm?artId=15509
Health Savings Accounts: Myth vs. Fact: http://www.ncpa.org/pub/ba/ba479/ba479.pdf
Congress Debates Health Reform: http://www.healthtaxcredits.org/media/CapHill%20Notes_August05pg4.pdf
Heartland Institute: Health Care News. http://heartland.org/Publications.cfm?pblId=2
Health Care Tax Credits for the Uninsured: http://www.ncpa.org/pub/ba/ba498/

Information Rich Health Savings Accounts (HSAs)

Project Description

The historic health savings account (HSA) legislation that the Congress passed as a part of the Medicare drug legislation is an extraordinarily important first step in the transformation of the American health and health care system that will save lives and money. The Center for Health Transformation has made the rapid adoption of HSAs one of its top priorities in 2005 and launched a Health Savings Account Project to coordinate activities in support of this priority.

These portable accounts will allow individuals to deposit money tax free, grow money tax-free, and to withdraw that money tax-free to pay for qualified medical expenses, including preventive care, health insurance deductibles, health insurance premiums for retirees, prescription drugs and long-term care services (including long-term care insurance). As such, information-rich HSAs, which are owned by individuals, are the first completely tax-free account in American history. They will begin to move us away from the current model in which insurance companies dominate the health care transaction. Instead, the information-rich HSA will enable transactions between doctor and patient in which the patient controls how dollars are spent.

In addition, the Center believes that it is vitally important that the information-rich HSAs offered by insurance companies be accompanied by information rich decision support and health management tools that will increase the ability of individuals to make intelligent decisions about the spending of their health dollars. Such decision support tools include price and quality information about doctors, hospitals, prescription drugs, and chronic care services. Health management tools include extensive information about an individual's health condition and treatment and management options. Many insurance companies already offer robust decision support and health management tools. With the introduction of information-rich HSAs, the Center believes that these tools will increase in user-friendliness and sophistication as more and more consumers with a first dollar interest in their health spending will demand more and better information about how to spend it wisely.

If you would like to learn more about how to become a member of the Information-rich Health Savings Account (HSA) Project, please contact Jim Frogue at 202-375-2001 or info@healthtransformation.net.

Transforming Health and Healthcare in Alaska
Saving Lives and Saving Money

October 6, 2005

Jim Frogue
State Project Director
The Center for Health Transformation
www.healthtransformation.net
202-375-2001

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Center for Health Transformation

- Acting as a catalyst to accelerate transformational change
- Identifying better solutions that provide more choices, and better health at lower cost
- Sharing those solutions with the widest array of opinion leaders and decision makers across all sectors and levels to accelerate their adoption by the system
- Helping create, advance and improve the public policies (state and federal) that will accelerate the transformation

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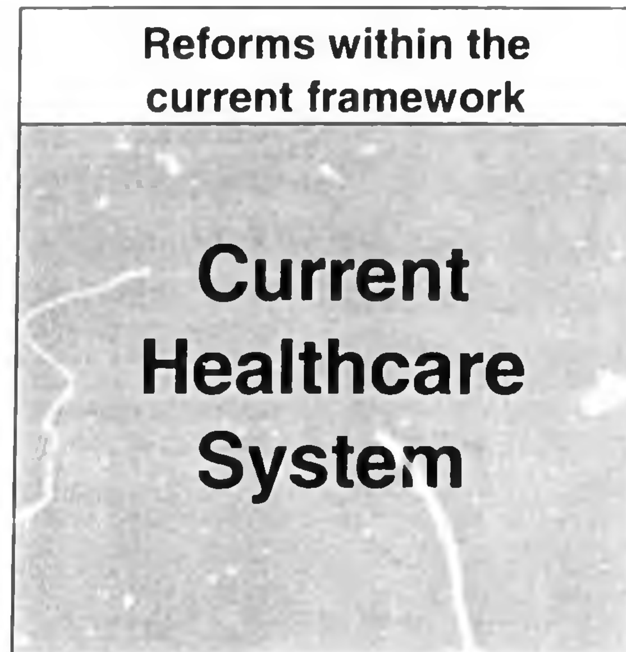
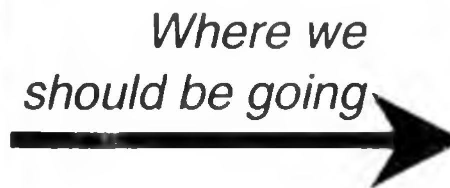
Health Transformation





To avoid change, most bureaucracies prefer the comfortable routine of explaining failure.

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What if in 1985 someone told you…

- That in 2005 there would be this thing called the Internet that is extremely inexpensive for everyone and on it you'll have (for free): Email, Google, Expedia, Edmunds, Monster, Amazon, Ebay, Instant Messaging, on-line bill paying, etc
- DVD players
- TiVo
- Ipods
- Cell phones that double as cameras

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Center for Health Transformation

Current System	21st Century System
Provider-centered	Individual-centered
Price-driven	Values-driven
45 million uninsured Americans	100% coverage
Hidden price and quality information	Transparent price and quality information
Knowledge-disconnected	Knowledge-intense
Slow diffusion of innovation	Rapid diffusion of innovation
Disease-focused	Prevention and health-focused
Paper-based	Electronically-based
Third party controlled market *(patient – provider – payor)*	Binary mediated market ***(individual – provider)***
Process-focused government	Outcomes-focused government
Limited choice	Increased choice
Predatory trial lawyer litigation system	New system of health justice
Overall cost increases	Overall cost decreases
Quantity and price measured	Quality of care and quality of life

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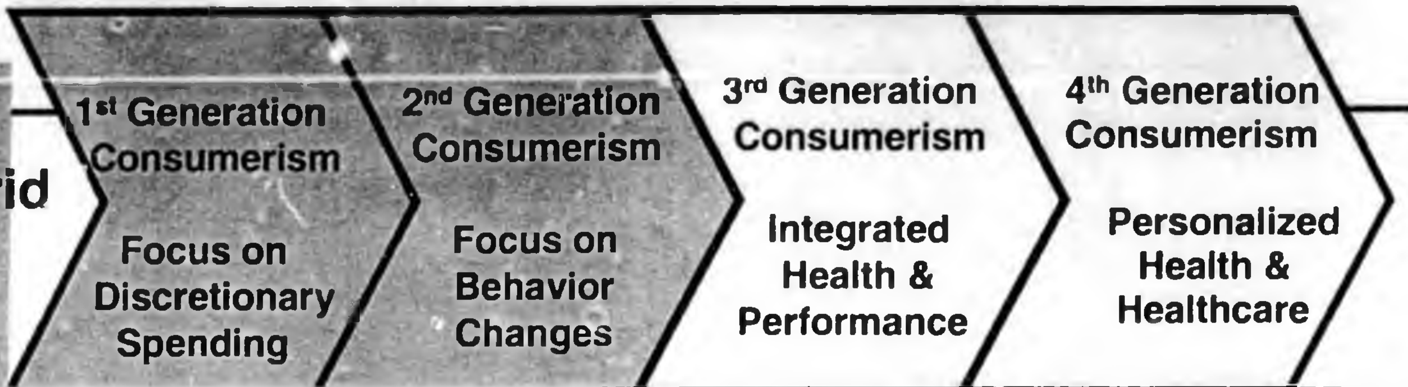

The Consumerism Grid

	1st Generation Consumerism: Focus on Discretionary Spending	2nd Generation Consumerism: Focus on Behavior Changes	3rd Generation Consumerism: Integrated Health & Performance	4th Generation Consumerism: Personalized Health & Healthcare
Personal Care Accounts	Initial Account Only	Activity & Compliance Rewards	Indiv. & Group Corporate Metric Rewards	Specialized Accts, Matching HRAs, Expanded QME
Wellness/Prevention Early Intervention	100% Basic Preventive Care	Web-based behavior change support programs	Worksite wellness, safety, stress & error reduction	Genomics, predictive modeling push technology
Disease and Case Management	Information, health coach	Compliance Awards, disease specific allowances	Population Mgmt, Integrated Hlth Mgmt, Integrated Back-to-Work	Wireless cyber – support, cultural DM, Holistic care
Information Decision Support	Passive Info Discretionary Expenses	Personal health mgmt, info with incentives to access	Health & performance info, integrated health work data	Arrive in time info and services, information therapy
Incentives & Rewards	Cash, tickets, Trinkets	Zero balance acct, activity based incentives	Non-health corporate metric driven incentives	Personal dev. plan incentives, health status related

HSAs vs. HRAs

HSAs	HRAs
Individually Owned	Employer owned
Interest Bearing	No interest
Fully portable	Remains with employer
Always tax free if 213d	Not addressed by IRS
Penalties if non-213d	Health care expenses only
Everyone eligible but Medicare	Eligible if employer allows it
Funded by owner and employer	Funded by employer only
Min/max deductibles	No min/max deductibles
Max contribution limits	No max contribution limits
No incentives for compliance	Incentives for compliance

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More Information on HSAs

www.cahi.org

www.hsadecisons.org

www.hsainsider.com

www.ehealthinsurance.com

www.treasury.gov

(click HSA section on left side)

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#	Company	CCHC Plan/Tools	Budgeted Health Inflation Trend for first year of CCHC Plan	Actual Health Inflation Trend First Year After CCHC Plan Introduced	# of Participating Employees	Notes
1.	Technology Company (CA)	Lumenos	+14%	-9%	2,294	2004 Results
2.	Manufacturing Company (MN)	Lumenos	+14%	-27%	1,704	2004 Results
3.	Health Care Company (TX)	Lumenos	+18%	-12%	4,000	Avg. 2003 and 2004 Results
4.	Hospital System	Humana	+15%	-31%	7,300	2003 Results
5.	Trover Health Solutions (KY)	Humana	+19%	-26%	750	2002 Results
6.	Logan Aluminum (KY)*	Aetna	--	-18.7%	1,000	2003 Results
7.	Mercy Health Plan (MO)	HealthTrio	+16%	-9%	300	2003 Results
8.	Wise Business Forms (PA, GA, IN)	Definity	+10%	-13.3%	500	2002 Results

Consumer Driven Health Care – Early Success Examples

Note: The above are early results and are not necessarily representative of the experience of each company utilizing consumer choice health plans. Year-to-year claim activity will vary and annual results will show more volatility if the population is small. For small employers with slightly higher or lower numbers, large claims will have a significant impact.

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Effects of Consumerism

- Generic substitution leading to 15 percent decrease in pharmacy spend
- Increase in use of preventive care from 2-3 percent to 5 percent of total spend
- 18 percent fewer outpatient doctor visits
- 62 percent of participants roll over money into the following year
- 44 percent of consumers report increase knowledge in managing their health care
- 27 percent of consumers report they are more actively pursuing healthy behaviors

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CHT Georgia Project

- Bring together employers group for pay-for-performance.
- Increase diabetes management of state employees and the Medicaid population.
- Advocate public policies that increase screening, education, and management.
- Identify/incent physicians following protocol.
- Impact key populations impacted by diabetes.
- Educate and impact women as key decision-makers.
- Use technology to communicate and manage (websites, insulin delivery, home monitoring)

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CHT Georgia Project

- Employers: BellSouth, Southern Company, UPS, Home Depot, Coca Cola
- Others: National Minority Health Month Foundation, Novo Nordisk, WellStar, Governor Perdue, CDC, ADA
- Employers in cooperation with self selected physicians and ***Bridges to Excellence*** providing optimal care with emphasis on diabetes prevention and treatment
- Pay $100 per diabetic, save $350 for net $250
- RAND Study 2004 – 55% of all care given was effective
  - Asthma, Diabetes, CHF, Depresssion = 140,000 deaths $143 bn

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Consumer "Right-to-Know"

- Do you have the right-to-know price and quality information from your health care providers?
  - YES – 93 percent
- Should "God" be in the Pledge of Allegiance?
  - YES – 91 percent

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Suggested Goals

- Full replacement consumer directed plans in state employee health plan by January 1, 2007
- Electronic health record for all state employees by January 1, 2007
- Publicity campaign led by the governor with involvement at all levels of government and private industry to highlight new and effective advances in health care consumerism and disease treatments
  - Emphasize examples that simultaneously save lives and save money
  - Involve interest groups that represent various diseases
- Create a culture of entrepreneurship in your state bureaucracies that values innovation where phrase "but that's the way we've always done it," is never heard again

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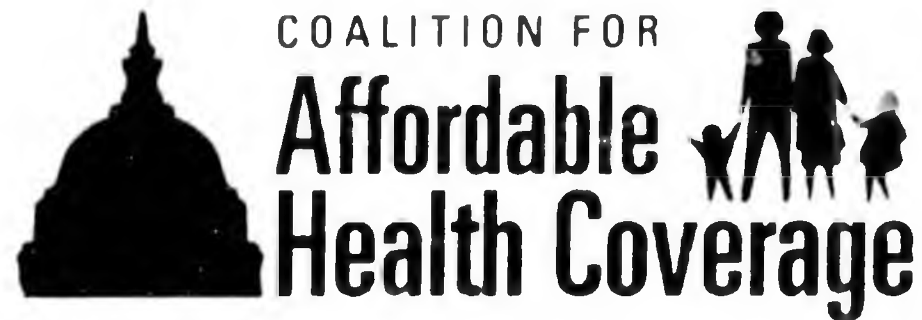
Health Savings Accounts:
What You Need to Know

Laura Trueman, Executive Director



HSA Overview

- A Health Savings Account (HSA) is a new way to have health insurance and establish a tax advantaged savings account for medical expenses.

- The account -- Health Savings Account (HSA) -- allows people to put money in and take money out tax-free, if it is spent on medical care.

- HSAs were created in Medicare legislation and signed into law on December 8, 2003.

Who Can Open A Health Savings Account?

- Anyone who has a qualified "High Deductible Health Plan" (HDHP).
- For 2006 HSA plans, a high deductible health plan has a minimum deductible of $1050 for individuals and $2100 for families.

Do HSA Owners Have Any Protections on How Much They Must Spend Out of Pocket?

- YES!
- Annual out-of-pocket expenses (including deductibles and co-pays) cannot exceed (for 2006):
  - $5,250 (self-only coverage)
  - $10,500 (family coverage)
    - Those amounts are indexed annually for inflation

Won't HSA Owners be Tempted to Skip Medical Care Since it Comes out of their pocket First?

- All Preventative Care is paid for at 100% coverage. The incentive is to encourage people to be proactive in managing their health.

- All physicals, mammograms, colonoscopies, and a whole host of other preventative services and drugs are covered with no copayment.

In Fact --- HSAs Do More to Encourage Preventative Care than Traditional Coverage

- Many traditional policies require that you meet an individual deductible or family deductible before they begin making payments. Then, they require copayments, usually 20%
- In comparison, HSA owners have no required deductible or copayments in order to receive 100% payment for preventative care, drugs, or diagnostic services.

HSA Rules
2006

Single		
Deductible	Contribution	Out-of-Pocket
$1050	$2700	$5250
Family		
$2100	$5450	$10,500

2006 HSA Contribution Rules

	HDHP Deductible	Maximum HSA Contribution (2005)
Single Coverage	$1,050	$1,050
	$1,500	$1,500
	$2,000	$2,000
	$2,700	$2,700
	$3,000	$2,700
Family Coverage	$2,100	$2,100
	$3,000	$3,000
	$4,000	$4,000
	$5,000	$5,000
	$6,000	$5,450

What About Prescription Drugs?

- Current status: HSA owners can have a separate prescription drug plan and receive insurance coverage for their expenses on drugs even before the $1050 deductible is met.
- Beginning in 2006, the transition period will end. Prescription drugs will be like all other medical expenses and they must pay the full cost of prescriptions with their own dollars until their deductible is met before coverage kicks in.
- **Important Exception**: Preventative Drugs are covered at 100% before any deductible is met.

If I Pay "Cash" for Drugs and Medical Services by Using My HSA Account, Won't I Be Stuck With the Highest Dollar Charge for those Services?

- No. You will receive the best negotiated rate that has been obtained by the insurance carrier… you will not be paying the usual (and often highest) prices that cash-paying customers are often charged.

Tax Treatment of HSA Expenditures

- Distribution is tax-free if taken for “qualified medical expenses”
  - Includes over-the-counter drugs
  - Premiums for qualified long-term care insurance
  - Dental and orthodontia treatment
  - Plastic Surgery
  - Mental Health treatment
  - Liberal definition of “qualified medical expenses”

HSA Owners Get Choice

- Consumers can decide what medical expenditures are most important to them, rather than having to weigh what is covered and what is not covered under a policy.

- Example: Smith family has general good health, but all three kids need braces. Traditional coverage does not provide coverage for this. However, under HSA plan, they can use their account to pay for the braces. If the braces cost a total of $12,000 for the three children, the HSA owner could save up to $4000 for the treatment, depending on their tax bracket.

Other HSA Advantages

- Portability: Health Savings Accounts are owned by the individual (not by the employer). If the employee leaves the job, they take their savings with them.

- Choice: Employer cannot restrict how distributions from an HSA are used.

Other Advantages of HSAs

- Roll Over: HSA Funds can be rolled over from year to year: No "use it or lose it rules" like Flexible Spending Accounts (FSAs).

- Money Can Grow: Accounts can be managed and invested just like an IRA.

Other HSA Advantages

- Positive Health Incentives: HSA owners are rewarded for healthy lifestyles. [Already, companies are seeing employees quit smoking after switching to HSA policies.]

- Protection for Occurrence of Catastrophic or Chronic Illness: By limiting the total out-of-pocket expense for HSA owners, those who do have illnesses are protected.

Who Is Offering HSAs?

- Federal Government - Offers several HSA options for federal employees.

- States: South Carolina, Arkansas, and Florida are all offering HSA plans to their state employees. [In just the first year, 30% of South Carolina's state employees have switched to an HSA plan.]

Who Is Offering HSAs?

- Small Businesses - Blue Cross Blue Shield indicates their strongest HSA customers are small business owners.

- Individuals are purchasing HSAs - About 1/3 of them were previously uninsured.

How Much Cheaper are HSAs than Traditional Plans?

- Average Price for a Traditional Individual Policy is $1800
- Average Premium (2005) for Individual HSA policy: $1344 (Source: eHealthInsurance.com)
- South Carolina State Employees: HSA Plan $1200 vs. Traditional Plan $2640 (SC Individual Deductible is $3000)

Do HSA Plans Save Employers Money?

- Yes. Studies by Humana, Blue Cross Blue Shield, and others show a significant decrease in health care cost inflation for HSA premiums.

- Why? Decreased use of emergency room, increased use of generic drugs. No evidence of savings coming from delaying or avoiding needed care.

HSA Plan Design Questions to Consider

- Should the employer make a contribution to the HSA Account?

- Should the deductible be higher than the minimum so that the premium is even lower than the traditional policy?

The Banking Questions on HSA Accounts

- Who can be an HSA Trustee or Custodian?
  - Banks, credit unions, insurance companies
  - Entities already approved by the IRS to be an IRA or Archer MSA trustee or custodian
  - Other entities can apply to the IRS to be approved as a non-bank trustee or custodian
- IRS has provided model HSA Trustee and Custodian Forms
- Most large carriers have an arrangement with a financial institution so that management is simpler.
- Debit Cards are being offered for HSA Accounts, easing transactions.

For Other Questions: U.S. Dept. of Treasury Assistance

- Web site - www.treas.gov (Click on "Health Savings Accounts") - contains:
  - All treasure guidance
  - Frequently asked questions
  - IRS forms and publications
  - HSA statute
  - Examples of tax savings from HSA contributions
  - Links to other useful sites
- Still have questions?
  - E-mail address: HSAInfo@do.treas.gov
  - Voice mailbox: (202) 622-4HSA

National Center for Policy Analysis

BRIEF ANALYSIS
No. 479
For immediate release:
Monday, July 19, 2004

Health Savings Accounts: Myth vs. Fact

by Laura Trueman

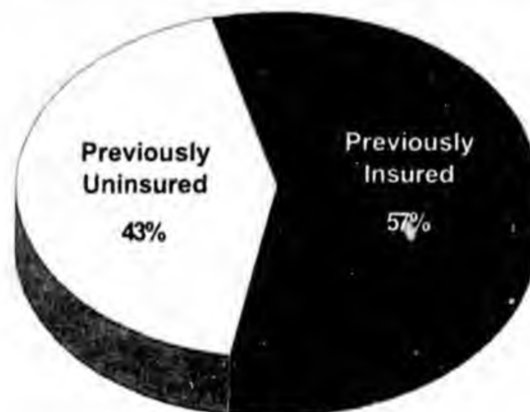
Last year, as Congress debated what would become the Medicare Modernization Act (P.L. 108-173), the media and most policymakers focused on the elephant in the room — major changes being made to the Medicare program affecting over 40 million senior citizens. But a "mighty mouse" occupied the same room, and went largely unnoticed. The law also created "Health Savings Accounts" (HSAs), allowing individuals who purchase high-deductible insurance policies to establish tax-free savings accounts for health care expenses. Early data has surprised critics by showing that HSAs are encouraging many Americans to obtain health insurance and save for their futures. Most importantly, many of the new HSA owners were formerly uninsured, defying initial prophecies that the accounts would only be utilized by the "young, healthy and wealthy."

Proponents have argued that the combination of health insurance with an HSA creates a "win-win" for the consumer: an individual purchases a high-deductible plan, which is more affordable month to month, allowing those who are unable to purchase a "Cadillac" plan to become insured. Consumers then funnel some of their premium savings into an HSA account. Over time, they save enough to pay the deductible and other out-of-pocket expenses. For example, under a typical arrangement, an individual might have a $1,000 deductible and deposit $500 in an HSA. The first $500 of medical expenses is paid from the HSA; the next $500 out of pocket, and above $1,000 the insurer pays the bills with a copayment from the consumer until the annual out-of-pocket cap is reached. HSA funds not spent remain in the account and grow tax-free. After a few years, the HSA could have sufficient funds to pay most, if not all, expenses not paid by the insurance plan. A key feature of HSAs is that the account stays with the individual regardless of job transitions and he or she can continue to accumulate the savings until retirement.

HSAs became available to consumers on January 1, 2004, and real data is emerging to replace speculation. In the first six months, tens of thousands of Americans have purchased HSAs. Two companies have collected and shared demographics about who is purchasing HSAs. Assurant Health (formerly Fortis) is one of the largest carriers operating in the individual and small group markets, and eHealthInsurance is an online source of health insurance for individuals and small businesses, offering insurance products from a number of carriers nationwide. The data provide a broad-based look at what is happening in the market. They also help separate myth from fact.

FIGURE I

Purchasers of Health Savings Accounts



Source: Assurant Health data for January to March 2004.

Myth: HSAs will not help to reduce the numbers of uninsured, because people without insurance coverage will be unable to afford an HSA policy.

Fact: HSAs have already reduced the number of uninsured Americans.

- Some 43 percent of HSA applicants did not indicate any prior coverage, according to Assurant. [See Figure I.]
- Nearly one-third (32.8 percent) of all HSA applicants to eHealthInsurance — and about half of those with incomes under $35,000 — had not had coverage for at least six months prior to enrollment.

Myth: Only the wealthy will purchase HSAs, because lower income individuals will not be able to contribute to their accounts.

Fact: HSA purchasers come from many income and vocational backgrounds.

- Nearly half (46 percent) of HSA purchasers have family incomes of less than $50,000, according to eHealthInsurance. [See Figure II.]
- Some 38 percent of its HSA purchasers have only high school or technical school training, says Assurant.
- Many HSA purchasers live in modest homes — 38 percent in homes with a market value of less than $125,000 — and 27 percent of enrollees have a net worth of less than $25,000 (Assurant).

Myth: Only the young will purchase HSAs, because older persons need insurance policies with better coverage for their medical conditions.

Fact: HSA purchasers are older than those purchasing traditional insurance. According to Assurant:

- More than two-thirds (70 percent) of HSA purchasers are over age 40. [See Figure II.]
- HSAs were purchased by a broad cross section of vocations, and less than 57 percent of purchasers were from professional and managerial occupations.
- Most HSA purchasers — 77 percent — are families with children; 8 percent are single parents, and 45 percent live in households of four or more people.

Myth: Insurers will "cherry pick" the healthiest applicants that present the least risk to the insurer.

Fact: Virtually all HSA applicants have been offered insurance coverage. Assurant Health was able to offer coverage for 93 percent of the HSA applications received.

Myth: Insurers will not be able to provide quality, low-cost health insurance to those who purchase HSA-eligible policies.

Fact: Insurers provide comprehensive coverage at a modest cost. Of the policies sold by eHealthInsurance, for example:

- More than 70 percent cost less than $100 per person, per month, and almost 95 percent of policies cost less than $200 per month.
- More than 95 percent of policies require beneficiaries to pay no more than 20 percent of the cost of office visits, surgery and diagnostic tests once enrollees meet their deductible.

Myth: Purchasers of HSAs will defer needed preventive care or avoid taking needed medications that are not covered by high-deductible insurance.

Fact: Data on those who purchased Medical Savings Accounts (MSAs), a precursor to HSAs, indicate enrollees are more likely to use preventive care and generic prescription drugs. According to Assurant Health, prior to 2004, when the less-restrictive HSAs supplanted MSAs:

- Purchasers of high deductible, tax-qualified MSAs made 31 percent more preventive care office visits, compared to people with conventional health insurance.
- Generic drug usage was consistently higher for MSA purchasers.

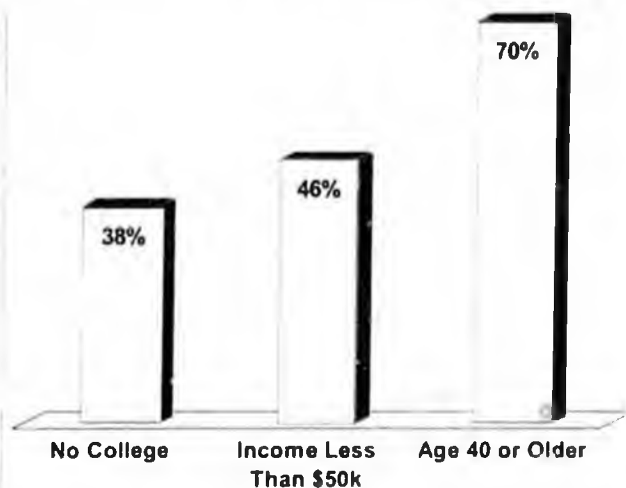
Myth: Very few people will purchase HSAs.

Fact: HSAs have gained wide popularity in the short time since their introduction.

- Assurant Health received applications representing 56,396 members for Individual HSAs in the first four months of 2004, far more than the number of MSA applications Assurant received in the first four months of 2003.
- A survey by Mercer Human Resource Consulting found that nearly three-quarters of employers are "very" or "somewhat likely" to offer HSAs by 2006.

FIGURE II

Purchasers of Health Savings Accounts



Source: Assurant Health data for January to March 2004; eHealthInsurance (income data).

Conclusion. Because passage of the Medicare law came too late for most employers to include an HSA plan as part their 2004 coverage options, the true impact of HSAs in the group market will not be felt until the 2005 open season. However, the data from the individual market have proven that HSAs are popular across all age and income groups due to the low-cost, high-quality health insurance coverage they provide. There is still much to be done to make health insurance more affordable to all Americans, but early experience with HSAs should make policymakers think seriously about how to harness the power of consumer choice and market incentives.

Laura Trueman is executive director of the Coalition for Affordable Health Coverage (CAHC.net).

Note: Nothing written here should be construed as necessarily reflecting the views of the National Center for Policy Analysis or as an attempt to aid or hinder the passage of any legislation.
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HSAs Spread Quickly, Surprise Critics

Written By: Laura Trueman
Published In: *Health Care News*
Publication Date: September 1, 2004
Publisher: The Heartland Institute

Last year, as Congress debated what would become the Medicare Prescription Drug, Improvement, and Modernization Act, the media and most policymakers focused on the elephant in the room: major changes being made to the Medicare program, affecting more than 40 million senior citizens.

But a "mighty mouse" occupying the same room went largely unnoticed. The law also paved the way for greater consumer acceptance of Health Savings Accounts (HSAs) by allowing individuals who purchase high-deductible insurance policies to establish tax-free savings accounts for health care expenses.

New Insurance Option

HSAs became available to consumers on January 1, 2004, and real data on their use is emerging. In the first six months of availability, tens of thousands of Americans purchased HSAs. From January to April of this year, more than 50,000 polices were issued by eHealthinsurance and Assurant alone. Data from other firms is not yet available.

The early data has surprised critics by showing HSAs are encouraging many Americans to obtain health insurance and save for their future health expenses. Most importantly, many of the new HSA owners were formerly uninsured, defying initial prophecies that only the "young, healthy, and wealthy" would utilize the accounts.

With an HSA, the consumer purchases a high-deductible insurance plan, which has significantly more-affordable premiums, allowing those who are unable to purchase a "Cadillac" health care plan to become insured. Consumers then funnel some of their premium savings into an HSA account. Over time, consumers save enough in this way to pay their deductibles and other out-of-pocket expenses.

Under a typical HSA arrangement, an individual might have a health insurance policy with a $1,000 deductible and deposit $500 in an HSA. The first $500 of medical expenses is paid from the HSA; the next $500 is paid out of pocket; and above $1,000 the insurer pays the bills with a copayment from the consumer until the annual out-of-pocket cap is reached. HSA funds not spent remain in the account, roll over to following years, and grow by earning tax-free interest.

After a few years, the HSA could have sufficient funds to pay most, if not all, of the health care expenses not covered by the insurance plan. Importantly, the HSA account stays with the individual regardless of job transitions, and he or she can continue to accumulate the savings until retirement.

New Data Rebut Anti-HSA Myths

Two companies have collected and shared demographics about who is purchasing HSAs: Assurant Health (formerly Fortis), one of the largest carriers operating in the individual and small group markets; and eHealthInsurance, an online source of health insurance for individuals and small businesses, offering insurance products from a number of carriers nationwide. The data provide a broad-based look at what is happening in the market. They also help separate the myths from the facts.

Myth: HSAs will not help to reduce the numbers of uninsured, because people without insurance coverage will be unable to afford an HSA policy.

Fact: HSAs already have reduced the number of uninsured Americans.

- Some 43 percent of HSA applicants reported they did not have prior insurance coverage, according to Assurant.

- Nearly one-third (32.8 percent) of all HSA applicants to eHealthInsurance, and about half of those with incomes under $35,000, had not had coverage for at least six months prior to their enrollment in the HSA.

Myth: Only the wealthy will purchase HSAs, because lower-income individuals will not be able to contribute to their accounts.
Fact: HSA purchasers come from many income and vocational backgrounds:

- Nearly half (46 percent) of HSA purchasers have family incomes of less than $50,000, according to eHealthInsurance.

- Some 38 percent of Asssurant HSA purchasers have only high school or technical school training, Assurant reported.

- Many HSA purchasers live in modest homes--38 percent in homes with a market value of less than $125,000--and 27 percent of enrollees have a net worth of less than $25,000, according to Assurant.

Myth: Only the young will purchase HSAs, because older persons need insurance policies with better coverage for their medical conditions.
Fact: HSA purchasers are older than those purchasing traditional insurance:

- More than two-thirds (70 percent) of HSA purchasers are over age 40.

- HSAs were purchased by people from a broad cross-section of vocations, and less than 57 percent of purchasers were from professional and managerial occupations.

- Most HSA purchasers--77 percent--are families with children; 8 percent are single parents; and 45 percent live in households of four or more people.

Myth: Insurers will "cherry pick" the healthiest applicants, who present the least risk to the insurer.
Fact: Virtually all HSA applicants have been offered insurance coverage. Assurant Health was able to offer coverage for 93 percent of the HSA applications it received.

Myth: Insurers will not be able to provide quality, low-cost health insurance to those who purchase HSA-eligible policies.
Fact: Insurers provide comprehensive coverage at a modest cost. Of the policies sold by eHealthInsurance, for example,

- More than 70 percent cost less than $100 per person per month, and almost 95 percent of policies cost less than $200 per person per month.

- More than 95 percent of policies require beneficiaries to pay no more than 20 percent of the cost of office visits, surgery, and diagnostic tests once enrollees meet their deductible.

Myth: Purchasers of HSAs will defer needed preventive care or avoid taking needed medications that are not covered by high-deductible insurance.

Fact: Data on those who have purchased Medical Savings Accounts (MSAs), a precursor to HSAs, indicate enrollees are more likely to use preventive care and generic prescription drugs than those with conventional health insurance.
According to Assurant Health, prior to 2004, when the less-restrictive HSAs supplanted MSAs,

- Purchasers of high-deductible, tax-qualified MSAs made 31 percent more preventive-care office visits than did people with conventional health insurance.

- Generic drug usage was consistently higher for MSA purchasers.

Myth: Very few people will purchase HSAs.
Fact: HSAs have gained wide popularity in the short time since their introduction.

- Assurant Health received applications representing 56,396 members for Individual HSAs in the first four months of 2004, far more than the number of MSA applications Assurant received in the first four months of 2003.

- A survey by Mercer Human Resource Consulting found nearly three-quarters of U.S. employers describe themselves as "very likely" or "somewhat likely" to offer HSAs by 2006.

More Growth Likely
Because passage of the Medicare law came too late for most employers to include an HSA plan as part of their 2004 coverage options, the true impact of HSAs in the group market will not be felt until 2005. However, the data from the individual market strongly suggests HSAs are becoming popular across all age and income groups because of the low-cost, high-quality health insurance coverage they provide.

Laura Trueman (ltrueman@cahc.net) *is executive director of the Coalition for Affordable Health Coverage (CAHC). An earlier version of this essay was published in July 2004.*

SENATE BILL NO. 11

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FOURTH LEGISLATURE - FIRST SESSION

BY SENATORS DYSON, Davis

Introduced: 1/11/05
Referred: Health, Education and Social Services, Labor and Commerce

A BILL

FOR AN ACT ENTITLED

1 **"An Act requiring certain hospitals to make certain disclosures on patient billings."**

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

3 *** Section 1.** AS 18.20 is amended by adding a new section to read:

4 **Sec. 18.20.078. Patient billing disclosures.** A hospital licensed under
5 AS 18.20.010 - 18.20.130 shall comply with the patient billing disclosure
6 requirements of AS 45.45.940 if AS 45.45.940 applies to the hospital.

7 *** Sec. 2.** AS 45.45 is amended by adding a new section to read:

8 **Sec. 45.45.940. Patient billing disclosures.** (a) A hospital that receives
9 government money for the purchase, construction, repair, equipping, or operation of
10 the hospital shall disclose on each patient billing

11 (1) the price that the hospital charges other patients who pay
12 negotiated rates for the same medical service item, including negotiated group and
13 government rates and individual discounts; and

14 (2) an itemized description of the costs and components used to
15 calculate the price of each medical service item on the patient billing, including the

1 cost subsidy for indigent individuals.
2 (b) In this section,
3 (1) "cost subsidy for indigent individuals" means the cost that is
4 included in the charge for medical service items billed by the hospital to compensate
5 the hospital for the uncollected costs that the hospital incurs to provide medical service
6 items to indigent individuals;
7 (2) "government money" means money from a state or municipal
8 governmental unit or the federal government, and includes money received by the
9 hospital under AS 18.25 or AS 18.26;
10 (3) "hospital" means a person licensed as a hospital under
11 AS 18.20.010 - 18.20.130;
12 (4) "medical service item" includes a hospital room, medication,
13 medical treatment, and medical supplies;
14 (5) "negotiated rate" means a rate negotiated for a category of patients
15 by another person, including an insurer, but does not include a rate negotiated by a
16 patient or the patient's relatives directly with the hospital for the patient's own medical
17 service items;
18 (6) "patient billing" means a billing for a patient that is provided to a
19 patient for a medical service item.

COMMONWEALTH NORTH

Alaska Primary Health Care: *OPPORTUNITIES & CHALLENGES*

Approved by the Board of Directors on June 7, 2005
Updated July 31, 2005

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EXECUTIVE SUMMARY

Why Alaska health care issues must be addressed and solved

Health care is not a goal or end in itself. The ultimate goal of health care and of this study is health and wellness for Alaskans. Alaskans must identify and improve the aspects of health care that are under our control. Many health care issues are national, that Alaskans cannot affect. Therefore, it is even more important to address and solve issues we can do something about. Furthermore, the demographics of an aging population will put foreseeable pressure on all fronts.

ACCESS

- Approximately 110,000 Alaskans have no health insurance coverage.
- Many others have minimal or inadequate coverage.
- Thousands are turning to hospital emergency rooms as a source of primary health care, often without ability to pay.
- Adequate health care in remote areas is a significant logistical, financial and educational challenge.

QUALITY

- Based on the 2004 National Healthcare Quality Report, Alaska has low rankings in several key measures of cancer, heart disease, maternal and child health, respiratory diseases, and nursing and home health care
- Many Alaskans are in high-risk health categories, many are not receiving adequate care.

COST

- Alaska health care costs are approximately 40% higher than Seattle (per Premera, corroborated by Providence and Alaska Regional)
- Medicaid costs to the State of Alaska are rising dramatically, to over $1 billion in 2005. It is placing a strain on the state budget.
- Health care insurance premiums are also rising dramatically, creating a significant burden on employers and employees.
- Alaska hospitals are losing tens of millions of dollars from uncollectable accounts arising from excessive emergency room use and they are unable to reduce the amount of emergency room care provided due to Federal law.

What can we do?

There are four major interrelated factors driving primary healthcare in Alaska today:

1. Health and wellness of the population
2. Availability of care and insurance
3. Affordability of care and insurance
4. Financial health of the stakeholders, such as employers, providers and individuals

These drivers are currently interacting in a "cost spiral" that is creating a very serious situation nationally and in Alaska. The rate of increase in the cost of health care is unsustainable—if unchecked health care increases will price employers out of the market. Already industries such as automobiles are threatened. We need to avoid similar impacts in Alaska.

We believe that with focus and coordination Alaskans can impact this "cost spiral" positively through specific actions in the four areas mentioned above:

1. Lifestyle and prevention: Raise public awareness and increase personal responsibility for wellness
2. Access: Make services and insurance more widely available
3. Quality: Continue improving quality of care that is delivered
4. Costs: Reduce costs of service delivery and insurance to make them more affordable

There are many health care initiatives already underway in these areas by various governmental and non-governmental entities. Some have proven to be effective and cost-efficient. Others show significant promise. Health care reform is complex and controversial, with multiple players and competing interests. Inconsistent tracking and trending create significant factual disputes about healthcare systems. Any major reform has potential to create both winners and losers.

Given this environment, the Study Group came to three overarching conclusions:

1. The Study Group process itself has been enlightening, educational and productive.
2. Every aspect of health care is complex. Understanding the system and improving it is beyond the capacity of any one element within the system.
3. The Study Group recommends that an ongoing body be established to continue and deepen this Group's work.

The time to act is now. Involvement of Alaskans in the health care debate is vital. Reform of some sort is inevitable, and Alaskans should control it as much as possible to our own benefit. Since there is no single forum today where the disparate players can come together to agree on facts, share solutions and craft a win-win for our unique Alaskan conditions, this Study Group recommend formation of- -

The Alaska Health Care Roundtable ("Roundtable")

The goals of the Roundtable are to continue communication and foster action among parties that have a long-term vested interest in health care reform. It must set a standard of credibility and create timely actionable ideas that can gather bipartisan support, get quick approval and become part of a long-term fiscal plan for Alaska. It would be a sounding board and facilitator for ideas and recommendations, with a focus on lifestyle and prevention, access, quality and cost.

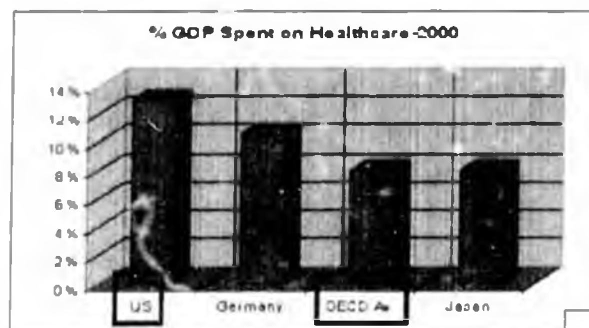
The core membership in the Roundtable would be self-selecting, comprised of members with a long-term compelling interest in improving the Alaska health care system. Examples of core members would be major employers at risk, health care providers and local foundations. A wide variety of other potential members, resources and ad hoc participants could be included as needed. Funding would be by voluntary contributions by the participants and the community.

INTRODUCTION

The big picture: National background issues and the state of health in the U.S.

While the focus of this study is factors controllable in Alaska, it is important to understand the national context in which we operate. The United States spends more on health care than any other country, measured either as a percentage of gross domestic product, or in terms of money spent per person. The OECD, or Organization for Economic Cooperation and Development, is a group of industrialized nations that are an appropriate benchmark for U.S. expenditures and performance.

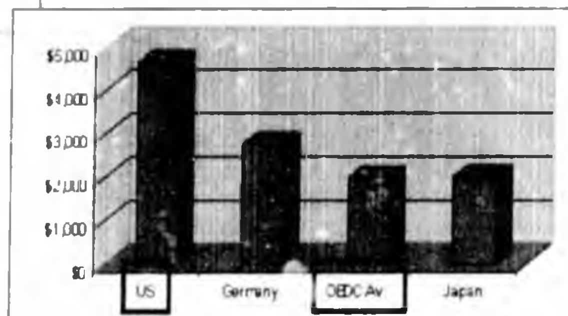
The National Situation - Spending



OECD—Organization for Economic Cooperation and Development

Source: Commonwealth Fund

Per capita health care expenditures by country



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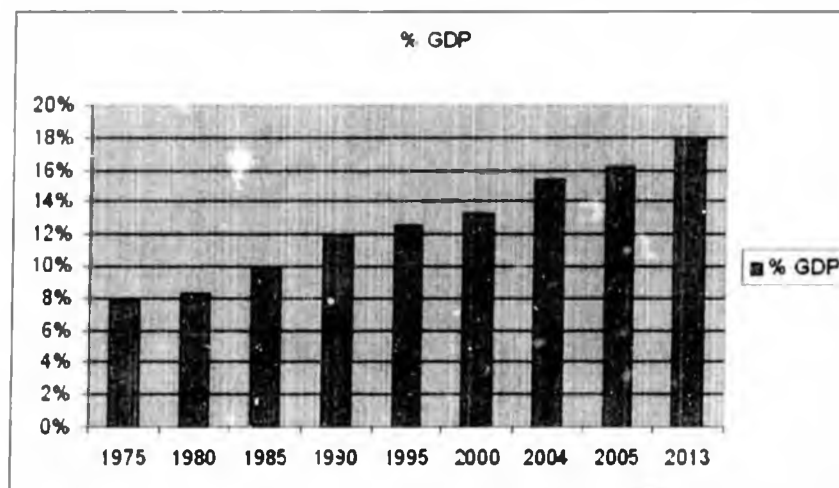
Health care spending has risen dramatically in recent years, increasing from about 8 % of the gross domestic product in 1975 to over 16% today. The Commonwealth Fund, a private nonpartisan foundation that supports independent research on health and social issues, projects that by 2013 the U.S. will be spending 18% of GDP on health care.

Many factors contribute to these increases. Often cited are huge costs caring for the last three months of life, advertising driven consumerism, high cost of technology, defensive medicine practiced to avoid malpractice suits, malpractice insurance, a fractionated payment system and massive cost shifting to those able to pay caused by inadequate or no health insurance for many Americans (and Alaskans). The crushing cost of health care threatens whole industries and affects our worldwide ability to compete economically.

The National Spending Situation:
Trend in Healthcare Costs as a % of GDP



Source: Commonwealth Fund

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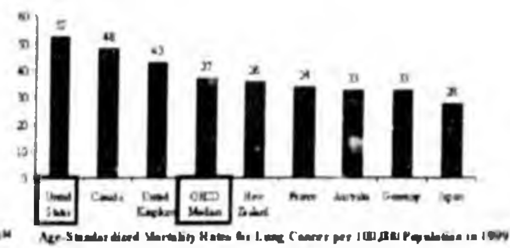
The **Commonwealth Fund** is a foundation specializing in health care issues.

In terms of outcomes, the United States has obtained poor results from the massive amounts invested. By many measures, the U.S. trails other industrialized nations, as represented by Organization of Economic Cooperation and Development averages. We also have a higher percentage of uninsured than most advanced countries, which tend to have centralized health care systems.

The National Situation: Outcomes

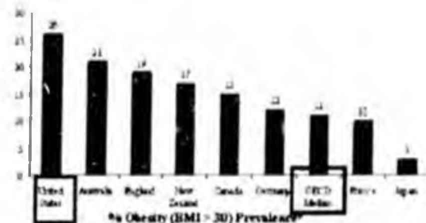
Age-Standardized Mortality Rates for Diabetes Mellitus per 100,000 Population in 1999

DIABETES



Age-Standardized Mortality Rates for Lung Cancer per 100,000 Population in 1999

LUNG CANCER



% Obesity (BMI > 30) Prevalence

OBESITY

And, the U.S. ranks only

- #28 overall in infant mortality
- #24 in life expectancy

Sources: OECD Health Data 2002
March of Dimes Data Center 2002
World Health Organization

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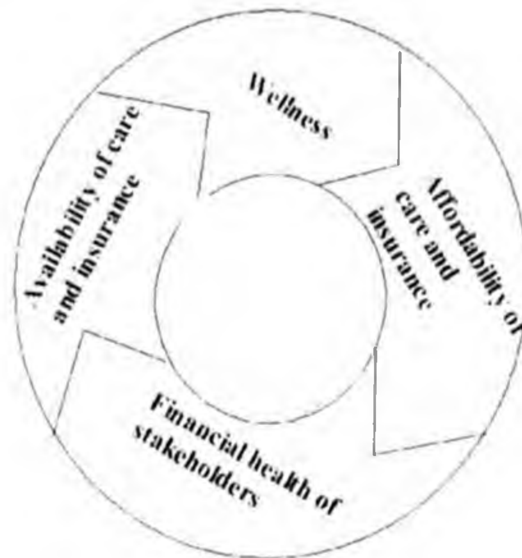
A conceptual framework of four primary healthcare factors can help us understand how all the different factors are interrelated.

Four Primary Healthcare Factors and how they are interrelated



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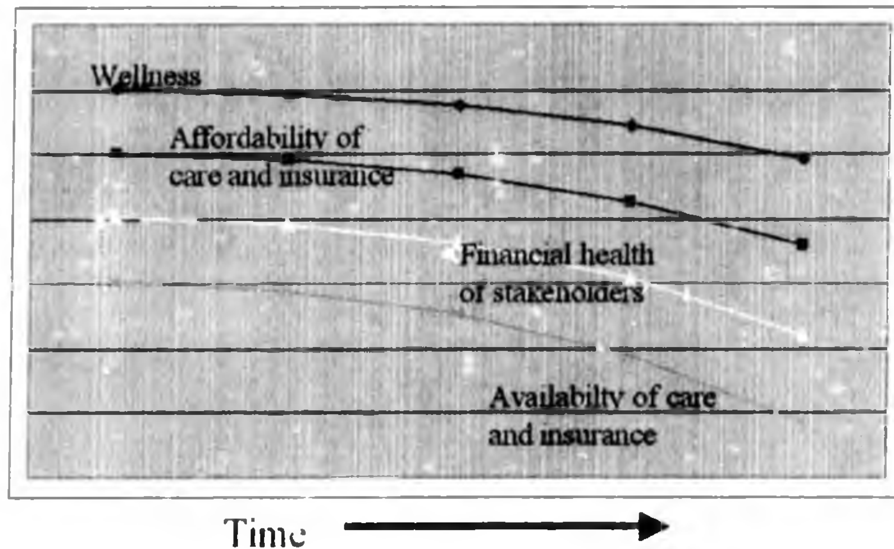
- Wellness of the population
- Affordability, coordination and quality of care and insurance
- Availability of care and insurance
- Financial health of stakeholders including:
  - Health care providers (physicians, clinics, hospitals)
  - Companies institutions and government

These factors are all part of a complete cycle. Each factor affects the other. Therefore they are portrayed in a circle.

As time goes on, each of these factors influences the others, with the ultimate result of either undermining or improving the health and wellness of our people.

The conceptual crux of the problem



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A significant problem is a de facto dynamic in our current U.S. health care policy.

The motto of a popular Alaska establishment embodies this unintended and unwanted de facto policy, to wit—

"We cheat the other guy and pass the savings on to you!"

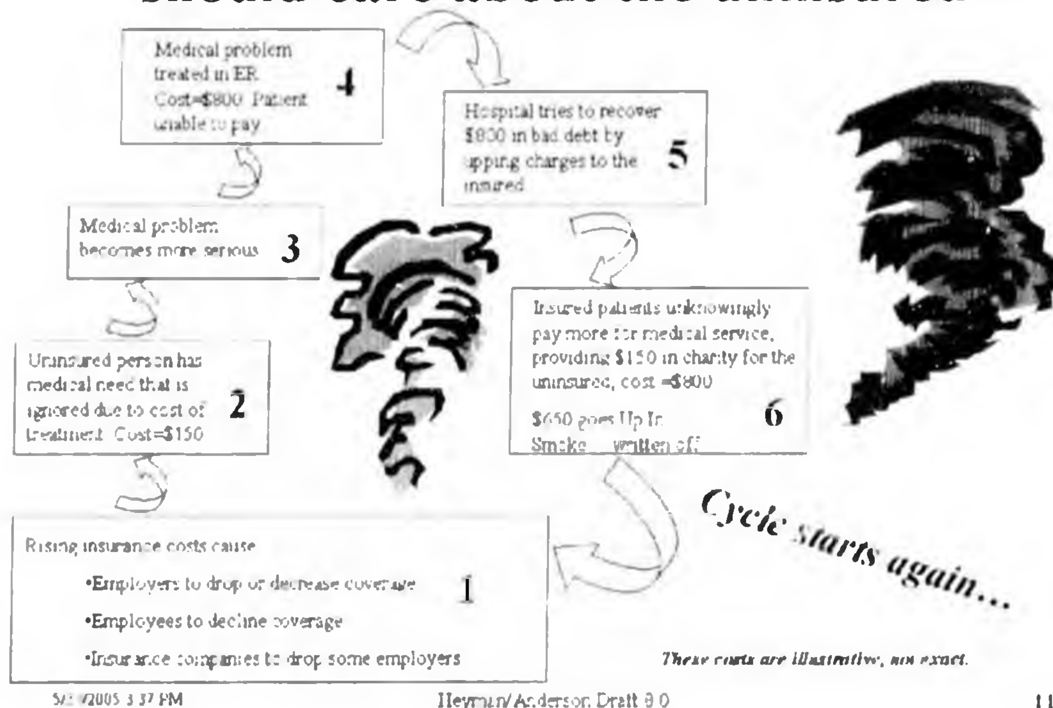
This phenomenon has impacts both nationally and in Alaska, and Alaskans are not always the beneficiary, creating serious cost shifting and economic dislocations.

A SIGNIFICANT ISSUE FOR HEALTH CARE IN ALASKA

The focus of this study is what can be done in Alaska. It does not address national issues such as a single payer system, rationing of health care or national structural issues. However, the following conceptual illustration is both a national and Alaska problem.

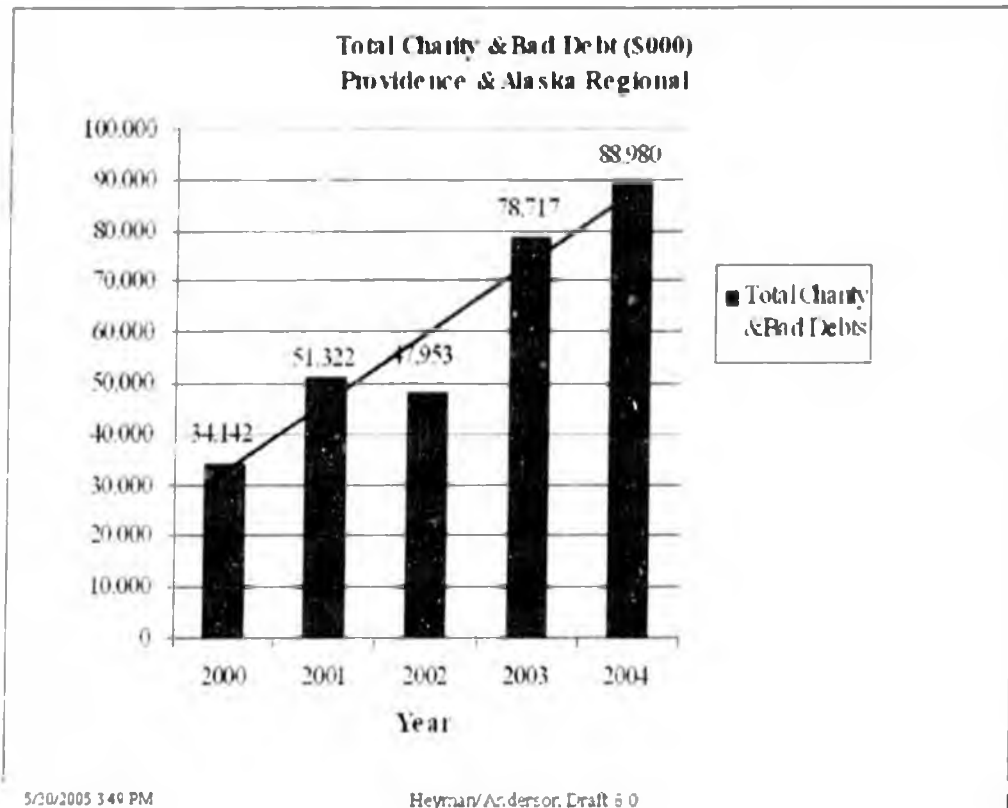
It shows how the high cost of health care causes people to postpone needed care, which increases ultimate costs of treatment, frequently and reluctantly performed by practitioners at unneeded and inappropriate levels. Often the emergency room of a hospital becomes a highly expensive primary care facility. If treated earlier, medical conditions could have better outcomes at a lower cost.

Why even a non-compassionate insured should care about the uninsured

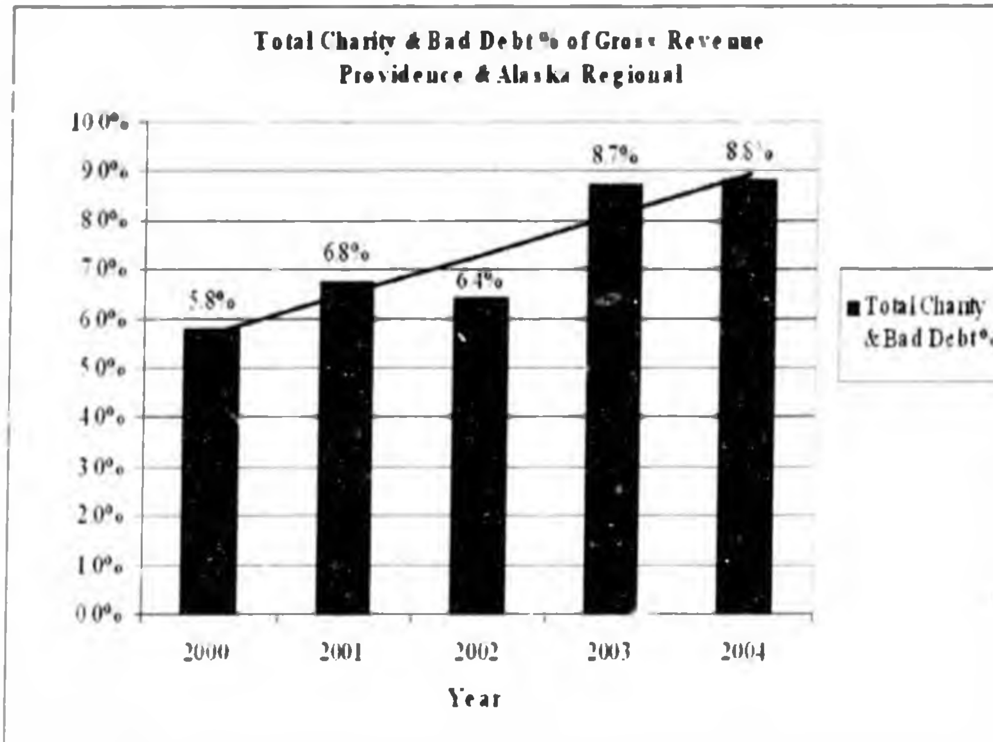


A federal law, the Emergency Medical Treatment and Active Labor Act ("EMTALA") requires that hospital emergency rooms treat and not turn away any patients who show up, regardless of ability to pay.

Emergency rooms are becoming primary care treatment centers for those without access to, or awareness of, alternatives. Current waits can be up to two hours, especially during high traffic times like early evenings or weekends. This creates inefficient use of specially trained staff and is enormously expensive. Many ER patients have no insurance coverage or other means to pay their bill. The financial burden then falls on the hospital to write off uncollectible accounts.



Note: the numbers above are in thousands of dollars. E.g. 88,980 = $88,980,000



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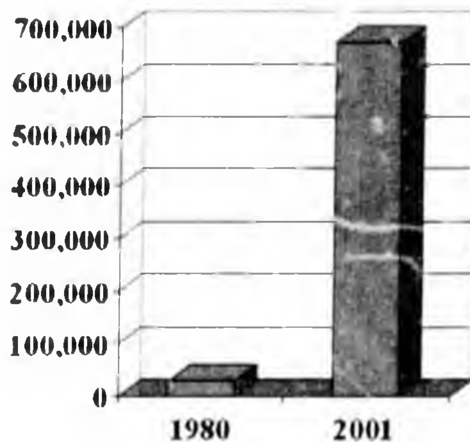
The financial impact on hospitals is even more acute than the slide above suggests. While the percentage of charity and bad debt compared to gross revenue has increased dramatically in recent years, the bottom line impact is significantly greater because actual hospital cash collections are much less than the gross revenue billings used in the chart above.

Hospitals are not the only ones affected. Individuals unable to pay medical expenses are filing for bankruptcy at staggering rates. Although Alaska data are not available, national data are noted below.

Personal Bankruptcies due to Health Care Costs-U.S.



- Between 1980 and 2001 medically driven bankruptcies increased 23 times
- 60% skipped doctors visits
- 47% skipped prescription medicines

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Source: American Medical Association 2/05 and a Harvard Law School/Medical School 2/05 studies.

70% of these debtors had some form of health insurance at the start.

Main factors cited for declaring bankruptcy were:

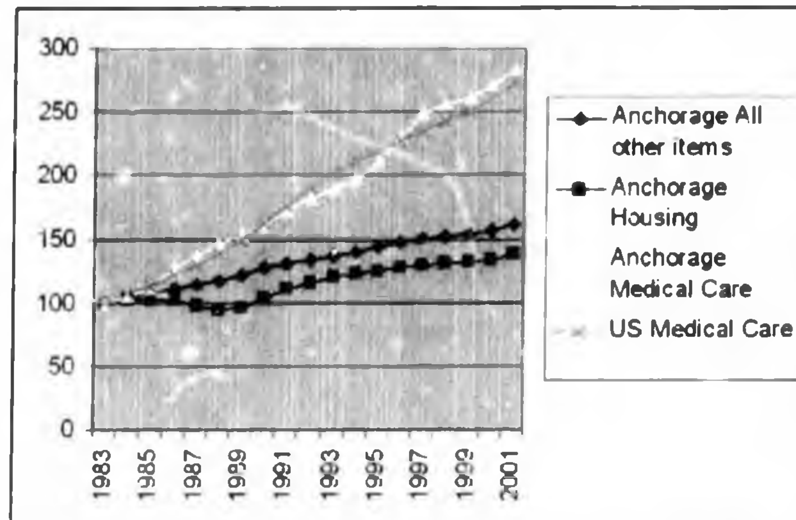
Hospital costs	42%
Prescription drug costs	21%
Doctor bills	20%

Cost: What do Alaskans pay? Why?

The impact of **bad debt** on the health care system has been clearly illustrated in the preceding charts.

Increasing Cost of Medical Care in Alaska

Anchorage CPI-U for selected components 1982-2001



Source: Alaska Economic Trends June 2004

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Premera, Alaska's largest health care insurer, reports that their **Alaska costs are about 40% higher than Seattle**. General observations by resource people have referenced a 40% differential overall, more in some specialties, less in others. Local hospitals have corroborated this differential. Other information points to even larger discrepancies on reimbursement rates for physicians. The Alaska Division of Medical Assistance Health Care Cost Analysis Report placed Alaska in the top five states in terms of the cost of medical and surgical procedures.

Small practices and increasing personnel costs contribute to the high cost of medicine in Alaska. Also there is general, but not substantiated, belief that the **Alaska population is too small to support HMOs**. Any discussion of managed care has been resisted by medical providers.

Dependence on "Fair Share" and other sources of federal dollars place about $800 million potentially at risk, an important share of current health care funding to Alaska. Alaska also faces **competition from other states** for willing providers. Furthermore, **reimbursement**

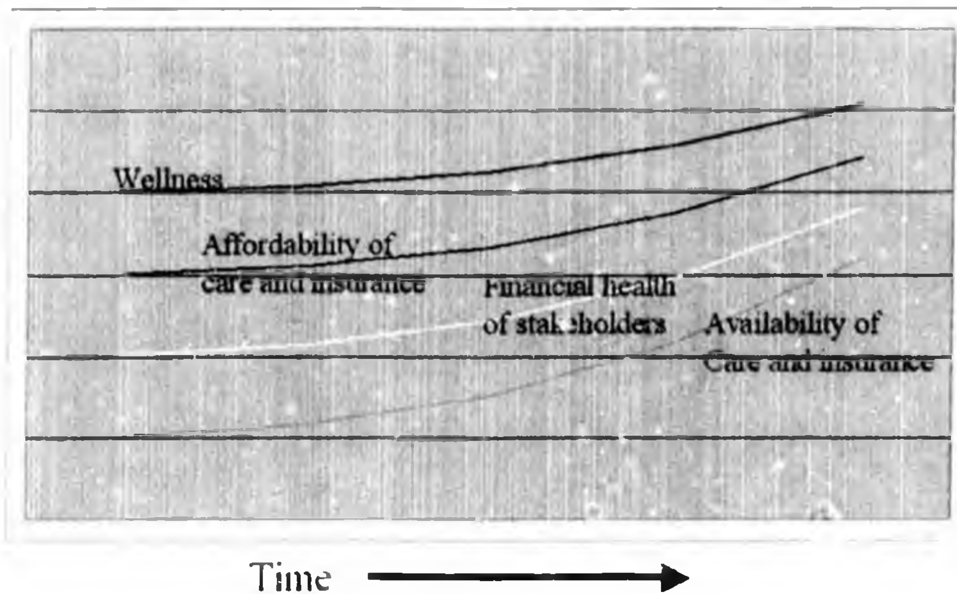
formulas are going down. The state is now paying over one billion dollars annually to pay Medicaid expenses.

Cost of health insurance—there is no public oversight of health care insurance rates by the Division of Insurance as there is in some other states. They are a result of negotiations between insurance companies and large groups.

The **Certificate of Need** situation needs to be objectively analyzed and considered as a component in a comprehensive statewide health care plan. Critics of the Certificate of Need claim the process stifles competition and innovation. Supporters claim it prevents unnecessary duplication of facilities and allows more rational allocation of assets.

The impact of tort issues on health care. The cost of malpractice insurance and defensive medicine is hard to quantify, but is deemed to be substantial. OB/GYN liability insurance is $60-65k/year. SB 67 puts a 250k cap on non-economic suffering. The California experience with a similar cap since 1975 has been positive. Alaska has only two traditional liability carriers. However, compared to U.S. averages, malpractice insurance costs in Alaska are middle of the pack.

Is a trend reversal possible in Alaska?



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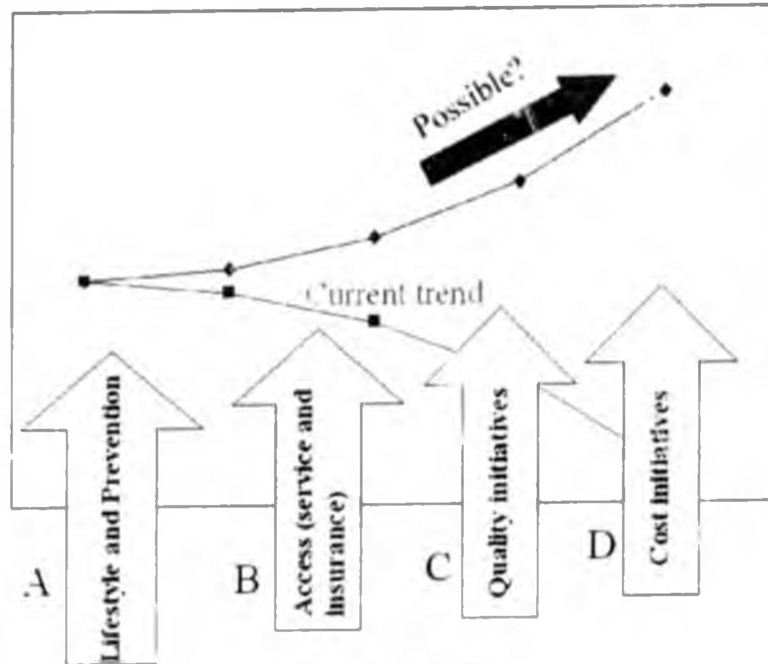
Perhaps, with coordinated and focused effort



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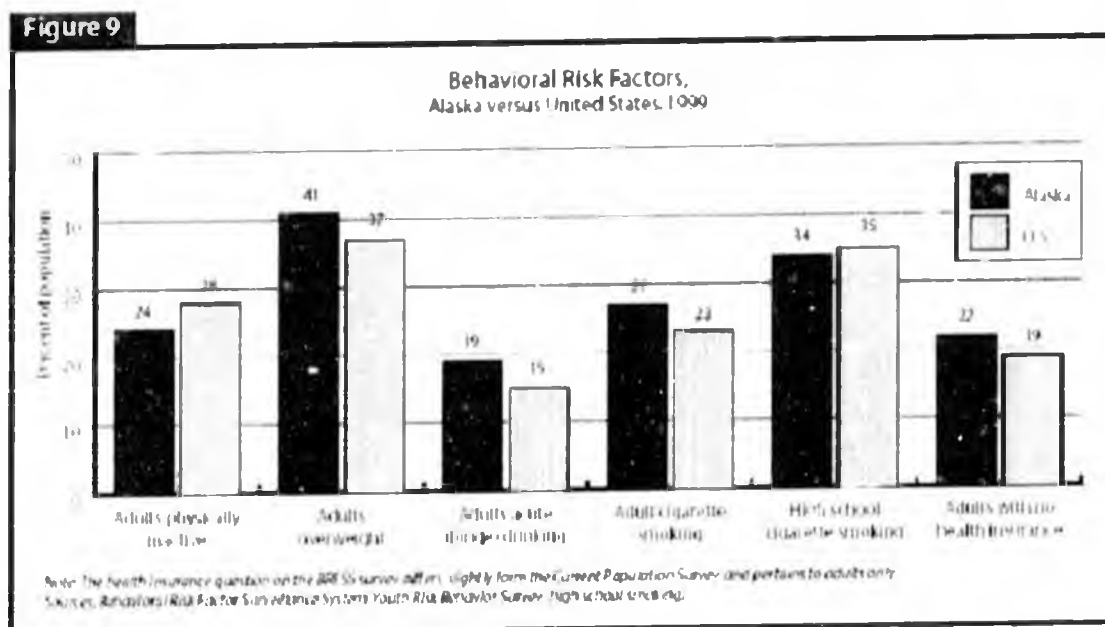
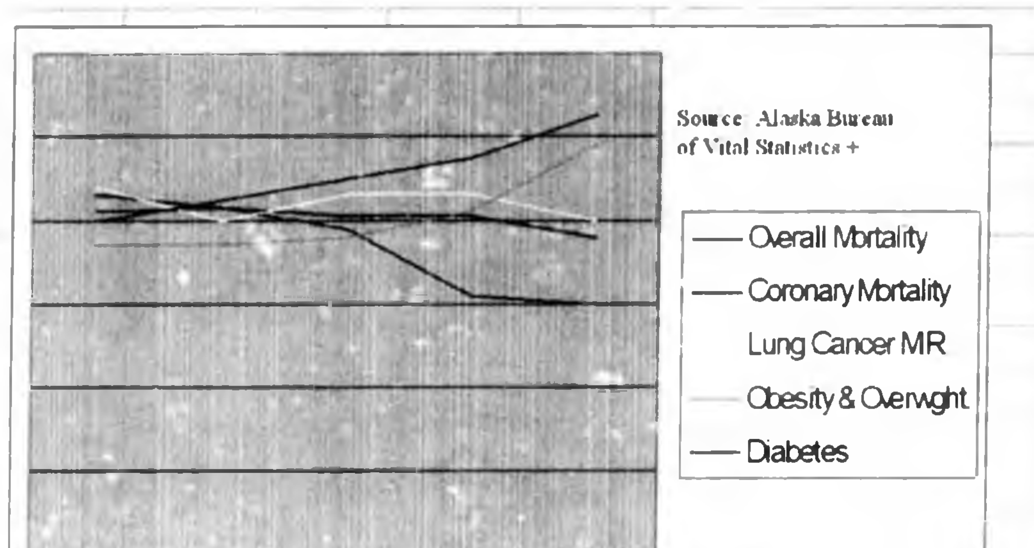
Quality of Alaska's health: Based on the 2004 National Health Care Quality Report of 100 measures of health care quality, Alaska is about average for the U.S. However, as the charts on page 7 indicate, the U.S. trails many other industrialized nations.

Unfortunately, Alaska mirrors poor National behavioral risk factors



Alaska Trends in major disease



Trends only—not incidence rates

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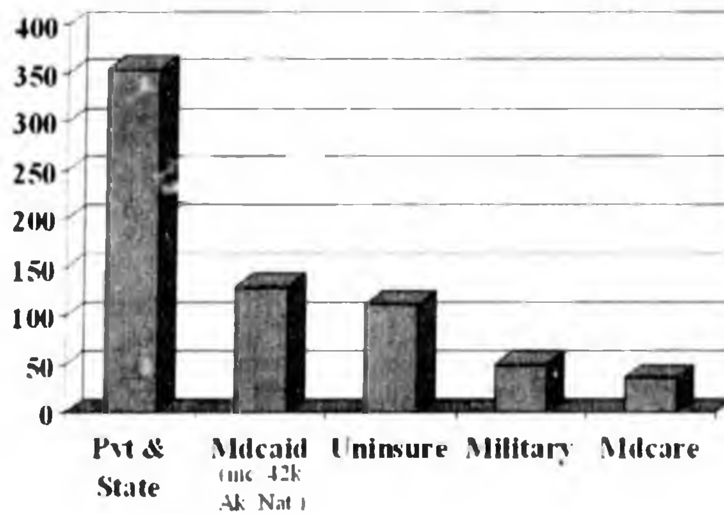
(Vertical axis is rates of disease, horizontal axis is time)

While progress has been made in heart and lung disease, obesity and diabetes have negative trends.

How is Alaska's health care being paid? What about those without coverage?

Currently about 110,000 Alaskans do not have health care insurance. Approximately 82% of Alaskans have some type of insurance coverage, as illustrated by the chart below. The column for private and state coverage includes state employees. Medicaid covers over 40,000 Alaska Natives, the remainder of which are covered under federal programs. Military and Medicare coverage rounds out the picture. However, an unquantified, but suspected to be substantial, number of people have inadequate insurance coverage.

Alaska's Insurance Coverage



Source: Navigant Consulting, AK Journal of Commerce

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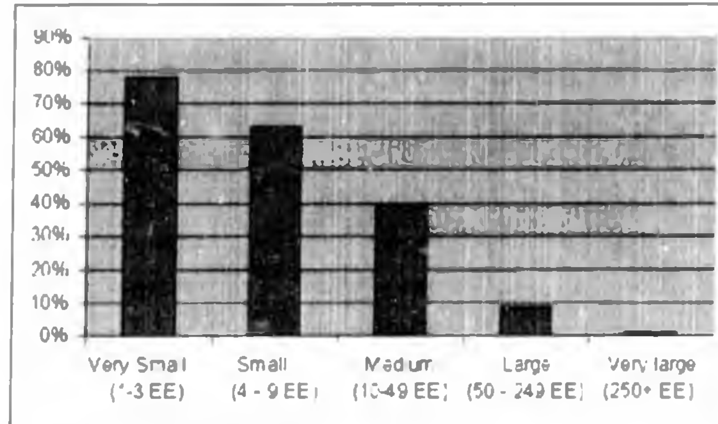
The majority of Alaskans without insurance work for smaller businesses.

Alaskan firms NOT offering health insurance



And only [illegible] of Alaskans were employed in firms with over 50 employees

Source: Alaska Dept. of Labor and Workforce Development, 2002

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Safety net providers

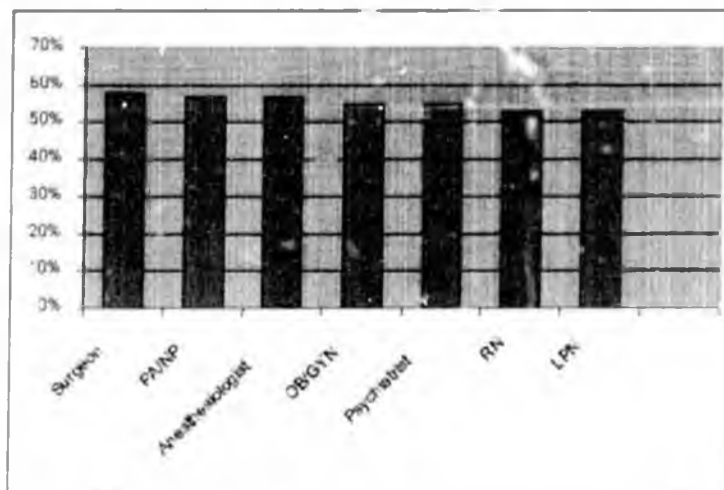
There are 34 federally sponsored Community Health Centers (CHC's) in Alaska. They see all patients and charge a sliding fee schedule based upon income. Although there are the Neighborhood Health Center in Anchorage and the Interior Community Health Center in Fairbanks (both federally sponsored CHSs), a large number of uninsured patients receive their care in the city's emergency rooms.

Under federal law, patients who visit the emergency rooms must be seen regardless of their ability to pay. This results in the uncompensated care that was referenced previously.

Although not safety net providers, the Alaska Native Health system provides care to an estimated 125,000 Alaska Natives through an extensive network of community health aid clinics, regional hospitals and a major referral center.

Healthcare Provider Shortages are Projected for Alaska

PERCENT OF PROVIDERS CURRENTLY MORE THAN 45 YEARS OF AGE



Source: AK Department of Labor

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Shortage of doctors: ½ doctors in Alaska are over 50. Fewer doctors are practicing than are licensed. Compared to the rest of the U.S., Alaska has 17-30% fewer doctors per capita, partly because we have a relatively younger population. However Alaskans are aging, and the need will increase. Today Alaska needs 472 more doctors than it has. The shortage will increase in the future. Statewide Alaska has a 25-30% shortage of physicians. Physicians are practicing fewer hours and retiring younger than in past decades. As a result it may require more than one new physician to replace a retiring one. 70% of doctors in the lower 48 practice near where they did their residency. The rate of return on a medical education is diminishing compared to other professions. Medical students average $100,000 of debt; specialties can be $250,000 with an average of 8 years post-graduate education. Similarly, graduating dentists average nearly $200,000 in debt. In contrast, graduating attorneys and MBA's begin earning money faster and with less debt.

Nurse Practitioners and Physician Assistants provide care to Alaskans in a wide variety of settings, including rural and urban primary care clinics, urban specialty practices, and remote critical access hospitals that were historically difficult to staff with other providers. There are over 200 physician assistants and 420 nurse practitioners working in Alaska. This gives Alaska one of the highest ratios of nurse practitioners per capita in the nation.

As in 25 other states nurse practitioners are licensed to practice autonomously. A recent Columbia University study (JAMA, 2000) and another from Yale University (1992), compared physician and nurse practitioner practice. They found that patients expressed a high degree of satisfaction with the care they received, that accuracy of diagnosis and health outcomes were equivalent, and that Nurse Practitioners provide quality, cost-effective care to their patients.

The role and extent of coverage of complementary and alternative medicine (chiropractic, acupuncture, etc.) in Alaska is undefined, but substantial. As of May 25, 2005, the Alaska Division of Occupational licensing listed the following numbers of active licenses for the following types of doctors:

Allopathic doctors (M.D.)	2,377
Chiropractic doctors (D.C.)	227
Osteopathic doctors (D.O.)	183
Podiatrist (D.P.M.)	20

SPECIFIC ALASKAN RECOMMENDATIONS FOR IMPROVEMENT

This Study Group has identified a continuum of challenges, many of which are interrelated to each other. While they may all be part of a whole, the Study Group identified discrete categories to more readily focus on how each recommendation may be best implemented. A chart below summarizes the recommendations and identifies which parties are affected by, or responsible for, each recommendation.

However, in the process of assessing health care in Alaska, and looking for improvements, the Study Group developed consensus on three overarching conclusions:

1. **The Study Group process itself, which includes representatives of all key components of the health care system in Alaska, has been enlightening, educational and productive. For the first time in recent years, key players have been able to share experiences and ideas in a supportive and cooperative environment.**

2. **Every aspect of health care is complex. Education, technology, funding, social and demographic factors, economics, federal and state laws and regulations all have many interrelated facets. Understanding the health care system, and improving it, are beyond the capacity of any one element within the system.**

3. **Therefore, a fundamental recommendation of the Study Group is that an ongoing body be established to achieve multiple goals:**

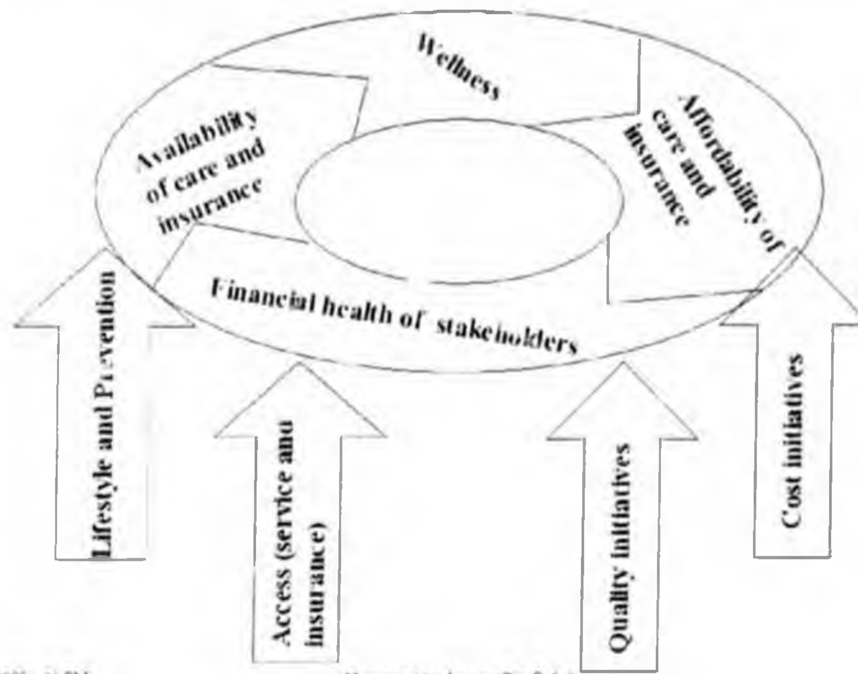
   a. **Continue the communication process started by this Study Group among the key elements in the Alaska health care system and the broader Alaska community.**

   b. **Create a body that will have a long-term vested interest in understanding and improving the system. Some solutions are immediate, others will take generations. But without consistent advocacy, the system is unlikely to make needed fundamental changes.**

   c. **Through the quality of its participants, and the comprehensiveness and depth of its vision, the body will set a standard of credibility that will sustain its ongoing operations and facilitate implementation of its recommendations.**

In that spirit, this Study Group offers the "Yarmon Plan" as a starting point for structuring such a body.

The **Roundtable** Proposal (The Yarmon Plan)



The Alaska Health Care Roundtable

Goals: a, b, c on the previous page. Create a timely, actionable package that will gather bipartisan political support, get quick approval, and become a significant part of a long-term fiscal plan for Alaska.

Focus: Access, quality and cost. Function as both a sounding board and facilitator for ideas and recommendations.

Structure: Create the "**Alaska Health Care Roundtable**"

Membership in the Roundtable: Self-selecting. Must have a core of members who have a long-term compelling interest in improving access, quality and cost of health care in Alaska. Examples of potential members would be:

a. Major employers
b. Providers
c. Foundations
d. Other participants as invited by the Roundtable

Funding: Voluntary contributions by the participants.

Strategic relationships: Form a research relationship with the **University of Alaska/Institute of Social and Economic Research (ISER)**. The Roundtable itself could focus on strategic policy and political analysis. UA would provide in-depth research as needed on a contract basis.

Tactics: Secure the support of major employers and secure their interest in funding such a Roundtable. There is no point in CWN issuing a major recommendation that will fall flat on its face. Get seven or more CEOs of major employers to make a financial commitment to the project and be present at its unveiling.

Create a package of recommendations that will be dynamic, compelling and politically impossible not to accept. Create a "win-win" atmosphere so all participants can claim victory.

Local or regional Roundtables can address "nuts and bolts" issues of cooperation, implementation, sharing and efficiency.

Potential resources, ad hoc participants or additional members: Business leaders of large businesses, business leaders of small businesses, Alaska Natives, labor, non-profit (Foraker Group), education, military, insurance industry, state government (legislature, administration), health care providers, Medicare, Medicaid

Summary table of recommendations with affected and responsible parties

The following chart summarizes various recommendations that were suggested in the course of our study. They are a starting point of menu items for the Roundtable to analyze and prioritize.

A = Parties affected by or benefiting from the listed Recommendation

R = Parties responsible for implementing the listed recommendation

Recommendation	Individuals	Legislature	Governor	Local Governments	Private Sector	Health Care Professionals & Institutions	Universities (or schools)	Insurance Companies
Lifestyle & Prevention								
1. Walkable community	AR			AR	AR	AR	AR	AR
2. Public Health role	A	R	R	AR	A	A	AR	A
3. School phys ed	A	R	R	AR	A	AR	R	A
4. Schools nix bad foods	AR	R	R	AR	A	AR	AR	A
5. Incentivize behaviors	AR	AR	AR	AR	AR	A	AR	AR
7. Rural dentistry	A	A	A	AR	A	AR	AR	AR
8. Drug/psych facilities	A	AR	AR	AR	A	AR	A	AR
9. U.S. preventive health recommendations	AR	AR	AR	AR	AR	AR	AR	AR
10. Circumpolar health studies	A	AR	AR	AR	A	A	A	A

Access	Indiv.	Legis.	Gov.	Loc Gv	Private	HC	Univ/Sc	Ins. Cos
1a. Expand WWAMI	A	R	R	A	A	AR	AR	AR
1b. Market AK To MDs	A	R	R	AR	AR	AR	A	AR
2. Cut liability ins. Cost factors	A	R	R	A	A	AR		AR
3. Cover uninsured	AR	AR	AR	AR	AR	AR	AR	AR
4. Pool small cos.	A	R	R	AR	AR	A		AR
5. Promote lower cost centers	A	AR	AR	AR	AR	AR	A	A
6. Same day non ER alternatives	A	R	R	AR	A	AR	A	AR
7. Examine other state models e.g. UT, ME	A	R	R	A		R	R	AR
8. More GME $ for family practice	A	R	R	A	A	AR	AR	A
9. Improve MD reimbursements	A	R	R	A	A	AR		AR
10. Medicare licensing requirement	A	R	R	A	A	A	A	A
11. Public insurance hearings	A	R	R	A	A	A	A	AR
Quality								
1. Evidence based prevention, Intervention	AR	AR	AR	AR	AR	AR	AR	AR
2. Use bench-marks	A	R	R	AR	AR	AR	AR	AR
3. Measure, disclose quality info	AR	AR	AR	AR	AR	AR	AR	AR
Costs								
1. Prevention education, intervention	AR	AR	AR	AR	AR	AR	AR	AR
2. Electronic medical records	A	AR	AR	AR	AR	AR	AR	AR
3. Drug formularies	AR	AR	AR	AR	AR	AR	A	AR
4. Health care <> State fiscal plan	A	AR	AR	AR	AR	AR	AR	AR
5. Disclose fees clearly	A	R	R	A	A	AR	A	AR
6. Community duplication dialogue	A			AR	AR	AR		AR
7. Joint purchasing	A			AR	AR	AR		A
8. Allocation & rationing	A	AR	AR	AR	A	AR	AR	AR
9. Fee transparency legislation	A	R	R	AR	A	AR	AR	AR
10. Legislative ins., reimbursement, tort solutions	A	R	R	AR	AR	AR	AR	AR

The impact of lifestyle and prevention

First and foremost, this is an issue of individual responsibility. This means that each of us is ultimately responsible for our own health, how we eat, exercise and live. Nevertheless, many collective societal educational and social efforts can help further acceptance of this individual responsibility through application of sound health maintenance principles.

Our society is not used to facing the facts of collective issues. They are not part of the national or state non-Native psyche. Currently, the health care industry plugs holes in the dike that are the result of unhealthy lifestyles. We need to go way upstream and focus on prevention.

Fortunately, we can learn from the positive example of reduction of smoking in America. Much remains to be done. Today's limited but meaningful success is the result of a long-term effort that lasted over a generation. Extensive public education, warning labels, laws banning smoking in public places and a consistent message from the health care community ultimately resulted in societal changes that now appear to have gained a self-reinforcing life of their own.

1. **Plan a "walkable community."**
    a. Land use designed to facilitate walking and biking can encourage cardiovascular health. Maintaining safe municipal trail systems, seasonal bike paths, and cleared wintertime walkways permit citizens to practice healthful life habits year around.
    b. Enlightened city planning and architecture can promote a more active lifestyle.
    c. As public demand for exercise opportunities grow, their inclusion in real estate development and city planning can improve property values.

2. **The role of public health as community educator and provider.** Municipal health departments need to serve many more people than those who seek care at the clinic. Promoting wellness and healthful living habits to the entire community is an essential part of the public health mission. This portion of the mission needs to be funded adequately in the budget.

3. **The importance of physical education in the schools— (not a "frill")** It is important to teach children about the relationship between health, diet and exercise. Not every child will want to join a sports team, but learning to be responsible for their own health by incorporating physical activity into their daily lives is an important health lesson that cannot be ignored.

4. **Eliminate internal inconsistencies and conflicts between programs and objectives.** For example, eliminate financial incentives in schools to promote unhealthy foods. Provide a financial alternative to schools that have come to rely upon income from selling junk foods in the schools.

5. **Incentivize healthy behaviors through workplace activities.** Convince the Top 49 Alaska businesses to educate their employees on healthy lifestyles and offer healthful workplace activities. The Top 49 businesses would represent a large percentage of the Alaska population not already covered by Federal or Alaska Native health care systems. Encourage a **Top 49 Health Summit** to facilitate understanding and participation of these large Alaska businesses.

6. Develop intervention programs for **promoting the traditional rural diet.**

7. **Reconsider rural access to dentistry as part of the study.** Many rural communities lack a sufficient population to support construction of a simple dental facility to house a full time dental practice. The investment required to maintain a facility for use by an itinerant dentist would likely need to be made by the community, possibly partnering with the state. Lack of roads prevents the use of mobile dental clinics that are used in other remote locations worldwide.

8. **Reduce the critical shortage of facilities for alcohol and drug detox, and psychiatric facilities. The lack of services these facilities provide can increase costs in the long run.** Persons affected by alcohol and drug use, and the accidents they cause, account for a significant portion of the population needing care in hospital emergency rooms and psychiatric facilities. Yet Alaska has too few beds to treat those in need of drug and alcohol recovery. As a result we are forced to tolerate that burden of higher healthcare costs. Detox beds make good economic and health policy sense.

9. Find ways to incorporate **U.S Task Force on Preventive Health** recommendations into medical practices, schools, work environments and homes.

10. **Continue the Institute of Circumpolar Health Studies** to analyze common problems and look for solutions that will work for all circumpolar peoples. Similar environments and cultures may result in shared knowledge that can benefit those in northern latitudes. Many health issues in Alaska relate to weather, the environment, subsistence food quantity and quality, potable water and sanitation issues. These are issues shared by other circumpolar peoples. Alliances with other circumpolar countries, and organizations like the Institute for Circumpolar Health Studies may provide new insights in resolving some of these issues.

Access improvement recommendations

1. **Workforce development issues**
   a. **Expand the WWAMI program.** Improve the supply of primary care providers (family practice physicians, internists, nurse practitioners, physician's assistants), especially outside of Anchorage. Current or potential shortages can be identified in specific specialties.
   b. **Market the Alaska lifestyle to Outside doctors.** JV with tourism, the State Medical Board, ASMA. Create a dog and pony show.

2. **Investigate and modify the factors that influence the cost of professional liability insurance**

3. **Reduce the number of uninsured Alaskans**— A non-government designed system is probably preferable to a government-operated system.

4. **Investigate pooling smaller companies a la the Foraker Group in an effort to reduce premium costs.**

5. **Promote lower cost models such as neighborhood health centers where appropriate**

6. Educate the public and promote same day access to **alternatives other than hospital emergency rooms**. This involves creation of more readily available and timely access to primary care. Alternatives could include increasing the number of primary care providers and clinics, establishing a variety of disincentives for visits for minor complaints, and establishing a system for care for the uninsured. Emergency rooms themselves may need to be reorganized and redesigned to separate life-threatening emergencies from routine medical needs.

7. **Examine uninsured models elsewhere; e.g. Utah, Maine and Florida.**

8. **Adjust the Medicare (GME) reimbursement formula for Family Practice Residency programs.**

9. **Ensure adequate government reimbursement to doctors, hospitals, community health centers, mid-level practitioners and community health aides without unreasonable bureaucratic burdens.**

10. **Consider making accepting Medicare patients a condition of licensure in Alaska. This has been done in Massachusetts.** Weigh the advantages of increased access for Medicare patients against the negative effect of attracting practitioners to Alaska.

11. Consider **public hearings for health care insurance and professional liability insurance rates** to facilitate price transparency. Currently insurance rates are largely negotiated between large institutional users and insurance carriers. As private contracts, the resulting rates are not disclosed. Individuals have little or no negotiating power and either have to accept or reject rates offered to them. The thought is that greater transparency could result in more favorable, or at least understandable, rates for individual consumers.

Quality improvement recommendations

1. **Promote and encourage primary prevention, early intervention, and evidence based practices by providers and payers of health care.**

2. **Use meaningful benchmarks; e.g. the Alaska 20/20 example.**

3. **Measure quality of service and make the information publicly available.**

Cost reduction recommendations

1. **Prevention through Public health education, and early intervention** Preventing illness will save more lives, more lost work time and more healthcare dollars than any other option available to us as a community. Consider the adage "the cheapest health insurance is healthcare you don't need." Measures include flu shots when they are recommended and vaccinations against common diseases. Encourage the following behaviors: weight control, regular exercise, avoiding cigarettes and excessive alcohol, fat, salt, and sugar, adequate water consumption, and controlling blood pressure.

2. Encourage and promote the establishment of an **Electronic Medical Record** with a common interface as a means to improved safety and efficiency of health care.

3. **Drug formularies**—utilize where appropriate and effective.

4. **Promote the strong interrelationship between cost of health care and a state fiscal plan** as a means of putting health and budget decisions in perspective

5. **Fee and billing transparency.** Mandatory disclosure of fees in advance of treatment and "understandability" standards for medical billing.

6. Encourage **local cooperation and sharing of services and facilities.** Promote community by community dialogue on the cost of duplication

7. Analyze the possibility of saving money by **joint purchasing** by appropriate parties.

8. **Allocation and rationing** might be considered if other measures fail to stabilize health care costs.

9. **Suggest legislation to mandate fee transparency**

10. **Consider legislative solutions to tort and liability issues.** Quantify professional liability insurance, patient reimbursement and tort issues—are there legislative solutions? Look at tort reform experiences Outside, such as MICRA, for ideas that might apply to Alaska.

SUCCESS STORIES AND PROMISING PROGRAMS

Alaska has a number of programs that have proven to be successful:

Lifestyle and prevention

- The South Central Foundation Primary Care Clinics place great emphasis on prevention. This results in some of the best state data for immunization rates, colorectal screening, mammograms and other standard preventive health interventions.

Access

- Anchorage Neighborhood Health Center
- Other community health centers
- Health aides in rural Alaska
- South Central Foundation has programs that have established same day access. Utilization rates for emergency room use and specialty services have fallen dramatically. Utilization rates of primary care services have also had a modest decrease.

Quality

- Hospital quality control programs have been established in all the major hospitals in Alaska with excellent results. For example, Providence Hospital received national recognition for reducing surgical site infections after joining a national collaborative focus on this issue. Alaska Regional Hospital was recognized for reducing pneumonias after intubations. The Alaska Native Medical Center has developed a national reputation for quality improvement activities working in close association with the Institute for Health Care Improvement. All of our major hospitals have joined the national initiative known as the "100,000 Lives Campaign" to save this many lives in U.S. hospitals by June 2006.

Costs

- The Alaska Federal Health Care Partnership, consisting of the DOD, VA, Coast Guard and the Alaska Native Health System, have been able to reduce costs by bulk purchasing and the sharing of clinical resources.

Other programs show promise:

- The State of Alaska has developed benchmarks for population health improvement targets in a document called "Healthy Alaskans 2010."

Lifestyle and prevention

- The Anchorage Daily News and a growing number of businesses are discussing wellness incentives in an effort to reduce health care costs. Generally all of these approaches are similar. Employees who agree to join this effort receive personal health care improvement plans and personalized coaching on a regular basis. Some companies offer health care premium discounts as an incentive to participate.

Access

- Anchorage Project Access is a developing physician initiative in Anchorage (adopting a national model) to provide free care to uninsured individuals who meet certain low-income criteria. Almost all physicians and hospitals currently provide uncompensated care. By organizing this effort, other communities with this program have been able to efficiently provide more care to the uninsured.

Quality

- A new initiative in the U.S., public reporting of quality indicators in hospitals and nursing homes, is being required by the Center for Medicaid/Medicare Services (CMS). Hospital quality reports are now available on the Web under the title of "Hospital Compare." Both the federal government and insurance companies are instituting "pay for performance" programs to improve service quality by hospitals and doctors. Countries like Great Britain have already introduced these programs.

APPENDIX

Key ideas in the 1994 CWN study "Health Care: Finding an Alaskan Solution"

1. The health care reform debate is complex and controversial, with multiple players with competing interests.

2. There are significant factual disputes about the health care system.

3. Health care reform creates winners and losers.

4. The most important conclusion for Alaskans: Involvement of Alaskans in the health care debate is vital. Some type of reform is inevitable and Alaskans must work to ensure that reform is responsive to our unique Alaskan conditions.

Study Group Participants

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Duane Heyman	Executive Director, Commonwealth North

The Charge

Alaska Primary Health Care – Opportunities & Challenges

Approved by the Commonwealth North Board on July 20, 2004

1. **Questions to be addressed:**

a) How is primary health care currently being delivered to Alaskans?
b) Are Alaskans receiving quality health care under the current scenario?
c) What does the future hold for health care in Alaska?
d) Are there ways to do a better job, such as by bridging the current multiple systems?

2. **Scope of study:**

The intention of this study is to focus on primary care – the need for Alaskans to receive basic health care. Recognizing there are a number of health care areas which merit similar attention such as long-term care, behavioral health, dental care, etc., the focus of this particular study is to address the past, present and future of primary health care in Alaska. The study will include an update/compilation of previous reports to provide a context.

- The study will briefly explore the historical delivery of health care and how that history impacts the present challenges Alaska faces. In providing this background, the study will also look at the health status of Alaskans – is it above/below that of other states or are we keeping pace?
- The study will explore the "drivers" behind the cost of health care in Alaska and will assess its impact, if any, upon economic development in the State. Access and quality of care/services are a critical determinant of cost within the various health systems in Alaska.
- This study will identify principal health care entities and look at the current multiple health systems – what are the benefits and challenges? Are they sustainable? What impact, if any, do these multiple systems have on the cost and quality of health care?
- There are a number of challenges facing health care providers and recipients. This study will identify those challenges and where possible, potential solutions.
- There are a number of examples where health care entities are collaborating. The study will highlight the best practices and identify additional areas of collaboration. The study will also take into account lessons learned from other states.

3. **Nature of report to be issued (Technical, Analytical, or Opinion):**

This report will analyze issues, identify a process for addressing them and suggest guiding principles. The report will provide background, current status and recommendations for change or further study. While the report will largely express opinions, it will address technical issues that are necessary aspects of the larger picture.

4. **Conflict of interest standards:**

The intent of the study is to represent a balance between the geographic, demographic, ethnic and economic interests in Alaska. It is expected that persons with interests in the outcome of the study will be members of the study group and will participate in its deliberations. Study group leaders should request that study group members identify their interests relative to specific points they advocate.

5. **Measure of success:**

This study will succeed by generating a greater understanding of and insight into health care issues in Alaska and areas in which health providers can work together for the mutual benefit of all Alaskans.

Resource People Interviewed

9.23.04 Ed Lamb, Al Parrish—Hospital perspectives

9.30.04 Barbara Russell—Premera

10.07.04 Alex Spector—VA, Lt. Col. Vic Rosenbaum—Elmendorf Hospital, Maj. Ward Hinger--TRICARE

10.14.04 Commissioner Joel Gilbertson

10.21.04 Paul Sherry—Alaska Native Tribal Health Consortium

10.28.04 Tessa Rinner—Denali Commission

10.28.04 The Maine Plan (Sergei Bogojavlensky, MD)

11.11.04 Norman Wilder MD, MBA (Regional), Roy Davis MD (Providence)—Quality and cost control initiatives

11.18.04 Rod Betit—State Hospital & Nursing Home Association

12.02.04 Catherine Schumacher MD—Access to health care in Anchorage

12.09.04 Cathy Giessel, MS, FNP-CS—The role of nurse practitioners

12.09.04 Harold Johnston, MD—Program Director, Alaska family Practice Residency

1.06.05 Joan Fisher – Executive Director, Anchorage Neighborhood Health Center and Medical Director, Dr. Tom Hunt and Beverly Wooley, Director, Anchorage Municipal Health Department

1.27.05 Janet Trautwein – VP Government Affairs, National Assn of Health Underwriters

1.28.05 (Forum) panel discussion with Commissioner Joel Gilbertson, Al Parrish, Randall Burns—Alaska Small Hospital Performance Improvement Network, Dr. David Snyder—Alaska Native Medical Center

2.03.05 James Jordan, Executive Director, Alaska State Medical Association

3.10.05 Ann Conway, Maine Center for Public Health

3.25.05 Joseph Ditre, Executive Director, Consumers for Affordable Health Care Foundation (Maine)

Have health insurance? Think you're well protected? *Think Again!*

You might think that debt and despair are problems only of the uninsured. If so, think again. Millions of Americans face enormous health care costs and risk financial ruin. You may see your friends, coworkers, or neighbors try to recover from a painful illness or a car accident. What you probably don't see is how little their health insurance covers or how costly their medical bills are. Millions of Americans suffer from devastating financial burdens at the same time they face serious illness or injury. The middle class, those with college degrees, decent jobs, health insurance—the group of people who feel secure and well-protected—are at high, and often highest, risk of being left penniless when serious illness hits.

Millions of *insured* Americans are spending their life savings on health care

- **51 million** *insured* Americans spent more than one-tenth of their income on health care
- **10.7 million** *insured* Americans spent more than a quarter of their paycheck on health care
- **6.8 million** *insured* Americans spent more than one-third of their income on health care

People who can't afford out-of-pocket costs delay and skip needed health care

- **Almost one in five** Americans reported postponing seeking medical care
- Of these, **more than one in three** said the delay resulted in a temporary disability that included significant pain and suffering
- And **more than one in ten** said the delay caused a long-term disability

Those who *do* seek medical care are often ruined financially

- **Every 30 seconds**, an American files for bankruptcy after having a health problem
- **About half** of all personal bankruptcy cases are due to medical reasons
- Among those whose illness led to bankruptcy, **more than three in four** *had insurance* at the onset of the illness
- The majority of the medically bankrupt had been to college, had responsible jobs, and had been homeowners

Bankrupt families lose more than their assets

- **One in five** went without food
- **A third** had utilities shut off
- **Nearly two-thirds** skipped needed doctor or dentist v[illegible]s

And it's likely to get worse ...

From 2000 to 2004, premiums paid by workers rose nearly three times faster than the average U.S. earnings

Alaska Health Summit Post Forum
Thursday, December 4, 2003, Anchorage Sheraton Hotel

Accessing Health Care

MISSION POSSIBLE!

Presented and Moderated by
Dr. Brian L. Saylor, Director, Institute for Circumpolar Health Studies, University of Alaska Anchorage and Dr. Lawrence D. Weiss, Research Professor of Public Health, Department of Health Sciences, University of Alaska Anchorage; MPH Program Coordinator.
Coordinated by
Sharon M. Cissna, M.S., Alaska State Representative, District 22

RECOMMENDATIONS

Prevention

Outpatient 330 Community Based Clinic Construction and Support

Technology Solutions

Informed Consumers

A State Insurance Plan

Survey Shows Business Leaders Believe Employees Will Shoulder More of Their Health Care Costs

Sep 14, 2005 - Washington, D.C.

As employees pay 29% of monthly health insurance premiums, business owners worry that rising costs will force workers to join ranks of uninsured. Poll of business leaders released at Capitol Hill summit of lawmakers and CEOs.

Faced with rising health care costs, small, medium and large businesses say they must continue to pass a portion of the increased costs on to their employees by requiring them to pay a mounting share of the premiums, co-pays, or deductibles, a new survey of business leaders shows. Four in five business owners (79 percent) who anticipate increases in their health care costs say they are concerned about their employees' ability to shoulder the projected increases. The Robert Wood Johnson Foundation today released *"Attitudes of Business Leaders Regarding Health Care Coverage"* at a Capitol Hill briefing led by legislators, governors, and Fortune 500 executives. The survey of more than 600 business owners and benefits managers whose companies currently pay for at least some health insurance benefits shows that companies of all sizes expect health care costs to jump an additional 12 percent over the next year. Business owners surveyed say they will ask their employees to pay an average of 21 percent of the increase. Survey respondents estimate that their employees

Healthy policies = Healthy children = Healthy budgets

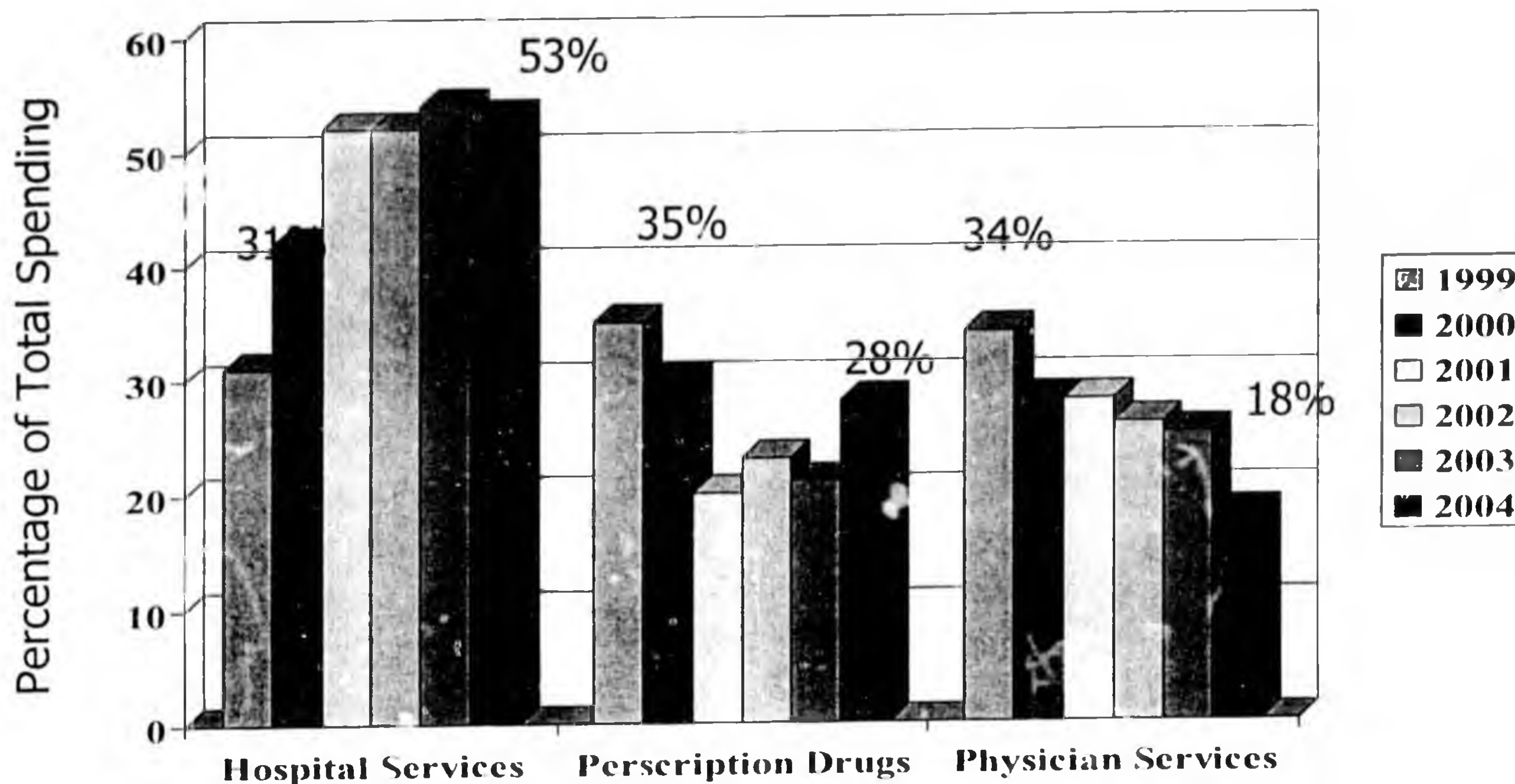
- *"Family-friendly" policies & incentives*
- *Mandated child care standards & quality control*
- *Support for education at all levels, including Pre-K*
- *Support for early preventative social service programs*
- *New & creative legislation*

Alaska Department of Labor

- "Why are (workers compensation) rates rising so much? The main reason is higher medical expenses. The cost for a common knee reconstruction surgery, for example, knee has nearly doubled from $5,225 in 1999 to $10,967 in 2004."

Greg O'Claray Commissioner of Labor and Workforce Development in a 2005 editorial

Spending Growth Continues To Be Dominated by Hospital Services



Employee Benefit Research Institute, Strunk, Gabel and Ginsburg, December 2004, Center for Studying Health System Change www.hschange.org

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Table 3: Cost for Nursing Home, Assisted Living, and Personal Care Assistant Services for Current 2005 Personal Care Program Enrollees

Type of Care	Average Daily Cost (1)	Average Annual Cost (1)	Total Annual Cost for Current PCA Enrollees (2)
Private Nursing Home	$561	$204,765	$702,343,950
Semi-Private Nursing Home	$435	$158,775	$544,598,250
Assisted Living Home	$125	$45,625	$156,493,750
Personal Care Assistant	$65	$23,725	$81,376,750

NOTES and SOURCES:

(1) Personal Care Assistant costs were derived by dividing total expenditures for the program in the first seven months (218 days) of FY2005 by the approximate number of enrollees. It is possible that further billing for services provided over this time period will be submitted. As a result, this figure should be viewed as a rough estimate only. Nursing Home and Assisted Living costs are from the MetLife Insurance "2004 Market Survey on Nursing Home and Home Health Care Costs and Assisted Living Costs," available online at www.pisco.com/LTCcosts.html

(2) These figures represent the estimated costs for the roughly 3,340 current enrollees in the PCA program for an entire year. The actual number of enrollees fluctuates over the course of a year. These calculations are, therefore, intended only for comparing costs among the different types of care for a constant population group and should not be considered estimates of actual annual expenditures.

Legislative Research Services, April 2005 Update of Report 04-155

February 2004, Legislative Research reported on the *"Impacts on Expenditures from Terminating the Personal Care Program".*

Family support services, in combination with PCA and respite care at 60 hours per week is one way to hold cost down.

With an additional 15 hours a week of family support services, caregivers could go back to working full time…

Adding 60 hrs/mo Family Support Services	$ 1260/mo.
Total Cost at home	$ 4881/mo.
Alzheimer Care (in Anchorage)	$ 6300/mo.
Nursing home care (Anchorage)	$11,000/mo.
Savings to the State	$1419/mo. to $ 6119/mo.

Family Support Cost Comparison (2005)

Personal Care Attendant	$ 65/day
Semi-Private Nursing Home*	$ 435/day
Savings to State	$ 370/day

*Private Nursing Homes (also available to Medicaid Waiver recipients should they choose: $561/day

A Traveling Provider

- A "Traveling Audiologist" has seen 593 patients at 24 remote clinics.
- Total cost: $46,000.
- Travel savings: $99,598 (for 271 patients)
- About 76% of the patients seen needed something done (meds, surgery, ongoing monitoring).
- About 24% were screened out.
- Now being implemented as a sustainable business.

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"Having [the traveling audiologist] go out to the villages is a huge financial benefit.

[She] saw 20 patients a day in Selawik which saved us $2400.00 in airfare alone, since those patients would have to be flown to Kotzebue for the same service. Since most of the patients she saw were minors, you can add on another $2400.00 for a parent to accompany the child.

On top of that, the child misses a day of school, the parent misses a day of work, and there are usually other children in the family whose care must be arranged."

Leslie Neely RN
Case Manager, ENT Clinic,
Kotzebue, AK

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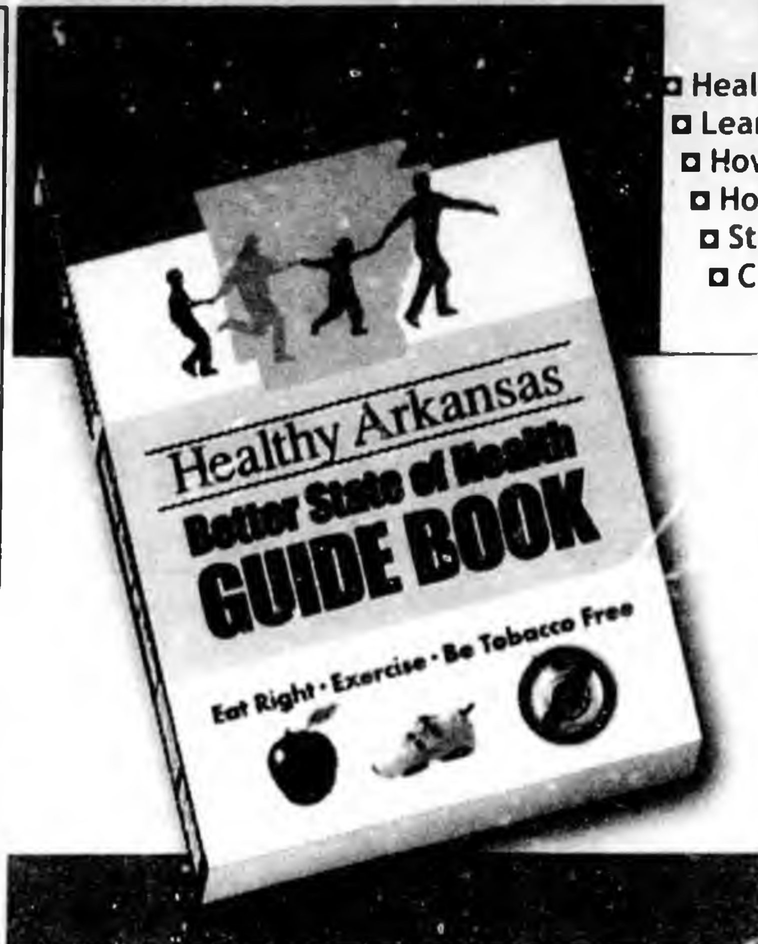

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Healthy Arkansas is a comprehensive effort to clearly define specific areas where behavioral changes can lead to healthier citizens. The burden of chronic diseases, including diabetes, stroke, lung and heart diseases, and cancer, is higher in Arkansas than in the nation generally.

Tobacco use, obesity, and physical inactivity are the three primary causes of these and other serious chronic conditions. The Healthy Arkansas website provides strategies to reduce and/or eliminate the three primary behavior-related causes of these diseases with information on nutrition, physical activity and smoking cessation.

Call 1-800-235-0002, or check the links below for more information

Community Resources

F.A.Q.

Site Map

A Step in the Healthy Direction

The Happy Birthday
BABY BOOK

SOS
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