SB

300

Alaska State Legislature

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Senator Bettye Davis

Senate Bill 300: Health Care: Plan/Commission/Facilities

"An Act establishing the Alaska Health Care Commission and the Alaska health care information office; relating to health care planning and information; and providing for an effective date."

Sponsor Statement

The Alaska Healthcare Strategies Council, established by Governor Sarah Palin, met during the 2007 Legislative Interim to set long term goals for the Healthcare of Alaskans. During the Legislative Interim, these legislatures, Healthcare professionals, and committed citizens of Alaska provided seven clearly delineated goals for "***Making Alaskans the healthiest people in the nation.***"

Among the Council's top recommendations, Senate Bill 300, sponsored by the Senate Health, Education, & Social Services committee, would establish the Alaska Health Care Commission to develop policy recommendations and oversee the newly formed Healthcare Information Office. The Alaska Health Care Commission would also oversee the database and website implementation and regarding healthcare and healthy living in Alaska.

The commission would be comprised of 15 members including Alaska Health Care Providers, a small business owner, state officials and public members. Chaired by the Medical Director of the Department of Health & Social Services, the Alaska Health Commission would meet regularly establishing specific goals designed to promote the health and well being of the citizens of the State of Alaska.

SB 300 will also establish the Alaska Health Care Information Office and related database Internet sites to provide transparency to Alaska Healthcare industry for Healthcare consumers. The Information provided by the Alaska Healthcare Information Office would be consistently updated as specified in the bill.

These two functions of the bill will provide the citizens of Alaska a great avenue for choosing Healthcare for themselves and their families. It is with Alaska's citizens in mind that your consideration and passage of this bill to the next committee of referral is requested.

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 300
() Publish Date:

ID(File name) SB300-DHSS-AHCIO-03-10-08
Dept. Affected: Health & Social Services
Title HEALTH CARE: PLAN/COMISSION/FACILITIES
RDU Commissioner's Office
Component AK Health Care Information Office
Sponsor SENATE HES
Requester SENATE HES
Component No. 2899

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include Inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2009**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Personal Services	494.9		494.9	494.9	494.9	494.9	494.9
Travel	18.0		18.0	18.0	18.0	18.0	18.0
Contractual	250.0		235.0	235.0	235.0	235.0	235.0
Supplies	22.2		10.0	10.0	10.0	10.0	10.0
Equipment	15.0		10.0	10.0	10.0	10.0	10.0
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**800.1**	**0.0**	**767.9**	**767.9**	**767.9**	**767.9**	**767.9**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (0)							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	800.1		767.9	767.9	767.9	767.9	767.9
1037 GF/Mental Health							
Other(Specify Type-do not abbreviate)							
Other(Specify Type-do not abbreviate)							
TOTAL	**800.1**	**0.0**	**767.9**	**767.9**	**767.9**	**767.9**	**767.9**

Estimate of any current year (FY2008) cost:

POSITIONS

Full-time	4		4	4	4	4	4
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

The bill creates the Alaska Health Care Information Office and related database Internet sites to provide consumers consistently updated information about health care facilities, prevention, and healthy living options in Alaska.

71000 Personal Services Two information technology positions are being requested to design, develop, implement, and support the dissemination of information on the internet for all health care facilities in the state to provide objective, unbiased, and factually based information on those facilities. In addition, an interactive website will be created to assist the public in obtaining timely and accurate information about personal responsibility in preventing chronic health conditions and promoting healthy living. Two planner positions will be needed to assist in research and data collection for the Commission.

Prepared by: Jay C. Butler, MD
Phone 269-8045
Division Chief Medical Officer
Date/Time 03/07/2008
Approved by: Karleen Jackson, Commissioner
Date 03/10/2008
Agency Department of Health and Social Services

ANALYSIS CONTINUATION

Funding is needed to support two existing positions—Public Information Officer and Publications Technician. These positions will coordinate internal and external communications for the Alaska Health Care Information Office.

72000 Travel
Travel and per diem for professional staff.

73000 Contractual
Professional services contracts will be needed to facilitate and supplement formative research methods to develop messages to promote healthy behaviors. Core Service RSAs will be required to provide lease space, telecommunications, mainframe connectivity, postage, etc.

74000 Supplies
In addition to day-to-day office supplies, FY09 includes one-time-only start-up costs such as computers, office furniture, reconfiguring leased space, wiring needs for connectivity, printers, fax, and photocopier.

75000 Equipment
FY09 includes a one-time-only purchase of a server; subsequent fiscal years provide for technology upgrades and maintenance.

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 300
() Publish Date:

ID(File name) SB300-DHSS-AHCC-03-10-08
Dept. Affected: Health & Social Services
Title HEALTH CARE: PLAN/COMISSION/FACILITIES
RDU Boards & Commissions
Component AK Health Care Commission
Sponsor SENATE HES
Requester SENATE HES
Component No. 2900

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2009**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Personal Services	173.1		173.1	173.1	173.1	173.1	
Travel	218.3		218.3	218.3	218.3	218.3	
Contractual	250.0		250.0	250.0	250.0	250.0	
Supplies	72.0		10.0	10.0	10.0	10.0	
Equipment	15.0		10.0	10.0	10.0	10.0	
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**728.4**	**0.0**	**661.4**	**661.4**	**661.4**	**661.4**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (0)							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match	728.4		661.4	661.4	661.4	661.4	
1004 GF							
1037 GF/Mental Health							
Other(Specify Type-do not abbreviate)							
Other(Specify Type-do not abbreviate)							
TOTAL	**728.4**	**0.0**	**661.4**	**661.4**	**661.4**	**661.4**	**0.0**

Estimate of any current year (FY2008) cost:

POSITIONS

Full-time	2		2	2	2	2	
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

This bill establishes the Alaska Health Care Commission in DHSS to develop policy recommendations and oversee websites and databases regarding health care issues and healthy living in Alaska. The Commission would be composed of 15 members and chaired by the DHSS Medical Director. The Commission would meet regularly in person and via teleconference. The Commission would sunset July 1, 2013, so no costs are projected for FY2014.

71000 Personal Services: Two new positions are needed to support the Commission. The bill states that an Executive Director would staff the Commisison; one administrative support position would also be needed.

72000 Travel: Travel and per diem for Commission staff and for 11 Commission members to conduct public meetings around Alaska. The four other members are legislators and would have per diem and travel covered. (Continued on Page 2)

Prepared by: Jay C. Butler, MD
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Date/Time 03/07/2008
Approved by: Karleen Jackson, Commissioner
Date 03/10/2008
Agency Department of Health and Social Services

ANALYSIS CONTINUATION

73000 Contractual

Professional services contracts will be needed to supplement staff research, and core service RSAs will be required to provide lease space, telecommunications, mainframe connectivity, postage, etc.

74000 Supplies

In addition to day-to-day office supplies, FY09 includes one-time-only start-up costs such as computers, office furniture, reconfiguring leased space, wiring needs for connectivity, printers, fax, and photocopier.

75000 Equipment

FY09 includes a one-time-only purchase of a server; subsequent fiscal years provide for technology upgrades and maintenance.

FISCAL NOTE

STATE OF ALASKA
2008 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: CS SB 300 HES
() Publish Date:

ID(File name) SB300CS(HES)-DHSS-CO-03-14-08
Dept. Affected: Health & Social Services
Title HEALTH CARE: PLAN/COMISSION/FACILITIES
RDU Departmental Support Services
Component Commissioner's Office

Sponsor SENATE HES
Requester SENATE HES
Component No. 317

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2009**	**FY 2009**	**FY 2010**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**
Personal Services							
Travel							
Contractual	325.0						
Supplies							
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**325.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES (0)							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts							
1003 GF Match							
1004 GF	325.0						
1037 GF/Mental Health							
Other(Specify Type-do not abbreviate)							
Other(Specify Type-do not abbreviate)							
TOTAL	**325.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2008) cost:

POSITIONS

Full-time							
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if necessary)*

CS SB300 (HES) requires the Department of Health and Social Services (DHSS) to contract for an independent study of the efficacy of the Certificate of Need (CON) program in Alaska. This fiscal note is an estimate based on two recent studies contracted out by the department. It is assumed the contractor would interact with the CON program to receive data and other pertinent information -- and that no work for the actual study would be conducted in DHSS. It is assumed the study would be completed in FY2009. One example study was a comprehensive rate-setting study for home and community-based services costing $325.0, which included a review of regulations and statutes, development of a new rate-setting system and assisting with the transition. The other was a Request for Proposal (RFP) for a Long Term Care Plan, requiring a contractor with extensive experience in analyzing health care systems at a state or regional level. The $320.0 RFP has generated several responsive bids.

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Date/Time 03/14/2008
Approved by: Karleen Jackson, Commissioner
Date 03/14/2008
Agency Department of Health and Social Services

Alaska Health Care Strategies Planning Council

Final Report: Summary and Recommendations

Making Alaskans the healthiest people in the nation...

December 23, 2007

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Executive Summary

On February 15, 2007, Governor Sarah Palin issued Administrative Order #232 establishing the Alaska Health Care Strategies Planning Council in the Office of the Governor. The purpose of the Council was to build the foundation for developing a statewide plan to identify both short-term and long-term strategies that effectively address issues related to access, cost and quality of health care for Alaskans. Members of the Council, all appointed by Governor Palin, are listed in Appendix C.

The Council interpreted its charge from Governor Palin broadly, to focus on the overall goal of improving the health of Alaskans. Within that broad charge, the Council considered health care to be an important component in improving the health of Alaskans. According to the Council, health care is a broadly defined term, relating to the prevention, treatment and management of illness, preserving mental, behavioral, physical health, and dealing with chemical dependency.

In accordance with the order, the Council reviewed and synthesized the extensive body of existing research on the subject, agreed upon the most salient facts, and identified the most significant health care issues in the state. Based on seven overarching healthcare challenges identified by the Council, members articulated the following seven comprehensive health care policy goals:

- *Personal responsibility and prevention in health care will be top priorities for government, the private sector, tribal entities, communities, families, and individuals;*
- *Health care costs for all Alaskans will consistently be below the national average;*
- *Alaska will have a sustainable health care workforce;*
- *All Alaskan communities will have access to clean and safe water and wastewater systems;*
- *Quality health care will be accessible to all Alaskans to meet their health care needs;*
- *Develop and foster the statewide leadership necessary to support a comprehensive statewide health care policy;*
- *Increase the number of Alaskans covered by health insurance and encourage employers to offer a range of health insurance options.*

Because of its short time frame, the Council was unable to address the Administrative Order's directive to present fiscal information to accompany each of the short- and long-term strategies. Unfortunately, with only 24 hours of face-to-face meeting time, identifying the fiscal impact of recommendations remains unaddressed, and must be a top priority in future consideration by this or subsequent bodies.

The Council's Vision and Long-term Goal

At its inaugural meeting on June 11, 2007, Council members articulated an overall vision of health care in Alaska – that ***"Alaskans are the healthiest people in the nation."*** This vision led to development of a concrete mission statement describing the ultimate

outcome of the Council's work: "***To develop strategies, including performance measures, to provide health care access to all Alaskans by 2014.***"

The "Fact-Based Process"

The work of the Council was facilitated through a "fact-based" process by Mr. Dennis McMillian, President and CEO of The Foraker Group, an Alaskan-based nonprofit corporation. Members were asked to review existing research and initiatives, and hear from subject-matter experts on the major issues in Alaska's health care system. Only those facts garnered from existing sources and/or presented to the Council at its meetings, and which were widely recognized by Council member as salient to the process, were allowed to remain in the conversation.

While time-consuming, the fact-based process allowed the development of a solid basis for discussing the issue of health care in Alaska, highlighting the major challenges with that system, and identifying realistic solutions to address those challenges.

Alaska's Health Care Challenges: A Strategic Plan for the Future

In the opinion of the Council, there are seven challenges requiring immediate and comprehensive attention in Alaska's health care system:

- *Prevention and personal responsibility don't play big enough roles in the health and health care of Alaskans;*
- *Receiving quality health care in Alaska is expensive, well above the national average, and increasing;*
- *There are significant shortages in the health care workforce across the state;*
- *Water and wastewater systems in many rural communities lead to health problems;*
- *Quality health care is difficult to access for many Alaskans, urban and rural;*
- *There must be consistent and focused state and local leadership to improve the health of Alaskans, and build a comprehensive health care system in Alaska;*
- *Health insurance is an important if as yet misunderstood part of comprehensive health and health care.*

Based on the vision of a healthy Alaska, a one-page "Alaska Health Care Action Plan" was developed by the Council. The plan appears in the following section, and includes a combination of long-term and short-term goals. Where applicable, the short-term strategies appear at the beginning of the relevant goals.

During its work the Council was able to generate dozens of possible solutions to address the challenges, much of that the result of "brain-storming." The identified solutions are presented in Appendix A. Most require development of implementation plans, which was considered beyond the scope of the Council's work, especially given the short window for completion of its tasks. Although they are not developed fully, the articulated solutions in the plan, and within Appendix A, present a real and actionable foundation for helping to meet the goals in the "Alaska Health Care Action Plan."

Alaska's Health Care Action Plan: "*Making Alaskans the healthiest people in the nation.*"
Long-Term Goals and Strategic Directions (2008 – 2014)

Goal One: Health costs for all Alaskans will consistently be below the national average.

- Increase the place of consumerism in health care purchasing by giving people control over their health care dollar – the foundations are accessible, transparent, evidence-based price/quality information about providers and services (short-term)
- Create an easily accessible and constantly updated website containing evidence-based price and quality information about health care providers and services (short-term)
- Increase community-based health care services, both public and private sector
- Stabilize the costs of health care by reducing the rate of increase relative to other states (national increase is 6%, decrease Alaskan rate to 4% annual increase)

Goal Two: Alaska will have a sustainable health care workforce.

- Increase WWAMI seats to 50 per year, and increase seats in UA Nursing and Nurse Practitioner programs (short-term)
- Develop policies and systems to alleviate the health care worker shortage, and prevent it from recurring
- Implement a doctoral-level nursing program at the University of Alaska to meet the 2015 deadline for Nurse Practitioner education requirements

Goal Three: All Alaskan communities will have clean and safe water and wastewater systems.

- Improve adherence to the state's existing water and wastewater treatment "plan," through the Village Safe Water Program

Goal Four: Quality health care will be accessible to all Alaskans to meet their health care needs.

- Expand tele-health and electronic health record systems, taking the lead in pursuing matching FCC grant funds (short-term)
- Increase presence of the public health system, particularly public health nurses, especially in rural communities (short-term)
- Increase access of Alaskans to a primary care provider and behavioral health provider when they are needed
- Decrease the likelihood that Alaskans will use emergency rooms for primary care
- Reduce the impact of existing barriers to health care accessibility by exploring private enterprise incentives
- Improve primary and long-term health care options for elders, particularly with regard to Medicaid and Medicare

Goal Five: Personal responsibility and prevention in health care will be top priorities for government, the private sector, tribal entities, communities, families, and individuals.

- Decrease the impact of obesity, smoking, substance abuse and other lifestyle factors on the health of Alaskans, through intense public education with public and private partners (short-term)
- Improve the likelihood that every Alaskan will choose to live a healthy lifestyle and make healthy lifestyle choices
- Increase the place of personal responsibility in health care decision making for all Alaskans

Goal Six: Develop and foster the statewide leadership necessary to develop and support a comprehensive statewide health and health care policy.

- Create an ongoing, quasi-independent, non-partisan, volunteer "Alaska Health Care Commission" in statute (short-term)
- Elevate the discussion of health care to a statewide audience

Goal Seven: Increase the number of Alaskans covered by health insurance

- Raise the eligibility criteria for Denali KidCare from the current 175% to 200% of federal poverty limits (short-term)
- Reduce potential for financial impact from catastrophic loss by supporting new and innovative approaches to insurance for individuals, which would be consumer-owned, portable, and purchased with pre-tax dollars
- All Alaskans have at least a catastrophic, incentive-based insurance option (i.e., high deductible coverage)
- Encourage employers, through varied incentives, to offer a range of insurance options/choices to employees – to include at a minimum, high deductible plans

Alaska's Health Care Challenges: Discussion and Recommendations
The Council engaged in lengthy discussion of the seven main challenges facing Alaska's health care system, and generated the following discussion points related to each.

- *Defining the specific problem or problems*
- *Why addressing them through comprehensive state action is important*
- *What should be done about it – in other words, identifying desired outcomes*

In addition to discussing what should be done to address each problem, the Council generated possible solutions and solicited public comment on the Health Care Action Plan. A Strategic Implementation Table (Appendix A) list the many solutions generated by the Council, and sets the foundation for implementation of selected short and long-term strategies. The full text of public comment will be presented to Governor Palin under separate cover, but the overriding themes contained within those comments are summarized in Appendix B.

Goal One: The High Cost of Health Care in Alaska

What's the problem? *The costs of producing quality health care are high, and therefore it is quite expensive to be a consumer of that care. The costs of health care in Alaska are already well above the national average, and like the rest of the nation, are increasing.*

Why this is important: *A new approach to this problem must be embraced if there is to be long-term, positive reform in Alaska's health care system. If Alaska continues along the same path, the results will remain unchanged. Reducing the rate of increase in the costs of health care is a "must do" priority, and Alaskans need to get the best value for health care dollars spent. Every health care dollar must be spent wisely. Broadly stated, the high cost of health care is a barrier to many Alaskans getting the health care they need. The present system supports the high and increasing costs of health care and inefficient utilization of health care dollars.*

What should be done about it: *Decreasing the rate of growth in health care costs in Alaska will require development of a high-quality health care system that is evidence-based, consumer driven and market-responsive. With respect to lowering costs, insurance that is portable and consumer-owned plays a central role, and requires much more discussion at the state level. Overall, giving people more control over their health care dollar is a central component, as is providing appropriate, accessible, transparent, and evidence-based cost and quality information about health care providers and services. In the short-term, one of the most important goals should be state creation of an easily accessible and up-to-date website providing health care cost and quality information to Alaskans. These strategies alone are not sufficient to reduce the overall cost of health care in Alaska, nor to reduce the rate of growth. Closely related are the subjects of personal responsibility, access to health care, increasing the number of health care providers, and insurance.*

Goal Two: The Health Care Workforce

What's the problem? *There are significant shortages in the health care workforce across the state. Alaska needs more health care workers throughout the system, at all levels.*

Why this is important: *Without ample health care workers, the system will continue to falter – it is already showing signs of strain. Lack of a sustainable health care workforce is a primary factor in the increasing costs of health care, and also in the decreasing access of health care for Alaskans. In addition, significant access issues exist in both urban and rural areas, which will likely require expansion of the health care workforce.*

What should be done: *Statewide policy should enable the creation of a sustainable health care workforce that alleviates the current shortage and prevents it from recurring. A good start is to "grow more of our own" within Alaska, by presenting health care professions more prominently as viable career options, with students continually encouraged to build the skills and the interests necessary to pursue health care careers. In the short-term, to increase primary care providers in the state, the number of WWAMI seats should be increased to meet the projected need of 50 per year in the next decade. In concert with that, the University of Alaska nursing doctorate degree should be implemented as well. The number of resident positions in the Family Practice Residency Program should be increased, as should the number of graduates in both the UA Nursing and Nurse Practitioner Programs.*

Goal Three: Sustainable Rural Water and Wastewater Systems

What's the problem: *Water and wastewater systems in many rural communities are inadequate, unsafe, or non-existent, and can be a major cause of health problems within those communities.*

Why this is important: *There is a strong correlation between the health of Alaska's rural residents, and water and wastewater safety. Building and operating clean drinking water and wastewater disposal systems is one of the most effective means for improving the health and wellness of rural Alaskans and rural communities.*

What should be done: *There is an active state program in place to bring sustainable and safe drinking water and wastewater disposal systems to all of Alaska's rural communities – the Village Safe Water Program. However, the real success of that program depends on the recognition by state policy makers that there is no "one size fits all" approach to bringing those systems to rural Alaska. What works in one community may not work in another. Efforts to provide infrastructure that the community can support in the future should continue. The state's long-term health care policy, therefore, should improve and ensure the state's adherence to the "plan" for bringing sustainable and appropriate safe water and wastewater systems to every Alaskan community.*

Goal Four: Access to Health Care

What's the problem? *Accessing quality health care is difficult for many Alaskans, both urban and rural. There is little consistency of access to health care for all Alaskans – some have it all the time, some have it some times, and some have it hardly at all. In Alaska's urban areas there is a lack of access to necessary specialized care and efficient "same-day" primary care. In rural communities, there is often no access at all to health care because of a variety of barriers, including costs, geography, transportation challenges, lack of providers and much more.*

Why this is important? *The lack of access to quality health care contributes to Alaskans' wellness challenges. Being able to guarantee timely access to primary care, in particular, presents significant challenges; but appropriate primary care is one of the most effective means for keeping Alaskans healthy. There was considerable discussion among members about the positive impact of Community Health Centers, and the state's public health nurses, in providing greater access to health and health care opportunities.*

There was agreement among Council members on two major points relevant to health care access. First, Community Health Centers (CHCs) are a valuable part of the "health care safety net" for Alaskans. Second, the state's public health nursing structure is one of the most important mechanisms for affording greater access to a wider range of health care. The problem with CHCs and public health nursing is that both programs are under-funded. Community Health Centers are federally funded, and most states provide supplemental financial assistance because CHCs are viewed as an important part of the overall health care system in those states. Partly due to the provision of health care services to the under-insured and uninsured, CHCs consistently face budgetary challenges. In Alaska, CHCs receive virtually no funding from the state. Similarly, the state's public health nursing system has been chronically under-funded for years. Ever-decreasing state dollars for the Public Health Division has meant that fewer and fewer public health nurses are able to do their important work improving the health of Alaskans.

What should be done: *Accessing health care should not be difficult for Alaskans, and broad policies that improve access to primary care and behavioral health care should be the focus of any state health care policy. Strategies should include: 1) the state becoming more actively engaged as an active investor in the Community Health Center system through supplemental funding and regulatory relief; 2) appropriate funding for and utilization of the state's Public Health Division, in particular the Public Health Nursing program; 3) building monetary and other incentives into the health care system which encourage Alaskans to more effectively utilize primary care opportunities; 4) leveraging information technologies such as tele-health and electronic health record systems which can improve access while reducing costs; and 5) reducing barriers to private clinicians practicing in underserved areas. In the very short term, the state could take the lead in guaranteeing that the required "match" associated with the current $10 million Federal Communications Commission tele-health grant is made.*

Goal Five: Prevention and Personal Responsibility

What's the problem: *Prevention and personal responsibility play too small a role in health care, including maintaining and improving health. While Alaskans may understand the connection between their lifestyle choices and their individual health, for the most part they do not make a connection between personal choices, having a personal stake in their health, and the cost of their health care. Alaskans are not optimally encouraged and equipped to make the kinds of choices that improve health and subsequently decrease health care costs.*

Why this is important: *More healthy Alaskans translates into fewer sick Alaskans, and improved quality of life with resultant cost savings. A clear understanding of the role of personal choice in individual health status and the impact on health care costs, as well as the central role of government in supporting health choices, are critical components in developing long-term strategic health and health care policies.*

What should be done about it: *Solving this problem requires a two-pronged approach. First, Alaskans must be encouraged to play a much greater role in their own wellness by having both a personal and financial "stake" in their own health. Having a "stake" in their own health is the product of a personal investment in wellness, and realizing the financial benefits of saved dollars by maintaining healthy lifestyles. In the opinion of the Council, the most effective mechanism for increasing the personal health investment of Alaskans is incentivizing and supporting positive change.*

Second, governments, school districts, tribal entities and other employers are uniquely situated to be catalysts for positive change. These entities have the influence to help Alaskans understand and make healthy choices, while at the same time avoiding those lifestyle decisions that contribute to poor health.

Goal Six: Statewide Leadership

What's the problem: *A lack of consistent statewide leadership makes development of comprehensive statewide health and health care policy challenging.*

Why this is important: *Public leaders have a pivotal role as catalysts for positive change. Commitment at the executive and legislative levels to comprehensive and lasting change will effect health and health care in Alaska.*

What should be done about it: *The Council believes that government has an obligation to "jump start" healthy choices through incentives, and in addition build the necessary incentive structures for the future. Positive change will be the result of a concerted effort by the governor and the legislature, through partnering with local communities, in a long-term commitment to maintain positive momentum. The key is elevating the discussion of health and health care to the statewide level.*

One of the most effective mechanisms for solidifying that long-term commitment to bringing positive change to Alaska's health care system is to establish through statute a quasi-independent "Alaska Health Care Commission," which would seek to provide advice on innovative solutions, and act as a catalyst for positive change. The Commission would be responsible for advising state leaders on incentivizing positive lifestyle choices; fostering ongoing research; controlling health care costs; improving access, and ensuring a sustainable health care workforce.

Goal Seven: Health Insurance

What's the problem: *Over 100,000 Alaskans – including more than 14,000 children – are without health insurance at some time during any given year. When insurance is made available, there is often a misconception that it should cover everything, from routine and predictable events to catastrophic occurrences and long-term care; this misconception increases the cost of health insurance beyond the reach of many Alaskans.*

Why this is important: *Having access to health insurance coverage is one of the most significant determinants of access to appropriate health care. Alaskans who do not have health insurance are often unable to get the services they need to become healthy, and to maintain wellness.*

When uninsured Alaskans do seek health and health care services, it is often for expensive chronic conditions which could possibly have been avoided if they had had health insurance coverage, or access to appropriate primary care. When Alaskans who may not be eligible for Medicaid and Denali KidCare do access health care, they are often unable to pay and often seek care in a hospital emergency room, which is the most expensive and inefficient mechanism for receiving primary care. The costs of such access are borne across the whole health care system, which raises the overall costs of health care in Alaska. When the uninsured who are not eligible for Medicaid and Denali KidCare do pay for health and health care services, they often do so at significant personal and family financial impact.

Not having insurance is only part of the problem, and simply providing insurance under the current structure is not the answer. With the exception of preventative health services, comprehensive health insurance is not an efficient way to pay for routine and predictable care, such as the common cold, ear infections, hang nails, and sprained ankles. Whereas health insurance IS the most important tool for protecting people from unplanned catastrophic health events, it is an inefficient way to pay for routine expenditures. Therefore, the current system, which relies on insurance to pay for routine and predictable health care expenses, raises the costs of premiums above the reach of many Alaskans.

What should be done about it: *More Alaskans need to be covered by efficient health insurance plans. Increasing the number of Alaskans covered by efficient health insurance will be the result of several specific actions. In the short-term, the Council recommends that the state immediately pursue and support change in the Denali KidCare program to make Alaskan children in families at 200% of the federal poverty level eligible for coverage. While there was a majority vote among Council members regarding this expansion of Denali KidCare coverage, the role of that program within an efficient and effective system of health care coverage is worthy of continued debate at the statewide level, through the recommended "Alaska Health Care Commission."*

To most effectively cover the adults and remaining children without health insurance, bringing consumerism to the forefront of Alaska's health insurance structure is important. Alaskans should have access to choices, through a wide range of health insurance options, including at the very least high deductible coverage with a strong prevention component. The key to success is insurance that at least covers catastrophic care, so no Alaskan suffers from the extreme financial burden of catastrophic or unanticipated health events. Whereas some uninsured Alaskans are not working, most are working for employers who would like to, but cannot necessarily afford to, provide health insurance coverage for their employees. Therefore, through incentives, Alaskan employers should be encouraged to offer a wide range of coverage choices, to include at a minimum, high deductible coverage.

Consumerism is an essential component of bringing rationality to the health insurance structure in Alaska, and extending coverage to as many Alaskans as possible. The key to success is insurance that at least covers catastrophic care, so no Alaskan suffers from the extreme financial burden of catastrophic or unanticipated health events. In addition, insurance must be consumer-owned, market-responsive and portable; this recommendation has received attention elsewhere in this report. Coverage options debated in the Council's discussions, which are by no means exhaustive, include Health Savings Accounts, Health Opportunity Accounts, and high-deductible plans with a strong prevention component. This list provides a solid foundation from which to continue the ongoing discussion about expanding health care coverage for all Alaskans.

Summary and Conclusions

Resolving the health and health care issues in Alaska will not be the result of a single solution. Instead, bringing real and lasting change means working together in partnership. Many of the solutions presented within this report fall squarely within the purview of state government. But no matter how committed state government is, solutions will not be forthcoming without involving all stakeholders as partners for change – from individual Alaskans to families, nonprofit organizations and private sector employers and employees, communities and local governments, tribal entities, state government, the governor, the legislature, and the federal government.

The Council has deliberately not prioritized solutions for solving the problems it has identified with the health and health care system in Alaska. Indeed, all of the problems must be addressed concurrently if real, long-term change is to take place. Having said that, within those identified by the Council, one is definitely the larger-order problem, meaning if we can solve it, many of the other problems will be alleviated. That problem is the lack of prevention and personal responsibility.

By improving the place of prevention and personal responsibility in the health and health care decision-making rubric of Alaskans, costs of health care could be lower than they otherwise would be. With concentration on a wellness model of health care, as well as state support for the Community Health Center system and a robust public nursing program, the current access problems could be significantly reduced. Most Alaskans will have both the motivation and the means to maintain their own wellness. And with greater wellness, the composition of the health care workforce will likely change, decreasing the dependence on health care professionals who are the most difficult and most expensive to attract and retain.

Becoming the healthiest people in the nation is indeed a grand vision – but it is real and achievable.

Respectfully Submitted,

The Alaska Health Care Strategies Planning Council
December 23, 2007

Appendix A: Strategy Implementation Table

2008 / 2009 / 2010 / 2011 / 2012 / 2013 / 2014

Short-Term Strategies *(for implementation between 2008 and 2010)*	Action Required (Policy, Regulation, Statute)	Expense	Implementation Timeline
• Create an ongoing and quasi-independent "Alaska Health Care Commission."			
• Promote incentives for clinic use, rather than the use of emergency rooms for routine/primary care.			
• Promote the use and expansion of Community Health Centers throughout the state.			
• More effectively target recruitment of health care professionals by marketing Alaska to rest of nation/world as a great place to live, work, raise a family, enjoy nature, etc.			
• Conduct a comprehensive, statewide health care workforce assessment.			
• Continue to support Alaska Native Tribal Health Consortium's ongoing efforts to develop sustainable, community-specific water and wastewater capacity in all villages.			
• Increase quality of and access to Telemedicine, Community Health Aides/Practitioners, Community Mental Health Aides and Community Dental Health Aides.			
• Implement a prevention-focused "Fit for Life" social marketing program that is multigenerational and culturally aware.			
• Emphasize the role of the public health nurses in prevention and wellness – from well-baby checks on up to flu shots for elders.			
• Support programs to encourage employers to offer employees "time off" for making healthy lifestyle choices and maintaining wellness.			
• Institute "Silver Sneakers Programs" – for elders – to keep elders healthy.			
• Ensure public health immunization funding.			
• Fund free and/or low-cost clinics, keeping in mind uninsured Alaskans.			
• Incorporate a "Wellness Certificate" into the PFD program, and give a five percent boost in the dividend for maintaining a healthy lifestyle.			
• Foster a state culture through policy that rewards schools for wellness.			
• Provide financial incentives for "healthy schools."			
• Support the ongoing efforts to establish comprehensive health care insurance options to employees of Alaska's nonprofit sector.			

• Pay the tuition – or forgive student loans – for residents from rural Alaska who are willing to practice – after graduation – in their home community.			
• Institute student loan forgiveness for medical/health professionals and para-professionals who make a commitment to stay in Alaska.			
• Provide grants for low-income vocational/tech students in Certified Nurses Assistant/Pharmacy Tech programs.			
• Increase the presence of public health system, particularly public health nurses, especially in rural communities.			
• Follow through on existing state plans for safe drinking water and wastewater, through the Village Safe Water Program and other efforts.			
• Support and expand telemedicine and tele-behavioral medicine – include education, maintenance and equipment upgrades.			
• Increase behavioral health training and support,			
• Increase available slots in Physician Assistant and Nurse Practitioner programs at the University of Alaska and with other academic partners.			
• Increase number of Residents in Family Practice Residency Program.			
• Create a greater awareness of the distinction between routine and predictable health care costs (less expensive) and unanticipated or catastrophic costs (more expensive).			
• Promote Health Savings Accounts and high deductible insurance plans – for individuals and employers.			
• Provide incentives for providers and consumers, with performance measures and rewards (for providers), based on evidence-based results.			
• Foster better informed consumers through creation of a dynamic (continuously updated) website providing transparent quality and cost information about medical services, prescriptions, etc.			
• Build teaching capacity in K-12 schools to excite young Alaskans about the physical sciences generally, and the health care field in particular.			
• Increase penalties for selling alcohol to youth.			

Long-Term Strategies *(for implementation between 2010 - 2014)*	Action Required (Policy, Regulation, Statute)	Expense	Implementation Timeline
• Support information technology improvements.			
• Promote insurance that is portable, consumer-focused and consumer owned, purchased with pre-tax dollars.			
• Increase Alaska WWAMI seats to 50 /year – the projected need to meet demand in the next 10 years.			
• Institute doctoral NP program at UAA.			
• Increase the availability of education programs for health care disciplines.			

• Expand State role in direct funding of and improving access to Community Health Centers.			
• Foster a consumer-directed health care approach to long-term care.			
• Encourage the implementation of a consumer-directed health care system.			
• Integrate "consumerism," encouraging people to shop around for the best quality and appropriate cost and consider personal responsibility.			
• Encourage formation of Tobacco Free communities, businesses and workplaces through Statewide Clean Indoor Air Act.			
• Institute/Increase Alcohol taxes.			
• Increase fluoride in drinking water.			
• Reduce barriers to establishing and running CHCs: (state and federal red tape).			
• Where establishing a CHC is difficult, encourage creation of public-private partnership in creating primary/urgent care clinics.			

Appendix B: Summary of Public Comment Received by the Council

- Support the Community Health Centers as a way to improve access and decrease use of the emergency room for primary care.
- Improve e-health
- Increase workforce, specifically mid-level practitioners
- Incorporate incentives to attract and retain necessary health care workers, including loan forgiveness and other repayment incentives
- Make sure to get the mix right of what is needed in the health care workforce
- Recruitment programs are best done in state
- Build interest in the health care field at the middle and high school level
- Develop a statewide group with oversight responsibility for recruitment and retention – because it cost too much for individual organizations to do it
- Eliminate shortage of UA educators in health care professions
- Put fluoride in rural water systems
- Improve the place of preventative dental service in the health care continuum
- Prevention, collaboration and partnerships are the key to improving access
- Building existing programs makes the most sense, versus making new programs and the associated structures
- Remove bureaucratic barriers to effective health care access
- Examine innovative solutions that involve Medicaid reimbursement
- Acknowledge and build upon the work of public health nurses and the public health nursing program
- Include alternative treatments when talking about prevention and personal responsibility
- Improve worksite health as a cost-saver
- Most feel there should be basic, portable insurance coverage for all Alaskans
- Concentrate on preventing sickness rather than curing it
- Should be at least some mechanism to insure a minimum coverage for all Alaskans
- People with disabilities have real trouble finding primary care – the state should close the gap in those services
- Alaskans need a range of services that are affordable – maybe the state should subsidize those services
    - Don't forget the severely disadvantaged - Alaska's working poor
- Funding for substance abuse and mental health are effective preventative services, which lead to increase wellness
- State must support the e-health FCC grant
- State should not be shy about supplementing the loss of federal Medicaid dollars with state support
- Behavioral health in Alaska has taken huge cuts, and the system is on the verge of crisis
- The broadly stated goals of the Council really skip over the importance of behavioral health and substance abuse as preventative factors

- Oral health needs to play a more significant role in overall health
- Need more dental techs in the health care workforce
- Realize that turning 65 in Alaska means no more health care for most elders
- Make it easy for people to navigate the health care system – now it is really difficult
- Remove barriers that prevent Alaskans from receiving necessary primary care, and to get Denali KidCare after birth
- There MUST be a continued forum for addressing health care issues in the long term

Appendix C: Alaska Health Policy Council Members

The council is composed of 14 Alaskans appointed by the governor:

- Jeff Davis of Anchorage has served as president of Premera Blue Cross Blue Shield of Alaska for nine years, which provides insurance for 180,000 Alaskans statewide.
- Cathy Giessel of Anchorage is a registered nurse and advanced nurse practitioner whose career and experience spans more than 30 years.
- Dr. Derek Hagen of Anchorage is a doctor of osteopathy associated with Primary Care Associates, the largest private family practice in the state.
- Thomas Hendrix, PhD, of Anchorage is an assistant professor at the University of Alaska School of Nursing specializing in the policy, economics, assessment, and fundamentals of health care.
- Don Kashevaroff of Anchorage is the chair and president of the Alaska Native Tribal Health Consortium, and serves as the primary spokesman for the Consortium regarding state and federal funding, legislation, and regulatory issues.
- Brian Slocum of Fairbanks is the administrator at Tanana Valley Clinic, the largest multi-specialty, multi-site practice in Alaska.
- Dr. Michael Carroll of Fairbanks is a private practice physician, specializing in internal medicine and oncology.
- Donna Fenske of Homer served the State of Alaska as a public health nurse from 1979 to 2004 and most recently has provided community health aide services in Port Graham and Nanwalek clinics, and nursing services to K-12 students in rural communities in the Kenai Peninsula Borough School District.
- Steve Horn of Soldotna is the executive director of the Alaska Behavioral Health Association whose members are the businesses that provide direct services to recipients of behavioral health services throughout the state.
- Dr. Cathy Baldwin-Johnson of Wasilla is a private practice family physician and the 2002 National Family Physician of the Year from the American Academy of Family Physicians.
- Karen Rhoades of Wasilla is the owner and operator of Northern Living Centers, a five bed assisted-living home.
- Tim Joyce of Cordova is a three-term mayor of the City of Cordova who has dealt with escalating community medical costs, a constant turnover of medical center administrators and a community medical center that is continually in need of city assistance.
- Rod Betit of Juneau is the president and CEO of the Alaska State Hospital and Nursing Home Association (ASHNA), a not-for-profit association with members representing hospitals, nursing homes, and Native Alaska health care providers.
- Dr. Bob Urata of Juneau has served as a family physician for over 23 years, and has served on the Bartlett Regional Hospital Board of Directors.
- Commissioner Karleen Jackson managed the Health Council. Serving as ex-officio, non-voting members were Senator Bettye Davis and Representative Peggy Wilson, chairs of the Health, Education and Social Services committees in the Alaska State Legislature.

Alaska State Legislature

Interim: (May - Dec.)
716 W. 4th Ave
Anchorage, AK 99501
Phone: (907) 269-0144
Fax: (907) 269-0148

Session: (Jan. - May)
State Capitol, Suite 30
Juneau, AK 99801-1182
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Senator_Bettye_Davis@legis.state.ak.us
http://www.akdemocrats.org

Senator Bettye Davis

Senate Bill 300: Health Care: Plan/Commission/Facilities

"An Act establishing the Alaska Health Care Commission and the Alaska health care information office; relating to health care planning and information; and providing for an effective date."

Bill Summary

Senate Bill 300 is a mirror of section 1 & 2 of SB 245 and excludes all eliminates of the Certificate of Need.

Senate Bill 300 creates the Alaska Healthcare Commission which would provide oversight to the Alaska Health Information Office. The Alaska Healthcare Commission would also create policy for the healthcare industry of Alaska promoting the constitutional obligation of the State to "protect and promote the public health". This 15 member commission would be made up of the Department of Health & Social Services Medical Director who would chair the commission; (1) Governor's representative; (1) member of the Commission on Aging; (3) public members appointed by the governor, one of which must be a small business owner; (3) public members representing the healthcare providers, physicians, and mental health, respectively; (2) Members of the Alaska State Legislature House of Representatives, (2) members representing the Alaska State Legislature Senate; (1) Member representing the Alaska Tribal Health care system; and (1) member representing the health care insurers.

Senate Bill 300 would also creates the Alaska Information Office which will provide data to Alaskans through the internet. This data would include medical costs comparisons, the top 100 medical prescriptions within the state, the top 100 medical procedures preformed within the state, and available hospital ratings, and consumer educational information.

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

March 12, 2008

Honorable Bettye Davis
Chair, Senate Health, Education and Social Services Committee
State Senate
State Capitol, Room 30
Juneau, AK 99801-1182

Transmitted by email: Senator_Bettye_Davis@legis.state.ak.us

RE: SB300 - Alaska Health Care Commission and Alaska Health Care Information Office

Dear Senator Davis:

The Alaska State Medical Association (ASMA) represents physicians statewide and is primarily concerned with the health of all Alaskans.

ASMA supports the concept of the establishment of the Alaska Health Care Commission (AHCC). However, ASMA might recommend that more than one seat be slotted for physicians. ASMA believes the AHCC purpose would be better served by physician members from diverse geographic areas as well as physicians representing different medical specialties.

ASMA appreciates and understands what SB300 is attempting to accomplish by the formation of the Alaska Health Care Information Office (AHCIO) and with the establishment of the internet based information database. However, ASMA can not support the provisions in SB300 creating the AHCIO and the data base for a host of reasons including drafting created questions, scope of its application, practical issues, and potential serious legal issues. Those concerns are summarized as follows:

- **Drafting/Definition Issues**
  - **No definition of "physician office"**
  - **"physician office" included in the definition of a facility which creates confusion in applicable provisions**
  - **No definition of a "medical procedure" (i.e. no common nomenclature such as CPT codes)**
  - **No definition of "health care providers"**
  - **No definition of "Types" of insurance**
  - **No definition of "amounts" of insurance**
  - **No definition of "actions" taken by Regulatory Agencies (e.g. after formal adjudication?)**
- **Legal Issues**
  - **Impairment of Contract**
  - **ERISA Pre-emption**
  - **Equal Application (e.g. dentists, chiropractors, advanced nurse practitioners, and optometrists not covered by SB300)**
  - **Confidentiality of Underlying Data which is reported**
- **Practical and Cost Issues**
  - **Frequency of Required Reporting May Impact Cost to Physicians as well as the Department**
  - **Unclear what "the costs to consumer" actually means (Does "actual" mean the actual cost after deductibles, co-pays, or other limitations in the insurance coverage?)**

(ASMA's comments will generally apply to physicians but some may be applicable to other health care professionals as well.)

The more detailed comments relating to the above summary follow.

First, the way in which the provisions creating AS18.09.100 through AS18.09.990, by including in the definitions of "health care facility" (AS18.09.990 (4)) a "physician's office" (AS18.09.990 (4)(F)), creates non-sensical practical situations. For example, what does it mean in AS18.09.120 (1) (p.9 lines 9-10) regarding a physician office to split costs between a facility component and a physician component. This is a provision more suited to in-patient hospital care. Please also note the term "physician office" is not defined. Does this mean each individual physician practice, each individual licensed physician, etc?

AS18.09.110 (p.7 lines 11-12) states the Department "may" require health care facilities to report data. This states the Department has discretion. Yet AS18.09.120 requires mandatory reporting beginning July 1, 2009. Does this mean the Department has discretion only between July 1, 2008 and July 2, 2009 as far as requiring reporting of the required data? It would also seem to be a daunting task for the Department to review the data individually with each physician licensed in this state.

AS18.09.110 (b)(E) (p.7 lines 25-27) requires that the data base has a listing of all licensed "health care providers" in the State. The term "health care providers" is not defined but could include those not covered by the provisions of this bill. For example, dentists, advance nurse practitioners, chiropractors, optometrists, etc. could fall in this category. Why would these health care providers not be covered by the requirements of SB300 while others are by being defined as a "health care facility"? This would also appear to be an unequal application of the law should SB300 be passed in its current form, and may not provide for the collection of data from other health care professionals that could be important to the consumers of health care.

AS18.09.110 (b) (4) (p.8 - lines 2-5) requires that the data base include a list of the 100 most commonly conducted medical procedures. The terms "medical procedure" is not defined and needs to be so common nomenclature is used - for example CPT codes for physicians. It is not specified but it is presumed that the reporting health care facilities, as defined, would need to report data on all the medical procedures provided. It could be the most commonly conducted procedures would be the lowest cost procedures. Potentially, the most expensive, least conducted, rare procedures would never be included in the data base. Another requirement of this provision, as well as AS18.09.120 (2) (p.9 line 12), requires respectively that the data base include and the health care facility provide the "cash" and "negotiated" price of a procedure. A "negotiated" price may, indeed, be the result of a contract entered into by a physician and a health insurance company. For competitive reasons, neither the physician nor the health insurance company may not want the terms of such documents disclosed. (Due to the small size of the health care community in Alaska, de-identified data may not solve this problem). This could provide for a legal issue surrounding impairment of contract. At a minimum, it could also result in a physician opting not to provide the data and have the department post on the data base that physician's failure to provide the information. (It is also possible that the terms of the contract could prohibit such disclosure). Another more serious issue is also raised.

The presumption, in the absence of any specific language in SB300, is that a physician would be required to report the "negotiated" price pursuant to a contract with a health insurer for fully insured plans as well as with self-insured plans. Having such a requirement apply to self-insured plans may be pre-empted by federal law and could not apply. The federal law is the Employee Retirement Income Security Act of 1974 (commonly known as ERISA). ERISA pre-emption issues are very complex and ASMA is not aware of any attorneys who are experts who live in Alaska. If ERISA pre-empts such reporting for physicians for self-insured plans, the data base's value would seemingly be greatly diminished, as reportedly a significant number of Alaskan's have health plans that are self-insured.

AS18.09.110 (b) (12) (p.8 lines 25-26) requires that actions taken by state of federal agencies be included in the data base. It is not clear if this requirement means that "actions" are those that are after final adjudication or if this includes initial allegations. It is recommended that a reported "action" be an action that has been fully adjudicated.

AS18.09.120 (a) (p.9, lines 5-7) addresses a reporting schedule set by the Department. The costs of reporting this data will vary with how often the data must be reported. Legislative guidance would be welcomed as to frequency of reporting. Should it be monthly, quarterly, semi-annually, annually, or whenever any price changes? The frequency also impacts the Department costs as well in part because it is required to review the data that goes onto the web site with those persons who provided it.

AS18.09.120 (a) (1) (p.9 lines 9-10) requires that physicians report "costs to and bills payable by the consumer...". AS18.09.990 (2) defines "costs to the consumer" as the actual price paid by the consumer. This language is unclear as to exactly what would need to be reported. Does this mean that what the consumer pays after the health plan pays (i.e. out of pocket after deductibles, co-pays, limitations, etc)? If so, this could be a daunting if not impossible task for the physician to determine because the amount owed changes as deductibles are met, co-pays decreased, to include just a few of the variables.

AS18.09.120 (a) (2) (p9, lines 11-12). This provision requires a physician to report the "...types and amounts of insurance..." accepted. The "types" of insurance should probably be defined even though it appears to be clear what is meant - private health insurance, Medicaid, Medicare, Worker's Compensation, etc. What is not known and needs definition is the term "amounts of insurance". Perhaps the insurance industry may provide you guidance in this area as ASMA has no idea of what this means.

Generally, there is no language that addresses the confidentiality of the underlying data - de-identified or not. Obviously the data on the internet would be available for all to see. But, the question remains if the underlying data in the Department's possession is subject to public inspection via a freedom of information request or other means. Transparency is usually a good element but it must not be at the cost of appropriate privacy and constitutional protection.

Due to the complex legal and practical issues raised, ASMA believes a great deal of work is necessary. ASMA does not see how these issues can be thoroughly researched and addressed in the time remaining in this session. ASMA would support the creation of the Alaska Health Care Commission and would commit to providing the names of a sufficient number of physicians to accomplish its work. Furthermore, it is recommended that the Alaska Health Information Office and the development of an appropriate data base not be addressed at this time in legislation. ASMA would suggest that the Alaska Health Care Commission itself be given the direct charge to develop a recommendation as to the formation of the Alaska Health Information Office and the development of a database in a manner that addresses the issues raised by ASMA and, certainly, other stakeholders.

Sincerely,

By: J. Ross Tanner, DO, President
For: The Alaska State Medical Association

STATE OF ALASKA
DEPT. OF HEALTH & SOCIAL SERVICES

Alaska Commission on Aging

SARAH PALIN, GOVERNOR

P.O. BOX 110693
JUNEAU, ALASKA 99811-0693
PHONE: (907) 465-3250
FAX: (907) 465-1398

March 12, 2008

The Honorable Bettye Davis, Chair
Senate Health, Education, and Social Services Committee
Alaska State Capitol, Room 30
Juneau, AK 99801-1182

Subject: Support Letter for SB 300, Creation of the Alaska Health Care Commission and the Alaska Health Care Information Office

Dear Chair Davis:

The Alaska Commission on Aging (ACoA) supports your sponsored legislation, SB 300, to create the Alaska Health Care Commission and the Alaska Health Care Information Office, and encourages members of the Senate HESS Committee to support this legislation as well.

The ACoA supports SB 300 because of its focus on improving public health outcomes that includes, as part of the Alaska Health Care Commission's responsibility, the directive to develop a statewide plan which: (1) identifies strategies to improve access to quality health care for all Alaska residents; (2) reduces the rate of growth in health care costs; (3) addresses the problem of workforce shortages by building Alaska's workforce capacity, which is particularly critical at this time to meet the health care needs of a growing aging population and when many health care providers are retiring or have plans to retire in the next five years; (4) improves community access to safe drinking water and wastewater systems; and (5) encourages the role of prevention and healthy lifestyles. It is also our understanding that this legislation would authorize the Alaska Health Care Information Office to create a data base that would list primary care clinics that cater to the uninsured and self-pay patients, physicians who accept patients with Medicare coverage, and information on the quality of health care facilities, among other useful consumer information.

These are all issues that are of utmost importance to older Alaskans who are increasingly challenged in obtaining access to primary care services because of physicians refusing to serve Medicare patients due to inadequate Medicare reimbursement rates in addition to the high cost of health care as a whole which is central to maintaining access for all Alaskans. Moreover, the measures identified in SB 300 can help to improve the transparency of health care services and reduce cost by offering comparative information on prices and quality measures to aid consumers in making informed health care decisions.

The ACoA very much appreciates having a seat reserved on the Alaska Health Care Commission to offer a voice for older Alaskans on decisions affecting health care services in our state.

We thank you for your consideration of our support for SB 300. Please feel free to contact Denise Daniello, ACoA's executive director at 465-4879, should you have questions regarding our position on this bill or desire further information.

Sincerely,

Banarsi Lal
Chair, Alaska Commission on Aging

Sincerely,

Denise Daniello
ACoA Executive Director

CC: Senator John Cowdery
Senator Fred Dyson
Senator Kim Elton
Senator Joe Thomas

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 3/6/08

FURTHER: Finance

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: 3/14/08

Health, Education and Social Services Committee considered

SENATE BILL NO. 300

SB 300 HEALTH CARE: PLAN/COMMISSION/FACILITIES

"An Act establishing the Alaska Health Care Commission and the Alaska health care information office; relating to health care planning and information; and providing for an effective date."

and recommends:

[X] be **replaced** with [ ] **SCS** or [X] **CS** SB 300 (HESS)

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** forthcoming

[ ] attached amendment(s)

[ ] adopt _____ Letter of Intent

[ ] further referral to _____ Committee

SENATE BILL:
[ ] Same Title
[ ] New Title

HOUSE BILL:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Invest.	Lapse	FY#
H.S.S	3/10	✓			
H.S.S	3/10	✓			
H.S.S.	3/10	✓			

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal			FY#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS	PRINTED LAST NAME	DO	DO NOT		
	Elton	✓			
	Thomas	✓			
	Dyson		✓		
	Coghill	✓			
~~Bettye Davis~~	~~DAVIS~~	~~✓~~			
CHAIR: Bettye Davis	DAVIS	✓			

25-LS1559\C
Mischel
3/14/08

CS FOR SENATE BILL NO. 300(HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FIFTH LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

A BILL

FOR AN ACT ENTITLED

"An Act establishing the Alaska Health Care Commission and the Alaska health care information office; relating to health care planning and information; relating to a certificate of need study; and providing for an effective date."

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

*** Section 1.** AS 18.05.010(b) is amended to read:

(b) In performing its duties under this chapter, **AS 18.09.** and AS 18.15.355 - 18.15.395, the department may

(1) flexibly use the broad range of powers set out in this title assigned to the department to protect and promote the public health;

(2) provide public health information programs or messages to the public that promote healthy behaviors or lifestyles or educate individuals about health issues;

(3) promote efforts among public and private sector partners to develop and finance programs or initiatives that identify and ameliorate health

problems;

(4) establish, finance, provide, or endorse performance management standards for the public health system;

(5) develop, adopt, and implement

(A) a statewide health plan under AS 18.09 based on recommendations of the Alaska Health Care Commission established in AS 18.09.010; and

(B) public health plans and formal policies through regulations adopted under AS 44.62 or collaborative recommendations that guide or support individual and community public health efforts;

(6) establish formal or informal relationships with public or private sector partners within the public health system;

(7) identify, assess, prevent, and ameliorate conditions of public health importance through surveillance; epidemiological tracking, program evaluation, and monitoring; testing and screening programs; treatment; administrative inspections; or other techniques;

(8) promote the availability and accessibility of quality health care services through health care facilities or providers;

(9) promote availability of and access to preventive and primary health care when not otherwise available through the private sector, including acute and episodic care, prenatal and postpartum care, child health, family planning, school health, chronic disease prevention, child and adult immunization, testing and screening services, dental health, nutrition, and health education and promotion services;

(10) systematically and regularly review the public health system and recommend modifications in its structure or other features to improve public health outcomes; and

(11) collaborate with public and private sector partners, including municipalities, Alaska Native organizations, health care providers, and health insurers, within the public health system to achieve the mission of public health.

*** Sec. 2.** AS 18.05.010(b), as amended by sec. 1 of this Act, is amended to read:

(b) In performing its duties under this chapter, AS 18.09, and AS 18.15.355 -

18.15.395, the department may

(1) flexibly use the broad range of powers set out in this title assigned to the department to protect and promote the public health;

(2) provide public health information programs or messages to the public that promote healthy behaviors or lifestyles or educate individuals about health issues;

(3) promote efforts among public and private sector partners to develop and finance programs or initiatives that identify and ameliorate health problems;

(4) establish, finance, provide, or endorse performance management standards for the public health system;

(5) develop, adopt, and implement

(A) a statewide health plan under AS 18.09 [BASED ON RECOMMENDATIONS OF THE ALASKA HEALTH CARE COMMISSION ESTABLISHED IN AS 18.09.010]; and

(B) public health plans and formal policies through regulations adopted under AS 44.62 or collaborative recommendations that guide or support individual and community public health efforts;

(6) establish formal or informal relationships with public or private sector partners within the public health system;

(7) identify, assess, prevent, and ameliorate conditions of public health importance through surveillance; epidemiological tracking, program evaluation, and monitoring; testing and screening programs; treatment; administrative inspections; or other techniques;

(8) promote the availability and accessibility of quality health care services through health care facilities or providers;

(9) promote availability of and access to preventive and primary health care when not otherwise available through the private sector, including acute and episodic care, prenatal and postpartum care, child health, family planning, school health, chronic disease prevention, child and adult immunization, testing and screening services, dental health, nutrition, and health education and promotion services;

(10) systematically and regularly review the public health system and recommend modifications in its structure or other features to improve public health outcomes; and

(11) collaborate with public and private sector partners, including municipalities, Alaska Native organizations, health care providers, and health insurers, within the public health system to achieve the mission of public health.

* **Sec. 3.** AS 18 is amended by adding a new chapter to read:

Chapter 09. Statewide Health Care Planning and Information.

Article 1. Alaska Health Care Commission; State Health Plan.

Sec. 18.09.010. Alaska Health Care Commission. The Alaska Health Care Commission is established in the Department of Health and Social Services. The purposes of the commission are

(1) to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the state;

(2) to review and approve the department's plan for a reporting data system, including the type of reporting entity or person, and the timing of reporting; and

(3) to review and approve facility health care information for placement on the department's Internet database established under AS 18.09.110.

Sec. 18.09.020. Composition; chair. (a) The commission consists of 15 members, as follows:

(1) the state officer assigned the duties of medical director for the department;

(2) one member representing the governor and appointed by the governor;

(3) one member who is a member of the Alaska Commission on Aging;

(4) three public members, in addition to members appointed under (5), (8), and (9) of this subsection, appointed by the governor; one of the members appointed under this paragraph must be a small business owner in the state;

(5) three public members who are health care providers, appointed by the governor, as follows: one representing hospitals, one representing physicians, and one representing mental health;

(6) two members from the house of representatives appointed by the speaker of the house of representatives;

(7) two members from the senate appointed by the president of the senate;

(8) one public member representing the Alaska tribal health care system appointed by the governor; and

(9) one public member representing health care insurers appointed by the governor.

(b) The medical director appointed under (a)(1) of this section shall serve as chair of the commission.

Sec. 18.09.030. Term of office. (a) Public members of the commission appointed under AS 18.09.020(a)(4), (5), (8), and (9) serve for staggered terms of five years.

(b) If a vacancy occurs in a public member's seat on the commission, the governor shall make an appointment for the unexpired portion of that member's term.

(c) The governor may remove a public member of the commission from office only for cause.

Sec. 18.09.040. Executive director. The commission shall employ an executive director with appropriate health care policy experience who may not be a member of the commission. The executive director serves at the pleasure of the commission. The commission shall establish the duties of the executive director. The executive director is in the partially exempt service under AS 39.25 (State Personnel Act).

Sec. 18.09.050. Staff. The department may assign employees of the department to serve as staff to the commission. The commission shall prescribe the duties of the commission staff.

Sec. 18.09.060. Bylaws. The commission, on approval of a majority of its membership and consistent with state law, shall adopt and amend bylaws governing

proceedings and other activities, including provisions concerning a quorum to transact commission business and other aspects of procedure; frequency and location of meetings; and establishment, functions, and membership of committees.

Sec. 18.09.070. Duties of the commission. (a) The commission shall serve as the state health planning and coordinating body. Consistent with state and federal law, the commission shall provide recommendations for and foster the development of a statewide health plan containing the following:

(1) a comprehensive statewide health care policy;

(2) a strategy for

(A) encouraging personal responsibility in prevention and healthy living for all residents of the state;

(B) reducing the rate of growth in health care costs for all residents of the state;

(C) improving access in communities to safe water and wastewater systems;

(D) developing a sustainable health care workforce in the state;

(E) improving access to quality health care for all residents of the state and increasing the number of residents of the state who are covered by insurance for health care services.

(b) The commission shall review and approve health care information for placement on the department's database developed under AS 18.09.110 and establish a schedule for implementation of the database and reporting requirements under AS 18.09.120.

(c) The commission shall submit to the governor and the legislature by January 15 of each year an annual report regarding the commission's recommendations and activities.

Sec. 18.09.080. Compensation, per diem, and expenses. A public member appointed to the commission under AS 18.09.020(a)(4), (5), (8), or (9) is not entitled to a salary, but is entitled to per diem, reimbursement for travel, and other expenses authorized by law for boards and commissions under AS 39.20.180.

Article 2. Alaska Health Care Information Office.

Sec. 18.09.100. Office. The Alaska health care information office is established in the department. The purpose of the office is to improve access by residents of the state to consistently updated

(1) information about health care services, price, and quality to aid consumers in making health care decisions; and

(2) information to encourage personal responsibility in prevention and healthy living.

Sec. 18.09.110. Dissemination of information. (a) The department shall establish and maintain an information database on the Internet of information about health care facilities in the state to provide objective, unbiased, and factually based information on health care services in the state. The department may require those health care facilities to provide information in a standard form or format to the department for placement in the database. Before information is placed on the database, the department shall review the information with the health care facility for accuracy.

(b) The database developed under (a) of this section must include the following:

(1) a list of preferred drugs approved by the department for reimbursement by the department;

(2) a complete list, organized by region and address, of

(A) health care facilities located in the state;

(B) licensed pharmacists and pharmacies located in the state;

(C) emergency and urgent care facilities located in the state;

(D) health insurance companies offering coverage in the state;

(E) health care providers licensed in the state, including the provider license number, type, and expiration date along with disciplinary actions, if any;

(F) long-term, in-home, and hospice care providers located in the state;

(G) public assistance offices of the department;

(3) a list of the 100 most commonly prescribed medications in the state

and the source and price, updated monthly, of the medications;

(4) a list of the 100 most commonly conducted medical procedures in the state, organized by the cash and negotiated price of the procedure at available providers and insurers, updated annually; the list must include medical procedures covered by workers' compensation under AS 23.30;

(5) available hospital ratings, including the rates of hospital acquired infections and mortality occurring at each hospital located in the state;

(6) consumer education information on topics that include body mass index, diet and nutrition, exercise, smoking cessation, and alcohol and drug addictions, that includes the location of available sites that provide care and treatment related to those issues;

(7) a list of procedures approved by state agencies for emergency response and treatment;

(8) disease management support information;

(9) insurance information that includes

(A) a navigator to determine insurance eligibility using a matrix of available insurers;

(B) links to Internet websites for purchasing insurance policies;

(C) an explanation of mandatory and optional insurance coverage;

(10) a list of primary care clinics that cater to uninsured and self-pay patients;

(11) a list of physicians who accept patients with Medicare coverage; and

(12) information on the quality of health care facilities, including any actions taken by state or federal agencies related to

(A) licensure and accreditation of a health care facility; or

(B) a licensed professional practicing in a health care facility.

(c) The department may contract with a private entity to provide services and information required under (a) of this section.

(d) The department shall develop and consistently update an Internet website

to provide residents of the state timely and accurate information regarding prevention and healthy living.

(e) The department shall post and make available information related to the commission, including the commission's annual reports under AS 18.09.070(c).

Sec. 18.09.120. Mandatory reporting. (a) Beginning July 1, 2009, a health care facility shall provide to the department, based on a schedule set by the department, the following information related to the facility's health care services for placement in the database developed under AS 18.09.110:

(1) information on costs to and bills payable by the consumer for health care services that include both facility and physician components of care;

(2) types and amounts of insurance and other payments accepted by the health care facility for health care services, including cash and negotiated prices;

(3) each location where the health care facility operates, and the hours of operation;

(4) the types and scope of health care services offered at the health care facility;

(5) the Internet address of any Internet website of the health care facility the purpose of which is to provide factual information to aid the consumer;

(6) any other readily accessible information that the department determines would help the consumer to make informed decisions about the health care facility's services.

(b) The department shall develop a standard form or format for reporting the information required in (a) of this section. The department shall adopt regulations specifying the timing and frequency of the reporting of the information required by (a) of this section.

(c) The department shall notify the health care facility of a failure to report under (a) of this section and give the health care facility an opportunity to contest or cure the failure. If the health care facility does not promptly cure the failure, the department shall post the notice of failure on the database developed under AS 18.09.110.

Sec. 18.09.130. Coordination of departments. The Department of

Administration, the Department of Commerce, Community, and Economic Development, the Department of Labor and Workforce Development, and the Department of Law shall

(1) provide to the department for placement on the database developed under AS 18.09.110 information regarding an adverse action taken against a health care facility in the state or against a licensed professional practicing in a health care facility in the state; and

(2) cooperate with the commission in the performance of its duties.

Article 3. General Provisions.

Sec. 18.09.900. Regulations. The department may adopt regulations under AS 44.62 (Administrative Procedure Act) to carry out the purposes of this chapter.

Sec. 18.09.990. Definitions. In this chapter,

(1) "commission" means the Alaska Health Care Commission established in AS 18.09.010;

(2) "costs to the consumer" means actual price paid by the consumer for health care services;

(3) "department" means the Department of Health and Social Services;

(4) "health care facility" means

(A) a facility licensed under AS 47.32;

(B) an independent diagnostic testing facility providing services in the state;

(C) a provider of a home and community based waiver service that is certified under regulations adopted by the department;

(D) a provider of personal care services that is certified under regulations adopted by the department;

(E) a licensed pharmacy; and

(F) a physician's office.

* **Sec. 4.** AS 39.25.120(c)(7) is amended to read:

(7) the principal executive officer of the following boards, councils, or commissions:

(A) Alaska Public Broadcasting Commission;

(B) Professional Teaching Practices Commission;

(C) Parole Board;

(D) Board of Nursing;

(E) Real Estate Commission;

(F) Alaska Royalty Oil and Gas Development Advisory Board;

(G) Alaska State Council on the Arts;

(H) Alaska Police Standards Council;

(I) Alaska Commission on Aging;

(J) Alaska Mental Health Board;

(K) State Medical Board;

(L) Governor's Council on Disabilities and Special Education;

(M) Advisory Board on Alcoholism and Drug Abuse;

(N) Statewide Suicide Prevention Council;

(O) the State Board of Registration for Architect, Engineers, and Land Surveyors;

(P) Alaska Health Care Commission;

*** Sec. 5.** AS 18.09.010, 18.09.020, 18.09.030, 18.09.040, 18.09.050, 18.09.060, 18.09.070, 18.09.080, 18.09.110(e), 18.09.130(2), 18.09.990(1); and AS 39.25.120(c)(7)(P) are repealed July 1, 2013.

*** Sec. 6.** The uncodified law of the State of Alaska is amended by adding a new section to read:

TRANSITION: REGULATIONS. The Department of Health and Social Services may proceed to adopt regulations necessary to implement the changes made by this Act. The regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the effective date of the statutory change.

*** Sec. 7.** The uncodified law of the State of Alaska is amended by adding a new section to read:

CERTIFICATE OF NEED STUDY. The Department of Health and Social Services shall contract with an entity that has no financial interest in providing health care services to conduct a comprehensive study of the effects of the certificate of need program in the state. The department shall provide a copy of the study to the legislature.

* **Sec. 8.** Section 2 of this Act takes effect July 1, 2013.

* **Sec. 9.** Section 6 of this Act takes effect immediately under AS 01.10.070(c).

* **Sec. 10.** Except as provided in secs. 8 and 9 of this Act, this Act takes effect July 1, 2008.