SB 172

<target><bill>SB 172</bill><subject>SB 172</subject><comm>HFIN26</comm></target>

ALASKA STATE LEGISLATURE

SENATOR DONALD C. OLSON

ALASKA
STATE CAPITOL
ROOM 508
JUNEAU, ALASKA 99801-1182

(907) 465-3707
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SPONSOR STATEMENT

Senate Bill 172 Alaska Health Care Commission

Alaska is currently facing serious healthcare cost, access and quality issues. Between 1991 and 2005, health care expenditures in our state more than tripled from $1.6 billion to $5.3 billion. Costs are expected to double again by 2013 to over $10 billion. All levels of government – state, local, and federal – are affected, and Alaska's economy cannot sustain this inflationary growth. The purpose of SB 172 is to establish in statute the Alaska Health Care Commission to address the need for health care reform in our state. This issue is complex and broad in scope, and cannot be dealt with adequately unless we have a permanent body to plan and follow through for long range comprehensive health care reform.

The two most recent groups to work on the issue of health care reform in Alaska, the Alaska Health Care Roundtable (2005) and the Alaska Health Care Strategies Planning Council (2007) both recommended that a permanent body be established to address the problem of health care reform. The Roundtable (which met for 2 years) and the Planning Council (which met for 6 months) recognized that the problem is too great to be effectively addressed through a short-term, ad-hoc body.

The Alaska Health Care Commission would be established in the Department of Health and Social Services, and would consist of a thirteen member body including public officials and private citizens. Representatives from both the executive and legislative branches of state government are included, as well as citizens representing the private business sector, the health care community, and consumers. Three members are to be ex officio appointees from the legislature and the governor's office. The composition and small size would enable efficient and effective teamwork and decision-making, while bringing a balance of viewpoints and perspectives.

The commission would provide its recommendations and support the development of a statewide plan to address the quality, accessibility, and availability of health care for all citizens of the State. A plan for reform will be based on education, sustainability, management efficiency, health care effectiveness, private-public partnerships, research, personal responsibility and individual choice.

Alaska's need for healthcare reform is pressing and must be dealt with thoroughly and efficiently, with a long range view towards meaningful and lasting change. The Alaska Health Care Commission would play an important role in this process, and it is essential that we make it a permanent component of the Department of Health and Social Services, so that present as well as future issues with Alaska's healthcare systems can be better anticipated, understood and addressed.

HOUSE COMMITTEE REPORT

(11)
Date Referred to Committee: April 14, 2010 **FURTHER REFERRALS:**

Date of Committee Action: 4/15/10

The FINANCE Committee considered: **CS FOR SENATE BILL NO. 172(FIN) am**

"An Act establishing the Alaska Health Care Commission in the Department of Health and Social Services; and providing for an effective date."

SB 172-ALASKA HEALTH CARE COMMISSION

Recommends it be replaced with [X] HCS *or* **[ ] CS** *for* CS SB 172 (FIN)
For Senate Bills with new title: [ ] Technical Title [ ] New Title: HCR_____ [X] Same Title [ ] New Title

[ ] attach amendments
[ ] add new referral to _____Committee
[ ] Letter of Intent_____Committee

List of Abbrev for Depts.:
ADM
CED
COR
CRT
EED
DEC
DFG
GOV
DHS
LWF
LAW
LEG
MVA
DNR
DPS
REV
DOT
UA

NEW **FISCAL NOTES** *Assigned by Chief Clerk's Office				
List by Dept(s):	*FN#	Fiscal	Indet.	Zero
DHS		✓		

PREVIOUS **FISCAL NOTES**				
List by Dept(s):	FN#	Fiscal	Indet.	Zero

Signing with recommendations	Printed Last Name	DP	DNP	NR	AM
	Thomas	✓			
	DOOGAN	✓			
	Joule	✓			
	Gara	✓			
	Foster	✓			
	HUSTEDAN	X			
Anna Fairclough	FAIRCLOUGH	✓			
	Salmon	X			
	KELLY	X			
Chair:	STOLTZE	X			
Chair:	Hawker	★			

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: HCS CSSB172(HSS)
() Publish Date:

Identifier (file name): HCS CSSB172(HSS)-DHSS-CO-04-14-10
Dept. Affected: Health & Social Services

Title: Alaska Health Care Commission
RDU: Departmental Support Services
Component: Commissioner's Office

Sponsor: Olson

Requester: House FIN
Component Number: 317

Expenditures/Revenues (Thousands of Dollars)

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

	Appropriation Required	Information					
OPERATING EXPENDITURES	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services	192.7		192.7	192.7	192.7	192.7	192.7
Travel	40.0		40.0	40.0	40.0	40.0	40.0
Contractual	236.8		257.3	257.3	257.3	257.3	257.3
Supplies	30.5		10.0	10.0	10.0	10.0	10.0
Equipment							
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**500.0**	**0.0**	**500.0**	**500.0**	**500.0**	**500.0**	**500.0**
CAPITAL EXPENDITURES							
CHANGE IN REVENUES ( )							

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	165.0		165.0	165.0	165.0	165.0	165.0
1003 GF Match	335.0		335.0	335.0	335.0	335.0	335.0
1004 GF							
1005 GF/Program Receipts							
1037 GF/Mental Health							
Other Interagency Receipts							
TOTAL	**500.0**	**0.0**	**500.0**	**500.0**	**500.0**	**500.0**	**500.0**

Estimate of any current year (FY2010) cost:

POSITIONS

Full-time	2.0		2.0	2.0	2.0	2.0	2.0
Part-time							
Temporary							

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

SB 172 establishes the Alaska Health Care Commission in DHSS 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. The commission would be composed of 13 members. Duties of the commission would include identification of strategies for improving the health of all Alaskans through encouraging personal responsibility for disease prevention and healthy living, reducing health care costs, eliminating health risks, developing a sustainable health care workforce, and increasing health insurance options.

(Continued on page 2)

Prepared by: Ward B. Hurlburt, MD, MPH, Chief Medical Office / Director
Phone 269-8126
Division: Public Health
Date/Time 4/14/10 3:58 PM

Approved by: Alison Elgee, Assistant Commissioner
Date 4/14/2010
DHSS Finance & Management Services

ANALYSIS CONTINUATION

A number of recent ad hoc groups formed to address the issue of health care reform in Alaska, including the Alaska Health Care Roundtable (2005), the Alaska Health Care Strategies Planning Council (2007) and the Alaska Health Care Commission formed under Admin Order #246 (2009), all recommended that a permanent body be established to address the problem of health care cost, quality and access. The problem is too great in scope and too complex to be able to plan and follow-through in just one or two years time through a short-term body. Most recently, the new federal health care laws enacted this past month significantly change the structure within which state health systems operate, and a state planning body is required to help evaluate the impact on Alaskans and Alaska's businesses and health care industry, and to provide recommendations on state implementation.

$500.0 ($165.0 Fed/$335.0 GF Match) is required for operations of the health care commission. Federal funding authority requested is based on a review and determination of the level of Medicaid administrative and other federal funding that could appropriately be allocated to support the commission's work. Funds will be expended as follows:

71000 Personal Services: The commission would be staffed by an Executive Director, $134.5 (range 23, step F), and an Administrative Assistant I, $58.2 (range 12).

There is currently an Executive Director's position in the department established to support the work of the one-year 2009 commission created under Admin Order #246. This is a temporary, off-budget, fully-exempt position, and the full-time PCN requested in this fiscal note for this position is a technical fix required to establish this position in the department's budget. The department created this position and implemented the work of the 2009 commission while requesting funding through a fiscal note during the 2009 session, or through a budget increment included in the 2010 budget request. When neither funding vehicle was successful, the department limited the work of the commission and absorbed the associated costs for the one-year effort, but the part of the agency forced to absorb the costs has had to forgo other planned acitvity for this fiscal year.

An Administrative Assistant is required to provide logistical and administrative staff support for the commission. The scope of work that will be required of the commission became exponentially more complicated with the enactment of the new federal health care laws. The administrative support work required to handle the logistics of commission member travel; organizing commission meetings; planning and implementing public communication strategies; establishing consultant contracts; managing day-to-day office functions; and tracking and following-up on the work of commission members, consultants, and related department programs and initiatives is a full-time job.

72000 Travel: Travel and per diem for commission staff and for 10 voting commission members to conduct quarterly face-to-face public meetings at various locations around the state.

73000 Contractual: Professional services contracts are required to supplement staff research with specialized expertise not available among department staff. The department will coordinate with and leverage other departmental health care research and analysis work with the work of the commission and the commission's consultants to the greatest extent possible. Other contractual line expenses will include meeting expenses such as transcriptionist and audio services and meeting space; and core service RSAs to provide office space, telecommunications, network connectivity, printing, postage, and IT support.

74000 Supplies: FY 11 includes start-up costs such as computers, office furniture, reconfiguring lease space, wiring needs for connectivity, printers, fax, and photocopies. Ongoing costs are for basic office supplies and small equipment purchases. Start-up supply costs of $20.5 in the first budget year will be shifted to the contractual services line after the first year to cover ongoing contractual needs.

Adopted
4/15/10

CONCEPTUAL AMENDMENT #1

OFFERED IN THE HOUSE BY REPRESENTATIVE HAWKER

TO: HCS CS SB 172 (HSS)

Page 3

Add as a voting member of the board, specified in Sec. 18.09.020 (outlined on page 3, line 8, through page 4, line 5):

"One member who is involved in the federal veterans' healthcare industry"

Sectional analysis: Alaska Health Care Commission Bill

Section 1

AS 18.05.010(b)- Establishes the Alaska Health Care Commission in the Department of Health and Social Services that will work toward recommendations for a statewide health plan under AS 18.09.

Statewide Health Care
Section 2

Sec 18.09.010-This section is the basic language to establish the Commission and outline the commission's primary objectives.

Sec 18.09.020-Creates a 10 member Commission made up of Health Professionals and the public including three ex officio appointees from the legislature and the governors office.

Sec. 18.09.030- Members will serve three year staggered terms. Should an opening occur prior to the completion of the term the governor shall appoint a replacement.

Sec. 18.09.040- Creates the position of executive director as a partially exempt position appointed by the commission.

Sec. 18.09.050- Permits the Department to assign employees to work with the Commission as support staff.

Sec. 18.09.060- The commission shall submit internally by-laws for consideration by the full Commission. By laws will establish quorum requirements, time and locations for meetings, etc. The section also defines conflicts of interests when voting and annual reporting requirements

Sec. 18.09.070- This section defines the duties of the Commission, to include goals and language for input from the public through the public hearing process.

Sec. 18.09.080- Standard language that allows members to receive per diem and travel but no salary for serving on the commission.

Sec. 18.09.900- Authorizes the Department to promulgate the necessary regulations to maintain the commission

Sec 18.09.990- Defines the use of the words commission and department.

Section 3

AS 39.25.120 (c)(7)- adds the commissions executive director position to the list of existing executive directors serving other boards and commissions.

Section 4

AS 44.66.010 (a)- Sunset- the commission expires unless renewed by the legislature on June 30, 2014

Section 5

Uncodified language- Permits the department to begin the regulatory process which can not take effect until this bill is singed into law.

Section 6

Uncodified language- The members already serving on the commission shall continue in their positions based on the staggering of their terms.

Section 7

Effective date- Immediate effective date clause.

STATE OF ALASKA

DEPT. OF HEALTH & SOCIAL SERVICES

Alaska Commission on Aging

SEAN PARNELL, GOVERNOR

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

February 2, 2010

Senator Donald Olson
Alaska State Capitol, Room 514
Juneau, AK 99801-1182

Subject: Support for SB 172

Dear Senator Olson:

The Alaska Commission on Aging (ACoA) is pleased to offer our support of SB 172 authored by you to extend the life of the Alaska Health Care Commission in the Department of Health and Social Services until 2014 with responsibilities to plan and implement strategies related to health care reform for all Alaskans across the life span.

As you know, the Alaska Health Care Commission was first established by Governor Palin in December 2008 to develop a statewide health plan and provide recommendations to address the quality, accessibility, and availability of health care for all Alaskans. We agree with the Commission's findings that the high cost of health care and access to primary care present serious challenges for our state. ACoA supports establishment of a state commission to comprehensively examine the multitude of issues related to improving health care services including improving access to affordable primary care in addition to promoting strategies for preventative care and chronic disease management.

Older Alaskans represent one of the largest consumer groups of health care services of all age categories. Access to primary care is of utmost concern for many Alaska seniors insured by Medicare who are challenged to find a physician particularly if they live in Anchorage, Fairbanks or the Mat-Su Borough. Limited access to essential health care services for older individuals can put these persons at greater health risk who may postpone going to a provider for the care they need only when their medical conditions become serious. Workforce shortages of health care workers, particularly doctors and nurses, pose a serious problem that affects all Alaskans and has a critical impact on people 65 years and older. The ACoA is pleased that these issues were identified in the Alaska Health Care Commission Report (2009) and look forward to working with the Health Care Commission to implement the Commission's recommendations.

We support SB 172 to extend the Alaska Health Care Commission. Please feel free to contact Denise Daniello, ACoA's executive director (465-4879) should you have questions or need additional information.

Sincerely,

Sharon Howerton-Clark
Chair, Alaska Commission on Aging

Sincerely,

Denise Daniello
ACoA Executive Director

Principles, Elements and Specific Steps

Draft 8 August 29, 2007

Proposal by the Alaska Health Care Roundtable to help the Council achieve the goals it identified at its first meeting:

Health Care Strategies Planning Council Mission Statement (Approved at the June 11, 2007 meeting)

Develop strategies, including performance measures, to provide health care access for all Alaskans by 2014 with the goal of making Alaskans the healthiest population in the nation.

The definition of "access" includes: coverage, affordability, timely service, quality of care, prevention, managing chronic conditions, workforce issues and cost.

Roundtable recommendations are as follows:

Principles of reform — Guidelines for creating effective specific action steps

- Creating healthier people who consume less medical services is the only major sustainable strategy to slow growth of health care costs.

- Plans, programs and policies must encourage and support the principle of individual responsibility to maintain and protect each person's health.

- Dramatically improve value for every health care dollar.
    - Health services that effectively educate and motivate individuals underpin an effective, efficient health care system. Prevention and timely appropriate levels of care earn strong return on investment (ROI) for both employer and public programs. Examples are immunization programs, hypertension or HIV screening, promoting prenatal care, etc.
    - Organizational wellness programs, government or private, are starting to prove that improving employee health is a win/win for both employees and employers.

- Financially support carefully planned experimentation with different types of health delivery models and payment models. Alaska is a highly diverse state. The wide variety of community sizes, many in remote areas, with differing access to care and different prevailing payment systems argues towards creating a variety of solutions from which to choose. Employers are particularly concerned about quality.

- All Alaskans need quality, affordable health care that provides:
  - Physical access
  - Financial access
  - Information access

- Facilitate universal participation in the most appropriate fashion for each individual. Forms of coverage or care include:
  - Employer-based
  - Individual-based
  - Federal programs
  - Military programs
  - Alaska Native programs

- Rely on and develop the private insurance market in sectors where it is currently working and other sectors where it can be logically employed. Avoid creating costly state bureaucracies that duplicate private sector capabilities.

- "Grow our own" health care practitioners at all levels as much as possible.
  - In-state education and clinical training increases the likelihood of keeping graduates in Alaska.
  - In-state education stems the flow of education dollars Outside and helps generate a sustainable economy.
  - Create specialized programs to meet the needs of rural Alaska.

- Collaboration and cooperation is essential. The problem is larger than any one part of the system can solve. Areas to address are financing and insurance, workforce development, facilities and citizen education. Private, state, federal and Native resources will need to be coordinated so all can contribute to the solution.

- Generate sufficient information and research, both in Alaska and from best practices Outside, to support sound fact-based decision making.

- Provide sufficient and appropriate facilities where necessary around the state. Emphasize regional planning, coordination, cooperation and efficiency.

- Develop a statewide electronic health record network that is secure and interoperable with existing systems to improve quality of care and reduce waste by providing necessary medical information to providers.

Elements of reform — Building blocks for a better system

- The problem is huge and complex. Businesses, individuals and governments all must contribute to managing and financing a new Alaskan health care system for it to be sustainable.

- We must stem erosion of employer-sponsored insurance. Keep what works and reshape or fill in as necessary. Reform plans should build on and improve existing parts of the system that work without harming those who are already well served.

- Information to evaluate costs and alternatives before and after treatment is an essential building block of individual financial responsibility. Information access and transparency seems like a basic need, but is elusive. Technology and disclosure requirements will help.

- Encourage adequate federal Medicare reimbursement of provider's costs, but cobble together work-arounds until that happens. This can include creative use of Medicare and Medicaid waivers. Keep track of the changing federal health care environment to uncover opportunities and influence needed change.

- Electronic health records are the cornerstone to modernizing Alaska's health care. Build on existing private and state-level initiatives.

- Develop navigation aids and fail-safe systems to help people gain access to and deal with complexities of the system. Navigation aids must take into account the human, as well as the technological networks, which build healthy lives.

- Alaska has information gaps that need to be filled to chart an optimum path to progress. Fundamental research will enable policy-makers to make sound decisions based on facts: 1. Quantify and identify the source of Alaska cost differentials vs. Outside. 2. Understand who is not covered or insufficiently covered. 3. Continue to define work force development challenges across the full job spectrum.

- Build on the many Alaskan programs that have proven effective or show promise in the areas of quality, access and cost control.

- Monitor and learn from other state's experience in coverage and cost control.

- Alaska will need an ongoing official state-wide group to monitor the ever-changing health care scene and find appropriate synergies.

Specific immediate steps to consider

- Establish an ongoing Alaska health care council/commission/board to coordinate public policy.
- Support and coordinate Alaska research and monitor national research and developments.
- Develop a variety of Alaska health care reform plans based on research to be able to compare and contrast their benefits, costs and impacts.
- Support the next step in development of Alaska electronic health records.
- Develop and monitor quantifiable health care goals for Alaska.
- Support workforce development capable of filling current and anticipated needs.
- Encourage primary care capability based on the "Medical Home" model which provides an ongoing health care point of contact. Examples are family physicians or community health centers.
- Monitor and improve liability and tort laws to help reduce malpractice insurance costs, encourage quality improvements and make Alaska a more attractive place to practice medicine.
- Encourage schools at all levels to foster healthy life styles and offer sports and exercise programs that build life long healthy habits.
- Work with the federal delegation and authorities to maximize federal support of Alaska projects and programs and to support national health care reform efforts that will benefit Alaskans.
    - E.g. Develop stand-alone Medicare clinics in major Alaska hubs via an open RFP process
- Identify pseudo-reform "myths"—things to avoid.

Pseudo-reform "myths" — Things to avoid

- Continued employer transfer of health care costs to employees.
- Assuming that "market forces" alone will make health care better and more efficient. Health Savings Accounts (HSAs) may be part of a total solution, but not the only solution. Even enlightened health care consumers do not have access to information they need to "shop around" for best value.
- Freezing or reducing state funding. The State of Alaska will need to make additional financial and programmatic investments as a full partner in a comprehensive solution.
- Reliance on the federal government to solve the problem. National solutions are necessary and hopefully will be forthcoming. However, in the interim, Alaska needs to do what it can to help itself.

- Assuming, hoping or praying that the problem will solve itself and go away. Effective, creative coordination of every tool available within Alaska is the only chance for success. An ongoing, adequately resourced council, commission or board will need to continue the work of the Alaska Health Care Strategies Planning Council.

Why we need to act now

- As a small state with significant resources, Alaska has the elements it needs to improve the health of its citizens in the long-term.
- Guiding principles will focus the creativity and coordination needed to achieve this lofty, but basic human goal.
- Unchecked, current health trends will create the first generation in 100 years that can expect a shorter life span than their parents.
- Insufficient federal reimbursements are transferring a huge financial burden to the private sector which in turn is passing costs on to employees.
- A mandatory rational system based on the strongest elements already in place can provide basic care for all Alaskans enabling a shift of emphasis towards prevention.
- Investing in prevention and individual responsibility offer high "bang for the buck." Healthy people feel better and place less financial demands on the system.
- The aging population will increase per capita costs of health. These increases can be mitigated by effective primary prevention and health promotion.
- Everyone and all parts of society need to be part of the solution—businesses, individuals and all levels of government.
- The health care system is not a goal in and of itself. The real goal is healthy Alaskans who know they will be properly cared for if they do get sick.

Background — An unsustainable deteriorating situation

- Many thanks to the Alaska Health Care Strategies Planning Council and key legislators for beginning a formal state dialogue.
- Businesses face annual double-digit increases in health care costs. This necessitates:
  - Cutting back coverage
  - Increasing employee financial contributions
  - Educating and empowering employees to develop healthier lifestyles
- The situation is bad and getting worse.
  - According to a July 2007 Commonwealth Fund report comparing states, Alaska ranks 26th overall, 36th for access and 49th in quality.
  - Medicare and Medicaid do not reimburse providers for their cost of doing business. This "pinch" is being passed on to businesses and insurers, creating an ever-escalating financial burden on them. Health care costs for businesses are a financial ball and chain not shared by international competitors.
  - Many Alaskans are without any health care coverage, or have inadequate coverage.
    - Over 90,000 Alaskans have no health care coverage—if living together, they would be the second largest city in Alaska.
    - Many more are under-insured.
  - Everyone has nominal access to some form of health care at the emergency room, but it is after-the-fact and expensive.
  - Many people in need do not know where to turn because of:
    - Lack of knowledge
    - Lack of money
    - Linguistic and cultural barriers
    - Crushing work and family schedules
  - Alaska is short 300 doctors today, with more needed to replace an aging work force. Similar shortages exist for nurses and other health practitioners.
  - Potential gas pipeline construction will further strain an already challenged Alaska health care system.

- The unhappy net result:
  - Alaska has the highest per capita state expenditures on health care in America ($8,000 per person).
  - America has the highest per capital health care expenditures in the world ($7,000 per person).
  - Alaska and America have poor health compared to other industrialized nations despite having greater expenditures on health care.
  - Alaskan and American businesses are becoming less competitive compared to international businesses in countries with public health care systems.

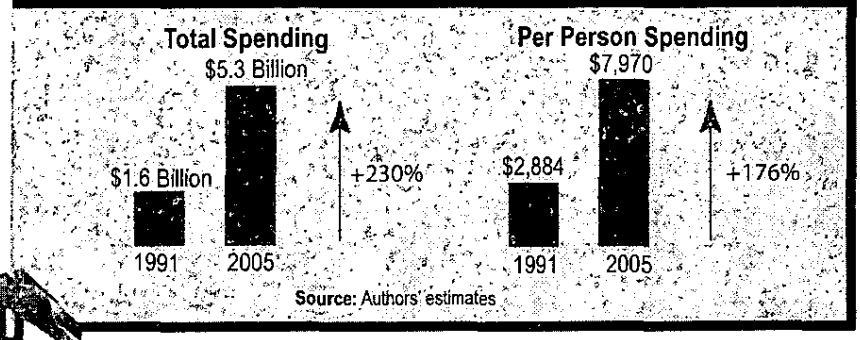
- A caring, humane and financially efficient society cannot continue this downward spiral. Serious national conversations and major state-level reform efforts are under way. Fortunately, Alaska has potential building blocks for a better system and guidelines to help use them.

Alaska's $5 Billion Health Care Bill—Who's Paying?

By Mark Foster and Scott Goldsmith

March 2006
UA Research Summary No. 6
Institute of Social and Economic Research • University of Alaska Anchorage

Figure 1. Growth in Alaska Health-Care Spending, 1991-2005



Spending for health care in Alaska topped $5 billion in 2005. Just how big is $5 billion? It is, for perspective, one-third the value of North Slope oil exports in 2005—a year of high oil prices. It's nearly one-sixth the value of everything Alaska's economy produced last year.

In 1991, health-care spending in Alaska was about $1.6 billion. Even after we take population growth into account, spending for health care increased 176% per Alaskan in 15 years. These soaring costs are taking a growing share of family and government budgets, increasing labor costs, and putting businesses at a competitive disadvantage.

The $5.3 billion in spending in 2005 was all for the 665,000 people who live in Alaska, but individuals didn't pay all the bills. They paid nearly 20% out of their pockets and through payroll deductions. Businesses (including non-profits) and governments paid about 80%. Of course, individual Alaskans and other Americans indirectly pay all these costs, because they buy goods and services, own businesses, and pay taxes.

What does health-care spending buy? Stays in the hospital, visits to doctors and dentists, prescription drugs, and more, as well as program administration and public health programs. Our estimates don't include capital expenditures.[1]

Who pays the bills, and how has that burden shifted as spending increased?

• *Private and government employers spent about $2 billion for employee health-care coverage in 2005.* For comparison, they paid $11.8 billion in wages in 2005. With rising costs, businesses and governments have become increasingly likely to pay health-care bills themselves—"self-insure"—rather than pay through insurance premiums.

• *Alaska households spent just over $1 billion for health care in 2005, up from $361 million in 1991.* That includes everything individual Alaskans spent—not only their out-of-pocket costs, but also what was deducted from their paychecks to help pay for health coverage through their employers.

• *Governments spent $2.2 billion for health care programs in 2005, up from $736 million in 1991.* Medicaid spending was almost $1 billion.

Health-care spending could double again by 2013, if current trends continue. Why are costs of medical care so high, and why are they increasing faster than everything else? Why have health-care costs in Alaska stayed higher than U.S. averages, even as other costs moved closer to national levels? Are we getting better care now? Who can't afford care?

We're starting to assemble data to help answer those questions. Alaskans face some hard choices about how to control costs but still have a health-care system that provides good care and is accessible to everyone. We hope to provide some useful insights.

This publication is the first step in ISER's research on the health-care industry. It starts with our new estimates of spending and of changes since 1991, when we last looked at health-care spending.[2] But cost alone is only one part of the complicated health-care story, and here we also begin looking at:

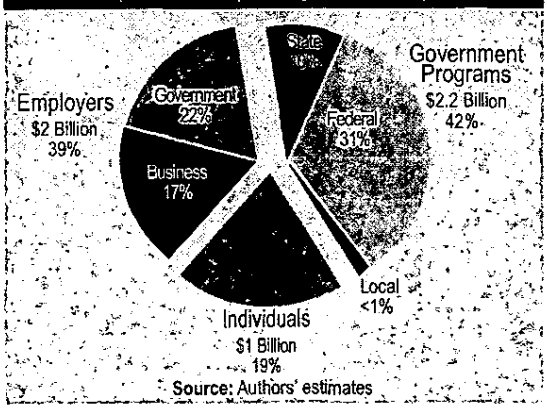
• Who are the most expensive patients? Our analysis of national data shows that the average "high-cost" patients aren't as expensive as you might think.

• Who is more likely to have health insurance provided through their jobs at a reasonable cost? Single people working for big companies.

• How does use of the health care system in the U.S. compare with use in other countries? Canadians and Australians seem to use their systems about as much.

• What is driving costs? Despite what many people think, there are no simple explanations: it's a puzzle with many pieces.

Figure 2. Who Pays The Bills?
(Total 2005 Spending: $5.3 Billion)



Understanding Alaska (UA) is a special series of ISER research studies examining Alaska economic development issues. The studies are paid for by the University of Alaska Foundation. UA reports are available from ISER's offices and at: **www.alaskaneconomy.uaa.alaska.edu**

Organization of Summary

We first describe what health-care dollars buy—what shares go to doctors, hospitals, drugs, and other expenses. Then we look in more detail at our estimates of health-care spending in 2005 and the changes since 1991. We think our estimates are a good effort to update our previous work. But the health-care industry is complex, and tracking all the spending is difficult.

After we talk about spending, we give readers a glimpse of related health-care issues. In some cases we have no Alaska data and rely on national figures, which are still useful in illustrating important issues.

Pages 4, 5, and 6 discuss access to, use of, and benefits from the health-care system: who is uninsured; who has health-care coverage and how that coverage is provided; which patients get the costliest care; how Americans' use of medical care compares with use by people in other industrialized countries; and whether we've gotten healthier in exchange for more spending.

Page 7 summarizes what we know about how medical costs in Alaska differ from the U.S. average, and page 8 concludes with a discussion about the many things that may be driving health-care costs.

Keep in mind that population growth and general inflation account for part of the increase in health-care spending since 1991. Alaska's population increased from about 570,000 in 1991 to 665,000 by 2005. Also, prices for everything Americans buy also went up, by about 43% nationwide and 39% in Anchorage. But prices of medical care nearly doubled (Figure 3).

What Are We Buying?

Figure 4 shows that as of 2000, more than 70% of Alaska's health-care spending was for hospital care and visits to doctors. Prescription drugs accounted for about 9% and dental care 7%. The "other" category includes medical products, health care provided on the job and in schools, and Medicaid payments for in-home care.

Nursing home and home health care made up only 2% of health-care spending in 2000, far short of the U.S. average of 11%—and that share actually dropped between 1990 and 2000, despite fast growth in the number of Alaskans over 65. There has been a shift in how long-term care is provided in Alaska. A change in Medicaid allowed payment for in-home and assisted-living care for people who would otherwise have been cared for in nursing homes.

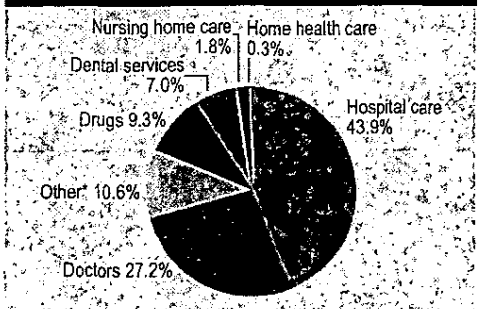
All types of health-care spending grew rapidly since 1990, but the fastest growth was in prescription drugs and the "other" category (described in the footnote to Figure 4).

How Has Spending Changed?

Table 1 details who paid for health-care in 2005. Figures 5 and 6 show changes in levels and shares of spending from 1991 to 2005.

• Growth in government spending wasn't uniform. The federal government's share of spending increased (Figure 5). Costs for Medicare and Medicaid more than quadrupled and costs for the Indian Health Service doubled.

Figure 4. What Are We Buying?
(Alaska Health Care Spending, 2000)



*Includes, among other things, durable and non-durable medical products, direct services employers provide employees, government expenditures in schools, and Medicaid payments that allow people to be cared for at home instead of in institutions.
Source: Center for Medicare and Medicaid Services

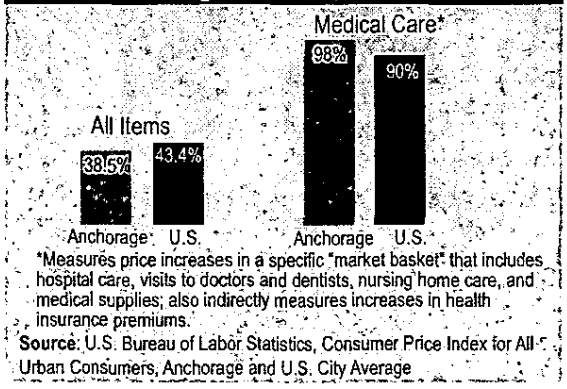
• State government's share dropped, partly because the federal government paid a bigger share of Medicaid costs in 2005 than in 1991.[3]

• Local government is the smallest government spender, but the local share of spending increased, mostly because of growing costs for employee health coverage.

• Employers saw the fastest growth. Combined spending by private and government employers increased about 290% (Figure 6).

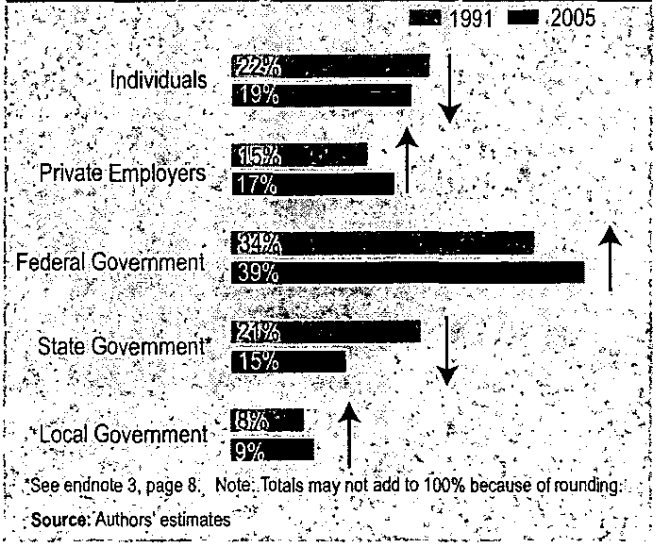
• Spending by individual Alaskans didn't go up as much—184%—but the $1 billion they spent in 2005 was still more than the $922 million businesses spent.

Figure 3. Increase in Consumer Price Index Anchorage and U.S., 1991-2005



*Measures price increases in a specific "market basket" that includes hospital care, visits to doctors and dentists, nursing home care, and medical supplies; also indirectly measures increases in health insurance premiums.
Source: U.S. Bureau of Labor Statistics, Consumer Price Index for All Urban Consumers, Anchorage and U.S. City Average

Figure 5. How Did Shares of Spending Change From 1991 to 2005, Among Those Who Buy Health Care?



See endnote 3, page 8. Note: Totals may not add to 100% because of rounding.
Source: Authors' estimates

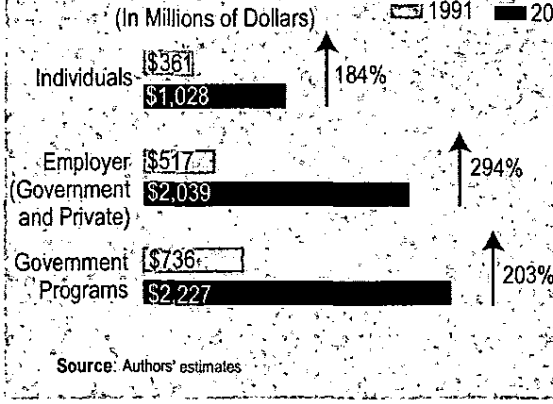
Table 1. Health-Care Spending in Alaska, Fiscal Year 2005
(Total Spending: $5.3 Billion)

Who Provides the Coverage?	Who Buys the Care? (In Million of Dollars)					
	Individuals	Businesses	Local Government	State Government	Federal Government	Total
Individuals	$1,028					$1,028
Out-of-pocket costs	$431					
Individual policies	$276					
Payments for employer-based insurance	$320					
Employers (Including retiree coverage)		$922	$454	$252	$411	$2,039
Insurance Premiums		$303	$103	$72	$75	
Self-Insured Costs[a]		$485	$352	$180	$115	
Military Medical Costs					$221	
Worker's Compensation (medical benefits)		$134				
Government Health Programs			$38	$535	$1,654	$2,227
Medicare					$419	
Medicaid				$303	$667	
Other Public Programs						
Federal						
Indian Health Service Contracts					$401	
Veterans' Affairs					$105	
Community Health Centers					$29	
State						
Grant to local governments, private groups				$116		
API, Pioneers' Homes				$55		
Other State-Administered				$31		
Elementary and Secondary Schools			$3	$8	$33	
WAMI Medical Education				$2		
Department of Corrections				$21		
Local						
Health and hospital spending			$35			
Total Spending	$1,028	$922	$492	$787	$1,950	$5,294

[a] Many organizations that self-insure—that is, they pay some of their bills themselves—also still carry some insurance to help cover extraordinary risks.

Source: Authors' estimates Note: Totals may not sum because of rounding.

Figure 6. How Did Spending Change From 1991 to 2005, Among Those Who Provide Coverage?



Source: Authors' estimates

Biggest Kinds of Changes

- Individual Alaskans have seen big increases not only in costs they notice most—how much they have to pay out of their own pockets—but also in less obvious costs: deductions from their paychecks to pay their share of employer-based insurance.
- Both private and government employers became much more likely to self-insure. Self-insurance costs made up about two-thirds of combined employer spending for insurance premiums and self-insurance in 2005, up from about one-third in 1991.
- Spending for Medicaid more than quadrupled (from $215 million to $970 million), so that in 2005 it alone made up nearly $1 in every $5 of health-care spending. Analysts attribute the fast growth of Medicaid nationwide to growing numbers of eligible Americans, including low-paid workers whose employers don't provide coverage and low-income seniors; to program expansion; to increasing prices of medical care; and to treatment of medical conditions at lower thresholds.

Health-Care Coverage

Most Alaskans—an estimated 87%—have some form of health-care coverage, either through private insurance or government programs.[4] Some people have more than one kind of coverage, so the percentages in Figure 7 add to more than 100%.

Around 64% of Alaskans are covered by private insurance, 38% by government programs, and nearly 13% have no coverage. Nationwide, 68% of people are covered by private insurance, 30% by government programs, and close to 16% have no coverage.

Alaskans are more likely to have coverage through the military (reflecting the state's large number of active-duty and retired military); the Indian Health Service (because Alaska Natives make up 20% of the population); and Medicaid (the joint federal-state program mainly for low-income and disabled people). Fewer Alaskans are covered by Medicare, because fewer are over 65.

We don't know characteristics of the 13% of Alaskans with no health-care coverage, but we know that nationwide the uninsured are most likely to be young adults and to have annual incomes below $25,000 (Figure 8).

Children in Alaska are more likely to have coverage than both adults in Alaska and children nationwide. Figure 9 shows that about 8% of children in Alaska had no coverage in 2003, compared with the U.S. average of nearly 12%.[5] The smaller share of uninsured children in Alaska is probably due to the fact that Alaska Native children are eligible for care through the Indian Health Service, and also to the Denali KidCare program, an extension of Medicaid that provides coverage for low-income children without other coverage.

It's outside the scope of this summary to describe all the ways that families, communities, and governments are affected because millions of Americans lack health insurance. But a recent report by the National Academy of Sciences broadly summarized those effects. It found that the uninsured are in worse health; that uninsured children are more likely to have development delays; that the direct costs of caring for uninsured Americans fall heavily on local communities; and that governments pay hospitals large public subsidies to offset their costs for uncompensated care.[6]

The 64% of Alaskans with private insurance either pay for that coverage themselves (through individual policies) or are covered through their jobs and share the costs with their employers. Figures 10, 11, and 12 show how the rising costs of medical care have affected health-insurance coverage for Alaskans working for private industry.

• Health insurance in Alaska was already more expensive in the 1990s and still is. In 2003, insurance premiums for family coverage at private firms were about $10,500 in Alaska and $9,200 nationwide. By 2005, those premiums had jumped to an average of $11,268 nationally (Figure 10).

• Premiums are higher in Alaska, but workers here pay a smaller share, as Figure 11 shows. As of 2003, employees at private firms in Alaska paid 11% of the premiums for single-person coverage and 17% for family coverage, compared with 17% for single-person coverage and 25% for family coverage nationwide. But employers, especially at small firms, have been shifting more insurance costs to workers. The 2005 UBA-Ingenix Health Plan Survey found that employees of businesses nationwide paid 43% of the premiums for family coverage.

Figure 7. Health-Care Coverage, Alaska and U.S., 2004

	Private Insurance	Medicaid	Medicare	Military	IHS only*	None
Alaska	63.5%	15.3%	7.3%	11.6%	4.2%	12.8%
U.S.	68.1%	12.9%	13.7%	3.7%	N/A	15.7%

*Authors' adjustment. See endnote 4, page 8.

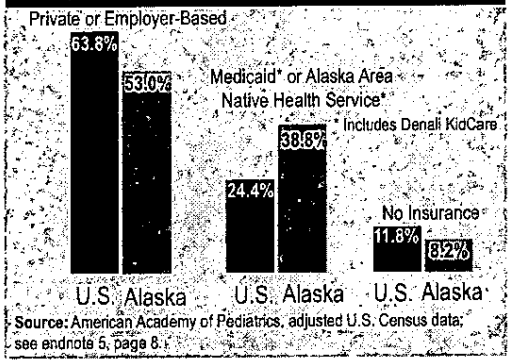
Note: Totals are more than 100% because some people have more than one coverage.
Source: U.S. Census Bureau, Current Population Survey, 2004

Figure 8. Who Is Most Likely To Be Uninsured in U.S.?

	Percent Uninsured
By Age	
18-24	31%
65+	1%
By Annual Income	
Less than $25,000	24%
$75,000+	8.4%

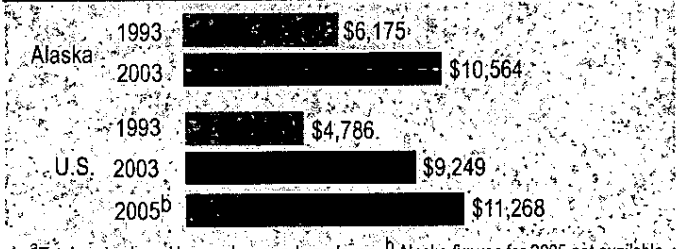
Source: U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the U.S.*, 2004

Figure 9. Health-Care Coverage for Children (18 and Under), Average 2001-2003



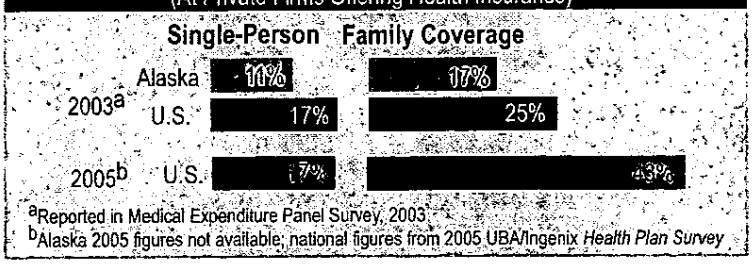
Source: American Academy of Pediatrics, adjusted U.S. Census data; see endnote 5, page 8.

Figure 10. Health Insurance Premiums For Family Coverage[a], Private Firms



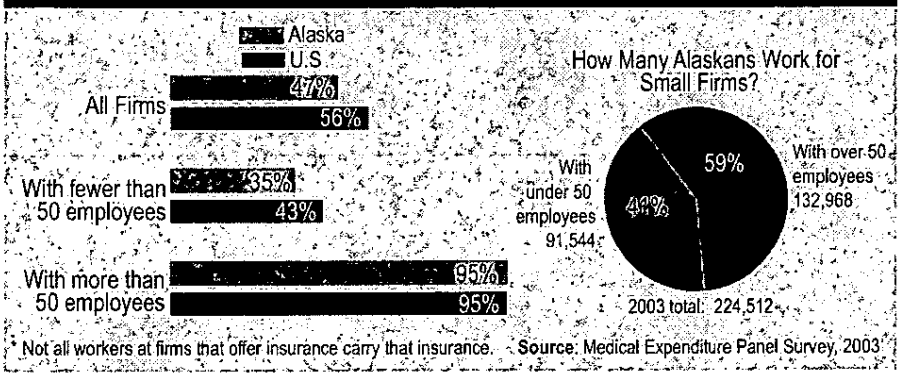
[a]Total costs shared by employer and employee. [b]Alaska figures for 2005 not available.
Sources: Medical Expenditure Panel Survey, U.S. Agency For Health Care Research and Quality, 2003; 2005 UBA/Ingenix *Health Plan Survey*

Figure 11. Share of Health Insurance Premiums Employees Pay
(At Private Firms Offering Health Insurance)



[a]Reported in Medical Expenditure Panel Survey, 2003.
[b]Alaska 2005 figures not available; national figures from 2005 UBA/Ingenix *Health Plan Survey*

Figure 12. Private Firms Offering Health Insurance,* Alaska and U.S., 2003



*Not all workers at firms that offer insurance carry that insurance. **Source:** Medical Expenditure Panel Survey, 2003

• Small Alaska businesses are less likely to offer insurance coverage. Only about a third of those with fewer than 50 employees offer coverage, compared with 43% nationwide (Figure 12).

A lot of Alaskans work for small businesses. In 2003, about 91,500 of the state's 224,500 private-industry employees worked for businesses with fewer than 50 employees. That's more than 40% of all those with jobs in private industry.

Who Costs the Most and the Least?

We've talked about the costs of health care and of health-care coverage. Now we turn to the other side of the equation: who's getting the benefits of the spending?

Health-care spending in Alaska was close to $8,000 per person in 2005. But not everyone is average. The cost of care for a few is significantly higher than average, but for many it's only a few hundred dollars a year.

As a first step toward understanding who gets the benefits of health-care spending, ISER analyzed national data on the characteristics of high- and low-cost patients. That data is from a federal panel survey—that is, a survey that follows households over time.

As Figure 13 shows, just 5% of patients nationwide account for almost half of all health-care spending in any given year, while at the other extreme 50% of patients account for just 3% of spending in a year.

A lot of Americans tend to think that the most expensive patients are probably very old, or suffering from some catastrophic illness or injury, and are possibly uninsured.

The high-cost patients are older; health-care costs do go up as people age.[7] But their average age is 57, and fewer than 40% are over 65. The average bill for high-cost patients in 2002, under $20,000, doesn't reflect major illnesses or end-of-life care. Rather, it's for a few days in the hospital for surgery, several visits to doctors, and significant spending for prescription drugs. Few of the high-cost patients—2%—are uninsured.

The low-cost patients are mostly young, averaging 28 years old. They may see a doctor or a dentist once a year, and they pay almost half their modest medicals bills out of their pockets.

Many of the low-cost group—nearly 20%—are uninsured. The share of uninsured patients in this group tracks with what the National Academy of Sciences has reported: that the uninsured often don't have any medical costs at all in a year, and among those who do, their expenses are less than half the average for people under 65.[8]

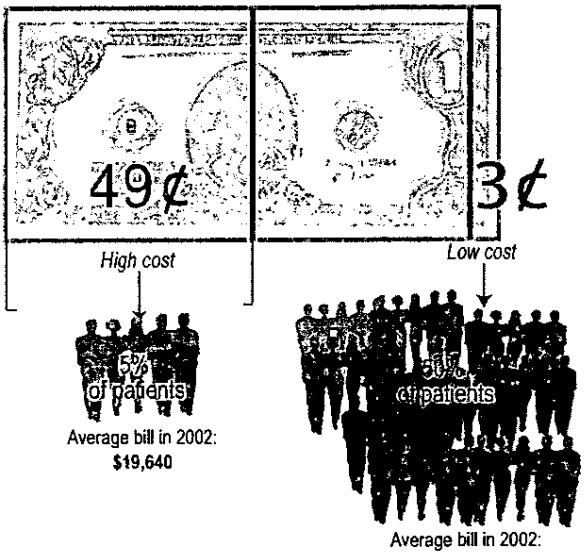
Keep in mind that it's easy to go from being a low-cost patient in one year to a much costlier one the next—a car accident, the sudden onset of an illness, or a hundred other unpredictable events can push anyone into the ranks of the high-cost patients.

Figure 13. Who Are the High-Cost and the Low-Cost Patients in the U.S.?

Distribution of Health-Care Spending on Patients, 2002

Who Are the High-Cost Patients?

- Mostly middle-aged people (average age 57), who are hospitalized for a few days, see doctors several times a year, and spend considerable money (average $3,000) on prescription drugs.
- About 40% are over 65
- They are from all income levels. A third have high incomes (family income over $80,000), and about a fifth are poor (family income under $18,000).
- Only 2% are uninsured. More than two-thirds have private insurance, and nearly a third are covered by government health programs, the most common being Medicare.
- They pay about 12% (average $2,400) of their bills out-of-pocket.



Who Are the Low-Cost Patients?

- Mostly young (average age 28), healthy people, who are likely to see a doctor and a dentist once a year and spend little (average $44) for prescription drugs.
- About 3% are over 65
- They are from all income levels, with almost the same breakdown as among high spenders: nearly a third have high incomes and about a fifth are poor.
- Nearly 20% are uninsured. About 17% are covered by government programs, most commonly Medicaid. The majority have private insurance.
- They pay about 40% (average $84) of their bills out-of-pocket.

Sources: *MEPS Statistical Brief No. 81, May 2005 and analysis of MEPS data by Stephanie Martin of ISER*

Do We Use More Medical Care?

Americans spend more on health care than anybody else. Do Americans increase health-care costs by getting more medical care than people in other developed countries? Or conversely, do countries with national health-care systems hold down costs by rationing care?

Figure 14 compares Americans with the British, Canadians, New Zealanders, and Australians on use of, access to, and satisfaction with their health-care systems. The comparison countries all have some form of national health-care system.

Overall, the comparisons show that residents of all four countries are almost equally likely to see doctors and have diagnostic tests, and that Americans are slightly more likely to take prescription drugs.

Figure 14. Use of Medical Care, U.S. and Selected Countries, 2004
(Percent of Survey Respondents)

	U.S.	Great Britain	New Zealand	Canada	Australia
Saw at least one doctor in previous 2 years	97%	95%	97%	95%	98%
Regularly take prescription drugs	46%	44%	39%	43%	39%
Had blood tests, x-rays, or other diagnostic tests in past 2 years	84%	71%	82%	84%	83%
Able to get doctor's appointment same day when sick	33%	41%	60%	27%	54%
Skipped medical tests, treatment or follow-up because of cost	27%	2%	20%	8%	18%
Rate regular doctor's care excellent or very good	61%	64%	74%	68%	71%
Among those who used emergency room, share who rate emergency services fair or poor	34%	23%	27%	27%	23%

Source: Commonwealth Fund International Health Policy Survey, 2004

Americans are, however, more likely to skip medical tests because of cost and less likely to get appointments the same day they call. They also seem to be somewhat less satisfied with care they get from their doctors and in the emergency room.

Are We Healthier?

Another important aspect of the health-care story is what we're getting in return for the high spending. Are Alaskans healthier than in 1990?

The answer seems mixed. In 2005 the United Health Foundation ranked Alaska as among the most improved states in health outcomes since 1990. Despite that improvement, the foundation still ranks Alaska somewhere in the mid-range of states on health measures—because 15 years ago Alaska was ranked toward the bottom.[9] Figure 15 illustrates some of the improvements Alaska has made since 1990.

Rates of infectious disease (which include hepatitis, tuberculosis, and many more) went from far above the U.S. average in 1990 to significantly below by 2005. Infant mortality dropped in Alaska and throughout the country.

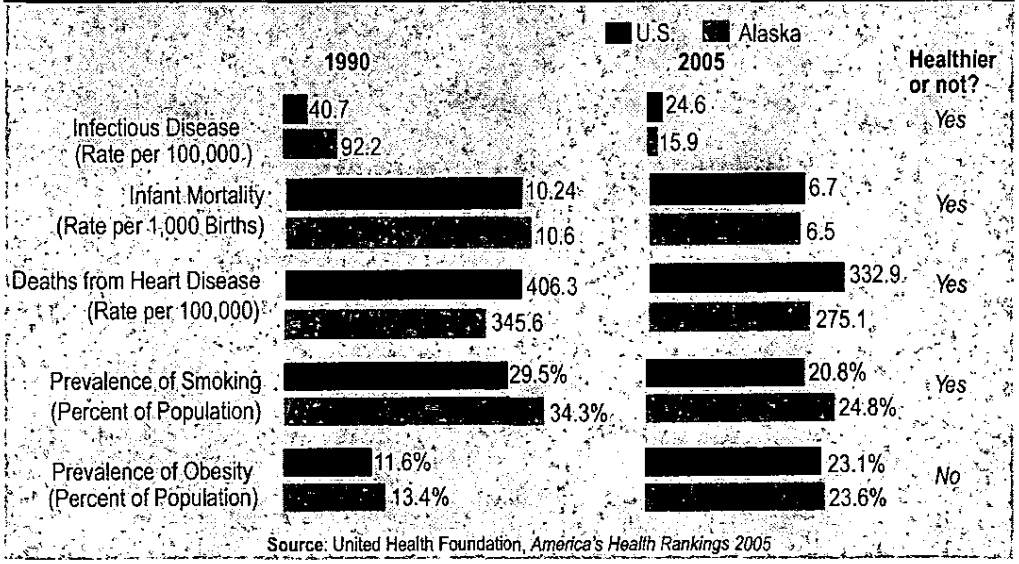
Declines in infectious disease and infant deaths in Alaska can be traced partly to public-health spending for immunizations, as well as for safe water and sewer systems, new housing, and better access to medical care in remote villages.[10] In Alaska and nationwide, advances in treatment and technology have also reduced infant deaths.

With improved treatments for heart disease, the rate of death from heart disease declined by 20% in Alaska since 1990, dropping slightly faster than the national rate.

Rates of smoking among Alaskans fell also, but Alaskans are still more likely to smoke than other Americans. Again, public-health campaigns to fight smoking likely contributed to the decline.

On the down side, Alaskans and other Americans are far more likely to be obese now than in 1990—and obese people are more likely to require treatment for diabetes and high blood pressure.

Figure 15. Are Alaskans Healthier Now Than in 1990?



Source: United Health Foundation, *America's Health Rankings 2005*

Alaska and U.S. Costs

Years ago, everything cost more in Alaska, and costs still remain high in remote areas. But in Anchorage and other urban places, the historically high costs of many things have moved closer to U.S. averages in recent times, as the population grew, local markets got bigger, and infrastructure and transportation improved.

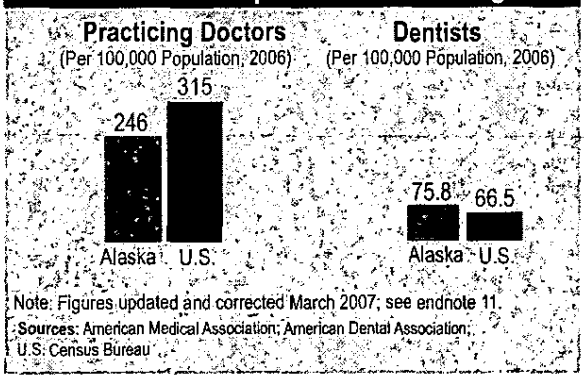
But costs of medical care haven't declined relative to U.S. averages. Overall medical costs are probably somewhere in the range of 25% higher in Alaska, but that cost difference varies quite a bit among services and procedures, and prices don't always reflect cost.

Alaska has fewer practicing doctors per capita than the nation as a whole, but somewhat more dentists—so how the supply of medical professionals may affect costs is not clear (Figure 16).

Figures 17 through 20 show some examples of cost differences, but it isn't a comprehensive picture.

- Overall costs of medical and surgical procedures in Alaska were about 18% above the U.S. average in 2001 and dental procedures 37% more (Figure 17).
- Average costs of a visit to a doctor's office were 30% higher in Alaska in 2001. But the average is a mix of private insurance and government payments. A private insurer in Anchorage and Fairbanks paid nearly twice as much as Medicare for an office visit in 2001, as Figure 18 shows.
- Alaskans don't use as many prescription drugs as other Americans—mostly because there are fewer Alaskans over 65—but we pay more. In 2003, the average price of retail prescriptions was 25% higher in Alaska.
- Costs of hospital care went up faster in Alaska than nationwide from 2000 to 2003—so in 2003 average expenses for a day in an Alaska hospital were 42% above the U.S. average, compared with 30% in 2000.

Figure 16. How Do Numbers of Alaska Doctors and Dentists Compare with U.S. Averages?



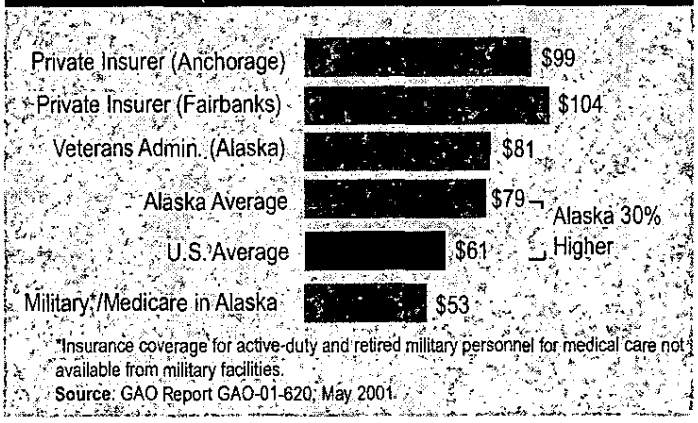
Note: Figures updated and corrected March 2007; see endnote 11.
Sources: American Medical Association; American Dental Association; U.S. Census Bureau

Figure 17. How Much Higher are Medical Costs in Alaska?
(Costs Paid by Private Insurer, 2000)

	Percent Above U.S. Average
Medical/Surgical Procedures	18.1%
Dental Procedures	37.7%

Source: Ingenix data base; cited in Alaska Division of Medical Assistance, HealthCare Cost Analysis, 2001

Figure 18. Costs of An Office Visit, Alaska and U.S., 2001
(Established Patient, 15 minutes)



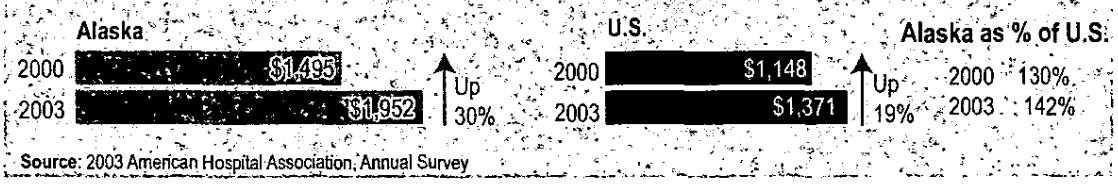
*Insurance coverage for active-duty and retired military personnel for medical care not available from military facilities.
Source: GAO Report GAO-01-620, May 2001

Figure 19. Prescription Use and Cost, Alaska and U.S., 2003

	Prescriptions Per Capita	Average Price of Retail Prescriptions	Average Cost Per Capita
United States	10.7	$52.97	$566.78
Alaska	6.3	$66.89	$421.41

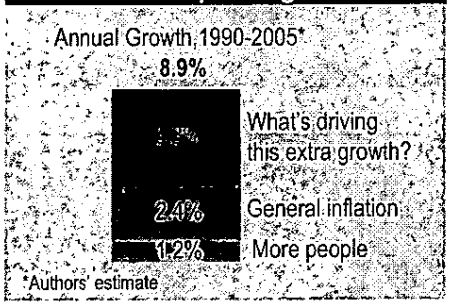
Source: Kaiser Family Foundation, based on data from Verispan, LLC.; Special Data Request, 2004; and U.S. Census Bureau, State Population Datasets for six Race Groups

Figure 20. Hospital Costs, Alaska and U.S. , 2000 and 2003
(Expenses per In-Patient Day)



Source: 2003 American Hospital Association, Annual Survey

Figure 21. What's Driving Health-Care Spending In Alaska?



What's Driving Costs? It's a Puzzle

Spending for health care in Alaska increased an average of nearly 9% a year from 1990 to 2005—and that figure doesn't reflect the big capital costs for building hospitals and clinics in the state since 1990.

More people and general inflation together account for only about 40% of that growth. So what's driving the rest?

Just about everybody has an opinion about what's pushing up medical costs, here and nationwide. Alaska has some special conditions—mostly small markets and high costs in rural areas—but other possible contributors to high costs are common to Alaska and the rest of the country.

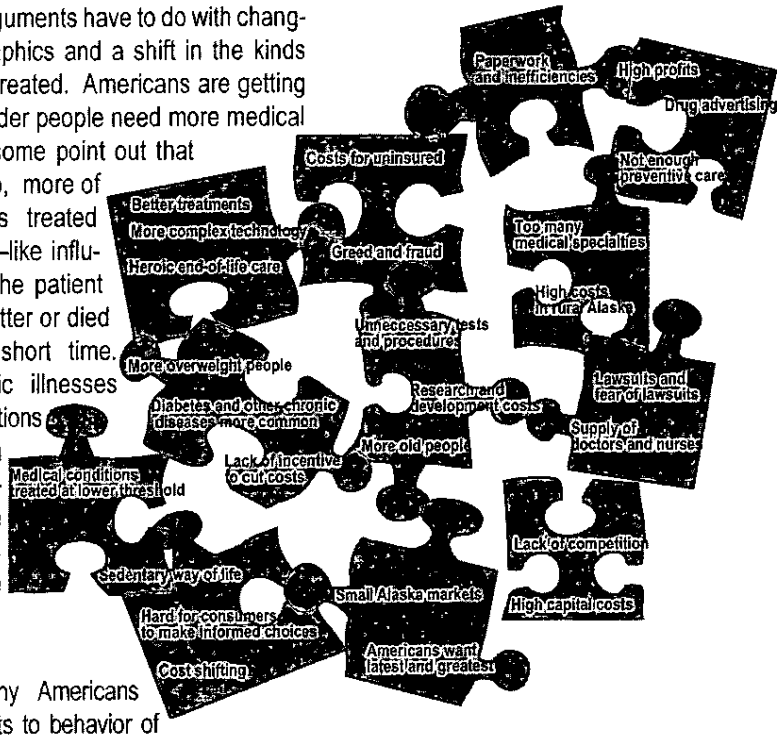
Some people think the big factors have to do with our system of delivering health care. Those include market forces—like lack of competition, for instance, and lack of incentives in many parts of the system to control costs—as well as inefficiencies created by the complexity of the U.S. system.

Other arguments related to the delivery system are that Americans get more medical care than they need, because most of the bills are still paid by health insurance. Others believe, by contrast, that costs of caring for uninsured people are responsible.

Others blame environmental factors, especially Americans eating too much and not exercising—leading to the spread of diabetes and other conditions requiring more care.

Still others say the growth has to do with changes in treatments and technology—treating conditions at lower thresholds (like the recent drop in the cholesterol level at which doctors recommend treatment); more effective but costlier treatments and prescription drugs; and more complex technology.

Other arguments have to do with changing demographics and a shift in the kinds of illnesses treated. Americans are getting older, and older people need more medical care. Also, some point out that decades ago, more of the illnesses treated were acute—like influenza—and the patient either got better or died in a fairly short time. Now, chronic illnesses and conditions—like high blood pressure—are common and require long-term treatment.



And many Americans link high costs to behavior of drug companies, the insurance industry, the medical and legal professions, and individual Americans. Such behavior would include, for instance, insurance and drug companies making high profits; doctors overbilling government programs; and patients filing lawsuits—causing doctors to practice "defensive medicine."

Probably there are other opinions we haven't discussed here. We're not endorsing any of them, but merely pointing out that many things could be contributing to rising costs—and it's a puzzle how all the pieces fit together. We will learn more as we study Alaska's health-care system. But for now, we want to emphasize that the answer to what is driving health-care costs is not simple, and finding solutions won't be simple either.

Endnotes

1. Our estimates are based on the Center for Medicare and Medicaid Services' definitions of personal health care spending. See http://www.cms.hhs.gov/NationalHealthExpendData/01_Overview.asp#TopOfPage. We have also included insurance costs, to capture the expenses paid by employers and employees.

2. ISER *Research Summary* No. 53, "The Cost of Health Care in Alaska," December 1992.

3. The decline in state share is expected to ameliorate somewhat beginning in FY 2006, due to a decision by the 9th District Appellate Court to disallow the Fair Share program that enabled tribal hospitals to receive a higher reimbursement than non-tribal hospitals for uncompensated care.

4. U.S. Census Bureau figures from the Current Population Survey classify Alaskans with coverage only through the Indian Health Service as "uninsured." We have adjusted those figures, separating those with IHS-only coverage from the uninsured. The adjustment is based on methods of the University of Minnesota's School of Medicine, State Health Access Data Center.

5. American Academy of Pediatrics figures for uninsured Alaska children are adjusted U.S. Census figures, separating children with IHS-coverage only from the "uninsured" category.

6. National Academy of Sciences, *Hidden Costs, Value Lost: Uninsurance in America*. Available at: http://www.nap.edu/catalog/10719.html Public subsidies for uncompensated care are illustrated in the State of Alaska's FY 2007 budget request, which includes $27 million to help Alaska hospitals pay for uncompensated care.

7. In 1999, for example, health-care spending for Americans 75 to 84 was seven times higher than for those 18 and under.

8. See note 6.

9. United Health Foundation, *America's Health Rankings*, 2005 edition.

10. See Chapter 3 in ISER report, *Status of Alaska Natives 2004*, May 2005.

11. Our original figure for number of dentists per 100,000 in Alaska was incorrect. We thank researchers at Health Planning and Systems Development in the Alaska Department of Social Services for helping us identify that error. A separate addendum, *Dentists in Alaska*, prepared in March 2007, provides more information about the source of the error and the correction. See: http://www.iser.uaa.alaska.edu/Publications/researchsumm/UA_RS6_addendum03_07.pdf

About the Authors: Mark Foster is a research consultant to ISER. Scott Goldsmith is a professor of economics at ISER. The authors thank their colleagues at ISER for their help—Rosyland Frazier, Virgene Hanna, Lexi Hill, Stephanie Martin, and Kerry Pride.

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This is the executive summary of the report by Commonwealth North. The entire 38 page report is posted on Basis in the bill Documents section. Finance committee staff can print out the entire report upon request.

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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TABLE OF CONTENTS

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.

COMMONWEALTH
NORTH

Resolution 2009-3
In support of continuing the Alaska Health Care Commission as proposed in Senate Bill 172
April 14, 2009

This resolution is based on the 2005 Commonwealth North study entitled "Alaska Primary Health Care: Opportunities and Challenges."

Commonwealth North:

Encourages the Alaska State Legislator to extend the life of the Alaska Health Care Commission

Requests all state legislators to approve authorizing legislation in Senate Bill 172; and

Forwards this resolution to all members of the Alaska State Legislature, Governor Sarah Palin, and Alaska's congressional delegation.

Resolved for the following reasons:

1. A body needs to be vested in the long term interest in understanding and improving the system; consistent advocacy is necessary make needed fundamental changes

2. 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

Approved by the Commonwealth North Board of Directors
April 14, 2009

David Wight, President

MUNICIPALITY OF ANCHORAGE

Department of Health and Human Services 907-343-6718

Mayor Dan Sullivan

SENIOR CITIZEN ADVISORY COMMISSION

February 9, 2010

The Honorable Donald Olson
State Capitol Room 506
Juneau AK, 99801

Dear Senator Olson,

RE: Letter of Support for SB 172

The Municipality of Anchorage Senior Citizens Advisory Commission strongly supports the passage of SB 172, which would extend the Alaska Health Care Commission until the year 2014.

Health care reform is an issue at the forefront of our country's executive and legislative agenda. Regardless of what shape national health care reform ultimately takes, Alaska will still have to address health care issues in our own state.

The Alaska Health Care Commission will recommend a statewide plan for addressing the availability, accessibility, and quality of health care for all Alaskans. We need an expert team to plan for long-term health care solutions in our state that is supported by our Legislature.

As Alaskans grow older and live longer, it is imperative that quality health care be available and accessible. The Commission supports SB 172 and urges passage of this important legislation.

Respectfully,

Dawnia Clements, Chair
Senior Citizens Advisory Commission
6800 Louise Court
Anchorage, AK 99507

CC: Senator Bettye Davis, Chair, Health and Social Services Committee
Senator Joe Paskvan, Vice-Chair, Health and Social Services Committee

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March 16, 2010

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

RE: SB 172 (Olson)--Support

Dear Chair Davis:

On behalf of the members of AARP in Alaska, we encourage you and your colleagues on the Senate Health and Social Services Committee to support SB 172, authored by Senator Donald Olson.

As you know, Governor Palin appointed a Health Care Commission that took on this enormous responsibility in 2009. Senator Olson serves on that Commission.

SB 172 would basically extend the life of the Alaska Health Care Commission until 2014 and give it responsibility to develop, adopt and implement the recommendations the Commission comes up with.

Alaska and our entire country have entered a period during which many health issues are being and will continue to be considered. Not all decisions will be made in Washington. No matter what the White House and Congress do, it is evident that every state will have to make health care work for its citizens. Indeed, if Congress does not take significant action, Alaska and the other states will have even greater responsibility to determine how we will deal with our own future health care issues.

As we review the responsibilities of the Commission as outlined in SB 172, it is obvious to us that this will be one of the most important teams to address issues that touch every single Alaskan.

We believe that it is critical that SB 172 passes to allow the Commissioners to take on this responsibility, knowing that they will have the support of the Legislature for an extended period.

AARP requests an "AYE" vote on SB 172.

Should you have any questions about our position, please feel free to contact me (586-3637) or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Joe Paskvan
Senator Johnny Ellis
Senator Joe Thomas
Senator Fred Dyson
Senator Donald Olson