# SB 172

<target><bill>SB 172</bill><subject>SB 172</subject><comm>SFIN26</comm></target>

# ALASKA STATE LEGISLATURE


## SENATOR DONALD C. OLSON

CAPITOL BUILDING
ROOM 514
JUNEAU, AK 99801-1182
PHONE: (907) 465-3707
FAX: (907) 465-4821


## Senate Bill 172 Alaska Health Care Commission

26-LS0790\A

### SPONSOR STATEMENT

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 ten 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 bring 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.

# 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.

# SENATE FINANCE COMMITTEE REPORT

DATE: 3/18/10

FURTHER:

DATE TURNED
IN TO OFFICE: _____

**Finance Committee** considered SENATE BILL NO. 172

SB 172 ALASKA HEALTH CARE COMMISSION

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

and recommends:

[√] be **replaced** with [ ] **SCS** or [√] **CS** SB 172 ( FIN )

[ ] adopt **previous** [ ] **SCS** or [ ] **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt _____Letter of Intent

[ ] further referral to _____Committee

**SENATE BILL:**
[ ] Same Title
[x] New Title

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

**NEW FISCAL NOTE(S):**

| Department | Date | Fiscal | Indet. | Zero | FN# |
|---|---|---|---|---|---|
| HSS | 4/7/10 | √ | | | |
| | | | | | |
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| | | | | | |
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**PREVIOUS FISCAL NOTE(S):**

| Department | Date | Fiscal | Indet. | Zero | FN# |
|---|---|---|---|---|---|
| | | | | | |
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[ ] **APPROPRIATION - no fiscal note**

| SIGNATURES AND RECOMMENDATIONS: | PRINTED LAST NAME | DO PASS | DO NOT PASS | NO REC | AMEND |
|---|---|---|---|---|---|
| | HUGGINS | X | | | |
| | Thomas | ✓ | | | |
| | EGAN | ✓ | | | |
| | OLSON | X | | | |
| | Ellis | X | | | |
| CO-CHAIR: | Hoffman | ✓ | | | |
| CO-CHAIR: | Stedman | ✓ | | | |

# FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

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

Identifier (file name): CSSB172-DHSS-CO-04-07-10
Dept. Affected: Health & Social Services

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

Sponsor: Olson

Requester: Senate FIN
Component Number: 106

**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 12 members. SB 172 closely parallels Administrative Order #246, the Governor's December 2008 order establishing a health care commission to address Alaska's health care challenges.

The current Alaska Health Care Commission's 2009 report included a formal policy recommendation to establish a permanent health care commission in statute to address the need for health care reform in Alaska.

(continued on page 2)

Prepared by: Ward B. Hurlburt, MD, MPH, Chief Medical Office / Director
Phone 269-8126
Division: Public Health
Date/Time 4/2/10 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
Date 4/7/2010
DHSS Finance & Management Services

(Revised 11/6/2009 OMB)

**ANALYSIS CONTINUATION**

(continued from page 1)

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 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 an ad-hoc body. Most recently, the new federal health care reform 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 advice on implementation.

$500.0 ($165.0 Fed/$335.0 GF Match) is required for operations of the health care commission, as follows:

**71000 Personal Services:** The bill states that an Executive Director (range 23, step F) would staff the commission, $134.5; in addition an Administrative Assistant I (range 12) is required to provide administrative support, $58.2.

**72000 Travel:** Travel and per diem for commission staff and for 12 commission members, including the two legislators, to conduct quarterly face-to-face public meetings at various locations around the state.

**73000 Contractual:** Professional services contracts will be needed to supplement staff research; meeting expenses such as transcriptionist, audio, and meeting space will be incurred; and core service RSAs will be required to provide lease space, telecommunications, mainframe connectivity, printing, postage, etc.

**74000 Supplies:** FY11 includes start-up costs such as computers, office furniture, reconfiguring leased space, wiring needs for connectivity, printers, fax, and photocopier. On-going 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 4-9-10

26-LS0790\P.1
Mischel
4/9/10

**AMENDMENT** 1

OFFERED IN THE SENATE BY SENATOR HUGGINS

TO: CSSB 172(HSS)

Page 3, line 6:

Delete "12"

Insert "13"

Page 3, line 8:

Delete "nine"

Insert "10"

Page 4, line 3:

Delete "and"

Page 4, following line 3:

Insert a new subparagraph to read:

"(J) one member who represents community health centers in the state; and"

Page 4, line 17:

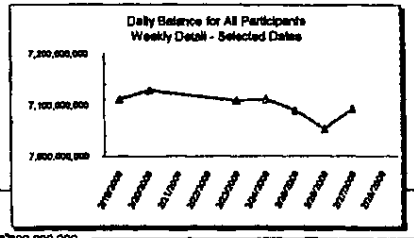
Delete "AS 18.09.020(1)(B) - (I)"

Insert "AS 18.09.020(1)(B) - (J)"



4481

# General Fund and Other Non-Segregated Investments (GeFONSI)



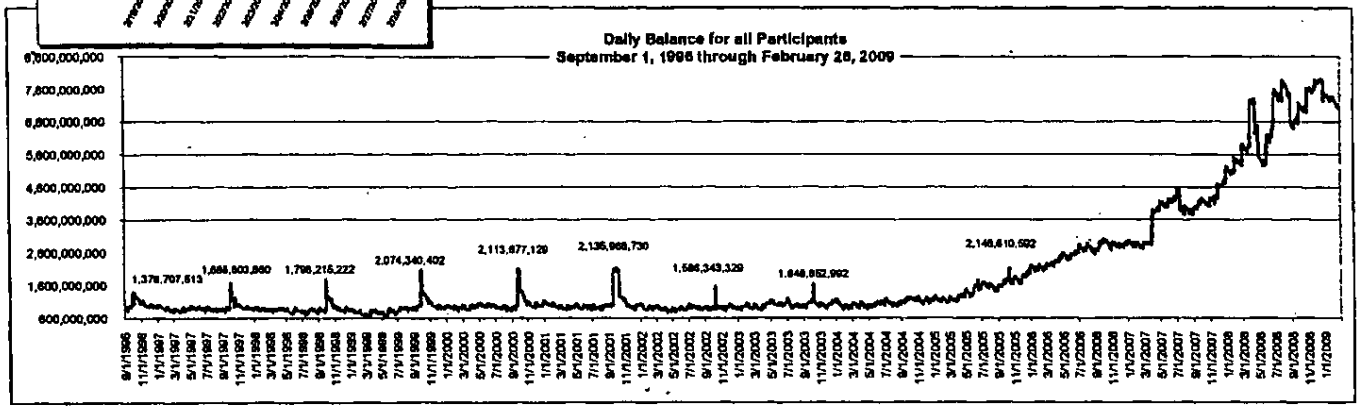

Historically, the operating General Fund has made up about 1/3 of the GeFONSI.

Beginning 7/1/99, daily balances shown below include unallocated receipts, some of which may be transferred to non-GeFONSI participants. The daily unallocated balance generally averages about $60 million and doubles at month end.

7/3/00: Transfers from CBR through GeFONSI not reflected below.

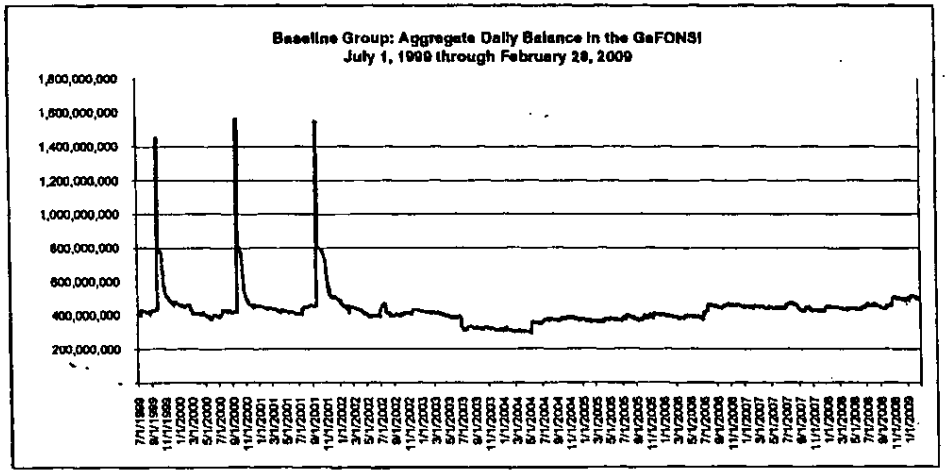
7/26/02: PFD Corporation transferred $897 million to the General Fund for the 2001 dividend. These funds along with $49 million previously invested in the GeFONSI have been invested separately. These balances do not appear on GeFONSI charts.

10/04: Electronic deposits of PFDs were not processed through the GeFONSI.




Baseline Group Information:
The baseline group was formed in February 1998 when Treasury considered the creation of a second GeFONSI. The baseline group is composed of participants (funds) which have demonstrated stable balances or predictable trends over time. This group, along with the General Fund, represents the core of the GeFONSI (based on daily balances). The baseline group contains the following participants (additional information is available from Treasury Division, Accounting Section):

21468 OHSR Substance Prevention*
21472 OHSR Response Account*
21477 Employee Assistance & Training
21478 Storage Tank Assistance
21496 Fishermen's Fund**
21497 Ratbelt Energy*
21503 Prevention Mitigation*
21504 Oil Restoration*
21511 Municipal CIP Matching Grants**
21512 Unincorporated CIP Matching Grants**
21516 Power Cost Equalization* (inactive 4/2005)
21520 School Fund
21530 Fish and Game Fund*
21560 AK Marine Highway**
21980 Agricultural Revolving Loan
21900 Commercial Fish Revolving Loan Fund
22078 Alaska Clean Water Fund*
22083 Power Project (inactive 4/2001)
22110 Highway Equipment Working Capital Fund - Operating
22115 Information Services
22160 Suspense and Deposits
22162 Public Advocacy Trust*
22170 Permanent Fund Dividend
22178 Alyeska Settlement*
22297 Student Loan Corp. - GF Appropriations*




* Indicates that the participant is credited with investment income.
** Indicates that the participant is credited with investment income only if appropriated by the State Legislature.

Treasury Division, Department of Revenue

# About the Commission

The Alaska Health Care Commission was established by Governor Palin on December 4, 2008 under Administrative Order #246. The Commission will serve as the state health planning and coordinating body, providing recommendations to the governor and the legislature on a comprehensive statewide health care policy and on strategies for improving the health of Alaskans.

Creation of the Alaska Health Care Commission follows from the work of the Alaska Health Care Strategies Planning Council. The Council was convened by the Governor in 2007 to develop a set of strategies for improving access to health care in Alaska. One of the Council's seven recommended goals was to develop the leadership necessary to support a comprehensive statewide health care policy through creation of an on-going commission.

The Alaska Health Care Commission consists of 10 members. Membership requirements are specified in the Administrative Order, and include the state's chief medical officer (who also serves as chairperson of the commission), an Alaska health care provider and an Alaska health care consumer, and one representative each from the Alaska tribal health system, the Alaska health insurance industry, the Alaska State Chamber of Commerce, and the Alaska State Hospital and Nursing Home Association. Three nonvoting members are representatives from the state Senate, House of Representatives, and executive branch. Governor Palin announced the appointment of the members to the commission on January 27, 2009.

The commission's first year of study and planning will culminate in a report to the governor and the legislature due January 15, 2010. This web site will be updated regularly with information on the meetings and work of the commission.

## Contact the Commission

Deborah Erickson
Executive Director
Alaska Health Care Commission
3601 C Street, Suite 902
Anchorage, AK 99503-5923
(907) 334-2474
(907) 269-0060 - Fax
deborah.erickson@alaska.gov


Sarah Palin
GOVERNOR

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

December 04, 2008

# ADMINISTRATIVE ORDER NO. 246

I, Sarah Palin, Governor of the State of Alaska, under the authority of art. III, secs. 1 and 24, of the Alaska Constitution, and in accordance with AS 44.19.145(c), establish the Alaska Health Care Commission (commission) in the Department of Health and Social Services.

## PURPOSE

The purpose of the commission is 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.

## DUTIES OF THE COMMISSION

The commission's duties are to:

1. serve as the state health planning and coordinating body;

2. consistent with state and federal laws, provide recommendations for and foster the development of a:

   A. comprehensive statewide health care policy;

   B. strategy for improving the health of Alaskans that includes

      i. encouraging personal responsibility in prevention and healthy living for all residents of the state;

      ii. a reduction in health care costs for all residents of the state to be below the national average;

      iii. access in communities of the state to safe water and wastewater systems;

      iv. the development of a sustainable health care workforce in the state;

      v. quality health care being accessible for all residents of the state; and

      vi. increasing the number of residents of the state who are covered by health

care insurance; and

3. submit a report to the Governor and the Legislature on or before January 15, 2010 regarding the commission's recommendations and activities.

## MEMBERSHIP

The commission consists of seven voting members appointed by the Governor, and the voting members serve at the pleasure of the Governor.

Voting members are:

1. the chief medical officer of the Department of Health and Social Services, who shall serve as the chair of the commission;
2. a representative from the tribal health community in this state;
3. a representative from the Alaska State Chamber of Commerce;
4. a representative from the Alaska State Hospital and Nursing Home Association;
5. a health care provider, who is
   A. actively practicing the provider's profession in this state;
   B. licensed in this state; and
   C. not affiliated with the Alaska State Hospital and Nursing Home Association;
6. a representative of the health insurance industry in this state; and
7. a health care consumer who is a resident of this state.

Non-voting members are:

1. an ex officio, non-voting member from the executive branch, appointed by the Governor;
2. an ex officio, non-voting member from the Alaska House of Representatives, appointed by the speaker of the house; and
3. an ex officio, non-voting member from the Alaska Senate, appointed by the president of the senate.

## ADMINISTRATIVE SUPPORT

The commission shall employ an executive director, 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 Department of Health and Social Services may assign employees of the Department of Health and Social Services to serve as staff to the commission. The commission shall prescribe the duties of the staff.

The commission shall, upon approval of a majority of its members and consistent with state law, adopt and amend, as necessary, bylaws governing its proceedings and all other activities.

**GENERAL PROVISIONS**

Commission members do not receive compensation as members of the commission. Members of the commission who are not state or federal employees are entitled to per diem and travel expenses in the same manner permitted for members of state boards and commissions. Per diem and travel expenses for members of the commission who are representatives of a state or federal agency are the responsibility of that agency.

To reduce costs, the commission may use teleconferencing and other electronic means to the extent practicable, in order to gain the widest public participation at minimum cost.

Meetings of the commission shall be conducted in accordance with AS 44.62.310 and 44.62.320 (Open Meetings of Governmental Bodies).

Records of the commission are subject to inspection and copying as public records under AS 40.25.110 - 40.25.220.

This Order takes effect immediately.

DATED at Anchorage, Alaska this 4th day of December, 2008.

/s/Sarah Palin
Governor

## PROPOSED HEALTH COMMISSION MEMBERS

**Sec. 18.09.020 Composition; chair**. The commission consists of 12 members as follows:

Nine voting members appointed by the governor as follows:

(1) The state officer assigned the duties of medical director for the department, who shall serve as chair;

(2) One member representing the tribal health community in the state;

(3) One member representing a statewide chamber of commerce who is not associated with health care;

(4) One member representing the Alaska State Hospital and Nursing Home Association

(5) One member who is a health care provider

(i) Actively practicing the provider's profession in the state;
(ii) Licensed to practice in the state; and
(iii) Not affiliated with the Alaska State Hospital and Nursing Home Association;

(6) One member who is a representative of the health insurance industry in the state;

(7) One member who is

(i) A health care consumer;
(ii) A resident of the state; and
(iii) Not employed by and does not have a business interest in the health care industry; and

(8) One member who is a primary care physician (i) licensed to practice in the state; (ii) board certified in family medicine or pediatric medicine; and (iii) who practices family medicine, primary care internal medicine, or pediatric medicine.

(9) One member who is a behavioral health care provider (i) licensed as a behavioral health practitioner is the state or (ii) employed as an administrator of an organization that provides behavioral health care services.

(2)Three nonvoting members appointed as follows:

(A)One ex officio member from the house of representatives, appointed by the speaker of the house of representatives;

(B)One ex officio member from the senate, appointed by the president of the senate;

(C)An ex officio member representing the Office of the Governor.

# 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

April 5, 2009

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, a bill to establish the Alaska Health Care Commission in the Department of Health and Social Services. This legislation is authored by you.

The purpose of the Alaska Health Care Commission is to provide recommendations for and facilitate development of a statewide health plan to address the quality, accessibility, and availability of health care for all Alaskans in a cost-effective manner. ACoA supports the establishment of a state commission to comprehensively and systematically address the multitude of issues related to improving health care services, including preventative care and chronic disease management within the primary care setting through collaboration with public and private partners.

Older Alaskans represent one of the largest consumer groups of health care services of all age categories. Access to primary care is of top concern for many Alaska seniors insured by Medicare who are challenged to find a primary care physician particularly if they live in Anchorage, Fairbanks, and 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. In addition, workforce shortages of health care workers, particularly nurses and doctors, is another serious problem that affects all Alaskans and has a critical impact on people 65 years and older. These are examples of issues that ACoA would like to see addressed by the Alaska Health Care Commission.

ACoA supports SB 172. We also ask you to consider including a seat on the Alaska Health Care Commission to represent the health care concerns of older Alaskans. Please feel free to contact Denise Daniello, ACoA's executive director (465-4879), should you have any questions regarding our position or request assistance from our office. Thank you for your sponsorship of SB 172.

Sincerely,

Sharon Howerton-Clark
Chair, Alaska Commission on Aging

Sincerely,

Denise Daniello
ACoA Executive Director

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

COMMONWEALTH NORTH

# Alaska Primary Health Care: *OPPORTUNITIES & CHALLENGES*

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


**Co-chairs:**
**Thomas Nighswander, M.D. and Marvin Swink**

**Editor: Duane Heyman**
**Hartig Fellow: Dan Kiley, D.D.S.**



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Alaska Regional Hospital
Dorsey & Whitney LLP
ConocoPhillips Alaska
Alaska Railroad Corporation
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## EXECUTIVE SUMMARY

### Why Alaska health care issues must be addressed and solved

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

**ACCESS**

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

**QUALITY**

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

**COST**

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

### What can we do?

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

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

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

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

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

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

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

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

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

### The Alaska Health Care Roundtable ("Roundtable")

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

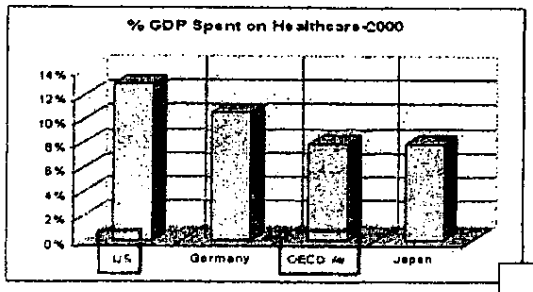
The core membership in the Roundtable would be self-selecting, comprised of members with a long-term compelling interest in improving the Alaska health care system. Examples of core members would be major employers at risk, health care providers and local foundations. A wide variety of other potential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

## INTRODUCTION

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

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

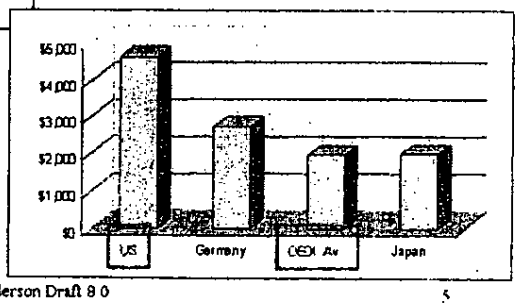
# The National Situation - Spending




OECD—Organization for Economic Cooperation and Development

Source: Commonwealth Fund

Per capita health care expenditures by country

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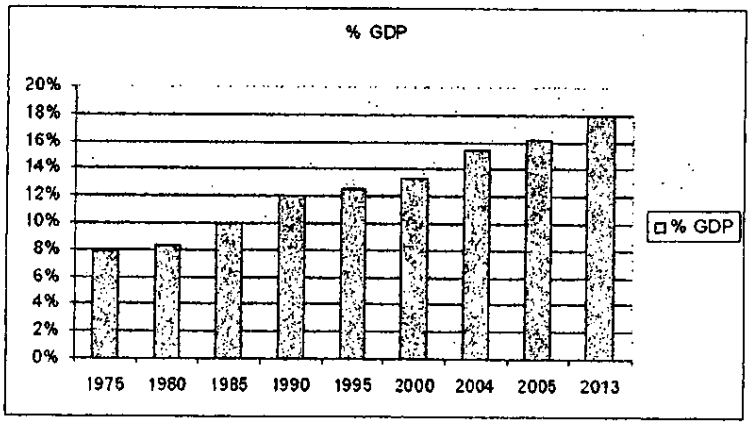
Health care spending has risen dramatically in recent years, increasing from about 8 % of the gross domestic product in 1975 to over 16% today. The Commonwealth Fund, a private nonpartisan foundation that supports independent research on health and social issues, projects that by 2013 the U.S. will be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

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

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




Source: Commonwealth Fund

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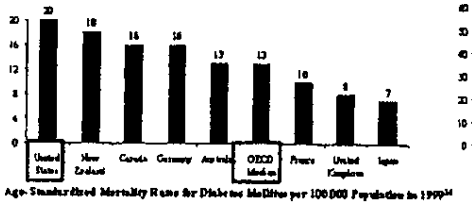
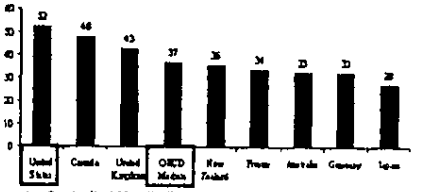
The **Commonwealth Fund** is a foundation specializing in health care issues.

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

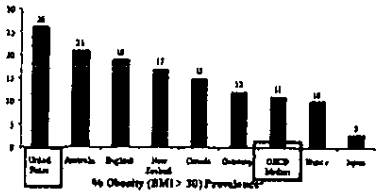
## The National Situation: Outcomes



DIABETES



LUNG CANCER



OBESITY

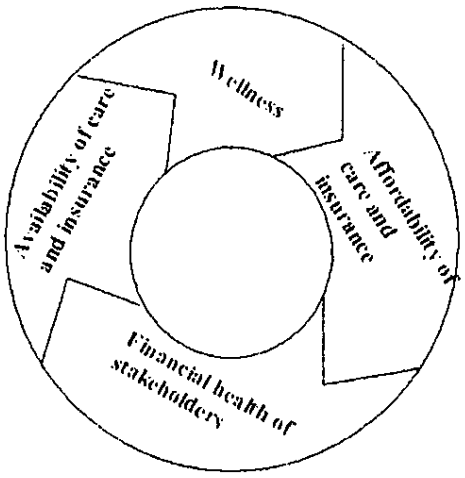
And, the U.S. ranks only

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

Source: OECD Health Data 2002,
March of Dimes Data Center 2002
World Health Organization 2000

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

# Four Primary Healthcare Factors and how they are interrelated

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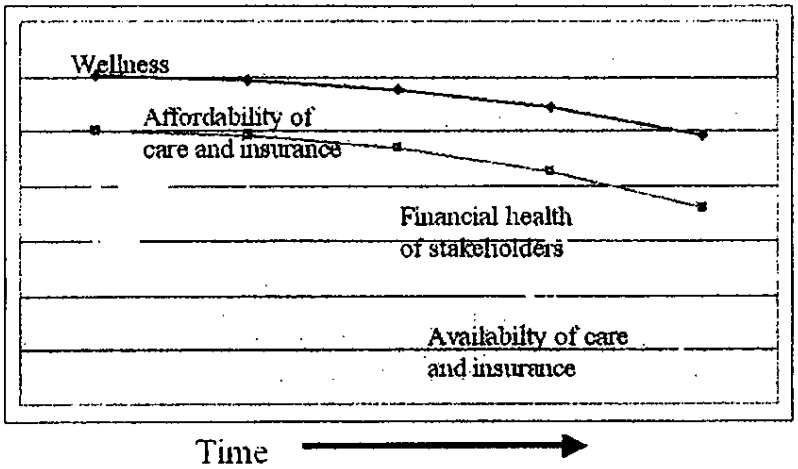
- Wellness of the population
- Affordability, coordination and quality of care and insurance
- Availability of care and insurance
- Financial health of stakeholders including:
  - Health care providers (physicians, clinics, hospitals)
  - Companies, institutions and government

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

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

# The conceptual crux of the problem

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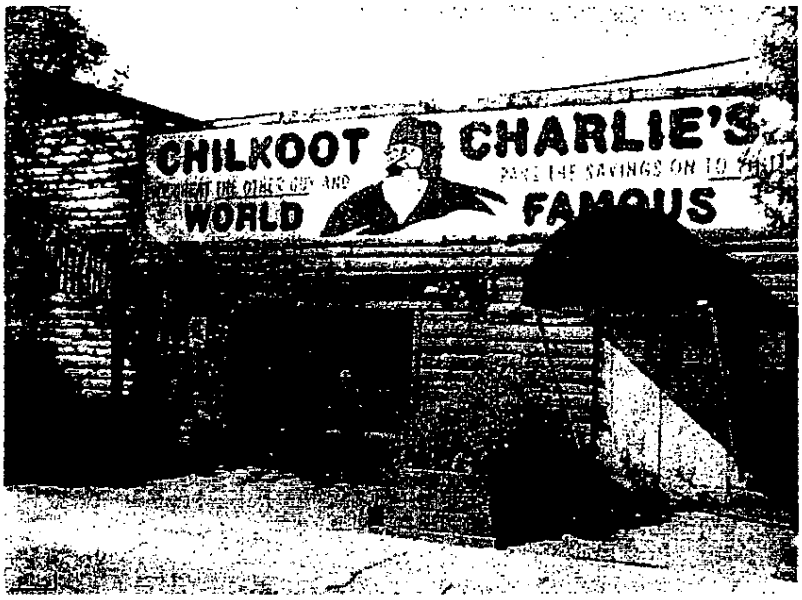
A significant problem is a de facto dynamic in our current U.S. health care policy.

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



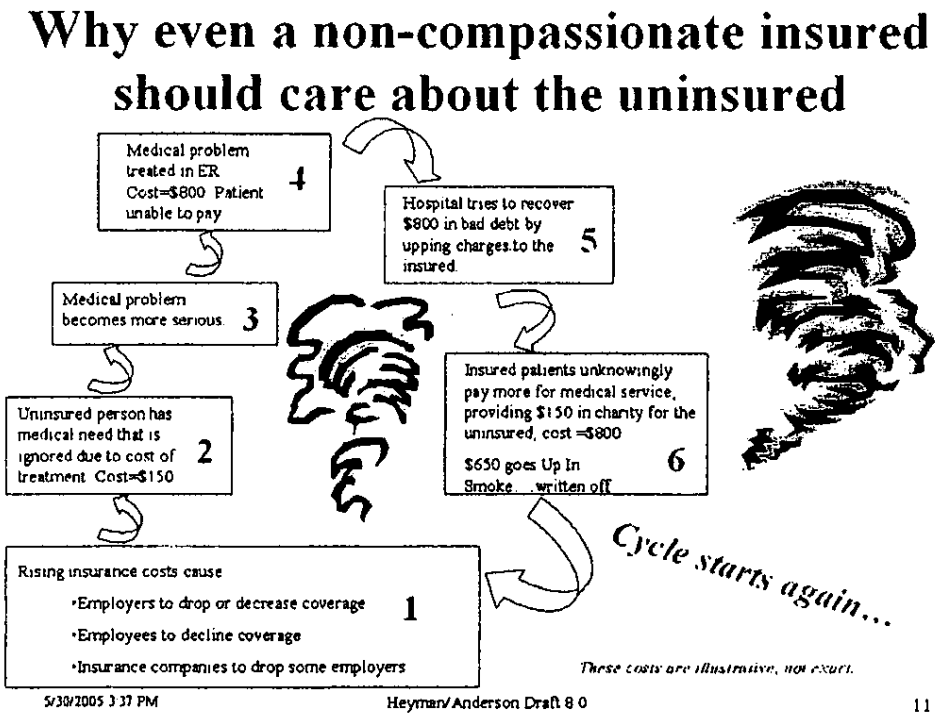

"We cheat the other guy and pass the savings on to you!"

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

## A SIGNIFICANT ISSUE FOR HEALTH CARE IN ALASKA

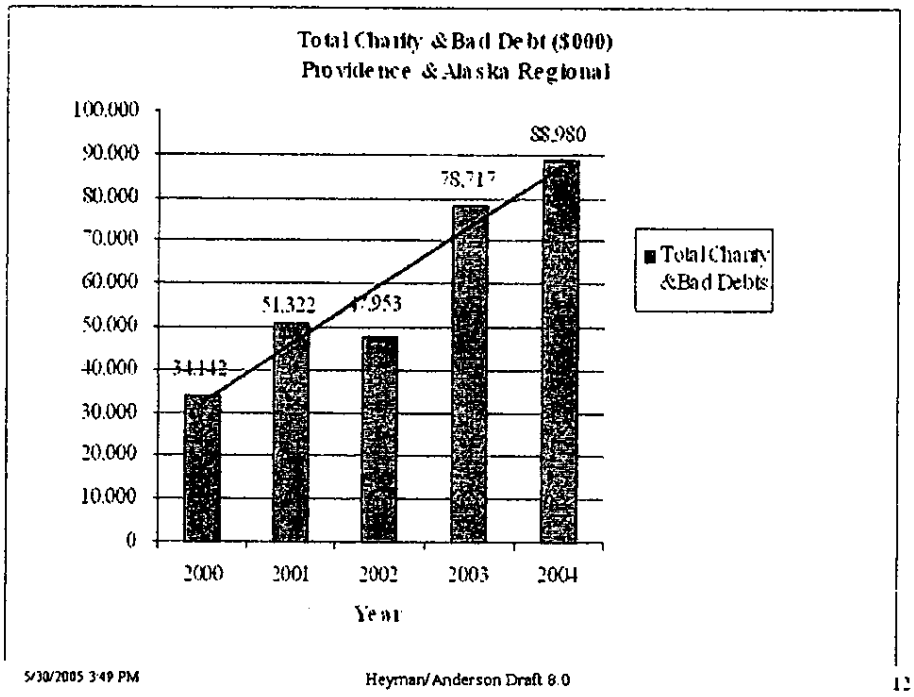
The focus of this study is what can be done in Alaska. It does not address national issues such as a single payer system, rationing of health care or national structural issues. However, the following conceptual illustration is both a national and Alaska problem.

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

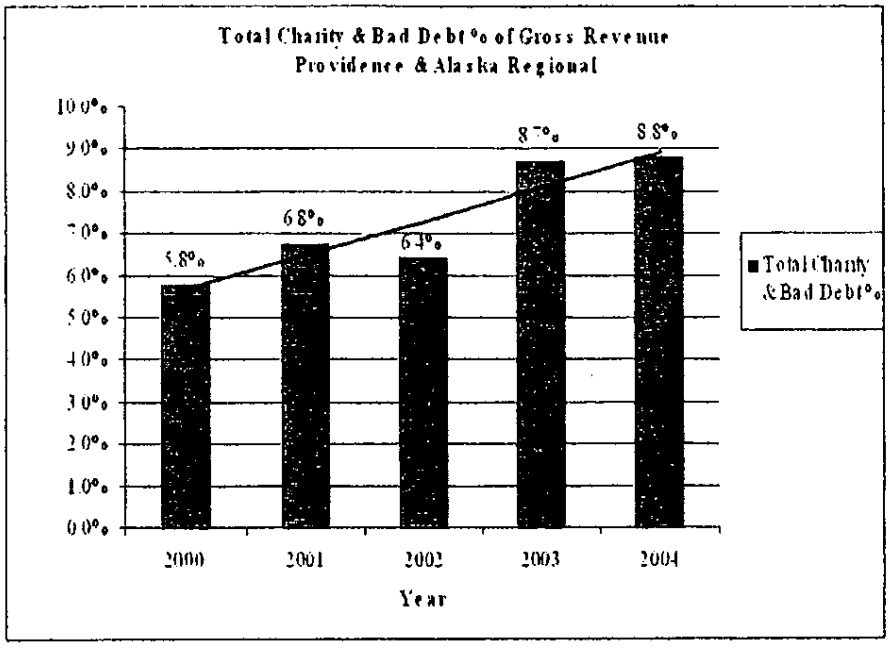



A federal law, the Emergency Medical Treatment and Active Labor Act ("EMTALA") requires that hospital emergency rooms treat and not turn away any patients who show up, regardless of ability to pay.

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




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

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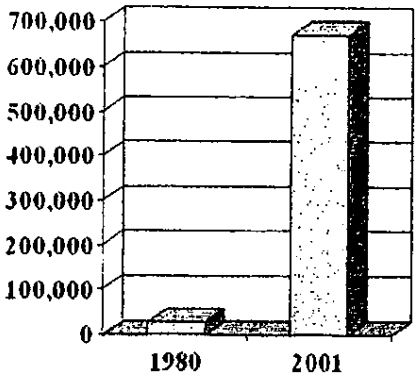
The financial impact on hospitals is even more acute than the slide above suggests. While the percentage of charity and bad debt compared to gross revenue has increased dramatically in recent years, the bottom line impact is significantly greater because actual hospital cash collections are much less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

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

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




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

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

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

Main factors cited for declaring bankruptcy were:

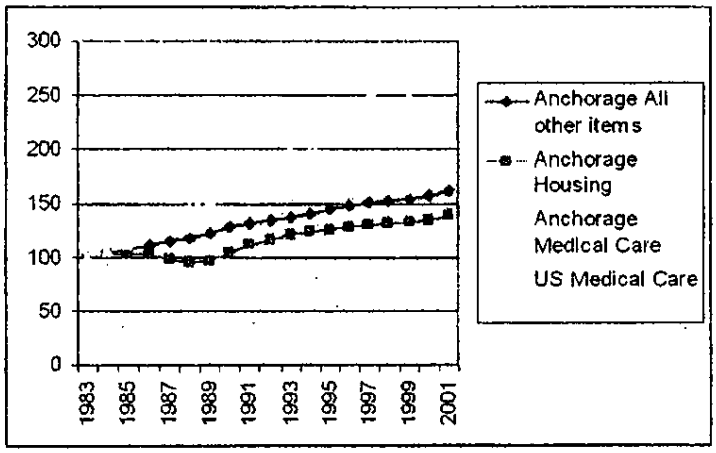
| | |
|---|---|
| Hospital costs | 42% |
| Prescription drug costs | 21% |
| Doctor bills | 20% |

**Cost: What do Alaskans pay? Why?**

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

# Increasing Cost of Medical Care in Alaska

Anchorage CPI-U for selected components 1982-2001




Source: Alaska Economic Trends June 2004

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

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

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

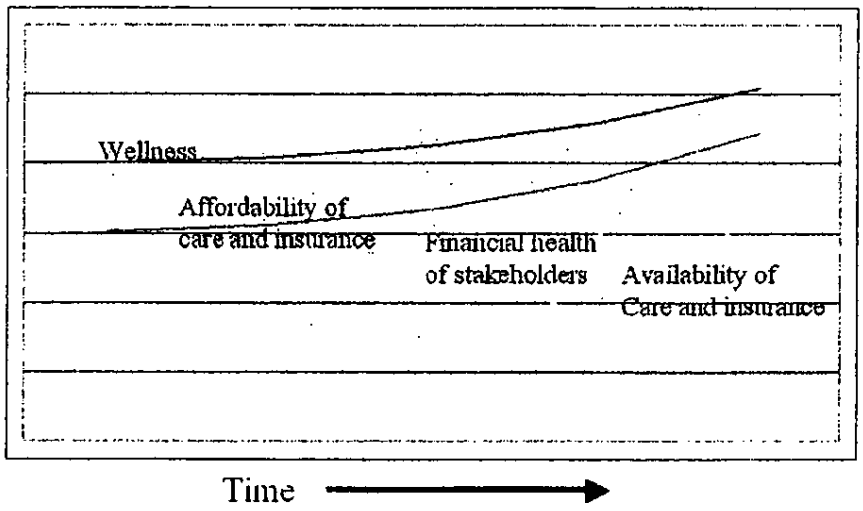
**formulas are going down**. The state is now paying over one billion dollars annually to pay Medicaid expenses.

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

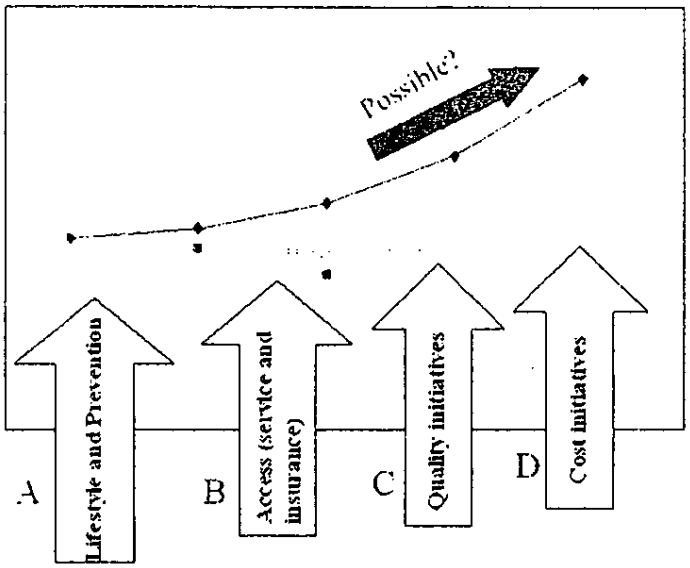
The **Certificate of Need** situation needs to be objectively analyzed and considered as a component in a comprehensive statewide health care plan. Critics of the Certificate of Need claim the process stifles competition and innovation. Supporters claim it prevents unnecessary duplication of facilities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

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

# Is a trend reversal possible in Alaska?



# Perhaps, with coordinated and focused effort

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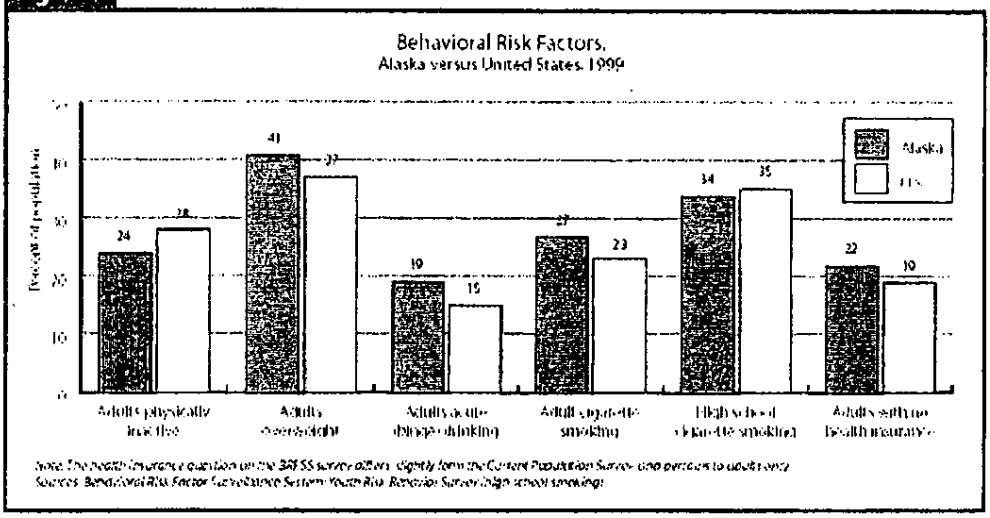
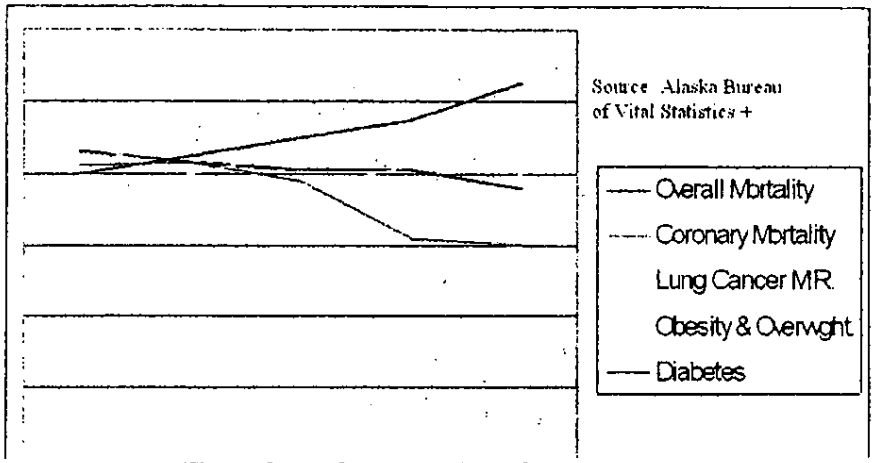
**Quality of Alaska's health: Based on the 2004 National Health Care Quality Report of 100 measures of health care quality, Alaska is about average for the U.S. However, as the charts on page 7 indicate, the U.S. trails many other industrialized nations.**

## Unfortunately, Alaska mirrors poor National behavioral risk factors

**Figure 9**



# Alaska Trends in major disease




**Trends only—not incidence rates**



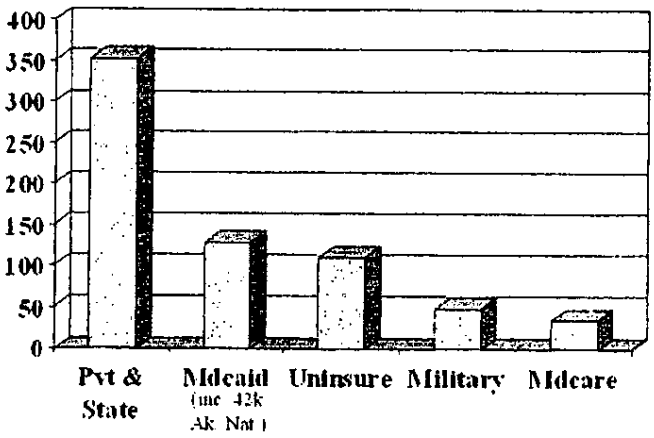
(Vertical axis is rates of disease, horizontal axis is time)

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

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

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

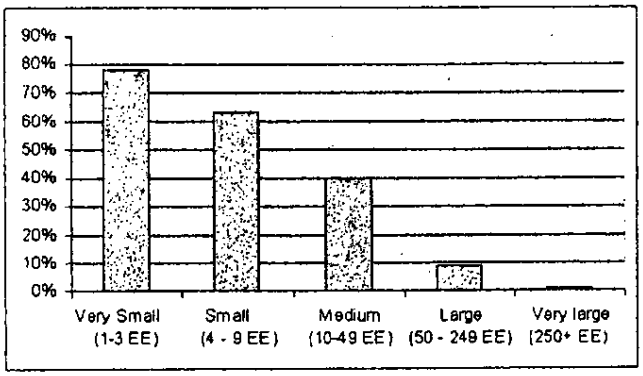
## Alaska's Insurance Coverage




Source Navigant Consulting, Ak Journal of Commerce

The majority of Alaskans without insurance work for smaller businesses.

# Alaskan firms NOT offering health insurance




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

Source: Alaska Dept of Labor and Workforce Development, 2002

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## Safety net providers

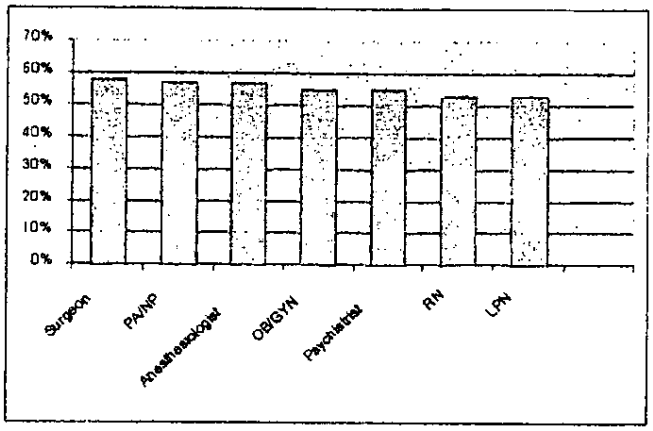
There are 34 federally sponsored Community Health Centers (CHCs) in Alaska. They see all patients and charge a sliding fee schedule based upon income. Although there are the Neighborhood Health Center in Anchorage and the Interior Community Health Center in Fairbanks (both federally sponsored CHSs),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

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

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

# Healthcare Provider Shortages are Projected for Alaska

PERCENT OF PROVIDERS CURRENTLY MORE THAN 45 YEARS OF AGE




Source: AK Department of Labor

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

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

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

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

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

## SPECIFIC ALASKAN RECOMMENDATIONS FOR IMPROVEMENT

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

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

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

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

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

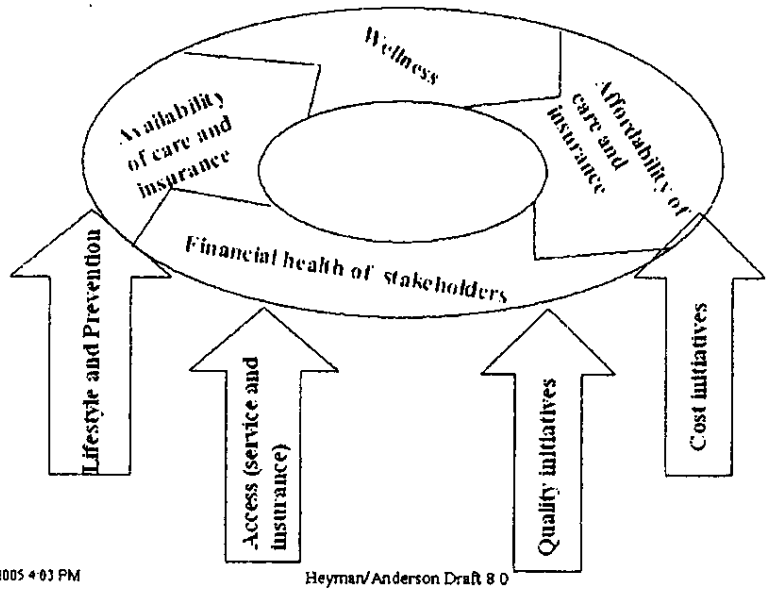
    a. **Continue the communication process started by this Study Group among the key elements in the Alaska health care system and the broader Alaska community.**

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

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

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

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




## The Alaska Health Care Roundtable

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

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

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

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

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

**Funding:** Voluntary contributions by the participants.

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

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

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

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

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

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

**A = Parties affected by or benefiting from the listed Recommendation**

**R = Parties responsible for implementing the listed recommendation**

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

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

## The impact of lifestyle and prevention

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

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

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

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

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

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

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

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

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

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

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

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

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

## Access improvement recommendations

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

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

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

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

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

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

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

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

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

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

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

## Quality improvement recommendations

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

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

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

## Cost reduction recommendations

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

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

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

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

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

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

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

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

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

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

## SUCCESS STORIES AND PROMISING PROGRAMS

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

Lifestyle and prevention

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

Access

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

Quality

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

Costs

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

**Other programs show promise:**

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

Lifestyle and prevention

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

Access

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

Quality

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

## APPENDIX

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

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

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

3. Health care reform creates winners and losers.

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

### Study Group Participants

Co-chairs: Thomas Nighswander, M.D and Marvin Swink
Editor: Duane Heyman
Hartig Fellow: Dan Kiley, DDS

Kathy Anderson, Eleanor Andrews, Sergei Bogojavlensky, MD, PC, Steven Boyd, Sharon Cissna, Bill Dann, Fred Dyson, Mark Foster, Alice Galvin, Ed D, Catherine Giessel, FNP-CS, Scott Goldsmith, Ph D, Joe Griffith, Parry Grover, Carolyn Heyman-Layne, David Hudspeth, Jewel Jones, Nancy King, Jonathan Kumin, Edward Lamb, Grace Long, Ph.D, John Patrick Luby, Tana Myrstol, Rebecca Parker, Al Parrish, Joanne Partain-Phelan, Jeff Ranf, Noel Rea, Tessa Rinner, David Snyder, MD, Greg Thies, Lawrence Weiss, Ph D, MS, Heather Wheeler, RD, Tim Wiepking, Kevin Wiley, Joan Wilson, James Yarmon

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| Dr. Elaine P. Maimon | Chancellor, University of Alaska Anchorage |
| Thomas Nighswander, MD | Assistant Dean, Alaska WWAMI Program; Medical Director, Qualis Health Alaska |
| Mary Ann Pease | Vice President, Investor Relations, Alaska Communications Systems, Inc. |
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| Eric Wohlforth | Attorney, Wohlforth, Vassar, Johnson and Brecht |
| James Yarmon | CEO, Yarmon Investments, Inc. |
| Duane Heyman | Executive Director, Commonwealth North |

## The Charge

### Alaska Primary Health Care – Opportunities & Challenges

**Approved by the Commonwealth North Board on July 20, 2004**

**1. Questions to be addressed:**

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

**2. Scope of study:**

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

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

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

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

**4. Conflict of interest standards:**

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

**5. Measure of success:**

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

## Resource People Interviewed

9.23.04 Ed Lamb, Al Parrish—Hospital perspectives

9.30.04 Barbara Russell—Premera

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

10.14.04 Commissioner Joel Gilbertson

10.21.04 Paul Sherry—Alaska Native Tribal Health Consortium

10.28.04 Tessa Rinner—Denali Commission

10.28.04 The Maine Plan (Sergei Bogojavlensky, MD)

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

11.18.04 Rod Betit—State Hospital & Nursing Home Association

12.02.04 Catherine Schumacher MD—Access to health care in Anchorage

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

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

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

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

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

2.03.05 James Jordan, Executive Director, Alaska State Medical Association

3.10.05 Ann Conway, Maine Center for Public Health

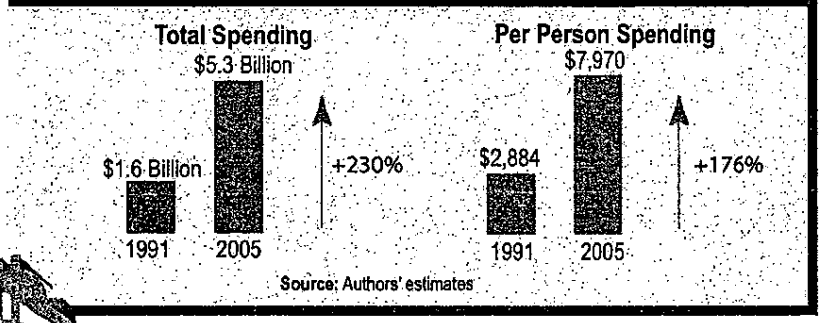
3.25.05 Joseph Ditre, Executive Director, Consumers for Affordable Health Care Foundation (Maine)

# 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:

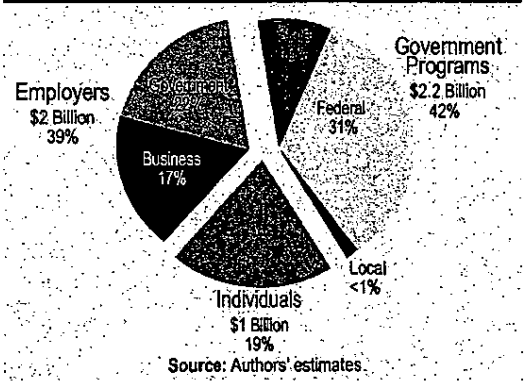
• Who are the most expensive patients? Our analysis of national data shows that the average "high-cost" patients aren't as expensive as you might think.

• 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.

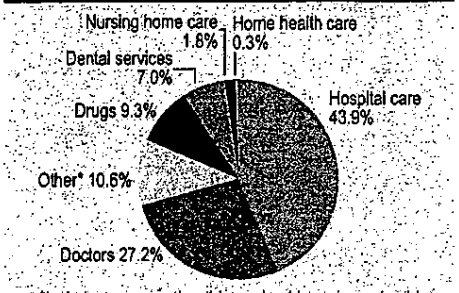
All types of health-care spending grew rapidly since 1990, but the fastest growth was in prescription drugs and the "other" category (described in the footnote to Figure 4).

## 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

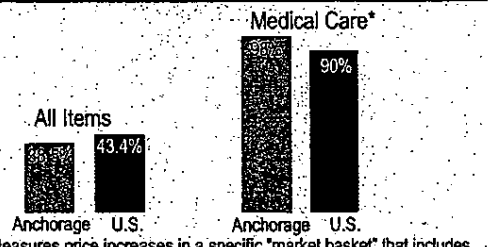
• State government's share dropped, partly because the federal government paid a bigger share of Medicaid costs in 2005 than in 1991.[3]

• 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).

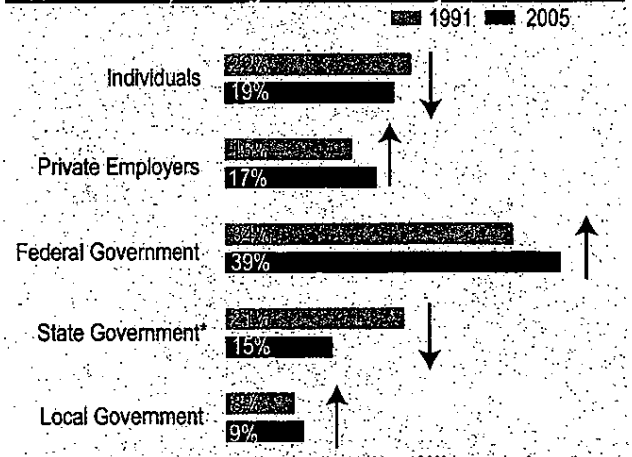
• Spending by individual Alaskans didn't go up as much—184%—but the $1 billion they spent in 2005 was still more than the $922 million businesses spent.

**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

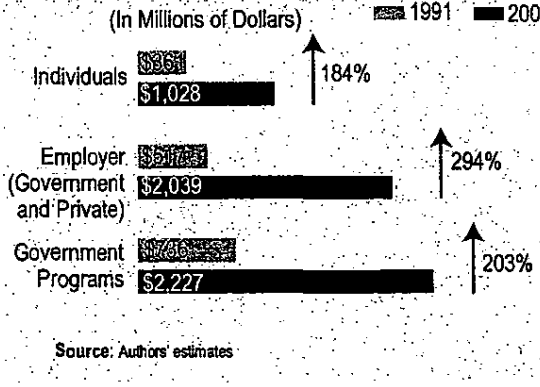
## Table 1. Health-Care Spending in Alaska, Fiscal Year 2005
(Total Spending: $5.3 Billion)

| Who Provides the Coverage? | Who Buys the Care? (In Millions of Dollars) | | | | | |
|---|---|---|---|---|---|---|
| | Individuals | Businesses | Local Government | State Government | Federal Government | Total |
| **Individuals** | $1,028 | | | | | $1,028 |
| Out-of-pocket costs | $438 | | | | | |
| Individual policies | $270 | | | | | |
| Payments for employer-based Insurance | $320 | | | | | |
| **Employers** (including retiree coverage) | | $922 | $454 | $252 | $411 | $2,039 |
| Insurance Premiums | | $303 | $63 | $72 | $75 | |
| Self-Insured Costs[a] | | $485 | $362 | $180 | $115 | |
| Military Medical Costs | | | | | $221 | |
| Worker's Compensation (medical benefits) | | $134 | | | | |
| **Government Health Programs** | | | $38 | $535 | $1,654 | $2,227 |
| Medicare | | | | | $949 | |
| Medicaid | | | | $303 | $667 | |
| Other Public Programs | | | | | | |
| Federal | | | | | | |
| Indian Health Service Contracts | | | | | $101 | |
| Veterans' Affairs | | | | | $105 | |
| Community Health Centers | | | | | $28 | |
| State | | | | | | |
| Grant to local governments, private groups | | | | $116 | | |
| API, Pioneers' Homes | | | | $55 | | |
| Other State-Administered | | | | $31 | | |
| Elementary and Secondary Schools | | | $3 | $8 | $96 | |
| WAMI Medical Education | | | | $2 | | |
| Department of Corrections | | | | $21 | | |
| Local | | | | | | |
| Health and hospital spending | | | $35 | | $11 | |
| **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.

**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.?**

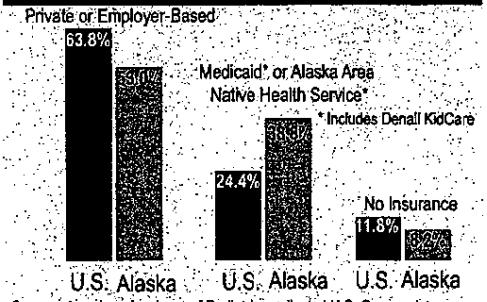
| By Age | Percent Uninsured |
|---|---|
| 18-24 | 31% |
| 65+ | 1% |
| **By Annual Income** | |
| Less than $25,000 | 24% |
| $75,000+ | 8.4% |

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

- 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).

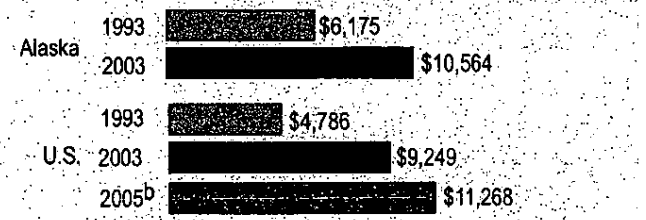
- Premiums are higher in Alaska, but workers here pay a smaller share, as Figure 11 shows. As of 2003, employees at private firms in Alaska paid 11% of the premiums for single-person coverage and 17% for family coverage, compared with 17% for single-person coverage and 25% for family coverage nationwide. 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 9. Health-Care Coverage for Children (18 and Under), Average 2001-2003**



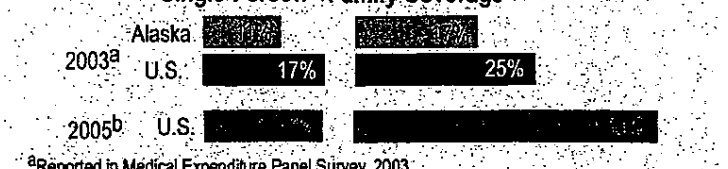

Source: American Academy of Pediatrics, adjusted U.S. Census data; see endnote 5, page 8.

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



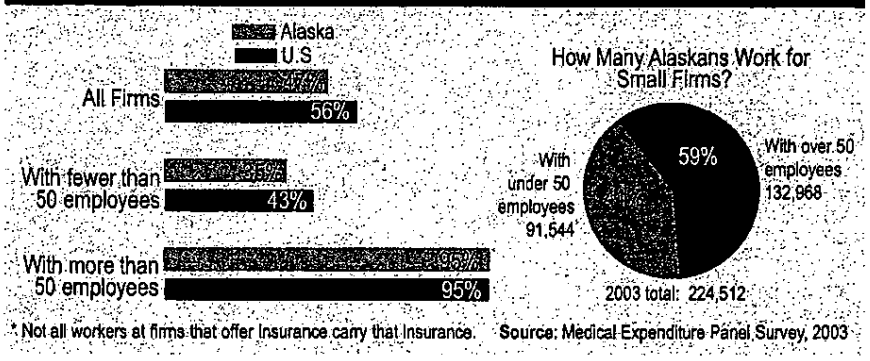

[a]Total costs shared by employer and employee. [b] Alaska figures for 2005 not available.
Sources: Medical Expenditure Panel Survey, U.S. Agency For Health Care Research and Quality, 2003; 2005 UBA/Ingenix *Health Plan Survey*

**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]

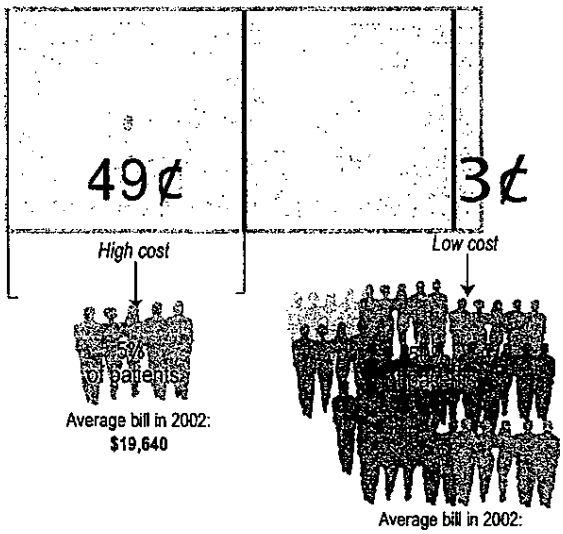
Keep in mind that it's easy to go from being a low-cost patient in one year to a much costlier one the next—a car accident, the sudden onset of an illness, or a hundred other unpredictable events can push anyone into the ranks of the high-cost patients.

## 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.

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.

**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

## 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.

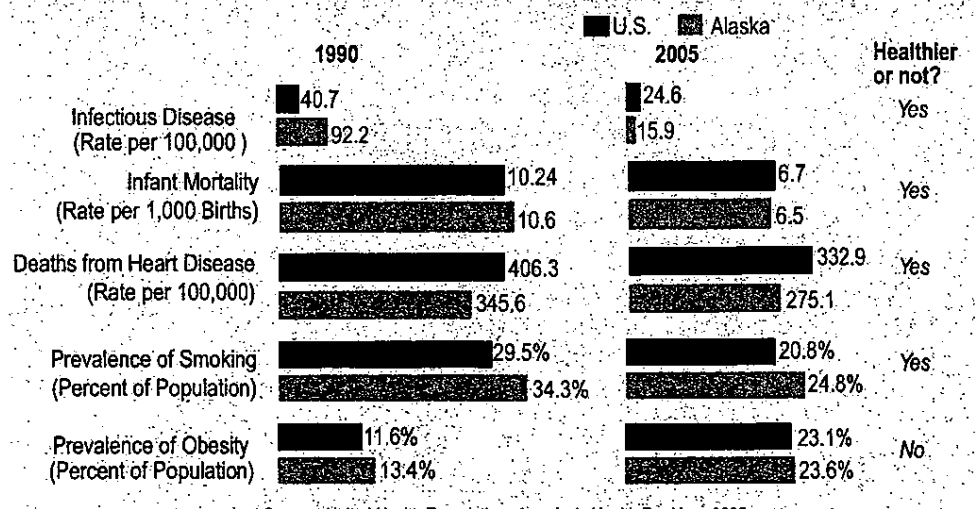
Declines in infectious disease and infant deaths in Alaska can be traced partly to public-health spending for immunizations, as well as for safe water and sewer systems, new housing, and better access to medical care in remote villages.[10] In Alaska and nationwide, advances in treatment and technology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

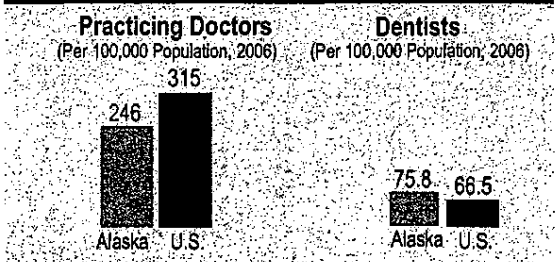
- Overall costs of medical and surgical procedures in Alaska were about 18% above the U.S. average in 2001 and dental procedures 37% more (Figure 17).

- 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?**



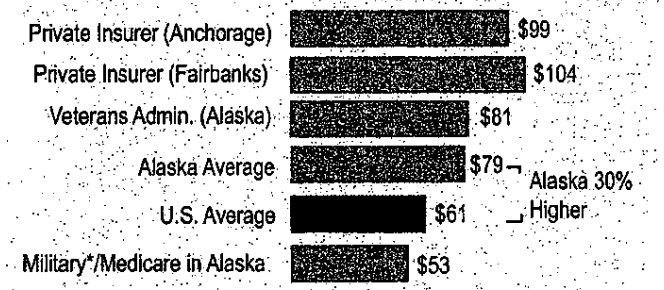

Note: Figures updated and corrected March 2007; see endnote 11.
Sources: American Medical Association; American Dental Association; U.S. Census Bureau

**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**

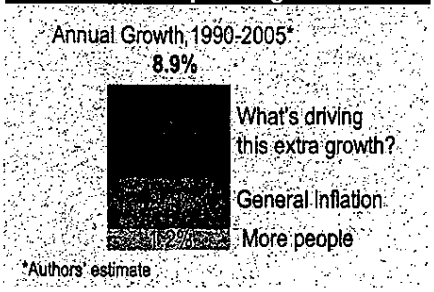
| | Prescriptions Per Capita | Average Price of Retail Prescriptions | Average Cost Per Capita |
|---|---|---|---|
| United States | 10.7 | $52.97 | $566.78 |
| Alaska | 6.3 | $66.89 | $421.41 |

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.

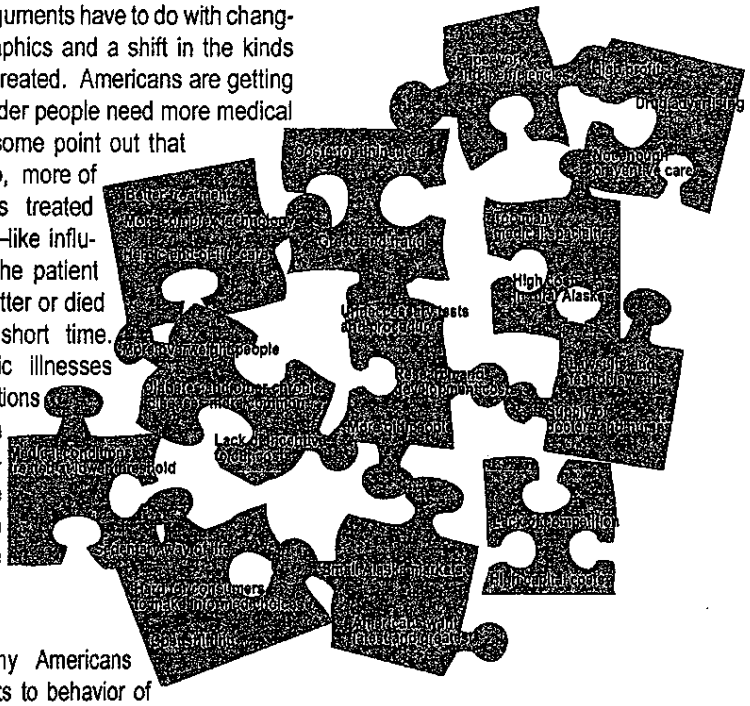
Some people think the big factors have to do with our system of delivering health care. Those include market forces—like lack of competition, for instance, and lack of incentives in many parts of the system to control costs—as well as inefficiencies created by the complexity of the U.S. system.

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.

Editor—Linda Leask • Graphic Artist—Clementia Martin

# 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 Health Care Strategies Planning Council

# Final Report: Summary and Recommendations

*Making Alaskans the healthiest people in the nation...*

December 23, 2007

# Table of Contents

## 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, Resolution, 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<br>*(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. | | | |

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

April 15, 2009

The Honorable Bettye Davis, Chair
Senate Health, Education 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 is just beginning to take on its enormous responsibility. Senator Olson serves on that Commission.

SB 172 would basically extend the life of the Alaska Health Care Commission until 2014.

Alaska and our entire country are about to enter a period during which many health issues will have 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.

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 that addresses 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, 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