SB 172

4825

4826

Comparison of Health Commission Authorizing Language

	Administrative Order #246	SB 172 OLSON	HB 25 Hawker	HB 75 Cissna
Name	Alaska Health Care Commission	Alaska Health Care Commission	Alaska Health Reform Policy Commission	Alaska Health Commission
Purpose	"...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."	"...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."	"...to consider the entire spectrum of health care related issues in the state and formulate targeted and specific policy recommendations to be considered by the legislature and by the executive branch."	"(1) to consider the entire spectrum of health care related issues in the state and formulate targeted and specific policy recommendations to be presented to the legislature and the executive branch; (2) to provide recommendations for and foster the development of a statewide plan to address the quality, accessibility, and affordability of health care for all citizens of the state; and (3) to provide an annual report to the legislature that includes a comprehensive list of policy options considered by the commission."
Organizational Location	Department of Health & Social Services	Department of Health & Social Services	Department of Health & Social Services	Department of Health & Social Services
Authorizing Date & Sunset	• Took effect 12/4/08 • Technically in effect for one year unless extended; members appointed through April 2010	• Takes effect immediately on signature of the Governor • Commission expires 06/30/14	• Takes effect immediately on signature of the Governor • Authorizing legislation repealed 7/1/15	• Takes effect 7/1/09 • No sunset

4827

	[illegible]	SB172-OLSON	HB25-Hawker	HB78-Cissna
Membership	• 10 Members (7 voting; 3 non-voting) • Appointed by the Governor : All voting Members and non-voting executive branch representative <u>Voting Members</u> • Chief Medical Officer DHSS (CHAIR) • Health care provider who is actively practicing profession and licensed in Alaska, and not affiliated with ASHNHA • Health care consumer Representatives of the: • Tribal health community • Alaska State Chamber of Commerce • Alaska State Hospital & Nursing Home Association (ASHNHA) • Health insurance industry <u>Non-Voting Members</u> Representatives of the: • executive branch • Alaska House of Representatives (appointed by Speaker of the House) • Alaska Senate (appointed by President of the Senate)	• 10 Members (7 voting; 3 non-voting) • Appointed by the Governor : All voting Members and non-voting executive branch representative • Staggered 3-year terms <u>Voting Members</u> • DHSS medical director (CHAIR) • Health care provider who is actively practicing profession and licensed in Alaska, and not affiliated with ASHNHA • Health care consumer (must be Alaska resident and may not be employed by or have a business in the health care industry) Representatives of the: • Tribal health community • Alaska State Chamber of Commerce • Alaska State Hospital & Nursing Home Association (ASHNHA) • Health insurance industry <u>Non-Voting Members</u> Representatives of the: • Office of the Governor • Alaska House of Representatives (appointed by Speaker of the House) • Alaska Senate (appointed by President of the Senate)	• 16 Members (11 voting; 5 non-voting) • Appointed by the Governor: All voting members and executive branch rep • 5-year terms <u>Voting Members</u> • DHSS Commissioner or Designee (CHAIR), plus • 10 members who have specialized training or experience and are recognized leaders in the members' field: o 3 members representing private health care interests o 3 members representing organizations that provide health care coverage, including ▪ An employer that provides employer-sponsored health insurance plan, ▪ A union that has a union health care trust, ▪ A 3rd party insurance provider o 2 members representing health care consumers o 1 member representing non-Native federal health care services o 1 member representing tribal health care services <u>Non-Voting Members</u> • 2 members from the Senate (appointed by President) • 2 members from the House (appointed by the Speaker) • 1 member appointed by the Governor	• 15 Members (all voting) • 3 members appointed by the Governor –health insurance industry rep, and two health care consumer/advocates. • Remaining members appointed by group they represent • Staggered 3-year terms • Chair annually elected by members <u>Voting Members</u> Representatives of: • AK Mental Health Trust Authority • UA health education and training programs • AK Native Tribal Health Consortium • AK Primary Care Association • AK State Hospital & Nursing Home Association • Health insurance industry • Alaska Nurses Association Plus • Health care consumer/advocate • Health care consumer/advocate who is a small business owner • 6 members of the legislature (2 majority and 1 minority caucus member from each body; at least 1 from each body must be HSS Committee member)

4828

Duties	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; 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.	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 statewide health plan containing the following: A. comprehensive statewide health care policy; B. strategy for improving the health of Alaskans that includes: i. encouraging personal responsibility for prevention, healthy living, and acquisition of health insurance; ii. reduces health care costs through • Enhanced market forces • Fraud reduction • Health information technology • Management efficiency • Preventative medicine • Successful innovations id'd by others • Other cost-saving measures iii. eliminates known health risks, including unsafe water and wastewater systems; iv. develops a sustainable health care workforce; v. improves access to quality health care; vi. increases the number of insurance options for health care services; and 3. Submit an annual report to the Governor and the Legislature by January 15 of each year regarding the commission's recommendations and activities.	1. Provide a public forum for the consideration and discussion of health policy alternatives; 2. develop, coordinate, and recommend to the legislature and to the governor health policy reform initiatives; 3. coordinate policy development with state, federal, and private sector interests that finance, provide, or regulate the delivery of health care; 4. coordinate health policy development among relevant state agencies; 5. develop policy recommendations to: (A) improve individual access to health insurance and health care services; (B) promote healthful life choices made by individuals; (C) contain health care costs; (D) enhance diversity of health care options; (E) improve quality of health care; (F) inform consumers; (G) meet current and future workforce needs in the health care industry; and 6. Develop viable financing proposals to support the commission's recommendations.	• Serve as the state health planning and coordinating body. • Provide recommendations for and foster the development of a statewide health plan containing the following: 1. a comprehensive statewide health care policy; 2. a strategy for (A) encouraging personal responsibility in prevention and healthy living for all residents of the state; (B) reducing health care costs for all residents of the state to below the national average; (C) ensuring access in communities to safe water and wastewater systems; (D) developing a sustainable health care workforce in the state; (E) ensuring access to quality health care being accessible for all residents of the state; and (F) increasing the number of residents of the state who are covered by insurance for health care services.

4829

Reports	Submit a report to the Governor and the Legislature on or before January 15, 2010 regarding the commission's recommendations and activities.	Submit an annual report to the Governor and the Legislature by January 15 of each year regarding the commission's recommendations and activities.	Submit an annual report to the legislature and governor by January 15 of each year summarizing the significant work, findings, and recommendations of the commission. The first report must include a 5-year strategic plan with prioritized, targeted, and defined objectives as well as an evaluation of the strengths, weaknesses, and relative performance of health care services and conditions in the state. Subsequent reports must include revisions to the plan (if any) and report on progress in meeting the objectives.	Submit an annual report to the legislature and governor by February 1 of each year and present key findings in person to the legislature. Report must summarize significant work, findings, and recommendations of the commission. The first report must include a 5-year strategic plan with prioritized, targeted, and defined objectives as well as an evaluation of the strengths, weaknesses, and relative performance of health care services and conditions in the state. Subsequent reports must include revisions to the plan (if any) and report on progress in meeting the objectives.
Administrative & General Provisions	• Employ 1 Executive Director • DHSS may assign employees to serve as staff to the commission • Shall adopt bylaws governing proceedings and activities • Members do not receive compensation • Members entitled to per diem and travel expenses • May use teleconferencing and other electronic means to the extent practicable • Meeting conducted in accord with Open Meetings Act (AS 44) • Records subject to inspection and copying as public records under AS 40	• Employ 1 Executive Director • DHSS may assign employees to serve as staff to the commission • Shall adopt bylaws governing proceedings and activities • Members do not receive salary • Members entitled to per diem and travel expenses	• Employ 1 Executive Director • Meet regularly in person or by teleconference • Quorum = majority of voting members • Votes of members to be recorded • Action requires affirmative vote of majority of voting members present • Member may not be recused from voting solely based on conflict of interest • Members not entitled to salary • Members entitled to per diem, reimbursement for travel, other expenses authorized under AS 39.20.180	• Employ 1 Executive Director • DHSS may assign employees to serve as staff to the commission • Maintain web site with info on commission and annual reports • Shall adopt bylaws governing proceedings and activities • Members not entitled to salary • Members entitled to per diem, reimbursement for travel, other expenses authorized under AS 39.20.180 • Departments of Administration; Commerce, Community & Economic Development; Labor & Workforce; and Law shall cooperate

4830

Additional Provisions	None	• Transition: The department may adopt regulations necessary to implement changes made by the act • Transition: The members appointed to the Alaska Health Care Commission established under Admin Order #246 shall serve as the members of the commission under AS 18.09.010 (as amended by this bill) for one-year to three-year staggered terms as determined by the governor.	None	• Requires mandatory reporting to DHSS by health care facilities on price, services offered, and other information • Requires DHSS to contract for a comprehensive study of the effects of the certificate of need program.

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 3/27/09 FURTHER: Finance

Date of 5-Day Notice: March 11, 2010
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: March 18, 2010

Health and Social Services 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 [X] **CS** SB172 (HSS)

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

[ ] attached amendment(s)

[ ] adopt ____ Letter of Intent

[ ] further referral to ____ Committee

SENATE BILL:
[X] Same Title
[ ] New Title

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

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#
H+SS	2/1/2010	✓			

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	PRINTED LAST NAME	DO PASS	DO NOT PASS	NO REC	AMEND
[signature]	ELLIS	✓			
[signature]	PASKVAN	X			
[signature]	Dyson			X	
CHAIR: Betty Davis	DAVIS	X			

4831

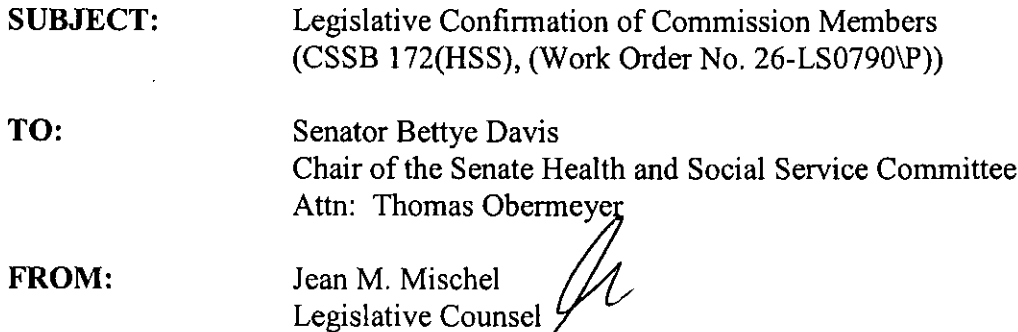
LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM March 17, 2010



SUBJECT: Legislative Confirmation of Commission Members
(CSSB 172(HSS), (Work Order No. 26-LS0790\P))

TO: Senator Bettye Davis
Chair of the Senate Health and Social Service Committee
Attn: Thomas Obermeyer

FROM: Jean M. Mischel
Legislative Counsel

Tom Obermeyer has asked for a memo that describes the limits of the legislature's role of confirmation in the review of the appointment of persons for positions in the executive branch.

*

Constitutionally, the underpinnings of the legislature's role in the confirmation of certain executive branch appointees to hold the office are to be found in two sections of article III of the Alaska Constitution, sections 25 and 26:

> **Department Heads.** The head of each principal department shall be a single executive unless otherwise provided by law. He shall be appointed by the governor, subject to confirmation by a majority of the members of the legislature in joint session, and shall serve at the pleasure of the governor, except as otherwise provided in this article with respect to the secretary of state. The heads of all principal departments shall be citizens of the United States.
>
> **Boards and Commissions.** When a board or commission ***is at the head of a principal department or a regulatory or quasi-judicial agency***, its members shall be appointed by the governor, subject to confirmation by a majority of the members of the legislature in joint session, and may be removed as provided by law. They shall be citizens of the United States. The board or commission may appoint a principal executive officer when authorized by law, but the appointment shall be subject to the approval of the governor.

(Emphasis added.)

4832

In *Bradner v. Hammond*, 553 P.2d 1 (Alaska 1976), the Alaska Supreme Court reached the conclusion that

> . . . ***the appointment of executive officers is an executive function***; for without such a power, the responsibility for executing executive duties would be diffused and the goal of separation of branches of government, avoiding too great a concentration of power in one branch, would be defeated.

and, further that

> . . . under Alaska's constitution confirmation is a specific attribute of the appointive power of the executive. Other courts which have been called upon to resolve this issue have been unanimous in their holdings that ***confirmation is not a distinct legislative power, but rather a part of the executive power of appointment which has in turn been delegated in some specific instances by constitution to the legislative branch of government.***

Bradner, at 6 - 7 (emphasis added; notes omitted).

*

Procedurally, the legislature's role in confirmation is spelled out almost entirely in AS 39.05.080.

The Alaska Health Care Commission established in CSSB 172(HSS) is an advisory board that does not sit at the head of a principal department, a regulatory agency, or a quasi-judicial agency. Therefore, the appointees to the commission are not subject to legislative confirmation by operation of the constitution. The legislative role is limited to establishing such commissions and to providing guidance to the legislature on the qualifications of commission members. The appointment itself is otherwise an executive function in which the legislature plays no role.

If I may be of further assistance, please advise.

JMM:lmb
10-009.lmb

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB172
() Publish Date:

Identifier (file name): SB172-DHSS-PHA-02-01-10
Dept. Affected: Health & Social Services
Title: Alaska Health Care Commission
RDU: Public Health
Component: Public Health Administration
Sponsor: Olson
Requester: Senate HSS
Component Number: 292

Expenditures/Revenu (Thousands of Dollars)

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

	Appropriation Required	Information					
OPERATING EXPENDIT	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services	134.5		134.5	134.5	134.5	134.5	134.5
Travel	35.0		35.0	35.0	35.0	35.0	35.0
Contractual	300.0		320.5	320.5	320.5	320.5	320.5
Supplies	20.5		10.0	10.0	10.0	10.0	10.0
Equipment	10.0		0.0	0.0	0.0	0.0	0.0
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**500.0**	**0.0**	**500.0**	**500.0**	**500.0**	**500.0**	**500.0**
CAPITAL EXPENDITURE							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

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

Estimate of any current year (FY2010) c 500.0

POSITIONS

Full-time	**1.0**		1	1	1	1	1
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if nece:*

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 10 members. SB 172 closely parallels Administrative Order #246 of December 2008 establishing a health care commission to address Alaska's health care challenges.

The current Alaska Health Care Commission recently adopted a formal policy recommendation to establish a permanent health care commission in statute to address the need for health care reform in Alaska. The

(continued on page 2)

Prepared by: Ward B. Hurlburt, MD, MPH, Chief Medical Officer/Director
Phone 269-8126
Division: Public Health
Date/Time 12/28/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner
DHSS Finance & Management Services
Date 2/1/2010

FISCAL NOTE

STATE OF ALASKA BILL NO. SB172

2010 LEGISLATIVE SESSION

ANALYSIS CONTINUATION

(Continued from Page 1)
The commission based this recommendation on the finding that the need for a plan to address health care cost, access and quality issues is greater than ever before. Health care expenditures in Alaska more than tripled between 1991 and 2005 from $1.6 billion to $5.3 billion. Costs are expected to double again, to over $10 billion, by 2013. The Alaska economy cannot sustain this inflationary growth, and government (all levels - local, state, and fed) carries 64% of this cost burden between the cost for government health care programs and provision of health care insurance for government employees. *(Data cited from "Alaska's $5 Billion Health Care Bill - Who's Paying?" UA Research summary No. 6, Institute of Social and Economic Research, University of Alaska, March 2006.)*

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.

$500.0 in state general funds is required for operations of the health care commission, as follows:

71000 Personal Services: The bill states that an Executive Director would staff the Commission; administrative support would be provided by existing DHSS staff. Personal services costs of $134.5 is Range 23, Step F.

72000 Travel Travel and per diem for Commission staff and for 8 Commission members to conduct quarterly face-to-face public meetings. The two other members are legislators and would have per diem and travel covered.

73000 Contractual Professional services contracts will be needed to supplement staff research, and core service RSAs will be required to provide lease space, telecommunications, mainframe connectivity, postage, etc.

74000 Supplies
In addition to day-to-day office supplies, FY11 includes start-up costs such as computers, office furniture, reconfiguring leased space, wiring needs for connectivity, printers, fax, and photocopier.

75000 Equipment
FY11 includes purchase of a server; in subsequent fiscal years provide technology upgrades and maintenance will be covered through the contractual line.

The bill becomes effective immediately upon the Governor's signature. This means there may be some limited costs in FY10 that will have to be absorbed by the Department of Health & Social Services.

4835

26-LS0790\P
Mischel
3/15/10

CS FOR SENATE BILL NO. 172(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): SENATOR OLSON

A BILL

FOR AN ACT ENTITLED

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

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

4 *** Section 1.** AS 18.05.010(b) is amended to read:
5 (b) In performing its duties under this chapter**, AS 18.09,** and AS 18.15.355 -
6 18.15.395, the department may
7 (1) flexibly use the broad range of powers set out in this title assigned
8 to the department to protect and promote the public health;
9 (2) provide public health information programs or messages to the
10 public that promote healthy behaviors or lifestyles or educate individuals about health
11 issues;
12 (3) promote efforts among public and private sector partners to
13 develop and finance programs or initiatives that identify and ameliorate health
14 problems;

L
4836

1 (4) establish, finance, provide, or endorse performance management
2 standards for the public health system;
3 (5) develop, adopt, and implement
4 **(A) a statewide health plan under AS 18.09 based on**
5 **recommendations of the Alaska Health Care Commission established in**
6 **AS 18.09.010; and**
7 **(B)** public health plans and formal policies through regulations
8 adopted under AS 44.62 or collaborative recommendations that guide or
9 support individual and community public health efforts;
10 (6) establish formal or informal relationships with public or private
11 sector partners within the public health system;
12 (7) identify, assess, prevent, and ameliorate conditions of public health
13 importance through surveillance; epidemiological tracking, program evaluation, and
14 monitoring; testing and screening programs; treatment; administrative inspections; or
15 other techniques;
16 (8) promote the availability and accessibility of quality health care
17 services through health care facilities or providers;
18 (9) promote availability of and access to preventive and primary health
19 care when not otherwise available through the private sector, including acute and
20 episodic care, prenatal and postpartum care, child health, family planning, school
21 health, chronic disease prevention, child and adult immunization, testing and screening
22 services, dental health, nutrition, and health education and promotion services;
23 (10) systematically and regularly review the public health system and
24 recommend modifications in its structure or other features to improve public health
25 outcomes; and
26 (11) collaborate with public and private sector partners, including
27 municipalities, Alaska Native organizations, health care providers, and health insurers,
28 within the public health system to achieve the mission of public health.
29 * **Sec. 2.** AS 18 is amended by adding a new chapter to read:
30 **Chapter 09. Statewide Health Care.**
31 **Article 1. Alaska Health Care Commission.**

L

4837

1 **Sec. 18.09.010. Alaska Health Care Commission.** The Alaska Health Care
2 Commission is established in the Department of Health and Social Services. The
3 purpose of the commission is to provide recommendations for and foster the
4 development of a statewide plan to address the quality, accessibility, and availability
5 of health care for all citizens of the state.
6 **Sec. 18.09.020. Composition; chair.** The commission consists of 12 members
7 as follows:
8 (1) nine voting members appointed by the governor as follows:
9 (A) the state officer assigned the duties of medical director for
10 the department, who shall serve as chair;
11 (B) one member who represents the tribal health community in
12 the state;
13 (C) one member who represents a statewide chamber of
14 commerce who is not financially associated with the health care industry;
15 (D) one member who represents the Alaska State Hospital and
16 Nursing Home Association;
17 (E) one member who is a health care provider and
18 (i) engaged in the active practice of the health care
19 provider's profession in the state;
20 (ii) licensed to practice in the state;
21 (iii) not affiliated with the Alaska State Hospital and
22 Nursing Home Association;
23 (F) one member who represents the health care industry in the
24 state;
25 (G) one member who is a
26 (i) health care consumer;
27 (ii) resident of the state; and
28 (iii) not employed by and does not have a business
29 interest in the health care industry;
30 (H) one member who is a licensed primary care physician in
31 the state and who is in the active practice of family medicine, primary care

L
4838

1 internal medicine, or pediatric medicine;
2 (I) one member who represents the Alaska Mental Health Trust
3 Authority; and
4 (2) three nonvoting members appointed as follows:
5 (A) one ex officio member from the house of representatives,
6 appointed by the speaker of the house of representatives;
7 (B) one ex officio member from the senate, appointed by the
8 president of the senate;
9 (C) an ex officio member representing the Office of the
10 Governor.
11 **Sec. 18.09.030. Public members' terms of office.** (a) Public members of the
12 commission serve for staggered terms of three years or until a successor is appointed.
13 (b) If a vacancy occurs in a public member's seat on the commission, the
14 governor shall make an appointment for the unexpired portion of that member's term.
15 (c) A public member may serve not more than two consecutive terms.
16 (d) In this section, "public member" means those members appointed under
17 AS 18.09.020(1)(B) - (I).
18 **Sec. 18.09.040. Executive director.** The commission shall employ an
19 executive director, who may not be a member of the commission. The executive
20 director serves at the pleasure of the commission. The commission shall establish the
21 duties of the executive director. The executive director is in the partially exempt
22 service under AS 39.25 (State Personnel Act).
23 **Sec. 18.09.050. Staff.** The department may assign employees of the
24 department to serve as staff to the commission. The commission shall prescribe the
25 duties of the commission staff.
26 **Sec. 18.09.060. Bylaws.** The commission, on approval of a majority of its
27 membership and consistent with state law, shall adopt and amend bylaws governing
28 proceedings and other activities, including provisions concerning
29 (1) a quorum to transact commission business and other aspects of
30 procedure;
31 (2) frequency and location of meetings;

L
4839

1 (3) establishment, functions, and membership of committees; and
2 (4) conflicts of interest that require
3 (A) a member to declare a substantial financial interest in an
4 official action and to request to be excused from voting in that instance;
5 (B) a ruling by the chair on a request by a member to be
6 excused from voting;
7 (C) an opportunity to override a ruling by the chair on a
8 majority vote;
9 (D) filing of a written disclosure form with the department that
10 lists all potential conflicts of interest of a member valued at more than $5,000
11 annually if the interest is related to health care system income affecting the
12 member or a member of the member's immediate family.
13 **Sec. 18.09.070. Duties of the commission.** (a) The commission shall serve as
14 the state health planning and coordinating body. Consistent with state and federal law,
15 the commission shall provide recommendations for and foster the development of a
16 statewide health plan containing the following:
17 (1) a comprehensive statewide health care policy;
18 (2) a strategy for improving the health of all residents of the state that
19 (A) encourages personal responsibility for disease prevention,
20 healthy living, and acquisition of health insurance;
21 (B) reduces health care costs by using savings from
22 (i) enhanced market forces;
23 (ii) fraud reduction;
24 (iii) health information technology;
25 (iv) management efficiency;
26 (v) preventative medicine;
27 (vi) successful innovations identified by other states;
28 and
29 (vii) other cost-saving measures;
30 (C) eliminates known health risks, including unsafe water and
31 wastewater systems;

L
4840

1 (D) develops a sustainable health care workforce;
2 (E) improves access to quality health care; and
3 (F) increases the number of insurance options for health care
4 services.
5 (b) The commission may hold public hearings to gather information and
6 opinions from health care consumers on matters before the commission. Hearings
7 shall be conducted under AS 44.62.210, except that the commission shall provide
8 public notice of hearings not less than 15 days before the conduct of the hearing and
9 include not fewer than three notices published in the statewide news media.
10 (c) The commission shall submit to the governor and the legislature by
11 January 15 of each year an annual report regarding the commission's
12 recommendations and activities. The report shall include voting records, copies of
13 financial disclosures, and conflicts of interest statements.
14 **Sec. 18.09.080. Compensation, per diem, and expenses.** A member
15 appointed to the commission under AS 18.09.020(1) is entitled to per diem,
16 reimbursement for travel, and other expenses authorized by law for boards and
17 commissions under AS 39.20.180.
18 **Article 2. General Provisions.**
19 **Sec. 18.09.900. Regulations.** The department may adopt regulations under
20 AS 44.62 (Administrative Procedure Act) to carry out the purposes of this chapter.
21 **Sec. 18.09.990. Definitions.** In this chapter,
22 (1) "commission" means the Alaska Health Care Commission
23 established in AS 18.09.010;
24 (2) "department" means the Department of Health and Social Services.
25 * **Sec. 3.** AS 39.25.120(c)(7) is amended to read:
26 (7) the principal executive officer of the following boards, councils, or
27 commissions:
28 (A) Alaska Public Broadcasting Commission;
29 (B) Professional Teaching Practices Commission;
30 (C) Parole Board;
31 (D) Board of Nursing;

4841

1 (E) Real Estate Commission;
2 (F) Alaska Royalty Oil and Gas Development Advisory Board;
3 (G) Alaska State Council on the Arts;
4 (H) Alaska Police Standards Council;
5 (I) Alaska Commission on Aging;
6 (J) Alaska Mental Health Board;
7 (K) State Medical Board;
8 (L) Governor's Council on Disabilities and Special Education;
9 (M) Advisory Board on Alcoholism and Drug Abuse;
10 (N) Statewide Suicide Prevention Council;
11 (O) the State Board of Registration for Architect, Engineers,
12 and Land Surveyors;
13 **(P) Alaska Health Care Commission;**
14 * **Sec. 4.** AS 44.66.010(a) is amended to read:
15 (a) Boards and commissions listed in this subsection expire on the date set out
16 after each:
17 (1) Alcoholic Beverage Control Board (AS 04.06.010) - June 30, 2010;
18 (2) Board of Parole (AS 33.16.020) - June 30, 2016;
19 (3) Regulatory Commission of Alaska (AS 42.04.010) - June 30, 2011;
20 (4) Alaska Commission on Aging (AS 47.45.200) - June 30, 2016;
21 (5) Council on Domestic Violence and Sexual Assault (AS 18.66.010)
22 - June 30, 2014;
23 (6) special education service agency (AS 14.30.600) - June 30, 2013;
24 (7) [REPEALED
25 (8)] Statewide Suicide Prevention Council (AS 44.29.300) - June 30,
26 2013;
27 **(8)** [(9)] Alaska Seismic Hazards Safety Commission (AS 44.37.065) -
28 June 30, 2012**;**
29 **(9) Alaska Health Care Commission (AS 18.09.010) - June 30,**
30 **2014**.
31 * **Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to

1 read:

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

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

8 TRANSITION: ALASKA HEALTH CARE COMMISSION. The members appointed
9 to the Alaska Health Care Commission, established by Administrative Order No. 246 dated
10 December 4, 2008, shall serve as the voting members of the Alaska Health Care Commission
11 under AS 18.09.010, enacted by sec. 2 of this Act, for one-year to three-year staggered terms
12 as determined by the governor according to AS 39.05.055.

13 * **Sec. 7.** This Act takes effect immediately under AS 01.10.070(c).

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM March 10, 2010

SUBJECT: Sectional Summary (CSSB 172(HSS), Draft Version "S")

TO: Senator Bettye Davis
Chair of the Senate Health and Social Services Committee
Attn: Thomas Obermeyer

FROM: Jean M. Mischel
Legislative Counsel

You have requested a sectional summary of the above-described bill. You also asked for a comparison of the "A" version and the "S" version. The only substantive difference in the two versions is the membership of the commission.

As a preliminary matter, note that a sectional summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Section 1. Adds a cross reference to the health plan and commission established in AS 18.09, added by section 2 of the bill, to the Department of Health and Social Services authority related to public health.

Section 2. Establishes the Alaska Health Care Commission in the Department of Health and Social Services for the purpose of providing recommendations for and fostering the development of a statewide plan to address health care issues in the state. Requires the commission to perform specified duties, to hold public hearings, and to submit an annual report to the legislature and to the governor.

Section 3. Adds the executive officer of the commission established in sec. 2 of the bill to the list of employees in the partially exempt state service classification under the state personnel act.

Section 4. Adds the commission established in sec. 2 of the bill to the list of boards and commissions for purposes of establishing an expiration date of June 20, 2014.

Section 5. Authorizes the Department of Health and Social Services to proceed to adopt regulations needed to implement the bill.

Section 6. Provides a temporary transition of commission members to include staggered terms of members currently serving on the commission established by executive order.

JMM:ljw
10-147.ljw

26-LS0790\S
Mischel
3/9/10

CS FOR SENATE BILL NO. 172(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): SENATOR OLSON

A BILL

FOR AN ACT ENTITLED

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

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

4 * **Section 1.** AS 18.05.010(b) is amended to read:
5 (b) In performing its duties under this chapter**, AS 18.09,** and AS 18.15.355 -
6 18.15.395, the department may
7 (1) flexibly use the broad range of powers set out in this title assigned
8 to the department to protect and promote the public health;
9 (2) provide public health information programs or messages to the
10 public that promote healthy behaviors or lifestyles or educate individuals about health
11 issues;
12 (3) promote efforts among public and private sector partners to
13 develop and finance programs or initiatives that identify and ameliorate health
14 problems;

L
4845

1 (4) establish, finance, provide, or endorse performance management
2 standards for the public health system;
3 (5) develop, adopt, and implement
4 **<u>(A) a statewide health plan under AS 18.09 based on</u>**
5 **<u>recommendations of the Alaska Health Care Commission established in</u>**
6 **<u>AS 18.09.010; and</u>**
7 **<u>(B)</u>** public health plans and formal policies through regulations
8 adopted under AS 44.62 or collaborative recommendations that guide or
9 support individual and community public health efforts;
10 (6) establish formal or informal relationships with public or private
11 sector partners within the public health system;
12 (7) identify, assess, prevent, and ameliorate conditions of public health
13 importance through surveillance; epidemiological tracking, program evaluation, and
14 monitoring; testing and screening programs; treatment; administrative inspections; or
15 other techniques;
16 (8) promote the availability and accessibility of quality health care
17 services through health care facilities or providers;
18 (9) promote availability of and access to preventive and primary health
19 care when not otherwise available through the private sector, including acute and
20 episodic care, prenatal and postpartum care, child health, family planning, school
21 health, chronic disease prevention, child and adult immunization, testing and screening
22 services, dental health, nutrition, and health education and promotion services;
23 (10) systematically and regularly review the public health system and
24 recommend modifications in its structure or other features to improve public health
25 outcomes; and
26 (11) collaborate with public and private sector partners, including
27 municipalities, Alaska Native organizations, health care providers, and health insurers,
28 within the public health system to achieve the mission of public health.
29 * **Sec. 2.** AS 18 is amended by adding a new chapter to read:
30 **Chapter 09. Statewide Health Care.**
31 **Article 1. Alaska Health Care Commission.**

1 **Sec. 18.09.010. Alaska Health Care Commission.** The Alaska Health Care
2 Commission is established in the Department of Health and Social Services. The
3 purpose of the commission is to provide recommendations for and foster the
4 development of a statewide plan to address the quality, accessibility, and availability
5 of health care for all citizens of the state.
6 **Sec. 18.09.020. Composition; chair.** The commission consists of 12 members
7 as follows:
8 (1) nine voting members appointed by the governor, including the state
9 officer assigned the duties of medical director for the department, who shall serve as
10 chair; and
11 (2) three nonvoting members appointed as follows:
12 (A) one ex officio member from the house of representatives,
13 appointed by the speaker of the house of representatives;
14 (B) one ex officio member from the senate, appointed by the
15 president of the senate;
16 (C) an ex officio member representing the Office of the
17 Governor.
18 **Sec. 18.09.030. Term of office.** (a) Public members of the commission
19 appointed under AS 18.09.020(1) serve for staggered terms of three years or until a
20 successor is appointed.
21 (b) If a vacancy occurs in a public member's seat on the commission, the
22 governor shall make an appointment for the unexpired portion of that member's term.
23 (c) A member may serve not more than two consecutive terms.
24 **Sec. 18.09.040. Executive director.** The commission shall employ an
25 executive director, who may not be a member of the commission. The executive
26 director serves at the pleasure of the commission. The commission shall establish the
27 duties of the executive director. The executive director is in the partially exempt
28 service under AS 39.25 (State Personnel Act).
29 **Sec. 18.09.050. Staff.** The department may assign employees of the
30 department to serve as staff to the commission. The commission shall prescribe the
31 duties of the commission staff.

1 **Sec. 18.09.060. Bylaws.** The commission, on approval of a majority of its
2 membership and consistent with state law, shall adopt and amend bylaws governing
3 proceedings and other activities, including provisions concerning
4 (1) a quorum to transact commission business and other aspects of
5 procedure;
6 (2) frequency and location of meetings;
7 (3) establishment, functions, and membership of committees; and
8 (4) conflicts of interest that require
9 (A) a member to declare a substantial financial interest in an
10 official action and to request to be excused from voting in that instance;
11 (B) a ruling by the chair on a request by a member to be
12 excused from voting;
13 (C) an opportunity to override a ruling by the chair on a
14 majority vote;
15 (D) filing of a written disclosure form with the department that
16 lists all potential conflicts of interest of a member valued at more than $5,000
17 annually if the interest is related to health care system income affecting the
18 member or a member of the member's immediate family.
19 **Sec. 18.09.070. Duties of the commission.** (a) The commission shall serve as
20 the state health planning and coordinating body. Consistent with state and federal law,
21 the commission shall provide recommendations for and foster the development of a
22 statewide health plan containing the following:
23 (1) a comprehensive statewide health care policy;
24 (2) a strategy for improving the health of all residents of the state that
25 (A) encourages personal responsibility for disease prevention,
26 healthy living, and acquisition of health insurance;
27 (B) reduces health care costs by using savings from
28 (i) enhanced market forces;
29 (ii) fraud reduction;
30 (iii) health information technology;
31 (iv) management efficiency;

L
4848

1 (v) preventative medicine;
2 (vi) successful innovations identified by other states;
3 and
4 (vii) other cost-saving measures;
5 (C) eliminates known health risks, including unsafe water and
6 wastewater systems;
7 (D) develops a sustainable health care workforce;
8 (E) improves access to quality health care; and
9 (F) increases the number of insurance options for health care
10 services.
11 (b) The commission may hold public hearings to gather information and
12 opinions from health care consumers on matters before the commission. Hearings
13 shall be conducted under AS 44.62.210, except that the commission shall provide
14 public notice of hearings not less than 15 days before the conduct of the hearing and
15 include not fewer than three notices published in the statewide news media.
16 (c) The commission shall submit to the governor and the legislature by
17 January 15 of each year an annual report regarding the commission's
18 recommendations and activities. The report shall include voting records, copies of
19 financial disclosures, and conflicts of interest statements.
20 **Sec. 18.09.080. Compensation, per diem, and expenses.** A member
21 appointed to the commission under AS 18.09.020(1) is not entitled to a salary, but is
22 entitled to per diem, reimbursement for travel, and other expenses authorized by law
23 for boards and commissions under AS 39.20.180.
24 **Article 2. General Provisions.**
25 **Sec. 18.09.900. Regulations.** The department may adopt regulations under
26 AS 44.62 (Administrative Procedure Act) to carry out the purposes of this chapter.
27 **Sec. 18.09.990. Definitions.** In this chapter,
28 (1) "commission" means the Alaska Health Care Commission
29 established in AS 18.09.010;
30 (2) "department" means the Department of Health and Social Services.
31 * **Sec. 3.** AS 39.25.120(c)(7) is amended to read:

1 (7) the principal executive officer of the following boards, councils, or
2 commissions:
3 (A) Alaska Public Broadcasting Commission;
4 (B) Professional Teaching Practices Commission;
5 (C) Parole Board;
6 (D) Board of Nursing;
7 (E) Real Estate Commission;
8 (F) Alaska Royalty Oil and Gas Development Advisory Board;
9 (G) Alaska State Council on the Arts;
10 (H) Alaska Police Standards Council;
11 (I) Alaska Commission on Aging;
12 (J) Alaska Mental Health Board;
13 (K) State Medical Board;
14 (L) Governor's Council on Disabilities and Special Education;
15 (M) Advisory Board on Alcoholism and Drug Abuse;
16 (N) Statewide Suicide Prevention Council;
17 (O) the State Board of Registration for Architect, Engineers,
18 and Land Surveyors;
19 **(P) Alaska Health Care Commission;**
20 * **Sec. 4.** AS 44.66.010(a) is amended to read:
21 (a) Boards and commissions listed in this subsection expire on the date set out
22 after each:
23 (1) Alcoholic Beverage Control Board (AS 04.06.010) - June 30, 2010;
24 (2) Board of Parole (AS 33.16.020) - June 30, 2016;
25 (3) Regulatory Commission of Alaska (AS 42.04.010) - June 30, 2011;
26 (4) Alaska Commission on Aging (AS 47.45.200) - June 30, 2016;
27 (5) Council on Domestic Violence and Sexual Assault (AS 18.66.010)
28 - June 30, 2014;
29 (6) special education service agency (AS 14.30.600) - June 30, 2013;
30 (7) [REPEALED
31 (8)] Statewide Suicide Prevention Council (AS 44.29.300) - June 30,

1 2013;

2 (8) [(9)] Alaska Seismic Hazards Safety Commission (AS 44.37.065) -

3 June 30, 2012;

4 **(9) Alaska Health Care Commission (AS 18.09.010) - June 30,**

5 **2014**.

6 * **Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to

7 read:

8 TRANSITION: REGULATIONS. The Department of Health and Social Services may

9 proceed to adopt regulations necessary to implement the changes made by this Act. The

10 regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the

11 effective date of the statutory change.

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

13 read:

14 TRANSITION: ALASKA HEALTH CARE COMMISSION. The members appointed

15 to the Alaska Health Care Commission, established by Administrative Order No. 246 dated

16 December 4, 2008, shall serve as the voting members of the Alaska Health Care Commission

17 under AS 18.09.010, enacted by sec. 2 of this Act, for one-year to three-year staggered terms

18 as determined by the governor according to AS 39.05.055.

19 * **Sec. 7.** This Act takes effect immediately under AS 01.10.070(c).

26-LS0790\E
Mischel
3/1/10

CS FOR SENATE BILL NO. 172(HSS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-SIXTH LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH AND SOCIAL SERVICES COMMITTEE

Offered:
Referred:

Sponsor(s): SENATOR OLSON

A BILL

FOR AN ACT ENTITLED

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

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

4 *** Section 1.** AS 18.05.010(b) is amended to read:
5 (b) In performing its duties under this chapter**, AS 18.09,** and AS 18.15.355 -
6 18.15.395, the department may
7 (1) flexibly use the broad range of powers set out in this title assigned
8 to the department to protect and promote the public health;
9 (2) provide public health information programs or messages to the
10 public that promote healthy behaviors or lifestyles or educate individuals about health
11 issues;
12 (3) promote efforts among public and private sector partners to
13 develop and finance programs or initiatives that identify and ameliorate health
14 problems;

1 (4) establish, finance, provide, or endorse performance management
2 standards for the public health system;
3 (5) develop, adopt, and implement
4 **(A) a statewide health plan under AS 18.09 based on**
5 **recommendations of the Alaska Health Care Commission established in**
6 **AS 18.09.010; and**
7 **(B)** public health plans and formal policies through regulations
8 adopted under AS 44.62 or collaborative recommendations that guide or
9 support individual and community public health efforts;
10 (6) establish formal or informal relationships with public or private
11 sector partners within the public health system;
12 (7) identify, assess, prevent, and ameliorate conditions of public health
13 importance through surveillance; epidemiological tracking, program evaluation, and
14 monitoring; testing and screening programs; treatment; administrative inspections; or
15 other techniques;
16 (8) promote the availability and accessibility of quality health care
17 services through health care facilities or providers;
18 (9) promote availability of and access to preventive and primary health
19 care when not otherwise available through the private sector, including acute and
20 episodic care, prenatal and postpartum care, child health, family planning, school
21 health, chronic disease prevention, child and adult immunization, testing and screening
22 services, dental health, nutrition, and health education and promotion services;
23 (10) systematically and regularly review the public health system and
24 recommend modifications in its structure or other features to improve public health
25 outcomes; and
26 (11) collaborate with public and private sector partners, including
27 municipalities, Alaska Native organizations, health care providers, and health insurers,
28 within the public health system to achieve the mission of public health.
29 * **Sec. 2.** AS 18 is amended by adding a new chapter to read:
30 **Chapter 09. Statewide Health Care.**
31 **Article 1. Alaska Health Care Commission.**

L
4853

1 **Sec. 18.09.010. Alaska Health Care Commission.** The Alaska Health Care
2 Commission is established in the Department of Health and Social Services. The
3 purpose of the commission is to provide recommendations for and foster the
4 development of a statewide plan to address the quality, accessibility, and availability
5 of health care for all citizens of the state.
6 **Sec. 18.09.020. Composition; chair.** The commission consists of 12 members
7 as follows:
8 (1) nine voting members appointed by the governor; and
9 (2) three nonvoting members appointed as follows:
10 (A) one ex officio member from the house of representatives,
11 appointed by the speaker of the house of representatives;
12 (B) one ex officio member from the senate, appointed by the
13 president of the senate;
14 (C) an ex officio member representing the Office of the
15 Governor.
16 **Sec. 18.09.030. Term of office.** (a) Public members of the commission
17 appointed under AS 18.09.020(1) serve for staggered terms of three years or until a
18 successor is appointed.
19 (b) If a vacancy occurs in a public member's seat on the commission, the
20 governor shall make an appointment for the unexpired portion of that member's term.
21 (c) A member may serve not more than two consecutive terms.
22 **Sec. 18.09.040. Executive director.** The commission shall employ an
23 executive director, who may not be a member of the commission. The executive
24 director serves at the pleasure of the commission. The commission shall establish the
25 duties of the executive director. The executive director is in the partially exempt
26 service under AS 39.25 (State Personnel Act).
27 **Sec. 18.09.050. Staff.** The department may assign employees of the
28 department to serve as staff to the commission. The commission shall prescribe the
29 duties of the commission staff.
30 **Sec. 18.09.060. Bylaws.** The commission, on approval of a majority of its
31 membership and consistent with state law, shall adopt and amend bylaws governing

L
4854

1 proceedings and other activities, including provisions concerning
2 (1) a quorum to transact commission business and other aspects of
3 procedure;
4 (2) frequency and location of meetings;
5 (3) establishment, functions, and membership of committees; and
6 (4) conflicts of interest that require
7 (A) a member to declare a substantial financial interest in an
8 official action and to request to be excused from voting in that instance;
9 (B) a ruling by the chair on a request by a member to be
10 excused from voting;
11 (C) an opportunity to override a ruling by the chair on a
12 majority vote;
13 (D) filing of a written disclosure form with the department that
14 lists all potential conflicts of interest of a member valued at more than $5,000
15 annually if the interest is related to health care system income affecting the
16 member or a member of the member's immediate family.
17 **Sec. 18.09.070. Duties of the commission.** (a) The commission shall serve as
18 the state health planning and coordinating body. Consistent with state and federal law,
19 the commission shall provide recommendations for and foster the development of a
20 statewide health plan containing the following:
21 (1) a comprehensive statewide health care policy;
22 (2) a strategy for improving the health of all residents of the state that
23 (A) encourages personal responsibility for disease prevention,
24 healthy living, and acquisition of health insurance;
25 (B) reduces health care costs by using savings from
26 (i) enhanced market forces;
27 (ii) fraud reduction;
28 (iii) health information technology;
29 (iv) management efficiency;
30 (v) preventative medicine;
31 (vi) successful innovations identified by other states;

1 and
2 (vii) other cost-saving measures;
3 (C) eliminates known health risks, including unsafe water and
4 wastewater systems;
5 (D) develops a sustainable health care workforce;
6 (E) improves access to quality health care; and
7 (F) increases the number of insurance options for health care
8 services.
9 (b) The commission may hold public hearings to gather information and
10 opinions from health care consumers on matters before the commission. Hearings
11 shall be conducted under AS 44.62.210, except that the commission shall provide
12 public notice of hearings not less than 15 days before the conduct of the hearing and
13 include not fewer than three notices published in the statewide news media.
14 (c) The commission shall submit to the governor and the legislature by
15 January 15 of each year an annual report regarding the commission's
16 recommendations and activities. The report shall include voting records, copies of
17 financial disclosures, and conflicts of interest statements.
18 **Sec. 18.09.080. Compensation, per diem, and expenses.** A member
19 appointed to the commission under AS 18.09.020(1) is not entitled to a salary, but is
20 entitled to per diem, reimbursement for travel, and other expenses authorized by law
21 for boards and commissions under AS 39.20.180.
22 **Article 2. General Provisions.**
23 **Sec. 18.09.900. Regulations.** The department may adopt regulations under
24 AS 44.62 (Administrative Procedure Act) to carry out the purposes of this chapter.
25 **Sec. 18.09.990. Definitions.** In this chapter,
26 (1) "commission" means the Alaska Health Care Commission
27 established in AS 18.09.010;
28 (2) "department" means the Department of Health and Social Services.
29 * **Sec. 3.** AS 39.25.120(c)(7) is amended to read:
30 (7) the principal executive officer of the following boards, councils, or
31 commissions:

1 (A) Alaska Public Broadcasting Commission;
2 (B) Professional Teaching Practices Commission;
3 (C) Parole Board;
4 (D) Board of Nursing;
5 (E) Real Estate Commission;
6 (F) Alaska Royalty Oil and Gas Development Advisory Board;
7 (G) Alaska State Council on the Arts;
8 (H) Alaska Police Standards Council;
9 (I) Alaska Commission on Aging;
10 (J) Alaska Mental Health Board;
11 (K) State Medical Board;
12 (L) Governor's Council on Disabilities and Special Education;
13 (M) Advisory Board on Alcoholism and Drug Abuse;
14 (N) Statewide Suicide Prevention Council;
15 (O) the State Board of Registration for Architect, Engineers,
16 and Land Surveyors;
17 **(P) Alaska Health Care Commission;**
18 * **Sec. 4.** AS 44.66.010(a) is amended to read:
19 (a) Boards and commissions listed in this subsection expire on the date set out
20 after each:
21 (1) Alcoholic Beverage Control Board (AS 04.06.010) - June 30, 2010;
22 (2) Board of Parole (AS 33.16.020) - June 30, 2016;
23 (3) Regulatory Commission of Alaska (AS 42.04.010) - June 30, 2011;
24 (4) Alaska Commission on Aging (AS 47.45.200) - June 30, 2016;
25 (5) Council on Domestic Violence and Sexual Assault (AS 18.66.010)
26 - June 30, 2014;
27 (6) special education service agency (AS 14.30.600) - June 30, 2013;
28 (7) [REPEALED
29 (8)] Statewide Suicide Prevention Council (AS 44.29.300) - June 30,
30 2013;
31 **(8)** [(9)] Alaska Seismic Hazards Safety Commission (AS 44.37.065) -

4857

1 June 30, 2012;
2 (9) **Alaska Health Care Commission (AS 18.09.010) - June 30,**
3 **2014**.
4 * **Sec. 5.** The uncodified law of the State of Alaska is amended by adding a new section to
5 read:
6 TRANSITION: REGULATIONS. The Department of Health and Social Services may
7 proceed to adopt regulations necessary to implement the changes made by this Act. The
8 regulations take effect under AS 44.62 (Administrative Procedure Act), but not before the
9 effective date of the statutory change.
10 * **Sec. 6.** The uncodified law of the State of Alaska is amended by adding a new section to
11 read:
12 TRANSITION: ALASKA HEALTH CARE COMMISSION. The members appointed
13 to the Alaska Health Care Commission, established by Administrative Order No. 246 dated
14 December 4, 2008, shall serve as the voting members of the Alaska Health Care Commission
15 under AS 18.09.010, enacted by sec. 2 of this Act, for one-year to three-year staggered terms
16 as determined by the governor according to AS 39.05.055.
17 * **Sec. 7.** This Act takes effect immediately under AS 01.10.070(c).

L
4858

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.

FISCAL NOTE

STATE OF ALASKA
2010 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB172
() Publish Date:

Identifier (file name): SB172-DHSS-PHA-02-01-10
Dept. Affected: Health & Social Services
Title: Alaska Health Care Commission
RDU: Public Health
Component: Public Health Administration
Sponsor: Olson
Requester: Senate HSS
Component Number: 292

Expenditures/Revenu (Thousands of Dollars)

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

	Appropriation Required	Information					
OPERATING EXPENDITU	**FY 2011**	**FY 2011**	**FY 2012**	**FY 2013**	**FY 2014**	**FY 2015**	**FY 2016**
Personal Services	134.5		134.5	134.5	134.5	134.5	134.5
Travel	35.0		35.0	35.0	35.0	35.0	35.0
Contractual	300.0		320.5	320.5	320.5	320.5	320.5
Supplies	20.5		10.0	10.0	10.0	10.0	10.0
Equipment	10.0		0.0	0.0	0.0	0.0	0.0
Land & Structures							
Grants & Claims							
Miscellaneous							
TOTAL OPERATING	**500.0**	**0.0**	**500.0**	**500.0**	**500.0**	**500.0**	**500.0**
CAPITAL EXPENDITURE							
CHANGE IN REVENUES							

FUND SOURCE (Thousands of Dollars)

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

Estimate of any current year (FY2010) c 500.0

POSITIONS

Full-time	1.0		1	1	1	1	1
Part-time							
Temporary							

ANALYSIS: *(Attach a separate page if nece:*

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 10 members. SB 172 closely parallels Administrative Order #246 of December 2008 establishing a health care commission to address Alaska's health care challenges.

The current Alaska Health Care Commission recently adopted a formal policy recommendation to establish a permanent health care commission in statute to address the need for health care reform in Alaska. The

(continued on page 2)

Prepared by: Ward B. Hurlburt, MD, MPH, Chief Medical Officer/Director
Phone 269-8126
Division: Public Health
Date/Time 12/28/09 12:00 AM

Approved by: Alison Elgee, Assistant Commissioner, DHSS Finance & Management Services
Date 2/1/2010

ANALYSIS CONTINUATION

(Continued from Page 1)
The commission based this recommendation on the finding that the need for a plan to address health care cost, access and quality issues is greater than ever before. Health care expenditures in Alaska more than tripled between 1991 and 2005 from $1.6 billion to $5.3 billion. Costs are expected to double again, to over $10 billion, by 2013. The Alaska economy cannot sustain this inflationary growth, and government (all levels - local, state, and fed) carries 64% of this cost burden between the cost for government health care programs and provision of health care insurance for government employees. *(Data cited from "Alaska's $5 Billion Health Care Bill - Who's Paying?" UA Research summary No. 6, Institute of Social and Economic Research, University of Alaska, March 2006.)*

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.

$500.0 in state general funds is required for operations of the health care commission, as follows:

71000 Personal Services: The bill states that an Executive Director would staff the Commission; administrative support would be provided by existing DHSS staff. Personal services costs of $134.5 is Range 23, Step F.

72000 Travel Travel and per diem for Commission staff and for 8 Commission members to conduct quarterly face-to-face public meetings. The two other members are legislators and would have per diem and travel covered.

73000 Contractual Professional services contracts will be needed to supplement staff research, and core service RSAs will be required to provide lease space, telecommunications, mainframe connectivity, postage, etc.

74000 Supplies
In addition to day-to-day office supplies, FY11 includes start-up costs such as computers, office furniture, reconfiguring leased space, wiring needs for connectivity, printers, fax, and photocopier.

75000 Equipment
FY11 includes purchase of a server; in subsequent fiscal years provide technology upgrades and maintenance will be covered through the contractual line.

The bill becomes effective immediately upon the Governor's signature. This means there may be some limited costs in FY10 that will have to be absorbed by the Department of Health & Social Services.

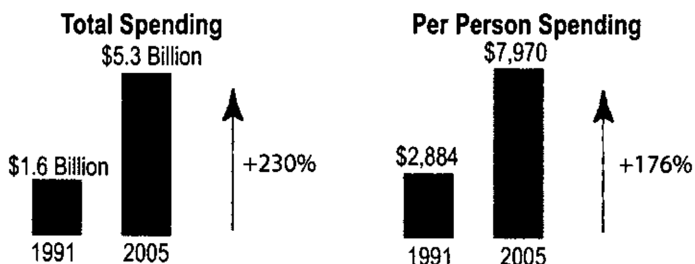
Understanding Alaska

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



Source: Authors' estimates

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:

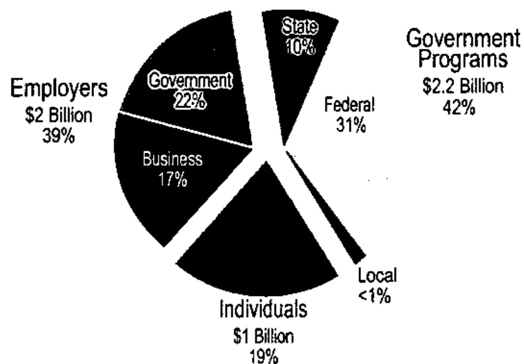
• Who are the most expensive patients? Our analysis of national data shows that the average "high-cost" patients aren't as expensive as you might think.

• 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)



Source: Authors' estimates

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.

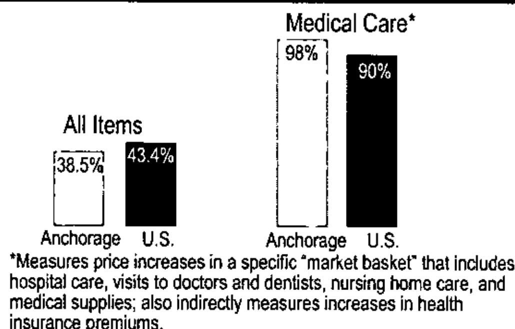
After we talk about spending, we give readers a glimpse of related health-care issues. In some cases we have no Alaska data and rely on national figures, which are still useful in illustrating important issues.

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).

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

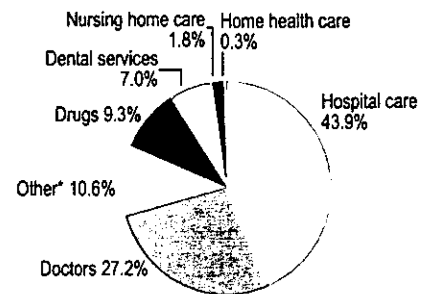
What Are We Buying?

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).

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



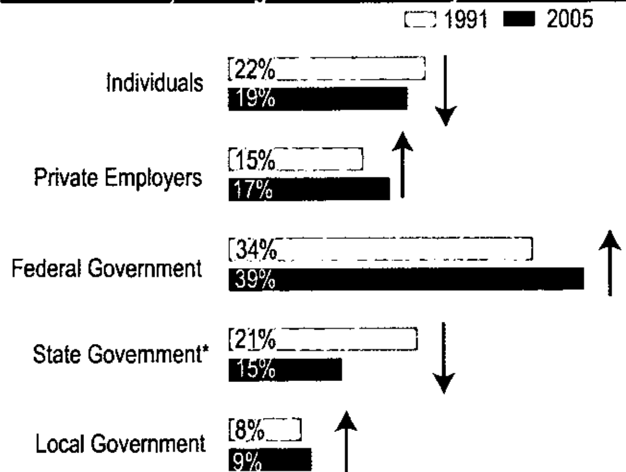
*Includes, among other things, durable and non-durable medical products, direct services employers provide employees, government expenditures in schools, and Medicaid payments that allow people to be cared for at home instead of in institutions.
Source: Center for Medicare and Medicaid Services

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.
- 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 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

4864

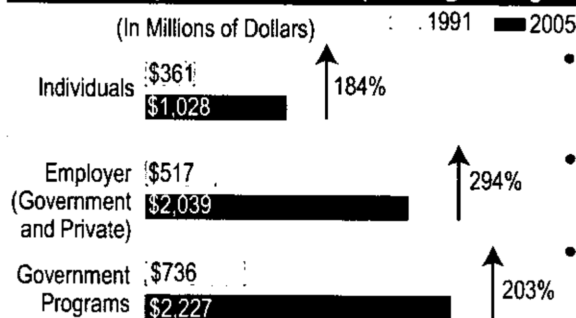
Table 1. Health-Care Spending in Alaska, Fiscal Year 2005
(Total Spending: $5.3 Billion)

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

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

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

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



Source: Authors' estimates

Biggest Kinds of Changes

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

4865

Health-Care Coverage

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

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

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

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

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

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

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

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

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

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

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

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

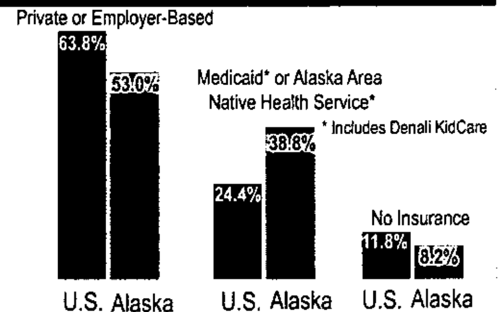
Note: Totals are more than 100% because some people have more than one coverage.
Source: U.S. Census Bureau, Current Population Survey, 2004

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

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

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

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



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

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

	Year	Premium
Alaska	1993	$6,175
	2003	$10,564
U.S.	1993	$4,786
	2003	$9,249
	2005[b]	$11,268

[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*

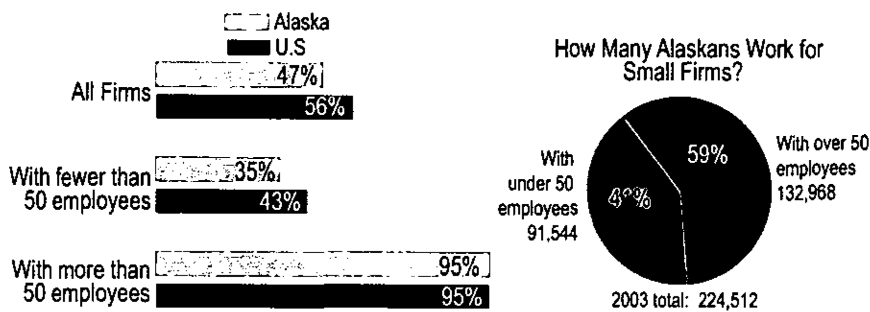
Figure 11. Share of Health Insurance Premiums Employees Pay (At Private Firms Offering Health Insurance)

		Single-Person	Family Coverage
2003[a]	Alaska	11%	17%
	U.S.	17%	25%
2005[b]	U.S.	17%	43%

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

4866

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.

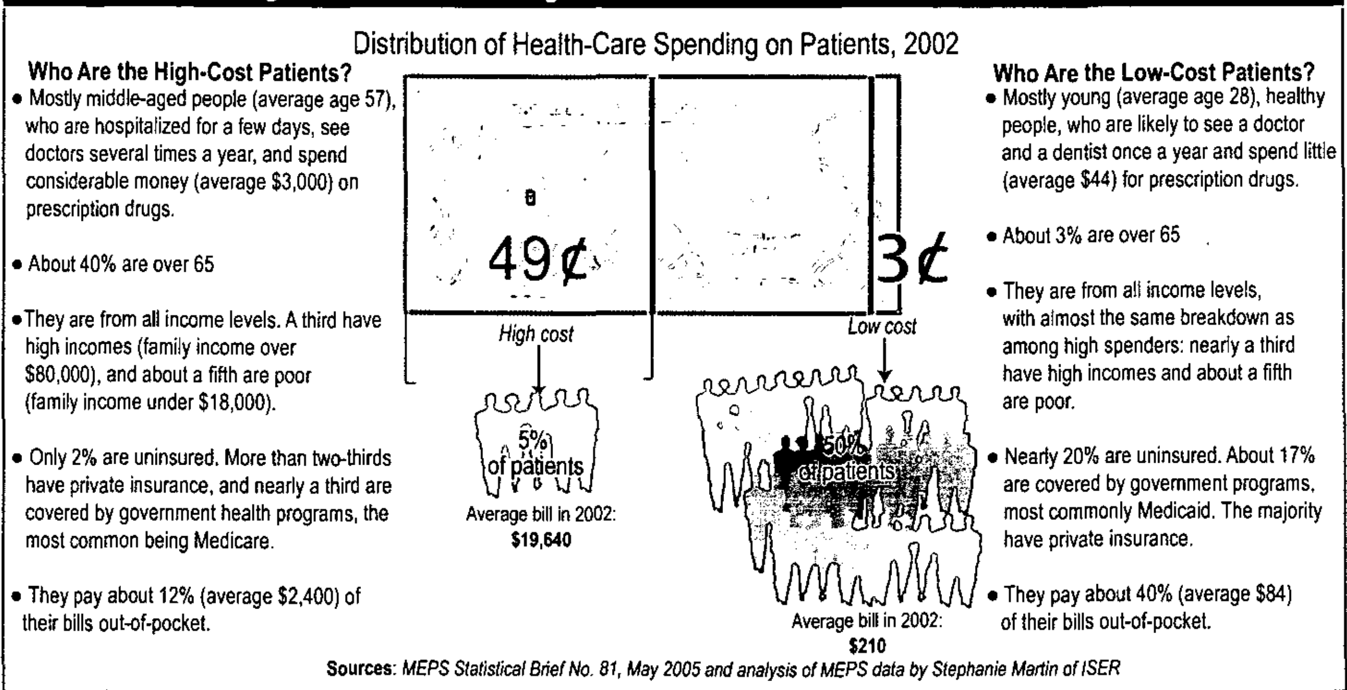
The high-cost patients are older; health-care costs do go up as people age.[7] But their average age is 57, and fewer than 40% are over 65. The average bill for high-cost patients in 2002, under $20,000, doesn't reflect major illnesses or end-of-life care. Rather, it's for a few days in the hospital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



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

4867

Do We Use More Medical Care?

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

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

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

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

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

Source: Commonwealth Fund International Health Policy Survey, 2004

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

Are We Healthier?

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

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

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

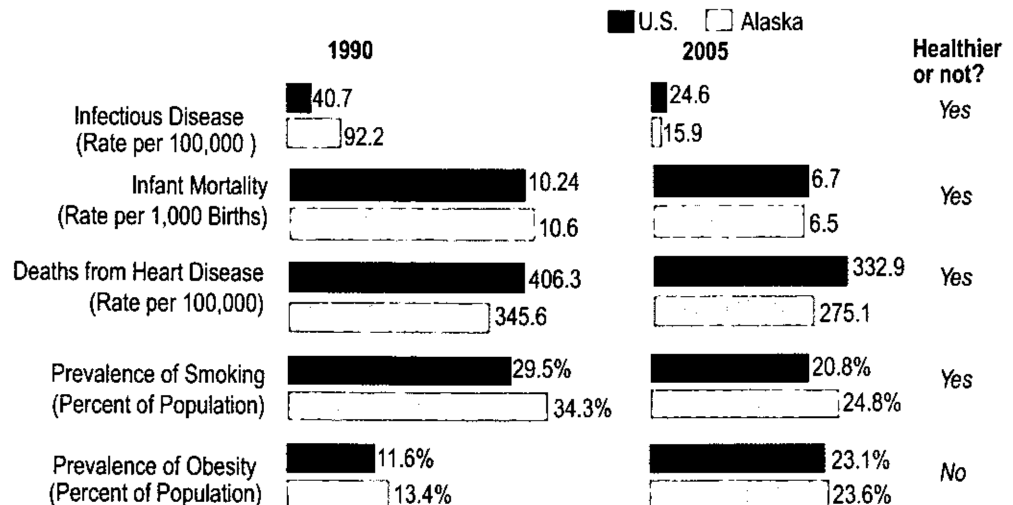
Declines in infectious disease and infant deaths in Alaska can be traced partly to public-health spending for immunizations, as well as for safe water and sewer systems, new housing, and better access to medical care in remote villages.[10] In Alaska and nationwide, advances in treatment and technology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

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

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

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

Figure 15. Are Alaskans Healthier Now Than in 1990?



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

4868

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.

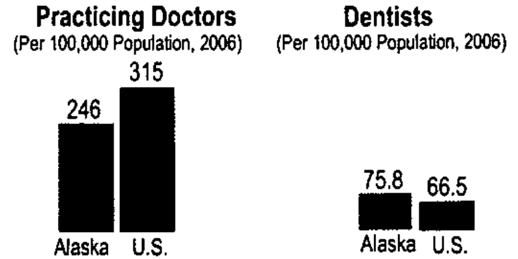
• Overall costs of medical and surgical procedures in Alaska were about 18% above the U.S. average in 2001 and dental procedures 37% more (Figure 17).

• 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?



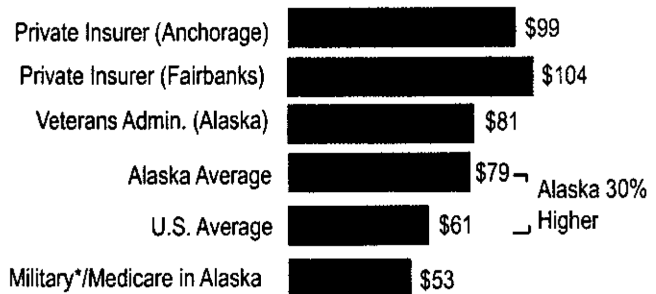
Note: Figures updated and corrected March 2007; see endnote 11.
Sources: American Medical Association; American Dental Association; U.S. Census Bureau

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)



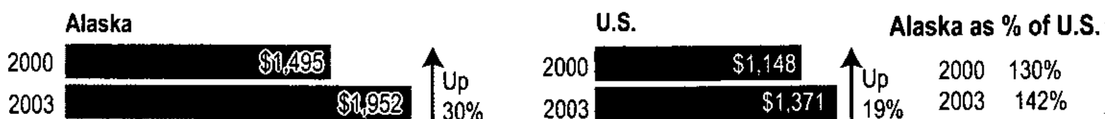
*Insurance coverage for active-duty and retired military personnel for medical care not available from military facilities.
Source: GAO Report GAO-01-620, May 2001

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)

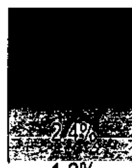


Source: 2003 American Hospital Association, Annual Survey

4869

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

Annual Growth,1990-2005*



*Authors' estimate

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.

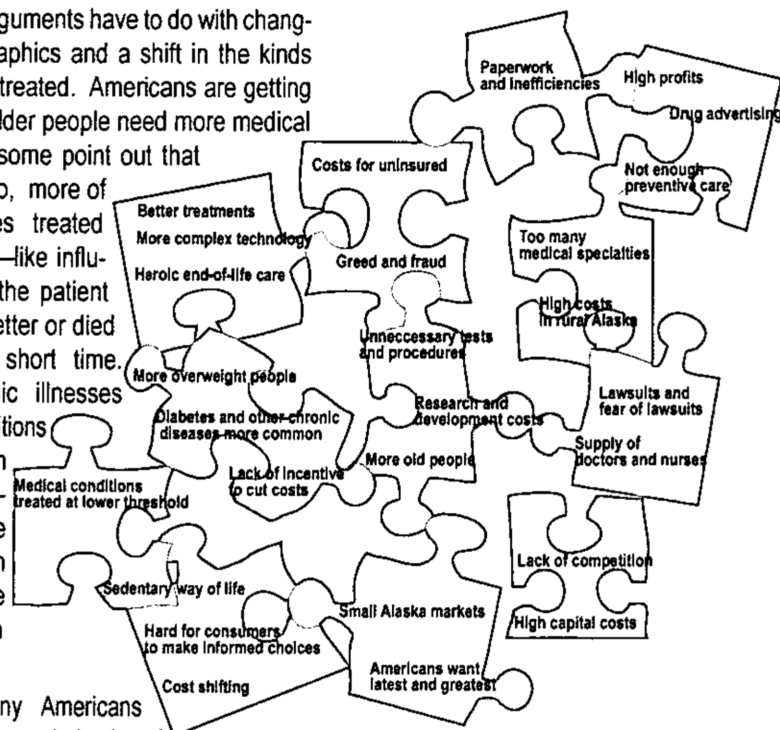
Some people think the big factors have to do with our system of delivering health care. Those include market forces—like lack of competition, for instance, and lack of incentives in many parts of the system to control costs—as well as inefficiencies created by the complexity of the U.S. system.

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**—Clemencia Merrill

4870

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.

UNDERWRITERS:
Providence Health System
Alaska Regional Hospital
Dorsey & Whitney LLP
ConocoPhillips Alaska
Alaska Railroad Corporation
AARP
Qualis Health

www.commonwealthnorth.org

Commonwealth North
810 N Street, Suite 202
Anchorage, Alaska 99501
Phone: (907) 276-1414
Fax: (907) 276-6350

E-mail: exec@commonwealthnorth.org

4871

TABLE OF CONTENTS

Executive Summary 3

Introduction: The big picture 5

A significant issue for health care in Alaska 11
- Cost 15
- Quality of Alaska's health 18
- How is Alaska's health care being paid? 20
- Alaska health care providers 22

Specific Alaskan recommendations for improvement 24
- The Alaska Health Care Roundtable 25
- Summary table of recommendations 27
- The impact of lifestyle & prevention 29
- Access improvement recommendations 30
- Quality improvement recommendations 32
- Cost reduction recommendations 32

Success stories and promising programs 33

Appendix 35
- Key ideas in the 1994 CWN study 35
- Study Group Participants 35
- 2004-2005 CWN Officers and Board of Directors 36
- The Charge 37
- Resource People Interviewed 38

4872

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

4873

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.

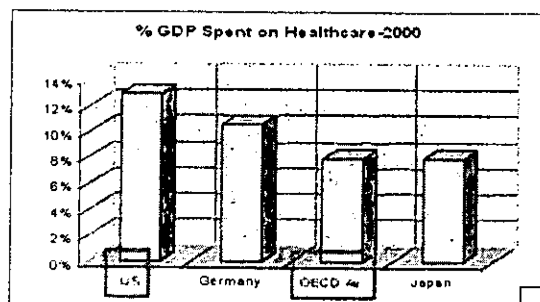
The core membership in the Roundtable would be self-selecting, comprised of members with a long-term compelling interest in improving the Alaska health care system. Examples of core members would be major employers at risk, health care providers and local foundations. A wide variety of other potential 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.

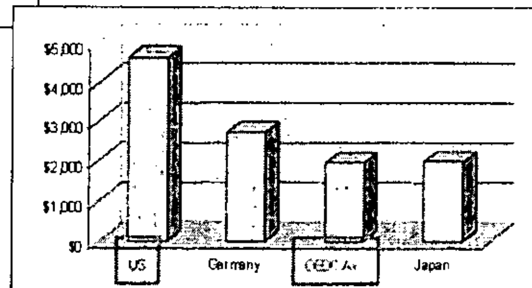
While the focus of this study is factors controllable in Alaska, it is important to understand the national context in which we operate. The United States spends more on health care than any other country, measured either as a percentage of gross domestic product, or in terms of money spent per person. 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

Per capita health care expenditures by country



Source: Commonwealth Fund

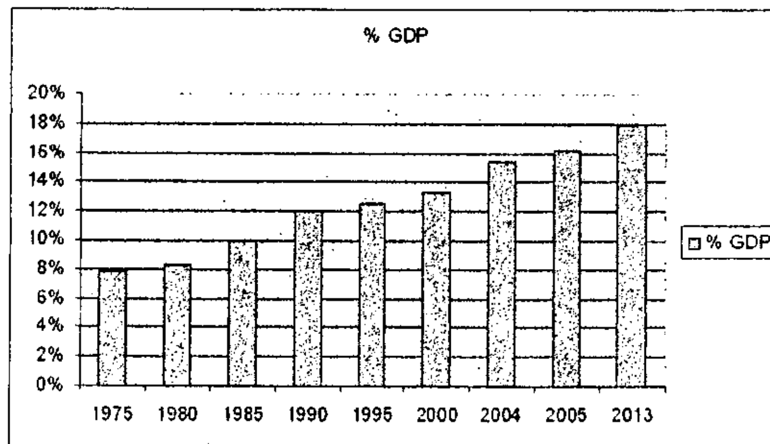
5/30/2005 2:27 PM   Heyman/Anderson Draft 8.0   5

4875

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



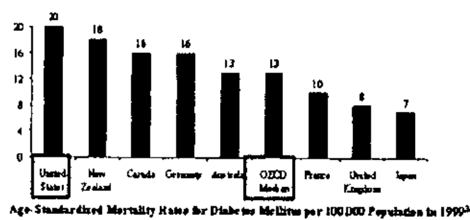
Source: Commonwealth Fund

5/30/2005 2:11 PM Heyman/Anderson Draft 8 0 4

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

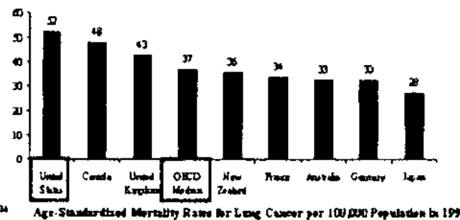
In terms of outcomes, the United States has obtained poor results from the massive amounts invested. By many measures, the U.S. trails other industrialized nations, as represented by Organization of Economic Cooperation and Development averages. We also have a higher percentage of uninsured than most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

The National Situation: Outcomes



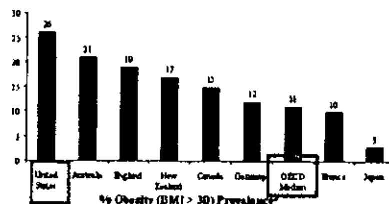
Age-Standardized Mortality Rates for Diabetes Mellitus per 100,000 Population in 1999

DIABETES



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

LUNG CANCER



% Obesity (BMI > 30) Prevalence

OBESITY

And, the U.S. ranks only

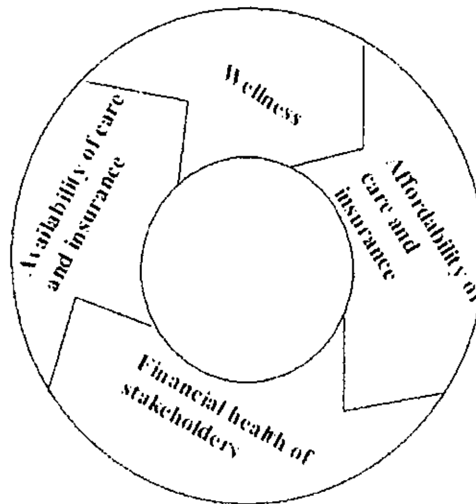
- #28 overall in infant mortality
- #24 in life expectancy

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

5/30/2005 3 08 PM Heyman/Anderson Draft 8 0 6

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



5/30/2005 3 20 PM   Heyman/Anderson Draft 8 0

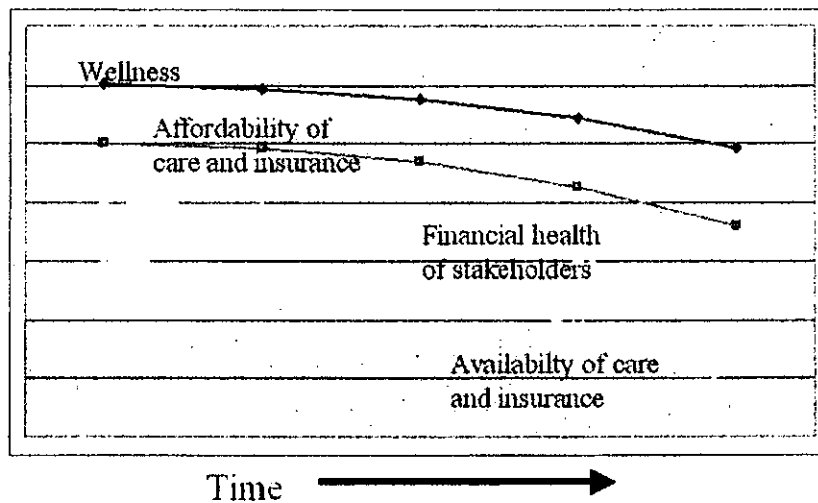
- Wellness of the population
- Affordability, coordination and quality of care and insurance
- Availability of care and insurance
- Financial health of stakeholders including:
    - Health care providers (physicians, clinics, hospitals)
    - Companies, institutions and government

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

4878

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



4879

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.

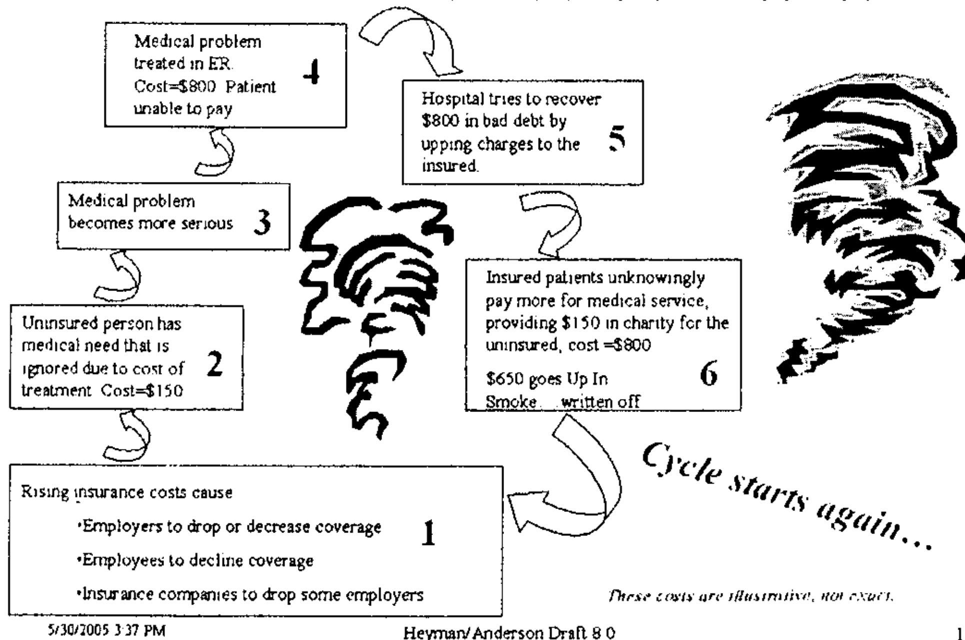
4880

A SIGNIFICANT ISSUE FOR HEALTH CARE IN ALASKA

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

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

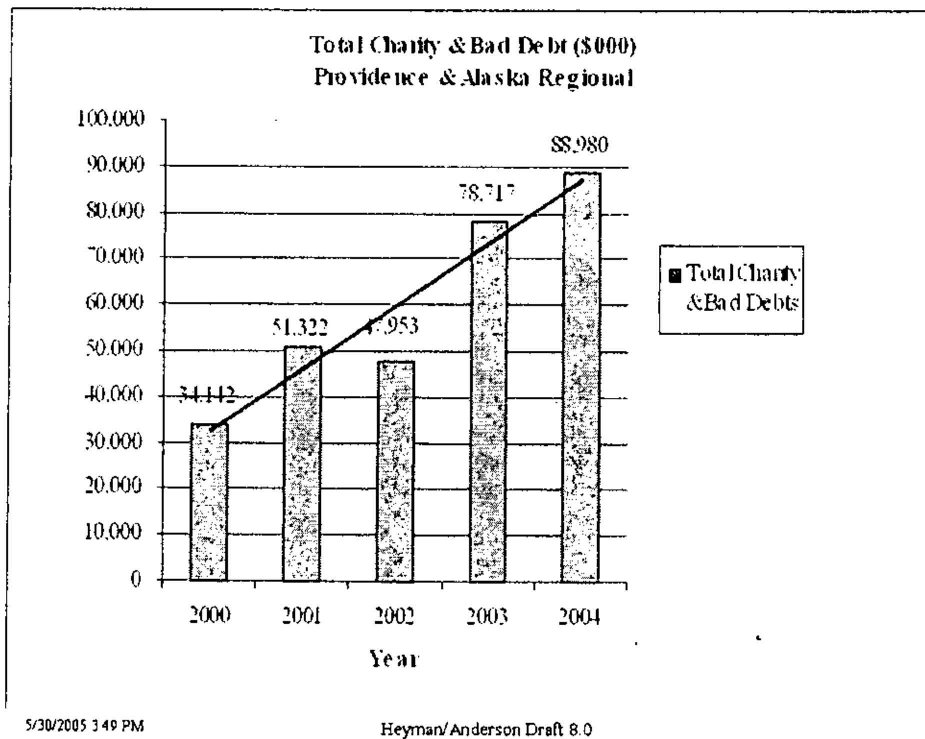
Why even a non-compassionate insured should care about the uninsured



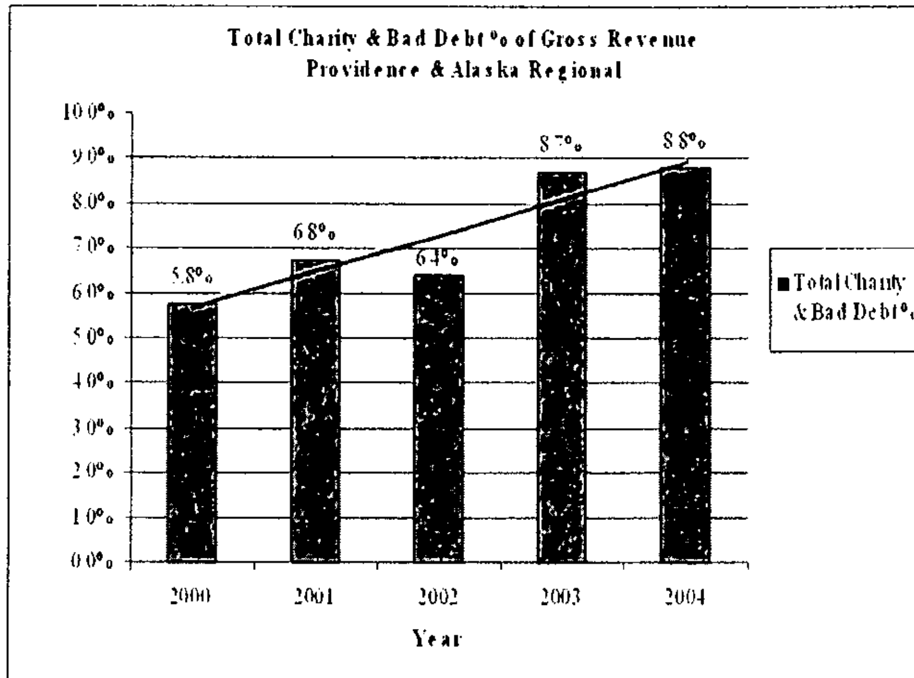
5/30/2005 3 37 PM Heyman/Anderson Draft 8 0 11

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

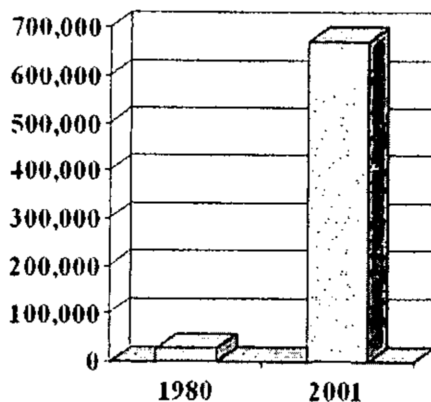


5/30/2005 3:50 PM Heyman/Anderson Draft 8.0 13

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

5/30/2005 4 02 PM Heyman/Anderson Draft 8.0 31

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:

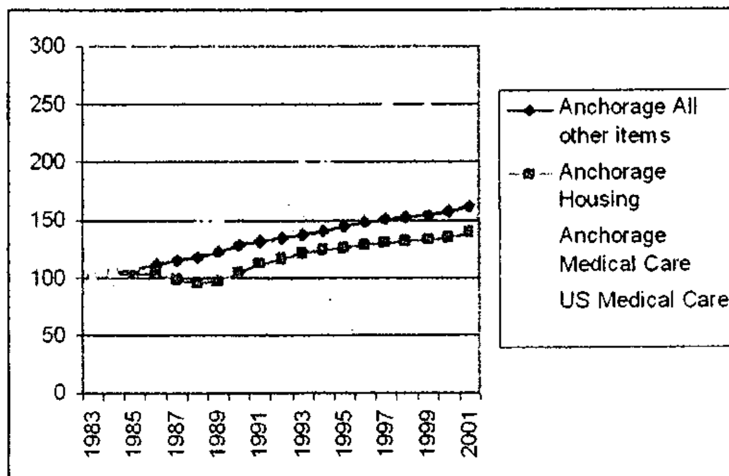
Hospital costs	42%
Prescription drug costs	21%
Doctor bills	20%

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

5/30/2005 4:01 PM Heyman/Anderson Draft 8.0

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**

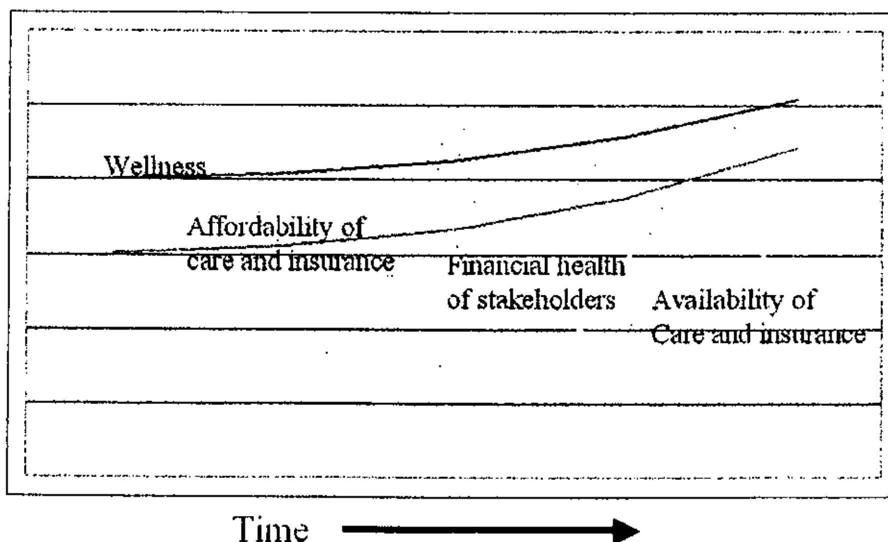
formulas are going down. The state is now paying over one billion dollars annually to pay Medicaid expenses.

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.

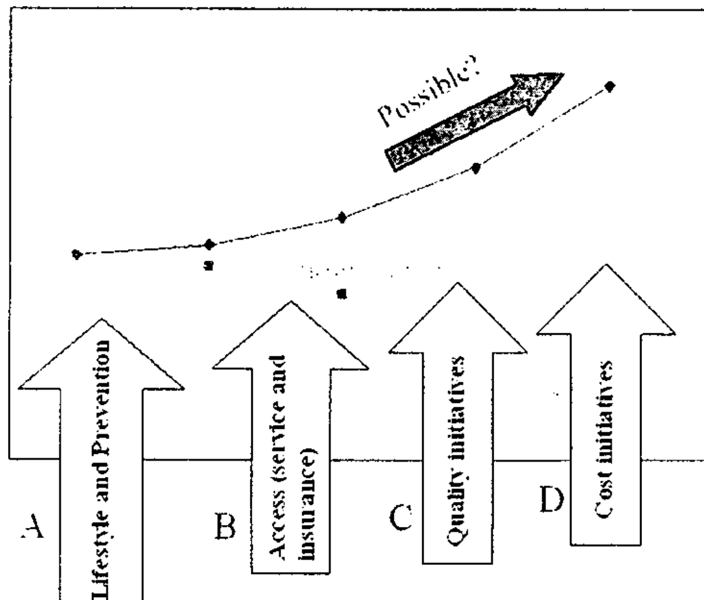
The **Certificate of Need** situation needs to be objectively analyzed and considered as a component in a comprehensive statewide health care plan. Critics of the Certificate of Need claim the process stifles competition and innovation. Supporters claim it prevents unnecessary duplication of facilities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

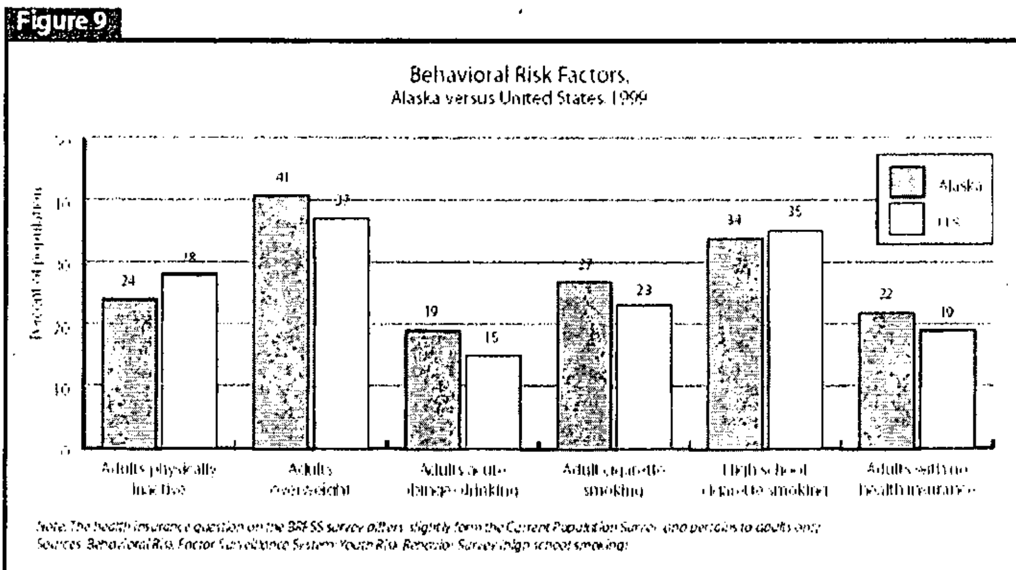


5/30/2005 3:55 PM Heyman/Anderson Draft 8.0 15

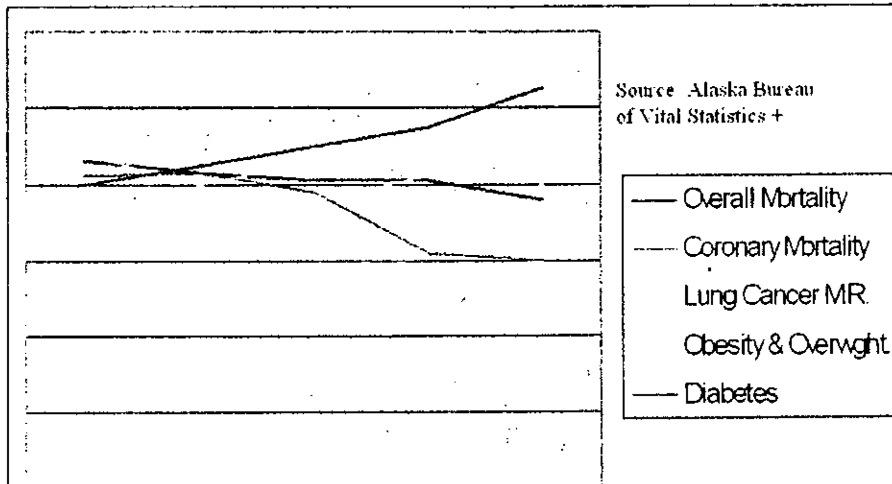
4887

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

Unfortunately, Alaska mirrors poor National behavioral risk factors



Alaska Trends in major disease



Trends only—not incidence rates

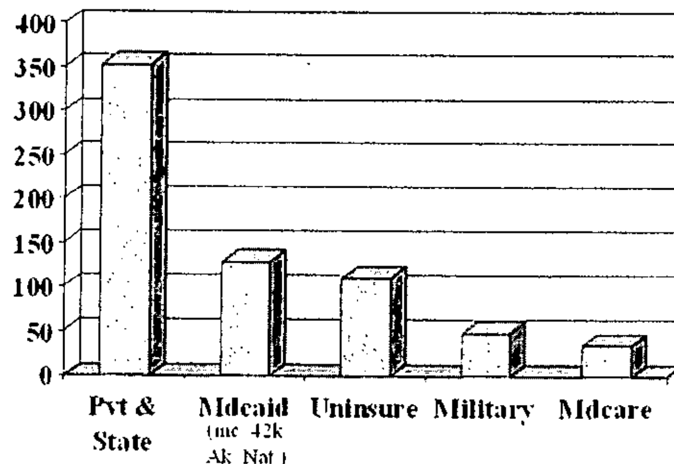
5/30/2005 3 57 PM Heyman/Anderson Draft 8.0 20

(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.



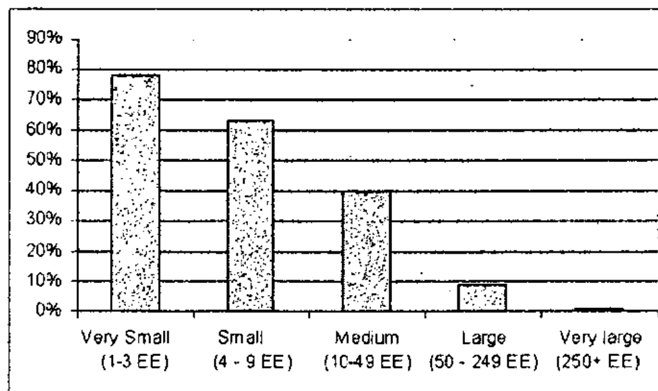
Source Navigant Consulting, Ak Journal of Commerce

5/30/2005 3 58 PM Heyman/Anderson Draft 8 0

4890

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

5/30/2005 3 59 PM Heyman/Anderson Draft 8.0 24

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.

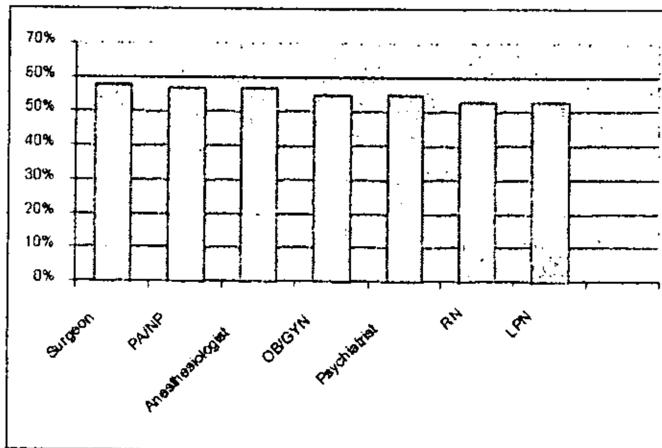
Under federal law, patients who visit the emergency rooms must be seen regardless of their ability to pay. This results in the uncompensated care that was referenced previously.

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.

4891

Healthcare Provider Shortages are Projected for Alaska

PERCENT OF PROVIDERS CURRENTLY MORE THAN 45 YEARS OF AGE



Source: AK Department of Labor

5/30/2005 4:00 PM Heyman/Anderson Draft 8.0 25

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.

4892

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:

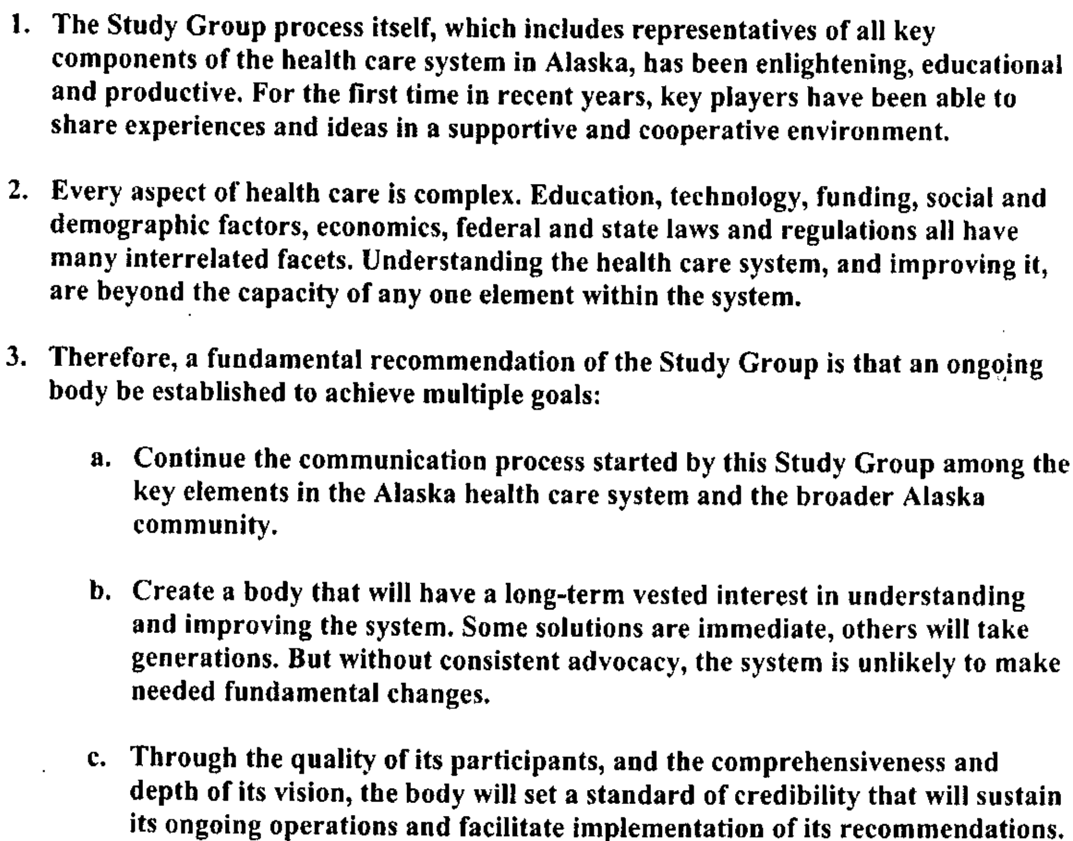
Allopathic doctors (M.D.)	2,377
Chiropractic doctors (D.C.)	227
Osteopathic doctors (D.O.)	183
Podiatrist (D.P.M.)	20

4893

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.**

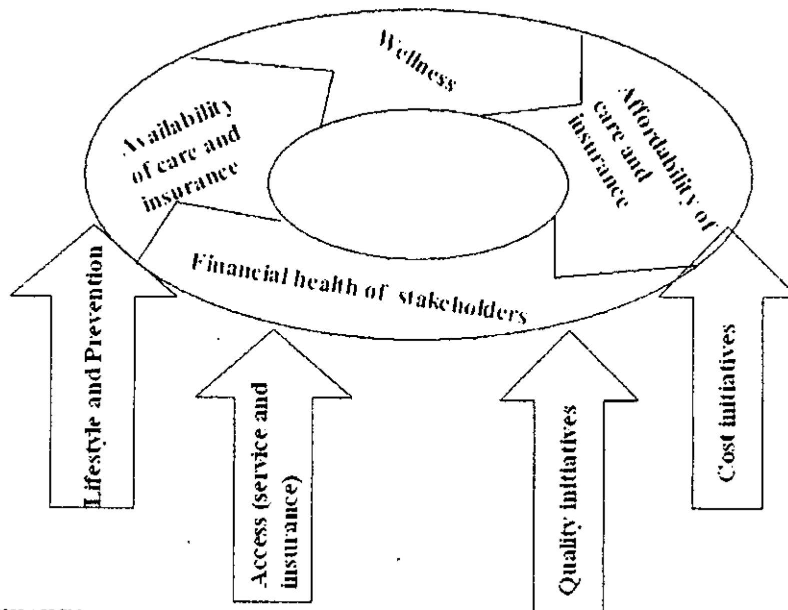
   b. **Create a body that will have a long-term vested interest in understanding and improving the system. Some solutions are immediate, others will take generations. But without consistent advocacy, the system is unlikely to make needed fundamental changes.**

   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.

4894

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



5/30/2005 4:03 PM Heyman/Anderson Draft 8.0 43

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

4896

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

4897

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

4898

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.

4899

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.

4900

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.

4901

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.

4902

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

4905

2004-2005 Commonwealth North Officers and Board of Directors

Jonathan Kumin President	Principal, Kumin Associates, Inc.
Janie Leask Vice President	Community Relations Manager, Alyeska Pipeline Service Company
Patrick K. Gamble Vice President	President & CEO, Alaska Railroad Corporation
Jeff Staser Vice President	Federal Chairman, Denali Commission
Morton Plumb Jr. Secretary	Director, Ted Stevens Anchorage International Airport
Jan Fredericks Treasurer	State Director, UAA Small Business Development Center
Joe Griffith Past President	CEO, Chugach Electric Association
Joe Farrell	Vice President and Chief Counsel, ConocoPhillips Alaska, Inc.
Dr. Alice J. Galvin	Learning & Organizational Development Advisor, BP Exploration
Walter J. Hickel	Former Governor; co-founder of Commonwealth North
Max Hodel	Founding president of Commonwealth North
Karen L. Hunt	Retired Judge, State of Alaska
Jewel Jones	Siebert Brandford Shank & Co., LLC
Marc Langland	President, Northrim Bank
Betsy Lawer	Vice Chair & Chief Operating Officer, First National Bank Alaska
James Linxwiler	Shareholder, Guess and Rudd, P.C.
Loren H. Lounsbury	Founding board member of Commonwealth North
Jeff B. Lowenfels	Lewis & Lowenfels
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.
Mike Sexton	Publisher/President, Anchorage Daily News
William Sheffield	Former Governor; founding board member
Marvin Swink	Senior Vice-President, Lynx Enterprises
Melinda Taylor	Communications Director, International Brotherhood of Electrical Workers
William J. Tobin	Editor, The Voice of the Times; founding board member
Mead Treadwell	CEO, Venture Ad Astra
Alma Upicksoun	Vice President, Chief Counsel, Arctic Slope Regional Corporation
Nancy Bear Usera	Senior Vice President, Corporate Relations, Alaska USA Federal Credit Union
David Wight	President & CEO, Alyeska Pipeline Service Company
Eric Wohlforth	Attorney, Wohlforth, Vassar, Johnson and Brecht
James Yarmon	CEO, Yarmon Investments, Inc.
Duane Heyman	Executive Director, Commonwealth North

4906

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.

4907

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)

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.

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.

4911

- 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.

4916

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

4918

Table of Contents

Executive Summary 1

The Council's Vision and Long-Term Goal 1

The "Fact-Based" Process 2

Alaska's Health Care Challenges: 2
A Strategic Plan for the Future

Alaska's Health Care Action Plan 3

Alaska's Health Care Challenges: 4
Discussion and Recommendations

Goal 1: *The High Cost of Health Care in Alaska* 4

Goal 2: *The Health Care Workforce* 5

Goal 3: *Sustainable Rural Water and Wastewater Systems* 5

Goal 4: *Access to Health Care* 6

Goal 5: *Prevention and Personal Responsibility* 7

Goal 6: *Statewide Leadership* 7

Goal 7: *Health Insurance* 8

Summary and Conclusions 9

Appendices 11

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."

4921

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

4922

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.*

4923

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.*

4924

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.*

4925

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.*

4927

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.

4928

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

4929

Appendix A: Strategy Implementation Table

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

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

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

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

4931

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

4932

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

4933

- 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

4934

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.

4935

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

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

Members of the Commisssion

Members

Jay Butler M.D., of Anchorage, is the chief medical officer for the state of Alaska. He has previously served as director of public health, state epidemiologist, Director of the Centers for Disease Control's Arctic Investigation Program, and medical director of infection control at the Alaska Native Medical Center. Butler has also been a program manager or professor of epidemiology for top national labs and health agencies, including the Centers for Disease Control, National Center for Infectious Diseases, Emory University School of Medicine, and the University of Wisconsin. He earned a bachelor's degree in zoology from North Carolina State University in 1981, and a medical degree from the University of North Carolina, Chapel Hill, in 1985. He fills a seat designated for the state's chief medical officer, and is the designated Chair of the commission.

C. Keith Campbell, of Seward, is a retired hospital administrator and national leader of the American Association of Retired Persons (AARP). Campbell served as chief executive officer of Seward General Hospital from 1971-90, and also held interim jobs as administrator of Seward's Wesleyan Rehabilitation and Care Center, and of the Seward Chamber of Commerce. As a member of AARP's national board of directors from 1996-2002, he served at different times as chairman and treasurer, and on numerous AARP committees dealing with health care, insurance, finance, and government affairs. He has also been elected to the Seward City Council and school board, and to the Kenai Peninsula Borough Assembly. He fills a seat representing health care consumers.

Valerie Davidson, of Anchorage, is senior director of legal and inter-governmental affairs for the Alaska Native Tribal Health Consortium in Anchorage, with extensive experience working in Bethel on Alaska Native health and tribal governance issues. She has previously worked for the Yukon Kuskokwim Health Corporation and as a state legislative staffer on rural health care issues. Davidson earned a bachelor's degree in elementary education from the University of Alaska Anchorage, and a law degree from the University of New Mexico's School of Law. She fills a seat representing Alaska tribal health care providers.

Jeffrey W. Davis, of Anchorage, has been involved in the delivery and funding of health care services for 25 years. He has served nine years as president of Premera Blue Cross Blue Shield of Alaska, which insures 180,000 Alaskans statewide, and previously was Premera's vice president of network development in Alaska, Washington and Oregon. Davis earned a bachelor's degree in biology from Whitman College and a master's degree in health services administration from the University of Washington. He fills a seat representing Alaska's health insurance industry.

Ryan Smith, of Soldotna, has been chief executive officer of the Central Peninsula General Hospital since 2006, and has worked in chief financial officer or other accounting positions for hospitals in Alaska, Wyoming and Utah since 1987. He currently is chair of the Alaska State Hospital and Nursing Home Association. Smith earned a bachelor's degree in accounting in 1990, and a master's degree in business administration in 1992, both from the University of Utah. He fills a seat designated for the Alaska State Hospital and Nursing Home Association.

Wayne Stevens, of Juneau, has been president and chief executive officer of the Alaska State Chamber of Commerce since 2004. He served as executive director of the Kodiak Chamber of Commerce from 1985 to 2004, and previously worked 11 years in customer service and cargo supervision for Wien Air Alaska. Stevens has served on the Southwest Alaska Municipal Conference, the Governor's Task Force on Regulatory Reform, the Kodiak Island Borough Mental Health Advisory Board, and in various leadership positions for Kodiak's hospital. Stevens has also served three terms on the Kodiak Island Borough Assembly. He fills the seat designated for the Alaska State Chamber of Commerce.

Larry Stinson M.D., of Palmer, is an anesthesiologist and co-owner of Advanced Pain Centers of

Larry Stinson M.D., of Palmer, is an anesthesiologist and co-owner of Advanced Pain Centers of Alaska, which operates clinics in Anchorage, Fairbanks and Wasilla. He has served as an anesthesiologist at Fairbanks Memorial Hospital, a brigade surgeon for the 6th Infantry Division (Light) at Fort Wainwright, and as a university clinical instructor. A board-certified anesthesiologist, he earned a bachelor's degree from the University of Alaska Fairbanks in 1980, and a medical degree from the University of Washington in 1984. He fills a seat representing Alaska health care providers.

Non-Voting Members

Linda Hall, of Anchorage, has been director of the Division of Insurance in the Department of Commerce, Community and Economic Development since 2003, and has 18 years experience as a commercial insurance broker. She is a past president of the Alaska Independent Insurance Agents and Brokers, and represented Alaska on the national organization's board 1997-2003. She is also past chair of the Alaska Workers Compensation Review and Advisory Committee. Hall fills a non-voting seat representing the executive branch of state government.

Representative Wes Keller, of Wasilla, has represented the Wasilla area in the Alaska State House of Representatives since 2007. He is co-chair of the House Health, Education and Social Services Committee, and chair of the Administrative Regulation Review Committee. Keller had previously worked eight years as a legislative aide, and as an Alaska Air National Guard pilot, building contractor, oilfield worker and contracting trainer. He earned a bachelor's degree from the University of Wisconsin in 1986. Keller was appointed by House Speaker Mike Chenault to fill a non-voting seat representing the House of Representatives on the commission.

Senator Donald Olson, of Golovin, has represented Northwest Alaska in the Alaska State Senate since 2000. He is a physician, commercial pilot and reindeer herder. Olson earned a bachelor's degree in chemistry from the University of Minnesota, a medical degree from Oral Roberts University School of Medicine, and a law degree from the University of Colorado School of Law. He chairs the Community and Regional Affairs Committee, and sits on the Senate Finance Committee. Olson was appointed by Senate President Gary Stevens to fill a non-voting seat representing the Senate on the commission.

4941

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

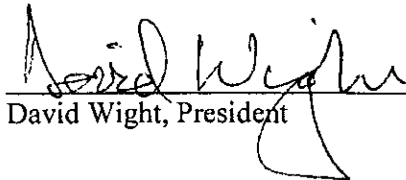
Requests all state legislators to approve authorizing legislation in Senate Bill 172; and

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

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

STATE OF ALASKA

DEPT. OF HEALTH & SOCIAL SERVICES

Alaska Commission on Aging

SEAN PARNELL, GOVERNOR

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

February 2, 2010

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

Subject: Support for SB 172

Dear Chair Davis:

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

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

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

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

Sincerely,

Sharon Howerton-Clark
Chair, Alaska Commission on Aging

Sincerely,

Denise Daniello
ACoA Executive Director

Cc: Senator Joe Paskvan, Vice-Chair
Senator Johnny Ellis
Senator Fred Dyson
Senator Donald Olson

Christian Science Committee on Publication for Alaska

P. O. Box 240976, Douglas, AK 99824
Phone: (907) 789-1544 Fax: (907) 364-2468
Email: Alaska@compub.org

To: Senator Bettye Davis, Chair
Members of the Senate Health and Social Services Committee

From: Beverly Smith, Christian Science Committee on Publication for Alaska

Date: February 3, 2010

RE: Senate Bill No. 172
An Act establishing the Alaska Health Care Commission in the Department of Health and Social Services; and providing for an effective date.

Thank you for giving me the opportunity to comment on SB 172.

In my capacity as Christian Science Committee on Publication for Alaska, one of my roles is to ensure that you have accurate information concerning spiritual healing as practiced in Christian Science, so that this cost effective and reliable form of care is not overlooked or restricted in the State's health care reform efforts. With regards to SB 172, I am here to request that access to spiritual care for the treatment and cure of disease be given appropriate consideration during the discussion of the development of a statewide health plan.

To facilitate this discussion I recommend that the bill mandate one of the duties of the Commission to be: **to recommend the extent to which and under what circumstances access to spiritual care should be addressed in a comprehensive statewide healthcare policy.**

Because healthcare reform discussions around the country, both at the federal and state levels, have raised issues that could impact the insurance coverage for spiritual care, it is important that these issues be discussed so as not to create unintended results that subvert this coverage and therefore limit access to spiritual care.

I noticed that the bill does not mandate health insurance for all Alaskans but asks the Commission to develop a strategy that encourages acquisition of health insurance, and that increases the number of insurance options for healthcare services.

Insurance is a topic I am interested in because if Alaskans pay health insurance premiums they should be able to be reimbursed for the healthcare they choose whether that be

4946

medical care or spiritual treatment. Existing law contains numerous examples of programs that offer benefits for spiritual care, including:

- Four plans under the Federal Employees Health Benefits Program (FEHBP) cover religious nonmedical nursing care and/or Christian Science practitioner services:
  - Government Employees' Health Association (GEHA)
  - Mail Handlers Benefit Plan
  - Special Agents Mutual Benefit Association
  - Association Benefit Plan

- Religious nonmedical nursing services are covered under the Medicare and Medicaid programs (see 42 U.S.C. §§ 1395x(ss) and 1395i-5).

- TRICARE (for military dependents) – Covers care in Christian Science nursing facilities, Christian Science nursing services, and Christian Science practitioner services.

- Under Section 223 of the Internal Revenue Code ("IRC"), funds contained in a Health Savings Account may be used to pay for spiritual care. Section 223 references the definition of "medical expenses" in Section 213(d) of the IRC, which has been interpreted to include Christian Science practitioner services and Christian Science nursing care.

- Alaska and a number of other states (e.g., California, Illinois, Kansas, Missouri, Oklahoma, Oregon, Texas) allow coverage of spiritual treatment through prayer in their governmental employees' health insurance plans. The Alaska Care plan for state employees and retired state workers covers treatment by "Christian Science Practitioners authorized by the Mother Church, First Church of Christ, Scientist, Boston, Massachusetts." (See Alaska Care Booklet, pg. 20.)

I would hope that the Commission would preserve the insurance coverage for spiritual care that we have now and recommend that it be expanded to include religious nonmedical nursing services. If the Commission were directed in statute to include access to spiritual care in its discussion of reform, this would prevent such access from being overlooked or minimized.

Christian Science is a method of spiritual care that is available to everyone. For over a century individuals from many different faith traditions have found Christian Science to be reliable and effective in addressing the challenges posed by injury and disease. For this reason, they will often choose religious nonmedical health care in lieu of medical care.

Access to reliable and cost-effective health care should be one of the primary goals of health care reform. For many Americans, the issue at hand is, in some ways, more fundamental: having the option to choose the method of health care that is most effective for them.

I am grateful to the sponsor of this bill for his effort in bringing solutions to the health care challenges in Alaska by seeking to establish an Alaska Health Care Commission, and I respectfully request that this Commission have the responsibility for discussing and recommending how access to spiritual treatment and care can be part of the overall health care plan for Alaska.

AARP Alaska
3601 C Street
Suite 1420
Anchorage, AK 99503

T 1-866-227-7447
F 907-341-2270
TTY 1-877-434-7598
www.aarp.org/ak

March 16, 2010

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

RE: SB 172 (Olson)--Support

Dear Chair Davis:

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

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

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

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

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

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

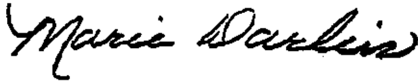
AARP requests an "AYE" vote on SB 172.

Jennie Chin Hansen, President
William D. Novelli, Chief Executive Officer

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

February 3, 2010

RE: SB 172 – Designation of a Primary Care Safety Net Seat on Health Commission

Dear Senate HSS Committee Chair Davis and Members of the Committee:

The Alaska Primary Care Association (APCA) wishes to thank the Committee for hearing SB 172. The APCA was part of the Commonwealth North Alaska Health Care Roundtable that issued the report "Alaska Primary Health Care – Opportunities and Challenges" in 2005 which included the recommendation that that an ongoing body be established. Please note that the title of the report includes the words "Alaska Primary Health Care."

The APCA wishes to point out that the composition of the Health Care Commission outlined in the bill does not currently provide expertise and representation for an extremely important and large segment of the health care delivery system: primary care and specifically, the primary care safety net.

Because primary care is the gateway to health care and an "umbrella" of sorts of multiple aspects of care delivery, encompassing the broad spectrum of fundamental medical, dental and behavioral health care; because it is a major part of the key to cost-savings and better health outcomes for Alaskans (prevention, patient responsibility, wise choices, etc. are basic to primary care); and because primary care will be a chief component of whatever plan Alaska develops to move us forward, representation on the Commission of primary care is extremely important. In addition, since a significant part of the Commission's assignment will be to address the uninsured problem and to ensure access to medically underserved Alaskans, representation of the primary care safety net as opposed to representation of solely primary care would provide a dual benefit.

In addition, the three largest health systems in Alaska are the hospitals, tribal health, and the Community Health Center system (the primary care safety net). Currently the bill includes a seat for the Alaska State Hospital and Nursing Home Association and the tribal health community, but it does not include a seat for the Community Health Centers.

As an added note, the APCA would like to point out that the Alaska State Chamber of Commerce adopted a position for this legislative session in favor of the establishment of a health commission in statue with the recommendation that the composition include a seat for primary care.

903 W. Northern Lights Blvd., Suite 200, Anchorage, AK 99503-2400
main: 907.929.2722 *fax:* 907.929.2734 www.alaskapca.org
supporting Alaskans' health care homes

The Alaska Primary Care Association represents 26 Community Health Center (CHC) organizations and other primary care providers throughout the state. The CHCs operate 142 clinic delivery sites in both rural and urban Alaska effectively and efficiently, seeing more than 81,000 patients in communities of all sizes. CHCs accept all patients regardless of their ability to pay, have a sliding fee scale, and are governed by local boards consisting of a majority of members who are patients. CHCs bring savings to the Medicaid system and receive the highest score possible from the Federal Office of Management and Budget for cost-effectively achieving their goal to provide quality access and improve health outcomes. A CHC primary care safety net representative on the Commission could offer invaluable input to the Commission to help improve the health care system in Alaska.

The APCA respectfully requests the Committee add a primary care safety net seat to the composition of the Commission in SB 172.

Promoting health care access to all Alaskans,

Shelley S. Hughes
Government Affairs Director

903 W. Northern Lights Blvd., Suite 200, Anchorage, AK 99503-2400
main: 907.929.2722 *fax:* 907.929.2734 www.alaskapca.org
supporting Alaskans' health care homes

MUNICIPALITY OF ANCHORAGE

Department of Health and Human Services

907-343-6718

Mayor Dan Sullivan

SENIOR CITIZEN ADVISORY COMMISSION

February 9, 2010

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

Dear Senator Olson,

RE: Letter of Support for SB 172

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

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

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

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

Respectfully,

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

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

NATIONAL CONFERENCE of STATE LEGISLATURES

The Forum for America's Ideas

Upcoming Events

NCSL Spring Forum
April 7-10, 2010
Washington, D.C.

For more information go to www.ncsl.org, click on the "Meetings" Tab.

News

State Legislatures

The National Magazine of Policy and Politics, online at www.ncsl.org - click on the "Magazine" tab.

Online Bookstore

Find the Most Comprehensive Policy Books Available at http://ecom.ncsl.org/bookstore

NCSL Blog: The Thicket at State Legislature

A Bipartisan Blog by and for Legislative Junkies at http://ncsl.typepad.com/the_thicket/

For more information, visit www.ncsl.org or call NCSL directly 303-364-7700

To: Tom Obermeyer

From: Brenda Erickson

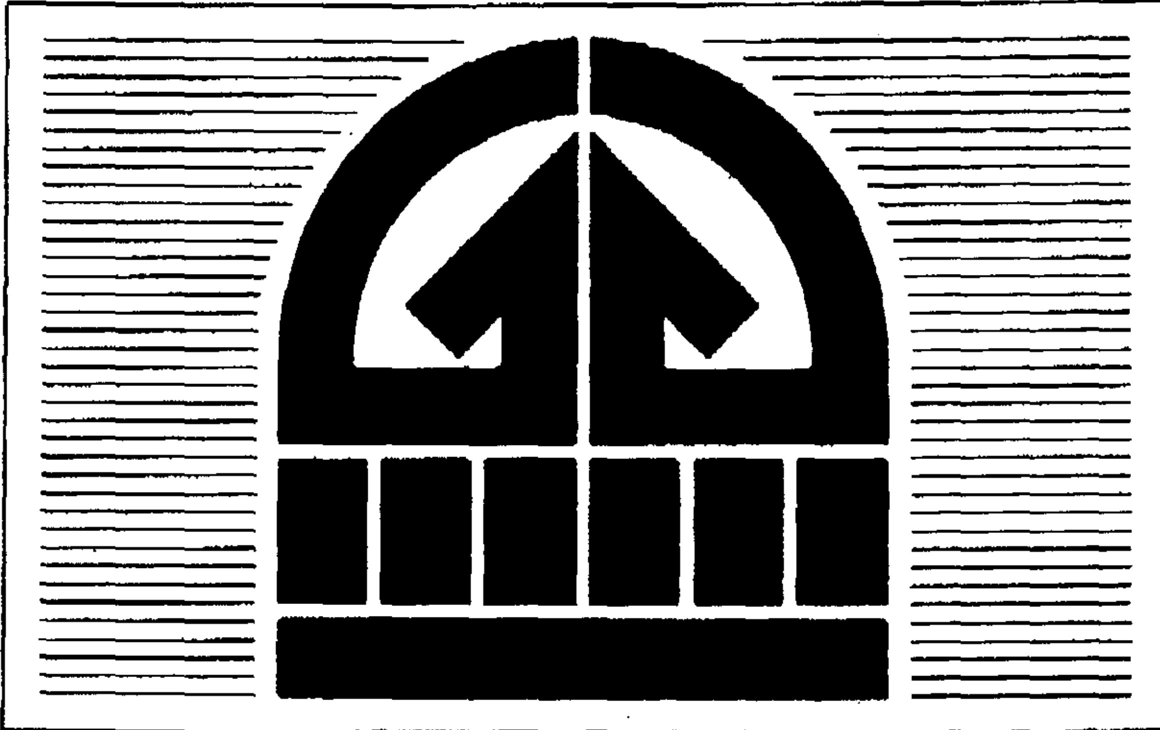
Message: Attached is the older NCSL document about legislators serving on boards & commissions that I mentioned.

Date: 3/17/10 Number of Pages Sent: 10

Denver Office:
7700 East First Place, Denver, CO 80230
Phone: (303) 364-7700 / Fax: (303) 364-7800

Washington, D.C. Office:
444 North Capitol Street, NW, Suite 515, Washington, D.C. 20001
Phone: (202) 624-5400 / Fax: (202) 737-1069

STATE LEGISLATIVE REPORT



Legislative Management Series

LEGISLATORS SERVING ON BOARDS AND COMMISSIONS

Vol. 8, No. 2 February, 1983

by

Rich Jones

An Information Service of the National Conference of State Legislatures
1125 17th Street, Suite 1500, Denver, Colorado 80202. Earl S. Mackey, Executive Director

LEGISLATORS SERVING ON BOARDS AND COMMISSIONS

by

Rich Jones
Legislative Management

The constitutional question of whether legislators may serve on boards and commissions has received considerable attention in 1982. A supreme court decision in North Carolina, an attorney general's opinion in Tennessee and current litigation in Kentucky and Mississippi all challenge the practice.

To document the extent to which legislators serve on boards and commissions and to identify the legal issues raised by this practice, the National Conference of State Legislatures (NCSL) surveyed the states. This report describes the legal issues raised by legislators serving on boards and commissions and discusses the results of the NCSL survey.

LEGAL ISSUES

Legislator service on boards and commissions has been challenged primarily on two grounds: the separation of powers doctrine and dual office holding prohibitions.

Separation of Powers. The separation of powers doctrine holds that the three branches of government have distinct powers and responsibilities. Interpreting this doctrine, the courts have generally ruled that legislators cannot serve as members of boards and commissions that exercise executive authority. Executive duties as defined by the courts include implementing legislative directives, overseeing and managing the daily affairs of administrative departments, setting standards and issuing regulations, tions, and controlling agency expenditures. As early as 1912 the Colorado Supreme Court ruled that the legislature could not create a legislative committee to act as an executive agent in carrying out a law.[1] In 1975, a Georgia court ruled unconstitutional the appointment of legislators to an oversight board responsible for constructing, maintaining and managing the World Congress Center because the appointments represented a legislative attempt to "retain some control over the process of the implementation [of legislation]". [2] Also, in 1976 the Kansas Supreme Court opined that although the separation of powers principle "does not in all cases prevent [legislators] from serving on boards and commissions", a legislatively controlled council that oversees the day-to-day operations of the department of administration unconstitutionally usurps powers of the executive.[3]

North Carolina. In January 1982, the North Carolina Supreme Court ruled that legislators serving on the Environmental Management Commission (EMC) violated that state's separation of powers provision. In State of North Carolina ex rel. v. Bone and Nash, the court determined that the EMC's duties, which include setting standards, adopting regulations, and issuing permits, "are administrative and executive in character and have no relation to the function of the legislative branch of government." The court also agreed with an earlier Georgia court's decision that "the legislature cannot constitutionally create a special instrumentality of government to implement specific legislation and then retain some control over the process of implementation by appointing legislators to the governing board of the instrumentality." While recognizing the value of cooperation between the legislative and executive branches, the court implied that cooperative efforts were constitutionally limited to study commissions and advisory bodies.

4956

The court did not address the question of legislators serving on boards and commissions other than the EMC, but its decision has been interpreted to apply to all North Carolina boards and commissions. As a result, the Legislative Research Commission completed an exhaustive study of the powers and duties of the boards and commissions on which legislators served and made three fundamental policy changes. First, legislators were removed from boards and commissions that exercise executive powers. Second, boards and commissions that could function effectively without executive authority, were made advisory and legislators retained their membership. Third, the power to appoint nonlegislative members to executive boards was removed from the legislative leaders and granted to the entire General Assembly.

Mississippi. The Mississippi attorney general filed suit in August 1982 to remove legislators from nine specific boards and commissions. In State of Mississippi v. William B. Alexander, et al., the attorney general argues that the boards in question exercise executive authority and the legislature, in violation of the separation of powers principle, is attempting to retain control over the process of implementing legislation by appointing legislators to them. He also contends that a violation of separation of powers occurs when a person serving in one branch exercises any power or function of another branch.

In its legal briefs, the legislature has taken the position that the separation of powers does not require an absolute division between the legislative and executive branches of government. Because this division is less than exact, a violation occurs only when a person serving in one branch "usurps the whole of the power of another branch." In the legislature's view, if the primary functions of a board or commission are legislative in nature, legislative members do not violate the separation of powers principle. In addition, Mississippi legislators contend that even if the primary functions are executive, the court should consider who performs the executive functions, whether the legislators constitute a minority position on the board, and what benefits accrue to the state through legislator service before ruling on the separation of powers questions.

In January, 1983, the Hinds County Circuit Court ruled that the legislators serving on the nine boards and commissions in question violated Mississippi's separation of powers constitutional provision. The legislature is expected to appeal the decision.

Kentucky. In Legislative Research Commission, et al. v. John Y. Brown, Jr. the Kentucky legislature asked the court to rule on the constitutionality of several acts passed during the 1982 session, including acts that appoint the Speaker of the House of Representatives and President Pro Tempore of the Senate to two boards and commissions and acts that empower the legislative leaders to make appointments to boards and commissions. The Franklin Circuit Court in November 1982 ruled that legislators could not serve on boards or agencies within the executive department without violating Kentucky's separation of powers provisions. The court also ruled that, "the powers to appoint members of boards is an essentially executive power which cannot be exercised by any member of the legislative department."

The case has been appealed by the Legislative Research Commission directly to the Kentucky Supreme Court which has agreed to hear it in early 1983.

Dual Office Holding Prohibitions. The second legal argument against legislator service on boards and commissions is based on constitutional prohibitions against dual office holding. Courts have generally defined a public office as one in which a person has independent authority to act under the law, either alone or with others of equal authority, to exercise the sovereign powers of the state. In a 1944 opinion, the Ohio Supreme Court ruled that state's dual office holding prohibition would preclude legislators from serving on boards and commissions that exercise sovereign powers of the state.[4] In California and Minnesota, attorneys general used court interpretations of

what constitutes a public office to determine whether legislators can serve on certain boards and commissions.

In January 1982, citing a provision of the Tennessee constitution that specifically prohibits legislators from holding any "office or place of trust, the appointment to which is vested in the executive or the General Assembly..." the Attorney General advised legislators that their service on nine boards and commissions was unconstitutional. The major dispute involved the speakers of the House and Senate serving as members of the State Building Commission. In light of this opinion, the leaders retained their membership but relinquished their voting privileges. This action has apparently resolved the question and no court challenge is expected.

RESULTS OF THE NCSL SURVEY

To gather information about the extent to which legislators serve on boards and commissions, the National Conference of State Legislatures surveyed research directors in all 50 states in 1982. NCSL asked about the types of boards on which legislators serve, whether there are restrictions placed on their service, how legislators are appointed to boards and commissions, and whether legislative leaders can appoint nonlegislators to boards and commissions. NCSL did not attempt to determine the number of boards and commissions with legislative members or the number of legislators serving on boards and commissions.

Types of Boards on Which Legislators Serve. NCSL grouped the different types of boards and commissions into five broad categories and asked whether legislators serve on any of these boards:

QUASI-JUDICIAL--boards that hear claims and issue decisions, promulgate rules and regulations, issue orders and act as appeal boards for administrative decisions.

BUDGETING--boards that formulate state budgets, allocate funds between departments, receive and allocate federal funds, and oversee agency expenditures.

POLICYMAKING--boards that gather data on the status of specific problems, advise and assist executive agency personnel and the legislature, recommend state actions, set priorities for state action and coordinate programs in a specific area.

REGULATORY--boards that set rates for services and products, determine eligibility for professions and trades, and approve applications for licenses.

MANAGEMENT--boards that oversee and administer state policy in specific areas, hire and oversee the performance of a full-time administrator and staff, award contracts and expend state funds, purchase equipment and services, and prepare an annual budget to carry out assigned responsibilities.

Although not included in the written descriptions, the NCSL staff also asked respondents whether legislators serve on advisory boards and commissions. Table 1 lists the types of boards and commissions on which legislators serve in each state.

Several observations can be drawn from the data:

1. Four states (Massachusetts, Michigan, New Mexico, and Virginia) indicate that legislators are strictly prohibited, either through constitutional provisions, statutes, or by court decisions, from serving on boards and commissions.

2. The most common state practice is for legislators to serve on advisory boards, a practice followed in 37 states. In 11 states, lawmakers can only serve on advisory bodies.

3. Although legislators serve on policymaking boards and commissions in 24 states, many respondents emphasized the advisory functions of these bodies thus reflecting further the tendency of legislators to serve on advisory bodies.

4. In 20 states, legislators serve on boards and commissions that exercise management responsibilities.

5. Except for rare exceptions, legislators do not serve on quasijudicial or regulatory boards and commissions.

Restrictions on Legislators' Service. Legislators tend to be treated the same as nonlegislative board members. For the most part, legislators have voting privileges and receive the same compensation as other members. In some states, legislators receive a per diem or expense reimbursement at the legislative rate which is unavailable to other board members. Only Maine and New Jersey prohibit legislators from receiving compensation.

Legislators' board terms generally coincide with their legislative terms. If they are defeated for election, their board term ends. In Texas and Utah, there are a few exceptions where a legislator's board term extends beyond the legislative term. Where legislators are appointed by legislative leaders, they generally serve at the pleasure of the leadership.

By California law, legislators are permitted to serve on boards and commissions "only to the extent that participation is not incompatible with their positions as members of the General Assembly."[5] The Virginia General Assembly enacted a statute precluding its members from serving on "boards and commissions within the executive branch which are responsible for administering programs established by the General Assembly."[6]

Appointments to Boards and Commissions. Table 2 lists how legislators are appointed to boards and commissions in each state and whether legislative leaders can make nonlegislative appointments.

The survey revealed that legislative leaders appoint legislators to boards and commissions in 38 states. Legislators are appointed by governors in 20 states and serve on boards and commissions by reason of their legislative position in 23 states. Most states use a combination of the methods to appoint legislators to boards and commissions.

In 26 states, legislative leaders can appoint nonlegislators to boards and commissions. This practice was changed as a result of the recent North Carolina litigation and is currently being challenged in Kentucky.

CONCLUSION

The recent cases pose significant challenges to the legislatures' authority and practice in Kentucky, Mississippi and North Carolina. For several reasons, however, the impact of these cases on other legislatures does not appear to be as significant. First, the recent Kentucky and North Carolina court rulings reaffirm previous state court decisions precluding legislators from serving on boards and commissions that exercise executive authority. Second, a review of current state practices clearly demonstrates a strong tendency for legislators to serve only on advisory bodies. The

4959

combination of legal precedents and state practices indicate that, for the most part, legislators currently confine their service to advisory boards and commissions and that the rulings in the current cases would only apply to limited situations in the other states.

4960

TABLE 1
TYPES OF BOARDS AND COMMISSIONS ON WHICH LEGISLATORS SERVE

STATE	QUASI-JUDICIAL	BUDGETING	POLICY-MAKING	REGULATORY	MANAGEMENT	ADVISORY
AL			X		X	
AK			X			X
AZ	X		X			X
AR			X	X		X
CA			X		X	
CO		X	X		X	X
CT		[7]	X			X
DE		X				X
FL						X
GA						X
HI			X			X
ID			X		X	X
IL					X	X
IN		[8]				X
IA		X	X		X	X
KS		X			X	X
KY[*]						
LA						X
ME			X			X
MD			X			X
MA	LEGISLATORS DO NOT SERVE ON BOARDS AND COMMISSIONS					
MI	LEGISLATORS DO NOT SERVE ON BOARDS AND COMMISSIONS					
MN			X		X	X
MS						
MO			X		X	
MT						X
NE			[9]			
NV						X
NH	X		X			
NJ		X			X	X
NM	LEGISLATORS DO NOT SERVE ON BOARDS AND COMMISSIONS					
NY[*]						
NC		X		X		X
ND		X	X		X	
OH		X	X		X	X
OK			X			X
OR			X		X	X
PA			X		X	X
RI						X
SC		X			X	
SD			X			X
TN					X	X
TX		X	X		X	X
UT	X		X		X	X
VT			X		X	X
VA	LEGISLATORS DO NOT SERVE ON BOARDS AND COMMISSIONS					
WA						X
WV						X
WI						X
WY					X	

[*] State did not return survey.

LEGISLATIVE APPOINTMENTS TO BOARDS AND COMMISSIONS

STATE	HOW LEGISLATORS ARE APPOINTED: LEADERS	GOVERNOR	POSITION	LEADERS POWERS TO APPOINT NONLEGISLATORS
AL	X	X	X	YES
AK	X	X		NO
AZ	X		X	NO
AR	X	X		YES
CA	X		X	YES
CO	X			YES
CT	X		X	YES
DE	X	X	X	YES
FL	X	X	X	YES
GA	X			NO
HI	X	X		NO
ID		X		YES
IL	X		X	YES [10]
IN	X	X	X	NO
IA	X	X		NO
KS	X		X	YES
KY[*]				
LA	X	X	X	[11]
ME	X	X		YES
MD	X	X		YES
MA	LEGISLATORS DO NOT SERVE ON B/C			NO
MI	LEGISLATORS DO NOT SERVE ON B/C			NO
MN	X		X	NO
MS	X		X	YES
MO	X			NO
MT		X		NO
NE	X		X	NO
NV	X	X		NO
NH	X			NO
NJ	X			YES
NM	LEGISLATORS DO NOT SERVE ON B/C			NO
NY[*]				
NC	X	X	X	NO [12]
ND	X			YES
OH	X		X	YES
OK	X			YES
OR	X	X		YES
PA	X	X	X	YES
RI	X		X	YES
SC			X	[13]
SD		X	X	YES
TN		X	X	NO
TX	X		X	YES
UT	X	X	X	YES
VT	X		X	NO
VA	LEGISLATORS DO NOT SERVE ON B/C			NO
WA	X			NO
WV	X			NO
WI	X		X	YES
WY	X			NO

[*] State did not return survey.

[1] Stockman v. Leddy, 129 P. 220 (1912).

[2] Greer v. Georgia, 212 S.E. 2d 836 (1975).

[3] State ex rel. Schneider v. Bennett, 547 P 2d 786 (1976).

[4] State ex rel. Herbert v. Ferguson, 142 Ohio St. 496 (1944).

[5] Government Code, Sections 14502, 14999.1, and 15770.

[6] Code of Virginia, Section 9-6.23

[7] Legislators serve on the Finance Advisory Committee which can only approve the transfer of funds between executive departments and between line item appropriations.

[8] Legislators serve on the Budget Committee which advises the budget director; powers are advisory only. Legislators also serve on the Commission on State Tax and Finance Policy; again, its powers are advisory only.

[9] Legislators generally serve on special study committees created by the legislature to advise the legislature. There is only one statutory board on which legislators serve that functions as an advisory committee to an executive body. However, no appointments to that board have been made in a number of years.

[10] Leaders can only make appointments to advisory boards and commissions.

[11] The legislature, by resolution, can make appointments to the board of ethics.

[12] As a result of the Bone decision, the power to appoint nonlegislators to executive boards and commissions is vested in the entire legislature instead of the leadership.

[13] Leaders can only make appointments to the Basic Skills Assessment Commission.

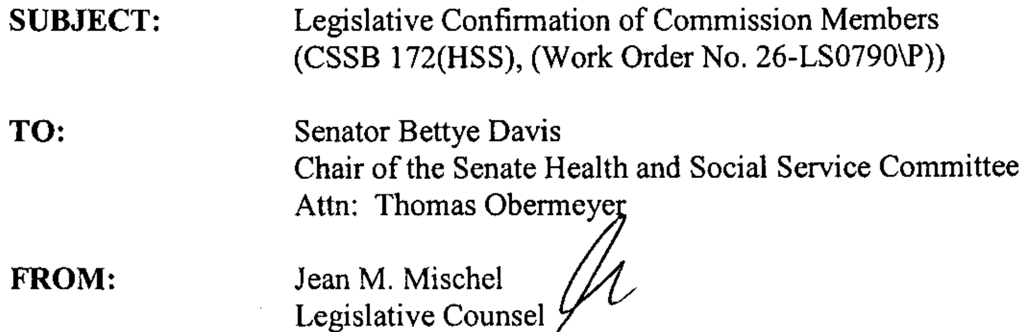
LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM March 17, 2010



SUBJECT: Legislative Confirmation of Commission Members
(CSSB 172(HSS), (Work Order No. 26-LS0790\P))

TO: Senator Bettye Davis
Chair of the Senate Health and Social Service Committee
Attn: Thomas Obermeyer

FROM: Jean M. Mischel
Legislative Counsel

Tom Obermeyer has asked for a memo that describes the limits of the legislature's role of confirmation in the review of the appointment of persons for positions in the executive branch.

*

Constitutionally, the underpinnings of the legislature's role in the confirmation of certain executive branch appointees to hold the office are to be found in two sections of article III of the Alaska Constitution, sections 25 and 26:

> **Department Heads.** The head of each principal department shall be a single executive unless otherwise provided by law. He shall be appointed by the governor, subject to confirmation by a majority of the members of the legislature in joint session, and shall serve at the pleasure of the governor, except as otherwise provided in this article with respect to the secretary of state. The heads of all principal departments shall be citizens of the United States.
>
> **Boards and Commissions.** When a board or commission ***is at the head of a principal department or a regulatory or quasi-judicial agency***, its members shall be appointed by the governor, subject to confirmation by a majority of the members of the legislature in joint session, and may be removed as provided by law. They shall be citizens of the United States. The board or commission may appoint a principal executive officer when authorized by law, but the appointment shall be subject to the approval of the governor.

(Emphasis added.)

4964

In *Bradner v. Hammond*, 553 P.2d 1 (Alaska 1976), the Alaska Supreme Court reached the conclusion that

> . . . ***the appointment of executive officers is an executive function***; for without such a power, the responsibility for executing executive duties would be diffused and the goal of separation of branches of government, avoiding too great a concentration of power in one branch, would be defeated.

and, further that

> . . . under Alaska's constitution confirmation is a specific attribute of the appointive power of the executive. Other courts which have been called upon to resolve this issue have been unanimous in their holdings that ***confirmation is not a distinct legislative power, but rather a part of the executive power of appointment which has in turn been delegated in some specific instances by constitution to the legislative branch of government.***

Bradner, at 6 - 7 (emphasis added; notes omitted).

*

Procedurally, the legislature's role in confirmation is spelled out almost entirely in AS 39.05.080.

The Alaska Health Care Commission established in CSSB 172(HSS) is an advisory board that does not sit at the head of a principal department, a regulatory agency, or a quasi-judicial agency. Therefore, the appointees to the commission are not subject to legislative confirmation by operation of the constitution. The legislative role is limited to establishing such commissions and to providing guidance to the legislature on the qualifications of commission members. The appointment itself is otherwise an executive function in which the legislature plays no role.

If I may be of further assistance, please advise.

JMM:lmb
10-009.lmb

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

SEAN PARNELL, GOVERNOR

P.O. BOX 240249
ANCHORAGE, ALASKA 99524-0249
PHONE: (907) 269-7800
FAX: (907) 269-0060

March 11, 2010

The Honorable Bettye Davis
Chair, Senate Health & Social Services Committee
Alaska State Senate
State Capitol Building, Rm. 30
Juneau, Alaska 99801

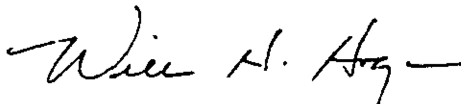
Re: SB 172 Alaska Health Care Commission

Dear Senator Davis,

This letter serves to update the letter I sent to you dated March 10 on this subject. The department's intent remains the same - to support the addition of two new seats in the bill to establish the Alaska Health Care Commission in statute, one each for a primary care physician and one for the behavioral health community. I agree with the language the bill's sponsor supports and I'm documenting that here in the interest of clarity and with the intent of supporting the work of the Senate HSS Committee to identify the appropriate membership of the commission.

The department's suggested language for Sec. 18.09.020 of SB 172 is provided on the following page. Please contact me at 465-3030 if you have any questions. Thank you.

Sincerely,



William H. Hogan
Commissioner

cc: Senator Donny Olson, Alaska State Senate

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

(1) nine voting members appointed by the governor as follows:

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

(B) one member representing the tribal health community in the state;

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

(D) one member representing the Alaska State Hospital and Nursing Home Association;

(E) 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;

(F) one member who is a representative of the health insurance industry in the state;

(G) 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;

(H) one member who is a primary care physician licensed to practice in the state, and who practices family medicine, primary care internal medicine, or pediatric medicine;

(I) one member representing the Alaska Mental Health Trust Authority; and

(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.

4967

ALASKA STATE LEGISLATURE

SENATOR DONALD C. OLSON

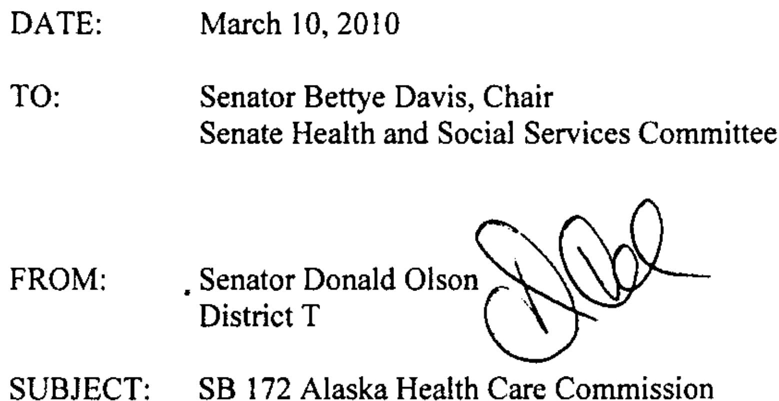
ALASKA
STATE CAPITOL
ROOM 508
JUNEAU, ALASKA 99801-1182

(907) 465-3707
FAX (907) 465-4821

MEMORANDUM
Distributed via email

DATE: March 10, 2010

TO: Senator Bettye Davis, Chair
Senate Health and Social Services Committee



FROM: Senator Donald Olson
District T

SUBJECT: SB 172 Alaska Health Care Commission

At today's hearing, there was some confusion regarding the composition of the proposed Alaska Health Care Commission. For the sake of clarity, the nine voting members I requested and would like to see named for inclusion on the Commission are as follows:

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

- One member representing the tribal health community in the state:

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

- One member representing the Alaska State Hospital and Nursing Home Association;

- One member who is a health care provider:

  a) actively practicing the provider's profession in the state;
  b) licensed to practice in the state; and
  c) not affiliated with the Alaska State Hospital and Nursing Home Association;

- One member who is a representative of the health insurance industry in the state;
- One member who is:

  a) a health care consumer;
  b) a resident of the state; and
  c) not employed by and does not have a business interest in the health care industry;
- One member who is a primary care physician licensed to practice in the state, and who practices family medicine, primary care internal medicine, or pediatric medicine; and
- One member representing the Alaska Mental Health Trust Authority.

With the confusion on the specific seats and the wording of each, I thought it would be best to clarify my intentions as the sponsor of the legislation being debated. Thank you for hearing my bill, and for working with me and my staff to try to establish the Alaska Health Care Commission in statute.

Cc: Senator Joe Paskvan, Vice-Chair, Health & Social Services Committee
Senator Johnny Ellis, Health & Social Services Committee
Senator Joe Thomas, Health & Social Services Committee
Senator Fred Dyson, Health & Social Services Committee
William Hogan, Commissioner, Department of Health & Social Services
Wilda Laughlin, Legislative Liaison, Department of Health & Social Services
Deborah Erickson, Executive Director, Alaska Health Care Commission
Jeff Jessee, CEO, Alaska Mental Health Trust Authority

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.~~ One member representing the Alaska Mental Health Trust Authority.

(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 AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

SEAN PARNELL, GOVERNOR

P.O. BOX 240249
ANCHORAGE, ALASKA 99524-0249
PHONE: (907) 269-7800
FAX: (907) 269-0060

March 10, 2010

The Honorable Bettye Davis
Chair, Senate Health & Social Services Committee
Alaska State Senate
State Capitol Building, Rm. 30
Juneau, Alaska 99801

Re: SB 172

Dear Senator Davis,

I understand the Senate HSS Committee will this afternoon consider potential amendments to SB 172, the bill that would establish the Alaska Health Care Commission in statute, to modify the composition of the membership and chair of the group. I write to offer the Department of Health & Social Services' position on the size, composition and chair of the commission.

The department believes the size of the body should remain relatively small to facilitate communication and decision-making among the group, and to maintain the intent of this body as an expert analysis and advisory body and not an advocacy group. In that vein, the department would agree with the addition of two additional seats, and believes the additional seats should be representative of primary care physicians and of the behavioral health provider community in Alaska. Additional expertise on primary medical care practice and behavioral health practice and administration are justified due to the importance of these two fields to access, delivery and cost of health care in Alaska.

The department also believes the commission should be chaired by the representative from the department to avoid the possibility of adverse perceptions of the work of the body if it were chaired by a member of one particular sector within the health care industry. It is also necessary to ensure there is adequate accountability in moving the work of this body forward – the department should ultimately be held accountable for compliance of this body with the law that establishes it.

The suggested language maintaining the composition as currently delineated in SB 172 with the addition of two seats, one each for primary care and behavioral health (highlighted), is provided on the following page. Please contact me at 465-3030 if you have any questions. Thank you.

Sincerely,

William H. Hogan, Commissioner
Department of Health & Social Services

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

(1) nine voting members appointed by the governor as follows:

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

(B) one member representing the tribal health community in the state;

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

(D) one member representing the Alaska State Hospital and Nursing Home Association;

(E) 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;

(F) one member who is a representative of the health insurance industry in the state;

(G) 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;

(H) one member who is a primary care physician who practices family medicine, primary care internal medicine, or pediatric medicine in the state;

(I) one member representing the behavioral health provider community in the state; and

(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

Transforming Health Care in Alaska

2009 Report/2010 – 2014 Strategic Plan

Alaska Health Care Commission

4974

Transforming Health Care in Alaska
2009 Report/2010-2014 Strategic Plan

Alaska Health Care Commission
Ward Hurlburt, MD, MPH, Chair
C. Keith Campbell
Valerie Davidson
Jeffrey Davis
Ryan Smith
Wayne Stevens
Lawrence Stinson, MD
Linda Hall
Senator Donny Olson, MD
Representative Wes Keller

Deborah Erickson, Executive Director

Prepared for
Governor Sean Parnell and
The Alaska Legislature
Under Administrative Order #246

January 2010

4975

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES
ALASKA HEALTH CARE COMMISSION

SEAN PARNELL, GOVERNOR
Bill Hogan, Commissioner

3601 C Street, Suite 902
ANCHORAGE, ALASKA 99503
PHONE: (907) 269-7800

January 15, 2010

To: The Honorable Sean Parnell, Governor, State of Alaska
The Honorable Gary Stevens, President, Alaska State Senate
The Honorable Mike Chenault, Speaker of the Alaska House of Representatives

We are pleased to present this report by the Alaska Health Care Commission in accordance with Administrative Order 246. The Commission was chartered by Governor Palin last winter 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. This report represents the efforts of the Commission over this past year to identify and analyze problems with Alaska's health care system, develop an initial set of recommendations, and chart a course for the future.

The health care challenges faced by Alaska at this time are daunting. Costs have reached unaffordable levels, more and more Alaskans have difficulty accessing care, the delivery system is fragmented, vacancy rates among the health care workforce are high, financing and payment mechanisms make no sense, variations in medical practice and quality are not well understood, and providers are becoming more and more frustrated as they become buried under layers of government rules intended to help fix these problems.

Action is required, but these problems are complex. There are no magic bullets, there is no one solution, and the improvements required will not occur overnight. A process of transformational change must be implemented that will guide Alaska's health care system down a path to become more patient-centered, more evidence-based, more coordinated, and more efficient. Health care providers need to be supported and provided the appropriate tools they need along the way.

At the same time we need to start getting a handle on cost sooner rather than later. The health care industry represents an important part of our state's economy and we need to be careful about forcing too much change too quickly, but the continuing escalation in health care costs poses a significant and real threat to Alaska's economy and the sustainability of state government. Continuing work on the part of a future Commission must focus on this challenge.

We are optimistic that this report offers hope for the future and will lead to a health care system that focuses on creating health and not just treating illness and injury, will provide value for Alaskans' health care dollar, meets the needs of both consumers and providers, and is sustainable over the long term.

Sincerely,

Ward B. Hurlburt III, MD, MPH	Deborah Erickson
Chair, Alaska Health Care Commission	Executive Director
Chief Medical Officer	Alaska Health Care Commission
Department of Health & Social Services	

Acknowledgements

This report represents the contributions of numerous individuals to whom the Commission would like to extend our thanks.

The Commission greatly appreciates the foresight of Governor Sarah Palin in establishing the Commission under Administrative Order 246.

The Commission is grateful for the leadership of our first Chair, Dr. Jay Butler, who was called to duty last spring by the U.S. Centers for Disease Control and Prevention to lead the nation's effort to develop and distribute vaccine to combat the novel H1N1 influenza pandemic. Dr. Butler was instrumental in launching the Commission, laying the groundwork and leading the critical first steps.

Special thanks goes to Department of Health & Social Services Commissioner William Hogan, who supported the Commission by loaning staff and providing information to the effort, and who stepped in as interim Chair on Dr. Butler's departure until the department's new Chief Medical Officer was named. The Commission would like to thank department staff who helped provide administrative and logistical support in their "spare time": Bonnie Caress, Nina Hauptman, Lucy Hansen, Shane Miller, Sherri Stears, and Serafine Bourne.

The Commission is most grateful to the Section of Health Planning and Systems Development in the Division of Health Care Services, who prepared a "primer" on health care in Alaska for the Commission (included as Appendix A of this report), and also supplied additional data, information and guidance in support of health care research and analysis by the Commission, including Deputy DHSS Commissioner William Streur, Pat Carr, Alice Rarig, Faith Allard, Neal Gilbertsen, Mark Millard, Mark Doughty, Karen Lawfer, and Jean Findley.

For the experts who took time out of their busy schedules to prepare presentations and other informational materials and make formal presentations to the Commission at our meetings – we are especially thankful: Dennis McMillian, Dwayne Heyman, Gina Perez, Paul Sherry, Fred Pearce, Donald Pathman, Karen Perdue, Dennis Valenzeno, Harold Johnston, Rosyland Frazer, Mark Foster, Tom Hunt, Joan Fisher, George Rhyneer, David Morgan, David Johnson, Valerie Davidson, Stewart Ferguson, William Streur, Doug Eby, Jan Harris, Pat Carr, James Nesbitt, Carl Ekstrom, Kathy Allely, Andrea Fenaughty, Karol Fink, Cathy Giesel, Sharon Cissna, and Alex Cahana.

And finally, the Commission appreciates the many members of the public who were devoted enough to the health of Alaskans to take time to attend Commission meetings in person or over teleconference and testify during public hearing portions of Commission meetings. And a special thanks to those who took the effort to review drafts of the report and provide comments to the Commission.

4977

Alaska Health Care Commission
2009 Report/2010-2014 Strategic Plan

Table of Contents

Executive Summary Pg. 8

I. Introduction Pg. 10

A. Purpose of this Report
B. Background on the Commission
C. Summary of 2009 Activities
D. The Commission's Vision for Transformation of Alaska's Health Care System

II. Health Care Delivery & Access Challenges in Alaska Pg. 15

A. The Cost of Health Care in the U.S.
B. The Cost of Health Care in Alaska
C. Health Insurance Coverage of Alaskans
D. Health Care Delivery System Challenges

III. 2009 Health Policy Findings & Recommendations Pg. 23

A. The Role of Consumers in Health Care Pg.24
1. Healthy Lifestyles
2. Primary Care Innovation

B. Statewide Leadership Pg. 26
1. Response to National Health Care Reform
2. Permanent State Health Planning Board

C. Health Workforce Development Pg. 28
1. General Workforce Findings & Recommendations
2. Physician Shortage

D. Health Information Technology Pg. 37
1. General HIT Findings & Recommendations
2. Health Information Exchange & Electronic Health Records
3. Telehealth

E. Access to Primary Care for Medicare Patients Pg. 45

IV. Health Care System Transformation Elements Pg. 50
A. Access to Health Care Pg. 50
1. Health Insurance Coverage
2. Health Care Workforce Development
3. Physical Health Services
4. Behavioral Health & Long Term Care
B. Cost & Quality (Value) Pg. 52
1. Cost of Care in Alaska
2. Primary Care Innovation
3. Value-Driven Purchasing
a) Leverage State Purchasing Power
b) Provider/Payer Cost Sharing Demonstration Projects
c) Cost and Quality Transparency
d) Evidence-Based Medicine
e) Payment Reform
f) Reporting and Non-Payment for Health Care Acquired Conditions
4. Fraud & Abuse Control
5. Tort Reform
6. Process Innovation Strategies
C. Prevention Pg. 58
1. Public Health: Population-Based Prevention
2. Safe Water & Sanitation Systems
3. Employee Health Risk Management

V. 2010 – 2014 Strategic Plan for Improving Alaska's Health Care System Pg. 61
A. 5-Year Planning Framework
B. Suggested Action Plan for 2009 Recommendations
C. 2010 Work Plan for the Alaska Health Care Commission

APPENDICES *Available on the Commission's Web Site* at
http://hss.state.ak.us/healthcommission/default.htm

Appendix A: Health Care in Alaska
1. How Health Care in Alaska is Provided
2. How Health Care in Alaska is Funded

Appendix B: Coordination of Health Care Planning Efforts in Alaska

Appendix C: Meeting Summaries & Other Commission Documents

Appendix D: Table of Abbreviations and Acronyms

4979

Executive Summary

A healthy citizenry is vital to the economy and governance of the state of Alaska. Good health, both physical and mental, is essential to all Alaskans' ability to actively participate in and contribute to their families, schools, places of employment, and communities. Access to quality health care is an important contributor to the health of Alaskans.

The Alaska Health Care Commission was created to address growing concern over the condition of Alaska's health care system. The delivery of care is fragmented. Costs are unaffordably high and continue to climb, seemingly out of control. Too many Alaskans lack health care coverage, or have coverage but can't find a doctor who will accept them as a patient. Levels and variations in the quality of care are not well understood. Consumers aren't happy. Providers are frustrated. The system as currently designed is not sustainable.

The health care system has come together in a piecemeal fashion over many decades. It is funded by a conglomeration of numerous public and private payers. Care is provided under layers of government rules and regulations. Some provider organizations are government, some are quasi-government, some are non-profit, and some are private for-profit businesses. Providers trained in different regions of the country and in different fields don't have a consistent approach to diagnosis and treatment.

A system this complex cannot be fixed over night. A journey of transformation that will be many years in the making is required to redesign and implement a more rational, coherent and sustainable system that will deliver the highest quality of care at the most reasonable price in a way that protects providers and their business interests, while protecting the interests of Alaska's health care consumers.

The Commission envisions a health care system for Alaska that places individual Alaskans and their families at the center of their health care experience and focuses on creating health, not simply treating illness and injury. In addition to producing healthy Alaskans, a transformed system will provide value for Alaskans' health care dollar – delivering high quality care as efficiently as possible at a reasonable price. In this system providers' business and professional interests and integrity will be maintained. Health care consumers will be satisfied with the level and quality of services they receive. And a final but essential element of this picture is that Alaska's health care system will be sustainable.

The Commission also identified four goals for a transformed health care system – that it will:

I. **Improve access** to health care services and affordable health insurance coverage.
II. Turn the curve on Alaska's medical inflation rate so that it is at least below the national rate, in order to **contain cost growth**.
III. Assure that health care services delivered in Alaska meet the highest **quality and safety** standards.
IV. **Focus on prevention**, not just clinical preventive services for individuals, but public health community-based policies and programs, to support improved health status and to control costs by reducing the burden of preventable illness and injury.

Understanding and supporting the consumer's role in health care was a primary interest of the Commission's, and became the central focus of their strategic approach to transformation of Alaska's health care system. Two aspects emerged as critical to addressing the goals of increased access, improved value (high quality at a reasonable price), and a focus on prevention – 1) individual lifestyle

4980

choices and the impact those choices have on health outcomes and demand for health care services; and 2) the role of primary care in placing the patient at the center of their health care experience.

A vital health care workforce and modern information management tools are the foundation upon which support for healthy lifestyles and a strong innovative primary care system depends. And the journey to a transformed health care system cannot continue without statewide leadership to see it through. On-going study, planning, and policy development is necessary to ensure Alaska's health care system is able to adapt to national health care reform, and to create a regulatory and reimbursement environment that supports the health care industry while it redesigns itself.

To achieve these goals the Commission recommends the following to the Governor and the Legislature:

A. Strengthen the consumer's role in health and health care
   - Support healthy lifestyles and create cultures of wellness
   - Develop patient-centered primary care models through payment reform, removal of barriers, and support for pilot projects

B. Foster statewide leadership to support health care transformation
   - Invest in the health policy infrastructure needed to respond to national reform
   - Establish a permanent state health planning and policy body in statute

C. Develop the health care workforce
   - Make workforce a priority on health care reform and economic development agendas
   - Strengthen the pipeline of future health care workers
   - Support workforce innovation and adaptation as patient care models evolve
   - Direct workforce planning to be more coordinated
   - Increase the supply of primary care physicians by
     - Supporting educational loan repayment and financial incentives for recruitment
     - Expanding the WWAMI Alaska medical school program as resources allow
     - Supporting planning for primary care residency programs

D. Deploy health information technology
   - Support health information technology adoption and utilization
   - Ensure public health connectivity
   - Ensure resulting information is used for optimization of medical care
   - Ensure privacy and security
   - Facilitate broadband telecommunications service access
   - Improve reimbursement for telemedicine

E. Improve access to primary care for Medicare beneficiaries
   - Increase the supply of primary care providers
   - Support Federally Qualified Health Centers and Rural Health Clinics
   - Request relief from federal reimbursement inequities and administrative burdens
   - Develop a PACE (Program of All-Inclusive Care for the Elderly) program

The Commission provides in this report an action plan suggesting the operational steps and resources required to implement each of these recommendations. The Commission also lays out a 5-year strategic planning framework designed to facilitate an ongoing comprehensive approach to health care system transformation. Also included is a description of additional strategies for potential inclusion in continued planning efforts, such as cost and quality transparency, evidence-based medicine, payment reform, fraud and abuse control, and public health system support. Finally – as the work represented in this report is only a beginning – a one-year work plan for this or a future health care commission is outlined for 2010 to guide the continuing journey of health care system transformation for Alaska.

4981

PART I: Introduction

A. Purpose of this Report

The purpose of this report is to convey the findings and recommendations of the Alaska Health Care Commission to Governor Parnell and the Alaska Legislature as required under Administrative Order (A.O.) 246. This report is intended to serve as a five-year strategic plan for strengthening Alaska's health care delivery system, and is meant to be a living document that will evolve each year over the course of the coming five years as problems are studied, various approaches are analyzed, and implemented strategies are evaluated. This plan will be updated and conveyed to the Governor and Legislature in subsequent annual reports of the Commission if the Commission is continued beyond this first year.

Included in this report are:

- Part I: an introduction including background on the Commission, a summary of the Commission's 2009 activities, and a description of the Commission's vision, goals and values;
- Part II: information on the challenges of delivering and accessing health care in Alaska;
- Part III: the Commission's proposed strategy for transformation of Alaska's health care system, including findings and recommendations on key issues analyzed during the year;
- Part IV: a brief explanation of the design elements required for health care system transformation identified this year that are recommended for future analysis;
- Part V: the strategic plan – laying out a framework for the five-year plan, providing a suggested action plan for implementation of the Commission's 2009 recommendations, and setting the Commission's work plan for 2010;
- Appendices: Background information on health and health care in Alaska, and additional documents produced by the Commission.

B. Background on the Alaska Health Care Commission

The Alaska Health Care Commission was established by Governor Palin on December 4, 2008 under A.O. 246 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 duties of the Commission as outlined in the Administrative Order are to:

I. Serve as the state health planning and coordinating body;
II. 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,
III. Submit a report to the Governor and the Legislature on or before January 15, 2010 regarding the Commission's recommendations and activities.

4982

Commission members were appointed by Governor Palin (with legislative representatives appointed by their respective bodies) January 27, 2009. Short biographies for each of the Commission members are included in Appendix D. The members of the Commission are:

Ward Hurlburt, MD, MPH[1]: Designated Chair; Chief Medical Officer for the Alaska Department of Health & Social Services; Anchorage.
C. Keith Campbell: Representing Consumers; Retired; Seward.
Valerie Davidson: Representing Alaska tribal health care providers; Senior Director of Legal and Inter-Governmental Affairs for the Alaska Native Tribal Health Consortium; Anchorage.
Jeffrey Davis: Representing Alaska's health insurance industry; President of Premera Blue Cross Blue Shield of Alaska; Anchorage.
Ryan Smith: Representing the Alaska State Hospital & Nursing Home Association; Chief Executive Officer of the Central Peninsula General Hospital; Soldotna.
Wayne Stevens: Representing the Alaska State Chamber of Commerce; President & CEO of the Alaska State Chamber of Commerce; Juneau.
Lawrence Stinson, MD: Representing Alaska health care providers; Anesthesiologist and co-owner of Advanced Pain Centers of Alaska.
Linda Hall (Ex-Officio): Representing the executive branch; Director of the Division of Insurance; Anchorage.
Representative Wes Keller (Ex-Officio): Representing the Alaska House of Representatives; Wasilla.
Senator Donny Olson (Ex-Officio): Representing the Alaska Senate; Golovin.

Creation of the Commission followed from the work of an earlier group convened by Governor Palin – the Alaska Health Care Strategies Planning Council – established under A.O. 232 in 2007. The Planning Council consisted of 17 members who met for 6 months, during which time they identified a series of goals and strategies for improving the health of and health care for Alaskans. The Council's recommendations included a strategy for creation of a permanent health planning commission established in state statute.

Governor Palin's issuance of A.O. 246 was meant to jump-start the Planning Council's recommendation for a permanent body while legislation to establish the Commission was pending in the Alaska Legislature. There are currently three bills under consideration by the legislature that would create a health care commission in statute – HB 25 (Hawker), HB 75 (Cissna), and SB 172 (Olson)[2]. If one of these bills passes during the 2010 session and is signed into law by Governor Parnell, the work of the current Commission will continue, but potentially with a slightly different charge and different members. If none of these bills pass, and unless Governor Parnell extends the life of the Commission through Administrative Order, the work of this Commission will end, but hopefully their one year of work and this report will add some value to on-going efforts to strengthen Alaska's health care delivery system and improve the health of Alaskans.

[1] Dr. Jay Butler served as Chair of the commission through mid-June. Commissioner William Hogan assumed the role of Chair in June through September. Dr. Hurlburt was appointed Chair of the commission following his appointment as Chief Medical Officer of DHSS in September.

[2] A table comparing the purpose, duties and membership of the bodies that would be created under each of these bills and A.O. 246 is included in Appendix D of this report.

4983

C. Summary of 2009 Activities

The Commission experienced a number of challenges during their first year, including lack of funding, turnover in the Chairperson's role, temporary reassignment of their one staff person, uncertainties caused by the efforts at the federal level to reform the nation's health care system, and unknowns about the future of the Commission itself. Despite these limitations the Commission was successful in analyzing a number of critical issues and developing the recommendations contained in this report.

The Commission focused this year on:
1. Developing a vision of a transformed health care system for Alaska, including goals and values for guiding decision making;
2. Defining a comprehensive health care system transformation strategy;
3. Identifying, analyzing and developing recommendations regarding a few critical priority issues;
4. Outlining a 5-year strategic planning framework, including identification of:
   a) a preliminary set of measures for tracking the performance of Alaska's health care system, and
   b) issues and strategies for future analysis and policy recommendation development.

The Commission identified as their initial priorities for analysis and policy recommendation development for this year the following issues:
- The consumer's role in health care
- Statewide leadership for strengthening the health care system
- Health care workforce development, with a focus on the physician workforce
- Health information technology
- Primary care access for Medicare patients

<u>2009 Accomplishments</u>

Meetings and public hearings: During 2009 the Commission held four face-to-face meetings: February 27-28 in Juneau; and May 1-2, August 25-26, and November 6-7 in Anchorage. All of these meetings were open to the public, and teleconferenced for members of the public unable to attend in person but interested in listening to the meeting or providing public testimony. A number of teleconferences were held during the year as well. Summaries of the meetings and teleconferences are included in Appendix D of this report. Four public hearings were held, three during the May, August, and November meetings, and one on December 14 through the Legislative Information Office teleconference system.
Administration: In their first months the Commission established meeting rules, a set of by-laws, a job description for the Executive Director, and appointed an Executive Director (initially hired by DHSS in February to expedite the first meeting of the Commission). A copy of the Commission's meeting rules, by-laws, and Executive Director job description are included in Appendix D of this report.
Communication and coordination: The Commission developed a website for posting information regarding their meetings as well as reference documents related to their priority focus areas (http://hss.state.ak.us/healthcommission/). A listserv was established to maintain communication with system stakeholders and members of the public interested in receiving periodic updates. As an initial step toward assuming the health planning coordination role noted in the Administrative Order, the Commission compiled an inventory of boards, committees, coalitions, and other organizations in Alaska involved in health planning in some way, as well as a list of health reports and plans (in Appendix C).
Products: The primary product developed by the Commission is this, their first report to the Governor and Legislature, which includes the Commission's vision, values and goals; findings and recommendations on the priority issues noted above, and a planning framework for the next five years.

4984

D. The Commission's Vision for Transformation of Alaska's Health Care System

"The health of the people is really the foundation upon which all their happiness and all their powers as a state depend." Benjamin Disraeli

A healthy citizenry is vital to the economy and governance of the state of Alaska. Good health, both physical and behavioral, is essential to all Alaskans' ability to actively participate in and contribute to their families, schools, places of employment, and communities. Access to quality health care is an important contributor to the health of Alaskans.

The Alaska Health Care Commission was created to address growing concern over the state of Alaska's health care system. The delivery of care is fragmented. Costs are unaffordably high and continue to climb, seemingly out of control. Too many Alaskans lack health care coverage, or have coverage but can't find a doctor who will accept them as a patient. Levels and variations in the quality of care are not well understood. Consumers aren't happy. Providers are frustrated. The system as currently designed is not sustainable.

The health care system has come together in a piecemeal fashion over many decades. It is funded by a conglomeration of numerous public and private payers. Care is provided under layers of government rules and regulations. Some provider organizations are government, some are quasi-government, some are non-profit, some are private business. Providers trained in different regions of the country and in different fields don't have a consistent approach to diagnosis and treatment. A system this complex cannot be fixed over night. A journey of transformation that will be many years in the making is required to redesign and implement a more rational, coherent and sustainable system that will deliver the highest quality of care at the most reasonable price in a way that protects providers and their business interests, while protecting the interests of their consumers.

Vision

Alaska's Health Care System

- Produces improved health status
- Provides value for Alaskans' health care dollar
- Delivers consumer and provider satisfaction
- Is sustainable

The first step this year in the Commission's journey toward transformation of Alaska's health care system was to design a picture of the ideal system. The Commission envisions a health care system for Alaska that places individual Alaskans and their families at the center and focuses on creating health, not simply treating illness and injury. In addition to producing healthy Alaskans, a transformed system will provide value for Alaskans' health care dollar – delivering high quality care as efficiently as possible at a reasonable price. In this system providers' business and professional interests and integrity will be maintained. Health care consumers will be satisfied with the level and quality of services they receive. And a final but essential element of this picture is that Alaska's health care system will be sustainable.

4985

Health Care Goals

I. Improved Access
II. Contained Cost
III. Safe, High Quality Care
IV. Prevention-Based

The Commission also identified four goals for a transformed health care system to support a targeted approach to identification of improvement strategies and performance measurement. The first goal is to improve access to 1) affordable health care insurance coverage, and 2) the services of a health care delivery system that is, itself, healthy. The second goal is to turn the curve on Alaska's medical inflation rate so that it is at least below the national rate, in order to contain cost growth. The third goal is to assure that health care services delivered in Alaska meet the highest quality and safety standards. The fourth goal is to focus on prevention, not just clinical preventive services for individuals, but public health community-based policies and programs, to support improved health status and to control costs by reducing the burden of preventable illness and injury.

Values

- Sustainability
- Efficiency
- Effectiveness
- Individual Choice
- Personal Engagement

The Commission agreed to the following set of values to guide planning and policy recommendation decisions for transformation of Alaska's health care system:

Sustainability: A redesigned health care system for Alaska must be sustainable in terms of: 1) government, private sector, and individual ability to financially support implementation over the long term; and, 2) health care provider ability to deliver quality care while maintaining a sound business operation.
Efficiency: A redesigned health care system for Alaska will minimize waste in clinical care and administrative processes.
Effectiveness: A redesigned health care system for Alaska will support practices best known to produce the best outcomes.
Individual Choice: A redesigned health care system for Alaska will provide information and options for Alaskans in terms of health care coverage and service providers.
Personal Engagement: A redesigned health care system for Alaska encourages and empowers Alaskans to exercise personal responsibility for healthy living and for obtaining and participating in their health care.

4986

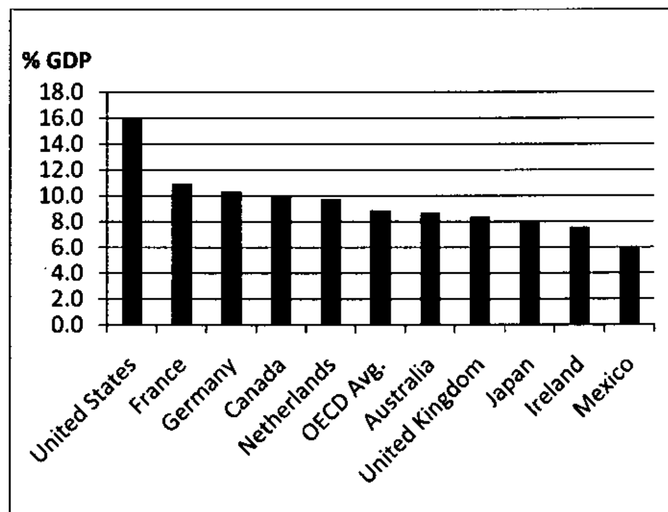
PART II: Health Care Delivery and Access Challenges in Alaska

The effort to transform Alaska's health care system to achieve the Commission's vision requires an accurate and complete understanding of the current condition of the system. A description of health care in Alaska – how it is structured, provided and funded – is included as Appendix A of this report. Here in Part II a discussion of some of the particular challenges associated with delivering and accessing health care in Alaska is discussed.

A. The Cost of Health Care in the U.S.

Health care spending in the United States has been growing faster than the economy for decades, doubling from 8% of the nation's gross domestic product (GDP) in 1970 to 16% in 2006. It is projected to increase to 20% of GDP, with total spending doubling from $2 trillion in 2006 to $4 trillion, by the year 2016.[i] A comparison of national health expenditures in the United States to other member countries of the Organization for Economic Cooperation and Development (OECD)(Figure 1) illustrates the challenge our nation faces in maintaining a competitive edge in today's global market place, as the increasing cost of health care contributes to higher prices for goods and services produced in the U.S.

FIGURE 1: National Health Expenditures as Percentage of National Gross Domestic Product, 2009



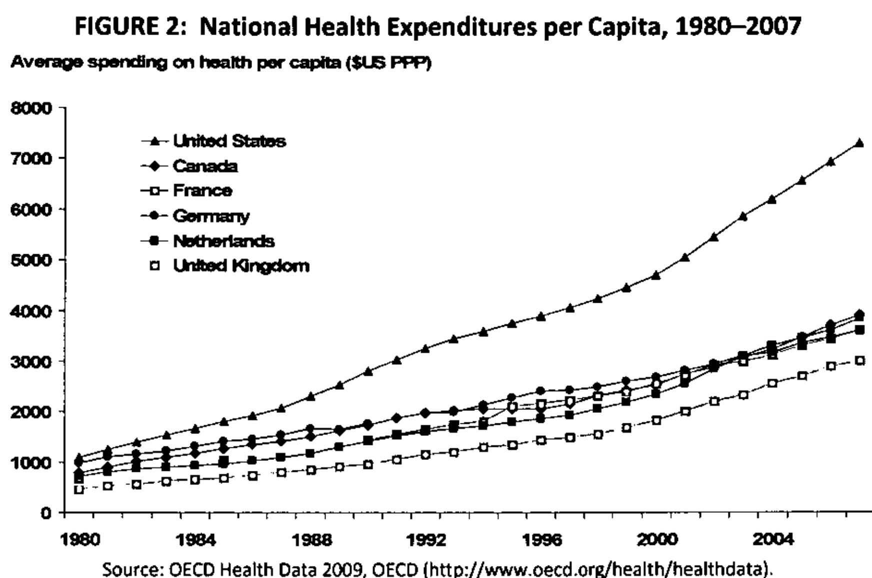
Source: OECD Health Data 2009, OECD (http://www.oecd.org/health/healthdata).

Higher costs in the United States do not necessarily reflect greater levels of health care resources. The U.S. has fewer physicians per capita than most other OECD countries, with 2.4 practicing physicians per 1,000 Americans compared to the OECD average of 3.1. The U.S. also has fewer hospital beds, with 2.7 acute care hospital beds per 1,000 Americans compared to the OECD average of 3.8 beds.[ii] Nor do higher costs mean that Americans have greater access to care. In 2004 97% of U.S. residents reported seeing at least one doctor in the previous 2 years, compared to 95% of Canadians and 98% of Australians. 84% of Americans reported having had a blood test, x-ray, or other diagnostic test in the past 2 years, compared to 84% of Canadians and 83% of Australians.[iii]

Higher health care spending does not translate into better outcomes in terms of health status. Life expectancy and infant mortality are not necessarily reflective of the quality of health care, but are two general measures of population health that indicate Americans, for all the investment in health care services, are not healthier overall. Life expectancy in 2007 was at 78.1 years in the U.S., placing it 24th among the 30 OECD nations; and the U.S. ranked 28th in infant mortality at 6.7 per 1,000 live births, ahead of only Mexico and Turkey.[iv]

Health care spending in the United States not only represents a higher proportion of our economy compared to other countries, average spending per person is significantly higher. Per capita national health expenditures in the United States increased 850% over the past three decades to $7,290 (Figure 2). The average OECD national health expenditure in 2007 was less than half that amount, at $2,984 per person.[v]

FIGURE 2: National Health Expenditures per Capita, 1980–2007



Source: OECD Health Data 2009, OECD (http://www.oecd.org/health/healthdata).

Just one result of the escalation in health care costs is the impact on the personal finances of America's families. In 1981 medical problems contributed to just 8% of personal bankruptcies in this country. By 2007 the share of bankruptcies attributable to a medical cause had increased to 62.1%.[vi]

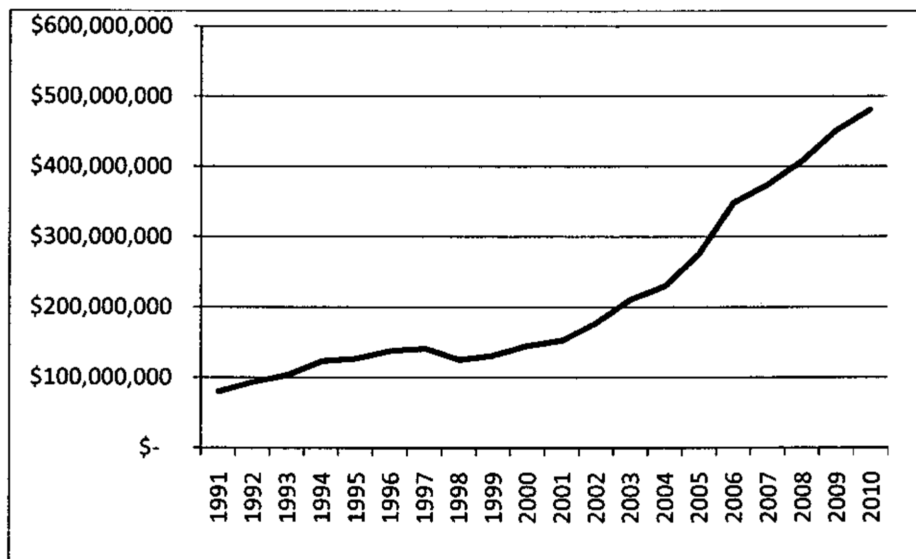
B. The Cost of Health Care in Alaska

The rapid rise in the cost of health care in the U.S. is reflected in Alaska as well. In 1993 the Health Resource & Access Task Force, a group convened by the Alaska Legislature to address questions of health care cost and access, projected health care spending in Alaska would "sky-rocket" from slightly below $1.6 billion in 1991 to nearly $5.6 billion in 2003. The HRATF determined that this "alarming" level of spending was inevitable if nothing was done to change the status quo.[vii] Today in 2009 estimated spending for health care in Alaska is over $6 billion.

Government (all levels – federal, state and local) pays 64% of Alaska's health care bill, including public insurance programs (Medicaid and Medicare), government employee and retiree insurance premiums, medical care for military personnel and dependents, Indian Health Service support of tribal programs, medical care provided through the Veterans' Administration, grants to Community Health Centers, operation of the state psychiatric hospital and Pioneers' Homes, and care for offenders incarcerated by the Department of Corrections. Private employers pay 17% of Alaska's health care bill in the form of health insurance premiums, self-insured costs, and Workers' Compensation medical benefits for their employees. Individual Alaskans pay the remaining 19% through premium contributions, co-payments, deductibles, and direct payment to providers.[viii]

The high cost of health care presents a significant fiscal challenge for the state of Alaska. State government is currently responsible for administering over $1.5 billion annually for all health care related expenditures (inclusive of costs for employees and retirees, Medicaid (including federal funds), a variety of grant programs, state health facilities, and services for inmates in state prisons). In 2004 Alaska had the highest annual Medicaid expenditure level per enrollee in the United States, at $10,417.[ix] State general fund expenditures for Medicaid grew from a little over $80 million in FY 1991 to over $408 million in FY 2008 – an increase of 410% during that 17 year period (Figure 3).[x]

FIGURE 3: Alaska State General Fund Medicaid Expenditures, 1991-2010



Source: FY 2010 DHSS Budget Overview
* FY 2009 and 2010 were estimated expenditures as of Nov 2008

Contributors to health care spending are numerous and varied, but there are two basic components driving total cost – price and utilization. Population increases and inflation are partly responsible for driving upward trends in utilization and pricing, but do not account fully for the rapid rise in health care spending in Alaska – which increased at an average annual growth rate of 8.9% per year between 1990 and 2005. Increased utilization due to a greater number of people living in Alaska made up 1.2% of the average annual spending increase, and general inflation contributed 2.4%. The reasons behind the remaining 5.3% average annual growth rate are not well understood.[xi]

4989

Increased utilization of the health care system is partly driven by the rising prevalence of health problems and the aging of the state's population. It is also influenced by payment systems that do not present incentives for patients and providers to keep spending in check. New technologies that provide additional diagnostic and therapeutic opportunities are another factor. Also contributing to utilization that may be higher than necessary is the practice of defensive medicine due to concern over medical liability. Fraudulent claims for medical services never rendered also play a role. One factor that may be a key in understanding and controlling utilization is waste in the system – by some estimates as much as 30% of total health care costs are for medical goods and services that are not medically necessary or are ineffective.

Prices of health care services and medical equipment, supplies and pharmaceuticals make up the other component contributing to total spending. The higher cost of living in Alaska contributes somewhat to higher health care prices, but the Consumer Price Index (CPI) for Anchorage increased a total of 38% for all items between 1991 and 2005, while the CPI for medical care in Anchorage increased 98% during that same period. Lack of economies of scale due to Alaska's small, widely dispersed population and also fragmentation and duplication in Alaska's health care system are assumed to contribute to higher prices. Medical liability is a component of price, as the cost of malpractice insurance premiums is passed on to the consumer. New medical technologies also play a role in higher prices, as the cost to providers of implementation is passed on to consumers.[xii]

One sign that the price of health care in Alaska is higher than in other states is the difference in reimbursement rates between Alaska and Washington State's Medicaid programs. Many of the professional fees paid by Alaska's Medicaid program are nearly three-times higher than those paid in Washington – Figure 4 provides just a few examples from the two states' 2009 Medicaid Fee Schedule.

FIGURE 4: Differences in Medicaid Fees, Washington State and Alaska, 2009

Description	Code	AK Fee	WA Fee	% Difference
Outpatient Office Visit – Lower Level	99212	$62.46	$22.69	175%
Outpatient Office Visit – Highest Level	99215	$221.58	$76.00	192%
Emergency Department Visit	99283	$109.14	$37.48	191%
Knee arthroscopy/Surgery	29881	$976.77	$358.08	173%
Gall bladder removal, laparoscopic	47563	$1,175.10	$412.29	185%
Cataract Surgery w/ lens implant	66984	$1,141.23	$394.44	189%

Source: Alaska Department of Health & Social Services, Division of Health Care Services, December 2009

Another indicator that Alaska's health care prices are generally higher is a comparison of spending for inpatient hospital services. In 2007 the average hospital adjusted expenses per inpatient day was $2,104 in Alaska – 24% higher than the national average of $1,696.[xiii] The average hospital cost per stay in Alaska was $27,171 compared to the 2007 national average of $15,455.[xiv]

And one more example of higher prices and overall costs comes from the Workers' Compensation program. Alaska has ranked 1st in the nation for cost of workers' compensation premium rates since 2005. Medical costs made up 72% of total benefit claims in Alaska in 2008, compared to the national average of 58%. The average medical cost per workers' compensation claim in Alaska was $40,000 per injury in 2008 compared to the national average of $26,000. Alaska's Workers' Comp medical fee schedule rates were the highest in the nation in 2006 – on average 3.5 times higher than Massachusetts, the state with the lowest rates.[xv] Below are a few examples of fees paid by Alaska's program compared to Washington's and Hawaii's.

4990

FIGURE 5: Differences in Workers' Comp Fees, Alaska, Washington and Hawaii 2006

Description	Code	AK Fee	WA Fee	HI Fee
Outpatient Office Visit – Mid Level	99213	$127.00	$76.00	$61.00
Radiology (MRI, spinal canal cervical)	72141	$2,339.00	$769.00	$634.00
General Medicine (nerve conduction)	95904	$219.00	$81.00	$66.00
Knee arthroscopy/Surgery	29881	$4,181.00	$869.00	$693.00
Physical Medicine (therapeutic proc)	97110	$83.00	$40.00	$32.00

Source: November 2009 Report of the Workers' Compensation Medical Services Review Committee, AK Dept of Labor & Workforce Development

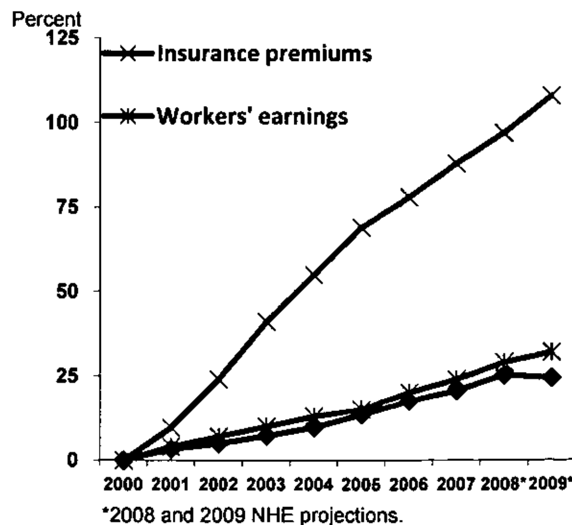
More research is required to understand the disparity in health care prices between Alaska and other states. A more comprehensive analysis of fees paid by all major payers and programs should be conducted. An analysis of variations in fees paid within Alaska as well as comparisons to other states should be included. Note the example from the above two tables in the disparity between fees paid by two different Alaskan programs for the same procedure – Alaska's Workers' Compensation program pays a professional fee for arthroscopic knee surgery (CPT 29881) that is more than four times higher than the fee paid by Alaska's Medicaid program. One other issue related to price and total cost that is not widely understood and should also be investigated is the difference between charges billed by providers and actual reimbursement levels, and how cost shifting occurs as providers adjust to changes in their payer mix and volume.

C. Health Insurance Coverage of Alaskans

Increased spending for health care translates into higher insurance premiums, as health insurance providers adjust to cover rising prices and growing utilization. Naturally therefore, as the overall cost of health care has increased over the years, the price of health insurance premiums has kept track. Unfortunately workers' wages have not kept pace with the rise in the cost of health insurance (Figure 6), and health care-related expenses are consuming a larger proportion of Americans' household income each year.

FIGURE 6: Premiums Rising Faster than Wages and Inflation[xvi]

Cumulative Changes in Components of U.S. National Health Expenditures and Workers' Earnings, 2000–2009



*2008 and 2009 NHE projections.

4991

In Alaska health insurance premiums for working families grew by 90.8% between 2000 and 2009. In comparison, the median earnings of Alaska's workers rose 17% during the same period. The average annual insurance premium for family health coverage in Alaska rose from $7,456 in 2000 to $14,226 in 2009. The average annual premium for individual health coverage rose from $2,923 to $5,626 during that same period.[xvii] The percentage of income spent on health care in Alaska (based on per capita averages) increased steadily from 11% in 1991 to 19% in 2004.

14% of Alaskans are uninsured or do not have access to military, Veteran's Administration or Indian Health Service-funded health care services. The following table (Figure 7) illustrates the proportion of Alaskans covered by various types of health care coverage.

FIGURE 7: Health Insurance Coverage by Type of Coverage in Alaska and the U.S.

Health Insurance Coverage Type Average for data years 2006-2008	**Alaska**		**United States**
	Count	**Percent of Total**	**Percent of Total**
Covered by Any Source	575,269	86.0%	85.0%
Employer	388,381	58.0 %	59.0%
Individual (self-purchased)	42,891	6.4 %	9.0%
Medicaid & Denali KidCare	78,636	11.8 %	13.4%
Medicare	57,384	8.6 %	13.9%
Military/VA	88,944	13.2 %	3.7%
Indian Health Service only[3]	28,095	4.2%	0.5%
Uninsured all year	93,648	14.0%	15.0%
Total	**668,917**	(percentages add up to more than 100% because of overlapping coverage types)	

Source: Current Population Survey (CPS), 2007-2009 surveys, 2009 data released September 2009.

84% of uninsured Alaskans belong to households with one or more workers. Most uninsured workers are self-employed, or employed by small businesses that do not offer health benefits or offer coverage they cannot afford. While nearly all firms with more than 100 employees provide health benefits, less than a quarter of Alaska's smallest businesses (those with fewer than 10 employees) offer health insurance. The seasonal nature of Alaska's workforce is an important factor in employer health coverage. The CPS survey data in the Figure 7 table does not capture Alaskans who only have coverage part of the year in the reported uninsured amount. It also does not account for Alaskans who are underinsured – those who have coverage but with such high deductibles and co-pay that they still face financial barriers to health care.[xviii]

[3] Figures in this table are adjusted to include as "covered" people of Alaska Native/American Indian race who may have access to IHS-Funded services. The CPS Survey includes IHS beneficiaries in the uninsured category if they have no 3rd-party health insurance coverage. The "Indian Health Service only" amount included here is an estimate based on respondents to the survey identified as "AI/AN only."

4992

D. Health Care Delivery System Challenges

Alaska experiences many health care delivery challenges, including the logistical difficulties and costs involved in providing care for a relatively small number of people spread over vast geographic distances, a delivery system that is highly fragmented, and an inadequate supply and distribution of health care workers.

Logistical Challenges

Alaska is the largest state in the nation geographically, encompassing an area greater than the next three largest states – Texas, California and Montana – combined. At the same time Alaska's population is among the smallest of the states. Alaska has the lowest population density in the U.S. with 1.2 persons per square mile compared to the U.S. average population density of 79.6. 26.1% of the state's population lives in communities of fewer than 2,500 people.[xix] The dispersion of such a small number of people over such a large area increases the difficulty and cost of delivering care here.

Approximately 75% of Alaska's more than 300 communities are not connected by road to a community with a hospital. Nearly a quarter of the state's population lives in towns and villages that can only be reached by boat or aircraft.[xx] Transportation costs are high – air travel between a village and the nearest community with a hospital generally costs more than $100, with airfare from some of the more remote villages to the tertiary care centers in Anchorage costing as much as $1,200. Geography and harsh weather conditions pose additional transportation barriers, and can be especially problematic in an emergency situation.

Transportation is not just an issue in terms of patients' ability to reach needed services. The cost of moving supplies, staff and equipment required to operate clinics and hospitals in rural Alaska can be formidable. For example, the price of heating fuel and gasoline in the most remote communities of the state reached as high as $10.00 per gallon this year – the cost of transporting the fuel to these communities was higher than the cost of the fuel itself.[xxi]

The cost of delivering services is also made higher by a loss of economies of scale associated with operating hospitals in sparsely populated regions and clinics in nearly every small community in the state – a necessity due to the remoteness and isolation of those locations. Some of Alaska's smallest communities with a clinic have as few as 50 residents. However, the loss of economies of scale to maintain the facilities is off-set somewhat by the innovative workforce solutions used to staff them, such as the Community Health Aide/Practitioner Program, and the use of telehealth technologies. Many of Alaska's most rural facilities are also highly subsidized by the federal government.

System Fragmentation and Duplication

Alaska's health care "system" is not a system, but an assortment of private, for-profit and non-profit, large and small medical businesses; hospitals and clinics to serve military personnel, retirees and their dependents; and hospitals and clinics owned and operated by tribal organizations. Health care organizations within the same sector (military, tribal health system, or private sector) do not have interoperable electronic information systems, care coordination systems, or business management processes. In addition to fragmentation in the delivery of services, there are a variety of payers financing health care services, including Medicare, Medicaid, private insurers, self-insured employers, the military and VA, the Indian Health Service, and individuals.

4993

Alaska has benefited from a strong military presence due to the state's strategic location, a strong tribal health system presence, and decades of representation in senior leadership in the U.S. Senate. Because of these three factors the federal government has played a lead role in development of Alaska's health care system, especially in rural Alaska as well as for medically underserved Alaskans statewide. And all Alaskans, not just the targeted service population, benefit from the presence of these services in communities where there might not otherwise be any health care delivery system. For example, the tribal health system provides care for non-Native individuals in remote communities where there are no other health care providers.

The downside of heavy federal investment in building the health care infrastructure is there are some communities that have multiple health care systems operating side-by-side. For example, one community of 9,000 people has both a community hospital and a tribal health system hospital. Another community of just 6,000 people has a community hospital, a tribal health system clinic, and a military clinic. Alaska's largest city, with a relatively small population of 285,000, has four hospitals – one military, one tribal, one for-profit, and one non-profit (plus two psychiatric hospitals). The facilities in these communities also serve regional (and in the largest city's case statewide) populations, but there is still an overabundance of infrastructure that leads to higher costs.

The duplication and fragmentation in Alaska's health care "system" is inefficient, and potentially unsustainable in the long-run if mechanisms for improved coordination and perhaps integration where appropriate are not implemented.

Health Care Workforce Shortages

Demand for health care workers rose sharply over the past decade. Alaska's health care employment sector experienced 40% job growth between 2000 and 2007, compared to 13% for all other industries, outpacing the state's population growth during that same period by five times.[xxii] The supply of new workers produced by Alaska's training and education programs plus those imported from outside Alaska cannot keep up.

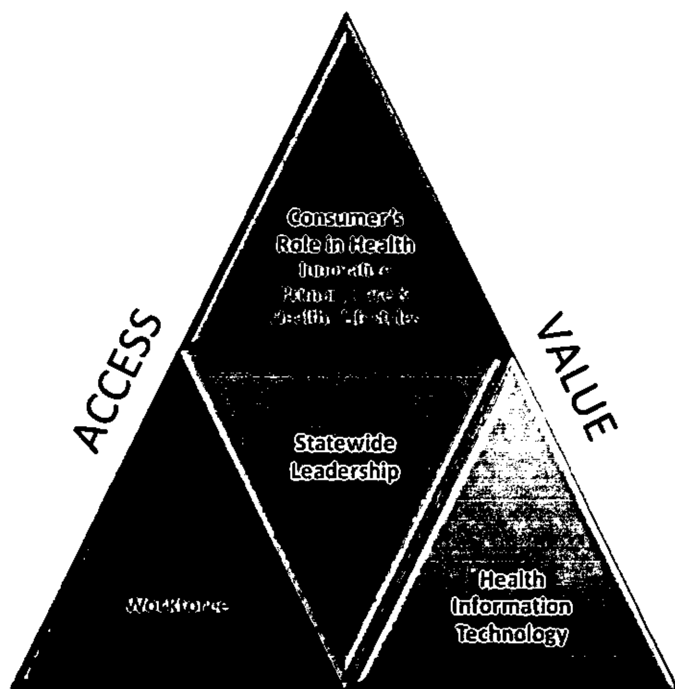
Alaskan health care employers had an estimated 3,529 number of vacant positions in 2007. Primary care occupations are experiencing vacancy rates of 15% - 20%. Pharmacist, therapist and certain nurse specialist positions are also experiencing high vacancy rates. Behavioral health occupations have a somewhat lower vacancy rate overall, but made up the highest proportion of vacancies with 1,033 vacant positions in 2007.[xxiii]

The costs health care organizations incur associated with recruitment and contracting for the services of temporary employees to cover vacancies is high. 80 Alaska health care organizations surveyed in 2005 reported spending $24 million in the preceding year for vacancies in 12 key health occupations.[xxiv] At least a portion of these costs may be passed on to consumers and insurers in the form of higher prices.

Delivery of health care is dependent on an adequate supply and distribution of qualified health care workers. 27 of Alaska's 30 boroughs and census areas contain federally designated health professional shortage areas. Staff shortages are one of the many challenges the Alaska health care delivery system is dealing with as it faces the future.

4994

PART III: 2009 Health Policy Findings & Recommendations



PREVENTION-BASED

Alaska Health Care Commission's Health Care Transformation Strategy

The Commission identified five priority issues for analysis this year:

A. The Consumer's Role in Health and Health Care

B. Statewide Leadership

C. Healthcare Workforce

D. Health Information Technology

E. Access to Primary Care for Medicare Patients

Understanding and supporting the consumer's role in health care was a primary interest of the Commission's, and became the central focus of their strategic approach to transformation of Alaska's health care system. Over the course of learning and discussions two aspects emerged as critical to addressing the goals of increased access, improved value (cost and quality), and a focus on prevention – 1) individual lifestyle choices and the impact those choices have on health outcomes and demand for health care services; and 2) the individual's central position in their health care experience. Support for healthy lifestyles and new innovations in patient-centered primary care are the pinnacle of the Commission's health care transformation strategy.

A vital health care workforce and modern information management tools are the foundation upon which support for healthy lifestyles and a strong innovative primary care system depends. And the journey to a transformed health care system cannot continue without statewide leadership to see it through. On-going study, planning, and policy development is necessary to ensure Alaska's health care system is able to adapt to national health care reform, and to create a regulatory and reimbursement environment that supports the health care industry while it redesigns itself.

The fifth priority issue identified this year is not part of the comprehensive strategy, but was recognized as an immediate crisis worthy of special attention – the problem Medicare beneficiaries in urban Alaska are experiencing with access to primary care. This problem just may be an early indicator – "the canary in the mine" – warning us of the looming health care crisis in our state if we don't take decisive action.

4995

A. The Role of Consumers in Health Care

1. Healthy Lifestyles

Finding A1a: Chronic disease is the leading cause of death and disability in the U.S. and Alaska.

Finding A1b: The majority of health care spending in the U.S. is for chronic disease.

Finding A1c: Three risk factors – tobacco use, poor diet and inactivity – contribute to the four leading chronic diseases – heart disease, diabetes, lung disease and cancer.

Finding A1d: Individual behavior is now the leading determinant of the health status of the population and contributor to premature death.

Finding A1e: Childhood obesity is a growing concern; for example, 33% of kindergarten and 1st grade students in the Anchorage School District are overweight or obese.

Finding A1f: Employee health risk behaviors can be changed through financial incentives coupled with other supports (e.g., coaching).

1.7 million Americans die each year from chronic disease, which cause 70% of all deaths. Cancer, heart disease, stroke, and lung disease are four of the top five leading causes of death in Alaska. 133 million Americans – nearly half our nation's population - live with at least one chronic condition. Individual health behaviors are the leading contributors to chronic disease. The World Health Organization estimates that 80% of heart disease, stroke and type 2 diabetes, and 40% of cancer, would be prevented if Americans stopped smoking, ate a healthy diet, and participated regularly in physical activity.

Complex medical care required over the prolonged course of illness and disability due to these conditions is costly. 75% of all health care expenditures are related to chronic disease. In Alaska, $600 million is spent annually for hospitalizations due to heart disease and stroke, and $419 million for all costs due to diabetes. The state of Alaska incurs an estimated $9-10 million in medical costs due to obesity for state employees alone each year. The doubling in the prevalence of obesity in the U.S. between 1985 and 2004 accounted for nearly 30% of the increase in annual health expenditures.

It is not possible to address the escalation in health care costs without addressing the problem of chronic disease. The Commission began an inquiry into strategies known to be effective at supporting behavior change and learned about the success of Alaska's Tobacco Program, which led to a reduction in adult smoking from 27% in 1991 to 22% in 2008. They also learned about successful worksite wellness programs. There is much more work to be done however - understanding what government, schools, work sites, and communities can do to support healthy choices requires on-going attention.

Recommendation A1a: The Commission recommends that the Governor and Alaska Legislature investigate and support additional strategies to encourage and support healthy lifestyles, including strategies to create cultures of wellness in any setting.

Recommendation A1b: The Commission recommends that the 2010 Alaska Health Care Commission continue evaluating the question of what works to support behavior change, and identify additional recommendations for future improvement.

4996

2. Primary Care Innovation

Finding A2a: Patient-centric health care delivery models based on a longitudinal relationship-based platform are effective at reducing unnecessary utilization of services by empowering patients to take more responsibility for their health and health care.

Primary care is the foundation of the health care delivery system – providing the main point of entry for secondary and tertiary care, and meeting the majority of patient needs for health education and disease prevention, initial assessment of health problems, treatment of acute and chronic health conditions, and overall management of a patient's health care services. There is increasing evidence that access to high-quality primary care improves health outcomes and reduces costs. However, the rising demand for services from an aging population and increasing chronic disease, coupled with the decreasing supply of primary care physicians, is sweeping our primary care system toward a crisis.

National health care reform discussions emphasize the importance of primary care, but tend to oversimplify the issues and solutions. Some suggest all that is required to improve access to primary care is increased reimbursement levels for primary care practitioners. Others suggest that primary care practitioners must be paid for additional services that are not currently reimbursable – those services they provide to assist with the coordination and management of a patient's care and health conditions over and above the time spent during the actual patient encounter. Reimbursement is part of the solution, but increases need to come through a restructured payment system that supports and rewards practitioners for delivering patient care in a new way.

The Commission believes that strengthening the provision of primary care is the key to transformation of the health care system, but they also determined that the current primary care model is antiquated. The traditional medical model based on episodic acute care is no longer the most effective and efficient approach to meeting patients' needs. They learned about a new patient-centered care model tried in our own backyard, the Southcentral Foundation's Nuka Model of Care, that's proven successful - demonstrating reductions in hospital days by 40% and emergency room and specialty visits by 50%.

The "Medical Home Model" is a term meant to describe the ideal concept for how primary care should be provided, but the Commission felt as though this term has become too much of a buzz word in the health care reform debates and that for many it simply implies paying primary care practitioners more for working in the same way. And so the Commission is avoiding use of that term, and is focusing on key characteristics of a modernized high quality primary care model:

- Patient and family centered
- Stable trusting relationship between care team and patient/family that continues over time
- Comprehensive, coordinated, and accessible care provided by integrated multidisciplinary teams
- Focus on health and wellness (physical, behavioral, social) rather than disease care

Alaskans need to be empowered to partner with their health care providers so they can be better stewards of their own health. This will require innovation in patient care at the primary care level.

Recommendation A2a: The Commission recommends that the Governor and Alaska Legislature aggressively pursue development of patient-centric care models through payment reform, removal of statutory and regulatory barriers, and implementation of pilot projects. Development of pilot projects should include definition of the patient-centric model, identification of performance standards and measures, and payment models that are outcome-based.

4997

B. Statewide Leadership

1. Response to National Health Care Reform

Finding B1a: National health care reform proposals under consideration by Congress will have a significant impact on Alaska's state and local governments, health care system, business community, citizens, and families.

Reform of the nation's health care system has been a top priority during 2009. The issue has been politically charged, with proponents stressing the importance of the increased access to health care coverage that would be afforded millions of Americans under the proposed reforms, and opponents decrying the increased national debt burden and inadequate attention to control of health care costs. At the core of the debate is a strong ideological divide over the appropriate role of government in health care.

Emotions are strong on both sides of the argument. The town hall meetings held by Alaska's U.S. Senators this summer and fall drew thousands of Alaskans – many with stories of desperation related to inadequate access to health care, and many others expressing fear and frustration over federal intrusion into what they believe is a personal matter. There's considerable misinformation and rhetoric from either side, with heavy use of popular media to attempt to sway public opinion. Over $150 million has been spent on TV ads alone this year by both sides.

Unfortunately there is no one entity in Alaska responsible for objectively analyzing the potential impacts of various reform proposals on our state government, health care system, businesses, and citizens. The federal legislation currently under consideration will dramatically change the federal structure within which state health systems operate, and state governments will play a significant role in implementation of federal health care reforms if and when they pass. New responsibilities states can expect to inherit under federal reforms will be both financial and administrative.

State government will incur additional financial responsibilities if Medicaid expansion is mandated. The Alaska Department of Health & Social Services (DHSS) estimates the fiscal impact of the proposed Medicaid expansion at nearly $450 million over a five year period. One considerable new administrative responsibility that appears likely is creation and operation of a state health insurance exchange. While many of the proposed changes are not slated to take effect until 2013 or 2014, a lot of work will be required during the interim to plan for implementation of new programs and systems.

Except for the ability to evaluate impacts of changes to Medicaid specifically, the state does not have capacity to analyze the effects of federal reform on our state. Regardless of whether federal reforms pass this year or not, the crisis in the nation's health care system will continue to drive federal proposals that will require analysis that could be provided by some form of a state health policy infrastructure.

Recommendation B1a: The Commission recommends that the Governor and Alaska Legislature invest in the state health policy infrastructure required to study, understand, and make recommendations to respond to the implications of national health care reform for Alaska.

4998

2. Permanent State Health Planning Board

> **Finding B2a:** The systems and policies for financing and delivering health care in Alaska are fragmented and complex, and the scope of the challenges involved in improving these systems is huge. Past efforts to improve health care in Alaska have been ad hoc in nature. A planning process to achieve health care system improvement must be sustained over time in order to ensure accountability for the achievement of meaningful change.

Over the two decades preceding the creation of the Commission, four groups have been formally convened to address the problems of access to and cost of health care. All of these entities were ad-hoc in nature with a limited lifespan, meeting over periods ranging from 6 months to 2 years. They all had limited time to study the issues and develop recommendations, and in the end no real authority or accountability for following through on their findings and proposed strategies.

In 1987 Governor Cowper created The Governor's Interim Commission on the Status of Health Care and the Health Care Industry in Alaska ("The Governor's Interim Health Care Commission" for short) under Administrative Order (A.O.) #100. The Governor's Interim Health Care Commission had 11 members and four staff, and held eight 2 to 3-day meetings over the course of nine months. The report they published in 1988 made 39 recommendations to the Governor and Alaska Legislature addressing insurance coverage expansion, access to long term care, cost controls, and state health planning.

In 1991 the Alaska Legislature created the Health Resources & Access Task Force. The 17-member HRATF held 14 monthly two-day meetings, producing a report calling for the creation of a single-payer system for Alaska. While their primary recommendation was never adopted, creation of a high-risk pool for Alaskans with pre-existing conditions who cannot otherwise obtain health insurance coverage – the Alaska Comprehensive Health Insurance Association (ACHIA) – followed from their work.

Ten years following the publication of HRATF's final report in 1993, a private group – Commonwealth North – created the Alaska Health Care Roundtable to improve access, quality and cost of health care in Alaska. The Roundtable had a 17-member executive committee representing public and private sector interests. They produced a report in 2005 focused on the improvement of primary care.

In 2007 Governor Palin created the Alaska Health Care Strategies Planning Council under A.O. #232. The Planning Council consisted of 17 members who met for 6 months, during which time they identified a series of goals and strategies for improving the health of and health care for Alaskans.

The two most recent groups recognized two problems with their ad hoc nature – 1) one year isn't long enough to get a handle on the complexity of the problems in our health care system and come up with a comprehensive approach to solutions; and 2) there was no way to ensure accountability for their efforts. Both groups recommended that a permanent health planning and policy body be established in statute to provide sufficient time for gathering information, studying the issues, and developing comprehensive solutions. The Commission concurred with their recommendation.

> **Recommendation B2a:** The Commission recommends that the Alaska Legislature establish an Alaska Health Care Commission in statute, similar in size to the Commission established under Administrative Order #246, to provide a focal point for sustained and comprehensive planning and policy recommendations for health care delivery and financing reform, and to ensure transparency and accountability for the public in the process.

4999

C. Health Workforce Development

1. General Workforce Development Findings & Recommendations

Finding C1a: Health care in Alaska is big business and represents a significant employment sector.

Finding C1b: Access to health care requires a sufficient supply and adequate distribution of health care providers. Successful achievement of the goal of expanding access to health care in Alaska is directly tied to health care workforce capacity and capability.

Finding C1c: Health care worker shortages in Alaska are widespread and costly.

Finding C1d: A comprehensive approach to health care workforce training includes strategies at every point on the training continuum (K12, post-secondary, graduate and post-graduate, on-the-job, continuing medical education).

Finding C1e: Alaskans have been particularly innovative in meeting their health care workforce needs.

Finding C1f: Many organizations, both public and private, have a stake in health care workforce development, and there are numerous programs and groups currently involved in health care workforce planning. There is evidence of collaboration in these planning and development efforts; however, not all related activities are fully coordinated.

Health care in Alaska is a six billion dollar industry, representing 16% of the state's gross domestic product.[xxv] It is also one of the biggest players in Alaska's labor market. With eight percent of the state's wage and salary jobs it leads all other industries except government, trade, and hospitality. Alaska's top employer is a health care provider – Providence Health & Services – employing over 4,000 people in 2008. Five of the top 20 employers in the state are health care organizations.[xxvi]

Health care is not only one of the largest employment sectors in Alaska, it is consistently the fastest growing. Between 2000 and 2007 the number of wage and salary jobs in the health care industry grew 40%, from 20,700 to 29,000, compared to just 13% for all other industries. Health care employment grew faster in Alaska than the U.S. overall, with 40% job growth compared to 19% in the U.S. from 2000 to 2007. Health care employment growth has outpaced Alaska's population growth rate by five times.[xxvii] The Alaska Department of Labor & Workforce Development projects the health care industry will continue to expand in the next decade, increasing by 25% between 2006 and 2016 and adding twice as many jobs as any other industry.[xxviii]

One other aspect of the health care industry important to the overall economy of the state is that there are health care jobs in virtually every community. There are at minimum paraprofessional health care providers in even the smallest villages. 23% of Alaska's health care workers are employed in rural areas.[xxix]

A functional health care system cannot be sustained without an adequate workforce. One key measure of access to health care is the supply of health care providers as a ratio to population. But having an adequate workforce goes beyond simple measures of supply. The workforce must be competent to provide high quality care that is culturally appropriate, must be literate in the use of health information

5000

technologies, and must be able to adapt to new patient care settings and models that provide integrated, interdisciplinary, patient-centered care. Having an adequate statewide supply of well trained providers is not enough either – workforce distribution is an important factor as well.

Meeting the demand of Alaska's health care industry for an increasing number of health care workers presents a significant challenge. The supply of new workers produced by Alaska's training and education system plus those imported from outside Alaska cannot keep up. Alaskan health care employers had an estimated 3,529 number of vacant positions in 2007. Primary care occupations (family physicians, general internists, nurse practitioners, physician's assistants, and community health aide/practitioners) are experiencing vacancy rates of 15% - 20%. 19% of psychiatrist positions were vacant in 2007. Other occupations for which shortages exist include pharmacists (23.7% vacancy rate), and therapists (physical, occupational, speech, and speech-language pathologists with vacancy rates ranging from 15.6 – 29.3%). Key nursing specialties also experience high vacancies, with a 23.4% vacancy rate for nurse case managers. Behavioral health occupations had a relatively lower vacancy rate at 13.9%, but made up the highest proportion of vacancies – with an estimated 1,033 vacant positions. In a 2007 survey of health care organizations conducted by the Alaska Center for Rural Health (and from which the above noted estimates are derived), 54% of respondents cited "inadequate pool of qualified workers" as the top reason for vacancies.[xxx]

The costs associated with these vacancies are high. 80 Alaska health care organizations surveyed in 2005 reported spending $24 million in the preceding year for vacancies in 12 key health occupations - $11 million on recruitment costs plus $13 million on itinerant temporary workers. They identified three main barriers to recruitment – locating qualified candidates, Alaska's geographic isolation and harsh climate, and the need to satisfy the lifestyle and employment requirements of spouses and other family members. [xxxi]

The approach to replenishing the health care workforce as the numbers of jobs grow and workers are lost through retirement and attrition includes a combination of "growing our own" strategies – providing training and education in and for Alaska, and importing workers from outside Alaska through a variety of recruitment strategies. There is a history of collaboration in Alaska as the health care industry has partnered with the University system and state and federal funding agencies in the development of health care education and training programs in order to improve our ability to "grow our own."

The University of Alaska (UA), the Alaska Legislature and Alaska's health care industry have demonstrated a commitment to increasing in-state health career training and education opportunities in recent years. The number of students in UA health programs increased 68% between 2001 and 2008. In the fall of 2007 UA had 3,501 students enrolled in health programs. UA now has 80 health programs statewide in various fields including allied and behavioral health, emergency services, health management, medical office management, nursing, primary care, public health, and therapies. In partnership with the health care industry and with financial support from health care organizations and the state Legislature, the UA has recently added or expanded a number of programs, including:

- Doubling the nursing program to more than 220 AAS and BS admissions each year, and providing AAS nursing programs in 12 communities;
- Doubling the number of WWAMI medical school seats from 10 to 20;
- Addition of radiologic technology in six locations;
- Development of cooperative programs with outside universities for occupational, speech and language therapies and audiology;
- Expansion of the distance Master's program in social work;

5001

- Provision of rural allied health training via distance delivery;
- Doubling the Master's of Public Health program to 70 distance students; and,
- Opening the Physician's Assistant program (beginning July 2009).[xxxii]

Training and education strategies do not begin at the post secondary level however. They include developing the pipeline of potential future Alaskan workers – reaching them early in their K12 education, making sure they have a solid foundation in math and science, and exposing them to potential careers in the health field. One program that helps young people explore health careers is the Area Health Education Center (AHEC). AHECs are federally and state funded programs meant to create formal relationships between university health programs and community partners to support health career education development. Alaska has an AHEC based out of UAA's School of Nursing, administered by the Alaska Center for Rural Health, and serving four regions of the state through partnerships with the Yukon Kuskokwim Health Corporation, Fairbanks Memorial Hospital, the Alaska Family Practice Residency Program, and Southeast Alaska Regional Health Consortium. In addition to encouraging Alaska's youth to pursue health careers, the AHEC facilitates clinical rotation opportunities and continuing education for health professionals in underserved areas. In addition to the AHEC program, Alaska's WWAMI program and also the Alaska Native Tribal Health Consortium administer a number of health career development programs.

Training and education strategies do not end at the post-secondary level either. They also include post-graduate programs such as graduate medical education (GME – residency programs for medical school graduates) and also non-physician programs such as clinical internships for Ph.D. psychologists. Alaska currently has one GME program, the Alaska Family Medicine Residency Program, and groups are in various stages of planning residency programs for pediatrics, psychiatry and internal medicine. Alaska lacks an internship for our Ph.D. doctoral students in psychology.

One other approach to addressing health care workforce shortages that must be noted – one for which Alaska is a proven leader – is innovation in the development of new types of workers and in the utilization of existing provider types. The extreme health care delivery challenges posed by the remoteness and isolation of many of Alaska's Bush communities led to a unique workforce innovation in the middle of the past century that has become a model for other countries with similar challenges – the Community Health Aide/Practitioner. Alaska's tribal health system has used that model to address behavioral health and oral health needs in more recent years, with the development of the Behavioral Health Aide and the Dental Health Aide Therapist Programs. Another innovation is Alaska's use of mid-level practitioners – nurse practitioners and physician's assistants – who have an expanded scope of practice to allow more independent practice by these providers than in many other states. Mid-level practitioners have played an important role in meeting the primary care needs of rural communities not large enough to support a physician practice in Alaska since the 1970s, and play an important role today in urban Alaska as well.

There are a number of collaborative health care workforce planning and development efforts currently underway. Following are some key examples:

- The Alaska Health Care Workforce Coalition (AHCWC) represents a large industry-led partnership that includes not only representatives of health care provider organizations, but also the three state government agencies that play an important role in health care workforce development – Health & Social Services, Education & Early Development, and Labor & Workforce Development, as well as K12 school districts, and the University of Alaska. This

5002

Coalition is in the process of developing a statewide strategic health care workforce plan for Alaska under the auspices of the Alaska Workforce Investment Board (AWIB). A draft of this plan is currently being circulated for public comment, and will be finalized and submitted to the AWIB for endorsement in February 2010.

- The Alaska Diversified Economic Planning Team, established under Administrative Order #249 by Governor Palin, is in the process of developing a statewide strategic comprehensive economic development plan for the state (the "Legacy Plan"). This team has 16 different workgroups currently in the process of addressing various aspects of economic development. One of the workgroups is addressing health care, as it is not only a major employer and driver of Alaska's economic engine; it is also an important support industry for other sectors of the economy. The Legacy Plan Health Care Workgroup, scheduled to produce a report in 2010, is primarily focusing on health workforce issues.

- Last year the Department of Health & Social Services (DHSS) established a position housed at UAF in the Office of the Associate Vice President for Health Programs and supported with funding from the Alaska Mental Health Trust Authority (AMHTA) charged with the responsibility for coordinating the numerous projects under AMHTA's Workforce Development Initiative with DHSS and UA behavioral health workforce projects.

- The Trust Training Cooperative, housed in the University of Alaska Anchorage (UAA) College of Health and Social Welfare's Center for Human Development, includes numerous partners focused on improving training coordination and availability for smaller and rural organizations servicing AMHTA beneficiaries. The Cooperative recently completed a behavioral health training needs assessment.

In addition to these various partnerships, coalitions and workgroups, there are a few entities that contribute routinely to research and analysis of Alaska's health care workforce.

- The Research and Analysis Section in the Alaska Department of Labor & Workforce Development;
- The Section of Health Planning and Systems Development in the Division of Health Care Services, Alaska Department of Health & Social Services; and
- The Alaska Center for Rural Health housed at UAA.

These examples demonstrate that many private and public entities are invested in health care workforce development, but there is no one entity responsible for coordination of all these activities. A single organization charged with coordination of the many health workforce development activities in the state, and designated to provide the organizational home to support implementation of the statewide strategic plan currently under development by the AHCWC, is needed. This would help minimize the possibility that efforts might be duplicated and wasted, or that gaps in important aspects of workforce development go unaddressed. The designated entity could ensure that a comprehensive approach to meeting Alaska's health care workforce needs is taken, including strategies to address:

- On-going assessment of Alaska's health care workforce size, composition and distribution
- Workforce innovations required for responding to transformation in patient care models
- Training needs along the continuum of K12 education through graduate medical education and including on-the-job training
- Improved recruitment and retention of health care workers
- Sustainability of the health care workforce planning, development and support infrastructure.

5003

Recommendation C1a: The Commission recommends that the Governor and Alaska Legislature maintain health care workforce development as a priority on Alaska's health care reform and economic development agendas.

Recommendation C1b: The Commission recommends that the Governor and Alaska Legislature explore strategies for strengthening the pipeline of potential future Alaska health care workers.

Recommendation C1c: The Commission recommends that the Governor and Alaska Legislature explore strategies for ensuring Alaska's health care workforce continues to be innovative and adaptive, and that it is responsive to emerging patient care models.

Recommendation C1d: The Commission recommends that the Governor designate a single entity with the responsibility for coordinating all health care workforce development planning activities in and for Alaska. Coordination and collaboration of funders, policymakers and stakeholders in workforce planning and development efforts should be encouraged to the greatest extent possible.

Recommendation C1e: The Commission recommends that the 2010 Alaska Health Care Commission continue studying health care workforce needs in coordination with other organizations and coalitions addressing this issue, and identify recommendations for additional improvements.

2. Physician Shortage

Finding C2a: The United States is facing a shortage of physicians as this provider population ages and enters retirement and the production is not expected to keep up with demand. As the physician shortage increases in the U.S. the competition for recruiting physicians to Alaska will become increasingly difficult.

Finding C2b: Alaska has a shortage of primary care physicians[4].

Finding C2c: New physicians face disincentives to entering primary care specialties.

Finding C2d: Providers stay to practice where they train.

Finding C2e: Mid-level medical practitioners (Nurse Practitioners and Physician's Assistants) and medical support staff (nurses, medical assistants, care coordinators, etc.) are essential occupations for addressing primary care physician shortages.

There are many professions that make up the health care workforce and all are vital to a functional health care delivery system. The Commission chose to focus on the physician workforce in their first year, in part because the one specific health care delivery challenge they chose to study this year is the problem of Medicare access to primary care doctors. For their analysis of the physician workforce the Commission benefited from a recent study by the Alaska Physician Supply Task Force completed in 2006.[xxxiii] The Task Force was commissioned by the President of the University of Alaska and the

[4] The Commission includes both osteopathic as well as allopathic medical doctors in their definition of physician. The Commission's definition of primary care physician is slightly different from most standard definitions – family practitioners, pediatricians, and general internists are included, but also psychiatrists, and Ob-Gyns are excluded.

5004

Commissioner of the Department of Health & Social Services to address questions regarding current and future need for physicians in Alaska, and to consider current and potential strategies for meeting estimated physician need.

The United States is experiencing a shortage of physicians which is expected to worsen as the baby boomer cohort of doctors enter retirement, the nation's population ages and requires more intensive medical services, and programs to educate new physicians have insufficient capacity to keep up with demand. A deficit of 96,000 to 200,000 physicians is projected nationwide by 2020.[xxxiv] In 2006 the Association of American Medical Colleges recommended the number of medical school slots in the country be increased by 30% by the year 2020. As the competition between states increases for a decreasing supply of physicians, it has become increasingly difficult to recruit out-of-state doctors to move to Alaska.[xxxv]

The Physician Supply Task Force determined that Alaska has a shortage of physicians that is expected to worsen over the next 20 years. They estimated that Alaska should have 375 more physicians today, based on an assumption that Alaska should have 110% of the current national average physician-to-population ratio. The ratio of physicians to population in Alaska is 2.05 doctors per 1000 population compared to 2.38 doctors per 1000 population nationwide. Their recommendation was to increase the number of additional physicians practicing in Alaska each year from the current net average annual increase of 38 (78 new minus 40 lost to retirement and attrition) by more than 50%, to 59 net new physicians per year.

The Commission was impressed by the thorough and professional analysis conducted by the Task Force, but challenged a couple of the assumptions they used to derive estimates of current and future shortages in Alaska. One assumption the Task Force made was that the national average physician to population ratio is representative of the level of need. Another was that Alaska should have 10% more than the national average because of the structural inefficiencies in our state's health care system, and because of the additional administrative and supervisory responsibilities associated with support of paraprofessionals (Community Health Aides/Practitioners) and mid-level practitioners. The Commission felt that this assumption did not account for the fact that these other provider types relieve the actual direct patient care burden for those physicians, nor did it account for the expanded scope of practice of mid-level practitioners in Alaska that allows more independent practice on their part.

Because of questions regarding some of the Task Force's assumptions, the Commission was not prepared to agree at this time that Alaska faces a crisis in total physician supply, but conceded there is evidence pointing to a shortage of primary care physicians. The Alaska Center for Rural Health's 2007 Alaska Health Workforce Vacancy Study estimated a 20% statewide vacancy rate for general internists, a 19% vacancy rate for psychiatrists, and a 15.8% vacancy rate for family physicians. The problem Alaska's seniors are experiencing finding a primary care physician who will accept new Medicare patients is another indicator of this problem. These signs coupled with the Commission's strategic focus on developing and strengthening new primary care patient care models led to a determination that Alaska is experiencing a shortage of primary care physicians, and a recommendation that the state's limited public resources spent on physician supply development should be focused on increasing the supply of primary care physicians specifically.

A consideration of strategies to increase the supply of primary care physicians requires an understanding of the disincentives new medical school graduates face to entering primary care specialties. According to the Association of American Medical Colleges, the average educational debt of

indebted graduates of the class of 2008 was $154,607, an increase of 11% over the previous year. 87% of graduating medical students carry outstanding loans, and 79% of graduating medical students have debt of at least $100,000.[xxxvi] The high level of debt most new physicians have to bear poses a significant disincentive to choosing to enter a primary care specialty, as these are the lowest paid fields. Other disincentives beyond relatively low pay exacerbated by high debt burden include the practice environments that tend to require more work hours, more on-call time, and a higher administrative burden for generalists, and also the higher prestige that is often associated with practicing as a specialist as opposed to a generalist. A combination of strategies for improving education, recruitment, and supporting innovative practice models is required to address the need for an increased supply of primary care physicians.[xxxvii]

Alaska is one of just 6 states that do not have their own medical school. Instead, Alaska participates in a collaborative medical education program, WWAMI (Washington, Wyoming, Alaska, Montana, and Idaho), that provides a medical school opportunity to rural states in the northwest. Instead of paying to support an in-state medical school, the Alaska Legislature appropriates funds to pay the University of Washington for the government subsidy portion of the WWAMI medical school, which is approximately $50,000 per student per year. In addition to the government subsidy, Alaska WWAMI students pay tuition of approximately $20,000 per year (equivalent to Washington in-state tuition for UW medical students).

The number of medical student seats Alaska supports in WWAMI is set in state law (AS 14.42.033). Alaska supported 10 seats since the beginning of the program in 1971, but the legislature doubled support to 20 seats beginning with the 2007 school year. Even after this 2-fold increase, Alaska has less than half the national average medical school capacity. The U.S. average number of medical school seats to population is 26.6 per 100,000, compared to 11.9 for Alaska.[xxxviii] The 30-member nation OECD average is 39.6/100,000.[xxxix] The Alaska Physician Supply Task Force recommended that Alaska expand participation in WWAMI to 30 and then eventually 50 seats.

The rate of return of Alaska WWAMI students to medical practice in Alaska is 47%, compared to the national average for all U.S. public medical schools which is 39%. Alaska medical students who participated in WICHE (Alaska's participation in WICHE medical school programs ended in 1995) had an 18% return rate. The actual return on investment for Alaska when the rate of return of all WWAMI students (including those entering Wyoming, Washington, Montana, or Idaho's program) to medical practice in Alaska is 88% of the number of seats Alaska has subsidized.[xl] As far as quality, the U.S. News & World Report ranked WWAMI as the #1 medical school for primary care in 2009 for the 15th consecutive year, and also #1 for both rural medicine and for family medicine for the 17th consecutive year.[xli]

The physician training pipeline ends with graduate medical education. Following completion of medical school, graduates have to complete a residency program in order to be licensed and practice in the United States. Residency programs vary in length. A family medicine residency is three years long. According to national studies physicians tend to stay and enter practice in the community where they complete their final residency training. Alaska was the last state in the nation to establish an in-state residency program, but since 1997 has had the Alaska Family Medicine Residency Program (AFMRP). The program expanded capacity from eight to 12 residency slots a few years ago. In the past 12 years AFMRP has graduated 75 family practice physicians. Of those 75 graduates, 80% have stayed to practice in Alaska, and over half of those who have stayed are practicing in rural Alaska. The AFMRP was designed to train physicians for practice in rural Alaska, so it is achieving its original goal.[xlii]

5006

A number of other residency programs are being considered for Alaska and are at various stages in the planning process. A pediatric residency program is being planned by a collaborative group including Providence, the Alaska Native Medical Center, and a number of private providers. This program would be a branch residency program of the UW Children's Hospital Pediatric Residency Program, with residents practicing in Alaska for four months out of each of the three years in the program. A psychiatric residency program planning process is underway with financial support from the Alaska Mental Health Trust Authority. This program would also be a branch program of UW, which has already developed a similar branch model in Spokane and Boise (these two programs have been successful in terms of retaining residency graduates to practice in their communities). Psychiatric residencies are four years in length, and the Alaska branch program would have the residents spending their first two years in Seattle, and their last two years in Alaska. One other residency program under consideration is for general internal medicine, but an organized planning effort has not quite coalesced at this point due to lack of financial support and leadership.

One barrier to development of residency programs in Alaska is funding. Most residency programs receive a significant portion of their operational funding from Medicare, which since its inception in 1965 considered educational activities in teaching hospitals a reimbursable expense. Because of the substantial growth in costs associated with support of graduate medical education (GME) – which in 2007 cost Medicare $8.8 billion – Congress imposed a cap in the Balanced Budget Act of 1997 on the number of residency positions Medicare could support. The cap was set at the number of residents who were training in a given teaching hospital as of December 31, 1996, and did not include provisions for making adjustments or redistribution based on need. This cap effectively locks Alaska out of the Medicare GME funding pool.[xliii]

Medical education expansion is an important strategy for increasing primary care physician supply, but the time it takes to prepare a college graduate to practice medicine is a minimum of seven years. In addition to increasing capacity for education of new physicians, other strategies to improve recruitment and retention of physicians from outside Alaska must be considered. Support-for-Service programs offer an important recruitment and retention tool for states. These programs provide current or future health practitioners with educational scholarships, educational loans, repayment of educational loans, or direct monetary incentives in return for a contractual obligation with the practitioner to serve a period of service in a needy area.

Loan repayment and financial incentive programs are the most popular form of support-for-service programs, as studies document service obligations established at the beginning of a practitioner's educational process (through a scholarship or loan) are less effective in terms of achieving the desired recruitment outcome as are loan repayment and financial incentive programs. Another benefit of loan repayment and financial incentive programs is that the return is immediate. One study documented a service completion rate of 94% and 93% respectively for loan repayment and financial incentive programs, compared to 63% and 41% respectively for scholarship and loan with service option programs.[xliv]

One last strategy the Commission considered for addressing the shortage of primary care physicians was the use of mid-level practitioners – physician's assistants and nurse practitioners – to help meet Alaska's primary care need. The recent support by the Alaska Legislature for establishing a PA training program at UAA is a significant step, but opportunities for expanding the use of "physician extender" occupations should be further explored.

5007

Recommendation C2a: The Commission recommends that the Governor and Alaska Legislature target the state's limited financial resources invested in physician workforce development to strengthening the supply of primary care physicians.

Recommendation C2b: The Commission recommends that the Governor and Alaska Legislature support development and maintenance of an educational loan repayment and direct financial incentive program in support of recruitment and retention of primary care physicians and mid-level practitioners.[5]

Recommendation C2c: The Commission recommends that the Governor and Alaska Legislature support the continued expansion of the WWAMI program. Future expansion should be supported as resources allow.

Recommendation C2d: The Commission recommends that the Governor and Alaska Legislature support graduate medical education for primary care and behavioral medicine. State financial support should continue for on-going operation of the Alaska Family Medicine Residency Program, and should be appropriated for the planning and development of in-state residency programs for pediatrics, psychiatry, and primary care internal medicine.

Recommendation C2e: The Commission recommends that the Governor and Alaska Legislature ask Alaska's congressional delegation to pursue federal policies to address equity in the allocation and distribution of Medicare Graduate Medical Education (GME) residency slots. The exclusion of new programs is not equitable, and there should be heavier weighting for primary care GME and for shortage areas.

Recommendation C2f: The Commission recommends that the Governor and Alaska Legislature explore strategies for improving the primary care delivery model and utilizing "physician extender" occupations as an additional approach to addressing the primary care physician shortage.

[5] The Commission's recommendation that an educational loan repayment and direct incentive program be established for Alaska to assist with addressing physician shortage specifically is not meant to exclude other provider types for which shortages are documented from such a program.

5008

D. Health Information Technology

1. General HIT Findings & Recommendations

Finding D1a: Development and utilization of electronic information management tools is essential to health care system improvement for the purpose of supporting:

- Increased health care efficiency and effectiveness; and
- Improved clinical quality and patient safety.

Health information technology is a broad concept that encompasses the use of electronic data and communication systems for compiling, maintaining and transmitting health information. The term "health information technology" (HIT) is more commonly used today to refer to electronic health records (EHR), health information exchange (HIE), and related data collection, storage, and management applications. These data and information management applications are dependent on many of the same technologies as telemedicine/telehealth, which is the use of telecommunication technology to provide clinical and other health services when participants are at different locations. For the purposes of this report the Commission includes both EHR/HIE and telemedicine/telehealth under an umbrella definition of HIT.

Broad adoption of interoperable EHR/HIE systems is widely regarded to be an essential element of health reform, necessary to support increased efficiency and effectiveness of health care and also to improve quality and patient safety.[xlv] Unfortunately the health care industry is far behind other industries, such as banking and commerce, in the adoption of electronic information management tools,[xlvi] and the United States lags as much as much as a dozen years behind other industrialized nations in the move from paper to electronic health records.[xlvii]

Telemedicine/telehealth has been used to improve access to health care in Alaska for decades[xlviii,xlix], and continued development, deployment and modernization of technologies supporting distance delivery of care is essential to meeting the Commission's goals of improved access at a reasonable cost. Alaska is benefiting from early work in telemedicine/telehealth, as collaborative efforts to deploy and support use of telecommunication strategies for expanding access to health care in the state became the catalyst for projects and eventually whole new organizations now devoted to supporting adoption of EHRs and development of a statewide HIE.

The Commission identified HIT – both EHR/HIE and telemedicine/telehealth - as an essential cornerstone of health care delivery system transformation for Alaska because it is required for successful implementation of virtually all potential specific strategies for health care improvement – from cost and quality transparency, to fraud reduction, to supporting evidence-based clinical practice. But it is important to note that HIT is not a magic bullet that will solve all health care system problems – it is a tool – it is not a goal in itself. The Commission also found that, while there is evidence that HIT adoption leads to improved efficiency and quality of health care, there is insufficient research into the question regarding the financial effects.[l,li]

Recommendation D1a: The Commission recommends that the Governor and Alaska Legislature take an aggressive approach to supporting adoption, utilization, and potential funding of health information technology, including health information exchange, electronic health records and telemedicine/telehealth that promise to increase efficiency and protect privacy.

5009

2. Health Information Exchange and Electronic Health Records

a) Development and Use of HIE/EHR

Finding D2a: Many providers in Alaska are at the early end of adopting electronic health records. Many still use paper records. Barriers to adoption of electronic health information technologies by Alaska's health care providers include:

- Start-up costs for new systems, including purchase of new hardware and software as well as costs associated with implementing new office procedures, training staff, and transitioning existing records from paper to electronic;
- The multitude of products on the market making evaluation and selection of one system time-consuming and costly for individual providers and small practices;
- Systems that are not user-friendly from the provider's perspective, i.e. are difficult, inflexible and time-consuming to use;
- Costs associated with on-going operation and maintenance; and,
- Antiquated and nonstandard eligibility and claims processing systems.

Finding D2b: Federal policies, such as the national incentive program funded under ARRA and pending Medicare payment penalties, are forcing rapid adoption of electronic health records by providers. Some Alaskan providers feel forced to move forward quickly while being concerned that standards are not yet fully in place and systems may not be ready.

Health care providers in Alaska have begun the transition of their medical record systems from paper to electronic format. A statewide survey conducted in 2009 to determine the current usage of EHRs and interest in their adoption among Alaska physician practices found that, of the 378 physicians and 62 clinic managers responding, 50% reported using an EHR and a third reported using ePrescribing.[6;lii] Survey respondents who did not use an EHR reported that the initial cost and practice disruption are the major barriers to adoption. Uncertainty about which EHR system to buy was also a significant barrier.

Before continuing it may be helpful to define a few key firms. The federal government, in their work to standardize HIT, has developed a compendium of terms. [liii] The new standardized definitions include:

- Electronic Health Records (EHRs) - "electronic records of health-related information on an individual that conform to nationally recognized interoperability standards and that can be created, managed and consulted by authorized clinicians and staff across more than one health care organization."
- Electronic Medical Records (EMRs) are distinguished from EHRs as being internal to one health care organization – "electronic records of health related information on an individual that conform to nationally recognized interoperability standards and that can be created, gathered, managed, and consulted by authorized clinicians and staff within one health care organization."
- Personal Health Records (PHRs) are distinguished from EHRs and EMRs as being managed and controlled by the individual patient – "electronic records of health-related information on an individual that conform to nationally recognized interoperability standards and that can be drawn from multiple sources while being managed, shared, and controlled by the individual.
- Health Information Exchange (HIE) is "the electronic movement of health-related information among organizations according to nationally recognized standards."

[6] The surveyors noted that the percentage of respondents reporting EHR usage could not be ascribed to the total population of Alaska physicians because of the self-selecting nature of the survey methodology.

5010

- Regional Health Information Organization (RHIO) - "a health information organization that brings together health care stakeholders within a defined geographic area and governs health information exchange among them for the purpose of improving health and care in that community."

The federal government is actively driving the health care industry toward broad adoption of HIT. In April 2004 President Bush established the Office of the National Coordinator for Health Information Technology (ONC).[liv] The ONC is charged with coordinating and promoting the deployment of interoperable electronic health information systems throughout the nation as well as other related health technology initiatives. This agency has been leading national standards development initiatives and administering related grant programs for the past five years.

In 2009 Congress included more than $20 billion in the American Recovery and Reinvestment Act (ARRA) for the development and adoption of health information technology under the Health Information Technology for Economic and Clinical Health (HITECH) Act. HITECH sets a goal of 2014 to increase dramatically the number of health care providers who have and effectively use EHRs and HIEs. The goal is to be achieved through an array of financial incentives, education, training and state-led actions.

Under HITECH Medicare will begin providing incentive payments of up to $44,000 for individual providers and $2 million for hospitals starting in 2011 for "meaningful use of electronic health records." Beginning in 2015 providers not using an EHR will be penalized through reductions to their reimbursement rate. CMS and ONC issued regulations on December 30, 2009 setting standards for the Medicaid and Medicare incentive programs, providing a definition of "meaningful use," and setting standards for certification of EHR technology. Under HITECH state governments also play a lead role in planning and implementation of efforts to establish HIE(s) for their state.[lv]

The Alaska Legislature passed SB 133 during the 2009 session, creating a statewide health information exchange system for Alaska and directing the Department of Health & Social Services to enter into a contract and to designate a qualified entity in the state to assist in the planning and implementation of the network. The Division of Health Care Services (DHCS) is leading this effort, and expects to award the HIE contract and designate the State HIE Entity this month (Jan 2010). DHCS is also responsible for development of a new Medicaid Management Information System (MMIS), and is working to ensure that the Statewide HIE Plan is closely coordinated with the State Medicaid HIT plan.[lvi]

Two non-governmental organizations active in the advancement of EHR/HIE in Alaska today are spin-offs from the Alaska Telehealth Advisory Council (ATAC), which was created in 1999 with federal funds earmarked to foster telemedicine in Alaska. ATAC's membership included DHSS, hospitals, tribal health organizations, professional provider groups, the insurance industry, the telecommunications industry, and the University of Alaska. The ATAC sunset in 2007, but while the group was active they developed many initiatives that are continuing to support deployment and use of telehealth applications and services. In 2005 the ATAC fostered the creation of the Alaska EHR Alliance (AEHRA), formed to support implementation of EHRs in physician practices, and ChartLink, formed to support development of a statewide HIE. Chartlink was incorporated as a 501(c)(3) in 2008 as the Alaska eHealth Network (AeHN). AEHRA conducted the EHR physician survey earlier in 2009, and is now in the process of selecting two recommended EHR vendors for Alaska's providers based on the results of that survey, and will negotiate reduced prices for Alaska's providers with those vendors.

5011

EHR/HIE-related health information management systems currently in use by state government in Alaska include:

- MMIS (Medicaid Management Information System): an electronic information management system the federal government requires all states maintain to process Medicaid claims and store and retrieve data needed to manage and audit the Medicaid program. Alaska's MMIS was implemented more than 20 years ago in 1987, and now new technology and federal requirements dictate the construction of a new system. The process to design, build and operate Alaska's new MMIS began in 2006 with release by DHCS of a Request for Proposal (RFP), and the resulting contract was awarded in 2007 to Affiliated Computer Services, Inc. (ACS). The new system currently under development is known as the Alaska Medicaid Health Enterprise. It expected to be operational by the fall of 2011.

- RPMS (Resource and Patient Management System): an information management system administered by the U.S. Indian Health Service that includes clinical, business practice, and administrative information management applications and is in use in most health care facilities within the IHS delivery system. In addition to a number of organizations within the Alaska Tribal Health System, the Alaska Division of Public Health's Public Health Nursing Section uses RPMS as the EHR/HIE for the state's public health centers.

- AKAIMS (the Alaska Automated Information Management System): a state government administered web-based management information system and clinical documentation tool for the state's behavioral health provider grantees. AKAIMS provides an EHR function in addition to supporting state and federal data reporting requirements. Behavioral health providers with their own clinical information systems are able to interface electronically to a data repository to allow compliance with state and federal reporting requirements.

- Several public health monitoring and population health protection systems: Disease tracking, biosurveillance and epidemiological investigations, and immunization monitoring are some of the governmental public health functions supported by information management systems. Systems currently in use by the Division of Public Health in DHSS include AK-STARS (infectious disease reporting system and database), VacTrAK (vaccine registry), the Alaska Cancer Registry, the Alaska Birth Defects Registry, and the Alaska Trauma Registry.

Financing currently supporting EHR/HIE development in Alaska includes:

- $10.4 million awarded by the Federal Communication Commission (FCC) Rural Health Care Pilot Program to the Alaska Native Tribal Health Consortium (on behalf of the private/public partnership now represented by AeHN) at the beginning of 2008 to unify electronic health care networks throughout the state and enable connectivity between rural and urban providers within Alaska and to the Lower 48. The FCC funds are supporting the design and construction of a statewide broadband network to facilitate exchange of health information, and to support telemedicine services, video conferencing, and voice-over-internet applications. The Alaska Legislature provided $500,000 in FY 09 through a capital appropriation to provide required matching funds in support of this project, and the Alaska Federal Health Care Partnership provided an additional $500,000 in matching funds.

5012

- $300,000 from ONC to assess Alaska privacy and security laws, and subsequently an additional $300,000 to develop policies and procedures for the secure and private exchange of health information. Alaska is one of the eight original member states in the Health Information Security and Privacy Collaboration (HISPC), which has been working together to develop inter-organizational privacy agreements. See the Privacy and Security section below for more information on this project.

- $2.5 million in capital funding was appropriated by the Alaska Legislature for the Alaska Primary Care Association in FY 2009 to support development of the Alaska Community Health Integrated Network, a Wide Area Network for Community Health Centers in Alaska to support development and sharing of electronic health records, practice management software, videoconferencing and telehealth applications.

Recommendation D2a: The Commission recommends that the Governor direct the Department of Health & Social Services to explore options for assisting providers (particularly smaller primary care practices and individual primary care providers) with adoption of electronic health record systems.

Recommendation D2b: The Commission recommends that the Governor ensure Alaska's statewide health information exchange supports providers who have not yet adopted their own electronic health record system by facilitating identification and purchase of systems that are interoperable with the state exchange.

Recommendation D2c: The Commission recommends that the Governor ensure that HIT is utilized to protect the public's health. Alaska's health information exchange should connect with electronic public health reporting systems to enable real-time disease reporting and rapid identification of public health threats.

Recommendation D2d: The Commission recommends that the Governor ensure that data available through the statewide health information exchange is utilized to identify opportunities for administrative efficiencies, coordination and optimization of care, and health care quality and safety improvement.

Recommendation D2e: The Commission recommends that the 2010 Alaska Health Care Commission track the development of the Alaska Statewide Health Information Exchange, Alaska's new Medicaid Management Information System (MMIS), and the use of ARRA funds for electronic health record deployment; and the Commission should continue to identify current issues, policy choices and recommendations based on these developments.

5013

b) Privacy and Security

Finding D2c: Alaskans are concerned about the privacy of their personal health information. Progress has been made by the federal government to develop national health information security and privacy protection standards, and Alaskans have participated in these efforts, but more work remains to be done.

For EHR and HIE efforts to be successful consumers and health care providers must trust their information will be kept confidential and secure. An appropriate balance must be struck between protection of individual privacy violations and breaches in system security, and the need to permit appropriate access to information. Policies that are too strict will decrease the value of electronic availability and exchange of information. Policies that are too lax will erode public trust and lead providers to implement restrictions to protect their patients.

Alaska is an original member state of the national Health Information Security and Privacy Collaboration (HISPC), a multi-state collaborative funded by the U.S. Department of Health & Human Services in 2006 to address the privacy and security challenges presented by electronic health information exchange. Governor Murkwoski initially designated the ATAC to be the state's HISPC representative, but a new designee has not been officially named by a Governor since the ATAC sunset in 2007. Alaska ChartLink now incorporated as the Alaska eHealth Network has been filling the role as Alaska's representative to HISPC, providing a coordinated approach to addressing privacy and security issues for Alaska.

In Phase I of the HISPC Privacy and Security Solutions project an assessment of the current privacy and security landscape in Alaska was completed. The assessment included an intensive investigation of current community practices and the legal environment. AeHN facilitated discussions with 250 Alaskan providers and consumers from across the state to identify security and privacy issues related to data sharing, and provided that information to the federal team working on national policy. Since that time AeHN participated representing Alaska on a multi-state collaborative that developed a set of standardized data sharing agreements and policies for the exchange of protected health information between private health entities, and between public health agencies. Other standardized policies and procedures developed under Phase III of HISPC include, a Privacy and Confidentiality Policy, a Policy and Procedure for Addressing Breaches of Confidentiality, an Identification and Authorization Policy, a Provider Participation Agreement, and a Patient Participation Agreement.

Federal efforts to protect privacy and security of electronic health information continues with the implementation of the HITECH Act, which includes a focus on privacy and security and expands current federal privacy and security protections already in place under HIPAA (the Health Insurance Portability and Accountability Act). At the state level, SB 133 requires the HIE State Designated Entity to adopt an opt-out provision which will allow individual Alaskans to request removal from the data sharing system. The next step in HIE development for Alaska may include an update of medical records laws to support privacy and security in the emerging electronic environment.

Recommendation D2f: The Commission recommends that the Governor designate a statewide entity with the responsibility for ensuring broad implementation of health information security and privacy protections. The entity should participate in on-going efforts at the national level to identify security and privacy standards, should oversee application of those standards to Alaska's statewide health information exchange, and should identify a process for Alaskan patients to opt out of participation in the health information exchange.

5014

3. Telehealth/Telemedicine

Finding D3a: Alaskans have been particularly innovative in the use of telecommunications technologies as one way to bridge our vast geography and address health care access challenges.

Finding D3b: Barriers to adoption and use of telemedicine include:[7]

- Insufficient telecommunications connectivity in some rural Alaskan communities;
- Inadequate access to training for providers and their staff;
- Medical licensure restrictions across state borders;
- Misalignment of payment systems between costs and benefits.

Telemedicine – literally "medicine across distance" - is the use of medical information exchanged from one site to another via electronic communications to improve patients' health status. The term "telehealth" encompasses a broader definition of remote health care delivery that is not limited to clinical services.[lvii] Alaska has been a leader in the development and utilization of telehealth applications as a mechanism for improving access to care for nearly a century - from a 674 mile dogsled relay to transport desperately needed diphtheria anti-toxin to the residents of Nome in the winter of 1925[8] - to CB radio communication between doctors in regional hospitals and Community Health Aides in village clinics during the 1960s – to remote monitoring of ICU patients in rural community hospitals by critical care specialists in urban medical centers today.

The Alaska Federal Health Care Partnership (AFHCP) was founded in 1995 to support collaborative efforts among federal health care providers, including shared training opportunities, service contracts, and technology. The Partnership includes the Department of Defense (Air Force 3rd Medical Group, Bassett Army Hospital), Veteran's Administration (Alaska Regional Office), US Coast Guard, Indian Health Service, and tribal health organizations. The Partnership has launched a number of telehealth initiatives over the years for beneficiaries of their federal programs, including a home telehealth monitoring and care coordination program, a teleradiology project, and a telebehavioral health initiative.

The AFHCP created the Alaska Federal Health Care Access Network (AFHCAN) in 1998. AFHCAN is federally funded and operated by the Alaska Native Tribal Health Consortium. It provides telehealth solutions to 248 sites throughout Alaska, including tribal health organizations, Army, Air Force, and Coast Guard sites, and state public health nursing centers.[lviii] They also now serve customers in other states and other countries, including Greenland and Panama. AFHCAN started out with the deployment of store-and-forward applications due to limited availability of broadband connectivity in the state, but has expanded to add video conferencing applications with the increasing access to high-speed lines with greater data capacity.

Other telemedicine programs actively involved in improving access to health care in the state today include the Alaska Rural Telehealth Network, Providence's REACH system (for remote evaluation of stroke) and eICU, the Alaska Psychiatric Institute's Telebehavioral Health Care Services Program, and the Southeast Alaska Regional Health Consortium Telebehavioral Health Program.

---

[7] The order of the bullets in this finding is not meant to imply priority order of significance.

[8] Coordination of the relay effort was achieved through communications by Morse code transmitted over telegraph lines.

5015

An essential telecommunication service necessary for meeting today's telehealth and also HIE/EHR needs is broadband - advanced communications systems capable of providing high-speed transmission of services such as data, voice, and video over the Internet and other networks.[lix] There are 82 communities in Alaska without broadband service, and an additional 31 communities with unknown Internet connectivity levels.[lx] There are currently a number of federally funded programs supporting expansion and subsidies for broadband service in the state, including:

- The Rural Health Care Program of the FCC's Universal Services Fund (USF), administered by the Universal Service Administration Company, which provides health facilities in rural communities with affordable telecommunication services by subsidizing telecom and Internet access charges related to the use of telemedicine and telehealth. The Health Planning and Systems Development Section in the Division of Health Care Services provides technical assistance to rural health clinics across the state to help with the annual USF application process. 240 health clinics in rural Alaska submitted applications to this program in FY 2009.[lxi]

- The Regulatory Commission of Alaska and the Alaska Department of Commerce, Community and Economic Development have provided federally funded grants for a number of years (since 2003) to telecommunications carriers and cable operators to provide broadband Internet service in rural Alaskan communities. The Rural Alaska Broadband Internet Access Grant Program provides up to 75% of the funding required to expand broadband service into rural communities, and subsidizes rates for these services so that they are comparable to those paid by residents of Anchorage, Fairbanks and Juneau for a period of at least two years after expansion project completion.[lxii]

- The American Recovery and Reinvestment Act of 2009 included $7.5 billion to increase broadband access in underserved areas of the country, and also included associated funding to create a nationwide map of broadband availability. The Denali Commission received a federal stimulus grant under this initiative in November 2009 to map broadband access in Alaska down to the census block level. The project will identify availability of wireless, cable, fiber optic and telephone services along with connection speeds, and is expected to be completed by 2012. A number of Alaskan telecommunication companies have already applied for stimulus funds to continue the deployment of broadband to rural Alaska.

Recommendation D3a: The Commission recommends that the Governor and Alaska legislature work with federal and local partners to ensure all Alaskan communities have access to broadband telecommunications infrastructure that provides the connectivity and bandwidth necessary to optimize use of health information technologies.

Recommendation D3b: The Commission recommends that the Governor direct the Alaska Department of Health & Social Services to investigate innovative reimbursement mechanisms for telemedicine-delivered services; test new payment methodologies through Medicaid, and work with other payers to encourage adoption of successful methodologies.

5016

E. Access to Primary Care for Medicare Patients

Finding E(a): Alaska's Medicare-eligible population is growing.

Finding E(b): Medicare patients in some areas of Alaska experience trouble accessing primary care. The communities experiencing the most trouble with access are those with larger populations, notably Anchorage.

Finding E(c): One contributor to the Medicare access problem is an insufficient supply of primary care physicians willing to accept and retain Medicare patients in larger urban centers.

Finding E(d): Health care providers report Medicare's burdensome administrative requirements, onerous audits, and what they find to be insufficient reimbursement rates as the primary reasons for limiting or denying provision of Medicare services.

Finding E(e): Care for Medicare patients is often more complex and time-intensive than for the general patient population.

Finding E(f): Mid-level practitioners are increasingly being used to solve the Medicare access problem.

Finding E(g): Health care providers report Medicare's physician and mid-level practitioner reimbursement schemes are not rational and not reliable.

Finding E(h): Health care providers commonly report that Medicare's audit process designed to weed out fraud and abuse in the system focuses more on identification of billing errors than intentional fraud, incentivizes audit contractors to pursue and penalize providers for unintentional billing errors, and unnecessarily places an onerous administrative and legal burden on providers. The audit process, which appears to physicians to be based on an assumption of guilt, serves as a disincentive for Alaska providers to provide care for Medicare patients.

<u>**Background**</u>

Medicare is the federal government's health insurance program for the elderly (age 65 and older) and disabled. Created by Congress in 1965, it is partially funded with payroll taxes, and is administered by the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health & Human Services. Medicare benefits include:

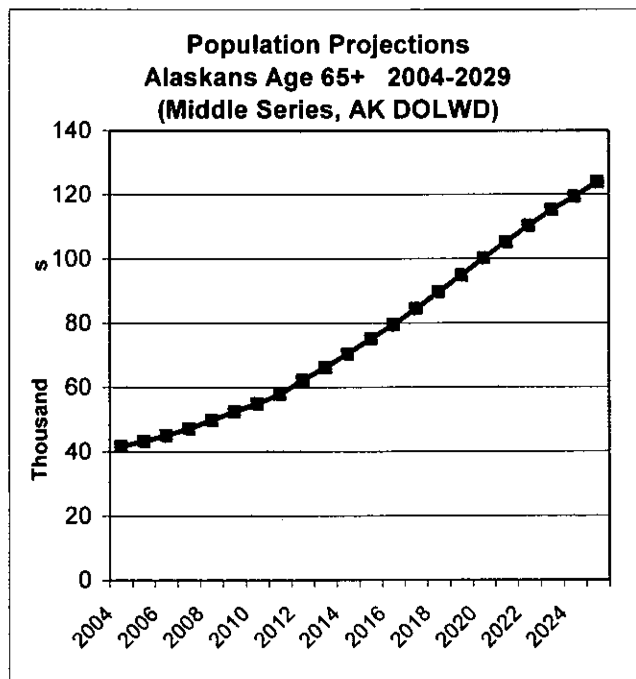
- **Part A (Hospital Insurance)**, covering inpatient hospital stays, some care in skilled nursing facilities, and hospice.
- **Part B (Medical Insurance)**, covering medically necessary services not covered under part A, such as outpatient hospital care, physician services, some preventive services, diagnostic tests, and durable medical equipment.
- **Part C (Medicare Advantage)**, an optional fee-for-service plan that provides Part A and Part B benefits through a private health insurance plan.
- **Part D (Medicare Prescription Drug Plan),** provides prescription drug coverage.

Medicare premiums are highly subsidized by the federal government, and spending for Medicare has grown steadily since its inception with costs doubling every four years between 1966 and 1980. Medicare costs, now at $495 billion, accounted for 19% of all health care expenditures in the U.S. in 2009. One strategy the federal government implements to control soaring costs is limiting the physician payment rate.

The sustainable growth rate (SGR) formula for Medicare was created by Congress in 1997 to limit Medicare growth. The SGR, which is tied to the GDP, triggers reductions in the Medicare physician payment rate when costs rise too steeply – which has been the case each year since the SGR was created. Congress has not had the political will to enforce the reductions however, and has intervened each year to block them. While the statutory payment reductions have not been enforced, the SGR has had the effect of limiting potential payment rate increases. This strategy has not had the intended effect however, as reduced or limited payment rates are offset by increased utilization and total Medicare costs have continued to rise.

Another variable in Medicare physician rate setting are geographic differentials. Alaska has benefited from successful efforts by our congressional delegation to enact legislative provisions to boost the reimbursement rate for Alaskan physicians by increasing Alaska's geographic differential. Effective January 2009 Alaska's Medicare physician reimbursement rate was set permanently in federal law at 29% above the national average.

In 2008 there were 59,435 Alaskan Medicare beneficiaries, approximately 82% of whom were aged 65 or older with the remainder qualifying due to disability. The number of Alaskans aged 65 and older has more than doubled over the past two decades, from 22,095 in 1990 to 49,455 in 2008. That number is projected to nearly triple again by the year 2030 to 134,391.



The Problem

Many Alaskan Medicare beneficiaries, particularly those in more urban communities, report they have trouble finding a physician to take them as a patient. A study conducted by the Institute for Social and Economic Research (ISER) at UAA in 2008 confirmed there are few primary care physicians in Anchorage who will accept new Medicare patients.[lxiii] The researchers found that only 17% of Anchorage primary care physicians accept new Medicare patients compared to 61% nationally.[lxiv]

Driving this problem is the growing demand for Medicare services due to 1) the aging of Alaska's population, and 2) the need for increasingly complex care to treat and manage chronic conditions. As noted above, Alaska is experiencing significant growth in the Medicare eligible population that is expected to continue over the next two decades. The growing number of Medicare beneficiaries is compounded by the amount of extra time and effort it takes to treat a typical Medicare patient. One study found that for every 100 Medicare patients a primary care physician treats, that physician potentially has to interact with 99 other physicians in 53 different practices as they work to coordinate treatment of multiple and complicated health problems.[lxv]

The problem of growing demand is compounded by an inadequate supply of primary care physicians. Physicians report Medicare's low reimbursement rates, about one-third less than what private insurance pays in Alaska, as a primary reason behind decisions to not accept new Medicare patients or opt out of the Medicare system entirely. Other factors playing into these decisions include Medicare's burdensome administrative requirements, and a federal government audit process that is onerous and punitive. If there were more primary care physicians they would be able to spread the Medicare patient load and physician practices might more easily be able to absorb losses from lower reimbursement and increased paperwork.

Potential Solutions

Recognizing that the ability to drive changes in federal policy is limited, the Commission felt the most effective state-based strategy for addressing the Medicare access problem is to increase the supply of primary care providers, following similar recommendations to those specified in Part III.C of this report. The Commission was particularly interested in the opportunity to develop an internal medicine residency program for Alaska. One of the few primary care practices in Anchorage that was accepting new Medicare patients until recently was the Family Medicine Residency Program, but they had to cap the number of seniors they could accept as the elder portion of their patient population had grown to the point that the residents were not able to get the amount of experience with younger populations they needed. An internal medicine residency program would provide a dual benefit by producing more primary care physicians who specialize in treating adults and who are likely to stay in Alaska to practice, and by also creating a new clinical practice that would accept Medicare patients.

The Commission heard from a couple of groups proposing to expand clinical capacity. One group proposed starting a new for-profit primary care practice that would see Medicare patients exclusively, and would be staffed by a physician-led nurse practitioner team. The Commission had reservations regarding the proposed care model, which would limit a patient's ability to be seen for multiple conditions at the same time. The complex care needs of this population are too great and require a high level of coordination. The Commission also felt that a for-profit practice should be able to make the business case to investment partners if the proposal was viable, and that government investment would

5019

not be appropriate. A second group suggested that expansion of the Anchorage Neighborhood Health Center (ANHC) would support the ability to expand the Medicare patient population seen there, but a specific request was not made of the Commission, and the ANHC recently received a sizeable state capital grant ($10 M) to support the planned expansion. The Commission felt that state government strategies for expanding medical clinic capacity are most appropriately targeted at Federally Qualified Health Centers and Rural Health Clinics – which are non-profit safety net providers such as the ANHC.

The Commission determined that it was also necessary to request assistance again from Alaska's congressional delegation with seeking relief from Medicare's inequitable reimbursement rates, burdensome administrative requirements, and onerous audit conditions. There were questions about how the administrative requirements of Medicare compare to Medicaid and other 3rd party insurance providers, and a suggestion was made to investigate that question in order to support the request.

One new program the Commission considered as a potential solution to the Medicare access problem was PACE (Programs of All-Inclusive Care for the Elderly). PACE is a Medicare and Medicaid program that provides community-based care and services for older adults and people over 55 living with disabilities who would otherwise require nursing home level of care. PACE programs are required to provide a comprehensive set of wrap-around integrated medical and social services managed by an interdisciplinary team of health care professionals. Eligible Alaskans on Medicare choosing to participate in this optional program would be guaranteed access to primary care.

Initially started as a Medicare demonstration project in 1978, PACE proved so successful in improving outcomes for families and patients, health care providers, government and other payers, that it has been replicated in 31 states by 69 PACE organizations that serve nearly 18,000 individuals today. An evaluation by the federal government (then HCFA now CMS) conducted during the 1990s that studied the impacts of PACE on a wide variety of outcomes found that it resulted in long-lasting decreases in nurse visits to the home, inpatient hospital admissions, inpatient hospital days, and nursing home days. In addition, this study found that PACE enrollees lived longer and spent more days in the community than did non-PACE participants in a similar demographic control group.

The estimated number of Alaskans dually-eligible for both Medicare and Medicaid living in the Municipality of Anchorage is 7,539.[lxvi] An estimated 10% may be eligible to participate in a PACE program. Two Anchorage health care organizations, Providence and Southcentral Foundation, have expressed some interest in potentially developing a PACE program in the community.

States may elect PACE as an optional Medicaid benefit through the Medicaid State Plan Amendment process. Approval of a State Plan Amendment by CMS does not obligate the state to implement a PACE program, but provides the option and positions the department and interested providers to move forward with program development.

Because only the frail elderly and disabled are eligible to participate in PACE, and those individuals are likely to be receiving higher levels of specialty care already, eligible participants are not as likely to be among those Medicare patients experiencing problems with access to health care. Developing a PACE program in Alaska would most likely make only a very small impact on the Medicare access problem, but because of the many other benefits a PACE program would offer eligible Alaskans, the Commission determined the state should facilitate development of this program.

5020

Recommendation E(a): The Commission recommends that the Governor and Alaska Legislature improve the supply of primary care providers in order to enable increased access to care for Medicare patients by:

- Supporting a student loan repayment and financial incentive program for primary care providers practicing in Alaska and serving Medicare patients (and including other service requirements deemed necessary to meet the needs of the underserved);
- Supporting development of a primary care internal medicine residency program;
- Supporting WWAMI program expansion as resources allow; and,
- Supporting mid-level practitioner development.

Recommendation E(b): The Commission recommends that the Governor and Alaska Legislature explore strategies for removing barriers to the development of designated Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), facilitating development through state application for federal shortage designations for Medicare populations and supporting planning for new and expanded FQHCs/RHCs.

Recommendation E(c): The Commission recommends that the Governor and Alaska Legislature work with Alaska's Congressional delegation to improve Medicare's reimbursement scheme to ensure the sustainability of care to Medicare patients.

Recommendation E(d): The Commission recommends that the Governor and Alaska Legislature ask Alaska's congressional delegation to pursue federal policies to redesign the Medicare audit process so that it focuses more on identification and prosecution of fraudulent practices than on billing errors. Reported financial incentives for audit contractors should be eliminated and replaced with performance measures. Concern over billing errors should be addressed through provider training and performance reports, not through audit processes designed to weed out fraud and abuse.

Recommendation E(e): The Commission recommends that the Governor and Alaska Legislature commission an analysis comparing Medicare to Medicaid and private insurance administrative requirements, including recommendations for streamlining public insurance administrative procedures to make them more user-friendly.

Recommendation E(f): The Commission recommends that the Governor facilitate development of PACE programs in Alaska by directing the Department of Health & Social Services to submit a State Plan Amendment to the U.S. Centers for Medicare and Medicaid Services (CMS) to add PACE as a Medicaid service, and to identify and remove barriers to development of PACE programs.

5021

PART IV: Health Care System Transformation Elements

A number of issues and potential strategies were identified by the Commission as important to a comprehensive approach to health care reform for Alaska. Potential elements of health care system transformation identified for future study are described briefly in this part of the report, and a suggested approach for planning related to these issues is provided in Part V.

A. Access to Health Care

1. Health Insurance Coverage

Because federal health care reform efforts underway during 2009 have focused primarily on increasing health insurance coverage, the Commission decided it would not be prudent to evaluate state options for expanding coverage until Congress completes their work.

Future study of access to health care coverage will require analysis and understanding of:

- **National reforms adopted in and for Alaska.** Strategies for increasing health insurance coverage in pending federal legislation include creation of a new government-administered insurance plan ("public option"), creation of health insurance exchanges, creation of non-profit member-operated health insurance cooperatives ("Co-ops"), expansion of Medicaid eligibility, individual and employer mandates requiring purchase of insurance, subsidies for low income individuals to purchase insurance, and insurance market reforms. If federal legislation passes, future state health commission work should include analyzing options and making recommendations for state policy direction needed to implement federal reforms at the state level. At a minimum, the work of this or a future commission to consider health insurance coverage expansion will require study of the impact of national reforms in Alaska.

- **Alaska's private insurance market.** Only 23% of Alaskans have health insurance purchased on the private market. An additional 32% have insurance through their employers' self-insured plan (exempt from state regulation under federal law (ERISA)). The remaining 45% of Alaskans have insurance through a public plan (Medicaid/Medicare), have health care provided by the military or the tribal health system, or are uninsured. Consideration of insurance market reform strategies will require study of the potential impact on Alaska's health care system since less than a quarter of the population is covered by the state-regulated insurance market.[lxvii]

- **The challenge small businesses face in obtaining insurance coverage for their employees.** Most of Alaska's smallest businesses (those with fewer than 10 employees) cannot afford to offer health benefits to their employees. 52% of uninsured Alaskans are employed adults (9% are unemployed adults, and the remainders are children and others not in the work force). Those studying this issue in the future can benefit from the work conducted by the Department of Health & Social Services on health insurance coverage in Alaska during 2005-2007 under a grant from the Robert Wood Johnson Foundation. One of the findings from that study is the importance of understanding the seasonal nature of Alaska's workforce. Other results from that study were obtained from surveys and focus groups conducted with Alaska business owners regarding their ability to obtain insurance for their employees and the barriers they face.

5022

2. Health Care Workforce Development

Alaskans' access to quality health care is dependent on the availability of a well trained health care workforce with sufficient numbers of workers in the right occupations and the right locations to meet the needs of the population. The focus by the Commission during their first year on the physician workforce was just a first small step and only one component in what should be a comprehensive and sustained approach to development and implementation of a health care workforce strategy for Alaska. As noted in Part III, Section C of this report, there are numerous organizations collaborating on various aspects of health care workforce planning and development. Future study and improvement of Alaska's health care workforce cannot occur in isolation but must consider and build on these other efforts, and a comprehensive approach to addressing Alaska's health care workforce needs must include strategies to address:

- On-going assessment of Alaska's health care workforce size, composition and distribution
- Workforce innovations required for responding to transformation in patient care models
- Training needs along the continuum of K12 education through graduate medical education and including on-the-job training
- Improved recruitment and retention of health care workers
- Sustainability of health care workforce planning, development and support infrastructure

3. Physical Health Care Services

Individual services and systems of care within the health care delivery system need to be better understood and considered as part of future work to improve the system. During this year the Commission heard specific concerns about access to dental services, and the condition of Alaska's Trauma System. Those two areas could be a starting point for delving deeper into analysis of Alaska's health care system. Additional areas might include pharmacy, vision care, and preventive services.

4. Behavioral Health & Long Term Care

The Commission noted that any effort to transform Alaska's health care system should consider the system from the consumer's perspective. From the individual health care consumer's perspective their behavioral health and long term care needs cannot be separated from their physical health needs. For that reason alone future health care planning and policy development efforts need to consider these other systems and services, and another important factor necessitating their inclusion is that behavioral health and long term care are significant cost drivers in the increasing cost of health care.

The Commission did not attempt in their first year to address issues related specifically to the funding and delivery of behavioral health and long term care in Alaska. In part because there are other groups working on planning for behavioral health and long term care improvement, such as the Alaska Mental Health Trust Authority, the Alaska Mental Health Board, the Advisory Board on Alcoholism and Drug Abuse, the Alaska Commission on Aging, and the Department of Health & Social Services, while there is no other entity charged with examining the broader health care delivery system. Future work must not leave these sectors out however. Recent plans, such as the Comprehensive Integrated Mental Health Plan and the State Plan for Long Term Care Services, should be reviewed.

5023

If this or a future Commission wishes to foster innovation in transforming Alaska's health care system to better support a healthier Alaskan population they will need to coordinate with the behavioral health and long term care planning entities to ensure they are taking an integrated and holistic approach while not duplicating efforts.

B. Cost & Quality (Value)

The trend in state and federal health care reform efforts has been moving away from more simplistic cost control measures, such as caps on fees, towards a focus on improved value, thus most strategies to address the cost of care cannot be separated from strategies to improve quality.

1. Understanding the Cost of Care in Alaska

Information presented in Part II of this report indicates costs are higher in Alaska compared to other states, but a thorough understanding of the underlying reasons why costs vary is required prior to making specific policy recommendations to address the problem. Is it due to an insufficient supply of providers and insufficient competition between providers? Is there higher utilization of medical services in our state, and if so is it due to waste in the system or due to a higher prevalence of complex health conditions? How does fragmentation of the health care delivery system affect overall costs? Are payers unable or unwilling to negotiate the lowest possible price for services?

An important aspect of understanding variations in cost and underlying cost drivers is understanding how cost shifting occurs when one payer or set of payers underpays a health care provider (pays less than the costs the provider incurs to deliver the service). Prices charged are typically higher than the cost of care (and beyond profit margin) to make up for capped reimbursement by some providers, low fees negotiated with contract payers, and uncompensated care provided for uninsured and underinsured individuals who are not able to pay. Further analysis of cost drivers and cost shifting is needed to support development and implementation of successful strategies to control cost and improve value.

2. Primary Care Innovation

One of the Commission's central strategies for improving health care cost and quality is innovation in the patient care model at the primary care level. A lot of work must be done to implement the Commission's recommendation (#A2a) in support of primary care innovation. A collaborative effort with the primary care provider community and the Alaska Department of Health & Social Services needs to be undertaken to define the care model in more specificity beyond the identified characteristics, performance standards and measures must be developed, required internal organization supports for providers must be identified (such as information technology, knowledge management strategies for evidence-based practice, and development of effective teams), as well as requirements for a supportive payment and regulatory environment.

3. Value-Driven Purchasing

The fee-for-service approach to purchasing health care drives up the overall cost of care by incentivizing the provision of more services, and more costly services, while offering no incentives for improved quality or efficiency. "Value-driven purchasing" (VDP) identifies and implements purchasing practices intended to improve the value of health care services by holding providers accountable for both the quality and cost of services delivered to patients. VDP strategies include establishing standardized quality measures and reporting requirements, reporting of health care price and quality information, and use of direct incentives or disincentives to providers and consumers to promote improved quality of care and health outcomes as well as greater value for dollars spent. There are a number of strategies that could be studied to start Alaska on the road to value-driven purchasing.

a) Leverage State Purchasing Power
State government in Alaska represents a substantial payer for health care services. The state spent over $1.5 billion last year in Medicaid expenditures, payment of state employee and retiree claims (not counting benefit credits paid to union health trusts), payment of state employee Workers' Compensation medical claims, and purchase of health care services for incarcerated offenders in the state correctional system. Collaboration between these state programs to develop shared value-driven purchasing strategies could provide significant market-share leverage for improving health care quality and cost in this state. This is an area that warrants additional study and potential recommendations.

b) Provider/Payer Cost Sharing Demonstration Projects
Because of the way the fee-for-service payment system is structured, health care providers may face situations where implementing measures that will reduce overall costs in the system and save money for the payer will actually increase the cost the provider incurs while reducing their revenue. This may be particularly true of hospitals, when investing in a costly new technology will improve patient outcomes and reduce hospital bed days. Future work on this issue could involve working with Alaska's hospitals to determine the extent to which these types of situations might delay innovation (and thereby delay improved patient outcomes and overall system costs), and consider the advisability of cost sharing demonstration projects.

c) Cost and Quality Transparency
Consumers need to know the price and quality of their health care options in order to make informed decisions and support their ability to participate more fully in their care. Empowering consumers with information not only supports improved decision-making on their part, but drives the entire system to provide better care for less money. An infrastructure to support transparency of health care cost and quality for Alaskan consumers, compiling and analyzing data on pricing and quality measures for physician services and hospital care and producing public information through an accessible and understandable reporting mechanism, does not currently exist.

Creating a system to provide transparency is not as simple as it may sound however. Pricing of individual services might be misleading without a more comprehensive picture of the total cost of care for a given condition and the expected outcomes of various care options. And transparency to support a market-based approach is not the only solution to the health care cost and quality problem. Health care is different than other goods and services, and all the conditions required for a competitive market do not exist in the health care market. Consumers do not fully control all of their health care dollars, and they cannot participate fully in all aspects of clinical decision-making about their care. In addition, many

5025

health care decisions are made for consumers in urgent or emergent situations when the consumer is severely ill, injured or under too much emotional stress to participate in their care decisions.

The potential benefits of and barriers to developing an information system to support consumer choice need to be fully understood as part of a strategic approach to making the system more transparent in order to improve quality and control costs.

d) Evidence-Based Medicine

The Dartmouth Atlas of Health Care[lxviii] and numerous other studies have consistently demonstrated wide variations in practice patterns and use of health care resources across geographic regions of the United States – the tests and treatment a patient with a given health condition receives varies based on the location in the country where the care is received. The waste in the health care system due to misused medical resources is estimated to represent as much as 30% of health care spending. Moreover, research has documented those regions of the country where there is overuse of health care resources and resulting higher spending actually have lower quality of care and worse health outcomes.[lxix lxx lxxi]

Decreasing the variability in health care services and spending requires the application of evidence-based medicine, which seeks to improve the decision-making of individual health care providers as they make diagnosis and treatment decisions about individual patients, to engage the patient in making informed decisions about their care, and to improve the policies of payers and health care delivery organizations. Evidence-based medicine is defined as a set of principles and methods intended to ensure that to the greatest extent possible, population-based policies and individual medical decisions are consistent with evidence of effectiveness and benefit." [lxxii] The core idea behind evidence-based medicine is that the right care must be provided to the right patient in the right place at the right time and at the right price. And that all the determinations about what constitute these "right" decisions are based on the best available scientific evidence.

Improving evidence-based medical decision making may be the key to increasing value in health care – decreasing cost and increasing quality. There are a number of roles public policy can play in supporting and driving the use of evidence-based medicine. One state government example comes from Washington state, which has enacted a set of statutory provisions authorizing the state's public payers (Medicaid, Workers' Compensation, state government employee benefit plans, and the corrections department) to use evidence-based methods to improving quality of care, reduce wasteful use of health care resources, and determine what benefits should be covered.[lxxiii] Continuing work to improve value must include identification of the best approaches to expanding the application of evidence-based medicine in Alaska

e) Payment Reform[lxxiv]

The current fee-for-service payment system rewards health care providers for volume, not value. The financial incentives in this system lie entirely in the provision of more health care services and the sale of more health care commodities regardless of the quality of care provided, and may actually serve as a disincentive to creating health. Movement away from fee-for-service to new payment methodologies will require capacity for electronic information management, and therefore development and implementation of health information technology.

Reform of payment methodologies to reward quality can evolve in an incremental approach that can be initially pilot tested and gradually implemented to prevent harm to health care providers and their

5026

business interests, and in a way that supports providers as they transform the health care system over time. Research is required to guide implementation of new payment methods, and careful evaluation is required to assess cost-effectiveness, impact on quality of care and patient outcomes, and identification of unintended consequences. Following are three value-driven payment strategies this or a future Commission might choose to analyze and for which they might develop policy recommendations.

- ***Pay-for-Performance***
  A pay-for-performance program provides a bonus payment for health care providers meeting certain standards of quality on a predetermined set of clinical measures. One approach would provide incentives for improvement over baseline performance as well. One challenge to developing a pay-for-performance program in Alaska will be the small size of many of Alaska's hospitals and the lack of any large primary care group practices, as sufficient patient volume to provide statistically valid measurement of quality is required.

- ***Patient-Centered Primary Care Enhanced Service Payment***
  The Commission in this report recommends the state of Alaska aggressively pursue development of innovative models of patient-centered primary care. Implementation of this recommendation will require further work to develop a detailed definition including the criteria a practice will have to meet in order to be deemed as meeting the new standard of care. The level and source of funding as well as the reimbursement mechanism for enhanced payment to support these new patient care models will need to be identified as well. As Medicaid is the state's largest payer, the Department of Health & Social Services is the logical entity to begin this next level of planning in support of the development of a Medicaid pilot program. DHSS might look to partner with other state agency health care purchasers and also private health insurance companies operating in Alaska to expand the reach of such a program.
- ***Bundled Payment Systems***
  Payment bundling provides a global fee for a specified set of services. Development of this payment system could be evolved over time, starting with bundling of a limited set of hospital services related to certain acute care episodes (related to certain illness diagnoses for a specified period of time – for example, coronary artery bypass surgery and extending 30 days beyond discharge); and expanding over time to include physician inpatient care and post-acute care. A particular challenge to implementing this strategy in Alaska is the lack of integrated care networks here. Hospitals would initially have to contract with physicians and other service providers required to deliver the suite of services potentially needed to treat the bundled diagnoses or procedures. Other challenges involve the lack of sophistication of information and accounting systems of many of Alaska's smaller hospitals, the need to identify standards to ensure cost reduction does not negatively impact quality, mechanisms for avoiding "cherry-picking" of patients with the potential for fewer complications, and ways to reduce exposure to risk for providers.

f) Reporting and Non-Payment for "Never Events" and other Health Care Acquired Conditions
"Never events", as suggested by the term, are occurrences of medical errors that should never happen. The National Quality Forum maintains a list of 28 Serious Reportable Adverse Events considered "never events." Examples include surgery performed on the wrong body part, surgery performed on the wrong patient, leaving a foreign object in a surgical patient, patient death or disability due to use of a contaminated device, and patient death or disability due to a medication error.

5027

CMS enacted a policy on July 31, 2008 to deny Medicare payment for medical services provided by a hospital for care required as the result of a never event. The new CMS policy also authorized State Medicaid Directors to enact this same policy in their state Medicaid program. A number of private insurance companies also have non-payment for never event policies.

Health care acquired infections, such as MRSA and C.Diff, are not included on the "never event" list; however the U.S. Centers for Disease Control and Prevention estimate that, in hospitals alone, these infections account for 1.7 million infections and result in 99,000 deaths annually. Many more are estimated to occur in other health care settings such as day-surgery clinics.

Required public reporting of these conditions can serve as an incentive for health care providers to increase efforts to prevent these problems, and also provide the public health system with information needed to assist health care providers with prevention techniques. Statutorily mandated health care acquired conditions reporting has been considered by the Alaska legislature in the past, and a plan for developing a health care acquired conditions reporting system is currently under development by the Alaska Division of Public Health in the Department of Health & Social Services.

Future work on this issue could include an assessment of the incidence of medical errors in Alaska, the extent to which never event payment policies have been adopted in Alaska, and if there are opportunities for expanded and improved use of this policy as well as other strategies for reducing the occurrence of medical errors and improving patient safety.

4. Fraud & Abuse Control

The National Health Care Anti-Fraud Association, a public-private partnership of insurance company and government health care payers, estimates that a minimum of 3% of national health care expenditures is lost to fraud and abuse. Health care fraud - intentional misrepresentation or deception for the purpose of receiving higher reimbursement – can take many forms. One of the more common forms is for criminals to obtain patient information and pose as fictitious doctors, billing public and private insurance plans for service that was never rendered. The increased cost to payers for these fraudulent claims translates into increased premiums for private insurance holders and increased taxes to support Medicaid and Medicare.

It is difficult to determine the actual extent and impact of fraud and abuse in the health care sector – one cannot survey the criminals to determine how much they are making – but future work on this issue could include analysis of the current systems in place for fraud and abuse detection, investigation and prosecution for Alaska's Medicaid program and utilized by the insurance industry here. This analysis could include a look at current capacity, including funding and staffing levels, current practices, and also criminal penalties in state statute.

5. Tort Reform

Costs associated with medical liability (medical malpractice insurance premium costs, malpractice awards, and the practice of defensive medicine) are believed to be one driver of increasing health care costs, and reform of related civil justice laws has been one cost control strategy suggested in health care reform debates at the federal and at state levels. Estimates of potential savings from medical malpractice reform vary, but two very recent studies predict measurable savings. The Congressional Budget Office, in an October 2009 study for Senator Hatch, pegs the potential cost savings at 0.5% of

5028

total national health care spending. The National Bureau of Economic Research estimates, in a September 2009 study, that three different types of medical tort reform could reduce premiums for employer-sponsored health insurance plans by 1 to 2% each.

This is one strategy that has been addressed at least partially in Alaska. In 2005 the Alaska Legislature passed the Alaska Medical Injury Compensation Reform Act, limiting noneconomic damage awards for personal injury resulting from health care services to $250,000 (limit increases to $400,000 for wrongful death or injury resulting in permanent physical impairment that is more than 70% disabling). Alaska's court system also plays a role – discouraging frivolous lawsuits through Alaska Civil Rule 82, which requires the losing party to tort litigation to pay attorney fees and court costs to the prevailing party.

Future work related to this issue could include evaluation of the impact of the medical liability reform law passed in 2005 and study of additional strategies, such as regulation of medical malpractice insurance providers and development of programs to encourage alternatives to litigation.

6. Process Innovation Strategies

One other factor driving higher cost and reduced quality is operational inefficiency in the delivery of health care services. Inefficiencies associated with both direct medical services and those associated with administrative and logistical support services can benefit from systematic efforts to streamline work processes and drive out waste. [lxxv] Health care managers have been successfully applying process-innovation strategies that are popular in the manufacturing industry to improve efficiency and quality of their services. Examples of problems tackled range from reducing the number of mistakes in invoices, to reducing the number of patients requiring intravenous antibiotics, to shortening the length of stay in chronic obstructive pulmonary disease patients.[lxxvi]

Two popular process-innovation strategies in use in health care systems today are Lean Thinking and Six Sigma. Lean Thinking (also known as Toyota Production System (TPS), or simply "Lean") came out of the Japanese auto industry. Lean provides an integrated set of tools, principles, and practices focused on waste reduction and synchronizing work flow, utilizing an extended process flowchart as a tool for identifying non-value-added steps and bottlenecks. Six Sigma was originally introduced by Motorola as a method for driving company-wide quality improvement. It provides an organizational structure of project leaders and project owners, and a problem-solving strategy similar to medical practice – information gathering followed by careful diagnosis, application of "treatment," and follow-up to determine efficacy.

Future work to improve efficiency in health care service delivery processes in Alaska could include analysis of the extent to which manufacturing industry process innovation strategies are being applied by Alaska's major health care providers. Options and opportunities for fostering the transformation in the culture of Alaska's health care businesses to focus on continuous improvement could be identified. Also methods for spreading the adoption of process innovation strategies, for example by supporting forums for sharing best practices and providing technical assistance, could be considered.

5029

C. Prevention

1. Public Health: Population-Based Health Promotion & Disease/Injury Prevention

Many diseases and injuries are preventable. Simple, non-medical, individual approaches to prevention such as hand washing, eating healthy foods, exercising, not smoking, drinking alcohol in moderation if at all, and wearing bicycle helmets and life jackets go a long way towards avoiding illness and injury. Individuals acting alone cannot create all of the conditions necessary to ensure good health however.[lxxvii]

Since antiquity societal leaders recognized the importance of communal action to protect and promote the health of community members. Some of the rules described in the Old Testament were intended to prevent illness in the community from contaminated food or to prevent the spread of communicable disease. Today governments act to ensure safe food and water, maintain sanitation systems, provide vaccinations, deliver maternal and child health services, enact public polices such as seat belt laws, and operate programs such as tobacco control in order to optimize the health of the population under their jurisdiction.

Public health is defined as "what society does collectively to assure the conditions for people to be healthy."[lxxviii] There are two main characteristics of public health – 1) it is concerned with prevention rather than cure, and 2) it is concerned with population-level rather than individual-level health issues. Public health protects and improves communities by preventing epidemics and the spread of disease, promoting healthy lifestyles for children and families, protecting against hazards in homes, work sites, communities and the environment, assuring high quality health care services, and preparing for and responding to emergencies.

The significant improvements in health status in the United States during the 20th century – such as the increase in life expectancy from 45 years in 1900 to over 75 years in 2000 – are primarily due to public health interventions. Only five years of this 30 year increase in the average lifespan of Americans is attributable to the aggregate effects of improvements in medical care.[lxxix] 25 years of this gain are due to advances in public health. [lxxx] Attainment of the Commission's vision to transform Alaska's health care system so it focuses on creating health and not simply treating illness and injury requires an understanding of and support for Alaska's public health system.

A report by the Institute of Medicine published in 2002 found that the nation's governmental public health infrastructure had been neglected, and an overhaul of its components (e.g., workforce, laboratories, public health law) was needed to ensure quality of services and optimal performance. Governmental public health agencies are the backbone of the public health system but do not work alone. Other organizations and sectors of society – including the health care delivery system, communities, business, the media, and academia are important partners in the public health system.[lxxxi]

In Alaska the state legislature is charged under the constitution to "provide for the promotion and protection of public health" (Constitution of the State of Alaska, Article VII, Section 4). The legislature has paid attention to the needs of Alaska's public health infrastructure over the years. For example, by funding construction of two new technologically modern public health laboratories during the past 10 years, and by passing comprehensive reform of the state's public health laws as they relate to public health functions (AS 18.15) in 2005. But a review of Alaska's public health system has not been conducted in over a decade, and the capacity of the system to meet the need for population-based health promotion and disease and injury prevention is not well understood.

5030

Future work by the Commission could include analyzing the adequacy of Alaska's public health infrastructure, and developing policy recommendations to ensure the state's public health system is sufficiently supported to deliver population-based disease and injury prevention and health promotion services.

2. Safe Water and Sanitation Systems

Safe water and waste water systems are essential to the prevention of disease. At the turn of the last century infectious diseases such as typhoid and cholera were the leading cause of death in the United States. Today many of those diseases have been virtually eliminated - in large part due to modern sanitation systems.

The association between safe drinking water and gastrointestinal illness has long been recognized, but a recent study conducted in Alaska by the CDC Arctic Investigation Program found a link between in-home water service and higher rates of respiratory and skin infections as well. The CDC team noted as "particularly disturbing" their finding that villages in one region with low in-home water service (less than 10% of homes served) experienced a respiratory infection hospitalization rate that was five-times higher than that of the general U.S. population, and a pneumonia hospitalization rate among infants that was 11-times higher.[lxxxii] This study demonstrates the importance of having safe water that is not only available in the local community for drinking, but is also readily and easily available in the home for hygiene use.

Nearly every home in the U.S. – 99.4% according to the 2000 U.S. Census – now has running water and flush toilets. Alaska ranks last in the nation, with 93.7% of Alaska homes having these basic services. In rural Alaska however, only 77% of homes have modern sanitation facilities.[lxxxiii]

Support for improved sanitation systems in rural Alaska has been underway for some time, beginning with efforts of the Indian Health Service in the 1960s. In 1972 the state of Alaska enacted the Village Safe Water Act and began contributing state resources for construction of water projects. In 1994 the Rural and Native Sanitation Development Program, jointly funded by the state and federal government, was implemented. When this program began only 37% of rural Alaska households had adequate sanitation facilities. Today the Alaska Department of Environmental Conservation administers the Village Safe Water Program in partnership with the Alaska Native Tribal Health Consortium, providing state and federal funds totaling approximately $60 million annually as well as technical assistance to Alaska's smallest communities to design and construct water and wastewater systems.

Future work on the part of the Commission could include developing an understanding of the state's plan for bringing sustainable and appropriate safe water and wastewater systems to every Alaskan community, and developing policy recommendations to ensure the state's adherence to that plan.

5031

3. Employee Health Risk Management

Health care spending on individuals with one chronic condition is more than twice that for people without such conditions, and spending is nearly 15 times greater on individuals with five chronic conditions. Employers and their insurance plans are increasingly working to change enrollees' health behaviors as a means of achieving cost savings.

Health Risk Management Programs offer incentives such as lower premiums or contributions to HSAs for employees who agree to participate in the program. These programs generally require a health risk assessment and health improvement goals supported by lifestyle management tools, health coaches, and disease management plans.

Health Risk Management Programs have demonstrated effectiveness in reducing the rate of increase in health insurance premiums over time. The City and Borough of Juneau has a long standing program (since 1989), and over the years their premium rate increases have consistently been below the regional average. Safeway has flat-lined employee health benefit cost increases for four years straight since implementation of such a program. Providence Alaska, which is self-insured, launched a program in November of this year based on findings that the program will reduce costs.

While this strategy has primarily been about cost control, it demonstrates how a focus on prevention can work to make individual Alaskans healthier while achieving the added benefit of lowered costs.

5032

PART V: 2010-2014 Strategic Plan for Transforming Alaska's Health Care System

A. 5-Year Planning Framework

The Commission's recommended five-year strategic planning framework is comprised of six essential elements:

I. **Develop a Vision of Alaska's Transformed Health Care System**
Accomplished in 2009 – Documented in Part I of this Report.

II. **Accurately Describe Alaska's Current Health Care System**
Begun in 2009 – Documented in Part II and Appendix A of this Report.
Next Steps:
   1. Identify gaps in knowledge (e.g., why are prices for health care services higher in Alaska?)
   2. Fill in the gaps and complete the picture
   3. Analyze impact of national health care reform on Alaska

III. **Build the Foundation for a Transformed Health Care System**
   - **Statewide Leadership**
   - **Workforce Development**
   - **Health Information Technology**

Begun in 2009 – Documented in Part III of this Report.
Next Steps:
   1. Track implementation of 2009 recommendations
   2. Implement 2009 recommendations requiring Commission action
   3. Continue analysis and identification of solutions for further recommendations

IV. **Design Elements Required for Transformation of Alaska's Health Care System**
Begun in 2009 – Documented in Part III and IV of this Report.
Next Steps:
   1. Continue working on design elements for primary care innovation and healthy lifestyles
   2. Prioritize additional potential strategies (identified in Part IV) for analysis and recommendations

V. **Measure Progress of Health Care Transformation**
First Steps:
   1. Work with system stakeholders to identify and develop consensus on indicators to measure progress (see potential indicator set below).
   2. Develop data collection and analysis capacity for indicators that are not currently measurable.
   3. Report progress on an annual basis to Governor, Legislature, and the general public.

VI. **Communicate with the Public & Engage Stakeholders**
Begun in 2009 – Commission Public Communication Plan included in Appendix D of this Report.
Next Steps: Implement Commission Public Communication Plan

5033

Potential Health Care System Transformation Measures

1. Increase Access
    - Percent of Alaskans insured
    - Percent of Alaskans who have a specific source of on-going care
    - *Measure of insurance affordability*
    - *Indicator of workforce supply*
2. Control Costs
    - Annual growth rate in total health system expenditures in Alaska
    - Annual growth rate in Alaska's Medicaid expenditures
    - Impact on Alaska's state budget: new spending, net savings, new revenues
    - *Measure of provider revenues based on value*
3. Safe, High-Quality Care
    - Percent of population receiving key preventive services or screenings
    - Percent of Alaskans with chronic conditions controlled
    - Percent reduction in gap between benchmark and actual levels of quality
    - Percent reduction in gap between benchmark and actual levels of safety
4. Focus on Prevention
    - Percent of Alaskan communities with safe water and wastewater systems
    - Percent of Alaskans reporting health risks
        - Percent of Alaskans who smoke cigarettes
        - Percent of Alaskans who are obese
        - Percent of Alaskans who are binge drinkers
    - Percent of Alaskans with moderate to severe depression
    - Death rate among Alaskans due to injury (intentional and unintentional)

5034

5035

B. Suggested Action Plan for 2009 Recommendations

Recommendation	Responsible Party and Action	Timeline and Resources
A1a: The Commission recommends that the Governor and Alaska Legislature investigate and support additional strategies to encourage and support healthy lifestyles, including strategies to create cultures of wellness in any setting.	**Governor:** 2010 - Direct DHSS to investigate and develop recommendations for effective strategies to encourage and support healthy lifestyles of Alaskans. **Legislature:** 2011-2014 - Identify and consider politically and financially feasible strategies requiring legislation and/or appropriation based on recommendations from the Governor.	**Jan 2010 – Dec 2014** **Cost:** Initial (2010) cost: $0; Future costs variable depending on availability of funding and approach to implementation
A1b: The Commission recommends that the 2010 Alaska Health Care Commission continue evaluating the question of what works to support behavior change, and identify additional recommendations for future improvement.	**Commission:** Include healthy lifestyles strategies analysis and recommendation development on 2010 work plan; Coordinate with DHSS investigation of same question.	**Jan 2010 – Dec 2010** **Cost:** $0 (assumes funding of Recommendation B2a)
A2a: The Commission recommends that the Governor and Alaska Legislature aggressively pursue development of patient-centric care models through payment reform, removal of statutory and regulatory barriers, and implementation of pilot projects. Development of pilot projects should include definition of the patient-centric model, identification of performance standards and measures, and payment models that are outcome-based.	**Governor:** Direct DHSS to: 1) collaborate w/the AHCC to define patient-centric care models and identify performance standards and measures; 2) pursue grant opportunities to obtain funding for piloting medical home models of care; and, 3) identify statutory and regulatory barriers to development of such care models. **Legislature:** Consider future requests for removal of statutory barriers and financial support for pilot projects and new payment methodologies.	**Jan 2010 – Dec 2014** **Cost:** Initial (2010) cost: $0; (assumes funding of Recommendation B2a) Future costs variable depending on availability of funding and need for pilot project funding.
B1a: The Commission recommends that the Governor and Alaska Legislature invest in the state health policy infrastructure required to study, understand, and make recommendations to respond to the implications of national health care reform for Alaska.	**Governor:** Direct DHSS to develop proposal for development of health policy analysis capacity.	**Jan 2010 – Dec 2014** **Cost:** Initial (2010) cost: $0; Future costs to be determined
B2a: The Commission recommends that the Alaska Legislature establish an Alaska Health Care Commission in statute, similar in size to the Commission established under Administrative Order #246, to provide a focal point for sustained and comprehensive planning and policy recommendations for health care delivery and financing reform, and to ensure transparency and accountability for the public in the process.	**Legislature:** Pass legislation to establish a Health Care Commission in statute, and fund associated fiscal note. **Governor:** Sign passed legislation into law	**Jan 2010 – Apr 2010** **Cost:** $500,000 annual operating budget (based on DHSS fiscal notes for pending legislation)

5036

C1a: The Commission recommends that the Governor and Alaska Legislature maintain health care workforce development as a priority on Alaska's health care reform and economic development agendas.	**Governor:** Direct state agencies to ensure future health care and economic development plans consider health workforce needs and strategies. **Legislature:** Direct legislative committees to ensure health care and economic development agendas consider workforce needs and strategies.	**Jan 2010 – Dec 2014** **Cost:** $0
C1b: The Commission recommends that the Governor and Alaska Legislature explore strategies for strengthening the pipeline of potential future Alaska health care workers.	**Governor:** 2010 – Direct DEED, DHSS, and DoLWD to collaborate together and with stakeholders on the investigation and development of recommendations for strengthening the health workforce pipeline. **Legislature:** 2011-2014 - Identify and consider politically and financially feasible strategies requiring legislation and/or appropriation based on recommendations from the Governor.	**Jan 2010 – Dec 2014** **Cost:** $0
C1c: The Commission recommends that the Governor and Alaska Legislature explore strategies for ensuring Alaska's health care workforce continues to be innovative and adaptive, and that it is responsive to emerging patient care models.	**Governor:** 2010 – Direct DHSS to consider innovative approaches to health workforce development. **Legislature:** 2011-2014 – Consider future requests for legislation and financing of health workforce innovations.	**Jan 2010 – Dec 2014** **Cost:** $0
C1d: The Commission recommends that the Governor designate a single entity with the responsibility for coordinating all health care workforce development planning activities in and for Alaska. Coordination and collaboration of funders, policymakers and stakeholders in workforce planning and development efforts should be encouraged to the greatest extent possible.	**Governor:** 2010 – Direct DHSS to collaborate with system stakeholders to develop a recommendation for the most appropriate entity to be charged with the responsibility for health care workforce development planning coordination.	**Jan 2010 – Dec 2014** **Cost:** Estimated $0 - $250,000 depending on capacity and needs of designated entity
C1e: The Commission recommends that the 2010 Alaska Health Care Commission continue studying health care workforce needs in coordination with other organizations and coalitions addressing this issue, and identify recommendations for additional improvements.	**Commission:** Include health workforce planning coordination, analysis, and recommendation development on 2010 work plan	**Jan 2010 – Dec 2010** **Cost:** $0 (assumes funding of Recommendation B2a)
C2a: The Commission recommends that the Governor and Alaska Legislature target the state's limited financial resources invested in physician workforce development to strengthening the supply of primary care physicians.	**Legislature:** Limit future appropriations intended to increase the supply of practicing physicians in the state to utilization for primary care physicians only (Family Physicians, Pediatricians, General Internists, and Psychiatrists).	**Jan 2010 – Dec 2014** **Cost:** $0

5037

C2b: The Commission recommends that the Governor and Alaska Legislature support development and maintenance of an educational loan repayment and direct financial incentive program in support of recruitment and retention of primary care physicians and mid-level practitioners.	**Legislature:** Pass legislation to establish educational loan repayment and financial incentive program to support recruitment and retention of primary care providers. **Governor:** Sign passed legislation into law	**Jan 2010 – Apr 2010** **Cost:** Estimated $1.5 - $7.5M annually
C2c: The Commission recommends that the Governor and Alaska Legislature support the continued expansion of the WWAMI program. Future expansion should be supported as resources allow.	**Legislature:** Pass legislation to continue WWAMI expansion as state general fund resources allow. **Governor:** Sign passed legislation into law	**Jan 2010 – Apr 2010** **Cost:** $600,000 (estimated annual cost of 4-seat expansion in 4th year)
C2d: The Commission recommends that the Governor and Alaska Legislature support graduate medical education for primary care and behavioral medicine. State financial support should continue for on-going operation of the Alaska Family Medicine Residency Program, and should be appropriated for the planning and development of in-state residency programs for pediatrics, psychiatry, and primary care internal medicine.	**Governor:** 2010 – Direct UA to collaborate with system stakeholders to develop proposals for development of pediatric, psychiatric and primary care internal medicine residency programs for Alaska. **Legislature:** 2011-2014 – Consider future requests for state participation in support of residency program development and operation.	**Jan 2010 – Dec 2014** **Cost:** Initial (2010) cost: $0; Future costs variable depending on availability of funding and approach to implementation
C2e: The Commission recommends that the Governor and Alaska Legislature ask Alaska's congressional delegation to pursue federal policies to address equity in the allocation and distribution of Medicare Graduate Medical Education (GME) residency slots. The exclusion of new programs is not equitable, and there should be heavier weighting for primary care GME and for shortage areas.	**Governor:** Send letter to congressional delegation. **Legislature:** Send letter to congressional delegation.	**Jan 2010 – Apr 2010** **Cost:** $0
C2f: The Commission recommends that the Governor and Alaska Legislature explore strategies for improving the primary care delivery model and utilizing "physician extender" occupations as an additional approach to addressing the primary care physician shortage.	**Governor:** Direct DHSS to work with health workforce development stakeholders to make planning for physician extender and primary care team worker occupations a high priority. **Legislature:** Consider future requests for health workforce development targeted at primary care.	**Jan 2010 – Dec 2014** **Cost:** Initial (2010) cost: $0; Future costs variable depending on availability of funding and approach to implementation
D1a: The Commission recommends that the Governor and Alaska Legislature take an aggressive approach to supporting adoption, utilization, and potential funding of health information technology, including health information exchange, electronic health records and telemedicine/telehealth that promise to increase efficiency and protect privacy.	**Governor:** Follow development of the state HIE and consider future requests for support of HIT needs. **Legislature:** Consider future requests for HIT development.	**Jan 2010 – Dec 2014** **Cost:** Initial (2010) cost: $0; Future costs to be determined

5038

D2a: The Commission recommends that the Governor direct the Department of Health & Social Services to explore options for assisting providers (particularly smaller primary care practices and individual primary care providers) with adoption of electronic health record systems.	**Governor:** Direct DHSS to work with the state HIE contractor and AK EHR Alliance on exploration of options for assisting small primary care practices with adoption of EHRs.	**Jan 2010 – Dec 2014** **Cost:** Initial (2010) cost: $0; Future costs to be determined
D2b: The Commission recommends that the Governor ensure Alaska's statewide health information exchange supports providers who have not yet adopted their own electronic health record system by facilitating identification and purchase of systems that are interoperable with the state exchange.	**Governor:** Direct DHSS to work with the state HIE contractor and AK EHR Alliance on facilitating identification of EHR systems that are interoperable with the state HIE.	**Jan 2010 – Dec 2014** **Cost:** Initial (2010) cost: $0; Future costs to be determined
D2c: The Commission recommends that the Governor ensure that HIT is utilized to protect the public's health. Alaska's health information exchange should connect with electronic public health reporting systems to enable real-time disease reporting and rapid identification of public health threats.	**Governor:** Direct DHSS to work with the state HIE contractor and the Division of Public Health on integration of electronic real-time disease reporting systems in the statewide exchange.	**Jan 2010 – Dec 2014** **Cost:** Initial (2010) cost: $0; Future costs to be determined
D2d: The Commission recommends that the Governor ensure that data available through the statewide health information exchange is utilized to identify opportunities for administrative efficiencies, coordination and optimization of care, and health care quality and safety improvement.	**Governor:** Direct DHSS to work with state HIE contractor to identify potential uses of data from the exchange to support health care quality, safety, and efficiency improvement opportunities.	**Jan 2010 – Dec 2014** **Cost:** Initial (2010) cost: $0; Future costs to be determined
D2e: The Commission recommends that the 2010 Alaska Health Care Commission track the development of the Alaska Statewide Health Information Exchange, Alaska's new Medicaid Management Information System (MMIS), and the use of ARRA funds for electronic health record deployment; and the Commission should continue to identify current issues, policy choices and recommendations based on these developments.	**Commission:** Include HIE, MMIS and ARRA EHR status review, analysis and recommendation development on 2010 work plan **DHSS:** Provide quarterly report to the AHCC on status of HIE, MMIS, and ARRA EHR implementation	**Jan 2010 – Dec 2010** **Cost:** $0 (assumes funding of Recommendation B2a)
D2f: The Commission recommends that the Governor designate a statewide entity with the responsibility for ensuring broad implementation of health information security and privacy protections. The entity should participate in on-going efforts at the national level to identify security and privacy standards, should oversee application of those standards to Alaska's statewide health information exchange, and should identify a process for Alaskan patients to opt out of participation in the health information exchange.	**Governor:** Direct DHSS to collaborate with the state HIE contractor and system stakeholders to develop a recommendation for the most appropriate entity to be charged with the responsibility for implementation of health information security and privacy protections.	**Jan 2010 – Dec 2010** **Cost:** $0

5039

D3a: The Commission recommends that the Governor and Alaska legislature work with federal and local partners to ensure all Alaskan communities have access to broadband telecommunications infrastructure that provides the connectivity and bandwidth necessary to optimize use of health information technologies.	**Governor & Legislature: Jan 2010 – Dec 2011:** Follow Denali Commission's 2-year broadband mapping initiative. **Jan 2012 – Dec 2014:** Work with local, federal and private sector partners to address gaps in service where identified.	**Jan 2010 – Dec 2014** **Cost:** $0; Future costs to be determined
D3b: The Commission recommends that the Governor direct the Alaska Department of Health & Social Services to investigate innovative reimbursement mechanisms for telemedicine-delivered services; test new payment methodologies through Medicaid, and work with other payers to encourage adoption of successful methodologies.	**Governor:** Direct DHSS to investigate and develop a project proposal for pilot testing innovative reimbursement mechanisms for telemedicine-delivered services through Medicaid.	**Jan 2010 – Dec 2014** **Cost:** Initial (2010) cost: $0; Future costs to be determined
E(a): The Commission recommends that the Governor and Alaska Legislature improve the supply of primary care providers in order to enable increased access to care for Medicare patients by: o Supporting a student loan repayment and financial incentive program for primary care providers practicing in Alaska and serving Medicare patients (and including other service requirements deemed necessary to meet the needs of the underserved); o Supporting development of a primary care internal medicine residency program; o Supporting WWAMI program expansion as resources allow; and o Supporting mid-level practitioner development.	**Same as for Recommendations C2a – C2f**	**Same as for Recommendations C2a – C2f**
E(b): The Commission recommends that the Governor and Alaska Legislature explore strategies for removing barriers to the development of designated Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs), facilitating development through state application for federal shortage designations for Medicare populations and supporting planning for new and expanded FQHCs/RHCs.	**Governor:** 2010 - Direct DHSS to investigate and develop recommendations for facilitating support of FQHCs and RHCs. **Legislature:** 2011-2014 - Identify and consider politically and financially feasible strategies requiring legislation and/or appropriation based on recommendations from the Governor.	**Jan 2010 – Dec 2014** **Cost:** Initial (2010) cost: $0; Future costs variable depending on availability of funding and approach to implementation
E(c): The Commission recommends that the Governor and Alaska Legislature work with Alaska's Congressional delegation to improve Medicare's reimbursement scheme to ensure the sustainability of care to Medicare patients.	**Governor:** Send letter to congressional delegation to initiate discussion. **Legislature:** Send letter to congressional delegation to initiate discussion.	**Jan 2010 – Dec 2010** **Cost:** $0

5040

E(d): The Commission recommends that the Governor and Alaska Legislature ask Alaska's congressional delegation to pursue federal policies to redesign the Medicare audit process so that it focuses more on identification and prosecution of fraudulent practices than on billing errors. Reported financial incentives for audit contractors should be eliminated and replaced with performance measures. Concern over billing errors should be addressed through provider training and performance reports, not through audit processes designed to weed out fraud and abuse.	**Governor:** Send letter to congressional delegation to initiate discussion. **Legislature:** Send letter to congressional delegation to initiate discussion.	**Jan 2010 – Apr 2010** **Cost:** $0
E(e): The Commission recommends that the Governor and Alaska Legislature commission an analysis comparing Medicare to Medicaid and private insurance administrative requirements, including recommendations for streamlining public insurance administrative procedures to make them more user-friendly.	**Governor:** Direct DHSS to investigate and develop a recommendation for a process to compare public and private insurance administrative requirements.	**Jan 2010 – Dec 2014** **Cost:** Initial (2010) cost: $0; Future costs to be determined
E(f): The Commission recommends that the Governor facilitate development of PACE programs in Alaska by directing the Department of Health & Social Services to submit a State Plan Amendment to the U.S. Centers for Medicare and Medicaid Services (CMS) to add PACE as a Medicaid service, and to identify and remove barriers to development of PACE programs.	**Governor:** Direct DHSS to develop and submit SPA to CMS adding PACE as an Alaska Medicaid benefit, and to develop capacity to negotiate rates with providers interested in developing a PACE program.	**Jan 2010 – Dec 2010** **Cost:** $200,000 (estimated by DHSS; for actuarial consultant and Office of Rate Review staff)

C. 2010 Work Plan for the Alaska Health Care Commission

Following is a suggested approach to continuing the work of the Alaska Health Care Commission through 2010. This plan will need to be adapted and more details added based on the level of financial and staff resources allocated to this work once financing is determined.

- **Analyze Variations in Pricing and Resulting Cost Shifting in Alaska's Health Care Delivery System**
  - Contract with consultants who have expertise in health economics and health care business management.

- **Analyze Impact of National Health Care Reform** - If national reform legislation passes:
  - Identify state government roles and responsibilities for implementation
  - Analyze and determine potential impact on Alaska's health care system
  - Develop recommendations for Governor and Legislature for maximizing potential benefits and minimizing potential harms

- **Track Implementation of the Commission's 2009 Recommendations**
  - Monitor status of relevant bills during legislative session
  - Consult with Governor's Office on interest and approach to implementing recommendations requiring Governor's action
  - Commission staff to report quarterly to the Commission on status of implementation

- **Implement 2009 Recommendations Requiring Commission Action**
  - Recommendation A1b: Continue studying and develop additional recommendations to support healthy lifestyles
  - Recommendation A2a: Collaborate with DHSS and primary care provider community on definition of patient-centric care model and development of performance standards and measures.
  - Recommendation C1e:
    - Coordinate with the DHSS/AMHTA/UA Behavioral Health Workforce Partnership, Alaska Health Care Workforce Development Coalition and the Legacy Plan Health Care Workgroup
    - Continue analysis of health care workforce issues and develop additional recommendations
  - Recommendation D1b:
    - Coordinate with DHSS to receive a quarterly report on the development of the new statewide health information exchange, the new Medicaid Management Information System, and the use of ARRA funding for electronic health record deployment
    - Continue analysis of health information technology issues and strategies and develop additional recommendations

- **Prioritize, Analyze and Develop Recommendations on Potential Access, Value (Cost Containment and Quality Improvement), and Prevention Strategies described in Part IV of 2009 Report**

- **Implement the Commission's Public Communication Plan**

- **Develop an Evaluation Plan for Tracking the Performance of Alaska's Health Care System**
  - Work with health care system stakeholders to finalize performance metrics that will provide a snapshot of the efficiency, effectiveness, and safety of Alaska's health care delivery system.
  - Identify system for compiling, analyzing, and reporting performance metrics data.

5041

End Notes

PART II

[i] "Bending the Curve." Commonwealth Fund. December 2007
[ii] "Health at a Glance 2009: OECD Indicators," Organization for Economic Cooperation and Development. 2009.
[iii] Foster, M, Goldsmith, S. "Alaska's $5 Billion Health Care Bill – Who's Paying?" UA Research summary No. 6, Institute of Social and Economic Research, University of Alaska, March 2006.
[iv] "Health at a Glance 2009: OECD Indicators," Organization for Economic Cooperation and Development. 2009.
[v] "Health at a Glance 2009: OECD Indicators," Organization for Economic Cooperation and Development. 2009.
[vi] Himmelstein, D., et al, "Medical Bankruptcy in the United States, 2007: Results of a National Study," American Journal of Medicine, May 2009.
[vii] The State of Alaska Health Resources and Access Task Force Final Report, January 1993.
[viii] Foster, M, Goldsmith, S. "Alaska's $5 Billion Health Care Bill – Who's Paying?" UA Research summary No. 6, Institute of Social and Economic Research, University of Alaska, March 2006.
[ix] "National Health Expenditure Data, Health Expenditures by State," Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group. February 2007.
[x] "Fiscal Year 2010 Budget Overview." State of Alaska Department of Health & Social Services, January 2009.
[xi] Foster, M, Goldsmith, S. "Alaska's $5 Billion Health Care Bill – Who's Paying?" UA Research summary No. 6, Institute of Social and Economic Research, University of Alaska, March 2006.
[xii] "Key Issues in Analyzing Major Health Insurance Proposals." Congressional Budget Office. December 2008.
[xiii] State Health Facts – Hospital Adjusted Expenses Per Inpatient Day 2007. Kaiser Family Foundation. April 2009.
[xiv] "November2009 Report of the Workers' Compensation Medical Services Review Committee," Alaska Department of Labor and Workforce Development.
[xv] "November2009 Report of the Workers' Compensation Medical Services Review Committee," Alaska Department of Labor and Workforce Development.
[xvi] Source: K. Davis, *Why Health Reform Must Counter the Rising Costs of Health Insurance Premiums*, (New York: The Commonwealth Fund, Aug. 2009).
[xvii] "Costly Coverage: Premiums Outpace Paychecks in Alaska." Families USA. September 2009.
[xviii] Information provided by Section of Health Planning and Systems Development, AK DHSS, October 2009.
[xix] "Alaska Population Overview 2005-2006." Alaska Department of Labor and Workforce Development.
[xx] Healthy Alaskans 2010 Volume I. Alaska Department of Health & Social Services.
[xxi] "Current Community Conditions: Fuel Prices Across Alaska." Alaska Division of Community & Regional Affairs. July 2009.
[xxii] "Alaska's 10-Year Occupational Forecast," Alaska Economic Trends, Alaska Department of Labor & Workforce Development, Vol.29, #1, January 2009.
[xxiii] 2007 Alaska Health Workforce Vacancy Study. Alaska Center for Rural Health, UAA. July 2007.
[xxiv] The Status of Recruitment Resources and Strategies (SORRAS) II 2005-2006. Alaska Center for Rural Health. UAA.

PART III

[xxv] Foster, M, Goldsmith, S. "Alaska's $5 Billion Health Care Bill – Who's Paying?" UA Research summary No. 6, Institute of Social and Economic Research, University of Alaska, March 2006.
[xxvi] "Alaska's Health Care Industry," Alaska Economic Trends, Alaska Department of Labor & Workforce Development, Vol.28, #2, February 2008.
[xxvii] "Alaska's Health Care Industry," Alaska Economic Trends, Alaska Department of Labor & Workforce Development, Vol.28, #2, February 2008.
[xxviii] "Alaska's 10-Year Occupational Forecast," Alaska Economic Trends, Alaska Department of Labor & Workforce Development, Vol.29, #1, January 2009.
[xxix] "Alaska's Health Care Industry," Alaska Economic Trends, Alaska Department of Labor & Workforce Development, Vol.28, #2, February 2008.
[xxx] 2007 Alaska Health Workforce Vacancy Study. Alaska Center for Rural Health, UAA. July 2007.
[xxxi] The Status of Recruitment Resources and Strategies (SORRAS) II 2005-2006. Alaska Center for Rural Health. UAA.

5042

[xxxii] Karen Perdue, Associate Vice President, University of Alaska Health Programs, presentation to the Alaska Health Care Commission on May 1, 2009.
[xxxiii] "Securing an Adequate Number of Physicians for Alaska's Needs: Report of the Alaska Physician Supply Task Force," August 2006.
[xxxiv] Cooper, R.A., "Medicine and public issues: weighing the evidence for expanding physician supply," Annals of Internal Medicine, 141(9), 705-711, 2004.
[xxxv] "Securing an Adequate Number of Physicians for Alaska's Needs: Report of the Alaska Physician Supply Task Force," August 2006.
[xxxvi] Association of American Medical Colleges 2008 Graduation Questionnaire.
[xxxvii] FCIM, "Generating More Generalists: An Agenda of Renewal for Internal Medicine," Annals of Internal Medicine, Vol 119, No 11, December 1993.
[xxxviii] Information provided by Dr. Dennis Valenzeno in letter dated December 23, 2009, citing data from Key Physician Data by State, Association of American Medical Colleges, January 2006.
[xxxix] "Health at a Glance 2009: OECD Indicators," Organization for Economic Cooperation and Development. 2009.
[xl] Dr. Dennis Valenzeno, Director, UAA WWAMI Biomedical Program, presentation to the Alaska Health Care Commission on May 1, 2009.
[xli] U.S. News & World Report Graduate School Rankings, April 23, 2009.
[xlii] Dr. Harold Johnston, Director, Alaska Family Medicine Residency Program, presentation to the Alaska Health Care Commission on May 1, 2009.
[xliii] Iglehart, J., "Medicare, Graduate Medical Education, and New Policy Directions," N Eng J Med, 359;6. August 7, 2008.
[xliv] Pathman, DE, et al, "Outcomes of States' Scholarship, Loan Repayment, and Related Programs for Physicians," Medical Care, Vol 42, No 6, June 2004.
[xlv] Chaudry, B, et al., "Systematic review: Impact of Health Information Technology on Quality, Efficiency, and Costs of Medical Care," Annals of Internal Medicine, 144(1), 742-752, 2006.
[xlvi] Center for Health Transformation. "Taking the Paper Out of Paperwork: How Electronic Administration Can Save the U.S. Health System Billions." 2009 CHF White Paper.
[xlvii] Anderson, GF, et al., "Health Care Spending and Use of Information Technology in OECD Countries," Health Affairs, Vol 25 No 3, May/June 2006.
[xlviii] Ferguson, SA, et al, "Impact of Store-and-Forward Telehealth in Alaska: A Seven Year Retrospective," AFHCAN Telehealth, ANTHC, 2009.
[xlix] Patricoski, C, "Alaska Telemedicine: Growth Through Collaboration," International Journal of Circumpolar Health 63:4, 2004.
[l] Chaudhry, B, et al, "Systematic Review: Impact of Health Information Technology on Quality, Efficiency, and Costs of Medical Care," Ann Intern Med. 2006; 144:742-752.
[li] Goldzweig, CL, et al, "Costs and Benefits of Health Information Technology: New Trends from the Literature," Health Affairs 28, No. 2, 2009: w282-w293.
[lii] Cracium Research, "Status of EHR Use in Alaska," Produced for Alaska EHR Alliance, Inc., May 11, 2009.
[liii] "Defining Key Health Information Technology Terms," The National Alliance for Health Information Technology Report to the Office of the National Coordinator for Health Information Technology. April 28, 2008.
[liv] White House, "Executive Order: Incentives for the Use of Health Information Technology and Establishing the Position of the National Health Information Technology Coordinator," April 27, 2004.
[lv] State Alliance for eHealth, "Preparing to Implement HITECH: A State Guide for Electronic Health Information Exchange," 2009 Report.
[lvi] William Streur, Deputy Commissioner, DHSS, Testimony to the Commission, August 25 and November 6, 2009.
[lvii] American Telemedicine Association (http://www.americantelemed.org)
[lviii] Ferguson, SA, et al, "Impact of Store-and-Forward Telehealth in Alaska: A Seven Year Retrospective," AFHCAN Telehealth, ANTHC, 2009.
[lix] Federal Communications Commission (http://www.fcc.gov/broadband)
[lx] Regulatory Commission of Alaska, Rural Alaska Broadband Internet Access Grant Program Grant Application Guidance, http://rca.alaska.gov/RCAWeb/Documents/Broadband/Round4GrantApplicationGuide.pdf, 2008.

5043

[lxi] Health Planning & Systems Development Section, "Status Report on Telehealth and Health Information Technology Programs and Initiatives in Alaska," DHSS/DHCS, June 2009.
[lxii] Regulatory Commission of Alaska, Rural Alaska Broadband Internet Access Program, http://rca.alaska.gov/RCAWeb/Programs/BroadbandInternetGrant.aspx
[lxiii] Frazier, R., Foster, M., "How Hard is it for Alaska's Medicare Patients to Find Family Doctors?" Institute of Social and Economic Research, University of Alaska Anchorage, UA Research Summary No. 14, March 2009.
[lxiv] Foster, M., Frazier, R., "Response to Questions: Analysis of Potential effects on Alaska of Proposed Health Care Reform Legislation," Institute of Social and Economic Research, UAA, November 24, 2009.
[lxv] Dr. Tom Hunt, Medical Director of the Anchorage Neighborhood Health Center, presentation to the Alaska Health Care Commission on May 1, 2009 (citing article from Annals of Internal Medicine Feb 17 2009 edition).
[lxvi] Dual eligible data from the Division of Health Care Services, Alaska Department of Health & Social Services, October 2009.

PART IV
[lxvii] Information provided by the Alaska Division of Insurance, November 2009.
[lxviii] www.dartmouthatlas.org
[lxix] Institute of Medicine, "Crossing the Quality Chasm," National Academy Press, 2001.
[lxx] Fisher, ES, et al, "The Implications of Regional Variations in Medicare Spending. Part 1: The Content, Quality, and Accessibility of Care," Annals of Internal Medicine, 138, 2003.
[lxxi] Wennberg JE, Fisher ES, Skinner JS, "Geography and the Debate Over Medicare Reform," Health Affairs, February 2002.
[lxxii] Tunis, S., "Reflections on Science, Judgment, and Value in Evidence-Based Decision Making: A Conversation with David Eddy," Health Affairs, Web Exclusive, June 19, 2007. Eddy, D., "Evidence-Based Medicine: A Unified Approach," Health Affairs, Vol. 24, No. 1, Jan/Feb 2005.
[lxxiii] Franklin, GM, Budenholzer, BR, "Implementing Evidence-Based Health Policy in Washington State," N Engl J Med 361;18, October 29, 2009.
[lxxiv] *Cite IOM's Crossing the Quality Chasm, and Commonwealth Fund's Path to a High Performance Health System, and Gawande's article*
[lxxv] De Koning, H, et al, "Lean Six Sigma in Healthcare," Journal for Healthcare Quality, March/April 2006.
[lxxvi] Institute for Healthcare Improvement, "Going Lean in Health Care," 2005.
[lxxvii] Gostin, LO. Public Health Law: Power, Duty, Restraint. University of California Press. 2000.
[lxxviii] Institute of Medicine. The Future of Public Health. 1988.
[lxxix] Bunker JP, Frazier HS, Mosteller F. Improving health: measuring effects of medical care. Milbank Quarterly 1994;72:225-58.
[lxxx] CDC (1999). "Ten great public health achievements—United States, 1900–1999". *MMWR Morb Mortal Wkly Rep* **48** (12): 241–3. http://cdc.gov/mmwr/preview/mmwrhtml/00056796.htm. Reprinted in: *JAMA* **281** (16): 1481. 1999. 10.1001/jama.281.16.1481
[lxxxi] Institute of Medicine. The Future of the Public's Health in the 21st Century. 2002.
[lxxxii] Hennessy, TW, Ritter, T. "The Relationship Between In-Home Water Service and the Risk of Respiratory Tract, Skin, and Gastrointestinal Tract Infections Among Rural Alaska Natives." Am J Public Health. 2008;98:2072-2078.
[lxxxiii] Alaska Department of Environmental Conservation Village Safe Water Program Description (http://dec.alaska.gov/water/vsw/pdfs/vswbrief.pdf), accessed 01-04-10.

5044

ALASKA HEALTH CARE COMMISSION 2009 REPORT

APPENDIX A

HEALTH CARE IN ALASKA

I. How Health Care in Alaska is Provided

A. Health Care Delivery Systems: Private, Tribal, Military and VA — Page A 2
B. Facilities — Page A11
C. Health Care Providers — Page A27
D. Health Information Technology — Page A37

II. How Health Care in Alaska is Funded

A. Introduction — Page A41
B. Funding Sources, Expenditures and Coverage — Page A42

Prepared for the Alaska Health Care Commission
by the
Section of Health Planning & Systems Development
Division of Health Care Services
Alaska Department of Health & Social Services

5045

APPENDIX A: HEALTH CARE IN ALASKA

I. HOW HEALTH CARE IN ALASKA IS PROVIDED

A. HEALTH CARE DELIVERY SYSTEMS: PRIVATE, TRIBAL, MILITARY AND VETERANS ADMINISTRATION

INTRODUCTION

People in Alaska obtain care for health needs through three different systems: the private sector, the military and Veterans' Administration health system, and the Alaska Tribal Health System. The "private sector" can be defined as any services provided by non-military/VA or non-tribal providers. It includes hospitals, physicians, dentists, mental health and substance abuse professionals, and various kinds of clinics. It also includes a wide array of support services such as pharmacies, imaging centers, renal dialysis centers, medical supplies and equipment sales and service, medical transportation services, nursing homes, rehabilitation centers, residential psychiatric treatment facilities, and home care and hospice.

The tribal and governmental systems represent a larger portion of both facilities and service providers in Alaska than in other states, since one fifth of the population (about 135,000) is eligible for services in the tribal system, and 14% percent (about 90,000) are covered by the military system. (In the U.S. as a whole the proportions are 2% tribal and 4% military.)[1]

In Alaska, services that are provided by federal or state governments directly (rather than through reimbursement or an insurance program) are mostly Veterans Administration and military services for active duty and former service people in the Army, Air Force, and the Coast Guard. State and local government services are limited primarily to state psychiatric hospital, Pioneer Homes, public health services,[2] and some locally owned and operated clinics. Governments also play a major role in reimbursing private and tribal providers for the costs of providing care (rather than providing care directly) through Medicare, Medicaid and other programs. Governments also contract with or provide grants to private, tribal and for-profit organizations to provide services.

Alaska's health services have evolved in response to many factors including geography, population needs and traditions, and historical events. Many of Alaska's hospitals are former tuberculosis control hospitals built by the U.S. Public Health Service to treat the epidemic of the early 20th century. Then Alaska's location gave it a critical military and communication defense role for the country during World War II and during the Cold War of the 1950s and 1960s. The major role of the federally recognized tribes in planning and implementing a coordinated system

[1] U.S. Bureau of the Census, 2000 Census.

[2] Services include immunizations, well child care, services related to infections diseases, sexually transitted disease screening, treatment and partner management, newborn hearing screening, family planning, and home visits for follow-up on referrals of high risk families with children.

of care for Alaska Natives, through an agreement with the Indian Health Service called "compacting," has supported and determined the development of care in rural areas of the state.

Health care is a major contributor to the state's economy. Health care accounted for eight percent of Alaska's employment in 2006, with 29,000 workers, and payroll of about $1.2 billion. Most of the jobs were in the private and tribal sectors – 93%. Fully one third of Alaska's health care employees worked in physicians', dentists' and other health practitioners' offices, with 40% in hospitals, and 9% in nursing home and other residential care. About 9% worked in outpatient care centers such as ambulatory surgery centers, dialysis centers, imaging facilities, and other diagnostic and treatment facilties, 6% worked in home health care, and 2% in other ambulatory care settings. Seven of the twenty five largest health care employers were tribal organizations – they accounted for 6,000 employees of 16,640 in those twenty five firms. Thus employment in the non-tribal private sector was likely about 23,000 in 2007, or at least 6% of the state's total employment.[3]

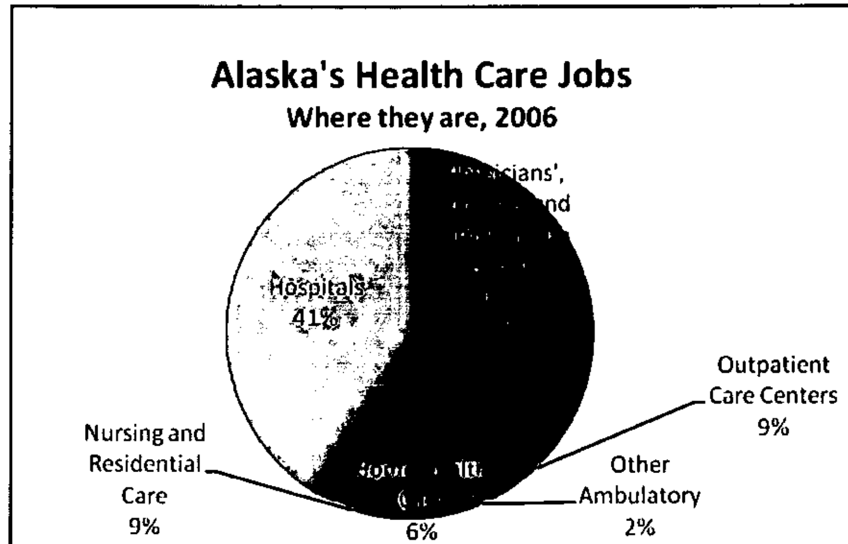
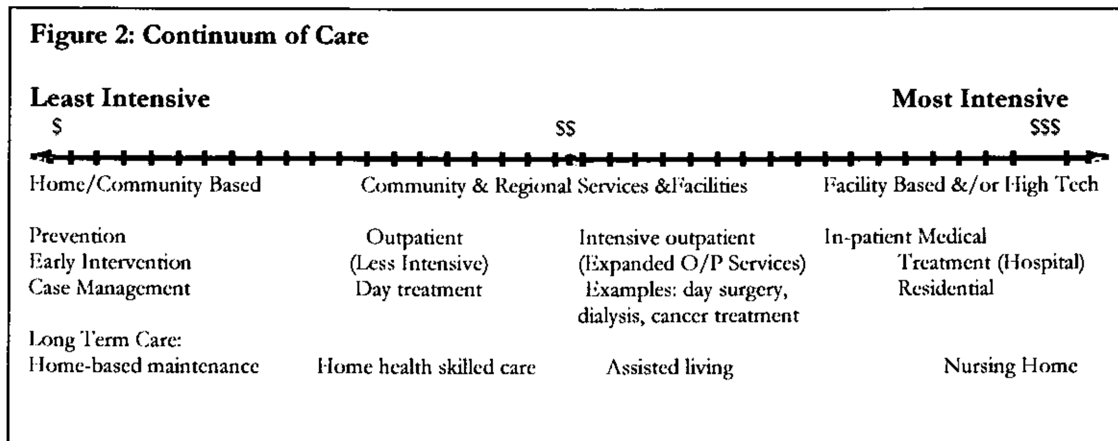


Figure 1: Alaska's Health Care Jobs, 2006

Thinking of health care services as a "continuum" of care from prevention through treatment, rehabilitiation, and maintenance of optimum health can help one comprehend the many different services, facilities and programs. A simplified graphical presentation shows relationships of some of the key components in Figure 2.



[3] Fried, N. "Alaska's Health Care Industry," Alaska Economic Trends, Anchorage, February 2008.

5047

1. PRIVATE HEALTH CARE SECTOR

The private health care sector includes an array of services from highly specialized diagnosis and treatment to primary care, prevention, and supporting goods and services. Firms range from self-employed professionals, contractors and small businesses to national corporations. Even the not-for-profit health services include very large entities like Providence Alaska Health Systems, the largest employer in Alaska with about 4,000 employees in 2006,[4] to small community-based community health centers like Bethel Family Health Services with 9 employees. Seattle, Washington is still the nearest source for some highly specialized services such as heart and other organ transplants and severe trauma treatment.

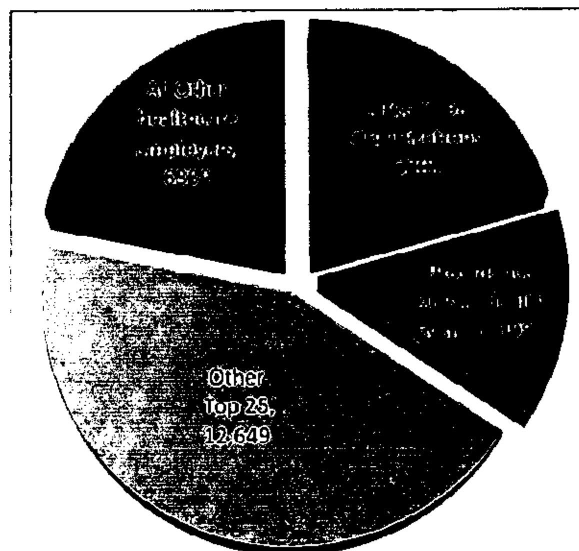


Figure 3: Distribution of Health Care Employment 2006

Only two of Alaska's hospitals are for-profit entities, Alaska Regional Hospital and North Star psychiatric hospital. However many of the free-standing diagnostic, treatment and ambulatory services facilties are for-profit entities. Private sector physicians, dentists, psychologists and other practitioners are either self-employed or have incorporated to pay themselves and staff salaries. Drug stores, medical supply companies, and many other support services are for-profit firms.

Nearly one-third (approximately 10,000) of all health industry jobs in 2007 were in private hospitals. Hospitals are major employers because "they're labor intensive and provide around–the–clock care; three shifts of workers cycle through the hospitals each day.[5]" The Alaska Department of Labor identifies 82 percent of Alaska's non-military employment in hospitals to be in the privately owned and managed facilities rather than local public or tribal facilities.

The private not-for-profit organizations include community-based Community Health Centers and mental health service agencies that receive grants from federal and state government programs. Although these organizations must meet guidelines of public programs, most are not government-run organizations – their boards of directors, employment policies, salary rates, goals and programs are governed by their own bylaws and policies.

[4] Fried, N., "The Trends 100," Alaska Economic Trends, Anchorage, July 2009. P. 6.
[5] Ibid., p. 9.

5048

In Alaska, no "managed care organizations" exist in the private sector, and formal provider networks are lacking. However informal referral patterns, and "panels" of preferred providers associated with a variety of insurance programs, result in some structured relationships, and some facilities and groups are affiliated or jointly managed.

2. ALASKA TRIBAL HEALTH SYSTEM

The Alaska Tribal Health System (ATHS) is a voluntary affiliation of nearly 40 tribes and tribal organizations providing health services to American Indians/Alaska Natives (AI/AN) in Alaska. The ATHS is a diverse and multifaceted health care system that has developed over the last 30 years since passage of the 1975 Indian Self-Determination and Education Assistance Act (ISDEA). Each of the tribal health organizations within the ATHS is owned and operated independently, while remaining interconnected via the system's sophisticated patterns of referrals and their primary and common mission of improving the health status of Alaska's American Indian/Alaska Native (AI/AN) population.

Alaska has 228 federally recognized tribes, accounting for about 135,000 people. At present, Alaska Native villages are situated mostly along the coast and rivers of Alaska. The dispersal of the communities across a huge, mostly roadless territory accounts in large part for the creation of the innovative statewide health system.

As part of its trust responsibility to Native people, the federal government is required to provide a basic level of health care services to the AI/AN population. The trust responsibility deems these services "pre-paid" with aboriginal lands and authority that tribes ceded to the U.S. government in treaties. In 1975, Congress created a process for transferring Bureau of Indian Affairs and Indian Health Service health programs to tribal governments through the Indian Self-Determination and Education Assistance Act (ISDEA, Public Law 93-638). In doing so, Congress noted the past inadequacies of Native American health care, and reaffirmed its intention to involve tribes in health care programs through tribal self-governance.[6]

---

[6]From Jumping Through Hoops: Traditional Healers And The Indian Health Care Improvement Act, 4 DePaul Journal of Health Care Law 843-860, 844-847 (Summer 1999), accessed on http://academic.udayton.edu/health/02organ/Indian03.htm August 10, 2009:

"In passing the Act, Congress noted the government's "unique legal relationship with, and resulting responsibility to" Indians, necessitated the creation of a comprehensive health care system. The IHCIA set forth the following goals for the IHS:

(1) to assure Native Americans access to high-quality comprehensive health services in accordance with need;

(2) to assist tribes in developing the capacity to staff and manage their own health programs and to provide opportunities for tribes to assume operational authority for IHS programs in their communities; and

(3) to be the primary federal advocate for Native Americans with respect to health care matters and to assist them in accessing programs to which they are entitled. Subsequent amendments in 1992 extended the purpose of the IHCIA to raising the health status of Native Americans over a specified period of time to the level of the general United States population. Additionally, the IHCIA sought a high level of participation by Indian tribes in the planning and management of IHS programs, services, and demonstration projects under subsequent self-determination amendments.

The Alaska Native Medical Center (ANMC), a 156 bed facility in Anchorage, serves as the referral center for specialty care. The other tribally administered hospitals (former US Public Health Service hospitals) are located in the six rural communities of Sitka, Barrow, Bethel, Dillingham, Kotzebue and Nome. There are 36 tribal health centers and 176 tribal community health aide clinics. In many rural areas of the state tribal health organizations are the only health care providers available, and serve everyone in the area regardless of race or IHS-beneficiary status.

The federal Indian Health Service (transferred from the Bureau of Indian Affairs to the US Public Health Service in 1955) manages an Alaska Area Native Health Service office (one of eleven Area Offices) that works in conjunction with nine tribally operated service units to provide comprehensive health services to about 135,000 Alaska Native people. Services funded in-part by IHS are delivered by tribal health organizations, or under contract with non tribal service providers. The federal government through the IHS holds title to six tribally operated hospitals[7] and three tribally operated health centers in Alaska (on St Paul Island, Annette Island and Tanana Village) and is responsible for their maintenance.

Together, the tribal organizations that compose the ATHS operate an $800 million (FY2006) health care sector, and employ more than 7,000 full and part-time staff statewide. Beneficiaries are not charged for most services received within the ATHS. Financing for the entirety of the ATHS's programs is split between a variety of sources, including federal and state grants and contracts for specific services; Medicaid, Medicare, and private insurance revenue; rural sanitation funding; and other smaller sources of funding. While the Indian Health Service represents the largest funding source, it accounts for only 60% of total revenue.

The Alaska Tribal Health Compact, which authorizes tribes and tribal health organizations to operate health and health-related programs, was formed October 1,1994. The Alaska Native Tribal Health Consortium (ANTHC) was organized as a statewide non-profit health service organization owned by Alaska Natives and managed by all tribes in Alaska. Other "compact" organizations under P.L. 93-638 include the tribal health corporations that serve regions and specific communities. ANTHC manages all statewide health services formerly provided by the Indian Health Service. ANTHC has responsibility for essential statewide services, including the Alaska Native Medical Center,which it manages in conjunction with the Southcentral Foundation (the regional tribal health organization serving Anchorage and the surrounding communities).

The Compact is the umbrella agreement (also identified as P.L. 93-638, Title-V Self-Governance Compact) that sets forth the terms and conditions of the government-to-government relationship between Alaska Native tribes and/or tribal organizations, and the United States government through the Indian Health Service.[8] The 23 tribes and tribal organizations that belong to the Compact include:

---

[7] The Alaska Native Medical Center in Anchorage, Samuel Simmons in Barrow, Kanakanak in Dillingham, Maniilaq Health Center in Kotzebue, Mt. Edgecumbe in Sitka, and Yukon-Kuskowim Delta Hospital in Bethel. Norton Sound Hospital in Nome is the only tribally managed hospital that is not Federally-owned.

[8] http://www.anhb.org/index.cfm?section=Advocacy

(footnote continued)

5050

- Alaska Native Tribal Health Consortium
- Aleutian//Pribilof Islands Association Inc.
- Annette Island and SU--Metlakatla Indian Community
- Arctic Slope Native Association
- Bristol Bay Area Health Corporation
- Chugachmiut
- Copper River Native Association
- Council of Athabascan Tribal Governments
- Eastern Aleutian Tribes Inc.
- Ketchikan Indian Community
- Kenaitze Indian Tribe
- Knik Tribal Council
- Kodiak Area Native Association
- Maniilaq Association
- Mt. Sanford Tribal Consortium
- Native Village of Eklutna
- Norton Sound Health Corporation
- Seldovia Village Tribe
- Southcentral Foundation
- SouthEast Alaska Regional Health Consortium
- Tanana Chiefs Conference Inc.
- Yakutat Tlingit Tribe
- Yukon-Kuskokwim Health Corporation

In addition, there are 17 tribes and tribal organizations that contract with the Indian Health Services to provide health services under P.L. 93-638, Title I.

ANTHC Maps are available on www.anthc.gov
in formats that can be printed to large sheets for more legible readability:[9]

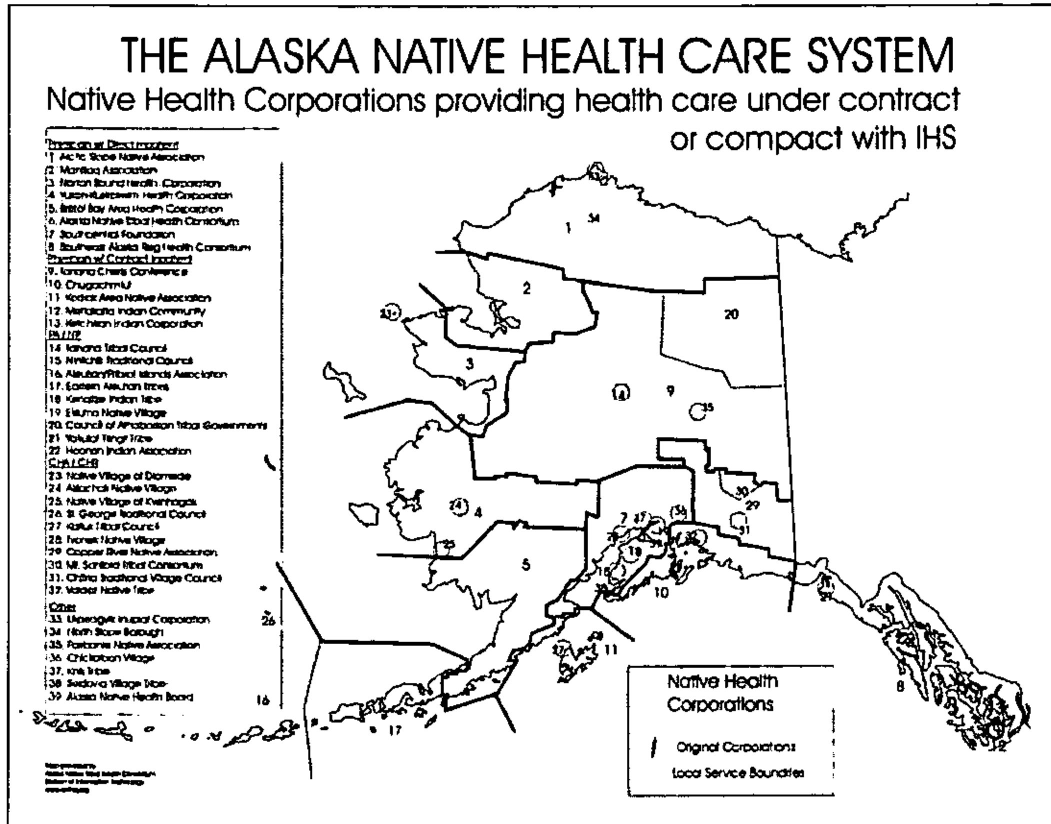


Figure 4: Map of Alaska Native Health Care System

3. U.S. MILITARY AND THE VETERANS AFFAIRS SYSTEMS

U.S. Department of Defense

About 50,000 active duty military and dependent Alaskans are eligible for health care services provided by the Department of Defense. Military retirees and veterans (numbering 76,000[10]) have access to certain services. The U.S. Air Force has responsibility for all military, dependents' and veterans' health care in the southern part of the state, and the U.S. Army is responsible for serving these populations in the northern part of the state. A major health center serves each of these areas: Elmendorf AFB Hospital serves the Southern Region,[11] and Bassett

[9] Maps of the Tribal system as well as resource materials about its components are available on the website http://www.anthc.org/ref/maps/ .

[10] US Department of Veterans Affairs, http://www1.va.gov/opa/fact/statesum/akss.asp accessed 8/13/2009

[11] Southern Region: The 3rd Medical Group, Elmendorf AFB, Alaska is responsible for military services including Air Force, Army, Navy, Marine, Coast Guard, Army/Air National Guard and reserve services units and family members of active duty service personnel.. The health care services provided by the 3rd Medical Group include:

a. Primary Care- Pediatrics, Family Practice, Flight Medicine, Internal Medicine and Dental.

(footnote continued)

5052

Army Community Hospital serves the Northern Region.[12] The Veterans' Administration runs an outpatient medical center in Anchorage, and clinics in Fairbanks, Wasilla and Kenai.[13] When a patient requires highly specialized care, he or she may be referred to a private sector hospital or, more often, to military medical centers out of state. The military has medical centers to serve local military installations in Alaska as well as to provide for surge capacity in times of emergencies. Alaska's military forces have the capability of airlifting complete surgical and hospital facilities to any part of the world or to provide services in times of national emergencies.

The Department of Defense (DOD) TRICARE program (formerly CHAMPUS) is a regionally managed health coverage program for active duty and retired members of the uniformed services, their families and survivors. TRICARE is not an insurance plan, but a health care entitlement program, funded by the U.S. Department of Defense (DoD) for active duty, Guard and Reserve and retired members of the military, and their eligible family members and survivors. TRICARE for Life now provides health care coverage to TRICARE beneficiaries 65 years of age or older. Beneficiaries need to pay the premium for participation in Medicare Part B (physician and other non-inpatient care). TRICARE provides services at military treatment facilities, and supplements that with access to civilian health care networks where necessary (much like the IHS Contract Health Care program).

---

b. Specialty Care- Women's Health Clinic (OB/GYN), Physical and Occupational Therapy, Optometry/Ophthalmology, Ear/Nose/Throat, Surgery, and Nutritional Medicine
c. Ancillary- Pharmacy, Radiology, Laboratory
d. Inpatient services including Intensive Care Unit and Labor & Delivery
e. Emergency Care- Emergency Room (ER)
f. Supplementary Services-Family Advocacy Program/Social Work/Mental Health/Health Promotions and Life Skills.

[12] Northern Region: Bassett Army Community Hospital, Fort Wainwright, Alaska is attached to the Alaska Command, and reports to Chief of All Army Medical Services at Walter Reed Army Hospital. It serves Fort Wainwright, Eielson Air Force Base, Fort Greely and it associated units. Remote army sites are provided with health services through Troop Medical Clinics at Fort Richardson, Fort Greely and Eielson Air Force Medical Clinic. The health care services provided by are:

a. Primary Care
b. Women's Health Care
c. Orthopedics
d. Audiology
e. Health Promotion
f. Medical Laboratory and X-Ray
g. Mental Health Care
h. Dental Care
i. Pharmacy

[13] Sources:

- 3rd Medical Group Elmendorf AFB website: www.elmendorf.af.mil/units/3rd Medical Group
- Alaska VA Healthcare System and Regional Office: www.visn20.med.va.gov/Alaska. and, www.va.gov/hac/forbeneficiaries/champva.asp
- MEDDAC – Fort Wainwright, Alaska website: www.wainwright.army.mil/sites/local

Alaska Veterans Administration (VA) Healthcare System

The Alaska VA Healthcare System and Regional Office offer primary, specialty, and mental health outpatient care. Services are provided at the Anchorage VA Medical Center, on Elmendorf Air Force Base (through a joint venture with the USAF), and through fee-based arrangements with community hospitals in Fairbanks, Wasilla and Kenai.[14] The VA Medical Center in Anchorage also features a comprehensive Homeless Veteran Service consisting of a Domiciliary Residential Rehabilitation Treatment Program, Veterans Industries, Psychosocial Residential Rehabilitation Treatment Program, VA Supported Housing Program and outreach. These health care services are provided and coordinated through the Anchorage VA Medical Center. In addition to this center of care, the Veterans Administration has established a system of Community Based Outpatient Clinics located at Fort Wainwright, Kenai, and Wasilla.

A pilot project announced in September 2009 is intended to enable veterans to get care through community health centers or other local clinics with Veteran's Administration reimbursement so that less travel for care should be involved.

Coast Guard Clinics

The US Coast Guard history of service in Alaska dates back to the Revenue Cutter Service. Coast Guard personnel and their families are stationed throughout Alaska, including remote sites such as Port Clarence, St. Paul, Attu, Dutch Harbor, and Shoal Cove. Coast Guard clinics in Kodiak, Juneau, Sitka, and Ketchikan support the health care needs of the nearly 5,000 Coast Guard members and their families in Alaska.[15]

Alaska Federal Health Care Partnership

Alaska Federal Health Care Partnership (AFHCP) is a voluntary partnership of the organizations serving the federal health care beneficiaries in Alaska. AFHCP combines the healthcare resources of the Alaska Native Medical Center, Alaska Native Tribal Health Consortium, Department of Defense, Department of Homeland Security, Department of Veterans Affairs, U.S. Coast Guard, and the Indian Health Service. The combined beneficiary population of these organizations is over 250,000 with some beneficiaries having dual, or even triple, eligibility within the health and wellness provider systems. The Partnership represents over 250 health care facilities across the state-- from isolated village clinics staffed by health aides in the most remote parts of Alaska, to the Alaska Native Medical Center, the military hospitals in Anchorage and Fairbanks, and the extensive VA clinical services in the Anchorage area.[16]

[14] About eighty health care providers are paid for by the Veterans Administration at the Elmendorf AFB Hospital, for providing emergency room care, intensive care and staffing for a medical services unit. The Veterans Administration also provides social workers to this hospital.

[15] http://www.afhcp.org/coast%20guard.html

[16] Alaska Federal Health Care Partnership website http://www.afhcp.org/index.html accessed 8/13/2009

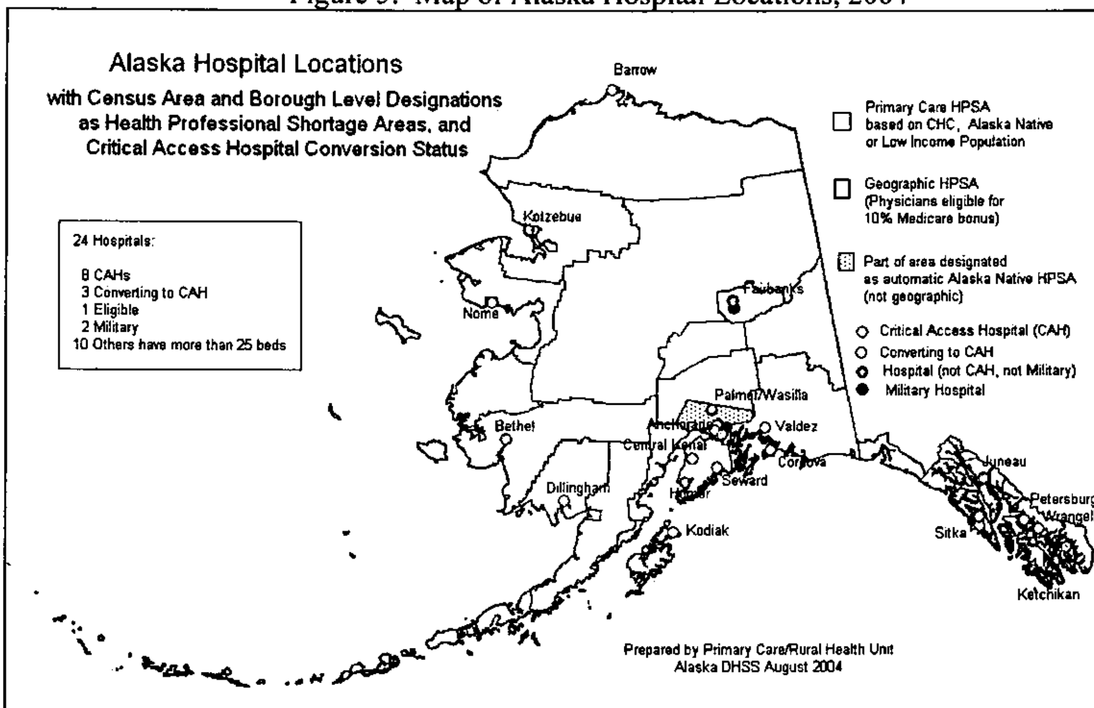
B. FACILITIES

I. MEDICAL FACILITIES

1. HOSPITALS

There are 27 hospitals in Alaska: 24 that provide general acute care (including two military and seven tribally operated hospitals), and three specialized hospitals (one long term acute care and two psychiatric hospitals).[17] The greatest concentration of hospitals is in the Anchorage/Mat-Su region.[18] The relatively large hospitals in Anchorage and Fairbanks serve as referral facilities for providers from rural areas of the state. Hospitals in Seattle also serve as key referral destinations for residents of Alaska in need of "high tech" and specialty services.

Figure 5: Map of Alaska Hospital Locations, 2004



Statewide, there are 1,562 beds in Alaska hospitals, not including those operated by the military. Of those beds, 154 are psychiatric in the two specialized hospitals, 60 are "long term acute care,"

[17] A general acute care hospital must provide surgical, anesthesia, perinatal, medical, nursing, pharmaceutical, dietetic, laundry, medical records, radiological, laboratory, and emergency care services. Such a hospital must also provide speech, occupational, or physical therapy services. A rural primary care hospital or a critical access hospital must provide the services of a general acute care hospital except that the provision of surgical, anesthesia, perinatal, speech, occupational therapy, or physical therapy services is optional. A long-term acute care hospital must provide medical, nursing, pharmaceutical, dietetic, occupational therapy, physical therapy, laundry, medical records, radiological, social work, respiratory, and laboratory services. (7 AAC 12.105)

[18] http://www.hss.state.ak.us/dph/Healthplanning/publications/healthcare/default.htm (Alaska Health Care Data Book, figure 4.170)

and 1348 are acute care beds (of which 146 are identified as swing beds that can be used for acute or long term care).

TABLE 1: ALASKA HOSPITALS, 2008

Region/Hospital	Location	Licensed Beds**	Governance
Anchorage Matanuska-Susitna Region			
Providence Alaska Medical Center	Anchorage	326	Private Non-Profit
Alaska Regional Hospital	Anchorage	250	Private For-Profit
Alaska Native Medical Center	Anchorage	150	Tribal Health Corporation; Federal ownership
Air Force Medical Center – Elmendorf	Anchorage	105	Federal Military
Mat-Su Regional Medical Center	Palmer	74	Private Non-profit
St. Elias Long Term Acute Care Hospital	Anchorage	60	Private Non-Profit
Alaska Psychiatric Institute	Anchorage	80	Public State
North Star Hospital	Anchorage	74	Private For-Profit
Interior Region			
Fairbanks Memorial Hospital	Fairbanks	152	Private Non-Profit
Bassett Community Army Hospital	Ft. Wainwright	55	Federal Military
Southeast Region			
Bartlett Regional Hospital	Juneau	71	Public Municipal
Ketchikan General Hospital*	Ketchikan	25	Public Municipal
Petersburg Medical Center*	Petersburg	12	Public Municipal
Mt Edgecumbe Hospital	Sitka	27	Tribal Health Corporation; Federal ownership
Sitka Community Hospital *	Sitka	12	Public Municipal
Wrangell Medical Center*	Wrangell	8	Public Municipal
Gulf Coast Region			
South Peninsula Hospital*	Homer	22	Public Municipal
Providence Kodiak Island Medical Center*	Kodiak	25	Public Municipal
Providence Seward Medical Center*	Seward	6	Public Municipal
Central Peninsula Community Hospital	Soldotna	49	Public Municipal
Providence Valdez Community Hospital *	Valdez	11	Public Municipal
Cordova Community Medical Center*	Cordova	13	Public Municipal
Southwest Region			
Yukon-Kuskokwim Delta Regional Hospital	Bethel	50	Tribal Health Corporation; Federal ownership
Kanakanak Hospital*	Dillingham	16	Tribal Health Corporation; Federal ownership
Northern Region			
Norton Sound Regional Hospital*	Nome	18	Tribal Health Corporation
Simmonds Memorial Hospital*	Barrow	14	Tribal Health Corporation; Federal ownership
Manillaq Medical Center*	Kotzebue	18	Tribal Health Corporation; Federal ownership

*Critical Access Hospital

** Total beds include licensed and/or certified acute care and swing beds. Many hospitals are operating with fewer beds than the number licensed.

Data Source: Health Facilities List, Licensing and Certification Section, Division of Public Health 2009

The scope of services provided by Alaska's urban hospitals has been changing dramatically. Bed counts have remained quite stable in the last decade, but hospital "campuses" have grown to accommodate an array of emerging technologies and day treatment services that were formerly available only as inpatient services or out-of-state. Examples of services that have been introduced by hospital systems in the last five years include: cardiac catherization, cardiac electrophysiology ablation, cardiac rehabilitation, chemotherapy and cancer services, renal dialysis, pediatric medicine, birthing centers, outpatient surgery, sleep disorder testing, sports medicine rehabilitation, and expanded hospice and home care. The addition or expansion of these services to Alaska's urban hospitals has provided an incentive to physicians and businesses that support these services to establish residence and to provide care in Alaska, often partnering with the hospital care system. This has allowed Alaskans to receive care in-state.

Alaska's hospitals in communities with populations smaller than 30,000 – that is, outside of Anchorage, Mat-Su, Fairbanks and Juneau – are recognized to be critical "economic engines" of their communities, providing jobs directly, and providing assurance of emergency services and access to care for residents of their service areas, and for employers who want to attract workers. The Balanced Budget Act of 1997 (Public Law 105-33) established the Medicare Rural Hospital Flexibility Program, a national program designed to assist states and rural communities in improving access to health care services in rural areas through the development of limited service hospitals and rural health networks. Thirteen Alaska hospitals (see table above) are now certified by Medicare as Critical Access Hospitals (CAH) enabling them to obtain cost-based reimbursement rates from the Federal Medicare program.

Critical Access Hospital Certification

A Critical Access Hospital (CAH) is an acute care facility that provides emergency, outpatient, and limited inpatient services and may be linked to full service hospitals and other types of providers in a rural health network. CAHs generally provide inpatient care for up to 96 hours, unless discharge or transfer is precluded due to inclement weather or other emergency conditions. CAHs may maintain up to 25 beds to furnish both acute and skilled nursing level care, provided that no more than 15 of these beds are used for acute care at any one time. A CAH may operate nursing home beds or provider-based services like home health. CAHs are reimbursed on a "reasonable cost" basis for services provided to Medicare beneficiaries.

Trauma Center Designation

Alaska's highest level Trauma Center (Level II) is the Alaska Native Medical Center (ANMC). Level II Trauma Centers provide comprehensive trauma care, serving as the lead trauma facility for a geographical area. Emergency physicians and nurses are available in-house to provide direct patient care and initiate resuscitation and stabilization. Prompt availability of general surgeons and certain specialty surgeons is required. A Level II Trauma Center also provides educational outreach and prevention programs, and assumes responsibility for trauma system leadership in the absence of a Level I Trauma Center. Under ACS criteria, Level I centers must conduct trauma research and teach trauma care physicians. Cities in Alaska do not have the patient loads or academic medical centers to support this level of care and the nearest Level I

Trauma Center is located in Seattle. There are four Level IV-designated Trauma Centers in Alaska: Norton Sound Regional Hospital (Nome), Yukon-Kuskokwim Delta Regional Hospital (Bethel), Mt. Edgecumbe Hospital (Sitka), and Sitka Community Hospital (Sitka).

2. Outpatient Facilities

Recent changes in technology and medical practice have allowed patients to receive some services as outpatients rather than being hospitalized. Outpatient services can be performed in a hospital setting or in a freestanding facility. Currently the State of Alaska licenses ambulatory surgery centers, and birthing centers, as authorized by Alaska Statute 47.32. (It also licenses hospitals that may offer ambulatory surgery and ESRD services.)[19] In addition, Alaska has Medicare certified end stage renal disease facilities.

An ambulatory surgical facility provides surgery and anesthesia service, in some cases including pain management and diagnostic services, in an outpatient setting. Ambulatory Surgery Centers (ASC) (which may be called outpatient surgery centers or same-day surgery centers when part of a hospital) perform procedures that are more intensive than those done in the average doctor's office, but not so intensive as to require a hospital stay.

In order for a facility to be licensed as an ASC, services must comply with the state's standards for surgical and anesthesia services in general acute care hospitals. There are also requirements, similar to hospital medical staff regulations,[20] for physicians working in these licensed facilities. Currently there are nine licensed Ambulatory Surgery Centers in the state.

Freestanding Birthing Centers are facilities which are not a hospital or in a hospital, where births are planned to occur away from the mother's residence following normal, uncomplicated pregnancy. The state has eight licensed Birthing Centers: one each in Juneau, Soldotna and Fairbanks, and three in Anchorage and two Wasilla.

Alaska also has Medicare certified facilities for treatment of end stage renal disease, commonly referred to as dialysis centers. Dialysis is used to provide an artificial replacement for lost kidney function. It may be used for acutely ill patients who have suddenly but temporarily lost their kidney function and require services for only a short time period; but is used mostly for patients who have permanently lost their kidney function and require dialysis for a long, indefinite period of time. The state currently has seven Medicare certified End State Renal Disease facilities.[21]

Other diagnostic and testing services now being established in some instances as freestanding businesses are imaging (including Magnetic Resonance Imaging and CT Scan), sleep studies,

---

[19] Per AS 47.32.010

[20] Purpose and accountability include that "the provisions of AS 47.05.300 - 47.05.390, regarding criminal history, criminal history checks, criminal history use standards, and a centralized registry, apply to entities listed in (b) of this section, as provided in AS 47.05.300 ."

[21] Licensing and Certification Section, Division of Public Health 2009

and laboratories. Such entities are being called "Independent Diagnostic Testing Facilities" (IDTF)when they are not engaged in patient treatment, but perform diagnostic tests by certified non-physician personnel under physician supervision. These facilities are independent of a hospital or physician's office. The state does not license IDTFs but does monitor the credentials of staff performing tests and the proper functioning of diagnostic equipment used by the facility.

3. Community Health Centers (CHCs) and Special Clinic Certifications

Community Health Centers (CHCs, sometimes referred to as "330 Clinics") are non-profit, community-based organizations that provide health care to low income and medically underserved areas and populations. The CHC program was established under section 330 of the Public Health Services Act, and federal grant funding is provided through the US Department of Health and Human Services, Health Resources and Services Administration (HRSA).[22]

Similar to many outpatient medical clinics, CHCs are required to provide typical primary care services[23] including:

- Health services related to family medicine, internal medicine, pediatrics, obstetrics, or gynecology provided by physicians, physician's assistants, nurse practitioners, nurse midwives, and health aides.
- Diagnostic laboratory and radiological services.
- Preventive services (prenatal services; screening for breast and cervical cancer; well-child services; immunizations; screenings for communicable diseases, environmental contaminants, and chronic health conditions; pediatric eye, ear, and dental screenings to determine the need for vision and hearing correction and dental care; family planning services; and preventive dental services.)
- Emergency medical services.
- Pharmaceutical services.

Additionally, community health centers are expected to provide:

- Referrals to providers of health related services including substance abuse and mental health services.
- Patient case management services including counseling, referral, and follow-up services.
- Patient education regarding health conditions and the availability and use of health services.

---

[22] For criteria for designation of Medically Underserved Areas/Populations and and health professional shortage areas, see http://bhpr.hrsa.gov/shortage/index.htm, www.hss.state.ak.us/dhcs/healthplanning or http://www.hss.state.ak.us/dph/healthplanning/primarycare/MUA.htm

[23] Primary care is the provision of professional, comprehensive health services that include health education and disease prevention, initial assessment of health problems, treatment of acute and chronic health problems, and the overall management of an individual's or family's health care services. It entails first-contact care of persons with undifferentiated illnesses, comprehensive care that is not disease or organ specific, care that is longitudinal in nature and care that includes the coordination of other health services.

CHCs differ from privately run physician offices and clinics in several ways. They are required to include a majority of consumer representatives on their Boards of Directors. Their funding is contingent upon demonstration in their funding proposals and utilization reports that they attend to the health status of the entire community in addition to the clinic's patient population. This often means that CHCs participate in prevention program opportunities to address such conditions as diabetes, hypertension, or chronic obesity. Further, chronic care management, medical homes, and the benchmarking of patient outcomes have been the foci of health center activities.

US Department of Health and Human Services, Health Resources and Services Administration, Bureau of Primary Health Care periodically makes US Public Health Service, Section 330 funds available to CHCs to expand their scope of services. Oral health and mental health services are two of the services that have been the focus of additional funding available to CHCs. Many Alaska CHCs have taken advantage of these funding opportunities, and increasingly CHCs are co-locating or otherwise integrating the provision of general dentistry and behavioral health services into their primary care clinics.

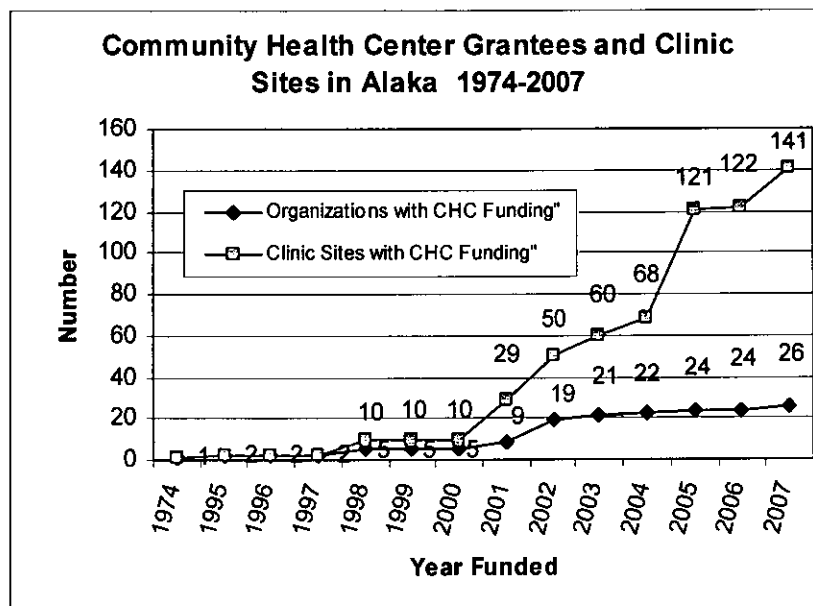


Figure 6: Growth in Number of Community Health Center Grantees and Clinics, 1974 - 2007

Between 1995 and 2009 the number of Community Health Centers in Alaska that were funded in part through Section 330 of the Public Health Service Act grew from two provider agencies – the Anchorage Neighborhood Health Center and Interior Neighborhood Health Center (Fairbanks) who were operating four sites in 1995, to 26 agencies operating 145 healthcare delivery sites.[24]

Community Health Centers are by definition "Federally Qualified Health Centers," or "FQHCs," which are further defined by section 1861 of the Social Security Act. [25] Tribally managed clinics are also FQHCs.

[24] Based on the sites listed as reporting to the Bureau of Primary Health Care's Uniform Data System. ftp://ftp.hrsa.gov/bphc/pdf/uds/2007/07Rollup_StateAK_08Jul2008.pdf

[25] Section 1861 of the Social Security Act "(4) The term "Federally qualified health center" means an entity which—

(A)(i) is receiving a grant under section 330 (other than subsection (h)) of the Public Health Service Act, or (ii)(I) is receiving funding from such a grant under a contract with the recipient of such a grant, and (II) meets the requirements to receive a grant under section 330 (other than subsection (h)) of such Act;

(B) based on the recommendation of the Health Resources and Services Administration within the Public Health Service, is determined by the Secretary to meet the requirements for receiving such a grant;

(C) was treated by the Secretary, for purposes of part B, as a comprehensive Federally funded health center as of January 1, 1990; or

(D) is an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act[423]."

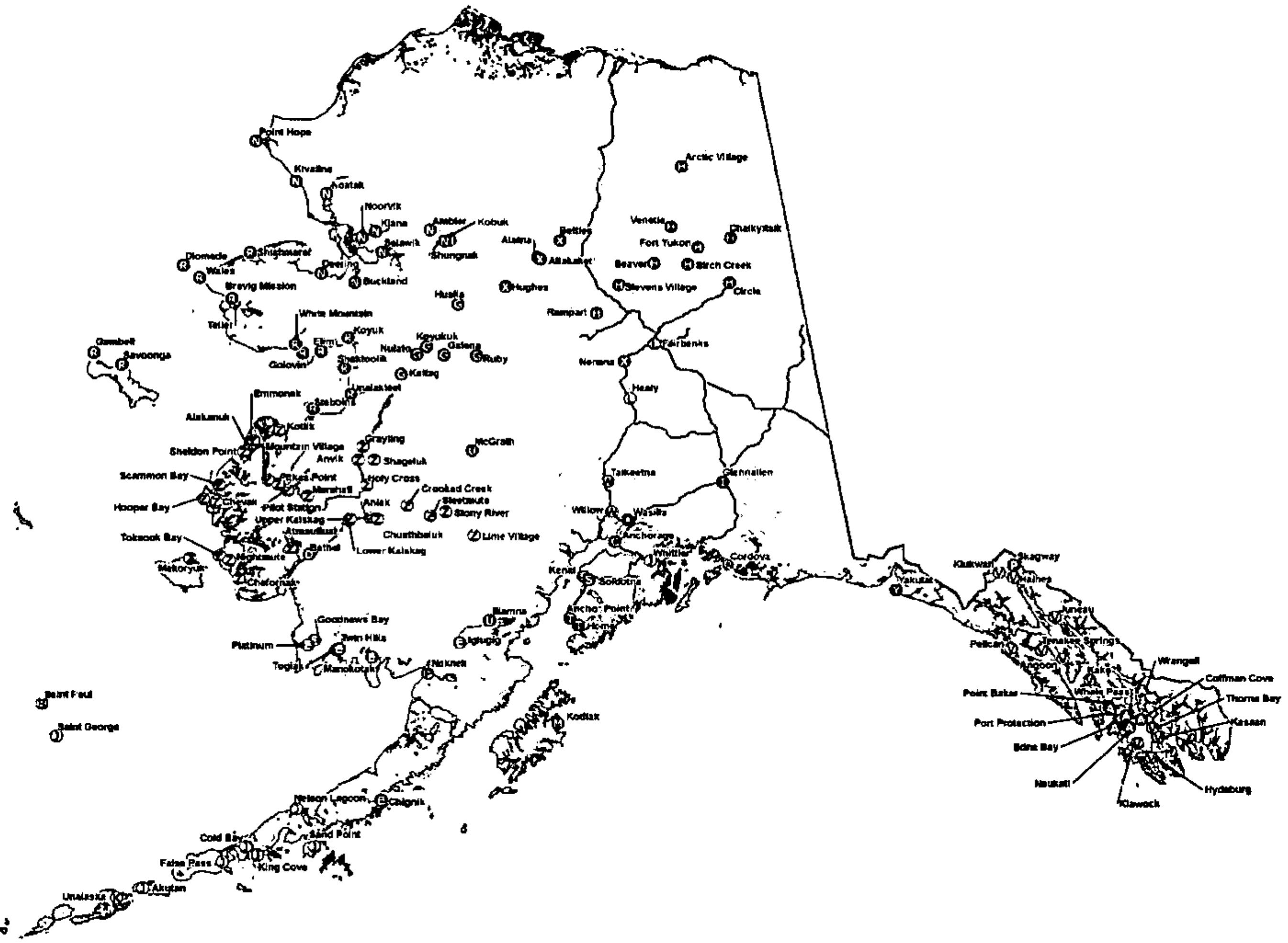
5061

5062

Figure 7: Map of the Alaska Community Health Centers, Prepared by Alaska Primary Care Association (David Wilson), Jan. 2009

Legend

- A Alaska Island Community Services
- B Aleutian Pribilof Islands Association
- C Anchorage Neighborhood Health Center
- D Bethel Family Clinic
- E Bristol Bay Area Health Corporation
- F Bristol Bay Borough
- G City of Galena
- H Council of Athabascan Tribal Governments
- I Cross Road Medical Center
- J Eastern Aleutian Tribes
- K Iliuliuk Family & Health Services
- L Interior Community Health Center
- M Kodiak Community Health Center
- N Maniilaq Association
- O Mat-Su Health Services
- P Municipality of Skagway
- Q Native Village of Eyak
- R Norton Sound Health Corporation
- S Peninsula Community Health Services of Alaska
- T Seldovia Village Tribe
- U Southcentral Foundation
- V SouthEast Alaska Regional Health Consortium
- W Sunshine Community Health Center
- X Tanana Chiefs Conference
- Y Yakutat Tlingit Tribe
- Z Yukon Kuskokwim Health Corporation



Frontier Extended Stay Clinics

In remote frontier areas of the country weather and distance can prevent patients who experience severe injury or illness from obtaining immediate transport to an acute care hospital. For residents in some of these communities providers offer observation services traditionally associated with acute care inpatient hospitals until the patient can be transferred or is no longer in need of transport. A Medicare demonstration project is under development in Alaska in which "Frontier Extended Stay Clinics" (FESCs) would be able to be reimbursed more adequately for the extended services provided to Medicare and Medicaid patients, as Medicare certified providers of these services.

Rural Health Clinics

A Rural Health Clinic is a clinic certified to receive special Medicare and Medicaid reimbursement. The purpose of the RHC program is improving access to primary care in underserved rural areas. RHCs must provide outpatient primary care and laboratory services, and are required to use a team approach of physicians and midlevel practitioners such as nurse practitioners, physician assistants, and certified nurse midwives to provide services. The clinic must be staffed at least 50% of the time with a midlevel practitioner.

RHCs can be for-profit or non-profit entities, and can be either publicly or privately owned and operated. Medicare visits are reimbursed based on allowable costs, and Medicaid visits are reimbursed under the cost-based method or an alternative Prospective Payment System (PPS). This may result in an increase in reimbursement over typical Medicare and Medicaid fee-for-service reimbursement rates.[26]

Rural Health Clinic certification was established under the Rural Health Clinics Act, passed by Congress and signed into law in 1977. The goal of this Act was twofold. First, it encouraged the utilization of physician assistants (PAs) and nurse practitioners (NPs) by providing reimbursement for services to Medicare and Medicaid patients by these health professionals, even in the absence of a full-time physician.[27] Second, it created a cost-based reimbursement

---

[26] Downloaded 08-17-09: http://www.raconline.org/info_guides/clinics/rhcfaq.php#whatis

[27] A physician assistant (PA) is a licensed health professional who practices medicine under the supervision of a physician. A physician assistant provides a broad range of health care services that were traditionally performed by a doctor. As part of the physician/PA team, a physician assistant exercises considerable autonomy in diagnosing and treating illnesses. What a physician assistant does varies with training, experience, and state laws. In general, PA's can provide approximately 80 percent of the services typically provided by a family physician. They perform physical exams, diagnose illnesses, develop and carry out treatment plans, order and interpret lab tests, suture wounds, assist in surgery, provide preventive health care counseling, and in 39 states, can write prescriptions. A PA can do whatever is delegated to him/her by the supervising physician and allowed by law. The scope of the PA's practice corresponds to the supervising physician's practice. For example, the PA working with a surgeon would be skilled in surgical techniques in the operating room, perform pre- and post-operative care, and be able to perform special tests and procedures.

Nurse Practitioner: The American Academy of Nurse Practitioners defines Nurse Practitioners as licensed independent practitioners who practice in ambulatory, acute and long term care as primary and/or specialty care providers. They provide nursing and medical services to individuals, families, and groups according to their area of practice/specialty. In addition to diagnosing and managing acute episodic and chronic illness, they also emphasize *(footnote continued)*

5063

mechanism for services when provided at clinics located in "underserved" rural areas.[28] Because of subsequent changes in the Medicare law authorizing Medicare Part B coverage for PAs and NPs in all practice settings (not just RHCs), the original incentive for utilizing PAs and NPs was diminished. However, because a RHC gets reimbursed the same amount from Medicare and Medicaid regardless of whether the patient is seen by a mid-level provider (MLP) such as a PA, NP, Certified Nurse Midwife (CMN), or physician, the clinic continues to have a strong incentive to utilize these practitioners whenever it is clinically appropriate.

In Alaska where a majority of rural primary health care programs have been run with funding from the Indian Health Services (IHS) and Section 330 Community Health Center grants (USDHHS Health Resources and Services Administration), the RHC program has not provided the same financial advantages that it has in other states. Tribally managed clinics have more favorable reimbursement rates than Rural Health Clinics for their Medicare and Medicaid patients. Also, many of the tribal clinics are already within the Community Health Center program.

There are currently three Medicare-certified Rural Health Clinics in Alaska: the Edgar Nollner Health Center in Galena, the Hoonah Midlevel Practice Clinic, and the Yakutat Community Health Center.

4. Physician, Dentist and Other Professional Offices

Many physicians and dentists in Alaska are practicing in solo practice offices, but many share professional office space with others or form group practice offices. Some are primary care physician offices, others include one or more specialties. Physicians and dentists, as well as other specialty service providers, are concentrated in Alaska's largest communities, likely due to the amenities available, support staff availability, referral resources, and access to other resources. As noted above, about a third of health care jobs are in health practitioners' offices, according to the industry survey data of the Alaska Department of Labor.[29] Thus in terms of practice settings, professional offices are the most common place of work.

Urgent care centers

Some physicians operate their office as an urgent care center or clinic. They have been established in Anchorage, Fairbanks, Juneau, Kenai, and the Matanuska-Susitna Valley. These can be operated by a single physician or group of practitioners, or the center can be affiliated with a hospital based health care system. Urgent care centers are primarily used to treat patients who have an injury or illness that requires immediate care, on an unscheduled or walk-in basis, but who's condition is not serious enough to warrant a visit to a hospital emergency department. Often urgent care clinics are not open on a continuous basis, unlike a hospital emergency room,

---

health promotion and disease prevention, incorporating teaching and counseling of individuals, families, and groups as a major part of their practice.

[28] "Underserved" means that an area has too few providers to meet the needs of the population. For official designation as an "underserved" area, the area needs to be found to be a "health professional shortage area," or HPSA, as defined in Federal regulations. The Alaska Primary Care Office in AKDHSS handles designation applications to the USDHHS health Services and Resources Administration, HRSA.
[29] Fried, N. "Alaska's Health Care Industry," *Alaska Economic Trends*, February 2008.

5064

but provide extended hours compared to a primary care physicians office. They often provide basic laboratory and imaging services, and referral is made to the appropriate health care provider for follow-up care and treatment. Urgent care centers have the same licensing requirements as that of a primary care physician's office or practice.

5. Mid-Level Provider Clinics

Mid-level providers (MLPs) include Nurse Practitioners, Certified Nurse Midwives, and Physician's Assistants.[30] Clinics staffed by MLPs include a handful of private clinics established by these providers. Several community clinics (such as Gustavus and Hoonah) run by communities or tribal organizations have hired mid-level providers as full-time or part-time staff, since the community does not have a population base sufficient to support a physician practice. Another example of mid-level clinic models in use in Alaska is the workplace clinic model used on the North Slope, where oil companies provide contracted physician's assistant services for their employees.

6. Publicly provided clinical medical services

Services provided by state and local health departments include the Municipality of Anchorage and State Public Health Nursing and emergency preparedness immunization programs' services, Early and Periodic Diagnosis and Testing (EPSDT), home visits to high risk newborns and families (upon referral), newborn hearing screening, infectious disease follow-up including follow-up of contacts, Sexually Transmittted Diseases screening and partner management, foodborne outbreak follow-up, and other services.

Alaska Health Fairs and various periodic volunteer programs including the "Northern Edge" training program (sponsored and carried out by the military) bring additional screening, health education, and in some instances treatment services, to selected communities each year. Also, for several years, Anchorage Project Access has organized voluntary donations of services by physicians, especially specialists, and has matched patients with physicians. The Anchorage Neighborhood Health Center (providing primary care services as a Community Health Center) has referred a number of its patients requiring more highly specialized care than the CHC can provide.

7. Comment on Health Care Safety Net

"Health Care Safety Net" is a term used to refer to health care providers who are required by law to see patients regardless of ability to pay. The"health care safety net" includes a wide variety of providers delivering care to low-income and other vulnerable populations, including the uninsured and those covered by Medicaid. Major safety net providers include public hospitals and community health centers as well as teaching and community hospitals, private physicians, and other providers who deliver a substantial amount of care to these populations.

[30] Definition of NPs and PAs in previous footnote.

5065

8. Health Facilites and the "Certificate of Need" Requirement

The Certificate of Need (CON) program as established in statute AS 18.07 is intended to promote the rational planning of health care facilities and health care services, improve citizen access to and choice of health care facility services, review the availability of qualified human resources available to staff facilities and provide services, contain the costs to the state for health care facility services paid for by public funds, and avoid the proliferation of unneeded health care facilities and services in the state through the application of approved standards, review of the needs and activities of an area, and considering input from residents.[31]

The certificate of need requirements of AS 18.07 apply to the following health care facilities licensed under AS 47.32:[32]

- an acute care hospital;
- a critical access hospital;
- an ambulatory surgical center;
- an intermediate care facility for the mentally retarded;
- a nursing facility;
- a psychiatric hospital;
- a residential psychiatric treatment center.

The CON requirements also apply to certain health care facilities that are not licensed under AS 47.32: independent diagnostic testing facilities and kidney dialysis centers. For facilities other than nursing homes and residential psychiatric treatment centers, the process is required if costs will exceed $1.3 million (as of 2009, threshold raised $50,000 each fiscal year).

II. LONG TERM CARE SERVICES AND FACILITIES

Long term care is distinct from acute care, which focuses on curing an illness or restoring an individual to a previous state of better health. Long term care encompasses a broad range of assistance, services, and supports to meet health and personal care needs over an extended period of time, from nursing home care to home based assistance.

The primary goal of long term care services is to enable senior citizens and disabled individuals to remain in their homes or communities and includes not only health care but services necessary to maintain quality of life including such things as housing and transportation.

Long term care is provided in a range of settings known as a "continuum of care" depending on an individual's needs and preference (Figure 8).[33] Most long term care is non-skilled personal care assistance, commonly referred to as custodial care, such as help performing everyday Activities of Daily Living (ADL) such as bathing and dressing, in the individual's home. Another level of care in the patient's home is home health care provided by skilled and licensed

---

[31] As articulated in public notice for regulations 8/12/2009

[32] Certificate of Need Program website http://www.hss.state.ak.us/dph/healthplanning/cert_of_need/

[33]Definitions for ***Continuum of Care Matrix,***
http://www.hss.state.ak.us/dph/healthplanning/movingforward/matrices/RDdefs.htm

5066

medical professionals. Alaska currently has 16 licensed Home Health Care agencies which provide skilled medical care to patients in their homes. Of these 16 agencies, nine are hospital based.

Long Term Care Continuum
← Least intensive/home based Moat intensive/institutional →

Home:	Day Services:	Assisted Living	Nursing Home
Home health aide Personal care attendant Prevention counseling Family support Dietary and exercise guidelines Meals on Wheels Hospice care – home visits	Adult day care Skilled nursing visits/home health service Physical/Occupational therapy Dialysis	Pioneer Home (may have medical care on or off site)	Rehabilitation Center Hospital Hospice care - institutional

Figure 8: Long Term Care Continuum of Care

When a patient is terminally ill, regardless of age, hospice care can be a choice for the patient and their family. Hospice care provides support by both medical professionals and trained volunteers focusing on the palliation, or relief of symptoms, of a terminally ill patient. This support can be physical, emotional, spiritual, or social. The State currently has 12 licensed Hospice agencies.

Senior housing provides living arrangements designed for handicapped accessibility and convenient access to services. When a senior citizen or disabled individual is no longer able to remain in his or her own home, or with supportive family members, other types of residential care may be available to allow the person to remain in the community. Group homes with assistive services are called "assisted living" facilities. Alaska Pioneer Homes are state-run assisted living homes. Assisted living beds (other than Pioneer Homes) average 2200 annually according to State Certification and Licensing, in about 260 homes.[34] The six Pioneer Homes have 508 beds. Skilled Nursing Facilities (SNFs) or nursing homes provide intensive services for those needing a higher level of care. They offer both short and long-term placements for senior who require significant nursing interventions each day. Alaska has 15 nursing homes with 716 beds.[35]

Assuming that age-specific migration and mortality patterns will remain similar to the current (2000-2005) patterns, it is projected that the population aged 65 and older will nearly triple by

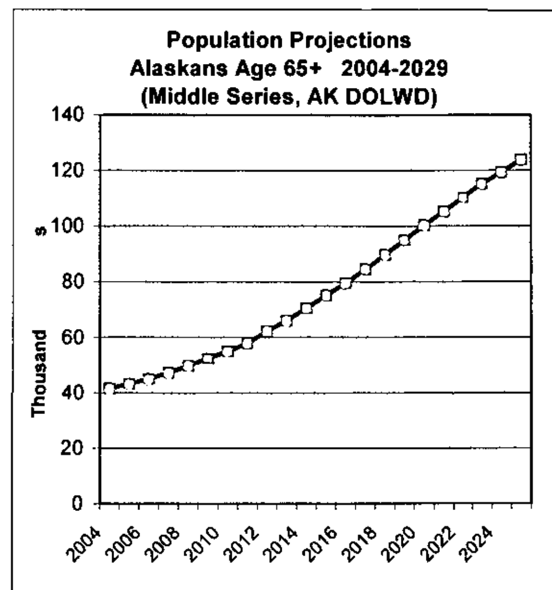
[34] 2009 count is 269 licensed senior assisted living facilities with 2,346 beds.
[35] Current Facilities List, by email from Certification and Licensing, July 31, 2009

5067

2025, from about 43,000 people in 2005 to about 124,000 in 2025.[36] Those who are 85 and over have the highest rates of use of long term care.

The Commission on Aging along with the Department of Health and Social Services, through their 2008-2011 Plan identifies the goal of Alaska seniors staying in their communities, and having access to an integrated array of health and social supports along the continuum of care.[37] These goals identify the concern for individuals to be able to maintain quality life through the least invasive and expensive services required in the continuum of care.

Figure 9: Population Projections Alaskans Age 65+, 2004-2029



The goal of keeping people in their homes and communities is also expressed through planning for services for individuals with developmental disabilities, to provide home and community based services where possible, for housing and support for employment.

Table 2: Number of Agencies Providing Long Term Care Services

Selected Agencies Providing Long Term Care Services	Number	Types of Employees	Beds (if applicable)
Home Health	16	PCA, Home Health Aide, RN	n.a.
Hospice	12	RN, LPN, Volunteers, LSW, others	n.a.
Senior Center	45*		n.a.
Pioneer Home	6		550
Assisted Living	269		2,346
Nursing Homes	15	RN, LPN, aides, physician supervision	716

*45 senior centers receive state or tribal funding; several others are known to exist with community funding.

[36] Alaska Population Projections, Alaska Department of Labor, 2007

[37] http://www.hss.state.ak.us/acoa/StatePlan.htm

III. BEHAVIORAL HEALTH FACILITIES

Facilities that offer care to people with mental illness and substance abuse problems range from community clinics (least intensive services) to hospitals for acute psychiatric care (North Star with 74 beds and Alaska Psychiatric Institute with 80 beds). Additional hospitals in Juneau, Fairbanks and regional hubs provide evaluation, stabilization, and short-term treatment and referral. Thirteen (13) non-profit organizations receive grants to provide residential substance abuse treatment.[38] Detoxification beds are available in Anchorage, Juneau, and Fairbanks.

Alaska has six Residential Psychiatric Treatment Centers in Anchorage for youth (total 183 beds), and a total of 438 residential psychiatric beds for youth (2009), distributed as follows:

- Northwest: 14
- Southwest: 13
- Anchorage/Mat-Su: 165
- Southeast: 114
- Interior: 117
- Kenai/Kodiak: 15

In addition, there are approximately 320 beds in "Treatment Resource Homes" with behavioral health services for youth. Most are located in the Anchorage Municipality and Matanuska-Susitna Borough.

Agencies across the state receive grant funds from the Department of Health and Social Services and the Alaska Mental Health Trust Authority[39] to assist residents with behavioral health needs and help to prevent suicide, substance abuse, and other problems. Approximately 65 organizations are receiving grants from the Department of Health and Social Services Division of Behavioral Health in FY 2010 to provide behavioral health treatment and recovery services.(See Behavioral Health Grantees List).

[38] These are:

Sitka Counseling and Prevention
Rainforest Recovery
Southeast Alaska Regional Health Corporation
Salvation Army Clitheroe
Southcentral Foundation
Akeela, Inc.
Volunteers of America - ARCH
Alaska Rehabilitation Services - Nugen's Ranch
Bristol Bay Area Health Corporation
Central Peninsula Hospital - Serenity House
Tanana Chiefs Conference
Fairbanks Native Association
Yukon Kuskokwim Health Corporation

[39] The Alaska Mental Health Trust Authority is a state corporation that administers the Alaska Mental Health Trust, a perpetual trust managed on behalf of Trust beneficiaries. The Trust operates much like a private foundation, using its resources to ensure that Alaska has a comprehensive integrated mental health program to serve Trust beneficiaries. Detailed elements of the program are included in the Alaska Statutes. (AS 47.30)

5069

By default, the Department of Corrections (DOC) has become the single largest provider of mental health care in Alaska. A 2006 study found that approximately 42 percent (1,524 of 3,628 as of June 30, 2006) of the people incarcerated in Alaska correctional facilities were Trust beneficiaries, with mental illness, substance-related disorders and/or mental disabilities.[40] Also many youth within the Division of Juvenile Justice system have a co-occurring disorder (substance related disorder accompanied by a mental health disorder). A current alternative to incarceration for adults with severe mental illness is diversion into Anchorage or Palmer Coordinated Resources Projects (therapeutic courts). Therapeutic court programs are also operating in Bethel and Fairbanks.

The DHSS Behavioral Health Integration Project, supported by the Co-occurring State Incentive Grant (COSIG) from SAMHSA, has developed the state's capacity to serve clients with co-occurring disorders. Integration of behavioral health and primary care has been advanced by some Section 330 Community Health Centers that have received special funding from HRSA to include services for mental health and substance abuse.

The Department of Health and Social Services coordinates with the Alaska Mental Health Trust Authority and associated boards to develop the Comprehensive Integrated Mental Health Plan to address the needs of Alaskans with mental and emotional illness, alcoholism and substance use disorders, brain injury, developmental disabilities, and Alzheimer's disease and related dementia. The Department and the Trust convene the interested parties to review and plan for population needs, facilities, workforce, and multiple program initiatives.

IV. EMERGENCY MEDICAL SERVICES

Seven Regional EMS Programs (three non-profit EMS councils, three programs based in regional health corporations, and one program residing in a borough-wide fire department) work with the community-based emergency medical services to be sure that emergency medical services personnel (EMTs) are available to respond to the emergency medical needs of Alaska's citizens and visitors, and to be sure that the personnel and their ambulances and air transport are properly equipped. The State Division of Public Health and Alaska Council on EMS have duties to certify EMTs and work with the EMS programs on their training, reporting and assurance of adequate equipment. "Medevacs" (air rescues) play a major role in Alaska.

[40] Hornby Zeller Associates, Inc. (December, 2007). *A Study of Trust Beneficiaries in the Alaska Department of Corrections*, p. ii. This does not include individuals in custody in community residential centers or in the contracted facility in Arizona.

5070

C. Health Care Providers

Health care professionals include a variety of specialists and primary care providers in medicine, dentistry, mental health and substance abuse services, and support services. In recent years, concerns about current and potential shortages of health care professionals have led to several studies of supply and demand, recruitment, and retention of physicians and other health care providers in Alaska.[41]

Primary Care and Specialty Medical Providers

Primary care services in Alaska are provided by a spectrum of providers, including over 800 primary care physicians, many of about 700 licensed mid-level providers (physician assistants and nurse practitioners), and about 550 Community Health Aides and Community Health Practitioners (see description below). The state licensing database (relying on address listed by the license applicant) shows that most physicians are located in larger communities, those with at least 1,000 people. Some of the physicians and mid-level practitioners practice in Community Health Centers and Rural Health Clinics (RHCs).

Several of the smallest hospitals have hired physicians directly to ensure staffing, and most larger hospitals as well as the tribally managed facilities have hired physician staff members, to serve as emergency room physicians, "hospitalists," or generalists who work in outpatient, inpatient and itinerant services.

Three quarters of primary care physicians (including family practice doctors, internists, pediatricians and obstetrician-gynecologists) are in the Anchorage-Wasilla, Fairbanks and Juneau areas. Recruitment and retention are difficult in remote areas. Turnover of health personnel is an ongoing problem.

The National Health Service Corps "scholars" program (with six placements in Alaska in 2009) and loan repayment program (with ten placements in Alaska in 2009), and the Indian Health Service loan repayment program, provide financial support in exchange for service for physicians and mid-level providers committed to work in health professional shortage areas.[42] A federal grant approved in September 2009 for a state-federal loan repayment program will expand the loan repayment opportunities for at least two years.

[41] Securing an Adequate Number of Physicians for Alaska's Needs, Alaska Physician Supply Task Force Report, August 2006 http://www.hss.state.ak.us/commissioner/Healthplanning/publications/assets/PSTF-06.pdf;
SORRAS I: Status of Recruitment Resources and Strategies (2004),
http://www.hss.state.ak.us/dph/healthplanning/publications/assets/SORRASreport.pdf;
SORRAS II: Status of Recruitment Resources and Strategies 2005–2006,
http://nursing.uaa.alaska.edu/acrh/projects/sorras_report05-06.htm ; and
Alaska Center for Rural Health, 2007 Alaska Health Workforce Vacancy Study,
http://nursing.uaa.alaska.edu/acrh/index_downloads/workforce_7-24-07_body-final.pdf
[42] For explanation and criteria for shortage designations, see Alaska Primary Care Office webpage http://www.hss.state.ak.us/dph/healthplanning/primarycare/PC_home.htm and USDHHS Health Resources and Services Administration, Shortage Designation Branch, http://bhpr.hrsa.gov/shortage/

5071

Specialists are more likely to be in the largest urban areas where they can rely on access for their patients to the tertiary care hospitals (those with more advanced services), the support staff and other support services that can support their practices. Ninety one percent of psychiatrists practice in the Anchorage-Wasilla, Fairbanks and Juneau areas, and 89% of other specialists are located in these urban areas.

Table 3: Licensed Physician, Mid-level and Dental Workforce, by Type, by Region. 2009

Region/Census Area	Medical Doctor	Osteo-path	Physician Assistant	Nurse Practitioner	Dentist	Hygienist
Statewide	1461	122	320	490	486	444
Anchorage/Mat-Su	967	76	179	315	279	287
Gulf Coast	112	15	29	48	53	50
Interior	163	17	55	52	70	50
Northern	19	5	14	9	10	5
Southeast	162	6	22	47	55	48
Southwest	38	3	21	19	19	4
Statewide	100%	100%	100%	100%	100%	100%
Anchorage/Mat-Su	66%	62%	56%	64%	57%	65%
Gulf Coast	8%	12%	9%	10%	11%	11%
Interior	11%	14%	17%	11%	14%	11%
Northern	1%	4%	4%	2%	2%	1%
Southeast	11%	5%	7%	10%	11%	11%
Southwest	3%	2%	7%	4%	4%	1%

*Generalists and Specialists (34 are licensed as specialists, without a "generalist" license)

Source: Alaska Division of Corporations, Business and Professional Licensing, Department of Commerce, Community, and Economic Development (2009).

Table 4: Alaska Physicians with Active Licenses, by Region and by Specialty, 2009

Specialty Group:	Anchorage -Mat-Su	Gulf Coast	Interior	North	South-east	South-west	Grand Total
FAMILY PRACTICE	207	57	41	21	67	27	420
INTERNAL MEDICINE	142	12	32	1	19	2	208
PEDIATRICS	91	2	13		13	5	124
OBSTETRICS AND GYNECOLOGY	59	3	9		2		73
GENERAL PRACTICE			1				1
PRIMARY CARE Total:	499	74	96	22	101	34	826
SURGERY	117	17	21		17		172
EMERGENCY MEDICINE	63	9	15		13	2	102
ANESTHESIOLOGY	68	4	12		6		90
PSYCHIATRY	64	5	8		11		88
RADIOLOGY	37	7	8	1	7		60
PATHOLOGY	24	2	3		1		30
OPHTHALMOLOGY	21	2	4		2		29
OTOLARYNGOLOGY	22	1	4		2		29
NEUROLOGY	14	2	2		1		19
UROLOGY	15	1	1		1		18
PHYSICAL MEDICINE/REHABILITATION	13				1		14
CARDIOVASCULAR DISEASE	13						13
DERMATOLOGY	8	1	2				11
MEDICAL ONCOLOGY	5						5
PREVENTIVE MEDICINE	4				1		5
RADIATION ONCOLOGY	4		1				5
AEROSPACE MEDICINE	1	1	1			1	4
ALLERGY AND IMMUNOLOGY	3				1		4
GASTROENTEROLOGY	4						4
NEONATAL-PERINATAL MEDICINE	3						3
OCCUPATIONAL MEDICINE	3						3
RHEUMATOLOGY	3						3
ANATOMIC AND CLINICAL PATHOLOGY	1				1		2
ENDOCRINOLOGY, DIABETES, AND METABOLISM	2						2
INFECTIOUS DISEASE	2						2
NEPHROLOGY	2						2
PEDIATRIC CARDIOLOGY	2						2
INTERVENTIONAL CARDIOLOGY	1						1
PEDIATRIC HEMATOLOGY-ONCOLOGY	1						1
PSYCHIATRY AND NEUROLOGY			1				1
PULMONARY DISEASE			1				1
SPORTS MEDICINE	1						1
Grand Total	**1020**	**126**	**180**	**23**	**166**	**37**	**1552**
Population (2008 Population Estimates)	367509	75876	104421	23612	69202	39100	679720
Physicians per 1000 population	2.78	1.66	1.72	0.97	2.40	0.95	2.28

Source: July 2009 Occupational Licensing Database. Active (AA status) resident physicians.

Nurses: RNs and LPNs are licensed; Certified Nurse Aides and Personal Care Attendants are not licensed. It should be noted that many nurses cycle into and out of Alaska from out-of-state employment services that help to fill needs for either specialist or generalist nurses, when local supply is insufficient to meet local needs. Data on numbers of such seasonal and/or temporary nurses is not available.

Region/Census Area	RN (Registered Nurse)	Practical Nurse
Statewide	6334	735
Anchorage/Mat-Su	4089	412
Gulf Coast	629	67
Interior	731	150
Northern	90	24
Southeast	660	70
Southwest	135	12
Statewide	100%	100%
Anchorage/Mat-Su	65%	56%
Gulf Coast	10%	9%
Interior	12%	20%
Northern	1%	3%
Southeast	10%	10%
Southwest	2%	2%

Table 5: Licensed Nurses

Physical and Occupational Therapists, active and resident in Alaska, August 2009:

Region/Census Area	Physical Therapists	Occupational Therapists
Statewide	421	186
Anchorage/Mat-Su	269	123
Gulf Coast	49	24
Interior	51	18
Northern	1	1
Southeast	43	20
Southwest	8	0
Statewide	100%	100%
Anchorage/Mat-Su	64%	66%
Gulf Coast	12%	13%
Interior	12%	10%
Northern	0%	1%
Southeast	10%	11%
Southwest	2%	0%

Table 6: Licensed Therapists, 2009

5074

Pharmacists: 471 pharmacists and 1246 pharmacy technicians are licensed in 2009 in Alaska. The vacancy study by Alaska Center for Rural Health suggests that thre is a serious shortage of these professionals.

Region/Census Area	Pharmacist	Pharmacy Tech
Statewide	471	1,246
Anchorage/Mat-Su	294	778
Gulf Coast	51	125
Interior	59	160
Northern	3	35
Southeast	55	130
Southwest	9	18
Statewide	100%	100%
Anchorage/Mat-Su	62%	62%
Gulf Coast	11%	10%
Interior	13%	13%
Northern	1%	3%
Southeast	12%	10%
Southwest	2%	1%

Table 7: Licensed Pharmacists and Techs, 2009

Behavioral Health Providers

Many rural Alaska communities have either only part-time workers helping with behavioral health needs or no mental health services other than the occasional itinerant provider. The *2009 Alaska Health Workforce Vacancy Study*[43] showed that the vacancy rates for all behavioral health occupations were about 10%, with psychiatrist and clinical psychologist vacancy rates about 16% statewide.

To help bridge the gaps in services, the Alaska Native Tribal Health Consortium has been developing a training certification program for behavioral health aides (BHAs). Currently there are 117 village-based behavioral health aide positions throughout the state, being funded by multiple sources. (Not all of these positions use the title BHA but they all operate within the BHA scope of practice). Where possible, BHA services are integrated into primary care settings.

Behavioral health professionals with current active licenses in Alaska (in August 2009) include 88 psychiatrists; 132 clinical psychologists (PhD); 417 licensed professional counselors; 77 marriage and family therapists; 488 social workers (bachelor's and master's level); and 40 psychological associates. Approximately 480 certified chemical dependency counselors, counselor technicians, and traditional counselors provide services throughout the state; many also have state behavioral health professional licenses. The levels and requirements for certification for the many categories of provider are summarized on the website of the Alaska Commission for Behavioral Health Certification.[44]

---

[43] http://nursing.uaa.alaska.edu/acrh/

[44] Alaska Commission for Behavioral Health Certification
http://www.nattc.org/getCertified/certification.asp?oldID=sakacbhc

5075

Sixty four of the State's 88 active licensed psychiatrists (73%) are located in Anchorage-Mat-Su area. Seventy percent of psychologists are in this area. Many are in private practice, others work partially or wholly as contractors or employees within the tribal system, the military or not-for-profit service agencies. Several Alaska-based and out of state psychiatrists itinerate to regional medical centers to provide psychiatric assessments and to oversee treatment for residents. Telemedicine has become a tool for increasing access to psychiatric services with links to remote sites across the state, through the tele-behavioral health program based at the Alaska Psychiatric Institute, the telebehavioral health network based at the Alaska Native Health Consortium, and through the Department of Corrections' links to prisons from Anchorage.

Table 8: Active Alaska Resident Licensed Providers in Behavioral Health (August 2009)

Region	Psychia -trist	Clinical Psycholo gist	Licensed Professional Counselor	Marriage & Family Counselor	Clinical Social Worker (BA, MSW, LCSW)	Psych Associate
Statewide	88	132	417	77	488	40
Anchorage -Mat-Su	64	92	230	51	259	30
Gulf Coast	5	10	30	6	41	3
Interior	9	16	64	9	71	6
North	0	1	10	0	13	0
Southeast	10	12	65	6	68	1
Southwest	0	1	18	5	36	0
Statewide	100%	100%	100%	100%	100%	100%
Anchorage -Mat-Su	73%	70%	55%	66%	53%	73%
Gulf Coast	6%	8%	7%	8%	8%	8%
Interior	10%	12%	15%	12%	15%	16%
North	0%	1%	2%	0%	3%	0%
Southeast	11%	9%	16%	8%	14%	3%
Southwest	0%	1%	4%	6%	7%	0%

ALLIED HEALTH PROVIDERS

Allied health professions are clinical health care professions distinct from medicine, dentistry, and nursing, but generally supporting those services in helping to meet patients' needs. Although they are an integral part of the overall delivery of care and assist in making the health care system function, there is relatively little information tracking these workers, except for the categories of workers for whom licensure is required by state law. Their salaries and other costs are generally rolled into administrative or program costs. The Alaska Center for Rural Health at University of Alaska Anchorage conducted a study called the Alaska Health Care Workforce

5076

Vacancy Study which identified allied health providers employed, positions available and vacancies.[45] Also, the Occupational Database files posted by the Alaska Department of Labor provide regular reports of employment by quarter, and total workers employed in each occupation each year, by standardized occupational code. Selected allied health occupations are listed in the following table, showing the average quarterly employment in Alaska for 2007 calendar year.

Table 9: Allied Health Employment (Average per Quarter, 2007)

Occupation	Average quarterly employment
Dental Assistant	1079
Dental Hygienist	584
Dental Lab Tech	59
EMT/ETT & Paramedic (308 licensed paramedics '09)	356
Medical & Clinical Lab Technician	297
Medical & Clinical Lab Technologist	238
Medical Records Technician	433
"Other" health technician (SOC code 292099)	401
Optician (74 licensed as dispensing opticians '09)	140
Optometrist (98 licensed, '09)	30
Pharmacy Technician (1126 licensed '09)	544
Psychiatric Technician	253
Physical Therapy Assistant	52
Radiologic Technician	428
Respiratory Therapist	165
Sonographer	39
Surgical Tech	94

Source : Alaska Department of Labor and Workforce Development, Occupational Database, http://laborstats.alaska.gov/?PAGEID=67&SUBID=212, accessed 8/10/2009

IV. PARAPROFESSIONALS (CHA/P, DHA, BHA)

The Community Health Aide (CHA) Program was developed in the 1950s in response to a number of health concerns including the tuberculosis epidemic, high infant mortality, and high rate of injuries in rural Alaska. In 1968, the CHA Program received formal recognition and congressional funding. The long history of cooperation and coordination between the federal and state governments and the tribal health organizations has facilitated improved health status in rural Alaska.

[45] http://nursing.uaa.alaska.edu/ACRH/projects/archives/ahw_vacancy.htm

5077

The CHA Program now consists of a network of approximately 550 Community Health Aides/Practitioners (CHA/Ps) in over 170 rural Alaska villages. CHA/Ps work within the guidelines of the 2006 *Alaska Community Health Aide/Practitioner Manual*, which outlines assessment and treatment protocols. There is an established referral relationship, which includes mid-level providers, physicians, regional hospitals, and the Alaska Native Medical Center. In addition, providers such as public health nurses, physicians, and dentists make visits to villages to see clients in collaboration with the CHA/Ps.

The Alaska Area Native Health Service has the responsibility for provision of medical and health related services to Indian Health Service beneficiaries residing in Alaska. These services are provided by tribal organizations within the Alaska Tribal Health System. The village based CHA/Ps are a vital link in the delivery system.

Community Health Aides are selected by their communities to receive training. Training centers are located in Anchorage, Bethel, Nome, and Sitka. There are four sessions of CHA training; each lasts three to four weeks. Between sessions, the CHAs work in their clinics completing a skills list and practicum. Completion of the four session training curriculum and successful completion of a clinical skills preceptorship and examination, qualify the CHA as a Community Health Practitioner (CHP). CHA/Ps at any level of training may obtain certification by the Community Health Aide Program Certification Board.

The Community Health Aide Program model is currently being used as a template to develop programs in the areas of dental care, behavioral health, and elder care.[46]

VI. COMPLEMENTARY AND ALTERNATIVE HEALTH PRACTITIONERS

The National Library of Medicine (Medical Subject Headings (MeSH) Section, 2002) classifies alternative medicine under the term complementary therapies. This is defined as therapeutic practices which are not currently considered an integral part of conventional allopathic medical practice. Therapies are termed as *Complementary* when used in addition to conventional treatments and as *Alternative* when used instead of conventional treatment.

The Office of Alternative Medicine, National Institutes of Health (Bethesda, Maryland, April 1995) defined "complementary and alternative medicine (CAM) as a broad domain of healing resources that encompasses all health systems, modalities, and practices and their accompanying theories and beliefs, other than those intrinsic to the politically dominant health system of a particular society or culture in a given historical period. CAM includes all such practices and ideas self-defined by their users as preventing or treating illness or promoting health and well being. Alternative therapies include, but are not limited to folk medicine, herbal medicine, diet fads, homeopathy, faith healing, new age healing, chiropractic, acupuncture, naturopathy,

---

[46] http://www.akchap.org/GeneralInfo.cfm

massage, and music therapy. In Alaska, licensed alternative or complementary providers are chiropractors, acupuncturists and naturopaths.[47]

Table 10: Licensed Complementary/Alternative Providers, 2009

Region/Census Area	Licenced Complementary/Alternative Providers		
	Chiropractors	Acupuncturists	Naturopaths
Statewide	220	74	37
Anchorage/Mat-Su	141	48	22
Gulf Coast	25	10	3
Interior	23	7	8
Northern	3	0	0
Southeast	24	9	4
Southwest	4	0	0
Statewide	100%	100%	100%
Anchorage/Mat-Su	64%	65%	59%
Gulf Coast	11%	14%	8%
Interior	10%	9%	22%
Northern	1%	0%	0%
Southeast	11%	12%	11%
Southwest	2%	0%	0%

Source: Alaska Division of Corporations, Business and Professional Licensing, Department of Commerce, Community, and Economic Development (2009).

[47] http://www.pitt.edu/~cbw/altm.html

Table 11: Summary of Major Health Occupational Groups' Employment Levels, 2007

Occupational Database: Alaska Health Care Employment	**Calendar Year 2007 Employment**	
("Covered employment" -- does not include self-employed or military)	Total People Employed in the Jobs during 2007	Average Quarterly Employment 2007
Allied Health	13,952	9,422
Nursing	10,088	7,581
Home Health Aides	3,497	2,191
Behavioral Health Professionals	3,480	2,394
Dental	2,805	1,806
Other professionals	2,737	1,941
Administration	1,719	1,304
Physicians	1,070	804
Lab techs	819	552
Pharmacists, Podiatrists & Speech/Language Pathologists	723	533
Mid-Levels (Physician Assistants, Nurse Practitioners)	595	382
EMTs (emergency medical technicians)	553	356
Radiologic Techs	547	428
Chiropractors	62	45
Grand Total	*42,647*	*29,737*

Source: Alaska Department of Labor and Workforce Development, Research and Analysis Section
The worksheet contains the count of workers by occupation for the calendar year. These files are continuously updated and posted to the Web periodically. Six months must pass before data for a particular quarter is considered complete.
The Occupational Database (ODB) contains occupation and place of work information for each wage and salary worker covered by unemployment insurance employed in Alaska. This data series differs from others published by Research and Analysis in that it provides information on each unique worker/employer combination rather than an average monthly employment count or a count of the number of jobs at a particular point in time.

Worker Count Data Limitation: The count of workers is comprised of each unique worker/employer combination. Workers holding jobs with multiple employers are counted more than once.
The worker count is presented for each calendar quarter and summarized for the calendar year. The calendar year totals represent the unique worker/employer count. An employee working all four quarters for the same employer is counted only once.
Occupation codes are based on the Standard Occupational Classification (SOC) system as published by the Office of Management and Budget in October 2000.
Self-employed are NOT included in the figures above. Note that 45 chiropractors were employed on average each quarter in "covered" employment – however there are 218 licensed chiropractors in Alaska with active licenses, so it is likely many are self-employed, not in employment covered by unemployment insurance.

5080

D. HEALTH INFORMATION TECHNOLOGY

HEALTH INFORMATION TECHNOLOGIES IN ALASKA

Health Information Technology (HIT) is expected to be a means to achieve more affordable, safe, and accessible health care. Digital applications available for use by health-care providers and organizations include personal health records (PHRs), electronic health records (EHRs), electronic medical records (EMRs), computerized physician order entry (CPOE) systems, and health information exchange (HIE) systems. All are governed by privacy and confidentiality regulations. Each of these refers to a different set of services:

- Personal health records are records the patient can have in his/her possession, to share with any health care provider seen, and have updated with each visit. Digital PHRs may be kept on a digital memory stick for the patient to carry. They may be self-contained or a copy of a record maintained by a provider.
- Electronic health records and electronic medical records are the mechanisms for replacing paper records with digital ones, that can be easier for doctors or other providers to "search" for medical history, prescriptions and lab results, and that can be stored locally or in a remote location for electronic retrieval or for "exchange" with another provider. Although they are often used interchangeably, there is a difference between EHR and EMR. The EHR is a comprehensive, longitudinal, record of the patient's medical history or complete medical record. EMR refers to the individual pieces of the EHR such as laboratory results, electrocardiograms, prescriptions, history and physical exams, post operative reports, radiology reports, etc.
- Computerized physician order entry (CPOE) is a process of electronic entry of medical practitioner instructions for the treatment of patients (particularly hospitalized patients) under his or her care. These orders are communicated over a computer network to the medical/nursing staff or clinical departments (pharmacy, laboratory or radiology) responsible for fulfilling the order. CPOE has the potential to decrease delays in order completion, reduce errors related to handwriting or transcription, allows order entry at the point-of-care or off-site, provides an opportunity to double check for duplicate or incorrect doses or tests, and simplifies inventory and posting of charges
- Health information exchange systems provide for electronic transfer of patient record information for various possible purposes: to store records in a central place for programs that have multiple service sites; for sending referrals or requested, approved reports between providers. Such information can be limited or comprehensive according to the permissions granted to a potential recipient based on need to know and the patient's requests and approvals.

Digital telehealth systems, such as teleradiology, laboratory reports, telebehavioral health, telepharmacy, and distance learning systems utilizing videoconferencing equipment are also emerging as ways intended to be cost-effective means to improve health care quality and outcomes.

ELECTRONIC HEALTH RECORD USE IN ALASKA

The Alaska EHR Alliance completed a state-wide survey of physicians (378 respondents) and clinic managers (62 respondents) to assess the status of EHR use in Alaska. 29 communities were represented in the survey.[48] This survey found that there are currently at least 55 different EHR systems currently being used in healthcare practices across the state. Of those 55 different EHR systems, no single entity holds a significant portion of the EHR market in Alaska with the two leading products being Centricity (11%) and eClinicalWorks (8%). Most (74%) of EHRs in use include a practice management system. Half of the EHRs are connected to labs and one third are connected to one or more pharmacy. One third of the EHRs in the survey did not connect to any other entity.

E-PRESCRIBING

Adoption of e-prescribing has been identified as being critically important to the advancement of e-Health. E-prescribing is recognized as a gateway technology that could speed the development of EHRs and widespread use of other HIT initiatives. Beginning January 1, 2009, CMS will provide an incentive to "successful e-prescribers." The Medicare e-Prescribing incentive is a new program authorized under the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008. The program begins January 1, 2009, and provides incentives for eligible professionals who are "successful e-prescribers." Efforts to maximize implementation of e-prescribing systems statewide could result in increase systemic use of other e-health components such as personal health records and electronic health records in both the private and public sectors of health care.

Additionally, there is a disincentive for health-care providers who do not become "successful e-prescribers" by 2012. Under rules adopted by the USDHHS Center for Medicare and Medicaid Services (CMS), eligible professionals who are not "successful e-prescribers" by 2012 will be subject to a differential payment (penalty) for Medicare services beginning in 2012. The differential payment would result in the physician getting 99 percent of the total allowed charges of the eligible professional's physician fee schedule payments in 2012, 98.5 percent in 2013, and 98 percent in 2014.

HEALTH INFORMATION EXCHANGE SYSTEM DEVELOPMENT

The current "system" of health information exchange for Alaskan healthcare providers is a conglomeration of disparate systems with a variety of capabilities and structural platforms that may or may not be interoperable with each other. An integrated Health Information Exchange HIE system is needed to bring the disparate systems together into one functional product that will improve access to critical health information by healthcare providers and the citizens of Alaska in an interoperable, secure, safe, and efficient manner.

Senate Bill 133 (SB 133), passed in the 2009 legislative session, is intended to modernize Alaska's health-care IT infrastructure by providing for development of a secure electronic Health Information Exchange (HIE) system that will bridge connections between disparate EHR

[48] Status of EHR Use In Alaska, 05/11/ 2009: http://www.aehra.org/images/downloads/summary_of_ehr_survey_findings_52009.pdf retrieved 08/11/2009

systems. A standards-based HIE will allow individual Alaskans to manage their own personal health records and to authorize their personal health-care providers to exchange electronic medical records in a timely, secure manner. The intended outcome of a fully implemented Alaska Health Information Exchange Network is to improve the patients' access to care, reduce unnecessary testing and procedures, improve patient safety, reduce health agency administrative costs, and enhance rapid response to public health emergencies.

The Alaska Department of Health & Social Services is the process of soliciting proposals for the statewide HIE Entity as authorized by SB 133.

TELEHEALTH

The Alaska Federal Health Care Access Network (AFHCAN) is a telehealth system composed of 248 sites across the state. A total of 44 federal beneficiary organizations participate in the network, including Native and tribal groups, veteran and military providers, and the state of Alaska. AFHCAN initially focused on developing store-and-forward telehealth solution, but has recently expanded into broadband video conferencing telehealth solutions. Store-and-forward solutions were initially developed in response to the limited availability of broadband connectivity in Alaska. Now, however, broadband connectivity supports the larger data payloads and image sets that are often part of an electronic consultation. It has become clear that store-and-forward telehealth offers significant advantages in a distributed multi-organizational health-care environment due to the flexibility it affords providers to respond to cases at their convenience.

Every year, the Alaska Native Medical Center (ANMC) responds to approximately 3,000 telehealth cases and handles 66 percent of these consultations in the same day. Perhaps more impressive is that 50 percent of these cases are responded to within 60 minutes. While store-and-forward was specifically designed to enhance primary care access, approximately 25 percent of all cases today are specialty consultation requests. Video conferencing capacity is also increasing at a rate of three to four times every 12–18 months, with a large deployment of endpoints (funded through the Alaska Federal Health Care Partnership) planned at ANMC in 2009–10 consistent with the growth of video teleconferencing capability at most of the regional health corporations throughout Alaska.

Department of Corrections psychiatric services unit has used video conferencing since [2000], for Anchorage-based psychiatrist and psychologist to provide follow-up and counseling to prisoners in facilities around the state.

The Alaska Psychiatric Institute (API) Tele-Behavioral Health care Services (TBHS) program was originally envisioned under the auspices of the Alaska Telehealth Advisory Council to serve rural communities in south-central and northern Alaska. The API TBHS multidisciplinary team of mental health clinicians provides behavioral health-care services to rural communities throughout Alaska by way of advanced video-teleconferencing technology. The program has continued to grow in the specific number of sites that may access psychiatry because of continuing integration with other information technology, video teleconferencing, and health-care provider networks across Alaska, including the Alaska Native Tribal Health Consortium,

5083

Alaska Federal Health Care Access Network (AFHCAN), the Alaska Rural Telehealth Network (ARTN), and GCI Connect M.D., a medical network that is comprised of over 200 facilities including clinics, hospitals, and medical corporations in the Pacific Northwest and Alaska.[49]

The Alaska Rural Telehealth Network (ARTN) is operational in 11 communities across Alaska, including Soldotna, Cordova, Petersburg, Wrangell, Valdez, Kodiak, Seward, Sitka, Glennallen, Unalaska, and Homer. All sites have digital X-ray capability and most have digital mammography. A Picture Archive and Communications System (PACS) has been implemented system-wide. The PACS is a computer network dedicated to the storage, retrieval, distribution, and presentation of various types of images including ultrasound, mammography, X-ray, computerized tomography (CT), and positron emission tomography (PET). It allows facilities to have their images read from an off-site location (i.e. a Radiologist not located in their facility), which is commonly referred to as teleradiology. The PACS also replaces the need for facilities to maintain hardcopy images on-site by digitally archiving the diagnostic images on the central storage facility – a server located at the Wide Area Network (WAN) core in Anchorage.

[49] GCI ConnectM.D., Medical Network Overview: http://www.connectmd.com/mednet.htm retrieved 04/05/2009.

II. HOW HEALTH CARE IN ALASKA IS FUNDED

A. Introduction

Health care in Alaska is funded by individuals, businesses, and local, state and federal government sources. Individuals pay out-of-pocket costs and contributions to insurance premiums amounting to one fifth of total expenditures. Businesses contribute almost another fifth of the total through purchase of insurance premiums, support for self-insurance programs, and worker's compensation medical benefits. Together the individual and business contributions, "private" sources, account for 38 percent of the total – just under $2 billion of the $5.3 billion total expenditures for health care in Alaska in 2005.

The most comprehensive recent Alaska-focused analysis of funding of health care (not including public health activities or facility construction) by ISER (UAA Institute of Social and Economic Research), identified Federal Government programs as the largest purchaser of these services, accounting for another 38 percent of the total -- $2 billion of the total of $5.3 billion. Local and state government expenditures for covering employee health benefits, for Medicaid and for other programs, make up the remaining 24 percent of the total.

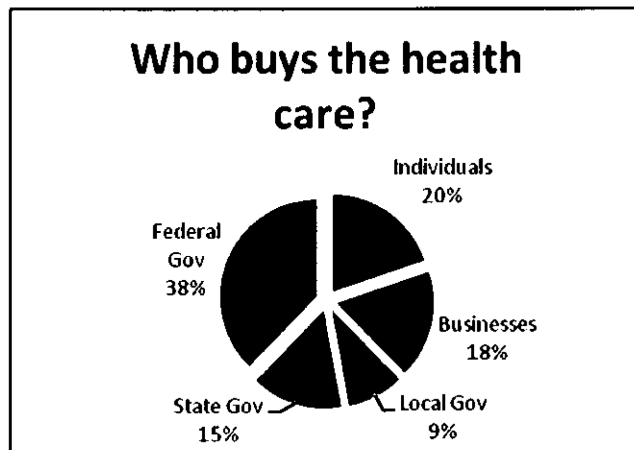


Figure 10: Health Care Purchasers in Alaska, 2005

Table 12: Health-Care Spending in Alaska, FY 2005

Who provides the coverage?	Who Buys the Health Care? (Millions of dollars)					
	Individuals	Businesses	Local Government	State Government	Federal Government	Total*
Individuals	$1,028					$1,028
Employers		$922	$454	$252	$411	$2,039
Government Health Programs			$38	$535	$1,654	$2,227
Total Spending	$1,028	$922	$492	$787	$1,950	$5,294

Source: *Alaska's $5 Billion Health Care Bill – Who Pays?* March 2006 UA Research Summary No. 6. Institute of Social and Economic Research, University of Alaska, Anchorage

Nearly a quarter of the Federal share is accounted for by military health services ($221,000), insurance premiums and self-insured costs. Half of the Federal share is attributable to Medicare and Medicaid claims paid, and another quarter covers Indian Health Service, veteran's benefits, community health centers and payments for services in elementary and secondary schools. ISER's previous study (1991) provides a base for comparison of rate of increase. In the fifteen year period, employer costs quadrupled, while government program expenditures tripled, and individual's contributions almost tripled.

B. Funding Sources: Expenditures, Services and Facilities Supported, and Covered Populations

A summary of "health care coverage" based on responses to the US Census Bureau's annual Current Population Survey (CPS) shows the following types of reported coverage by insurance programs and public programs (Table 13).

Table 13: Health Insurance Coverage of Alaskans, 2006-2008 Average

Health Insurance Coverage Type Average for data years 2006-2008	**Alaska**		**United States**
	Count	**Percent of Total**	**Percent of Total**
Covered by Any Source	547,203	81.8%	84.5%
Employer	388,381	58.0 %	59.0%
Individual (self-purchased)	42,891	6.4 %	9.0%
Medicaid & Denali KidCare	78,636	11.8 %	13.4%
Medicare	57,384	8.6 %	13.9%
Military/VA	88,944	13.2 %	3.7%
Uninsured all year	121,713	18.2%	15.5%
Total	668,917	(percentages add up to more than 100% because of overlapping coverage types)	

Source: Current Population Survey (CPS), 2007-2009 surveys, 2009 data released September 2009

It is important to note that if otherwise-uninsured American Indians and Alaska Natives are redefined as "covered," then the estimate becomes 14% "uninsured" in Alaska (15% in the US) By CPS definition, "uninsured" includes people of Alaska Native and American Indian Race who may have access to IHS-funded services. In Alaska this is 19% of the uninsured. 63% of

Alaska Natives are covered by private insurance (36%) or public programs (27%), 36% have no health insurance.[50]

Being "underinsured" (lacking insurance coverage or personal resources to pay for specific services, or being required to pay deductibles or co-payments that exceed personal resources) is a major problem to many individuals even though they have some coverage. It is also an issue for their health care providers. How many people are "underinsured" is not known. Data are available from surveys asking people about their perceptions, for example, did you decide not to see a doctor or other health care provider because of cost? Data from hospitals about levels of charity care, "self-pay" patients, and "left against medical advice" may be informative.

a. **Private Insurance** – including all employment-based except military, and individually purchased policies -- $2.281 billion (43% of total)
   - Private insurance is generally interpreted to mean both the insurance products sold to employers and employees, and to individuals, whether the employment is for a private for profit or not-for-profit firm. Individuals who pay for private insurance are likely to pay for a policy premium, and then also to pay co-payments, deductibles, and out-of-pocket costs of any services not covered by the insurance policy. The ISER estimates[51] found that about 42 percent of individuals' costs were for such out-of-pocket expenses .
   - Expenditures for "self-insured" programs include employers' contributions to such programs. In Alaska, about two thirds of all employers' (non-military) contributions are to such self-insured plans, while only one third is for "insurance premiums" in the private sector, for the insurance products regulated by the State's Division of Insurance.
   - Covered lives: the most recent Alaska Division of Insurance survey of health insurers reported 86,645 individuals were covered under comprehensive health insurance plans at year-end 2008. These numbers are reported by the insurers. The estimate suggests that as many as 340,00 individuals are covered through employer-based "self-insured" plans. (See table of Coverage Type above.)
   - Rolling up the expenditures managed by private insurance and "self insured" (private and public) entities, and the premium payments by individuals, the ISER report estimates $1.685 billion in expenditures for what we generally consider "employment based health insurance." This accounts for about 32% of health care expenditures in FY2005.

---

[50] Tribal contract health care facilities are legally required to serve their tribal members. Other qualified American Indians/Alaska Natives may be eligible to receive care as determined by the organization. This policy makes it difficult or impossible for an American Indian or Alaska Native who leaves his tribal home for education or employment to receive the health care services to which he is legally entitled. This lack of "portability" as well as limitations in some of the services that can be provided is the basis for the Census Bureau determination not to count IHS beneficiary status as "heath insurance coverage."

[51] *Alaska's $5 Billion Health Care Bill – Who Pays?* March 2006 UA Research Summary No. 6. Institute of Social and Economic Research, University of Alaska, Anchorage

5087

b. Public insurance and coverage

i. Medicare -- $0.419 billion (Federal)

Medicare provides coverage for health care for about 54,000 individuals in Alaska including 44,000 senior citizens (age 65 and over) and about 10,000 disabled individuals and people with end stage renal disease. Allowable costs include "Part A" (primarily inpatient) services, "Part B" (primarily outpatient/physician/clinic services) for those participating and paying a monthly enrollment fee, and certain prescription drugs under "Part D" for those who have selected that option. With the aging of the baby boomers, a cohort of about 5,000 new "seniors" will join the ranks of the senior population over the next five years, while about 1,800 deaths per year will deplete the population 65 years and over, so the net increase may be over 3,000 Medicare-eligible people per year.

For the individuals with end stage renal disease, benefits include inpatient, outpatient, and home dialysis (including training, equipment and supplies, and drugs) – not paid for are blood, transportation, or dialysis aides or technicians coming to house. Although dialysis facilities reimbursed must be certified by Medicare (CMS), a patient can obtain services at any approved site in the country, so travel is not restricted for individuals who need service usually two or three times a week. Kidney transplant costs are also allowable – organ registration fees, laboratory tests for the patient and potential donors, full cost of care for donor, and immunosuppressant drugs.

Physician participation/availability: Concern about availability of physicians who will accept Medicare patients has emerged in Alaska in the last five years. The issue arose when a two-year special reimbursement rate for Alaska physicians (effective in 2004 and 2005, providing a differential for Alaska physicians 67% above the US average) sunset in January 2006. For the three years 2006-2008, the Medicare differential for Alaska was about 5% above the US average. A new geographic differential for Alaska (29% above the US average) for "physician work" was effective January 1, 2009, but the reports of physician non-participation continue.

First in Fairbanks, then Anchorage, participants at health care forums and articles in newspapers across the state reported that physicians – especially primary care providers - - were refusing to accept new Medicare patients, and in some cases were telling established patients they would no longer see them. This selective refusal to see Medicare patients appears generally not to have been followed up by notification to CMS that the provider was "opting out" of the Medicare program, so the officially reported "participation rate" for Alaska providers is still high (11% opt-out rate reported in March 2009 by ISER).[52]

[52] Frazier, Rosyland and Foster, Mark, "How hard is it for Alaska's Medicare Patients to Find Family Doctors?" March 2009, UA Research Summary No. 14. Institute of Social and Economic Research, University of Alaska Anchorage.

5088

Provider non-participation has major consequences for patients who may have Medicare as "primary" payer and state retirement benefits or state employment or other insurance as secondary payer, since refusal of the primary payer to pay results in denial of all payers. As a result, individuals who thought they were very well insured found themselves paying out of pocket for all their health care costs or having to seek care from new providers. Medicare patients able to reach a federally funded community health center (CHC) can obtain at least primary care services at such clinics.

The CHCs have experienced very large increases in the number of Medicare patients seen each year since 2000 – from about 3,000 in 2002 to 7,000 in 2007. Some of the increase is attributable to the addition of community health center sites, but most of the increase is believed to have occurred in the urban clinics. In 2007 about 15 percent of all Medicare enrollees were using CHCs as at least one source of care. Anchorage Neighborhood Health Center Executive Director has reported dramatically increased numbers of Medicare patients using the Center, and also increased referrals to the Anchorage Project Access, which matches patients to specialists who have volunteered to see a certain number of charity care cases.

ii. Medicaid - $0.303 billion State of Alaska, $0.667 billion Federal (FY 2005)

Medicaid is an "entitlement program" created by the federal government, but administered by the state, to provide payment for medical services for low-income citizens. People qualify for Medicaid by meeting income and asset standards and by fitting into a specified eligibility category. Under federal rules, DHSS has authority to limit services as long as the services provided are adequate in "amount, duration, and scope" to satisfy the recipient's medical needs.

Medicaid began as a program to pay for health care for poor people who were unable to work. It covered the aged, the blind, the disabled, and single parent families. Over the years, Medicaid has expanded to cover more people. For instance, children and pregnant women may qualify under higher income limits and without asset limits. Alaska's Medicaid expansion for these children and pregnant women is called Denali KidCare. Families with unemployed parents may qualify, and families who lose regular Family Medicaid because a parent returns to work may continue to be covered for up to one year.

There have also been changes in the eligibility rules for people who need the level of care provided in an institution, such as a nursing home. Now, most Alaskans who need — but cannot afford — this expensive care may qualify for Medicaid. In addition, provisions within the Alaska Medicaid program give some people who need an institutional level of care the opportunity to stay at home to receive that care.

5089

iii. Dual Eligibility (for Medicare and Medicaid) – annual expenditure amounts for either program included in above totals

Low income seniors and disabled people may have "dual eligibility" for Medicare and Medicaid coverage, in which case Medicare pays first for what it covers, and Medicaid only pays for services (including beneficiary cost sharing) that are not paid by Medicare. In Alaska, Medicaid generally covers the cost of the Part B (currently $96.40/month) for all recipients. Part B is the part of Medicare that covers physician, outpatient, some pharmaceutical, and other treatment and rehabilitation services. Part A covers hospital services; few people have to pay premiums for Part A, but Alaska Medicaid will pay those for dual eligibles if necessary.

Also Medicaid recipients do not have to pay a Part D (Pharmacy Benefit) ($37/month) premium for basic plans, and have greatly reduced cost-sharing.

iv. Indian Health Service Funds for Alaska Natives and American Indians - $0.401 billion Federal (FY 2005)

Alaska Natives and American Indians in Alaska from Federally recognized tribes are entitled to health care provided by Indian Health Service, in Alaska primarily through tribal contracts to provide health care services. A portion of these funds are used for "contract health services," purchase of specialty or out of area care from non-tribal providers for beneficiaries when the services are not available through the tribal system.

c. Other

i. COBRA: The *Consolidated Omnibus Budget Reconciliation Act* (*COBRA*) provides certain former employees, retirees, spouses, former spouses, and dependent children the right to temporary continuation of health coverage at group rates. This coverage, however, is only available when coverage is lost due to certain specific events. Group health coverage for COBRA participants is usually more expensive than health coverage for active employees, since usually the employer pays a part of the premium for active employees while COBRA participants generally pay the entire premium themselves. It is ordinarily less expensive, though, than individual health coverage. Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. The law amends the Employee Retirement Income Security Act, the Internal Revenue Code and the Public Health Service Act to provide continuation of group health coverage that otherwise might be terminated.[53]

ii. ACHIA: The Alaska Comprehensive Health Insurance Association (ACHIA) was created by the Alaska State Legislature in 1992 to provide access to health insurance

[53] http://www.dol.gov/ebsa/faqs/faq_consumer_cobra.html downloaded 08-17-09

5090

coverage to all residents of the state who are unable to obtain individual health insurance due to a preexisting medical condition and who meet certain eligilibity requirements.[54]

iii. Federal Programs providing care (includes some of the SAMHSA funds)
Military care provision (direct)
Veterans services
Tri-care – insurance-like coverage for dependents
Federal employee benefits

iv. Federal Grants: support operating costs (fixed grant amounts each year) for Community Health Centers, and support Frontier Extended Stay Clinic demonstration project development – also limited direct services provided by several small demonstration projects – but little actually go to patient care which is covered through the claims-based programs.

v. Denali Commission: Federal funding of village clinics, regional clinics and hospital clinics, also some behavioral health facilities.

vi. Anchorage Muni: Maternal Child Health, immunizations (public health activities that relate to provision of health care – there are also many monitoring, assessment, prevention, health education – health promotion, protection and disease prevention activities not addressed here; see http://www.muni.org/departments/health/pages/default.aspx.)

vii. Volunteer activities:

- Anchorage Project Access (APA) uses a volunteer network of providers to increase access to health care for low-income uninsured members of the Anchorage area. Currently, 333 physicians, 98 mid-level providers, and other support services participate in APA's provider network. Patients are carefully screened for income eligibility, and cannot be eligible for other programs. Since December 2005, APA has processed over 2,035 applications for eligibility, with over 1,110 applicants meeting program eligibility guidelines and receiving medical treatment. See www.anchorageprojectaccess.org.

viii. State general funds:

- Public health services that provide direct care – Early and Periodic Screening, Diagnosis and Testing (EPSDT), newborn hearing screening, immunization clinics, other.

- Division of Juvenile Justice, Department of Corrections, Office of Children's Services, Department of Education each pay for health services for clients to some degree.

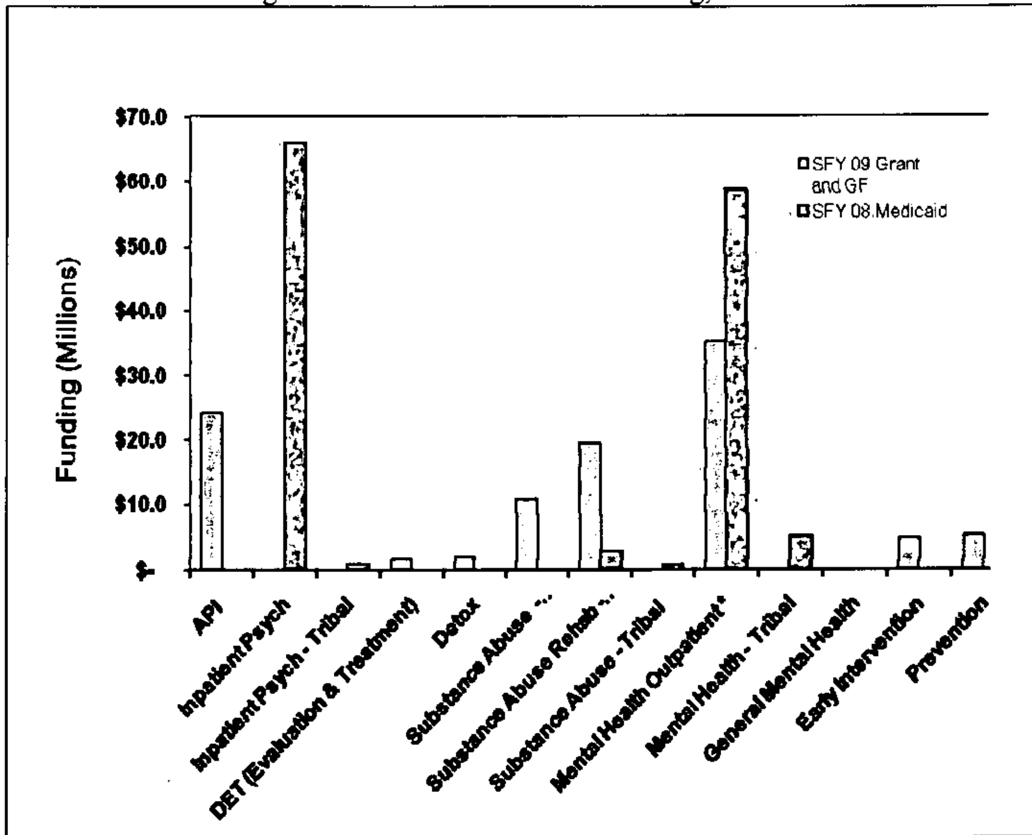
[54] www.achia.com

5091

- Fishermen's Fund: Established in 1951, the Fishermen's Fund provides for the treatment and care of Alaska licensed commercial fishermen who have been injured while fishing on shore or off shore in Alaska. Benefits from the Fund are financed from revenue received from each resident and nonresident commercial fisherman's license and permit fee.

- Division of Behavioral Health funds for provision of behavioral health services (i.e., not services billable to insurance). Note in the figure below, showing the funding of the continuum of care, that the majority of state funding (both Medicaid and operating API) go to the most intensive mental health and substance abuse treatment services.

Figure 11: Behavioral Health Funding, SFY09



Source: Alaska Division of Behavioral Health, Policy and Planning Unit, March 2009