

**2/08/11**

**PRESENTATIONS :**

**ALASKA HEALTH**

**CARE COMMISSION**

**& ALASKA**

**CHILDREN'S**

**JUSTICE ACT**

**TASK FORCE**

<TARGET><BILL></BILL><SUBJECT>2-08-11 PRESENTATIONS  
ALASKA HEALTH CARE COMMISSION and ALASKA CHILDREN'S  
JUSTICE ACT TASK  
FORCE</SUBJECT><COMM>HHSS27</COMM></TARGET>

## **Alaska Health Care Commission's 2010 Report**

**Presentation to the House HSS Committee**

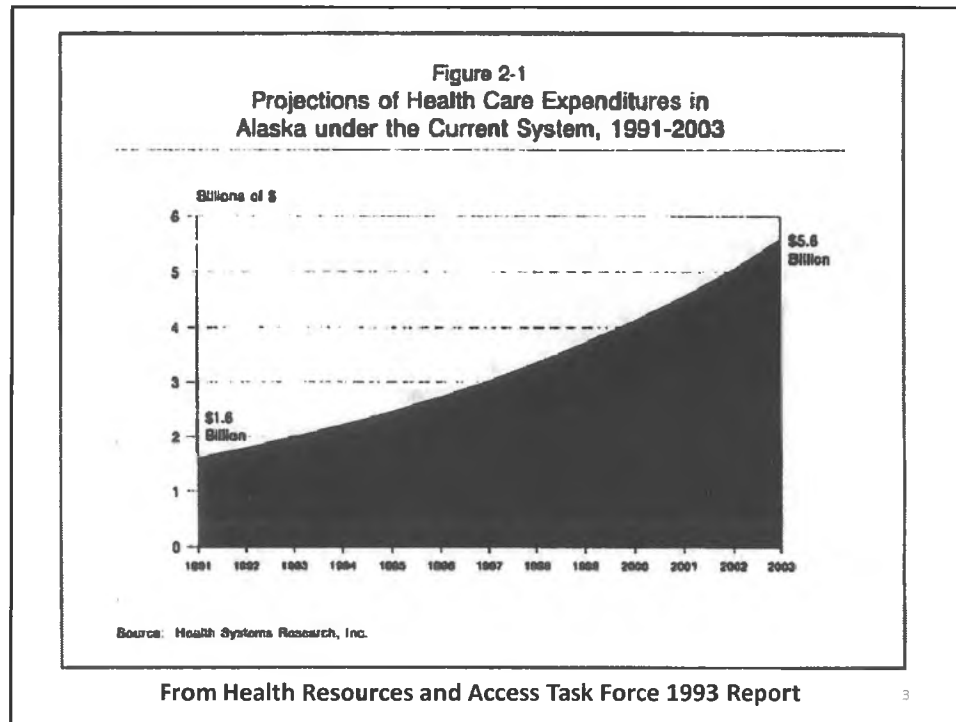
Deborah Erickson, Executive Director

Ward Hurlburt, MD, MPH, Chair

February 8, 2011

### **A Brief History of Health Reform Attempts in Alaska...**

<b>1987 – 1988</b>	Governor's Interim Health Care Commission
<b>1991 – 1993</b>	Health Resources & Access Task Force
<b>1993 – 1994</b>	Commonwealth North (CWN) Report
<b>2003 – 2005</b>	CWN Alaska Health Care Roundtable
<b>2007</b>	Alaska Health Strategies Planning Council



## Significance of Health Care to SOA

- State Operating Budget (\$7.3 B (FY 11; w/o debt))
  - Medicaid \$1.4 B (DHSS \$2.3 B)
  - Education 1.4 B
  - Transportation .7 B
  - University of Alaska .8 B
  - Public Safety .2 B
  - Courts .1 B
  - Corrections .3 B

## Alaska Health Care Commission

- Created by Governor Palin under Admin Order # 246
  - Convened February 2009 – January 2010
  - Released 2009 Report 1/15/10
  - Terminated with release of report
- SB 172 established Commission in statute (AS 18.09.010)
  - Passed by the Legislature April 2010
  - Signed into Law by Governor Parnell June 2010
  - New members appointed September 2010
    - Transition clause retained former members
  - Convened October 2010
  - Released 2010 Report 1/15/11

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## Alaska Health Care Commission

AS 18.09.010

### **Purpose:**

Foster development of a statewide plan to address quality, accessibility and availability of health care for all citizens of the state

### **Duties:**

- State health planning and coordinating body
- Foster development of:
  - Comprehensive statewide health care policy
  - Strategy for improving the health of Alaskans
- Annual Report due to Governor and Legislature January 15

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## Membership

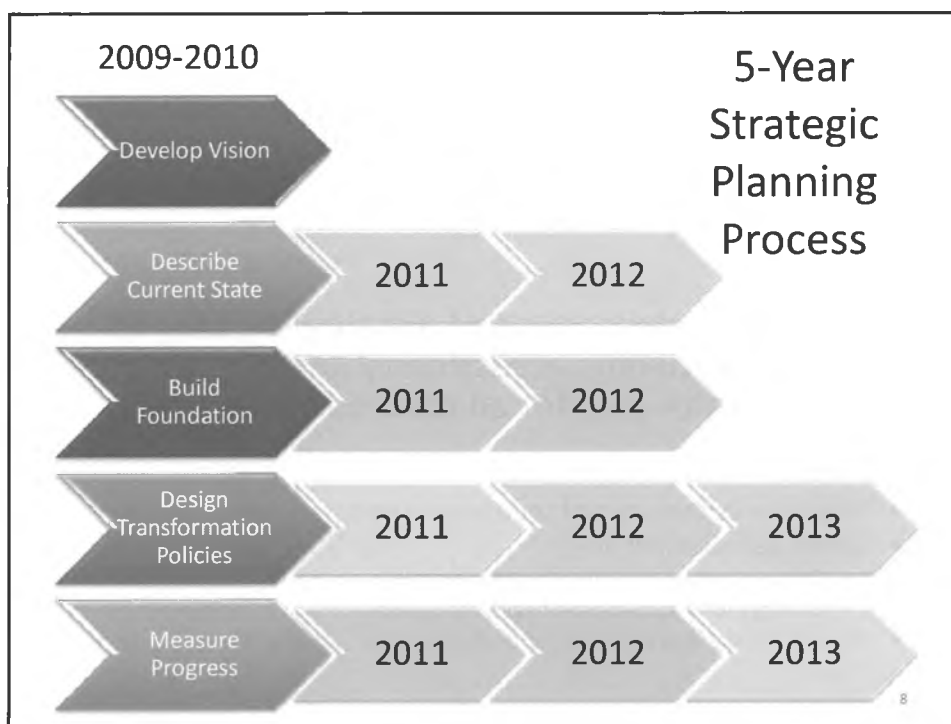
### 11 Voting Members *(New seats added by SB 172 italicized)*

- DHSS Chief Medical Officer – designated Chair *Ward Hurlburt, MD, MPH*
- Tribal health community *Valerie Davidson*
- Statewide chamber of commerce *Wayne Stevens*
- Alaska State Hospital & Nursing Home Association *Patrick Branco*
- Health care provider *Larry Stinson, MD*
- Health insurance industry *Jeff Davis*
- Health care consumer *Keith Campbell*
- *Primary care physician T. Noah Laufer, MD*
- *Alaska Mental Health Trust Authority Emily Ennis*
- *Community health centers David Morgan*
- *U.S. Dept. of Veterans' Affairs health care industry Col. Paul Friedrichs, MD*

### 3 Ex-Officio Members

- House of Representatives *Wes Keller*
- Senate *Donny Olson, MD*
- Office of the Governor *Linda Hall*

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## Develop Vision

### Vision

*Alaska's health care system produces improved **health** status, provides **value** for Alaskan's health care dollar, delivers consumer and provider **satisfaction**, and is **sustainable**.*

### Reform Goals

- I. Increased Access
  - II. Controlled Costs
  - III. Improved Quality
  - IV. Prevention-Based
- } VALUE

### Values

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

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## Describe Current State

- I. Description of System (2009 Report)
- II. Overview of Federal Reform/Impact on AK (2010)
- III. Analysis of Current Conditions (planned for 2011)
  - A. Cost Analysis (total expenditures; services & payers; cost drivers)
  - B. Price Comparison Study
  - C. Health Status Assessment
- IV. Analysis of Current Conditions (potential for 2012?)
  - D. Quality of Care Study (utilization, efficiency, appropriateness, effectiveness of care)

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## Describe Current State

### I. Description of System (2009 Report)

- How Health Care in Alaska is Delivered & Funded
- Issues Identified:
  - Costs are unaffordably high and continue to climb
  - The delivery of health care services is fragmented
  - Financing and payment mechanisms are complex
  - Many Alaskans lack health insurance
  - Some Alaskans cannot find a doctor to care for them
  - There are high vacancy rates in Alaska's health care workforce
  - Levels and variations in quality of care are not well understood
  - Consumers and health care providers are frustrated
  - The system as currently designed is not sustainable

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## Describe Current State

### The High Cost of Care in Alaska

- Alaska has the highest annual Medicaid expenditure level per enrollee in the nation at \$10,417 (2004)
- Alaska has ranked first in the nation for cost of Workers' Comp premium rates since 2005
  - Alaska has the highest Worker's Comp medical fee schedule rates in the nation – on average 3.5 times higher than the state with the lowest rates (2006)
  - Medical costs make up 72% of total Worker's Comp benefit claims in Alaska, compared to the national average of 58% (2008)
  - Alaska's average medical cost per Workers' Comp claim is \$40K per injury compared to the national average of \$26K (2008)
- The average cost per hospital stay in Alaska is \$27,171 compared to the national average of \$15,455 (2007)
- The price for medical care in Anchorage doubled between 1991 and 2005, while the Anchorage CPI for all items increased 38% during that same period

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### Differences in Medicaid Fees, 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%

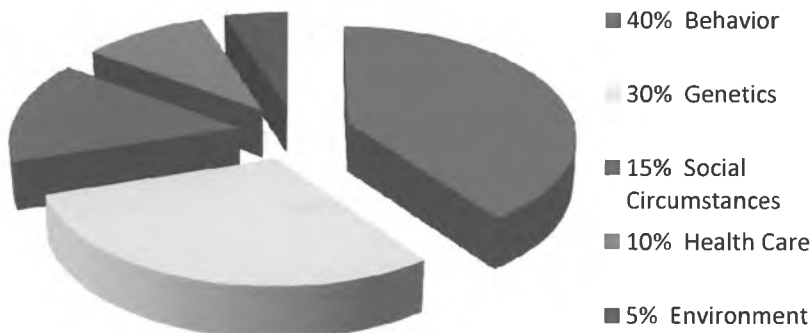
### Differences in Workers' Comp Fees, 2006

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

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## Describe Current State

### Determinants of Health



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## Describe Current State

### Chronic Disease accounts for

- 70% of all deaths in the U.S.
- 4 of the 5 leading causes of death in AK
- 75% of all health care expenditures

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## Describe Current State

### III. Analysis of Current Conditions (planned for 2011)

- A. Cost Analysis (total expenditures; services & payers; cost drivers)
- B. Price Comparison Study
- C. Health Status Assessment

### IV. Analysis of Current Conditions (potential for 2012?)

- D. Quality of Care Study (efficiency, appropriateness, effectiveness of care)

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#### Variables Contributing to Cost of Health Care

Cost (total expenditures) =

Price (per process) x Utilization

Utilization =

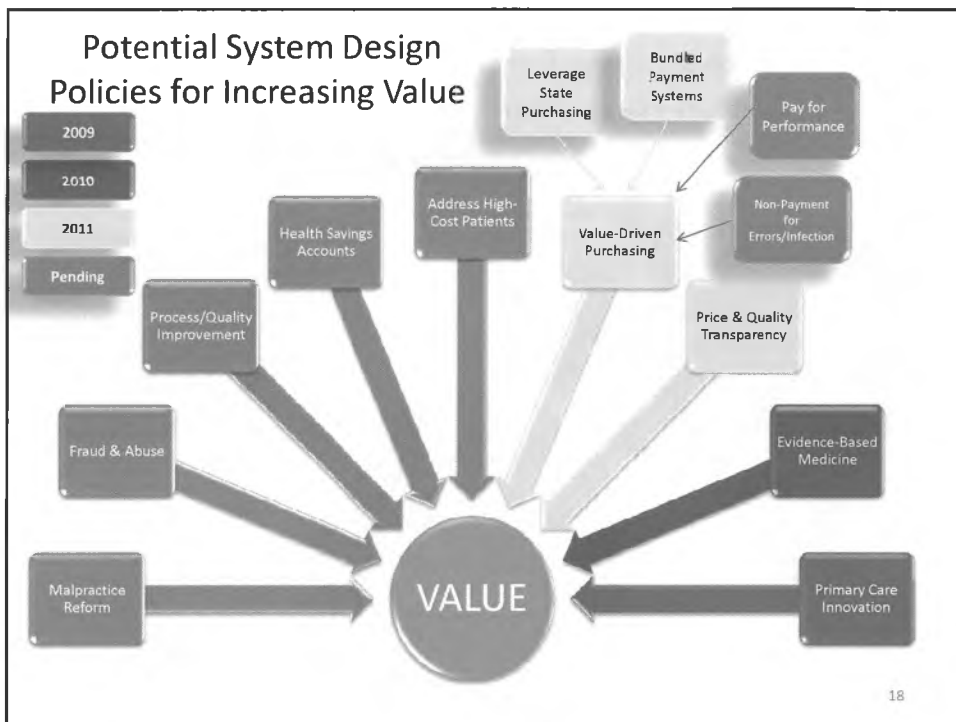
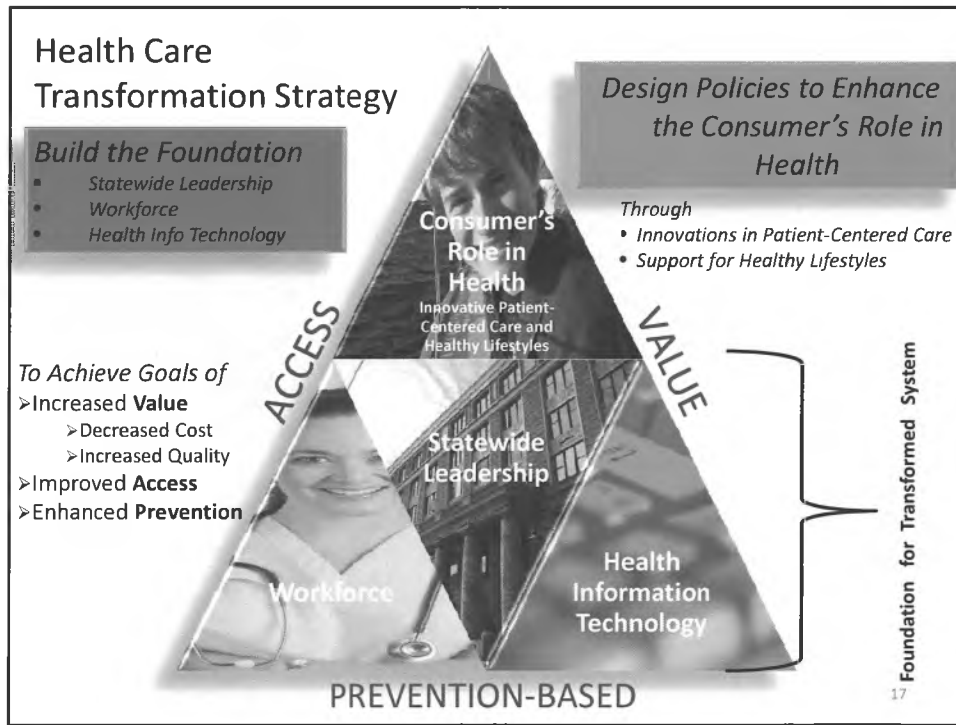
# Conditions

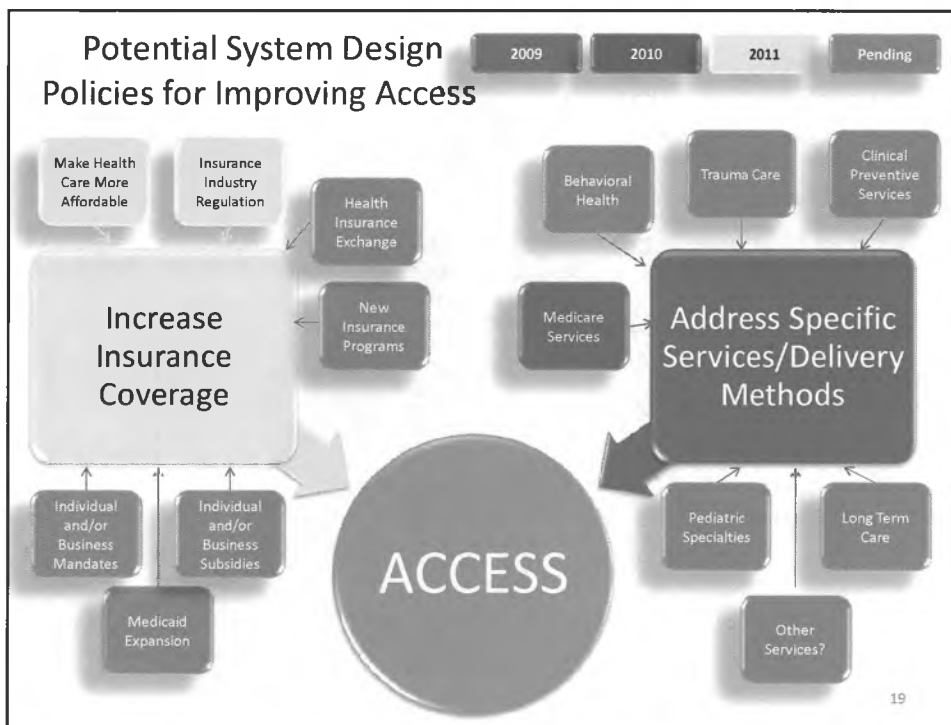
X # Episodes of Care /Condition

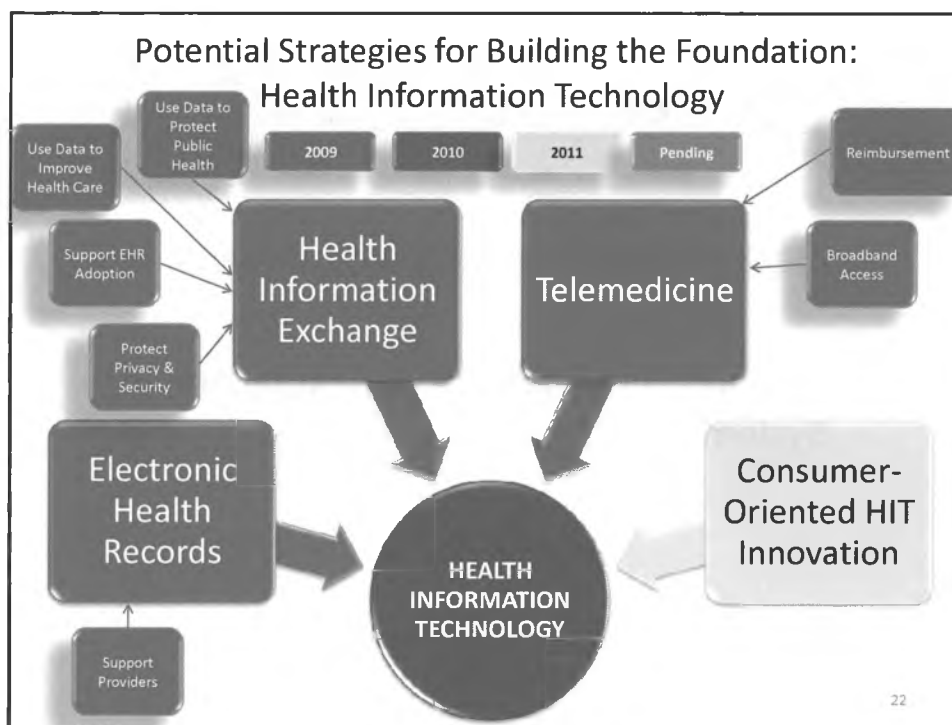
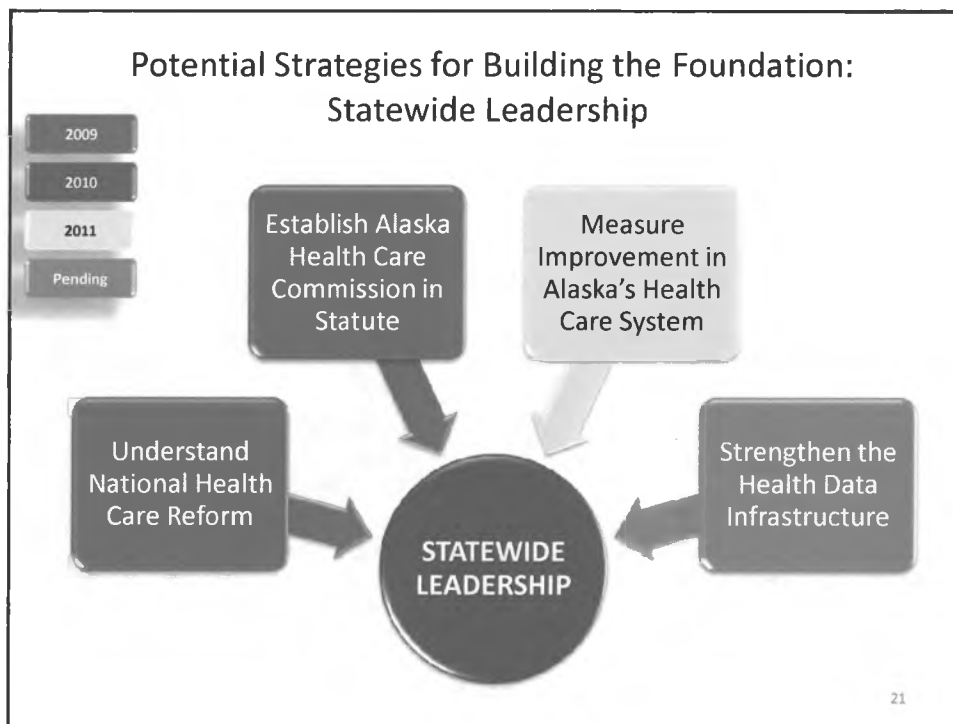
X # of Services (by type)/Episodes of Care

X # of Processes /Service

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## Measure Progress

- ✓ Track Implementation of Recommendations
- ✓ Measure Improvement in Health Care System Over Time

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## Potential Health Care System Improvement Measures

- I. Increase Access
  - Percent of Alaskans Uninsured
  - Percent of Alaskans who have a specific source of on-going care
  - *Measure of insurance affordability?*
  - *Indicator of workforce supply?*
- II. 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: Annual change in spending and revenue; net savings
  - *Measure of provider revenue based on value rather than volume*
- III. Safe, High-Quality Care
  - Percent of population receiving key preventive services
  - 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
- IV. Focus on Prevention
  - Percent of Alaskan homes with safe water and wastewater systems
  - Percent of Alaskans reporting health risks
    - Percent of Alaskans who smoke cigarettes
    - Percent of Alaskans who are obese or overweight
    - Percent of Alaskans who are binge drinkers
  - Percent of Alaskans with moderate to severe depression
  - Death rate among Alaskans due to injury (intention and unintentional)

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## 2010 Report

- **Introduction** – Background, Purpose, Planning Framework, 2010 Activities
- **Description of Current Condition of Alaska's Health Care System**
  - Summarizes 2009 Information and Findings
  - New 2010 Information: Federal Reform in AK
  - Study Plans for 2011
    - Health Care Spending & Cost Drivers in Alaska
    - Health Care Pricing & Reimbursement in Alaska
    - Health Status of Alaskans
    - Services: Long Term Care; Trauma Care
- **Recommendations for Health Care Transformation**
  - Status of Implementation of 2009 Recommendations
  - New 2010 Recommendation: Evidence-Based Medicine
  - Strategies for Consideration in 2011:
    - Price & Quality Transparency
    - Value-Driven Purchasing (Payment Bundling; Leverage State Purchasing)
    - Insurance Regulations
    - On-Line Community Health Information System
    - Measure Improvement in Alaska's Health Care System
    - Consumer-Oriented Health Information Technology Innovation

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## Status of 2009 Recommendations

### 2010 Activities to Strengthen Consumer's Role

- **Support Healthy Lifestyles and Create Culture of Wellness**
  - *"Choose Respect" Initiative launched by Gov. Parnell March 2010*
  - *Alaskans taking on Childhood Obesity Collaborative MOA July*
  - *Alaska Food Policy Council Created*
  - *\$375.0 GF appropriated to DHSS/DPH for Obesity Prevention/Control*
  - *StopSuicideAlaska web portal created*
- **Develop Patient-Centered Primary Care Model**
  - *DHSS received federal grant for PC Medical Home pilots*
  - *Southcentral Foundation PCC 1<sup>st</sup> practice in AK to achieve NCQA recognition – others following suit*
  - *AK Primary Care Association launched initiative to support member clinic transition to Patient-Center Medical Home model*

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## Status of 2009 Recommendations

### 2010 Activities to Foster Statewide Leadership

- **Invest in Health Policy Infrastructure to Respond to National Reform**
  - *SOA engaged in lawsuit regarding constitutionality*
  - *Commission tracking; high-level impact analysis*
- **Establish Permanent State Health Policy Body**
  - *Commission established in statute (AS 18.09.010) with passage of SB 172*
  - *Members appointed September 2010; Convened October 2010*

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## Status of 2009 Recommendations

### 2010 Workforce Development Activities

- Make health care workforce development a priority
- Strengthen the pipeline of future workers
- Explore strategies for innovation and adaptation
- Designate single, coordinating entity for workforce planning
  - *Alaska Health Workforce Coalition completed the "Alaska Health Workforce Plan" – adopted by the Alaska Workforce Investment Board May 2010*
  - *Alaska Department of Labor & Workforce Development received federal grant to develop strategic plan for health workforce development*

## Status of 2009 Recommendations

### 2010 Workforce Development Activities

- Increase Supply of Primary Care Physicians by
  - Supporting educational loan repayment/financial incentive program
  - Expand WWAMI as resources allow
  - Support primary care residency program development (continue supporting family medicine residency, support development of pediatric, psychiatry, and internal medicine residencies)
- *Legislation to develop state loan repayment/financial incentive program did not pass in 2010*
- *Pediatric and psychiatry residency programs planned – ready for implementation in 2012*
  - *Psychiatry residency will require state financial support*

## Status of 2009 Recommendations

### 2010 Activities to Deploy Health Information Technology

- Support Health Information Technology (HIT) Adoption & Utilization; Ensure Privacy & Security
  - DHSS awarded \$3 M contract to Alaska eHealth Network (AeHN) to develop Alaska's Health Information Exchange (HIE) – AeHN is designated entity responsible for privacy & security
  - AeHN awarded HIE vendor contract to Orion Health
  - AeHN received \$3.6 M federal grant to establish HIT Regional Extension Center
  - Alaska EHR Alliance selected two EHR vendors for Alaska providers
  - 2009 Provider EHR Survey Updated
  - Two hospitals began offering EHRs at reduced prices for affiliated providers
  - University of Alaska created two HIT certificate training programs
  - DHSS planned implementation of Medicaid EHR Incentive Program
- Expand Broadband Telecommunication Infrastructure
  - Connect Alaska chartered – new non-profit formed to expand broadband in Alaska
  - 1<sup>st</sup> web-based statewide broadband availability map launched in September
  - \$117 M in federal grants received by broadband service providers to expand and improve connectivity in rural Alaska
  - 257 rural health clinics in Alaska received FCC subsidies for telecommunications/Internet access
- Develop Reimbursement Mechanisms for Telemedicine

## Status of 2009 Recommendations

### 2010 Activities to Improve Medicare Access

- Improve the supply of primary care providers
- Support Federally Qualified Health Center (FQHCs) and Rural Health Clinics (RHCs)
- Request relief from Federal Reimbursement Inequities and Administrative/Audit Burden
- Develop Programs of All-Inclusive Care for the Elderly (PACE)
  - *New Medicare Clinics started/planned*
    - *Mat-Su Community Medicine opened in Wasilla in November*
    - *Providence Senior Care Center scheduled to open in January 2011*
    - *Alaska Medicare Clinic, Inc. received \$1 M state capital grant to support start-up*
  - *Clinic/Capacity Expansion supported: Anchorage Neighborhood Health center received new \$6 M state capital grant (in addition to \$10 M received earlier) plus new \$8 M federal grant to support clinic*
  - *Health care organizations in Anchorage are studying feasibility of PACE*
  - *Sen. Begich included amendment in the Affordable Care Act*

## New 2010 Recommendations

### Foster the Use of Evidence-Based Medicine

- Encourage and support State health care programs to
  - engage in application of high grade evidence-based medicine (EBM) in benefit design and provider payment methods
- Require/Direct State health care programs to
  - Coordinate development and application of EBM policies
  - involve health care providers and consumers in decision-making related to application of EBM to public policy
  - Incorporate data on patient compliance in developing provider payment methods and benefit design
- Implement a web-based data system for public health information

## Thank You

*For more information please visit the  
Commission's web site at:*

<http://hss.state.ak.us/healthcommission/>

Question? Comments?



# **Transforming Health Care in Alaska**

**2010 Report/2010-2014 Strategic Plan**

**Alaska Health Care Commission**



# **Transforming Health Care in Alaska**

## **2010 Report/2010-2014 Strategic Plan**

### **Alaska Health Care Commission**

**Ward Hurlburt, MD, MPH, Chair**

**Patrick Branco**

**C. Keith Campbell**

**Valerie Davidson**

**Jeffrey Davis**

**Emily Ennis**

**Paul Friedrichs, MD**

**T. Noah Laufer, MD**

**David Morgan**

**Wayne Stevens**

**Lawrence Stinson, MD**

**Ex Officio Members:**

**Linda Hall**

**Senator Donny Olson, MD**

**Representative Wes Keller**

**Deborah Erickson, Executive Director**

**Prepared for**

**Governor Sean Parnell and**

**The Alaska Legislature**

**In accordance with AS 18.09.070**

**January 2011**

# STATE OF ALASKA

## DEPT. OF HEALTH AND SOCIAL SERVICES ALASKA HEALTH CARE COMMISSION

**SEAN PARNELL, GOVERNOR**

3601 C Street, Suite 902  
Anchorage, Alaska 99503

PHONE: (907) 269-7800

January 15, 2011

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 of the Alaska Health Care Commission in accordance with AS 18.09.070. SB 172 was signed into law on June 21, 2010 establishing the Alaska Health Care Commission in statute (AS 18.09.010). Commission members were appointed on September 15 and the new Commission convened for the first time October 14. While the new Commission only just started their work during the last quarter of 2010 there is much to report.

The Commission was able to spend time this past quarter studying progress made during 2010 related to the Commission's 2009 recommendations and also learning about federal health reform and its implications for Alaska. The Commission will remain focused on developing Alaskan solutions to Alaska's health care challenges, but is tracking implementation of federal reform to understand how it may be affecting Alaska's health care environment. To that end, the Commission learned about provisions in the new federal law and also compiled information about action taken so far in Alaska. The Commission also contracted with the Institute for Social & Economic Research to study potential impacts of the impending changes to Alaska's health care system and Alaska's economy. This report documents what the Commission has learned.

Our greatest concern is the continuing escalation in health care costs, which is making health insurance increasingly unaffordable for Alaska's families and businesses and driving government spending for health care programs to new heights. During 2011 we will continue digging deeper into understanding this problem through new studies on health care spending trends and cost drivers, and comparisons of pricing and reimbursement for health care services in Alaska compared to other states. We will also focus on studying potential solutions, such as primary care innovation and price and quality transparency. In addition we will continue studying needs and opportunities for improving health status, supporting health workforce development, and deploying health information technology. These plans are included in this report.

We are grateful for the foresight of the Alaska Legislature and Governor Parnell in establishing the Commission in statute and providing resources to support continuing work to address the challenge of transforming Alaska's health care system so that it is sustainable, provides value for Alaskans' health care dollar, meets the needs of patients and providers, and focuses on health.

Sincerely,  
Ward B. Hurlburt, MD, MPH  
Chair, Alaska Health Care Commission  
Chief Medical Officer & Public Health Director  
Department of Health & Social Services

Deborah Erickson  
Executive Director  
Alaska Health Care Commission

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**APPENDICES** Available on the Commission’s Web Site at: <http://hss.state.ak.us/healthcommission/>

**Appendix A:** Commission’s Health Care Transformation Strategies

**Appendix B:** State of Alaska Federal Health Care Reform Review Documents

**Appendix C:** Economic Impact of the Federal Patient Protection and Affordable Care Act (report by Mark A. Foster & Associates/Institute for Social & Economic Research)

**Appendix D:** Voting Records, Summary of Public Comments, Meeting Summaries, and Ethics Reports

## Executive Summary

### **Background**

The Alaska Health Care Commission was established in Chapter 9 of Title 18 in Alaska Statute this year with the implementation of SB 172, which was signed into law by Governor Parnell in June 2010. Commission members were appointed in September and the new Commission convened for the first time in October. The new body continued the work of the original Commission which was organized and met during 2009 under Governor's Administrative Order #246. This report reflects work accomplished since the launch of the new Commission in the last quarter of 2010, describes how it builds on and continues the work begun in 2009, and lays the groundwork for 2011 activities.

The Commission's process for transforming Alaska's health care system began with identification of a vision, goals and values of the ideal system, and is now in a continuing cycle of learning about current challenges, designing policies for achieving the vision, and evaluating progress. The core of the transformation strategy rests on building a strong foundation for the system through health workforce development, deployment of health information technology, and statewide leadership. The focus of the core transformation strategy is to strengthen the consumer's role in health through innovations in patient-centered care and by fostering healthy lifestyles.

### **Understanding Alaska's Health Care Challenges**

To better understand why Alaska's health care system is not achieving the vision, the Commission started in 2009 by describing how health care in Alaska is delivered and funded (Appendix A of the 2009 report). Particular concerns identified in the 2009 report included that:

- The high and rising cost of health care in Alaska is unsustainable;
- Health insurance coverage in Alaska is inadequate;
- Providers and patients experience logistical challenges in the delivery of and in accessing health care services;
- Fragmentation and duplication in Alaska's health care system creates inefficiencies;
- Alaska suffers from shortages and maldistribution of health care workers;
- Health status, health risk behaviors and changing demographics contribute to high utilization of health care services;
- The State of Alaska does not have an infrastructure and capacity to provide leadership for health care system improvement;
- Use of modern health information technology is taking hold in Alaska, but much remains to be done; and,
- Alaskan Medicare enrollees living in urban areas have trouble accessing primary care.

In 2010 the Commission added to learning about Alaska's health care system challenges by compiling information on the new federal health care reform law. In addition to reviewing and providing summaries of the law's provisions and noting activities related to implementation in Alaska that occurred during 2010, the Commission also contracted with the Institute for Social & Economic Research to provide an analysis of the potential economic impact of the law on Alaska.

In 2011 the Commission will continue studying current challenges in Alaska health care delivery and financing with a focus on health care spending trends and cost drivers, pricing and reimbursement for health services, and health conditions contributing to utilization of services. The Commission will also review the status of statewide planning for long term care and for trauma system improvement.

## Alaska Health Care System Transformation Strategies

The Commission's 2009 recommendations for health care system transformation still stand – the Commission is building on those recommendations to develop a mosaic of strategies intended to increase value, improve access and support prevention. These strategies focus on enhancing the consumer's role in health through supporting healthy lifestyles and fostering innovations in health care delivery, building statewide leadership for health policy development, strengthening the supply and distribution of health care workers, promoting the use of health information technology, and improving access to primary care for Medicare enrollees.

2010 saw a number of developments related to the Commission's 2009 recommendations.

- **Consumers' Role/Healthy Lifestyles:** Governor Parnell launched a domestic violence and sexual assault initiative aimed at preventing harm through creating a culture of respectful relationships. The Commissioners of the Departments of Health & Social Services (DHSS) and Education & Early Development collaborated to convene a task force targeting obesity prevention and control among Alaska's school children. The legislature invested in the state's obesity and control program, and Alaska's first food policy council was created to improve the supply and distribution of Alaska-produced foods and improve the nutrition literacy of Alaskans.
- **Consumer's Role/Primary Care Innovation:** DHSS received federal grant funds that will be used to pilot test and evaluate patient-centered medical homes for children; a number of Alaska health care organizations are implementing the patient-centered medical home model in their practices and seeking NCQA recognition; and the Alaska Primary Care Association began an initiative to support Alaska's 142 community health center sites' movement towards adoption of innovative care models.
- **Statewide Leadership:** Creation of the Alaska Health Care Commission in AS 18.09.010 this year implemented the recommendation for a permanent state health planning and policy body. No new resources were allocated to support analysis and implementation of federal health care reform due to the state challenge regarding constitutionality of the new law and questions regarding severability of the challenged provisions from the whole law; however, state agencies and other organizations are tracking federal implementation, complying with legally mandated requirements, and investigating optional provisions that align with existing policies and programs.
- **Health Workforce Development:** The Alaska Health Workforce Coalition completed the "Alaska Health Workforce Plan," which was adopted by the Alaska Workforce Investment Board in May, and received a federal grant to develop a strategic plan for implementing the comprehensive plan. None of the proposed bills that would have created and funded a state health professions educational loan repayment and financial incentive program passed during the 2010 session, but a federal grant with matching funds from stakeholders enabled the creation of such a program for at least one year. Two new primary care residency programs for training pediatricians and psychiatrists in Alaska are closer to reality with progress made in planning during the year.
- **Health Information Technology:** DHSS awarded the State Health Information Exchange (HIE) Entity grant to the Alaska eHealth Network (AeHN) in April, and in November AeHN awarded a contract to Orion Health to build the system. AeHN also received a federal grant to establish a regional health IT extension center to provide technical assistance to health care providers. The Alaska EHR Alliance established preferred vendor agreements with two electronic health record (EHR) vendors to simplify the selection process and guarantee reduced pricing for Alaska providers. Broadband telecommunications service providers received \$117 million in federal grants to support expansion in rural communities; and Connect Alaska, a new non-profit formed to expand broadband access, was created and launched Alaska's first statewide interactive online broadband availability map.

- **Medicare Access:** A new clinic intended to alleviate the primary care access problem for seniors in the Mat-Su was opened this year, and two new clinics devoted to providing health care for seniors in Anchorage were planned during 2010 and will open early in 2011: The Senior Care Center at Providence, which is subsidized by Providence Health & Services, and the Alaska Medicare Clinic, which is subsidized by a FY 11 state capital grant. In addition the Anchorage Neighborhood Health Center will open doors of a new clinic doubled in size with more room and staff to accommodate additional Medicare recipients and medical clinic space devoted to seniors.

New 2010 Recommendations made by the Commission relate to the significance of **Evidence-Based Medicine** for improving the quality of health care by emphasizing the need for critical assessment skills in understanding and applying findings from medical research to clinical practice and to health care policies. The importance of protecting the practitioner's and the patient's role in making clinical decisions is emphasized. The importance of shared decision-making and also patient compliance is recognized to balance reliance on the medical system to improve quality. The need for reliable data and information to guide decision-making is also noted.

The Commission has identified a number of additional strategies to study and consider for 2011 recommendations. For improving value – by increasing quality and controlling costs – the Commission will analyze additional strategies for fostering patient-centered primary care, mechanisms for providing transparency in health care pricing and quality, bundled payment systems, and the possibility of leveraging state purchasing power to drive quality improvement. For supporting community efforts to foster healthy lifestyles, the Commission will consider the need for an on-line interactive public health information system. To strengthen statewide leadership, the Commission will finalize a set of indicators for measuring improvement in Alaska's health care system over time.

## **Part I: Introduction**

### **A. Purpose of this Report**

The purpose of this report is to convey the 2010 findings and recommendations of the Alaska Health Care Commission to Governor Parnell and the Alaska Legislature as required under Alaska Statute 18.09.070. This report builds on the work of the original Alaska Health Care Commission (created by Governor Palin under Administrative Order #246) which in their 2009 Report presented a 5-year strategic planning framework as a “roadmap” for strengthening Alaska’s health care delivery system. The 2009 report was described as a living document meant to evolve each year as problems of health care quality, cost and access are studied, potential solutions are analyzed, and implemented strategies are evaluated. This new report documents the continuation of that process.

Included in this report are:

- Part I: an introduction including background on the Commission, a summary of the Commission’s 2010 activities, and a description of the Commission’s strategic planning framework;
- Part II: information on the challenges of delivering and accessing health care in Alaska, and plans for additional study of current challenges in 2011;
- Part III: the Commission’s recommendations for transformation of Alaska’s health care system, including a status report on implementation of the Commission’s 2009 recommendations, findings and recommendations on the one new strategy studied this year, and strategies that will be considered in 2011;
- Appendices: information on the new federal health care law and its implementation in Alaska, an analysis of the potential economic impact on Alaska of the new federal health care law, and additional information by and about the Commission.

### **B. Background on the Commission**

The Alaska Health Care Commission was first established by Governor Palin on December 4, 2008 under Administrative Order #246. Original Commission members were appointed on January 27, 2009 and the Commission met throughout 2009, producing a report on their findings and recommendations in January 2010. The Commission created under A.O. #246 terminated with the production of that report.

The Alaska Health Care Commission was established in state statute (AS 18.09.010) this year with the passage of Senate Bill (SB) 172 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. SB 172 was passed by the Alaska Legislature on April 17, 2010 and subsequently signed into law by Governor Parnell on June 21, 2010.

Duties of the Commission prescribed by AS 18.09.070:

- I. Serve as the state health planning and coordinating body;
- II. Provide recommendations for and foster the development of a:
  1. Comprehensive statewide health care policy;

2. Strategy for improving the health of Alaskans that
  - i. Encourages personal responsibility for disease prevention, healthy living and acquisition of health insurance;
  - ii. Reduces health care costs;
  - 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; and,
  - vi. Increases the number of insurance options for health care services.
- III. Submit a report to the Governor and the Legislature by January 15 of each year regarding the Commission's recommendations and activities.

Former Commission members were reappointed under the transition clause included in SB 172, and new members were appointed by Governor Parnell September 15, 2010. Legislative representatives were reappointed by their respective bodies. Short biographies for each of the Commission members are provided on the Commission's web site at [www.hss.state.ak.us/healthcarecommission](http://www.hss.state.ak.us/healthcarecommission). The members of the Commission are:

**Ward Hurlburt, MD, MPH:** Designated Chair; Chief Medical Officer for the Alaska Department of Health & Social Services; Anchorage.

**Patrick Branco:** Representing the Alaska State Hospital & Nursing Home Association; Chief Executive Officer of Ketchikan General Hospital; Ketchikan.

**C. Keith Campbell:** Representing consumers; retired hospital administrator and former AARP Chair; 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.

**Emily Ennis:** Representing the Alaska Mental Health Trust Authority; Executive Director of Fairbanks Resource Agency; Fairbanks.

**Col. Paul Friedrichs, MD:** Representing the U.S. Department of Veterans Affairs health care system; Commander of the Air Force/Veterans' Affairs Joint Venture Hospital at Elmendorf; Anchorage.

**T. Noah Laufer, MD:** Representing primary care physicians; family medicine physician and president of Medical Park Family Care; Anchorage.

**David Morgan:** Representing community health centers; Reimbursement Director for the Southcentral Foundation; Anchorage.

**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; Anchorage.

**Linda Hall (Ex-Officio):** Representing the Governor's Office; Director of the Alaska 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.

## C. Summary of 2010 Activities

The formal work of the Commission was paused for the first 9 months of 2010 following termination of the 2009 Commission until the new body was established in statute and members were appointed in September. The group was then able to hold two face-to-face meetings during 2010, one in October and one in November. At these first meetings the new members were introduced to the work of the 2009 Commission, and the group received updates on several issues studied during the previous year. Despite the short timeframe available for developing this year's annual report, the Commission:

1. Revised their Core Transformation Strategy
2. Developed recommendations for a key strategy to improve value: Evidence-based Medicine
3. Identified issues to be analyzed in 2011
4. Prioritized new policy options for study and recommendation development in 2011.

### 2010 Accomplishments

**Meetings and public hearings:** During 2010 the Commission held three face-to-face meetings, all in Anchorage: January 8 (this was the last meeting of the 2009 Commission to incorporate changes based on public comment, finalize and approve the 2009 report to the Governor and legislature); October 14-15; and November 16-17. 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. Summaries of the meetings and the Commission's voting record are included in Appendix D of this report. Public hearings were held during both the October and November meetings, and a summary of comments received from the public is also included in Appendix D.

**Administration:** In their first months the new Commission reviewed meeting rules, updated and approved changes to the by-laws, approved a budget for SFY 2011, and received ethics training from the State's ethics attorney. A copy of the Commission's meeting rules, by-laws, SFY 2011 budget, and ethics handbook are available on the Commission's website (see website address below).

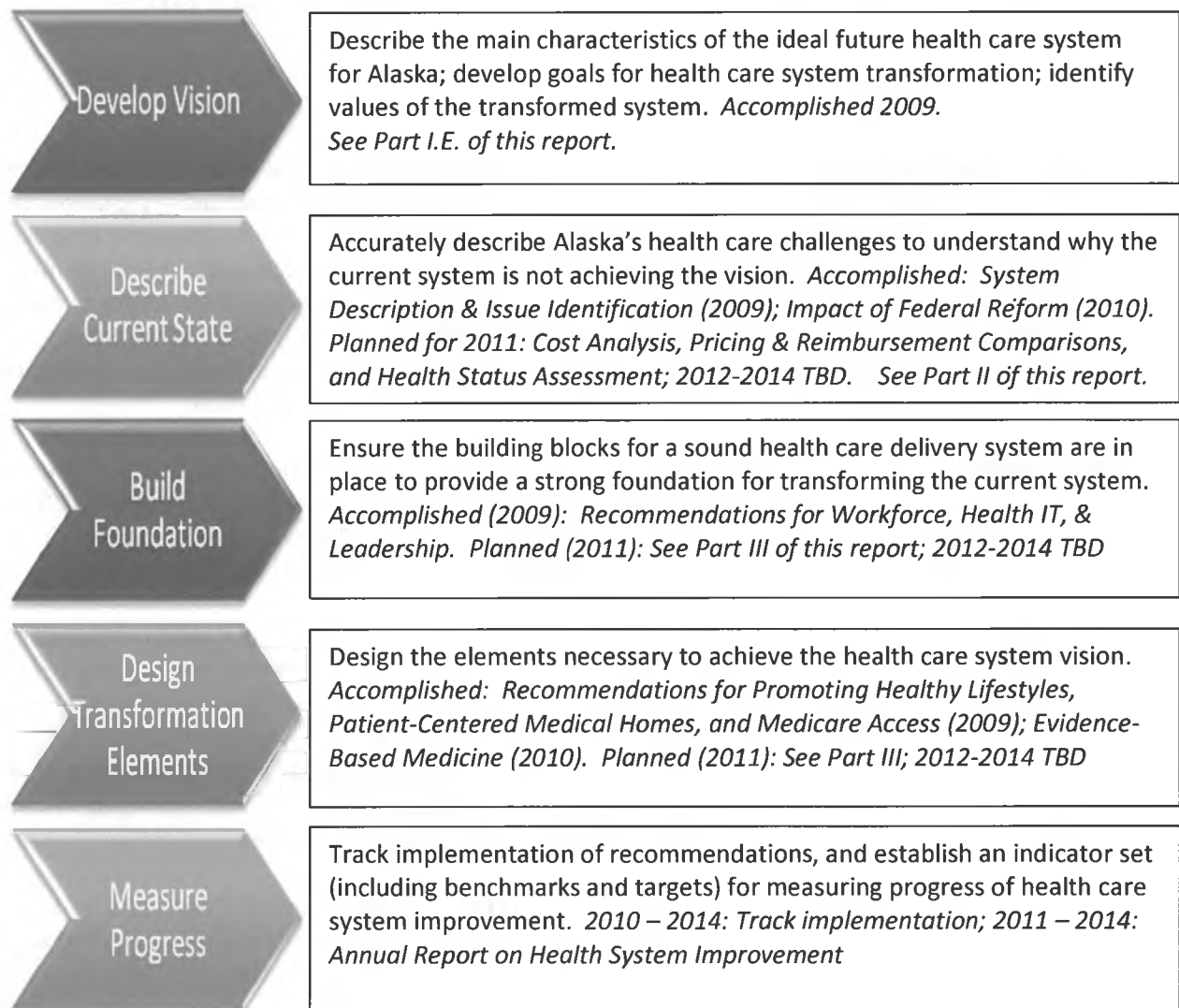
**Communication and coordination:** The Commission updated and maintained a website for posting information regarding their meetings as well as reference documents related to their priority focus areas (<http://hss.state.ak.us/healthcommission/>). A listserv established in 2009 to maintain communication with system stakeholders and members of the public interested in receiving periodic updates was also updated, expanded and utilized. The Commission also maintained 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 (also available on the website).

**Products:** The main product from 2010 is this annual report, which includes analysis and recommendations related to the value-improvement strategy of evidence-based medicine, and an overview and analysis of potential impact of the new federal health care law (P.L. 111-148, the Affordable Care Act) on Alaska.

## D. 2010 – 2014 Strategic Plan Framework

In 2009 the initial Commission developed a 5-year strategic planning framework to guide the process for improvement of Alaska’s health care system. The new Commission is following the same process, depicted graphically below with a brief note about the status of implementing each process step. Note that except for the first step of developing a vision the process is not sequential - the steps in the process are being implemented concurrently and continually.

### Strategic Planning Process & Implementation Status



## **E. The Commission's Vision for Transformation of Alaska's Health Care System**

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 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 of their health 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 is one that is sustainable over time.

## 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.

- I. **Access:** Access to affordable health care coverage and to a viable and vital health care delivery system is improved.
- II. **Cost:** The cost of health care is controlled so that the medical inflation rate in Alaska is below the national rate.
- III. **Quality:** Alaskans can be assured that health care services they receive in Alaska meet the highest quality and safety standards.
- IV. **Prevention:** A focus on preventive services, both clinical preventive services for individuals and community prevention policies, will support improved health status and control costs by reducing the burden of preventable disease 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.

## F. Core Transformation Strategy

The figure below depicts in graphic form the core strategies identified by the Commission for transforming Alaska's health care system to achieve their vision, and the relationship of those strategies to one another and to the planning process.

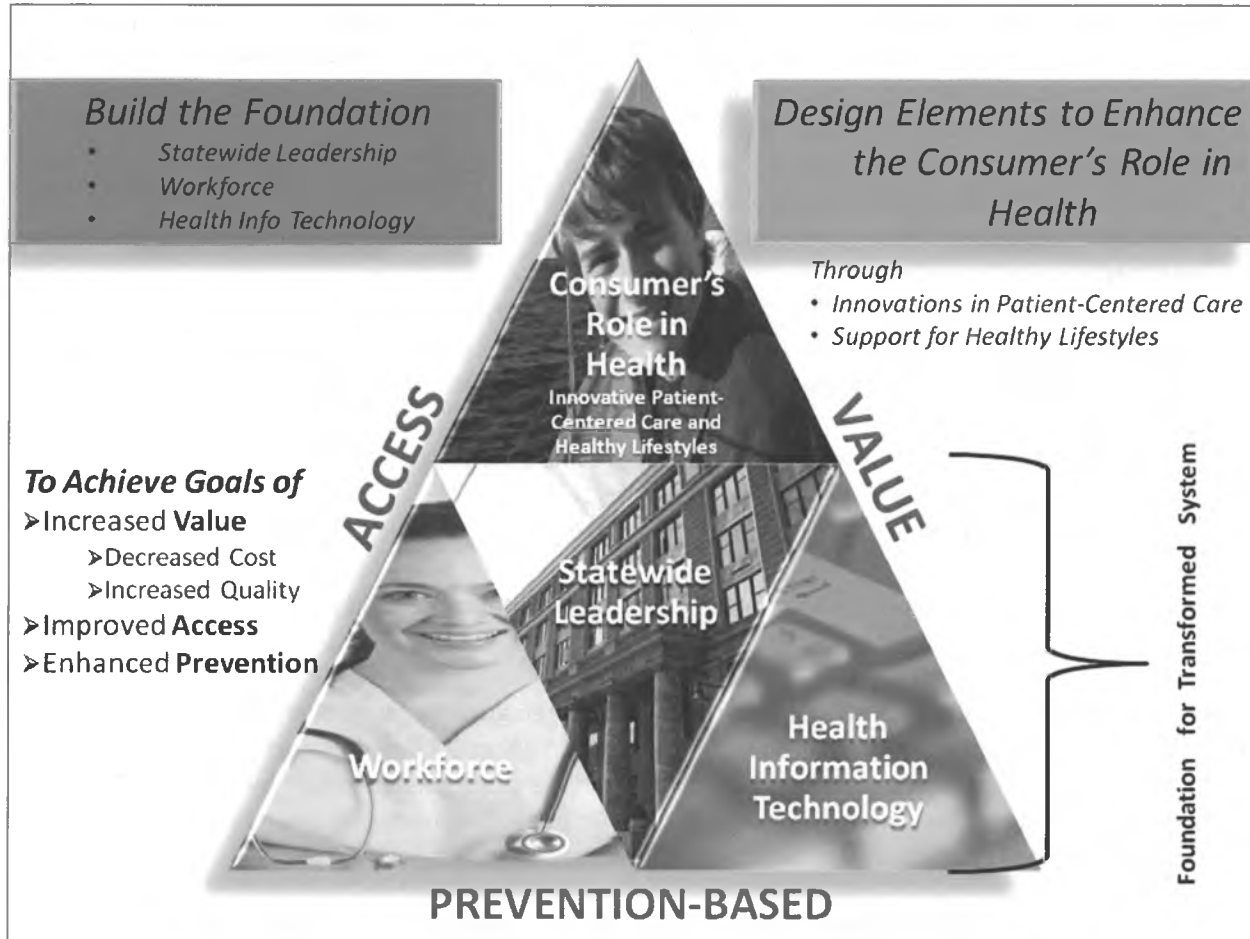


Figure 1: Alaska Health Care Commission's Core Strategy for Health Care System Transformation

Understanding and supporting the consumer's role in health care is the central focus of Commission's strategic approach to transformation of Alaska's health care system. Two aspects of the consumer's role are 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 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 an innovative patient-centered system depend. 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 create a regulatory and reimbursement environment that supports the health care industry while it redesigns itself.

## Part II: Understanding Alaska's Health Care System Challenges

### A. Summary of 2009 Findings

To better understand why Alaska's health care system is not achieving the Commission's vision, the 2009 Commission started by describing how health care in Alaska is delivered and funded (Appendix A of the 2009 report). The commission also received numerous presentations and reviewed existing reports to identify a series of challenges that contribute to the current problems in the system. Particular concerns identified in the 2009 report included that:

- The high and rising cost of health care in Alaska is unsustainable;
- Health insurance coverage in Alaska is inadequate;
- Providers and patients experience logistical challenges in the delivery of and in accessing health care services;
- Fragmentation and duplication in Alaska's health care system creates inefficiencies;
- Alaska suffers from shortages and maldistribution of health care workers;
- Health status, health risk behaviors and changing demographics contribute to high utilization of health care services;
- The State of Alaska does not have an infrastructure and capacity to provide leadership for health care system improvement;
- Use of modern health information technology is taking hold in Alaska, but much remains to be done; and,
- Alaskan Medicare enrollees living in urban areas have trouble accessing primary care

**Health Care Costs:** Health care spending in the U.S. has been growing faster than the economy for decades, doubling from 8% of the nation's GDP in 1970 to 16% in 2006 and projected to increase to 20% by 2016. Per capita national health care expenditures in the U.S. increased 850% over the past three decades. High costs for health care contribute to higher prices for goods and services produced in the U.S., challenging our ability to maintain a competitive edge in the global market place.

In 1993 the Alaska Health Resource & Access Task Force projected health care spending in Alaska would "sky-rocket" from slightly below \$1.9 billion in 1991 to nearly \$5.6 billion in 2003. In 2009 spending was estimated at over \$6 billion. State general fund expenditures for Medicaid grew more than five-fold between FY 91 and FY 08 from a little over \$80 million to over \$408 million. In 2005 government paid 64% of Alaska's health care bills, private employers paid 17%, and individual Alaskans paid 19%.

Alaska has the highest annual Medicaid expenditure level per enrollee in the U.S. Alaska has also ranked 1<sup>st</sup> in the nation for cost of workers' compensation premium rates since 2005, with medical costs making up 72% of total benefit claims in Alaska in 2008 compared to the national average of 58%. Signs that prices for health care are higher in Alaska than other states include differences in reimbursement rates between our Medicaid and Workers Comp programs and those of other states. A comparison of Alaska's Medicaid rates to Washington state's indicate our fees are two to three times higher. 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).

**Health Insurance Coverage:** Increased spending for health care translates into higher insurance premiums, as health insurance providers adjust to cover rising prices and growing utilization. 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 premium for individual health coverage rose from \$2,923 to \$5,626 during that same period. The percentage of income spent on health care in Alaska 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 beneficiary health care services. 84% of uninsured Alaskans belong to households with one or more workers. Most uninsured workers are self-employed, or employed in small businesses that do not offer health benefits or offer coverage they cannot afford. Nearly all Alaskan firms with more than 100 employees provide health benefits, while less than a quarter of Alaska's smallest businesses (<10 employees) offer insurance. The seasonal nature of Alaska's workforce is an important factor in employer health coverage – data on coverage does not account for those who are insured only part of the year. There is also insufficient data on Alaskans who are underinsured – those who have coverage but with such high deductibles and co-pay that they still cannot afford care.

**Logistical Challenges:** The dispersion of Alaska's relatively small population over a large geographic area increases the cost and complexity of delivering care here. Approximately 75% of Alaska's communities are not connected by road to a community with a hospital, and nearly a quarter of the state's population lives in towns and villages that can only be reached by boat or aircraft.<sup>1</sup> Transportation costs associated both with patient travel and also with moving supplies, staff and equipment to operate clinics and hospitals in rural Alaska can be formidable.

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.

**Health 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.

Some communities 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.

**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.<sup>ii</sup> 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.<sup>iii</sup>

**Health Status, Health Risk Behaviors and Changing Demographics:** Health conditions and demographics drive utilization of health care services and spending for health care services. Alaska experiences high rates of chronic disease, behavioral health conditions, and injuries. Three health risk behaviors (tobacco use, poor diet, and inactivity) are the primary contributors to development of chronic diseases such as heart disease, diabetes, lung disease, and cancer. Tobacco use in Alaska has been declining due to significant investment of resources in prevention and control, but increases in Alaska's rates of obesity are alarming. The total population of Alaska is steadily increasing, and the number of Alaskans aged 65 and older has more than doubled over the past two decades and is projected to nearly triple again by the year 2030.

**Statewide Leadership for Health Care System Improvement:** Over the two decades preceding the creation of the Commission four groups had been formally convened to address the problems of access to and cost of health care. All of those entities had been ad-hoc in nature and met over periods ranging from 6 months to 2 years. Existing resources for health care planning are fragmented, and also insufficient for analyzing the complexity of pending federal health care reforms for their impact on Alaska. Lack of sustainable capacity and a coordinated, long-term approach to health care planning and policy development hampers the ability to provide statewide leadership for health care system improvement.

**Health Information Technology:** There is significant governmental and private sector interest in deploying the use of health information technology to improve efficiency and effectiveness of health care. President Bush established the Office of the National Coordinator for Health Information Technology in 2004, and in 2009 Congress appropriated more than \$20 billion for the development and adoption of health information technology under the HITECH Act. The Alaska Legislature passed SB 133 during the 2009 session to create a statewide health information exchange (HIE) system for Alaska. Two non-governmental organizations in the state – the Alaska eHealth Network and the Alaska EHR Alliance formed in recent years to support implementation of electronic health records (EHRs) in physician practices and foster the development of a HIE.

There is also a history of innovative uses of telecommunications technologies for delivering health care in Alaska, and now growing support for development and utilization of these technologies. The Alaska Federal Health Care Access Network provides telehealth applications to 248 sites throughout Alaska. Other telemedicine programs involved in improving access to health care in the state include the Alaska Rural Telehealth Network, Providence's REACH system and eICU, the Alaska Psychiatric Institute's Telebehavioral Health Care Services Program, and the Southeast Alaska Regional Health Consortium

Telebehavioral Health Program. Insufficient access to broadband telecommunication services hampers further development and deployment of telehealth in some rural communities.

**Medicare Enrollee Access to Primary Care:** A study conducted by the Institute for Social & Economic Research in 2008 confirmed anecdotal information that many Alaskan Medicare beneficiaries living in urban communities, particularly Anchorage, have trouble finding a primary care physician to take them as a patient. The researchers found that only 17% of Anchorage primary care physicians accept new Medicare patients compared to 61% nationally.

**Finding Statements from 2009 Report:** Following are the Finding Statements included in the 2009 report associated with each of the core strategies that were studied and for which recommendations were developed.

#### Strengthen the Consumer's Role – Support Healthy Lifestyles

- Chronic disease is the leading cause of death and disability in the U.S. and Alaska.
- The majority of health care spending in the U.S. is for chronic disease.
- Three risk factors – tobacco use, poor diet and inactivity – contribute to the four leading chronic diseases – heart disease, diabetes, lung disease and cancer.
- Individual behavior is now the leading determinant of the health status of the population and contributor to premature death.
- Childhood obesity is a growing concern; for example, 33% of kindergarten and 1<sup>st</sup> grade students in the Anchorage School District are overweight or obese.
- Employee health risk behaviors can be changed through financial incentives coupled with other supports (e.g., coaching).

#### Strengthen the Consumer's Role – Foster Innovative Primary Care Models

- 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.

#### Develop Statewide Leadership – Response to National Health Care Reform

- 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.

#### Develop Statewide Leadership – State Health Policy Board

- 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.

#### Develop the Health Care Workforce

- Health care in Alaska is big business and represents a significant employment sector.
- 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.

- Health care worker shortages in Alaska are widespread and costly.
- 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).
- Alaskans have been particularly innovative in meeting their health care workforce needs.
- 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.

#### Workforce – Physician Supply

- 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.
- Alaska has a shortage of primary care physicians<sup>1</sup>.
- New physicians face disincentives to entering primary care specialties.
- Providers stay to practice where they train.
- 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.

#### Deploy Health Information Technology

- 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.

#### Deploy Health Information Technology – Electronic Health Records

- 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 in 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.

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<sup>1</sup> 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.

- 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.

#### Deploy Health Information Technology – Ensure Privacy & Security

- 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.

#### Deploy Health Information Technology – Telehealth/Telemedicine

- 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.
- Barriers to adoption and use of telemedicine include:<sup>2</sup>
  - 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.

#### Improve Access to Primary Care for Medicare Beneficiaries

- Alaska’s Medicare-eligible population is growing.
- 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.
- 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.
- 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.
- Care for Medicare patients is often more complex and time-intensive than for the general patient population.
- Mid-level practitioners are increasingly being used to solve the Medicare access problem.
- Health care providers report Medicare’s physician and mid-level practitioner reimbursement schemes are not rational and not reliable.
- 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.

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<sup>2</sup> The order of the bullets in this finding is not meant to imply priority order of significance.

## B. 2010 Analysis: Overview & Impact of the Federal Health Care Law

For their 2010 report the Commission compiled summary information on the new federal health care law and Alaska's response to enacted provisions to-date. The Commission is not charged with developing recommendations on the implementation of federal reform, but plans to track implementation in order to understand how the law may affect the health care landscape in Alaska as they continue developing state-specific solutions to Alaska's health care challenges. As part of this effort the Commission contracted with the Institute for Social and Economic Research (ISER) at the University of Alaska Anchorage to provide a report on the projected economic impact of the new law on Alaska.

An overview of the law, brief information on enactment status in Alaska to-date, and a summary of preliminary estimates of the health care and economic impact to Alaska are provided in this section. Additional information and the full ISER report are included in Appendices B and C.

### Overview & Status in Alaska

Federal health care reform is enacted under three new federal laws passed in March and April 2010:

- P.L. 111-148: The Patient Protection and Affordable Care Act (PPACA)
- P.L. 111-152: The Health Care and Education Reconciliation Act
- P.L. 111-159: The TRICARE Affirmation Act

PPACA is structured as follows (the names of these titles do not reflect the exact names assigned in the legislation – they are modified to be more descriptive):

- Title I** Private Health Care Coverage
- Title II** Public Health Care Coverage (primarily Medicaid changes)
- Title III** Health Care Delivery and Payment (primarily Medicare changes)
- Title IV** Prevention and Public Health
- Title V** Health Care Workforce
- Title VI** Fraud, Waste and Abuse
- Title VII** Pharmaceuticals
- Title VIII** CLASS Act (Community Living Assistance Services & Supports)
- Title IX** Taxes and Fees
- Title X** Amendments (changes made to the original bill (Titles I-IX) prior to passage)

This overview describes PPACA as amended by Title X and the two subsequent laws. The provisions described in this overview take effect at various points over the next eight to ten years. A number of key provisions took effect during 2010. Most of the more significant changes take effect in 2014.

#### **Title I – Private Health Care Coverage**

The private health care coverage provisions set forth in Title I impose a series of new rules on health insurance plans, create state-based Health Insurance Exchanges, create a number of new health insurance programs, require individuals and employers to participate in purchasing health coverage or pay a penalty, and provide subsidies for low-income individuals, small businesses, and employers providing health insurance for early retirees.

New health insurance rules include prohibitions against pre-existing condition exclusions, lifetime and annual limits, and coverage rescissions. They also require expansion of coverage to dependents up to 26 years of age and require benefit packages to include clinical preventive services. Health insurers are required to guarantee issuance and renewal of coverage. A minimum Medical Loss Ratio (MLR) will be imposed, requiring insurance companies to pay out 85% of their premium revenue in medical claims (80% for insurers covering the individual and small group market). New community rating rules will limit variations in rates to certain ratios based only on age, region, family composition and tobacco use. Risk adjustment will be required in individual and small group markets and in the Exchange. This title also imposes a series of new administrative simplification and standardization requirements on insurance plans. Grants are made available to States to conduct premium rate reviews, and to establish an Office of Health Insurance Consumer Assistance to assist and advocate for consumers with private coverage in the individual and small group markets.

A Health Insurance Exchange will be established for every state by 2014. The Exchanges are intended to provide an electronic web-based marketplace where individuals and small businesses of under 100 employees (and eventually large businesses) will be able to comparison shop for health plans. State governments are given the option of designing and establishing the Exchanges, and federal planning grants are provided to States choosing to develop their own Exchange. States are also given the option of partnering with other States to create regional or multi-state Exchanges. The Exchanges may be administered by a government agency or non-profit entity, and are required to be self-sustaining within one year of implementation. The federal government will establish Exchanges for the states in which the State government chooses not to participate.

Other health insurance programs and entities that are established in Title I include 1) a temporary high risk health insurance pool program, intended to offer coverage to those with pre-existing conditions until the prohibition on exclusions takes effect (for children for plan years starting after 9/23/10; for adults for plan years starting after 1/1/14); 2) a temporary (2010 – 2014) early-retiree reinsurance program that will subsidize health plans provided by employers offering insurance to retirees not yet qualified for Medicare; 3) a Health Care Cooperative program, which will create non-profit member-operated health insurance companies in each state; 4) Health Choice Compacts, which will allow insurance companies to sell plans across state lines for those States that have entered into a compact agreement; and 5) Multi-State Health Plans that the federal Office of Personnel Management will establish in every state.

Individuals will be required to have a qualified health plan or pay a tax penalty. The tax penalty will be \$695/year (family penalty capped at 3-times the individual penalty, or \$2,085) or 2.5% of household income (whichever is greater), and will be phased in starting in 2014 reaching the full amount noted here in 2016 (and indexed to CPI thereafter). Exemptions to the individual mandate apply for financial hardship, religious objections, American Indians/Alaskan Natives (due to the federal government's trust obligation under treaty to provide their health care), and if the lowest cost coverage option exceeds 8% of household income.

U.S. citizens and legal immigrants with incomes between 133% - 400% of federal poverty level (FPL) whose employer does not offer coverage with a value of at least 60%, or for which the employee's contribution is 9.5% of income, will be eligible for subsidies in the form of premium credits. Amounts of the credits will be tied to the cost of certain plans in the region and set on a sliding scale based on income level. The premium credits will be advanceable and available for purchase of insurance through

the Exchange. In addition to premium credits, cost sharing subsidies will be provided to individuals and households whose income is between 100% - 400% FPL.<sup>3</sup>

Larger employers (over 50 full-time employees (FTEs)) will be required to offer their employees a qualified health plan or pay a tax penalty. Employers offering health plans will face penalties if one or more of their employees choose to purchase coverage through an Exchange and receives a federal subsidy (under certain conditions). Employers who do not offer coverage will be required to pay \$2,000/FTE (first 30 FTEs are excluded from calculation) if one or more of their employees receive a subsidy through the exchange. Employers who do offer coverage will be required to pay \$2,000/FTE or \$3,000/subsidized employee (whichever is less) if one or more of their employees receive a subsidy.

Small employers (for this provision defined as 25 or fewer employees with average annual wages of less than \$50,000) that purchase health insurance for employees will receive a tax credit of up to 35% of the employer's contribution (25% for non-profit employers) if that contribution is at least 50% of the premium cost for 2010 through 2013. Starting in 2014 the tax credit increases to 50% (35% for non-profits), but then ends two years later. The full tax credits are available for the smallest businesses (10 FTEs or less and average annual wages less than \$25,000) and phases out as business size increases.

*Status in Alaska:*

- *State Lawsuit Challenging the Individual Mandate: Alaska is participating in the 20-state Florida-led lawsuit against the federal government over the enactment of PPACA. One of the two main complaints asserted in the suit is regarding the federal government's constitutional authority to require individuals to purchase health insurance. The lawsuit was heard in a Florida district court in December, and is expected to proceed to the appellate courts and eventually be heard by the U.S. Supreme Court in 2012 or 2013.*
- *High Risk Pool: The State of Alaska supported and facilitated the application by the state's existing high risk pool, the Alaska Comprehensive Health Insurance Association, for the new federal high risk pool. \$13 million was allocated for Alaska's federally-subsidized pool, and coverage began September 1, 2010. Television and other media have been used to advertise the availability of the subsidized insurance program. 24 Alaskans had enrolled as of December 17.*
- *Early Retiree Reinsurance Program: The following Alaskan employers and unions had been approved for participation in this program by the US DHHS as of December 20: Alaska Electrical Health and Welfare Fund, Alaska Pipe Trades UA Local 367 Health & Security, Alaska Teamster-Employer Welfare Trust, Alaska USA Federal Credit Union, Alyeska Pipeline Service Company, Municipality of Anchorage, State of Alaska Retirement and Benefits Plan, Tongass Timber Trust.*
- *Health Insurance Rate Review: The State of Alaska chose not to apply for the state Health Insurance Rate Review grant made available in July (and again in October) citing onerous grant requirements, lack of state statutory authority to pre-approve health insurance rates for most health insurance plans, and sufficient existing capacity to review health insurance rates. At this date it is unknown whether state legislation will be introduced during the 2011 legislative session to adopt new federal insurance standards in state law.*
- *Consumer Information & Assistance: The State of Alaska chose not to apply for the state Consumer Information and Assistance grant made available in September citing concerns over sustainability of capacity created with one-time funds, and insufficient need (the Alaska Division*

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<sup>3</sup> The Hyde amendment applies to the use of federal funds in these programs, and prohibits the use of federal subsidy funds for the purchase of coverage for abortion (except in the case of rape or incest or to save the life of the mother).

*of Insurance currently has sufficient capacity to respond to consumer inquiries and complaints in its existing consumer assistance program).*

- *Health Insurance Exchange: The State of Alaska chose not to apply for the state Health Insurance Exchange planning grant made available in September. At this date it is unknown whether state legislation will be introduced during the 2011 legislative session to establish an Alaska health insurance exchange.*

## **Title II – Public Health Care Coverage**

PPACA changes the role of the Medicaid program in the health care system by moving the program from one that covers certain safety-net populations to one that covers all individuals under certain income limits so that it becomes the floor for all insurance coverage in the country. The law expands Medicaid eligibility to everyone under 65 years of age, including childless adults, whose incomes are under 138% of FPL (the new minimum eligibility level is 133% but PPACA also imposes a required 5% income disregard effectively increasing the level to 138%). A maintenance of effort requirement took effect on enactment of the law in March to prohibit States from reducing eligibility for adults between now and when the expansion takes effect in 2014. The maintenance of effort requirement for children is in place until September 30, 2019.

The federal government will absorb 100% of the increased cost associated with the expansion population during the first four years, then States will begin sharing in the cost at phased in levels until the State share is 10% in 2020. States have the option of expanding eligibility prior to 2014, but would do so at their regular match rate (about 50% for Alaska). Of significance is a policy change in PPACA that requires States to change to a new eligibility determination method based on modified adjusted gross income. A number of new enrollment procedure changes are included as well, along with a requirement for States to integrate Medicaid enrollment into the Health Insurance Exchange.

A number of provisions add new requirements for covered services, such as freestanding birth center and comprehensive tobacco cessation services for pregnant women; and also makes available new State options to add services, such as family planning for low income individuals. Changes are made to certain payments and reimbursements, such as a new prohibition against federal Medicaid payments to States for services related to health care acquired conditions, and a change to the prescription drug rebate. Optional programs to test new payment methodologies include hospital bundled payment and Accountable Care Organization demonstration projects. There are also incentives and options intended to increase home and community based services in lieu of facility-based services for individuals requiring long term care.

### *Status in Alaska:*

- *Medicaid Maintenance of Effort: the Alaska Medicaid program is required to maintain eligibility standards, methods and procedures for adults until January 2014 and for children until October 2019.*
- *Medicaid Expansion:*
  - *As noted above, Alaska is participating in the 20-state Florida-led lawsuit against the federal government over the enactment of PPACA. One of the challenges under the lawsuit is regarding the unfunded federal mandate imposed by the Medicaid expansion.*
  - *Preliminary estimates released by the Alaska Department of Health & Social Services (DHSS) this summer project that the 2014 expansion will cover approximately 30,000 new enrollees<sup>iv</sup>. The Urban Institute, applying Alaska data to a national model, projects*

*the expansion will add between 42,794 to 59,914 new Medicaid enrollees (33,106 – 49,061 of whom will have been previously uninsured)\*.*

- *DHSS is not currently planning to apply for the early expansion option.*
- *New Service Requirements: The Alaska Medicaid program previously exercised the option to cover all the services now mandated under provisions enacted in Title II, including freestanding birth centers and comprehensive tobacco cessation services for pregnant women. These changes are not expected to impact Alaska, other than by eliminating the flexibility the state once had to remove these services from the covered services list, and by requiring a new billing methodology for freestanding birth centers.*
- *Maternal, Infant, and Early Childhood Home Visiting Program: The following organizations were awarded grants under this program in 2010:*
  - *AK Department of Health & Social Services (DHSS): \$584,256*
  - *Southcentral Foundation: \$345,000*
  - *Fairbanks Native Association: \$250,000*
  - *Kodiak Area Native Association: \$236,000*
- *Personal Responsibility Education Program (PREP): DHSS was awarded two grants in 2010 totaling \$849,985 under this program, which focuses on fostering healthy relationships and preventing teen pregnancy. DHSS chose not to apply for an abstinence education grant made available under this title as the relatively small amount allocated to Alaska would not fund the grant requirements, a match was required, and the same services will be provided under the PREP program.*
- *Aging & Disability Resource Centers (ADRC): DHSS applied for but did not receive the ADRC grant made available under Title II in 2010.*
- *Money Follows the Person Rebalancing Demonstration: DHSS did not apply for a planning grant made available for this program, and does not intend to apply to participate in the demonstration project (grant application due in January 2011).*
- *Medical Home for Medicaid Enrollees with Chronic Conditions: Federal planning funds for this demonstration project will be made available in January through Medicaid match at the state's pre-ARRA FMAP rate. DHSS has not yet made a decision regarding whether to plan for and participate in this demonstration.*

### **Title III – Health Care Delivery and Payment Changes**

Title III intends to control health care costs and improve quality through a series of delivery system and payment changes driven primarily through the Medicare program. Increases in Medicare costs will be limited by restructuring payments to Medicare Advantage plans, reducing annual market basket updates for inpatient hospital, home health, skilled nursing facility, hospice and other Medicare providers. Providers organized as Accountable Care Organizations will be allowed to participate in cost savings they achieve for the Medicare program as long as they meet certain quality thresholds. The Center for Medicare and Medicaid Innovation is created to test new payment and service delivery models, and the Independent Payment Advisory Board is created to develop proposals for reducing per capita rate of growth in Medicare if spending exceeds target growth rates. The Secretary of HHS is vested with broad authority to implement payment reform models that prove to be effective at improving quality and reducing the rate of cost growth.

Medicare will reduce payments to hospitals for excess preventable hospital readmissions and for hospital-acquired conditions. Bonus payments will be made to hospitals in counties with the lowest

Medicare spending. Medicare will establish a Hospital Value-Based Purchasing Program to pay hospitals based on performance on certain quality measures. Plans to implement value-based purchasing for skilled nursing facilities, home health agencies, and ambulatory surgical centers will be developed. A Medicare pilot program to test payment bundling for acute inpatient hospital, physician, outpatient hospital, and post-acute care services for an episode of care that begins three days prior to a hospitalization and ends 30 days following discharge is created. A home health demonstration program intended to prevent hospitalization and improve cost, patient outcomes and satisfaction is also created.

The Medicare Part D “doughnut hole” is phased out starting with a \$250 rebate check provided to all Medicare beneficiaries entering this drug coverage gap in 2010 and phasing down the coinsurance rate until it is eliminated altogether in 2020. A program to strengthen trauma center capacity is created, along with a demonstration program to develop models for regional emergency care systems.

*Status in Alaska:*

- *MIPPA (Medicare Improvements for Patients & Providers Act) Medicare Outreach: DHSS was awarded \$65,454 for Medicare Outreach to low-income and rural Alaskans.*
- *The only other major provision under Title III known to have taken effect in Alaska during 2010 was the issuance of the \$250 rebate checks to Medicare enrollees in the prescription drug “doughnut hole.” A few of the provisions impacting Medicare reimbursement also began taking effect in 2010.*

**Title IV – Prevention and Public Health**

Title IV establishes or reauthorizes and funds a series of programs intended to reduce the burden of disease in the population. It establishes the National Prevention, Health Promotion & Public Health Council and a Prevention and Public Health Fund to coordinate and support prevention, wellness, and public health activities. National committees to develop and disseminate recommendations on effectiveness of clinical and community preventive services are authorized.

Medicaid and Medicare coverage of preventive services is expanded. The Fair Labor Standards Act is amended to require employers to provide reasonable break times and private locations for employees who are nursing mothers to express breast milk. Chain restaurants will be required to disclose the nutritional content of the food items they sell.

“Community Transformation” and “Healthy Aging, Living Well” grants aimed at reducing chronic disease rates and addressing health disparities through wellness activities are funded, and a worksite wellness program to provide technical assistance and funding to small businesses is also established. A grant program to support school-based health centers is created. A grant program to support oral health promotion and disease prevention is created. Programs to improve immunization coverage and continue federal support of public health epidemiology and laboratory capacity are authorized or reauthorized.

*Status in Alaska:*

- *Much of the new funding appropriated to the new National Prevention & Public Health Fund was diverted by the US DHHS to fund workforce programs authorized but not funded under Title V.*
- *The following grants were awarded to the Alaska Division of Public Health under provisions in Title IV during 2010:*

- *Strengthening Public Health Infrastructure (\$100,000)*
- *HIV/AIDS Surveillance – Lab Reporting (\$41,909)*
- *Epidemiology & Laboratory Capacity (\$473,908)*
- *Behavioral Risk Factor Surveillance System Supplemental (\$68,265)*
- *Strengthening Tribal Public Health Infrastructure: The Alaska Native Tribal Health Consortium and the SE Alaska Regional Health Consortium were each awarded \$100,000 under this new program.*
- *School-Based Health Centers Capital Program: None of the three school-based health centers (Juneau-Douglas High School/Juneau, Mt. Edgecumbe High School/Sitka, and Clark Middle School/Anchorage) applied to participate in this 1-year equipment grant opportunity.*

### **Title V – Health Care Workforce**

Title V establishes a National Workforce Advisory Committee and requires a national health care workforce assessment be conducted. There are a number of new scholarship and educational loan repayment programs created and existing programs are expanded, with certain emphases on primary care and preventive specialties, nursing, oral health, public health, geriatrics, and behavioral health. It increases the National Health Services Corps and eliminates the cap on the number of commissioned officers in the Public Health Service Regular Corps, and also expands the use of the Reserve Corps (renamed Ready Reserve Corps) in times of a public health emergency. It also expands Area Health Education Centers.

The number of Medicare-funded physician training positions (Graduate Medical Education (GME) for residency training) will be increased by redistributing unused positions with priority given to primary care and general surgery, and by expanding eligible training sites to allow for outpatient health center-based residency training programs. A number of provisions also support the development of training programs in different patient care models, such as medical homes, chronic disease management, and integration of primary and specialty health care into behavioral health care settings. This Title also includes a provision for a 10% bonus payment under Medicare to primary care physicians and general surgeons practicing in health professional shortage areas.

#### *Status in Alaska:*

- *State Health Care Workforce Development: The Alaska Workforce Investment Board (AWIB)/ Department of Labor & Workforce Development (DOLWD) in collaboration with the Alaska Health Workforce Planning Coalition received a \$150,000 grant in September to develop a strategic plan for health workforce development in Alaska.*
- *Health Occupations Training for Low Income and TANF Recipients: DOLWD also collaborated with DHSS to apply for funding for this program but did not receive a grant. The Cook Inlet Tribal Council was awarded \$1,463,627 in September under the tribal organizations provision for this program.*
- *Primary Care Service Integration in Behavioral Health Centers: Alaska Island Community Services (in Wrangell) was awarded a grant of \$296,836 under this program in September.*
- *Primary Care Residency Expansion: This grant opportunity became available in July, but did not support planning and development for new residency programs and therefore was not a potential funding stream for development of the new psychiatric or pediatric residency programs in Alaska. The Alaska Family Medicine Residency Program chose not to apply due to concerns over sustainability as the grant would only support addition of new residency slots for one year.*

- *Physicians Assistant Training Program: The UAA Physicians Assistant Training Program was not eligible to apply under the grant opportunity made available by this program in July (only accredited PA schools were eligible, and the PA program at UAA is accredited under the University of Washington's MEDEX program).*
- *Family-to-Family Health Information Centers: This program, initially created in 2005, was reauthorized under PPACA. Stone Soup Group, an Anchorage-based non-profit, was previously funded under this program and received a continuation grant of \$96,700 in July to provide information and training to families of special needs children.*
- *No Alaskan organizations are known to have applied for the following grant opportunities made available under provisions in Title V during July:*
  - *Personal and Home Care Aide State Training Program (competitive 6-grantee demonstration project)*
  - *Advanced Nursing Education Expansion Program*
  - *Nurse Managed Health Clinics*
  - *Nursing Assistant and Home Health Aide Program*

#### **Title VI – Fraud, Waste and Abuse**

Title VI will require transparency related to financial relationships between health care provider and supplier entities. New provider enrollment processes for Medicare and Medicaid are created, as well as a new database for sharing provider data among federal programs and between federal and State programs. Providers and suppliers will be required to establish compliance programs, and face increased penalties for false claims. State Medicaid programs are required to implement the Medicare RAC (Recovery Audit Contractor) Program.

The Elder Justice Act is created under this title, which addresses prevention and intervention in the abuse and neglect of individuals aged 60 or older, creating an Elder Justice Coordinating Council, and providing funding to State Adult Protective Services and Long Term Care Ombudsman programs. A medical malpractice demonstration program is also created, which will provide grants to States to test alternatives to tort litigation. This title also establishes a non-profit Patient-Centered Outcomes Research Institute to identify priorities for a national comparative outcomes research project agenda.

#### *Status in Alaska:*

- *Medicare RAC Program Expanded to Medicaid: AK DHSS submitted a request to US DHHS to extend the deadline for Alaska's compliance with this new requirement from April 1, 2011 to October 1, 2011. The department currently has a contract in place with Myers and Stauffer to conduct audits of Medicaid providers required under state law (AS 47.05.200). This contract is up for annual renewal 10-1-11. The department's intent is to align the state audit program as much as possible with the new RAC program. It will not be possible however to fully integrate the two Medicaid audit programs, as the state program pays the audit contractor a flat fee, while the federal RAC program requires audit contractors be paid on a contingency fee basis.*
- *Nationwide Program for Long Term Care Worker Background Checks: The DHSS/Division of Public Health's Section of Certification & Licensing received a grant of \$1 million in October under this program.*
- *Other Provisions: Additional changes enacted under this Title that will potentially impact the Alaska's Medicaid program are currently under analysis by DHSS, including extension of the*

*period for collection of overpayments, termination of provider participation in Medicaid if terminated under Medicare, and required participation in the National Correct Coding Initiative.*

#### **Title VII - Pharmaceuticals**

Title VII authorizes the FDA to approve generic versions of biologic drugs, and expands the 340B program, which is a program limiting the cost of covered outpatient drugs to certain federal grantees.

*Status in Alaska:*

- *Unknown*

#### **Title VIII – CLASS Act**

The Community Living Assistance Services and Supports Act will establish a national, voluntary long term care insurance program starting in 2011. The program requires five-year vesting, and will provide a cash benefit of no less than \$50 per day to help aged or disabled individuals to stay in their home. The benefit may also be used to cover nursing home costs. Premiums will be paid through payroll deductions.

*Status in Alaska:*

- *The federal government is required to establish this new national program in 2011.*

#### **Title IX – Taxes and Fees**

New taxes and fees imposed in order to finance the new programs established under PPACA started in 2010 with a 10% excise tax on indoor tanning. There are a series of new taxes and fees imposed on the health care industry and health care products, such as an annual fee on the pharmaceutical industry (starting at \$2.8 billion in 2012 and increasing over time), an annual fee on the health insurance industry (starting at \$8 billion in 2014 and increasing over time), and a 2.3% sales tax on medical devices starting in 2013. The tax deduction for employers receiving Medicare Part D retiree subsidies is eliminated.

The Medicare payroll tax is increased starting in 2013 by 0.9% (from 1.45% to 2.35%) for individuals who make over \$200,000/year (\$250,000/year for married couples filing jointly). The payroll tax increase applies only to the employee, not the employer share of the tax. There is also a new 3.8% tax imposed on the unearned income for high-income individuals in that same tax bracket. The revenue from that tax is intended to flow to the Medicare program. Starting in 2018 a new excise tax will be imposed on employer-sponsored high-value insurance plans. Otherwise known as the “Cadillac tax”, this tax will be imposed on plans valued at more than \$10,200 for individual plans and \$27,500 for family coverage, and will be assessed at 40% of the amount over those thresholds.

*Status in Alaska:*

- *The one Title IX provision that took effect in 2010 was the new federal 10% sales tax on indoor tanning.*

## **Title X - Amendments**

There are a few stand-alone provisions included in Title X (not amending other sections of PPACA). Of significance to Alaska's health care system is a provision that expands funding for Community Health Centers and another that permanently reauthorizes the Indian Health Care Improvement Act. There is one provision specific to Alaska that created the Federal Interagency Task Force to Improve Access to Health Care in Alaska, which was charged with assessing access to health care for beneficiaries of federal health care systems in Alaska.

### *Status in Alaska:*

- *Federal Interagency Task Force to Improve Access to Health Care in Alaska: The Task Force was convened in July, conducted a site visit in August, and issued its report and disbanded in September. A copy of the Task Force's report is available on the Commission's website.*
- *Community Health Center Construction/Renovation: Two Alaska CHCs received grants in October in the first round of funding made available under this program – the Anchorage Neighborhood Health Center (\$8 million) and the SE Alaska Regional Health Consortium (\$1,299,147).*
- *The Alaska Native Health Board sponsored workshops during 2010 for its member tribal health care organizations and partners on changes made under the Indian Health Care Improvement Act reauthorization and associated amendments.*

## **Economic Impact of the Federal Affordable Care Act (ACA) on Alaska**

Executive Summary of October 2010 Presentation to Commission (included in Appendix C), by Mark A. Foster & Associates/Institute for Social & Economic Research.

### **Overview – How much might it cost by 2019?**

- The Medicaid Expansion and Individual Mandate may result in a *net* increase of roughly 60,000 insured individuals in Alaska by 2019; reducing the number of uninsured by about 50% over baseline projections
- The *net effect on overall Alaska health care spending* in 2019 may be an increase of roughly 3%, consisting of:
  - An increase of roughly 4% associated with an increase in utilization of medical care by the newly insured and those whose existing insurance coverage will be increased to comply with new requirements
  - An increase to close the Medicare prescription drug “donut hole”
  - Decreases associated with:
    - Medicare reductions in allowable growth rates – including hospitals, skilled nursing facilities, long term care hospitals, inpatient rehabilitation facilities, hospice, and home health
    - Insurance and provider discounts imposed or negotiated
    - Reductions in utilization associated with the shift of financial resources away from health insurance and toward income in response to the 40% excise tax on high cost plans

### Changes in Funding Sources in Alaska, 2019 – Who Pays?

- Federal support for the Medicaid Expansion *and* subsidies for households <400% of federal poverty level (FPL) are the primary sources of funding for the insurance expansion – totaling roughly \$800 million in Alaska in 2019
- The increased federal support for the insurance expansions will be offset by:
  - Reductions in the overall level of spending on Medicare including:
    - Increments for closing the Medicare prescription drug benefit “donut hole” [<\$10M], and
    - Decrements associated with reductions in rate updates and changes in payments for hospitals, skilled nursing facilities, long term care hospitals, inpatient rehabilitation facilities, hospice, and home health [\$60M]
    - Increased Medicare taxes on high income families [\$90M]
    - New 40% excise tax on high cost health plans (approx 50% of health plans in Alaska in 2019 may be subject to the excise tax) [\$280M]
    - New fees on drugs, medical devices, health insurance, changes in tax deductions and Health Savings Accounts (HSA) rules [\$80M]

### Impact on Households

*In aggregate*, Alaskan households may spend on the order of 1-2% more on health care, which is the net effect of several factors including:

- Subsidies
  - Federal support of coverage expansions – including insurance premium support, cost sharing subsidies, and Medicaid expansion
- Insurance Mandate
  - Increased costs for households who purchase insurance to comply with the mandate; even after subsidies and cost support, households can be expected to pay on the order of 8-9% of income on health insurance
  - Penalties of 2.5% of income for households who decline to purchase health insurance
- Taxes and Fees
  - 40% excise tax on high cost health plans
  - New fees on drugs, medical devices, health insurance providers, changes in tax deductions and Health Savings Accounts rules

**The net effect of the ACA on households varies considerably by income level, whether previously insured, and the age of householder.** Low and moderate-income level older households and high medical expense households tend to be net beneficiaries. Healthier, higher-income households with no insurance or high deductible plans tend to be net payers. Previously insured households <400% of federal poverty guidelines (\$110,280 for a family of four in 2010) are slated to receive insurance subsidies that increase as household incomes decrease. With some limited exceptions, uninsured households above 138% of federal poverty level can be expected to spend roughly 8-9% of their income (after subsidies) to purchase health insurance or spend up to 2.5% of their income as a penalty for noncompliance with the individual mandate. In the individual and small group market, young singles (not covered under their parents’ plans) and young families can expect to pay more under health insurance reform while those over 55 can expect to pay less due to a mandate to limit age differentials (previously market rates for insurance tended to more closely track the actuarial costs by age group).

### **Impact on Private Business**

In aggregate, Alaskan businesses may see a reduction in spending on health care of around 3%, which is the net effect of several factors including:

- A reduction in the number of firms offering health insurance with employees migrating to the new Exchange for subsidized coverage; sign-up rates in the new Exchange are likely to be higher for low to moderate wage employees (<400% of FPL) who are in line to receive larger subsidies as a portion of their income in the Exchange
- Firms with 50 or more employees may offer insurance or be required to pay an assessment when their employees use subsidies in the new Exchange

### **Impact on key economic sector competitiveness**

Resource development and export sectors with high wages and benefits appear likely to experience the 40% excise tax on high cost plans sooner than their competitors in other states. Large fishing and tourism enterprises may be faced with challenging “pay or play” penalties due to the high cost of medical care. Small fishing and tourism enterprises may not see the same proportion of small business tax credits due to a relatively small proportion of employees with “low wages” as compared to other states.

## C. Issues Prioritized for Study in 2011

### 1. Health Care Costs

Health care costs are higher in Alaska compared to other states<sup>vi</sup>, 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 to make up for capped reimbursement by some payers, low fees negotiated with contract payers, and uncompensated care provided for uninsured and underinsured individuals who are unable 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.

The high and continued escalation in health care costs in Alaska was a primary concern of the Commission in 2009, and they identified the need for additional analysis to better understand what is driving those costs as a top priority for future study. To understand the main variables influencing cost the Commission was introduced to this simple formula in 2009:

$$\text{Cost (total spending)} = \text{Price (paid)/process unit} \times \text{Utilization}$$

During 2010 they were introduced to a more detailed breakdown of the utilization variable:

**Utilization =**

$$\begin{aligned} & \# \text{ of health conditions} \\ & \times \# \text{ of episodes of care/condition} \\ & \times \# \text{ of services (by type)/episode of care} \\ & \times \# \text{ of process units/service} \end{aligned}$$

This formula is providing a framework to guide plans for studying the cost of health care in 2011.

**A. Health Care Spending and Cost Driver Analysis** – In order to better understand the current cost of health care in Alaska in terms of total spending in the state for health care services the Commission has contracted with the Institute for Social and Economic Research (ISER) at the University of Alaska Anchorage to conduct an analysis. ISER conducted similar analyses in the past – once in 1992 and more recently in 2005 (published in March 2006 with 2005 data).<sup>vii</sup> ISER will provide updated information on current spending by payer and service category, will expand past analyses of cost drivers, and will also include an analysis of opportunity costs of high health spending. The final report, expected in April 2011, will include:

- A review of historical spending trends, health insurance and health provider costs, and distribution of public and private payers;
- A ten-year spending forecast;

- An analysis of cost drivers, including:
  - Demand
    - Demographic trends
    - Technology
    - Nature and extent of insurance coverage
    - Tax treatment of benefits
    - Supply sensitive and preference sensitive demand considerations
  - Supply
    - Inefficient organization
    - Physician supply
  - Other factors (e.g., institutional factors, research)
- An analysis of opportunity costs of health spending (in Alaska and compared to the U.S.), including health spending trends as a percentage of GDP compared to other sectors, implications of health spending trends in terms of potential cuts to other public programs and/or tax increases, and description of what higher spending in Alaska buys.

**B. Health Care Price and Reimbursement Study** - The Commission will contract with a health care actuarial consulting firm with expertise in the analysis of system-wide health care pricing and reimbursement to conduct a study comparing health care provider third party and private-pay charges and reimbursement in Alaska to charges and reimbursement for the same services in Washington and Oregon, and to also benchmark those charges against public coverage such as Medicare, Medicaid, Workers Compensation, TriCare, and the Veteran's Administration. Specific analyses to be requested will include:

- Comparisons of billed and allowed non-facility provider charges, on a per unit basis, for the top 25 most commonly used codes;
- Comparisons of billed and allowed non-facility provider charges, on a per unit basis, for the top 25 most commonly used codes by specific major specialties, including but not limited to family practice, pediatrics, internal medicine, ob/gyn, orthopedics, urology, gastroenterology, cardiology, neurology, general surgery, cardiothoracic surgery, interventional cardiology, ENT, ophthalmology, diagnostic imaging, and chiropractic;
- Comparisons of facility-based provider charges.

The range of billed and allowed charges for each grouping of codes by specialty, as well as the mean and the 50<sup>th</sup> and 80<sup>th</sup> percentile, will be included. The consultant will also be asked to identify the major drivers of the pricing and reimbursement differences between Alaska and the other states.

In addition, to assist the Commission in better understanding the challenges Alaska physicians face in delivering Medicare services under the current reimbursement structure, the consultant will be asked to include an analysis of variations in the cost of providing primary care (including compensation, materials and overhead) to Medicare recipients in Alaska compared to other regions of the study, and a description of the major factors driving differences resulting in under-reimbursement of Alaskan physicians by the Medicare program.

The Commission intends to award this contract in January 2011 and hopes to take delivery of the final report by July 2011.

**C. Health Status Assessment** - The Commission is interested in learning how the “health conditions” variable in the cost equation is driving utilization of and spending for health care services, and has asked the Department of Health & Social Services to provide information on the health status of the Alaskan population, including health trends and health disparities, with comparisons to national averages. The Commission anticipates the information will include data on chronic and infectious disease, injury (both intentional and unintentional), health risk behaviors (including substance abuse), mental illness, and disabling conditions. The Commission hopes to receive the state health status report by July 2011.

### **3. Long Term Care**

Alaska’s long term care system is recognized as being one of the most balanced in the nation in terms of supporting people to live in their home and in community settings as opposed to institutions. However, the growing cost of providing long term care services is a critical issue facing Alaska’s Medicaid program, and Alaska’s senior population is projected to triple over the next twenty years. Current challenges in addition to escalating costs and concerns over system capacity include the need to improve quality in assisted living and other home and community based services, and inadequate services for individuals with maladaptive or severe behavior issues. During 2011 the Commission will compile recent long term care studies, plans and other information available, and will invite a presentation by state leaders grappling with the long term care challenges in our state.

### **4. Trauma System**

Injury is the leading cause of death for Alaskans who are one to 44 years of age. A trauma system that provides rapid appropriate response and treatment is critical to reducing death and disability due to injury. The Department of Health & Social Services made trauma system development a priority two years ago and commissioned a study by the American College of Surgeons Committee on Trauma. Progress has been made since the release of the Committee’s November 2008 report. For example HB 168, establishing the Uncompensated Trauma Care Fund to incentivize hospitals to meet trauma center standards, passed during the 2010 legislative session and was signed into law in June; and, DHSS created and filled a Trauma System Coordinator position to support development of a trauma system strategic plan. During 2011 the Commission will learn about the status of trauma system improvement in our state.

## Part III: Alaska Health Care System Transformation Strategies

### A. Status of Implementation of 2009 Commission Recommendations

The Commission intends their recommendations from prior years to continue standing as current recommendations unless and until they decide to modify or eliminate them based on further study. To that end the Commission will track, consider and report on implementation of our prior year recommendations over time. During 2010 progress was made related to all of the 2009 Commission recommendations. Following is a summary of these developments.

#### A. Strengthen the Consumer's Role in Health and Health Care

1. Support healthy lifestyles and create cultures of wellness
2. Develop patient-centered primary care models through payment reform, removal of barriers, and support for pilot projects

#### Healthy Lifestyles

State agencies operate a number of programs aimed at supporting healthy lifestyles, including programs to prevent and control specific diseases and conditions and also risk behaviors such as: obesity, tobacco use, alcohol & drug abuse (including Fetal Alcohol Spectrum Disorders), suicide, unintentional injuries, domestic violence & sexual assault, child abuse, infectious disease, chronic disease, autism, and metabolic and other genetic disorders. Following are significant new efforts initiated and resources invested during 2010.

- Governor Parnell launched "Choose Respect" in March 2010, a new initiative to stop the epidemic of domestic violence and sexual assault in Alaska. As an early phase of this initiative, the Governor proposed and won passage of several new laws during the 2010 legislative session targeted at sexual and domestic violence offenders. The Governor's initiative is now aiming to prevent domestic violence and sexual assault from occurring in the first place by working towards creating a culture that emphasizes respect for others and zero tolerance of violence against women and children.
- The Alaska Department of Health & Social Services (DHSS) implemented two new initiatives related to obesity and chronic disease prevention and control:
  - Alaskans Taking on Childhood Obesity: DHSS collaborated with the Alaska Department of Education & Early Development (DEED) to create "ATCO" – a Task Force convened by the Commissioners of the two state agencies and including the Anchorage School District, Alaska Association of School Boards, and the Alaska Native Tribal Health Consortium to develop recommendations regarding strategies to reverse the trend of increasing rates of overweight and obesity among Alaska's children. The two state agencies (DHSS and DEED) formalized their agreement to collaborate in school-based obesity prevention and reduction efforts in a Memorandum of Agreement signed by Commissioner Hogan and Commissioner LeDoux in July.
  - Alaska Food Policy Council (AFPC): DHSS collaborated with the Alaska Division of Agriculture, US Department of Agriculture, Farm Bureau, Alaska Center for the Environment, and Alaska Root Sellers to create the first food policy council in Alaska. The goal of the new council is to expand

Alaska's food production, improve supply and distribution of locally grown and produced products, decrease hunger, support the use of traditional and local foods, and increase nutrition literacy of consumers.

- DHSS also received an annual operating budget increase of \$375,000 in state general funds in the SFY 11 budget to support the Division of Public Health's Obesity Prevention & Control Program. The new state funding will not support new efforts, but replaces federal funding received through hard earmarks and under ARRA to support obesity prevention and control over the past decade. Without the new state funds and with federal support drying up the program may have been discontinued.
- The Statewide Suicide Prevention Council launched a new web portal in November, [www.StopSuicideAlaska.org](http://www.StopSuicideAlaska.org), offering information and resources for individuals and groups in Alaska to support efforts to prevent suicide and help with recovery after a loss.

#### **Patient-Centered Primary Care**

During 2010 DHSS received a federal grant under CHIPRA (Children's Health Insurance Program Reauthorization Act) that will provide funding for piloting and evaluating patient-centered medical home care models to improve children's health care in primary care clinics in Alaska. The department released a grant Request for Proposals in November and intends to make grant awards to pilot sites in January 2011.

In June of this year the Southcentral Foundation's (SCF) Primary Care Center became the first practice in Alaska to achieve NCQA (National Committee for Quality Assurance) recognition as a patient-centered medical home (level III; effective 2010-2013). In July the University of Alaska Anchorage was awarded a 2-year federal grant to evaluate SCF's adoption of the medical home model in terms of its impact on the cost and quality of care.

This past year the Providence Family Medicine Center/Alaska Family Medicine Residency Program transitioned to a patient-centered medical home care model. The new Providence Senior Care Center, scheduled to open in January 2011, is building its practice based on the same model.

The Alaska Primary Care Association (APCA) launched an initiative in 2010 to support their members' efforts to transform their clinics and practices to a medical home model. APCA contracted with Primary Care Development Corporation to hold a learning session for member clinics and organizations on how to become a recognized medical home. APCA is currently investigating opportunities for developing a set of "Alaskanized" patient-centered medical home standards that will be based on national standards but modified to accommodate special features of health care delivery in Alaska (such as mid-level practitioner led clinics in rural communities too small to support physician practices).

#### **B. Foster Statewide Leadership to Support Health Care Transformation**

1. Invest in the health policy infrastructure needed to respond to national reform
2. Establish a permanent state health planning and policy body in statute

#### **National Reform**

Following passage of the federal health care reform laws in March and April Governor Parnell directed the State Attorney General to join the Florida-led multi-state lawsuit challenging the law on two primary points: 1) the constitutionality of the federal government's authority to require individuals to purchase

health insurance or pay a penalty, and 2) the imposition of an unfunded mandate on state government by expansion of the Medicaid program.

Due to the Administration's constitutional challenge to the new federal laws, state agencies are proceeding cautiously regarding implementation of new programs created by the laws. State agency staff have been working to assess requirements imposed on state government and to consider options to participate in potential funding opportunities. Decisions to participate in optional programs and regarding how to implement required provisions are being made on a case-by-case basis by program managers and agency executives based on alignment with current policies and programs.

Information that has been made public to-date by state and federal agencies on analyses and implementation of the new laws in Alaska is included in this report in Part II.B and Appendix B.

### **State Health Planning & Policy Body**

The Alaska Legislature passed SB 172 establishing the Alaska Health Care Commission in statute on the final day of the legislative session in April. The bill was transmitted to the Governor in June and signed into law June 21. The new law is very similar to Governor Palin's order that established the original Commission (Administrative Order #246). The most substantive change is the addition of four new voting member seats. SB 172 also included a transition clause to automatically appoint former members appointed under A.O. #246 to the new Commission. New Commission members were appointed September 15 and the Commission convened for the first time in October of this year.

### **C. Develop the Health Care Workforce**

1. Make workforce a priority on health care reform and economic development agendas
2. Strengthen the pipeline of future health care workers
3. Support workforce innovation and adaptation as patient care models evolve
4. Direct workforce planning to be more coordinated
5. 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 primary care residency program development and operation

### **Health Workforce Planning**

The Alaska Health Workforce Coalition completed the "Alaska Health Workforce Plan," which was adopted by the Alaska Workforce Investment Board in May 2010. In September the Department of Labor & Workforce Development (DOLWD) received a federal grant to develop a strategic plan for health workforce development in Alaska. DOLWD is using these funds to support the work of the Coalition to develop an action plan based on the new comprehensive statewide plan. The Coalition anticipates the action plan will be drafted by the spring of 2011. The Coalition also launched a new website this year (<https://sites.google.com/site/alaskahealthworkforcecoalition/>) and has been holding monthly planning meetings.

### **Educational Loan Repayment & Financial Incentives**

A number of bills introduced in the 26<sup>th</sup> legislature (2009-2010) would have created and funded a state educational loan repayment and financial incentive program to support recruitment of health care professionals to serve underserved areas and populations in Alaska, but none of these bills passed.

During 2010 the Department of Health & Social Services started a loan repayment program, SHARP (Supporting Healthcare Access through loan Re-Payment), funded with a 1-year \$600,000 federal grant and additional funds provided by the Alaska Mental Health Trust Authority and health care organizations. The annual loan repayment benefit provides up to \$35,000 for Tier-1 professions or \$20,000 for Tier-2 professions for two years, and is paid directly to the practitioner's lender. Eligible practitioners are primary care physicians, nurse practitioners, physician's assistants, dentists, dental hygienists, psychiatrists, psychologists, clinical social workers, psychiatric nurse specialists, licensed professional counselors, and marriage and family therapists serving in identified high-needs areas and facilities. The first grants issued under this program were awarded in June to 14 practitioners based in Anchorage, Bethel, Dillingham, Kenai, Homer, Petersburg, Talkeetna, Tok and Wrangell, as follows: \$230,000 to five behavioral health providers, \$140,000 to two dental care providers, and \$361,771 to seven primary medical care providers.

#### **Primary Care Residency Programs**

Of the three new residency programs noted as a need in the Commission's 2009 recommendations, there was significant progress made related to planning and development for two during 2010:

- Alaska Pediatric Residency: The new pediatric residency program will be a three-year branch program of the UW Children's Hospital Pediatric Residency Program. Residents will complete a four-month rotation in Alaska during each of the three years in training; will train in Anchorage, Fairbanks and Juneau; and will have opportunities for placement in both urban and rural and tribal health system and private industry sites. The new pediatric residency program will support 12 residents starting in 2012. Planners do not anticipate requesting funding from the State of Alaska for support. Financial support will be provided by Southcentral Foundation, Providence Health and Services System, Banner Health System, SouthEast Alaska Regional Health Consortium, and the Seattle Children's Hospital.
- Alaska Psychiatry Residency: The new psychiatry residency program will be a four-year branch program of the University of Washington Psychiatry Residency Program. Residents will spend their first two years training in Seattle, and the last two years in Alaska. The program could begin as early as the summer of 2012, and at full capacity 11 residents will be enrolled in the program each year. Residents will train with both urban and rural providers of psychiatric care, and their training will emphasize primary care integration, telepsychiatry and rural/remote consultation. Financial support will be provided by Southcentral Foundation, Anchorage Community Mental Health Trust, Fairbanks Memorial Hospital, Providence Health and Services System, and the Alaska Psychiatric Foundation. Planners anticipate requiring State of Alaska funding in addition to industry and other support to start and maintain operation of this program.

#### **D. Deploy Health Information Technology**

1. Support health information technology adoption and utilization
2. Ensure public health connectivity
3. Ensure resulting information is used for optimization of medical care
4. Ensure privacy and security
5. Facilitate broadband telecommunications service access
6. Improve reimbursement for telemedicine

In April 2010 the Alaska Department of Health & Social Services awarded a \$3 million four-year contract to the Alaska eHealth Network (AeHN) to serve as the state's official Health Information Exchange (HIE) management entity. In November AeHN awarded a contract to Orion Health to provide the technology for Alaska's statewide exchange. Initial pilots to begin connecting hospitals and clinics in certain test sites are slated to begin in April 2011. The program creates a system for securely moving electronic health records (EHRs) between participating health care providers; provides connectivity to referral providers in Alaska and the lower 48; supports telemedicine (high-resolution image transfer, videoconferencing, and Voice-over-Internet applications); and creates a system to track chronic disease across the state, coordinate care programs and improve patient health.

Also in April AeHN received a federal grant of \$3,632,357 to establish a Regional Health IT Support Center (also known as the Regional Extension Center, or "REC") to provide technical assistance to health care providers in the selection and implementation of EHRs. One of AeHN's goals is to assist smaller providers with implementing EHR systems and achieving "meaningful use" (standards for qualifying for incentive payments and avoiding penalties). Services include EHR readiness assessment, vendor selection and contracting assistance, practice workflow redesign, training, and IT support ("geek team"). Alaska's REC began offering services in September.

Following a 2009 survey of Alaskan providers on EHR adoption that identified difficulty in selecting an EHR vendor as a top barrier, the Alaska EHR Alliance launched an 8-month process to select two EHR vendors to endorse for Alaska's providers. In April 2010 the Alliance selected e-MDs and Greenway Medical Technologies as the preferred vendors. Under the endorsement Alaska providers are offered reduced pricing and access to pre-negotiated contracts to simplify the EHR selection process, in addition to the assurance that the vendors were carefully vetted from an initial field of 250 potential vendors by a team of Alaska health care system stakeholders. This project was funded by AeHN through a grant from the State of Alaska.

The Alaska EHR Alliance also updated their 2009 survey of Alaskan providers in January 2010 by contacting clinics that reported not having EHRs in the 2009 survey. Of the 94 clinics that responded to the follow-up survey, 24 had acquired new EHRs in the past year and an additional 18 were planning to do so.

In addition to the contracts negotiated by the Alliance with e-MDs and Greenway, two Alaska hospitals began offering EHRs at a reduced price to affiliated physicians this year. Central Peninsula Hospital in Soldotna offers eClinical Works and Providence offers Epic as remote-hosted EHRs, providing hosting, maintenance and subsidies to independent physician practices choosing to adopt their systems.

The University of Alaska partnered with Dakota State University this year to create Alaska's first Health Information Technology Workforce Training Program. The program offers two certificates available through the UAS Sitka Campus providing noncredit continuing education courses via online delivery. The two certificates, one for Health IT Redesign, Planning, and Management, and the other for Health IT Implementation and Technical Support, fulfill the requirements for roles defined by the federal Office of the National Coordinator (ONC) for Health IT. This program is federally funded by the American Recovery and Reinvestment Act of 2009 (ARRA).

In July CMS published final regulations to implement the Medicare and Medicaid EHR Incentive Programs created by ARRA. These programs will begin providing financial incentives to health care providers making "meaningful use" of electronic health records in 2011. Federal regulations also issued

in July implement the EHR Certification Program. Authorized testing and certification bodies are now certifying EHR technologies as meeting compliance standards required for achieving meaningful use.

Significant 2010 developments related to expansion of broadband availability and support in Alaska include:

- The creation of Connect Alaska at the beginning of the year. Connect Alaska is a subsidiary non-profit of Connected Nation (a national non-profit formed to expand broadband across the U.S.), and received a \$1.9 million federal NTIA (National Telecommunications and Information Administration) grant through the Denali Commission to map broadband connectivity in Alaska.
- The launch of Alaska's first statewide broadband availability map in September. Connect Alaska, in partnership with the Alaska Department of Commerce, Community and Economic Development, developed the web-based interactive map with funding from the federal NTIA grant (appropriated under ARRA). The map will be continually updated, and is available at [www.connectak.org](http://www.connectak.org).
- Receipt of \$117 million in federal grants and loans by broadband service providers to expand and improve broadband connectivity to rural SW Alaska communities (and also Tanana and Cordova).
- Receipt by 257 health clinics in rural Alaska of FCC subsidies for telecommunication and internet access costs.

**E. Improve Access to Primary Care for Medicare Beneficiaries**

1. Increase the supply of primary care providers
2. Support Federally Qualified Health Centers and Rural Health Clinics
3. Request relief from federal reimbursement inequities and administrative burdens
4. Develop a PACE (Program of All-Inclusive Care for the Elderly) program

Expansion of clinical capacity intended to help alleviate the primary care access problem for Medicare beneficiaries is the main area of progress during 2010 related to the Commission's recommendations. One new clinic that accepts Medicare patients opened this year, and two new clinics were planned during 2010 and will open in early 2011:

- Mat-Su Community Medicine, currently staffed by one physician who is board certified in both pediatrics and internal medicine, opened in November. The new clinic accepts Medicare patients, and is being subsidized by Mat-Su Regional Medical Center.
- Providence Senior Care Center will open in January 2011. It will initially be staffed by two internal medicine physicians and one nurse practitioner with hopes to add two additional internists by the summer. Care delivery will be based on the patient-centered medical home model. The Center will accept patients 55 years of age and older, and estimates that approximately 70% of the patients will be Medicare enrollees. Providence Health & Services is subsidizing the start-up and operation of this clinic.
- Alaska Medicare Clinic, Inc., a new non-profit, received a \$1 million state grant in the FY 2011 capital budget to support start-up costs for a new clinic devoted solely to Medicare enrollees. This clinic will be directed by a physician and primarily staffed with mid-level practitioners, nurses and medical assistants. It will not use a patient-centered medical home care model, but planners have developed a streamlined care delivery process. Administrative operations will also be streamlined since the practice will be limited to a single payer and a specific patient population. Clinic organizers are hoping to open in February.

In addition to these new clinics the Anchorage Neighborhood Health Center (ANHC), a Federally Qualified Health Center, is implementing a project to relocate and expand clinic capacity from 20,000 ft<sup>2</sup> to 42,000 ft<sup>2</sup>. During 2010 ANHC received a new \$6 million state capital grant (in addition to \$10 million in state capital funds received in prior year budgets), and also an \$8 million federal grant under the Patient Protection & Affordable Care Act (PPACA), to support this \$28 million project. The new facility will have 3 medical pods, one dedicated to seniors, and use a patient-centered medical home model. August 2012 is the scheduled move-in date for the new facility.

Health care organizations in Anchorage are continuing to study the feasibility of creating a PACE program, but are not yet prepared to begin active planning with the Department of Health & Social Services on a reimbursement model, which will be the next step towards development of a CMS waiver to develop a PACE program for Alaska.

Individuals commenting at recent public hearings of the Commission have noted a provision included in the federal Patient Protection & Affordable Care Act through an amendment offered by Sen. Begich that intends to provide state governments an avenue for subsidizing Medicare payments to providers with state-funded grants (P.L. 111-148, Sec. 5606 added by Sec. 10501). It is unclear whether this provision overcomes the legal restriction prohibiting providers from accepting supplemental payment for Medicare services.

#### **Continuing Work Needed on 2009 Recommendations**

While progress has been made during 2010 in every area the 2009 Commission addressed more effort is needed to implement the initial set of recommendations, including on-going work to:

- Develop policies and capacity to encourage and support healthy lifestyles;
- Foster the development of innovative patient-centered primary care models including integration of primary medical care and behavioral health services;
- Track implementation of federal health reform legislation;
- Create sustainable capacity for health workforce planning and development;
- Improve health professions recruitment and retention through a state educational loan repayment and financial incentive program;
- Develop and support graduate medical education programs for training psychiatry, pediatric, and internal medicine residents in Alaska;
- Support health information technology deployment; and,
- Achieve improvements in federal Medicare policies.

The Commission will continue tracking progress made on the 2009 recommendations and will periodically review and potentially refine and add to these recommendations over time.

## B. 2010 Commission Recommendations

Note: The numbering system for Strategies, Findings, and Recommendations continues from 2009.

### A.3. Consumer's Role/Value: Foster the use of Evidence-Based Medicine

**Finding A.3.a:** Waste in the health care system due to misused medical resources is estimated to represent as much as 30% of health care spending.

**Finding A.3.b:** Evidence-based medicine can increase the effectiveness of medical treatment, improve the quality of health care, and reduce health care costs.

**Finding A.3.c:** Public and private health care sectors have demonstrated an increasing interest in applying evidence-based medicine to policy and practice in response to high and rising costs and variations in quality of health care.

**Finding A.3.d:** Involvement of health care providers and patients in decision-making is essential to the successful application of evidence-based medicine to clinical practice and public and private payer policies.

**Finding A.3.e:** Existing mechanisms to assess patients' compliance with evidence-based medical recommendations are limited.

**Finding A.3.f:** Assessing the outcomes of health care interventions is challenging due to limitations on collecting and sharing data among patients, clinicians, payers, and government agencies.

*"Evidence-based medicine is the practice of medicine in which the physician finds, assesses, and implements methods of diagnosis and treatment on the basis of the best available current research, their clinical expertise, and the needs and preferences of the patient."*

Mosby's Medical Dictionary, 8<sup>th</sup> edition, 2009 Elsevier

Health care expenditures are consuming an increasing proportion of Alaska's and the United States' gross domestic product (GDP) each year, but there is no indication that higher spending is producing better health outcomes for individuals or populations. Furthermore, there is growing evidence that a significant proportion of health care delivered in the United States is ineffective, inappropriate, or unnecessary, potentially wasting hundreds of billions of dollars. An oft-cited estimate is that waste in the health care system due to misused medical resources represents as much as 30% of health care spending. There is a costly gap between the care patients need and the care they actually receive.<sup>viii</sup>

Highlighting the problem of inconsistent and inappropriate use of health services is the Dartmouth Atlas of Health Care<sup>ix</sup> and numerous other studies, which have consistently demonstrated wide variations in practice patterns across geographic regions of the United States. The tests and treatment patients receive varies based on the location in the country where the care is provided. Moreover, research has documented those regions of the country where there is overuse of health care resources and higher spending actually have lower quality of care and worse health outcomes.<sup>x xi xii</sup>

Coinciding with increased recognition of the gap in the quality of care is an evolution in the nature of medical practice toward shared decision-making. A generation ago patients typically relied on their physician to make decisions for them regarding their care. The physician would determine the best

course of treatment based on their training, continuing education and journal reviews, and clinical experience. Today health care decision making is becoming a shared process that includes the provider's clinical judgment but also takes account of the patient's personal values and preferences and presents them with choices based on the best available scientific evidence of what course of treatment might work best for them.

A growing trend in clinical practice that is demonstrating improvement in quality and cost of care and that also supports better patient engagement in decision-making about their care is "evidence-based medicine." Evidence-based medicine (EBM) is a model of clinical practice intended to improve the quality, safety and effectiveness of care by applying scientific evidence of effectiveness and benefit to individual medical decisions. It uses the best available, high-grade evidence to support the clinician's and patient's decision-making process.

The practice of EBM dates back to ancient times, with accounts of efforts to study and understand the health outcomes of different treatment regimens found from Ancient Greece and China and even documented in the Bible.<sup>xiii</sup> Archie Cochrane, a physician and epidemiologist from Scotland, is acknowledged as the father of modern EBM. His 1972 text "Effectiveness and Efficiency: Random Reflections on Health Services" is noted as having had a profound influence on the practice of medicine and on the evaluation of medical interventions. His work led to the founding of the Cochrane Collaboration which is an international, nonprofit, independent organization dedicated to making up-to-date, accurate information about the effects of health care readily available worldwide.

The term "evidence-based medicine" is relatively new. It came into use in the early 1990s and was first formally defined by David Sackett in 1996 as "the conscientious and judicious use of current best evidence from clinical care research in the management of individual patients."<sup>xiv</sup> More recently David Eddy integrated the definition to include application of evidence to policy development with his definition published in 2005, defining EBM 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.<sup>xv</sup>

Numerous public and private organizations have demonstrated increasing interest in supporting the use of evidence-based medicine to improve health care quality and contain costs, for example:

- The Blue Cross Blue Shield Association established the Technology Evaluation Center (TEC) in 1985 to provide health care decision makers with timely, rigorous and credible assessments that synthesize the available evidence on the diagnosis, treatment, management, and prevention of disease. Current TEC clients include Kaiser Permanente and the Centers for Medicare and Medicaid Services.<sup>xvi</sup>
- The Veterans Health Administration established the Quality Enhancement Research Initiative in 1998 to support the application of new research findings into routine clinical practice to improve the quality of health care for Veterans.<sup>xvii</sup>
- The Agency for Healthcare Research and Quality (AHRQ), the lead Federal agency charged with improving the quality, safety, efficiency, and effectiveness of health care in the United States, established the Effective Health Care Program in 2003 (under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003) to support the production of health care effectiveness research for clinicians, consumers, and policymakers.<sup>xviii</sup>

- The Oregon Center for Evidence-based Policy was created at the Oregon Health & Science University in 2003. Current projects of the Center include 1) the Drug Effectiveness Review Project (DERP), which supports the application of the best available evidence on effectiveness and safety comparisons between drugs in the same class to public policy and decision making; and, 2) the Medicaid Evidence-based Decisions Project (MED), which makes high quality evidence available to participating State Medicaid Programs to support benefit design and coverage decisions.<sup>xix</sup>
- Washington state enacted a set of statutory provisions between 2003 and 2006 authorizing the state's public payers (Medicaid, Workers' Compensation, state government employee benefit plans, and the corrections department) to use evidence-based methods to improve the quality of care, reduce wasteful use of health care resources, and determine what benefits should be covered.<sup>xx</sup>
- In 2006 the Institute of Medicine convened the "Roundtable on Evidence-Based Medicine", which is working through a series of workshops and publications to explore opportunities for achieving the Roundtable's goal that "by 2020, 90% of clinical decisions will be supported by accurate, timely, and up-to-date clinical information and will reflect the best available evidence."<sup>xxi</sup>
- The Patient Protection & Affordable Care Act (P.L. 111-148) enacted in 2010 established a private, non-profit Patient-Centered Outcomes Research Institute to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by carrying out research projects that provide high-grade, relevant evidence on how diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed. Members of the Board of Governors of the new Institute were recently appointed by the U.S. Government Accountability Office (GAO).<sup>xxii</sup>

A critical aspect of EBM is the importance of understanding the quality of evidence and the appropriate application of evidence to an individual medical decision or population policy decision. Many unfortunate decisions have been made based on inadequate information or information derived from poor quality research or by those who misinterpreted the findings. The media is filled with stories of drugs being pulled off the market due to newly identified dangerous side-effects (e.g., Vioxx, Avandia, and Meridia), and commonly used medical therapies found to be potentially harmful (e.g., hormone replacement therapy) or no more effective compared to less invasive, less costly treatments (e.g., arterial stents). This has led to significant confusion on the part of the public and skepticism regarding whether to ever believe any medical research at all.

Skepticism on the part of the public is not misplaced – an estimated 90% of published medical information is flawed.<sup>xxiii</sup> It is therefore essential that health care professionals understand how to translate evidence into practice. It is relatively easy to learn basic critical appraisal skills, and training in how to critically evaluate the medical literature and apply it is increasingly available. Methods for grading the quality of evidence and the strength of recommendations have been developed and are in wide use. A growing number of organizations evaluate clinical studies and make medical information based on high grade evidence available publicly. Other challenges to applying EBM in clinical practice, such as the overwhelming volume of research and information available to guide clinical decision making, should in time be more easily managed with the assistance and growing use of health information technologies by health practitioners and patients.

It should be noted that there has been some controversy around the term “evidence-based medicine.” Some borne out of concern that the intent is to turn clinicians into automatons through imposed decisions based on required instructions (“cookbook medicine”). Others who have heard the term in recent use by public entities fear it is a government initiative, intended to take individual health care decisions out of the hands of providers and their patients. It is neither, and acknowledging these potential concerns and ensuring the appropriate use of EBM can guard against these concerns becoming realized.

*“Evidence based medicine is not “cookbook” medicine. Because it requires a bottom up approach that integrates the best external evidence with individual clinical expertise and patients’ choice, it cannot result in slavish, cookbook approaches to individual patient care. External clinical evidence can inform, but can never replace, individual clinical expertise, and it is this expertise that decides whether the external evidence applies to the individual patient at all and, if so, how it should be integrated into a clinical decision. Similarly, any external guideline must be integrated with individual clinical expertise in deciding whether and how it matches the patient’s clinical state, predicament, and preferences, and thus whether it should be applied.”*

*David Sackett, et al, 1996<sup>xxiv</sup>*

Resources available for health care are not infinite, and policy decisions regarding their use are made by health care payers in the public and private sector every day. Evidence-based medicine is a model of individual clinical practice and population policy decision-making that can serve to ensure limited resources are targeted to the most effective and efficient services. Application of evidence-based medicine to the public policy arena should not increase government control over health care decisions, but should ensure that government officials are being more responsible stewards of the public funds with which they are entrusted. The goal should always be to increase the quality of care and improve health care outcomes by ensuring information on which decisions are being made is valid and accurate.

The ideal health care system for Alaska should be designed to apply high-grade evidence in support of a collaborative health care choice for each patient and provider. The system should also be designed to support application of high-grade evidence by public officials who have the qualifications and training to critically appraise medical literature, and through a public process that is transparent and includes stakeholders in public policy decision-making regarding allocation of limited public medical care dollars.

In Alaska state government is a significant payer for health care services. State programs that purchase health care such as the Medicaid program, state employee and retiree health plans, corrections and Workers’ Compensation could provide leadership in incentivizing improved quality and efficiency of care through the use of evidence-based medicine. Public policies based on the application of evidence-based medicine should enhance the consumers’ role in health by fostering informed discussions between patients and providers with the goal of improving the health outcomes of medical decisions.

**Recommendation A.3.a:** The Commission recommends that the Governor and Alaska Legislature encourage and support State health care programs to engage in the application of high grade evidence-based medicine in making determinations about benefit design (covered services, prior authorization requirements, patient cost-sharing differentials) and provider payment methods.

**Recommendation A.3.b:** The Commission recommends that the Governor require State health care programs to coordinate development and application of evidence-based medicine policies to create a consistent approach to supporting improved quality and efficiency in Alaska’s health care system.

**Recommendation A.3.c:** The Commission recommends that the Governor require State health care programs to involve health care providers and consumers in decision making related to the application of evidence-based medicine to public policy. The purpose of such involvement is to support a transparent process leading to policies that avoid restricting access to appropriate treatment and that foster informed discussions between patients and clinicians in which individualized, evidence-based choices improve the quality of health care.

**Recommendation A.3.d:** The Commission recommends that the Governor direct State health care programs to seek to incorporate data on patient compliance in developing new provider payment methods and benefit design.

**Recommendation A.3.e:** The Commission recommends that the Alaska Department of Health & Social Services implement a web-based data system for public health information.

## C. Strategies under Consideration for Study in 2011

*Note: The numbering system for Strategies continues from 2009 and 2010.*

### **A.1. Consumers' Role/Prevention: Healthy Lifestyles - On-line Community-Based Health Data System**

During 2009 the Commission learned that chronic disease is the leading cause of death and disability in the U.S. and Alaska, that the majority of health care spending is for chronic disease, and that individual behaviors such as tobacco use, poor diet and inactivity are now the leading determinants of the health status of the population and contributors to premature death. The Commission recommended that the State investigate strategies to encourage and support healthy lifestyles, including strategies to create cultures of wellness in any setting.

Communities play an important role in creating local environments that support healthy lifestyles. Design of roads, walkways and public transportation systems; school policies regarding nutrition, physical education, and extracurricular activity; development of non-profit organization programs; local ordinances such as those pertaining to clean indoor air; and, organization of local medical services and systems are all examples of where communities can act to influence the health of their residents.

A critical resource for community health improvement planning is timely and relevant data on local health factors to guide identification and prioritization of program strategies, support alignment with health goals, and enable measurement of progress and evaluation of outcomes. During their November 2010 meeting the Commission heard from a representative of an Alaskan community health foundation about the need for and opportunity to develop a public access, web-based data and information system to support local health status reporting and improvement planning. The Commission identified this strategy as a priority for study during 2011.

### **A.2. Consumers' Role/Value: Primary Care Innovation - Next Steps**

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.

In preliminary learning about innovative patient-centered primary care models during 2009 the Commission found that these models are effective at reducing unnecessary utilization of services by empowering patients to take more responsibility for their health and health care. Key characteristics of patient-centered primary care include a stable trusting relationship between the patient and their health care practitioners; care that is provided by a multidisciplinary team; whole-person orientation (addressing all life stages, prevention and wellness, acute and chronic conditions, and both mind and body); care that is coordinated and/or integrated (including integration of primary medical care and behavioral health services); emphasis on quality and safety; and enhanced access (through open scheduling and modern communication options). The Commission recommended the State aggressively pursue development of these care models through payment reform, removal of statutory and regulatory barriers, and implementation of pilot projects.

During 2011 the Commission will engage in additional learning to identify more specific strategies for advancing the patient-centered primary care medical home model in Alaska, including strategies for integrating primary medical care with behavioral health services.

#### **A.4. Consumers' Role/Value: Increase Price & 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, but the present system of health care pricing and reimbursement has been characterized as "forcing sick and anxious people to shop around blindfolded for cost-effective care."<sup>xv</sup> 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 prices 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 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 a system providing price and quality information to support consumer choice need to be fully understood as part of a strategic approach to making the system more transparent with the goal of improving value (increasing quality/controlling costs). During 2011 the Commission will study national trends in price and quality transparency and identify opportunities for applying transparency strategies to improve value in Alaska's health care system.

#### **A.5. Consumer's Role/Value: Bundled Payment Systems**

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. Payment bundling is one value-driven payment method with the potential for rewarding quality over volume.

Payment bundling provides a global fee for a specified set of services. Development of this type of payment system could be phased in 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 in our state. Hospitals would 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 sophisticated information and accounting systems in many of Alaska's smaller hospitals, the need to identify standards to ensure changes in reimbursement do 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. 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. During 2011 the Commission will analyze the opportunities for testing bundled payment systems in Alaska.

#### **A.6. Consumer's Role/Value: Leverage State Purchasing Power**

State government in Alaska represents a substantial payer for health care services. The state spent over \$1.5 billion in FY 2009 in Medicaid expenditures, state employee and retiree claims (not counting benefit credits paid to union health trusts), state employee Workers' Compensation medical claims, and purchase of health care services for incarcerated offenders in the state correctional system. In 2011 the Commission will study potential benefits and barriers to collaboration between these state programs to develop shared value-driven purchasing strategies --- leveraging their purchasing power to drive improved health care quality and cost in Alaska.

#### **A.7. Consumer's Role/Access: Insurance Industry Regulation/Deregulation**

One cornerstone of the new federal health care legislation (the Affordable Care Act) is reform of the private insurance market through a series of new federal regulatory requirements. The federal government envisions these reforms will be implemented through and by state insurance regulators. There are questions and concerns regarding the impact of these new requirements on the insurance industry, on future prices for insurance premiums, and on the States' role in insurance regulation.

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.<sup>xxvi</sup> 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. During 2011 the Commission will study opportunities for improving access to and value of health care through insurance market regulation (and deregulation) in the context of the changes imposed by the Affordable Care Act.

#### **B.3. Statewide Leadership: Measuring Health System Improvement**

The Commission and State leaders in government, business and the health care industry need a mechanism for tracking how Alaska's health care system is performing over time, and whether Commission recommendations are having intended results in health system improvement. During 2011 the Commission will develop a set of indicators that are measurable and that best represent the status of our health care system relative to attainment of the four goals of increased access, controlled costs, improved quality, and prevention-focused. The Commission will also set benchmarks and targets for each measure, with the intention of reporting annually in future years on the progress of health system improvement. Following are examples of potential indicators.

##### 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 homes with safe water and wastewater systems
    - Percent of Alaskans reporting health risks
      - Percent of Alaskans who smoke cigarettes
      - Percent of Alaskans who are overweight or 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)

### **C. Workforce Development - Next Steps**

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 Commission focused during 2009 on the physician workforce as 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. There are numerous organizations collaborating on various aspects of health care workforce planning and development, and further 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

During 2011 the Commission will coordinate with the Alaska Health Care Workforce Coalition to identify opportunities for sharing and leveraging resources to develop strategies for health workforce development in our state.

One specific workforce strategy that the Commission also intends to track during 2011 is improvement of the licensure process for health care professionals in Alaska.

### **Pending Strategies for Future Consideration**

In addition to the policy options and other strategies for which recommendations were developed in 2009 and 2010 and those described above for consideration in 2011, the following options have been identified for study by the Commission at some point in the future. Most of these options were identified during 2009 and are briefly described in the Commission's 2009 report.

#### **A. Consumer's Role in Health**

##### **I. Value (Cost & Quality)**

- Move to value-driven purchasing
  - Pay-for-Performance
  - Medical error/infection reporting and non-payment
- Control fraud and abuse
- Reform the malpractice system
- Support process and quality improvement
- Increase consumer participation in payment for services
  - Health Savings Accounts
- Identify additional innovative patient-centered health care strategies to address
  - High-cost beginning and end of life care
  - Medicaid high-cost clients

##### **II. Access**

- Increase insurance coverage
  - New insurance programs
  - Health insurance exchange
  - Individual and/or business subsidies
  - Individual and/or business mandates
  - Medicaid Expansion
- Address availability of specific services
  - Behavioral health
  - Long term care
  - Trauma care
  - Clinical preventive services
  - Pediatric specialties

##### **III. Prevention**

- Safe water and sanitation systems
- Employee health risk management programs

#### **B. Statewide Leadership**

- Strengthen the Health Data Infrastructure

## End Notes

- <sup>i</sup> Healthy Alaskans 2010 Volume I. Alaska Department of Health & Social Services.
- <sup>ii</sup> "Alaska's 10-Year Occupational Forecast," Alaska Economic Trends, Alaska Department of Labor & Workforce Development, Vol.29, #1, January 2009.
- <sup>iii</sup> 2007 Alaska Health Workforce Vacancy Study. Alaska Center for Rural Health, UAA. July 2007.
- <sup>iv</sup> See State of Alaska Medicaid Budget Impact Analysis included in the "Summary of Medicaid Requirements Included in PPACA" presented by DHSS to the Senate HSS Committee August 3, 2010 and included in Appendix B.
- <sup>v</sup> "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL", Prepared by the Urban Institute for the Kaiser Commission on Medicaid & the Uninsured, May 2010
- <sup>vi</sup> Alaska Health Care Commission, "Transforming Health Care in Alaska: 2009 Report/2010-2014 Strategic Plan," January 2010.
- <sup>vii</sup> 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.
- <sup>viii</sup> Institute of Medicine, "Crossing the Quality Chasm," National Academy Press, 2001.
- <sup>ix</sup> [www.dartmouthatlas.org](http://www.dartmouthatlas.org)
- <sup>x</sup> Institute of Medicine, "Crossing the Quality Chasm," National Academy Press, 2001.
- <sup>xi</sup> 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.
- <sup>xii</sup> Wennberg JE, Fisher ES, Skinner JS, "Geography and the Debate Over Medicare Reform," *Health Affairs*, February 2002.
- <sup>xiii</sup> Claridge, JA, Fabian, TC, "History and Development of Evidence-based Medicine," *World Journal of Surgery*, 29, 547-553, 2005.
- <sup>xiv</sup> Sackett DL et al, "Evidence based medicine: what it is and what it isn't," *British Medical Journal*, 312:71-72, 1996.
- <sup>xv</sup> Eddy, DM, "Evidence-Based Medicine: A Unified Approach," *Health Affairs*, Vol. 24, No.1, Jan/Feb 2005.
- <sup>xvi</sup> <http://www.bcbs.com/blueresources/tec/>
- <sup>xvii</sup> <http://www.queri.research.va.gov/>
- <sup>xviii</sup> <http://effectivehealthcare.ahrq.gov/index.cfm>
- <sup>xix</sup> <http://www.ohsu.edu/xd/research/centers-institutes/evidence-based-policy-center/>
- <sup>xx</sup> Franklin, GM, Budenholzer, BR, "Implementing Evidence-Based Health Policy in Washington State," *N Engl J Med* 361;18, October 29, 2009.
- <sup>xxi</sup> Institute of Medicine. 2009. *Leadership Commitments to Improve Value in Healthcare: Toward Common Ground: Workshop Summary*. Washington, DC: The National Academy Press.
- <sup>xxii</sup> <http://www.gao.gov/press/pcori2010sep23.html>
- <sup>xxiii</sup> Ioannidis JPA. Why Most Published Research Findings are False. *PLoS Med* 2005; 2(8):696-701. PMID 17593900.
- <sup>xxiv</sup> Sackett DL et al, "Evidence based medicine: what it is and what it isn't," *British Medical Journal*, 312:71-72, 1996.
- <sup>xxv</sup> Reinhardt, UE, "The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy," *Health Affairs*, Vol.25, No.1, Jan/Feb 2006.
- <sup>xxvi</sup> Information provided by the Alaska Division of Insurance, November 2009.

Alaska Health Care Commission 2010 Report

## **Appendix A**

### **Commission's Health Care Transformation Strategies**

**Alaska Health Care Commission  
Current & Potential Health Care Transformation Strategies**

This matrix is intended to illustrate the connections between the Commission’s 5-Year Strategic Planning Framework, the Commission’s Goals, the Commission’s Core Strategies (the Pyramid), and the “Design Elements” (general policy strategies and specific strategies/tactics).

Current 2009 Strategies are highlighted in Green (followed by reference to recommendation number)
2010 Strategy is highlighted in Blue
Strategies identified for study in 2011 are highlighted in Yellow

<b>GOALS &amp; CORE STRATEGIES</b>	<b>DESIGN ELEMENTS (General Policy Strategies)</b>	<b>DESIGN ELEMENTS (Specific Strategies/Tactics)</b>
<b>Increase Value (Lower Cost &amp; Improve Quality)</b>		
<i>Build the Foundation:</i> Health Information Technology (D) – See “FOUNDATION” below for strategies		
<i>Design the Elements Required for System Transformation</i>	Foster Primary Care Innovation (A2a)	
	Foster use of Evidence-Based Medicine	
	Increase Price & Quality Transparency	
	Move to Value-Driven Purchasing	
		Leverage State Purchasing Power
		Bundled Payment Systems
		Pay-for-Performance
		Medical Error/Infection Reporting & Non-Payment
	Control Fraud & Abuse	
	Reform Malpractice System	
	Support Process & Quality Improvement	
	Health Savings Accounts	
	Address High Cost Patients	
<b>Improve Access</b>		
<i>Build the Foundation:</i> Health Care Workforce (C) – See “FOUNDATION” below for strategies		
<i>Build the Foundation:</i> Health Information Technology (D) – See “FOUNDATION” below for strategies		

<b>Design the Elements Required for System Transformation</b>	Increase Insurance Coverage	
		Make Health Care More Affordable
		Insurance Industry Regulation/Deregulation
		Health Insurance Exchange
		New Insurance Programs
		Medicaid Expansion
		Individual Mandates
		Business Mandates
		Individual Subsidies
		Business Subsidies
	<b>Address Specific Services &amp; Delivery Methods</b>	
	Medicare Services	
		Improve supply of primary care providers using C2 strategies (Ea)
		Support planning for FQHCs and RHCs (Eb)
		Work with Delegation to improve Medicare Reimbursement (Ec)
		Work with Delegation to improve Medicare Audit Policies (Ed)
		Study administrative requirements to simplify/streamline (Ee)
		Facilitate Development of PACE (Ef)
	Behavioral Health	
	Trauma Care	
	Clinical Preventive Services	
	Pediatric Specialties	
	Long Term Care	
<b>Become Prevention-Based</b>		
<b>Design the Elements Required for System Transformation</b>	Public Health/Community-Based Prevention	
		Identify State Policy Strategies to Support Healthy Lifestyles (A1a,b)
		On-Line Health Information System
		Safe Water and Sanitation Systems
	Employee Health Risk Management	

<b>Build the Foundation for a Transformed Healthcare System</b>		
<b>HIT: Health Information Technology (D)</b>		
	Support Development of HIT that Increases Efficiency & Protects Privacy (D1a)	
		Explore Options for Assisting Providers with Adoption of EHR Systems (D2a)
		Alaska's HIE should guide Providers new to EHRs (D2b)
		Utilize HIT to protect Public Health; HIE should include real-time reporting (D2c)
		Utilize data from HIE to improve health care (D2d)
		Track and continue studying HIT development in Alaska (D2e)
		Designate entity responsible for HIT security and privacy (D2f)
		Ensure Alaskan communities have access to broadband telecom (D3a)
		Investigate innovative telemedicine reimbursement methodologies (D3b)
		Explore Consumer-Oriented/Patient-Centered HIT Innovations
<b>Health Care Workforce (C)</b>		
	Maintain Workforce Development as a Priority (C1a)	
	Strengthen the "Pipeline" of Potential Future Workers (C1b)	
	Explore Strategies for Innovative & Adaptive Workforce (C1c)	
	Designate Entity Responsible for Workforce Planning & Development (C1d)	
	Coordinate with AK HC Workforce Coalition on Continuing Efforts (C1e)	
	Strengthen Primary Care Physician Supply (C2)	
		Target State \$\$s for Physician Supply Development to Primary Care (C2a)
		Establish Loan-Repayment & Financial Incentive Program (C2b)
		Expand WWAMI as Resources Allow (C2c)
		Support Alaska Family Medicine Residency Program (C2d)
		Establish Psychiatric, Pediatric and Internal Medicine Residency Programs (C2d)

		Request Equity from Feds in GME Slot Allocation (C2e)
		Explore Primary Care Delivery Model and Physician Extender Innovations (C2f)
<b>Statewide Leadership (B)</b>		
	Understand National Health Care Reform (B1a)	
	Establish AK Health Care Commission in State Statute (B1b)	
	Identify Indicator Set for Measuring Improvement in Alaska's Health Care System	
	Strengthen the Health Data Infrastructure	

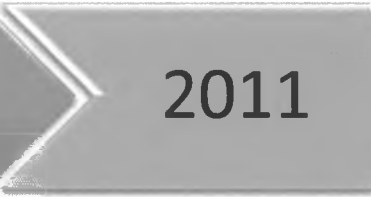
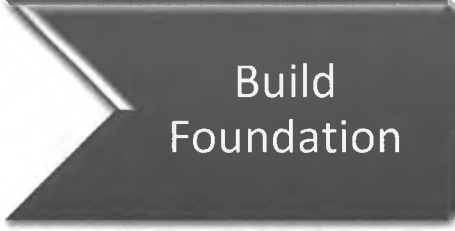
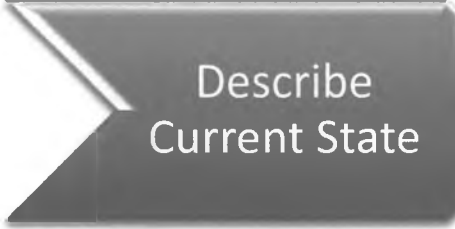
# **The Alaska Health Care Commission's Approach to Reforming Alaska's Health Care System**

Planning Process,  
Transformation Strategy,  
and Policy Options

Revised at 01-07-11 Meeting

2009-2010

# 5-Year Strategic Planning Process



# Develop Vision

## Vision

*Alaska's health care system produces improved **health** status, provides **value** for Alaskan's health care dollar, delivers consumer and provider **satisfaction**, and is **sustainable**.*

## Reform Goals

- I. Increased Access
  - II. Controlled Costs
  - III. Improved Quality
  - IV. Prevention-Based
- } VALUE

## Values

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

# Describe Current State

- I. Description of System (2009 Report)
- II. Overview of Federal Reform/Impact on AK (2010)
- III. Analysis of Current Conditions (planned for 2011)
  - A. Cost of Health Care in Alaska
    - 1. Spending Analysis (total expenditures; services & payers; cost drivers)
    - 2. Price and Reimbursement Comparison Study
    - 3. Health Status Assessment
  - B. Long Term Care System
  - C. Trauma System
- IV. Analysis of Current Conditions (potential for 2012?)
  - D. Quality of Care Study (efficiency, appropriateness, effectiveness of care)

# Describe Current State

## I. Description of System (2009 Report)

- How Health Care in Alaska is Delivered & Funded
- Issues Identified:
  - High, Rising & Unsustainable Cost of Care
  - Inadequate Insurance Coverage
  - Logistical Challenges
  - System Fragmentation & Duplication
  - Workforce Shortages & Maldistribution
  - Health Status, Health Behaviors & Demographics
  - Leadership Challenges
  - Health Information Technology Development
  - Specific Medicare Access Problem

# Describe Current State

## Variables Contributing to Cost of Health Care

**Cost** (total expenditures) =

**Price** (per process) x **Utilization**

**Utilization** =

**# Conditions**

X **# Episodes of Care** /Condition

X **# of Services** (by type)/Episodes of Care

X **# of Processes** /Service

# Describe Current State

- III. Analysis of Current Conditions (planned for 2011)
    - A. Cost Analysis (total expenditures; services & payers; cost drivers)
    - B. Price Comparison Study
    - C. Health Status Assessment
  
  - IV. Analysis of Current Conditions (potential for 2012?)
    - D. Quality of Care Study (efficiency, appropriateness, effectiveness of care)
- 

## Variables Contributing to Cost of Health Care

Cost (total expenditures) =

Price (per process) x Utilization

Utilization =

# Conditions

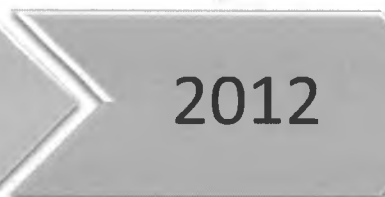
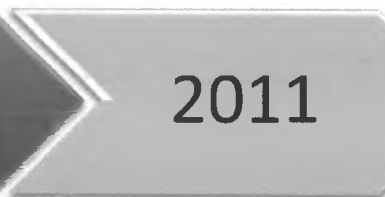
X # Episodes of Care /Condition

X # of Services (by type)/Episodes of Care

X # of Processes /Service

2009-2010

# 5-Year Strategic Planning Process



# Health Care Transformation Strategy

## *Build the Foundation*

- *Statewide Leadership*
- *Workforce*
- *Health Info Technology*

*Design Elements to Enhance the Consumer's Role in Health*

## Consumer's Role in Health

Innovative Patient-Centered Care and Healthy Lifestyles

Through

- *Innovations in Patient-Centered Care*
- *Support for Healthy Lifestyles*

ACCESS

VALUE

Statewide Leadership

Workforce

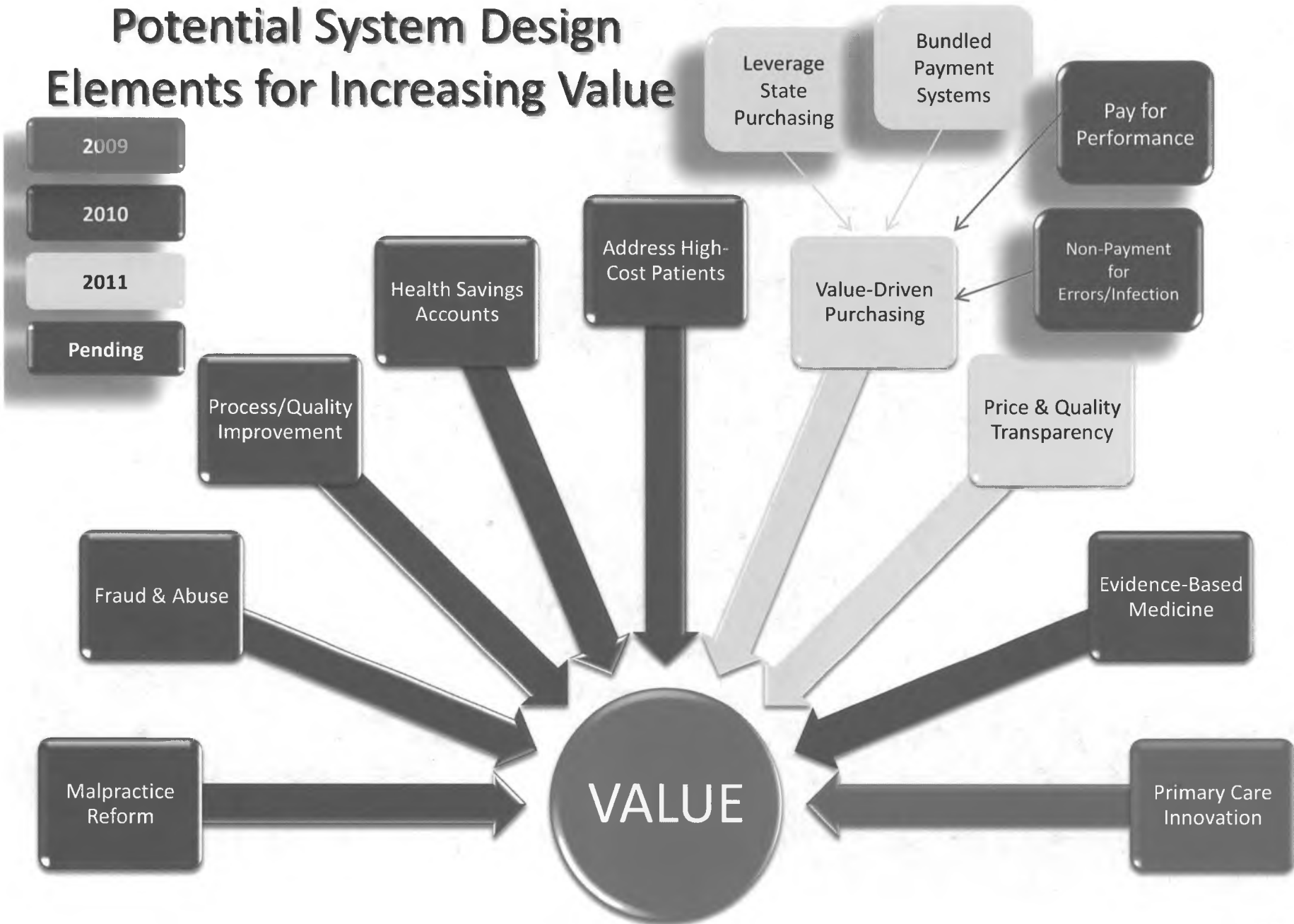
Health Information Technology

PREVENTION-BASED

## *To Achieve Goals of*

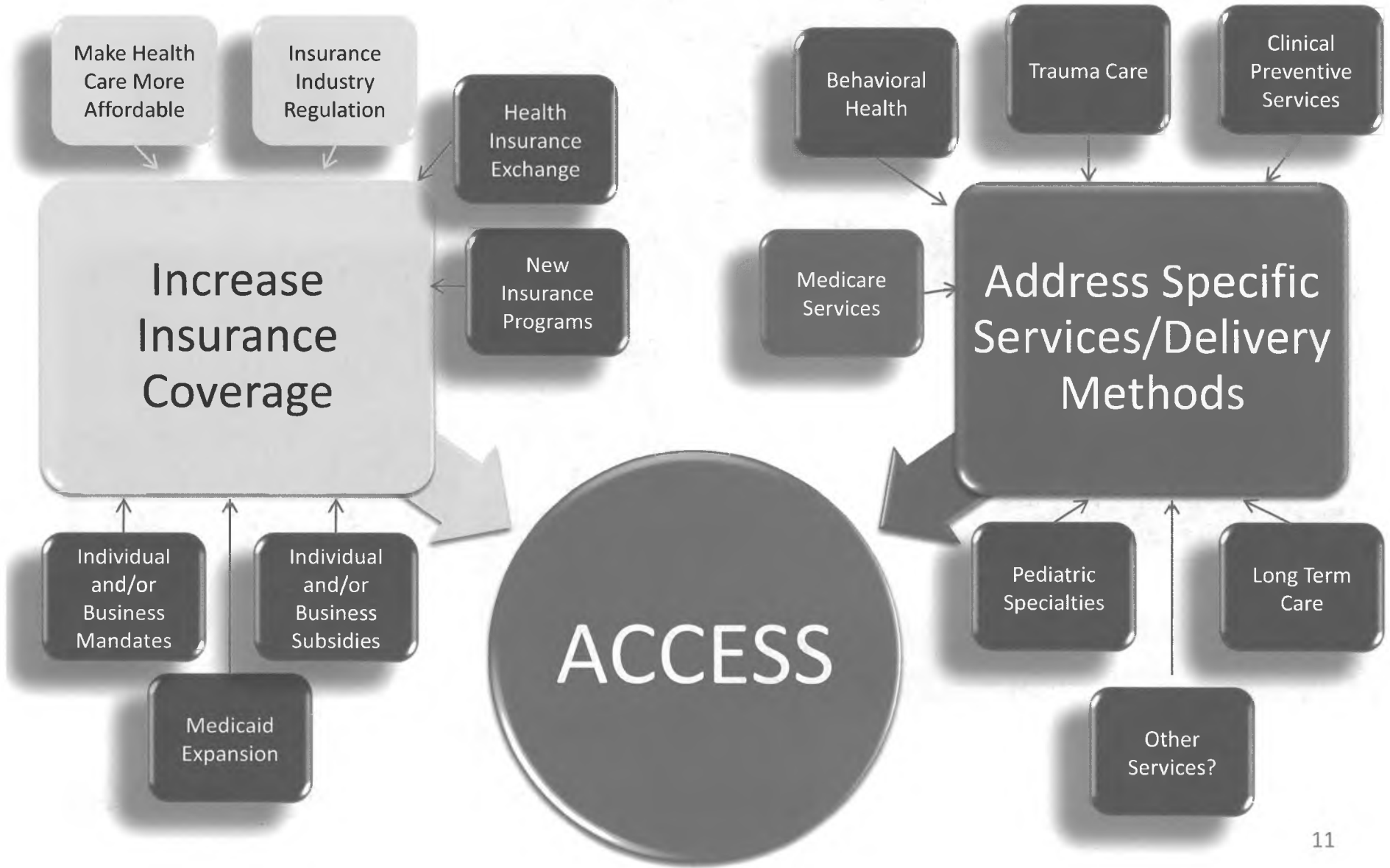
- **Increased Value**
  - Decreased Cost
  - Increased Quality
- **Improved Access**
- **Enhanced Prevention**

# Potential System Design Elements for Increasing Value



# Potential System Design Elements for Improving Access

2009    2010    2011    Pending



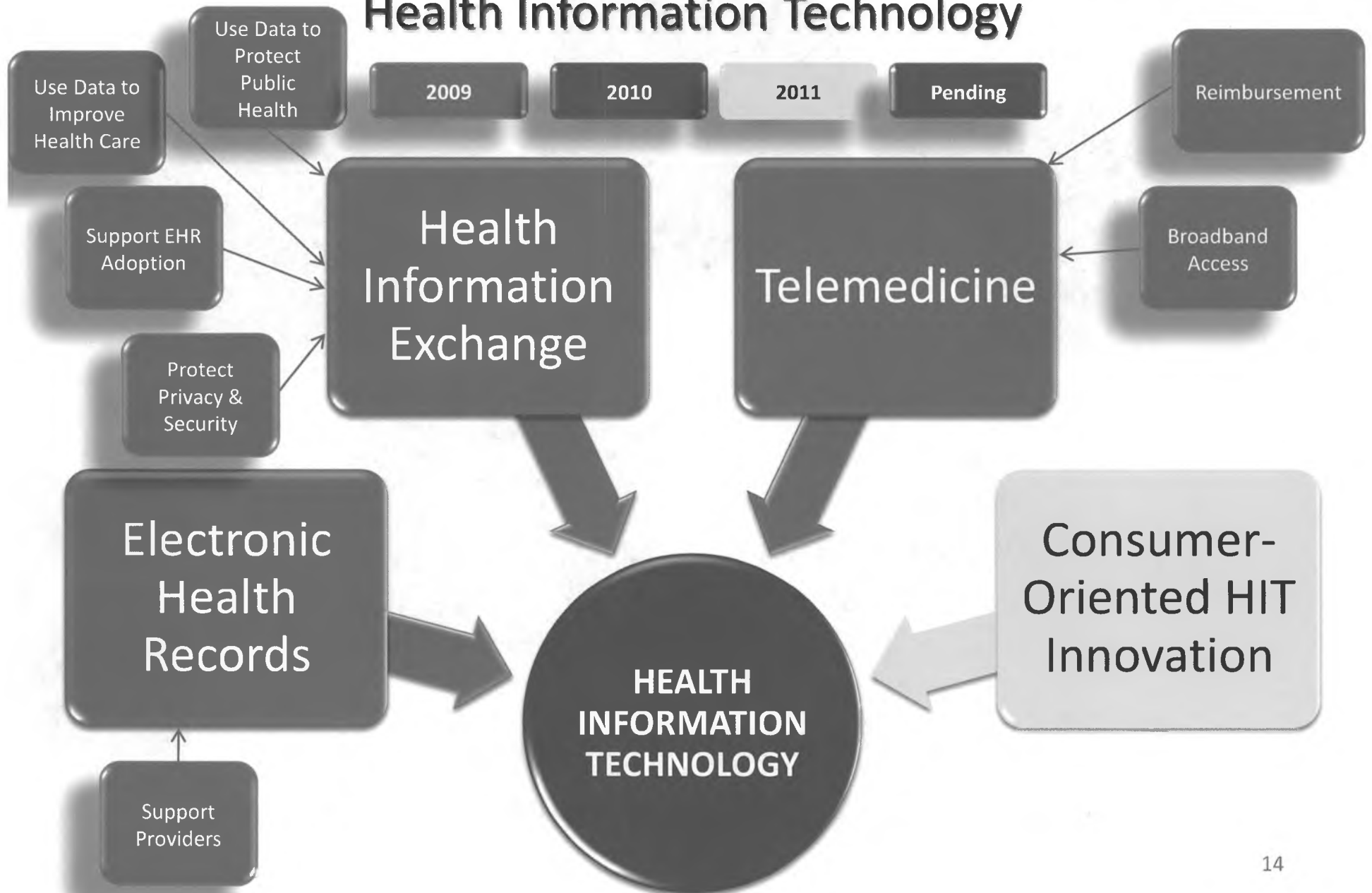
# Potential System Design Elements for Enhanced Prevention



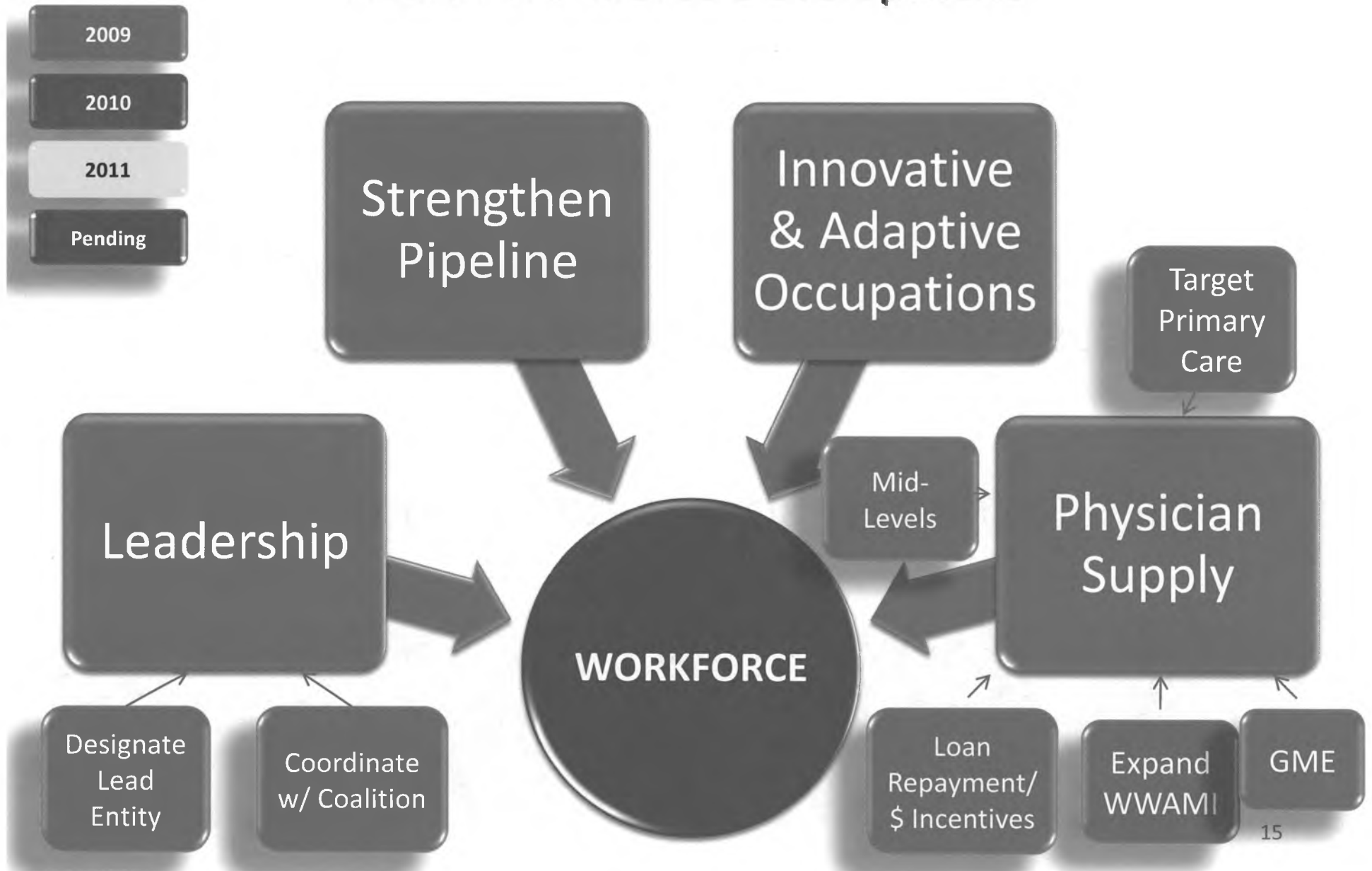
# Potential Strategies for Building the Foundation: Statewide Leadership



# Potential Strategies for Building the Foundation: Health Information Technology



# Potential Strategies for Building the Foundation: Health Workforce Development



# Measure Progress

- ✓ Track Implementation of Recommendations
- ✓ Measure Improvement in Health Care System Over Time

# Potential Health Care System Improvement Measures

## I. Increase Access

- Percent of Alaskans Uninsured
- Percent of Alaskans who have a specific source of on-going care
- *Measure of insurance affordability?*
- *Indicator of workforce supply?*

## II. 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: Annual change in spending and revenue; net savings
- *Measure of provider revenue based on value rather than volume*

## III. Safe, High-Quality Care

- Percent of population receiving key preventive services
- 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

## IV. Focus on Prevention

- Percent of Alaskan homes with safe water and wastewater systems
- Percent of Alaskans reporting health risks
  - Percent of Alaskans who smoke cigarettes
  - Percent of Alaskans who are obese or overweight
  - Percent of Alaskans who are binge drinkers
- Percent of Alaskans with moderate to severe depression
- Death rate among Alaskans due to injury (intention and unintentional)

Alaska Health Care Commission 2010 Report

## **Appendix B**

### **State of Alaska Federal Health Care Reform Review Documents**

**PPACA Provisions Impacting State of Alaska Policy and Programs (preliminary list)**

Updated: 01/05/11

Sorted by 1) Category, then 2) Effective Date

Provision	Citations P.L. 111-148 P.L. 111-152 (HCERA)	State Option or Mandate	Effective Date	Date Action Required by Feds Done
<b>MISCELLANEOUS PROVISIONS</b>				
Misc: State Grants to Health Care Providers	5606, 10501	optional	3/23/2010	
Misc: AK Fed Interagency Health Care Access Task Force	5104, 10501	optional	3/23/2010	
Misc: Inclusion of Info re: importance of health care power of attorney in transition planning for foster kids	2955	mandatory	10/1/2010	9/30/2010
Misc: Grants to States to develop new IT systems to Implement HIT Enrollment Standards (no appropriation)	1561	optional		
Misc: Indian Health Care Improvement Act Reauthorization	10221	n/a		
Misc: State Demonstration Programs to Evaluate Alternatives to Current Medical Tort Litigation	10607	optional	10/1/2010	
<b>HEALTH INSURANCE PROVISIONS</b>				
Health Insurance Consumer Information/Assistance	1002	optional	3/23/2010	9/10/2010
Health Insurance Rate Review	1003	mandatory	3/23/2010	7/7/2010
Health Insurance High Risk Pool	1101	optional	6/23/2010	5/31/2010
Health Insurance Federal Web Portal	1103, 10102	n/a	7/1/2010	5/7/2010
Health Insurance Market Reforms	1001, 10101; 1201, 10103	mandatory	9/23/2010	
Health Insurance administrative simplification requirements	1104, 10109	mandatory		
Health Plan Eligibility and Claim Status			1/1/2013	
Electronic Funds Transfers			1/1/2014	
Encounter Info, Enrollment, Referral, etc.			1/1/2016	
Health Insurance: Health Care Cooperatives	1322	optional	7/1/2013	
Health Insurance Exchange	1311	optional	1/1/2014	9/1/2010
Health Insurance: Multi-State Health Plans (fed Office of Personnel Mgmt Contracts)	1334, 10104	n/a	1/1/2014	
Health Insurance: Health Care Choice Compacts	1333	optional	1/1/2016	

<b>STATE EMPLOYER PROVISIONS</b>				
SOA as Employer: Break Time/Location for Nursing Mothers	4207	mandatory	3/23/2010	implmnt'd 7/1/10 submitted 7/3/10
SOA as Employer: Temporary Reinsurance Program for Early Retirees	1102, 10102	optional	6/23/2010	
SOA as Employer: Elimination of Annual and Lifetime Limits	1001, 10101	mandatory	9/23/2010	
SOA as Employer: Extension of dependent coverage up to age 26	1001; HCERA 2301	mandatory	9/23/2010	
SOA as Employer: Prohibition on Preexisting Condition Exclusions	1201, 1255	mandatory	9/23/2010	
SOA as Employer: CLASS Act - Long Term Care Insurance Program	8002, 10801, 10802	optional	1/1/2011	
SOA as Employer: Report value of health care benefits on W2s (compliance date changed to 2012)	9002	mandatory	1/1/2011	1/1/2012
SOA as Employer: Provisions affecting HSAs, FSAs, and HRAs	9003, 9004, 9005, 10902; HCERA 1403	mandatory	1/1/2011	
SOA as Employer: Uniform Notice of Coverage	1001, 10101	mandatory	3/23/2012	
SOA as Employer: Tax on Health Plans to fund Patient-Centered Outcomes Research	6301, 10602	mandatory	7/1/2012	
SOA as Employer: Increase in FICA Taxes on Earned Income	9015, 10906; HCERA 1402	mandatory	1/1/2013	
SOA as Employer: Employee Notices Regarding Exchange	1512	mandatory	3/1/2013	
SOA as Employer: Mental Health and Substance Use Disorder Services Included in Essential Benefits Package	1302, 10104	mandatory	1/1/2014	
SOA as Employer: Reporting to IRS of Health Insurance Coverage	1502	mandatory	1/1/2014	
SOA as Employer: Employer Mandate to Provide Coverage - Penalties for Employers Offering Coverage	1513, 10106, 10108; HCERA 1003	mandatory	1/1/2014	
SOA as Employer: Employer Mandate - Free Choice Vouchers	10108	mandatory	1/1/2014	
SOA as Employer: Excise Tax on High Cost Employer-Sponsored Health Coverage ("Cadillac Tax")	9001, 10901; HCERA 1401	mandatory	1/1/2018	
<b>MEDICAID PROVISIONS (sorted by mandatory/optional, then effective date, then Sec #)</b>				
Medicaid CHIP Program extended until 2015	10203	mandatory	2/4/2009	
Medicaid Prescription Drug Rebate	2501	mandatory	1/1/2010	
Medicaid impact due to Medicare Part D Clawback changes resulting from d-hole closure?	3315; HCERA 1101	mandatory	1/1/2010	
Medicaid Maintenance of Effort Required	2001(b)	mandatory	3/23/2010	
Medicaid mandatory coverage for freestanding birth center svcs.	2301	mandatory	3/23/2010	
Medicaid concurrent care for children	2302	mandatory	3/23/2010	
Medicaid definition of "medical assistance" includes both the means of payment for care as well as the care and services	2304	mandatory	3/23/2010	
Medicaid: Drug rebates extended to Medicaid managed care organizations <b>WON'T APPLY IN ALASKA</b>	2501(c)	mandatory	3/23/2010	

Medicaid Integrity - Face-to-Face encounter with patient required before MD may certify eligibility for Home Health or DME	6407, 10605	mandatory	3/23/2010?	
Medicaid Integrity - Extended Period for Collection of Overpayments	6506	mandatory	3/23/2010	
Medicaid mandatory coverage of comprehensive tobacco cessation services for pregnant women	4107	mandatory	10/1/2010	
Medicaid - Revisions to state plan option to provide HCB services under section 1915(i)	2402	mandatory	10/1/2010	
Medicaid Integrity - Recovery Audit Contractor Program	6411	mandatory	12/31/2010	
Medicaid - Providing adequate pharmacy reimbursement	2503; HCERA 1101	mandatory	1/1/2011	
Medicaid Integrity - Termination of Provider Participation in Medicaid if Terminated under Medicare	6501	mandatory	1/1/2011	
Medicaid Integrity - States Mandated to Use National Correct Coding Initiative	6507	mandatory	1/1/2011	
Medicaid Integrity - Provider screening and other enrollment requirements	6401, 10603; HCERA 1304	mandatory	3/23/2011	
Medicaid - Prohibit Medicaid payments to states for services related to health care acquired conditions	2702, 10303	mandatory	7/1/2011	
Medicaid Increase reimbursement for primary care physicians (fully federally funded) - <i>WON'T APPLY IN ALASKA</i>	HCERA 1202	mandatory	1/1/2013	
Medicaid: Insurance administrative simplification requirements ( <i>according to Covington &amp; Burling this applies to Medicaid too</i> )	1104, 10109	mandatory	1/1/2013	
Medicaid DSH reduction	HCERA 1203	mandatory	10/1/2013	
Medicaid end of performance bonus payments for CHIP	2101	mandatory	10/1/2013	
Medicaid expansion of coverage to newly eligibles up to 133% FPL	2001, 10201	mandatory	1/1/2014	
Medicaid mandatory coverage for children ages 6-19 to 133% FPL	2001	mandatory	1/1/2014	
Medicaid: Mental Health Parity in Benchmark Benefits Minimum Essential Coverage (note MH Parity & Addiction Act of 2008)	2001(c)(3)	mandatory	1/1/2014	
Medicaid use of modified adjusted gross income for eligibility determination; states to apply 5% disregard (raises to 138% FPL)	2002; HCERA 1004(a)(2)	mandatory	1/1/2014	
Medicaid prohibited use of asset or resource tests for purposes of determining eligibility	2002	mandatory	1/1/2014	
Medicaid mandatory coverage of foster care children up to age 26	2004, 10201	mandatory	1/1/2014	
Medicaid enrollment simplification and standardization	2201	mandatory	1/1/2014	
Medicaid - Protection against spousal impoverishment for recipients of HCB services through CY 2018	2404	mandatory	1/1/2014	
Medicaid prohibited from excluding coverage of barbiturates, benzodiazepines, and tobacco cessation products	2502	mandatory	1/1/2014	
Medicaid new reporting requirements, including total # of enrolled under state plan or waiver	2001(d); 10201	mandatory	1/1/2015	
Medicaid Enhanced FMAP for targeted low-income children increased by 23% but no increase in allotment	2101, 10203	mandatory	10/1/2015	

Medicaid Cost effectiveness test for premium assistance to children	10201(b)(2)(A)	optional	2/4/2009	
Medicaid global capitated payments to safety net hospitals demonstration project	2705	optional	10/1/2009	
Medicaid State option to provide family planning services to low-income individuals	2303	optional	3/23/2010	
Medicaid - States may provide CHIP coverage to children of state employees under specified conditions	2101	optional	3/23/2010	
Medicaid Early Expansion Option	2001, 10201	optional	4/1/2010	
Medicaid Money Follows the Person Rebalancing Demonstration Project	2403	optional	4/22/2010	9/7/2010 1/7/2011
Medicaid demonstration project to allow pmt to private IMDs (emergency psychiatry demonstration)	2707	optional	10/1/2010	
Medicaid State option to provide health homes to enrollees w/chronic conditions	2703	optional	1/1/2011	
Medicaid: grants to states to provide chronic disease prevention incentives to Medicaid beneficiaries	4108	optional	1/1/2011	
Medicaid Incentive payments to states to increase % of LTC spending on non-institutional services	10201	optional	10/1/2011	
Medicaid State plan option to offer HCB Services under Sec. 1915(k) (Community First Choice)	2401; HCERA 1205	optional	10/1/2011	
Medicaid hospital bundled payment demonstration project	2704	optional	1/1/2012	
Medicaid demonstration project to allow pediatric medical providers to organize as ACOs	2706	optional	1/1/2012	
Medicaid FMAP Increase of 1% if prev. svcs covered w/no cost share (includes MH)	4106	optional	1/1/2013	
Medicaid option to increase eligibility to 200% FPL for individuals otherwise eligible for the Exchange	2001	optional	1/1/2014	
Medicaid - premium assistance program for all Medicaid eligibles (including cost effectiveness test)	2003(a)(1)(A), 10203(b)(2)(B)	optional	1/1/2014	
Medicaid - hospitals permitted to make presumptive eligibility determinations for all Medicaid eligible populations	2202	optional	1/1/2014	
Medicaid Adult Health Quality Measures	2701	optional	1/1/2014	
<b>HEALTH CARE DELIVERY SYSTEM PROVISIONS</b>				
Health System: State/Tribal Grants for Community Health Teams	3502, 10321	optional	3/23/2010	
Health System: Regionalized Systems for Emergency Care	3504	optional	3/23/2010	
Health System: Trauma Care Centers	3505	optional	3/23/2010	
Health System: Patient Navigator Outreach & Chronic Disease Prevention Program	3510	optional	3/23/2010	6/11/2010
Health System: "New Access Points" (Community Health Centers)	10503	optional	3/23/2010	11/17/2010

<b>HEALTH CARE WORKFORCE PROVISIONS</b>				
Workforce: State Health Care Workforce Development Grants	5102	optional	3/23/2010	7/19/2010
Workforce: Public Health Workforce Recruitment & Retention Loan Repayment Program	5204	optional		
Workforce: Nurse Managed Health Clinics	5208	optional	3/23/2010	7/19/2010
Workforce: Elimination of Cap on Commissioned Corps	5209	optional	3/23/2010	
Workforce: Establishing a Ready Reserve Corps	5210	optional	3/23/2010	
Workforce: Expansion of Physician Assistant Training Programs	5301; 4002	optional	3/23/2010	7/19/2010
Workforce: Advanced Nursing Education Expansion	5308; 4002	optional	3/23/2010	7/19/2010
Workforce: Nursing Assistant and Home Health Aide Program	5309	optional	3/23/2010	7/22/2010
Workforce: Grants to Promote the Community Health Workforce	5313; 10501	optional	3/23/2010	
Workforce: Fellowship Training in Public Health	5314	optional	3/23/2010	
Workforce: Mental & Behavioral Health Education and Training Grants	5306	optional	3/23/2010	
Workforce: Demonstration Project to Provide Aid to Low-Income Individuals for Ed and Training in HC Occupations w/Shortages	5507	optional	3/23/2010	8/5/2010
Workforce: Demonstration Project to Develop Core Training Competencies and Programs for Personal Home Care Aides	5507	optional	3/23/2010	7/19/2010
Workforce: Primary Care Residency Expansion	5508; 4002	optional	3/23/2010	7/19/2010
<b>PUBLIC HEALTH PROVISIONS</b>				
Public Health: Maternal, Infant, and Early Childhood Home Visiting Programs	2951	optional	3/23/2010	7/9/2010
Public Health: Postpartum Depression Grants	2952	optional		
Public Health: Personal Responsibility Education	2953; 10201	optional	3/23/2010	6/8/2010 8/30/2010
Public Health: Abstinence Education	2954	optional	3/23/2010	8/30/2010
Public Health: National Prevention, Health Promotion and Public Health Council	4001	n/a	3/23/2010	
Public Health: Prevention & Public Health Fund (\$500M approp FFY 10 growing to \$2B/yr in FFY 15 and each year after)	4002	optional	3/23/2010	
<i>Strengthening the Public Health Infrastructure Grant Program</i>	4002	optional	3/23/2010	8/9/2010
<i>Tobacco Cessation (Healthy Communities)</i>	4002	optional	3/23/2010	9/3/2010
<i>Behavioral Risk Factor Surveillance System Supplemental</i>	4002	optional	3/23/2010	9/8/2010
<i>Communities Putting Prevention to Work</i>	4002	optional	3/23/2010	n/a (prior app)
<i>HIV/AIDS Surveillance: Enhancing Lab Reporting</i>	4002	optional	3/23/2010	9/2/2010

Public Health: School-Based Health Center Grant Program	4101	optional	3/23/2010	7/30/2010
Public Health: Oral Healthcare Prevention Grant Program	4102	optional		
Public Health: Community Transformation Grants	4201	optional		
Public Health: Healthy Aging, Living Well Public Health Grant Program	4202	optional		
Public Health: Immunization Coverage Improvement Program	4204	optional		
Public Health: Epidemiology & Laboratory Capacity Grants	4304; 4002	optional	3/23/2010	8/27/2010
Public Health: Childhood Obesity Demonstration Project (appropriation \$25 M total FFY 10-14)	4306	optional	3/23/2010	
Public Health: Reauthorization of EMS for Children Program	5603	optional	3/23/2010	
Public Health: Nationwide Program for National and State background checks on direct patient access EEs of LTC facilities	6201	optional	3/23/2010	8/9/2010
Public Health: Support for Pregnant and Parenting Teens (\$25M/yr appropriated for 10 yrs)	10211-10214	optional	3/23/2010	8/2/2010
Public Health: National Diabetes Report Card and Vital Statistics Data Collection Improvement	10407	?		
<b>SENIOR &amp; LONG-TERM CARE PROVISIONS</b>				
Seniors: Aging and Disability Resource Centers	2405	optional	3/23/2010	7/30/2010
Seniors: MIPPA Medicare Outreach for Part D, Low Income, Rural (includes appropriation to ADRCs)	3306	optional	3/23/2010	7/30/2010
Seniors: Elder Justice Services	6701	optional		
Seniors: Adult Protective Services Grant Program	6703	optional		
Seniors: State Demonstration Program Concerning Elder Abuse	6703	optional		
LTC: CLASS Act (Community Living Assistance Services & Supports)	8002	mandatory	1/1/2011	
LTC: Standards and Requirements for SNFs and Nursing Homes	6102-6106	mandatory		
<b>BEHAVIORAL HEALTH PROVISIONS</b>				
Co-locating Primary and Specialty Care in Community-Based Mental Health Settings (demonstration grant program)	5604	optional	3/23/2010	
Mental health & substance use disorder services included in essential benefits package	1302, 10104	mandatory	1/1/2014	
Mental health parity in the Exchange	1311, 10104, 10203	mandatory	1/1/2014	

State of Alaska								
Current State Operating Agency Grant/Contract Opportunities Under PPACA								
Updated: 01/05/11								
				Closed				
				Open				
Provision	Citation	Guidance Released	CFDA #	Application Due	SOA Lead Agency	Application Submitted	Date Awarded	Award Amount
Health Insurance: Consumer Assistance	1002	7/22/2010	93.519	9/10/2010	DCCED/DOI	SOA Declined to Apply		n/a
Health Insurance: Rate Review	1003	6/7/2010	93.511	7/7/2010	DCCED/DOI	SOA Declined to Apply		n/a
Health Insurance: Rate Review (re-release)	1003	9/1/2010	93.511	10/1/2010	DCCED/DOI	SOA Declined to Apply		n/a
Health Insurance: High Risk Pool	1101	5/10/2010	n/a	5/31/2010	DCCED/DOI	5/28/2010	7/19/2010	\$13,000,000
Health Insurance: Health Insurance Exchange	1311	7/29/2010	93.525	9/1/2010	DCCED/DOI	SOA Declined to Apply		n/a
Health Insurance: Exchange IT Infrastructure Design	1311	10/29/2010	93.525	12/22/2010	DCCED/DOI	SOA Declined to Apply		
SOA as Employer: Reinsurance for Early Retirees	1102, 10102	6/29/2010	n/a	n/a	DOA/DRB	7/3/2010	8/31/2010	indefinite
<i>actual reimbursement amount is dependent on claims and availability of funding</i>								
Workforce: State Health Care Workforce Development	5102; 4002	6/17/2010	93.509	7/19/2010	DOL/AWIB	7/19/2010	9/28/2010	\$150,000
Workforce: Health Professions for TANF Recipients	5507	6/21/2010	93.093	8/5/2010	DOL/AWIB	8/4/2010	No Award	\$0
<i>Note: Cook Inlet Tribal Council was awarded \$1,463,627 under this program</i>								
Public Health: Maternal, Infant and Early Childhood Home Visiting	2951	6/10/2010	93.505	7/9/2010	DHSS/DPH	7/9/2010	7/21/2010	\$584,256
Public Health: Personal Responsibility Education (Teen PG Prv Tier 2)	2953, 10201	4/8/2010	93.297	6/8/2010	DHSS/DPH	6/8/2010	9/30/2010	\$599,985
Public Health: Personal Responsibility Education	2953, 10201	7/30/2010	93.092	8/30/2010	DHSS/DPH	8/26/2010	9/30/2010	\$250,000
Public Health: Title V State Abstinence Education Grant Program	2954	7/30/2010	93.235	8/30/2010	DHSS/DPH	SOA Declined to Apply		n/a
<i>\$70K AK allocation insufficient to cover grant requirements; match required</i>								
Public Health: Nationwide Program for LTC Worker Background Checks	6201	6/4/2010	93.506	8/9/2010	DHSS/DPH	8/9/2010	10/6/2010	\$1,500,000
Public Health: Support for Pregnant & Parenting Teens	10211-10214	7/1/2010	93.500	8/2/2010	DPS/CDVSA	7/30/2010	No Award	\$0
Public Health: Strengthening Public Health Infrastructure	4002	7/8/2010	93.507	8/9/2010	DHSS/DPH	8/9/2010	9/20/2010	\$100,000
Public Health: HIV/AIDS Surveillance: Enhancing Lab Reporting	4002	8/3/2010	93.523	9/2/2010	DHSS/DPH	9/1/2010	9/24/2010	\$41,909
Public Health: Building Epidemiology and Laboratory Capacity	4304; 4002	8/3/2010	93.521	8/27/2010	DHSS/DPH	8/27/2010	9/24/2010	\$473,908
Public Health: Tobacco Cessation (Healthy Communities Supplemental)	4002	8/3/2010	93.520	9/3/2010	DHSS/DPH	SOA Declined to Apply		n/a
<i>\$50K AK allocation insufficient to cover grant requirements</i>								
Public Health: Communities Putting Prevention to Work	4002	8/12/2010	93.724	n/a	DHSS/DPH	n/a	No Award	\$0
<i>Program initially funded under ARRA. AK applied then - app. was approved, but not funded. Feds then allocated some of the PPACA 4002 \$s to fund some of the approved/not-funded apps submitted under ARRA - AK not funded in this round</i>								
Public Health: Behavioral Risk Factor Surveillance System Supplement.	4002	8/13/2010	93.520	9/8/2010	DHSS/DPH	9/7/2010	9/30/2010	\$68,265
Seniors/LTC: Aging & Disability Resource Centers	2405	6/3/2010	93.048	7/30/2010	DHSS/DSDS	7/30/2010	No Award	\$0

Seniors/LTC: MIPPA Medicare Outreach (Part D, Low Income, Rural)	3306	6/3/2010	93.071	7/30/2010	DHSS/DSDS	7/30/2010	9/27/2010	\$65,454
			93.518					
Seniors/LTC: Money Follows the Person Demo Planning (\$200K each)	2403	8/3/2010	93.791	9/7/2010	DHSS/DSDS	SOA Declines to Apply		n/a
Seniors/LTC: Money Follows the Person Rebalancing Demonstration	2403	7/23/2010	93.791	1/7/2011	DHSS/DSDS	SOA Declines to Apply		n/a
Seniors/LTC: Dual Eligibles Demonstration Project	3021	12/13/2010	RFP-CMS-2011-0009	2/1/2011	DHSS/DSDS	Decision to Apply Pending		
<b>Grant/Contract Opportunities Under PPACA for Universities, Providers, and other non-State Entities</b>					<b>Eligible Applicants</b>			
Updated: 01/05/11								
Patient Navigator Outreach and chronic Disease Prevention	3510		93.191	6/11/2010	Providers	Unknown		
Workforce: Personal and Home Care Aide State Training Program	5507	6/17/2010	93.512	7/19/2010	No AKns applied;6-grantee demo project			
Family-to-Family Health Info Ctr (created '05; reauthed under PPACA)	5507				2010: Stone Soup Group	7/27/2010	\$96,700	
		10/26/2010	93.504	12/15/2010	2011 Announcement			
Workforce: Advanced Nursing Education Expansion Program	5308; 4002	6/17/2010	93.513	7/19/2010	Nurse Schools	Unknown		
Workforce: Primary Care Residency Expansion	5508; 4002	6/17/2010	93.510	7/19/2010	Acrdtd Res Pgms	AFMR did not apply		
Workforce: Physician Assistant Training Program	5301; 4002	6/17/2010	93.514	7/19/2010	PA Training Pgms	AK PA Program did not apply		
Nurse Managed Health Clinics	5208	6/17/2010	93.515	7/19/2010	ANP Clinics	Unknown		
Workforce: Nursing Assistant and Home Health Aide Program	5309		93.503	7/22/2010	Training Pgms	Unknown		
Workforce: Nurse Retention Grants	5309	12/3/2010	93.359	1/21/2011	Schools of Nursing and Health Care Facilities			
Tribal Maternal, Infant, and Early Childhood Home Visiting Program	2951		93.508	7/26/2010	Tribal Health Organizations	Southcentral Foundation	\$345,000	
						Fairbanks Native Assn	\$250,000	
						Kodiak Area Native Assn	\$236,000	
School-Based Health Centers Capital Program (1-yr grt for Equip only)	4101	6/30/2010	93.501	7/30/2010	School-based health ctrs	no AKn orgs applied		
School-Based Health Centers (2nd issuance)	4101	10/4/2010	93.501	12/1/2010	School-based health ctrs			
Prevention Center for Healthy Weight (1 national grantee)	4002		93.522	8/16/2010	Research Centers	no AKn orgs applied		
"New Access Points" (new community health centers)	10503	8/9/2010	93.527	11/17/2010	Multiple Eligibility Requirements			
Workforce: Health Professions Opportunities for Tribal Organizations	5507	6/21/2010	93.093	8/5/2010	Tribal Orgs			
					Cook Inlet Tribal Council	9/28/2010	\$1,463,627	
Public Health: Strengthening Tribal Public Health Infrastructure	4002	7/8/2010	93.507	8/9/2010	Tribal Health Organizations	ANTHC	9/20/2010	\$100,000
						SEARHC	9/20/2010	\$100,000
Primary Care Service Integration in Behavioral Health Centers	5604; 4002				Community Organizations	AICS	9/24/2010	\$296,836
						Alaska Island Community Services, Wrangell		
Community Health Center Construction/Renovation	10503				Anchorage Neighborhood Health Center	10/8/2010	\$8,000,000	

				SE Alaska Regional Health Consortium	10/8/2010	\$1,299,147
Community Health Center Expanded Services Initiative	10503	10/26/2010	93.527	1/6/2011	Supplemental Funding for Existing Community Hlth Ctrs	
					Formula-based funding	
Medicare Rural Community Hospital Demonstration Project	3123	8/30/2010	93.773&4	10/14/2010	Hospitals in qualifying rural areas are eligible	
					Hospitals eligible for CAH are not eligible	
Workforce: Workforce Diversity Grant	5404	12/3/2010	93.178	1/14/2011	Schools of Nursing & Academic Health Centers	
Teaching Health Centers that offer Primary Care GME	5508	11/29/2010	93.530	12/30/2010	Teaching Health Centers that offer residency training	
<b>2011: New State Operating Agency Grant/Contract/Funding Opportunities Anticipated Under PPACA</b>						
<i>Includes only those programs for which appropriations are specified, for which state governments are eligible, and that will begin in FFY 2011</i>						
<i>Does not include programs that first began under PPACA in FFY 2010</i>						
Incentives for Prevention of Chronic Disease in Medicaid	4108				Grants to states to provide incentives for Medicaid beneficiaries to participate in prevention programs	Begins 1/1/2011 \$100 M appropriated for 5 year period beginning 1/1/2011
State Medicaid Option to Provide Health Homes for Enrollees with Chronic Conditions	2703				Provides states the option of enrolling Medicaid beneficiaries with chronic conditions into a health home. States will receive 90% FMAP for two years. Also provides for planning grants.	Begins 1/1/2011 "Planning Grants" is authorization to spend up to \$500K matched at pre-ARRA FMAP for planning activities
Medicaid Emergency Psychiatry Demonstration Project	2707				Demonstration project in up to 8 states - states required to reimburse non-publicly owned or operated institutions for mental illness for services to Medicaid beneficiaries 21-64 years of age who need emergency assistance.	FFY 2011 \$75 M for FY 2011 (available until 12/31/2015)
Community First Choice Option (State Medicaid Option)	2401; and 1205 HCERA				Optional Medicaid service through which states can offer community-based services for beneficiaries with disabilities	Begins 10/1/2010 FMAP increased by 6% for cost of services provided under this option.
Community Transformation Grants	4201				State & local governments, non-profits, and tribes are eligible. Grants to support community efforts to reduce chronic disease and health disparities by promoting healthy lifestyles.	FFY 2011 \$220 million will be transferred from the Prevention & PH Fund in FFY 2011 for this program

**Summary of Medicaid Requirements Included in PPACA**

Following is a preliminary summary of each PPACA provision identified in an initial review as having or potentially having an impact on the State of Alaska Medicaid program. Identification of all provisions that may impact Alaska’s Medicaid program is not yet complete, and the descriptions presented here are preliminary pending additional guidance from the federal government.

Provision Title	Section # Citation	Effective Date	Explanation
<b>Mandatory Coverage of Certain Populations, Including Federal Funding (FMAP) Changes</b>			
Maintenance of Effort Requirement	2001	3/23/2010	This provision requires the State to maintain eligibility standards, methodologies and procedures at a level that is at, or less restrictive than, the levels in place on the date of enactment of PPACA. This provision in PPACA following on the one in ARRA essentially means there are many changes States will not be able to make to their Medicaid programs between July 1, 2008 and January 1, 2014 (out to October 1, 2019 for children under age 19); therefore, Alaska’s ability to take cost-saving actions in these areas is limited for a five-year period (11 years for children). This provision in ARRA was a condition of accepting additional federal funds through the enhanced Federal Medical Assistance Percentage (FMAP) rate, but the PPACA requirement is not accompanied by additional federal support
Mandated Expansion to 133% (138%) FPL with Enhanced FMAP	2001; 10201	1/1/2014	<p>This provision expands the Medicaid program beginning in 2014 by creating a new, mandatory category of Medicaid eligibility for legal residents under the age of 65 with income no greater than 133% of the federal poverty level (FPL). A provision in Sec. 2002 requires States to apply a mandatory 5% income disregard, effectively raising the eligibility level to 138% FPL. Sec. 2001 also stipulates that the benefits be provided as defined in the Benchmark Benefits Package, and requires mental health service parity for that package. The federal government will fully fund the expansion through FFY 2016, then States will be required to cover 5% of the cost in 2017, increasing to 10% in FFY 2020 and beyond. A State option to expand eligibility to this new group early is included in this provision as well, but the expansion would be funded at the State’s current FMAP rate (about 50%).</p> <p>Most people who are eligible for Alaska’s Chronic and Acute Medical Assistance Program (CAMA), which is fully funded with State general funds, will fall into this new Medicaid eligibility group. Many individuals who receive substance abuse or mental health services funded with State general fund grants will also fall within this group. As a result, while the</p>

			required expansion will cost Alaska State general fund dollars, the increased cost may be offset by State general fund savings.
Medicaid Mandatory Coverage of Children Ages 6-19 under 133% FPL	2001	1/1/2014	This provision means that some, probably a small proportion, of current Denali KidCare enrollees will now be eligible under Medicaid. No new person is added to Medicaid eligibility by this provision, but would only move from one program to another with the same benefits and services. The administrative workload may include computer systems changes to recognize this different eligibility grouping, which also translates to the loss of the enhanced CHIP match rate.
Mandatory Coverage of Foster Care Children Up to Age 26	2004; 10201	1/1/2014	This will be a new mandatory group different from the larger mandatory Medicaid expansion up to 133% FPL. This group will be composed of those persons enrolled in Medicaid on the date they aged out of foster care. This group will receive the full Medicaid benefit array, not the Benchmark Benefits of the newly eligible; and at the usual FMAP, not the enhanced FMAP for the newly eligible. It appears this eligibility is retroactive for anyone meeting the requirements, not just those aging in after 1/1/2014. DHSS must begin looking at records to identify those with future eligibility for this benefit, possibly notifying them to maintain contact information or looking at the PFD records for whereabouts. Federal regulations should address identification issues for those that reside in states other than where they were in foster care. This has the potential to be administratively difficult for the retroactively eligible group and for those that move from state to state.
CHIP Program Authorization Extended until FFY 15; 23% Increase in CHIP FMAP FFY 16 thru FFY 19	2101; 10203	2/4/2009 CHIP Exten.  10/1/2015 CHIP FMAP Increase	This Children's Health Insurance Program (CHIP) reauthorization extends funding through 9/30/2014, permitting continued federal funding of Denali KidCare (DKC), but PPACA also seems to assume that Congress will do a further program extension, given there is a corresponding 23% FMAP boost to the already enhanced CHIP FMAP starting in FFY 16. As a result of this the FMAP for Alaska DKC would increase from about 66% to 89%. The 23% increase in CHIP FMAP will be in affect from 10/1/2015 to 9/30/2019.
<b>New Eligibility Determination Requirements</b>			
Mandatory Use of Modified Adjusted Gross Income (MAGI) for Eligibility Determination; Required 5% Disregard (effectively increasing upper limit to 138% FPL); and, Prohibited Use of Resource or Asset Test When Determining	2002; HCERA 1004	1/1/2014	The provisions in this section of PPACA will require fundamental changes to the State's current eligibility process and procedures. Under these provisions States are required to change the methodology for determining income eligibility for Medicaid to the use of "modified adjusted gross income" (MAGI) and household income as defined for federal tax purposes. States are also prohibited from using income or expense disregards, but are required to disregard the difference between the monetary equivalent of the upper income eligibility limit and the upper income limit increased by 5% - in effect increasing the upper income eligibility limit from 133% to 138% FPL. States will also be prohibited from applying any assets or resources tests for purposes of determining eligibility (with certain exceptions). Current Alaska policies likely meet the new asset test requirements.

Eligibility			<p>States are required to submit for approval by CMS a transition plan for changing methodologies and procedures for income eligibility determination.</p> <p>Until federal regulations and guidance are issued on these provisions it is not possible to determine the full impact, other than to conclude there will be a multitude of changes. For example, it is unclear whether we will be required to maintain current eligibility processes for some eligibility groups and create this new process for others; whether we will be required to apply both processes to insure we meet the maintenance of effort requirements; whether we will have to connect with the IRS to gather MAGI determination information, or if the IRS will determine MAGI for those who have filed income tax returns; etc.</p>
Presumptive Eligibility by Hospitals	2202	1/1/2014	<p>It is unclear whether this provision creates a State option to permit hospitals to make a presumptive eligibility determination for any individual potentially eligible for Medicaid, or if it in fact allows hospitals to make the determination regardless of State choice. If federal clarification indicates that the provision may be implemented at each hospital's discretion, then this provision creates an issue for all States. One concern is the State workload associated with training hospital staff on new eligibility processes and maintaining the training over time. In addition, permitting hospitals to use a separate process to assure their claims are paid due to presumption of eligibility would not be consistent with the Insurance Exchange approach that is to be up and running by this date. Individuals will be able to access the web portal at the hospital and apply for subsidized coverage for Medicaid at the time of service, though the hospital would not be guaranteed payment for the immediate service. If the Exchanges work as envisioned then there should no longer be need for presumptive eligibility or any other special eligibility determination and enrollment processes.</p>
Protection Against Spousal Impoverishment	2404	1/1/2014	<p>Sec 2404 is a 5-year language substitution that removes 'at the option of the State' and replaces it with a broad description of all sections of the law by which a person could access home and community-based services. Alaska already takes a broad and expansive approach to avoid spousal impoverishment (State Plan Amendment Supplement 13 to Attachment 2.6-A), so it is unlikely that this provision will have any impact, but potential impact cannot be fully determined until after federal regulations implementing this provision have been promulgated.</p>
<b>New Enrollment Requirements</b>			
Health Insurance Administrative Simplification	1104; 10109	7/1/2011	<p>This provision requires the U.S. DHHS to adopt a uniform set of rules for electronic transactions between health care providers and health plans for actions such as health plan eligibility, claim status, and electronic funds transfer. These standards will apply to all health care providers and health plans governed by HIPAA, and therefore these provisions</p>

			will also apply to Medicaid. This primarily pertains to Health Information Technology/Health Information Exchange standards and formats and standardization of claims forms. The new operating rules are to be determined by 7/1/2011 with implementation no later than 1/1/2016.
Health Information Technology (HIT) Enrollment Standards and Protocols	1561	9/23/2010	This provision directs the U. S. DHHS to develop interoperable and secure standards and protocols that facilitate electronic enrollment of individuals in Federal and State health and human services programs. It also directs HHS to award grants to States to develop new and adapt existing technology systems to implement the new HIT (Health Information Technology) enrollment standards and protocols, but it does not include an appropriation or specific authorization for this grant program.
End of CHIP Enrollment Performance Bonus	2101	10/1/2013	This year Alaska received a bonus payment of almost \$800,000 based on performance measures. There is no way to project future eligibility for this award, thus no way to determine any impacts, positive or negative, to the ending of the bonus program.
Medicaid and CHIP Enrollment Simplification	2201	1/1/2014	<p>This provision requires States to set up a website where people can compare the benefits and costs of subsidized coverage through the Health Insurance Exchange and Medicaid, and also apply for or renew Medicaid enrollment. This website must link to the Exchange. The State Medicaid program must accept eligibility determinations made by the Exchange. The State must enroll people into health plans under the Exchange and establish premium assistance amounts when they are determined not to be eligible for Medicaid or CHIP. The State must coordinate medical assistance for those also eligible for coverage provided through the Exchange. In addition the State must conduct outreach and enrollment efforts to multiple broadly defined vulnerable populations.</p> <p>All of these requirements will require significant additional resources to comply with the law.</p>
<b>Mandatory Coverage of Certain Services and Changes in Service Definitions and Requirements</b>			
Freestanding Birth Centers	2301	3/23/2010	Alaska already covers these birthing centers under Medicaid; however the new requirement under PPACA to cover these services appears to require we pay the facility fee separate from the practitioner fees. When CMS approved our current Medicaid State Plan Amendment (SPA) they insisted the facility fee be combined with the practitioner fee. To comply with PPACA we will need to commit staff and resources to develop and submit to CMS for approval a new SPA, promulgate new regulations, develop a facility fee separate from the practitioner fee, and make computer system changes to implement the new reimbursement methodology.
Medical Assistance Definition Expanded	2304	3/23/2010	Previous court cases upheld the definition of "medical assistance" under the Medicaid Act to be payment for part or all of the service. PPACA expands the definition to include "or the care and services themselves, or both," meaning States are not just liable for paying

			for health benefits for Medicaid recipients, but also for ensuring provision of the care and services. This is characterized as a “clarifying,” “technical” change, but could increase lawsuits against States by enrollees claiming delays or other access to and problems in delivery of services.
Comprehensive Tobacco Cessation Services for Pregnant Women	4107	10/1/10	The law requires Medicaid to cover counseling and pharmacotherapy for cessation of tobacco use by pregnant women, and prohibits a co-pay associated with these services. Alaska currently covers tobacco cessation products and counseling by physicians, mid-level providers and pharmacists.
Barbiturates, Benzodiazepines, and Tobacco Cessation Products	2502	1/1/2014	Certain classes of drugs are excluded from mandatory Medicaid coverage, leaving inclusion as a State option. PPACA removes barbiturates, benzodiazepines, and smoking and tobacco cessation agents from the excludable drug list. This provision has no effect on Alaska as our Medicaid program already covers these drugs.
Home and Community Based Services under the State Plan	2402	3/23/2010	Most provisions under Sec. 2402 are optional for States, but 2402(a) requires the Secretary to issue regs requiring States to ensure long term care service systems are allocated to meet the changing needs of beneficiaries and to maximize independence; provide support and coordination to design an individualized, self-directed, community-supported life; and improve coordination and regulation of providers. Until the regs are issued the State impact cannot be determined. Given the statutory language for this provision and based on experience with the recent CMS HCBS review, we can anticipate that CMS will provide very detailed instructions on how States operate such programs in the future.
<b>Reimbursement and Payment Structure Changes</b>			
Prohibit Medicaid Payments to States for Services Related to Health Care Acquired Conditions	2702; 10303	7/1/2011	This provision intends to reduce avoidable death, disability and health care costs through imposition of a financial penalty for health care services that must be provided as the result of a medical error or infection acquired during the provision of a medical service. The Secretary of HHS must promulgate regulations by 7/1/2011 that will prohibit federal payment to State Medicaid programs for any amounts expended for medical assistance required as the result of a health care-acquired condition. Unlike a number of other states, Alaska does not have a health care acquired infections or conditions reporting requirement, though the Alaska Division of Public Health recently launched a Health Care Associated Infections Prevention Program.
Medicaid Reduction of Disproportionate Share Hospital (DSH) Payments	HCERA 1203	1/1/2012	Assuming current Alaska spending patterns continue for hospital DSH payments this provision will have no impact. Federal DSH funds are capped for each state based on federal statute. Alaska historically has not had sufficient GF to fully expend the federal allotment, thus reducing the federal allotment should not negatively impact Alaska, though it may limit future possibilities for expanded use of these funds.
<b>Fraud, Waste and Abuse Provisions</b>			

Extended Period for Collection of Overpayments	6506	3/23/2010	<i>Analysis pending</i>
Provider Screening & Enrollment Requirements	6401	3/23/2011	The State will be required to assure compliance with new requirements for medical providers and suppliers included in this section. The HHS Secretary is to establish regulations within 180 days to impose new Medicaid (and Medicare) provider screening procedures that must include a licensure check, and may include a criminal background check, fingerprinting, random site visits, database checks, and/or other measures determined appropriate based on the risk of fraud, waste and abuse. The screening requirements will be imposed for new enrollees beginning 3/23/2011; 3/23/2012 for providers who were already enrolled 3/23/2010. Other enrollment requirements include certain disclosures, and participation in compliance programs. The State will also be required to participate in a national system for reporting criminal and civil convictions and negative licensure actions. The State conducts many of these activities now, but without federal regulations, it is not possible to determine the new level of effort.
Face-to-Face Encounter Required for Home Health Services and DME Eligibility Certification	6407; 10605	?	This provision requires physicians or mid-level practitioners to have a face-to-face encounter with Medicaid (and Medicare) clients prior to certifying eligibility for home health services, durable medical equipment, or other items or services as required by the HHS Secretary.
Medicare Recovery Audit Contractor (RAC) Program Expanded to Medicaid	6411	12/31/2010	<i>Analysis pending</i>
Termination of Provider Participation in Medicaid if Terminated under Medicare	6501	1/1/2011	<i>Analysis pending</i>
States Mandated to Use National Correct Coding Initiative	6507	1/1/2011	<i>Analysis pending</i>
<b>Other Medicaid Provisions and Potential Issues</b>			
Prescription Drug Rebate Change	2501	1/1/2010	<i>Analysis pending</i>
Medicare Part D "Donut Hole" Closure	3315; HCERA 1101	1/1/2010	No direct impact, however, since State Medicare Part-D "clawback" payments to the federal government subsidize the increased premium payments for coverage of the doughnut hole for seniors who are dually-eligible under Medicare and Medicaid. Since the

			doughnut hole will be reduced each year over the next several years until it no longer exists starting in 2020 for all Medicare beneficiaries, state clawback obligations should be reassessed.
Community Living Assistance Services & Supports (CLASS) Act	8002	1/1/2011	This provision creates a new national voluntary long term care insurance program, and it includes an obligation for State Medicaid programs to conduct by 1/1/2013 a needs assessment of public and non-profit long term care service providers' ability to serve as fiscal agents, employers and providers of long term care services for CLASS beneficiaries; designate or create such entities, including in rural and underserved areas; and ensure that these additional requirements do not impede current capacity for self-directed home and community-based service delivery.
New Medicaid Reporting Requirements	2001; 10201	1/1/2015	This provision adds to the annual reporting requirements new requirements for reporting total enrollment, newly enrolled, and yet to be determined sub classifications of enrollees. It also adds a new requirement for reporting on outreach and enrollment processes, and whatever else the Secretary might deem necessary.
Community Health Center Expansion	10503; HCERA 2303	10/1/2010	PPACA appropriates \$9.5 billion for FFYs 2011 through 2015 to increase operational support for federally funded community health centers (CHCs). An additional \$1.5 billion is appropriated to expand funding for construction and renovation. Expansion of the National Health Service Corps under PPACA will also partially support enhancement of CHC staffing. The community health center system in Alaska expanded significantly over the past 15 years, and currently includes 26 grantees operating 142 clinic delivery sites. Approximately half of the grantees are tribal health organizations. Medicaid services provided to AI/AN patients in tribal health organization facilities are reimbursed by the federal government at 100% FMAP. Addition or expansion of tribal health organization CHCs will enhance federal support of the Medicaid program. Addition or expansion of non-tribal CHCs will increase workload for the Office of Rate Review in AK DHSS/Division of Health Care Services associated with establishing and maintaining cost-based encounter rates.

### ***State Medicaid Options & Demonstration Projects***

PPACA includes numerous Medicaid program options and demonstration projects intended to:

- Expand eligibility further to serve more people under Medicaid (e.g., early expansion option, increase to 200% FPL)
- Support expansion of certain services (e.g., family planning, preventive services)
- Test payment reform methodologies (e.g., hospital bundled payment)
- Support home and community-based services over institutional care (e.g., Community 1<sup>st</sup> Choice, incentives for non-institutional LTC services)
- Test new delivery system models (e.g., health homes, accountable care organizations)

The Medicaid options and demonstration projects available to States under PPACA are listed below in chronological order by effective date.

<b>Medicaid Options &amp; Demonstration Projects</b>	<b>Section</b>	<b>Effective Date</b>
Demonstration of Global Capitated Payment to Safety Net Hospitals	2705	10/1/2009
Option to Provide Family Planning Services to Low-Income Individuals	2303	3/23/2010
Option to Provide CHIP Coverage to Children of State Employees	2101	3/23/2010
Early Expansion Option	2001; 10201	4/1/2010
Money Follows the Person Rebalancing Demonstration Project	2403	4/22/2010
Demonstration Project to Allow Payment to Private Institutions for Mental Diseases	2707	10/1/2010
Option to Provide Health Homes to Enrollees with Chronic Conditions	2703	1/1/2011
Grants to States to Provide Chronic Disease Prevention Incentives to Medicaid Beneficiaries	4108	1/1/2011
Incentive Payments to States to Increase the Percentage of Long Term Care Spending on Non-Institutional Services	10201	10/1/2011
Option to Offer Home & Community Based Services Under Sec. 1915(k) (Community First Choice)	2401; HCRA 1205	10/1/2011
Hospital Bundled Payment Demonstration Project	2704	1/1/2012
Demonstration Project to Allow Pediatric Medical Providers to Organize as Accountable Care Organizations	2706	1/1/2012
FMAP Increase of 1% if Preventive Services are Covered with No Cost-Sharing Requirements	4106	1/1/2013
Option to Increase Eligibility to 200% FPL for Individuals Otherwise Eligible for the Exchange	2001	1/1/2014
Grant Hospitals Permission to Make Presumptive Eligibility Determinations for all Medicaid Eligible Populations ( <i>or mandatory?</i> )	2202	1/1/2014
Premium Assistance Program for all Medicaid Eligibles (including Cost Effectiveness Test)	2003; 10203	1/1/2014

## State of Alaska Medicaid Budget Impact Analysis

	Projected Change in State General Fund Expenditures (in thousands)						
	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020
Medicaid Expansion to 138% FPL	0	0	0	3,878.9	8,814.1	11,039.5	15,351.6
Absorb CAMA into Medicaid	(953.0)	(1,963.4)	(2,081.5)	(2,150.4)	(2,211.2)	(2,319.1)	(2,406.1)
CHIP FMAP Increase by 23%	0	0	(6,245.7)	(8,855.9)	(9,417.7)	(10,015.2)	(2,662.6)
Drug Rebate Shift to Fed Gov	7,500.0	7,500.0	7,500.0	7,500.0	7,500.0	7,500.0	7,500.0
<b>Net "Cost" to State of Alaska</b>	<b>6,547.0</b>	<b>5,536.6</b>	<b>(827.4)</b>	<b>372.6</b>	<b>4,685.2</b>	<b>6,205.2</b>	<b>17,782.9</b>

	Projected Increase in Federal Medicaid Spending (in thousands)						
	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020
Federal Spending for Expansion	74,114.3	152,695.8	161,899.6	167,722.4	173,061.6	181,773.4	189,030.2
Federal Spending for CHIP FMAP	0	0	6,245.7	8,855.9	9,417.7	10,015.2	2,662.6
<b>New Federal Medicaid Spending</b>	<b>74,114.3</b>	<b>152,695.8</b>	<b>168,145.2</b>	<b>176,578.3</b>	<b>182,479.3</b>	<b>191,788.6</b>	<b>191,692.9</b>

	Projected Number of New Medicaid Enrollees (does not include CAMA clients)						
	SFY 2014	SFY 2015	SFY 2016	SFY 2017	SFY 2018	SFY 2019	SFY 2020
	29,188	30,884	31,038	31,193	31,349	31,506	31,663

**Medicaid Expansion, CHIP, & CAMA Projections developed by:** AK DHSS/FMS Medicaid Budget Group

### Assumptions & Data Sources for Medicaid and CAMA Projections

Data Source for uninsured up to 138% and privately insured up to 100% FPL: Current Population Survey

Date Source for population and projected population growth: AK Department of Labor & Workforce Dev

Assumptions:

- CHIP (Denali KidCare) eligibility remains at 175% FPL
- Expansion implemented January 1, 2014
- Expansion covers those up to 138% FPL (133% + mandatory 5% income disregard)
- 75% uninsured non-AI/AN Alaskans below 138% FPL will enroll
- 50% uninsured AI/AN below 138% will enroll
- 60% of AN/AI services/costs will be at tribal facilities at 100% FMAP
- Individuals on CAMA will be moved to Medicaid
- 50% of privately insured Alaskans <100% FPL will move to Medicaid
- Population growth for adults 0.5% per year (AK DOLWD)
- Population growth for children 0.8% per year (AK DOLWD)
- Per capita cost based on average 2009 FM&TM group spending
- Per capita cost growth is 5.5% per year
- Those previously on CAMA will cost more than other new enrollees

**Medicaid Drug Rebate Revenue Loss Projections developed by:**  
The Alaska DHSS Medicaid Program Pharmacist

**Assumptions for Medicaid Drug Rebate Revenue Loss Projections:**

- Estimated drug rebate revenue for Alaska for this year is \$30 million.
- Projected revenue loss assumes a 25% share will now go to the federal government.

**Other Potential State Costs not Included:**

- **Costs for work needed to implement the expansion related to:**
  - Analysis & Planning
  - Administrative and Operational Changes
  - Data System Changes
  - Increased Enrollment
- **Costs associated with increased enrollment of those currently eligible but not enrolled**
  - The so-called “woodwork effect” – assumes those who are Medicaid eligible but currently chose not to enroll will choose to enroll when faced with paying a tax penalty otherwise.

**Other Potential State Revenues and Savings not Included:**

- **Medicare Part D Clawback** – Will the State’s payment to the federal government to cover Medicaid GF’s share of the Part D premium for dual-eligibles be reduced or eliminated with the closure of the doughnut hole?
  - Alaska’s annual Medicare Part D Clawback payment to the federal government for the past couple years has been approximately \$20.4 million
  - Due to the ARRA FMAP reduction Alaska is saving approximately \$4.7 million in SFY 10 and will save approximately \$2.5 million in SFY 11. That savings is not reflected here as it is not related to PPACA, and because other ARRA FMAP savings are not included.
- **State Behavioral Health & Substance Abuse Grants** – Will the State be able to significantly reduce or eliminate grants that currently subsidize these services as safety-net clients become covered under the Medicaid expansion or through the Insurance Exchange, and as the Mental Health Parity Act and mental health parity provisions under PPACA take effect?
- **Federal Grants** – New federal grant and contract programs authorized under PPACA will provide additional revenue opportunities for Alaska health programs both within and outside State government. Potential new grant revenues are not included in these projections.

# MEMORANDUM STATE OF ALASKA

## DEPARTMENT OF LAW

**TO:** Mike Nizich  
Chief of Staff  
Office of the Governor

**DATE:** April 19, 2010

**FROM:** Daniel S. Sullivan  
Attorney General

**SUBJECT:** Constitutional Analysis of the  
Patient Protection Affordable  
Care Act and Health Care and  
Education Affordability  
Reconciliation Act of 2010

The Governor has requested that the Department of Law analyze the constitutionality of the recently enacted Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act of 2010 (hereinafter “the Act”). Our analysis and recommendation on whether Alaska should join the 20 other states challenging the constitutionality of the Act are detailed in the following memorandum.

### Executive Summary

The Patient Protection and Affordable Care Act was passed by the U.S. Congress on March 21, 2010, and signed by the President on March 23, 2010. The Health Care and Education Affordability Reconciliation Act of 2010 was passed by the U.S. Congress on March 25, 2010, and signed by the President on March 30, 2010. Combined, these two bills constitute an enormous and complex piece of federal legislation that is over 2,200 pages and imposes hundreds of new requirements on states, businesses, health care providers, non-profit entities, and individuals. The following provisions are the most relevant with regard to an analysis of the constitutionality of this federal legislation.

The Act contains an “individual mandate” that requires uninsured Americans to purchase health insurance if they do not fall within one of the individual mandate’s exceptions. This mandate expressly requires U.S. citizens and legal residents to have federal government-approved “qualifying” health insurance coverage beginning in 2014. Those who refuse to purchase a government-approved health insurance plan will have to pay a tax penalty of \$695 per year or 2.5% of their annual income, whichever is higher. The Act imposes numerous new requirements on the terms of health insurance policies and plans under which American citizens will be covered. Most of these requirements

involve expanding the terms and conditions of health insurance plans. The Act also significantly expands Medicaid eligibility for low-income individuals.

Finally, the Act requires each state to establish an “American Health Benefit Exchange” to facilitate the purchase of federal qualifying health plans, provide for the establishment of a “Small Business Health Options Program,” and meet other requirements described in the Act. To qualify to be listed on the exchange, a health benefit plan must abide by numerous federal regulations, which will be promulgated at a future date. If a state fails to establish a health benefit exchange, the Act requires the Secretary of Health and Human Services to establish and operate an exchange within that state.

In analyzing the constitutionality of the Act, it is critical to keep in mind as a legal touchstone the fundamental structural principles of the U.S. Constitution as they relate to the American system of government. More specifically, to ensure that no single government entity wields too much power, the Framers of the U.S. Constitution created vertical and horizontal separations of power. The vertical separation is between the federal and state governments and their respective powers. The horizontal separation consists of the division of authority and limited powers among the three branches of the federal government. These structural principles, which are fundamental components of the U.S. Constitution, were adopted by the Framers to ensure the protection of the liberty interests of the American people.

The Act’s individual mandate is the most troubling and constitutionally suspect component of this expansive legislation. Such a federal dictate is clearly unprecedented. Congress’ own budget arm, the Congressional Budget Office, has stated that a “mandate requiring all individuals to purchase health insurance *would be an unprecedented form of federal action; [t]he government has never required people to buy any good or service as a condition of lawful residence in the United States.*” Nevertheless, in the “findings” section of the Act, Congress attempts to make the case that it has the authority to require an individual mandate pursuant to its powers under the Commerce Clause of the U.S. Constitution.

While it is certainly correct that modern Supreme Court jurisprudence has greatly expanded the scope of congressional power under the Commerce Clause, it is also true that no court – and certainly not the Supreme Court – has ever authorized federal action similar to the individual mandate based on Congress’ Commerce Clause authority or any other enumerated power in the Constitution. Moreover, while acknowledging Congress’ expansive Commerce Clause powers, recent Supreme Court cases have also emphasized the need for limits to such powers. Without such discernable limits, Congress’ Commerce Clause powers could end up nullifying and making irrelevant other fundamental components of

the U.S. constitutional structure, particularly states' rights, federalism, and the individual liberty interests of the American people.

Given the unprecedented scope of the Act's individual mandate and Supreme Court jurisprudence recently emphasizing limits to Congress' Commerce Clause powers, we believe that the Supreme Court could find that the individual mandate is beyond the scope of Congress' Commerce Clause powers.

We also believe that it is not in Alaska's interest to acquiesce to the significant expansion of the federal government's power as embodied in the Act's individual mandate. History has shown that our state's interests, perhaps uniquely among states in the Union, are negatively affected by growing federal power that often disregards, or is inimical to, what is in the public interest of Alaska and our citizens. Whether one agrees with the need for comprehensive health care reform or not, such reform is not in Alaska's public interest if it is accomplished in a manner that allows for a constitutional shortcut that dramatically expands the reach of the federal government's powers at the expense of states' rights, constitutional limits on Congress, and the liberty interests of our citizens. We therefore recommend that Alaska join 20 other states in challenging the constitutionality of the Act on the grounds that the Commerce Clause and Tenth Amendment of the U.S. Constitution do not authorize the Act's unprecedented individual mandate requirement.

In defending its authority to enact the Act's individual mandate, the federal government will likely claim that even if Congress does not have the authority for such a mandate under its Commerce Clause powers, it nevertheless has the authority pursuant to the Constitution's Tax and Spending Clause because the individual mandate entails a tax penalty. Supreme Court jurisprudence on this issue has shifted over the years with two somewhat conflicting lines of precedent. The first is an extremely broad reading of Congress' tax and spending powers that generally has upheld most congressional tax enactments as constitutional if they raise revenue. But another line of Supreme Court cases has held that Congress cannot resort to its taxing power to effectuate an end which otherwise is not within the scope of its other enumerated powers under Article I of the U.S. Constitution. These differing lines of Supreme Court precedent have never been reconciled. Thus, it is not clear how the Supreme Court would rule on the issue of whether Congress has the authority under its taxing power to enact the individual mandate even if it lacks such authority under the Commerce Clause.

Our analysis with regard to certain other claims challenging the constitutionality of the Act has resulted in similar uncertain conclusions. For example, there is a colorable claim that the individual mandate's tax penalty is a "direct tax." Under Article I, § 9, direct taxes must be apportioned, and because

the individual mandate's tax penalty is not apportioned, it may be an invalid exercise of Congress' taxing authority. A claim can also be made that the Medicaid mandate exceeds Congress' power under Article I and violates the Tenth Amendment of the U.S. Constitution. However, Supreme Court jurisprudence on such issues is sparse, as is detailed factual information regarding such claims, which makes it very difficult to have definitive conclusions about the merits of such claims.

On the other hand, there have been a number of other claims challenging the constitutionality of the Act, such that various provisions violate Due Process, Privileges and Immunities, Equal Protection, and the First Amendment. We have examined many of these claims and find that in general they would be unlikely to succeed.

## **I. OVERVIEW OF THE HEALTH CARE BILL**

The Patient Protection and Affordable Care Act was passed by the U.S. Congress on March 21, 2010, and signed by the President on March 23, 2010, and the Health Care and Education Affordability Reconciliation Act of 2010 was passed by the U.S. Congress on March 25, 2010, and signed by the President on March 30, 2010.<sup>1</sup> This legislation, referred to as "the Act" in this memorandum, is an enormous and complex piece of federal legislation that consists of over 2,200 pages and imposes hundreds of new requirements on states, businesses, health care providers, non-profit entities, and individuals. The following provisions are the most relevant with regard to an analysis of the constitutionality of this federal legislation.<sup>2</sup>

### **A. The Individual and Employer Mandates**

The Act contains an "individual mandate" that requires uninsured Americans to purchase health insurance if they do not fall within one of the individual mandate's exceptions. The Act expressly requires U.S. citizens and

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<sup>1</sup> The Patient Protection and Affordable Care Act (H.R. 3590, as amended in the Senate (Dec. 24, 2009)) ("H.R. 3590") and the Health Care and Education Affordability Reconciliation Act of 2010 (amendment in the nature of a substitute to H.R. 4872).

<sup>2</sup> Other agencies within Alaska's state government are reviewing how to implement the Act, as well as the numerous implications that the Act will have on the state.

legal residents to have “qualifying” health coverage beginning in 2014.<sup>3</sup> Individuals without qualifying coverage, i.e., those who refuse to purchase a government-approved health insurance plan, will have to pay a tax penalty of \$695 per year or 2.5% of income, whichever is higher, beginning in 2016.<sup>4</sup> The penalty will be a lower amount in 2014 and 2015 because Congress has phased-in the penalty provisions.<sup>5</sup>

Exemptions to the mandate will be granted: (1) for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, and incarcerated individuals; (2) if the lowest cost government-approved plan option available exceeds eight percent of an individual’s income; and (3) if an individual’s income is below the Commerce Department’s poverty level.<sup>6</sup> The Act expressly provides that failure to pay the penalty cannot result in criminal liability.<sup>7</sup>

Similarly, the Act contains a mandate for employers, which is titled “Shared Responsibility for Employers.”<sup>8</sup> This provision takes effect on January 1, 2014. Under the Act, employers with over 200 full-time employees must automatically enroll new employees in a government approved plan.<sup>9</sup> Additionally, companies with 50 or more employees, at least one of whom is entitled to the federal subsidy for health insurance premium payments, must offer

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<sup>3</sup> H.R. 3590, §§ 5000A(a)(c)-(e) (2009). The Act provides for subsidies that attempt to make mandatory coverage affordable for all eligible persons. H.R. 3590 § 5000A(e).

<sup>4</sup> H.R. 3590, § 5000A(c). Individuals who fail to maintain minimum essential coverage will be subject to a penalty equal to the greater of: (1) 2.5% of household income in excess of the taxpayer’s household income (with a maximum of \$2,085 for a family); or (2) \$695 per uninsured adult in the household.

<sup>5</sup> H.R. 3590, § 5000A(c)(3)(B). In 2014, the penalty will be the greater of 1% of household income over the filing threshold or \$95. In 2015, it will be the greater 2% of household income over the filing threshold or \$325. Beginning in 2016, it will be the greater of 2.5% or \$695.

<sup>6</sup> H.R. 3590, § 5000A(e).

<sup>7</sup> H.R. 3590, § 5000A(g)(2)(A) (“WAIVER OF CRIMINAL PENALTIES – In the case of any failure by a taxpayer to timely pay any penalty imposed by this section, such taxpayer shall not be subject to any criminal prosecution or penalty with respect to such failure.”).

<sup>8</sup> H.R. 3590, § 1513.

<sup>9</sup> H.R. 3590, § 1511.

health insurance benefits or face a financial penalty of \$2000 per employee.<sup>10</sup> Companies with fewer than 50 workers would be exempt from the per-employee penalty. These employers could be eligible to receive tax incentives and credits for offering health care coverage.<sup>11</sup>

This mandate will also apply to state and local governments.

## **B. Required Health Benefit Policy Terms**

The Act also imposes new requirements on the terms of health insurance policies under which U.S. citizens and businesses will be covered. Under the Act, insurers may not, among other things: (1) establish lifetime limits on the dollar value of benefits or annual limits on the dollar value of benefits (effective 2014);<sup>12</sup> (2) rescind a policy, except in the event of fraud or misrepresentation by the insured;<sup>13</sup> or (3) exclude an individual from coverage due to that individual's pre-existing condition.<sup>14</sup>

Additionally, insurers must: (1) provide coverage for childhood immunizations, breast cancer screenings, and other preventative health care practices;<sup>15</sup> (2) allow a parent to carry an adult child on his or her policy until the child reaches the age of 26;<sup>16</sup> and (3) allow the insured to renew his or her policy, if the insurer continues to offer that type of policy.<sup>17</sup>

All insurers must provide individuals a standardized summary of benefits and coverage explanation that complies with regulations to be developed by the Secretary of Health and Human Services.<sup>18</sup> All insurers must also provide a

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<sup>10</sup> H.R. 4872, § 1003(a).

<sup>11</sup> H.R. 3590, § 1513. The Reconciliation Act lessened the amount of this penalty by subtracting 30 from the number of employees for the purpose of calculating the per-employee penalty. H.R. 4872, § 1003(a).

<sup>12</sup> H.R. 3590, § 2711.

<sup>13</sup> H.R. 3590, § 2712.

<sup>14</sup> H.R. 3590, § 2704.

<sup>15</sup> H.R. 3590, § 2713.

<sup>16</sup> H.R. 3590, § 2714.

<sup>17</sup> H.R. 3590, § 2703.

<sup>18</sup> H.R. 3590, § 2715.

standardized process for coverage determinations and claims that provides certain procedural protections for the insured.<sup>19</sup>

### **C. Expansion of Coverage for Lower-Income Individuals and Families**

The Act expands Medicaid eligibility for low-income individuals. Beginning in January 2014, all children, parents, and childless adults who are not presently entitled to Medicaid and whose family incomes are at or below 133% of the federal poverty line will become eligible for Medicaid.<sup>20</sup> The federal government will fund 100% of the additional cost of providing care for newly-covered individuals between January 1, 2014, and December 31, 2016, and it will pay a decreasing percentage of the additional cost in subsequent years.<sup>21</sup> As these federal Medicaid payments decline, states will likely have to pick up these additional expenses.

The Act also provides for a tax credit to those lower-income individuals and families who do not qualify for Medicaid to assist in paying the cost of health insurance premiums. This “premium assistance credit” is calculated on a sliding scale – the lower a person or family’s income, the higher the tax credit.<sup>22</sup> Additionally, the Act reduces the maximum out-of-pocket costs that may be paid by lower-income individuals, as compared to the standard ceiling for out-of-pocket costs.<sup>23</sup>

### **D. The Health Benefit Exchange Provision**

The Act’s exchange provision requires each state to establish an “American Health Benefit Exchange” no later than January 1, 2014.<sup>24</sup> The health benefit exchanges are designed to allow individuals and small businesses to access and compare health insurance policies through a centralized clearinghouse. The exchanges must facilitate the purchase of federal qualifying health plans, provide for the establishment of a “Small Business Health Options Program,” and meet

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<sup>19</sup> H.R. 3590, § 2719.

<sup>20</sup> H.R. 3590, § 2001(a)(1).

<sup>21</sup> H.R. 3590, § 2001(a)(3).

<sup>22</sup> H.R. 3590, § 1401.

<sup>23</sup> H.R. 3590, § 1402.

<sup>24</sup> H.R. 3590, § 1311(b)(1).

other requirements described in the Act.<sup>25</sup> To qualify for listing on the exchange, a health benefit plan must abide by regulations, to be established by the Secretary of Health and Human Services, governing marketing, enrollment, presentation of benefits in a standard format, and other matters.<sup>26</sup> The Act authorizes grants of money to the states for activities related to the establishment of the health benefit exchange.<sup>27</sup>

If a state fails to establish a health benefit exchange, the Act requires the Secretary of Health and Human Services to establish and operate an exchange within that state. The Secretary will do so if: (1) the state does not elect to apply standards that the Secretary adopts by regulation for establishing and operating exchanges, or (2) the Secretary determines by January 1, 2013, that the state will not have an operational exchange by January 1, 2014, or that the state has not taken actions necessary to implement related requirements.<sup>28</sup>

#### **E. The Disaster Provision**

The Act's disaster provision adjusts the federal medical assistance percentage for Medicaid funding to states suffering major, statewide disasters. The provision applies only if, at any time during the preceding seven fiscal years, the President declared a major disaster in that state and determined that, because of the disaster, every county or parish in the state qualified for public assistance from the federal government.<sup>29</sup> Other conditions also apply.<sup>30</sup>

## **II. FOUNDATIONAL PRINCIPLES OF THE U.S. CONSTITUTION**

### **A. Horizontal and Vertical Separation of Powers**

In analyzing the constitutionality of the Act, it is critical to keep in mind as a legal touchstone the fundamental structural principles of the U.S. Constitution as they relate to the American system of government. More specifically, to ensure that no single government entity wields too much power, the Framers of the U.S. Constitution created vertical and horizontal separations of power. The vertical separation is between the federal and state governments and their respective

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<sup>25</sup> H.R. 3590, § 1311(b)(1).

<sup>26</sup> H.R. 3590, § 1311(c).

<sup>27</sup> H.R. 3590, § 1311(a)(1)-(3).

<sup>28</sup> H.R. 3590, § 1321(c).

<sup>29</sup> H.R. 3590, § 2006.

<sup>30</sup> H.R. 3590, § 2006.

powers. The horizontal separation consists of the division of authority and limited powers among the three branches of the federal government. These structural principles, which are fundamental components of the U.S. Constitution, were adopted by the Framers to ensure the protection of the liberty interests of the American people.<sup>31</sup>

As James Madison wrote: “In the compound republic of America, the power surrendered by the people is first divided between two distinct governments, and then the portion allotted to each subdivided among distinct and separate departments. Hence a double security arises to the rights of the people. The different governments will control each other, at the same time that each will be controlled by itself.”<sup>32</sup> And more recently the Supreme Court stated, “Just as the separation and independence of the coordinate branches of the Federal Government serve to prevent the accumulation of excessive power in any one branch, a healthy balance of power between the States and the Federal Government will reduce the risk of tyranny and abuse from either front.”<sup>33</sup>

## **B. Congress’ Limited Enumerated Powers**

One critical mechanism that the Framers devised to keep the federal government in check was to provide Congress with enumerated powers. Article I, § 1, of the U.S. Constitution provides Congress only with the “legislative powers herein granted[.]” Article I, § 8, lists Congress’ legislative powers. To effectuate this limited grant of authority, this section of the Constitution states that Congress may “make all laws which shall be necessary and proper for carrying into execution the *foregoing powers*[.]”<sup>34</sup> Put simply: “The powers delegated by the proposed Constitution to the federal government are few and defined.”<sup>35</sup>

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<sup>31</sup> *Gregory v. Ashcroft*, 501 U.S. 452, 458 (1991) (“This federalist structure of joint sovereigns preserves to the people numerous advantages. It assures a decentralized government that will be more sensitive to the diverse needs of a heterogeneous society; it increases opportunity for citizen involvement in democratic processes; it allows for more innovation and experimentation in government; and it makes government more responsive by putting the States in competition for a mobile citizenry. . . . The constitutionally mandated balance of power between the States and the Federal Government was adopted by the Framers to ensure the protection of our fundamental liberties.”).

<sup>32</sup> The Federalist No. 51.

<sup>33</sup> *Gregory*, 501 U.S. at 458.

<sup>34</sup> Art. I, § 8, cl. 18 (emphasis added) (the “Necessary and Proper Clause”).

<sup>35</sup> The Federalist No. 45 (J. Madison).

In one of our country's most important Supreme Court decisions, *Marbury v. Madison*, Chief Justice Marshall enshrined this bedrock principle: "The powers of the legislature are defined and limited; and those limits may not be mistaken or forgotten."<sup>36</sup> More recently, the Supreme Court succinctly observed that "[e]very law enacted by Congress must be based in one or more of its powers enumerated in the Constitution."<sup>37</sup>

The foundational principle that Congress has limited power is supplemented, and in some ways held in tension with another well-accepted principle: Congress has broad implied powers.<sup>38</sup> Indeed, "[a] government ought to contain in itself every power requisite to the full accomplishment of the objects committed to its care, and to the complete execution of the trusts for which it is responsible; free from every other control, but a regard to the public good and to the sense of the people."<sup>39</sup> This proposition was endorsed by the Supreme Court nearly 200 years ago and has been accepted ever since.<sup>40</sup>

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<sup>36</sup> *Marbury v. Madison*, 5 U.S. (1 Cranch) 137, 176 (1803).

<sup>37</sup> *United States v. Morrison*, 529 U.S. 598, 607 (2000).

<sup>38</sup> The tension between Congress' "enumerated powers" and "implied powers" has led to disputes since President Washington's first administration, when some leaders wanted Congress to charter a bank. Critics countered that nothing in the Constitution authorizes Congress to form a bank. To resolve this debate, President Washington asked his cabinet whether the authority to form a bank could be inferred from the powers that are enumerated in the Constitution. Thomas Jefferson said "no." Alexander Hamilton disagreed; he explained that in order to carry out the powers it was expressly granted, Congress must have implied powers. President Washington sided with Hamilton. And the Supreme Court, when it eventually heard this dispute many years later, vindicated President Washington's decision. See Laurence H. Tribe, *American Constitutional Law* § 5-3 at 799 (3d ed. 2000) (citing *McCulloch v. Maryland*, 17 U.S. 317 (1819)).

<sup>39</sup> The Federalist No. 31 (A. Hamilton).

<sup>40</sup> See *McCulloch v. Maryland*, 17 U.S. 316, 421 (1819) ("We admit, as all must admit, that the powers of the government are limited, and that its limits are not to be transcended. But we think the sound construction of the constitution must allow to the national legislature that discretion, with respect to the means by which the powers it confers are to be carried into execution, which will enable that body to perform the high duties assigned to it, in the manner most beneficial to the people. Let the end be legitimate, let it be within the scope of the constitution, and all means which are appropriate, which are plainly adapted to that end, which are not prohibited, but consist with the letter and spirit of the constitution, are

Throughout our nation's history the Supreme Court has balanced these competing principles, and, as will be discussed in more detail below, has struck down laws when Congress' actions exceed its enumerated and implied powers. Any analysis of the constitutionality of the more-than 2,200 page Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act must keep in mind, and use as a touchstone, these fundamental principles of our Constitution.

### III. OVERVIEW OF THE INDIVIDUAL MANDATE

#### A. "An Unprecedented Form of Federal Action"

The individual mandate, or the "individual responsibility requirement" as it is referred to in the Act, requires uninsured individuals to obtain a government-approved minimal level of health insurance or face a tax penalty.<sup>41</sup> It is undisputed that Congress has never before imposed anything like the individual mandate on American citizens.

Indeed, Congress' own budget and research arms acknowledged just how unprecedented this mandate is. In evaluating the individual mandate, the Congressional Budget Office stated:

*A mandate requiring all individuals to purchase health insurance would be an unprecedented form of federal action. The government has never required people to buy any good or service as a condition of lawful residence in the United States. An individual mandate would have two features that, in combination, would make it unique. First, it would impose a duty on individuals as members of society. Second, it would require people to purchase a specific service that would be heavily regulated by the federal government.*<sup>42</sup>

More recently, the Congressional Research Service stated that "[w]hether such a requirement would be constitutional under the Commerce Clause is perhaps the most challenging question posed by such a proposal, as it is a novel issue whether

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constitutional."); *see generally* Laurence H. Tribe, *American Constitutional Law* § 5-3 at 799 (3d ed. 2000).

<sup>41</sup> H.R. 3590, § 5000A.

<sup>42</sup> Congressional Budget Office, *The Budgetary Treatment of an Individual Mandate to Buy Health Insurance* (1994) (emphasis added); available at <http://www.cbo.gov/ftpdocs/48xx/doc4816/doc38.pdf>.

Congress may use this clause to require an individual to purchase a good or a service.”<sup>43</sup>

**B. Congress Relies on Its Commerce Clause and Tax and Spending Clause Authority to Impose the Individual Mandate**

To justify the constitutionality of imposing an individual mandate on qualifying American citizens who lack health insurance, the federal government will argue that the mandate is authorized by the U.S. Constitution’s Commerce Clause. Indeed, in the Act’s “findings” section, Congress expressly attempts to make the case that it has the authority to enact the individual mandate pursuant to its Commerce Clause powers. This section states that the individual mandate “is commercial and economic in nature, and substantially affects interstate commerce[.]”<sup>44</sup> As explained in more detail below, this is the criteria that Congress must satisfy to justify acting under the Commerce Clause.

The findings section then goes into significant detail about how health care and health insurance affect the nation’s economy.<sup>45</sup> To bolster this finding that the

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<sup>43</sup> Congressional Research Service, *Requiring Individuals to Obtain Health Insurance: A Constitutional Analysis* 3 (2009), available at [http://assets.opencrs.com/rpts/R40725\\_20090724.pdf](http://assets.opencrs.com/rpts/R40725_20090724.pdf).

<sup>44</sup> H.R. 3590 § 5000A.

<sup>45</sup> See H.R. 3590 § 1501(a)(2), which provides: (A) The requirement regulates activity that is commercial and economic in nature: economic and financial decisions about how and when health care is paid for, and when health insurance is purchased.

(B) Health insurance and health care services are a significant part of the national economy. National health spending is projected to increase from \$2,500,000,000,000, or 17.6 percent of the economy, in 2009 to \$4,700,000,000,000 in 2019. Private health insurance spending is projected to be \$854,000,000,000 in 2009, and pays for medical supplies, drugs, and equipment that are shipped in interstate commerce. Since most health insurance is sold by national or regional health insurance companies, health insurance is sold in interstate commerce and claims payments flow through interstate commerce.

(C) The requirement, together with the other provisions of this Act, will add millions of new consumers to the health insurance market, increasing the supply of, and demand for, health care services. According to the Congressional Budget Office, the requirement will increase the number and share of Americans who are insured.

(D) The requirement achieves near-universal coverage by building upon and strengthening the private employer-based health insurance system, which covers

individual mandate affects commerce, Congress also cites *United States v. South-Eastern Underwriters Association*, 322 U.S. 533 (1944), where the Supreme Court “ruled that insurance is interstate commerce subject to Federal regulation.”<sup>46</sup>

The federal government will also likely argue that the individual mandate is authorized by Congress’ taxing power under the U.S. Constitution’s Tax and Spending Clause. The individual mandate provision is codified in section 5000A of the Internal Revenue Code. The provision will be enforced by the IRS and imposes a tax penalty on qualifying individuals who decide not to purchase federally approved health insurance.

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176,000,000 Americans nationwide. In Massachusetts, a similar requirement has strengthened private employer-based coverage: despite the economic downturn, the number of workers offered employer-based coverage has actually increased.

(E) Half of all personal bankruptcies are caused in part by medical expenses. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will improve financial security for families.

(F) Under the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.), the Public Health Service Act (42 U.S.C. 201 et seq.), and this Act, the Federal Government has a significant role in regulating health insurance which is in interstate commerce.

(G) Under sections 2704 and 2705 of the Public Health Service Act (as added by section 1201 of this Act), if there were no requirement, many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement, together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.

(H) Administrative costs for private health insurance, which were \$90,000,000,000 in 2006, are 26 to 30 percent of premiums in the current individual and small group STAT.244markets. By significantly increasing health insurance coverage and the size of purchasing pools, which will increase economies of scale, the requirement, together with the other provisions of this Act, will significantly reduce administrative costs and lower health insurance premiums. The requirement is essential to creating effective health insurance markets that do not require underwriting and eliminate its associated administrative costs.

<sup>46</sup> H.R. 3590 § 1501(a)(3).

This memorandum will principally focus on whether Congress possesses the power to impose the individual mandate under the Commerce Clause and the Tax and Spending Clause of the U.S. Constitution.

#### **IV. DOES THE INDIVIDUAL MANDATE VIOLATE THE COMMERCE CLAUSE?**

##### **A. An Overview of the Supreme Court's Early Commerce Clause Jurisprudence**

Under the U.S. Constitution's Commerce Clause, Congress has the power "[t]o regulate Commerce with foreign Nations, and among the several States."<sup>47</sup> Congress has corresponding authority under the Necessary and Proper Clause to pass legislation that constitutes a reasonable means to effectuate the regulation of interstate commerce.<sup>48</sup>

The Supreme Court's "understanding of the reach of the Commerce Clause, as well as Congress' assertion of authority thereunder, has evolved over time."<sup>49</sup> For this reason, any analysis of the Commerce Clause will benefit from a review of the Supreme Court's landmark 1995 *United States v. Lopez* decision where the Court discusses in detail the development of its Commerce Clause jurisprudence.

The *Lopez* Court begins by explaining that the Supreme Court first defined the nature of Congress' commerce power in *Gibbons v. Ogden*, 22 U.S. (9 Wheat) 1, 189-190 (1824):

Commerce, undoubtedly, is traffic, but it is something more: it is intercourse. It describes the commercial intercourse between nations, and parts of nations, in all its branches, and is regulated by prescribing rules for carrying on that intercourse.<sup>50</sup>

Chief Justice Marshall elaborated that the commerce power "is the power to regulate; that is, to prescribe the rule by which commerce is to be governed. This power, like all others vested in congress, is complete in itself, may be exercised to

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<sup>47</sup> Art. I, § 8, cl. 3.

<sup>48</sup> Art. I, § 8, cl. 18; see *McCulloch v. Maryland*, 17 U.S. at 421-422.

<sup>49</sup> *Gonzales v. Raich*, 545 U.S. 1, 15-16 (2005).

<sup>50</sup> *United States v. Lopez*, 514 U.S. 549, 553 (1995) (quoting *Gibbons*, 9 Wheat at 189-190).

its utmost extent, and acknowledges no limitations, other than are prescribed in the constitution.”<sup>51</sup>

The *Gibbons* Court went on to acknowledge at least one important limitation on Congress’ Commerce Clause power: “It is not intended to say that these words comprehend that commerce, which is completely internal, which is carried on between man and man in a State, or between different parts of the same State, and which does not extend to or affect other States. Such a power would be inconvenient, and is certainly unnecessary. . . . The enumeration presupposes something not enumerated; and that something, if we regard the language, or the subject of the sentence, must be the exclusively internal commerce of a State.”<sup>52</sup>

As *Lopez* notes, for over sixty years thereafter, “the Court’s Commerce Clause decisions dealt but rarely with the extent of Congress’ power, and almost entirely with the Commerce Clause as a limit on state legislation that discriminated against interstate commerce.”<sup>53</sup>

Beginning in the late 19th century, because of a significant increase in industrialization, Congress began to rely on the Commerce Clause to regulate national economic activities. For example, in 1887, Congress enacted the Interstate Commerce Act, and, in 1890, Congress enacted the Sherman Antitrust Act.<sup>54</sup> “These laws ushered in a new era of federal regulation under the commerce power. When cases involving these laws first reached this Court, we imported from our negative Commerce Clause cases the approach that Congress could not regulate activities such as ‘production,’ ‘manufacturing,’ and ‘mining.’”<sup>55</sup> Under this more restrained theory of the Commerce Clause, the Supreme Court was active and struck down federal legislation.<sup>56</sup>

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<sup>51</sup> *Lopez*, 514 U.S. at 553.

<sup>52</sup> *Id.* at 553 (quoting *Gibbons*, 9 Wheat at 194-195).

<sup>53</sup> *Id.* at 553-554 (collecting cases).

<sup>54</sup> *Id.* at 554.

<sup>55</sup> *Id.* (citing *United States v. E.C. Knight Co.*, 156 U.S. 1, 12 (1895) (“Commerce succeeds to manufacture, and is not part of it”) and *Carter v. Carter Coal Co.*, 298 U.S. 238, 304 (1936) (“Mining brings the subject matter of commerce into existence. Commerce disposes of it”)).

<sup>56</sup> *Id.* at 554 (citing *A.L.A. Schechter Poultry Corp. v. United States*, 295 U.S. 495, 851-852 (1935) (striking down regulations that fixed the hours and wages of individuals employed by an intrastate business because the activity being regulated related to interstate commerce only indirectly)).

During the New Deal, however, a sea change in the Supreme Court's jurisprudence occurred. "In *NLRB v. Jones & Laughlin Steel Corp.*, 301 U.S. 1, 57 (1937), the Court upheld the National Labor Relations Act against a Commerce Clause challenge, and in the process, departed from the distinction between 'direct' and 'indirect' effects on interstate commerce."<sup>57</sup> The Court specifically held that intrastate activities that "have such a close and substantial relation to interstate commerce that their control is essential or appropriate to protect that commerce from burdens and obstructions" are within Congress' power to regulate.<sup>58</sup>

## **B. The Expansion of Congressional Authority Under Modern Commerce Clause Jurisprudence**

Thus, in 1937, the Supreme Court departed from its restrained 19th century precedents and significantly expanded Congress' authority under the Commerce Clause. The Supreme Court announced: "The power to regulate commerce is the power to enact 'all appropriate legislation' for 'its protection and advancement.'"<sup>59</sup> The Supreme Court added, "[t]he power of Congress over interstate commerce is not confined to the regulation of commerce among the states. It extends to those activities intrastate which so affect interstate commerce or the exercise of the power of Congress over [commerce] as to make regulation of [these activities] appropriate[.]"<sup>60</sup>

In one of its most expansive readings of the Commerce Clause to date, the Supreme Court, in *Wickard v. Filburn*, upheld the application of regulations promulgated under the Agricultural Adjustment Act, which were designed to control the volume of wheat moving in interstate and foreign commerce in order to avoid surpluses and abnormally low wheat prices.<sup>61</sup> In challenging the Act, Filburn, a farmer, argued that Congress' power to regulate commerce did not authorize it to regulate wheat production that was "wholly for consumption on the farm."<sup>62</sup> The Supreme Court, in a unanimous opinion, rejected this argument.<sup>63</sup>

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<sup>57</sup> *Lopez*, 514 U.S. at 555.

<sup>58</sup> *Id.* (quoting *Jones & Laughlin Steel Corp.* 301 U.S. at 37).

<sup>59</sup> *Jones & Laughlin Steel Corp.*, 301 U.S. at 36-37 (quoting *The Daniel Ball*, 77 U.S. (10 Wall.) 557, 564 (1870)).

<sup>60</sup> *United States v. Darby*, 312 U.S. 100, 118 (1941) (holding that Congress has the authority to establish a federal minimum wage).

<sup>61</sup> 317 U.S. 111 (1942).

<sup>62</sup> *Wickard*, 317 U.S. at 118.

The *Lopez* Court explains why these decisions expanded Congress' authority over commerce:

*Jones & Laughlin Steel* and *Wickard* ushered in an era of Commerce Clause jurisprudence that greatly expanded the previously defined authority of Congress under that Clause. In part, this was a recognition of the great changes that had occurred in the way business was carried on in this country. Enterprises that had once been local or at most regional in nature had become national in scope. But the doctrinal change also reflected a view that earlier Commerce Clause cases artificially had constrained the authority of Congress to regulate interstate commerce.<sup>64</sup>

With this framework, Congress used its expanded Commerce Clause power to regulate many matters that were previously considered far outside the scope of the Commerce Clause.<sup>65</sup> For example, in the Civil Rights cases, motel and restaurant owners argued that the Civil Rights Act cannot be constitutional because it impairs their right to contract and infringes on their liberty interests to deny service to whomever they please.<sup>66</sup> The Supreme Court forcefully rejected

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<sup>63</sup> *Wickard*, 317 U.S. at 127-28 (“The effect of the statute before us is to restrict the amount which may be produced for market and the extent as well to which one may forestall resort to the market by producing to meet his own needs. That appellee’s own contribution to the demand for wheat may be trivial by itself is not enough to remove him from the scope of federal regulation where, as here, his contribution, taken together with that of many others similarly situated, is far from trivial.”).

<sup>64</sup> *Lopez*, 514 U.S. at 556.

<sup>65</sup> See, e.g., *Darby*, 312 U.S. at 118 (holding that Congress has the authority to establish a federal minimum wage and require employers to maintain records in order to ensure compliance with the new law); *United States v. Wrightwood Dairy Co.*, 315 U.S. 110, 119 (1942) (holding that the commerce power extends to the regulation of intrastate milk pricing); *Perez v. United States*, 402 U.S. 146 (1971) (holding that Congress has authority under the Commerce Clause to impose criminal penalties on intrastate extortionate credit transactions); *Hodel v. Va. Surface Mining & Reclamation Ass’n, Inc.*, 452 U.S. 264, 288 (1981) (holding that Congress could regulate intrastate surface coal mining).

<sup>66</sup> *Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241, 254-55 (1964), and *Katzenbach v. McClung*, 379 U.S. 294, 298 (1964) (holding that the Commerce Clause authorizes Congress to pass the Civil Rights Act, which banned

these claims because racial discrimination at motels and restaurants does impact commercial activity.<sup>67</sup>

More recently, in *Gonzales v. Raich*, the Supreme Court found that in the course of regulating the national illegal market in marijuana, Congress could forbid the local, noncommercial, production and consumption of medical marijuana. The *Raich* court explained that as part of a scheme to regulate narcotics it was “necessary and proper” for Congress to also regulate local non-economic behavior even when it did not cross state lines.<sup>68</sup> As Justice Scalia observed in his concurring opinion: “Where necessary to make a regulation of interstate commerce effective, Congress may regulate even those intrastate activities that do not themselves substantially affect interstate commerce.”<sup>69</sup>

### C. Modern Limits On Congress’ Commerce Clause Power

But this expansive interpretation of Congress’ Commerce Clause powers has not been without limits. In the landmark 1995 decision of *United States v. Lopez*, the Supreme Court, driven by renewed federalism concerns and a fear that Congress had virtually unlimited powers under the Commerce Clause, ruled, for the first time in decades, that Congress had exceeded its Commerce Clause power. More specifically, the *Lopez* Court struck down a federal law mandating a gun-free zone around public school campuses because it was “a criminal statute that by its terms has nothing to do with ‘commerce’ or any sort of economic enterprise, however broadly one might define those terms.”<sup>70</sup> The Supreme Court added that “[t]o uphold the Government’s contentions [that the Act was authorized by the Commerce Clause], we would have to pile inference upon inference in a manner that would . . . convert congressional authority under the Commerce Clause to a general police power of the sort retained by the States.”<sup>71</sup>

*Lopez* was not a rogue decision. Five years later, in *United States v. Morrison*, the Supreme Court invalidated as beyond Congress’ Commerce Clause powers the portion of the Violence Against Women Act that created civil liability

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motel and restaurant owners from discriminating against African-Americans, because discrimination in interstate travel affects interstate commerce).

<sup>67</sup> *Id.*

<sup>68</sup> 545 U.S. 1, 24 (2005) (quotations omitted).

<sup>69</sup> *Raich*, 545 U.S. at 34.

<sup>70</sup> *Lopez*, 514 U.S. at 561.

<sup>71</sup> *Id.* at 567.

for gender-based violent crimes.<sup>72</sup> The *Morrison* Court held: “We . . . reject the argument that Congress may regulate noneconomic, violent criminal conduct based solely on that conduct’s aggregate effect on interstate commerce. The Constitution requires a distinction between what is truly national and what is truly local. In recognizing this fact we preserve one of the few principles that has been consistent since the Clause was adopted. The regulation and punishment of intrastate violence that is not directed at the instrumentalities, channels, or goods involved in interstate commerce has always been the province of the States.”<sup>73</sup>

But perhaps most importantly, *Lopez* and *Morrison* emphasized the need for tangible and meaningful limits to Congress’ Commerce Clause powers.<sup>74</sup> The Supreme Court underscored “that even under our modern, expansive interpretation of the Commerce Clause, Congress’ regulatory authority is *not without effective bounds*.”<sup>75</sup> The Supreme Court also stated that the “scope of the interstate commerce power must be considered in the light of our dual system of government and may not be extended so as to embrace effects upon interstate commerce so indirect and remote that to embrace them, in view of our complex society, would effectually obliterate the distinction between what is national and what is local and create a completely centralized government.”<sup>76</sup>

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<sup>72</sup> 529 U.S. 598 (2000).

<sup>73</sup> *Morrison*, 529 U.S. at 617-618 (citations omitted).

<sup>74</sup> *Id.* at 615-616 (“Petitioners’ reasoning, moreover, will not limit Congress to regulating violence but may, as we suggested in *Lopez*, be applied equally as well to family law and other areas of traditional state regulation since the aggregate effect of marriage, divorce, and childrearing on the national economy is undoubtedly significant.”).

<sup>75</sup> *Id.* at 608 (emphasis added).

<sup>76</sup> *Id.* (quotations omitted). The Supreme Court went on to explain that if an Act of Congress does not regulate commercial activity, Congress has no authority under the Commerce Clause. *Id.* at 610 (citing *Lopez*, 514 U.S. at 567) (“The possession of a gun in a local school zone is in no sense an economic activity that might, through repetition elsewhere, substantially affect any sort of interstate commerce”). Thus, for an Act of Congress to withstand judicial scrutiny the persons being regulated, or their conduct, “must have a commercial character, and the purposes or the design of the statute must have an evident commercial nexus.” *Id.* at 611.

**D. Does Congress Have Authority Under the Commerce Clause to Impose the Individual Mandate?**

Based on the foregoing, the Supreme Court has identified three broad categories of activity that Congress may regulate under its commerce power. First, Congress may regulate the use of the channels of interstate commerce. Second, Congress is empowered to regulate and protect the instrumentalities of interstate commerce, or persons or things in interstate commerce. And third, Congress' commerce authority includes the power to regulate activities that "substantially affect" interstate commerce.<sup>77</sup>

The focus here will be on the third category, the "substantially affects" test, because health insurance reform and the individual mandate have nothing to do with the channels or instrumentalities of interstate commerce.

To evaluate whether an activity that is not in interstate commerce is authorized under the "substantially affects" test, the relevant questions are: (1) whether Congress had a rational basis for finding that activity being regulated affects interstate commerce, and (2) if it had such a basis, whether the means it selected to regulate the activity are reasonable and appropriate.<sup>78</sup>

We therefore need to examine whether health insurance substantially affects interstate commerce and, if it does, whether the individual mandate is a reasonable and appropriate means to regulate this market. As Justice Scalia explained, when an Act of Congress regulates interstate commerce, Congress also has the authority under the Necessary and Proper Clause to regulate local non-economic activities if the regulation of the local non-economic activity "is a necessary part of a more general regulation of interstate commerce. [In this

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<sup>77</sup> *Raich*, 545 U.S. at 16-17.

<sup>78</sup> *Heart of Atlanta Motel, Inc.*, 379 U.S. at 258; *see also Raich*, 545 U.S. at 18, 24 (explaining if an Act or comprehensive statutory scheme regulates interstate commerce then Congress can also regulate non-economic activities if the specific provision is necessary to effectively regulate the interstate market); *Lopez*, 514 U.S. at 561 (noting that Congress can regulate non-economic conduct if it is an "essential part of a larger regulation of economic activity, in which the regulatory scheme could be undercut unless the intrastate activity were regulated."); *Darby*, 312 U.S. at 121 (explaining legislation regulating local conduct will be sustained "when the means chosen, although not themselves within the granted power, [are] nevertheless deemed appropriate aids to the accomplishment of some purpose within an admitted power of the national government.").

context] the relevant question is simply whether the means chosen are ‘reasonably adapted to the attainment of a legitimate end under the commerce power.’<sup>79</sup>

(1) “Substantially Affect” Analysis

The first prong of this test requires an examination of whether the Act or, alternatively, the individual mandate, substantially affects interstate commerce. It is generally well accepted that health insurance is a financial product that is purchased by millions of businesses and individuals throughout the nation and thus deals with economic transactions and substantially affects interstate commerce.<sup>80</sup> Thus, as a preliminary matter, the Act falls within Congress’ power under the Commerce Clause.

In arguing that the individual mandate is constitutional, the federal government will also likely assert that Congress found that the existence of millions of uninsured Americans and the decision to not have insurance substantially affects the national health insurance market.<sup>81</sup> This finding is

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<sup>79</sup> *Raich*, 545 U.S. at 37 (Scalia, J., concurring); *accord Darby*, 312 U.S. at 122-125 (holding that Congress could require employers to maintain records in order to demonstrate compliance with a regulatory scheme because this non-commercial intrastate activity was “an appropriate means to a legitimate end” of regulating interstate commercial conduct).

<sup>80</sup> *See United States v. South-Eastern Underwriters Ass’n*, 322 U.S. 533, 540 (1944) (“Perhaps no modern commercial enterprise directly affects so many persons in all walks of life as does the insurance business. Insurance touches the home, the family, and the occupation or the business of almost every person in the United States.”).

<sup>81</sup> *See* H.R. 3590, § 1501(a)(2). The findings section first explains that the mandate requirement “regulates” commercial “activity,” i.e.: “economic and financial decisions about how and when health care is paid for, and when health insurance is purchased.” The findings section then links the mandate to the achievement of specific statutory goals. Paragraph 2(A), for example, specifies that without the mandate, “some individuals would make an economic and financial decision to forego health insurance coverage and attempt to self-insure, which increases risk to households and medical providers.” Paragraph 2(F) puts the cost of providing uncompensated care to the uninsured at \$43,000,000,000, which raises family premiums by \$1,000 per year. Paragraph 2(G) also notes that 62 percent of all personal bankruptcies are caused by medical expenses, and states that the requirement, by increasing health insurance coverage, will strengthen financial security for families. Paragraph 2(I) explains why and how the mandate

entitled to substantial deference.<sup>82</sup> Thus, based on Congress' findings, the federal government will contend that uninsured individuals affect interstate commerce.

(2) Did Congress Select "Reasonable and Appropriate" Means?

The second prong of the analysis requires us to examine whether the imposition of the individual mandate is reasonable and appropriate – i.e., whether the individual mandate is needed to effectuate health insurance reform and whether the means chosen by Congress are reasonably adapted to the end permitted by the Constitution: the regulation of interstate commerce.<sup>83</sup>

Under this theory, the federal government will likely assert that the mandate is "reasonable and appropriate" because it furthers Congress' goal of health care reform. More specifically, Congress found that covering more people is expected to reduce health care costs by addressing the free-rider and adverse selection problems.<sup>84</sup> The federal government will also contend that the individual mandate is "reasonable and appropriate" because without it keeping premium costs down would be difficult or impossible health insurance reform would likely unravel. Indeed, Congress essentially makes this claim in the Act's findings section.<sup>85</sup>

Thus, the federal government will very likely argue that Congress may regulate the decision to not purchase insurance, even if it is viewed as a

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will minimize "adverse selection" and "broaden the risk pool" to "lower health insurance premiums."

<sup>82</sup> See *Raich*, 545 U.S. at 22.

<sup>83</sup> *Raich*, 545 U.S. at 34-35 (Scalia, J., concurring) (collecting cases discussing the relationship between the Necessary and Proper Clause and the "substantially affects" analysis). Justice Scalia explains that "the category of activities that substantially affect interstate commerce is *incomplete* because the authority to enact laws necessary and proper for the regulation of interstate commerce is not limited to laws governing intrastate activities that substantially affect interstate commerce. Where necessary to make a regulation of interstate commerce effective, Congress may [also] regulate even those intrastate activities that do not themselves substantially affect interstate commerce." *Id.* at 35 (citations and quotations omitted).

<sup>84</sup> See H.R. 3590, § 1501(a)(2).

<sup>85</sup> See H.R. 3590, § 1501(a)(2) (finding that to defray the increased costs caused by expanding health benefits, Congress needed to expand the pool of people insured).

noneconomic local activity, because increasing the number of insured is a necessary part of a more general regulation of an interstate commercial activity: the health insurance market. And as the Supreme Court has stated, Congress may regulate local non-economic activity if it is “an essential part of a larger regulation of economic activity, in which the regulatory scheme could be undercut unless the intrastate activity were regulated.”<sup>86</sup>

### (3) Problems with the Federal Government’s Likely Arguments

There are, however, potential weaknesses with the foregoing arguments.

First, the Supreme Court has never authorized Congress to regulate the “inactivity” of American citizens. A critical distinction exists between the individual mandate and past efforts to regulate noncommercial activities: unlike the farmer in *Wickard*, a person without health insurance, or one who declines to purchase it, is not engaged in *any* activity. Indeed, all of the Supreme Court’s Commerce Clause cases are predicated on an individual or business engaged in some type of activity or conduct that impacts the economy – e.g., racial discrimination at restaurants and motels<sup>87</sup> or the consumption of home-grown wheat<sup>88</sup> or marijuana.<sup>89</sup> Congress’ individual mandate, on the other hand,

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<sup>86</sup> *Lopez*, 514 U.S. at 561; *see also Heart of Atlanta Motel, Inc.*, 379 U.S. at 272 (Black, J., concurring) (“since the *Shreveport Case* this Court has steadfastly followed, and indeed has emphasized time and time again, that Congress has ample power to protect interstate commerce from activities adversely and injuriously affecting it, which but for this adverse effect on interstate commerce would be beyond the power of Congress to regulate.”); *Wrightwood Dairy Co.*, 315 U.S. at 118-119 (“Congress plainly has power to regulate the price of milk distributed through the medium of interstate commerce, and it possesses every power needed to make that regulation effective. The commerce power is not confined in its exercise to the regulation of commerce among the states. . . . It is no answer to suggest, as does respondent, that the federal power to regulate intrastate transactions is limited to those who are engaged also in interstate commerce. The injury, and hence the power, does not depend upon the fortuitous circumstance that the particular person conducting the intrastate activities is, or is not, also engaged in interstate commerce.”). *But see Morrison*, 529 U.S. at 611 (“in those cases where we have sustained federal regulation of intrastate activity based upon the activity’s substantial effects on interstate commerce, the activity in question has been some sort of economic endeavor.”).

<sup>87</sup> *Heart of Atlanta Motel, Inc.*, 379 U.S. at 254-55.

<sup>88</sup> *Wickard*, 317 U.S. at 125.

presupposes power over Americans for literally doing nothing. The Congressional Budget Office also recognized this essential point when it expressed its own concerns about the individual mandate. “Federal mandates typically apply to people as parties to economic transactions, rather than as members of society.”<sup>90</sup>

Second, the Supreme Court has never held that Congress can require individuals who are not engaged in any activity to purchase something in the private market or face a penalty. Even the Congressional Research Service cautioned that it is a “challenging” and “novel” question whether Congress may use the Commerce Clause “to require an individual to purchase a good or service.”<sup>91</sup> The Commerce Clause provides Congress with the power to “regulate commerce . . . among the several states,” but this power does not extend to *requiring citizens* to engage in commerce.<sup>92</sup>

To allow this to happen would create powers in the federal government that are indistinguishable from general police powers,<sup>93</sup> which are reserved to the states, in derogation of our Constitution’s important limitations on federal legislative authority. The Supreme Court has specifically warned against such an expansive reading of the Commerce Clause. “The scope of the interstate commerce power must be considered in the light of our dual system of government and may not be extended so as to embrace effects upon interstate commerce so indirect and remote that to embrace them, in view of our complex

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<sup>89</sup> *Raich*, 545 U.S. at 22-24.

<sup>90</sup> Congressional Budget Office, *The Budgetary Treatment of an Individual Mandate to Buy Health Insurance* (1994) at 2, available at <http://www.cbo.gov/ftpdocs/48xx/doc4816/doc38.pdf>.

<sup>91</sup> Congressional Research Service, *Requiring Individuals to Obtain Health Insurance: A Constitutional Analysis* at 3 (2009), available at [http://assets.opencrs.com/rpts/R40725\\_20090724.pdf](http://assets.opencrs.com/rpts/R40725_20090724.pdf).

<sup>92</sup> U.S. Const. Art. I, § 8.

<sup>93</sup> Broadly speaking, the phrase “police power” describes “the residual prerogatives of sovereignty which the states had not surrendered to the federal government.” Laurence H. Tribe, *American Constitutional Law* § 6-4 at 1046 (3d ed. 2000); *see also The License Cases*, 46 U.S. 504, 584 (1847) (“the police powers of a state . . . are nothing more or less than the powers of government inherent in every sovereignty to the extent of its dominions”); *Day-Brite Lighting, Inc. v. Missouri*, 342 U.S. 421, 424 (1952) (“the police power is not confined to a narrow category; it extends . . . to all the great public needs.”). It is generally understood that Congress does not have broad “police powers” because its authority to act is limited by Article I’s enumerated powers.

society, would effectually obliterate the distinction between what is national and what is local and create a completely centralized government.”<sup>94</sup>

Third, to uphold the individual mandate a court would have to ignore the Supreme Court’s recent admonition in *Lopez* and *Morrison* that Congress does not have unlimited Commerce Clause power. As one leading commentator has written, the “focus of the [*Lopez*] Court’s analysis, and the basis for its holding, was a search for judicially cognizable limits to the increasingly amorphous and seemingly unbundled ‘substantive effects’ test that has developed [since 1937].”<sup>95</sup>

But if the individual mandate is upheld as constitutional, the concept of Commerce Clause limits would be rendered illusory, providing Congress with potential authority to regulate practically any sphere of American life.<sup>96</sup> For example, Congress can certainly regulate the car industry. Indeed, the federal government now owns a substantial stake in General Motors (GM). However, if the individual mandate is upheld under the Commerce Clause, could it then follow that Congress can require consumers shopping for vehicles to purchase a GM vehicle under threat of a tax surcharge in order for the federal government to more effectively manage GM? More on point, under the threat of a tax penalty, could Congress amend the Patient Protection and Affordable Care Act to require all Americans to purchase a federally-approved gym membership in order to lower obesity and blood pressure rates to reduce overall health care costs? If the Act’s individual mandate is held to be a viable exercise of Congress’ powers, the answer to these hypotheticals might well be yes.

(4) The Individual Mandate Should Be Beyond the Scope of Congress’ Commerce Clause Powers

In conclusion, while it is certainly correct that modern Supreme Court jurisprudence has greatly expanded the scope of congressional power under the Commerce Clause, it is also true that no court – and certainly not the Supreme Court – has ever authorized federal action similar to the individual mandate based on Congress’ Commerce Clause authority or any other enumerated power in the

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<sup>94</sup> *Lopez*, 514 U.S. at 557 (quotations omitted).

<sup>95</sup> See Laurence H. Tribe, *American Constitutional Law* § 5-4 at 817-18 (3d ed. 2000).

<sup>96</sup> Cf. *Morrison*, 529 U.S. at 615-616 (“Petitioners’ reasoning, moreover, will not limit Congress to regulating violence but may, as we suggested in *Lopez*, be applied equally as well to family law and other areas of traditional state regulation since the aggregate effect of marriage, divorce, and childrearing on the national economy is undoubtedly significant.”).

Constitution. Moreover, while acknowledging Congress' expansive Commerce Clause powers, recent Supreme Court cases have also emphasized the need for limits to such powers. Without such discernable limits, Congress' Commerce Clause powers could end up nullifying and making irrelevant other fundamental components of the U.S. constitutional structure, particularly states' rights, federalism, and the individual liberty interests of the American people.

Given the unprecedented scope of the Act's individual mandate and Supreme Court jurisprudence recently emphasizing limits to Congress' Commerce Clause powers, we believe that the Supreme Court could find that the individual mandate is beyond the scope of Congress' Commerce Clause powers.

### **E. The Individual Mandate and Alaska's Public Interest**

With regard to the individual mandate, it is not in Alaska's interest to acquiesce to such a significant expansion of the federal government's power. History has shown that our state's interests, perhaps uniquely among states in the Union, are negatively affected by growing federal power that often disregards, or is inimical to, the interest in the public interest of Alaska and our citizens.<sup>97</sup>

Whether one agrees with the need for comprehensive health care reform or not, such reform is not in Alaska's public interest if it is accomplished in a manner that allows for a constitutional shortcut that dramatically expands the reach of the federal government's powers at the expense of states' rights, constitutional limits on Congress, and the liberty interests of our citizens.<sup>98</sup>

Moreover, if the individual mandate is deemed a legitimate exercise of Congress' Commerce Clause powers then the critically important separation of powers and federalism framework of the U.S. Constitution, which is designed to "ensure liberty,"<sup>99</sup> will be further eroded at the expense of Alaska's and Alaskans' interests. Therefore, we recommend that this exercise of unprecedented congressional power be challenged in court on the grounds that the Commerce

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<sup>97</sup> For instance, over the last several decades the federal government has consistently hindered or stopped responsible resource development within our state's borders. The examples are too numerous to list, but they range from closing off ANWR to the recent denial of permits in the National Petroleum Reserve.

<sup>98</sup> Commentators have noted that there are many ways to undertake comprehensive health care reform that falls comfortably within Congress' enumerated powers.

<sup>99</sup> See *Gregory*, 501 U.S. at 458.

Clause of the U.S. Constitution does not authorize the Act's individual mandate requirement.

## V. DOES THE ACT VIOLATE CONGRESS' TAX POWER?

Although Congress is clearly basing its authority to institute an individual mandate on its Commerce Clause power, in defending the mandate from constitutional challenges, the federal government will also likely argue that Congress has the authority to require an individual mandate based on its taxing power. We therefore turn to the question of whether the taxing power under the U.S. Constitution authorizes Congress to enact the individual mandate.

### A. Overview of the Act's Tax Penalty Provision

The Act requires U.S. citizens and legal residents to purchase or maintain a minimum level of government-approved health insurance coverage.<sup>100</sup> Minimum essential coverage includes various government-sponsored programs, eligible employer-sponsored plans, plans available for purchase in the individual market, grandfathered group health plans, and other coverage as approved by the Secretary of Health and Human Services in coordination with the Secretary of the Treasury.<sup>101</sup>

As noted above, qualifying individuals who fail to maintain minimum essential coverage will be subject to a penalty equal to the greater of: (1) 2.5% of household income in excess of the taxpayer's household income (with a maximum of \$2,085 for a family); or (2) \$695 per uninsured adult in the household. The fee for an uninsured individual under age 18 is one-half of the adult fee.<sup>102</sup> The total household tax may not exceed 300 percent of the per-adult tax.<sup>103</sup> This provision is effective for tax years beginning after December 31, 2013, although the tax amount will be phased in beginning in 2014–2016 and will be indexed for inflation after 2016.<sup>104</sup> The use of liens and seizures as a means of enforcing this

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<sup>100</sup> H.R. 3590, §§ 5000A(b), (f).

<sup>101</sup> H.R. 3590, § 5000A(a). This requirement would not apply to everyone – e.g., it does not apply to individuals who cannot afford coverage, American Indians, Alaska Natives, or those who maintain religious objections. H.R. 3590 §§ 5000A(d), (e).

<sup>102</sup> H.R. 3590, § 5000A(c)(3)(C).

<sup>103</sup> H.R. 3590, § 5000A(c)(2).

<sup>104</sup> H.R. 3590, § 5000A(c)(3)(B).

tax is not authorized to enforce this tax, and noncompliance will not trigger criminal penalties.<sup>105</sup>

## B. Congress' Taxation Power

Under Article I, § 8, of the U.S. Constitution, Congress has the power “to lay and collect taxes, duties, imposts and excises, to pay the debts and provide for the common defense and general welfare of the United States.” Congress’ taxing power is broad. However, Supreme Court jurisprudence on this issue has shifted over the years. Relevant to the individual mandate analysis, there are two lines of precedent that the Supreme Court has followed with regard to “regulatory taxes.”

As an initial matter, there is no disputing that Congress has “especially broad latitude in creating classifications and distinctions in tax statutes.”<sup>106</sup> As Justice Rehnquist explained: “The passage of time has only served to underscore the wisdom of that recognition of the large area of discretion which is needed by a legislature in formulating sound tax policies. . . . It has, because of this, been pointed out that in taxation, even more than in other fields, legislatures possess the greatest freedom in classification. . . . the presumption of constitutionality can be overcome only by the most explicit demonstration that a classification is a hostile and oppressive discrimination against particular persons and classes.”<sup>107</sup>

Along these lines, the Supreme Court has generally held that if an enactment raises revenue (assuming the tax does not implicate the double jeopardy or excessive fines clauses<sup>108</sup>) then it is constitutional.<sup>109</sup> And since 1937, the

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<sup>105</sup> H.R. 3590, § 5000A(g)(2)(A).

<sup>106</sup> *Regan v. Taxation With Representation of Washington*, 461 U.S. 540, 547 (1983).

<sup>107</sup> *Id.* at 547.

<sup>108</sup> *See Dep't of Revenue, Mont. v. Kurth Ranch*, 511 U.S. 767 (1994) and *United States v. Bajakajian*, 524 U.S. 321 (1998); *see also Marchetti v. United States*, 390 U.S. 39, 44 (1968) (holding that a tax cannot violate the constitutional prohibition against self-incrimination).

<sup>109</sup> *See, e.g., Sonzinsky v. United States*, 300 U.S. 506, 513-14 (1937) (holding that a tax does not cease to be valid because it discourages or regulates conduct or even deters the activities being taxed); *United States v. Sanchez*, 340 U.S. 42, 44-45 (1952) (same); *see also Helvering v. Davis*, 301 U.S. 619, 640 (1937) (holding that Congress acts within its constitutional powers when it raises revenue through taxation and redistributes it to serve the general welfare).

Supreme Court has never invalidated a penalty as an unconstitutional regulatory tax.<sup>110</sup>

Indeed, under these broad readings of Congress' tax power, the Supreme Court has generally held that Congress can often do through the Tax and Spending Clause what it cannot do directly under other enumerated powers.<sup>111</sup> "From the beginning of our government, the courts have sustained taxes although imposed with the collateral intent of effecting ulterior ends which, considered apart, were beyond the constitutional power of the lawmakers to realize by legislation directly addressed to their accomplishment."<sup>112</sup> It is therefore well accepted that a tax statute does not "necessarily fall because it touches on activities which Congress might not otherwise regulate."<sup>113</sup>

Federal appellate courts have not shown any willingness to depart from these general principles that underscore Congress' broad taxing authority.<sup>114</sup>

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<sup>110</sup> Laurence H. Tribe, *American Constitutional Law* § 5-7 at 845-46 (3d ed. 2000).

<sup>111</sup> See, e.g., *United States v. Butler*, 297 U.S. 1, 65-66 (1936) (noting that power to tax is not limited by the direct grants of legislative power found in Art. I, § 8); *New York v. United States*, 505 U.S. 144, 156-57, 167-78 (1992) (upholding regulation of states through conditional spending while striking down regulations purportedly passed under the commerce power); see also *Kansas v. United States*, 214 F.3d at 1198-202 (noting that the Tenth Amendment and the Tax and Spending Clause "are essentially mirror images of each other: if the authority to act has been delegated by the Constitution to Congress, then it may act pursuant to Article I; if not, the power has been reserved to the states by the Tenth Amendment."); *Litman v. George Mason University*, 186 F.3d 544, 556-57 & n.1 (4th Cir. 1999) (noting that Congress' tax authority is not dependent on the other grants of power in Art. I, § 8).

<sup>112</sup> *Magnano Co. v. Hamilton*, 292 U.S. 40, 47 (1934).

<sup>113</sup> *Sanchez*, 340 U.S. at 44.

<sup>114</sup> See, e.g., *United States v. Grier*, 354 F.3d 210, 215 (3d Cir. 2003); *United States v. Thomson*, 361 F.3d 918, 921 (6th Cir. 2004) (rejecting argument that Congress unconstitutionally exercised its taxing power; "[h]aving required payment of a transfer tax and having required registration as an aid in collection of that tax, Congress under the taxing power may reasonably impose a penalty on possession of unregistered weapons . . . to discourage the transferor . . . from transferring the firearm without paying the tax"); *United States v. Lim*, 444 F.3d 910, 913 (7th Cir. 2006) (noting that courts will tolerate "overtly regulatory statutes so long as they have a plausible nexus to taxation"); *United States v. Hall*,

Nonetheless, such power is not without limits. In a second and related line of cases, the Supreme Court has ruled that Congress cannot impose a “tax” in order to penalize conduct that it could not regulate under another provision of the Constitution.<sup>115</sup>

For example, in *Bailey v. Drexel Furniture Co.*, 259 U.S. 20 (1922), the Supreme Court addressed the constitutionality of the Child Labor Tax Law. Drexel was engaged in the manufacture of furniture. It was assessed a tax penalty for having employed and permitted to work in its factory a boy under 14 years of age, which resulted in a ten percent tax on the company’s net profits for that year. The company sued, attacking the Child Labor Tax Law on the ground that it is a regulation of the employment of child labor, which is a state, and not federal, function. The federal government defended the Act on the ground that it is a mere excise tax levied by Congress under its broad power of taxation conferred by Article I, § 8 of the U.S. Constitution.

The Supreme Court rejected the government’s arguments. It tartly observed that “a court must be blind not to see that the so-called tax is imposed to stop the employment of children within the age limits prescribed. Its prohibitory

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171 F.3d 1133, 1142 (8th Cir. 1999) (holding “that Congress had the authority under the taxing clause to define as a crime the possession of an unregistered silencer” because the enactment, while regulatory in nature, was also designed to raise revenue); *Marigold v. Comeux*, 945 F.2d 409 (9th Cir. 1991) (upholding Tax Injunction Act under Congress’ taxation power because it imposes a tax); *United States v. Dalton*, 960 F.2d 121, 125-26 (10th Cir. 1992) (noting that Congress has power to impose registration requirements for machine gun ownership under its tax power even though the main purpose of the tax was regulatory); *Mobile Republican Assembly v. United States*, 353 F.3d 1357, 1360-62 (11th Cir. 2003) (upholding federal campaign finance law designed to regulate local political organizations that imposed an additional tax on organizations that fail to make required disclosures).

<sup>115</sup> *United States v. Kahriger*, 345 U.S. 22, 31 (1953) (“Penalty provisions in tax statutes added for breach of a regulation concerning activities in themselves subject only to state regulation have caused this Court to declare the enactments invalid.”) *overruled on other grounds by Marchetti v. United States*, 390 U.S. 39 (1968). See generally *A Healthy Debate*, 158 U. Pa. L. Rev. PENNUMBRA 93, 100 (“the problem with basing the [Act’s individual] mandate on Congress’s taxing power is not that such power cannot be used in a regulatory fashion; indeed, the Court has specifically authorized taxing schemes with regulatory effects. The problem is that this particular regulatory scheme (the health insurance-purchase mandate) exceeds Congress’s regulatory power.”).

and regulatory effect and purpose are palpable.”<sup>116</sup> The Court then held that it will not enforce “laws of Congress dealing with subjects not entrusted to Congress, but left or committed by the supreme law of the land to the control of the states.”<sup>117</sup> Significantly, the Court added that it would not let Congress attempt to regulate conduct by imposing penalties through its taxation power.<sup>118</sup>

Similarly, in *United States v. Butler*, 297 U.S. 1 (1937), the Supreme Court held that the Agricultural Adjustment Act was unconstitutional because it imposed a tax on processors of farm products that was coupled with payments to induce farmers not to produce. The Supreme Court explained that the design of the Act was *not* to raise revenue for the government, “but by its operation shows the exaction laid upon processors to be the necessary means for the intended control of agricultural production.”<sup>119</sup> The Court held that the tax imposed was a pretext “for bringing about a desired end. . . . It is a statutory plan to regulate and control agricultural production, a matter beyond the powers delegated to the federal government. The tax, the appropriation of the funds raised, and the direction for their disbursement, are but parts of the plan. They are but means to an unconstitutional end.”<sup>120</sup>

The Supreme Court concluded: “The power of taxation, which is expressly granted, may, of course, be adopted as a means to carry into operation another power also expressly granted. But resort to the taxing power to effectuate an end which is not legitimate, not within the scope of the Constitution, is obviously inadmissible.”<sup>121</sup> Accordingly, the Supreme Court struck down the tax as unconstitutional.

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<sup>116</sup> 259 U.S. at 22.

<sup>117</sup> *Bailey*, 259 U.S. at 22. *But see* John G. Nowak *Constitutional Law* § 5.5 at 231 (8th ed. 2010) (“The Tenth Amendment, however, is not a specific limitation on the federal taxing power. Although *Bailey* held that the federal government had violated the Tenth Amendment by infringing on the power reserved to the state, in modern times the Court does not apply the Tenth Amendment in this manner. The court treats the Tenth Amendment as a redundancy.”).

<sup>118</sup> *Id.*

<sup>119</sup> *Butler*, 297 U.S. at 59

<sup>120</sup> *Id.* at 61, 68. *But see* Erwin Chemerinsky, *Constitutional Law, Principles and Policies* § 3.4 at 198 (1997) (“This aspect of *Butler* has never been followed.”).

<sup>121</sup> *Id.* at 69.

### C. Can Congress Impose an Individual Mandate Under its Taxing Power?

The first step in evaluating the constitutionality of the individual mandate tax requires us to consider whether Congress could reasonably conclude that the tax provision in the Act promotes the general welfare of the country.

“In considering whether a particular [tax] is intended to serve general public purposes, courts should defer substantially to the judgment of Congress.”<sup>122</sup> In fact, the level of deference to the congressional decision is such that the Court “has more recently questioned whether ‘general welfare’ is a judicially enforceable restriction at all.”<sup>123</sup> “No more essential or important power has been conferred upon the Congress and the presumption that an Act of Congress is valid applies with added force and weight to a levy of public revenue.”<sup>124</sup>

Here, the tax penalty appears to meet this first test because Congress has found that it is necessary for “promoting a healthy populace, expanding access to health insurance, and preventing members of the public from being driven into poverty by medical costs surely count as contributions to the general welfare.”<sup>125</sup> Congress has also found that taxing uninsured people helps to pay for the costs of the reform.<sup>126</sup>

The second, and more difficult issue, is whether Congress has the authority to impose the individual mandate under threat of a tax to secure compliance with the regulatory scheme. As explained above, there appear to be two conflicting lines of precedent that have never been fully reconciled by the Supreme Court.

On the one hand, a tax that is explicitly used as a penalty to enforce a mandate is unconstitutional if the mandate is not authorized by the Constitution. In other words, Congress cannot circumvent its limited powers by using its taxing authority as a backdoor way to regulate conduct.<sup>127</sup> Based on these cases, if the individual mandate is unconstitutional under the Commerce Clause then the tax

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<sup>122</sup> *South Dakota v. Dole*, 483 U.S. 203, 207 (1987).

<sup>123</sup> *Id.* at 207 n.2 (citing *Buckley v. Valeo*, 424 U.S. 1, 90-91 (1976) (per curiam)).

<sup>124</sup> *United States v. Jacobs*, 306 U.S. 363, 370 (1937).

<sup>125</sup> *A Healthy Debate*, 158 U. Pa. L. Rev. PENNUMBRA 93, 102.

<sup>126</sup> H.R. 3590, § 1501(a)(2).

<sup>127</sup> *See, e.g., Bailey*, 259 U.S. at 20.

penalty is unconstitutional because Congress is misusing its taxation power to regulate in an area reserved exclusively for the states.

In defending the individual mandate, the federal government will likely counter, based on the other line of cases discussed above, that the court should reject the argument that the mandate is an impermissible “regulatory” tax for the simple reason that the enactment, on its face, is designed to raise revenue to pay for expanded health care.<sup>128</sup> The federal government might also argue that the *Bailey* and *Butler* line of cases is no longer followed by the Supreme Court.<sup>129</sup>

One problem with this argument is that the Supreme Court has never directly repudiated the principle that when Congress has no other independent regulatory authority, a regulatory tax raises constitutional issues.<sup>130</sup> “Penalty provisions in tax statutes added for breach of a regulation concerning activities in themselves subject only to state regulation have caused this Court to declare the enactments invalid.”<sup>131</sup> And while the Supreme Court has not used this principle to invalidate an act of Congress since the 1930s, this may have more to do with the fact that Congress has not, apparently, enacted mandates that were outside of Congress’ authority to act and that were enforced with penalty provisions.

Indeed, one explanation for why the Supreme Court has ignored *Bailey* and *Butler* for most of the last seventy years is that the Supreme Court’s jurisprudence has allowed for virtually unlimited Congressional power under the Commerce Clause.<sup>132</sup> As a consequence, the limitations imposed by the pre-1937 tax cases,

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<sup>128</sup> See, e.g., *Sonzinsky*, 300 U.S. at 513-14.

<sup>129</sup> *Bob Jones Univ. v. Simon*, 416 U.S. 725, 741 n.12 (1974) (“It is true that the Court in those [pre-1937] cases drew what it saw at the time as distinctions between regulatory and revenue-raising taxes. But the Court has subsequently abandoned such distinctions.”); *United States v. Lipscomb*, 299 F.3d 303, 319 (5th Cir. 2002) (“Although the *Butler* Court did hold that the Tenth Amendment cabined Congress’s spending power, the Court quickly abandoned this view.”); Cf. *Kansas v. United States*, 214 F.3d 1196, 1201 n.6 (10th Cir. 2000) (discussing how the Court has abandoned analogous limitations on Congress’ spending authority; the *Lochner* era Court “relied on an overly narrow view of Congress’ enumerated powers”).

<sup>130</sup> See, e.g., *Bailey*, 259 U.S. at 20.

<sup>131</sup> *Kahriger*, 345 U.S. at 31 (citations and quotations omitted).

<sup>132</sup> See Laurence H. Tribe, *American Constitutional Law* § 5-7 at 845-46 (3d ed. 2000) (“The breadth of the commerce clause, as construed by the Court starting in 1937, rendered moot any consideration of whether a tax was

such as *Bailey and Butler*, became moot because of Congress' sweeping power over all commerce – i.e., it simply did not matter whether the tax provision was a penalty imposed to enforce a regulation because the regulatory act was authorized by the Supreme Court's broad interpretation of Congress' power under the Commerce Clause. Accordingly, while the Supreme Court has not used the pre-1937 tax cases to strike down an act of Congress in decades, the Supreme Court may re-examine the scope of Congress' tax authority because it has recalibrated and limited its Commerce Clause jurisprudence in *United States v. Lopez* and *United States v. Morrison*.

Additionally, it simply should not be the case under our constitutional system that Congress has unfettered power to force individuals to purchase government approved goods in the private marketplace under threat of a tax penalty. “If any regulatory measure with a monetary penalty for refusal to comply is considered a tax, then many of Congress' powers would be superfluous, since Congress could essentially regulate anything that fell within the subject matter of [the Tax and Spending] clause simply by imposing monetary penalties on those who fail to comply.”<sup>133</sup>

In sum, it is unclear how a court will respond to this issue given the competing lines of cases, which have never been reconciled. Nevertheless, this is by no means a reason why the state should not challenge the constitutionality of the individual mandate. To the contrary, it is worth challenging Supreme Court precedents which ostensibly provide Congress with unlimited taxing authority. Indeed, the notion of unlimited taxing authority directly conflicts with Supreme Court case law that a regulatory tax is invalid if its very application presupposes a taxpayer violation of a series of specified conditions promulgated along with the tax. It is also worth challenging this regulatory tax because the tax conflicts with our constitutional framework; i.e., allowing Congress to force individuals to do something under threat of a tax penalty would mean that Congress has limitless power under its taxing authority.

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‘regulatory’; because there also seemed to be an independent source of federal regulatory authority . . . nothing would turn on the revenue/regulation distinction. Accordingly, if *United States v. Lopez* marks the beginning of a new era, it may also render salient, for the first time in more than half a century, the distinction between ‘regulatory’ and ‘revenue’ taxes for purposes of Congress' powers.”).

<sup>133</sup> Ilya Somin, *Does Congress Have the Authority to Enact a Health Insurance Mandate Using Its Power to Tax?*, THE VOLOKH CONSPIRACY, Dec. 24, 2009, <http://volokh.com/2009/12/24/does-congress-have-the-power-to-enact-a-health-insurance-mandate-using-its-power-to-tax/>

## **VI. DOES THE ACT UNCONSTITUTIONALLY IMPAIR STATES' RIGHTS?**

The following examines whether key aspects of the Act violate the rights of states under the U.S. Constitution.

### **A. The Tenth Amendment**

Analysis of whether federal legislation violates states' rights commonly involves the Tenth Amendment, which provides that "[t]he powers not delegated to the United States by the Constitution, nor prohibited by it to the states, are reserved to the states respectively, or to the people." In certain lines of cases, the Supreme Court has interpreted this amendment and the extent of its reach in close conjunction with the Congress' Article I powers. "If a power is delegated to Congress in the Constitution, the Tenth Amendment expressly disclaims any reservation of that power to the States; if a power is an attribute of state sovereignty reserved by the Tenth Amendment, it is necessarily a power the Constitution has not conferred on Congress."<sup>134</sup> Thus, as discussed above, if Congress exceeded the scope of its Commerce Clause power by enacting the Act's individual mandate, then it also violated the Tenth Amendment.<sup>135</sup>

The remainder of this section will examine other provisions of the Act that may violate Alaska's Tenth Amendment rights because Congress has arguably "invad[ed] the province of state sovereignty reserved by the Tenth Amendment."<sup>136</sup>

### **B. The Health Benefit Exchange Requirement**

The Act's exchange provision requires each state to establish an "American Health Benefit Exchange" no later than January 1, 2014.<sup>137</sup> The exchanges must facilitate the purchase of qualifying health plans, provide for the establishment of a "Small Business Health Options Program," and meet other requirements described in the legislation.<sup>138</sup> This mandate will likely impose significant costs on states. But if a state fails to comply, the Act requires the Secretary of Health and Human Services to establish and operate an exchange within that state. The

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<sup>134</sup> *New York v. United States*, 505 U.S. 144, 156 (1992).

<sup>135</sup> *Id.* at 156-57.

<sup>136</sup> *Id.* at 156.

<sup>137</sup> H.R. 3590, § 1311(b)(1).

<sup>138</sup> H.R. 3590, § 1311(b)(1).

Secretary will do so if: (1) the state does not elect to apply standards that the Secretary adopts by regulation for establishing and operating exchanges; (2) the Secretary determines by January 1, 2013, that the state will not have an operational exchange by January 1, 2014; or (3) that the state has not taken actions necessary to implement related requirements.<sup>139</sup>

Without this second provision allowing the federal government to establish a state's required health benefit exchange, the exchange requirement would be constitutionally suspect. "Congress may not simply 'commandeer[r] the legislative processes of the States by directly compelling them to enact and enforce a federal regulatory program.'"<sup>140</sup> "[T]he Constitution has never been understood to confer upon Congress the ability to require the States to govern according to Congress' instructions."<sup>141</sup> "We have always understood that even where Congress has the authority under the Constitution to pass laws requiring or prohibiting certain acts, it lacks the power directly to compel the States to require or prohibit those acts."<sup>142</sup> "The Federal Government may neither issue directives requiring the States to address particular problems, nor command the States' officers, or those of their political subdivisions, to administer or enforce a federal regulatory program. . . . [S]uch commands are fundamentally incompatible with our constitutional system of dual sovereignty."<sup>143</sup>

But Congress may, through less direct methods, encourage states to regulate in particular ways. For example, Congress may attach conditions on states' receipt of federal funds or, "where Congress has the authority to regulate private activity under the Commerce Clause,<sup>144</sup> . . . [it may] offer States the choice of regulating that activity according to federal standards or having state law pre-empted by federal regulation."<sup>145</sup> The Supreme Court concluded that these less direct methods of influencing states' actions are consistent with the federalism principles of the Tenth Amendment because of the discretion they leave with the states' citizens:

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<sup>139</sup> H.R. 3590, § 1321(c).

<sup>140</sup> *New York v. United States*, 505 U.S. at 161 (quoting *Hodel v. Va. Surface Mining & Reclamation Ass'n, Inc.*, 452 U.S. 264, 288 (1981)).

<sup>141</sup> *New York v. United States*, 505 U.S. at 162 (citing *Coyle v. Smith*, 221 U.S. 559, 565 (1911)).

<sup>142</sup> *New York v. United States*, 505 U.S. at 166 (citations omitted).

<sup>143</sup> *Printz v. United States*, 521 U.S. 898, 935 (1997).

<sup>144</sup> Congress' Commerce Clause authority is addressed above.

<sup>145</sup> *New York v. United States*, 505 U.S. at 167 (citations omitted).

By either of these methods, as by any other permissible method of encouraging a State to conform to federal policy choices, the residents of the State retain the ultimate decision as to whether or not the State will comply. If a State's citizens view federal policy as sufficiently contrary to local interests, they may elect to decline a federal grant. If state residents would prefer their government to devote its attention and resources to problems other than those deemed important by Congress, they may choose to have the Federal Government rather than the State bear the expense of a federally mandated regulatory program, and they may continue to supplement that program to the extent state law is not pre-empted.<sup>146</sup>

In the Act, Congress took the second approach with regard to the health benefits exchange. Although the Act requires states to establish exchanges, the consequence of failing to satisfy the requirement is that the federal government will establish the exchange. It remains to be seen how that would be done. If the federal government's involvement still imposed significant costs on states, or "commandeered" state resources, then there still could be a claim under the Tenth Amendment. But in terms of a facial challenge to this requirement under the Act, because the statute offers states a choice, it is premature to file a suit on this claim at this time because the Supreme Court's jurisprudence in this area suggests that the Act's exchange requirement does not violate the Constitution.

### **C. The Medicaid Expansion Requirement**

The Act expands Medicaid eligibility for low-income individuals. Beginning in January 2014, all children, parents, and childless adults who are not presently entitled to Medicaid and whose family incomes are at or below 133% of the federal poverty line will become eligible for Medicaid.<sup>147</sup> The federal government will fund 100% of the additional cost of providing care for newly-covered individuals between January 1, 2014, and December 31, 2016, and it will pay a decreasing percentage of the additional cost in subsequent years, which will then be born by states.<sup>148</sup>

An argument can be made that the legislation creates an unfunded mandate because it requires states to considerably expand their Medicaid programs without the necessary federal support. As noted above, however, the Medicaid expansion

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<sup>146</sup> *New York v. United States*, 505 U.S. at 168.

<sup>147</sup> H.R. 3590, § 2001(a)(1).

<sup>148</sup> H.R. 3590, § 2001(a)(3).

is arguably not unconstitutional because states are given an option. That is, to avoid these onerous requirements states could simply withdraw from the Medicaid program.

It is, however, highly unlikely that a state could or would pursue this option because by doing so the state would leave many persons uninsured. One can therefore argue that Medicaid expansion is unconstitutional because it imposes conditions on the receipt of federal funds in a manner that constitutes unconstitutional “coercion.”

In addressing this “coercion” legal theory, the Supreme Court has held that Congress’ Spending Clause authority allows it to impose conditions on the receipt of federal funds.<sup>149</sup> The Supreme Court concluded in *New York v. United States* that this method of influencing states’ actions is consistent with the federalism principles of the Tenth Amendment because “[i]f a State’s citizens view federal policy as sufficiently contrary to local interests, they may elect to decline a federal grant.”<sup>150</sup> Yet the Supreme Court also acknowledged in *South Dakota v. Dole* that it has “recognized that in some circumstances the financial inducement offered by Congress might be so coercive as to pass the point at which ‘pressure turns into compulsion.’”<sup>151</sup>

The Supreme Court has never discussed this principle in detail. Thus, we turn to lower federal courts examination of this limit on Congress’ federal spending power.

The Ninth Circuit characterized the *Dole* decision as concluding that the Supreme Court “would only find Congress’ use of its spending power impermissibly coercive, if ever, in the most extraordinary circumstances.”<sup>152</sup> Applying that standard, the Ninth Circuit rejected California’s “coercion theory” challenge to the federal government’s requirement that, to receive Medicaid funds, states must agree to provide emergency medical services to illegal aliens.<sup>153</sup> Observing that it previously noted that “no party challenging the conditioning of

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<sup>149</sup> *New York v. United States*, 505 U.S. at 167; *South Dakota v. Dole*, 483 U.S. 203, 206 (1987).

<sup>150</sup> *Id.* at 168.

<sup>151</sup> *South Dakota v. Dole*, 483 U.S. at 211 (citing *Steward Mach. Co. v. Davis*, 301 U.S. 548, 590 (1937)).

<sup>152</sup> *California v. United States*, 104 F.3d 1086, 1092 (9th Cir. 1997).

<sup>153</sup> *Id.* at 1092.

federal funds has ever succeeded under the coercion theory,”<sup>154</sup> the Ninth Circuit concluded that “to the extent that there is any viability left in the coercion theory, it is not reflected in the facts of this record.”<sup>155</sup>

Other circuits have likewise rejected claims based on the coercion theory.<sup>156</sup> But when the Fourth Circuit rejected a coercion theory claim, it suggested that the theory has more viability in that circuit than elsewhere.<sup>157</sup> Still, the Fourth Circuit more recently observed that, “[a]lthough there might be a

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<sup>154</sup> *California v. United States*, 104 F.3d at 1092 (citing *Nevada v. Skinner*, 884 F.2d 445, 448 (9th Cir. 1989)); see also *Nevada*, 884 F.2d at 448 (“[C]an a sovereign state which is always free to increase its tax revenues ever be coerced by the withholding of federal funds – or is the state merely presented with hard political choices? The difficulty if not the impropriety of making judicial judgments regarding a state’s financial capabilities renders the coercion theory highly suspect” (footnotes omitted)).

<sup>155</sup> *California v. United States*, 104 F.3d at 1092.

<sup>156</sup> *N.H. Dep’t of Empl. Sec. v. Marshall*, 616 F.2d 240, 246 (1st Cir. 1980) (rejecting claim that requirements of Federal Unemployment Tax Act were coercive; “We do not agree that the carrot has become a club because rewards for conforming have increased.”); *Padavan v. United States*, 82 F.3d 23, 29 (2d Cir. 1996) (rejecting claim that potential loss of federal Medicaid funds coerced New York to provide emergency medical services to illegal immigrants); *West Virginia v. U.S. Dep’t of Health & Human Servs.*, 289 F.3d 281, 291-93 (4th Cir. 2002) (rejecting claim that threatened loss of all or part of federal Medicaid reimbursements if state failed to adopt program to recover funds from estates of deceased Medicaid recipients constituted coercion violating Tenth Amendment); *Texas v. United States*, 106 F.3d 661, 666 (5th Cir. 1997) (rejecting claim that potential loss of federal Medicaid funds coerced Texas to provide emergency medical care to undocumented aliens); *Kansas v. United States*, 214 F.3d 1196, 1202 (10th Cir. 2000) (rejecting challenge to conditions imposed under Personal Responsibility and Work Opportunity Reconciliation Act on state’s receipt of federal welfare funds; [T]he coercion theory is unclear, suspect, and has little precedent to support its application.”).

<sup>157</sup> *West Virginia v. U.S. Dep’t of Health & Human Servs.*, 289 F.3d at 288, 290 (noting that, while other circuits “have expressed strong doubts about the viability of the coercion theory,” “the coercion theory is not viewed with such suspicion” in the Fourth Circuit).

federal funding condition that is unconstitutionally coercive, neither the Supreme Court nor any federal court of appeals has yet identified one.”<sup>158</sup>

In short, a court might conclude that withdrawing from the Medicaid program would be so burdensome on states that new and extremely costly conditions imposed on the states for participation constituted unconstitutional coercion. However, because this doctrine is not well developed, and because projections for Alaska’s specific costs estimates are not yet finalized, it is unclear how a court would respond to such claims.

## VII. MISCELLANEOUS ARGUMENTS

### A. Equal Protection Claims

Some have suggested that requiring individuals to buy health insurance violates the equal protection clause because Congress has exempted certain categories of persons, such as those with incomes under the poverty line. Others have indicated that it violates equal protection to exempt individuals in certain trades or who are members of a union from additional taxation.

These arguments need not detain us long. “Legislatures have especially broad latitude in creating classifications and distinctions in tax statutes.”<sup>159</sup> “Congressional selection of particular entities or persons for entitlement to this sort of largesse is obviously a matter of policy and discretion not open to judicial review.”<sup>160</sup> Indeed, with “taxation, even more than in other fields, legislatures possess the greatest freedom in classification.”<sup>161</sup> Thus, to withstand an equal protection challenge to a tax classification, the federal government merely needs to show that “any reasonably conceivable state of facts ... could provide a rational basis for the classification.”<sup>162</sup> This test is so low that Congress’ classification

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<sup>158</sup> *Constantine v. Rectors and Visitors of George Mason Univ.*, 411 F.3d 474, 493 (4th Cir. 2005).

<sup>159</sup> *Regan*, 461 U.S. at 546.

<sup>160</sup> *Id.* (quotations omitted). For example, in *Maher v. Roe*, 432 U.S. 464 (1977), the Supreme Court considered legislative decisions not to subsidize abortions, even though other medical procedures were subsidized. The Supreme Court rejected equal protection challenges to the statutes.

<sup>161</sup> *Id.* at 547.

<sup>162</sup> *Gilmore v. County of Douglas*, 406 F.3d 935, 940 (8th Cir. 2005).

“may be based on rational speculation unsupported by evidence or empirical data.”<sup>163</sup>

Moreover, “[t]he presumption of constitutionality can be overcome only by the most explicit demonstration that a classification is a hostile and oppressive discrimination against particular persons and classes.”<sup>164</sup>

Based on the above, the Act will very likely withstand an equal protection challenge. First, there is no evidence that the Act’s classifications are a “hostile and oppressive discrimination against particular person or classes.” Second, while some may see certain exemptions or deductions as unfair, tax exemptions and deductions are “a matter of grace [that] Congress can, of course, disallow . . . as it chooses.”<sup>165</sup>

## **B. Due Process Claims**

Some have alleged that by mandating that all private citizens purchase health care coverage under penalty of law, the Act violates the Due Process Clause of the Fifth Amendment.

The Supreme Court routinely rejects due process challenges to tax laws. “The claim that a particular tax is so unreasonably high and unduly burdensome as to deny due process is both familiar and recurring, but the Court has consistently refused either to undertake the task of passing on the ‘reasonableness’ of a tax that otherwise is within the power of Congress or of state legislative authorities, or to hold that a tax is unconstitutional because it renders a business unprofitable.”<sup>166</sup> Simply put, it is highly unlikely that due process is violated by the imposition of a tax for the failure to purchase health insurance.

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<sup>163</sup> *FCC v. Beach Communications, Inc.*, 508 U.S. 307, 315 (1993).

<sup>164</sup> *Regan*, 461 U.S. at 547 (quoting *Madden v. Kentucky*, 309 U.S. 83, 87-88 (1940)).

<sup>165</sup> *Id.* at 549.

<sup>166</sup> *City of Pittsburgh v. Alco Parking Corp.*, 417 U.S. 369, 373-74 (1971); see also *Charles C. Steward Mach. Co. v. Davis*, 301 U.S. 548, 588-90 (1937) (observing that it is unlikely that the Court would ever find a tax unduly coercive); *Alaska Fish Salting & By-Products Co. v. Smith*, 255 U.S. 44, 48-49 (1921) (“Even if the tax should destroy a business it would not be made invalid or require compensation upon that ground alone. Those who enter upon a business take that risk. . . . We know of no objection to exacting a discouraging rate as the alternative to giving up a business, when the legislature has the full power of taxation.”).

### C. The Direct Tax Claim

Some have argued that the tax penalty violates Article 1, § 9, of the U.S. Constitution, which provides that while Congress has “[t]he general power to ‘lay and collect taxes . . . [that power] is limited by section 2 of the same article, which requires ‘direct’ taxes to be apportioned, and section 9, which provides that ‘no capitation, or other direct, tax shall be laid, unless in proportion to the census’ directed by the Constitution to be taken.”<sup>167</sup>

More specifically, some contend that the individual mandate’s tax penalty applies without regard to property, profession, or any other circumstance, and is unrelated to any taxable event or activity. It is to be levied upon persons for their failure to do something. Because it applies without regard to property, profession, or any other circumstance, it is a direct tax that must be apportioned by the population of each state. And since the tax penalty is a direct tax and is not apportioned, it violates Article I, § 9, of the U.S. Constitution.

To analyze the merits of this claim, we must examine the difference between a direct and indirect tax. Direct taxes are a general tax on the entire population.<sup>168</sup> Indirect taxes are excise taxes.<sup>169</sup> Generally speaking, an excise tax is a tax that the state imposes on a taxpayer after the occurrence of an event or when a taxpayer exercises a certain right or privilege.<sup>170</sup>

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<sup>167</sup> *Bromley v. McLaughn*, 280 U.S. 124 (1929). The Constitution recognizes four types of taxes: (1) “Duties, Imposts and Excises,” generally called indirect taxes, which must be uniform throughout the United States (Art. I, § 8); (2) capitation, or other direct taxes, which may only be imposed “in Proportion to the Census” among the states (Art. 1, § 2; Art. 1, § 9); (3) export taxes, which are prohibited (Art. 1, § 9); and (4) the income tax, permitted by the 16th Amendment, which can be imposed without apportionment among the states.

<sup>168</sup> *Murphy v. I.R.S.*, 493 F.3d 170, 181 (D.C. Cir. 2007) (“Only three taxes are definitely known to be direct: (1) a capitation, U.S. CONST. art. I, § 9, (2) a tax upon real property, and (3) a tax upon personal property.”).

<sup>169</sup> *New Neighborhoods, Inc. v. W. Va. Workers’ Comp. Fund*, 886 F.2d 714, 719 (4th Cir. 1989).

<sup>170</sup> *United States v. 4,432 Mastercases of Cigarettes, More or Less*, 448 F.3d 1168, 1185 (9th Cir. 2006) (explaining that an excise tax is “imposed on the performance of an act . . . or the enjoyment of a privilege. The quintessential excise tax in our country is the sales tax.”) (citing Black’s Law Dictionary 563 (6th ed.1990)); see also 9E Am.Jur.2d Bankruptcy § 3099 (“For priority purposes, an ‘excise tax’ covers practically any tax which is not an ad valorem tax and

The Supreme Court has long struggled to explain where the legal dividing line is between direct and indirect taxes.<sup>171</sup> Indeed, “there are almost as many classifications of direct and indirect taxes as there are authors.”<sup>172</sup> This can be explained, in part, by the fact that “[n]either the record of the constitutional convention nor the state ratification debates defines with any clarity the meaning of the term ‘direct tax’[.]”<sup>173</sup>

To determine whether a tax is direct or indirect, lower courts have examined whether “the tax is more akin, on the one hand, to a capitation or a tax upon one’s ownership of property, or, on the other hand, more like a tax upon a use of property, a privilege, an activity, or a transaction.”<sup>174</sup> Federal courts have also used a range of definitions to define what constitutes an indirect tax. For example, some courts have stated that “an excise tax is a pecuniary obligation imposed by a government to defray expenses of an authorized undertaking.”<sup>175</sup> Sometimes federal courts have stated that “[a] tax laid upon the happening of an

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which is imposed on the performance of an act, the engaging in an occupation, or the enjoyment of a privilege.”).

<sup>171</sup> *Spreckels Sugar Ref. Co. v. McClain*, 192 U.S. 397, 413 (1902) (observing that “taxes that are direct and those which are to be regarded simply as excises” is “often very difficult to be expressed in words”).

<sup>172</sup> *Murphy*, 493 F.3d at 182 (quotations omitted).

<sup>173</sup> *Union Elec. Co. v. United States*, 363 F.3d 1292, 1297 (Fed. Cir. 2004) (citing *2 The Records of the Federal Convention of 1787*, at 350 (Max Farrand ed., Yale Univ. Press, 1966) (Aug. 20, 1787) (“Mr. King [a delegate to the constitutional convention] asked what was the precise meaning of direct taxation? No one answer[ere]d.”). Part of the confusion may be explained by how the direct tax clauses were included in the U.S. Constitution. “They do not represent an independent judgment about the proper system for direct taxation, but were part and parcel of a larger compromise over slavery at the Philadelphia Convention. Quite simply, the South would get three-fifths of its slaves counted for purposes of representation in the House and the Electoral College, if it was willing to pay an extra three-fifths of taxes that could be reasonably linked to overall population. The origins of the clauses in a larger political compromise explain an otherwise embarrassing fact – the Founders didn’t have a very clear sense of what they were doing in carving out a distinct category of “direct” taxes for special treatment.” Bruce Ackerman, *Taxation and the Constitution*, 99 Colum. L. Rev. 1, 4 (1999).

<sup>174</sup> *Murphy*, 493 F.3d at 183.

<sup>175</sup> *New Neighborhoods, Inc.*, 886 F.2d at 719.

event, as distinguished from its tangible fruits, is an indirect tax which Congress . . . undoubtedly may impose.”<sup>176</sup>

The federal government will likely argue that the tax penalty provision does not have to be apportioned because it is an income tax or an indirect tax. The tax is designed as an income tax with a floor: a person who must purchase insurance, but does not, must either pay 2.5% of their household income or \$695, whichever is greater. Income taxes do not have to be apportioned.<sup>177</sup>

If a court rejects the contention that the tax penalty is an income tax, the federal government will argue that the tax penalty more closely resembles an indirect tax because it is not a general tax levied on *all* individuals. Instead it is only imposed on those who must purchase health insurance but refuse to do so. The federal government will likely add that the tax penalty cannot be construed to be a general tax because the amount of the tax is based on a percentage of an individual’s income, which means that not everyone will pay the same amount. The conclusion that the mandate is an indirect tax is also bolstered by other considerations: (1) in an analogous situation, courts have held that a tax penalty imposed on employers who fail to carry required insurance constitutes an excise tax<sup>178</sup> and (2) courts have historically construed the “direct tax” clause narrowly.<sup>179</sup>

Nevertheless, given that the lack of clarity in this area of the law, it is difficult to predict how a court would rule on whether the individual mandate tax penalty is a direct tax.

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<sup>176</sup> *Tyler v. United States*, 281 U.S. 497, 502 (1930).

<sup>177</sup> The Sixteenth Amendment eliminated any requirement that income taxes imposed by Congress be apportioned among the states. *See Eisner v. Macomber*, 252 U.S. 189, 205 (1920).

<sup>178</sup> *See, e.g., In re DeRoche*, 287 F.3d 751, 753 (9th Cir. 2002) (citing *Bliemeister v. Indus. Comm’n of Ariz.*, 251 B.R. 383, 394-96 (Bankr. Ariz. 2000)); *New Neighborhoods, Inc.*, 886 F.2d at 718-20 (holding that premiums owed by employers – who fail to purchase worker compensation insurance – to West Virginia Workers’ Compensation Fund constituted excise taxes).

<sup>179</sup> *See* Bruce Ackerman, *Taxation and the Constitution*, 99 Colum. L. Rev. 1, 4-5 (1999) (collecting cases).

#### D. Legislative Process Infirmities

Many observers have alleged that the legislative process in enacting the Act was corrupt and unfair. Some specifically complain that certain Senators were bribed with specific provisions.

For example, the health care legislation's disaster provision adjusts the federal medical assistance percentage for Medicaid funding to states suffering major, statewide disasters. The provision applies only if, at any time during the preceding seven fiscal years, the President declared a major disaster in that state and determined that, because of the disaster, every county or parish in the state qualified for public assistance from the federal government.<sup>180</sup> Other conditions also apply.<sup>181</sup> In support of the provision, some contend that infusions of federal disaster assistance funds and the departure of poorer residents in the wake of a disaster artificially inflate the per capita income of a disaster-struck state, leading to reduced federal Medicaid funding for that state.<sup>182</sup> Apparently only Louisiana currently qualifies for the benefits of the disaster provision, although the provision could apply to other states.<sup>183</sup>

Regardless of the specific claims that one might bring against the legislative process, the State of Alaska and private parties likely lack standing to file a suit.

“Whether styled as a constitutional or prudential limit on standing, the [Supreme] Court has sometimes determined that where large numbers of Americans suffer alike, the political process, rather than the judicial process, may

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<sup>180</sup> H.R. 3590, § 2006.

<sup>181</sup> H.R. 3590, § 2006.

<sup>182</sup> Peter Overby, *With Health Care Bill, One Day You're In . . .* (Mar. 19, 2010), [www.npr.org/templates/story/story.php?storyId=124933273](http://www.npr.org/templates/story/story.php?storyId=124933273); Jonathan Tilove, *Louisiana Medicaid provision survives health bill changes* (Mar. 7, 2010), [www.nola.com/politics/index.ssf/2010/03/post\\_323.html](http://www.nola.com/politics/index.ssf/2010/03/post_323.html).

<sup>183</sup> Peter Overby, *With Health Care Bill, One Day You're In . . .* (Mar. 19, 2010), [www.npr.org/templates/story/story.php?storyId=124933273](http://www.npr.org/templates/story/story.php?storyId=124933273); Jonathan Tilove, *Louisiana Medicaid provision survives health bill changes* (Mar. 7, 2010), [www.nola.com/politics/index.ssf/2010/03/post\\_323.html](http://www.nola.com/politics/index.ssf/2010/03/post_323.html); Pablo Martinez Monsivais, *Chart: Highlights of health care bill* (Mar. 19, 2010), [www.usatoday.com/news/washington/2010-03-18-health-bill-table\\_n.htm](http://www.usatoday.com/news/washington/2010-03-18-health-bill-table_n.htm).

provide the more appropriate remedy for a widely shared grievance.”<sup>184</sup> Based upon this reasoning, the Supreme Court has repeatedly stated, “We will not . . . entertain citizen suits to vindicate the public’s nonconcrete interest in the proper administration of the laws.”<sup>185</sup>

Such claims amount to little more than attempts “to employ a federal court as a forum in which to air . . . generalized grievances about the conduct of government.”<sup>186</sup> Therefore, “assertion of a right to a particular kind of Government conduct, which the Government has violated by acting differently, cannot alone satisfy the requirements of Art. III without draining those requirements of meaning.”<sup>187</sup>

This principle applies with particular force to “cases where the harm at issue is not only widely shared, but is also of an abstract and indefinite nature—for example, harm to the common concern for obedience to law.”<sup>188</sup> “The abstract nature of the harm (for example, injury to the interest in seeing that the law is obeyed) deprives the case of the concrete specificity . . . which . . . prevents a plaintiff from obtaining what would, in effect, amount to an advisory opinion.”<sup>189</sup>

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<sup>184</sup> *Fed. Election Comm’n v. Akins*, 524 U.S. 11, 23 (1998) (citing cases).

<sup>185</sup> *Massachusetts v. E.P.A.*, 549 U.S. at 516-17; *see also Lance v. Coffman*, 549 U.S. 437, 442 (2007) (per curiam) (noting that the “[t]he only injury plaintiffs allege is that the law . . . has not been followed. This injury is precisely the kind of undifferentiated, generalized grievance about the conduct of government that we have refused to countenance in the past.”); *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 573-74 (1992) (“We have consistently held that a plaintiff raising only a generally available grievance about government—claiming only harm to his and every citizen’s interest in proper application of the Constitution and laws, and seeking relief that no more directly and tangibly benefits him than it does the public at large—does not state an Article III case or controversy.”); *Pa. Prison Soc’y v. Cortes*, 508 F.3d 156, 161 (3d Cir. 2007) (holding voters and taxpayers lacked standing to assert a “generalized grievance[ ] of concerned citizens”);

<sup>186</sup> *Valley Forge Christian Coll. v. Am. United For Separation of Church and State*, 454 U.S. 464, 479 (1982) (quotation, alteration omitted).

<sup>187</sup> *Id.* at 483.

<sup>188</sup> *Akins*, 524 U.S. at 23.

<sup>189</sup> *Id.* at 24.

Moreover, “standing in no way depends on the merits of plaintiffs’ contention that particular conduct is illegal.”<sup>190</sup>

For example, in *Schlesinger v. Reservists Committee To Stop the War*, 418 U.S. 208 (1974), the Supreme Court addressed standing to bring a challenge under the Constitution’s Incompatibility Clause, which provides that “no Person holding any Office under the United States, shall be a Member of either House during his Continuance in Office.”<sup>191</sup> Citizen-taxpayers brought a lawsuit contending that Members of Congress who were also members of the military Reserves violated the Incompatibility Clause. The Supreme Court dismissed for lack of standing, holding “that standing to sue may not be predicated upon an interest of the kind alleged here which is held in common by all members of the public, because of the necessarily abstract nature of the injury all citizens share.”<sup>192</sup>

Similarly, in refusing to accept as judicially cognizable a taxpayer organization’s complaint that the conveyance of government-owned property to an educational institution supervised by a religious order violated the Establishment Clause of the First Amendment, the Supreme Court stated:

Although [plaintiffs] claim that the Constitution has been violated, they claim nothing else. They fail to identify any personal injury suffered by the plaintiffs as a consequence of the alleged constitutional error, other than the psychological consequences presumably produced by observation of conduct with which one disagrees. This is not an injury sufficient to confer standing under Art. III, even though the disagreement is phrased in constitutional terms.<sup>193</sup>

Applying these principles to the legislative process that produced the Act will likely bar a lawsuit that sought to challenge this process because such an action would: (1) amount to a generalized grievance related to the conduct of government and (2) amount to no more than an abstract and widely shared harm related to a common concern that Congress has abused its power.

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<sup>190</sup> *Warth v. Seldin*, 422 U.S. 490, 500 (1975).

<sup>191</sup> Art. I, § 6, cl. 2.

<sup>192</sup> *Schlesinger*, 418 U.S. at 220.

<sup>193</sup> *Valley Forge Christian Coll.*, 454 U.S. at 479. *Cf. Logan v. Zimmerman Brush Co.*, 455 U.S. 422, 432-433 (1982) (“the legislative determination provides all the process that is due.”).

But even assuming the state has standing, we do not have any viable claims to challenge the legislative process. We considered whether certain provisions, like the disaster funding, violated the Constitution's Spending Clause, which authorizes Congress to "pay the debts and provide for the common defense and general welfare of the United States."<sup>194</sup> A provision that financially benefits only one state arguably does not serve the "general welfare of the United States." But, as explained above, the Supreme Court defers substantially to Congress' judgment in determining what serves the general welfare.<sup>195</sup> "The level of deference to the congressional decision is such that the Court has more recently questioned whether 'general welfare' is a judicially enforceable restriction at all."<sup>196</sup> So a court is unlikely to conclude that the disaster provision violates the Spending Clause.

We also considered whether other constitutional claims might provide grounds for a state to challenge the disaster provision, but we could find none. The Privileges and Immunities and Equal Protection Clauses of the Fourteenth Amendment<sup>197</sup> do not seem applicable because they "protect people, not States."<sup>198</sup> Similarly, the privileges and immunities provision of Article IV, § 2 of the Constitution<sup>199</sup> protects "citizens," not states.<sup>200</sup> And states are not "persons" for purposes of the Fifth Amendment's Due Process Clause.<sup>201</sup> Because these

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<sup>194</sup> Art. I, § 8, cl. 1 of the U.S. Constitution.

<sup>195</sup> *Helvering v. Davis*, 301 U.S. 619, 640-41 (1937) (quoting *United States v. Butler*, 297 U.S. 1, 67 (1936)).

<sup>196</sup> *South Dakota v. Dole*, 483 U.S. at 207 n.2 (citing *Buckley v. Valeo*, 424 U.S. 1, 90-91 (1976) (per curiam)).

<sup>197</sup> U.S. Const. amend. XIV, § 1 ("All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the state wherein they reside. No state shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any state deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.").

<sup>198</sup> *Pennsylvania v. New Jersey*, 426 U.S. 660, 665 (1976).

<sup>199</sup> U.S. Const. art. IV, § 2, cl. 1 ("The citizens of each state shall be entitled to all privileges and immunities of citizens in the several states.").

<sup>200</sup> *Cf. Hemphill v. Orloff*, 277 U.S. 537, 548-50 (1928) (corporation cannot claim benefits that article IV, section 2 assures corporation's members).

<sup>201</sup> *Conn. Dep't of Soc. Servs. v. Leavitt*, 428 F.3d 138, 147 (2d Cir. 2005); *Okla. ex rel. Okla. Tax Comm'n v. Int'l Registration Plan, Inc.*, 455 F.3d 1107,

clauses' protections do not extend to states, as states, they do not seem to provide a basis for a state to challenge the constitutionality of the disaster provision.

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1113-14 (10th Cir. 2006) (both citing *South Carolina v. Katzenbach*, 383 U.S. 301, 323-24 (1966)).

Alaska Health Care Commission 2010 Report

## **Appendix C**

### **ISER Report on Economic Impact of the Affordable Care Act on Alaska**

**Federal Health Reform –  
Economic Impact on Alaska**  
*[\*With PRELIMINARY Estimates\*]*

Prepared for: Alaska Health Care Commission  
By: Mark A. Foster, MAFA  
October 14, 2010

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14 October 2010

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## Disclosures

- **Mark A. Foster, Principal, Mark A. Foster & Associates (MAFA)**
  - Business consultant for economically regulated industries: energy, utilities, telecom and health care. Working on health care policy and health economics research with UAA ISER occasionally *since 2005*, "Alaska's \$5 billion Health Care Industry" (March 2006, with Scott Goldsmith), telemedicine business models (UAA ISER, ANTHC, ASHPIN, Matt Berman), workforce development issues (UAA ISER, ASHPIN), review of State Level Health Care Reform models (UAA ISER), and Medicare Access Issues (Rosylind Frazier & Linda Leask, UAA ISER). Thanks to Fran Ulmer, Steve Colt & Heather Hudson, ISER Directors, for their continued support of public policy research in Alaska.
  - Alaska Power & Telephone. HydroWest International Board of Directors, recently served on ML&P Board of Directors, chair of Finance & Audit Committee
- **Caveats**
  - **The analysis and opinions presented here have been independently developed and do not necessarily reflect the views of any clients.**
  - These are *preliminary* \*reconnaissance-level\* estimates based on readily available public data and analysis from the CMS Chief Actuary, American Academy of Actuaries and others that have been proportionally scaled to Alaska and adjusted to reflect an Alaska market outlook.
  - The health reform package involves a large change in health insurance and health care sectors. These preliminary estimates of impacts on Alaska contain *significant uncertainty*. Nonetheless, these estimates should help shed some light on the magnitude and direction of changes that may result from federal reform – *assuming it is fully implemented*.

## Overview

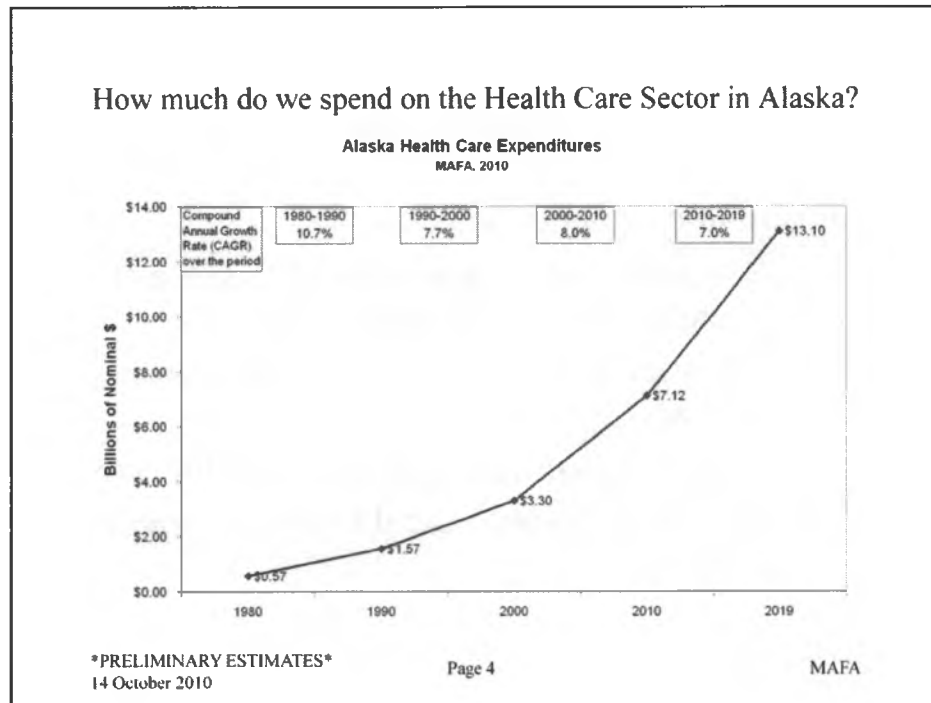
- **Baseline Projections**
  - How much do we spend on health care/health insurance sector in Alaska?
  - Where do Alaskans obtain their health care coverage?
- **How might health coverage and health care costs change under federal health insurance reform?**

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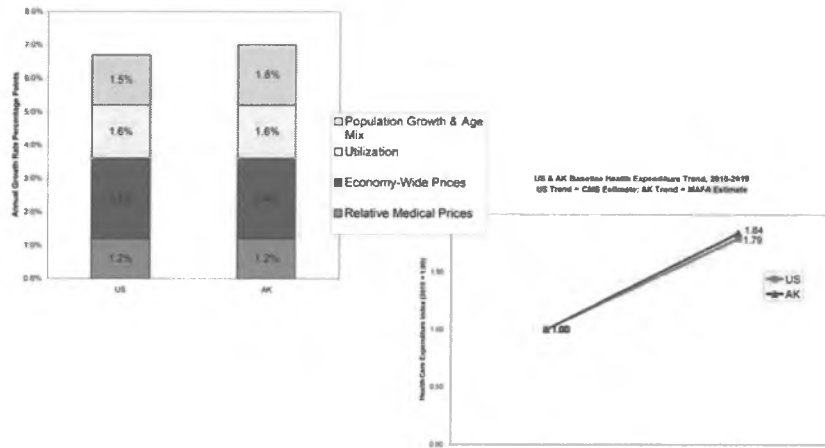
## How much do we spend on the Health Care Sector in Alaska?



Note the differences in compound annual growth rates across each of the decades and the projection going forward.

## Baseline Spending Projections to 2019 – AK & US

Factors Contributing to Projected Baseline Growth in Health Care Expenditures, 2010-2019



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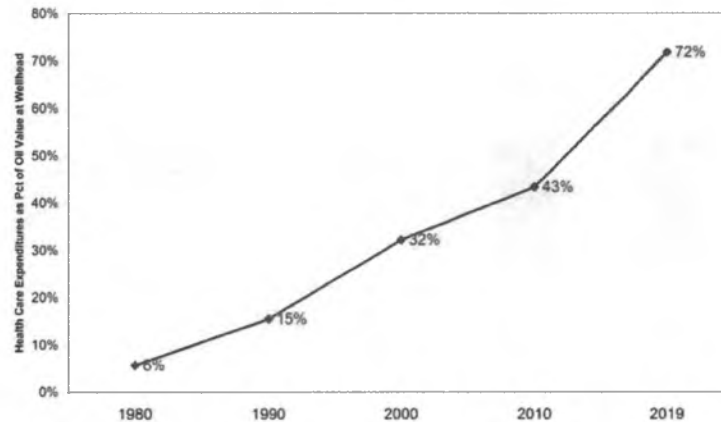
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These preliminary estimates rely upon State of Alaska Department of Labor population projections, including a rapid increase in the proportion of the population 65 and older which tend to drive costs higher faster.

## How much do we spend on the Health Care sector in Alaska?

Alaska Health Care Expenditures as Pct of Oil Value at Wellhead  
MAFA Analysis, 2010



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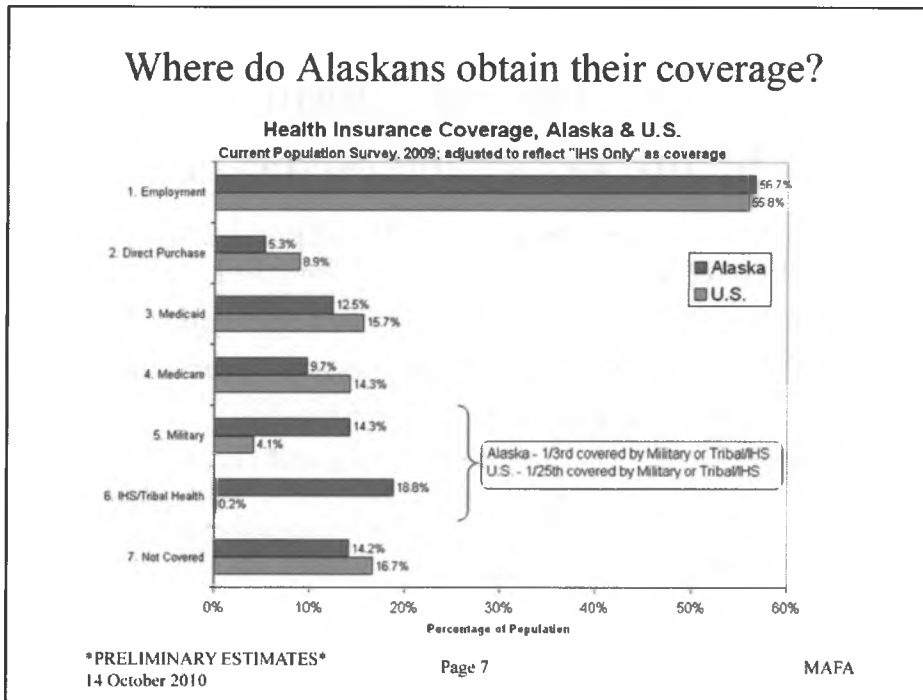
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Another way to look at health care spending is in terms of how quickly it has grown relative to the primary value-add economic driver of the Alaska economy – the well head value of oil.

### Sources:

1. Oil: State of Alaska Department of Revenue, Revenue Forecast Update (April 2010), adjusted to reflect CY2010; Historic Values from DNR, DOG Volumes, DOR ANS Wellhead Value
2. Health Care: MAFA Estimate based on CMS NHE Estimates for Alaska (2004), forecast to CY2020 based on Alaska Department of Labor population size and age distribution estimates

## Where do Alaskans obtain their coverage?



Note Well: Many Alaskans have multiple health care coverage, hence the total of individual coverage sources adds to more than the population.

The Military and Indian Health Service/Tribal Health systems provide coverage to roughly 1/3 of Alaskans. Combined, these two systems provide 8X more coverage as a proportion of the population in Alaska compared to the U.S. average.

Also note material differences between Alaska and U.S. with respect to:

2. Direct Purchase (3.6 pct points)
3. Medicaid (3.2 pct points)
4. Medicare (4.6 pct points)

## How does federal reform address health insurance coverage?

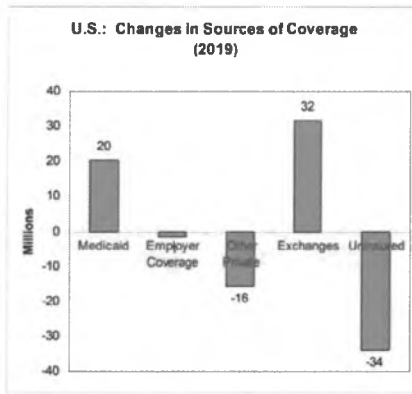
- Medicaid expansion for adults not previously eligible; up to 133% of Federal Poverty Level
- Individual mandate with subsidies & exceptions
- Pay or play mandate for Business >50 employees
- Subsidies for Business <50 employees
- Insurance coverage mandates = young adults up to 26 years on parents plan, “free” preventative services, phase out of benefit limits (exceptions emerging from regulations process), guarantee coverage to all consumers under age 19, mental health coverage

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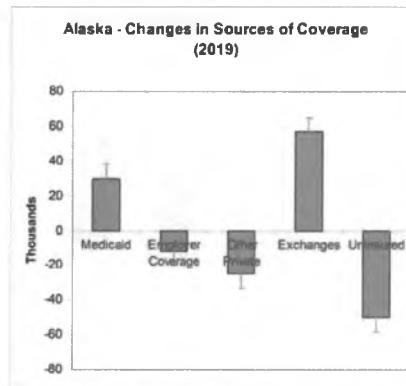
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## Health Reform: Projected Changes in Sources of Coverage, 2019 (5 years after individual insurance mandate begins)



Source: CMS Office of the Actuary (22 Apr 2010)



Source: MAFA Preliminary Estimate – CMS Office of the Actuary (22 Apr 2010) with Preliminary Alaska Market Adjustments

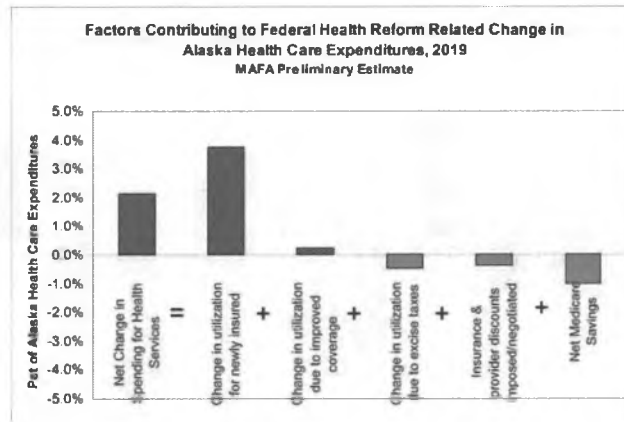
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This is a preliminary estimate of the implications of the Federal Health Care Reform package on health insurance coverage in the U.S. and Alaska **in 2019, a full five years after the individual insurance mandate takes effect**, based on scaling the CMS Office of the Actuary Estimates (22 April 2010) estimate proportions to Alaska with *preliminary adjustments* based on Alaska Market differences from national averages.

## Factors Contributing to Change in Spending



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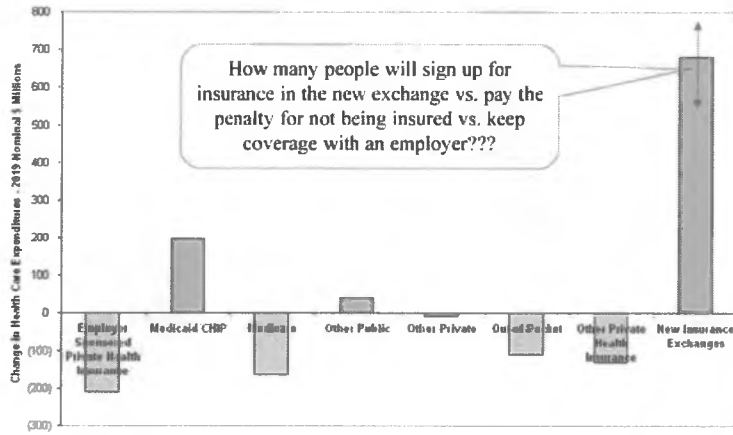
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Here is a summary of the basic factors associated with the Affordable Care Act (ACA) which drive health care expenditures.

## Summary of Shifts in Health Expenditures in Alaska, 2019

### Impact of Federal Health Reform on Health Care Expenditures - Alaska (2019)

Source: CMS Impact Estimates (April 22, 2010) Applied to Alaska with Local Market Adjustments



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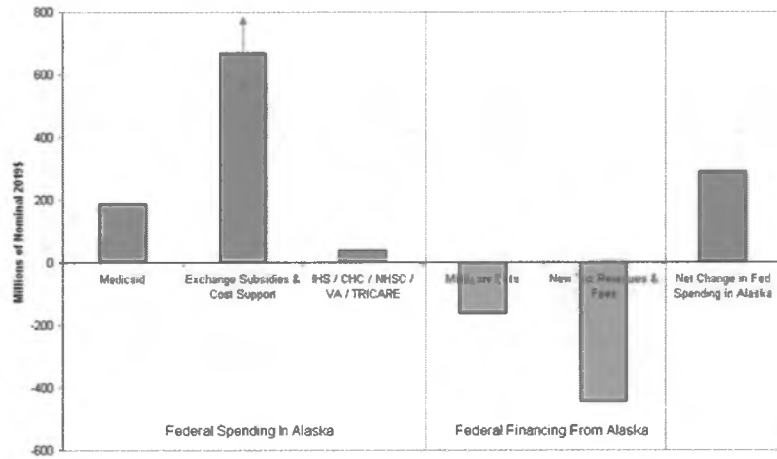
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## Change in Federal Spending in & Revenues from Alaska, 2019

### Change in Federal Spending in & Revenues from Alaska, 2019

Source: CMS Office of the Actuary (April 22, 2010); JCT (March 20, 2010); with adjustments for Alaska Market



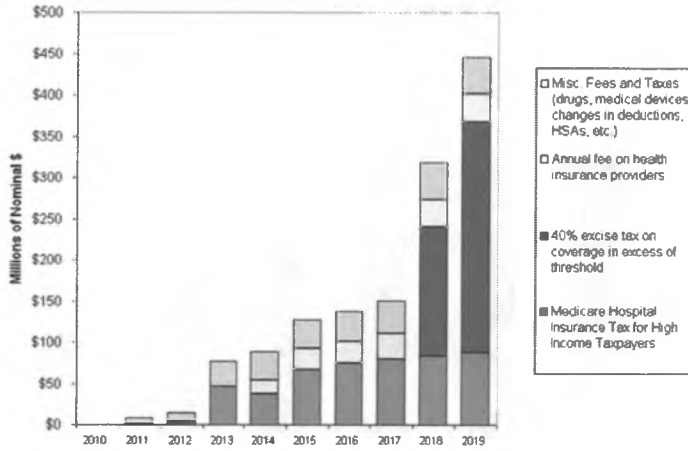
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# Alaska Households – Taxes & Fees

**New Taxes & Fees for Alaska Households under Federal Health Reform**



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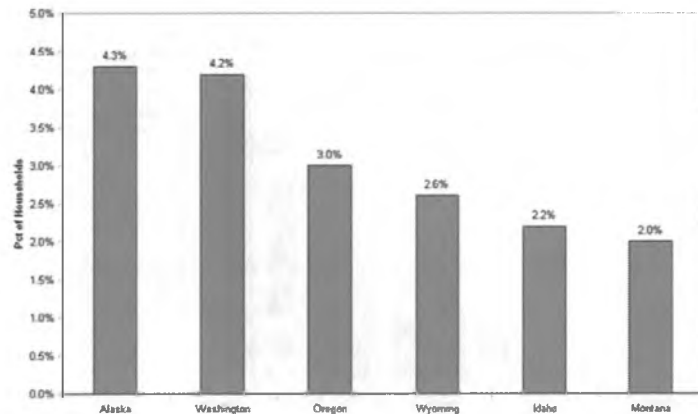
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## Alaska Households – Taxes & Fees:

Medicare Hospital Tax on income and investment income lands disproportionately on AK & WA due to higher proportion of household incomes > \$200K/year

Households with Incomes > \$200,000  
(American Community Survey, 2006-2008)



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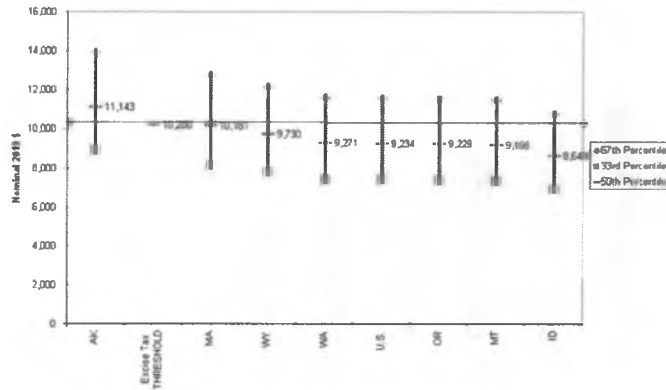
It appears that Alaska has roughly the same proportion of households with “high income” as Washington State (and it turns out the U.S. as a whole) – we use the American Community Survey data from 2006-2008 as a proxy for the proportion of high income households (>\$250,000) in the U.S. and in the Western States that would be subject to the Medicare Hospital Tax.

It appears that several other Western States (OR, WY, ID, MT) have a smaller portion of high income households and their economies can expect a lower *relative* federal Medicare Hospital Tax burden on their economies as a result.

## Alaska Household Taxes & Fees:

**40% excise tax on health insurance above excise tax thresholds hits Alaskan households disproportionately due to higher cost of health care and health insurance in AK**

Estimate of Single Premiums in Selected Western States/U.S. in 2019  
Source: MEPS, 2008; Projected to 2019



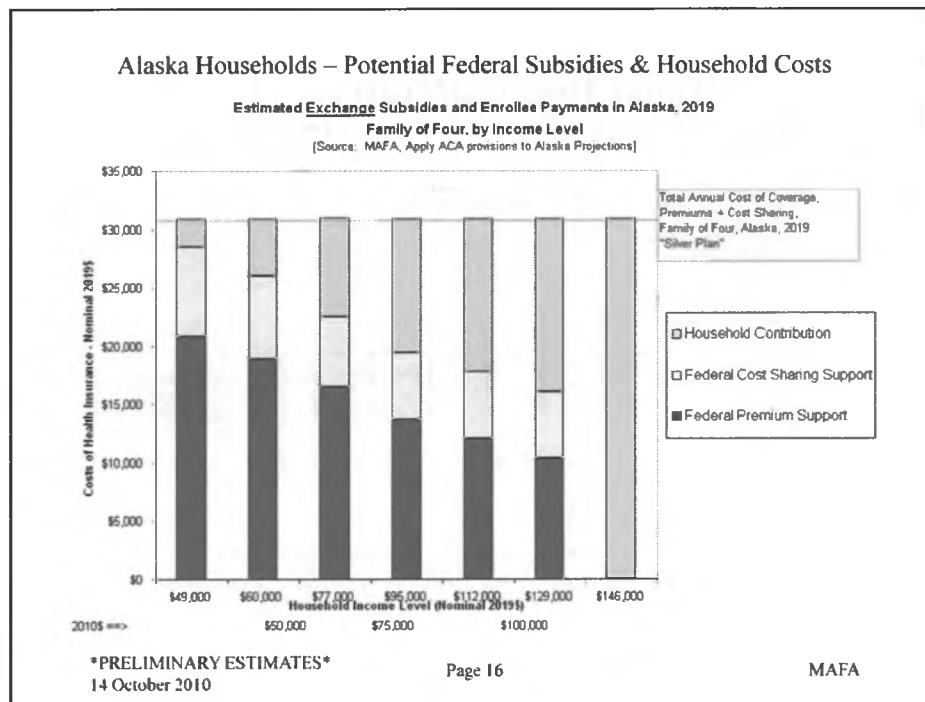
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Based on current projections of cost increases and starting with a higher cost base of Alaska insurance, the 40% excise tax on high cost insurance may have a larger impact on the residents of Alaska compared to other states as a rapidly increasing portion of Alaskan health insurance plans look likely to exceed the excise tax thresholds by 2019.

This projection illuminates current trends. It does not attempt to anticipate potential adjustments in wage/benefit ratios in compensation packages that are likely to occur as employees and employers adjust wages and benefits in light of the new tax on benefits.



The PPACA provides for premium subsidies and cost sharing support for those with incomes <400% of federal poverty guidelines who enroll in health insurance offerings through the new insurance Exchange.

This chart is an estimate of the Exchange subsidies (premium support plus cost sharing support) and enrollee contributions toward health care costs for a family of four in Alaska in 2019 separated into household income levels that correspond to the mid point of the poverty level “bins” established in the PPACA, e.g., 133-150%, 151-200%, 201-250%, 251-300%, 301-350%, 351-400% of FPL.

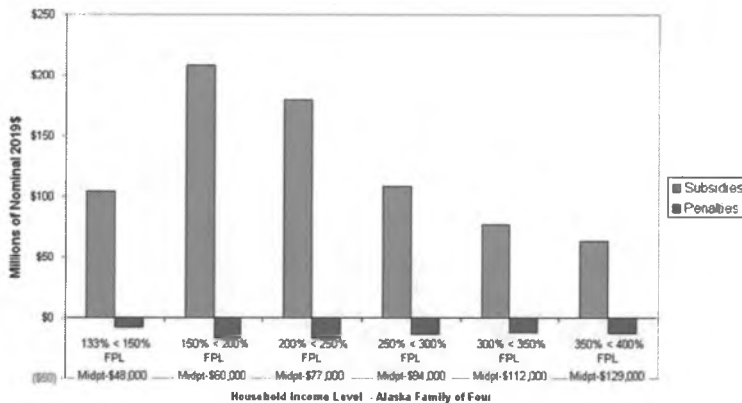
Please note that any household contributions to these insurance costs are made with after tax dollars as compared to health insurance offered by employers that is under the 40% excise tax threshold (\$27,500 for a family plan). You’ll note the estimated cost of health insurance for our “reference plan” for a family of four (“Silver Plan” described in the PPACA) is \$30,900 for premiums **and** cost sharing (deductibles, co-pays).

Also note that the *household contribution* as a percentage of household income is projected to run from 5% for households with incomes 138%-150% of FPL to around 20% for for households between 400%-500% of FPL.

Alaska Households - Aggregate Estimate of Subsidies & Penalties by Income, 2019

Aggregate Household Subsidies (<400% of FPL) & Penalties by Income Levels, AK, 2019

(Estimates assuming 50% sign-up in exchange and 50% either retain or find Employer Sponsored Insurance or pay penalty and remain uninsured)



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The net effect of higher poverty guidelines and a higher cost of care/insurance in Alaska is a relatively high level of premium subsidies and cost sharing support that could potentially flow to Alaskan households eligible for subsidies and cost sharing.

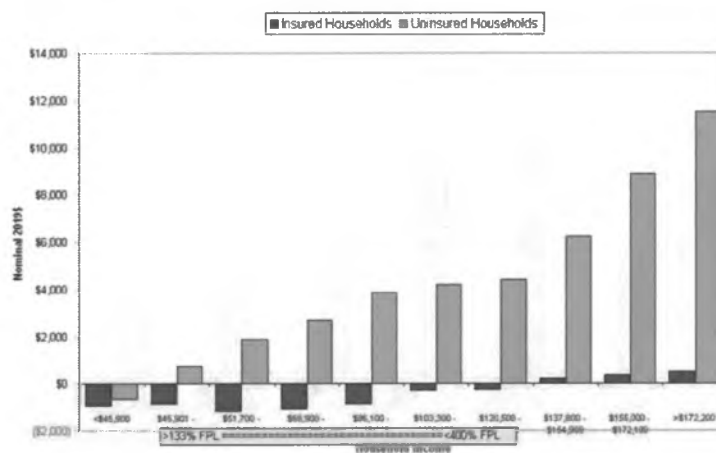
Here, assuming 50% of those eligible enroll in the new Exchange and 50% either retain or find Employer Sponsored Insurance or pay the penalty and remain uninsured, we estimate, based the proportion of the population in each income bin in 2019, the aggregate amount of subsidies and penalties that might be received/paid by Alaskan households.

In addition, American Indians/Alaska Natives (AI/AN) do not have to pay co-pays or other cost sharing if their income does not exceed 300 percent of Federal Poverty Guidelines. The higher proportion of AI/AN in Alaska creates the *potential* for additional federal cost sharing subsidies depending upon whether AI/AN households sign up for insurance under the new Exchange.

Given the relatively generous subsidies and cost support available to individuals in the Exchanges compared to the relatively limited amount of support available to businesses, it would not be surprising to see a number of businesses consider dropping insurance coverage and increasing wages in order to provide a net benefit to their employees and reduce their overall cost of labor at the same time. It is also worth noting that Employer Sponsored Health Benefits under the excise tax thresholds are pre-tax, while purchases of mandated health insurance in the Exchange will use after-tax income, which becomes a consideration in the discussion between employers/employees over potential shifts in wage/benefit policies.

## Alaska Households - Change in Spending by Income, 2019

Changes in Avg. Alaskan Household Health Spending Under Reform, 2019



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Please note that this represents the aggregate average of:

Previously non-group insured who shift to the subsidized Exchange

Previously employer-sponsored insured who shift to the subsidized Exchange

Previously employer-sponsored insured who stay with their employer-sponsored coverage

Previously uninsured who shift to the subsidized Exchange

Previously uninsured who remain uninsured and pay a penalty

Previously uninsured who remain uninsured and are exempt from the mandate and associated penalties

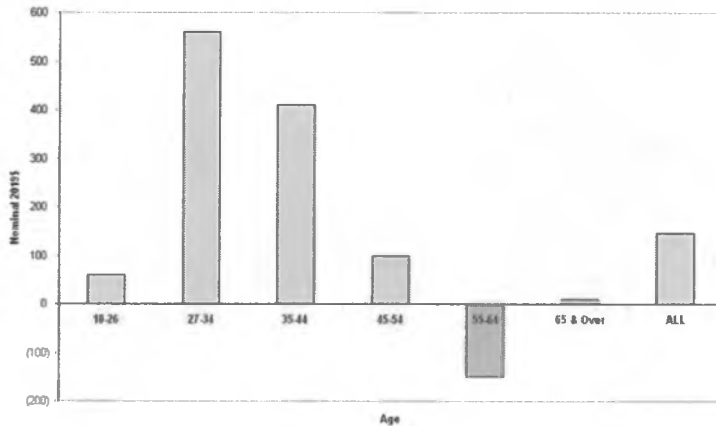
The significant changes *in health spending* by income associated with health reform include:

In aggregate average, households that change from Employer Sponsored Insurance to the Subsidized Exchange and receive a net reduction in expenditures due to generous subsidies relative to previous support for health care from their employer.

Previously uninsured who receive both subsidies and cost support to cover a portion of their total health care bill, but most also come up with additional out of pocket cost support (deductibles, co-pays) beyond what they would have without health insurance.

## Alaska Households - Change in Spending by Age of Household Head, 2019

Changes in Average Annual Family Health Spending by Age of Household Head - Alaska  
Source: MAFA Estimates, June 2010



\*PRELIMINARY ESTIMATES\*  
14 October 2010

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MAFA

The change in the average annual family health spending by age is primarily driven by the change in expenditures by age associated with the new enrollees in the subsidized insurance Exchange.

Some of the new enrollees in the Exchange are coming from the non-group market where premium age bands are typically on the order of 5:1 – which tend to reflect the underlying cost of care across age groups.

Some of the new enrollees in the Exchange are coming from the Employer-Sponsored Insurance market where premiums are typically based on the age distribution of the employer's pool of covered employees and tend to reflect actuarial age variation on the order of 5:1 or more.

Some of the new enrollees in the Exchange are coming from the ranks of the uninsured, where previous out of pocket expenditures tend to track direct costs which tend to roughly vary more in line with the insurance market.

The PPACA limits premium variation due to age to 3:1, in essence shifting costs to a younger demographic and reducing costs for an older demographic relative to the prior market where prices tended to follow costs more closely.

		Alaska Business – Overview of Key Provisions by Segment		
AVERAGE ANNUAL WAGES/INCOME	>\$200,000 Net Income	Subject to 40% excise tax on coverage amount above \$10,500/\$27,300 thresholds (single households)  Subject to insurance mandate as individual. Subject to new Medicare taxes. Individual premiums may increase as offset to declining deductibles & co-pays decline under new rules		
	>\$50,000	Subject to insurance mandate as individual. Individual premiums increase as deductibles and co-pays decline to new std. Subsidies available for incomes up to \$69,270/\$141,158 (2019\$)	Exempt from "pay or play" insurance mandate	Subject to "pay or play" insurance mandate Median Coverage Cost Est (2019) = \$10,600/26,700 Penalty for firms where at least one employee receives subsidies in the exchange = \$2,000 per full time employee (first 30 Employees not counted)
	<\$50,000	Subject to insurance mandate as individual. Individual premiums increase as deductibles and co-pays decline to new std Subsidies available from Exchange	Exempt from "pay or play" insurance mandate Phase I (2010-2013) tax credits available <26 employees Phase II (>2014) tax credits available for two years, <26 employees	Subject to "pay or play" insurance mandate Median Coverage Cost Est (2019) = \$10,600/26,700 Penalty for firms where at least one employee receives subsidies in the exchange = \$2,000 per full time employee (first 30 Employees not counted)
		Self-employed	<50 employees	>50 employees
FIRM SIZE by NUMBER OF EMPLOYEES				
*PRELIMINARY ESTIMATES*		Page 20		MAFA
14 October 2010				

Note well that self-employed, roughly 10% of employment in Alaska (similar to U.S.) who are currently purchasing insurance in the non-group ("individual") market will tend to see an increase in premiums associated with changes in coverage requirements and will in essence be making a larger contribution into the health insurance pool in order to support lower income and less healthy individuals.

To the extent that the self-employed make more than \$200,000 single/\$250,000 household, they will also be subject to additional Medicare taxes.

Effect of Health Reform on Premiums for Health Insurance in 2019

Table 1 - Alaska			
Effect of ACA on Average Premiums for Health Insurance in 2019			
	Percentage of Market		
	NonGroup	Small Group	Large Group
Distribution of Nonelderly Population Insured in Respective Markets	12%	12%	76%
Under the ACA			
Differences in Average Premiums Relative to Baseline			
Due to:			
Difference in Amount of Insurance Coverage	+26% to +32%	0% to +4%	0% to +3%
<i>Cap on deductibles, more first \$ coverage, unlimited lifetime claims</i>			
Difference in Price of a Given Amount of Insurance Coverage for a Given Group of Enrollees	0% to -10%	-1% to -4%	negligible
<i>Open exchange competition may lead to lower prices, alternatively more competitive insurance market may have less bargaining leverage vs. local hospitals and physician groups</i>			
Difference in Types of People with Insurance Coverage			
<i>Healthier new pool vs. anti-selection bias</i>	-10% to +5%	-1% to +2%	0% to -3%
<b>Total Difference Before Accounting for Subsidies</b>	<b>+8% to +32%</b>	<b>+2% to -2%</b>	<b>+3% to -3%</b>

\*PRELIMINARY ESTIMATES\*  
14 October 2010

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MAFA

Please note that this analysis lays out the estimated changes in health insurance premiums by type of insurance market **before subsidies are applied**.

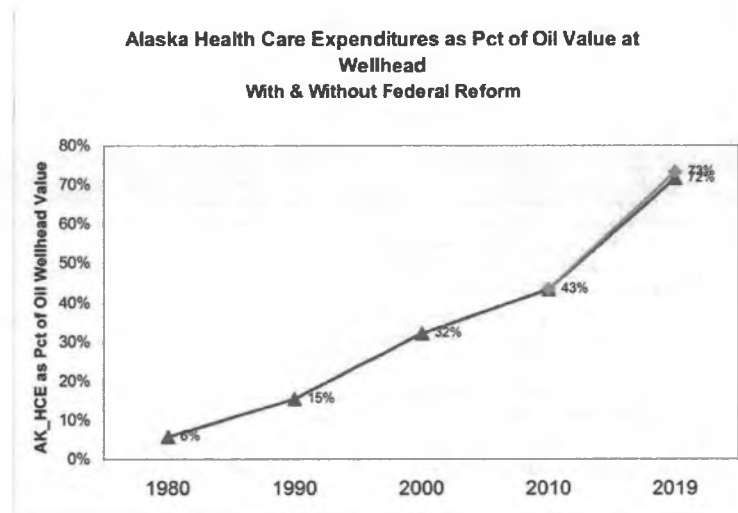
For the net effect of the health insurance cost changes and new subsidies, see

Slide 16 “Alaska Households – Potential Federal Subsidies & Household Costs”

Slide 18 “Alaska Households – Change in Spending by Income”

Slide 19 “Alaska Households – Change in Spending by Age of Household Head”

## Alaska Health Care Sector Expenditures, 2019



\*PRELIMINARY ESTIMATES\*  
14 October 2010

Page 22

MAFA

Finally, it is worth noting that the incremental impact of health care reform might be on the order of \$250 million in net new health care expenditures on \$18 billion of Oil Wellhead Value in Alaska; which amounts to a 1.4% increase.

While the increase associated with the ACA may be a relatively small increase in overall health expenditures, it can also be seen by those who are concerned with rapidly escalating cost growth as a lost opportunity.

Current and past Congressional Budget Office (CBO) directors have become increasingly concerned that rapidly escalating health care costs, especially for federal programs [Medicaid and Medicare], are simply not sustainable. See also Joe Newhouse, Implied Federal Tax Rates required to sustain Medicare on its current trajectory, figure 4, "Assessing Health Reform's Impact on Four Key Groups of Americans", Health Affairs, September 2010.

### **Large uncertainties remain.**

Will the Medicare reductions for hospitals, nursing homes and home health to capture "productivity" be sustainable or will additional expenditures be required to sustain Medicare?

Will Medicare reductions be made in physician payments similar to the "productivity" adjustments slated for hospitals, nursing homes and home health?

If the slated Medicare productivity savings are achieved, will they be an artifact of "cost-shifting" (accepting lower margins for Medicare while increasing margins for other payers) or will the productivity savings reflect more efficient operations throughout the hospital, nursing home and home health enterprise and be shared by all health insurance payers?

Will top down global budgeting controls help bend the cost curve at the same time there is an aggregate reduction in out-of-pocket spending by individuals as costs are shifted to others, especially federal subsidy and cost support programs?

Alaska Health Care Commission 2010 Report

## **Appendix D**

**Voting Records**

**Summary of Public Comments**

**Ethics Reports**

## 2010 Commission Voting Record

Updated: 01-14-11

Date	Motion	Vote
10-14-10	To approve the Commission's SFY2011 budget as presented	Moved by Commissioner Davidson for unanimous consent (second not required). The motion was passed with Unanimous Consent with no objection. Individual votes were not recorded. Voting members present: Ward Hurlburt, Patrick Branco, Keith Campbell, Valerie Davidson, Jeffrey Davis, Emily Ennis, Paul Friedrichs, Timothy Noah Laufer, David Morgan, Wayne Stevens, Larry Stinson
11-16-10	To approve amendments to the Commission bylaws originally presented at the October Commission meeting	Moved by Commissioner Stevens. Seconded by Commissioner Campbell. Passed unanimously. Individual votes were not recorded. Voting members present: Ward Hurlburt, Patrick Branco, Keith Campbell, Valerie Davidson, Jeffrey Davis, Emily Ennis, Paul Friedrichs, Timothy Noah Laufer, David Morgan, Wayne Stevens, Larry Stinson
01-07-11 <i>(votes taken at this early 2011 meeting that were pertinent to the 2010 Report are included in the 2010 Voting Record)</i>	<p>To approve the 1-4-11 draft 2010 Evidence-Based Medicine Findings as final.</p> <p>To amend Finding A.3.d by changing the word "consumers" to "patients"</p> <p>To add new Finding A.3.e "Existing mechanisms to assess patients' compliance with evidence-based medical recommendations are limited."</p>	<p>Moved by Commissioner Campbell. Seconded by Commissioner Stevens.</p> <p>Moved by Commissioner Friedrichs, seconded by Commissioner Laufer. Vote to Approve: Hurlburt, Campbell, Davis, Ennis, Friedrichs, Laufer, Stevens, Stinson. Opposed: Morgan.</p> <p>Moved by Commissioner Friedrichs. Passed unanimously.</p> <p>Motion to approve 2010 Evidence-Based Medicine findings as amended passed unanimously. 9 of 11 voting members were present: Hurlburt, Campbell, Davis, Ennis, Friedrichs, Laufer, Morgan, Stevens, and Stinson.</p>

01-07-11	<p>To approve the 1-4-11 draft 2010 Evidence-Based Medicine Recommendations as final.</p> <p>To add new Recommendation A.3.d “State health care programs will seek to incorporate data on patient compliance in developing new provider payment methods and benefit design.”</p>	<p>Moved by Commissioner Campbell. Seconded by Commissioner Ennis.</p> <p>Moved by Commissioner Morgan, seconded by Commissioner Stevens. Motion to approve amendment passed unanimously.</p> <p>Motion to approve 2010 Evidence-Based Medicine recommendations as amended passed unanimously. 9 of 11 voting members were present: Hurlburt, Campbell, Davis, Ennis, Friedrichs, Laufer, Morgan, Stevens, and Stinson.</p>
01-07-11	<p>To add new 2010 Evidence-Based Medicine Finding A.3.f “Assessing the outcomes of health care interventions is challenging due to limitations on collecting and sharing data among patients, clinicians, payers, and government agencies.”</p>	<p>Moved by Commissioner Friedrichs. Voting to approve: Campbell, Davis, Ennis, Friedrichs, Laufer, Morgan, Stevens, and Stinson. Opposed: Hurlburt.</p> <p>9 of 11 voting members were present: Hurlburt, Campbell, Davis, Ennis, Friedrichs, Laufer, Morgan, Stevens, and Stinson.</p>
01-07-11	<p>To add new 2010 Evidence-Based Medicine Recommendation A.3.e “The Commission recommends the State of Alaska DHSS implement a web-based data system for public health information.”</p>	<p>Moved by Commissioner Stevens, Seconded by Commissioner Friedrichs. Passed Unanimously.</p> <p>9 of 11 voting members were present: Hurlburt, Campbell, Davis, Ennis, Friedrichs, Laufer, Morgan, Stevens, and Stinson.</p>
01-07-11	<p>To approve the 2010 report as amended.</p>	<p>Passed unanimously.</p> <p>9 of 11 voting members were present: Hurlburt, Campbell, Davis, Ennis, Friedrichs, Laufer, Morgan, Stevens, and Stinson.</p>

## 2010 Record of Public Comments Received by the Alaska Health Care Commission

Updated: 1-2-2011

Subject	Commenter	Summary of Comments	Form & Date
Access to Care; Alaskans with Brain Injuries	Jennifer Charvet; Alaska Brain Injury Network; Anchorage	The needs of Alaskans with brain injuries are great and span the entire health spectrum. The Network has a ten-year state plan to best meet the needs of Alaskans and suggest it may be of help in the Commission's work.	Public Hearing 10-14-10
Workforce; Recruitment and Retention	Rebekah Smith; 4 <sup>th</sup> year WWAMI Student; Anchorage	In order to keep Alaskan medical students in Alaska, there needs to be more educational opportunities here, specifically more residency options.	Public Hearing 10-14-10
PPACA; Insurance Market Reform	Pat Luby; AARP Alaska; Anchorage	The State of Alaska should implement the PPACA provision extending dependent coverage to 26 years of age for the State retiree health plan.	Public Hearing 10-14-10
Role of Nurses in Health Reform; Workforce	Debbie Thompson; Alaska Nurses' Association; Anchorage	The Alaska Nurses' Association is in support of the Commission and recognizes the importance of the Commission's work. A representative from the group will be present at all further meetings, and the Association would like to be as involved as possible in the meetings. Ms. Thompson was later asked to discuss the recommendations that the Nurses Association have for the Commission in increasing the amount of nurses in Alaska as well as the quality of life of nurses.	Public Hearing 10-14-10
Workforce; Recruitment & Retention	Shelley Hughes; Alaska Primary Care Association	The licensing process should be more efficient than 6-12 months long. The scope of practice barriers need to be removed. A state controlled incentive program needs to be established for recruitment and retention.	Public Hearing 11-16-10
PPACA; Medicare Access	Woolsey Lent; concerned citizen	The Commission should support Sen. Begich's Medicare state grant provision included in the Patient Protection & Affordable Care Act.	Public Hearing 11-16-10
Long term care	Kay Branch; Alaska Native Tribal Health Consortium (ANTHC)	ANTHC recently completed a feasibility study on development of a Native long term care facility. Alaska has the fastest growing senior population, but has added no new nursing home beds (except 2 in Homer and 8 in Juneau) since 1980s. The Commission should included long term care as part of the continuum of health care.	Public Hearing 11-16-10

Prevention; Community Health Data	Katherine Farnham (on behalf of Elizabeth Ripley, MatSu Health Foundation)	MatSu is working on a community health assessment. DHSS needs permanent, sustainable community health data, to support local coalitions' work. Offered to present at further meeting on idea for public-private partnership to develop this data system. Goal: better access to existing health data.	Public Hearing 11-16-10
Workforce; Emergency Medical Services	Dr. Koehler, Ft. Wainwright/ Fairbanks; ACEMS	Volunteer pre-hospital emergency medical workers are critical and should be included in health workforce planning.	Public Hearing 11-16-10
Prevention; Nutrition & Physical Activity; Dieticians	Leslie Shallcross; Alaska Dietetic Association	Include Registered Dieticians in health care planning. Improving nutrition and engagement in physical activity are important health care strategies.	Public Hearing 11-16-10
Insurance Benefit Design; Spiritual Care	Bev Smith	Requesting that state of Alaska make appropriate accommodation for spiritual care in any key health care bills to ensure that the public will continue to have access to spiritual care in conjunction with any state health care reform legislation.	Meeting With Executive Director 12-8-10

### Comments Received During Public Comment Period (Dec. 14-30, 2010)

Subject	Commenter	Summary of Contents	Form and Date
Health Reform	Arndt von Hippel, M.D. (ret.)	Dr. von Hippel provided an electronic copy of his book <u>Better Health Care at Half the Cost</u> . (331 pages; available to commission members on request)	Email 12-15-10
Workforce; Emergency Medical Services	Danita Koehler, M.D.	Include volunteer EMTs in workforce assessment and development.	Email 12-22-10
Insurance Benefit Design; Rehabilitation Services	Cindy Chapman, Commission on Rehabilitation Counselor Certification (Arlington, VA)	Alaska should include Rehabilitation Services as a covered service in insurance benefit design under PPACA.	Letter dated 12-21-10 transmitted via email 12-23-10
Medical Home	Eric Britten	Support near term development of an Alaska medical home pilot project and development of an Alaska medical home model. Add recommendation that Alaska medical home pilot projects and future model include standards that ensure evidence-based medicine guides decision making.	Letter dated 12-27-10 transmitted via email 12-27-10

Behavioral Health; Long Term Care	Delisa Culpepper, Alaska Mental Health Trust Authority (Anchorage)	Behavioral health and long term care are important and costly issues in the health care discussion. Keep them on the list of issues and strategies for future study and recommendations by the commission, and reference this list in the report.	Email 12-29-10
Rural Health; Healthy Lifestyles; Workforce; Health Information Technology	Nancy Merriman, Denali Commission (Anchorage)	Highlight unique factors that rural Alaskans face in living healthy lifestyles. Include Behavioral Health Aide and Dental Health Aide/Therapists in discussions on Alaskan innovations in health care. The supply and distribution of sound health care facilities across the state should be addressed. Explore graduate medical education opportunities provided through the Affordable Care Act. The Alaska EHR Alliance updated their physician survey in March 2010, and completed the review process and has recommended two EHR vendors for private practices in Alaska.	Letter dated 12-29-10 transmitted via email 12-30-10
Health Care Definition; Stakeholder Engagement; Billing; Health System Measures	Randi Sweet	Include a definition of "health care." Look for opportunities to involve other organizations in health system improvement. Investigate opportunities for streamlining billing processes as part of payment bundling and primary care innovation strategies. Reframe health status indicators so they are positive to encourage healthy lifestyles, rather than negative (e.g., identify % of Alaskans how don't smoke, not % of Alaskans who do).	Email 12-30-10
Evidence-Based Medicine; Patient Responsibility	Elizabeth Turgeon, M.D. (Wasilla)	Emphasize patient responsibility – don't just emphasize provider quality and evidence-based medicine. The medical home model defined by the Academy of Family Physicians would be an effective tool in the plan for Alaska health care.	Email 12-30-10
Patient Responsibility; Evidence-based Medicine; Workforce; Patient-Centered Medical Home; Cost of Care	Deborah Kiley, DNP, ANP, FAANP (Anchorage)	Incorporate personal engagement/ responsibility throughout all initiatives. What are the outcomes of evidence-based medicine programs? Studies on workforce should not be limited to physicians. Patient-centered care has been practiced by nurses for a century – include nurse practitioner practices in medical home pilots. The cost of health care needs to include an analysis of what it costs providers to operate a practice in Alaska.	Email 12-30-10
Patient Responsibility	Beth L.	Patients need to be expected to take responsibility and be compliant.	Email 12-30-10

Primary Care; Payment Reform; Tort Reform	Christopher Sahlstrom, MD (Wasilla)	Agree that primary care is the foundation of a cost-effective and high quality health care system. Especially support family medicine physicians. Concerned about bundled payment. High costs are not due to fee-for-service, but to defensive medicine. Alaska needs strict tort reform.	Email 12-30-10
Behavioral Health	J. Kate Burkhart, Advisory Board on Alcoholism & Drug Abuse and Alaska Mental Health Board (Juneau)	Do not ignore the significance of the behavioral health challenges and the importance of behavioral health needs and issues in Alaska. Include a more holistic view of health and incorporate behavioral health in the Commission's developing plan.	Letter dated 12-30-10 transmitted via e-mail 12-30-10
Healthy Lifestyles; Workforce; Medical Homes; Medicaid; Veterans' Care	Shelley Hughes, Alaska Primary Care Association (Anchorage)	The Commission should recommend that the Governor lead a health challenge encouraging healthy lifestyles, support a state loan repayment/incentive program to recruit health care providers, and support a medical home pilot project. During 2011 the Commission should study access to and usage of primary care, and also underinsurance. During 2011 the Commission should consider as strategies Denali KidCare expansion, inclusion of behavioral health providers at primary care clinics in State Medicaid Plan, streamlined processes for Veterans who do not have access to VHA facilities, policies to encourage health care performed by all types of Health Aides, and efficient health professions licensing.	Document transmitted via e-mail 12-30-10
Medical Homes	Marilyn Kasmar, Alaska Primary Care Association (APCA) (Anchorage)	Medical homes empower patients to become more active participants in the management of their health, improve patient satisfaction, increase clinical quality and safety, improve provider and staff satisfaction and is a catalyst for controlling the escalating cost of health care. APCA is working to support transformation of Alaska's Community Health Centers to medical home – however, current nationally accepted medical home standards cannot be widely implemented across Alaska. Include a recommendation in the 2010 report supporting the commencement of planning for an Alaska medical home pilot in 2011.	Letter dated 12-30-10 transmitted via e-mail 12-30-10
Long Term Care	Denise Daniello, Alaska Commission on Aging (Juneau)	Seniors, persons with developmental disabilities, and other vulnerable Alaskans depend on long-term supports to help them remain in their homes and communities.	e-mail 12-31-10

# STATE OF ALASKA

**DEPT. OF HEALTH AND SOCIAL SERVICES**  
ALASKA HEALTH CARE COMMISSION

**SEAN PARNELL, GOVERNOR**

3601 C Street, Suite 902  
Anchorage, Alaska 99503  
PHONE: (907) 269-7800

**DATE:** January 3, 2010

**TO:** Kamie Willis, Litigation Assistant  
Opinions, Appeals, & Ethics Section  
Department of Law

**FROM:** Ward Hurlburt, MD, MPH, Chair  
Alaska Health Care Commission  
Department of Health & Social Services



**SUBJECT:** Executive Branch Ethics Act, AS 39.52 Quarterly Report: Oct. – Dec. 2010

As designated ethics supervisor and chair for the Alaska Health Care Commission, I wish to advise you that I have received no notifications of potential violations or requests for ethics determinations under the Ethics Act (AS 39.52) and have made no written determinations for this quarter.

No other commissioner disclosed a potential conflict of interest at a recorded public meeting during this quarter.

# Ethics Supervisor Quarterly Statistical Summary\*

Reporting Period: October 1, 2010 – December 31, 2010

## Alaska Health Care Commission

<u>Type of Disclosure</u>	<u>Number Reviewed</u>
---------------------------	------------------------

*All agencies, boards, commissions and public corporations:*

Notices of Potential Violation	<u>0</u>
Requests for Ethics Determination	<u>0</u>
Gifts	<u>0</u>
Gifts from Other Governments	<u>0</u>
Interests in Contracts, Grants, Leases, Loans	<u>0</u>

*Agencies only:*

Outside Employment or Services	<u>      </u>
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*Boards, commissions and public corporations only:*

Conflicts of Interest stated orally at board/commission meetings	<u>0</u>
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\* Please report the total number of written disclosures in each category, regardless of disposition. You need not report informal oral or email contacts, only those disclosures submitted on ethics disclosure forms.

\* Attach this summary to your regular quarterly report.

# 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

**DATE:** October 8, 2010

**TO:** Kamie Willis, Litigation Assistant  
Opinions, Appeals, & Ethics Section  
Department of Law

**FROM:** Ward Hurlburt, MD, MPH, Chair  
Alaska Health Care Commission  
Department of Health & Social Services



**SUBJECT:** Executive Branch Ethics Act, AS 39.52 Quarterly Report: July – Sept 2010

As designated ethics supervisor and chair for the Alaska Health Care Commission, I wish to advise you that I have received no notifications of potential violations or requests for ethics determinations under the Ethics Act (AS 39.52) and have made no written determinations for this quarter.

As designated ethics supervisor and chair, I wish to report that the Alaska Health Care Commission did not meet during this quarter. Legislation establishing this commission was signed into law in June and the members were appointed by Governor Parnell September 14, 2010. The commission will hold its first meeting later in October.

# Ethics Supervisor Quarterly Statistical Summary\*

Reporting Period: July 1, 2010 – September 30, 2010

## Alaska Health Care Commission

<u>Type of Disclosure</u>	<u>Number Reviewed</u>
---------------------------	------------------------

*All agencies, boards, commissions and public corporations:*

Notices of Potential Violation	<u>0</u>
Requests for Ethics Determination	<u>0</u>
Gifts	<u>0</u>
Gifts from Other Governments	<u>0</u>
Interests in Contracts, Grants, Leases, Loans	<u>0</u>

*Agencies only:*

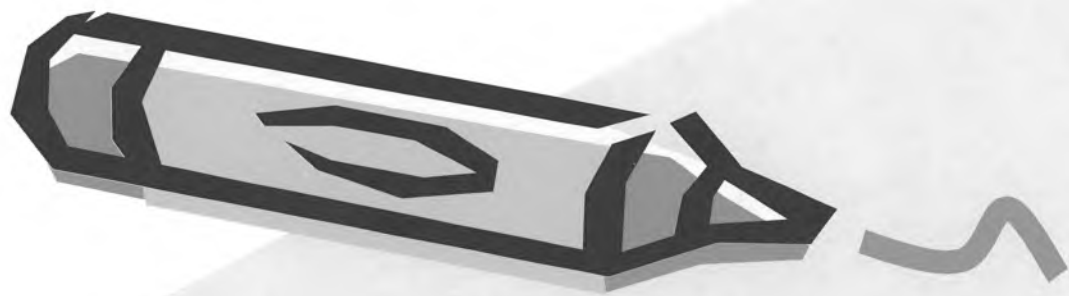
Outside Employment or Services	<u>    </u>
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*Boards, commissions and public corporations only:*

Conflicts of Interest stated orally at board/commission meetings	<u>0</u>
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\* Please report the total number of written disclosures in each category, regardless of disposition. You need not report informal oral or email contacts, only those disclosures submitted on ethics disclosure forms.

\* Attach this summary to your regular quarterly report.



# Alaska Children's Justice Act Task Force

Presentation to HSS Committee, Alaska Legislature  
February 8, 2011



# Introduction

- History of the Task Force
  - Founded 1999
  - Federally mandated to evaluate system response to child abuse in state & make recommendations for changes
    - Multidisciplinary/statewide representation
    - Federal population-based funding
- Membership & contact information
- Annual update to the legislature



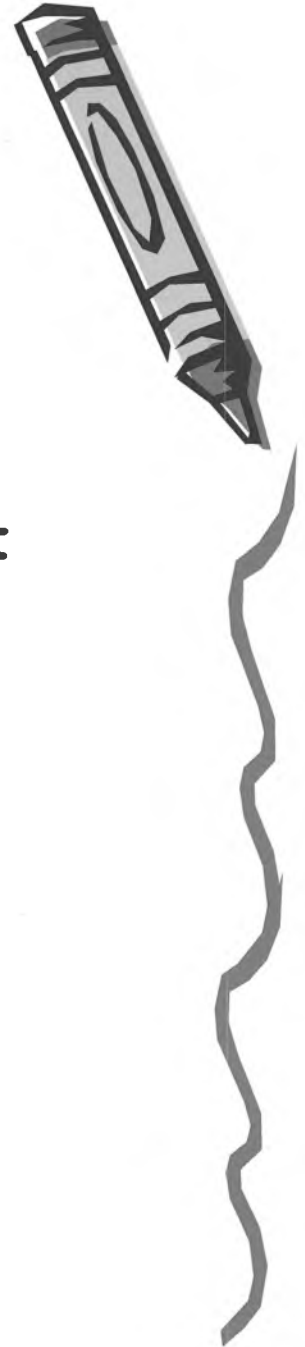
# Update

- 2010 Task Force Projects
- Child maltreatment data update
- Gaps in our laws
- Costs to our state
- Recommendations



# Some Issues Identified

- Ongoing need for education
- Wide variation in interpretation of laws and policies across state
- Gaps in our laws
- Sexual exploitation of children via the Internet
- Child sex trafficking in Alaska



# 2010 Projects

- Ongoing distribution Mandated Reporter training CD
- Sponsorship 2010 Alaska Child Maltreatment Conference
  - Collaboration with Alaska Children's Alliance
- Scholarships
  - For Alaskans working in the field
- Netsmartz link on website
- Multidisciplinary Team Guidelines
  - Also on website



SCAN

# Child Maltreatment Data In Alaska

Data collected by the  
Surveillance of Child Abuse & Neglect (SCAN) program

Jared W. Parrish, MS  
SCAN Program Director/Epidemiologist

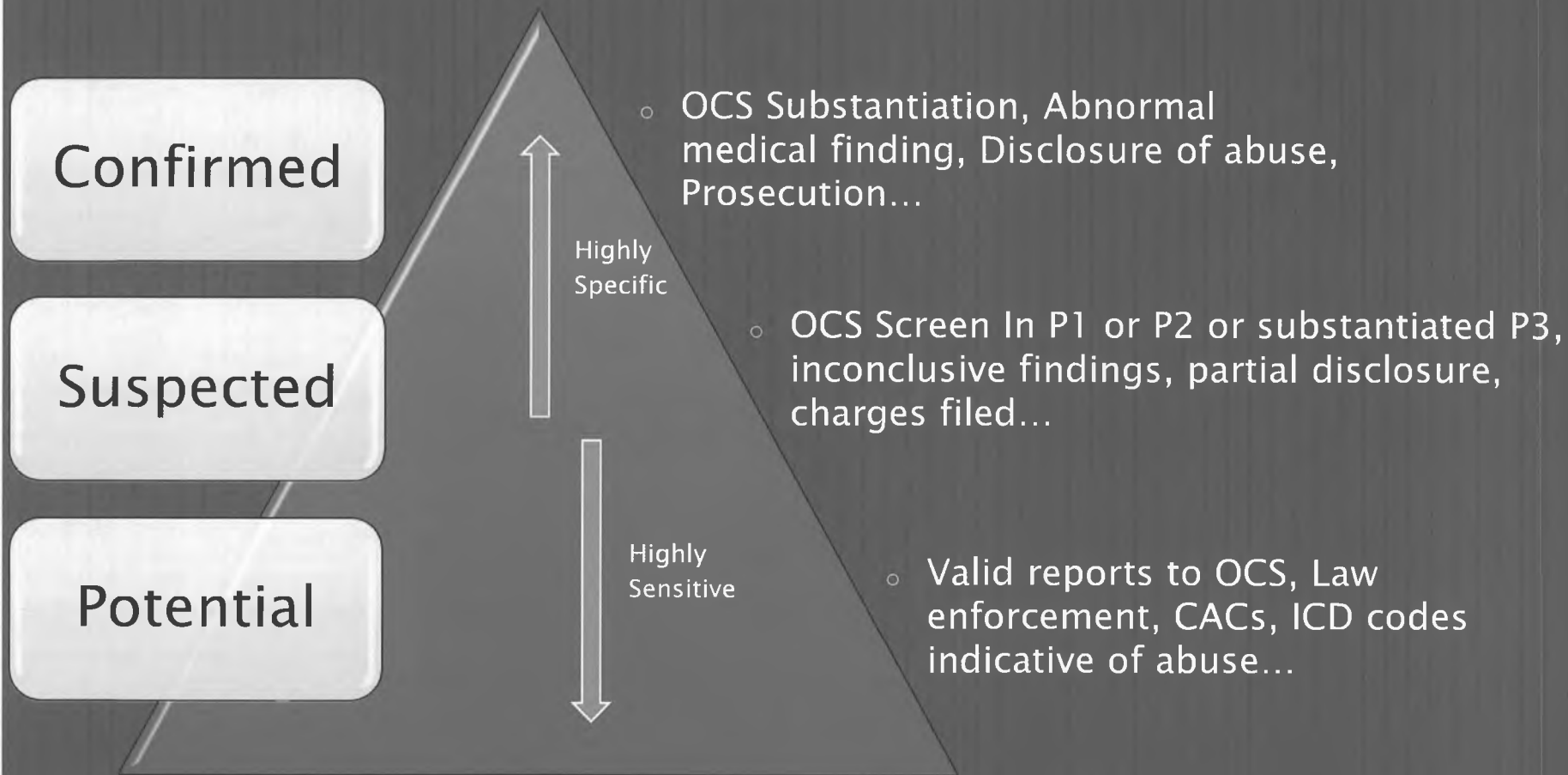
Alaska Division of Public Health  
Women's, Children's, & Family Health Section  
Maternal & Child Health Epidemiology Unit



# Public Health Surveillance

- Ongoing systematic collection and unification of existing data
- No single agency has jurisdictional responsibility of all Child Maltreatment
- Apply standardized definitions and data elements developed by CDC
- Measure “true” magnitude of the problem over time
- Identify risk/protective factors & offer recommendations
- Death and injury

# Case Designation



# Maltreatment-related Deaths



# Maltreatment-related child deaths

Deaths occurring between 2000–2008,  
children ages 0 – 9 years

- Approximately 1 out of every 5 (20%) child deaths is maltreatment-related
  - ~ 1 out of every 4 (25%) for Alaska Native children
- Nearly 3 out of every 4 (~75%) maltreatment-related deaths occur to infants
- Rate of Maltreatment-related death



# Maltreatment-related Injury



SCAN

# Research in Alaska Indicates:

<u>Factor</u>	<u>aOR</u>	<u>95%CI</u>
□ Those receiving public aid	2.48	(1.9–3.2)
□ Low maternal age or education	1.98	(1.5–2.6)
□ Maternal tobacco use	1.92	(1.5–2.5)
□ Maternal DVSA	1.92	(1.4–2.7)
□ Unmarried marital status	1.82	(1.4–2.4)
□ Maternal substance abuse	1.68	(1.3–2.2)
□ 2 or more children	1.51	(1.2–2.0)

---

**\*80% of maltreated children have 2 or more of these risk factors**

# Maltreatment – Any Type

- ▣ In 2008 ~ 12,400 children were the potential victims of at least one incident of maltreatment
  - Among the children experiencing Maltreatment, 24% had at least one incident confirmed
  - ~ 150 – 630 per 10,000 children experience at least one form of maltreatment each year
  - As many as 34 children a day are potentially maltreated, or 3,000 during this 90 day legislative session

# Maltreatment – Neglect

- ▣ In 2008 ~ 8,900 children were the potential victims of at least one incident of neglect
  - Among the children experiencing neglect, 25% had at least one incident confirmed
  - ~ 114 – 450 per 10,000 children experience at least one incident of neglect each year
  - As many as 25 children a day ,or 2,200 during this 90 day legislative session

# Maltreatment – Physical Abuse

- ▣ In 2008 ~ 2,700 children were the potential victims of at least one incident of physical abuse
  - Among the children experiencing Physical Abuse, 22% had at least one incident confirmed
  - ~ 33 – 137 per 10,000 children experience at least one incident of physical abuse each year
  - As many as 7 children a day, or 630 during this 90 day legislative session

# Maltreatment – Sexual Abuse

- In 2008 ~ 1,900 children were the potential victims of at least one incident of sexual abuse
  - Among the children experiencing sexual abuse, 16% had at least one incident confirmed
  - ~ 24 – 98 per 10,000 children experience at least one incident of sexual abuse each year
  - Potentially 5 children a day, or 450 during this 90 day legislative session

# Gaps in our laws

- Abusive head trauma:
  - Child left blind, partially deaf, seizure disorder, physical and mental disabilities
  - Because child did not die highest crime is Assault 1



# Gaps in our laws

- Torture
  - Starvation - withholding food as discipline
  - Cigarette lighter burning of 3 year old for not saying ABCs correctly



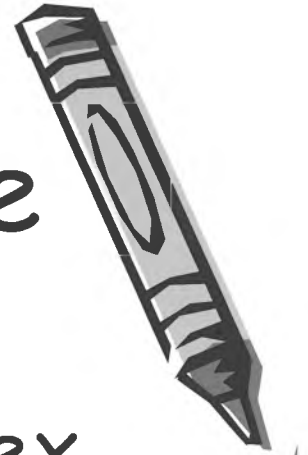
# Gaps in our laws

- Multiple forms of physical abuse over time in toddler - highest charge  
= Assault one without aggravators



# Gaps in our laws: sexual abuse

- Sexual abuse of a 5 year old = offense to 19 year old having sex with 15 year old
- No way to charge adult for sexual crimes committed as teen



# Gaps in our laws: sexual abuse

- Foster/step siblings - cannot charge with incest, cannot charge with SAM if <4 year difference
- Child on child - no way to require evaluation/treatment if <12



# What does this cost?

- Medical & mental health care
  - Short and long term
- Child protection system
- Criminal justice system
- Future earnings
- Quality of life



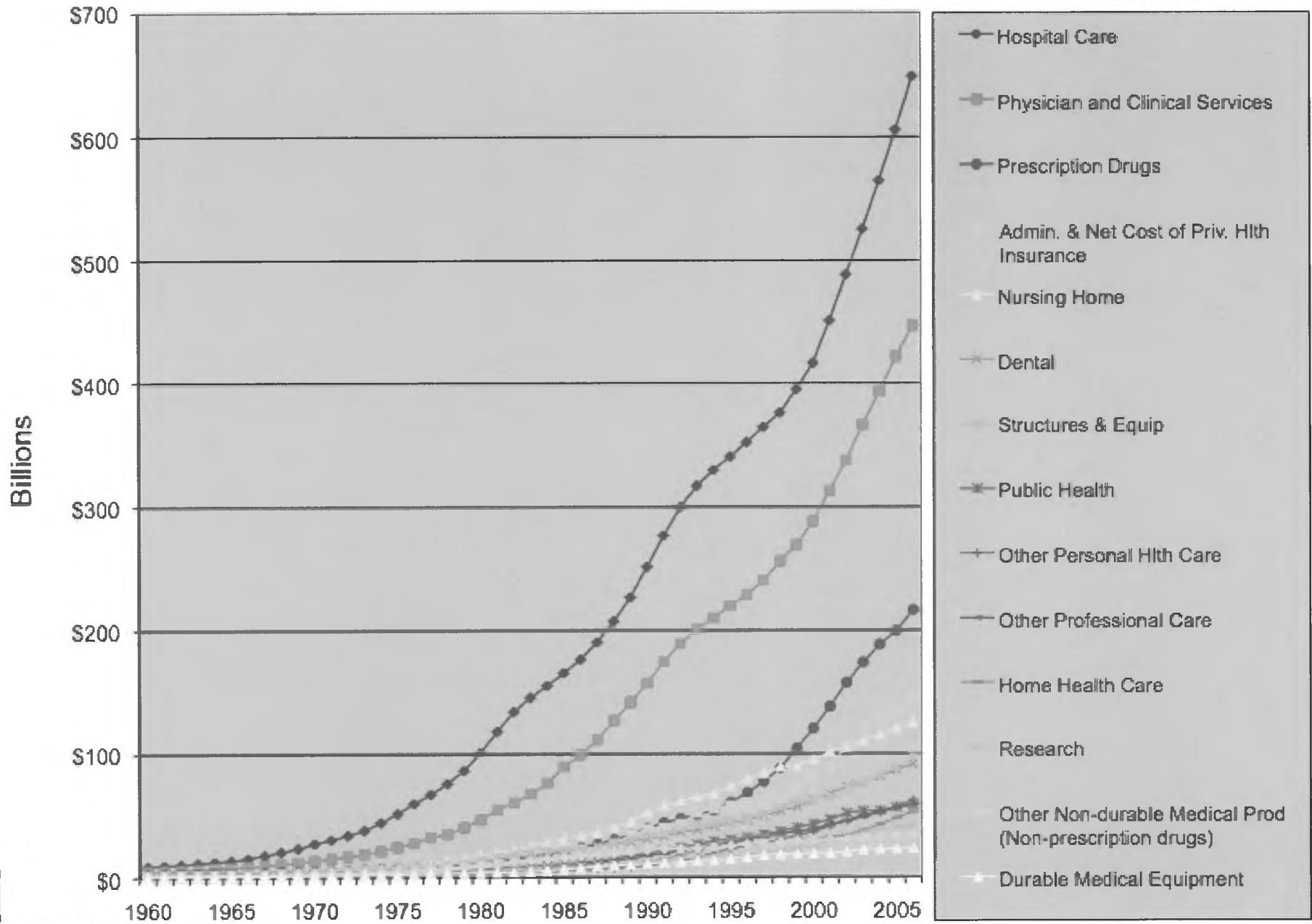
# "Turning Gold Into Lead"

- Adverse Childhood Experiences Studies
- "...much of what is recognized as common in adult medicine is the result of what is not recognized in childhood."
- Link to ALL most common causes of adult disease and death in US today



[www.cdc.gov](http://www.cdc.gov)





# Direct Annual Costs of Child Abuse & Neglect in the US

- Hospitalization >\$6.6 billion
- Mental Health Care >\$1.0 billion
- Child Welfare System >\$25 billion
- Law Enforcement >\$33 million
- TOTAL DIRECT >\$33 BILLION



# Indirect Annual Costs

- Special Education >\$2.4 billion
- Mental Health & Health Care >\$68 million
- Juvenile Delinquency >\$7.1 billion
- Lost Productivity >\$33 billion
- Adult Criminality \$28 billion
- **TOTAL INDIRECT \$70 Billion**



# Total Annual Cost of Child Abuse and Neglect in the US

- Direct Costs \$33,101,302,133
- Indirect Costs \$70,652,715,359
- **TOTAL COST**  
**\$103,754,017,492**



# Cost of Child Abuse & Neglect in Alaska

- Future earnings • \$ 23,666,000
- Medical care • \$ 2,540,500
- Mental health • \$ 55,724,600
- Property damage • \$ 50,000
- Public programs • \$ 27,131,900
- Quality of life • \$391,390,200
- **TOTAL** • **\$500,503,200**



# What are we willing to pay to keep kids safe?

- Georgia's Willingness to Pay to Prevent Child Maltreatment Survey 2008
  - Willingness to pay ~\$150/person to reduce number of deaths from child maltreatment
  - Estimated value of child's life \$15,000,000
- What are we willing to pay to keep kids safe in Alaska?



We need champions for  
children!



# In Juneau:

- Support for Governor's Choose Respect Initiative
  - Be sure children are included



# In your community

- Support for your local Child Advocacy Center
- Support for effective prevention programs



# 2011 Alaska CJATF Projects

- Legislative changes
  - Need for legislative champions to work with Task Force
  - Hold offenders accountable
  - Prevent future victimization
- Gather more information on:
  - Child trafficking
  - Child on-line sexual exploitation



# Remember:

- During this legislative session:
  - ~3000 children may be maltreated
  - ~450 children may be sexually abused
  - ~630 children may be physically abused
  - ~2200 children may be neglected
  - With a price tag of >\$123,000,000



"The world is a dangerous place to live not because of the people who are evil, but because of the people who don't do anything about it."

-Albert Einstein





# Children's Safety Network

National Injury and Violence Prevention Resource Center

Cost of Child Abuse and Neglect in Alaska (Year 2006 Incidence, Year 2007 Costs)							
Abuse Type	Future Earnings	Medical Care	Mental Health	Property Damage	Public Programs	Quality of Life	Total
<i>Sexual Abuse</i>	\$1,025,300	\$386,600	\$4,504,500	\$0	\$586,300	\$45,068,500	\$51,571,200
<i>Physical Abuse</i>	\$5,082,200	\$1,849,600	\$6,315,800	\$39,000	\$3,126,200	\$86,580,900	\$102,993,700
<i>Mental Abuse</i>	\$6,816,800	\$0	\$31,579,100	\$0	\$15,601,000	\$158,987,800	\$212,984,700
<i>Serious Neglect</i>	\$224,900	\$43,800	\$13,250,300	\$0	\$7,805,000	\$74,111,200	\$95,435,200
<i>Fatal</i>	\$10,516,800	\$260,500	\$74,900	\$11,000	\$13,400	\$26,641,800	\$37,518,400
<b>Total</b>	<b>\$23,666,000</b>	<b>\$2,540,500</b>	<b>\$55,724,600</b>	<b>\$50,000</b>	<b>\$27,131,900</b>	<b>\$391,390,200</b>	<b>\$500,503,200</b>

**Definitions:**

**Medical Care** includes payments for hospital and physician care, as well as emergency medical transport, rehabilitation, prescriptions, allied health services, medical devices, and insurance claims processing. For fatalities, also include coroner and premature burial costs.

**Mental Health Care** includes payments for services by psychiatrists, psychologists, social workers, and pastoral counselors. Also includes insurance claims processing.

**Future Earnings** includes wages, fringe benefits, schoolwork, and housework lost by the injured. This estimate excludes earnings lost by family and friends caring for the injured.

**Public Programs** include police, fire, paramedic, ambulance, and helicopter transport costs. Social services and victim assistance costs are also included in this category. It excludes mental health services costs.

**Property Damage and Loss** is the value of property damage and of property taken and not recovered.

**Quality of Life** places a dollar value on pain, suffering and lost quality of life to the victim and their family. The value is computed from jury awards for pain, suffering, and lost quality of life due to physical injuries and fear. For murders, this value is computed from the amount people routinely spend (in dollars or time) to reduce their risk of death.

**Source:**

Children's Safety Network-Economics and Data Analysis Resource Center, at the Pacific Institute for Research and Evaluation, Calverton, MD, 2009. The costs were adapted to Alaska using a state-specific price adjusters. All costs were calculated using incidents reported in the Child Maltreatment 2006, National Center on Child Abuse and Neglect Data Set. For more information contact Monique Sheppard at [mshppard@pire.org](mailto:mshppard@pire.org).

CSN ([www.childrendefinesafetynetwork.org](http://www.childrendefinesafetynetwork.org)) is funded by the Health Resources and Services Administration's Maternal and Child Health Bureau (U.S. Department of Health and Human Services).

A project of the Education Development Center, Inc.

**CHILDREN'S JUSTICE ACT TASK FORCE  
(Update February 2011)**

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