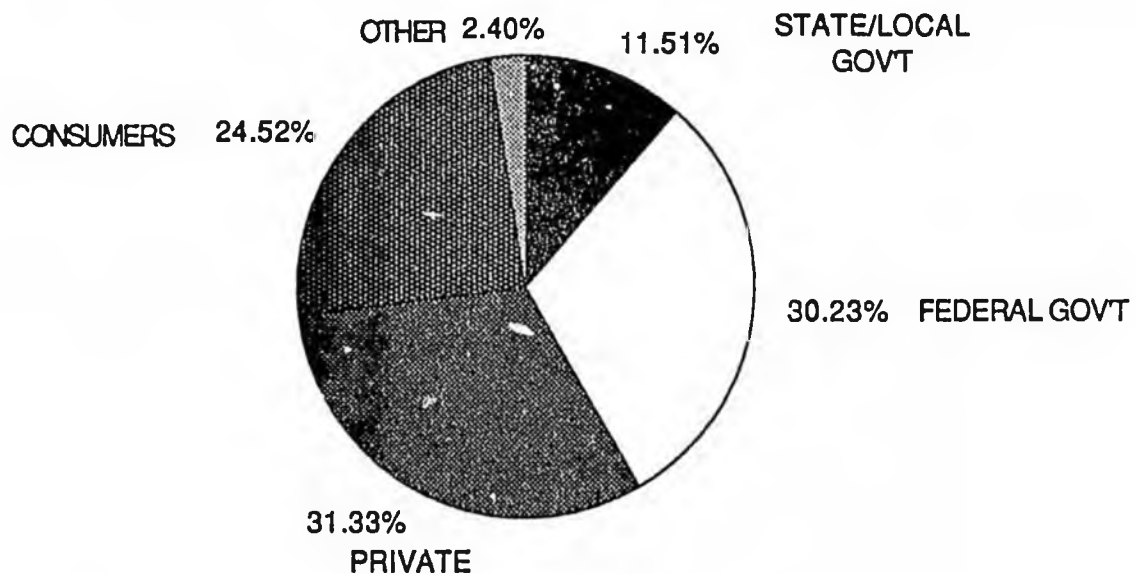


Leg. Finance-House & Senate Finance Comte Files (1991-1992) 921

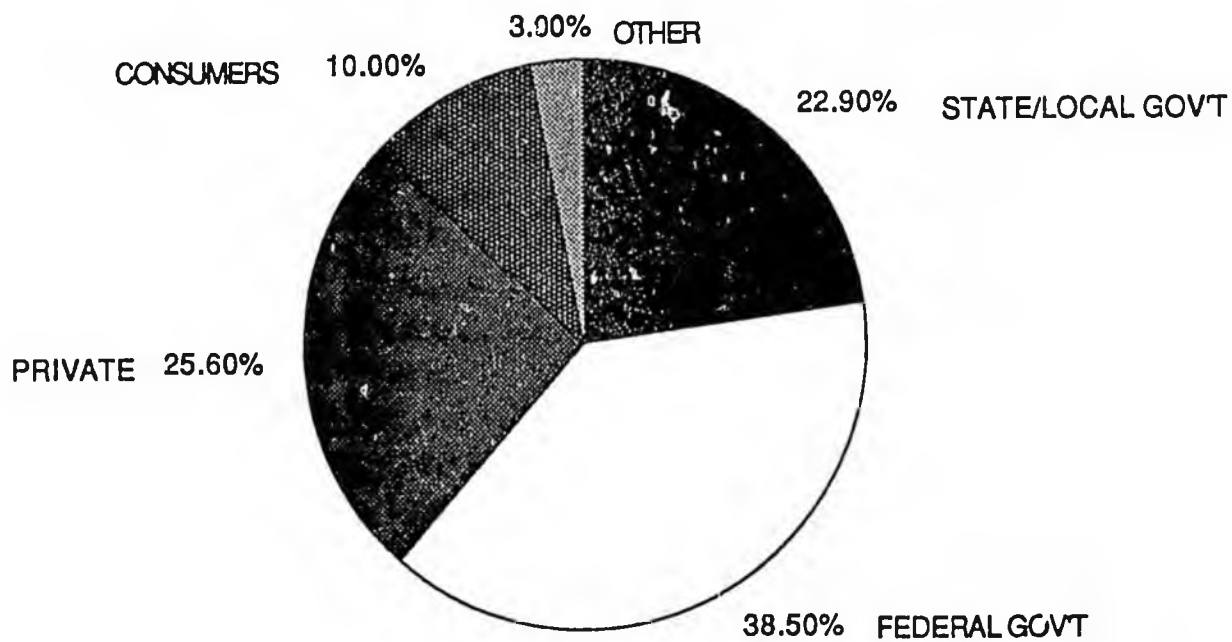
HCCC-TF EXHIBIT THREE

PERCENT OF U.S. HEALTH CARE EXP. BY SOURCE OF PAYOR



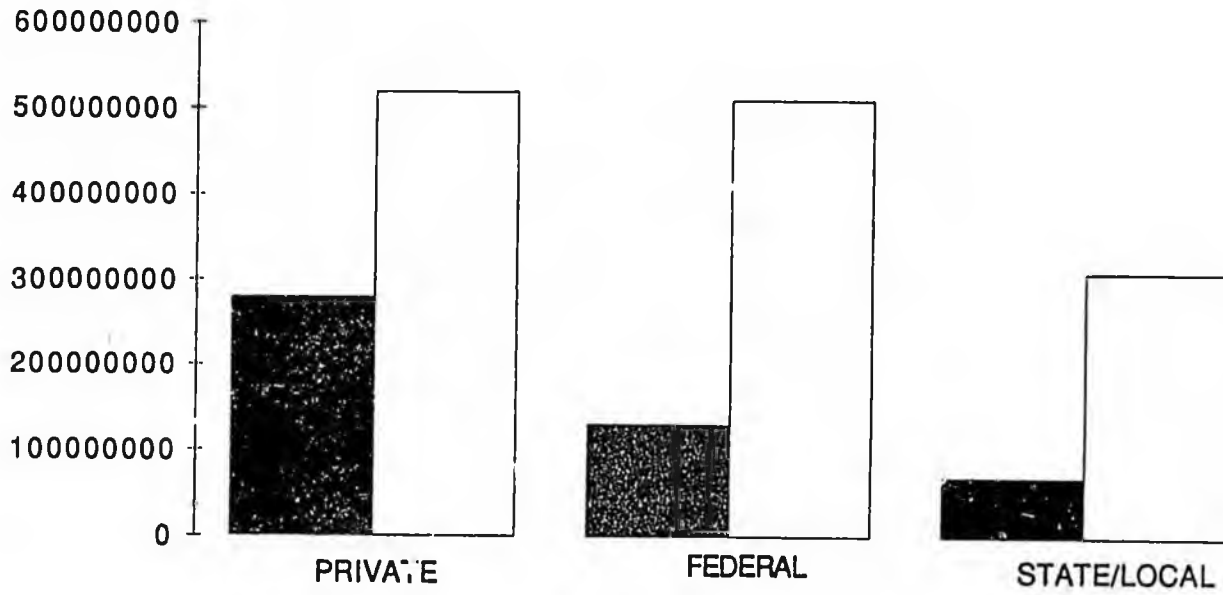
HCCC-TF EXHIBIT FOUR

PERCENT OF ALASKA HEALTH CARE EXP. BY SOURCE OF PAYOR



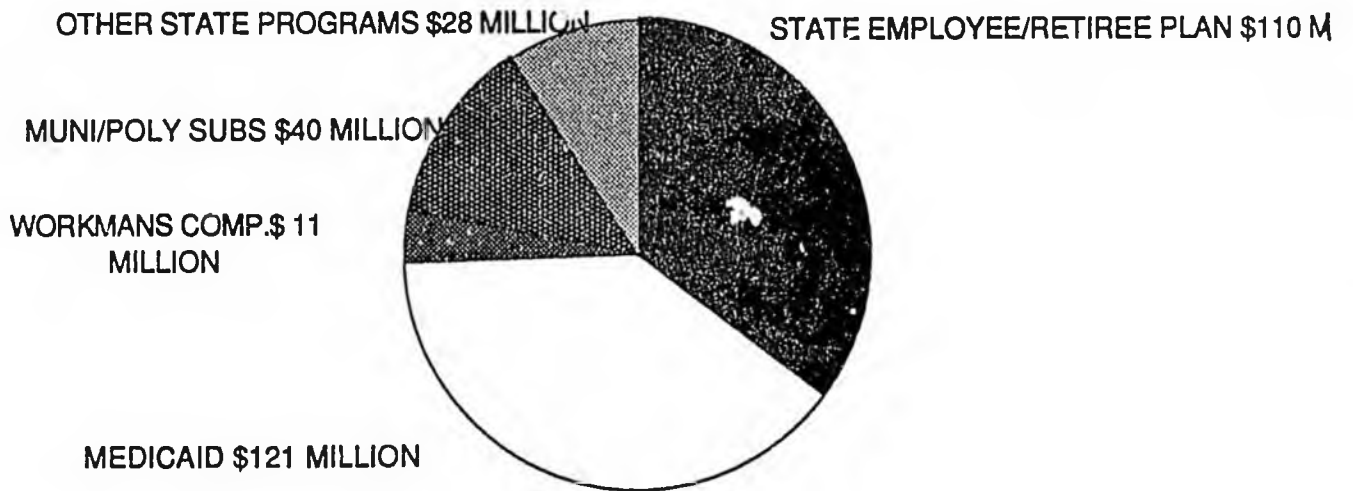
HCCC-TF EXHIBIT FIVE

STATE OF ALASKA HEALTH CARE EXPENDITURES 1979 VS 1989



HCCC-TF EXHIBIT SIX

1989 STATE OF ALASKA HEALTH CARE EXPENDITURES BY STATE PROGRAM



HCCC-TF EXHIBIT SEVEN

STATE OF ALASKA
PER CAPITA HEALTH CARE EXPENDITURE ANALYSIS
1979-1989

	1979	1984	1989
POPULATION	401,000	522,000	534,000
HEALTH CARE EXP. \$480. MILLION		\$710. MILLION	\$1.34 BILLION
PER CAPITA HEALTH CARE EXP.	\$1197.00	\$1360.00	\$2524.00

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE
REPORT

SECTION FOUR

CAUSES OF RISING HEALTH CARE COSTS IN ALASKA

CAUSES OF RISING HEALTH CARE COSTS IN ALASKA

The Task Force in its expanded role, has investigated the problems and causes of rapidly rising health care expenditures in Alaska. The Task Force used public testimony, surveys, research (statewide & nationally) along with a detailed analysis of the delivery and financing of health care in Alaska in its investigation.

During this review the Task Force has identified not a sole culprit but numerous contributing factors that must be dealt with in an all encompassing manner to provide long term relief and health care expenditure management.

LIFE STYLE RELATED

Alaska residents like those in the lower 49 have seen increasing health care treatments due to life style injuries and diseases. These include alcohol and drug abuse, sports related injuries, cancer, AIDS and heart disease as the major expenditure causes in Alaska.

COST SHIFTING FROM OTHER HEALTH PROGRAMS

Alaska has to recognize the impact of cost shifting on the total cost of health care. When other programs either cut back or reimburse providers at lower levels these liabilities are directly transferred to other payors.

In addition, when programs make either enhancements or reductions in benefit levels these add additional costs or program burdens.

UNINSURED / UNDERINSURED ALASKA RESIDENTS

It is estimated that there are 90,000 Alaska residents that are without health care protection, in addition there are a substantial number that do not have adequate coverage.

These residents are prevented from regular preventative care that would eliminate more serious and costly future health care needs. Also compounding the health care cost problem is when the uninsured / underinsured residents receive treatment they cannot afford. This is recognized by the health care provider as uncompensated care, but this cost is generally spread out among the other payors.

NEED FOR PREVENTATIVE CARE, WELLNESS INCENTIVES AND HEALTH CARE EDUCATION

More and more evidence points out the significant value in promoting wellness and preventative medicine. Through health education and programs that cover and promote preventative medicine Alaskans could improve their overall health and help reduce unnecessary expenditures.

Health care education and preventative medicine programs must be designed with up to date information and continually adjusted to changing medical trends, findings and advancements. These programs must also continually educate the public and recognize changes in lifestyle, surroundings and perception of health.

One example of a health promotion, education and prevention program is the "Healthy Beginnings Program" recommended by the Health Care Cost Containment Task Force and instituted by the State for the employee health insurance plan in early 1990.

The "Healthy Beginnings Program" is a program for women and their babies starting with the first trimester, with screening for potential moderate or high risk pregnancies to determine steps necessary to eliminate or reduce the risk of a premature or unhealthy delivery.

The program centers around early intervention, education and wellness along with continued communication with the mother throughout her pregnancy.

Since the inception of the "New Beginnings Program" mothers who have participated in the program are reducing the number of low birth weight deliveries. The program has also saved the State Employee health plan millions of dollars.

Promoting health education, wellness and prevention is a cost effective way to help assure Alaska residents are receiving health care at the appropriate time and level of treatment necessary.

HIGH COST OF MEDICAL TECHNOLOGY AND WASTE

During the last five years two new facets of medical inflation have come to light. These are new technology and waste in the medical delivery system.

In recent years new technology in the form of equipment, procedures, treatments and medicines has greatly improved our ability as a nation to prolong life. While this has had a substantial effect on being able to keep people alive it has also come with substantial additional health care expenditures.

Alaska has also participated in this race for the newest and best medical technology. While we too have been able to improve the longevity of our residents the cost has been significant.

A method must be developed to assure that the technology is available to residents without duplication or undue cost to the health care delivery system. In addition we must weigh the benefits and cost of any new technology that has a substantial effect on the Alaska health care delivery system.

DIRECT AND INDIRECT MALPRACTICE INSURANCE COSTS

Malpractice insurance premiums and the associated costs continue to be a significant component of health care expenditures in Alaska. While many attempts have been made to improve and or reform the system no significant in roads have been made to reduce the overall costs.

Malpractice premiums paid to insurance companies are only one part of the equation. Of equal importance and much more difficult to measure is the practice of defensive medicine by health care providers attempting to avoid a "claim".

The problem is not only one of cost but of those providers who go without coverage or inadequate protection. It is estimated that approximately 25% of physicians and 50% of obstetric / gynecologic practitioners in Alaska are uninsured for malpractice.

The malpractice problem must be dealt with in any comprehensive strategy to manage health care expenditures in Alaska, it should be done on a systemic approach, including loss prevention, education, financing of protection and the ability to project and limit losses.

HEALTH INSURANCE CARRIERS ROLE

Health insurance carriers play an important role in the delivery and financing of health insurance in Alaska. In Alaska there are only seven insurance companies with any volume selling health insurance policies. Three nonresident companies have control of approximately 90% of the market place.

Alaska health insurance carriers have made constrictions in their underwriting standards and at the same time generally set premiums based on cost of claims plus overhead expenses & profit and instituted cost containment programs.

This limited the risk for carriers but placed additional burdens on access to health insurance adding to the population of those underinsured / uninsured.

It is recognized that writing and servicing health insurance policies in Alaska may be somewhat more expensive than in the other 49 states. However, Alaska is a large and growing marketplace that needs affordable health protection.

GROWTH OF NEW MANDATED COVERAGES AND HEALTH CARE SPECIALTIES

Alaska like most other states has passed a number of measures (sixteen since 1985) that mandate additional coverages for health care services in health insurance policies. This proliferation of mandated coverages adds to overall health care expenditures in Alaska.

Although many of these measures can be justified, in the future all measures that expand the mandated coverage list should be evaluated by the legislature for total long term impact on the health care delivery system in Alaska.

New health care specialties have become an important component in the Alaska health care delivery system however, the trade off is a reduction in primary care providers especially in the rural areas.

HEALTH CARE PROFESSIONAL TRAINING AND RETENTION

The future of the health care delivery system in Alaska revolves around the ability to train and retain quality health care professionals in Alaska. The programs in place today must be revisited and revised to keep up with the primary and emergency care needs of Alaska especially in rural Alaska.

GENERAL OBSERVATIONS

Alaska has no central authority to provide health care planning, review of delivery, quality, access, and financing of health care protection. Alaska needs to have, in place, as the Health Care Cost Containment Task Force recommended, long term strategies to assure the medical delivery system remains accessible and affordable.

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE
REPORT

SECTION FIVE

HEALTH CARE DELIVERY SYSTEM
FINDINGS AND SURVEY RESULTS

ALASKA HEALTH CARE DELIVERY SYSTEM FINDINGS

The Task Force in its expanded duties reviewed the health care delivery system in Alaska and its important role in managing health care expenditures in Alaska.

During this review the Task Force recognized the importance in continuing the work already done in building a health care delivery system of which we can be proud. But in order to continue to expand and improve the system certain long range plans and controls must be implemented.

ALASKA LARGE GEOGRAPHIC AREA AND RURAL POPULATION

Alaska has an enormous land area and residents in largely rural areas that require health care. Alaska does have a good rural health care delivery system, but it is not immune from the problems such as long distance travel for care, limited health care services in some areas, difficulty in attracting and retaining health care professionals in rural areas and small facilities with limited services.

However only about 20% of the health care expenditures in Alaska are expended in the areas outside of the cities of Anchorage, Fairbanks and Juneau.

URBAN ALASKA HEALTH CARE DELIVERY SYSTEMS

Alaska expends about 80% of its health care dollars in its three largest cities (Anchorage, Fairbanks, Juneau) creating another set of complexities in delivering health care to Alaska residents.

Because the urban areas have larger populations and many rural residents receive health care in these cities, they are able to generally support more health care facilities and providers normally found in cities of like size.

The isolation from neighboring states also creates the need for self supporting health care delivery systems.

OUT OF STATE HEALTH CARE DELIVERY SYSTEMS

Alaska's health care delivery system relies on the systems of other states for certain treatments and as an alternate choice for residents.

Many Alaska residents choose to receive treatment or hospitalization in other states for a variety of reasons. These include the lack of available care in state or simply as a matter of convenience or comfort.

It is difficult to determine the amount of health care that is provided to residents by out of state providers. However, the out of state delivery system provides an important alternate delivery system and an equally important safety valve.

This system of receiving care must be continually monitored to assure that it provides care with out detracting or escalating health care costs for Alaska.

OTHER HEALTH CARE DELIVERY SYSTEMS IN ALASKA

Alaska has a number of other programs providing health care to residents. These include, Indian Health Service (I.H.S.), Civilian Health And Medical Programs for Uniformed Services (CHAMPUS), Veterans Administration (VA), Medicare, Medicaid and Public Health Systems.

In order assure and maintain an efficient health care delivery system in Alaska all systems must, when feasible, coordinate and share information to prevent duplication, gaps in service and fueling medical inflation.

SURVEY RESULTS

The survey done by the Task Force was designed to give greater insight to health insurance plans offered by Alaska employers, the costs for these plans, who is covered by health insurance, and additional data and perspectives from health care providers.

Over 300 surveys were mailed to various groups in Alaska including, municipalities, school districts, health care providers and private sector employers.

The survey questions were tailored to gather specific information relative to each category of respondent.

Questions ranged from those eligible / ineligible for employer health plans, number of employees, plan design, employee/employer contributions, cost containment measures implemented, premium costs, ideas to help reduce ever increasing health care costs and the reasons for these increasing costs.

Questionnaires sent to health care providers had additional questions to determine their specific perspective about rising health care costs and certain contributing factors *ie.*; bad debt, malpractice insurance costs and others.

The survey results gave us information that previously was not available. These included the range of employer sponsored health plan designs, eligibility, associated premium costs, cost containment strategies employed, and respondents perspective, and impressions about the health care delivery system in Alaska.

In comparison to the State of Alaska active employee health plan, the survey results showed:

- (1) the state no longer had either the most expensive health plan (64% of respondent's plans premium or premium equivalent was in excess of the states \$385. per month) and,
- (2) no longer was the State's plan the best in coverage (54% of respondents provide similar or better benefits).

With respect to the number of respondents offering health insurance;

- (1) surprisingly 94% do offer some form of health insurance to their full-time employees while,
- (2) none of the respondents provide coverage for part-time, seasonal, or occasional employees.

The majority of respondents have implemented ways to reduce their health plan costs;

- (1) seventy one percent have implemented at least two cost containment measures, and
- (2) sixty percent have also made benefit changes in the last two years.

In addition respondents also are implementing alternate financing of health insurance. Thirty one percent have self insured their plans.

The survey confirmed earlier information that the majority of health insurance in Alaska is underwritten by three carriers: Aetna, Blue Cross and Great West.

The survey asked specific questions about respondent's opinions relating to cost containment techniques that have worked for them and those that did not. Results showed that 55% of respondents felt that second surgical opinions and preferred provider organizations did not demonstrate significant savings. Seventy percent felt that utilization review, large case management and self insurance had positive results.

Respondents offered the following ways to control health care cost (shown with the percent of respondents offering each).

Statewide plan.....	67%
Malpractice reform.....	55%
Regulate provider rates.....	53%
Provide insurance for uninsured..	50%

In addition, the survey asked respondents their views of the major contributors to rising cost of health care in Alaska (shown with the percent of respondents for each).

Health care providers.....	67%
Malpractice insurance.....	64%
Overbuilt facilities.....	59%
Insurance carriers.....	55%
Plan members.....	48%
New technology.....	46%

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE
REPORT

SECTION SIX

TASK FORCE RECOMMENDATIONS

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE

RECOMMENDATIONS

The Health Care Cost Containment Task Force has over the last twenty-two months reviewed the rapidly increasing costs of health care in Alaska and have identified not one sole culprit but many contributing factors that collectively drive the health care economy in Alaska.

The Task Force has identified the following main components that should be focused on as a minimum starting point to bring health care expenditures in control for Alaska.

- * Cost shifting from other programs
- * Federal program cost shifting
- * Improve health care delivery and financing systems
- * Uninsured / underinsured Alaska State residents
- * Accessibility of care
- * Mandated coverage costs
- * Improve the involvement and education for end users
- * Collect current and meaningful health care data
- * Institute preventative medicine programs

The Health Care Cost Containment Task Force makes the following recommendations which are designed to provide affordable quality health care access for all Alaska residents.

A. Create an authority that would establish and maintain health care provider payment and utilization schedules taking into consideration geographic location, actual provider cost, availability, and medical necessity (potentially using an established system as a foundation). The schedules will be used by all public sector employers and available to private sector as well.

And:

Would establish a voluntary health care protection procurement and financing pool to maximize purchasing power for;

- i. State, local government and political subdivisions.
- ii. Underinsured / uninsured for State residents.
- iii. Public / small employers plan.

This authority would be governed by a board and would assure that access to quality affordable was available to all Alaskans.

B. Collection and analysis of state health care utilization and cost data, to recognize trends and recommend solutions to the appropriate entity.

C. Expanded monitoring and certifying of facilities expansion and substantial equipment technological purchases to assure need and eliminate duplication or unnecessary expense. This would require revision of the C.O.N. statutes currently in place.

D. Promote health awareness, preventative medicine and quality health care for all state residents.

E. Provide quality affordable health care access for Alaska residents who are underinsured / uninsured.

F. Continue to evaluate the effect of Federal program changes and maximize the use of Federal Funds.

G. Promote health care professional training and retention in Alaska.

H. Develop a way for the sole proprietor and small employer to provide health coverage to employees and their dependents.

I. Continue to evaluate alternate and self funding as an option for the state employees and retirees plans. Include in the next Request For Proposal a request for bids on a comprehensive and unbundled basis.

J. Form a cross section focus task force to continue to study and make recommendations to assure quality, affordable, health care access for all Alaskans.

TASK FORCE RECOMMENDATIONS FOR LEGISLATION

The Task Force recognizes the need for specific legislation to provide for a comprehensive approach to produce cost effective quality health care access to all Alaska residents.

Two separate but interrelated pieces of legislation are being recommended and endorsed by the task force. These are:

ALASKA STATE HEALTH RESOURCES AUTHORITY (ASHRA)

Creation of the Alaska State Health Resources Authority (ASHRA) SB 83, HB 71 which once enacted would be empowered to manage the access, delivery, quality, planning and financing of health care in Alaska.

The authority would be implemented in two phases:

PHASE ONE

By July 1, 1992 create and begin implementation of a statewide health care provider reimbursement schedules and utilization standards, which shall be used by all Alaska public employers and available for use by all other Alaska employers by application to the authority.

This provision requires the authority to create a system or method that streamlines or results in cost efficient payments to providers, and includes schedules of maximum allowable reimbursement for health care related services. These schedules would be based on actual provider cost, geographic regions, and availability of care. In addition, this provision creates the statewide utilization standards system to monitor, track and validate patterns of treatment by health care providers. This assures that cost efficient and cost

effective care is provided with out compromising the quality of care for participants in the authority.

The authority would also be required to issue an impact statement on all certificate of need applications within 60 days of notice. this will allow the authority to determine the cost implication of these proposed certificates or changes to existing certificates.

IMPACT

The goal of this phase is to reduce the rise in medical inflation for participants in the authority to at or about Consumer Price Index from its current level of about 20% per year. Another goal is to minimize cost shifting to other health care programs. With out this phase, health care expenditures in Alaska would top \$10 billion by the year 2000. The State of Alaska's portion of this increase would exceed 3.0 billion. At the same time the ranks of uninsured residents would total 25% of our population. (exhibits one, and two)

PHASE TWO (optional procurement of insurance)

Beginning after July 1, 1992, the Authority is directed to procure or provide comprehensive group health insurance for Alaska public employers and other employers in the state who elect to participate.

This would expand the pool of subscribers and maximize the opportunities for health care cost management and should realize significant additional savings for those participating in the authority.

In addition to creating the most comprehensive, cost effective, and efficient method of providing a variety of types of health care plans, the Authority must meet the coverage requirements resulting from negotiated agreements.

The authority is also required to review and where feasible provide health insurance protection for the uninsured and underinsured Alaska residents.

No later than January 1, 1993 the authority would develop and offer a health insurance protection plan for the sole / small Alaskan employer.

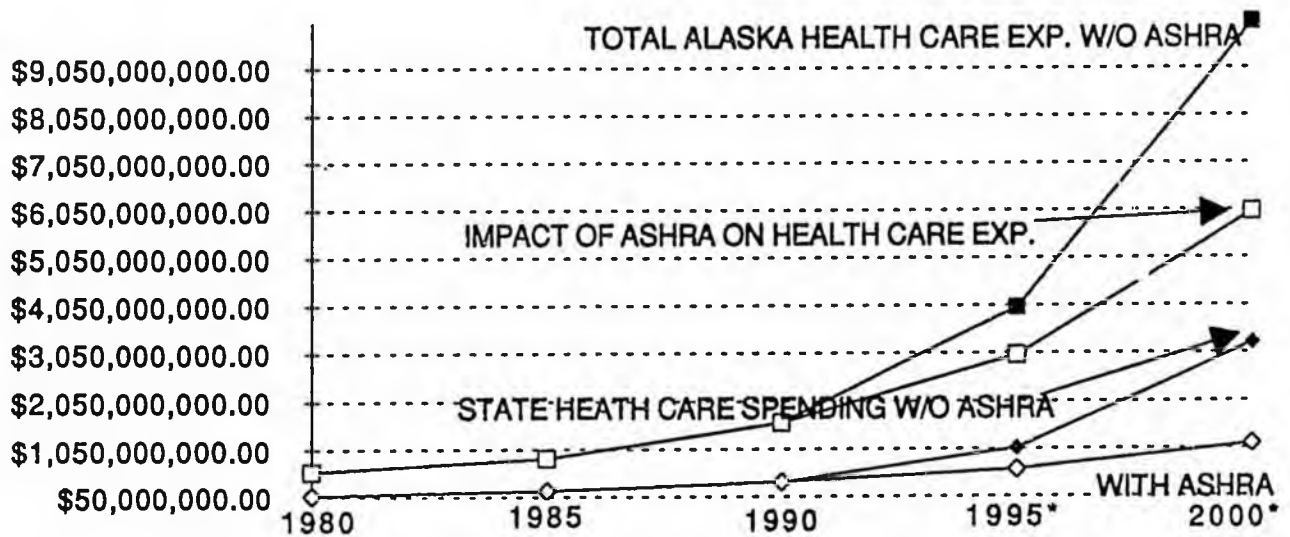
IMPACT

Phase two would bring together the provider reimbursement and utilization management components with the delivery and financing of health care in Alaska. This will enable the state, through the authority, to provide access to quality cost effective health care for all Alaska residents.

ASHRA EXHIBIT ONE; illustrates the estimated impact on total and the states portion of health care expenditures as compared without the effect of ASHRA. Total health care expenditures would be reduced in the year 2000 from \$10 billion to under \$6.0 billion and the states portion would be reduced from \$3.28 billion to \$2.0 billion. For a total estimated cost of health care savings of \$4.0 billion in the year 2000.

ASHRA EXHIBIT ONE

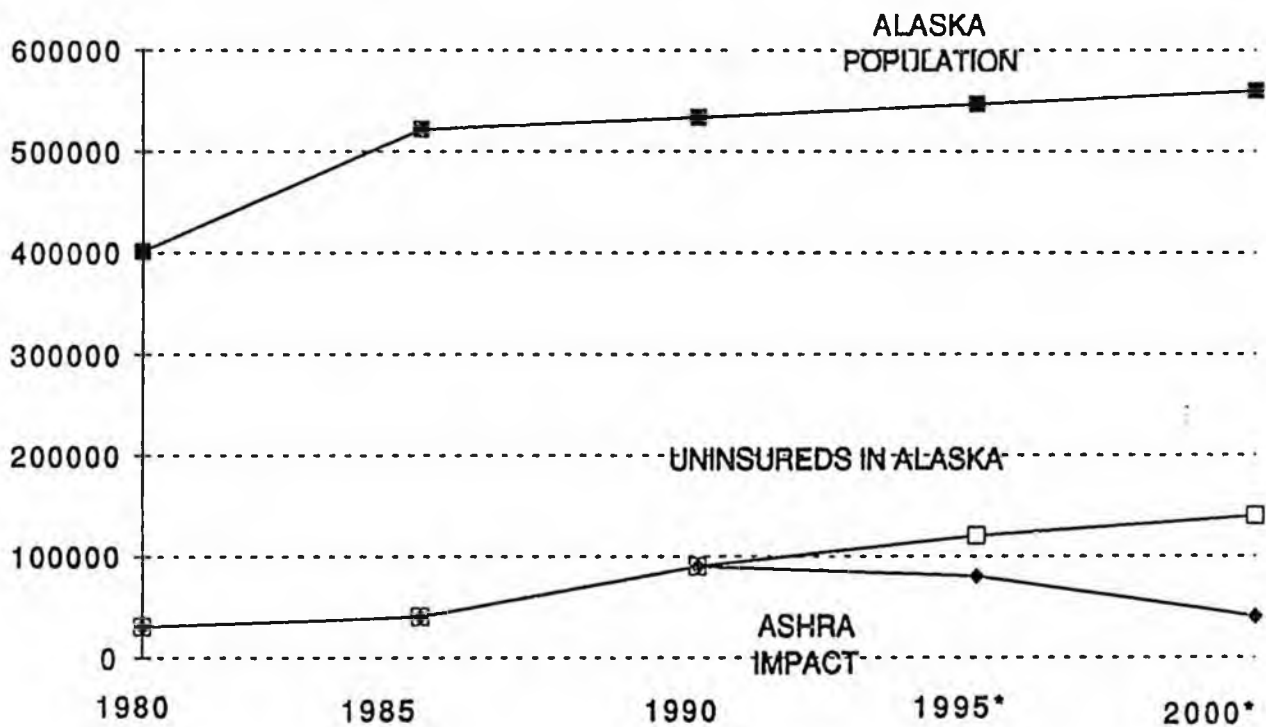
ESTIMATED IMPACT OF ASHRA ON HEALTH CARE EXPENDITURES IN ALASKA



ASHRA EXHIBIT TWO; illustrates the estimated impact of ASHRA on the uninsured population in Alaska. ASHRA would reduce by the year 2000 the number of Alaska residents without health insurance to about 40,000 from the 120,000 projected without ASHRA.

ASHRA EXHIBIT TWO

ESTIMATED IMPACT OF ASHRA ON THE UNINSURED POPULATION IN ALASKA



COMPANION LEGISLATION

THE CERTIFICATE OF NEED PROGRAM (C.O.N.), SB 84, HB 69

Proposed legislation would amend AS 18.07 to create a rational frame work for the planning and development of all health care services in the state to ensure promotion and protection of public health, the providing of equitable access to health services, and the avoidance of unnecessary increases in health care costs.

By amending AS 18.07 the Certificate Of Need program would regain an important role in the approval process for health care facilities, technology, modification, expansion or change of purpose. This change would not only provide the system an early warning device but a way to accurately measure the initial and future cost impact to the total health care delivery system.

The task force has identified that the cost of facilities and technology has a direct impact on the total cost of health care and, therefore, should be prospectively managed.

PROPOSED RESOLUTION

THE HEALTH RESOURCES AND ACCESS TASK FORCE

The task force recommends the adoption of a concurrent resolution creating a HEALTH RESOURCES AND ACCESS TASK FORCE to continue the study of this issue study forward recommendations regarding access to affordable, quality health care for all Alaskans.

The foundation of knowledge, education and demonstrated success of the Health Care Cost Containment Task Force must be built upon in order to see implementation of long term solutions to the health care crisis in Alaska.

The ideal approach is to take the expertise developed in the Health Care Cost Containment Task Force and combine the ambitions of the

Universal Task Force (ch.179, SLA 1990) to create a hybrid focus group to simultaneously work on the management of health care expenditures in Alaska while improving access to quality health care.

It is envisioned that the work plan and resources of the group would have the depth to investigate all facets of health care access and financing in Alaska as compared to alternate solutions implemented by other countries, provinces, states and other health care programs.

This focus group membership should include:

- Legislative Branch
- Executive Branch
- Private Sector Employers
- Non Profit Sector
- Health Care Consumer
- Health Care Providers
- Medically Indigent
- Labor Organization

It is important to have further work done in this area, and to provide information and input to the Alaska State Health Resources Authority.

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE
REPORT

SECTION SEVEN

OPEN / UNRESOLVED ALASKA
HEALTH CARE DELIVERY ISSUES

OPEN / UNRESOLVED
ALASKA HEALTH CARE
DELIVERY ISSUES

The Health Care Cost Containment Task Force has, in its effort to find the cause of the rapidly increasing cost of health care in Alaska, found several contributing factors that need further investigation.

DELIVERY AND ACCESS

Delivery of health care in Alaska has been found to be one of the greatest contributors to the increasing cost of health care. Traditional approaches to delivering health care when applied to the large geographic area of Alaska has created a hodge podge of service which is often inadequate, underutilized and thus more costly than what can be offered through a coordinated statewide system of delivery. In addition, the increasing population of underinsured and uninsured receiving uncompensated care causes additional strain on urban, as well as, rural facilities and providers.

Included within the problems of delivery and access to health care in Alaska are answers to some of the increased cost of health care. Some of these are overbuilt facilities, new technology which is often underutilized, a lack of prevention programs, the need for statewide planning, and inadequate financing of health care for all Alaskans.

UNINSURED / UNDERINSURED

The health of small businesses in Alaska is often dependent upon a limited number of individuals each of whom is very important to the operation of an organization which has no insurance for its employees or must pay an unreasonable price for limited coverage.

As the cost of health care increases, many of these sole proprietorships and small businesses and their employees are forced to join the ranks of the underinsured or uninsured.

HIDDEN COSTS

Malpractice insurance coverage is a continuing problem not only adding to the cost of some medical procedures but increasing health care cost in general. Many health care providers believe it is necessary to practice defensive medicine as a means to lessen potential liability. This induced caution is reflected in additional laboratory test, unnecessary use of technology, exploratory surgery, increased inpatient time, and other practices that increase the cost of health care for everyone.

MANAGING THE SYSTEM

Oversight will be necessary in any effort to coordinate access to federal state and local delivery systems. Attempts to merge or attract additional sources of financing and coordinate the use of facilities for persons needing health care in Alaska will require guidance. Even the operation and activities of the Alaska State Health Resources Authority the creation of which is supported by this Task Force as recommended in section 8 will require at least periodic oversight.

These issues represent some of the more obvious areas causing the cost of health care to increase and indicate a need to continue the work that has been started. While the work of the Health Care Cost Containment Task Force has brought to light some areas where millions of dollars in cost savings have already been achieved much more remains to be done. To establish realistic, reliable and efficient controls on the cost of health care and provide access to all Alaskans will require a great deal more work than has been completed to date

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE
REPORT

SECTION EIGHT

ATTACHMENTS



NEA-ALASKA

AFFILIATED WITH THE NATIONAL EDUCATION ASSOCIATION

ANCHORAGE REGIONAL OFFICE

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ANCHORAGE, ALASKA 99503
(907) 274-0536

JUNEAU OFFICE

105 MUNICIPAL WAY, SUITE 302
JUNEAU, ALASKA 99801
(907) 586-3090

FAIRBANKS REGIONAL OFFICE

2118 CUSHMAN STREET
FAIRBANKS, ALASKA 99701
(907) 456-4435

February 11, 1991

To: **Senator Pearce, Chair**
Members, Senate Labor and Commerce Committee

Re: **SB 83; "An Act relating to the Alaska State Health Resources Authority; relating to the delivery, quality, and financing of health care for residents of the state, and to the issuance of certificates of need; and providing for an effective date."**

NEA-Alaska supports and encourages your favorable consideration of SB 83. It represents a sound and viable alternative to the cost, quality, and utilization of health care services, especially as it may pertain to public school district employees.

Currently, school district employees are covered by a variety of health care plans with a broad range of benefits at differing levels of premium costs.

Many districts are disadvantaged in their ability to maximize benefit coverages at reasonable costs and have seen these costs increase at alarming rates in recent years.

Access to utilization standards, more efficient administrative and provider reimbursement systems, and the opportunity for reducing premium costs and for improving benefits through participation in expanded group pools represents substantial opportunity for employers and employees alike.

Implementation of the provisions in SB 83 is a critical step if we are to effectively deal with health care costs in Alaska.

Thank you for your consideration of our recommendation.

Respectfully submitted,

Bob Manners
Executive Director

Don Oberg
President

cc: **Senator Duncan**



ALASKA STATE EMPLOYEES ASSOCIATION
AFSCME Local 52, AFL-CIO

February 11, 1991

Hon. Jim Duncan, State Senator
Pouch V
Juneau, Alaska 99811

Dear Senator Duncan:

On behalf of the Alaska State Employees Association and its 9,000 members statewide, I want to thank you for introducing Senate Bill 83, which seeks to establish an Alaska State Health Resources Authority to help cap the state's increasing health care costs.

As you know from your experience with the Alaska Health Care Cost Containment Task Force, health care costs to Alaskans exceeded \$1.5 billion in 1989 and have been rising at a rate of more than 20% each of the past five years. These cost increases have concomittantly increased the costs of health insurance premiums for all Alaskan employers, including the State of Alaska, making it more and more difficult for them to continue health care coverage for their employees.

Clearly, something needs to be done to bring down or, at the very least, check Alaska's spiraling health care costs and SB 83 takes the right approach.

For its part, ASEA/AFSCME Local 52 has agreed to a defined contribution to health care costs in its collective bargaining agreement with the state, but this is only a step in what should be a comprehensive attempt to contain costs throughout Alaska.

Furthermore, SB 83 makes inherently good public policy. Such an approach benefits union's, such as ASEA, by mitigating their health care costs; it benefits the State by lowering its operating costs; and it benefits private sector employers by reducing their cost of doing business with the state.

Again, my thanks to you and your colleagues on the Health Care Cost Containment Task Force for tackling a complex, difficult and controversial subject.

Respectfully yours,

Buddy Maupin
Buddy Maupin, Business Manager
ASEA/AFSCME Local 52, AFL-CIO

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NFIB Alaska

National Federation of
Independent Business

February 11, 1991

The Honorable Jim Duncan
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Duncan:

The legislative agenda of NFIB/Alaska is determined by our ballot. The ballot is our annual poll of our membership on a series of issues deemed critical to small business. A majority vote, of the members in response to the poll, sets our policy and position on legislative issues.

I have previously shared the results of the entire poll with your office. Now that you have introduced SB 83 - Alaska State Health Resource Authority - the objective of this letter is to share with you some thoughts on the bill.

The idea of a voluntary health insurance program appears to be a viable means of providing health insurance to the uninsured population in Alaska. Small businesses are willing to provide health insurance to employees, as long as the cost is not prohibitive. A voluntary pooling approach is a more acceptable alternative than a legislative mandate that all employers must provide health insurance coverage for their employees.

The key elements to NFIB/Alaska members support of the concept of pooling are: the program would be voluntary, administered by private insurance companies and affordable.

For your records the following are the results of the 1991 NFIB/Alaska ballot questions regarding health insurance:

Should legislation be passed in order to create a voluntary health insurance plan which would be administered by private insurance companies and which would pool small businesses together so they could purchase employee health insurance at group rates?

Yes 72.2% No 17.0% Undecided 10.8%

a. If this pooling of employers in order to purchase health insurance was available, would you participate?

Yes 50.2% No 19.3% Undecided 30.5%

State Office
9159 Skywood Lane
Juneau, AK 99801
(907) 789-4278



The Guardian of
Small Business

Senator Duncan
February 11, 1991
Page: 2

b. Should employers be allowed the option of having their employees pay part of the premium cost of health insurance purchased through the above pooling plan?

Yes 90.0%

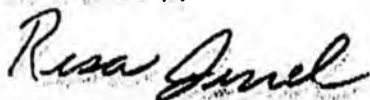
No 5.2%

Undecided 4.8%

NFIB/Alaska hopes this information regarding the views of small business owners on this issues will be useful to you. If you have any questions regarding this information, please do not hesitate to contact me.

I look forward to working with you on SB 83 and other issues of importance to the small business members of NFIB/Alaska.

Sincerely,



Resa Jerrel
NFIB/Alaska
State Director

RESOLUTION

BE IT RESOLVED BY THE JUNEAU FORUM ON THE 1991 ALASKA CONFERENCE ON AGING:

WHEREAS health care expenditures in Alaska have risen from \$480 million in 1979 to over \$1.5 billion in 1989, a per capita increase of \$1327.00 per person per year; and

WHEREAS the number of uninsured or underinsured Alaskans is now estimated at over 90,000 persons; and

WHEREAS a large number of the uninsured and underinsured are senior citizens; and

WHEREAS the Alaska State Health Care Cost Containment Task Force was created early in 1989 to find ways to control the ever increasing cost of health care in Alaska; and

WHEREAS the Alaska State Health Care Cost Containment Task Force has as a result of its research and investigation identified ways to control the rising cost of health care in Alaska; and

WHEREAS the Task Force has endorsed Senate Bill 83 and the changes proposed therein necessary to rising health care cost; and

WHEREAS the Juneau Forum of the 1991 Alaska Conference on Aging has reviewed the findings and recommendations of the Alaska State Health Care Cost Containment Task Force;

BE IT RESOLVED by the Juneau Forum of the 1991 Alaska Conference on Aging that the rising cost of health care is a serious problem for senior citizens; and be it

FURTHER RESOLVED that the Juneau Forum of the 1991 Alaska Conference on Aging strongly supports the cost containment measures proposed in Senate Bill 83; and be it

FURTHER RESOLVED that the Juneau Forum of the 1991 Alaska Conference on Aging strongly supports the Legislatures passage Senate Bill 83, creating the Alaska State Health Resources Authority.

Adopted:

JUNEAU FORUM
1991 ALASKA CONFERENCE ON AGING

By: *Dorian Comm. on Aging*

Chairperson: *Lauris S. Parker*
Lauris S. Parker

AASB

ASSOCIATION OF ALASKA SCHOOL BOARDS

1990 CORE RESOLUTIONS



passed by the membership
1990 ANNUAL STATEWIDE CONFERENCE

ASSOCIATION OF ALASKA SCHOOL BOARDS

TUESDAY, NOVEMBER 13, 1990

**SUBJECT: ADMINISTRATION
90-36
HEALTH INSURANCE**

WHEREAS, the Alaska Legislature through the work of the Health Care Cost Containment Task Force is looking at measures to control the rate of increase in the cost of health care for all Alaskans; and

WHEREAS, the cost of health insurance has increased sharply in recent years and shows no signs of stabilizing; and,

WHEREAS, school districts are required to operate within a fixed budget and need to stabilize costs as much as possible to allow for reasonable planning for a sound educational program; and,

WHEREAS, the increasing cost of providing health insurance to school employees has a significant impact on the operating budget of school districts in Alaska; and,

WHEREAS, Alaska school districts have demonstrated that insurance pooling has been an effective means of stabilizing insurance costs for their types of coverage;

NOW THEREFORE BE IT RESOLVED that the Association of Alaska School Boards aggressively investigate the feasibility of pooling for school district employee health insurance as a viable alternative for providing cost containment on a significant budget item.



RIGHT OR PRIVILEGE: SHOULD EVERYONE HAVE ACCESS TO BASIC HEALTH CARE?

"In a civilized society, every member of society should have access to a basic package of health services." Uwe Reinhardt, a Princeton economist and member of the National Leadership Commission on Health Care, has likened this to the guarantee of universal access to public education. Yet, the United States and South Africa are the only major industrialized powers that fail to guarantee access to health care.

Americans struggle with the issue of whether health care is a right or a privilege. In a country that has the best health care technology in the world, nearly 37 million of its citizens do not have health insurance. Those who cannot afford to pay, often called the "medically indigent," face major access barriers to health care services.

In the absence of a national health policy, the health care access and rights debate is centered in state legislative chambers. Medical indigency and uncompensated health care costs were identified as top priority issues for the 1989 legislative sessions, and will continue to demand attention in the 1990s. The three primary concerns identified by legislators are ensuring access to health care, paying for it, and expanding the availability of insurance to uninsured persons. Health care analysts have suggested that while in past years state legislatures proceeded slowly, states are now taking a leadership position on these issues. Access, cost, and quality issues continue to headline the policy concerns of consumers, providers, and payers.

Financing health care for people who do not have private insurance or who are not eligible for government programs is a major problem for state legislatures. Medical indigency has taken on greater urgency in recent years because of changes in the health care system. In the past, health care providers used a portion of their profits from paying patients to subsidize the costs of care to this nonpaying group. Recent efforts by insurers, the business community, and government to reduce their health care costs have made it increasingly difficult for providers to continue this practice. The focus of this article is universal access to health care and state efforts to ensure availability.

Who are the medically indigent?

The term "medically indigent" usually applies to low-income uninsured people who are unable to pay for their medical care. Others may also be included in a state's definition, including insured persons who cannot afford to pay for services not covered by their policies, or for high insurance deductibles or co-payments. Even middle-class individuals may be considered medically indigent if they cannot pay for the costs of a catastrophic illness or accident. The following items reveal information about uninsured and medically indigent people that may be of interest to state lawmakers:

- o Although Medicaid eligibility criteria vary widely among states, on the average, an American with two children may earn no more than \$6,036 annually to qualify for Medicaid. In *Alabama*, a family of three can earn no more than \$1,418 per year to be eligible for Medicaid, in *California*, the threshold is \$10,704.
- o One in three Americans is without adequate insurance coverage and millions go without basic health care services.
- o Nearly one-third of Hispanic Americans are uninsured.
- o More than one in five African Americans do not have health insurance.
- o One-third of the uninsured are children, including some five million adolescents aged 10 to 18. Uninsured children receive 40 percent less physician care than insured children, according to the National Association of Children's Hospitals & Related Institutions (NACHRI).
- o Forty-four percent of uninsured children live in families with incomes below the federal poverty level.
- o Almost 20 percent of uninsured children live with an adult who is insured through the workplace.
- o The incidence of uninsured residents is almost twice as high in the Western and Southern states than in the North Central and Northeastern states.
- o Persons without health insurance "self ration" by seeing a doctor about 65 percent as frequently as those with coverage or by not even seeking medical care.
- o Millions of persons who do receive health care services, but either cannot pay or do not pay for them, generate billions of dollars of uncompensated health care costs each year.

"Establishing priorities in health care is a necessary step toward defining adequate health care." Sen. John Kitzhaber, MD,
President, Oregon State Senate

Should the health system be restructured?

The last several years have witnessed a shift in public policy approaches to meeting the needs of the medically indigent. The health care system is seeing a change in the "Robin Hood" ethic of compliance with the expectation that providers are somehow obliged to serve patients regardless of their ability to pay. Public debate is brewing about how much health care is "adequate" for those who cannot pay for it. As this debate continues, several factors point to a health care system with growing problems:

- o Health care costs continue to skyrocket. In 1988, national health expenditures were 11.3 percent of the gross national product (GNP), the broadest measure of U.S. economic activity. By 1993, health care spending will grow to an estimated 13 percent of the GNP.
- o The gap between the medical "haves" and "have nots" is widening.
- o Millions of Americans report financial barriers to receiving adequate health care.
- o The U.S. has one of the highest infant mortality rates in the industrialized world, exceeding that of 16 other developed nations.
- o Our nation's safety net is fraying. Public hospitals are endangered and no longer have the resources to serve as health providers of last resort.
- o The ability of hospitals to absorb uncompensated care costs has diminished as their ability to shift costs has declined and as the uninsured population has grown.
- o Physicians report that the aged, poor, and uninsured utilize emergency rooms as a primary source of health care and that overcrowding is severely limiting the public's right to timely and good quality care.
- o Access to emergency medical and trauma services is threatened by the continuing problems of health care financing and because so many emergency room patients are uninsured. Emergency room closures present access problems even for those who are fully insured.
- o U.S. hospitals and emergency rooms with too many patients and too few beds are in a widespread and growing crisis, according to the American College of Emergency Physicians (ACEP).
- o In some quarters, Medicare and Medicaid are equated with charity care because reimbursements under these programs sometimes are far below costs.
- o Medicaid eligibility has been eroded over the past decade, government reimbursement levels and "red tape" inhibit physicians from treating the poor, and emergency rooms have been labeled as the "opening through which debts blow."

These and other problems fuel the national health care debate. State legislators find themselves in the middle of the fray.

Can change be expected?

The overriding problem will not be solved right away, and the issues raised as a result will set the agenda for change. Inequities in the distribution and provision of care will require change at many levels. The need for change is apparent, but there is no consensus as to what form the change will take in light of expectations versus economic realities.

Can improvement at the state and local level resolve the increasing financial burden of providing care on the national level? Department of Health and Human Services Secretary Louis Sullivan, MD has declared that state and local government and private employers must share in the solution to the problem. Scholars suggest that total resources be determined in the context of federal and state budgets.

Rationing has been proposed as one possible solution to the current crisis of cost in health care. Advocates believe the allocation of resources makes funding decisions more rational.

"In an era of federal budget deficits and tight state budgets, how to assist the medically indigent has become a question of what is the most efficient allocation of limited dollars."

Katherine Swartz and Debra Lipson, *Strategies for Assisting the Medically Uninsured*

Rationing also has been criticized as an unhealthy "stopgap" measure that denies care to the most deserving segments of the medically indigent population. Proponents argue that a two-tier system is developed, offering "second class" medicine in a top quality environment.

Over the past five years, the states have taken the lead in developing legislation to address the growing problem of paying for and ensuring access to medical services for the medically indigent. States have experimented with a number of different programs for the indigent. The majority of state legislatures have enacted or considered bills to expand access to and finance health care for medically indigent persons.

Conclusion

The answer to the question of whether access to basic health care for all is a right or a privilege is both political and policy oriented. The U.S. Supreme Court has determined that there is no constitutional right to medical care, even to medical care that is lifesaving. Future solutions will come from Congress and the individual state legislatures. Changes to the current health care system will require an examination of the following:

1. Community interdependency — the inevitable conclusion that no one group can do it alone.
2. Voluntary action — the acceptance of short-term and intermediate strategies to develop an equitable and affordable long-term solution.
3. Decision making process — the promise of specific benefits or the rationing of health care services.



FYI

For further information on project activities, contact:

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STATE ACTIVITY

Hawaii

"Hawaii did it first," said State Representative Jim Shon, chair of Hawaii's Health Committee in the House of Representatives, referring to the state's 1989 Universal Health Care Insurance Act. "By guaranteeing health care insurance for all of Hawaii's people, we have taken another step toward national leadership in health care."

The new law focuses on basic coverage for preventive primary care, prenatal care, childhood immunizations, mammograms, pap smears, and all aspects of outpatient care. Also included are an expansion of Medicaid services and specially targeted health services for gap groups that have difficulty obtaining conventional insurance, such as the homeless. Fifty thousand uninsured Hawaiians will gain health insurance coverage under the new law. The state Department of Health will administer the program and purchase health care coverage for specific services from private health insurance contractors for individuals who qualify for, and choose to purchase the bargain coverage on a sliding-fee-scale basis. These are primarily low-income individuals who cannot participate in existing programs and do not have the means to purchase private health care insurance coverage.

Massachusetts

The Health Security Act of 1988 created one of the most comprehensive health insurance plans in the nation. The law guarantees the gradual introduction, over four years, of coverage for all residents. The legislation was designed to expand the number of businesses providing insurance to their employees. Other uninsured persons are to receive insurance through a state program administered by the new Department of Medical Security. By 1992, businesses with more than five employees will be required to pay a surcharge of 12 percent of each full-time employee's first \$14,000 in wages into a health insurance trust fund, up to a maximum of \$1,680 per employee.

Employers who provide health insurance can deduct those costs from the surcharge, resulting in major new costs only to employers who do not provide insurance. Although this approach is designed to comply with the federal Employee Retirement Income Security Act (ERISA) provisions, it is unclear whether it would survive a court challenge. The law also provides positive incentives for small businesses to provide insurance before the 1992 deadline. A number of insurers are in the implementation phase of the health insurance program and some 15,000 residents have gained insurance coverage from the state; most are disabled unemployed adults, disabled children, pregnant women, and people who have left welfare to take a job without insurance. However, Massachusetts is currently in the midst of a serious economic crisis that is likely to affect the universal health law. Critics worry that the state will not carry its share of the costs.

California

In the last 10 years California's uninsured population has risen approximately 60 percent to 5.2 million people. Two-thirds of the uninsured residents are either employed or dependents of someone who is employed. Two bills signed into law this fall are designed to ensure coverage to all working residents by 1992:

A task force authorized under Chapter 829 (AB 350) will report to the legislature March 1, 1990 on the statutory responsibility of employers

to provide employees with insurance and changes in insurance rate-setting practices to ensure that coverage is both available and affordable.

Chapter 797 (SB 1207) expands eligibility for small business tax credits for employer-sponsored health coverage. A tax credit of up to \$25 a month per employee (or 25 percent of the cost paid or incurred during a tax year by an employer to provide coverage) to firms that provide benefits equal to or better than those in the basic program. Eligible firms are those that employ 25 or fewer workers and employers will be required to pay at least 75 percent of the premiums. The tax credit will take effect in January 1992.

Oregon

In Oregon, over 400,000 people — one out of every five living in the state — have no health coverage. In the absence of a federally approved national health policy, Oregon arrived at the following prescription to provide access to health care for everybody:

Of the 300,000 Oregonians living below the Federal Poverty Level (FPL), only 160,000 are being served by the state Medicaid program. Chapter 836 (SB 27) revises the current state Medicaid program to expand eligibility and redesign the health care package. Eligibility would expand by allowing all residents under 100 percent FPL to have access to Medicaid benefits. Currently, eligibles include families under 58 percent FPL, pregnant women with young children up to 100 percent FPL, medically needy, and aged, blind, and disabled.

The benefit package would be redesigned by the Health Service Commission appointed to review all health services, as generally prescribed by the act, and rank them in order of most important to least important. The commission will present its recommendations to the Joint Legislative Committee on Health Care, which will make recommendations to the Emergency Board. The Emergency Board and subsequent Ways and Means Committees will appropriate funds on a per capita rate, which will determine the quality of the health care package. Revenue shortfalls will not result in reduction in eligibles or provider rates, but by reduction in the benefit package.

A tax credit program was established in 1988 to encourage small businesses, who have not previously offered health care benefits, to provide such benefits. In return, the employer receives an affordable benefit package and a tax credit of up to \$25 per employee per month for as long as the employer provides the benefit. Chapter 381 (SB 935) attempts to provide access to health care for uninsured working Oregonians by expanding the existing tax credit program administered by the Insurance Pool Governing Board and creating incentives and rewards to employers who provide health benefits.

Chapter 838 (SB 531) addresses the problem of providing health care services to the uninsured and uninsurable and the need to spread the cost to as broad a base as possible. The measure establishes the Oregon Medical Insurance Pool Board as a state agency to supervise a medical insurance risk pool. It also appropriates \$1 in million general funds to the Oregon Medical Insurance Pool Account.

Other

In New York, state health commissioner David Axelrod, MD, proposed a universal insurance coverage plan, with elements of cost control, in September of this year. The UNY*Care plan is expected to be introduced in the 1990 legislative session. In Pennsylvania, state representative Donald W. Dorr introduced a package of bills to increase the availability of health insurance and health services.

MEDICAL INDIGENCY PROJECT

The National Conference of State Legislatures (NCSL) has a strong commitment to assisting state legislatures with a variety of medical indigency issues. NCSL is assembling a consortium of funders to address the problems of medical indigency. The Colorado Trust and American College of Emergency Physicians are the first to support the Medical Indigency Project. NCSL received a two-year grant from the Colorado Trust to assist state legislators in developing policies on health care for the medically indigent. The Colorado Trust is a private foundation established in 1985. Its primary mission is to promote and enhance the health and well-being of all people, particularly the citizens of Colorado. The American College of Emergency Physicians strives to provide a unifying direction of purpose in the field of emergency medicine. The college provides information regarding the practice of emergency medicine and encourages training of emergency physicians, with the aim of improving emergency room care.

The project conducts on-site technical assistance, publishes periodic reports, and maintains an information clearinghouse on innovative state programs of care for the medically indigent. The project also will produce three newsletters on issues concerning the medically indigent. ProjectNotes is the first in a series of reports on access to care, financing, and the quality of health care for the medically indigent.

TECHNICAL ASSISTANCE

Technical assistance services offer legislatures programs tailored specifically to their state's situation. Assistance in the past has included special workshops, assistance with drafting legislation, and special testimony.

A number of states have expressed an interest in technical assistance for 1989 - 1990 on a variety of topics related to the issue of medical indigency. Requests for technical assistance come from states with large medically indigent populations and states that have experienced a recent increase in this group. States chosen to receive technical assistance are determined according to state need, issue area, potential impact on the legislative process, and legislative interest. If your state legislature is interested in more information on technical assistance programs concerning issues affecting the medically indigent, please contact project staff.

PUBLICATIONS

The Medical Indigency Project has produced a variety of publications and other information resources on major medical indigency health policy issues. One copy of each publication is provided upon request at no cost to state legislators, legislative staff, and state legislative libraries. Please contact NCSL's Book Order Department at the number listed in the FYI section.

INFORMATION CLEARINGHOUSE

The Medical Indigency Project and other health projects have developed an extensive information clearinghouse on a variety of health topics. The information clearinghouse guarantees legislators and legislative staff a quick, reliable, and knowledgeable source of information when research reports and legislation are being formulated. NCSL's Health Services Program fields over 1,000 information requests a year from legislative offices, health departments, other health care professionals, and the media.

Requests cover a broad range of medical indigency topics, including: uncompensated care, Medicaid eligibility and expansion, funding sources, health insurance regulation, risk pools, mandated health benefits, and state programs for the medically indigent. The resources of the Medical Indigency Project information clearinghouse may be accessed by contacting project staff.

MEETINGS AND SEMINARS

NCSL's Annual Meeting and other seminars and conferences provide an opportunity to reach a large number of interested legislators. Health issues are always among the most important sessions at these meetings and draw large audiences. Information on upcoming workshops will be included in future editions of ProjectNotes.

National Conference
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HEALTH CARE FOR THOSE WHO CANNOT ALWAYS AFFORD CARE

The headlines of the nation's newspapers and periodicals mark the absence of a national health care assurance policy: "US Must Cure Health Care Ills;" "State Health Care Funding Criticized;" "Can You Afford to Get Sick?: The Battle Over Health Benefits;" "US Rations Health Care;" and "Deciding What Medical Care the Poor Can Have: Lists Are Drawn Up." State and federal efforts to better the health care system are fragmented and often work at cross purposes. The lack of agreement on a solution begs the unanswered question: who is responsible?

Health care expenditures have escalated astronomically in the last 25 years. Health care costs consumed 5.9 percent of the Gross National Product (GNP) in 1965. The U.S. Department of Commerce has reported that the nation's health care tab was \$600 billion in 1989, or 11.5 percent of the GNP. Those billions, up 10 percent from 1988 total health care expenditures, translate into approximately \$2,400 per person. 1990 health spending is expected to reach \$661 billion. At the same time, the number of uninsured has grown substantially.

Medical indigency and health insurance are top priority issues for the 1990 legislative sessions. Health insurance issues are explicitly tied to medical indigency policy. Improving access to health care is of concern to medical indigency policymakers as millions of uninsured people report financial barriers to receiving needed care. Mandating health insurance benefits, establishing financial incentives for employer-paid coverage, and creating state-sponsored insurance plans are a few of the key issues facing state lawmakers today.

INSURANCE STATUS

Recent efforts to help solve the problems of medical indigency and uncompensated care focus on the "insurance status" of the population. Lack of insurance leads to an abundance of problems for individuals and health care providers alike. If they can't afford to pay cash or the insurance deductible, the 37 million Americans without health insurance must rely on the goodwill of hospitals, doctors, and other providers. Lack of health insurance or insufficient insurance coverage is not an exclusive problem of the unemployed, the elderly, or persons living in rural areas.

- o A decade ago, approximately 25 million Americans under age 65 did not have health insurance. Today, 37 million Americans, approximately 16 percent of the nation's population, have no health insurance coverage at all, more people than the combined populations of New York, New Jersey, and Illinois.
- o Of the uninsured and increasingly underinsured Americans, the majority have ties to the workplace. Twenty-three million "working poor" have jobs or are dependents of workers.
- o Almost one third of uninsured employees work for employers who do not offer insurance. More than one-third of uninsured workers do not participate in their employer's health insurance plan even if they are eligible. Approximately one-third of uninsured workers do not qualify for their employer's health plans.¹
- o Underinsured people are those who cannot pay for their share of insurance deductibles or copayments or for medical care not covered by their insurance policies. Fifty million Americans are covered only part of the year, and millions more are covered by inadequate plans for catastrophic illness or accident. Nearly every health care consumer has the potential of facing medical expenses for which he or she cannot pay because insurance policies generally have a cap on expenditures.
- o The uninsurable or "high risk" population consists of an estimated one to two million people with high health risks, such as heart disease, diabetes, or acquired immunodeficiency syndrome (AIDS). Many are refused health insurance coverage and others cannot afford to purchase an individual policy, which usually is offered for a much higher premium.
- o Researchers believe that the uninsurable population is growing and attribute the increase to the following factors: insurers are adopting more restrictive health insurance standards due to an increasingly competitive insurance market; not as many employers are providing health insurance benefits because of escalating costs; and advances in technology enable insurers to identify people who have potentially costly illnesses.
- o Others presumably can pay for their care but do not. For example, some people who have insurance do not pay their deductible or copayment amount. It is unclear how many insured people have difficulty paying these costs.

- o Seventeen percent, representing 9.5 million women of child-bearing age (15 to 44), have no private or public health insurance.² Researchers have concluded that 9 percent of women who have private insurance have policies that provide inadequate coverage for maternity care.³
- o Between the ages of 15 and 44, women's need for health services is substantially higher than men's because of reproductive health needs, including perinatal care and contraception. Furthermore, the reproductive years are the time period when women's health most affects society as a whole, by determining the health of the next generation.
- o Burdens of inadequate and incomplete insurance coverage weigh heavily on minority women. A disproportionate burden of illness falls on ethnic minorities, especially African-American women, giving rise to a greater need for health care.

Among the factors contributing to the growth in the uninsured population are the following: a smaller percentage of poor people are covered by Medicaid, because states have limited eligibility over the years to help control costs; most new jobs in the past 10 years are in the service sector, where employees are less likely to be covered by health insurance; and work-based dependent coverage appears to be declining. For this reason many state initiatives focus on expanding work-based insurance coverage, either by giving employers incentives or by requiring them to make insurance available.

¹ Irene Fraser, *Promoting Health Insurance in the Workplace: State and Local Initiatives to Increase Private Coverage* (Chicago: American Hospital Association, 1988).

² Kay Johnson, Director, Health Division, Children's Defense Fund, quoted in *Hunger Action Forum*, Vol. 2, No. 8, August 1989.

³ Paula Braveman, MD, et al., "Women Without Health Insurance: Links Between Access, Poverty, Ethnicity, and Health," *The Western Journal of Medicine*, 1988 December: 149: 708-11.

FINANCING INSURANCE COVERAGE

"A major reason why so many people lack health insurance is that state government regulations are increasing the costs of insurance and pricing millions of people out of the market for insurance. Freedom of choice in health insurance means being able to buy a health insurance policy tailored to individual and family needs. This is a freedom that is rapidly vanishing from the health insurance marketplace." John C. Goodman and Gerald L. Musgrave, *Freedom of Choice in Health Insurance*, National Center for Policy Analysis

All 50 states have mandated benefit laws which typically require employers that offer group health plans to include specific benefits. During the past 20 years, states across the U.S. have imposed nearly 700 of these mandates. This approach has become increasingly more controversial when employers are mandated to provide insurance coverage. The National Center for Policy Analysis estimated that in 1986, between 14 percent and 25 percent, or 5.2 million to 9.3 million of the people without health insurance, had no insurance because state governments imposed special interest regulations that mandated expensive coverage.

States are struggling with the financial realities of health care mandates. States are not always in a financial position to respond to urgent health care needs. The vagaries of funding a multitude of state programs sometimes require states to mandate employer-based expansions of health care services. Financing programs at times is simply beyond the capabilities of current state budgets. However, employer-based mandates are not the only alternative available, a variety of state approaches are presented below:

- o One approach to insuring the employed uninsured population is to expand the number of employers who offer health benefits.
- o Another approach is to develop mechanisms that enable employees who cannot afford their share of the premium for work-based insurance, especially for dependents, to purchase insurance at affordable rates.
- o Unemployed uninsured people also may benefit from programs that enable more workers to purchase insurance, if they are allowed to participate.
- o The problems facing the underinsured may require insurance policies to provide coverage for more services, such as mental health benefits, mammography screenings, and maternity care.
- o Another approach is to exempt certain covered services from cost-sharing requirements.

In 1990 many states will consider these approaches as well as state risk pools for the one to two million Americans deemed uninsurable.

- o At least 15 states have insurance risk share pools to help provide access to insurance for high risk individuals who otherwise would have trouble obtaining coverage.
- o The costs to risk pool participants are usually 25 to 50 percent higher than premiums paid by persons with private insurance.
- o Even with the high contributions paid by covered people, risk pool programs must be subsidized to cover their costs.

State legislatures and the federal government are considering a variety of other financing mechanisms. Alternatives include using funds from general revenues, changing the estate and gift tax laws, increasing tobacco and alcohol taxes, creating tax incentives for expanding health coverage, enacting state risk pool arrangements, mandating benefits, and Medicaid expansions.

WHOSE RESPONSIBILITY?

STATE

State governments are faced with increasing health care costs for the medically indigent and are under pressure to find more adequate and equitable means to finance health care. The following state examples illustrate the innovative ways in which states address these issues:

COLORADO

The Colorado Health Care Access Act (HB 1034) was introduced by Representative Carol Taylor-Little and Senator Sally Hopper in January of this year. The legislation, patterned after the 1989 Oregon Basic Services package, proposes to address the access problem in two ways: first, by guaranteeing basic health coverage for everyone with incomes under the federal poverty line and committing not to reduce eligibility or provider payment due to budget constraints; and second, by giving small employers a tax incentive to provide health insurance for their employees, a strategy intended to help the working poor. The act would add as many as 170,000 Coloradans with incomes below the federal poverty line to the expanded Medicaid program, many of whom would be children. Up to 245,000 Colorado workers and their families in thousands of small firms also are expected to benefit.

Under the proposal, an independent, objective commission comprised of health care providers, consumers, and experts in health care financing, delivery, and ethics would develop a list of health care services in order of priority, according to the benefits and costs of each service. The proposal requires the commission to consult with the Joint Review Committee for the Medically Indigent, the Joint Budget Committee, and the House and Senate health committees.

Sponsors of the legislation hope to benefit business in three ways: by giving small employers access to low-cost health insurance through a state pool; by providing a tax credit to small employers who purchase insurance through the pool; and by giving all employers valuable information on the effectiveness and appropriateness of services prioritized by the commission, which employers can use in designing more cost-effective benefit packages, thus helping them to control costs.

GEORGIA

In 1989 Representative E.M. Childers, chair of the House Health and Ecology Committee, authored a resolution in the Georgia General Assembly creating the Access to Health Care Commission (1989 Georgia Laws, p. 1749, HR 162). The commission is charged with studying factors that limit access to health care in Georgia and making recommendations concerning programs and policies to improve access in the state. The commission is composed of 30 members: six representing the state General Assembly (health, insurance, and appropriations committees); health providers (hospitals

physicians, nurses, and health centers); health consumers; business; insurers; and state organizations.

A comprehensive solution to the problem of medical indigence is the goal. Georgia has one of the highest infant mortality rates in the United States. Eighteen percent of the population under age 65 is uninsured, including 55 percent of families with income between 50 and 100 percent of the federal poverty level. Of particular concern are the following rural health issues: 40 percent of the state's population are located in rural areas; 50 percent of the population aged 65 and above are located in rural areas; and problems exist with the financial instability of the state's rural hospitals.

INDIANA

Legislation enacted in 1989 (1989 Indiana Acts, P.L. 327, SEA 385) established a Commission on State Health Policy. The commission is intended to improve the effectiveness of programs financed by the state and the effectiveness and delivery of health care services in the state. A study and recommendations are to include research on access to health care, the cost of health care and its underlying factors, preventive health care, and the role of healthy lifestyles. The act also creates a State Health Policy Advisory Committee to provide information and assist the commission in the performance of its duties. The commission is to submit an interim report to the governor and the General Assembly before November 1, 1990, and a final report before November 1, 1991.

The Steering Committee on Health Care for the Medically Underserved, a coalition of health care providers, business, government, and consumer representatives, issued a report calling for state-supported demonstration projects to test private financing mechanisms for uninsured and underinsured residents. The projects are intended to help the state develop an overall policy for financing the delivery of health care services to the working poor. The committee recommended that the state expand its Medicaid program to cover more women, children, and infants who cannot afford health care. It also recommended that the state study ways to develop other public programs to increase health coverage for the indigent.

MISSOURI

In December 1989, Representative Gail L. Chatfield proposed sweeping legislation to create the Missouri Universal Health Assurance Plan (HB 1127). The sponsor emphasized that the intent of the legislation is to provide increased health care coverage to citizens who are currently uninsured by restructuring the state's financing mechanisms so that individuals, businesses, and providers of health care may all benefit. The proposed legislation would cover a range of options, including: mandatory employer coverage, direct state subsidies of individual premiums, and expansions of Medicaid. The basic premise behind the bill is to establish a Canadian style comprehensive health program with three guiding principles: universal access, cost containment, and quality assurance.

The Canadian system mentioned above is perceived to have one of the best health care systems in the developed world. The model is best described as a single-payer public system providing affordable, universal coverage. Each province has its own system, although all provinces conform to basic rules of universality and accessibility.

The Missouri plan is intended to replace the patchwork of private and public insurance with a single state insurance program for which everyone is eligible and within which every resident will have access to a basic package of health care services. The proposed plan would consolidate all of the money presently being paid by private companies and individuals, as well as the state, federal, and local governments into a single fund. Finally, the plan contains quality assurance provisions for constant monitoring and improvement of the quality of care.

OTHER

Nearly 1.8 million residents of North Carolina either have no health insurance or inadequate coverage. A task force of the North Carolina Institute of Medicine has proposed creation of a comprehensive health-benefits plan that would represent the minimum level of insurance coverage to which all citizens would have access. The plan would include comprehensive coverage for primary care, particularly preventive services, but would provide for only 10 days of inpatient care in order for the coverage to remain affordable. The gross cost of the plan would be \$1.4 billion, but institute officials contend that the net cost would be much lower -- about \$700 million -- because of savings resulting from reductions in cost shifting and out-of-pocket expenditures by the medically indigent.

In Washington state, a bill introduced late in 1989 would create the Universal Health Access Program, based on the Canadian health care system. Nearly 700,000 people -- 15 percent of the population -- remain uninsured and unable to afford health services. Representative Dennis Braddock hopes that a universal health system will enable the state to combine and streamline the various health care programs currently operated by the state with a price tag of \$3 billion a year.

FEDERAL

Federal proposals also have addressed the issue of how to better protect uninsured, underinsured, and uninsurable Americans.

The Pepper Commission, created by the now-repealed Medicare Catastrophic Coverage Act of 1988, is currently formulating recommendations on how to deal with the insurance crisis, curb costs, and widen access to care. Among the issues being discussed are the following: implementation of employer-paid health insurance for workers and dependents coupled with a new payroll tax to buy coverage for those lacking insurance; creation of a single government agency empowered to set rates for Medicaid and Medicare; and expansion of Medicaid. The "play or pay" option already

has been embraced or proposed in some states, e.g., Massachusetts, Colorado, Oregon, and Washington. However, critics fear it would hurt small firms and trigger unemployment.

The Social Security Advisory Council, a private sector panel studying the system, has until July 1990 to draft a report, with a final report on the health care system due to the Department of Health and Human Services by January 1991. The Council, unlike the Pepper Commission, has no congressional mandate, and no major changes or restructuring are expected to be suggested.

Congress has passed several initiatives to expand Medicaid coverage. The current trend is to expand Medicaid whereby states are able to address the health care needs of pregnant women, infants, and children in low-income families. Forty-one states have raised Medicaid income eligibility to at least the full federal poverty level. Of these, nine have increased their eligibility levels to the maximum allowed -- 185 percent of federal poverty.

LABOR/BUSINESS

The U.S. Chamber of Commerce, the National Association of Manufacturers, and other business groups are pushing for government action. Business representatives maintain that they "have done all we can do" to manage health care costs. Employers realize that if they do not insure workers they pay dearly. They subsidize the cost of care provided to workers whose employers do not provide health care. The issue of health care costs is one of the most bitterly fought at the bargaining table, e.g., "Baby Bell" contract, Pittston Coal Company strike.

Unions have played a major role in developing employer-based health care coverage for working families. Until recently, such coverage provided access to care for most working Americans and their families. But the health insurance system has evolved during the past decade because of the shifting economy. Over the years, organized labor has fought to protect workers from increased health care costs. However, only 29 percent of employers today offer 100 percent reimbursement for health care, compared with 53 percent just five years ago. A growing number of workers are no longer provided family coverage or cannot afford high monthly premium contributions to insure spouses and children. Working families are now paying more for their health care, if they can afford to pay for it all.

In order to control skyrocketing costs, an AFL-CIO grassroots campaign seeks to develop a five-point national health care program that would: place a cap on all health care expenditures, assure all Americans access to basic health care services, invest in technology assessment, develop guides for physicians to consult in treating various conditions, and inform consumers about cost and quality of health care services by making materials available to all consumers. Federation President Lane Kirkland has stressed that the AFL-CIO's objectives are to launch a "combined federal-state program that will control health care inflation, require all businesses to do their fair share in providing health care protection to employees, provide coverage for the poor and unemployed, effectively monitor the quality of health care,

and eliminate unnecessary procedures."

"Results of the 1987 National Medical Expenditure Survey indicate that many employees would prefer alternatives to costly, high-option traditional insurance, although many employers do not offer them. Furthermore, employees seem willing to trade some reductions in deductibles and copayments for additional protection against catastrophic medical expenses. But the appeal of more traditional high-option benefits, such as first-dollar coverage for hospital stays, will lead many employees to choose the high-option plans, no matter how financial incentives are changed to favor low-option plans and HMOs." Pamela Farley Short and Amy K. Taylor, National Center for Health Services Research.

More Americans are paying more for their own health costs, according to the Employee Benefit Research Institute. Of 1,000 Americans surveyed, about 43 percent paid higher monthly premiums in the last two years; another 32 percent paid more for deductibles; and about 40 percent paid more copayments and dependent-coverage costs. Critics argue that what we do not need are programs that are little more than "band-aids," stop-gap measures that moderate the inequities individuals now experience in the distribution and provision of medical care in our nation.

The question remains, where will responsibility lie? Policymakers at both the state and federal level continue to struggle with these issues. Is a national legislative solution the answer? Some argue that only a federal solution is equitable. On the other hand, federal proposals are often characterized as preemptive of state authority. States are wary of federal interventions that strip state flexibility and displace state plans to deal with the problem. Are individual state solutions the answer? States are in varying degrees of fiscal health. Many contend that piecemeal state solutions will further hamper efforts at "universality." The debate continues, and states retain the authority to address their own needs and develop service systems designed to best respond to their unique circumstances.



FYI



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COMING IN APRIL

ALTERNATIVE FUNDING SOURCES FOR CARE OF THE MEDICALLY INDIGENT

Medical indigency issues continue to dominate health care agendas across the nation. Legislators feel pressure from a variety of sources to address the problem, including health care advocates, business leaders, physicians, and hospitals, most notably public hospitals. The last few years have witnessed a shift in public policy approaches to meeting the needs of the medically indigent. The goal of presenting state information in ProjectNotes has been to inform state legislators of these approaches.

A variety of approaches have been proposed and implemented to help solve the problem and legislators are keenly aware that what works for one state may not be acceptable or feasible in another. Proven and promising strategies states have used to control health care costs while seeking alternative revenue sources to fund care for the medically indigent are highlighted in the April edition of ProjectNotes.

TECHNICAL ASSISTANCE UPDATE

The Medical Indigency Project has sponsored state technical assistance programs in Alaska, Colorado, Kansas, Nevada, Oklahoma, South Carolina, and Wisconsin. The April edition of ProjectNotes recaps these programs and tracks legislative activity surrounding the issue of medical indigency in the state since the program presentation.

1989 HEALTH CARE LEGISLATION REVIEW

The Health Services Program is currently compiling the seventh in a series of NCSL publications summarizing significant health care laws passed by the 50 states, commonwealths, and territories in 1989. The section on Medical Indigency will be previewed in the April edition of ProjectNotes.

MEDICAL INDIGENCY ProjectNotes

MEDICAL INDIGENCY PROJECT

The National Conference of State Legislatures (NCSL) has a strong commitment to assisting state legislatures with a variety of medical indigency issues. NCSL is assembling a consortium of funders to address the problems of medical indigency. The Colorado Trust and American College of Emergency Physicians are the first to support the Medical Indigency Project. NCSL received a two-year grant from the Colorado Trust to assist state legislators in developing policies on health care for the medically indigent. The Colorado Trust is a private foundation established in 1985. Its primary mission is to promote and enhance the health and well-being of all people, particularly the citizens of Colorado. The American College of Emergency Physicians strives to provide a unifying direction of purpose in the field of emergency medicine. The college provides information regarding the practice of emergency medicine and encourages training of emergency physicians, with the aim of improving emergency room care.

The project conducts on-site technical assistance, publishes periodic reports, and maintains an information clearinghouse on innovative state programs of care for the medically indigent. The project also will produce three newsletters on issues concerning the medically indigent. ProjectNotes is the first in a series of reports on access to care, financing, and the quality of health care for the medically indigent.

TECHNICAL ASSISTANCE

Technical assistance services offer legislatures programs tailored specifically to their state's situation. Assistance in the past has included special workshops, assistance with drafting legislation, and special testimony.

A number of states have expressed an interest in technical assistance for 1989 - 1990 on a variety of topics related to the issue of medical indigency. Requests for technical assistance come from states with large medically indigent populations and states that have experienced a recent increase in this group. States chosen to receive technical assistance are determined according to state need, issue area, potential impact on the legislative process, and legislative interest. If your state legislature is interested in more information on technical assistance programs concerning issues affecting the medically indigent, please contact project staff.

PUBLICATIONS

The Medical Indigency Project has produced a variety of publications and other information resources on major medical indigency health policy issues. One copy of each publication is provided upon request at no cost to state legislators, legislative staff, and state legislative libraries. Please contact NCSL's Book Order Department at the number listed in the FYI section.

INFORMATION CLEARINGHOUSE

The Medical Indigency Project and other health projects have developed an extensive information clearinghouse on a variety of health topics. The information clearinghouse guarantees legislators and legislative staff a quick, reliable, and knowledgeable source of information when research reports and legislation are being formulated. NCSL's Health Services Program fields over 1,000 information requests a year from legislative offices, health departments, other health care professionals, and the media.

Requests cover a broad range of medical indigency topics, including: uncompensated care, Medicaid eligibility and expansion, funding sources, health insurance regulation, risk pools, mandated health benefits, and state programs for the medically indigent. The resources of the Medical Indigency Project information clearinghouse may be accessed by contacting project staff.

MEETINGS AND SEMINARS

NCSL's Annual Meeting and other seminars and conferences provide an opportunity to reach a large number of interested legislators. Health issues are always among the most important sessions at these meetings and draw large audiences. Information on upcoming workshops will be included in future editions of ProjectNotes.

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Stateside

Discussions with Health Policymakers

by Linda Demkova



January 1991

Alliance Strives for Universal Coverage

In 1988, after a legislative effort that would have allowed all Minnesota residents to buy into a basic "Chevrolet" insurance plan to cover health care costs fell apart in a dispute over financing, Rep. Paul Anders Ogren decided it was time to do what has become known in the political world as "networking."

The themes sounded again during the debate over the Minnesota insurance plan, Ogren said, "was that it will become a magnet for people who are ill, that it will put [the state] at an economic disadvantage relative to its neighbors, that the problem has to be solved by federal action, because of the sheer complexity and the cost."

Looking around, however, Ogren realized that many other states were also trying to address the problems of the uninsured and that a few – most notably Massachusetts and Oregon – had actually succeeded in enacting substantive reforms. The problem, in his view, was that they were doing so in isolation, with no means for sharing information and learning how to avoid each other's mistakes. "There was no resource network for progressive legislators pushing for universal health care at a state level," he observed.

That's when the Minnesota Democrat hit on the idea of launching the State Alliance for Universal Health Care – "as sort of a signal to legislators across the country that we can be a damned sight bolder than we've been thus far."

In mid-December, in concert with the Health Committee of the National Conference of State Legislatures (NCSL), the Alliance co-sponsored

a special two-day seminar on the theme "Expanding Access to Health Care." The session, a follow-up to the Alliance's first formal meeting, which was held in August 1990 in Nashville, took place just before the NCSL's regular state-federal assembly in Washington, D.C., and attracted 60 attendees. Among the featured speakers were Sen. Edward M. Kennedy (D-MA) and maverick Senator-elect Paul Wellstone (D-MN).

In separate interviews after the seminar, State Health Notes talked about the Alliance and the prospects for enactment of a universal health care system with both Ogren and Ohio Rep. Robert F. Hagan (D), who is member of the Alliance's board of directors.

"A Dollar is A Dollar"

The immediate aim of the Alliance is to build "a coalition of legislative leaders... committed to the guarantee of universal health care in each of our states." Longer term, according to the mission statement drafted in April 1990, "our collective efforts must and will culminate in a national resolution, through the Congress and President" in support of universal care.

At present, neither Ogren nor Hagan sees signs that federal policymakers are close to achieving that goal or that they are committed to helping the states achieve it by eliminating some of the barriers that Congress has, over the years, thrown in the states' way.

"The reason for the proliferation of organizations like the Alliance," said Hagan, the chief sponsor of the Universal Health Insurance for Ohio

(UHIO) plan, which is modeled on Canada's national health system, "is the realization that the federal government cannot do it." Problems – ranging from the failure of the savings and loan industry and the burgeoning budget deficit at home to the threatening situation in the Persian Gulf – will continue to divert Washington policymakers from the health system crisis, the Ohio lawmaker said.

At the same time, Hagan said, the federal government has thrown up roadblocks – things such as ERISA, the federal pension law that bars states from requiring companies that self-insure to comply with mandated health insurance benefits and risk-pool laws, and a cumbersome waiver process that discourages the states from experimenting with Medicaid reforms. "I would like to see a waiver granted that would allow one state to implement a single-payer system and work it out over a period of five to ten years," he said.

The concept underlying the UHIO plan is not a new one, after all, Hagan continued. "This is something that has been implemented in Canada. At some point, we have to admit that someone had a better idea." Like Canada, which sold its system province to province, "we have to go state to state until we convince [the federal government] of the need for a national plan." Until that happens, "we'll have to take responsibility for our own problems. What I've realized is that when they are viewed from that perspective, the problems are not nearly as big."

Part of the problem, Ogren says, is that liberal congressional leaders like Kennedy have been unwilling to admit

that their dream of a national health plan is unlikely to be realized any time soon. He likens the struggle to an old religious tradition: "I'm half Jewish and at Passover, we always say, 'Next year in Jerusalem.' The problem is, we've been saying it for 2000 years, and it's never quite next year." At the seminar, he said that he told Kennedy, "Just in case you don't get there next year, how about loosening the reins on the states so that we can make modest progress at our parochial level while the grand plan is forged here in Washington?" The response? "Next year in Jerusalem," he laughed.

Despite the lack of flexibility, Ogren said he is convinced that the states can, on their own, make a significant difference in solving the problems of the uninsured. "Those states that throw up their hands and say 'We can't afford it, Washington has to do it,' are dreamers. A dollar is a dollar, whether it's raised by the states or the federal government," he asserted.

Interim Steps

There are "some short-term benefits coming out of the scrutiny of the insurance sector," Ogren noted. While states may not be able to regulate companies that choose to self-insure, "they can certainly institute community rating and eliminate discrimination on the basis of age, sex and preexisting conditions, and really take health insurance back to where it was 20 years ago, when the young and the old, men and women, the healthy and the ill, were blended into a single comprehensive pool.

"I don't know if it will go as far as full-fledged community rating," the lawmaker said, "but we're going to come closer to the roots of what insurance is presumably all about."

A problem with what most states are now doing, he continued, "is that there is little pretense of health

care reform. There is quite a bit of insurance reform, but as [states] pick their enemies, they're looking at only half of the equation. They're looking almost exclusively at the administrative cost component, and I don't think it's as simple as that."

Short of moving to a single-payer system, the states can also set for themselves the goal of coordinating various health programs. On average, Ogren said, "the states administer about a half dozen different health care programs, often in a half dozen different agencies, with a half dozen different reimbursement mechanisms. If they can streamline all of those programs, wrap them into a single state-administered program that incorporates the uninsured ... the program would also be a competitor in the marketplace." It would encompass not only the poor enrolled in Medicaid and the uninsured but also would attract people who are now buying insurance individually and would give it up gladly because of preposterous rates."

A principal aim of the Alliance is to coordinate independent state efforts. "There are lots of mistakes that won't have to be replicated because we'll have the chance to see what works and what doesn't. Now, state legislators largely work in a consummate vacuum."

A parallel aim is "to see what our collective voice can mean here in Washington." NCSL has "a very diffused voice. It cannot advocate for a specific position because it must encompass all positions."

Outside Reaction

Since it was formed, the Alliance has attracted a small cadre of legislators who share Ogren's belief. Also on the board are Sens. John Kitzhaber (OR), Paula Hollinger (MD) and Stanley C. Walker (VA) and Reps. James Shon (HI), Dennis Braddock

(WA), John Timmer (SD), John McDonough (MA), Gene Davis (UT) and Gail Chatfield (MO). All but Timmer are Democrats.

Clearly not all legislators embrace the Alliance's mission statement. Delaware Rep. Jane Maroney (R), a self-described "states' rights person" – said she believes that states can and should solve their own problems, "so I have an argument conceptually" with the need for federal intervention. Even so, Maroney said, "there is no reason not to debate a system such as the one in place in Canada. We need dialogue. The chemistry of good will takes time to develop."

Not even those who agree with the goal of universal care are necessarily convinced that the Alliance is an ideal vehicle for reaching it. Ogren and his board are "senior, credible people," but they are appealing only to a subset of legislators. They are committed to specific, fundamental change, but there is no evidence that they have swayed some of their more mainstream colleagues," an attendee at the December seminar noted. "They don't seem to feel that they have to market their position. Their audience seems to be people who are already committed to the goal and who need information to translate it into program changes."

Ogren reiterated that the Alliance – which he termed "truly political, not at all policy-oriented" – was not created to dictate a common tool or model program for achieving universal access but rather to facilitate the exchange of information among the states.

The Alliance, Hagan asserted, does have room for other viewpoints, provided potential members are committed to three major principles: universality of coverage; cost containment; and a belief that health care is a right.

SENATE BILL NO. 83

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATORS DUNCAN, Zharoff, Rodey

Introduced: 1/23/91

Referred: L&C, HES and Finance

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to the Alaska State Health Resources Authority; relating to the delivery,
2 quality, and financing of health care for residents of the state, and to the issuance of
3 certificates of need; and providing for an effective date."

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

5 * **Section 1. PURPOSE.** The purpose of this Act is to

6 (1) by July 1, 1992, create and begin implementation of a statewide health care provider
7 reimbursement system and utilization standards;

8 (2) after July 1, 1992, provide comprehensive group health insurance for the state,
9 municipalities, school districts, other employers in the state who elect to participate, and all eligible
10 employees of the state, a municipality, a school district, or other employer in the state who elect to
11 participate in the group insurance offered by the Alaska State Health Resources Authority;

12 (3) expand the pool of subscribers and maximize the opportunities for health care cost
13 management and economies of scale when purchasing group health insurance;

14 (4) maintain an efficient provider reimbursement system to reduce the administrative cost

1 to providers who are serving employees of participants;

2 (5) maintain a statewide health care data base and utilization standards to control
3 inappropriate or improper utilization practices and to reduce the rate of inflation in the cost of health care
4 in the state;

5 (6) create the most comprehensive, cost-effective, and efficient method of providing a
6 variety of types of health care insurance necessary to meet the coverage requirements of a participant
7 resulting from negotiated employee contracts;

8 (7) realize the potential savings that will result if approximately 135,000 active and
9 retired state, municipal, and school district employees and their dependents participate in the group health
10 insurance program offered by the authority;

11 (8) evaluate the need for mandatory participation in the group health insurance offered
12 by the authority; and

13 (9) evaluate the need for group health insurance for residents of the state who are
14 uninsured or underinsured.

15 * Sec. 2. AS 18.07.035 is amended to read:

16 Sec. 18.07.035. APPLICATION AND FEES. Application for a certificate of need shall
17 be made to the department upon a form provided by the department and must contain the
18 information the department requires to reach a decision under AS 18.07.041 - 18.07.111. Each
19 application for a certificate of need must be accompanied by an application fee established by
20 the department by regulation. A copy of each application for a certificate of need, except an
21 application for a temporary or emergency certificate issued under AS 18.07.071, shall be
22 provided to the Alaska State Health Resources Authority.

23 * Sec. 3. AS 18.07.041 is amended to read:

24 Sec. 18.07.041. STANDARD OF REVIEW FOR APPLICATIONS FOR CERTIFICATES
25 OF NEED. The office shall grant a sponsor a certificate of need or modify a certificate of need
26 if the availability and quality of existing health care resources or the accessibility to those
27 resources is less than the current or projected requirement for health services required to maintain
28 the good health of Alaska citizens. A certificate of need may not be issued, except for a
29 temporary or emergency certificate under AS 18.07.071, unless the office has received a
30 determination from the Alaska State Health Resources Authority regarding the effect of the
31 certificate of need on the cost of group health insurance.

1 * Sec. 4. AS 21 is amended by adding a new chapter to read:

2 CHAPTER 77. STATE INSURANCE.

3 Sec. 21.77.010. AUTHORITY CREATED; REQUIRED REIMBURSEMENT SYSTEM
4 AND UTILIZATION STANDARDS. (a) There is established within the Department of
5 Administration a nonprofit incorporated legal entity known as the Alaska State Health Resources
6 Authority.

7 (b) The authority shall, by July 1, 1992, establish and begin implementation of a health
8 care provider reimbursement system and utilization standards. The state, a municipality, or a
9 school district shall use the health care provider reimbursement system and utilization standards
10 established by the authority for eligible employees of the state, a municipality, or a school
11 district. With the approval of the authority, other employers in the state may use the health care
12 provider reimbursement system and utilization standards established by the authority.

13 (c) The authority shall, no earlier than July 1, 1992, establish a group health insurance
14 pool or pools of eligible employees of the state, a municipality, or a school district if the
15 employer has elected to participate in the group health insurance obtained by the authority and
16 may provide group health insurance to employees of other groups that elect to participate in the
17 group health insurance pool provided by the authority. Employees of other groups that elect to
18 participate shall use the reimbursement system and utilization standards established by the
19 authority.

20 (d) Upon application by an eligible state program, the authority may, beginning July 1,
21 1992, allow the eligible state program to participate in the group health insurance pool provided
22 by the authority.

23 Sec. 21.77.015. REQUIRED COOPERATION BY STATE AGENCIES. An agency of
24 the state that provides health care or that provides funds to purchase health care shall, to the
25 maximum extent possible, cooperate in the development of the use of the health care provider
26 reimbursement system and utilization standards established by the authority, including sharing
27 relevant information.

28 Sec. 21.77.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The authority shall
29 be managed by a board of directors composed of nine members appointed by the governor. The
30 governor shall appoint at least one but not more than two members as representatives from each
31 of the following:

- 1 (1) the executive branch;
- 2 (2) labor organizations;
- 3 (3) school districts;
- 4 (4) municipalities;
- 5 (5) private sector employers;
- 6 (6) health care providers.

7 (b) Members of the board serve staggered terms of four years. The board shall elect
8 from its membership a president, vice-president, and secretary. Members of the board serve
9 without compensation but are entitled to receive per diem and travel expenses authorized for
10 boards and commissions under AS 39.20.180. Members of the board are subject to AS 39.50.

11 **Sec. 21.77.030. GENERAL POWERS.** The authority may

12 (1) beginning July 1, 1992, exercise the powers granted to insurers under the laws
13 of the state; if the authority acts as an insurer, the authority shall comply with the requirements
14 applicable to insurers under this title;

- 15 (2) sue or be sued;
- 16 (3) enter into contracts or agreements;
- 17 (4) establish administrative or accounting procedures;
- 18 (5) collect, invest, and disburse funds;
- 19 (6) charge fees for providing administrative services;
- 20 (7) establish appropriate levels of reserves to cover the expenses of the authority;
- 21 (8) adopt necessary regulations and procedures for implementation of this chapter.

22 **Sec. 21.77.040. DUTIES OF BOARD; ANNUAL REPORT.** The board shall

23 (1) in providing group health insurance required under this chapter, provide
24 comprehensive coverage at the lowest possible cost per eligible employee;

25 (2) provide to the governor and to the legislature an annual report covering the
26 previous fiscal year's activities of the authority;

27 (3) review each application for a certificate of need under AS 18.07.041 and
28 within 60 days after receiving a copy of the application determine the effect of issuing the
29 certificate on the cost of the group health insurance required under this chapter; a copy of the
30 determination shall be provided to the office of planning and research in the Department of
31 Health and Social Services;

1 (4) every third fiscal year. include in the annual report a cost and benefit analysis
2 of the activities of the authority.

3 Sec. 21.77.050. STAFF AND PROFESSIONAL SERVICES CONTRACTS. The
4 authority shall employ an executive director who serves at the pleasure of the authority as its
5 chief administrative officer. The executive director may, with the approval of the authority,
6 select and employ additional staff as necessary. Employees of the authority are in the exempt
7 service under AS 39.25.110. In addition to its staff of regular employees, the authority may
8 contract for the services of consultants and professional, technical, and financial advisors the
9 authority considers necessary for the purpose of developing information, conducting hearings,
10 studies, investigations, or other proceedings, or otherwise exercising its powers.

11 Sec. 21.77.060. PROCUREMENT OF INSURANCE. (a) The authority shall, after
12 July 1, 1992, obtain a policy or policies of group health insurance covering eligible employees
13 of an employer that has elected to participate, from an insurer authorized to transact business in
14 the state under AS 21.09, or act as a self-insurer if the authority determines that self-insurance
15 can provide the desired insurance coverage and benefits at a lower cost per eligible employee.

16 (b) Except when acting as a self-insurer, the authority shall obtain group health insurance
17 in compliance with the provisions of AS 36.30 and shall make available bid specifications for
18 desired group health insurance benefits to all insurance carriers licensed in the state and qualified
19 to provide the desired benefits. The specifications shall be made available at least once every five
20 years.

21 Sec. 21.77.070. ALASKA STATE HEALTH RESOURCES FUND. The Alaska state
22 health resources fund is created in the general fund. The fund consists of money appropriated
23 by the legislature. The fund shall be managed and invested by the board. The board may expend
24 money from the fund to carry out the provisions of this chapter.

25 Sec. 21.77.080. INSURANCE PREMIUMS. The authority shall provide that sufficient
26 funds are collected to provide authorized benefits, reserves, and to pay the expenses of the
27 authority. Reserves remaining at the termination of an insurance contract shall be invested by
28 the authority in the same manner as retirement funds are invested under AS 14.25.180.

29 Sec. 21.77.090. PARTICIPATION; WAIVER. (a) The state, a municipality, a district,
30 or other employer in the state may participate in the group insurance coverage provided by the
31 authority. If the state, municipality, district, or other employer elects to participate, the state,

1 municipality, district, or other employer shall continue to participate unless a waiver is granted
2 by the board.

3 (b) In determining whether a waiver should be granted, the board shall establish
4 minimum benefit and financial standards for the desired group health insurance coverage. The
5 minimum benefit and financial standards and the proposed time schedule for responsive offers
6 shall be sent to all participants at the time the request for proposal for the desired group health
7 insurance coverage is issued. A participant seeking a waiver of coverage shall match the
8 minimum benefit and financial standards set out in the request for proposal for the desired group
9 health insurance coverage. Participants shall submit documentation of their insurance coverage
10 matching the board's minimum benefit and financial requirements before the deadline established
11 by the board. The board may approve or disapprove a waiver of participation based on the
12 documentation submitted by the participant regarding the benefit and financial standards
13 established by the board.

14 (c) A participant may separately provide for health insurance coverage additional to that
15 offered by the authority.

16 Sec. 21.77.100. DEFINITIONS. In this chapter,

17 (1) "authority" means the Alaska State Health Resources Authority;

18 (2) "board" means the board of directors of the Alaska State Health Resources
19 Authority;

20 (3) "district" has the meaning given in AS 14.17.250;

21 (4) "eligible employee" means an employee of a participant who qualifies for
22 group health benefits as determined by the participant;

23 (5) "eligible state program" means a program in which an agency of the state
24 provides health care or provides funds to purchase health care for persons who are not employees
25 of the state;

26 (6) "employer" means the state, a municipality, a district, a collective bargaining
27 unit, the board of a public corporation of the state created within a principal executive
28 department, a self-employed person, or a person employing one or more persons in a business
29 or industry;

30 (7) "fund" means the Alaska state health resources fund;

31 (8) "group health insurance" means coverage that may include life insurance,

1 accidental death and dismemberment, medical care and treatment, dental care, eye care, and other
2 group health coverage as determined by the authority;

3 (9) "municipality" includes a public corporation established by a municipality;

4 (10) "participant" means the state, a municipality, a district, or other employer in
5 the state;

6 (11) "reimbursement system" means a system or method that streamlines or results
7 in cost efficient payments to health care providers, and includes schedules of maximum allowable
8 reimbursement for health care related services based on geographic regions, actual provider costs,
9 and availability of services;

10 (12) "state" means the executive, legislative, and judicial branches of state
11 government, and includes the University of Alaska and a public corporation of the state created
12 within a principal executive department;

13 (13) "utilization standards" means a system to monitor, track, and verify patterns
14 of treatment by health care providers that assures that cost efficient and cost effective care is
15 provided within accepted medical standards without reducing the quality of care.

16 * Sec. 5. AS 37.07.030 is amended to read:

17 Sec. 37.07.030. RESPONSIBILITIES OF THE LEGISLATURE. The legislature shall

18 (1) provide for a budget review function;

19 (2) analyze the comprehensive operating and capital improvements programs and
20 financial plans recommended by the governor;

21 (3) adopt legislation to authorize implementation of the governor's comprehensive
22 operating and capital improvements programs and financial plans or appropriate alternatives to
23 those plans;

24 (4) provide for a post-audit function to cover financial transactions, program
25 accomplishment, and compliance with legislative intent;

26 (5) adopt or revise the estimate of receipts required to balance the succeeding
27 fiscal year's budget in order that ~~proposed expenditures~~ do not exceed estimated receipts for that
28 fiscal year;

29 (6) adopt, revise, or initiate revenue measures in order to balance the succeeding
30 fiscal year's budget and the capital improvements section of the budget for the succeeding six
31 years;

1 (7) appropriate funds for the operation of the Alaska State Health Resources

2 Authority.

3 * Sec. 6. AS 39.25.110 is amended by adding a new paragraph to read:

4 (30) employees of the Alaska State Health Resources Authority.

5 * Sec. 7. AS 39.50.200(b) is amended by adding a new paragraph to read:

6 (52) Alaska State Health Resources Authority (AS 21.77).

7 * Sec. 8. REPORT. The Alaska State Health Resources Authority shall report to the Alaska State
8 Legislature by March 1, 1992, on the progress made by the authority in establishing a health care
9 provider reimbursement system and utilization standards.

10 * Sec. 9. This Act takes effect immediately under AS 01.10.070(c).

SENATE BILL NO. 84

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATOR DUNCAN

Introduced: 1/23/91
 Referred: HESS and Finance

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to state coordination of health planning and development; abolishing the
 2 Statewide Health Coordinating Council; and providing for an effective date."

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

4 * Section 1. AS 18.07 is amended by adding a new section to read:

5 Sec. 18.07.005. LEGISLATIVE PURPOSE. It is the purpose of this chapter to create
 6 a rational framework for the planning and development of all health care services in the state to
 7 ensure promotion and protection of public health, provide equitable access to health services, and
 8 avoid unnecessary increases in health care costs.

9 * Sec. 2. AS 18.07.021 is amended to read:

10 Sec. 18.07.021. STATE HEALTH PLANNING AND DEVELOPMENT [AGENCY].
 11 The [OFFICE OF PLANNING AND RESEARCH IN THE] department is responsible for [THE]
 12 state health planning and development, [AGENCY DESIGNATED UNDER 42 U.S.C.
 13 300m(b)(3). THE OFFICE] shall [PERFORM THE FUNCTIONS ENUMERATED UNDER 42
 14 U.S.C. 300m-2,] administer the certificate of need program outlined in AS 18.07.031 - 18.07.111

1 [AS 18.07.041 - 18.07.111], and shall perform other functions prescribed in this chapter.

2 * Sec. 3. AS 18.07.031 is repealed and reenacted to read:

3 Sec. 18.07.031. CERTIFICATE OF NEED REQUIRED. (a) Unless authorized under
4 the terms of a certificate of need issued by the department, a person may not

5 (1) make a capital expenditure of \$1,000,000 or more for construction of a health
6 care facility;

7 (2) convert a building, in whole or in part, for use as a health care facility if the
8 fair market value of the converted part of the building is greater than \$500,000 and the sum of
9 the fair market value plus additional capital expenditures made to facilitate the conversion equals
10 or exceeds \$1,000,000;

11 (3) alter or redistribute the bed capacity of a health care facility by more than 10
12 beds or 10 percent of the number of beds in the facility, whichever is fewer;

13 (4) add or eliminate a category of health services to or from those provided by
14 the health care facility; or

15 (5) acquire a health care facility at a cost of \$1,000,000 or more.

16 (b) The dollar thresholds in (a) of this section apply to total anticipated costs. Costs of
17 constructing or acquiring a health care facility may not be artificially divided, fragmented, or
18 structured to circumvent the requirements of this section.

19 * Sec. 4. AS 18.07.035 is amended to read:

20 Sec. 18.07.035. APPLICATION AND FEES. Application for a certificate of need shall
21 be made to the department upon a form provided by the department and must contain the
22 information the department requires to reach a decision under AS 18.07.031 - 18.07.111
23 [AS 18.07.041 - 18.07.111]. Each application for a certificate of need must be accompanied by
24 an application fee established by the department by regulation.

25 * Sec. 5. AS 18.07.051 is amended by adding a new subsection to read:

26 (b) A certificate of need is valid only for the defined scope, physical location, and person
27 stated in the certificate.

28 * Sec. 6. AS 18.07.061 is amended to read:

29 Sec. 18.07.061. MODIFICATION AND TERMINATION OF ACTIVITIES. The
30 certificate holder shall apply to the department [OFFICE] for a modification of the certificate
31 [BEFORE TERMINATING PART OF THE ACTIVITIES AUTHORIZED BY THE TERMS OF

1 ISSUANCE, BUT THE CERTIFICATE HOLDER IS NOT REQUIRED TO OBTAIN THE
2 ACQUIESCENCE OF THE OFFICE] before transferring the certificate or modifying or
3 terminating all or part of the activities authorized by the certificate. If a certificate holder
4 intends to terminate [TERMINATES] all of the activities authorized by a certificate, the
5 certificate holder is required to apply to [NOTIFY] the department [OFFICE] 60 days before
6 termination and to surrender the certificate to the department [OFFICE] within 30 days after
7 [OF] termination.

8 * Sec. 7. AS 18.07.061 is amended by adding new subsections to read:

9 (b) An application for transfer of a certificate shall be made on forms provided by the
10 department and must contain

11 (1) evidence, of the type the department may require by regulation, that the
12 transferee is able to assume ownership or operation of the health care facility and to provide the
13 appropriate health services;

14 (2) evidence that the transferee is acquiring the health care facility at no more
15 than its current fair market value; and

16 (3) other information that the department may require.

17 (c) Transfer of a certificate is subject to conditions the department considers necessary.

18 * Sec. 8. AS 18.07.071 is repealed and reenacted to read:

19 Sec. 18.07.071. EMERGENCY CERTIFICATES. (a) The department shall *expedite*
20 review of an application for a certificate of need under AS 18.07.031(a)(1) that is required to

21 (1) eliminate or prevent imminent safety hazards as defined by a federal, state,
22 or local fire, building, or life safety code or regulation;

23 (2) comply with state licensure standards; or

24 (3) comply with accreditation standards, compliance with which is required to
25 receive federal reimbursement.

26 (b) An application approved under (a) of this section may be approved only to the extent
27 that the capital expenditure is required to eliminate or prevent the hazards or to comply with the
28 standards described in (a) of this section.

29 * Sec. 9. AS 18.07 is amended by adding a new section to read:

30 Sec. 18.07.079. FINAL DECISION. (a) Within 150 days after it determines that it has
31 received a complete application, the department shall take one or more of the following actions:

1 (1) approve part or all of the application and issue a certificate of need that
2 includes conditions that the department considers appropriate; the conditions must be directly
3 related to the activities for which the application was made;

4 (2) deny a certificate of need;

5 (3) recommend modifications to the application; if the applicant agrees to modify
6 the application, the department may defer a final decision on the application for 30 days after
7 receiving the modified application and all additional information to support the modifications;
8 deferral for more than 30 days under this paragraph may be made by the department only after
9 written findings that there is good cause for deferring the decision and that deferral is in the
10 public interest.

11 (b) The department shall send the final written findings and decision to the applicant and
12 to other persons who request a copy of the findings and decision. If the final decision is to
13 approve an application, the department shall issue a certificate of need to the applicant.

14 * Sec. 10. AS 18.07.081(a) is amended to read:

15 (a) The department [OFFICE], a member of the public who is substantially affected by
16 activities authorized by the certificate, [OR] another applicant for a certificate of need, or a
17 health care facility that either provides services similar to the proposed activity or has
18 indicated to the department in writing within the year preceding the decision to grant the
19 certificate an intention to provide similar services to a health service population that
20 includes all or part of the health service population served under the certificate of need may
21 request [INITIATE] a hearing to obtain modification, suspension or revocation of an existing
22 certificate of need by filing an accusation with the department [COMMISSIONER] as prescribed
23 under AS 44.62.360. A revocation, modification, or suspension of an outstanding certificate may
24 not be undertaken unless it is in accordance with AS 44.62.330 - 44.62.630.

25 * Sec. 11. AS 18.07.081(c) is amended to read:

26 (c) A certificate of need shall be suspended if an accusation is filed before the
27 commencement of activities authorized under AS 18.07.079 [AS 18.07.041] that charges that
28 factors upon which the certificate of need was issued have changed [,] or new factors have been
29 discovered that significantly alter the need for the activity authorized. [A SUSPENSION OF A
30 CERTIFICATE MAY NOT EXCEED 60 DAYS. AT THE END OF THIS PERIOD OR
31 SOONER, THE OFFICE SHALL REVOKE OR REINSTATE THE CERTIFICATE].

1 * Sec. 12. AS 18.07.081(d) is amended to read:

2 (d) A certificate of need may be revoked if

3 (1) the certificate holder [SPONSOR] has not shown continuing progress toward
4 commencement of the activities authorized under AS 18.07.079 within one year after
5 [AS 18.07.041 AFTER SIX MONTHS OF] issuance;

6 (2) the certificate holder [APPLICANT] fails, without good cause, to complete
7 activities authorized by the certificate;

8 (3) the certificate holder [SPONSOR] fails to comply with the provisions of this
9 chapter or regulations adopted under this chapter;

10 (4) the certificate holder [SPONSOR] knowingly misrepresents a material fact
11 in obtaining the certificate;

12 (5) the facts charged in an accusation filed under (c) of this section are
13 established; or

14 (6) the certificate holder [SPONSOR] fails to provide services authorized by the
15 terms of the certificate.

16 * Sec. 13. AS 18.07.081(e) is amended to read:

17 (e) A person who files [MAY NOT FILE] an accusation seeking suspension or
18 revocation of a certificate of need under this section, knowing that the charges stated in the
19 accusation are untrue or that the charges do not constitute grounds for revocation or suspension
20 under this chapter, is guilty of a class B misdemeanor.

21 * Sec. 14. AS 18.07.091 is repealed and reenacted to read:

22 Sec. 18.07.091. REPORTING REQUIREMENTS, PENALTIES, AND INJUNCTION.

23 (a) The department shall require all health care facilities operating in the state to periodically
24 file reports required by the department by regulation.

25 (b) The department shall require a certificate holder to file with the department,
26 periodically during the development stage and annually after that until completion of the activity
27 authorized under AS 18.07.031, a report demonstrating that the activity is in compliance with all
28 provisions of the certificate of need.

29 (c) If the department finds that a person has substantially failed or refused to comply
30 with AS 18.07.031 - 18.07.111 or a regulation adopted under those sections, the department may
31 take one or more of the following actions:

- 1 (1) issue an order directing the person to stop the questioned activity;
2 (2) deny, suspend, revoke, or modify a construction license required under
3 AS 18.20.020 as related to the questioned activity;
4 (3) suspend a payment to be made by the department to the person for capital and
5 operating expenses relating to the questioned activity;
6 (4) deny, suspend, revoke, or modify a certificate of need; or
7 (5) issue an order against a person who violates a provision of AS 18.07.031 -
8 18.07.111 or a regulation adopted under those sections imposing a civil penalty of not more than
9 \$20,000.

10 (d) Before imposing a sanction listed in (c) of this section, the department shall give
11 reasonable notice of and an opportunity for a hearing.

12 (e) Notwithstanding AS 44.62.330 - 44.62.630, if the department finds that there will be
13 a significant and adverse effect upon the public interest caused by substantial failure or refusal
14 of a person to comply with AS 18.07.031 - 18.07.111 or a regulation adopted under those
15 sections, the department may issue an order that does one or more of the following:

- 16 (1) directs the person to stop the questioned activity;
17 (2) suspends a construction license required under AS 18.20.020 as related to the
18 questioned activity; or
19 (3) suspends a payment to be made by the department to the person for capital
20 and operating expenses relating to the questioned activity.

21 (f) Notwithstanding AS 44.62.330 - 44.62.630, an order under (e) of this section takes
22 effect immediately upon service by the department and remains in effect pending the decision
23 after any hearing that may have been requested unless the person served can demonstrate to the
24 department's satisfaction that the questioned activity is not subject to the application and review
25 requirements of AS 18.07.031 - 18.07.111, or that the person would likely prevail on the merits
26 and that allowing the activity to continue is in the public interest.

27 (g) Injunctive relief against a violation of AS 18.07.031 - 18.07.111 or a regulation
28 adopted under those sections may be obtained from a court of competent jurisdiction by the
29 department, a certificate holder who is adversely affected by the violation, or a member of the
30 public substantially and adversely affected by the violation.

31 * Sec. 15. AS 18.07.101 is amended to read:

1 Sec. 18.07.101. REGULATIONS. The department [COMMISSIONER] shall adopt, in
2 accordance with the Administrative Procedure Act (AS 44.62), regulations that establish
3 procedures under which a person [SPONSORS] may apply [MAKE APPLICATION] for a
4 certificate [CERTIFICATES] of need required by this chapter, establish the amount of
5 variation that may occur in an activity authorized by a certificate of need without requiring
6 a modification of the certificate, [AND THAT] govern the review of those applications by the
7 department [OFFICE], establish requirements for a uniform statewide system of reporting
8 financial and other operating data, establish reasonable fees for applications and other
9 services, and otherwise carry out the purposes of this chapter.

10 * Sec. 16. AS 18.07.111 is repealed and reenacted to read:

11 Sec. 18.07.111. DEFINITIONS. In this chapter

12 (1) "category of health services" means a service that is recognized as a distinct
13 service for the purposes of health care facility licensure and certification under regulations
14 adopted under AS 18.20.010 - 18.20.130, except that "service" does not include the lawful
15 practice of a profession or vocation conducted independently of a health care facility and in
16 accordance with applicable licensing laws of the state;

17 (2) "certificate" means a certificate of need;

18 (3) "certificate of need" means a written order of the department that sets out the
19 affirmative findings that a proposed activity sufficiently satisfies the plans and criteria prescribed
20 for such an activity by this chapter and by department regulations and that permits the certificate
21 holder to proceed with the activity;

22 (4) "commencement of activities" means, with the intent to continue until it is
23 completed,

24 (A) the visible commencement of actual operations, on the ground, which
25 is readily recognizable as such, for the construction of a building, the alteration of the bed
26 capacity of a health care facility, or the provision for or deletion of an existing category
27 of health services to consumers; or

28 (B) a significant step toward acquisition of a health care facility;

29 (5) "complete activities" means the substantial performance of the work required
30 to comply with the terms of issuance of the certificate of need that all parties participating in
31 those activities have obligated themselves to perform;

1 (6) "construction" means excavation, erection, alteration, modification,
2 reconstruction, modernization, improvement, extension, or other development by or on behalf of
3 a health care facility and includes the lease or purchase of equipment;

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

5 (8) "health care facility" means an institutional health service provider licensed
6 in whole or in part by the state under AS 18.20.010 - 18.20.130, whether public or private,
7 whether a partnership or corporation, whether organized for profit or not, and includes a hospital,
8 psychiatric hospital, substance abuse hospital, tuberculosis hospital, skilled nursing facility,
9 kidney disease treatment center (including freestanding hemodialysis units), intermediate care
10 facility, ambulatory surgical facility, freestanding emergency care facility, osteopathic facility,
11 independent diagnostic laboratory, and central service facility; "health care facility" does not
12 include

13 (A) an Alaska Pioneers' Home administered by the Department of
14 Administration under AS 44.21.020(10) and AS 47.55;

15 (B) the offices of private physicians or dentists, whether in individual or
16 group practice, occupied on a regular basis to perform the range of diagnostic and
17 treatment services usually performed by physicians and dentists on an outpatient basis;

18 (C) office buildings built or leased by or on behalf of a health care facility
19 for the exclusive use of physicians, dentists, and other practitioners of the healing arts,
20 or other investments made by or on behalf of a health care facility, unless capital
21 expenditures or operating expenses will be charged or reimbursed in the future as costs
22 for providing patient services offered by the health care facility; and

23 (9) "person" means an individual, corporation, company, partnership, firm,
24 association, organization, business trust, estate, or government entity, and includes a health care
25 facility.

26 * Sec. 17. AS 18.20.050 is amended to read:

27 Sec. 18.20.050. DENIAL, SUSPENSION, OR REVOCATION OF LICENSE. The
28 department may deny, suspend, or revoke a license in a case in which it finds that there has been
29 a substantial failure to comply with the requirements established under AS 08.64.336,
30 AS 18.07.031 - 18.07.111, or AS 18.20.060 - 18.20.080. The license of a nursing facility, as
31 defined in AS 18.20.390, also may be suspended or revoked by the department under

1 AS 18.20.310(a)(5).

2 * Sec. 18. AS 44.29.100 is amended to read:

3 Sec. 44.29.100. ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE. There
4 is established in the Department of Health and Social Services an advisory board on alcoholism
5 and drug abuse. [THE BOARD SHALL FUNCTION AS A STANDING COMMITTEE OF THE
6 STATEWIDE HEALTH COORDINATING COUNCIL ESTABLISHED UNDER AS 18.07.011.]

7 * Sec. 19. AS 47.30.475(b) is amended to read:

8 (b) Money available under this section shall be awarded by the department to applicants
9 on the basis of community need, but only if the award is consistent with the annual
10 implementation plan developed under 42 U.S.C. 3001-2(b)(2) (National Health Resources
11 Planning and Development Act of 1974) by the health systems agency for the health system area
12 in which the applicant is located [AND THE STATE HEALTH PLAN DEVELOPED BY THE
13 STATEWIDE HEALTH COORDINATING COUNCIL UNDER 42 U.S.C. 300m-3(c)(2)(A),] and
14 only after consideration of comment and advice of the Advisory Board on Alcoholism and Drug
15 Abuse. In awarding grants, the department shall further consider the amount of money that is
16 available for all applications and whether an application would contribute to the wise
17 development of a comprehensive program of alcoholic and drug abuse rehabilitation and
18 prevention.

19 * Sec. 20. AS 18.07.011, 18.07.041, 18.07.081(b); AS 18.08.020(2), 18.08.090(11); and
20 AS 18.26.030(a)(4)(B) are repealed.

21 * Sec. 21. This Act takes effect immediately under AS 01.10.070(c).

SENATE CONCURRENT RESOLUTION NO. 10
IN THE LEGISLATURE OF THE STATE OF ALASKA
SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATORS DUNCAN, Kerttula, Pourchot, Menard

Introduced: 2/13/91
Referred: HESS and Finance

A RESOLUTION

1 **Establishing a Health Resources and Access Task Force.**

2 **BE IT RESOLVED BY THE LEGISLATURE OF THE STATE OF ALASKA:**

3 **WHEREAS** estimated annual expenditures for health care in Alaska have risen by 300 percent
4 in the last 10 years from \$480 million to over \$1.5 billion; and

5 **WHEREAS** over 90,000 residents of the state cannot afford to pay their medical bills, are not
6 covered by a group health insurance plan, do not qualify for public assistance programs, and cannot
7 afford to pay individual health insurance premiums; and

8 **WHEREAS**, if current trends continue, it is estimated that expenditures for health care in the
9 state will increase to at least \$10 billion by the year 2000 and over 25 percent of the state's residents
10 will be uninsured; and

11 **WHEREAS** the legislature, aided by the Health Care Cost Containment Task Force, has achieved
12 savings in the costs of health care in the state totaling over \$20 million in fiscal years 1990 and 1991;
13 and

14 **WHEREAS** every resident should have access to a basic level of health care regardless of
15 income and should not become financially destitute before obtaining health care; and

16 **WHEREAS** the legislature recognizes that there is a continuing need to develop and evaluate

1 ways to manage health care expenditures in the state;

2 **BE IT RESOLVED** by the Alaska State Legislature that the Health Resources and Access Task
3 Force is established with the following primary purposes:

4 (1) to design a cost-efficient program that allows access to a basic level of health care
5 services for all state residents;

6 (2) to continue the work of the Health Care Cost Containment Task Force in seeking
7 ways to achieve savings in the cost of health care in the state; and

8 (3) to define a strategy for implementing a health care program covering all Alaskans and
9 a strategy for continuing to contain the costs of health care in the state; and be it

10 **FURTHER RESOLVED** that the task force shall

11 (1) solicit advice and information from the medically indigent, health care consumer
12 groups, the insurance industry, health care providers, labor organizations, emergency services personnel,
13 large and small businesses, the Medical Care Advisory Committee, the Alaska Native Health Service,
14 actuaries, the public, and others;

15 (2) investigate and gather data relating to health care quality, access, delivery, payment
16 systems, and financing in the state, especially in rural areas;

17 (3) ascertain and review successful health care protection methods in other states,
18 territories, and countries and other health care alternatives, including ways of providing health care for
19 persons without insurance or with limited health care protection;

20 (4) continue to update an accurate estimate of the number of people who are unable to
21 receive necessary health care services in the state, which patients are generating unpaid medical bills,
22 which state residents are uninsured or lack adequate insurance, which health care providers are providing
23 uncompensated care, who is paying for the cost of uncompensated care, and the total cost of
24 uncompensated care in the state;

25 (5) identify those health care services necessary to achieve an acceptable minimum level
26 of health care for all state residents and to examine those health care services that provide the most care
27 for the most people at the least cost, including prevention services;

28 (6) monitor and evaluate experience under the state employee and retiree health plans;

29 (7) evaluate the potential benefits of health education, wellness plans, and prevention
30 plans for all residents;

31 (8) develop strategies to support health care professions training and the retention of
32 health care professionals in the state;

1 (9) recommend ways to coordinate services among nonprofit health care providers, profit
2 making health care providers, the state division of public health, the United States Department of
3 Veterans Affairs, the United States Department of Defense, and the Alaska Native Health Service in
4 order to achieve a more efficient and effective health care delivery system;

5 (10) review ways to maximize the use of federal funds for health care programs in the
6 state;

7 (11) investigate ways to reduce costs associated with malpractice insurance coverage,
8 including its effect on the cost of health care in the state;

9 (12) consider the feasibility of redistributing funds currently spent by the state on health
10 care in order to provide residents with affordable and equitable care;

11 (13) provide advice and assistance to other public agencies involved in health care
12 programs; and

13 (14) pursue other sources of funding for the expenses of the task force; and be it

14 **FURTHER RESOLVED** that the task force shall consist of 14 members and two alternates as
15 follows:

16 (1) three members of the Senate appointed by the President of the Senate, one of whom
17 shall be designated as an alternate;

18 (2) three members of the House of Representatives appointed by the Speaker of the
19 House, one of whom shall be designated as an alternate;

20 (3) two persons representing the executive branch, appointed by the Governor;

21 (4) eight members chosen by the members appointed under paragraphs (1) - (3) as
22 follows: one individual representing the medically indigent, two individuals representing private
23 employers who are not health care providers, two individuals representing health care providers, one
24 individual representing nonprofit organizations, one consumer of health services who is not an employer
25 or health care provider, and one individual representing labor organizations; and be it

26 **FURTHER RESOLVED** that the members of the task force shall elect from among themselves
27 a chair and a vice-chair and that the conduct of the task force meetings shall be in sessions open to the
28 public where all interested parties may provide information; and be it

29 **FURTHER RESOLVED** that, within funds made available for the purpose, the task force may
30 hire staff and contract for services to perform its duties; and be it

31 **FURTHER RESOLVED** that the task force shall report its findings and recommendations to
32 the Governor and the legislature by February 1, 1992, and February 1, 1993; and be it

1 **FURTHER RESOLVED** that the task force is terminated at 11:59 p.m. on February 1, 1993.

HOUSE BILL NO. 69

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVES BOYER, Navarre

Introduced: 1/23/91

Referred: Health, Education and Social Services, Judiciary, Finance

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to state coordination of health planning and development; abolishing the
2 Statewide Health Coordinating Council; and providing for an effective date."

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

4 * Section 1. AS 18.07 is amended by adding a new section to read:

5 Sec. 18.07.005. LEGISLATIVE PURPOSE. It is the purpose of this chapter to create
6 a rational framework for the planning and development of all health care services in the state to
7 ensure promotion and protection of public health, provide equitable access to health services, and
8 avoid unnecessary increases in health care costs.

9 * Sec. 2. AS 18.07.021 is amended to read:

10 Sec. 18.07.021. STATE HEALTH PLANNING AND DEVELOPMENT [AGENCY].
11 The [OFFICE OF PLANNING AND RESEARCH IN THE] department is responsible for [THE]
12 state health planning and development, [AGENCY DESIGNATED UNDER 42 U.S.C.
13 300m(b)(3). THE OFFICE] shall [PERFORM THE FUNCTIONS ENUMERATED UNDER 42
14 U.S.C. 300m-2,] administer the certificate of need program outlined in AS 18.07.031 - 18.07.111

1 [AS 18.07.041 - 18.07.111], and shall perform other functions prescribed in this chapter.

2 * Sec. 3. AS 18.07.031 is repealed and reenacted to read:

3 Sec. 18.07.031. CERTIFICATE OF NEED REQUIRED. (a) Unless authorized under
4 the terms of a certificate of need issued by the department, a person may not

5 (1) make a capital expenditure of \$1,000,000 or more for construction of a health
6 care facility;

7 (2) convert a building, in whole or in part, for use as a health care facility if the
8 fair market value of the converted part of the building is greater than \$500,000 and the sum of
9 the fair market value plus additional capital expenditures made to facilitate the conversion equals
10 or exceeds \$1,000,000;

11 (3) alter or redistribute the bed capacity of a health care facility by more than 10
12 beds or 10 percent of the number of beds in the facility, whichever is fewer;

13 (4) add or eliminate a category of health services to or from those provided by
14 the health care facility; or

15 (5) acquire a health care facility at a cost of \$1,000,000 or more.

16 (b) The dollar thresholds in (a) of this section apply to total anticipated costs. Costs of
17 constructing or acquiring a health care facility may not be artificially divided, fragmented, or
18 structured to circumvent the requirements of this section.

19 * Sec. 4. AS 18.07.035 is amended to read:

20 Sec. 18.07.035. APPLICATION AND FEES. Application for a certificate of need shall
21 be made to the department upon a form provided by the department and must contain the
22 information the department requires to reach a decision under AS 18.07.031 - 18.07.111
23 [AS 18.07.041 - 18.07.111]. Each application for a certificate of need must be accompanied by
24 an application fee established by the department by regulation.

25 * Sec. 5. AS 18.07.051 is amended by adding a new subsection to read:

26 (b) A certificate of need is valid only for the defined scope, physical location, and person
27 stated in the certificate.

28 * Sec. 6. AS 18.07.061 is amended to read:

29 Sec. 18.07.061. MODIFICATION AND TERMINATION OF ACTIVITIES. The
30 certificate holder shall apply to the department [OFFICE] for a modification of the certificate
31 [BEFORE TERMINATING PART OF THE ACTIVITIES AUTHORIZED BY THE TERMS OF

1 ISSUANCE, BUT THE CERTIFICATE HOLDER IS NOT REQUIRED TO OBTAIN THE
2 ACQUIESCENCE OF THE OFFICE] before transferring the certificate or modifying or
3 terminating all or part of the activities authorized by the certificate. If a certificate holder
4 intends to terminate [TERMINATES] all of the activities authorized by a certificate, the
5 certificate holder is required to apply to [NOTIFY] the department [OFFICE] 60 days before
6 termination and to surrender the certificate to the department [OFFICE] within 30 days after
7 [OF] termination.

8 * Sec. 7. AS 18.07.061 is amended by adding new subsections to read:

9 (b) An application for transfer of a certificate shall be made on forms provided by the
10 department and must contain

11 (1) evidence, of the type the department may require by regulation, that the
12 transferee is able to assume ownership or operation of the health care facility and to provide the
13 appropriate health services;

14 (2) evidence that the transferee is acquiring the health care facility at no more
15 than its current fair market value; and

16 (3) other information that the department may require.

17 (c) Transfer of a certificate is subject to conditions the department considers necessary.

18 * Sec. 8. AS 18.07.071 is repealed and reenacted to read:

19 Sec. 18.07.071. EMERGENCY CERTIFICATES. (a) The department shall expedite
20 review of an application for a certificate of need under AS 18.07.031(a)(1) that is required to

21 (1) eliminate or prevent imminent safety hazards as defined by a federal, state,
22 or local fire, building, or life safety code or regulation;

23 (2) comply with state licensure standards; or

24 (3) comply with accreditation standards, compliance with which is required to
25 receive federal reimbursement.

26 (b) An application approved under (a) of this section may be approved only to the extent
27 that the capital expenditure is required to eliminate or prevent the hazards or to comply with the
28 standards described in (a) of this section.

29 * Sec. 9. AS 18.07 is amended by adding a new section to read:

30 Sec. 18.07.079. FINAL DECISION. (a) Within 150 days after it determines that it has
31 received a complete application, the department shall take one or more of the following actions:

1 (1) approve part or all of the application and issue a certificate of need that
2 includes conditions that the department considers appropriate; the conditions must be directly
3 related to the activities for which the application was made;

4 (2) deny a certificate of need;

5 (3) recommend modifications to the application; if the applicant agrees to modify
6 the application, the department may defer a final decision on the application for 30 days after
7 receiving the modified application and all additional information to support the modifications;
8 deferral for more than 30 days under this paragraph may be made by the department only after
9 written findings that there is good cause for deferring the decision and that deferral is in the
10 public interest.

11 (b) The department shall send the final written findings and decision to the applicant and
12 to other persons who request a copy of the findings and decision. If the final decision is to
13 approve an application, the department shall issue a certificate of need to the applicant.

14 * Sec. 10. AS 18.07.081(a) is amended to read:

15 (a) The department [OFFICE], a member of the public who is substantially affected by
16 activities authorized by the certificate, [OR] another applicant for a certificate of need, or a
17 health care facility that either provides services similar to the proposed activity or has
18 indicated to the department in writing within the year preceding the decision to grant the
19 certificate an intention to provide similar services to a health service population that
20 includes all or part of the health service population served under the certificate of need may
21 request [INITIATE] a hearing to obtain modification, suspension or revocation of an existing
22 certificate of need by filing an accusation with the department [COMMISSIONER] as prescribed
23 under AS 44.62.360. A revocation, modification, or suspension of an outstanding certificate may
24 not be undertaken unless it is in accordance with AS 44.62.330 - 44.62.630.

25 * Sec. 11. AS 18.07.081(c) is amended to read:

26 (c) A certificate of need shall be suspended if an accusation is filed before the
27 commencement of activities authorized under AS 18.07.079 [AS 18.07.041] that charges that
28 factors upon which the certificate of need was issued have changed [,] or new factors have been
29 discovered that significantly alter the need for the activity authorized. [A SUSPENSION OF A
30 CERTIFICATE MAY NOT EXCEED 60 DAYS. AT THE END OF THIS PERIOD OR
31 SOONER, THE OFFICE SHALL REVOKE OR REINSTATE THE CERTIFICATE].

1 * Sec. 12. AS 18.07.081(d) is amended to read:

2 (d) A certificate of need may be revoked if

3 (1) the certificate holder [SPONSOR] has not shown continuing progress toward
4 commencement of the activities authorized under AS 18.07.079 within one year after
5 [AS 18.07.041 AFTER SIX MONTHS OF] issuance;

6 (2) the certificate holder [APPLICANT] fails, without good cause, to complete
7 activities authorized by the certificate;

8 (3) the certificate holder [SPONSOR] fails to comply with the provisions of this
9 chapter or regulations adopted under this chapter;

10 (4) the certificate holder [SPONSOR] knowingly misrepresents a material fact
11 in obtaining the certificate;

12 (5) the facts charged in an accusation filed under (c) of this section are
13 established; or

14 (6) the certificate holder [SPONSOR] fails to provide services authorized by the
15 terms of the certificate.

16 * Sec. 13. AS 18.07.081(e) is amended to read:

17 (e) A person who files [MAY NOT FILE] an accusation seeking suspension or
18 revocation of a certificate of need under this section, knowing that the charges stated in the
19 accusation are untrue or that the charges do not constitute grounds for revocation or suspension
20 under this chapter, is guilty of a class B misdemeanor.

21 * Sec. 14. AS 18.07.091 is repealed and reenacted to read:

22 Sec. 18.07.091. REPORTING REQUIREMENTS, PENALTIES, AND INJUNCTION.

23 (a) The department shall require all health care facilities operating in the state to periodically
24 file reports required by the department by regulation.

25 (b) The department shall require a certificate holder to file with the department,
26 periodically during the development stage and annually after that until completion of the activity
27 authorized under AS 18.07.031, a report demonstrating that the activity is in compliance with all
28 provisions of the certificate of need.

29 (c) If the department finds that a person has substantially failed or refused to comply
30 with AS 18.07.031 - 18.07.111 or a regulation adopted under those sections, the department may
31 take one or more of the following actions:

- 1 (1) issue an order directing the person to stop the questioned activity;
- 2 (2) deny, suspend, revoke, or modify a construction license required under
- 3 AS 18.20.020 as related to the questioned activity;
- 4 (3) suspend a payment to be made by the department to the person for capital and
- 5 operating expenses relating to the questioned activity;
- 6 (4) deny, suspend, revoke, or modify a certificate of need; or
- 7 (5) issue an order against a person who violates a provision of AS 18.07.031 -
- 8 18.07.111 or a regulation adopted under those sections imposing a civil penalty of not more than
- 9 \$20,000.

10 (d) Before imposing a sanction listed in (c) of this section, the department shall give

11 reasonable notice of and an opportunity for a hearing.

12 (e) Notwithstanding AS 44.62.330 - 44.62.630, if the department finds that there will be

13 a significant and adverse effect upon the public interest caused by substantial failure or refusal

14 of a person to comply with AS 18.07.031 - 18.07.111 or a regulation adopted under those

15 sections, the department may issue an order that does one or more of the following:

- 16 (1) directs the person to stop the questioned activity;
- 17 (2) suspends a construction license required under AS 18.20.020 as related to the
- 18 questioned activity; or
- 19 (3) suspends a payment to be made by the department to the person for capital
- 20 and operating expenses relating to the questioned activity.

21 (f) Notwithstanding AS 44.62.330 - 44.62.630, an order under (e) of this section takes

22 effect immediately upon service by the department and remains in effect pending the decision

23 after any hearing that may have been requested unless the person served can demonstrate to the

24 department's satisfaction that the questioned activity is not subject to the application and review

25 requirements of AS 18.07.031 - 18.07.111, or that the person would likely prevail on the merits

26 and that allowing the activity to continue is in the public interest.

27 (g) Injunctive relief against a violation of AS 18.07.031 - 18.07.111 or a regulation

28 adopted under those sections may be obtained from a court of competent jurisdiction by the

29 department, a certificate holder who is adversely affected by the violation, or a member of the

30 public substantially and adversely affected by the violation.

31 * Sec. 15. AS 18.07.101 is amended to read:

1 Sec. 18.07.101. REGULATIONS. The department [COMMISSIONER] shall adopt, in
2 accordance with the Administrative Procedure Act (AS 44.62), regulations that establish
3 procedures under which a person [SPONSORS] may apply [MAKE APPLICATION] for a
4 certificate [CERTIFICATES] of need required by this chapter, establish the amount of
5 variation that may occur in an activity authorized by a certificate of need without requiring
6 a modification of the certificate, [AND THAT] govern the review of those applications by the
7 department [OFFICE], establish requirements for a uniform statewide system of reporting
8 financial and other operating data, establish reasonable fees for applications and other
9 services, and otherwise carry out the purposes of this chapter.

10 * Sec. 16. AS 18.07.111 is repealed and reenacted to read:

11 Sec. 18.07.111. DEFINITIONS. In this chapter

12 (1) "category of health services" means a service that is recognized as a distinct
13 service for the purposes of health care facility licensure and certification under regulations
14 adopted under AS 18.20.010 - 18.20.130, except that "service" does not include the lawful
15 practice of a profession or vocation conducted independently of a health care facility and in
16 accordance with applicable licensing laws of the state;

17 (2) "certificate" means a certificate of need;

18 (3) "certificate of need" means a written order of the department that sets out the
19 affirmative findings that a proposed activity sufficiently satisfies the plans and criteria prescribed
20 for such an activity by this chapter and by department regulations and that permits the certificate
21 holder to proceed with the activity;

22 (4) "commencement of activities" means, with the intent to continue until it is
23 completed,

24 (A) the visible commencement of actual operations, on the ground, which
25 is readily recognizable as such, for the construction of a building, the alteration of the bed
26 capacity of a health care facility, or the provision for or deletion of an existing category
27 of health services to consumers; or

28 (B) a significant step toward acquisition of a health care facility;

29 (5) "complete activities" means the substantial performance of the work required
30 to comply with the terms of issuance of the certificate of need that all parties participating in
31 those activities have obligated themselves to perform;

1 (6) "construction" means excavation, erection, alteration, modification,
2 reconstruction, modernization, improvement, extension, or other development by or on behalf of
3 a health care facility and includes the lease or purchase of equipment;

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

5 (8) "health care facility" means an institutional health service provider licensed
6 in whole or in part by the state under AS 18.20.010 - 18.20.130, whether public or private,
7 whether a partnership or corporation, whether organized for profit or not, and includes a hospital,
8 psychiatric hospital, substance abuse hospital, tuberculosis hospital, skilled nursing facility,
9 kidney disease treatment center (including freestanding hemodialysis units), intermediate care
10 facility, ambulatory surgical facility, freestanding emergency care facility, osteopathic facility,
11 independent diagnostic laboratory, and central service facility; "health care facility" does not
12 include

13 (A) an Alaska Pioneers' Home administered by the Department of
14 Administration under AS 44.21.020(10) and AS 47.55;

15 (B) the offices of private physicians or dentists, whether in individual or
16 group practice, occupied on a regular basis to perform the range of diagnostic and
17 treatment services usually performed by physicians and dentists on an outpatient basis;

18 (C) office buildings built or leased by or on behalf of a health care facility
19 for the exclusive use of physicians, dentists, and other practitioners of the healing arts,
20 or other investments made by or on behalf of a health care facility, unless capital
21 expenditures or operating expenses will be charged or reimbursed in the future as costs
22 for providing patient services offered by the health care facility; and

23 (9) "person" means an individual, corporation, company, partnership, firm,
24 association, organization, business trust, estate, or government entity, and includes a health care
25 facility.

26 * Sec. 17. AS 18.20.050 is amended to read:

27 Sec. 18.20.050. DENIAL, SUSPENSION, OR REVOCATION OF LICENSE. The
28 department may deny, suspend, or revoke a license in a case in which it finds that there has been
29 a substantial failure to comply with the requirements established under AS 08.64.336,
30 AS 18.07.031 - 18.07.111, or AS 18.20.060 - 18.20.080. The license of a nursing facility, as
31 defined in AS 18.20.390, also may be suspended or revoked by the department under

1 AS 18.20.310(a)(5).

2 * Sec. 18. AS 44.29.100 is amended to read:

3 Sec. 44.29.100. ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE. There
4 is established in the Department of Health and Social Services an advisory board on alcoholism
5 and drug abuse. [THE BOARD SHALL FUNCTION AS A STANDING COMMITTEE OF THE
6 STATEWIDE HEALTH COORDINATING COUNCIL ESTABLISHED UNDER AS 18.07.011.]

7 * Sec. 19. AS 47.30.475(b) is amended to read:

8 (b) Money available under this section shall be awarded by the department to applicants
9 on the basis of community need, but only if the award is consistent with the annual
10 implementation plan developed under 42 U.S.C. 300l-2(b)(2) (National Health Resources
11 Planning and Development Act of 1974) by the health systems agency for the health system area
12 in which the applicant is located [AND THE STATE HEALTH PLAN DEVELOPED BY THE
13 STATEWIDE HEALTH COORDINATING COUNCIL UNDER 42 U.S.C. 300m-3(c)(2)(A),] and
14 only after consideration of comment and advice of the Advisory Board on Alcoholism and Drug
15 Abuse. In awarding grants, the department shall further consider the amount of money that is
16 available for all applications and whether an application would contribute to the wise
17 development of a comprehensive program of alcoholic and drug abuse rehabilitation and
18 prevention.

19 * Sec. 20. AS 18.07.011, 18.07.041, 18.07.081(b); AS 18.08.020(2), 18.08.090(11); and
20 AS 18.26.030(a)(4)(B) are repealed.

21 * Sec. 21. This Act takes effect immediately under AS 01.10.070(c).

HOUSE BILL NO. 71

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVES BOYER, Navarre

Introduced: 1/24/91

Referred: Labor and Commerce, Health, Education and Social Services, Finance

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to the Alaska State Health Resources Authority; relating to the delivery,
2 quality, and financing of health care for residents of the state, and to the issuance of
3 certificates of need; and providing for an effective date."

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

5 * Section 1. PURPOSE. The purpose of this Act is to

6 (1) by July 1, 1992, create and begin implementation of a statewide health care provider
7 reimbursement system and utilization standards;

8 (2) after July 1, 1992, provide comprehensive group health insurance for the state,
9 municipalities, school districts, other employers in the state who elect to participate, and all eligible
10 employees of the state, a municipality, a school district, or other employer in the state who elect to
11 participate in the group insurance offered by the Alaska State Health Resources Authority;

12 (3) expand the pool of subscribers and maximize the opportunities for health care cost
13 management and economies of scale when purchasing group health insurance;

14 (4) maintain an efficient provider reimbursement system to reduce the administrative cost

1 to providers who are serving employees of participants;

2 (5) maintain a statewide health care data base and utilization standards to control
3 inappropriate or improper utilization practices and to reduce the rate of inflation in the cost of health care
4 in the state;

5 (6) create the most comprehensive, cost-effective, and efficient method of providing a
6 variety of types of health care insurance necessary to meet the coverage requirements of a participant
7 resulting from negotiated employee contracts;

8 (7) realize the potential savings that will result if approximately 135,000 active and
9 retired state, municipal, and school district employees and their dependents participate in the group health
10 insurance program offered by the authority;

11 (8) evaluate the need for mandatory participation in the group health insurance offered
12 by the authority; and

13 (9) evaluate the need for group health insurance for residents of the state who are
14 uninsured or underinsured.

15 * Sec. 2. AS 18.07.035 is amended to read:

16 Sec. 18.07.035. APPLICATION AND FEES. Application for a certificate of need shall
17 be made to the department upon a form provided by the department and must contain the
18 information the department requires to reach a decision under AS 18.07.041 - 18.07.111. Each
19 application for a certificate of need must be accompanied by an application fee established by
20 the department by regulation. A copy of each application for a certificate of need, except an
21 application for a temporary or emergency certificate issued under AS 18.07.071, shall be
22 provided to the Alaska State Health Resources Authority.

23 * Sec. 3. AS 18.07.041 is amended to read:

24 Sec. 18.07.041. STANDARD OF REVIEW FOR APPLICATIONS FOR CERTIFICATES
25 OF NEED. The office shall grant a sponsor a certificate of need or modify a certificate of need
26 if the availability and quality of existing health care resources or the accessibility to those
27 resources is less than the current or projected requirement for health services required to maintain
28 the good health of Alaska citizens. A certificate of need may not be issued, except for a
29 temporary or emergency certificate under AS 18.07.071, unless the office has received a
30 determination from the Alaska State Health Resources Authority regarding the effect of the
31 certificate of need on the cost of group health insurance.

1 * Sec. 4. AS 21 is amended by adding a new chapter to read:

2 CHAPTER 77. STATE INSURANCE.

3 Sec. 21.77.010. AUTHORITY CREATED; REQUIRED REIMBURSEMENT SYSTEM
4 AND UTILIZATION STANDARDS. (a) There is established within the Department of
5 Administration a nonprofit incorporated legal entity known as the Alaska State Health Resources
6 Authority.

7 (b) The authority shall, by July 1, 1992, establish and begin implementation of a health
8 care provider reimbursement system and utilization standards. The state, a municipality, or a
9 school district shall use the health care provider reimbursement system and utilization standards
10 established by the authority for eligible employees of the state, a municipality, or a school
11 district. With the approval of the authority, other employers in the state may use the health care
12 provider reimbursement system and utilization standards established by the authority.

13 (c) The authority shall, no earlier than July 1, 1992, establish a group health insurance
14 pool or pools of eligible employees of the state, a municipality, or a school district if the
15 employer has elected to participate in the group health insurance obtained by the authority and
16 may provide group health insurance to employees of other groups that elect to participate in the
17 group health insurance pool provided by the authority. Employees of other groups that elect to
18 participate shall use the reimbursement system and utilization standards established by the
19 authority.

20 (d) Upon application by an eligible state program, the authority may, beginning July 1,
21 1992, allow the eligible state program to participate in the group health insurance pool provided
22 by the authority.

23 Sec. 21.77.015. REQUIRED COOPERATION BY STATE AGENCIES. An agency of
24 the state that provides health care or that provides funds to purchase health care shall, to the
25 maximum extent possible, cooperate in the development of the use of the health care provider
26 reimbursement system and utilization standards established by the authority, including sharing
27 relevant information.

28 Sec. 21.77.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The authority shall
29 be managed by a board of directors composed of nine members appointed by the governor. The
30 governor shall appoint at least one but not more than two members as representatives from each
31 of the following: