SCOMM

68:5

Official Business

COMMITTEE:

DATE: 3-14-89

SIGN-IN

Subject of meeting:
Health Care Costs

PLEASE PRINT!

NAME	ADDRESS	PHONE	REPRESENTING	DO YOU WANT TO TESTIFY?
MICHELLE CASTANEDO	POB 22130 JUNEAU AK 99802	463-4949	ASEA/AFSCME	
Bruce Cummings	Box C-0220, Juneau 99811	465-4409	Dept. Administration	
Karen Perdue	Box H, Juneau 99811	465-3030	Dept of H SS	
GREG O'CLARAY	124 FRONT ST JN. 99801	586-6090	MTD AFL-CIO	
Mike Navarre	Box V Juneau, AK	465-3718	Legis.	
M. Boyer	" "	3466	"	
Jan Lunca	Box r Juneau AK	465-4766	Legis	

Alaska Court System

State of Alaska

303 "K" STREET
ANCHORAGE, ALASKA
99501

ARTHUR H. SNOWDEN II
ADMINISTRATIVE DIRECTOR

(907) 274-8611

March 17, 1989

Senator Tim Kelly
Senate President
Alaska State Legislature
P. O. Box V
Juneau, Alaska 99811

Re: Health Care Cost Containment

Dear Senator Kelly:

The Department of Administration, the Alaska Court System and the Legislature Affairs Agency comprised the Health Benefits Task Force in June, 1988. We understood the purpose of the task force was to gather information about state employee health benefits and make recommendations for change to the Department of Administration. The task force met once each month, gathered a myriad of information, listened to consultants, Aetna representatives, other public agency employers and reviewed several position papers and documents about the state health care system. It was the expectation of the Alaska Court System that the task force would make specific recommendations that would be implemented by the Department of Administration. Unfortunately, the Department of Administration felt that it could not implement any recommendations due to the constraints of various collective bargaining agreements, so the chair of the task force, Chuck Taylor, terminated the task force in December, 1988.

While working with the task force, the court system reviewed the health benefit plans of the Municipality of Anchorage, the Teamsters Health and Welfare Trust and the University of Alaska. We also met with their representatives to determine their plans' potential application to state employees. We also examined

health plans from the private sector as well as from other states. To better inform ourselves of the issues facing the state, we reviewed cost containment studies and attended seminars sponsored by the International Foundation of Employee Benefit Plans. We also obtained materials on health promotion and wellness to assist in planning for future cost containment. I'm enclosing a copy of a bibliography of materials we gathered if you would like more information on individual topics.

Our research led us to the conclusion that the state did not have sufficient demographic information about its employees to make reasoned health care benefit choices. Although the task force asked the state's consultant and Aetna for employee demographics, the information they provided was generally insufficient. We strongly suggested that the state work with a consultant who could assist in gathering the necessary cost data and demographic information.

In researching cost information, the Legislative Affairs Agency conducted a survey of dental costs in Juneau to determine the variation in pricing as well as the average cost for certain standard procedures. The court system conducted a similar survey in Anchorage, a copy of which is enclosed. We believe that surveys of this type should be conducted statewide with most health care providers and that the results be made available to all employees.

During the first few meetings of the task force we asked that representatives of the bargaining units be invited to participate. The Department of Administration did invite them, but not until the final two meetings. Given the complexity of the issues and the need for all employees to be informed of the significant problems in the present health benefits plan, participation by union representatives is essential. After considerable research we believe that the state's plan can best be managed by an employer-employee health benefits trust. A trust comprised of people with the necessary expertise to make informed choices would provide both management experience as well as continuity for the state. It would also remove health benefits from the bargaining process, so that long term planning for all state employees can be achieved. These trusts have worked well in the private sector in Alaska.

When the task force was dissolved, I reiterated the court system's approach to the health care benefits problem in my December 14, 1988 letter to Deputy Commissioner Taylor. It was, and still remains, our position that costs should be contained first through management of the health care system and, second, by making those changes that will least impact the employees. We also made specific recommendations in the letter, a copy of which I have enclosed.

Although the court system is not a member of the new task force, we would appreciate the opportunity to share with its members our concerns and information. If you have any questions with regard to our work to date on this issue, please contact either Jan Strandberg or me.

Sincerely,

Arthur H. Snowden, II
Administrative Director

Attachments

cc: Senator Jim Duncan
Representative Mike Navarre
Representative Mark Boyer
Jan Strandberg

03-89-46

HEALTH BENEFITS RESOURCES

STATE OF ALASKA

1. Health Insurance Costs. Five-year summary of costs to state (Alaska).

2. An Analysis of Healthcare Cost Management Alternatives for Alaska. Division of Retirement & Benefits in conjunction with Mercer-Meidinger. Jan. & Feb. 1988.

3. Discussion Paper Presented to State of Alaska Task Force on Employee Health Care Benefits. Mercer-Meidinger-Hansen. Sept. 1988.

4. State of Alaska Task Force on Employee Healthcare Benefits Meeting. Prepared by Aetna Life Ins. Oct. 1988.

HEALTH PLANS FROM PUBLIC & PRIVATE SECTOR

A. Municipality of Anchorage

1. Flexible Benefits Plan. Municipality of Anchorage memo to employees. 5/2/88.

2. MOA - CHAMP. March 1988; Letter of Agreement between MOA and AMEA.

B. Private Companies

1. Employee Benefits Programs for: Bank of America, Quaker Oats and First Chicago Bank.

C. States

1. California PERS. Adverse Selection in a Large Health Benefit Program.

2. "The Call to Rome and Other Obstacles to State-Level Innovation." Public Administration Review. March/April 1987.

3. State Efforts at Health Care Cost Containment: 1986 Update. National Conference of State Legislatures.

HEALTH PROMOTION & WELLNESS

1. "Workplace Health Enhancement." INTER ALIA Journal of the State Bar of Nevada. Jan. 1982-83.

2. "Using Healthcare Data to Direct Risk Reduction Efforts."

The National Center for Health Promotion. 1988.

3. Promoting Prenatal Health in the Workplace. Prepared by March of Dimes. Washington Business Group on Health. Nov. 1986.

4. Preventing Alcohol & Drug Abuse Through Programs at Workplace. Washington Business Group on Health. Feb. 1987.

5. Health Promotion and the Labor Union Movement. Washington Business Group on Health. July 1986.

6. "Using Healthcare Data to Direct Risk Reduction Efforts." The National center for Health Promotion. 1988.

7. Using Incentives to Promote Employee Health. Washington Business Group on Health. Feb. 1986.

8. Worksite Wellness Media Report Research Update 1988. Washington Business Group on Health. Feb. 1988.

9. Worksite Wellness Media Report Research Update 1987. Washington Business Group on Health. Feb. 1988.

COST CONTAINMENT STUDIES

1. "Cost Management Case Study: State of Arizona." - edited version. ...By Design.

2. Healthcare Cost Containment in the Public Sector. A Mercer-Meidinger Survey. 1986.

3. Paying Physicians: Commentary. Case Western Reserve Law Review. 1986.

4. IBIS Conference Addresses Cooperative Efforts to Control Employee Benefits Costs. Employee Benefit Plan Review. Aug. 1984.

5. Taking Charge: A Buyer's Guide to Managing Health Benefits. Integrated Health Management Associates. 1985.

MISCELLANEOUS

1. "Self-Insured Health Plans." Health Care Financing Review. Winter 1986.

2. "Selecting a Utilization Review Organization - A Step by Step Process." Employee Benefits Journal. June 1987.

3. Management Hotline: Health Benefits for An Aging Workforce.

4. Health Care - Employees Accept Health Care Changes, Study Finds. Journal of Accountancy. Nov. 1985.

5. Health Care Cost Management Conference. Sept.29-Oct.1, 1988.

6. Pooled Funds. William Jermain. Aug. 1988.

7. Alaska Employee Benefits Institute. International Foundation of Employee Benefit Plans. Aug. 31. 1988.

8. Section 89: "ERISA-fying" Health & Welfare Plans. International Foundation of Employee Benefit Plans. Sept. 1988.

Alaska Court System
Anchorage Dental Survey
12/88

Provider code --->					2	3	4	5
		Service Category:						
Service:		Max	Min	Avg				
Routine exam	(adult)	$110	$10	$31	$30	$25	$25	$20
	(child)	45	15	29				
Oral prophylaxis	(adult range)	84	25	60	60	50	55	60
	(child range)	80	22	45	45		45	
4 bitewing x-rays	(adult)	58	10	28	10	25	24	20
	(child)	58	10	29				
Stannous flouride	(adult)	23	5	13	*	*	*	*
	(child)	21	5	12				
1 surface amalgam filling	(adult)	100	40	66	60	60	65	70
	(child)	80	42	68				
2 surface amalgam filling	(adult)	125	64	86	76	70	90	90
	(child)	105	55	83				
Root canal: "ant."	(adult)	350	135	271	250	225	270	260
"bicus."	(adult)	450	275	335			345	
"molar"	(adult)	575	250	404	395	325	395	440
1 surface composite	(adult range)	137	40	78	75	60	85	85
Porcelain/gold crown	(adult range)	700	205	511	510	475	480	525
Full gold crown	(adult range)	700	425	515	510	475	480	545
Complete upper denture	(adult range)	1,500	395	783	750	650	800	650 725

Notes:
* included with cleaning
** service not provided
*** children only

Alaska Court System
Anchorage Dental Survey
12/88

Provider code --->		6	7	8	9	10	11	12	13
Service:									
Routine exam	(adult)	$35	$35	$30	$25	$20	$35	$22	$25
	(child)			20	20				
Oral prophylaxis	(adult range)	60	60	60	60	60	65	65 70	55
	(child range)	50	40 45		25	45	50		50
4 bitewing x-rays	(adult)	20	30	25	25	10	20	40	30
	(child)								
Stannous flouride	(adult)	20	*		20	13	10	*	*
	(child)								
1 surface amalgam filling	(adult)	65	55	65	65	80	50	65	65
	(child)	60							
2 surface amalgam filling	(adult)	80	80	85	80	90	75	92	75
	(child)	75							
Root canal: "ant."	(adult)	225	275	300	225	250	325	280	195
"bicus."	(adult)	275	325	350	300	300	350		
"molar"	(adult)	400	450	400	350	350	400	430	250
1 surface composite	(adult range)	90	75	85	70	80	75	60	75
Porcelain/gold crown	(adult range)		480	525	485	450	500	510	485
Full gold crown	(adult range)	425	480	525	485	450	500	510	485
Complete upper denture	(adult range)	700	750 900	800	550	750	650	850	625

Notes:
* included with cleaning
** service not provided
*** children only

Alaska Court System
Anchorage Dental Survey
12/88

Provider code --->		14	15	16	17	18	19	20	21
Service:									
Routine exam	(adult)	$20	$35	$35	$15	$40	$35	$33	$46
	(child)	15							
Oral prophylaxis	(adult range)	60	60	55	60	80	65	64	46
	(child range)	45			48	55	50	50	
4 bitewing x-rays	(adult)	20	45	25	35	40	30	26	20
	(child)								
Stannous flouride	(adult)	*	10	15	*	15	*	*	*
	(child)					10			
1 surface amalgam filling	(adult)	70	75	55	58	54	70	62	58
	(child)								
2 surface amalgam filling	(adult)	80	85	85	65	78	90	82	78
	(child)								
Root canal: "ant."	(adult)	300	275	225	325	275	285	256	**
"bicus."	(adult)	375	325	300	395	325	365	332	
"molar"	(adult)	457	450	425	425	400	445	464	
1 surface composite	(adult range)	90	100	60	58	66	80	62	78
					65			102	
Porcelain/gold crown	(adult range)	575	525	480	525	510	565	496	485
Full gold crown	(adult range)		525	480	525		565	496	485
Complete upper denture	(adult range)	875	850	650	850	900	825	856	**

Notes:
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** service not provided
*** children only

Alaska Court System
Anchorage Dental Survey
12/88

Provider code --->		22	23	24	25	26	27	28	29
Service:									
Routine exam	(adult)	$20	$40	$25	$30	$25	$20	$30	$110
	(child)		30	25		18	20		36
Oral prophylaxis	(adult range)	60	58	60	60	56	60	50	65
	(child range)		40	45		46	45 50		41
4 bitewing x-rays	(adult)	30	30	40	25	28	32	25	58
	(child)						20		58
Stannous flouride	(adult)	*	10		10		*	10	21
	(child)								21
1 surface amalgam filling	(adult)	60	60	65	70	58	80	60	65
	(child)						80		65
2 surface amalgam filling	(adult)	85	103	80	80	78	105	75	82
	(child)						105		82
Root canal: "ant."	(adult)	250	200	250	250	265	325	275	302
"bicus."	(adult)	310	289	300	300	330	375	325	450
"molar"	(adult)	410	325	368	375	405	450	425	496
1 surface composite	(adult range)	70 90	68 137	65	70	78	90 90	60	88 88
Porcelain/gold crown	(adult range)	500	468 489	500	535	488	550	495	588
Full gold crown	(adult range)	500	489			505	550	495	588
Complete upper denture	(adult range)	700	750	750 800	1,000	750	850	850	875

Notes:
* included with cleaning
** service not provided
*** children only

Alaska Court System
Anchorage Dental Survey
12/88

Provider code --->		30	31	32	33	34	35	36	37
Service:									
Routine exam	(adult)	$32	$35	$26	$25	$55	$60	$15	$35
	(child)	32	35	25		45		15	35
Oral prophylaxis	(adult range)	60	55 65	65	84	60	60	60	60
	(child range)	50	50	48		45		50	40
4 bitewing x-rays	(adult)	20	48	28	35	20	25	30	25
	(child)	20	48	26				30	15
Stannous flouride	(adult)	5	10	15	10	*	*	*	15
	(child)	5	10	*					15
1 surface amalgam filling	(adult)	70	80	75	57	70	58	75	70
	(child)	70	80	75				70	70
2 surface amalgam filling	(adult)	80	90	102	79	80	70	85	90
	(child)	80	90	102			85	80	90
Root canal: "ant."	(adult)	270	270	295	295	275	265	250	250
"bicus."	(adult)	365	320		325	300	295	300	300
"molar"	(adult)	445	380	345	425	325	395	370	450
1 surface composite	(adult range)	80	100 100	82 75	79	75	65 85	85 85	70 70
Porcelain/gold crown	(adult range)	565	510 510	525	485	495	525	495	545
Full gold crown	(adult range)	565	510	525	485	525	525	495	545
Complete upper denture	(adult range)	850	700	700	900	775	750 800	695	800

Notes:
* included with cleaning
** service not provided
*** children only

Alaska Court System
Anchorage Dental Survey
12/82

Provider code --->		38	39	40	41	42	43	44	45
Service:									
Routine exam	(adult)	$45	$25	$32	$45	$40	$45	$51	$45
	(child)	45			45	30	30		25
Oral prophylaxis	(adult range)	60	60	65	60	58	50	64	55 60
	(child range)	45 50	45		45 50	40	35	48	50
4 bitewing x-rays	(adult)	*	30	34	*	30	50	25	*
	(child)						35	20	
Stannous flouride	(adult)	*		5	*	10	*	*	*
	(child)								
1 surface amalgam filling	(adult)	**	70	**	**	60	55	60	70
	(child)						42		70
2 surface amalgam filling	(adult)	**	90	**	**	103	70	119	95
	(child)						55		95
Root canal: "ant."	(adult)	315	270	310	315	200	225	**	300
"bicus."	(adult)	375	365	355	375	289	300		375
"molar"	(adult)	435	445	440	435	325	375		395
1 surface composite	(adult range)	78 90	75	95	78 90	68 137	55 42	60 65	95
Porcelain/gold crown	(adult range)	550	545	550	550	468	450	205 210	490
Full gold crown	(adult range)	550	545	550	550	489	450	529	490
Complete upper denture	(adult range)	800	745	800	800	750	650	1,500	750

Notes:
* included with cleaning
** service not provided
*** children only

Alaska Court System
Anchorage Dental Survey
12/88

Provider code --->		46	47	48	49	50	51	52	53
Service:									
Routine exam	(adult)	$35	$20	$10	$35	$33	$34	$34	$26
	(child)	35						15	
Oral prophylaxis	(adult range)	80	60	25	58	35 80	65	62	60
	(child range)	80	45 50	22			49	38	45
4 bitewing x-rays	(adult)	30	25	10	30	20	17	30	16
	(child)	30				55			
Stannous flouride	(adult)	*	*	5	15	18	16	*	23
	(child)								9
1 surface amalgam filling	(adult)	65	55	49	75	100	95	61	65
	(child)								
2 surface amalgam filling	(adult)	80	75	77	105	125	110	72	85
	(child)								
Root canal: "ant."	(adult)	330	265	275	295	235	340	236	250
"bicus."	(adult)	390	325	375	345		420	315	285
"molar"	(adult)	450	395	475	395	250	500	372	325
1 surface composite	(adult range)	70	75	64	85 90		95	84	65 75
Porcelain/gold crown	(adult range)	495	525	435	525	450 700	600	487	485
Full gold crown	(adult range)	495	525	435	525	450 700	600	487	485
Complete upper denture	(adult range)	840	755	395	700	750 1,300	1,000	782	750

Notes:
* included with cleaning
** service not provided
*** children only

Alaska Court System
Anchorage Dental Survey
12/88

Provider code --->		54	55	56	57	58	59	60	61
Service:									
Routine exam	(adult)	$20	$15	$15	$35	$20	$22	$35	$20
	(child)								
Oral prophylaxis	(adult range)	60	60	62	60	60	58	55	60
	(child range)	45	50			45	38		
4 bitewing x-rays	(adult)	35	30	20	25	20	18	35	20
	(child)								
Stannous flouride	(adult)	*	*	15		*	*	*	*
	(child)								
1 surface amalgam filling	(adult)	85	75	83	81	70	62	75	70
	(child)		70	63					
2 surface amalgam filling	(adult)	105	85	103	64	90	92	85	90
	(child)		80	73					
Root canal: "ant."	(adult)	295	250	285	**	285	300	225	260
"bicus."	(adult)		300	325		385	365	285	
"molar"	(adult)		370	415		445	490	385	440
1 surface composite	(adult range)	95	85	113	64	75	84	75	85
Porcelain/gold crown	(adult range)	575	495	555	595	500	565	495	525
Full gold crown	(adult range)	575	495	545	595	500	565	495	545
Complete upper denture	(adult range)	750	695	950	750	600	750	850	650

Notes:
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*** children only

Alaska Court System
Anchorage Dental Survey
12/88

Provider code --->		62	63	64	65	66	67	68	69
Service:									
Routine exam	(adult)	$33	$20	$20	$30	$40	$22	$35	$22
	(child)								
Oral prophylaxis	(adult	60	60	40	55	60	65	65	58
	range)				60		70		
	(child	50			40			50	38
	range)				45				
4 bitewing x-rays	(adult)	35	30	20	25	40	40	35	18
	(child)								
Stannous flouride	(adult)	*	*	9	*	20	*		*
	(child)			*				*	
1 surface amalgam filling	(adult)	65	60	40	60	50	65	55	62
	(child)								
2 surface amalgam filling	(adult)	85	85	70	75	75	92	70	92
	(child)								
Root canal: "ant."	(adult)	350	250	350	275	300	280	295	300
"bicus."	(adult)	425	310	400	325	350		350	365
"molar"	(adult)	575	410	450	375	450	430	400	490
1 surface composite	(adult	75	90	40	75	60	60	65	84
	range)		70						
Porcelain/gold crown	(adult	600	500	425	550	500	510	525	565
	range)								
Full gold crown	(adult	600	500	425	550	500	510	525	565
	range)								
Complete upper denture	(adult	800	700	550	775	600	850	900	750
	range)					900			

Notes:
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** service not provided
*** children only

Alaska Court System
Anchorage Dental Survey
12/88

Provider code --->		70	71	72	73	74	75	76	77
Service:									
Routine exam	(adult)	$35	$35	$30	***	$20	$25	$15	$25
	(child)			25	35				
Oral prophylaxis	(adult range)	60	62	60	***	70	55	60	60
	(child range)	45		30	36				
4 bitewing x-rays	(adult)	30	20	10	***	20	35	40	30
	(child)			10	14				
Stannous flouride	(adult)		15		*		10		5
	(child)								
1 surface amalgam filling	(adult)	65	73	70	***	60	52	65	75
	(child)				68				
2 surface amalgam filling	(adult)	85	93	95	***	80	67	75	95
	(child)				78				
Root canal: "ant."	(adult)	295	285	275	135	225	295	325	205
"bicus."	(adult)	325	325	300		275	325	345	275
"molar"	(adult)	375	415	325		350	400	345	350
1 surface composite	(adult range)	75	83	70	***	65	85	85	85
				95	68		95		100
Porcelain/gold crown	(adult range)	550	545	525		515	500	465	450
Full gold crown	(adult range)	550	545	525		515	500	485	450
Complete upper denture	(adult range)	750	900	750		900	900	755	695

Notes:
* included with cleaning
** service not provided
*** children only

December 14, 1988

Charles E. Taylor
Deputy Commissioner
Department of Administration
P.O. Box C
Juneau, Alaska 99811

Dear Chuck:

The termination of the Health Benefits Task Force has left the other two branches of government in the unenviable position of waiting for the executive branch to negotiate a health benefits package with the unions before the determination of the package for other state employees.

I would like to restate the court system's approach to the health care benefits problem. We believe that costs should be first contained through management of the health care system and by making those changes that have the least impact on employees. As we agreed, at this time the state does not have sufficient demographic or cost information to make reasoned decisions about specific cuts. However, after reviewing and attempting to analyze the materials provided to us by Aetna and Mercer-Meidinger-Hansen, we want to reiterate these specific recommendations:

(1) form a trust comprised of management and union officials as well as representatives of the other two branches of government that will be responsible for the provision and management of health benefits for state employees;

(2) explore the feasibility of self-insurance;

(3) implement utilization review, coordination of benefits and caps on mental health, substance abuse and chiropractic services;

(4) manage the utilization of prescription drugs;

(5) review the usual, customary and reasonable charges for Alaskan health services;

(6) review the Mendocino plan as well as other health incentive and wellness programs for potential implementation in Alaska; and

(7) gather the demographic and cost data necessary to determine whether other specific services should be capped or eliminated.

We believe that these recommendations should be implemented as

soon as possible. To the extent of our resources, we will assist in compiling information that you believe may be helpful. By separate cover, we will provide you with the results of our Anchorage Dental Survey. Our staff counsel will also provide you with the information she has gathered about employee incentive plans and wellness programs. Although we anticipate that we will support your legislative package, we cannot agree to support the concept of flexible benefits without a thorough cost-benefit analysis. Please let me know if you would like our assistance in other areas.

Very truly yours,

Arthur H. Snowden, II
Administrative Director

MEMBER

TENTH ALASKA LEGISLATURE
ELEVENTH ALASKA LEGISLATURE
TWELFTH ALASKA LEGISLATURE
THIRTEENTH ALASKA LEGISLATURE
FOURTEENTH ALASKA LEGISLATURE
FIFTEENTH ALASKA LEGISLATURE
SIXTEENTH ALASKA LEGISLATURE

OFFICE OF THE PRESIDENT

SENATOR TIM KELLY

P.O. BOX V
JUNEAU, ALASKA 99811
(907) 465-3822

P.O. BOX 210001
ANCHORAGE, ALASKA 99521
(907) 561-7612

April 29, 1989

MEMORANDUM

To: All members
Health Care Cost Containment
Task Force

From: Senator Tim Kelly, Chair TDK

Re: End of session report.

Much has happened since our meeting on April 12. Attached is a sequence of correspondence which chronicles the progress of our efforts. Included for your record is an exerpted transcript of the April 12 meeting that pertains to Barbara Huff's motion.

I am very pleased with the progress of the Task Force to date and all members' contributions to that success. Moreover, the prospects for significant accomplishments during the interim must be viewed with increased confidence. I am hopeful that the funding for this continued effort will be appropriated.

I expect our next meeting will take place in early or mid June. Note that there is a proposed work plan for your review and consideration in the attachments. I will be contacting you after the session to select a date that best accomodates Task Force members' schedules.

OFFICE OF THE PRESIDENT

MEMBER

TENTH ALASKA LEGISLATURE
ELEVENTH ALASKA LEGISLATURE
TWELFTH ALASKA LEGISLATURE
THIRTEENTH ALASKA LEGISLATURE
FOURTEENTH ALASKA LEGISLATURE
FIFTEENTH ALASKA LEGISLATURE
SIXTEENTH ALASKA LEGISLATURE

SENATOR TIM KELLY

P.O. BOX V
JUNEAU, ALASKA 99811
(907) 465-3822

P.O. BOX 210001
ANCHORAGE, ALASKA 99521
(907) 561-7612

April 29, 1989

MEMORANDUM

To: Rep. Sam Cotten, Speaker

Sen. Johne Binkley, Co-chair
Sen. Rick Uehling, Co-chair
Senate Finance Committee

Rep. Ron Larson, Co-chair
Rep. Lyman Hoffman, Co-chair
House Finance Committee

From: Sen. Tim Kelly, Chair
Health Care Cost Containment
Task Force

TDK

Re: Significant progress on reducing FY 90 health care costs.

I am pleased to submit the attached report for your information. It signals additional success of the Task Force to focus on, encourage, and stimulate cost saving measures that will have a substantial effect on FY 90 and all future budget requirements for state employee health care.

While this is an important step, it by no means concludes or exhausts the opportunities for other savings and cost containment measures that could be equally significant. In this regard, I hope you share my confidence in the interim work of the Task Force to further realize our common goals.

STATE OF ALASKA

DEPARTMENT OF ADMINISTRATION

DIVISION OF LABOR RELATIONS

STEVE COWPER, GOVERNOR

P.O. BOX C
JUNEAU, ALASKA 99811-0220
PHONE: (907) 465-4404

April 28, 1989

Senator Tim Kelly
Chairman
Health Cost Containment Task Force
P.O. Box V
Juneau, AK 99811

Dear Senator Kelly:

Re: Health Insurance Negotiations

Please accept this letter as a status report on health insurance benefit negotiations between the State of Alaska (State) and the Alaska State Employees Association (ASEA).

The parties are proceeding with all haste in the negotiation of an interim agreement intended to take effect on July 1, 1989, or as soon thereafter as possible. The parties recognize and are making every effort to respond to the need for cost containment measures to take effect as early in FY 90 as possible.

To that end, ASEA presented a proposal to the State on April 13, 1989, and subsequently refined on April 25, as reflected in the attached conceptual proposed. The parties have met daily since in an effort to refine this proposal into acceptable contract language on those elements which are feasible for adoption in Alaska. The parties have, and continue, to confer telephonically with the State's insurance carrier (Aetna) regarding the practicality, mechanics and cost of implementing some or all of these containment measures on or about July 1.

Not surprisingly, we are finding that some of these measures can be taken, but perhaps not by July 1 (August 1 is more realistic). Nevertheless, we have every hope that adoption of these measures will produce savings exceeding ten percent (10%) of the current premium price.

The parties will continue to pursue these negotiations with the intent of completing our negotiations by May 15, 1989.

Please do not hesitate to contact representatives of either party if you have any questions regarding this matter.

Sincerely,

Don Wasserman
Chief Spokesman
ASEA/AFSCME

Dianne Corso
Chief Spokesman
State of Alaska

DW/DC/vcy
P0428bac
Enclosure:
cc: All Members
Health Care Cost Containment Task Force

PROPOSED CHANGES

Savings: Unknown	1.	Annual re-enrollment, identification of spouse and dependents with birthdates. Issue new enrollment cards annually.
Savings: Unknown	2.	Eliminate dual enrollment (husband and wife both employed by state). State pay Plan 1 SBS premium.
Savings: 6%	3.	Utilization Review (Aetna's Healthline). $400 reduction for noncompliance.
Savings: 3%	4.	Outpatient Precertification (provided by Aetna). $400 reduction for noncompliance.
Savings: .5%	5.	Cover skilled nursing care at 100% when used in place of in patient hospital stay.
Savings: 1-1.5%	6.	Managed second surgical opinion (Aetna provided through "Healthline) $400 reduction for noncompliance.
Savings: $260,000 per site	7.	On site concurrent review (provided by Aetna).
Savings: Unknown	8.	Managed mental health (provided by Aetna)
Savings: Unknown	9.	High risk pregnancy management (Provided by Aetna)
Savings: Unknown	10.	Travel/ambulance provisions revised to allow transportation costs to place that is determined to be more appropriate and cost effective
Savings: .25%	11.	Place a $750 annual maximum for care provided by chiropractors.
Savings: 1%+	12.	Prescription drug card program. $5.00 co-pay name brand drugs, $0.00 co-pay generic drugs. Mail order drug program $0.00 co-pay.

Savings: 1%	13.	Dollar limit for alcoholism/drug abuse treatment, a maximum per admission and a lifetime maximum. ? To be refined
Savings: Unknown	14.	Provide for plan to subrogate claims
Impact: Unknown	15.	Provide for deductible to be $100 for employee, $100 for spouse and combined deductible of $100 for all children
Savings: .3%	16.	Patient audit program with employee sharing in savings. Employee to receive 50% up to $400 per year.
Cost: 2%	17.	Provide orthodontia at 50% of U.C.R. with lifetime maximum of $1,500.
Savings: Unknown	18.	Provide for a mandatory pretreatment plan to be submitted to the carrier for authorization when dental care is expected to exceed $500.
Impact: Unknown	19.	Remove $400 lifetime maximum on medically required contact lenses.
Impact: Perhaps Slight	20.	Modify effective date of coverage for seasonal employees. Option for employee to delay start of coverage and have coverage extend past date of layoff.

13.55%	Total Savings
2.0%	Cost

11.55%	Net Savings + Unknown Savings

OFFICE OF THE PRESIDENT

MEMBER

TENTH ALASKA LEGISLATURE
ELEVENTH ALASKA LEGISLATURE
TWELFTH ALASKA LEGISLATURE
THIRTEENTH ALASKA LEGISLATURE
FOURTEENTH ALASKA LEGISLATURE
FIFTEENTH ALASKA LEGISLATURE
SIXTEENTH ALASKA LEGISLATURE

SENATOR TIM KELLY

P.O. BOX V
JUNEAU, ALASKA 99811
(907) 465-3822

P.O. BOX 210001
ANCHORAGE, ALASKA 99521
(907) 561-7612

April 13, 1989

MEMORANDUM

To: Senator Johne Binkley, Co-chair
Senator Rick Uehling, Co-chair
Senate Finance Committee

From: Senator Tim Kelly, Chair
Health Care Cost Containment TOK
Task Force

Re: Funding for the Task Force interim activities.

Attached is the proposed work plan for the Health Care Cost Containment Task Force. The initial phase has been successfully completed and we are well toward achieving success in phase two.

Management and ASEA have agreed to take up cost containment items adopted by the Task Force (attached) as a priority in their current negotiations. They have also agreed to report back to the Task Force by April 29 on the mutual acceptance of these cost containing measures. Any collective bargaining success at that juncture could have an immediate affect on the $17,500,000 health care cost increase proposed for FY 90. We estimate that implementation of these initial cost containment measures alone could save a minimum of $6,500,000 annually.

I believe that it is most important that the Task Force continue this initial success during the interim and through next session. Without the focussed attention and active legislative presence and involvement in this area, I fear that the attainment of substantive health care cost reductions will lag or just not be realized. In that view, the health care cost issue for next session will be much more unacceptable.

I also want to mention that I believe it is imperative that we take a look at all of the health care costs being defrayed by the general fund. This will include the more than $95 million expended by the Department of Health and Social Services on medicare/medicaid programs.

I estimate the cost for this effort as $150,000 and will provide whatever detail you may need. I would appreciate a reappropriation of this amount to the Health Care Cost Containment Task Force, with an immediate effective date, so we can continue the progress made.

Health Care Cost Containment Task Force

Work Plan

Initial Phase March/April 89

Review and recommend areas for implementation to reduce FY 89 costs (Supplemental).

Identify areas for review that could be used to reduce future year costs.

Phase Two May - End of Session 89

Receive reports from administration, and bargaining units regarding initial cost containment provisions negotiation.

Establish plan to implement initial cost containment provisions.

Identify additional areas for consideration to control Health Care Costs.

Phase Three June - August 89

Monitor progress on initial cost containment implementation.

Start to formulate plan of action for second level cost containment measures (i.e.: p.p.os, delivery systems, monitoring)

Phase Four Sept. Oct. Nov. 1989

Take testimony from participants, providers and other interested parties on Health care delivery, quality and costs.

Review and recommend cost management techniques that the State could use to reduce Health Care Costs (all methods medicaid etc.)

Phase Five Dec 89 - Jan 90

Work towards implementation of second level cost containment techniques.

Identify level three Health care cost management techniques.

Phase Six Jan 90 - Forward

Continue to review health care cost management strategies.

4/12/89 Health Care Cost Containment Task Force

Passed

I MOVE THAT THE TASK FORCE ADOPT THE HEALTH CARE COST CONTAINMENT MEASURES SUBMITTED IN THE GALLAGHER MARCH 29, 1989, REPORT AS FOLLOWS;

UTILIZATION REVIEW ★
OUTPATIENT PRECERTIFICATION
MANAGED SECOND SURGICAL OPINION
MANAGED MENTAL HEALTH
HIGH RISK PREGNANCY MANAGEMENT
ONSITE CONCURRENT REVIEW
WELLNESS PROGRAMS
MAIL ORDER PRESCRIPTION DRUG PLAN

IN ADDITION TO;

HOSPITAL AUDITS ★
PARTICIPANT INCENTIVE PLAN

AND THAT THE TASK FORCE RECOMMEND THE STATE AND THE RESPECTIVE UNIONS ADDRESS THESE IMEDIATELY AS A PRIORITY ISSUE IN AN ATTEMPT TO REDUCE COST FOR FY 89/90.

Alaska State Legislature

Official Business

P.O. BOX V
State Capitol
Juneau, Alaska 99811

April 12, 1989

MEMORANDUM

To: Rep. Sam Cotten, Speaker

Sen. Johne Binkley, Co-chair
Sen. Rick Uehling, Co-chair
Senate Finance Committee

Rep. Ron Larson, Co-chair
Rep. Lyman Hoffman, Co-chair
House Finance Committee

From: Sen. Tim Kelly, Chair TDK
Rep. Mike Navarre, Vice Chair Mike
Health Care Cost Containment
Task Force

Re: FY 89 and FY 90 health care cost reductions.

At today's meeting of the Task Force Commissioner Andrews, Department of Administration, agreed that the FY 89 supplemental appropriation could be reduced by two administrative actions identified by the Task Force. The general fund reduction amounts are as follows:

Premium Tax Refund	$1,300,000
Extended Liability Reserve	2,400,000
Total Reduction	$3,700,000

There is some difficulty on how to allocate the reduction among the budget units, but we are assured that it can be done.

With these savings the health care cost supplemental should be in the neighborhood of $8,100,000 from general funds. It should be noted that this is nearly a 50 % reduction from what was originally requested.

The Task Force has initiated additional efforts to reduce FY 90 health care costs. Union and management groups will be meeting to attempt agreement on specific cost containment measures prior to the end of this session. A successful report back to the Task Force could have immediate FY 90 budget implications.

HEALTH CARE COST CONTAINMENT TASK FORCE
April 12, 1989
1:05 p.m.

MEMBERS PRESENT

Senator Tim Kelly, Chairman
Alaska State Senate
P.O. Box V
Juneau, Alaska 99811
(907) 465-3822

Representative Mike Navarre, Vice Chairman
Alaska House of Representatives
P.O. Box V
Juneau, Alaska 99811
(907) 465-3779

Senator Jim Duncan
Alaska State Senate
P.O. Box V
Juneau, Alaska 99811
(907) 465-4766

Representative Mark Boyer
Alaska House of Representatives
P.O. Box V
Juneau, Alaska 99811
(907) 465-3466

Bruce Cummings, Director
Division of Labor Relations
Department of Administration
P.O. Box C
Juneau, Alaska 99811
(907) 465-4404

Michelle Castanedo, Representative
Alaska State Employees Association
240 Main Street, Suite 200
Juneau, Alaska 99801
(907) 463-4949

Don Hitchcock, Director
Division of Risk Management
Department of Administration
P.O. Box C
Juneau, Alaska 99811
(907) 465-2180

Barbara Huff, President
Anchorage Municipal Employees Assoc.
P.O. Box 100392

Anchorage, Alaska 99510
(907) 269-4236

Karen Purdue, Deputy Commissioner
Department of Health
& Social Services
P.O. Box H
Juneau, Alaska 99811-0601
(907) 465-3030

MEMBERS ABSENT:

Greg O'Claray, Representative
Marine Engineers Beneficial Assoc.
124 Front Street
Juneau, Alaska 99801
(907) 586-6040

COMMITTEE CALENDAR

WITNESS REGISTER

ACTION NARRATIVE

Excerpted from Health Care Cost Containment Task Force meeting dated 4/12/89.

BARBARA HUFF: What I would like to do to kind of wrap up the second portion of this agenda is make a motion, which I do have in writing so that if we need to get photo copies for everybody to take a look at is have me read it into the record and maybe we can get it passed around. But I think in general what it's doing is tying in with, I guess the comment that Jeff has made, looking at the various cost containment issues that have been bounced around. I guess I feel real comfortable speaking on this and advocating this process because myself did go through this with the Municipality of Anchorage. It was a very, very successful process, one that both of the parties bought into and we've got some happy folks out there as far the employees that

are under that particular program. I think that the process that the state and the unions involved here are looking at, this can be very, very keyed, because whatever kind of changes are implemented out there, everybody has got to be a part of that process to look at a positive implementation. And part of the motion that we're looking at laying on the table here would actually tie that all together and get everybody on the right direction here.

SENATOR DUNCAN: Why don't we just hold until we get your motion back then, unless there is some further discussion, so that we can look at the motion and then, perhaps, if you want to offer it, we can discuss it at that point. Were there any other comments prior to doing that?

BARBARA HUFF: I will go ahead and read this motion into the record. [reads]

I move that the task force adopt a health care cost containment measure submitted in the Gallagher March 29, 1989 report as follows:

Utilization review; outpatient precertification; managed second surgical opinion; managed mental health; high risk pregnancy management; onsite current review; wellness programs; mail order prescription drug plan.

In addition to that, there were two items that we had originally discussed, at least within labor, and I had thought that the entire task force had talked about them

and that was to include the hospital audits and participant incentive plans and that the task force recommend the state and the respective unions address these immediately as a priority issue in an attempt to reduce cost for FY 89/90.

SENATOR DUNCAN: Are you making that as a motion? Okay, we have the motion up. Are there any questions or discussion on what Barbara is proposing?

REP. BOYER, et al. Discussion on premium and deductible implications.

CUMMINGS: Yes, if I may Mr. Chairman. Although I don't take any offense to this motion, I want the record to reflect that the State and various and sundry units have been .... reviewing most if not all these issues for the last two years. Essentially without resolution at this point, but been an awful lot of work done. And,....its been in two respects. The monetary contribution that the state would make to a plan. And then given that contribution, whatever that may be, what the plan would look like. What you suggest sounds like a form of self insurance (BOYER discussion above). That is a concept that merits some exploration. But at this time we are focussing our attention on the bargaining process, at the level of contribution being paid by the state. And then within that, what the benefit structures look like. I would the

record reflect that the parties have not been idle in examining many of these over the last two years.

HUFF: Clarification. We have a motion on the table here. There's not been a second, but yet we seem to be going into discussion.

SEN. DUNCAN: Actually, a second is not needed. I understand what Mr. Cummings point is. Perhaps I could ask Barbara or even Michelle, as the unions were involved I guess in putting together this motion, what does it mean (pause) what does the bottom statement mean that the task force recommends the state respectively address immediately as a priority issue. What does that mean?

HUFF: Senator, maybe I can address this, and correct me if I'm wrong here. I guess where I'm going back to is what I have gone through with the municipality, and I don't take any offense to the two years that the parties have been trying to reach some sort of agreement. I don't want to get into the middle of it. I don't know what's been going on, but I guess what we wanted to see happen here, at least from our perspective, the way that we were able to get through the process was to take health care cost containment, take it over here, set it down and deal with that particular issue, separate from all the other negotiating processes out there, recognizing that ASEA is

currently in the contract negotiations. We've got some substantial problems out there; they do need to be addressed. I don't think anybody has two more years to be dealing through that process. The intent of my motion was to take the cost containment issues, put them on the table, and have the unions and the Administration sit down and go through those particular areas where they can agree on. Their conceptual agreement on the utilization review, which there are a lot of items on here that I think can be put together and be put together rather quickly and, of course, for the education process of the membership, and so on and so forth. I think you've got at least an avenue here to make something real positive come out of this process. I'm just real concerned that this task force will disband and the union will go one way, the Administration will go another way, and what have we accomplished here? No offense to either of the parties sitting here, but I think it was the intent of the motion was to assure and maybe some sort of report or something coming back to the task force as to what has been accomplished, either in a 15 or a 30-day or 60-day period of time so that [indisc.] is on both parties to come up with a project.

SENATOR DUNCAN: Michelle, do you concur, basically, with what Barbara is saying?

MICHELLE CASTANEDO: Yes, I want to make it clear that we do not want to take this out of the bargaining process. We want to make it a priority, we want to deal with this issue immediately, today, tomorrow, but we don't want to remove it from the table, but we are willing to put our entire focus on health care and resolving these issues of discussing cost containment immediately. And we are willing to come back in a time [indisc.] and report to this committee.

BARBARA HUFF: Maybe if I add too. The intent was not to remove it from the negotiating process but to put it as a very important separate item to be resolved immediately.

REPRESENTATIVE NAVARRE: I think what she is asking is that we make sure that we expedite this review and the savings that can be realized. She did leave one important factor out though, that while the Administration is going one way and the union is going another way, the legislature will go a different way.

BRUCE CUMMINGS: Well I think Barbara's points are real well taken as far as addressing it immediately, and I am particularly concerned with the correlation between this effort and the FY 90 budget process. So I don't know what sort of time line ought to be put on this amendment, but I [indisc.] we discuss [indisc.] left to the task force on at

least where the parties are and substantially there is only one set of negotiations going on at this time that deals with this issue -- that's a majority of employees where we don't have 12 different labor organizations actively negotiating this issue.

SENATOR DUNCAN: I agree that there should be a time limit but my thought, although Senator Kelly said he hoped the next meeting would be after the session over, it's my thought, unless it's going to be an impossibility, that we should have a report back on this particular cost containment item prior to that happening, prior to the legislature adjourning. It could be a very short meeting and then teleconference even it we had to.

MICHELLE CASTANEDO: I know that the state and ASEA have agreed to a negotiations schedule and I don't have that in front of me. I don't know -- I know we're meeting the rest of this week and I don't know beyond that when we're meeting. So it may be an impossibility to return with a report unless it fits in with the schedule that has been set forth. If not, then maybe we can meet, we can alter the schedule and meet, but at this point I couldn't say without looking at our schedule and talking to our negotiating committee.

BRUCE CUMMINGS: Mr. Chairman, I'd certainly permit that the state can make an appropriate schedule modification at this time so whatever we can work out with ASEA. I view this schedule as a plan, but like all plans it can be modified.

MICHELLE CASTANEDO: Be modified -- I agree.

KAREN PURDUE: I want to say that I think that this a positive step in the sense that these items here, for instance audits, are things that maybe can be easily dispensed with. There are certainly things that when we set out as a goal of this committee is to look at cost containment measures that wouldn't hit the pocket book of the employee and there are some things on here, I think, that are clearly in that category -- in fact, all of these are that way, so perhaps they would be quickly and easily dealt with.

MICHELLE CASTANEDO: Yeah, from the union's point of view, I don't see that any of these are going to take a whole lot of dialogue. I think we basically just need to agree that we agree that this is the way we are going to set forth implementing these, and I know that our parent union has adopted many of these cost containment measures all over the country, so it is not a new concept to them and they are agreeable.

REPRESENTATIVE BOYER: Is it anticipated that we would back out $6.5 million from the FY 90 budget -- that's the dollar amount that I think was tagged to these particular cost containment items, and if so, does that provide enough opportunity in FY 89 for those negotiations or agreements to take place so that you don't actually result in a short fund of the 100 line that results in layoffs.

SENATOR DUNCAN: I think that can be inferred, however, until there's agreement between the unions and the Executive Branch that all these can be done that made up the $6 million, you know. Those may not all happen, but from what I hear Michelle saying and what she said at the last meeting, as I recall, based on the initial presentation by Mr. Malek and the discussion with the unions, those first three or four items the health [indisc.], the precertification and whatever else was there didn't seem to be insurmountable cost containment [indisc.] -- that those were something that they could possible agree with. My understanding was that Aetna and Mr. Malek together had identified a possible $6 million reduction -- is that correct that those were put into effect?

JEFF MALEK: I think the next step is as you outlined here is to get a general accord as to how you want to proceed the fundamentals and the general design of it and then ask the providers of service, Aetna, and how it's going to be

done, what the actual impact would be on the premium. In the past they've run through all these gyrations of costing out this option and that option without having a clear grasp of what do you really want to do, and now with that then we can come back, or with them, can come back and give you a definitive number as to the impact.

SENATOR DUNCAN: Perhaps this motion could be worded such that we would ask the administration and ASEA to put together a schedule to talk about this, make that a priority, to get back to Chairman Kelly with that schedule. And when we get that, have a better means to schedule and review the results. Its pretty tough I guess, because you don't know your negotiating schedule for us to tell you to be back by May 8 or May 5 to have any assurance that that could be done.....But I think it is clear that it should be a priority. And that perhaps we could request that in the next day or two, you could work out that schedule for addressing these issues and get back to us. Would that be fair?

BRUCE CUMMINGS: Since the parties happen to be here this week, I presume that should not be difficult to talk to now. [indisc.] If I may in response to Rep. Boyer. Again correlating between what happens in negotiation with the budget, I would like to emphasize is what you see in all these areas are cost containment estimates. And we have

already received some information disputing the accuracy of the estimates. So I... You don't really know in one sense, what the effect will be until long after you have made the changes. That makes it difficult to budget predicated on those changes and certainly about what the actual affect would be. The legislature is going to have to do what it has to do and we'll try and respond for it.

KAREN PERDUE: But we are very clear that if we were attempting a utilization review, there would be substantial savings immediately. So, times' a wasting.

MICHELLE CASTANEDO: Yep. Let's move on with it. We have no problem putting a schedule together and getting back to Senator Kelly with that.

SENATOR DUNCAN: Perhaps we could ask to get back by the end of the w[illegible]k with that schedule, we could..(indisc.)

MICHELLE CASTANEDO: Do our best.

SENATOR DUNCAN: I think it is important to come to the process with

MICHELLE CASTANEDO: Sure.

SENATOR DUNCAN: Could you incorporate that into your motion, Barbara.

BARBARA HUFF: Sure.

SENATOR DUNCAN: I'm not sure you need to restate the whole thing. I guess just down at the bottom, where we're talking about is a priority issue, that we're asking ASEA and the administration to put together a schedule as to when they can address this. And inform the chairman by the end of the week, so that we can schedule another meeting.

REP. MIKE NAVARRE: Isn't there some administrative work that needs to be done by both the administration and by Aetna in order to implement some of this. So they ought to be involved in that discussion, I think.

SENATOR DUNCAN: I would assume the administration would. I think that is a very good point. Any other discussion on this motion.

KAREN PERDUE: Could I make one point. I've some questions on the hospital audit lines. By this, do you mean claim's audits, or would you infer in this, as a friendly amendment, audits provider services also. Was that your intent?

BRUCE CUMMINGS: And provider audits?

KAREN PERDUE: And provider audits. You mean excuse from the audit or the claim. [indisc] You didn't mean to only include hospitals in here.

BARBARA HUFF: No actually, I guess from our only personal experience, that has been one probably major substantial area, where we have found problems just in billing for things that were not utilized during the process or whatever.

KAREN PERDUE: We've certainly got our own mess to clean up to, but I just wondered.

MICHELLE CASTANEDO: Just for the record, these are just among the things we will discuss for cost containment. There could be others, this will not, this is not it. This isn't the beginning of, and the end. So,

SENATOR DUNCAN: This may be expanded.

MICHELLE CASTANEDO: This may very well be expanded.

SENATOR DUNCAN: So are we, I'm not sure, will we ever adopt this motion.

KAREN PERDUE: We haven't,

SENATOR DUNCAN: I don't think we have, is everyone comfortable, do they understand what the motion is. Would you request, Dave?

DAVE GRAY: If I can make a recommendation, if you want to have, it's kind of a written record, if you read that last sentence, the task force recommends the state and the respective unions address these immediately as a priority issue in an attempt to reduce cost and report back to the task force

SENATOR DUNCAN: Well, first yes, this is getting a little bit complicated, I'm not sure how we word it, but the first report back, the first request was that they work out a schedule to sit down and address these, and report back to the Chairman by the end of the week, what that schedule is. When they are going to be addressing these issues, because what the task force wants it as a priority. And then, based on that schedule, we can then determine when they, they can even make a recommendation how they think it would take them to come to resolving the issues and report back to the task force. On that basis [indisc] set the meeting. Where your open ended, but the problem is don't know when they can get together, I guess, basically. Bruce, do you have any other suggestion on that.

BRUCE CUMMINGS: No, of course, we, it's easier for us, we're here. I think at this point it's essential we shall [indisc] per principle on [indisc].

SENATOR DUNCAN: I think there's a clear understanding the bottom line is everybody has this as a priority, wants it to be addressed as quickly as possible and would like to report back to the task force as quickly as possible. If it could be done before the end of the legislative session, I think that would be most beneficial. If for some reason because schedules, etcetera, can't be, then that's understood also, but I think that the intent is that we try to get that report back as quickly as possible. Realizing the legislature is pretty busy in these last 15 days, 25 days or whatever it is, we wouldn't have a long meeting, but if we could get a report back, I think it would be worthwhile to have it.

BARBARA HUFF: Mr. Chair, just a, maybe a point of clarification here, the intent would not be that the parties would necessarily report with what they had already completed, but just a status report on how things were going. It's that basic.

SENATOR DUNCAN: If they've completed something, they can report back on that.

BARBARA HUFF: Well, that would even be more wonderful.

SENATOR DUNCAN: Well, that would be for you even more wonderful, right, I mean, I'm not prejudging, right, what they'll do, but whatever

BARBARA HUFF: It's a possibility.

SENATOR DUNCAN: Yea. Any other discussion on the motion.

REP. MIKE NAVARRE: Discussion with Barbara on notice to the employees on utilization of the Health Care plan.

SENATOR DUNCAN: I've think we've set, we've passed the motion. You did not object, right. [person unknown] No objection. That is taken care of.

Alaska State Legislature

SENATOR JIM DUNCAN

P. O. BOX V JUNEAU, ALASKA 99811-3100

(907) 465-4766

COMMITTEES:
FINANCE
VICE CHAIR – HEALTH EDUCATION & SOCIAL SERVICES
BUDGET & AUDIT
BANKING & ECONOMIC DEVELOPMENT

July 27, 1989

MEMORANDUM

To: Senator Kelly, Chair
Health Care Cost Containment
Task Force

Mr. Miles Collins, Procurement Officer
Legislative Affairs Agency

From: Senator Duncan, member
Mr. Bruce Cummings, member
Ms. Michelle Castanedo, member
RFP No. 143 review committee

Re: Rating of proposals offered to Request For Proposals No. 143.

On June 30, 1989 the Legislative Affairs Agency issued RFP No. 143 for procuring consultant services necessary for the work and objectives of the Health Care Cost Containment Task Force. In accordance with legislative procurement procedures, public notice of the request was advertised in the major cities of the state. At the July 26 deadline for submittal, three firms had presented proposals for the consulting services. They are Richard Block & Assoc./Milliman & Robertson, Arthur J. Gallagher & Co., and Mercer Meidinger Hansen Inc.

The review committee applied a uniform set of evaluation criteria to determine the relative merit of each proposal. These criteria were specified in the RFP and pertained to the experience of the firm, the experience of individuals assigned to the consultation, knowledge of current cost trends and containment or reduction measures applicable to the State's health care situation, the fee schedule and the Alaska company bonus.

Consolidation of the review committee members' independent rating of the three proposals has determined that Arthur J. Gallagher & Co. has submitted the superior proposal. We therefore recommend that Arthur J. Gallagher & Co. be selected as the most responsible and responsive offerer to RFP No. 143.

HEALTH CARE COST CONTAINMENT TASK FORCE----Consultant Proposal Rating

Consolidated score of three reviewers

BIDDER NAME	A EXPERIENCE OF FIRM Max. rating = 25	B EXPERIENCE OF INDIVIDUALS Max. rating = 30	C KNOWLEDGE OF WORK Max. rating = 30	D SCHEDULE OF FEES Max. rating = 10	E ALASKA OFFEROR 5	TOTALS
Richard Block/ Milliman & Robertson	rating = (i) clients (ii) scope of svcs (iii) depth of exp. (iv) effectiveness	rating = (i) clients (ii) scope of svcs (iii) depth of exp. (iv) effectiveness	rating =	rating =	rating =	171
Arthur Gallagher	rating = (i) clients (ii) scope of svcs (iii) depth of exp. (iv) effectiveness	rating = (i) clients (ii) scope of svcs (iii) depth of exp. (iv) effectiveness	rating =	rating =	rating =	240
Mercer, Meidinger, & Hansen	rating = (i) clients (ii) scope of svcs (iii) depth of exp. (iv) effectiveness	rating = (i) clients (ii) scope of svcs (iii) depth of exp. (iv) effectiveness	rating =	rating =	rating =	187

HEALTH CARE COST CONTAINMENT

TASK FORCE

AGENDA

August 1, 1989 meeting
1:30 p.m.

1. Selection of contractor for professional services pursuant to RFP No. 143.

2. Work calendar and agenda for late August meeting.

HEALTH CARE COST CONTAINMENT TASK FORCE

Membership

Sen. Tim Kelly, Chair
Alaska State Senate
Box V
Juneau, Ak. 99811
Phone: 465-3822

Sen. Jim Duncan
Alaska State Senate
Box V
Juneau, Ak. 99811
Phone: 465-4766

Michele Castanedo
Representative
Alaska State Employees Assoc.
240 Main St., Suite 200
Juneau, Ak. 99801
Phone: 463-4949

Bruce Cummings, Director
Division of Labor Relations
Dept. of Administration
Box C
Juneau, Ak. 99811
Phone: 465-4404

Don Hitchcock, Director
Division of Risk Management
Dept. of Administration
Box C
Juneau, Ak. 99811
Phone: 465-2180

Rep. Mike Navarre, V. Chair
House of Representatives
Box V
Juneau, Ak. 99811
Phone: 465-3779

Rep. Mark Boyer
House of Representatives
Box V
Juneau, Ak. 99811
Phone: 465-3466

Barbara Huff, President
Anchorage Municipal
Employees Assoc.
P.O. Box 100392
Anchorage, Ak. 99510
Phone: 269-4236

Greg O'Claray
Representative
MEBA
124 Front St.
Juneau, Ak. 99801
Phone: 586-6040

Karen Perdue
Dep. Commissioner
Dept. of Health &
Social Services
Box H
Juneau, Ak. 99811-0601
Phone: 465-3030

OFFICE OF THE PRESIDENT

MEMBER

TENTH ALASKA LEGISLATURE
ELEVENTH ALASKA LEGISLATURE
TWELFTH ALASKA LEGISLATURE
THIRTEENTH ALASKA LEGISLATURE
FOURTEENTH ALASKA LEGISLATURE
FIFTEENTH ALASKA LEGISLATURE
SIXTEENTH ALASKA LEGISLATURE

SENATOR TIM KELLY

P.O. BOX V
JUNEAU, ALASKA 99811
(907) 465-3822

P.O. BOX 210001
ANCHORAGE, ALASKA 99521
(907) 561-7612

August 1, 1989

MEMORANDUM

To: Representative Davis, Chair
Legislative Council

From: Senator Kelly, Chair
Health Care Cost Containment
Task Force

Re: Selection of consultant services pursuant to Request For Proposals No. 143.

On June 30, 1989 the Legislative Affairs Agency issued RFP No. 143 for procuring consultant services necessary for the work and objectives of the Health Care Cost Containment Task Force. In accordance with legislative procurement procedures, public notice of the request was advertised in the major cities of the state. At the July 26 deadline for submittal, three firms had presented proposals for the consulting services. They are Richard Block & Assoc./Milliman & Robertson, Arthur J. Gallagher & Co., and Mercer Meidinger Hansen Inc.

A proposal review subcommittee of the Task Force applied a uniform set of evaluation criteria to determine the relative merit of each proposal. These criteria were specified in the RFP and pertained to the experience of the firm, the experience of individuals assigned to the consultation, knowledge of current cost trends and containment or reduction measures applicable to the State's health care situation, the fee schedule and the Alaska company bonus. Consolidation of the review committee members' independent rating of the three proposals determined that Arthur J. Gallagher & Co. had submitted the superior proposal.

At the August 1 meeting of the Task Force, Arthur J. Gallagher & Co. was selected as the most responsible and responsive offerer to RFP No. 143. As chair of the Task Force, I am responsible for all expenditures of funds for this type of committee. Pursuant to legislative proceedures,

expenditures above $5,000 require Legislative Council approval. I therefore recommend that the Legislative Council approve a contract with Arthur J. Gallagher & Co. for professional services to the Task Force. The contract is not to exceed $75,000 for professional services rendered and $20,000 reimbursement for travel, lodging and other expenses approved by the project director.

HEALTH CARE COST CONTAINMENT TASK FORCE
Juneau, Alaska
January 4, 1990 -- 10:30 a.m.

MEMBERS PRESENT

Senator Tim Kelly
Senator Jim Duncan
Representative Mike Navarre
Representative Mark Boyer
Michelle Castanedo
Don Hitchcock
Greg O'Claray
Bruce Cummings
Barbara Huff

DRAFT

MEMBERS ABSENT

Karen Perdue

OTHERS PRESENT

Jeff Malek, Consultant to the Task Force,
Gallagher & Co.

Patrick McConnell, Bartlett Memorial Hospital, Juneau

Patrick Pechacek, Touche Ross & Co.

Mike Coughlin, Deputy Director,
Dividion of Retirement & Benefits, Department of
Administration

Lynn Withrow, AEtna Life Insurance Co.

Reid Stoops, representing AEtna, Juneau

Emmitt Wilson, representing Humana Hospital, Anchorage

Ray Gillespie, representing Charter North, Anchorage

Dr. Patricia Conners-Allen, representing Alaska Chiropractic
Society

Dave Gray, Senator Kelly's office

NARRATIVE (Because of a defective tape recording system, the following is reconstructed from notes taken by the recording secretary and Dave Gray, Senate Aide).

Senator Kelly called the meeting to order in the Senate Finance Committee room at 10:47 a.m. and called the roll of the Task Force members present. Jeff Malek was requested to begin his report to the Task Force.

Jeff Malek presented an overview of two states, Utah and Hawaii, that have pooled the health care coverage of all state and local government employees. The Utah health plan, established in 1977, covers over 70,000 state, county, city and school district employees, retirees and their dependents. Hawaii's plan was established in 1962 and pools 110,000 employees, retirees and their dependents of the same government catagories. Also presented were funding, coverage, and management features distinct to each plan (see written report).

Ensuing questions and discussion by Task Force members centered on the implications for the collective bargaining process of each states' multi-union representation and on premium cost comparisons. In the first case it was observed that Hawaii has only one school district whereas Alaska has fifty four, each with a set of one or more different collective bargaining units. Greg O'Claray said that at an earlier meeting it was thought that a pool could offer several levels of benefits so that there was the ability to pick and chose in various negotiations. Senator Duncan expressed the importance of collective bargaining and the need to have further knowledge and understanding on how it could be accommodated in a pool.

In the second case, the quoted $500 per employee per month premium cost of the Hawaii plan with 40% paid by the employees stimulated lengthy discussion. It was observed that to make a relative comparison with Alaska's current premium cost would require a side by side analysis of the two plans benefit structure and utilization. Senator Duncan said it would also require a relative comparison of the two areas' health care provider charge and fee structures. Jeff Malek said this will be done.

Jeff Malek proceeded with the second topic of the agenda, provider payment systems. In previous meetings there had been discussion of the diagnostic related group (DRG) payment system utilized by Medicare. The system pays physician charges in the 75th percentile of usual, reasonable and customary charges as opposed to the state plan which pays at the 95th percentile of UCR. The Medicare payment schedule can stimulate cost shifting to other public and private sector plans by individual hospitals in order to recover Medicare losses.

Medicare is changing from the DRG (hospitals only) system to a relative value system, called Resource Based Relative Value

Scale (RBRVS), that extends to all physician services. The new fee schedule will be determined by the product of the (1) the relative value for the service, (2) the conversion factor for the year, and (3) the geographic adjustment for the fee schedule area. The relative value for the service will be a combination of a work component, a practice expense component, and a malpractice component. No variation in conversion factors may be made on the basis of whether a physician is a specialist.

Jeff Malek said the most significant aspect of the new system is the possibility changing Medicare medical practice because of the new system's shift of economic incentives away from an invasive treatment bias. One study simulating the effects of RBRVS for the current volume and cost of Medicare projected a 56% increase of payments for evaluation and management services, a 42% decrease of payments for invasive procedures, a 30% decrease of payments for imaging services, and a 5% decrease for laboratory services.

Jeff Malek continued that the most important issue for the state would be what cost shifting effects will occur as a result of the reallocations imposed by the Medicare RBRVS. He said that a number of major insurers and states are considering adopting a relative value system approach to correlate to the new Medicare system.

Additional information on the state health plans' experience was presented in agenda item 3. The analysis included 1987 statistics with previous 1988 and 1989 information regarding inpatient and outpatient service expenditures, inpatient confinements in excess of $50,000, and range of expense reports. Also presented were listings of the top 20 inpatient facilities, top 20 outpatient facilities, and top 50 non-inpatient providers ranked by submitted expenses.

Patrick McConnell asked if this latter information could also be presented to reflect the nature and cost of a hospital's submitted expenses in comparison with the other listed facilities, such as expenses per case. Lynn Whithrow said this could be done.

Jeff Malek presented correspondence regarding difficulties of implementation for Vision Services Plan in Juneau and their resolution.

David Gray presented an outline for the Task Force report to the legislature, due on January 31. The outline structured

the Task Force's activities and considerations into a short term, mid term, and long term format. Gray observed that while there is much achievement to be reported, many of the long term solutions being investigated are partially complete and lack sufficiency for hard and confident recommendations. There was discussion on finishing the work of the Task Force by January 31 on progress to date versus extending the life of the Task Force. With the latter, discussion focussed on the value of completion of work in progress and additional opportunities to achieve cost containment.

Senator Duncan moved that the Task Force recommend an extention of the deadline for completion of its work to February 15, 1991. The motion was approved without objection.

Senator Duncan moved that the Task Force contract with David Gray to provide executive director services during the extended time period. The motion was approved without objection.

Senator Kelly asked David Gray to research actions pending before Congress that would affect Medicare/Medicaid payment schedules and other financial obligations of the state and report to the Task Force members.

It was agreed that the next meeting of the Task Force will be on Monday, January 29. The meeting is for the review of the draft report to the legislature. The draft will be sent to members by January 25.

Senator Kelly adjourned the meeting at 12:16 p.m.

HEALTH CARE COST CONTAINMENT TASK FORCE
January 29, 1990
1:05 p.m.

DRAFT

MEMBERS PRESENT

Senator Tim Kelly, Chairman
Alaska State Senate
P.O. Box V
Juneau, Alaska 99811
(907) 465-3822

Representative Mike Navarre, Vice-Chairman
Alaska House of Representatives
P.O. Box V
Juneau, Alaska 99811
(907) 465-3779

Senator Jim Duncan
Alaska State Senate
P.O. Box V
Juneau, Alaska 99811
(907) 465-4766

Representative Mark Boyer
Alaska House of Representatives
P.O. Box V
Juneau, Alaska 99811
(907) 465-3466

Bruce Cummings, Director
Division of Labor Relations
Department of Administration
P.O. Box C
Juneau, Alaska 99811
(907) 465-4404

George Masten, Representative
Alaska State Employees Association
3601 "C" Street
Anchorage, Alaska 99801
(907) 463-4949

Don Hitchcock, Director
Division of Risk Management
Department of Administration
P.O. Box C
Juneau, Alaska 99811
(907) 465-2180

Barbara Huff, President
Anchorage Municipal Employees Assoc.
P.O. Box 100392

Anchorage, Alaska 99510
(907) 269-4236

Greg O'Claray, Representative
Marine Engineers Beneficial Assoc.
124 Front Street
Juneau, Alaska 99801
(907) 586-6040

MEMBERS ABSENT

Karen Purdue, Deputy Commissioner
Department of Health
& Social Services
P.O. Box H
Juneau, Alaska 99811-0601
(907) 465-3030

OTHERS PRESENT

Jeff Malek
Gallagher Company
Consultant to the Task Force

Dave Gray, Senate Aide
Juneau, Alaska

ACTION NARRATIVE
TAPE 1, SIDE 1
Number 001

Senator Kelly called the Health Cost Containment Task Force to order at 12:30 p.m., and called the roll. He announced the task force would be addressing a report by Jeff Malek, Consultant to the task force, dated January 29, 1990.

Mr. Malek came before the committee members to address the report. He referred to Section 1, "Alternate Funding Arrangements" and said some of the arrangements that could be selected to meet state needs would be premium delay, minimum premium, self insurance employ. Mr. Malek explained that the state pays a set premium rate each month to AETNA for protection against all risks. He continued to

explain that AETNA reviews and pays the claims, and provides administrative services with the premiums. The state's plan is an experienced rated plan whereby, good or bad financial experience of a given year will affect the rating for the next year. He noted at the termination of the contract with AETNA, AETNA has the right to apply any deficit or surplus against deficit. He noted that in the back of Section 1, there are charts that illustrate how the funding mechanisms work. Mr. Malek continued to describe the charts.

Number 272

Mr. Malek explained page 7 of the report is a graph which illustrates the option of doing a minimum premium where the state would hold the reserves. The state holds the margin and reserves, pays the claims as they are presented, and pays purely the expenses.

Mr. Malek said page 8 addresses self-funding or self-insurance. He said there is a common misconception that self-funding means that the state takes all the risk. Most plans have some reinsurance or risk shifting at some point. If claims exceed a predetermined level, that risk would be shifted to a carrier. He noted there are two ways of self-funding or self-insuring. One is to completely self-fund and the other is self-funded with reinsurance.

Mr. Malek continued to explain the benefits of self-funding. He said pooling is a vehicle which allows the state to fund benefits in any way such as fully insured, partially insured, etc.

Number 314

Mr. Cummings discussed the suggestion of by self-funding, Alaska would be exempt from their own laws on mandatory coverage. Mr. Malek said there are many clients that have self-funded plans and declare themselves exempt from state mandated coverage laws. He noted there are self-funded plans that do follow state regulations.

Mr. Malek referred to funding arrangements and said the cash that would either be held in the reserves or for claims to be paid in the future, should be set aside in a separate account or trust and be accountable so that the money is there to pay benefits when they are due.

Mr. Malek continued to explain several charts in his report in relation to premiums, charges and interest credits from AETNA.

Mr. Masten referred to fully insured plans and said if the contract was terminated and if there was a run-out and

money left over in that reserve, would it still come back. Mr. Malek indicated it would.

Mr. Malek referred to reserves and said they are set aside in a separate fund. A deficit is created by more claims in administration expense versus premium intake. This year, there was more premium intake than claims and expenses, and that created a the surplus which allowed for a no rate increase on February 1. He discussed the processes followed in the past.

Greg O'Claray asked what the performance in investments has been with the general fund in terms of percentage of interest over the last year. Senator Kelly said this would be looked into.

Number 570

Mr. Malek explained Section 2 deals with State Employees Health Benefit Plans. He informed the members that some of the pacific region health plans are listed as to how many participants there are, who pays what part of the cost, and approximately the cost. Mr. Malek noted the data was compiled with figures from a national survey. It is very difficult to have 100 percent accuracy as many states have many plans. In 1989, rising costs of health plans were slightly over 20 percent. Mr. Malek said Section 2

discusses what portions of the state plan the employees pay. He said twenty-nine of fifty states currently pay 100 percent of the cost for employee coverage. Twelve out of fifty states pay the full cost for employees and their dependents. Mr. O'Claray asked Mr. Malek if he is discussing the premium dollar cost or the benefit level. Mr. Malek said it is the premium cost. Mr. Malek continued to discuss the coverage of health care in the U.S.

Number 623

Mr. Malek informed the members exhibit 8 outlines the number of employees covered by a plan. There was discussion regarding HMO's.

Exhibit 9 outlines the total cost paid by the employees in the state. He discussed a sample comparison between Alaska, California, Hawaii, Oregon and Washington. He said the California and the Hawaii plan asks for contributions from their employees on employee and family coverage.

Mr. Malek noted at the last meeting of Health Cost Containment Task Force he incorrectly reported the premium rate of Hawaii. The composite rate was added twice. Instead of it being $500 per month it is approximately $250 per month.

Number 676

Senator Kelly asked Mr. Malek how he accounts for the tremendous increases in rates in Alaska. Mr. Malek said the cost has been rising at 20 percent for the last five years. He said there has been no restrictions on utilization which has been changed through cost containment. He said it if medical costs are rising at 20 percent, premiums will rise at least 20 percent.

Number 720

Mr. Malek referred to Section 3, "Mandated Group Health Insurance Coverage," and said it is important to understand that whenever laws are passed to mandate a benefit or health coverage, you must look at what the end result or end cost is to all parties. The argument against mandated health insurance benefits is that mandating will increase insurance costs unnecessarily. He continued to discuss the subject of mandated coverage. Mr. Malek noted that since 1983, Alaska has enacted eleven coverages and changes.

Number 827

Mr. Malek said Section 4 is titled "Pooling." He referred to Hawaii and how they deal with their unions. Approximately 90 percent of their active employees are

covered by bargaining units. He said a standard level of benefits is provided for all entities which allows the negotiators of labor and management to set what portion the state will pay. Mr. Malek continued to discuss the pooling concepts and administrative costs of Hawaii, and Utah.

TAPE 1, SIDE 2

Number 040

Mr. Malek explained states that have implemented pooling are saving considerable dollars through plan design and wellness programs. Cost containment provisions have been implemented that are similar to Alaska's provisions. He said Utah has a three phase wellness plan which includes screening, education and assistance. Mr. Malek said the report includes a description of Utah's Flexplan and a copy of their wellness plan which are long-term cost saving techniques. He continued to discuss Utah's insurance plan and the savings compared to Alaska's.

Number 368

Representative Navarre referred to the state paying a lot of money for medical costs in different areas of the state and as a result, medical companies and providers are enticed to come to Alaska. Once the companies come to Alaska, it drives a bigger demand on state dollars in order

to fund the provider costs. Mr. Malek agreed with Representative Navarre. He said what is confusing with pooling is you may not build a internal organization to pay the claims. AETNA or another firm may be hired to do it. He said a vehicle is needed to pull all the pieces together to collect the premiums that distribute benefits.

Senator Kelly stated he isn't convinced that the savings are real savings as he would perceive this working politically within the State of Alaska. If a perfect plan could be written, take the plan out of the public process and have solid control, it could work. It would depend on how the pooling plan is put together.

Mr. Malek referred to taking the plan outside of state run entities and said the legislature needs to set up an entity and, currently, there isn't a mechanism to do that. There was continued discussion regarding possible problems and advantages which may be encountered in implementing a pooling plan.

Number 532

At 1:45 p.m. Senator Kelly recessed the Health Cost Containment Task Force meeting. He noted the meeting would be called back to order at 4:30 p.m.

Senator Kelly called the Health Cost Containment Task Force meeting back to order at 4:38 p.m., January 29, 1990.

Mr. Malek explained to the members that pooling is a concept, it is multi faceted, and can become very confusing. Several of the ideas that have been discussed in the past regarding the authority that may be created by SB 254, introduced by Senator Duncan, may be the beginning step and would work towards a Hawaii or Utah based plan. He stated that until Alaska starts to become a buying group and works as a cohesive group in order to purchase health care at discounted rate, health care will continue to escalate beyond what the cost of inflation is for components. Therefore, if the authority provides a vehicle or mechanism for all the state entities to become a buying group, it would give the people in the authority to work with one payment schedule. If authority works on negotiating a set rate with doctors, hospitals and providers, the authority could then provide, to its members, the published rates of payment. Mr. Malek said the idea is to get appropriate care and appropriate utilization at an appropriate price. Mr. Malek noted SB 254 doesn't have the ability to hire staff. There was continued discussion between Mr. Malek and Senator Duncan in relation to SB 254.

Number 757

Mr. Malek discussed Section 5 of his report titled "Cost Shifting." He said Medicare is having the same problem that Alaska has in relation to rising costs. Medicare is under budget constraints to start looking at ways to reduce the cost. He said under SB 254, the authority could utilize a physician payment schedule which is a way to determine appropriate reasonable costs for specific areas. Mr. Malek said the reason Medicare did this, is their physician charges were raising 16 to 17 percent per year. He informed the members Medicare is going to build a uniform national fee schedule for each of the 7,000 types of physician services. The fee schedule will be phased in 1992, and will be portable to be used by other entities. He explained the schedule will prevent physicians from back-billing the patients more than 15 percent. He also informed the task force members that if the state doesn't get on to something similar, Alaska will get cost sifted from Medicare. Mr. Malek noted the fee schedule has been endorsed by the American Medical Association.

Mr. Malek referred to the "Attachments" section of the report and said there are several briefs on the bill, how it is designed, and how it will be phased in.

Number 829

Dave Gray, Senate Aide, came before the task force to discuss the Health Care Cost Containment Task Force Report to the Legislature. Mr. Gray explained the report is presented in three different phases. He said the task forces intention was the accomplishment of finding a premium tax refund as as well as getting money back from the extended liability reserve refund of about $1.8 million in the first case and $2.4 million in the second case. He referred to the premium tax and said there would active and retirees separation so the money coming back to the general fund was in the neighborhood of $3.5 million. The task force took on a mid range effort which was the task force's recommendations on health care cost containment items that didn't interfere with collective bargaining prerogatives. Mr. Gray said there was a request of the task force that they begin an enrollment process for both active and retired employees with provisions recommended by the task force and cost containment provisions that were negotiated with the ASEA contract. This accomplished savings of approximately $600 thousand per month or approximately $7 million per year. It was also recommended there be an audit of the AETNA claims operation.

TAPE 2, SIDE 1

025

Mr. Gray referred to the retiree's program and said the task force requested an attorney general's opinion as to which areas of cost containment can be applied to the program. He said reenrollment has also been recommended to determine who is actually on the plan.

Mr. Gray explained as a result of the cost containment items implemented and other experience of the health plans, new rates have been established for active and retired employees. For active employees it is $385 per employee, per month, and for retired employees the cost is $244 per month. Mr. Gray discussed some of the long-range items, apart from the health plan, that the task force has been reviewing to help reduce or contain medical inflationary rates.

Mr. Gray said with negotiated purchasing groups, approximately 15 to 40 percent can be saved. Senator Kelly noted his concern that those figures are a little optimistic. He asked if any of the members would object to changing the figures to 5 to 20 percent. There weren't any objections.

Number 221

Mr. Gray referred to the long-range section of the report and said some people feel wellness programs and tap harley

trust arrangements for managing health plans should be included. There was continued discussion between Senator Kelly and Mr. O'Claray regarding the trust arrangements.

Senator Kelly said the task force would be asking for an extension and the report would be put in its final version and submitted to the legislature on January 31, 1990.

Mr. Gray explained information pertaining to the estimates of active and retired employees within the different groups such as state employees, local government employees, school employees, Medicaid/Medicare eligible people, etc. He informed the task force members there are approximately 80,000 members and noted the figures will be more accurate when the enrollment is completed. There was discussion regarding this matter.

The task force members continued to discuss health insurance provisions that were implemented on December 1, 1989. Mr. Cummings noted the provisions implemented were a combination of recommendations from the task force and different items negotiated at the bargaining table.

Number 512

Senator Kelly adjourned the Health Cost Containment Task Force meeting at 5:28 p.m.

OFFICE OF THE PRESIDENT

MEMBER

TENTH ALASKA LEGISLATURE
ELEVENTH ALASKA LEGISLATURE
TWELFTH ALASKA LEGISLATURE
THIRTEENTH ALASKA LEGISLATURE
FOURTEENTH ALASKA LEGISLATURE
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SENATOR TIM KELLY

P.O. BOX V
JUNEAU, ALASKA 99811
(907) 465-3822

P.O. BOX 210001
ANCHORAGE, ALASKA 99521
(907) 561-7612

January 15, 1990

MEMORANDUM

To: All Members
Health Care Cost Containment
Task Force

From: Senator Kelly, Chair

Re: Task Force meeting on January 29, 1990.

The next meeting for the Task Force is scheduled for Monday, January 29, 1990 at 12:00 a.m., noon, in the Senate Finance Committee room. This meeting is the review and revision of a draft Task Force report to the legislature. The report should be in the members possession by January 25.

Attached with this announcement are minutes of the January 4 meeting, addenda that accompany Jeff Malek's January 4 report, and an analysis of recent federal actions that pertain to the Medicare/Medicaid program.

MEMORANDUM January 16, 1990

To: All Members
Health Care Cost Containment
Task Force

From: Dave Gray
Senate Aide

Re: Federal legislation that affects Medicare/Medicaid payment schedules.

At the January 4 meeting, Senator Kelly requested a status report on pending federal legislation or recent enactments that either affect the Medicaid/Medicare payment system and/or impose new costs and responsibilities upon the state governments.

In the waning howrs of this last session of Congress, substantial changes to the Medicaid/Medicare system were incorporated in the Omnibus Budget Reconciliation Act (OBRA 89). It is difficult to report with certainty all the ramifications. At the present time, Congressional staff, federal agencies, and Alaska's Department of Health & Social Services are still sorting through and analysing provisions of the act. However, there are several features readily apparent:

(1) A relative value payment schedule (RBRVS) is mandated for Medicare for 1992. Studies to determine geographic area adjustment factors and volume statistics for the schedule will commence this year.

(2) The state is obligated to an expanded coverage of pregnant women and children up to six year of age.

(3) The state is obligated for certain nursing training costs as well as making up the difference of reduced Medicaid expenditures for certain programs and services mandated in the Nursing Home Reform provisions of OBRA 87.

The initial estimates of fiscal impact to the state for the latter two are $7,000,000 and $1,400.000, respectively.

I have attached several publications that partially report on OBRA 89. Some have inaccuracies, but they should sense of the extent and complexity of the changes (there are 107 sections in the bill relating to Medicaid and Medicare).

HEALTH CARE COST CONTAINMENT TASK FORCE
Juneau, Alaska
January 4, 1990 -- 10:30 a.m.

MEMBERS PRESENT

Senator Tim Kelly
Senator Jim Duncan
Representative Mike Navarre
Representative Mark Boyer
Michelle Castanedo
Don Hitchcock
Greg O'Claray
Bruce Cummings
Barbara Huff

DRAFT

MEMBERS ABSENT

Karen Perdue

OTHERS PRESENT

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Patrick Pechacek, Touche Ross & Co.

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Ray Gillespie, representing Charter North, Anchorage

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Jeff Malek proceeded with the second topic of the agenda, provider payment systems. In previous meetings there had been discussion of the diagnostic related group (DRG) payment system utilized by Medicare. The system pays physician charges in the 75th percentile of usual, reasonable and customary charges as opposed to the state plan which pays at the 95th percentile of UCR. The Medicare payment schedule can stimulate cost shifting to other public and private sector plans by individual hospitals in order to recover Medicare losses.

Medicare is changing from the DRG (hospitals only) system to a relative value system, called Resource Based Relative Value

Scale (RBRVS), that extends to all physician services. The new fee schedule will be determined by the product of the (1) the relative value for the service, (2) the conversion factor for the year, and (3) the geographic adjustment for the fee schedule area. The relative value for the service will be a combination of a work component, a practice expense component, and a malpractice component. No variation in conversion factors may be made on the basis of whether a physician is a specialist.

Jeff Malek said the most significant aspect of the new system is the possibility changing Medicare medical practice because of the new system's shift of economic incentives away from an invasive treatment bias. One study simulating the effects of RBRVS for the current volume and cost of Medicare projected a 56% increase of payments for evaluation and management services, a 42% decrease of payments for invasive procedures, a 30% decrease of payments for imaging services, and a 5% decrease for laboratory services.

Jeff Malek continued that the most important issue for the state would be what cost shifting effects will occur as a result of the reallocations imposed by the Medicare RBRVS. He said that a number of major insurers and states are considering adopting a relative value system approach to correlate to the new Medicare system.

Additional information on the state health plans' experience was presented in agenda item 3. The analysis included 1987 statistics with previous 1988 and 1989 information regarding inpatient and outpatient service expenditures, inpatient confinements in excess of $50,000, and range of expense reports. Also presented were listings of the top 20 inpatient facilities, top 20 outpatient facilities, and top 50 non-inpatient providers ranked by submitted expenses.

Patrick McConnell asked if this latter information could also be presented to reflect the nature and cost of a hospital's submitted expenses in comparison with the other listed facilities, such as expenses per case. Lynn Whithrow said this could be done.

Jeff Malek presented correspondence regarding difficulties of implementation for Vision Services Plan in Juneau and their resolution.

David Gray presented an outline for the Task Force report to the legislature, due on January 31. The outline structured

the Task Force's activities and considerations into a short term, mid term, and long term format. Gray observed that while there is much achievement to be reported, many of the long term solutions being investigated are partially complete and lack sufficiency for hard and confident recommendations. There was discussion on finishing the work of the Task Force by January 31 on progress to date versus extending the life of the Task Force. With the latter, discussion focussed on the value of completion of work in progress and additional opportunities to achieve cost containment.

Senator Duncan moved that the Task Force recommend an extention of the deadline for completion of its work to February 15, 1991. The motion was approved without objection.

Senator Duncan moved that the Task Force contract with David Gray to provide executive director services during the extended time period. The motion was approved without objection.

Senator Kelly asked David Gray to research actions pending before Congress that would affect Medicare/Medicaid payment schedules and other financial obligations of the state and report to the Task Force members.

It was agreed that the next meeting of the Task Force will be on Monday, January 29. The meeting is for the review of the draft report to the legislature. The draft will be sent to members by January 25.

Senator Kelly adjourned the meeting at 12:16 p.m.

89 - FY1

National Conference of State Legislatures

William T. Pound Executive Director

444 North Capitol Street, N.W. Washington, D.C. 20001 (202) 624-5400

INFORMATION ALERT

November 29, 1989

MEDICAID EXPANSIONS

Reconciliation legislation sent to the President contains Medicaid expansions that will affect states during the 1990 fiscal year and thereafter. The major changes enacted by Congress in H.R. 3299 include:

* mandating states to provide Medicaid coverage to pregnant women, infants and children up to age 6 who are in families with incomes up to 133% of the federal poverty level ($13,380 for a family of three). Effective April 1, 1990, this mandate will then supercede similar, but less broad, expansions enacted as a result of the Medicare Catastrophic Coverage Act of 1988. This new mandate is estimated to cost states $110 million in FY 90.

* requiring states to provide coverage to correct physical and mental problems identified through EPSDT screenings. This mandate is estimated to cost states $20 million in FY 90.

* requiring states to include ambulatory services provided by federally-qualified health centers in their Medicaid benefit packages and to pay 100% of reasonable costs for these services. This mandate will cost states $8 million in FY 90.

* requiring states to cover services of certified pediatric or family nurse practitioners regardless of supervisory or association status with physicians (effective 7-1-90).

* requiring states to coordinate Medicaid and WIC programs, including notification of pregnant women and children under age 5, who are Medicaid eligible, regarding the availability of WIC benefits.

* codifying current regulatory requirements that stipulate that provider payments must be sufficient to insure that services will be made available to the Medicare population to the same extent that they are available to the general population.

* providing $30 million in federal demonstration grant money for states, divided equally over the next three fiscal years. The demonstration projects must test alternative ways of providing health coverage to pregnant women and children under age 20 who are in families with incomes under 185% of the federal poverty level. Alternatives that could qualify might include HMO enrollment, state basic health plans for the uninsured and private employer-group insurance.

Congress also repealed all of the Medicare Catastrophic Coverage Act of 1988 except for Medicaid buy-in, spousal impoverishment and Medicaid expansion provisions for pregnant women and infants. Perhaps of even greater importance to states, catastrophic care repeal effectively cancels state Medicaid savings anticipated by having expanded skilled nursing and other services covered by Medicare.

For more information, contact Jan Trettner at (202) 624-8689.

"Information Alert" is a publication of the NCSL Office of State-Federal Relations that provides up-to-date information on issues under consideration

MCDERMOTT, WILL & EMERY

HEALTH LAW UPDATE

Vol. 6, No. 24 November 30, 1989

FINAL BUDGET RECONCILIATION LEGISLATION -- IMPACT ON PHYSICIANS AND OTHER PART B SUPPLIERS

In a frantic burst of activity before Thanksgiving, Congress reached agreement on deficit reduction legislation for fiscal year 1990. The legislation makes many important changes to the Medicare program. The following is a summary of the provisions of the bill that are likely to be of greatest interest to physicians and other suppliers of services under Part B of Medicare. Other Updates discuss those provisions of the bill which primarily affect hospitals and HMOs, the final language of the physician self-referral amendments, and the key Medicaid provisions of the legislation.

- Gramm-Rudman Sequestration. The automatic 2.1% reduction in Part B payments, which was implemented when Congress failed to pass a deficit reduction bill by the deadline set under the Gramm-Rudman law, will be continued through March 31, 1990.

- Physician Payment Reform. The bill includes a three-part package that makes very significant changes in the way Medicare will pay for physicians' services.

  - National Fee Schedule. The bill instructs the Health Care Financing Administration (HCFA) to replace the current methodology for paying physicians under Medicare with a fee schedule based on a resource-based relative value scale (RVS), which attempts to quantify the relative work associated with particular services. The scale will be adjusted to reflect local variations in practice costs, including malpractice insurance expenses, as well as the opportunity costs involved in training for a particular specialty. The new system will be phased in over a period of several years, beginning January 1, 1992. The new payment methodology will result in increases in fees for most primary care and other so-called "cognitive" services, and reductions in fees for surgery and other procedural services. Because the new system will reduce the existing disparities in fees across geographic areas, physicians in rural areas and most smaller cities will generally benefit relative to physicians in areas where fees are currently substantially higher than the national average.

•• Limits on Balance Billing. Nonparticipating physicians or their patients will continue to receive from Medicare only 95% of the amounts paid to participating physicians. In addition, the amount that nonparticipating physicians may charge will be limited. In general, the limit will be 125% of the Medicare-allowed amount during 1991, 120% during 1992, and 115% thereafter. The maximum allowable actual charge (MAAC) limits will be repealed as of December 31, 1991.

•• Volume Performance Standards. The bill mandates the establishment of "volume performance standards" for Medicare payments for physicians' services. The standards will be set each year based on the previous year's expenditures, adjusted for inflation and changes in population and technology. Evidence of inappropriate utilization will also be taken into account. Carriers will be required to monitor physicians' billing patterns and to inform physicians whose utilization patterns vary significantly from other physicians in the area. If actual aggregate expenditures exceed the applicable standard, fee increases for subsequent years will be reduced, unless Congress intervenes.

• Interim Reductions. Beginning April 1, 1990, payment levels will be reduced for so-called "overvalued" procedures, i.e., any procedure whose current payment level exceeds by at least 10% the amount that will be paid for the procedure under the new fee schedule to be implemented in 1992. Payments for such procedures will be reduced by one-third of the difference between current rates and the new payment level, with a maximum reduction of 15%. Among the approximately 35 procedures (representing about 240 CPT codes) that will likely be subject to these reductions are hip replacement, arthroscopic knee surgery, insertion of a pacemaker, coronary artery bypass graft, appendectomy, removal of gallbladder, hernia repair, cystoscopy, transurethral resection of the prostate, hysterectomy, dilation and curettage, carpal tunnel repair, cataract extraction, and retinal repair.

• Radiology Reimbursement. Payments for radiology services will be reduced by an across-the-board 4%, beginning April 1, 1990. The existing radiology fee schedule will continue to be used as the basis of payment for radiology services. Physicians who specialize in nuclear medicine will be paid for the period April 1, 1990 through December 31, 1991 based on a formula that combines the 1988 payment methodology with the radiology fee schedule.

• Anesthesia Reimbursement. Effective April 1, 1990, anesthesiologists and certified registered nurse anesthetists will no longer be permitted to "round up" the number of time units to the next whole number; claims will have to be submitted using fractional time units. The existing anesthesia fee schedule will continue to be used as the basis of payment for anesthesia services.

• Medicare Economic Index Update. There will be no increase in Medicare prevailing charges until April 1, 1990. At that time, prevailing charges for primary care services will be increased by approximately 5.3% above 1989 levels, while prevailing charges for other services will be increased by 2.0%. No increase will be given in 1990 for charges for "overvalued" procedures, or for radiology or anesthesiology services.

• Outcomes Research. The bill authorizes the establishment of a new agency within the Public Health Service, to be known as the Agency for Health Care Policy and Research, to promote research evaluating the usefulness, effectiveness, and appropriateness of specific procedures and methods of treatment, and to convey the findings to individual practitioners. The new agency will also be given substantial responsibility for evaluating new health care technologies and for developing guidelines for the diagnosis and treatment of particular conditions. The legislation authorizes the expenditure of several hundred million dollars to fund the agency's activities.

• Pap Smears. Effective July 1, 1990, Medicare will cover screening pap smears. They may be furnished once every three years, or more frequently for women who are at high risk of developing cervical cancer.

• Payments to Clinical Laboratories. Effective January 1, 1990, payments for a clinical laboratory service may not exceed 93% of the national median fee for that service. On January 1, 1990, all fee schedules will be increased by the 1989 increase in the consumer price index.

• Mental Health Services. The annual cap on Medicare payments for mental health services will be lifted. Effective July 1, 1990, clinical psychologists and social workers will become fully eligible for direct payment from Medicare, subject to certain restrictions.

• Durable Medical Equipment. There will be no increase in payment rates during 1990. Payments for seat lift chairs and transcutaneous electrical nerve stimulation devices will be reduced by 15%, effective April 1, 1990. Motorized wheelchairs will be paid under the rules applicable to

"routinely purchased" items. Payment for rentals of equipment used for enteral or parenteral feeding will be limited to 15 months.

• End Stage Renal Disease Program. The composite rate under Method I will be maintained at current levels through September 30, 1990. Effective February 1, 1990, payments under Method II may not exceed the composite rate for hospital-based facilities; an additional 30% will be permitted for continuous cycling peritoneal dialysis.

If you have any questions or would like further information about these provisions, please contact any of the following McDermott, Will & Emery attorneys:

Michael L. Blau	Boston	617/345-5010
James M. Gaynor, Jr.	Chicago	312/984-7546
Kathleen H. Drummy	Los Angeles	213/551-9321
Michael A. Romansky	Washington	202/778-8069

McDermott, Will & Emery

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American Medical
NEWS
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DECEMBER 1, 1989

INSIDE

Conferees approve RBRVS, say no to expenditure targets

By Sharon McIlrath
AMN STAFF

WASHINGTON — After a harrowing 60 hours, a package of sweeping changes in Medicare's MD payment system appeared to be off the critical list at press time Nov. 20 and on its way to passage as part of a 1990 budget bill.

The package, which uses a resource-based relative value scale (RBRV3) as its foundation, would begin a five-year phase-in of a new Medicare fee schedule in 1992. Balance billing by non-participating MDs would be limited to 115% of the fee schedule amount. But the plan does not include the controversial expenditure targets that Rep. Fortney "Pete" Stark (D, Calif.) and the Bush Administration had insisted be a part of any payment reform.

Stitched together by conferees from the three congressional Medicare committees, the reform package is attached to a budget proposal for fiscal year 1990 that calls for about $1 billion in MD payment curbs. Only three days earlier, reform had been declared dead for the year, and its resuscitation reportedly came only after the House leadership forced Stark to compromise.

Congress was about to consider a plan to:
- Freeze MD fees and continue an automatic 2% payment reduction until April 1, 1990.
- Slice radiology, anesthesiology, and 'overpriced procedures' after that date.
- Raise fees for primary care by 5.3% and fees for all other services by 2% on April 1.
- Increase hospital rates by 3.75% in suburban areas and 8.5% in rural communities.
- Prohibit self-referrals to clinical labs.

THE OUTCOME thus was seen as a victory for the American Medical Association and primary care medical specialties, who had pulled out all the stops to bring about the survival of an RBRVS and the amputation of expenditure targets. But Stark and White House budgeteers are said to be "furious" at the setback, and the

*See **RBRVS**, page 30*

Calls for regulation, ads, education

Broad anti-smoking package introduced

By Laurie Jones
AMN STAFF

WASHINGTON — For the

- Tobacco-belt town restricts smoking. Page 2
- Does commercial violate

Rep. Henry Waxman
Would have preferred expansions in Medicaid.

RBRVS

Continued from facing page

expected to reduce the spending that Medicare would have incurred in 1990 under current law by at least $2.7 billion, as agreed to in a budget blueprint adopted earlier this year.

Final numbers and details weren't clear at press time, but a plan adopted by the conferees apparently would achieve more than $1 billion of the savings through curbs on physician payments. The remainder would come from holding down hospital rates and making significant reductions in payments for some durable medical equipment.

LAWMAKERS also are claiming significant savings from a proposal that would extend a requirement (set to expire in 1990) that Part B premiums be set at a level equal to 25% of program costs. But the administration recently announced a higher premium for next year based on the assumption that the 25% requirement will expire, so the savings from this provision appear illusory.

Despite the Senate's vow to limit their reconciliation package to items with clear savings attached, the conferees also attached some non-savers to the measure. Two that would have little or no impact on spending would delay a ban on physician incentive payments in HMOs until April 1991 and prohibit physicians from referring patients to clinical labs in which they had a financial interest.

In addition, the measure contains several items that will boost Medicare costs next year, including coverage for Pap smears and for clinical psychologists and social workers and the elimination of the current $1,375 cap on outpatient mental health services. Conferees rejected expanded Medicaid benefits for pregnant women and children, however, thereby risking the wrath of Rep. Henry Waxman (D, Calif.), and perhaps the outcome of their package.

IN GENERAL the lawmakers have little disagreement on the types of cuts they will make in Part B. But at press time there was still a remote possibility that conferees would go back and look for stiffer MD pay curbs to make room for the Medicaid expansions Waxman so desperately wants.

As tentatively agreed to, however, the MD provisions would continue current payment rates for all services until April 1, 1990. This means that a 5.3% fee update scheduled for Jan. 1 would not take place. But a cut of 2% on each Medicare claim that has been applied since Oct. 17 would continue until the freeze was lifted in April.

The 2% cut was required after Congress failed to meet a deadline for enacting legislation to meet 1990 deficit reduction targets. Nearly all other federal programs also had funds "sequestered," but physicians are being subjected to special treatment because cuts in most other programs would end with the enactment of a final budget bill. For hospitals, the sequester would end Dec. 31.

EVEN AFTER the freeze and sequester are lifted, only primary care visits would receive the full 5.3% update that was to occur in January. Prevailing charge limits for most other services would rise by 2%. But charges for anesthesiology, radiology, and about 30 "overvalued" procedures would be held at the 1989 level and then subjected to further cuts.

In anesthesiology, the cuts would be achieved by substituting for the current method, which is based on 15-minute time segments, one of payments based on actual time. An update in the radiology fee schedule would be held to somewhere between 2% and 4%, depending on how much savings was still needed to meet the $2.7 billion target.

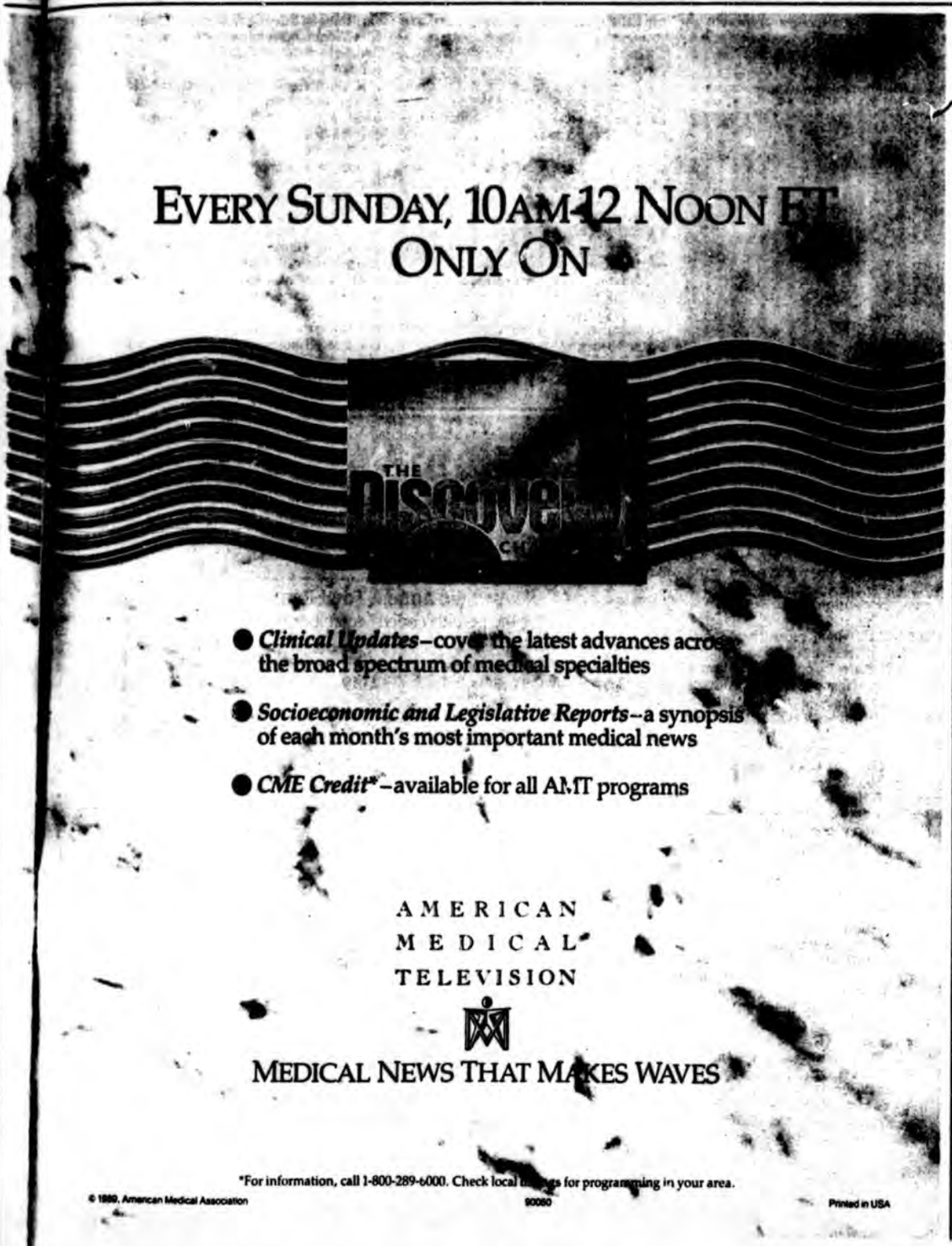
Revising past year's "overpriced" terminology, the conferees have designated as "overvalued" any procedure that exceeds the expected price under an RBRVS-based fee schedule by at least 10%. Prevailing charges in each locality would be reduced by one-third of the difference between the current prevailing charge and a geographically adjusted RBRVS fee.

The size of the cut thus would vary from area to area but could never exceed 15%.

Some physicians also would be affected by a proposal that prohibits self-referrals to clinical labs but exempts office labs as well as those owned by hospitals, HMOs, rural providers, and Puerto Rican providers. The provision, which is modest in comparison to one Stark had pushed for, also requires MDs to disclose any financial interest in other businesses to which they refer patients.

Hospitals would see rate hikes under the provision that vary by location. Without the changes, Medicare's prospective prices would have risen by 5.5% to cover inflation. But under the conferees' budget proposal, suburban hospitals would receive a 3.75% increase; large urban hospitals, a 4.4% increase; and rural facilities, an 8.5% jump.

The package also contains a number of other provisions aimed at improving the financial health of rural facilities and those with a disproportionate share of indigent patients. A Finance Committee proposal to reduce a special payment adjustment for hospitals' indirect costs for graduate medical education was dropped.



The Omnibus Budget Reconciliation Act of 1989

Background

The first session of the 101st Congress remained deadlocked on final passage of a FY 90 budget reconciliation bill for several months despite early agreement on a budget resolution and agreement on the framework for a reconciliation bill to reduce the federal budget deficit to the required target of less than $110 billion ($100 billion plus a $10 billion "cushion").

The House-approved version of the bill, passed October 5 by a 333-91 margin, included the capital gains tax reduction sought by the administration as well as a repeal of most of the provisions of the Medicare Catastrophic Coverage Act of 1988.

In an effort to speed passage of the budget bill, the Senate approved a stripped-down version of reconciliation by a 87-7 vote on October 13. The Senate bill contained only revenue-raising and cost-cutting provisions and no longer included previously approved child health, child care, and Social Security provisions nor did it include the capital gains tax reduction included in the House bill. The Senate had hoped to force the House to limit the scope of its bill to deficit reduction items but the House members did not agree, wishing instead to consider provisions such as catastrophic care, child care, and revisions and expansions of Medicaid as part of the budget bill. Ultimately many of these provisions were considered as separate legislation or delayed until the second session of the 101st Congress.

House and Senate conferees began meeting the week of October 23 to resolve differences in the revenue-raising and spending-reduction provisions of the bill. The dispute over the capital gains tax ended on November 2 when the White House and the Senate Republican leadership dropped their effort to include the provision in the budget reconciliation bill. This led to a final agreement on the reconciliation bill and the decision to consider the repeal of the catastrophic health care coverage act and child care legislation as separate bills. In exchange for his decision not to press for a reduction in the capital gains tax during this session of Congress, the president challenged legislators to produce a budget reconciliation bill that would achieve at least $14 billion in deficit reductions or face a veto. In the event of a veto, President Bush indicated that he would favor leaving in place the $16.1 billion in automatic spending reductions (sequestration) that took effect October 1 under the Gramm-Rudman-Hollings deficit reduction law due to Congress' failure to enact the budget reconciliation bill by that date. (The $16.1 billion figure was reestimated by the Office of Management and Budget at approximately $12.3 billion due to changes in appropriations levels.)

The Omnibus Budget Reconciliation Act of 1989 (H.R. 3299) was finally enacted on November 22. The House approved the bill, 272-128, and the Senate passed it by voice vote. President Bush signed the bill into law (P.L. 101-239) on December 19.

According to Congressional Budget Office (CBO) calculations, the bill will reduce the federal deficit in FY 90 by $17.75 billion through $6.9 billion in spending reductions and $5.6 billion in additional revenues. To meet President Bush's challenge to include only "real" savings in the bill, however, approximately $300 million in questionable program cuts and $2.7 billion from accelerated collection of several taxes are not included in the final total. The final "official" total deficit reduction included in the bill is $14.7 billion, which meets the requirements of Gramm-Rudman-Hollings by reducing the FY 90 federal budget deficit to approximately $105 billion—below the target of $110 billion. To reach that target, however, the bill saves $4.55 billion by retaining the automatic across-the-board spending cuts for 130 days through February 7. Under the revised sequestration, nonexempt domestic program spending will be reduced by an amount equal to approximately 1.4 percent for the full FY 90. The original full-year sequestration called for a 5.3 percent reduction in all nonexempt domestic spending. The effect of the sequestration process on individual programs is not yet clear.

The remainder of this article will describe the program revisions in health and human service programs in the Omnibus Budget Reconciliation Act of 1989.

Medicaid Provisions

Both the House Energy and Commerce Health Subcommittee and the Senate Finance Committee had placed maternal and child health initiatives high on the list of Medicaid budget priorities early in the process. The House and Senate committees both wrestled with other expansions such as providing home- and community-based care to the frail elderly and to individuals with mental retardation and developmental disabilities.

The House Energy and Commerce Committee approved a budget reconciliation package reflecting the Medicaid agenda of the Health Subcommittee's chairman, Rep. Henry A. Waxman (D-Calif.). The Senate Finance Committee approved a recon-

Alaska will have to adopt $13.6 m. 11 in FY91

ciliation package that contained maternal and child health provisions that were much more modest than the package originally envisioned by the chairman, Sen. Lloyd Bentsen (D-Texas) and other members. The Senate package did not expand home- and community-based services.

The Senate, which took its reconciliation package to the floor after the House, came under heavy fire from the White House and others for failing to achieve true deficit reduction. The President stated that only a stripped-down version of the reconciliation bill that achieved real savings and reductions would be acceptable. Bowing to pressure, Senate Democrats decided to strip the bill of all "extraneous" provisions. Provisions that cost money or were budget neutral were considered extraneous and stricken.

The Senate then attempted to get the House to agree to strip its own bill, which was successful to a limited degree. The final Medicaid provisions are considerably pared down from both the original House version and the Senate Finance Committee version. The White House ultimately agreed to the provisions.

As noted, the final reconciliation bill continues current budget sequestration until the end of the first week in February. This effectively means a cut of approximately 1.4 percent in Medicaid administrative costs over a 12-month period.

An analysis of specific provisions of the bill affecting Medicaid programs follows.

Section 6401: Mandatory Coverage of Infants, Children, and Pregnant Women

The provision requires Medicaid coverage of infants, children up to age six, and pregnant women up to 133 percent of the federal poverty level effective April 1, 1990, with delays available for required state legislation (other than appropriations).

The provision is considerably less than what Bentsen had included in his original child health legislation, S. 1201, which would have required coverage of infants and pregnant women up to 185 percent of the federal poverty level and coverage of children up to age six up to 100 percent of poverty without a phase-in period. The provision is similar to the version passed by the Senate Finance Committee and narrower than the original House reconciliation bill, which would have required coverage of infants and pregnant women up to 185 percent of poverty over a four-year phase-in period and coverage of children up to 18 up to 100 percent of poverty over 12 years.

The legislation adds a new maintenance of effort provision to the statute in subsection 1902(A)(iv) which requires states that have established eligibility for infants and pregnant women that is higher than 133 percent of the federal poverty level to maintain that level and not reduce it. The relevant poverty level is in the state plan (whether or not approved by the Health Care Financing Administration [HCFA] at the time of enactment), or the percentage specified in state authorizing legislation, or the level for which state funds were appropriated. This language was contained in the original House Infant Mortality Amendments, but was part of a mandate to 185 percent of poverty.

This maintenance of effort provision should be viewed within the context of another maintenance of effort provision added by the Medicare Catastrophic Coverage Act (MCCA) of 1988, which was not repealed with the repeal of the new Medicare benefits under MCCA. This particular maintenance provision, found at 1902(c), stipulates that a state plan cannot be approved if Aid to Families with Dependent Children (AFDC) payment levels are reduced to a level in effect prior to May 1, 1988.

Section 6402: Payment for Obstetrical and Pediatric Services

The legislation adds a new section, 1927, to the Social Security Act codifying current regulations, with some changes, to require that obstetrical and pediatric service payments be sufficient to assure a Medicaid client access to care that is equivalent to that of the general population in a geographic area. States must submit a state plan amendment (by April 1, 1990, and annually thereafter) that specifies payment rates by procedure for the upcoming year. The secretary can request supporting data. HCFA has 90 days to review the plan. If it is not approved, a state must immediately submit a revised plan.

Beginning in 1992, the state must submit with the plan amendment statewide average plan payment rates for obstetrical and pediatric services broken out for each metropolitan area and the rest of the state for the prior two years. A 1992 plan amendment would include this data from 1990.

Obstetrical services are defined as noninstitutional services covered by the state plan provided to a pregnant women by an obstetrician, obstetrician-gynecologist, family practitioner, nurse midwife, or family nurse practitioner.

Pediatric services are defined as noninstitutional services covered by the state plan provided to a client under 18 years by

a pediatrician, family practitioner, or pediatric nurse practitioner. (For both pediatric and obstetric services, in- and outpatient hospital services are considered institutional.) The provision is effective April 1, 1990.

Sections 6402 (c) and 6404: Federally Funded Health Centers

Sections 6402(c) and 6404 require reimbursement for all covered ambulatory services delivered in federally qualified health centers. These two statutory sections appear to be somewhat inconsistent, however. Centers are defined as receiving grants under sections 329, 330, and 340 of the Public Health Service Act. The second citation, however, allows some health centers to meet the definition/criteria for two years without actually receiving any Public Health Service funds. Section 6402(c) specifies that Medicaid must cover services delivered to children and pregnant women while section 6404 requires payment for services delivered to all Medicaid clients. The conference report language seems to refer to the provisions of the second citation. The statute specifies that payment for services must reflect 100 percent of reasonable costs as per section 10929(a)(13)(E) of the act.

The effective dates are July 1, 1990, for section 6402(c) and April 1, 1990, for section 6404. Both provisions allow a delay when state legislation (other than for appropriations) is required.

Congressional staff have indicated that the second citation, Section 6404, is the correct and intended language that should be implemented.

Section 6403: EPSDT Services

This section codifies current regulations with some changes. Specifically, screenings at intervals outside the periodicity schedule must be permitted and screenings must include coverage of blood tests and health education. The conference report indicates dental screens are to commence before the age of five. The state must cover all services allowed under Medicaid to "correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services..." regardless of whether these services are included in the state plan.

The legislation further states that "nothing in this title shall be construed as" limiting participation in Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Services to only those providers who can provide all EPSDT services and that providers can participate even if they only provide one EPSDT service. The intent here seems to be to preclude states from establishing specific EPSDT providers, though the language does not seem to mandate this.

This section also requires the HHS secretary to establish state-specific EPSDT participation goals by July 1, 1990, and annually thereafter. States will also be required to report by April 1, 1990, (and annually thereafter) in a uniform manner: the number of children who received screening; the number of children referred for corrective treatment; the number of children receiving dental services; and eventually, the extent to which the state met participation goals each year. Report data must be broken down by age group and basis of eligibility.

It is unclear exactly how this provision is to be interpreted. While it is fairly clear that the provision no longer permits any amount or duration limits on services, whether a state can restrict the setting in which services are provided remains unclear. Congressional staff are uncertain on this point. It appears that a state can specify the service setting, although final interpretation will rest with HCFA.

This provision was originally contained in S. 1201 and in the original Senate Finance Committee budget reconciliation bill. The provision is effective April 1, 1990, unless otherwise noted.

Section 6405: Required Coverage of Nurse Practitioners

States are required to reimburse for the services of a certified pediatric or family nurse practitioner if state law or regulation recognizes such practitioners, whether or not the nurse practitioner operates in association with, or under the supervision of, a physician or other health care provider. The provision is effective July 1, 1990.

Section 6406: Coordination with WIC

Medicaid agencies must coordinate operations with the Special Supplemental Food Program for Women, Infants, and Children (WIC). States must provide notice of and referral information on the WIC Program to all pregnant, breastfeeding, and postpartum women, and children under age five. The provision is effective July 1, 1990.

Section 6407: Demonstration Projects

The legislation authorizes a $10 million federal share in each of FY 90, FY 91, and FY 92 for alternative insurance programs in several states. The programs must target uninsured children under 20 years old and pregnant women with family incomes below 185 percent of the federal poverty line who are not otherwise Medicaid-eligible.

Section 6408: Other Medicaid Provisions

Institutions for Mental Diseases (IMDs)—The HHS secretary is required to study the effect of excluding nonelderly residents of IMDs from Medicaid coverage. The legislation also requires an HHS cost/benefit study of providing coverage for subacute psychiatric facility services under Medicaid. The report is due Oct. 1, 1990. This section also imposes a moratorium until 180 days after the submission of the report on any HCFA action against two Michigan facilities.

Texas 1115 Waiver—The legislation extends the Texas waiver for elderly personal care until July 1, 1990.

Hospice Payments—The legislation requires states electing hospice coverage to reimburse at a level equal to at least 95 percent of the Medicaid skilled nursing facility or intermediate-care facility rate for coverage of hospice clients in these facilities.

Buy-In for Working Disabled—The legislation requires coverage of Medicare Part A premiums for disabled workers who are eligible to enroll in Part A by virtue of the new section 1818(A) of the act. The income limit is 200 percent of the federal poverty level as determined in accordance with the SSI Program; the resource limit is twice the SSI resource level. Income-related cost-sharing for premiums may be imposed for eligible individuals with incomes between 150 and 200 percent of the federal poverty level.

States are divided on whether this is a large population and on the significance of this provision, which first appeared in the House budget reconciliation bill. In any case it will add administrative complexity to an already complicated eligibility system. Section 6408 is effective July 1, 1990, unless state legislation other than appropriations is required.

Section 6411: Miscellaneous Medicaid Technical Amendments

Qualified Medicare Beneficiary Buy-In—The legislation amends section 1902(f) of the act to require 209 (B) state to use the Medicare Catastrophic Coverage Act (MCCA) income and resource eligibility standards rather than any more restrictive standards used under section 1902(f). This provision is consistent with court decisions in at least one state and is effective Jan. 1, 1989, as included in MCCA.

Donated Funds/State Taxes—The legislation imposes a moratorium until Dec. 31, 1990, on any HCFA regulations that would change the use of state taxes or donated funds for the Title XIX draw-down of federal matching funds.

Disproportionate Share Hospital Payments—The legislation includes special provisions for the New Jersey Uncompensated Care Trust Fund and a transition rule for Missouri. The provision is effective as if included in the Omnibus Budget Reconciliation Act of 1987 (OBRA 87).

Fraud and Abuse—The legislation allows Medicaid and Medicare to exclude a provider who has lost the right to renew or apply for a license due to issues of competence, financial integrity, or performance. Current law already allows the exclusion of providers who have lost their license. This section also clarifies that the provision that allows payments to nonparticipating entities for emergency care does not extend to hospital emergency room services if the hospital itself is excluded from participation. Further, Medicaid may not contract for direct or indirect services with a risk-based provider that has a contractual agreement with another entity excluded from the program. Cited services include health care, utilization review, medical social work, or administrative services. The provision is effective upon enactment.

Spousal Impoverishment—The legislation amends section 1917(c) of the act to preclude a transfer without penalty of assets from a community spouse to another individual. This provision corrects a technical problem with the original law that allowed a community spouse to transfer assets without penalty, although this was not the intent of Congress. The provision is effective upon enactment.

This provision also amends section 1902(f) of the act so that 209(B) states must use MCCA eligibility rules under section 1924 for spousal impoverishment/eligibility determinations. Sections 1924(b)(2) and (d) of the act regarding attribution and protection of income are also amended by this provision to permit recalculations of these amounts at redetermination in the case of an individual requiring a second period of continuous institutionalization longer than 30 days, even though the conference report language does not indicate this. The conference report does indicate that resource rules are to be applied

only once at the beginning of the first period of institutionalization, but this issue is not addressed in statute. This one-time resource calculation appeared in the original House reconciliation bill. APWA had expressed concern about it on the grounds that a one-time calculation is unworkable for younger populations that may qualify for spousal impoverishment provisions at an early point in life and then again many years later, at which point the couple's resources may be considerably different. Discussions with congressional staff indicate that Congress only envisioned the applicability of this provision to the elderly whose resources do not change significantly, even though nonelderly populations are eligible. It should be stressed that this one-time resource calculation provision is not included in the statutory language of the bill.

Tennessee Health Insuring Organization—This provision continues the waiver of the 75 percent enrollment rule for the Tennessee Primary Care Network until June 30, 1992.

Day Habilitation and Related Services—The legislation prohibits the HHS secretary from taking any disallowance for day habilitation and related services covered under a state plan approved before June 30, 1989. It also prohibits the secretary from withdrawing approval of such a state plan, pending publication of final regulations that specify allowable services. The final regulations can only be applied prospectively.

Medically Needy Income Levels—The legislation prohibits HHS from publishing final rules before Dec. 31, 1990, that implement the proposed regulations of Sept. 26, 1989, with specific reference to requiring all medically needy eligibility for individuals to be based on the AFDC payment standard for a single-member family. The House had unsuccessfully attempted to implement a moratorium on all of the September 26 proposed regulations.

Transitional Coverage—The legislation amends sections 1925(a)(3) and (b)(3) of the act to clarify that transitional Medicaid coverage is available unless the household ceases to include a child whether or not the child is dependent under IV-A. This section also permits continuation of the current nine-month transitional benefits after the April 1, 1990, implementation of Family Support Act coverage to allow some clients who would be ineligible under the new coverage to finish their period of transitional eligibility under the old rules. Provisions of this action became effective upon enactment. The effect of this provision is also to clarify that people eligible for the current four-month extension before April 1, 1990, due to increased earnings or number of hours worked, are only eligible for that four-month extension and cannot be made eligible for the transitional coverage. Congressional staff have made it clear that this population was never intended to be made eligible for the new benefits.

Section 6901 : Nursing Home Reform

Feb. 2, 1989, Regulations—The legislation delays implementation of the February 1989 regulations pertaining to requirements for nursing facilities until Oct. 1, 1990.

Nurse Aide Training—The legislation delays the effective date for completion of training and competency evaluation programs from Jan. 1, 1990 until Oct. 1, 1990. It also delays requirements for individuals employed as of Jan. 1, 1990, (instead of July 1, 1989) from Jan. 1, 1990, until Oct. 1, 1990. The provision also requires the HHS secretary to publish proposed regulations on nurse aide training within 90 days of enactment, although the conference report indicates that this provision was not accepted. The legislation adds training and competency requirements that include knowledge of the needs of the cognitively impaired but this does not become effective until 90 days after enactment. The legislation also clarifies that a nurse aide must be permitted competency evaluation by means other than a written exam and that the testing can occur in a facility of current or future employment. It also clarifies that nurse aides cannot be charged for the costs of training and evaluation.

A nurse aide shall be deemed to have met training requirements if the program was completed before July 1, 1989 (rather than Jan. 1, 1989), and if one of two conditions is met. A nurse aide will have met requirements if he or she is found competent after receiving not less than 60 hours of state-approved training before July 1, 1989, and at least 15 hours of supervised practical nurse aide training, or regular in-service education. Or, a nurse aide will have met requirements if he or she received 100 hours of training prior to July 1, 1989 and was found competent. A state also may waive the requirements of 1919(b)(5)(A) of the act for an individual who can demonstrate that he or she served as a nurse aide at one or more facilities with the same owner for at least 24 consecutive months before the date of enactment of this act. The provision is effective as if included in OBRA 87.

Enhanced Matching Rate—The legislation clarifies that federal financial participation is available for training and

competency evaluation programs at an enhanced rate for the period from July 1, 1988, through June 30, 1990. It also prohibits the HHS secretary from taking into account or allocating amounts expended for nurse aide training and competency conducted before Oct. 1, 1990, on the basis of the proportion of residents eligible for Medicaid or Medicare. The provision is effective as if included in OBRA 87.

Preadmission Screening and Annual Resident Review—The legislation requires the HHS secretary to publish proposed rules within 90 days of enactment.

Enforcement—The legislation clarifies that Medicaid enforcement rules/decisions apply to facilities or portions thereof that are certified for participation in both Medicaid and Medicare.

Survey/Certification—The legislation clarifies that federal financial participation (FFP) is available at the current rate of 75 percent for survey and certification activities before Oct. 1, 1990. FFP then moves to 90 percent in FY 91, 85 percent in FY 92, 80 percent in FY 93, and back to 75 percent in FY 94 and thereafter.

Medicare Provisions

Section 6012: Medicare Buy-In for Working Disabled

The legislation creates a new section 1818(A) of the act to provide a Medicare Part A buy-in potential for nonaged individuals who have lost Title II disability benefits because their earnings exceed the Substantial Gainful Activity (SGA) threshold. When the SGA level is reached, Medicare coverage is terminated 36 months after the loss of cash assistance. This provision allows such an individual to enroll in Medicare Part A within seven months after they are notified of the loss of their Medicare entitlement. The individual can also enroll during the normal January to March window. Enrollment would terminate if the individual was no longer disabled or failed to pay premiums. The provision is effective July 1, 1990.

Section 6013: Qualified Medicare Beneficiaries (QMB) Buy-In

The legislation amends section 1818 of the act to provide that the HHS secretary shall, upon request by a state, modify an existing section 1834 agreements for QMB Part-A enrollment and premium payment. The provisions of section 1834(c) through (f) shall apply to the automatic Part A enrollment in the same manner as they currently apply to Part B automatic enrollment. The provision is effective after Jan. 1, 1990.

Section 6102: Physician Payment Reform, Medicaid Payments

Subsection (e)(8) of the legislation requires the Physician Payment Review Commission (PPRC) to study physician payments under Title XIX. The commission shall specifically examine the adequacy of reimbursement, physician participation, and client access. The PPRC must submit a report to Congress by July 1, 1991. This language appears broader than the original House language. The conference report indicates that this provision was not accepted in the final bill but it nonetheless appears in statute.

Medicaid Transition/SSI Issues

Section 8003: Medicaid Transitional Coverage

The legislation permanently extends four-month transitional Medicaid eligibility for families who lose AFDC due to increased child support collections. The original provision expired on Oct. 1, 1989, and the effective date in this legislation is retroactive to that date.

Section 8008: SSI Outreach for Children

The legislation requires the HHS secretary to work with states and private agencies that have knowlege of potential SSI recipients to establish an ongoing outreach program. The provision is effective approximately three months after enactment.

Section 8010: Deeming Income for Disabled Children

The legislation provides that the SSI parental income and resource deeming rules do not apply for a disabled child living at home if the child would qualify for SSI while residing in an institution and is eligible for Medicaid home- and community-based waiver services (section 1915(c)) or the Katie Beckett option (section 1902(e)(3)). Such children would then be eligible to receive the $30 per month SSI personal needs allowance (PNA) while living at home as if they were hospital-

ized. The provision is effective six months after enactment.

This provision does not appear to greatly effect eligibility for Section 1092(e)(3) services because under that section children are deemed to be recipients of SSI for eligibility purposes according to Title XIX. The impact on eligibility in states with Section 1915(c) waivers is less clear.

The House Ways and Means Human Resources Subcommittee did not wish this provision to affect Medicaid eligibility in any way, intending only to provide an SSI PNA to these children. Nonetheless the criteria for receipt of the PNA through the exclusion of parental income and resources stipulate that a child is, among other things, "eligible for" section 1915(c) services. A child with family income at 300 percent of the SSI level (if a state uses the special income rule for eligibility) may be eligible for waiver services but the waiver enrollment may be at its maximum, preventing the child from getting into the program. They would thus be "eligible" but not enrolled. As a result it is unclear whether a child would become categorically needy due to the SSI nondeeming provision, which may occur based on the child's eligibility for Medicaid optional categorically needy status, despite the fact that the child cannot enroll. Therefore the child would still be considered SSI-eligible in the community and subsequently become Title XIX-eligible for all Medicaid services (which must be viewed within the context of the new EPSDT provisions, section 6403 of the legislation).

If this amendment causes these children to become eligible for Title XIX services despite waiver enrollment caps, the impact on states with waiver programs could be substantial. Further clarification of this provision will be needed.

Section 8012: SSI Eligibility for Couples Living Apart

The legislation amends the current requirement that an aged, blind, or disabled couple must live apart for six months before individual SSI eligibility can be established. The new provision would permit individual determinations after a full calendar month had passed since the date of separation. The provision is effective Oct. 1, 1990.

Section 8013: Exclusion of Interest on Burial Space

Interest and other accruals on the value of a burial space would be excluded from countable income and resources for SSI eligibility. Current rules require that only the first $1,500 in burial funds, including interest, be excluded from resources. Burial spaces are also currently excluded but interest on them is not. The provision is effective four months after enactment.

Section 8014: Exclusion of Income-Producing Property

If a person is dependent on property as a means of self-support (including tools, livestock, and machinery), then the value of the property will not be counted against the equity value of the person's property (e.g., this property is not subject to the $6,000/6 percent rule). Income generated from this property would be considered countable income for SSI eligibility purposes. The provision is effective five months after enactment.

Future Medicaid Initiatives

The House Energy and Commerce Health Subcommittee has indicated that it will pursue in 1990 those pieces of the original House Medicaid reconciliation bill that were not enacted in 1989. This includes coverage of older children up to 100 percent of the federal poverty level (or perhaps up to 133 percent of the federal poverty level in the wake of this most recent legislation); coverage of infants and pregnant women up to 185 percent of the federal poverty level; optional community-based services for individuals with mental retardation and related conditions; optional home- and community-based services for the frail elderly; and mandatory hospice coverage.

The home- and community-based services legislation has been opposed by APWA due to the stringent maintenance of effort provisions contained in both bills, stringent employee protection provisions that administrators believe are unworkable, and mandatory Intermediate Care Facilities for the Mentally Retarded (ICF/MR) reform legislation along the lines of the OBRA 87 nursing home reform contained in the MR legislation.

The House will also be working to develop AIDS legislation that will seek, among other things, greater coordination of human services, including Medicaid.

Bentsen seems committed to further Medicaid expansions and changes for maternal and child health to complete the agenda set in the reconciliation legislation approved by the Finance Committee this fall. This would mean changes in presumptive eligibility and coverage up to 185 percent of the

federal poverty level for infants and pregnant women.

The effect next year's budget reconciliation debate will have on Title XIX remains unclear. It is uncertain whether the House Budget Committee will approve funds for Medicaid expansions and whether additional funds will be allocated. The president now seems opposed to any further expansions of Medicaid. The White House had opposed Medicaid expansions toward the end of the last session in an effort to achieve true deficit reduction, yet the final Medicaid package signed by the president closely resembles the Title XIX agenda of the Bush campaign. Since President Bush signed a package that fulfills his campaign pledge, support for any further expansion is questionable.

Child Welfare Provisions

The first session of the 101st Congress passed a significant package of child welfare provisions as part of the 1990 budget reconciliation bill. Following several congressional hearings at which APWA testified, Rep. Thomas Downey (D-N.Y.), acting chair of the Ways and Means Subcommittee on Human Resources, introduced a package of child welfare amendments. The subcommittee staff director unveiled the contents of the package publicly for the first time during APWA's third quarterly meeting before the Children, Family, and Adult Service Committee June 6, 1989. The Downey proposal included provisions from H.R. 2185, The Child Welfare and Foster Care Amendments of 1989, introduced by Rep. Robert T. Matsui (D-Calif.). The subcommittee adopted the Downey package with few changes, although the funding mechanism to pay for these and other children's initiatives evoked much disagreement from subcommittee Republicans. The Ways and Means Committee approved the Downey child welfare amendments as part of its budget reconciliation package, but dropped the controversial funding provision.

The Senate Finance Committee had approved a package of child welfare amendments offered by Bentsen to be included in the Senate reconciliation bill. The Senate, however, as explained earlier, stripped "extraneous amendments" from the Senate reconciliation package and as a result the child welfare amendments were set aside. The reconciliation bill approved by the House, however, did retain all the Ways and Means child welfare amendments. House and Senate conferees negotiated on the House-passed child welfare provisions and agreed to the following amendments to the Social Security Act Titles IV-E and IV-B adopted by both the House and Senate.

Section 8001: Extension of Authority to Transfer Foster Care Funds to Child Welfare Services

The legislation extends the foster care ceilings and the authority to transfer foster care funds to child welfare services for three years through Sept. 30, 1992. The bill permanently increases the Title IV-B child welfare services appropriations level at which a mandatory foster care ceiling is triggered from $266 million to $325 million. These provisions were effective on Oct. 1, 1989.

Section 8002: Independent Living

The legislation extends the current independent living initiatives program through FY 92. The entitlement ceiling for the program increases to $50 million for FY 90, $60 million for FY 91, and $70 million for FY 92. Beginning in FY 91 states will be required to provide 50 percent matching funds on funding above $45 million. The provision is effective retroactively to Oct. 1, 1989.

HHS issued an Information Memorandum (ACYF-IM-89-23) to the states on Dec. 14, 1989, requesting that applications for FY 90 funding be submitted to the department no later than Feb. 1, 1989.

The legislation also requires HHS to evaluate the effectiveness of the independent living initiatives program. The study must involve a control group of children who did not participate in the program. No date for completion was specified.

Section 8006: Foster and Adoptive Parent Training

This provision increases the federal reimbursement for foster- and adoptive-parent training from 50 percent to 75 percent and broadens the type of activities that may be included. In addition to travel and per diem, reimbursable activities would include short-term training to increase support and assistance to Title IV-E foster and adoptive children. Current and prospective foster and adoptive parents and the staff of licensed or approved child care institutions providing care to foster and adoptive children receiving Title IV-E foster care maintenance payments would be eligible for such training. The increased match is available for Oct. 1, 1989, through Sept. 30, 1992.

LEGISLATIVE TELECONFERENCE NETWORK

SIGN-IN SHEET

SPONSOR: SEN. KELLY

SUBJECT: HEALTH CARE COST CONTAINMENT

START/END TIME: _____ DATE: JUNE 4, 1990

PLEASE PRINT

	NAME/REPRESENTING	ADDRESS	PHONE #	TESTIFY	OBSERVE	BILL #
1	Malek / A.J. Gallegos	In Juneau				
2	Harlan Knudson	Health Associates 319 Seward, Juneau	586 1796		✓	
3	Steve LeBrun / ACLU	Seattle				
4	MIKE COUGHLIN - ADMIN	PO BOX CR JUNEAU 99811	465-4470			
5	TIM Kanady	1111 W. Fireweed, Suite 100 Anch 99503	272-2700			
6	LARRY BUSCH BLUE CROSS of WA & ALASKA	PO Box 327 Seattle WA 98111	~~907~~ 206-361-3045		✓	
7	JEFF DUZENBERY Blue Cross of WA. & Ak	3111 C ST. STE. 100 ANCHORAGE, AK. 99503	907-561-5065		✓	
8	George D MASTEN ASEA/AFSCME	3111 C St. Ste 325 Anchorage WA 99503	907 561-6661		✓	
9	RAY Gillespie - CHAMBER	10390 MEND. LP Rd JUNEAU, ALASKA	(907) 463-3371		✓	
10	Jeff Whittaker / OMB - Policy Gov's Office	PO Box AD Juneau, AK	(907) 465 3568		✓	
11	Don Seiler Positive Health Options	2841 Riverside Juneau 99801	(907) 789-2181			
12	Don Valentine	2501 ARCTIC BLVD ANCH AK	274-7211		✓	
13						
14						
15						
16						
17						
18						

LEGISLATIVE TELECONFERENCE NETWOR

SIGN-IN SHEET

SPONSOR: SEN. DUNCAN

SUBJECT: HEALTH CARE COST CONTAINMEN

START/END TIME: 9:30 DATE: JULY 11, 1990

PLEASE PRINT

	NAME/REPRESENTING	ADDRESS / PHONE NUMBER	FOR/AGAINST	TESTIFY	OBSERVE
1	Harlan Knudson	319 Seward # 11 Juneau, AK			
2	Tim D. Chin	3111 C St. Ste 200			
3	Jeff Duzenbury	3111 C St Ste. 100			X
4	Patrick Allen	Aetna			
5	Ben Hodge	Aetna			
6	GARTH HANSEN	Alaska Hospital Juneau			X
7	Gayle Kinepper	Chamber North			X
8	Kay Gillespie	" "			X
9	Seth Mattheiss	Gov's Office - Policy			X
10	Pat Pecharek	Deloitte & Touche		X	
11	Judy Heyman	Aetna		X	
12	ROSS BLAKE	AETNA			
13	ROBERT L. CORE	P.O. BOX H Health & Soc. Serv. Dept. Juneau, AK 99811			X
14	Lynn Withrow	Aetna			X
15	Diane Taylor	Aetna			X
16	Reed Staples	"			X
17	Richard Waller	Humana Hospital Alaska			X
18	Jeff Jones	A.J. Gallagher & Co Juneau			

COMMITTEE TAPE LOG

COMMITTEE: _____ DATE: 9-6-90 TIME: started

SUBJECT: Health care cost containment Task force

WITNESSES: _____

BILL	TAPE #	SIGNIFICANT INFORMATION
		Tape one - side A
Duncan	0.03	called the meeting to order
Kaplek	1.26	okay - the boys that are listed
Duncan	5.53	Great I think that
Gray	6.03	Um maybe Jim, we've got
Duncan	7.37	um there I might add to that
Gray	9.03	also its our intention
Duncan	8.11	In November
Pardue	8.14	Question,
Gray	8.21	um, I've received
Pardue	9.17	So, a month
Gray	9.20	I'd say a month
Coe	9.56	um We're trying to
Duncan	10.33	Okay any questions
Dixon	11.12	I didn't expect to be the first
[illegible]	22.27	Okay then
	22.31	I just wanted to
	23.53	Your facility
		Tanana Chiefs does serve
		what % of the
		I don't know
		think our stat
		out TCC

COMMITTEE TAPE LOG

COMMITTEE: _____ DATE: 9-6-90 TIME: started

SUBJECT: Health care cost containment Task force

WITNESSES: _____

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Duncan	22.27	okay then
Clarey	22.31	I just wanted to
Gray	22.53	Your facility
Dixon	23.12	Tanana Chiefs does serve
Gray	24.00	what % of the
Dixon	24.09	I don't know
Gingrich	24.25	I think our stat
Dixon	24.34	But TCC

BILL	TAPE #	SIGNIFICANT INFORMATION
Malek	24.59	Do yours, do you
Dixon	25.06	Yes We try to have
Malek	26.27	So the theory is
Dixon	26.53	back n forth
Pardue	27.52	Really are
Dixon	28.03	and We do have very
Malek	28.17	Now the
Dixon	28.29	Uh we provide
Pardue	28.59	of a person
Dixon	29.03	yes
Malek	29.07	So you
Dixon	29.12	We have two different
Malek	29.52	Do you have one
Dixon	29.54	Andrew Issac
Coe	30.24	I've known of you
Dixon	30.48	no I
		* Tape Change Tape 1 Side B *
Coe	0.01	
Dixon	0.12	You know one of things we
Malek	1.43	how long ago
Dixon	1.47	uh 1986
Pardue	2.00	I worked on the
Dixon	2.16	they have a clinic
Grays	3.01	you think that can apply
Duncan	3.31	ya getting started
Gingerich	3.47	the long term
Duncan	3.56	uh the
Gingerich	5.16	Specific to the four things

BILL	TAPE #	Tape 1 Side B SIGNIFICANT INFORMATION
Duncan	5.59	Uh that was the
Gingerich	6.04	Luthran Employee Health
Duncan	9.21	What is the
Gingerich	9.26	Uh #600.00
Duncan	9.58	I was just wondering if I may
Gingerich	10.02	Uh their not now
Dave Gray	10.53	Were not all looking at you
Gingerich	11.02	Um what we
Duncan	11.45	I'm just curious
Gingerich	17.14	a couple of years ago
Duncan	17.50	Primarily
Gingerich	17.53	When we followed
Dave Gray	18.18	Let me ask you a question
Gingerich	18.48	What something like this
Pardue	19.35	Yes is that
Gingerich	19.48	It is what is
Pardue	19.50	one thing about
Gingerich	20.03	the, I do know
Melek	20.38	Um If I could
Gingerich	20.47	Uh its
Gingerich	20.51	actually we were seeing
Melek	21.11	and you
Gingerich	21.15	Well its a self back n forth
Dave Gray	21.45	excuse me
Gingerich	21.53	total
Melek	22.02	that includes
Gingerich	22.10	thats
Pardue	22.23	The

BILL	TAPE #	SIGNIFICANT INFORMATION
Coe	22.42	Jim does your plan
Gingerich	22.50	Actually no
Coe	23.25	another thing I wanted
Malek	24 07	the rest of
Pardue	24 33	The — does your policy
Gingerich	25.02	actually this
Malek	25.34	But don't you think
Gingerich	25.53	uh yes and that gets into this
Malek	27 34	If I could ask you
Gingerich	27 47	Were among the
Malek	27 51	and your putting
Pardue	28.09	So that charity
Gingerich	28.24	Fairbanks has
Pardue	29 11	How much
Gingerich	29.15	I think that (Back n forth)
Gingerich	29.25	Well three
Gingerich	30 01	Now I've asked to have
Duncan	30 26	What are you
Paul Gray	21 33	You get
Pardue	30 44	When you look at the
Gingerich	31 05	as an employer
Malek	31 26	how
		* Tape Change Tape 2 side A *
Gingerich	0 01	Cont'd testimony
Malek	0 34	What about
Gingerich	0 41	about 50%
Malek	0.53	With 50%
Gingerich	1 07	We looked at it

BILL	TAPE #	SIGNIFICANT INFORMATION
Malek	1.55	you still offer the
Gingerich	2.14	I think it's to be honest w/the
Pardue	2.50	and the other
Gingerich	3.08	I have to make choices
Malek	3.22	that would be
Gingerich	3.29	as a matter of fact
Duncan	3.42	But then
Pardue	3.57	Fairbanks does one thing
Coe	4.23	did Fairbanks have
Gingerich	4.31	Well according to the recent
Pardue	5.05	I thought
Boyer	5.12	the numbers
Duncan	5.29	Okay anything else?
Gingerich	5.31	Well I guess back to
Boyer	5.59	But the increased
Castoreda	6.28	Another thing
Gingerich	6.40	Cost Shifting
Dave	7.11	didnt I read in
Gingerich	7.26	Yours talking about the
Malek	8.41	What
Gingerich	8.45	about a (back n forth)
Pardue	9.02	
Pardue	9.40	I had a question for you
Gingerich	10.18	
Pardue	11.41	What about this
Gingerich	11.57	Ya but realty is making
Boyer	12.09	Changing the Medicaid
Gingerich	12.30	you just have to be

BILL	TAPE #	SIGNIFICANT INFORMATION
Coe	12.53	Was there a
Gingerich	12.59	I've reviewed it
Pardue	13.19	It's also very incredible
Boyer	13.39	I was sitting on staff
Gingerich	14.10	I think what
Coe	14.23	Uh yes Jim I just wanted
Gingerich	14.36	Yes and that (back n forth)
Malek	15.27	How much of
Gingerich	15.34	actually more
Duncan	16.09	Okay
Pardue	16.11	just one more
Duncan	16.49	Okay
Dixon	16.51	I also wanted
Duncan	17.30	Okay I guess thats it
Spectator	17.45	Uh I just
Duncan	17.51	and again if there is anyone
	19.18	end of meeting

HCCC TF Hearing

Jerry Neer

215 Sister Dana Taylor

340 Greg – Sister

360 Bard → Sister County Plan?

379 Karen → Sister

407 Malek → Sister Uncompensated

Uncompensated

625 ↑ Johnson Selby

632 Soldana Hospital

Second Side

31 Malek → Kenai

27 Barb.

100 Berkshire

230 Barb to Berk

350 Hitchcock to Berk

370 Malek to Berk.

500 Soldana

560 Malek to Soldana

635 Dan Miller Valdez.

765

2nd Tape

10 Sharon Anderson

121 " Kentucky Uninsured

218 Sister

(2)

240 Mike in solarium

274 Barb + Sharon & Sis

290 Mark to " "

Mark to Human
Uncompensated.

JUNEAU

600? Dr Fagin

Second side Dr Fagin

3rd tape

DeINA

COMMITTEE TAPE LOG

COMMITTEE: Health Care Task Force DATE: 9-10-90 TIME: 10:010

SUBJECT:

MEMBERS: Present: Jay Duncan, Chair, Bruce Cummings, Peg O'Clarey

SPEAKER	TAPE #/ Side A	SIGNIFICANT INFORMATION
Jay Duncan	001	Opening comments by Duncan & present - Written
Jeff	070	Spks to 4 areas focusing on
Tom Armstrong	120	Lakeside Recovery Bothell, Wash. Support for SB 550. Spks to kind of problems they have had and what they have done to resolve them. PRO's - Utilization review process
	245	Addiction treatment. PRO does not distinguish Person treated on short-term basis will usually relapse Bill as written answers all problems they have had
Jeff	311	What percent AR business? 25 - 30 percent
Cummings	315	?
Armstrong		Feels everyone on even standard
Peg O'Clarey	340	Testimony Spks. Bill makes Organization More efficient.

Health Care Task Force - 9-10-90

SPEAKER	TAPE #	SIGNIFICANT INFORMATION
Jeff	380	Cases side-by-side utilization treatment different?
Jeff	410	How much business uncompensated care?
Armstrong		About 10%.
Jeff		Pursue line of questions
Hartley Knudson	500	Reinform and build bridges re: Overall Costs of Health Care
Jeff	570	Perspective on what happens to Health Care and Ability
Grant	580	St. Johns Nursing Home Administrator - Problem re matching St. benefits
D'Clarey	630	Preferred provider arrangement. Monthly premium for employees? $450 - 500 range for employee + dependents
Cummings	646	Employee only? Different rates depending on...
Gray	660	Thought about pooling arrangements? How tried.
Dawson	690	Why employees at higher risk?
Jeff Swinson	700	Higher utilization in

Health Care Task Force 9-10-90

SPEAKER	TAPE #	SIGNIFICANT INFORMATION
Joe Henson	740	Shattuck & Grummet: 20 employees not enough for Blue Cross pools.
Duncan	775	All nursing homes go together be cheaper?
Henson		Not necessarily - experience factor.
Duncan	802	Set up two different prices?
Jeff	825	Part dealing w/ carriers guidelines
Joe Henson	843	Two approaches to this
Harlow Knudson	860	Insurance pool for uninsurable. Cmte. look at option
Tape 1 side	2	
Joe Henson	001	Problem with small grp.
Jeff	018	Two side to coin
~~Armstrong~~ Barb Gamblin	050	Finance officer, Bartlett Memorial Hospital responds to questions.
Jeff	122	Uncompensated care coming from? Percentage increasing? Charity cases?
Garth?	158	Comment on costs. AK unique competing w/ state.
		BMH - $380 per person a month.
Jeff	264	Change in out-patient care?
Duncan	290	Review Nursing Home figures

Health Care Task Force. 9-10-90

SPEAKER	TAPE #	SIGNIFICANT INFORMATION
Joe Hunison		Responds to Duncan
Jeff	330	Happening now . . .
Cummings	340	Differences in st plan & city plan
Jeff	379	What drive behind increasing Costs as providers?
Harlan Knudson	390	Thinks there are 3 or 4 things.
Jeff	478	Rural system - way to make it more efficient?
Knudson	508	Asking providers to fill out survey.
	535	Utilization review bill
Doroth Hamm	540	Average increase at BMH has been 6 % per yr
Cumming	555	Organization supporting utilization?
Duncan	570	Chiropractor referral not accepted at BMH discussion
Knudson	640	Probably take statutory change.
Knudson	670	Spoke to another piece of leg.
Knudson	695	Ideal issue concern statewide pub employees system
Ray Gallagher	750	Folks from Charter will be testifying
Reed Bleaps		Aetna folks will be there.
		adj 11:40 AM.

HEALTH CARE COST CONTAINMENT TASK FORCE

Membership

Sen. ~~Tim Kelly~~ Jon Pearce, ~~Chair~~
Alaska State Senate
Box V
Juneau, Ak. 99811
Phone: 465-3822

Sen. Jim Duncan Chair
Alaska State Senate
Box V
Juneau, Ak. 99811
Phone: 465-4766

Michele Castanedo
Representative
Alaska State Employees Assoc.
240 Main St., Suite 200
Juneau, Ak. 99801
Phone: ~~463-4949~~ 274 0536

Bruce Cummings, Director
Division of Labor Relations
Dept. of Administration
Box C
Juneau, Ak. 99811
Phone: 465-4404

Don Hitchcock, Director
Division of Risk Management
Dept. of Administration
Box C
Juneau, Ak. 99811
Phone: 465-2180

Rep. Mike Navarre, V. Chair
House of Representatives
Box V
Juneau, Ak. 99811
Phone: 465-3779

Rep. Mark Boyer
House of Representatives
Box V
Juneau, Ak. 99811
Phone: 465-3466

Barbara Huff, President
Anchorage Municipal
Employees Assoc.
P.O. Box 100392
Anchorage, Ak. 99510
Phone: 269-4236 337 6688

Greg O'Claray
Representative
MEBA
124 Front St.
Juneau, Ak. 99801
Phone: 586-6040

Karen Perdue
Dep. Commissioner
Dept. of Health &
Social Services
Box H
Juneau, Ak. 99811-0601
Phone: 465-3030

Callaghan
Fax 415 543 1309

Official Business

COMMITTEE: HEALTH CARE TASK FORCE

DATE: 9-10-90

Subject of meeting:

SIGN-IN

PLEASE PRINT!

NAME	ADDRESS (MAILING) & (ZIP)	PHONE	REPRESENTING	DO YOU WANT TO TESTIFY?
TOM ARMSTRONG	LAKESIDE RECOVERY BOTHELL, WA / ALASKA	206 823-3116	LAKESIDE NARTP	YES UTIL. REVIEW
Harlan Knudson	AK ST. Hospital & Nursing Home Assn	586-3790	S Juneau	Yes
Bill Quinn	240 MAIN, SUITE 502 JUNEAU 99801	907 463 4949	AK STATE EMPLOYEES ASSOC/ AFSCME LOCAL 52	NO
Jerry Reinwand	175 S. Franklin St. Juneau, Alaska 99801	586-8966		NO
Joe Hoversten	301 Seward St. Juneau, AK 99801	907 586-2414	Shattuck & Grummett.	NO.
J. Bixby	Lakeside Recovery Juneau	7804948	Lakeside	NO
Bob Mumm	705 Munipal Way # 302 Juneau Ak	586-3090	NEA	NO
GARTH HAMBLIN	3260 HOSPITAL DRIVE JUNEAU, AK 99801	586-840-	BARTLETT HOSPITAL	YES
Rick Urion	Box 20868 Juneau 99802	463-5688	Ak State Medical Ass'n	no

LEGISLATIVE TELECONFERENCE NETWOR

SIGN-IN SHEET

SPONSOR: Sen. Duncan

SUBJECT: Health Care Cost Containment

START/END TIME: _____ DATE: 9-20

PLEASE PRINT

	NAME/REPRESENTING	ADDRESS	PHONE #	TESTIFY	OBSERVE	BILL #
1						
2	Reed Staggs / Hetnet	Box 1211 Juneau	463-3223		✓	
3	Steve LeBrun / Aetna	Seattle, WA	(206) 461-2803			
4	Richard Bondi / Aetna	Middletown, CT	203 636-4577			
5	Judith Stetson	Anchorage AK 99511	561-0011			
6	Kathy Cronen / Blue Cross	North Anchorage, AK	258-7575		✓	
7	R Snyder	ANCH	562-7661		✓	
8	Sister Donna Taylor	Anchorage	562-2211	✓		
9	Steve Berkshire	North Star Adolescent Hospital Anchorage	277-0122	✓		
10						
11						
12						
13						
14						
15						
16						
17						
18						

LEGISLATIVE TELECONFERENCE NETWOR:

SIGN-IN SHEET

SPONSOR: HCCC

SUBJECT:

START/END TIME: 9:30 DATE: 9/21/90

PLEASE PRINT

	NAME/REPRESENTING	ADDRESS	PHONE #	TESTIFY	OBSERVE	BILL #
1	Steve LeBrun / AEYNG	1501 4th Ave Seattle, WA 98101	206-467 2803			
2	Reed Staggs / Senate	Box 1211 Juneau	586-3300		—	
3	BARTLETT MEMORIAL HOSPITAL (GARTH HAMBLIN)	3260 HOSPITAL DR JUNEAU	586-8402		✓	
4	Harlan Knutsen			✓		
5	Charles McKee	c/o A.T.O.M. 216 E 53rd anch 99518		✓		
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						

Alaska State Legislature

SENATOR JIM DUNCAN

P. O. BOX V JUNEAU, ALASKA 99811-3100

(907) 465-4766

COMMITTEES:
FINANCE
VICE CHAIR – HEALTH EDUCATION & SOCIAL SERVICES
BUDGET & AUDIT
BANKING & ECONOMIC DEVELOPMENT

Nov. 20, 1990

MEMORANDUM

To: All Members
Health Care Cost Containment
Task Force

From: D. Gray, Staff

Re: Trip report and scheduling.

This last week was fairly productive. The meeting with the hospital administrators was a positive exchange of ideas and attitudes toward cost containment. Attached is our draft position (?) paper and their response to it. Also attached is a resolution of the school boards association endorsing the efforts of the Task Force. The session with the Municipal League went equally well with other panel members and audience participants showing recognition of the extent of the problem and support of the Task Force.

On Friday, the TRS board adopted the containment items recommended by the Task Force, thus mirroring the earlier action of the PERS board and opening the way to implementation.

Two additional meetings are being set up for Dec. 6 or 7. One is an exchange of ideas session with Ray Schalow and some of his doctors. The other is with major private sector employers. Also, Sen. Duncan will be travelling to D. C. in mid-December to talk with National groups and Maryland officials.

The next meeting of the full Task Force will be in January. Jeff and I are to get a rough draft report to you in mid december for review. I expect this draft to go through several revisions before the collective wisdom of the Task Force is accurately presented.

Also attached is some other correspondence.

Michelle looks good in her 8th month of pregnancy.

DRAFT

STATE OF ALASKA

HEALTH CARE COST CONTAINMENT TASK FORCE
POSITION PAPER

OCTOBER, 1990

DRAFT

HCCCTF 9/90-2

10-26-61 FRI 13:29 GALLAGHER HEFFERNAN P.02

DRAFT

PURPOSE

It is the intention of this document to give an overall perspective of ideas and suggested solutions for the slowing of rapidly rising health care inflation in the State of Alaska, for State sponsored plans and residents, and in order to promote discussions with interested groups around the State.

OVERVIEW

Health care costs in Alaska are rising at a pace two and three times the inflation rate for all other goods services. In 1989, total Alaska health care expenditures are estimated to be 1.5+ billion dollars up from an estimated 250 million dollars in 1979, with no substantiating population changes.

Health care inflation has been rising at a rate of over 20% each of the last five years in Alaska. These trends are not unique to Alaska alone. Nationally, the Federal Government and virtually all other states are seeking ways to reduce these costs or slow the inflation rate associated with health care costs.

These rapidly rising costs are further exasperating to the uninsured/underinsured population in Alaska, which has been estimated at more than 50,000 residents. Not only has the State Government seen substantial increases in its own premium costs, so has every employer providing health insurance for their employees, making it very difficult and in some cases impossible, to continue coverage.

The Health Care Cost Containment Task Force initially was charged with the task of investigating, analyzing and recommending ways to reduce or stabilize the health insurance costs for State of Alaska employees, retirees and their dependents. With this work completed and showing favorable results, the Task Force's charge was expanded during the last session to include reviewing the health care costs for all Alaska residents.

The Task Force, in its expanded role, has investigated the problem of rapidly increasing health care costs in Alaska through public testimony, surveys, research (statewide and nationally) and analysis of options available to the State.

During this review the Task Force has identified not a sole culprit, but numerous contributing factors that must be reviewed in a collective manner in order to provide the best solution. The contributing factors the Task Force identified include:

- Small/Inefficient Medical Care Delivery Systems
- Overbuilt Health Care Facilities
- High Cost Of Medical Technology
- High Malpractice Insurance Costs
- Limited Competition For Providers/Insurers
- High Overhead/Administrative Costs
- Limited Wellness Promotion And Resources
- Large Population Of Uninsured/Underinsured
- High Incidence Of Psychological/Substance Abuse Treatment Needs
- Cost Shifting By Other Public/Private Entities
- Life Style Diseases/Injuries

Although a substantial list of contributing factors, each must be addressed in order to achieve the goal of stabilized medical costs in Alaska.

DP

10-26-61 FRI 13:29 GALLAGHER HEFFERNAN P.03

DRAFT

FINDINGS

The Health Care Cost Containment Task Force since its inception has been reviewing the causes for the rapidly rising health care costs in the State of Alaska not only for State sponsored health plans, but health care costs in general statewide. The Task Force has identified the following areas for further consideration:

A. Health Care Provider Payment and Utilization Schedules

B. Health Care Purchasing Groups (Pooling)

C. Health Care Coverage for the Underinsured/Uninsured

D. Health Care Facilities and Technology Management (Revised Certificate Of Need Program)

E. Health Promotion and Preventative Medicine

F. Promotion of Health Care Professionals' Education and Retention in the State of Alaska.

These areas have gained considerable attention over the last several years with respect to controlling cost, both within the State of Alaska and in other parts of the Nation. This paper is intended to give you a brief overview of proposed Task Force recommendations. The final report will be issued early in 1991 for legislative consideration. Several of the above mentioned areas could be combined to provide maximum effectiveness in containing health care costs for Alaska.

PROPOSED RECOMMENDATIONS

The Task Force proposes the establishment of a **Health Resources Authority**; whereby a vehicle is created to:

1. establish and maintain health care provider payment and utilization schedules;

2. health care purchasing group (pooling); and

3. a method to provide health care coverage for the underinsured and uninsured residents of Alaska.

This authority could also cover other facets of health care delivery system including; utilization review standards, direct involvement in a revised certificate of need program, health promotion and preventative medicine, and the collection of data in order to recognize trends early and provide solutions to health care cost delivery and utilization.

DRAFT

10-26-61 FRI 13:30 GALLAGHER HEFFERNAN P.04

During the last legislature, Senator Duncan introduced Senate Bill 254, that would have created a health insurance authority. This health insurance authority, although similar in nature, would be expanded in order to better address the multi-faceted nature of the health care industry and allow more flexibility, and to provide health care at the most reasonable cost to those involved in the authority. It is intended that participation in the authority would be mandatory for all State employer entities with health care provider payment and utilization schedules, and would be voluntary for participating health care purchasing groups. Also, under the health care purchasing aspect, it is envisioned that this would provide a vehicle for health care coverage for the underinsured/uninsured.

The authority's purpose would be to work with employers, providers and State agencies to provide the most cost effective health care delivery system for Alaska residents. This would be achieved through the management of price, utilization, supply and demand of health care within the Alaska system.

Phase I - The Health Resources Authority would be phased in over a time period, whereby the provider payment and utilization schedules would be first starting in January 1992 (possibly utilizing RBRVS schedules instituted by Medicare with certain modifiers and extensions for hospital and ancillary charges). Also included in the first phase would be a direct involvement in the health care facilities and technology management through the certificate of need program.

Phase II would include the voluntary pooling of the ~~state~~ employers for the purposes of purchasing health on a large group basis. Phase II-A would include the underinsured and uninsured, and possibly a small business program. These programs would be under the umbrella of purchasing group, but somewhat segregated as to experience, plan of benefits and premium rating.

The Task Force looks forward to additional input regarding the Health Resources Authority legislation in order to provide the most effective vehicle to manage health care cost for Alaska.

Other areas identified by the Task Force for improvement in health care cost controls and utilization would be the health promotion and prevention programs for State residents. Specifically, these include well child care, prenatal care, and care given to elderly residents of Alaska.

Also of concern to the Task Force is the promotion of health care professionals' training and retention within the State of Alaska. It is envisioned that this program could be an expansion of certain programs already established within the State.

10-26-61 FRI 12:30 GALLAGHER HEFFERNAN P.05

UNCOMPENSATED CARE

DRAFT

INTRODUCTION

All paying consumers share the cost of uncompensated care through cost shifting. As government and large private health care payors become more cost conscious, the system has less elasticity to serve the uninsured and underinsured.

Alaska's health care economy is small and thus quite fragile when compared with other states, with only 17 acute care hospitals and 1.5 billion dollars in expenditures. According to the Health Care Cost Containment Task Force analysis an unusually large percentage of the health care will be paid by government payors, including school districts, municipalities and state employees. As the State Legislature embarks on major pooling efforts to derive maximum buying power for their health care dollar, it should equally examine strategies to deal with the victims of cost shifting, predominantly those working families who are employed in small businesses, and those who simply cannot afford the high premiums of insurance.

The Problem:

The United States has always had many individuals without health insurance, but evidence suggest their ranks are growing, up nationally from the 25 million in the 1970's to more than 31 million individuals today. Although no one really knows, health planners estimate Alaska has over 50,000 uninsured today.

The stunning realty of the uninsured problem is that of those without coverage are working families who incomes put them above the poverty line. Many of these people are employed by small businesses that increasingly cannot afford any or limited coverage with the astronomical increase in health care premiums.

As health care costs have risen, major payors have become much more prudent buyers of care. The introduction of more competition into the health care arena has meant the problems of the uninsured, that were more or less masked before the 1980's, can no longer remain hidden.

To attack the problem of the uninsured requires thoughtful examination of who is in need of health care service. No current data exists in Alaska about the characteristics of the uninsured. Nationally, Dr. Gail Wilensky, current administrator of HCFA in her published work has divided the uninsured into three basic groups:

1. The Non-Working Uninsured. The person typically thought of as medically indigent, these people are jobless, homeless, very poor or chronically ill. They account for approximately 25% of the uninsured population. Many currently cannot qualify for medicaid because they are either not categorically or income eligible. Expansion of medicaid income limits, categories or medicaid buy-ins are common approaches to this group.

2. The Medically Uninsurable. Persons who are unable to obtain insurance because of a pre-existing condition. They probably account for less than 1% of the uninsured population, and while they are small in number these individuals are very expensive to serve because they have high medical needs. States have had a difficult time grappling with successful, affordable solutions for these individuals, usually done through high risk pools where the losses are financed by spreading them to larger insured populations.

10-26-61 FRI 13:31 GALLAGHER HEFFERNAN P.06

3. The Employed Uninsured. These working individuals and their dependents account for approximately 70% of the uninsured population. About one-half of these are children. Clearly to solve the uninsured problems requires fashioning a solution for this population.

The Solution:

The Task Force is seeking effective affordable strategies that can allow more Alaskans who are uninsured or underinsured to have coverage. One thing that can be learned from other states who have dealt with this problem, is that there is no one major answer or cure. The answer probably lies in chipping away at the uninsured problem through multiple strategies.

The job of the Health Care Cost Containment Task Force is to recommend solutions and to set the stage for the more detailed work of the legislatively created task force who will deal with this beginning this Spring.

1. **Use of Federal Funds.**

   One solution which forms a base of most states' financing schemes is full leveraging of federal funds. Many providers testified that medicare and medicaid programs were "not paying their fair share". Federal Government payors continue to drive a hard bargain. Unfortunately, Alaska has little effect on this federal policy. Expansion of eligible groups and income levels under medicaid is still the most expedient way to leverage additional federal funds and extend coverage.

   In particular, the medically needy program provides a way for some participants with catastrophically high medical bills to "spend down" and then qualify for medicaid. This program would allow for two parent families with children to exhaust their resources and then seek some relief from mounting medical bills. For example, Trauma injury and pre-natal claims would be two areas. It would also greatly assist the elderly person in a nursing home who cannot currently qualify for medicaid because he or she possess a monthly retirement income. Each month they would be allowed to "spend down" this amount and become eligible for medicaid.

   34 states and the District of Columbia have such a program, and many of them have been in place for decades. The Alaska Legislature would have to authorize such a program in our state. Detailed costs are being compiled by the Department of Health and Social Services.

   Other medicaid financing schemes would also be explored. Among them are the raising of the income standards of medicaid coverage for pregnant women from 133% of poverty to 185% of poverty and medicaid buy-ins.

2. Re-Establishing and strengthening the hospital chapter of revenue sharing.

   Under study.

3. Financing and delivering health care coverage for small businesses.

   Under study.

DRAFT

STATE OF ALASKA

HEALTH CARE COST CONTAINMENT TASK FORCE REPORT

HEALTH CARE EXPENDITURES STUDY

JULY 11, 1990

PERCENT OF U.S. HEALTH CARE EXP. BY SOURCE OF PAYMENT 1989

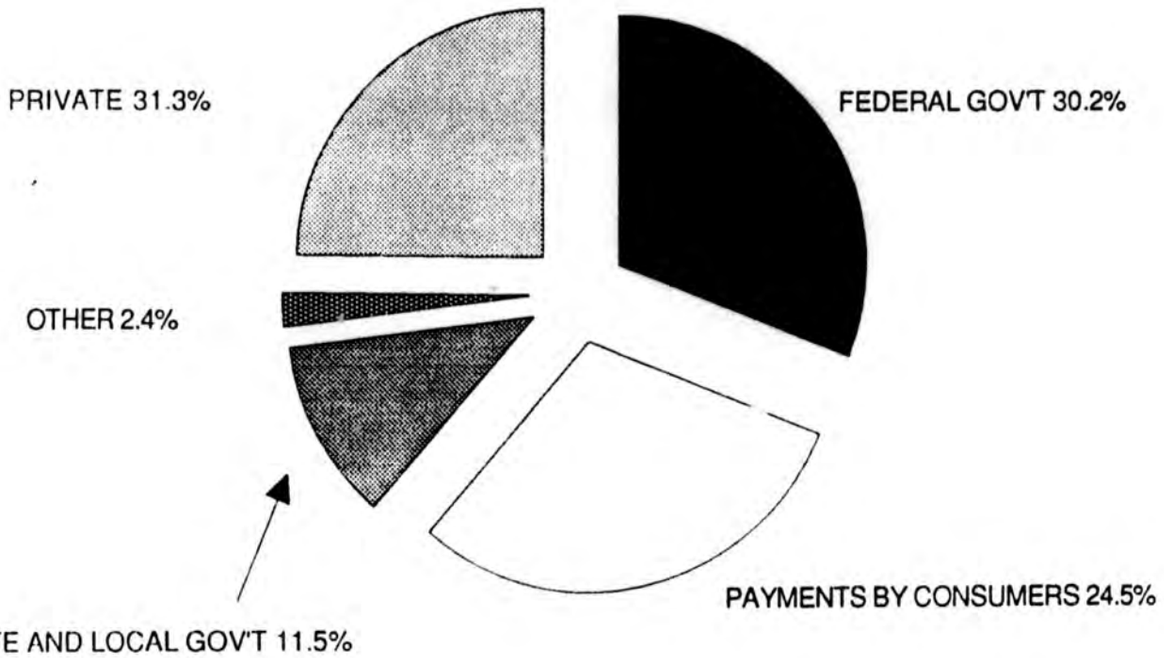


Chart2

PERCENT OF ALASKA HEALTH CARE EXP. BY SOURCE OF PAYMENT 1989

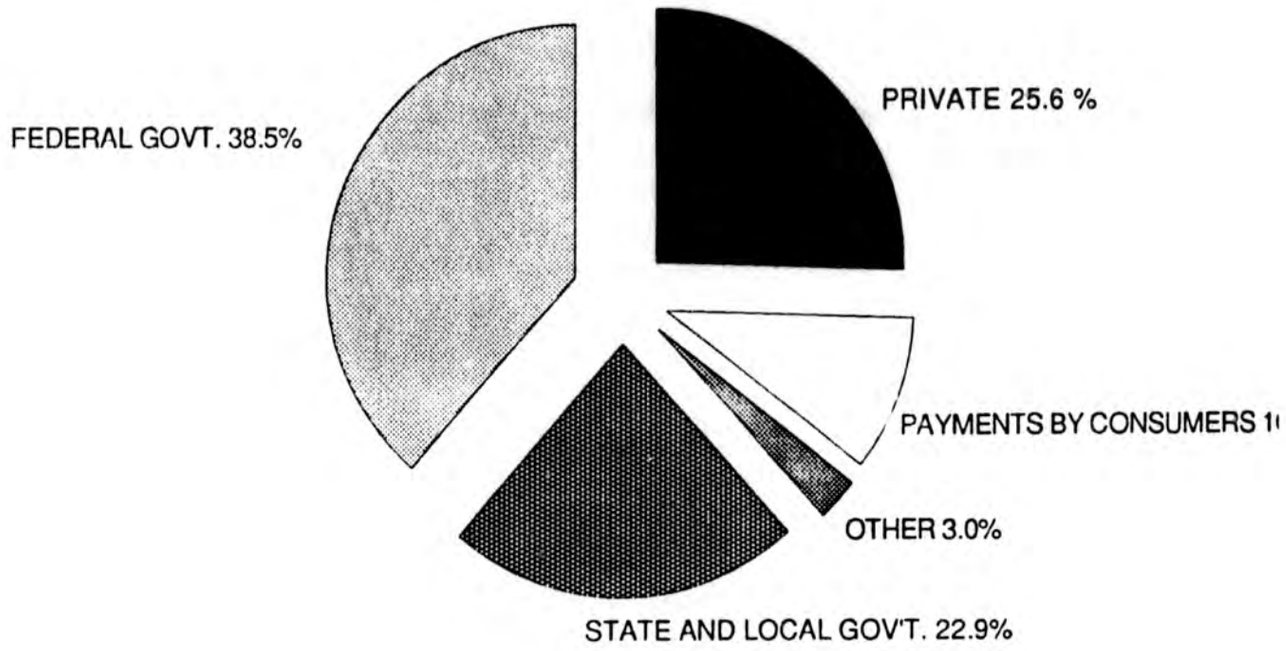
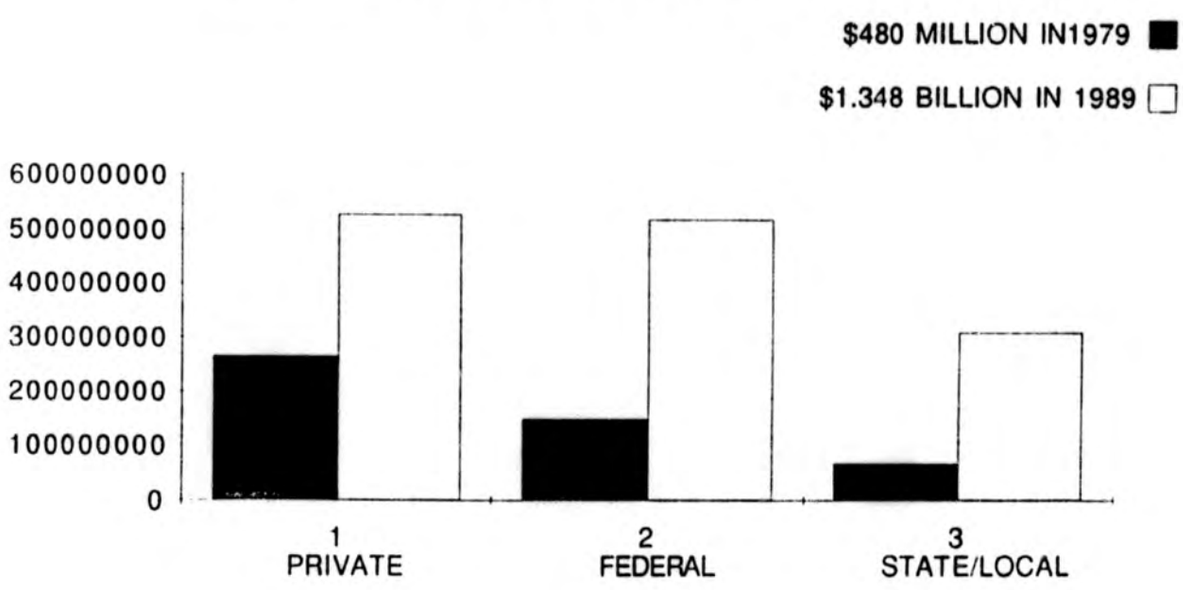
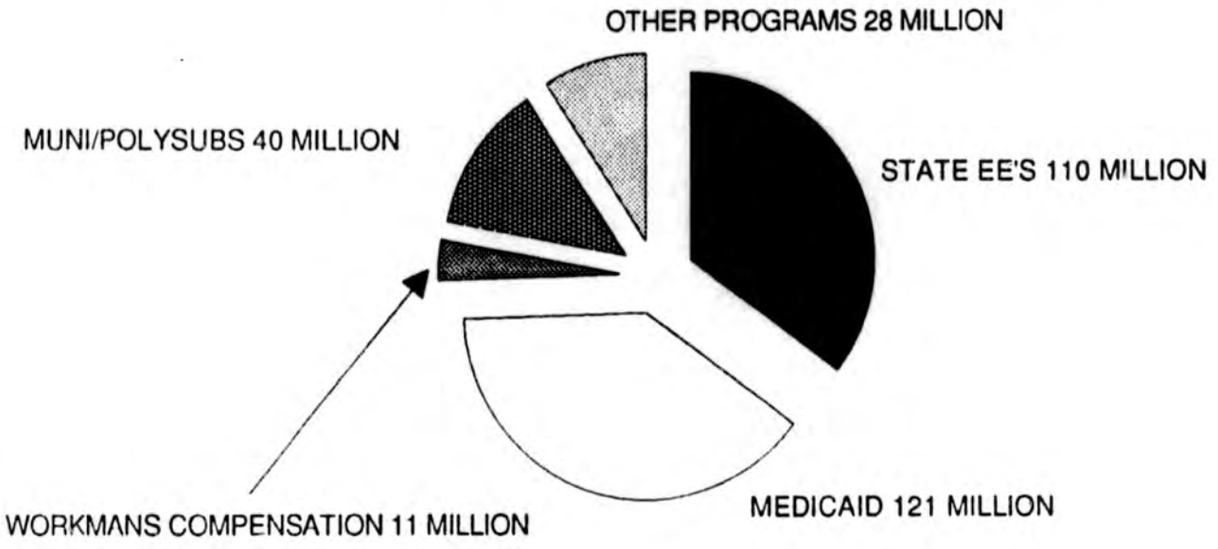


CHART 3

STATE OF ALASKA HEALTH CARE EXPENDITURES 1979 VS 1989



1989 STATE OF ALASKA HEALTH CARE EXPENDITURES FOR STATE AND LOCAL GOV'T.

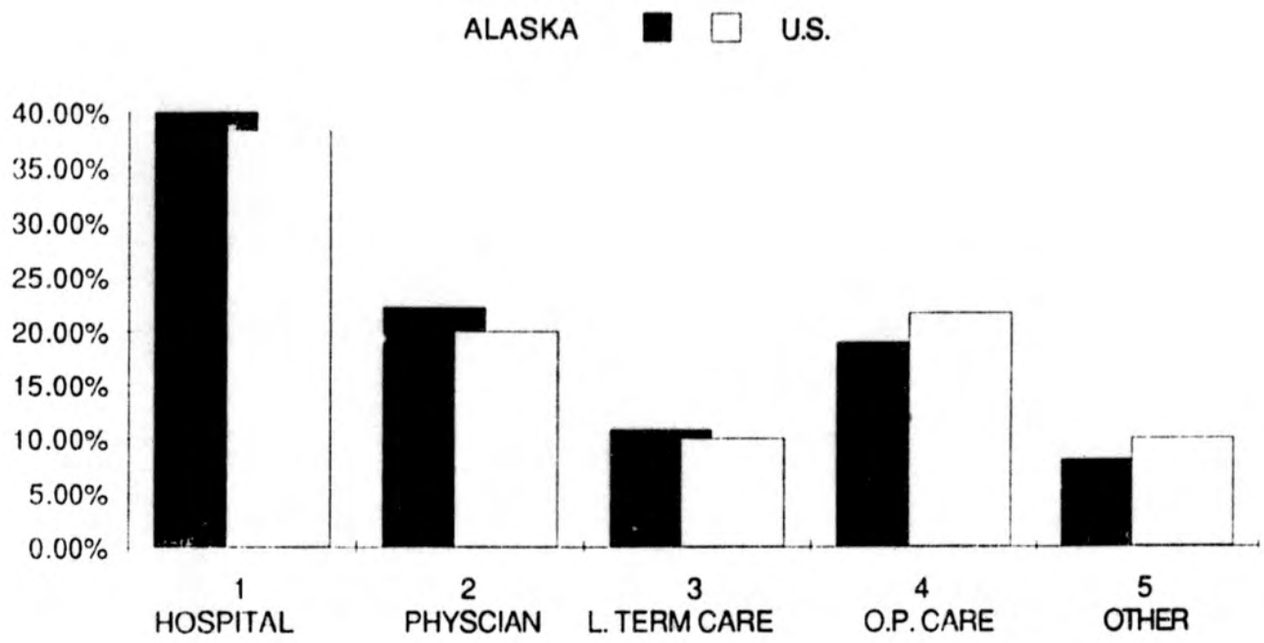


TOTAL STATE GOV'T HEALTH CARE EXPENDITURES

1989----------310 MILLION

CHART 5

ALASKA VS U. S. HEALTH CARE EXPENDITURES BY SERVICE CATAGORY
1989



STATE OF ALASKA

	1979	1984	1989
POPULATION	401,000	522,000	534,000
H.C. EXPD.	$480 MILL.	$710 MILL.	$1.34 BILL.
PER.CAP. H.C. EXP.	$1197.00	$1360.00	$2524.00

STATE OF ALASKA
HEALTH CARE EXPENDITURES STUDY

METHODOLOGY

Due to the nature of this study it was necessary to compile statistics from numerous sources in order to supplement our existing health care data base.

This information while current and credible had to be manipulated to assure that the parameters and time periods were similar.

The evaluation and reporting of data is according to standard statistical analysis procedures in order to assure accuracy within +/- 10%.

THE INFORMATION CONTAINED IN THIS REPORT IS OUR INTERPELLATION OF THE DATA ON HEALTH CARE EXPENDITURES IN ALASKA AND THE UNITED STATES.

SOURCES

Battelle Study
Dept. of Health and Social Services*
Division of Retirement and Benefits*
Division of Insurance*
State Demographer*
Institute of Social and Economic Research (Univ. of Alaska)
Health Care Financing Administration (HCFA)
U. S. Bureau of The Census

*State of Alaska

DEFINITION OF HEALTH CARE PAYORS

STATE / LOCAL GOVERNMENT (Alaska)

State employees/retirees and dependents (=EE)
Political subdivisions employees/retirees and dependents
Medicaid recipients (50%)
Workmans Compensation medical benefits
Community based health programs
Pioneer Homes
General relief medical

FEDERAL

Federal employees / retirees and dependents
Indian Health Services
CHAMPUS
Veterans Administration
Medicare
Medicaid (50%)

PRIVATE

Private pay
Private health insurance

DIRECT CONSUMER PAYMENTS

Health care costs paid directly by residents to providers (deductibles,co-payments, uninsured procedures

HEALTH CARE COST CONTAINMENT TASK FORCE

1990

ESTIMATED POPULATIONS OF ALASKANS WHOSE HEALTH CARE COSTS ARE DIRECTLY, INDIRECTLY, OR PARTIALLY PROVIDED FOR BY THE STATE

Employee/Retiree	Dependents	Totals
1. State Active Employees		
13,000	17,500	30,500
2. Retirees (State, Muni, School)(PERS & TRS).		
10,500	9,800	
Up to 60% reside in state		
6,300	5,900	12,200
3. Local Govt. Active Employees (PERS)		
13,600	18,400	32,000
4. Teacher Actives (TRS)		
8,200	11,000	19,200
5. Univ. of Alaska		
3,035	3,204	6,239
6. Corrections (prisioners)		
2,516		2,516
7. Ak. Railroad		
551		551

8. Medicaid Eligibles.
Div. Of Medical Assistence

41,000	41,000
	(144,206)

a) There is exists a measure of double counting in any summation of the figures. Some dependents, for example, will also be accounted for in other employment tabulations.

b) Estimates of dependents in items 3 and 4 assume that the groups exhibit the same age and sex characteristics as in group 1.

ESTIMATED POPULATIONS OF RESIDENTS WHOSE HEALTH CARE COSTS ARE PROVIDED FOR BY THE FEDERAL GOVERNMENT

9. Federal Employees (non-military)

14,642	14,642

10. Federal retirees (in Ak).

4,532	4,532

11. Indian Health Service

83,000	83,000

12. Military		
	22,792	22,792
14. Military dependents (CHAMPUS)		
	54,703	54,703
15. Medicare		
		XXXXXXXXXXX
		(179,669)

ESTIMATES OF POPULATION OF RESIDENTS WHO ARE UNINSURED AND OTHERWISE DO NOT QUALIFY FOR STATE AND FEDERAL HEALTH CARE PROGRAMS.

A. Governor's Task Force on Health Care (1988)	40,000
B. Consultant to Pepper Commission (to be published, 1990)	90,000
C. Family Incorporated Foundation (1990)	88,000

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

J O I N T M E E T I N G

Health Care Cost Containment Task Force
AND
Alaska State Hospital & Nursing Home Association

Tuesday, November 13, 1990
12 Noon - 3:00 p.m.

Hotel Captain Cook -- Quadrant Room, Anchorage

H/S c/s

12 Noon

1. Convene - Lunch

12:30 p.m.

2. Introductions

   A. Harlan Knudson, ASHNHA President/CEO
   B. Senator Jim Duncan, Task Force Chair

3. Task Force Survey - Health Facility Health Insurance Costs/Benefits

4. Follow-up to Report Hospital Net Revenues Distributed Task Force Meeting September 20, 1990, Anchorage

5. Review Draft Health Care Cost Containment Task Force Position Paper, October, 1990

6. Other Issues

3:00 p.m.

7. Adjournment

# # #

319 SEWARD STREET #11 • JUNEAU, AK 99801 • (907) 586-1790 • FAX (907) 463-3573

DRAFT DISCUSSION PAPER DRAFT

Health Care Cost Containment Task Force -- Alaska State Hospital & Nursing Home Association

November 13, 1990
Hotel Captain Cook, Anchorage

Members, Task Force on Health Care Cost Containment

Senator Jim Duncan, Chair, Juneau
Senator Drue Pearce, Anchorage
Representative Mike Navarre, Vice-Chair, Kenai
Representative Mark Boyer, Fairbanks
Michele Castanedo, State Employees Assn, Anchorage
Bruce Cummings, Div. of Labor Relations, Juneau
Don Hitchcock, Div. of Risk Management, Juneau
Barbara Huff, Anchorage Municipal Employees
Greg O'Claray, MEBA, Juneau
Karen Perdue, Department of Health & Social Services, Fairbanks
Staff: David Gray
Consultant: Jeff Malek
A.J. Gallagher & Company
San Francisco

ASHNHA Executive & Legislative Committees

John Vowell, Chairman, Wrangell
Sister Dona Taylor, Chairman-elect, Anchorage
Gary Grandy, Petersburg, Secretary/Treasurer
Jim Gingerich, Immediate Past Chair, Fairbanks
Tom Boling, AHCA Delegate, Anchorage
Ed Mahn, AHA Delegate, Ketchikan

Legislative Committee
Sister Dona Taylor, Chair, Providence Hospital
Mike Lockwood, Central Peninsula General
Ed Mahn, Ketchikan General Hospital
Tom Boling, Our Lady of Compassion Care Center
John Salness, Kodiak Island Hospital
Steve Berkshire, North Star Hospital
Harlan R. Knudson, President/CEO
Jerry Reinwand, Lobbyist
Resource: Karl Garber, Director of Finance
Our Lady of Compassion Care Center

David Hennigan, Asst. Administrator of Finance, Providence Hospital

PURPOSE - DISCUSSION PAPER

To continue the dialogue between the Task Force on Health Care Cost Containment and representatives of hospitals and nursing homes on health care costs in Alaska and options for containing or controlling costs, while assuring access to quality cost effective health care for all citizens.

Health care costs in Alaska are rising at a pace two and three times the inflation rate for all other goods services. In 1989, total Alaska health care expenditures are estimated to be 1.5+ billion dollars up from an estimated 250 million dollars in 1979, with no substantiating population changes.

Health care inflation has been rising at a rate of over 20% each of the last five years in Alaska. These trends are not unique to Alaska alone. Nationally, the Federal Government and virtually all other states are seeking ways to reduce these costs or slow the inflation rate associated with health care costs.

These rapidly rising costs are further exasperating to the uninsured/underinsured population in Alaska, which has been estimated at more than 50,000 residents. Not only has the State Government seen substantial increases in its own premium costs, so has every employer providing health insurance for their employees, making it very difficult and in some cases impossible, to continue coverage.

The Health Care Cost Containment Task Force initially was charged with the task of investigating, analyzing and recommending ways to reduce or stabilize the health insurance costs for State of Alaska employees, retirees and their dependents. With this work completed and showing favorable results, the Task Force's charge was expanded during the last session to include reviewing the health care costs for all Alaska residents.

The Task Force, in its expanded role, has investigated the problem of rapidly increasing health care costs in Alaska through public testimony, surveys, research (statewide and nationally) and analysis of options available to the State.

COMMENTS/RECOMMENDATIONS - Alaska State Hospital & Nursing Home Association

***Hospitals and nursing homes acknowledge and share the concerns of the Legislature and Task Force on the impact health costs are having on access to care.

Recommendation: (Draft) The data and findings of the Task Force be presented to the Task Force on Universal Health Care along with the editorial comment on the complexity of attempting to resolve cost questions while protecting the rights of all individuals to health care.

During this review the Task Force has identified not a sole culprit, but numerous contributing factors that must be reviewed in a collective manner in order to provide the best solution. The contributing factors the Task Force identified include:

* Small/Inefficient Medical Care Delivery Systems
* Overbuilt Health Care Facilities
* High Cost Of Medical Technology
* High Malpractice Insurance Costs
* Limited Competition For Providers/Insurers
* High Overhead/Administrative Costs
* Limited Wellness Promotion of Uninsured/Underinsured
* Large Population Of Uninsured/Underinsured
* High Incidence Of Psychological/Substance Abuse Treatment Needs
* Cost Shifting By Other Public/Private Entities
* Life Style Diseases/Injuries

Although a substantial list of contributing factors, each must be addressed in order to achieve the goal of stabilized medical costs in Alaska.

COMMENTS/RECOMMENDATIONS - Alaska State Hospital & Nursing Home Association

***The question is raised on whether or not small hospitals should be labeled inefficient, without strong collaborative data. Small hospitals are not the drivers of health costs in Alaska.

Added to the list of contributing factors for health care costs should be:
- small population served in large geographic area.
- labor costs
- low co-insurance and deductibles within state employee program
- under utilization community health system
- threat of professional liability

Recommendation: (Draft) Develop the methodology and funding to collect and distribute the data that will substantiate the above.

This was debated. Surveys show state plans now in norm even with hospital plans.

The Health Care Cost Containment Task Force since its inception has been reviewing the causes for the rapidly rising health care costs in the State of Alaska not only for State sponsored health plans, but health care costs in general statewide. The Task Force has identified the following areas for further consideration:

A. Health Care Provider Payment and Utilization Schedules

B. Health Care Purchasing Groups (Pooling)

C. Health Care Coverage for the Underinsured/Uninsured

D. Health Care Facilities and Technology Management (Revised Certificate of Need Program)

E. Health Promotion and Preventative Medicine

F. Promotion of Health Care Professionals' Education and Retention in the State of Alaska.

These areas have gained considerable attention over the last several years with respect to controlling cost, both within the State of Alaska and in other parts of the Nation. This paper is intended to give you a brief overview of proposed Task Force recommendations. The final report will be issued early in 1991 for legislative consideration. Several of the above mentioned areas could be combined to provide maximum effectiveness in containing health care costs for Alaska.

COMMENTS/RECOMMENDATIONS - Alaska State Hospital & Nursing Home Association

***Is there a need for insurance pooling if all citizens are guaranteed access to a health insurance program with rates based on Alaska or community experience? Not on the list is the need for an Alaska Health Care Policy and a strategy to implement that policy. The right to health care should be reconfirmed. Questions covering who receives care, what type of care is provided, how care is paid for, and who pays for care need to be addressed and answered in that policy.

Recommendation: (Draft) Recommend that the Legislature and Governor identify the decade of the 90s as the time to establish and implement health policy in Alaska assuring all citizens of access to quality, cost effective health care by the year 2000.

The Task Force proposes the establishment of a Health Resources Authority; whereby a vehicle is created to:

1. establish and maintain health care provider payment and utilization schedules;

2. health care purchasing group (pooling); and

3. a method to provide health care coverage for the underinsured and uninsured residents of Alaska.

This authority could also cover other facets of health care delivery system including; utilization review standards, direct involvement in a revised certificate of need program, health promotion and preventative medicine, and the collection of data in order to recognize trends early and provide solutions to health care cost delivery and utilization.

During the last legislature, Senator Duncan introduced Senate Bill 254, that would have created a health insurance authority. This health insurance authority, although similar in nature, would be expanded in order to better address the multi-faceted nature of the health care industry and allow more flexibility, and to provide health care at the most reasonable cost to those involved in the authority. It is intended that participation in the authority would be mandatory for all State employer entities with health care provider payment and utilization schedules, and would be voluntary for participating health care purchasing groups. Also, under the health care purchasing aspect, it is envisioned that this would provide a vehicle for health care coverage for the underinsured/uninsured.

The authority's purpose would be to work with employers, providers and State agencies to provide the most cost effective health care delivery system for Alaska residents. This would be achieved through the management of price, utilization, supply and demand of health care within the Alaska system.

Phase I - The Health Resources Authority would be phased in over a time period, whereby the provider payment and utilization schedules would be first starting in January 1992 (possibly utilizing RBRVS schedules instituted by Medicare with certain modifiers and extensions for hospital and ancillary charges). Also included in the first phase would be a direct involvement in the health care facilities and technology management through the certificate of need program.

Phase II would include the voluntary pooling of the employers in the State for the purposes of purchasing health on a large group basis. Phase II-A would include the underinsured and uninsured, and possibly a small business program. These programs would be under the umbrella of purchasing group, but somewhat segregated as to experience, plan of benefits and premium rating.

The Task Force looks forward to additional input regarding the Health Resources Authority legislation in order to provide the most effective vehicle to manage health care cost for Alaska.

Other areas identified by the Task Force for improvement in health care cost controls and utilization would be the health promotion and prevention programs for State residents. Specifically, these include well child care, prenatal care, and care given to elderly residents of Alaska.

Also of concern to the Task Force is the promotion of health care professionals' training and retention within the State of Alaska. It is envisioned that this program could be an expansion of certain programs already established within the State.

COMMENTS/RECOMMENDATIONS - Alaska State Hospital & Nursing Home Association

***Should there be discussion on the need to have a single "Health Resource Authority" for all employers, public and private?

Recommendation: (Draft) To begin the process of establishing a rate setting process for private health insurance programs, it is recommended that the Health Resource Authority negotiate with hospitals a usual and customary payment schedule, based on charges in the prevailing local area; maintained with an automatic inflation adjustment which specifically reflects the economic realities impacting Alaska hospitals, while not denying the need for balance billing.

All paying consumers share the cost on uncompensated care through cost shifting. As government and large private health care payors become more cost conscious, the system has less elasticity to serve the uninsured and underinsured.

Alaska's health care economy is small and thus quite fragile when compared with other states, with only 17 acute care hospitals and 1.5 billion dollars in expenditures. According to the Health Care Cost Containment Task Force analysis an unusually large percentage of the health care will be paid by government payors, including school districts, municipalities and state employees. As the State Legislature embarks on major pooling efforts to derive maximum buying power for their health care dollar, it should equally examine strategies to deal with the victims of cost shifting, predominantly those working families who are employed in small businesses, and those who simply cannot afford the high premiums of insurance.

The Problem:

The United States has always had many individuals without health insurance, but evidence suggest their ranks are growing, up nationally from the 25 million in the 1970's to more than 31 million individuals today. Although no one really knows, health planners estimate Alaska has over 50,000 uninsured today.

The stunning realty of the uninsured problem is that of those without coverage are working families who incomes put them above the poverty line. Many of these people are employed by small businesses that increasingly cannot afford any or limited coverage with the astronomical increase in health care premiums.

As health care costs have risen, major payors have become much more prudent buyers of care. The introduction of more competition into the health care arena has meant the problems of the uninsured, that were more or less masked before the 1980's, can no longer remain hidden.

To attack the problem of the uninsured required thoughtful examination of who is in need of health care service. No current data exists in Alaska about the characteristics of the uninsured. Nationally, Dr. Gail Wilensky, current administrator of HCFA in her published work has divided the uninsured into three basic groups:

1. The Non-Working Uninsured. The person typically thought of as medically indigent, these people are jobless, homeless, very poor or chronically ill. They account for approximately 25% of

the uninsured population. Many currently cannot qualify for medicaid because they are either not categorically or income eligible. Expansion of medicaid income limits, categories or medicaid buy-ins are common approaches to this group.

2. The Medically Uninsurable. Persons who are unable to obtain insurance because of a pre-existing condition. They probably account for less than 1% of the uninsured population, and while they are small in number these individuals are very expensive to serve because they have high medical needs. States have had a difficult time grappling with successful, affordable solutions for these individuals, usually done through high risk pools where the losses are financed by spreading them to larger insured populations.

3. The Employed Uninsured. These working individuals and their dependents account for approximately 70% of the uninsured population. About one-half of these are children. Clearly to solve the uninsured problems requires fashioning a solution for this population.

COMMENTS/RECOMMENDATIONS - Alaska State Hospital & Nursing Home Association

***The Legislature and Task Force are to be congratulated for expanding the scope of work of the Task Force to include the very important issue of the uninsured and underinsured and the impact that has on the cost of care.

Recommendation: The Task Force in its final report recognize the growing problem of the uninsured in long term care.

The Task Force is seeking effective affordable strategies that can allow more Alaskans who are uninsured or underinsured to have coverage. One thing that can be learned from other states who have dealt with this problem, is that there is no one major answer or cure. The answer probably lies in chipping away at the uninsured problem through multiple strategies.

The job of the Health Care Cost Containment Task Force is to recommend solutions and to set the stage for the more detailed work of the legislatively created task force who will deal with this beginning this Spring.

1. Use of Federal Funds.

   One solution which forms a base of most states' financing schemes is full leveraging of federal funds. Many providers testified that medicare and medicaid programs were "not paying their fair share." Federal Government payors continue to drive a hard bargain. Unfortunately, Alaska has little effect on this federal policy. Expansion of eligible groups and income levels under medicaid is still the most expedient way to leverage additional federal funds and extend coverage.

   In particular, the medically needy program provides a way for some participants with catastrophically high medical bills to "spend down" and then qualify for medicaid. This program would allow for two parent families with children to exhaust their resources and then seek some relief from mounting medical bills. For example, Trauma injury and prenatal claims would be two areas. It would also greatly assist the elderly person in a nursing home who cannot currently qualify for medicaid because he or she possess a monthly retirement income. Each month they would be allowed to "spend down" this amount and become eligible for medicaid.

   34 states and the District of Columbia have such a program, and many of them have been in place for decades. The Alaska Legislature would have to authorize such a program in our state. Detailed costs are being compiled by the Department of Health and Social Services.

   Other medicaid financing schemes would also be explored. Among them are the raising of the income standards of medicaid coverage for pregnant women from 133% of poverty to 185% of poverty and medicaid buy-ins.

2. Reestablishing and strengthening the hospital chapter of revenue sharing.

   Under study.

3. Financing and delivering health care coverage for small businesses.

   Under study.

COMMENTS/RECOMMENDATIONS - Alaska State Hospital & Nursing Home Association

***The maximizing of federal funds has been done to a great deal in Alaska, but will need to be increased in 1992 with the passage by Congress of additional Medicaid benefits in the 1991 Budget Reconciliation Act.

The idea of introducing the use of state revenue sharing to assist in underwriting charity care is a good one and the Association would welcome the opportunity to assist in the preparation of approriate legislation.

The American Hospital Association has long been an advocate of mandated employee insurance benefits. A study on how state government could provide incentives to large employers and financial assistance to small ones for a basic health care insurance coverage is needed.

Recommendation: (Draft) The Task Force should endorse the expansion of the Medicaid program as contained in the 1991 federal Budget Reconciliation Act.

The Task Force is asked to recommend to the 1991 Legislature for increased funding in the General Relief Medical Exception program with a portion of that increase for long term care.

There should be a study completed on the need for refunding the state catostrophic program.

The findings of the Task Force should be presented to the Universal Health Care Task Force.

The Task Force should recommend that all employers promote the availability of long term care insurance.

The Legislature should be asked to investigate the use of revenue sharing to assist in underwriting charity care.

A study on assuring all Alaskans access to affordable basic health insurance programs should be authorized by the Legislature and supported by the Governor.

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HEALTH CARE COST CONTAINMENT TASK FORCE November, 1990

FACILITY FINANCIAL INFORMATION

HOSPITALS	Seward General 6/30/89	Percent of Revenue	Providence Hospital 12/31/89	Percent of Revenue	Central Peninsula 6/30/89	Percent of Revenue	Charter North 12/31/89	Percent of Revenue	Sitka Community 6/30/89	Percent of Revenue	Valdez Community 12/31/88	Percent of Revenue	Bartlett Memorial 6/30/89	Percent of Revenue
Total Revenue	0		144,029,998		12,361,793		0		3,880,106		1,403,839		15,907,522	
Less: Contractual Adjustments		ERR	(17,184,848)	11.39%	(401,363)	3.27%		ERR	(81,268)	1.74%	(105,976)	5.00%	(756,873)	4.85%
Charity Care		ERR	(4,034,506)	3.27%	(407,452)	2.71%		ERR	0	0.00%	(1,331)	0.06%	(467,865)	2.87%
Bad Debts		ERR	(7,562,851)	5.02%	(803,520)	8.02%		ERR	(135,757)	2.91%	(170,205)	8.03%	(650,654)	4.00%
Total Revenue Deductions	0		(29,882,406)		(1,802,343)		0		(217,025)		(277,512)		(1,873,582)	
Other Operating Revenue			5,814,440		86,878				76,222		8,887		132,721	
Net Revenue	0		118,302,032		10,646,329		0		3,739,303		1,135,314		14,166,650	
Expenses:														
Salary/Wage/Benefits		ERR	(80,395,292)	40.06%	(8,434,486)	62.04%		ERR	(2,769,187)	59.41%	(1,060,330)	50.40%	(7,863,110)	49.31%
Depreciation/Amortization/Rent		ERR	(10,723,409)	7.11%	(1,075,094)	7.16%		ERR	(444,875)	9.54%	(70,485)	3.32%	(1,260,324)	7.79%
Interest Expense		ERR	-	0.00%	(934,723)	6.22%		ERR	(286,450)	6.15%	0	0.00%	(661,755)	4.07%
All Other Operating Expenses		ERR	(41,714,170)	27.67%	(4,313,824)	28.72%		ERR	(1,167,186)	25.04%	(707,407)	33.37%	(4,943,564)	30.37%
Total Operating Expense	0		(112,832,871)		(12,758,127)		0		(4,667,618)		(1,846,211)		(14,736,762)	
Non-Operating Revenue			1,700,569		2,089,615				784,748		706,785		235,857	
Non-Operating Expense		FRR		0.00%	(20,503)	0.14%		ERR		0.00%		0.00%	(32,881)	0.20%
Net Income/(Loss)	0	ERR	8,257,730	5.48%	437,214	2.81%	0	ERR	(283,565)	-4.80%	(4,112)	-0.19%	(360,315)	-2.25%
		ERR		100.0%		100.0%		ERR		100.0%		100.0%		100.0%
Liability Insurance:														
1989					341,690				191,789		86,041		481,184	
1990					286,531				94,488		52,178			

HEALTH CARE COST CONTAINMENT TASK FO

FACILITY FINANCIAL INFORMATION

HOSPITALS	Humana Hospital 9/31/89	Percent of Revenue	Valley Hospital 12/31/89	Percent of Revenue	Fairbanks Memorial 12/31/89	Percent of Revenue
Total Revenue	0		0		40,388,604	
Less: Contractual Adjustments		ERR		ERR	(4,388,858)	10.58%
Charity Care		ERR		ERR	(208,164)	0.50%
Bad Debts		ERR		ERR	(813,523)	2.20%
Total Revenue Deductions	0		0		(5,409,546)	
Other Operating Revenue					1,855,785	
Net Revenue	0		0		35,874,843	
Expenses:						
Salary/Wage/Benefits		ERR		ERR	(20,340,800)	48.91%
Depreciation/Amortization/Rent		ERR		ERR	(2,422,414)	5.83%
Interest Expense		ERR		ERR	(925)	0.00%
All Other Operating Expenses		ERR		ERR	(12,072,412)	29.03%
Total Operating Expense	0		0		(34,836,351)	
Non-Operating Revenue					220,150	
Non-Operating Expense		ERR		ERR		0.00%
Net Income/(Loss)	0	ERR	0	ERR	1,258,642	3.03%
		ERR		ERR		100.0%
Liability Insurance:						
1989					1,317,335	
1990					1,353,662	

HEALTH CARE COST CONTAINMENT TASK FORCE

FACILITY FINANCIAL INFORMATION

NURSING HOMES	St. Ann's 12/31/89	Percent of Revenue	Wesleyan 6/30/89	Percent of Revenue	Mary Conrad Center 12/31/89	Percent of Revenue	Our Lady of Compassion 12/31/89	Percent of Revenue	Heritage House 12/31/89	Percent of Revenue	Denali 12/31/89	Percent of Revenue
Total Revenue	3,160,980		3,169,363		6,296,197		18,097,000		2,853,961		5,488,476	
Less: Contractual Adjustments	(498,589)	15.38%	(894,815)	28.96%	(542,197)	8.30%	(4,848,000)	28.02%	(540,779)	18.92%	(1,151,352)	20.42%
Charity Care	0	0.00%	0	0.00%	(22,093)	0.34%	(400,000)	2.18%	0	0.00%	(53,489)	0.95%
Bad Debts	0	0.00%	0	0.00%	(25,716)	0.40%	(1,000)	0.01%	(151,966)	5.32%	(76,271)	1.35%
Total Revenue Deductions	(498,589)		(894,815)		(590,006)		(5,347,000)		(692,745)		(1,281,112)	
Other Operating Revenue	7,208		0		140,026		134,000		3,952		23,604	
Net Revenue	2,669,599		2,174,548		5,847,007		12,884,000		2,165,168		4,230,968	
Expenses:												
Salary/Wage/Benefits	0	0.00%	(1,915,461)	55.75%	(2,481,654)	38.35%	(8,241,000)	44.85%	(947,768)	33.16%	(3,160,992)	56.07%
Depreciation/Amortization/Rent	0	0.00%	(84,949)	2.47%	(960,308)	14.84%	(983,000)	5.24%	(165,346)	5.79%	(107,698)	1.91%
Interest Expense	0	0.00%	0	0.00%	(1,091,198)	16.86%	(1,445,000)	7.86%	(380,332)	13.31%	(72,324)	1.28%
All Other Operating Expenses	(2,657,706)	81.09%	(1,071,120)	31.18%	(1,107,709)	17.12%	(2,191,000)	11.93%	(516,941)	18.09%	(1,284,778)	22.79%
Total Operating Expense	(2,657,706)		(3,071,530)		(5,640,850)		(12,860,000)		(2,010,387)		(4,625,792)	
Non-Operating Revenue	77,430		266,283		34,100		142,000		0		125,461	
Non-Operating Expense	0	0.00%	0	0.00%	0	0.00%	0	0.00%	(17,872)	0.62%	0	0.00%
Net Income/(Loss)	88,323	2.75%	(630,688)	-18.36%	240,247	3.71%	166,000	1.01%	137,109	4.80%	(269,363)	-4.78%
		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%
Liability Insurance:												
1989	110,467		15,200		0		9,201		4,000		16,075	
1990	88,717		16,285		0		14,294		4,000		12,452	

HEALTH CARE COST CONTAINMENT TASK FORCE

FACILITY FINANCIAL INFORMATION

COMBINED FACILITIES	Petersburg General 6/30/89	Percent of Revenue	Cordova Community 6/30/89	Percent of Revenue	Wrangell General 6/30/89	Percent of Revenue	South Peninsula 6/30/89	Percent of Revenue	Norton Sound 9/30/89	Percent of Revenue	Ketchikan General 6/30/89	Percent of Revenue	Kodiak Island 12/31/89	Percent of Revenue
Total Revenue	2,481,262		1,922,948		1,978,223		5,774,315				11,490,620			
Less: Contractual Adjustments	(257,499)	9.07%	(141,850)	6.63%	(148,106)	6.69%	(1,008,273)	13.63%		ERR	(410,368)	3.5%		ERR
Charity Care	(22,195)	0.78%	(16,007)	0.73%	(102,022)	4.61%		0.00%		ERR	(58,900)	0.5%		ERR
Bad Debts	(20,813)	0.73%	(101,755)	4.82%	(97,660)	4.41%		0.00%		ERR	(338,257)	2.8%		ERR
Total Revenue Deductions	(300,507)		(258,612)		(347,788)		(1,008,273)		0		(817,532)		0	
Other Operating Revenue	55,501		32,053				78,153				237,629			
Net Revenue	2,236,256		1,695,588		1,631,435		4,847,195		0		10,910,717		0	
Expenses:														
Salar./Wage/Benefits	(1,367,822)	49.19%	(1,153,212)	52.34%	(1,278,644)	57.81%	(3,505,447)	47.50%		ERR	(7,095,782)	58.9%		ERR
Depreciation/Amortization/Rent	(559,488)	19.71%	(550,152)	24.97%	(174,281)	7.87%	(572,906)	7.76%		ERR	(527,834)	4.4%		ERR
Interest Expense	0	0.00%	0	0.00%	(18,259)	0.82%		0.00%		ERR		0.0%		ERR
All Other Operating Expenses	(489,090)	17.23%	(527,641)	23.95%	(610,479)	27.58%	(2,584,272)	35.01%		ERR	(3,559,568)	29.6%		ERR
Total Operating Expense	(2,416,410)		(2,231,005)		(2,082,663)		(6,662,625)		0		(11,183,184)		0	
Non-Operating Revenue	381,681		248,508		234,328		1,527,089				389,591			
Non-Operating Expense	(1,402)	0.05%		0.00%		0.00%	(272,614)	3.69%		ERR		0.0%		ERR
Net Income/(Loss)	120,125	4.23%	(286,010)	-13.02%	(216,802)	-9.80%	(560,955)	-7.60%	0	ERR	37,124	0.3%	0	ERR
		100.0%		100.0%		100.0%		100.0%		ERR		100.0%		ERR
Liability Insurance:														
1989	50,000		56,013		67,500		140,370				110,125			
1990	50,000		53,295		84,000		167,213				125,001			

HEALTH CARE COST CONTAINMENT TASK FORCE

FACILITY FINANCIAL INFORMATION

SUMMARY	COMBINED FACILITIES	Percent of Revenue	HOSPITALS	Percent of Revenue	NURSING HOMES	Percent of Revenue
Total Revenue	21,646,358		217,891,962		39,065,067	
Less: Contractual Adjustments	(1,872,894)	7.40%	(22,866,488)	9.97%	(8,873,732)	21.87%
Charity Care	(199,133)	0.75%	(6,019,510)	2.61%	(425,582)	1.19%
Bad Debts	(559,485)	2.10%	(10,336,410)	4.49%	(254,953)	0.84%
Total Revenue Deductions	(2,731,512)		(39,322,426)		(9,484,267)	
Other Operating Revenue	404,336		8,374,934		309,500	
Net Revenue	21,321,192		186,944,471		29,871,290	
Expenses:						
Salary/Wage/Benefits	(14,401,907)	53.88%	(98,070,843)	42.91%	(16,748,875)	41.85%
Depreciation/Amortization/Rent	(2,384,671)	8.94%	(18,804,581)	8.95%	(2,281,301)	5.70%
Interest Expense	(18,258)	0.07%	(1,883,853)	0.82%	(2,888,854)	7.47%
All Other Operating Expenses	(7,771,050)	29.13%	(84,918,581)	28.17%	(8,828,253)	22.06%
Total Operating Expense	(24,575,887)		(181,677,838)		(30,846,283)	
Non-Operating Revenue	2,621,183		8,145,724		845,282	
Non-Operating Expense	(274,818)	1.03%	(52,884)	0.02%	(17,672)	0.04%
Net Income/(Loss)	(907,510)	-3.40%	8,359,594	4.00%	(247,373)	-0.62%
		100.0%		100.0%		100.0%
Liability Insurance:						
1989	441,008		2,308,027		154,943	
1990	458,509		1,796,848		135,728	

ALASKA ACUTE CARE FACILITY AND LONG TERM CARE FACILITY 1989 REVENUES

FACILITY	(1) MEDICARE REVENUE	(2) MEDICAID/VRM. REVENUE	(3) OTHER PATIENT REVENUE	(4) TOTAL PATIENT	(5) OTHER REVENUE	(6) TOTAL REVENUE
ALASKA PSYCHIATRIC INSTITUTE	538,544	884,254	10,398,891	11,817,689	65,861	11,883,550
BARTLETT MEMORIAL HOSPITAL	2,640,614	997,743	12,269,165	15,907,522	96,000	16,003,522
CENTRAL PENINSULA HOSPITAL	1,184,277	11,270,390	492,873	12,947,994	2,642,287	15,084,081
CHARTER NORTH HOSPITAL	289,736	N/A	16,353,461	16,643,197	108,710	16,931,907
CORDOVA COMMUNITY HOSPITAL	178,554	1,029,990	714,444	1,922,988	32,594	1,955,582
DENALI CENTER	658,191	3,888,460	947,826	3,887,477	149,063	5,037,542
FAIRBANKS MEMORIAL HOSPITAL	5,060,841	4,639,262	30,568,302	40,308,405	34,904	40,343,309
HARBORVIEW DEVELOPMENTAL CENTER	0	7,134,678	0	7,134,678	245,307	7,379,985
HERITAGE PLACE	234,964	2,079,382	329,813	2,633,961	33,843	2,909,804
HOPE COTTAGES	0	4,255,762	3,230,178	7,485,940	311,893	7,797,833
HUMANA HOSPITAL ALASKA	1,445,298	10,060,155	63,416,306	74,921,757	842,811	75,764,568
KETCHIKAN GENERAL HOSPITAL	1,201,306	3,278,987	7,810,328	12,490,621	393,337	12,883,958
KODIAK ISLAND HOSPITAL	372,589	1,344,072	5,486,127	7,202,788	536,879	7,739,667
KOTZEBUE SENIOR CITIZENS CENTER	N/A	N/A	N/A	N/A	N/A	N/A
MARY CONRAD CENTER	0	3,300,000	178,182	3,478,182	174,734	3,652,916
NORTH STAR HOSPITAL	N/A	N/A	N/A	N/A	N/A	N/A
NORTON SOUND REGIONAL HOSPITAL	302,697	1,601,928	4,478,909	6,383,534	1,022,432	7,405,966
OUR LADY OF COMPASSION CARE CENTER	1,098,421	13,267,032	1,731,697	16,097,128	275,797	16,372,925
PETERSBURG GENERAL HOSPITAL	199,449	1,478,177	803,636	2,481,262	374,552	2,855,814
PROVIDENCE HOSPITAL	24,270,947	23,167,399	96,391,652	144,029,998	6,725,009	150,755,007
SEWARD GENERAL HOSPITAL	350,118	189,431	1,377,716	1,917,265	387,280	2,304,545
SITKA COMMUNITY HOSPITAL	562,697	371,130	2,946,278	3,880,105	843,346	4,723,451
SOUTH PENINSULA HOSPITAL	400,293	2,123,779	3,250,243	5,774,315	1,626,461	7,400,776
ST ANN'S NURSING HOME	0	2,872,732	282,040	3,154,772	80,638	3,230,410
VALDEZ COMMUNITY HOSPITAL	57,933	120,536	1,225,870	1,403,939	715,672	2,119,611
VALLEY HOSPITAL	453,352	2,409,447	12,002,201	14,865,000	365,719	15,228,719
WESLEYAN NURSING HOME	0	3,169,364	0	3,169,364	266,293	3,435,657
WRANGELL COMMUNITY HOSPITAL	94,255	61,951	1,796,061	1,952,267	287,954	2,240,221

N/A = Not Available
070390

(3) OTHER PATIENT: OUT OF POCKET AND INSURANCE

(5) OTHER REVENUE: GRANTS, BONDS, REVENUE-SHARING

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ALASKA ACUTE CARE FACILITY AND LONG TERM CARE FACILITY
1989 TOTAL EXPENSES AND CAPITAL EXPENSES

FACILITY	TOTAL EXPENSES	TOTAL CAPITAL	PERCENTAGE OF CAPITAL-RELATED EXPENSES
ALASKA PSYCHIATRIC INSTITUTE	14,497,469	271,929	1.88%
BARTLETT MEMORIAL HOSPITAL	13,205,083	1,844,512	13.97%
CENTRAL PENINSULA HOSPITAL	11,685,847	2,128,076	18.21%
CHARTER NORTH HOSPITAL	12,512,870	2,320,420	18.54%
CORDOVA COMMUNITY HOSPITAL	2,366,873	581,999	24.59%
DENALI CENTER	4,602,881	352,524	7.72%
FAIRBANKS MEMORIAL HOSPITAL	32,282,447	2,312,763	7.16%
HARBORVIEW DEVELOPMENTAL CENTER	7,384,995	196,973	2.67%
HERITAGE PLACE	2,002,306	584,470	29.19%
HOPE COTTAGES	7,577,840	353,442	4.66%
HUMANA HOSPITAL ALASKA	40,468,630	7,866,807	19.44%
KETCHIKAN GENERAL HOSPITAL	10,924,803	983,190	8.96%
KODIAK ISLAND HOSPITAL	6,604,132	403,636	6.11%
KOTZEBUE SENIOR CITIZENS CENTER	N/A	N/A	N/A
MARY CONRAD CENTER	5,494,666	2,334,700	42.58%
NORTH STAR HOSPITAL	N/A	N/A	N/A
NORTON SOUND REGIONAL HOSPITAL	6,355,640	593,758	9.34%
OUR LADY OF COMPASSION CARE CENTER	12,675,010	2,361,546	18.63%
PETERSBURG GENERAL HOSPITAL	2,366,643	574,866	24.29%
PROVIDENCE HOSPITAL	100,247,371	16,415,553	16.38%
SEWARD GENERAL HOSPITAL	2,027,191	124,495	6.14%
SITKA COMMUNITY HOSPITAL	4,276,840	663,171	15.51%
SOUTH PENINSULA HOSPITAL	6,235,519	608,882	9.76%
ST ANN'S NURSING HOME	2,650,501	313,371	11.82%
VALDEZ COMMUNITY HOSPITAL	1,785,122	83,905	4.70%
VALLEY HOSPITAL	9,773,835	1,120,489	11.46%
WESLEYAN NURSING HOME	2,898,495	105,964	3.66%
WRANGELL COMMUNITY HOSPITAL	1,885,216	185,304	9.83%

N/A = Not Available (New Facilities)

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School Boards Association

SUBJECT: ADMINISTRATION
NEW
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.

RECOMMENDATION: ADOPT 2d

Employee Benefits Division
Mail Address:
P.O. Box 8092
Walnut Creek, CA 94596-8092
415-932-7200

Office Location:
Suite 300
201 N. Civic Drive
Walnut Creek, CA 94596

Fax: 415-977-8730

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DIV. OF RETIREMENT & BENEFITS

October 9, 1990

Mr. Pat Peachacek
Deloitte Touche
1600 Landmark Towers
St. Paul, Minn 55102

RE: GROUP INSURANCE POLICIES - 392675

Dear Pat:

Outlined on the enclosed exhibits, are the indicated rate increases for the Actives and SBS Option I accounts for the State of Alaska.

Exhibit I, illustrates the SBS I experience for the period January 1, 1990 through September 21, 1990. The premium has been adjusted to reflect the 53% rate increase which was effective February 1, 1990. To the Expected Loss Ratio, the necessary inflation, expense and claim fluctuation components were added. As illustrated the indicated rate change is a 10.4% rate decrease. At this time, we would recommend maintaining the existing rate levels.

Exhibit II, illustrates the Active rating for Suffix 10 without the SBS Option I premium and claim experience. The indicated net change increased from our original 5.0% increase to a 6.5% increase without the SBS I experience. Again, at this time, it is our recommendation that the existing rates be maintained effective February 1, 1991 and any shortfall would be offset by the Premium Stabilization Reserve.

Please let Ms. Withrow know if you have any questions regarding this renewal.

Very truly yours,

Catherine C. Isham

Catherine C. Isham
Financial Consultant
Western Home Office
Ætna Life Insurance Company

CCI/ja

c: Mike Coughlin, Deputy Director, State of Alaska
Scott C. Keyes, Deloitte Touche, Minneapolis
Bill Aleman, Regional Director, Ætna, EBD
Phil French, Regional Vice President, Ætna, EBD
Lynn Withrow, Sr. Account Executive, Ætna, EBD - Seattle

10/9/90

Aetna LIFE & CASUALTY

Exhibit II

STATE OF ALASKA

ACTIVES

SUMMARY OF RATE ACTION
Combined Health Coverages
ERG - A, Suffix 10

DEPT. OF ADMINISTRATION
OCT 2 1 1990
DIVISION OF LABOR

I. EXPERIENCE PERIOD: 9/1/89 - 9/1/90

	PAID CLAIMS	+	ESTIMATED UNR	-	PRIOR RUNOFF	=	INCURRED CLAIMS
Medical	$41,728,292		$6,001,225		$6,938,565		$40,790,952
Dental	$7,020,329		$869,432		$946,621		$6,943,140
Drugs	$1,598,066		$410,022		$923		$2,007,165
TOTALS	$50,346,687		$7,280,679		$7,886,109		$49,741,257
			Adjusted Incurred Claims				$47,662,072
			Paid Premium				$62,205,730
			Expected Loss Ratio				76.6%

II. SUMMARY OF RATE ACTION

	% of Current Premium	Dollars	% of Renewal Premium
Current Billed Premium		$62,091,984	
1 Expected Loss Ratio	76.6%	$47,574,920	71.9%
2 Trend	20.7%	$12,853,041	19.4%
3 Expected Loss Ratio 2/91 - 2/92	97.3%	$60,427,961	91.3%
4 Expenses @ 4.0% of Expected Claims	3.9%	$2,417,118	3.7%
5 Claim Fluctuation Margin @5.0%	5.3%	$3,307,636	5.0%
6 Net Required Premium	106.5%	$66,152,715	100.0%
7 Indicated Net Change	6.5%	$4,060,731	6.1%

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10/9/90

Aetna LIFE & CASUALTY

Exhibit I

STATE OF ALASKA

SBS OPTION I

SUMMARY OF RATE ACTION
Comprehensive Medical Coverage
ERG - A, Suffix 10

I. EXPERIENCE PERIOD: 1/1/90 - 9/21/90

	PAID PREMIUM	ADJUSTED PREMIUM	PAID CLAIMS	EXPECTED LOSS RATIO
SBS I	$2,393,226	$2,603,226	$1,500,651	57.6%

II. SUMMARY OF RATE ACTION

	% of Current Premium	Dollars	% of Renewal Premium
Current Billed Premium		$3,600,000	
1 Expected Loss Ratio	57.6%	$2,075,250	64.3%
2 Trend	14.9%	$536,400	16.6%
3 Expected Loss Ratio 2/91 - 2/92	72.5%	$2,611,650	81.0%
4 Expenses @ 5.0% of Expected Claims	3.6%	$130,582	4.0%
5 Claim Fluctuation Margin @ 15.0%	13.4%	$483,923	15.0%
6 Net Required Premium	89.6%	$3,226,155	100.0%
7 Indicated Net Change	-10.4%	($373,845)	

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Ray Gillespie
Gillespie & Associates
Lobbying & Governmental Affairs

10390 Mendenhall Loop Road
Juneau, Alaska 99801
(907) 463-3375

November 14, 1990

The Honorable Jim Duncan
Alaska State Senate
P.O. Box V
Juneau, Alaska 99811

Re: SB 550, Certification of Utilization Review Providers

Dear Senator Duncan:

As the Task Force begins to draft its report to the legislature, I would like to take this opportunity to share thoughts on certification/accreditation of utilization review providers (SB 550).

As you know, the Task Force has taken testimony from numerous health providers that standardization of utilization review is necessary given the proliferation of review firms. This type of legislation helps ensure that utilization review firms do not unfairly restrict access to medical care, promotes uniformity of review standards, paperwork and procedures with which health care providers must deal, and promotes cooperation between the providers and the review organizations. In addition, legislation such as SB 550 tends to protect the rights of the patient and ensure that private review agents are fully qualified to perform the utilization review. In addition it ensures confidentiality of patient medical records.

At least 10 states have enacted legislation regulating the practice of private utilization review agents. In the past year alone, Georgia, Kentucky, Maryland, Mississippi, South Carolina and Virginia have enacted such legislation. Typically the legislation requires companies conducting utilization review to obtain a certification either from the State Department of Health or the Commissioner of Insurance. Generally, in order to be certified, a utilization review firm must submit certain information to show:

1. the critera and procedures used in evaluating hospital and medical care;

2. the type and qualifications of personnel performing utilization review;

3. procedures and policies ensuring that a private review agent is reasonably accessible to patients and providers during normal business hours;

4. submit policies and procedures ensuring the applicable state and federal laws protecting confidentiality are followed; and

5. procedures that ensures providers may seek reconsideration of adverse decisions.

Please consider this information and the testimony provided to the Task Force concerning the need for utilization review legislation. Should you need other or further information or have questions concerning SB 550, please feel free to call upon me.

Again, we urge the Task Force to seriously consider a favorable recommendation to the Legislature for utilization review legislation such as SB 550.

Sincerely,

Raymond A. Gillespie

LEGISLATIVE TELECONFERENCE NETWORK

SIGN-IN SHEET

SPONSOR: ____________________

SUBJECT: [illegible]

START/END TIME: ____________ DATE: ____________

PLEASE PRINT

	NAME/REPRESENTING	ADDRESS	PHONE #	TESTIFY	OBSERVE	BILL #
1	Don Valesko Local 71	2501 Arctic Blvd Anch AK	276 7211		–	
2	Valerie Baffone Local 71	" "	" "			
3	Karen Perdue	DHSS Box H, Juneau	465-3030			
4	Barbara Huff	P.O. Box [illegible] Anch	[illegible]			
5	[illegible]	LAA				
6	Jan [illegible]	[illegible] Anch	264-8228			
7	Warren Endicott	Pouch V	465-3800			
8	JIM JOHNSEN / APEA	340 N. FRANKLIN ST	6-2334		✓	
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1	PENNY PALMQUIST ASEA/AFSCME LOCAL 52	3111 C STREET, SUITE 325 ANCHORAGE, AK 99503	561-6661		X	
2	Jeff Whittekiend OMB-Policy Gov's Office	PO BOX AD Juneau	465-3568			
3	Steve LeBrun / AETNA	Seattle -	467-2803 (206)			
4	JEFF Duzenbery / Blue Cross WA. AK.	3111 CST. STE. 100 Anch. AK. 99503	907-561-5065		✓	
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