

ALASKA LEGISLATURE SPECIAL COMMITTEE / SUBJECT FILES 8672
1714.5 SCOMM 68: HEALTH CARE COST CONTAINMENT TASK FORCE, 1989-91

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 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.

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January 15, 1990

MEMORANDUM

To: All Members
Health Care Cost Containment
Task Force

From: Senator Kelly, Chair *SK*

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 hours 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

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

Patrick McConnell, Bartlett Memorial Hospital, Juneau

Patrick Pechacek, Touche Ross & Co.

Mike Coughlin, Deputy Director,
Division 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 categories. 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 extension 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.

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I N F O R M A T I O N A L E R T

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.

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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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1359H

NEWS

American Medical Association

DECEMBER 1, 1989

INSIDE



9 Whither waste

Public health fears have spurred increased concern about the regulation of medical waste and the need to find an inexpensive, yet effective, disposal system.



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 (RBRVS) 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.

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.

Fortney "Pete" Stark (D, Calif.) and the Bush Administration had insisted be a part of any payment reform. Stitched together by confer-

ees 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.

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 first time in his 27 years in Congress,

- 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 ex-

pire 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-savings 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 psycholo-

gists 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.

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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-

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

*Alaska will have
to adopt \$13.6 million FY91*

a pediatrician, family practitioner, or pediatric nurse practitioner. (For both pediatric and obstetric services, in- and out-patient 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) Ser-

vices 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.

Will have to be added

Still evaluating maybe expand

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 legisla-

tion amends section 1902(f) of the act to require 209 (B) states 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 knowledge 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 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

BILL #
OBSERVE
TESTIFY

NAME/REPRESENTING

ADDRESS

PHONE #

1	<u>Malcolm A. Gillespie for Governor</u>				
2	<u>Harlan Anderson</u>	<u>Health Association</u> <u>319 Second, S.W. Juneau</u>	<u>586</u> <u>1296</u>		☒
3	<u>Steve Lebrun / AKSU</u>	<u>Seattle</u>			
4	<u>Mike Caughtlin - ADMIN</u>	<u>PO Box CR</u> <u>JUNEAU 99811</u>	<u>465-</u> <u>4470</u>		
5	<u>Tim Kanady</u>	<u>1113 W. Firwood, Suite 100</u> <u>Anch</u> <u>99503</u>	<u>272-2700</u>		
6	<u>LARRY BUDSCH</u>	<u>PO Box 327</u>			☒
7	<u>BLUE CROSS OF ALASKA</u>	<u>Seattle WA 98111</u>	<u>907-361-3045</u>		☒
8	<u>Jeff Duxenberg</u>	<u>3111 CST. STE. 100</u> <u>ANCHORAGE, AK 99503</u>	<u>907-561-5065</u>		☒
9	<u>George V. Masten</u>	<u>3111 CST. STE. 325</u>	<u>907-561-6661</u>		☒
10	<u>RAY GILLESPIE - CHAIRMAN</u>	<u>ANCHORAGE, WA 99503</u>			☒
11	<u>John Whitaker / OMB-Polym</u>	<u>10390 MEMP. LANE</u> <u>JUNEAU, ALASKA</u>	<u>907-463-3371</u>		☒
12	<u>Don Seiler</u>	<u>PO Box AD</u> <u>Juneau, AK</u>	<u>907-463-3371</u>		☒
13	<u>Don Seiler</u>	<u>2841 Riverside</u> <u>Juneau 99801</u>	<u>(907) 789-2181</u>		
14	<u>Don Seiler</u>	<u>2501 Arctic Blvd Anch</u> <u>AK</u>	<u>274-7211</u>		☒
15					
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LEGISLATIVE TELECONFERENCE NETWORK



SIGN-IN SHEET

SPONSOR: SEN. DUNCAN

SUBJECT: HEALTH CARE COST CONTAINMENT

START/END TIME: 9:30

DATE: JULY 11, 1990

PLEASE PRINT

	NAME/REPRESENTING	ADDRESS / PHONE NUMBER	FOR/AGAINST	TESTIFY	ORSTRIVE
1	Harlan Knudson	319 Seward St # 11 Juneau, AK			
2	Tim D. Child	3111 C St. E. 20			
3	Jeff Duzendberg	3111 C St. Ste. 100			X
4	Patricia Allen	Aetna			
5	Ben Hodge	Aetna			
6	GARTH HANBUN	BARTLETT HOSP. THE JUNEAU			X
7	Gayle Knepper	Chs. for Norton			X
8	Kay Gillespie	"			X
9	Jetta Wuttke	Covs Office. Poling			X
10	Pat Pecharck	Deloitte & Touche		X	
11	Judy Heyman	Aetna		X	
12	ROSS BLAKER	AETNA			
13	ROBERT L. COLE	P.O. BOX 14 DEPT. of HEALTH & SOC. SERV. JUNEAU, AK 99801			X
14	Lynn Withrow	Aetna			X
15	Diane Taylor	Aetna			X
16	Reed Stoops	"			X
17	Richard Waller	Humana Hospital Alaska			X
18	Jeff Moore	A. J. Gallagher & Co. Inc.			

COMMITTEE TAPE LOG

COMMITTEE: _____

DATE: 9-6-90

TIME: _____

SUBJECT: Health care cost containment Task Force

WITNESSES: _____

started

BILL	TAPE #	SIGNIFICANT INFORMATION
		Tape one - side A
Duncan	0.03	called the meeting to order
Walek	1.26	okay - the items 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
Nixon	11.12	I didn't expect to be the first
Duncan	22.27	okay then
	22.31	I just wanted to
	22.53	your facility
	22.53	Tanana Chiefs does serve
	22.53	what % of the
	22.53	I don't know
	22.53	think our stat
	22.53	out too

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
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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
TEST. Dixon	11.12	I didn't expect to be the first
Duncan	22.27	okay then
O'Clary	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
	24.41	

BILL	TAPE #	SIGNIFICANT INFORMATION
Malek	24.59	Do you, do you
Dixon	25.00	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	wh we provide
Pardue	28.59	At 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 Isaac
Cole	30.34	I've known of you
Dixon	30.48	no I
* Tape Change Tape 1 Side B *		
Cole	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
Gray	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 #	Jape 1 Side B	SIGNIFICANT INFORMATION
Duncan	5.59	uh that was the	
Gingerich	6.04	Juthran Employee Health	
Duncan	9.21	What is the	
Gingerich	9.26	uh \$1000 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	18.40	What something like this	
Pardue	19.35	Gym is that	
Gingerich	19.45	It is what is	
Pardue	19.50	one thing about	
Gingerich	20.02	the, I do know	
Malek	20.38	Gym If I could	
Gingerich	20.47	uh its	
Gingerich	20.57	actually we were seeing	
Malek	21.11	and you	
Gingerich	21.15	Well its a self back n forth	
Dave Gray	21.45	excuse me	
Gingerich	21.53	total	
Malek	22.02	That includes	
Gingerich	22.10	thats	
Pardue	22.23	The	

BILL	TAPE #	SIGNIFICANT INFORMATION
Coe	22.42	Jim does your plan
Gingrich	22.50	Actually no
Coe	23.25	Another thing I wanted
Malek	24.07	the rest of
Pardue	24.33	The ~ does your policy
Gingrich	25.02	actually this
Malek	25.34	But don't you think
Gingrich	25.53	uh yes and that gets into this
Malek	27.34	If I could ask you
Gingrich	27.47	were among the
Malek	27.51	and your putting
Pardue	28.08	is that charity
Gingrich	28.24	fairbanks has
Pardue	29.11	How much
Gingrich	29.15	I think that (Back n forth)
Gingrich	29.25	well three
Gingrich	30.01	Now I've asked to have
Duncan	30.26	what are you
Pardue	30.33	You got
Pardue	30.44	When you look at the
Gingrich	31.05	as an employer
Malek	31.26	how
Tape Change Tape 2 side A		
Gingrich	0.01	cont'd testimony
Malek	0.34	what about
Gingrich	0.41	about 50%
Malek	0.53	with 50%
Gingrich	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	Harbancs does one thing
Col	4.23	did Harbancs have
Gingerich	4.31	Well according to the recent
Pardue	5.05	I thought
Boyer	5.12	the number
Duncan	5.29	Okay anything else?
Gingerich	5.31	Well I guess back to
Boyer	5.59	But the increased
Castro	6.28	Another thing
Gingerich	6.40	Cost Shifting
Dave	7.11	didn't I read in
Gingerich	7.26	You're 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 reality 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 none
Duncan	16.09	Okay
Pardue	16.11	just one more
Duncan	16.49	okay
Dixon	16.51	I also wanted
Duncan	17.36	okay I guess that's it
Spectator	17.45	uh I just
Duncan	17.59	and again if there is anyone
	19.18	end of meeting

HCCC TF Housing

215 Jerry Nier
Sister Donna Taylor
340 Greg - Sister
360 Barb → Sister County Plan?
379 Karen → Sister
407 Malak → Sister Uncompensated
Uncompensated

625 ↑ Johnson Selby
632 Soldotna Hospital

Second Side

21 Malak is Kennel
27 Barb.

100 Berkshire
230 Barb to Berk
350 Hitchcock to Berk
370 Malak to Berk
500 Soldotna
560 Malak to Soldotna
635 Dan Moller Valdez.
765

2nd Tape

10 Sharon Anderson
121 " Kentucky Uninsured
218 Sister

(2)

240

Mike to Solomon

274

Barb & Sharon & Sis

290

Malak to " "

542

Malak to Aaron
Uncompensated

Tuneau

600?

Dr. Fagin

Second side

Dr. Fagin

3rd tape

Delva

COMMITTEE TAPE LOG

COMMITTEE: Health Care Task Force

DATE: 9-10-90

TIME: 10:01

SUBJECT: _____

MEMBERS: Sen Duncan, Bruce Cummings, Prof O'Clary

Present: Chair

SPEAKER	TAPE #/ <u>Side A</u>	SIGNIFICANT INFORMATION
Sen Duncan	001	Opening comments by Duncan of present situation
Jeff	070	Spts to 4 areas focusing on
Tom Armstrong	120	Lakeside Recovery, Bothell, Wash. Support for SB 550. Spts to kind of problems they have had and what they have done to resolve them.
	245	PR O's - Utilization review process. Addiction treatment. PR O bears no liability. Person treated on short-term basis will usually relapse. Bill as written answers all problems they have had.
Jeff	314	What percent AR business? 25-30 percent
Cummings	315	?
Armstrong		Puts everyone on even standard
Duncan	340	Testimony Ibs. Bill make organization more efficient?

Health Care Task Force - 9-10-90

PAGE: 2

SPEAKER	TAPE #	SIGNIFICANT INFORMATION
Jeff	380	Cases side-by-side Utilization treatment difference?
Jeff	410	How much business unreimbursed care?
Armstrong		About 10%.
Jeff		Purpose line of question
Horton Hudson	500	Reinforce and build bridges on overall costs of health care.
Jeff	570	Perspective on what happens to health care and ability
Grant	580	St. Ann's Nursing Home Administration - Problem matching st. benefits Preferred provider arrangement
DiClaray	630	Monthly premium for employees? \$450 - 500 range for employees + dependents
Cumming	646	Employee only? Different rates depending on...
Gray	660	Thought abt pooling arrangements? How tried.
Deacon	690	Why employees at higher risk?
Joe Hudson	700	Higher utilization

Health Care Task Force 9-10-90

SPEAKER	TAPE #	SIGNIFICANT INFORMATION
Joe Huisman	740	Sketch 1/ Brunner. 20 employees not enough for Blue Cross pools.
Werner	775	All nursing homes go together be cheaper?
Huisman		Not necessarily experience factor.
Werner	802	See up two different pools?
Jeff	825	Part dealing w/ carriers guidelines
Joe Huisman	843	Two approaches to this
Werner	860	Insurance pool for uninsured Cmte. look at option
THP side	2	
Joe Huisman	001	Problem with small group
Jeff	018	Two side to coin
Barth	050	Finance officer. Bartlett Memorial Hospital responds to questions
Jeff	122	Uncompensated care coming from 2. Percentages increasing? Charity cases?
Barth?	158	Comments on costs. AK unique competing w/ state. BMH - \$380 per person a month
Jeff	244	Change in out-patient care?
Werner	290	Review Nursing Home Acquires

Health Care Task Force - 9-10-90

PAGE: 4

SPEAKER	TAPE #	SIGNIFICANT INFORMATION
Joe Dennis		Responds to Duran
Jeff	330	Happening now
Cunningham	340	Differences in st plan & city plan
Jeff	379	What drive behind Mercuri costs as providers?
Don Knudson	390	Thinks there are 3 or 4 things
Jeff	478	Rural system - way to make it more efficient?
Knudson	508	Asking providers to free out survey.
	535	Utilization Review bill
Don Hamaker	540	Average increase at B M H has been 6-7% per yr
Cunningham	555	Organizations supporting utilization?
Duran	570	Chiropractor referral not accepted at B M H discussion
Knudson	640	Probably take statutory change.
Knudson	670	Spent 2-3 years prior 7 leg.
Knudson	695	Final issue concern statewide pub employees system
Ray Ballinger	750	Julia from Charter will be testifying
Red Bloop		Paton folks will be there
		Adj 11:40 AM.

HEALTH CARE COST CONTAINMENT TASK FORCE

Membership

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

Sen. Jim Duncan, *Chair*
Alaska State Senate
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Phone: 465-4766

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House of Representatives
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Phone: 465-3779

Rep. Mark Boyer
House of Representatives
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Anchorage Municipal
Employees Assoc.
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Anchorage, Ak. 99510
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MEBA
124 Front St.
Juneau, Ak. 99801
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Karen Perdue
Dep. Commissioner
Dept. of Health &
Social Services
Box H
Juneau, Ak. 99811-0601
Phone: 465-3030

Callagher
FAX 415 543 1309



Official Business

COMMITTEE:
HEALTH CARE
TASK FORCE

DATE: 9-10-90

SIGN-IN

Subject of meeting:

PLEASE PRINT!

NAME

ADDRESS

(MAILING) & (ZIP)

PHONE

REPRESENTING

**DO YOU WANT
TO TESTIFY?**

TOM ARMSTRONG	LAKE SIDE RECOVERY BOTHELL, WA / ALASKA	206 823-3116	LAKE SIDE NARTP	YES UTIL. REVIEW
Harlan Knudson	AK ST. Hospital & Nursing Home Assn	586- 3790	ST. Jude	YES
Bill Quinn	240 MAIN, SUITE 702 JUNEAU 99801	907 463 4949	AK STATE EMPLOYEES ASSO C/ AFSCME LOCAL 52	NO
Terry Reinwand	175 S. Franklin St. Juneau, Alaska 99801	586-5966		NO
Joe Hoverson	301 Seward St. Juneau, AK 99801	907-586-2414	Shattuck & Grummett.	NO.
Jodi Bishop	Lakeside Recovery Juneau	780 4948	Lakeside	NO
Bob Munnis	Post Office Way #302 Juneau AK	586-3090	NEA	NO
GARTH HAMBLIN	# 3260 HOSPITAL DRIVE JUNEAU, AK 99801	586-840	BARTLETT HOSPITAL	YES
Rick Urior	Box 20868 Juneau 99802	463-5682	AK State Medical Ass'n	NO

LEGISLATIVE TELECONFERENCE NETWORK



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	URL #
1						
2	Reed Stoops / Homer	Box 1211 Juneau	463-3223		✓	
3	Steve W Brun / AKNA	Seattle, WA	(206) 467-2803			
4	Michael Bondi / AKNA	Middletown, CT	203-636-4577			
5	Judith Stetter	Anchorage AK 99511	261-0011			
6	Gail y Cronen / North	Anchorage, AK	258-7575		✓	
7	R Schuler	Anch	562-2261		✓	
8	Sister Donna Taylor	Anchorage	562-2211	✓		
9	Steve Berkshire	North Star Protestant Hospital Anchorage	277-0222	✓		
10						
11						
12						
13						
14						
15						
16						
17						
18						

LEGISLATIVE TELECONFERENCE NETWORK



SIGN-IN SHEET

SPONSOR: NCCS

SUBJECT: _____

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

PLEASE PRINT

	NAME/REPRESENTING	ADDRESS	PHONE #	TESTIFY	OFFERIVE	BILL #
1	Steve LeBrun / AECNA	1501 4th Ave Seattle, WA 98101	206-467-2803			
2	Reed Storgs / AECNA	Box 1211 Juneau	586-3340			
3	BARTLETT MEMORIAL HOSPITAL (ARTH HANBLIN)	3260 HOSPITAL DR JUNEAU	586-8402			
4	Harlan Knutsen					
5	Charles McKee	% A.T.O.M. 216 E 53rd Ave 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

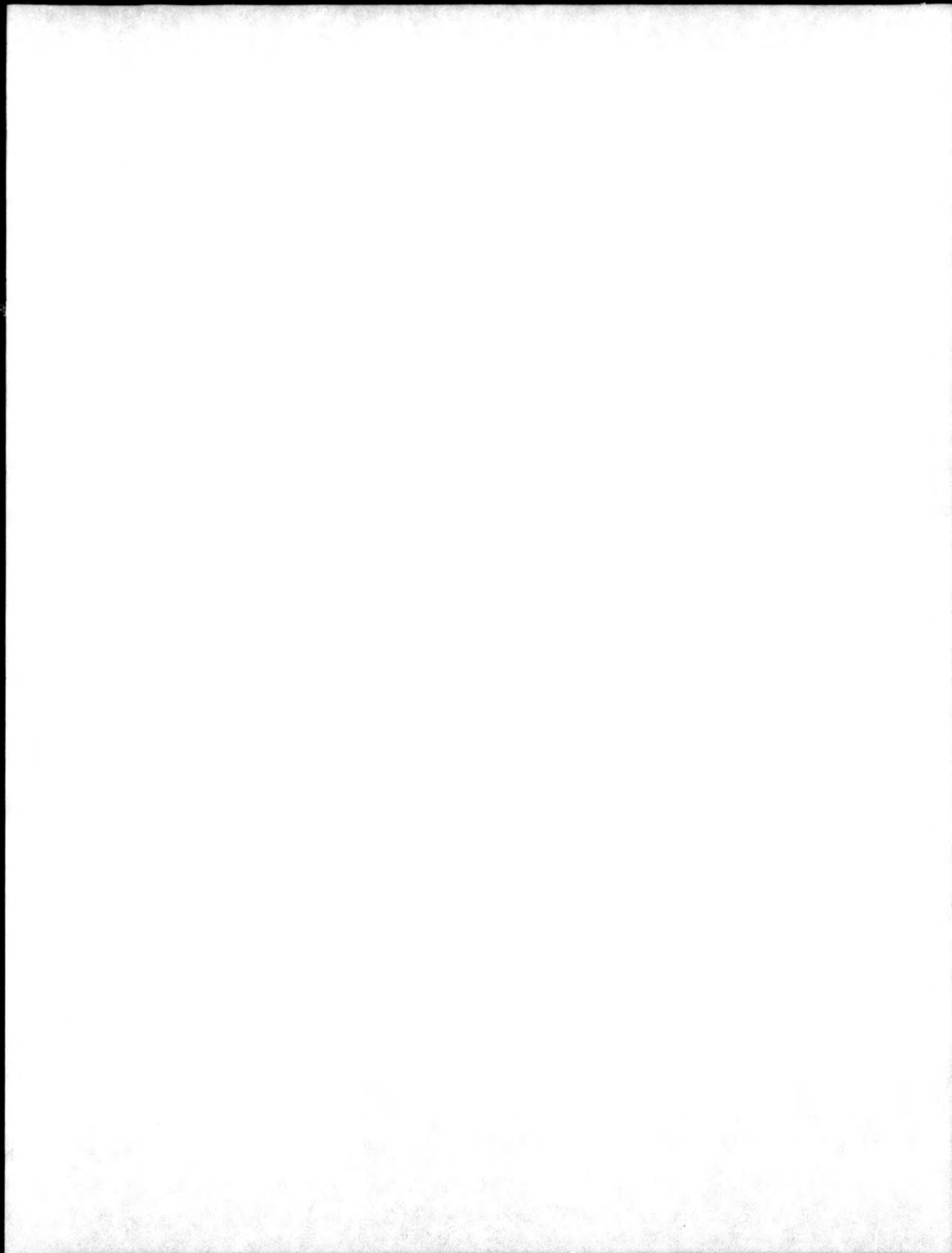
STATE OF ALASKA

HEALTH CARE COST CONTAINMENT TASK FORCE POSITION PAPER

OCTOBER, 1990

DRAFT

HCCCTF9/90-2



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

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

HCCCTF9/90-2

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.

HCCCTF9/90-3

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 reality 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.

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.

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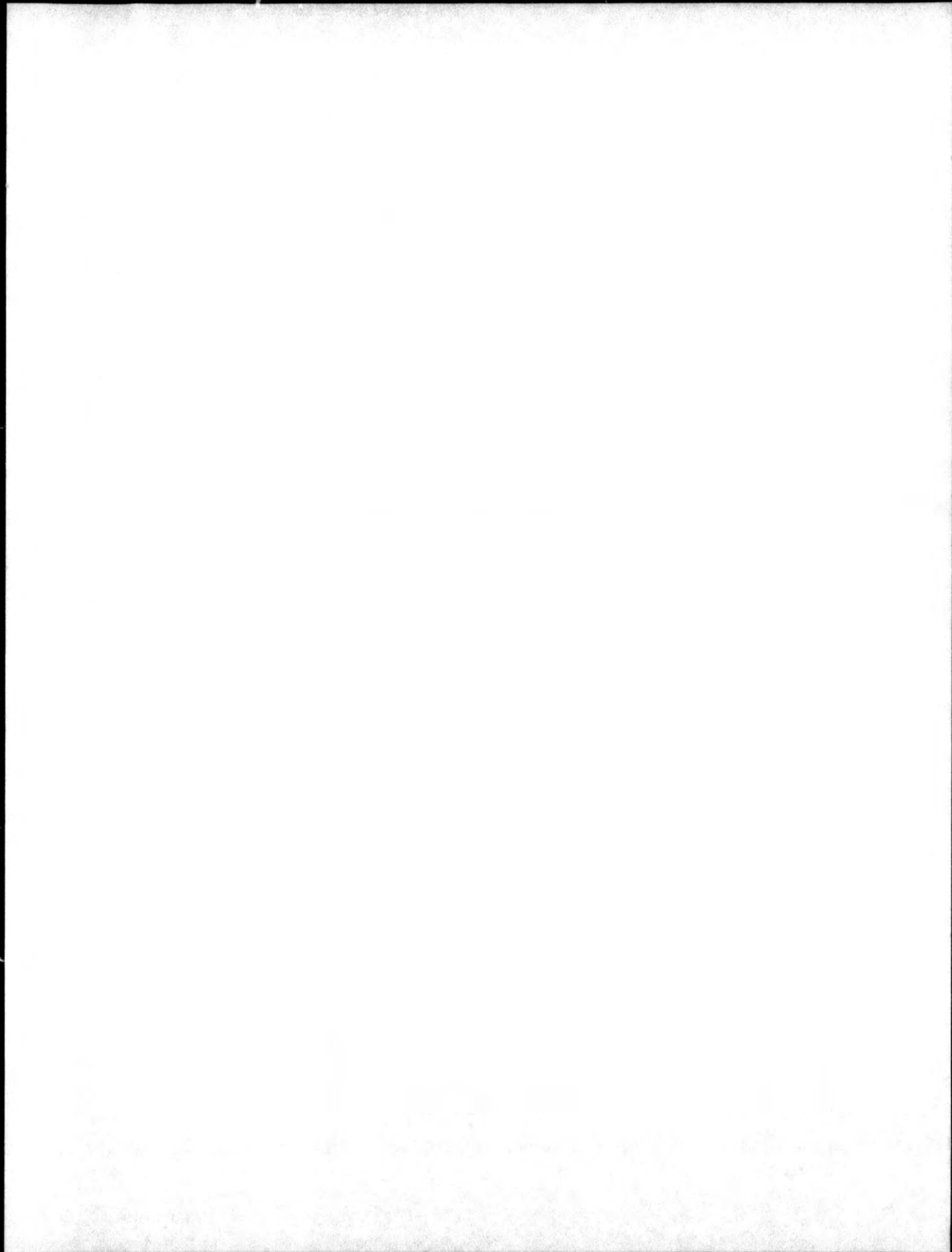
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Under study.

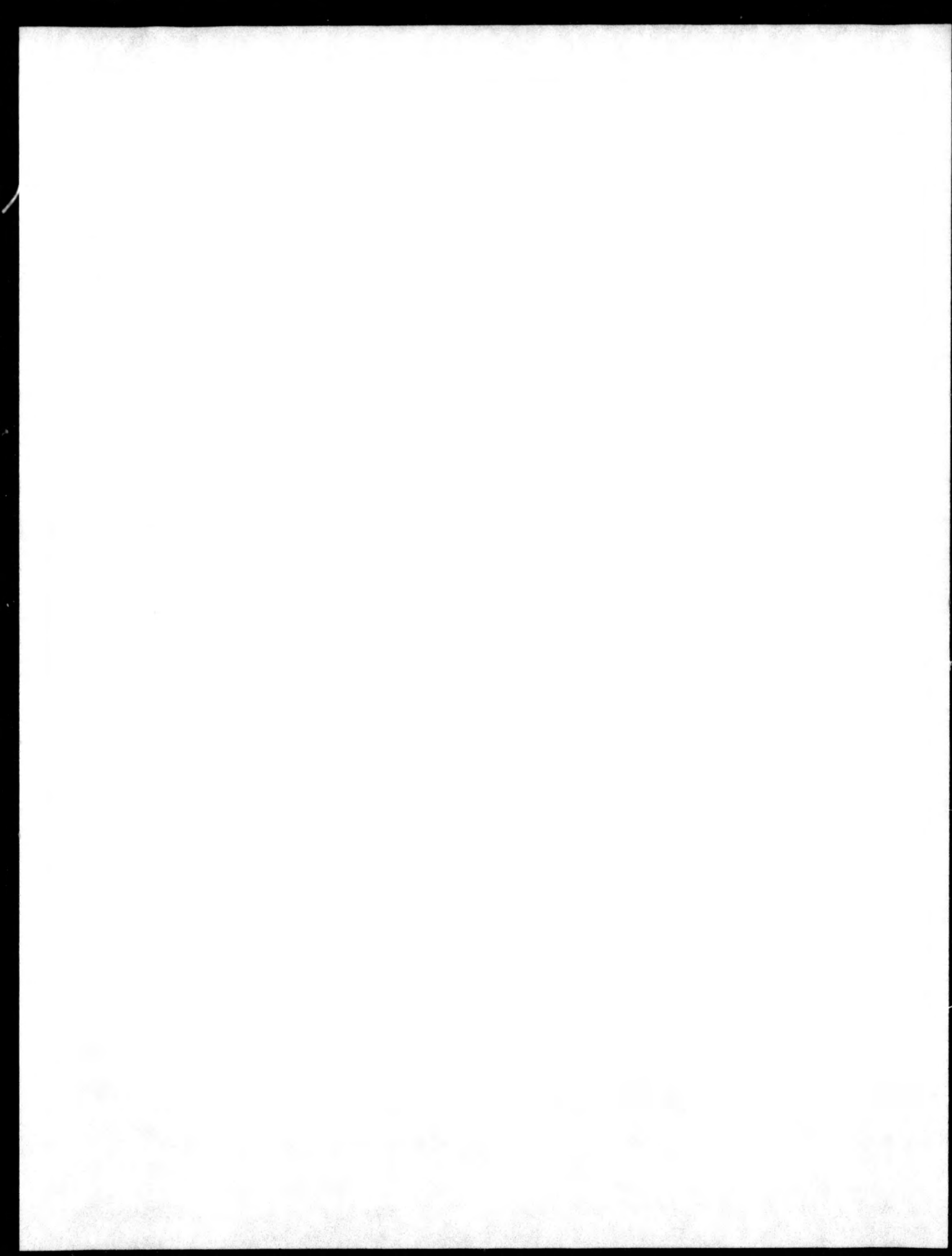
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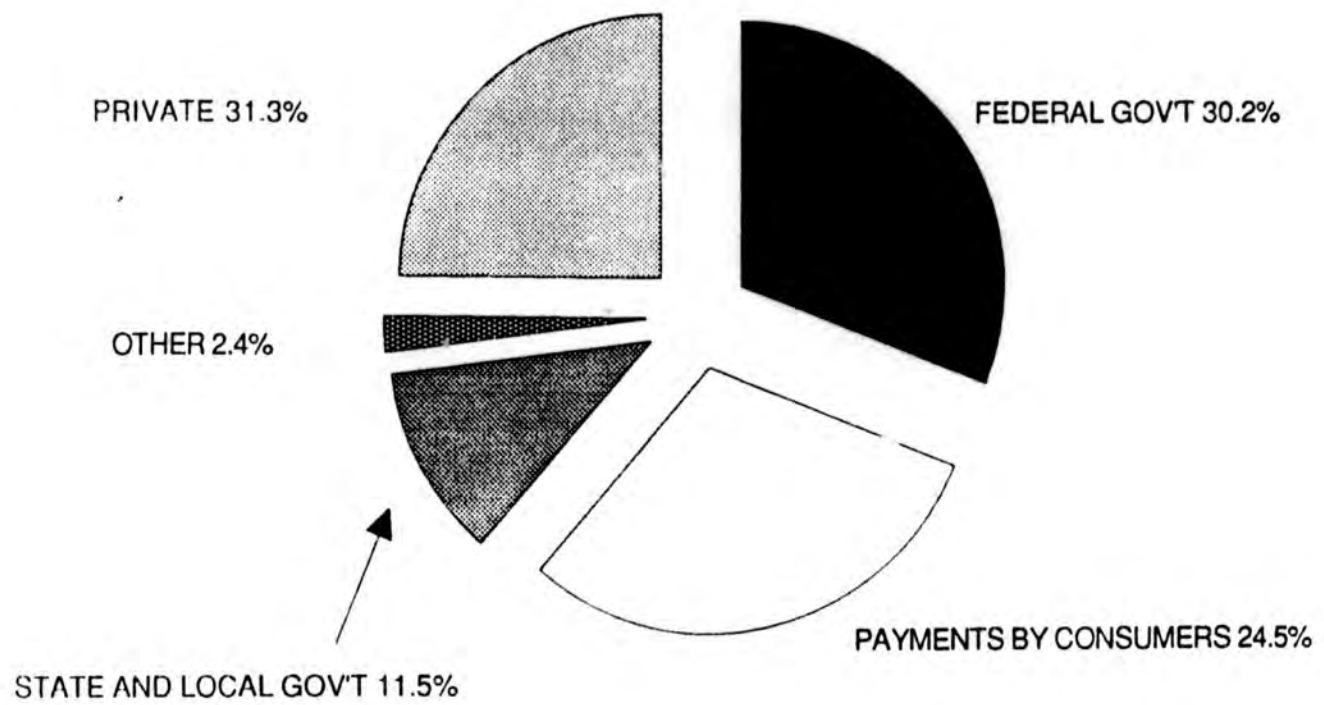
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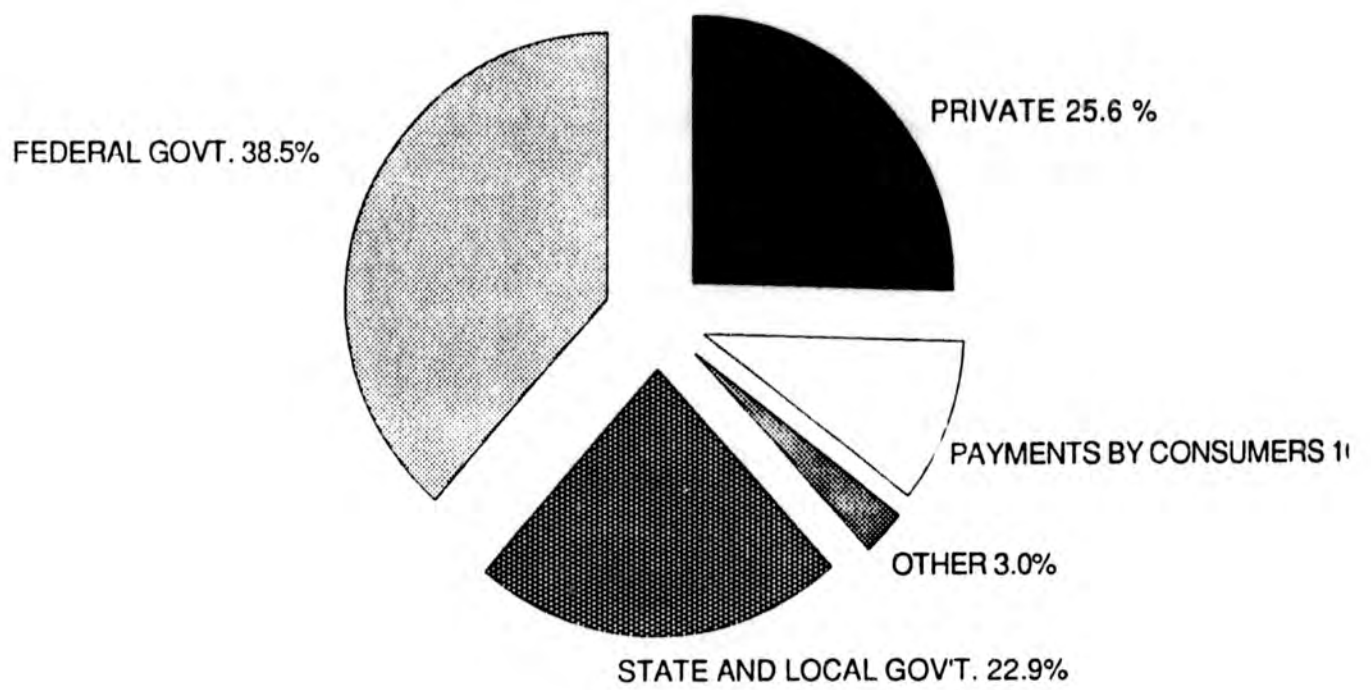
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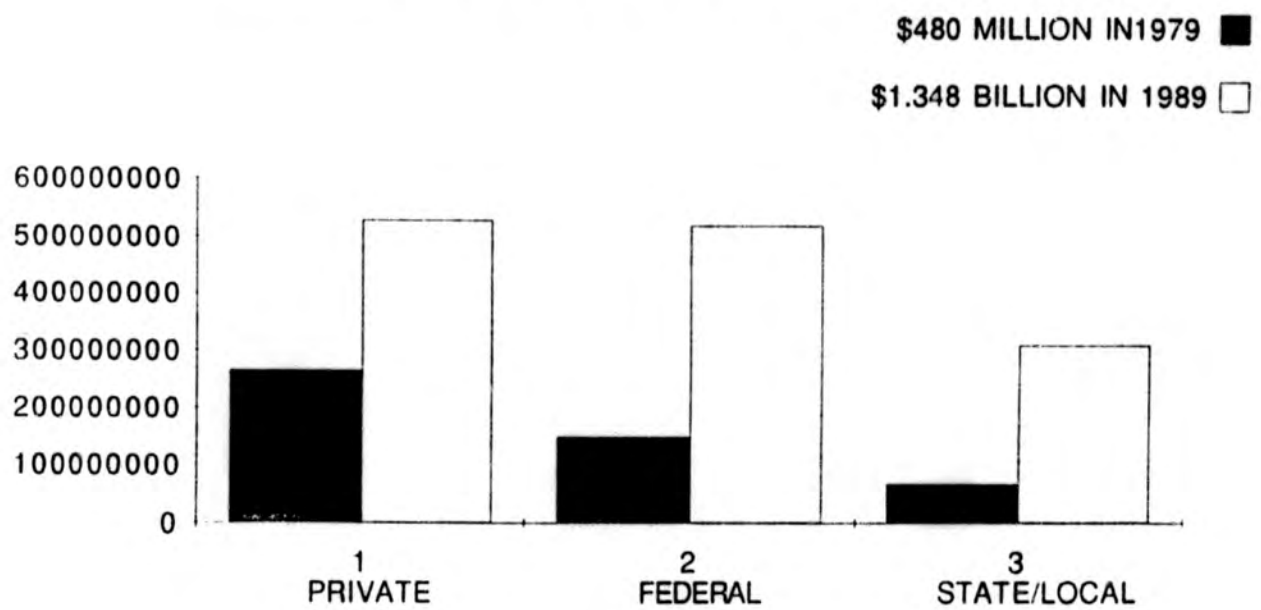
PERCENT OF U.S. HEALTH CARE EXP. BY SOURCE OF PAYMENT 1989



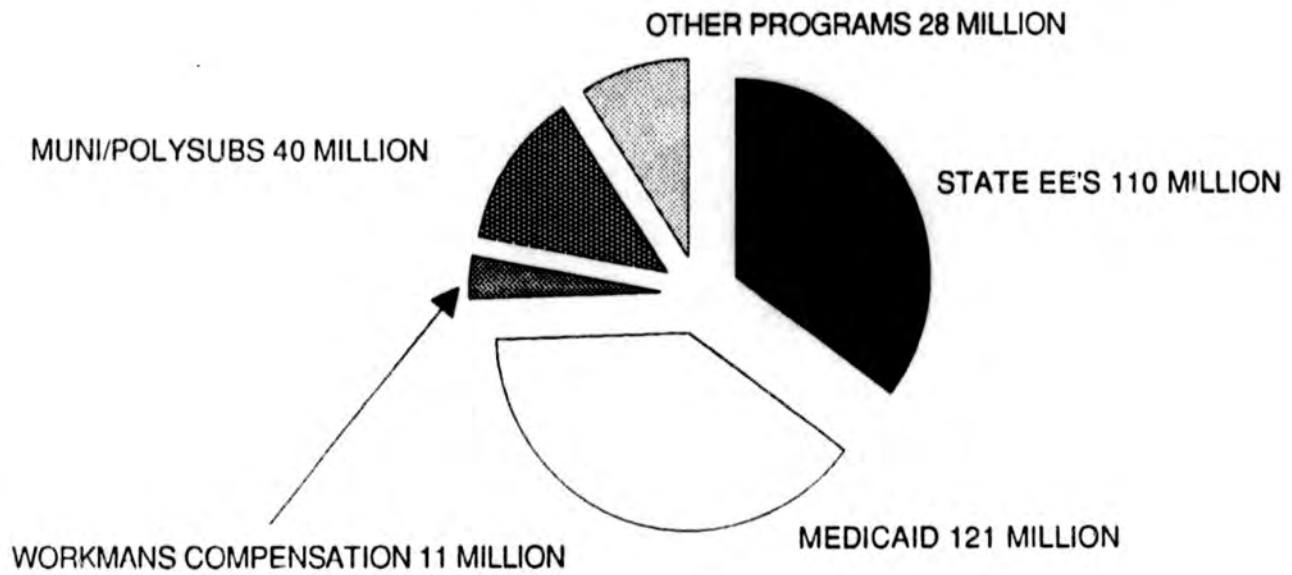
PERCENT OF ALASKA HEALTH CARE EXP. BY SOURCE OF PAYMENT 1989



STATE OF ALASKA HEALTH CARE EXPENDITURES 1979 VS 1989



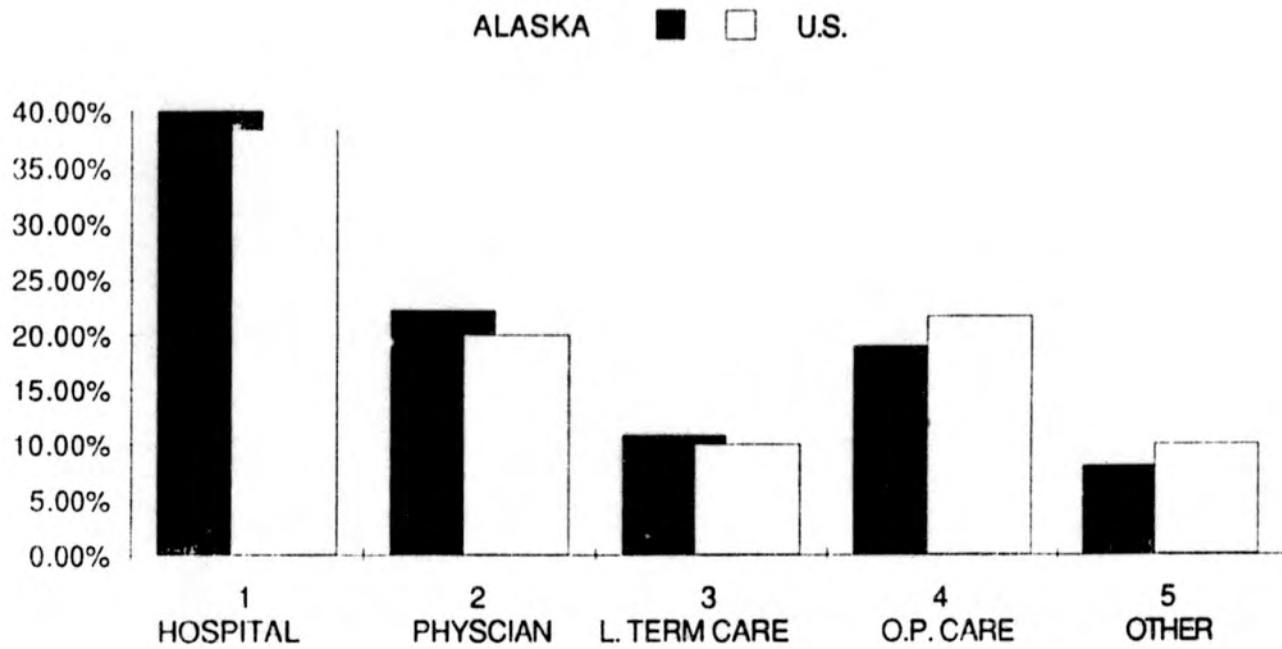
1989 STATE OF ALASKA HEALTH CARE EXPENDITURES FOR STATE AND
LOCAL GOVT.



TOTAL STATE GOV'T HEALTH CARE EXPENDITURES

1989-----310 MILLION

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

[illegible]

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

<u>Employee/Retiree</u>	<u>Dependents</u>	<u>Totals</u>
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 (prisoners)		
2,516		2,516
7. Ak. Railroad		
551		551

8. Medicaid Eligibles.
Div. Of Medical Assistance

41,000

41,000

(144,206)

a) There 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

XXXXXXXXXXXX

(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

UK

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 4/5

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

#

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: 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.
(Draft)

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

← This was debated. Survey's 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: 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.
(Draft)

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: 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.
(Draft)

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 reality 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.

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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 appropriate 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: The Task Force should endorse the expansion of the Medicaid program as contained in
(Draft) 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 catastrophic 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.

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 12/31/89	Percent of Revenue	Bartlett Memorial 6/30/89	Percent of Revenue
Total Revenue	0		144,029,998		12,361,793		0		3,800,106		1,403,939		15,007,522	
Less: Contractual Adjustments		ERR	(17,164,948)	11.30%	(441,363)	3.27%		ERR	(81,288)	1.74%	(105,978)	5.00%	(758,073)	4.85%
Charity Care		ERR	(4,934,500)	3.27%	(407,452)	2.71%		ERR	0	0.00%	(1,331)	0.00%	(467,065)	2.07%
Bad Debts		ERR	(7,562,951)	5.02%	(803,520)	6.02%		ERR	(135,757)	2.01%	(170,205)	0.03%	(850,454)	4.00%
Total Revenue Deductions	0		(29,662,406)		(1,652,335)		0		(217,025)		(277,512)		(1,873,592)	
Other Operating Revenue			5,814,440		86,878				76,222		8,887		132,721	
Net Revenue	0		119,362,032		10,846,329		0		3,739,303		1,135,314		14,166,650	
Expenses:														
Salary/Wage/Benefits		ERR	(60,305,202)	40.00%	(6,434,406)	42.04%		ERR	(2,769,107)	59.41%	(1,080,330)	50.40%	(7,803,110)	40.31%
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	(288,450)	6.15%	0	0.00%	(861,755)	4.07%
All Other Operating Expenses		ERR	(41,714,170)	27.67%	(4,313,824)	28.72%		ERR	(1,167,184)	25.04%	(707,407)	31.37%	(4,843,564)	30.37%
Total Operating Expense	0		(112,832,871)		(12,758,127)		0		(4,667,616)		(1,846,211)		(14,736,742)	
Non-Operating Revenue			1,700,569		2,589,615				704,748		786,785		235,857	
Non-Operating Expense		ERR	-	0.00%	(20,603)	0.14%		ERR	-	0.00%	-	0.00%	(32,081)	0.20%
Net Income/(Loss)	0	ERR	8,257,730	5.40%	437,214	2.81%	0	ERR	(273,565)	-4.00%	(4,112)	-0.10%	(366,315)	-2.25%
		ERR		100.0%		100.0%		ERR		100.0%		100.0%		100.0%
Liability Insurance:														
1989					341,698				101,788		88,041		481,184	
1990					286,531				94,480		52,170			

HEALTH CARE COST CONTAINMENT TASK FO

FACILITY FINANCIAL INFORMATION

HOSPITALS	Humana Hospital 9/31/88	Percent of Revenue	Valley Hospital 12/31/88	Percent of Revenue	Fairbanks Memorial 12/31/88	Percent of Revenue
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Total Revenue	0		0		40,309,604	
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Less: Contractual Adjustments		ERR		ERR	(4,300,050)	10.50%
Charity Care		ERR		ERR	(200,104)	0.50%
Bad Debts		ERR		ERR	(913,523)	2.20%

Total Revenue Deductions	0		0		(5,400,546)	
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Other Operating Revenue					1,055,705	
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Net Revenue	0		0		35,074,843	
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Expenses:

Salary/Wage/Benefits		ERR		ERR	(20,340,000)	40.91%
Depreciation/Amortization/Rent		ERR		ERR	(2,422,414)	5.03%
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)	
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Non-Operating Revenue					220,150	
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Non-Operating Expense		ERR		ERR		0.00%
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Net Income/(Loss)	0	ERR	0	ERR	1,250,642	3.03%
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		ERR		ERR		100.0%
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Liability Insurance:

1989					1,317,335	
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1990					1,353,662	
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HEALTH CARE COST CONTAINMENT TASK FORCE

FACILITY FINANCIAL INFORMATION

NURSING HOMES	St. Ann's 12/31/88	Percent of Revenue	Vesleyan 8/30/88	Percent of Revenue	Mary Conrad Center 12/31/88	Percent of Revenue	Our Lady of Compassion 12/31/88	Percent of Revenue	Heritage House 12/31/88	Percent of Revenue	Denali 12/31/88	Percent of Revenue
Total Revenue:	3,160,980		3,169,363		6,296,107		18,097,000		2,853,861		5,488,476	
Less: Contractual Adjustments	(488,588)	15.38%	(884,815)	28.36%	(542,187)	8.38%	(4,848,000)	26.82%	(540,778)	18.92%	(1,151,352)	20.42%
Charity Care	0	0.00%	0	0.00%	(22,893)	0.34%	(400,000)	2.18%	0	0.00%	(53,488)	0.95%
Bad Debts	0	0.00%	0	0.00%	(25,716)	0.40%	(1,000)	0.01%	(151,866)	5.32%	(78,271)	1.35%
Total Revenue Deductions	(488,588)		(884,815)		(589,896)		(5,347,000)		(692,745)		(1,281,112)	
Other Operating Revenue	7,200		0		140,826		134,000		3,952		23,804	
Net Revenue	2,669,599		2,174,548		5,647,007		12,884,000		2,165,168		4,230,968	
Expenses:												
Salary/Wage/Benefits	0	0.00%	(1,815,481)	55.75%	(2,481,854)	39.35%	(8,261,000)	44.85%	(947,788)	33.16%	(3,168,892)	56.07%
Depreciation/Amortization/Rent	0	0.00%	(84,949)	2.47%	(880,308)	14.86%	(883,000)	5.24%	(185,346)	5.78%	(107,698)	1.91%
Interest Expense	0	0.00%	0	0.00%	(1,091,198)	18.86%	(1,445,000)	7.88%	(388,332)	13.31%	(72,324)	1.28%
All Other Operating Expenses	(2,657,706)	81.88%	(1,071,120)	31.18%	(1,107,708)	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)		(5,640,858)		(12,840,000)		(2,010,387)		(4,625,792)	
Non-Operating Revenue	77,430		266,293		34,100		142,000		0		125,461	
Non-Operating Expense	0	0.00%	0	0.00%	0	0.00%	0	0.00%	(17,672)	0.62%	0	0.00%
Net Income/(Loss)	88,323	2.75%	(630,688)	-18.36%	240,247	3.71%	186,000	1.01%	137,109	4.00%	(268,363)	-4.78%
		100.0%		100.0%		100.0%		100.0%		100.0%		100.0%
Liability Insurance:												
1989	110,487		15,200		0		9,201		4,000		16,875	
1990	88,717		18,285		0		14,294		4,000		12,452	

HEALTH CARE COST CONTAINMENT TASK FORCE

FACILITY FINANCIAL INFORMATION

COMBINED FACILITIES	Petersburg General 6/30/88	Percent of Revenue	Cordova Community 6/30/88	Percent of Revenue	Wrangell General 6/30/88	Percent of Revenue	South Peninsula 6/30/88	Percent of Revenue	Horton Sound 6/30/88	Percent of Revenue	Ketchikan General 6/30/88	Percent of Revenue	Kodiak Island 12/31/88	Percent of Revenue
Total Revenue	2,481,262		1,822,848		1,878,223		5,774,315				11,480,620			
Less: Contractual Adjustments	(257,499)	9.87%	(141,850)	8.43%	(140,106)	8.00%	(1,006,273)	13.63%	ERR		(418,368)	3.5%		ERR
Charity Care	(22,195)	0.78%	(18,807)	0.73%	(102,022)	4.81%		0.00%	ERR		(58,909)	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)		(259,412)		(347,788)		(1,006,273)		0		(817,532)		0	
Other Operating Revenue	55,501		32,853				78,153				237,628			
Net Revenue	2,236,256		1,895,589		1,831,435		4,847,195		0		10,910,717		0	
Expenses:														
Salary/Wage/Benefits	(1,367,822)	49.18%	(1,153,212)	52.34%	(1,278,844)	57.81%	(3,585,447)	47.50%	ERR		(7,085,782)	58.8%		ERR
Depreciation/Amortization/Rent	(559,488)	18.71%	(550,152)	24.97%	(174,281)	7.87%	(572,808)	7.78%	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	(488,880)	17.23%	(527,641)	23.95%	(818,479)	27.50%	(2,584,272)	35.01%	ERR		(3,558,568)	29.8%		ERR
Total Operating Expense	(2,416,190)		(2,231,005)		(2,082,603)		(6,652,625)		0		(11,183,184)		0	
Non-Operating Revenue	381,881		248,508		234,328		1,527,009				388,581			
Non-Operating Expense	(1,402)	0.05%		0.00%		0.00%	(272,614)	3.60%	ERR			0.0%		ERR
Net Income/(Loss)	120,125	4.23%	(288,810)	-13.82%	(218,802)	-8.00%	(588,955)	-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		58,813		67,500		148,370				118,125			
1990	50,000		53,295		84,000		187,213				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
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Total Revenue	23,648,269		212,881,962		38,885,967	
Less: Contractual Adjustments	(1,872,884)	7.40%	(22,888,488)	9.87%	(8,873,332)	21.87%
Charity Care	(180,133)	0.75%	(8,818,518)	2.81%	(1,125,582)	1.18%
Bad Debts	(558,485)	2.10%	(18,338,418)	4.48%	(254,953)	0.64%
Total Revenue Deductions	(2,731,512)		(39,322,424)		(9,404,267)	
Other Operating Revenue	486,338		8,374,934		388,588	
Net Revenue	21,321,182		186,844,471		28,871,288	

Expenses:

Salary/Wage/Benefits	(14,481,887)	53.88%	(88,878,843)	42.81%	(18,748,875)	41.85%
Depreciation/Amortization/Rent	(2,388,871)	8.94%	(18,888,881)	8.95%	(2,281,381)	5.78%
Interest Expense	(18,258)	0.07%	(1,888,853)	0.82%	(2,888,854)	7.47%
All Other Operating Expenses	(2,771,858)	28.13%	(88,818,881)	28.17%	(8,828,253)	22.88%
Total Operating Expense	(24,575,887)		(188,877,838)		(38,848,283)	
Non-Operating Revenue	2,821,182		8,145,724		845,282	
Non-Operating Expense	(274,818)	1.83%	(52,888)	0.82%	(17,872)	0.84%
Net Income/(Loss)	(887,518)	-3.48%	8,358,584	4.88%	(247,373)	-0.82%
		100.0%		100.0%		100.0%

Liability Insurance:

1989	441,888	2,388,827	154,843
1990	458,588	1,788,848	135,728