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**THE STATE OF ALASKA
HEALTH RESOURCES AND ACCESS TASK FORCE**

FINAL REPORT

to

the Governor and Legislature

APPENDIX

January 1993

Alaska State Legislature
Health Resources and Access Task Force
State Capitol
Juneau, Alaska 99801-1182

APPENDIX
FINAL REPORT TO THE GOVERNOR AND LEGISLATURE

Health Resources and Access Task Force
January 1993

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APPENDIX A

Legislative Resolve 45

Establishing a Health Resources and Access Task Force

STATE OF ALASKA

THE LEGISLATURE

1991

Source

HCS CSSCR 10(FIN)

Legislative
Resolve No.

45



Establishing a Health Resources and Access Task Force.

evaluate ways to manage health care expenditures in the state;

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

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

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

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

FURTHER RESOLVED that the task force shall

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FURTHER RESOLVED that the task force shall consist of 17 members as follows:

(1) three members of the Senate appointed by the President of the Senate;

(2) three members of the House of Representatives appointed by the Speaker of the House;

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

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

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

FURTHER RESOLVED that, within funds made available for the purpose, the task force

may hire staff and, subject to approval by the Alaska Legislative Council, contract for services to perform its duties under procurement procedures adopted by the council; and be it

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

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

APPENDIX B

Estimated 1991 Health Spending in Alaska
By Source of Funds (and sources for table)

Table II
ESTIMATED 1991 HEALTH SPENDING IN ALASKA
BY SOURCE OF FUNDS
(In Thousands of Dollars)

Detail	Individual	Business	Local	State	Federal	TOTAL
Employment-Based:						\$460,121
Insurance Premiums	\$61,164	\$121,418	\$39,906	\$47,929	\$35,402	28.80%
Self-Insured Plans	\$30,861	\$65,379	\$48,774	\$9,290		
Subtotal/Employment-Based	\$92,024	\$186,796	\$88,681	\$57,218	\$35,402	
Other Private						\$77,547
Individual Policies and Coverage through Fraternal Orgs and Auto Liability Insurance	\$29,458					4.85%
Workers' Compensation		\$48,089				
Out-Of-Pocket:						\$255,602
Expenses of Uninsured	\$255,602					16.00%
Co-payments/Deductibles						
Non-covered Services						
Medicare:				\$964	\$90,000	\$90,964
						5.69%
Medicaid:						\$214,550
Federal					\$109,248	13.43%
State				\$95,326		
Medicaid Administration				\$4,276	\$5,700	
Other Public						
Federal:						\$308,561
IHS/AANS					\$206,153	19.32%
Veteran's Affairs					\$46,476	
CHAMPUS payments					\$14,647	
Military Support					\$41,284	
State:						\$160,455
Pioneer's Homes				\$12,436		10.04%
Youth Corrections Health Care				\$662		
API, Harborview				\$19,270		
Grants to Regional Health Corporations				\$7,066	\$313	
Selected state health services				\$27,977		
Revenue Sharing for Health				\$5,026		
Other grants for health				\$21,799		
Community Mental Health Grants				\$27,995		
Fisherman's Fund				\$1,230		
General Relief Medical				\$7,672		
Other State Health Spending				\$29,009		
Local:						\$29,713
Local Taxes in Support of Hospitals						1.86%
Other Local Health Spending (net of state grants)			\$29,713			
Total	\$377,084	\$234,885	\$118,394	\$317,926	\$549,223	\$1,597,513
As a % of total spending	23.60%	14.70%	7.41%	19.90%	34.38%	

Source: Data originally compiled by ISER, UAA from various sources. Selected entries updated by Health Systems Research, Inc.

**SOURCES FOR TABLE 1: ESTIMATED 1991
HEALTH SPENDING IN ALASKA BY SOURCE OF FUNDS**

Much of the data presented in Table 1 were originally compiled from various sources by the Institute for Social and Economic Research (ISER), UAA. ISER's documentation is presented below. In general, HCFA definitions of categories have been followed, and the same sources have been used whenever possible. Selected entries also were updated by Health Systems Research, Inc. The sources for these updated entries are identified below by bold text.

A. EMPLOYMENT-BASED COVERAGE

Employment-based health expenditures are those moneys paid by third party payers. These expenditures can be broken down into two categories: costs to employers who purchase private insurance, and costs to employers who self-insure.

In estimating the relative shares of employment-based health care coverage costs that were borne by employers and employees, it was assumed that 80% of total costs were paid by employers, and 20% of costs were paid by employees.

1. Private Insurance Premiums

HCFA includes the administrative costs and profit of health insurers as health care expenditures. Thus, the relevant cost figure for employers purchasing private insurance is premiums paid. The Alaska DCED, Division of Insurance, publishes in its annual report a figure for total premium payments to medical service corporations (in Alaska, this is only Blue Cross and Vision Care of Alaska) and premiums paid to commercial insurers.

Figures for total premiums earned in 1991 for group coverage for both commercial insurers and Blue Cross/Blue Shield were provided by the Division of Insurance. This figure includes premiums paid by all employers in the state, and is not broken down between private and government employers. In order to estimate premium costs for different payers, state, federal, and local government costs were identified as described below, and these identified costs were subtracted from total premiums paid, giving premium costs for private employers.

- a. Local Government. Total costs were estimated based on a cost of \$400/month per employee, a figure in the middle of the range of health insurance costs for local government employees based on various Anchorage municipal and school district contracts. It was assumed that 45% of total costs for local governments other than Anchorage (which is largely self-insured) are for private insurance, while 55% are for self-insurance.
- b. State Government. For executive branch employees, the Alaska Division of Retirement and Benefits provided the premium amount per month per employee; the FY 92 Budget shows the number of employees by department. Number of employees * premium amount = estimated premiums for executive branch employees.
- c. Federal Government/Civilian. Total premium costs for calendar year 1991 for federal civilian employees in Alaska were provided by the U.S. Office of Personnel Management.

2. Self-Insured Plan Costs

Self-insurance costs for different payers were estimated as follows:

- a. Local Government. This figure is the sum of: 1) costs for the Municipality of Anchorage for FY 1991, provided by the Municipality's Employee Relations, Benefits Department; 2) costs for the Anchorage School District, provided by the District's Benefits Department; and 3) 55% of estimated total costs for other local government employees, based on an assumed cost of \$400 per month.
- b. State Government. The University of Alaska at Anchorage is the only self-insured state employer. Total costs were provided by statewide accounting.
- c. Private Employers. No exact figure for self-insured costs for private businesses is available. National estimates developed by the HIAA indicate that between 50% and 55% of employers self-insure. In work done for the State of Alaska's Health Care Cost Containment Task Force, Noble Lowndes estimated that self-insured health benefits paid in Alaska equaled 35% of total employer costs for Alaska. We have applied this 35% figure to private businesses' health care expenditures to estimate self-insured health benefit costs.

B. OTHER PRIVATE INSURANCE

1. Individual Policies, etc.

This figure represents premiums paid by individuals who purchase their own health insurance as well as the medical insurance portion of auto liability insurance policies. **The Division of Insurance supplied a figure for non-group premiums earned in 1991 for both commercial insurers and Blue Cross/Blue Shield. The most recent figures available from the Division for coverage through fraternal organizations, auto liability insurance, and credit accident and health insurance were from 1990, and these 1990 figures were included in the total in Table 1.**

2. Workers' Compensation

This figure represents premiums paid in Alaska and was provided by the National Council on Compensation Insurance.

C. OUT-OF-POCKET

Out-of-pocket costs have been estimated based on the assumption that they equal 16% of total expenditures. This assumption is derived by following HCFA's methodology for using data from the Consumer Expenditure Survey. This results in an estimate of roughly 16% of all expenditures, which is higher than an estimate of 10% developed by Noble Lowndes for the Health Care Cost Containment Task Force.

D. MEDICARE

Total federal benefit payments in Alaska for FFY 91 were provided by the Bureau of Data Management and Strategy, HCFA. State monies represent FY 91 1928.8 Medicaid Part B buy-in costs, provided in the Division of Medical Assistance 1991 Annual Report.

E. MEDICAID

Figures represent FY 91 costs and are from the Division of Medical Assistance 1991 Annual Report, as well as the state budget for the Medical Assistance Administration.

F. OTHER PUBLIC FUNDS

1. Federal

- a. IHS/AANS. Figures are from the FY 1991 Alaska Area Program Information Summary, Alaska Area Native Health Service.
- b. Veterans' Affairs. Expenditures in Alaska for FY 91 were provided by the Director of Field Support for the Western Region, Department of Veterans' Affairs, Washington, DC.
- c. CHAMPUS Payments. Total CHAMPUS expenses for FY 1991 were provided by the Office of CHAMPUS in Aurora, Colorado.
- d. Military Support. Expenses for military facilities were estimated based on FY 90 budget information provided by Elmendorf Hospital. These budget figures were doubled based on the assumption that costs at Basset Hospital were similar to costs at Elmendorf, giving a total cost estimate.

2. State

- a. Pioneer's Homes. Estimate prepared by Noble Lowndes for the state's FY 91 budget, based on 1990 state spending. These may duplicate Medicare expenditures.
- b. Youth Corrections. Estimate of 1990 spending prepared by Noble Lowndes.
- c. Revenue Sharing for Health. Hospitals and health clinics portion for FY 91, as reported by the DCRA.
- d. Other State Health Spending. This category includes correctional facilities, elementary and secondary schools, and retirees. **The figure for elementary and secondary schools is a revised estimate prepared by ISER based on applying the percentage of "Pupil Support" monies spent on health care in Anchorage schools to 1990 statewide pupil support expenditures.** The other elements of this figure (correctional facility and retiree expenditures) are based on an estimate of 1990 spending prepared by Noble Lowndes.
- d. All other categories of state spending are from the state budget, and are FY 91 authorized monies.

3. Local

Local government spending was estimated based on 1990 Government Finances and State Government Finances data. Intergovernmental transfers from state government to local governments for health and hospitals were subtracted from the total spent by local governments to estimate actual total local expenditures. Federal government transfers to local governments could not be identified, and this figure may therefore include some federal monies. There should not, however, be any double counting of expenditures.

APPENDIX C

"Report to the Health Resources and Access Task Force,

January 1992"

by Oliver Scott Goldsmith, Ph.D.,

University of Alaska

Institute of Social and Economic Research

REPORT OF THE HEALTH RESOURCES AND ACCESS TASK FORCE JANUARY 1992

by
Oliver Scott Goldsmith, PhD.
Institute of Social and Economic Research
University of Alaska Anchorage

I. CALCULATION OF THE COST ASSOCIATED WITH EXCESS CAPACITY IN ALASKA COMMUNITY HOSPITAL ACUTE CARE BEDS

SUMMARY

Three approaches were used to characterize the costs which result because Alaska acute care community hospitals have more beds than required to serve current needs. The analyses have been done in the aggregate using cost and utilization data covering a short period of time. The results are intended as general indications of the magnitudes of potential savings to the medical system from reconfiguration of resources. The results are not intended to serve as comprehensive analyses of individual facilities. This would require much more detail regarding the both the costs of providing each particular type of care as well as more historical perspective.

There is an cost associated with the underutilization of Alaska community hospital acute care facilities. The total annual cost to Alaskans in 1989 to pay for surplus empty beds has been estimated to range from \$5.8 to \$20.8 million--2 to 7 percent of total acute care facility costs dependent upon assumptions. The surcharge per inpatient day varies across hospitals--ranging from \$0 in those hospitals without excess capacity up to \$663. To the extent that hospital charges to patients include the cost of replacement of these surplus beds, this is a real cost born by Alaska consumers increasing the cost for health care services.

If hospitals with excess capacity could be rebuilt with fewer acute care beds, and in addition, if they could be built so that the cost of an inpatient day were no more than twice the national average cost for hospitals of similar size, the annual savings to the Alaska health care system could be \$42 million--15 percent of total annual acute care facility costs.

A policy of redirecting patients from hospitals with low occupancy rates to more centralized facilities would reduce costs depending upon transportation costs and the extent to which outpatient and long term care costs at co-located facilities would be effected. As an example, a potential annual system savings of between \$229 thousand

and \$391 thousand could be achieved by redirecting the patients from the acute care facilities in Wrangell and Petersburg to Ketchikan.

BACKGROUND

The primary calculation of the excess capacity in Alaska community hospital acute care hospitals is based on a comparison of Alaska occupancy rates in 1989 with occupancy rates for acute care facilities of similar size in the US as a whole for the same period.

The use of national occupancy rates as a benchmark involves several shortcomings including:

1) The US average occupancy rates have fallen considerably during the last 2 decades and are currently near historical lows (Figure I.1. using data from the American Hospital Association). This is largely due to technological changes and financial incentives designed to minimize the length of hospital stay.

2) The efficient level of excess capacity involves a tradeoff between the cost of maintaining empty beds and the likelihood that demand on any given day will exceed capacity. In Alaska important considerations in making this tradeoff include seasonal peaks in demand and the small size of the population in individual community hospital service territories.

3) Alaska occupancy rates may increase over time reflecting the aging of the population. The current low level of demand can be seen by comparing the average number of inpatient days per capita for the Alaska population with the US average. The average Alaskan spends about .5 inpatient days in the hospital annually while in the US as a whole the figure is closer to .9 inpatient day per capita (Figure I.2. using data from the American Hospital Association. {Note that inpatient days per capita for the US are represented by the entire length of each bar while inpatient days per capita for Alaska are represented by the bottom and more darkly shaded portion of the bar}).

4) Occupancy rate calculations vary somewhat over time due to random events.

The Alaska community hospital acute care occupancy rate averaged across all hospitals is 45%. The range is from 11% to 61%. The occupancy rate is higher in the larger cities--50% in Anchorage and Fairbanks--than in the remainder of the state--35%. The average is lower for co-located facilities (32 %) than for facilities that only include acute care (46 %). These figures compare to a US average of 57% for similar sized facilities (Figure I.3. using data from the American Hospital Association. {Note that 4 Alaska hospitals, with bed capacities of 36, 37, 25, and 15 respectively had occupancy rates in excess of the national average for similar sized facilities.}). Using this national

Figure I.1

US OCCUPANCY RATES BY SIZE

COMMUNITY HOSPITALS

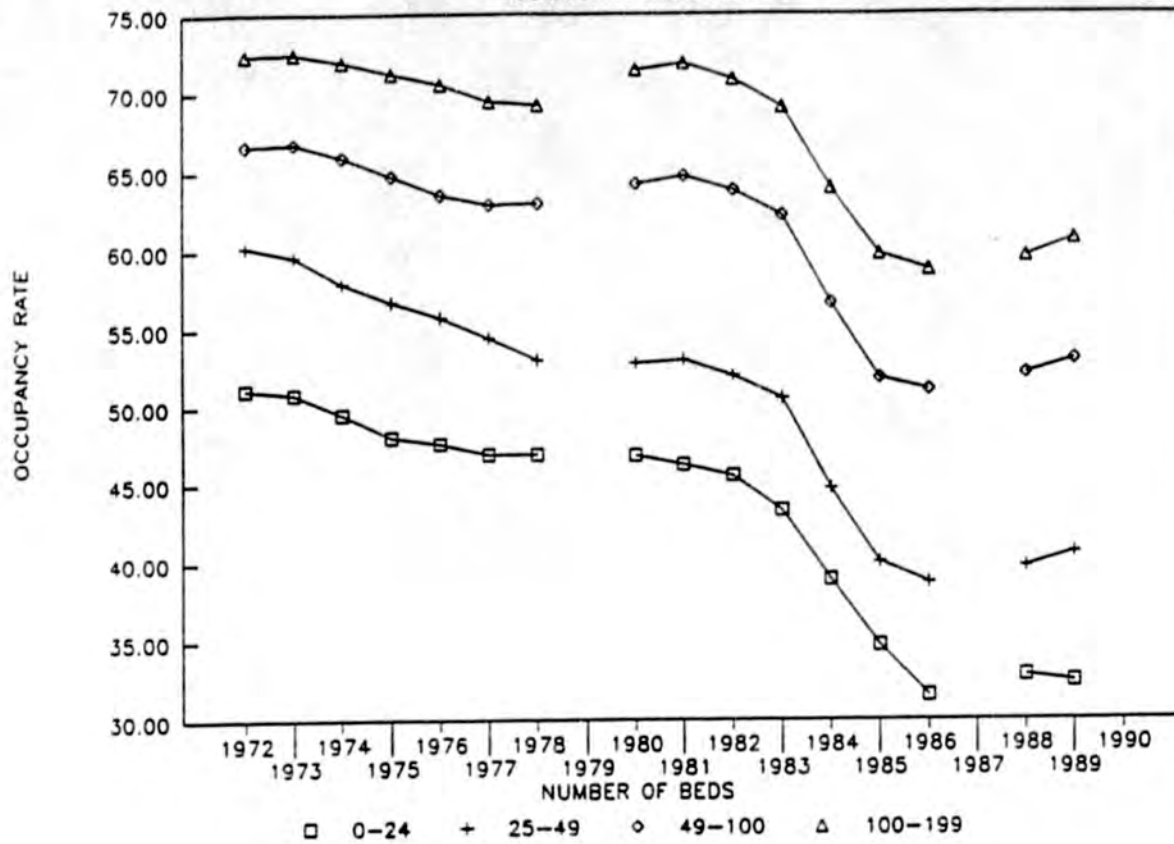
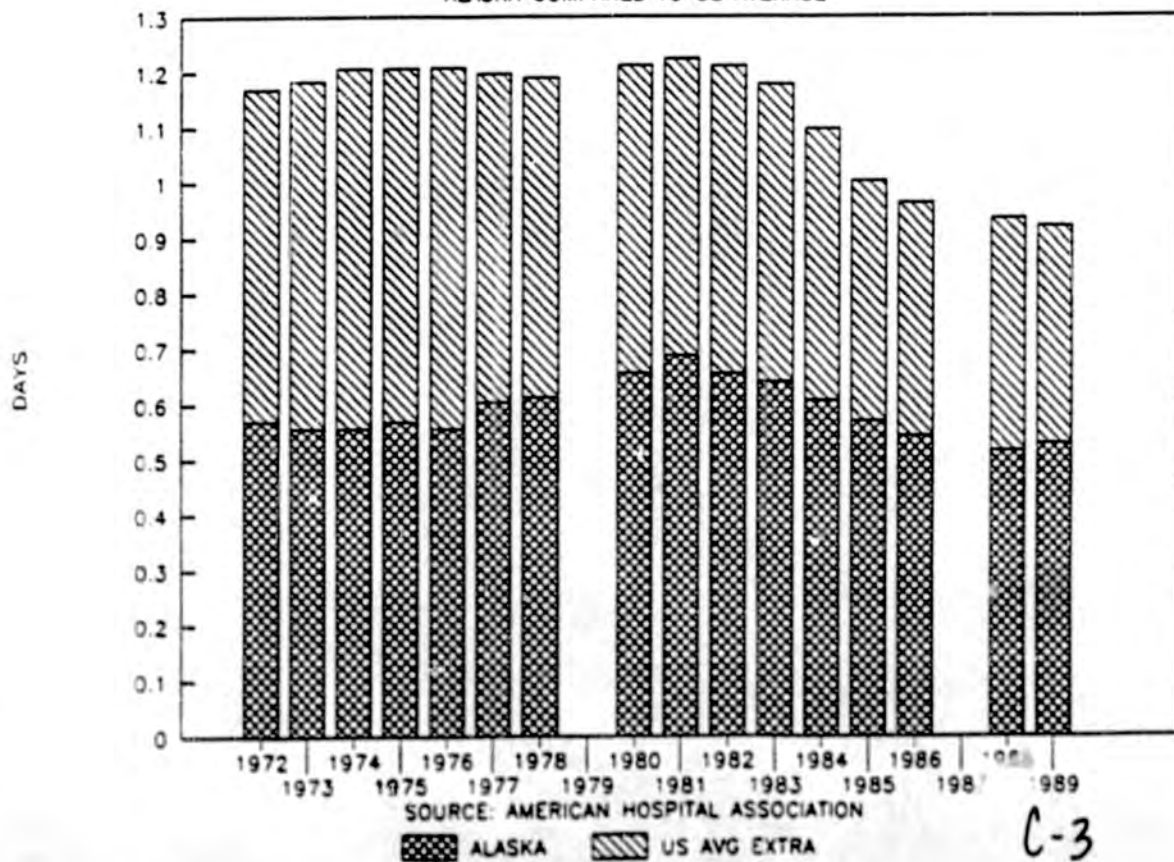


Figure I.2

HOSPITAL INPATIENT DAYS PER CAPITA

ALASKA COMPARED TO US AVERAGE



SOURCE: AMERICAN HOSPITAL ASSOCIATION

Figure I.3

OCCUPANCY RATE BY SIZE OF HOSPITAL

ALASKA COMMUNITY HOSPITALS: ACUTE CARE

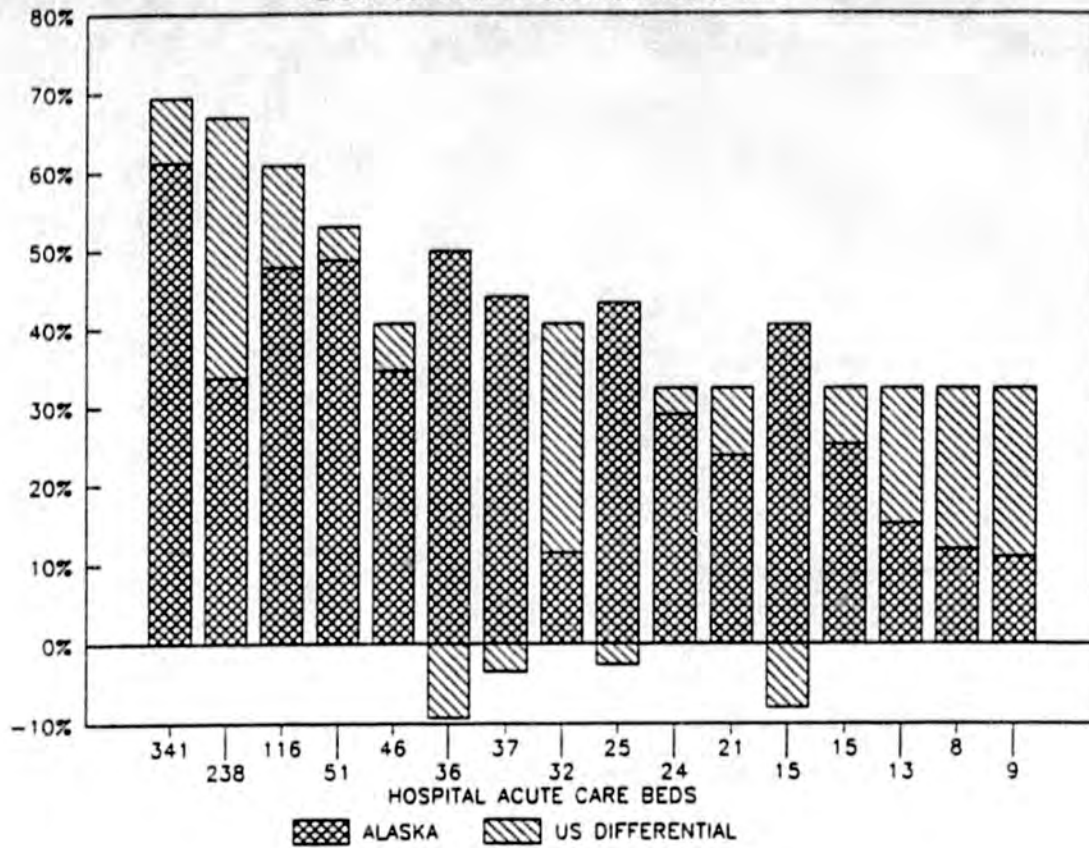
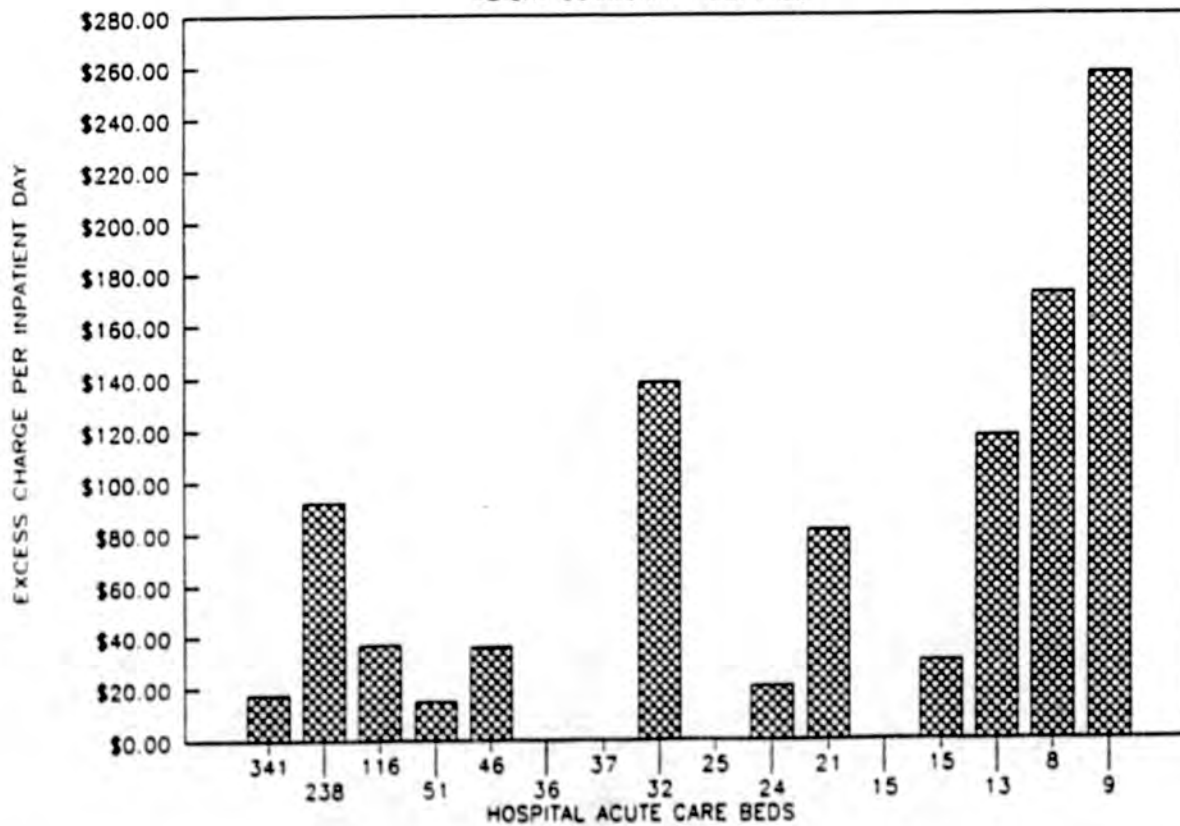


Figure I.4

EXCESS BED PREMIUM BY HOSPITAL SIZE

ALASKA COMMUNITY HOSPITALS



average as the benchmark, 12 of the 16 community acute care facilities have surplus excess capacity. At the US average occupancy rate, 229 of the 1027 acute care beds are surplus (22%). Most are in the large cities (all but 47), and only 15 are in co-located facilities (facilities with Long Term Care Beds).

The cost of current excess capacity is also calculated using the assumption of an occupancy rate of 75% as a standard. The high cost of acute care beds argues for the most efficient use of those beds. Nationally in the early 1970s the occupancy rate for mid-sized hospitals approached 75%

THE COST OF EXCESS CAPACITY

The cost of excess capacity was calculated 3 ways.

[1] THE SURCHARGE CONSUMERS PAY FOR EXCESS CAPACITY

(Refer to the Surplus Excess Capacity Analysis Worksheets which show the surcharge using three different sets of assumptions.)

QUESTION--How much does each inpatient pay per day and how much does the system as a whole pay to maintain the current surplus of acute care beds in the community hospital system?

RESULTS--With a national average occupancy rate standard the surcharge for surplus excess capacity varies by hospital from \$0 to \$257 dollars per inpatient day (Figure 1.4.), and totals \$5.8 million annually assuming fixed costs are 10% of total costs. The surcharge for surplus excess capacity ranges from \$0 to \$386 dollars per inpatient day, and totals \$8.7 million annually assuming fixed costs are 15% of total costs. The surcharge for surplus excess capacity varies by hospital from \$0 to \$514 dollars per inpatient day, and totals \$11.6 million annually assuming fixed costs are 20% of total costs.

With a 75% occupancy benchmarkd the surcharge for surplus excess capacity ranges from \$27 to \$331 dollars per inpatient day, and totals \$10.4 million annually assuming fixed costs are 10% of total costs. The surcharge for surplus excess capacity ranges from \$41 to \$497 dollars per inpatient day, and totals \$15.6 million annually assuming fixed costs are 15% of total costs. The surcharge for surplus excess capacity varies by hospital from \$55 to \$663 dollars per inpatient day, and totals \$20.8 million annually assuming fixed costs are 20% of total costs.

These estimates represent a real cost to health care consumers if hospital charges include the cost of these excess beds.

ASSUMPTIONS--Three alternate assumptions concerning fixed costs were employed. The lowest assumption was that 10% of inpatient acute care costs are fixed and that 90% vary with the number of patients served. This is based on the fact that the hospitals report 11% of their costs to be for capital and alternatively they report that 9% of their costs are for depreciation. One would expect most capital costs to be fixed with respect to the number of patients served. In the short run all costs are fixed. However this is a long run analysis which assumes that hospitals are minimizing their costs given their existing facilities and patient demands. In the long run they are able to vary most elements of cost to achieve this minimum, but short of rebuilding facilities from the ground

up not all costs can be considered variable.

The intermediate and highest assumptions regarding fixed cost are 15% and 20% of the total. These are based on the idea that some of the personnel costs are also independent of the number of patients served. There is some evidence from American Hospital Association data that some personnel costs are fixed. They report that the ratio of hospital employees to inpatient days is higher in Alaska than the national average. This may be due to the fact that small hospitals must maintain certain staff even if they are not fully utilized. The implication is that additional inpatient days would not require a proportional increase in staffing levels.

There are two alternative assumptions for the target occupancy rate. The first is based on the notion that the appropriate amount of average unused capacity should be the same as the current experience in hospitals of similar size in the entire US. However because of declining occupancy rates in the US during this decade one cannot assume that these rates represent an appropriate standard. In fact the number of acute care beds in the US is declining in response to declining occupancy rates.

The alternative benchmark occupancy rate is based on the assumption that the appropriate occupancy rate is 75%. Medium sized hospitals in the US operated at approximately this rate through the 1970s. It seems unlikely that Alaska hospitals on average could operate at a higher occupancy rate than this because of seasonality, daily fluctuations in demand, and uncertainties associated with the rate of population increase. However no formal analysis has been conducted to determine the potential maximum occupancy rate which Alaska hospitals might be able to achieve if they could be redesigned to meet current needs, which are in a constant state of flux, more efficiently.

The figures for expenditures per inpatient day represent the cost of acute care divided by the number of inpatients and consequently includes outpatient acute care. It would be preferable to base the analysis on inpatient care expenditures only, but the available data does not allow for this.

Data from the American Hospital Association suggests that Alaska consumers act more like other Americans in their consumption of outpatient services at hospitals than they do in their consumption of inpatient services. This means that there may be less underutilization of outpatient services in Alaska hospitals than of inpatient services. If this is true the calculated excess capacity figures could be biased upward. Since less than 25% of revenues are derived from outpatient services however, the size of the potential bias is relatively small.

The analysis assumes that all acute care expenditures are reported by the hospitals and that the expenditures include a charge for the replacement of facilities as they wear out. To the extent that hospital reported expenditures do not include a charge for replacement, the cost of operation is understated. In addition if this cost is not included

in charges then current users may not be paying the full surplus bed surcharge. The analysis further assumes that for co-located facilities the portion of total costs attributable to the operation of the acute care portion of the hospital is properly reported as such.

The surplus excess bed surcharge is set at \$0 for the 4 facilities with occupancy rates above the national average.

METHODOLOGY--The reported acute care expenditure per inpatient day for each hospital is divided into a fixed and variable component based on the fixed cost percentage assumption. The acute care expenditure per inpatient day is then calculated based on the number of inpatient days implied by the higher assumed benchmark occupancy rate. This expenditure is the sum of a fixed and variable component. The variable component is the same at the high occupancy level as at the low occupancy level. The fixed cost per inpatient day is lower at the higher occupancy rate because it is a fixed amount spread over a larger number of inpatient days. The difference in expenditure per inpatient day at the lower and higher occupancy rates is the difference in fixed cost per inpatient day between the two cases. This represents the surcharge for surplus bed capacity per inpatient day.

DATA SOURCE--Bed capacity data, inpatient days and expenditures for Alaska acute care community hospitals were taken from information provided by the hospitals to the Medicaid Rate Setting Commission. Use of this data source allowed for the calculation of occupancy rates comparable to the definition used by the American Hospital Association which was the source for the national average data on occupancy and expenditures. The Alaska expenditure information excluded the costs associated with long term care, but included the costs associated with outpatient care. The US expenditure data included the costs associated with long term care for co-located facilities, but these comprise an insignificant percent of the total costs for the US community hospitals. The data was for the most recent fiscal year available, which varied somewhat among hospitals, but generally covered 1989. The data base included the 16 community hospitals in the state of which 7 are co-located facilities (facilities that provide both acute care and long term care).

ACUTE CARE BEDS COMMUNITY HOSPITAL (CO-LOCATED FACILITY)	AVERAGE OR SUM	ANCH & FRBKS	AVERAGE/SUM NET ANCH & FRBKS	AVERAGE/SUM ACUTE CARE FACILITIES	AVERAGE/SUM CO-LOCATED FACILITIES

[1] SURPLUS EXCESS CAPACITY ANALYSIS					
available beds in acute care	1,027	695	332	899	128
potential utilization days	375,950	253,675	122,275	328,135	47,815
actual utilization	167,839	125,652	42,187	152,354	15,485
occupancy rate	44.64%	49.53%	34.50%	46.43%	32.39%
national occupancy rate (AHA 89)	58.17%	67.01%	39.84%	61.36%	36.28%
percent of national rate	76.74%	73.92%	86.59%	75.66%	89.26%
beds at national occupancy rate	798	512	285	685	113
utilization at national occupancy rate	218,703	169,984	48,719	201,356	17,348
excess beds	229	183	47	214	15
excess available bed days	50,864	44,332	6,532	49,002	1,863
excess capacity percent of beds	22.31%	26.27%	14.01%	23.81%	11.78%
outpatient visits	431,563	329,679	101,884	398,897	32,666
ratio outpatient visits/inpatient days	2.57	2.62	2.42	2.62	2.11
expenditures	\$296,313,764	\$202,223,011	\$94,090,753	\$253,030,907	\$43,282,857
% expenditures acute care	96%	100%	86%	100%	74%
expenditures for acute care	\$284,839,130	\$202,223,011	\$82,809,424	\$253,030,907	\$32,118,656
% expenditures fixed [a]	10%	10%	10%	10%	10%
item:actual capital/total	11%	12%	8%	12%	7%
item:actual depreciation/total	9%	9%	8%	9%	8%
fixed expenditures	\$28,483,913	\$20,222,301	\$8,280,942	\$25,303,091	\$3,211,866
variable expenditures	\$256,355,217	\$182,000,710	\$74,528,482	\$227,727,816	\$28,906,790
expenditures per inpatient day					
actual: total	\$1,697	\$1,609	\$1,963	\$1,661	\$2,074
fixed	\$170	\$161	\$196	\$166	\$207
variable	\$1,527	\$1,448	\$1,767	\$1,495	\$1,867
at national average occupancy: total	\$1,658	\$1,567	\$1,937	\$1,620	\$2,052
fixed	\$130	\$119	\$170	\$126	\$185
variable	\$1,527	\$1,448	\$1,767	\$1,495	\$1,867
EXCESS BED PREMIUM (ANNUAL)					
per inpatient day [b]	\$39	\$42	\$26	\$40	\$22
total (all inpatient days) [c]	\$5,791,669	\$4,768,937	\$1,122,732	\$5,385,660	\$406,009
per admission	\$149	\$182	\$81	\$157	\$89
EXCESS BED PREMIUM % of Charge	2.03%	2.36%	1.24%	2.13%	1.26%

Note: Several Facilities have occupancy rates exceeding the national average.

[a] If more patient days, how much of the costs of the hospital would remain constant--not grow.

[b] The premium for the average patient day.

[c] The sum of the premium over all patient days.

ACUTE CARE BEDS
COMMUNITY
HOSPITAL
(CO-LOCATED FACILITY)

1	2	3	4	5
341	238	116	51	46
PROVIDENCE	HUMANA/ ALASKA	FAIRBANKS MEM.	BARTLETT MEM.	CENTRAL PENINSULA

[1] SURPLUS EXCESS CAPACITY ANALYSIS

available beds in acute care	341	238	116	51	46
potential utilization days	124,465	86,870	42,340	18,615	16,790
actual utilization	76,073	29,333	20,246	9,071	5,825
occupancy rate	61.12%	33.77%	47.82%	48.73%	34.69%
national occupancy rate (AHA 89)	69.30%	66.80%	60.70%	53.00%	40.60%
percent of national rate	88.20%	50.55%	78.78%	91.94%	85.45%
beds at national occupancy rate	301	120	91	47	39
utilization at national occupancy rate	86,254	58,029	25,700	9,866	6,817
excess beds	40	118	25	4	7
excess available bed days	10,181	28,696	5,454	795	992
excess capacity percent of beds	11.80%	49.45%	21.22%	8.06%	14.55%
outpatient visits	146,948	67,522	115,209	13,395	20,119
ratio outpatient visits/inpatient days	1.93	2.30	5.69	1.48	3.45
expenditures	\$112,832,871	\$54,553,789	\$34,836,351	\$16,470,474	\$14,229,320
% expenditures acute care	100%	100%	100%	100%	100%
expenditures for acute care	\$112,832,871	\$54,553,789	\$34,836,351	\$16,470,474	\$14,229,320
% expenditures fixed [a]	10%	10%	10%	10%	10%
item:actual capital/total	14%	11%	7%	9%	8%
item:actual depreciation/total	10%	9%	7%	8%	9%
fixed expenditures	\$11,283,287	\$5,455,379	\$3,483,635	\$1,647,047	\$1,422,932
variable expenditures	\$101,549,584	\$49,098,410	\$31,352,716	\$14,823,427	\$12,806,388
expenditures per inpatient day					
actual: total	\$1,483	\$1,860	\$1,721	\$1,816	\$2,443
fixed	\$148	\$186	\$172	\$182	\$244
variable	\$1,335	\$1,674	\$1,549	\$1,634	\$2,199
at national average occupancy: total	\$1,466	\$1,768	\$1,684	\$1,801	\$2,407
fixed	\$131	\$94	\$136	\$167	\$209
variable	\$1,335	\$1,674	\$1,549	\$1,634	\$2,199
EXCESS BED PREMIUM (ANNUAL)					
per inpatient day [b]	\$18	\$92	\$37	\$15	\$36
total (all inpatient days) [c]	\$1,331,852	\$2,697,754	\$739,330	\$132,711	\$207,017
per admission	\$93	\$418	\$137	\$49	\$100
EXCESS BED PREMIUM % of Charge	1.18%	4.95%	2.12%	0.81%	1.45%

Note: Several Facilities have occupancy rates exceeding the national average.

[a] If more patient days, how much of the costs of the hospital would remain constant--not grow.

[b] The premium for the average patient day.

[c] The sum of the premium over all patient days.

ACUTE CARE BEDS

COMMUNITY
HOSPITAL
(CO-LOCATED FACILITY)

6	36	7	37	8	32	9	25	10	24
VALLEY HOSPITAL		KETCHIKAN GENL (CLF)		SEWARD GENERAL		KODIAK ISLAND (CLF)		SITKA COMMUNITY	

[1] SURPLUS EXCESS CAPACITY ANALYSIS

available beds in acute care	36	37	32	25	24
potential utilization days	13,140	13,505	11,680	9,125	8,760
actual utilization	6,557	5,959	1,333	3,946	2,539
occupancy rate	49.90%	44.12%	11.41%	43.24%	28.98%
national occupancy rate (AHA 89)	40.60%	40.60%	40.60%	40.60%	32.10%
percent of national rate	122.91%	108.68%	28.11%	106.51%	89.46%
beds at national occupancy rate	44	40	9	27	21
utilization at national occupancy rate	5,335	5,483	4,742	3,705	2,838
excess beds	(8)	(3)	23	(2)	3
excess available bed days	(1,222)	(476)	3,409	(241)	299
excess capacity percent of beds	-22.91%	-8.68%	71.89%	-6.51%	10.54%
outpatient visits	12,183	19,319	2,328	4,229	11,280
ratio outpatient visits/inpatient days	1.86	3.24	1.75	1.07	4.44
expenditures	\$10,795,000	\$14,299,525	\$2,558,612	\$7,251,452	\$4,908,279
% expenditures acute care	100%	81%	100%	78%	100%
expenditures for acute care	\$10,795,000	\$11,520,384	\$2,558,612	\$5,669,745	\$4,908,279
% expenditures fixed [a]	10%	10%	10%	10%	10%
item: actual capital/total	10%	6%	6%	3%	10%
item: actual depreciation/total	9%	4%	3%	5%	9%
fixed expenditures	\$1,079,500	\$1,152,038	\$255,861	\$566,975	\$490,828
variable expenditures	\$9,715,500	\$10,368,345	\$2,302,751	\$5,102,771	\$4,417,451
expenditures per inpatient day					
actual: total	\$1,646	\$1,933	\$1,919	\$1,437	\$1,933
fixed	\$165	\$193	\$192	\$144	\$193
variable	\$1,482	\$1,740	\$1,727	\$1,293	\$1,740
at national average occupancy: total	\$1,646	\$1,933	\$1,781	\$1,437	\$1,913
fixed	\$165	\$193	\$54	\$144	\$173
variable	\$1,482	\$1,740	\$1,727	\$1,293	\$1,740
EXCESS BED PREMIUM (ANNUAL)					
per inpatient day [b]	\$0	\$0	\$138	\$0	\$20
total (all inpatient days) [c]	\$0	\$0	\$183,939	\$0	\$51,749
per admission	\$0	\$0	\$458	\$0	\$84
EXCESS BED PREMIUM % of Charge	0.00%	0.00%	7.19%	0.00%	1.05%

Note: Several Facilities have occupancy rates exceeding the national average.

[a] If more patient days, how much of the costs of the hospital would remain constant--not grow.

[b] The premium for the average patient day.

[c] The sum of the premium over all patient days.

ACUTE CARE BEDS

COMMUNITY
HOSPITAL
(CO-LOCATED FACILITY)

21	15	15	13	8
11 NORTON SOUND (CLF)	12 SOUTH PENINSULA (CLF)	13 VALDEZ COMM.	14 CORDOVA COMM. (CLF)	15 PETERSBURG (CLF)

[1] SURPLUS EXCESS CAPACITY ANALYSIS

available beds in acute care	21	15	15	13	8
potential utilization days	7,665	5,475	5,475	4,745	4,015
actual utilization	1,813	2,211	1,377	718	479
occupancy rate	23.65%	40.38%	25.15%	15.13%	11.93%
national occupancy rate (AHA 89)	32.40%	32.40%	32.40%	32.40%	32.40%
percent of national rate	73.00%	124.64%	77.63%	46.70%	36.82%
beds at national occupancy rate	15	19	12	6	3
utilization at national occupancy rate	2,483	1,774	1,774	1,537	1,301
excess beds	6	(4)	3	7	5
excess available bed days	670	(437)	397	819	822
excess capacity percent of beds	27.00%	-24.64%	22.37%	53.30%	63.18%
outpatient visits	3,056	0	9,913	0	6,062
ratio outpatient visits/inpatient days	1.69	0.00	7.20	0.00	12.66
expenditures	\$7,115,296	\$7,191,757	\$1,846,211	\$2,583,678	\$2,469,070
% expenditures acute care	77%	72%	100%	61%	53%
expenditures for acute care	\$5,454,591	\$5,199,780	\$1,846,211	\$1,579,416	\$1,302,625
% expenditures fixed (a)	10%	10%	10%	10%	10%
item: actual capital/total	6%	7%	4%	16%	14%
item: actual depreciation/total	7%	8%	4%	21%	21%
fixed expenditures	\$545,459	\$519,978	\$184,621	\$157,942	\$130,262
variable expenditures	\$4,909,132	\$4,679,802	\$1,661,590	\$1,421,474	\$1,172,362
expenditures per inpatient day					
actual: total	\$3,009	\$2,352	\$1,341	\$2,200	\$2,719
fixed	\$301	\$235	\$134	\$220	\$272
variable	\$2,708	\$2,117	\$1,207	\$1,980	\$2,448
at national average occupancy: total	\$2,927	\$2,352	\$1,311	\$2,083	\$2,548
fixed	\$220	\$235	\$104	\$103	\$100
variable	\$2,708	\$2,117	\$1,207	\$1,980	\$2,448
EXCESS BED PREMIUM (ANNUAL)					
per inpatient day (b)	\$81	(\$0)	\$30	\$117	\$172
total (all inpatient days) (c)	\$147,258	(\$0)	\$41,308	\$84,178	\$82,297
per admission	\$219	(\$0)	ERR	\$304	\$556
EXCESS BED PREMIUM % of Charge	2.70%	-0.00%	2.24%	5.33%	6.32%

Note: Several Facilities have occupancy rates exceeding the national average.

[a] If more patient days, how much of the costs of the hospital would remain constant--not grow.

[b] The premium for the average patient day.

[c] The sum of the premium over all patient days.

ACUTE CARE BEDS

9

COMMUNITY
HOSPITAL
(CO-LOCATED FACILITY)

16
WRANGELL
GENL
(CLF)

[1] SURPLUS EXCESS CAPACITY ANALYSIS

available beds in acute care	9
potential utilization days	3,285
actual utilization	359
	11.48%
occupancy rate	10.93%
national occupancy rate (AHA 89)	32.40%
percent of national rate	33.73%
beds at national occupancy rate	3
utilization at national occupancy rate	1,064
excess beds	6
excess available bed days	705
excess capacity percent of beds	66.27%
outpatient visits	0
ratio outpatient visits/inpatient days	0.00
expenditures	\$2,372,079
% expenditures acute care	59%
expenditures for acute care	\$1,392,414
% expenditures fixed (a)	10%
item: actual capital/total	9%
item: actual depreciation/total	12%
fixed expenditures	\$139,241
variable expenditures	\$1,253,173
expenditures per inpatient day	
actual: total	\$3,879
fixed	\$388
variable	\$3,491
at national average occupancy: total	\$3,622
fixed	\$131
variable	\$3,491
EXCESS BED PREMIUM (ANNUAL)	
per inpatient day (b)	\$257
total (all inpatient days) (c)	\$92,276
per admission	\$756
EXCESS BED PREMIUM % of Charge	6.63%

Note: Several Facilities have occupancy rates exceeding the national average.

- [a] If more patient days, how much of the costs of the hospital would remain constant--not grow.
- [b] The premium for the average patient day.
- [c] The sum of the premium over all patient days.

C-13

ACUTE CARE BEDS

COMMUNITY
HOSPITAL
(CO-LOCATED FACILITY)

AVERAGE
OR
SUM

ANCH & FRBKS

AVERAGE/SUM
NET
ANCH & FRBKS

AVERAGE/SUM
ACUTE CARE
FACILITIES

AVERAGE/SUM
CO-LOCATED
FACILITIES

[1] SURPLUS EXCESS CAPACITY ANALYSIS

available beds in acute care	1,027	695	332	899	128
potential utilization days	375,950	253,675	122,275	328,135	47,815
actual utilization	167,839	125,652	42,187	152,354	15,485
occupancy rate	44.64%	49.53%	34.50%	46.43%	32.39%
national occupancy rate (AHA 89)	58.17%	67.01%	39.84%	61.36%	36.28%
percent of national rate	76.74%	73.92%	86.59%	75.66%	89.26%
beds at national occupancy rate	798	512	285	685	113
utilization at national occupancy rate	218,703	169,984	48,719	201,356	17,348
excess beds	229	183	47	214	15
excess available bed days	50,864	44,332	6,532	49,002	1,863
excess capacity percent of beds	22.31%	26.27%	14.01%	23.81%	11.78%
outpatient visits	431,563	329,679	101,884	398,897	32,666
ratio outpatient visits/inpatient days	2.57	2.62	2.42	2.62	2.11
expenditures	\$296,313,764	\$202,223,011	\$94,090,753	\$253,030,907	\$43,282,857
% expenditures acute care	96%	100%	88%	100%	74%
expenditures for acute care	\$284,839,130	\$202,223,011	\$82,809,424	\$253,030,907	\$32,118,656
% expenditures fixed (a)	15%	15%	15%	15%	15%
item: actual capital/total	11%	12%	8%	12%	7%
item: actual depreciation/total	9%	9%	8%	9%	8%
fixed expenditures	\$42,725,870	\$30,333,452	\$12,421,414	\$37,954,636	\$4,817,798
variable expenditures	\$242,113,261	\$171,889,559	\$70,388,011	\$215,076,271	\$27,300,857
expenditures per inpatient day					
actual: total	\$1,697	\$1,609	\$1,963	\$1,661	\$2,074
fixed	\$255	\$241	\$294	\$249	\$311
variable	\$1,443	\$1,368	\$1,668	\$1,412	\$1,763
at national average occupancy: total	\$1,638	\$1,546	\$1,923	\$1,600	\$2,041
fixed	\$195	\$178	\$255	\$188	\$278
variable	\$1,443	\$1,368	\$1,668	\$1,412	\$1,763
EXCESS BED PREMIUM (ANNUAL)					
per inpatient day (b)	\$59	\$63	\$39	\$61	\$33
total (all inpatient days) (c)	\$8,687,503	\$7,153,406	\$1,534,098	\$8,078,490	\$609,014
per admission	\$223	\$273	\$121	\$235	\$134
EXCESS BED PREMIUM % of Charge	3.05%	3.54%	1.85%	3.19%	1.90%

Note: Several Facilities have occupancy rates exceeding the national average.

(a) If more patient days, how much of the costs of the hospital would remain constant--not grow.

(b) The premium for the average patient day.

(c) The sum of the premium over all patient days.

ACUTE CARE BEDS	341	238	116	51	46
COMMUNITY HOSPITAL (CO-LOCATED FACILITY)	1 PROVIDENCE	2 HUMANA/ ALASKA	3 FAIRBANKS MEM.	4 BARTLETT MEM.	5 CENTRAL PENINSULA

(1) SURPLUS EXCESS CAPACITY ANALYSIS

available beds in acute care	341	238	116	51	46
potential utilization days	124,465	86,870	42,340	18,615	16,790
actual utilization	76,073	29,333	20,246	9,071	5,825
occupancy rate	61.12%	33.77%	47.82%	48.73%	34.69%
national occupancy rate (AHA 89)	69.30%	66.80%	60.70%	53.00%	40.60%
percent of national rate	88.20%	50.55%	78.78%	91.94%	85.45%
beds at national occupancy rate	301	120	91	47	39
utilization at national occupancy rate	86,254	58,029	25,700	9,866	6,817
excess beds	40	118	25	4	7
excess available bed days	10,181	28,696	5,454	795	992
excess capacity percent of beds	11.80%	49.45%	21.22%	8.06%	14.55%
outpatient visits	146,948	67,522	115,209	13,395	20,119
ratio outpatient visits/inpatient days	1.93	2.30	5.69	1.48	3.45
expenditures	\$112,832,871	\$54,553,789	\$34,836,351	\$16,470,474	\$14,229,320
% expenditures acute care	100%	100%	100%	100%	100%
expenditures for acute care	\$112,832,871	\$54,553,789	\$34,836,351	\$16,470,474	\$14,229,320
% expenditures fixed [a]	15%	15%	15%	15%	15%
item:actual capital/total	14%	11%	7%	9%	8%
item:actual depreciation/total	10%	9%	7%	8%	8%
fixed expenditures	\$16,924,931	\$8,183,068	\$5,225,453	\$2,470,571	\$2,134,398
variable expenditures	\$95,907,940	\$46,370,721	\$29,610,898	\$13,999,903	\$12,094,922
expenditures per inpatient day					
actual: total	\$1,483	\$1,860	\$1,721	\$1,816	\$2,443
fixed	\$222	\$279	\$258	\$272	\$366
variable	\$1,261	\$1,581	\$1,463	\$1,543	\$2,076
at national average occupancy: total	\$1,457	\$1,722	\$1,666	\$1,794	\$2,389
fixed	\$196	\$141	\$203	\$250	\$313
variable	\$1,261	\$1,581	\$1,463	\$1,543	\$2,076
EXCESS BED PREMIUM (ANNUAL)					
per inpatient day [b]	\$26	\$138	\$55	\$22	\$53
total (all inpatient days) [c]	\$1,997,778	\$4,046,632	\$1,108,995	\$199,067	\$310,525
per admission	\$139	\$627	\$205	\$74	\$150
EXCESS BED PREMIUM % of Charge	1.77%	7.42%	3.18%	1.21%	2.18%

Note: Several Facilities have occupancy rates exceeding the national average.

[a] If more patient days, how much of the costs of the hospital would remain constant--not grow.

[b] The premium for the average patient day.

[c] The sum of the premium over all patient days.

ACUTE CARE BEDS

COMMUNITY
HOSPITAL
(CO-LOCATED FACILITY)

6	7	8	9	10
VALLEY HOSPITAL	KETCHIKAN GENL (CLF)	SEWARD GENERAL	KODIAK ISLAND (CLF)	SITKA COMMUNITY

[1] SURPLUS EXCESS CAPACITY ANALYSIS

	36	37	32	25	24
available beds in acute care	36	37	32	25	24
potential utilization days	13,140	13,505	11,680	9,125	8,760
actual utilization	6,557	5,959	1,333	3,946	2,539
occupancy rate	49.90%	44.12%	11.41%	43.24%	28.98%
national occupancy rate (AHA 89)	40.60%	40.60%	40.60%	40.60%	32.40%
percent of national rate	122.91%	108.68%	28.11%	106.51%	89.46%
beds at national occupancy rate	44	40	9	27	21
utilization at national occupancy rate	5,335	5,483	4,742	3,705	2,838
excess beds	(8)	(3)	23	(2)	3
excess available bed days	(1,222)	(476)	3,409	(241)	299
excess capacity percent of beds	-22.91%	-8.68%	71.89%	-6.51%	10.54%
outpatient visits	12,183	19,319	2,328	4,229	11,280
ratio outpatient visits/inpatient days	1.86	3.24	1.75	1.07	4.44
expenditures	\$10,795,000	\$14,299,525	\$2,558,612	\$7,251,452	\$4,908,279
% expenditures acute care	100%	81%	100%	78%	100%
expenditures for acute care	\$10,795,000	\$11,520,384	\$2,558,612	\$5,669,745	\$4,908,279
% expenditures fixed [a]	15%	15%	15%	15%	15%
item: actual capital/total	10%	6%	6%	3%	10%
item: actual depreciation/total	9%	4%	3%	5%	9%
fixed expenditures	\$1,619,250	\$1,728,058	\$383,792	\$850,462	\$736,242
variable expenditures	\$9,175,750	\$9,792,326	\$2,174,820	\$4,819,283	\$4,172,037
expenditures per inpatient day					
actual: total	\$1,646	\$1,933	\$1,919	\$1,437	\$1,933
fixed	\$247	\$290	\$288	\$216	\$290
variable	\$1,399	\$1,643	\$1,632	\$1,221	\$1,643
at national average occupancy: total	\$1,646	\$1,933	\$1,712	\$1,437	\$1,903
fixed	\$247	\$290	\$81	\$216	\$259
variable	\$1,399	\$1,643	\$1,632	\$1,221	\$1,643
EXCESS BED PREMIUM (ANNUAL)					
per inpatient day [b]	\$0	(\$0)	\$207	\$0	\$31
total (all inpatient days) [c]	\$0	(\$0)	\$275,908	\$0	\$77,623
per admission	\$0	(\$0)	\$686	\$0	\$125
EXCESS BED PREMIUM % of Charge	0.00%	-0.00%	10.78%	0.00%	1.58%

Note: Several Facilities have occupancy rates exceeding the national average.

[a] If more patient days, how much of the costs of the hospital would remain constant--not grow.

[b] The premium for the average patient day.

[c] The sum of the premium over all patient days.

C-16

ACUTE CARE BEDS	21	15	15	13	8
COMMUNITY HOSPITAL (CO-LOCATED FACILITY)	11 NORTON SOUND (CLF)	12 SOUTH PENINSULA (CLF)	13 VALDEZ COMM.	14 CORDOVA COMM. (CLF)	15 PETERSBURG (CLF)

(1) SURPLUS EXCESS CAPACITY ANALYSIS					
available beds in acute care	21	15	15	13	8
potential utilization days	7,665	5,475	5,475	4,745	4,015
actual utilization	1,813	2,211	1,377	718	479
occupancy rate	23.65%	40.38%	25.15%	15.13%	11.93%
national occupancy rate (AHA 89)	32.40%	32.40%	32.40%	32.40%	32.40%
percent of national rate	73.00%	124.64%	77.63%	46.70%	36.82%
beds at national occupancy rate	15	19	12	6	3
utilization at national occupancy rate	2,483	1,774	1,774	1,537	1,301
excess beds	6	(4)	3	7	5
excess available bed days	670	(427)	397	819	822
excess capacity percent of beds	27.00%	-24.64%	22.37%	53.30%	63.18%
outpatient visits	3,056	0	9,913	0	6,062
ratio outpatient visits/inpatient days	1.69	0.00	7.20	0.00	12.66
expenditures	\$7,115,296	\$7,191,757	\$1,846,211	\$2,583,678	\$2,469,070
% expenditures acute care	77%	72%	100%	61%	53%
expenditures for acute care	\$5,454,591	\$5,199,780	\$1,846,211	\$1,579,416	\$1,302,625
% expenditures fixed [a]	15%	15%	15%	15%	15%
item:actual capital/total	6%	7%	4%	16%	14%
item:actual depreciation/total	7%	8%	4%	21%	21%
fixed expenditures	\$818,189	\$779,967	\$276,932	\$236,912	\$195,394
variable expenditures	\$4,636,403	\$4,419,813	\$1,569,279	\$1,342,504	\$1,107,231
expenditures per inpatient day					
actual: total	\$3,009	\$2,352	\$1,341	\$2,200	\$2,719
fixed	\$451	\$353	\$201	\$330	\$408
variable	\$2,557	\$1,999	\$1,140	\$1,870	\$2,312
at national average occupancy: total	\$2,887	\$2,352	\$1,296	\$2,024	\$2,462
fixed	\$329	\$353	\$156	\$154	\$150
variable	\$2,557	\$1,999	\$1,140	\$1,870	\$2,312
EXCESS BED PREMIUM (ANNUAL)					
per inpatient day [b]	\$122	\$0	\$45	\$176	\$258
total (all inpatient days) [c]	\$220,887	\$0	\$61,962	\$126,268	\$123,446
per admission	\$328	\$0	ERR	\$456	\$834
EXCESS BED PREMIUM % of Charge	4.05%	0.00%	3.36%	7.99%	9.48%

Note: Several Facilities have occupancy rates exceeding the national average.

- [a] If more patient days, how much of the costs of the hospital would remain constant--not grow.
 [b] The premium for the average patient day.
 [c] The sum of the premium over all patient days.

ACUTE CARE BEDS

9

COMMUNITY
HOSPITAL
(CO-LOCATED FACILITY)

16
WRANGELL
GENL
(CLF)

[1] SURPLUS EXCESS CAPACITY ANALYSIS

available beds in acute care	9
potential utilization days	3,285
actual utilization	359
	11.48%
occupancy rate	10.93%
national occupancy rate (AHA 89)	32.40%
percent of national rate	33.73%
beds at national occupancy rate	3
utilization at national occupancy rate	1,064
excess beds	6
excess available bed days	705
excess capacity percent of beds	65.27%
outpatient visits	0
ratio outpatient visits/inpatient days	0.00
expenditures	\$2,372,079
% expenditures acute care	59%
expenditures for acute care	\$1,392,414
% expenditures fixed [a]	15%
item:actual capital/total	9%
item:actual depreciation/total	12%
fixed expenditures	\$208,862
variable expenditures	\$1,183,552
expenditures per inpatient day	
actual: total	\$3,879
fixed	\$582
variable	\$3,297
at national average occupancy: total	\$3,493
fixed	\$196
variable	\$3,297
EXCESS BED PREMIUM (ANNUAL)	
per inpatient day [b]	\$386
total (all inpatient days) [c]	\$138,413
per admission	\$1,135
EXCESS BED PREMIUM % of Charge	9.94%

Note: Several Facilities have occupancy rates exceeding the national average.

- [a] If more patient days, how much of the costs of the hospital would remain constant--not grow.
[b] The premium for the average patient day.
[c] The sum of the premium over all patient days.

ACUTE CARE BEDS

COMMUNITY
HOSPITAL
(CO-LOCATED FACILITY)AVERAGE
OR
SUM

ANCH & FRBKS

AVERAGE/SUM
NET
ANCH & FRBKSAVERAGE/SUM
ACUTE CARE
FACILITIESAVERAGE/SUM
CO-LOCATED
FACILITIES

[1] SURPLUS EXCESS CAPACITY ANALYSIS

available beds in acute care	1,027	695	332	899	128
potential utilization days	375,950	253,675	122,275	328,135	47,815
actual utilization	167,839	125,652	42,187	152,354	15,485
occupancy rate	44.64%	49.53%	34.50%	46.43%	32.39%
national occupancy rate (AHA 89)	58.17%	67.01%	39.84%	61.36%	36.28%
percent of national rate	76.74%	73.92%	86.59%	75.66%	89.26%
beds at national occupancy rate	798	512	285	685	113
utilization at national occupancy rate	218,703	169,984	48,719	201,356	17,348
excess beds	229	183	47	214	15
excess available bed days	50,864	44,332	6,532	49,002	1,863
excess capacity percent of beds	22.31%	26.27%	14.01%	23.81%	11.78%
outpatient visits	431,563	329,679	101,884	398,897	32,666
ratio outpatient visits/inpatient days	2.57	2.62	2.42	2.62	2.11
expenditures	\$296,313,764	\$202,223,011	\$94,090,753	\$253,030,907	\$43,282,857
% expenditures acute care	96%	100%	88%	100%	74%
expenditures for acute care	\$284,839,130	\$202,223,011	\$82,809,424	\$253,030,907	\$32,118,656
% expenditures fixed [a]	20%	20%	20%	20%	20%
item:actual capital/total	11%	12%	8%	12%	7%
item:actual depreciation/total	9%	9%	8%	9%	8%
fixed expenditures	\$56,967,826	\$40,444,602	\$16,561,885	\$50,606,181	\$6,423,731
variable expenditures	\$227,871,304	\$161,778,409	\$66,247,539	\$202,424,726	\$25,694,925
expenditures per inpatient day					
actual: total	\$1,697	\$1,609	\$1,963	\$1,661	\$2,074
fixed	\$339	\$322	\$393	\$332	\$415
variable	\$1,358	\$1,288	\$1,570	\$1,329	\$1,659
at national average occupancy: total	\$1,618	\$1,525	\$1,910	\$1,580	\$2,030
fixed	\$260	\$238	\$340	\$251	\$370
variable	\$1,358	\$1,288	\$1,570	\$1,329	\$1,659
EXCESS BED PREMIUM (ANNUAL)					
per inpatient day [b]	\$79	\$84	\$53	\$81	\$45
total (all inpatient days) [c]	\$11,583,338	\$9,537,874	\$2,045,464	\$10,771,320	\$812,018
per admission	\$298	\$364	\$161	\$313	\$179
EXCESS BED PREMIUM % of Charge	4.07%	4.72%	2.47%	4.26%	2.53%

Note: Several Facilities have occupancy rates exceeding the national average.

[a] If more patient days, how much of the costs of the hospital would remain constant--not grow.

ACUTE CARE BEDS
COMMUNITY
HOSPITAL
(CO-LOCATED FACILITY)

1	2	3	4	5
341	238	116	51	46
PROVIDENCE	NUMANA/ ALASKA	FAIRBANKS MEM.	BARTLETT MEM.	CENTRAL PENINSULA

[1] SURPLUS EXCESS CAPACITY ANALYSIS

available beds in acute care	341	238	116	51	46
potential utilization days	124,465	86,870	42,340	18,615	16,790
actual utilization	76,073	29,333	20,246	9,071	5,825
occupancy rate	61.12%	33.77%	47.82%	48.73%	34.69%
national occupancy rate (AHA 89)	69.30%	66.80%	60.70%	53.00%	40.60%
percent of national rate	88.70%	50.55%	78.78%	91.94%	85.45%
beds at national occupancy rate	301	120	91	47	39
utilization at national occupancy rate	86,254	58,029	25,700	9,866	6,817
excess beds	40	118	25	4	7
excess available bed days	10,181	28,696	5,454	795	992
excess capacity percent of beds	11.80%	49.45%	21.22%	8.06%	14.55%
outpatient visits	146,948	67,522	115,209	13,395	20,119
ratio outpatient visits/inpatient days	1.93	2.30	5.69	1.48	3.45
expenditures	\$112,832,871	\$54,553,789	\$34,836,351	\$16,470,474	\$14,229,320
% expenditures acute care	100%	100%	100%	100%	100%
expenditures for acute care	\$112,832,871	\$54,553,789	\$34,836,351	\$16,470,474	\$14,229,320
% expenditures fixed [a]	20%	20%	20%	20%	20%
item:actual capital/total	14%	11%	7%	9%	8%
item:actual depreciation/total	10%	9%	7%	8%	8%
fixed expenditures	\$22,566,574	\$10,910,758	\$6,967,270	\$3,294,095	\$2,845,864
variable expenditures	\$90,266,297	\$43,643,031	\$27,869,081	\$13,176,379	\$11,383,456
expenditures per inpatient day					
actual: total	\$1,483	\$1,860	\$1,721	\$1,816	\$2,443
fixed	\$297	\$372	\$344	\$363	\$489
variable	\$1,187	\$1,488	\$1,377	\$1,453	\$1,954
at national average occupancy: total	\$1,448	\$1,676	\$1,648	\$1,786	\$2,372
fixed	\$262	\$188	\$271	\$334	\$417
variable	\$1,187	\$1,488	\$1,377	\$1,453	\$1,954
EXCESS BED PREMIUM (ANNUAL)					
per inpatient day [b]	\$35	\$184	\$73	\$29	\$71
total (all inpatient days) [c]	\$2,663,705	\$5,395,509	\$1,478,661	\$265,422	\$414,033
per admission	\$185	\$836	\$274	\$98	\$200
EXCESS BED PREMIUM % of Charge	2.36%	9.89%	4.24%	1.61%	2.91%

Note: Several Facilities have occupancy rates exceeding the national average.

[a] If more patient days, how much of the costs of the hospital would remain constant--not grow.

ACUTE CARE BEDS

COMMUNITY
HOSPITAL
(CO-LOCATED FACILITY)

6	7	8	9	10
VALLEY HOSPITAL	KETCHIKAN GENL (CLF)	SEWARD GENERAL	KODIAK ISLAND (CLF)	SITKA COMMUNITY

[1] SURPLUS EXCESS CAPACITY ANALYSIS

available beds in acute care	36	37	32	25	24
potential utilization days	13,140	13,505	11,680	9,125	8,760
actual utilization	6,557	5,959	1,333	3,946	2,539
occupancy rate	49.90%	44.12%	11.41%	43.24%	28.98%
national occupancy rate (AHA 89)	40.60%	40.60%	40.60%	40.60%	32.40%
percent of national rate	122.91%	108.68%	28.11%	106.51%	89.46%
beds at national occupancy rate	44	40	9	27	21
utilization at national occupancy rate	5,335	5,483	4,742	3,705	2,838
excess beds	(8)	(3)	23	(2)	3
excess available bed days	(1,222)	(476)	3,409	(241)	299
excess capacity percent of beds	-22.91%	-8.68%	71.89%	-6.51%	10.54%
outpatient visits	12,183	19,319	2,328	4,229	11,280
ratio outpatient visits/inpatient days	1.86	3.24	1.75	1.07	4.44
expenditures	\$10,795,000	\$14,299,525	\$2,558,612	\$7,251,452	\$4,908,279
% expenditures acute care	100%	81%	100%	78%	100%
expenditures for acute care	\$10,795,000	\$11,520,384	\$2,558,612	\$5,669,745	\$4,908,279
% expenditures fixed [a]	20%	20%	20%	20%	20%
item: actual capital/total	10%	6%	6%	3%	10%
item: actual depreciation/total	9%	4%	3%	5%	9%
fixed expenditures	\$2,159,000	\$2,304,077	\$511,722	\$1,133,949	\$981,656
variable expenditures	\$8,636,000	\$9,216,307	\$2,046,890	\$4,535,796	\$3,926,623
expenditures per inpatient day					
actual: total	\$1,646	\$1,933	\$1,919	\$1,437	\$1,933
fixed	\$329	\$387	\$384	\$287	\$387
variable	\$1,317	\$1,547	\$1,536	\$1,149	\$1,547
at national average occupancy: total	\$1,646	\$1,933	\$1,643	\$1,437	\$1,892
fixed	\$329	\$387	\$108	\$287	\$346
variable	\$1,317	\$1,547	\$1,536	\$1,149	\$1,547
EXCESS BED PREMIUM (ANNUAL)					
per inpatient day [b]	\$0	(\$0)	\$276	(\$0)	\$41
total (all inpatient days) [c]	\$0	(\$0)	\$367,877	(\$0)	\$103,497
per admission	\$0	(\$0)	\$915	(\$0)	\$167
EXCESS BED PREMIUM % of Charge	0.00%	-0.00%	14.38%	-0.00%	2.11%

Note: Several Facilities have occupancy rates exceeding the national average.

[a] If more patient days, how much of the costs of the hospital would remain constant--not grow.

ACUTE CARE BEDS

	21	15	15	13	8
COMMUNITY HOSPITAL (CO-LOCATED FACILITY)	11 NORTON SOUND (CLF)	12 SOUTH PENINSULA (CLF)	13 VALDEZ COMM.	14 CORDOVA COMM. (CLF)	15 PETERSBURG (CLF)

[1] SURPLUS EXCESS CAPACITY ANALYSIS

available beds in acute care	21	15	15	13	8
potential utilization days	7,665	5,475	5,475	4,745	4,015
actual utilization	1,813	2,211	1,377	718	479
occupancy rate	23.65%	40.38%	25.15%	15.13%	11.93%
national occupancy rate (AHA 89)	32.40%	32.40%	32.40%	32.40%	32.40%
percent of national rate	73.00%	124.64%	77.63%	46.70%	36.82%
beds at national occupancy rate	15	19	12	6	3
utilization at national occupancy rate	2,483	1,774	1,774	1,537	1,301
excess beds	6	(4)	3	7	5
excess available bed days	670	(437)	397	819	822
excess capacity percent of beds	27.00%	-24.64%	22.37%	53.30%	63.18%
outpatient visits	3,056	0	9,913	0	6,062
ratio outpatient visits/inpatient days	1.69	0.00	7.20	0.00	12.66
expenditures	\$7,115,296	\$7,191,757	\$1,846,211	\$2,583,678	\$2,469,070
% expenditures acute care	77%	72%	100%	61%	53%
expenditures for acute care	\$5,454,591	\$5,199,780	\$1,846,211	\$1,579,415	\$1,302,625
% expenditures fixed [a]	20%	20%	20%	20%	20%
item:actual capital/total	6%	7%	4%	16%	14%
item:actual depreciation/total	7%	8%	4%	21%	21%
fixed expenditures	\$1,090,918	\$1,039,956	\$369,242	\$315,883	\$260,525
variable expenditures	\$4,363,673	\$4,159,824	\$1,476,969	\$1,263,533	\$1,042,100
expenditures per inpatient day					
actual: total	\$3,009	\$2,352	\$1,341	\$2,200	\$2,719
fixed	\$602	\$470	\$268	\$440	\$544
variable	\$2,407	\$1,881	\$1,073	\$1,760	\$2,176
at national average occupancy: total	\$2,846	\$2,352	\$1,281	\$1,965	\$2,376
fixed	\$439	\$470	\$208	\$205	\$200
variable	\$2,407	\$1,881	\$1,073	\$1,760	\$2,176
EXCESS BED PREMIUM (ANNUAL)					
per inpatient day [b]	\$162	\$0	\$60	\$234	\$344
total (all inpatient days) [c]	\$294,515	\$0	\$82,616	\$168,357	\$164,595
per admission	\$438	\$0	ERR	\$608	\$1,112
EXCESS BED PREMIUM % of Charge	5.40%	0.00%	4.47%	10.66%	12.64%

Note: Several Facilities have occupancy rates exceeding the national average.

[a] If more patient days, how much of the costs of the hospital would remain constant--not grow.

ACUTE CARE BEDS

9

COMMUNITY
HOSPITAL
(CO-LOCATED FACILITY)

16
WRANGELL
GENL
(CLF)

[1] SURPLUS EXCESS CAPACITY ANALYSIS

available beds in acute care	9
potential utilization days	3,285
actual utilization	359
	11.48%
occupancy rate	10.93%
national occupancy rate (AHA 89)	32.40%
percent of national rate	33.73%
beds at national occupancy rate	3
utilization at national occupancy rate	1,064
excess beds	6
excess available bed days	705
excess capacity percent of beds	66.27%
outpatient visits	
ratio outpatient visits/inpatient days	0.00
expenditures	\$2,372,079
% expenditures acute care	59%
expenditures for acute care	\$1,392,414
% expenditures fixed [a]	20%
item: actual capital/total	9%
item: actual depreciation/total	12%
fixed expenditures	\$278,483
variable expenditures	\$1,113,931
expenditures per inpatient day	
actual: total	\$3,879
fixed	\$776
variable	\$3,103
at national average occupancy: total	\$3,365
fixed	\$262
variable	\$3,103
EXCESS BED PREMIUM (ANNUAL)	
per inpatient day [b]	\$514
total (all inpatient days) [c]	\$184,551
per admission	\$1,513
EXCESS BED PREMIUM % of Charge	13.25%

Note: Several Facilities have occupancy rates exceeding the national average.

[a] If more patient days, how much of the costs of the hospital would remain constant--not grow.

C-23

ACUTE CARE BEDS

COMMUNITY
HOSPITAL
(CO-LOCATED FACILITY)AVERAGE
OR
SUM

ANCH & FRBKS

AVERAGE/SUM
NET
ANCH & FRBKSAVERAGE/SUM
ACUTE CARE
FACILITIESAVERAGE/SUM
CO-LOCATED
FACILITIES

[1] SURPLUS EXCESS CAPACITY ANALYSIS

available beds in acute care	1,027	695	332	899	128
potential utilization days	375,950	253,675	122,275	328,135	47,815
actual utilization	167,839	125,652	42,187	152,354	15,485
occupancy rate	44.64%	49.53%	34.50%	46.43%	32.39%
Benchmark occupancy rate	75.00%	75.00%	75.00%	75.00%	75.00%
percent of national rate	59.53%	66.04%	46.00%	61.91%	43.18%
beds at national occupancy rate	613	459	154	557	56
utilization at national occupancy rate	281,963	190,256	91,706	246,101	35,861
excess beds	414	236	178	342	72
excess available bed days	114,124	64,604	49,519	93,747	20,376
excess capacity percent of beds	40.35%	33.96%	53.73%	38.09%	56.18%
outpatient visits	431,563	329,679	101,884	398,897	32,666
ratio outpatient visits/inpatient days	2.57	2.62	2.42	2.62	2.11
expenditures	\$296,313,764	\$202,223,011	\$94,090,753	\$253,030,907	\$43,282,857
% expenditures acute care	96%	100%	88%	100%	74%
expenditures for acute care	\$284,839,130	\$202,223,011	\$82,809,424	\$253,030,907	\$32,118,656
% expenditures fixed [a]	10%	10%	10%	10%	10%
item:actual capital/total	11%	12%	8%	12%	7%
item:actual depreciation/total	9%	9%	8%	9%	8%
fixed expenditures	\$28,483,913	\$20,222,301	\$8,280,942	\$25,303,091	\$3,211,866
variable expenditures	\$256,355,217	\$182,000,710	\$74,528,482	\$227,727,816	\$28,906,790
expenditures per acute care inpatient day					
actual: total	\$1,697	\$1,609	\$1,963	\$1,661	\$2,074
fixed	\$170	\$161	\$196	\$166	\$207
variable	\$1,527	\$1,448	\$1,767	\$1,495	\$1,867
at national average occupancy: total	\$1,628	\$1,555	\$1,857	\$1,598	\$1,956
fixed	\$101	\$106	\$90	\$103	\$90
variable	\$1,527	\$1,448	\$1,767	\$1,495	\$1,867
EXCESS BED PREMIUM (ANNUAL)					
per inpatient day [b]	\$69	\$55	\$106	\$63	\$118
total (all inpatient days) [c]	\$10,376,000	\$6,349,994	\$4,026,006	\$8,693,667	\$1,682,334
per admission	\$267	\$242	\$317	\$253	\$370
EXCESS BED PREMIUM % of Charge	3.64%	3.14%	4.86%	3.44%	5.24%

Note: Several Facilities have occupancy rates exceeding the national average.

[a] If more patient days, how much of the costs of the hospital would remain constant--not grow.

ACUTE CARE BEDS

COMMUNITY
HOSPITAL
(CO-LOCATED FACILITY)

	1	2	3	4	5
	PROVIDENCE	HUMANA/ ALASKA	FAIRBANKS MEM.	BARTLETT MEM.	CENTRAL PENINSULA

[1] SURPLUS EXCESS CAPACITY ANALYSIS

available beds in acute care	341	238	116	51	46
potential utilization days	124,465	86,870	12,340	18,615	16,790
actual utilization	76,073	29,333	20,246	9,071	5,825
occupancy rate	61.12%	33.77%	47.82%	48.73%	34.69%
Benchmark occupancy rate	75.00%	75.00%	75.00%	75.00%	75.00%
percent of national rate	81.49%	45.02%	63.76%	64.97%	46.26%
beds at national occupancy rate	278	107	74	33	21
utilization at national occupancy rate	93,349	65,153	31,755	13,961	12,593
excess beds	63	131	42	18	25
excess available bed days	17,276	35,820	11,509	4,890	6,768
excess capacity percent of beds	18.51%	54.98%	36.24%	35.03%	53.74%
outpatient visits	146,948	67,522	115,209	13,395	20,119
ratio outpatient visits/inpatient days	1.93	2.30	5.69	1.48	3.45
expenditures	\$112,832,871	\$54,553,789	\$34,836,351	\$16,470,474	\$14,229,320
% expenditures acute care	100%	100%	100%	100%	100%
expenditures for acute care	\$112,832,871	\$54,553,789	\$34,836,351	\$16,470,474	\$14,229,320
% expenditures fixed [a]	10%	10%	10%	10%	10%
item: actual capital/total	14%	11%	7%	9%	8%
item: actual depreciation/total	10%	9%	7%	8%	8%
fixed expenditures	\$11,283,287	\$5,455,379	\$3,483,635	\$1,647,047	\$1,422,932
variable expenditures	\$101,549,584	\$49,098,410	\$31,352,716	\$14,823,427	\$12,806,388
expenditures per acute care inpatient					
actual: total	\$1,483	\$1,860	\$1,721	\$1,816	\$2,443
fixed	\$148	\$186	\$172	\$182	\$244
variable	\$1,335	\$1,674	\$1,549	\$1,634	\$2,199
at national average occupancy: total	\$1,456	\$1,758	\$1,658	\$1,752	\$2,312
fixed	\$121	\$84	\$110	\$118	\$113
variable	\$1,335	\$1,674	\$1,549	\$1,634	\$2,199
EXCESS BED PREMIUM (ANNUAL)					
per inpatient day [b]	\$27	\$102	\$62	\$64	\$131
total (all inpatient days) [c]	\$2,088,161	\$2,999,255	\$1,262,578	\$576,916	\$764,716
per admission	\$145	\$465	\$234	\$213	\$369
EXCESS BED PREMIUM % of Charge	1.85%	5.50%	3.62%	3.50%	5.37%

Note: Several Facilities have occupancy rates exceeding the national average.

[a] If more patient days, how much of the costs of the hospital would remain constant--not grow.

ACUTE CARE BEDS

COMMUNITY
HOSPITAL
(CO-LOCATED FACILITY)

36	37	32	25	24
6 VALLEY HOSPITAL	7 KETCHIKAN GENL (CLF)	8 SEWARD GENERAL	9 KODIAK ISLAND (CLF)	10 SITKA COMMUNITY

[1] SURPLUS EXCESS CAPACITY ANALYSIS

available beds in acute care	36	37	32	25	24
potential utilization days	13,140	13,505	11,680	9,125	8,760
actual utilization	6,557	5,959	1,333	3,946	2,539
occupancy rate	49.90%	44.12%	11.41%	43.24%	28.98%
Benchmark occupancy rate	75.00%	75.00%	75.00%	75.00%	75.00%
percent of national rate	66.53%	58.83%	15.22%	57.66%	38.65%
beds at national occupancy rate	24	22	5	14	9
utilization at national occupancy rate	9,855	10,129	8,760	6,844	6,570
excess beds	12	15	27	11	15
excess available bed days	3,298	4,170	7,427	2,898	4,031
excess capacity percent of beds	33.47%	41.17%	84.78%	42.34%	61.35%
outpatient visits	12,183	19,319	2,328	4,229	11,280
ratio outpatient visits/inpatient days	1.86	3.24	1.75	1.07	4.44
expenditures	\$10,795,000	\$14,299,525	\$2,558,612	\$7,251,452	\$4,908,279
% expenditures acute care	100%	81%	100%	78%	100%
expenditures for acute care	\$10,795,000	\$11,520,384	\$2,558,612	\$5,669,745	\$4,908,279
% expenditures fixed [a]	10%	10%	10%	10%	10%
item:actual capital/total	10%	6%	6%	3%	10%
item:actual depreciation/total	9%	4%	3%	5%	9%
fixed expenditures	\$1,079,500	\$1,152,038	\$255,861	\$566,975	\$490,828
variable expenditures	\$9,715,500	\$10,368,345	\$2,302,751	\$5,102,771	\$4,417,451
expenditures per acute care inpatient					
actual: total	\$1,646	\$1,933	\$1,919	\$1,437	\$1,933
fixed	\$165	\$193	\$192	\$144	\$193
variable	\$1,482	\$1,740	\$1,727	\$1,293	\$1,740
at national average occupancy: total	\$1,591	\$1,854	\$1,757	\$1,376	\$1,815
fixed	\$110	\$114	\$29	\$83	\$75
variable	\$1,482	\$1,740	\$1,727	\$1,293	\$1,740
EXCESS BED PREMIUM (ANNUAL)					
per inpatient day [b]	\$55	\$80	\$163	\$61	\$119
total (all inpatient days) [c]	\$261,357	\$474,265	\$216,927	\$240,066	\$301,146
per admission	\$154	\$275	\$540	\$190	\$487
EXCESS BED PREMIUM % of Charge	3.35%	4.12%	8.48%	4.23%	6.14%

Note: Several Facilities have occupancy rates exceeding the national average.

[a] If more patient days, how much of the costs of the hospital would remain constant--not grow.

ACUTE CARE BEDS

COMMUNITY
HOSPITAL
(CO-LOCATED FACILITY)

21	15	15	13	8
11	12	13	14	15
NORTON	SOUTH	VALDEZ	CORDOVA	PETERSBURG
SOUND	PENINSULA	COMM.	COMM.	
(CLF)	(CLF)		(CLF)	(CLF)

[1] SURPLUS EXCESS CAPACITY ANALYSIS

available beds in acute care	21	15	15	13	8
potential utilization days	7,665	5,475	5,475	4,745	4,015
actual utilization	1,813	2,211	1,377	718	479
occupancy rate	23.65%	40.38%	25.15%	15.13%	11.93%
Benchmark occupancy rate	75.00%	75.00%	75.00%	75.00%	75.00%
percent of national rate	31.54%	53.84%	33.53%	20.18%	15.91%
beds at national occupancy rate	7	8	5	3	1
utilization at national occupancy rate	5,749	4,106	4,106	3,559	3,011
excess beds	14	7	10	10	7
excess available bed days	3,936	1,895	2,729	2,841	2,532
excess capacity percent of beds	68.46%	46.16%	66.47%	79.82%	84.09%
outpatient visits	3,056	0	9,913	0	6,062
ratio outpatient visits/inpatient days	1.69	0.00	7.20	0.00	12.66
expenditures	\$7,115,296	\$7,191,757	\$1,846,211	\$2,583,678	\$2,469,070
% expenditures acute care	77%	72%	100%	61%	53%
expenditures for acute care	\$5,454,591	\$5,199,780	\$1,846,211	\$1,579,416	\$1,302,625
% expenditures fixed (a)	10%	10%	10%	10%	10%
item:actual capital/total	6%	7%	4%	16%	14%
item:actual depreciation/total	7%	8%	4%	21%	21%
fixed expenditures	\$545,459	\$519,978	\$184,621	\$157,942	\$130,262
variable expenditures	\$4,909,132	\$4,679,802	\$1,661,590	\$1,421,474	\$1,172,362
expenditures per acute care inpatient					
actual: total	\$3,009	\$2,352	\$1,341	\$2,200	\$2,719
fixed	\$301	\$235	\$134	\$220	\$272
variable	\$2,708	\$2,117	\$1,207	\$1,980	\$2,448
at national average occupancy: total	\$2,803	\$2,247	\$1,252	\$2,024	\$2,491
fixed	\$95	\$127	\$45	\$44	\$43
variable	\$2,708	\$2,117	\$1,207	\$1,980	\$2,448
EXCESS BED PREMIUM (ANNUAL)					
per inpatient day (b)	\$206	\$109	\$89	\$176	\$229
total (all inpatient days) (c)	\$373,436	\$239,997	\$122,710	\$126,076	\$109,542
per admission	\$555	\$706	ERR	\$455	\$740
EXCESS BED PREMIUM % of Charge	6.85%	4.62%	6.65%	7.98%	8.41%

Note: Several Facilities have occupancy rates exceeding the national average.

[a] If more patient days, how much of the costs of the hospital would remain constant--not grow.

ACUTE CARE BEDS

9

COMMUNITY
HOSPITAL
(CO-LOCATED FACILITY)

16
WRANGELL
GENL
(CLF)

[1] SURPLUS EXCESS CAPACITY ANALYSIS

available beds in acute care	9
potential utilization days	3,285
actual utilization	359
	11.48%
occupancy rate	10.93%
Benchmark occupancy rate	75.00%
percent of national rate	14.57%
beds at national occupancy rate	1
utilization at national occupancy rate	2,464
excess beds	8
excess available bed days	2,105
excess capacity percent of beds	85.43%
outpatient visits	0
ratio outpatient visits/inpatient days	0.00
expenditures	\$2,372,079
% expenditures acute care	59%
expenditures for acute care	\$1,392,414
% expenditures fixed [a]	10%
item: actual capital/total	9%
item: actual depreciation/total	12%
fixed expenditures	\$139,241
variable expenditures	\$1,253,173
expenditures per acute care inpatient	
actual, total	\$3,879
fixed	\$388
variable	\$3,491
at national average occupancy: total	\$3,547
fixed	\$57
variable	\$3,491
EXCESS BED PREMIUM (ANNUAL)	
per inpatient day [b]	\$331
total (all inpatient days) [c]	\$118,952
per admission	\$975
EXCESS BED PREMIUM % of Charge	8.54%

Note: Several Facilities have occupancy rates exceeding the national average.

[a] If more patient days, how much of the costs of the hospital would remain constant--not grow.

ACUTE CARE BEDS COMMUNITY HOSPITAL (CO-LOCATED FACILITY)	AVERAGE OR SUM	ANCH & FRBKS	AVERAGE/SUM NET ANCH & FRBKS	AVERAGE/SUM ACUTE CARE FACILITIES	AVERAGE/SUM CO-LOCATED FACILITIES

[1] SURPLUS EXCESS CAPACITY ANALYSIS					
available beds in acute care	1,027	695	332	899	128
potential utilization days	375,950	253,675	122,275	328,135	47,815
actual utilization	167,839	125,652	42,187	152,354	15,485
occupancy rate	44.64%	49.53%	34.50%	46.43%	32.39%
Benchmark occupancy rate	75.00%	75.00%	75.00%	75.00%	75.00%
percent of national rate	59.53%	66.04%	46.00%	61.91%	43.18%
beds at national occupancy rate	613	459	154	557	56
utilization at national occupancy rate	281,963	190,256	91,706	246,101	35,861
excess beds	414	236	178	342	72
excess available bed days	114,124	64,604	49,519	93,747	20,376
excess capacity percent of beds	40.35%	33.96%	53.73%	38.09%	56.18%
outpatient visits	431,563	329,679	101,884	398,897	32,666
ratio outpatient visits/inpatient days	2.57	2.62	2.42	2.62	2.11
expenditures	\$296,313,764	\$202,223,011	\$94,090,753	\$253,030,907	\$43,282,857
% expenditures acute care	96%	100%	88%	100%	74%
expenditures for acute care	\$284,839,130	\$202,223,011	\$82,809,424	\$253,030,907	\$32,118,656
% expenditures fixed [a]	15%	15%	15%	15%	15%
item:actual capital/total	11%	12%	8%	12%	7%
item:actual depreciation/total	9%	9%	8%	9%	8%
fixed expenditures	\$42,725,870	\$30,333,452	\$12,421,414	\$37,954,636	\$4,817,798
variable expenditures	\$242,113,261	\$171,889,559	\$70,388,011	\$215,076,271	\$27,300,857
expenditures per inpatient day					
actual: total	\$1,697	\$1,609	\$1,963	\$1,661	\$2,074
fixed	\$255	\$241	\$294	\$249	\$311
variable	\$1,443	\$1,368	\$1,668	\$1,412	\$1,763
at national average occupancy: total	\$1,594	\$1,527	\$1,804	\$1,566	\$1,897
fixed	\$152	\$159	\$135	\$154	\$134
variable	\$1,443	\$1,368	\$1,668	\$1,412	\$1,763
EXCESS BED PREMIUM (ANNUAL)					
per inpatient day [b]	\$103	\$82	\$159	\$95	\$177
total (all inpatient days) [c]	\$15,564,000	\$9,524,991	\$6,039,010	\$13,040,500	\$2,523,501
per admission	\$400	\$363	\$476	\$379	\$555
EXCESS BED PREMIUM % of Charge	5.46%	4.71%	7.29%	5.15%	7.86%

Note: Several Facilities have occupancy rates exceeding the national average.

[a] If more patient days, how much of the costs of the hospital would remain constant--not grow.

[b] The premium for the average patient day.

[c] The sum of the premium over all patient days.

ACUTE CARE BEDS

COMMUNITY
HOSPITAL
(CO-LOCATED FACILITY)

1	2	3	4	5
PROVIDENCE	HUMANA/ ALASKA	FAIRBANKS MEM.	BARTLETT MEM.	CENTRAL PENINSULA

[1] SURPLUS EXCESS CAPACITY ANALYSIS

available beds in acute care	341	238	116	51	46
potential utilization days	124,465	86,870	42,340	18,615	16,790
actual utilization	76,073	29,333	20,246	9,071	5,825
occupancy rate	61.12%	33.77%	47.82%	48.73%	34.69%
Benchmark occupancy rate	75.00%	75.00%	75.00%	75.00%	75.00%
percent of national rate	81.49%	45.02%	63.76%	64.97%	46.26%
beds at national occupancy rate	278	107	74	33	21
utilization at national occupancy rate	93,349	65,153	31,755	13,961	12,593
excess beds	63	131	42	18	25
excess available bed days	17,276	35,820	11,509	4,890	6,768
excess capacity percent of beds	18.51%	54.98%	36.24%	35.03%	53.74%
outpatient visits	146,948	67,522	115,209	13,395	20,119
ratio outpatient visits/inpatient days	1.93	2.30	5.69	1.48	3.45
expenditures	\$112,832,871	\$54,553,789	\$34,836,351	\$16,470,474	\$14,229,320
% expenditures acute care	100%	100%	100%	100%	100%
expenditures for acute care	\$112,832,871	\$54,553,789	\$34,836,351	\$16,470,474	\$14,229,320
% expenditures fixed (a)	15%	15%	15%	15%	15%
item:actual capital/total	14%	11%	7%	9%	8%
item:actual depreciation/total	10%	9%	7%	8%	8%
fixed expenditures	\$16,924,931	\$8,183,068	\$5,225,453	\$2,470,571	\$2,134,398
variable expenditures	\$95,907,940	\$46,370,721	\$29,610,898	\$13,999,903	\$12,094,922
expenditures per inpatient day					
actual: total	\$1,483	\$1,860	\$1,721	\$1,816	\$2,443
fixed	\$222	\$279	\$258	\$272	\$366
variable	\$1,261	\$1,581	\$1,463	\$1,543	\$2,076
at national average occupancy: total	\$1,442	\$1,706	\$1,627	\$1,720	\$2,246
fixed	\$181	\$126	\$165	\$177	\$169
variable	\$1,261	\$1,581	\$1,463	\$1,543	\$2,076
EXCESS BED PREMIUM (ANNUAL)					
per inpatient day (b)	\$41	\$153	\$94	\$95	\$197
total (all inpatient days) (c)	\$3,132,242	\$4,498,882	\$1,893,867	\$865,375	\$1,147,075
per admission	\$218	\$697	\$350	\$320	\$554
EXCESS BED PREMIUM % of Charge	2.78%	8.25%	5.44%	5.25%	8.06%

Note: Several Facilities have occupancy rates exceeding the national average.

(a) If more patient days, how much of the costs of the hospital would remain constant--not grow.

(b) The premium for the average patient day.

(c) The sum of the premium over all patient days.

ACUTE CARE BEDS

COMMUNITY
HOSPITAL
(CO-LOCATED FACILITY)

6	7	8	9	10
VALLEY HOSPITAL	KETCHIKAN GENL (CLF)	SEWARD GENERAL	KODIAK ISLAND (CLF)	SITKA COMMUNITY

[1] SURPLUS EXCESS CAPACITY ANALYSIS

available beds in acute care	36	37	32	25	24
potential utilization days	13,140	13,505	11,680	9,125	8,760
actual utilization	6,557	5,959	1,333	3,946	2,539
occupancy rate	49.90%	44.12%	11.41%	43.24%	28.98%
Benchmark occupancy rate	75.00%	75.00%	75.00%	75.00%	75.00%
percent of national rate	66.53%	58.83%	15.22%	57.66%	38.65%
beds at national occupancy rate	24	22	5	14	9
utilization at national occupancy rate	9,855	10,129	8,760	6,844	6,570
excess beds	12	15	27	11	15
excess available bed days	3,298	4,170	7,427	2,898	4,031
excess capacity percent of beds	33.47%	41.17%	84.78%	42.34%	61.35%
outpatient visits	12,183	19,319	2,328	4,229	11,280
ratio outpatient visits/inpatient days	1.86	3.24	1.75	1.07	4.44
expenditures	\$10,795,000	\$14,299,525	\$2,558,612	\$7,251,452	\$4,908,279
% expenditures acute care	100%	81%	100%	78%	100%
expenditures for acute care	\$10,795,000	\$11,520,384	\$2,558,612	\$5,669,745	\$4,908,279
% expenditures fixed [a]	15%	15%	15%	15%	15%
item:actual capital/total	10%	6%	6%	3%	10%
item:actual depreciation/total	9%	4%	3%	5%	9%
fixed expenditures	\$1,619,250	\$1,728,058	\$383,797	\$850,462	\$736,242
variable expenditures	\$9,175,750	\$9,792,326	\$2,174,815	\$4,819,283	\$4,172,037
expenditures per inpatient day					
actual: total	\$1,646	\$1,933	\$1,919	\$1,437	\$1,933
fixed	\$247	\$290	\$288	\$216	\$290
variable	\$1,399	\$1,643	\$1,632	\$1,221	\$1,643
at national average occupancy: total	\$1,564	\$1,814	\$1,675	\$1,346	\$1,755
fixed	\$164	\$171	\$44	\$124	\$112
variable	\$1,399	\$1,643	\$1,632	\$1,221	\$1,643
EXCESS BED PREMIUM (ANNUAL)					
per inpatient day [b]	\$83	\$119	\$244	\$91	\$178
total (all inpatient days) [c]	\$541,886	\$711,398	\$325,391	\$360,099	\$451,719
per admission	\$232	\$412	\$809	\$285	\$730
EXCESS BED PREMIUM % of Charge	5.02%	6.18%	12.72%	6.35%	9.20%

Note: Several Facilities have occupancy rates exceeding the national average.

[a] If more patient days, how much of the costs of the hospital would remain constant--not grow.

[b] The premium for the average patient day.

[c] The sum of the premium over all patient days.

ACUTE CARE BEDS

COMMUNITY
HOSPITAL
(CO-LOCATED FACILITY)

21	15	15	13	8
11	12	13	14	15
NORTON	SOUTH	VALDEZ	CORDOVA	PETERSBURG
SOUND	PENINSULA	COMM.	COMM.	
(CLF)	(CLF)		(CLF)	(CLF)

[1] SURPLUS EXCESS CAPACITY ANALYSIS

available beds in acute care	21	15	15	13	8
potential utilization days	7,665	5,475	5,475	4,745	4,015
actual utilization	1,813	2,211	1,377	718	479
occupancy rate	23.65%	40.38%	25.15%	15.13%	11.93%
Benchmark occupancy rate	75.00%	75.00%	75.00%	75.00%	75.00%
percent of national rate	31.54%	53.84%	33.53%	20.18%	15.91%
beds at national occupancy rate	7	8	5	3	1
utilization at national occupancy rate	5,749	4,106	4,106	3,559	3,011
excess beds	14	7	10	10	7
excess available bed days	3,936	1,895	2,729	2,841	2,532
excess capacity percent of beds	68.46%	46.16%	66.47%	79.82%	84.09%
outpatient visits	3,056	0	9,913	0	6,062
ratio outpatient visits/inpatient days	1.69	0.00	7.20	0.00	12.66
expenditures	\$7,115,296	\$7,191,757	\$1,846,211	\$2,593,678	\$2,469,070
% expenditures acute care	77%	72%	100%	61%	53%
expenditures for acute care	\$5,454,591	\$5,199,780	\$1,846,211	\$1,579,416	\$1,302,625
% expenditures fixed [a]	15%	15%	15%	15%	15%
item: actual capital/total	6%	7%	4%	16%	14%
item: actual depreciation/total	7%	8%	4%	21%	21%
fixed expenditures	\$818,189	\$779,967	\$276,932	\$236,912	\$195,394
variable expenditures	\$4,636,403	\$4,419,813	\$1,569,279	\$1,342,504	\$1,107,231
expenditures per inpatient day					
actual: total	\$3,009	\$2,352	\$1,341	\$2,200	\$2,719
fixed	\$451	\$353	\$201	\$330	\$408
variable	\$2,557	\$1,999	\$1,140	\$1,870	\$2,312
at national average occupancy: total	\$2,700	\$2,189	\$1,207	\$1,936	\$2,376
fixed	\$142	\$190	\$67	\$67	\$65
variable	\$2,557	\$1,999	\$1,140	\$1,870	\$2,312
EXCESS BED PREMIUM (ANNUAL)					
per inpatient day [b]	\$309	\$163	\$134	\$263	\$343
total (all inpatient days) [c]	\$560,154	\$359,996	\$184,065	\$189,114	\$164,312
per admission	\$832	\$1,059	ERR	\$683	\$1,110
EXCESS BED PREMIUM % of Charge	10.27%	6.92%	9.97%	11.97%	12.61%

Note: Several Facilities have occupancy rates exceeding the national average.

[a] If more patient days, how much of the costs of the hospital would remain constant--not grow.

[b] The premium for the average patient day.

[c] The sum of the premium over all patient days.

ACUTE CARE BEDS

9

COMMUNITY
HOSPITAL
(CO-LOCATED FACILITY)

16
WRANGELL
GENL
(CLF)

[1] SURPLUS EXCESS CAPACITY ANALYSIS

available beds in acute care	9
potential utilization days	3,285
actual utilization	359
	11.48%
occupancy rate	10.93%
Benchmark occupancy rate	75.00%
percent of national rate	14.57%
beds at national occupancy rate	1
utilization at national occupancy rate	2,464
excess beds	8
excess available bed days	2,105
excess capacity percent of beds	85.43%
outpatient visits	0
ratio outpatient visits/inpatient days	0.00
expenditures	\$2,372,079
% expenditures acute care	59%
expenditures for acute care	\$1,392,414
% expenditures fixed [a]	15%
item: actual capital/total	9%
item: actual depreciation/total	12%
fixed expenditures	\$208,862
variable expenditures	\$1,183,552
expenditures per inpatient day	
actual: total	\$3,879
fixed	\$582
variable	\$3,297
at national average occupancy: total	\$3,382
fixed	\$85
variable	\$3,297
EXCESS BED PREMIUM (ANNUAL)	
per inpatient day [b]	\$497
total (all inpatient days) [c]	\$178,428
per admission	\$1,463
EXCESS BED PREMIUM % of Charge	12.81%

Note: Several Facilities have occupancy rates exceeding the national average.

[a] If more patient days, how much of the costs of the hospital would remain constant--not grow.

[b] The premium for the average patient day.

[c] The sum of the premium over all patient days.

C-33

ACUTE CARE BEDS

COMMUNITY
HOSPITAL
(CO-LOCATED FACILITY)AVERAGE
OR
SUM

ANCH & FRBKS

AVERAGE/SUM
NET
ANCH & FRBKSAVERAGE/SUM
ACUTE CARE
FACILITIESAVERAGE/SUM
CO-LOCATED
FACILITIES

[1] SURPLUS EXCESS CAPACITY ANALYSIS

available beds in acute care	1,027	695	332	899	128
potential utilization days	375,950	253,675	122,275	328,135	47,815
actual utilization	167,839	125,652	42,187	152,354	15,485
occupancy rate	44.64%	49.53%	34.50%	46.43%	32.39%
Benchmark occupancy rate	75.00%	75.00%	75.00%	75.00%	75.00%
percent of national rate	59.53%	66.04%	46.00%	61.91%	43.18%
beds at national occupancy rate	613	459	154	557	56
utilization at national occupancy rate	281,963	190,256	91,706	246,101	35,861
excess beds	414	236	178	342	72
excess available bed days	114,124	64,604	49,519	93,747	20,376
excess capacity percent of beds	40.35%	33.96%	53.73%	38.09%	56.18%
outpatient visits	431,563	329,679	101,884	398,897	32,666
ratio outpatient visits/inpatient days	2.57	2.62	2.42	2.62	2.11
expenditures	\$296,313,764	\$202,223,011	\$94,090,753	\$253,030,907	\$43,282,857
% expenditures acute care	96%	100%	88%	100%	74%
expenditures for acute care	\$284,839,130	\$202,223,011	\$82,809,424	\$253,030,907	\$32,118,656
% expenditures fixed [a]	20%	20%	20%	20%	20%
item:actual capital/total	11%	12%	8%	12%	7%
item:actual depreciation/total	9%	9%	8%	9%	8%
fixed expenditures	\$56,967,826	\$40,444,602	\$16,561,885	\$50,606,181	\$6,423,731
variable expenditures	\$227,871,304	\$161,778,409	\$66,247,539	\$202,424,726	\$25,694,925
expenditures per acute care inpatient day					
actual: total	\$1,697	\$1,609	\$1,963	\$1,661	\$2,074
fixed	\$339	\$322	\$393	\$332	\$415
variable	\$1,358	\$1,288	\$1,570	\$1,329	\$1,659
at national average occupancy: total	\$1,560	\$1,500	\$1,751	\$1,534	\$1,838
fixed	\$202	\$213	\$181	\$206	\$179
variable	\$1,358	\$1,288	\$1,570	\$1,329	\$1,659
EXCESS BED PREMIUM (ANNUAL)					
per inpatient day [b]	\$137	\$109	\$212	\$127	\$236
total (all inpatient days) [c]	\$20,752,001	\$12,699,988	\$8,052,013	\$17,387,333	\$3,364,667
per admission	\$533	\$404	\$635	\$506	\$740
EXCESS BED PREMIUM % of Charge	7.29%	6.28%	9.72%	6.87%	10.48%

Note: Several Facilities have occupancy rates exceeding the national average.

[a] If more patient days, how much of the costs of the hospital would remain constant--not grow.

ACUTE CARE BEDS

COMMUNITY
HOSPITAL
(CO-LOCATED FACILITY)

[1] SURPLUS EXCESS CAPACITY ANALYSIS

	341	238	116	51	46
	1	2	3	4	5
	PROVIDENCE	HUMANA/ ALASKA	FAIRBANKS MEM.	BARTLETT MEM.	CENTRAL PENINSULA
available beds in acute care	341	238	116	51	46
potential utilization days	124,465	86,870	42,340	18,615	16,790
actual utilization	76,073	29,333	20,246	9,071	5,825
occupancy rate	61.12%	33.77%	47.82%	48.73%	34.69%
Benchmark occupancy rate	75.00%	75.00%	75.00%	75.00%	75.00%
percent of national rate	81.49%	45.02%	63.76%	64.97%	46.26%
beds at national occupancy rate	278	107	74	33	21
utilization at national occupancy rate	93,349	65,153	31,755	13,961	12,593
excess beds	63	131	42	18	25
excess available bed days	17,276	35,820	11,509	4,890	6,768
excess capacity percent of beds	18.51%	54.98%	36.24%	35.03%	53.74%
outpatient visits	146,948	57,522	115,209	13,395	20,119
ratio outpatient visits/inpatient days	1.93	2.30	5.69	1.48	3.45
expenditures	\$112,832,871	\$54,553,789	\$34,836,351	\$16,470,474	\$14,229,320
% expenditures acute care	100%	100%	100%	100%	100%
expenditures for acute care	\$112,832,871	\$54,553,789	\$34,836,351	\$16,470,474	\$14,229,320
% expenditures fixed [a]	20%	20%	20%	20%	20%
item:actual capital/total	14%	11%	7%	9%	8%
item:actual depreciation/total	10%	9%	7%	8%	8%
fixed expenditures	\$22,566,574	\$10,910,758	\$6,967,270	\$3,294,095	\$2,845,864
variable expenditures	\$90,266,297	\$43,643,031	\$27,869,081	\$13,176,379	\$11,383,456
expenditures per acute care inpatient					
actual: total	\$1,483	\$1,860	\$1,721	\$1,816	\$2,443
fixed	\$297	\$372	\$344	\$363	\$489
variable	\$1,187	\$1,488	\$1,377	\$1,453	\$1,954
at national average occupancy: total	\$1,428	\$1,655	\$1,596	\$1,689	\$2,180
fixed	\$242	\$167	\$219	\$236	\$226
variable	\$1,187	\$1,488	\$1,377	\$1,453	\$1,954
EXCESS BED PREMIUM (ANNUAL)					
per inpatient day [b]	\$55	\$204	\$125	\$127	\$263
total (all inpatient days) [c]	\$4,176,323	\$5,998,509	\$2,525,155	\$1,153,833	\$1,529,433
per admission	\$290	\$930	\$467	\$427	\$738
EXCESS BED PREMIUM % of Charge	3.70%	11.00%	7.25%	7.01%	10.75%

Note: Several Facilities have occupancy rates exceeding the national average.

[a] If more patient days, how much of the costs of the hospital would remain constant--not grow.

C-35

ACUTE CARE BEDS

COMMUNITY
HOSPITAL
(CO-LOCATED FACILITY)

6	36	37	32	25	24
6	7	8	9	10	
VALLEY HOSPITAL	KETCHIKAN GENL (CLF)	SEWARD GENERAL	KODIAK ISLAND (CLF)	SITKA COMMUNITY	

[1] SURPLUS EXCESS CAPACITY ANALYSIS

available beds in acute care	36	37	32	25	24
potential utilization days	13,140	13,505	11,680	9,125	8,760
actual utilization	6,557	5,959	1,333	3,946	2,539
occupancy rate	49.90%	44.12%	11.41%	43.24%	28.98%
Benchmark occupancy rate	75.00%	75.00%	75.00%	75.00%	75.00%
percent of national rate	66.53%	58.83%	15.22%	57.66%	38.65%
beds at national occupancy rate	24	22	5	14	9
utilization at national occupancy rate	9,855	10,129	8,760	6,844	6,570
excess beds	12	15	27	11	15
excess available bed days	3,298	4,170	7,427	2,898	4,031
excess capacity percent of beds	33.47%	41.17%	84.78%	42.34%	61.35%
outpatient visits	12,183	19,319	2,328	4,229	11,280
ratio outpatient visits/inpatient days	1.86	3.24	1.75	1.07	4.44
expenditures	\$10,795,000	\$14,299,525	\$2,558,612	\$7,251,452	\$4,908,279
% expenditures acute care	100%	81%	100%	78%	100%
expenditures for acute care	\$10,795,000	\$11,520,384	\$2,558,612	\$5,669,745	\$4,908,279
% expenditures fixed [a]	20%	20%	20%	20%	20%
item: actual capital/total	10%	6%	6%	3%	10%
item: actual depreciation/total	9%	4%	3%	5%	9%
fixed expenditures	\$2,159,000	\$2,304,077	\$511,722	\$1,133,949	\$981,656
variable expenditures	\$8,636,000	\$9,216,307	\$2,046,890	\$4,535,796	\$3,926,623
expenditures per acute care inpatient					
actual: total	\$1,646	\$1,933	\$1,919	\$1,437	\$1,933
fixed	\$329	\$387	\$384	\$287	\$387
variable	\$1,317	\$1,547	\$1,536	\$1,149	\$1,547
at national average occupancy: total	\$1,536	\$1,774	\$1,594	\$1,315	\$1,696
fixed	\$219	\$227	\$58	\$166	\$149
variable	\$1,317	\$1,547	\$1,536	\$1,149	\$1,547
EXCESS BED PREMIUM (ANNUAL)					
per inpatient day [b]	\$110	\$159	\$325	\$122	\$237
total (all inpatient days) [c]	\$722,515	\$948,530	\$433,854	\$480,132	\$602,291
per admission	\$309	\$550	\$1,079	\$380	\$973
EXCESS BED PREMIUM % of Charge	6.69%	8.23%	16.96%	8.47%	12.27%

Note: Several Facilities have occupancy rates exceeding the national average.

[a] If more patient days, how much of the costs of the hospital would remain constant--not grow.

C-36

ACUTE CARE BEDS

COMMUNITY
HOSPITAL
(CO-LOCATED FACILITY)

21	15	15	13	15
11 NORTON SOUND (CLF)	12 SOUTH PENINSULA (CLF)	13 VALDEZ COMM. (CLF)	14 CORDOVA COMM. (CLF)	15 PETERSBURG (CLF)

[1] SURPLUS EXCESS CAPACITY ANALYSIS

available beds in acute care	21	15	15	13	8
potential utilization days	7,665	5,475	5,475	4,745	4,015
actual utilization	1,813	2,211	1,377	718	479
occupancy rate	23.65%	40.38%	25.15%	15.13%	11.93%
Benchmark occupancy rate	75.00%	75.00%	75.00%	75.00%	75.00%
percent of national rate	31.54%	53.84%	33.53%	20.18%	15.91%
beds at national occupancy rate	7	8	5	3	1
utilization at national occupancy rate	5,749	4,106	4,106	3,559	3,011
excess beds	14	7	10	10	7
excess available bed days	3,936	1,895	2,729	2,841	2,532
excess capacity percent of beds	68.46%	46.16%	66.47%	79.82%	84.09%
outpatient visits	3,056	0	9,913	0	6,052
ratio outpatient visits/inpatient days	1.69	0.00	7.20	0.00	12.66
expenditures	\$7,115,296	\$7,191,757	\$1,846,211	\$2,583,678	\$2,469,070
% expenditures acute care	77%	72%	100%	61%	53%
expenditures for acute care	\$5,454,591	\$5,199,780	\$1,846,211	\$1,579,416	\$1,302,625
% expenditures fixed [a]	20%	20%	20%	20%	20%
item:actual capital/total	6%	7%	4%	16%	14%
item:actual depreciation/total	7%	8%	4%	21%	21%
fixed expenditures	\$1,090,918	\$1,039,956	\$369,242	\$315,883	\$260,525
variable expenditures	\$4,363,673	\$4,159,824	\$1,476,969	\$1,263,533	\$1,042,100
expenditures per acute care inpatient					
actual: total	\$3,009	\$2,352	\$1,341	\$2,200	\$2,719
fixed	\$602	\$470	\$268	\$440	\$544
variable	\$2,407	\$1,881	\$1,073	\$1,760	\$2,176
at national average occupancy: total	\$2,597	\$2,135	\$1,163	\$1,849	\$2,262
fixed	\$190	\$253	\$90	\$89	\$87
variable	\$2,407	\$1,881	\$1,073	\$1,760	\$2,176
EXCESS BED PREMIUM (ANNUAL)					
per inpatient day [b]	\$412	\$217	\$178	\$351	\$457
total (all inpatient days) [c]	\$746,872	\$479,994	\$245,420	\$252,152	\$219,083
per admission	\$1,110	\$1,412	ERR	\$910	\$1,480
EXCESS BED PREMIUM % of Charge	13.69%	9.23%	13.29%	15.96%	16.82%

Note: Several Facilities have occupancy rates exceeding the national average.

[a] If more patient days, how much of the costs of the hospital would remain constant--not grow.

ACUTE CARE BEDS

9

COMMUNITY
HOSPITAL
(CO-LOCATED FACILITY)

16
WRANGELL
GENL
(CLF)

[1] SURPLUS EXCESS CAPACITY ANALYSIS

available beds in acute care	9
potential utilization days	3,285
actual utilization	359
	11.48%
occupancy rate	10.93%
Benchmark occupancy rate	75.00%
percent of national rate	14.57%
beds at national occupancy rate	1
utilization at national occupancy rate	2,464
excess beds	8
excess available bed days	2,105
excess capacity percent of beds	85.43%
outpatient visits	0
ratio outpatient visits/inpatient days	0.00
expenditures	\$2,372,079
% expenditures acute care	59%
expenditures for acute care	\$1,392,414
% expenditures fixed [a]	20%
item: actual capital/total	9%
item: actual depreciation/total	12%
fixed expenditures	\$278,483
variable expenditures	\$1,113,931
expenditures per acute care inpatient	
actual: total	\$3,879
fixed	\$776
variable	\$3,103
at national average occupancy: total	\$3,216
fixed	\$113
variable	\$3,103
EXCESS BED PREMIUM (ANNUAL)	
per inpatient day [b]	\$663
total (all inpatient days) [c]	\$237,904
per admission	\$1,950
EXCESS BED PREMIUM % of Charge	17.09%

Note: Several Facilities have occupancy rates exceeding the national average.

[a] If more patient days, how much of the costs of the hospital would remain constant--not grow.

[2] SAVINGS FROM REBUILDING HOSPITALS TO EFFICIENT SIZE

(Refer to the Downsizing Analysis Worksheet)

QUESTION--If the Alaska community hospital acute care facilities were replaced with smaller facilities that could maintain national average occupancy rates and at the same time could be operated at a cost no greater than double the national average, how would average costs per inpatient day and for the health care system as a whole be impacted?

RESULTS--The downsizing would eliminate 228 beds and the potential annual saving would be \$156 per inpatient day, and \$41.7 million annually. Half of the savings would occur in Anchorage and Fairbanks.

ASSUMPTIONS--The average cost per acute care inpatient day in Alaska community hospitals is \$1,697 compared to the national average of \$771--a difference of 120 %. The range of average daily expenditures for Alaska hospitals is from a low of \$1,483 to a high of \$3,879. As shown in Figure I.5, the daily expenditure is inversely related to hospital size as measured by the number of beds. It is also inversely related to occupancy rates since small hospitals tend to have lower occupancy rates. Only two Alaska hospitals have costs per acute care inpatient day that are less than double the national average. The average daily inpatient expenditure includes outpatient care costs and this tends to exaggerate the cost differential between Alaska and the US average. On the other hand the cost differential for medical care in Alaska as measured by the available indices is below 100%. Consequently a target differential for planning purposes of 100% for this analysis does not seem unreasonable.

When hospitals are being designed and built all costs are variable since this is the time that the size of the hospital is determined. In fact for extremely small hospitals there will be some minimum size below which fixed costs can no longer be reduced. For example, there is a minimum number of nurses required to staff even the smallest hospital.

The national average occupancy rates were used as the benchmark for sizing the Alaska hospitals.

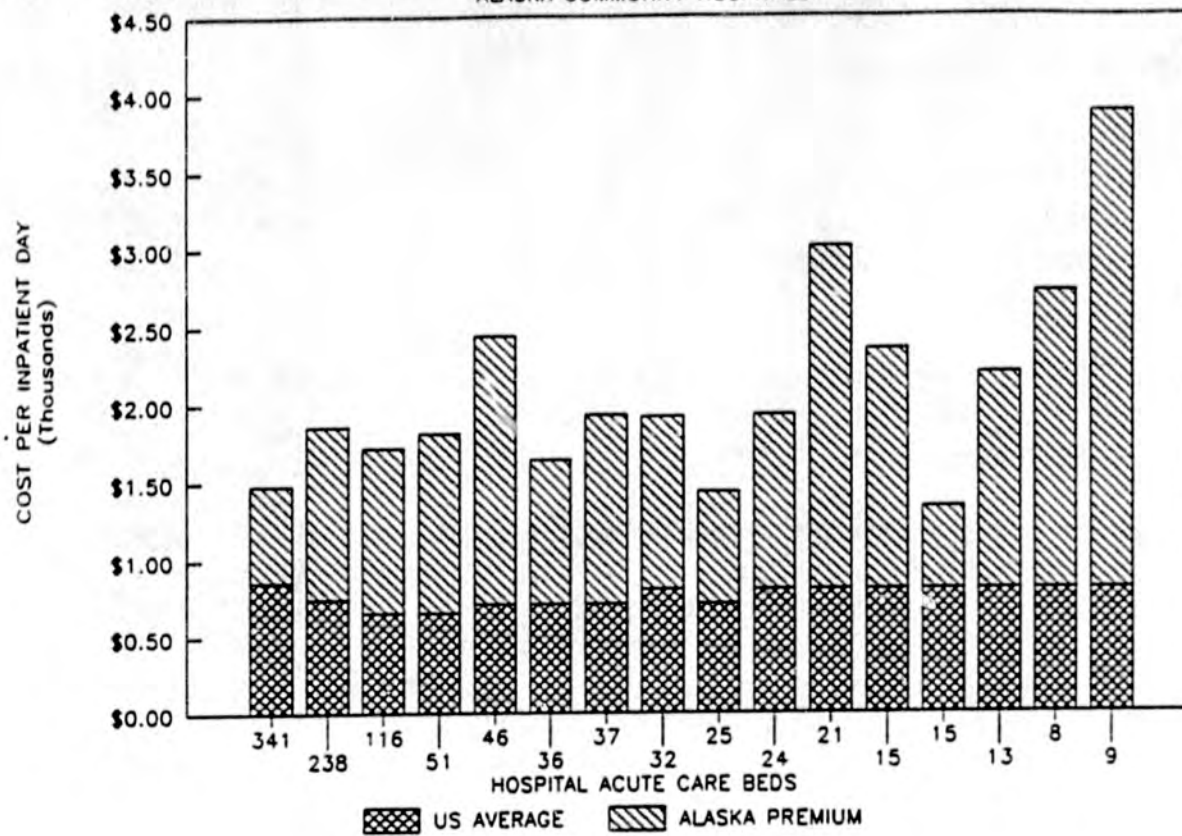
Expenses in two Alaska hospitals were calculated at less than 2 times the national average. In this analysis no savings was achieved by resizing these hospitals when in fact downsizing could lead to savings through the elimination of excess capacity for these facilities.

In assuming the national average expense per inpatient day as the standard we recognize that hospital costs are influenced by average age of facility, the types of

Figure 1.5

COST PER INPATIENT DAY

ALASKA COMMUNITY HOSPITALS



services offered, etc. The data does not allow this detail in the analysis.

The analysis looks at the savings in one year. It does not take into account that demand for facility utilization is changing over time.

METHODOLOGY--The cost per inpatient day in US hospitals of a size appropriate for each Alaska location based on the national average occupancy rate was compared to the reported cost per inpatient day at Alaska hospitals. The US hospital expenses were doubled and the difference between these expenses across all inpatients and the reported Alaska expenses across all inpatients was calculated. This is the estimate of potential savings from downsizing.

DATA SOURCE--Occupancy rates for Alaska acute care hospitals as well as expenditures per inpatient day were based on information provided by the hospitals to the Medicaid Rate Setting Commission. The expenditure information excluded the costs associated with Long Term Care, but included the costs associated with outpatient care. The data was for the most recent fiscal year available, which varied somewhat among hospitals, but generally covered 1989. The data includes the 16 community hospitals in the state. Co-located facilities are indicated on the worksheet. All expenses, including replacement costs, are assumed included in the data. The national average data was obtained from the American Hospital Association.

COMMUNITY HOSPITAL (CO-LOCATED FACILITY)	AVERAGE OR SUM	AVERAGE/SUM NET ANCH & FRBKS	AVERAGE/SUM ACUTE CARE FACILITIES	AVERAGE/SUM CO-LOCATED FACILITIES
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[2] DOWNSIZING ANALYSIS

available beds	1,027	332	899	128
actual utilization	167,839	42,187	152,354	15,485
occupancy rate	44.64%	34.50%	46.43%	32.39%
national occupancy rate	58.17%			
target beds	799	287	685	114
change from current level	228	45	214	14
expenditures per inpatient day	\$1,697	\$1,963	\$1,661	\$2,074
US avg expenditures per inpatient day	\$771	\$730	\$774	\$748
ratio: Ak/US avg	2.20	2.69	2.15	2.77
US avg expenditures -- doubled	\$1,541	\$1,459	\$1,549	\$1,497
potential saving from reconstruction				
per inpatient day	\$156 ^a	\$504 ^a	\$112 ^a	\$578
annual total	\$41,733,524	\$22,413,990	\$32,632,499	\$9,101,025

^a Does not reflect fact that 2 hospitals
have costs less than double national average

COMMUNITY HOSPITAL (CO-LOCATED FACILITY)	1 PROVIDENCE	2 HUMANA/ ALASKA	3 FAIRBANKS MEM.	4 BARTLETT MEM.	5 CENTRAL PENINSULA	6 VALLEY HOSPITAL	7 KETCHIKAN GENL (CLF)	8 SEWARD GENERAL
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[2] DOWNSIZING ANALYSIS

available beds	341	238	116	51	46	36	37	32
actual utilization	76,073	29,333	20,246	9,071	5,825	6,557	5,959	1,333
occupancy rate	61.12%	33.77%	47.82%	48.73%	34.69%	49.90%	44.12%	11.41%
national occupancy rate	69.30%	66.80%	60.70%	53.00%	40.60%	40.60%	40.60%	40.60%
target beds	301	120	91	47	39	44	40	9
change from current level	40	118	25	4	7	(8)	(3)	23
expenditures per inpatient day	\$1,483	\$1,860	\$1,721	\$1,816	\$2,443	\$1,646	\$1,933	\$1,919
US avg expenditures per inpatient day	\$856	\$743	\$654	\$654	\$709	\$709	\$709	\$804
ratio: Ak/US avg	1.73	2.50	2.63	2.78	3.45	2.32	2.73	2.39
US avg expenditures -- doubled	\$1,712	\$1,486	\$1,308	\$1,308	\$1,418	\$1,418	\$1,418	\$1,608
potential saving from reconstruction								
per inpatient day	\$0	\$374	\$413	\$508	\$1,025	\$228	\$515	\$311
annual total	\$0	\$10,964,951	\$8,354,583	\$4,605,606	\$5,969,470	\$1,497,174	\$3,070,522	\$415,148

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COMMUNITY HOSPITAL (CO-LOCATED FACILITY)	9 KODIAK ISLAND (CLF)	10 SITKA COMMUNITY	11 NORTON SOUND (CLF)	12 SOUTH PENINSULA (CLF)	13 VALDEZ COMM. (CLF)	14 CORDOVA COMM. (CLF)	15 PETERSBURG (CLF)	16 WRANGELL GENL (CLF)
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[2] DOWNSIZING ANALYSIS

available beds	25	24	21	15	15	13	8	9
actual utilization	3,946	2,539	1,813	2,211	1,377	718	479	359
occupancy rate	43.24%	28.98%	23.65%	40.38%	25.15%	15.13%	11.93%	10.93%
national occupancy rate	40.60%	32.40%	32.40%	32.40%	32.40%	32.40%	32.40%	32.40%
target beds	27	21	15	19	12	6	4	3
change from current level	(2)	3	6	(4)	3	7	4	6
expenditures per inpatient day	\$1,437	\$1,933	\$3,009	\$2,352	\$1,341	\$2,200	\$2,719	\$3,879
US avg expenditures per inpatient day	\$709	\$804	\$804	\$804	\$804	\$804	\$804	\$804
ratio: Ak/US avg	2.03	2.40	3.74	2.93	1.67	2.74	3.38	4.82
US avg expenditures -- doubled	\$1,418	\$1,608	\$1,608	\$1,608	\$1,608	\$1,608	\$1,608	\$1,608
potential saving from reconstruction								
per inpatient day	\$19	\$325	\$1,401	\$744	\$0	\$592	\$1,111	\$2,271
annual total	\$74,317	\$825,567	\$2,539,287	\$1,644,492	\$0	\$424,872	\$532,393	\$815,142

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[3] SAVINGS FROM CHANGING SERVICES PROVIDED AT UNDERUTILIZED HOSPITALS

(Refer to Facility Reconfiguration Worksheet)

QUESTION--Is there a cost savings from reconfiguration of existing facilities?

RESULTS--Using the example of serving the acute care inpatient needs of Petersburg and Wrangell by transferring them to Ketchikan, the net savings estimate ranges from \$229 thousand to \$391 thousand annually. Savings for other reconfigurations depend upon relative costs of service in different locations (usually less at larger and more fully utilized facilities) and costs of patient transportation.

The transfer of inpatients to Ketchikan would reduce the daily inpatient cost not only for patients from Wrangell and Petersburg because they would receive care at the less costly Ketchikan hospital, but also for the current users of the Ketchikan hospital because fixed costs would be shared among a larger number of patients and thus reduce the cost per patient. The cost savings would be partially offset by the fact that residents of Wrangell and Petersburg would incur travel costs to get to and from Ketchikan for care.

ASSUMPTIONS--Fixed costs range from 10% to 20% of total expenses. Facilities which lose patients can be put to some other use, for example long term care, which would absorb these fixed costs. The outpatient services currently provided at Wrangell and Petersburg would continue to be provided in those communities at their current cost. The transportation cost associated with each admission from Wrangell and Petersburg into Ketchikan is \$400. This is an arbitrary figure.

The acute care facilities at Petersburg and Wrangell have a combined total of 17 beds with an occupancy rate of 11%. The cost per acute care inpatient day at the three facilities is as follows (the outpatient service expenditures are included in these figures):

Ketchikan	\$1,933
Petersburg	\$2,719
Wrangell	\$3,879

METHODOLOGY--The cost at Ketchikan of providing services for the patients now handled at Wrangell and Petersburg is calculated (including outpatient costs). The savings in expense from closing the acute care beds in Wrangell and Petersburg is netted out. This results in a savings in the 10% fixed cost case (assuming the fixed costs in Wrangell and Petersburg are allocated to an alternative use) of \$1.2 million annually. From this savings the transportation costs are netted out. This reduces the savings to \$1.1 million annually. Finally the cost of outpatient care provided in Wrangell and Petersburg is added back in at the current amount. This is approximately \$.9 million. This reduces the net savings to \$229 thousand which is the result of a reduction in costs

of \$918 thousand in Wrangell and Petersburg partially offset by a \$768 thousand increase in costs associated with the provision of care at Ketchikan.

DATA SOURCE--Occupancy rates for Alaska acute care hospitals as well as expenditures per inpatient day were based on data provided by the hospitals to the Medicaid Rate Setting Commission. The expenditure information excluded the costs associated with long term care, but included the costs associated with outpatient care. The data was for the most recent fiscal year available, which varied somewhat among hospitals, but generally covered 1989. The data includes the 16 community hospitals in the state. Co-located facilities are indicated on the worksheet. All expenses, including replacement costs, are assumed included in the data. The national average data was obtained from the American Hospital Association.

COMMUNITY HOSPITAL (CO-LOCATED FACILITY)	ISER			
	AVERAGE OR SUM	7 KETCHIKAN GENL (CLF)	15 PETERSBURG (CLF)	16 WRANGELL GENL (CLF)

[3] FACILITY RECONFIGURATION				
Facilities Moved	1 2	PETERSBURG WRANGELL		
available beds		37	8	9
potential utilization days		13,505	4,015	3,285
present utilization		5,959	479	359
ADD: transfers in		838		
MINUS: transfers out			479	359
net utilization		6,797	0	0
occupancy rate with transfers		50.33%	0.00%	0.00%
national occupancy rate		40.60%	32.40%	32.40%
percent of national rate		123.96%	0.00%	0.00%
expenditures for acute care		\$11,520,384	\$1,302,625	\$1,392,414
% expenditures fixed		10%	10%	10%
fixed expenditures		\$1,152,038	\$130,262	\$139,241
variable expenditures		\$10,368,345	\$1,172,362	\$1,253,173
expenditures per inpatient day				
local demand				
total		\$1,933	\$2,719	\$3,879
fixed		\$193	\$272	\$388
variable		\$1,740	\$2,448	\$3,491
transfer				
total		\$1,740	\$2,448	\$3,491
fixed		\$0	\$0	\$0
variable		\$1,740	\$2,448	\$3,491
transportation cost				
per patient			\$400	\$400
number of admissions	270		148	122
total	\$108,000		\$59,200	\$48,800
total system acute care expenditures				
before transfer	\$285,149,862	\$11,520,384	\$1,302,625	\$1,392,414
after transfers (with fixed costs)	\$284,182,403	\$12,978,459	\$130,262	\$139,241
after transfers (no fixed costs)	\$283,912,899			
acute care expenditure savings				
continue to pay fixed costs	\$967,459	(\$1,458,076)	\$1,172,362	\$1,253,173
fixed costs reallocated	\$1,236,963	(\$1,458,076)	\$1,302,625	\$1,392,414
system savings net of transportation cost				
continue to pay fixed costs	\$859,459	(\$1,458,076)	\$1,113,162	\$1,204,373
fixed costs reallocated	\$1,128,963	(\$1,458,076)	\$1,243,425	\$1,343,614
Outpatient expenditures	\$5,833,480	\$4,933,249	\$474,963	\$425,268
Share of acute care		56.02%	40.04%	51.09%
System savings net of transportation cost and outpatient cost				
continue to pay fixed costs	(\$40,772)	(\$1,458,076)	\$638,199	\$779,104
fixed costs reallocated	\$228,732	(\$1,458,076)	\$768,462	\$918,346
Savings per transferred inpatient day	\$273			
fixed costs reallocated				

COMMUNITY HOSPITAL (CO-LOCATED FACILITY)	ISER			
	AVERAGE OR SUM	7 KETCHIKAN GENL (CLF)	15 PETERSBURG (CLF)	16 WRANGELL GENL (CLF)

[3] FACILITY RECONFIGURATION				
Facilities Moved	1 2	PETERSBURG WRANGELL		
available beds		37	8	9
potential utilization days		13,505	4,015	3,285
present utilization		5,959	479	359
ADD: transfers in		838		
MINUS: transfers out			479	359
net utilization		6,797	0	0
occupancy rate with transfers		50.33%	0.00%	0.00%
national occupancy rate		40.60%	32.40%	32.40%
percent of national rate		123.96%	0.00%	0.00%
expenditures for acute care		\$11,520,384	\$1,302,625	\$1,392,414
% expenditures fixed		20%	20%	20%
fixed expenditures		\$2,304,077	\$260,525	\$278,483
variable expenditures		\$9,216,307	\$1,042,100	\$1,113,931
expenditures per inpatient day				
local demand				
total		\$1,933	\$2,719	\$3,879
fixed		\$387	\$544	\$776
variable		\$1,547	\$2,176	\$3,103
transfer				
total		\$1,547	\$2,176	\$3,103
fixed		\$0	\$0	\$0
variable		\$1,547	\$2,176	\$3,103
transportation cost				
per patient			\$400	\$400
number of admissions	270		148	122
total	\$108,000		\$59,200	\$48,800
total system acute care expenditures				
before transfer	\$285,149,862	\$11,520,384	\$1,302,625	\$1,392,414
after transfers (with fixed costs)	\$284,289,898	\$12,816,451	\$260,525	\$278,483
after transfers (no fixed costs)	\$283,750,890			
acute care expenditure savings				
continue to pay fixed costs	\$859,964	(\$1,296,067)	\$1,042,100	\$1,113,931
fixed costs reallocated	\$1,398,971	(\$1,296,067)	\$1,302,625	\$1,392,414
system savings net of transportation cost				
continue to pay fixed costs	\$751,964	(\$1,296,067)	\$982,900	\$1,065,131
fixed costs reallocated	\$1,290,971	(\$1,296,067)	\$1,243,425	\$1,343,614
Outpatient expenditures	\$5,833,480	\$4,933,249	\$474,963	\$425,268
Share of acute care		56.02%	40.04%	51.09%
System savings net of transportation cost and outpatient cost				
continue to pay fixed costs	(\$148,267)	(\$1,296,067)	\$507,937	\$639,863
fixed costs reallocated	\$390,740	(\$1,296,067)	\$768,462	\$918,346
Savings per transferred inpatient day fixed costs reallocated	\$466			

II. ALASKA EMPLOYMENT BY INDUSTRY AND FIRM SIZE

The proportion of workers employed in the public sector in Alaska in 1990 was twice the national average (US Department of Commerce, Bureau of Economic Analysis). This includes both full and part time employment and consequently may include some double counting. The percentages were as follows:

	Alaska	US Average
Total Public	30.0%	15.4%
Military	9.2	2.0
Federal Civilian	5.7	2.4
State and Local	15.1	11.1

This information suggests that a smaller proportion of the population in Alaska is provided or potentially provided with employer based health insurance from private employers. This is likely true even though a larger portion of the Alaska public employment may be part time (such as the National Guard) and thus not covered by health insurance.

The proportion of Alaska workers who were self-employed in 1990 is also considerably above the national average (17.5 percent compared to 14.4 percent). This is due in large part to the importance of fish harvesting and construction in the Alaska economy. Since this data also includes part time workers who may have health insurance coverage in other jobs (teachers who fish or professors who have a consulting business), it is not clear from this data whether the health insurance problems of the self employed are more severe in Alaska than elsewhere.

Seasonality is a characteristic of several important Alaska industries including seafood harvesting and processing, forest products, construction, and tourism. The extent of variation in employment in these industries is indicated by the percent change from the minimum to the maximum monthly employment over the year. Percent changes during 1990 were (Alaska Department of Labor, Alaska Economic Trends, August 1991):

Industry	Percent Change in Employment From Minimum to Maximum Month
All Industries	24 %
Construction	70
Seafood Processing	322
Lumber and Wood Products	118
Hotels and Motels (Tourism)	56

The seasonality of employment is accompanied by a high turnover rate of employment. This is indicated by the fact that 17 percent of Alaska workers--53 thousand--were non-residents in 1988 (the last year before the oil spill cleanup economic boom). These non-resident workers were concentrated in the seasonal industries--seafood, timber, construction, and tourism. Non-residents in seafood processing comprised 51 percent (15 thousand) of all workers in the industry (Alaska Department of Labor, Nonresidents Working in Alaska).

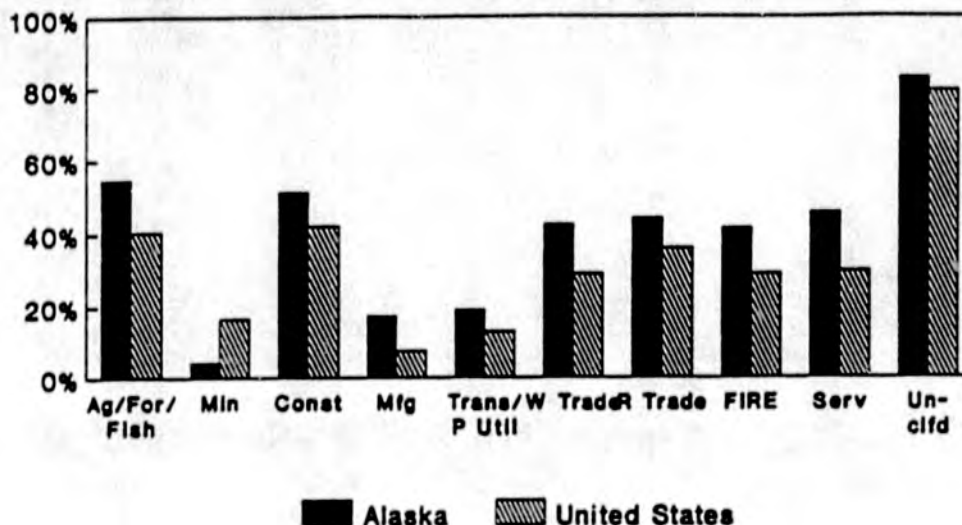
Within the private economy in Alaska the average firm size is less than the national average for all industries except mining/petroleum which in Alaska is dominated by a small number of large firms. (The data on firm size excludes the self employed such as many miners and fishermen. US Department of Commerce, County Business Patterns for 1988.)

39 percent of private employees in Alaska work in firms with fewer than 20 employees compared to the national average of 27 percent (Figure II.1). This represents about 53 thousand Alaskan workers who are primarily in the trade and service sectors but include all industries (Figure II.2 and Figure II.3).

Many of the largest firms in Alaska are in seasonal industries. In 1989 the firm with the largest number on the payroll at some time during the year was Veco Inc. which was the primary contractor for the oilspill cleanup effort. Of the 32 firms that has more than 1000 employees on the payroll during the year 11 can be identified with the seasonal industries of seafood processing, tourism, or oilspill cleanup. (Alaska Department of Labor, special computer printout of 1989 employment by firm)

Figure II.1

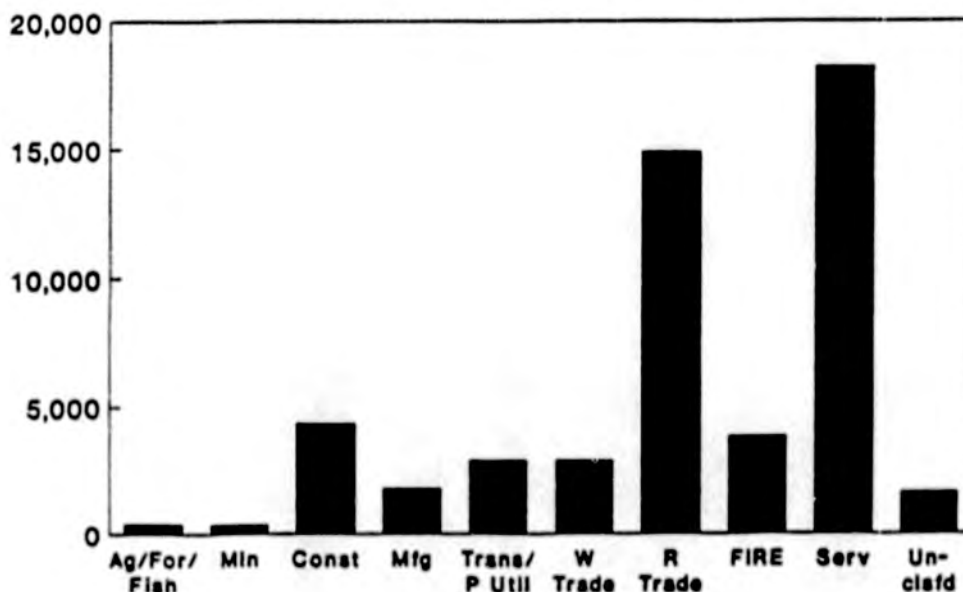
**Percent of Employees in Alaska and U.S.
That Are In Firms That Have
Fewer Than 20 Employees**



Values for Alaska are not reported for Ag/For/Fish, Trans/P Util, and W Trade where no. of employees was fewer than 5.

Figure II.2

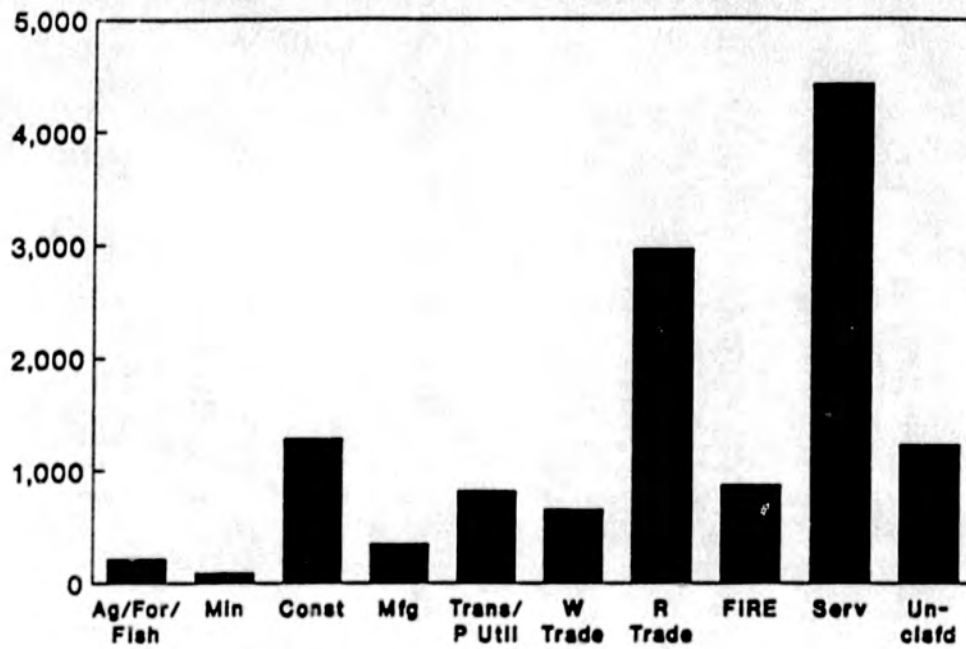
**Number of Employees in Alaska Firms
that have fewer than 20 Employees**



Values for Ag/For/Fish, Trans/P Util, and W Trade are for firms having 5-19 employees.

Figure II.3

**Number of Alaska Firms
with fewer than 20 Employees**



III. MEASURES OF THE MEDICAL COST OF LIVING DIFFERENTIAL FOR ALASKA AND MEDICAL INFLATION

Studies of the cost of living differential between Anchorage and the rest of the US consistently report that the differential is twice as large for medical care compared to the overall budget for a consumer. These studies measure the relative price for only that portion of medical expenditures paid directly by consumers, and then only for a small sample of items. They typically exclude the prices of items paid by government, such as the majority of long term care costs, and the cost of employer contributions to health insurance. Consequently they should be considered only a very imprecise measure of the differences in prices for medical care in Anchorage compared to the rest of the US. In addition they do not measure price differences between locations in Alaska outside of Anchorage and the lower 48 states.

The 1991 Anchorage cost of living differential compared to the US city average as measured by the US Chamber of Commerce was 73 percent for health care compared to 35 percent for the composite index (Figure III.1)(ACCRA INDEX for 1991:1).

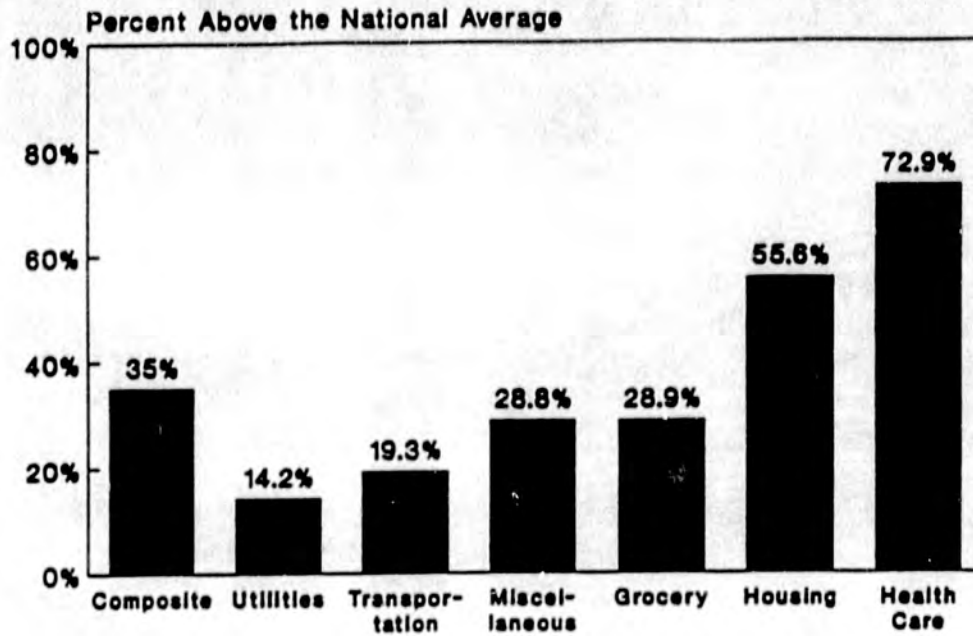
The Anchorage cost of living differential compared to Seattle for medical care was 30 percent compared to 16 percent for the total differential as reported in 1985 in the Alaska Geographic Differential Study (April 1985 by the McDowell Group for Alaska Department of Administration).

The cost of medical care for a family of 4 was estimated to be 60 percent above the US urban average in Anchorage in 1981. This compared to a differential for the entire family budget ranging from a low of 22 percent for a high income family to a high of 46 percent for a low income family (Figure III.2) (US Department of Labor, 3 Family Budgets 1981, [last published in 1981]).

The Alaska differential in the price of medical care, whatever its specific value, has remained constant over time as measured by the medical care component of the Anchorage Consumer price index. This measure of the rate of inflation in medical care costs from year to year has increased at approximately the same rate as the US average since the mid 1970s (Figure III.3) (US Department of Labor, Consumer Price Index for All Urban Consumers).

Figure III.1

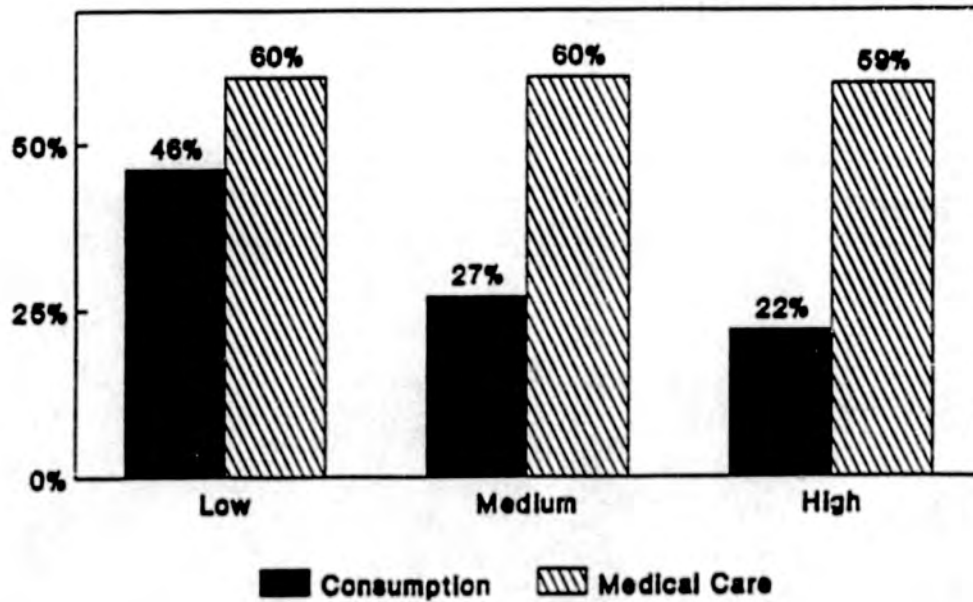
**Anchorage Cost of Living Differential
According to the US Chamber of Commerce**



ACCRA 1991:1

Figure III.2

**3 Family Budgets in Anchorage
Total Consumption and Medical Care
Percent Above the US City Average, 1981**



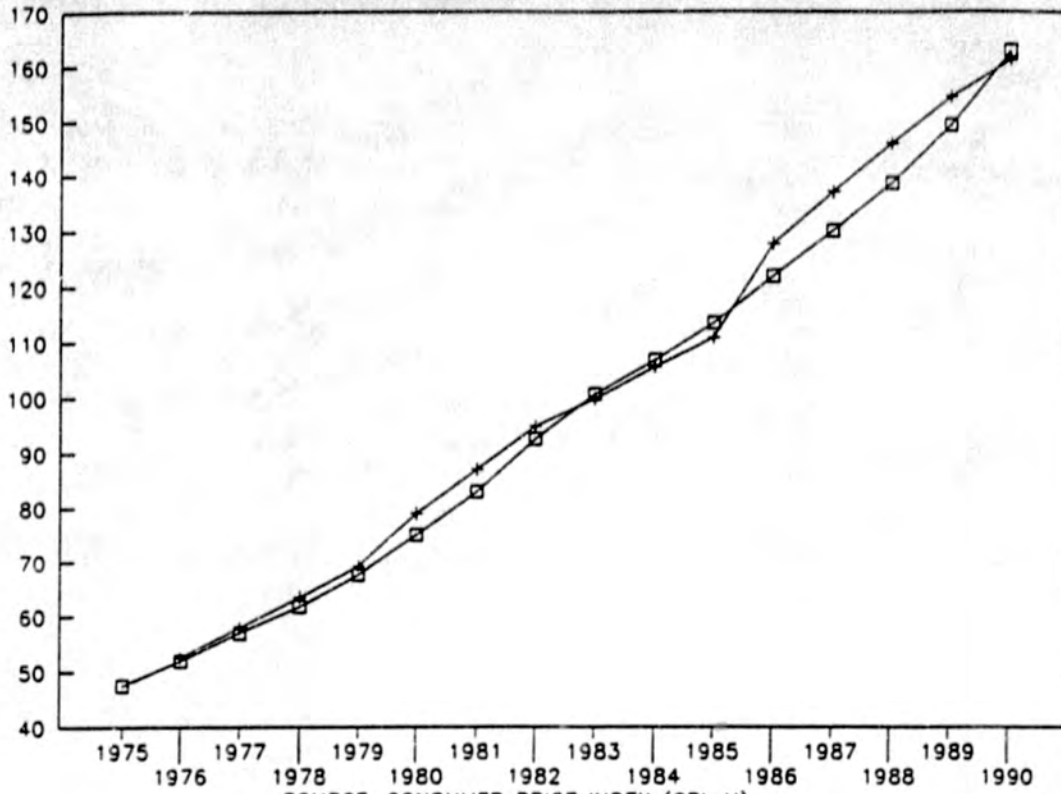
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Figure III.3

MEDICAL CARE CONSUMER PRICE INDEX

ANCHORAGE AND THE US AVERAGE

1982-84=100



SOURCE: CONSUMER PRICE INDEX (CPI-U)

□ US AVERAGE + ANCHORAGE

IV. DEMOGRAPHIC CHANGE IN ALASKA AND ITS INFLUENCE ON HEALTH CARE EXPENDITURES

The population of Alaska has grown at three times the national average since Alaska became a state. The annual growth rate averaged 3 percent between 1960 and 1990 in Alaska. During the same period the average annual growth rate of the US population was 1.1 percent. In the most recent decade Alaska population increased 37 percent--a 3.2 percent average annual rate of growth.

As important for medical care expenditures as the growth in the total population has been the aging of the Alaska population. This is because average health care expenditures by the elderly are about three times the average for the entire population. Data from the Health Care Financing Administration shows that health care spending per capita is related to age. Specifically the annual per capita expenditure for the entire population on health care in 1987 was \$1,776 but \$5,360 for the over 65 population (Health Care Financing Review, Summer 1989, Volume 10, Number 4).

The over 65 population is a small percentage of the total population in Alaska, particularly in relation to the US as a whole. In 1990 4.1 percent of the Alaska population was 65+ compared to 12.3 percent for the US.

More significant however is the rate of growth of the 65+ population in the state. During the first decade of statehood the 65+ population grew at a slower rate than the total--2.1 percent. In the 1970s the 65+ population began increasing at a faster rate than the total population--5.6 percent. In the decade of the 1980s the 65+ population grew at the annual average rate of 6.8 percent--twice as fast as the total population. In contrast, in the US as a whole the 65+ population grew at the rate of 2.1 percent annually during the 1980s.

The net result of this growth is that the age structure of the Alaska population is approaching that of the nation as a whole. Not only is 65+ population becoming a larger portion of the total, the average age of the population is increasing. In particular between 1980 and 1990 the population aged 35-44 increased the most--49 thousand--while the population aged 19-24 declined by 4 thousand. The average age of males in Alaska is now 28.4 compared to 31.5 for the total US. The average age of females in Alaska is 28.5 compared to 33.8 for the total US.

V. PROJECTING ALASKA HEALTH CARE EXPENDITURES

Health care expenditures in a population increase over time as a result of 4 factors- general inflation, medical inflation in excess of the general inflation rate, increases in population, and increases in utilization and the intensity of use.

If the rate of medical inflation in the 1990s is the same as it has been for the last 15 years and nothing else changes health care expenditures in Alaska will more than double by 2000 to \$3 billion annually.

Population growth and aging will add to the increase. Economic projections suggest that the rate of population growth in the 1990s will be less than in prior decades (see for example Economic Projections for Southcentral Alaska:1990-2015, ISER 1991). If that is the case and the population increases only 100 thousand during the 1990s this will engender \$500 million in additional health care expenditures annually. On the other hand if we assume a continuation of the historical rate of population increase, an additional 241 thousand Alaskans will reside in the state in 2000. These Alaskans will add \$1.5 billion to health care expenditures in the state at that time.

These projections assume that each age cohort of the population grows at the historical rate or, in the lower case, at a fixed percentage of the historical rate. As a consequence the 65+ population increases at a faster rate than the overall population and contributes to increased expenditures through greater utilization of health services than the average resident. The projections make no other assumptions about changes in utilization rates for health care services or for the intensity of use. If age specific utilization rates increase, or if the intensity of care for particular health problems increases total health care expenditures would be higher than projected here.

VI. HISTORICAL PERFORMANCE STATISTICS OF ALASKA COMMUNITY ACUTE CARE HOSPITALS

Community acute care hospitals in Alaska can be historically compared with similar sized hospitals in the rest of the United States using information collected and disseminated by the American Hospital Association.

When interpreting these comparisons two important factors must be kept in mind.

First, several of the Alaska community hospitals are co-located facilities which means that they contain long term care beds in addition to acute care beds. (Of the total of 1148 beds in the 16 community acute care hospitals in Alaska 121, 10.5 percent, are not acute care beds. [Medicaid Rate Setting Commission data]) In the nation as a whole co-located facilities are not as common as in Alaska. Therefore although the national data contains some long term care beds mixed in with the acute care beds, the proportion is smaller than for Alaska. This is important because the occupancy rate of long term care beds is generally higher than for acute care beds, and the cost per inpatient day of long term care is generally much lower than for acute care beds.

Second, the average number of beds per hospital is much smaller in Alaska than in the United States as a whole. In comparing Alaska to the US the US data has been weighted by the actual Alaska hospital bed size distribution. This results in data that is directly comparable to Alaska. For example the utilization rate for all US hospitals in 1989 was 66.2 percent. But if the US had the same size distribution of hospitals as Alaska the occupancy rate would have been 57.4 percent. This later figure is used for comparison with the Alaska occupancy rate of 48.9 percent.

INPATIENT DAYS PER CAPITA (Figure VI.1)--After subtracting out the large military and Native components of the Alaska population, inpatient days per capita in Alaska community hospitals (.53 days in 1989) have remained at about half the national average (.92 in 1989) since the early 1970s. This is probably explained by the young age of the Alaska population and the fact that some Alaskans travel to other states for their hospitalization.

OUTPATIENT VISITS PER CAPITA (Figure VI.2)--After subtracting out the large military and Native components of the Alaska population, outpatient visits per capita in Alaska community hospitals (.99 visits per capita in 1989) are less than the national average (1.17 visits per capita in 1989). However Alaskans are more comparable to the US average in their use of outpatient services than in their use of inpatient services.

AVERAGE LENGTH OF STAY (Figure VI.3)--The average length of stay in Alaska hospitals is less than the US average although it is increasing while the average stay in

Figure VI.1
ALASKA COMMUNITY HOSPITALS
INPATIENT DAYS PER CAPITA

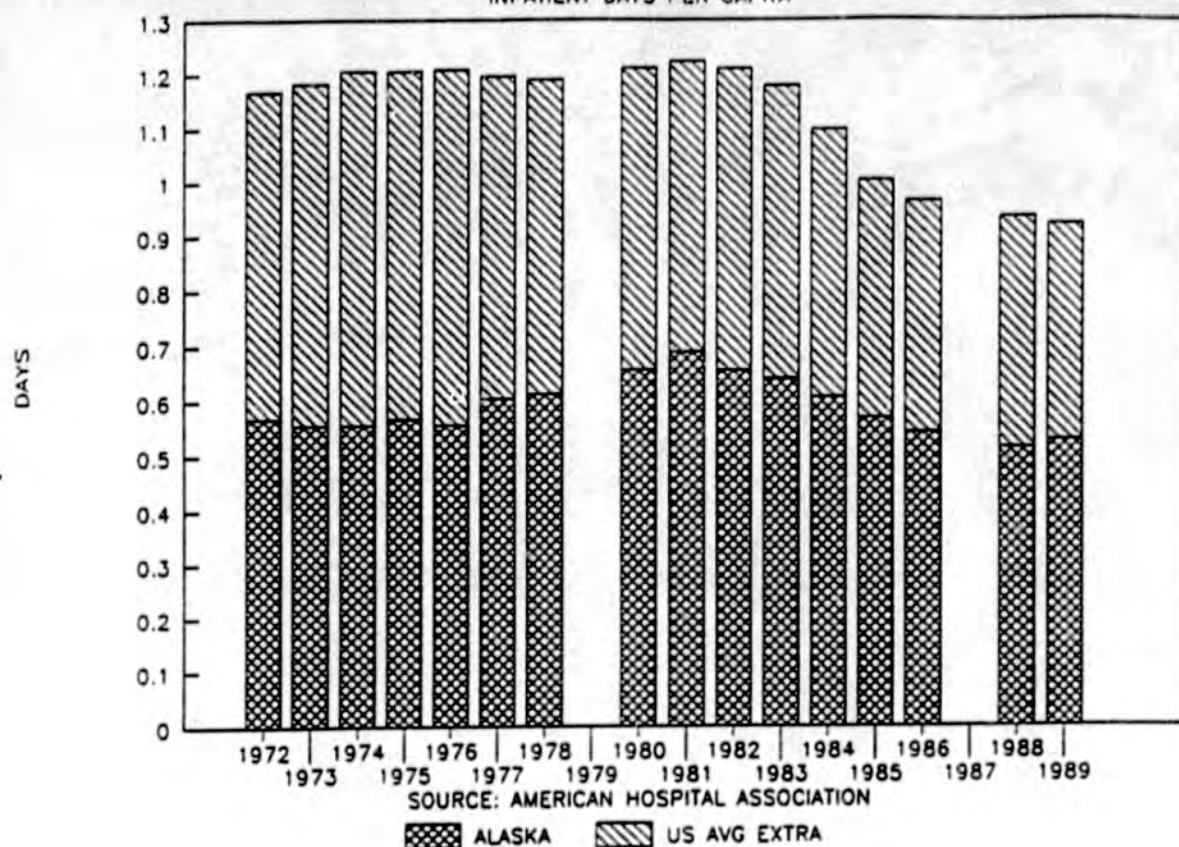


Figure VI.2
ALASKA COMMUNITY HOSPITALS
OUTPATIENT VISITS PER CAPITA

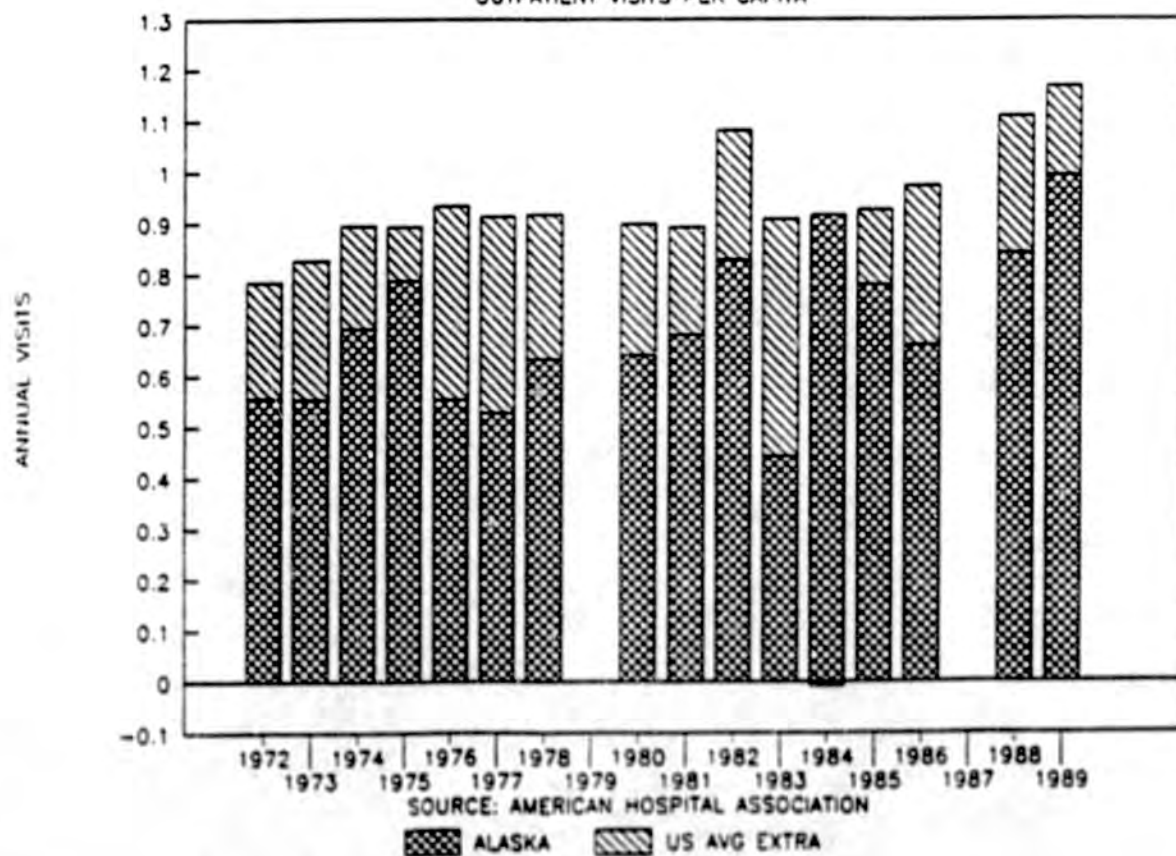


Figure VI.3
ALASKA COMMUNITY HOSPITALS
AVERAGE LENGTH OF STAY

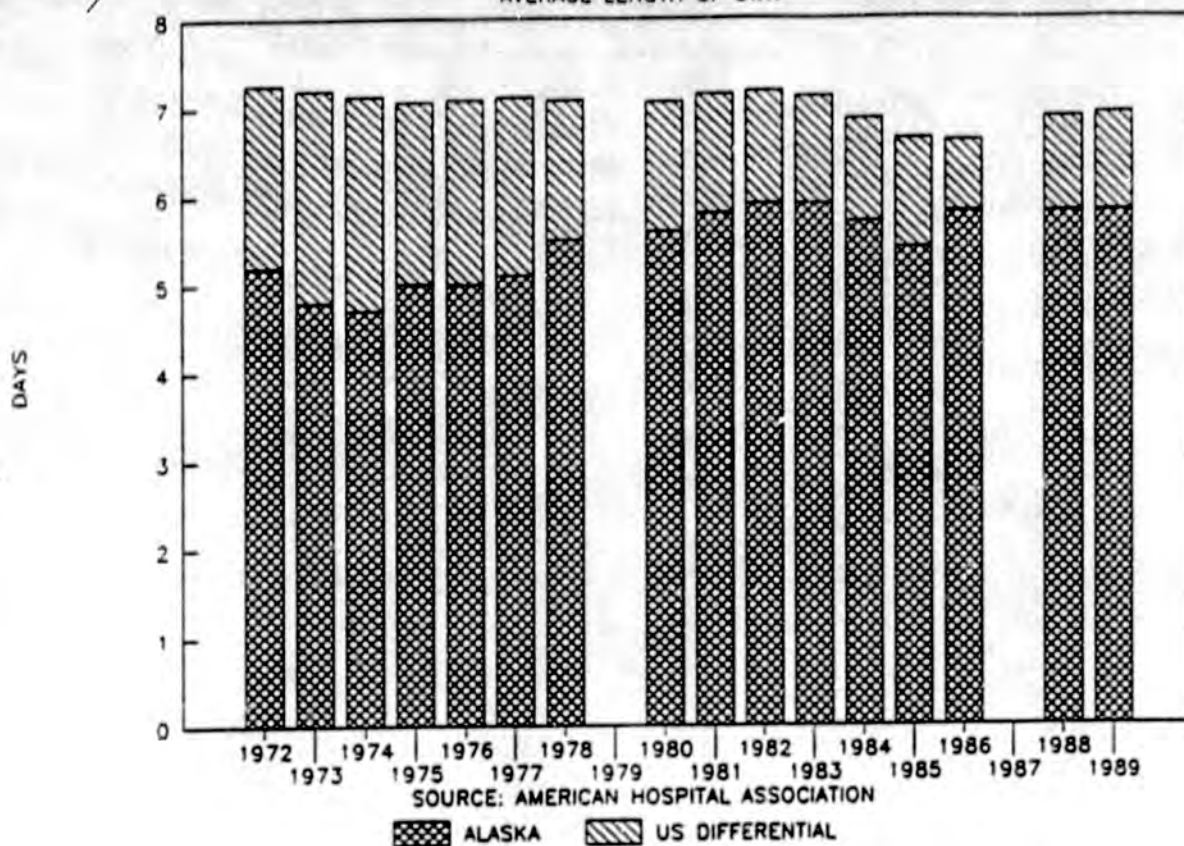
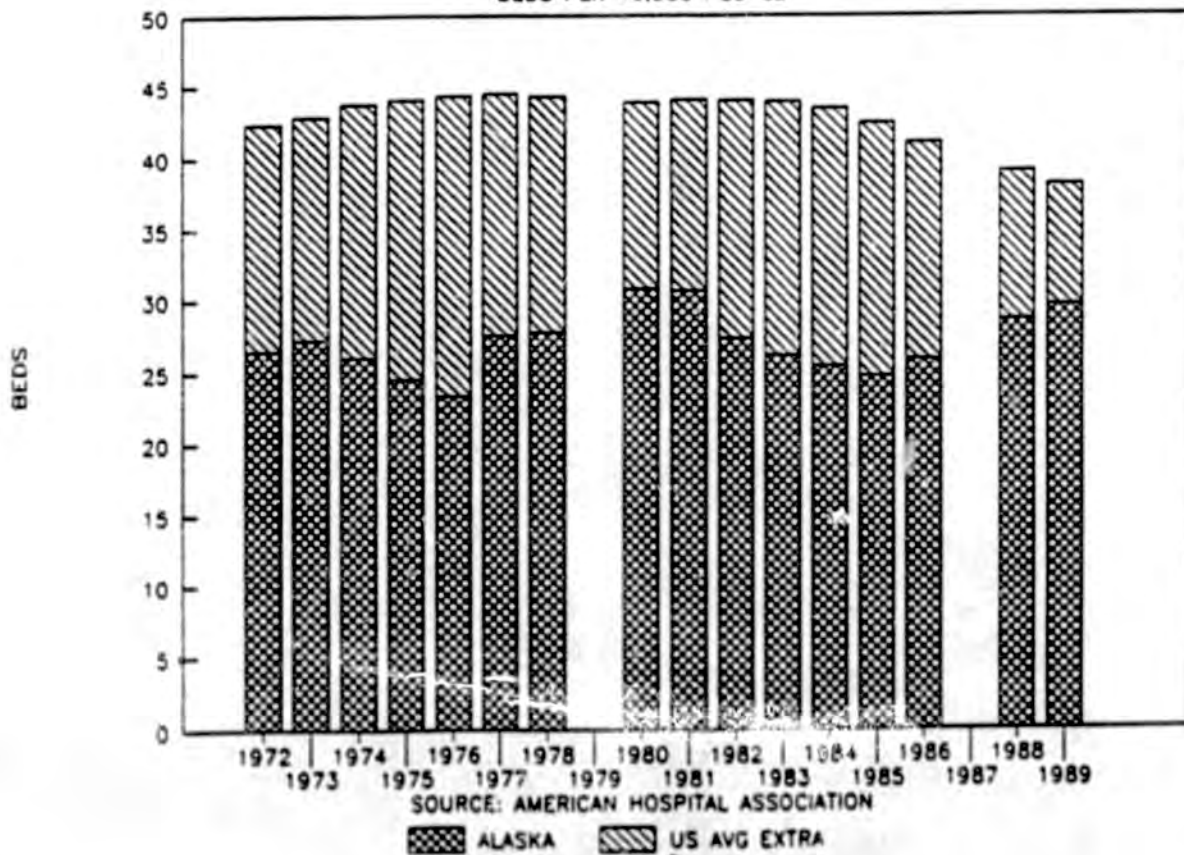


Figure VI.4
ALASKA COMMUNITY HOSPITALS
BEDS PER 10,000 PEOPLE



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hospitals across the US is declining. In 1989 the average length of stay in Alaska hospitals was 5.8 days. The US average was 6.9 days.

BEDS PER 10,000 POPULATION (Figure VI.4)--After subtracting out the large military and Native components of the Alaska population, the number of beds per 10,000 population is considerably below the national average. There are 30 beds in Alaska for 10,000 population. In the US as a whole there are 38 beds for every 10,000 population. This is consistent with lower than average inpatient and outpatient visits per capita. The number of beds per capita in the US have been falling since the mid 1980s. In Alaska there is no such trend.

INPATIENT DAYS (Figure VI.5)--The number of inpatient days has fallen in Alaska in recent years after increasing sharply in the 1970s. In the US inpatient days has also fallen in recent years.

OCCUPANCY RATE (Figure VI.6)--The occupancy rate in Alaska community hospitals has in recent years been below the national average. In 1989 the rate for Alaska was 48.9 percent compared to 57.4 percent for the nation as a whole. The occupancy rate in Alaska hospitals was above the national average for 4 years in the mid 1980s. Occupancy rates both in Alaska and the nation as a whole have fallen since the mid 1980s. This is consistent with the fact that both admissions and inpatient days are lower in Alaska than in the mid 1980s. Occupancy rate is defined as the number of inpatient days (excluding newborns) divided by total beds multiplied by 365 (excluding newborn bassinets).

EXPENSES PER ADJUSTED PATIENT DAY (Figure VI.7. & Figure VI.8)--Expenses in Alaska hospitals per adjusted patient day are considerably above the US average. In 1989 the facility cost per adjusted patient day in Alaska hospitals was \$996--76 percent above the national average of \$565. Historically this differential has ranged from 60 to over 100 percent. Long term care costs are included for Alaska co-located facilities in this comparison. Because of the lower cost and higher occupancy rate for long term care beds (a 91% occupancy rate in 1989 based on Medicaid Rate Setting Commission data), the Alaska figure underestimates the cost for acute care per adjusted patient day.

The cost per adjusted patient day has increased at a rate in excess of the rate of medical inflation as measured by the medical care component of the Anchorage consumer price index. The average growth rate in cost has been 13.8 percent.

The use of an adjusted patient day takes into account outpatient utilization of hospitals by combining inpatient days with an estimate of outpatient visits converted to patient days. This is done by dividing outpatient visits by the ratio of the average cost for an inpatient day to the average cost of an outpatient visit.

For example assume that the average cost of an inpatient day is \$1000 and the

Figure VI.5
INPATIENT DAYS: ALASKA AND THE US
COMMUNITY HOSPITALS

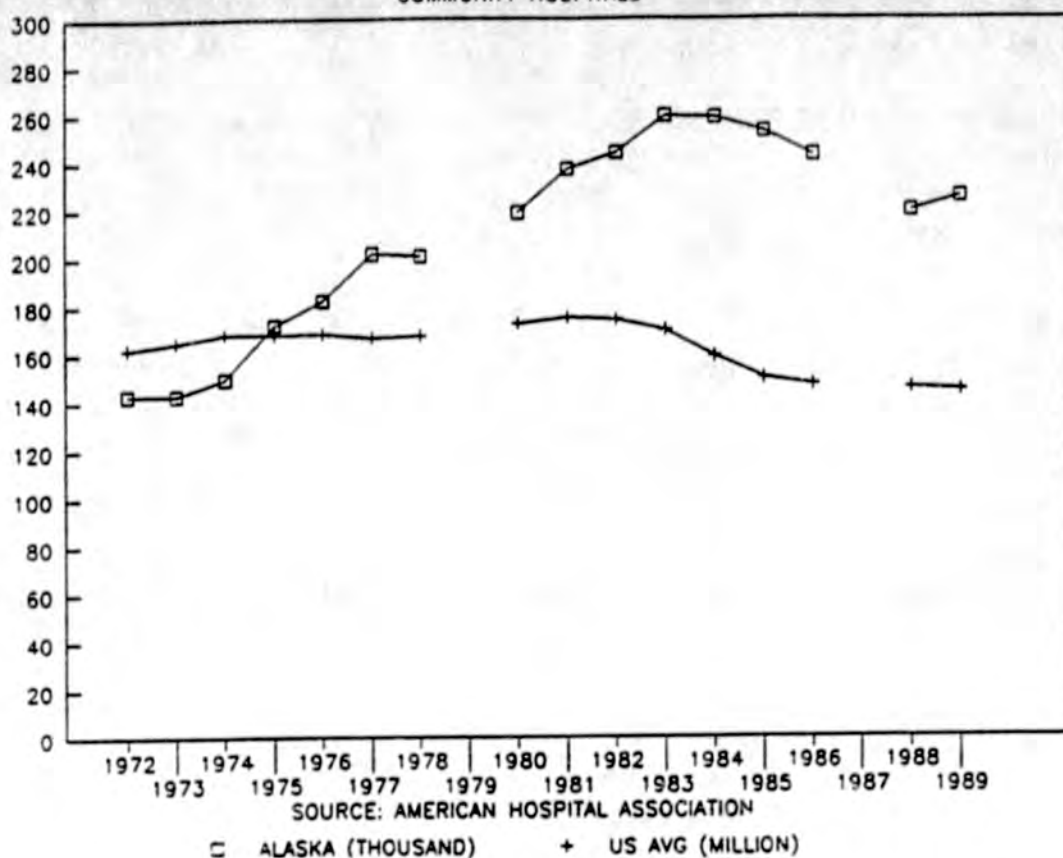
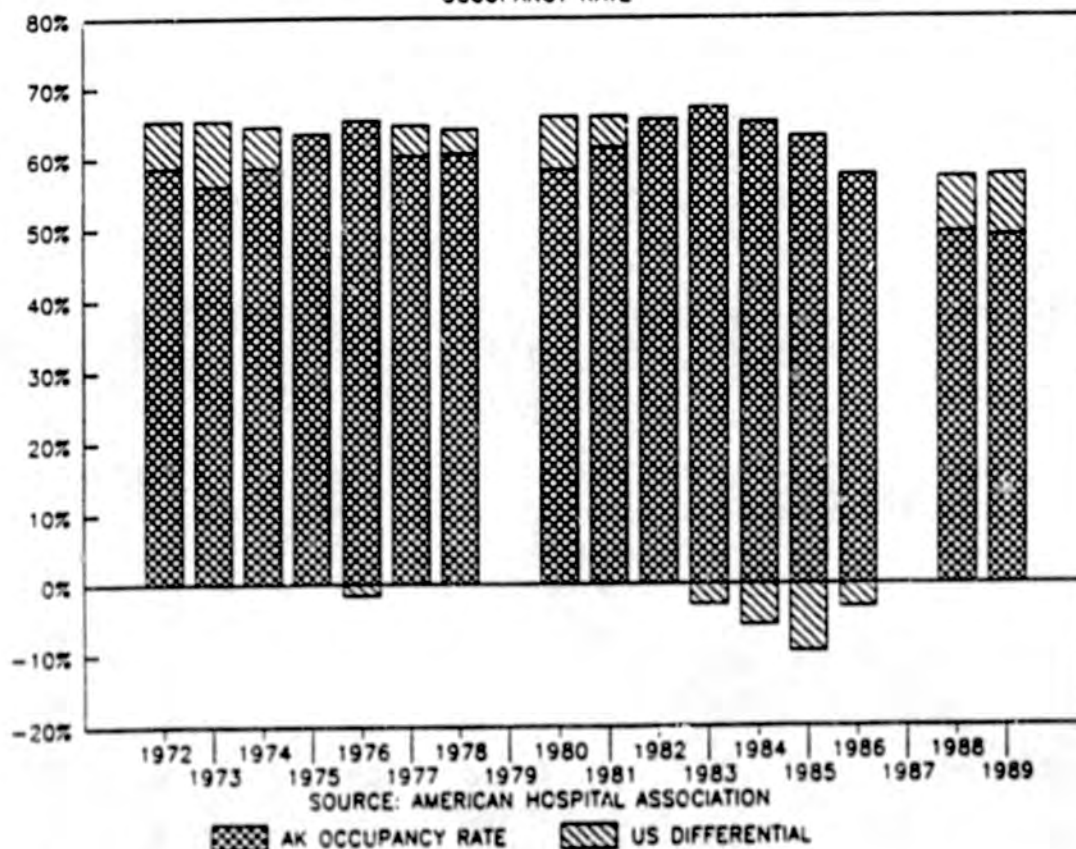


Figure VI.6
ALASKA COMMUNITY HOSPITALS
OCCUPANCY RATE



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Figure VI.7
ALASKA COMMUNITY HOSPITALS
 EXPENSES PER ADJUSTED PATIENT DAY

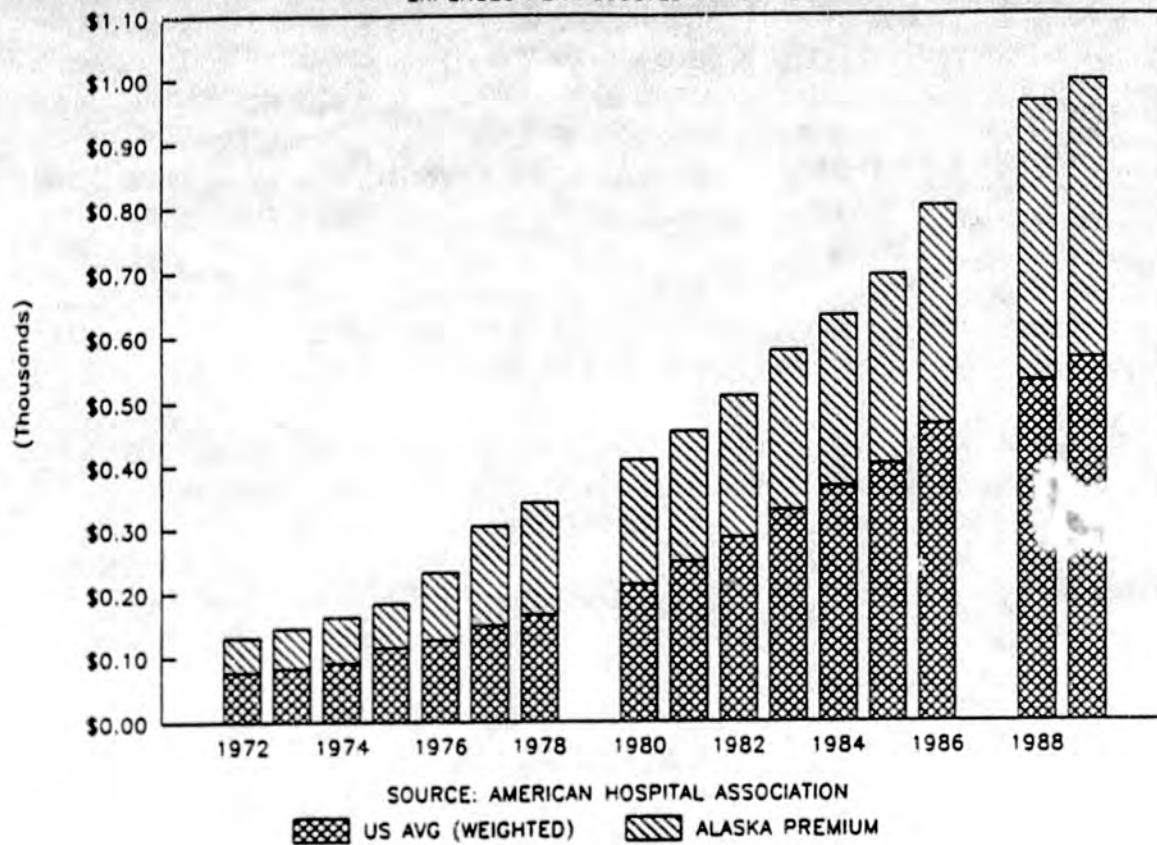
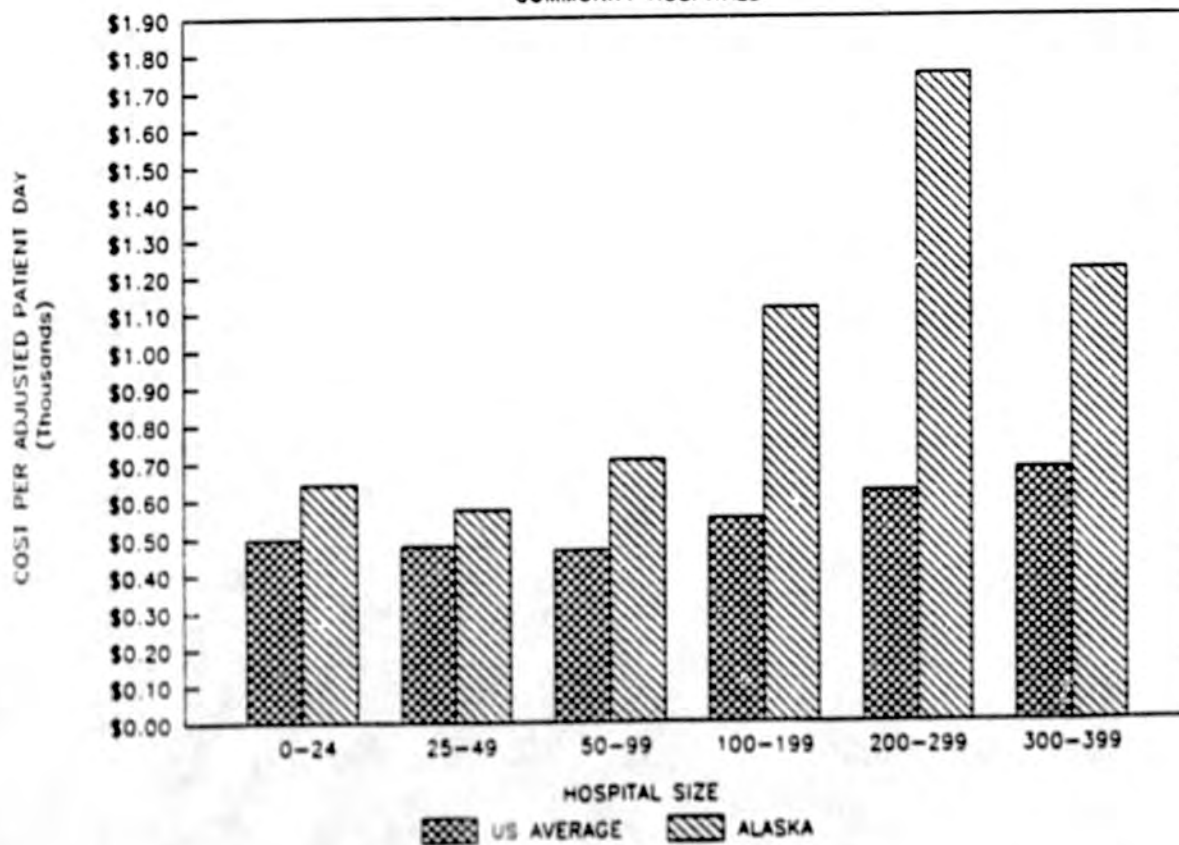


Figure VI.8
COST PER ADJUSTED PATIENT DAY
 COMMUNITY HOSPITALS



average cost of an outpatient visit is \$200 so that the ratio of the two is 5. This suggests that the cost of treating 5 outpatients is equal to the cost of one inpatient day. Outpatient visits can then be converted to patient days for direct comparison with inpatient days by dividing the total number of outpatient visits by 5. If there are 800 inpatient days and 1500 outpatient visits, the number of adjusted patient days in this example would be 800 plus 300 ($1500/5$) equals 800. If total hospital costs are divided among adjusted patient days, some of the cost of providing services is allocated to outpatients.

The Alaska differential in cost appears to be a function of the size of the hospital with larger hospitals having a larger cost differential. This result is due to the fact that the small hospitals are the co-located facilities with long term care beds.

AVERAGE PAYROLL (Figure VI.9)--The average payroll in Alaska community hospitals is considerably above the national average. The average annual payroll in 1989 in Alaska, excluding benefits, was \$36 thousand compared to \$23 thousand for the US as a whole. The differential, which is currently 55 percent, has historically ranged between 37 and 72 percent. Payroll and benefits account for more than half of total hospital expenses but average payroll which is growing at an average rate of 9.8 percent is not increasing at as rapid a rate as total hospital costs.

STAFF (Figure VI.10)--The hospital staffing level per 1000 adjusted patient days in Alaska is above the US average. In 1989 the Alaska staffing level was 11.9 per 1000 compared to 10.9 for the US as a whole. The staff per 1000 adjusted patient days has been increasing over time both in Alaska and in the US as a whole. In Alaska it has grown at an average annual rate of 2.3 percent.

Figure VI.9
ALASKA COMMUNITY HOSPITALS
AVERAGE PAYROLL

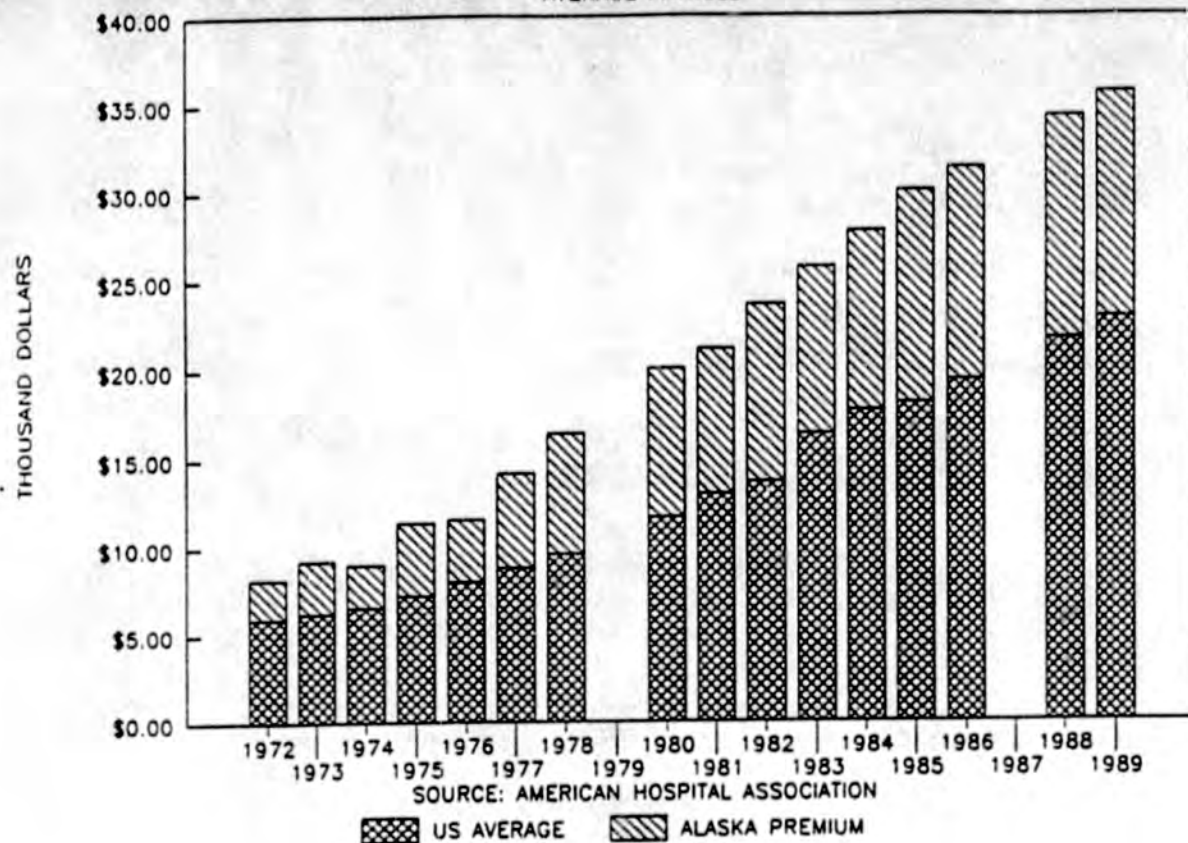
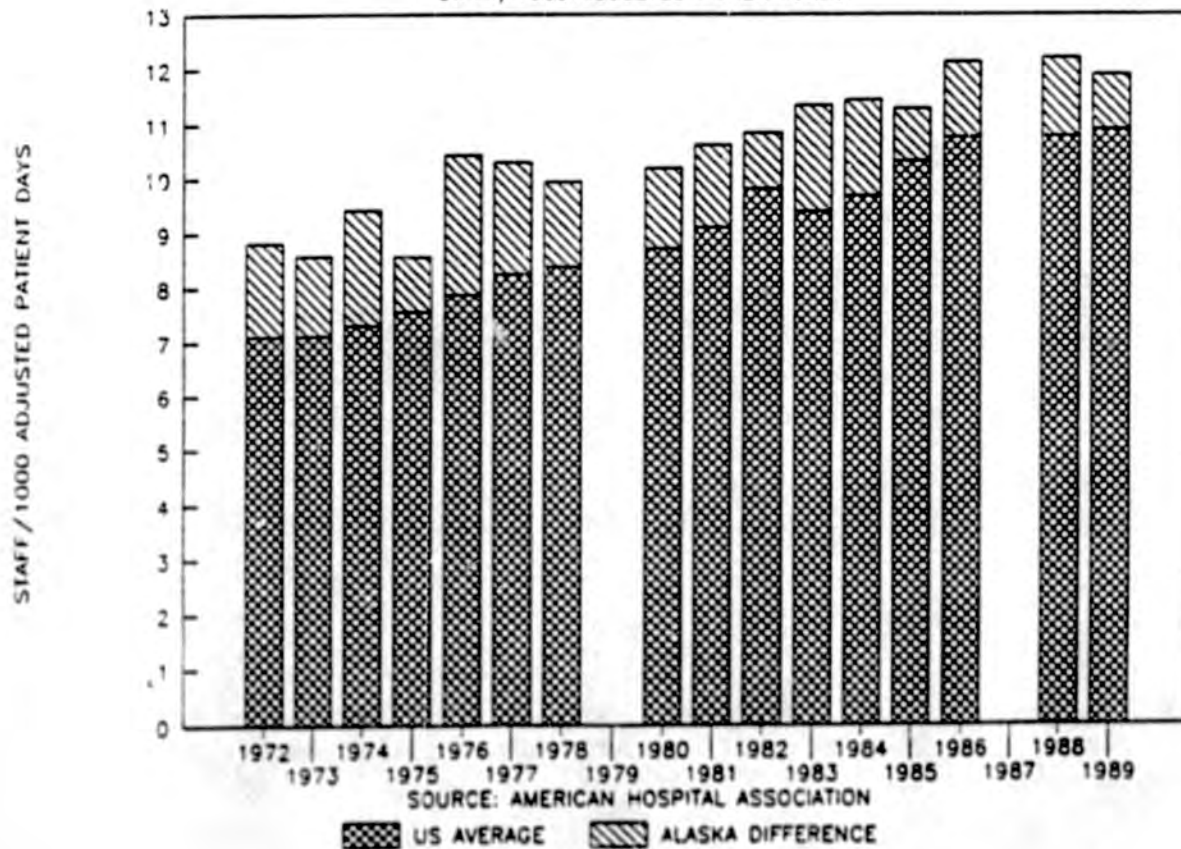


Figure VI.10
ALASKA COMMUNITY HOSPITALS
STAFF/1000 ADJUSTED PATIENT DAYS



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Memo

To: Health Resources and Access Task Force

From: Scott Goldsmith
Institute of Social and Economic Research
University of Alaska Anchorage

Subject: Additional Findings for Inclusion in Draft Interim Report

Date: January 10, 1992

Charges/Prices for Health Services in Alaska

The state average for expenses per adjusted patient day in Alaska community hospitals as reported by the American Hospital Association has historically ranged from 60 to 100 percent above the national average. The Alaska differential in 1989 was 76 percent above the national average. The average annual growth rate in this measure of cost has been 13.8 percent.

Average payroll in Alaska community hospitals as reported by the American Hospital Association has historically been from 37 to 72 percent above the national average. The Alaska differential in 1989 was 55 percent above the national average. The average annual growth rate in this measure of cost has been 9.8 percent.

Patient Utilization Patterns in Alaska

Inpatient days per capita as reported by the American Hospital Association have historically been considerably less than the national average. After subtracting out the Native and military from the Alaskan population, the number of inpatient days per capita in Alaska community hospitals was .53 compared to the national average of .92. The young average age of the population and the selection of out of state hospital care by some Alaskans explain this phenomenon.

Outpatient days per capita as reported by the American Hospital Association have historically been below the national average. After subtracting out the Native and military from the Alaskan population, the number of outpatient visits per capita in Alaska community hospitals was .99 in 1989 compared to the national average of 1.17 visits.

Average length of stay as reported by the American Hospital Association has historically been below the national average. The average length of stay in Alaska community hospitals in 1989 was 5.8 days compared to the national average of 6.9 days.

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MEMO

TO: Health Resources and Access Task Force

FROM: Scott Goldsmith

SUBJECT: Summary of Analysis of Cost of Excess Capacity in Alaska
Community Acute Care Facilities

DATE: January 10, 1992--Revised on January 22, 1992

Occupancy rates in Alaska community acute care facilities have historically been below the national average for comparable sized hospitals except during the economic boom of the mid 1980's. In 1989 the Alaska rate was 45% compared to the US average of 57%.

Using the national average occupancy rate as a benchmark, 12 of the 16 Alaska acute care facilities had surplus beds in 1989.

These 229 surplus beds represent 22% of the total 1,027 beds. 183 are located in the Anchorage/Fairbanks area (26% of that market) with 47 in the remainder of the state (14% of that market).

The annual cost of maintaining the beds defined as surplus in this way is conservatively estimated at between \$5.8 and \$11.6 million, adding 2% to 4% to total hospital costs.

Using a 75% target occupancy rate--a more rigorous standard than the current national average--increases the estimate of excess capacity cost to the range of \$10.4 to \$20.8 million annually.

Reduction of the excess capacity costs requires that hospitals be reconfigured to the appropriate size to serve their market. This can only be accomplished after a case by case evaluation to determine whether it is cost effective to eliminate, downsize, or reallocate resources to other health related needs.

The reallocation of resources currently tied up in excess capacity could simultaneously reduce the cost and increase the quality of health care in the state.

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APPENDIX D

Memo to Members, Alaska Health Resources and Access Task Force

Regarding Additional Information

From Lawrence Bartlett, Ph.D., Health Systems Research, Inc.

Washington, D. C.

February 11, 1992

HSR inc. _____

HEALTH SYSTEMS RESEARCH, INC.

DATE: February 11, 1992
TO: Members, Alaska Health Resources and Access Task Force
FROM: Larry Bartlett *LB*
RE: Additional Information

At your February 1-2 meeting, you identified several areas in which you requested of me either additional information or recommendations. These areas are the following:

- Recommendations concerning the elements of revised provider reimbursement systems;
- Information on the Maryland hospital rate setting system and on global budgeting approaches;
- Suggestions on how to approach providing access to the various subgroups within the uninsured population; and
- The identification of the pros and cons of establishing a single pool versus multiple pools.

My comments in each of these areas are presented below.

A. Recommendations on New Reimbursement Systems

With respect to the characteristics of revised reimbursement systems, I would begin by noting that the most important aspect of these new systems is that they are to be developed and implemented within the broader context of statewide expenditure goals. That is, these reimbursement systems and their rates should be structured so that they result in expenditures that fall within the targets established by the state's health care Authority/Commission. To the extent possible, the overall state expenditure target should be subdivided into separate targets for major services such as hospital care, physician services, etc. It also may be appropriate to set a separate sub-goal for capital expenditures, which should be closely coordinated with the state's certificate of need policies.

I understand that your discussions, based upon the content of the CHIPRA proposal, are moving toward the establishment of an overall expenditure goal that would limit increases in health care expenditures in Alaska to the annual rate of growth of the Consumer Price Index (CPI). In developing this overall expenditure goal, the appropriate baseline would be health care spending in a prior year. And, while the overall objective would be to limit increases in this baseline to increases in the overall rate of inflation (CPI), it may be appropriate to adjust this rate of growth (either upward and downward) to reflect such factors as:

- Changes in the size and/or demographic characteristics (e.g., age distribution) of the state's population that may affect the need/demand for health care in the future;
- Changes in technology that may increase or decrease health care costs;
- Improvements in health care productivity;
- The identification and reduction of the provision of unnecessary health care;
- Desired changes in some segments of the population's (e.g., the uninsured's) access to adequate health care services;
- Reductions in administrative costs; and
- Other such factors as the state Commission/Authority may determine to be appropriate.

Having established these expenditure goals, the payment systems for individual providers should be designed to result in expenditures that fall within these targets. With respect to the reimbursement system to be used for inpatient hospital services, we would suggest the following elements:

- The unit of payment be made on a DRG-specific per discharge basis;
- The base for the expenditure target for inpatient hospital care (and the reimbursement levels paid to individual facilities) should be actual hospital costs in a prior period. As noted in the above discussion concerning adjustments, the state Authority/Commission may determine that, in some future year, this cost base should be adjusted above or below the CPI to reflect such factors as increased hospital use that might result from expanded health care coverage/increased access, or the introduction of new cost saving technology that would reduce hospital expenses; and

- The prices or charge levels that result from this payment system would be higher than these cost levels to account for such factors as facilities' uncompensated care loads and/or Medicare payment rates that may not be sufficient to cover costs.

For payment of physician services, we would recommend a reimbursement system that utilizes resource-based relative value scale (RBRVS). The specifics of the systems used to reimburse for other services should be developed by the state Commission/Authority.

B. Information on the Maryland Hospital Rate-setting System and on Global Budgeting Proposals

Enclosed are several documents (including one that is somewhat dated, but nonetheless contain good information) describing the State of Maryland's hospital rate-setting system.

It is my understanding that Nancy Cornwell has sent to you one or two articles that discuss global budgeting. In addition, I have enclosed the section of the health care reform bill recently reported out by the U.S. Senate Human Resources Committee that describes its proposed approach to the establishment of global expenditure goals and the design of reimbursement systems to meet these goals. You may wish to review this legislative language with respect to the information presented in the previous section.

C. Additional Information on the Uninsured

Nancy Cornwell's February 3 memo to me indicated that the Task Force raised several specific questions about the characteristics of uninsured Alaskans. They are:

- How many full-time/full-year uninsured workers had adequate incomes and could therefore afford private insurance? How many have inadequate incomes?
- How many uninsured children are in low-income families?
- How many children are "uninsurable?"

This section provides estimates of the number of uninsured full-time workers in Alaska by household poverty status, as well as the number of uninsured children by poverty status. These estimates were derived from a combined sample of the Alaska portion of the Current Population Survey for 1988 through 1991. The survey data for these years were combined to increase sample size and provide more robust

estimates of the size and characteristics of this population. However, we would caution that problems of small sample size still exist and that not all table cells contain statistically reliable estimates. We present these figures only to provide the Task Force with an "order-of-magnitude" sense of the characteristics of the state's uninsured population. The percentages shown in the table represent the portion of the population subgroup that falls within a given poverty range; they sum across each row. We would also note that, based upon the Task Force's instructions that Alaska Natives be assumed to be covered through the Alaska Area Native Health Service, these estimates of uninsured Alaskans exclude Alaska Natives.

With respect to the issue of a family's ability to purchase health care coverage, a 1989 study by the National Health Care Campaign found that, in most states, it is only when families earn more than 250% of the poverty level that they begin to accumulate the disposable income required to contribute toward a portion of premium costs. On a more applied basis, states that have established programs providing subsidized insurance coverage will often use something close to 200% of poverty as the upper limit for eligibility for some form of subsidy. Under many of these programs, families with income between 100% and 200% of poverty can purchase coverage on an income-related sliding scale basis, while families below the poverty level are usually not required to contribute to a portion of premium costs.

**TABLE 1.
UNINSURED ALASKANS BY AGE AND POVERTY STATUS
(EXCLUDES NATIVE ALASKANS)**

AGE	POVERTY STATUS				
	≤100%	101-200%	201-300%	over 300%	TOTAL
<18	3,877 (18%)	4,481 (21%)	6,214 (29%)	6,728 (32%)	21,300
18-24	2,222 (20%)	2,385 (21%)	2,135 (19%)	4,589 (40%)	11,331
25-49	6,059 (17%)	8,604 (23%)	7,371 (20%)	14,636 (40%)	36,670
50-64	1,374 (20%)	834 (12%)	1,191 (18%)	3,352 (50%)	6,751
TOTAL	13,532 (18%)	16,304 (21%)	16,911 (22%)	29,305 (39%)	76,052

The 1991 annual federal poverty level for Alaska, which varies by family size, was set at \$13,930 for a family of three. As indicated in Table 1 above, approximately 60% of uninsured non-Native Alaskan children were in households with income above 200% of the federal poverty level (e.g., \$27,860 for a family of three). Nearly a third were in families with annual incomes above 300% of poverty. Also presented in this table is the poverty distribution of uninsured non-elderly adults by age categories. In

general, a similar poverty distribution can be seen in the adult population, although uninsured adults are more likely to be in households with incomes above 300% of poverty than uninsured children.

Table 2 examines the poverty status of uninsured non-Native Alaskans (both children and adults) according to the employment status of the head of the household. As can be seen in this table, the poverty distribution of uninsured non-Native Alaskans varies significantly according to the family head's employment status. Over 40% of uninsured Alaskans in families in which the head of the household reported being unemployed the entire year were also in households whose income fell below the federal poverty level. By contrast, not more than 7% of uninsured Alaskans in families where the head of the household was reported to have worked either full time or part time for the entire year fell below the poverty line.

TABLE 2. UNINSURED ALASKANS BY FAMILY POVERTY STATUS AND EMPLOYMENT STATUS OF THE HEAD OF THE HOUSEHOLD (EXCLUDES NATIVE ALASKANS)					
HEAD OF HOUSEHOLD EMPLOYMENT STATUS	POVERTY STATUS				
	≤100%	101-200%	201-300%	over 300%	TOTAL
Full-time/ Full-year	2,201 (7%)	5,431 (17%)	6,787 (21%)	18,117 (56%)	32,538
Part-time/ Full-year	153 (6%)	871 (27%)	1,026 (41%)	668 (27%)	2,518
Full-time/ Part-year	4,882 (19%)	6,956 (26%)	8,039 (23%)	8,424 (32%)	26,301
Part-time/ Part-year	2,826 (41%)	1,548 (23%)	1,534 (23%)	904 (13%)	6,812
Not Employed	3,554 (44%)	1,709 (21%)	1,449 (18%)	1,375 (17%)	8,087
TOTAL	13,616 (18%)	16,315 (21%)	16,835 (22%)	29,488 (39%)	76,254

Not surprisingly, uninsured Alaskans in households where the head was employed full time, full year reported the highest incomes, with over half reporting incomes in excess of 300% of poverty and another fifth having incomes between 200% and 300% of poverty. It should be noted that this category (i.e., uninsured in households in which the head was employed full time, full year) represented the

largest segment of the non-Native uninsured population. For the next largest category -- those in households in which the family head worked full time, part year -- approximately a third reported incomes in excess of 300% of poverty, while less than a quarter were in the 200% to 300% of poverty range.

In addition to the above tables, we are enclosing as an attachment to this memo a copy of additional descriptive statistics on uninsured non-Native Alaskans that we generated from our analysis of the CPS. These tables provide further information on the age, income, employment status and other characteristics of this uninsured population. Individual Task Force members may find in these tables information that will be useful to them in deciding which access-related policy options to pursue.

On the question of the number of "uninsurable" Alaskans, as I discussed with the Task Force at an earlier meeting, it is difficult to accurately determine the number of individuals who are "uninsurable" because this is a function of: (a) the health characteristics of the individual (which are not collected in the surveys we normally use for measuring the number of uninsured persons); (b) whether the individual is seeking coverage under a large or small group policy; and (c) insurers' medical underwriting practices. Therefore, we are not able to develop precise estimates of the number of either uninsurable children or adults. However, very rough national estimates place the number of uninsurable persons at about 1-2% of the total population. Given the tightening of medical underwriting that has occurred in recent years, this 2% figure now would likely represent a conservative estimate. If applied to Alaska, it would mean that there are approximately 2,500 children and 5,500 non-elderly adults (excluding Native Alaskans) who might be considered "uninsurable" if they were subjected to a medical underwriting process.

With respect to the Task Force's question about how it might approach extending coverage to the various uninsured subgroups, I would note the following options, each of which was discussed in previous Task Force sessions:

- Subsidized coverage for low-income children;
- Subsidized coverage for low-income individuals and families that is not provided through the workplace (e.g., the State of Washington's Basic Health Plan);
- Subsidies to small businesses that have not previously offered health care coverage to their workers;
- Expansion of the "hour-bank" concept to cover more full-time/part year workers and their families; and/or
- A "pay or play" approach that would either require employers to provide health care coverage for their full-time workers or pay additional taxes.

If you desire, we will begin to develop estimates of the impact of these options and will be prepared to discuss them with you at your February 29 - March 1 meeting.

D. Single Versus Multiple Pools

You also asked that I outline the pros and cons of establishing either a single pool or multiple pools through which individuals and businesses could purchase health care coverage in Alaska. Before doing so, it would be helpful to establish working definitions of a "single pool" and "multiple pools," as these terms may mean different things to different people.

As the term is being used here, a single pool refers to a mechanism through which any individual or business can purchase coverage at a premium cost that is based upon the experience of all persons enrolled in the pool (i.e., a community rate). Under a single pool approach, the same rate could be charged for each and every person enrolling in the pool (a true community rate), or pool rates could vary by such things as the age and sex of the individual.¹ In this latter case, the rate for a particular age-sex category would still be based upon the experience of all persons in the pool who fell into that category. Under this concept of a single pool, the basic benefit package would be the same for all individuals.

A multiple pool approach does not necessarily mean that a number of separate administrative entities are established, but rather that the establishment of rates is not based upon the experience of all enrolled individuals, even if they have the same age and sex characteristics. Rather, separate rates are established for certain subgroups with other similar characteristics, such as businesses or unions involved in the same industries (e.g., logging, fishing or retail sales), or even businesses of a similar size. For these subgroups (or "blocks of business" as they are known) a range of different approaches are possible for establishing rates, ranging from a single rate for a block to age and sex-specific rating within each block. Under a multiple pool approach there is no need for benefit packages to be the same across separate pools or blocks of business.

With respect to the relative pros and cons of establishing a single pool versus a structure with multiple pooling arrangements, these are summarized in Table 3, on the next page.

¹ Note that some parties might use an even more narrow definition of a "single pool" to include only arrangements that establish a single rate for all enrollees, regardless of age or sex, or one that uses only two rates: one for children, the other for adults.

TABLE 3.	
SINGLE POOL	MULTIPLE POOLS
PROS	
▪ Spreads risk/costs over a greater number of people. ▪ Reduces premium costs to persons with greatest medical needs. ▪ Some administrative cost savings likely to result.	▪ More likely to attract healthier, lower cost individuals and businesses than a single pool approach. ▪ Increased ability to target benefits packages to individual businesses, etc. ▪ Better able to compete in private insurance marketplace.
CONS	
▪ Increases premium costs to healthy, low cost individuals/businesses. Unless enrollment is mandatory, may cause them to seek coverage elsewhere. ▪ As result of above, higher risk of adverse selection vis-a-vis private insurance market. ▪ Allowing the purchase of optional benefits could increase administrative costs and the risk of adverse selection.	▪ Greater potential for undesirable discrimination if pools are defined too narrowly. ▪ Higher risk categories of businesses to face higher premiums. ▪ Administrative costs likely to be somewhat higher than single pool approach.

However, it should be noted that there are many variations on these basic definitions that could serve to reduce the distinction between a single pool and multiple pools. For example, while providing for the establishment of multiple pools, a state could also stipulate that unlike the current practice of establishing the rate for a business within a particular block of business upon both the experience of the business itself and the overall block or pool, the state could require that only age and sex differences be used to establish rates for individuals within a given block of business or pool.

While the issue of whether to establish a single pool or to allow the establishment of individual blocks of business within the pool for rating purposes is an important one, I would suggest that it is also a complex one and does not need to be fully resolved in legislative language. The Task Force might wish to focus its discussions on the question of what definition of "equity" is most appropriate with respect to establishing the pool(s). Should equity be defined as having each enrollee within the pool be responsible for an equal share of overall pool costs (i.e., community rating)? Or should equity be defined as setting rates that come as close as possible

to having individuals or businesses be responsible for their own share of pool expenses (i.e., experience rating)? The outcome of this discussion can provide direction to the state Authority/Commission that will have responsibility for the final design of the pool(s). While enactment of small group market reforms will reduce this risk, it will not eliminate it entirely if the pool differs from other insurers in important areas, such as medical underwriting.

I would emphasize, however, that whatever the Task Force's resolution of the somewhat philosophical questions raised above, a key issue in establishing either a single pool or multiple pools is to structure them so that they are not at a competitive disadvantage with respect to other private insurers in the marketplace. That is, private insurers should not be allowed to attract the healthiest segment of the population with lower rates and dump the higher risk individuals into these pool(s).

Finally, with respect to economies of scale or efficiencies associated with pooling arrangements, we would anticipate that, all other things being equal, a single pool offering a single benefit package would be somewhat less costly to administer than an approach involving multiple blocks of business. However, if variations from these basic models are introduced (e.g., the offering of optional benefits to members of the single pool approach) or if one approach utilizes medical underwriting and the other does not, the existence and/or magnitude of these administrative cost differences are likely to change. It should also be emphasized that the administrative cost savings associated with pooling approaches is highly dependent upon the nature of the entities to be enrolled in the pool. For example, a pool that provides coverage to thirty thousand individuals who are workers or the dependents of workers of three large firms can be expected to have significantly lower administrative costs than a thirty thousand enrollee pool that draws its membership from three thousand small businesses, each having ten enrollees.

Attachments:

1. Information on the Maryland hospital rate-setting system
2. Section of the HealthAmerica bill relating to global budgets and payment systems
3. Additional analyses of Alaska's non-Native uninsured population, based upon Current Population Survey data

APPENDIX E

Worksheet: Computations of Actual Costs which were
Shifted to Other Payors to Cover Charity Care, Bad Debt,
and Hill Burton Free Care at Alaska's Acute Care
Community Hospitals, 1990"

By Nancy Cornwell, Health Resources and Access
Task Force Project Director, January 26, 1992

"Letter to Nancy Cornwell"

From Garrey Peska, Alaska State Hospital and Nursing
Home Association, January 13, 1992

"Letter to Senator Jim Duncan and Representative Johnny Ellis,
Co-Chairmen, Health Resources and Access Task Force"

From Garrey Peska, Alaska State Hospital and Nursing Home Association
January 10, 1992

WORKSHEET: COMPUTATION OF ACTUAL COSTS
WHICH WERE SHIFTED TO OTHER PAYORS TO COVER CHARITY CARE,
BAD DEBT, AND HILL BURTON FREE CARE AT
ALASKA'S ACUTE CARE COMMUNITY HOSPITALS, 1990

	1990					
	Total Charity, Bad Debt, & Hill Burton Free Care at Full Chg. Rate(x)	FY 90 Cost to Full Chg. Ratio		Actual Cost to Provide Charity Bad Debt & Hill Burton Free Care	Other State & Local Govt. Revenue (most is revenue sharing)	Beds (1989 MRAC bed count)
(Acute Care)						
Bartlett	\$1,409,717	x .837	=	\$1,179,933	123,056	51
Fairbanks	1,628,227	x .8234	=	1,340,682	1,674,890	116
Humana	4,832,276	x .9437	=	4,560,219	847,438	228
Ketchikan	993,774	x .8812	=	875,714	123,055	37
Providence	11,481,542	x .6519	=	7,484,817	140,000	341
(M) Seward	-0-	-0-	=	-0-	182,485	32
- Sitka	176,853	1.0232	=	180,956	250,000	24
(Co-located)						
Kodiak	823,250*	x .9335	=	786,504	134,460	25
Petersburg	31,527*	x 1.0476	=	33,028	127,670	8
Wrangell	392,286*	x .8870	=	347,958	127,724	9
Total				16,771,811	3,730,778	881
				(6% of total net revenues)		(acute care only)

Note: 10 of 16 acute care community hospitals reporting; 881 of 1027 acute care community hospital beds reporting, or 86% of acute care community hospital beds in Alaska. (*Includes 47 nursing beds at Kodiak, Petersburg and Wrangell). Total net revenues in 1990 equalled \$283,409,999.

Source: N. Cornwell, HRATF Project Director 1/26/92.

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

January 13, 1992

Ms. Nancy Cornwell
Staff Assistant
Legislative Health Resources & Access Task Force
P.O. Box Y
Juneau, AK 99811

Dear Nancy:

As you requested, I have prepared the attached worksheets separating respondent facilities by type.

Table #1 lists the respondent facilities that operate only acute care beds.

Table #2 lists the respondent facilities that operate only nursing care beds.

Table #3 lists the respondent facilities that operate both acute care and nursing care beds.

You also asked that I add some information about the number of beds represented by the respondents and the number of beds state wide.

I have added the number of beds in each of the respondent facilities to the bottom of the attached worksheets.

The respondent facilities represent 978 acute care beds and 594 nursing care beds. This information comes from the 1990 Alaska Hospital Survey published by the State Department of Health & Social Services on April 1, 1991.

The 1990 Alaska Hospital Survey shows there was a total 1,645 acute care beds and 1,120 nursing care beds state wide.

The respondents to our survey then represent 59.5% of the total acute care beds and 53% of the total nursing care beds state wide.

In reviewing the uncompensated care amounts shown on the attached tables, please keep in mind that the second largest facility in the state reported that their charity care amount was "unavailable". With such significant data missing, it is impossible for me to estimate the total amount of uncompensated care for all facilities in the state in 1990.

Sincerely,


Garrey M. Peska, C.P.A.
Vice President for Finance

Fiscal Year 1990 Data - Acute Care	Bartlett	Fairbanks	Humana	Ketchikan	Providence	Seward	Sitka	Total
Total Full Charges	19,676,844	47,053,731	85,798,873	15,513,106	172,471,593	2,305,008	4,533,354	347,352,509
LESS								
Charity care	0	492,000	0	13,542	4,544,604	0	0	5,050,146
Bad debts	1,157,473	1,136,227	4,832,276	811,515	5,921,054	0	176,853	14,035,398
Hill Burton free care	252,244	0	0	168,717	1,015,884	0	0	1,436,845
Total Charity, Bad Debts & Hill Burton	1,409,717	1,628,227	4,832,276	993,774	11,481,542	0	176,853	20,522,389
Contractual discounts or allowances	1,088,805	5,377,678	15,806,362	956,093	31,179,458	250,060	89,644	54,748,100
Total uncompensated care	2,498,522	7,005,905	20,638,638	1,949,867	42,661,000	250,060	266,497	75,270,489
Total Net Revenue	17,178,322	40,047,826	65,160,235	13,563,239	129,810,593	2,054,948	4,266,857	272,082,020
Acute Care Beds	51	177	238	46	365	32	24	933
Nursing Beds	0	0	0	0	0	0	0	0

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Alaska State Hospital and Nursing Home Association Data Collection

Table #2

Fiscal Year 1990 Data - Nursing Care	Denali	Heritage	MaryConrad	Our Lady	St. Ann's	Wesley	Total
Total Full Charges	5,905,613	2,871,742	7,471,307	19,841,000	3,481,433	3,206,614	42,777,709
LESS							
Charity care	56,000	0	0	128,000	0	21,405	205,405
Bad debts	20,332	8,254	53,237	53,000	0	101,204	236,027
Hill Burton free care	0	0	0	0	0	0	0
Total Charity, Bad Debts & Hill Burton	76,332	8,254	53,237	181,000	0	122,609	441,432
Contractual discounts or allowances	1,172,180	774,741	172,787	5,713,000	354,826	319,692	8,507,226
Total uncompensated care	1,248,512	782,995	226,024	5,894,000	354,826	442,301	8,948,658
Total Net Revenue	4,657,101	2,088,747	7,245,283	13,947,000	3,126,607	2,764,313	33,829,051
Acute Care Beds	0	0	0	0	0	0	0
Nursing Beds	101	45	66	224	45	66	547

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Fiscal Year 1990 Data - Co-located	Kodiak	Petersburg	Wrangell	Total
Total Full Charges	8,210,388	2,356,912	2,674,246	13,241,546
LESS				
Charity care	0	0	199,901	199,901
Bad debts	657,264	28,900	141,436	827,600
Hill Burton free care	165,986	2,627	50,949	219,562
Total Charity, Bad Debts & Hill Burton	823,250	31,527	392,286	1,247,063
Contractual discounts or allowances	222,205	251,766	192,533	666,504
Total uncompensated care	1,045,455	283,293	584,819	1,913,567
Total Net Revenue	7,164,933	2,073,619	2,089,427	11,327,979
Acute Care Beds	25	11	9	45
Nursing Beds	19	14	14	47

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ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

January 10, 1992

Senator Jim Duncan &
Representative Johnny Ellis, Co Chairmen
Legislative Health Resources & Access Task Force
P.O. Box Y
Juneau, Alaska 99811

Gentlemen:

The Alaska State Hospital and Nursing Home Association conducted a financial data survey of member facilities over the past month at the request of your task force.

We asked the members to report their 1990:

- Charity care, bad debts and Hill Burton free care
- Revenues at full charge and allowances or discounts by payer
- Operating Costs with depreciation stated separately
- Other sources of operating revenues (State Revenue Sharing, etc.)
- Outstanding debt and annual debt service

Questionnaires were mailed out on December 5, 1991 and follow up mail and telephone requests for responses were made at the end of December.

Sixteen of ASHNHA's 26 private hospital and nursing home members responded to the requests for information. A separate worksheet is attached showing the data for each respondent.

The respondents are listed in Table #1 on the following page in order according to size.

Table #1 shows that of the \$403,371,764 billed by the respondents for 1990 services, \$317,239,050 was actually collected.

The difference of \$86,132,714 is shown on Chart #1 as "Total 1990 Unpaid Charges for Services".

The amount shown on Chart #1 is the total of Bad debts, charity care, Hill Burton free care and discounts taken by other payers such as Medicaid and Medicare.

Chart #1 shows that 36.79% of the 1990 unpaid charges was due to the Medicaid reimbursement rate, 23.82% was due to the Medicare reimbursement rate, 17.53% was from bad debts, etc.

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Chart #2 shows the break down of the total \$22,210,884 in bad debts, charity and Hill Burton free care. Charity care represents 67.98% of that total.

Chart #3 shows the break down of the \$63,921,830 in contractual discounts or allowances taken by payers. Medicaid made up 49.58% of that total and Medicare represented another 32.09%.

Task force members and staff have expressed interest in the facilities' cost to charges ratios. That ratio is shown on line 16 of each facility worksheet for 1990.

Members have also asked for details regarding outstanding debt at each facility. That information is on line 14 of the facility worksheets.

Comparing lines 12(A) and 11(C) of the facility worksheets shows that 9 of the 16 respondents had operating costs that exceeded ordinary net operating revenue during 1990.

We hope this information helps answer some of the questions your task force members are trying to answer as you work on issues related to health resources and access.

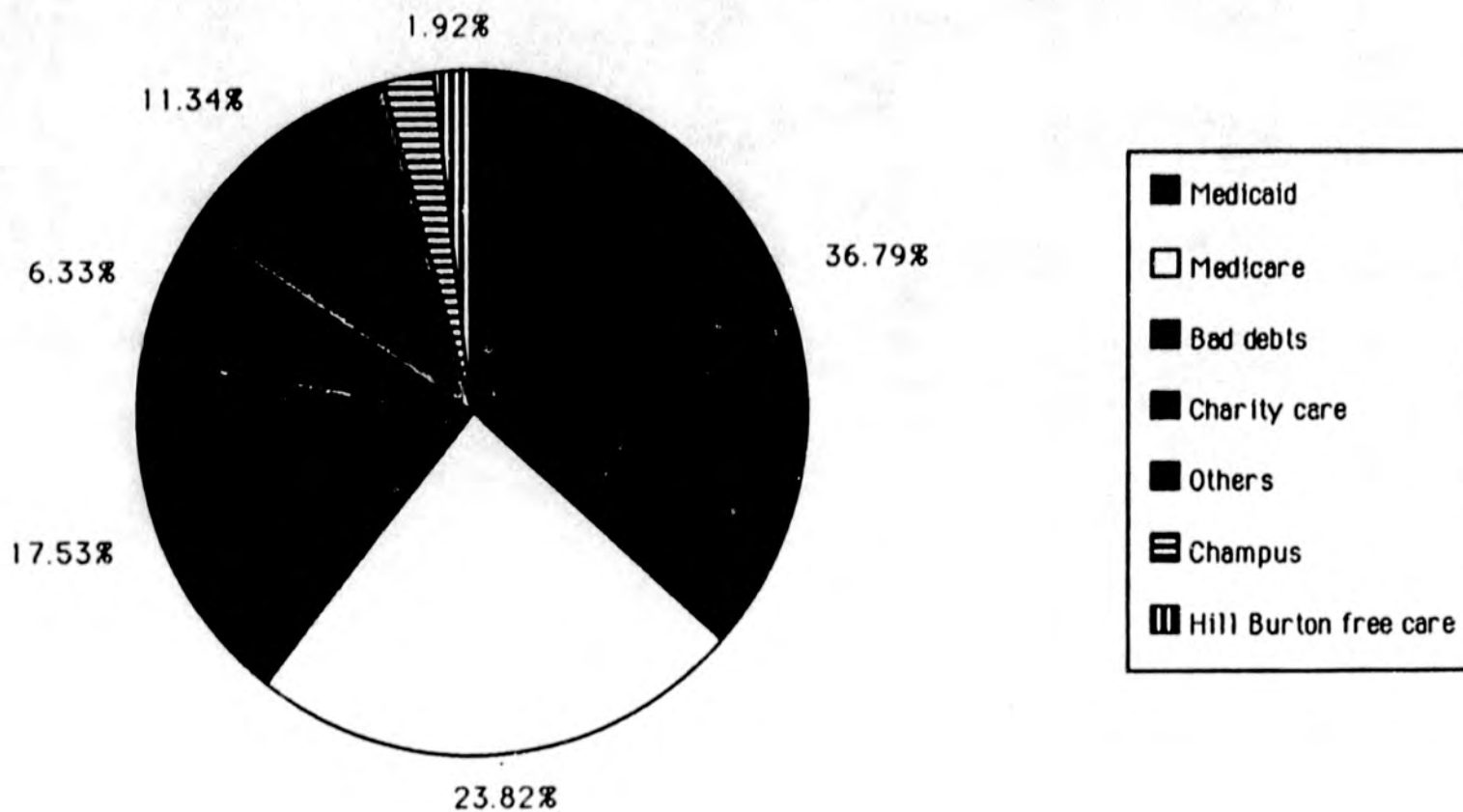
Sincerely,



Garrey M. Peska, C.P.A.
Vice President / Finance

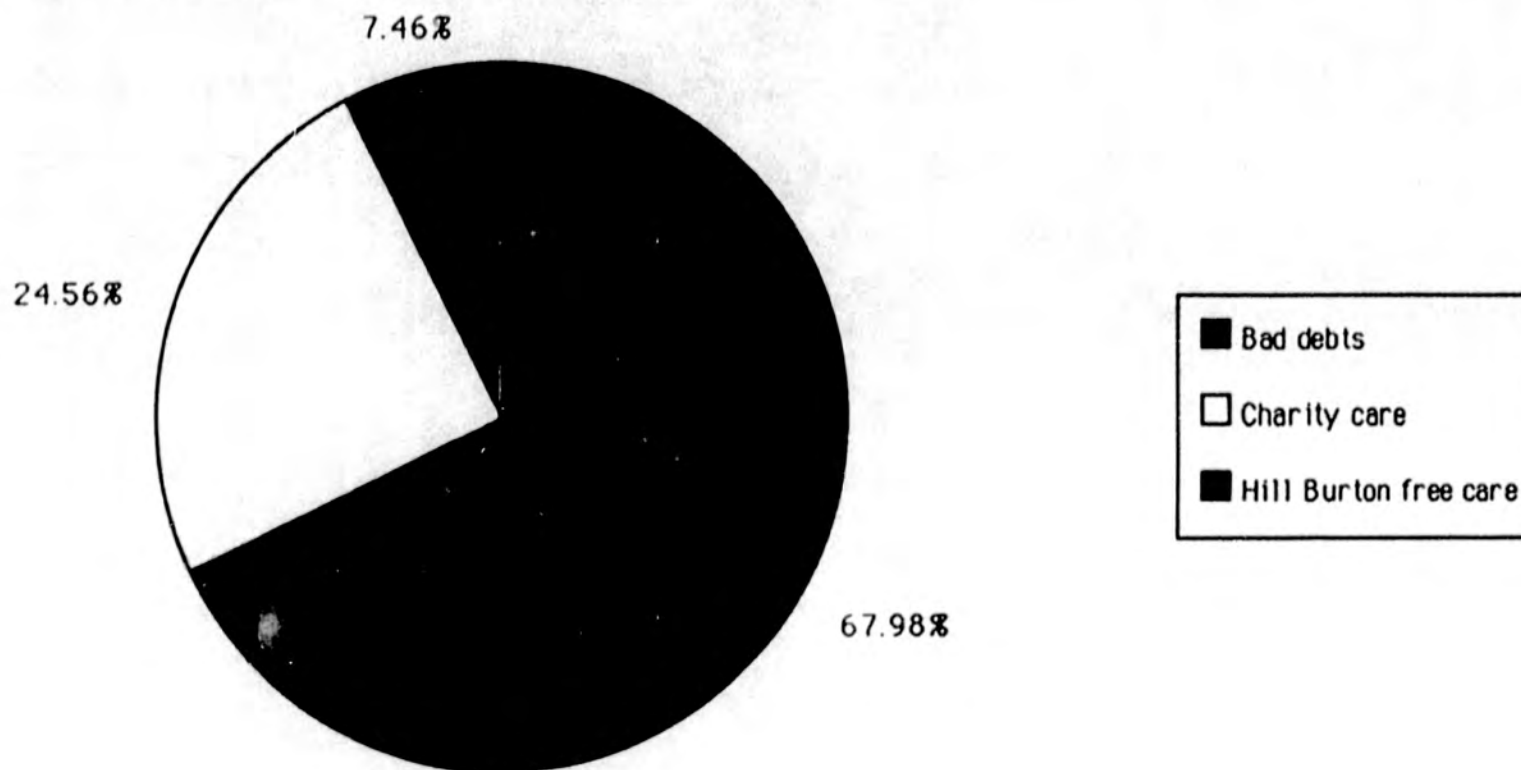
Facilities Responding to ASHNHA Questionnaire by 1/7/92:	1990 Revenues at the Full Charge Rates	1990 Actual Collections (Net Revenue)
Providence Hospital	172,471,593	129,810,593
Humana Hospital - Alaska	85,798,873	65,160,235
Fairbanks Memorial Hospital	47,053,731	40,047,826
Our Lady of Compassion Care Center	19,841,000	13,947,000
Bartlett Memorial Hospital	19,676,844	17,178,322
Ketchikan General Hospital	15,513,106	13,563,239
Kodiak Island Hospital	8,210,388	7,164,933
Mary Conrad Center	7,471,307	7,245,283
Denali Center	5,905,613	4,657,101
Sitka Community Hospital	4,533,354	4,266,857
St. Ann's Nursing Home	3,481,433	3,126,607
Wesley Rehabilitation & Care Center	3,206,614	2,764,313
Heritage Place	2,871,742	2,088,747
Wrangell General Hospital	2,674,246	2,089,427
Petersburg General Hospital	2,356,912	2,073,619
Seward General Hospital	2,305,008	2,054,948
Total Fiscal Year 1990 Full Charges Reported - 16 facilities	403,371,764	317,239,050

Total 1990 Unpaid Charges for Services \$86,132,714

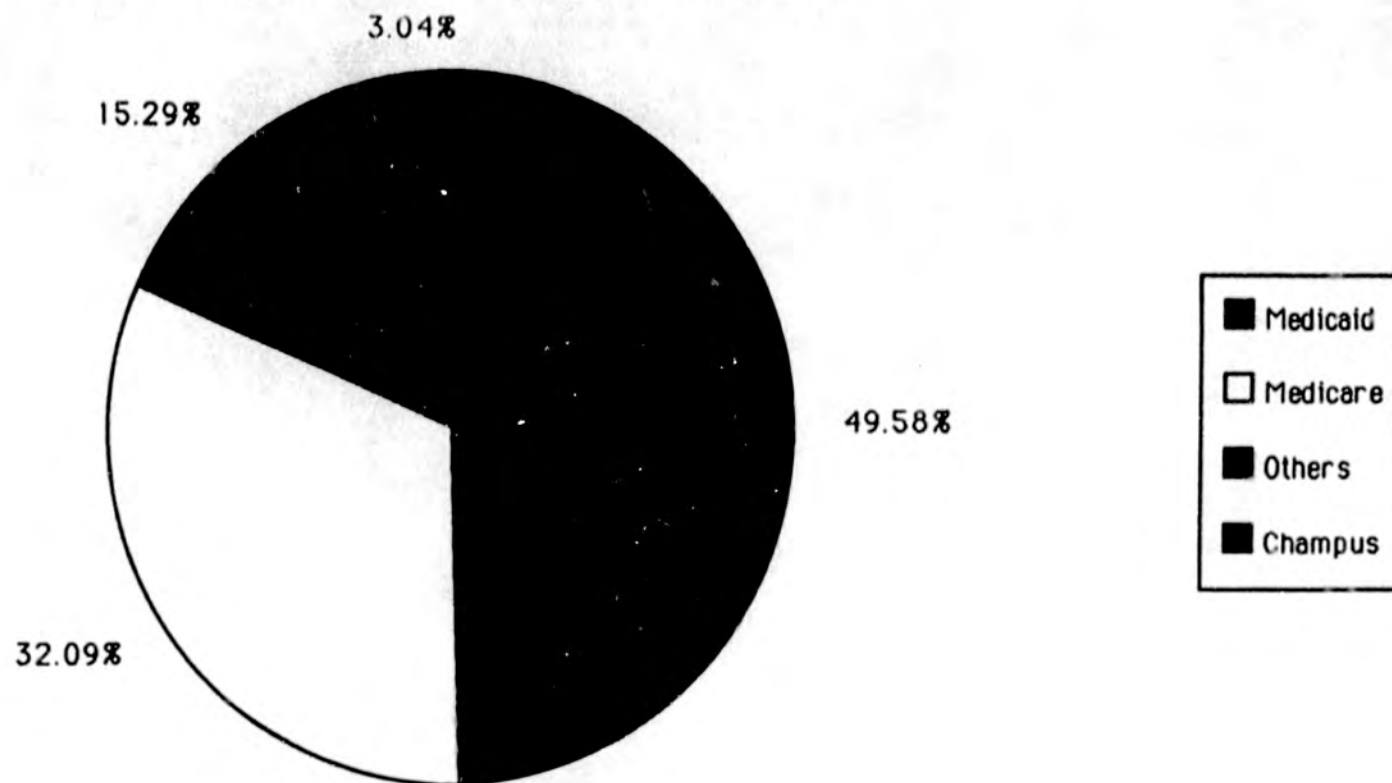


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Total 1990 Bad debts, Charity and Hill Burton \$22,210,884



Total 1990 Contractual Discounts / Allowances \$63,921,830



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Alaska State Hospital Nursing Home Association Data Collection

Question Number	FACILITY NAME: Bartlett Memorial Hospital	Percent of Total Charges	(A) Revenues At the full Charge Rate	(B) Contract Allowances Discounts	(C) Actual Collections (Net Revenue)	(D) % of net Revenues to Full Charges
	Uncompensated Care					
1 (A)	Charity care /	0 %	0		0	
1 (B)	Bad debts	6 %	1,157,473	1,157,473	0	
1 (C)	Hill Burton free care	1 %	252,244	252,244	0	
	Federal Payers					
2	Medicaid	8 %	1,485,454	188,342	1,297,112	87.32%
3	Medicare	17 %	3,274,652	688,281	2,586,371	78.98%
4	Indian Health Service	3 %	541,600	54,756	486,844	89.89%
5	Champus	1 %	120,985	0	120,985	100.00%
6	Veterans' Administration	3 %	556,673	0	556,673	100.00%
7	Other (Worker's Comp.)	3 %	678,524	0	678,524	100.00%
	Charges not covered by State & Federal programs			157,426	-157,426	
	Private Payers					
8	Blue Cross	9 %	1,864,295	0	1,864,295	100.00%
9	Commercial Insurance	33 %	6,456,391	0	6,456,391	100.00%
10	Paid by Patient	17 %	3,288,553	0	3,288,553	100.00%
11 (A)	Subtotal 1990 charges for services	100 %	19,676,844	2,498,522	17,178,322	87.30%
	Explanation:					
11 (B)	Other Payer:					
11 (C)	Total 1990 charges for services		19,676,844	2,498,522	17,178,322	87.30%
12 (A)	Total 1990 operating costs		16,470,464	N/A		
12 (B)	Depreciation included in operating costs		1,181,654	N/A		
	Other sources of operating revenues					
13	State Government			N/A		
	Revenue Sharing		123,056	N/A		
	Other - Cafeteria, rental income, misc. supply sales		264,313	N/A		
	Local Government			N/A		
	Taxation		0	N/A		
	General Fund		0	N/A		
	Other non service revenues			N/A		
14 (A)	Amount of your outstanding general obligation debt		9,469,522	N/A		
14 (B)	Type of debt Local Gov't General Obligation Bonds		Tax Exempt	N/A		
15 (A)	Debt service paid by your facility in FY 90		275,057	N/A		
15 (B)	Debt service paid by third party:		0			
	Local Government		670,000	N/A		
	Corporate parent		N/A	N/A		
	Other		N/A	N/A		
16	FY '90 Cost to Full Charge ratio (12A / 11C)		83.70%			
	Questions or Comments? Contact:					
	Garrey M. Peska, CPA					
	Vice President for Financial Affairs					
	Alaska State Hospital & Nursing Home Association					
	319 Seward St. #11					
	Juneau, Alaska 99801					
	Phone (907) 586-1790 Fax (907) 463-3573					

Alaska State Hospital Nursing Home Association Data Collection

Question Number	FACILITY NAME: Denali Center	Percent of Total Charges	(A) Revenues At the full Charge Rate	(B) Contract Allowances Discounts	(C) Actual Collections (Net Revenue)	(D) % of net Revenues to Full Charges
	Uncompensated Care					
1 (A)	Charity care	1 %	56,000	56,000	0	0.00 %
1 (B)	Bad debts	0 %	20,332	20,332	0	0.00 %
1 (C)	Hill Burton free care	0 %	0		0	
	Federal Payers					
2.	Medicaid	69 %	4,096,696	635,517	3,461,179	84.49 %
3.	Medicare	12 %	690,139	289,126	401,013	58.11 %
4.	Indian Health Service	1 %	85,307	20,678	64,629	75.76 %
5.	Champus	0 %	0		0	
6.	Veterans' Administration	4 %	253,837	61,014	192,823	75.96 %
7.	Other	0 %	0		0	
	Private Payers					
8.	Blue Cross	0 %	0		0	
9.	Commercial Insurance	5 %	285,937	28,035	257,902	90.20 %
10.	Paid by Patient	7 %	409,918	137,810	272,108	66.38 %
11 (A)	Subtotal 1990 charges for services	100 %	5,898,166	1,248,512	4,649,654	78.83 %
	Explanation:					
11 (B)	Other Payer: Respite / Adult Day Care		7,447	0	7,447	
11 (C)	Total 1990 charges for services		5,905,613	1,248,512	4,657,101	78.86 %
12 (A)	Total 1990 operating costs		4,858,460	N/A		
12 (B)	Depreciation included in operating costs		109,789	N/A		
	Other sources of operating revenues					
13	State Government			N/A		
	Revenue Sharing		113,018	N/A		
	Other (explain) _____			N/A		
	Local Government			N/A		
	Taxation		0	N/A		
	General Fund		0	N/A		
	Other non service revenues - Miscellaneous		33,234	N/A		
14 (A)	Amount of your outstanding general obligation debt		0	N/A		
14 (B)	Type of debt (taxable, tax exempt, other)		N/A	N/A		
15 (A)	Debt service paid by your facility in FY 90		0	N/A		
15 (B)	Debt service paid by third party:		0			
	Local Government			N/A		
	Corporate parent		N/A	N/A		
	Other		N/A	N/A		
16	FY '90 Cost to Full Charge ratio (12A / 11C)		82.27 %			
	Questions or Comments? Contact:					
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Alaska State Hospital Nursing Home Association Data Collection

Question Number	FACILITY NAME Fairbanks Memorial Hospital	Percent of Total	(A) Revenues At the Full Charge Rate	(B) Contract Allowances Discounts	(C) Actual Collections (Net Revenue)	(D) % of net Revenues to Full Charges
			Charges			
	Uncompensated Care					
1 (A)	Charity care	1 %	492,000	492,000	0	0.00 %
1 (B)	Bad debts	2 %	1,136,227	1,136,227	0	0.00 %
1 (C)	Hill Burton free care		0	0	0	
	Federal Payers					
2	Medicaid	12 %	5,431,972	1,761,687	3,670,285	67.57 %
3	Medicare	19 %	9,104,600	2,418,410	6,686,190	73.44 %
4	Indian Health Service	7 %	3,119,688	77,401	2,342,287	75.08 %
5	Champus	2 %	968,211	0	968,211	100.00 %
6	Veterans' Administration	4 %	1,995,045	27,045	1,968,000	98.64 %
7	Other	5 %	2,326,064	274,670	2,051,394	88.19 %
	Private Payers					
8	Blue Cross	5 %	2,167,178	26,944	2,138,234	98.66 %
9	Commercial Insurance	34 %	16,039,716	84,481	15,955,235	99.47 %
10	Paid by Patient	9 %	4,278,030	5,040	4,272,990	99.88 %
11 (A)	Subtotal 1990 charges for services	100 %	47,058,731	7,005,905	40,052,826	85.11 %
	Explanation:					
	Unknown		-5,000		-5,000	
11 (B)	Other Payer:					
11 (C)	Total 1990 charges for services		47,053,731	7,005,905	40,047,826	85.11 %
12 (A)	Total 1990 operating costs		38,743,293	N/A		
12 (B)	Depreciation included in operating costs		349,148	N/A		
	Other sources of operating revenues					
13	State Government			N/A		
	Revenue Sharing		139,871	N/A		
	Other (explain) "Other operating revenue"		1,535,019	N/A		
	Local Government			N/A		
	Taxation		0	N/A		
	General Fund		0	N/A		
	Other non service revenues (explain) "Interest income med waste disposal, miscellaneous"		82,097	N/A		
14 (A)	Amount of your outstanding general obligation debt		0	N/A		
14 (B)	Type of debt (taxable, tax exempt, other)		N/A	N/A		
15 (A)	Debt service paid by your facility in FY 90		0	N/A		
15 (B)	Debt service paid by third party:		0			
	Local Government		N/A	N/A		
	Corporate parent		N/A	N/A		
	Other		N/A	N/A		
16	FY '90 Cost to Full Charge ratio (12A / 11C)		82.34 %			
	Questions or Comments? Contact:					
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Alaska State Hospital Nursing Home Association Data Collection

Question Number	FACILITY NAME: Heritage Place	Percent of Total Charges	(A) Revenues At the full Charge Rate	(B) Contract Allowances Discounts	(C) Actual Collections (Net Revenue)	(D) % of net Revenues to Full Charges
SOURCE OF REVENUES (Fiscal year ended during 1990)						
Uncompensated Care						
1 (A)	Charity care	0 %	0	0	0	
1 (B)	Bad debts	0 %	8,254	8,254	0	0.00 %
1 (C)	Hill Burton free care	0 %	0		0	
Federal Payers						
2	Medicaid	87 %	2,496,065	688,265	1,807,800	72.43 %
3	Medicare	8 %	243,277	28,012	215,265	88.49 %
4	Indian Health Service	0 %	0		0	
5	Champus	3 %	96,000	45,566	50,434	52.54 %
6	Veterans' Administration	0 %	0		0	
7	Other	0 %	0		0	
Private Payers						
8	Blue Cross	0 %	4,000	1,401	2,599	64.98 %
9	Commercial Insurance	0 %	0		0	
10	Paid by Patient	1 %	24,146	11,497	12,649	52.39 %
11 (A)	Subtotal 1990 charges for services	100 %	2,871,742	782,995	2,088,747	72.73 %
Explanation						
11 (B)	Other Payer					
11 (C)	Total 1990 charges for services		2,871,742	782,995	2,088,747	72.73 %
12 (A)	Total 1990 operating costs		2,183,235	N/A		
12 (B)	Depreciation included in operating costs		163,634	N/A		
Other sources of operating revenues						
13	State Government			N/A		
	Revenue Sharing		46,777	N/A		
	Other (explain) _____			N/A		
	Local Government			N/A		
	Taxation		0	N/A		
	General Fund		0	N/A		
	Other non service revenues			N/A		
14 (A)	Amount of your outstanding general obligation debt		3,206,714	N/A		
14 (B)	Type of debt (taxable, tax exempt, other)		Other	N/A		
15 (A)	Debt service paid by your facility in FY 90		501,660	N/A		
15 (B)	Debt service paid by third party:					
	Local Government		0	N/A		
	Corporate parent		N/A	N/A		
	Other		N/A	N/A		
16	FY '90 Cost to Full Charge ratio (12A / 11C)		76.02 %			
Questions or Comments? Contact:						
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Alaska State Hospital Nursing Home Association Data Collection

FACILITY NAME: Humana Hospital - Alaska		Percent	(A) Revenues	(B) Contract	(C) Actual	(D) % of net
Question		of Total	At the full	Allowances	Collections	Revenues to
Number	SOURCE OF REVENUES (Fiscal year ended during 1990)	Charges	Charge Rate	Discounts	(Net Revenue)	Full Charges
	Uncompensated Care					
1 (A)	Charity care		Unavailable		0	
1 (B)	Bad debts	6 %	4,832,276	4,832,276	0	0.00 %
1 (C)	Hill Burton free care	0 %			0	
	Federal Payers					
2	Medicaid	14 %	11,840,266	6,446,834	5,393,432	45.55 %
3	Medicare	16 %	13,981,425	5,891,303	8,090,122	57.86 %
4	Indian Health Service	0 %			0	
5	Champus	0 %			0	
6	Veterans' Administration	0 %			0	
7	Other	0 %		3,468,225	-3,468,225	
	Private Payers					
8	Blue Cross	6 %	5,407,376		5,407,376	
9	Commercial Insurance	58 %	49,737,530		49,737,530	
10	Paid by Patient	0 %			0	
11 (A)	Subtotal 1990 charges for services	100 %	85,798,873	20,638,638	65,160,235	75.95 %
	Explanation:					
11 (B)	Other Payer:					
11 (C)	Total 1990 charges for services		85,798,873	20,638,638	65,160,235	75.95 %
12 (A)	Total 1990 operating costs		57,427,624	N/A		
12 (B)	Depreciation included in operating costs		4,993,486	N/A		
	Other sources of operating revenues					
13	State Government			N/A		
	Revenue Sharing		0	N/A		
	Other (explain) _____		847,438	N/A		
	Local Government			N/A		
	Taxation		0	N/A		
	General Fund		0	N/A		
	Other non service revenues			N/A		
14 (A)	Amount of your outstanding general obligation debt			N/A		
14 (B)	Type of debt (taxable, tax exempt, other)			N/A		
15 (A)	Debt service paid by your facility in FY 90		0	N/A		
15 (B)	Debt service paid by third party:		0			
	Local Government			N/A		
	Corporate parent		N/A	N/A		
	Other		N/A	N/A		
16	FY '90 Cost to Full Charge ratio (12A / 11C)		66.93 %			
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Alaska State Hospital Nursing Home Association Data Collection

FACILITY NAME: Ketchikan General Hospital		Percent	(A) Revenues	(B) Contract	(C) Actual	(D) % of net
Question		of Total	At the full	Allowances	Collections	Revenues to
Number	SOURCE OF REVENUES: (Fiscal year ended during 1990)	Charges	Charge Rate	Discounts	(Net Revenue)	Full Charges
	Uncompensated Care					
1 (A)	Charity care	0 %	13,542	13,542	0	0.00%
1 (B)	Bad debts	5 %	811,515	811,515	0	0.00%
1 (C)	Hill Burton free care	1 %	168,717	168,717	0	0.00%
	Federal Payers					
2	Medicaid	0 %			0	
3	Medicare	0 %			0	
4	Indian Health Service	0 %			0	
5	Champus	0 %			0	
6	Veterans' Administration	0 %			0	
7	Unknown per facility	94 %	14,519,332	956,093	13,563,239	93.42%
	Private Payers					
8	Blue Cross	0 %			0	
9	Commercial Insurance	0 %			0	
10	Paid by Patient	0 %			0	
11 (A)	Subtotal 1990 charges for services	100 %	15,513,106	1,949,867	13,563,239	87.43%
	Explanation:					
11 (B)	Other Payer:					
11 (C)	Total 1990 charges for services		15,513,106	1,949,867	13,563,239	87.43%
12 (A)	Total 1990 operating costs		13,669,525	N/A		
12 (B)	Depreciation included in operating costs		589,327	N/A		
	Other sources of operating revenues					
13	State Government			N/A		
	Revenue Sharing		123,055	N/A		
	Other (explain):		0	N/A		
	Local Government			N/A		
	Taxation		0	N/A		
	General Fund		0	N/A		
	Other non service revenues		456,485	N/A		
14 (A)	Amount of your outstanding general obligation debt		900,000	N/A		
14 (B)	Type of debt -- Private Contract			N/A		
15 (A)	Debt service paid by your facility in FY 90		0	N/A		
15 (B)	Debt service paid by third party:					
	Local Government		0	N/A		
	Corporate parent		N/A	N/A		
	Other		N/A	N/A		
16	FY '90 Cost to Full Charge ratio (12A / 11C)		88.12 %			
	Questions or Comments? Contact:					
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Alaska State Hospital Nursing Home Association Data Collection

FACILITY NAME: Kodiak Island Hospital		Percent	(A) Revenues	(B) Contract	(C) Actual	(D) % of net
Question		of Total	At the full	Allowances	Collections	Revenues to
Number	SOURCE OF REVENUES (Fiscal year ended during 1990)	Charges	Charge Rate	Discounts	(Net Revenue)	Full Charges
Uncompensated Care						
1 (A)	Charity care		0	0	0	
1 (B)	Bad debts	8 %	657,264	657,264	0	0.00 %
1 (C)	Hill Burton free care	2 %	165,986	165,986	0	0.00 %
Federal Payers						
2	Medicaid	21 %	1,763,813	110,123	1,653,690	93.76 %
3	Medicare	9 %	743,157	18,063	725,094	97.57 %
4	Indian Health Service	2 %	164,653		164,653	100.00 %
5	Champus	7 %	605,936		605,936	100.00 %
6	Veterans' Administration	4 %	324,650		324,650	100.00 %
7	Other	3 %	248,095	94,019	154,076	62.10 %
Private Payers						
8	Blue Cross	6 %	463,450		463,450	100.00 %
9	Commercial Insurance	20 %	1,616,920		1,616,920	100.00 %
10	Paid by Patient	18 %	1,456,464		1,456,464	100.00 %
11 (A)	Subtotal 1990 charges for services	100 %	8,210,388	1,045,455	7,164,933	87.27 %
Explanation						
11 (B)	Other Payer:					
11 (C)	Total 1990 charges for services		8,210,388	1,045,455	7,164,933	87.27 %
12 (A)	Total 1990 operating costs		7,664,113	N/A		
12 (B)	Depreciation included in operating costs		339,388	N/A		
Other sources of operating revenues						
13	State Government			N/A		
	Revenue Sharing		134,450	N/A		
	Other (explain) _____		0	N/A		
	Local Government			N/A		
	Taxation		0	N/A		
	General Fund		0	N/A		
	Other non service revenues "Interest & Cafeteria"		328,008	N/A		
14 (A)	Amount of your outstanding general obligation debt		0	N/A		
14 (B)	Type of debt (taxable, tax exempt, other)			N/A		
15 (A)	Debt service paid by your facility in FY 90		0	N/A		
15 (B)	Debt service paid by third party:		0			
	Local Government			N/A		
	Corporate parent		N/A	N/A		
	Other		N/A	N/A		
16	FY '90 Cost to Full Charge ratio (12A / 11C)		93.35 %			
Questions or Comments? Contact:						
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Alaska State Hospital and Nursing Home Association Data Collection

Question Number	FACILITY NAME: Mary Conrad Center	Percent of Total Charges	(A) Revenues At the full Charge Rate	(B) Contract Allowances Discounts	(C) Actual Collections (Net Revenue)	(D) % of net Revenues to Full Charges
Uncompensated Care						
1 (A)	Charity care	0 %	0	0	0	
1 (B)	Bad debts	1 %	53,237	53,237	0	0.00 %
1 (C)	Hill Burton free care	0 %	0	0	0	
Federal Payers						
2	Medicaid	95 %	7,120,415	172,787	6,947,628	97.57 %
3	Medicare	0 %	0		0	
4	Indian Health Service	0 %	0		0	
5	Champus	0 %	0		0	
6	Veterans' Administration	0 %	0		0	
7	Other	0 %	0		0	
Private Payers						
8	Blue Cross	0 %			0	
9	Commercial Insurance	0 %			0	
10	Paid by Patient	4 %	297,655	0	297,655	100.00 %
11 (A)	Subtotal 1990 charges for services	100 %	7,471,307	226,024	7,245,283	96.97 %
Explanation:						
11 (B)	Other Payer:					
11 (C)	Total 1990 charges for services		7,471,307	226,024	7,245,283	96.97 %
12 (A)	Total 1990 operating costs		6,043,738	N/A		
12 (B)	Depreciation included in operating costs		974,936	N/A		
Other sources of operating revenues						
13	State Government			N/A		
	Revenue Sharing		0	N/A		
	Other (explain):		0	N/A		
	Local Government		0	N/A		
	Taxation		0	N/A		
	General Fund		0	N/A		
	Other non service revenues			N/A		
	"Interest income & beauty shop"		45,921			
14 (A)	Amount of your outstanding general obligation debt		8,678,888	N/A		
14 (B)	Type of debt (taxable, tax exempt, other)		Bond	N/A		
15 (A)	Debt service paid by your facility in FY 90		569,403	N/A		
15 (B)	Debt service paid by third party:		0			
	Local Government			N/A		
	Corporate parent		N/A	N/A		
	Other		N/A	N/A		
16	FY '90 Cost to Full Charge ratio (12A / 11C)		80.89 %			
Questions or Comments? Contact:						
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Alaska State Hospital Nursing Home Association Data Collection

FACILITY NAME: Our Lady of Compassion Care Center		Percent	(A) Revenues	(B) Contract	(C) Actual	(D) % of net
Question		of Total	At the full	Allowances	Collections	Revenues to
Number	SOURCE OF REVENUES (Fiscal year ended during 1990)	Charges	Charge Rate	Discounts	(Net Revenue	Full Charges
Uncompensated Care						
1 (A)	Charity care	1 %	128,000	128,000	0	
1 (B)	Bad debts	0 %	53,000	53,000	0	
1 (C)	Hill Burton free care	0 %	0		0	
Federal Payers						
2	Medicaid	84 %	16,734,000	5,207,000	11,527,000	68.88 %
3	Medicare	4 %	846,000	371,000	475,000	56.15 %
4	Indian Health Service	0 %	0		0	
5	Champus	0 %	0		0	
6	Veterans' Administration	3 %	654,000	132,000	522,000	79.82 %
7	Other	0 %	0		0	
Private Payers						
8	Blue Cross	0 %	0		0	
9	Commercial Insurance - ALL	3 %	648,000	3,000	645,000	99.54 %
10	Paid by Patient	4 %	778,000	0	778,000	100.00 %
11 (A)	Subtotal 1990 charges for services	100 %	19,841,000	5,894,000	13,947,000	70.29 %
Explanation:						
11 (B)	Other Payer:					
11 (C)	Total 1990 charges for services		19,841,000	5,894,000	13,947,000	70.29 %
12 (A)	Total 1990 operating costs		13,130,000	N/A		
12 (B)	Depreciation included in operating costs		983,000	N/A		
Other sources of operating revenues						
13	State Government			N/A		
	Revenue Sharing			N/A		
	Other (explain) _____			N/A		
	Local Government			N/A		
	Taxation		0	N/A		
	General Fund		0	N/A		
	Other non service revenues *Cost Recoveries &		0	N/A		
	Undesignated Investment Income		130,000			
14 (A)	Amount of your outstanding general obligation debt		17,703,000	N/A		
14 (B)	Type of debt (taxable, tax exempt, other)		Tax exempt	N/A		
15 (A)	Debt service paid by your facility in FY 90		2,020,000	N/A		
15 (B)	Debt service paid by third party:					
	Local Government		N/A	N/A		
	Corporate parent		N/A	N/A		
	Other		N/A	N/A		
16	FY '90 Cost to Full Charge ratio (12A / 11C)		66.18 %			
Questions or Comments? Contact:						
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Alaska State Hospital Nursing Home Association Data Collection

Question Number	FACILITY NAME: Petersburg General Hospital	Percent of Total Charges	(A) Revenues At the Full Charge Rate	(B) Contract Allowances Discounts	(C) Actual Collections (Net Revenue)	(D) % of net Revenues to Full Charges
	Uncompensated Care					
1 (A)	Charity care	0.00%	0	0	0	
1 (B)	Bad debts	1.23%	28,900	28,900	0	0.00%
1 (C)	Hill Burton free care	0.11%	2,627	2,627	0	0.00%
	Federal Payers					
2	Medicaid	55%	1,304,104	55,170	1,248,934	95.77%
3	Medicare	12%	287,905	177,754	110,151	38.26%
4	Indian Health Service	2%	36,445	823	35,622	97.74%
5	Champus, Coast Guard & V.A.	2%	55,261	14,302	40,959	74.12%
6		0%		3,717	-3,717	-100.00%
7	Other	0%	0		0	
	Private Payers					
8	Blue Cross, & Other Commercial Insurers	19%	451,578		451,578	100.00%
9					0	
10	Paid by Patient	8%	190,092		190,092	100.00%
11 (A)	Subtotal 1990 charges for services	100%	2,356,912	283,293	2,073,619	87.98%
	Explanation:					
	Unknown					
11 (B)	Other Payer:					
11 (C)	Total 1990 charges for services		2,356,912	283,293	2,073,619	87.98%
12 (A)	Total 1990 operating costs		2,469,069	N/A		
12 (B)	Depreciation included in operating costs		525,233	N/A		
	Other sources of operating revenues					
13	State Government			N/A		
	Revenue Sharing		127,670	N/A		
	Other (explain):			N/A		
	Local Government			N/A		
	Taxation		0	N/A		
	General Fund		0	N/A		
	Other non service revenues "Miscellaneous"		42,880	N/A		
14 (A)	Amount of your outstanding general obligation debt		0	N/A		
14 (B)	Type of debt (taxable, tax exempt, other)		N/A	N/A		
15 (A)	Debt service paid by your facility in FY 90		0	N/A		
15 (B)	Debt service paid by third party:		0			
	Local Government		N/A	N/A		
	Corporate parent		N/A	N/A		
	Other		N/A	N/A		
16	FY '90 Cost to Charge ratio (12A / 11C)		104.76%			
	Questions or Comments? Contact:					
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Alaska State Hospital Nursing Home Association Data Collection

FACILITY NAME: Providence Hospital		Percent	(A) Revenues	(B) Contract	(C) Actual	(D) % of net
Question		of Total	At the Full	Allowances	Collections	Revenues to
Number	SOURCE OF REVENUES (Fiscal year ended during 1990)	Charges	Charge Rate	Discounts	(Net Revenue)	Full Charges
	Uncompensated Care					
1 (A)	Charity care	3 %	4,544,604	4,544,604	0	0.00 %
1 (B)	Bad debts	3 %	5,921,054	5,921,054	0	0.00 %
1 (C)	Hill Burton free care	1 %	1,015,884	1,015,884	0	0.00 %
	Federal Payers					
2	Medicaid	19 %	32,090,000	15,556,778	16,533,222	51.52 %
3	Medicare	16 %	27,903,000	10,480,433	17,422,567	62.44 %
4	Indian Health Service	1 %	1,900,000	0	1,900,000	100.00 %
5	Champus	3 %	5,827,000	1,884,718	3,942,282	67.66 %
6	Veterans' Administration	5 %	9,379,000	656,000	8,723,000	93.01 %
7	Other	0 %	0		0	
	Private Payers					
8	Blue Cross	4 %	6,500,000	975,000	5,525,000	85.00 %
9	Commercial Insurance	37 %	63,002,593	327,000	62,675,593	99.48 %
10	Paid by Patient	8 %	14,388,458	1,299,529	13,088,929	90.97 %
11 (A)	Subtotal 1990 charges for services	100 %	172,471,593	42,661,000	129,810,593	75.26 %
	Explanation					
11 (B)	Other Payer:					
11 (C)	Total 1990 charges for services		172,471,593	42,661,000	129,810,593	75.26 %
12 (A)	Total 1990 operating costs		119,920,000	N/A		
12 (B)	Depreciation Included in operating costs		10,614,000	N/A		
	Other sources of operating revenues					
13	State Government			N/A		
	Revenue Sharing		140,000	N/A		
	Other (explain) _____		0	N/A		
	Local Government			N/A		
	Taxation		0	N/A		
	General Fund		0	N/A		
	Other non service revenues (explain)			N/A		
14 (A)	Amount of your outstanding general obligation debt		71,270,759	N/A		
14 (B)	Type of debt (taxable, tax exempt, other)		Tax Exempt	N/A		
15 (A)	Debt service paid by your facility in FY 90		8,988,000	N/A		
15 (B)	Debt service paid by third party:		0			
	Local Government		N/A	N/A		
	Corporate parent		N/A	N/A		
	Other		N/A	N/A		
16	FY '90 Cost to Full Charge ratio (12A / 11C)		69.53 %			
	Questions or Comments? Contact:					
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	Juneau, Alaska 99801					
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Alaska State Hospital Nursing Home Association Data Collection

FACILITY NAME: Seward General Hospital		Percent	(A) Revenues	(B) Contract	(C) Actual	(D) % of net
Question	of Total	At the Full	Allowances	Collections	Revenues to	
Number	SOURCE OF REVENUES: (Fiscal year ended during 1990)	Charges	Charge Rate	Discounts	(Net Revenue)	Full Charges
	Uncompensated Care					
1(A)	Charity care		0	0	0	
1(B)	Bad debts		0	0	0	
1(C)	Hill Burton free care		0	0	0	
	Federal Payers					
2.	Medicaid	10%	238,619	66,084	172,535	72.31%
3.	Medicare	27%	616,978	38,350	578,628	93.78%
4.	Indian Health Service	0%			0	
5.	Champus	0%			0	
6.	Veterans' Administration & Ak Native Health Service	8%	193,925	6,387	187,538	96.71%
7.	Other	0%			0	
	Private Payers					
8.	Blue Cross	5%	112,875	0	112,875	100.00%
9.	Commercial Insurance	31%	708,924	10,739	698,185	98.49%
10.	Paid by Patient	19%	433,687	128,500	305,187	70.37%
11 (A)	Subtotal 1990 charges for services	100%	2,305,008	250,060	2,054,948	89.15%
	Explanation:					
	Unknown					
11 (B)	Other Payer:					
11 (C)	Total 1990 charges for services		2,305,008	250,060	2,054,948	89.15%
12 (A)	Total 1990 operating costs		2,558,612	N/A		
12 (B)	Depreciation included in operating costs		81,788	N/A		
	Other sources of operating revenues					
13	State Government			N/A		
	Revenue Sharing		182,485	N/A		
	Other (explain)			N/A		
	Local Government			N/A		
	Taxation		453,280	N/A		
	General Fund			N/A		
	Other non service revenues (explain)			N/A		
14 (A)	Amount of your outstanding general obligation debt		0	N/A		
14 (B)	Type of debt (Capital Leases)		103,874	N/A		
15 (A)	Debt service paid by your facility in FY 90		31,419	N/A		
15 (B)	Debt service paid by third party:		0			
	Local Government		N/A	N/A		
	Corporate parent		N/A	N/A		
	Other		N/A	N/A		
16.	FY '90 Cost to Full Charge ratio (12A / 11C)		111.00%			
	Questions or Comments? Contact:					
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	Vice President for Financial Affairs					
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Alaska State Hospital Nursing Home Association Data Collection

FACILITY NAME: Sitka Community Hospital		Percent	(A)Revenues	(B)Contract	(C)Actual	(D)% of net
Question	of Total	At the Full	Allowances	Collections	Revenues to	
Number	SOURCE OF REVENUES: (Fiscal year ended during 1990)	Charges	Charge Rate	Discounts	(Net Revenue	Full Charges
	Uncompensated Care					
1(A)	Charity care		0	0	0	
1(B)	Bad debts	4 %	176,853	176,853	0	0.00%
1(C)	Hill Burton free care		0	0	0	
	Federal Payers					
2.	Medicaid	8 %	340,981	28,395	312,586	91.67%
3.	Medicare	22 %	996,065	60,985	935,080	93.88%
4.	Indian Health Service	0 %	0		0	
5.	Champus	0 %	0		0	
6.	Veterans' Administration	0 %	0		0	
7.	Other ("State of Ak, Indian Health, VA")	5 %	245,407		245,407	100.00%
	Private Payers					
8.	Blue Cross	0 %	0		0	
9.	Commercial Insurance	53 %	2,395,076	264	2,394,812	99.99%
10.	Paid by Patient	8 %	378,972		378,972	100.00%
11 (A)	Subtotal 1990 charges for services	100%	4,533,354	266,497	4,266,857	94.12%
	Explanation:					
11 (B)	Other Payer:					
11 (C)	Total 1990 charges for services		4,533,354	266,497	4,266,857	94.12%
12 (A)	Total 1990 operating costs		4,638,705	N/A		
12 (B)	Depreciation included in operating costs		461,499	N/A		
	Other sources of operating revenues					
13	State Government			N/A		
	Revenue Sharing		250,000	N/A		
	Other (explain) "Other operating revenue"			N/A		
	Local Government			N/A		
	Taxation		0	N/A		
	General Fund		0	N/A		
	Other non service revenues (explain) Interest Income		88,073	N/A		
	Miscellaneous		90,958			
14 (A)	Amount of your outstanding general obligation debt		0	N/A		
14 (B)	Type of debt (taxable, tax exempt, other)		N/A	N/A		
15 (A)	Debt service paid by your facility in FY 90		0	N/A		
15 (B)	Debt service paid by third party:		0			
	Local Government		272,200	N/A		
	Corporate parent		N/A	N/A		
	Other		N/A	N/A		
16.	FY '90 Cost to Full Charge ratio (12A / 11C)		102.32%			
	Questions or Comments? Contact:					
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Alaska State Hospital Nursing Home Association Data Collection

FACILITY NAME: St. Anns Nursing Home		Percent	(A)Revenue	(B)Contract	(C)Actual	(D)% of net
Question		of Total	At the Full	Allowances	Collections	Revenues to
Number	SOURCE OF REVENUES: (Fiscal year ended during 1990)	Charges	Charge Rate	Discounts	(Net Revenue	Full Charges
	Uncompensated Care					
1 (A)	Charity care		0	0	0	
1 (B)	Bad debts		0	0	0	
1 (C)	Hill Burton free care		0	0	0	
	Federal Payers					
2.	Medicaid	98%	3,397,205	354,065	3,043,140	89.58%
3.	Medicare	0%	0		0	
4.	Indian Health Service	0%	0		0	
5.	Champus	0%	0		0	
6.	Veterans' Administration	0%	6,161	761	5,400	87.65%
7.	Other	0%	0		0	
	Private Payers					
8.	Blue Cross	0%	0		0	
9.	Commercial Insurance	0%	0		0	
10.	Paid by Patient	2%	78,067		78,067	100.00%
11 (A)	Subtotal 1990 charges for services	100%	3,481,433	354,826	3,126,607	89.81%
	Explanation:					
11 (B)	Other Payer:					
11 (C)	Total 1990 charges for services		3,481,433	354,826	3,126,607	89.81%
12 (A)	Total 1990 operating costs		2,756,675	N/A		
12 (B)	Depreciation included in operating costs		46,780	N/A		
	Other sources of operating revenues					
13	State Government			N/A		
	Revenue Sharing			N/A		
	Other (explain)_____			N/A		
	Local Government			N/A		
	Taxation		0	N/A		
	General Fund		0	N/A		
	Other non service revenues (explain) Interest Income		55,336	N/A		
	Miscellaneous 4,173. Cafeteria 8,573.		12,746			
14 (A)	Amount of your outstanding general obligation debt		78,954	N/A		
14 (B)	Type of debt (taxable, tax exempt, other)		Tax Exempt	N/A		
15 (A)	Debt service paid by your facility in FY 90		24,000	N/A		
15 (B)	Debt service paid by third party:		0			
	Local Government		N/A	N/A		
	Corporate parent		N/A	N/A		
	Other		N/A	N/A		
16	FY '90 Cost to Full Charge ratio (12A / 11C)		79.18%			
	Questions or Comments? Contact:					
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Alaska State Hospital Nursing Home Association Data Collection

Question Number	FACILITY NAME Wesley Rehabilitation & Care Center	Percent of Total Charges	(A) Revenues At the full Charge Rate	(B) Contract Allowances Discounts	(C) Actual Collections (Net Revenue)	(D) % of net Revenues to Full Charges
Uncompensated Care						
1(A)	Charity care	1 %	21,405	21,405	0	0.00%
1(B)	Bad debts	3 %	101,204	101,204	0	0.00%
1(C)	Hill Burton free care	0 %	0		0	
Federal Payers						
2	Medicaid	86 %	2,760,516	302,149	2,458,367	89.05%
3	Medicare	0 %	0		0	
4	Indian Health Service	0 %	0		0	
5	Champus	0 %	0		0	
6	Veterans' Administration	1 %	42,240	6,746	35,494	84.03%
7	Other	2 %	70,188	10,116	60,072	
Private Payers						
8	Blue Cross	0 %	0		0	
9	Commercial Insurance	0 %	0		0	
10	Paid by Patient	7 %	211,051	681	210,380	99.68%
11 (A)	Subtotal 1990 charges for services	100%	3,206,614	442,301	2,764,313	86.21%
Explanation:						
11 (B)	Other Payer:					
11 (C)	Total 1990 charges for services		3,206,614	442,301	2,764,313	86.21%
12 (A)	Total 1990 operating costs		2,963,525	N/A		
12 (B)	Depreciation included in operating costs		916,902	N/A		
Other sources of operating revenues						
13	State Government			N/A		
	Revenue Sharing		69,937	N/A		
	Other (explain) "In-Kind Rent Contribution"		129,600	N/A		
	Local Government			N/A		
	Taxation		0	N/A		
	General Fund		0	N/A		
	Other non service revenues			N/A		
14 (A)	Amount of your outstanding general obligation debt		0	N/A		
14 (B)	Type of debt (taxable, tax exempt, other)		N/A	N/A		
15 (A)	Debt service paid by your facility in FY 90		0	N/A		
15 (B)	Debt service paid by third party:		0			
	Local Government			N/A		
	Corporate parent		N/A	N/A		
	Other		N/A	N/A		
16	FY '90 Cost to Full Charge ratio (12A / 11C)		92.42%			
Questions or Comments? Contact:						
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Alaska State Hospital Nursing Home Association Data Collection

Question Number	FACILITY NAME: Wrangell General Hospital SOURCE OF REVENUES: (Fiscal year ended during 1990)	Percent of Total Charges	(A) Revenues At the full Charge Rate	(B) Contract Allowances Discounts	(C) Actual Collections (Net Revenue)	(D) % of net Revenues to Full Charges
Uncompensated Care						
1 (A)	Charity care	8 %	199,901	199,901	0	
1 (B)	Bad debts	5 %	141,436	141,436	0	
1 (C)	Hill Burton free care	2 %	50,949	50,949	0	
Federal Payers						
2.	Medicaid	31 %	816,319	119,043	697,276	85.42 %
3.	Medicare	7 %	189,992	52,350	137,642	72.45 %
4.	Indian Health Service	3 %	78,543	3,315	75,228	95.78 %
5.	Champus	0 %	0		0	
6.	Veterans' Administration	3 %	67,714	2,347	65,367	96.53 %
7.	Other	0 %			0	
Private Payers						
8.	Blue Cross	5 %	141,504	60	141,444	99.96 %
9.	Commercial Insurance	16 %	426,240	15,418	410,822	96.38 %
10.	Paid by Patient	19 %	482,564		482,564	100.00 %
11 (A)	Subtotal 1990 charges for services	100 %	2,595,162	584,819	2,010,343	77.47 %
Explanation:						
11 (B)	Other Payer: H.B. Physician		79,084		79,084	
11 (C)	Total 1990 charges for services		2,674,246	584,819	2,089,427	78.13 %
12 (A)	Total 1990 operating costs		2,372,079	N/A		
12 (B)	Depreciation included in operating costs		291,012	N/A		
Other sources of operating revenues						
13	State Government			N/A		
	Revenue Sharing		127,724	N/A		
	Other (explain)			N/A		
	Local Government			N/A		
	Taxation		0	N/A		
	General Fund		0	N/A		
	Other non service revenues "Federal Grant"		20,425	N/A		
14 (A)	Amount of your outstanding general obligation debt		230,000	N/A		
14 (B)	Type of debt (taxable, tax exempt, other)		Bonds	N/A		
15 (A)	Debt service paid by your facility in FY 90		0	N/A		
15 (B)	Debt service paid by third party:		0			
	Local Government		20,000	N/A		
	Corporate parent		N/A	N/A		
	Other		N/A	N/A		
16.	FY '90 Cost to Full Charge ratio (12A / 11C)		88.70 %			
Questions or Comments? Contact:						
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APPENDIX F

Public Health in Health Care Reform
Presentation to the Health Resources and Access Task Force
By Peter Nakamura, MD
Alaska Division of Public Health
August 25, 1992

OUTLINE

- I. Opening Statement
- II. Description of Public Health
 - 1. Mission of Public Health
 - 2. Participants in Public Health
 - 3. Core Functions of Public Health
- III. Public Health Status and Trends in Alaska
 - 1. Mortality and Morbidity
 - 2. Budget
 - 3. Staffing
 - 4. Events
- IV. Trends Within the Division of Public Health
- V. Trends Within Other Divisions of the Department of Health and Social Services
- VI. Public Health Challenges in Alaska
- VII. The Role of Public Health in Health Care Reform
- VIII. Issues for Consideration

H.R.A.T. PRESENTATION

August 25, 1992

Alaska's Public Health

I. OPENING STATEMENT

Thank you for giving me this opportunity to present the picture of Public Health, the status of Public Health in Alaska and the role of Public Health in Health Care Reform.

My presentation will be given in the following format:

The description of Public Health

1. Mission of Public Health
2. Participants in Public Health
3. Core Functions of Public Health

Status of Public Health in Alaska

1. Public Health Trends in Alaska
 - Morbidity/Mortality
 - Fiscal and Human Resource Investments
 - Public Health Services (Activities)
 - Factors Affecting the Organizational picture of Public Health and Resource Allocation
2. Present Status of the Public Health in Alaska
3. Challenges to Public Health in Alaska

The role of Public Health in Health Care Reform and how it should be affected by the ultimate design of the Health Care Reform Package.

Establishment and commitment to a public health agenda for Alaska.

II. DESCRIPTION OF PUBLIC HEALTH

1. The Mission of Public Health The Mission of Public Health is to assure those conditions that will result in the maximum mental, physical, and social health of the public. In pursuit of this mission, there is often conflict between the interests leading to individual health versus the public's health. One of many examples of this is the decision made recently by the Division of Public Health when it eliminated the funding support for a program providing growth hormone to a limited number of individuals in order to preserve more public related services such as public health nursing and epidemiologic surveillance.

2. Participants in Public Health The mission of public health is addressed by individuals, private organizations, and all communities as well as by public agencies. Prevention, health

promotion, issues of access to care, health care cost containment, priorities of care, and other issues affecting public health are joint responsibilities. The government health agency has the unique responsibility to see to it that vital elements are in place and that the mission is adequately addressed. A state public health agency is responsible for those essential and critical public health services that cannot or will not be provided by the private sector.

3. The Core Functions The core functions of public health agencies at all levels of government are (1) assessment, (2) policy development, and (3) assurance.

Overhead I Representative Subset of Public Health Activities

Assessment refers to the collection, assembly, analysis and the publication of information about the health of the public. THIS IS A FUNCTION THAT CANNOT BE DELEGATED. The content and manner of release of information must not be manipulated in a way that it meets the needs of special interest groups. It is understandable and rational that if these responsibilities are abrogated, the data will be collected and placed in a format that best meets the self interest of those given this task.

Policy Development involves the broad participation of public, private organizations, and individuals. The state's role in the process is to give overall guidance and assurance that the public interest is served. Policy is affected through a variety of ways including planning, resource allocation, public information, legislative testimony, policy leadership, and negotiation. The public health agency must be equipped for this role by its access to technical knowledge and professional expertise. It is well stated in the publication, A Vision of Public Health, that used judiciously, the knowledge base of public health tempers the excesses of partisan politics and makes for more just decision.

Assurance is a core public sector function that is to make sure that necessary services are provided to reach agreed upon goals; either by requiring it or by providing services directly. Assurance implies the maintenance of a level of service needed to attain an intended impact or outcome that is achievable, given the resources and techniques available. Carrying out the assurance function as it relates to public safety and the implementation of legislative mandates requires the exercise of authority. It is Public Health's responsibility to provide those necessary services when they cannot or will not be provided by the private sector. A guarantee of services acts as a barrier to service cuts which tend to fall on the most vulnerable in hard times. Assured services can be targeted to major public health problems such as those identified in the Year 2000 planning process. Each of the interventions selected has real and quantifiable impacts on health costs and public health. Public Health's use of the statutory process has often been a mechanism for assuring these necessary services. Competition is often advocated as a mechanism for addressing the spiraling cost of health care, but there must be

Activities of Six State Agencies, 1984^a

	Number of States (n = 6)		Number of States (n = 6)
I. ASSESSMENT		III. ASSURANCE (<i>continued</i>)	
A. Data Collection		A. Inspection (<i>continued</i>)	
Vital Records	6	Housing, Public,	
Morbidity	3	Lodging, Re-	
Health Facilities	4	creational Faci-	
Health Manpower	5	ity Safety	6
Health System		Health Facility	
Funds	5	Safety	5
Health Interview		B. Licensing	5
Surveys	2	C. Health Education	
Health Trends		Education	5
Analysis	3	Health Promotion,	
Health Status		Disease Preven-	
Assessment	5	tion	2
B. Epidemiology		D. Environment	
Communicable Dis-		Air Quality	3
ease	6	Occupational	
Health Screening	6	Health and	
Laboratory Anal-		Safety	5
ysis	6	Radiation Control	6
C. Research		Solid Waste Man-	
Research Projects	4	agement	3
Laboratory Re-		Hazardous Waste	
search	1	Management	3
II. POLICY DEVELOPMENT		Public Water Sup-	
A. Policy		ply	5
Goals Developed		Individual Water	
Through Health		Supply	4
Assessments	1	Sewage Disposal	5
Standards for Local		E. Personal Health	
Health Agencies	5	Maternal and Child	
B. Health Planning		Health	6
State Health Plan-		Home Health	4
ning	2	Immunizations	6
Categorical Plans	5	Dental Health	6
Certificate of Need	5	Mental Health	5
III. ASSURANCE		Alcohol Abuse	5
A. Inspection		Drug Abuse	5
Food and Milk		Chronic Disease	6
Control	6	Inpatient Facilities	2
Product Safety,		F. Resources Develop-	
Substance Con-		ment	6
trol	3		

^aThis list is a representative subset of activities listed for all states in Tables A.4 through A.6 of Appendix A.

SOURCE: Public Health Foundation, 1986, pp. 2, 3, 10, 19, 27, 33, 37, 38, 39, 40, 41.

some assurance that the most vulnerable and the most neglected are not isolated and excluded.

A principle achievement of the practice of public health is to prevent or modify those public health conditions that negatively impact on the nation's health care bill.

BC I	Work Related Deaths in the Private Sector
BC II	Leading Causes of Years of Potential Life Lost
BC III	Leading Causes of Death in Alaska
BC IV	Prevalence of Behavioral Risk Factors
LG I	Unintentional Injuries from Drowning
LG II	Unintentional Spinal Cord Injuries
Table II.	Economic Impact of Public Health Practice).
	EPI Overheads: Tuberculosis Medical Services
	AIDS/HIV Medical Treatment
	Questionable Investment
	Combined Chart of 8 Graphs

Economics of Prevention and Public Health

With improved efforts in the areas of Prevention and Public Health, this nation can save lives and valuable health care resources. For example:

1. For every \$1 spent on immunization, \$10 is saved.
2. Teenage pregnancies cost the government more than \$20 billion/year. \$1 in family planning can save more than \$4 in health and welfare costs.
3. It costs \$50,000 before a low birth weight child can leave the hospital, versus \$4,800 for comprehensive prenatal care and delivery.
4. \$1 in maternity care coordination saved \$2 in newborn care.
5. \$15,000 to educate a child born addicted to drugs or alcohol versus \$3,000 to educate a health child per year.

FY 92 Authorized/FY 93 Gov. Budget Requests

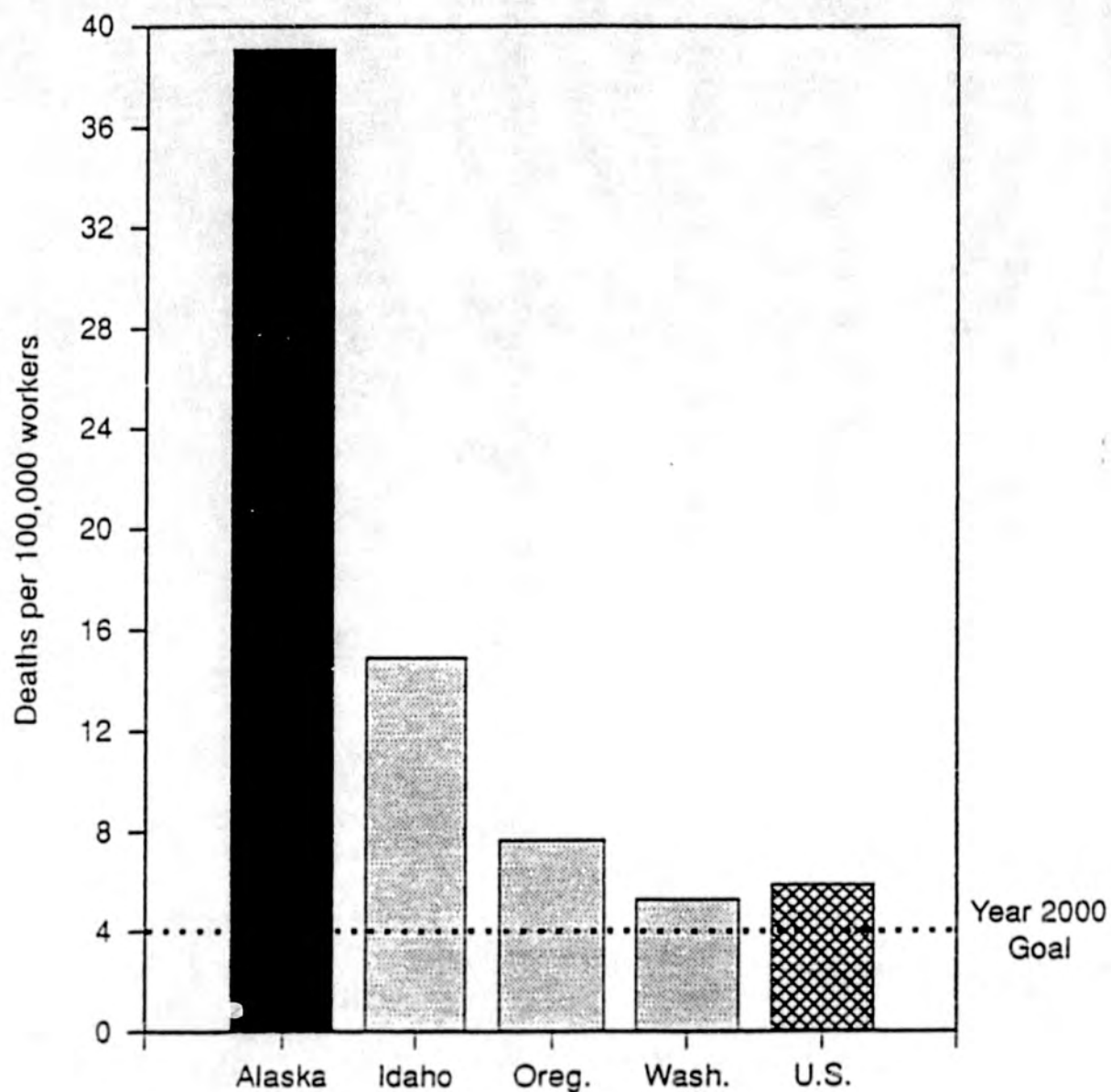
Social Cultural Influence of Public Health

I am sure that most of you are familiar with the recent incident reported in our local and national press about the slaughter of walrus on the coast of Alaska.

EPI Overheads: Anch Times News Article - Walrus
Lung Cancer - Alaska
Lung Cancer - Tobacco Dependence

The subsequent defense for the disposal of the meat and organs was based on the alleged contamination by toxic levels of lead and mercury. Scientifically flawed data was presented to support this defense. A successful presentation of this case would have resulted in the termination of the Native practice of subsistence

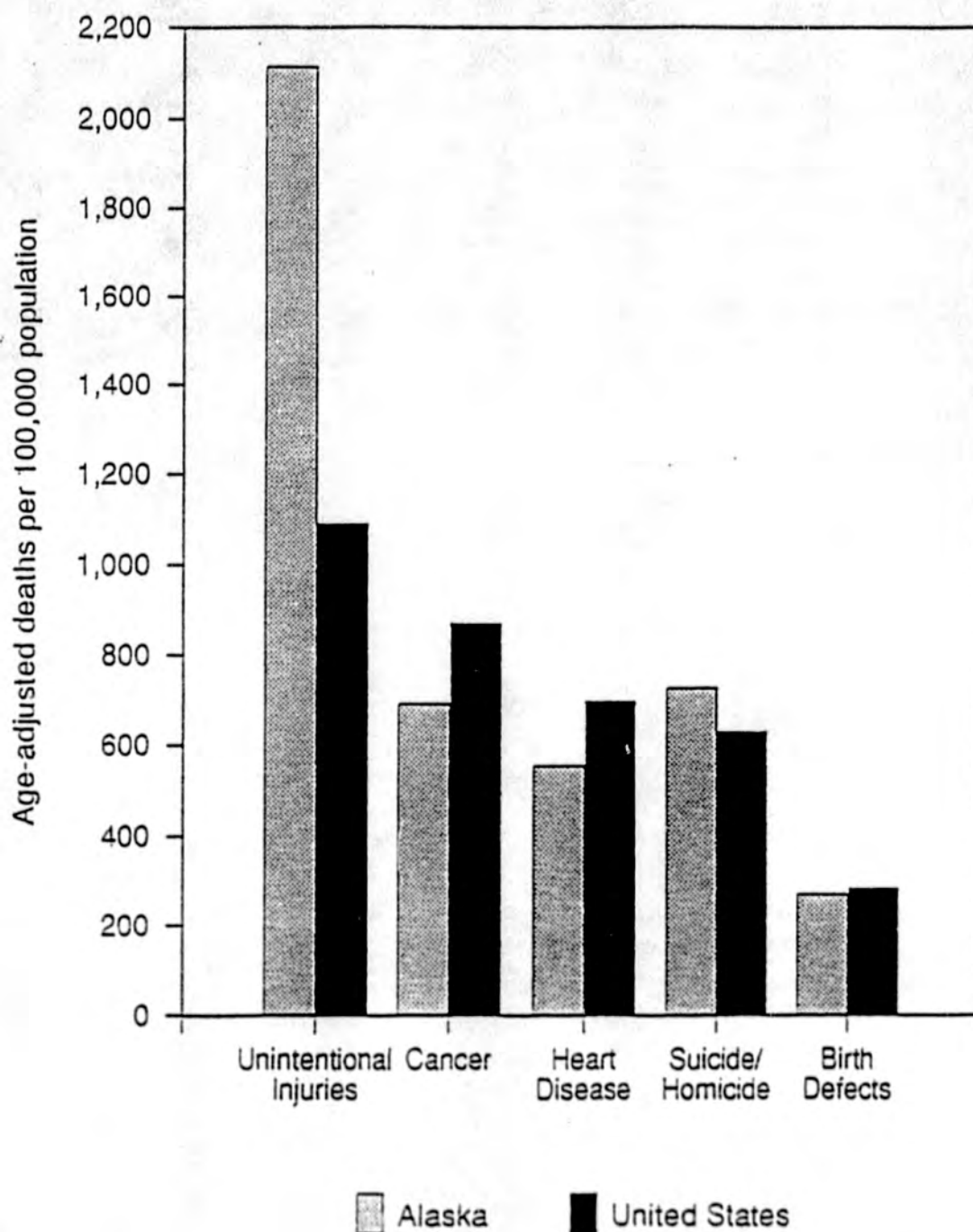
Work-Related Deaths in the Private Sector Alaska, Region, and United States 1988



Source: "Alaska Health Profile, 1992", Centers for Disease Control,
U.S. Dept. of Health and Human Services

CDC

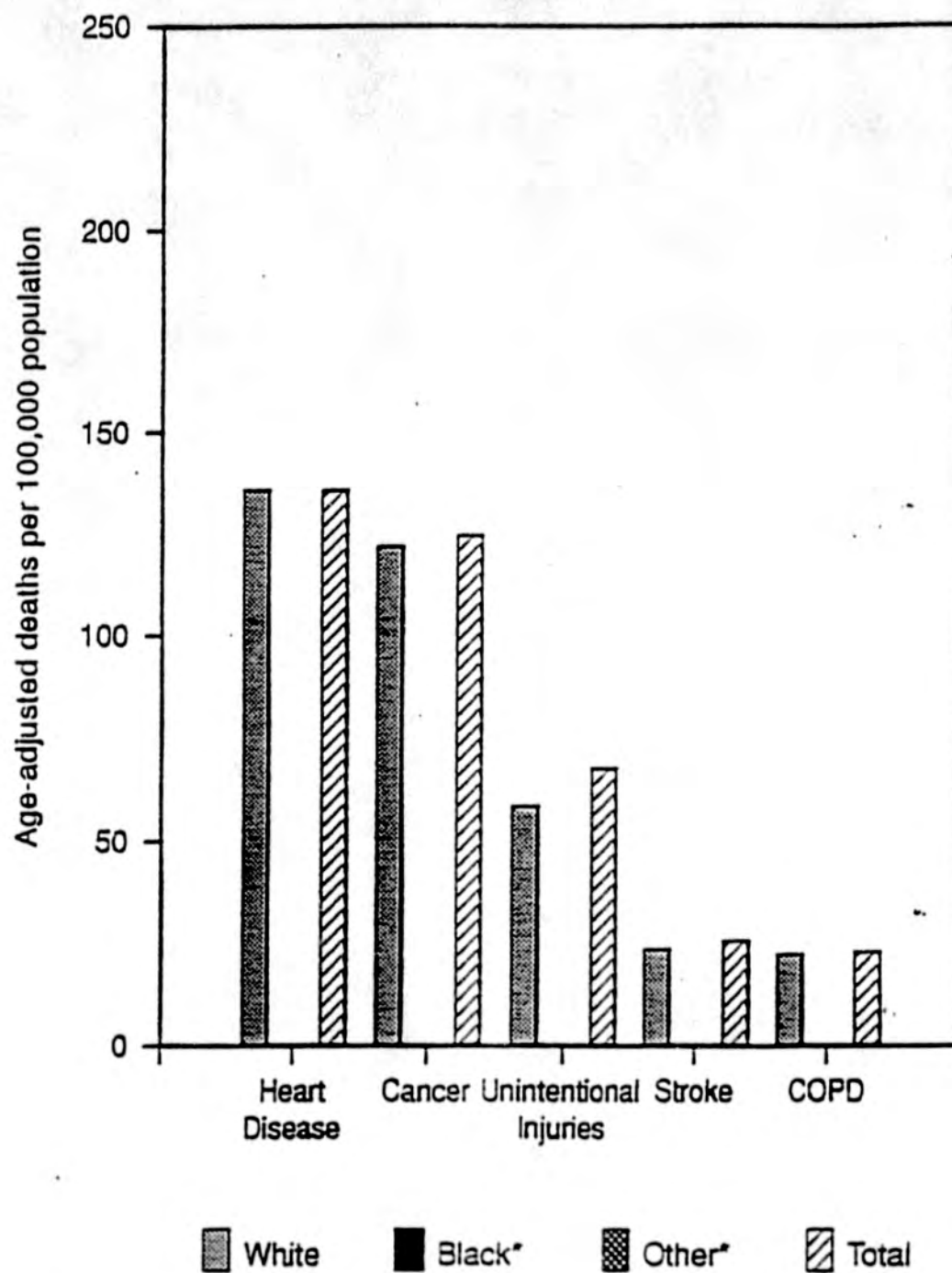
Leading Causes of Years of
Potential Life Lost (YPLL) Before Age 65
Alaska and United States
1989



Source: "Alaska Health Profile, 1992", Centers for Disease Control,
U.S. Dept. of Health and Human Services

CDC

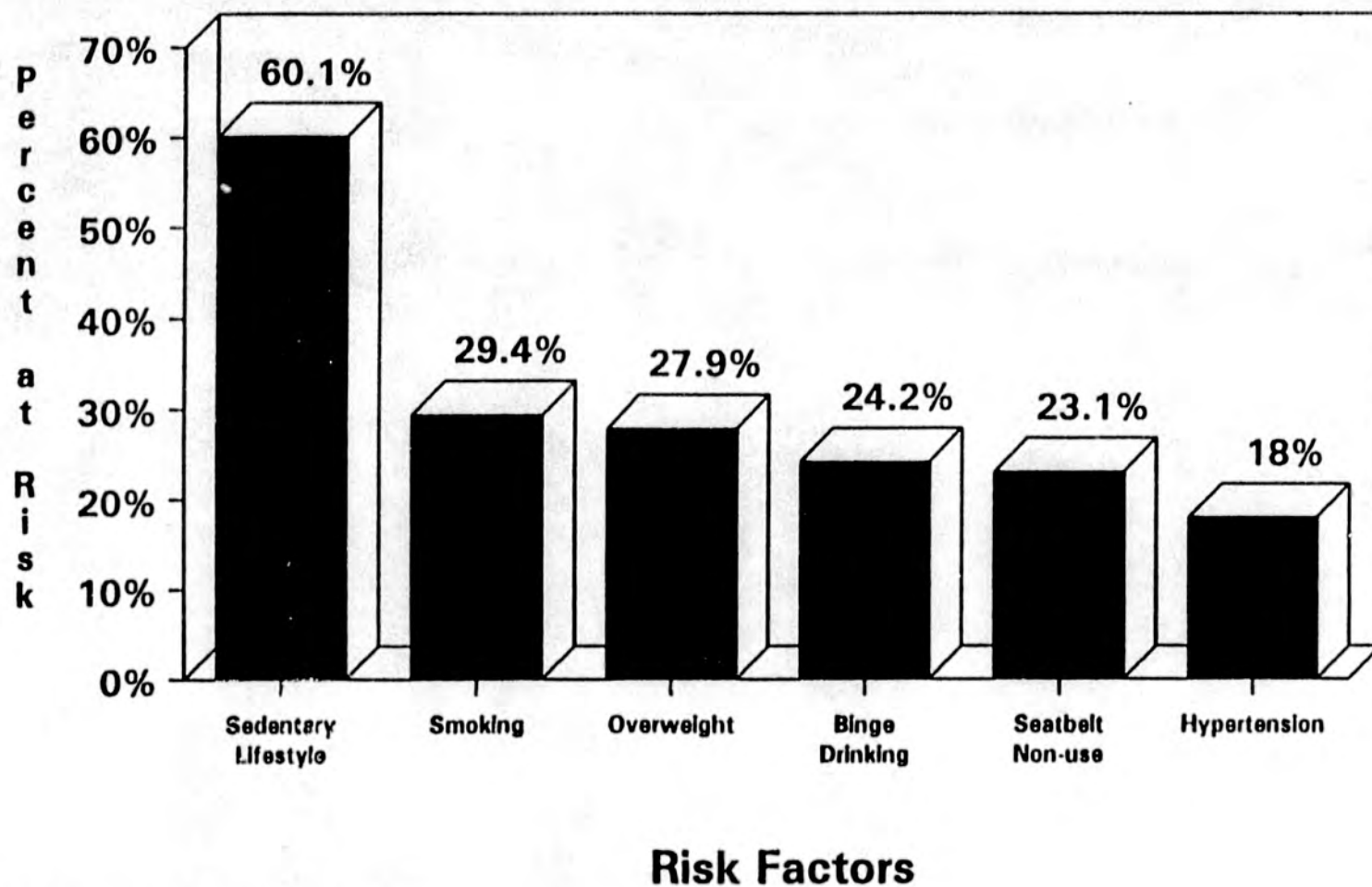
Leading Causes of Death Alaska 1987-1989



*See Appendix.

CDC

Prevalence of Behavioral Risk Factors Alaska 1990



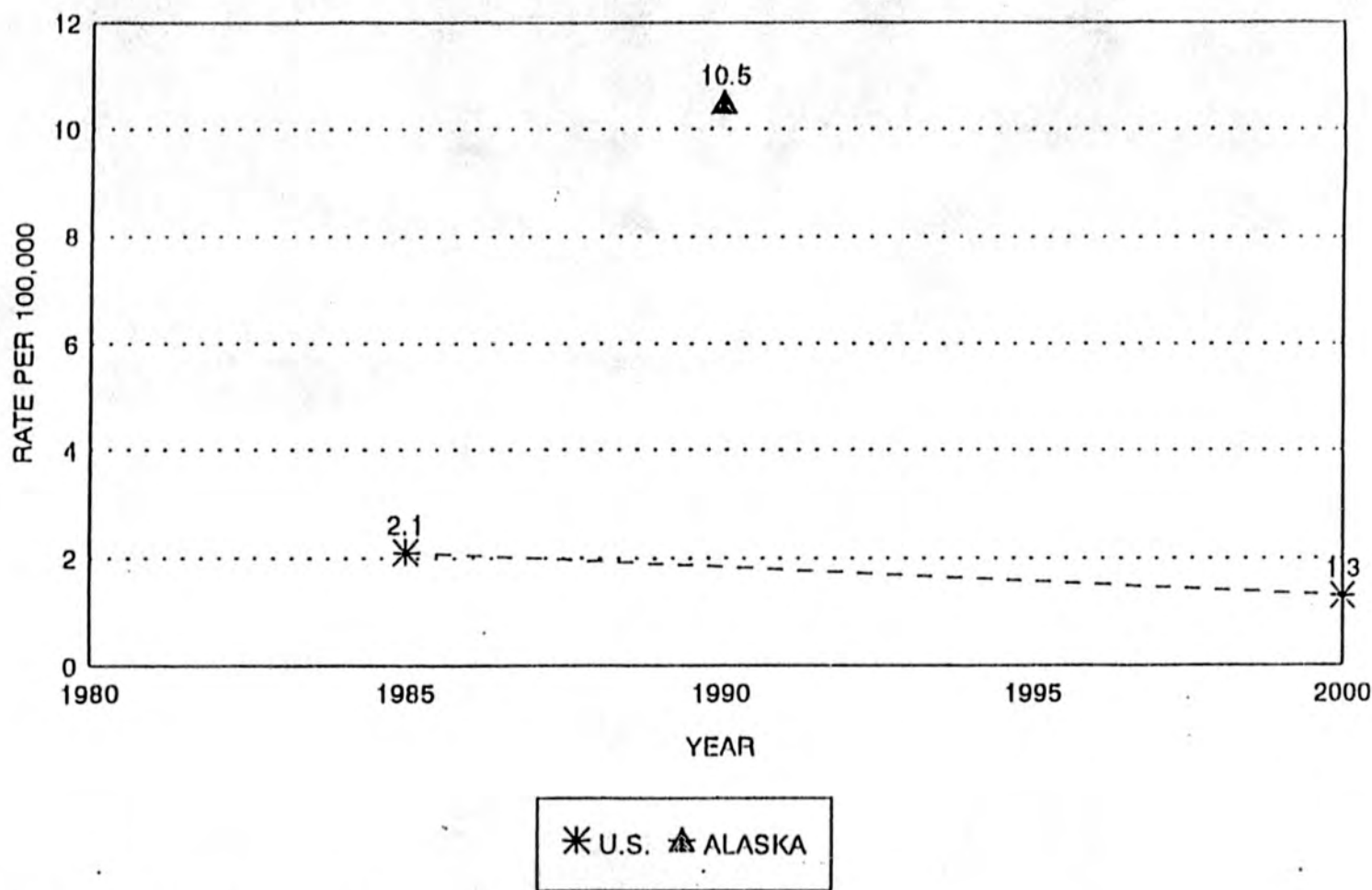
BRFSS 1990 Point in Time Survey

UNINTENTIONAL INJURIES

9.5 Reduce Death Rate From Drowning

F-10

Assessment and analysis identifies and quantifies the magnitude of a problem. Policy development allows the targeting of resources and technology to the causes of the problem to affect measured changes. A sample year 2000 objectives table is enclosed to demonstrate the use of data in achieving health objectives.



U.S. data 1987; Alaska 1990; all rates are age-adjusted
Alaska Bureau of Vital Statistics

TABLE II.

The Economics of Prevention

This table demonstrates the impact of public health practice. These are presented only as a sampling of the numerous interventions that positively impact on the nation's health care expenditures.

Condition	Overall Magnitude	Avoidable intervention (1)	Cost per patient (2)
Heart disease	7 million with coronary artery disease 500,000 deaths/yr 284,000 bypass procedures/yr	Coronary bypass surgery	\$30,000
Cancer	1 million new cases/yr 510,000 deaths/yr	Lung cancer treatment	\$29,000
		Cervical cancer treatment	\$28,000
Stroke	600,000 strokes/yr 150,000 deaths/yr	Hemiplegia treatment and rehabilitation	\$22,000
Injuries	2.3 million hospitalizations/yr 142,500 deaths/yr 177,000 persons with spinal cord injuries in the United States	Quadriplegia treatment and rehabilitation	\$570,000 (lifetime)
		Hip fracture treatment and rehabilitation	\$40,000
		Severe head injury treatment and rehabilitation	\$310,000
HIV Infection	1-1.5 million infected 118,000 AIDS cases (as of Jan 1990)	AIDS treatment	\$75,000 (lifetime)
Alcoholism	18.5 million abuse alcohol 105,000 alcohol-related deaths/yr	Liver transplant	\$250,000
Drug abuse	Regular users: 1-3 million, cocaine 900,000, IV drugs 500,000, heroin Drug-exposed babies: 375,000	Treatment of drug-affected baby	\$63,000 (5 years)
Low birth weight baby	260,000 LBWB born/yr 23,000 deaths/yr	Neonatal intensive care for LBWB	\$10,000
Inadequate immunization	Lacking basic immunization series: 20-30%, aged 2 and younger 3%, aged 6 and older	Congenital rubella syndrome treatment	\$354,000 (lifetime)

(1) Examples (other interventions may apply).
 (2) Representative first-year costs, except as noted. Not indicated are non-medical costs, such as lost productivity to society.

Source: "Healthy People 2000"

Tuberculosis Medical Services

Hospitalization
Bronchoscopy
Pleural biopsy
Gastric lavage
CAT scans
MRI
Surgery
Drug administration
Intensive care
Pulmonary functions testing



Individual
Clinical
Services

**Public Health Services to control
TB and prevent its spread:**

Surveillance
Case reporting
Laboratory services
Provision of drugs
Quarantine
Screening programs
Education and training



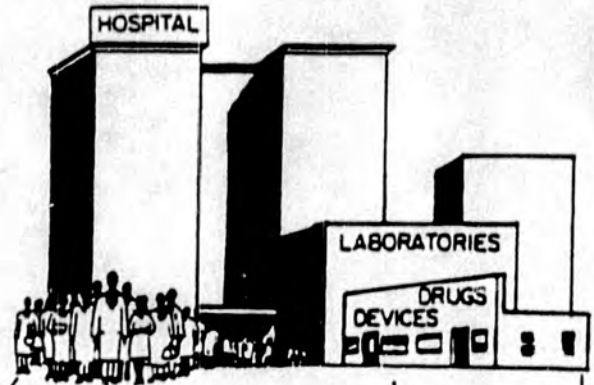
Skin test screening
Epidemiologic investigation
Contact tracing
INH prophylaxis
Directly observed therapy
Expert clinical consultation
Outreach to high risk populations
Quality assurance
Evaluation
Engineering controls for
institutions (corrections, hospitals)



Public Health

AIDS/HIV Medical Treatment

Lung biopsy
AZT
Cancer chemotherapy
Radiation treatment
Pneumocystis carinii pneumonia
Meningitis
Blood transfusion
Sepsis
Parenteral Nutrition
Intravenous antibiotics
Platelet transfusions
Kidney dialysis



Individual
Patient

Counseling and testing
Contact tracing
Education and training
HIV testing
Surveillance
Reporting
Policy development
Surveys
Legal expertise
Laboratory capacity
Access to treatment

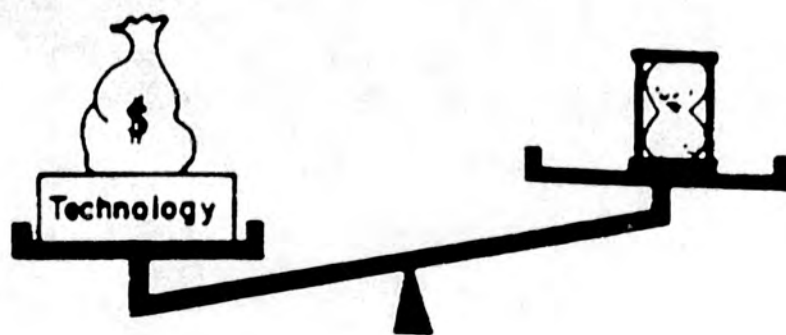


Prevention
Risk reduction
Behavior changes



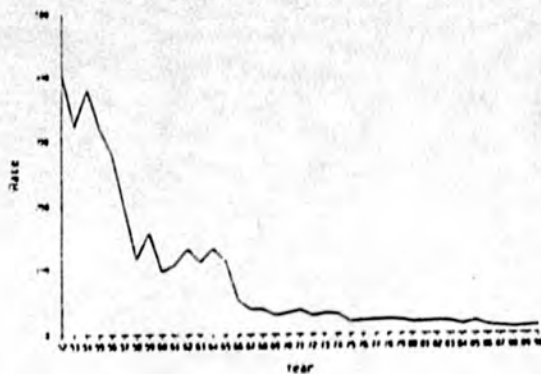
Public Health

Questionable Investment

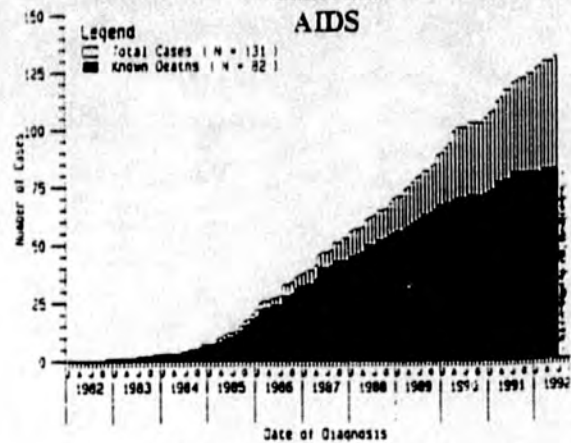


1. Excessive cost vs.
limited life expectancy
2. Sophisticated technology vs.
poor prognosis

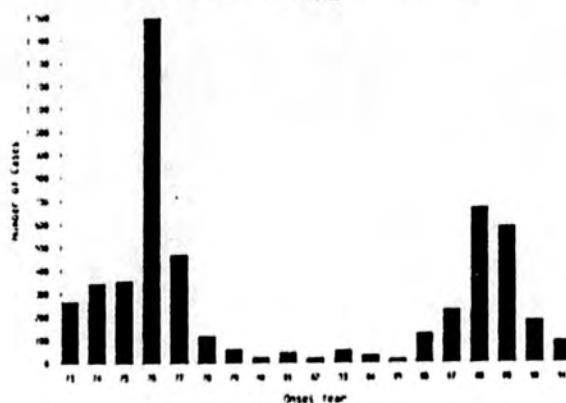
Annual Tuberculosis Case Rates, Alaska, 1952-90
(Rate per 100,000 population)



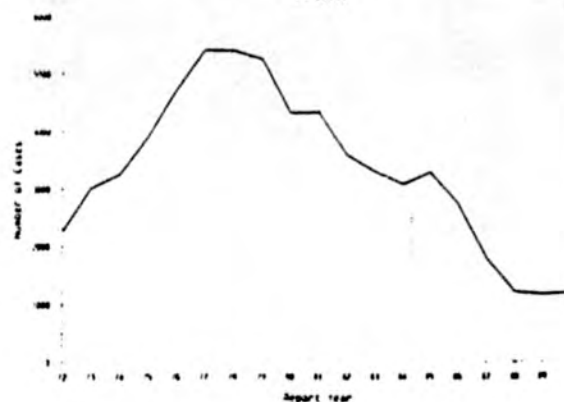
Cumulative Cases
AIDS



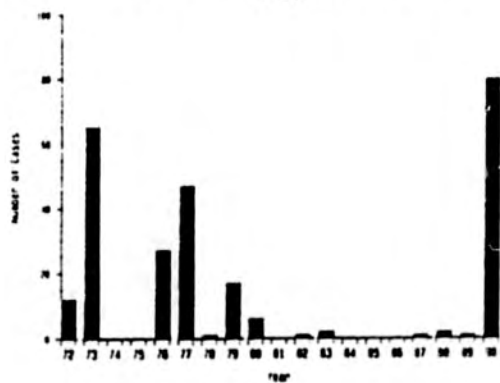
Hepatitis A, Alaska, Onset 1973 - 1991
N = 5185



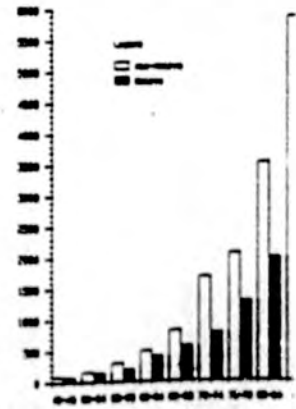
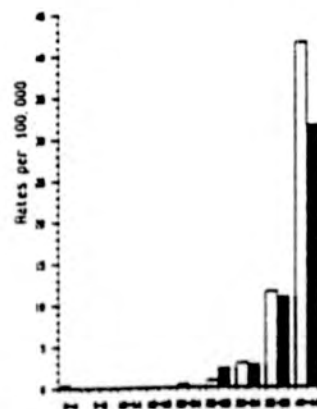
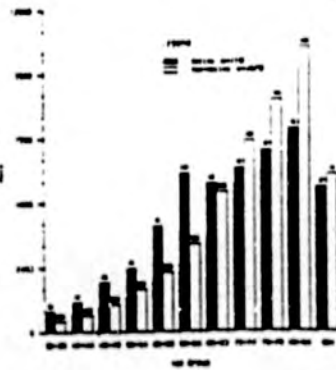
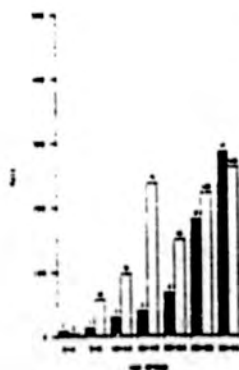
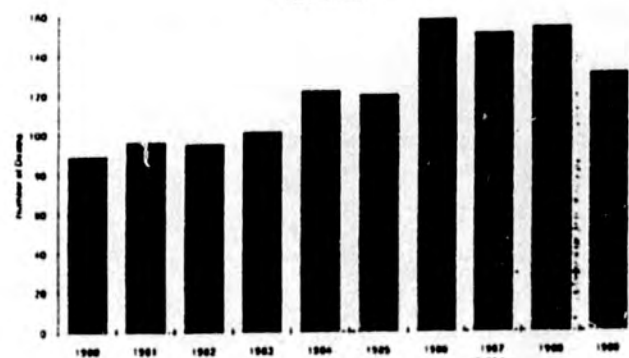
Gonorrhea in Alaska, 1972 - 1990
N = 61,711



Measles in Alaska, January 1972 - June 1990
N = 262



Tobacco Abuse and Lung Cancer Mortality
Alaska 1980-1989



Diabetes prevalence in Alaska, 1984-1986. Rates per 100,000: N = 1,719

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FIGURE 1-Cardiovascular Deaths in Alaska 1980-89 (average annual rate and 1988-89 rate by age group and sex)

Department of Health and Social Services FY 1992 Authorized and FY 1993 Gov Budget Requests

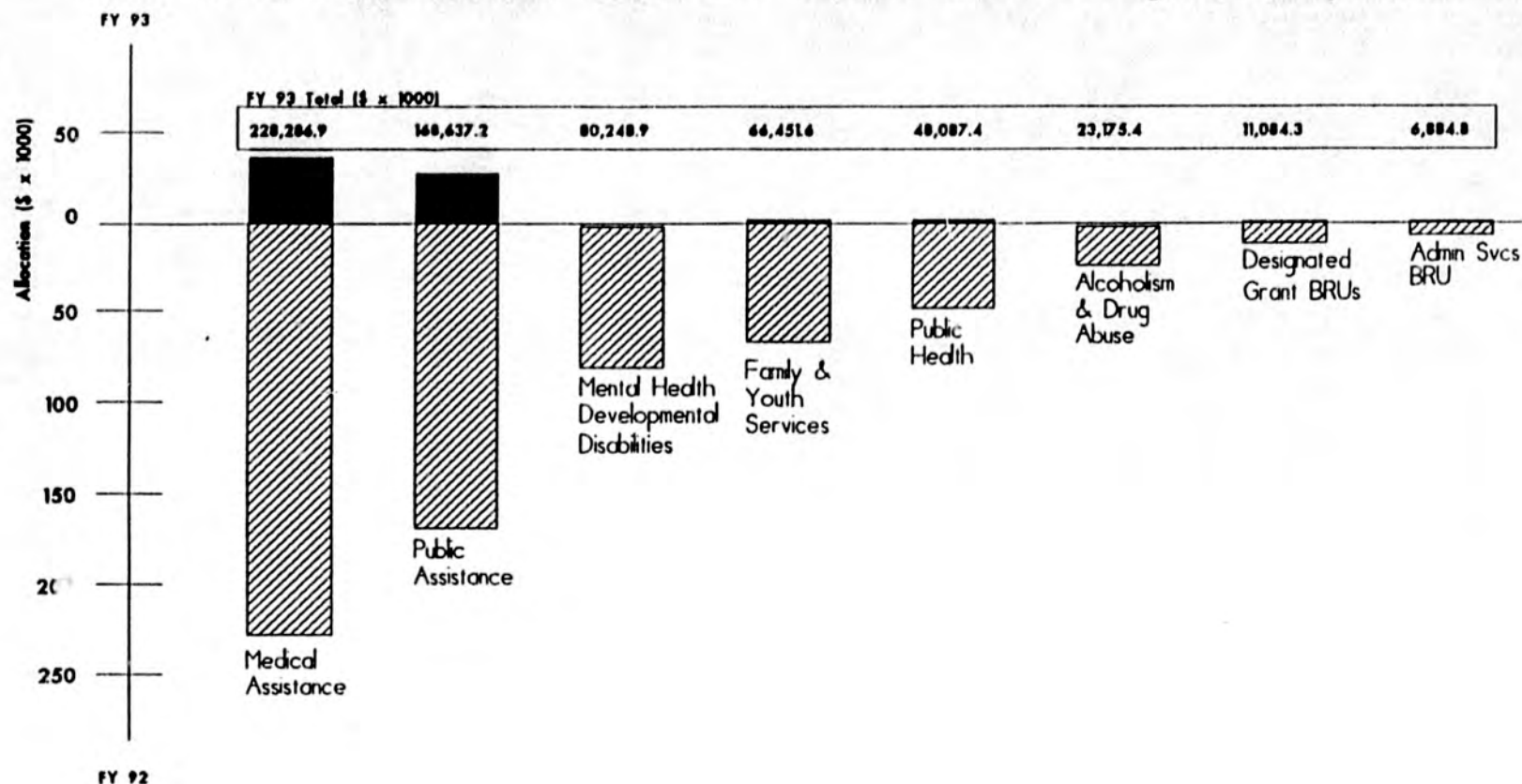


Table demonstrates allocation of DHSS funds and growth trends

LUNG CANCER

ALASKA

NUMBER OF CASES

1950

1980

1988

6

85

143

LUNG CANCER

TOBACCO DEPENDENCE

	<u>1950</u>	<u>1980-1989</u>
<u>Native</u>		
Lung Cancer	1	244
Tobacco	0	48
 <u>Total Population</u>		
Lung Cancer	6	1,176
Tobacco	0	267

"I'm sure they pick up whatever is around them - whether it's natural or man-caused, I don't know," he said.

hunting upon which many of our Native communities are dependent. Careful review and analysis of the data by the State Epidemiologist was able to demonstrate that the data and conclusion were in error. This resulted in the subsequent preservation of a traditional and necessary food source. I have shared this anecdote to demonstrate

just one example of the critical impact of public health practice on health, economics, and social/cultural ways of Alaskans.

III. PUBLIC HEALTH STATUS AND TRENDS IN ALASKA

The picture of public health and the public health system in Alaska often defies logic. What we see at any one moment in time is not the product of a long-range strategic plan, but the result of a number of variable influences. These variables include the available resources, manpower and technology, as well as changing disease patterns, national interests, the force of law and the significant influence of political bias.

1. Mortality and Morbidity

M&M I. Inadequate Prenatal Care Summary 1987-91

M&M II. Infant Mortality Rate Smoking/Drinking Mothers

M&M III. Mean Birthrate by Race of Mother/Risk Factors

2. Budget The overall authorized budget for the Division of Public Health has increased from 25 million dollars in 1982 to 52.5 million dollars in 1992. The budget adjusted to the consumer price index to show the true purchasing power reflects an adjusted budget in 1992 to be \$41 million. The non G.F. (federal and program income) changed from 3.8 million in 1982 to 16.57 million in 1992 and accounted for 1/3 of the total division appropriation.

Overheads: Per Capita Funding History

Appropriations FY 82-93

LG III Budget for the Division of Public Health

— Table III Budget Activities Within the Division of Public Health 1982-1992

Table IV Budget Activities Within the Division of Public Health 1982-1992

Table V Regional BRU Budgets 1982-1992

Table VI Total Division Budget 1982-1992

Budget trends affecting the activities within the Division of Public Health will be covered by sections. A number of significant changes within the Division were accounted for by the shifting of sectional budgets and budget activities between different budget components and between different divisions and departments. An example of this is the transfer of the WIC budget to MCH in 1984 and back to its own budget activity in 1990.

3. Staffing (State Division of Public Health): The numbers of personnel reflected on Tables XI and XII for each component and budget activity often reflect the shifting from one component to another or the addition or loss of some program services. Comments

Birthweight Under 500 g.

YEAR	# of Births Less Than 500G	Maternal Tobacco Use	Maternal Smokeless Tobacco Use	Maternal Alcohol Use	Total Births
1987	5				11681
1988	15				11283
1989	8	2722	387	1250	11652
1990	5	2754	393	1029	11889
1991	15	2684	374	1048	11556
1992*	1	1235	214	448	5228

*1992 data is incomplete

Inadequate Prenatal Care Summary, 1987-1991, Whites Only

YEAR	No Prenatal Care	Percent of Total White Births	Inadequate Prenatal Care **	Percent of Total White Births	Total White Births
1987	56	.68%	624	7.62%	8192
1988	65	.85%	522	6.79%	7690
1989	45	.57%	419	5.29%	7926
1990	61	.76%	470	5.83%	8066
1991	81	1.04%	385	4.96%	7761

Inadequate Prenatal Care Summary, 1987-1991, Natives Only

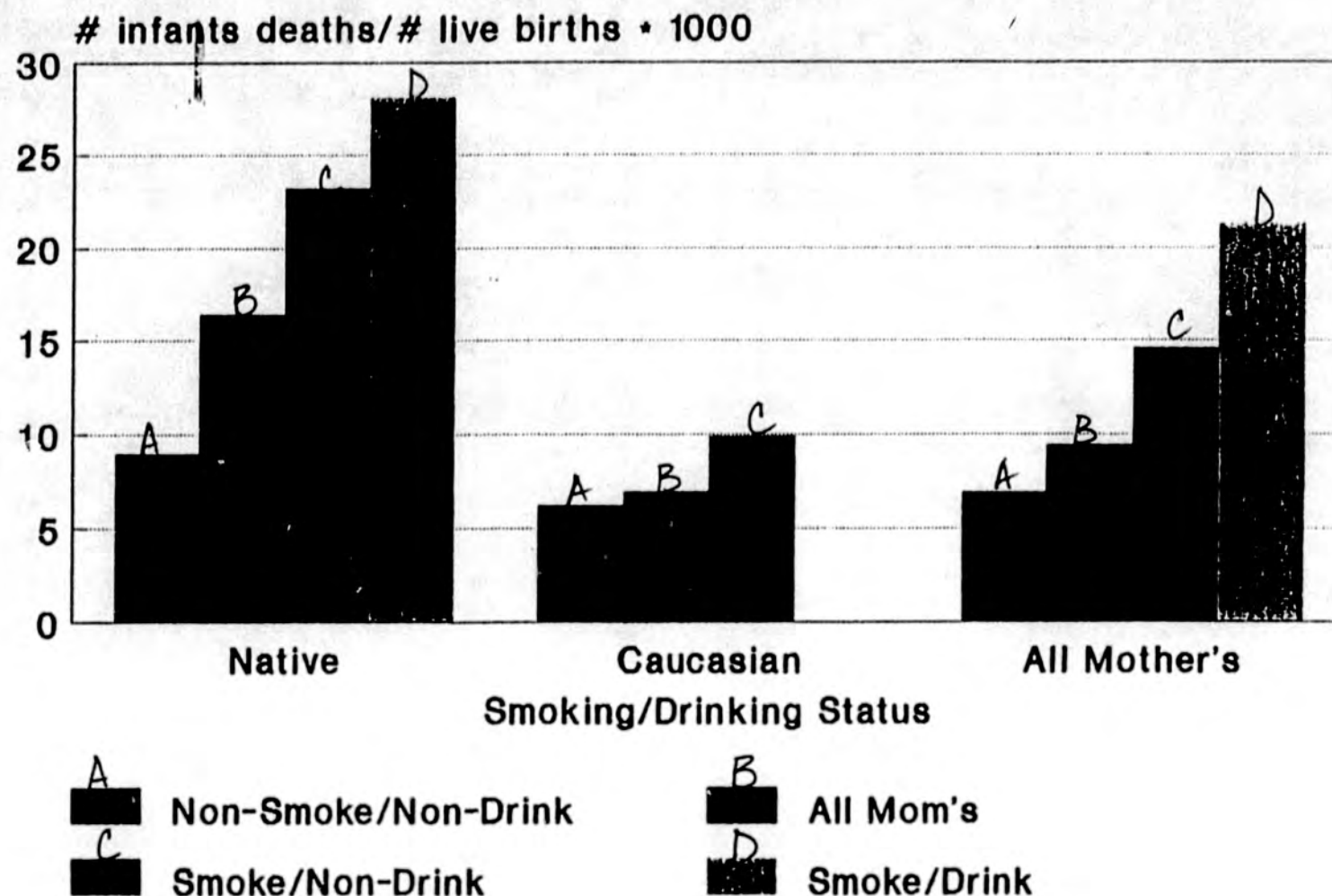
YEAR	No Prenatal Care	Percent of Total Native Births	Inadequate Prenatal Care **	Percent of Total Native Births	Total Native Births
1987	34	1.33%	480	18.75%	2560
1988	33	1.25%	425	16.05%	2648
1989	30	1.09%	345	12.59%	2740
1990	44	1.56%	365	12.94%	2820
1991	45	1.62%	357	12.87%	2773

** Inadequate Prenatal Care includes those mothers who reported receiving no prenatal care, as well as those mothers who did not report receiving prenatal care.

1990 & 1991 data is provisional at this time.

Race has been determined using the mothers race.

Infant Mortality Rate (ID Rate) from Live Births to Alaskan Mom's



1989-1990 birth certificates

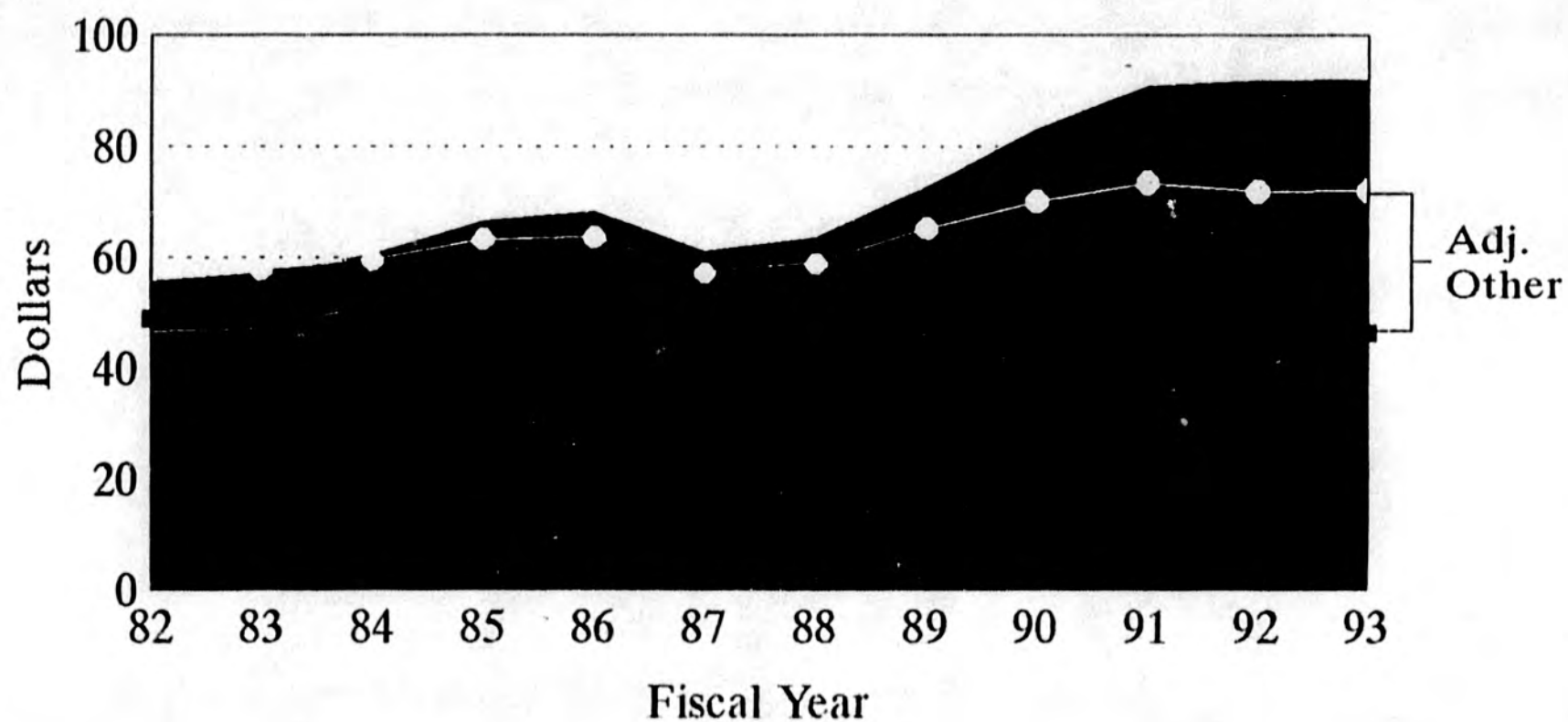
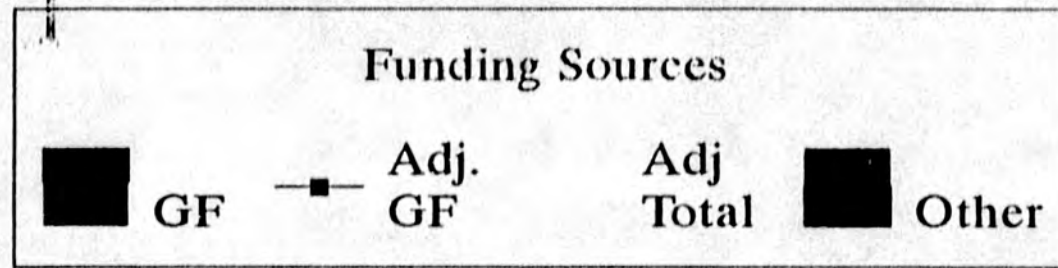
MEAN BIRTHWEIGHT BY RACE OF MOTHER
AND RISK FACTORS
(1989-1990)

F-23

	ALL		CAUCASIAN		NATIVE		OTHER	
	NUMBER OF BIRTHS	MEAN BIRTHWEIGHT (GRAMS)	NUMBER OF BIRTHS	MEAN BIRTHWEIGHT (GRAMS)	NUMBER OF BIRTHS	MEAN BIRTHWEIGHT (GRAMS)	NUMBER OF BIRTHS	MEAN BIRTHWEIGHT (GRAMS)
NON-SMOKER, NON-DRINKER	17166	3518	12440	3533	3001	3581	1725	3298
SMOKER, NON-DRINKER	4168	3312	2516	3278	1465	3400	187	3068
DRINKER, NON-SMOKER	963	3514	573	3570	355	3434	35	3399
SMOKER, DRINKER	1317	3227	514	3220	748	3249	55	2984

Division of Public Health

Per Capita Funding History



DIVISION OF PUBLIC HEALTH
Funding History

	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
Total Funding	\$24,542,800	\$26,339,300	\$30,218,000	\$34,799,800	\$36,975,100	\$33,517,600	\$34,252,200	\$38,848,600	\$44,525,800	\$50,092,600	\$52,448,800	\$52,572,100
Inflation Adjusted	\$25,638,090	\$26,561,714	\$29,335,822	\$32,830,000	\$34,236,204	\$31,082,593	\$31,424,037	\$34,505,893	\$37,416,471	\$40,397,258	\$40,974,063	\$41,071,853
Per Capita \$	\$55.30	\$56.84	\$60.72	\$66.67	\$68.31	\$61.26	\$63.69	\$72.78	\$83.32	\$91.07	\$91.96	\$92.18
Adjusted PC\$	\$57.77	\$57.30	\$58.05	\$62.89	\$63.25	\$58.72	\$58.43	\$64.98	\$70.02	\$73.44	\$71.85	\$72.02
GF Funding	\$20,747,700	\$21,864,000	\$25,847,100	\$27,871,500	\$29,345,600	\$25,712,100	\$26,428,800	\$29,485,600	\$32,341,500	\$34,396,800	\$35,875,900	\$33,900,400
Adj. GF Funding	\$21,741,889	\$22,060,484	\$24,900,097	\$26,293,868	\$27,171,852	\$23,807,500	\$24,246,422	\$26,326,429	\$27,177,731	\$27,739,355	\$28,026,047	\$26,484,688
Per Capita GF	\$46.75	\$47.22	\$51.54	\$53.39	\$54.21	\$48.95	\$49.14	\$55.53	\$60.52	\$62.53	\$62.81	\$58.44
Adjusted PC GF	\$48.99	\$47.61	\$50.04	\$50.37	\$50.20	\$43.48	\$45.08	\$49.58	\$50.86	\$50.43	\$49.15	\$46.44
Other Funding	\$3,794,900	\$4,455,300	\$4,568,900	\$6,928,300	\$7,629,500	\$7,835,500	\$7,823,800	\$9,161,000	\$12,184,100	\$15,695,800	\$16,570,900	\$18,671,700
Adjusted Other\$	\$3,896,201	\$4,491,230	\$4,435,825	\$6,536,132	\$7,064,352	\$7,255,093	\$7,177,615	\$8,179,464	\$10,236,740	\$12,657,903	\$12,946,016	\$14,587,265
Per Capita Other	\$8.55	\$9.61	\$8.18	\$13.27	\$14.09	\$14.31	\$14.55	\$17.25	\$22.80	\$26.54	\$29.06	\$32.74
Adjusted PC Other	\$8.78	\$9.69	\$8.91	\$12.52	\$13.05	\$13.25	\$13.35	\$15.40	\$19.16	\$23.01	\$22.70	\$25.58

Year	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992
Population*	443,800	463,400	497,600	522,000	541,300	547,600	537,800	531,000	534,400	550,043	570,300	570,300

* Population figures are from the Department of Labor for 1981 through 91, the 1992 population is not adjusted.

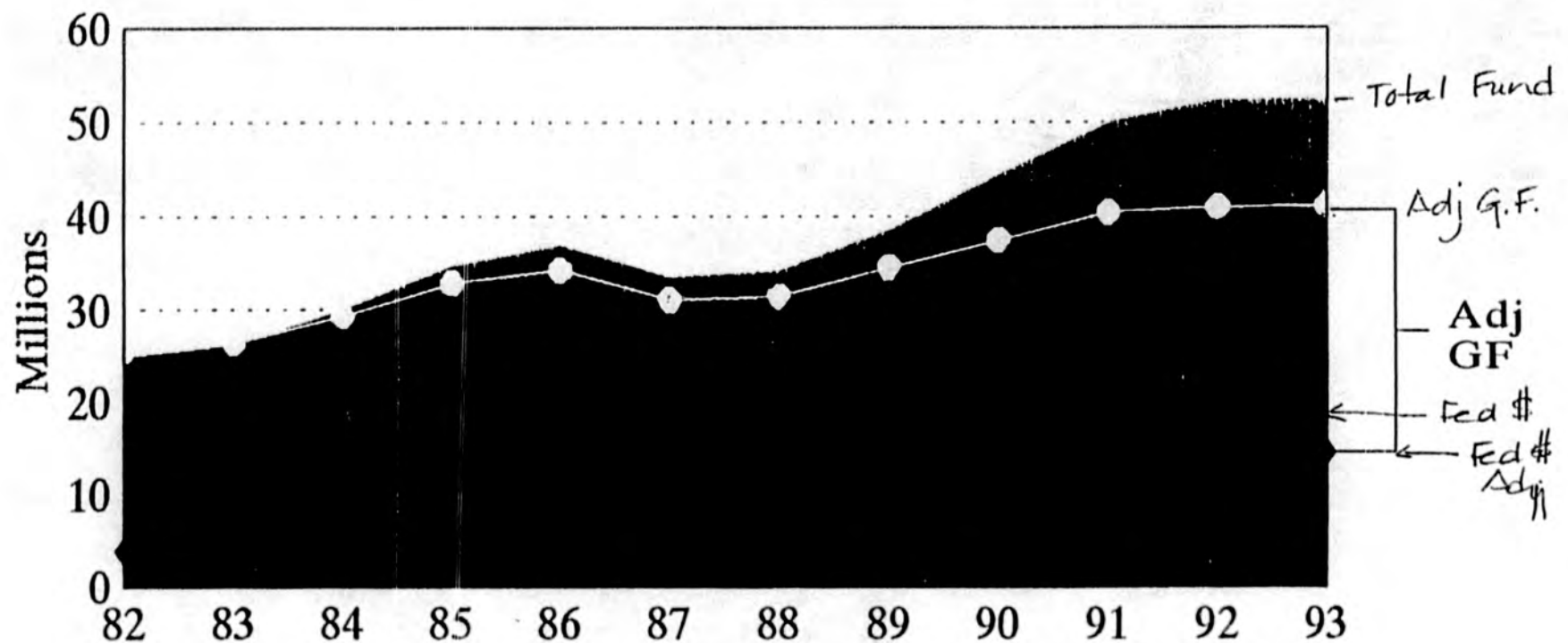
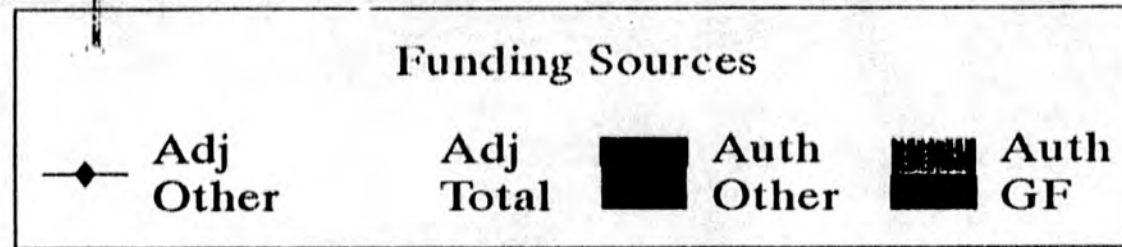
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Division of Public Health

Appropriations FY82-93

Adjustments made using Anchorage Consumer Price Index to show Real Purchasing Power



FY92 CPI used to calculate FY93 adjusted figures

Division of Public Health
Appropriations FY82-92

Nursing	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92*	FY 93*
GF	4,469,000	5,131,000	6,910,300	7,035,500	6,939,900	6,462,700	7,664,000	6,703,100	10,601,900	11,104,300	11,103,900	9,043,000
Other	1,359,100	1,270,000	1,209,000	1,375,500	1,608,300	1,732,100	1,632,100	1,567,700	1,999,500	2,260,400	2,257,700	2,264,100
TOTAL	5,828,100	6,401,000	8,125,300	8,411,000	8,548,200	8,194,800	9,296,100	10,270,800	12,601,400	13,364,700	13,361,600	11,307,100

WIC	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92*	FY 93*
GF	94,000	105,600							707,900	1,107,900	1,107,600	1,567,600
Other	1,039	1,429							5,033	6,561	6,942	7,786,700
TOTAL	1,132,900	1,534,600	N/A	N/A	N/A	N/A	N/A	N/A	5,741,100	7,669,900	8,049,300	9,354,300

Maternal, Child and Family Health	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92*	FY 93*
GF	3,294,100	3,870,000	3,494,400	3,474,800	3,226,300	2,806,900	2,765,400	3,581,900	4,093,900	4,235,100	4,036,200	3,628,100
Other	1,008,800	1,155,300	2,800,500	4,025,000	4,346,300	4,246,100	4,496,100	5,092,900	1,816,200	2,321,000	2,001,300	2,106,400
TOTAL	4,302,900	5,025,300	6,294,900	7,499,800	7,572,600	7,053,000	7,261,500	8,674,800	5,910,100	6,556,100	6,037,500	5,734,500

LABS	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92*	FY 93*
GF	1,468,800	1,666,200	2,053,200	2,215,800	2,199,000	1,903,600	2,215,200	2,214,800	2,113,400	2,144,200	2,178,600	2,173,200
Other	84,500	42,100	40,000	58,800	41,000	211,000	2,000	0	60,000	100,000	90,000	379,000
TOTAL	1,553,300	1,708,300	2,093,200	2,274,600	2,240,000	2,114,600	2,217,200	2,214,800	2,173,400	2,244,200	2,268,600	2,552,200

Administration	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92*	FY 93*
GF	2,914,400	3,120,400	1,795,400	1,512,500	1,447,100	1,184,900	654,000	795,600	518,900	625,500	900,300	565,200
Other	94,200	96,100	296,000	731,000	443,400	105,300	105,300	93,900	96,300	699,800	1,137,300	982,000
TOTAL	3,008,600	3,216,500	2,091,400	2,243,500	1,890,500	1,290,200	759,300	889,500	615,200	1,325,300	2,037,600	1,547,200

Epidemiology	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92*	FY 93*
GF	1,294,200	1,425,400	2,052,600	2,125,500	2,770,600	1,888,300	1,735,700	1,878,100	1,963,400	1,993,600	1,993,600	2,164,000
Other	149,400	62,900	163,400	265,700	673,200	655,500	857,000	620,600	858,000	977,600	1,443,500	2,409,700
TOTAL	1,443,600	1,488,300	2,216,000	2,391,200	3,443,800	2,543,800	2,592,700	2,498,700	2,821,400	2,971,200	3,437,100	4,573,700

Emergency Medical Services Training and Licensing	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92*	FY 93*
GF							375,600	400,100	407,600	424,700	452,100	433,600
Other							0	28,200	228,700	557,700	566,600	360,800
TOTAL	N/A	N/A	N/A	N/A	N/A	N/A	375,600	428,300	636,300	982,400	1,018,700	794,400

Bureau of Vital Statistics	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92*	FY 93*
GF	384,300	415,400	422,000	359,900	345,900	286,700	441,100	710,200	721,700	732,700	749,000	696,200
Other	0	0	0	65,000	100,000	154,400	0	101,000	105,400	200,400	409,200	432,000
TOTAL	384,300	415,400	422,000	424,900	445,900	441,100	441,100	811,200	827,100	933,100	1,158,200	1,128,200

Post Mortem	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92*	FY 93*
GF				711,500	618,300	753,900	463,400	600,000	463,400	750,000	696,000	696,000
Other	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	N/A	N/A	N/A	711,500	618,300	753,900	463,400	600,000	463,400	750,000	696,000	696,000

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Infant Learning Program Grants

GF	1,395,800	1,253,100	1,760,300	1,636,200	2,011,200	1,742,200	1,991,100	2,156,100	2,436,100	3,136,100	4,736,100	4,736,100
Other	60,000	60,000	60,000	330,700	330,700	330,700	330,700	330,700	330,700	330,700	330,700	330,700
TOTAL	1,455,800	1,313,100	1,820,300	1,966,900	2,341,900	2,072,900	2,321,800	2,486,800	2,766,800	3,466,800	5,066,800	5,066,800

Community Health Grants

GF	4,284,100	3,331,400	4,131,600	4,000,800	4,272,600	4,023,200	3,055,300	1,884,800	1,744,600	1,328,700	1,258,100	1,258,100
Other	0	0	0	0	0	0	0	0	0	0	313,800	313,800
TOTAL	4,284,100	3,331,400	4,131,600	4,000,800	4,272,600	4,023,200	3,055,300	1,884,800	1,744,600	1,328,700	1,571,900	1,571,900

Emergency Medical Services Grants

GF			1,500,400	1,713,100	1,843,400	1,711,900	1,674,100	1,703,000	1,702,100	1,702,100	1,599,500	1,559,500
Other			0	0	0	0	0	0	0	0	0	0
TOTAL	N/A	N/A	1,500,400	1,713,100	1,843,400	1,711,900	1,674,100	1,703,000	1,702,100	1,702,100	1,599,500	1,559,500

Health Promotion

GF	155,900	164,000				0	0	0	0	0	0	0
Other	0	339,900	0	0	0	313,800	313,800	313,800	313,900	313,800	0	0
TOTAL	155,900	503,900	N/A	N/A	N/A	313,800	313,800	313,800	313,900	313,800	0	0

AIDS Program

GF							498,000	498,000	506,700	504,700	392,200	0
Other					0	0	0	720,000	1,000,000	1,011,200	1,079,100	0
TOTAL	N/A	N/A	N/A	N/A	N/A	N/A	498,000	1,218,000	1,506,700	1,515,900	1,471,300	0

Teen Pregnancy

GF											107,800	0
Other											0	0
TOTAL	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	107,800	0

Manilaq Public Health

GF	993,100	958,500	1,520,900	879,600	850,400	698,600	690,500	793,200	793,200	924,100	873,400	931,600
Other	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	993,100	958,500	1,520,900	879,600	850,400	698,600	690,500	793,200	793,200	924,100	873,400	931,600

Manilaq Senior Center

GF				934,100	972,800	809,100	868,300	868,300	868,300	1,014,700	814,800	0
Other				0	0	0	0	0	0	0	0	0
TOTAL	N/A	N/A	N/A	934,100	972,800	809,100	868,300	868,300	868,300	1,014,700	814,800	0

Norton Sound Health

GF				1,014,500	1,222,500	904,000	917,200	1,071,700	1,071,700	1,126,700	1,219,300	1,175,400
Other				76,600	86,600	86,600	86,600	86,600	86,600	86,600	0	0
TOTAL	N/A	N/A	N/A	1,091,100	1,309,100	990,600	1,003,800	1,158,300	1,158,300	1,213,300	1,219,300	1,175,400

Norton Sound SA

GF				257,700	257,700	214,200	106,000	106,000	106,000	106,000	100,400	100,400
Other				0	0	0	0	0	0	0	0	0
TOTAL	N/A	N/A	N/A	257,700	257,700	214,200	106,000	106,000	106,000	106,000	100,400	100,400

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Tanana Chief Health Corporation												
GF					367,900	321,900	313,700	365,500	365,500	290,500	257,100	257,100
Other					0	0	0	0	0	0	0	0
TOTAL	N/A	N/A	N/A	N/A	367,900	321,900	313,700	365,500	365,500	290,500	257,100	257,100

Yukon-Kuskokwim Health Corporation												
GF								1,018,900	1,018,900	1,018,900	965,300	965,300
Other								85,100	135,100	135,100	0	0
TOTAL	N/A	N/A	N/A	N/A	N/A	N/A	N/A	1,104,000	1,154,000	1,154,000	965,300	965,300

South East Area Regional Health Corporation												
GF								136,300	136,300	136,300	129,100	129,100
Other								120,500	120,500	140,500	0	0
TOTAL	N/A	N/A	N/A	N/A	N/A	N/A	N/A	256,800	256,800	276,800	129,100	129,100

Medical Services Unit												
GF	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	1,202,400
TOTAL	0	0	0	0	0	0	0	0	0	0	0	1,202,400

Home Health												
GF	428,900	442,400	0	0	0	0	0	0	0	0	0	1,820,900
Other	0	0	0	0	0	0	0	0	0	0	0	104,100
TOTAL	428,900	442,400	0	0	0	0	0	0	0	0	0	1,925,000

Division of Public Health												
GF	21,176,600	21,884,000	25,647,100	27,871,500	29,345,600	25,712,100	26,428,600	29,485,600	32,341,500	34,396,800	35,875,900	33,900,400
Other	3,794,900	4,455,300	4,568,900	6,928,300	7,629,500	7,835,500	7,823,600	9,161,000	12,184,100	15,695,800	16,570,900	18,671,700
TOTAL	24,971,500	26,339,300	30,216,000	34,799,800	36,975,100	33,547,600	34,252,200	38,646,600	44,525,600	50,092,600	52,446,800	52,572,100

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Division of Public Health
Appropriations Adjusted by the Anchorage Consumer Price Index FY82-92 (Real Purchasing Power)

Nursing	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93*
GF	4,588,296	5,172,884	6,714,854	6,637,264	6,425,833	5,903,981	7,031,193	7,770,625	8,909,160	8,955,081	8,674,922	7,064,044
Other	1,395,380	1,280,242	1,173,786	1,297,642	1,489,167	1,603,796	1,497,339	1,399,732	1,680,252	1,822,903	1,763,828	1,768,828
TOTAL	5,983,676	6,453,126	7,888,641	7,934,906	7,915,000	7,587,778	8,528,532	9,170,357	10,589,412	10,777,984	10,438,750	8,833,672

WIC	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93*
GF	96,509	106,452							594,874	893,468	865,313	1,224,688
Other	1,067	1,441							4,230	5,291	5,423	6,083,359
TOTAL	1,163,142	1,546,976	N/A	N/A	N/A	N/A	N/A	N/A	4,824,454	6,184,597	6,288,516	7,308,047

Maternal, Child and Family Health	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93*
GF	3,382,033	3,901,210	3,392,621	3,278,113	2,987,315	2,598,981	2,537,064	3,198,125	3,440,252	3,415,403	3,153,281	2,834,453
Other	1,035,729	1,164,617	2,716,932	3,797,170	4,024,352	3,931,574	4,124,862	4,547,232	1,526,218	1,871,774	1,563,516	1,645,625
TOTAL	4,417,762	5,065,827	6,111,553	7,075,283	7,011,667	6,530,556	6,661,927	7,745,357	4,966,471	5,287,177	4,716,797	4,480,078

LABS	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93*
GF	1,508,008	1,679,637	1,993,398	2,090,377	2,036,111	1,762,593	2,032,294	1,977,500	1,775,966	1,729,194	1,702,031	1,697,813
Other	86,756	42,440	38,835	55,472	37,963	195,370	1,835	0	50,420	80,645	70,313	296,094
TOTAL	1,594,764	1,722,077	2,032,233	2,145,849	2,074,074	1,957,963	2,034,128	1,977,500	1,826,387	1,809,839	1,772,344	1,993,906

Administration	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93*
GF	2,992,197	3,145,565	1,743,107	1,426,887	1,339,907	1,097,130	600,000	710,357	436,050	504,435	703,359	441,563
Other	96,715	98,875	287,379	609,623	410,556	97,500	98,606	83,839	80,924	564,355	888,516	767,188
TOTAL	3,088,912	3,244,440	2,030,485	2,116,509	1,750,463	1,194,630	698,606	794,196	516,975	1,068,790	1,591,875	1,208,750

Epidemiology	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93*
GF	1,328,747	1,436,895	1,992,816	2,005,189	2,565,370	1,748,426	1,592,385	1,676,875	1,649,916	1,607,742	1,718,047	1,690,625
Other	153,388	63,407	158,641	250,660	623,333	606,944	786,239	554,107	721,008	788,387	1,127,734	1,882,578
TOTAL	1,482,136	1,500,302	2,151,456	2,255,849	3,188,704	2,355,370	2,378,624	2,230,982	2,370,924	2,396,129	2,845,781	3,573,203

Emergency Medical Services Training and Licensing	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93*
GF							344,587	357,232	342,521	342,500	353,203	338,750
Other							0	25,179	192,185	449,758	442,656	281,875
TOTAL	N/A	N/A	N/A	N/A	N/A	N/A	344,587	382,411	534,706	792,258	795,859	620,625

Bureau of Vital Statistics	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93*
GF	394,559	418,750	409,709	339,528	320,278	265,463	404,679	634,107	606,471	590,887	585,156	543,906
Other	0	0	0	61,321	92,593	142,963	0	90,179	88,571	161,613	319,688	337,500
TOTAL	394,559	418,750	409,709	400,849	412,870	408,426	404,679	724,286	695,042	752,500	904,844	881,406

Post Mortem	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93*
GF				671,226	572,500	698,056	425,138	535,714	389,412	604,839	543,750	543,750
Other				0	0	0	0	0	0	0	0	0
TOTAL	N/A	N/A	N/A	671,226	572,500	698,056	425,138	535,714	389,412	604,839	543,750	543,750

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Infant Learning Program - Grants

GF	1,433,060	1,263,206	1,709,029	1,543,585	1,862,222	1,613,148	1,826,697	1,925,089	2,047,143	2,529,113	3,700,078	3,700,078
Other	61,602	60,484	58,252	311,981	306,204	306,204	303,394	295,268	277,899	266,694	258,359	258,359
TOTAL	1,494,661	1,323,690	1,767,282	1,855,566	2,168,426	1,919,352	2,130,091	2,220,357	2,325,042	2,795,806	3,958,438	3,958,438

Community Health Grants

GF	4,398,460	3,358,266	4,011,262	3,774,340	3,956,111	3,725,185	2,803,028	1,682,857	1,466,050	1,071,532	982,891	982,891
Other	0	0	0	0	0	0	0	0	0	0	245,156	245,156
TOTAL	4,398,460	3,358,266	4,011,262	3,774,340	3,956,111	3,725,185	2,803,028	1,682,857	1,466,050	1,071,532	1,228,047	1,228,047

Emergency Medical Service Grants

GF			1,456,699	1,616,132	1,706,852	1,585,093	1,535,872	1,520,536	1,430,336	1,372,661	1,249,609	1,218,359
Other			0	0	0	0	0	0	0	0	0	0
TOTAL	N/A	N/A	1,456,699	1,616,132	1,706,852	1,585,093	1,535,872	1,520,536	1,430,336	1,372,661	1,249,609	1,218,359

Health Promotion

GF	160,062	165,323				0	0	0	0	0	0	0
Other	0	342,641	0	0	0	290,556	287,890	280,179	263,782	253,065	0	0
TOTAL	160,062	507,964	N/A	N/A	N/A	290,556	287,890	280,179	263,782	253,065	0	0

AIDS Program

GF							456,881	444,643	425,798	407,016	306,406	0
Other					0	0	0	642,857	840,336	815,484	843,047	0
TOTAL	N/A	N/A	N/A	N/A	N/A	N/A	456,881	1,087,500	1,266,134	1,222,500	1,149,453	0

Teen Pregnancy

GF											14,219	0
Other											0	0
TOTAL	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	84,219	0

Manilaq Public Health

GF	1,019,610	966,230	1,476,602	829,811	787,407	646,852	633,486	708,214	666,555	745,242	682,344	727,813
Other	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	1,019,610	966,230	1,476,602	829,811	787,407	646,852	633,486	708,214	666,555	745,242	682,344	727,813

Manilaq Senior Center

GF				881,226	900,741	749,167	796,606	775,268	729,664	618,306	636,563	0
Other				0	0	0	0	0	0	0	0	0
TOTAL	N/A	N/A	N/A	881,226	900,741	749,167	796,606	775,268	729,664	618,306	636,563	0

Norton Sound Health

GF				957,075	1,131,944	837,037	841,468	956,875	900,588	908,629	952,578	918,281
Other				72,264	80,185	80,185	79,450	77,321	72,773	69,839	0	0
TOTAL	N/A	N/A	N/A	1,029,340	1,212,130	917,222	920,917	1,034,196	973,361	978,468	952,578	918,281

Norton Sound SA

GF				243,113	238,611	198,333	97,248	94,643	89,076	85,484	78,438	78,438
Other				0	0	0	0	0	0	0	0	0
TOTAL	N/A	N/A	N/A	243,113	238,611	198,333	97,248	94,643	89,076	85,484	78,438	78,438

Tanana Chiefs Health Corporation

GF					340,648	298,056	287,798	326,339	307,143	226,210	200,859	200,859
Other					0	0	0	0	0	0	0	0
TOTAL	N/A	N/A	N/A	N/A	340,648	298,056	287,798	326,339	307,143	226,210	200,859	200,859

Yukon-Kuskokwim Health Corporation

GF								909,732	856,218	821,694	754,141	754,141
Other								75,982	113,529	108,952	0	0
TOTAL	N/A	N/A	N/A	N/A	N/A	N/A	N/A	985,714	969,748	930,645	754,141	754,141

South East Area Regional Health Corporation

GF								121,696	114,538	109,919	100,859	100,859
Other								107,589	101,261	113,306	0	0
TOTAL	N/A	N/A	N/A	N/A	N/A	N/A	N/A	229,285	215,798	223,226	100,859	100,859

Medicaid Services Unit

GF	0	0	0	0	0	0	0	0	0	0	0	0
Other	0	0	0	0	0	0	0	0	0	0	0	939,375
TOTAL	0	0	0	0	0	0	0	0	0	0	0	939,375

Home Health

GF	440,349	445,968	0	0	0	0	0	0	0	0	0	1,422,578
Other	0	0	0	0	0	0	0	0	0	0	0	81,328
TOTAL	440,349	445,968	0	0	0	0	0	0	0	0	0	1,503,906

Division of Public Health

GF	21,741,889	22,060,484	24,900,097	26,293,868	27,171,652	23,807,500	24,246,422	26,326,429	27,177,731	27,739,355	28,028,047	26,484,688
Other	3,896,201	4,491,230	4,435,825	6,536,132	7,064,352	7,255,093	7,177,615	8,179,464	10,238,739	12,657,903	12,946,016	14,587,266
TOTAL	25,638,090	26,551,714	29,335,922	32,830,000	34,236,004	31,062,593	31,424,037	34,505,893	37,416,471	40,397,258	40,974,063	41,071,953

*The Anchorage Consumer Price Index used for FY93 is the same as FY92. The new CPI won't be calculated until December, 1992

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Division of Public Health

Appropriations FY82-92

Adjusted by the Anchorage Consumer Price Index and Actual Authorizations

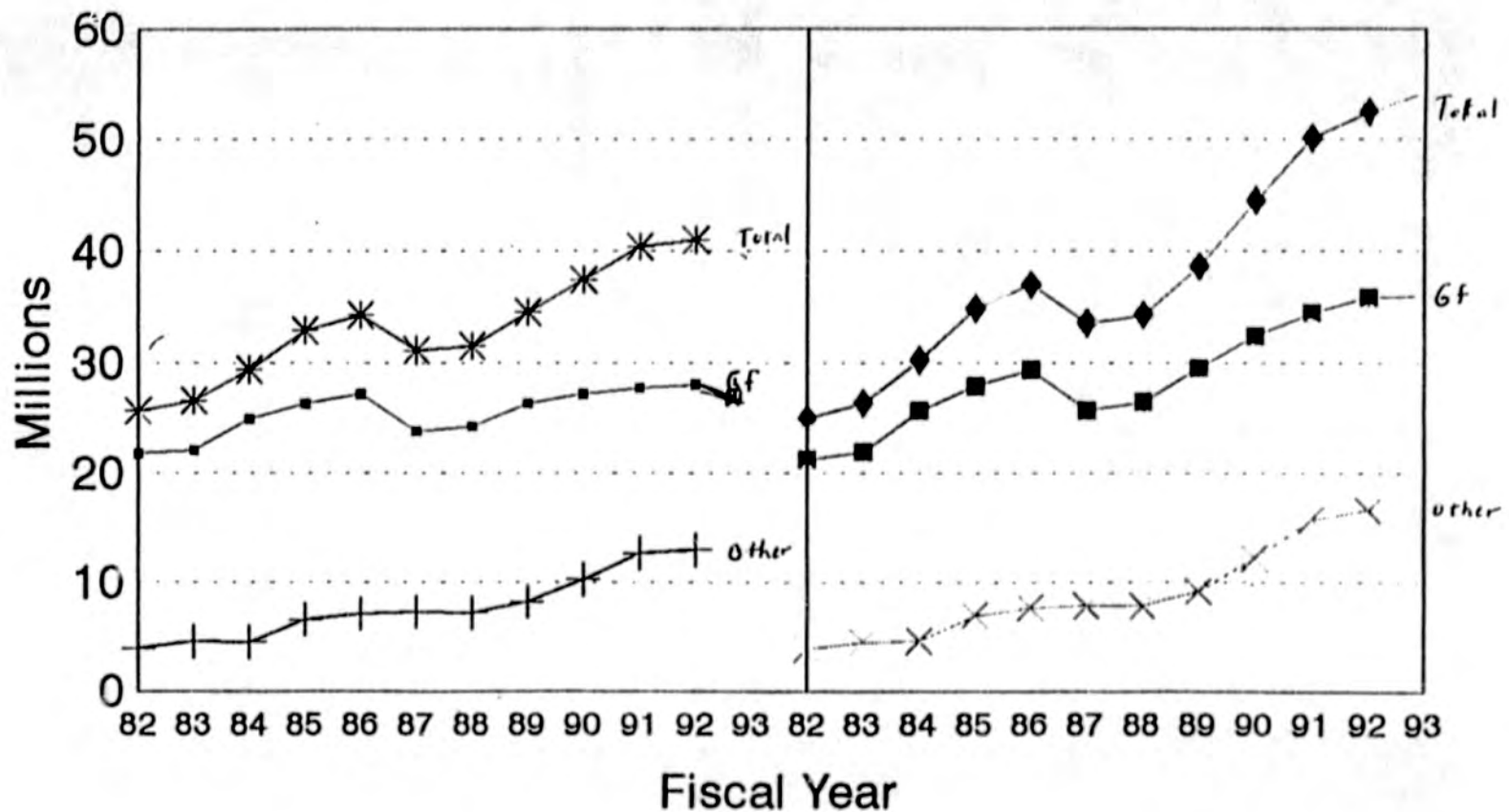
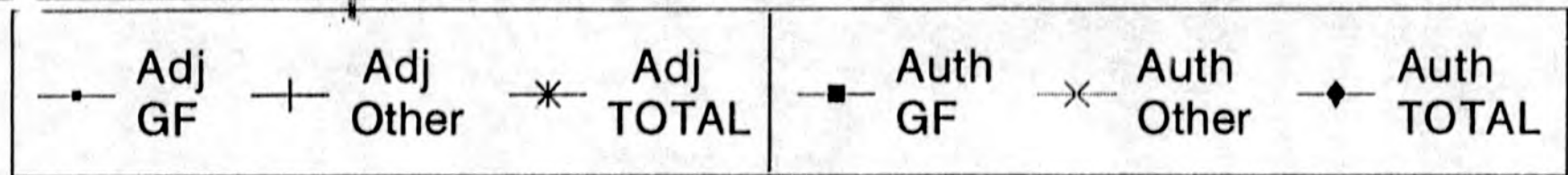


TABLE III.

Division of Public Health
Appropriations FY82-92

Nursing	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92*	FY 93*
GF	4,897,300	5,574,000	6,916,300	7,035,500	6,939,900	6,462,700	7,664,000	8,703,100	10,601,900	11,104,300	11,103,900	
Other	1,359,100	1,270,000	1,209,000	1,375,500	1,608,300	1,732,100	1,632,100	1,567,700	1,999,500	2,260,400	2,257,700	
TOTAL	6,257,000	6,844,000	8,125,300	8,411,000	8,548,200	8,194,800	9,296,100	10,270,800	12,601,400	13,364,700	13,361,600	

WIC												
GF	94,000	105,600							707,900	1,107,900	1,107,600	
Other	1,039	1,429							5,033	6,561	6,942	
TOTAL	1,132,900	1,534,600	N/A	N/A	N/A	N/A	N/A	N/A	5,741,100	7,668,900	8,049,300	

Maternal, Child and Family Health

GF	3,294,100	3,870,000	3,494,400	3,474,800	3,226,300	2,806,900	2,765,400	3,581,900	4,093,900	4,235,100	4,036,200	
Other	1,008,800	1,155,300	2,800,500	4,025,000	4,346,300	4,246,100	4,496,100	5,092,900	1,816,200	2,321,000	2,001,300	
TOTAL	4,302,900	5,025,300	6,294,900	7,499,800	7,572,600	7,053,000	7,261,500	8,674,800	5,910,100	6,556,100	6,037,500	

LABS												
GF	1,468,800	1,666,200	2,053,200	2,215,800	2,199,000	1,903,600	2,215,200	2,214,800	2,113,400	2,144,200	2,178,600	
Other	84,500	42,100	40,000	58,800	41,000	211,000	2,000	0	60,000	100,000	90,000	
TOTAL	1,553,300	1,708,300	2,093,200	2,274,600	2,240,000	2,114,600	2,217,200	2,214,800	2,173,400	2,244,200	2,268,600	

Administration

GF	2,914,400	3,120,400	1,795,400	1,512,500	1,447,100	1,184,900	654,000	795,600	518,900	625,500	900,300	
Other	94,200	96,100	296,000	731,000	443,400	105,300	105,300	93,900	96,300	699,800	1,137,300	
TOTAL	3,008,600	3,216,500	2,091,400	2,243,500	1,890,500	1,290,200	759,300	889,500	615,200	1,325,300	2,037,600	

Epidemiology

GF	1,294,200	1,425,400	2,052,600	2,125,500	2,770,600	1,888,300	1,735,700	1,878,100	1,963,400	1,993,600	1,993,600	
Other	149,400	62,900	163,400	265,700	673,200	655,500	857,000	620,600	858,000	977,600	1,443,500	
TOTAL	1,443,600	1,488,300	2,216,000	2,391,200	3,443,800	2,543,800	2,592,700	2,498,700	2,821,400	2,971,200	3,642,600	

Emergency Medical Services Training and Licensing

GF							375,600	400,100	407,600	424,700	452,100	
Other							0	28,200	228,700	557,700	566,600	
TOTAL	N/A	N/A	N/A	N/A	N/A	N/A	375,600	428,300	636,300	982,400	1,018,700	

TABLE IV.

Bureau of Vital Statistics											
GF	384,300	415,400	422,000	359,900	345,900	286,700	441,100	710,200	721,700	732,700	749,000
Other	0	0	0	65,000	100,000	154,400	0	101,000	105,400	200,400	409,200
TOTAL	384,300	415,400	422,000	424,900	445,900	441,100	441,100	811,200	827,100	933,100	1,158,200

Post Mortem											
GF				711,500	618,300	753,900	463,400	600,000	463,400	750,000	696,000
Other	0	0	0	0	0	0	0	0	0	0	0
TOTAL	N/A	N/A	N/A	711,500	618,300	753,900	463,400	600,000	463,400	750,000	696,000

Infant Learning Program Grants											
GF	1,395,800	1,253,100	1,760,300	1,636,200	2,011,200	1,742,200	1,991,100	2,156,100	2,436,100	3,136,100	4,736,100
Other	60,000	60,000	60,000	330,700	330,700	330,700	330,700	330,700	330,700	330,700	330,700
TOTAL	1,455,800	1,313,100	1,820,300	1,966,900	2,341,900	2,072,900	2,321,800	2,486,800	2,766,800	3,466,800	5,066,800

Community Health Grants											
GF	4,284,100	3,331,400	4,131,600	4,000,800	4,272,600	4,023,200	3,055,300	1,884,800	1,744,600	1,328,700	1,258,100
Other	0	0	0	0	0	0	0	0	0	0	313,800
TOTAL	4,284,100	3,331,400	4,131,600	4,000,800	4,272,600	4,023,200	3,055,300	1,884,800	1,744,600	1,328,700	1,571,900

Emergency Medical Services Grants											
GF			1,500,400	1,713,100	1,843,400	1,711,900	1,674,100	1,703,000	1,702,100	1,702,100	1,599,500
Other			0	0	0	0	0	0	0	0	0
TOTAL	N/A	N/A	1,500,400	1,713,100	1,843,400	1,711,900	1,674,100	1,703,000	1,702,100	1,702,100	1,599,500

Health Promotions											
GF	155,900	164,000				0	0	0	0	0	0
Other	0	339,900	0	0	0	313,800	313,800	313,800	313,900	313,800	0
TOTAL	155,900	503,900	N/A	N/A	N/A	313,800	313,800	313,800	313,900	313,800	0

AIDS Program											
GF							498,000	498,000	506,700	504,700	392,200
Other					0	0	0	720,000	1,000,000	1,011,200	1,079,100
TOTAL	N/A	N/A	N/A	N/A	N/A	N/A	498,000	1,218,000	1,506,700	1,515,900	1,471,300

TABLE V.

Teen Pregnancy											
GF											107,800
Other											0
TOTAL	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	107,800

Maniilaq Public Health											
GF	993,100	958,500	1,520,900	879,600	850,400	698,600	690,500	793,200	793,200	924,100	873,400
Other	0	0	0	0	0	0	0	0	0	0	0
TOTAL	993,100	958,500	1,520,900	879,600	850,400	698,600	690,500	793,200	793,200	924,100	873,400

Maniilaq Social Services											
GF			934,100	972,800	809,100	868,300	868,300	868,300	868,300	1,014,000	814,800
Other			0	0	0	0	0	0	0	0	0
TOTAL	N/A	N/A	934,100	972,800	809,100	868,300	868,300	868,300	868,300	1,014,000	814,800

Norton Sound Health											
GF			1,014,500	1,222,500	904,000	917,200	1,071,700	1,071,700	1,126,700	1,219,300	
Other			76,600	86,600	86,600	86,600	86,600	86,600	86,600	0	
TOTAL	N/A	N/A	1,091,100	1,309,100	990,600	1,003,800	1,158,300	1,158,300	1,213,300	1,219,300	

Norton Sound SA											
GF			257,700	257,700	214,200	106,000	106,000	106,000	106,000	100,400	
Other			0	0	0	0	0	0	0	0	
TOTAL	N/A	N/A	257,700	257,700	214,200	106,000	106,000	106,000	106,000	100,400	

Tanana Chief Health Corporation											
GF				367,900	321,900	313,700	365,500	365,500	280,500	257,100	
Other				0	0	0	0	0	0	0	
TOTAL	N/A	N/A	N/A	367,900	321,900	313,700	365,500	365,500	280,500	257,100	

Yukon-Kuskokwim Health Corporation											
GF							1,018,900	1,018,900	1,018,900	965,300	
Other							85,100	135,100	135,100	0	
TOTAL	N/A	N/A	N/A	N/A	N/A	N/A	1,104,000	1,154,000	1,154,000	965,300	

TABLE VI.

South East Area Regional Health Corporation											
GF								136,300	136,300	136,300	129,100
Other								120,500	120,500	140,500	0
TOTAL	N/A	N/A	N/A	N/A	N/A	N/A	N/A	256,800	256,800	276,800	129,100

Division of Public Health											
GF	21,176,600	21,884,000	25,647,100	27,871,500	29,345,600	25,712,100	26,428,600	29,485,600	32,341,500	34,396,800	35,875,900
Other	3,794,900	4,455,300	4,568,900	6,928,300	7,629,500	7,835,500	7,823,600	9,161,000	12,184,100	15,695,800	16,570,900
TOTAL	24,971,500	26,339,300	30,216,000	34,799,800	36,975,100	33,547,600	34,252,200	38,646,600	44,525,600	50,092,600	52,446,800

on personnel changes will be made during the description of trends within the sections of the Division of Public Health.

Tables VII. and VIII. Staffing: Division of Public Health

IV. TRENDS IN SECTIONS WITHIN THE DIVISION OF PUBLIC HEALTH

Bureau of Vital Statistics

The major trend in the budget for the Bureau of Vital Statistics is the increasing shift to program receipts.

LG IV	Real and Nominal Budgets
LG V	Positions

The drop in FY 80 represents a reallocation of resources away from Vital Statistics. Because of statutory requirement for registration, the reporting and health information side of the Bureau is all that could be dropped. This led to a drop in the quality of the data reported, as all field activities and data validation was discontinued.

Health professionals and officials began raising the alarm at least as early as 1984 when The Centers for Disease Control (CDC) study of Alaska's high rate of infant mortality concluded that "Data on Alaska's infant mortality must be interpreted with caution because of several deficiencies--two deficiencies may have resulted in falsely low mortality rates."

In 1986 studies of Alaskan's suicide rate further documented serious deficiencies in the data and finally made us understand that the state could not recognize a problem when it existed, much less adequately plan for programs to address health problems without timely, accurate and reliable vital statistics. Critically important issues like infant mortality and suicide only scratch the surface. Vital statistics are crucial in identifying the nature and extent of alcohol and drug related deaths, quantifying the nature and causes of injury death, designing and tracking the efficacy and efficiency of state and federal health and prevention programs, and estimating the size and distribution of population changes, to name only a few key uses.

Upon recognizing the problems, the Department was determined to solve them. The Bureau of Vital Statistics was first moved into the Division of Public Health, where the majority of the departmental users of the data are located, thus assuring the interest and priority necessary to address the problems. The Legislature agreed to allocate additional funding and positions and the Bureau has been rebuilt over the last 4 years.

By 1991, the Bureau was back to the same level of real expenditures as 1978, and was once again able to collect accurate health data, produce health status information and accomplish program evaluation for the Division.

Table IX. Actual Expenditures and Positions

TABLE VII. STAFFING: DIVISION OF PUBLIC HEALTH

	Nursing	WIC	MCFH	Labs	PH Admin	Epi	EMS	BVS	Medicaid	Home Hlth	Total
FY 93*											
PFT	164	8	43	39	15	44	9	20	11	3	346
PPT	16		5	1			1				23
Total	170	8	48	40	15	44	10	20	11	3	369
FY 92**											
PFT	162	9	42	34	18	51	10	20	11		357
PPT	17		5	2		2	1				27
Total	179	9	47	36	18	53	11	20	11	0	384
FY 91											
PFT	164	9	43	34	12	47	10	18			337
PPT	19		6	2		4	1	1			33
Total	183	9	49	36	12	51	11	19	0	0	370
FY 90											
PFT	159	10	39	34	11	45	10	16			324
PPT	19	1	3	2		4	1	2			32
Total	178	11	42	36	11	49	11	18	0	0	356
FY 89											
PFT	158		37	34	9	42	6	16			302
PPT	19		1	2		4	1	2			29
Total	177	0	38	36	9	46	7	18	0	0	331
FY 88											
PFT	141		39	35	8	21	6	14			264
PPT	19		2	7		1	1	1			31
Total	160	0	41	42	8	22	7	15	0	0	295
FY 87											
PFT	141		40	36	19	25					261
PPT	19			7		1					27
Total	160	0	40	43	19	26	0	0	0	0	288
FY 86											
PFT	141		40	36		24					241
PPT	19			7		1					27
Total	160	0	40	43	0	25	0	0	0	0	268
FY 85											
PFT	142		46	39	22	24					273
PPT	18			5		1					24
Total	160	0	46	44	22	25	0	0	0	0	297

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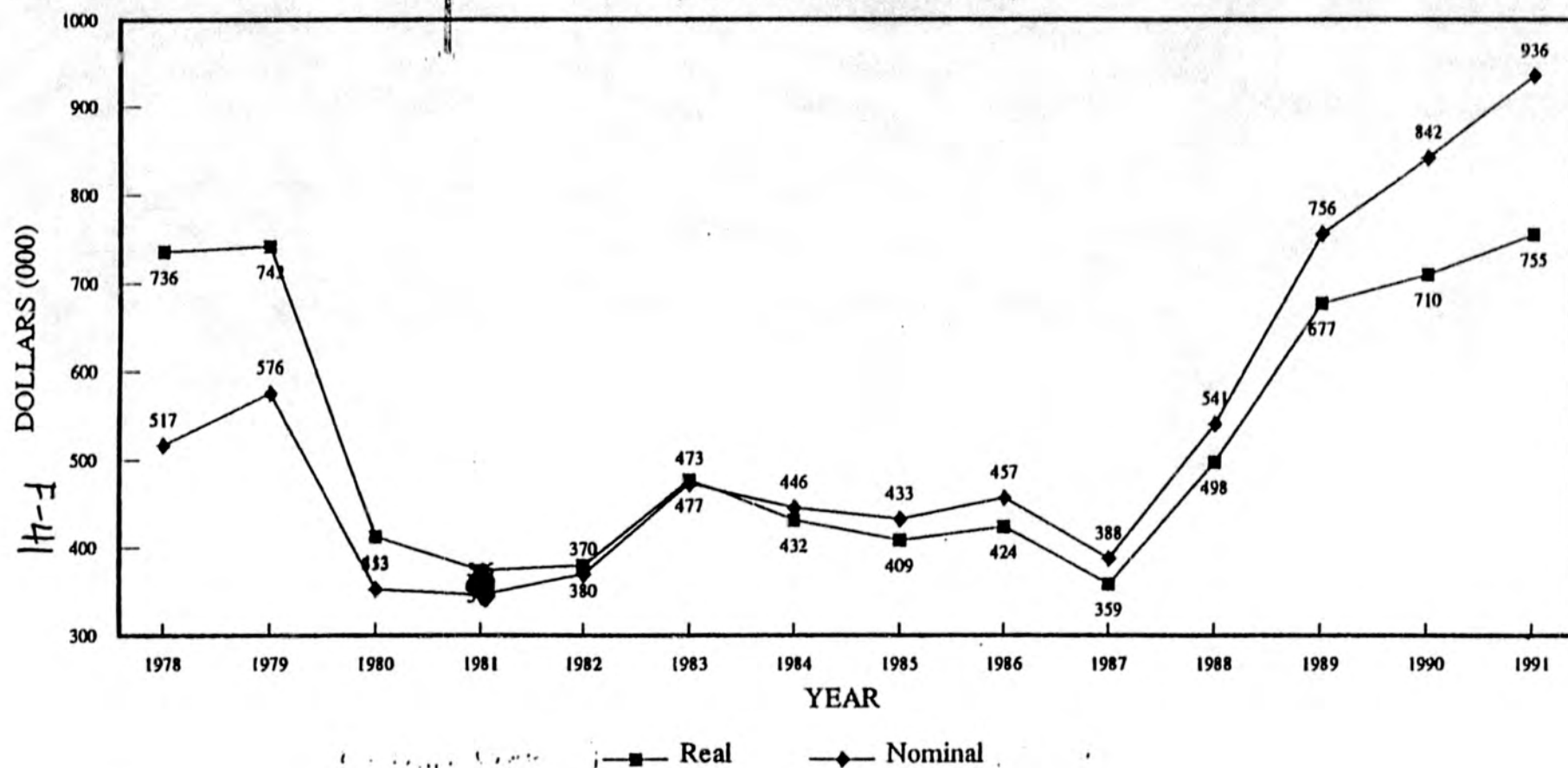
TABLE VIII. STAFFING: DIVISION OF PUBLIC HEALTH

	Nursing	WIC	MCFH	Labs	PH Admin	Epi	EMS	BVS	Medicaid	Home Hlth	Total
FY 84											
PFT	145		45	39	19	25					273
PPT	22		1	6							29
Total	167	0	46	45	19	25	0	0	0	0	302
FY 83											
PFT	145		47	39	22	23					276
PPT	21		2	6							29
TOTAL	166	0	49	45	22	23	0	0	0	0	305
FY 82											
PFT	146		43	38	15	23	5				270
PPT	23		5	6			1				35
TOTAL	169	0	48	44	15	23	6	0	0	0	305
FY 81											
PFT	149		43	32	17	24	4				269
PPT	23		11	6			1				41
TOTAL	172	0	54	38	17	24	5	0	0	0	310
FY 80											
PFT	26		39	71	15	22	4				177
PPT	1		8	11			1				21
TOTAL	27	0	47	82	15	22	5	0	0	0	198

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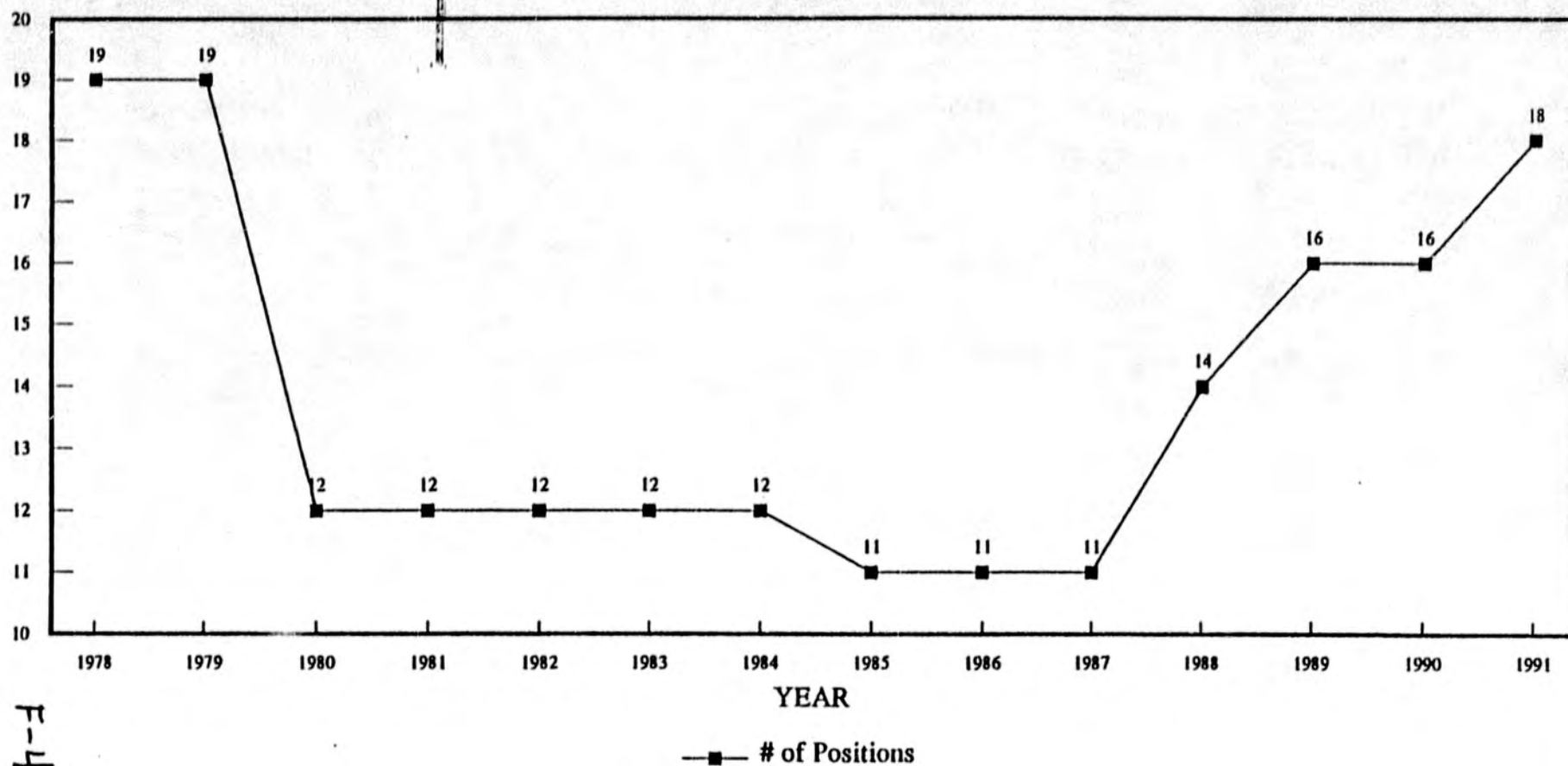
BUREAU OF VITAL STATISTICS

(ACTUAL EXPENDITURES)



BUREAU OF VITAL STATISTICS

(PFT)



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TABLE IX. Actual Expenditures and Positions

BUREAU OF VITAL STATISTICS

ACTUAL EXPENDITURES & POSITIONS

1978-1991

	1978	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992 **
BUDGET															
FF	85	132	106								74	87	101	142	146
GF	425	441	243	346	370	415	446	368	357	288	367	433	206	326	362
PR						58		65	100	100	100	104	385	381	387
MHT												132	150		
I/A	7	3	4											87	264
TOTAL EXPEND															
NOMINAL \$	517	576	353	346	370	473	446	433	457	388	541	756	842	936	1159 **
* REAL \$	736	742	413	374	380	477	432	409	424	359	498	677	710	755	902 **
POSITIONS															
PFT	19	19	12	12	12	12	12	11	11	11	14	16	16	18	20
PPT	1	1						1	1	1	1	2	2	1	
	20	20	12	12	12	12	12	12	12	12	15	18	18	19	20

* INFLATION ADJUSTED DOLLARS (1983 base)

** CONFERENCE COMMITTEE (AUTHORIZED NOT ACTUALS)

Emergency Medical Services

In 1980 the unintentional injury death rate in Alaska was 108.75 per 100,000, so there was a 39 percent reduction between 1980 and 1989, to 65.87 per 100,000.

EMS Unintentional Injury Deaths

The EMS Section now has a statewide trauma registry which collects data from every hospital in Alaska on patients hospitalized for a traumatic injury. Vital statistics data on traumatic injury deaths occurring outside a hospital also are added to the registry. Although data is not yet complete for a full calendar year, it is estimated that over 4,500 persons are hospitalized every year for traumatic injuries. The trauma register can be used to evaluate the quality of treatment of trauma victims in the prehospital and hospital setting, and it can be used to design and evaluate injury prevention programs.

In 1985, the total cost of injury in the U.S. was estimated to be \$158 billion. Since Alaska had .22 percent of the U.S. population in 1990, the total annual cost of injury in Alaska (including medical care, lost work time, rehabilitation, etc.), would be at least \$347,600,000 in 1985 dollars. Since Alaska's injury death rate is much higher than the national average, it is very likely that injuries in this state currently cost over one-half billion dollars per year.

Alaska has over 1800 state certified EMT-1's (basics), 500 EMT II's (intermediate), 400 EMT III's (intermediate plus some advanced cardiac training), 150 Mobile Intensive Care Paramedics, and 200 certified EMT instructors. Two-thirds of the pre-hospital EMS providers in Alaska are volunteers.

*EMS Ground/Air Ambulance Services.
Appropriations FY 82-93
Staffing FY 82-93*

Today there are EMT's and/or Community Health Aides (trained to the ETT or EMT level) in virtually every village in Alaska. Most physicians, nurses, and mid-level practitioners in rural hospitals and clinics have had advanced trauma, cardiac, and pediatric training, with partial assistance from the State EMS program.

Nursing

PHN I. Itinerant Map
PHN II. Health Centers 1986 and 1992

The largest and most widely dispersed component in the Division is the Section of Nursing. PHN's are a direct service component of the Division. To most small communities, the public health nurse is the "Health Department." Public health nurses in Alaska serve all communities of any size with a childhood population.

Prior to the budget crisis in FY 87, public health nurses operated out of 28 health centers (See PHN II - 1986 MAP). The FY 87 and more recent budget reductions have resulted in the closure of seven health centers either through attrition or consolidation of staff to other sites (See PH III - 1992 MAP). The rationale for doing this may be flawed. Public health nursing services are provided mainly to underinsured women and needy children in both urban and rural communities, and there is a greater need for services than can be provided with current staff. Airline routes determine the most efficient means of delivering services to rural communities. With reduced work force and no additional travel funds, there is no way to continue present level of services.

IV. Summary Table PHN Nursing Budget Table

Since 1980, the nursing component has gained only 11 positions, but has had to take on multiple new programs.

A fully functional and operational RPMS Data System is required to get the information needed to compute true resource needs.

V. Pie Chart

Lacking a centralized management data system for nursing, the data that follows is taken from an EPSDT time study done 10/21/91 to 11/15/91. The time study documented that most PHNs work some overtime with a few exceeding 200 hours a month, but are paid for 150 hours. The average time spent on behalf of each of 19,000 clients was about 20 minutes. Analysis of the time study data showed that 34% of PHN time was spent in communicable disease activities (includes immunizations), 50% was spent in EPSDT, other well child activities and family health programs for children, 10.6% was spent in teen pregnancy, ante/postpartum and family planning services, and 5.4% on chronic disease and other adult services.

PHN VI. Budget Summary by Line Item

Another factor influencing flexibility is the creeping dependence on Medicaid funding. In FY 80, the nursing component had four 100% Medicaid funded nursing positions and relied on 7.5% of its general funds to come from Medicaid. In FY 93, the nursing component has 100% funded positions and a 19.8% dependence on Medicaid.

PHN VII. Budget Summary by Funding Source.

Nursing has had tremendous new program demands placed on its limited resources, coupled with less experienced staff. The nursing component has had an enviable average retention rate of greater than six years. The single largest deterrent to recruitment is an unstable funding source. Under the best of circumstances it takes three to six months to recruit and place an experience PHN in a rural community.

The obvious result of shrinking public health nursing resources is that many underinsured women and children will not get any preventive health services.

To have any effect on many current public health problems requires long-term commitment and trust that can only be gained through continuity. Impact teams to provide immunizations, EPSDT screening and tuberculin tests are stop-gap measures that give little job satisfaction. They are important public health services, but do not allow an experienced PHN to utilize her/his unique skills nor have much impact on larger public health issues. Public health nurses could make a difference in health care cost containment if given the appropriate opportunity.

Community Health Grants

Grants I. Community Health Grants

Community Health Aide Program: This program provides state support for the training and supervision of community health aides. The program is mandated in AS 18.28.010-100. The statute provides a formula for funding eligible agencies, and caps the formula at the FY 85 authorization level. Due to inequitable distributions to designated BRUs and budget reductions made during the past eight years, the grant program is currently funded at 89% of the full formula level.

Rural Health Clinic Program: This program provides start-up funds and operational subsidies to mid-level practitioner clinics located in rural Alaskan communities that do not have local access to the same or higher level of primary medical care. Funding for this program has been reduced a number of times during the past ten years. The most recent reductions were made in FY 92 (-13%) and FY 86 (-10%).

General Health Services: This program provided designated grants to agencies historically funded to provide specific health services such as cancer screening and dental services. Funding for his program was eliminated through a Governor's veto in FY 91.

Epidemiology Mission

The Section of Epidemiology is responsible for surveillance, investigation, and control of acute and chronic diseases and injuries through defining causal factors, identifying and directing control measures, and providing a basis for policy development, program planning and evaluation.

"A foundation stone for public health activities is an assessment and surveillance capacity that identifies problems, provides data to assist in decisions about appropriate actions, and monitors progress. Epidemiology has long been considered the essential science of public health, and a strong assessment and surveillance system based on epidemiologic principles is a fundamental part of a technically competent public health activity."

Emphasis program areas include 1) sexually transmitted diseases, 2) Tuberculosis, 3) immunization, 4) diabetes, 5) injury surveillance and control, 6) cancer, 7) health hazard assessment and risk analysis, 8) occupational health, 9) cardiovascular disease and 10) Circumpolar Health.

The scientific expertise accumulated within the Section of Epidemiology has allowed Alaska to successfully seek and acquire federal resources to address the numerous health needs of our citizens.

The science of epidemiology has been instrumental in achieving the many successful health outcomes that ultimately are reflected in the cost of health care for Alaskans.

EPI Overheads: Newspaper Heading (Collage)

Anch Daily News

Hooper Bay Article

Fiscal Years Graph

Fiscal Years Table

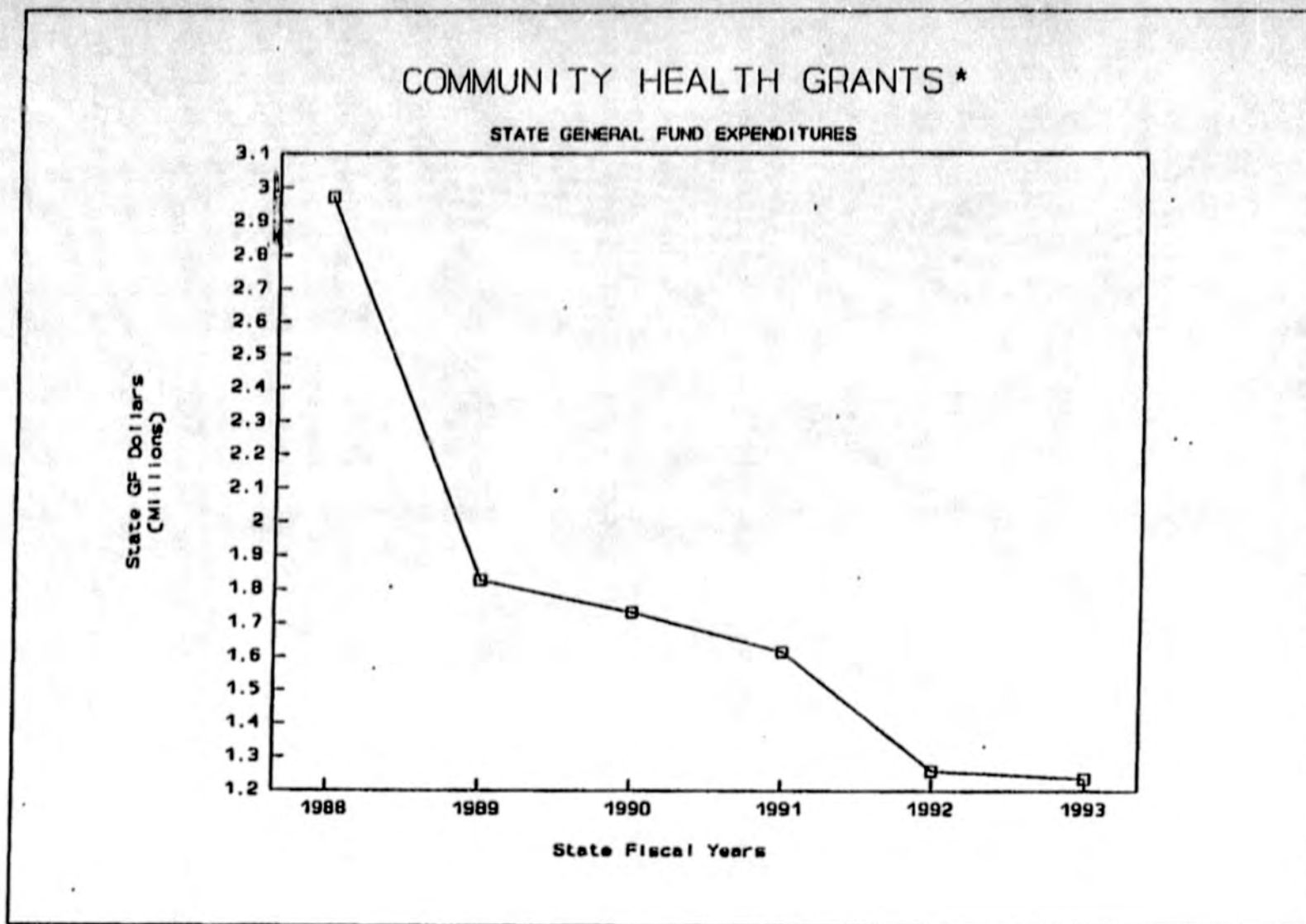
Family Health

In recent years Family Health has assumed a role in bringing various other public and private provider groups and agencies together and insuring public input into the planning processes. An example of this is the development of the PL 99-467 Early Intervention Plan. The Section provided the leadership, over a three year period, that brought together hundreds of providers, parents and policy makers through various committees and working groups, to produce an Early Intervention Plan for a system of care for the birth to three special needs population that is supported by consumers, providers and funding agencies. Thus, there needs to be support for public health positions with a variety of technical expertise to support the policy-making process internally and externally.

The Section has responsibility to assure that core Family Health services are available in the state. Wherever possible, we support the concept that the state be a direct service provider only when there is no other viable local option. Currently, reproductive services such as family planning counseling and contraceptives, are not available to large numbers of women of child-bearing age in Alaska. Thus, it is imperative that core services be defined and that funding be provided to assure access for all Alaskans. The economic and personal costs to the state of not fulfilling these basic needs will be enormous.

During the past two years, as a result of a significant effort on the part of staff, the federal dollars have increased significantly. Also, the Section has pursued other funding sources, such as the infant formula rebates, which now generate in excess of a million dollars a year to serve additional low income pregnant and breastfeeding woman and children.

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* Does not include community health grant programs funded through the designated BRUs.

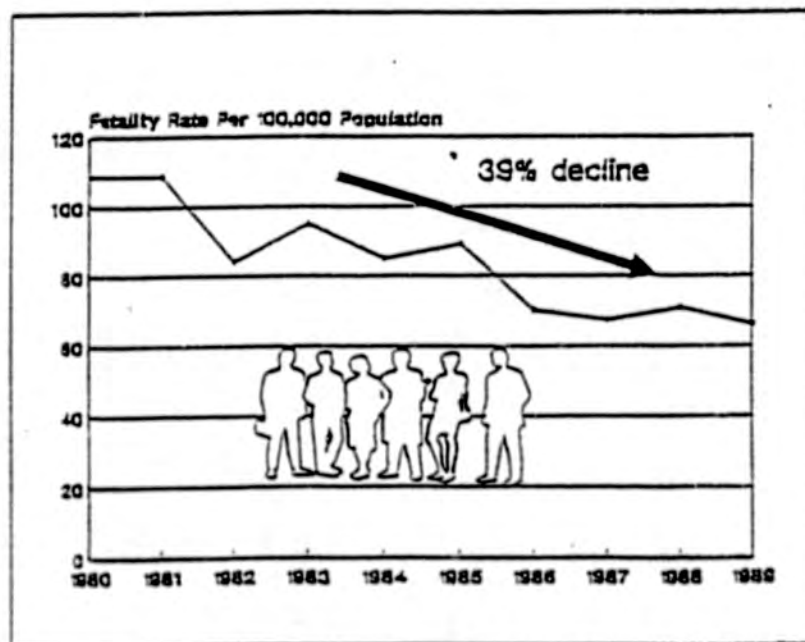
1988 to 1989: Not a true reduction; reflects transfer of CHA funds to newly formed YKHC and SEARHC BRUs.

1989 to 1993: Reflects true downward trend in state funding for community health services grants; elimination of designated general health services grants, 13% reduction in rural health clinic grant funds, and 4% reduction in CHA grant funds.

UNINTENTIONAL INJURY DEATHS BY YEAR

Information taken from Causes of Death in Alaska 1950, 1980-1989, State of Alaska, DHSS/Public Health/Epidemiology, August, 1991.

Year of Death	Number	Population	Fatality Rate per 100,000
1980	437	401,851	108.75
1981	472	433,800	108.81
1982	390	463,400	84.16
1983	473	497,600	95.06
1984	444	522,000	85.06
1985	483	541,300	89.23
1986	384	547,600	70.12
1987	362	537,800	67.31
1988	377	531,000	71.00
1989	352	534,400	65.87



GROUND AMBULANCE SERVICES

YEAR	ADVANCED LIFE SUPPORT	BASIC LIFE SUPPORT	# CERTIFIED SERVICES	# SERVICES
*1983	24	11	35	71
1984	29	15	44	72
1985	33	16	49	73
1986	34	19	53	73
1987	34	27	61	80
1988	36	29	65	80
1989	37	34	71	84
1990	33	42	75	84
1991	35	42	77	81
1992	36	42	78	87

*Regulations Implemented 03/03/83

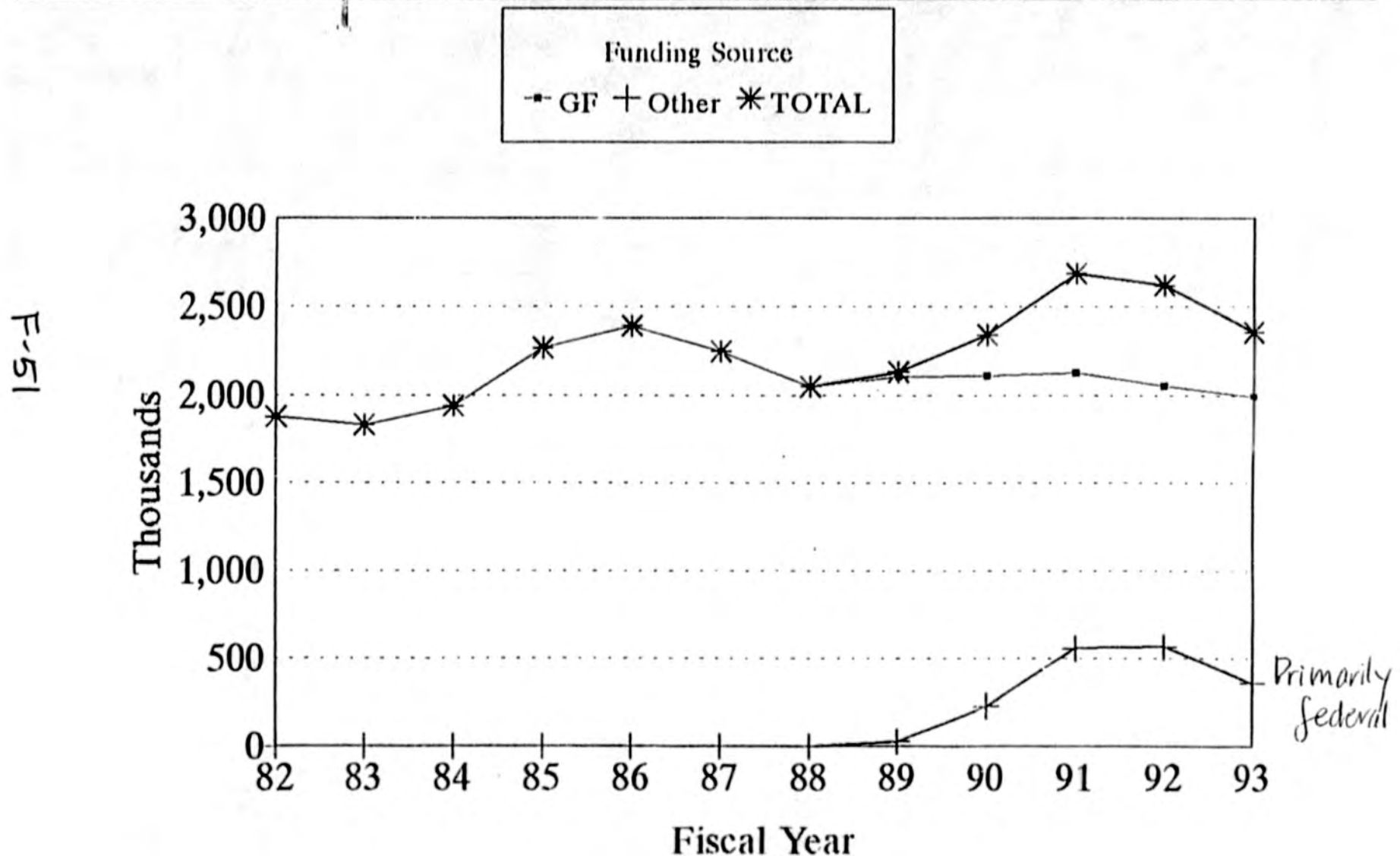
AIR MEDICAL SERVICES

YEAR	MEDEVAC	CRITICAL CARE	SPECIALTY TRANSPORT
*1985	2	2	1 -
1986	3	4	1
1987	5	5	1
1988	5	6	1
1989	5	6	1
1990	6	6	1
1991	6	6	1
1992	7	6	1

*Regulations Implemented 09/28/85

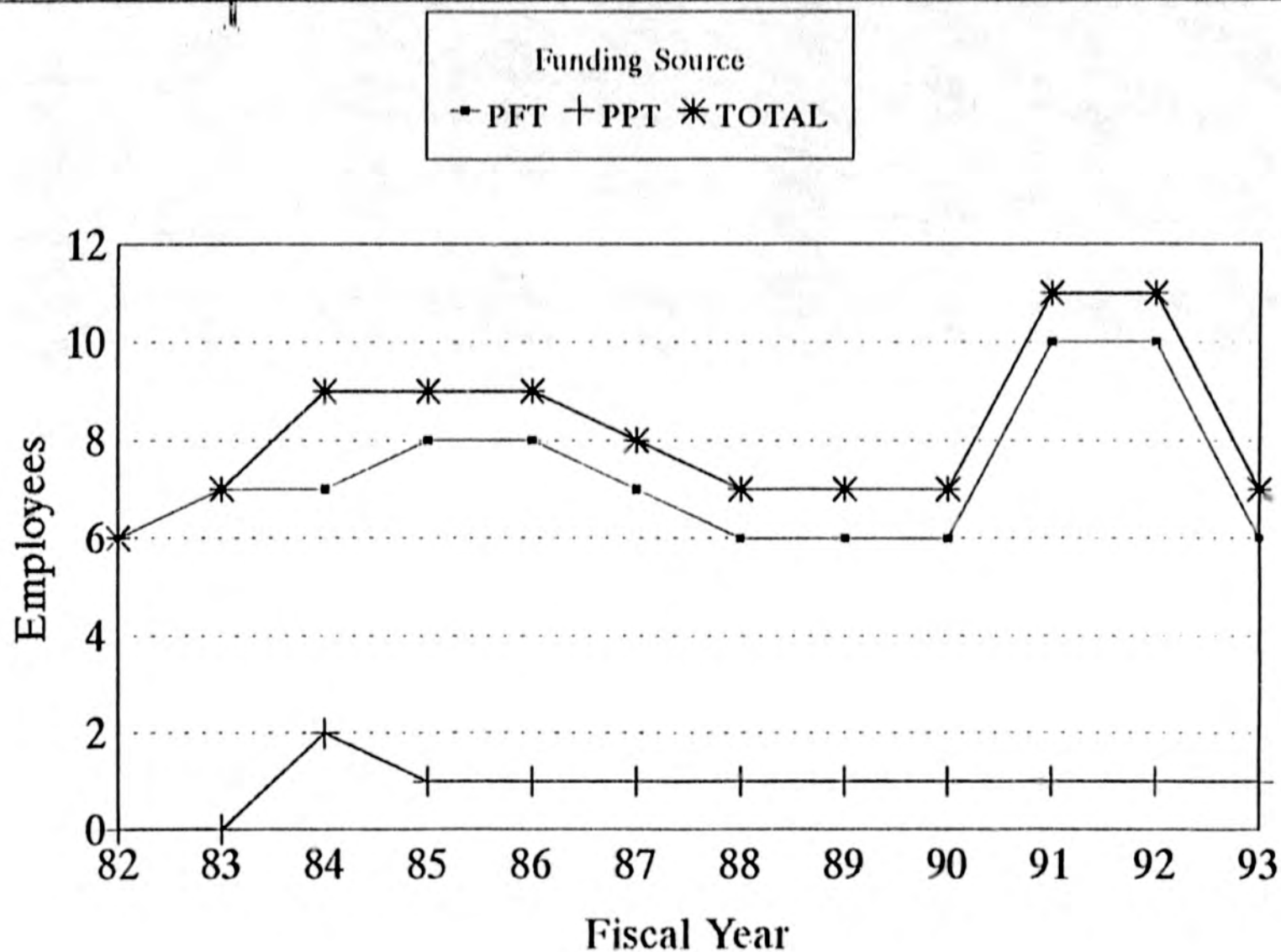
Emergency Medical Services Section

Appropriations FY82-93

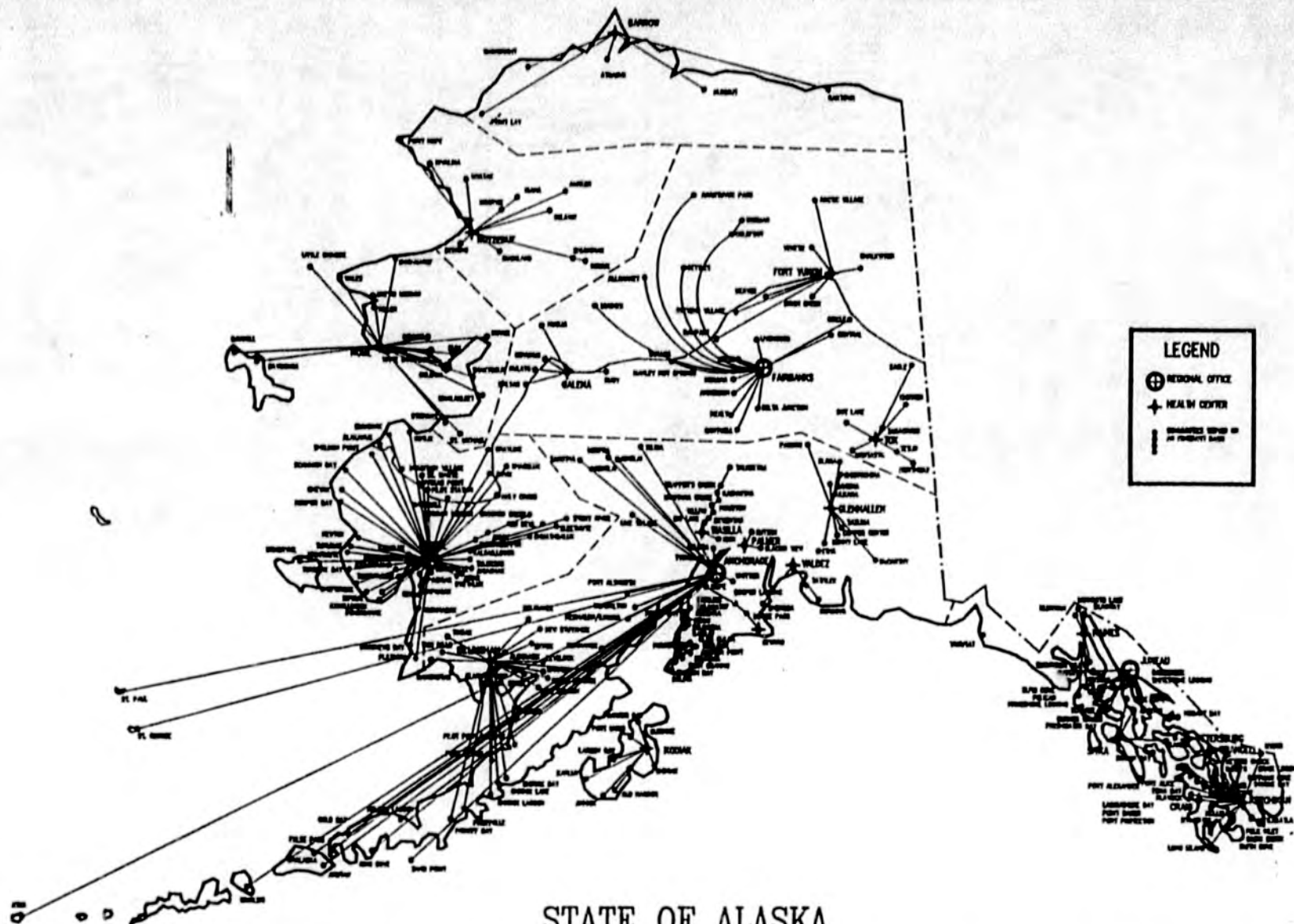


Emergency Medical Services Section

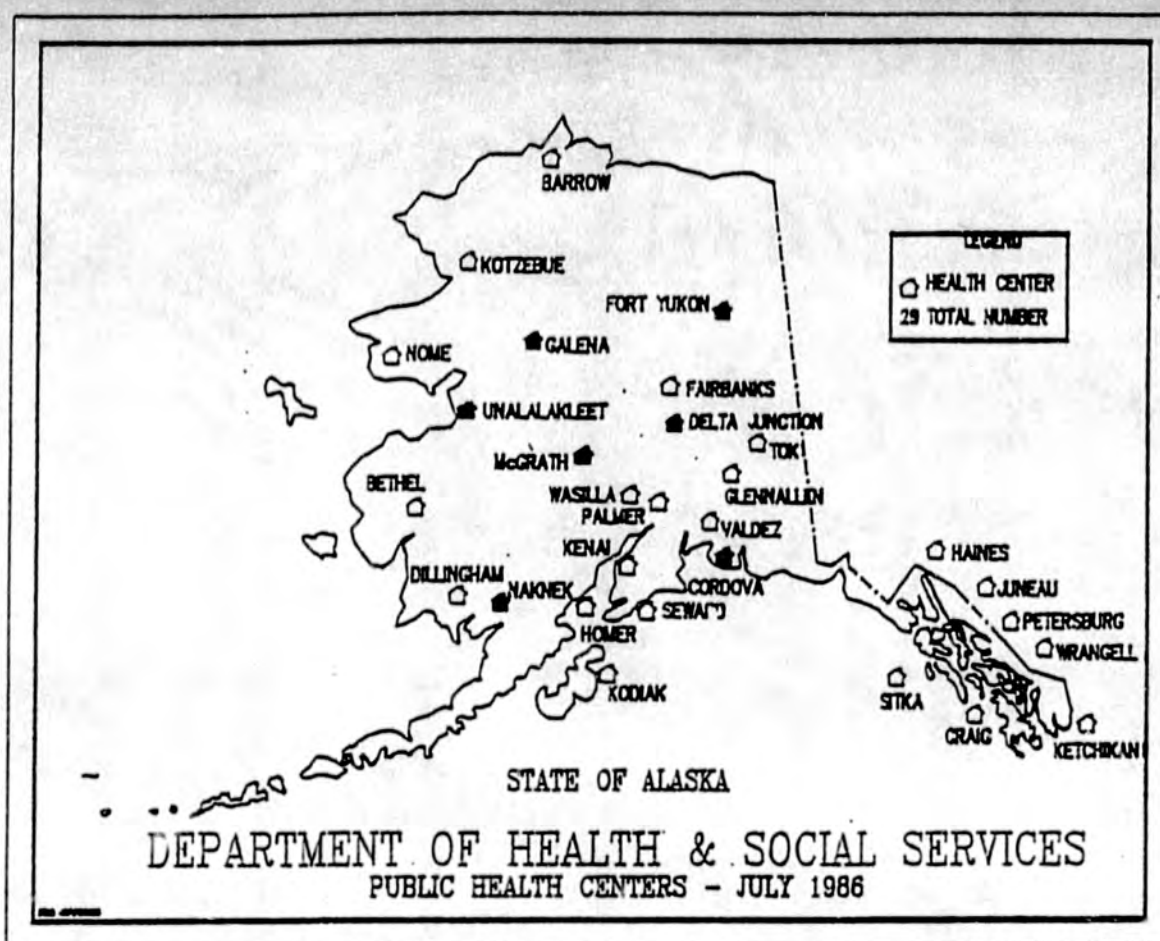
Staffing FY82-93



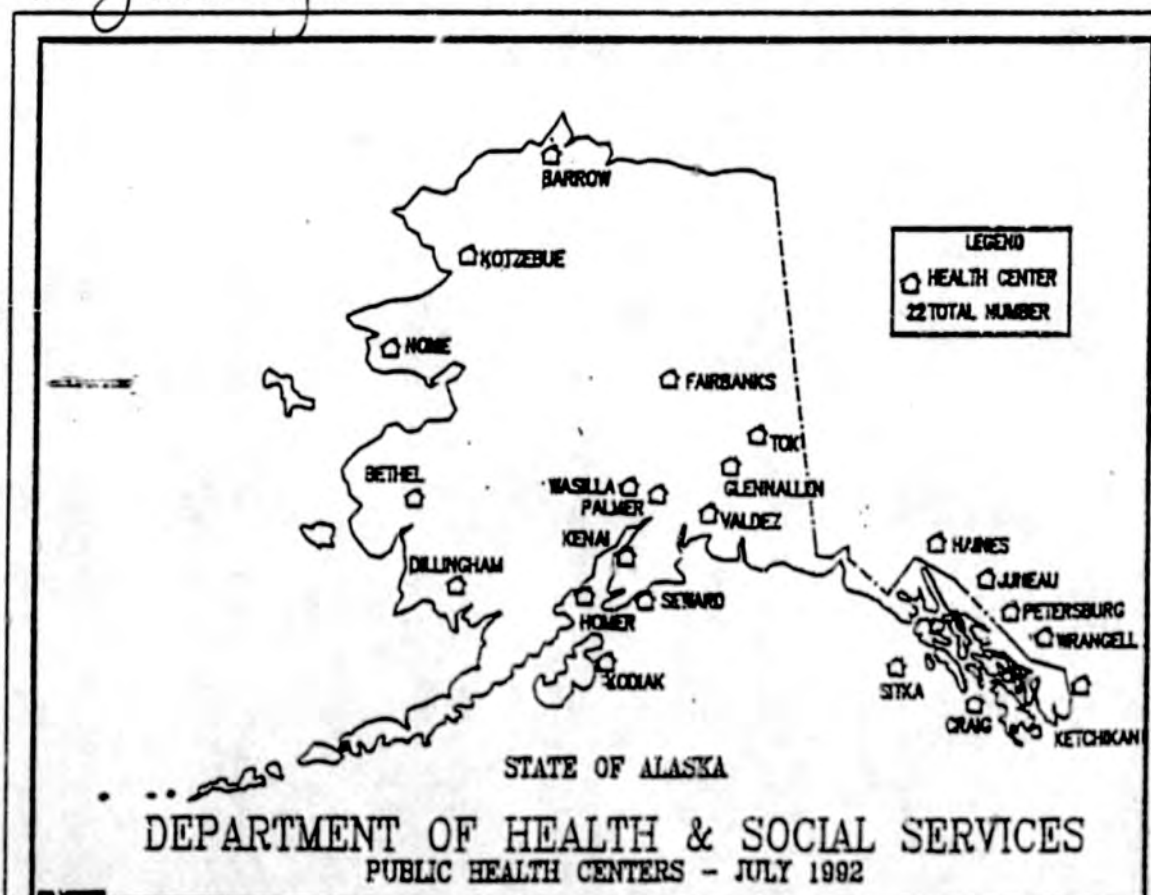
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STATE OF ALASKA
 DEPARTMENT OF HEALTH & SOCIAL SERVICES
 PUBLIC HEALTH NURSING
 MARCH, 1992



7 health centers eliminated since 1986 due to decreases in funding.



Section of Nursing

Summary of Program & Budget Changes: FY 1970 - FY 1993

August 17, 1992

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PHN II. SUMMARY TABLE

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Fiscal Year	Alaska Population	Number of Positions*	Positions Lost	Positions Gained	Funding**	Major Program Changes
1970	300,382	90	n/a	n/a	1,239.7	70-75 added cancer screening, STD, FP, EPSDT
1975		139	n/a	n/a	2,358.5	'76-80 added mumps, influenza, & pneumococcal vaccine program
1980	401,851	158	0	0	5,137.6	stopped doing small pox vaccination
1981		172	1	15	6,255.1	Manilaq & NSB grants \$ and positions lost, EPSDT positions gained
1982		169	3	0	6,337.2	Home Health Demonstration Project in, lost EPSDT positions Hep B project work added - no additional resources
1983		166	3	0	7,326.3	Home Health Aide contracts transferred to Nursing component from DFYS
1984		167	1	2	6,824.1	Norton Sound grants moved to BRU Reorganization of Interior Region
1985		160	7	0	7,305.0	HIV/AIDS alternate test sites expected with 0 added resources
1986	547,600	160	0	0	7,585.0	
1987	537,800	160	0	0	6,666.3	major budget deficit - layoff of 14 PHNs - closed Cordova & Delta health centers
1988	531,000	160	0	0	7,774.6	Instituted fee-for-service by legislative intent w/0 fiscal note absorbed RPMS responsibility, Anchorage grant moved in
1989		167	1	8	8,061.2	RPMS, Healthy Baby Project, GICCY, Prenatal II -- all with new expectations, lost Supply Officer to Administration
1990	550,043	172	0	5	8,570.8	new positions for EPSDT due to OBRA '89, NCAST project funded 1 PFT, 2 PPT for AIDS funded in EPI established & supervised by Nursing RPMS positions established
1991		186	0	14	9,829.7	
1992		182	4	0	10,508.7	closed Naknek & McGrath Health Centers, added Haemophilus b Program HHI into its own component, lost Ft. Yukon PHN, expected to add lead screening, OSHA, CLIA & Hep B for infants, AIDS positions into Nursing
1993		169	15	2	9,824.9	moved Medicaid Unit & Healthy Baby Project to Admin.

* PCNs include both nurse and staff

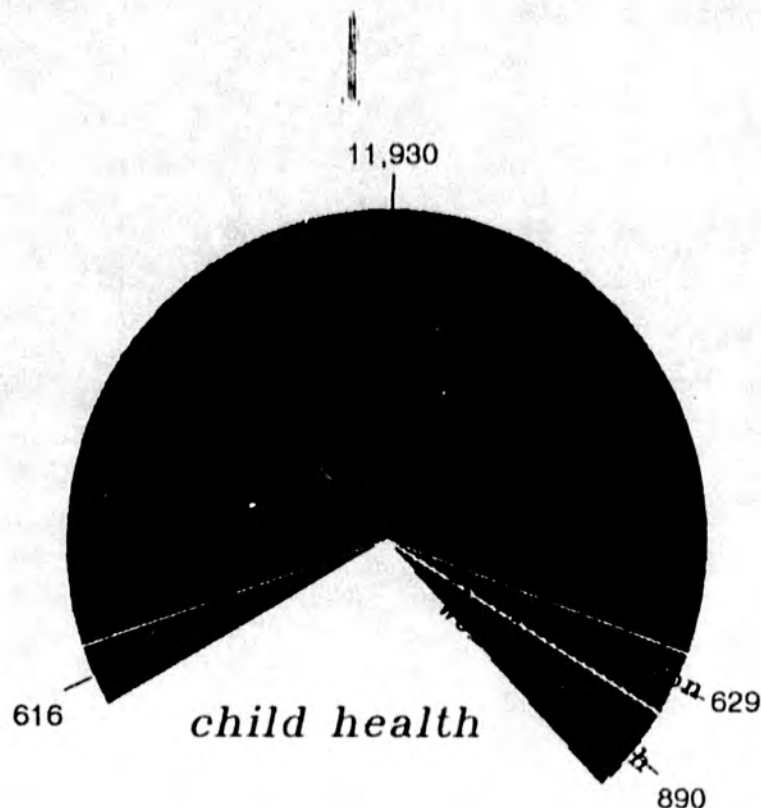
**Funding for field nursing, admin, and EPSDT

FY	Actual Total	Grants	H.H.	Homemaker	Subtotal	G.F.	Other	M.O.A.	NSHC	NSB	Manilaq	Total \$
1980	5,137.6	0.0	0.0	0.0	5,137.6	4,229.3	908.3	846.0	0.0	0.0	0.0	5,983.6
1981	6,255.1	0.0	0.0	0.0	6,255.1	5,277.8	977.3	846.0	0.0	0.0	0.0	7,101.1
1982	6,727.4	390.2	0.0	0.0	6,337.2	4,899.3	1,437.9	846.0	0.0	184.7	205.5	7,573.4
1983	7,716.5	390.2	0.0	0.0	7,326.3	5,664.9	1,661.4	846.0	0.0	184.7	205.5	8,562.5
1984	8,176.7	688.3	664.3	0.0	6,824.1	5,616.0	1,208.1	924.1	296.2	184.7	207.4	8,436.5
1985	8,154.0	184.7	664.3	0.0	7,305.0	5,929.5	1,375.5	873.1	337.4	184.7	256.3	8,956.5
1986	8,475.5	226.2	664.3	0.0	7,585.0	6,055.7	1,529.3	839.1	364.4	226.2	256.3	9,271.0
1987	7,545.7	235.8	643.6	0.0	6,666.3	5,249.1	1,417.2	834.9	367.5	235.8	256.3	8,360.8
1988	8,654.0	235.8	643.6	0.0	7,774.6	6,357.6	1,417.0	856.0	346.2	235.8	220.9	9,433.5
1989	9,934.6	1,287.5	585.9	0.0	8,061.2	6,431.9	1,629.3	914.5	408.8	266.3	251.3	9,902.1
1990	12,022.5	1,354.5	608.6	1,488.6	8,570.8	6,650.7	1,920.1	1,004.5	469.5	382.0	138.7	10,565.5
1991	13,334.6	1,404.5	611.8	1,488.6	9,829.7	7,534.5	2,295.2	973.5	518.2	373.0	225.1	11,919.5
1992	13,725.0	1,404.5	611.8	1,200.0	10,508.7	8,251.6	2,257.1	914.5	601.8	373.0	399.5	12,797.5
1993	11,307.1	1,214.6			10,092.5	7,828.4	2,264.1	815.0	576.8	332.5	385.3	12,202.1

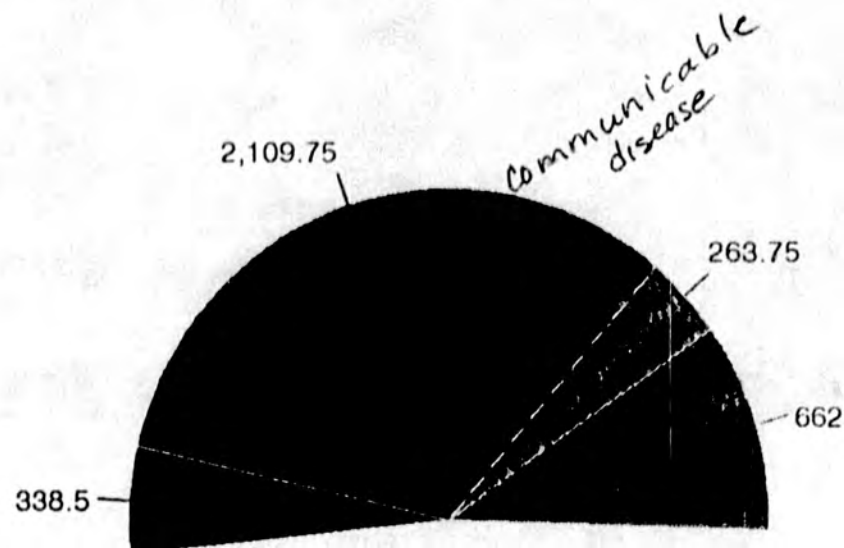
PH Nursing Budget Showing Grants, BRUs, and Other Funded Services

Public Health Nursing Program

F-57



Individuals Served
by Program Category



Hours of Service
by Program Category

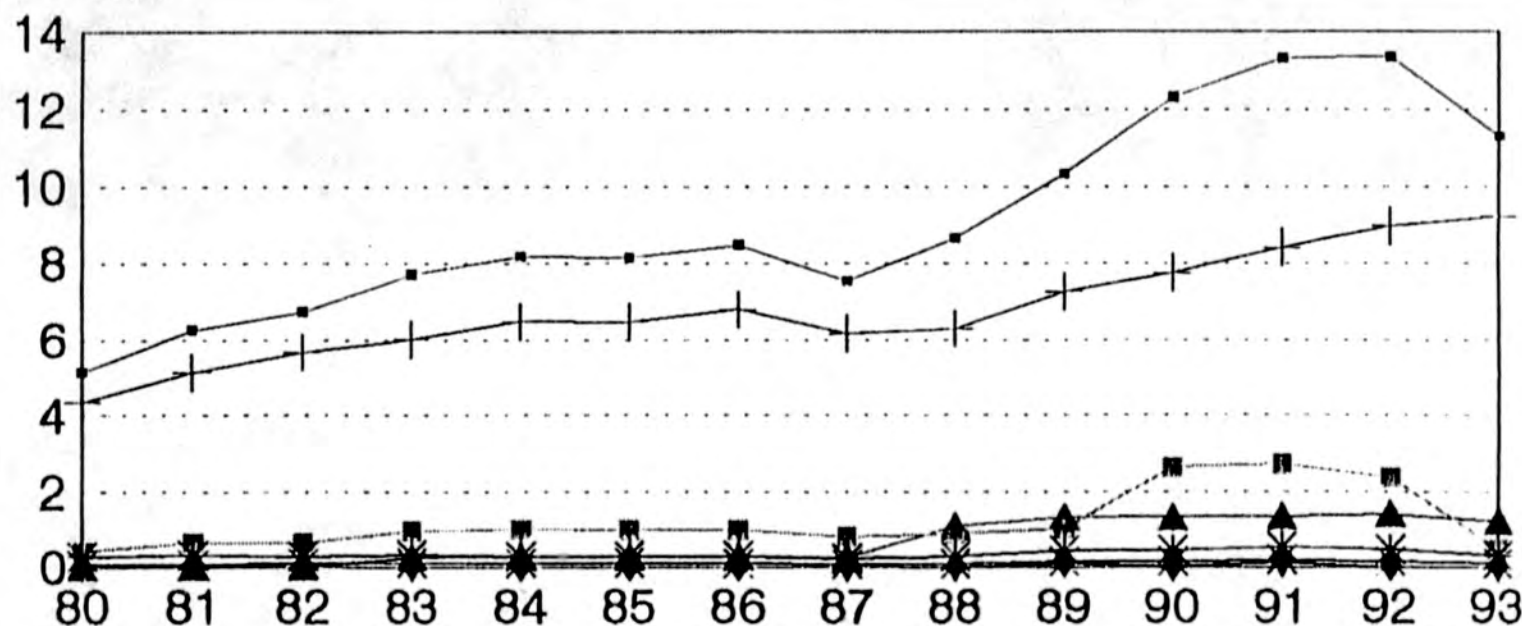
BUDGET SUMMARY BY LINE ITEM

FY80-93

Actual + PERS. SERV. * TRAVEL
 CONTRACT 300 * COMMOD. ♦ EQUIP.
 ▲ GRANTS

F-58

Millions



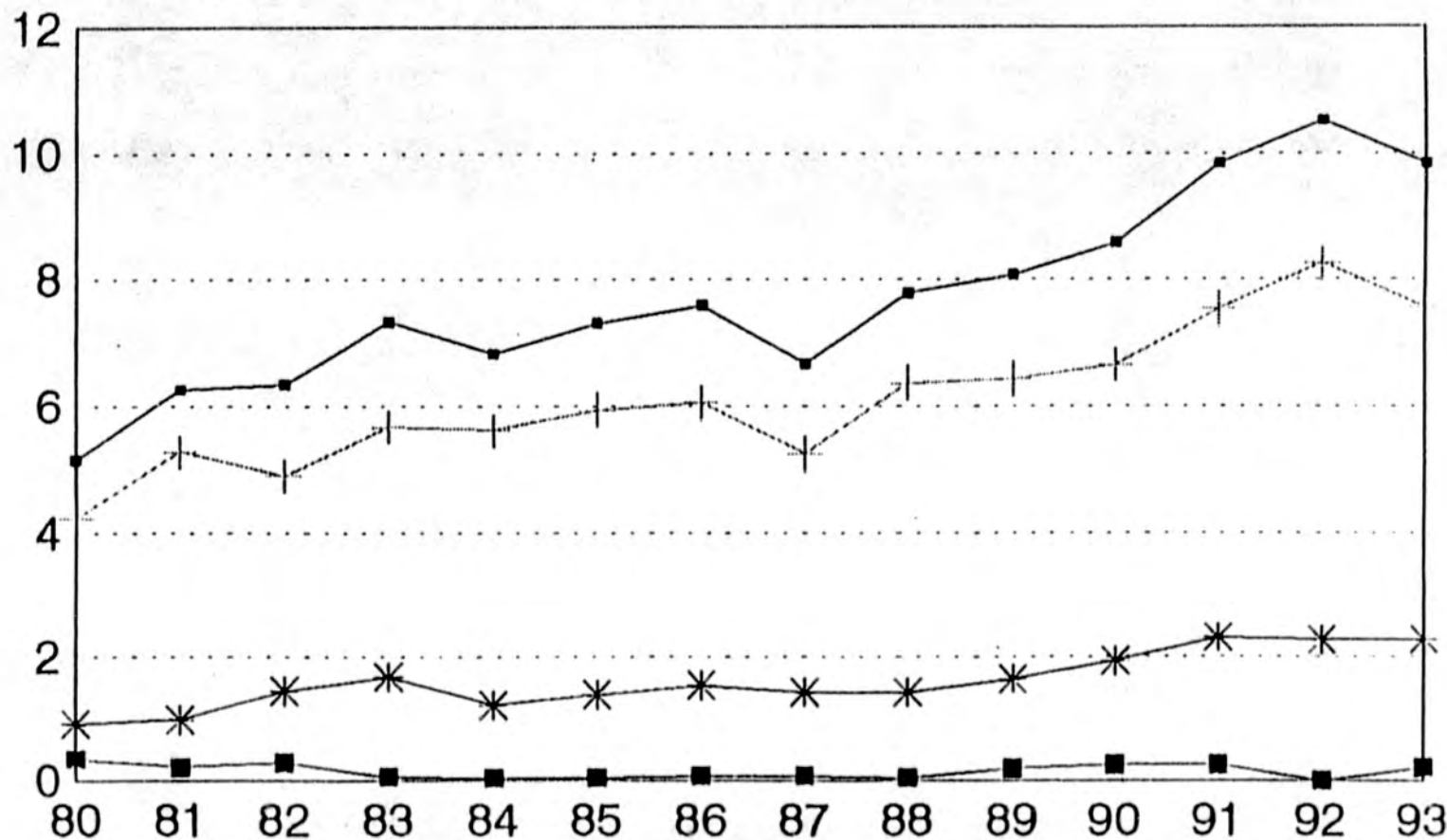
FY80-91 Actual FY92-93 AUTH

FIELD NURSING AND ADMINISTRATION BUDGET BY FUNDING SOURCE

FY 80-93

TOT. FUNDS + G.F. * IA ■ FEDERAL

MILLIONS



Medicaid & Healthy Baby included through FY92. Out in FY 93.

...and the percentages and rank of Native deaths caused by heart disorders and malignant neoplasms



State gives Skagway residents 'clean bill' of health

MAN'S ARK Skagway residents have been given a 'clean bill' of health by the state health department. The department's report, which was released last week, shows that the town's health is in good shape. The report also notes that the town's health is better than it was in 1988, shortly after the lead contamination was discovered. The report shows that the town's health is in good shape, with no health problems from lead in Skagway, and the town's health is better than it was in 1988, shortly after the lead contamination was discovered. The report also notes that the town's health is better than it was in 1988, shortly after the lead contamination was discovered.

Hot tubs are hotbeds for newly recognized infection

AIDS remains urgent problem

They show there's no health problem from lead in Skagway, and the town's health is better than it was in 1988, shortly after the lead contamination was discovered. The report also notes that the town's health is better than it was in 1988, shortly after the lead contamination was discovered.

Sexually transmitted virus suspect in infant

These were the leading causes of Native deaths from 1980-1988. The figure stands for the number of deaths per 100 population.

Child's electrocution spurs House reform

Child's electrocution spurs House reform. The House is considering a bill to reform the state's electrical code, following the death of a young boy who was electrocuted while playing with a power cord.

Midnaugh: No health problem from lead

Midnaugh: No health problem from lead. The state health department's report shows that the town's health is in good shape, with no health problems from lead in Skagway, and the town's health is better than it was in 1988, shortly after the lead contamination was discovered.

AIDS IN RURAL ALASKA

AIDS in rural Alaska. The state health department is conducting a study to determine the prevalence of AIDS in rural Alaska. The study is part of a larger effort to understand the spread of the disease in the state.

Native population of TB

Native population of TB. The state health department is conducting a study to determine the prevalence of tuberculosis in the Native population of Alaska. The study is part of a larger effort to understand the spread of the disease in the state.

Mauling of infant under investigation

Mauling of infant under investigation. The state health department is investigating the death of a young boy who was mauled by a dog. The investigation is ongoing, and the state is working to determine the cause of the death.

Herpes outbreak

Herpes outbreak. The state health department is conducting a study to determine the prevalence of herpes in the state. The study is part of a larger effort to understand the spread of the disease in the state.

State winning fight to rid

State winning fight to rid. The state health department is conducting a study to determine the prevalence of a disease in the state. The study is part of a larger effort to understand the spread of the disease in the state.

botulism outbreak

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AIDS case in the rise

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State will provide

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Risking radon

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Finding may be key to diabetes

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Deaths of kids operating all-terrain vehicles

Deaths of kids operating all-terrain vehicles. The state health department is conducting a study to determine the prevalence of deaths of kids operating all-terrain vehicles in the state. The study is part of a larger effort to understand the spread of the disease in the state.

Illness prevalent in cleanup crews

Dr. John Middaugh said Alaska is in the grip of a rare virus of warm weather. He said the virus is the cause of a rash of illnesses among cleanup crews.

State urges vaccinations for kids

The Alaska Section of Epidemiology is urging parents with children under 12 years of age to have their children vaccinated.

As in other parts of the state, there have been 37 cases of botulism in the North Slope Borough and in Anchorage.

Dr. Michael Jones of the epidemiology section said that this type of botulism is rare in Alaska.

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Native mortality

Child's electrocution spurs House reform

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Anchorage Daily News

WASKE, 1976 Pulitzer Prize Gold Medalist
 David E. Drilly
 Publisher

Susan Nightingale
 Editorial Page Editor

Katherine Fanning, Editor and Publisher 1971 to 1983
 Lawrence Fanning, Editor and Publisher 1987 to 1991

Alaska's Only Morning Newspaper • Founded in 1946 by Norman C. Brown

Anchorage Daily News

NO 230 80 PAGES

ANCHORAGE, ALASKA, SATURDAY, AUGUST 18, 1990

PRICE

The Crown Point disaster isn't over

Six months have passed since the toxic chemical leak at Crown Point, but the disaster isn't over for the people who lived there. Twenty-nine of the 33 families still report health problems when they return to their homes, and refuse to move back.

It's easy to wonder if the residents are truly advantage of the state's disaster relief. The Division of Emergency Services has earmarked \$517,000 for housing, clean-up of homes, and even mental health counseling. An epidemiologist has said that lineages don't appear to cause the

residents don't dispute that the Moose Point residents become ill when they return to their homes, and the report notes that chemical odors still linger in many homes — though the concentrations are below those known to cause health reactions. The epidemiologist said psychological stress from the disaster, rather than the chemical leak, is the

Ally News Sunday, May 31, 1992

ALLEY HOSPITAL:

of illnesses after poisonous gas leak leaves
 yees wondering and hospital officials mum

housing for those unable to return. That help must continue as long as residents need it.

Crown Point cleanup

Sight of respirator bothers

Residents are up their noses at the appearance of workers equipped with respirators touched a raw nerve. "They've been telling us for a month that it's safe to return to our homes," said Cliff Judkins, owner and operator of the Crown Point Lodge. "They said if you couldn't smell it and it didn't bother you, you could move back in. Then their clean-up crew shows up wearing moon suits and respirators. It's safe for us to breathe it, but not for them."

Judkins is not the only person shocked by the arrival of the men in the masks. "If you had faith in the



By DAVID HULEN
 Daily News Staff Writer

Toxic metals foul stream near mine

Until recently, state officials have said they weren't sure what was causing the muddy banks just down a hill from Red Dog's bleeding mine pit. But they said this week they are convinced the mine is causing the increased leaching.

Red Dog Mine

Nuclear fish?

Arctic pollution is widespread

It's a relief to read that scientists will soon be assessing nuclear waste in arctic waters off the Russian coast. Twenty scientists and researchers from six nations will board a Russian ship in July to begin charting dumping sites and testing them.

The New York Times reports from Russia that Norway and Russia are both concerned about fishing grounds in the Barents and Kara seas, where nuclear dumping occurred for over 30 years. It's no wonder since their fishing fleets fuel a fish-exporting industry that weighs a lot of weight.

But smaller fish-exporting and fish-eating countries, like Greenland, are also at risk. Russia-Greenland fishing treaty signed in March allows the latter's cod fishermen to fish in the Barents Sea, while Russian fishermen can fish in Greenland's waters. With the most recent news of Russian nuclear dumping, it makes you wonder who's getting the better deal (especially since the Greenlanders are entitled to only 8,500 tons over 11 years, but the Russians can scoop up 31,400 tons).

Advisory report says Valdez resident face benzene gas-related cancer risk

By DAVID BOND 3-20-92
 TIMES WRITER

Valdez residents face a big city cancer risk from benzene gas emitted by the loading of oil tankers at the Alyeska Marine Terminal, according to a report released Thursday by the watchdog Regional

Alyeska Pipeline Service Co. spokeswoman Mamie Isaacs blasted the report's risk assess-

complies with all federal emission standards, but some emissions the terminal, including cancer-causing benzene and other volatile organic compounds, are not regulated by the EPA because their risk to humans in Valdez has been determined to be low.

THE BACK PAGE

HOOPER BAY: Broken fluoride pump blamed by officials

Continued from Page A-1

"It appeared what was going on was that the mechanism was pumping only fluoride into the tank, when it should have been pumping both water and fluoride," said Bruce Erickson, western regional manager for the state Department of Environmental Conservation. "It happened right in front of our guy who was out there this week."

As the level of water in the tank dropped lower on day, the equipment show had automatically filled with water from a well. But a second pump injected fluoride into the system, and not water. Erickson said the fluoride concentration in the tank was suddenly a dead to public water supply.

including those in Anchorage and many villages in Alaska — to reduce tooth decay.

As in many rural Alaska villages, Hooper Bay residents make regular trips to central wells where they fill 5-gallon buckets and haul them home.

Tests of water taken from the holding tank in question, in the center of the village, showed fluoride levels at nearly 18 times the concen-



ROBIN POWELL / Anchorage Daily News

drank, because his family dumped it out before it could be tested.

People who got their water from a second public well in another section of town didn't get sick. The suspect well remains shut off, and villagers are now also getting water from another well at the village school, as well as ponds and an administrator.

There's no among local health agencies reference guide much fluoride to cause sudden when consumed.

But doctors here are probably people in Hooper Bay and recent scientific literature shows that the level in Hooper is dangerous.

"The woman that was hospitalized earlier this week, at this point we can say with quite a bit of certainty that her illness — which could have killed her — was from the fluoride," Dr. Donn Kruse, medical director of the Yukon-Kuskokwim Health Corp., told KTVU-TV in Bethel.

Yet the report makes little mention of what exposure levels it would take to trigger immediate illness in people. The report mentions a 3-year-old who died after eating 200 fluoride tablets.

Thirty-four students in a New Mexico elementary school got badly sick to their teeth drinking water in which a liter measured per million, according to the report. It was 1 to 5 parts

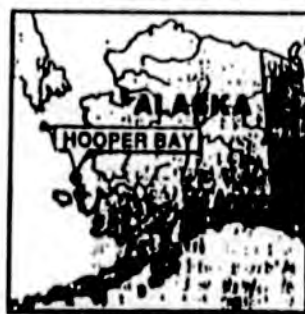
nothing too specific of the literature. Michael Kamrin, at the Institute of Environmental Toxicology at State University, really aren't sure people were exposed to these levels, you're it."

Fluoride illness may have hit 260

State finds Hooper Bay case may be worst ever

By DAVID HULEN 7/1-92 ADN
Daily News reporter

More than 260 villagers in Hooper Bay — nearly 10 times more than previously reported — may have suffered fluoride poisoning last month after drinking water laced with dangerous levels of the chemical, according to a new state study issued Tuesday.



ROBIN POWELL / Anchorage Daily News

A 41-year-old man died after drinking large amounts of water from a village well, and the Hooper Bay incident is now believed to be the largest outbreak of fluoride poisoning ever reported, according to the new study by doctors in the state's Section of Epidemiology.

The report describes a string of serious blunders — from malfunctioning pumps to a barely functioning local government — that

led to fluoride being added at levels nearly 10 times what is considered safe by the federal government.

Dominic Smith died and his 37-year-old wife was hospitalized on Memorial Day weekend after high levels of

Please see Back Page, ALASKA

Mystery sickness hits Hooper Bay

By DAVID HULEN
Daily News reporter

A mysterious illness in a western Alaska coastal village has left a 41-year-old man dead, his sister hospitalized and two other villagers suffering from nausea, vomiting, diarrhea and tingling hands and arms.

Health authorities were scrambling Tuesday to figure out what was making people sick in Hooper Bay, a Yup'ik Eskimo settlement of more than 900 people on the Bering Sea coast northwest of Bethel.

Between 20 and 30 villagers have complained of less serious, flu-like symptoms in the village in recent days, according to Dr. Donn Kruse, medical director of the Yukon-Kuskokwim Health Corp. in Bethel. No one is sure if those illnesses are connected to the more serious cases, he said.

A team from the state Division of Public Health's Section of Epidemiology was scheduled to arrive in the village today to learn more about the illnesses.



ROBIN POWELL / Anchorage Daily News

"There are many questions, and so far, not many answers," said Dr. Michael Beller, one of the epidemiologists going to the village.

Nearly all of those who became ill had recently drunk water from one of two public wells in the village, leading some residents to suspect that the water in the well was contaminated. The well was shut off over the weekend, and officials from the state Department of Environmental Conserva-

Please see Back Page, HOOPER BAY

Bad pump, water

Malfunction likely link to man's death

By DAVID HULEN
Daily News reporter 5-30-92

A malfunctioning pump probably caused very high levels of fluoride in a tank of drinking water in the village of Hooper Bay sometime last week, when one man died and between 20 and 30 other villagers suddenly became ill, state environmental authorities said on Friday.

Doctors are still investigating the death of 41-year-old Dominic Smith, the near-death of his sister and the sudden, flu-like symptoms in virtually everyone else who drank water from one of two public wells in the village. Doctors strongly suspect fluoride poisoning — the symptoms match — but they're still waiting for autopsy results and other laboratory tests to say for sure.

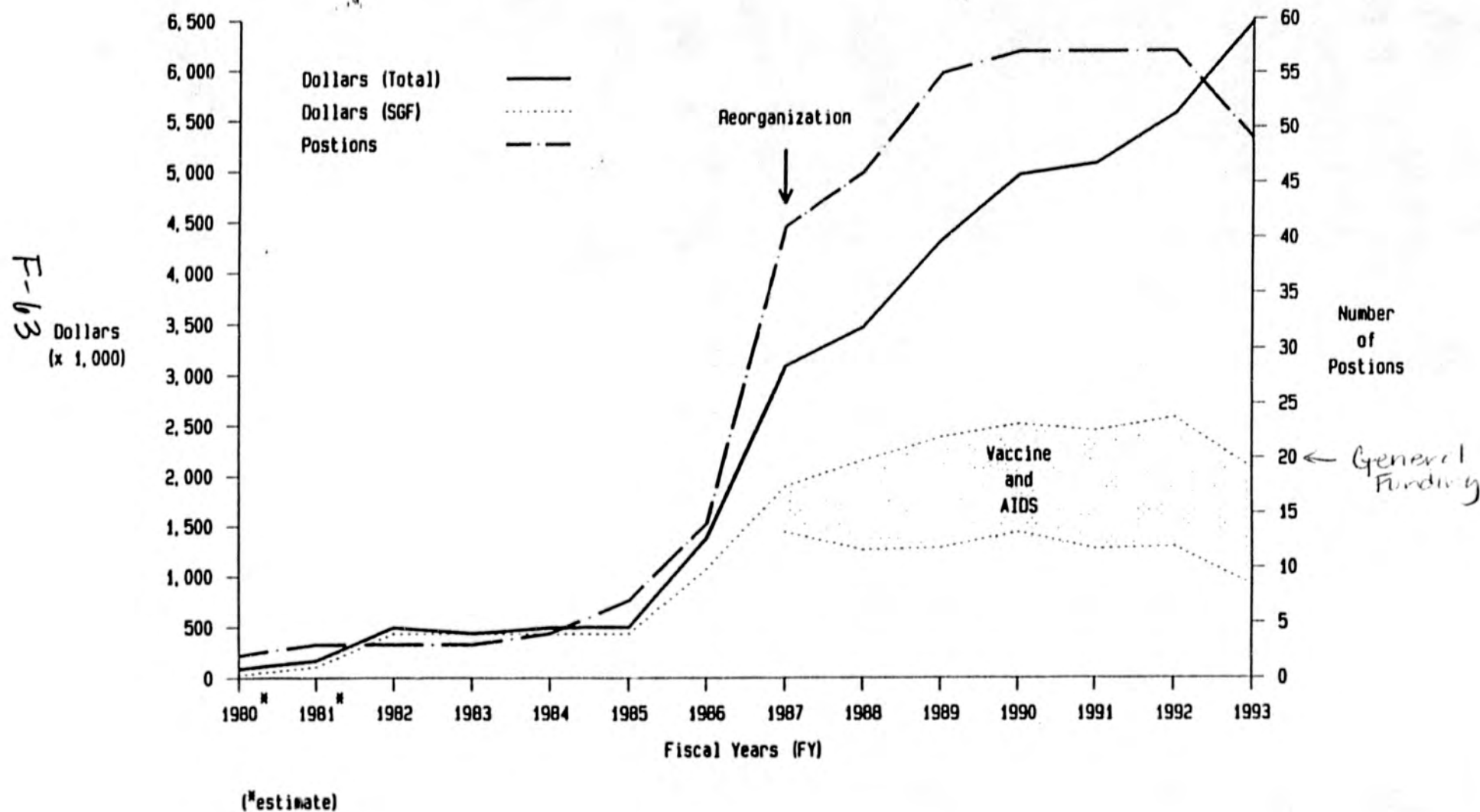
Smith's sister, Melba Joseph, was released from the Bethel hospital this week, and virtually no one else has been reported ill with similar symptoms since the water supply was shut off last weekend. People suffered nausea, vomiting, diarrhea and fatigue and some also had neurological symptoms such as tingling hands and arms.

Officials with the Department of Environmental Conservation said on Friday they were still not entirely sure what happened. But they had become more and more convinced that a malfunction put too much fluoride in the water.

Please see Back Page, HOOPER BAY

Section of Epidemiology

Fiscal Years 1980 - 1993



Fiscal Year	Number of Positions	Total Budget	SGF (Total)	Federal (Total)	(SGF) Vaccine	(SGF) AIDS
FY80	2	85.0	25.0	60.0		
FY81	3	165.0	105.0	60.0		
FY82	3	492.1	432.1	60.0		
FY83	3	433.9	433.9	-		
FY84	4	491.7	426.7	65.0		
FY85	7	498.7	433.7	65.0		
FY86	14	1,374.7	1,068.0	306.7		
FY87	41	3,081.5	1,888.3	1,193.2	*453.0	
FY88	46	3,457.9	2,148.6	1,309.3	*392.6	*498.0
FY89	55	4,303.1	2,376.1	1,927.0	*600.0	*498.0
FY90	57	4,953.3	2,505.9	2,447.4	*575.4	*498.0
FY91	57	5,065.8	2,442.2	2,623.6	*671.5	504.7
FY92	57	5,555.1	2,571.3	2,983.8	*883.7	397.2
FY93	49	6,466.7	2,071.3	**4,395.4	*885.2	271.4

* These amounts are included in the SGF totals.

** Includes the following anticipated new awards in FY93:

Injury-Violence	\$150.0
Hepatitis B	\$569.2
Breast & Cervical Cancer	\$250.0
Immunization Action Plan	<u>\$300.0</u>
	\$1,269.2

F-64

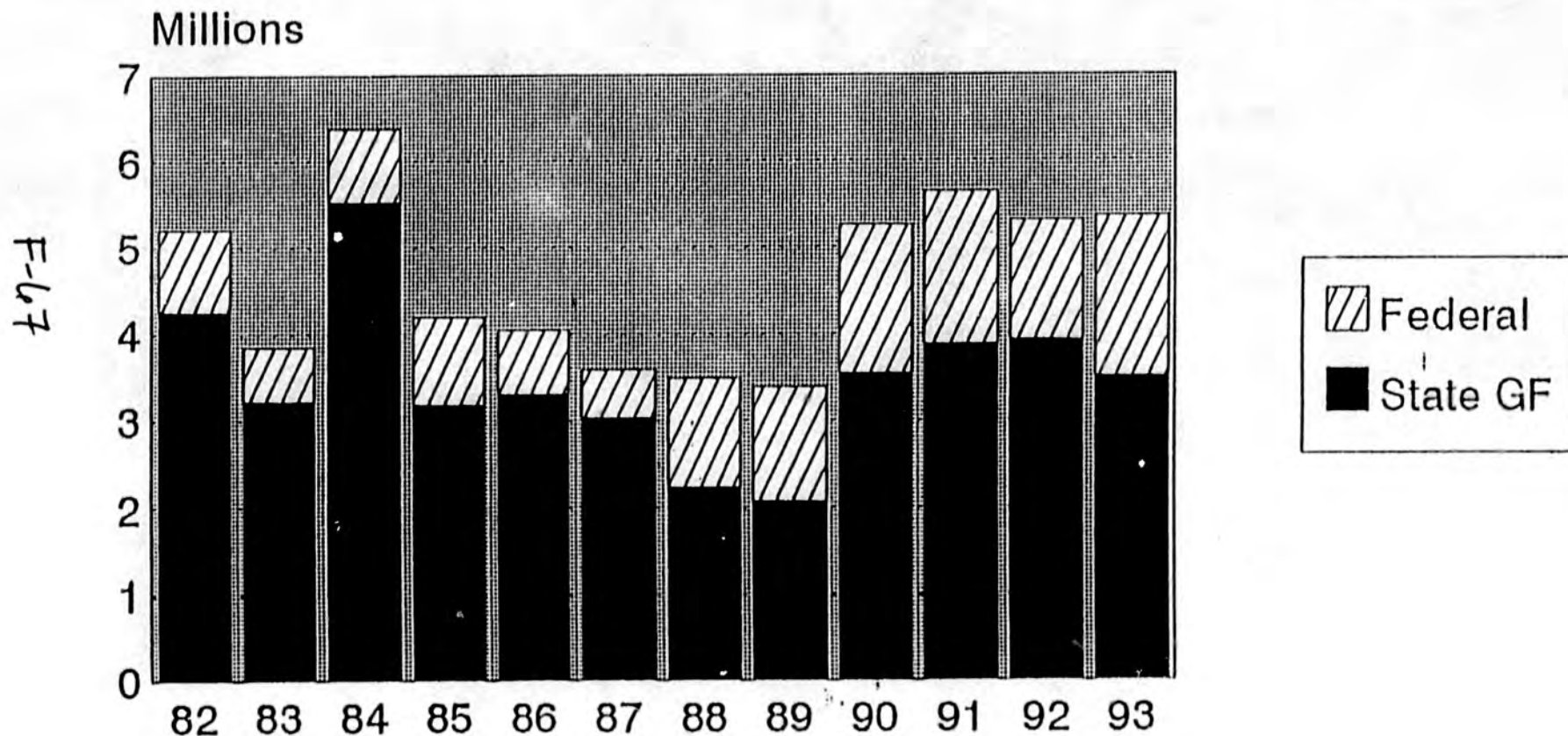
[illegible]

	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2027	2028	2029	2030	2031	2032	2033	2034	2035	2036	2037	2038	2039	2040	2041	2042	2043	2044	2045	2046	2047	2048	2049	2050	2051	2052	2053	2054	2055	2056	2057	2058	2059	2060	2061	2062	2063	2064	2065	2066	2067	2068	2069	2070	2071	2072	2073	2074	2075	2076	2077	2078	2079	2080	2081	2082	2083	2084	2085	2086	2087	2088	2089	2090	2091	2092	2093	2094	2095	2096	2097	2098	2099	2100	2101	2102	2103	2104	2105	2106	2107	2108	2109	2110	2111	2112	2113	2114	2115	2116	2117	2118	2119	2120	2121	2122	2123	2124	2125	2126	2127	2128	2129	2130	2131	2132	2133	2134	2135	2136	2137	2138	2139	2140	2141	2142	2143	2144	2145	2146	2147	2148	2149	2150	2151	2152	2153	2154	2155	2156	2157	2158	2159	2160	2161	2162	2163	2164	2165	2166	2167	2168	2169	2170	2171	2172	2173	2174	2175	2176	2177	2178	2179	2180	2181	2182	2183	2184	2185	2186	2187	2188	2189	2190	2191	2192	2193	2194	2195	2196	2197	2198	2199	2200	2201	2202	2203	2204	2205	2206	2207	2208	2209	2210	2211	2212	2213	2214	2215	2216	2217	2218	2219	2220	2221	2222	2223	2224	2225	2226	2227	2228	2229	2230	2231	2232	2233	2234	2235	2236	2237	2238	2239	2240	2241	2242	2243	2244	2245	2246	2247	2248	2249	2250	2251	2252	2253	2254	2255	2256	2257	2258	2259	2260	2261	2262	2263	2264	2265	2266	2267	2268	2269	2270	2271	2272	2273	2274	2275	2276	2277	2278	2279	2280	2281	2282	2283	2284	2285	2286	2287	2288	2289	2290	2291	2292	2293	2294	2295	2296	2297	2298	2299	2300	2301	2302	2303	2304	2305	2306	2307	2308	2309	2310	2311	2312	2313	2314	2315	2316	2317	2318	2319	2320	2321	2322	2323	2324	2325	2326	2327	2328	2329	2330	2331	2332	2333	2334	2335	2336	2337	2338	2339	2340	2341	2342	2343	2344	2345	2346	2347	2348	2349	2350	2351	2352	2353	2354	2355	2356	2357	2358	2359	2360	2361	2362	2363	2364	2365	2366	2367	2368	2369	2370	2371	2372	2373	2374	2375	2376	2377	2378	2379	2380	2381	2382	2383	2384	2385	2386	2387	2388	2389	2390	2391	2392	2393	2394	2395	2396	2397	2398	2399	2400	2401	2402	2403	2404	2405	2406	2407	2408	2409	2410	2411	2412	2413	2414	2415	2416	2417	2418	2419	2420	2421	2422	2423	2424	2425	2426	2427	2428	2429	2430	2431	2432	2
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1

MCFH EXPENDITURES

By Funding Source

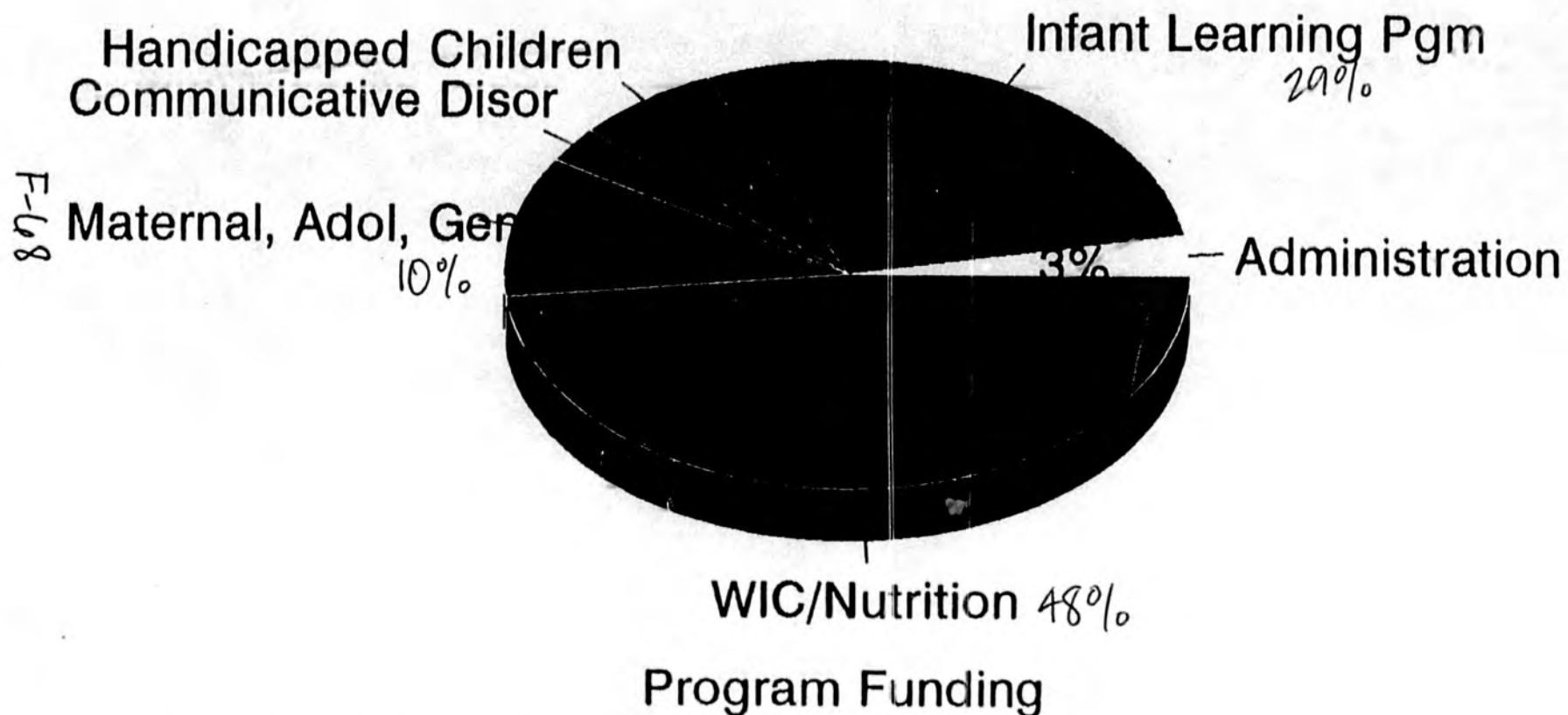


FY93 is Mgmt Plan Estimate

Increase in FY 90 State GF due to GICCY + \$543,000; Prematernal from DFYS + \$600,000; Metabolic Screening from Labs + \$135,000

Section of Family Health

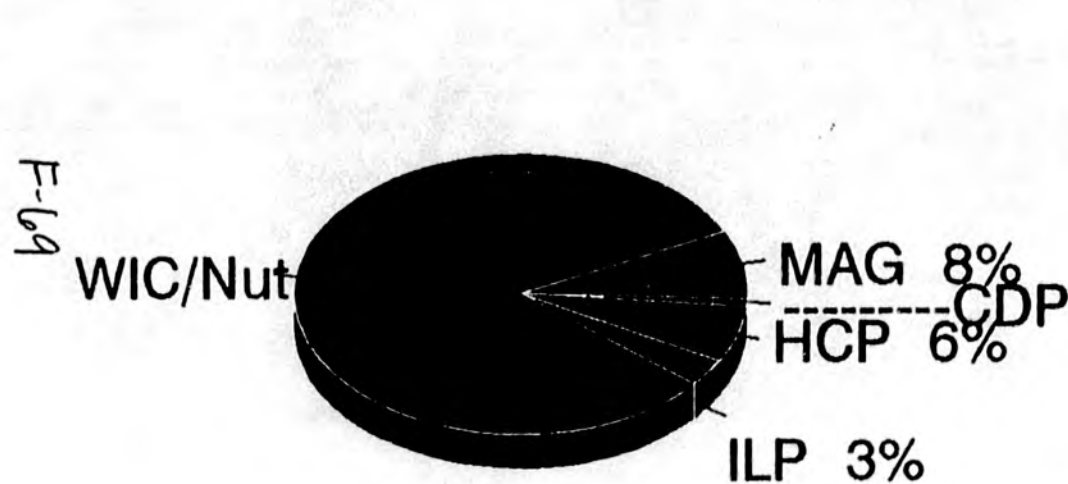
Funding by Program - 1993



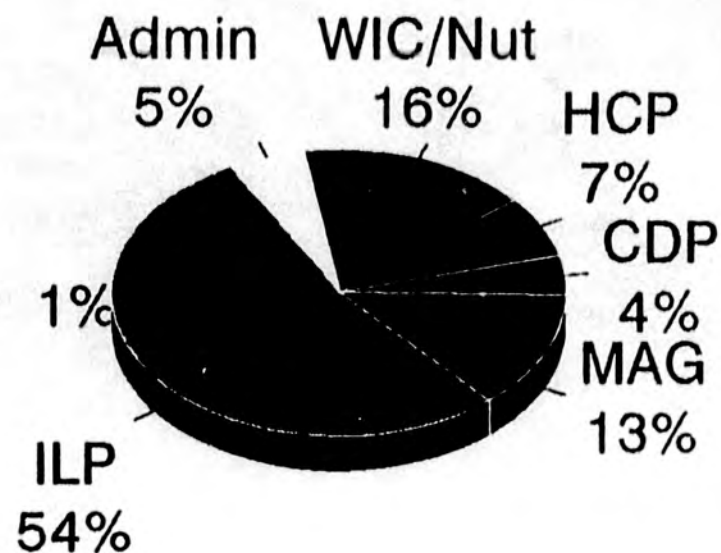
Includes Federal and State Funds
Total Funding = \$19,705,763

Section of Family Health

Federal VS. State Funding - 1993



Federal Funding



State Funding

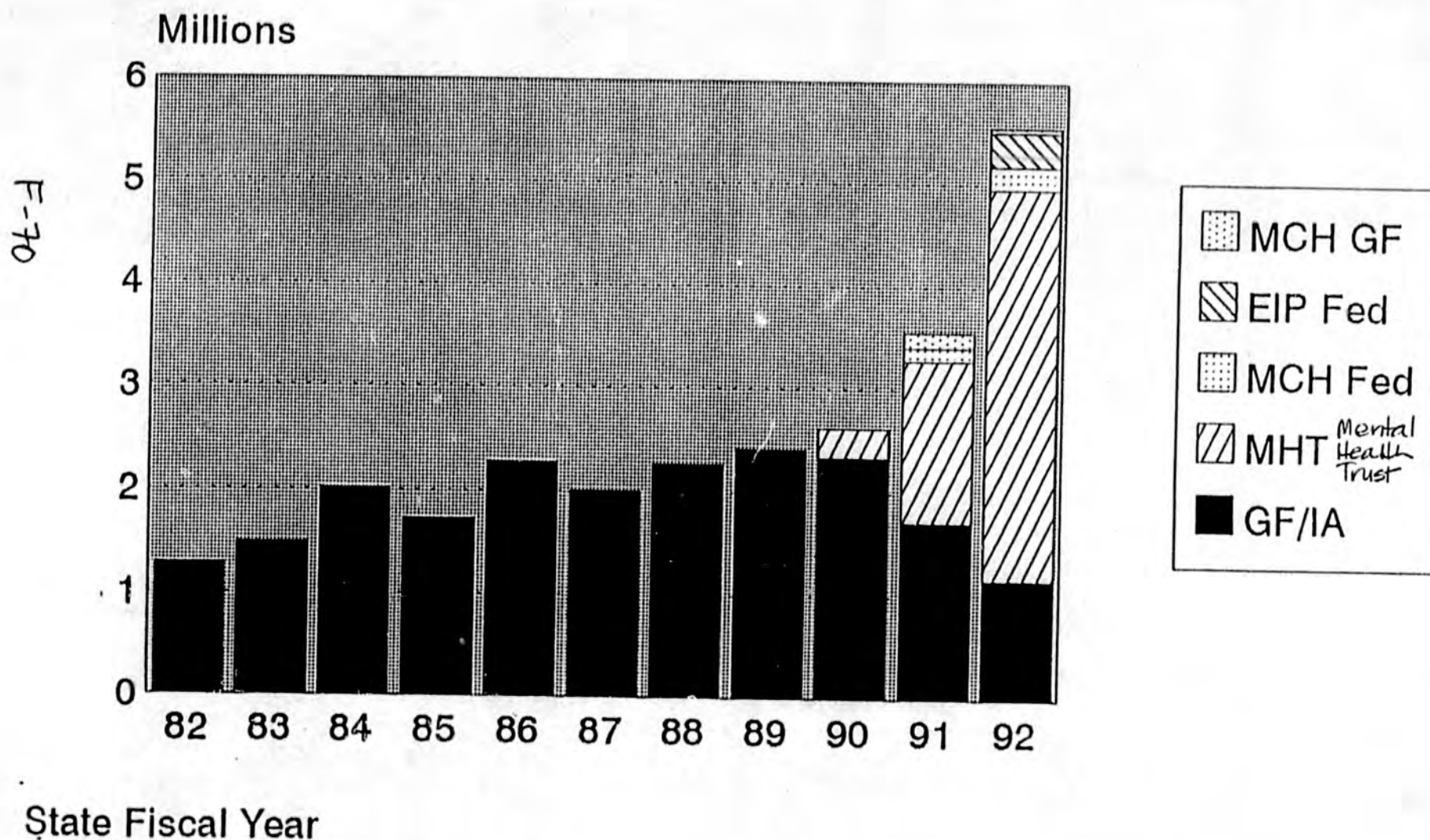
Total Funding = \$19,705,763

Federal Funding \$9,632,303/State Funding \$10,073,460

ILP EXPENDITURES

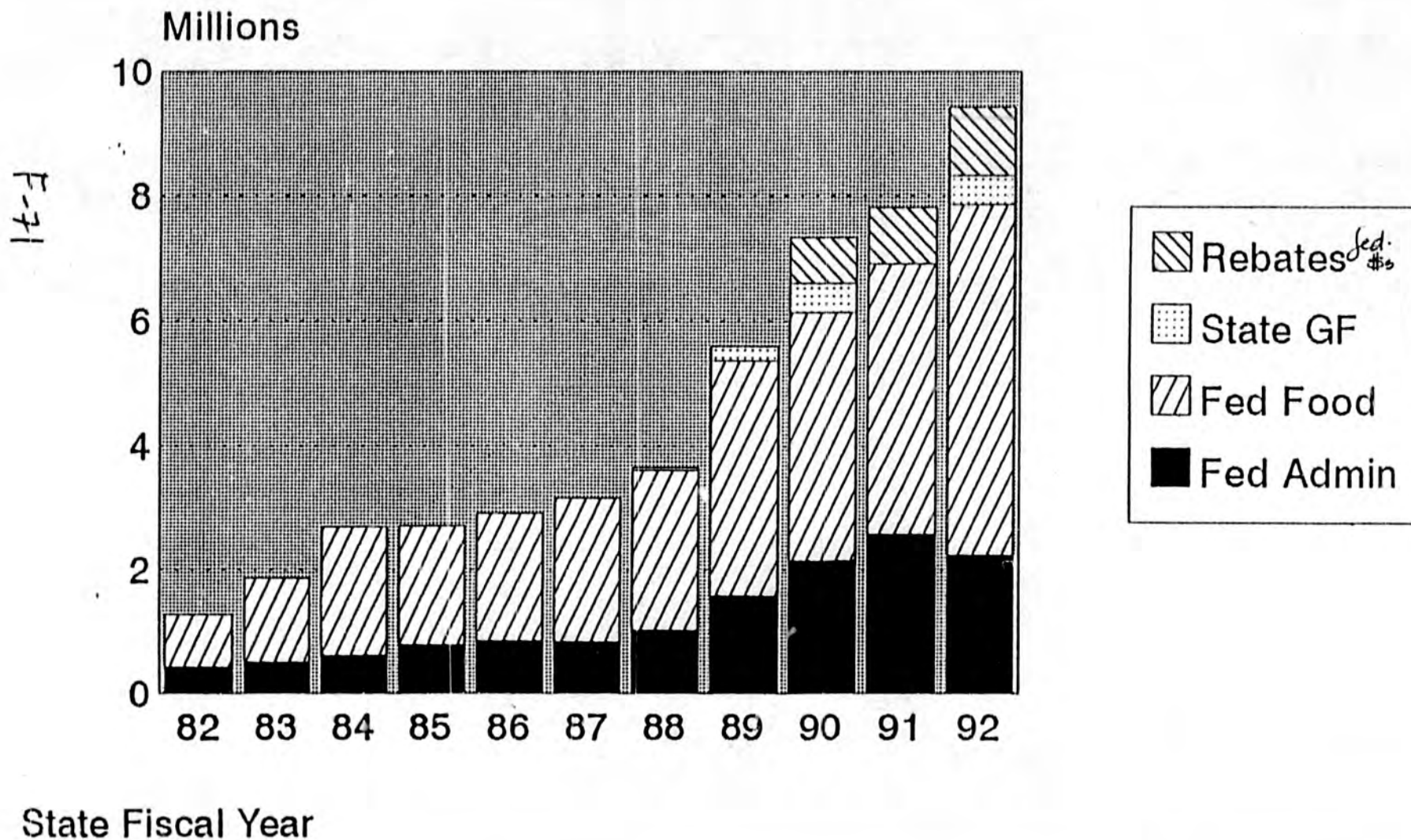
By Funding Sources

Infant Learning Program



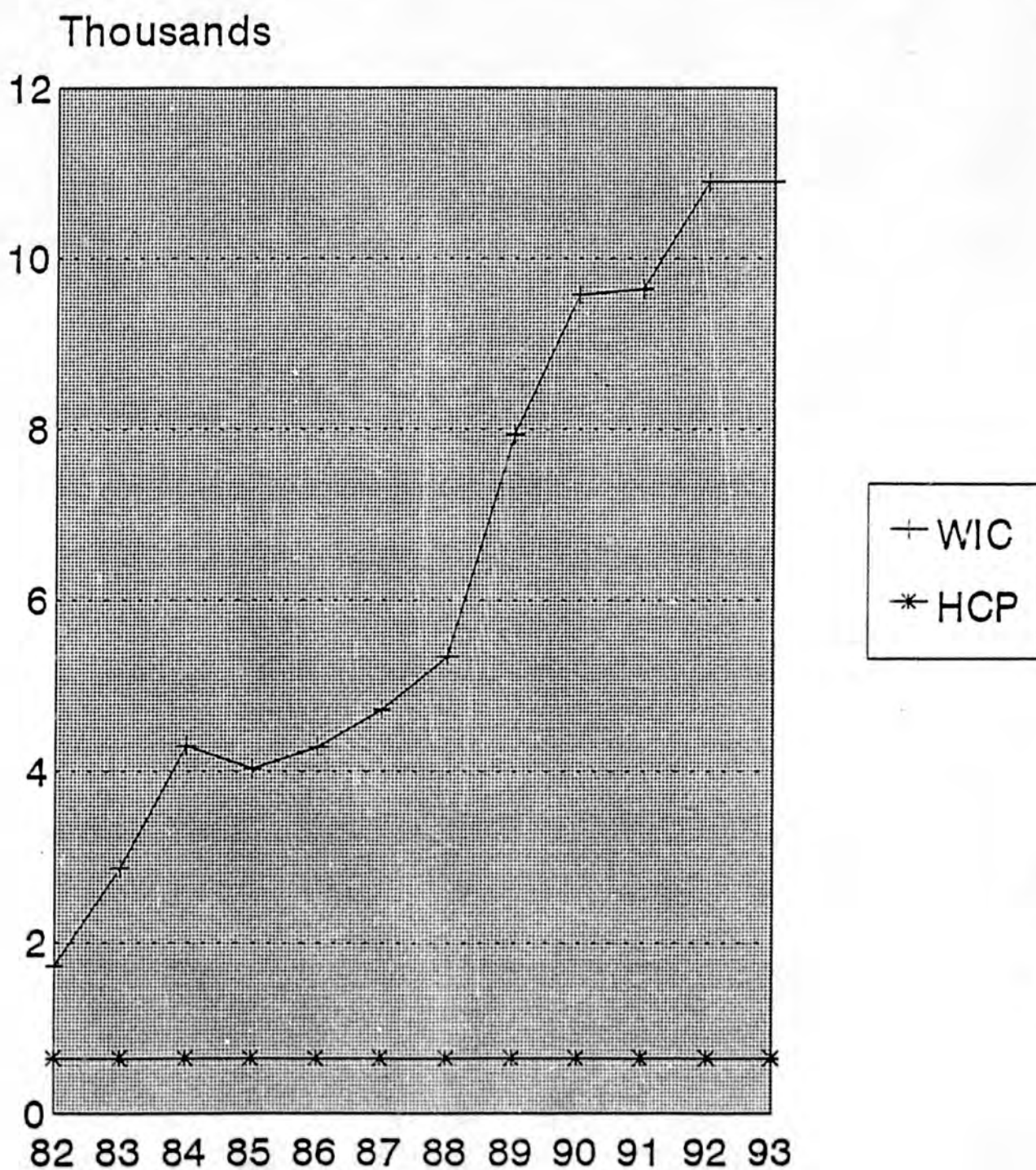
WIC EXPENDITURES

By Funding Sources



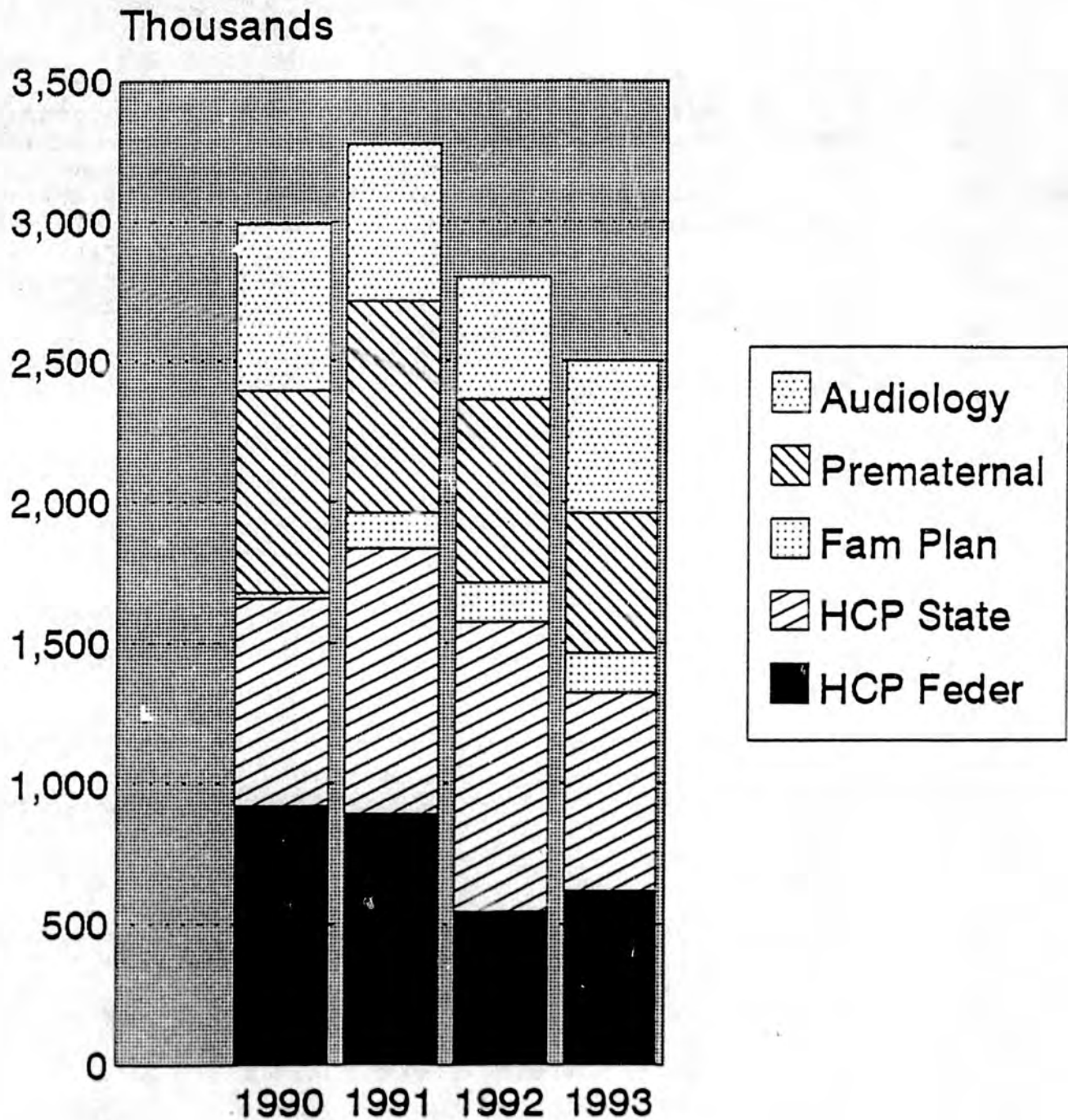
CLIENTS SERVED BY PROGRAM

Maternal, Child & Family Health



F-72

Family Health Program Expenditures



Section of Laboratories

The Section of Public Health Laboratories is one of the primary service arms of the Division. Its three laboratories located in Anchorage, Juneau and Fairbanks have daily interaction with all of the state's health care providers, assisting them with issues regarding infectious disease diagnosis, data interpretation, and technical training.

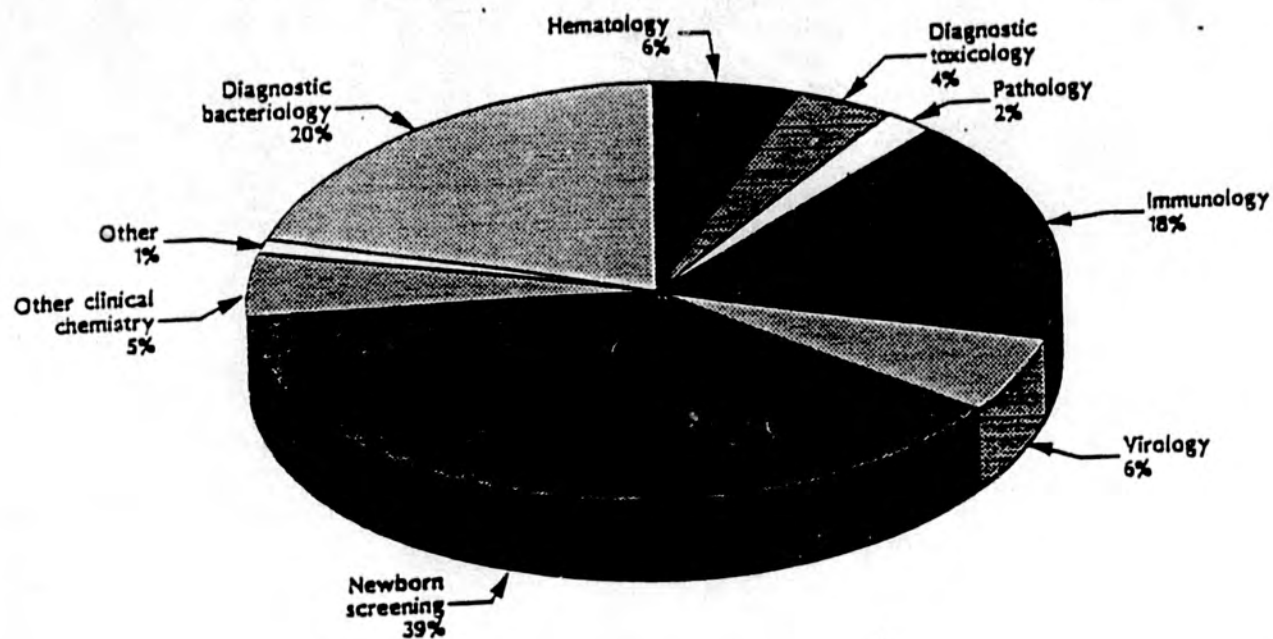
LABS Pie Chart
 Table
 Cartoon
 Appropriations FY 82-93
 Staffing FY 82-93

While it appears that these laboratories function identically to private clinical laboratories, that is not the case. Public Health laboratories, like their private counterparts, do provide testing and reports on individual patients; however, they also aggregate their test results by populations. These data are essential to the assessment of the impact of 1) specific infectious diseases on the population as a whole, i.e. influenza statewide; or on population subsets, i.e. Hepatitis A in Juneau, 2) the success of public health programs such as the childhood immunization program versus outbreaks of vaccine preventable disease; or the improvement of the Angoon water supply and cases of Giardia 3) general improvement of Alaska's health status using comprehensive data sets collected over time. Such data are provided to both the National Centers for Disease Control and the Section of Epidemiology.

Another area of difference between the public and private laboratory is quality assurance. Both types of laboratories have elaborate systems in place to assure that test results are accurate and validated. However, the public laboratory is also concerned about the quality of all laboratory information in the state. To that end, the Section of Laboratories provides consultation, quality assurance information and materials, and training to all laboratories in Alaska. We also serve as a reference to any laboratory which may need verification or identification beyond its technical capability.

During the decade shown on the budget spread sheet, Division of Public Health Appropriations FY82-92, Alaska's Public Health Laboratories have undergone many programmatic and budget changes. These are outlined in Fig 2. Laboratories are primarily funded by the General Fund and have been significantly impacted by each major budget reduction in turn. The overall result has been a significant loss of service and technical capacity in order to stay within the constraints of the budget allocation. Fig 3 shows the model for public health laboratories nationally. Alaska laboratories in FY93 are functioning in only three of the diagnostic areas shown--bacteriology, immunology and virology. Further cuts will cause additional losses of services, data for monitoring, assurance, planning and/or medical evaluation; and of laboratory quality.

FIGURE 4A.
STATE PUBLIC HEALTH LABORATORY DIAGNOSTIC SPECIMENS,
BY CATEGORY, FISCAL YEAR 1988



TOTAL: 23.6 MILLION SPECIMENS

3 labs -

Anchorage
Juneau
Fairbanks

F-75

DIVISION OF PUBLIC HEALTH LABORATORIES

Fiscal Year	Gen Fund	Staff	Workload	Comments
FY82	1,634.5	41	155,172	Included drinking water chem & Bacti, PT program, PSP
FY83	1,907.8	42	173,753	
FY84	2,250.8	42	198,947	DWI Data Communications Grant Rabies Vaccine Project IHS Hepatitis B program
FY85	2,369.8	41	164,392	Drinking water testing moved to DEC, DWI testing begun Premarital testing stopped
FY86	2,240.0	41		Began HIV testing; 930 tests
FY87	2,114.6	40	120,234	Dropped Strep Throat Testing PT program reduced
FY88	2,217.2	38	111,510	DWI Program moved to Public Safety, Drug testing for DOC Fairbanks started
FY89	2,214.8	38	116,792	
FY90	2,173.4	39	110,174	Added Radiologic Health Prgm. Dropped Drug testing
FY91	2,244.2	39	112,326	Increases in HIV, TB, HepA&B
FY92	2,268.6	40	??	HIV tests increased to 17,000 testing.

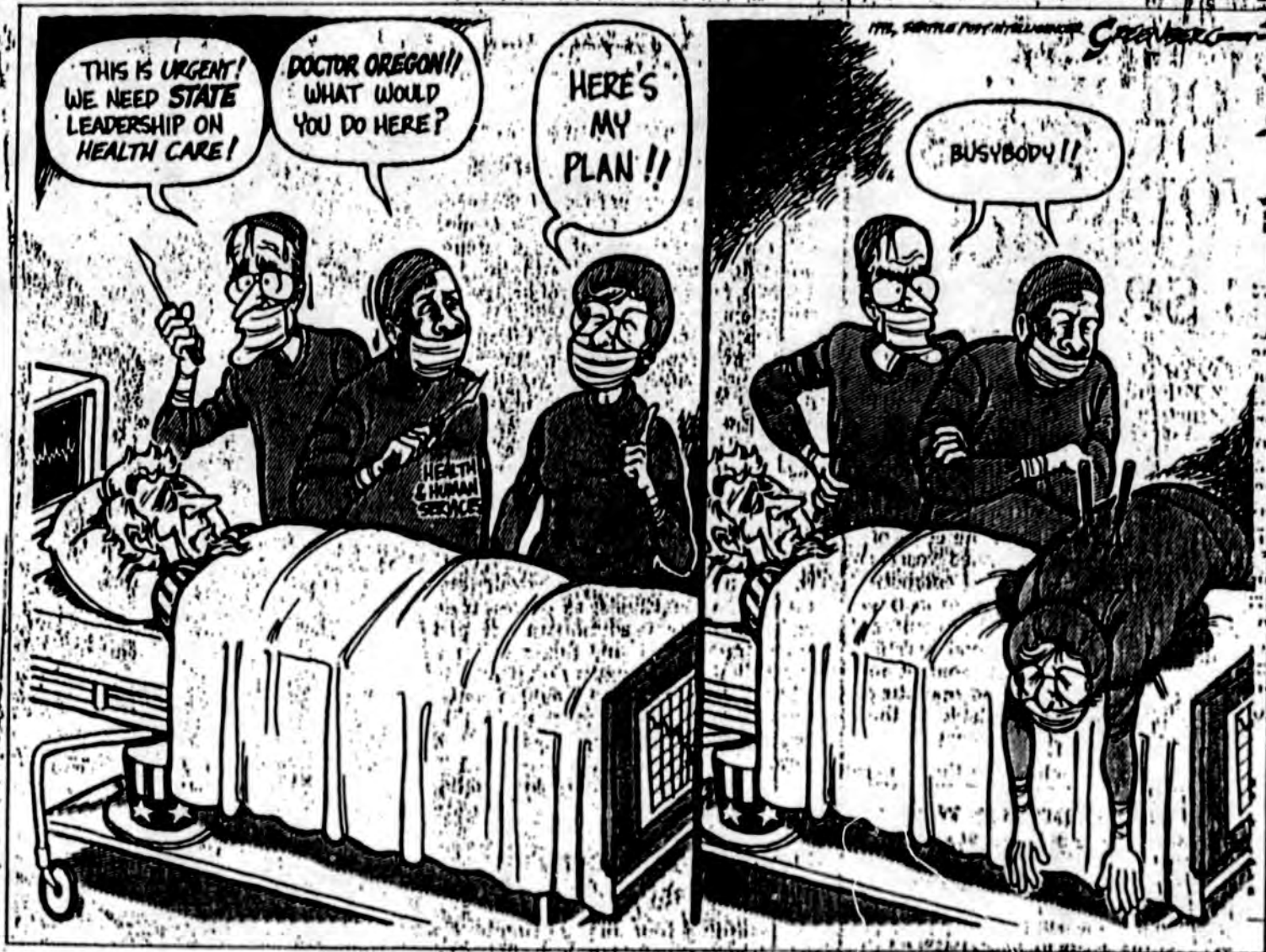
F-76

Seattle Post-Intelligencer

The voice of the Northwest since 1863

Publisher: Virgil Fassio
Executive Editor: J.D. Alexander
Editorial Page Editor: Charles J. Dunlap
Managing Editor: Kerry Slagle
Associate Editor: Thomas A. Read
Business Manager: William R. Cobb

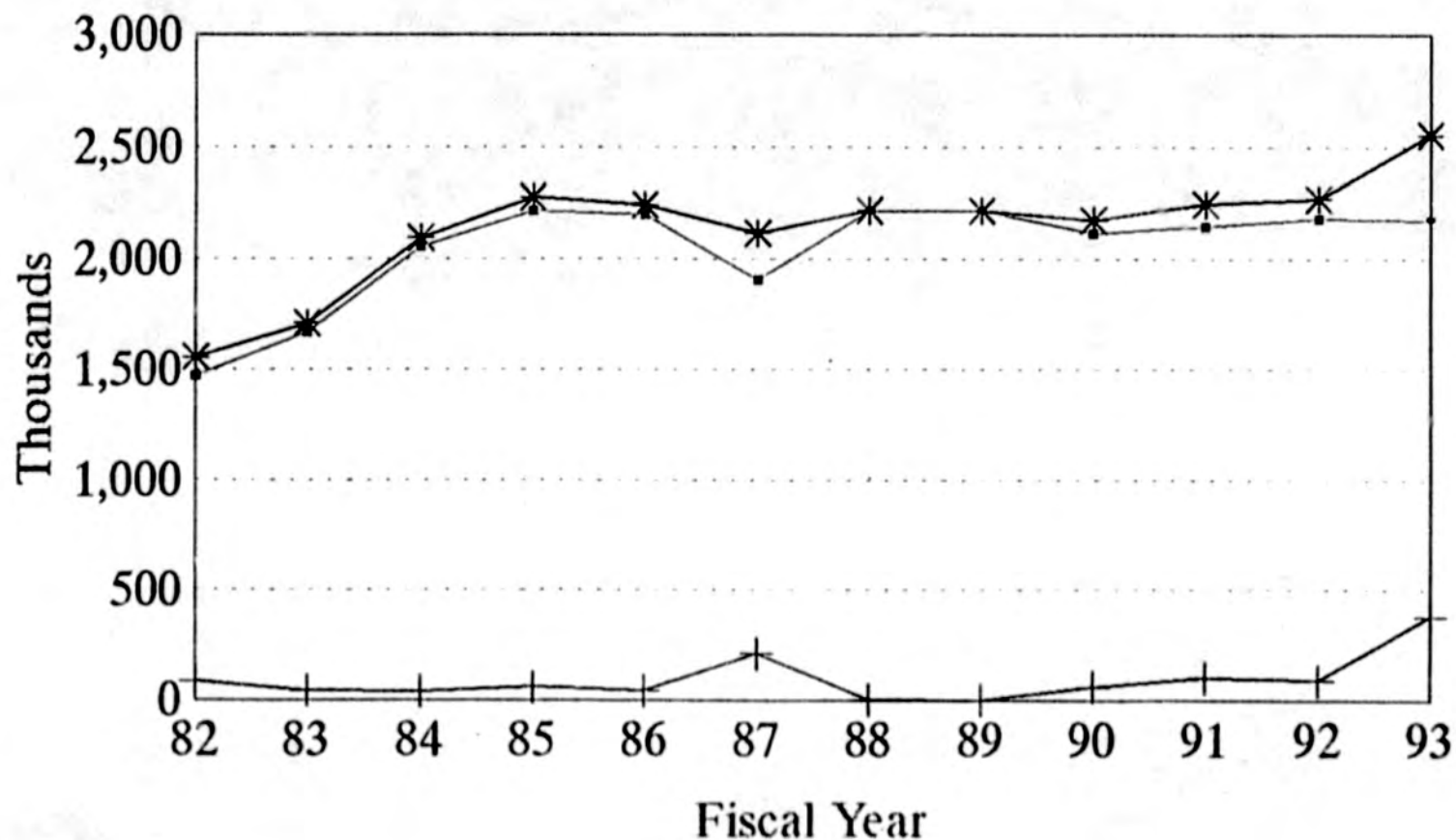
F-77



Laboratory Section

Appropriations FY82-93

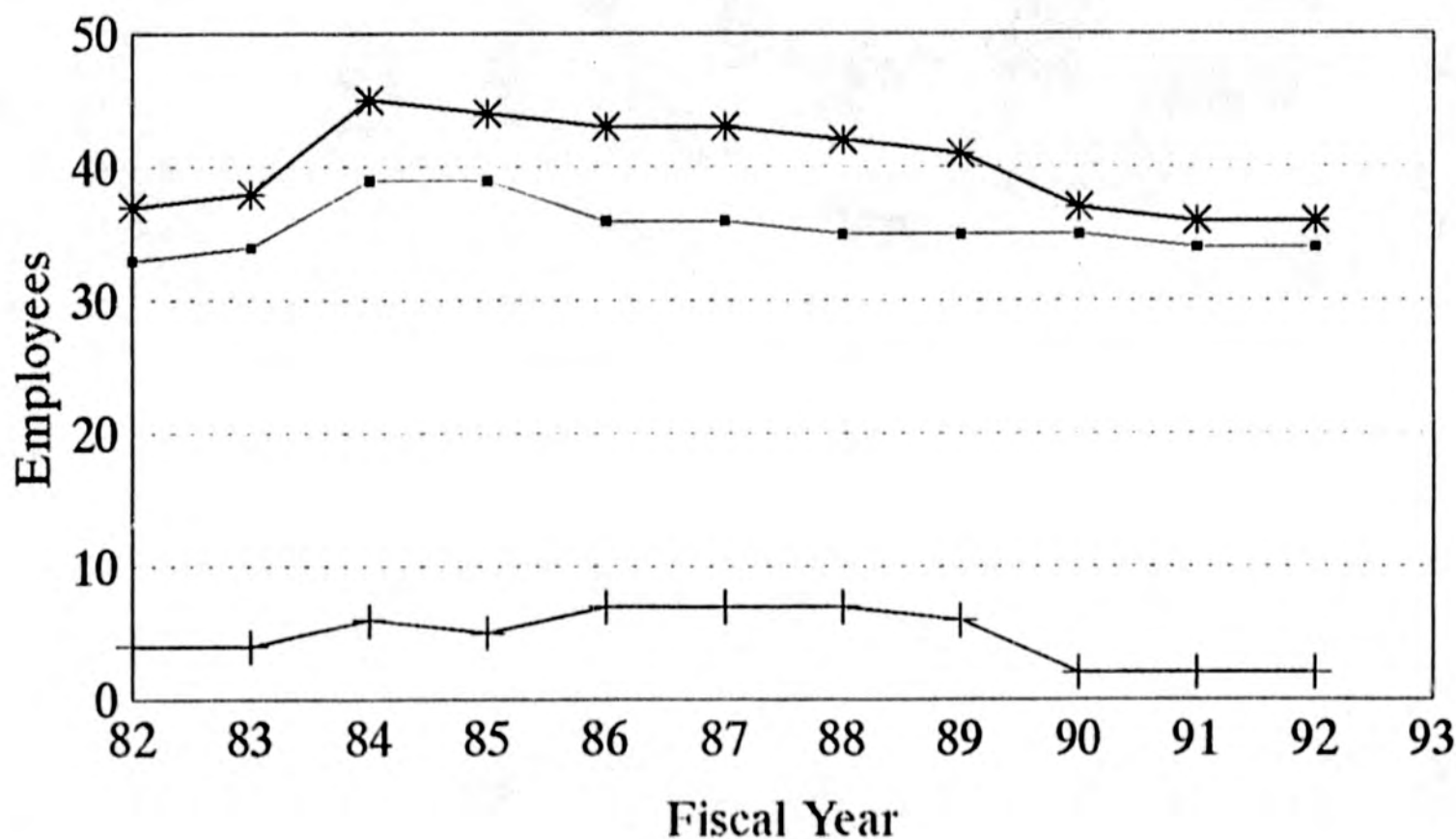
Funding Source
■ GF + Other * TOTAL



Laboratory Section

Staffing FY82-93

Funding Source
■ PFT + PPT * TOTAL



There has been considerable debate regarding the privatization of the public health laboratories in Alaska. While it is true that most individual diagnostic laboratory services could be requested from a private clinical laboratory, there are ramifications which should be considered. As already noted, statistical data regarding the health status of the Alaskan population are lost. This is especially true when out-of-state laboratories are used. Technical expertise which is not duplicated anywhere else in the state is lost during staff reductions. The overall cost of testing increases as workload is redistributed to multiple, for-profit laboratories. Access to diagnostic services is limited to those who can pay or have insurance. Especially with transmittable diseases, lack of early diagnosis and intervention leads to more disease.

There are good and compelling reasons for a state public health laboratory in Alaska and for its continued role in Public Health Care. In FY93, the Section of Laboratories will be moving to become more financially self-sufficient by aggressively seeking federal grant support and by collecting third party reimbursement. It is very important to note that Laboratories will never be 100% self-sufficient. "The poor are always with us" and in Alaska the state has a constitutional obligation to protect their health.

The State Public Health Laboratories have the potential to take on a larger portion of diagnostic Public Health Care. Present constraints are financial and physical. FY93 and beyond should see an improvement in the fiscal picture; only Legislative support can solve the physical problems. Of particular concern is the facility in Anchorage. This laboratory is housed on the top floor of an old and deteriorating office building. There have been numerous electrical, plumbing and ventilation problems. At least two staff have become tuberculosis positive, most likely work-related. The building is situated on the edge of the 4th Avenue fault line. The Department has made the replacement of the laboratory a priority for capitol funding. It is hoped that this funding will become available soon and that a serious disaster will not occur in the interim.

V. TRENDS WITHIN OTHER DIVISIONS OF THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES

In the introduction to this presentation I stated that the Mission of Public Health is the joint responsibility of individuals, communities, the private sector and public agencies. My discussion has focused on the activities within the Division of Public Health for whose direction I have been given the leadership. Those federal, state and local agencies responsible for public safety, housing, education, and environmental conservation, are but examples of public programs having a significant role in bringing about and protecting the public's health. The services provided or not provided by the other divisions within the Department of Health and Social Services must be reviewed in a similar manner to ascertain the full impact of the Department's capabilities in meeting the assessment, policy development and assurance functions of Public Health. The other divisions within the Department are (1) the Division of Mental Health and Development Disabilities, (2)

the Division of Alcohol and Substance Abuse, (3) the Division of Youth and Family Services, (4) the Division of Public Assistance, and, (5) the Division of Medical Assistance.

VI. PUBLIC HEALTH CHALLENGES IN ALASKA

1. Declining resources in the face of escalating health care costs.
2. Increasing prevalence of health care problems resulting from life style practices (smoking, substance abuse, dietary indiscretions, sedentary life, sexual indiscretions, alcohol and substance abuse.
3. The emergence of new challenges for which we have limited technology for treatment (AIDS, DRUG RESISTANT TB).
4. Continued problems relating to access to health care (economic, cultural, geographic).
5. The ability to meet well-intentioned but costly new federal and state mandates. (OSHA bloodborne pathogens regulations, lead screening, CLIA standards, American Disabilities Act).
6. Competition for resources (maternal and infant needs, elderly Alaskans, handicapped and disabled, mentally impaired, rural needs, urban needs, political interests, etc).
7. Toxic and hazardous waste risks.
8. Health manpower recruitment and retention.
9. Safe water and waste disposal
10. Domestic violence, child abuse and neglect and other issues resulting from societal ills.
11. Chronic diseases and our aging population.
12. Suicides (especially among our Alaska youth).

VII. THE ROLE OF PUBLIC HEALTH IN HEALTH CARE REFORM

Health Care Reform is driven by the need to address issues of access to care and the escalating cost of care. Public Health is an essential tool for addressing those issues.

Assessment is critical to provide the data and information needed to drive public health policy. We must know the issues of concern, the magnitude of these issues, and the human and economic cost.

Public policy based on the assessment function and scientific knowledge will effect the most beneficial use of our resources in attaining public health. Fiscal and Human resources can be

directed to those conditions that contribute most heavily to human distress and monetary expenditures.

The public health profession has experienced a great deal of discomfort at the minimum role it has played in the health care reform debate. It is now a consensus that public health should be at the table to assure that consideration is given to their contributions in any reform discussion. Unfortunately, public health is often equated only to preventive health services such as childhood immunizations, maternal care, or school exams.

I am now convinced that public health should not only be at the table in health care reform deliberations, but a strong public health agenda should be fully implemented even while the discussion is taking place. Public Health, with its emphasis on prevention and health promotion, is only a part of the continuum of any health care system, but is a critical core component. The identified functions of public health are not dependent upon the eventual configuration of the health care payment system nor the way in which clinical care will be provided. Public Health, with its core functions of assessment, policy development, and assurance based on a commitment of prevention, is driven by the principles of cost containment and access to essential services. The eventual reform package may shift the responsibility for these activities to a different delivery system but the critical factor is that they be in place. If public health is placed in the competitive arena with clinical care and its fate left to the less than fully informed or to the politically motivated, there is no assurance that it will survive.

VIII. ISSUES FOR CONSIDERATION

- I. COMMIT THE STATE OF ALASKA TO A PUBLIC HEALTH AGENDA THAT ESTABLISHES PUBLIC HEALTH AS THE FOUNDATION TO ANY HEALTH CARE REFORM PACKAGE.
- II. CHARGE THE DEPARTMENT OF HEALTH AND SOCIAL SERVICES WITH THE RESPONSIBILITY FOR DEVELOPING THE CORE FUNCTIONS OF ASSESSMENT, POLICY DEVELOPMENT, AND ASSURANCE. ASSURED SERVICES ARE TO BE JUSTIFIED BY THEIR IMPACT ON THE QUALITY OF PUBLIC HEALTH AND THEIR INFLUENCE ON COST CONTAINMENT, AND ACCESS TO HEALTH CARE.
- III. ENCOURAGE THE STATE TO GUARANTEE SUPPORT FOR THE FISCAL REQUIREMENTS OF THE PUBLIC HEALTH AGENDA APPROVED AND ENDORSED BY THE CITIZENS OF ALASKA AND THEIR ELECTED PUBLIC OFFICIALS. FUNDING FOR THOSE CORE FUNCTIONS THAT HAVE BEEN DETERMINED TO BE ESSENTIAL SHOULD BE TAKEN OUT OF THE COMPETITIVE ARENA AND PROTECTED AS A NECESSARY FOUNDATION OF ALASKA'S HEALTH CARE SYSTEM.

APPENDIX G

Presentation of the Public Health/Service Delivery Subcommittee
of the Health Resources and Access Task Force on
Problems Facing Rural, Under-Utilized Hospitals and
Alternatives to Closing

By Karen Perdue

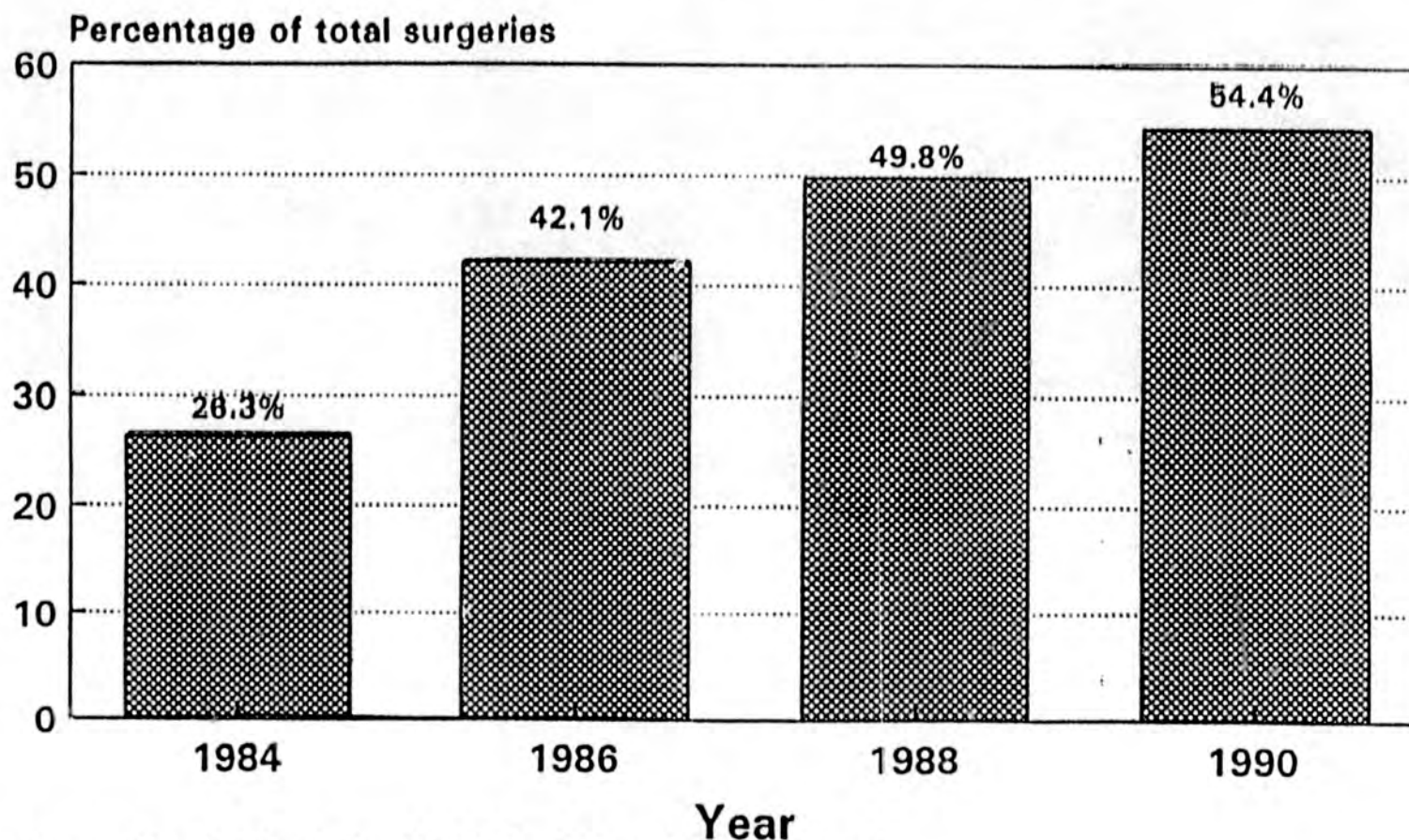
September 25, 1992

Community Hospital Closures

<u>Year</u>	<u>Rural</u>	<u>Urban</u>	<u>Total</u>
1980	15	30	45
1981	11	16	27
1982	15	9	24
1983	7	18	25
1984	18	27	45
1985	20	27	47
1986	36	32	68
1987	40	37	77
1988	46	39	85
1989	44	21	65
1990	28	22	50
1991	29	16	45

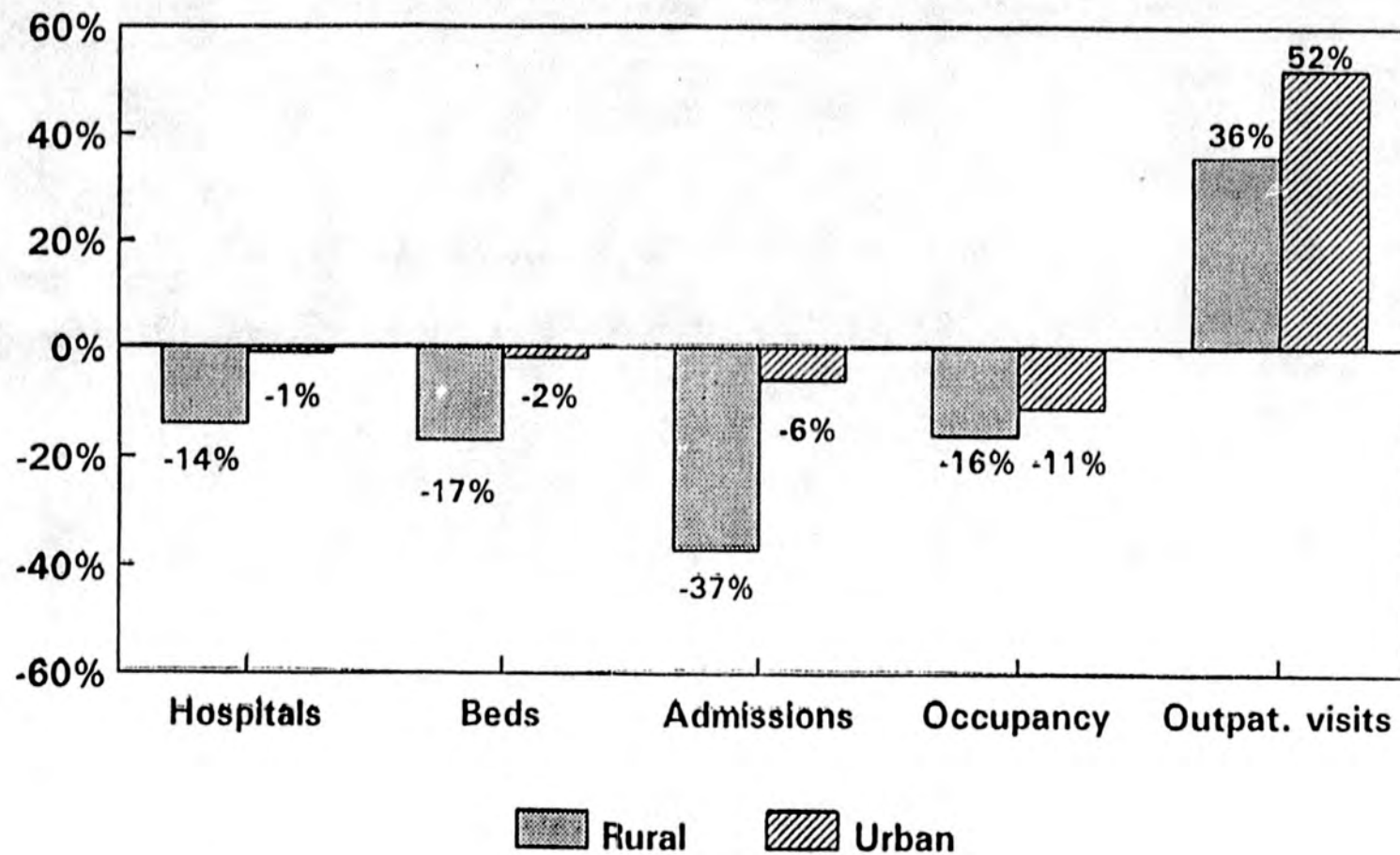
Source: Congressional Budget Office, 1991

Percentage of Total Surgeries Performed On an Outpatient Basis in Rural Community Hospitals



Source: *Hospital Statistics, 1989-90, AHA* and *Environmental Assessment for Rural Hospitals, 1992, AHA*

Changes in Characteristics of Community Hospitals, 1980 and 1990



Source: Hospital Statistics
1991-1992, AHA

Characteristics of Communities That Have Developed Alternative Models

- **Geographically isolated**
- **Population in service area less than 5000**
- **Limited number of hospital beds**
- **Facilities receive tax support from either the
county or hospital district**

G-4

KEY PROBLEMS ADDRESSED BY MODELS

- Community in danger of losing access to basic health care services; hospital had closed or on brink of closure
- Hospital is in financial distress
- Low patient census
- Shortage of health care personnel
- Not in compliance with Medicare's conditions of participation and certain state licensure requirements

Examples of Alternative Models

- Models that include acute-care beds
 - Montana Medical Assistance Facility (MAF)
 - California Alternative Rural Hospital
 - Rural Primary Care Hospital
 - Federal EACH/PCH Program grantees include:
California, Colorado, Kansas, New York
North Carolina, South Dakota, West Virginia
- Models that do not include acute-care beds
 - Cle Elum Family Medicine Center,
Cle Elum, Washington
 - Silverheels Health Center, Fairplay, Colorado

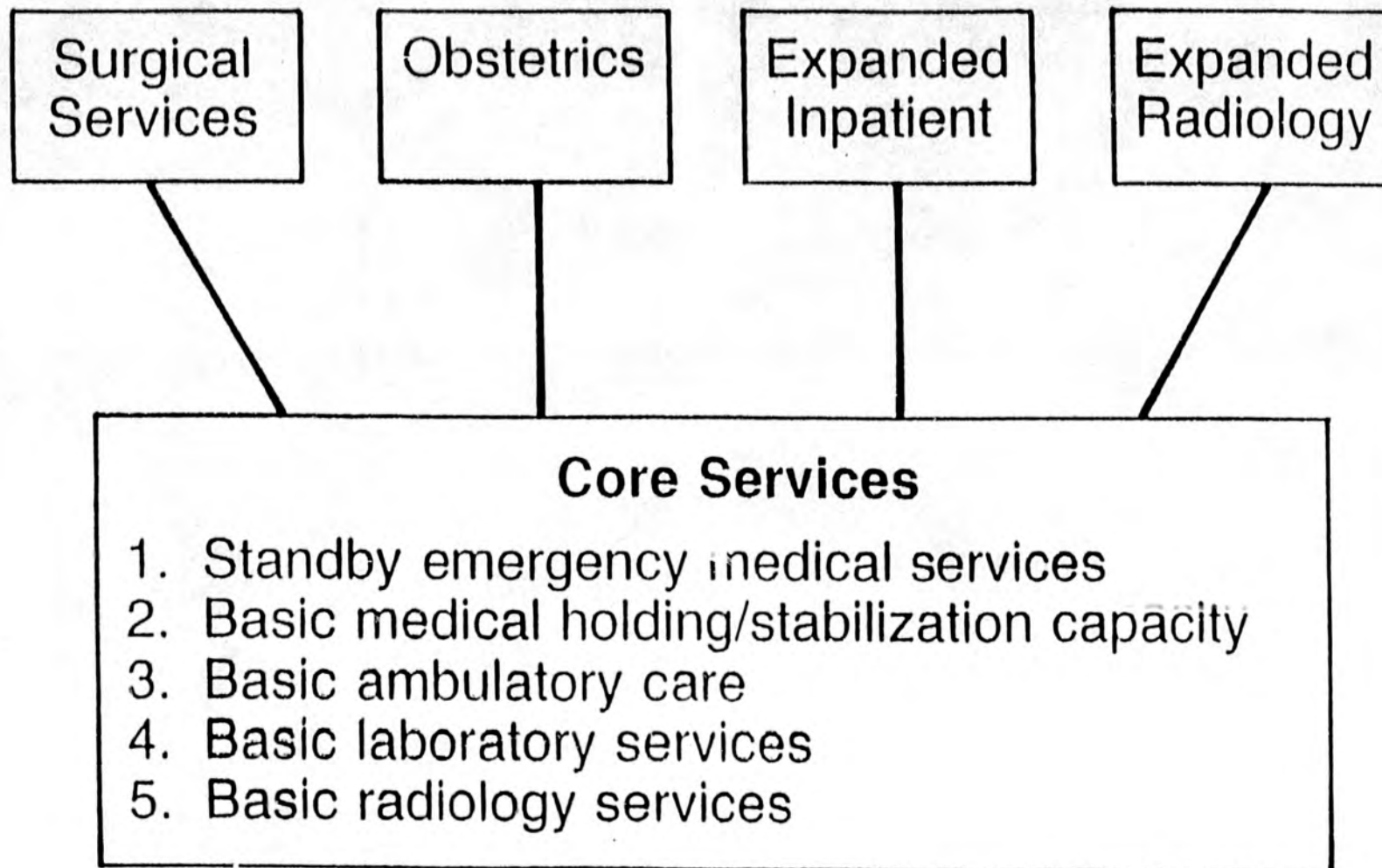
G-6

Approaches for Limiting the Scope of Inpatient Services

- **Limit length of stay**
 - 96 hours -- Montana Medical Assistance Facility
 - 72 hours -- Essential Access Community Hospital Program
- **Modular approach**
 - Certifies hospital to provide a group of core services which may be augmented by various service modules
- **Develop admissions and transfer/referral policies based on DRG approach with 3 day initial evaluation period, concurrent utilization review and exceptions review**

G-7

Modular Approach



G-8

Reimbursement

- Montana MAF project has received a waiver permitting payment on a cost-reimbursement basis from Medicare
- Rural Primary Care Hospitals initially will be paid on a cost-reimbursement basis with the possibility of a prospective payment system developed in the future
- California Pilot projects maintain compliance with Medicare conditions of participation
- Private insurers usually follow Medicare's lead
- Models without acute care beds receive only Part B payments as for a physicians office practice, but no payment for the additional costs of providing emergency room services or for LTC services
- Most facilities require local tax support

Characteristics of Caseload in Small Rural Hospitals (FY 1991)

- Top 10 DRGs account for 41% of total caseload of small rural hospitals.
- Top 20 DRGs account for 57% of total caseload of small rural hospitals.
- For most DRGs, transfer rate to other hospitals is usually less than 10%.
- If there was a 3-day limit on length of stay, small rural hospitals would lose more than half of their current caseload.

Source: HCFA Medpar Data

Most Frequent DRGs in Rural Hospitals With Average Daily Census Less Than 10 (FY 1991)

DRG	Description	# of Cases	% of Total Cases	ALOS
89	simple pneumonia and pleurisy	12,242	8.5	6.2
127	heart failure and shock	11,500	7.9	5.3
140	angina pectoris	6,027	4.2	3.1
14	specific cerebro- vascular disorders	5,581	3.9	6.2
182	esophagitis, gastroenteritis and misc. digestive disorders	5,332	3.7	4.2

Source: HCFA Medpar Data

Findings of Expert Panel on DRGs Appropriate for Limited Service Rural Hospitals

- **Assumptions**

- No inpatient surgery
- No obstetrics
- Only primary care providers admit patients
- No blood banking
- Only basic radiology services available

- **109 DRGs Appropriate for Alternative Models**

- Low intensity medical cases capable of being managed by primary care providers without availability of secondary or tertiary level diagnostic and therapeutic backup services

G-12

Relevance of Alternative Models

- **Options/alternatives when faced with hospital conversion/closure decisions**
- **Models for regionalizing health services to meet community needs**
- **Smaller hospitals could benefit from greater flexibility in licensure requirements**
- **Ambulatory health center could expand to offer inpatient services for stabilization/holding of acute care patients**

Session Overview

Alternative Mechanisms for Financing Rural Health Services

- **Federal Initiatives**

- Rural Health Clinics (RHC)
- Federally Qualified Health Centers (FQHC)
- Special hospital payment categories under medicare
- Physician payment reform

- **State Initiatives**

- Prepayment mechanisms under Medicaid and state programs for the uninsured

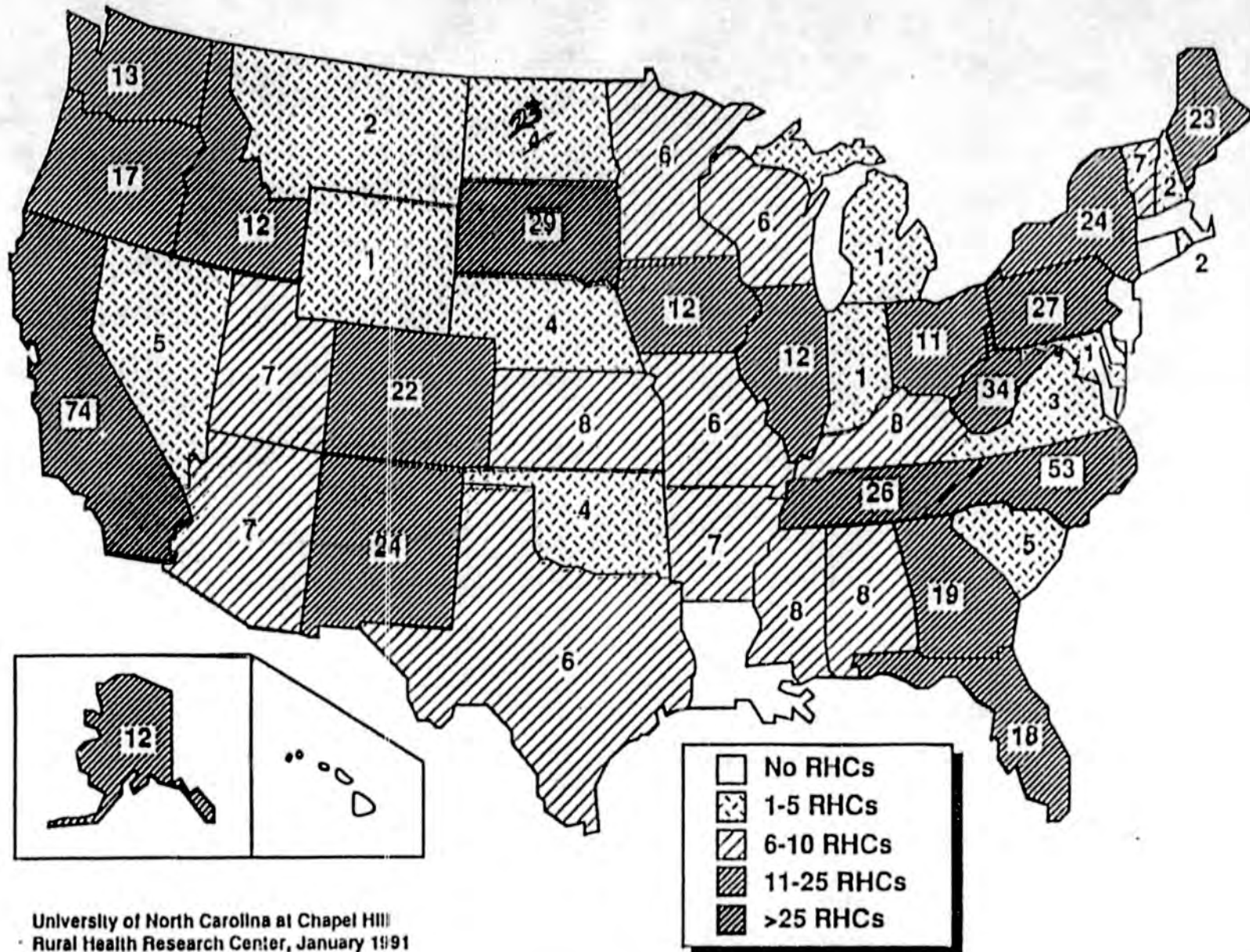
- **Local Options**

- Health service districts

G-14

Number of Rural Health Clinics by State

Designated as of October 16, 1990



Special Designations for Rural Hospitals and Their Effect on PPS Payments

Hospital Category	Hospitals ^a		Percentage Increase in PPS Payments Attributed to Special Payment Provisions (Estimated, 1991) ^b
	Number	Percent	
All Rural Hospitals	2,569	100.0	5.8
Rural Hospitals with Special Designations			
Rural referral	256	10.0	9.3
Sole community	533	20.7	13.3
Medicare-dependent	541	21.1	8.2
Total	1,330	51.8	9.9
Other Rural Hospitals	1,239	48.2	0

SOURCE: Congressional Budget Office

a. Based on hospital classifications in September 1991.

b. Increase in payments to hospitals in each category relative to what payments would be to those hospitals if they did not have special designations. The estimates are based on hospital classifications in January 1991.

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Change in Medicare Payments by Specialty

Specialty	Percent Change
Medical	20
Internal medicine	16
Family practice	37
Surgical	-11
Ophthalmology	-17
General surgery	-9
Orthopedic surgery	-10
Urology	-3
Thoracic surgery	-20
Otolaryngology	7
Obstetrics/gynecology	1
Hospital-based	NA
Radiology	-21
Other physicians	6

SOURCE: Physician Payment Review Commission simulations.

6-17

Change in Medicare Payments by Geographic Area

Area	Percent change by specialty group		
	Medical	Surgical	All physicians
Large metropolitan (more than 3 million)	10	-15	-4
Mid-sized metropolitan (1-3 million)	14	-14	-5
Small metropolitan (fewer than 1 million)	22	-9	1
Large rural county (more than 25,000)	28	-5	12
Small rural county (fewer than 25,000)	34	-8	13

Source: Physician Payment Review Commission simulations with the Part B Medicare Annual Data (BMAD) provider file.

APPENDIX H

Presentation to the Public Health/Service Delivery Subcommittee
of the Health Resources and Access Task Force
on the Alaska Area Native Health Service Delivery System and
Resources/Demographics and Health Status of Alaskan

Natives/Future Trends

by David Mather, Dr.P.H.

April 25, 1992

ALASKA AREA NATIVE HEALTH SERVICE

SUMMARY

The Alaska Area Native Health Service, (AANHS) is a Federal Bureau providing personnel health, community health, and community sanitation services to approximately 90,000 Alaskan Natives. (*The census bureau figure for Alaskan Natives in 1991 is 85,388. The AANHS automated statewide medical record system, RPMS shows 87,368 unduplicated active records in 1991.*) The AANHS provides these services through a combination several funding and delivery mechanisms. It directly operates federal hospitals and clinics, in Anchorage, Ketchikan, and Barrow; it contracts with "tribal organizations" to operate (mostly federally owned) hospital and clinics in other locations; and, it purchased care through the private sector for services which it cannot provide through the above mechanisms. In addition, the sanitation branch has designed and built over 300 million dollar worth of water and sewer systems in Alaskan Native villages, usually through cooperative agreements with the village governments.

INPATIENT CARE

The IHS/tribal system operates inpatient hospitals in Anchorage, Barrow, Nome, Kotzebue, Bethel, Dillingham, and Sitka. Overall the IHS/tribal system provided about 66,000 inpatient bed days to IHS beneficiaries in 1991. This compares to 167,839 bed days which were provided in community hospitals in Alaska in 1991. Overall although the Alaskan Native population is on approximately 16% of the state population, the IHS/ tribal system accounts for 28% of the inpatient bed days produced in the state. Outside of Anchorage, Fairbanks and Juneau Fairbanks their were about 32,000 bed days provided in community hospitals and equal number provide in IHS/tribal facilities.

The increased utilization of IHS beneficiaries of hospital services can be attributed primarily to increased average length of stay in IHS/tribal facilities, although their is also a higher admission rate for Alaskan Natives. Alaskan Natives also do not receive significant amounts of care in facilities located out of the state.

OUTPATIENT CARE

The IHS/tribal system provided 416,000 outpatient visits in their hospitals and health centers in 1991. Ambulatory care health centers, staffed with physicians, are located in each of the hospitals mentioned above as well as in Fairbanks, Ketchikan, Metlakatla, and Kodiak. Smaller health centers staffed with mid-level providers are located in about 15 communities, and Health Aide clinics staffed with Health Aides or Community Health Practitioners are located in 171 Native Villages across the state. An additional 250,000 Health Aide visits were recorded in 1991. Physicians from IHS/tribal facilities itinerant to each Alaskan Native Village one or more times (depending on size) to provide direct acute care, chronic disease management, and health aide training and support.

Dental care is provided throughout the state in each of the major outpatient facilities. Dentists also itinerant to each village to provide comprehensive care to school children and appointment and emergent care to adults.

Comprehensive pharmacy services are also provided from each ambulatory care center. In addition regional pharmacies support the smaller satellite health centers and Community Health Aide clinics as well as providing a mail out auto refill service for rural patients.

COMMUNITY HEALTH AND BEHAVIORAL HEALTH CARE ACTIVITIES

A recent focus of attention, of both state and national Native Health efforts has been on preventative, public health and behavioral health and substance abuse and treatment activities. Recent programs have been developed specifically to treat alcohol/drug abuse among adolescents, and pregnant women. Alcohol treatment programs have been expanded, and FAS/FAE prevention programs have been developed in each regional program.

Large public health campaigns have been successfully undertaken in Hepatitis B immunization and prevention, (as well as a monitoring program for known carriers), and Hib immunization of infants.

SANITATION

IHS engineers located primarily in Anchorage provide design, and construction for locate water and sewer projects in Alaskan Native

Villages across the state. In FY91 \$25,000,000 was spent on village water projects. In addition IHS engineers assist in the design and coordination of State of Alaska village safe water projects which provide a similar service with funding from the State of Alaska.

IHS/tribal sanitarians located in field service units provide institutional services, support and training for village water operators, and support and assistance to village governments in dealing with a variety of environmental issues.

FEDERAL FUNDING

The Indian Health Service is funded as a discretionary program at the federal level. In 1991 the AANHS received approximately two hundred million dollars in direct federal operational appropriations to support the activities of the AANHS and tribal contractors.

Recent support for the IHS has been comparatively strong with increases nationally averaging about 6% a year. Several special initiatives have brought additional resources to Alaska including special support of the Community Health Aide Program, special support of tribal contractors operating IHS programs and special initiatives in public health.

OTHER RESOURCES

The IHS/tribal system has come to rely increasingly on alternate resources to supplement the direct IHS appropriation which has not kept up with medical inflation and population growth.

In 1977, Congress passed the Indian Health Care Improvement Act with allowed IHS/tribal facilities to collect Medicare and Medicaid for services provided to Natives eligible for these programs. Congress also provided that this Medicaid funding would be in a special category and would not be subject to a state match. By law the funds collected from these sources were to be used to expand the services available to IHS beneficiaries.

In the past ten years collections from Medicaid and Medicare have increased from insignificant to approximately \$22,000,000 in 1991. In addition Medicaid provides additional support to the system by paying directly for such items as patient travel, eyeglasses, long term care and for care in private facilities on referral when the

patient is eligible for this care. Eligibility for Medicare and Medicaid is highly variable across the state, however statewide approximately 35% of Alaskan Natives are currently eligible (with much higher percentages potentially eligible).

IHS and tribal facilities also can collect from other insurance companies for care provided to IHS beneficiaries. State wide 15% to 20% of the IHS beneficiary population is covered by some type of private coverage. Current estimates are that approximately 6 million dollars a year are collected from this source although exact figures are not available.

Tribally operated health programs also participate in the mental health and public health grant programs offered by the State of Alaska. Especially in many of the more remote communities the tribal contractors are the only organizations with the organizational capacity and professional staff to support mental health, alcohol treatment, infant learning, and rural health clinic programs offered by the State. Funding for these programs has remained relatively static over the past five years with decreases in public health programs being offset by increases in mental health mandated by the Mental Health trust suit.

Overall the IHS/tribal health care system has become very dependent on alternate resources for support of the basic health care delivery system.

DEMOGRAPHICS/HEALTH STATUS ALASKA NATIVES-FUTURE TRENDS

The Alaska Native population is the youngest and fastest growing population in the state. With a average age of 22 years and growth rate double the non-native population.

This high rate of young people in the population has dramatized the high rates of diseases traditionally associated with young populations. Alaskan HIV infection rates are highest in the Native population, suicide and homicide rates continue 3 to 4 times the national average. Problems from substance abuse, including FAS/FAE and brain damage associated with inhalant abuse in young children are still on the rise.

The age structure however has tended to mask other chronic and acute problems traditionally associated with older populations.

Many of these problems have not been seen in the Alaskan Native population and are the result of recent life style changes. Alaskan Natives now have one of the highest (age adjusted) mortality rates from malignant neoplasm's in the United States. Most of this can be attributed to increase rates of lung cancer due to widespread introduction and use of cigarettes in the 1950's and 1960's. In addition diabetes rates are increasing to increase to levels which will soon required substantial additional medical resources to deal with the complications of kidney failure and blindness.

As the age structure changes the increased crude rates of the above conditions due to aging alone will rapidly tax the existing IHS/tribal health care system creating additional demands for tertiary care, chronic care, home care and long term care.

FUTURE ISSUES TRENDS IN THE DELIVERY SYSTEM

There are several organizational issues revolving around Tribal self determination issues. Expectations are that the trend for contracting will continue with the contracting of the remaining IHS directly operated facilities. Both economic and political incentives will push in this direction.

There has been additional pressure to splinter the current delivery system with smaller and smaller delivery units. The number of small tribal contractors is rapidly increasing. New federal initiatives in self governance will provide additional pressures which could break up the existing delivery system.

There is also every indication that the IHS/tribal service providers will rely increasingly on "alternate resources". This has been the fastest growing revenue segment for the providers and there is a consensus among providers that it will continue to grow faster than direct federal appropriation in the foreseeable future.

Briefing paper of the
Health Resources and Access Task force
August, 1992

DEMOGRAPHICS

1. Alaska Native Population 90,000.
2. Average Age 22 years.
3. < 5 years most numerous age group.
4. 30% of the population < 18 years.
5. 66% rural, 34% urban.
6. Population is increasing 3% yearly.
7. Fastest growing population segments are < 18 years, > 60 years.
8. Life expectancy for Alaska Native men is 63 years.
Life expectancy for Alaska Native women is 71 years.
9. 46% of Alaska Native > 25 years have completed high school.

HISTORICAL HEALTH PROBLEMS

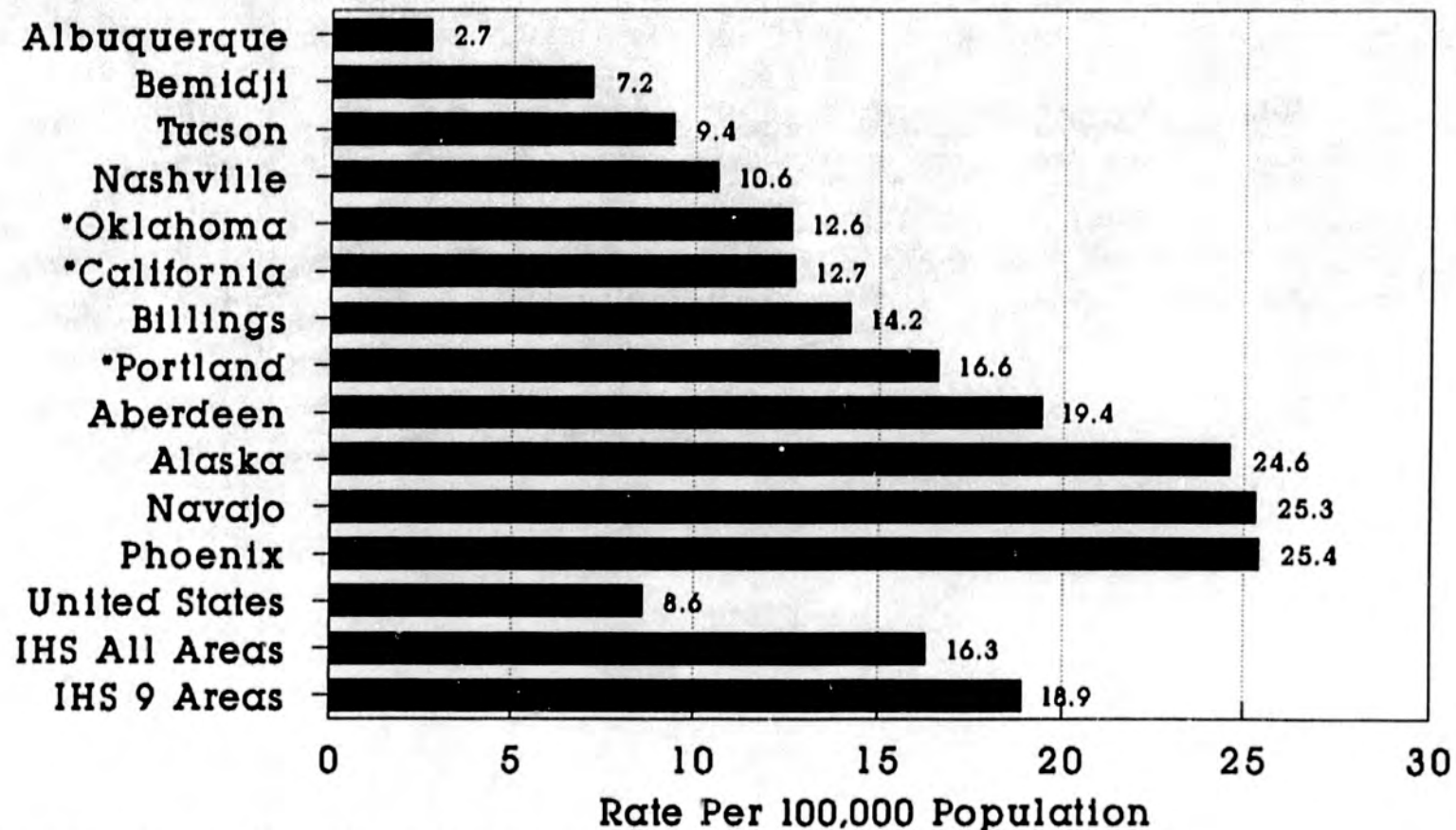
CAUSES OF DEATH, 1950, 1988 BY PERCENT

<u>CAUSES</u>	<u>1950</u>	<u>1988</u>
Infection	45.8%	1.3%
Respiratory	13.2%	7.2%
* Unintentional Injury	9.6%	21.7%
* Heart Disease	5.3%	16.2%
Congenital Causes	3.0%	6.0%
* Cancer	2.4%	15.7%
* Intentional Injury	1.7%	11.1%
Stroke	1.4%	3.6%
Other Causes	17.6%	17.2%

FUTURE HEALTH TRENDS

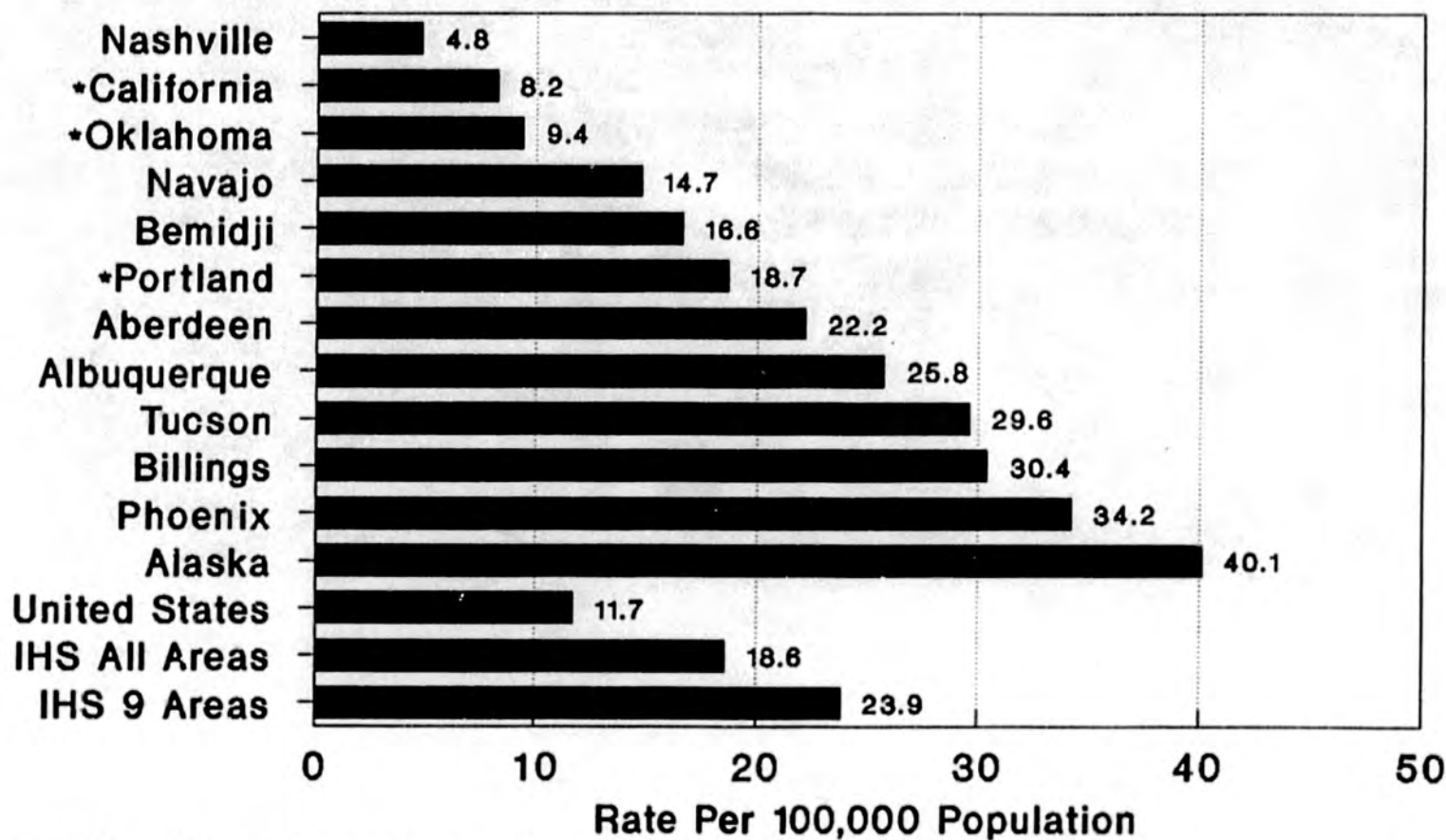
- * Economic conditions in villages will cause dislocation of young people to regional and urban centers.**
- * High (and rising) rates of cancer, and heart disease will severely stress tertiary care facilities, and create a need for home care of the chronically ill, as well as skilled nursing home beds.**
- * The number of disabling conditions secondary to FAS/FAE, and inhalant abuse, will rise steadily, creating a need for solutions.**
- * The high rate of obesity in Alaska Native children and the rising rate of gestational diabetes predict a rising rate of adult onset diabetes with blindness and renal complications requiring hospital care and the need for dialysis centers.**

Age-Adjusted Homicide Mortality Rates 1987



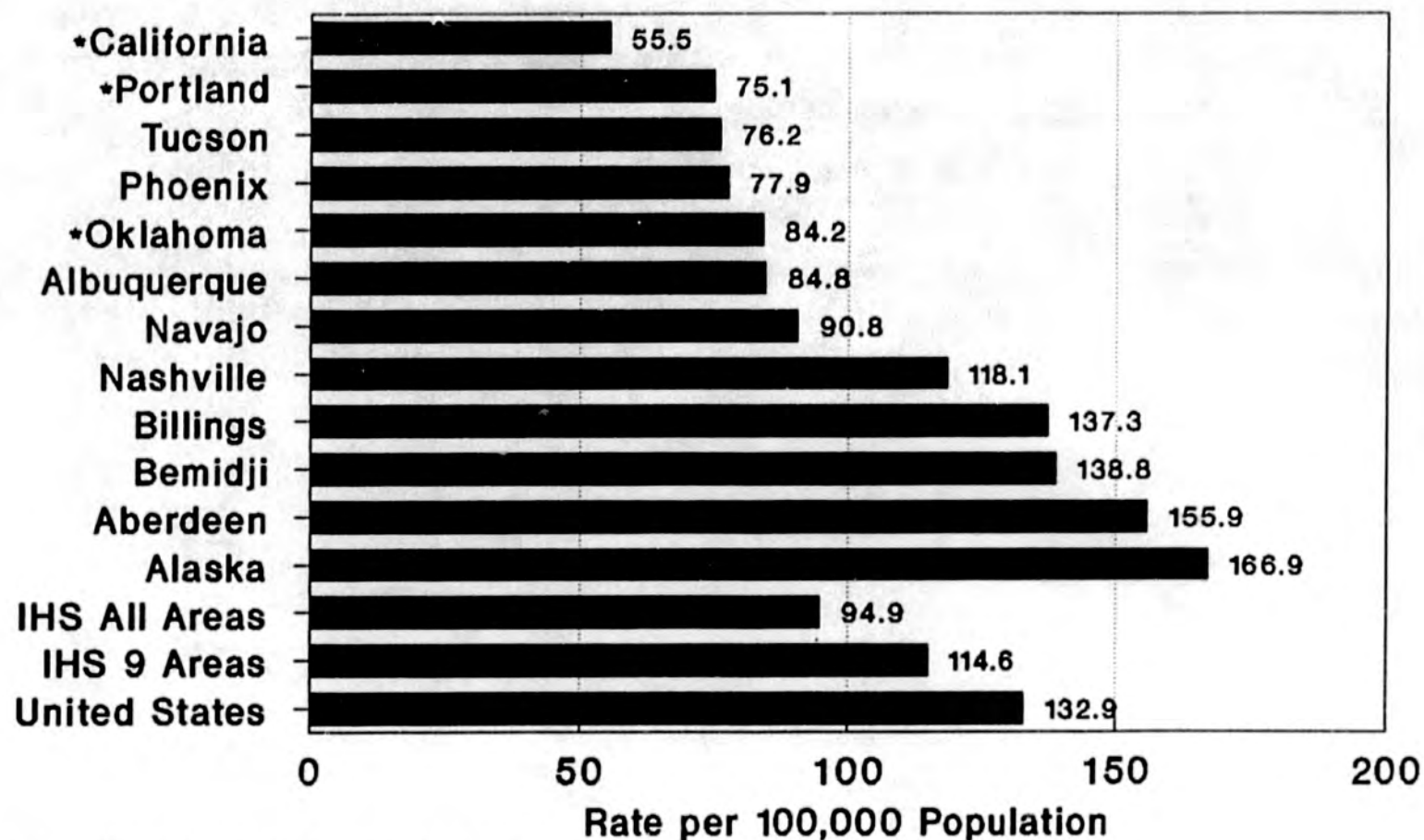
* Apparent problems in underreporting
of Indian race on death certificates

Age-Adjusted Suicide Mortality Rates 1987



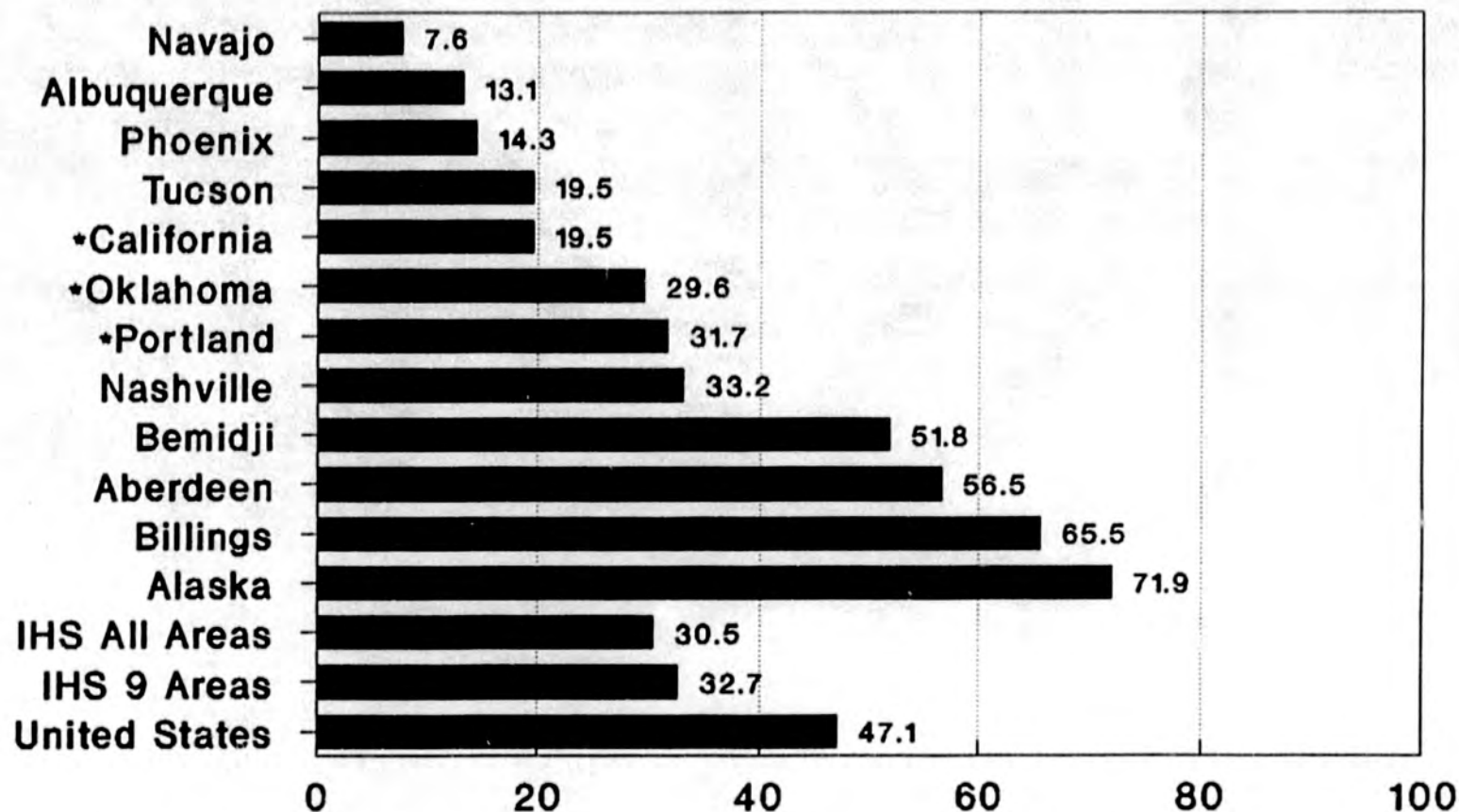
•Apparent problems in underreporting
of Indian race on death certificates

Age-Adjusted Malignant Neoplasm Mortality Rates 1987



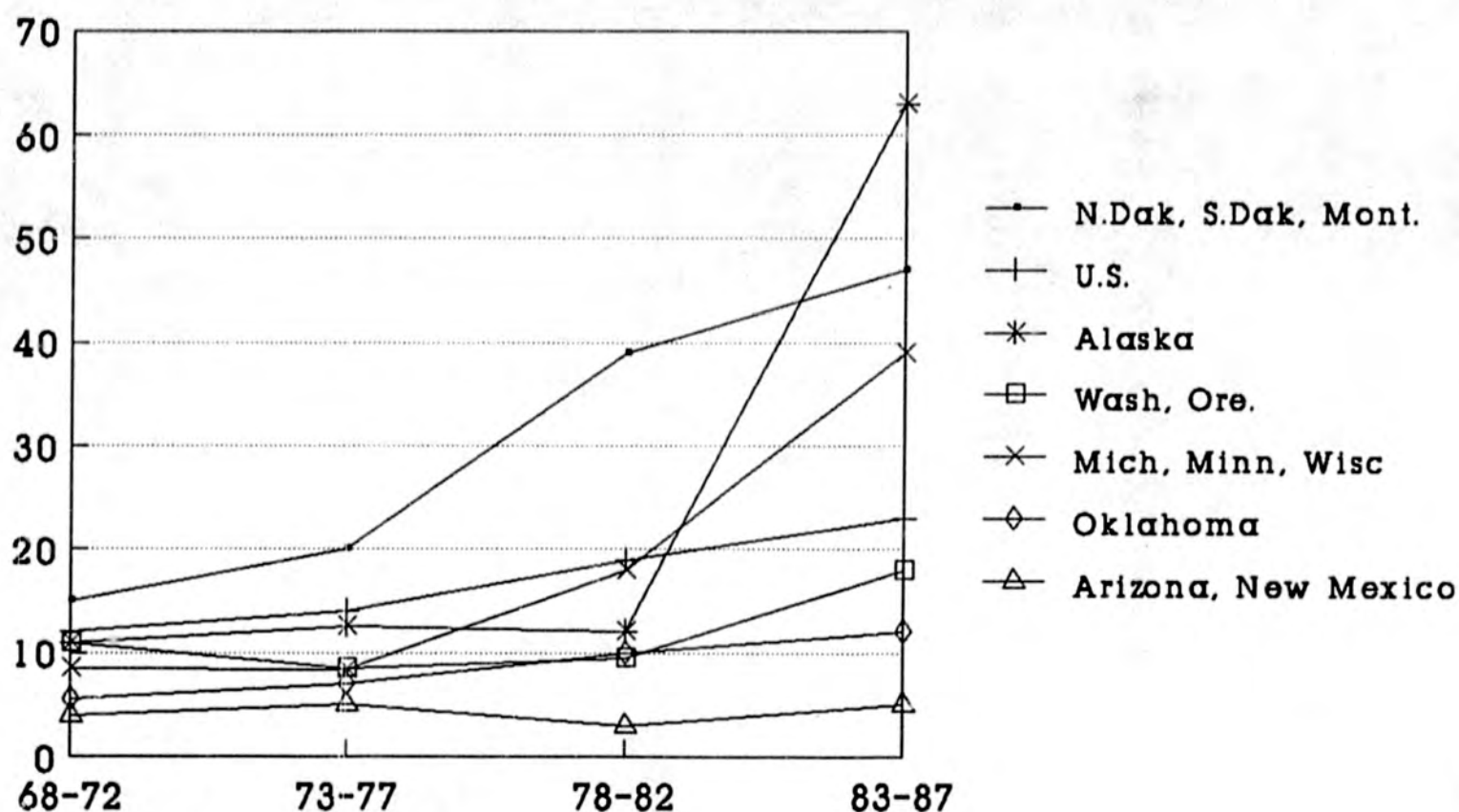
*Apparent problems in underreporting of Indian race on death certificates

Age-Adjusted Lung Cancer Mortality Rates, 1984-1988



•Apparent problems in underreporting Indian race on death certificates

Trends in Lung Cancer Mortality, 1968-1987. Native Americans in Selected States Compared to All U.S.



Rates Age-adjusted to the 1970 U.S. Pop.

**FEDERAL CAPITAL PROJECTS
ALASKA AREA NATIVE HEALTH SERVICE**

ANCHORAGE NATIVE MEDICAL CENTER

\$180M

- o FINAL BID PACKAGES BEING PREPARED
- o BID OPENING LATE OCTOBER
- o 3.5 YEAR CONSTRUCTION PERIOD

BARROW QUARTERS

\$18M

- o CONSTRUCTION CONTRACT AWARDED DECEMBER 91
- o FOUNDATION COMPLETE, MODULES ON BARGE
- o OCCUPANCY DECEMBER 92

KOTZEBUE HOSPITAL

\$63M

- o ORIGINAL BID JANUARY 91
- o REDESIGNED AND REPACKAGED INTO TWO PHASES
 - FOUNDATION
 - BUILDING
- o FOUNDATION CONTRACT AWARDED SUMMER 91 TO VECO
- o BUILDING CONTRACT AWARDED APRIL 92 TO HOFFMAN
- o FOUNDATION CONSTRUCTION UNDERWAY
- o BUILDING MATERIALS ON BARGE
- o 3 YEAR CONSTRUCTION PERIOD
- o OCCUPANCY LATE 94

KOTZEBUE QUARTERS

\$25M

- o NANA DESIGN/BUILD/LEASE PROPOSAL WITHDRAWN
- o LAND PURCHASED WINTER OF 92
- o GOVT. A/E SELECTION UNDERWAY
- o OCCUPANCY PROJECTED LATE 94

ADVANCED PLANNING

PROGRAM DOCUMENTS BEING PREPARED

- o BETHEL QUARTERS
- o ST. PAUL QUARTERS
- o METLAKATLA QUARTERS

EARLY PLANNING

PHASE II PRIORITY SYSTEM APPLICATIONS COMPLETED

- o NEW ST. PAUL CLINIC
- o NEW METLAKATLA CLINIC
- o FAIRBANKS CLINIC EXPANSION
- o NOME HOSPITAL EXPANSION
- o NEW BARROW HOSPITAL

APPENDIX I

"Memo to the Health Resources and Access Task Force" from
Bradley J. Whistler, Planning Section,
Alaska Department of Health and Social Services
October 21, 1991

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF ADMINISTRATIVE SERVICES

WALTER J. HICKEL, GOVERNOR

THEODORE A. MALA, COMMISSIONER

P.O. BOX 110650

JUNEAU, ALASKA 99811-0650

PHONE: (907) 465-3082

MEMORANDUM

DATE: October 21, 1991

TO: Health Resources and Access Task Force
The Honorable Jim Duncan, Co-Chair
The Honorable Johnny Ellis, Co-Chair

THRU: Larry J. Streuber, Planning Section Chief
Division of Admin. Services - Planning

FROM: Bradley J. Whistler, Health Planner
Division of Admin. Services - Planning

SUBJECT: High-Tech Equipment and Hospital Procedures

Per your request, attached is a listing of some of the costs and charges of high-tech medical equipment and services. Also, I have included a short explanation of each type of equipment/service.

Introduction

Literally, medical technology is the application of medical knowledge for practical purposes. High-tech is generally considered to be more advanced or sophisticated technology. Many of the medical services we consider as high-tech are medical applications of instruments developed for the physical sciences (such as Magnetic Resonance Imaging-MRIs and lasers). Other equipment, such as respirators and heart/lung machines, were developed for surgical applications.

Much of what we associate as the quality of care we receive in the United States is exemplified by high-tech medical services. Computerized tomography (CT) scans have reduced the need for exploratory surgery. MRI systems have reduced the need for the injection of contrast media, often necessary with CT scans and other radiology procedures. Technological advancements in medicine have often reduced or replaced more invasive procedures and improved the quality of care.

However, there is little doubt that high-tech medical services contribute to the increasing cost of health care. One study, published in the January 1989 issue of Business and Health, estimated the contribution of new technology (equipment and procedures) to total health care cost increases at 11%.

What high-tech equipment/procedures are provided in Alaska?

The first page of the handout (see attached) lists some information on selected hi-tech procedures in Alaska. Definitions of the equipment and services is provided on the next page. There are four points to be made from this chart:

1 - The equipment is expensive. Of the equipment listed, costs run from 1 to several million dollars. Remodeling, construction, and installation costs can increase the cost of the service by another 30-50%.

2- The useful life of hi-tech equipment is pretty short. I have listed the American Hospital Association's estimated useful life periods for the equipment. This is because maintenance costs and upgrades for the equipment escalate quickly and after five years it is usually less expensive to replace the equipment.

3- The table illustrates that most of Alaska's high-tech medical services are located in Anchorage. This is not surprising because of the population distribution in the State. Further, because of the cost of hi-tech equipment it is usually only available at larger medical facilities.

4 - Utilization patterns for the equipment pretty much parallel the population size of the communities served.

We have little information on procedure charges as the Department has little involvement with the monitoring of fees. Medicaid or commercial insurance companies would likely be a better source for this information.

What new high-tech medicine can we expect in Alaska?

The next step in diagnostic imaging seems to be positron emission tomography (PET) scanners. These scanners offer advantages in the diagnosis of diseases of cardiovascular and central nervous systems. Currently, these scanners are located at research hospitals in the United States.

As for other procedures, we do not have a lot of information for the Task Force. The Planning Section's contact with new procedures is usually through "letters of intent" filed by the facilities when they are considering a project or through literature, as other state programs deal with these issues. The hospital and medical associations are likely a better source for this information.

Good news/bad news for Alaska:

Given the desire to control medical costs, the public must decide on the proper balance of access, quality of care and cost of services. What is good news from the perspective of reduced medical costs is likely bad news for access to the services. Further, especially with high-tech procedures increased access can reduce the quality of care. I will approach the good news/bad news scheme from the point of our goal being to reduce medical costs.

Good news for Alaska:

There is not a lot of high tech medical procedures in the State, although this may change. Given the population density in the state and the size of the municipalities, few hospitals have purchased high-tech equipment. Patients usually travel to Anchorage or the lower 48 for these services.

Alaska has a young population, with a median age of 28.5 years. Traditionally, the high birth rate and immigration of young adults have kept Alaska's median age one of the lowest in the nation. Older adults usually have emigrated from Alaska and this trend could be seen as early as the 40-45 age group. Although, Alaska's age adjusted rates are always good, deaths due to heart disease, cancer, cerebrovascular and chronic obstructive pulmonary disease are well below national averages. Since many high tech services are used for the detection and treatment of these diseases, Alaska's demand for high-tech services is reduced.

Bad news for Alaska:

Alaska's population is aging. Like the national trend Alaska's population age 65 and above is increasing. Although the number of elderly in Alaska, 4.1% is one of the lowest in the nation, the rate of increase, 94.5% from 1980-1990, is one of the highest in the nation. This rate of growth is expected to continue as adults in lower age brackets are remaining in the State.

Facilities which have been largely subsidized by state-funding, through capital appropriations and Medicaid, will have to look for alternative revenue sources if these programs are reduced. Lower hospital occupancy rates, nationwide, have put pressure on facilities to evaluate services for potential revenue. Although, expensive to implement, high tech procedures often bring in revenue as medical fees for the procedures are expensive and more patients remain in the community for treatment. Once referred out for diagnosis, it is likely the patients will remain in the referral area for treatment of the diagnosed problem. Further, in many states the high-tech procedures are reimbursed at higher Medicaid rates than primary care medical services. As an example of revenue from high tech procedures, in the Certificate of Need application for a new MRI at Humana Hospital, the facility estimated a yearly average net income from the service of \$570,000 for the first three years of operation.

High tech procedures are also attractive to facilities and the communities for a number of other reasons:

- It helps the facility to compete with other facilities for patients as there are fewer referrals and it raises the perceived quality of care;
- it aids in attracting physicians, especially specialists into the community;
- it provides training and career opportunities for staff and makes retaining staff easier;

Health Resources and Access Task Force

Page 4

- physicians in the community are very supportive, and may pressure facilities to purchase equipment, as more patients will remain in the community for treatment; and
- many of the hospitals in Alaska are owned by the municipalities, further, they are some of the largest private employers in their communities, generally what is in the best financial interest of the facility is also in the best financial interest of the community.

However, there are several problems with the addition of high-tech procedures to smaller communities. These problems include:

- Duplication of expensive services in the state
- Overuse of equipment - once purchased, physicians are more likely to refer patients for hi-tech services. This is for a variety of reasons including: intrinsic reasons - the availability of the equipment creates a need to use it, malpractice/liability reasons, and in some part to justify the purchase of the equipment.
- Adequate training on the services are usually not available in the communities. Recruitment of experienced personnel may be a problem.
- Most important - Quality of care: Medical research has demonstrated, specifically with many high tech services, that quantity correlates with patient outcomes. Practice with the equipment and volume of procedures make it more likely pathology in early stages will be detected. For surgical procedures, like open heart surgery, the volume of procedures performed makes the surgeons better and patient outcomes are improved.

The distances between communities and between the communities and tertiary care hospitals in Alaska, has often helped justify expanded medical services in these communities. It is no different with high tech services. The problem is compounded by the fact that transportation and lodging costs for medical procedures, when a patient is referred outside the community, are often at the patients expense and are often not reimbursed by third party payers.

What Alaska is doing to contain high-tech costs?

The major regulatory control of high tech services in Alaska is through the State's Certificate of Need program. Larry Streuber, Planning Section Chief, discussed many of the points on the Certificate of Need Program with the Task Force. To summarize:

The addition of new services is subject to Certificate of Need review only if expenditures are \$1 million or greater.

Of states which regulate the medical services, Alaska is at the high end of the spectrum at the \$1 million threshold for new services.

Only medical services offered at hospitals are subject to review. Non-facility providers, such as physicians groups, may offer the service without Certificate of Need review. This has occurred to a greater degree in other states, but it has happened in Alaska.

Cost of the equipment generally decreases with time, to the point that it no longer meets the CON threshold. For example, the purchase of CT Scanners is generally no longer subject to review, unless there are substantial construction and installation costs. Another example is the purchase of used equipment, like Bartlett and Ketchikan General Hospitals are considering with the purchased of "second hand" MRIs.

The Department decision making process is hindered by a lack of guidelines and standards. Many of the standards in the State Health Plan, prepared in 1984, are out of date. Some new services, such as the MRI, were not addressed in the health plan. There is a need to develop standards, specific to the distribution of the population, for Alaska.

What are other states doing?

Other states have implemented additional measures to place controls on high-tech services. Besides population and utilization standards for the addition of new services, states have implemented:

- controls to monitor the appropriate use of equipment and procedures;
- state review of fees and fee increases to be sure the fees are reasonable; and
- some states are considering expanding state review to non-facility providers including group and private physician practices.

These controls have often been coupled with mandatory fee and utilization reporting mechanisms. The reporting requirements give the regulatory agencies access to information which allow trend and comparative analysis of the data.

The Department has not been involved in rate setting other than for the State Medicaid program. Further, utilization review has been sporadic. Last year, the Department began collecting utilization information for selected medical services in the Hospital Survey. This survey was last done in 1983. Although, response from the facilities has been very good, there still are problems in collecting the information through a voluntary process. Not all facilities are supplying all of the requested information and response times are slow.

Further, the Department has not seen any information from other sources to determine how Alaska's utilization rates for these services relate to other states or national averages. Nor have we seen a method, to determine if any of these procedures were inappropriate. Without this additional analysis, it is hard to determine if additional regulation of these services in Alaska is warranted.

Summary:

I believe high tech medical procedures are a factor in increasing health care costs, but these procedures are not a major influence on health care costs in Alaska, at this time. However, analysis of fees and utilization should be done to determine the appropriateness of current high tech costs. Demographic and economic pressures will likely increase the future amount of high tech services in the State, therefore now is the appropriate time to determine what actions the State should take assure adequate access to the services, establish guidelines as to where and when the services should be made available, and determine the extent to which the State regulation of these services is appropriate. Further, these guidelines need to take into account the distribution of the population in Alaska and remoteness of many of the municipalities in the State. Lastly, if access to high-tech services is reduced as a cost management strategy, evaluation of increased funding/coverage for transportation for these services should be considered.

Attachment

HIGH TECH EQUIPMENT AND UNITS

Type of Equipment/Services	Equipment Cost*	AHA Estimated Useful Life	Hospital	Hospital Location	**Utilization	Average Price Per Procedure	Other
CT Scanners		5 years	Bartlett Memorial Ketchikan General AK Area Native Med Humana Providence Valley Fairbanks Memorial	Juneau Ketchikan Anchorage Anchorage Anchorage Palmer Fairbanks	548 574 1943 3449 7932 1188 2827		
MRI Systems	\$2.5 \$2.0 \$0.3-0.6 \$0.3-0.6	5 years	Humana Providence Fairbanks Memorial Bartlett Ketchikan General	Anchorage Anchorage Fairbanks Juneau Ketchikan	3135 3205 1400 550 proj.	\$800 (range: \$336-1280) \$847 (range: \$700-1243) (range: \$750-850)	1.5 Tesla MRI 1.5 Tesla MRI 1.5 Tesla MRI - Projected first year utilization Bartlett Hospital Board is moving towards the purchase of a used/new 0.5 Tesla MRI. Ketchikan General is considering the purchase of a 0.5 Tesla MRI.
PET Scans	\$2.0-5.0	5 years	NONE		—		Cost varies between units with or without cyclotrons.
Cardiac Catheterization Labs	\$2.2	7-8 years	Humana Providence	Anchorage Anchorage	375 1135	Approximately \$2,500 - \$8,800	Costs vary: Diagnostic v. Therapeutic
Extracorporeal Shock Wave Lithotriptors	\$1.0-2.0	5 years	Providence	Anchorage	39		Began operating in August 1990. Equipment was not purchased, rather it is operated in a fee for service arrangement.
Neonatal ICU	—	—	Humana Providence Fairbanks Memorial	Anchorage Anchorage Fairbanks	1:19 301 108		
Open Heart Surgery Unit	—	—	Providence	Anchorage	292		
Organ Transplant Unit	—	—	NONE		—		

NOTE: The equipment cost, listed above, does not include construction and installation costs. Construction and installation of the equipment often increases the overall cost of the project by another 30-50%.

* Equipment cost in millions of dollars.

** Equipment utilization is reported by number of procedures and service utilization is reported by inpatient discharges.

CT Scanner: Computerized tomography (CT) or computer axial tomography (CAT) is a diagnostic technique which combines the use of x-ray equipment and computers to produce images of tissue structures at predetermined depths. The images are in the form cross sections.

MRI System: Magnetic Resonance Imaging (MRI) is a diagnostic technique in which the patient's body is subjected to a strong magnetic field which causes hydrogen ions to align within the magnetic field. A sequence of radiofrequency pulses are briefly applied to the area to be imaged. The hydrogen nuclei absorb energy from the radiofrequency pulses and when the pulse is terminated the tissue emits a weak radiofrequency signal which is received by an antenna within the MRI device. A series of computerized operations are performed to convert the signal into a visual image. MRI procedures reduce the need for contrast materials to visual tissues and hard tissues of the body do not obscure the image from the MRI. This often makes the MRI the diagnostic procedure of choice for imaging the brain, spinal cords and joints. The MRI can be used to visualize single or multiple tissue slices in the sagittal, axial or coronal planes.

PET Scanner: Positron Emission Tomography (PET) is a diagnostic technique based on the detection of positrons. Labeled substances (carbon 11, nitrogen 13, or oxygen 15) are introduced into the body. These isotopes are taken up by tissues in relation to the metabolic activity of the tissue. In the tissue these substances emit positrons which ultimately emit photons. Detectors surrounding the patient are linked to a computer which constructs an image built upon the distribution of the radiolabels within body tissues. The PET scan is valuable for images of the brain and heart since the images produced provide information on the structure and metabolic activity of these tissues.

Cardiac Catheterization Lab: A cardiovascular imaging system consists of a generator, specialized x-ray equipment, a film changer, high speed movie film, and video cameras. Cardiac imaging is used in three types of procedures:

- **Cardiac Catheterization:** In this procedure a catheter and imaging equipment is used to determine the function and extent of pathology of the heart and coronary arteries.
- **Percutaneous Transluminal Coronary Angioplasty:** In this procedure a catheter, imaging equipment and a balloon are used to dilate narrowed coronary arteries. Once the balloon is in the area of the constriction it is inflated several times to widen the lumen of the blood vessel. This procedure is also known as "balloon angioplasty" and reduces the need for coronary bypass surgery.
- **Vascular Studies:** This procedure is similar to cardiac catheterization and is used to look for blockages of blood vessels other than those of the heart.

Extracorporeal Shock Wave (ESW) Lithotripter: This equipment in which shock waves are focused upon renal or gall stones to shatter the stones. The fragments are then passed through the ducts and eliminated from the body. The ESW lithotripters are generally used on stones less than 2 cm and eliminates the need for more invasive procedures.

Neonatal ICU: A neonatal intensive care unit is a unit within a hospital which contains a variety of sophisticated mechanical devices and special equipment for the management and care of premature and seriously ill newborn infants. The unit is staffed by specially trained nurses and neonatologists who are highly trained in the pathophysiology of newborns.

Open Heart Surgery: Open heart surgery is a surgery on the heart in which the heart chambers are fully open and visible. A heart/lung machine is used to divert blood around the heart during the procedure. Open heart surgery is often used to correct congenital or acquired pathologies of the heart wall(s), septum or valves.

Organ Transplant: Organ or tissue transplantation is a surgical procedure in which a diseased organ is replaced with a healthy, living substitute. The donor organ is usually taken from a person who has just died, however up to one third of transplanted kidneys are taken from living relatives of the patient. The following transplants are performed in the United States (in descending order of frequency): cornea, kidney, heart, liver, pancreas, and heart-lung.

APPENDIX J

Letter from J. S. Johnston, NORCAL
to Maureen Weeks, Legislative Research Agency

March 11, 1992

Alaska Office

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Anchorage, Alaska 99503-0008

(907) 563-3111
(907) 562-7800 (TOLL FREE)

March 11, 1992

Ms. Maureen Weeks, Analyst
Alaska State Legislature
Legislative Research Agency
P. O. Box Y
Juneau, Alaska 99611-3100

RE: Your Informational Request of January 20, 1992

Dear Ms. Weeks:

This is in response to yours of January 20, 1992. I have attempted to answer those of your questions which can be answered, per our previous agreement, on the basis of readily accessible data and without time consuming research. I am responding only to Sections I. and II. of your inquiry. NORCAL's underwriting department is responding to the other sections under separate cover. This information is being provided to you on a confidential basis and this letter is not intended for republication.

I. Claims

1. I am aware of several limited studies accomplished through MICA. One is Joyce Wainscott's study which I recall you saying that you have. Another study was a limited one prepared by MICA's Chief Executive Officer Mary Pierce in the spring of 1989 in response to a request for information relative to then House Bill 350 introduced by Representatives Donley and Gruenberg and specific to the issue of subsidizing premiums for rural physicians practicing obstetrics (copy attached). Ms. Pierce also responded in the fall of 1989 to an informational request from OMB's Jetta Whittaker (copy attached). In addition I believe that information was submitted in 1990 to various state agencies and probably to the Legislature relative to the planned acquisition of MICA by NORCAL. Some of that information may have included information about claims. I did not participate in preparing it and don't have access to it so I'm not sure about that.
2. I cannot respond intelligently to this question because our numbers are so small as to be statistically insignificant. NORCAL insures only a percentage of the physicians in Alaska. There are several other major carriers and there is a relatively large uninsured physician population.

Therefore I don't have access to information about claims filed against the majority of Alaskan physicians. When dealing with a population base as small as the number of physicians in Alaska and with access to information about only a minority percentage of that pool, information is so limited as to prevent any comments on trending.

3. I don't believe there was a number three on your original letter.
4. I am not sure how you are defining "providers." We insure both physicians and hospitals. Four (4) of our insured hospitals currently have lawsuits outstanding against them. Twenty three (23) of our insured physicians have lawsuits currently outstanding against them. As I have already explained we insure less than 50% of the physicians in the state. The hospitals that we insure are among the smallest in the state and so, even though we insure over 50% of Alaska hospitals, we do not insure the ones that would be likely, simply due to their size and patient population, to be generating the most claims. So again, you need to realize that this information is statistically not going to be helpful.
5. Again, referencing all of the caveats enumerated in number 4 above, two of our insured hospitals have two suits each pending and two of our physicians each have two pending suits.
6. I cannot give you specific answers to this. Your first question references the time taken to resolve a medical malpractice claim and I would refer you to the problems presented by different definitions and our computer data base enumerated above in number 4. There are somewhat different problems in providing the answer to your second question involving the time taken to resolve lawsuits. Under MICA's administration we tracked information about the date on which a matter was reported to MICA. Frequently that report was made by our insured soon after the incident in question or at the time medical records were requested. Often suit was not filed for many months or several years after that date of report. I could give you the date of the report and I could give you an approximate date on which payment, if any, was made but those numbers would be relatively meaningless since the period of time might span five years, two of which occurred between the time our insured reported the matter to us and the time suit was filed. I have no way of accessing, via the computer, information that would target the actual date on which a claim was presented or a lawsuit was filed in comparison to the actual date on which definitive resolution and/or payment was accomplished.

I certainly have, as I'm sure every claims person has, anecdotal stories about claims that have taken a very short time or very long time to resolve. One that is fresh in my memory is a formal claim presented on

11/27/91 which was resolved with payment of \$225,000 on 2/18/92, a period of less than twelve weeks. Some of the cases that take a long time to conclude judging from the date of report do so because suit is not filed until the end of the statute of limitations. Others take a long time to work through the court system for one reason or another. We are going to trial the end of this calendar year in a matter that occurred in February 1987 and which was scheduled to go to trial last year. The trial was put over because an unanticipated change in the patient's medical condition occurred and it was deemed in everyone's best interest to further define that before proceeding to trial. I find that the time needed to get a case to trial varies in different judicial districts given the work load of the various judges. These are but a few of the various factors that impact the time it takes to resolve a lawsuit.

II. Payments (Settlements and Awards)

1. Again, the studies I have already referenced in I.1. are the only ones that I am aware of accomplished through this office. I would expect that the Division of Insurance or the Alaska State Medical Society might have further information.
2. In 1991 the average payment for meritorious claims against providers was \$89,093.43. This is the average of 11 payments. Ten of those were settlements and the average settlement award was \$82,964.09. The other one was a jury award which was \$150,386.78. The highest payment was \$200,000 and the lowest was \$12,500.
3. Again, I think that our figures are so small as to be insignificant and misleading for trending purposes. For example, if I were to use the year 1991 as outlined above and gave you the "average jury verdict" it would be a sample of one case. To say that the average jury verdict for 1991 is \$150,386.78 is very misleading. If that particular case had resulted in a jury verdict of \$25,000 or \$10,000,000 the information would appear far better or worse than it presently does.
3. (Here is another number 3. Perhaps it should be a 4.) Because they were cases in which MICA was involved, I am personally aware of 4 settlements or verdicts in excess of \$1,000,000. All of these were made during or prior to 1988 and I believe they have been covered in reports previously submitted and referenced above. Nevertheless I will repeat them. \$2.2 million was paid in 1987 on behalf of an insured obstetrician alleged to have been negligent in his care of a pregnant woman resulting in damage to her infant at the time of delivery in 1985. Approximately \$2.7 million was paid in 1987 on behalf of an insured hospital for alleged negligence in the treatment of a young child with

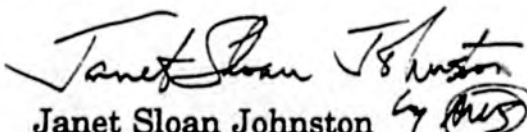
Maureen Weeks
March 11, 1992
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resultant brain damage. \$1.75 million was paid in June of 1988 as a result of a jury verdict against an Alaskan hospital held responsible for the allegedly negligent treatment rendered by physicians in the emergency room. And finally, approximately \$1.9 million was paid in 1988 on behalf of an emergency room physician allegedly negligent in his treatment of a patient who presented to the emergency room in 1984. As indicated, only one of these suits was settled by jury verdict and no appeal was taken. The rest were settlements. Geographically the cases came from Anchorage, Fairbanks, a community in Southeast Alaska, and a community in Northwestern Alaska.

5. The figures quoted above in number II.2. for the year 1991 reveal a sample high payment of \$200,000 and a sample low payment of \$12,500.
6. A claimant is a patient, guardian or heir of a patient who asserts that injury resulted from the negligence of our insureds. Approximately 41 percent of claims result in payment to claimants in an average amount of \$65,000 since inception of the company.
7. Average defense costs are around \$16,000. Average costs of defending a case through trial are around \$60,000.
8. I have no knowledge of this and cannot respond.

I hope this information is helpful and extend my appreciation for your patience in waiting to receive it.

Sincerely,


Janet Sloan Johnston
Branch Unit Manager
Claims

J-4

APPENDIX K

Current Rates for Professional Liability Insurance in Alaska

Provided by Loreen Killian

Medical Indemnity Exchange of California

October 1992,

and

1992 Rate Chart,

NORCAL Mutual Insurance Company

MEDICAL INDEMNITY EXCHANGE OF CALIFORNIA

Current Rates
for Professional Liability Insurance in Alaska
(mature rates, i.e. 5th year of practice onward)

\$1/\$3 million
(most commonly purchased)

OB Neurosurgery Orthopedics with Spinal Surgery \$79,948	For \$2/4 million + 20% non-surgery + 27% surgery specialty For \$5/7 million + 45% non-surgery + 62% surgery
General Surgery Orthopedics without Spinal Surgery ENT with > 5% Plastic Surgery \$42,328	Tail, on leaving practice is approximately 170% of mature annual rate paid 1 time.
ENT with > 5% PS Ophthalmology Internal Medicine Pediatrics Family Practice (No Surgery) Psychiatry \$26,456 \$13,524 \$11,760 \$10,584 \$ 6,468	Discounts on starting practice 1st year 75% 2nd year 40% 3rd year 20% 4th year 10% MIEC expects a 5% decrease in rate in February 1993

Source: Loreen Killian, October 1992, (800-227-4527).

**TO DETERMINE YOUR
ANNUAL RATE:**

1 Identify your class.

SPECIALTY CLASS

Administrative Medicine	2
Allergy	2
Anesthesiology	6
Cardiac Surgery	8
Cardiology	4
Colon & Rectal Surgery	7
Dermatology (No Cosmetic Surgery)	2
Dermatology (Including Cosmetic Surgery)	8
Diagnostic Radiology	2
Emergency Room Practice	5
Endocrinology	2
F.P. / G.P. (No Surgery)*	2
F.P. / G.P. (Assist Surgery-Own Patients)	3
F.P. / G.P. (Minor Surgery** or Assist)	4
F.P. / G.P. (Prenatal Only-No Delivery)	4
F.P. / G.P. (Including Obstetrics)***	7
F.P. / G.P. (Major Surgery)	7
Gastroenterology	2
General Medicine	2
General Preventive Medicine	2
General Surgery	7
Gynecology Only	7
Hematology	2
Internal Medicine (Excluding Left-Heart Cath.)	2
Internal Medicine (Including Left-Heart Cath.)	4
Neonatology	4
Nephrology	2
Neurology	2
Neurosurgery	9
Nuclear Medicine	4
Obstetrics and Gynecology	8
Oncology	2
Ophthalmology (Excluding R.K.)	3
Oral and Maxillofacial Surgery	7
Orthopedic Surgery	8
Orthopedic Surgery (Including Total Joints, Spinal Surgery, Insertion Prosthetic)	9
Otolaryngology	7
Otolaryngology (Including Plastic Surgery)	8
Pathology	1
Pediatrics	2
Perinatology	4
Physical Medicine and Rehabilitation	2
Plastic Surgery	8
Psychiatry	1
Pulmonary Disease	2
Rheumatology	2
Surgical Assistant	4
Therapeutic Radiology	5
Thoracic Surgery	7
Urology	6
Vascular Surgery	8

* No Surgery includes minor office procedures.

** Minor Surgery includes vasectomy, tonsillectomy, adenoidectomy, dilation and curettage (except for abortion), biopsy, circumcision, hemorrhoidectomy, myringotomy, other minor office procedures and assisting in surgery.

*** Includes all procedures classified as Minor Surgery plus obstetrics (with regional anesthesia therein, but excluding Caesarean sections) and abortion.

Alaska

1992 Rates

NORCAL
Mutual
Insurance
Company

Professional
Liability
Insurance

Alaska Office
4000 Old Seward Highway
Suite 203
Anchorage, Alaska 99503
(907) 563-3414

 **NORCAL**
Mutual Insurance Company

 **NORCAL**
Mutual Insurance Company

2 Select Your Limits of Liability.

Refer to the limits column in the table at right. The first amount is the "Each Claim" limit. The second amount is the "Aggregate per Calendar Year" limit.

3 Find Your Annual Rate.

Select your inception date from the table at right.

A. Refer to 1-1-92 unless you are transferring from another claims-made program and wish to apply for Prior Acts Coverage.

B. If you are applying for Prior Acts Coverage, refer to the date you would want Prior Acts Coverage to begin. (Prior Acts Coverage protects you for claims resulting from occurrences and accidents that happened while you were insured with another company.)

C. If your requested inception date falls between those listed or after 1-1-92, your premium will be prorated accordingly.

4 Discounts & Savings.

These rates do not include any premium reductions, such as discounts and dividends.

Since 1979 NORCAL has returned more policyholder premium (approximately \$130 million) than any other doctor-owned company in the country.

Loss Prevention discounts are available if you participate in our Risk Management Program.

New-to-practice physicians are eligible for a 75% discount the first year, 50% the second year and further discounts for the next five years. Part-time discounts of 50% are also available to eligible insureds.

Class	Limits of Liability [†] (Millions of Dollars)	I N C E P T I O N D A T E				
		1-1-92	1-1-91	1-1-90	1-1-89	1-1-88 or earlier
1	200k/600k	\$ 2,237	\$ 2,879	\$ 3,917	\$ 4,570	\$ 4,520
	500k/1M	2,644	3,503	4,891	5,496	5,697
	1M/2M	3,232	4,403	6,297	7,124	7,396
	1M/3M	3,327	4,550	6,526	7,388	7,673
2	200k/600k	\$ 3,041	\$ 4,112	\$ 5,841	\$ 6,597	\$ 6,846
	500k/1M	3,720	5,151	7,464	8,474	8,808
	1M/2M	4,700	6,651	9,809	11,186	11,641
	1M/3M	4,859	6,896	10,190	11,627	12,102
3	200k/600k	\$ 3,732	\$ 5,169	\$ 7,494	\$ 8,508	\$ 8,843
	500k/1M	4,643	6,566	9,674	11,030	11,478
	1M/2M	5,960	8,583	12,823	14,673	15,284
	1M/3M	6,174	8,910	13,335	15,266	15,904
4	200k/600k	\$ 4,459	\$ 6,284	\$ 9,233	\$ 10,521	\$ 10,946
	500k/1M	5,615	8,056	12,001	13,722	14,291
	1M/2M	7,286	10,615	15,997	18,346	19,122
	1M/3M	7,558	11,032	16,648	19,098	19,908
5	200k/600k	\$ 6,080	\$ 8,767	\$ 13,111	\$ 15,007	\$ 15,633
	500k/1M	7,783	11,376	17,185	19,720	20,558
	1M/2M	10,243	15,145	23,070	26,529	27,672
	1M/3M	10,643	15,758	24,029	27,637	28,830
6	200k/600k	\$ 7,182	\$ 10,455	\$ 15,747	\$ 18,057	\$ 18,820
	500k/1M	9,257	13,633	20,710	23,799	24,819
	1M/2M	12,253	18,225	27,881	32,093	33,485
	1M/3M	12,741	18,972	29,048	33,443	34,896
7	200k/600k	\$ 7,700	\$ 11,249	\$ 16,988	\$ 19,491	\$ 20,319
	500k/1M	9,949	14,696	22,369	25,718	26,824
	1M/2M	13,199	19,675	30,144	34,711	36,221
	1M/3M	13,728	20,485	31,409	36,175	37,751
8	200k/600k	\$ 12,562	\$ 18,699	\$ 28,620	\$ 32,949	\$ 34,385
	500k/1M	16,452	24,657	37,925	43,714	45,627
	1M/2M	22,069	33,265	51,365	59,263	61,873
	1M/3M	22,984	34,666	53,554	61,795	64,519
9	200k/600k	\$ 17,221	\$ 25,837	\$ 39,767	\$ 45,845	\$ 47,855
	500k/1M	22,682	34,203	52,831	60,959	63,645
	1M/2M	30,571	46,288	71,702	82,790	86,455
	1M/3M	31,854	48,256	74,775	86,345	90,169