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STATE OF ALASKA

**HEALTH RESOURCES AND ACCESS
TASK FORCE**

Interim Report to the Governor and Legislature

APPENDIX

Adopted, January 11, 1992

APPENDICES

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Appendix B: Background Information on Health Care Access Issues, Prepared for the Alaska Health Resources and Access Task Force by Lawrence Bartlett, Ph.D., Health Systems Research, Inc., Washington, D.C., September 18, 1991.

Appendix C: Background Information on Health Care Cost Issues, Prepared for the Alaska Health Resources and Access Task Force by Lawrence Bartlett, Ph.D., Health Systems Research, Inc., Washington, D.C., September 18, 1991.

Appendix D: "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.

Appendix E: "Memo to Nancy Cornwell regarding Summary of Utilization Rates for the 1990 Alaska Hospital Survey and comparison to U.S. Averages", from Bradley J. Whistler, Planning Section, Alaska Department of Health and Social Services, October 9, 1991.

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Appendix H: "Retention and Attraction of Practitioners in Rural Alaska", presented to the Health Resources and Access Task Force by Rodman Wilson, MD, Task Force member, November 18, 1991.

Appendix I: "Memo to the Alaska State Legislature, Health Resources and Access Task Force", from Jeff Gingold, Blue Cross of Washington and Alaska, January 1992. "Memo to Nancy Cornwell, Project Director, Health Resources and Access Task Force", from Phyllis Finn for Jeff Gingold, January 17, 1992.

Appendix J: Health Care Legislation Under Consideration by the Health Resources and Access Task Force.

Appendix K: "The Comprehensive Health Insurance and Payment Reform Act of 1992 (CHIPRA), An Outline for Model Health Care Reform Legislation", draft, by the Health Access and Cost Containment Council, January 21, 1992.

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Appendix M: "Memo to Nancy Cornwell", from Larry Bartlett, Health Systems Research, Inc., January 23, 1992.

Appendix N: "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.

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.

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

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;

(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 non-profit 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

Background Information on Health Care Access Issues

Prepared for the Alaska Health Resources and Access Task Force by

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

Washington, D. C.

September 18, 1991

**BACKGROUND INFORMATION
ON HEALTH CARE ACCESS ISSUES**

Prepared for the
Alaska Health Resources and
Access Task Force

Prepared by
Lawrence Bartlett, Ph.D.
Health Systems Research, Inc.
Washington, DC

September 18, 1991

ESTIMATED SIZE OF UNINSURED POPULATION IN U.S., 1987

- **Point-in-time
estimate:** **34-36 million**

- **Uninsured
entire year:** **24.5 million**

- **Uninsured part
of the year:** **23.3 million**

- **Uninsured at some
time during year:** **47.8 million**

Source: Short, AHCPR, National Medical
Expenditure Survey

HEALTH CARE COVERAGE OF U.S. NON-ELDERLY POPULATION, 1987

<u>Coverage</u>	<u>Number of Persons (millions)</u>	<u>Percentage of Population</u>
■ Private		
Employment-based	140.8	65.9%
--Direct	71.2	33.3%
--Indirect	69.6	32.6%
Other private	19.7	9.2%
■ Public	26.2	12.2%
Medicare	3.2	1.5%
Medicaid	18.5	8.7%
Champus	5.9	2.7%
No health insurance	34.4	16.1%

Source: EBRI Analysis of the March 1990 CPS

THE UNINSURED IN ALASKA

DEFINITION:

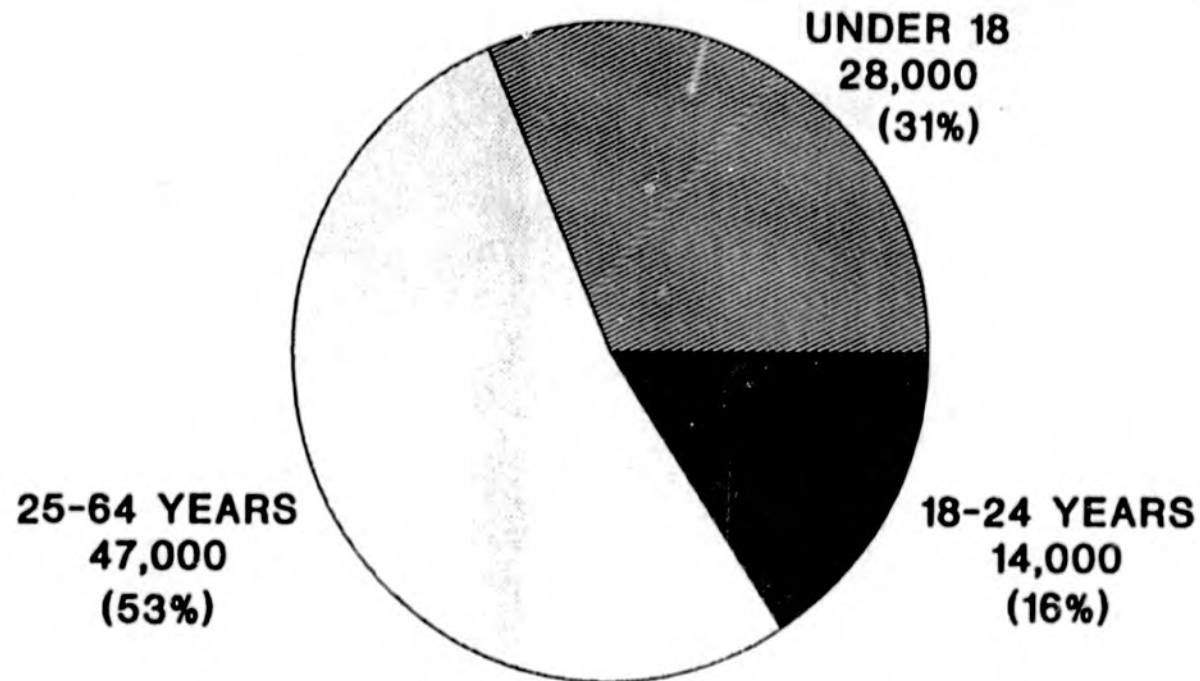
The uninsured are persons who lack third party health care coverage, such as private insurance, Medicare or Medicaid.

ESTIMATED SIZE:

According to data from the Alaska portion of the 1988 and 1989 Current Population Survey, approximately 90,000 Alaskans indicated they were uninsured. This represents about 18.8% of the state's under-65 population.

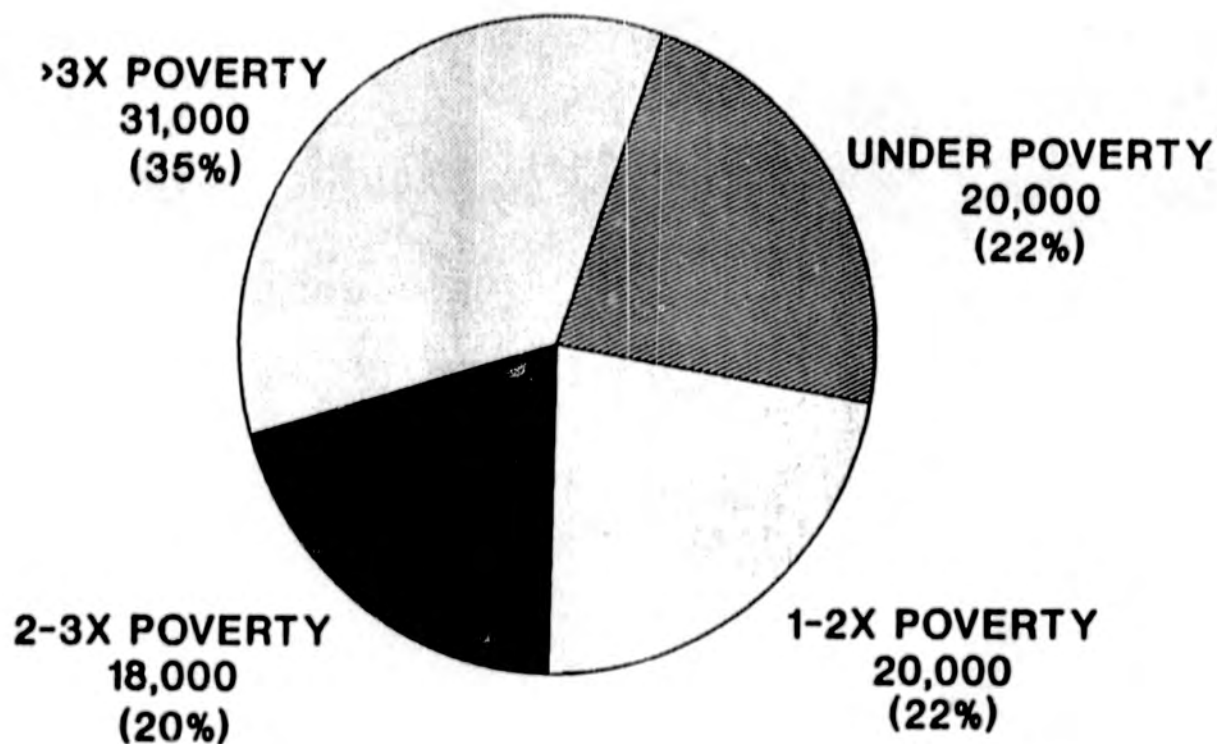
Of the persons identified in the survey as native Americans, a slightly lower proportion (16.3%, which represents about 13,800 persons) reported having no health care coverage.

UNINSURED ALASKANS By Age



Source: Health Systems Research, Inc.
Analysis of March 1988 and 1989 CPS

UNINSURED ALASKANS By Poverty Status



Source: Health Systems Research, Inc.
Analysis of March 1988 and 1989 CPS

1988 POVERTY GUIDELINES

HOUSEHOLD SIZE

ANNUAL INCOME

1

\$ 5,770

2

\$ 7,730

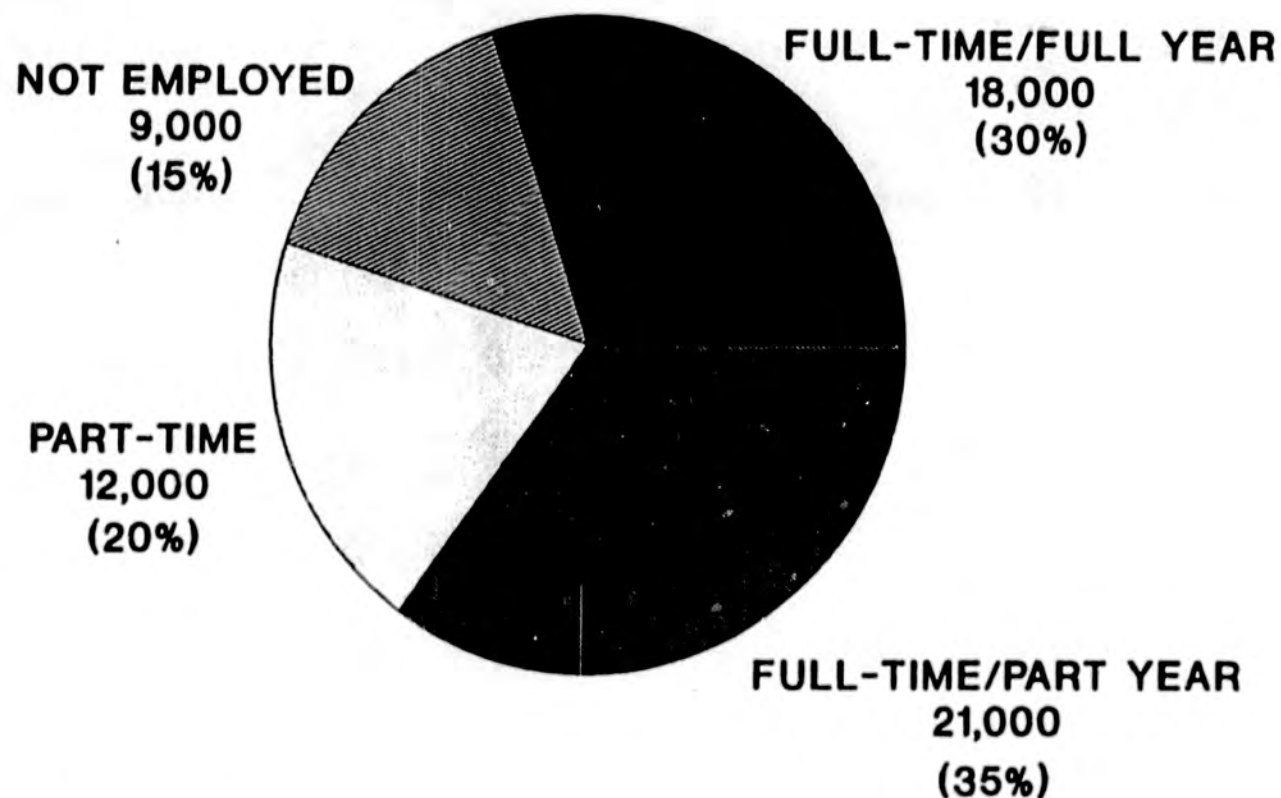
3

\$ 9,690

4

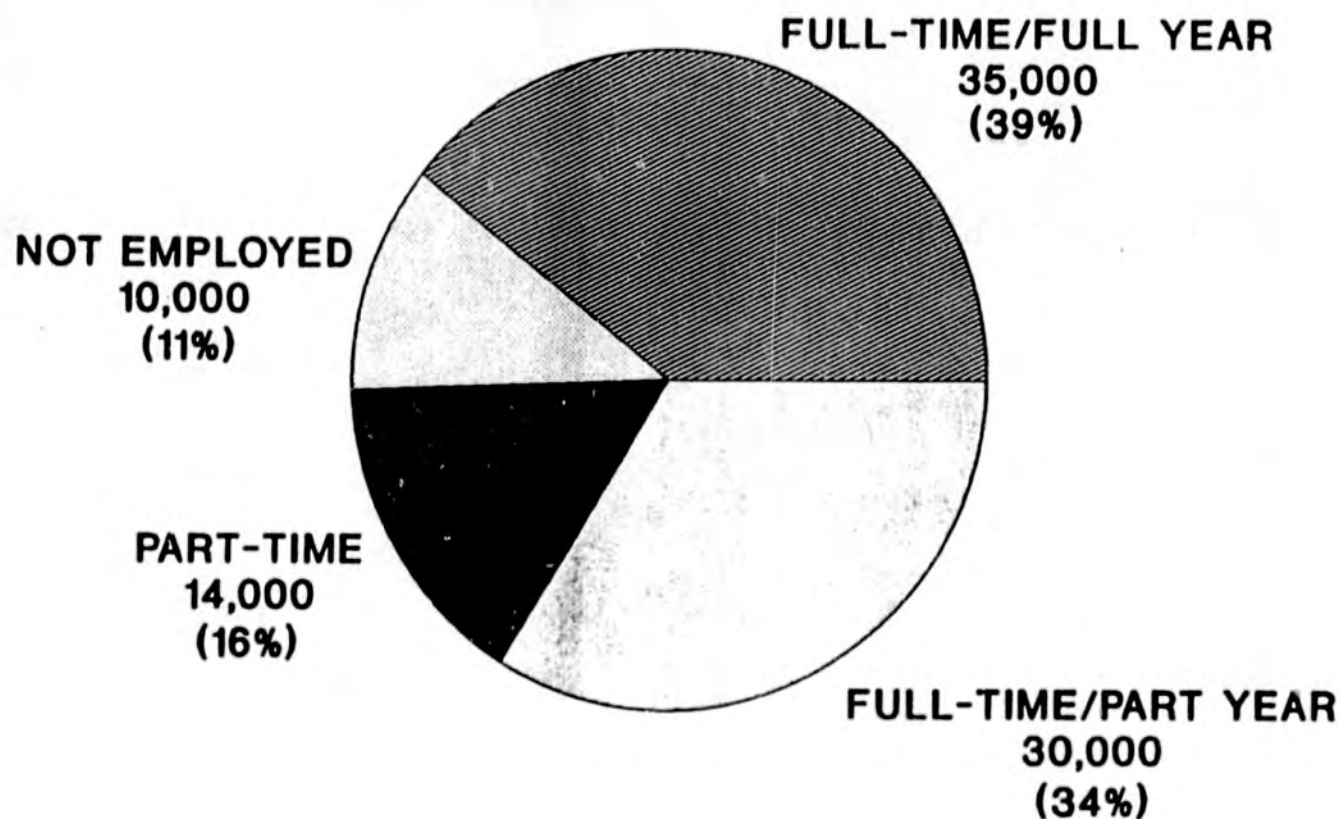
\$11,650

EMPLOYMENT STATUS OF UNINSURED ALASKANS Ages 18-64



Source: Health Systems Research, Inc.
Analysis of March 1988 and 1989 CPS

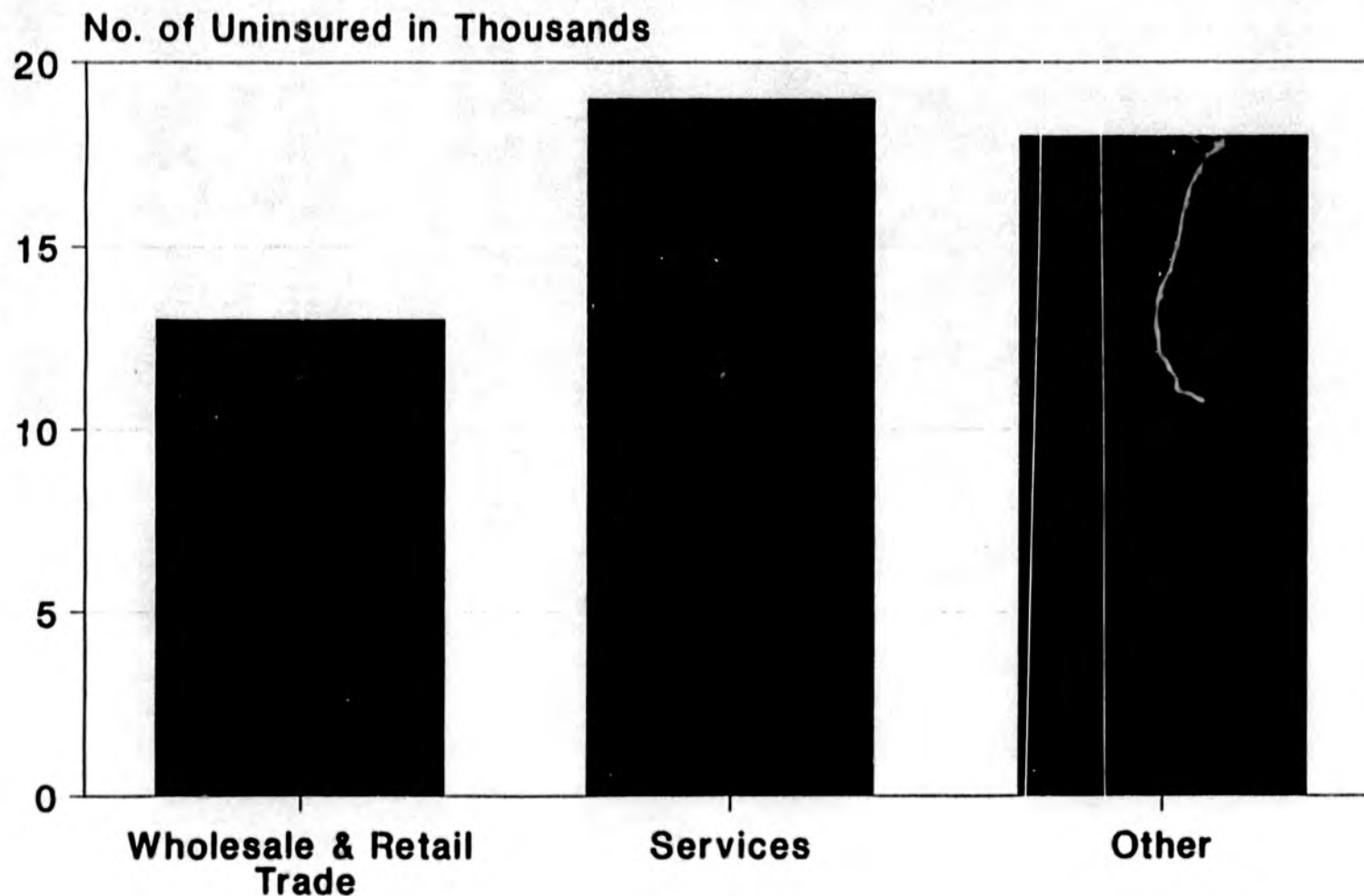
DISTRIBUTION OF UNINSURED ALASKANS By Employment Status of Family Head



Source: Health Systems Research, Inc.
Analysis of March 1988 and 1989 CPS

UNINSURED WORKERS IN ALASKA

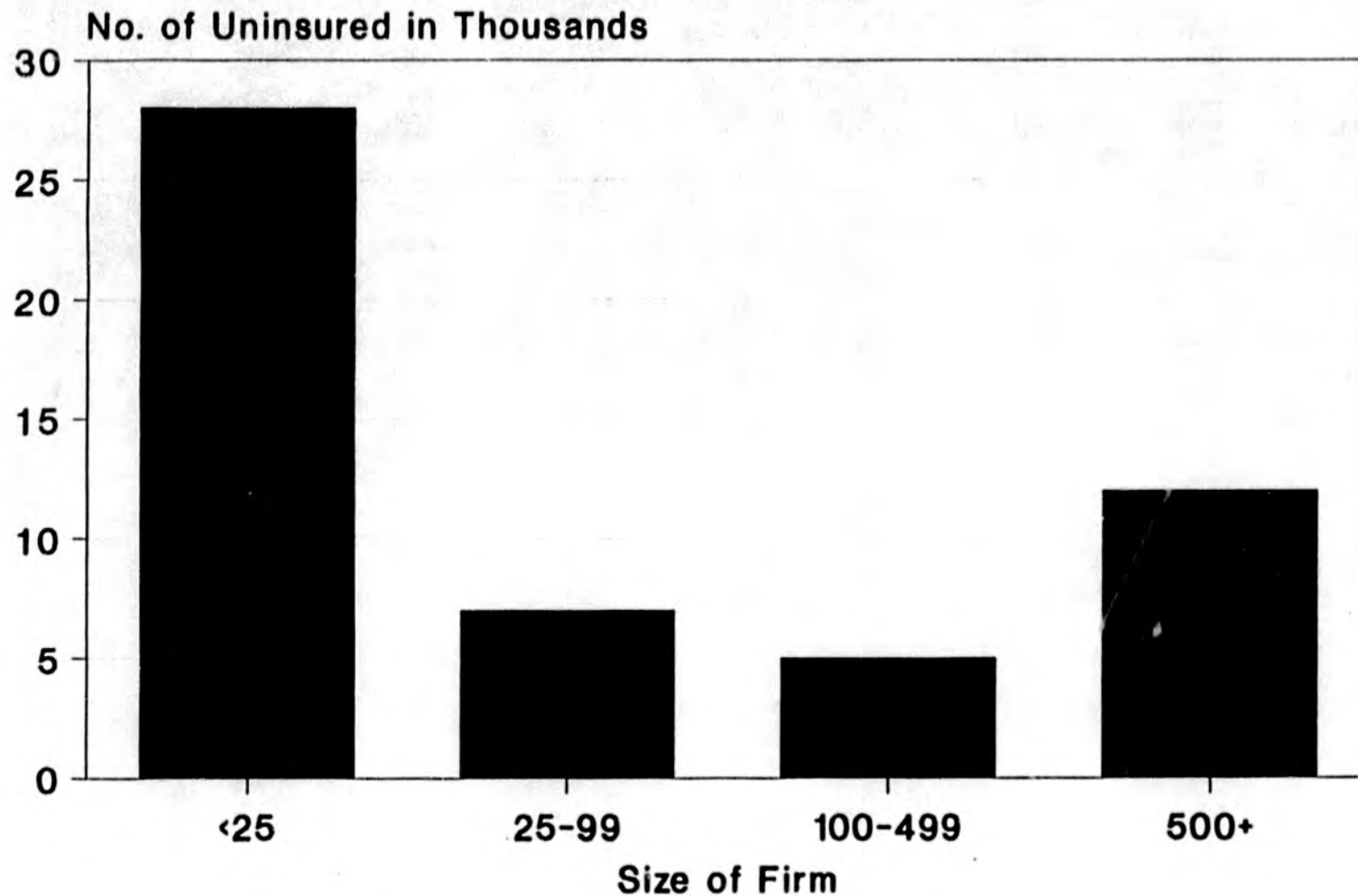
By Industry



Source: Health Systems Research, Inc.
Analysis of March 1988 and 1989 CPS

UNINSURED WORKERS IN ALASKA

By Size of Firm



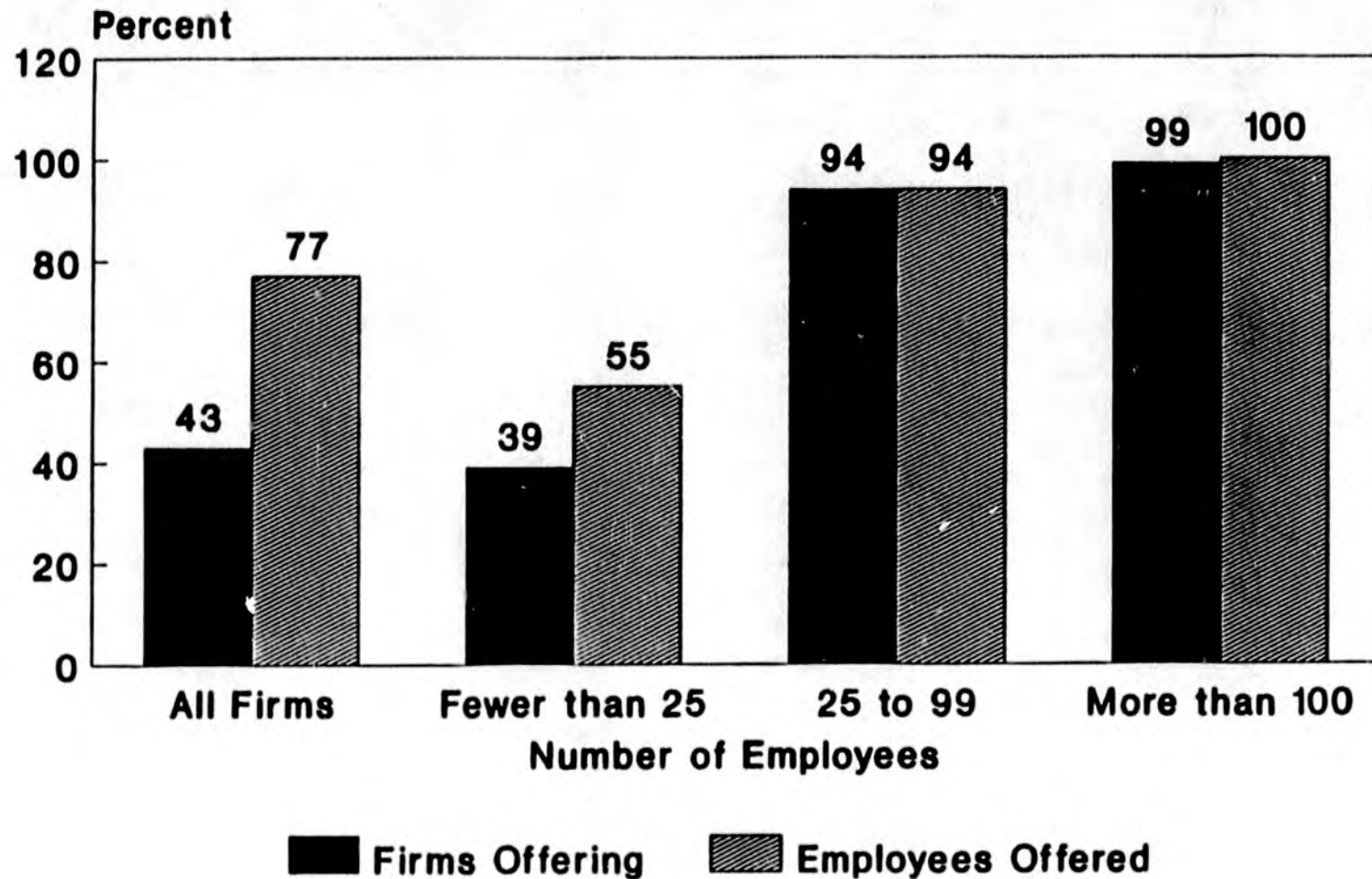
Source: Health Systems Research, Inc.
Analysis of March 1988 and 1989 CPS

NUMBER OF ALASKAN FIRMS BY EMPLOYMENT SIZE CLASS

	<u><10</u>	<u>10-24</u>	<u>25-99</u>	<u>100-249</u>	<u>250+</u>
ALL INDUSTRIES	10,628	1,847	834	176	82
Ag, Forestry & Fishing	152	20	4	1	0
Mining	117	28	29	15	6
Construction	1,382	181	64	9	2
Manufacturing	289	95	77	24	15
Seafood Processing	38	27	46	14	9
Lumber & Wood Products	54	14	16	7	1
Transportation	910	161	104	24	13
Trade	2,793	593	245	49	22
Wholesale	596	130	57	8	1
Retail	2,197	463	188	41	21
Finance, Ins. & Real Estate	671	113	55	6	4
Services	4,314	656	256	48	20

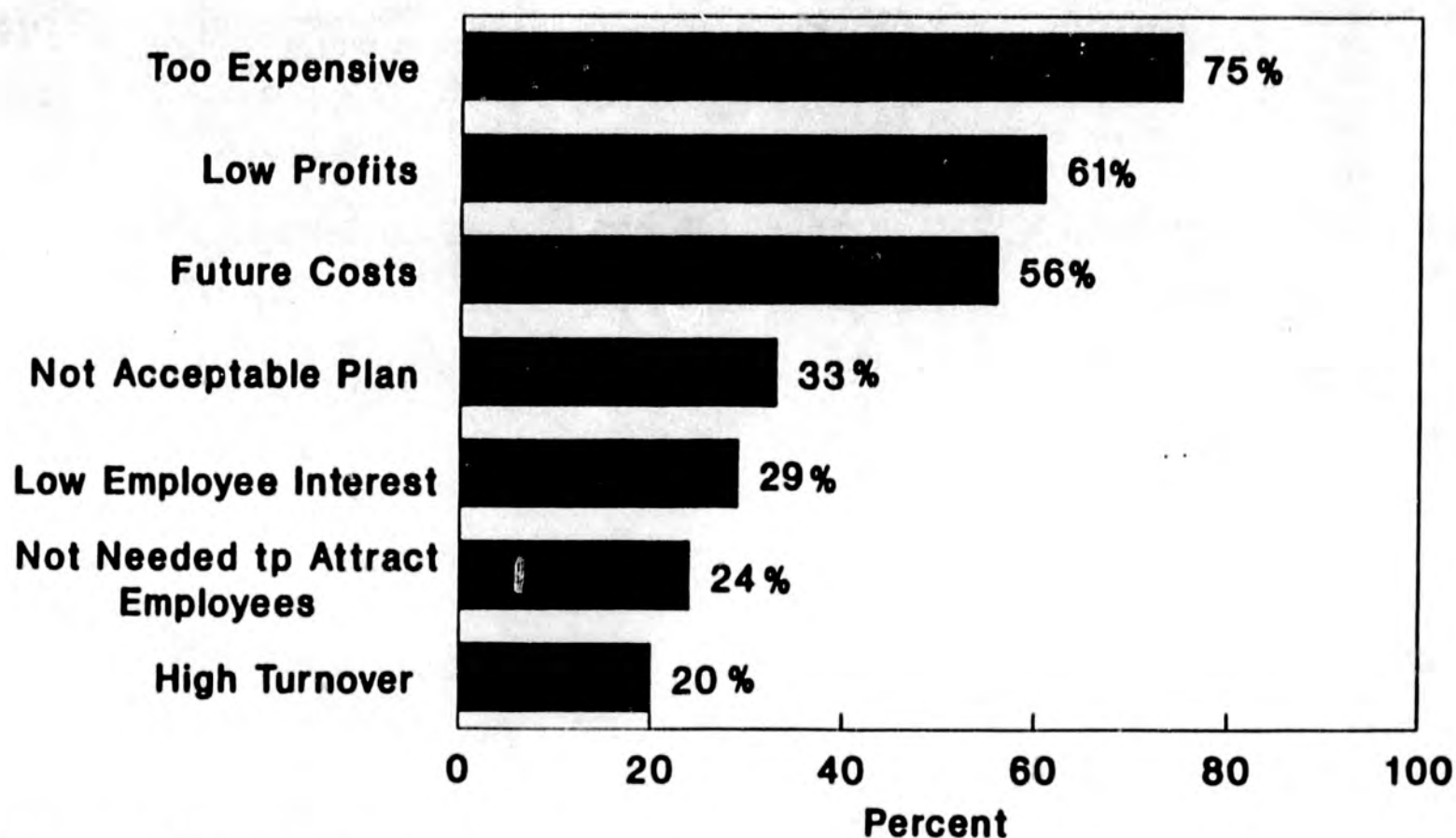
B-12

Larger Firms Are More Likely to Offer Health Benefits, 1989



Source: HIAA 1989 Employer Survey

Percent of Firms Citing Particular Reasons as a Very Important Reason for Not Offering Health Insurance



Source: HIAA 1989 Employer Survey

B-14

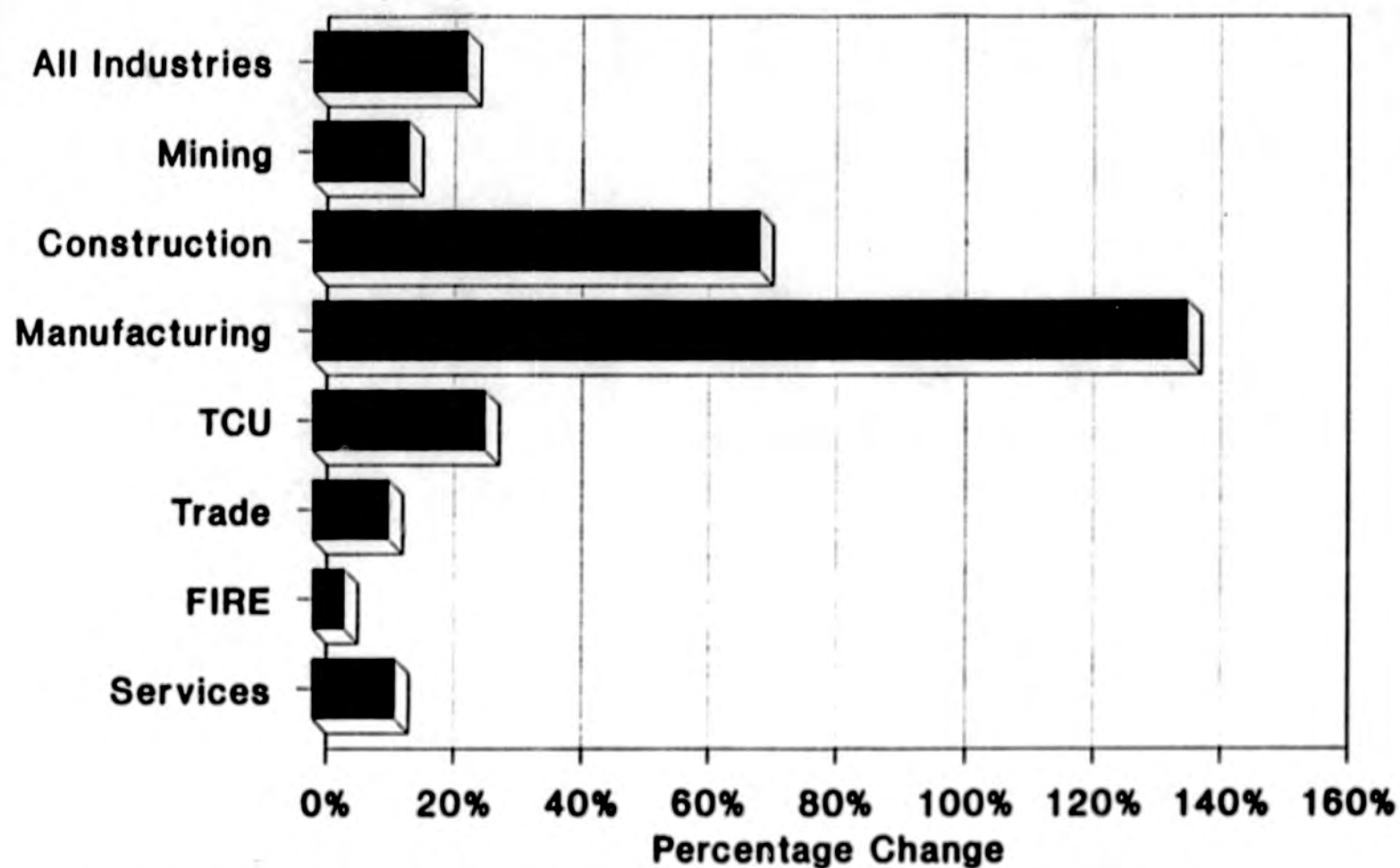
BREAKDOWN OF INSURANCE COMPANY ADMINISTRATIVE EXPENSES (Percentage of Incurred Claims)

<u>Number of Employees</u>	<u>General^a</u>	<u>Profit & Risk</u>	<u>Commission</u>	<u>Total</u>
1 to 4	23.1	8.5	8.4	40.0
5 to 9	21.0	8.0	6.0	35.0
10 to 19	17.5	7.5	5.0	30.0
20 to 49	14.9	6.8	3.3	25.0
50 to 99	10.0	6.0	2.0	18.0
100 to 499	8.9	5.5	1.6	16.0
500 to 2,499	7.8	3.5	0.7	12.0
2,500 to 9,999	5.9	1.8	0.3	8.0
10,000 or more	4.3	1.1	0.1	5.5

Source: CRS - Private Health Insurance: Options for Reform, Sept. 20, 1990.

^a Includes claims administration, general administration, interest credit, and premium taxes.

Seasonal Fluctuation in Employment by Industry



Source: Alaska Department of Labor,
Research and Analysis Section

**Average Monthly Employment for Alaskan Employers
October 1989 through September 1990¹**

	Avg. Firm Size	Maximum Employment/Firm Employment	Month	Minimum Employment/Firm Employment	Month	% Change Maximum to Minimum
All Industries	13.3	14.9	July	12.0	Jan	24
Ag, Forestry & Fishing	6.0	7.7	Aug	4.6	Jan	66
Mining	70.0	75.4	June	65.3	Apr	15
Construction	7.1	8.7	Aug	5.1	Jan	70
Manufacturing	36.7	57.0	July	24.1	Dec	137
Seafood Processing	77.0	146.6	July	34.7	Dec	322
Lumber & Wood Products	36.5	46.9	Oct ²	21.5	Feb	118
Transportation	19.8	22.2	Aug	17.5	Dec	27
Truck & Warehouse	12.7	13.9	Aug	11.2	Jan	24
Water Transportation	12.6	16.3	Aug	10.2	Jan	61
Air Transportation	37.9	40.4	Aug	34.6	April	17
Communications	32.8	33.6	Nov	31.6	April	6
Utilities	11.5	13.7	June	7.3	Dec	87
Trade	13.6	14.5	Aug	12.9	Jan	12
Wholesale	10.5	11.1	June	9.9	Jan	12
Retail Trade	14.5	15.5	Aug	13.7	Feb	13
General Apparel & Merch.	18.9	21.2	Dec	17.3	April	22
Food Stores	38.1	40.3	Aug	35.7	Dec	13
Eating & Drinking	16.2	17.8	July	15.0	Jan	19
Finance, Ins. & R.E.	11.9	12.1	June	11.6	April	5
Services	10.0	10.7	June	9.4	Jan	13
Hotels & Motels	19.5	25.1	July	16.1	Jan	56

¹ Most recent 12 months of ES-202 data available.

² Peak employment in the timber industry normally occurs in June. Because of a downturn in the timber industry which began in late 1989, employment in October of that year was higher than employment in June of 1990.

Source: Alaska Department of Labor, Research & Analysis Section.

APPENDIX C

Background Information on Health Care Cost Issues

Prepared for the Alaska Health Resources and Access Task Force by

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

Washington, D.C.

September 18, 1991

BACKGROUND INFORMATION ON HEALTH CARE COST ISSUES

**Prepared for the
Alaska Health Resources and
Access Task Force**

**Prepared by
Lawrence Bartlett, Ph.D.
Health Systems Research, Inc.
Washington, DC**

September 18, 1991

THE NATION'S HEALTH CARE SPENDING 1989

TOTAL: \$604.1 BILLION (11.6% of GNP)

WHERE IT CAME FROM:

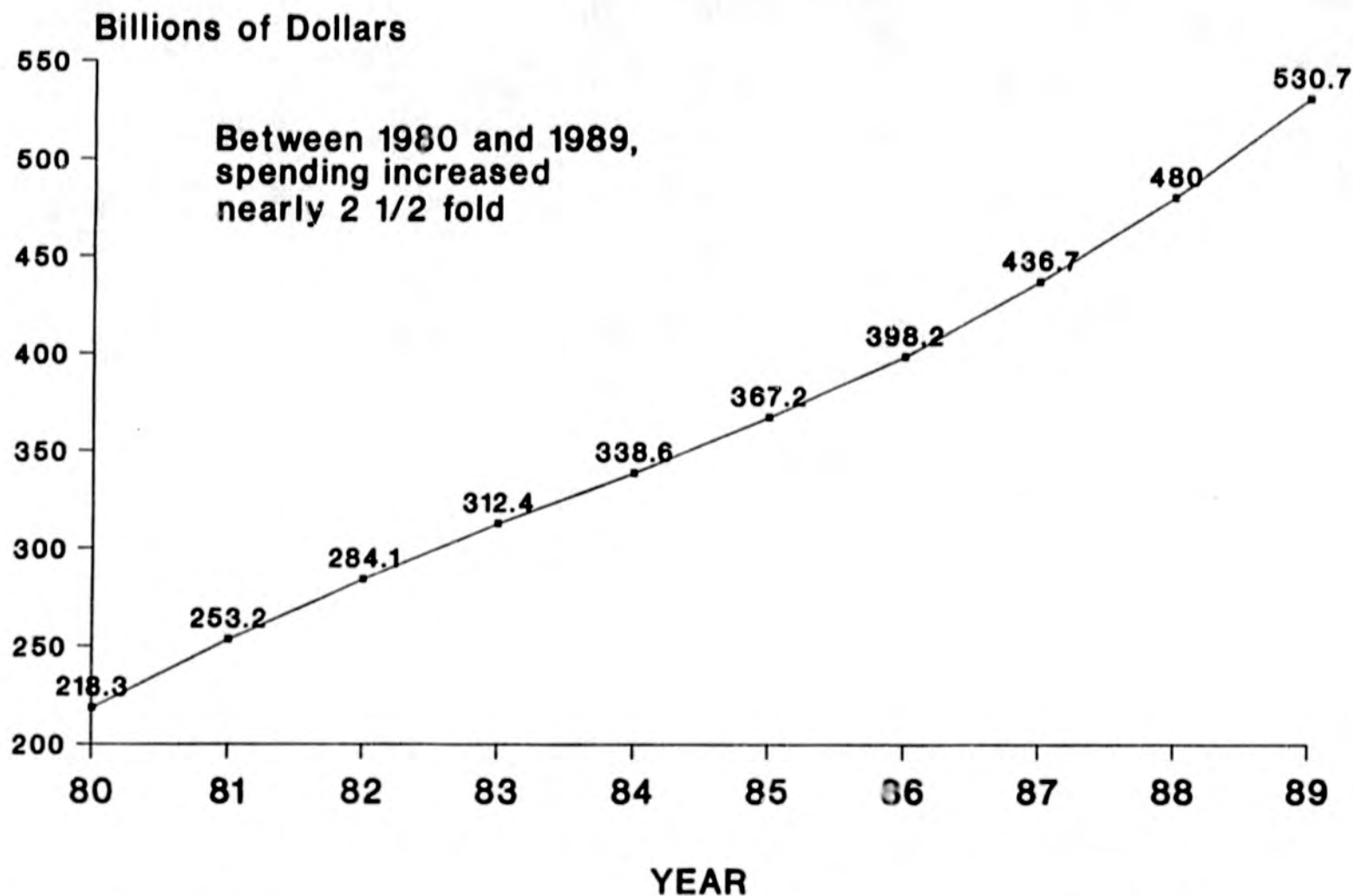
- Private health insurance 33%**
- Out of pocket 21%**
- Other private 4%**
- Medicare 17%**
- Medicaid 10%**
- Other government programs 15%**

THE NATION'S HEALTH CARE SPENDING 1989 (cont.)

WHERE IT WENT:

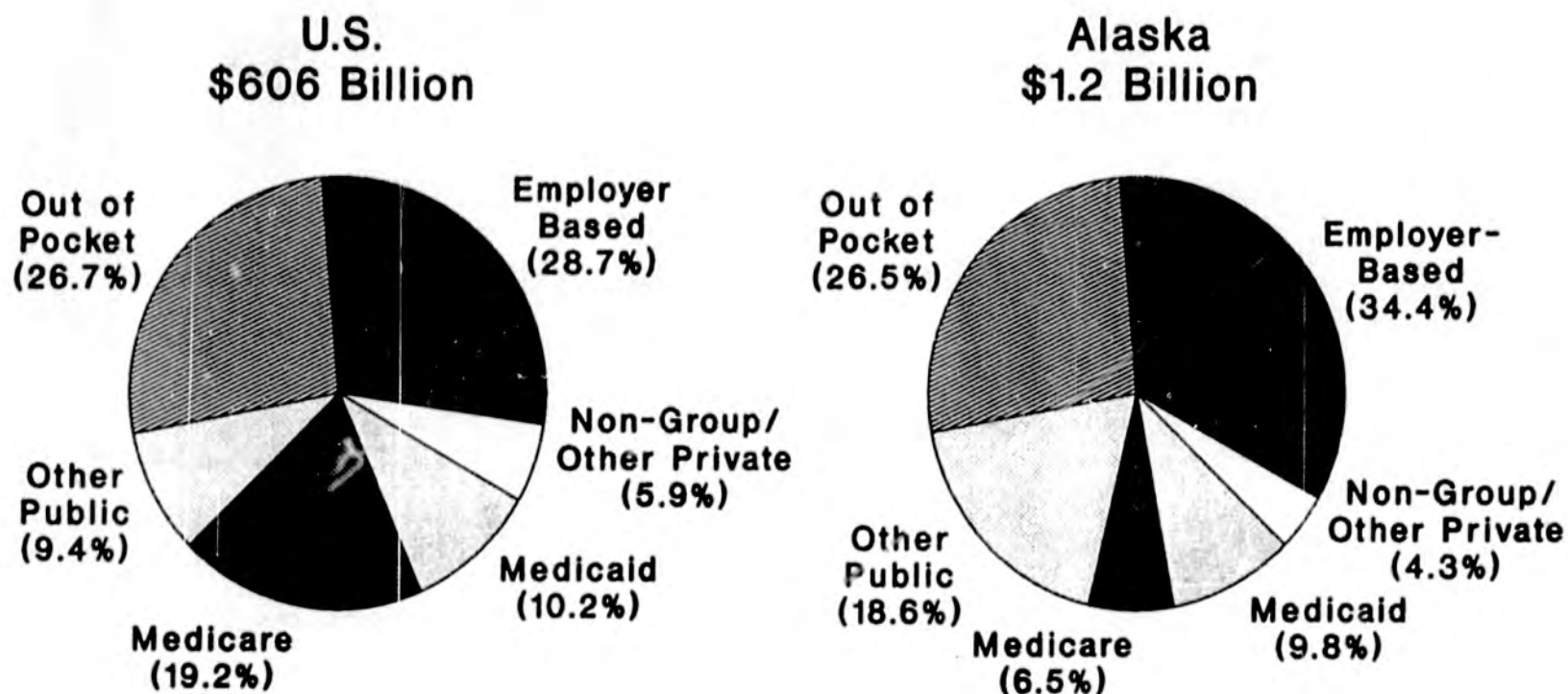
- **Personal health care** **88%**
 - Hospital care **39%**
 - Physician services **19%**
 - Nursing home care **8%**
 - Drugs **7%**
 - Dental **5%**
 - Other professional services **5%**
 - Vision **2%**
 - Other **2%**
- **Program administration and net cost of health insurance** **6%**
- **Government public health activities** **3%**
- **Research and construction** **3%**

PERSONAL HEALTH CARE EXPENDITURES U.S., 1980-89



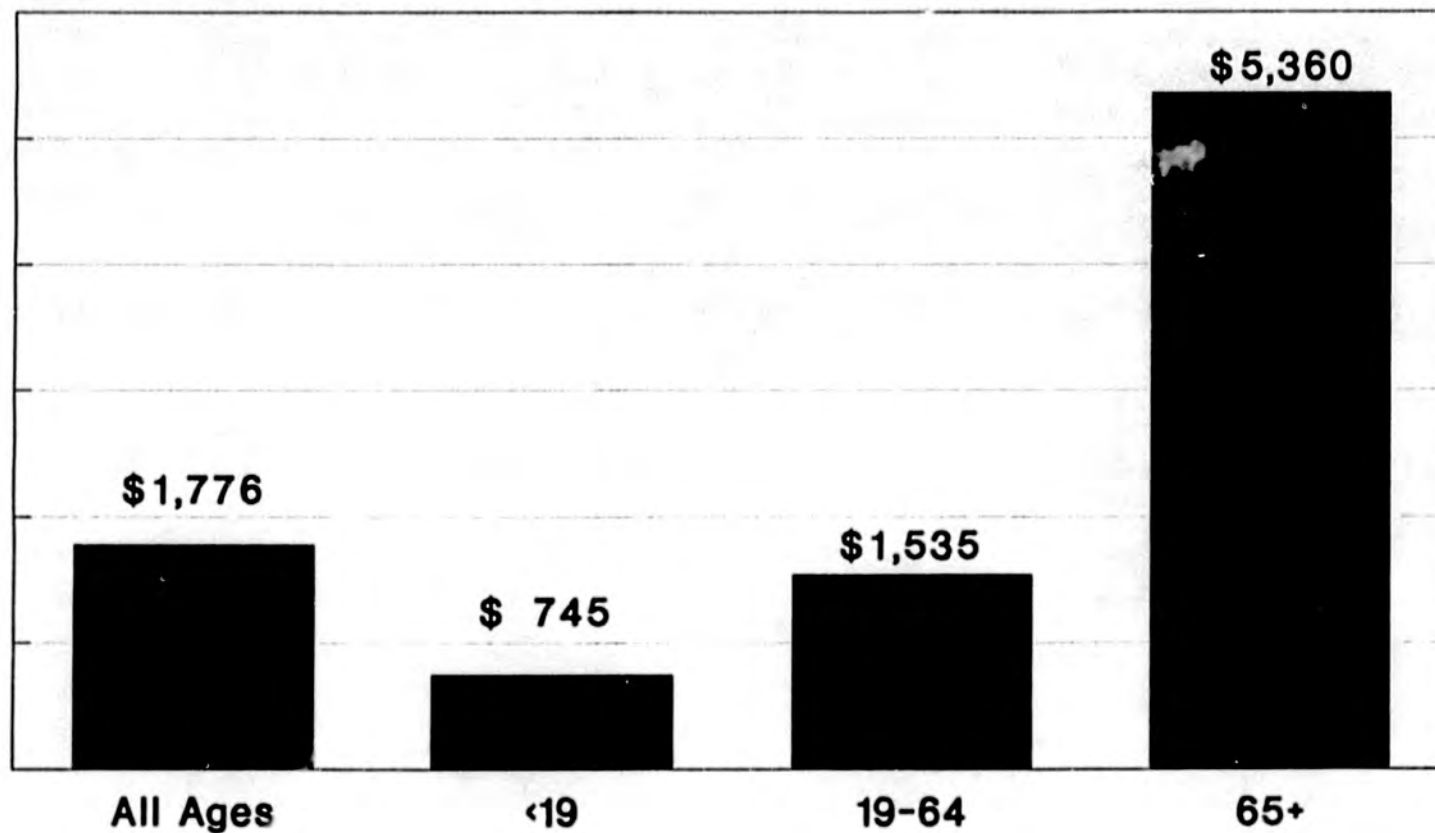
Source: HCFA, DHHS

ESTIMATED SOURCES OF PAYMENT FOR PERSONAL HEALTH EXPENDITURES U.S. and Alaska, 1990



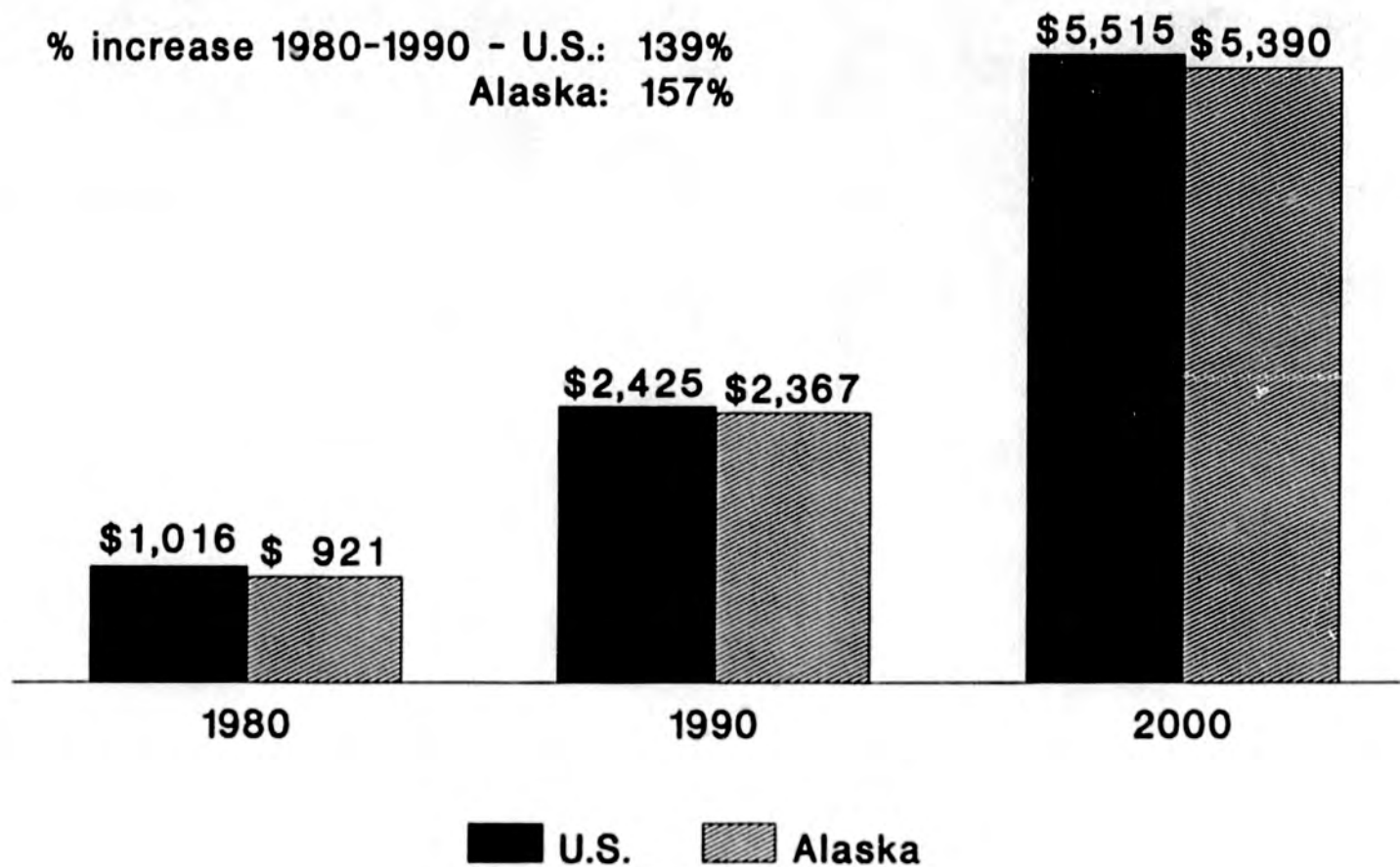
Source: Families U.S.A. Foundation

ESTIMATED PER CAPITA HEALTH CARE SPENDING, BY AGE U.S. 1987



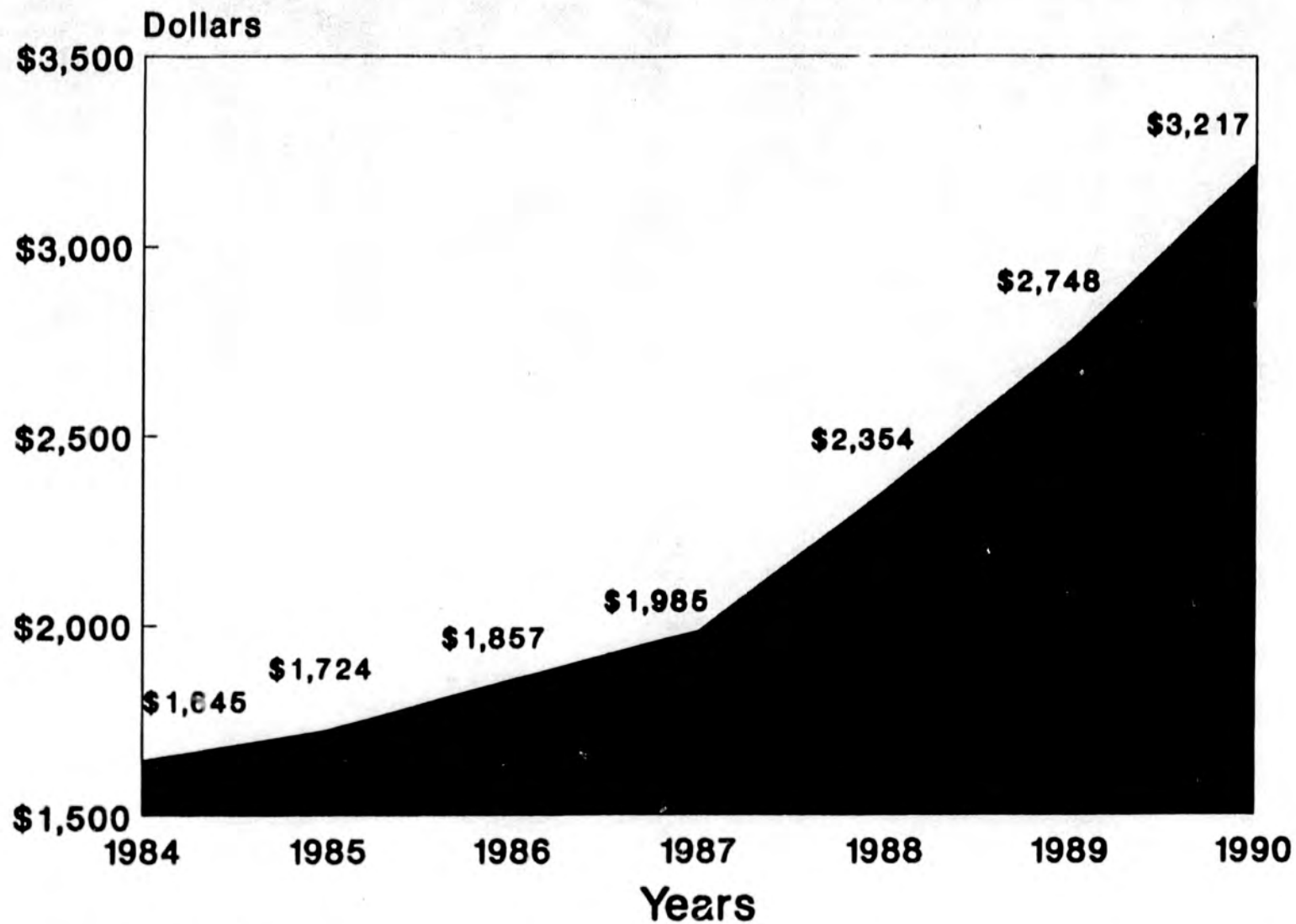
Source: HCFA, DHHS

ESTIMATED PER CAPITA HEALTH CARE EXPENDITURES U.S. & ALASKA 1980, 1990 & 2000



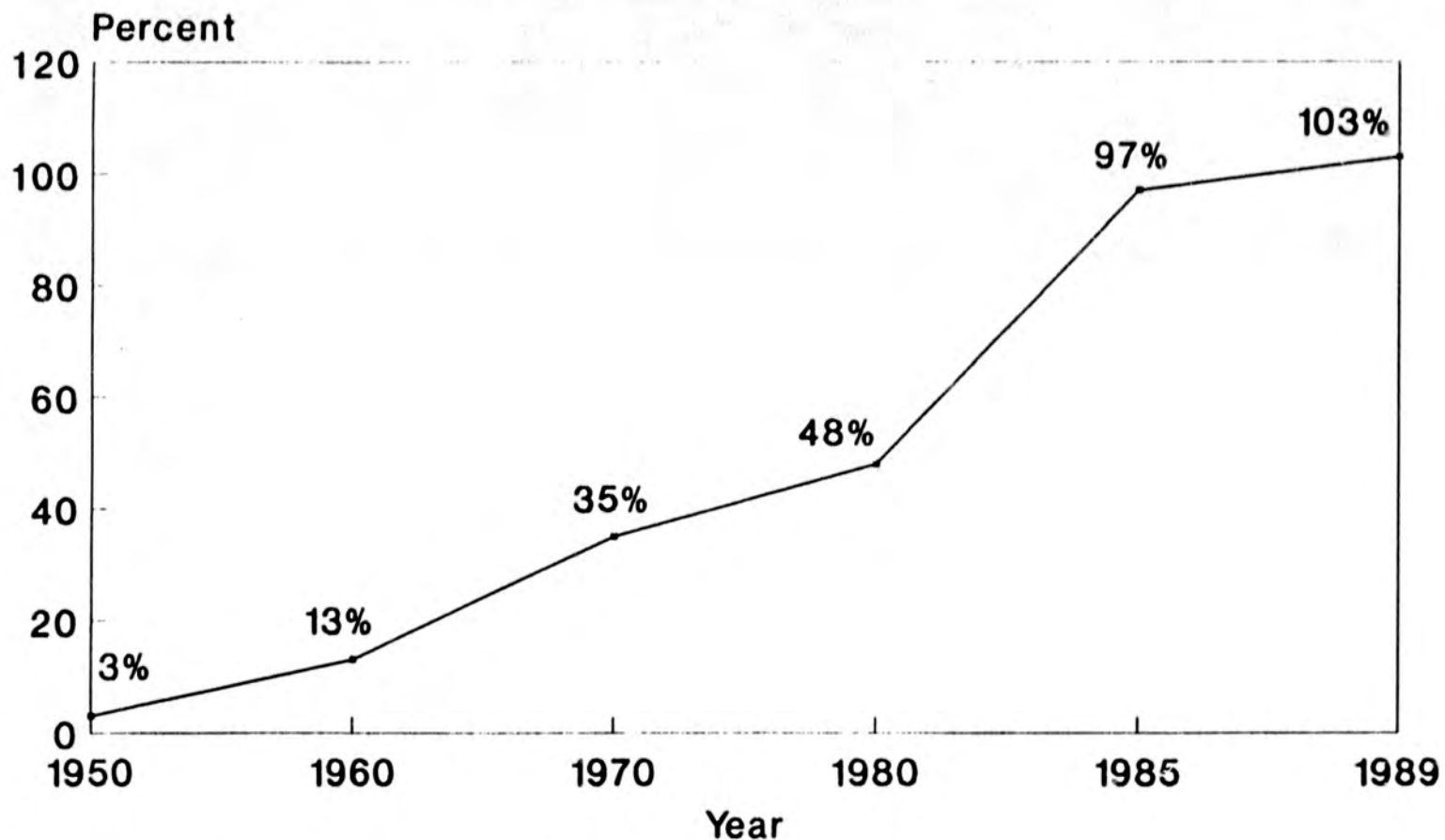
Source: Families U.S.A. Foundation

Average Health Care Costs Per Employee



Source: Foster Higgins

Employer Spending on Health Insurance as a Percentage of Corporate After- Tax Profits, Selected Years



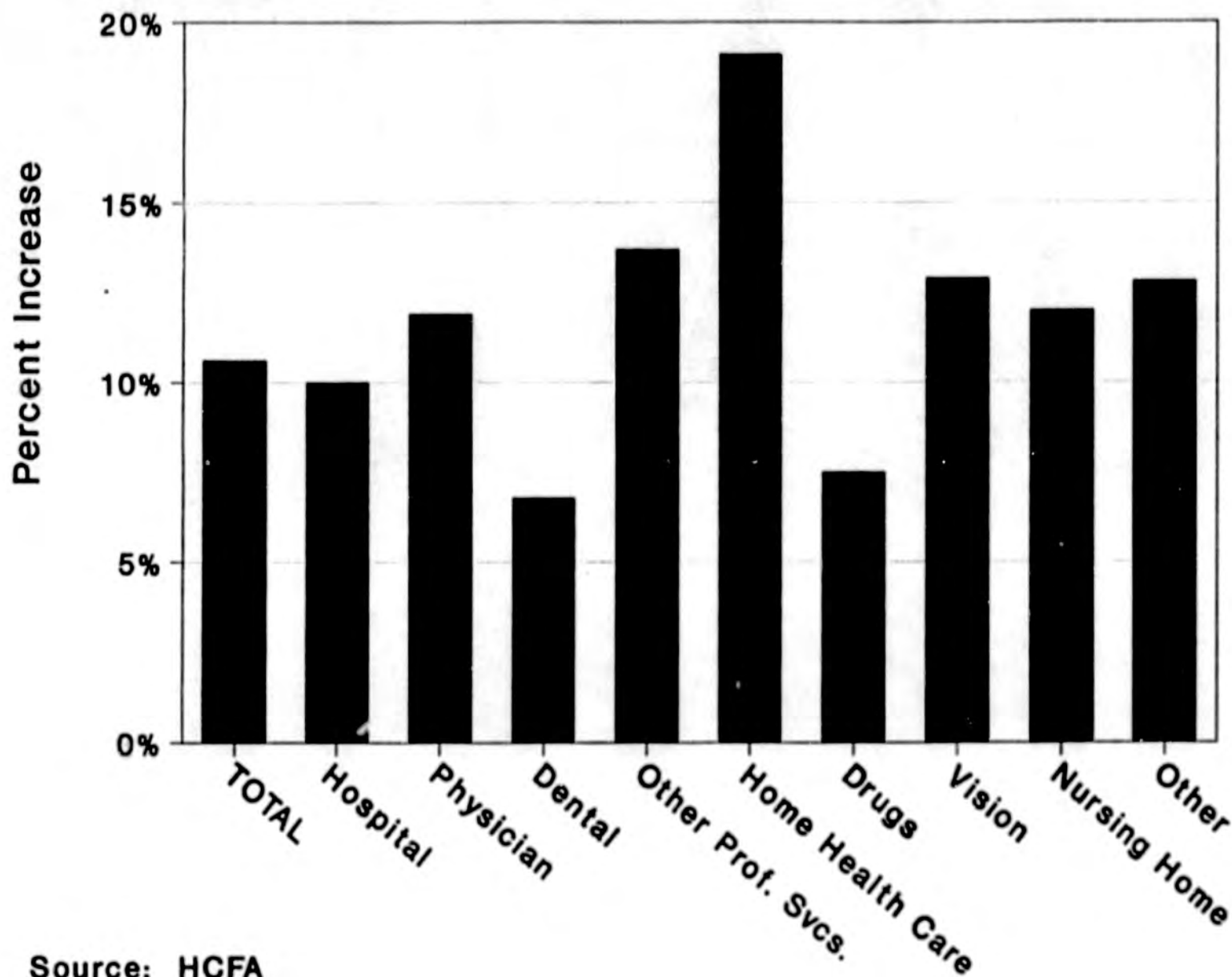
Source: EBRI tabulations of U.S. Dept. of Commerce data

FACTORS IN THE INCREASE OF PERSONAL HEALTH CARE EXPENDITURES: U.S. 1988-89

■ Economywide inflation	44%
■ Industry-specific inflation	21%
■ Population changes	9%
■ Other factors	26%
	100%

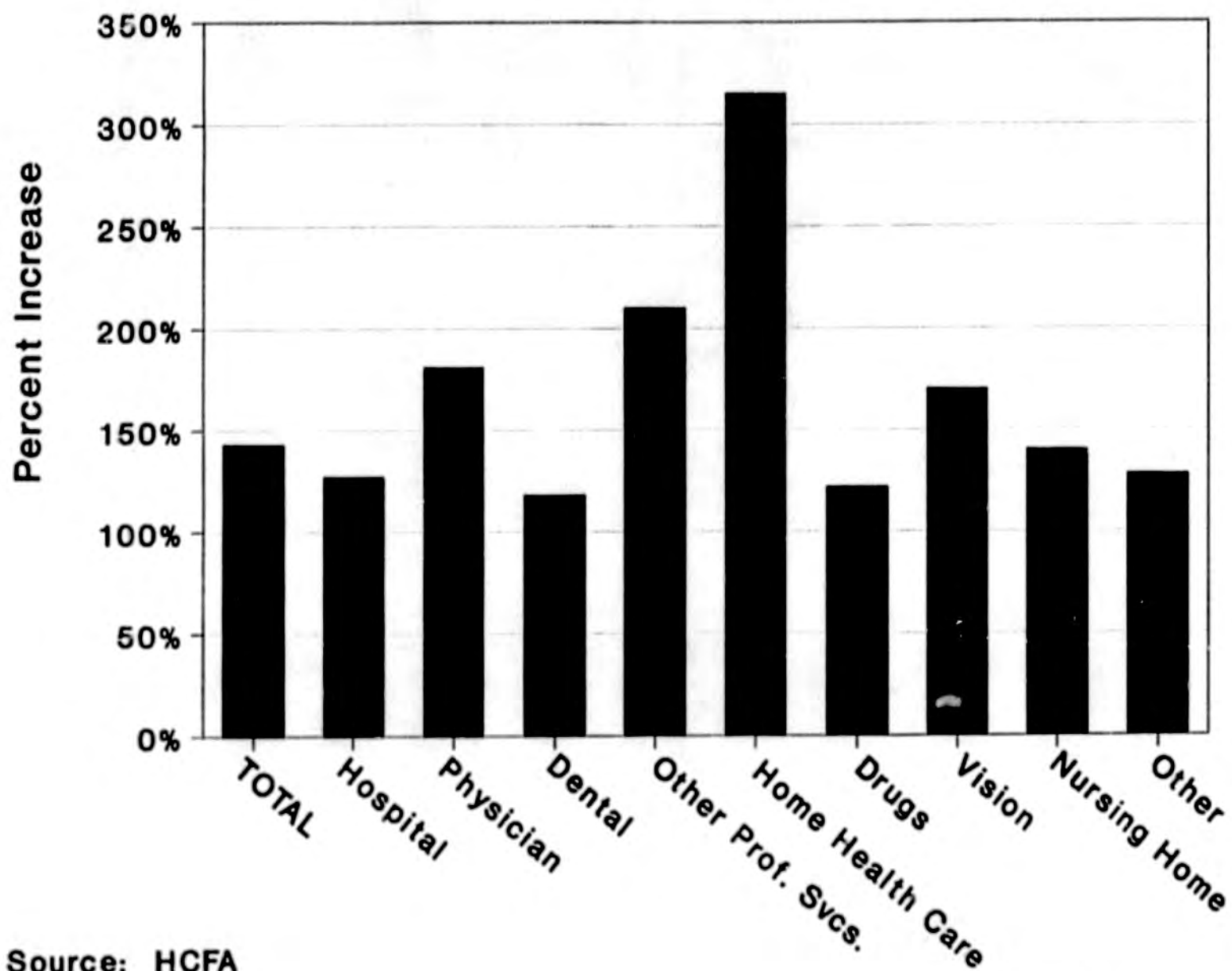
Source: Office of National Cost Estimates, U.S. DHHS

GROWTH RATES IN PERSONAL HEALTH CARE SPENDING, TOTAL AND BY TYPE OF COVERAGE U.S., 1988-89



Source: HCFA

GROWTH RATES IN PERSONAL HEALTH CARE SPENDING, TOTAL AND BY TYPE OF COVERAGE U.S., 1980-89

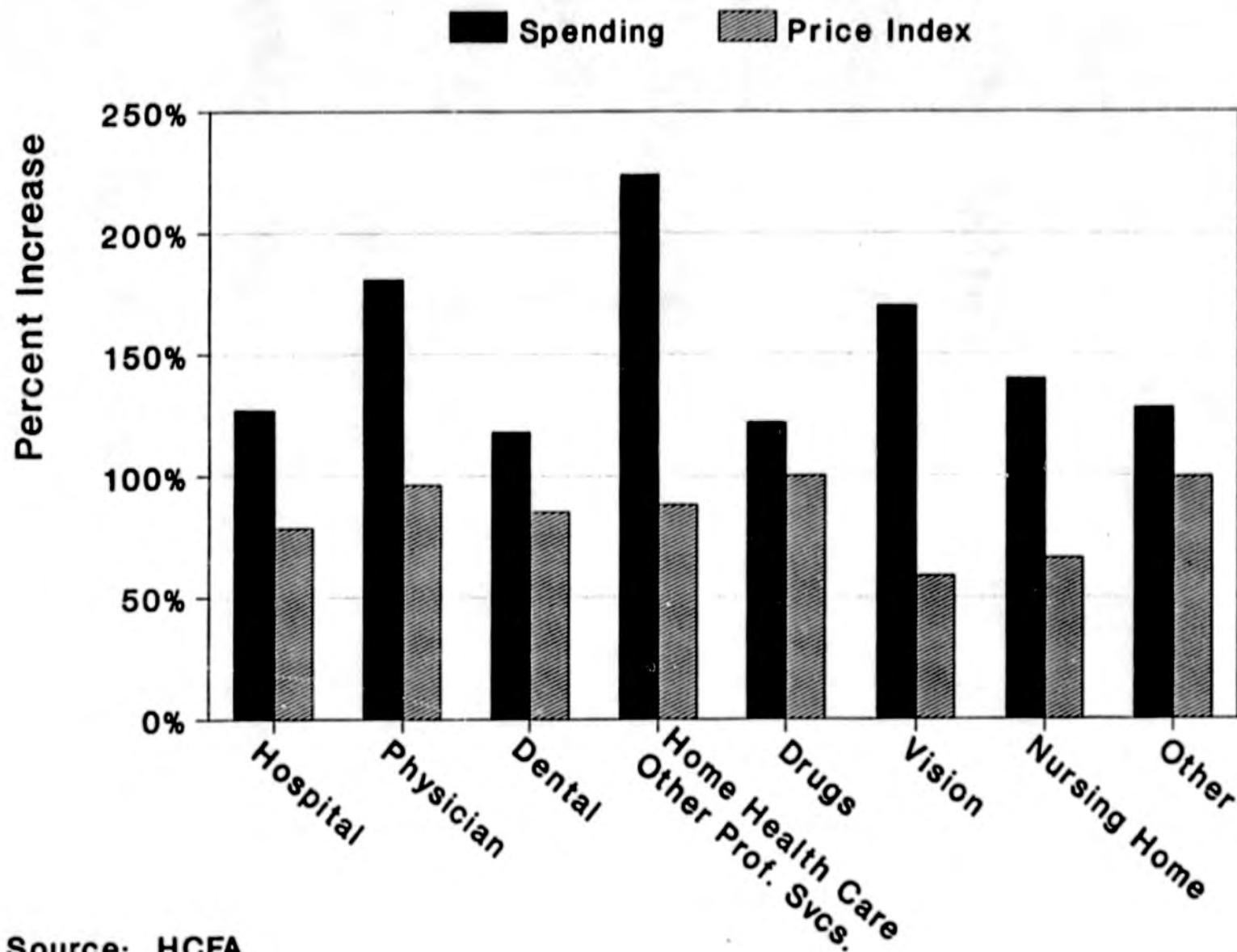


Source: HCFA

C-12

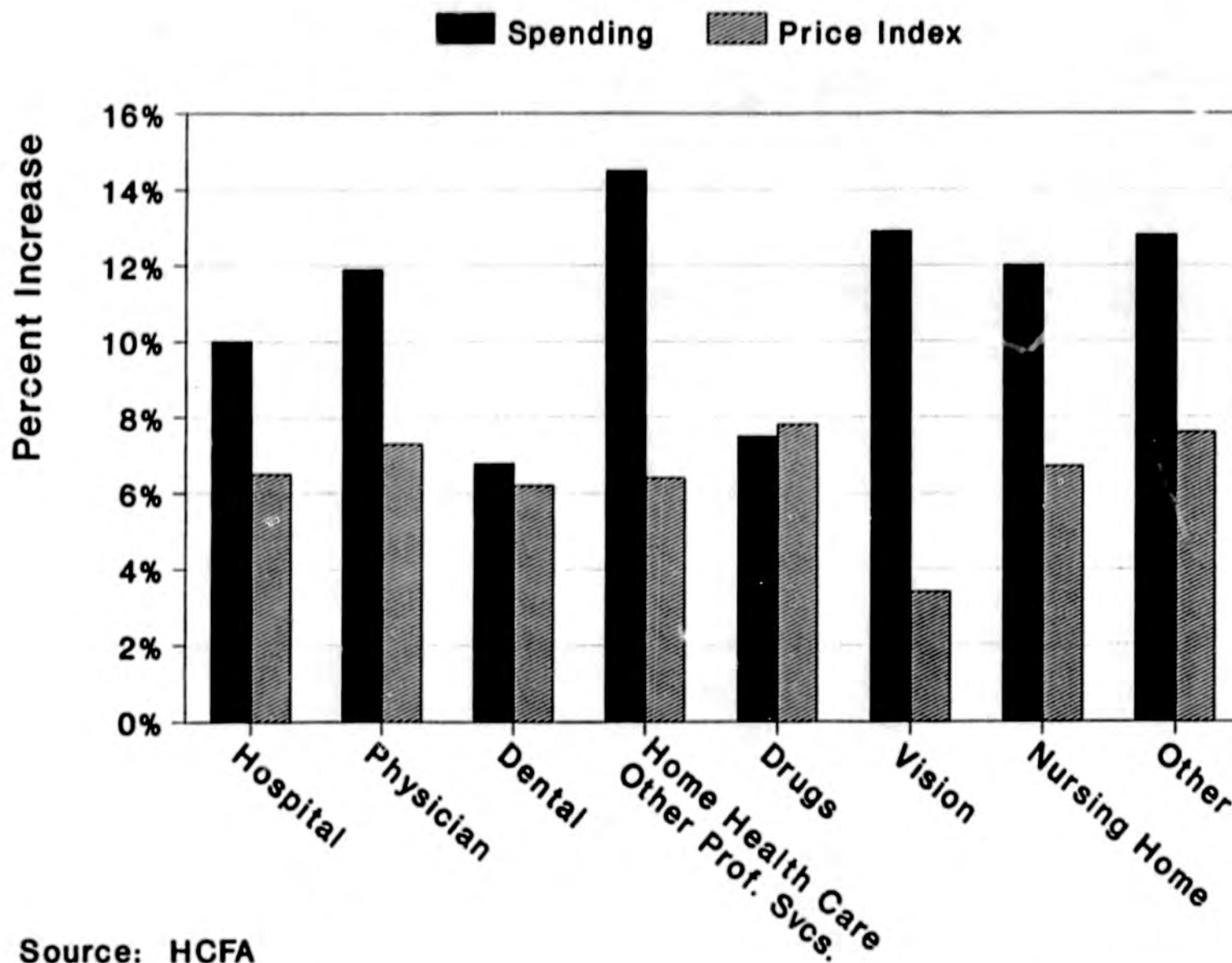
HEALTH SYSTEMS RESEARCH, INC.

GROWTH RATES IN PERSONAL HEALTH CARE SPENDING COMPARED TO PRICE INDEXES U.S., 1980-89

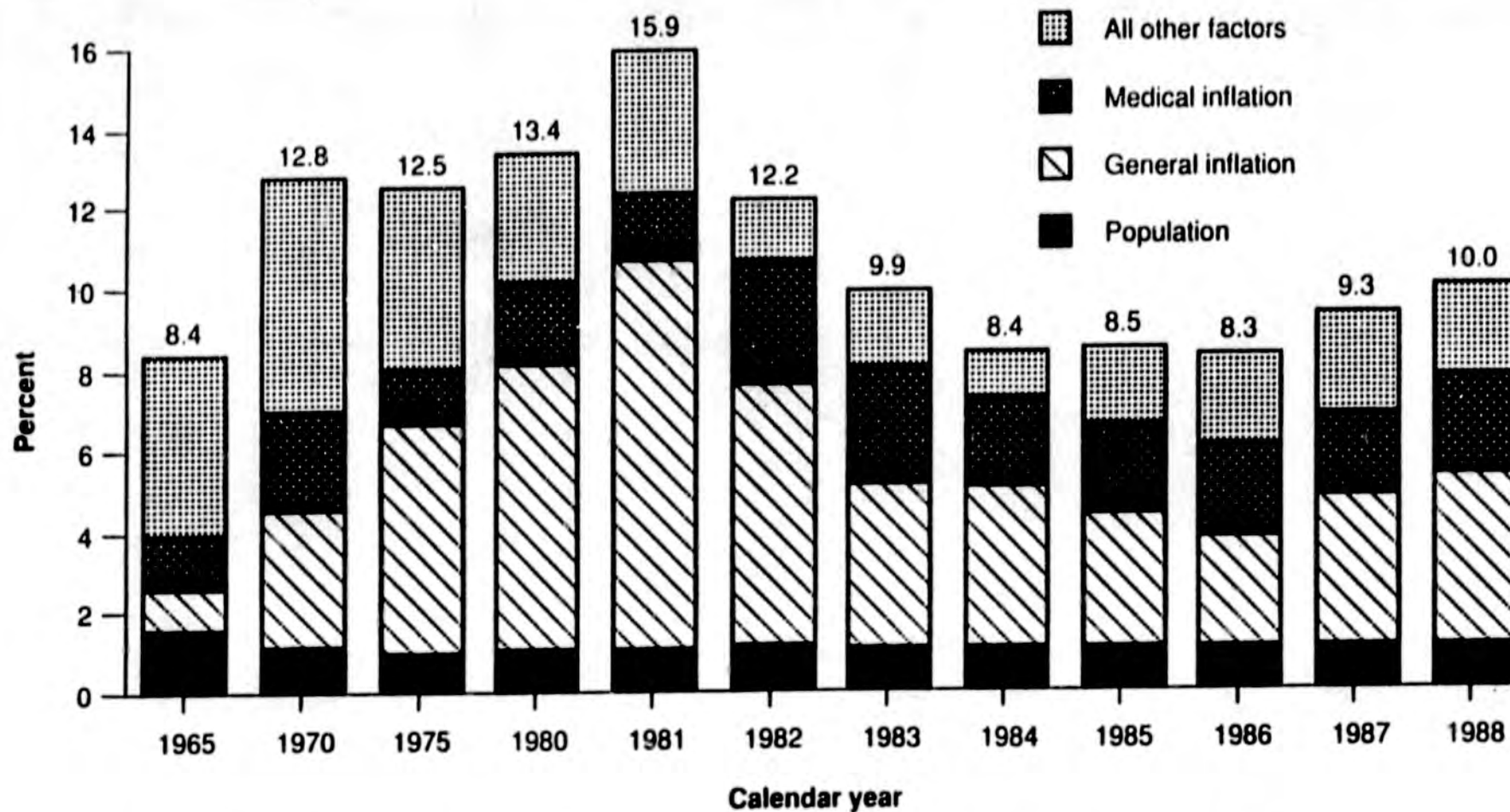


Source: HCFA

GROWTH RATES IN PERSONAL HEALTH CARE SPENDING COMPARED TO PRICE INDEXES U.S., 1988-89



**Factors accounting for average annual growth in personal health care expenditures:
Selected calendar years 1965-88**



SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Office of National Cost Estimates.

APPENDIX D

"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

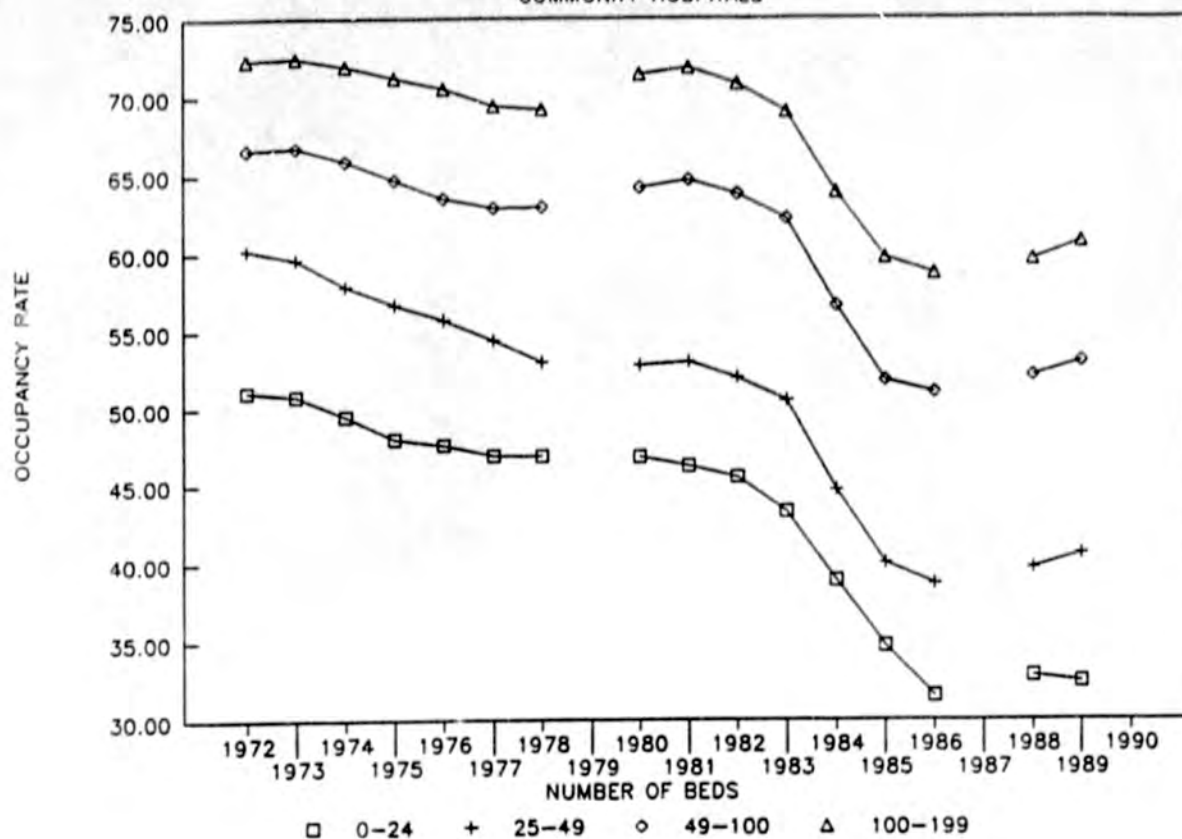


Figure I.2
HOSPITAL INPATIENT DAYS PER CAPITA
ALASKA COMPARED TO US AVERAGE

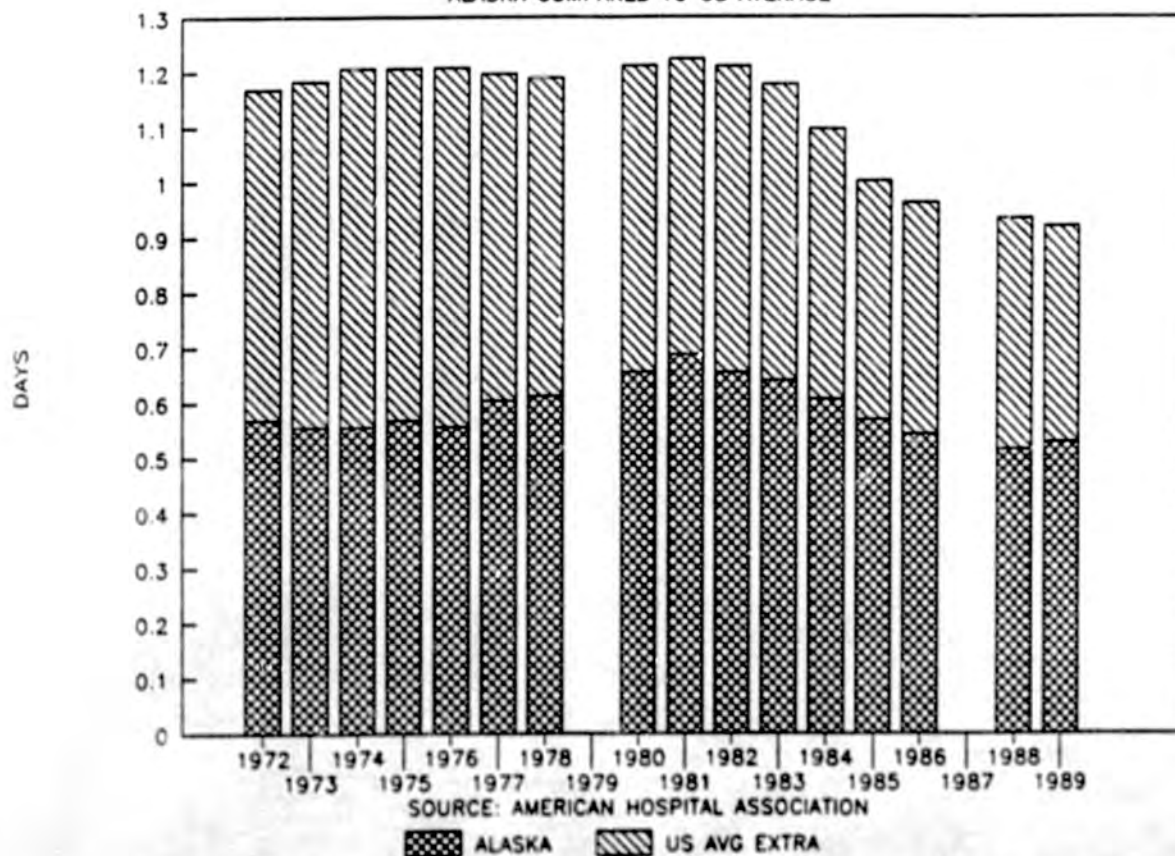


Figure I.3

OCCUPANCY RATE BY SIZE OF HOSPITAL

ALASKA COMMUNITY HOSPITALS: ACUTE CARE

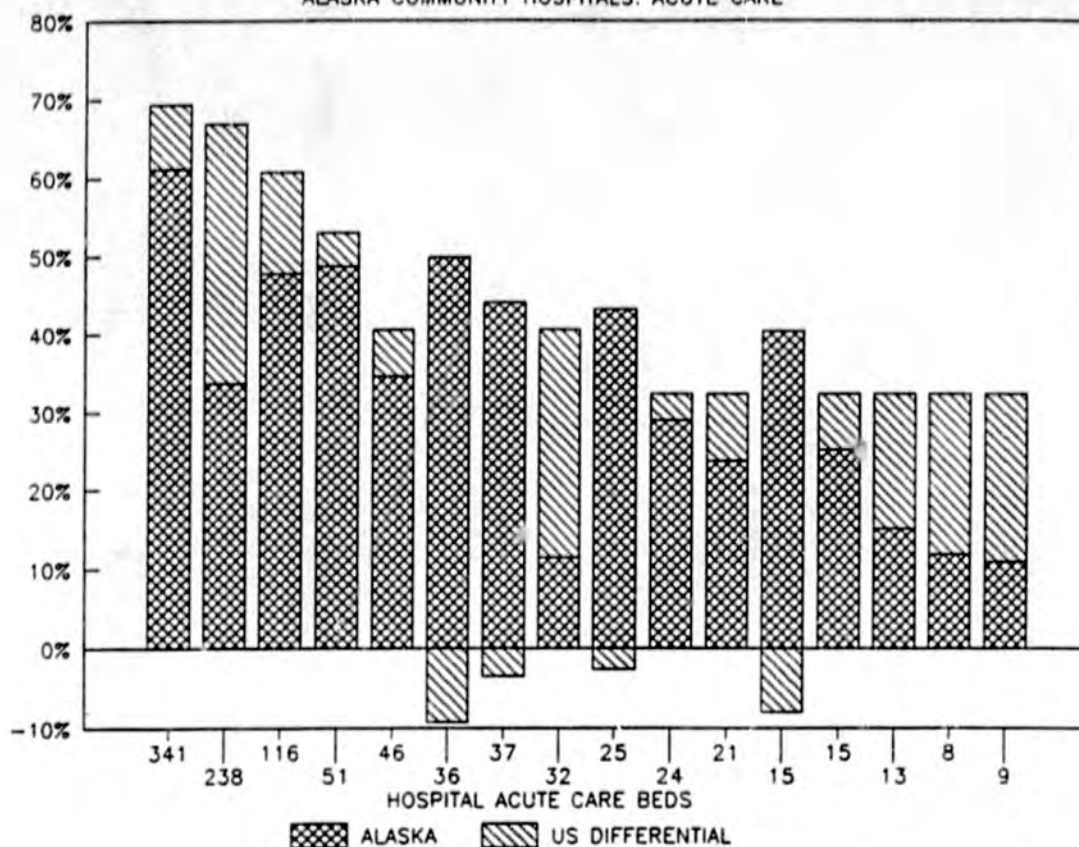
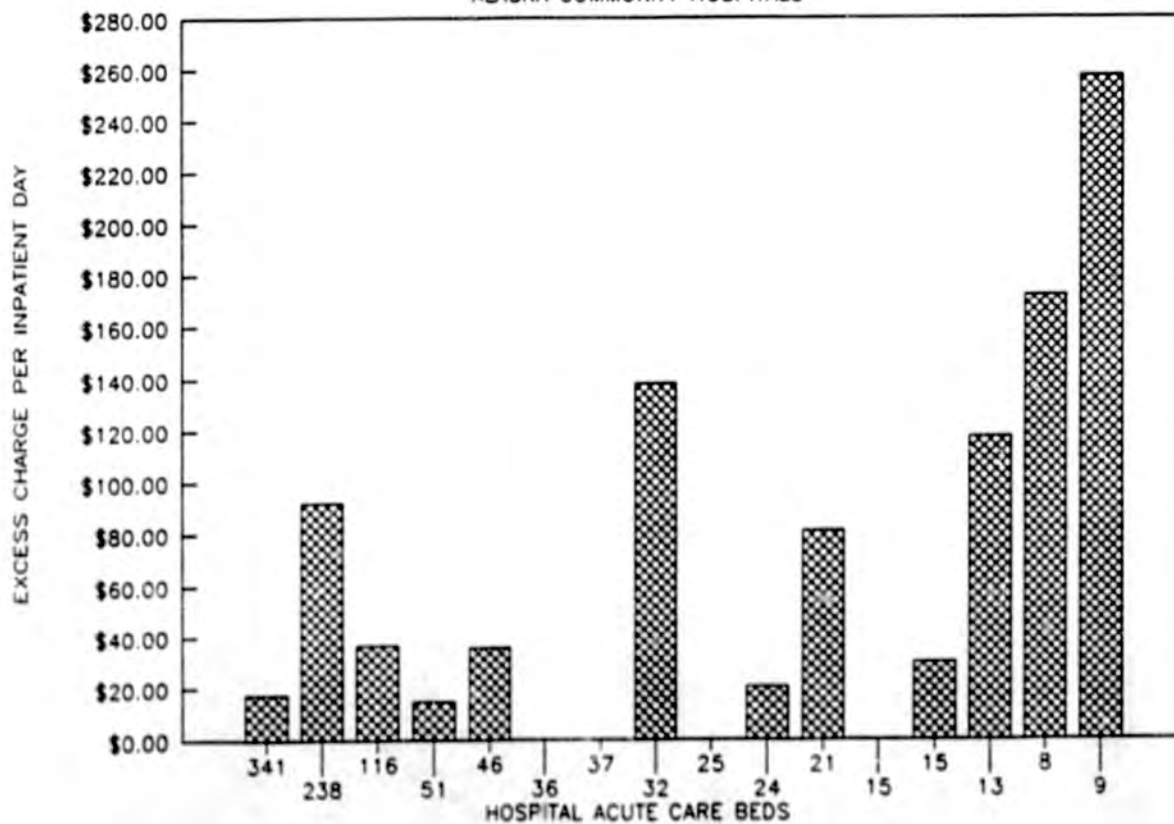


Figure I.4

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 I.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	201,355	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]	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	\$1,022,732	\$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] 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%
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%	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 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

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

[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]	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)	377	819	822
excess capacity percent of beds	27.00%	34.64%	22.37%	53.30%	63.18%
outpatient visits	3,056	0	9,913	0	6,162
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	\$2,700	\$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	\$554
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.

ACUTE CARE BEDS

COMMUNITY
HOSPITAL
(CO-LOCATED FACILITY)AVERAGE
OR
SUMAVERAGE/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]	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.

D-14

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	89.20%	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)

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

[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]	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.

D-16

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)	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	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]	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

	341	238	116	51	46
1 COMMUNITY HOSPITAL (CO-LOCATED FACILITY)	2 PROVIDENCE	3 HUMANA/ ALASKA	4 FAIRBANKS MEM.	5 BARTLETT MEM.	6 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	86.20%	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]	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)

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

[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%	108.66%	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

COMMUNITY
HOSPITAL
(CO-LOCATED FACILITY)

21	15	15	13	8
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%
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]	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	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 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.

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]	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	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%
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)

6	7	8	9	10
36	37	32	25	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%
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]	\$361,257	\$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	\$2,243	\$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 in patient 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	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%
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	36	37	32	25	24
COMMUNITY HOSPITAL (CO-LOCATED FACILITY)	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]	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	\$1,564	\$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 SOUND (CLF)	SOUTH PENINSULA (CLF)	VALDEZ COMM.	CORDOVA COMM. (CLF)	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	6,062
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	\$2,700	\$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.

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	\$484	\$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	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%
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]	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.

ACUTE CARE BEDS

COMMUNITY
HOSPITAL
(CO-LOCATED FACILITY)

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

[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.

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%
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]	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 1.5, 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.

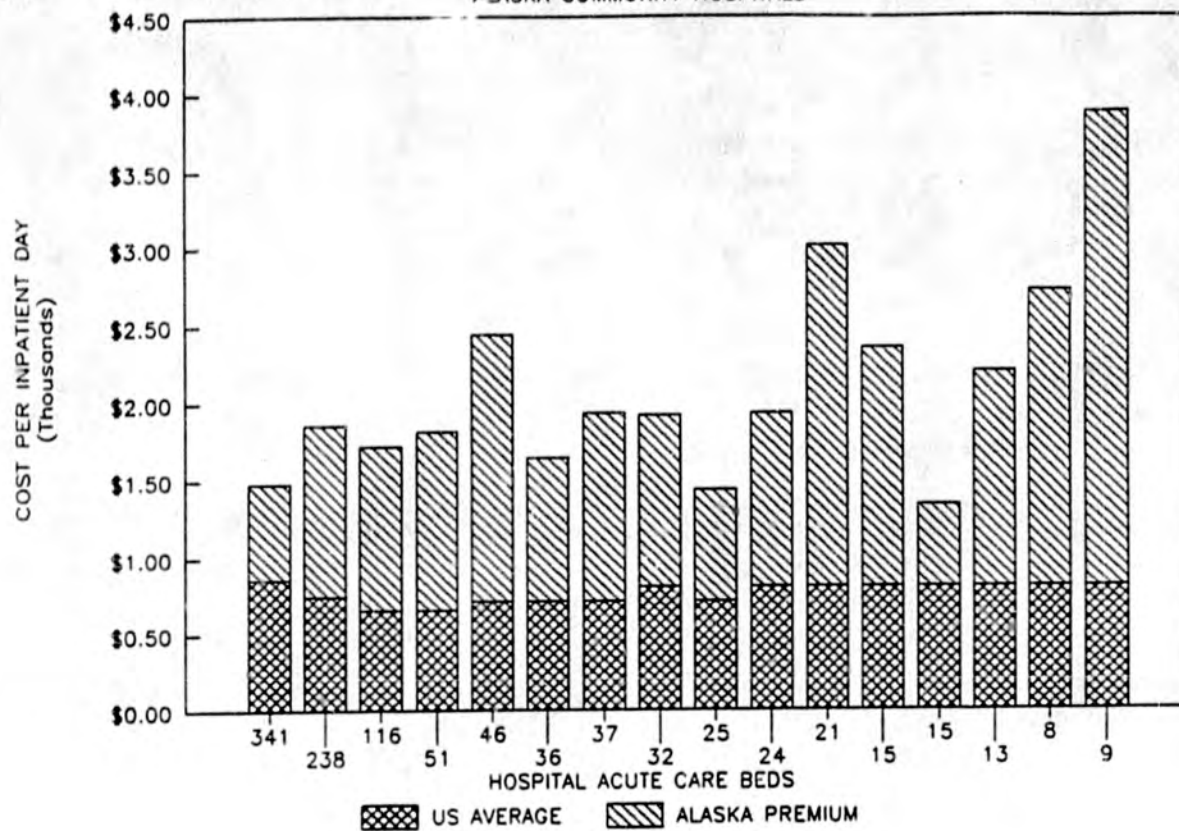
Expenses in two Alaska hospitals were calculated at less than 2 times the national average. In this analysis no savings was achieved by resizing these hospitals when in fact downsizing could lead to savings through the elimination of excess capacity for these facilities.

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 I.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

HOSPITAL.WK1

ISER

12-Dec-91

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

[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

D-42

COMMUNITY HOSPITAL (CO-LOCATED FACILITY)	9 KODIAK ISLAND (CLF)	10 SITKA COMMUNITY	11 NORTON SOUND (CLF)	12 SOUTH PENINSULA (CLF)	13 VALDEZ COMM.	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
ra' : 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	\$825,587	\$2,539,287	\$1,644,492	\$0	\$424,872	\$532,393	\$815,142

[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 fixed costs reallocated	\$273			

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	\$912,346
Savings per transferred inpatient day	\$466			
fixed costs reallocated				

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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).

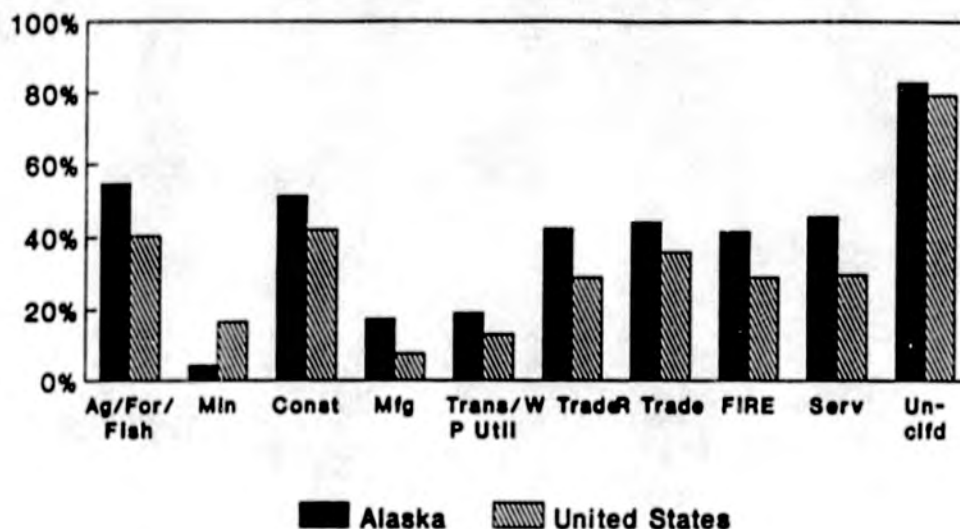
Within the private economy in Alaska the average firm size is less than the national average for all industries except mining/petroleum which in Alaska is dominated by a small number of large firms. (The data on firm size excludes the self employed such as many miners and fishermen. US Department of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

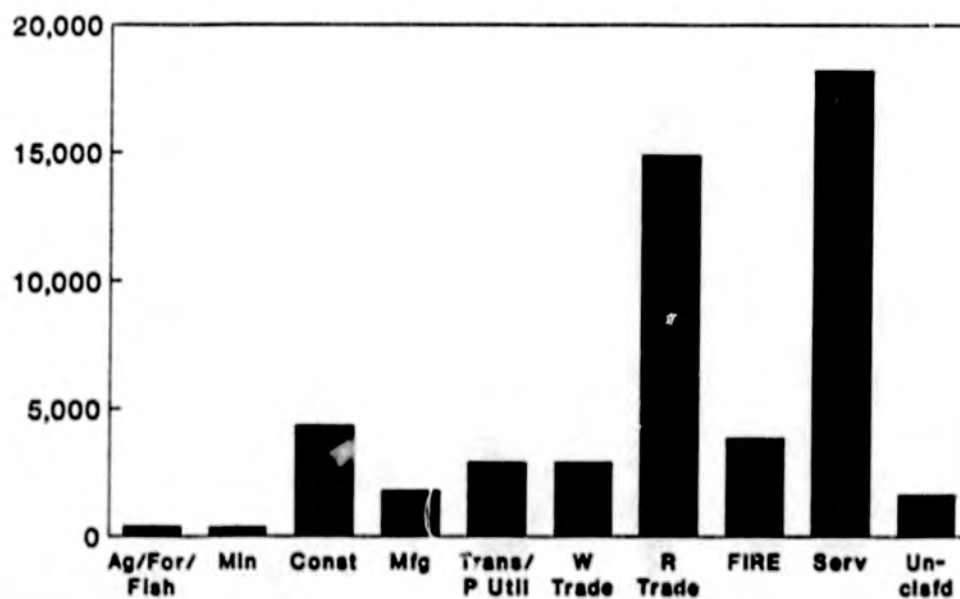
**Percent of Employees in Alaska and U.S.
That Are In Firms That Have
Fewer Than 20 Employees**



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

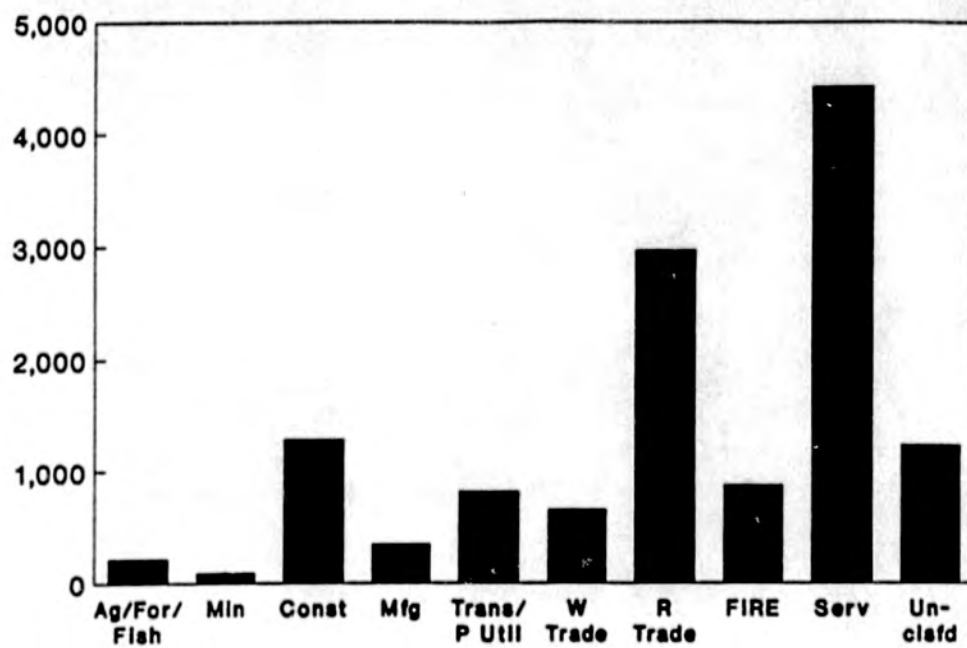
**Number of Employees in Alaska Firms
that have fewer than 20 Employees**



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).

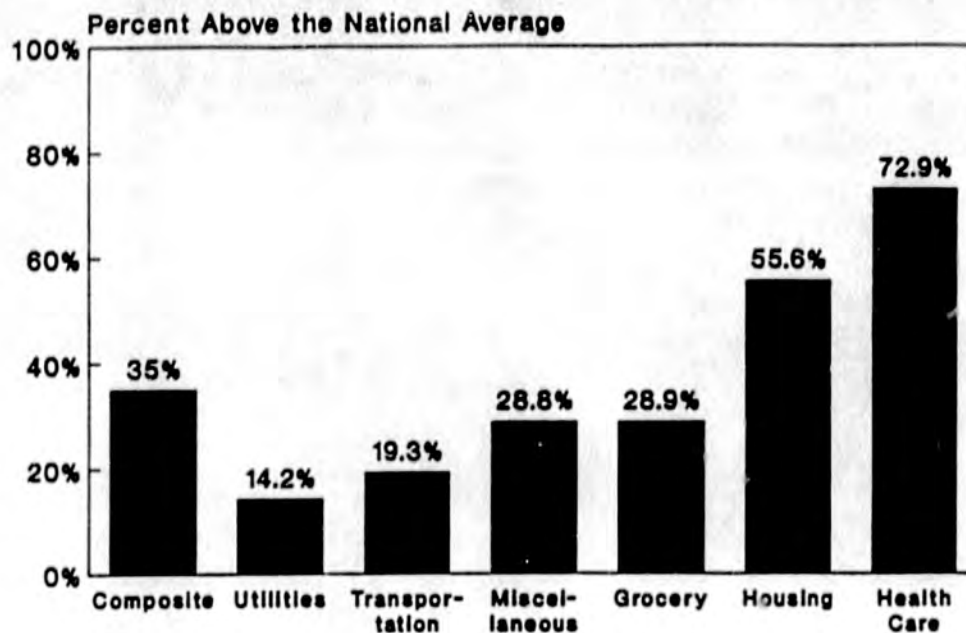
The Anchorage cost of living differential compared to Seattle for medical care was 30 percent compared to 16 percent for the total differential as reported in 1985 in the Alaska Geographic Differential Study (April 1985 by the McDowell Group for Alaska Department of Administration).

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**

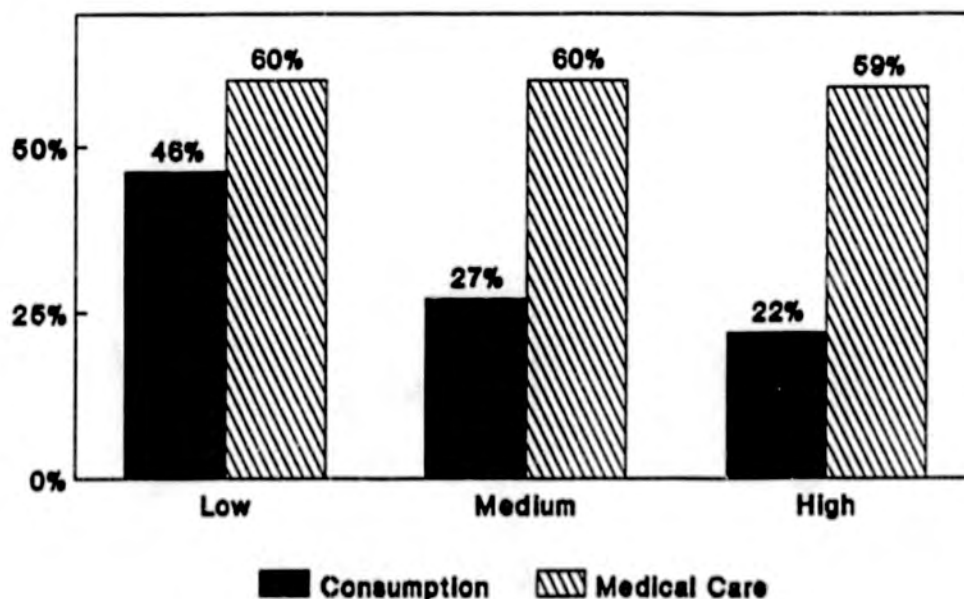
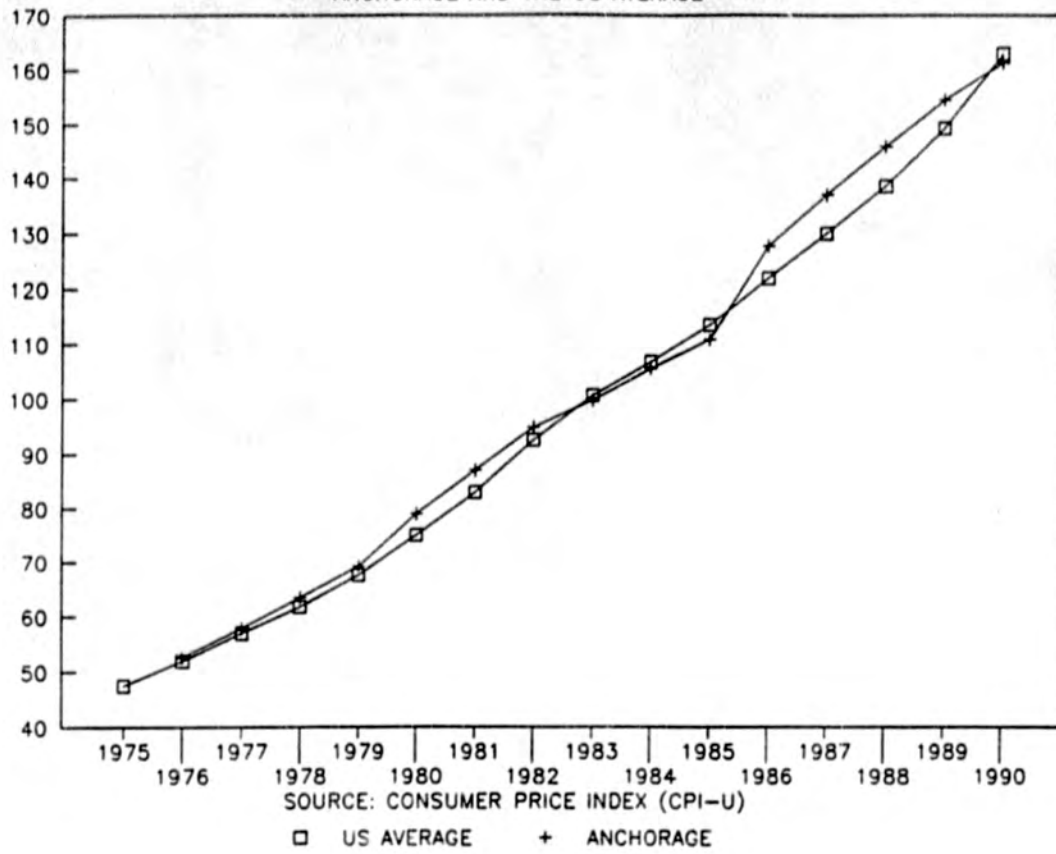


Figure III.3

MEDICAL CARE CONSUMER PRICE INDEX

ANCHORAGE AND THE US AVERAGE

1982-84=100



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

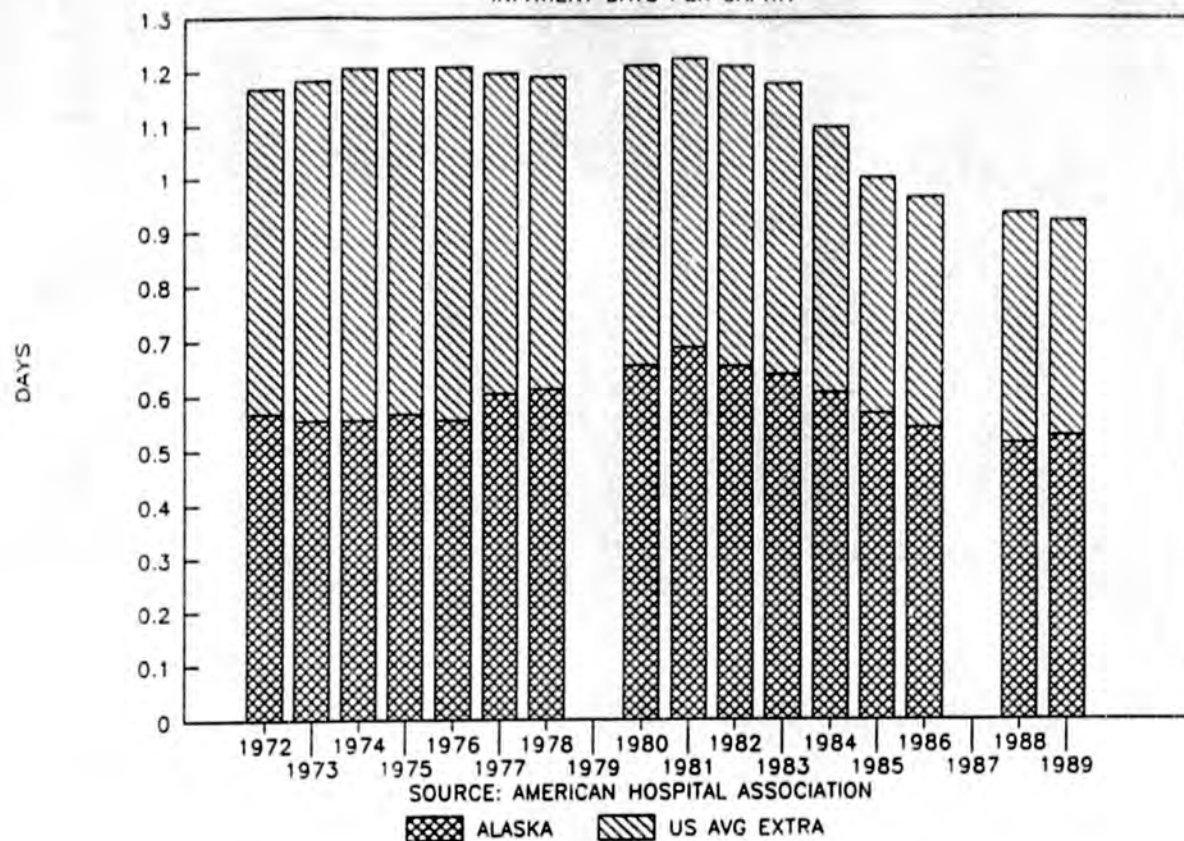


Figure VI.2

ALASKA COMMUNITY HOSPITALS
OUTPATIENT VISITS PER CAPITA

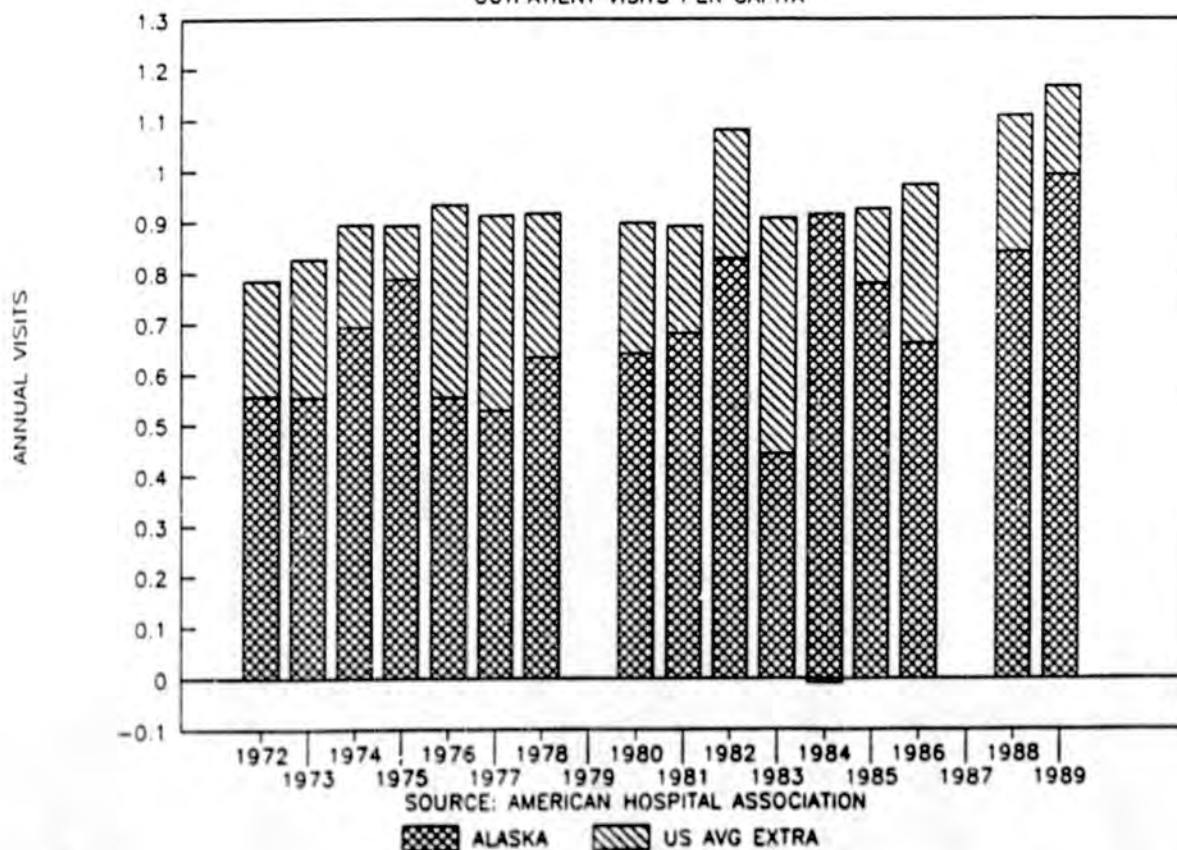


Figure VI.3
ALASKA COMMUNITY HOSPITALS
AVERAGE LENGTH OF STAY

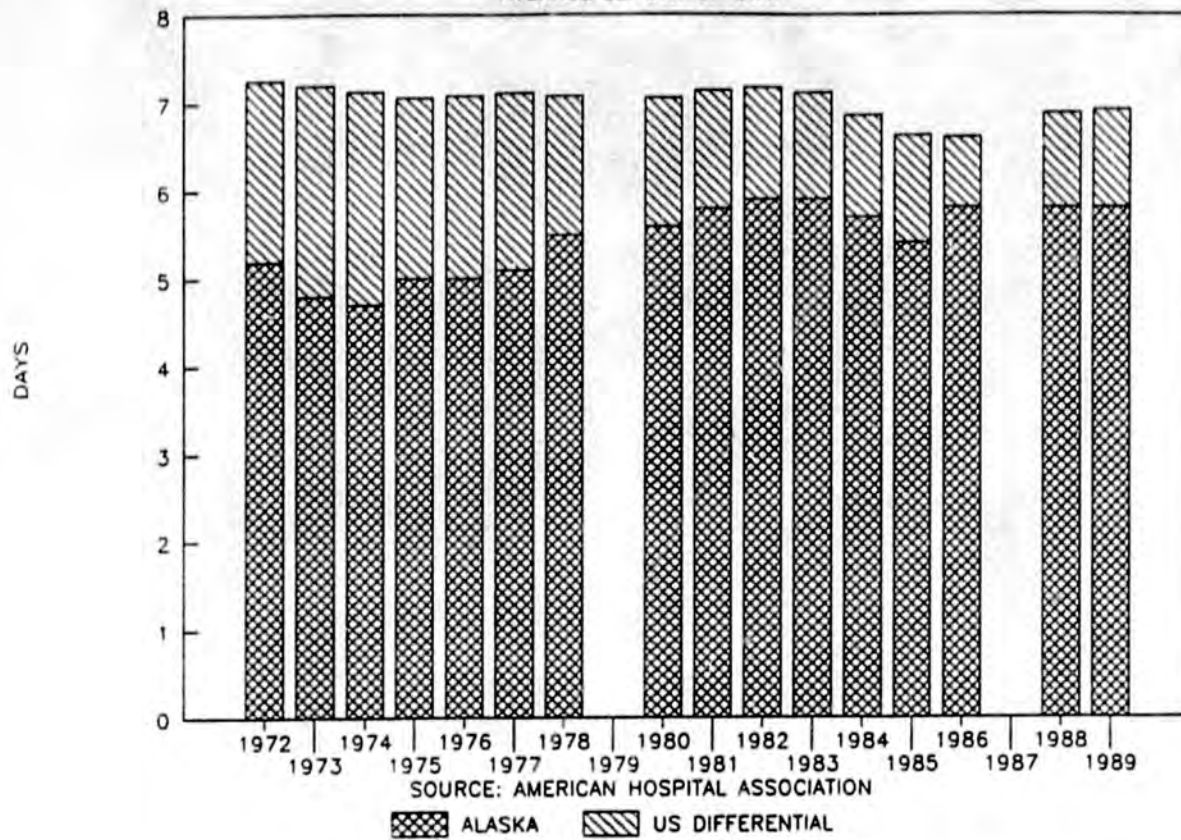
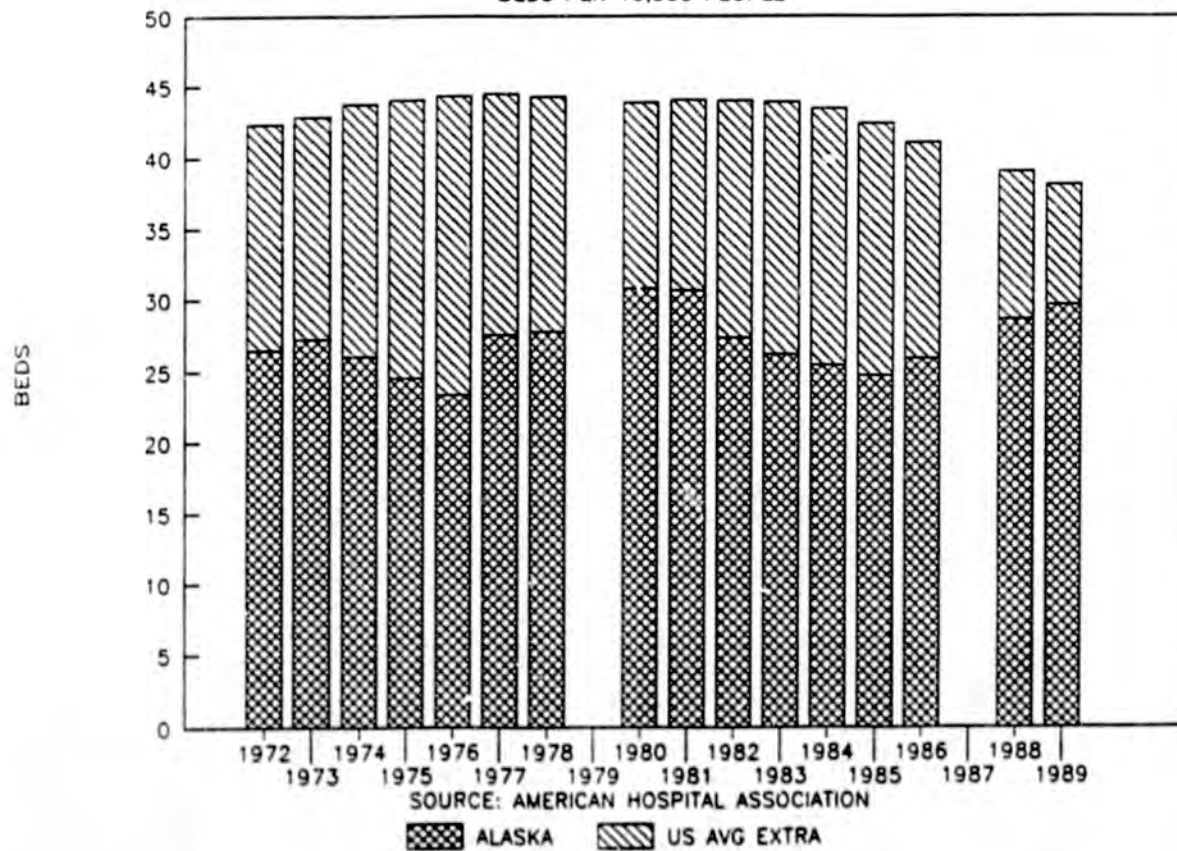


Figure VI.4
ALASKA COMMUNITY HOSPITALS
BEDS PER 10,000 PEOPLE



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

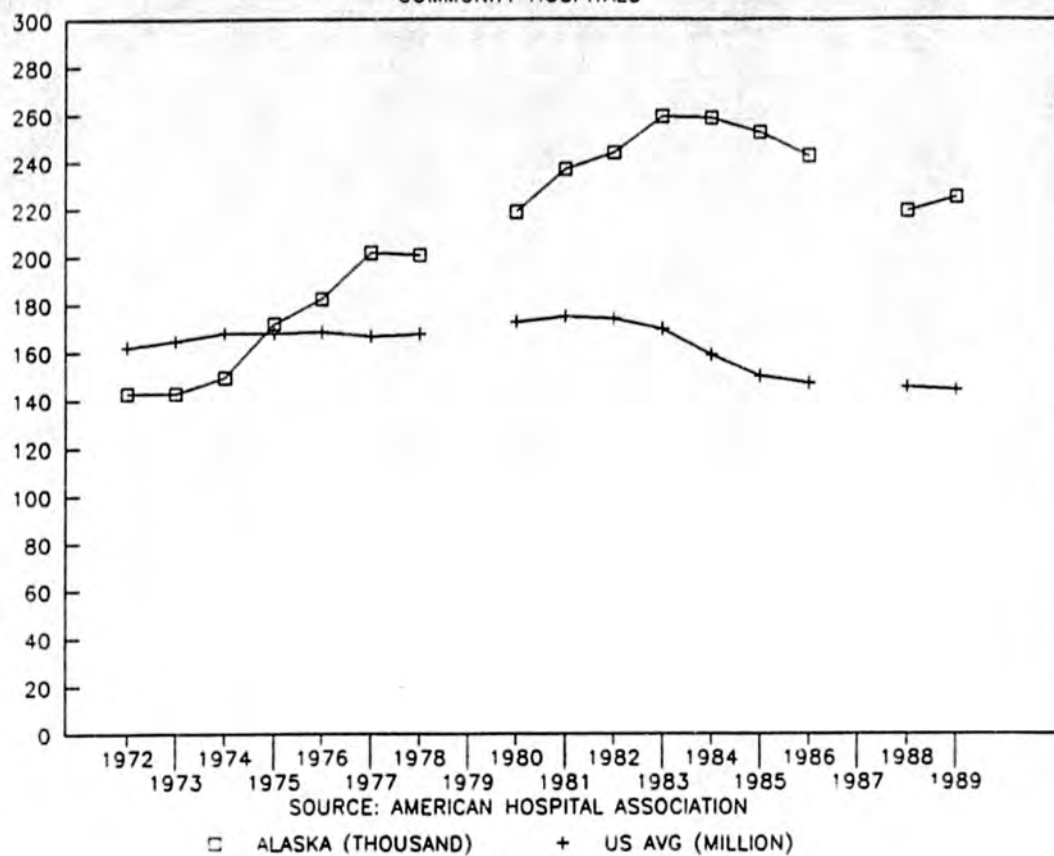


Figure VI.6
ALASKA COMMUNITY HOSPITALS
OCCUPANCY RATE

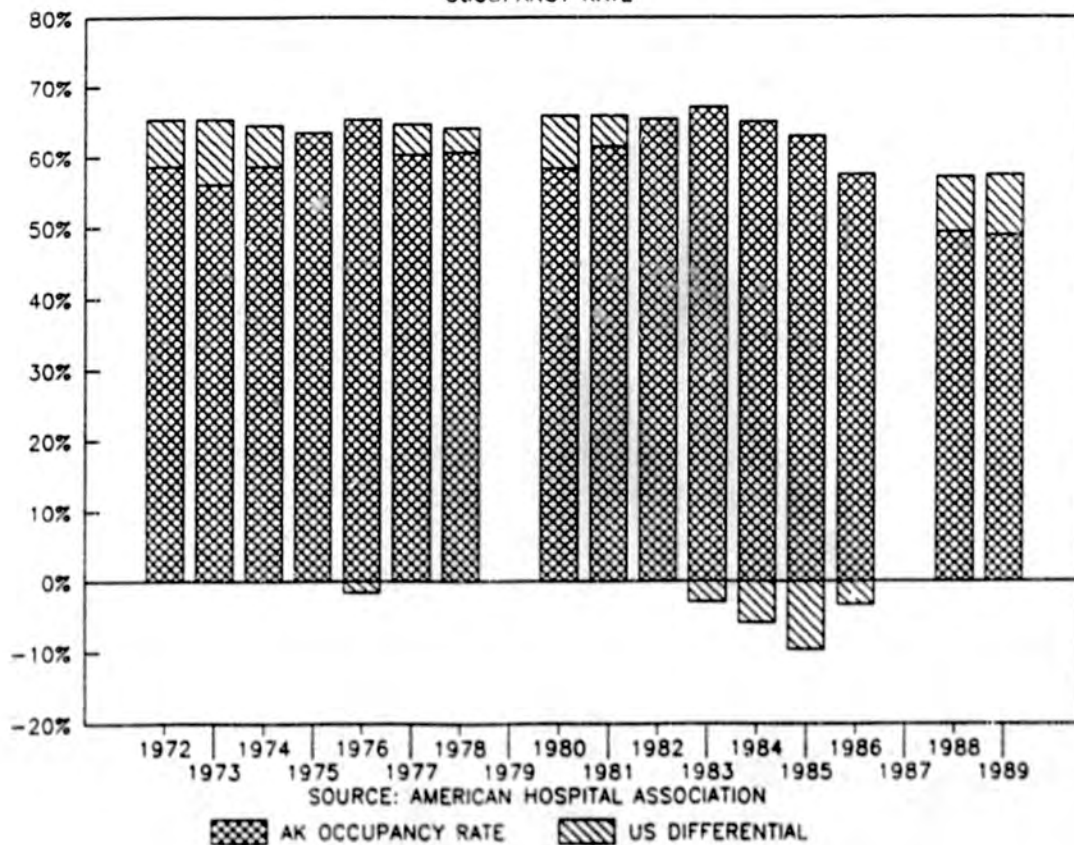


Figure VI.7
ALASKA COMMUNITY HOSPITALS
 EXPENSES PER ADJUSTED PATIENT DAY

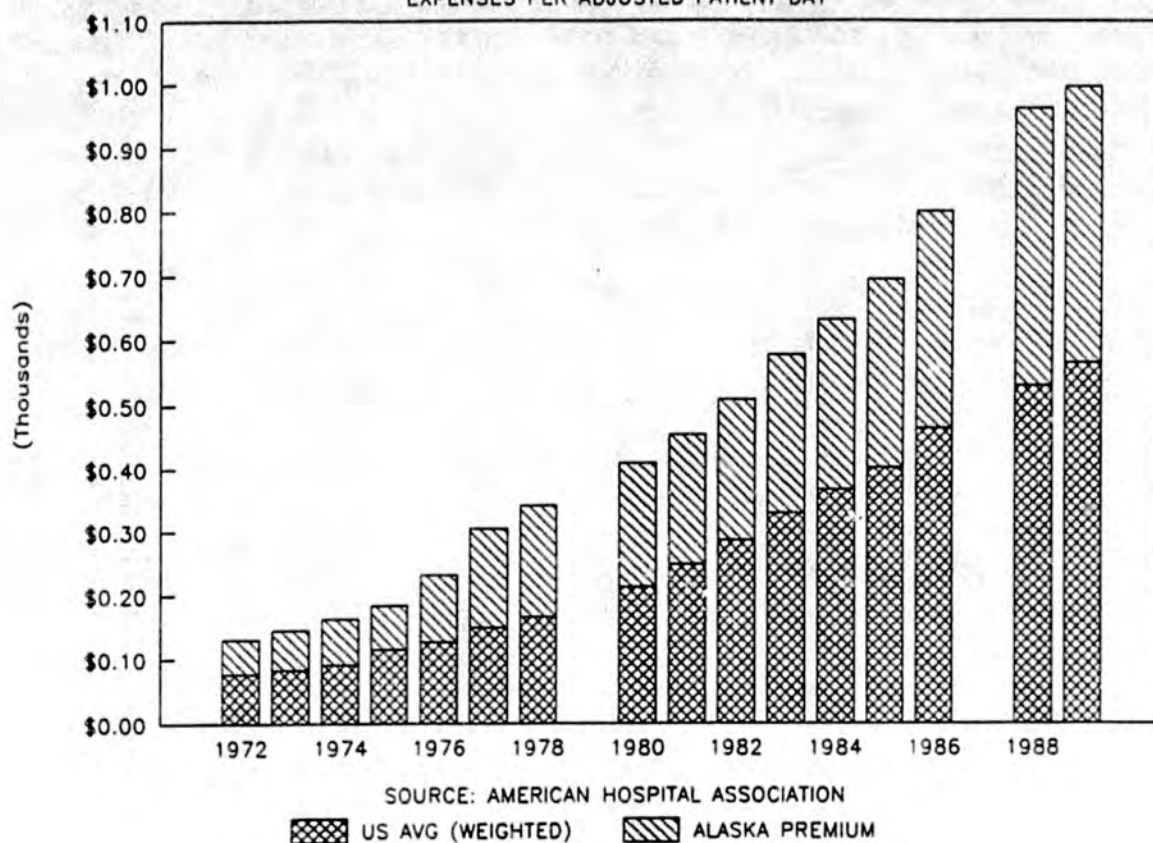
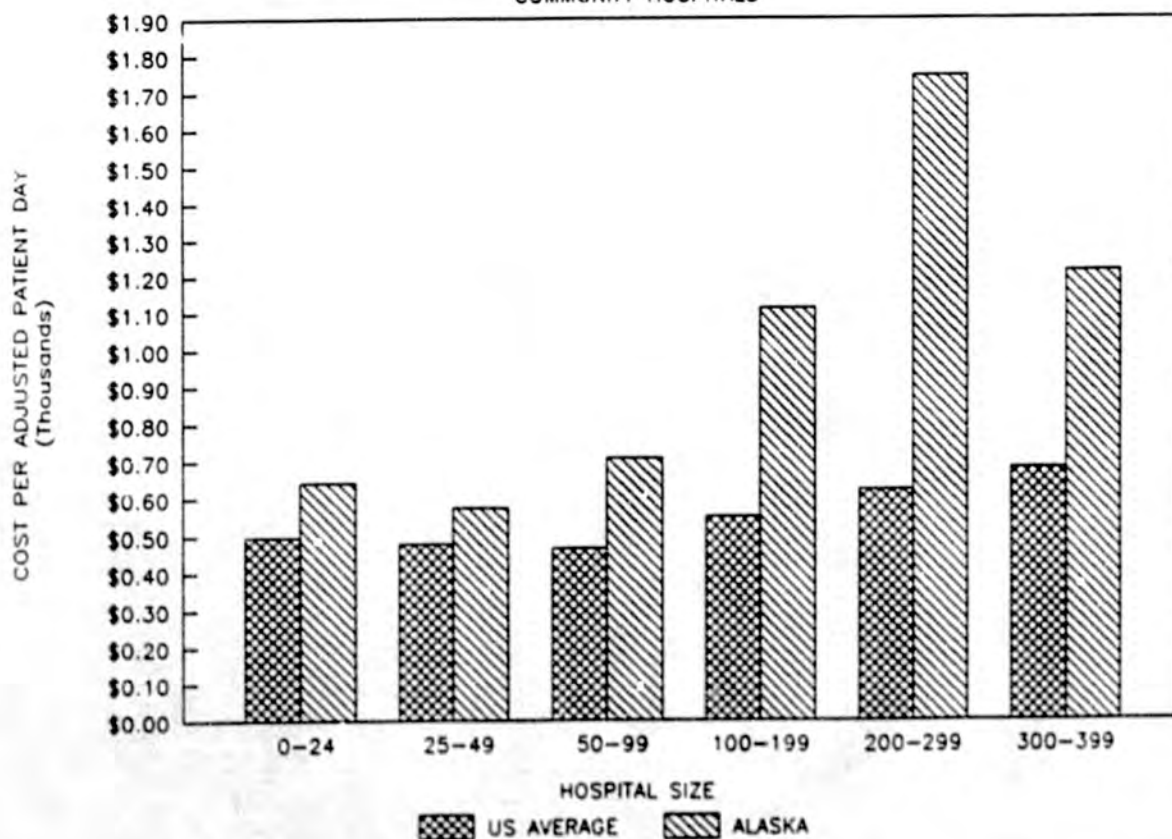


Figure VI.8
COST PER ADJUSTED PATIENT DAY
 COMMUNITY HOSPITALS



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

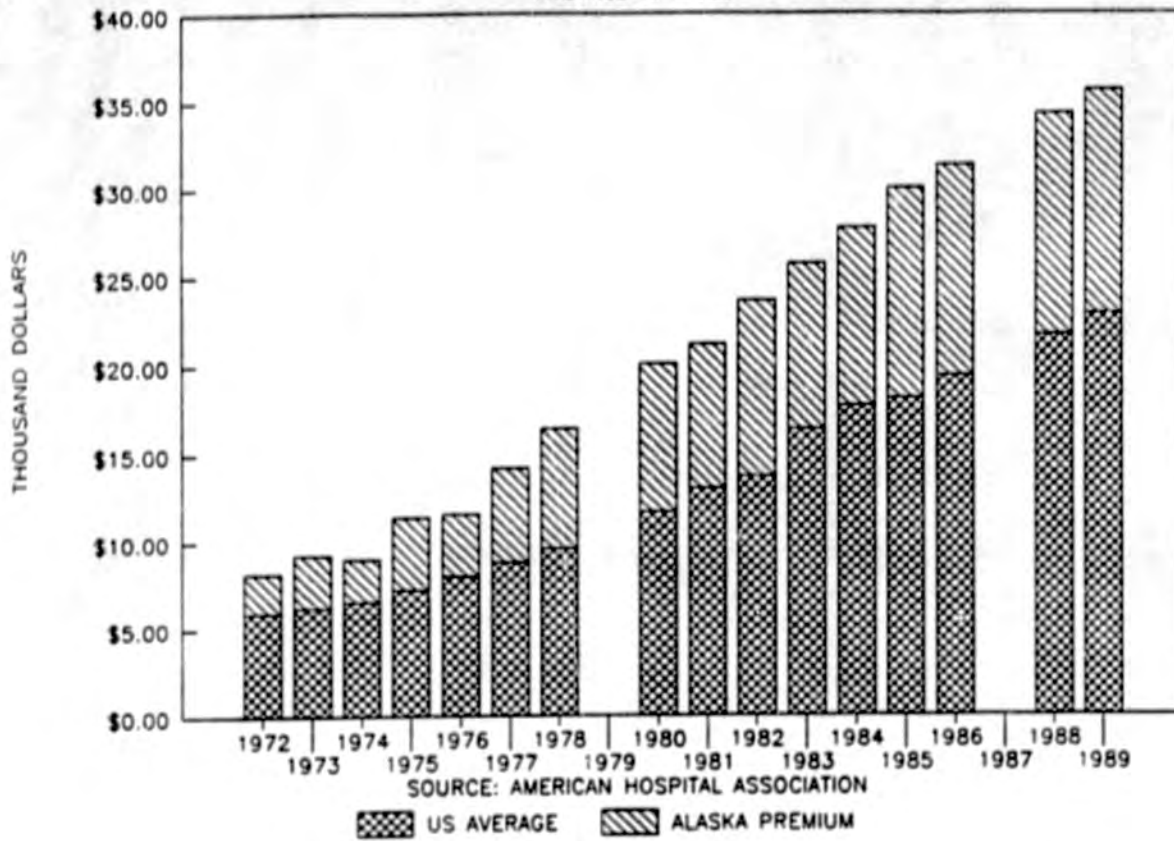
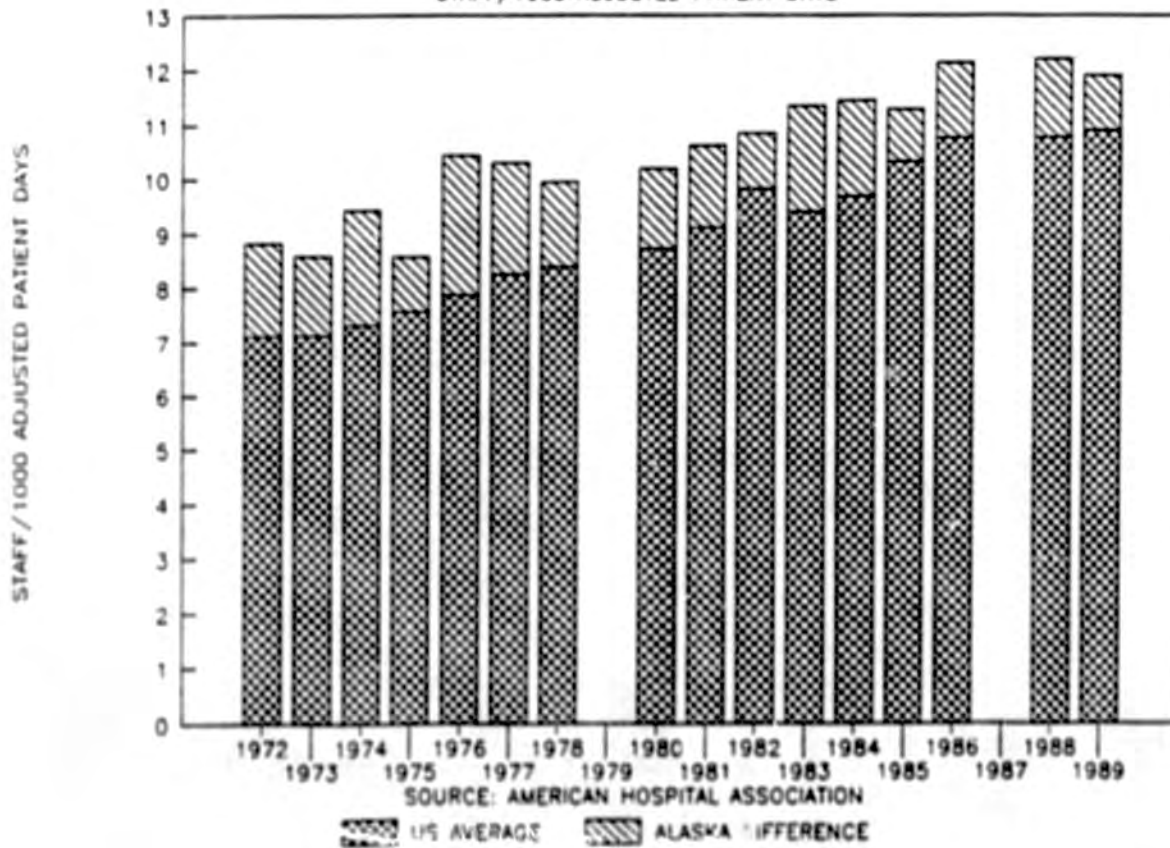


Figure VI.10
ALASKA COMMUNITY HOSPITALS
STAFF/1000 ADJUSTED PATIENT DAYS



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.

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.

APPENDIX E

"Memo to Nancy Cornwell regarding Summary of Utilization
Rates for the 1990 Alaska Hospital Survey and
comparison to U.S. Averages"

from Bradley J. Whistler, Planning Section,
Alaska Department of Health and Social Services

October 9, 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 9, 1991

TO: Nancy Cornwell, Project Director
Health Resources and Access Task Force

FROM:  Bradley J. Whistler, Research Analyst
Department of Health & Social Services
Division of Admin. Services - Planning Section

SUBJECT: Summary of Utilization Rates from the "1990 Alaska Hospital Survey" and comparison to U.S. averages

This memorandum is to respond to the Health Resources and Access Task Force request for information on utilization of Alaska health care facilities. I have attached eight tables which summarize utilization information on Alaska acute and long-term care facilities from the 1983 Annual Alaska Hospital Survey and the 1990 Alaska Hospital Survey. I have not included utilization information on Alaska's four specialized care facilities.

Acute Care Facilities

Tables 1 and 2 list utilization data for each acute care facility for 1982, the last time the hospital survey was conducted, and 1989. During this time frame, available statewide acute care beds increased from 1,475 in 1982 to 1,645 beds in 1989. During this same period, the statewide average occupancy rates declined from 59.2% to 45.8%. Although starting at a lower base point, this reflects a national trend of lower acute care occupancy rate. This has occurred as third party payers have implemented measures to limit hospital admissions and reduce the length of stay in these facilities. Further, as a cost containment measure, many procedures which were previously performed in these facilities are done on an outpatient basis.

From 1982 to 1989, average U.S. hospital occupancy rates decreased from 77.4% to 69.6%. Community hospital occupancy rates followed this same trend, although the occupancy rates were slightly lower, 75.3% to 66.2%. I have attached a table, Table 3, which compares Alaska acute care occupancy rates with U.S. averages for hospitals Health Resource and of similar size and type of ownership. Tables 4 and 5 provide a graphical representation of these acute care utilization trends. The utilization data by facility size and ownership provides a better comparison to national averages since small, rural hospitals generally have lower occupancy rates than their larger, urban counterparts. Nevertheless, many facilities in Alaska are significantly below U.S. averages. This is likely a reflection of the smaller size of the communities, the younger age of the general population and the number of inpatient beds in these facilities. Lastly, it is important to remember the U.S. averages are not the same as optimal utilization standards. The trend has been for hospitals to reduce the number of inpatient beds, as inpatient occupancy rates have dropped, and expand outpatient services. The national averages likely reflect that this process is not complete.

Hospital utilization information for the United States is from the American Hospital Association (AHA) publication entitled, Hospital Statistics: A Comprehensive Summary of U.S. Hospitals, 1990-1991. The data is from AHA registered hospitals in the United States. The publication does not indicate if mean, mode or median measures are used for U.S. occupancy rates. As stated above, the comparisons are enlightening on how Alaska facilities compare to other U.S. facilities, however it does not supplant the need for developing utilization standards.

The construction and/or renovation of many of these facilities has been subsidized by the State through capital grants and to a greater extent by Medicaid reimbursement (reimbursement rates include facility depreciation). In some cases, it may be more appropriate (cost effective) for these communities to be served by alternative (emergency care) facilities. Montana and California have recently established state-sponsored demonstration projects for alternative health facilities to their failing small, rural hospitals.

In Alaska, hospitals have been a priority for many of the municipalities due to the distances between major cities in the State and inclement weather which can restrict travel. Further, travel and lodging expenses incurred by patients generally are not reimbursed by third-party payment sources. This has served as a catalyst for the expansion of health care services in the local area, rather than referring to higher level medical service areas. The facilities also serve to help municipalities recruit health care professionals, especially specialists, into the area. Lastly, in many of the communities the hospital is a major employer. Capturing health care dollars in the community has become an important economic issue as communities are searching for economic diversification and more revenue. It is likely there would be resistance by the municipalities to downsize the facilities to "alternative" acute care facilities.

Long-Term Care Facilities

Tables 6 and 7 list 1982 and 1989 utilization data for each long-term care facility. Statewide nursing care beds increased from 954 in 1982, to 1,114 in 1989 for a 16.8% increase. During the same period, statewide average occupancy rates have dropped from 90.0% to 86.7%, however, as Table 8 illustrates, the average occupancy rate in Alaska remains slightly above the national average. It is worth noting, that there is variation in the occupancy rates between facilities, however not to the extent seen in the acute care facilities. The average occupancy rate is skewed by the high demand for nursing care beds at State Pioneers' Homes.

Lastly, it is important to note that even small changes in occupancy rates at long-term care facilities are important, since long-term care is a labor intensive, expensive health service. Further, Medicaid is the major reimbursement source for these services. The average Medicaid reimbursement rate for nursing care beds increased from \$130 per day, in 1982, to \$202 per day, in 1989 (an increase of 55.4%). Guide to the Nursing Home Industry, published by Health Care Investment Analysts, lists the 1988 U.S. average net patient revenue at nursing homes as \$51.27 per day. The highest average net patient revenue was in Hawaii at \$88.69 per day (Alaska was not listed). The average net patient revenue in Washington State \$58.82 per day and Oregon's average was \$54.32 per day. Although, the daily Medicaid reimbursement rate and net patient revenue are not identical terms, the comparison indicates Alaska's per diem charges for nursing care beds is substantially higher than the national average.

Attachments

cc Larry J. Streuber, Planning Section Chief

Table 1
Acute Care Facilities Utilization Summary
1982

Area	Facility	Acute Care Beds	Total Discharges	Total Patient Days	Average Daily Census (# of Patients)	Average Length of Stay (# of Days)	Occupancy Rate (Percent)
SOUTHEAST							
	Bartlett Memorial Hospital	64	2742	11431	31.3	4.17	48.9%
	Ketchikan General Hospital	46	1839	8345	22.9	4.54	49.7%
	Mt. Edgecumbe/SEARHC	70	1171	12064	33.1	10.30	47.2%
	Petersburg General Hospital	13	264	831	2.3	2.93	17.5%
	SIrka Community Hospital	24	862	3215	8.8	3.73	36.7%
	Wrangell General Hospital	9	261	862	2.4	3.30	26.2%
SOUTHCENTRAL							
	Anchorage ANS/PHS Hospital	170	4315	37405	102.5	8.67	60.3%
	Branch Naval Hospital Adak	16	514	1267	3.6	2.46	23.1%
	Bristol Bay PHS/ANS Hospital	28	714	2422	6.6	3.39	23.7%
	Central Peninsula Hospital	30	1803	6896	18.9	3.62	63.0%
	Cordova Community Hospital	12	287	1046	2.9	3.64	23.9%
	Elmendorf AFB Hospital	85	4971	25309	0.0	5.09	73.0%
	Fakh Hospital	8	415	986	2.7	2.38	45.0%
	Humana/Alaska	199	0	42184	115.6	ERR	58.1%
	Kodiak Island Hospital	25	1315	4807	12.8	3.50	50.5%
	Providence Hospital	250	12850	75732	207.5	5.85	63.0%
	Seward General Hospital	32	384	1594	4.4	4.15	13.6%
	South Peninsula Hospital	13	0	2926	8.0	ERR	61.7%
	Valdez Community Hospital	15	229	823	1.7	2.72	11.4%
	Valley Hospital	19	1115	3669	10.1	3.31	53.2%
	Yukon-Kuskokwim Delta PHS/ANS Hosp.	60	1688	7336	20.1	3.69	40.2%
NORTH							
	Bassett ARMY Hospital	82	0	0	0.0	ERR	0.0%
	Barrow PHS/ANS Hospital	17	600	1911	5.2	3.19	30.8%
	Fairbanks Memorial Hospital	145	8536	42368	116.1	4.96	80.1%
	Kotzebue PHS/ANS Hospital	31	781	2974	6.1	3.81	26.3%
	Norton Sound Regional Hospital	15	768	2938	8.0	3.83	53.7%
	TOTAL:	1475	48844	300961	824.8	5.24	59.2%

Notes: Average Daily Census does not include patients at Bassett Army Hospital
Average Length of Stay does not include Humana/Alaska, South Peninsula and Bassett Army Hospitals
Occupancy Rate does not include Bassett Army Hospital

Source: 1983 Annual Alaska Hospital Survey

Prepared by: Planning Section, Division of Administrative Services
Department of Health and Social Services
July 10, 1991

Table 2
Acute Care Facilities Utilization Summary
1989

Area	Facility	Acute Care Beds	Total Discharges	Total Patient Days	Average Daily Census (# of Patients)	Average Length of Stay (# of Days)	Occupancy Rate (Percent)
SOUTHEAST							
	Bartlett Memorial Hospital	51	2879	9859	27.0	3.31	53.0%
	Ketchikan General Hospital	48	1728	5288	14.5	3.06	31.5%
	Mt. Edgecumbe/BEARHC	78	2037	14248	39.0	6.99	50.0%
	Petersburg General Hospital	11	140	489	1.3	3.35	11.7%
	Sitka Community Hospital	24	727	2641	7.2	3.63	30.1%
	Wrangell General Hospital	9	128	307	0.8	2.40	6.3%
SOUTHCENTRAL							
	Anchorage ANS/PHS Hospital	170	4473	32744	89.7	7.32	52.8%
	Branch Naval Hospital Adak	15	523	1375	3.8	2.83	25.1%
	Bristol Bay PHS/ANS Hospital	15	488	1338	3.7	2.85	24.4%
	Central Peninsula Hospital	46	2874	9344	25.6	3.49	55.7%
	Cordova Community Hospital	13	226	830	1.7	2.79	13.3%
	Elmendorf AFB Hospital	75	5387	23147	83.4	4.30	84.8%
	Humana/Alaska	238	7534	34583	84.7	4.59	39.8%
	Kodiak Island Hospital	25	1505	4389	12.0	2.80	47.9%
	Providence Hospital	365	14219	87477	239.7	6.15	65.7%
	Seward General Hospital	32	392	1218	3.3	3.10	10.4%
	South Peninsula Hospital	20	778	2530	6.9	3.25	34.7%
	Valdez Community Hospital	15	257	733	2.0	2.85	13.4%
	Valley Hospital	36	229	1308	3.6	5.71	10.0%
	Yukon-Kuskokwim Delta PHS/ANS Hosp.	51	1928	6878	18.3	3.46	35.9%
NORTH							
	Bassett ARMY Hospital	69	1383	4336	11.8	3.14	17.2%
	Barrow PHS/ANS Hospital	14	510	1800	4.4	3.14	31.3%
	Fairbanks Memorial Hospital	177	6905	25073	68.7	3.83	38.8%
	Kotzebue PHS/ANS Hospital	31	781	2283	6.2	2.97	20.0%
	Norton Sound Regional Hospital	19	673	1741	4.8	2.59	25.1%
TOTAL:		1645	58582	275291	754.2	4.70	45.8%

Source: 1990 Alaska Hospital Survey

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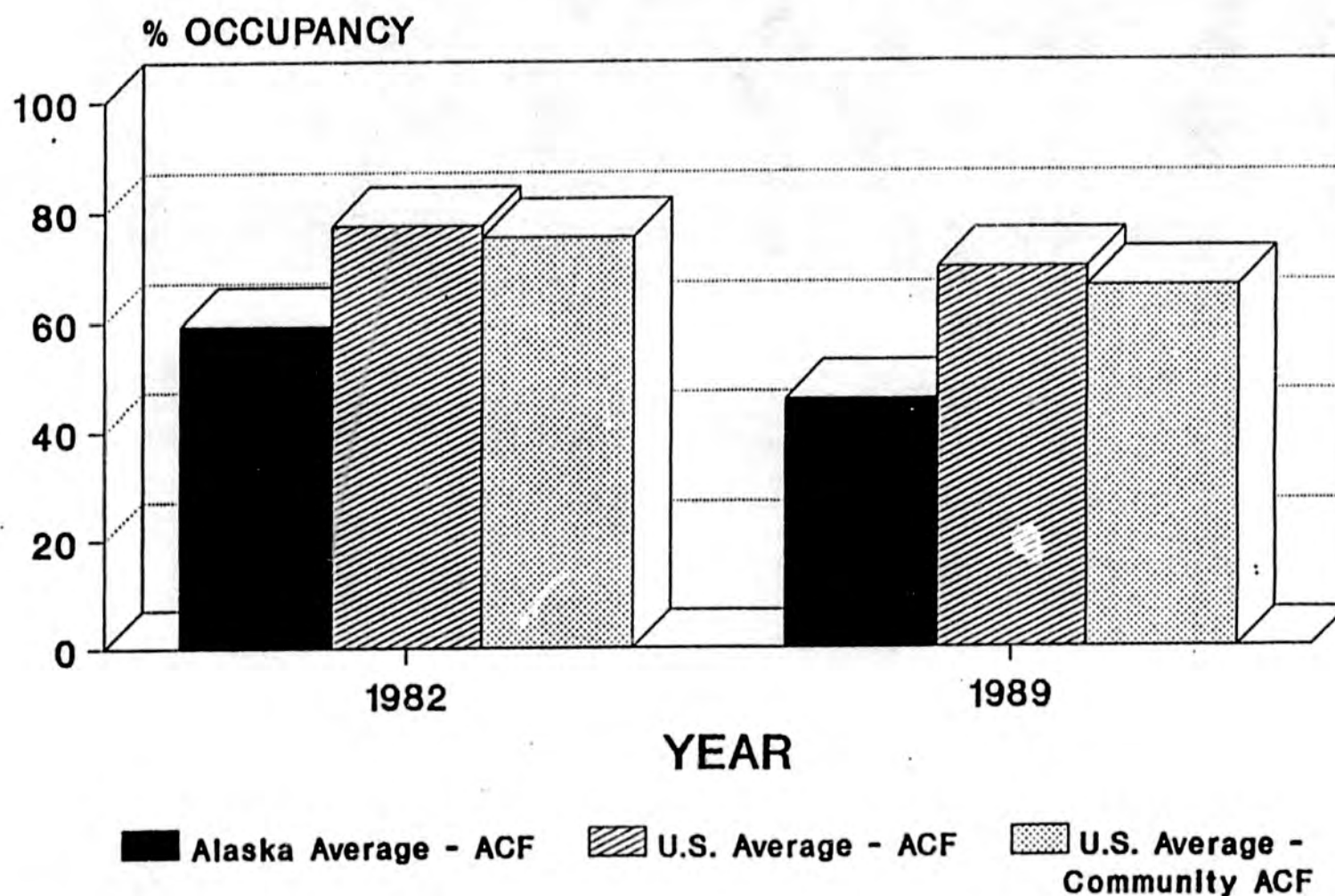
Prepared by: Planning Section, Division of Administrative Services
Department of Health and Social Services
July 10, 1991

Table 3
Acute Care Facilities Utilization
Comparison to U.S. Average for Facilities of Similar Size and Type of Ownership
1989

Size	Facility	TYPE OF OWNERSHIP	Occupancy Rate (Percent)	Occupancy Rate - U.S. Average by Number of Beds & Type of Ownership	Occupancy Rate Difference Actual - U.S. Average
1-24 Beds	Barrow ANS/PHS Hospital	Federal Government	31.3%	43.8%	-12.5%
	Branch Naval Hospital - Adak	Federal Government	25.1%	43.8%	-18.7%
	Bristol Bay ANS/PHS Hospital	Federal Government	24.4%	43.8%	-19.4%
	Cordova Community Hospital	Local Government	13.3%	30.6%	-17.3%
	Norton Sound Regional Hospital	Private - Non-profit	25.1%	33.1%	-8.0%
	Petersburg General Hospital	Local Government	11.7%	30.6%	-18.9%
	Sitka Community Hospital	Local Government	30.1%	30.6%	-0.5%
	South Peninsula Hospital	Private - Non-profit	34.7%	33.1%	1.6%
	Valdez Community Hospital	Private - Non-profit	13.4%	33.1%	-19.7%
	Wrangell General Hospital	Private - Non-profit	9.3%	33.1%	-23.8%
25-49 Beds	Central Peninsula Hospital	Local Government	55.7%	38.2%	17.5%
	Ketchikan General Hospital	Local Government	31.5%	38.2%	-6.7%
	Kodlak Island Hospital	Local Government	47.9%	38.2%	9.7%
	Kotzebue ANS/PHS Hospital	Federal Government	20.0%	45.7%	-25.7%
	Seward General Hospital	Local Government	10.4%	38.2%	-27.8%
	Valley Hospital	Private - Non-profit	10.0%	41.6%	-31.6%
50-99 Beds	Bartlett Memorial Hospital	Local Government	53.0%	53.4%	-0.4%
	Bassett Army Hospital	Federal Government	17.2%	53.6%	-36.4%
	Elmendorf AFB Hospital	Federal Government	84.6%	53.6%	31.0%
	Mt. Edgecumbe/SEARHC	Federal Government	50.0%	53.6%	-3.6%
	Yukon Kuskokwim Delta ANS/PHS Hosp.	Federal Government	35.9%	53.6%	-17.7%
100+ Beds	Anchorage ANS/PHS Hospital	Federal Government	52.8%	63.2%	-10.4%
	Fairbanks Memorial Hospital	Private - Non-profit	38.8%	63.1%	-24.3%
	Humana/Alaska Hospital	Investor Owned (For Profit)	39.8%	50.1%	-10.3%
	Providence Hospital	Private - Non-profit	65.7%	68.5%	-2.8%

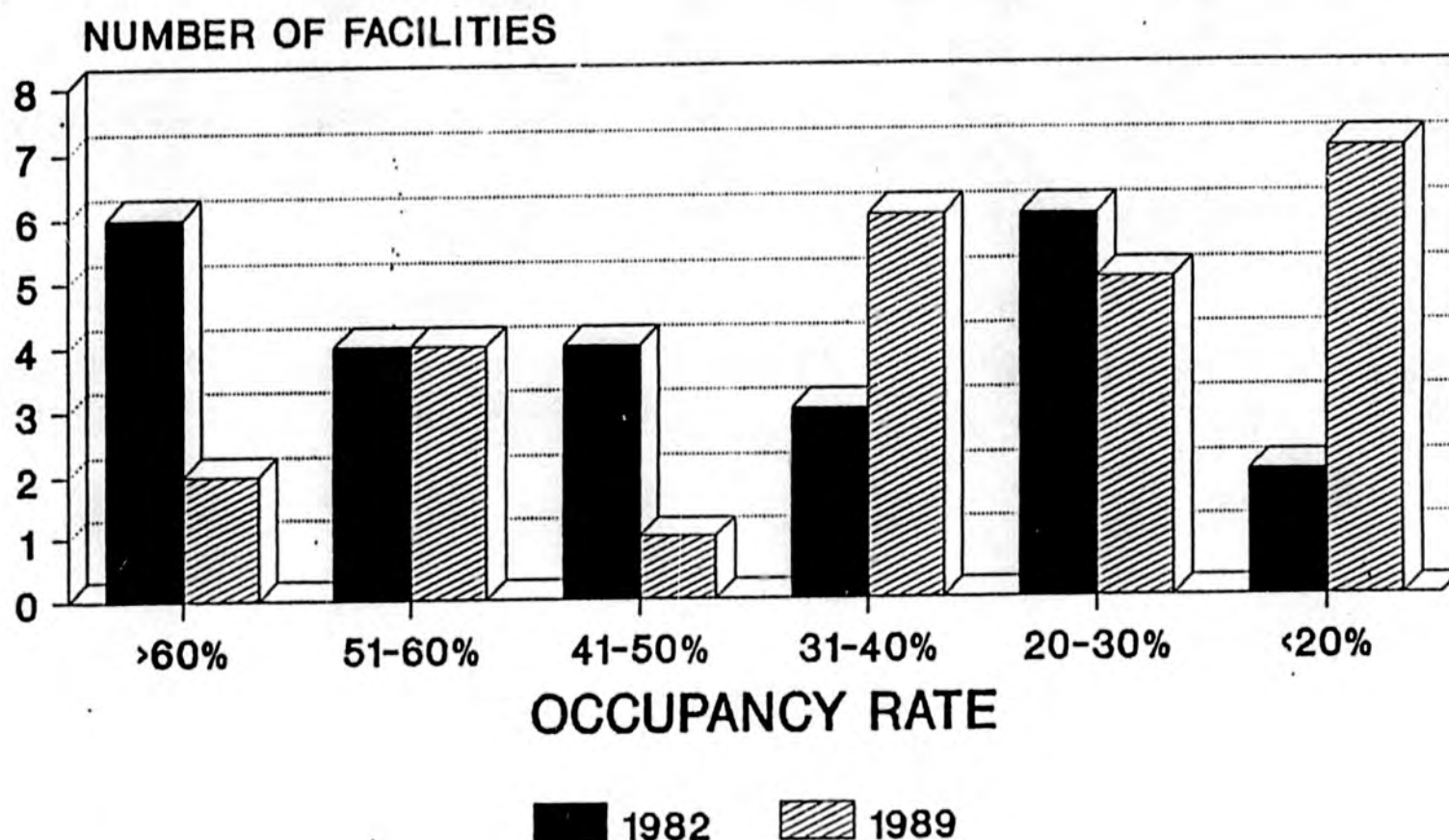
Note: *AHA Hospital Statistics - A Comprehensive Summary of U.S. Hospitals, 1990-1991* is the source for U.S. Average Occupancy Rates.

Table 4
Acute Care Facility (ACF) Utilization
1982 & 1989 Occupancy Rates



Source: U.S. Averages are from the American Hospital Assoc.
publication, "Hospital Statistics", 1990.

Table 5
Alaska Acute Care Facilities
Distribution of Occupancy Rates



NOTE: U.S. AVERAGE OCCUPANCY RATE FOR
COMMUNITY HOSPITALS WAS 75.3% IN 1982
AND 66.2% IN 1989.

Prepared by: Planning Section, Division of Administrative Services
 Department of Health and Social Services
 July 10, 1991

Table 6
 Long-Term Care Facility Utilization
 1982

Area	Facility	Long-Term Care Beds	Total Patient Days	Average Daily Census (# of Patients)	Occupancy Rate (Percent)
SOUTHEAST					
	Island View Manor	46	13,260	36.3	79.0%
	Ketchikan Pioneers' Home*	30	10,665	29.2	97.4%
	Mt. Edgecumbe - PHS	8	1,076	2.9	36.8%
	Petersburg General Hospital	12	4,138	11.3	94.5%
	Sitka Pioneers' Home*	50	17,776	48.7	97.4%
	St. Ann's Nursing Home	42	13,527	37.1	88.2%
	Wrangell General Hospital	14	5,045	13.8	98.7%
SOUTHCENTRAL					
	Anchorage Pioneers' Home*	95	33,773	92.5	97.4%
	Cordova Community Hospital	8	2,461	6.7	84.3%
	Harborview	96	31,381	86.0	89.6%
	Hope Park Cottages	30	10,815	29.6	98.8%
	Kodiak Island Hospital	19	6,033	16.5	87.0%
	Nakotia	216	68,195	186.8	86.5%
	Norton Sound Hospital	6	1,712	0.0	78.2%
	Palmer Pioneers' Home*	55	19,553	53.6	97.4%
	South Peninsula General Hospital	4	1,415	3.9	96.9%
	Valley Hospital	4	595	1.6	40.8%
	Wesleyan Nursing Home	64	23,340	63.9	99.9%
NORTH					
	Careage North	101	29,652	81.2	80.4%
	Fairbanks Pioneers' Home	54	18,980	52.0	96.3%
	TOTAL:	954	313,392	858.6	90.0%

*Note: These Pioneers' Homes did not report patient days for the nursing care beds. The listed data are estimated from historical utilization trends from the "Monthly Pioneers' Homes Occupancy Reports".

Source: 1983 Annual Alaska Hospital Survey

Prepared by: Planning Section, Division of Administrative Services
Department of Health and Social Services
July 10, 1991

Table 7
Long-Term Care Facility Utilization
1989

Area	Facility	Long-Term Care Beds	Total Patient Days	Average Daily Census (# of Patients)	Occupancy Rate (Percent)
SOUTHEAST					
	Island View Manor	46	11,424	31.3	68.0%
	Junesu Pioneers' Home	34	11,680	32.0	94.1%
	Ketchikan Pioneers' Home	30	10,220	28.0	93.3%
	Petersburg General Hospital	14	5,110	14.0	100.0%
	Sitka Pioneers' Home	41	9,525	28.1	63.8%
	St. Ann's Nursing Home	45	13,864	38.0	84.5%
	Wrangell General Hospital	14	4,374	12.0	85.6%
SOUTHCENTRAL					
	Anchorage Pioneers' Home	94	33,580	92.0	97.9%
	Cordova Community Hospital	10	3,181	8.7	88.6%
	Harborview - Sourdough Place	80	26,184	71.7	89.6%
	Heritage Place	45	10,383	28.4	63.2%
	Hope Park Cottages	40	14,414	39.5	98.7%
	Kodiak Island Hospital	19	6,621	18.1	95.5%
	Mary Conrad Center	68	22,828	62.5	94.8%
	Our Lady of Compassion	224	78,895	0.0	94.0%
	Palmer Pioneers' Home	55	19,285	52.8	98.1%
	South Peninsula General Hospital	18	5,781	15.8	88.0%
	Wesleyan Nursing Home	88	17,865	48.9	74.2%
NORTH					
	Denali Center	101	27,325	74.9	74.1%
	Fairbanks Pioneers' Home	48	18,425	45.0	93.8%
	Kotzebue Senior Center*	9	1,069	2.9	32.5%
	Quyaana Care Center	15	4,377	12.0	78.9%
TOTAL:		1,114	352,388	985.4	86.7%

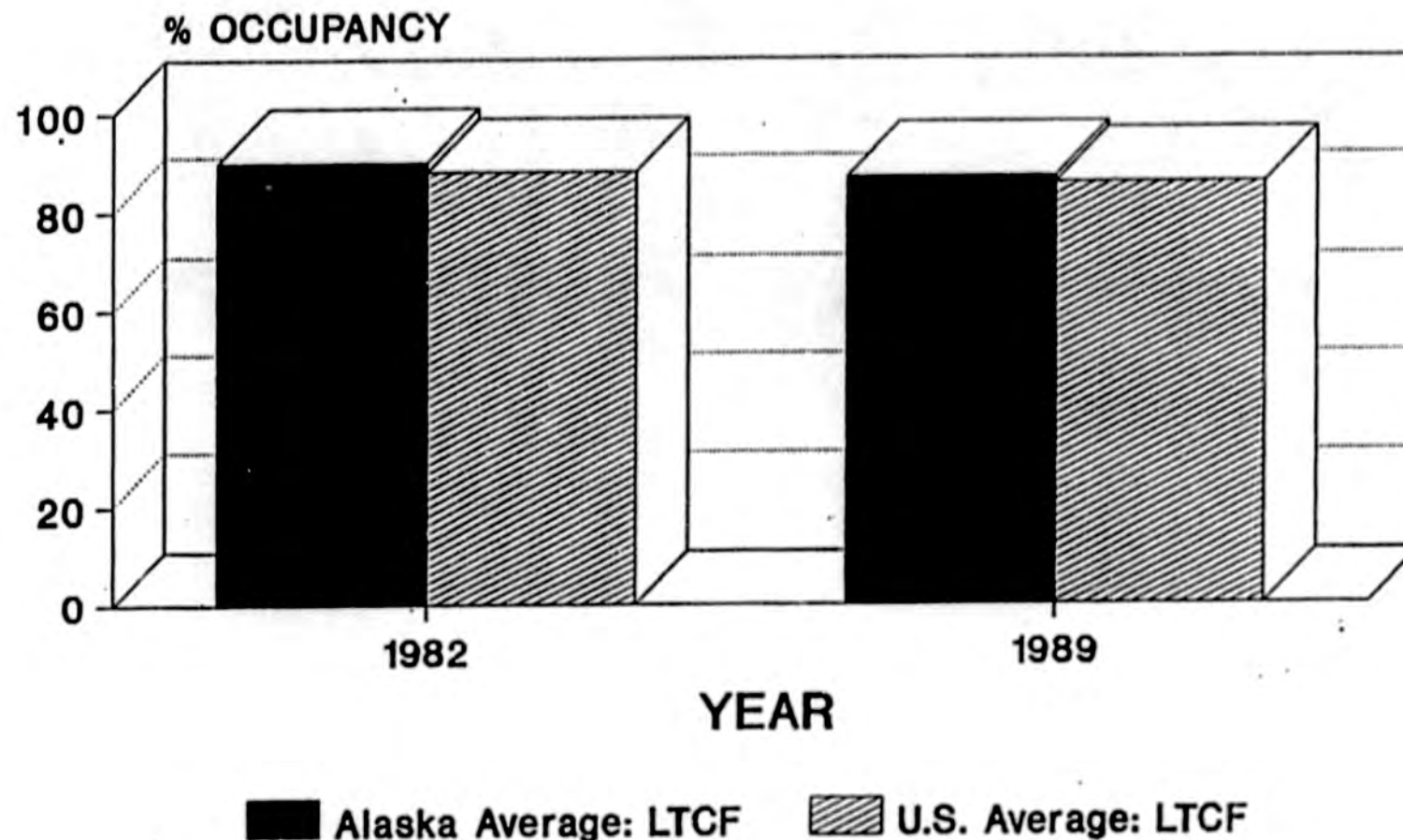
* Note: Actual utilization was higher since this facility opened on August 4, 1989. The occupancy rate for the time period the facility was open is 79.2%.

Source: 1990 Alaska Hospital Survey Report

E-10

Table 8

Long-Term Care Facility (LTCF) Utilization 1982 & 1989 Occupancy Rates



Source: U.S. Averages are from the
American Hospital Assoc. publication
"Hospital Statistics", 1990.

APPENDIX F

"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.

Health Resources and Access Task Force
Page 3

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;

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- 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.

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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 1166 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 \$847 (range: \$336-1260) (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	89		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	149 301 206		
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 radioisotopes 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 G

(Untitled) Data and Information Presented to the
Health Resources and Access Task Force

November 18, 1991

by Steve LeBrun, Aetna Life Insurance Company

Alaskan's Covered by Aetna Plans

Alaskan's covered by Aetna Plans, 1990:	46,700 (Employees)
(est. in-state residents)	<u>60,710 (Dependents)</u>
	107,410 (Total)

"Conventional" Plan Enrollment: 37,500 (Employees)

"Self Insured/Administrative Service" Enrollment: 9,200 (Employees)

<u>Number of Employees</u>	<u>Number of Plans</u>
Less than 10 employees	25
10 - 25 employees	42
25 - 99	24
100 - 499	8
500 - 999	3
1,000 or more employees	9

Notes

- Dependent coverage actuarially assumed to be 130% of employee total (i.e. 1.3 dependents per employee)
- Aetna does not underwrite individual plans other than individual group conversion plans
- All self-insured customers are in 500 employee or larger employer size category

COMPARISON OF COST LEVEL PERCENTAGES

<u>COVERAGE</u>	<u>995</u>	<u>997</u>	<u>998</u>	<u>999</u>	<u>ALASKA</u>
SURGICAL	119%	145%	118%	113%	123%
RADIOLOGY	112	122	101	110	110
LABORATORY	119	119	125	129	118
MEDICAL	141	162	138	131	142
DENTAL	131	144	133	109	132

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Average Charge Comparison - Medical Services/Procedures

CPT Codes	Zip Codes				All Alaska	All WA State	National
	995 to 996	997	998	999			
Physician Office - New Patient							
90015 Intermediate	\$80	\$101	\$81	\$85	\$82	\$62	\$57
90020 Comprehensive	\$145	\$180	\$136	\$109	\$144	\$122	\$101
Physician Office - Established Patient							
90060 Intermediate	\$58	\$70	\$57	\$58	\$60	\$43	\$28
90080 Comprehensive	\$128	\$170	\$120	\$113	\$132	\$96	\$78
Hospital Medical Services							
90220 Initial, Comprehensive	\$192	\$207	\$198	\$180	\$195	\$132	\$134
90250 Subsequent Visit, Intermediate	\$64	\$64	\$57	\$57	\$63	\$43	\$44
Consultations							
90620 Initial, Comprehensive	\$177	\$206	\$183	\$160	\$178	\$141	\$129
Psychotherapy							
90844 Individual, 45-50 minutes	\$93	\$98	\$83	\$84	\$92	\$79	\$67

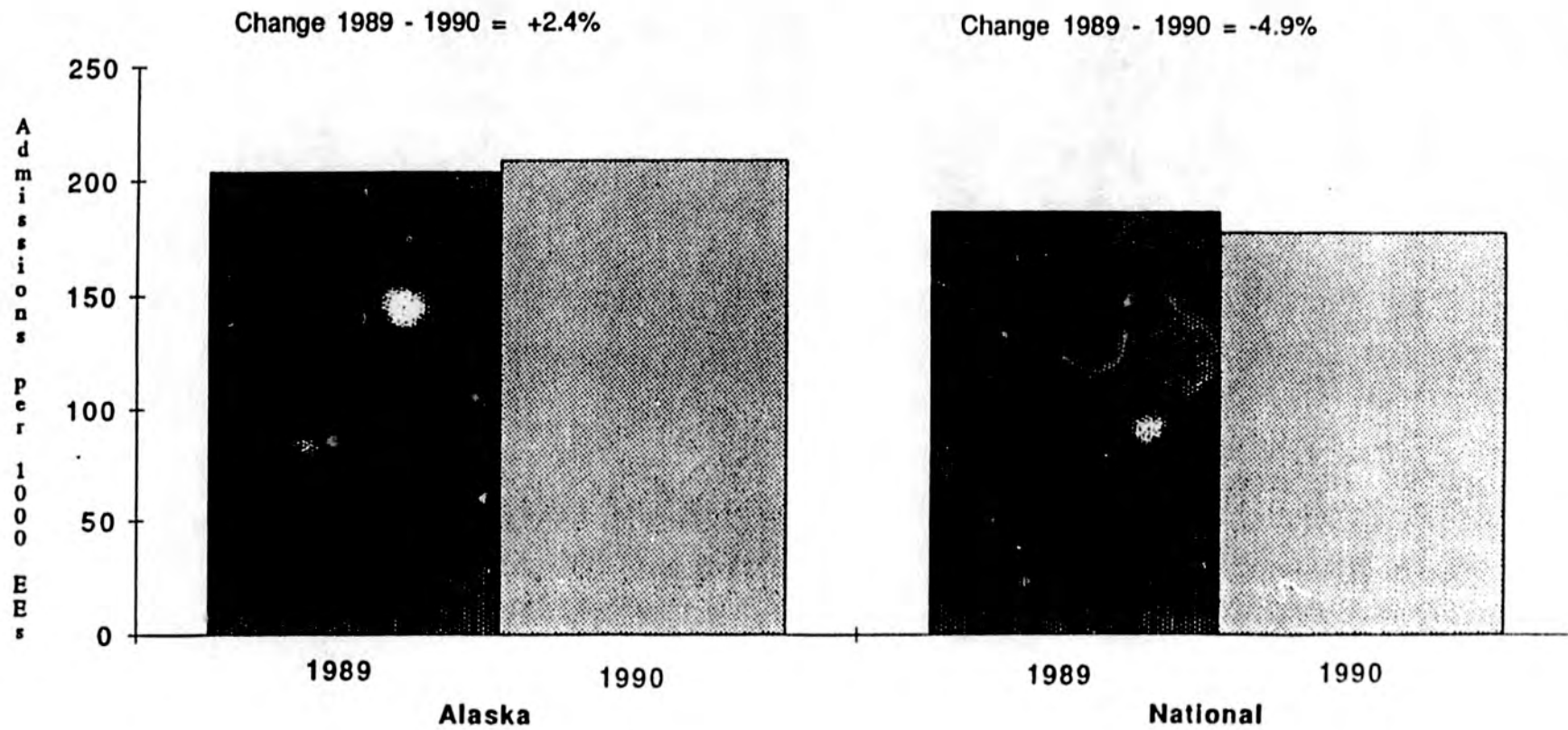
Average Charge Comparison - Surgical Services/Procedures

CPT Codes	Alaska	Washington State	National
Integumentary			
10060 Incision & Drainage Abscess, Simpl.	\$87	\$53	\$62
11100 Biopsy of Skin, One Lesion	\$109	\$67	\$75
19120 Excision Benign Breast Tumor	\$709	\$468	\$586
Musculoskeletal			
20610 Arthrocentesis, Major Joint	\$90	\$49	\$59
29881 Arthroscopy, w/Biopsy, Flexible	\$1,962	\$1,627	\$2,027
Respiratory			
31625 Bronchoscopy, w/Biopsy, Flexible	\$630	\$478	\$533
Cardiovascular			
33513 Coronary, Artery Bypass, 4 Arteries	\$8,440	\$5,250	\$6,091
92982 Coronary Angioplasty	\$2,097	\$1,631	\$2,335
Digestive			
43235 Upper GI Endoscopy	\$507	\$360	\$445
44950 Appendectomy	\$1,279	\$937	\$1,034
45300 Proctosigmoidoscopy, Diagnostic	\$109	\$65	\$74
Male Genital			
55700 Needle Biopsy of Prostate	\$278	\$148	\$239
Female Genital			
58120 Dilation and Curettage	\$528	\$443	\$609
58150 Total Hysterectomy	\$2,402	\$1,902	\$2,221
Maternity			
59400 Normal Delivery w/Pre & Post-Natal Care	\$1,500	\$2,035	\$1,985
Other			
72131 CT Scan - Spine	\$322	\$383	\$470
72141 MRI - Spine	\$733	\$893	\$871

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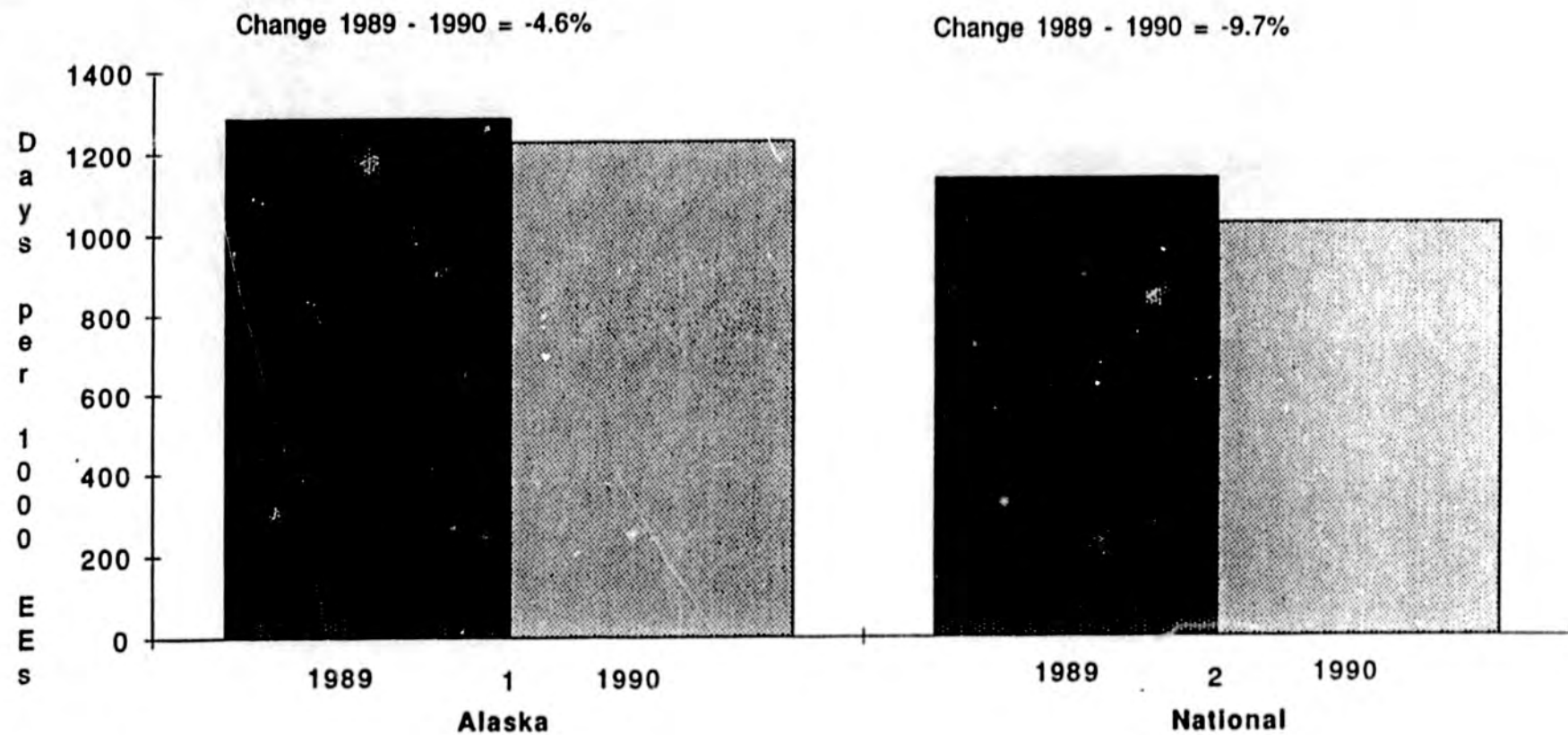
INPATIENT UTILIZATION

Ætna Alaska vs. Ætna National



Inpatient Utilization

Ætna Alaska vs. Ætna National



NORMATIVE EXPERIENCE
AETNA ALASKA VS. AETNA NATIONAL
1990
AVERAGE PER DAY

MAJOR DIAGNOSTIC CATEGORY	SUBMITTED EXPENSE			COVERED EXPENSE		BENEFITS PAYABLE		LENGTH OF STAY	
	ALASKA	NAT'L	ALASKA PERCENT TO NATIONAL	ALASKA	NAT'L	ALASKA	NAT'L	ALASKA	NAT'L
NERVOUS SYSTEM	\$1,376	\$1,161	119%	\$1,310	\$1,103	\$1,185	\$8,098	8.2	8.5
EYE DISEASE	\$1,149	\$1,516	76%	\$1,113	\$1,441	\$1,001	\$3,583	2.6	2.9
EAR, NOSE AND THROAT	\$1,523	\$1,424	107%	\$1,442	\$1,344	\$1,358	\$3,165	3.0	2.7
RESPIRATORY	\$1,525	\$1,157	132%	\$1,505	\$1,097	\$1,303	\$5,556	4.8	5.9
CIRCULATORY	\$2,068	\$1,839	112%	\$2,025	\$1,749	\$1,842	\$7,911	4.8	5.2
DIGESTIVE	\$1,280	\$1,182	108%	\$1,208	\$1,123	\$1,109	\$4,685	4.2	4.8
HEPATOBIILIARY	\$1,366	\$1,386	99%	\$1,323	\$1,319	\$1,194	\$6,512	4.4	5.7
MUSCULOSKELETAL	\$1,638	\$1,354	121%	\$1,567	\$1,278	\$1,452	\$5,724	4.4	5.2
SKIN, BREAST	\$1,266	\$1,176	108%	\$1,244	\$1,114	\$1,135	\$4,419	4.0	4.6
ENDOCRINE	\$1,325	\$1,052	126%	\$1,297	\$999	\$1,185	\$4,365	4.9	5.1
KIDNEY	\$1,295	\$1,249	104%	\$1,280	\$1,188	\$1,170	\$4,251	3.5	4.1
MALE REPRODUCTIVE	\$1,599	\$1,305	123%	\$1,529	\$1,232	\$1,338	\$4,335	3.1	4.1
FEMALE REPRODUCTIVE	\$1,456	\$1,295	112%	\$1,434	\$1,213	\$1,325	\$4,195	3.8	4.0
PREGNANCY, CHILDBIRTH	\$1,311	\$1,083	121%	\$1,256	\$1,011	\$1,136	\$2,427	2.5	2.8
NEWBORNS	\$893	\$662	135%	\$868	\$635	\$770	\$1,783	3.3	3.4
BLOOD DISORDERS	\$1,597	\$1,337	119%	\$1,501	\$1,277	\$1,412	\$7,323	6.3	6.7
MYELOPROLIFERATIVE	\$1,212	\$1,532	79%	\$1,205	\$1,458	\$1,125	\$7,571	8.0	6.0
INFECTIOUS	\$1,628	\$1,183	138%	\$1,419	\$1,111	\$1,141	\$5,845	6.7	6.1
MENTAL DISORDERS	\$683	\$593	115%	\$670	\$583	\$614	\$10,169	14.9	20.4
SUBSTANCE ABUSE	\$459	\$442	104%	\$438	\$423	\$380	\$6,868	16.0	19.0
INJURY; POISONING	\$1,260	\$1,277	99%	\$1,236	\$1,215	\$1,157	\$4,513	4.7	4.3
BURNS	\$1,110	\$1,509	74%	\$1,107	\$1,490	\$1,076	\$11,997	6.1	9.3
SELECTED	\$670	\$882	76%	\$656	\$841	\$595	\$5,681	6.1	7.9
UNCLASSIFIED	\$1,354	\$1,415	96%	\$1,312	\$1,359	\$1,256	\$8,254	6.0	7.0
TOTAL	\$1,223	\$1,047	117%	\$1,181	\$997	\$1,074	\$4,944	4.7	5.8

* Major Diagnostic Categories are groupings of DRG's.

**Aetna Alaska Book of Business includes all health claims processed in 1990, for services incurred in 995, 997, 998, 999 Medical Expense Areas (M.A.'s).

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**NORMATIVE EXPERIENCE
AETNA ALASKA VS. AETNA NATIONAL
1990
AVERAGE PER ADMISSION**

MAJOR DIAGNOSTIC CATEGORY	SUBMITTED EXPENSE		ALASKA PERCENT TO NATIONAL	COVERED EXPENSE		BENEFITS PAYABLE		LENGTH OF STAY	
	ALASKA	NAT'L		ALASKA	NAT'L	ALASKA	NAT'L	ALASKA	NAT'L
NERVOUS SYSTEM	\$11,325	\$9,887	115%	\$10,780	\$9,395	\$9,751	\$8,098	8.2	8.5
EYE DISEASE	\$2,930	\$4,393	67%	\$2,837	\$4,176	\$2,552	\$3,583	2.6	2.9
EAR, NOSE AND THROAT	\$4,603	\$3,887	118%	\$4,359	\$3,669	\$4,103	\$3,165	3.0	2.7
RESPIRATORY	\$7,363	\$6,784	109%	\$7,266	\$6,432	\$6,678	\$5,556	4.8	5.9
CIRCULATORY	\$10,028	\$9,601	104%	\$9,816	\$9,129	\$8,929	\$7,911	4.8	4.8
DIGESTIVE	\$5,375	\$5,717	94%	\$5,073	\$5,428	\$4,658	\$4,685	4.2	4.8
HEPATOBIILIARY	\$6,053	\$7,911	77%	\$5,864	\$7,528	\$5,293	\$6,512	4.4	5.7
MUSCULOSKELETAL	\$7,156	\$6,997	102%	\$6,844	\$6,605	\$6,342	\$5,724	4.4	5.2
SKIN, BREAST	\$5,112	\$5,411	94%	\$5,022	\$5,126	\$4,584	\$4,419	4.0	4.6
ENDOCRINE	\$6,479	\$5,328	122%	\$6,341	\$5,060	\$5,794	\$4,365	4.9	5.1
KIDNEY	\$4,546	\$5,180	88%	\$4,493	\$4,927	\$4,106	\$4,251	3.5	4.1
MALE REPRODUCTIVE	\$5,004	\$5,289	95%	\$4,786	\$4,994	\$4,188	\$4,335	3.1	4.1
FEMALE REPRODUCTIVE	\$5,547	\$5,200	107%	\$5,464	\$4,871	\$5,051	\$4,195	3.8	4.0
PREGNANCY, CHILDBIRTH	\$3,321	\$3,037	109%	\$3,182	\$2,834	\$2,876	\$2,427	2.5	2.8
NEWBORNS	\$2,930	\$2,237	131%	\$2,848	\$2,246	\$2,526	\$1,783	3.3	3.4
BLOOD DISORDERS	\$10,015	\$8,953	112%	\$9,415	\$8,548	\$8,855	\$7,323	6.3	6.7
MYELOPROLIFERATIVE	\$9,753	\$9,208	106%	\$9,693	\$8,763	\$9,054	\$7,571	8.0	6.0
INFECTIOUS	\$10,979	\$7,242	152%	\$9,568	\$6,799	\$7,698	\$5,845	6.7	6.1
MENTAL DISORDERS	\$10,192	\$12,077	84%	\$10,003	\$11,875	\$9,157	\$10,169	14.9	20.4
SUBSTANCE ABUSE	\$7,367	\$8,412	88%	\$7,021	\$8,051	\$6,100	\$6,868	16.0	19.0
INJURY, POISONING	\$5,866	\$5,482	107%	\$5,753	\$5,216	\$5,384	\$4,513	4.7	4.3
BURNS	\$6,800	\$13,957	49%	\$6,782	\$13,785	\$6,588	\$11,997	6.1	9.3
SELECTED	\$4,080	\$6,962	59%	\$3,999	\$6,636	\$3,624	\$5,681	6.1	7.9
UNCLASSIFIED	\$8,058	\$9,978	81%	\$7,807	\$9,579	\$7,474	\$8,254	6.0	7.0
TOTAL	\$5,758	\$6,036	95%	\$5,563	\$5,746	\$5,058	\$4,944	4.7	5.8

* Major Diagnostic Categories are groupings of DRG's.

**Aetna Alaska Book of Business includes all health claims processed in 1990, for services incurred in 995, 997, 998, 999 Medical Expense Areas (MLA's).

Alaska State Health Benefit Mandates

Alcoholism & Drug Abuse Treatment

Law: SB 363

Synopsis:

Coverage for treatment of alcoholism or drug abuse must include

(1) benefits of at least \$7,000 per two consecutive benefit years

(2) a lifetime maximum of at least \$14,000

No insurer may:

---impose a deductible or copay amount, pre-existing limitation, claim payment methodology, or precertification notification requirement different from that which applies to other covered expenses

---deny reimbursement for actual services rendered solely because the treatment was interrupted or not completed

cost impact:

Alcoholism/Drug Abuse expenses comprise 2-3% of a typical health plan's total medical benefit payments. Complete exclusion of coverage would potentially save an equivalent amount, not taking into account the potential increased claim costs for treatment of the medical complications of substance abuse and the potential increase in disability/time loss work benefits

Mammogram Screening

Law: HB 45

Synopsis:

Requires insurers to provide coverage for routine mammogram screening (i.e. in the absence of symptomatic evidence of the existence of a disease) under group medical policies; coverage must be provided on a basis no less favorable than for other radiological examinations covered under the policy. Minimum requirements are:

--one baseline mammogram between ages 35-40

--one mammogram every two years between ages 40-50

--annual mammograms thereafter

cost impact:

Depending on the composition of the employee group, the additional cost to a plan is approximately .7%-1.4%; however, since this is a preventive benefit, there would be assumed future long term savings to offset the cost of the procedure

Medical Coverage for Alaska's Children

- All plans underwritten or administered by Aetna in Alaska include coverage for dependent children
- Aetna's medical plans do not differentiate between employee and dependent coverage in terms of coverage and benefits (with one exception--not all plans include dependent child pregnancy benefits) Otherwise all plans, regardless of size, include some level of coverage for physician and nursing services, hospital care, laboratory expenses, prescription drugs, medical or surgical equipment, etc.
- dependents are covered from birth (and standardly including routine nursery charges) until age 19; and then beyond age 19 (standardly to age 23) if attending school on a regular basis and dependent on the insured employee for support
- coverage for a child with a developmental disability or physical handicap can be continued past the maximum age for as long as the person remains unable to earn his or her own living because of the handicap and remains chiefly dependent on the insured employee for support
- there is an increasing tendency for employers to require some employee contribution toward the cost of dependent coverage; the cost to employees ranges from a nominal \$10-20 monthly contribution to a 100% employee contribution obligation; cost-sharing with respect to dependent coverage is more prevalent among small employers
- preventative care benefits for children (such as immunizations and routine physical examinations) are an optional plan provision and standardly not included by Employers; a review of ten Aetna Alaska medical plans with 200+ employees found two employers that included a preventive care benefit for children; in our small employer product market we estimate that less than 10% of employers plan sponsors include any preventive care benefits

Aetna Small Group Market Information

Aetna supports reforms to the small group market to guarantee the availability of coverage to all small employers and to provide greater rate stability to these employers:

- All carriers writing coverage in this market should be required to provide both a basic benefit plan (free of state mandated benefits) and a standard benefit plan to any small employer that wants coverage, *regardless of the health status* of the employer or its employees
- All plans sold to small employers should be *guaranteed renewable*
- Carriers should be required to *accept whole groups*
- Rejecting high risk individuals from a group would be prohibited
- Pre-existing condition limitations should be *limited* to no more than 12 months
- *Continuity of coverage* should be provided by prohibiting re-application of pre-existing condition limitations for coverage that is continuous (i.e. to an employee switching jobs or an employer switching carriers)
- Two limitations should be placed on carriers use of experience rating in order to *make rates more predictable*: First, renewal rates should not increase by more than the increase in medical "trend" plus a maximum of 15%; Second, for groups with similar case characteristics, the initial and subsequent rates charged to these groups should not vary by more than a maximum of 50%
- A prospective *reinsurance mechanism* should be established to allow the carriers to spread the risk of the losses caused by high risk employer groups. Financing of the losses of this program should be done in two steps. First, all small group carriers should be assessed a charge of up to 4% of small group premium. If there are remaining losses, all carriers should be assessed for all insured employer groups

Small Group Market -- Response to Task Force Inquiries

- Aetna accepts or rejects whole groups, not individuals, as regards 10-200 employee groups; however, for groups of 2-9 employees we do ask for individual evidence of good health for entrants to the plan; Aetna does not accept groups but exclude certain conditions;
- For groups of 2-200 employees the percentage of administrative costs to total premium collected is 11% to 13.5%. This is a national average; we do not specifically differentiate among the states.
- As of the 1st quarter 1991, the average monthly premium charge per employee for 2-200 employee groups underwritten in Alaska was \$306.61
- All industries, business or professions are eligible for coverage; there are no blanket prohibitions or automatic Home Office rejections of any group based solely on occupational categories; we have broad representation of industries in our current book of business
- Pre-existing condition limitations are included in all size plans
If the group constitutes *transferred business* (i.e. employees insured on the Aetna plan effective date were previously insured under a prior insurance carrier) then the following limitations apply: For groups with fewer than 10 employees, expenses for preexisting conditions to a limit of \$2,000 will be covered during the first 365 days insured under an Aetna plan
For larger groups, Benefits for covered medical benefits will be paid to the extent the prior plan would have provided benefits. The benefit payable will be the lesser of the normal Aetna benefit in the absence of a pre-existing condition limitation and the unused portion of the maximum amount payable for that condition under the prior plan. In no event will Aetna pay less than the normal Aetna benefit payable on the first \$2,000 (groups of 10-49 employees) or \$4,000 (groups of more than 50 employees) of covered expense during the first 365 days insured under the Aetna plan.
If the group was *previously uninsured*, expenses for a preexisting condition will not be covered for the first 365 days insured under the new Aetna plan. However, for employee groups of 50 or more employees, up to \$4,000 of expenses incurred in connection with a preexisting condition will be considered a covered expense for which benefits are available.

UTILIZATION MANAGEMENT

Utilization Management (UM) involves reviewing inpatient, outpatient and selected specialist procedures, as well as special testing, before, during and after treatment. This helps assure that care is medically necessary and appropriate for a patient's clinical condition. It also helps direct members to cost-effective settings whenever possible.

BEFORE TREATMENT

- **Inpatient Precertification** reviews the medical necessity, appropriateness and setting for planned hospital, psychiatric and substance abuse treatment facilities, hospice and skilled nursing facility admissions. We establish optimal lengths of stay and identify opportunities for individual case management. Precertification involves the use of comprehensive guidelines developed by specialists in the appropriate fields regarding appropriateness and effectiveness of treatments and services for the entire range of medical conditions.

Precertification involves a review of the clinical information about the patient's condition, the proposed site of service, the length of stay, the health care resources required and the proposed procedure or treatment. Based on the information provided at the time of the review, we certify that the proposed site, service or treatment appears to meet the applicable health benefits plan's contract requirement that covered services be medically necessary and appropriate.

Review determinations are not directions to the provider to offer or refuse any course of treatment; they are rather assessments of the medical necessity or appropriateness of proposed care for the purpose of offering an advance indication concerning benefits. Utilization reviewers have no authority (and seek no such authority) to direct the provider of care or the patient to do or omit anything, and the provider and patient are always the final arbiters of any treatment plan. Utilization review denials simply indicate that the proposed treatment does not meet the medical necessity or appropriateness requirement in the absence of new information or changed circumstances; this is subject to rights of appeal at the certification and claim stages.

Last year our inpatient precertification programs cut our customers' overall claim costs by over \$150 per employee per year.

- **Outpatient Precertification** performs the same types of reviews for targeted high-cost or frequently utilized outpatient diagnostic tests and procedures. The development of Outpatient Precertification (OPP) was necessitated by the significant rise (15% to 20% annually) in both the utilization and cost of outpatient care. OPP integrates the most up-to-date computer technology with procedure-specific expert decision support in the form of clinical protocols to determine the medical necessity of certain outpatient tests and procedures.

For procedures to be included in our outpatient certification review process:

- adequate information and consensus opinion is needed from the medical literature on when these procedures should and should not be performed;
- the procedures must be of high enough cost and performed frequently enough so that review is cost effective;
- evidence is needed that the procedure is being performed for inappropriate reasons.

Following extensive literature research on each test/procedure, criteria are established and taken to a panel of expert clinical physicians for review. The result of this exhaustive process is a protocol consisting of algorithms which allows one to obtain needed clinical information from patients and physicians and, more importantly, to arrive at consistent decisions.

Physician reviewers assist in the precertification process, as necessary. Additionally, the nurses' decisions are audited, and ongoing monitoring is conducted via computer-generated traces.

In 1990, these programs reduced our customer's costs by reducing targeted procedures 15 percent.

- **Managed Second Opinion** identifies patients scheduled for targeted high-cost or frequently utilized surgical procedures who might benefit from a second opinion. Here, our medical managers use medical criteria developed by expert physician panels. This helps patients and their doctors determine the clinical appropriateness of the proposed treatment and evaluate alternatives.
- **Healthy Beginnings** identifies expectant mothers who may be at increased risk and provides them with prenatal education. The expectant mother is encouraged to visit an obstetrician and assisted in finding one, if necessary. When a potential high risk situation is identified, follow-up calls are made every two weeks until a doctor is identified and the doctor is notified of the woman's status. If necessary, follow-up calls are continued throughout the pregnancy, and rescreening is done at the end of the second trimester for all participants. Additional educational materials are distributed at each stage of pregnancy. In addition, an Aetna physician reviews high risk cases and contacts the attending physician, if necessary. Case management goes on throughout delivery and postnatal care. A subsequent call is made to the patient asking for help in evaluating the program. This innovative Aetna program is designed to reduce the chances of expensive neonatal care and to enhance overall quality.

The rate of low-birth-weight infants born to women enrolled in Healthy Beginnings is just 3.4 percent. This compares favorably with a national low birth-weight rate of 6 percent to 8 percent.

- **Computerized Medical Guidelines** help our nurse consultants determine whether to certify a proposed procedure - or refer it for medical director review. The guidelines also help our nurses avert the unnecessary use of health services, which improves quality and reduces costs. The guidelines are used in our inpatient and outpatient precertification, managed second opinion and prenatal health programs. They were developed after extensive research and with direct physician input.

- **Focused Psychiatric Review** precertifies and concurrently reviews psychiatric and substance abuse care. Master's level clinicians work with admitting physicians to promote the development of realistic treatment plans and identify alternative treatment methods. *Last year, this program saved our customers nearly \$6,000 - and reduced lengths of stay by 10 days - per confinement. Plans saving per employee can range from \$100 to \$300 per year.*
- **Institutes of Excellence** are leading institutions specializing in complicated, high cost, low frequency medical procedures such as transplants. These facilities have a demonstrated ability to achieve positive clinical outcomes. We negotiate preferential case rates with these facilities, and when appropriate, will direct members to them.
- **MEDIS (Medical Information System) Technology Data Base** provides our medical manager with the latest medical literature reviews and research information. This helps them make better precertification decisions and offer up-to-the minute information to plan members and providers.

DURING TREATMENT

- **On-Site Concurrent Review** monitors the patient's progress and the need for continued confinement. In selected locations, our nurses work on-site directly with the attending physician, the facility's staff, and if appropriate, the patient and the patient's family. In this way, Aetna nurses can help facilitate the discharge planning process. *This process saved our customers over \$300 per employee per year.*
- **Concurrent Quality Monitoring** is a process in which nurse consultants identify potential quality problems and report quality issues directly to our medical director, if appropriate, for immediate intervention. Nurses also flag issues such as unexpected returns to surgery.
- **Discharge Planning** involves identifying as early as possible any care that may be needed after discharge. The process identifies quality, cost-effective alternatives such as home health care. We also assist in making necessary arrangements prior to discharge. Through these efforts, patients can receive quality care and save money at the same time.
- **Individual Case Management** matches a patient's needs with available community resources in extremely complicated or lengthy cases, such as trauma, multiple sclerosis or cancer. Our extensive network of case management affiliates allows us to perform on-site assessments in many locations throughout the country. Nurse consultants monitor the appropriateness of the setting and treatment plan in the kinds of cases mentioned above. By seeking alternatives to traditional care and researching extra-contractual benefits. *Our nurses saved over \$68,000 per case for our customers.*

AFTER TREATMENT

We're refining existing methods and developing new methods to measure *actual* outcomes against outcome *standards*. After we collect this information, we look for ways to improve medical performance and clinical quality. We accomplish this through the following activities:

- **Provider Profiling and Trend Analysis** analyzes provider utilization and cost trends and identifies areas of overutilization and underutilization.
- **Retrospective Quality Reviews** are conducted and reviewed by Quality Assurance committees in accordance with national guidelines. These groups analyze specific cases and look for trends that may indicate problems.
- **Focuses Audits** examine the medical indication for certain common procedures with wide treatment variability, such as Caesarian delivery. Furthermore, they measure health care value by examining the type, quantity and cost of procedures used and the health outcome.

Network Management

Alternatives to traditional indemnity programs began to emerge in the 1970's. Encouraged by an Act of Congress in 1973, Health Maintenance Organizations (HMO's) were distinguished by their use of a closed network of providers, provider risk sharing, and tight control over delivery of care. In the 1980's, Preferred Provider Organizations (PPO's) were developed to provide both in and out-of-network benefits for a negotiated fee. Employers have accepted both HMO's and PPO's as viable means of delivering health care benefits.

Over the last decade there has been a dramatic shift from traditional indemnity plans to managed care programs. In 1980 only about 4% of all members covered by group health were enrolled in a managed care plan. Today, it is estimated that 30% of the group participate in HMO's and PPO's, and their numbers continue to grow each year. Health industry analysts project that 30% of health care enrollees could be participating in a PPO and 20% in an HMO by the year 2000. Aetna has provider networks in over 150 major metropolitan areas and more than 2.4 million members as of 1st quarter, 1990. *Aetna has approximately 1,000 hospitals and more than 75,000 physicians under contract. As a percentage of total claims PPO savings are 7-9%.*

State Of Alaska Employee Medical Plan

Analysis of Recent Cost Containment Activities

Plan Changes Introduced December 1989:

- Inclusion of a family of Aetna medical cost management programs, called "Healthline," designed to promote cost-effective and appropriate utilization of inpatient and outpatient medical services, and informed healthcare consumer behavior, including:
 - inpatient precertification, concurrent review, and discharge planning related to hospital care as well as psychiatric and substance abuse treatment facility care, including on-site nursing review at selected facilities
 - advance review of selected high cost or frequently utilized outpatient surgeries, diagnostic tests and procedures
 - a prenatal care information and advocacy service designed to reduce the risk of low birth weight babies
 - a general health care information service designed to promote health awareness, locate community healthcare resources and help individuals understand plan benefits and treatment alternatives
- Miscellaneous other changes including introduction of both vision care and pharmacy provider network plans, inclusion of optional mail order drug purchase plan, \$200 increase in annual employee out-of-pocket maximum

Plan Program Performance Results:

- One Study of the impact of Healthline Utilization Review concluded that the State Active Employee Plan's total inpatient care costs in 1990 were 14.4% lower than they would have been had the program not been in effect. Overall, inpatient days of confinement decreased 24%. Confinement days per 1000 employees decreased even more significantly--33.9%--for inpatient stays related to psychiatric and substance abuse disorders.
- Another evaluation of the State Employee Plan done to quantify the impact of the inclusion of precertification procedures determined that the program saved \$230.90 per employee per year. These savings translated into a return of \$10.24 for each dollar spent during the study period.

- Research done to study the impact of the On-Site Concurrent Review program administered in Anchorage concluded that in 1990 the program saved the State \$136 per employee. This saving translated into a 9% reduction in inpatient hospital costs for State employees with on-site nursing review compared to otherwise similar groups without the local review service.
- Two studies have been conducted to determine the cost saving impact of the Outpatient Procedure Precertification Programs implemented in December 1989. One analysis indicated that the per employee benefits paid for the tests and procedures encompassed by the program resulted in a 7.2 decrease in such expenses. Another evaluation concluded that decreases in utilization rates, compared to a control group without the program, resulted in total program savings of \$718, 908 in 1990.
- Preliminary review of the Healthy Beginnings prenatal care program has shown reduced cost per day for premature births and a reduced average of benefits paid for participants.

•

1990 Plan Utilization Cost Results:

- Total per employee benefits paid decreased 6% as compared to a 10% increase in Aetna's national Book of Business experience
- Had the State not implemented plan changes, a projection of expected utilization and expense inflation increases resulted in an estimated savings of 21%
- the overall "expense gap" between the State's plan costs and Aetna's national plan cost average decreased by 38% as a result of the the favorable State plan experience as contrasted to the deteriorating experience of comparison groups
- total inpatient hospital expenses decreased by 8.8% compared to an 8.7 increase for the rest of Aetna's Alaska customers
- the average hospital confinement length of stay decreased by 12%
- inpatient days of confinement decreased 24.1% (compared to a national comparison group decrease of 11.5%)
- the State paid portion of covered expense was 89% in 1990 compared to 91% in 1989; the employee paid portion of covered expenses increased from 9% to 11%

Price/Cost Analysis--Alaska vs. Lower 48

- analysis based on Aetna customer data as recorded in claim payment system
- data based on submitted charges and therefore not affected by plan design differences
- data *not* adjusted for impact of variables such as claimant demographics, intensity of illness, or case mix

• **Reasonable & Customary Charges--AK vs. National**
(analysis as of February 1990--comparison of submitted charges at the 85th percentile level)

--Alaska charge levels were higher than U.S. average in all 5 profiled expense areas -- range was +10% (radiology) to +42% (non-surgical physician services)

--Surgery charges were 23% above national average and laboratory charges were 18% above national average

• **Physician charges--Non-surgical services**
(based on review of 8 common medical services, including office and hospital visits and consultations -- data as of 8-31-91)

--On average Alaska charges are 33% higher than Washington State (range of +16- +48%)

--On average Alaska charges are 54% higher than U.S. national average (range of +37-- +114%)

• **Physician charges --Surgical Services**
(based on review of 15 frequently-performed surgical services-- data as of 8-31-91)

--Alaska charges higher than U.S. average national charge for 11 of 15 procedures

• **Hospital Costs -- Average Charge Per Day**
(based on 1990 calendar year data)

--average cost per day in Alaska is 17% higher than the National average cost per day of confinement; cost includes both room & board and ancillary costs

• **Hospital Utilization**

(based on 1990 calendar year data)

--both admissions per 1000 employees as well as days of confinement per 1000 employees are marginally higher in Alaska than in the lower 48; rates for both utilization indicators are decreasing in both Alaska and nationally, that at a lesser rate in Alaska compared to the lower 48

APPENDIX H

"Retention and Attraction of Practitioners in Rural Alaska"

presented to the Health Resources and Access Task Force

by Rodman Wilson, MD, Task Force member

November 18, 1991

Attraction and Retention of Practitioners in Rural Areas

Rural areas of America by and large have always been underserved medically. Small towns have difficulty in recruiting and retaining MDs and other health professionals.

In other states people as a rule can at least drive to a city for care and rural physicians often go 20-60 miles to a town with a hospital to attend their patients if there is no hospital where they practice. In many areas of Alaska neither patients or physicians can do this.

In addition, unlike in most other areas of USA, a dual system of care exists in Alaska: care for Alaska Natives and care for others. This creates special problems in rural areas where it is difficult and wasteful to provide two sets of facilities and personnel.

Table 1. Distribution of physicians in Alaska

~~Table 2. Numbers of physicians by specialty in Alaska~~

Table 2. Proportions of physicians by specialty in USA, Canada, and Alaska.

Table 3. Current needs for physicians in rural Alaska

A. Incentives to practice in small communities:

1. high stature in community
2. less likely to be sued
3. good place to rear children
4. good recreation
5. simpler life

B. Disincentives to practice in small communities:

- | | |
|---------------------------|---------------------------|
| 1. professional isolation | 7. spouse unhappy: |
| 2. on-call all the time | cultural aridity |
| 3. can't get away | few stores |
| 4. can't do OB because of | few jobs |
| exposure/liab ins cost | interpersonal dynamics |
| 5. no local CME | of small towns |
| 6. more no pay/low pay | 8. children disadvantaged |
| patients | if schools are poor |

C. How to improve recruitment and retention:

1. train more FPs and fewer specialists at universities
2. develop community-based family practice residencies (physicians tend to settle where they train)
3. scholarships or loan forgiveness for promise to locate in rural area
4. promote nurse practitioners and physician extenders (but this does not solve vacation coverage for MDs)
5. develop intrastate pool of practitioners for vacation and CME coverage
6. encourage communities to plan and develop realistic array of services & recruit personnel (Amundson)
7. subsidize liability insurance; immunity for selected health services; alter tort law otherwise
8. simplify billing (MDs often do this themselves in small communities to reduce overhead)
9. devise a system that pays for everyone's care (this alone would solve most of the problems above)

Table 1

PHYSICIAN DISTRIBUTION IN ALASKA

As of September 30, 1991

Town	Private Practice	Public Health	Military	Municipal State & Fed.	TOTAL
Adak			4		4
Anchor Point	1				1
Anchorage	359	68	54	15	496
Barrow		6			6
Bethel		17			17
Chugiak	2				2
Cordova	2				2
Craig	1				1
Delta Junction	1				1
Dillingham	1	5			6
Eagle River	10				10
Fairbanks	102	8	33	1	144
Glennallen	2				2
Haines	2				2
Homer	6				6
Juneau	36	5		2	43
Kenai	4				4
Ketchikan	18	4	1		23
Kodiak	13	2	1		16
Kotzebue		6			6
Metlakatla		1			1
Nome		7			7
Palmer	22				22
Petersburg	2				2
Seldovia	1				1
Seward	2				2
Sitka	9	11	1		21
Soldotna	21				21
Talkeetna	1				1
Tok	1				1
Valdez	2				2
Wasilla	11				11
Wrangell	1				1
TOTAL	633	140	94	18	885

Table 2

Proportions of Physicians by Specialty in USA, Canada, & AK

A. Percentage of Physicians in Family Practice USA & Canada

	1985*	1988+
USA	13.1 %	13.3
Canada	51.5	52.8

- * Clare FL, et al. Data watch: trends in health personnel. Health Affairs, Winter, 1987.
 + Canadian Health Insurance: Lessons for the United States. US General Accounting Office, June 1991

B. Numbers of Physicians Giving Patient Care by Specialties
USA 1990^o

primary care)	Family practice	66,418 (13.6%)	) 46%
	Medical specialties includes internal medicine & sub-specialties; pediatrics; OB-Gyn	157,934 (32.4)	
	Surgical specialties except OB-Gyn	128,552 (26.4)	
	Other specialties includes anesthesiology, neurology, psychiatry, radiology, pathology, public health, and others	134,892 (27.6)	
	Total	487,796 (100.0)	

^o American Medical Association

C. Physicians in Private Practice in Alaska by Specialty
Sept 30, 1991

(categories as above)

Family practice	158 (24.7)	) 50%
Medical specialties	161 (25.2)	
Surgical specialties	321 (50.1)	
Other specialties		
Total	640 (100.0)	

Alaska State Medical Association

D. USPHS & Native Health Corporation Physicians
Jan 1, 1991

FP/GP	73 (53.7)
Medical specialties	28 (20.6)
Surgical & other specialties	35 (25.7)
	136 100.0

Table ³/₄

Current Needs for Physicians in Rural Alaska
October 1991*

Indian Health Service/Alaska Native Health Corporations
need approx 20 new physicians annually in rural areas
because of rapid turnover.

Private family practice vacancies in Alaska towns:
(information incomplete)

Ketchikan	1	Petersburg	1
Wrangell	1	Haines	1
Craig	1	Juneau	2
Sitka	2	Valdez	1

Note: A group doing OB in Juneau recently stopped; they
were doing 25% of deliveries in Juneau.

* Sources: Thomas Nighswander, MD, USPHS, Anchorage
Thomas H. Wood, MD, Petersburg
Barbara J. Doty, MD, Wasilla

APPENDIX I

"Memo to the Alaska State Legislature,
Health Resources and Access Task Force"

From Jeff Gingold, Blue Cross of Washington and Alaska

January 1992

"Memo to Nancy Cornwell, Project Director,
Health Resources and Access Task Force"

From Phyllis Finn for Jeff Gingold

January 17, 1992



P O Box 327
Seattle, Washington 98111-0327

REPORT

DATE: January, 1992

TO: ALASKA STATE LEGISLATURE
HEALTH RESOURCES AND ACCESS TASK FORCE

FROM: Jeff Gingold
Vice President, General Counsel
BLUE CROSS OF WASHINGTON AND ALASKA

Blue Cross of Washington and Alaska is an independent, non-profit organization licensed as a prepaid health care services contractor in Washington and a hospital and medical services contractor in Alaska. As such, Blue Cross is one of the largest administrators of private and government health care programs in both states.

Committed to responding to the needs of Washington and Alaska residents, Blue Cross is recognized as a leader in the development of integrated and innovative products and services which provide access to quality, affordable health care and benefit programs.

ALASKANS COVERED BY BLUE CROSS OF WASHINGTON AND ALASKA

BCWA covered approximately 81,000 Alaska citizens, including Federal Employees, in 1990. This represented about 30% of the insured population and 20% of the total population.

COVERED ALASKANS
AS OF 12/31/91

(Not including Federal Employees)

<u>CATEGORY</u>	<u>GROUPS</u>	<u>SUBSCRIBERS (EMPLOYEES)</u>	<u>MEMBERS</u>
<u>Individual</u>	-	5,083	10,437
<u>Groups</u>			
5 to 24	245	2,857	5,418
25 to 99	68	3,453	6,002
100+	69	19,057	50,044
<u>GRAND TOTAL</u>	<u>382</u>	<u>30,450</u>	<u>71,901</u>

TRENDS

Source: Noble Lowndes

PRIMARY FACTORS:

- * Inflation - increased cost of medical services
- * Leveraging - reduced buying power of deductibles and coinsurance
- * Cost-shifting - reduced Medicaid and Medicare reimbursements
 - .. RBRVS - statewide versus geographic movement of services from office to institution
 - .. HCFA proposed not to fund hospital bonds
 - .. Federal versus state Medicaid - federal funding to decrease
 - .. HHS regulates referrals by providers to invested business' - increase non-Medicare/Medicaid referrals
- * Anti-Selection - shifting of employees to managed care
- * Technological Advances - increasing costs of equipment and services
- * Social Shifts - requirements to allocate funds for AIDS, psychiatric and substance abuse care
- * Utilization - increasing use of equipment and services

OUT-OF-STATE SERVICES

Alaskans covered by group plans received 22% of their services (measured by cost) out-of-state. Individual (non-group) enrollees received 29% of their care outside of Alaska. The combined total was 23%.

MEDICAL UNDERWRITING

BCWA declines approximately 10% of medically underwritten applications. However, this probably overstates the affects on overall access. Most enrollees are not medically underwritten. Of those who are, individuals declined by one carrier may apply to other carriers. Some will be accepted for coverage; others may be declined more than once and this would be inflate the percentage.

DEPENDENT COVERAGE
(Group Contracts)

On average, BCWA covered approximately 2.4 members (people) per contract (employee/subscriber) in Alaska compared to 1.8 members per contract in Washington. This equates to 1.4 dependents per subscriber.

The following are eligible to be enrolled as dependent children:

- . a natural child of the subscriber or spouse
- . an adopted child of the subscriber or spouse
- . a legally designated minor ward of the subscriber or spouse that meets BCWA's legal guardianship criteria
- . a child that has been physically placed with the subscriber, in accordance with state law, for the purpose of adoption.

Eligible children must also be under 23 years old, unmarried, and claimed as dependents on the subscriber's federal income tax return. However, if an otherwise eligible child does not qualify to be claimed as a dependent on the subscriber's federal income tax return, that child will be eligible if the subscriber or subscriber's eligible spouse is required by court order to provide health care coverage for that child. An optional eligibility provision for experience-rated groups covers dependent children until age 19 and then from age 19 to age 23 if the dependent child is a full-time student attending an accredited educational institution. Coverage may continue past the limiting age for an unmarried dependent child who cannot support himself or herself because of a developmental or physical disability, providing we are provided with proof of the child's disability and dependent status.

Any care connected with a dependent child's pregnancy is excluded except for care furnished in the direct treatment of a complication of pregnancy. Experience-rated groups have the option of providing obstetrical care benefits (pregnancy, childbirth, and related conditions) for dependent children.

Hospital nursery care at birth for a well baby will be covered, provided the mother is an inpatient and is receiving benefits for obstetrical delivery under the contract. Charges for nursery care for a well baby are combined with the mother's hospital charges and benefits are provided under the mother's coverage. The following physician services for well baby care during the initial hospital confinement of the newborn at birth are covered and provided under the enrolled baby's coverage:

- . The initial newborn examination and a second examination performed prior to discharge from the hospital.
- . Circumcision.

Hospital and physician nursery care for an ill baby is covered as any other medical condition under the enrolled baby's coverage.

Outpatient preventive care benefits for children are available to experience-rated groups as an optional provision.

ADVANTAGECARE

Synopsis:

AdvantageCare is a cost containment program designed to promote the most cost-effective setting for medically necessary care. The program consists of a combination of several interrelated Blue Cross services which include:

Preadmission Review: Initial call from a hospital, physician's office staff or enrollee when a nonemergent hospital admission is planned. During the call a determination is made regarding the medical necessity of the inpatient level of care.

Admission Review: Call initiated after an urgent or emergent admission has taken place. The inpatient admission is reviewed for medical necessity and appropriateness of the inpatient level of care.

Length of Stay Assignments: At the time of preadmission or admission review the AdvantageCare nurse assigns a target "length of stay", or number of inpatient days initially approved for the proposed treatment plan. Assignment of a length of stay is automated and is per the Professional Activity Study (PAS) 50th percentile, Western Region, with some modifications indicated by local Blue Cross experience.

Concurrent Review: Telephonic review with the hospital occurs when the enrollee remains in the hospital beyond the initial assigned length stay. Concurrent review is focused so that the process can be individualized depending on the cost saving mechanisms the hospital currently utilizes. Once the medical necessity of the enrollee's continued stay is established, another length of stay is assigned based on the information received regarding the plan of care. When appropriate, the case is referred to Individual Case Management.

Individual Case Management: AdvantageCare nurses identify case situations in which intervention may provide a more cost-effective and care-effective alternative. Any alternatives proposed are discussed further with the discharge planner, the enrollee, and their physician.

BESTBEGINNINGS

Synopsis:

BestBeginnings is a prenatal program designed to help reduce the high dollar costs and complications associated with low birth weight and premature infants by promoting education about prenatal care and encouraging women to adopt healthy life styles.

Enrolled expectant mothers are encouraged to call a BestBeginnings' registered nurse in the first trimester of pregnancy. The caller is interviewed to identify areas of potential problems during the pregnancy. A packet of educational and informational materials is sent to the participant. Follow-up calls are made two weeks after the materials are mailed to see if the information was received and whether there are any questions. The nurse will keep in touch with the expectant mothers throughout pregnancy to educate and support them.

All participants are encouraged to obtain regular maternity care. The BestBeginnings nurse will assist (as needed) the woman to clarify her provider's instructions and explanations. The nurse will support the provider's plan of care. When necessary, the nurse can initiate Individual Case Management through the patient's physician to coordinate needed services. The BestBeginnings program is included in all community-rated group programs as the groups renew and is available as an option for experience-rated groups.

ALASKA STATE MANDATED HEALTH BENEFITS
(Group Contracts)

ALCOHOLISM & DRUG ABUSE TREATMENT
Insurance Law: AS 21.42.365

Synopsis:

Coverage for treatment of alcoholism or drug abuse must provide:

- . benefits of at least \$7,000 over two consecutive benefit years; and lifetime benefits of at least \$14,000

The insurer may not:

- . impose a different deductible or copayment, claim payment methodology, or prenotification of treatment requirement than that used in determining the benefits for treating another covered illness;
- . limit coverage by provisions that are not applicable to other covered major illnesses;
- . limit treatment services to either an inpatient or outpatient service;
- . exclude from coverage the cost of medically necessary treatment received at an approved treatment facility;
- . or deny reimbursement for actual services rendered solely because treatment was interrupted or not completed.

Cost Impact:

Covered expenses for alcoholism/drug abuse treatment represent approximately 2%-3% of the average health care program's total medical benefit payments.

ALASKA STATE MANDATED HEALTH BENEFITS
(Group Contracts)
(Continued)

MAMMOGRAM SCREENING
Insurance Law: AS 21.42.375

Synopsis:

Coverage for low-dose mammography screening must be provided on a basis that is not less favorable than for other radiological examinations. The minimum coverage required includes:

- . a baseline mammogram for a person who is at least 35 years of age but less than 40 years of age;
- . one mammogram every two years for a person who is at least 40 years of age but less than 50 years of age;
- . an annual mammogram for a person who is at least 50 years of age;
- . a mammogram at any age for a person with a history of breast cancer or whose parent or sibling has a history of breast cancer, upon referral by physician.

Cost Impact:

Coverage of mammogram screening in our health care programs has resulted in an additional cost of .7% - 1.4%. It is assumed these costs will be partially offset long term by a medical claims savings resulting from this screening procedure.

ALASKA STATE MANDATED HEALTH BENEFITS
(Group Contracts)
(Continued)

COVERED PROVIDERS

Insurance Law: AS 21.36.090(d)

Synopsis:

Benefits must be provided without discrimination for services rendered within the scope of his-her occupational license by a state licensed physician (M.D.), dentist, osteopath, optometrist, chiropractor, nurse midwife, advanced nurse practitioner, naturopath, physical therapists, or occupational therapist.

Cost Impact:

Cost impact varies depending on which provider type is being analyzed. The following are examples of cost impact (as a percentage of medical expenses) for various provider types:

Chiropractor	2%-3%
Naturopath	.1%
Physical/Occupational Therapist	.5%
Physician (including osteopath & podiatrist)	28%
Psychologist/psychiatrist	1%-2%
Optometrist (including ophthalmologist for routine vision exams)	34%
Dentist	15%-16%

1990 AVERAGE CHARGE COMPARISON

Source: Blue Cross and Blue Shield Association

CPT4 CODES	ALASKA REGIONS				TOTAL ALASKA	TOTAL WASH	NATL	
	01	02	03	04				
PHYSICIAN OFFICE-NEW PATIENT								
90015	Intermediate	\$80	\$113	\$76	\$128	\$82	\$61	\$51
90020	Comprehensive	141	173	144	245	143	117	90
PHYSICIAN OFFICE-ESTABLISHED PATIENT								
90060	Intermediate	59	70	58	77	61	44	38
90080	Comprehensive	124	173	124	188	130	96	73
HOSPITAL MEDICAL SERVICES								
90220	Initial, Comprehen	189	202	202	275	195	140	124
90250	Subsequent Visit	64	63	59	80	64	46	52
CONSULTATIONS								
90620	Initial, Comprehen	181	198	180	375	183	147	134
PSYCHOTHERAPY								
90844	Individual 45-50 minutes	93	101	79	59	92	85	87

1990 AVERAGE CHARGE COMPARISON

Source: Blue Cross and Blue Shield Association

CPT4 CODES	ALASKA	WASHINGTON	NATIONAL
INTEGUMENTARY			
10060 Incision & Drainage Abscess	\$60	\$47	\$63
11100 Biopsy of Skin, One Lesion	83	61	68
19120 Excision Benign Breast Tumor	669	469	483
MUSCULOSKETETAL			
20610 Arthrocentesis, Major Joint	79	48	56
29881 Arthroscopy, w/Biopsy, Flexible	1,974	1,597	1,547
RESPIRATORY			
31625 Bronchoscopy, w/Biopsy, Flexib	593	492	465
CARDIOVASCULAR			
33513 Coronary, Artery Bypass, 4 Art	7,500	5,373	4,841
92982 Coronary Angioplasty	2,118	1,708	1,807
DIGESTIVE			
43235 Upper GI Endoscopy	435	379	415
44950 Appendectomy	1,276	888	799
45300 Proctosigmoidoscopy, Diagnosti	79	66	76
MALE GENITAL			
55700 Needle Biopsy of Prostate	373	161	232
FEMALE GENITAL			
58120 Dilation & Curettage	507	437	466
58150 Total Hysterectomy	2,112	1,882	1,554
MATERNITY			
59400 Normal Delivery w/Pre & Postna	1,492	1,884	1,588
OTHER			
72131 CT Scan - Spine	205	216	261
72141 MRI - Spine	453	630	574

Blue Cross of Washington and Alaska
Summary of Institutional Inpatient Admissions by Diagnosis Category
Alaska Subscribers
Incurred from 01/90 through 09/90

Diagnosis Category	Diagnosis Descriptions	Average Length of Stay	Eligible Charge per Admit	Eligible Charge per Day	Admits per 1000 Members	Days per 1000 Members	Elig Chrg per 1000 Members
001 - 139	Diseases - Infective/Parasitic	6.10	\$9,124	\$1,497	0.81	4.95	\$7,414
140 - 239	Neoplasms	5.58	\$9,138	\$1,639	2.36	13.16	\$21,563
240 - 279	Diseases - Endocrine, Nutritional, Metabolic	3.13	\$4,290	\$1,372	0.73	2.30	\$3,151
280 - 289	Diseases - Blood/Blood Organ	2.45	\$3,312	\$1,349	0.17	0.42	\$569
290 - 319	Mental Disorders	14.47	\$6,993	\$483	3.28	47.49	\$22,948
320 - 389	Diseases - Nervous Systems/Sense Organs	3.78	\$4,583	\$1,212	0.78	2.95	\$3,581
390 - 459	Diseases - Circulatory System	5.09	\$11,012	\$2,163	3.27	16.63	\$35,965
460 - 519	Diseases - Respiratory System	3.42	\$4,554	\$1,331	2.92	10.00	\$13,307
520 - 579	Diseases - Digestive System	4.17	\$6,237	\$1,494	3.84	16.05	\$23,976
580 - 629	Diseases - Genitourinary System	3.15	\$4,928	\$1,565	2.63	8.27	\$12,937
630 - 679	Delivery/Complications of Preg/Birth	3.31	\$3,858	\$1,166	10.58	34.99	\$40,811
680 - 709	Diseases - Skin/Subcutaneous Tissue	3.89	\$4,482	\$1,151	0.30	1.16	\$1,331
710 - 739	Diseases - Musculoskeletal System	3.98	\$6,494	\$1,632	2.27	9.02	\$14,715
740 - 759	Congenital Anomalies	2.65	\$5,878	\$2,215	0.41	1.08	\$2,388
760 - 779	Diseases Peculiar to Newborn Infants	10.26	\$18,682	\$1,822	0.67	6.89	\$12,554
780 - 799	Symptoms and Ill-defined Conditions	2.95	\$4,264	\$1,448	2.30	6.77	\$9,796
800 - 999	Injury and Adverse Effects	4.17	\$7,106	\$1,704	3.69	15.38	\$26,208
9--	Supplementary Classification	6.45	\$11,333	\$1,757	1.08	6.95	\$12,220
Total		4.86	\$6,307	\$1,298	42.08	204.45	\$265,434

SMALL GROUP MARKET

Blue Cross of Washington and Alaska Community rates groups of 5 to 99 employees.

Groups of 5 to 14 employees are medically underwritten (health statement required/proof of good health) on an accept/reject basis for the group. If the group is accepted, the individuals are allocated a risk code and two levels of rates are developed. The first set of rates provide coverage for all individuals. The second set of rates cover only those individuals with acceptable risk codes. The group elects which approach they wish to enroll on.

Groups of 15 to 99 employees are quoted on a guarantee issue basis.

Rates for Community groups are developed from base product rates which are adjusted for group demographics (size, age, sex, area, industry, contribution, participation, dependent content, medical conditions, etc.) trend, workplace smoking policy, HMO availability, duration of coverage, experience and expenses. Each group will have a unique rate under this rating approach.

January 17, 1992

VIA FACSIMILE

TO: Nancy Cornwell, Project Director
Health Resources and Access Task Force

FROM: Phyllis Finn
for Jeff Gingold

SUBJECT: RESPONSE TO YOUR QUESTIONS

Jeff Gingold asked that I get this response to you today by FAX as he had to be absent from the office and you would be expecting this response from BCWA.

1. The federal employees in the State of Alaska have approximately thirteen carriers from which to choose their medical coverage each year. Blue Cross Blue Shield Service Benefit Plan is one of the options. There are 18,763 federal employees in Alaska. Out of that number we have a total of 7,286 or 39% as of April 1991. Our Open Season gains have brought this number of enrolled up to 7,488 as of January 10, 1992.
2. For Alaskans covered by group plans that receive their services out-of-state, Blue Cross has no way of knowing whether the member happened to be out-of-state when a medical condition that needed attention came up or if a trip was made expressly to seek medical services out-of-state. Either way, all services would have to be "medically necessary" to be covered. We would have no way of determining if these out-of-state services were for acute care only---we would surmise many are covered students at out-of-state schools or working out-of-state. This would also encompass the Alaskan who lives in another state for part of each year or is traveling or on vacation. So, basically, the response would be that no, all out-of-state services are not for acute care only.
3. What size groups does BCWA use medical underwriting and how many in this group? BCWA medically underwrites groups size 5 - 14. There are 168 groups in this category; 1,403 subscribers (employees) or 2,695 members.
4. BCWA does not use DRGs in our claims payment. For this reason we would not be able to furnish you with any comparisons for Washington State. On the national level, if it would be helpful to you, we could check with other Blue Cross Blue Shield plans across the country and ask if any of them have any DRG charts available that could be used for a comparison. Please let us know if this would be useful for you to have.

5. In attempting to respond to your question on how Alaska compares to Alaska for overall charges, physician and hospital charges, etc., our data indicates that physician charges are generally higher in Alaska than in Washington.

It is more difficult to compare average hospital costs and lengths of stay because of differences in the way data is accumulated. Averages can be misleading because of variations in case mix (diagnoses of different complexity groups together, complications for specific diagnoses, and physician condition of patients), and variations in types of institutional providers between the two states.

Subject to these disclaimers, our data shows that institutional costs per day appear higher in Alaska, but length of stay appears longer in Washington.

pf

APPENDIX J

Health Care Legislation Under Consideration
By the Health Resources and Access Task Force

HOUSE CS FOR CS FOR SENATE BILL NO. 44 (STATE AFFAIRS)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY THE HOUSE STATE AFFAIRS COMMITTEE

Offered: 5/17/91

Referred: Finance

Sponsor(s): SENATORS KERTTULA, Pourchot, Duncan

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to the establishment and operation of state veterans' home facilities; and
2 providing for an effective date."

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

4 * Section 1. PURPOSE. The purpose of this Act is to direct the Department of Military and
5 Veterans' Affairs to establish and operate state veterans' homes in a manner that would make them
6 eligible for the maximum amount of federal funds.

7 * Sec. 2. AS 18.07.111(9) is amended to read:

8 (9) "health care facility" means a private, municipal, state, or federal hospital,
9 psychiatric hospital, tuberculosis hospital, skilled nursing facility, kidney disease treatment center
10 (including freestanding hemodialysis units), intermediate care facility, and ambulatory surgical
11 facility; the term excludes

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

14 (B) the offices of private physicians or dentists whether in individual or

1 group practice; and

2 (C) a state veterans' home administered by the Department of

3 Military and Veterans' Affairs;

4 * Sec. 3. AS 44.35.020 is amended by adding a new subsection to read:

5 (c) The Department of Military and Veterans' Affairs shall apply for federal assistance
6 to establish and operate state veterans' home facilities. The department, within available funds,
7 shall establish and operate veterans' homes in the Matanuska-Susitna Valley area and at other
8 sites designated by the adjutant general.

9 * Sec. 4. This Act takes effect immediately under AS 01.10.070(c).

SENATE BILL NO. 45

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATOR KERTTULA

Introduced: 1/21/91

Referred: State Affairs and Finance

Funding Information: General Fund \$3,000,000

Other Funds -0-

\$3,000,000

A BILL

FOR AN ACT ENTITLED

1 "An Act making an appropriation to the Department of Administration for establishment
2 of a state veterans' home; and providing for an effective date."

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

4 * Section 1. The sum of \$3,000,000 is appropriated from the general fund to the Department of
5 Administration for the state share of the cost of applying for federal funds, conducting a feasibility study
6 for a state veterans' home, acquiring land for a state veterans' home, and planning, designing, and
7 constructing or otherwise acquiring a state veterans' home.

8 * Sec. 2. The appropriation made by this Act is for a capital project and is subject to lapse under
9 AS 37.25.020.

10 * Sec. 3. This Act takes effect on the effective date of an Act enacted by the Seventeenth Alaska
11 State Legislature directing the Department of Administration to establish and operate a state veterans'
12 home.

HOUSE CS FOR CS FOR SENATE BILL NO. 67 (FINANCE)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY THE HOUSE FINANCE COMMITTEE

Offered: 5/21/91

Referred: Rules

Sponsor(s): SENATORS JONES, Zharoff, Menard, Hoffman

REPRESENTATIVE Taylor

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to state aid for health facilities; and providing for an effective date."

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

3 * Section 1. AS 18.25 is amended by adding new sections to read:

4 Sec. 18.25.011. GRANT APPLICATIONS. (a) On or before June 15, a person,
5 including a municipality, may submit a grant application to the department for a health facility
6 construction grant.

7 (b) A project for which a certificate of need is required under AS 18.07.031 - 18.07.111
8 at the time of the grant application is not eligible for a grant under AS 18.25.011 - 18.25.035
9 unless a certificate has been issued to the health facility that is the subject of the application, and
10 the certificate is in effect at the time of the application.

11 (c) A project is not eligible for a grant under AS 18.25.011 - 18.25.035 unless the
12 applicant has submitted a five-year master plan for the construction of the health facility on or
13 before September 1 of the fiscal year in which the application is submitted; the master plan must
14 include a description of the applicant's fixed asset inventory system and preventive maintenance

1 program, a detailed scope of work, an estimated project budget, an operation, maintenance, and
2 financial feasibility study, and a documentation of the conditions justifying the project, including
3 a signed statement by an architect or engineer verifying any code violation documented in the
4 plan.

5 (d) The grant application must include

6 (1) evidence that the applicant has secured and will maintain adequate property
7 loss insurance for the replacement cost of the health facility or a program of insurance acceptable
8 to the department; and

9 (2) evidence acceptable to the department that the proposed project is a capital
10 construction project and not part of a preventive maintenance program or regular custodial care
11 program.

12 Sec. 18.25.013. HEALTH FACILITIES REVIEW BOARD ESTABLISHED. (a) There
13 is created in the Department of Health and Social Services the Health Facilities Review Board
14 composed of seven members consisting of the following persons appointed by the governor and
15 who serve at the pleasure of the governor:

16 (1) an architect licensed under AS 08.48;

17 (2) an engineer licensed under AS 08.48;

18 (3) a representative nominated by the Alaska Municipal League;

19 (4) a representative from the department;

20 (5) a representative of a health facility;

21 (6) a representative of the Alaska Area Native Health Service; and

22 (7) a representative of the office of management and budget in the Office of the

23 Governor.

24 (b) To the extent possible and except for the board members described under (a)(4) and
25 (7) of this section, the board members must be representative of all areas of the state.

26 (c) The members serve for staggered terms of three years.

27 (d) The members of the board shall elect a member of the board as chair.

28 (e) The board shall hold at least one meeting each year. The board may hold additional
29 meetings at the call of the chair or of a majority of the board members.

30 Sec. 18.25.015. BOARD DUTIES. (a) The board shall annually

31 (1) review the master plans submitted by applicants under AS 18.25.011;

1 (2) with regard to the plans reviewed under (1) of this subsection, establish and
2 transmit to the department a revised and updated five-year construction grant schedule that
3 establishes the priorities among the proposed health facility construction projects and serves the
4 best interest of the state and the municipality or area in which the health facility is located.

5 (b) The primary criteria for establishing the priorities under (a) of this section are
6 (1) the degree of threat to the health or safety of facility occupants; and
7 (2) the degree of potential harm to building integrity as it affects the building's
8 ability to support health care functions in a cost-effective manner.

9 (c) The board shall establish by regulation additional criteria for establishing the priorities
10 under (a) of this section. The criteria must include at least the following factors:

- 11 (1) the ability of the project or project phase to be self-supporting;
12 (2) access to other sources of funding, including funding from the parent
13 corporation of the health facility, if applicable;
14 (3) the overall capital requirements and operating cost efficiency over the lifetime
15 of the facility;
16 (4) the community or area need for the facility as compared to alternative means
17 for providing the care;
18 (5) the level of care required to provide basic cost effective and efficient health
19 services;
20 (6) the effect of the grant award on the overall position of the applicant as
21 compared to health facilities that are not eligible to receive grants under AS 18.25.011 -
22 18.25.035.

23 (d) The board may reject a grant application and omit it from the construction grant
24 schedule if

- 25 (1) the applicant provides incomplete information or documentation on the project;
26 (2) the board determines that existing facilities can adequately serve the program
27 requirements, or that an alternative project is in the best interests of the state; or
28 (3) the board determines that the project is not in the best interests of the state
29 or the municipality or area in which the health facility is located.

30 Sec. 18.25.017. DEPARTMENT ACTION. (a) Before a grant application is submitted
31 to the board, the department shall verify the amounts and reasons for the items in the budget for

1 each grant application.

2 (b) With regard to the construction grant schedule established by the board under
3 AS 18.25.015, the department shall transmit the construction grant schedule, including the
4 budgets verified under (a) of this section, to the governor by October 15 of each year and to the
5 legislature within the first 10 days of each regular legislative session.

6 Sec. 18.25.019. PUBLIC NOTICE AND HEARING. On or before July 15 of each year,
7 the department shall provide public notice of the grant applications made under AS 18.25.011
8 and the priorities established under AS 18.25.015. After public notice has been given, the
9 department shall, not later than August 15 of each year, hold a public hearing on the priorities
10 established under AS 18.25.015. In this section, "public notice" means notice published in a
11 newspaper of general circulation and notice to each person who has requested notice about the
12 grant requests from the department.

13 Sec. 18.25.021. AWARD. (a) The department shall award grants in the order of the
14 projects' priorities on the date the appropriation bill funding the health facility construction grant
15 fund becomes law, regardless of an administrative or judicial review pending under
16 AS 18.25.023. An administrative or judicial review pending under AS 18.25.023 at the time that
17 grants are awarded may not delay the funding of grants.

18 (b) If a project is assigned a new priority ranking under AS 18.25.023 after the date the
19 appropriation bill for the health facility construction grant fund becomes law, a grant shall be
20 awarded for the project in accordance with the new priority ranking at the next time that health
21 facility construction grants are awarded under AS 18.25.011 - 18.25.035.

22 Sec. 18.25.023. ADMINISTRATIVE AND JUDICIAL REVIEW. (a) An applicant
23 under AS 18.25.011 may not request reconsideration of a decision of the board unless the request
24 is based on reasonable issues of fact or law. The request must be in writing and include a
25 statement of the specific changes desired, and a summary of the evidence supporting the
26 applicant's claim that the board has erred in its review of the applicant's grant application. A
27 request for reconsideration must be submitted to the board by the first day of the public hearing
28 held under AS 18.25.019. The board shall review its decision on the basis of the request by the
29 applicant and determine whether its decision should be changed. The board shall issue its
30 determination in writing within 15 days after the last day of the public hearing held under
31 AS 18.25.019.

1 (b) An applicant under AS 18.25.011 may appeal an adverse decision of the board under
2 (a) of this section by filing a written notice of appeal with the commissioner within 15 days after
3 the date of the board's decision. The notice of appeal must state the legal and factual basis for
4 the appeal and the precise relief sought. The failure of the applicant to include an issue in a
5 notice of appeal constitutes a waiver of the right to have the issue considered. Not later than 10
6 days after receipt of a notice of appeal, the commissioner shall appoint a hearing officer who is
7 qualified under AS 44.62.350(c) to consider the appeal. If the hearing officer finds that the
8 notice of appeal does not raise a reasonable issue of fact or law, the hearing officer shall issue
9 a written decision denying the appeal. Denial of an appeal by a hearing officer is a final decision
10 that may be appealed under (d) of this section. If the hearing officer finds that the notice of
11 appeal raises a reasonable issue of fact or law, the hearing officer shall conduct a hearing on
12 those issues and recommend a decision to the commissioner. The hearing officer shall issue a
13 decision on the appeal not later than 60 days after being appointed. The commissioner shall
14 consider the recommended decision of the hearing officer within 10 days after receipt and may
15 adopt all, part, or none of the recommended decision or may remand the issue to the hearing
16 officer for further hearings. The commissioner shall issue a decision in writing within 10 days
17 after consideration of the hearing officer's decision.

18 (c) The hearing officer may consolidate appeals under (b) of this section if the notices
19 of appeal raise related issues of fact or law.

20 (d) An applicant under AS 18.25.011 may appeal an adverse decision of a hearing officer
21 or the commissioner under (b) of this section to the superior court in the manner provided by
22 AS 44.62.560 - 44.62.570 and the Alaska Rules of Appellate Procedure.

23 (e) The board shall adopt regulations governing procedures for the reconsideration and
24 appeal of decisions under (a) - (c) of this section. The regulations adopted under this subsection
25 are not required to conform to AS 44.62.330 - 44.62.630, but must be consistent with minimum
26 standards of due process.

27 (f) An applicant under AS 18.25.011 may not request reconsideration of or appeal a
28 priority determination on the grounds that a revised priority assigned to another project, due to
29 a reconsideration or appeal under this section, has resulted in a lower priority being accorded to
30 the applicant's project.

31 Sec. 18.25.025. GRANT AGREEMENT AND CONDITIONS. (a) The department shall

1 enter into a written agreement with the grantee before it distributes grant funds under
2 AS 18.25.011 - 18.25.035.

3 (b) The department shall require in the grant agreement that the grantee

4 (1) agree to construction of the health facility as described by the certificate of
5 need, if any, issued to the facility under AS 18.07.031 - 18.07.111;

6 (2) provide reasonable assurance by a means acceptable to the department that
7 the cost of the project will be uniform with the costs of the most current construction projects
8 in the area;

9 (3) agree to submit to the department for department approval a description and
10 justification of a cost overrun before the grantee agrees to pay for the overrun and before the
11 department distributes money to the grantee to pay for the overrun;

12 (4) agree to place the grant funds in an interest-bearing account and not to use
13 the interest or the grant funds for a purpose other than the project;

14 (5) agree to limit equipment purchases to that required for the facility operation;

15 (6) submit project budgets for department review and agree that the grant amount
16 may, at the discretion of the department, be reduced or increased by amounts equal to the
17 amounts by which contracts vary from the budget amounts approved by the department;

18 (7) submit to the department for approval, before advertising for bids for the
19 construction contract, a plan for construction that includes specifications, final construction
20 drawings, and proposed contract documents;

21 (8) submit for department review a tabulation of all bids received, a complete
22 copy of the lowest bid, a copy of the proposed notice to proceed with construction, and a copy
23 of the proposed construction contract;

24 (9) submit for department review and acceptance documentary evidence that the
25 project is being accomplished in accordance with all the assertions in the grantee's five-year
26 master plan and grant application;

27 (10) submit sufficient assurances that the project will be used for the stated
28 purposes of the grant for the expected useful lifetime of the facility;

29 (11) agree to conform to all applicable governmental codes and standards,
30 including the most recently adopted state statutes and regulations on building, health, mechanical,
31 electrical, fire, safety, and handicap accessibility, and those covering the planning, construction,

1 and operation of the health facility;

2 (12) agree to comply with

3 (A) the department's single audit requirements;

4 (B) AS 37.05.321, prohibiting the use of grant funds and earnings to
5 influence legislative action;

6 (C) the reporting requirements of AS 36.05 and AS 36.10; and

7 (D) 42 U.S.C. 2000a - 2000h-6 (Civil Rights Act of 1964), 29 U.S.C. 621-
8 634 (Age Discrimination in Employment Act of 1967), 7 U.S.C. 2027 (Food Stamp Act
9 of 1977), and the department's requirements for implementation of the federal statutes
10 listed in this subparagraph;

11 (13) identify anticipated operating costs and revenue and the sources of funding
12 that may be requested if costs exceed projected revenue;

13 (14) complete the project in a timely manner to a fully functional condition and
14 submit periodic status reports not less than every six months to the department detailing work
15 completed to date, a summary of expenditures compared with the approved budget, and an
16 explanation of any deviation from the approved work, schedule, or budget; and

17 (15) agree to comply with other requirements that the department, notwithstanding
18 AS 37.05.318, may reasonably impose on grantees and that are necessary to meet the intent of
19 the grant.

20 (c) Except as provided under (b) or (d) of this section, a cost of construction for a health
21 facility may be paid under a grant awarded under AS 18.25.021 without regard to whether the
22 cost was incurred before the

23 (1) award of the grant; or

24 (2) effective date of an appropriation to the health facility construction grant fund
25 for the year in which the grant is funded.

26 (d) The maximum percentage of the costs of planning and designing, including
27 engineering, that are incurred before awarding a grant and that may be paid under the grant may
28 not exceed 15 percent.

29 (e) The grantee may not satisfy more than five percent of the grantee's share of the total
30 cost of the health facility with items other than cash.

31 (f) Except as limited by (e) of this section, the fair market value of land acquisition and

1 site preparation may be included in the grantee's share of the total cost of the health facility.
2 The fair market value shall be determined as of the date when the grant application is submitted
3 under AS 18.25.011.

4 (g) The direct expenses of the grantee to administer the project may not exceed 10
5 percent of the grant.

6 Sec. 18.25.027. GRANT APPROPRIATIONS. Within the general appropriation bill
7 submitted to the legislature under AS 37.07.020, the governor shall include an appropriation for
8 health facility construction grants in the succeeding fiscal year as determined by the priority list
9 and budgets transmitted to the governor under AS 18.25.017.

10 Sec. 18.25.029. AMOUNT OF GRANTS. For each project included in a grant awarded
11 under AS 18.25.021, the state shall pay 75 percent of the total costs of construction incurred for
12 the project by the grantee during the fiscal year for which the grant is made.

13 Sec. 18.25.031. DISTRIBUTION OF GRANT. After the effective date of the agreement
14 for a grant under AS 18.25.011 - 18.25.035, the department shall advance 20 percent of the grant
15 to the grantee. The department shall base subsequent payments from the grant on payment
16 requests submitted by the grantee for the costs of construction incurred by the grantee for the
17 grant project. The department may not make a further payment under the grant until the grantee
18 has exhausted the advance.

19 Sec. 18.25.033. HEALTH FACILITY CONSTRUCTION GRANT FUND. The health
20 facility construction grant fund is created as an account in the general fund. The fund shall be
21 used to make grants under AS 18.25.011 - 18.25.035 for the costs of construction of health
22 facilities. Legislative appropriations under AS 18.25.011 - 18.25.035 for the costs of construction
23 of health facilities shall be deposited in the fund.

24 Sec. 18.25.035. DEFINITIONS. In AS 18.25.011 - 18.25.035,

25 (1) "board" means the Health Facilities Review Board;

26 (2) "costs of construction" means the cost of acquiring, constructing, enlarging,
27 repairing, remodeling, equipping, or furnishing health facilities and includes the total of all costs
28 of financing and carrying out the project, including

29 (A) the cost of necessary studies, surveys, plans and specifications,
30 architectural, engineering and other special services, the acquisition of real property, site
31 preparator. and development, and the acquisition of machinery and equipment necessary

- 1 for the project;
- 2 (B) the direct expenses of the grantee to administer the project;
- 3 (C) the cost of financing the project, including interest on bonds issued
- 4 to finance the project; and
- 5 (D) the cost of other items, including indemnity and surety bonds and
- 6 premiums on insurance, legal fees, fees and expenses of trustees, depositaries, financial
- 7 advisors, and paying agents for the bonds issued;
- 8 (3) "health facility" means a nursing home or a facility that provides
- 9 hospitalization for inpatient medical and surgical care of acute illness or injury or obstetric care,
- 10 but does not include a nursing home or facility that has more than 200 beds.
- 11 * Sec. 2. AS 18.25.035(3) is repealed and reenacted to read:
- 12 (3) "health facility" means a nursing home or a facility that provides
- 13 hospitalization for inpatient medical and surgical care of acute illness or injury or obstetric care.
- 14 * Sec. 3. AS 18.25.100 is repealed and reenacted to read:
- 15 Sec. 18.25.100. REGULATIONS. The department shall adopt regulations to implement
- 16 this chapter.
- 17 * Sec. 4. AS 46.11.900(7) is amended to read:
- 18 (7) "state financial assistance" means a loan, grant, guarantee, insurance, payment,
- 19 rebate, subsidy, or other form of state assistance other than aid under AS 05.35.010 - 05.35.070,
- 20 AS 14.11, AS 18.25.011 - 18.25.035, and AS 29.60, including the purchase by a state agency of
- 21 a loan to finance the construction or purchase of a residential building;
- 22 * Sec. 5. AS 18.25.010, 18.25.020, 18.25.030, 18.25.070, 18.25.080, 18.25.090, and 18.25.110 are
- 23 repealed.
- 24 * Sec. 6. Section 2 of this Act takes effect July 1, 1996.
- 25 * Sec. 7. Except as provided in sec. 6, this Act takes effect July 1, 1991.

CS FOR HOUSE BILL NO. 214 (HES)**IN THE LEGISLATURE OF THE STATE OF ALASKA****SEVENTEENTH LEGISLATURE - FIRST SESSION****BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE**

Offered: 4/5/91

Referred: Finance

Sponsor(s): REPRESENTATIVES DAVIDSON, Kubina, Koponen, C.Davis, Taylor, Gonzales

A BILL**FOR AN ACT ENTITLED**

1 "An Act relating to state aid for nonprofit health facilities; and providing for an effective
2 date."

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

4 * Section 1. AS 18.25 is amended by adding new sections to read:

5 Sec. 18.25.011. GRANT APPLICATIONS. (a) On or before June 15, a municipality
6 or a nonprofit organization may submit a grant application to the department for a nonprofit
7 health facility construction grant.

8 (b) A project for which a certificate of need is required under AS 18.07.031 - 18.07.111
9 at the time of the grant application is not eligible for a grant under AS 18.25.011 - 18.25.035
10 unless a certificate has been issued to the health facility that is the subject of the application, and
11 the certificate is in effect at the time of the application.

12 (c) A project is not eligible for a grant under AS 18.25.011 - 18.25.035 unless the
13 applicant has submitted a five-year master plan for the construction of the health facility on or
14 before September 1 of the fiscal year in which the application is submitted; the master plan must

1 include a description of the applicant's fixed asset inventory system and preventive maintenance
2 program, a detailed scope of work, an estimated project budget, an operation, maintenance, and
3 financial feasibility study, and a documentation of the conditions justifying the project, including
4 a signed statement by an architect or engineer verifying any code violation documented in the
5 plan.

6 (d) The grant application must include

7 (1) evidence that the applicant has secured and will maintain adequate property
8 loss insurance for the replacement cost of the health facility or a program of insurance acceptable
9 to the department; and

10 (2) evidence acceptable to the department that the proposed project is a capital
11 construction project and not part of a preventive maintenance program or regular custodial care
12 program.

13 Sec. 18.25.013. HEALTH FACILITIES REVIEW BOARD ESTABLISHED. (a) There
14 is created in the Department of Health and Social Services the Health Facilities Review Board
15 composed of seven members consisting of the following persons appointed by the governor and
16 who serve at the pleasure of the governor:

17 (1) an architect licensed under AS 08.48;

18 (2) an engineer licensed under AS 08.48;

19 (3) a representative nominated by the Alaska Municipal League;

20 (4) a representative from the department;

21 (5) a representative of a nonprofit health facility;

22 (6) a representative of the Alaska Area Native Health Service; and

23 (7) a member of the general public.

24 (b) The members serve for staggered terms of three years.

25 (c) The members of the board shall elect a member of the board as chair.

26 (d) The board shall hold at least one meeting each year. The board may hold additional
27 meetings at the call of the chair or of a majority of the board members.

28 Sec. 18.25.015. BOARD DUTIES. (a) The board shall annually

29 (1) review the master plans submitted by applicants under AS 18.25.011;

30 (2) with regard to the plans reviewed under (1) of this subsection, establish and
31 transmit to the department a revised and updated five-year construction grant schedule that

1 establishes the priorities among the proposed health facility construction projects and serves the
2 best interest of the state and the municipality or area in which the health facility is located.

3 (b) The board shall establish by regulation its criteria for establishing the priorities under
4 (a) of this section. The criteria must include at least the following factors:

- 5 (1) the degree of threat to the health or safety of facility occupants;
- 6 (2) the degree of potential harm to building integrity as it affects the building's
7 ability to support health care functions in a cost effective and efficient manner;
- 8 (3) the ability of the project or project phase to be self-supporting;
- 9 (4) access to other sources of funding;
- 10 (5) the overall capital requirements and operating cost efficiency over the lifetime
11 of the facility;
- 12 (6) the community or area need for the facility as compared to alternative means
13 for providing the care;
- 14 (7) the level of care required to provide basic cost effective and efficient health
15 services;
- 16 (8) the effect of the grant award on the overall position of the applicant as
17 compared to health facilities that are not eligible to receive grants under AS 18.25.011 -
18 18.25.035.

19 (c) The board may reject a grant application and omit it from the construction grant
20 schedule if

- 21 (1) the applicant provides incomplete information or documentation on the project;
- 22 (2) the board determines that existing facilities can adequately serve the program
23 requirements, or that an alternative project is in the best interests of the state; or
- 24 (3) the board determines that the project is not in the best interests of the state
25 or the municipality or area in which the health facility is located.

26 Sec. 18.25.017. DEPARTMENT ACTION. (a) Before a grant application is submitted
27 to the board, the department shall verify the amounts and reasons for the items in the budget for
28 each grant application.

29 (b) With regard to the construction grant schedule established by the board under
30 AS 18.25.015, the department shall transmit the construction grant schedule, including the
31 budgets verified under (a) of this section, to the governor by October 15 of each year and to the

1 legislature within the first 10 days of each regular legislative session.

2 Sec. 18.25.019. PUBLIC NOTICE AND HEARING. On or before July 15 of each year,
3 the department shall provide public notice of the grant applications made under AS 18.25.011
4 and the priorities established under AS 18.25.015. After public notice has been given, the
5 department shall, not later than August 15 of each year, hold a public hearing on the priorities
6 established under AS 18.25.015. In this section, "public notice" means notice published in a
7 newspaper of general circulation and notice to each person who has requested notice about the
8 grant requests from the department.

9 Sec. 18.25.021. AWARD. (a) The department shall award grants in the order of the
10 projects' priorities on the date the appropriation bill funding the nonprofit health facility
11 construction grant fund becomes law, regardless of an administrative or judicial review pending
12 under AS 18.25.023. An administrative or judicial review pending under AS 18.25.023 at the
13 time that grants are awarded may not delay the funding of grants.

14 (b) If a project is assigned a new priority ranking under AS 18.25.023 after the date the
15 appropriation bill for the nonprofit health facility construction grant fund becomes law, a grant
16 shall be awarded for the project in accordance with the new priority ranking at the next time that
17 nonprofit health facility construction grants are awarded under AS 18.25.011 - 18.25.035.

18 Sec. 18.25.023. ADMINISTRATIVE AND JUDICIAL REVIEW. (a) An applicant
19 under AS 18.25.011 may not request reconsideration of a decision of the board unless the request
20 is based on reasonable issues of fact or law. The request must be in writing and include a
21 statement of the specific changes desired, and a summary of the evidence supporting the
22 applicant's claim that the board has erred in its review of the applicant's grant application. A
23 request for reconsideration must be submitted to the board by the first day of the public hearing
24 held under AS 18.25.019. The board shall review its decision on the basis of the request by the
25 applicant and determine whether its decision should be changed. The board shall issue its
26 determination in writing within 15 days after the last day of the public hearing held under
27 AS 18.25.019.

28 (b) An applicant under AS 18.25.011 may appeal an adverse decision of the board under
29 (a) of this section by filing a written notice of appeal with the commissioner within 15 days after
30 the date of the board's decision. The notice of appeal must state the legal and factual basis for
31 the appeal and the precise relief sought. The failure of the applicant to include an issue in a

1 notice of appeal constitutes a waiver of the right to have the issue considered. Not later than 10
2 days after receipt of a notice of appeal, the commissioner shall appoint a hearing officer who is
3 qualified under AS 44.62.350(c) to consider the appeal. If the hearing officer finds that the
4 notice of appeal does not raise a reasonable issue of fact or law, the hearing officer shall issue
5 a written decision denying the appeal. Denial of an appeal by a hearing officer is a final decision
6 that may be appealed under (d) of this section. If the hearing officer finds that the notice of
7 appeal raises a reasonable issue of fact or law, the hearing officer shall conduct a hearing on
8 those issues and recommend a decision to the commissioner. The hearing officer shall issue a
9 decision on the appeal not later than 60 days after being appointed. The commissioner shall
10 consider the recommended decision of the hearing officer within 10 days after receipt and may
11 adopt all, part, or none recommended decision or may remand the issue to the hearing
12 officer for further hearings. The commissioner shall issue a decision in writing within 10 days
13 after consideration of the hearing officer's decision.

14 (c) The hearing officer may consolidate appeals under (b) of this section if the notices
15 of appeal raise related issues of fact or law.

16 (d) An applicant under AS 18.25.011 may appeal an adverse decision of a hearing officer
17 or the commissioner under (b) of this section to the superior court in the manner provided by
18 AS 44.62.560 - 44.62.570 and the Alaska Rules of Appellate Procedure.

19 (e) The board shall adopt regulations governing procedures for the reconsideration and
20 appeal of decisions under (a) - (c) of this section. The regulations adopted under this subsection
21 are not required to conform to AS 44.62.330 - 44.62.630, but must be consistent with minimum
22 standards of due process.

23 (f) An applicant under AS 18.25.011 may not request reconsideration of or appeal a
24 priority determination on the grounds that a revised priority assigned to another project, due to
25 a reconsideration or appeal under this section, has resulted in a lower priority being accorded to
26 the applicant's project.

27 Sec. 18.25.025. GRANT AGREEMENT AND CONDITIONS. (a) The department shall
28 enter into a written agreement with the grantee before it distributes grant funds under
29 AS 18.25.011 - 18.25.035.

30 (b) The department shall require in the grant agreement that the grantee

31 (1) agree to construction of the health facility as described by the certificate of

1 need, if any, issued to the facility under AS 18.07.031 - 18.07.111;

2 (2) provide reasonable assurance by a means acceptable to the department that
3 the cost of the project will be uniform with the costs of the most current construction projects
4 in the area;

5 (3) agree to submit to the department for department approval a description and
6 justification of a cost overrun before the grantee agrees to pay for the overrun and before the
7 department distributes money to the grantee to pay for the overrun;

8 (4) agree to place the grant funds in an interest-bearing account and not to use
9 the interest or the grant funds for a purpose other than the project;

10 (5) agree to limit equipment purchases to that required for the facility operation;

11 (6) submit project budgets for department review and agree that the grant amount
12 may, at the discretion of the department, be reduced or increased by amounts equal to the
13 amounts by which contracts vary from the budget amounts approved by the department;

14 (7) submit to the department for approval, before advertising for bids for the
15 construction contract, a plan for construction that includes specifications, final construction
16 drawings, and proposed contract documents;

17 (8) submit for department review a tabulation of all bids received, a complete
18 copy of the lowest bid, a copy of the proposed notice to proceed with construction, and a copy
19 of the proposed construction contract;

20 (9) submit for department review and acceptance documentary evidence that the
21 project is being accomplished in accordance with all the assertions in the grantee's five-year
22 master plan and grant application;

23 (10) submit sufficient assurances that the project will be used for the stated
24 purposes of the grant for the expected useful lifetime of the facility;

25 (11) agree to conform to all applicable governmental codes and standards,
26 including the most recently adopted state statutes and regulations on building, health, mechanical,
27 electrical, fire, safety, and handicap accessibility, and those covering the planning, construction,
28 and operation of the health facility;

29 (12) agree to comply with

30 (A) the department's single audit requirements;

31 (B) AS 37.05.321, prohibiting the use of grant funds and earnings to

1 influence legislative action;

2 (C) the reporting requirements of AS 36.05 and AS 36.10; and

3 (D) 42 U.S.C. 2000a - 2000h-6 (Civil Rights Act of 1964), 29 U.S.C. 621-
4 634 (Age Discrimination in Employment Act of 1967), 7 U.S.C. 2027 (Food Stamp Act
5 of 1977), and the department's requirements for implementation of the federal statutes
6 listed in this subparagraph;

7 (13) identify anticipated operating costs and revenue and the sources of funding
8 that may be requested if costs exceed projected revenue;

9 (14) complete the project in a timely manner to a fully functional condition and
10 submit periodic status reports not less than every six months to the department detailing work
11 completed to date, a summary of expenditures compared with the approved budget, and an
12 explanation of any deviation from the approved work, schedule, or budget; and

13 (15) agree to comply with other requirements that the department, notwithstanding
14 AS 37.05.318, may reasonably impose on grantees and that are necessary to meet the intent of
15 the grant.

16 (c) Except as provided under (b) or (d) of this section, a cost of construction for a health
17 facility may be paid under a grant awarded under AS 18.25.021 without regard to whether the
18 cost was incurred before the

19 (1) award of the grant; or

20 (2) effective date of an appropriation to the nonprofit health facility construction
21 grant fund for the year in which the grant is funded.

22 (d) The maximum percentage of the costs of planning and designing, including
23 engineering, that are incurred before awarding a grant and that may be paid under the grant may
24 not exceed 15 percent.

25 (e) The fair market value of land acquisition and site preparation may be included in the
26 grantee's share of the total cost of the health facility. The fair market value shall be determined
27 as of the date when the grant application is submitted under AS 18.25.011.

28 (f) The direct expenses of the grantee to administer the project may not exceed 10
29 percent of the grant.

30 Sec. 18.25.027. GRANT APPROPRIATIONS. Within the general appropriation bill
31 submitted to the legislature under AS 37.07.020, the governor shall include an appropriation for

1 nonprofit health facility construction grants in the succeeding fiscal year as determined by the
2 priority list and budgets transmitted to the governor under AS 18.25.017.

3 Sec. 18.25.029. AMOUNT OF GRANTS. For each project included in a grant awarded
4 under AS 18.25.021, the state shall pay up to 80 percent of the total costs of construction
5 incurred for the project by the grantee during the fiscal year for which the grant is made.

6 Sec. 18.25.031. DISTRIBUTION OF GRANT. After the effective date of the agreement
7 for a grant under AS 18.25.011 - 18.25.035, the department shall advance 20 percent of the grant
8 to the grantee. The department shall base subsequent payments from the grant on payment
9 requests submitted by the grantee for the costs of construction incurred by the grantee for the
10 grant project. The department may not make a further payment under the grant until the grantee
11 has exhausted the advance.

12 Sec. 18.25.033. NONPROFIT HEALTH FACILITY CONSTRUCTION GRANT FUND.
13 The nonprofit health facility construction grant fund is created as an account in the general fund.
14 The fund shall be used to make grants under AS 18.25.011 - 18.25.035 for the costs of
15 construction of nonprofit health facilities. Legislative appropriations under AS 18.25.011 -
16 18.25.035 for the costs of construction of nonprofit health facilities shall be deposited in the fund.

17 Sec. 18.25.035. DEFINITIONS. In AS 18.25.011 - 18.25.035,

18 (1) "board" means the Health Facilities Review Board;

19 (2) "costs of construction" means the cost of acquiring, constructing, enlarging,
20 repairing, remodeling, equipping, or furnishing nonprofit health facilities and includes the total
21 of all costs of financing and carrying out the project, including

22 (A) the cost of necessary studies, surveys, plans and specifications,
23 architectural, engineering and other special services, the acquisition of real property, site
24 preparation and development, and the acquisition of machinery and equipment necessary
25 for the project;

26 (B) the direct expenses of the grantee to administer the project;

27 (C) the cost of financing the project, including interest on bonds issued
28 to finance the project; and

29 (D) the cost of other items, including indemnity and surety bonds and
30 premiums on insurance, legal fees, fees and expenses of trustees, depositaries, financial
31 advisors, and paying agents for the bonds issued;

1 (3) "health facility" means a nursing home or a facility that provides
2 hospitalization for inpatient medical and surgical care of acute illness or injury or obstetric care;

3 (4) "nonprofit" means qualified for an exemption under 26 U.S.C. 501 from
4 federal income tax.

5 * Sec. 2. AS 18.25.100 is repealed and reenacted to read:

6 Sec. 18.25.100. REGULATIONS. The department shall adopt regulations to implement
7 this chapter.

8 * Sec. 3. AS 46.11.900(7) is amended to read:

9 (7) "state financial assistance" means a loan, grant, guarantee, insurance, payment,
10 rebate, subsidy, or other form of state assistance other than aid under AS 05.35.010 - 05.35.070,
11 AS 14.11, AS 18.25.011 - 18.25.035, and AS 29.60, including the purchase by a state agency of
12 a loan to finance the construction or purchase of a residential building;

13 * Sec. 4. AS 18.25.010, 18.25.020, 18.25.030, 18.25.070, 18.25.080, 18.25.090, and 18.25.110 are
14 repealed.

15 * Sec. 5. This Act takes effect July 1, 1991.

SENATE BILL NO. 73**IN THE LEGISLATURE OF THE STATE OF ALASKA****SEVENTEENTH LEGISLATURE - FIRST SESSION****BY SENATOR KERTTULA**

Introduced: 1/22/91
Referred: L&C and Finance

A BILL**FOR AN ACT ENTITLED**

1 "An Act relating to health insurance; and providing for an effective date."

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

3 * Section 1. LEGISLATIVE FINDINGS AND INTENT. (a) The legislature finds that

4 (1) access by residents to basic health care services is a natural, essential, and unalienable
5 right that is protected by art. VII, sec. 4, of the Constitution of the State of Alaska;

6 (2) many small employers in the state cannot afford to provide health insurance for their
7 employees;

8 (3) the state can improve the health care services available to employees and other
9 residents of the state who are uninsured or underinsured;

10 (4) many residents under 65 years of age lack access to basic health care services because
11 they are not able to purchase health care insurance at a reasonable price or because they are restricted
12 from purchasing health insurance by the practices of the insurance industry;

13 (5) lack of access to health care negatively affects the health status of the uninsured by
14 the delay or lack of medical treatment, thereby increasing the incidence of disease and illness in the

1 state;

2 (6) the cost of providing hospital care to the uninsured is a burden on all health care
3 consumers and certain businesses in the state.

4 (b) It is the intent of the legislature to promote the accessibility of health care services for all
5 of the state's citizens, a public purpose for which public money may be expended.

6 * Sec. 2. AS 21 is amended by adding a new chapter to read:

7 CHAPTER 55. STATE HEALTH INSURANCE.

8 ARTICLE 1. HEALTH INSURANCE AUTHORITY.

9 Sec. 21.55.010. CREATION AND PURPOSE. (a) The Health Insurance Authority is
10 established. The authority is a public corporation and an instrumentality of the state in the
11 Department of Commerce and Economic Development but has a legal existence independent of
12 and separate from the state.

13 (b) The purpose of the authority is to provide, on a basis calculated to reduce or contain
14 the costs of the program, a program of health insurance coverage for eligible residents of the state
15 who are not otherwise covered by a health insurance plan, a self-insurance health plan, a medical
16 assistance program, or another plan or program that provides for payment by a third-party payor
17 for health care services.

18 Sec. 21.55.020. BOARD OF DIRECTORS. (a) The authority is governed by a board
19 of seven directors. The directors are the commissioner of commerce and economic development,
20 the commissioner of health and social services, the director of the division of insurance, a rep-
21 resentative of the insurance industry, a representative of health care providers, and two
22 representatives of enrollees, appointed by the governor.

23 (b) Members of the board who represent the insurance industry, health care providers,
24 and enrollees serve staggered terms of four years. A vacancy in a directorship shall be filled for
25 the unexpired term in the same manner as the original appointment.

26 (c) The directors must be state residents and shall comply with the requirements of
27 AS 39.50 (Conflict of Interest). The directors of the authority serve without compensation, but
28 are entitled to travel and per diem expenses authorized by law for state boards and commissions
29 under AS 39.20.180.

30 Sec. 21.55.030. APPOINTMENT AND POWERS OF EXECUTIVE DIRECTOR. The
31 board shall appoint an executive director of the authority who serves at the pleasure of the board

1 and may be removed by the board at any time. The executive director must have educational
2 qualifications and administrative and other experience that the board determines to be necessary
3 for the performance of the duties of executive director. The executive director shall appoint and
4 may remove agents and subordinate officers that the executive director considers necessary and
5 may establish divisions and subdivisions within the authority. The position of executive director
6 is in the exempt service.

7 Sec. 21.55.040. DEPUTY EXECUTIVE DIRECTOR. The executive director shall
8 appoint a person to serve as deputy executive director of the authority. The deputy executive
9 director shall perform the duties that the executive director determines and shall, in the case of
10 a vacancy in the office of executive director and during the executive director's absence or
11 disability, exercise the powers and perform the duties of that office. The deputy executive
12 director must have educational qualifications and administrative and other experience that the
13 executive director determines to be necessary for the performance of the duties of deputy
14 executive director. The position of deputy executive director is in the exempt service.

15 Sec. 21.55.050. GENERAL POWERS. The authority may

- 16 (1) adopt regulations to implement this chapter;
- 17 (2) make contracts and execute all instruments necessary or convenient for
18 carrying out its business;
- 19 (3) acquire, own, hold, dispose of, and encumber personal property and lease real
20 property in the exercise of its powers;
- 21 (4) enter into agreements or transactions with a federal, state, or municipal
22 agency, or other public institution, or with a private individual, partnership, firm, corporation,
23 association, or other entity;
- 24 (5) procure insurance in connection with its duties in the amounts and from
25 insurers ~~as may be necessary or desirable~~;
- 26 (6) provide a health insurance program through the purchase of health insurance
27 plans from the private sector, including managed health care plans; the financial assumptions
28 underlying these purchasing arrangements shall be made on an actuarially sound basis;
- 29 (7) design and revise a basic schedule of health care services that enrollees in the
30 health insurance program are entitled to receive, including those services that are typically
31 included in employer sponsored health benefit plans in the state; the authority may adopt

1 schedules of covered health care services that differ from the basic schedule and that apply to
2 specific classes of enrollees;

3 (8) provide a health insurance plan for individuals who are uninsured; the health
4 insurance shall emphasize preventative and primary care by requiring nominal copayments for
5 that coverage, and, shall deemphasize inpatient hospital care by requiring a large deductible and
6 copayment for that coverage;

7 (9) provide a group health insurance plan to employers who have at least one but
8 not more than 15 full-time employees and who have not offered a group health insurance plan
9 to their employees within the previous year;

10 (10) negotiate with hospitals in the state to obtain a discount on charges for
11 inpatient and outpatient care;

12 (11) maintain a prudent level of reserve funds to protect the solvency of the health
13 insurance fund established under AS 21.55.080; and

14 (12) conduct studies concerning the status of health care in the state, including
15 the effect on consumers and businesses of programs established under this chapter.

16 Sec. 21.55.060. TYPES OF INSURANCE PLANS. (a) The authority shall make
17 available health care insurance to all eligible residents who are not covered by a health insurance
18 plan, a self-insurance plan, or the medical assistance program under AS 47.07. The authority
19 may not operate as an insurance company but shall make health insurance plans available to
20 eligible residents of the state through the purchase of health insurance plans, including managed
21 health care plans, from private health insurance companies. The authority shall endeavor to
22 purchase health insurance plans in an economical manner and shall enroll individuals in managed
23 health care plans when practical.

24 (b) The authority shall make available group health insurance for employees and
25 dependents to an employer who has at least one but not more than 15 full-time employees, who
26 elects to participate, and whose employees have not participated in a group health insurance plan
27 in the previous year. Group health insurance shall be made available by the purchase of group
28 health insurance plans from private health insurers. The authority may require employers
29 participating in the group health insurance plan to contribute up to 50 percent of the premium
30 cost of the insurance. An employer who elects to participate must enroll at least 75 percent of
31 the full-time employees of the employer in the health insurance plan offered by the authority.

1 Sec. 21.55.070. PURCHASE OF INSURANCE. (a) The authority shall

2 (1) subject to appropriation, negotiate with and purchase, on the terms that it
3 considers to be in the best interest of the authority and its enrollees, from health insurance
4 companies licensed in this state, policies of group general or blanket insurance providing hospital,
5 surgical, medical, and other health insurance benefits covering all eligible residents and their
6 dependents not enrolled in a health insurance plan, self-insurance health plan, or the medical
7 assistance program;

8 (2) execute all agreements or contracts pertaining to the policies or amendments
9 to them for and on behalf and in the name of the authority; the authority may negotiate a contract
10 for a term not exceeding three years that it considers to be the most advantageous to the authority
11 and its enrollees;

12 (3) endeavor to contract with health insurance companies only for managed health
13 care plans or for health insurance plans that employ other methods to reduce costs of health care
14 services;

15 (4) offer an individual enrollee a choice of at least two plans providing health care
16 insurance benefits; not more than 30 percent of the enrollees may be enrolled in a health
17 insurance plan of a single health insurance company, unless the authority determines that it is in
18 the best interest of enrollees to enroll more than 30 percent of enrollees in a health insurance plan
19 of a single health insurance company;

20 (5) adopt regulations regarding eligibility criteria, enrollment, contribution, and
21 termination policies;

22 (6) establish procedures by which individuals who participate or are seeking to
23 participate in the health insurance program of the authority may appeal determinations of
24 noneligibility, enrollment, contribution, and termination;

25 (7) allow, on an annual basis, an opportunity for enrollees to transfer their
26 enrollments among participating health insurance plans;

27 (8) establish a schedule of premium contributions, copayments, deductibles, or
28 coinsurance amounts to be paid by individual enrollees and for group health insurance purchased
29 by the authority; the schedule must establish a sliding scale of payments for enrollees based on
30 family income and size and other factors determined to be appropriate by the authority; the
31 schedule must require enrollees to pay 100 percent of the premium contributions if their income

1 substantially exceeds the nonfarm poverty guidelines of the United States Office of Management
2 and Budget;

3 (9) in coordination with the Department of Revenue, allow an enrollee to annually
4 contribute the enrollee's permanent fund dividend towards the premium amount paid by the
5 individual enrollee; and

6 (10) require a health insurance company that provides health care benefits under
7 this chapter to establish grievance procedures that are approved by the authority.

8 (b) A health insurance plan provided by the authority to its enrollees through a contract
9 with a health insurance company shall provide a reasonable range of health care service, to
10 enrollees, access to an adequate range of health care providers, and at a minimum, the following
11 benefits:

- 12 (1) inpatient and outpatient acute hospital services;
13 (2) inpatient and outpatient physician services;
14 (3) diagnostic and screening tests;
15 (4) preventive care;
16 (5) prenatal and well-baby care; and
17 (6) medically necessary emergency health services.

18 Sec. 21.55.075. **PREMIUM SUBSIDY.** An employer who elects to participate in the
19 group health insurance offered by the authority and who in the previous calendar year had a net
20 business income of less than \$20,000 as verified by federal income tax returns, shall receive a
21 premium subsidy of the employer's contribution equal to the following:

- 22 (1) in the first year of participation, 50 percent of the employer's contribution;
23 (2) in the second year of participation, 25 percent of the employer's contribution.

24 Sec. 21.55.080. **HEALTH INSURANCE FUND.** The health insurance fund is established
25 as a separate account in the general fund. The fund shall be administered by the authority and
26 used to purchase insurance under AS 21.55.070. The fund consists of appropriations by the
27 legislature and private grants or contributions.

28 Sec. 21.55.250. **DEFINITIONS.** In this chapter,

- 29 (1) "authority" means the Health Insurance Authority created in AS 21.55.010;
30 (2) "eligible resident" means a resident who is less than 65 years of age and
31 whose gross family income at the time of enrollment is less than twice the nonfarm poverty

1 guidelines of the United States Office of Management and Budget;

2 (3) "enrollee" means a person who becomes a member of an insurance program
3 of the authority either individually or as a member of a family;

4 (4) "full-time employee" means an employee who works more than 30 hours in
5 a week;

6 (5) "health care services" means supplies, care, and services of medical, surgical,
7 optometric, dental, podiatric, chiropractic, psychiatric, therapeutic, diagnostic, preventive,
8 rehabilitative, supportive, or geriatric nature, including inpatient and outpatient acute hospital care
9 and services, and services provided by a community health center, or by a health maintenance
10 organization;

11 (6) "health insurance" means an individual or group contract or other plan
12 providing coverage of health care services that is issued by a health insurance company, a
13 hospital service corporation, a medical service corporation, or a health maintenance organization;
14 "health insurance" includes disability insurance under AS 21.12.050;

15 (7) "health insurance company" means a company that engages in the business
16 of health insurance;

17 (8) "health maintenance organization" means a company that provides or arranges
18 for the provision of health care services to enrolled members in exchange primarily for a prepaid
19 per capita or aggregate fixed sum;

20 (9) "hospital service corporation" has the meaning given in AS 21.87.330;

21 (10) "managed health care plan" means a health insurance plan that provides or
22 arranges for, supervises and coordinates health care services to enrolled participants, including
23 plans administered by health maintenance organizations and preferred provider organizations;

24 (11) "medical service corporation" has the meaning given in AS 21.87.330;

25 (12) "resident" means a person living in the state as defined by the authority by
26 regulation; it does not include a person who moved to the state for the sole purpose of securing
27 health insurance under this chapter; confinement of a person in a nursing home, hospital, or other
28 medical institution in the state is not by itself sufficient to qualify the person as a resident.

29 * Sec. 3. AS 36.30.015(e) is amended to read:

30 (e) The board of directors of the Alaska Railroad Corporation and the Health Insurance
31 Authority shall adopt procedures to govern the procurement of supplies, services, professional

1 services, and construction. The procedures must be substantially equivalent to the procedures
2 prescribed in this chapter and in regulations adopted under this chapter.

3 * Sec. 4. AS 36.30.850(b) is amended by adding a new paragraph to read:

4 (23) contracts of the Health Insurance Authority (AS 21.55).

5 * Sec. 5. AS 39.25.110 is amended by adding a new paragraph to read:

6 (30) the executive director, deputy executive director, and other staff of the Health
7 Insurance Authority.

8 * Sec. 6. AS 39.50.200(b) is amended by adding a new paragraph to read:

9 (52) Health Insurance Authority (AS 21.55)

10 * Sec. 7. PHASE-IN COVERAGE. (a) Notwithstanding AS 21.55.060, the Health Insurance
11 Authority shall, subject to appropriation, establish phase-in coverage for state health insurance required
12 by this Act on a regional, statewide, or population basis that is designed to test the relative advantages
13 and disadvantages of providing health insurance, particularly managed health care plans, to persons
14 lacking health insurance. Phase-in coverage shall be established through contracts with health insurance
15 companies, hospital service corporations, medical service corporations, or health maintenance
16 organizations. The authority shall use phase-in coverage as part of a plan to provide health insurance
17 to the uninsured on an orderly and gradual basis. Phase-in coverage shall be purchased for a period not
18 to exceed four years; coverage found by the authority to be an efficient and effective method of
19 providing health care services to the uninsured may be purchased by the authority on a permanent basis,
20 under the provisions of AS 21.55.

21 (b) The authority shall require that an insurer with which it contracts under this section submit
22 annually to the authority a report of the demographics and utilization patterns of the enrollees.

23 * Sec. 8. COMMISSION CREATED. (a) The Commission on Health Insurance Reform is
24 established to

25 (1) examine and determine what alternatives, if any, exist to provide citizens of the state
26 with an improved health care delivery and health care insurance system;

27 (2) recommend improvements to the competitive environment in the health insurance
28 system;

29 (3) review the affordability and availability of actuarially sound nongroup and Medicare
30 supplementary health insurance coverage; and

31 (4) study the implications of the provisions of this Act relative to preferred provider

1 arrangements and relative to the relationship between nonparticipating providers and hospital and medical
2 service corporations.

3 (b) The commission consists of a representative of a nonprofit hospital or medical service
4 corporation, a representative of the Department of Law, a representative of health care consumer groups,
5 a representative of health maintenance organizations, and a chair, to be appointed by the governor.

6 (c) The commission shall make its recommendations to the governor and the legislature before
7 October 1, 1992, and shall issue a final report before November 15, 1992.

8 * Sec. 9. TRANSITION. The initially appointed members of the board of the Health Insurance
9 Authority that are serving staggered terms, shall serve terms set by the governor under AS 39.05.055(2).

10 * Sec. 10. Section 8 of this Act is repealed January 1, 1993.

11 * Sec. 11. This Act takes effect July 1, 1991.

SENATE BILL NO. 74

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATOR KERTTULA

Introduced: 1/22/91

Referred: L&C and Finance

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to pooled health insurance for individuals who are uninsured or denied
2 adequate coverage; and providing for an effective date."

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

4 * Section 1. PURPOSE. It is the purpose of this Act to provide access to health insurance to all
5 residents of the state who are presently denied adequate health insurance or who are considered
6 uninsurable.

7 * Sec. 2. AS 21 is amended by adding a new chapter to read:

8 CHAPTER 55. STATE HEALTH INSURANCE.

9 ARTICLE 1. COMPREHENSIVE HEALTH INSURANCE ASSOCIATION.

10 Sec. 21.55.010. CREATION; MEMBERSHIP. There is established a nonprofit
11 incorporated legal entity to be known as the Comprehensive Health Insurance Association.
12 Membership consists of all licensed hospital or medical service corporations in the state that offer
13 subscriber contracts for major medical coverage and all insurers licensed to transact health
14 insurance in the state that offer policies for major medical coverage on an expense incurred basis.

1 All members shall maintain membership in the association as a condition of doing health
2 insurance business, or being able to offer subscriber contracts, in the state.

3 Sec. 21.55.020. BOARD OF DIRECTORS; ORGANIZATION. The board of directors
4 of the association shall be made up of seven individuals selected by participating members,
5 subject to approval by the director of the division of insurance. The director or the director's
6 designee shall serve as a nonvoting ex officio member of the board. In determining voting rights
7 at members' meetings, a member is entitled to vote in person or proxy. The vote shall be a
8 weighted vote based upon the member's premiums for health insurance for major medical
9 coverage on an expense incurred basis, or the member's subscriber fees, derived from or on
10 behalf of state residents in the previous calendar year, as determined by the director. In
11 approving members of the board, the director shall consider, among other things, whether all
12 types of participating members are fairly represented. Members of the board other than the
13 director or the director's designee may be reimbursed from the association for expenses incurred
14 by them as members, but may not otherwise be compensated by the association for their services.
15 The costs of conducting meetings of the association and its board of directors shall be borne by
16 members of the association.

17 Sec. 21.55.030. GENERAL POWERS. The association may

- 18 (1) exercise the powers granted to insurers under the laws of the state;
19 (2) sue or be sued;
20 (3) enter into contracts with insurers, similar associations in other states, or with
21 other persons for the performance of administrative functions;
22 (4) establish administrative and accounting procedures for the operation of the
23 association.

24 Sec. 21.55.040. PLAN OF OPERATION. (a) The association shall submit to the
25 director a plan of operation and amendments necessary or suitable to assure the fair, reasonable,
26 and equitable administration of the association. The plan of operation and amendments become
27 effective upon approval in writing by the director. If the association fails to submit a suitable
28 plan of operation by a date that is 180 days after the effective date of this Act, or if at subsequent
29 time the association fails to submit suitable amendments to the plan, the director may, after notice
30 and hearing, adopt reasonable regulations necessary or advisable to effectuate the provisions of
31 this chapter. These regulations shall continue in force until modified by the director or

1 superseded by a plan submitted by the association and approved by the director.

2 (b) All members of the association shall comply with the plan of operation.

3 (c) The plan of operation shall

4 (1) establish procedures whereby all the powers and duties of the association
5 under this chapter will be performed;

6 (2) establish procedures for handling assets of the association;

7 (3) establish the amount and method of reimbursing members of the board of
8 directors under AS 21.55.020;

9 (4) establish regular places and times for meetings of the board of directors;

10 (5) establish procedures for records to be kept of all financial transactions of the
11 association, its agents, and the board of directors;

12 (6) provide that a member insurer aggrieved by a final action or decision of the
13 association may appeal to the director within 30 days after the action or decision;

14 (7) establish procedures whereby selections for the board of directors will be
15 submitted to the director;

16 (8) contain additional provisions necessary or proper for the execution of the
17 powers and duties of the association.

18 Sec. 21.55.050. ADMINISTRATIVE PROCEDURE ACT. The association is exempt
19 from the Administrative Procedure Act (AS 44.62).

20 Sec. 21.55.060. TAX EXEMPTION. The association is exempt from the payment of fees
21 and taxes levied by the state or any of its political subdivisions except taxes levied on real or
22 personal property.

23 ARTICLE 2. STATE HEALTH INSURANCE PLANS.

24 Sec. 21.55.100. TYPES OF INSURANCE PLANS. (a) The association shall make
25 available to residents who are high risks an individual state plan of health insurance. The
26 association shall offer three alternatives related to deductibles as described in AS 21.55.120.

27 (b) The association shall make available to residents who are high risks and 65 years of
28 age or older a Medicare supplement plan that meets the minimum policy standards and minimum
29 benefit standards established by regulations adopted by the director under AS 21.89.060.

30 (c) The association may not deny coverage under a state plan to a resident who satisfies
31 the requirements of AS 21.55.300 - 21.55.310. The association shall determine whether a person

1 is a high risk in accordance with AS 21.55.500(9) and the director's regulations.

2 Sec. 21.55.110. MINIMUM BENEFITS OF STATE HEALTH INSURANCE PLAN.

3 Except as provided in AS 21.55.120 - 21.55.140, the minimum standard benefits of a health
4 insurance plan offered under AS 21.55.100(a) shall be benefits with a lifetime maximum of
5 \$1,000,000 per individual for usual, customary, reasonable, or prevailing charges or, when
6 applicable, the allowance agreed upon between a provider and the writing carrier for charges, for
7 the following medical services performed for an individual covered by the plan for the diagnosis
8 or treatment of nonoccupational disease or nonoccupational injury:

9 (1) hospital services;

10 (2) subject to the limitations of AS 21.36.090(d), professional services that are
11 rendered by a physician or by a registered nurse at the physician's direction, other than services
12 for mental or dental conditions;

13 (3) the diagnosis or treatment of mental conditions, as defined in regulations of
14 the director, rendered during the year on other than an inpatient basis, up to a yearly maximum
15 benefit of \$4,000;

16 (4) legend drugs requiring a physician's prescription;

17 (5) services of a skilled nursing facility for not more than 120 days in a policy
18 year;

19 (6) home health agency services up to a maximum of 270 visits in a calendar year
20 if the services commence within seven days following confinement in a hospital or skilled
21 nursing facility of at least three consecutive days for the same condition, except that in the case
22 of an individual diagnosed by a physician as terminally ill with a prognosis of six months or less
23 to live, the home health agency services may commence irrespective of whether the covered
24 person was previously confined or, if the covered person was confined, irrespective of the seven-
25 day period, and the yearly benefit for medical social services may not exceed \$200;

26 (7) hospice services for up to six months in a calendar year;

27 (8) use of radium or other radioactive materials;

28 (9) outpatient chemotherapy;

29 (10) oxygen;

30 (11) anesthetics;

31 (12) nondental prosthesis and maxillo-facial prosthesis used to replace any

1 anatomic structure lost during treatment for head and neck tumors or additional appliances
2 essential for the support of the prosthesis;

3 (13) rental, or purchase if purchase is more cost effective than rental, of durable
4 medical equipment that has no personal use in the absence of the condition for which it was
5 prescribed;

6 (14) diagnostic x-rays and laboratory tests;

7 (15) oral surgery for excision of partially or completely unerupted impacted teeth
8 or excision of a tooth root without the extraction of the entire tooth;

9 (16) services of a licensed physical therapist rendered under the direction of a
10 physician;

11 (17) transportation by a local ambulance operated by licensed or certified
12 personnel to the nearest health care institution for treatment of the illness or injury and round trip
13 transportation by air to the nearest health care institution for treatment of the illness or injury if
14 the treatment is not available locally; if the patient is a child under 12 years of age, the
15 transportation charges of a parent or legal guardian accompanying the child may be paid if the
16 attending physician certifies the need for the accompaniment;

17 (18) confinement in a licensed or certified facility established primarily for the
18 treatment of alcohol or drug abuse or in a part of a hospital used primarily for this treatment, for
19 a period of at least 45 days within any calendar year;

20 (19) alternatives to inpatient services as defined by the association in the state
21 plan benefits;

22 (20) second surgical opinions;

23 (21) other services that are medically necessary in the treatment or diagnosis of
24 an illness or injury as may be designated or approved by the director.

25 **Sec. 21.55.120. DEDUCTIBLES AND COPAYMENTS.** (a) A state plan other than a
26 Medicare supplement plan may require deductibles of \$200 a person, \$500 a person, or \$1,000
27 a person. The amount of the deductible may not be greater when a service is rendered on an
28 outpatient basis than when that service is offered on an inpatient basis. Expenses incurred during
29 the last three months of a calendar year and actually applied to an individual's deductible for that
30 year shall also be applied to that individual's deductible in the following calendar year. The
31 \$200 maximum, the \$500 maximum, and the \$1,000 maximum may be adjusted yearly to corre-

1 spond with the change in the medical care component of the Consumer Price Index, as adjusted
2 by the director. The base year for the computation shall be the first full calendar year of
3 operation of the association.

4 (b) A state plan other than a Medicare supplement plan shall require a maximum
5 copayment of 20 percent for charges for all types of health care in excess of the deductible and
6 50 percent for services described in AS 21.55.110(3) in excess of the deductible.

7 (c) The sum of the deductible and copayments required in any calendar year under a plan
8 may not exceed a maximum limit of \$2,000 per covered individual. Covered expenses incurred
9 after the applicable maximum limit has been reached shall be paid at the rate of 100 percent of
10 usual, customary, reasonable, or prevailing charges, except that expenses incurred for treatment
11 of mental and nervous conditions shall be paid at the rate of 50 percent. The \$2,000 maximum
12 shall be adjusted yearly to correspond with the change in the medical care component of the
13 Consumer Price Index as adjusted by the director.

14 (d) In this section, "Consumer Price Index" means the Consumer Price Index for all
15 urban consumers for the Anchorage Metropolitan Area compiled by the Bureau of Labor
16 Statistics, United States Department of Labor.

17 Sec. 21.55.130. PREEXISTING CONDITIONS. (a) A preexisting condition exclusion
18 in a state plan may not exclude coverage of a preexisting condition unless

19 (1) the condition first manifested itself within the period of three months
20 immediately before the effective date of coverage in a manner that would cause a reasonably
21 prudent person to seek diagnosis, care, or treatment; or

22 (2) medical advice or treatment was recommended or received within the period
23 of three months immediately before the effective date of coverage.

24 (b) A policy may not exclude coverage for a loss due to preexisting conditions for a
25 period greater than six months following the effective date of coverage.

26 (c) A state plan issued to a person whose previous subscriber contract, health policy, or
27 Medicare supplement policy was involuntarily terminated shall credit the time covered under the
28 previous contract or policy toward an exclusion for preexisting conditions under the state plan
29 if the previous contract or policy had a similar preexisting condition exclusion and the person
30 applies for a state plan within 31 days after termination of the previous contract or policy. If a
31 person covered by this subsection is accepted by the writing carrier and pays a specified premium

1 for retroactive coverage, the state plan is effective retroactively to the date that the person's
2 previous contract or policy terminated.

3 Sec. 21.55.140. CARE AND SERVICES NOT COVERED. A state plan may not
4 provide benefits for charges for the following:

5 (1) care for an injury or disease either

6 (A) arising out of and in the course of an employment subject to a
7 workers' compensation or similar law or where the benefit is required to be provided
8 under a workers' compensation policy to a sole proprietor, business partner, or
9 corporation officer; or

10 (B) to the extent benefits are payable without regard to fault under a
11 coverage statutorily required to be contained in a motor vehicle or other liability insurance
12 policy or equivalent self-insurance;

13 (2) treatment for cosmetic purposes other than surgery for the prompt repair of
14 an accidental injury sustained while covered or for replacement of an anatomic structure removed
15 during treatment of tumors;

16 (3) travel, other than transportation covered under AS 21.55.110(17);

17 (4) private room accommodations to the extent it is in excess of the institution's
18 most common charge for a semiprivate room;

19 (5) services or articles to the extent that the charge exceeds the reasonable charge
20 in the locality for the service;

21 (6) services or articles that are determined not to be medically necessary, except
22 for the fabrication or placement of the prosthesis as specified in AS 21.55.110(12) and (2) of this
23 section;

24 (7) services or articles that are not within the scope of the license or certificate
25 of the institution or individual rendering the services or articles;

26 (8) services or articles furnished, paid for or reimbursed directly by or under any
27 law of a government, except as otherwise provided in this chapter;

28 (9) services or articles for custodial care or designed primarily to assist an
29 individual in the activities of daily living;

30 (10) service charges that would not have been made if no insurance existed or that
31 the covered individual is not legally obligated to pay;

- 1 (11) eyeglasses, contact lenses, or hearing aids or the fitting of them;
2 (12) dental care not specifically covered by this chapter;
3 (13) services of a registered nurse who ordinarily resides in the covered
4 individual's home, or who is a member of the covered individual's family or the family of the
5 covered individual's spouse;
6 (14) experimental procedures; and
7 (15) services and supplies for which the patient was not charged.

8 Sec. 21.55.150. STATE PLAN PREMIUMS. (a) The association may not charge a rate
9 for coverage issued by or through the association that is excessive, inadequate, or unfairly
10 discriminatory.

11 (b) The association shall use separate scales of premium rates based on age and
12 geographic location of the insured.

13 (c) The five members of the association that insure, or have subscriber contracts with,
14 the largest number of individuals in the state under plans with benefits substantially equivalent
15 to the state plan benefits shall submit to the association an estimate of the rate that would be
16 actuarially sound for a person who is a standard risk for coverage substantially equivalent to the
17 state plan. The premium for a state plan may not exceed 125 percent of the average of those five
18 estimates.

19 ARTICLE 3. ADMINISTRATION OF PLANS.

20 Sec. 21.55.200. SELECTION OF WRITING CARRIERS. The association shall develop
21 bid specifications for members that wish to be selected as a writing carrier to administer a state
22 plan. The selection of the writing carrier shall be based upon criteria including the member's
23 proven ability to handle a large number of health insurance cases or subscriber contracts, efficient
24 claim paying capacity, and the estimate of total charges for administering the plan.

25 Sec. 21.55.210. DUTIES OF WRITING CARRIERS. (a) The writing carrier shall
26 perform the administrative and claims payment functions required by this section. The writing
27 carrier shall provide these services for a period of three years, unless a request to terminate is
28 approved by the director. The director shall approve or deny a request to terminate within 90
29 days of its receipt. A failure to make a final decision on a request to terminate within the
30 specified period shall be considered an approval. Six months before the expiration of each three-
31 year period, the association shall invite submissions of policy forms from members of the

1 association, including the writing carrier. The association shall follow the provisions of
2 AS 21.55.210 in selecting a writing carrier for the subsequent three-year period.

3 (b) The writing carrier shall provide to all eligible persons enrolled in a state plan an
4 individual policy or certificate, setting out a statement of the insurance protection to which the
5 person is entitled, with whom claims are to be filed, and to whom benefits are payable. The
6 policy or certificate must indicate that coverage was obtained through the association.

7 (c) The writing carrier shall submit to the association and the director on a quarterly basis
8 a report on the operation of the state plans. Specific information to be contained in the report
9 shall be determined by the association.

10 (d) Claims shall be paid by the writing carrier and shall indicate that the claim was paid
11 under a state plan. A claim payment shall include a telephone number that can be used for
12 inquiries regarding the claim.

13 (e) The writing carrier shall be reimbursed from the state plan premiums received for its
14 direct and indirect expenses for administering the plan. Direct and indirect expenses shall include
15 a pro rata reimbursement for that portion of the writing carrier's administrative, printing, claims
16 administration, management and building overhead expenses that are assignable to the
17 maintenance and administration of the state plans. The association shall approve cost accounting
18 methods to substantiate the writing carrier's cost reports consistent with generally accepted
19 accounting principles. Direct and indirect expenses may not include costs directly related to the
20 original submission of policy forms before selection as the writing carrier.

21 (f) The writing carrier shall at all times when carrying out its duties under this chapter
22 be considered an agent of the association.

23 Sec. 21.55.220. OPERATION OF THE PLAN. (a) Upon notification of eligibility under
24 AS 21.55.320, a person may enroll in a state plan by payment of the appropriate state plan
25 premium to the writing carrier.

26 (b) An employer that has in its employ one or more eligible persons enrolled in a state
27 plan may make all or a portion of a state plan premium payment directly to the writing carrier.

28 (c) Each member of the association shall share the losses due to claims expenses of the
29 state plans issued or approved for issuance by the association, and shall share in the operating
30 and administrative expenses incurred or estimated to be incurred by the association incident to
31 the conduct of its affairs. Claims expenses of the state plan that exceed the premium payments

1 allocated to the payment of benefits shall be the liability of the members. Each member shall
2 share in the claims expense of the state plans and operating and administrative expenses of the
3 association in an amount equal to the ratio of the member's total fees for subscriber contracts or
4 total health insurance premiums, received from or on behalf of state residents, as divided by the
5 total subscriber fees and health insurance premiums received by all members from or on behalf
6 of state residents, as determined by the director.

7 (d) The association shall make an annual determination of each member's liability, if any,
8 and may make an annual fiscal year end assessment if necessary. The association may also,
9 subject to the approval of the director, provide for interim assessments against the members as
10 may be necessary to assure the financial capability of the association in meeting the incurred or
11 estimated claims expenses of the state plans and operating and administrative expenses of the
12 association until the association's next annual fiscal year end assessment. Payment of an
13 assessment is due within 30 days of receipt by a member of written notice of a fiscal year end
14 or interim assessment. Failure by a member to tender to the association the assessment within
15 30 days shall be grounds for revocation of a member's certificate of authority. A member that
16 ceases to do health insurance business in the state, or ceases to offer subscriber contracts in the
17 state, due to revocation, suspension, or voluntary surrender of its certificate of authority remains
18 liable for assessments through the calendar year that the health insurance business ceased. The
19 association may decline to levy an assessment against a member if the assessment would not
20 exceed \$10. Assessments paid by a member are a general expense of the member.

21 (e) Net gains, if any, from the operation of the state plans shall be held at interest and
22 used by the association to offset future losses due to claims expenses of a state plan or allocated
23 to reduce state plan premiums.

24 ARTICLE 4. ENROLLMENT IN THE STATE HEALTH INSURANCE PLAN.

25 Sec. 21.55.300. ELIGIBILITY FOR STATE HEALTH INSURANCE. (a) Except as
26 provided in (b) of this section, a state resident who is a high risk is eligible to enroll in a state
27 plan described in AS 21.55.100.

28 (b) A person may not be covered by the state plan while covered by another health
29 insurance policy or subscriber contract. Upon ceasing to be a resident a person is not eligible
30 to purchase or renew coverage under a state plan, but previously purchased coverage remains in
31 effect for the period covered by payments made while a resident.

1 (c) Additional eligibility requirements may not be imposed by the director, the
2 association, or a writing carrier.

3 Sec. 21.55.310. ENROLLMENT BY AN ELIGIBLE PERSON. A person may enroll in
4 a state plan by applying to the writing carrier. The application must include the following:

- 5 (1) name, address, age, and length of residency of the applicant;
6 (2) a designation of the plan desired, including deductible option chosen;
7 (3) information relevant to whether the person is a high risk.

8 Sec. 21.55.320. WRITING CARRIER'S RESPONSE. Within 30 days after receiving the
9 certificate described in AS 21.55.310, the writing carrier shall either reject the application for
10 failing to comply with the requirements of AS 21.55.300 and 21.55.310 or forward the eligible
11 person a notice of acceptance and billing information.

12 Sec. 21.55.330. EFFECTIVE DATE OF POLICIES. (a) Except as provided in (b) of
13 this section and AS 21.55.130(c), insurance under a state plan is effective immediately upon
14 receipt of the first quarterly premium, and is retroactive to the date of the application, if the
15 applicant otherwise complies with the requirements of this chapter.

16 (b) Insurance under a state plan is effective retroactively to the date that the person's
17 previous contract or policy terminated if the person

18 (1) applies for a state plan within 60 days after the previous contract or policy
19 terminated;

20 (2) is accepted by the writing carrier; and

21 (3) pays a specified premium for the period of retroactive coverage.

22 Sec. 21.55.340. SOLICITATION OF ELIGIBLE PERSONS. (a) The association, under
23 a plan approved by the director, shall disseminate appropriate information to the residents of the
24 state regarding the existence of the state plans and the means of enrollment. Means of
25 communication may include use of the press, radio, and television, as well as publication in
26 appropriate state offices and publications.

27 (b) The association shall devise and implement means of maintaining public awareness
28 of the provisions of this chapter regarding the state plans and shall administer this chapter in a
29 manner that facilitates public participation in the state plans.

30 (c) Selling or marketing of qualified state plans is limited to licensed health insurance
31 agents.

1 (d) An insurer or hospital or medical service corporation that rejects or applies
2 underwriting restrictions to an applicant for a subscriber contract, a health insurance policy, or
3 a Medicare supplement plan in the state shall notify the applicant of the existence of the state
4 plans, the requirements for being accepted, and the procedure for applying.

5 ARTICLE 5. GENERAL PROVISIONS.

6 Sec. 21.55.400. DUTIES OF DIRECTOR. The director may

7 (1) approve the selection of the writing carrier by the association and approve the
8 association's contract with the writing carrier including the coverages and premiums to be
9 charged;

10 (2) contract with the federal government or another unit of government to ensure
11 coordination of the state plans with other governmental assistance programs;

12 (3) undertake directly or through contracts with other persons studies or
13 demonstration programs to develop awareness of the benefits of this chapter; and

14 (4) adopt regulations necessary to administer this chapter.

15 Sec. 21.55.410. STATE NOT LIABLE. The state is not liable for acts or omissions of
16 the association or a writing carrier under this chapter, nor is the state liable for payment of a
17 claim under a state plan issued by a writing carrier.

18 Sec. 21.55.500. DEFINITIONS. In this chapter

19 (1) "association" means the Comprehensive Health Insurance Association created
20 in AS 21.55.010;

21 (2) "copayment" means the portion of the eligible expenses, in excess of the
22 deductible, for which the insured is responsible;

23 (3) "deductible" means the portion of eligible expenses for which the insured is
24 responsible in each calendar year under AS 21.55.120(a);

25 (4) "health insurance" means an individual or group contract or other plan
26 providing coverage of health care services that is issued by a health insurance company, a
27 hospital service corporation, a medical service corporation, or a health maintenance organization;
28 "health insurance" includes disability insurance under AS 21.12.050;

29 (5) "home health agency services" means any of the following services provided
30 upon recommendation of a licensed physician as part of a treatment plan:

31 (A) intermittent or part-time nursing services of a registered professional

1 nurse or a licensed practical nurse, that are provided to a person under the continued
2 direction of the person's physician and within the limitation of the nurse's license;

3 (B) nursing services that are provided to a person at the person's
4 residence, including a residential care facility or adult boarding home; a hospital, skilled
5 nursing facility or intermediate care facility is not considered a residence;

6 (C) home health aide services that are prescribed by and under the
7 continued direction of a physician and supervised by a professional nurse;

8 (D) home health aide services that are provided to a person at the person's
9 residence, as described in (B) of this paragraph;

10 (E) physical and occupational therapy services, speech pathology, and
11 audiology services that are prescribed by a physician and provided to a person by or
12 under the supervision of a qualified practitioner; these services may be provided to a
13 person who is a patient in an intermediate care facility or skilled nursing facility;

14 (6) "hospice services" means services provided under a coordinated comprehensive
15 program of palliative and supportive care on a 24-hour, seven days per week basis for persons
16 who have been diagnosed as terminally ill and their families by an interdisciplinary team of
17 professionals or volunteers under an incorporated central administration that has a physician as
18 medical director;

19 (7) "major medical coverage" means a health insurance contract, or a subscriber
20 contract, that provides benefits for hospital and medical care with potential lifetime maximum
21 benefits per insured of at least \$10,000;

22 (8) "medical social services" means services rendered the patient under the
23 direction of a physician by a qualified social worker holding a master's degree from an accredited
24 school of social work, including assessment of the social, psychological and family problems
25 related to or arising out of the covered person's illness and treatment, appropriate action and
26 utilization of community resources to assist in resolving the problems, and participation in the
27 development of treatment for the covered person;

28 (9) "resident" means a person who is physically present in the state, has lived in
29 the state for at least the six consecutive months immediately preceding application for a state
30 plan, and intends to remain permanently in the state; "resident" also includes a person who is not
31 physically present in the state if the person lived in the state for at least six of the nine months

1 immediately preceding application for a state plan and the person's absence from the state is for
2 medical treatment or education; a person ceases to be a resident if the person is absent from the
3 state for more than 90 consecutive days for reasons other than for medical treatment or education;

4 (10) "residents who are high risks" means residents who

5 (A) have been rejected for medical reasons after applying for a subscriber
6 contract, a policy of health insurance, or a Medicare supplement policy by at least two
7 association members within the six months immediately preceding the date of application
8 for a state plan; or

9 (B) have had a restrictive rider placed on a subscriber contract, a health
10 insurance policy, or a Medicare supplement policy;

11 (11) "state plan" means a policy of insurance offered by the association through
12 a writing carrier;

13 (12) "usual, customary, reasonable, or prevailing charge" means the charge for
14 a medical care procedure, service, or supply item that is the lowest of the following amounts:

15 (A) the billed amount for the medical service provider's actual charge;

16 (B) the charge usually made by that provider for performing that procedure
17 or service or for providing the supply item; or

18 (C) the customary charge, based on a profile of charges made for the same
19 medical procedure, service, or supply item in the same geographical area by other
20 providers that have performed the same procedure or service or can provide the same
21 supply item;

22 (13) "writing carrier" means the insurer or insurers selected by the association and
23 approved by the director to administer a state plan.

24 * Sec. 3. The association established by sec. 2 of this Act shall make available to residents the plans
25 required by AS 21.55.100, enacted in sec. 2 of this Act, by January 1, 1992.

26 * Sec. 4. This Act takes effect immediately under AS 01.10.070(c).

CS FOR SENATE BILL NO. 83 (L&C)
IN THE LEGISLATURE OF THE STATE OF ALASKA
SEVENTEENTH LEGISLATURE - FIRST SESSION

BY THE SENATE LABOR AND COMMERCE COMMITTEE

Offered: 4/22/81
Referred: HES, Finance

Sponsor(s): SENATORS DUNCAN, Zharoff, Rodey

A BILL

FOR AN ACT ENTITLED

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

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

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

6 (1) by July 1, 1992, create and begin a phased implementation of geographic specific
7 health care provider reimbursement systems and utilization standards;

8 (2) after July 1, 1992, begin the procurement or provision of a comprehensive group
9 health insurance program for individuals, groups of individuals, or employers that the authority
10 determines do not have health insurance or for employers who elect to have the authority procure or
11 provide insurance on the employer's behalf; employer group health insurance may include coverage for
12 eligible employees and dependents;

13 (3) assure financial protection for participants and beneficiaries, provide equitable
14 payment to health care providers, and slow the increase in health care expenditures;

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1 (4) expand the pool of subscribers and maximize the opportunities for health care cost
2 management and economies of scale when purchasing group health insurance;

3 (5) maintain efficient provider reimbursement systems to reduce the administrative cost
4 to providers who are serving employees of participants;

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

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

11 (8) realize the potential savings that will result if approximately 135,000 active and
12 retired state, municipal, and school district employees and their dependents participate in the
13 reimbursement systems and utilization standards offered by the authority; and

14 (9) continue to evaluate and where feasible offer a health insurance program for those
15 sectors of the state that remain uninsured or underinsured.

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

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

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

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

1 certificate of need on the cost of group health insurance.

2 * Sec. 4. AS 24.20.206 is amended to read:

3 Sec. 24.20.206. DUTIES. The Legislative Budget and Audit Committee shall

4 (1) report to the legislature its recommendations relating to the confirmation of
5 appointees to the Board of Trustees of the Alaska Permanent Fund Corporation;

6 (2) annually review the long-range operating plans of all agencies of the state
7 which perform lending or investment functions;

8 (3) review periodic reports from all agencies of the state which perform lending
9 or investment functions;

10 (4) present a complete report of investment programs, plans, performance, and
11 policies of all agencies of the state which perform lending or investment functions to the
12 legislature within 30 days after the convening of each regular session;

13 (5) present to the legislature within 30 days after the convening of each regular
14 session a review of the report of the governor under AS 37.07.020(d) with recommendations for
15 needed legislation;

16 (6) in conjunction with the finance committee of each house recommend annually
17 to the legislature the investment policy for the general fund surplus and for the income from the
18 permanent fund;

19 (7) provide for an annual post audit and annual operational and performance
20 evaluation of the Alaska Permanent Fund Corporation investments and investment programs;

21 (8) provide for an annual operational and performance evaluation of the Alaska
22 Housing Finance Corporation and the Alaska Industrial Development and Export Authority; the
23 performance evaluation shall include, but is not limited to, a comparison of the effect on various
24 sectors of the economy by public and private lending, the effect on resident and nonresident
25 employment, the effect on real wages, and the effect on state and local operating and capital
26 budgets of the programs of the Alaska Housing Finance Corporation and the Alaska Industrial
27 Development and Export Authority;

28 (9) provide for an annual post audit and annual operational and performance
29 evaluation of the Alaska State Health Resources Authority.

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

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

- 1 (1) provide for a budget review function;
2 (2) analyze the comprehensive operating and capital improvements programs and
3 financial plans recommended by the governor;
4 (3) adopt legislation to authorize implementation of the governor's comprehensive
5 operating and capital improvements programs and financial plans or appropriate alternatives to
6 those plans;
7 (4) provide for a post-audit function to cover financial transactions, program
8 accomplishment, and compliance with legislative intent;
9 (5) adopt or revise the estimate of receipts required to balance the succeeding
10 fiscal year's budget in order that proposed expenditures do not exceed estimated receipts for that
11 fiscal year;
12 (6) adopt, revise, or initiate revenue measures in order to balance the succeeding
13 fiscal year's budget and the capital improvements section of the budget for the succeeding six
14 years;

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

16 **Authority.**

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

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

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

20 (52) Alaska State Health Resources Authority (AS 44.87).

21 * Sec. 8. AS 44 is amended by adding a new chapter to read:

22 **CHAPTER 87. STATE INSURANCE AUTHORITY.**

23 **Sec. 44.87.010. AUTHORITY CREATED; REQUIRED REIMBURSEMENT SYSTEMS**
24 **AND UTILIZATION STANDARDS. (a)** There is established within the Department of
25 **Administration a nonprofit incorporated legal entity known as the Alaska State Health Resources**
26 **Authority.**

27 **(b) The authority shall**

28 **(1)** by July 1, 1992, create and begin a phased implementation of geographic
29 specific health care provider reimbursement systems and utilization standards within the
30 boundaries of municipalities that have a population of 20,000 or more as reflected by the 1990
31 United States census; the health care provider reimbursement systems and utilization standards

1 required under this paragraph shall be in operation by December 31, 1993;

2 (2) create and begin a phased implementation of geographic specific health care
3 provider reimbursement systems and utilization standards within the boundaries of communities
4 that have a population of less than 20,000 as reflected by the 1990 United States census; the
5 health care provider reimbursement systems and utilization standards required under this
6 paragraph shall be in operation by July 1, 1995;

7 (3) establish the reimbursement systems and utilization standards prospectively
8 utilizing the most accurate information available to the authority regarding defined reliable
9 components of the reimbursement systems and utilization standards; components for the
10 reimbursement systems must include but are not limited to

11 (A) effort and time by provider;

12 (B) technological advances resulting in new equipment, staff, or training;

13 (C) facilities and practice expense;

14 (D) training as a specialist that expands or improves service;

15 (E) professional liability insurance;

16 (F) resolution of rate disputes and associated expenses;

17 (G) geographic modifier;

18 (H) uncollectible debt expenses;

19 (I) availability of services modifier;

20 (J) charity caseload modifier;

21 (K) uncompensated care net cost;

22 (L) long-term elder care expenses;

23 (M) employee expenses resulting from competition with state employee

24 salaries;

25 (N) specialist recruitment expenses;

26 (O) capital costs;

27 (P) Medicaid rates;

28 (Q) actual provider charges as of January 1, 1991;

29 (4) assign relative weight to each component specified in (3) of this subsection
30 and may further define each component;

31 (5) publish, not later than July 1, 1992, a guide for health care providers, insurers,

1 and participants that describes and explains how to use the reimbursement systems and utilization
2 standards;

3 (6) establish health care information and data reporting procedures; the procedures
4 shall be established in cooperation with health care providers and insurers.

5 (c) A health care provider and a person paying a claim shall use the health care provider
6 reimbursement systems and utilization standards established by the authority when billing for
7 services provided to a public employer or a public employee. Other employers may elect to use
8 the reimbursement systems and utilization standards, if the use is approved by the authority.

9 (d) Upon application by an employer or an eligible state program, the authority may,
10 beginning July 1, 1992, allow the employer or the eligible state program to participate in a group
11 health insurance pool established by the authority.

12 (e) Not later than July 1, 1992, the authority shall design and procure or provide a basic
13 health insurance program for employers who elect to participate and who have

14 (1) 50 or fewer full-time employees;

15 (2) been refused coverage by two or more health insurance carriers in the last 12
16 months; or

17 (3) not provided health insurance coverage to their employees in the last 12
18 months.

19 (f) A plan required under (e) of this section

20 (1) must emphasize preventative and protective health services;

21 (2) must include provisions to streamline marketing and payment of claims to
22 providers and participants;

23 (3) must include the reimbursement systems and utilization standards described
24 in (b) of this section;

25 (4) may utilize insurance agents or brokers licensed in this state to assist in the
26 marketing and servicing of the plan.

27 (g) The authority shall submit recommendations to the legislature for providing financial
28 incentives for employers to provide health protection for their employees and dependents.

29 (h) At least 60 days before implementing a phase of the reimbursement systems and
30 utilization standards, the authority shall provide public notice and accept public comments on that
31 phase of the reimbursement systems and utilization standards.

1 Sec. 44.87.015. REQUIRED COOPERATION BY STATE AGENCIES. An agency of
2 the state that provides health care or that provides funds to purchase health care shall, to the
3 maximum extent possible, cooperate in the development of the use of the health care provider
4 reimbursement systems and utilization standards established by the authority, including sharing
5 relevant information.

6 Sec. 44.87.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The authority shall
7 be managed by a board of directors composed of nine members appointed by the governor. The
8 governor shall appoint at least one but not more than two members as representatives from each
9 of the following:

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

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

20 Sec. 44.87.030. GENERAL POWERS. The authority may

21 (1) beginning July 1, 1992, exercise the powers granted to insurers under the laws
22 of the state; if the authority acts as an insurer, the authority shall comply with the requirements
23 applicable to insurers under AS 21;

- 24 (2) sue or be sued;
- 25 (3) enter into contracts or agreements;
- 26 (4) establish administrative or accounting procedures;
- 27 (5) collect, invest, and disburse funds;
- 28 (6) charge fees for providing administrative services;
- 29 (7) establish appropriate levels of reserves to cover the expenses of the authority;
- 30 (8) adopt necessary regulations and procedures for implementation of this chapter.

31 Sec. 44.87.040. DUTIES OF BOARD; ANNUAL REPORT. The board shall

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

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

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

10 (4) establish a grievance procedure to resolve disputes between the authority and
11 participants;

12 (5) every third fiscal year, include in the annual report a cost and benefit analysis
13 of the activities of the authority;

14 (6) analyze the health care needs of the state population that is uninsured or
15 underinsured;

16 (7) provide recommendations to the legislature not later than February 15, 1992,
17 for a systematic approach or plan with alternatives including liabilities and financing alternatives
18 that may be considered to assure access to affordable quality health insurance for all state
19 residents; the recommendations must be updated each year;

20 (8) provide recommendations to the legislature not later than February 15, 1993,
21 for the design of a program with alternatives including liability and financing alternatives to
22 provide health care insurance to state residents who

23 (A) are not covered by health insurance;

24 (B) have been refused health insurance coverage by two or more health
25 insurance carriers in the last 12 months;

26 (C) have been considered uninsurable for health coverage; or

27 (D) are unable to pay for basic health care protection and do not qualify
28 for any other health care protection program or plan;

29 (9) beginning January 1, 1994, periodically review and update the reimbursement
30 systems and utilization standards established by the authority, and evaluate the need for
31 reimbursement systems and utilization standards in other areas of the state.

1 Sec. 44.87.050. STAFF AND PROFESSIONAL SERVICES CONTRACTS. The
2 authority shall employ an executive director who serves at the pleasure of the authority as its
3 chief administrative officer. The executive director may, with the approval of the authority,
4 select and employ additional staff as necessary. Employees of the authority are in the exempt
5 service under AS 39.25.110. In addition to its staff of regular employees, the authority may
6 contract for the services of consultants and professional, technical, and financial advisors the
7 authority considers necessary for the purpose of developing information, conducting hearings,
8 studies, investigations, or other proceedings, or otherwise exercising its powers.

9 Sec. 44.87.060. PROCUREMENT OF INSURANCE. (a) The authority may, after
10 July 1, 1992, begin to procure a policy or policies of comprehensive group health insurance
11 covering an individual or an employer that the authority determines does not have health
12 insurance or for whom health insurance could be more cost effective if procured by the authority.
13 The authority may procure or, if procurement of insurance is not economically feasible, provide
14 group health insurance to employers who elect to participate. Group health insurance may
15 include coverage for eligible employees and dependents. The authority shall procure the
16 insurance from an insurer authorized to transact business in the state under AS 21.09, or the
17 authority may elect to act as a self-insurer if the authority determines that self-insurance can
18 provide the desired insurance coverage and benefits at a lower cost per eligible employee and the
19 authority complies with (c) of this section.

20 (b) The authority, no earlier than July 1, 1992, may establish a group health insurance
21 pool or pools of eligible employers that elect to participate in the group health insurance obtained
22 by the authority. Coverage provided under this subsection must include eligible employees and
23 dependents. Employers that elect to participate shall use the reimbursement systems and
24 utilization standards established by the authority.

25 (c) Except when acting as a self-insurer, the authority shall procure or provide group
26 health insurance in compliance with the provisions of AS 36.30 and shall make available bid
27 specifications for desired group health insurance benefits to all insurance carriers licensed in the
28 state and qualified to provide the desired benefits. The specifications shall be made available at
29 least once every five years.

30 (d) Before the authority elects to act as a self-insurer, the authority shall solicit proposals
31 for the required coverage from insurers licensed in this state to offer health insurance. If after

1 the proposal process has been completed, the authority determines that the desired coverage or
2 benefits are not available from insurers licensed in this state or the authority can provide the
3 desired coverage and benefits at a lower cost per eligible person, the authority may submit a plan
4 of the intended self-insurance coverage and benefits to the legislature. The authority may not
5 begin acting as a self-insurer until the legislature has approved the self-insurance plan submitted
6 by the authority.

7 (e) The authority, when procuring or providing insurance, may create pools or subpools
8 of participants to accurately track premium, experience, and exposure by category. The authority
9 may employ risk sharing mechanisms to limit the total exposure and premium claim volatility
10 of the authority or a participant.

11 Sec. 44.87.070. ALASKA STATE HEALTH RESOURCES FUND. The Alaska state
12 health resources fund is created in the general fund. The fund consists of money appropriated
13 by the legislature. The fund shall be managed and invested by the board. The board may expend
14 money from the fund to carry out the provisions of this chapter.

15 Sec. 44.87.080. INSURANCE PREMIUMS. The authority shall provide that sufficient
16 funds are collected to provide authorized benefits, reserves, and to pay the expenses of the
17 authority. Reserves remaining at the termination of an insurance contract shall be invested by
18 the authority in the same manner as retirement funds are invested under AS 14.25.180.

19 Sec. 44.87.090. PARTICIPATION; WAIVER. (a) The state, a municipality, a district,
20 or other employer in the state may participate in the group insurance coverage provided by the
21 authority. If the state, municipality, district, or other employer elects to participate, the state,
22 municipality, district, or other employer shall continue to participate unless a waiver is granted
23 by the board.

24 (b) In determining whether a waiver should be granted, the board shall establish
25 minimum benefit and financial standards for the desired group health insurance coverage. The
26 minimum benefit and financial standards and the proposed time schedule for responsive offers
27 shall be sent to all participants at the time the request for proposal for the desired group health
28 insurance coverage is issued. A participant seeking a waiver of coverage shall match the
29 minimum benefit and financial standards set out in the request for proposal for the desired group
30 health insurance coverage. Participants shall submit documentation of their insurance coverage
31 matching the board's minimum benefit and financial requirements before the deadline established

1 by the board. The board may approve or disapprove a waiver of participation based on the
2 documentation submitted by the participant regarding the benefit and financial standards
3 established by the board.

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

6 Sec. 44.87.900. DEFINITIONS. In this chapter,

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

8 (2) "board" means the board of directors of the Alaska State Health Resources
9 Authority;

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

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

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

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

20 (7) "full-time employee" means a person who works 30 or more hours in a week;

21 (8) "fund" means the Alaska state health resources fund;

22 (9) "group health insurance" means coverage that may include medical care and
23 treatment, dental care, eye care, and other group health coverage as determined by the authority;

24 (10) "health care provider" has the meaning given in AS 21.88.900;

25 (11) "municipality" includes a public corporation established by a municipality;

26 (12) "participant" means a person who participates in the group health insurance
27 procured or provided by the authority;

28 (13) "reimbursement systems" means systems or methods that streamline or result
29 in cost efficient payments to health care providers, and includes schedules of maximum allowable
30 reimbursement for health care related services based on geographic regions, actual provider costs,
31 and availability of services;

1 (14) "state" means the executive, legislative, and judicial branches of state
2 government, and includes the University of Alaska and a public corporation of the state created
3 within a principal executive department;

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

- 7 * Sec. 9. REPORT. The Alaska State Health Resources Authority shall report to the Alaska State
8 Legislature by March 1, 1992, on the progress made by the authority in establishing a health care
9 provider reimbursement systems and utilization standards.
- 10 * Sec. 10. This Act takes effect immediately under AS 01.10.070(c).

HOUSE BILL NO. 71
IN THE LEGISLATURE OF THE STATE OF ALASKA
SEVENTEENTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVES BOYER, Navarre

Introduced: 1/24/91

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

A BILL
FOR AN ACT ENTITLED

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

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

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

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

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

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

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

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1 to providers who are serving employees of participants;

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

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

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

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

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

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

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

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

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

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

2 CHAPTER 77. STATE INSURANCE.

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

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

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

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

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

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

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

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

Sec. 21.77.030. GENERAL POWERS. The authority may

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 Sec. 21.77.100. DEFINITIONS. In this chapter,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18 (1) provide for a budget review function;

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

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

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

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

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

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

Authority.

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

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

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

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

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

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

SENATE BILL NO. 84

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATOR DUNCAN

Introduced: 1/23/91

Referred: HESS and Finance

A BILL

FOR AN ACT ENTITLED

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

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

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

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

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

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

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SB 84

New Text Underlined (DELETED TEXT BRACKETED)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 (2) comply with state licensure standards; or

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

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

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

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

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

4 (2) deny a certificate of need;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 Sec. 18.07.111. DEFINITIONS. In this chapter

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 AS 18.20.310(a)(5).

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

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

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

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

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

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

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HOUSE BILL NO. 69
IN THE LEGISLATURE OF THE STATE OF ALASKA
SEVENTEENTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVES BOYER, Navarre

Introduced: 1/23/91

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

A BILL

FOR AN ACT ENTITLED

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

23 (2) comply with state licensure standards; or

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

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

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

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

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

4 (2) deny a certificate of need;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11 Sec. 18.07.111. DEFINITIONS. In this chapter

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 AS 18.20.310(a)(5).

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

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

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

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

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

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

SENATE BILL NO. 138

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATOR ZHAROFF

Introduced: 2/22/91

Referred: HES and Finance

Funding Information: General Fund \$3,000,000

Other Funds -0-

\$3,000,000

A BILL

FOR AN ACT ENTITLED

1 "An Act making an appropriation for a grant to the City of Unalaska for the Unalaska
 2 Health Care Clinic facility; and providing for an effective date."

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

4 * Section 1. The sum of \$3,000,000 is appropriated from the general fund to the Department of
 5 Administration for payment as a grant under AS 37.05.315 to the City of Unalaska for planning, design,
 6 and construction of the Unalaska Health Care Clinic facility.

7 * Sec. 2. This Act takes effect immediately under AS 01.10.070(c).

HOUSE BILL NO. 173
IN THE LEGISLATURE OF THE STATE OF ALASKA
SEVENTEENTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVES JACKO, C.Davis

Introduced: 2/27/91

Referred: Health, Education and Social Services, Finance

Funding Information: General Fund \$3,000,000

Other Funds -0-
\$3,000,000

A BILL

FOR AN ACT ENTITLED

1 "An Act making an appropriation for a grant to the City of Unalaska for the Unalaska
2 Health Care Clinic facility; and providing for an effective date."

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

4 * Section 1. The sum of \$3,000,000 is appropriated from the general fund to the Department of
5 Administration for payment as a grant under AS 37.05.315 to the City of Unalaska for planning, design,
6 and construction of the Unalaska Health Care Clinic facility.

7 * Sec. 2. This Act takes effect immediately under AS 01.10.070(c).

SENATE BILL NO. 210

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATORS FRANK, Fahrenkamp

Introduced: 3/15/91

Referred: HES and Finance

Funding Information:	General Fund	\$11,000,000
	Other Funds	<u>-0-</u>
		\$11,000,000

A BILL

FOR AN ACT ENTITLED

1 "An Act making an appropriation for a long-term health care facility in Fairbanks; and
 2 providing for an effective date."

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

4 * Section 1. The sum of \$11,000,000 is appropriated from the general fund to the Department of
 5 Health and Social Services for payment as a grant under AS 37.05.316 to the Greater Fairbanks
 6 Community Hospital Foundation, Inc., for the planning, design, engineering, and construction of a
 7 regional long-term health care facility in Fairbanks.

8 * Sec. 2. The appropriation made by this Act is for a capital project and is subject to AS 37.25.020.

9 * Sec. 3. This Act takes effect July 1, 1991.

HOUSE BILL NO. 6
IN THE LEGISLATURE OF THE STATE OF ALASKA
SEVENTEENTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVES BOYER, Koponen, Sharp, Moyer

Introduced: 1/21/91

Referred: Health, Education and Social Services, Finance

Funding Information:	General Fund	\$11,000,000
	Other Funds	<u>-0-</u>
		\$11,000,000

A BILL
FOR AN ACT ENTITLED

1 "An Act making an appropriation for a long-term health care facility in Fairbanks; and
2 providing for an effective date."

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

4 * Section 1. The sum of \$11,000,000 is appropriated from the general fund to the Department of
5 Administration for payment as a grant under AS 37.05.315 to the Fairbanks North Star Borough for a
6 grant to the Greater Fairbanks Community Hospital Foundation for the planning, design, engineering,
7 and construction of a regional long-term health care facility in Fairbanks.

8 * Sec. 2. For the purposes of AS 37.05.315(b), the appropriation made by sec. 1 of this Act is for
9 a grant to a municipality for construction of a public facility.

10 * Sec. 3. This Act takes effect July 1, 1991.

SENATE BILL NO. 239

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Introduced: 4/5/91

Referred: HES, L&C, Finance

A BILL

FOR AN ACT ENTITLED

1 "An Act providing for the licensing and regulation of private health care review agents;
2 and providing for an effective date."

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

4 * Section 1. AS 08.01.010 is amended by adding a new paragraph to read:

5 (33) regulation of private review agents under AS 08.85.

6 * Sec. 2. AS 08 is amended by adding a new chapter to read:

7 CHAPTER 85. PRIVATE REVIEW AGENTS.

8 Sec. 08.85.010. PURPOSE. The purpose of this chapter is to

9 (1) promote the delivery of quality health care in a cost-effective and efficient
10 manner;

11 (2) foster greater coordination between those paying for health care services and
12 health care providers in the conduct of utilization review activities;

13 (3) assure protection for patients, state employers, and health care providers by
14 ensuring that private health care review agents are qualified to perform utilization review

1 activities and to make informed decisions on the appropriateness of medical care; and

2 (4) ensure that private review agents maintain the confidentiality of medical
3 records in accordance with applicable state and federal laws.

4 Sec. 08.85.020. LICENSE REQUIRED. (a) A person who is affiliated with, under
5 contract to, or acting on behalf of a health care insurer or a person doing business in the state,
6 whether or not for profit, may not perform a utilization review in this state unless a private
7 review agent license is held by the person, the person's employer, or another for whom the
8 person is providing those services under contract. This section does not apply to a person
9 affiliated with a hospital.

10 (b) The department shall issue a license to an applicant that meets the requirements of
11 this chapter and regulations adopted under this chapter.

12 (c) A license issued under this chapter is not transferable and expires biennially on a date
13 determined by the department.

14 Sec. 08.85.030. APPLICATION FOR LICENSE. (a) An applicant for a private review
15 agent license shall submit an application to the department and pay an application fee set by
16 regulation. The application must be on a form approved by the department.

17 (b) An applicant is entitled to a license if the applicant submits and the department
18 approves a utilization review plan that will be provided to patients and providers that includes

19 (1) the specific review standards, criteria, and procedures to be used in evaluating
20 hospital or outpatient care that has been proposed or is being or has been delivered;

21 (2) those circumstances under which utilization review may be delegated to a
22 hospital utilization review program;

23 (3) the provisions by which patients or providers may seek prompt reconsideration
24 or appeal of adverse decisions by the private review agent and the time period in which the
25 private review agent must respond to the request for reconsideration or appeal;

26 (4) the number, type, and qualifications of the personnel employed by or under
27 contract with the private review agent to perform the utilization review including

28 (A) the requirement that a private review agent have available the services
29 of sufficient numbers of registered nurses with masters degrees, or similarly qualified
30 persons, supported and supervised by physicians trained in the appropriate specialty area,
31 to carry out its utilization review activities, or to have appropriate numbers of physicians

1 trained in the appropriate specialties for which utilization review is being conducted; and
2 (B) a requirement that only a physician trained in a relevant specialty or
3 subspecialty and licensed in the state be permitted to make a final determination that care
4 rendered, being rendered, or to be rendered in that specialty or subspecialty is medically
5 inappropriate;

6 (5) the procedures and policies to ensure that a representative of the private
7 review agent is reasonably accessible to patients and providers at least five days a week during
8 normal business hours and that payment will not be denied for treatment rendered

9 (A) during a period when a private review agent is not accessible; or

10 (B) when the appeal of an adverse decision is pending;

11 (6) the requirement that, except in exceptional circumstances, a determination that
12 care rendered, being rendered, or to be rendered is medically inappropriate may not be made until
13 an appropriately qualified review physician has conferred with the patient's attending physician
14 and reviewed all pertinent information concerning the medical care delivered or proposed;

15 (7) the requirement that a determination that care rendered, being rendered, or to
16 be rendered is medically inappropriate must include the written evaluation and findings of the
17 reviewing physician;

18 (8) the procedures and policies to ensure that all applicable state and federal laws
19 to protect the confidentiality of individual medical records are followed;

20 (9) prohibitions against a private review agent entering a hospital to interview a
21 patient unless the attending physician is advised of the interview with reasonable advance notice,
22 and the attending physician or the physician's designee is allowed to attend the interview;

23 (10) a prohibition against an incentive payment provision or plan contained in a
24 private review agent's contract with an entity paying for health care services under which the
25 agent's compensation is based on controlling the amount charged for services, duration of
26 services, or setting in which services are rendered and a prohibition against the agent receiving
27 the incentive payment;

28 (11) a copy of the written material intended to be sent to patients and providers
29 to inform them of the requirements of the utilization review plan;

30 (12) a list of the health care insurers for which the private review agent is
31 performing utilization review in the state and a brief description of the services it is providing

1 for each client, including an affirmation that a payment incentive provision or plan designed to
2 control the amount, duration, or setting in which services are rendered does not exist with respect
3 to each client;

4 (13) evidence of liability insurance carried by the private review agent to cover
5 potential liability from its activities under this chapter in an amount, type, nature, and carrier
6 satisfactory to the department;

7 (14) provisions that, in the absence of fraud, prohibit retrospective denial of
8 payment for treatment after it has been initially approved by the private review agent;

9 (15) other information the department determines to be appropriate.

10 Sec. 08.85.040. RENEWAL OF LICENSE. (a) The department shall renew the license
11 of a private review agent holding a license under AS 08.85.020 if, before the license expires, the
12 agent

13 (1) files an application for renewal, including the information required under
14 AS 08.85.030(b), and submits the appropriate renewal fee; and

15 (2) meets the qualifications for issuance of a license under AS 08.85.020(b).

16 (b) An application for renewal of a private review agent license must include a list of
17 all complaints made to the agent by patients or providers and a brief description of how the
18 complaints were resolved, including the nature of the complaint, the review process, and the time
19 between the filing of the complaint and its resolution.

20 Sec. 08.85.050. DENIAL OF LICENSE OR RENEWAL APPLICATION. (a) Before
21 denying an application for a private review agent license or for renewal of a license, the
22 department shall provide the applicant with reasonable time to supply additional documentation
23 establishing that the applicant is entitled to a license or to renewal of a license.

24 (b) An applicant who is denied a license or renewal of a license shall be afforded the
25 opportunity for a hearing. The hearing shall be conducted by the department. The hearing shall
26 be held in accordance with AS 44.62.330 - 44.62.630.

27 Sec. 08.85.060. REVOCATION OF LICENSE. (a) The department may revoke a
28 license if the holder fails to comply with a utilization review plan filed by the holder under
29 AS 08.85.030(b) or otherwise violates a provision of this chapter or a regulation adopted under
30 this chapter.

31 (b) Before revoking a license under this section, the department shall provide the license

1 holder with reasonable time to supply additional information demonstrating the holder's
2 compliance with the requirements of this chapter.

3 (c) A license holder whose license is proposed for revocation by the department shall be
4 afforded the opportunity for a hearing. The hearing shall be held in accordance with
5 AS 44.62.330 - 44.62.630.

6 Sec. 08.85.070. COMPLAINTS AGAINST LICENSE HOLDER. (a) A patient or
7 provider may file a complaint with the department alleging that a private review agent is not in
8 compliance with this chapter or the regulations adopted under this chapter or with other
9 applicable federal or state law. The complaint may request that the department revoke the license
10 of the agent or require that the agent demonstrate to the department proof of compliance.

11 (b) Proceedings under this section shall be conducted in accordance with AS 44.62.330 -
12 44.62.630.

13 (c) If the department fails to render a decision on a complaint brought by a patient or
14 provider within 90 days, the patient or provider shall have the right to bring suit in the superior
15 court to compel the department to take an action specified in (a) of this section.

16 (d) This section may not be construed to deprive a patient, a provider, a private review
17 agent, or a health care insurer of a right available under other provisions of law.

18 Sec. 08.85.080. REGULATIONS. The department shall adopt regulations to implement
19 the provisions of this chapter, including regulations

20 (1) establishing license application and renewal fees in an amount sufficient to
21 pay for the costs to the department of administering this chapter;

22 (2) establishing rules of procedure consistent with AS 44.62.330 - 44.62.630.

23 Sec. 08.85.090. EXEMPTION. A private review agent that operates solely under contract
24 with the federal government or an agency of the federal government for utilization review of
25 patients eligible for health related services under 42 U.S.C. 1395 - 1395ccc (Subchapter XVIII
26 of the Social Security Act), 42 U.S.C. 1396 - 1396s (Subchapter XIX of the Social Security Act),
27 and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is exempt
28 from the licensing requirements of this chapter.

29 Sec. 08.85.100. LIST OF PRIVATE REVIEW AGENTS. The department shall
30 periodically provide a list of licensed private review agents and the expiration date for their
31 licenses to all hospital utilization review programs and to other individuals or organizations

1 requesting the list. The department may charge a reasonable fee for providing the list.

2 Sec. 08.85.110. PATIENT CONFIDENTIALITY AND RECORDS. (a) A private review
3 agent may not disclose or publish individual medical records or other confidential information
4 obtained in the performance of activities as a private review agent, except that an agent may
5 provide patient information to a third party to which the agent is under contract or with which
6 it is affiliated.

7 (b) A person seeking payment of a reimbursement for hospital or medical services may
8 not invoke the privilege of confidentiality arising from a physician-patient relationship to
9 withhold pertinent information from review of those services by a private review agent.

10 (c) Notwithstanding the provisions of this chapter or another law, a patient is entitled to
11 inspect and copy records developed or maintained by a private review agent pertaining to the
12 health care rendered, being rendered, or proposed to be rendered to the patient.

13 (d) This chapter may not be construed to allow a private review agent to take actions that
14 violate a state or federal statute or regulation concerning confidentiality of patient records.

15 Sec. 08.85.150. DEFINITIONS. In this chapter,

16 (1) "department" means the Department of Commerce and Economic
17 Development;

18 (2) "health care insurer" means a person in the business of making payments for
19 the medical care of others, and includes an insurance company, a nonprofit health service plan,
20 a health maintenance organization, a preferred provider organization, an employee assistance
21 program, and a health insurance service organization;

22 (3) "private review agent" means a person who performs a utilization review and
23 who is affiliated with, under contract to, or acting on behalf of a person doing business in the
24 state, whether or not for profit, or of a health care insurer, but who is not affiliated with a
25 hospital;

26 (4) "provider" means a health care provider as defined in AS 18.23.070;

27 (5) "utilization review" means a system for reviewing the appropriate and efficient
28 allocation of hospital and outpatient resources and services given, being given, or proposed to
29 be given to a patient or group of patients, including the approval or denial, or recommendation
30 of approval or denial, of payment for hospital or medical services;

31 (6) "utilization review plan" means a description of the criteria, procedures, and

1 standards governing utilization review activities performed by a private review agent.

2 * Sec. 3. AS 44.62.330(a) is amended by adding a new paragraph to read:

3 (57) Department of Commerce and Economic Development concerning the
4 licensing and regulation of private review agents under AS 08.85.

5 * Sec. 4. AS 08.85.080 and 08.85.150, enacted by sec. 2 of this Act, take effect immediately under
6 AS 01.10.070(c).

CS FOR HOUSE BILL NO. 269 (HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY THE HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered: 5/3/91

Referred: Labor & Commerce, Finance

Sponsor(s): REPRESENTATIVES BOYER, Navarre

A BILL

FOR AN ACT ENTITLED

1 "An Act providing for the licensing and regulation of private health care review agents;
2 and providing for an effective date."

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

4 * Section 1. AS 08.01.010 is amended by adding a new paragraph to read:

5 (33) regulation of private review agents under AS 08.85.

6 * Sec. 2. AS 08 is amended by adding a new chapter to read:

7 CHAPTER 85. PRIVATE REVIEW AGENTS.

8 Sec. 08.85.010. PURPOSE. The purpose of this chapter is to

- 9 (1) promote the delivery of quality health care in a cost-effective and efficient
10 manner;
11 (2) foster greater coordination between those paying for health care services and
12 health care providers in the conduct of utilization review activities;
13 (3) assure protection for patients, state employers, and health care providers by
14 ensuring that private health care review agents are qualified to perform utilization review

1 activities and to make informed decisions on the appropriateness of medical care; and

2 (4) ensure that private review agents maintain the confidentiality of medical
3 records in accordance with applicable state and federal laws.

4 Sec. 08.85.020. LICENSE REQUIRED. (a) A person who is affiliated with, under
5 contract to, or acting on behalf of a health care insurer or a person doing business in the state,
6 whether or not for profit, may not perform a utilization review in this state unless a private
7 review agent license is held by the person, the person's employer, or another for whom the
8 person is providing those services under contract. This section does not apply to a person
9 affiliated with a hospital.

10 (b) The department shall issue a license to an applicant that meets the requirements of
11 this chapter and regulations adopted under this chapter.

12 (c) A license issued under this chapter is not transferable and expires biennially on a date
13 determined by the department.

14 Sec. 08.85.030. APPLICATION FOR LICENSE. (a) An applicant for a private review
15 agent license shall submit an application to the department and pay an application fee set by
16 regulation. The application must be on a form approved by the department.

17 (b) An applicant is entitled to a license if the applicant submits and the department
18 approves a utilization review plan that will be provided to patients and providers that includes

19 (1) the review standards, criteria, and procedures to be used in evaluating hospital
20 or outpatient care that has been proposed or is being or has been delivered;

21 (2) those circumstances under which utilization review may be delegated to a
22 hospital utilization review program;

23 (3) the provisions by which patients or providers may seek prompt reconsideration
24 or appeal of adverse decisions by the private review agent and the time period in which the
25 private review agent must respond to the request for reconsideration or appeal;

26 (4) the number, type, and qualifications of the personnel employed by or under
27 contract with the private review agent to perform the utilization review including

28 (A) the requirement that a private review agent have available the services
29 of sufficient numbers of registered nurses, supported and supervised by physicians trained
30 in the appropriate specialty area, to carry out its utilization review activities, or to have
31 appropriate numbers of physicians trained in the appropriate specialties for which

1 utilization review is being conducted; and

2 (B) a requirement that only a physician trained in a relevant specialty or
3 subspecialty be permitted to make a final determination that care rendered, being
4 rendered, or to be rendered in that specialty or subspecialty is medically inappropriate;

5 (5) the procedures and policies to ensure that a representative of the private
6 review agent is reasonably accessible to patients and providers at least five days a week during
7 normal business hours in this state and that payment will not be denied for treatment rendered
8 that is found to be medically appropriate and within policy coverage;

9 (6) the requirement that, except in exceptional circumstances, a determination that
10 care rendered, being rendered, or to be rendered is medically inappropriate may not be made until
11 an appropriately qualified review physician has conferred with the patient's attending physician
12 and reviewed pertinent information concerning the medical care delivered or proposed;

13 (7) the requirement that a determination that care rendered, being rendered, or to
14 be rendered is medically inappropriate must include the written evaluation and findings of the
15 reviewing physician;

16 (8) the procedures and policies to ensure that all applicable state and federal laws
17 to protect the confidentiality of individual medical records are followed;

18 (9) prohibitions against a private review agent entering a hospital to interview a
19 patient unless the attending physician is advised of the interview with reasonable advance notice.
20 and the attending physician or the physician's designee is allowed to attend the interview;

21 (10) a prohibition against an incentive payment provision or plan contained in a
22 private review agent's contract with an entity paying for health care services under which the
23 agent's compensation is based on controlling the amount charged for services, duration of
24 services, or setting in which services are rendered and a prohibition against the agent receiving
25 the incentive payment;

26 (11) a copy of the written material intended to be sent to patients and providers
27 to inform them of the requirements of the utilization review plan;

28 (12) a list of the health care insurers for which the private review agent is
29 performing utilization review in the state and a brief description of the services it is providing
30 for each client, including an affirmation that a payment incentive provision or plan designed to
31 control the amount, duration, or setting in which services are rendered does not exist with respect

1 to each client;

2 (13) evidence of liability insurance carried by the private review agent to cover
3 potential liability from its activities under this chapter in an amount, type, nature, and carrier
4 satisfactory to the department;

5 (14) provisions that, in the absence of fraud, prohibit retrospective denial of
6 payment for treatment, except in cases of policy limitations or exclusions, after it has been
7 initially approved by the private review agent;

8 (15) other information the department determines to be appropriate.

9 Sec. 08.85.040. RENEWAL OF LICENSE. (a) The department shall renew the license
10 of a private review agent holding a license under AS 08.85.020 if, before the license expires, the
11 agent

12 (1) files an application for renewal, including the information required under
13 AS 08.85.030(b), and submits the appropriate renewal fee; and

14 (2) meets the qualifications for issuance of a license under AS 08.85.020(b).

15 (b) An application for renewal of a private review agent license must include a list of
16 all complaints made to the agent by patients or providers and a brief description of how the
17 complaints were resolved, including the nature of the complaint, the review process, and the time
18 between the filing of the complaint and its resolution.

19 Sec. 08.85.050. DENIAL OF LICENSE OR RENEWAL APPLICATION. (a) Before
20 denying an application for a private review agent license or for renewal of a license, the
21 department shall provide the applicant with reasonable time to supply additional documentation
22 establishing that the applicant is entitled to a license or to renewal of a license.

23 (b) An applicant who is denied a license or renewal of a license shall be afforded the
24 opportunity for a hearing. The hearing shall be conducted by the department. The hearing shall
25 be held in accordance with AS 44.62.330 - 44.62.630.

26 Sec. 08.85.060. REVOCATION OF LICENSE. (a) The department may revoke a
27 license if the holder fails to comply with a utilization review plan filed by the holder under
28 AS 08.85.030(b) or otherwise violates a provision of this chapter or a regulation adopted under
29 this chapter.

30 (b) Before revoking a license under this section, the department shall provide the license
31 holder with reasonable time to supply additional information demonstrating the holder's

1 compliance with the requirements of this chapter.

2 (c) A license holder whose license is proposed for revocation by the department shall be
3 afforded the opportunity for a hearing. The hearing shall be held in accordance with
4 AS 44.62.330 - 44.62.630.

5 Sec. 08.85.070. COMPLAINTS AGAINST LICENSE HOLDER. (a) A patient or
6 provider may file a complaint with the department alleging that a private review agent is not in
7 compliance with this chapter or the regulations adopted under this chapter or with other
8 applicable federal or state law. The complaint may request that the department revoke the license
9 of the agent or require that the agent demonstrate to the department proof of compliance.

10 (b) Proceedings under this section shall be conducted in accordance with AS 44.62.330 -
11 44.62.630.

12 (c) If the department fails to render a decision on a complaint brought by a patient or
13 provider within 90 days, the patient or provider shall have the right to bring suit in the superior
14 court to compel the department to take an action specified in (a) of this section.

15 (d) This section may not be construed to deprive a patient, a provider, a private review
16 agent, or a health care insurer of a right available under other provisions of law.

17 Sec. 08.85.080. REGULATIONS. The department shall adopt regulations to implement
18 the provisions of this chapter, including regulations

19 (1) establishing license application and renewal fees in an amount sufficient to
20 pay for the costs to the department of administering this chapter;

21 (2) establishing rules of procedure consistent with AS 44.62.330 - 44.62.630.

22 Sec. 08.85.090. EXEMPTION. A private review agent that operates solely under contract
23 with the federal government or an agency of the federal government for utilization review of
24 patients eligible for health related services under 42 U.S.C. 1395 - 1395ccc (Subchapter XVIII
25 of the Social Security Act), 42 U.S.C. 1396 - 1396s (Subchapter XIX of the Social Security Act),
26 and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) is exempt
27 from the licensing requirements of this chapter.

28 Sec. 08.85.100. LIST OF PRIVATE REVIEW AGENTS. The department shall
29 periodically provide a list of licensed private review agents and the expiration date for their
30 licenses to all hospital utilization review programs and to other individuals or organizations
31 requesting the list. The department may charge a reasonable fee for providing the list.

1 Sec. 08.85.110. PATIENT CONFIDENTIALITY AND RECORDS. (a) A private review
2 agent may not disclose or publish individual medical records or other confidential information
3 obtained in the performance of activities as a private review agent, except that an agent may
4 provide patient information to a third party to which the agent is under contract or with which
5 it is affiliated.

6 (b) A person seeking payment of a reimbursement for hospital or medical services may
7 not invoke the privilege of confidentiality arising from a physician-patient relationship to
8 withhold pertinent information from review of those services by a private review agent.

9 (c) Notwithstanding the provisions of this chapter or another law, a patient is entitled to
10 inspect and copy records developed or maintained by a private review agent pertaining to the
11 health care rendered, being rendered, or proposed to be rendered to the patient.

12 (d) This chapter may not be construed to allow a private review agent to take actions that
13 violate a state or federal statute or regulation concerning confidentiality of patient records.

14 Sec. 08.85.150. DEFINITIONS. In this chapter,

15 (1) "department" means the Department of Commerce and Economic
16 Development;

17 (2) "health care insurer" means a person in the business of making payments for
18 the medical care of others, and includes an insurance company, a nonprofit health service plan,
19 a health maintenance organization, a preferred provider organization, an employee assistance
20 program, and a health insurance service organization;

21 (3) "private review agent" means a person who performs a utilization review and
22 who is affiliated with, under contract to, or acting on behalf of a person doing business in the
23 state, whether or not for profit, or of a health care insurer, but who is not affiliated with a
24 hospital;

25 (4) "provider" means a health care provider as defined in AS 18.23.070;

26 (5) "utilization review" means a system for reviewing the appropriate and efficient
27 allocation of hospital and outpatient resources and services given, being given, or proposed to
28 be given to a patient or group of patients, including the approval or denial, or recommendation
29 of approval or denial, of payment for hospital or medical services;

30 (6) "utilization review plan" means a description of the criteria, procedures, and
31 standards governing utilization review activities performed by a private review agent.

1 * Sec. 3. AS 44.62.330(a) is amended by adding a new paragraph to read:

2 (57) Department of Commerce and Economic Development concerning the
3 licensing and regulation of private review agents under AS 08.85.

4 * Sec. 4. AS 08.85.080 and 08.85.150, enacted by sec. 2 of this Act, take effect immediately under
5 AS 01.10.070(c).

SENATE BILL NO. 242
IN THE LEGISLATURE OF THE STATE OF ALASKA
SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATOR COLLINS

Introduced: 4/5/91
Referred: L&C, HES, Finance

A BILL
FOR AN ACT ENTITLED

1 "An Act relating to health insurance for small employers; and providing for an effective
2 date."

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

4 * Section 1. FINDINGS. The legislature finds that

5 (1) an unacceptable number of residents of this state are without appropriate health care
6 because of the rapid increase in the cost of health care, the lack of access to health care, and the lack
7 of availability of health insurance coverage;

8 (2) maintenance of proper coverage of employees and dependents of employees of small
9 employers under a health benefit plan is important to ensuring the availability of appropriate health care
10 for the residents of this state and provides more stability and predictability of both rate increases and
11 coverage continuation.

12 * Sec. 2. AS 21 is amended by adding a new chapter to read:

13 CHAPTER 55. SMALL EMPLOYER HEALTH INSURANCE.

14 ARTICLE 1. SMALL EMPLOYER HEALTH REINSURANCE ASSOCIATION.

1 Sec. 21.55.010. CREATION; MEMBERSHIP. There is established a nonprofit
2 incorporated legal entity to be known as the Small Employer Health Reinsurance Association.
3 Membership consists of all licensed hospital or medical service corporations in the state that offer
4 subscriber contracts for health benefits, all welfare arrangements, and all insurers licensed to
5 transact health insurance in the state that offer a health benefit plan. All members shall maintain
6 membership in the association as a condition of doing health insurance business, or being able
7 to offer subscriber contracts, in the state.

8 Sec. 21.55.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The board of
9 directors of the association consists of nine individuals selected by participating members, subject
10 to approval by the director. The director or the director's designee shall serve as a nonvoting
11 ex officio member of the board. In approving members of the board, the director shall consider,
12 among other things, whether all types of participating members are fairly represented.

13 (b) To the extent possible, one board member shall represent a health maintenance
14 organization, one board member shall represent a hospital or medical service corporation, at least
15 six board members' principal health insurance business shall be in the small employer market,
16 and one board member's principal health insurance business shall be in the large employer
17 market. Members of the board other than the director or the director's designee may be reim-
18 bursed from the association for expenses incurred by them as members, but may not otherwise
19 be compensated by the association for their services. The costs of conducting meetings of the
20 association and its board of directors shall be borne by the association.

21 Sec. 21.55.030. GENERAL POWERS. The association may

22 (1) exercise the powers granted to insurers under the laws of the state, except that
23 the association may not issue insurance;

24 (2) sue or be sued;

25 (3) enter into contracts with insurers, similar associations in other states, or with
26 other persons for the performance of administrative functions;

27 (4) establish administrative and accounting procedures for the operation of the
28 association;

29 (5) take legal action as necessary to avoid the payment of improper claims against
30 the association;

31 (6) design the array of health coverage products for which reinsurance will be

1 provided and issue reinsurance policies;

2 (7) establish rules, conditions, and procedures pertaining to the reinsurance of
3 members' risks by the association;

4 (8) establish appropriate rates, rate schedules, rate adjustments, rate classifications,
5 and other actuarial functions appropriate to the operation of the association;

6 (9) assess members under the provisions of this chapter and make advance interim
7 assessments as may be reasonable and necessary for organizational and interim operating
8 expenses; interim assessments shall be credited as offsets against regular assessments due
9 following the close of the fiscal year;

10 (10) appoint from among members appropriate legal, actuarial, and other
11 committees as are necessary to provide technical assistance in the operation of the association.

12 Sec. 21.55.040. PLAN OF OPERATION. (a) The association shall submit to the
13 director a plan of operation and amendments necessary or suitable to assure the fair, reasonable,
14 and equitable administration of the association. The plan of operation and amendments become
15 effective upon approval in writing by the director. If the director has not approved or
16 disapproved a plan of operation submitted by the association within 90 days after receiving the
17 plan of operation, the plan of operation is considered approved by the director. If the association
18 fails to submit a suitable plan of operation by a date that is 180 days after the effective date of
19 this Act, or if at subsequent time the association fails to submit suitable amendments to the plan,
20 the director may, after notice and hearing, adopt reasonable regulations necessary or advisable
21 to effectuate the provisions of this chapter. These regulations shall continue in force until mod-
22 ified by the director or superseded by a plan submitted by the association and approved by the
23 director.

24 (b) All members of the association shall comply with the plan of operation.

25 (c) The plan of operation must

26 (1) establish procedures for the performance of the powers and duties of the
27 association under this chapter;

28 (2) establish procedures for handling assets of the association and for an annual
29 fiscal report to the director;

30 (3) establish the amount and method of reimbursing members of the board under
31 AS 21.55.020;

- 1 (4) establish regular places and times for meetings of the board;
- 2 (5) establish procedures for records to be kept of all financial transactions of the
- 3 association, its agents, and the board;
- 4 (6) provide that a member insurer aggrieved by a final action or decision of the
- 5 association may appeal to the director within 30 days after the action or decision;
- 6 (7) establish procedures for the submission to the director of selections for the
- 7 board;
- 8 (8) provide for reinsuring risks under the provisions of this section;
- 9 (9) provide for collecting assessments from all members to provide for claims
- 10 reinsured by the association and for administrative expenses incurred or estimated to be incurred
- 11 during the period for which the assessment is made;
- 12 (10) provide protection for guaranteed issue insurers from the financial risk
- 13 associated with small employers that present poor credit risks;
- 14 (11) establish standards for the coverage of small employers that have high
- 15 employee turnover;
- 16 (12) establish an appeals process for guaranteed issue insurers to seek relief when
- 17 a guaranteed issue insurer has experienced an unfair share of administrative and credit risks;
- 18 (13) determine the adjusted average market premium prices for small employer
- 19 health plans sold in this state;
- 20 (14) establish participation standards at issue and renewal for reinsured cases;
- 21 (15) establish and maintain a list of guaranteed issue insurers;
- 22 (16) establish standards for those conditions under which a guaranteed issue
- 23 insurer would not be required to write business received from a particular agent or broker; and
- 24 (17) provide for selection of an administering insurer and establish the
- 25 administering insurer's powers and duties;
- 26 (18) contain additional provisions necessary or proper for the execution of the
- 27 powers and duties of the association.

28 Sec. 21.55.050. HEALTH CARE REINSURANCE. (a) A member may only reinsure
29 coverage of an eligible employee of a small employer or a dependent of an eligible employee of
30 a small employer with the association under the following provisions:

- 31 (1) regarding a small employer health benefit plan, the association shall reinsure

1 the level of coverage provided;

2 (2) regarding a plan other than a small employer health benefit plan, the
3 association shall reinsure the level of coverage provided up to, but not exceeding, the level of
4 coverage provided in a small employer health benefit plan;

5 (3) regarding the coverage provided to small employers, the insurer or welfare
6 arrangement, or, to the extent permitted under 29 U.S.C. 1001 - 1459, other benefit arrangement
7 shall be required to use high-cost case management, hospital precertification techniques, and other
8 cost containment techniques as established by the association;

9 (4) regarding eligible employees, and their dependents, who are hired subsequent
10 to the commencement of the employer's coverage by an insurer, welfare arrangement, or other
11 benefit arrangement and who are not late enrollees, coverage may be reinsured by a
12 nonguaranteed issue insurer within 60 days of the commencement of coverage under the plan;

13 (5) regarding eligible employees, and their dependents, who are hired subsequent
14 to the commencement of the employer's coverage by a guaranteed issue insurer and who are not
15 late enrollees, coverage may be reinsured by the guaranteed issue insurer

16 (A) within 60 days of the commencement of coverage under the plan; or

17 (B) commencing on a date established by the board but not later than 18
18 months after the association becomes operational on the first plan anniversary after the
19 small employer coverage has been in effect with the small employer for at least three
20 years and every third year anniversary thereafter;

21 (6) regarding eligible employees, and their dependents, who are employed by a
22 small employer as of the date the employer's coverage by the guaranteed issue insurer
23 commences, coverage may be reinsured

24 (A) within 60 days of the commencement of the employer's coverage with
25 the insurer or welfare arrangement, or other benefit arrangement except in the case of late
26 enrollees; or

27 (B) commencing on a date established by the board but not later than 18
28 months after the association becomes operational on the first plan anniversary after the
29 small employer coverage has been in effect with the small employer for at least three
30 years and every third year anniversary thereafter;

31 (7) regarding eligible employees and their dependents, a guaranteed issue insurer

1 may reinsure the entire employer group

2 (A) within 60 days of the commencement of the group's coverage under
3 the plan;

4 (B) in the case where a new entrant to an employer group is reinsured
5 under the provisions of (4) of this subsection, on the first plan anniversary after the new
6 entrant became a member of the employer's plan; or

7 (C) commencing on a date established by the board but not later than 18
8 months after the association becomes operational on the first plan anniversary after the
9 small employer coverage has been in effect with the small employer for at least three
10 years and every third year anniversary thereafter;

11 (8) regarding employees or dependents reinsured under (4), (5), or (6) of this
12 subsection, reinsurance may not be provided until \$5,000 in benefit payments have been made
13 for services provided during that calendar year for that reinsured employee or dependent; in this
14 paragraph "benefit payments" include those payments that would have been reimbursed through
15 reinsurance in the absence of the annual \$5,000 deductible; the amount of the deductible shall
16 be periodically reviewed by the board and may be adjusted for appropriate factors as determined
17 by the board.

18 (b) If an employer group is covered under a plan other than a small employer health plan
19 and the insurer chooses to reinsure the group subsequent to the initial coverage period, or if a
20 new individual joins the group and the insurer wants to reinsure that individual, the insurer may
21 not require the employer to change to a small employer health plan and the insurer shall allow
22 the employer to maintain the same benefit plan and reinsure only the portion of the plan
23 consistent with a small employer health plan.

24 (c) Except as provided in (d) of this section, premium rates charged for coverage
25 reinsured by the association shall be established as follows:

26 (1) for whole group reinsurance coverage, 1.5 multiplied by the adjusted average
27 market premium price established by the association for that classification or group with similar
28 characteristics and coverage, for eligible employees, and dependents of eligible employees, of a
29 small employer all of whose coverage is reinsured with the association, minus a ceding expense
30 factor determined by the association;

31 (2) for individual reinsurance coverage, 5.0 multiplied by the adjusted average

1 market premium price established by the association for an individual in that classification or
2 group with similar characteristics and coverage, with respect to an eligible employee, or the
3 employee's dependents, minus a ceding expense factor determined by the association.

4 (d) Premium rates charged for reinsurance by the association to a health maintenance
5 organization that is approved by the Secretary of Health and Human Services as a federally
6 qualified health maintenance organization under 42 U.S.C. 300 and, as a health maintenance
7 organization, is subject to requirements that limit the amount of risk that may be ceded to the
8 association, may be modified to reflect the portion of risk that may be ceded to the association.

9 (e) If a health benefit plan coverage for a small employer is entirely or partially reinsured
10 with the association, the premium charged to the small employer for a rating period for the
11 coverage issued under this section may not be more than 1.5 times the adjusted average market
12 premium price established by the association for that classification or group with similar
13 characteristics and coverage.

14 (f) In determining the assessment, if any, that is collected from a member, the following
15 provisions apply:

16 (1) following the close of a fiscal year, the administering insurer shall determine
17 the net premiums, the association expenses for administration and the incurred losses, if any, for
18 the year, taking into account investment income and other appropriate gains and losses; for
19 purposes of this subsection, health benefit plan premiums earned by an insurer, welfare
20 arrangement, or other benefit arrangement shall be established by adding paid claim losses and
21 administrative expenses of the insurer, welfare arrangement, or other benefit arrangement; health
22 benefit plan premiums and benefits paid by a member that are less than an amount determined
23 by the board to justify the cost of collection may not be considered for purposes of determining
24 an assessment; in this paragraph, "net premiums" means health benefit plan premiums less
25 administrative expense allowances;

26 (2) a net loss for the year shall be covered first by assessment against members
27 to the extent provided as follows:

28 (A) assessments shall first be apportioned by the board among all
29 members in proportion to the member's respective share of the total premiums net of
30 reinsurance premiums paid for coverage under this chapter earned in this state from health
31 benefit plans covering small employers and to the extent permitted under 29 U.S.C.

1 1001 - 1459, apportioned among other benefit arrangements covering small employers
2 during the calendar year coinciding with or ending during the fiscal year of the
3 association, or apportioned on another equitable basis reflecting coverage of small
4 employers as may be provided in the plan of operation; an assessment shall be made
5 under this subparagraph against a health maintenance organization that is approved by the
6 secretary of health and human services as a federally qualified health maintenance
7 organization under 42 U.S.C. 300e, subject to an assessment adjustment formula adopted
8 by the board and approved by the director for qualified health maintenance organizations
9 that recognizes the restrictions imposed on qualified health maintenance organizations
10 under federal law; the adjustment formula shall be adopted by the board and approved by
11 the director before the first anniversary of the operation of the association;

12 (B) an assessment under (2)(A) of this subsection shall be capped at four
13 percent of premiums charged for health benefit plans covering a small employer;

14 (3) if assessments exceed actual losses and administrative expenses of the
15 association, the excess shall be held in an interest bearing account and used by the board to offset
16 future losses or to reduce association premiums; in this paragraph, "future losses" include a
17 reserve for incurred but not reported claims;

18 (4) the board shall annually determine a member's proportion of participation in
19 the association based on annual statements and other reports determined necessary by the board
20 and filed by the member with the board; an insurer, welfare arrangement, or other benefit
21 arrangement shall report to the board a claim payment made and administrative expense incurred
22 in this state on an annual basis on a form prescribed by the director;

23 (5) the plan of operation must include a provision for the imposition of an interest
24 penalty for late payment of assessments;

25 (6) a member may request a deferment from the director, in whole or in part,
26 from an assessment issued by the board; the director may defer, in whole or in part, the
27 assessment of a member if, in the opinion of the director payment of the assessment would
28 endanger the ability of the member to fulfill the member's contractual obligations;

29 (7) in the event an assessment against a member is deferred in whole or in part,
30 the amount by which the assessment is deferred may be assessed against the other members in
31 a manner consistent with the basis for assessments set out in this subsection; the member

1 receiving a deferment shall remain liable to the association for the amount deferred; the director
2 may attach conditions to a deferment.

3 Sec. 21.55.060. ADMINISTRATIVE PROCEDURE ACT. The association is exempt
4 from the Administrative Procedure Act (AS 44.62).

5 Sec. 21.55.070. TAX EXEMPTION. The association is exempt from the payment of fees
6 and taxes levied by the state or any of its political subdivisions except taxes levied on real or
7 personal property.

8 Sec. 21.55.080. LIMITATION OF LIABILITY. A member of the association is not
9 liable for civil damages resulting from an act or omission of the member on behalf of the
10 association unless the member acts with gross negligence or intentional misconduct.

11 ARTICLE 2. SMALL EMPLOYER HEALTH INSURANCE PLANS.

12 Sec. 21.55.100. APPLICABILITY. (a) An individual or group health benefit plan is
13 subject to the provisions of this chapter if the plan provides health care benefits covering one or
14 more employees of a small employer and if one of the following conditions are met:

15 (1) all or a portion of the premium or benefits is paid by a small employer or a
16 covered individual is reimbursed, through wage adjustments or otherwise, by a small employer
17 for all or a portion of the premium; or

18 (2) the health benefit plan is treated by the employer or a covered individual as
19 part of a plan or program for the purposes of 26 U.S.C. 106 or 26 U.S.C. 162 (Internal Revenue
20 Code).

21 (b) Except as provided in this chapter, other provisions of law requiring the coverage or
22 the offer of coverage of a health care service or benefit and other provisions of law requiring the
23 reimbursement, utilization, or consideration of a specific category of a licensed or certified health
24 care practitioner do not apply to a health benefit plan offered or delivered to a small employer.

25 (c) Except as provided in this chapter, a health benefit plan offered to a small employer
26 is not subject to a law that would

27 (1) inhibit an insurer, welfare arrangement, or other benefit arrangement from
28 contracting with providers or groups of providers regarding health care services or benefits;

29 (2) impose a restriction on the ability to negotiate with providers regarding the
30 level or method of reimbursing care or services provided under the health benefit plan;

31 (3) require an insurer, welfare arrangement, or other benefit arrangement to either

1 include a specific provider or class of provider when contracting for health care services or
2 benefits, or to exclude a class of provider that is generally authorized by law to provide health
3 care.

4 Sec. 21.55.110. UNDERWRITING AND RATING REQUIREMENTS. Health benefit
5 plans covering small employers and, to the extent permitted under 29 U.S.C. 1001 - 1459, other
6 benefit arrangements covering small employers, are subject to the following provisions:

7 (1) preexisting conditions provisions may not exclude or limit coverage for a
8 period beyond 12 months following the individual's effective date of coverage and may only
9 relate to conditions that had, during the six months immediately preceding the effective date of
10 coverage, occurred in a manner that would cause an ordinarily prudent person to seek medical
11 advice, diagnosis, care, or treatment or for which medical advice, diagnosis, care, or treatment
12 was recommended or received, or that related to a pregnancy existing on the effective date of
13 coverage:

14 (2) in determining whether a preexisting condition limitation provision applies to
15 an eligible employee or dependent, all health benefit plans shall credit the time the person was
16 covered under a previous employer based health benefit plan provided by an insurer or welfare
17 arrangement if the previous coverage was continuous to a date not more than 30 days before the
18 effective date of the new coverage, exclusive of the applicable service waiting period under the
19 health benefit plan;

20 (3) the health benefit plan and, to the extent permitted under 29 U.S.C. 1001 -
21 1459, other benefit arrangements covering small employers must be renewable with respect to
22 all eligible employees or dependents at the option of the policyholder, contract holder, or small
23 employer except for

24 (A) nonpayment of the required premiums by the policyholder, contract
25 holder, or employer;

26 (B) noncompliance with health benefit plan provisions;

27 (C) a health benefit plan of an employer under which the total number of
28 insured individuals covered under all of the health benefit plans of one employer is less
29 than the total number of individuals or percentage of individuals required by participation
30 requirements under a specific health benefit plan of that employer; or

31 (D) a health benefit plan issued by an insurer or welfare arrangement that

1 ceases doing business in the small employer market under AS 21.55.140;

2 (4) notwithstanding (3) of this section, a health benefit plan or coverage provided
3 to an individual covered by a health benefit plan subject to the provisions of this chapter may
4 be rescinded, cancelled, or not renewed for fraud, material misrepresentation, or concealment by
5 an applicant, employee, dependent, or small employer or an agent of an applicant, employee,
6 dependent, or small employer;

7 (5) an insurer or a welfare arrangement, and, to the extent permitted by 29 U.S.C.
8 1001 - 1459, a benefit arrangement may not exclude an eligible employee or dependent who
9 would otherwise be covered under a health benefit plan on the basis of an actual or expected
10 health condition of the person, except that an insurer, welfare arrangement, or other benefit
11 arrangement may exclude a late enrollee for the greater of 18 months or the remainder of the
12 three-year reinsurance period, as provided under AS 21.55.060;

13 (6) an insurer or a welfare arrangement doing business in the small employer
14 market retains the authority to underwrite and rate small employer groups using accepted
15 underwriting and actuarial practices; small employer groups that are declined because they fail
16 to satisfy insurer or welfare arrangement underwriting requirements shall be notified by the
17 insurer or welfare arrangement that the insurer or welfare arrangement will not issue a health
18 benefit plan to the small employer, that the small employer is eligible for a small employer health
19 plan provided by a guaranteed issue insurer, and shall be provided with a list, prepared by the
20 board, containing the address, telephone number, and service area of all guaranteed issue insurers;

21 (7) a health benefit plan issued by a insurer, welfare arrangement, or, to the extent
22 permitted by 29 U.S.C. 1001 - 1459, another benefit arrangement, may not limit or exclude, by
23 use of a rider or amendment applicable to a specific individual, coverage by type of illness,
24 treatment, medical condition, or accident, except for preexisting conditions or diseases as
25 permitted under (1) of this section;

26 (8) a health benefit plan and, to the extent permitted by 29 U.S.C. 1001 - 1459,
27 another benefit arrangement shall make coverage available to eligible employees of a small
28 employer without a service waiting period, except that a small employer may impose a service
29 waiting period for eligible employees of the small employer if the small employer chooses from
30 the service waiting periods offered by the insurer or welfare arrangement; a service waiting
31 period offered by an insurer or welfare arrangement may not exceed 90 days;

1 (9) the benefit structure of a health benefit plan subject to the provisions of this
2 chapter may be changed by the insurer or welfare arrangement to make it consistent with the
3 benefit structure contained in a health benefit plan being marketed to new groups;

4 (10) regarding a health benefit plan of an insurer or welfare arrangement, the
5 premium rates charged or offered for a rating period for the same or similar coverage under a
6 health benefit plan covering a small employer with similar case characteristics as determined by
7 the insurer or welfare arrangement may not vary from the applicable midpoint rate by more than
8 35 percent of the applicable midpoint rate, as to

9 (A) a health benefit plan issued on or after July 1, 1991; and

10 (B) within three years after July 1, 1991, for a health benefit plan issued
11 before July 1, 1991;

12 (11) regarding a health benefit plan issued before July 1, 1991, if an insurer or
13 welfare arrangement charged or offered a premium rate for the same or similar coverage under
14 a health benefit plan covering a small employer with similar case characteristics as determined
15 by the insurer or welfare arrangement, and the premium rate exceeds the applicable midpoint rate
16 by more than 35 points of the applicable midpoint rate, an increase in premium rates for a new
17 rating period may not exceed the sum of

18 (A) a percentage change in the base premium rate measured from the first
19 day of the prior rating period to the first day of the new rating period, plus

20 (B) an adjustment due to a change in case characteristics or plan design
21 of the small employer, as determined by the insurer or welfare arrangement;

22 (12) a premium rate may not vary by more than 15 percent based on industry
23 classification;

24 (13) subject to the provisions of (10), (11), and (12) of this section, an increase
25 in a premium rate for a new rating period may not exceed the sum of

26 (A) a percentage change in the base premium rate measured from the first
27 day of the prior rating period to the first day of the new rating period plus 15 percent,
28 adjusted on a pro rata basis for a rating period greater or lesser than one year, of the base
29 premium rate for the new rating period; and

30 (B) an adjustment due to a change in case characteristics or plan design
31 of the small employer, as determined by the insurer or welfare arrangement;

1 (14) when offering for sale a health benefit plan to a small employer, an insurer
2 or welfare arrangement shall make a reasonable disclosure as part of its solicitation and sales
3 materials of

4 (A) the extent to which premium rates for a specific small employer are
5 established or adjusted in part based on the actual or expected variation in claims costs
6 or actual or expected variation in health condition of the employees and dependents of
7 the small employer;

8 (B) the provisions concerning the insurer's or welfare arrangement's right
9 to change a premium rate; and

10 (C) provisions relating to renewability of a policy or contract;

11 (15) compliance with the underwriting and rating requirements contained in this
12 chapter shall be demonstrated through actuarial certification; insurers or welfare arrangements
13 offering a health benefit plan to a small employer shall file annually with the director an actuarial
14 certification stating that the underwriting and rating methods of the insurer or welfare
15 arrangement

16 (A) comply with accepted actuarial practices;

17 (B) are uniformly applied to health benefit plans covering small
18 employers; and

19 (C) comply with the provisions of this chapter.

20 Sec. 21.55.120. GUARANTEED ISSUE INSURERS. (a) Guaranteed issue insurers shall
21 offer at least one small employer health plan to a small employer requesting a small employer
22 health plan and shall provide at least the coverage of a small employer health plan to a small
23 employer requesting the coverage.

24 (b) Guaranteed issue insurers may

25 (1) reinsure an individual with a group or may reinsure an entire group subject
26 to the provisions of AS 21.55.060;

27 (2) as provided for in the association's plan of operation,

28 (A) require advance premium deposits for poor credit risks; and

29 (B) make special arrangements to cover an employee in a small employer
30 group with exceptionally high employee turnover rates;

31 (3) appeal to the board for a finding that the guaranteed issue carrier is

1 experiencing an unfair share of administrative or credit risk; if the board determines that a
2 guaranteed issue carrier has experienced an unfair burden, the board may grant the guaranteed
3 issue carrier a decreased reinsurance price to offset administrative expenses or temporarily
4 suspend the guaranteed issue insurer's requirement to guarantee issue.

5 Sec. 21.55.130. SMALL EMPLOYER HEALTH BENEFIT PLANS. (a) The board shall
6 design small employer health benefit plans that are eligible for reinsurance by the association.
7 The board shall establish the form and level of coverage to be made available by insurer or
8 welfare arrangements, and to the extent permitted under 29 U.S.C. 1001 - 1459, other benefit
9 arrangements in the small employer health benefit plans. In designing the small employer health
10 benefit plans, the board shall also establish benefit levels, deductibles, coinsurance factors,
11 exclusions, and limitations for the small employer health benefit plans. The form and level of
12 coverage established by the board must specify those components of a health benefit plan offered
13 by an insurer of a small employer that may be reinsured.

14 (b) A small employer health benefit plan may include cost containment features
15 including, but not limited to

16 (1) utilization review of health care services, including review of the medical
17 necessity of hospital and physician services;

18 (2) case management benefit alternatives;

19 (3) selective contracting with hospitals, physicians, and other health care
20 providers;

21 (4) reasonable benefit differentials applicable to participating and nonparticipating
22 providers; and

23 (5) other provisions for the cost effective management of a small employer health
24 benefit plan.

25 (c) The small employer health benefit plan established for use by health maintenance
26 organizations must be consistent with the basic method of operation of health maintenance
27 organizations.

28 (d) A small employer health benefit plan shall be submitted to the director for approval.

29 (e) After the director's approval of the small employer health benefit plans submitted by
30 the board, an insurer or welfare arrangement, or, to the extent permitted by 29 U.S.C. 1001 -
31 1459, other benefit arrangements may certify to the director, in the form and manner prescribed

1 by the director, that the small employer health benefit plans filed by the insurer or welfare
2 arrangement, or other benefit arrangement are in substantial compliance with the provisions in
3 the corresponding approved board plan. Upon receipt by the department of certification described
4 in this subsection, the insurer or welfare arrangement, or other benefit arrangement may use the
5 certified plan until the director, after notice and hearing, disapproves the use of the plan.

6 Sec. 21.55.140. CONDITIONS FOR CEASING TO DO BUSINESS. An insurer or a
7 welfare arrangement may cease doing business in the small employer market if the insurer or
8 welfare arrangement provides notice of the decision to cease doing business in the small
9 employer market to the division, the board, the policyholder or contract holder, and the employer,
10 and coverage under a health benefit plan subject to this chapter is continued for one year after
11 the date of the notice required under this section. An insurer or a welfare arrangement that
12 ceases doing business in the small employer marketplace may not reenter the small employer
13 marketplace for a period of five years from the date of the notice required under this section.

14 Sec. 21.55.250. DEFINITIONS. In this chapter,

15 (1) "adjusted average market premium price" means, as determined by the board,
16 the arithmetic mean of all guaranteed issue insurer's premium rates for a given small employer
17 health benefit plan sold to groups with similar case characteristics by all insurers or welfare
18 arrangements selling small employer health benefit plans in the state;

19 (2) "association" means the Small Employer Health Reinsurance Association
20 created in AS 21.55.010;

21 (3) "base premium rate" means

22 (A) as to a health benefit plan covering one or more employees of a small
23 employer, the lowest new business premium rate prescribed by the insurer or welfare
24 arrangement for the same or similar coverage under a plan or arrangement covering a
25 small employer with similar case characteristics; and

26 (B) as to an insurer or welfare arrangement not issuing a new health
27 benefit plan to a small employer, the lowest rate charged a small employer for the same
28 or similar coverage under a plan covering a small employer with similar case
29 characteristics;

30 (4) "board" means the board of directors of the association;

31 (5) "case characteristics" means with respect to a small employer, the geographic

1 area in which the employees reside, the age and sex of the individual employees and dependents,
2 the appropriate industry classification as determined by the insurer or welfare arrangement, or
3 other benefit arrangement, the number of employees and dependents and other objective criteria
4 as may be established by the insurer or welfare arrangement, or other benefit arrangement;

5 (6) "dependent" means the spouse or child of an eligible employee, subject to
6 applicable terms of the health benefit plan covering the employee;

7 (7) "eligible employee" means an employee who works on a full-time basis, with
8 a normal work week of 30 or more hours, and includes a sole proprietor, a partner of a
9 partnership or an independent contractor, provided the sole proprietor, partner, or contractor is
10 included as an employee under a health benefit plan of a small employer, but does not include
11 an employee who works on a part-time, temporary, or substitute basis;

12 (8) "financially impaired" means a member that is not insolvent but is

13 (A) determined by the director to be potentially unable to fulfill the
14 member's contractual obligations; or

15 (B) placed under an order of rehabilitation or conservation by a court of
16 competent jurisdiction;

17 (9) "guaranteed issue insurer" means an insurer that

18 (A) is one of the top 10 insurers based on total premium volume in the
19 small employer market as determined by the board; and

20 (B) an insurer that informs the board that the insurer wishes to become
21 a guaranteed issue insurer, except that an insurer wishing to become a guaranteed issue
22 insurer shall notify the board of the insurer's intention to become a guaranteed issue
23 insurer one year in advance of the insurer becoming a guaranteed issue insurer;

24 (10) "health benefit plan" means a hospital or medical expense policy, health,
25 hospital, or medical service corporation contract, a plan provided by an insurer or welfare
26 arrangement, and a health maintenance organization contract offered by an employer, but does
27 not include a policy covering only accident, credit, dental, disability income, long-term care,
28 hospital indemnity, Medicare supplement, specified disease, vision care, coverage issued as a
29 supplement to liability insurance, worker's compensation insurance, automobile medical payment
30 insurance, or insurance under which benefits are payable with or without regard to fault and that
31 is statutorily required to be contained in a liability insurance policy or equivalent self-insurance;

1 (11) "initial enrollment period" means the period of time specified in the health
2 benefit plan during which an individual is first eligible to enroll in a small employer health
3 benefit plan; the period of time may not be less than 30 days nor more than 60 days commencing
4 on the day following the end of a service waiting period required by the small employer of all
5 employees before the employees are eligible to participate in a small employer health benefit
6 plan;

7 (12) "insurer" has the meaning given in AS 21.90.900 and includes a health
8 maintenance organization, a hospital service corporation, and a medical service corporation;

9 (13) "late enrollee" means an eligible employee or dependent who requests
10 enrollment in a small employer's health benefit plan following the initial enrollment period
11 provided under the terms of the first plan for which the employee or dependent was eligible
12 through the small employer, except that an eligible employee or dependent may not be considered
13 a late enrollee if

14 (A) the individual

15 (i) was covered under another employer provided health benefit
16 plan at the time the individual was eligible to enroll;

17 (ii) states, at the time of the initial eligibility, that coverage under
18 another employer health benefit plan was the reason for declining enrollment;

19 (iii) has lost coverage under another employer health benefit plan
20 as a result of the termination of employment, the termination of the other plan's
21 coverage, death of a spouse, or divorce or dissolution of marriage; and

22 (iv) requests enrollment within 31 days after the termination of
23 coverage under another employer health benefit plan; or

24 (B) the individual is employed by an employer who offers multiple health
25 benefit plans and the individual elects a different health benefit plan during an open
26 enrollment period; or

27 (C) a court has ordered coverage to be provided for a spouse or minor
28 child under a covered employee's plan and request for enrollment is made within 31 days
29 after issuance of the court order;

30 (14) "member" means all insurers issuing health benefit plans, welfare
31 arrangements and, to the extent permitted under 29 U.S.C. 1001 - 1459 (Employee Retirement

1 Income Security Act), other benefit arrangements providing health benefit plans in this state;

2 (15) "midpoint rate" means for a small employer with similar case characteristics
3 and plan designs, as determined by the applicable insurer or welfare arrangement for a rating
4 period, the arithmetic average of the applicable base premium rate and the corresponding highest
5 premium rate;

6 (16) "other benefit arrangement" means a health benefit plan offered by a small
7 employer who is in whole, or in part, self-insured;

8 (17) "plan of operation" means the articles, bylaws, and operating rules of the
9 association adopted by the board;

10 (18) "preexisting conditions provision" means a policy provision that excludes or
11 limits coverage for charges or expenses incurred during a specified period following the insured's
12 effective date of coverage as to a condition that, during a specified period immediately preceding
13 the effective date of coverage, had manifested itself in a manner that would cause an ordinarily
14 prudent person to seek medical advice, diagnosis, care, or treatment, or for which medical advice,
15 diagnosis, care, or treatment was recommended or received and includes a pregnancy existing on
16 the effective date of coverage;

17 (19) "service waiting period" means a period of time after full-time employment
18 begins before an employee is first eligible to enroll in an applicable health benefit plan offered
19 by the small employer;

20 (20) "small employer" means a person, firm, corporation, partnership, or
21 association actively engaged in business whose total employed work force consisted of, on at
22 least 50 percent of its working days during the preceding year, more than two but not more than
23 25 eligible employees, the majority of whom are employed within the state; in determining the
24 number of eligible employees, companies that are affiliated companies or that are eligible to file
25 a combined tax return for purposes of federal taxation, are considered one employer; except as
26 otherwise specifically provided, provisions of this chapter that apply to a small employer that has
27 a health benefit plan continue to apply until the plan anniversary following the date the employer
28 no longer meets the requirements of this definition;

29 (21) "welfare arrangement" means a multiple employer welfare arrangement as
30 defined in 29 U.S.C. 1003, but does not include a multiple employer welfare arrangement that
31 is fully insured as provided in 26 U.S.C. 1060.

1 * Sec. 3. AS 21.86.260(a) is amended to read:

2 (a) Except as provided in AS 21.55 and in this chapter, this title does not apply to a
3 health maintenance organization that obtains a certificate of authority under this chapter. This
4 subsection does not apply to an insurer licensed under AS 21.09 or a hospital or medical service
5 corporation licensed under AS 21.87 except with respect to its health maintenance organization
6 activities authorized by and regulated under this chapter.

7 * Sec. 4. AS 21.87.340 is amended to read:

8 Sec. 21.87.340. OTHER PROVISIONS APPLICABLE. In addition to the provisions
9 contained or referred to previously in this chapter, the following chapters and provisions of this
10 title also apply with respect to service corporations to the extent applicable and not in conflict
11 with the express provisions of this chapter and the reasonable implications of the express
12 provisions, and for the purposes of the application the corporations shall be considered to be
13 mutual "insure's":

- 14 (1) AS 21.03
- 15 (2) AS 21.06
- 16 (3) AS 21.09, except AS 21.09.090
- 17 (4) AS 21.18.010
- 18 (5) AS 21.18.030
- 19 (6) AS 21.18.040
- 20 (7) AS 21.18.120
- 21 (8) AS 21.21.321
- 22 (9) AS 21.36
- 23 (10) AS 21.42.345 - 21.42.365
- 24 (11) AS 21.51.120
- 25 (12) AS 21.53
- 26 (13) AS 21.54.020
- 27 (14) AS 21.55
- 28 (15) AS 21.69.400
- 29 (16) [(15)] AS 21.69.520
- 30 (17) [(16)] AS 21.69.600, 21.69.620, and 21.69.630
- 31 (18) [(17)] AS 21.78

1 (19) [(18)] AS 21.89.040

2 (20) [(19)] AS 21.89.060

3 (21) [(20)] AS 21.90.

4 * Sec. 5. TRANSITION. Within 180 days after the board is organized under AS 21.55.020, enacted
5 in sec. 2 of this Act, the board of directors of the Small Employer Health Reinsurance Association shall
6 submit a small employer health benefit plan to the director of the division of insurance for approval.
7 Notwithstanding AS 21.55.120(a), enacted in sec. 2 of this Act, a guaranteed issue insurer is not required
8 to offer a small employer a health benefit plan until 60 days after the director of the division of
9 insurance has approved a small employer health benefit plan.
10 * Sec. 6. This Act takes effect July 1, 1991.

SENATE BILL NO. 244

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATOR HOFFMAN

Introduced: 4/8/91

Referred: CRA, HES, Finance

Funding Information: General Fund \$3,400,000

Other Funds -0-

\$3,400,000

A BILL

FOR AN ACT ENTITLED

1 "An Act making an appropriation for a Yupik elders nursing home in Bethel; and
 2 providing for an effective date."

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

4 * Section 1. The sum of \$3,400,000 is appropriated from the general fund to the Department of
 5 Health and Social Services for payment as a grant under AS 37.05.316 to the Association of Village
 6 Council Presidents, Inc., for the planning, design, engineering, and construction of a Yupik elders nursing
 7 home in Bethel.

8 * Sec. 2. The appropriation made by this Act is for a capital project and is subject to AS 37.25.020.

9 * Sec. 3. This Act takes effect July 1, 1991.

SENATE BILL NO. 290

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATOR COLLINS

Introduced: 5/13/91

Referred: L&C, HES, Finance

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to access for children to preventive health services; and providing for
2 an effective date."

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

4 * Section 1. LEGISLATIVE INTENT. The legislature finds that increased access to health care
5 services could improve children's health and reduce the incidence and costs of childhood illness and
6 disabilities among children in the state. Many children do not have preventive services available or
7 funded and, for those who do, lack of access is a restriction to getting service. It is the intent of the
8 legislature that a nonprofit corporation be organized to facilitate a program to bring preventive health
9 care services to children, if necessary, through the use of school facilities when more appropriate sites
10 are unavailable, and to provide comprehensive health insurance coverage to children. A goal for the
11 corporation is to cooperate with existing preventive service programs funded by the public or the private
12 sector.

13 * Sec. 2. AS 18 is amended by adding a new chapter to read:

14 CHAPTER 27. ALASKA HEALTHY KIDS CORPORATION.

1 Sec. 18.27.010. CREATION OF CORPORATION. There is created the Alaska Healthy
2 Kids Corporation, a nonprofit public corporation and government instrumentality in the
3 Department of Health and Social Services, but having a legal existence independent and separate
4 from the state.

5 Sec. 18.27.020. BOARD OF DIRECTORS. (a) The corporation shall operate subject
6 to the supervision and approval of a board of directors chaired by the director of the division of
7 insurance in the Department of Commerce and Economic Development or a designee of the
8 director, and composed of 10 other members selected by the governor for three-year terms of
9 office as follows:

10 (1) one member from among three persons nominated by the Alaska Council of
11 School Administrators;

12 (2) one member from among three persons nominated by the Association of
13 Alaska School Boards;

14 (3) one member who is an employee of the Department of Education;

15 (4) two members from among five members nominated by the Alaska chapter of
16 the American Medical Association;

17 (5) one member representing hospitals in the state;

18 (6) two members who are representatives of authorized health care insurers or
19 subscribers' groups who do business in the state;

20 (7) two members who are employees of the Department of Health and Social
21 Services.

22 (b) Members of the board of directors serve at the pleasure of the governor. The board
23 shall appoint an executive director who is responsible for other staff authorized by the board.

24 (c) Board members who are not state employees do not receive compensation but are
25 entitled to per diem and travel expenses as provided for members of boards and commissions
26 under AS 39.20.180.

27 (d) There is no liability on the part of, and a cause of action may not arise against, a
28 member of the board of directors, or its employees or agents, for an action they take in the good
29 faith performance of their powers and duties under this chapter.

30 Sec. 18.27.030. POWERS AND DUTIES. (a) The corporation shall phase in a program
31 to

1 (1) organize school children groups to facilitate the provision of preventive health
2 care services to children and to provide comprehensive health insurance coverage to children and
3 their family members;

4 (2) arrange for the collection of family or employer payments or premiums, in
5 an amount to be determined by the board of directors, from all participant families or employers
6 to provide for payment for preventive health care services or premiums for comprehensive
7 insurance coverage and for the actual or estimated administrative expenses incurred during the
8 period for which family or employer payments are made;

9 (3) establish the administrative and accounting procedures for the operation of the
10 corporation;

11 (4) establish, with consultation from appropriate professional organizations,
12 standards for preventive health services and providers and comprehensive insurance benefits
13 appropriate to children and their family members;

14 (5) establish eligibility criteria that children and their family members must meet
15 in order to participate in the program;

16 (6) establish procedures under which applicants to and participants in the program
17 may have grievances reviewed by an impartial body and reported to the board of directors of the
18 corporation;

19 (7) establish participation criteria and, if appropriate, contract with an authorized
20 insurer to provide administrative services to the corporation;

21 (8) contract with authorized insurers, or any provider of health care services
22 meeting standards established by the corporation, for the provision of comprehensive insurance
23 coverage and preventive health care services to participants; and

24 (9) develop and implement a plan to publicize the corporation, the eligibility
25 requirements of the program, and the procedures for enrollment in the program and to maintain
26 public awareness of the corporation and the program.

27 (b) The corporation may

28 (1) employ staff necessary to properly administer the corporation;

29 (2) as appropriate, enter into contracts with school districts or other agencies to
30 provide on site information, enrollment, and other services necessary to the operation of the
31 corporation;

1 (3) accept grants, loans, or advances of money or property from a public or
2 private source for the purposes of this chapter;

3 (4) take other actions necessary to implement the purposes of the corporation.

4 Sec. 18.27.040. COVERAGE IS SECONDARY. Coverage under the corporation's
5 program is secondary to any other available private coverage held by the participant child or
6 family member. The corporation may establish procedures for coordinating benefits under this
7 program with benefits under other public and private coverage.

8 Sec. 18.27.050. LICENSING NOT REQUIRED; FISCAL OPERATION. (a) The
9 corporation is not considered an insurer. The officers, directors, and employees of the
10 corporation are not considered to be agents of an insurer. Neither the corporation nor an officer,
11 director, or employee of the corporation is subject to the licensing requirements of AS 21 or the
12 regulations of the Department of Commerce and Economic Development adopted under AS 21.
13 However, the division of insurance may require that a marketing representative used and
14 compensated by the corporation be appointed as a representative of the insurers or health services
15 providers with which the corporation contracts.

16 (b) The board is responsible for all corporate operations.

17 (c) The division of insurance of the Department of Commerce and Economic
18 Development shall supervise liquidation or dissolution of the corporation and shall have, with
19 respect to the liquidation or dissolution, all power granted to it under AS 21.

20 Sec. 18.27.060. THE ALASKA HEALTHY KIDS TRUST FUND. There is created the
21 Alaska healthy kids trust fund in the Department of Health and Social Services. It consists of
22 appropriations made to it. Money in the fund may be used only by the corporation.

23 Sec. 18.27.070. ACCESS TO RECORDS; CONFIDENTIALITY; PENALTIES. (a)
24 Notwithstanding any other laws to the contrary, the corporation shall have access to the medical
25 records of a student upon receipt of permission from a parent or guardian of the student. The
26 medical records may be maintained by state and local agencies. Confidential information
27 obtained by the corporation under this subsection shall remain confidential and is exempt from
28 public inspection and copying under AS 09.25.110 - 09.25.120. The corporation or the staff or
29 agents of the corporation may not release to a state or federal agency, to a private business or
30 person, or to another entity confidential information received under this subsection.

31 (b) A violation of this section is a class B misdemeanor.

1 Sec. 18.27.080. DEFINITIONS. In this chapter,

2 (1) "board" means the board of directors of the corporation;

3 (2) "corporation" means the Alaska Healthy Kids Corporation.

4 * Sec. 3. Notwithstanding AS 18.27, as enacted by sec. 2 of this Act, the Alaska Healthy Kids
5 Corporation may not select more than four sites at which to implement its program without prior
6 approval of the legislature by law.

7 * Sec. 4. This Act takes effect July 1, 1992.

HOUSE BILL NO. 149

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVES DAVIDSON, Kubina, C.Davis, Taylor

Introduced: 2/20/91

Referred: Health, Education and Social Services, Finance

Funding Information: General Fund \$36,917,116

Other Funds -0-
\$36,917,116**A BILL****FOR AN ACT ENTITLED**

1 "An Act making appropriations for grants to certain hospitals for hospital construction and
2 renovation; and providing for an effective date."

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

4 * Section 1. The sum of \$14,250,000 is appropriated from the general fund to the Department of
5 Health and Social Services for payment as a grant under AS 37.05.316 to the Kodiak Island Borough
6 Hospital and Intermediate Care Facility for construction of the facility, contingent on the Kodiak Island
7 Borough appropriating at least \$4,750,000 for the construction. The borough may make an in kind
8 contribution to satisfy up to five percent of this requirement.

9 * Sec. 2. The sum of \$8,603,438 is appropriated from the general fund to the Department of Health
10 and Social Services for payment as a grant under AS 37.05.316 to the Seward General Hospital for
11 renovation and construction of the hospital, contingent on the City of Seward appropriating at least
12 \$2,867,813 for the renovation and construction. The city may make an in kind contribution to satisfy
13 up to five percent of this requirement.

14 * Sec. 3. The sum of \$14,063,678 is appropriated from the general fund to the Department of Health

1 and Social Services for payment as a grant under AS 37.05.316 to the Ketchikan General Hospital for
2 renovation and construction of the hospital, contingent on the City of Ketchikan appropriating at least
3 \$4,687,893 for the renovation and construction. The city may make an in kind contribution to satisfy
4 up to five percent of this requirement.

5 * Sec. 4. This Act takes effect immediately under AS 01.10.070(c).

HOUSE BILL NO. 150

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVES ELLIS, Brown

Introduced: 2/20/91

Referred: Health, Education and Social Services, Finance

Funding Information: General Fund \$1,280,000

Other Funds -0-
\$1,280,000**A BILL****FOR AN ACT ENTITLED**

1 "An Act making a special appropriation to the Department of Health and Social Services
2 for a grant to the Anchorage Neighborhood Health Center; and providing for an effective
3 date."

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

5 * **Section 1. FINDINGS.** The legislature finds that the Anchorage Neighborhood Health Center
6 provides primary medical, dental, and related health services necessary to meet community needs; the
7 center is the only source of primary health care for low income persons in Anchorage; the center can
8 only treat 25 percent of the over 48,000 low income persons in Anchorage due to a shortage of space;
9 expansion of the center is necessary in order to meet community needs for health care services.

10 * **Sec. 2.** The sum of \$1,280,000 is appropriated from the general fund to the Department of Health
11 and Social Services for payment as a grant under AS 37.05.316 to the Anchorage Neighborhood Health
12 Center for expansion of facilities.

13 * **Sec. 3.** The appropriation made by this Act is for a capital project and lapses under AS 37.25.020.

14 * **Sec. 4.** This Act takes effect July 1, 1991.

HOUSE BILL NO. 311

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVES SHARP, M.W. Miller, Gonzales

Introduced: 5/1/91

Referred: Health, Education & Social Services, Finance

Funding Information: General Fund \$3,500,000

Other Funds -0-
\$3,500,000

A BILL

FOR AN ACT ENTITLED

1 "An Act making a special appropriation to the Department of Health and Social Services
2 for a grant to the Fairbanks Health Center; and providing for an effective date."

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

4 * Section 1. FINDINGS. The legislature finds that

5 (1) the Fairbanks Health Center is the primary source of health care for low income
6 persons in the Interior and provides immunizations and basic health care for infants and elderly, health
7 care for pregnant teens and teenage mothers, family planning, and other basic health care needs;

8 (2) the existing facility and site cannot meet the growing demands of its clientele, which
9 has tripled since the center was built 34 years ago; and

10 (3) construction of a new facility is necessary in order to meet community needs for
11 health care services.

12 * Sec. 2. The sum of \$3,500,000 is appropriated from the general fund to the Department of Health
13 and Social Services for payment as a grant under AS 37.05.316 to the Fairbanks Health Center for
14 construction of a new health care facility.

- 1 * Sec. 3. The appropriation made by this Act is for a capital project and lapses under AS 37.25.020.
- 2 * Sec. 4. This Act takes effect July 1, 1991.

7-LS1486A
Lauterbach
9/17/91

HOUSE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA
SEVENTEENTH LEGISLATURE - SECOND SESSION

BY REPRESENTATIVE ELLIS

Introduced:
Referred:

A BILL**FOR AN ACT ENTITLED**

1 "An Act establishing the Alaska Children's Health Corporation; and relating to insurance."

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

3 * Section 1. AS 21 is amended by adding a new chapter to read:

4 CHAPTER 55. HEALTHY START PROGRAM.

5 ARTICLE 1. ALASKA CHILDREN'S HEALTH CORPORATION.

6 Sec. 21.55.010. CREATION OF CORPORATION. There is created the Alaska
7 Children's Health Corporation as a public corporation. The corporation is an instrumentality of
8 the state within the Department of Commerce and Economic Development, but it has a legal
9 existence independent of and separate from the state.

10 Sec. 21.55.020. PURPOSE OF THE CORPORATION. (a) The corporation's purpose
11 is to

12 (1) administer the Alaska children's health care plan as described in this chapter;

13 (2) purchase health insurance coverage for children who are eligible for the plan
14 under AS 21.55.110; and

(3) manage the Alaska children's health fund created under AS 21.55.200.

(b) The corporation is not considered an insurer. The directors and employees of the corporation are not considered to be agents of an insurer. Neither the corporation nor a director or employee of the corporation is subject to the licensing requirements of this title. However, the division of insurance may require that a marketing representative used and compensated by the corporation be appointed as a representative of the insurers with which the corporation contracts.

Sec. 21.55.030. BOARD OF DIRECTORS. (a) The corporation is governed by a board of directors consisting of the commissioner of commerce and economic development, the commissioner of health and social services, and five other members appointed by the governor. The five appointed members must include persons who are experienced in providing health care, managing large funds, providing health insurance, and promoting child welfare.

(b) Board members shall serve staggered terms of four years.

(c) The board members shall select from among themselves a chair and a vice-chair.

(d) Members of the board receive no compensation for their services but are entitled to per diem and travel allowances authorized by law for other boards and commissions under AS 39.20.180.

(e) The board shall meet at least twice a year at times and locations determined by the chair. Four members of the board constitute a quorum.

(f) The board may hire an executive director to assist it in carrying out its duties. The executive director may hire other necessary staff. The executive director and other employees of the board serve at the pleasure of the board and are in the exempt service under AS 39.25.110.

ARTICLE 2. ALASKA CHILDREN'S HEALTH CARE PLAN.

Sec. 21.55.100. CONTENTS OF PLAN. (a) The Alaska children's health care plan consists of the following medical services for children who are eligible under AS 21.55.110:

- (1) outpatient physician services;
- (2) clinic services;
- (3) diagnostic, screening, and preventive services;
- (4) dental services, except orthodontics;
- (5) rehabilitation therapy;
- (6) medical supplies;

- (7) outpatient laboratory and x-ray services;
- (8) immunizations;
- (9) prescription eyeglasses and vision care; and
- (10) prescription drugs.

(b) The board may, by regulations adopted under AS 44.62 (Administrative Procedure Act), determine the scope of the services listed in (a) of this section and add other categories of services that will be covered under the plan. A new category of service is not covered under the plan until an insurer agrees to cover it.

Sec. 21.55.110. ELIGIBILITY FOR THE PLAN. A child is eligible for coverage under the plan if

- (1) the child is under the age of 18 and a resident of the state;
- (2) the child does not have health care coverage under another public or private health insurance plan;
- (3) the child's household income is below 300 percent of the income level established under AS 47.25.310 - 47.25.420 for eligibility for aid to families with dependent children;
- (4) the child is not eligible for medical coverage under AS 47.07 (Medicaid); and
- (5) a portion of the premium for plan coverage is paid on behalf of the child, as determined by the board under AS 21.55.130.

Sec. 21.55.120. APPLICATION PROCESS. (a) The parent or guardian of a child may request an application packet for plan coverage on behalf of the child by notifying the board directly or by completing the relevant section of the child's permanent fund dividend application form as provided under AS 43.23.017.

(b) Upon direct notification by an interested person or upon notification from the Department of Revenue of the name and mailing address of a person who has requested an application packet for the plan under (a) of this section, the board shall send an application packet to the person requesting it.

(c) An application packet sent under (b) of this section must include

- (1) a description of the health care coverage available under the plan;
- (2) a copy of the sliding fee schedule used by the board to determine a family's premium co-payment responsibility;

- 1 (3) an explanation of the eligibility requirements for the plan; and
2 (4) an application form to be returned to the board if the person wants to apply
3 for coverage on behalf of an eligible child.

4 (d) Within 30 days after receiving a completed application for plan coverage, the board
5 shall either notify the applicant about whether the child is approved for coverage or request
6 additional information necessary to determine the child's eligibility. If the board determines that
7 a child is eligible for the plan, the notification of eligibility sent under this subsection must
8 include a determination of amount of the premium co-payment required under AS 21.55.140.

9 (e) The board's denial or withdrawal of plan coverage for a child may be appealed to the
10 superior court.

11 Sec. 21.55.130. ADMINISTRATION OF PLAN. (a) The board shall administer the
12 Alaska children's health care plan by

13 (1) soliciting and accepting funds from private sources for deposit into the
14 children's health fund created under AS 21.55.200;

15 (2) evaluating bids and purchasing insurance from one or more insurers to provide
16 plan coverage to children who are eligible under AS 21.55.110;

17 (3) marketing the plan in a manner designed to make its existence known to the
18 parents and guardians of children who may be eligible for the plan;

19 (4) evaluating applications for plan coverage and determining the eligibility of
20 children for plan coverage;

21 (5) determining the premium co-payment that is required under AS 21.55.140.

22 (b) The board shall adopt regulations under AS 44.62 (Administrative Procedure Act) to
23 implement this chapter.

24 Sec. 21.55.140. CO-PAYMENTS OF PREMIUMS. (a) Coverage under the plan is
25 contingent upon co-payment of part of the insurance premium, as determined by the board. The
26 board shall adopt a sliding scale for co-payments that takes into account the income and
27 resources of the child's household.

28 (b) The board, in cooperation with the Department of Revenue, shall adopt regulations
29 under which a parent or guardian may request that a child's permanent fund dividend be reduced
30 by the Department of Revenue to provide the premium co-payment for the child's plan coverage.

31 (c) The board shall deposit co-payments received under this section into the general fund.

1 The department of administration shall separately account for premium co-payments deposited
2 into the general account by the board. The estimated annual balance in the account may be used
3 by the legislature to make appropriations to the fund established under AS 21.55.200.

4 Sec. 21.55.150. CONFIDENTIALITY OF RECORDS. (a) Information received by the
5 board in an application for plan coverage is confidential and is not subject to public inspection
6 and copying under AS 09.25.110 - 09.25.120.

7 (b) A board member or employee of the corporation who divulges information in
8 violation of (a) of this section is guilty of a class B misdemeanor.

9 ARTICLE 3. ALASKA CHILDREN'S HEALTH FUND.

10 Sec. 21.55.200. CREATION OF FUND. There is created in the corporation the Alaska
11 children's health fund. It consists of money donated to the corporation from private sources and
12 appropriations made to the fund.

13 Sec. 21.55.210. USE OF THE FUND. The board may use money in the fund

14 (1) to pay insurance premiums for the Alaska children's health care plan; and

15 (2) for the board's expenses incurred in administration of the plan and the fund.

16 ARTICLE 4. GENERAL PROVISIONS.

17 Sec. 21.55.290. DEFINITIONS. In this chapter,

18 (1) "board" means the board of directors of the Alaska Children's Health
19 Corporation established under AS 21.55.010;

20 (2) "corporation" means the Alaska Children's Health Corporation established
21 under AS 21.55.010;

22 (3) "fund" means the Alaska children's health fund established under
23 AS 21.55.200;

24 (4) "plan" means the Alaska children's health care plan described under
25 AS 21.55.100.

26 Sec. 21.55.299. SHORT TITLE. This chapter may be cited as the Healthy Start Program.

27 * Sec. 2. AS 39.25.110 is amended by adding a new paragraph to read:

28 (30) the executive director and other employees of the Alaska Children's Health
29 Corporation (AS 21.55).

30 * Sec. 3. AS 39.30 is amended by adding a new section to read:

31 Sec. 39.30.092. BIDDER REQUIREMENT. An insurer may not submit a bid under

1 AS 39.30.090 for a type of medical care coverage that is included in the Alaska children's health
2 care plan under AS 21.55 unless the insurer also submits a bid to the Alaska Children's Health
3 Corporation to cover that type of medical care under AS 21.55.

4 * Sec. 4. AS 43.23. is amended by adding a new section to read:

5 Sec. 43.23.017. ALASKA CHILDREN'S HEALTH PLAN. (a) The department shall
6 include on the permanent fund dividend application form for children a question requesting
7 whether the child's parent or guardian wishes to

8 (1) apply for coverage of the child under the Alaska children's health care plan
9 established under AS 21.55;

10 (2) pay for the child's coverage under AS 21.55 by deduction from the child's
11 permanent fund dividend.

12 (b) Within 30 days after receiving an application form that indicates interest in the
13 Alaska children's health plan, the department shall notify the Alaska Children's Health
14 Corporation of the names and mailing addresses of persons who have indicated on a permanent
15 fund dividend form that they would like to apply on behalf of a child for coverage under the
16 Alaska children's health care plan.

17 (c) The department, in cooperation with the Alaska Children's Health Corporation, shall
18 adopt regulations governing how it will honor a parent's or guardian's request that a child's
19 permanent fund dividend be reduced by the department to provide the premium co-payment for
20 the child's coverage under the Alaska children's health care plan.

21 * Sec. 5. TRANSITIONAL PROVISION. Notwithstanding AS 21.55.030(b), enacted by sec. 1 of
22 this Act, the governor shall set the terms of the first five appointed members of the board of directors
23 of the Alaska Children's Health Corporation so that one of the appointed members serves a two-year
24 term, two members serve three-year terms, and two members serve four-year terms.

APPENDIX K

"The Comprehensive Health Insurance and Payment
Reform Act of 1992 (CHIPRA),
An Outline for Model Health Care Reform Legislation", draft
By the Health Access and Cost Containment Council
January 21, 1992

ALASKA PHYSICIAN/HOSPITAL HEALTH ACCESS & COST CONTAINMENT
COUNCIL

THE COMPREHENSIVE HEALTH INSURANCE AND PAYMENT REFORM
ACT OF 1992 (CHIPRA):
AN OUTLINE FOR MODEL HEALTH CARE REFORM LEGISLATION

January 21, 1992

DRAFT

I: INTRODUCTION:

The Comprehensive Health Insurance and Payment Reform Act of 1992 (CHIPRA) establishes access for the people of Alaska to a program of basic health care benefits that utilizes market forces to restrain spiralling costs. CHIPRA creates an insurance pool and a broad-based preferred provider organization (PPO) through which providers agree to discount fees to pool members. Creation of the PPO is predicated upon fundamental tort reform, prompt payment of claims, uniformity of utilization review standards and use of a standard health claims form.

CHIPRA does not replace existing insurance programs, which remain free to compete with CHIPRA policies in the marketplace. CHIPRA can be utilized by the currently insured as well as by the uninsured and uninsurable. Small businesses may also participate.

Participation in the CHIPRA pool is required for all residents of the state of Alaska not otherwise covered by an individual, family, private employer plan, or a federal program. A single premium structure, based on sex and age, will be mandated regardless of group size. Funding will be by a combination of individual contributions, use of the Permanent Fund dividend on a sliding-scale based on income, and by a sales tax on the purchase of products associated with a high risk of disease or injury. A special tax on companies selling health insurance in Alaska but *not* offering CHIPRA policies is included as an additional revenue enhancement option. Insurance policies will be sold by private insurance agents or, in the case of large employee groups, can be purchased directly from the carrier. Any carrier may offer, and any insurance agent market CHIPRA policies, in much the same fashion that Alaska lending institutions market home mortgages sponsored by the Alaska Housing Finance Corporation in competition with traditional mortgage instruments.

CHIPRA's coverage provisions contain strong financial incentives for promoting preventive health services.

A reimbursement and benefits review commission is established in order to negotiate fee discounts; recommend and publish reasonable, voluntary reimbursement sched-

ules; publish a list of services or procedures that are not covered by the program; establish a set of uniform utilization review standards; and set payment ceilings for providers who increase charges in excess of the annual rate of increase of the Consumer Price Index (CPI), unless such increases can be justified to the Commission. Publication of the reimbursement schedule, coupled with mandatory disclosure of individual provider fee schedules upon patient request, will exert potent market pressures to eliminate "outlier" fees.

II. PROVISIONS

A: CREATION OF A REIMBURSEMENT AND BENEFITS REVIEW COMMISSION:

An independent commission shall be established and shall, on a defined, regular basis: review and amend the basic health benefits package; negotiate the provider discount; establish and publish a voluntary fee schedule for procedures; review and define non-covered services; review and define inefficacious services; establish a uniform set of utilization review standards; and collect, review and evaluate data on the performance and effectiveness of the program. The Commission shall be empowered (and funded) to hire nationally recognized expert consultants to assist it in these determinations. The results of these determinations shall be published and distributed to all Permanent Fund dividend recipients on an annual basis, along with the Permanent Fund dividend application.

Should the rate of increase in some providers' charges exceed the rate of increase of the Consumer Price Index for the most recent 12-month period, the Commission shall be authorized to invoke limiting charge levels on the providers involved, unless the increases can be justified to the Commission. This provision applies equally to individual and institutional providers.

The Commission shall consist of representatives of each of the following interest groups: hospitals, physicians, employers, the health insurance industry, the public and state and local government. Method of selection, terms of appointment, salaries, supporting staff and means of enforcing its decisions are to be defined.

B: DEFINITION OF HEALTH BENEFITS PLAN:

A basic but comprehensive health plan would be defined and adopted by the Commission. The plan shall be defined as the covered services currently provided to State of Alaska retirees, modified as follows:

1. Basic inpatient and outpatient services are covered according to the scope of coverage defined below. These include indicated laboratory and radiological studies.
2. The deductible and co-insurance shall be waived for approved routine preventive services to adults and for prenatal, well-baby and well-child care. Limits shall be imposed on the number of "waivered" services per calendar year.
3. Non-covered services:
 - a: Dental care other than emergency extractions and repair of trauma,
 - b: Corrective lenses other than after ocular surgery or for conditions other than myopia, hyperopia, presbyopia and regular astigmatism,
 - c: Cosmetic surgery other than for major congenital deformities, trauma, cancer and related conditions,
 - d: Inpatient care for substance abuse, other than for the immediate, life-threatening consequences thereof (lifetime benefit of one covered inpatient recreational drug overdose episode),
 - e: Experimental treatments or procedures,
 - f: Chiropractic services,
 - g: Homeopathic and naturopathic services,
 - h: Treatments or procedures defined by the Reimbursement and Benefits Review Commission as inefficacious or of doubtful value for the preservation of or improvement in the quality of life.

C: SCOPE OF COVERAGE:

A deductible of \$1000 per participant per year shall apply, with a maximum out-of-pocket limit of \$5,000 per family. The plan will pay 80% of the balance after the deductible has been met. The deductible and co-insurance shall be on a sliding scale for those receiving other low-income benefits and shall be waived for approved routine preventive care for adults and for routine prenatal and well-baby and well-child care. An annual limit shall be established for these "waivered" services. Participants may opt for lower deductibles and co-insurance, but the costs of such additional premiums shall be borne by the participant and/or the employer, and not by the pool. There will be a lifetime annual benefit limit of \$1,000,000 per subscriber.

D: CREATION OF INSURANCE POOL AND PREFERRED PROVIDER ORGANIZATION; PAYMENT OF PREMIUMS; ELIGIBILITY:

1. An insurance pool is created to obtain coverage for its members at an initial discount of 5% below providers charges to the Alaska Medicaid program for 1991. A participating provider may not collect more than 95% of such

charges from all sources for CHIPRA policyholders. New providers will be reimbursed at 95% of the average 1991 Alaska Medicaid charges for their geographic areas.

2. Individuals, employees and groups of employees are eligible to participate.
3. Premiums will be based on age and sex, (no experience rating) although discounts shall be granted to non-smokers.
4. A premium tax shall be levied on every non-CHIPRA health policy written by private insurers in the state, and shall be deposited in the CHIPRA fund. A sales tax on the purchase of products associated with a high risk of disease or injury shall be levied if actuarial studies or experience with the program reveal a shortfall. A contribution to the CHIPRA fund will be made by private insurance companies for every non-CHIPRA policy issued in Alaska.
5. Any person wishing to participate in the program must be eligible to receive a Permanent Fund dividend.
6. All insurance carriers must pay, deny or challenge in writing claims within 15 working days of receipt by the all-payor claims clearing house (cf. item M), with interest penalties payable thereafter, provided the claim form is fully completed.

E: PROVIDER CHARGES:

Providers shall maintain a single fee or charge schedule for services, except when separate schedules are a requirement of law or regulation, or when separate schedules are negotiated with an entity (not an individual or a family) purchasing or contracting for health services to a population group. This(these) schedule(s) shall be made available upon request to members of the group(s) to which they apply.

F: GENERAL HEALTH INSURANCE PROVISIONS (for CHIPRA and non-CHIPRA policies.

All health insurance carriers doing business in Alaska shall:

1. Accept the 1992 revised HCFA 1500 form as the standard form for all claims.
2. Adopt the utilization review standards as defined by the Reimbursement and Benefits Review Commission.
3. Adhere to the same standards for claims payment as CHIPRA participants.

G: MEDICAL LIABILITY REFORM

Based on the uniform standards for medical malpractice cases outlined in the Health Equity and Access Improvement Act of 1991, central elements of malpractice reform under CHIPRA shall be:

1. Expedited medical malpractice settlements,
2. Alternative dispute resolution,
3. Mandatory periodic payments of awards,
4. Caps on non-economic damages,
5. Limitation on both defense and plaintiff attorney fees,
6. Several liability for non-economic damages,
7. Uniform statute of limitations,
8. Protection for certain high-risk specialties (e.g., obstetrics).

H: STANDARDIZED UTILIZATION REVIEW MONITORING SYSTEM:

All hospitals with a bed capacity in excess of 45 would be required to establish a multidisciplinary team whose purpose is to implement a utilization and outcome oriented approach to hospitalization, based on uniform guidelines established by the Commission. The hospital will provide annual reporting data to the Commission. The hospital will be at risk financially for prescribed standards of utilization and will be prohibited from billing any third party or patient for defined excess utilization. Third party utilization review will be eliminated for large hospitals under this approach.

I: EMPLOYER PROVIDED COVERAGE:

All employers having three or more full-time employees would be required to provide basic health insurance coverage to employees and their dependents through the basic health plan pool if they are not already providing other health insurance with the same basic benefits. Employers already providing other insurance may switch to a CHIPRA policy; differences in deductibles, co-insurance, etc. (if any) will then have to be settled between employer and employees on the same basis as any change in employee benefits.

J: COMPLIANCE BY ALL STATE AND FEDERAL AGENCIES:

All federal and state agencies who are providing health care in Alaska shall be expected to comply with the same rules and regulations that apply to the private sector. This includes licensure and certificates of need, as examples. The intent of this provision is to begin the process of levelling the playing field as the Commission attempts to reduce rate of increase in health care spending.

K: CERTIFICATE OF NEED REFORM:

The certificate of need law will be amended to require *all* institutional providers of health services to be in compliance.

L: HOSPITAL PRICE REVIEW:

All hospitals will be required to submit annual rate information. The information will be in a prescribed format and will enable the Commission to measure the actual increase in rates proposed. Any hospital increasing its rates faster than the CPI must request a rate review hearing before the Commission. The results of the review will be made available to the public, in sufficient detail and clarity to justify the increase. An appeal mechanism shall be established.

M: ALL PAYOR CLAIMS CLEARING HOUSE:

All claims for services provided under all insurance programs doing business in the state shall be submitted [electronically] to a single claims paying clearing house. The clearing house will process claims and remit payment within 15 days of entry into the system. In addition, the clearing house shall abstract claims data for routine submission to the Commission. Insurance companies operating in the state will bear the cost of the clearing house and will be prohibited from incorporating the costs into the group rating process.

N: MEDICAID ELIGIBILITY TECHNICIANS:

All hospitals with more than 45 beds will be required to employ eligibility technicians for the purpose of providing assistance to the population; the technicians shall be deputized by the state to make eligibility determinations for Medicaid and GRM. The hospital will be required to adhere to all state requirements in the conduct of this activity. The intent of this provision is to provide greater access to the Medicaid and GRM programs, possibly increasing the number of enrollees and reducing the uninsured population.

O: LICENSURE:

All institutional health care providers determined by the Commission to be essential to the cost efficiency of the health care system will be required to obtain a state license. The state will establish minimum licensure standards for each type of institutional health care provider, and will require evidence that the provider, prior to being granted a new or renewal license, has conformed to the applicable certificate of need laws.

P: HEALTH INSURANCE PREMIUM REVIEW:

A health insurance company doing business in Alaska which desires to increase premiums faster than the CPI, must request a premium review hearing before the Commission. The results of the review will be made available to the public, in sufficient detail and clarity to justify the increase. An appeal mechanism shall be established.

FOR MORE INFORMATION CONTACT:

Harlan Knudson, Alaska State Hospital & Nursing Home Assn - 586-1790
Rick Urion, Alaska State Medical Association - 463-5088, Juneau

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K-6

APPENDIX L

"Letter to Senator Jim Duncan, Co-Chair, Alaska State
Health Resources and Access Task Force,
regarding Health Care Expenditures Report Retrospective Review"
From Jeff Malek, Noble Lowndes
January 7, 1992

January 7, 1992

Senator Jim Duncan, Co-Chair
Alaska State Health Access and Resource Task Force
Alaska State Legislature
Box V
Juneau, Alaska 99801

Health Care Expenditures Report Retrospective Review

As you are aware on July 11, 1990 a report was issued to the Health Care Cost Containment Task Force entitled "Health Care Expenditures Study". This report as accepted by the Task Force was not initially received with much interest, other than by the committee, however once the information was included in the Task Forces' report in early 1991 some groups took exception to the figures. Many felt that the health care expenditures in Alaska nor the under/uninsured population could be as great as presented.

Now nearly eighteen months has passed since the release of the "Health Care Expenditures Study" it seems appropriate to review the estimated vs. actual costs, methodology and determine how accurate the report is.

Methodology for retrospective review:

1. Review initial sources of data and update data
Sources included but are not limited to:

Alaska Native Health Services

American Association of Retired Persons (AARP)

American Medical Association

Battelle Study

Department of Health and Social Services*

Division of Insurance*

Division of Retirement and Benefits*

Families USA Foundation

Health Care Financing Administration (HCFA)

Health Care Financing Review

Health Insurance Association of America

Indian Health Service (IHS)

Institute of Social and Economic Research (University of Alaska)

National Conference of State Legislators (NCSL)

National Governors Association (NGA)

Noble Lowndes Data Base

Physicians Payment Review Commission

State Demographer*

U.S. Bureau of the Census (1990)

U.S. Department of Defense

U.S. Department of Health and Human Services

U.S. Department of Labor

* State of Alaska

2. **Reevaluate Data Valuation model**

Due to the fact that no one source has compiled health care data since 1982 (HCFA), it was necessary to compile statistics from numerous sources to supplement and verify our existing data base. Then it was appropriate to check the data base for duplication and budget/estimated vs. actual expenditures. This exercise validated the data and included manipulation to assure the parameters and time periods matched.

The data evaluation model is based on Noble Lowndes statistical analysis procedures and is accurate to +/- 3%.

3. **Data Valuation Model Process**

- A. Output first run data and isolate data problems or voids
- B. True up data (when feasible)

- C. Output second run data and run stop checks
- D. Add factors for current year trend, incurred but not expended health care costs, utilization and socio-economic trends
- E. Final run and evaluation

These steps were performed separately and cumulatively for the years 1979, 1984, 1989 and 1990.

The results are as follows:

Total health care expenditures for State of Alaska residents. This is based on our sole interpellation of the data in Alaska and the United States.

<u>1979</u>	<u>1984</u>	<u>1989</u>	<u>1990</u>	<u>1991</u>
\$481.25 Million	\$710.31 Million	\$1.36 Billion	\$1.523 Billion	TBD

Due to the variances in reporting and analysis we have noticed that our results may vary from other sources, however based on our in depth Alaska specific analysis we remain confident in the results.

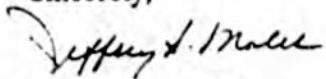
One report "Families USA Foundation Report, Rising Health Costs in America" October, 1990 shows total health care spending in Alaska for 1990 at \$1.242 billion. The variances in data highlight the differences, for example the Families USA report estimates "other public health care expenditures as \$231 Million when the Alaska State budget was \$310 million alone, not including municipality or other public spending.

You may recall that during the December 1990 meeting at Families USA with Representative Boyer, yourself and myself, they stated that their estimates, while state specific, were derived from national estimates allocated by state. This would account for the difference between our health care expenditure report and theirs.

With respect to the under/uninsured population in Alaska estimates for 1990 and beyond we still remain confident in the 90,000 estimate released in the February, 1991 Health Care Cost Containment Task Force report. In fact new data may actually reveal that the under/uninsured population may have taken another leap during 1991. As this and other pertinent information develops we will provide the specifics to you.

If we can answer any questions or can provide additional information please feel free to contact me.

Sincerely,


Jeffrey A. Malek
Principal

APPENDIX M

"Memo to Nancy Cornwell"

From Larry Bartlett, Health Systems Research, Inc.

January 23, 1992

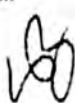
HSR inc.

HEALTH SYSTEMS RESEARCH, INC.

DATE: January 23, 1992

TO: Nancy Cornwell

FROM: Larry Bartlett



BY FAX

-
1. I don't have the Rand cite you're looking for. However, I believe the RWJ survey shows that a significant portion of uninsured people delay receiving needed care because of financial barriers. This would lend some support to this argument that, when they do receive care, their condition may have progressed to a more serious stage.
 2. With respect to assessing the impact of Alaska's younger population per capita health expenditures, please note the following:
 - Jeff Malek's January 7th memo to Jim Duncan placed Alaska health care expenditures at \$1.523 billion. If this figure is divided by the 1990 Census estimate of 550,043 Alaskans, per capita expenditures equal \$2,769.
 - While the Family USA figure placed U.S. per capita expenditures at \$2,424 for 1990, the material from the AMA provided by Dr. Wilson indicated that the U.S. per capita figure for 1990 is \$2,566, (if all expenditure categories are included). You have to decide which of these two figures is most comparable to Jeff's estimate.
 - A federal study entitled Health Care Expenditures by Age Group, 1977 and 1987, (D.R. Waldo, et al., Health Care Financing Review, Summer 1988, Volume 10, No. 4), estimated that in 1987 per capita spending for individuals under 19 was approximately 48.5% of per capita spending for persons 19-64, while per capita spending for those 65 and over was nearly three and a half times that for the 19-64 year old population. Using these ratios, we can develop a rough measure of the impact of Alaska's younger population on per capita health spending by either developing a per capita estimate for Alaska using the U.S. age distribution (i.e., What would Alaska's per capita cost look like if the age distribution of its population was the same as the U.S.?) or by applying Alaska's age distribution to the average U.S. per capita estimate (i.e., What would the U.S. figure look like if the country had Alaska's younger age profile?).
 - If Alaska were assumed to have the same age distribution as the U.S., its average per capita health care expenditures for 1990 would have increased to \$3,486. If the U.S. were assumed to have the same age distribution as Alaska, national per capita expenditures would be reduced to \$2,039. This figure could then be better compared to the Alaska estimate of \$2,768. In either case, once this crude adjustment for differences in age distributions is made, per capita Alaska health care costs are shown to be significantly higher relative to the U.S. average.

APPENDIX N

"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
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.

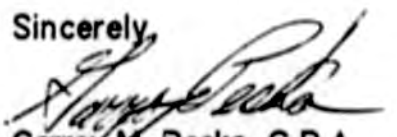
The respondent facilities represent 978 acute care beds and 594 nursing care beds. This information comes from the 1990 Alaska Hospital Survey published by the State Department of Health & Social Services on April 1, 1991.

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

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
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

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

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.

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.

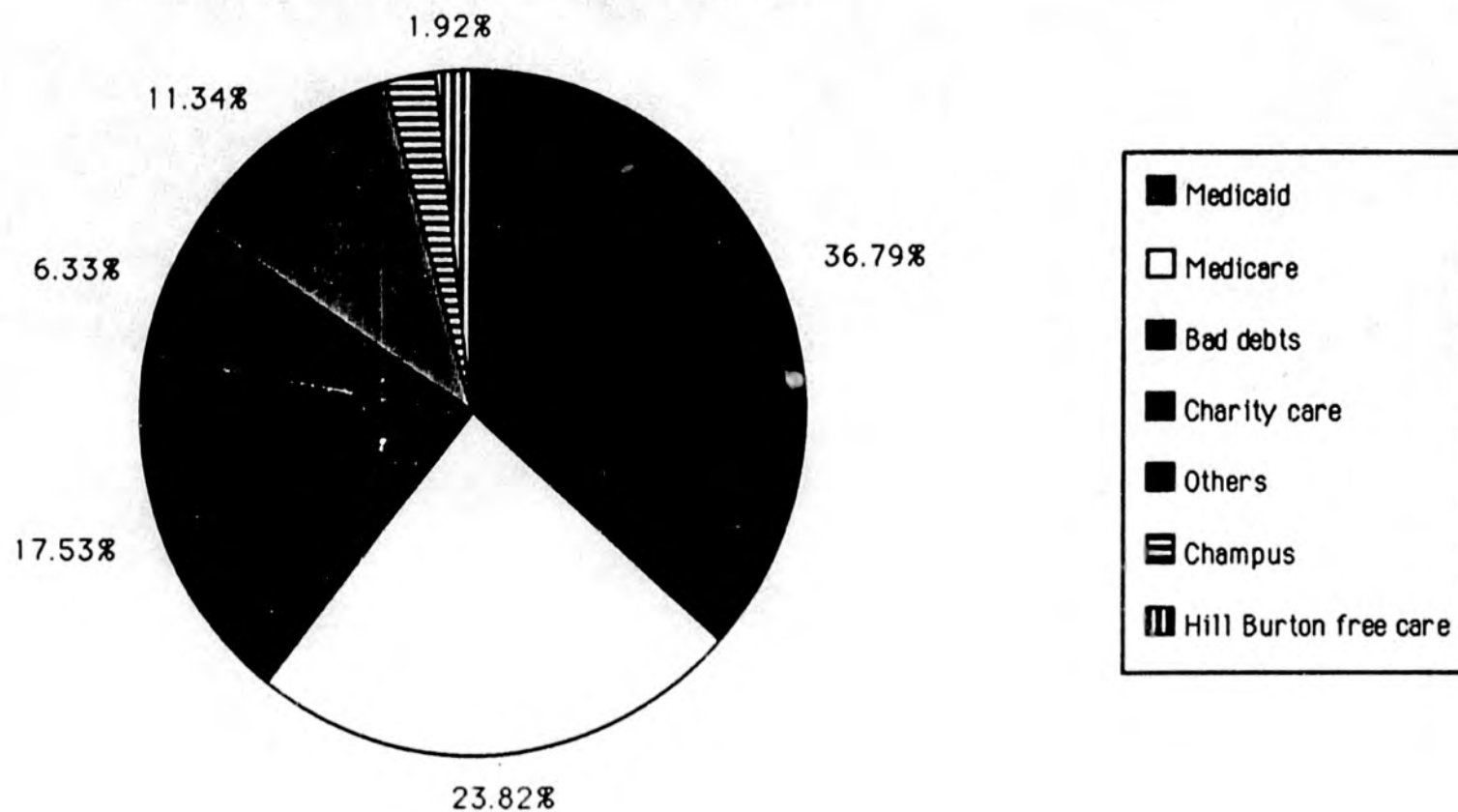
Sincerely,



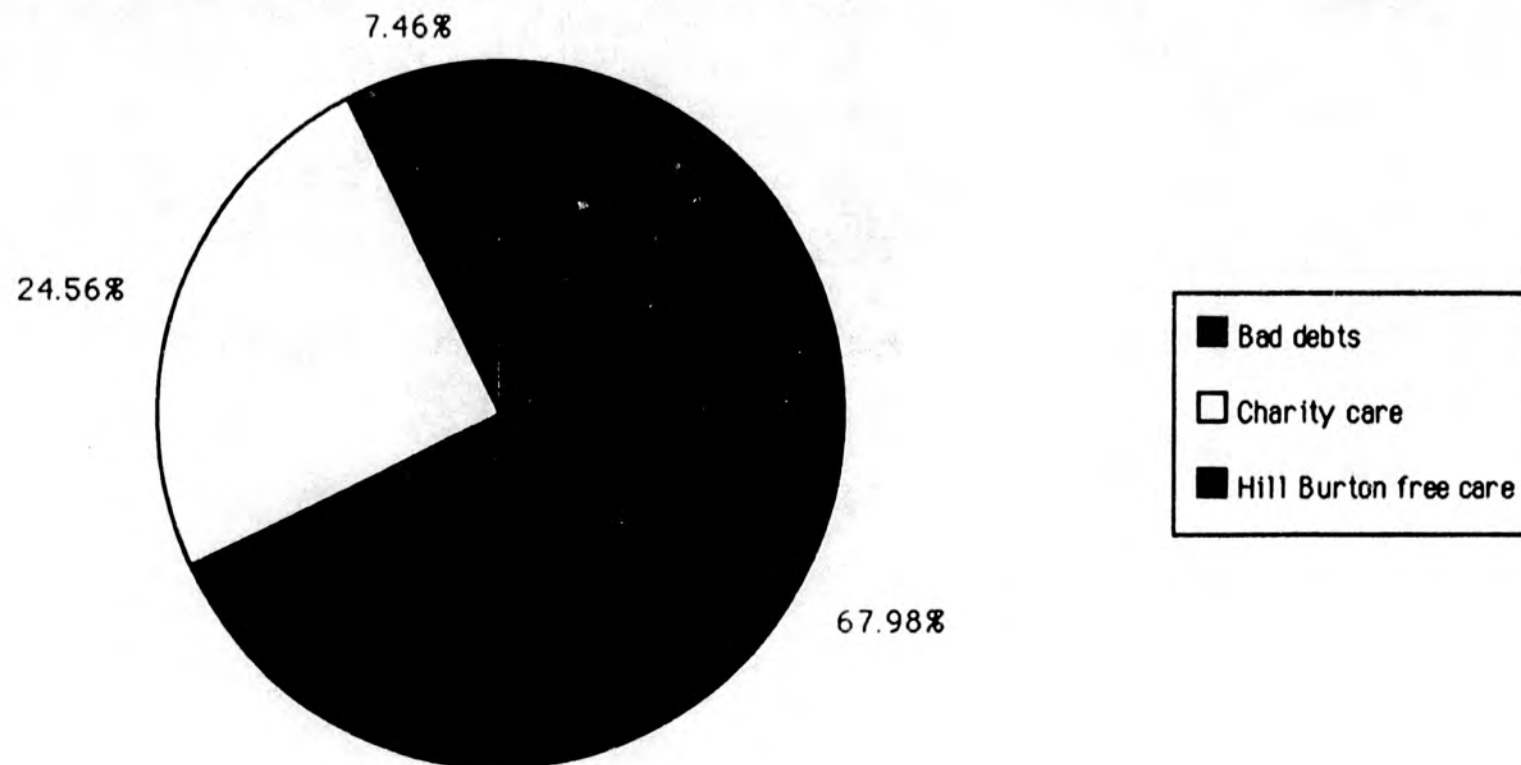
Garrey M. Peska, C.P.A.
Vice President / Finance

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

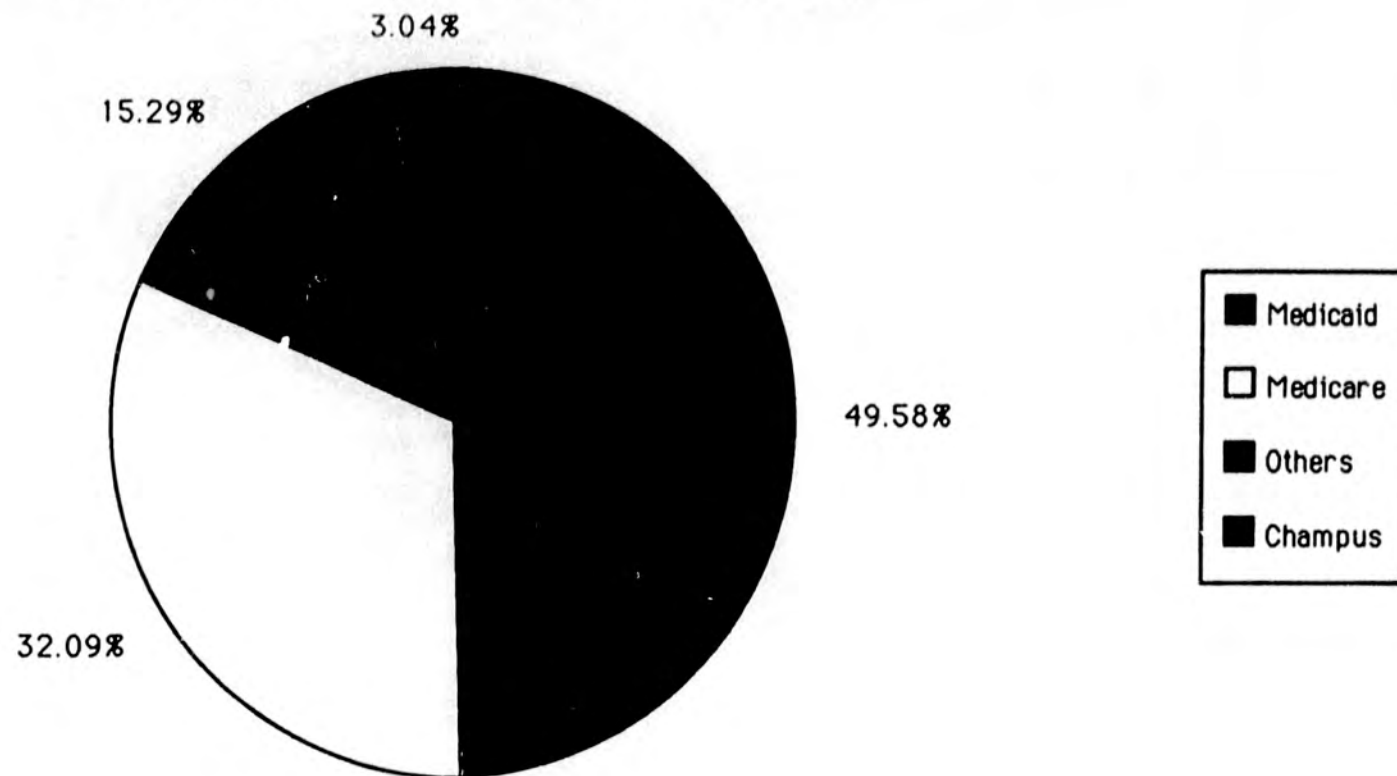
Total 1990 Unpaid Charges for Services \$86,132,714



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



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



N-12

Alaska State Hospital Nursing Home Association Data Collection

FACILITY NAME: Bartlett Memorial 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	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

FACILITY NAME: Denali 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 %	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 %			
	Question 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: Fairbanks 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	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	777,401	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	28,944	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:					
	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

FACILITY NAME: Heritage Place		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	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:					
	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: Humana Hospital - Alaska	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		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 %			
	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: Ketchikan 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	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		456,486	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:					
	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: Kodiak Island 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	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:					
	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 and Nursing Home Association Data Collection

FACILITY NAME: Mary Conrad 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	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:					
	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: Our Lady of Compassion 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
SOURCE OF REVENUES: (Fiscal year ended during 1990)						
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 & Undesignated investment income		0	N/A		
			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:						
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

FACILITY NAME: Petersburg 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	0.00%	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:						
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: Providence 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
SOURCE OF REVENUES: (Fiscal year ended during 1990)						
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	15 %	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:						
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

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:					
	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

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:					
	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: St. Anns Nursing Home SOURCE OF REVENUES: (Fiscal year ended during 1990)	Percent of Total Charges	(A)Revenue 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		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:					
	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: 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
SOURCE OF REVENUES: (Fiscal year ended during 1990)						
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:						
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

FACILITY NAME: Wrangell 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	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:					
	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					