

ALASKA LEGISLATURE SPECIAL COMMITTEE / SUBJECT FILE 8672

2189 SCOMM 86: HEALTH RESOURCES & ACCESS TASK FORCE, 1991-93

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SCOMM 86: HEALTH RESOURCES & ACCESS TASK FORCE 1991-93

LEGISLATIVE MEMBERSHIP:

SENATOR JIM DUNCAN, CO-CHAIR
SENATOR-ELECT JOHNNY ELLIS, CO-CHAIR
REPRESENTATIVE MARK BOYER
SENATOR JALMAR KERTTULA
REPRESENTATIVE MIKE NAVARRE
SENATOR ROBIN TAYLOR
(THE TASK FORCE ALSO INCLUDES EXECUTIVE BRANCH AND PUBLIC MEMBERS)

Established by LR 45, 1991 (SCR 10)

Contents: 4" of summary minutes and reports. 119 tapes are also available of meetings held 6/6/91 - 1/27/93.

See also SCOMM 68, Health Care Cost Containment Task Force, 1989-1991.

LIST OF FILES (PAGE 1)

MICROFICHE #

1. SUMMARY MINUTES 9/18/91 - 9/26/92
2. INTERIM REPORT, 1/11/92
3. INTERIM REPORT - APPENDIX, 1/11/92
4. HEALTH CARE REFORM FINANCIAL RECOMMENDATIONS, 3/14/92
5. FINAL REPORT, 1/93
6. FINAL REPORT - APPENDIX, 1/93
7. FINAL REPORT - PUBLIC INPUT, 1/93

1:98

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HEALTH RESOURCES AND ACCESS TASK FORCE
Sen. Duncan/Rep. Ellis, Co-Chairs

Minutes and Tapes Inventory
...1991-1993...

TAPE # DATE BILL NUMBER AND SIGNIFICANT INFORMATION

Note: None of the minutes are on computer. Tapes and hard copies of the minutes available from the Legislative Library. Minutes are also available in SCOMM 86 (Microfiche).

1991

1	Jun.6	No minutes, tape only
2,3	Aug.01	No minutes, tape only
4-11	Sept.18+19	Minutes Available
12-19	Oct.14+15	" "
20-27	Nov.18+19	" "

1992

28-37	Jan.9+10	Minutes Available
38-43	Feb.01+02	" "
44-46	Mar.15+16	" "
47-53	Feb.29 + Mar.06	" "
54-59	Mar.14+15	" "
59A	Mar.17	No minutes, tapes only / Radio Interview
60-65	Jun.24+25	Minutes Available
66-73	Jul.20+21	" "
74-81	Aug.24+25	" "
82-88	Sept.25+26	" "
89	Oct.13	No minutes, tape only

HEALTH RESOURCES ACCESS
Tapes and Minutes 1991

TAPE#	DATE	BILL NUMBER AND SIGNIFICANT INFORMATION		
90	Oct.14	"	"	"
91-92	Oct.15	"	"	"
93-94	Oct.19	"	"	"
95-96	Oct.20	"	"	"
97-98	Oct.21	"	"	"
99-100	Oct.22	"	"	"
101-110	Oct.22+23	"	"	"
111-118	Nov.12+13	"	"	"

1993

119	Jan.27	FINAL REPORT TO THE GOVERNOR AND THE LEGISLATURE (tape only)
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HEALTH RESOURCES AND ACCESS TASK FORCE
Summary Minutes
September 18 and 19, 1991

THESE MINUTES INCLUDE ONLY FORMAL DECISIONS MADE BY THE TASK FORCE AND THEREFORE DO NOT INCLUDE DISCUSSION OR RESEARCH SUGGESTIONS.

I. RULES FOR CONDUCTING PUBLIC MEETINGS

Meetings will be conducted in an informal style until which time it is necessary to use Robert's Rules of Order.

Proxies are not allowed.

II. MEMBER PARTICIPATION

Members may have a designee. The member should indicate if the designee is permanent or temporary.

The designee must be identified in writing before the next meeting (October 14 and 15).

When the member is absent, the designee may vote on behalf of member.

III. ELECTION OF CO-CHAIRS/VICE CHAIR

Senator Jim Duncan and Representative Johnny Ellis were elected as permanent Co-Chairs; Dr. Rodman Wilson was elected as Vice Chair. (Action by unanimous consent.)

IV. GUIDING PRINCIPLES

The Health Resources and Access Task Force drafted the following principles to be used to guide the development of public policy.

PREAMBLE

The Constitution provides that the State of Alaska is responsible for the public health. However, each Alaskan bears individual responsibility to maintain a healthful lifestyle.

Health care costs can best be contained by an educated public, committed to wellness. The state must take an aggressive role in working with all Alaskans on health and safety education and the prevention of illness.

Access

1. All Alaskans should have access to adequate, effective, appropriate, and quality health care services without regard to financial means or status.
2. A basic level of health care will be defined by the Task Force to which everyone has access, with priority on effective, appropriate, and quality care, especially preventive and primary care, early diagnosis and treatment, and incentives for healthful lifestyles.

Financing

3. All Alaskans share a responsibility to obtain and pay for adequate health care for themselves and their dependents, but the government should participate in financing care for those unable to pay.
4. Responsibility for the financing of options should be equitably distributed among payers.
5. Options for improving access should minimize the negative impacts on businesses and on current employer health benefit plans and should not be an incentive for providers to reduce or drop coverage. Employers are encouraged to participate with their employees to meet the responsibility regarding care for their own health needs.

Cost Containment

6. Health care expenditure controls should be essential elements of approaches to expand access to care for the uninsured and to ensure continued adequate coverage for those currently insured.
7. Use of cost sharing may be considered to control excessive utilization but should take into account ability to pay.
8. Approaches should include incentives to seek and provide care in the most efficient and cost effective manner and location, including contractual arrangements for patient management and utilization controls.
9. Providers should be reimbursed at reasonable levels. These and other health care policies should promote efficient service delivery and availability and constrain unnecessary expenditures.
10. Individuals should have an informed and reasonable choice in selecting health care providers although they may be restricted to certain providers in cases where these arrangements significantly increase the cost-effectiveness of this care.

General

11. Approaches to expand access to care for the uninsured should be as simple to administer as possible and avoid duplication of resources. Special attention should be given to minimizing the administrative burden on small businesses, providers and consumers.
12. Program policy design should be sensitive to the culture and problems of provider availability and accessibility, especially in rural areas.

V. NEXT MEETING(S)

The next two meeting of the Task Force will be October 14 and 15 and November 18 and 19, 1991. Both meetings will be held at the Anchorage Legislative Information Office.

HEALTH RESOURCES AND ACCESS TASK FORCE
Summary Minutes
October 14 and 15, 1991
Anchorage Legislative Information Offices

I. MINUTES OF SEPTEMBER 18 AND 19 MEETING

Adopted as presented.

II. GUIDING PRINCIPLES

Adopted by unanimous consent.

III. PRESENTATIONS/DISCUSSIONS

The Task Force heard presentations on:

- Summary of revenues, expenditures, and uncompensated care in Alaska's sixteen community hospitals, by Dr. Scott Goldsmith, ISER.
- Demographic trends/firm size in Alaska impacting health care expenditures, by Dr. Scott Goldsmith, ISER.
- Factors that drive Aetna's health care premiums, by Steve LeBrun, Aetna.
- Rural health care systems and the Community Health Services Development model, application to Alaska's alcohol-related problems, by Dr. Bruce Amundson.
- Cost-containment options implemented in other states, by Dr. Larry Bartlett, Health Systems Research, Inc.
- Certificate of Need in Alaska, Alaska's Nursing Home Census, by Larry Streuber, DHSS Planning Section.
- High-tech medical equipment and units, by Brad Whistler, DHSS Planning Section.
- Access options implemented in other states, by Dr. Larry Bartlett, Health Systems Research, Inc.
- Role of the Division of Insurance in regulating health insurers in Alaska, mandated benefits, by David Walsh and Chris Ulmann, Division of Insurance.
- Comprehensive reforms implemented/recommended in other states, by Larry Bartlett, Health Systems Research, Inc.

Health Resources and Access Task Force
Continued, Summary Minutes

IV. OPTIONS FOR FURTHER STUDY AND POSSIBLE RECOMMENDATION DURING
NEXT LEGISLATIVE SESSION

The Task Force identified the following options for further study at their next several meetings with the goal of determining which they will make recommendations on during the next legislative session.

1. Examine regulatory, reimbursement, and demonstration/pilot project approaches (i.e. alternative facility models) to address the excess capacity problem.
2. Expand access for kids (including medically needy option for women and children).
3. (Some form of) Regulatory reform in small group market.
4. (Options for uninsured: explore such things as) Hour banks for seasonal/part-time workers.
5. Data gathering (including providers rates (charges) review, insurer rate review, making data available to consumers, flow of medical expenditures outside the state, reinstatement of planning function).
6. Strengthening Certificate of Need process.
7. Retention and attraction of primary care health workers to medically under-served areas.
8. Utilization review standards.
9. Pooling concept.

V. OPTIONS FOR FURTHER STUDY AFTER NEXT LEGISLATIVE SESSION

The Task Force identified the following options for further study after the next legislative session.

1. Caps on malpractice awards.
2. Alternate dispute resolution for malpractice cases.
3. Identify non-efficacious procedures.
4. High-risk pool/comprehensive health insurance association.

Health Resources and Access Task Force
Continued, Summary Minutes

5. Expand local access available at community.
6. Universal access/coverage.
7. Single-payor.
8. Philosophy: micro vs. macro management.
9. Development of reimbursement schedules and utilization standards.

IV. NEXT MEETINGS

The next two meetings of the Task Force will be November 18 and 19 and December 13 and 14 at the Anchorage Legislative Information Offices.

HEALTH RESOURCES AND ACCESS TASK FORCE
Summary Minutes
November 18 and 19, 1991

I. MINUTES OF OCTOBER 14 AND 15 MEETING

Adopted as presented.

II. RESIGNATION/APPOINTMENT OF MEMBERS

Accepted Paul Sherry's resignation. Moved and appointed David Mather to position representing non-profit organizations.

Acknowledged Roberley Waldron as Commissioner Bear-Usera's designee.

III. PRESENTATIONS/DISCUSSIONS

Uncompensated Care (based on charges) in Alaska's community hospitals, by Dr. Scott Goldsmith, ISER.

Survey data from Alaska State Hospital and Nursing Home Association members on uncompensated care, by Garrey Peska, Financial Issues Consultant, ASHNHA.

Aetna Presentation: Alaskans Covered by Aetna plans; Comparisons of Cost Levels; Average Charge Comparison for Medical Services/Procedures and Surgical Services/Procedures; Inpatient Utilization-Admissions per 1,000 Eligible Enrollees; Average Per Day and Average Per Admission for Major Diagnostic Category; Submitted Expenses, Covered Expenses, Benefits Payable, Length of Stay; Costs Associated with Alaska State Health Benefit Mandates; Medical Coverage for Alaska's Children; Aetna Small Group Market Information; Utilization Management by Aetna; and, Analysis of Recent Cost Containment Activities for the State of Alaska Employee Medical Plan, by Steve LeBrun, Aetna.

Blue Cross Caring Foundation of Southeastern Pennsylvania, by Jeffrey Duzenbery, Blue Cross of Washington and Alaska.

Implementing Medicaid's Medically Needy Option in Alaska, by Gordan Landes, Alaska Division of Medical Assistance.

How labor unions have used hour banks to extend health care coverage to members, by Mano Frey, AFL-CIO.

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Geographical distribution of physicians in Alaska by specialty; Proportions of physicians by specialty in USA, Canada, and Alaska; and, current need for physicians in rural Alaska, by Rodman Wilson, MD, Task Force member.

Three scenarios: Cost impacts of excess capacity in Alaska's facilities, by Scott Goldsmith, ISER.

How could Medicaid change its rate setting method to provide incentives for facilities to reduce their excess capacity, by Jack Nielsen, Medicaid Rate Advisory Commission.

V. OPTIONS DISCUSSED BY THE TASK FORCE

At their October meeting, the Task Force identified a number of options they wanted to study further and consider making recommendations on during the next legislative session. At this meeting, the Task Force listened to presentations related to the options (see above) and discussed each option. Decisions related to each option are described below:

Option: Utilization Review Standards

The Task Force agreed to keep this option under consideration.

Larry Bartlett offered to provide some information on UR standards that Health Systems Research, Inc. developed for another state.

The Task Force requested the Division of Insurance provide additional UR case history information.

Option: Pooling Concept

The Task Force agreed to keep this option under consideration.

The Task Force requested Senator Duncan present SB 83 at their next meeting.

The Task Force requested the Health Access and Cost Containment Council present their plan to the Task Force.

The Task Force recognized the need to discuss cost containment approaches which should be considered by the Task Force when developing comprehensive health care reform. They agreed to invite the Health Access and Cost Containment Council to come to their next meeting and discuss potential cost containment approaches.

Option: Regulatory Approach to Small Group Market Reform

The Task Force agreed to keep this option under consideration.

The Task Force requested the Division of Insurance present the National Association of Insurance Commissioners' model on regulatory reform at their next meeting.

Option: Data Gathering

The Task Force agreed to keep this option under consideration.

Option: Regulatory (including Certificate of Need), reimbursement, and demonstration/pilot project approaches to addressing excess capacity problem

The Task Force agreed to keep the Certificate of Need option under consideration.

The Task Force requested the Alaska State Hospital and Nursing Home Association address the Task Force regarding their specific objections to the Certificate of Need bill currently before the Legislature.

The Task Force requested Scott Goldsmith develop criteria for building a new facility.

Option: Retention and attraction of primary care health workers in medically underserved areas

The Task Force agreed to keep this option under consideration.

Option: Hour Banks for Seasonal/Part-time Workers

Representative Boyer indicated he plans to develop legislation related to state employees. The Task Force made no further decision.

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Option: Expand Access for Kids

The Task Force agreed to keep this option under consideration.

V. OTHER TASK FORCE ACTION

The ASHNHA offered to survey its members to collect information on uncompensated care based on actual provider costs. Representative Boyer requested ASHNHA include in the survey information on local bonded indebtedness.

Representative Ellis requested that Steve LeBrun from Aetna and a representative from Blue Cross attend all future Task Force meetings and participate in Task Force discussions.

Senator Duncan and Representative Navarre agreed to look into the possibility of extending Larry Bartlett's current contract or entering into a new contract with him.

VI. NEXT MEETING

The Task Force cancelled its December 13 and 14 meeting and scheduled a three-day meeting for January 9, 10, and 11 in Juneau.

HEALTH RESOURCES AND ACCESS TASK FORCE
Draft Summary Minutes
January 9, 10, and 11, 1992

I. MINUTES OF NOVEMBER 18 AND 19, 1992 MEETING

Adopted as presented.

II. PRESENTATIONS/DISCUSSIONS

Senator Duncan presented Senate Bill No. 83 (and provided background information) including its approach to pooling and cost containment, who it covers, how they will benefit, and what is required to put it in place. The task force discussed Senate Bill No. 83 and the pooling concept.

The Health Access and Cost Containment Council presented the "Comprehensive Health Insurance and Payment Reform Act "(CHIPRA) of 1992: An Outline for Model Health Care Reform Legislation" (January 6, 1992, draft) as well as a comparison that they prepared of Senate Bill No. 83 and CHIPRA.

Larry Bartlett, a consultant to the task force, prepared a comparison of Senate Bill No. 83 and CHIPRA and presented it to the task force. The task force discussed the comparison.

The Alaska State Hospital and Nursing Home Association presented 1990 information on sixteen hospitals and nursing homes including sources of revenue (charity care, bad debt, and Hill Burton free care; government payors; private payors; and other sources including state and local governments), total operating costs (with depreciation reported separately), and outstanding debt and debt service. For the revenue sources, they reported each by "revenues at the full-charge rate", contract allowances/discounts, and actual collections.

Blue Cross of Washington and Alaska presented information to the task force on Alaskans covered by Blue Cross, trends, out-of-state services, medical underwriting, dependent coverage, AdvantageCare, BestBeginnings, Alaska's mandated health benefits, a comparison of 1990 charge levels, a summary of institutional admissions by diagnosis category, and a description of their involvement in the small group market.

The Alaska State Hospital and Nursing Home Association presented their objections to Senate Bill No. 84 (revisions to the Certificate of Need process) and their support for Senate Bills No. 67 and 111.

Health Resources and Access Task Force
Draft Summary Minutes, Page 2
January 9, 10, and 11, 1992

(continued, II. Presentations/Discussions)

Scott Goldsmith with the University of Alaska's Institute of Social and Economic Research presented his findings on excess capacity in Alaska's acute care community hospitals.

III. Interim Report to the Governor and Legislature

The task force reviewed the draft interim report prepared by staff and made a series of changes and additions.

The Interim Report was adopted as revised by unanimous consent.

IV. POLICY OPTIONS UNDER TASK FORCE CONSIDERATION/NEXT MEETINGS

The task force decided to pursue the development of a comprehensive health reform package with the hope of introducing it during the 1992 legislative session. They scheduled the following work sessions and formal meetings with the intention of recommending specific legislation to the governor and legislature by March 16, 1992.

Meeting Schedule:

<u>Dates</u>	<u>Type of Meeting</u>	<u>Location</u>
February 1, 2 (Sat., Sun.)	Work Session	Anchorage*
February 15, 16 (Sat., Sun.)	Work Session	Anchorage*
February 29, March 1 (Sat., Sun.)	Work Session	Anchorage*
March 14 (Sat.)	Work Session	Juneau**
March 15 (Sun.)	Formal Meeting	Juneau**

*The Anchorage meetings will be held in the Anchorage Legislative Information Office, 3111 C Street, 9:00 am - 5:00 pm.

**The Juneau meetings will be in the State Capitol, Senate Finance Committee Room, 9:00 am - 5:00 pm. The formal meeting will be teleconferenced.

HEALTH RESOURCES AND ACCESS TASK FORCE
WORK SESSION
Summary Minutes
February 1 and 2, 1992

I. Minutes of January 9, 10, and 11, 1992

Adopted as presented.

II. Capital Grants Criteria

Scott Goldsmith presented demand based hospital occupancy rate standards. He reporting applying this standard to Alaska's hospitals, that Alaska's acute care community hospitals have excess capacity.

After some discussion, the task force requested Scott incorporate the demand based hospital occupancy standards into Scott's "Criteria for Cost Effective Investment in Acute Care" (originally presented at the task force's January meeting). They also requested that Scott and Jay Livey recommend to the task force how these standards could be incorporated into Senate Bill No. 84 and/or Senate Bill No. 67.

III. Cost/Price Controls

The task force discussed how to control overall health care spending (specifically the idea of setting global spending limits) and the feasibility and merits/problems associated with various reimbursement systems in both hospital and physician settings (including fee-for-service, per diem, DRGs, and capitation).

The task force agreed on the following assumptions:

- Cost/price controls have to be a part of a comprehensive solution.
- A global spending limit should also be a part of a comprehensive solution.
- The base, over a 12-month period, should not increase more than the CPI (general inflation rate).

The task force did not come to a conclusion as to what the base should be or how to incorporate the base into a reimbursement system. The task force requested Larry Bartlett recommend an appropriate base for facilities and physicians as well as make suggestions about how to incorporate the base and inflation factor into the reimbursement system. They also requested information from Larry on Maryland's system, how it works procedurally and what their experience had been. Larry also offered to send some information on "global budgeting".

IV. NAIC models and Senate Bill No. 242

Chris Ulmann briefly reviewed the National Association of Insurance Commissioners' models:

- Small Employer Health Insurance Availability Model Act
(PROSPECTIVE REINSURANCE MODEL)
- Small Employer Health Insurance Availability Model Act
(ALLOCATION MODEL)
- Model Health Plan for Uninsurable Individuals Act
(HIGH RISK POOL MODEL)

Senator Collins presented background information on Senate Bill No. 242 which is similar to the NAIC's prospective reinsurance model. The task force also discussed the relative impacts of SB 242 and a high-risk pool. The task force requested the Division of Insurance prepare a comparison of the NAIC's high risk pool model and Senate Bill No. 74 for their next meeting.

IV. Access and Pooling

The task force reviewed the characteristics of Alaska's uninsured population. They speculated on the composition of this population (i.e., how many full-time/full-year uninsured workers have adequate incomes and therefore can afford private insurance; how many full-time, full-year uninsured workers have inadequate incomes and therefore can not afford private insurance; how many uninsured children are low income; how many are uninsurable.) The task force requested Larry Bartlett provide some guidance to them on how they might approach the various sub-groups within the uninsured population and asked Nancy Cornwell to discuss with Larry the possibility of providing cross-tabulations on Alaska's uninsured population for selected characteristics.

The task force also discussed single vs. multiple pools. They requested Larry Bartlett outline the pros and cons of a single vs. multiple pools. For the purpose of this analysis, they developed the following assumptions:

- Everyone in the state has coverage although they may not be in either the single pool or one of the multiple pools.
- Alaska Natives have coverage through the Alaska Area Native Health Service.

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Work Session, Summary Minutes, Page 3
February 1 and 2, 1992

The task force requested that Aetna and Blue Cross develop premium estimates for two groups: (1) all Alaskans (a single pool), and (2) uninsured Alaskans (a single pool). For the purpose of this request, they asked the insurers to use the CHIPRA benefit package. They requested premium estimates be provided for three different deductibles: \$250, \$500, and \$1,000 deductibles, and broken down by age (interested in children), and finally, if dental care was added to the benefit package.

HEALTH RESOURCES AND ACCESS TASK FORCE
WORK SESSION
Draft Summary Minutes
February 15 and 16, 1992

I. Minutes of February 1 and 2, 1992 meeting

Adopted as presented.

II. Access/Pooling

The task force's reviewed Larry Bartlett's February 11 memo and agreed to request that he develop estimates of the impact of the options for extending coverage to various uninsured subgroups (listed on page 6 of that memo):

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

In addition, they requested that Larry provide estimates for "all kids in Alaska".

Steve LeBrun, Aetna Life Insurance Company, presented premium estimates to the task force.

The Division of Insurance presented a comparison of the National Association of Insurance Commissioners' high-risk pool model and Senate Bill No. 74.

III. Cost/Price Controls

The task force reviewed the suggestions in Larry Bartlett's February 11 memo. They agreed on the following assumptions regarding cost/price controls:

- A global spending limit or goal for all health care expenditures in Alaska will be established by a health care authority or commission.

III. Certificate of Need

Scott Goldsmith with the Institute of Social and Economic Research presented "suggested changes to proposed legislation (Senate Bill No. 84) to strengthen the Certificate of Need process". Larry Streuber with the Alaska Department of Health and Social Services presented information from other states on how they have obtained the statutory authority to set standards and criteria for their Certificate of Need processes.

IV. Malpractice

Dr. Wilson briefed the task force on the history of medical malpractice in Alaska. Larry Bartlett also presented information on medical malpractice reforms in other states.

V. Senate Bill No. 74

Dr. Annette Thorn, Senator Kerttula's staff, presented background information on Senate Bill No. 74 which establishes a corporation to provide coverage to high-risk individuals and medicare supplement policies to the elderly.

HEALTH RESOURCES AND ACCESS TASK FORCE
WORK SESSION
Summary Minutes
February 29 and March 1, 1992

I. Minutes of February 15 and 16, 1992

Adopted as presented.

II. Draft Interim Recommendations

The task force agreed that recommendations developed at this meeting would reflect the group's support for concepts rather than specific legislative bills. All draft interim recommendations described in these summary minutes are recommended for immediate enactment by the legislature unless otherwise noted.

III. Cost Containment

The task force divided its recommendations on cost containment into three areas:

- A. Global budgeting including global spending limits, reimbursement systems, data collection/analysis, common claims forms, utilization standards, and time frames for claims payments;
- B. The regulation of utilization review agents; and,
- C. The authority to review and approve or disapprove rates filed by health insurers.

A. Global Budgeting

The task force reaffirmed their support for the concepts of global budgeting and reimbursement system reforms made at their previous meetings:

- A global spending limit or goal for all health care expenditures in Alaska will be established by a health care authority or commission.

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February 29 and March 1, 1992

- The global spending goal will limit the annual rate of increase in health care expenditures to increases in the Consumer Price Index (CPI). The base for the goal is overall spending in a given prior year. (A "prior year" rather than the "current year" is used to avoid incentives for increasing current spending and consequently the base.) The annual targets established in this manner can be adjusted (by the authority/commission) to reflect the following factors:
 - Changes in the size and/or demographic characteristics (e.g., age distribution) of the state's population that may affect the need/demand for health care in the future;
 - Changes in technology that may increase or decrease health care costs;
 - Improvements in health care productivity;
 - The identification and reduction of the provision of unnecessary health care;
 - Desired changes in some segments of the population (e.g., the uninsured's) access to adequate health care services;
 - Increases or decreases in the costs associated with medical malpractice premiums and awards as appropriate;
 - Reductions in administrative costs; and,
 - Other such factors as the state authority/commission may determine to be appropriate (i.e., epidemics and disasters).
- The overall limit or goal for health care expenditures will be subdivided, establishing limits or sub-goals for hospital care expenditures, physician services expenditures, etc.
- All providers will comply with the payment or reimbursement system for providers which includes rates and sanctions for non-compliance.
 - For health care facilities (and the reimbursement levels for individual facilities), the base for the expenditure goal will be actual costs in a prior year.

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Summary Minutes, Page 3
February 29 and March 1, 1992

-For hospitals, the unit of payment will be on a DRG-specific per discharge basis. Price or charge levels will be increased above cost levels to account for uncompensated care and/or Medicare rates that are not sufficient to cover costs.

-For physician services, the reimbursement system will utilize resource-based relative value scale (RBRVS).

-For other services, the authority/commission will develop the specific reimbursement systems.

The task force discussed in detail how a reimbursement system would be structured under a global spending limit. They recognized that providers must be required to participate in the system utilizing rates and that there must be sanctions for non-compliance. Larry Bartlett advised the task force that due to technical sophistication required, "global budgeting" is extremely challenging to implement and will take several years representing several phases of development to implement.

Building on the global budgeting model, the task force supported the additional concepts:

- Data collection is an essential element of global budgeting. The authority/commission will have the authority and capacity to collect and analyze all health care data necessary to do global budgeting.
- The authority/commission will develop a uniform billing and common claims form which all payors (including self-pay) and providers will be required to use.
- The authority/commission will develop utilization standards.
- The authority/commission will establish requirements for the timely payments of claims by all payors. A target is 15 working days from the receipt of a clean claim.

B. The Regulation of Utilization Review

The task force supported the concept of regulating health review agents.

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February 29 and March 1, 1992

C. The Authority to Review Rates Filed by Health Insurers

The task force supported the concept of providing the state Commissioner of Insurance the authority to review and approve or disapprove rates filed by all health insurers, both non-profit and commercial, proposing to sell group and/or individual insurance in Alaska.

IV. Access

Jeff Gingold with Blue Cross of Washington and Alaska presented some information on children's programs and costs of coverage.

Annette Thorn, MD, with Senator Kerttula's office presented background information on Senate Bill No. 73.

Larry Bartlett presented estimates of enrollees and cost for the following options:

- Establish a subsidized program to provide ambulatory care to certain low-income Alaskan children;
- Establish a subsidized non-employment based program to provide health care coverage to low-income adults and children;
- Establish a program to provide subsidies to employers that previously did not provide health care coverage for their workers; and,
- Establish a "pay-or-play" requirement for Alaskan businesses.

The task force divided its recommendations on access into four areas:

- A. Small group market reform
- B. State sponsored pools
- C. Subsidies
- D. "Pay-or-Play" approach

A. Small group market reform

The task force supported the concept of small group market reform.

Health Resources and Access Task Force
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February 29 and March 1, 1992

In addition to the above-mentioned insurance industry reforms, the task force supported the concept of "community rating". They recommended the commission/authority identify the effects of mandating community rating (for all private groups as well as pools created by the authority/commission) and report to the legislature its findings and recommendations within one year of the creation of the commission/authority.

The task force also supported the concept of "minimizing medical underwriting". They recommended the authority/commission identify the effects of restricting the degree to which private insurers (for private groups) and the authority/community (for pools created by the authority/commission) can practice medical underwriting and report to the legislature its findings and recommendations within one year of the creation of the commission/authority.

The task force recognized that in order for state-sponsored pools to avoid attracting a disproportionate share of high-risk individuals and thereby decreasing their viability, such pools must employ the same rating and underwriting practices used by private insurers. Therefore, these small group market reforms are an essential first ingredient to establishing state-sponsored pools.

B. State-Sponsored Pools

The task force supported the concept that both individuals and groups would be eligible to join state-sponsored pools.

The task force supported the concept of establishing a high-risk pool. In supporting the concept of a high-risk pool, the task force chose not to endorse either an assessment level on insurers or a particular level of state subsidy typically used to finance such a pool, or a specific premium cap for enrollees. The task force recognized that the need for a high-risk pool would diminish as insurers moved closer to community rating and away from medical underwriting.

C. State Subsidies

The task force, recognizing that it is often necessary to provide incentives to groups and individuals to become insured, established the following order of priority for state subsidies (1 = highest, 4 = lowest):

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February 29 and March 1, 1992

1. Pregnant women and low-income children;
2. Low income adults and children (not included under "1" above);
3. high-risk individuals; and,
4. small businesses.

The task force supported the concept that the highest priority benefits for pregnant women and low-income children (their highest priority group for a state subsidy), is "comprehensive services" (preventive, ambulatory, and inpatient services) for pregnant women and "ambulatory services only" for low-income children.

D. "Pay-or-Play" Approach

The task force did not recommend any immediate action regarding the "pay-or-play" approach but agreed that they would consider it further.

V. Establishment of an Entity to Oversee Cost Containment/Access Initiatives

The task force supported the concept that the state structure an entity to oversee cost containment and access initiatives so that they function in the most efficient manner possible and not duplicate functions in other entities.

VI. Medical Malpractice

The task force received information from both the Alaska Trial Lawyers and the Alaska State Medical Association regarding the voluntary arbitration process. They agreed they did not have enough information to make any recommendations at this meeting regarding medical malpractice. They made several additional requests for information and will reconsider at their next meeting.

VII. Health Planning/Certificate of Need

The task force supported the concept of strengthening the Certificate of Need process including the recommendation directing the Department of Health and Social Services to promulgate standards in regulation establishing "need" and determining whether a Certificate of Need will be awarded. The task force recommends that Certificate of Need apply to all health facilities including Pioneers' Homes, Veterans Homes, and doctors' offices for expensive medical equipment. The task force recommends that federal facilities voluntarily comply with Certificate of Need and file impact statements with the Department.

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February 29 and March 1, 1992

VIII. Grants for Facilities Construction

Senator Lloyd Jones presented background information on Senate Bill No. 67. The task force did not make any decisions about this bill but discussed the need for communities to consider alternative facilities, the need for the state to pursue alternative forms of licensure for such facilities, and the need for communities to contribute funds for facility construction.

Larry Bartlett suggested the task force may want to consider a spending limit on capital construction as sub-goal of the global spending limit for health care expenditures.

HEALTH RESOURCES AND ACCESS TASK FORCE
Draft Summary Minutes
March 14 and 15, 1992

I. Minutes of February 29 and March 1, 1992

Approved as amended.

II. Medical Malpractice

Dan Hensley, representing the Alaska Action Trust (Alaska Trial Lawyers) presented information on medical malpractice reforms requested by the task force as well as the Alaska Action Trust's positions on some of the reform strategies being considered by the task force.

Dr. Wilson presented, in their order of priority, CHIPRA's medical malpractice reform strategies.

David Walsh, Director of the Division of Insurance, presented information, requested by the task force, on the impact of tort reform on medical malpractice premiums, on whether limiting the statute of limitations for minors would reduce the medical malpractice premiums, and on recent trends in earned premiums and incurred losses in Alaska.

Larry Weiss, Ph.D., a professor of sociology at the University of Alaska, Anchorage, made a brief presentation during which he described a few of the findings of his recent research on mismanagement in the private insurance industry and the resulting negative effects on individuals who rely on the industry for their health care coverage. He also presented information demonstrating the relative importance of health insurance to the insurance industry as a whole. Based on his research, Dr. Weiss urged the task force to support a single-payor system and not to rely on the private health insurance industry to provide sustainable coverage for Alaskans.

The task force considered a series of motions related to medical malpractice which were to be added to their Draft Interim Recommendations, dated March 1, 1992.

III. DRAFT INTERIM RECOMMENDATIONS

The task force considered a series of motions amending the Draft Interim Recommendations (document dated March 1, 1992 as well as amendments made earlier in this meeting under medical malpractice discussion). They agreed to handle the amendments section by section.

I. Introduction

Motion to: Change "enactment" to "consideration" in second paragraph.

Vote: UNANIMOUS CONSENT.

The task force agreed to add that all task force recommendations be considered by the legislature as a package.

III. Administrative entity to oversee cost containment and pooling initiatives supported by the task force

Motion to: Add "access" to the types of initiatives supported by the task force (so it reads...administrative entity to oversee cost containment, access, and pooling initiatives supported by the task force).

Vote: UNANIMOUS CONSENT.

Motion to: Substitute "authority/commission" for "administrative entity" throughout entire document.

Vote: UNANIMOUS CONSENT.

Motion to: Insert "establish at the outset" after commission in first sentence.

Vote: UNANIMOUS CONSENT.

IV. ACCESS

A. Small Group Market Reform

Motion to: Adopt subsection 4A (small group market reform).

Vote: UNANIMOUS CONSENT.

B. State high-risk pool created by law

Senator Kerttula requested that the seventh paragraph on page 5 be moved up accordingly and named: "B. State high-risk pool enacted by law" and re-number the other subsections C, D, and E. Task force agreed to this request.

C. Community rating/minimizing medical underwriting

Motion to: Make the third and fourth paragraphs on page 5 a section (with above title) and then add to each paragraph that the time frame for reporting back to the legislature on its findings and recommendations should occur within one year of the creation of the authority/commission.

Vote: UNANIMOUS CONSENT.

D. Pools created by authority/commission

Motion to: Adopt subsection 4D (pools created by authority/commission).

Vote: UNANIMOUS CONSENT.

E. State Subsidies

(Main) motion to: Adopt subsection 4E (State subsidies).

Motion to amend main motion: Change "subsidy" to "incentive".

Vote on amendment: (PASSED)

Yes	9
No	8

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Draft Summary Minutes
March 14 and 15, 1992; Page 7

V. GOALS/WORK PLAN/NEXT MEETING

The task force had a lengthy discussion on their goals and future work plans. They made several research requests to the staff. They also listed several items for their next meeting and tentatively scheduled it for June 25 and 26.

HEALTH RESOURCES AND ACCESS TASK FORCE
Draft Summary Minutes
June 24 and 25, 1992

I. Minutes of March 14 and 15, 1992/Other business

The minutes were approved as presented.

Co-Chair Duncan indicated the legislature had approved a \$167,000 budget for the task force which is subject to the governor's signature/veto. The governor must sign the operating budget bill by mid-July.

Nancy Cornwell, Project Director for the task force, explained that a Request for Proposal was issued on June 1 seeking proposals to provide professional services to the task force. Three firms responded to the RFP including: the Health Policy Analysis Program of the University of Washington; Health Systems Research, Inc.; and, Nobel & Lowndes - Consultants and Actuaries. Nancy reported the co-chairs appointed the following proposal review team: Co-Chairs Duncan and Ellis, Vice-Chair Rodman Wilson, MD, Dr. David Mather, and Nancy Cornwell. Nancy reported on June 24 that the team members were still scoring the proposals.

On June 25, Nancy reported the total points for each of the three proposals (500 points possible). Health Systems Research, Inc. received the highest number of total points.

II. Outcomes of Recent Legislative Session

The task force reviewed the committee status of 15 health care reform bills. Of these, only Senate Bill 74 (establishing a high-risk pool) passed the legislature and has been signed by the governor.

III. Outcomes of the Alaska Health Summit/Discussion

Denny DeGross, President of the Alaska Public Health Association, made a presentation on the Alaska Health Summit which took place in Anchorage on April 29 through May 1. Most of the public (task force) members participated in the event. (The findings and recommendations presented by Mr. DeGross will be included in the task force members' packets for the July meeting.)

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June 24 and 25, 1992, Page 2

IV. Overview of Successful Health Reform Legislation in Other States

Larry Bartlett, Director of Health Systems Research, Inc., made a presentation regarding health care reform legislation in other states, describing in detail the health care reform legislation recently enacted in Minnesota and Vermont.

V. Work Plan

The task force developed the following work plan for the period June 1992 through January 1993.

<u>Date</u>	<u>Work Plan</u>
June 1992	1. At June 24 and 25 task force meeting: a. Develop/refine this work plan b. (Review) Access (strategies/discussion): -Pay or Play -Garamendi's -ERISA waivers c. Establish subcommittees (3) -Malpractice -Public health/delivery system -Public information
July 1992	1. Develop "statement of problem" materials for community meetings 2. Continue data collection/analysis efforts 3. At July 24 and 25 task force meeting: a. (Continue reviewing) Access strategies/discussion: -single-payor approaches -community rating -Garamendi's (outstanding item from June meeting) -benefit packages b. Discussion with interests groups c. Status reports by subcommittees

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Draft Summary Minutes
June 24 and 25, 1992, Page 3

Continued, work plan.

- August 1992
1. At August 24 and 25 task force meeting:
 - a. (Continue reviewing) Access strategies/discussion:
 - impact analysis
 - financing options
 - (adopt) preliminary (access/financing) recommendations
 - b. (Review) cost containment strategies:
 - discussion/refinement (of recommendations)
 - c. Status reports of subcommittees
 - d. Discussions with interest groups
- Sept. 1992
1. At the September 25 and 26 task force meeting:
 - a. (Continue review of) Access and Cost Containment strategies: Wrap up (preliminary recommendations)
 - b. Impact Analysis/Financing
 - further analyses
 - c. Reports by subcommittees
 - (Adopt) preliminary recommendations
 - d. Discussions with interest groups
- Oct. 1992
1. At the October task force meeting:
 - a. (Wrap up any) Loose ends/overflow (items carried over or new items from July, Aug., and Sept. meetings)
 - b. Administrative structure
 - (-adopt preliminary recommendations)
 2. Prepare draft of final report
- Nov. 1992
1. Draft of final report mailed to task force members
 2. At the November task force meeting:
 - a. Review/finalize draft (of final report)
- Dec. 1992
1. By December 15, mail final report to legislators, governor, public

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June 24 and 25, 1992, Page 4

continued, work plan

Jan. 1993 1. At January 1993 meeting, meet with
 legislators regarding recommendations

VI. "Pay of Play" Option/ERISA Waiver

Larry Bartlett presented information on the "pay or play" approach, a strategy developed by states to deal with the problems associated with the federal Employee Retirement Income Security Act (ERISA). The pay or play approach is considered a "second best" alternative for states that have decided to "shore-up" the existing employer-based financing system. Three states, Massachusetts, Oregon, and Florida, have enacted a pay or play provision as part of their comprehensive health reform strategies. (Materials presented by Larry Bartlett will be included in the task force members' packets for the July meeting.)

VII. Future meetings

The task force scheduled the following meeting, all to be held in Anchorage:

July 20 and 21, 1992 (Monday, Tuesday)
August 24 and 25, 1992 (Monday, Tuesday)
September 25 and 26, 1992 (Friday, Saturday)

HEALTH RESOURCES AND ACCESS TASK FORCE
Draft Summary Minutes
July 20 and 21, 1992

I. Minutes of June 24 and 25, 1992

The minutes were adopted as presented.

II. Review of "Access" Reform Strategies and Other Access Related Issues

Larry Bartlett, Health Systems Research, Inc., made a presentation on the following access strategies:

- Current System
- Small Market Regulatory Reform
- State-Sponsored Pools
- Premium Subsidies: Individuals, Businesses
- Community Rating

- Pay-or-Play
- Unified Payer System/Blended Approach
- Single Payer System

The first set of access strategies, current system, small market regulatory reform, state-sponsored pools, premium subsidies, and community rating, are intended to shore-up the existing health care financing system. Under these strategies, obtaining health care coverage is voluntary. "Universal access" is not an expected outcome.

The second set of access strategies, pay-or-play, unified payer/blended approach, and single payer system, establish mandates for coverage and financing. They are expected to yield "universal access" and are more than likely to require a waiver from the federal Employee Retirement Insurance Security Act (ERISA).

(Materials presented by Larry Bartlett will be included in the task force members' packets for the August meeting.)

The task force decided that they wanted their final recommendations to include both short and long-term recommendations, the later expected to require a waiver from ERISA.

Rodman Wilson, MD, chair of the Malpractice Subcommittee, reported the subcommittee met on July 15 and July 20. The subcommittee will be re-considering the ten tort law and rule changes recommended by the Health Access and Cost Containment Council (CHIPRA) as well as several alternative dispute resolution systems including: voluntary arbitration; a fault-based administrative alternative proposed by the American Medical Association; a pre-paid, two path approach proposed by Jerry Near; and, a no-fault professional liability plan.

IV. Brief Presentations by Interest Groups

Betty Elsner with the Alaska League of Women Voters presented findings from the League's recent health care study.

Mary Troll with the Alzheimer's Association described the access problems facing alzheimer patients in Alaska.

Marie MacKenzie with the American Association of Retired Persons presented AARP's proposed Health Care America plan.

Tim Feller with the Alaska Green Party criticized the task force for not inviting Yukon health officials to address the task force and for not including the party as a member of the task force. Tom Macchia, also with the Green Party, explained that the party has developed general guidelines for health care reform (included in June packet) in Alaska but has not to date a detailed health care plan.

V. Future Meetings

Senator Duncan reminded the task force the next full task force meeting is scheduled for August 24 and 25 at the Anchorage Legislative Information Office. The Public Information Subcommittee will meet during lunch on August 24 and the Public Health/Service Delivery System Subcommittee will meet on the morning of August 25. The Malpractice Subcommittee did not schedule a meeting.

HEALTH RESOURCES AND ACCESS TASK FORCE
Draft Summary Minutes
August 24 and 25, 1992

I. Minutes of July 20 and 21, 1992.

The minutes were adopted as presented.

II. Review of "Access" Reform Strategies and Other Access Related Issues

Larry Bartlett, Health Systems Research, Inc. made a presentation on several "access" related issues. Each is briefly described below. Discussion followed each issue.

Bartlett described an "access" alternative which emerged from the repeal of Medicare Catastrophic Act which enables states to amend their Medicaid state plans to cover all pregnant women and children up to one year of age regardless of income. Only two states, Washington and Minnesota, have taken advantage of this alternative.

Bartlett presented a summary of state laws in Maine, Massachusetts, Minnesota, New Jersey, New York, Oregon and Vermont which require pure or quasi-community rating. In the interest of moving toward phasing in community rating in Alaska, a subcommittee was appointed to make a specific recommendations to the task force. David Mather was appointed chair of the subcommittee; Roxanna Horschel, Jerry Near, Roberley Waldron, and Dave Walsh/Thelma Snow Walker were appointed members.

Financing sources for the single payer system were discussed. Larry Bartlett explained he will be completing an analysis of the various revenue sources discussed and present it to the task force in October.

Bartlett presented information on the State Care Act of 1992, sponsored by Senators Leahy and Pryor. Its purpose is "to encourage and assist state-based comprehensive health care reform efforts by developing a streamlined and expanded "one-stop-shop" waiver approval process that removes overly burdensome regulatory and statutory Medicare, Medicaid, and ERISA requirements".

III. Review and Discussion of "Cost Containment/Global Budgeting" Recommendations

Nancy Cornwell presented 1990 health care spending data for Alaska which was recently compiled by ISER.

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August 24 and 25, 1992, Page 2

The task force reviewed their global budgeting recommendations including the steps necessary to move to a global budgeting system. Bartlett presented projections of total health care spending in Alaska: (1) if left unchecked, and (2) if the annual growth in spending was reduced to 5.5 percent by 1997.

IV. Medical Malpractice: Report of the August 3 - 5 Agency for Health Care Policy and Research User Liaison Program Conference

Representative Mike Navarre, who attended the conference, made a brief report to the task force. (Copies of some of the conference materials will be made available to the task force.)

(Sister Dona Taylor, who also attended the conference, was not in attendance due to an illness. She will be providing a written report.)

V. Review and Discussion of Guiding Principles

Several revisions to the task force's guiding principles were proposed but no decisions were made. The task force agreed to take this item up again at their September meeting.

VI. Brief Reports by Subcommittees

The Public Information Subcommittee recommended that a series of community meetings be scheduled to allow individuals and organizations from communities across the state to provide information to the task force on "how the current health care system creates problems for them" and on "any recommendations they have for reforming the system". The task force agreed to schedule four community meetings and four teleconference hearings. Staff will consult with individual task force members to schedule the specific dates and chairs for the meetings.

The Public Health/Delivery System Subcommittee reported Dr. Peter Nakamura, MD, Director of the Alaska Division of Public Health, had briefed them on the status and trends of the State's public health programs. The subcommittee also reported that David Mather had briefed them on the Alaska Area Native Health Service system.

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Draft Summary Minutes
August 24 and 25, 1992, Page 3

The task force agreed the subcommittee reports should be to the staff one week prior to the October task force meeting.

VII. Brief Presentations by Interest Groups

The following individuals made brief presentations to the task force:

Ellen Ganley, et. al., described the Fairbanks Community Health Project and findings of its work groups.

Patty Hong, President of the Alaska Nurses Association, presented the "Nursing's Agenda for Health Care Reform" and commented on how the task force's guiding principles do or do not conform with the nursing agenda.

Resa Jerrel, State Director of the National Federation of Independent Businesses/Alaska, presented information on the problems facing small business owners and some of the solutions acceptable to NFIB members.

Captain Preston Rider, Commanding Officer of the Fairbanks Corps, Salvation Army, described the pro bono medical and dental clinic (Health Care Access Program) operated by the Salvation Army in Fairbanks and the population served by the clinic.

Harold Johnson, MD, Medical Director of the Anchorage Neighborhood Health Center, described the services and population serviced at the center. Dr. Johnson also made recommendations for reforming the health care system.

VIII. Future Meetings

Senator Duncan reminded the task force the next task force meeting is scheduled for September 25 and 26. September 25 will be a full day of subcommittee meetings and the 26th will be a regular task force meeting. The October meeting was scheduled for October 22 and 23.

HEALTH RESOURCES AND ACCESS TASK FORCE
Draft Summary Minutes
September 25 and 26, 1992

I. Minutes of August 24 and 25, 1992.

The minutes were adopted as presented.

II. Draft Outline of Final Report

Nancy Cornwell, project director, presented a draft outline of the final report and described the process for its development and review by the task force. Task force members were encouraged to contact Nancy with specific suggestions.

III. Review and Discussion of Guiding Principles

Major revisions to the task force's guiding principles were made by Rod Wilson and Peter Nakamura. Several hours of discussion and numerous votes resulted in revised (September 1992) Guiding Principles (attached).

IV. Brief Reports by the Subcommittees

David Mather, chair of the Community Rating Subcommittee, reported the subcommittee met on September 25 and developed a series of recommendations which would result in a quasi-community rating environment for small groups in Alaska.

Rodman Wilson, MD, chair of the Malpractice Subcommittee, reported the subcommittee met on September 25 and developed two recommendations, one on collateral sources and one on studying and establishing a mandatory alternative dispute resolution system in Alaska.

Karen Perdue, chair of the Public Health/Service Delivery Subcommittee, reported the subcommittee met on September 25 and is working on the development of recommendations in four areas: recruitment and retention, public health, creation of more flexible facility and provider licensure standards, and the Indian Health System in a global budgeting/single payer system. The subcommittee scheduled a meeting for October 13 at 2:30 pm.

Trish O'Gorman, chair of the Public Information Subcommittee, reported the subcommittee met on September 25. She indicated the task force's October meeting would be the final opportunity for interest groups to make brief presentations. In addition, a schedule of the community meetings/public hearings which begin October 12 was provided.

V. Brief Presentations by Interest Groups

The following brief presentations were made:

Stan Steadman, Chair, and Mike Lockwood, Co-Chair, of the Kenai Peninsula Borough Health Care Advisory Council presented the mission of the council and described the community planning process the council is currently undertaking.

Lori Brown, RPh, President, and Linda Hamm, RPh, and Karen Marcey, RPh, Members, of the Alaska Pharmaceutical Association presented the concern that pharmaceuticals are often left out of major health care reform proposals. They also described the existing reimbursement and coverage problems for pharmaceuticals as well as concerns that many Alaskan employers are contracting with firms outside of Alaska to provide pharmaceuticals to beneficiaries.

Dr. Pat Conners-Allen, DC, Liaison for the Alaska Chiropractic Society presented a statement to the task force urging them to include chiropractic care in the basic benefit package for all Alaskans.

Dr. Julie Robinson, DDS, Secretary of the Alaska Dental Society, presented her group's proposal for a direct reimbursement plan for dental care.

Denny DeGross, President of the Alaska Public Health Association, supported statements made by Dr. Peter Nakamura, MD, echoing the importance of the core functions of public health as a part of a health care system and of any health care reform package. He also supported the need for a statewide health planning process in Alaska and urged the work of the task force must continue in some form if significant health care reform is to be realized.

Dr. James Nesbitt, MD, and Dr. Alexander, MD, representing the Alaska Chapter of the American Academy of Pediatrics described the problems created when children do not receive health care on a timely basis because they are uninsured or underinsured. They also presented Rep. Robert Matsui's (D-CA) "Children's and Pregnant Women's Health Insurance Act of 1991" and urged the task force to consider recommending a similar program for Alaska.

Kathy Allelly, Chair, and Laurel Putnam, Member, of the Health Committee of the Governor's Council on Disabilities and Special Education described the health needs of some disabled children as well as the need for a developmental center in Alaska. They also described how these children often lose their coverage if they are insured in a small group.

Mr. Robert Clark, CEO of the Bristol Bay Area Health Corporation and representing the Alaska Native Health Board, presented some of the financing and reimbursement problems facing the Native health corporations in Alaska. He described the lower health status of Alaska Natives and the need to make further improvements including the need for basic sanitation in many of the villages in Alaska. He also described how the Native health corporations are in some cases providing care to non-Natives in areas where private providers are not available.

Steven Conn, Executive Director of the Alaska Public Interest Research Group, commented on all of the task force's interim recommendations as well as the special needs of Alaska Natives and the problems with the Indian Health Service system.

Revised, September 1992

GUIDING PRINCIPLES

Preamble

The Constitution provides that the State of Alaska is responsible for the public health. However, each Alaskan bears individual responsibility to maintain a healthful lifestyle.

The vision of health care reform for Alaska must go beyond the issues of access, financing, and cost containment. It must include a health care program that merges the personal health care delivery system with a population-oriented public health program based on the principles of health promotion, health protection, and disease prevention.

Health care costs can best be contained by an educated public, committed to wellness. The state must take an aggressive role in working with all Alaskans on health and safety education and the prevention of illness.

Access

All Alaskans should have access to timely, appropriate, and adequate health care without regard to personal financial means.

A basic level of health care should include prevention, primary care, early diagnosis and treatment, and incentives for healthful lifestyles.

Financing

All Alaskans have a responsibility to obtain and pay for adequate health care for themselves and their dependents. It is the responsibility of society at large to adequately finance care for those unable to pay.

Responsibility for the financing of care should be equitably distributed among payers.

Continued, Guiding Principles, Revised, September 1992

Cost Containment

Health care costs can be extended to everyone only if overall costs are contained. Duplicate coverage should be avoided.

Use of cost sharing may be considered to control excessive utilization but should take into account ability to pay.

Health care should be provided in the most efficient and cost effective manner and location and may include contractual arrangements for patient management and utilization controls.

Payments to providers should be reasonable and fair.

Health services based on disease prevention, health promotion, and health protection must be promoted as a major influence on cost containment.

General

Individuals should have an informed and reasonable choice in selecting health care providers. However, they may be restricted to certain providers in cases where such arrangements are more cost-effective.

Systems to maintain and expand access and control costs should be as simple to administer as possible.

Design of programs should be sensitive to cultures and community needs, including the special problems in rural areas of access and availability of providers.

A public health system based on the core functions of assessment, policy development, and assurance of essential public health services must be established and maintained as the foundation of an effective health program for Alaska.

SCOMM

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STATE OF ALASKA

**HEALTH RESOURCES AND ACCESS
TASK FORCE**

Interim Report to the Governor and Legislature

Adopted, January 11, 1992

THE STATE OF ALASKA
HEALTH RESOURCES AND ACCESS TASK FORCE

Interim Report
to the
Governor
and
Legislature

Adopted, January 11, 1992

Alaska State Legislature
Health Resources and Access Task Force
State Capitol
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**MEMBERSHIP OF THE
HEALTH RESOURCES AND ACCESS TASK FORCE**

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Co-Chair

Representative Johnny Ellis
Co-Chair

Senator Virginia Collins

Senator Jalmar Kerttula

Representative Mark Boyer

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Trish O'Gorman
Representing Medically
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Karen Perdue
Representing Consumers

Sister Dona Taylor
Representing Providers

Rodman Wilson, MD
Vice Chair
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STAFF

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EXECUTIVE SUMMARY

The United States spends more on health care than most other industrial countries. In the 1980s, employers began to pay a dramatically larger percentage of their after-tax profits and households a larger share of their after-tax income on health care.

U.S. health care spending grew at nearly twice the rate of general inflation in the 1980s. Total health spending in Alaska was \$1.5 billion in 1990, up from \$481 million in 1979. This dramatic rise in the cost of health care generated significant concern for those who finance health care, primarily employers. It raised questions about what they are paying for and why costs are rising.

Concerns about higher costs influenced insurers to become increasingly defensive and selective. Their practices have affected all employers but particularly small employers. These groups more frequently experience high and unanticipated rate increases and a larger share of their premium goes toward administrative costs. Small group insurance practices have directly excluded some groups and individuals with pre-existing conditions, health needs, and those that work in certain industries. Higher premiums have influenced employers to share more of the costs with their employees, to drop dependent coverage, and even health care as a benefit. As a result, an increasing proportion of the Alaskan population is without health care coverage. Approximately 90,000 Alaskans are uninsured. Eighty-five percent of the uninsured Alaskan adults have some link to the work force and of those that work, 55 percent work for small businesses. Trends also suggest a growing percentage of insured Alaskans have inadequate coverage.

The uninsured and individuals with inadequate coverage generate significant unpaid medical bills. In addition, some payors reimburse providers below what it cost them to provide the services. All costs incurred by providers for services which are underpaid or not paid are shifted to other payors, most notably, employers who provide health insurance for their workers and taxpayers. As costs are shifted, premiums for the insured increase and the pressure increases on employers to control costs, ask employees to pay more of their premiums, and reduce and even drop coverage.

Some aspects of Alaska's health care access and cost problems are unique. The task force was able to obtain information on only some of those aspects. For example, charge levels for health care services in Alaska are generally higher than the national average. Occupancy rates at our community hospitals have historically been below the national average. It is estimated that Alaska has 229 surplus beds in our hospitals which cost Alaska's health care payors between \$5.8 and \$11.6 million per year. In 1990, 10 acute

care community hospitals shifted \$16.8 million of actual costs to other payors to cover costs associated with charity care, bad debt, and Hill Burton free care. Alaskans living in rural and remote areas of the state defer treatment because of the travel or costs required. Alaskans have to travel to Anchorage or another state to access the majority of high-tech medical services. And some Alaskan communities have a shortage of family practice physicians.

These problems have existed in Alaska for a long time. However, these problems have grown so significantly in the 1980s that more Alaskans are at risk of becoming uninsured or underinsured. Employers, taxpayers, policymakers, health care providers, labor organizations, consumers, and insurers recognize that changes must be made in the way we finance and utilize health care services.

The Health Resources and Access Task Force has brought the major health care interests together. Their charge is to design a program that will provide access to a basic level of health care services for all Alaskans and a strategy to contain health care costs. This report contains their interim findings. It also lists the policy options under their consideration. The task force expects to recommend specific legislation to the governor and legislature by March 16, 1992.

SUMMARY OF FINDINGS

HEALTH CARE ACCESS PROBLEM-UNDERSTANDING TO DATE

The Size and Characteristics of the Uninsured Population in Alaska

- In 1989, approximately 90,000 Alaskans had no health care coverage.
- In 1989, approximately 28,000 Alaskan children were uninsured.
- In 1989, twenty-thousand uninsured Alaskans had incomes below the federal poverty level and another 20,000 had incomes one and two times the poverty level. Thirty-one thousand uninsured Alaskans had incomes greater than three times the poverty level.
- In 1989, of the 61,000 nonelderly uninsured adult Alaskans, 51,000 had some link to the work force.
- In 1989, of the 51,000 uninsured Alaskan workers, 28,000 were employed by small businesses with fewer than 25 employees.

Why Some Employers do Not Provide Health Insurance Benefits

- According to a 1989 HIAA survey, 75 percent of employers when asked the reasons for not offering health insurance, said it was too expensive.

Problems Facing Small Groups

- Small groups seeking health care coverage more frequently experience practices which directly exclude groups or individuals or coverage for certain pre-existing medical conditions.
- "Select and ultimate" rating approaches used in conjunction with pre-existing condition limitations can result in high and unanticipated rate increases which often motivates groups to change insurance carriers.
- Tiered rating structures used by the small group insurers result in very high rates for groups with health needs. These rates frequently drive these groups out of the market.
- Manual rating used by small group insurers result in higher premiums for older employees and women, regardless of their health status.
- Some small businesses in certain industries cannot find insurers that will write policies for their employees.

- For comparable benefit packages, health plan costs are 10 to 40 percent higher for small employers. Small business owners overwhelmingly cite the cost of coverage as the most important reason for not offering health insurance coverage.
- The administrative expenses of insurers, reflected in premiums offered, are significantly higher for small groups than large groups.
- Only a handful of insurers sell to small groups in Alaska.

The Consequences of Having an Uninsured Population

- A larger share of the uninsured report having a lower health status than the insured.
- The uninsured use fewer services overall than the insured. However, when they do use services, it is more likely to be late in the course of a disease and in costly institutional settings such as emergency rooms.
- The uninsured (and underinsured) generate significant unpaid medical bills which ultimately are paid by employers who offer health insurance for their workers, taxpayers, and health care providers who absorb costs not paid by other sources.

Other Indicators of the Health Care Access Problem in Alaska

- If the national estimate "that one-quarter of the privately-insured under 65 population is underinsured" is accurate in Alaska, then it can be estimated that about 60,000 nonelderly Alaskans are underinsured.
- Some Alaskans who are covered by Medicaid and Medicare may have difficulty finding a provider that will treat them.
- Some Alaskans defer medical treatment because of the travel required to see a health care provider or costs associated with travel.

HEALTH CARE COST PROBLEM-UNDERSTANDING TO DATE

Indicators of the Health Care Cost Problem

- Health care spending in the United States is increasing much faster than general inflation.
- Total health care spending in Alaska in 1990 was estimated to be \$1.523 billion, up from \$481.25 million in 1979.
- In Alaska, per capita health care spending increased 111 percent from \$1,197 in 1979 to \$2,524 in 1989.

- In 1987, per capita health care spending for the elderly in the U.S. was four times greater than for children under 19 years of age. Population trends suggest the elderly will consume an even larger share of total health care spending in future years.
- Alaska's 1990 per capita health care spending was 36 percent above the age-adjusted national average.

Who Pays the Health Care Bill in Alaska and What Services are They Paying For

- The federal, state, and local governments pay a larger proportion of the health care bill in Alaska as compared to the U.S. as a whole.
- In 1990, 38.4 percent of all U.S. health care spending went for hospital care, 18.9 percent for physician services, 8.2 percent for drugs and nondurables, 7.9 percent for nursing home care, and 12.1 percent for nonpersonal services.

The Consequences of High Health Care Expenditures

- Health care spending represents an increasing share of the GNP in the United States.
- The United States spends more on health care than most other industrial countries.
- Employers are spending a higher percentage of their corporate after-tax profits on health insurance.
- Households are spending a larger percent of their after-tax income on health care.
- During the 1980s, out-of-pocket expenditures increased faster than medical care prices due in part to increased employee cost-sharing. Both the percentage of plans requiring premium cost-sharing and the dollar amounts contributed by employees have increased in the 1980s.
- In 1989, nearly two-thirds of 43 major labor walkouts in the United States were disputes over health benefits.
- A larger percentage of Alaskans are becoming uninsured.

Factors Contributing to the Increase in Health Care Expenditures

- Between 1975 and 1987, general price inflation accounted for 51.3 percent of the increase in personal health expenditures in the U.S. while medical price inflation contributed 19.5 percent. Population growth accounted for another 8.8 percent of the increase and all other factors including changes in utilization, the intensity of the services used, and the aging of the population together contributed 20.4 percent of the growth in expenditures.
- In the United States, between 1975 and 1988, population growth was a fairly constant contributor to the growth in health care spending. General inflation, medical inflation, and all other factors varied as contributors over the same period.
- Population growth, one factor known to contribute to the increase in health care expenditures, increased at a 3.2 percent average annual rate in Alaska in the 1980s as compared to 1.1 percent for the U.S. as a whole.
- Medical price inflation in Anchorage has increased at approximately the same rate as the U.S. average.

FACTORS WHICH CONTRIBUTE TO HEALTH CARE ACCESS AND COST PROBLEMS IN ALASKA

Charges/Prices for Health Services in Alaska

- Charge levels for health care services in Alaska are generally higher than the national average.
- Between 1972 and 1989, the average expenses per adjusted patient day in Alaska's acute care community hospitals ranged from 60 to 100 percent above the national average.
- Between 1972 and 1989, the average annual payroll per employee in Alaska's acute care community hospitals was 37 to 72 percent above the national average.
- Alaska's Medicaid reimbursement rate for nursing home beds is three times the U.S. average net patient revenue for nursing home care.

Patient Utilization Patterns in Alaska

- Occupancy rates in Alaska's acute care community facilities have historically been below the national average for comparably-sized hospitals except during the economic boom of the 1980s. In 1989, the Alaska average occupancy rate was 45 percent compared to the U.S. average of 57 percent for similar-sized facilities.

- On an average per capita basis, Alaskans have historically spent considerably fewer days in Alaska's acute care community hospitals than the U.S. population as a whole spent in U.S. hospitals. In addition, once admitted, Alaskans on the average have shorter lengths of stay as compared to the U.S. population as a whole.
- Outpatient utilization at Alaska's acute care community hospitals has historically been below the national average.

Excess Capacity in Alaska's Acute Care Community Hospitals

- Using the national average as the bench mark, 12 of Alaska's 16 acute care community hospitals have excess capacity or beds. At the U.S. average occupancy rate, 229 of the 1,027 acute care beds in Alaska are surplus. Eighty percent of the surplus beds are in Anchorage and Fairbanks. Only 15 excess beds are in co-located facilities (both acute care and nursing home beds).
- The total annual cost to Alaskans in 1989 to pay for surplus beds has been estimated to range from \$5.8 to \$11.6 million or 2 to 4 percent of the total annual acute care facility costs.
- Using a more rigorous standard for occupancy, 75 percent, and a fixed cost assumption of 20 percent, the annual cost of excess capacity in Alaska's acute care facilities would be as high as \$20.8 million.

High-Tech Medical Equipment and Services in Alaska

- Alaskans must travel to Anchorage or other states to access the majority of high-tech medical services. Some high-tech services are available in Fairbanks and a few are available in Juneau, Palmer, and Ketchikan.
- Alaska's demand for high-tech medical equipment and services is reduced.
- Alaska does not presently have excessive amounts of high-tech equipment and units. The equipment and units increase health care expenditures in Alaska but are not a major influence at this time.
- Increased access to high-tech medical equipment, particularly in smaller communities, may result in higher health care expenditures, increased use, and diminished quality of care.

Mandated Benefits in Alaska

- Alaska has only two significant mandated benefits. Together they have a minor cost impact on individual insurance premiums.

Uncompensated Care/Cost-Shifting to Public and Private Payors

- In 1990, ten hospitals, representing 86 percent of the acute care community hospital beds in Alaska, shifted \$16.8 million of actual costs to other payors to cover costs associated with charity care, bad debt, and Hill Burton free care. This traditional method of financial hospital care provided to the uninsured (and underinsured) and other shortfalls from government health care financing programs can result in significant increases in prices that most Alaska hospitals charge privately insured persons.

Distribution of Physicians in Alaska

- Some Alaskan communities, particularly in Southeast, have insufficient numbers of family practice physicians.

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CHAPTER ONE INTRODUCTION

During the 1991 legislative session, the Alaska State Legislature passed Legislative Resolve 45 which created the Health Resources and Access Task Force. The primary purposes of the task force are:

- (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 to contain the costs of health care in the state.

(The resolution creating the task force includes 14 specific tasks related to these primary purposes. Appendix A contains the resolution.)

The Health Resources and Access Task Force was created as a result of an agreement between legislative and executive branch leaders that a single unified task force would continue the work of the Health Care Cost Containment Task Force and begin the work of the Universal Health Care Task Force.

The Health Resources and Access Task Force consists of 17 members including three members of the Senate, three members of the House, three members representing the executive branch, and eight public members representing the medically indigent, employers, health care providers, health insurers, nonprofit organizations, consumers, and labor organizations.

The task force, created in May of 1991, ends on February 1, 1993. The legislative and executive branch members met in June and August 1991 to organize and appoint the public members. The full task force met in September, October, November 1991 and January 1992. During those meetings, the task force developed an understanding of the health care access and cost problems facing Alaska and reviewed approaches implemented by other states in resolving similar problems. In addition, they drafted guiding principles and began the development of options aimed at resolving some of the health care problems facing Alaska.

Numerous individuals participated in task force meetings and presented information including Steve LeBrun with Aetna Life Insurance Company; Bruce Amundson, M.D.; Harlan Knudson and Garrey

Peska representing the Alaska State Hospital and Nursing Home Association; Jeffrey Duzenbery and Jeff Gingold with Blue Cross of Washington and Alaska; Jennifer Christian, M.D., (President of the Alaska State Medical Association) and David Hennigan representing the Health Access and Cost Containment Council; Jay Livey, Kim Busch, Jack Nielsen, Gordan Landes, Larry Streuber and Bradley Whistler with the Alaska Department of Health and Social Services; and, Dave Walsh and Chris Ulmann with the Alaska Division of Insurance. Numerous presentations were also made by Larry Bartlett, Ph.D., Director of Health Systems Research, Inc. and Scott Goldsmith, Ph.D., with the Institute of Social and Economic Research. In addition to the seventeen task force members, a number of individuals also participated as designees of members including Kim Busch, James Gingerich, Jay Livey, Pat Smutz, Dave Walsh, and Roberley Waldron.

Legislative Resolve 45 requires the task force to report its findings and recommendations to the governor and legislature by February 1, 1992 and February 1, 1993. This report represent their interim findings and lists the options under their consideration. It also contains much of the information presented at their meetings to date.

Chapter Two contains guiding principles drafted by the task force to be used to develop and evaluate public policy options.

Chapter Three describes several indicators of the extent to which Alaskans do not have access to appropriate, affordable health care. It also describes the difficult problems facing those who are at the greatest risk of not having insurance and the consequences of their not having access. Several indicators of the high cost of health care in Alaska are also described as well as the consequences of and the factors which contribute to high costs. This chapter also contains information on factors which the task force suspect contribute to the health care access and cost problems in the state and for which they were able to obtain Alaska-specific information.

Chapter Four lists the options which are under consideration by the task force.

CHAPTER TWO GUIDING PRINCIPLES

At its September meeting, the Health Resources and Access Task Force drafted the following principles to be used to guide the development of public policy. These principles will assist the task force in evaluating options under their consideration.

PREAMBLE

The Constitution provides that the State of Alaska is responsible for the public health. However, each Alaskan bears individual responsibility to maintain a healthful lifestyle.

Health care costs can best be contained by an educated public, committed to wellness. The state must take an aggressive role in working with all Alaskans on health and safety education and the prevention of illness.

Access

1. All Alaskans should have access to adequate, effective, appropriate, and quality health care services without regard to financial means or status.
2. A basic level of health care will be defined by the task force to which everyone has access, with priority on effective, appropriate, and quality care, especially preventive and primary care, early diagnosis and treatment, and incentives for healthful lifestyles.

Financing

3. All Alaskans share a responsibility to obtain and pay for adequate health care for themselves and their dependents, but the government should participate in financing care for those unable to pay.
4. Responsibility for the financing of options should be equitably distributed among payers.
5. Options for improving access should minimize the negative impacts on businesses and on current employer health benefit plans and should not be an incentive for providers to reduce or drop coverage. Employers are encouraged to participate with their employees to meet the responsibility regarding care for their own health needs.

Cost Containment

6. Health care expenditure controls should be essential elements of approaches to expand access to care for the uninsured and to ensure continued adequate coverage for those currently insured.
7. Use of cost sharing may be considered to control excessive utilization but should take into account ability to pay.
8. Approaches should include incentives to seek and provide care in the most efficient and cost effective manner and location, including contractual arrangements for patient management and utilization controls.
9. Providers should be reimbursed at reasonable levels. These and other health care policies should promote efficient service delivery and availability and constrain unnecessary expenditures.
10. Individuals should have an informed and reasonable choice in selecting health care providers although they may be restricted to certain providers in cases where these arrangements significantly increase the cost-effectiveness of this care.

General

11. Approaches to expand access to care for the uninsured should be as simple to administer as possible and avoid duplication of resources. Special attention should be given to minimizing the administrative burden on small businesses, providers and consumers.
12. Program policy design should be sensitive to the culture and problems of provider availability and accessibility, especially in rural areas.

CHAPTER THREE
HEALTH CARE ACCESS AND COST PROBLEMS
STUDIED BY TASK FORCE

The Health Resources and Access Task Force developed an understanding of the access and cost problems facing Alaska by reviewing national and state data. In many cases, their review was limited by the lack of comprehensive data and their understanding based on problems for which they could obtain data.

Many Alaskans do not have access to appropriate, affordable and timely health care. One significant indicator of the "access problem" is the size of the uninsured population. Section (A) of this chapter describes:

- the size and characteristics of the uninsured population in Alaska;
- some of the reasons employers do not provide health insurance benefits;
- the problems facing small groups (who are at the highest risk of being uninsured or becoming uninsured);
- the consequences of having an uninsured population; and,
- some other indicators of the access problem in Alaska.

The high cost of health care is overwhelmingly cited by employers as the most important reason for not offering health care coverage. Section (B) of this chapter describes:

- indicators of the magnitude of the health care "cost problem" in Alaska including who pays the health care bill in Alaska and what they are paying for;
- the consequences of high expenditures; and,
- factors that contribute to rising expenditures.

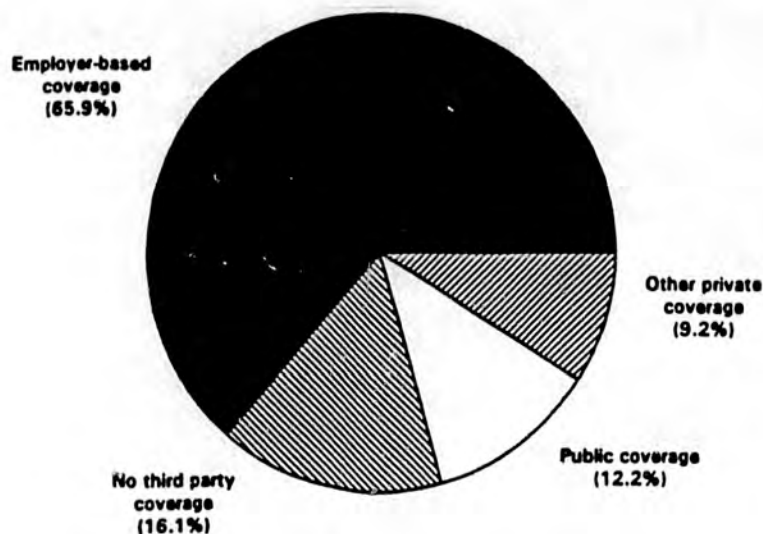
Section (C) of this chapter includes Alaska-specific information on factors which the task force suspects contribute to the health care access and cost problems in the state. As the task force discovered, some of these factors are more significant than others. The factors include:

- charges or prices for health services in Alaska;
- patient utilization patterns in Alaska;
- excess capacity in Alaska's acute care community hospitals;
- the extent of high-tech medical equipment and units in Alaska;
- mandated benefits in Alaska;
- uncompensated care in Alaska's acute care community hospitals and cost-shifting to public and private payors; and,
- the distribution of physicians in Alaska.

A. HEALTH CARE ACCESS PROBLEM-UNDERSTANDING TO DATE

Unlike many industrial countries, the United States relies primarily on employers to finance health care. In 1989, 65.9 percent of the nonelderly U.S. population had employer-based coverage, 9.2 percent had other private coverage, 12.2 percent had public coverage including Medicare, Medicaid, and Champus, and 16.1 percent had no third party coverage.¹ One significant indicator of the access problem is the size of the uninsured population.

Figure 1. Nonelderly Population with Selected Sources of Health Care Coverage in the United States, 1989



Source: Employee Benefit Research Institute analysis of March 1990 CPS data.

The Size and Characteristics of the Uninsured Population in Alaska

The task force reviewed data on the characteristics of the uninsured population in Alaska. Of the uninsured, some have tried to obtain health care coverage but have not been able to find an willing insurer. Others have been offered rates that are unaffordable. Still other uninsured Alaskans have not attempted to obtain coverage.

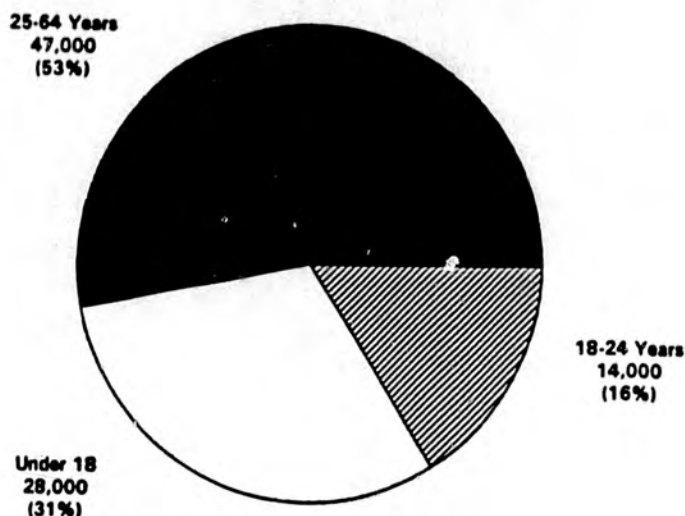
- In 1989, approximately 90,000 Alaskans had no health care coverage.

An analysis of data from the Alaska portion of the 1988 and 1989 Current Population Survey (CPS) revealed that in 1989 approximately 90,000 Alaskans had no health care coverage such as private

insurance, Medicaid, or Medicare, and lack any other third-party health care coverage. This represented 18.8 percent of the state's population. The 90 percent confidence range for this 1989 estimate of uninsured Alaskans is 90,000 plus or minus 23,000 individuals or between 67,000 and 113,000 Alaskans.² Another analysis indicates the number of uninsured Alaskans grew at a faster rate between 1980 and 1988 than the national average.³

- In 1989,⁴ approximately 28,000 Alaskan children were uninsured.

Figure 2. Uninsured Alaskans by Age, 1989

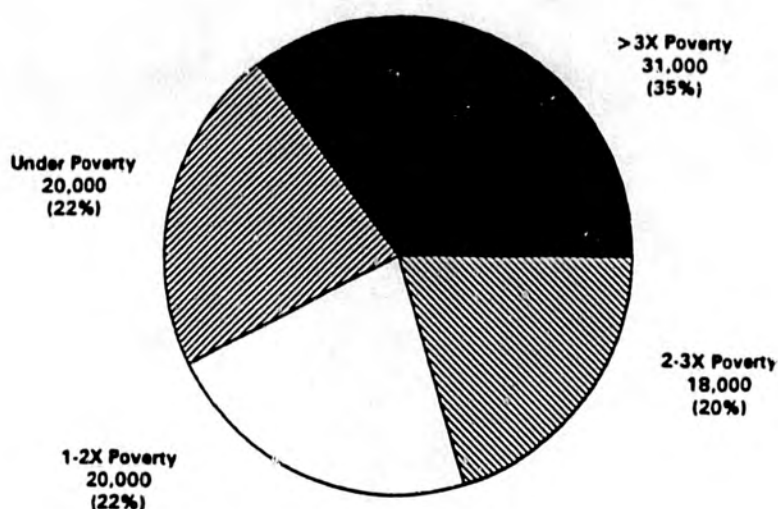


Source: Health Systems Research Inc., analysis of March 1988 and 1989 CPS.

- In 1989, twenty-thousand uninsured Alaskans had incomes below the federal poverty level and another 20,000 had incomes one and two times the poverty level. Thirty-one thousand uninsured Alaskans had incomes greater than three times the poverty level.⁵

The 1989 Alaska federal poverty level income for a family of 4 was \$15,120.⁶

Figure 3. Uninsured Alaskans by Poverty Status, 1989

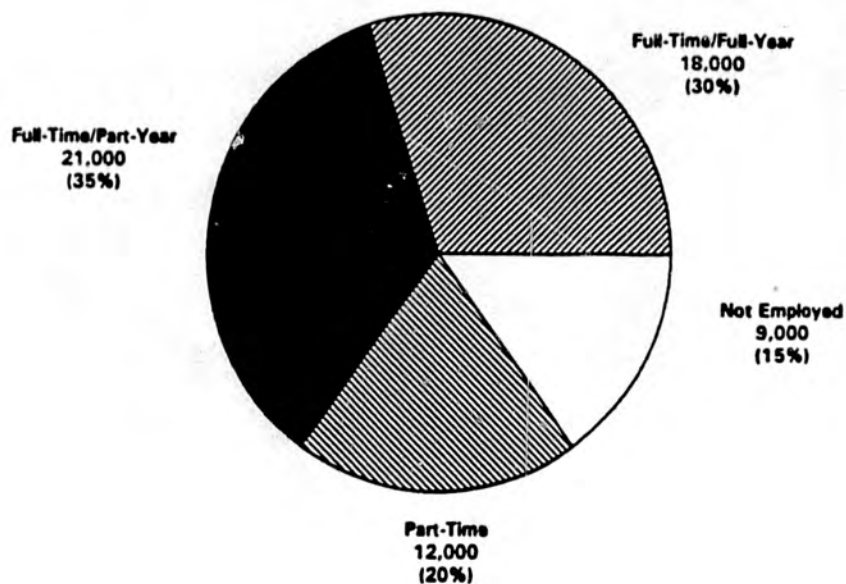


Source: Health Systems Research, Inc., analysis of March 1988 and 1989 CPS.

- In 1989, of the 61,000 nonelderly uninsured adult Alaskans, 51,000 had some link to the work force.

The CPS analysis revealed 85 percent of the uninsured nonelderly adults (ages 18-64) were employed for at least some portion of the year in which they were uninsured. Only 15 percent were unemployed the entire year.

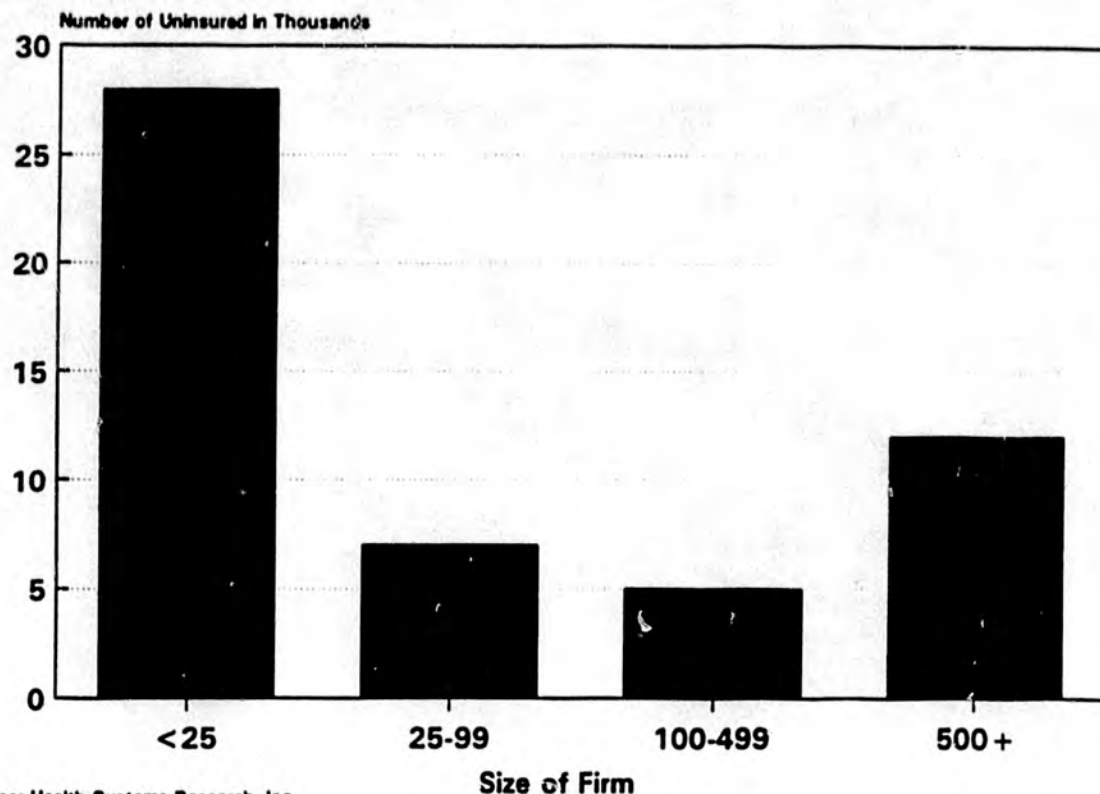
Figure 4. Employment Status of Uninsured Alaskans, 1989
Ages 18-64



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

- In 1989, of the 51,000 uninsured Alaskan workers, 28,000 were employed by small businesses with fewer than 25 employees.⁸

Figure 5. Uninsured Workers in Alaska by Size of Firm, 1989



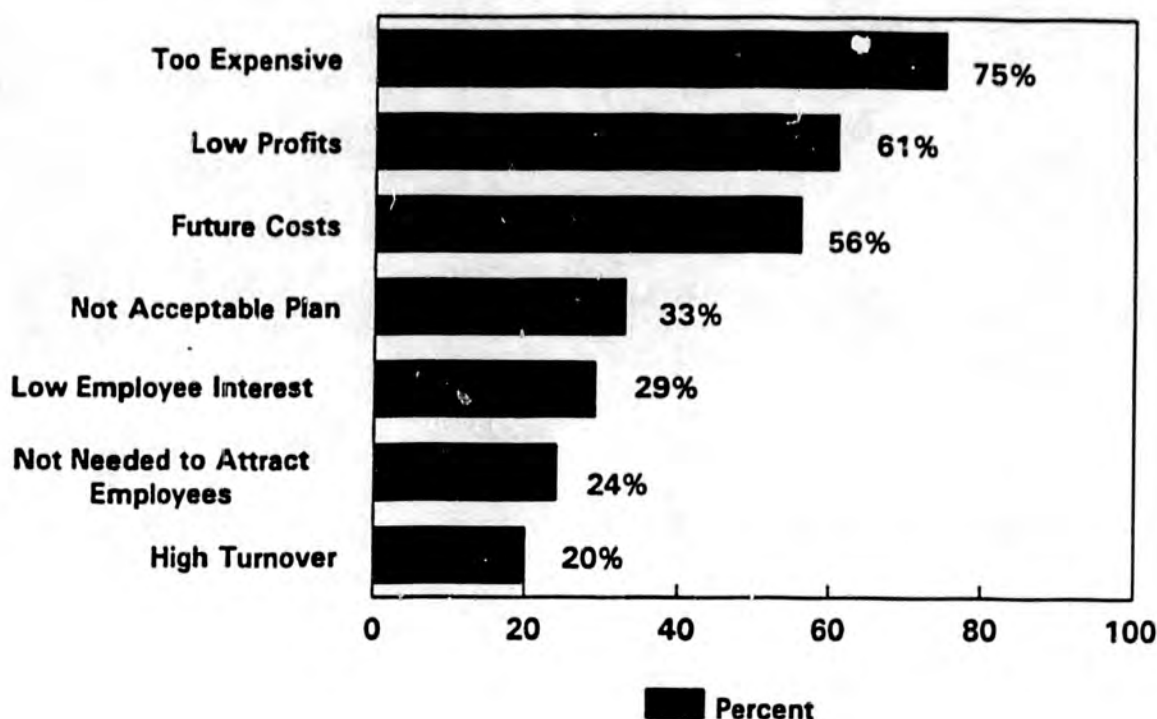
Source: Health Systems Research, Inc., analysis of March 1988 and 1989 CPS.

Why Some Employers Do Not Provide Health Insurance Benefits

- According to a 1989 HIAA survey, 75 percent of employers when asked the reasons for not offering health insurance, said it was too expensive.

In the same survey, employers identified other reasons for not providing coverage.

Figure 6. Percent of Firms Citing Particular Reasons as a Very Important Reason for Not Offering Health Insurance



Source: HIAA 1989 Employer Survey.

Problems Facing Small Groups

Small groups with fewer than 25 employees are the highest risk of being uninsured or becoming uninsured. A description of the problems these groups face in securing and retaining insurance coverage is described below.

The nature of small businesses has historically contributed to the difficulty in providing adequate and continuous coverage to employees at an affordable cost. New businesses start up and fail at a rapid rate. Employee turnover in small businesses is higher and they employ more part-time workers. High fluctuations in monthly cash flows and seasonality of work may also contribute to the difficulty in providing coverage.

The small group insurance market experienced serious problems during the 1980s when prices rose disproportionately and some insurers experienced significant losses. Many insurers left this

market and those that remain adopted increasingly defensive practices.

- Small groups seeking health care coverage more frequently experience practices which directly exclude groups or individuals or coverage for certain pre-existing medical conditions.

Some insurers in the small group market are requiring extensive medical histories and/or medical exams before agreeing to provide coverage to a group. Medical underwriting practices, typically not required for larger groups, help the insurer identify high risk individuals. Insurers may attempt to avoid a loss by refusing to cover a particular individual or a pre-existing health condition. They may adjust their proposed premium to cover the anticipated exposure due to the high risk condition, or they may refuse the entire group. Pre-existing condition limitations, which usually last between 12 and 36 months, preclude coverage for care related to a medical condition which pre-dated the purchase of the policy.¹⁰

- "Select and ultimate" rating approaches used in conjunction with pre-existing condition limitations can result in high and unanticipated rate increases which often motivates groups to change insurance carriers.

Small group insurers frequently use a "select and ultimate" rating approach where an initial rate is given to a group for a period during which certain pre-existing limitation exclusions are in effect. A subsequent and frequently higher rate is offered as coverage for treatment of the previously excluded medical conditions becomes effective. Faced with large increases in rates, businesses may seek coverage from a different carrier which often results in employees with chronic health problems facing another waiting period.¹¹

- Tiered rating structures used by the small group insurers result in very high rates for groups with health needs. These rates frequently drive these groups out of the market.

Small group insurers divide or segment pools based on claims experience and projected risk in attempt to provide lower rates for low use groups. Each segment receives a corresponding rate. The result is high rates for small groups with health needs.¹²

- Manual rating used by small group insurers result in higher premiums for older employees and women, regardless of their health status.

Insurers frequently "manually rate" small groups offering premiums based on the age, sex, and area of those seeking coverage. The

insurance industry practice is to "avoid cross-subsidization" by charging premiums for each subscriber based on what that person is expected to use. The result is that premiums for young, single individuals, particularly men are low in comparison to premiums for older employees and or businesses with predominately a female work force.¹³

- Some small businesses in certain industries cannot find insurers that will write policies for their employees.

Some small businesses whose employees may have greater exposure to certain hazards on-the-job such as small aviation firms and heavy equipment operators cannot find insurers that will write policies for their employees. Health care providers sometimes experience these problems because they are suspected of being high users. Other groups who are considered financially unstable including those that are predominately seasonal are sometimes excluded from coverage without regard to health status or their ability to pay.¹⁴

- For comparable benefit packages, health plan costs are 10 to 40 percent higher for small employers. Small business owners overwhelmingly cite the cost of coverage as the most important reason for not offering health insurance coverage.^{15, 16, 17}

A 1987 study prepared for the Small Business Administration found that health plan costs, with comparable plans and benefits, were 10 to 40 percent higher for small businesses than for larger businesses.¹⁸

- The administrative expenses of insurers, reflected in premium⁹⁴ offered, are significantly higher for small groups than large⁹⁵ groups.

A 1990 Congressional Research Service study which examined the administrative expenses of insurers as a percentage of claims paid. Administrative expenses were defined as expenses for claims and general administration, interest credit, premium taxes, profit and risk, and commission. Although individual policies may vary, this study found that the smallest groups may pay as much as 40 percent of their incurred claims toward administrative costs and the largest groups as little as 5.5 percent.¹⁹

Figure 7. Breakdown of Insurance Company Administrative Expenses
(Percentage of Incurred Claims)

<u>Number of Employees</u>	<u>General*</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: Congressional Research Service

* Includes claims administration, general administration, interest credit, and premium taxes.

The Health Insurance Association of America also reports administrative expenses. Their data reflects a similar distribution in the types of administrative expenses but a smaller range (25 percent of incurred claims for groups with fewer than 25 employees and 6 percent for groups of 2,500 or more employees).²⁰

- Only a handful of insurers sell to small groups in Alaska.

According to the Division of Insurance, at this time only nine insurers sell to the small groups in Alaska.²¹

Thirty-nine percent of private employees work in firms with fewer than 20 employees or about 53,000 Alaskans. These workers are primarily employed in the trade and services sectors but include all industries.²²

The Consequences of Having An Uninsured Population

Both the uninsured individual and other health care payors bear the consequences of having an uninsured population.

- A larger share of the uninsured report having a lower health status than the insured.²³
- The uninsured use fewer services overall than the insured. However, when they do use services, it is more likely to be late in the course of a disease and in costly institutional settings such as emergency rooms.

A 1986 Health Interview Survey found the uninsured see a physician two-thirds as often as the insured and spend three-fourths as many days in the hospital. They are more likely to rely on emergency rooms for routine services.^{24, 25}

- The uninsured (and underinsured) generate significant unpaid medical bills which ultimately are paid by employers who offer health insurance for their workers, taxpayers, and health care providers who absorb costs not paid by other sources.

Uncompensated care or unpaid medical bills are generated by the uninsured when they are unable to pay for their medical care. Health care providers must shift or absorb the costs of services to the uninsured to other health care payors ultimately increasing the cost of health care for the insured. (Uncompensated care and cost-shifting will be discussed in Section (C) of this chapter.)

Other Indicators of the Health Care Access Problem in Alaska

Other indicators of the access problem are described below.

- If the national estimate "that one-quarter of the privately-insured under 65 population is underinsured" is accurate in Alaska, then it can be estimated that about 60,000 nonelderly Alaskans are underinsured.

The underinsured have health care coverage but it does not adequately cover necessary care. Although, the underinsured have not been sufficiently identified, one study which relied on national data, estimated that "more than one quarter of the privately-insured under 65 (population) have no protection against expensive hospital stays".²⁶ The 1989 Current Population Analysis reported 239,000 nonelderly Alaskans had private health care coverage.²⁷ Assuming the national estimate of the size of the underinsured population is accurate in Alaska, it can be estimated that about 60,000 nonelderly Alaskans are underinsured.

Since this study was completed, the number of individuals who are underinsured has probably grown given the trend toward increased employee cost-sharing. Trends in recent years show more health care plans are requiring employees to share the cost of premiums. In addition, employees contributions for deductibles and co-payments are increasing. Both trends suggest the financial

barriers to health care in the United States are increasing, even for the insured. In the 1980s this has resulted in aggregate out-of-pocket expenses growing faster than medical prices.²⁸

- Some Alaskans who are covered by Medicaid may have difficulty finding a provider that will treat them.

Although this problem appears to be much less prevalent in Alaska than in some other states, a few providers may be reluctant to accept lower payments, the extra paperwork, or other problems associated with serving the Medicaid populations.²⁹

- Some Alaskans defer medical treatment because of the travel required to see a health care provider or costs associated with travel.

Alaskans living in remote and rural areas of the state often travel great distances and at significant costs to obtain health care. The Alaska Native Health Board recently reported the unmet need for patient travel was \$4.9 million in Fiscal Year 1990. Forty percent of all their patients who need to travel for medical care defer treatment because they lack money for airfare.³⁰

B. HEALTH CARE COST PROBLEM-UNDERSTANDING TO DATE

The cost of health care and health insurance in the United States is so high that employers and individuals are finding it increasingly unaffordable. Two indicators of the magnitude of the health care cost problem, the rate of spending and per capita spending, are described below.

Indicators of the Health Care Cost Problem

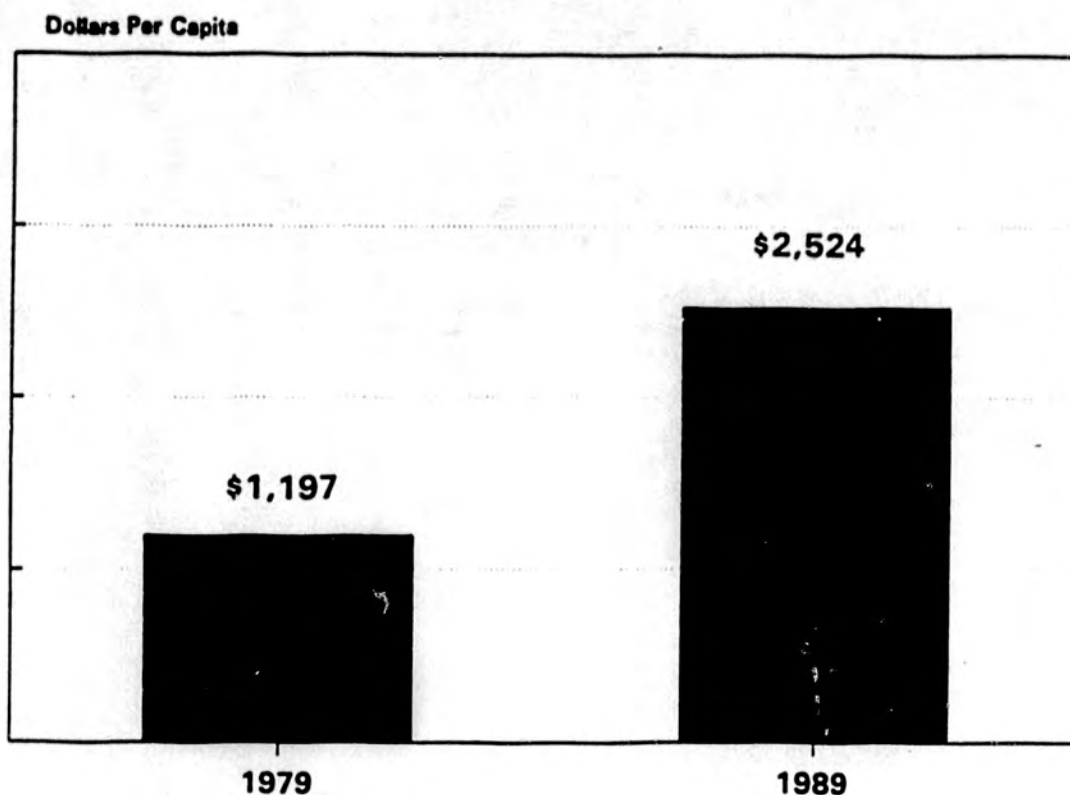
- Health care spending in the United States is increasing much faster than general inflation.

Total U.S. spending for health care climbed 167 percent from \$249 billion in 1980 to \$666 billion in 1990. General inflation accounted for roughly half the increase.³¹

- Total health care spending in Alaska in 1990 was estimated to be \$1.523 billion, up from \$481.25 million in 1979.³²

- In Alaska, per capita health care spending increased 111 percent from \$1,197 in 1979 to \$2,524 in 1989.³³

Figure 8. Estimated Alaska Per Capita Health Care Spending
1979 and 1989

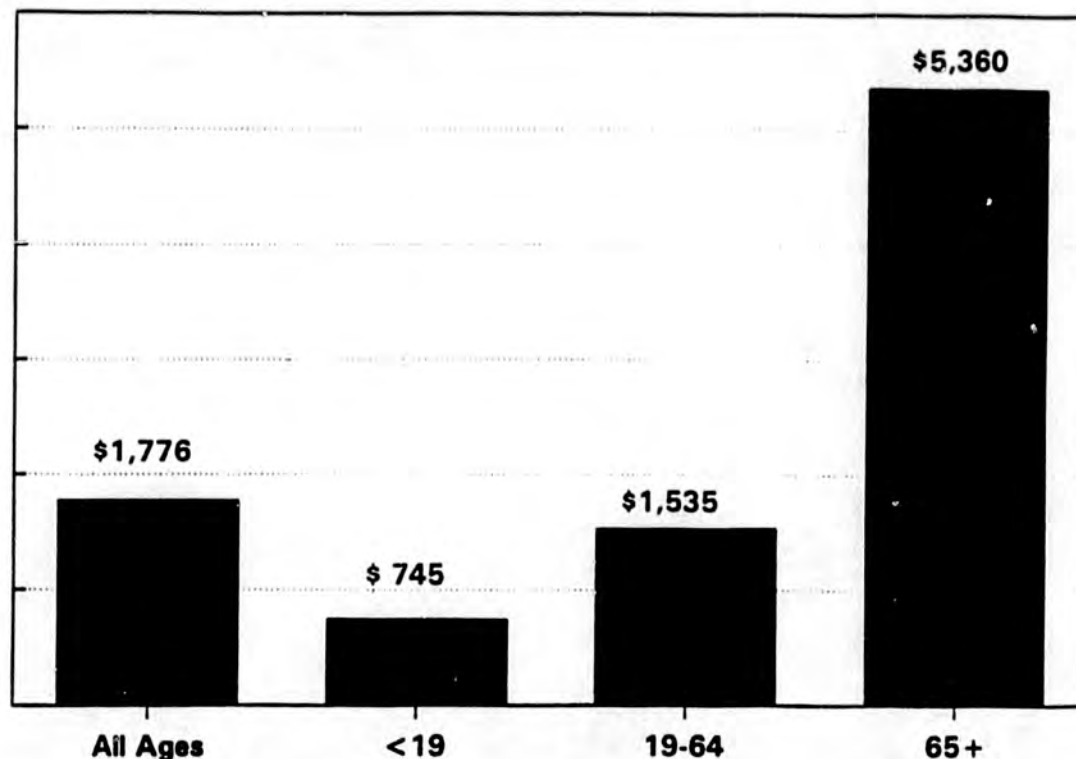


Source: Alaska Health Care Cost Containment Task Force.

- In 1987, per capita health care spending for the elderly in the U.S. was four times greater than for children under 19 years of age. Population trends suggest the elderly will consume an even larger share of total health care spending in future years.

In 1987, health expenditures for the people over age 65 averaged \$5,360 per capita as compared to \$1,535 for adults between the ages of 19 and 64 and \$745 for children under 19 years of age. The elderly consume a disproportionate share of both hospital and nursing home services.³⁴

Figure 9. Estimated U.S. Per Capita Health Care Spending
By Age Group, 1987



Source: Health Care Financing Administration.

The proportion of health care spending on the elderly in the United States is likely to grow given that the elderly currently represent about 12 percent of the U.S. population and are expected to increase to 21 percent by 2030. In Alaska, the 1990 elderly population was 4.1 percent of the total population. However, Alaska's elderly population is growing at a faster rate than U.S. elderly population. In the 1980s, the over 65 population in Alaska grew at an average annual rate of 6.8 percent in contrast to the U.S. elderly population which grew at average annual rate of only

2.1 percent.³⁵

The growth rate of the elderly population is expected to have significant effects on public sector health spending since the services for the elderly are financed disproportionately by the public sector.³⁶

- Alaska's 1990 per capita health care spending was 36 percent above the age-adjusted national average.

Alaska's relatively young population results in lower per capita health care spending. The federal study cited above estimated that in 1987, per capita health care spending for individuals under 19 years was approximately 48.5 percent 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, the effect of Alaska's younger population on per capita expenditure levels can be estimated as follows. If the U.S. were assumed to have the same age distribution as Alaska, it is estimated that 1990 national per capita health care spending would have been only \$2,039. By comparison, Alaska's 1990 per capita health care spending was \$2,769, or 36 percent above the national age-adjusted average.³⁷

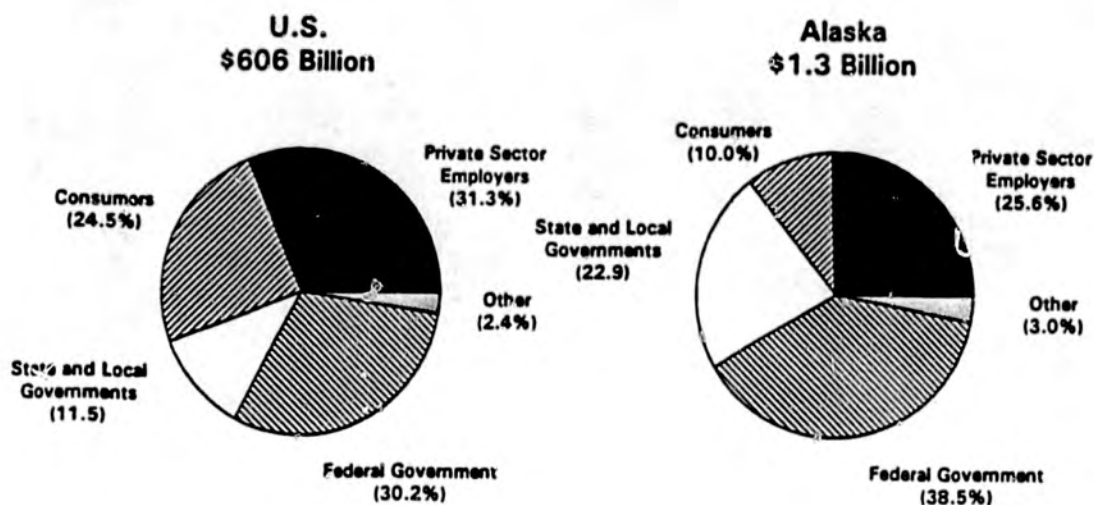
Who Pays the Health Care Bill in Alaska and What Services are They Paying For

All health care payors absorbed these tremendous increases in spending. Who is paying and the services they are paying for are described below.

- The federal, state, and local governments pay a larger proportion of the health care bill in Alaska as compared to the U.S. as a whole.³⁸

While total health spending in Alaska was estimated to be \$1.523 billion in 1990, the sources of payment in Alaska are available for 1989 as reported below.³⁹

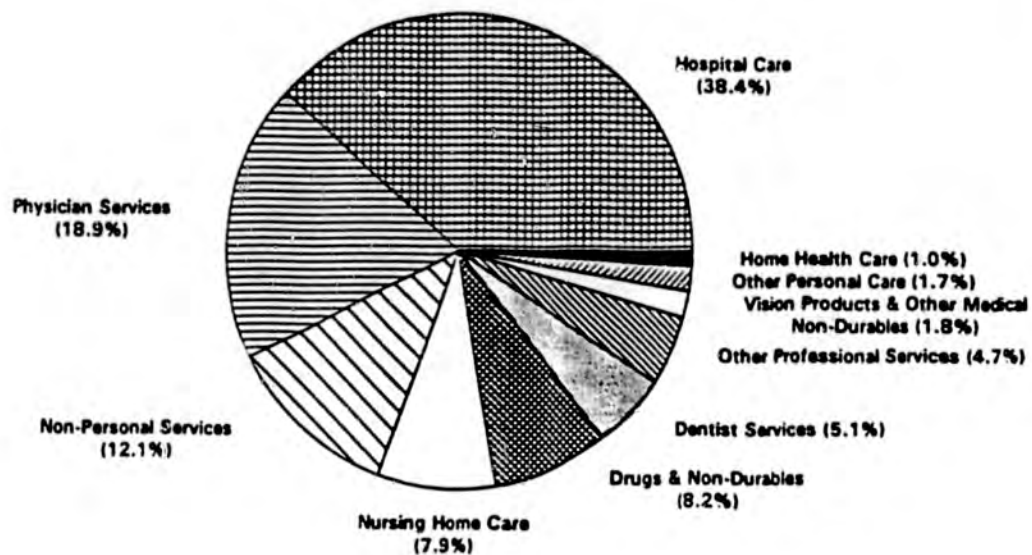
Figure 10. Sources of Payment for Health Care Expenditures, U.S. and Alaska, 1989



Source: Alaska Health Care Cost Containment Task Force.

- In 1990, 38.4 percent of all U.S. health care spending went for hospital care, 18.9 percent for physician services, 8.2 percent for drugs and nondurables, 7.9 percent for nursing home care, and 12.1 percent for nonpersonal services.⁴⁰

Figure 11. U.S. Health Care Expenditures
by Type of Expenditure, 1990



Source: Health Care Financing Administration.

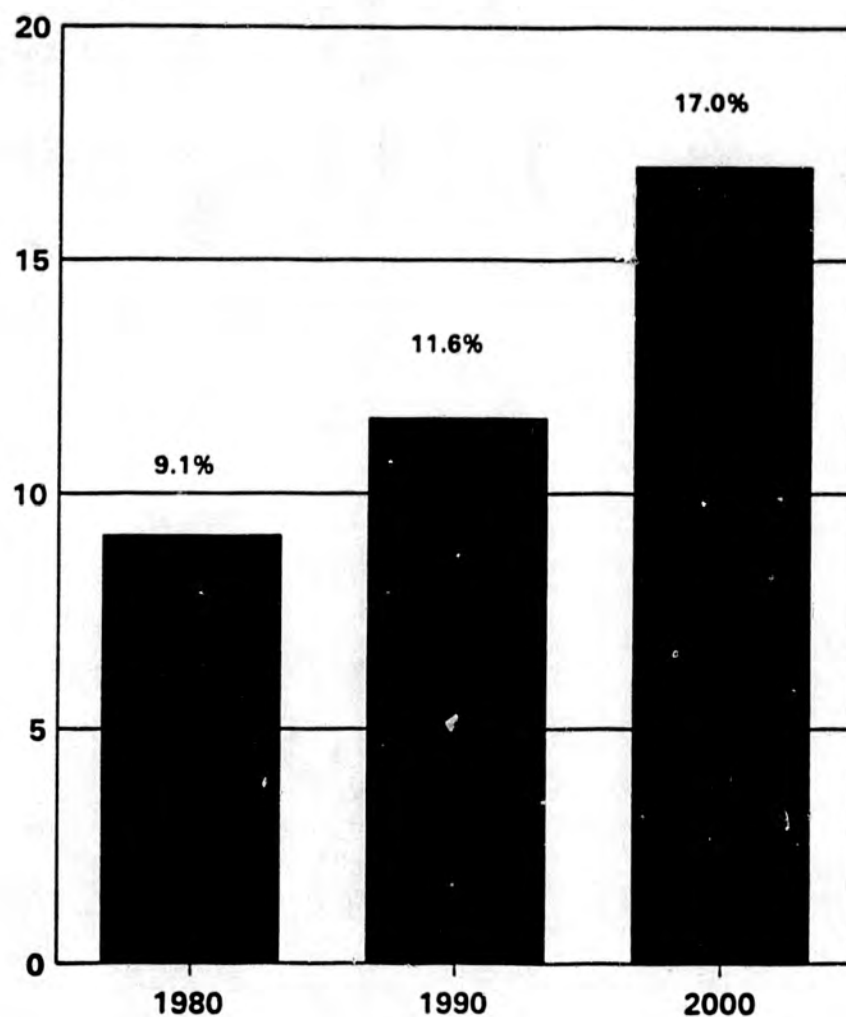
Between 1980 and 1989, spending for physician services grew at an average annual rate of 12.2 percent while spending for nursing home services grew at a slower 10.2 average annual rate. Spending for hospital services grew at the slowest rate of the three with an average annual rate of 9.6 percent. These growth rates are due in part to the change in hospital use patterns. In the 1980s, hospitals began providing more outpatient settings and the number of inpatients days and the number of admissions declined. The growth in physician services can also be attributed to the common fee-for-service reimbursement system which creates incentives for the physician to increase the number of services they provide, the supply of physicians particularly specialists who tend to be better compensated than primary care physicians, and the use of new medical technologies and services.⁴¹

The Consequences of High Health Care Expenditures

Described below are indicators of the consequences of high health care expenditures on the economy, business, and employees.

- Health care spending represents an increasing share of the GNP in the United States.⁴²

Figure 12. U.S. Health Care Spending as a Percent of Gross National Product, Selected Years



Source: Congressional Research Service