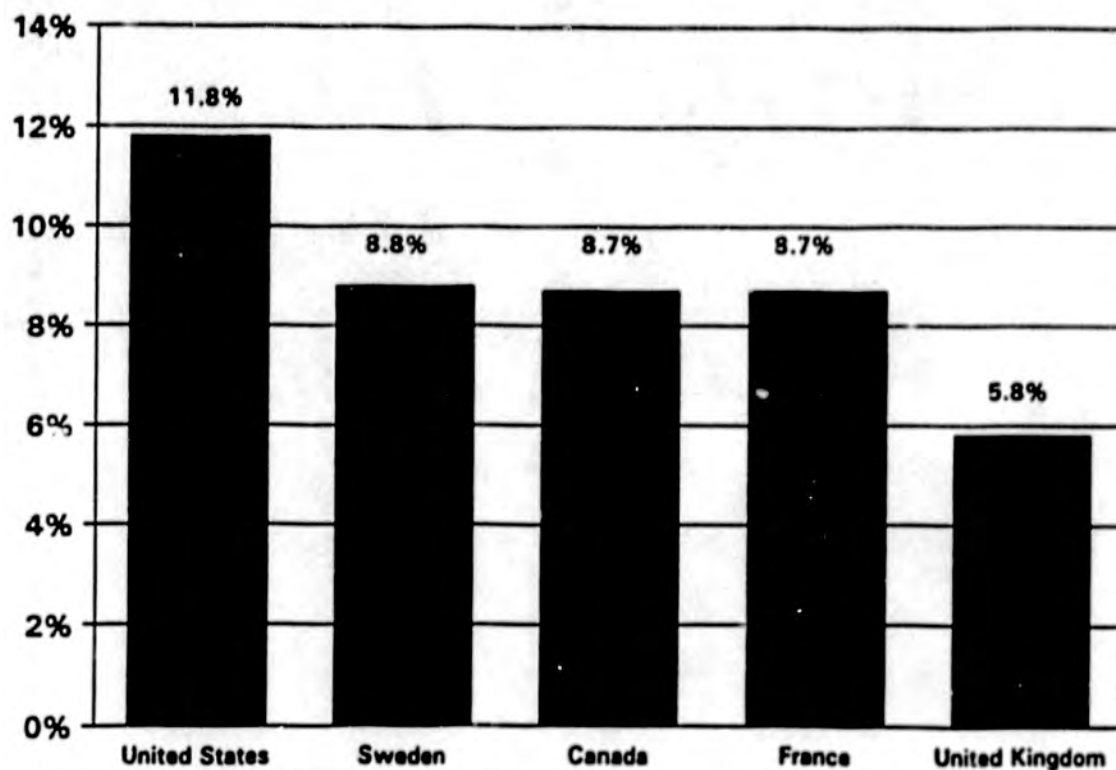


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- The United States spends more on health care than most other industrial countries.⁴³

Figure 13. Health Spending as a Percent of Gross Domestic Product, Selected Countries, 1989

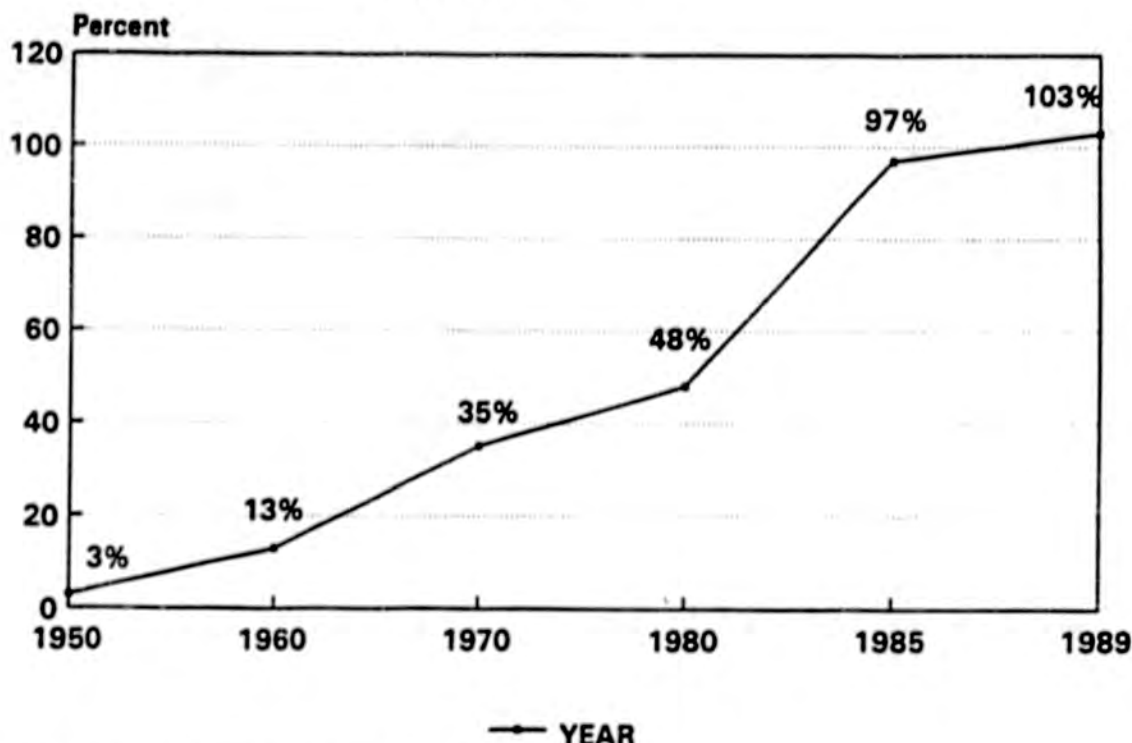


Source: Schleber, George and Jean-Pierre Pollier, Int'l Health Spending Issues and Trends, "Health Affairs", Spring 1991.

- Employers are spending a higher percentage of their corporate after-tax profits on health insurance.

According to the Employee Benefits Research Institute, health insurance was only 35 percent of corporate after-tax profits in 1970. By 1980, it had increased to 48 percent and had grown to 103 percent by 1989.⁴⁴

Figure 14. Employer Spending on Health Insurance as a Percentage of Corporate After-Tax Profits, Selected Years



Source: Employee Benefit Research Institute tabulations of U.S. Dept. of Commerce data.

- Households are spending a larger percent of their after-tax income on health care.

In 1982-83, households on the average spent 4.1 percent of their incomes on health care. By 1982-83, it had increased to 5.0 percent.⁴⁵

- 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.

According to the U.S. Bureau of Labor Statistics, the proportion of workers required to pay part of their individual coverage increased from 21 percent to 46 percent between 1982 and 1988 and from 51 percent to 65 percent for family coverage. In addition, the average per employee premium costs for workers with individual coverage increased from \$31 to \$72 over the same period and from \$171 to \$320 for family coverage.⁴⁶

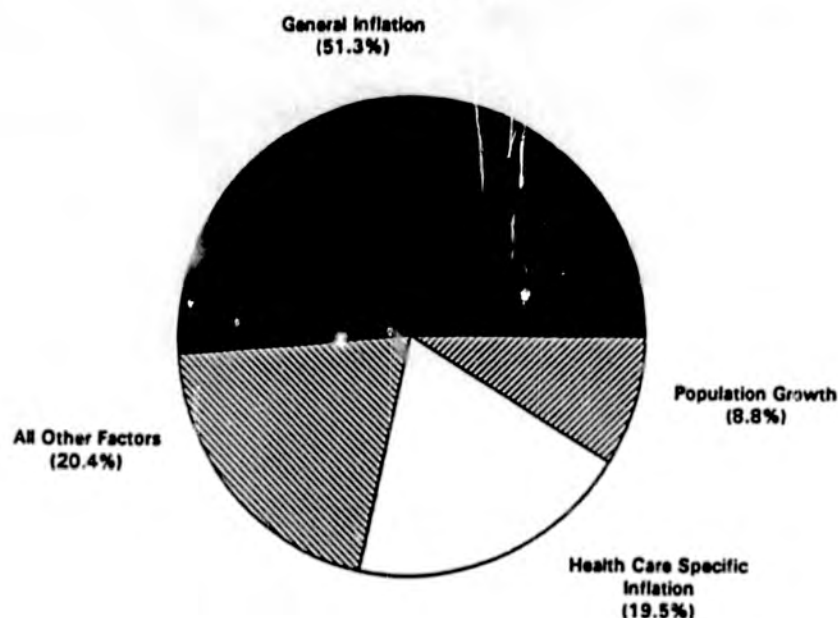
- In 1989, nearly two-thirds of 43 major labor walkouts in the United States were disputes over health benefits.⁴⁷
- A larger percentage of Alaskans are becoming uninsured.⁴⁸

Factors Contributing to the Increase in Health Care Expenditures

Health care expenditures are affected by complex and interrelated factors. Three factors which can be measured directly are the change in population, general price inflation, and medical price inflation. Other factors, more difficult to measure, include the introduction of new medical technologies, the change in the mix of services consumed, and the increase in the use of medical services.

- 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.⁴⁹

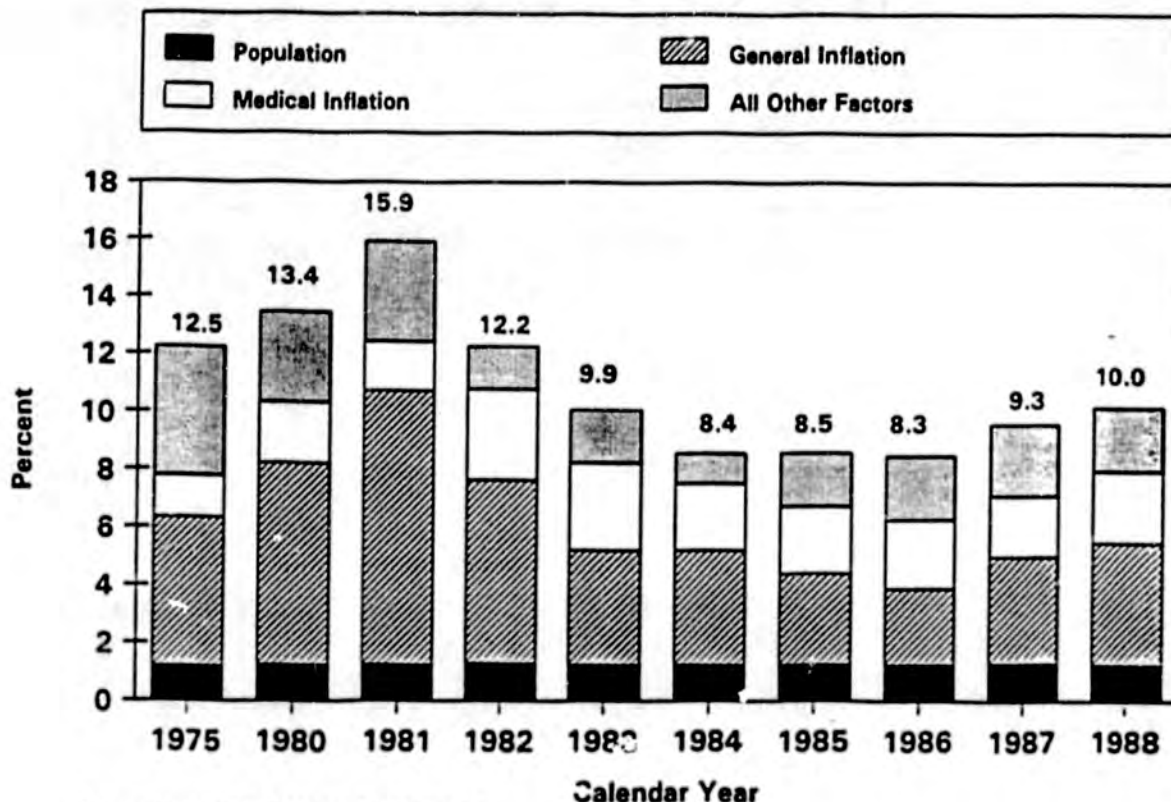
Figure 15. Factors Affecting Changes in
U.S. Personal Health Expenditures,
1975-1987



Source: National Committee for Quality Health Care.

- 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.⁵⁰

Figure 16. Factors Accounting for Average Annual Growth in U.S. Personal Health Care Expenditures: Selected Calendar Years, 1975-1988



Source: Health Care Financing Administration

- 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.⁵¹
- Medical price inflation in Anchorage has increased at approximately the same rate as the U.S. average.

Between 1975 and 1990, the medical component of the Anchorage Consumer Price Index increased at approximately the same rate as the medical component for the U.S. CPI. Medical price differentials for other Alaska locations are not available.⁵²

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

The task force identified a number of additional factors they suspect contribute to the health care access and cost problems in Alaska. Of those the task force identified, they obtained Alaska-specific information on the following: charges/prices for health services, patient utilization patterns, excess capacity in Alaska's acute care community hospitals, the use of high tech medical equipment and units in Alaska, mandated benefits, uncompensated care resulting in the shifting of costs to private payors, and the distribution of physicians in Alaska.

Charges/Prices for Health Services in Alaska

Described below is data and findings on charges or prices for health services in Alaska. It was provided to the task force by Aetna Life Insurance Company, Blue Cross of Washington and Alaska, the University of Alaska's Institute of Social and Economic Research (ISER), and the Alaska Department of Health and Social Services. Aetna and Blue Cross information comes from their customer data as recorded in their claims payment systems. Data reported by ISER was obtained from the American Hospital Association and represents the sixteen acute care community hospitals in Alaska. (See Appendices D, E, G, and I for background information.)

- Charge levels for health care services in Alaska are generally higher than the national average.

An Aetna comparison of submitted charges in February 1990 identified that Alaska charge levels were higher than the U.S. average in five profiled expense areas.⁵³

Aetna reviewed eight common non-surgical medical services including office and hospital visits and consultations in 1991. On the average, Alaska charges were 54 percent higher than the national average and 33 percent higher than Washington state.⁵⁴ Data provided by Blue Cross on the same non-surgical medical services substantiates this finding.⁵⁵

A review of physician charges for surgical services for Aetna's customers revealed 1991 Alaska charges were higher than the U.S. average for 11 of the 15 frequently-performed services.⁵⁶

The 1990 average charge per day for hospital care in Alaska for Aetna's customers was 17 percent higher than the national average. Data from Blue Cross also confirmed that the average per day hospital charges are higher in Alaska.⁵⁷

Aetna reviewed 24 major diagnostic categories and found that its

average charge for hospital care for these categories was 17 percent higher in Alaska than the national average in 1990.⁵⁸

- 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.

ISER examined data from the American Hospital Association between 1972 and 1989 and compared the average expenses per adjusted patient day. For that period, the average annual growth rate in Alaska for this measure was 13.8 percent. In 1989, Alaska's average was 76 percent above the national average.⁵⁹

- 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.

ISER examined average payroll as a contributor to costs for health care in Alaska. Again using data provided by the American Hospital Association from 1972 - 1989, they compared average annual payroll in Alaska and U.S. hospitals. Historically, the average annual growth for this measure in Alaska has been 9.8 percent. In 1989, average payroll per employee in Alaska's acute care community hospitals was 55 percent above the national average.⁶⁰

- Alaska's Medicaid reimbursement rate for nursing home beds is three times the U.S. average net patient revenue for nursing home care.

In 1989, the average Medicaid reimbursement rate for nursing care beds in Alaska was \$202 per day as compared to the 1988 U.S. average net patient revenue for nursing care of \$51.27 per day. Hawaii comes closest to Alaska with a 1988 average net patient revenue for nursing home care of \$88.69 per day.⁶¹

Patient Utilization Patterns in Alaska

There is considerably more utilization data available on Alaska's hospitals and nursing homes than on outpatient services. As a result, most of the information reviewed by the Task Force focused on inpatient uses. This should not be interpreted that outpatient utilization patterns are less important to the Task Force.

The University of Alaska's Institute of Social and Economic Research (ISER) compiled and analyzed data from the Medicaid Rate Advisory Commission and the American Hospital Association and presented the following findings, as well as a report included in Appendix D.

- 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.

Occupancy rates are the best overall measure of inpatient utilization of hospitals.⁶² ISER examined occupancy rates in Alaska and U.S. hospitals between 1972 and 1989 and found both have fallen since the mid-1980s. Although many factors have contributed to lower occupancy rates, changes in federal and state inpatient reimbursement systems are widely accepted as having provided incentives for shorter lengths of stay and fewer hospital admissions.⁶³

The occupancy rate in Alaska's sixteen acute care community hospitals averaged 45 percent in 1989. The rates ranged from 11 to 61 percent. The average occupancy rate was higher in Anchorage and Fairbanks, at 50 percent, than in the remainder of the state at 35 percent. The average was even lower in co-located facilities (those including both acute care and nursing home beds) at 32 percent than for facilities with only acute care beds which averaged 46 percent. Four of Alaska's acute care community hospitals had occupancy rates above the national average for similar-sized facilities in 1989.⁶⁴

- 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.

ISER examined inpatient days per capita and length of stay data between 1972 and 1989 for Alaska's acute care community hospitals and U.S. hospitals.⁶⁵ In 1989, they found the number of inpatient days per capita in Alaska's acute care community hospitals was 0.53 days as compared with the national average of 0.92 days. The average length of stay in Alaska's acute care community hospitals was 5.9 days in 1989 as compared to the national average of 6.9 days. The young average age of Alaska's population and the selection of out-of-state hospital care by some Alaskans contribute to these utilization patterns in Alaska's hospitals.⁶⁶ Blue Cross confirmed that length of stays for their Alaska customers in Alaska's hospitals are shorter than in Washington's hospitals.⁶⁷

- Outpatient utilization at Alaska's acute care community hospitals has historically been below the national average.

ISER examined outpatient utilization at Alaska's acute care

community hospitals and U.S. hospitals between 1972 and 1989.⁶⁸ They calculated the number of outpatient visits per capita and found an average of 0.99 visits per capita in 1989 in Alaska's acute care community hospitals as compared with 1.17 visits in U.S. hospitals.⁶⁹

Excess Capacity in Alaska's Acute Care Community Hospitals

There has been a lack of direction from the State of Alaska regarding standards for hospital size. In the mid-1980s, the State significantly reduced its health planning efforts and has not issued a state health plan since 1984. The Certificate of Need process continues in Alaska but without the goals and standards that a state health plan could provide. Capital grants continue to be provided to individual communities for facility construction without a clear policy from the State.

The task force observed that Alaska's acute care community hospitals on the average are much smaller than U.S. hospitals as a whole and that they tend to have more beds than necessary to meet current demand. The Institute of Social and Economic Research (ISER) analyzed the costs associated with excess capacity in Alaska's sixteen acute care community hospitals. Three approaches were used to characterize the costs which result because these hospitals have more beds than required to serve current needs. The analyses were done in aggregate using cost and utilization data covering only 1989. The data was provided by the Medicaid Rate Advisory Commission and the American Hospital Association. ISER's results are intended to serve as general indicators of the costs of excess capacity and are not intended as comprehensive analyses of individual facilities or the need for these services in individual communities.

ISER's primary comparison of excess capacity in Alaska's acute care community hospitals was based on a comparison of Alaska occupancy rates in 1989 with occupancy rates for acute care facilities of similar size in U.S. hospitals for the same period. The complete analysis is in Appendix D.

- 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).⁷⁰
- 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.

ISER calculated the range of costs using the assumption that 10 percent (lower limit) to 20 percent (upper limit) of the total acute care facility costs were fixed. Costs were calculated based on actual occupancy rates in 1989 and then compared to costs for Alaska's acute care community hospitals assuming the occupancy rates were equal to hospitals of similar size in the entire U.S. during the same period.⁷¹

- 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.

The use of national occupancy rates is not necessarily a desirable benchmark. For comparison purposes, ISER also calculated the cost of excess capacity using the assumption of an occupancy rate of 75 percent as a standard. The high costs of acute care beds argues for the most efficient use of those beds. Nationally in the 1970s,⁷² the occupancy rate for mid-sized hospitals approached 75 percent. In addition, Alaska's 1984 State Health Plan established occupancy rate goals of 80 percent for Level IV communities (population between 40,000 and 750,000) and 65 percent for Level III communities (populations between 1,500 and 60,000).⁷³

High-Tech Medical Equipment and Services in Alaska

Data and findings on the cost and accessibility of high-tech medical equipment and services was provided to the Task Force by the Planning Section of the Alaska Department of Health and Social Services and is described below. (See Appendix F.)

It is widely recognized that the increased use of high-tech medical equipment and services has improved the quality of health care in the United States, as well as contributed to the rise in health care expenditures. MRIs (magnetic resonance imaging), CT scans (computerized tomography), cardiac catheterization labs, neonatal intensive care units, and open heart surgery units are examples of the more expensive equipment and services which have improved the quality of health care.

- 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.⁷⁴
- Alaska's demand for high-tech medical equipment and services is reduced.

Alaska's relatively young population and lower rates of death for certain chronic diseases has the effect of reducing the demand for

many high-tech medical services. Alaska's death rates for heart disease, cancer, cerebrovascular and chronic obstructive pulmonary disease are below the national average. Many high-tech medical services are commonly used to detect and treat these diseases.⁷⁵

- 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.

The amount of high-tech medical equipment and units is due in part to lower demand and the fact that Alaska's many small hospitals can not afford them or do not have the medical personnel to use them. The Department concluded high-tech medical equipment is not contributing excessively to rising health care expenditures at this time.⁷⁶

- 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.

Pressures on smaller hospitals (particularly those with low occupancy rates) to increase revenues and retain patients are likely to increase the desire to make available high-tech medical services in their communities. Once in place, the tendency is to use it. More specialized personnel needed to operate the equipment and the equipment itself will tend to increase expenditures. More importantly, "medical research has demonstrated specifically with high-tech medical services that quantity (of services provided) correlates with (improved) patient outcomes".⁷⁷

Mandated Benefits in Alaska

Proponents of mandated benefits argue that they provide needed access to services and to certain individuals or groups. Opponents argue that they invariably drive up the cost of coverage. AS 21.36.090(d) requires that employers must offer benefits for the following state licensed providers types: chiropractor, naturopath, physical/occupational therapist, physician (including osteopath and podiatrist), psychologist and psychiatrist, optometrist, and dentist. However, the costs of providing these benefits can be limited by capping the maximum benefits paid.⁷⁸

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

AS 21.45.365 requires an employer with 20 or more employees to provide at least \$7,000 (over two consecutive years) in alcoholism and drug abuse treatment benefits (with a maximum lifetime benefit of \$14,000). AS 21.42.375 requires coverage for routine mammogram

screening according to a schedule. Both Aetna Life Insurance Company and Blue Cross of Washington and Alaska recently estimated the cost impacts of the alcoholism/drug abuse treatment benefit were between 2 to 3 percent of a typical health care plan's total medical benefit payment and between 0.7 and 1.4 percent for the mammogram screening.⁷⁹

Uncompensated Care in Alaska's Acute Care Community Hospitals and Cost-Shifting to Public and Private Payors

Persons who receive health services but either cannot or do not pay for them generate substantial uncompensated health care costs each year. In addition, some payors reimburse providers below their full-charge level. Costs incurred by providers for services which are underpaid or not paid must be shifted to other payors including employers who provide health insurance to their workers and taxpayers.

- 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.

Data provided by the Alaska State Hospital and Nursing Home Association was used to calculate the actual costs associated with charity care, bad debt, and Hill Burton free care. These costs may have been offset by the \$3.7 million in revenues from state and local governments. The \$16.8 million figure may significantly understate the magnitude of cost-shifting at Alaska's acute care community hospitals. Industry representative have stated that public payors such as Medicare and Medicaid do not cover the cost of delivering services to those clients. If this is the case, then costs associated with the delivery of services to Medicare and Medicaid patients are shifted to private payors. The task force will continue to work to determine the magnitude of the cost-shifting in Alaska.⁸⁰

Data on cost-shifting for physician services is nearly impossible to obtain although of no less interest to the task force.

Distribution of Physicians in Alaska

An insufficient supply of family practice physicians in Alaska may contribute to both the health care cost and access problems.

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

An October 1991 estimate suggested the Alaska Area Native Health Service and health corporations need about 20 new physicians annually in rural Alaska due to high turnover. In addition, 10 family practice physicians are currently needed in seven communities in Southeast Alaska and Valdez.⁸¹

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CHAPTER FOUR

OPTIONS UNDER CONSIDERATION BY THE TASK FORCE

Many states have faced the similar complex health care problems and experimented with innovative approaches in order to assure appropriate and affordable health care to their citizens. The task force reviewed all the major approaches implemented in other states. They have relied on presentations made by Lawrence Bartlett, Ph.D., Director of Health Systems Research, Inc. for much of this information. Two documents have also served as references, the National Academy for State Health Policy's Access and the Uninsured: A Guide for States (April 1991) and the Congressional Research Service's report on Controlling Health Care Costs (January 1990). Listed below are the options under consideration by the Task Force.

At their October meeting, the Task Force identified the following set of options which they were to study over their next several meetings.

- Examine regulatory, reimbursement, and demonstration/ pilot project approaches (i.e. alternative facility models) to address the excess capacity problem.
- Expand access for kids (including medically needy option for women and children).
- (Some form of) Regulatory reform in small group market.
- (Options for uninsured: explore such things as) Hour banks for seasonal/part-time workers.
- Data gathering (including providers rates (charges) review, insurer rate review, making data available to consumers, flow of medical expenditures outside the state, reinstatement of health planning function).
- Strengthening Certificate of Need process.
- Retention and attraction of primary care health workers to medically under-served areas.
- Utilization review standards.
- Pooling concept.
- Malpractice reform.
- Alternate dispute resolution for malpractice cases.
- Identify non-efficacious procedures.
- High-risk pool/comprehensive health insurance association.
- Expand local access available at the community.
- Universal access/coverage.
- Single-payor/all-payor.
- Philosophy: micro vs. macro management.
- Development of reimbursement schedules and utilization standards.

At their November and January meetings, the task force had lengthy discussions about these options and numerous pieces of legislation.

Also at the January meeting, they reviewed and compared two comprehensive health reform proposals, Senate Bill No. 83 and the Health Access and Cost Containment Council's "Comprehensive Health Insurance Payment and Reform Act" (CHIPRA). (Senate Bill No. 83 as well as all other legislation currently under consideration by the task force is contained in Appendix J. The CHIPRA proposal can be found in Appendix K.) 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. In order to accomplish this goal, they scheduled three work sessions in February and a regular meeting in March at which they will adopt their recommendations. The task force expects to recommend specific legislation to the governor and legislature by March 16, 1992.

(LIST OF) APPENDICES
(Appendices are published in a separate document.)

Appendix A: Legislative Resolve 45, Establishing A Health Resources and Access Task Force

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

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

Appendix D: "Report to the Health Resources and Access Task Force, January 1992", by Oliver Scott Goldsmith, Ph.D., University of Alaska, Institute of Social and Economic Research.

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

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

Appendix G: (Untitled) Data and Information Presented to the Health Resources and Access Task Force, November 18, 1991, by Steve LeBrun, Aetna Life Insurance Company.

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

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

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

Continued, Appendices

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

Appendix L: "Letter to Senator Jim Duncan, Co-Chair, Alaska State Health Resources and Access Task Force, regarding Health Care Expenditures Report Retrospective Review", from Jeff Malek, Noble Lowndes, January 7, 1992.

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

Appendix N: "Worksheet: Computations of Actual Costs which were Shifted to Other Payors to Cover Charity Care, Bad Debt, and Hill Burton Free Care at Alaska's Acute Care Community Hospitals, 1990", by Nancy Cornwell, Health Resources and Access Task Force Project Director, January 26, 1992. "Letter to Nancy Cornwell", from Garrey Peska, Alaska State Hospital and Nursing Home Association, January 13, 1992. "Letter to Senator Jim Duncan and Representative Johnny Ellis, Co-Chairmen, Health Resources and Access Task Force", from Garrey Peska, Alaska State Hospital and Nursing Home Association, January 10, 1992.

ENDNOTES

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Personal health care excludes all nonpersonal health care which in 1989 was 12 percent of total health care spending in the United States. Nonpersonal health care includes program administration, administrative costs of private health insurance and profits earned by private health insurers; noncommercial health research, new construction, and government public health activities.

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40. Expenditure data recently released by the Health Care Financing Administration. American Medical Association, "Advocacy Briefs: U.S. Health Care System, Facts on How U.S. Health Dollars are Spent", October 1991. Nonpersonal health expenditures include program administration, administrative costs of private insurers

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59. Goldsmith.

60. Goldsmith.

61. Whistler, B., Planning Section, Alaska Department of Health and Social Services, "Memo to Nancy Cornwell, Project Director, Health Resources and Access Task Force," (Juneau, October 9, 1991). (See Appendix E.)

According to Alaska Department of Health and Social Services, although the comparison of Medicaid reimbursement rates in Alaska and the U.S. net patient revenue for nursing care beds are not identical, they do serve to demonstrate that Alaska's per diem charges for nursing care beds are substantially higher than the national average.

62. Occupancy rate is defined as the number of inpatient days (excluding newborns) divided by total beds multiplied by 365 days (excluding newborn bassinets).

63. Goldsmith.

64. Goldsmith.

65. ISER assumed the Alaska Native and military populations are primarily served by federal hospitals and therefore subtracted out these populations when computing these indicators.

66. Goldsmith.

67. Gingold.

68. ISER assumed the Alaska Native and military populations are primarily served by federal hospitals and therefore subtracted out those populations when computing these indicators.

69. Goldsmith.

70. Goldsmith.

71. Goldsmith.

72. Goldsmith.

73. State Health Planning and Development Agency, State Health Plan for Alaska5, Volume 1 (Juneau: Alaska Department of Health and Social Services, June 1984).

74. Whistler, B., Planning Section, Alaska Department of Health and Social Services, "Memo to the Health Resources and Access Task Force (Juneau, October 21, 1991). (See Appendix F.)

75. Whistler, (October 21, 1991).

76. Whistler, (October 21, 1991).

77. Whistler, (October 21, 1991).

78. In conversation with Chris Ulmann, Alaska Division of Insurance, January 15, 1992.

79. LeBrun, Gingold. (See Appendices G and I.)

80. Calculated from data provided to the Health Resources and Access Task Force by the Alaska State Hospital and Nursing Home Association. (See Appendix N).

81. Wilson, R., "(Untitled) Data and Information Presented to the Health Resources and Access Task Force on the distribution and need for physicians in Alaska, November 18, 1991". (See Appendix H).

SCOMM

86:3



STATE OF ALASKA

**HEALTH RESOURCES AND ACCESS
TASK FORCE**

Interim Report to the Governor and Legislature

APPENDIX

Adopted, January 11, 1992

APPENDICES

Appendix A: Legislative Resolve 45, Establishing A Health Resources and Access Task Force

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

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

Appendix D: "Report to the Health Resources and Access Task Force, January 1992", by Oliver Scott Goldsmith, Ph.D., University of Alaska, Institute of Social and Economic Research.

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

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

Appendix G: (Untitled) Data and Information Presented to the Health Resources and Access Task Force, November 18, 1991, by Steve LeBrun, Aetna Life Insurance Company.

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

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

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

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

Continued, Appendices

Appendix L: "Letter to Senator Jim Duncan, Co-Chair, Alaska State Health Resources and Access Task Force, regarding Health Care Expenditures Report Retrospective Review", from Jeff Malek, Noble Lowndes, January 7, 1992.

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

Appendix N: "Worksheet: Computations of Actual Costs which were Shifted to Other Payors to Cover Charity Care, Bad Debt, and Hill Burton Free Care at Alaska's Acute Care Community Hospitals, 1990", by Nancy Cornwell, Health Resources and Access Task Force Project Director, January 26, 1992. "Letter to Nancy Cornwell", from Garrey Peska, Alaska State Hospital and Nursing Home Association, January 13, 1992. "Letter to Senator Jim Duncan and Representative Johnny Ellis, Co-Chairmen, Health Resources and Access Task Force", from Garrey Peska, Alaska State Hospital and Nursing Home Association, January 10, 1992.

APPENDIX A

Legislative Resolve 45

Establishing A Health Resources and Access Task Force

STATE OF ALASKA

THE LEGISLATURE

1991

Source

HCS CSSCR 10(FIN)

Legislative Resolve No.

45



Establishing a Health Resources and Access Task Force.

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

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

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

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

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

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

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

evaluate ways to manage health care expenditures in the state;

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

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

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

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

FURTHER RESOLVED that the task force shall

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) eight members chosen by the members appointed under paragraphs (1) - (3)

as follows: one individual representing the medically indigent, one individual representing private employers who are not health care providers, two individuals representing health care providers, one individual representing a health insurer that offers health insurance in the state, one individual representing nonprofit organizations, one consumer of health services who is not an employer or health care provider, and one individual representing labor organizations; and be it

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

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

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

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

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

APPENDIX B

Background Information on Health Care Access Issues

Prepared for the Alaska Health Resources and Access Task Force by

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

Washington, D. C.

September 18, 1991

**BACKGROUND INFORMATION
ON HEALTH CARE ACCESS ISSUES**

Prepared for the
Alaska Health Resources and
Access Task Force

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

September 18, 1991

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

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

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

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

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

Source: Short, AHCPR, National Medical
Expenditure Survey

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

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

Source: EBRI Analysis of the March 1990 CPS

THE UNINSURED IN ALASKA

DEFINITION:

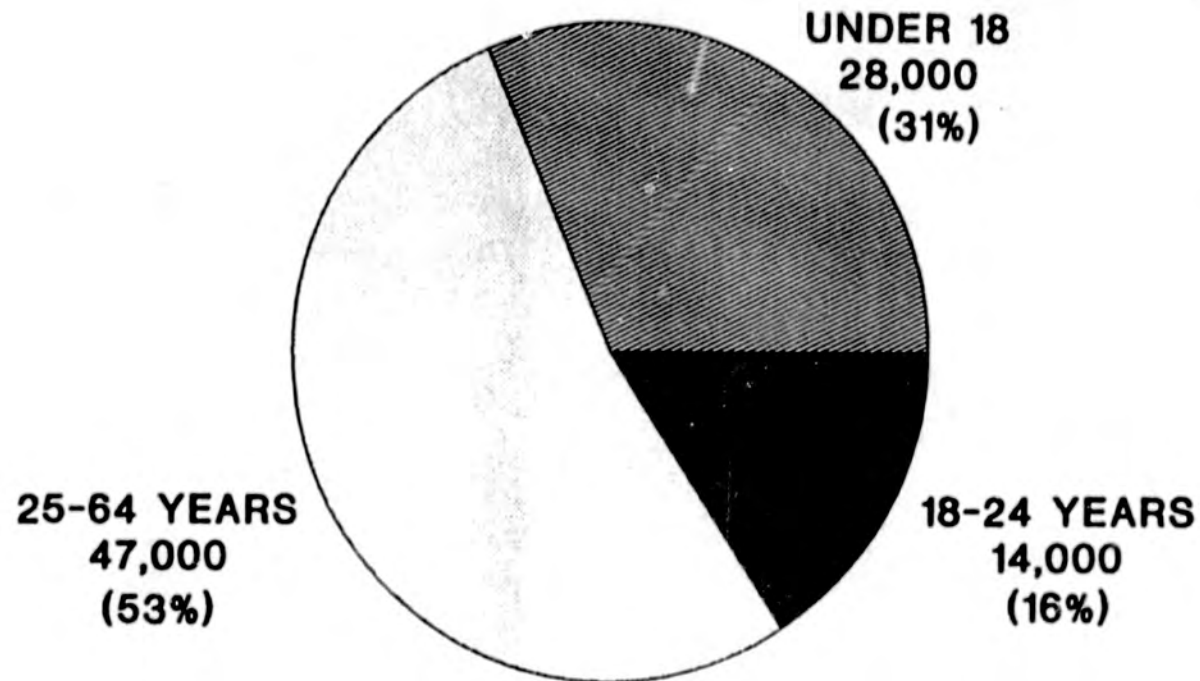
The uninsured are persons who lack third party health care coverage, such as private insurance, Medicare or Medicaid.

ESTIMATED SIZE:

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

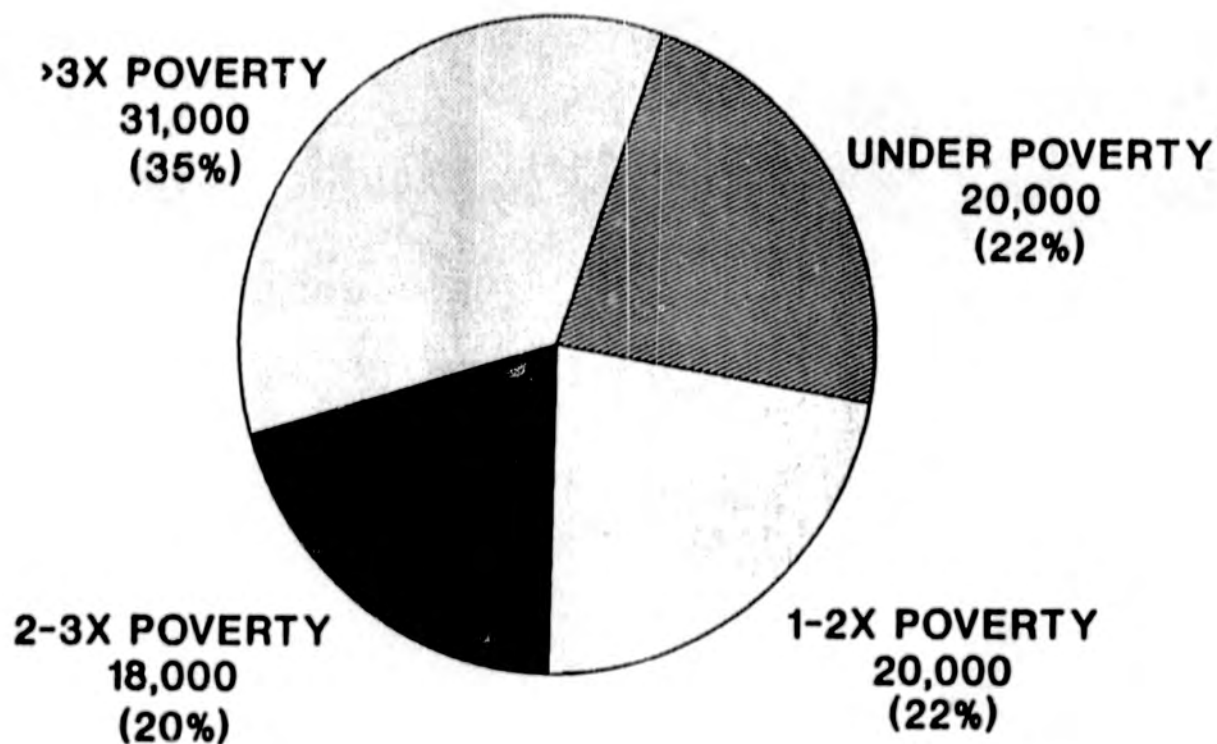
Of the persons identified in the survey as native Americans, a slightly lower proportion (16.3%, which represents about 13,800 persons) reported having no health care coverage.

UNINSURED ALASKANS By Age



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

UNINSURED ALASKANS By Poverty Status



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

1988 POVERTY GUIDELINES

HOUSEHOLD SIZE

ANNUAL INCOME

1

\$ 5,770

2

\$ 7,730

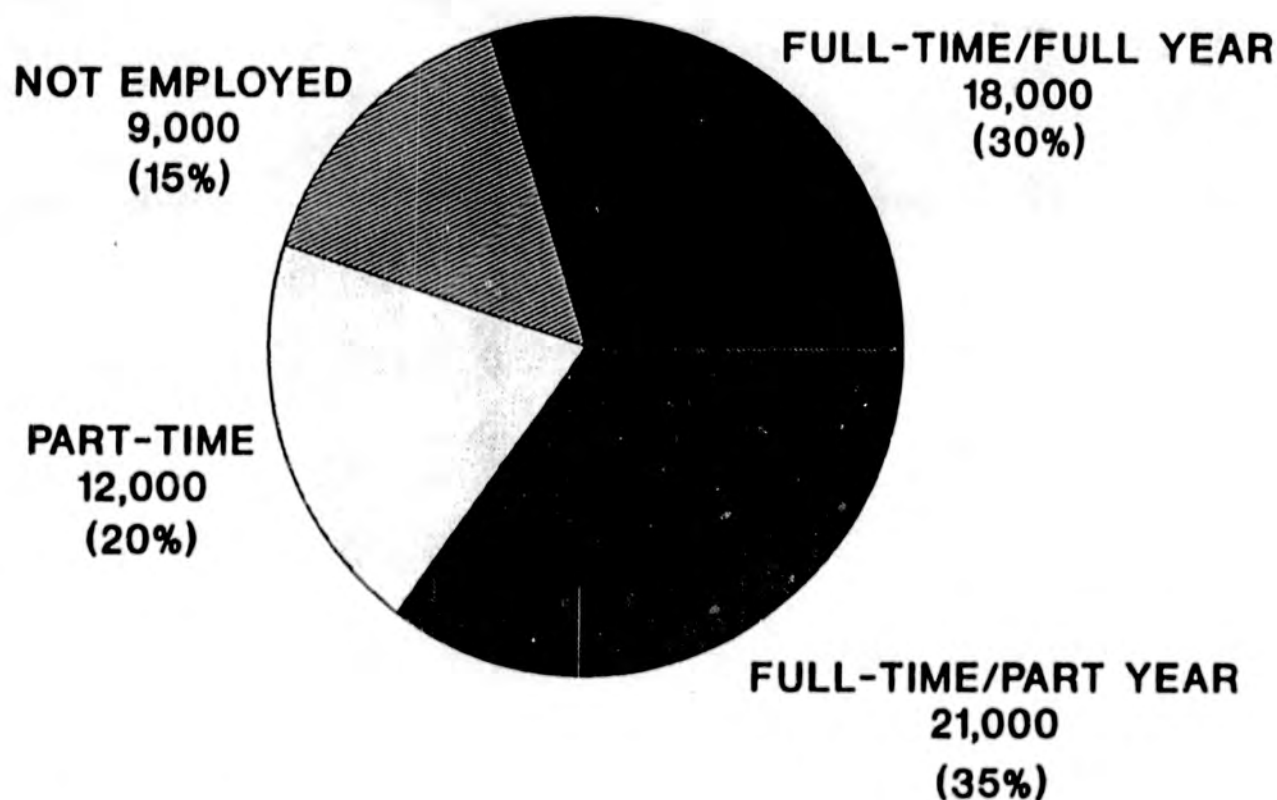
3

\$ 9,690

4

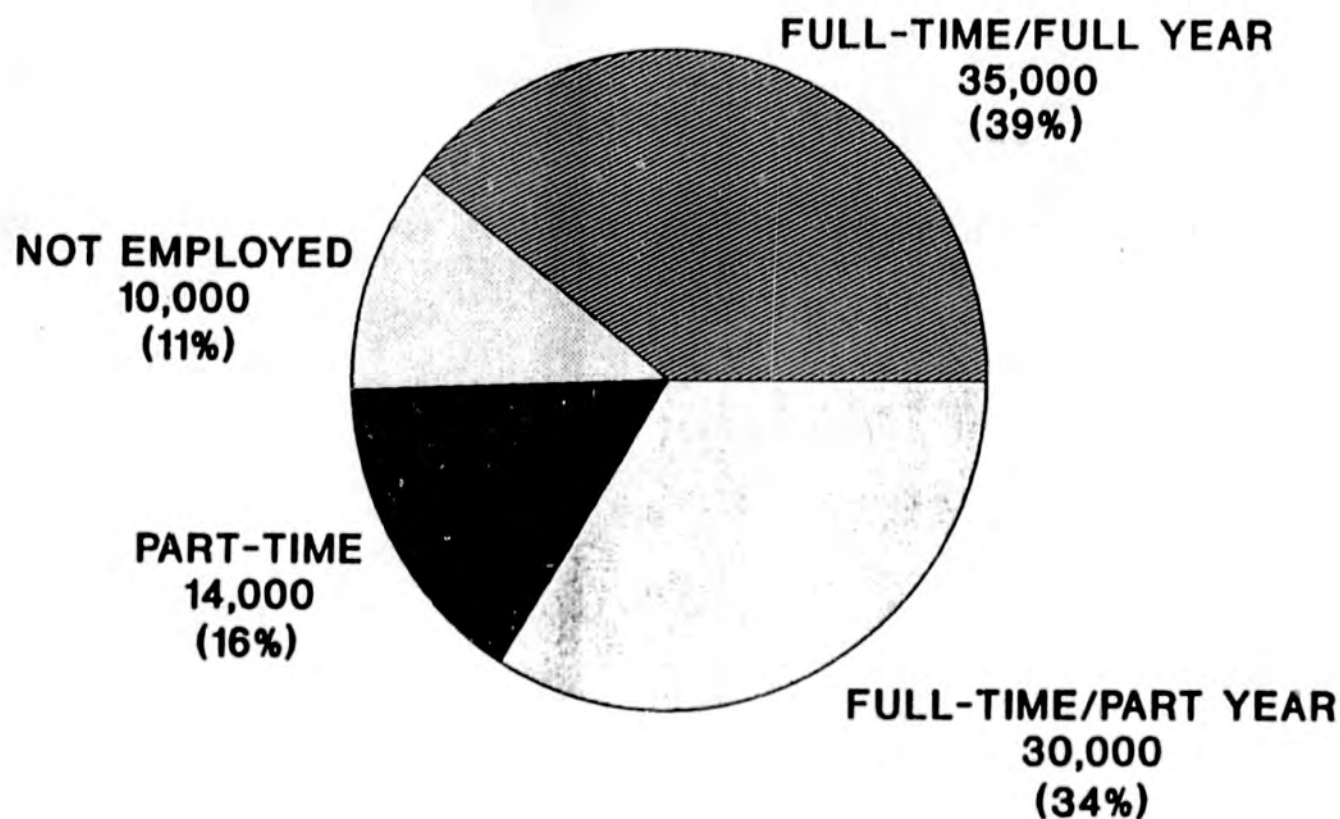
\$11,650

EMPLOYMENT STATUS OF UNINSURED ALASKANS Ages 18-64



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

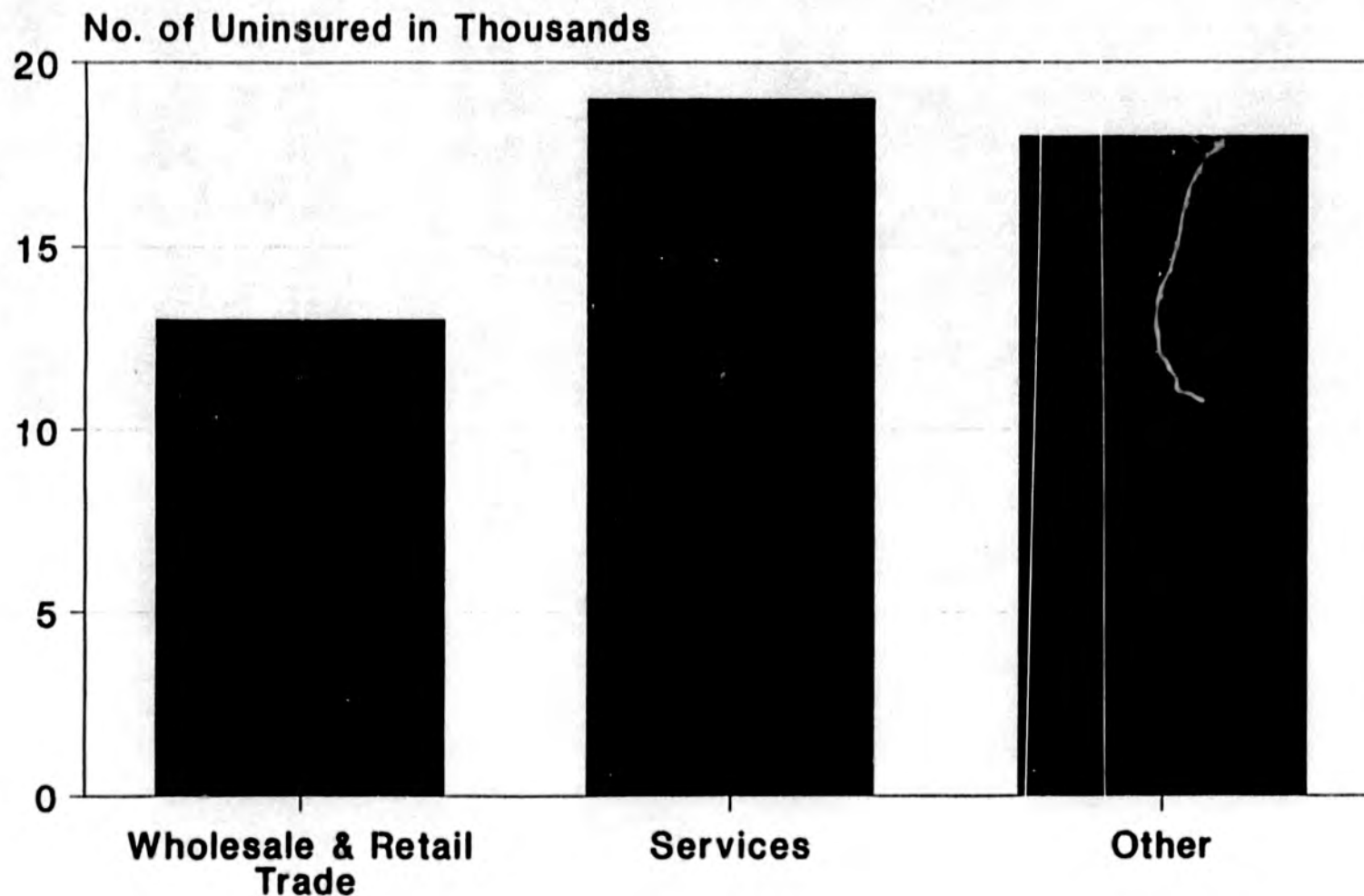
DISTRIBUTION OF UNINSURED ALASKANS By Employment Status of Family Head



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

UNINSURED WORKERS IN ALASKA

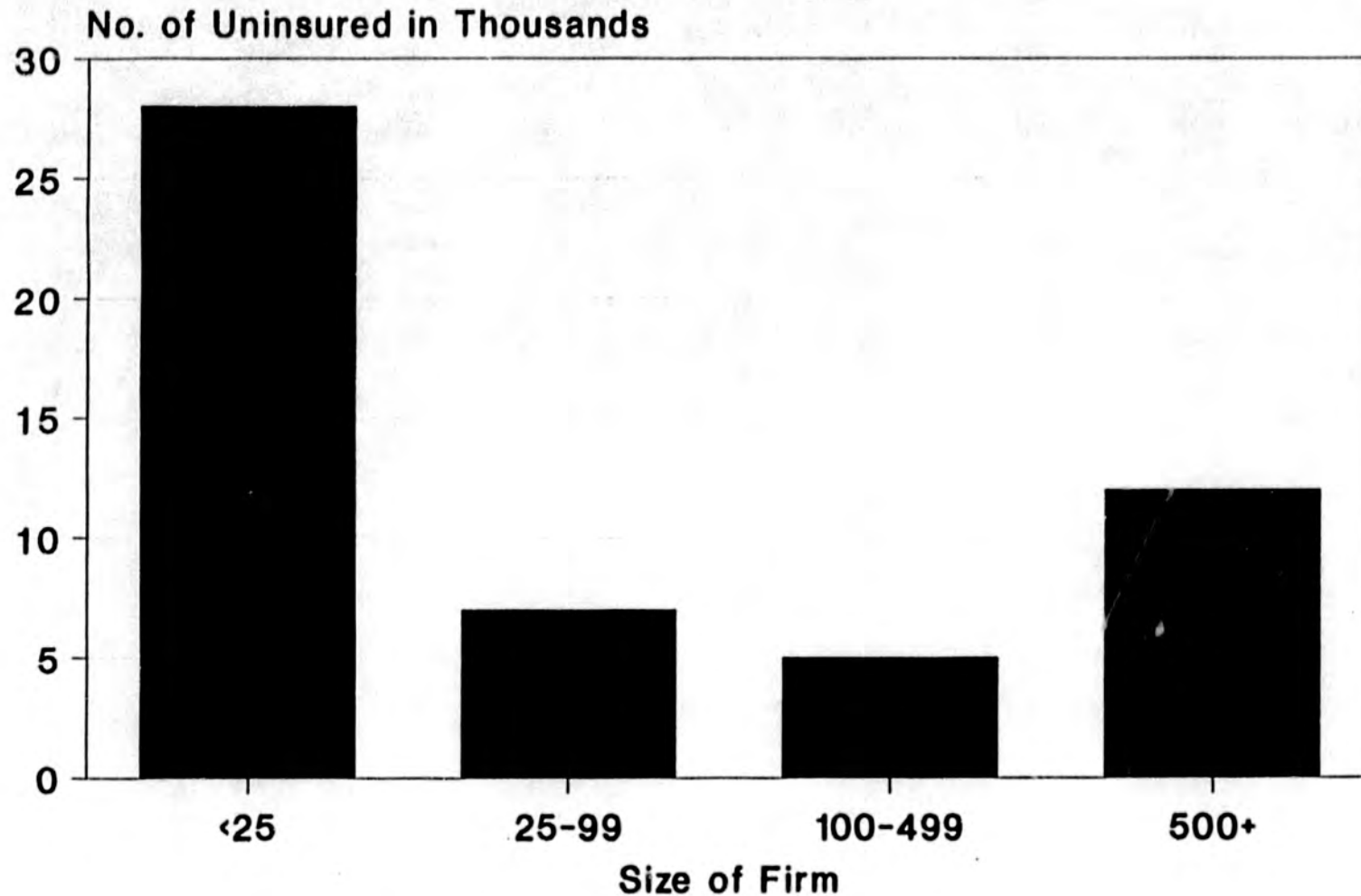
By Industry



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

UNINSURED WORKERS IN ALASKA

By Size of Firm



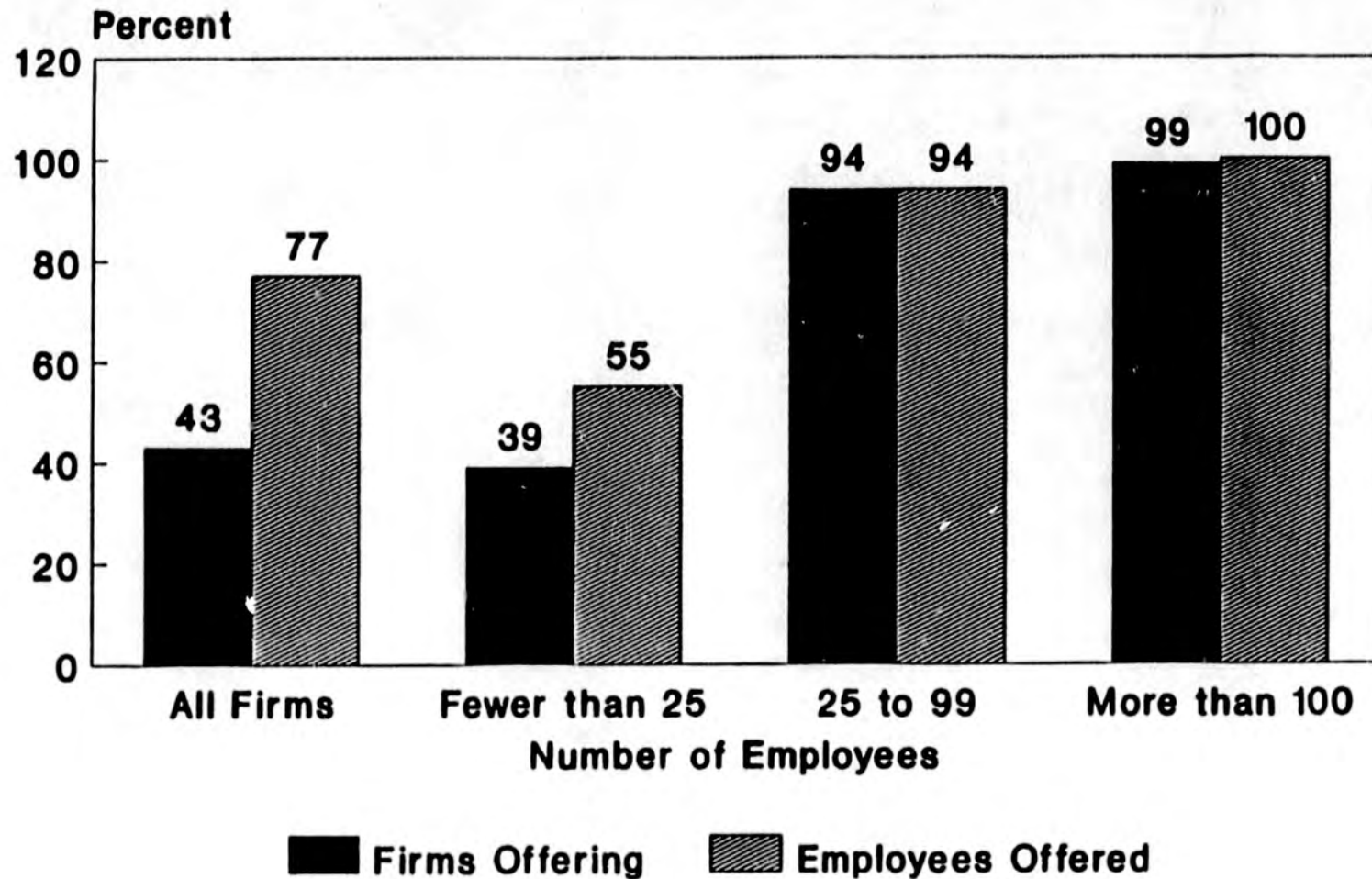
Source: Health Systems Research, Inc.
Analysis of March 1988 and 1989 CPS

NUMBER OF ALASKAN FIRMS BY EMPLOYMENT SIZE CLASS

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

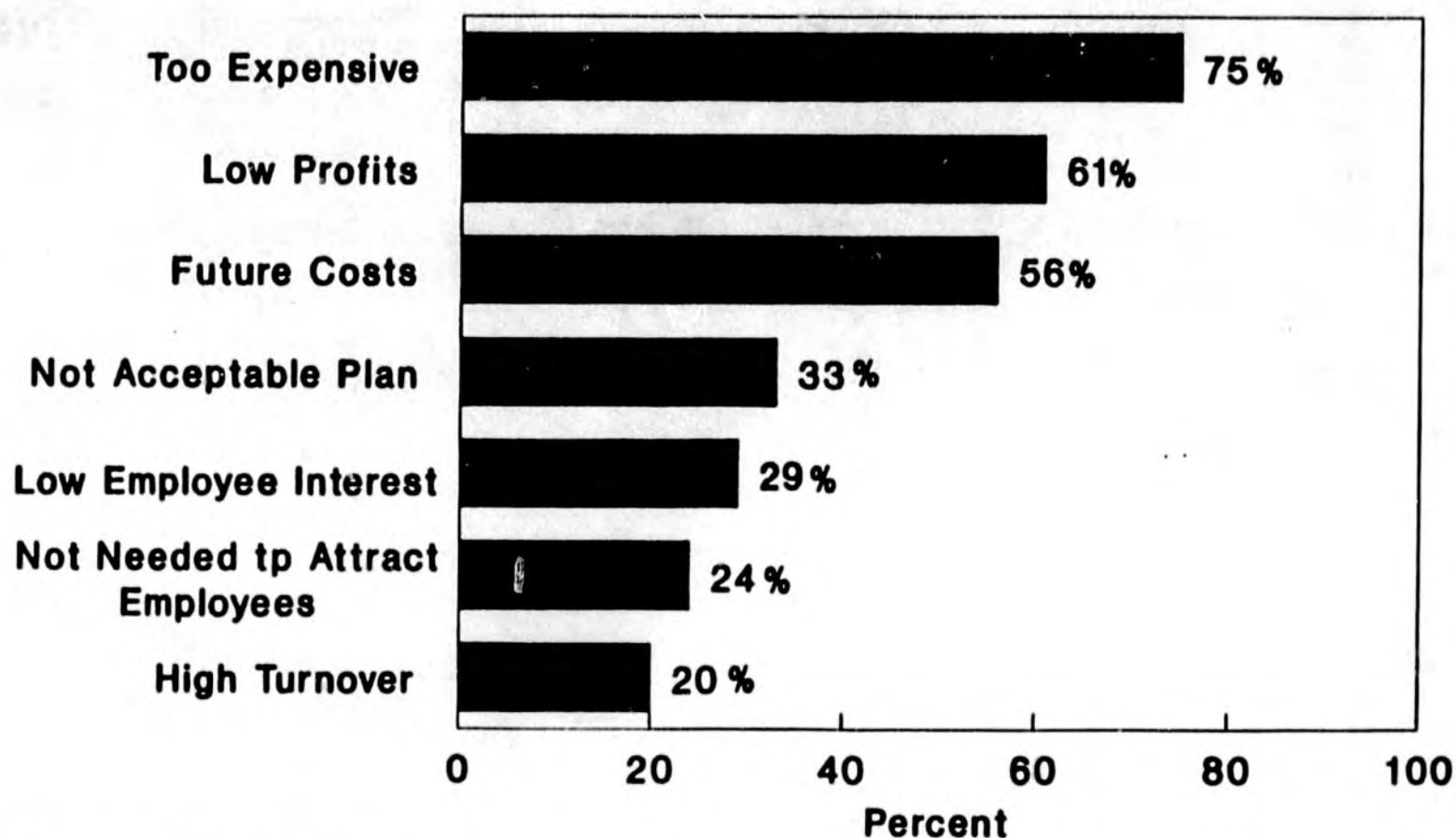
B-12

Larger Firms Are More Likely to Offer Health Benefits, 1989



Source: HIAA 1989 Employer Survey

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



Source: HIAA 1989 Employer Survey

B-14

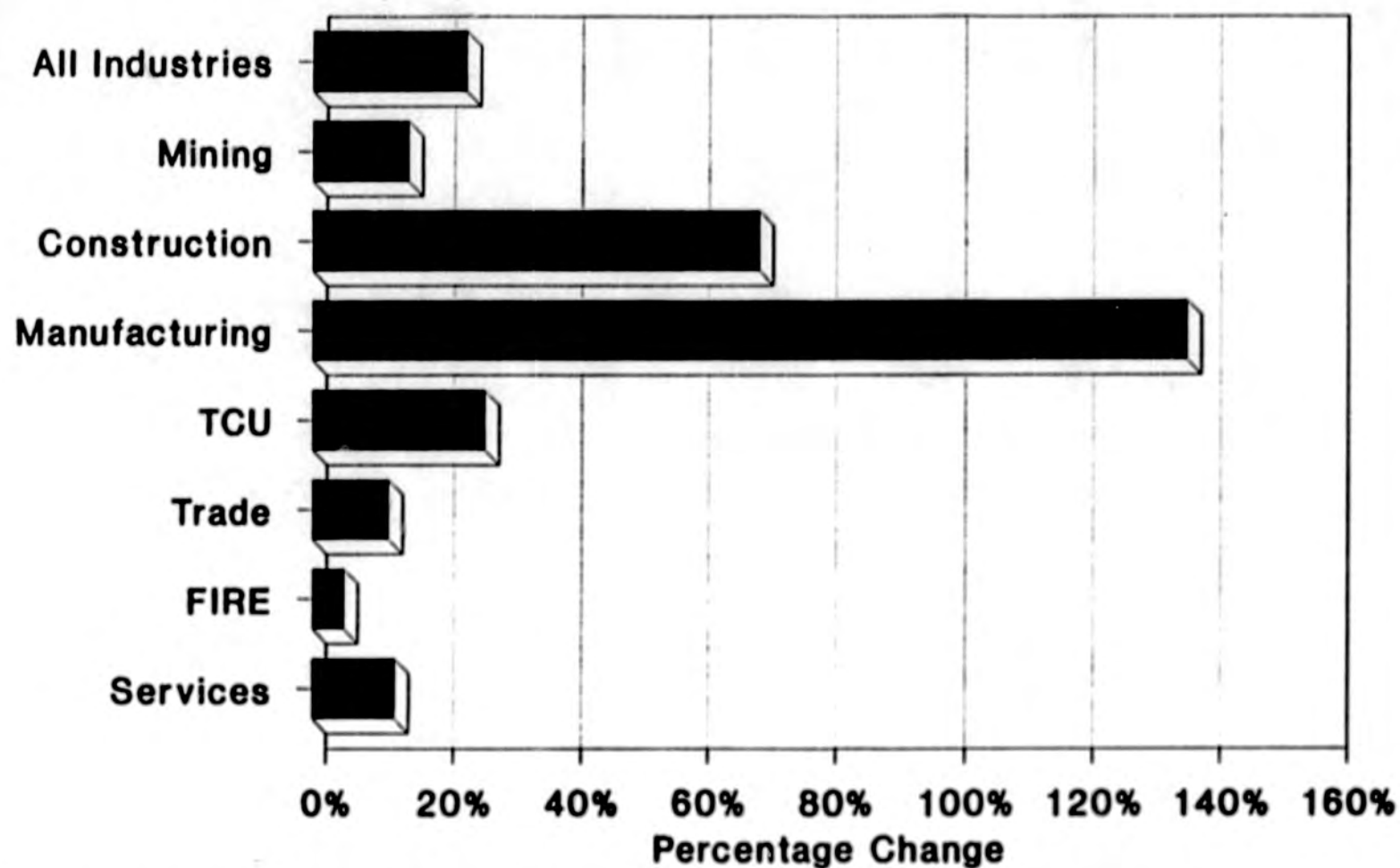
BREAKDOWN OF INSURANCE COMPANY ADMINISTRATIVE EXPENSES (Percentage of Incurred Claims)

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

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

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

Seasonal Fluctuation in Employment by Industry



Source: Alaska Department of Labor,
Research and Analysis Section

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

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

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

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

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

B-17

CORRECTION

**THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY**

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

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

B-17

APPENDIX C

Background Information on Health Care Cost Issues

Prepared for the Alaska Health Resources and Access Task Force by

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

Washington, D.C.

September 18, 1991

BACKGROUND INFORMATION ON HEALTH CARE COST ISSUES

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

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

September 18, 1991

THE NATION'S HEALTH CARE SPENDING 1989

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

WHERE IT CAME FROM:

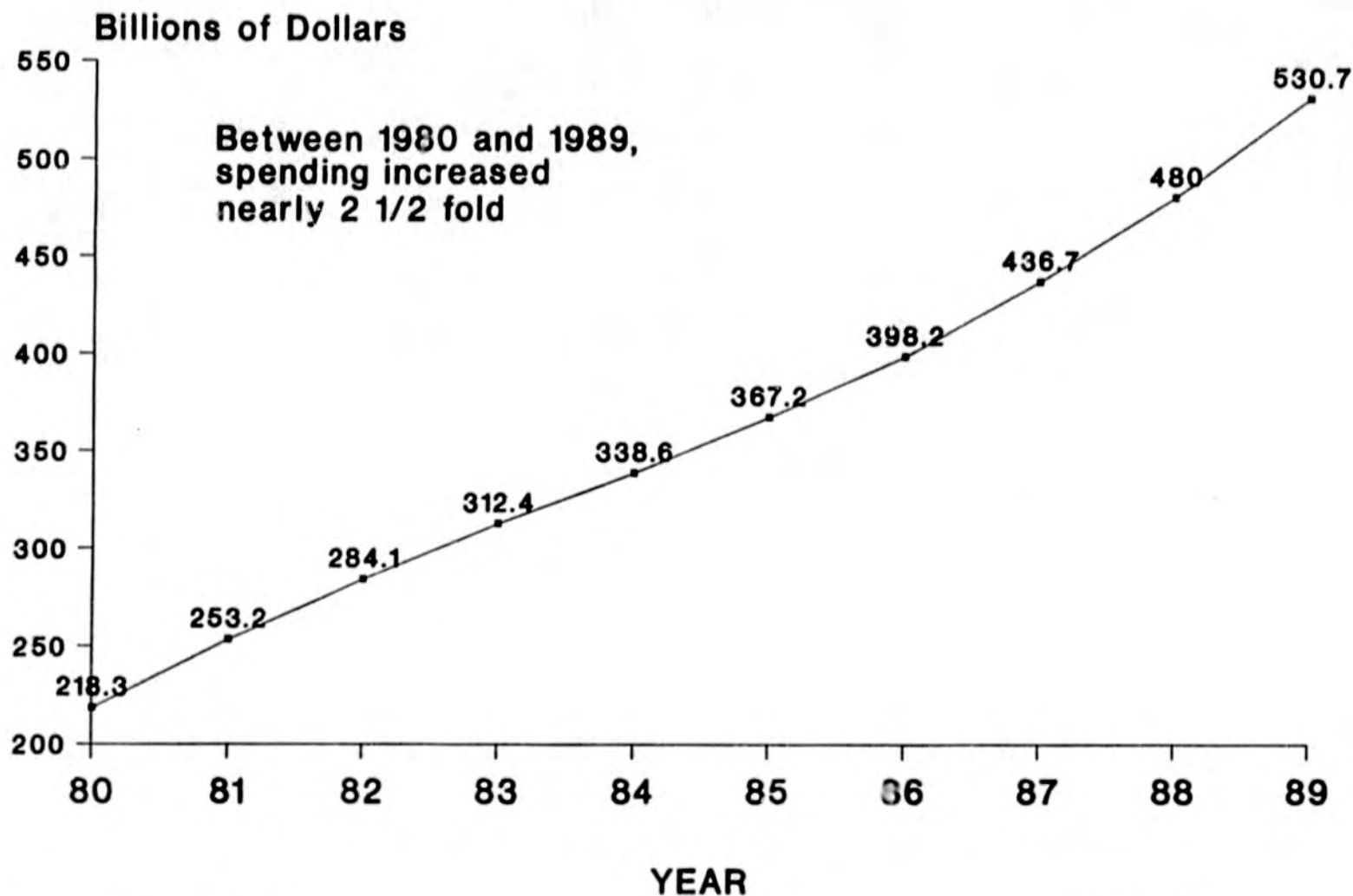
- Private health insurance 33%**
- Out of pocket 21%**
- Other private 4%**
- Medicare 17%**
- Medicaid 10%**
- Other government programs 15%**

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

WHERE IT WENT:

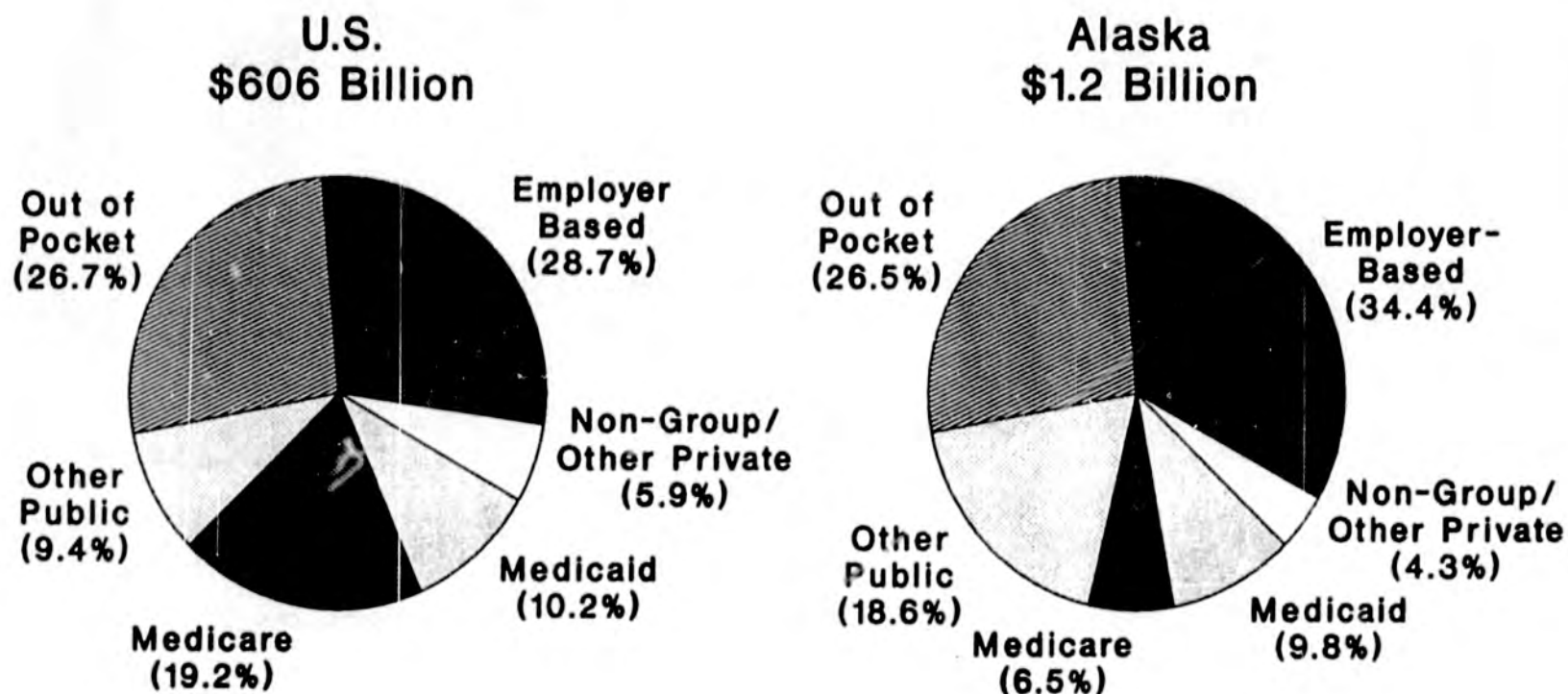
■	Personal health care	88%
-	Hospital care	39%
-	Physician services	19%
-	Nursing home care	8%
-	Drugs	7%
-	Dental	5%
-	Other professional services	5%
-	Vision	2%
-	Other	2%
■	Program administration and net cost of health insurance	6%
■	Government public health activities	3%
■	Research and construction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

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



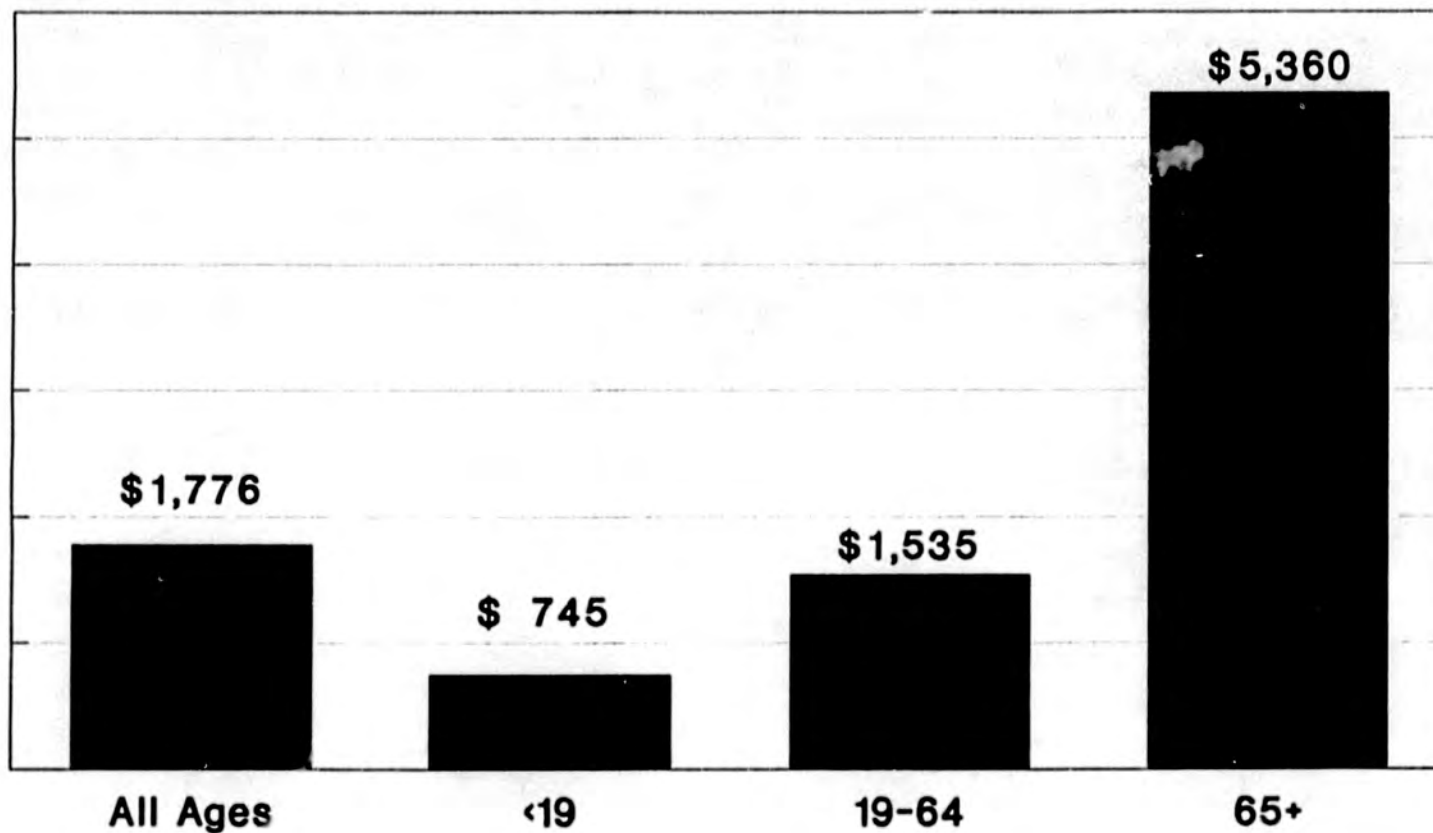
Source: HCFA, DHHS

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



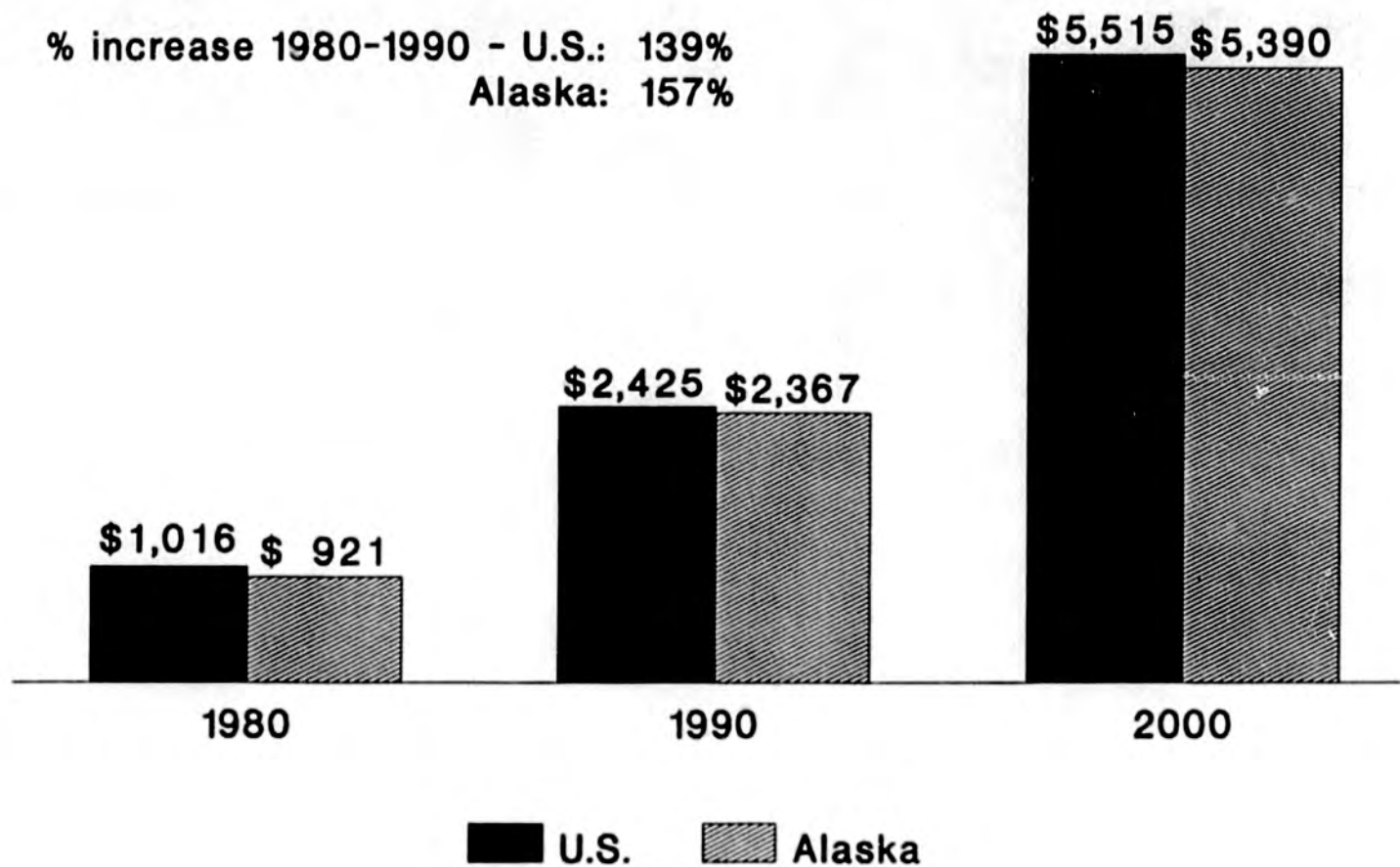
Source: Families U.S.A. Foundation

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



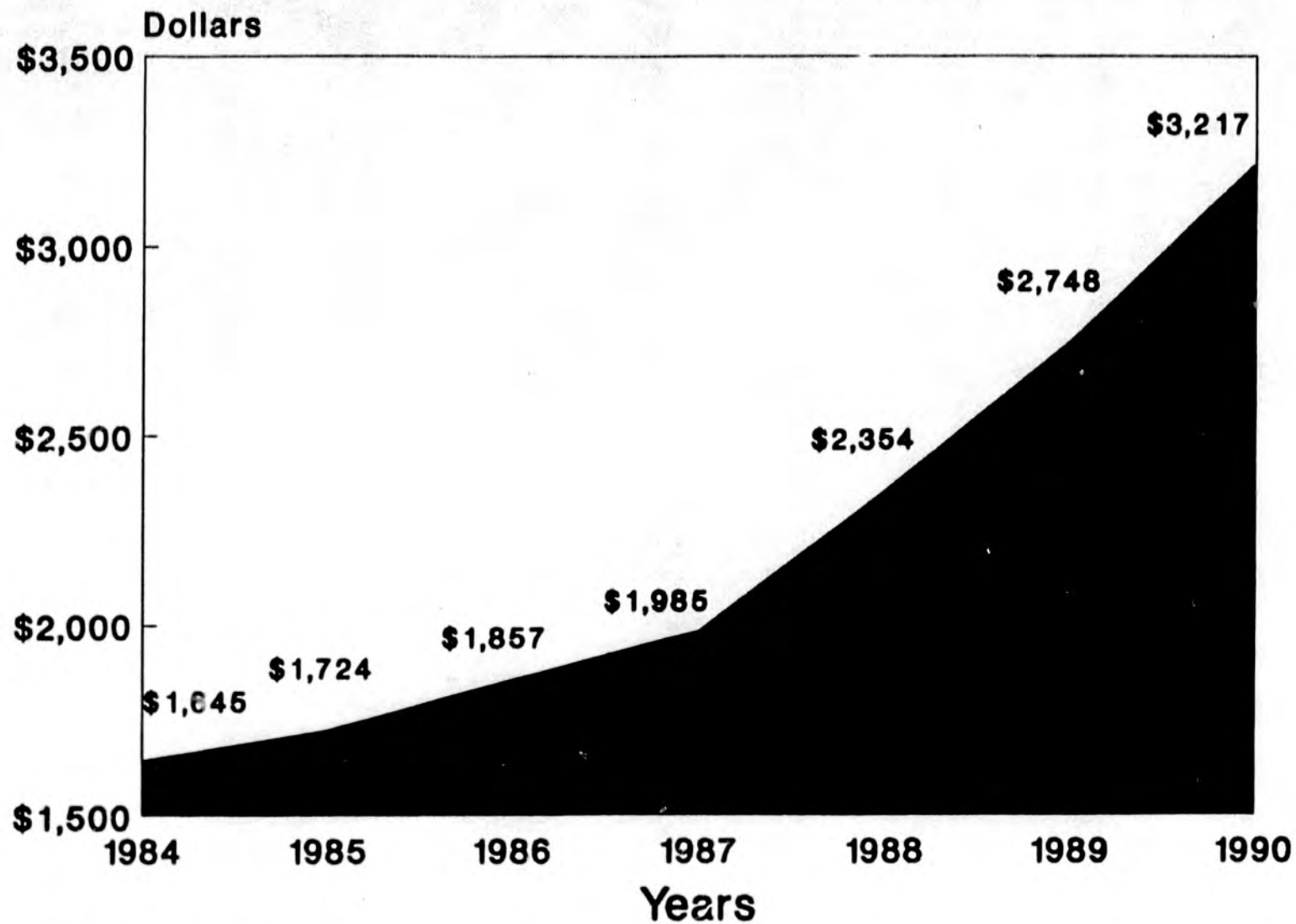
Source: HCFA, DHHS

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



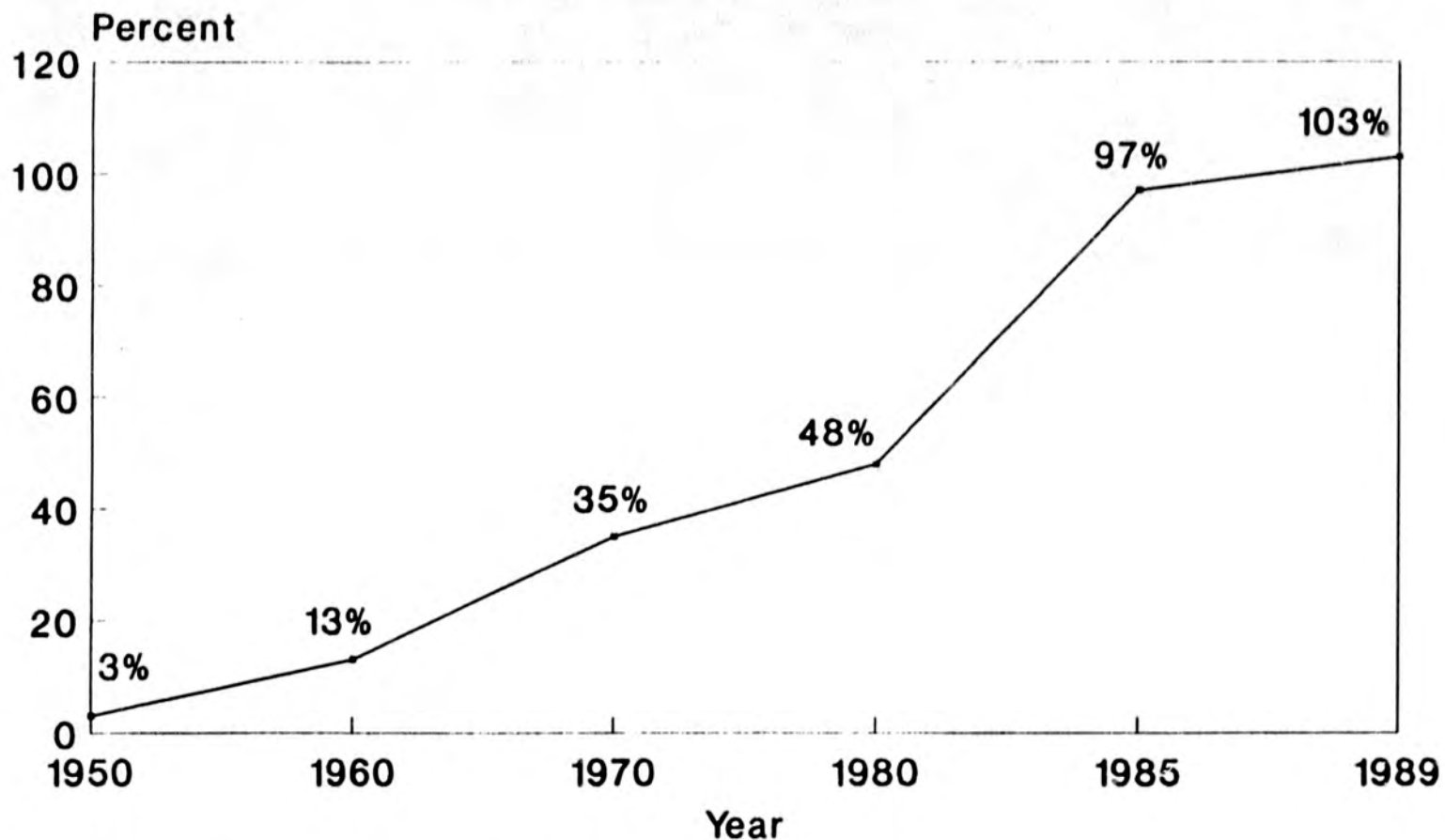
Source: Families U.S.A. Foundation

Average Health Care Costs Per Employee



Source: Foster Higgins

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



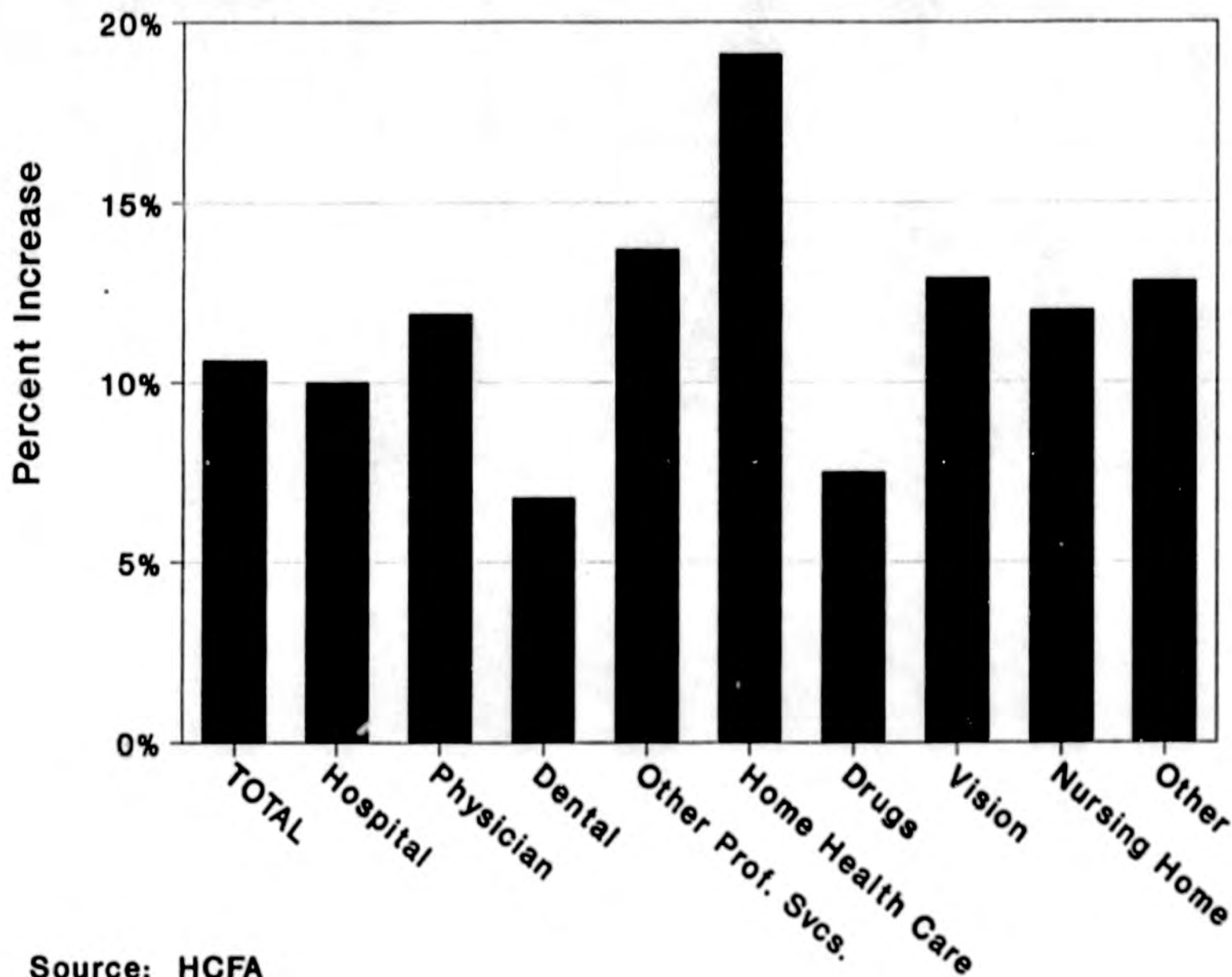
Source: EBRI tabulations of U.S. Dept. of Commerce data

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

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

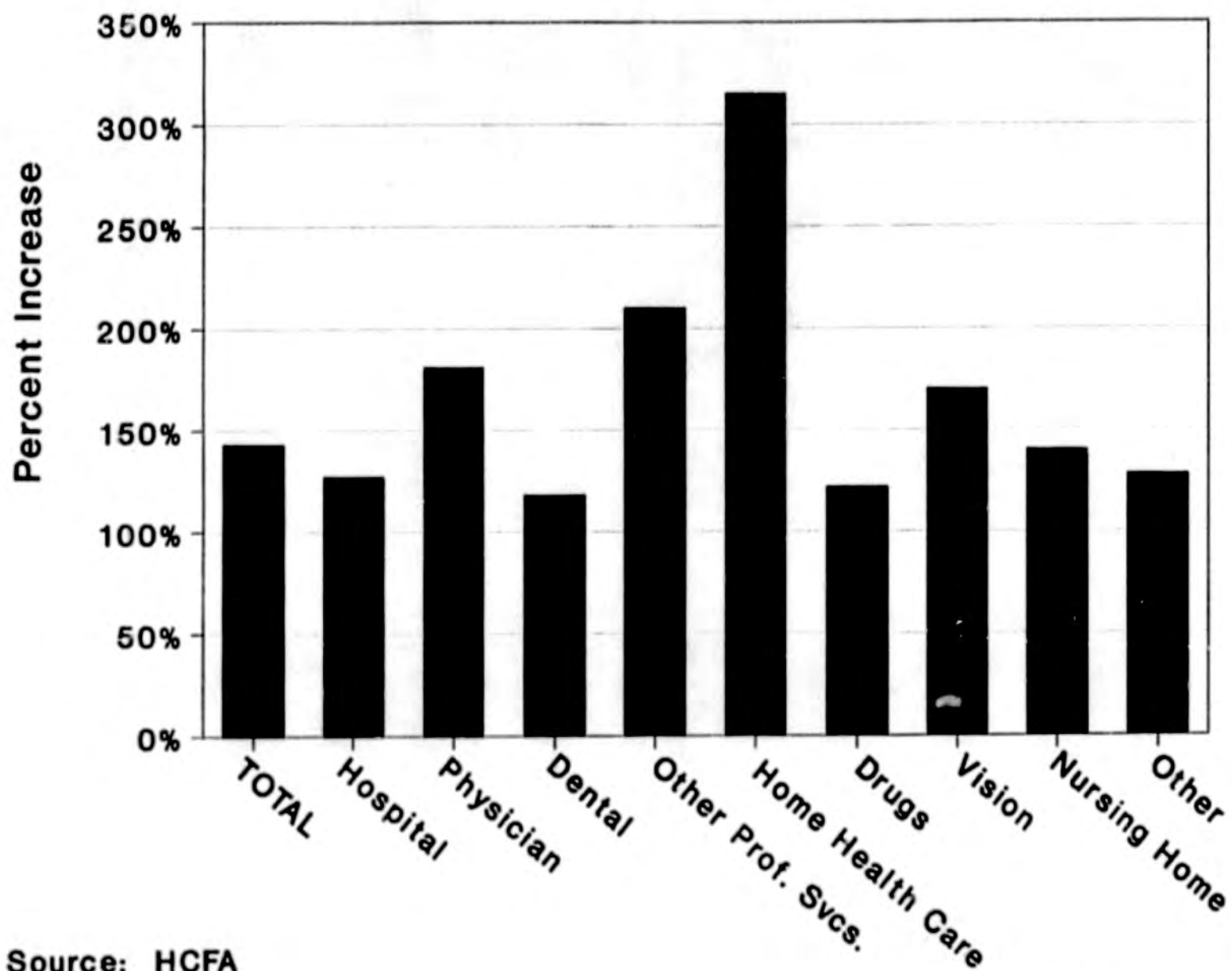
Source: Office of National Cost Estimates, U.S. DHHS

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



Source: HCFA

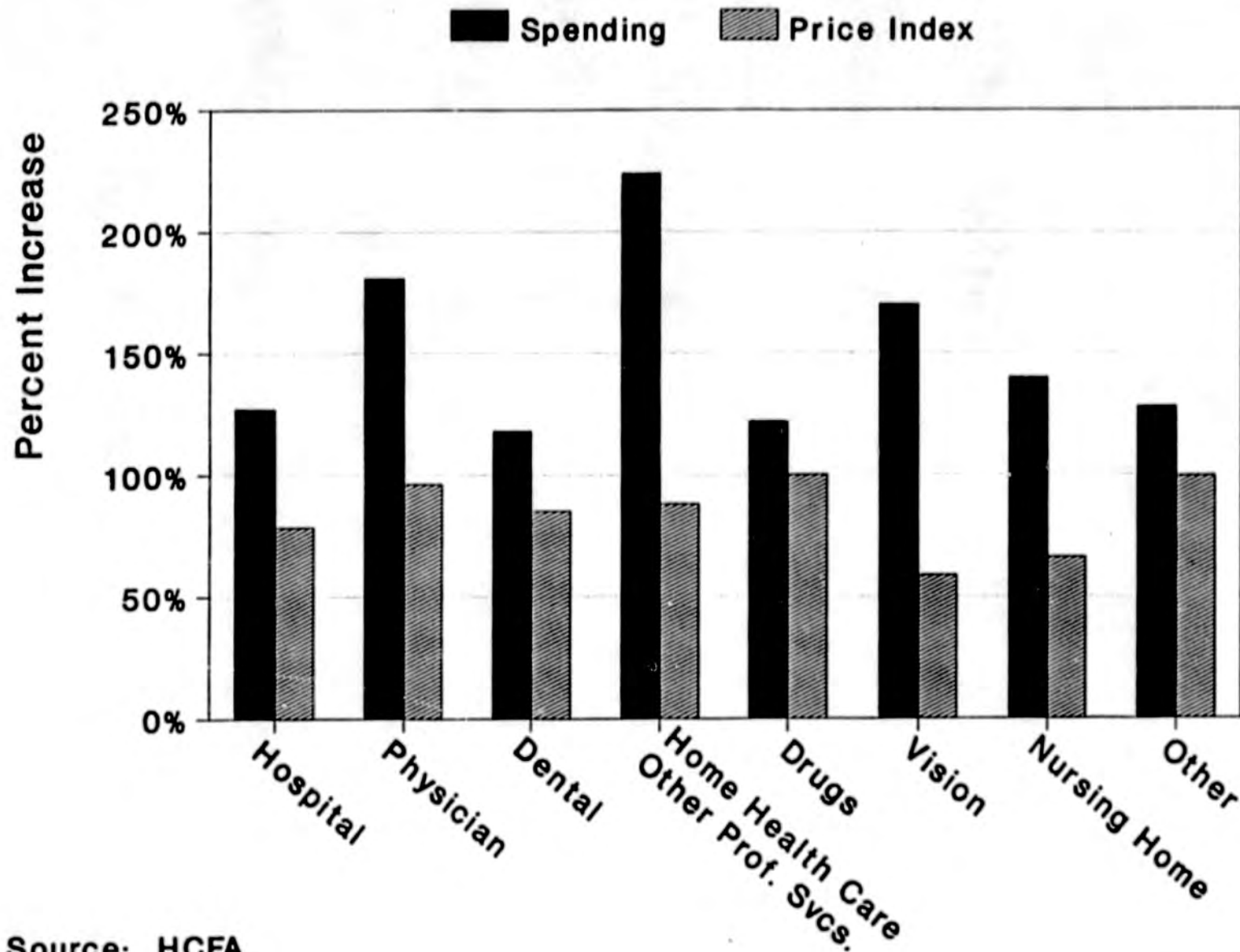
GROWTH RATES IN PERSONAL HEALTH CARE SPENDING, TOTAL AND BY TYPE OF COVERAGE U.S., 1980-89



Source: HCFA

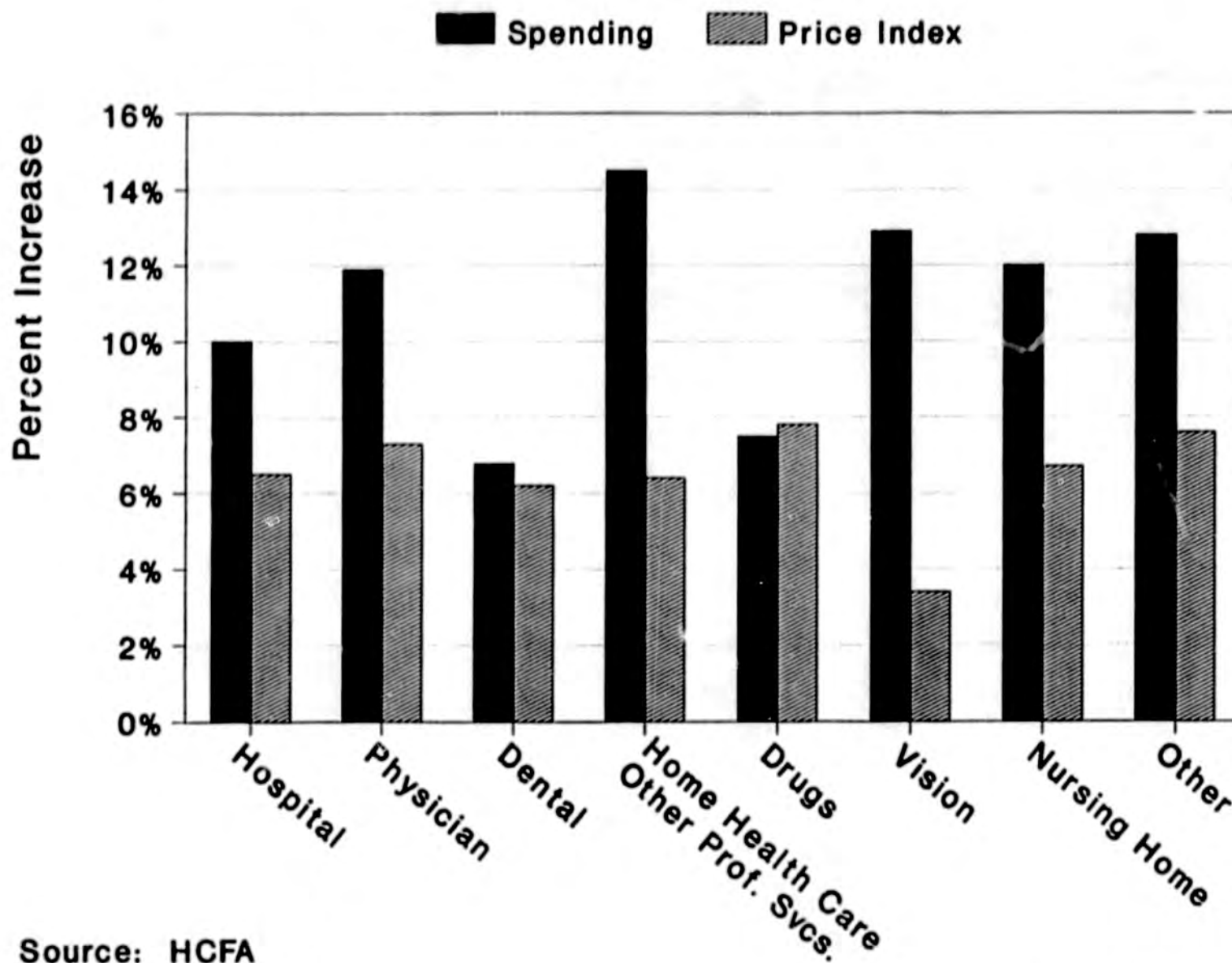
C-12

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

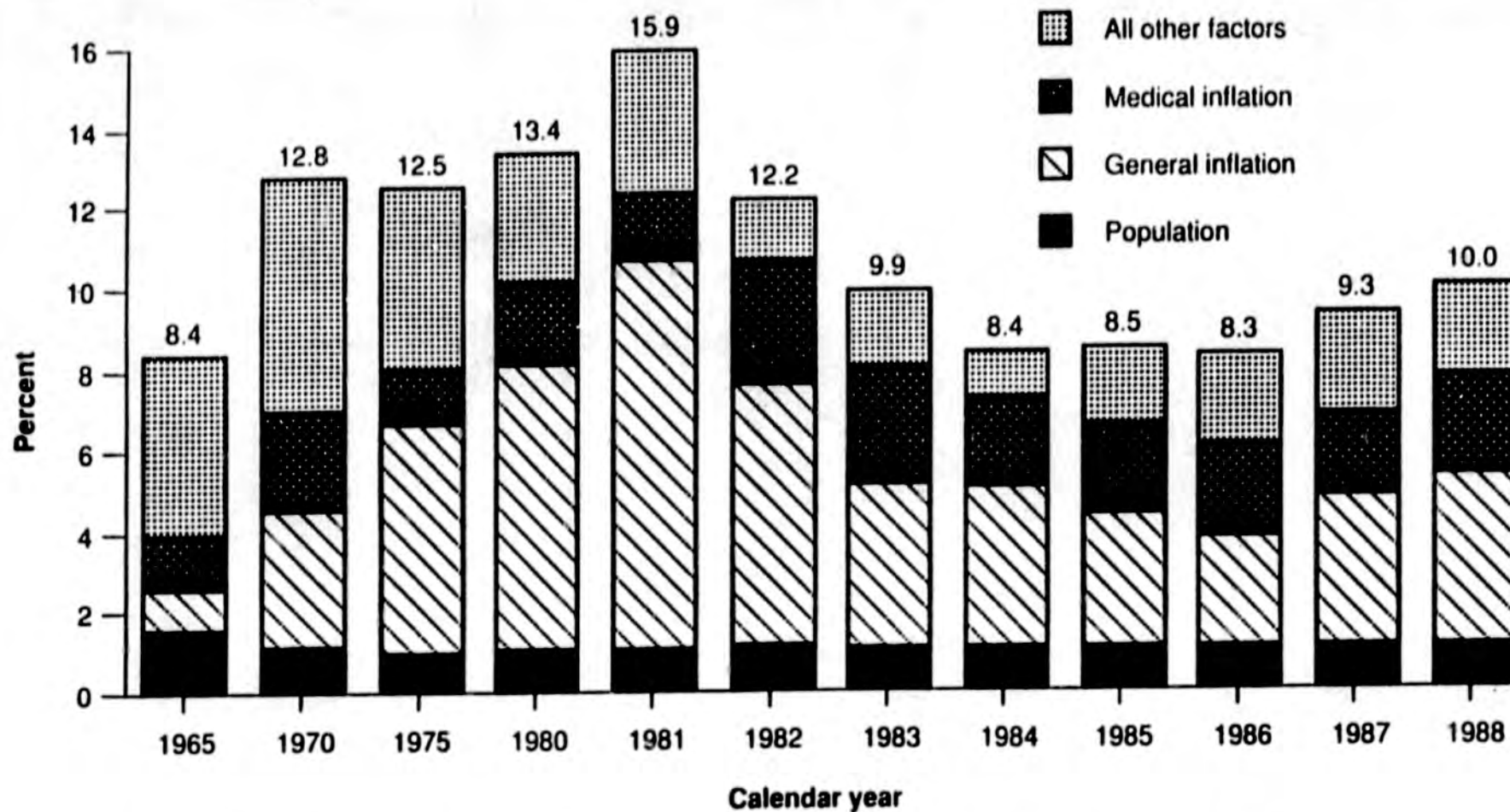


Source: HCFA

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



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



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

APPENDIX D

"Report to the Health Resources and Access Task Force,

January 1992"

by Oliver Scott Goldsmith, Ph.D.,

University of Alaska

Institute of Social and Economic Research

REPORT OF THE HEALTH RESOURCES AND ACCESS TASK FORCE JANUARY 1992

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

SUMMARY

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

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

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

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

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

BACKGROUND

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

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

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

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

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

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

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

Figure I.1
US OCCUPANCY RATES BY SIZE
COMMUNITY HOSPITALS

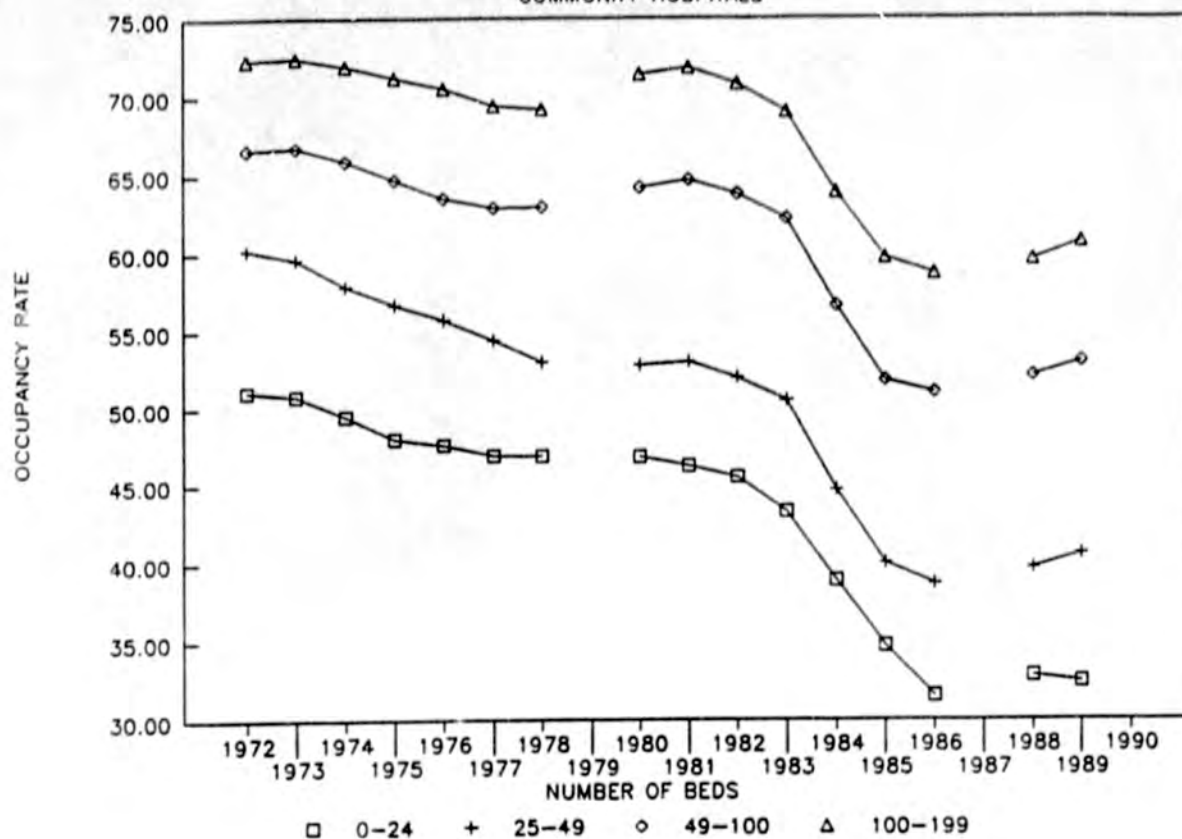


Figure I.2
HOSPITAL INPATIENT DAYS PER CAPITA
ALASKA COMPARED TO US AVERAGE

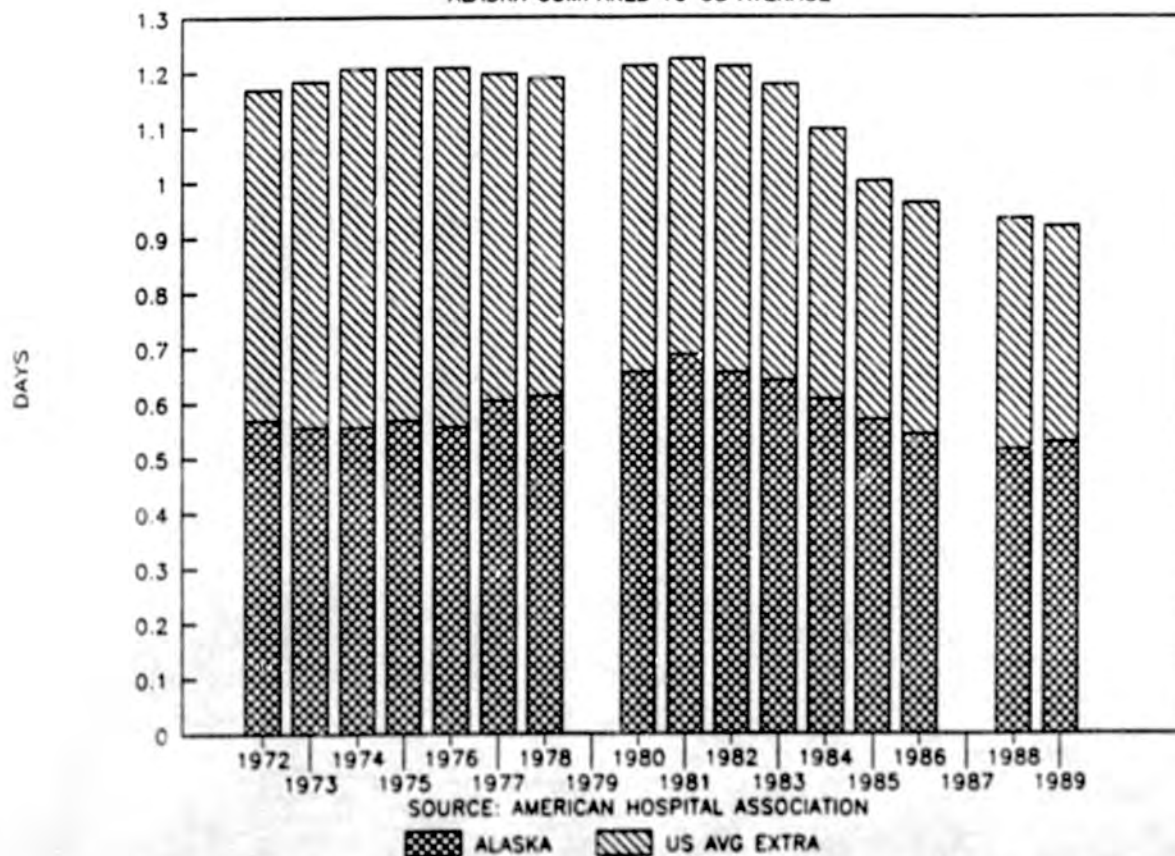


Figure I.3

OCCUPANCY RATE BY SIZE OF HOSPITAL

ALASKA COMMUNITY HOSPITALS: ACUTE CARE

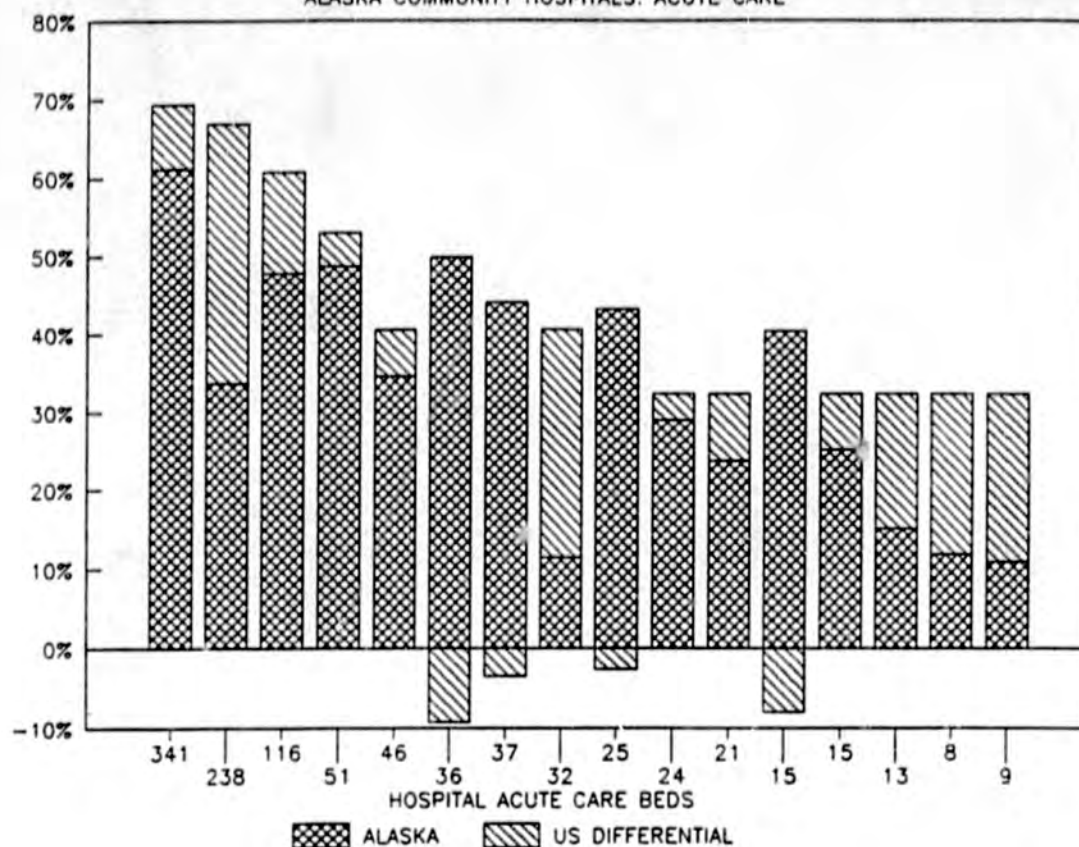
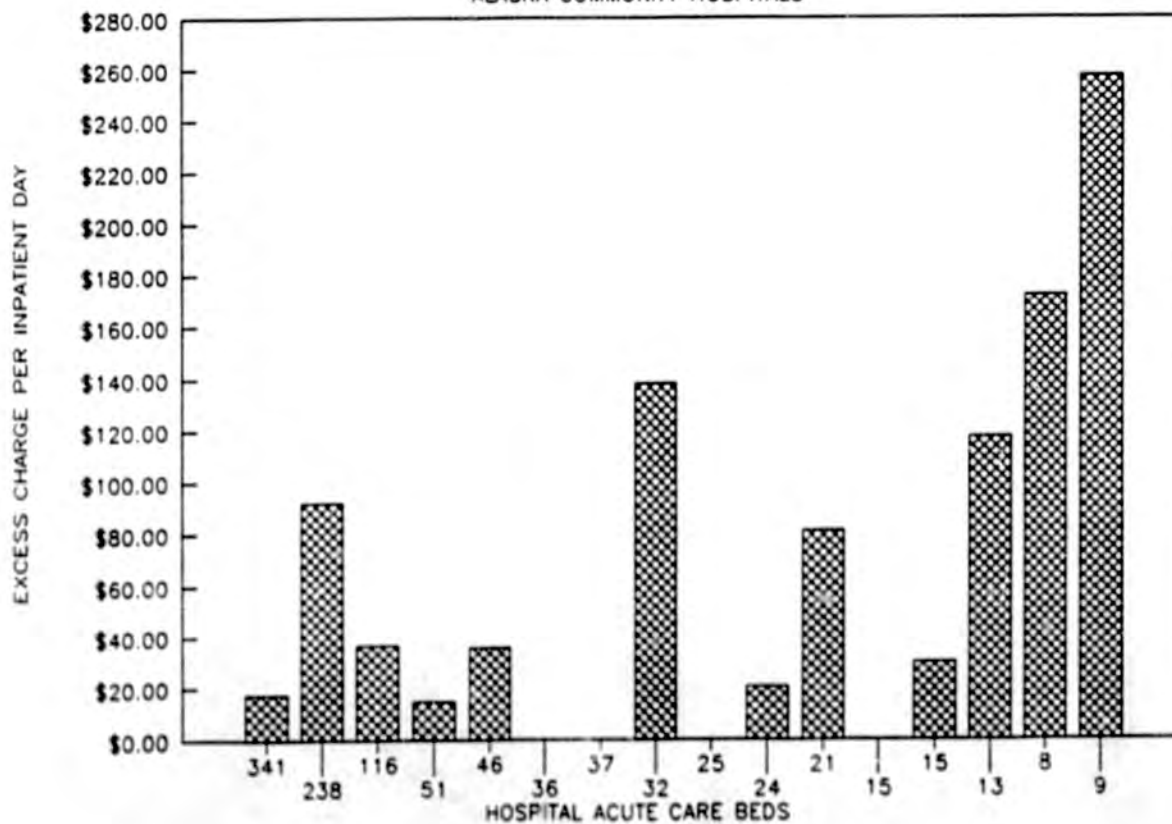


Figure I.4

EXCESS BED PREMIUM BY HOSPITAL SIZE

ALASKA COMMUNITY HOSPITALS



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

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

THE COST OF EXCESS CAPACITY

The cost of excess capacity was calculated 3 ways.

[1] THE SURCHARGE CONSUMERS PAY FOR EXCESS CAPACITY

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

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

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

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

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

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

up not all costs can be considered variable.

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

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

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

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

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

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

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

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

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

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

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

[1] SURPLUS EXCESS CAPACITY ANALYSIS					
available beds in acute care	1,027	695	332	899	128
potential utilization days	375,950	253,675	122,275	328,135	47,815
actual utilization	167,839	125,652	42,187	152,354	15,485
occupancy rate	44.64%	49.53%	34.50%	46.43%	32.39%
national occupancy rate (AHA 89)	58.17%	67.01%	39.84%	61.36%	36.28%
percent of national rate	76.74%	73.92%	86.59%	75.66%	89.26%
beds at national occupancy rate	798	512	285	685	113
utilization at national occupancy rate	218,703	169,984	48,719	201,355	17,348
excess beds	229	183	47	214	15
excess available bed days	50,864	44,332	6,532	49,002	1,863
excess capacity percent of beds	22.31%	26.27%	14.01%	23.81%	11.78%
outpatient visits	431,563	329,679	101,884	398,897	32,666
ratio outpatient visits/inpatient days	2.57	2.62	2.42	2.62	2.11
expenditures	\$296,313,764	\$202,223,011	\$94,090,753	\$253,030,907	\$43,282,857
% expenditures acute care	96%	100%	88%	100%	74%
expenditures for acute care	\$284,839,130	\$202,223,011	\$82,809,424	\$253,030,907	\$32,118,656
% expenditures fixed [a]	10%	10%	10%	10%	10%
item:actual capital/total	11%	12%	8%	12%	7%
item:actual depreciation/total	9%	9%	8%	9%	8%
fixed expenditures	\$28,483,913	\$20,222,301	\$8,280,942	\$25,303,091	\$3,211,866
variable expenditures	\$256,355,217	\$182,000,710	\$74,528,482	\$227,727,816	\$28,906,790
expenditures per inpatient day					
actual: total	\$1,697	\$1,609	\$1,963	\$1,661	\$2,074
fixed	\$170	\$161	\$196	\$166	\$207
variable	\$1,527	\$1,448	\$1,767	\$1,495	\$1,867
at national average occupancy: total	\$1,658	\$1,567	\$1,937	\$1,620	\$2,052
fixed	\$130	\$119	\$170	\$126	\$185
variable	\$1,527	\$1,448	\$1,767	\$1,495	\$1,867
EXCESS BED PREMIUM (ANNUAL)					
per inpatient day [b]	\$39	\$42	\$26	\$40	\$22
total (all inpatient days) [c]	\$5,791,669	\$4,768,937	\$1,022,732	\$5,385,660	\$406,009
per admission	\$149	\$182	\$81	\$157	\$89
EXCESS BED PREMIUM % of Charge	2.03%	2.36%	1.24%	2.13%	1.26%

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

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

[b] The premium for the average patient day.

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

ACUTE CARE BEDS

COMMUNITY
HOSPITAL
(CO-LOCATED FACILITY)

[1] SURPLUS EXCESS CAPACITY ANALYSIS

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

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

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