

ALASKA LEGISLATURE SPECIAL COMMITTEE/SUBJECT FILE 8672
2195 SCOMM 86: HEALTH RESOURCES & ACCESS TASK FORCE, 1991-93

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Finding #9: Many Alaskans who currently have health care coverage fear that it will not provide adequate protection for them if they develop a serious medical problem.

The Task Force asked Alaskans to express their views about our current health care system by circulating a survey. Four hundred and sixty-two (462) surveys were returned to the Task Force. They included 124

PERSONAL STORIES . . .

"My insurance has become too costly and next month I will have to do without . . . I am endangering my life daily and the financial future of my family. No one should have to live in this fear that grows daily."

-- (signed) "Helpless," Anchorage

from our community meetings/public hearings, 243 from the Anchorage Daily News; (who put the survey in their editorial column), 79 from the Anchorage Neighborhood Health Center, 6 from the Anchorage Rescue Mission, and 10 from Bean's Cafe. Obviously, the survey results were not generated using a random method, but nonetheless, they did give the Task Force some indication of the concerns of certain Alaskans about our health care system. (Complete survey results are published in a separate document.)

Of those Alaskans who returned our survey the vast majority expressed significant concern about the adequacy and stability of their health care coverage and their ability to pay for out-of-pocket medical expenses. Specifically:

- 85 percent of respondents worry "a great deal" or "quite a lot" that their out-of-pocket costs for medical bills will increase rapidly over the next few years.
- 82 percent worry "a great deal" or "quite a lot" about having to pay very expensive medical bills which are not covered by health insurance.
- 75 percent worry "a great deal" or "quite a lot" that the benefits under their current health care plan will be cut back substantially.
- 75 percent worry "a great deal" or "quite a lot" that they will have to pay a much larger premium for their current health care plan.
- 67 percent worry "a great deal" or "quite a lot" that they will lose health insurance which they now have.

PERSONAL STORIES . . .

"As my health declined, I wasn't able to work . . . The constant hassles concerning medical coverage were overwhelming. My credit was scarred as I was unable to continue minimal payments."

-- Kenai Resident

Finding #10: In spite of the significant amount it spends on health care, the health status of Alaska's population is among the worst in the nation.

Although Alaska's age-adjusted per capita health care spending is 27 percent above the national average, the Task Force found that this higher spending has not translated into a better health status.

- **A 1992 study by Northwestern National Life Insurance Company (NWNL) ranked the "general health of Alaska's population" the 46th worst among the 50 states (Eckstein, T.E., and Associates, Inc. 1992).**

Rankings such as those in the NWNL study are used by insurers to establish premiums. For each state, the population's overall health is measured using seventeen criteria in five major areas: disease, lifestyle, access to health care, occupational safety and disability, and mortality. Examples of Alaska's rankings for specific criteria include:

<u>Selected Health Criteria</u>	<u>Ranking</u>
Support for Public Health Care	50
Infectious Disease	49
Occupational Fatalities	48
Unemployment	45
Access to Primary Care	43
Premature Death	40
Prevalence of Smoking	40
Violent Crime	28
Infant Mortality	25

- **The American Public Health Association recently published a state-by-state report of the health of each state's population. Alaska ranked higher in this report than in the NWNL ranking in part because of the indexes chosen.¹⁵ Even so, Alaska ranked lower than might have been expected,**

¹⁵ The American Public Health Association (APHA) examined statistics on twenty-five measures of health for each state. These measures were the basis for the five categories for which APHA developed composite rankings. There were several measures where Alaska ranked high. Some of these high rankings reflect Alaska's unique service delivery system, while others suggest high levels of government spending for health and other services. Alaska ranked relatively high in the following measures: primary care physicians per capita, adequate prenatal

given the higher than average level of age-adjusted per capita health care spending (APHA 1992).

APHA tabulated statistics for five health categories and ranked each state. Alaska's rankings were as follows:

Category	Ranking
Healthy Behaviors	44
Healthy Environment	36
Medical Care Access	25
Healthy Neighborhoods	23
Community Health Services	3

The Task Force also examined additional data on the health of Alaskans at several meetings. We found that age-adjusted death rates in Alaska for certain preventable diseases were substantially higher than the national average. Alaskans have above average death rates for unintentional injuries (primarily occupation-related), for chronic obstructive pulmonary disease (primarily attributable to smoking), for chronic liver disease (primarily attributable to alcohol), and for suicide (Alaska Bureau of Vital Statistics 1992).

Finding #11: A strong public health program based on disease prevention, health promotion, and public health protection is essential to controlling health care costs and to achieving a healthy populace. The State of Alaska does not have a policy that assures the presence of a strong, fully-functioning public health program.

Given the overall poor health of Alaskans described under Finding #10, and the fact that effective public health programs can improve health status, the Task Force felt it was particularly important to examine the state's public health system.

care, fluoridated water, average public assistance payment per family, education spending per capita, childhood poverty rate, government health spending per capita, sanitation and sewerage spending per capita, and public health workers per capita.

Several public health officials briefed the Task Force on the roles and responsibilities of public health providers in Alaska. While we were reminded of the State's responsibility to provide health assessment, health policy development, and to assure the presence of essential, effective public health services, the Task Force nonetheless found that:

- **The capability of the Division of Public Health to carry out the State's public health responsibilities continues to be diminished at a time when program responsibilities are increasing.**

In the last decade, the level of per capita public health spending by the State of Alaska from the General Fund has remained flat after being adjusted for inflation (\$48.99 in 1982 vs. \$49.15 in 1992). This has occurred despite the fact that during this period, the Division of Public Health's program responsibilities have grown substantially due to new technologies and changing patterns of disease (e.g., AIDS, drug-resistant tuberculosis, substance abuse) (Appendix F). Unfortunately, the Task Force fears that State funding for public health programs will be further diminished unless there is greater recognition of the role they play in protecting and maintaining the health of the state's population.

Finding #12: The financial access issue aside, basic health care services are not available to many Alaskans because of transportation problems and problems with the mix, distribution, and coordination of the state's health care resources.

The Task Force observed that Alaska has access and cost problems because of the maldistribution of health care resources. Many Alaskans live in areas where health care services are not available or where there are shortages of health care personnel. In other areas, there is more capacity in the system than is needed. While sufficient resources exist in some communities, Alaskans will often go outside of those communities for care. Finally, even though Alaska Natives have access to health care through the Alaska Area Native Health Service, their health needs far outstrip available resources.

- **Alaskans living in remote and rural areas often find that only the most basic health care services are available in their communities. Access to advanced services requires travel, frequently hundreds of mile by air. Many cannot afford to travel and defer their medical treatment.**

Alaskans living in remote and rural areas of the state often travel great distances at significant cost to obtain health care. The Alaska Native Health Board 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 (Alaska Native Health Board 1991).

- **Alaska has an inadequate supply and maldistribution of primary care practitioners.**

Alaska is directly affected by the nationwide shortage of primary care practitioners. Alaska currently has twenty federally designated Health Professional Shortage Areas and ten designated Medically Underserved Areas. Together, these areas include nearly a third of the population and cover two-thirds of the state (ADHSS 1992). In many Alaskan communities, the population base is too small to support a financially viable physician practice. The State of Alaska, recognizing this aspect of Alaska's health care system, has liberal practice standards that allow mid-level practitioners, such as nurse practitioners and physician assistants, to practice with minimal supervision and to write prescriptions (ADHSS 1992). Although many communities rely on mid-level practitioners for care, Alaskans still encounter serious difficulties in receiving needed primary care, and additional primary care physicians are still needed.

The Task Force was advised, on a number of occasions, that:

- **Difficulties in recruiting and retaining health care professionals in Alaska contribute to the lack of access to appropriate, cost-effective health care for Alaskans, particularly in rural areas.**

Alaskan providers have the greatest difficulty retaining adequate numbers of nurses, physical therapists, occupational therapists, and diagnostic technicians. Other categories of health care professionals which are difficult to find are administrators, physicians, bio-medical technicians, and workers in the areas of patient billing, medical records, personnel, social work, and alcohol and mental health counseling (Rural Alaska Health Education Center 1992).

Further, individual Alaskan health care practitioners, particularly in rural areas, experience high rates of turnover. In Alaska's many small, isolated communities, health care professionals do not have a peer support group and must be on-call 24 hours a day, 7 days a week. In addition, the undersupply of health care professionals, cultural and social barriers, isolation, and limited transportation and communication systems all contribute to "burnout" among practitioners.

Recruitment has become increasingly difficult as salary expectations have increased. Salaries, particularly those offered in rural Alaskan communities, have

become less competitive than those offered outside of Alaska over the past decade (ADHSS 1992).

Efforts to recruit health care practitioners in Alaska are limited by the lack of data on such items as the characteristics of professionals who are most likely to want to practice in Alaska (particularly rural Alaska), factors that increase the number of applicants for positions in these areas, and provider characteristics most important to employers and consumers (ADHSS 1992).

Recruiters have found an important factor in getting practitioners to locate and practice in rural areas is their exposure to rural settings during their medical education. Alaska lacks formalized in-state clinical sites for primary health care students. In addition, there are only rudimentary free-standing medical residency programs in the state, and none for family practitioners (ADHSS 1992).

While there are significant shortages of health care professionals:

- **It is estimated that nearly one quarter of the hospital beds in Alaska's acute care community hospitals represent excess capacity, yet it costs Alaska's health care payers as much as \$21 million annually to maintain them.**

There has been a lack of direction from the State of Alaska regarding standards for hospital size. Further, there were some major renovations and new construction of community hospitals when Alaska's revenues from oil peaked in the early 1980s. These projects were based on occupancy rates using the rapid rate of population growth experienced in the state at that time. As population growth rates diminished, the recession hit in the mid- to late 1980s, and a national trend toward decreasing utilization of care for patients in "inpatient" settings was realized, it became apparent that the State had overestimated the need for hospital beds.¹⁶

Also 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 and achieves some savings but without the goals and standards that a state health plan could provide. Capital grants continue to be provided to some individual communities for facility construction without a clear policy from the State.

Alaska's acute care community hospitals are on the average much smaller than U.S. hospitals as a whole. Using the national average as the benchmark, the Institute of Social and Economic Research (ISER) found that twelve of Alaska's sixteen acute

¹⁶ Anchorage projects were more justified, but some projects in smaller communities created significant excess capacity. Not all the projects which were proposed were built however as State funding declined in the 1980s.

care community hospitals had excess capacity in 1989. At the U.S. average occupancy rate, 229 (or 22 percent) of the 1,027 acute care beds in Alaska were surplus. The total annual cost to Alaskans to pay for surplus beds was estimated to range from \$5.8 to \$11.6 million or 2 to 4 percent of the total annual acute care facility costs. However, applying a more rigorous standard, and what some consider a more reasonable goal for occupancy, 75 percent,¹⁷ and a fixed cost assumption of 20 percent, the annual cost of excess capacity in Alaska's acute care facilities was found to be as high as \$20.8 million. (The complete analysis is in Appendix C, Section 1.)

Compounding this excess capacity problem, the Task Force observed that:

- **Even as Alaska's small communities continue to maintain fully-licensed hospitals, many residents leave their communities to go to a larger hospital for care.**

The Task Force found that many of Alaska's small hospitals have very low occupancy rates.¹⁸ However, because residents of communities with small, under-utilized hospitals often go to larger hospitals in other areas to receive care instead of to their local hospitals, the Task Force felt that these facilities will find it difficult to substantially reduce their surplus capacity.

The Task Force reviewed approaches taken in rural communities in other states when faced with the possibility of closing under-utilized, financially troubled community hospitals.¹⁹ Often, these hospitals are converted and licensed as "alternative" facilities, thus maintaining some type of medical facility presence in the community. Many different models for converting hospitals to alternative facilities exist, but in general they involve changing the mix of services, limiting the length of stay, providing only certain core services, and establishing transfer policies with more advanced facilities. For example, a "converted" hospital might continue to provide only emergency services, routine obstetrical care, and outpatient services.

The Task Force was concerned to find that instead of moving towards an "alternative facility" model, many Alaskan hospitals with low occupancy rates are

¹⁷ In the 1970s, the occupancy rate for mid-sized hospitals in the U.S. 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).

¹⁸ Examples of small Alaskan hospitals with low occupancy rates, based on 1989 figures, include: Cordova Hospital, with 13 beds and a 15 percent occupancy rate; Petersburg Hospital, 8 beds and 12 percent occupancy; Wrangell General Hospital, 9 beds and 11 percent occupancy; and Seward General Hospital, 32 beds and 11 percent occupancy. (See Appendix C, Section 1.)

¹⁹ The Task Force reviewed models from the States of Montana, California, Washington, Colorado, and Kansas for converting hospitals into alternative inpatient facilities.

moving in the opposite direction. In order to attract patients who may currently be seeking care at larger hospitals, some small hospitals are seeking to duplicate costly, high-tech services offered in Alaska's tertiary care centers.

Finally, the Task Force found that the State of Alaska has not created incentives to encourage the conversion of under-utilized hospitals into alternative facilities. Indeed, the ability and willingness of Alaskan communities to convert under-utilized hospitals to alternative facilities is restricted by State licensure standards, Medicare's conditions of participation, and Alaska's revenue sharing statute (AS 29.60.120) which greatly favors hospitals of ten beds or more (Appendix G; Agency for Health Care Policy Research 1991).

- **Alaska does not presently have excessive amounts of expensive high-tech medical equipment. However, in recent months, physicians and physician groups in Alaska's urban areas have shown increasing interest in offering high-tech services that will duplicate services offered at hospitals in these areas. Small community hospitals have also shown an increased interest in acquiring high-tech equipment.**

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. However, at the same time the proliferation of new technology has been a driving factor behind escalating health care costs.

In October 1991, the Department of Health and Social Services reported to the Task Force that the current levels of high-tech medical equipment and services available in Alaska were not excessive (see Appendix I). However, recent interest by physicians in providing high-tech services in their offices may change this situation.

In Alaska, a Certificate of Need (CON) is currently required for new medical services or equipment located in a hospital setting and costing \$1 million or more. Because current CON law does not apply to projects in non-hospital-based settings, many of the high-tech projects under consideration by private physicians and physician groups would not require review or approval by the State. Even purchases of such equipment by small hospitals may avoid the Certificate of Need process if they obtain used equipment that costs less than \$1 million. The excessive proliferation of medical technology could thus become an additional factor contributing to rising health care expenditures in Alaska.

- **A lack of effective coordination between the four principal health care systems in Alaska, the private sector, the Alaska Area Native Health Service (AANHS), the State of Alaska, and the military, has contributed to excess capacity in some rural communities and a lack of access to**

facilities and some services for some segments of the population in others.

In some Alaska communities, services are duplicated at facilities run by different segments of the health care system because of insufficient coordination of health care resources. For example, Sitka, with a population of 9,000, has two general acute care hospitals, one operated by the local government and the other by a tribal organization under contract to the AANHS. Both hospitals, which offer virtually identical services, are under-utilized.

Other communities suffer from the opposite problem--facilities whose services are needed by the community are unable to offer those services to some segments of the population due to restrictions on who is eligible for treatment. The Task Force has noted recent progress in this area, however. For example, in the western and northern regions of the state, four out of the five general acute care facilities are federally-owned, and have historically been restricted to serving only Alaska Natives. Contracts to operate three of these hospitals--in Dillingham, Bethel and Kotzebue--have recently been awarded by the AANHS to local organizations that are attempting to expand services to all residents of these communities.

- **By nearly all measures, the health status of Alaska Natives is significantly lower than other Alaskans. The health needs of Alaska Natives far outstrip the resources available through the Alaska Area Native Health Service and its tribal contractors. Many villages do not have basic water and sanitation services which are essential to the control of disease.**

As part of their trust responsibility, the federal government is required to provide health care to all Alaska Natives. This is accomplished through the Alaska Area Native Health Service and its tribal contractors. Funding for this system in Alaska, which serves approximately 90,000 Alaska Natives, has not kept pace in recent years with the growth of the Alaska Native population and health care spending trends. Providers in this system have been encouraged to enhance collections from Medicaid, Medicare, and other third-party payers in an effort to make up for the shortfall in funding. Yet, as a group, Alaska Natives' health needs are greater than other Alaskans. Their HIV infection rate is the highest in the state and death rates for suicide and homicide continue to be three to four times the national average. Substance abuse problems, including fetal alcohol syndrome/effect and brain damage associated with inhalant abuse are still on the rise. Alaska Natives have one of the highest age-adjusted mortality rates from cancer in the U.S. and diabetes is increasing. Water and sanitation services, which are taken for granted in urban Alaska, are not available in many Alaska Native villages (see Appendix H).

Finding #13: The way in which we handle claims of injury arising from medical care is unsatisfactory to almost everyone. It compensates only a few of the victims, is slow, costly, and agonizing to both claimants and providers.

The Task Force recognized that there is considerable disagreement over how much our system of resolving claims of medical malpractice contributes to rising health care expenditures and inappropriate patterns of practice. We also acknowledged that our current system is not necessarily the best way to resolve such claims. Many of the Task Force's observations of our system of handling claims are based on national studies and studies in other states, although there is considerable documented experience on the subject in Alaska (Weeks 1992).

Every year, patients in Alaska are injured by medical care. Comprehensive data on the numbers of medical injuries are not available. Two landmark studies, one in New York and one in California, showed that 3.7 percent and 4.65 percent, respectively, of large samples of hospitalized patients are injured by medical care. About one quarter of those patients are injured because of negligent care - 1.0 percent in the New York study and 0.8 percent in California. The majority of adverse events were minor and transient, but many were serious, and some caused or contributed to death (Harvard Medical Practice Study 1990; Danzon 1985). It is reasonable to assume that the age-adjusted rate of injury in Alaska is roughly the same as in New York and California.

- **Most medical injuries caused by negligence do not result in lawsuits.**

The New York study (Harvard Medical Practice Study) found that for every eight hospitalized patients negligently injured, only one patient filed a medical malpractice claim. In the California study, at most one in ten patients negligently injured filed a claim.

- **Many lawsuits alleging medical malpractice are without medical foundation.**

The New York study also found that more than eight of ten medical records of those who file claims show "no evidence of negligence or even injury".

- **On several occasions, the Task Force was advised that because the costs of bringing a case to trial are high, plaintiff attorneys in Alaska generally are reluctant to take a case unless they expect a settlement or award of at least \$100,000 (Weeks 1992).**

A significant part of the high cost of pursuing a medical malpractice lawsuit is the high cost of engaging expert witnesses. One plaintiff attorney says it is impossible to bring a medical malpractice case to trial in Alaska for less than \$75,000 (Weeks 1992). By the same token, NORCAL, which insures about 240 Alaskan physicians, reports that the "average cost of defending a case through trial is around \$60,000" (Appendix J).

- **Nationwide, studies have shown that fewer than half of all medical malpractice claims result in any payment to the claimant.**

Studies of closed claims found that payments to the claimant were paid in only 40 - 50 percent of cases (40 percent, Danzon 1985; 41 percent, Appendix J (NORCAL); 43 percent, GAO 1987b; "no more than half," Harvard Medical Practice Study 1990).

- **Less than half of the medical malpractice premium dollar goes to the patient in settlements and awards.**

A 1987 Rand Corporation study found that only 43 percent of every dollar spent on "higher-stakes" litigation, including medical liability, reaches the injured parties as compensation. A.M. Best estimated that the "total cost of medical malpractice direct losses paid" were \$2.29 billion or 41 percent of the \$5.6 billion paid in malpractice insurance premiums in 1989. The rest is spent on attorneys' fees for both sides, litigation expenses, and administrative expenses of insurers (Hensler et al. 1987; Lembo 1992).

- **Medical malpractice claims take a long time to be resolved.**

The 1987 GAO study also reported that the median length of time from injury to claim was 13 months (range <1 to 229 months), from injury to closing for claims without any payment was 17 months (range <1 to 132 months), and from injury to closing for claims closed with payment was 23 months (range <1 to 132 months) (GAO 1987b). In a study of only obstetrical malpractice cases, the average time from event to resolution was 33 months (Bovbjerg, Tancredi, and Gaylin 1991).

- **On numerous occasions, the Task Force voiced concern about the costs of and practices associated with defensive medicine. We found that the estimates of the costs of defensive medicine are inconclusive.**

Defensive practices include, in order of frequency as established in a 1983 study: (1) maintaining more detailed records, (2) referring more cases to other physicians, (3) ordering additional diagnostic tests, (4) spending more time with

patients, (5) not accepting certain types of cases, (6) increasing fees, and (7) providing additional treatments (Zuckerman 1984).

The American Medical Association (AMA) estimated in 1989 that the cost of the practice of "defensive medicine" by physicians was nearly \$21 billion. Of that, \$5.6 billion was spent by physicians for malpractice insurance premiums and \$15.1 billion on defensive medicine practices (AMA 1991). In 1989, \$21 billion represented about 18 percent of the total expenditures for physician services. Although the AMA's estimate appears to be made based on a thoughtful analysis, it is important to note that the core of the study was a physician survey. In addition, the AMA's estimate includes only costs associated with physicians' services and not other providers, most notably, hospitals. Therefore, it understates the total cost of defensive medicine in the U.S.

Other estimates of the cost of defensive medicine exist but the AMA's estimate is the most frequently cited. All the estimates are controversial, in part because of the difficulty in defining defensive medicine. The Office of Technology Assessment, a bipartisan research agency of the Congress, is currently developing its own estimates.

While the Task Force was concerned about costs associated with defensive medicine, we were also concerned how these practices can effect the quality of care provided and the level of trust between the physician and patient. For example, some tests and treatments can be detrimental to the health of the patient.

- **While total malpractice insurance premiums represented only 5 percent of total expenditures for physician services, individual physician premiums represent a significant cost of practicing medicine in Alaska.**

Medical Indemnity Exchange of California reports that the current annual rates for a \$1 million/\$3 million (most commonly purchased) professional liability insurance policy in Alaska are: \$79,948 for obstetrics, neurosurgery, orthopedics with spinal surgery; \$42,328 for general surgery, orthopedics without spinal surgery, ENT (ear, nose, and throat) with more than 5 percent plastic surgery; \$26,456 for ENT with less than 5 percent plastic surgery; \$13,524 for ophthalmology; \$11,760 for internal medicine and pediatrics; \$10,584 for family practice, no surgery; and, \$6,468 for psychiatry. NORCAL rates for a \$1 million/\$3 million policy for obstetrics are: \$64,519 for OB/GYN and \$37,751 for family practitioners with obstetrics (Appendix K).

- **The system for resolving claims of injury from medical care generates considerable uneasiness and disgruntlement among providers (Charles et al. 1985).**

The threat of litigation is perceived by providers to be ever-present. It colors virtually everything they do with respect to patients. While providers agree that their undivided attention should be focused upon what is best for their patients, physicians and other providers continually consider what is safest for themselves. This legal milieu influences clinical decisions when it should not, warps decisions on where to practice and whom to see, and shortens careers. For example, 29 percent of physicians practicing obstetrics stop delivering babies before age 45 and 67 percent before age 55 (Institute of Medicine 1989). Studies show that over 79 percent of practitioners of obstetrics report that they have been sued at least once during their careers (American College of Obstetricians and Gynecologists 1992).

- **Obstetricians in Alaska pay between \$65,000 and \$80,000 annually and family practitioners delivering babies between \$35,000 and \$40,000 annually for professional liability insurance. Nationally, practitioners of obstetrics and gynecology are sued more frequently than any other specialty (U.S. DHHS 1987). The average damage award paid by an obstetrician in 1984 was \$178,000, more than double the average paid by other specialties (Gehshan 1991). Nationally, one million dollar-plus awards are frequent in birth-injury cases (Nocon et al. 1987). Several have been awarded in Alaska.²⁰**

No group or specialty class of physicians is inherently more negligent than another, but some groups, such as obstetricians are sued more often than other providers (GAO 1987a). Settlements tend to be high and award by juries are typically high because the consequences of serious injury at birth are usually lifelong. Physicians who have practiced obstetrics and discontinued indicate professional liability issues as a primary cause including both the expectation for increased malpractice premiums and the fear of lawsuits (Rosenblatt and Wright 1987; Nesbitt et al. 1992).

- **Under the state's statute of limitations, malpractice cases involving injury to children can be filed up to two years after the age of 19. This requires physicians to have "tail" insurance to protect against claims filed many years after an alleged event. However, virtually all residua from birth or early-life injury or illness are obvious by the time a child is eight years old.²¹**

²⁰ Rodman Wilson, MD, December 2, 1992.

²¹ "Virtually all sequelae of birth injuries and illnesses early in life should be apparent by the time a child is eight years old", statement made by Marianne von Hippel, MD, behavioral pediatrician, November 6, 1992, Anchorage. "Most major residua of birth injuries and early life illnesses will be clearly apparent by six to eight years of age", statement made by Ron Brennan, MD, neurodevelopmental pediatrician, November 10, 1992, Anchorage.

- **Alaska law requires interest on civil judgments to be paid at rate of 10.5 percent per year from the date of notification of a lawsuit (AS 9.30.070). The accrued interest can add substantially to medical malpractice and other awards.**

The Task Force learned that the pre-judgement interest rate of 10.5 percent currently used in Alaska has not been adjusted since 1980. In contrast, federal courts use an approach that is more responsive to changing economic conditions, awarding pre-judgement interest using the yield of the 52-week U.S. Treasury bills (3.75% in November, 1992) as the rate of interest (Title 28, U.S. Code, 1961).

Pre-judgement interest is designed in part to deter casualty insurance companies from delaying settlement.²² However, interest payments can add significantly to medical malpractice awards. For example, if it takes five years to reach a verdict and make an award of \$500,000 in a case of injury from negligent medical care, an additional \$262,500 is added in accrued interest, making the total award \$762,500. In addition, it is possible that interest rates that are high may provide an incentive for plaintiffs' attorneys to delay in order to increase potential awards and thereby their contingency fees.

Finding #14: Most Alaskans believe that fundamental changes are needed in our health care system in order to make things work better. They also believe health care reform is an important issue that State government should address.

- **Nearly 90 percent of respondents to the Task Force's public opinion survey indicated that Alaskans want substantial change to our health care system.**

Of those Alaskans who returned the survey, 60 percent responded that "there were some good things in our health care system, but fundamental changes are needed to make it work better," while an additional 28 percent indicated "that so much is wrong with it, that we need to completely rebuild it."

- **Nearly all respondents indicated that health care reform is one of several important issues, if not the single most important issue, for State officials.**

²² Testimony by Dan Hensley to the Health Resources and Access Task Force, November 13, 1992.

Seventy-six percent of survey respondents indicated "that reform of Alaska's health care system should be one of several important issues for State officials" while an additional 21 percent believe that it is "the single most important issue for State officials."

- **Respondents overwhelmingly believe that the State government should play a role in controlling health care costs and ensuring access to basic health services for all Alaskans.**

Ninety-four percent of Alaskans who answered the Task Force's survey responded that "in the absence of national health care reform, the Alaska State government should play a more active role in controlling rising health care costs" while 96 percent indicated that "the State government should play a more active role in ensuring access to basic health services for all Alaskans."

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These fourteen findings, together with principles used by the Task Force to guide their policy decisions, are the basis upon which the Task Force made its recommendations. The Task Force's guiding principles are described in the next chapter.

CHAPTER THREE: GUIDING PRINCIPLES

At our September 1991 meeting, the Health Resources and Access Task Force developed guiding principles to be followed in the development of public policy. Our original principles were further refined in September and October 1992. The Task Force used these principles to evaluate alternative health care reform strategies.

PREAMBLE

The Alaska Constitution provides that the State of Alaska is responsible for the public health. However, each Alaskan bears individual responsibility to maintain and improve his or her own physical, mental, and emotional health and to pursue a healthful lifestyle. This fundamental responsibility lies with the individual--not the family, not schools, not churches, not employers, not health care providers, and not the government.

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 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 and appropriate health care without regard to personal financial means.

A health care plan 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 health care for themselves and their dependents. It is the responsibility of society at large to finance care for those unable to pay.

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

COST CONTAINMENT

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

Cost sharing requirements may be considered as a way of controlling 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 way to lower costs.

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 to control costs should be as simple to administer as possible.

Design of programs should be sensitive to cultural differences 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.

The Task Force's recommendations, which draw upon these guiding principles, are presented in Chapter Four.

CHAPTER FOUR: TASK FORCE RECOMMENDATIONS

A. OVERVIEW

This chapter presents the Task Force's recommendations for improving the financing and delivery of health care in the State of Alaska. In developing these recommendations, the Task Force recognized the skill and dedication of the hundreds of health care providers working throughout the state to improve the health status of its residents. However, the Task Force also has come to realize that these efforts are hampered by many aspects of the Alaskan health care system itself. In fact, to call the current method of health care delivery and financing in the state a "system" is inappropriate. The existing structure could more aptly be described as a "non-system" that allows health care costs to continue to spiral out of control, that leaves even the most basic health care coverage unaffordable for a large number of Alaskans, and that leaves an even greater number of Alaskans worried about the possible financial consequences of a serious illness in the family.

Given this situation, the Task Force agrees with the view expressed by the vast majority of Alaskans responding to its health care survey, who believe that fundamental changes must be made to the current structure of our health care system (see Finding #13). In our view, minor tinkering with the current structure is not sufficient to address the current health care crisis in Alaska. This conclusion is based upon our review of a considerable body of evidence indicating that, although a wide variety of incremental approaches and piecemeal solutions have been attempted over the past several decades, none has succeeded in controlling health care costs or providing access to basic health services to all Alaskans.

The Task Force has thus come to the unavoidable conclusion that "business as usual" approaches to dealing with the problems of our health care system will no longer suffice. We therefore propose a comprehensive strategy designed to:

1. Bring runaway health care costs under control and make health care affordable for all Alaskans;
2. Move to a unified health care financing system that will provide financial access to needed care for all Alaskans and eliminate the concerns and fears that many Alaskans have with our current health insurance system;
3. Increase the effectiveness and efficiency of the current health care delivery system by increasing the availability and coordination of health services throughout the state;

4. Improve the health status of Alaskans by ensuring adequate support for vital public health activities and emphasizing the importance of healthy lifestyles and access to preventive care; and
5. Make improvements in the way in which we resolve medical malpractice disputes.

The recommendations developed by the Task Force to achieve these objectives are as bold and as ambitious as the charge given to us by the Alaska State Legislature. They are based upon a careful assessment of the full array of possible approaches for addressing identified problems, a review of the relevant health services research and related scientific information, and the examination of the relevant experience of other states and countries that have enacted health care reform measures. We believe that they reflect Alaska's unique environment and the concerns and values of its residents. At the same time, they are also consistent with many of the major health care reform proposals being discussed at the national level.

The Task Force strongly believes that our proposed strategy represents the best way to improve the health of the state's population and to provide access to affordable, high quality health care to all Alaskans. We recognize, however, that our recommended solutions may be considered quite controversial. There are several reasons this may occur. The first is that our strategy includes a number of concepts or terms that may be unfamiliar to or misunderstood by the Alaskan public. The second reason is that, because our strategy calls for significant changes in the way in which the health care system currently operates, there may be certain individuals or groups who may feel threatened by these reforms and seek to paint an unrealistic picture of their implications.

For these reasons, the Task Force recognizes that the enactment of meaningful health care reform in Alaska may require a significant public education effort. We have begun this effort by documenting Alaska's health care problems in earlier chapters of this report. In this chapter, we will describe in detail our recommendations for addressing these problems. In doing so, we have attempted to further the public's understanding of this important issue by describing: the range of options we considered in many areas; why we selected certain alternatives; and what the impacts of our recommendations on health care costs and coverage are expected to be.

The Task Force proposes a comprehensive health care reform strategy that will:

1. *Bring runaway health care costs under control and make health care affordable for all Alaskans.*
2. *Move to a unified health care financing system that will provide financial access to needed care for all Alaskans.*
3. *Improve the health status of Alaskans by ensuring adequate support for vital public health activities.*
4. *Make improvements in the way we resolve medical malpractice disputes.*

B. TASK FORCE RECOMMENDATIONS

The Task Force's recommendations, which together provide a comprehensive strategy for improving the health of all Alaskans, can be broken down into the following major components:

- Cost Containment Efforts
- Health Care Access Improvements
- Public Health/Service Delivery System Enhancements
- Medical Malpractice Reform

Our recommendations in each of these areas are presented below.

COST CONTAINMENT RECOMMENDATIONS

RECOMMENDATION # 1:

The Task Force recommends the establishment of a statewide health care expenditure limit that would bring increases in health care spending in Alaska down to acceptable levels.

Because spiralling health care costs have had a negative economic impact on Alaskan individuals and businesses and have been an important factor contributing to the growing number of uninsured persons, the Task Force spent considerable time reviewing possible approaches to bring health care costs under control. Unfortunately, none of these approaches was found to be completely effective in controlling costs.¹ Among the approaches examined were:

- Utilization controls, such as prior authorization, second surgical opinion programs, etc. In general, these measures do decrease utilization, but have not brought overall costs under control.
- Managed care. More formal managed care systems, such as health maintenance organizations (HMOs), have not been accepted in Alaska and are therefore virtually non-existent. In other areas of the country where HMOs are more prevalent, they have resulted in initial reductions in health care spending, although over time, their health care spending grows at essentially the same rate as overall health care costs.

¹ For a good review of the experiences associated with different cost containment approaches, see Congressional Research Service. 1990. Controlling Health Care Costs. Washington, D.C. (January).

- Government price setting. Governmental price regulation, particularly in the area of hospital rate setting, has been shown in a number of cases to reduce the growth in health care spending. However, price setting approaches that focus on controlling the growth in unit prices (e.g., charges for physician office visits) may cause providers to increase the amount of services they provide to offset the effects of the price controls.
- Market-oriented competitive strategies. These efforts may enable larger purchasers to reduce their costs by negotiating discounts from providers. However, unless overall cost levels are reduced, the revenues lost to providers from these discounts may be recovered by charging higher prices to smaller purchasers, such as individuals or small business policy holders. In addition, in many areas of the state where the numbers of providers are limited, competitive strategies are likely to be ineffective.

Based upon this review of possible cost containment options, the Task Force concluded that any effective strategy to bring costs under control and make health care affordable to all Alaskans must include the establishment of an overall limit on health care spending in Alaska. Such expenditure limits or "global budgets" have succeeded in keeping increases in health care spending in a number of other countries, including Canada and West Germany, at levels that are more in line with growth in other segments of their economies.

Within the United States, a global budgeting approach for hospitals has also been used with considerable success by the State of Maryland and by the Rochester, New York community to control the growth in hospital spending without diminishing either the quality of or access to care. The establishment of statewide health care expenditure limits covering all services has also been the centerpiece of major health care reform legislation recently passed in the States of Minnesota and Vermont. At the national level, the concept of global budgeting, including the establishment of state-specific expenditure limits, has been a key component of a number of major health care reform proposals and was an important element of the health care reform strategy put forth by President-elect Bill Clinton during his campaign.

How Would a Statewide Health Care Expenditure Limit Work?

Under a global budgeting approach, an overall limit would be established for health care spending within the State of Alaska. This limit would not be set so as to cut health care spending below current levels, but would rather be designed to reduce its current rate of growth, which far outstrips the growth in inflation and in other sectors of the economy (see Finding #1 in Chapter Two). The Task Force believes that the objective of global budgeting should be to limit annual increases in health care spending to the overall rate of inflation, as reflected in the growth in the Consumer Price Index (CPI). We recommend that the limits be phased in over a three-year period beginning in 1994, with the data collection efforts initially required to establish the limits to be conducted in 1993. Annual adjustments to the target rate of growth could be made, as appropriate, to reflect such factors as:

- Changes in the size and/or demographic characteristics (e.g., age distribution) of the state's population that may affect the need/demand for health care in the future;
- Changes in technology and health care delivery that may increase or decrease health care costs;²
- The identification and reduction of the provision of unnecessary health care;
- Desired changes in some segments of the population's (e.g., the uninsured's) access to adequate health care services;
- Increases or decreases in the costs associated with medical malpractice premiums and awards as appropriate;
- Reductions in administrative costs; and
- Other such factors as a newly established Alaska Health Care Authority (AHCA) (to be described later in this chapter) may determine to be appropriate (e.g., changes in the burden of disease, epidemics, disasters, etc.).

To the extent possible, the overall statewide health care expenditure target should be subdivided, with separate subtargets established, at a minimum, for such major services as hospital care, physician services, etc. The Task Force also believes that it may be appropriate to establish a separate subtarget for capital expenditures, and to link the State's Certificate of Need policies to the global budgeting process to ensure that this target is not exceeded.

Once expenditure targets for different services have been established, reimbursement rates for health care providers would be set at levels that are expected to result in expenditures that fall within the limit for each provider type. This does not necessarily mean that the State would unilaterally set rates for each class of provider. Instead, the Task Force envisions that after establishing the expenditure targets for different services, the newly established Alaska Health Care Authority would then work with designated representatives of the various provider groups (e.g., the state medical

² The Task Force recognizes that the introduction of new health technologies has been a significant contributor to the rapid growth in health care costs. And while some technologies can improve patient outcomes, we also recognize that in many instances new technologies and procedures may be utilized inappropriately and may not necessarily have demonstrated a positive impact on health care outcomes. For these reasons, the Task Force felt that upward allowances for technology changes should be incorporated into the expenditure limits judiciously and be limited to technologies whose effectiveness has been clearly demonstrated through scientific study and for which utilization standards have been developed in a similarly scientific manner.

association and the state hospital and nursing home association) to identify a mutually acceptable set of reimbursement rates.

These reimbursement rates can initially be developed entirely by the provider community and could vary across providers of similar services. From the State's perspective, these reimbursement structures must meet the following basic requirements:

1. Given reasonable assumptions concerning anticipated utilization levels, reimbursement rates should result in total expenditures which will fall within the expenditure limit;
2. Different rates may not be charged to different payers by a provider;
3. For health care facilities overall, the base for the statewide expenditure goal will be actual costs in a base year. Actual base year costs will also be the basis for reimbursement levels for individual facilities;
4. 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 rates from any public payers (e.g., Medicare) that are not sufficient to cover costs;³
5. For physician services, the reimbursement schedules will utilize a resource-based relative-value scale (RBRVS); and
6. For other services, the Authority will work with the provider community to develop the specific reimbursement schedules as appropriate.

Only if (a) a provider group fails to initially propose an equitable reimbursement structure that can reasonably be expected to result in expenditures that fall within predetermined targets, and (b) subsequent negotiations between the State and that provider group fail to reach agreement on such a reimbursement schedule, will the State as a last resort establish and put into effect its own reimbursement schedule for their services.

If expenditures exceed the target in a given year without good cause, the Authority will be able to take appropriate measures to ensure compliance with the expenditure targets, including reducing the subsequent year's reimbursement levels to bring spending back within the expenditure limit. For example, if the target annual rate of growth for total hospital expenditures is 7.5 percent, but overall hospital spending in a given year increases by 9 percent, the Authority could bring hospital

³ It is the Task Force's expectation that the State of Alaska would request the necessary federal waivers to ensure that all payers comply with the reimbursement rates established as part of the global budgeting process.

spending back into line with the budget by allowing an increase of only 6 percent in the following year.

A key feature of the expenditure limit process will be the establishment of mechanisms through which detailed information on health care spending will be furnished to the various provider groups. This information will enable these groups to analyze spending patterns and assist them in identifying and addressing problems, such as inappropriate utilization or price increases in their own areas.⁴ The Task Force recommends that the State take the appropriate steps to provide the necessary anti-trust protections to providers participating in negotiations with the Authority or working with data from the Authority to address problems that are identified.

The State's involvement in data-related activities is discussed further in the next recommendation.

What are the Anticipated Impacts of Establishing Statewide Health Care Expenditure Limits?

It is the Task Force's view that the establishment of these expenditure limits will be effective in bringing skyrocketing health care costs under control. We believe this can be achieved without harming health care quality or causing health care to be "rationed." Rather, we would expect these limits to provide incentives for improving the efficiency of the state's health care delivery system and reducing the utilization of inappropriate and unnecessary services. The Task Force believes that the potential reductions in unnecessary utilization could be significant. For example, national research has found that a substantial portion of a growing number of expensive high-technology procedures have been found to be "medically inappropriate."⁵

The Task Force further anticipates that the establishment of expenditure limits would provide incentives for existing health care organizations or groups of health care providers to form new coordinated health care systems that would offer to provide comprehensive quality care to patients on a prepaid capitated basis. An incentive for the establishment of such managed care plans would be to exempt them from any reduction in their subsequent year's rates if they came in within their budget, even if fee-for-service providers exceeded their expenditure targets. These managed care systems would achieve their efficiencies through internal patient care management rather than through heavy-handed "over the shoulder" government regulation. Where the population base was sufficient to support several of these coordinated care plans,

⁴ For an interesting discussion of the use of information feedback to providers, see Lasker, R. et al. 1992. Realizing the Potential of Practice Pattern Profiling. *Inquiry* 29 (Fall): 287-297.

⁵ See, for example, Chassin, M. et al. 1987. Does Inappropriate Use Explain Geographic Variations in the Use of Health Care Services? *Journal of the American Medical Association* 258:2533-37.

competition between different managed care plans would provide a further incentive to holding down costs. These plans would be able to compete on the basis of price, quality, and patient satisfaction, but not on the basis of selecting only healthy patients and avoiding those with significant illness.

While the Task Force does not anticipate that the availability or the quality of health care services would be diminished by expenditure limits, as noted earlier, we do anticipate that the affordability of health care in Alaska would be substantially improved. The following analysis illustrates this point by assessing anticipated future growth in health care spending with and without an expenditure limit.

As indicated in Chapter Two (see Finding #1), health care spending in Alaska is estimated to have reached nearly \$1.6 billion in 1991. To estimate the cost impact of establishing spending limits, the Task Force developed projections of health care spending in Alaska, both with and without the limits, through the year 2003. Our projections reflect anticipated changes in the state's population and increases in health care spending due to other factors.

THE IMPACT OF STATEWIDE HEALTH CARE EXPENDITURE LIMITS

The establishment of statewide health care expenditure limits would:

- *Bring runaway health care costs under control;*
- *Not harm quality of care or result in health care rationing;*
- *Provide incentives for the development of coordinated health care systems that provide comprehensive quality care; and*
- *Significantly improve the affordability of health care in Alaska.*

Based upon population projections developed by the Alaska Department of Labor, the growth in the state's population can be expected to cause aggregate health care spending to rise by approximately 2.76 percent per year from 1991 through the year 2003. The aging of Alaska's population is expected to result in increases of approximately 0.4 percent per year during the same period. In addition, we assume that other factors, such as increases in prices, utilization levels, or intensity of care, would increase health care spending by another 8 percent per year. The combined effect of these three factors, when compounded, is an 11.4 percent annual rate of growth in health care spending. As indicated in Table 4-1, under this scenario health care spending in Alaska would increase from roughly \$1.6 billion in 1991 (column 1) to nearly \$5.6 billion by the year 2003 (see column 13), an increase of over 275 percent. That translates to approximately \$7,340 in health care spending per Alaskan in 2003.

The lower half of Table 4-1 presents projections of health care spending in Alaska under a system with expenditure limits. Under this scenario, the increases in health care spending due to population growth and aging remain unchanged. However, the target rate of growth due to factors other than population changes is reduced from 8 percent per year to 4 percent, which is assumed to be the average

Table 4-1
A COMPARISON OF PROJECTED HEALTH CARE EXPENDITURES IN ALASKA
UNDER THE CURRENT SYSTEM AND A SYSTEM WITH EXPENDITURE LIMITS, 1991 - 2003
(In Billions of \$)

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
	<u>1991</u>	<u>1992</u>	<u>1993</u>	<u>1994</u>	<u>1995</u>	<u>1996</u>	<u>1997</u>	<u>1998</u>	<u>1999</u>	<u>2000</u>	<u>2001</u>	<u>2002</u>	<u>2003</u>	<u>CUMULATIVE</u>
ALTERNATIVE A: Current System														
Baseline/Prior Year Expenditures	\$1.598	\$1.598	\$1.787	\$1.983	\$2.202	\$2.446	\$2.712	\$3.008	\$3.339	\$3.706	\$4.117	\$4.559	\$5.051	
1. Increase Due to Population Growth		\$0.053	\$0.043	\$0.048	\$0.053	\$0.057	\$0.064	\$0.071	\$0.080	\$0.090	\$0.086	\$0.096	\$0.108	
2. Increase Due to Aging of Population		\$0.004	\$0.006	\$0.008	\$0.009	\$0.009	\$0.010	\$0.011	\$0.013	\$0.015	\$0.019	\$0.022	\$0.025	
3. Increase Due to Other Factors @ 8.0%		<u>\$0.132</u>	<u>\$0.147</u>	<u>\$0.163</u>	<u>\$0.181</u>	<u>\$0.201</u>	<u>\$0.223</u>	<u>\$0.247</u>	<u>\$0.275</u>	<u>\$0.305</u>	<u>\$0.338</u>	<u>\$0.374</u>	<u>\$0.415</u>	
TOTAL: Projected Net Cost/Current System	\$1.598	\$1.787	\$1.983	\$2.202	\$2.446	\$2.712	\$3.008	\$3.339	\$3.706	\$4.117	\$4.559	\$5.051	\$5.599	\$42.107
ALTERNATIVE B: System With Expenditure Limits														
Baseline/Prior Year Expenditures	\$1.598	\$1.598	\$1.787	\$1.983	\$2.175	\$2.356	\$2.516	\$2.687	\$2.872	\$3.070	\$3.283	\$3.502	\$3.736	
1. Increase Due to Population Growth		\$0.053	\$0.043	\$0.048	\$0.052	\$0.055	\$0.059	\$0.064	\$0.069	\$0.074	\$0.068	\$0.074	\$0.080	
2. Increase Due to Aging of Population		\$0.004	\$0.006	\$0.008	\$0.009	\$0.008	\$0.009	\$0.010	\$0.011	\$0.013	\$0.015	\$0.017	\$0.019	
3. Increase Due to Other Factors under Expenditure Limits		<u>\$0.132</u>	<u>\$0.147</u>	<u>\$0.136</u>	<u>\$0.119</u>	<u>\$0.097</u>	<u>\$0.103</u>	<u>\$0.110</u>	<u>\$0.118</u>	<u>\$0.126</u>	<u>\$0.135</u>	<u>\$0.144</u>	<u>\$0.153</u>	
TOTAL: Net Cost of System With Expenditure Limits	\$1.598	\$1.787	\$1.983	\$2.175	\$2.356	\$2.516	\$2.687	\$2.872	\$3.070	\$3.283	\$3.502	\$3.736	\$3.988	\$35.552
ADDITIONAL COST (SAVINGS) OF SYSTEM WITH EXPENDITURE LIMITS														
	\$0.000	\$0.000	\$0.000	(\$0.027)	(\$0.090)	(\$0.196)	(\$0.321)	(\$0.467)	(\$0.636)	(\$0.833)	(\$1.057)	(\$1.315)	(\$1.611)	(\$6.555)

annual economy-wide inflation rate during this period.⁶ The information presented in Table 4-1 assumes that the 8 percent annual increase due to non-population changes is reduced to the target rate of 4 percent over the course of three years, beginning in 1994 and reaching the 4 percent per year level in 1997. As a result, once the expenditure limits are fully implemented, annual health care spending is projected to increase a total of 7.3 percent per year, rather than the 11.4 percent anticipated without the limits.

Based upon these assumptions, the establishment of expenditure limits would result in aggregate health care spending of \$3.988 billion in the year 2003 (column 13). This translates to a per capita cost of slightly less than \$5,000 per Alaskan in the year 2003, or about a third less than what it would have been without expenditure limits.

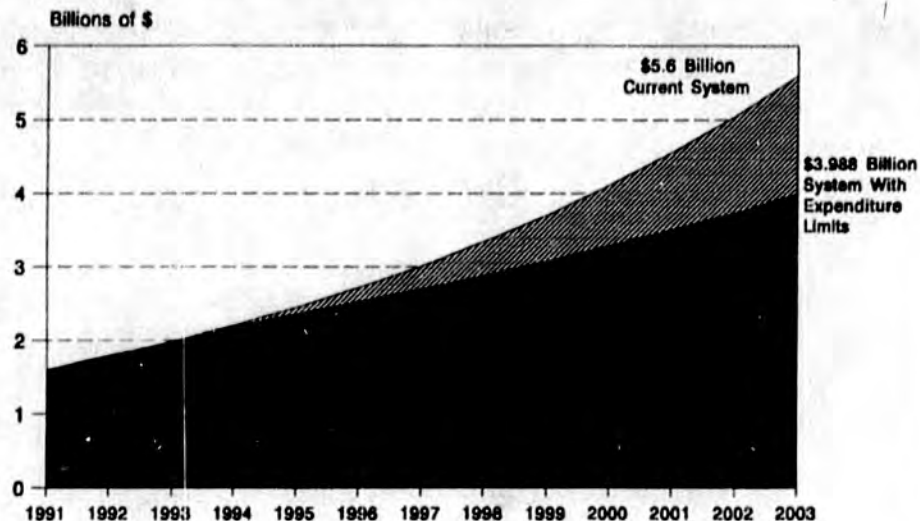
Further, cumulative health care spending over the period from 1991 through 2003 would total \$42.1 billion without expenditure limits (column 14), compared to less than \$35.6 billion with expenditure limits in place. This represents cumulative savings of \$6.55 billion statewide over the period in which the expenditure limits are in place. This represents cumulative savings of over \$8,500 per Alaskan. This difference in the growth in health care spending is depicted in Figure 4-1.

**HEALTH CARE EXPENDITURE
LIMITS: ANTICIPATED SAVINGS**

During the first ten years of operation, statewide health care expenditure limits could result in \$6.55 billion in statewide health care savings. That translates to over \$8,500 per Alaskan.

⁶ The target growth rate used in this analysis is consistent with that included in the State of Minnesota's health care reform legislation, which calls for increases in spending to be reduced to half of what they would otherwise have been. An earlier draft of this report used slightly higher assumptions for non-population based growth in health care spending in the absence of expenditure limits and for overall inflation (10% and 5%, respectively). In this analysis the assumptions concerning projected non-population-based health care spending increases and overall inflation rates have been reduced to 8% and 4%, respectively, to make them consistent with those used in federal projections of future health care spending. See Sonnefeld, S. et al. 1991. Projections of National Health Expenditures through the Year 2000. Health Care Financing Review 13 (Fall). To the extent that non-controlled growth in health care spending and inflation would exceed our assumptions, the savings resulting from the expenditure limits would increase.

Figure 4-1
Projected Health Care Expenditures in
Alaska under Alternative Systems, 1991 - 2003



Source: Health Systems Research, Inc.

RECOMMENDATION # 2:

The Task Force supports the passage of legislation to establish a single administrative entity to oversee the State's health care cost containment and access initiatives.

The Task Force recommends the establishment of the Alaska Health Care Authority (AHCA) at the State level, which would have responsibility for overseeing the development, implementation, and enforcement of the statewide expenditure limits, as well as other cost containment and access initiatives discussed later in this chapter. To ensure that it is able to carry out its significant responsibilities as effectively as possible, the Task Force further recommends that the Authority be structured to:

- Function as independently as possible;
- Be staffed by the most qualified individuals available; and
- Not include representation from provider groups, since the Authority will be responsible for negotiating with these groups.

The AHCA will be responsible for implementing the expenditure limits, which will include the conduct of negotiations with provider groups concerning reimbursement arrangements that will meet expenditure targets. The collection and analyses of comprehensive data on health care utilization and expenditures are also essential elements of the proposed global budgeting process. The AHCA must have the authority and capacity to collect and analyze all health care data necessary for the development, implementation, and monitoring of the health care expenditure limit process. As discussed under the prior recommendation, the Authority must also be able to share data on cost and utilization with the provider community in a timely manner through some form of feedback mechanism. Sharing information on utilization and expenditures with provider groups will assist in identifying possible problem areas and in making adjustments in their activities, as appropriate.

In addition to its responsibilities in the area of global budgeting, the Authority will also be charged with implementing other initiatives designed to reduce costs by increasing the efficiency of the current health care financing system. These initiatives include:

- The development of uniform billing and common claims forms which are to be used by all payers and providers;
- The development of uniform utilization review standards and criteria; and
- The establishment of requirements for the timely payment of claims by all payers, with the goal of providing payment within fifteen working days of receipt of an error-free or "clean" claim.

As a complement to the development of uniform utilization review standards by the proposed Alaska Health Care Authority, the Task Force also recommends the passage of legislation requiring the registration of utilization review agents operating in Alaska and the development of regulations by the Department of Commerce and Economic Development (DCED) to ensure their competency and their use of the uniform standards developed by the Authority.

Additional responsibilities of the Authority will be discussed in later recommendations.

RECOMMENDATION # 3:

The Task Force supports expanding the State's authority to review and approve or disapprove rates filed by health insurers.

In addition to establishing the Alaska Health Care Authority, the Task Force also supports expanding the authority of the State Director of Insurance to allow him

or her to approve or disapprove rate requests filed by all health insurers, both non-profit and commercial, that sell group and/or individual health insurance policies in Alaska. Currently the Director of Insurance does review rate filings submitted by insurance carriers. However, his ability to deny a rate filing is quite limited, even if it is determined that the rates requested are excessively high in relationship to the benefits to be paid. This expanded authority will provide the State with the ability to deny rate requests in such instances and will improve the State's ability to ensure that insurance premiums charged by all health insurers in Alaska are reasonable.

HEALTH CARE ACCESS RECOMMENDATIONS

The cost containment measures called for in the previous recommendations will slow the erosion in health care coverage caused by rapidly escalating costs. However, these efforts alone cannot be expected to remove the health care access barriers faced by the tens of thousands of Alaskans who lack health care coverage. To address the very real needs of uninsured Alaskans and to meet our mandate from the Legislature to design a program that will provide universal coverage to all of the state's residents, the Task Force believes that a major, fundamental change to our current health care financing structure is required.

As will be discussed in greater detail later in this section, after a careful assessment of the Alaskan environment as well as pros and cons associated with alternative approaches to providing universal coverage, including pay-or-play proposals and employer mandates, the Task Force has concluded that a single payer financing system is the most efficient, equitable, and appropriate model for Alaska.

The Task Force is committed to the belief that all Alaskans will benefit from a single payer system. Nonetheless, as noted earlier, we also recognize that the benefits of a single payer system may not be immediately evident to the Alaska public and to policymakers. Programs must be put in place to educate the public concerning the benefits of moving to such a system and to stimulate an expanded public dialogue on the issue. However, such a public education process may require time for it to have an effect.

Unfortunately, during the period in which this public education process and public debate will take place, the problems that exist within our current financing system will continue. Uninsured persons will die or be admitted for expensive hospital care for problems that could have been avoided through access to adequate primary care. Children without access to preventive care may develop lifelong limitation due to conditions that could have been treated if detected early. And thousands of Alaskans will continue to live with the fear that their current insurance may not be there when they need it.

Given this situation, the Task Force felt that, in spite of its commitment to a single payer system, it should also put forth recommendations for making incremental improvements to the existing financing system that have already been adopted in many other states and that could be enacted immediately by the Alaska State Legislature. The first four of the Task Force's access-related recommendations (Recommendations 4 through 7) focus on this short term strategy. Our final recommendation describes the Task Force's rationale for proposing a single payer system as the preferred approach for providing universal coverage.

RECOMMENDATION # 4:

The Task Force recommends the enactment of legislation establishing regulatory reform measures in the small group health insurance market.

As described in Chapter Two (see Finding #6), a significant proportion of uninsured Alaskans are either employees in small firms or dependents of these employees. As was also noted, a number of serious problems in the current small group health insurance market are likely to make health care coverage unattractive to many small businesses. These problems include:

- The refusal by some insurers to provide coverage to certain small businesses because of the type of work in which they are involved or the health status of their employees or their dependents;
- Premium levels charged by the same insurer that may vary widely across firms with similar employee characteristics;
- Premium setting practices that result in many small businesses being offered very attractive first year rates, but then being hit by double--or even triple--digit increases in their premium costs in the following years. These staggering increases cause many businesses not to enter the market in the first place, to drop their coverage, or to switch to another carrier;
- High administrative costs due to medical underwriting activities and the frequent switching of insurers that is promoted by insurer practices; and
- The dropping of some small businesses without notice or refusing to renew their coverage because of their claims experience.

A number of organizations, including the National Association of Insurance Commissioners (NAIC) have worked to develop a package of regulatory reform measures that would enable states to address these problems. The NAIC has developed a Small Employer Health Insurance Availability Model Act that incorporates many desired reform provisions. These provisions, which would apply to policies sold to employers with fewer than twenty-five employees, include:

- Guaranteed Issue and Renewability: All small group insurers must provide coverage to all eligible firms applying for coverage and may not terminate such coverage for other than good cause, such as non-payment of premiums.
- Whole Group Coverage: Insurance policies sold to small groups must provide coverage to all eligible employees and their dependents and cannot exclude certain individuals based upon their health status.
- Elimination of Multiple Waiting Periods for Pre-existing Conditions: Waiting periods for individuals with pre-existing conditions are to be waived if these individuals have previously fulfilled a waiting period and maintain continuous coverage.
- Development of Standardized Plans: To allow comparison shopping by small employers, each small group insurer must offer two standardized plans, one of which is to be a "bare bones" plan.
- Premium Rating Restrictions: Premium rate "bands" or restrictions would be established to limit variation in:
 - annual premium increases faced by individual small businesses; and
 - premium rates charged to different types or classes of small businesses.
- Reinsurance Pool: A statewide reinsurance pool should be established to spread the risk associated with the guaranteed issue requirements in the small group market.
- Data and Disclosure: Small group insurers must disclose their premium rating practices and renewability provisions to small businesses. Insurers must also maintain their records in proper order and submit an annual statement certifying that the rates they charge small businesses are actuarially sound and comply with all the above requirements.

Over half of the states have already enacted small group health insurance market reforms similar to those included in the NAIC Model Act. The Task Force believes that enactment of such regulatory reform efforts could reduce many problems that Alaska's small businesses encounter in attempting to obtain or maintain health care coverage for their workers. The Task Force therefore recommends that the Legislature enact the NAIC model statute as part of a short term strategy to improve access to health care coverage in the state. The Task Force further recommends that the elimination of multiple waiting periods for pre-existing conditions should also apply to persons moving from group to non-group coverage.

RECOMMENDATION # 5:

The Task Force recommends that the State of Alaska require insurers to move toward community rating in establishing premiums in the small group insurance market.

With respect to the development of premiums to be charged in the small group insurance market, the Task Force viewed the provisions in the NAIC Model Act calling for the use of specific rate bands to limit variations in premium rates as a starting point, rather than the endpoint, for reform in this area. To further reduce the variations in premiums in this market, the Task Force calls for the phased-in use of quasi-community rates in the small group marketplace. Specifically, the Task Force recommends:

- The use of health status/medical underwriting and gender as factors in the setting of premium rates should be phased out over a three- to five-year period.
- At the end of the phase-in period, the only allowed variations in premiums charged to small businesses in a given geographical region of the state (to be defined by the State Director of Insurance), would be for differences in age composition and occupation/industry among small groups, as well as for differences in the family status of group members (i.e., single vs. family coverage).
- Limits should be placed on the maximum variation allowed in a geographic region due to age and industry differences across small groups. In reviewing the approaches of several other states that recently passed legislation calling for the use of some form of community rating, the Task Force viewed favorably an approach incorporated in a Massachusetts statute, which specified that no small business could be

charged a premium greater than twice that of the lowest small group premium within a given geographical area. During the phase-in of this 2:1 rate band requirement, the statute requires that renewal rates not exceed the trend for the class, plus allowable adjustments, plus 10 percent.

- Within this quasi-community rate setting structure, the Task Force recommends that insurers be allowed to offer discounts for non-smoking and for participation in wellness programs.

While this shift to community rating will mean lower premiums for some higher risk groups, the Task Force recognizes that it may also mean, at least initially, higher premiums for some lower risk groups. However, the Task Force believes that the enactment of the expenditure limits described in an earlier recommendation will reduce the magnitude of these premium increases. We also recognize that other aspects of our recommendations--including prohibiting insurers from cancelling policies because of changes in health status or use and the gradual elimination of medical underwriting--mean that the higher premiums that may be paid by some groups will provide them with much more predictable and stable health care coverage than they had in the past.

It also should be noted that the Task Force's recommendations with respect to community rating are directed at the small group market, which we defined as including firms with two to twenty-five employees. At this time, we did not extend our recommendations concerning community rating to larger firms because of the concern that this requirement might spur them to drop coverage or to self-insure, thereby avoiding the State's regulatory requirements completely.⁷ However, the Task Force does recommend that the State Director of Insurance explore the feasibility and implications of extending these community rating requirements to firms with up to fifty employees.

The Task Force was also interested in extending its recommendations to the individual, non-group market. However, because of the significant potential for adverse selection that exists in the individual market, unless otherwise specified, our recommendations do not extend to that segment of the insurance marketplace.

⁷ The provisions of the federal Employee Retirement and Income Security Act of 1974 (ERISA) do not allow state governments to regulate self-funded employee health benefit plans.

RECOMMENDATION # 6:

The Task Force recommends the establishment of State-sponsored health insurance pooling arrangements.

During its deliberations, the Task Force reviewed information indicating that nationwide as much as 40 percent of premiums charged to very small businesses may be attributable to administrative costs. While the small group market reform provisions included in earlier recommendations are expected to reduce the administrative costs associated with providing coverage to small businesses, the Task Force also considered it appropriate for the State, through the newly established Health Care Authority, to establish one or more pooling arrangements through which both individuals and businesses, small and large, could purchase health care coverage. It is anticipated that certain additional efficiencies and economies could accrue to the members of these pool arrangements that would further reduce their premium costs. In designing these pools, the Task Force noted the importance of considering their medical underwriting and premium setting practices in relation to those of other insurers governed by the small market reform proposals to ensure that these State-sponsored pools are not damaged by the adverse selection that would result from other insurers subtly "dumping" undesirable risks into these pools.

RECOMMENDATION # 7:

The Task Force recommends the passage of legislation providing for publicly-subsidized coverage of uninsured low-income pregnant women and children who are not eligible for Medicaid.

Even with the recommendations concerning cost containment, market reform, and pooling measures in place, the Task Force recognizes that it would be necessary to provide some level of public subsidy to certain low-income uninsured persons if they are to be able to afford health care coverage (see Finding #4).

The Task Force determined that the populations to be given highest priority for receiving subsidized coverage should be low income pregnant women and children in families with incomes too high to be eligible for Medicaid but too low to be able to

purchase private health insurance on their own.⁸ Priority was given to these groups because of the documented improvements in birth outcomes and the cost savings associated with the receipt of prenatal care by pregnant women and the positive lifelong benefits associated with providing adequate primary and preventive care to children. The Task Force also determined that the positive health improvements resulting from public health care subsidies for these populations could be maximized by providing coverage of comprehensive services (e.g., prenatal and other preventive services, plus other ambulatory and inpatient care) for low income pregnant women and ambulatory care services for low income children.

Given these priorities, the Task Force recommends that legislation be enacted to establish a program providing State-subsidized insurance coverage for low-income children who are not eligible for Medicaid or Indian Health Service coverage and who are in families with incomes below 300% of the federal poverty level. In order to make the program more affordable at the outset, coverage would be provided for primary and preventive and/or ambulatory care services, but not for inpatient care.

Experience in other states has shown similar programs to be more attractive to families if they were perceived to foster self-sufficiency and were similar to private insurance in design. Therefore, the Task Force recommends that the program be given an identity apart from Medicaid, particularly the eligibility system. This would not preclude the Medicaid agency from administering the program if it proves most cost-effective, however serious consideration should be given to having a private insurer administer the program under contract to the State. The Task Force was heartened by expressions of interest from two major carriers in Alaska in being involved in such a program.

While coverage would be substantially subsidized by the State, premium sharing requirements in the range of \$50 - \$300 per year per child should be established on an income-related sliding scale basis. This premium sharing will not only reduce the required level of State subsidy, but also will give parents of enrolled children a sense of involvement and participation in contributing to coverage for their children.

As illustrated in Table 4-2 on the following page, approximately 14,600 uninsured Alaskan children would be eligible for coverage under this program. The Task Force estimates that roughly 8,200 children would actually enroll in the program, with nearly 90 percent of these children having no previous health care coverage. The remaining enrollees are expected to be children with private insurance that provides inadequate coverage of primary and preventive care. The annual cost of the program is estimated to be \$6.1 million, of which \$4.2 million would be financed by State subsidies. The remaining \$1.9 million would be paid by families in the form of premium contributions.

⁸ It should be noted that the Task Force identified high-risk individuals as another high priority population and in our interim recommendations we endorsed the establishment of a statewide high-risk insurance pool for this population. Legislation establishing such a pool was enacted last year by the Alaska State Legislature.

Table 4-2
ESTIMATES OF ENROLLEES AND COSTS UNDER
SUBSIDIZED AMBULATORY CARE PROGRAM FOR LOWER INCOME
ALASKAN CHILDREN NOT ELIGIBLE FOR MEDICAID OR IHS COVERAGE

<u>Income</u>	<u>Number of Uninsured Children</u>	<u>Number of Enrollees</u>	<u>Costs (in millions of \$)</u>		
			<u>State</u>	<u>Family</u>	<u>TOTAL</u>
Under Poverty	3,900	300	\$0.2	\$0.0	\$0.2
100-200% Poverty	4,500	2,900	\$1.8	\$0.4	\$2.2
200-300% Poverty	6,200	5,000	\$2.2	\$1.5	\$3.7
TOTAL	14,600	8,200	\$4.2	\$1.9	\$6.1

Source: Health Systems Research, Inc.

With respect to the coverage of low income pregnant women, the Task Force recognizes that, while federal laws enable the State of Alaska to extend Medicaid eligibility to pregnant women and infants in families with incomes up to 185% of poverty, the State currently has elected to provide coverage only to pregnant women and infants in families with incomes below 133% of poverty. The Task Force recommends that the State expand its Medicaid coverage for pregnant women and infants up to 185% of poverty. The FY 1994 cost of this expansion to the State is estimated to be \$3.8 million, which will be matched by an equal amount from the federal government. For uninsured women with incomes above this income level but below 300% of poverty, the Task Force recommends the establishment of a publicly-subsidized private insurance program providing comprehensive services.

RECOMMENDATION # 8:

The Task Force recommends the enactment of legislation establishing a single payer health care financing system to provide universal health care coverage for all Alaskans.

While the previous recommendations can be expected to result in short-term improvements in the availability and affordability of health care coverage, even with their enactment, tens of thousands of Alaskans will remain without health care coverage. After considerable examination of alternative approaches to provide health care coverage for all Alaskans, the Task Force concluded that the most appropriate model for achieving such a goal in Alaska is through the establishment of a single payer financing system. Our rationale for selecting this model is described below.

Why a Single Payer System?

In considering what financing structure would be the most appropriate for providing universal health care coverage in Alaska, the Task Force carefully considered a range of different models for achieving this goal. They included three of the major approaches that have been considered both in other states and at the national level:

- Mandated employment-based health care coverage;
- "Pay or Play" coverage requirements; and
- A single payer system.

Each of these approaches is described below.

- Mandated employment-based health care coverage.

Under this approach, all Alaska employers would be required to provide health care benefits for at least their full time workers. This requirement could also be extended to the dependents of these workers, and to part time workers, with employer premium contributions for this latter group adjusted on a sliding scale basis depending on the number of hours that they work.

To implement such a requirement, the State of Alaska would require a federal waiver of the Employee Retirement and Income Security Act of 1974, known as ERISA. This federal statute precludes states from regulating employee benefit programs and would preclude Alaska from requiring the provision of health care benefits. Only one state in the nation, Hawaii, has received a waiver of ERISA, because its employer mandate was established prior to ERISA's passage. Under this approach, a publicly subsidized health insurance plan also would have to be created to provide coverage for low income individuals and families not tied to the work force.

- "Pay or Play" approaches.

In an attempt to avoid the need for an ERISA waiver, a number of states have enacted legislation that does not directly require employers to provide health care benefits for their workers, but instead exempts employers that provide such coverage from newly established payroll taxes. The States of Massachusetts and Oregon have enacted these "Pay or Play" employer requirement, but have delayed their implementation to 1995. The State of Florida also has enacted legislation proposing a "pay or play" requirement if employers do not voluntarily extend coverage to their workers.

Like the employer mandated coverage approach, a pay or play approach would require the establishment of state-sponsored coverage for persons not linked to the work force or workers whose employer elected to pay the payroll tax rather than provide health benefits.

- A single payer system.

By a "single payer" system we mean a system under which all Alaska residents would be provided constant health care coverage through a unified funding mechanism. This would be in contrast to our current system under which whether or not a person has coverage is dependent upon whether his or her employer provides health benefits, whether or not their income is below a certain level to qualify for Medicaid, whether they are old enough to qualify for Medicare, or whether they would qualify for coverage under the Indian Health Service.

A single payer system does not mean that all health care providers would end up being government employees or that all health care facilities would be government owned. Under a single payer system, the current mix of private and public health care providers could continue to provide services and Alaskans would still have the ability to select the provider of their choice.

After a careful consideration of each of these possible approaches, the Task Force concluded that the most appropriate approach for providing universal coverage in Alaska is a single payer system. There are several important reasons why a single payer system is preferred to either an employer mandate or a "pay or play" approach, both of which are based upon our current system. They are the following:

1. The current mix of public, employer, and individual financing inevitably creates coverage gaps for some people, particularly when their employment status changes.

Linking health care coverage to employment is particularly difficult in Alaska. Given the seasonal nature of many of its industries, there are considerable fluctuations in employment during the course of the year. For example, an analysis of all but the state's very largest firms conducted by the Alaska Department of Labor found that employment in the "average" business fluctuated by 24 percent from the lowest employment month to the highest. In the very seasonal industries, those fluctuations were even greater. In seafood processing, for example, the highest monthly employment averaged over 300 percent higher than in the lowest month. The lumber and wood products, utilities, and construction industries were also found to have fluctuations of from 66 to 87 percent.⁹

2. Health care financing approaches that require all businesses to provide health care benefits or that levy additional taxes on those businesses that do not may threaten the economic viability of many small businesses in Alaska.

As discussed in Chapter Two, a significant proportion of uninsured Alaskans are workers employed by small businesses or the dependents of these workers. While many of the businesses that employ these uninsured workers might be able to afford to provide coverage for these workers, particularly in a system in which effective cost containment measures are in place, the financial status of some of these businesses might be jeopardized by the burden that either a health benefit mandate or a "pay or play" requirement would place upon them. The Task Force believes that a single payer approach offers greater flexibility to identify

⁹ Rae, B. 1991. Alaska's 13,476 Other Employers. Alaska Economic Trends (August).

funding sources and develop financing arrangements that will be less of a threat to the state's small businesses.

3. Multiple payer systems would not necessarily address the problems of cost shifting that exist in our current system.

Unless there was a requirement that all payers would pay the same amount to providers for comparable services, multiple payer approaches to providing universal coverage would not necessarily solve the problem of cost shifting, which places an inequitable burden on some payers. Under such a system, larger payers might be able to negotiate significant discounts in charges from providers, with losses in revenues being made up through higher charges to other, smaller payers. To the extent that public programs reduce their reimbursement levels below costs due to budgetary constraints, this source of cost shifting can also exist. Under a single payer system, by definition, a single rate would be paid to a given provider for a given service, so that no one's cost would be artificially increased.

4. Systems that are built upon the existing public-private financing arrangements can be expected to inherit its inefficiencies.

These inefficiencies exist because there are considerable administrative costs associated with conducting eligibility determinations for public program coverage, enrolling individuals in employment-based plans, and re-enrolling them when they change jobs and are lucky enough to obtain coverage at their second job. Given the seasonal fluctuations in employment discussed above, these costs are likely to be particularly high in Alaska.

There also are significant costs associated with having multiple insurers provide coverage. These administrative costs include not only insurer overhead, but also the cost to providers of filling out different forms and responding to varying requests from different insurers. In its study of the Canadian health care system, the U.S. General Accounting Office concluded that nationwide there would have been administrative cost savings of approximately \$67 billion in 1991 if the U.S. had adopted a Canadian-style single payer system--more than enough to cover the increased cost associated with covering all currently uninsured Americans.¹⁰ While the magnitude of GAO's estimates of administrative cost savings have been questioned by some analysts, most conclude that the administrative savings would nonetheless be significant.¹¹

¹⁰ General Accounting Office. 1991. Canadian Health Insurance: Lessons for the United States. Washington, D.C. (June).

¹¹ See Gauthier, A. et al. 1992. Administrative Costs in the U.S. Health Care System: The Problem or the Solution? Inquiry 29 (Fall).

What Would be the Impact of a Single Payer System on Health Care Costs in Alaska?

An analysis of the cost of moving to a single payer health care financing system that provides coverage to all Alaskans is presented in Table 4-3. This analysis assumes that a single payer system providing universal access is implemented in 1995, one year after the beginning of the phase-in of the expenditure limits. To the projections of health care expenditures in Alaska under a system with expenditure limits (see Table 4-1 in Recommendation #1) are added the following:

- The marginal costs associated with providing health care coverage to Alaska's currently uninsured population. These costs are based upon analyses which indicate that per capita health care costs for insured individuals are approximately 40 percent higher than for persons without health care coverage.¹²
- Anticipated administrative savings associated with a single payer system, which is based on a low-end estimate of 4 percent savings of total expenditures.¹³

As can be seen from Table 4-3, the administrative savings associated with the single payer system are estimated to exceed the anticipated marginal cost of covering Alaska's uninsured population. As a result, cumulative expenditures under this alternative scenario for the period 1991 to 2003 total \$34.9 billion (see column 14). This figure is significantly less than the cumulative cost of \$42.1 billion for maintaining the current system without expenditure limits or universal access, which is presented as Alternative A in Table 4-3. It is also less than the estimated \$35.55 billion in cumulative health care spending under a system under in which there are expenditure limits, but neither universal access nor a single payer system (see Table 4-1, Alternative B, column 14).

The savings in administrative costs that result from a single payer system would be enough to provide coverage to all uninsured Alaskans.

How Could a Single Payer System be Financed?

As the analysis presented above illustrates, the difficulty in restructuring our current health care financing system to one that is more equitable, efficient, and rational is not that it will cost more money. Rather, the problems are due to the fact that the public may have certain misconceptions about a single payer system, it may not be aware of the savings that could accrue from moving to such a system, and the

¹² Needleman, J. et al. 1990. The Health Care Financing System and the Uninsured. Submitted to the Office of Research, Health Care Financing Administration, DHSS (April 4).

¹³ For a fuller discussion of alternative estimates of administrative cost savings associated with a single payer system, see Gauthier et al. 1992.

Table 4-3
A COMPARISON OF PROJECTED HEALTH CARE EXPENDITURES IN ALASKA
UNDER THE CURRENT SYSTEM AND A SINGLE PAYER SYSTEM WITH EXPENDITURE LIMITS, 1991 - 2003
(In Billions of \$)

	(1) 1991	(2) 1992	(3) 1993	(4) 1994	(5) 1995	(6) 1996	(7) 1997	(8) 1998	(9) 1999	(10) 2000	(11) 2001	(12) 2002	(13) 2003	(14) CUMULATIVE
ALTERNATIVE A: Current System														
Baseline/Prior Year Expenditures	\$1.598	\$1.598	\$1.787	\$1.983	\$2.202	\$2.446	\$2.712	\$3.008	\$3.339	\$3.706	\$4.117	\$4.559	\$5.051	
1. Increase Due to Population Growth		\$0.053	\$0.043	\$0.048	\$0.053	\$0.057	\$0.064	\$0.071	\$0.080	\$0.090	\$0.086	\$0.096	\$0.108	
2. Increase Due to Aging of Population		\$0.004	\$0.006	\$0.008	\$0.009	\$0.009	\$0.010	\$0.011	\$0.013	\$0.015	\$0.019	\$0.022	\$0.025	
3. Increase Due to Other Factors @ 8.0%		\$0.132	\$0.147	\$0.163	\$0.181	\$0.201	\$0.223	\$0.247	\$0.275	\$0.305	\$0.338	\$0.374	\$0.415	
TOTAL: Projected Net Cost/Current System	\$1.598	\$1.787	\$1.983	\$2.202	\$2.446	\$2.712	\$3.008	\$3.339	\$3.706	\$4.117	\$4.559	\$5.051	\$5.599	\$42.107
ALTERNATIVE C: Single Payer System w/Expenditure Limits														
Baseline/Prior Year Expenditures	\$1.598	\$1.598	\$1.787	\$1.983	\$2.175	\$2.352	\$2.505	\$2.666	\$2.836	\$3.016	\$3.207	\$3.397	\$3.598	
1. Increase Due to Population Growth		\$0.053	\$0.043	\$0.048	\$0.052	\$0.054	\$0.059	\$0.063	\$0.068	\$0.073	\$0.067	\$0.072	\$0.077	
2. Increase Due to Aging of Population		\$0.004	\$0.006	\$0.008	\$0.009	\$0.008	\$0.009	\$0.010	\$0.011	\$0.012	\$0.015	\$0.016	\$0.018	
3. Increase Due to Other Factors under Expenditure Limits		\$0.132	\$0.147	\$0.136	\$0.119	\$0.097	\$0.103	\$0.110	\$0.117	\$0.124	\$0.132	\$0.139	\$0.148	
Savings Due to Expenditure Limits				(\$0.027)	(\$0.090)	(\$0.201)	(\$0.333)	(\$0.490)	(\$0.674)	(\$0.891)	(\$1.139)	(\$1.427)	(\$1.759)	
4. Additional Costs of Universal Access					\$0.094	\$0.098	\$0.102	\$0.106	\$0.110	\$0.114	\$0.119	\$0.124	\$0.128	
5. Administrative Savings of Single Payer System					(\$0.098)	(\$0.104)	(\$0.111)	(\$0.118)	(\$0.126)	(\$0.134)	(\$0.142)	(\$0.150)	(\$0.159)	
TOTAL: Net Cost of Single Payer System	\$1.598	\$1.787	\$1.983	\$2.175	\$2.352	\$2.505	\$2.666	\$2.836	\$3.016	\$3.207	\$3.397	\$3.598	\$3.810	\$34.928
ADDITIONAL COST (SAVINGS) OF SINGLE PAYER SYSTEM WITH EXPENDITURE LIMITS	\$0.000	\$0.000	\$0.000	(\$0.027)	(\$0.094)	(\$0.208)	(\$0.343)	(\$0.502)	(\$0.690)	(\$0.910)	(\$1.162)	(\$1.453)	(\$1.789)	(\$7.178)

fact that there would be major shifts in the distribution of responsibility for the financing of health care.

For example, with respect to this latter issue, the establishment of a non-employment-based single payer financing system would relieve both private and public employers--including private businesses, school districts, municipal governments, etc.--of the significant costs that most currently incur in providing employee health benefits. At the same time, however, it would require the identification of new sources of revenues to replace these expenditures. In addition, under a single payer system, other sources of health care dollars currently financing care in Alaska, such as Medicare, federal Medicaid funds, IHS, VA, etc., would continue to come into the state on a block grant-like basis but would go into a Statewide Universal Access Fund rather than be used to support individual facilities or finance care for specific program recipients.

The Task Force realizes that federal waivers will be required to integrate these federal health care funding streams into a single payer financing system. We also recognize that bringing these different programs into a single payer system must be done carefully and sensitively. For example, the Task Force recommends that the newly created Alaska Health Care Authority negotiate with Alaska Natives and the federal government to bring the IHS/tribal health care system within the single payer system. These negotiations will require changes to federal law and must recognize and address the following issues:

- Recommendations for change which affect the IHS/tribal health care delivery system in Alaska must recognize and support the federal trust responsibility to provide health care to Alaska Natives.
- Recommendations for universal coverage must provide the same rights for Alaska Natives as for all other Alaskans and must support at least the level of care currently available to Alaska Natives.
- Recommendations for cost control should capture and, if possible, enhance the direct federal appropriations currently going to the Alaska Area Native Health Service.
- Other issues regarding copayments and deductibles (prohibited by law in the IHS system), native preference in employment, etc. must be addressed.

As discussed above, employment-based and individually purchased health care coverage would be eliminated under a single payer system. Table 4-4 uses the estimates of 1991 health care spending in Alaska originally presented in Table 2-1 to estimate the need for new revenue sources to replace these private health insurance payments.

Table 4-4
SOURCES OF HEALTH CARE SPENDING IN ALASKA, 1991
(In Thousands of \$)

<u>SOURCES</u>	<u>ESTIMATED 1991 EXPENDITURES</u>
<u>1. Private Businesses</u>	
■ Insurance premiums	\$121,418
■ Self-insured payments	\$65,379
<u>2. Local Government</u>	
■ Insurance premiums	\$39,906
■ Self-insured payments	\$48,774
■ Local taxes to support hospitals/local spending	\$29,713
<u>3. State Government</u>	
■ Premium contributions for state employees	\$47,929
■ Self-insured payments	\$9,290
■ Medicaid	\$99,602
■ Other health programs	\$161,106
<u>4. Federal Government</u>	
■ Premium contributions for civilian employees	\$35,402
■ Medicare	\$90,000
■ Medicaid	\$114,948
■ IHS/AANHS	\$206,153
■ Veterans' Affairs	\$46,476
■ CHAMPUS and military	\$55,931
■ Other	\$313
<u>5. Workers' Compensation</u>	\$48,089
<u>6. Individual</u>	
■ Premium contributions for employment-based coverage	\$92,024
■ Individual policies and policies through fraternal orgs and auto liability insurance	\$29,458
■ Service-related cost sharing (copayments, deductibles), excess out-of-pocket expenses of uninsured	\$255,602
TOTAL, ALL EXPENDITURES:	\$1,597,513
TOTAL, EXPENDITURES IN SHADED AREAS:	\$537,668

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

If a single payer system had been put in place in 1991, the sources of health care spending that would not have been available are identified in the shaded boxes in Table 4-4. Expenditures for employment-based and non-group coverage, including the premium contributions made by businesses and individuals, are estimated to total \$489.6 million. If workers' compensation health care payments were included under the single payer system, which would eliminate this cost to employers, the total is \$537.7 million.

While the Task Force is not recommending a specific revenue source to replace these dollars, it recognizes that funds could come from a number of existing sources. These include:

- Payroll taxes;
- Income taxes;
- Sales taxes;
- Excise taxes; and
- Permanent Fund earnings.

Table 4-5 provides estimates of the amount of 1991 revenues that theoretically could have been available from a number of these different sources. As can be seen from this table, certain of these potential revenue sources, such as sales taxes on specific items or "sin" taxes on cigarettes and alcohol, would not raise revenues sufficient to replace group and non-group insurance premiums. However, several of these revenue sources, such as payroll tax, income tax, or Permanent Fund earnings, either alone or in combination with other revenue sources, could replace current premium contributions.

It should again be emphasized that these new revenue sources would not represent additional spending on health care, but would instead replace existing expenditures being made by Alaskan employers and individuals. For example, because employers would no longer have to make health care contributions on behalf of their workers and their dependents, it is expected that these savings would be passed on to the Alaskan workers in the form of higher wages, which in turn might be subject to a new payroll or income tax. It is this understanding of the need to redistribute, rather than increase, spending under a single payer system that must be communicated to the public if this model of universal access is to be accepted.

Table 4-5
POSSIBLE SOURCES OF REVENUES TO REPLACE
GROUP AND NON-GROUP HEALTH PREMIUMS/BENEFITS

A. PAYROLL TAX

(Based upon 1991 Non-agricultural Payroll of \$7.347 billion)

@ 3%	\$ 220 million
@ 5%	\$ 367 million
@ 7%	\$ 514 million
@ 8%	\$ 588 million
@ 9%	\$ 661 million

B. INCOME TAX

(Based upon 1990 Federal Taxable Income)

@ 1%	\$ 66.5 million
@ 3%	\$ 199 million
@ 5%	\$ 332 million
@ 10%	\$ 664 million

C. SALES TAX

1. General Tax on Retail Items

@ 1%	\$ 34 million
@ 6%	\$ 216 million

2. Sales Tax on Hotel and Lodging

@ 1%	\$ 1.9 million
@ 5%	\$ 9.0 million
@ 10%	\$ 18.6 million

D. EXCISE TAXES

1. Cigarette Tax

- Increasing tax per pack by 10¢ would raise about \$4.5 - \$5 million

2. Alcoholic Beverage Tax

- Equaling tax rate on alcoholic beverages: \$4.28 million
- Increasing tax to highest rate in other states: \$8.26 million

E. PERMANENT FUND EARNINGS (7/1/90 - 6/30/91) \$ 1.03 billion

Estimates for C. based upon: Alaska Department of Revenue, Revenue Potential of a General Sales Tax, January, 1989. Revenues from a 6% sales tax estimated by ISER, Fiscal Policy Paper No. 6, April 1991. Estimates for D. based upon: Alaska Department of Revenue, Revenue Alternatives, January, 1989.

PUBLIC HEALTH/SERVICE DELIVERY SYSTEM RECOMMENDATIONS

While the recommendations presented to this point address the problems with the affordability of health care services and problems with health care coverage faced by many Alaskans, as described in Chapter Two, the Task Force also identified significant problems with respect to the availability of needed health care services, particularly in many rural areas in the state, as well as problems associated with the lack of adequate public health interventions and the fragmentation of the existing health care delivery system. To address these problems, the Task Force developed recommendations concerning:

- The retention and recruitment of health care personnel;
- The creation of more flexible licensure standards;
- The expansion of the scope of the State's Certificate of Need program; and
- The strengthening of public health efforts.

The Task Force's recommendations for each of these areas are presented below.

RECOMMENDATION # 9:

The Task Force recommends that the State of Alaska develop initiatives to attract and retain qualified health care professionals in medically underserved areas of the state.

To address the need for qualified health care professionals in many underserved areas of the state, the Task Force recommends the development and implementation of a multi-faceted strategy designed to ensure an adequate supply of appropriately trained health care professionals in the state. Within this overall strategy, the Task Force specifically recommends that:

- The Alaska State Legislature should create a state student loan forgiveness program that provides for forgiveness of a specified loan amount each year for health practitioner service in an area designated as underserved by the Department of Health and Social Services.

- The State of Alaska and Alaska State Legislature should support the development of an Alaska-based family practice residency program. The State should stipulate a condition requiring rotations in rural and underserved areas.
- The State of Alaska and the Alaska State Legislature should support the development and maintenance of Alaska-based training and rotations for mid-level practitioners, nurses, and other health professionals. They should also provide incentives for the development and maintenance of continuing education particularly targeted to professionals that practice in underserved areas. Particular attention should be paid to recruiting local residents, especially Alaska Natives, into health care professions.
- The Task Force supports continued efforts by the State and the Rural Alaska Health Professions Foundation to analyze the specific recruitment and retention problems experienced in Alaska.

RECOMMENDATION # 10:

The Task Force supports the development of more flexible facility licensure standards.

In addition to the development of a statewide strategy for recruiting and retaining qualified health care professionals, the Task Force also believes that flexibility must be incorporated into the State's current facility licensure standards if needed health care resources are to be made available throughout the state in the most appropriate and cost efficient manner. To this end, the Task Force has developed the following specific recommendations:

- The State of Alaska, in conjunction with the provider community, should explore the creation of more flexible facility licensure standards that allow communities to choose from a broader range of levels and types of care. Facility licensure that provides the ability of mid-level clinics to expand their capabilities without becoming hospitals ought to be explored for rural communities, along with study of ways to give communities options to change the role of their existing hospitals or co-located systems. The Task Force wishes to stress that communities need to be given the responsibility for deciding levels of care and that communities that currently have plans for capital improvements to their facilities should not be impacted by this effort. This effort should be undertaken in the near future.

- The State of Alaska should join in national efforts to ensure that public programs, such as Medicare and Medicaid, acknowledge that the cost of delivering care in rural areas is different from the costs in urban areas and should be compensated accordingly.
- The Task Force supports the development of reimbursement systems which create incentives for increasing the number of primary care providers as well as the availability of primary care.
- Because Alaska lacks a primary care clinic system which can assist in meeting the primary health care needs of those who are uninsured or underinsured, the State of Alaska should continue to promote these models of care in their long-range planning and funding and should help communities become aware of federal funding opportunities that promote the availability of primary care.

RECOMMENDATION # 11:

The Task Force recommends the strengthening and expansion of the State's Certificate of Need program.

The Task Force supports strengthening the State's Certificate of Need process. To this end, it recommends that the Department of Health and Social Services be directed to promulgate in regulation standards establishing "need" and the criteria for determining when a Certificate of Need will be awarded. The Task Force also recommends that the requirements for Certificate of Need be extended to all health facilities, including Pioneers' Homes, Veterans Homes, and to expensive medical equipment to be located in any setting. The Task Force further recommends that federal facilities voluntarily comply with Certificate of Need requirements and file impact statements with the Department of Health and Social Services. It is estimated that it will take the Department approximately a year to develop standards once given the authority to do so.

RECOMMENDATION # 12:

The Task Force recommends that adequate resources be devoted to maintaining a strong public health infrastructure in Alaska.

In seeking to broaden access and improve the financing of health care in Alaska, the Task Force is aware that these efforts must be considered in a broader

context that reaffirms the primacy of public health as the cornerstone of community and personal health. Indeed, the twin goals of universal access to health care and containment of costs cannot be achieved without reshaping health care into a rational system based on prevention of disease and violence, promotion of healthful personal habits, and paying for diagnostic and treatment measures only if they are known to be effective. Indeed, the Task Force recognized the importance of prevention, the promotion of healthful lifestyles, and population-based public health services by integrating all of these into our guiding principles (see Chapter Three).

In addition, the Task Force also recognizes that clean air, clean land, clean water, and clean food are basic to good health. It is the responsibility of government to assure these basics exist and to engage as well in other core public health functions, such as the collection and analysis of vital data, the formulation of public health policy, and assuring the availability of essential health services to address problems such as infant mortality, drug and alcohol abuse, suicide, and domestic violence.

Because adequate public health services are paramount to the cost-effectiveness and efficiency of a reformed personal health care system, the Task Force strongly recommends that sufficient resources be devoted to maintaining a strong public health infrastructure in Alaska.

MEDICAL LIABILITY RECOMMENDATIONS

The Task Force developed several recommendations in an effort to address the problems identified in Chapter Two with the existing process for handling medical liability claims. These recommendations are described below.

RECOMMENDATION # 13:

The Task Force recommends reducing the statute of limitations for birth-related injuries from current law to the eighth birthday of the child.

Under the State of Alaska's current statute of limitations, malpractice cases involving injury to children can be filed up to two years after the age of nineteen. However, the Task Force has been informed that virtually all residua from birth or early-life injury or illness are obvious by the time a child is in school, and that subtle learning defects appearing after roughly age eight are almost always genetic. Nonetheless, "tail" insurance to protect against claims filed many years after the fact,

including those involving injuries to infants and children, is very expensive. Given these findings, the Task Force, in an effort to make obstetrical and pediatric care more available and affordable in Alaska, supports a change in the statute of limitations for medical malpractice claims, reducing it for birth-related injuries to the eighth birthday of the child.

RECOMMENDATION # 14:

The Task Force recommends that the State's existing pre-trial screening process for medical malpractice suits be replaced with a court ordered non-binding arbitration process.

The Task Force believes that because medical malpractice litigation is so cumbersome, costly, and unpredictable, alternative ways of resolving claims of injury by medical care that are quicker, fairer, and less disruptive are needed.

Several types of "alternative dispute resolution" (ADR) systems are currently being proposed or tested across the nation. Some are "no-fault" systems which, like workers' compensation laws, require only that the cause of injury be proved, not whether negligent care occurred. Another approach, called "accelerated compensation events," would pay awards for pre-selected, ordinarily avoidable poor outcomes without determination of cause or fault.

Another approach, arbitration, is frequently used to settle contractual disputes but has been used only infrequently in medical malpractice cases. Recently, however, its application to this area of litigation has received increased attention.

Arbitration can take various forms. Some states, including Alaska, have statutes allowing providers and patients to enter into binding arbitration agreements. However, as in the case of Alaska, overly restrictive statutory provisions--such as those that preclude providers from requiring patients to enter into agreements to arbitrate as a condition of care, that allow the unilateral revocation by the patient of the agreement to arbitrate, or that add the cumbersome requirement of having a panel of three arbitrators--have limited the use of this ADR process. Many proponents of arbitration propose eliminating such obstacles in order to provide broad flexibility to voluntary binding arbitration. Others suggest that non-binding arbitration be ordered by the courts every time a lawsuit is filed as a way to get quicker and more consistent resolution of medical malpractice lawsuits. It is not known whether mandatory non-binding arbitration will reduce overall costs associated with malpractice claims.

The Task Force recommends that a mandatory, court-ordered non-binding arbitration process be enacted in Alaska for all medical malpractice cases. The

process would entail the submission of all disputes to a neutral arbitrator with known skill in malpractice or other personal injury claims. The arbitrator would be selected from a panel developed by the courts with input from all parties. The arbitrator would conduct a hearing after each affected party had been provided reasonable opportunity (discovery) to investigate the claim. Either party would have the right to reject the arbitrator's decision and proceed to trial.

It is further recommended that the current three-person expert panel review system be replaced by having a single court-appointed physician or other provider serve as a neutral expert as an integral part of the proposed non-binding arbitration process. This expert should be adequately compensated and should have duties and responsibilities similar to those currently given to the expert advisory panel under AS 09.55.536, but should also be asked to render an opinion as to liability and to answer specific questions posed by the arbitrator.

In addition, the following time limits and requirements should be applied to the arbitration process:

- Parties to the suit will be allowed not more than 120 days from the date upon which the defendant files an answer to the complaint for discovery;
- The arbitration hearing may last no more than three days;
- The arbitrator will produce a decision in writing, admissible at trial, within thirty days;
- The entire arbitration process must be completed within 300 days from the date of filing of the lawsuit.

Lastly, the Task Force recommends that this court-ordered process be installed for an experimental period of five years, and that a study be conducted to assess: (1) litigant satisfaction with the process; (2) disposition rates to ensure that the process leads to timely resolution of claims; and (3) costs to litigants.

RECOMMENDATION # 15:

The Task Force recommends that the Legislature adjust the level of pre-judgement interest charged in medical malpractice cases from 10.5% to the prevailing interest rate.

As its final recommendation in the area of medical malpractice, the Task Force suggests that the Alaska State Legislature examine the reasonableness of the current

statutory requirement for the payment of pre-judgment interest in malpractice cases at the set annual rate of 10.5 percent (see Finding #13). The Task Force believes that a more reasonable approach to determining the pre-judgment interest rate would be to follow the federal courts in using the prevailing rate of yield of short-term U.S. Treasury bills.

C. IMPLEMENTATION TIMETABLE

The Task Force strongly encourages the Alaska State Legislature's prompt enactment of all of the recommendations presented in this chapter. The timetable for actual implementation of these recommendations is presented in Table 4-6 on the following page. As shown on this table, the Task Force also calls for immediate implementation of nearly all its recommendations following passage of the required legislation. The only exceptions to this are the following:

- Several steps will be involved in the implementation of the statewide health care expenditure limits. First and foremost will be the establishment of the Alaska Health Care Authority, which will have responsibility for implementing these limits. Assuming that legislation is enacted and the Authority established in the first half of 1993, during its first year of operation the Authority's activities will be focused on collecting the necessary data to establish the initial expenditure limits and obtaining the necessary federal waivers to ensure that payments made under federal programs to Alaska health care providers are consistent with those established through the Authority's negotiation process. Following this initial data collection period, the expenditure limits would be phased in over a three-year period, beginning in 1994 and ending in 1996. The statewide expenditure limits would be in full effect beginning in 1997.
- All but one of the Task Force's interim short term recommendations for improving access should be implemented immediately. For example, as indicated in Table 4-6, small group market reform would be implemented in 1993. However, as discussed earlier, the Task Force calls for the use of community rating in the small group market to be phased in over a three to five period. The small group market reforms would provide the basis for moving to the community ratings, with the rating bands established as part of this reform gradually tightened from 1994 through 1996 until the desired community rates are achieved.
- Finally, as discussed earlier, the Task Force strongly believes that a single payer financing system is the most appropriate model for providing coverage to all Alaskans. We recognize however, that while it is hoped that a single payer system will be enacted by the Alaska State Legislature in 1993, the possibility exists that further public education and

Table 4-6
Timetable for Implementation of Task Force Recommendations

<u>RECOMMENDATION</u>	<u>TIMEFRAME</u>
1. Establish Alaska Health Care Authority	Immediate
2. Establish Statewide Expenditure Limits	
▪ Collect/analyze data to establish initial limits	1993
▪ Obtain necessary federal waivers	1993
▪ Phase-in expenditure limits	1994 - 1996
▪ Expenditure limits in full effect	1997
3. Expand State's authority to approve/disapprove insurer rate filings	Immediate
4. Small market insurance reform	1993
5. Phase-in community rating in small group market	1994 - 1996
6. Establish State-sponsored health insurance pooling arrangements	1993
7. Establish program to cover low-income uninsured children and pregnant women	1993
8. Establish a single payer health care financing system	
▪ Conduct program of public education/dialogue on issue	1993 - 1994
▪ Negotiate and obtain necessary federal waivers to bring all payers into the system	1993 - 1994
▪ Implement single payer financing system	1995
9. Develop initiatives to attract and retain health professions in underserved areas	1993
10. Develop more flexible licensure standards	1993
11. Strengthen/expand Certificate of Need program	1993
12. Devote adequate resources to maintain a strong public health infrastructure	1993 onward
13. Reduce the statute of limitations for medical malpractice claims for birth-related injuries	1993
14. Replace existing pre-trial screening process with court ordered non-binding arbitration on a demonstration basis	1993 - 1998
15. Adjust the level of pre-judgement interest charged to the prevailing interest rate	1993

community-based dialogue will be required to generate the public support necessary for passage of this legislation. For this reason, the timetable presented in Table 4-6 calls for the conduct of a broad-based public education program designed to increase community awareness and discussion about the benefits of the single payer system. During the same time period, the Alaska Health Care Authority should be charged with the responsibility for developing detailed specifications for the single payer system, and engaging in discussions and negotiations with the federal government and representatives of the Alaska Native population to secure their participation in the system. Legislation should also be enacted authorizing the AHCA to submit requests for the federal waivers necessary to implement a single payer system.¹⁴ Based upon this timeframe, implementation of a single payer financing system in the state would begin in 1995.

With respect to the public education efforts directed at increasing Alaskans' awareness of the benefits of a single payer system, the Task Force recognizes that our authorization expires on February 1, 1993. Because we believe these public education efforts may be critically important to the successful establishment of the single payer system, we are extremely concerned that there be a single entity assigned responsibility for coordinating these education and outreach efforts and given sufficient resources to do so. We therefore strongly recommend that the legislation establishing the Alaska Health Care Authority also charge the Authority with the responsibility for coordinating efforts to increase the public's understanding and awareness of the benefits of a single payer system.

¹⁴ The Task Force recognizes that prior to the establishment of such a program in Alaska, legislation designed to provide universal coverage for all Americans may be enacted at the national level. If the approach to achieving universal coverage embodied in the federal statute is not a single payer model (i.e., it involves an employer mandate or a "pay or play" approach), given the Alaska environment and the problems associated with linking health care coverage and employment, the Task Force further urges that the Legislature authorize the Authority to request the necessary federal waivers to implement a single payer system in lieu of any other approaches that might be embodied in the federal statute.

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Appendix D: Memo to Members, Alaska Health Resources and Access Task Force, Regarding Additional Information, from Larry Bartlett, Health Systems Research, Inc., February 11, 1992.

Appendix E: Worksheet: Computations of Actual Costs Which Were Shifted to Other Payers to Cover Charity Care, Bad Debt, and Hill Burton Free Care at Alaska's Acute Care Community Hospitals, 1990, by Nancy Cornwell, 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, from Garrey Peska, January 10, 1992.

Appendix F: Public Health in Health Care Reform, Presentation to the Health Resources and Access Task Force, by Peter Nakamura, MD, Alaska Division of Public Health, August 25, 1992.

Appendix G: Presentation to the Public Health/Service Delivery Subcommittee of the Health Resources and Access Task Force on Problems Facing Rural, Under-utilized Hospitals and Alternatives to Closing, by Karen Perdue, September 25, 1992.

Appendix H: Presentation to the Public Health/Service Delivery Subcommittee of the Health Resources and Access Task Force on the Alaska Area Native Health Service Delivery System and Resources/Demographics and Health Status of Alaskan Natives/Future Trends, by David Mather, Dr.P.H., April 25, 1992.

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Appendix J: Letter from J.S. Johnston, NORCAL to Maureen Weeks, Legislative Research Agency, March 11, 1992.

Appendix K: Current Rates for Professional Liability Insurance in Alaska, Provided by Loreen Killian, Medical Indemnity Exchange of California, October 1992, and 1992 Rate Chart, NORCAL Mutual Insurance Company.

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

FINAL REPORT

to

the Governor and Legislature

APPENDIX

January 1993

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

APPENDIX
FINAL REPORT TO THE GOVERNOR AND LEGISLATURE

Health Resources and Access Task Force
January 1993

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APPENDIX A

Legislative Resolve 45

Establishing a Health Resources and Access Task Force

STATE OF ALASKA

THE LEGISLATURE

1991

Source

HCS CSSCR 10(FIN)

Legislative
Resolve No.

45



Establishing a Health Resources and Access Task Force.

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;

APPENDIX B

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

CORRECTION

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

STATE OF ALASKA

THE LEGISLATURE

1991

Source

HCS CSSCR 10(FIN)

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45



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(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;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

APPENDIX B

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

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

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

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

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

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

A. EMPLOYMENT-BASED COVERAGE

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

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

1. Private Insurance Premiums

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

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

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

2. Self-Insured Plan Costs

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

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

B. OTHER PRIVATE INSURANCE

1. Individual Policies, etc.

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

2. Workers' Compensation

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

C. OUT-OF-POCKET

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

D. MEDICARE

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

E. MEDICAID

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

F. OTHER PUBLIC FUNDS

1. Federal

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

2. State

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

3. Local

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

APPENDIX C

"Report to the Health Resources and Access Task Force,

January 1992"

by Oliver Scott Goldsmith, Ph.D.,

University of Alaska

Institute of Social and Economic Research

REPORT OF THE HEALTH RESOURCES AND ACCESS TASK FORCE JANUARY 1992

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

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

SUMMARY

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

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

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

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

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

BACKGROUND

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

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

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

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

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

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

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

Figure I.1

US OCCUPANCY RATES BY SIZE

COMMUNITY HOSPITALS

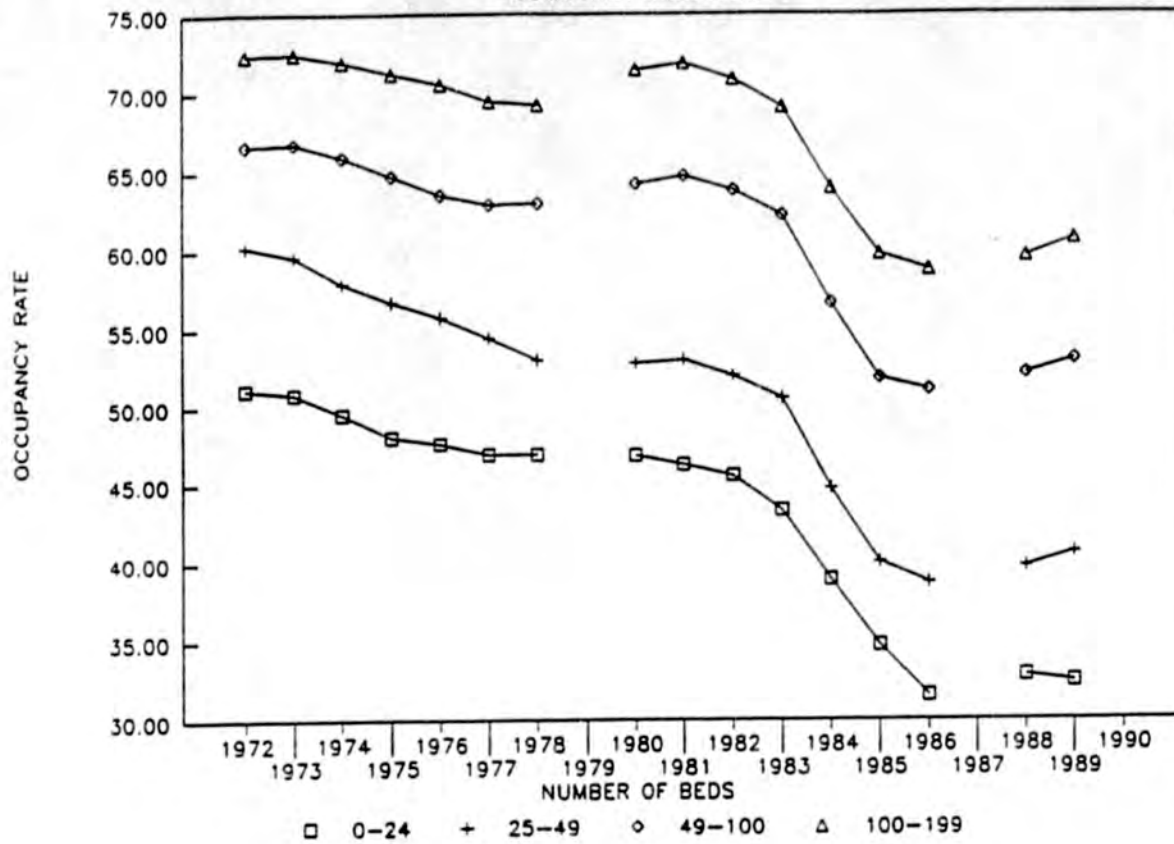
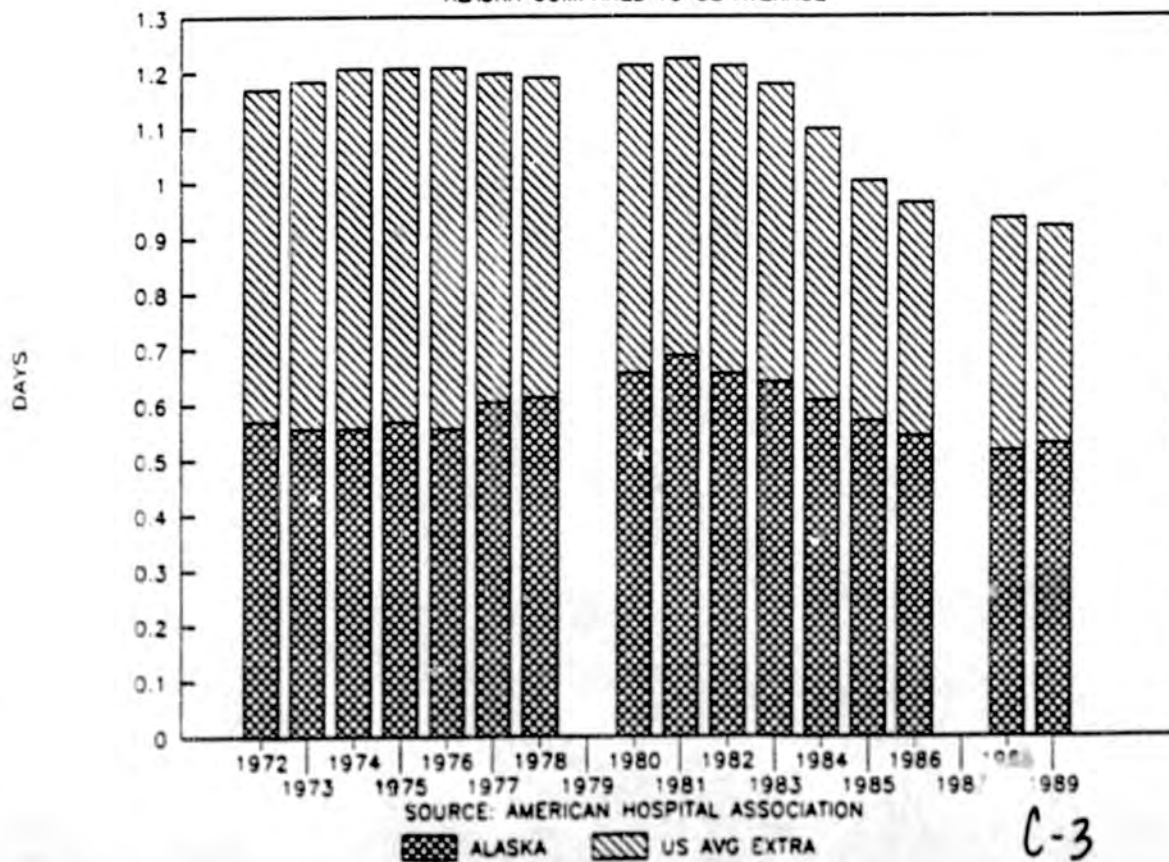


Figure I.2

HOSPITAL INPATIENT DAYS PER CAPITA

ALASKA COMPARED TO US AVERAGE



SOURCE: AMERICAN HOSPITAL ASSOCIATION

■ ALASKA ▨ US AVG EXTRA

Figure I.3

OCCUPANCY RATE BY SIZE OF HOSPITAL

ALASKA COMMUNITY HOSPITALS: ACUTE CARE

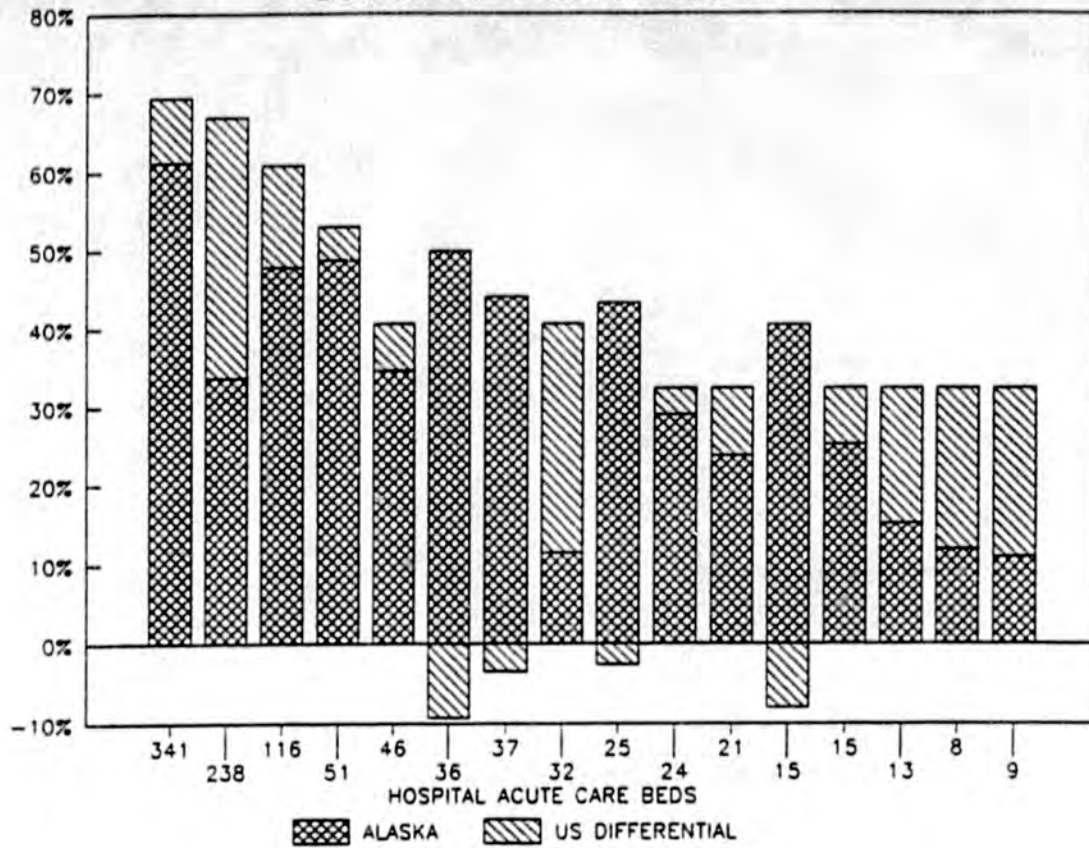
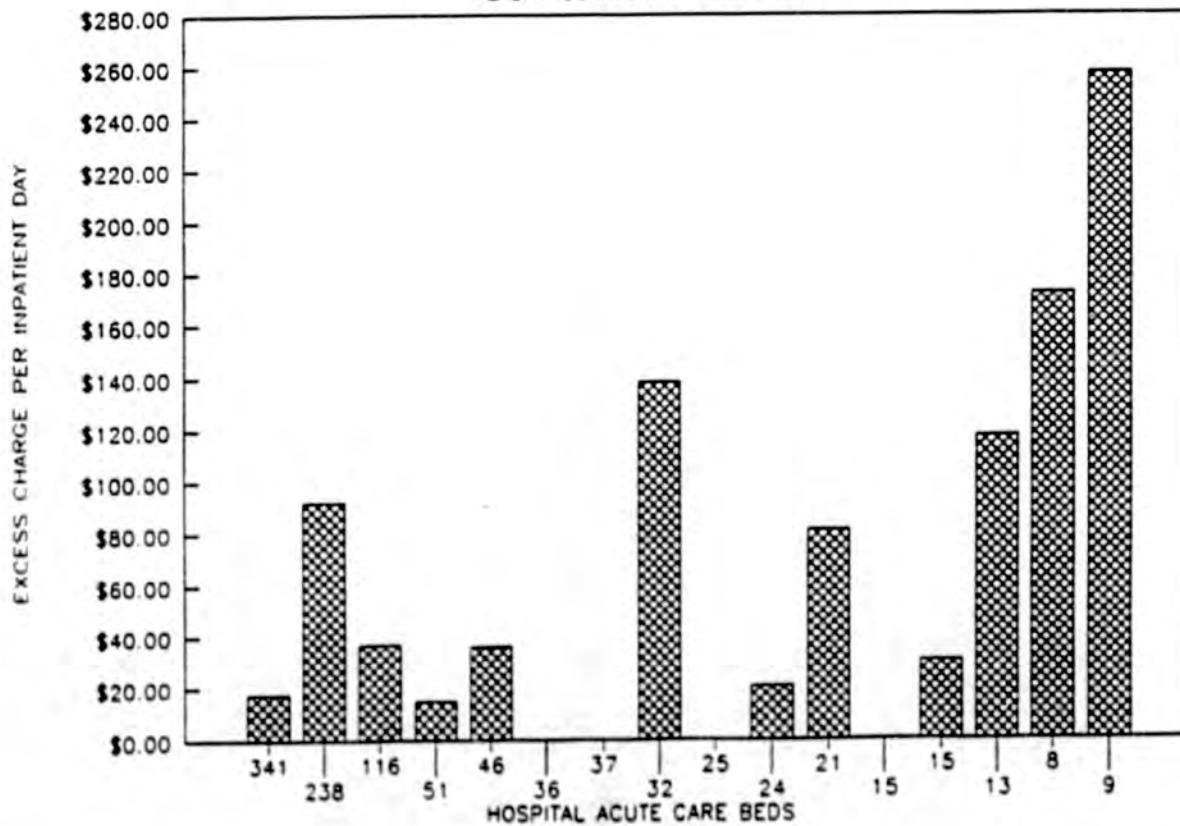


Figure I.4

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