Alaska MUNICIPAL League

TELEPHONES
(907) 586-1325
586-657

204 N. FRANKLIN ST.
JUNEAU, ALASKA 99801

Sectional Analysis - Senate CS for HB 947

Sec. 1. Makes AS 29.23.021 applicable to home rule municipalities.

Sec. 2. Deletes requirement that the number of members of a borough assembly may not exceed 11.

Sec. 3. Deletes reference to AS 29.23.023, which is repealed by Sec. 14 of this bill.

Sec. 4. Prohibits institutional representation.

Sec. 5. Requires assembly to determine if malapportioned; changes time limit from 4 months to 2 months; deletes reference to AS 29.23.023.

Sec. 6. Deletes reference to AS 29.23.023; requires changes in apportionment or composition to be made by ordinance - AS 29.23.025(d) requires voter approval of apportionment and composition ordinances.

Sec. 7. Clarifies wording and requires borough assembly to make a determination if malapportioned if petitioned by 50 registered voters who are residents of the borough.

Sec. 8. Lengthens time limit from 4 months to 6 months to adopt a reapportionment ordinance and clarifies wording about Dept. of C&RA providing for reapportionment.

Sec. 9. New section which provides review by the C&RA Commissioner if petitioned by 50 registered voters who are residents of the borough.

Sec. 10. Technical change in effective date of reapportionment plans.

Sec. 11. Provides for judicial review; makes section applicable to home rule and general law boroughs and to unified municipalities whose assemblies are not elected at large or whose charter does not contain reapportionment provisions.

Sec. 12. Permits reapportionment to change the regular term of office of an assemblyman; permits charter or ordinance to change when the regular term of office begins.

Sec. 13. Clarifies that charters for unified municipalities must contain provisions for reapportionment procedures.

Sec. 14. Repeals AS 29.23.023, which would require special elections on forms of representation, dual-plurality to implement, and extremely tight time limits.

Sec. 15 & 16. Effective date sections.

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204 N. FRANKLIN ST.
JUNEAU, ALASKA 99801

SCS CSHB 947 - Assembly Apportionment and Reapportionment

The borough assembly apportionment and reapportionment provisions of SCS CSHB 947 basically go back to what was in Title 29 prior to the complicated amendments that were adopted last session. In addition, this bill contains three improvements to the prior law:

1. deletes the dual majority provision, which required assembly adopted reapportionment ordinances to be ratified by the voters inside and outside cities;

2. clarifies that weighted voting is not permissable; and

3. clarifies that institutional representation is prohibited, per an attorney general's opinion.

HB
974

(7)

COMMITTEE REPORT

HOUSE

FURTHER: FINANCE

3/26/80

Date: 2 [illegible]

Mr. Speaker:

The Committee on COMMUNITY AND REGIONAL AFFAIRS has had HB 974

"An Act increasing state aid to municipalities for hospitals; and providing for an effective date."

under consideration d (a majority of the committee) (the committee) reports it back with the following recommendations:

[ ] do pass [ ] do not pass

[ ] do pass with attached amendments(s)

[ ] replace with CS for [illegible] [ ] same title [ ] new title

and recommends [illegible]

[ ] AND attaches a "Letter of Intent" [ ] New Fiscal Note

[ ] reports it back without recommendation

[ ] referred to the _____ Committee

MEMBERS SIGNING
DO PASS

MEMBERS HAVING
OTHER RECOMMENDATIONS:

[illegible]

[illegible]

CHAIRMAN

I 60 (Rev. 12/78)

My name is Edward Zeine. I am the administrator at Cordova Community Hospital, and am representing Alaska State Hospital Association. It is an honor and a privilege to REPRESENT THE ASSOCIATION AND testify before this committee on behalf of the House Bill 974. TESTIMONY IN 4 PARTS 1- JUSTIFICATION FOR SMALL HOSPITALS 2- COST INCREASE DATA 3- HOSPITAL COST CONTAINMENT 4- SPECIFIC ON CORDOVA

Rural hospitals in Alaska provide a service to the community that cannot be provided by any other means. Members of the community rely upon the hospital to provide them with life saving resources and stabilization of traumatic injuries and acute medicaal conditions that if were not available could mean uncessary loss of life or limbs. ~~In this particular phase of emergency care for acute traumatic physicaal or medical conditions~~ I'm speaking of. Additionally the hospitals provide modern up to date medical care for those less emergent conditions that ~~however~~ still require confienement in a hospital for treatment. The local rural hospital is utilized by citizens in the community for acute medical conditions due primarily to ~~the~~ their EASY ACCESS, THEIR knowledge of the professionalism that nurses and physicians in the community possess and the knowledge that they will receive individual attention. Another most important factor- when a person is recovering from an acute medical or surgical condition is that the person's family and friends are available to provide emotional support that helps lead to a path of recovery. Also the day to day knowledge of the welfare of patient's family, children or loved ones is immediately available ~~and~~ to the patient, ~~can be assured that all is well on the home front~~ THIS KNOWLEDGE contributes to the speedy recovery of the patient.

Those patients and families who desire religious services and assistance are able to have those services and assistance provided by those clergymen or pastors with whom they have had day to day contact. For these reasons and others, I believe soundly justify the existence and access to rural hospitals in Alaska.

It is our experience that the citizens living in ~~the rural towns~~ Alaska strongly support their health care facilities

The small hospital, although a most important factor in providing primary care is experiencing a tremendous increase in costs to the point of pricing itself to a ~~point~~ where the average worker is unable to afford the cost of that care in his community. Most businesses would attempt to increase sales to offset increased costs, however small rural hospitals are dependent on the local population which does not change, therefore utilization of services, or intensity factors does not change rapidly enough to impact upon the inflationary rate.

House Bill 974 would result in lessening the burden of cost of medical care to every citizen utilizing the services of ~~the local~~ hospitals. Examples of the increased costs hospitals are experiencing are as follows: Display Figures

Hospital Boards and Administrators of hospitals have participated in strong cost containment programs. As an example the Alaska State Hospital Association has developed a shared service program specifically where the small hospital joins with larger hospitals in purchasing of supplies. In this shared purchasing program a small hospital is able to purchase small quantities of certain medical supplies at the same cost as larger hospitals due to over all volume of purchases.

The Alaska Hospital Association has esatblished an audio/visual film programs that make educational materials available for boards, nursing services, etc. ~~available to the small hospitals~~ at little or no cost to hospitals.

Other areas of shared services that lessen costs to small hospitals in obtaining modern professional services are circuit riding controller, microfilming of medical records and x-rays and peer review programs.

I would like to assure this committee that the hospitals have taken strong cost containment measures in their individual facilities that ~~will~~

~~although they~~ lessen the total expenditures for operations, ~~which~~ ~~have~~ has had a large impact on containing increased costs because of the advancing inflationary rate.

Many of ~~the~~ our cities are required to grant financial aid to hospitals in order to keep the hospitals financially solvent. This has placed an undue burden on the operating costs of municipalities which can be absorbed only through new taxes to the citizens. The hospitals find themselves between spiraling increased costs and an outcry from the consumer absorbing these increases. Therefore the Alaska State Hospital Association strongly supports separate action by the legislature to increase revenue sharing for hospitals, ~~which~~ we believe ~~will~~ this can be supported by legislators from large cities as well as small communities as we suggest that there would be no opposition to providing support for high level health care to our citizens, ~~as~~ they have provided that support for health care legislation in the past.

~~THANK YOU~~.

A FEW MOMENTS NOW TO TALK SPECIFICALLY ABOUT CORDOVA COMMUNITY HOSPITAL

CITY OF CORDOVA IS SUPPORTING THE HOSPITAL IN ITS ROUTINE OPERATIONAL COSTS TO ABOUT $140,000 THIS FISCAL YEAR.

IN SUMMER, CORDOVA IS A HIGHY TRANSIENT POPULATION - ~~ADD~~ DUE TO CANNERY AND FISHING FLEET. WE EXPERIENCE A LARGE LIST OF UNCOLLECTABLE ACCOUNT FOR MANY TRANSIENTS CANNOT PAY WHEN THEY NEED HEALTH CARE AND WE DO NOT TURN THEM AWAY.

OUR HOSPITAL IS IN OLD BLDG, WE HAVE HAD WIND DAMANGE THIS YEAR WHICH WILL PLACE AN ADDITIONAL ~~$~~ FINANCIAL BURDEN ON THE CITY OF CORDOVA AND THE HOSPITAL OF 30-50 ~~thousand~~ dollars.

MEETING FEDERAL REGULATION FOR CERTIFICATION & LICENSURE OF THE HOSPITAL IS INCREASINGLY COSTLY - APPARENTLY ~~NO~~ MANY ARE UNAWARE THAT A CHANGE OR MODIFICATION OF HOSPITAL ONLY

Subsydize by city over $100,000

Bldg need repair

18 x 125,000 - $2,250 plus.

REQUIREMENTS USUALLY RESULTS IN INCREASED COSTS TO HOSPITAL TO COMPLY.
ALL OF THESE AREA IMPACT UPON THE HOSPITAL OPERATING BUDGET.
THE ONLY WAY HOSPITAL'S CAN GENERATE REVENUE IS TO CHARGE THE PERSON USING THE SERVICE - THAT IS THE PATIENT - EXCEPT FOR THIS REVENUE SHARING WHICH WILL HELP ALL CITIZENS IN ALASKA.
YOUR FAVORABLE PASSING OF THIS LEGISLATION WITH FULL FUNDING WILL BE APPRECIATED.

THANK YOU

Apr. 1, 1980

COMPARABLE COSTS:	78/79	79/80
M I C A	9,425.00 yr	18,027 ~~9,425~~.00yr
F I C A	6.05% gross	6.13% gross
Salary		9% Over base 78/79
Blue Cross -Single	34.96 mo.	36.78 mo.
Married	76.01	79.95
Family	105.97	111.46
Cordova Telephone	10.00 station	18.00 station
Cordova Electric	.054 per 1,000kw	.085 per 1,000kw
Air Freight (to Anchorage)	14.29 Minimum	16.45 minimum
Sea Land	14.47 per 100lb.	16.44 per100 lb/
Sea Land Plus	1% fuel surcharge	5% fuel surcharge
Motel - per night - single	40.00	45.00
double	48.00	54.00
Air Fare -rnd trip Anchorage	64.24	90.72
Copy Machine - paper	38.00 case	52.69 case
Fluid pak	36.30 case	65.00 case
Toilet Tissue	24.54 case	34.66 case
Plastic Can liners	15.83 case	33.95 case
Eggs	33.00 case	36.00 case
Milkman	21.60 case	28.14 case
Bread	20.80 case	23.84 case
Coffee	69.50 case	84.50 case
X-ray film - 500	514.94	565.79
Developer	38.52 case	41.63 case
Fixer	17.82 case	20.84 case
Ace Bandages - 6"	1.18 roll	1.88 roll
A B D Pads - 3"x3"	.04 per pad	.24 per pad
Penicillin - 500mg Tabs.	.18 tablet	.19 tablet
Teramyicin - 250mg Tabs.	.18 tablet	.22 tablet

FUEL COST - FEB 79 = .493 — FEB 80 = .866 - almost doubled -

ELECTRICITY - 18% INCREASE DUE TO FUEL ESCALATION.

4/23/80 **MEMORANDUM**

TO: Mike Doogan, John Crandahl
FROM: Marjorie Gorsuch, AA Rep. Parker
RE: CSHB 974

I don't know if you reviewed CSHB 974 (increasing state aid to municipalities for hospitals) in conjunction with your action on HB 192 although I note that the figures in Finance versionsof CSHB 192 do not reflect the changed amounts--but here is the fiscal note for CSHB974--it wasn't ready when the bill was passed out of our Committee.

LAA 15

HOUSE COMMUNITY AND REGIONAL AFFAIRS 4/17/80

TO: Lynn Wagener
FROM: Marjorie Gorsuch
RE: Fiscal Note

Attached for your review and for a fiscal note is CSHB 974 which has been signed out of committee. Please note the changed figure on line 16 (as compared with the HB 974) and the new section beginning on pagl line 20.

LAA 15

TO: Debi Behr
FROM: Marjorie Gorsuch
RE: Fiscal Note

Attached for your review and for a fiscal note is CSHB 974 which has been signed out of committee. Please note the changed figure on p. 1 line 16 (as compared with HB 974) and the new section beginning on page 1 line 20.

COMMITTEE MINUTES

Alaska State Legislature

House of Representatives

Committee on Community & Regional Affairs

Pouch V
State Capitol
Juneau, Alaska 99811

Official Business

BILL NUMBER AND TITLE: HB 974 Increasing State Aid to Municipalities for Hospitals

ORIGINAL SPONSOR: Branson
RECEIVED FROM:

OTHER SPONSORS:
FURTHER REFERRALS: Finance

HEARING DATE: 4/9/80

MEMBERS PRESENT:

Bill Parker	X	Pat Carney	X
Margaret Branson	X	Charlie Parr	X
Pat O'Connell		Fred Zharoff	X
		Ray Metcalfe	

Portia Kauffmann, Administrator of Health and Social Licensing, HESS
Reviews licensed bed and construction figures with committee as contained on information sheets prepared by the Dept. Question of confidentiality raised and method of dealing with issue, as recommended by the Attorney General discussed--that of using numbers to identify hospitals and income/expenditure categories.

Parr - Hospitals receiving state money should have information available. It's about time that a "freedom of information" act be passed.
Are long term care beds included in HB 974? (Yes)
Discussion of economy of scale would be helpful. Occupancy rate is the important factor. High vacany rate in the small hospitals. 60%-70% utilization necessary to break even.

Lowell Swartz, Coordinator of Health Facilities Development, HESS
Researched why small hospitals get more funding that large. A flat rate rather than per bed amount was used as small hospitals with 10 beds couldn't function with $10,000. Choice of 10 was arbitary. The rate has been raised over the years.

Doug Goldback, Finance Officer, HESS
Discussion of revenue figures contained in HESS informational material. Operating expense statements are not required to be turned in. There is already statutorial authority for funding hospital construction independent of the revenue sharing program. Remodeling money is also included in this.

Palmer McCarter, Director, Division of Local Government Assistance, C&RA
Explains that passage of HB 975, the funding for HB 974 is not necessary as long as a fiscal note is developed for HB 974 and accompanies the bill. Called attention to the increased fiscal note as the cost of living allowance had been inadvertantly omitted from the fiscal note for HB 975.

Parr - Questions how much money it is reasonable to appropriate? Formula seems arbitrary. Haven't heard any defense for the formula used.

COMMITTEE ACTION:
CSHB974 passed out of Committee.

TAPE #7 SIDE 2 Footage 130-1452

The Committee has received no indication of what they need to save. And no proof of what they need in the way of financial assistance has been offered. Revenue and expense sheets don't show need. They have only received a general statement that small hospitals need more than the large hospitals.

Palmer McCarter- Program shouldn't be within revenue sharing. Needs differ. Not responsibility of Dept. of C&RA to handle; HESS should administer. There should be an attempt to verify hospital construction costs. Over 25 % of program monies go to hospital construction. Whole review of operational and construction aid should be improved. Ak. Medical Facility exists as well. Piecemeal approach exists now to funding.

Parr - Average small hospitals losing $50,000 year. Across the board appraoch bothers him. May be giving one institution gravy (the small hospitals) and hurting another.

Chenoweth, Jack , Legal Research
The need issue should be discussed. General aid for health needs could be addressed. Redevelop a program for state assistance and limit funding to one year (June 30, 1981)to force discussion of alternatives. Departments could be directed to report back.

Parr - Letter of Intent could accompany bill.

Carney - Notes the present division of funding per bed. Suggests that 2 fiscal years might give adequate time for such a study. A logical explanation of the formula should be developed.

Ed Zine, Administrator Cordova Hospital

Support increase. Data is collected by the hospital Ass'n. on and "under 40 bed" "over 40 bed" basis. The average deficit if $50,000 for hospitals. Refers to graph which shows average daily use graphed.

Small hospitals have emergency medical care and it is difficult for small hospitals to economize as reducing staff is difficult. Have to have at least one nurse, cook, etc. even if there is only one patient. Multiple disciplinary teams do exist and are encouraged. Most small hospitals do have such teams as an economy measure. There is a need to give quality care even though a hospital is small.

In Cordova, the use of the budget category "restricted funds" in Cordova is connected to specific donations for a particular purpose.

Carney - The percentage of the increase suggested in the bills is not consistent.

Perry Lovitt, City Manager, Cordova

Comments on need of small hospitals.

Committee concurs in decision to have a study for 1 year; increase figures to $200,000 and $70,000; and direct HESS to conduct a study on general subject of hospital funding in a Committee Substitute.

Alaska State Legislature

House of Representatives

Committee on

Community & Regional Affairs

Pouch V
State Capitol
Juneau, Alaska 99811

Official Business

BILL NUMBER AND TITLE: HB 974 Revenue Sharing/Hospitals

ORIGINAL SPONSOR: Branson
RECEIVED FROM:

OTHER SPONSORS:
FURTHER REFERRALS: Finance

HEARING DATE: 4/2/80

MEMBERS PRESENT:

Bill Parker	X	Pat Carney	X
Margaret Branson	X	Charlie Parr	X
Pat O'Connell	X	Fred Zharoff	X
		Ray Metcalfe	X

Edward Zine, Administrator, Cordova Community Hospital. Testifying on behalf of the Hospital Association.
See copy of testimony attached.

Parr - Asks what % of the cost of care should the local people be paying?

Zine responds with the specifics of the Cordova situation.

Mary Foster, Dept. of Community and Regional Affairs
Dept. has no objection to the bill but sufficient funds need to be appropriated.
Ms. Foster was questioned on various points including the request for information on how much profit various hospitals make.

Carney - Suggests that the hospitals might be required to do cost accounting so that costs aren't passed along to the consumer.

Parr - Asks how much of the cost is borne by the patient and says that this is the point at issue. How muchis borne b the taxpayers from the general fund? Sees no justification for the existing formula or for the proposed change. No one seems to know why the formula is in its present form. Economy of scale needs to be looked at.

Lowell Swartz, Coordinator of Health Facilities Development, HESS
Recalls the rationale for the formula being that the larger the hospital, the more costly it would be to operate.

Zine - States that it is the opportunity for hospitals to increase utilization which allows them to increase revenues. Smaller communities don't have intensity factor. Cost of operation is therefore effected and lower in a large community.

COMMITTEE ACTION: Committee determines that additional information is necessary to act on bill including: *utilization figures; comparative costs; rate charged per day and amount of profit

No Action

TAPE # 6 SIDE 2 Footage 373-1736

Alaska State Legislature

House of Representatives

Committee on

Community & Regional Affairs

Official Business

Pouch V
State Capitol
Juneau, Alaska 99811

BILL WORK SHEET

BILL NUMBER HB 975 RE Appropriation DC&RA Grants for Hospitals

Received from ______________ Fical Note ______________
Referred to ______________ LAA Legal Contact ______________

CONTACTS:

Sponsor: House C&RA (Branson) Contacted 4/4 Hearing

✓ Ak. State Hospital Assn.
Max Kershieger
Ex Director
277-1633

Certificates of Need authorized for Sitka + Soldotna

Ed Zeni, Cordova Hospital

Jack Radkin? Juneau

✓ Jim Burns - Bartlett Memorial Hospital, Admin

Catagorize by size - Alternative proposal
$170,000
$200,000
$225,000

10 hospital 30 beds under
3 40-100 bed Ketch, Kodiak, Juneau
3 Over 100 Ak Providence, Fbks.

✓ Murray Foster

✓ Mimi Reynolds

✓ Lowell Smith - Coordinator Health Facility Development (3015) 2455

WO#8309
Cook

Original sponsor: Community and Regional Affairs Committee

IN THE HOUSE

BY THE COMMUNITY AND REGIONAL AFFAIRS COMMITTEE

CS FOR HOUSE BILL NO. 974

IN THE LEGISLATURE OF THE STATE OF ALASKA

ELEVENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to state aid for hospitals; and providing for an effective date."

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

* Section 1. Notwithstanding AS 43.18.010(h)(2)(A), during the fiscal year ending June 30, 1981, the Department of Community and Regional Affairs shall make payments under AS 43.18.010(h)(2) to a municipality which has the power to provide hospital facilities and services and which exercises the power on the basis of $1,000 per bed for each bed actually used for patient care limited to the number of beds provided for in the construction design of the hospital or $200,000 a hospital for those hospitals with 10 or more beds, or $70,000 a hospital for those hospitals with less than 10 beds, as the municipality may elect. Amounts received under this section may be used only for hospitals and shall be apportioned among qualifying hospitals as the municipality determines.

* Sec. 2. (a) The Department of Health and Social Services and the Department of Community and Regional Affairs shall jointly examine and report their recommendations on the extent to which the state should assist municipalities, nonprofit corporations, and others in the construction and operation of hospitals and health facilities.

(b) By February 1, 1981, the commissioner of health and social services shall submit to the legislature a report, accompanied by draft legislation, examining programs of state aid for hospital and health facility construction and operation, including both public and private facilities, and recommending a comprehensive health and hospital financial assistance program. The report

and accompanying legislation shall be based on health care and health facility need, expressed as a function of number of beds, occupancy rate of facilities, kinds of care and levels of service provided or not provided, or any other factors which the commissioner of health and social services reasonably believes should be the basis by which state assistance for hospitals and health facilities and their programs should be provided.

(c) The report and accompanying legislation presented under (b) of this section shall

(1) include, if necessary, reference to certificates of need legislation and any other current program of the federal or state government which applies in determining whether hospitals and health care facilities shall be constructed;

(2) recommend a permanent program of state assistance to municipalities for hospital care and health care services, whether provided by public or private facilities, which improves the level of care for the people of the state.

* Sec. 3. This Act takes effect July 1, 1980.

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST

Bill/Resolution No. CSHB No. 974

Title An Act increasing State aid to municipalities for hospitals

Requested by House Community & Regional Affairs Date 4/22/80

II. FISCAL DETAIL

Agency Affected Community & Regional Affairs

Program Category Affected Development

BRU, Program, or Subprogram(s) Affected Local Government Assistance-Grants

(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		1805.7	1805.7	1805.7	1805.7	1805.7
TOTAL		1805.7	1805.7	1805.7	1805.7	1805.7

FUNDING (Thousands of Dollars)

GENERAL FUND		1805.7	1805.7	1805.7	1805.7	1805.7
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		0	0	0	0	0
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

See attached fiscal note for HB No. 974. There would be no change in the additional funding required. Currently there are no municipalities in the program who have elected the less than 10 beds rate of entitlement.

IV. DATE 4/22/80 PREPARED BY Netta Crago

AGENCY Community & Regional Affairs

PHONE 465-4733

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. HB 974
Title An Act increasing State aid to municipalities for hospitals
Requested by C&RA Committee Date 4-4-80

II. FISCAL DETAIL
Agency Affected Community & Regional Affairs
Program Category Affected Development
BRU, Program, or Subprogram(s) Affected Local Government Assistance - Grants
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		1805.7	1805.7	1805.7	1805.7	1805.7
TOTAL						

FUNDING (Thousands of Dollars)

GENERAL FUND		1805.7	1805.7	1805.7	1805.7	1805.7
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		0	0	0	0	0
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

The additional cost of increasing the hospital's category to $200,000 per hospital with 10 or more beds, or $60,000 with less than 10 beds would be $1,805,690.

Based on $200,000 grants included in this bill and assuming no new hospitals will become eligible.

12 municipalities now receive $75,000 per hospital
($200,000 - $75,000 = $125,000 x 12 = $1,500,000)

Alaska Hospital now receives$175,000
($200,000 - $175,000 = $25,000)

IV. DATE 4-4-80 PREPARED BY Netta Crago
AGENCY Community & Regional Affairs
PHONE 465-4733

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 12/79)

Fairbanks Memorial now receives $155,000
($200,000 - $155,000 = $45,000)

Ketchikan General Hospital now receives $92,000
($200,000 - $92,000 = $108,000)

$1,500,000	
25,000	
45,000	
108,000	
$1,678,000	
127,690	COLA
$1,805,690	TOTAL ADDITIONAL FUNDING REQUIRED

THE LEGISLATURE OF THE STATE OF ALASKA
ELEVENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. CSHB No. 974
Title "An Act relating to state aid for hospitals: and providing for an effective date."
Requested by Community and Regional Affairs Committee Date 4-25-80

II. FISCAL DETAIL
Agency Affected Department of Health and Social Sevices
Program Category Affected Health
BRU, Program, or Subprogram(s) Affected SHPDA Resource Development
(Note: If more than one budget component is affected, separate line-item amounts and funding for each component in the analysis section.)

EXPENDITURES (Thousands of Dollars)

	FY 80	FY 81	FY 82	FY 83	FY 84	FY 85
100 PERSONAL SERVICES						
200 TRAVEL		9.				
300 CONTRACTUAL		50.				
400 COMMODITIES		1.				
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL		60.				

FUNDING (Thousands of Dollars)

GENERAL FUND		60.				
FEDERAL FUNDS						
OTHER (Specify Fund Source)						

POSITIONS

FULL TIME		0				
PART TIME		0				
TEMPORARY		0				

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

See Attached

Phoebe A Lindsey
Phoebe Lindsey

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

Prepared by: Lowell Swartz Date: 4-25-80
Division/Office: SHPDA PH: 465-3038
Department of Health & Social Services

Approval DHSS Mgt. & Bdgt: [illegible] Date: 4/29/80

33-001 (Rev. 12/79)
Modify by DHSS (11-28-79)

A study to determine the State's role in providing aid/support to Alaska's acute care facilities and how such aid/support should be disbursed should provide important policy and resource allocation direction for the State on this complex issue. Because of the health planning and policy considerations raised, the study should be conducted under the aegis of the DHSS Division of State Health Planning and Development with particular focus on its facilities development section.

With current Division staff limitations and work load commitments this scope of work would be contracted to a qualified research group with capabilities in and a working knowledge of Alaska's health care delivery system, health care economics, capital development in health care facilities, State plans for development as articulated by the Statewide Health Coordinating Council, State regulations and other dimensions. It is anticipated that the scope of work would require approximately $50,000.

To ensure input of affected/interested parties, a task force would be convened to advise the contractor and the Division on the study. The task force would include a hospital administrator, a representative of a third party payor, a consumer, a representative of the State's Medicaid program, a member of the Division's facilities development staff, a Health Systems Agency board member and a member of the Statewide Health Coordinating Council. The task force would meet in Anchorage, the most economical meeting site, at least three times during the study at an approximate cost of $3000 per meeting.

Costs are included to produce a report for select distribution at the conclusion of the study.

TO: Debi Behr
FROM: Marjorie Gorsuch
RE: Fiscal Note

Attached for your review and for a fiscal note is CSHB 974 which has been signed out of committee. Please note the changed figure on p. 1 line 16 (as compared with HB 974) and the new section beginning on page 1 line 20.

Tuesday

LAA 15

TESTIMONY

My name is Edward Zeine. I am the Administrator at Cordova Community Hospital, and I am representing Alaska State Hospital Association. It is an honor and a privilege to represent the Association and testify before this committee on behalf of the House Bill 974. My testimony will be in 4 parts: 1- Justification for small hospitals

2- Cost increase data

3- Hospital cost containment

4- Specifics on Cordova

Rural hospitals in Alaska provide a service to the community that cannot be provided by any other means. Members of the community rely upon the hospital to provide them with life saving resources and stabilization of traumatic injuries and acute medical conditions that if were not available could mean unnecessary loss of life or limb. Additionally the hospitals provide modern up-to-date medical care for those less emergent conditions that still require confinement in a hospital for treatment.

The local rural hospital is utilized by citizens in the community for acute medical conditions due primarily to their easy access, their knowledge of the professionalism that nurses and physicians in the community possess and the knowledge that they will receive individual attention. Another most important factor when a person is recovering from an acute medical or surgical condition is that the person's family and friends are available to provide emotional support that helps lead to a path of recovery. Also the day to day knowledge of the welfare of the patient's family, children or loved ones is immediately available to the patient.

Those patients and families who desire religious services and assistance are able to have those services and assistance provided by those clergymen or pastors with whom they have had day to day contact. For these reasons and others, I believe soundly justify the existence and access to rural hospitals in Alaska.

It is our experience that the citizens living in Alaska strongly support their health care facilities.

The small hospital, although a most important factor in providing primary care is experiencing a tremendous increase in costs to the point of pricing itself to where the average worker is unable to afford the cost of that care in his community. Most businesses would attempt to increase sales to offset increased costs, however small rural hospitals are dependent on the local population which does not change, therefore

utilization of services or intensity factors do not change rapidly enough to impact upon the inflationary rate.

House Bill 974 would result in lessening the burden of cost of medical care to every citizen utilizing the services of hospitals. Examplesof the increased costs hospitals are experiencing are as follows:

item	78/79 cost	79/80 cost
MICA	9,425.00/yr.	18,027.00/yr.
Salaries		9% increase over 78/79
Cordova Telephone	10.00/station	18.00 per station
Cordova Electric	.054 per 1,000 kw	.085 per 1,000 kw
Copy Machine paper	38.00 case	52.69 case
X-ray film - 500	514.94	565.79
Ace Bandages - 6"	1.18 roll	1.88 roll
A B D Pads -3"x3"	.04 per pad	.24 per pad
Fuel Cost	Feb. '79 = 1493	Feb.'80 = .866 (almost doubled)
Electricity - 18% increase due to fuel escalation		

Hospital Boards and Administrators of hospitals have participated in strong cost containment programs. As an example the Alaska State Hospital Association has developed a shared service program specifically where the small hospital joins with larger hospitals in purchasing of supplies. In this shared purchasing program a small hospital is able to purchase small quantities of certain medical supplies at the same cost as larger hospitals due to over all volume of purchases.

The Alaska Hospital Association has established an audio/visual film program that makes educational materials available for Hospital Boards, nursing services, etc. at little or no cost to hospitals.

Other areas of shared services that lessen costs to small hospitals in obtaining modern professional services are circuit riding controller, microfilming of medical records and x-rays and peer review programs.

I would like to assure this committee that the hospitals have taken strong cost containment measures in their individual facilities that lessen the total expenditures for operations, which has had a large impact on containing increased costs because of the advancing inflationary rate.

Many of our cities are required to grant financial aid to hospitals in order to keep the hospitals financially solvent. This has placed an undue burden on the operating costs of municipalities which can be

absorbed only through new taxes to the citizens. The hospitals find themselves between spiraling increased costs and an outcry from the consumers absorbing these increases. Therefore the Alaska State Hospital Association strongly supports separate action by the Legislature to increase revenue sharing for hospitals. We believe this can be supported by legislators from large cities as well as small communities as we suggest that there would be no opposition to providing support for high level health care to our citizens. They have provided that support for health care legislation in the past.

A few moments now to talk specifically about Cordova Community Hospital.

The City of Cordova is supporting the hospital in its routine operational costs to about $140,000 this fiscal year.

In the summer, Cordova is a highly transient population due to cannery and fishing fleet. We experience a large list of uncollectable accounts for many transients cannot pay when they need health care and we do not turn them away.

Our hospital is an old building. We have had wind damage this year which will place an additional financial burden on the city of Cordova and the hospital of 30-50 thousand dollars.

Meeting federal regulations for certification and licensing of the hospital is increasingly costly. Apparently many are unaware that a change or modification of hospital requirements usually results in increased costs to hospitals to comply.

All of these areas impact upon the hospital operational budget.

The only way hospitals can generate revenue is to charge the person using the service - that is the patient- except for this revenue sharing which will help all citizens in Alaska.

Your favorable passing of this legislation with full funding will be appreciated.

Thank you.

* * * ALL HOSPITALS * * *

There are 1459 general hospital beds in 11 federal hospitals and 17 "open to the public" hospitals. The beds are distributed as follows:

FEDERAL	LOCAL GOV'T	PRIVATE
7 USPHS - 381 beds	5 owned/operated - 125 beds	6 - 595 beds
4 Military 202 beds	6 owned/other op. 156 beds	
583 beds	281 beds	
40% of total	19% of total	41% of total

* * * GENERAL PUBLIC HOSPITALS * * *

A further breakdown of the 17 hospitals and 876 beds open to the public show:

(the number in parentheses is nursing home beds)

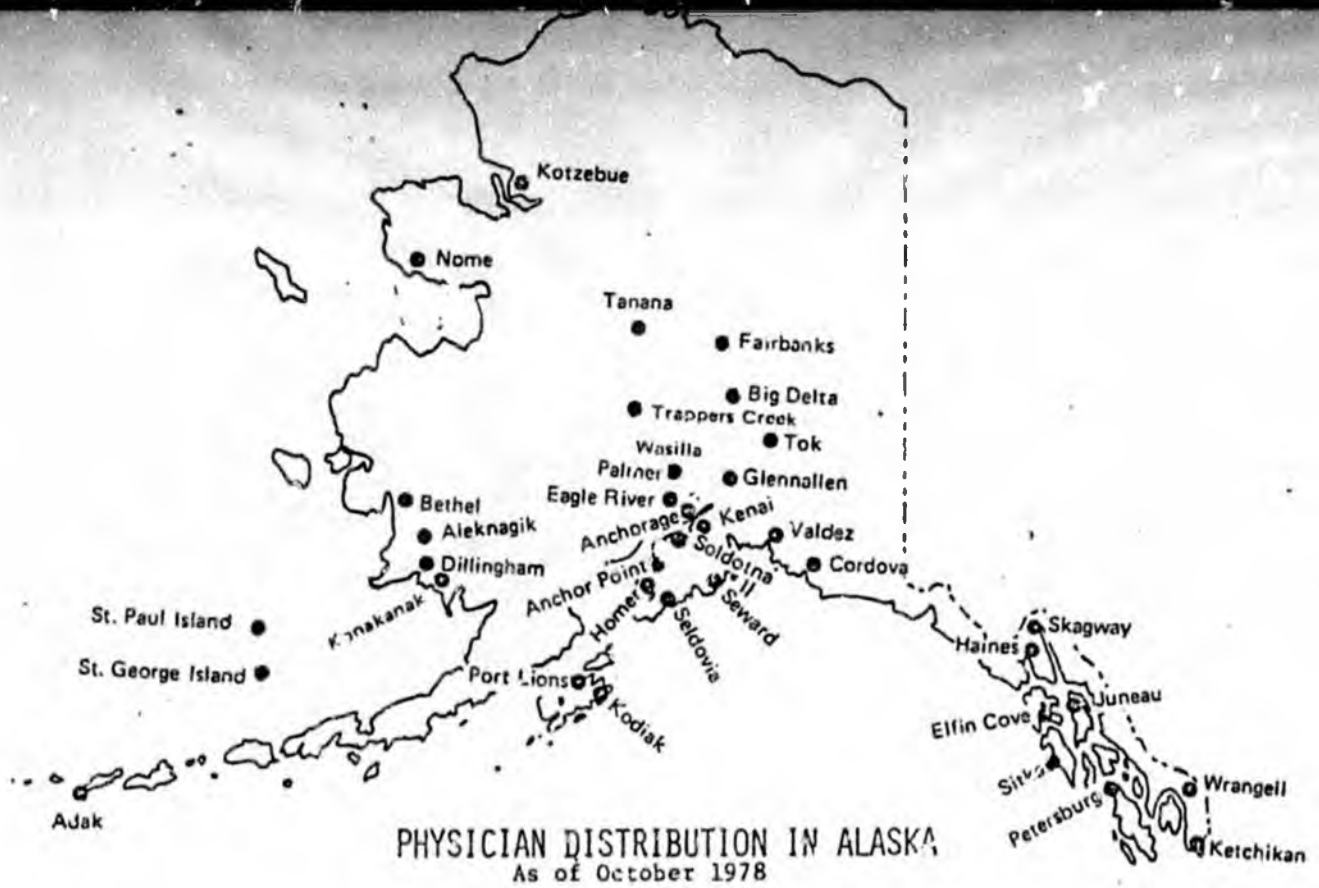
Under 20 beds		20 to 30 beds		31 to 100 beds		Over 100 beds	
Glenallen	6	Sitka	24	Ketchikan	44 (48)	Alaska	154
Wrangell	9 (14)	Kodiak	25(19)	Juneau	67	Fairbanks	155
Cordova	12 (8)	Seward	29		111 (48)	Providence	250
Homer	13 (4)	Soldotna	30				559
Nome	13 (6)		108 (19))				
Petersburg	13 (12)						
Valdez	15						
Palmer	17 (6)						
	98 (50)						
Hospitals	47%		23%		12%		18%
Beds	11%		12%		13%		64%

* * * NURSING HOMES * * *

There are 644 nursing home beds in Alaska. As noted above, there are 8 hospitals with 117 nursing home beds (18% of the total beds). There are 5 "free-standing" nursing homes;

St Ann's	Juneau	45 beds
Wesleyan	Seward	64 beds
Careage	Anchorage	101 beds
Careage N.	Fairbanks	101 beds
Nakoyia	Anchorage	216 beds
		527 beds

The State of Alaska operates 4 Pioneer Homes with 170 beds. There are plans to build in Ketchikan in direct competition with the beds already in existence.



PHYSICIAN DISTRIBUTION IN ALASKA
As of October 1978

Towns	Private Practice	USPHS	Military	Federal	Municipal State	Total
Adak			1			1
Aleknagik	1					1
Anchor Point	1					1
Anchorage	212	55	43	5	13	328
Barrow		3				3
Bethel		8		1		9
Cordova	3					3
Dillingham	1					1
Eagle River	2					2
Elfin Cove	1					1
Fairbanks	76	3	24		3	106
Glennallen	1					1
Haines	2					2
Homer	5					5
Indian	1					1
Juneau	18	4		1	5	28
Kenakanak		3				3
Kenai	1					1
Ketchikan	13	4	1	1		19
Kodiak	5		3			8
Kotzebue		5				5
Nome				5		5
Palmer	5					5
Petersburg	2					2
Port Lions	1					1
Seldovia	1					1
Seward	2					2
Sitka	5	7				12
Soldotna	8					8
St. Paul Island		1				1
Tanana		2				2
Valdez	2					2
Wasilla	3					3
Wrangell	2					2
Total	374	95	72	13	21	575
	65%	17%	12%	2%	4%	

Kake [illegible] Hospital [illegible]

ACUTE CARE BEDS/ CENSUS

LICENSED BEDS '78

Av. Daily Census '78

250
225
200
175
165
155
145
135
125
100
75
70
65
60
55
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PROVIDENCE
FAIRBANKS
ALAS. HOS.
RAHTLETT
KETCHIKAN
SOLDOTNA
SEWARD
KODIAK
SITKA
PALMER
VALDEZ
CORDOVA
PETERSBURG
WRANGELL

POSITION PAPER/Department of Health & Social Services

HOUSE BILLS 974 and 975

H.B. 974: "An Act increasing state aid to municipalities for hospitals; and providing for an effective date."

H.B. 975: "An Act making a special appropriation to the Department of Community and Regional Affairs for grants for hospitals; and providing for an effective date."

The majority of the State's general hospitals are located in communities having small populations. These hospitals have low occupancy rates expect during the summer months when the fishing and tourism industries are in full operation. Also, small hospitals lack volume purchasing power due to the small quantities of drugs and other medical supplies consumed in their operations. Some of the small hospitals must be subsidized by the communities in which they are located, thus placing an additional tax burden upon residents of the community.

House Bills 974 and 975 are designed essentially to aid hospitals in meeting operating expenses and ease the financial burden otherwise placed on communities.

The Department of Community and Regional Affairs receives and disburses grants under AS 43.18 to grant applicants and is the lead agency for testimony on the subject proposed legislation.

By: Joe Betit
Joe Betit
Acting Director

Approved by: Helen D Bailey
Commissioner
Department of Health
and Social Services

Date: 4-5-80

Date: 4-5-80

Facilities	Acute General Beds	Long Term Care Beds					
		LTC Beds	SNF Beds	ICF Beds	IMR Beds	Total	% LTC SNF/ICF Beds
Construction							
Alaska Hospital & Medical Center 197							
7/1/79 - 6/30/80	154 21 Substance Abuse Beds					154 175	
Alaska Psychiartric Institute NA							
7/1/79 - 6/30/80	200 Acute Psychiatric Beds					200	
Anchorage Pioneer Home NA							
7/1/79 - 6/30/80		20 (SNF)				20	100
Bartlett Memorial Hospital 67							
7/1/79 - 6/30/80	67					67	
Careage House Health Care Center NA							
7/1/79 - 6/30/80				101		101	100
Careage North Health Care Center NA							
7/1/79 - 6/30/80		101 (SNF/ICF)				101	100
Central Peninsula Hospital 30							
7/1/79 - 6/30/80	30					30	
Cordova Community Hospital 20							
7/1/79 - 6/30/80	12	8 (SNF/ICF)				20	40
Fairbanks Memorial Hospital 155							
7/1/79 - 6/30/80	155					155	
Fairbanks Pioneer's Home NA							
7/1/79 - 6/30/80		42				42	100
Faith Hospital 3							
7/1/79 - 6/30/80	6					6	
Glenmore Health Care Center NA							
12/24/77 - 6/30/78		100 (now Nakoyia)					

	Beds				SNF/ICF Beds
Nakoyia Health Care Center NA					
7/1/79 - 6/30/80		216 (SNF/ICF)		216	100
Harborview Developmental Center NA					
7/1/79 - 6/30/80			120	120	100
Hope Cottage New Chalet 21					
4/1/77 to 7/1/77			21	21	100
Hope Park Cottages 21					
7/1/79.- 6/30/80			21	21	100
Hope Cottages, Inc. - Ocean Park 10					
7/1/79 - 6/30/80			10	10	100
Ketchikan General Hospital & Island View Manor 92					
7/1/79 - 6/30/80	44	48 (SNF/ICF)		92	52
Kodiak Island Hospital 44					
7/1/79 - 6/30/80	25	19 (ICF)		44	43
Lake Otis Hospital NA					
Construction Only					
7/1/77	125			125	
Norton Sound Regional Hospital 22					
7/1/79 - 6/30/80	15	6 (ICF)		19	31.5
Petersberg General Hospital 25					
7/1/79 - 6/30/80	13	12 (SNF/ICF)		25	48
Providence General Hospital 206					
7/1/79 - 6/30/80	250			250	
Palmer Pioneer's Home NA					
7/1/79 - 6/30/80		56 (SNF)		56	100
Seward General Hospital 31					
7/1/79 -6/30/80	31	(1 Bed each increase-Pediatrics &		31 ICU/CCU)	

	Beds					SNF/ICF Beds
Sitka Community Hospital 24						
7/1/79 - 6/30/80	24				24	
Sitka's Pioneer Home NA						
7/1/79 - 6/30/80		52 (SNF)			52	100
St. Ann's Nursing Home 45						
7/1/79 - 6/30/80		45 (SNF/ICF			45	100
South Peninsula Hospital 15						
7/1/79 - 6/30/80	13	4 (SNF/ICF)			17	23.5
Valdez Community Hospital 15						
7/1/79 - 6/30/80	15				15	
Valley Hospital 23						
7/1/79 - 6/30/80	17	6 (SNF/ICF)			23	26.1
Wesleyan Nurisng Home, Inc. 64						
7/1/79 - 6/30/80		64 (SNF/ICF)			64	100
Wrangel General Hospital Long Term Care 23						
7/1/79 - 6/30/80	9	14			23	60

Symbol Explanation

LTC = Skilled Nursing and/or Intermediate Care

SNF = Skilled Nursing Facility

ICF = Intermediate Care Facility

IMR = Intermediate Care Facility for the Mentally Retarded

Sec. 18.20.070. Compliance with regulations. Each hospital in operation at the time the department adopts rules and regulations or minimum standards under §§ 10 — 130 of this chapter has a reasonable time, under the particular circumstances, not exceeding one year from the date of adoption within which to comply with them. (§ 40-6-8 ACLA 1949)

Sec. 18.20.080. Inspection and consultation for alterations. (a) The department shall make annual inspections and investigations of hospital facilities.

(b) The department may by regulation require that a licensee or applicant desiring to make a specified type of alteration or addition to its facilities or to construct new facilities shall, before commencing the alteration, addition or new construction, submit plans and specifications to the department for preliminary inspection and approval or recommendations with respect to compliance with the regulations and standards. (§ 40-6-9 ACLA 1949; am § 5 ch 112 SLA 1957)

Sec. 18.20.085. Hospital records retention. (a) Unless specified otherwise by the department a hospital shall retain and preserve records which relate directly to the care and treatment of a patient for a period of seven years following the discharge of the patient. However, the records of a patient under 19 years of age shall be kept until at least two years after the patient has reached the age of 19 years or until seven years following the discharge of the patient, whichever is longer. Records consisting of X-ray film are required to be retained for five years.

(b) The department shall by regulation define the types of records and the information required to be included in the records retained or preserved under (a) of this section. The department may by regulation specify records and information to be retained for longer periods than those set out in (a) of this section.

(c) If a hospital ceases operation, it shall make immediate arrangements, as approved by the department, for the preservation of its records.

(d) In this section, "hospital" includes those facilities defined as hospitals under §§ 130(1) and 2103, of this chapter. (§ 1 ch 41 SLA 1970)

Sec. 18.20.090. Information confidential. The department may not publicly disclose information received by it in a manner identifying an individual or hospital except in a proceeding involving the question of licensing. (§ 40-6-11 ACLA 1949)

Sec. 18.20.100. Annual report of department. The department shall prepare and publish an annual report of its activities and operations under §§ 20 — 130 of this chapter. (§ 40-6-12 ACLA 1949)

regulations prescribed thereunder prohibit disclosure of the name of the individual.

Soc. Sec. Rul., No. 70-6, Jan. 1970 (C. B. 1970, 155, HIR 27-70-1). [This ruling was originally reported at NEW DEVELOPMENTS ¶ 26,080.]

.28 **Drug Abuse Office and Treatment Act of 1972—Disclosure of patient records.**—Where patient records concerning drug abuse are received by the Social Security Administration from any source for use in the administration of the Social Security Act: (1) such records are not subject to the disclosure provisions of section 408 of the Drug Abuse Office and Treatment Act of 1972 (P. L. 92-255, unless they are maintained in connection with the performance of a drug abuse prevention function authorized or assisted under any provision of the Drug Abuse Act or any act amended by it; (2) in those situations where disclosure of such records is subject to both Part 401 of the Regulations (reported at ¶ 18,051 *et seq.*) and section 408, the provision with the greater restrictiveness with respect to whether and how the information may be disclosed is controlling.

Soc. Sec. Rul., No. 73-18 (C. B. 1973, 91). [This ruling was originally reported at NEW DEVELOPMENTS ¶ 25,807.]

.30 **Exchange of provider certification and termination information between Medicare and Medicaid agencies.**—See ¶ 14,751.21 in the "MEDICAID" division.

.31 **Exemptions from disclosure, Freedom of Information Act.**—[*The statutory exemption*—Exemption (3) of the Freedom of Information Act, 5 U. S. C. 552(b)(3), exempts from mandatory disclosure] matter "specifically exempted from disclosure by statute. . . ." The Government in the Sunshine Act amended exemption (3) with the result that the Department can no longer cite section 1106(a) [¶ 16,375] as authority for denying a Freedom of Information request. . . . Accordingly, any social security information previously withheld on this basis must be made available unless another Freedom of Information Act exemption applies or another statute, which qualifies under amended exemption (3), prohibits disclosure.

• • •

Although section 1106(a) no longer qualifies, there are other statutes affecting social security information which appear to meet the exemption (3) criteria as amended by the Sunshine Act. For example, . . . Section 1865(a)(2) of the Social Security Act, which protects the confidentiality of accreditation survey reports submitted by the Joint Commission on Accreditation of Hospitals, will continue to do so under the new disclosure rules. Sections 1106(d) and (e) of the Social Security Act, which protect certain official reports dealing with the operation of the health programs established by title XVIII of the Act, qualify under exemption (3) and will remain binding.

42 F. R. 14703, March 16, 1977.

Section 1865(a)(2) provides for the Joint Commission on Accreditation of Hospitals (JCAH), if authorized by the hospitals, to release to the Secretary (or a State agency designated by him) on a confidential basis copies of accreditation surveys of hospitals made by the JCAH. As section 1865(a)(2) allows no discretion on the part of the Secretary to disclose information obtained from JCAH, materials released under this provision are thus specifically exempted by statute from disclosure to the public under exemption (3) of the Freedom of Information Act, 5 U. S. C. 552(b)(3), as amended by section 5(b) of the Government in the Sunshine Act, Pub. L. 94-409, which became effective March 12, 1977. Because section 1106(a) of the Social Security Act neither precludes discretion to disclose nor provides specific criteria for withholding, it does not fall within exemption (3) of the Freedom of Information Act.

42 F. R. 58403, November 9, 1977.

[*The confidentiality exemption*—] Exemption (4), 5 U. S. C. 552(b)(4), protects "trade secrets and commercial or financial information obtained from a person and privileged or confidential." [Current case law on exemption (4) requires that data be "obtained from" a source outside the Executive Branch for exemption (4) to be applicable.]

42 F. R. 14703, March 16, 1977.

The regulation permitting disclosure of provider cost reports to the public (Reg. § 422.435) is invalid as it applies to the provider because it does not comply with the requirements of the Administrative Procedure Act in that: (1) it was not promulgated within the statutory authority of the Freedom of Information Act insofar as it pertains to the disclosure of information of a confidential nature, which is exempted by the FOIA (exemption (4)); and (2) it is an abuse of discretion on the part of HEW in that it is in derogation of 18 U. S. C. § 1905, a criminal statute that makes it illegal for any employee of a governmental agency to disclose information that concerns or relates to the trade secrets, operations, or confidential statistical data, amount, or source of any income, profits, losses, or expenditures of a corporation.

Parkridge Hospital, Inc. v. Blue Cross and Blue Shield of Tennessee, et al., USDC (E. D., Tenn.), Apr. 15, 1977. [This decision was originally reported at NEW DEVELOPMENTS ¶ 28,559.]

Pursuant to the Freedom of Information Act, government agencies are forbidden to release "trade secrets and commercial or financial information obtained from a per-

son and privileged or confidential." Since the information in provider cost reports is financial and confidential, HEW may not disclose the information to the public. Furthermore, a government agency may not go beyond its own regulations. The Social Security Act provides that no disclosure of information can be made except as prescribed by regulations, and the regulations provide for disclosure of information from financial reports and other records of providers only to certain Federal and State officers and employees. Accordingly, HEW was enjoined from acting beyond the scope of its own regulations and violating the confidentiality exemption (exemption (4)) of the Freedom of Information Act by releasing provider cost reports to the public in a case that arose when a competitor of a skilled nursing facility requested release of its unaudited cost report.

The court denied a motion for class action certification, in the belief that HEW would follow the court's orders, unless reversed by a higher court. However, the court noted that HEW plans to adopt new regulations permitting the disclosure of cost data reports.

Bryan S. McCoy, Jr., d/b/a Twinbrook Nursing Home v. Weinberger, USDC (W. D. Ky.), 386 F. Supp. 501 (1974). [This decision was originally reported at NEW DEVELOPMENTS ¶ 27,146.]

[*The privacy exemption*—] In applying the interim rules to social security information, in all likelihood the most pertinent Freedom of Information exemption will be exemption (6), 5 U. S. C. 552(b)(6), which protects "personnel and medical files and similar files the disclosure of which would constitute a clearly unwarranted invasion of personal privacy." This exemption requires the Department to weigh the individual's interest in privacy against the public interest served by disclosure. . . .

The balancing test may have . . . impact on other information . . . , for example, payments to individual physicians under the Medicare program. Although this information reflects at least to some degree the physician's income, a matter in which he has a privacy interest, disclosure would serve the strong public interest in the accountability of government programs, revealing how public funds are spent and the extent to which the funds are paid to individuals when acting in a business or professional capacity. [See .50, below, for specific instructions concerning disclosure of physician/supplier charge information.]

42 F. R. 14703, March 16, 1977.

.32 **Fees for information.**—Certain fees and charges have been established to recover some of the cost of disclosing information to the public under the provisions of the Freedom of Information Act. Providers, contractors, and State agencies are also required to pay appropriate fees for copies of reports they may request pertaining to other providers, contractors, or State agencies. Such fees are not reimbursable administrative costs under the Medicare program for contractors or State agencies. A provider may claim such fees as allowable costs only if the provider demonstrates to the intermediary that the information is necessary in developing and maintaining the operation of patient care facilities and activities. Members of Congress, when clearly requesting information on behalf of a constituent or other third party, are subject to the same fees and charges that would apply to the person represented, but they are exempt from charges in all other cases. No charge will be made to the public for inspection of disclosable documents, for normal mailing of requested materials, for time spent in deciding whether to provide information or securing approval, or for requests which result in charges of $5 or less.

Charges must also be made for disclosing information under the provisions of Regulation No. 1. In general, the fees will be the same as those charged for disclosing information under the Freedom of Information Act.

Fees.—Unless otherwise specified . . . , the following fees are to be charged for disclosing information:

A. *Photocopying.*—A charge of 10 cents per page (one side of a sheet) will be made for photocopying documents or records. If the page to be photocopied is too large to be printed on one photocopy, the charge is 10 cents per photocopy.

B. *Searching.*—When a request results in searching time in excess of one-half hour, a charge of $1.50 for each half-hour, excluding the first half-hour, will be made. This charge is in addition to any charges for photocopying materials. There is no searching fee for time spent photocopying.

C. *SSA-Printed Material.*—$.01 per printed page.

D. *Preparation of Materials from Punchcards, Magnetic Tape, or Microfilm.*—Charges for preparing materials from magnetic tape, microfilm, or punchcards will be based on the actual cost, as determined on a case-by-case basis. The intermediary or carrier will prepare an estimate of such costs and refer requests requiring preparation of materials from machine sources to the regional office for determination of the fee. The regional office will determine the fee based on the cost information submitted by the intermediary or carrier which will include the following:

1. *Personnel Salaries.*—Compute the time spent by all staff members (including analysts, supervisors, and clericals) in search-

Facility	(1) General Beds	SNF/ICF Beds	Total Bed Days Available	(1) Beds Utilized	% of Occupancy	(2) Rate
Institution #1	over 100		49,640	27,392	55.20	
Institution #2	over 100		73,000	35,096	48.08	188.59
Institution #3	50 - 100		21,535	9,314	43.25	207.20
Institution #4	under 50		10,220	2,724	26.65	274.15
Institution #5	under 50		8,030	3,283	45.90	140.39
Institution #6	over 100		52,979	34,073	64.31	184.06
Institution #71	under 50		1,825	576	31.50	
Institution #8	--					
		over 100	43,800	32,628	74.49	160.10
Institution #9	under 50		16,060	6,659	41.50	155.95
		under 50	17,520	15,627	89.20	73.71
Institution #10	under 50		8,395	4,150	49.43	
Institution #11	under 50		5,475	2,270	40.20	
		under 50	2,190	1,742	79.54	
Institution #12	under 50		4,745	995	21.00	178.53
		under 50	4,380	3,966	91.00	66.50
Institution #13	over 100		64,423	63,473	98.50	
Institution #14	under 50		12,045	1,742	14.51	232.42
Institution #15	under 50		8,395	3,452	41.12	203.
Institution #16	under 50		4,015	2,318	57.73	199.47
		under 50	1,460	705	48.29	169.62
Institution #17	--					
		under 50	16,425	4,970	30.30	
Institution #18	under 50		5,475	651	11.89	
Institution #19	under 50		5,475	2,133	38.96	
		under 50	2,190	1,803	82.33	
Institution #20	--					
		50 - 100	23,360	21,513	92.09	51.41
Institution #21	under 50		3,285	890	27.10	169.58
		under 50	5,110	5,110	100.00	66.96

Notes

1) General Beds includes critical care (ICU, CCU, PCU) beds but occupancy of these beds is not considered in utilization rate.
2) Facilities with no rates shown operate on a Fiscal Year ending 12/31. The 1979 rates have not yet been reported.

ALASKA'S HOSPITALS AND LONG TERM CARE FACILITIES

GENERAL BED AND UTILIZATION STATISTICS, continued

	ACUTE CARE				LONG TERM CARE				NEWBORN	
	Licensed Beds (1978)*	Admissions	Average Daily Census	Occupancy (percent)**	Licensed Beds (1978)*	Discharges	Average Daily Census	Occupancy (percent)**	Bassinets	Births
SC HSA, continued										
Anchorage Pioneers Home					20	42	N/A	N/A		
Elmendorf USAF	135*	6,041	92.6	68.6					28	859
Lake Otis										
U.S. Coast Guard Dispensary -- Kodiak	4[2]	307[2]	3.2[2]	22.7[2]					N/A	57[2]
Kodiak Island	25	1,129	11.5	46.1	19	--Data not available--			5	111
NavRegMedCen Bremerton, Adak Branch	15*	296	3.2	21.4					5	75
Kanakanak PHS	29*	534	6.4	22.0					N/A	61
Bethel PHS	42[2]	1,568[2]	20.2[2]	48.1[2]					12[2]	N/A
Norton Sound Regional	13**[4]	754	7.1	48.7	6	3	3.2	53.2	4	130
N HSA										
Kotzebue PHS	40*	1,002	13.2	32.9					6	112
Barrow PHS	14[2]	500[2]	4.9[2]	35.0[2]					5[2]	61[2]
Fairbanks Memorial	155**[4]	7,327	99.5	74.9					16[4]	1,134
Carcage North Health Care Center					101	244	73.8	73.0		
Fairbanks Pioneers Home					42	1[3]	42.0	100.0		
Bassett Army	38*	2,090	28.4	74.7					N/A	387
Tanana PHS	20[2]	513[2]	10.8[2]	54.0[2]					N/A	35[2]

*State licensing does not include PHS and military hospitals. For these facilities beds refer to beds set up and in

**Percent occupancy is based on licensed beds. Fairbanks Memorial percent occupancy was calculated for 126 licensed beds through October 5, 1978 and 155 licensed beds October 6--December 31, 1978. Norton Sound percent occupancy was calculated for 16 beds through June 30, 1978 and 13 beds July 1--December 31, 1978.

†Percent occupancy is based on licensed beds rather than beds in use. During 1978 St. Ann's Nursing Home had 25 beds in use. Percent occupancy calculated on beds in use would be 55.4%. Ketchikan General had 42 acute care beds in use (41.8% occupancy); Alaska Hospital and Medical Center had 118 beds in use (69.9% occupancy); and Providence had 215 beds in use (83.2% occupancy).

**Mt. Edgecumbe has 8 chronic care and 3 alcoholism treatment beds. The 8 chronic care beds accounted for 507 patient days, 1 discharge and a 17.3% occupancy. The 8 alcoholism treatment beds accounted for 2058 patient days, 69 discharges and a 72.3% occupancy.

[1]Data from Certification and Licensing, Alaska Department of Health and Social Services.

[2]Data from FY 1977 Annual Hospital Survey.

[3]Discharges.

[4]Alaska Hospital and Medical Center bassinet total includes 6 neonatal intensive care beds; Providence includes 14 neonatal intensive care beds; and Fairbanks Memorial includes 3 neonatal intensive care beds.

Facility	(1) General Beds	SNF/ICF Beds	Total Bed Days Available	(1) Beds Utilized	% of Occupancy	(2) Rate
Institution #1	over 100		49,640	27,3[illegible]	55.20	
Institution #2	over 100		73,000	35,098	48.08	188.59
Institution #3	50 - 100		21,535	9,314	43.25	207.20
Institution #4	under 50		10,220	2,724	26.65	274.15
Institution #5	under 50		8,030	3,283	45.90	140.39
Institution #6	over 100		52,979	34,073	64.31	184.06
Institution #71	under 50		1,825	576	31.50	
Institution #8	--					
		over 100	43,800	32,628	74.49	160.10
Institution #9,	under 50		16,060	6,659	41.50	155.95
		under 50	17,520	15,627	89.20	73.71
Institution #10	under 50		8,395	4,150	49.43	
Institution #11	under 50		5,475	2,270	40.20	
		under 50	2,190	1,742	79.54	
Institution #12	under 50		4,745	995	21.00	178.53
		under 50	4,380	3,966	91.00	66.50
Institution #13	over 100		64,423	63,473	98.50	
Institution #14	under 50		12,045	1,742	14.51	232.42
Institution #15	under 50		8,395	3,452	41.12	203.
Institution #16	under 50		4,015	2,318	57.73	199.47
		under 50	1,460	705	48.29	169.62
Institution #17	--					
		under 50	16,425	4,970	30.30	
Institution #18	under 50		5,475	651	11.89	
Institution #19	under 50		5,475	2,133	38.96	
		under 50	2,190	1,803	82.33	
Institution #20	--					
		50 - 100	23,360	21,513	92.09	51.41
Institution #21	under 50		3,285	890	27.10	169.58
		under 50	5,110	5,110	100.00	66.98

Notes

1) General Beds includes critical care (ICU, CCU, PCU) beds but occupancy of these beds is not considered in utilization rate.
2) Facilities with no rates shown operate on a Fiscal Year ending 12/31. The 1979 rates have not yet been reported.

ACUTE CARE BEDS/ CENSUS

LICENSED BEDS '78

Av. Daily Census '78

STATEMENT OF SUPPORT, REVENUE, AND EXPENSES AND CHANGES IN FUND BALANCES

Years ended June 30, 1979 and 1978

	Current Fund	Property Fund	Total All Funds 1979	Total All Funds 1978
PUBLIC SUPPORT AND REVENUE				
Public support				
Contributions	$ 263,262		$ 263,262	$ 320,366
Missionary support	611,238		611,238	486,422
Total Public Support	874,500		874,500	806,788
Revenue				
Operating income	639,420		639,420	686,020
Gain on sale of assets				2,400
Investment income	14,258		14,258	15,066
Other income				14,388
Total Revenue	653,678		653,678	717,874
Total Public Support and Revenue	1,528,178		1,528,178	1,524,662
EXPENSES				
Program activities				
Evangelism and church development	226,820	$ 237	227,057	158,125
Education	189,421	21,945	211,366	184,585
Medical	364,773	23,446	388,219	398,219
Mass media	171,834	4,968	176,802	60,495
Total Program Activities	952,848	50,596	1,003,444	801,424
Supporting activities				
Administration and general	415,303	46,142	461,445	540,610
Total Expenses	1,368,151	96,738	1,464,889	1,342,034
EXCESS PUBLIC SUPPORT AND REVENUE OVER EXPENSES	160,027	(96,738)	63,289	182,628
OTHER CHANGES IN FUND BALANCES				
Property and equipment purchased from current funds	(215,891)	215,891		
Correction - prior year transfer				(9,930)
Reclassification		(1,800)	(1,800)	(3,519)
Payment of notes				
Rental deposits		450	450	
	(55,864)	117,803	61,939	169,179
FUND BALANCE, beginning	457,514	1,567,604	2,025,118	1,855,939
FUND BALANCE, ending	$ 401,650	$1,685,407	$2,087,057	$2,025,118

See notes to financial statements.

STATEMENTS OF REVENUES AND EXPENSES
For the Years Ended June 30, 1979 and 1978

	1979	1978
Patient service revenue	$1,044,422	$966,314
Allowances and uncollectible accounts	53,084	(5,479)
Net patient service revenue	1,097,506	960,835
Operating expenses:		
Professional care of patients	452,232	403,606
Dietary	202,584	163,730
Household and property	158,213	145,808
General and administrative	241,885	209,863
Depreciation	45,076	41,509
	1,099,990	964,516
Income (loss) from operations	(2,484)	(3,681)
Nonoperating revenues:		
Contributions	6,629	15,845
Revenue sharing grant - State of Alaska	60,977	68,800
Interest income	18,666	14,557
Other	2,820	2,365
	89,092	101,567
Excess of revenues over expenses	$ 86,608	$ 97,886

The Notes to Financial Statements are an integral part of these statements.

Statements of Revenues and Expenses

Years ended June 30, 1979 and 1978

	1979	1978
Patient service revenue:		
Routine services to inpatients:		
Adults and children	$ 485,322	315,722
Newborns	3,865	5,250
	489,187	320,972
Special services to patients: (Schedule 1)		
Inpatients	135,392	126,557
Outpatients	92,025	100,059
	227,417	226,616
Unapplied contract adjustments (note 4)		
Medicare	4,765	172
Medicaid	29,713	(42,981)
Other	4,561	10,325
	39,039	(32,484)
Total operating revenue	755,643	515,104
Operating expenses: (Schedule 2)		
Professional	336,843	270,367
Nonprofessional	415,053	353,449
Depreciation	73,422	69,621
Total operating expenses	825,318	693,437
Loss from operations	(69,675)	(178,333)
Nonoperating revenues (expenses):		
Interest, net	(22,262)	(24,116)
Rent (note 2)	8,855	9,822
Contributions:		
State shared revenue	75,150	84,353
City of Wrangell	40,984	42,045
Other	135	683
Other, net	4,166	2,163
Total nonoperating revenue	107,028	114,950
Net revenues over (under) expenses	$ 37,353	(63,383)

See accompanying notes to financial statements.

STATEMENTS OF REVENUES AND EXPENSES
FOR THE YEARS ENDED JUNE 30, 1979 AND 1978

	1979	1978
OPERATING REVENUES:		
Patient service revenues	$4,441,507	$3,627,002
Deductions from patient service revenues (Note 1)	(369,177)	(238,161)
Net patient service revenues	4,072,330	3,388,841
Other operating revenues	77,851	65,969
Net operating revenues	4,150,181	3,454,810
OPERATING EXPENSES:		
Salaries and wages	2,333,139	2,026,628
Employee benefits and payroll taxes	382,757	303,120
Supplies and other expenses	1,201,027	993,678
Depreciation (Note 1)	86,441	56,317
Provision for equipment rental (Note 2)	10,320	10,298
Total operating expenses	4,013,684	3,390,041
Net revenues from operations	136,497	64,769
NONOPERATING REVENUES:		
State revenue sharing	81,615	87,951
Interest and other income, net	85,737	67,031
Total nonoperating revenues	167,352	154,982
Excess of revenues over expenses	$ 303,849	$ 219,751

The accompanying notes are an integral part of these statements.

STATEMENT OF REVENUE AND EXPENSES

June 30, 1979 and 1978

UNRESTRICTED FUND

	1979	1978
Patient Service Revenue:		
Hospital Inpatient	$176,815	$199,758
Hospital Outpatient	198,773	192,428
Nursing Home	188,296	182,806
Ancillary Service	119,042	
Total Patient Service Revenue	682,926	695,565
Less Contractual Allowances and Uncollectible Accounts	74,674	105,150
Net Patient Service Revenue	608,252	590,415
Grant Revenue	237,847	183,767
Grant Project Revenue (note 2)	21,602	2,799
Other Operating Revenue	5,516	10,344
TOTAL OPERATING REVENUE	873,217	787,325
Operating Expenses:		
Patient Service Expense	420,176	418,463
Plant and Operations	52,132	51,456
General and Administrative	150,963	164,050
Grant Expenses (note 2)	177,083	156,721
Other Expenses	228,256	134,328
Depreciation	54,664	50,770
Interest	2,313	650
Total Operating Expenses	1,085,587	976,438
Loss from Operations	212,370	189,113
Non-Operating Revenues:		
Revenue Sharing Grant	95,000	105,584
Rental Income	31,405	23,665
Contributions	938	50
Excess of Expenditures over Revenue	$ 85,027	$ 59,814

Years ended June 30, 1979 and 1978

	1979		Total All Funds	
	Unrestricted	Restricted	1979	1978
OPERATING REVENUES				
Medicaid - note 6	$1,161,759	$	$1,161,759	$1,141,774
State contract - note 6	1,184,500		1,184,500	1,075,770
Public support	19,827		19,827	31,981
Other	301,736		301,736	314,676
TOTAL OPERATING REVENUES	2,667,822	-0-	2,667,822	2,564,201
Contractual adjustments and bad debts	1,529		1,529	12,517
NET OPERATING REVENUES	2,666,293	-0-	2,666,293	2,551,684
OPERATING EXPENSES				
Salaries and wages	1,522,347		1,522,347	1,601,915
Employee benefits	182,137		182,137	199,192
Professional fees	185,285		185,285	63,554
Supplies	167,463		167,463	161,081
Utilities and services	54,588		54,588	106,604
Depreciation	63,389		63,389	54,437
Leases and rentals	168,445		168,445	168,814
Other	201,208		201,208	131,726
TOTAL OPERATING EXPENSES	2,544,862	-0-	2,544,862	2,487,324
EXCESS OF OPERATING REVENUES OVER OPERATING EXPENSES	121,431		121,431	64,360
OTHER INCOME				
Gain from disposal of assets	150		150	
Non-operating grants - note 7		620,000	620,000	20,000
Non-operating revenue - note 8		241,233	241,233	246,033
Other	38,160		38,160	9,923
TOTAL OTHER INCOME	38,310	861,233	899,543	275,956
OTHER EXPENSES				
Fund raising		36,405	36,405	75,780
EXCESS REVENUES OVER EXPENSES	159,741	824,828	984,569	264,536
OTHER CHANGES IN FUND BALANCES				
Net change in funds held in trust - note 9		6,046	6,046	6,515
BOARD TRANSFER TO RESTRICTED	(102,807)	102,807		
TRANSFER FROM RESTRICTED TO UNRESTRICTED	71,599	(71,599)		
FUND BALANCES, beginning	954,997	256,145	1,211,142	940,091
FUND BALANCES, ending	$1,083,530	$1,118,227	$2,201,757	$1,211,142

See notes to financial statements and accompanying accountants' opinion.

STATEMENTS OF REVENUES AND EXPENSES
For the Years Ended June 30, 1979 and 1978

	1979	1978
Patient service revenue	$1,044,422	$966,314
Allowances and uncollectible accounts	53,084	(5,479)
Net patient service revenue	1,097,506	960,835
Operating expenses:		
Professional care of patients	452,232	403,606
Dietary	202,584	163,730
Household and property	158,213	145,808
General and administrative	241,885	209,863
Depreciation	45,076	41,509
	1,099,990	964,516
Income (loss) from operations	(2,484)	(3,681)
Nonoperating revenues:		
Contributions	6,629	15,845
Revenue sharing grant - State of Alaska	60,977	68,800
Interest income	18,666	14,557
Other	2,820	2,365
	89,092	101,567
Excess of revenues over expenses	$ 86,608	$ 97,886

The Notes to Financial Statements are an integral part of these statements.

Statements of Revenues and Expenses

Years ended June 30, 1979 and 1978

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	489,187	320,972
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	227,417	226,616
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Other	4,561	10,325
	39,039	(32,484)
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Operating expenses: (Schedule 2)		
Professional	336,843	270,367
Nonprofessional	415,053	353,449
Depreciation	73,422	69,621
Total operating expenses	825,318	693,437
Loss from operations	(69,675)	(178,333)
Nonoperating revenues (expenses):		
Interest, net	(22,262)	(24,116)
Rent (note 2)	8,855	9,822
Contributions:		
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City of Wrangell	40,984	42,045
Other	135	683
Other, net	4,166	2,163
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Net revenues over (under) expenses	$ 37,353	(63,383)

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FOR THE YEARS ENDED JUNE 30, 1979 AND 1978

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Net operating revenues	4,150,181	3,454,810
OPERATING EXPENSES:		
Salaries and wages	2,333,139	2,026,628
Employee benefits and payroll taxes	382,757	303,120
Supplies and other expenses	1,201,027	993,678
Depreciation (Note 1)	86,441	56,317
Provision for equipment rental (Note 2)	10,320	10,298
Total operating expenses	4,013,684	3,390,041
Net revenues from operations	136,497	64,769
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Total nonoperating revenues	167,352	154,982
Excess of revenues over expenses	$ 303,849	$ 219,751

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STATEMENT OF REVENUE AND EXPENSES

June 30, 1979 and 1978

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General and Administrative	150,963	164,050
Grant Expenses (note 2)	177,083	156,721
Other Expenses	228,256	134,328
Depreciation	54,664	50,770
Interest	2,313	650
Total Operating Expenses	1,085,587	976,438
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Non-Operating Revenues:		
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Rental Income	31,405	23,665
Contributions	938	50
Excess of Expenditures over Revenue	$ 85,027	$ 59,814

Years ended June 30, 1979 and 1978

	1979		Total All Funds	
	Unrestricted	Restricted	1979	1978
OPERATING REVENUES				
Medicaid - note 6	$1,161,759	$	$1,161,759	$1,141,774
State contract - note 6	1,184,500		1,184,500	1,075,770
Public support	19,827		19,827	31,981
Other	301,736		301,736	314,676
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Professional fees	185,285		185,285	63,554
Supplies	167,463		167,463	161,081
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Depreciation	63,389		63,389	54,437
Leases and rentals	168,445		168,445	168,814
Other	201,208		201,208	131,726
TOTAL OPERATING EXPENSES	2,544,862	-0-	2,544,862	2,487,324
EXCESS OF OPERATING REVENUES OVER OPERATING EXPENSES	121,431		121,431	64,360
OTHER INCOME				
Gain from disposal of assets	150		150	
Non-operating grants - note 7		620,000	620,000	20,000
Non-operating revenue - note 8		241,233	241,233	246,033
Other	38,160		38,160	9,923
TOTAL OTHER INCOME	38,310	861,233	899,543	275,956
OTHER EXPENSES				
Fund raising		36,405	36,405	75,780
EXCESS REVENUES OVER EXPENSES	159,741	824,828	984,569	264,536
OTHER CHANGES IN FUND BALANCES				
Net change in funds held in trust - note 9		6,046	6,046	6,515
BOARD TRANSFER TO RESTRICTED	(102,807)	102,807		
TRANSFER FROM RESTRICTED TO UNRESTRICTED	71,599	(71,599)		
FUND BALANCES, beginning	954,997	256,145	1,211,142	940,091
FUND BALANCES, ending	$1,083,530	$1,118,227	$2,201,757	$1,211,142

See notes to financial statements and accompanying accountants' opinion.

STATEMENT OF SUPPORT, REVENUE, AND EXPENSES AND CHANGES IN FUND BALANCES

Years ended June 30, 1979 and 1978

	Current Fund	Property Fund	Total All Funds 1979	Total All Funds 1978
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Other income				14,388
Total Revenue	653,678		653,678	717,874
Total Public Support and Revenue	1,528,178		1,528,178	1,524,662
EXPENSES				
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	(55,864)	117,803	61,939	169,179
FUND BALANCE, beginning	457,514	1,567,604	2,025,118	1,855,939
FUND BALANCE, ending	$ 401,650	$1,685,407	$2,087,057	$2,025,118

See notes to financial statements.

CORRESPONDENCE

ALASKA STATE HOSPITAL ASSOCIATION INC.

5401 CORDOVA STREET
PHONE: 277-1633

ANCHORAGE, ALASKA 99503

March 3, 1980

Margaret Branson
Representative
Alaska Legislature
Pouch V
Juneau, Alaska 99811

Introduced by

Dear Representative Branson:

A serious problem is now facing Alaska's health providers, especially our hospitals. These institutions are caught between spiraling costs and an outcry from the consumers in absorbing those increases. A national hospital effort participated in by all of our facilities managed to reduce the amount of increases in costs through a conscientious cost containment effort during 1979. I have attached a copy of those efforts for your review.

It is becoming increasingly more difficult to hold the cost of hospital care down since a substantial portion of that expense is beyond management control: necessary new life saving technology is usually expensive; over half of the hospitals expense is for personnel wages and benefits; fixed overhead related to physical plant; energy requirements; cost of financing; and supply costs i.e. plastics, paper, etc., have increased dramatically over the past year.

While the cost of operation has increased, many of our smaller hospitals have realized a significant drop in cash flow, particularly due to delays in getting medicaid reimbursement and an increase in non-insured patients who must pay their bills over a period of time. I have selected four major areas where costs have increased dramatically to our institutions for your review.

Cost Increases

	78-79	80-81 (projected)
X-ray film (silver)	8%	60%
plastics	7%	10%
Labor	14.4%	?
Energy		
National		
Fuel oil	56%	?
Alaska		
Fuel oil	61%	?
National		
Electricity	14%	?
Alaska		
Electricity	17.7	?

(Statistics were taken from the 1980 Department of Labor CPI report; U S News and World report, February 3, 1980, and 1978-79 Alaska Hospital Association Group Purchasing analysis.)

Due to the unprecedented increases in costs for electricity, fuel, plastics, and other necessary hospital products, in addition to the present ecomony as it relates to hospital reimbursement we request that the minimum revenue sharing hospital support be increased from $75,000 to $200,000. This additional support would largely offset the unprecedented inflation and cash flow problems our hospitals are facing, holding costs down to patients and meeting immediate cash flow needs.

Thank you for your consideration of this request, and should you need further information please contact our office at your convenience.

Sincerely,

Max Kersbergen
Executive Director

MK/ic

Enclosure

cc: Governor Hammond
Arliss Sturgulewski
Al Camosso
Jalmar Kerttula

PROVIDENCE
HOSPITAL

3200 PROVIDENCE DRIVE - POUCH 6604
ANCHORAGE, ALASKA 99502
PHONE: (907) 276-4511

SISTERS OF
PROVIDENCE

SERVING IN THE WEST SINCE 1856

April 7, 1980

The Honorable Bill Parker
Chairman, Community & Regional
Affairs
Pouch V
Juneau, Alaska 99811

Position Paper: H.B. 974 - "An Act increasing state aid to municipalities for hospitals; and providing for an effective date"

H.B. 975 - "An Act making a special appropriation to the Department of Community and Regional Affairs for grants for hospitals; and providing for an effective date"

Dear Representative Parker:

Providence Hospital has reviewed H.B. 974 and H.B. 975 and supports passage of both bills.

Our major point of support is that the increase in funding will help our many smaller hospitals retain viability in their communities. It is important that these smaller hospitals continue to be resources for health care services in the many outlying areas, as people in those communities look to them to be staffed and available when the need arises. This additional financial support will help to assure that this happens.

We also recognize that the financial support to the larger institutions might be cut back a small amount, and we are willing to accept this possibility.

We also re-emphasize that revenue sharing funds for hospitals should have a direct pass through to the hospitals. This will assure us that we will be getting our money in a timely fashion and will cut back in unnecessary red tape at the municipality level. Line 18 of H.B. 974 indicates that the funds may be used only for hospitals. We would like to see this amended to must. On line 19, if there is a direct pass through of funds, we see no reason to include the words, "as the municipality determines."

It is important that these hospitals continue to remain strong and provide needed services. Without these funds, it may be very difficult for them to do so. Thank you for the opportunity of expressing our position. If you should need additional clarification, please feel free to contact us at any time.

Sincerely,

Al M. Camosso
Administrator

AMC/mm

cc: Senator Arliss Sturgulewski
Senator Glenn Hackney
Senator Mike Colletta
Senator John Sackett
Representative Ramona Barnes
Representative C. V. Chatterton
Max Kersbergen
William Dann
Charles Rigden
Ron Hammett
Donald DeMers
Jack Brown
Alaskan Hospital Administrators
Advisory Board

BARTLETT MEMORIAL HOSPITAL

P. O. BOX 3-3000 • JUNEAU, ALASKA • TELEPHONE (907) 586-2611
MILE 3 — GLACIER HIGHWAY

April 7, 1980

Representative Parker, Chairman
Community & Regional Affairs Committee
Alaska State Legislature
Pouch V
Juneau Ak 99811

HB 974 REVENUE SHARING-HOSPITALS

There are 16 hospitals within organized municipalities that are eligible for grants from the State of Alaska. They are:

40 Beds & Under	41-100 Beds	Over 100 Beds
Cordova	Juneau	Alaska-Anchorage
Homer	Ketchikan	Fairbanks
Nome	Kodiak	Providence-Anch.
Palmer		
Petersburg		
Seward		
Sitka		
Soldotna		
Valdez		
Wrangell	(Glenallen is in an "unorganized" region)	

The rationale for subsidizing is that these hospitals are necessary for the common good of their community. The 10 hospitals of 40 beds or less are absolutely essential to their communities. However, they are not economically feasible due to their small size and underutilization. Most of them operate with a skeleton staff which precludes any significant cost reductions. Cash flow is a constant and serious problem! They desperately need to be subsidized by their local and state government.

The medium and large size hospitals also need subsidizing to keep their charges within reasonable reach of Alaskans.

We propose that this legislation be changed to set up three seperate categories of grants that recognize the needs of the different hospitals. The smaller hospitals because of their need to offset their fixed costs and the larger hospitals to offset the larger expenses of operation. The patients (Alaskans) are the beneficiaries.

HB 974 Revenue Sharing-Hospitals (con'd)

A possible schedule would be:

Licensed Beds	No.of Hospitals	Grant	Total
40 beds & under	10	$200,000	$2,000,000
41 - 100 beds	3	$225,000	$ 675,000
Over 100 beds	3	$250,000	$ 750,000
	TOTAL ANNUAL GRANT		$3,425,000

Attached hereto is an excerpt from DHSS's MEDICAL FACILITIES PLAN (Nov. 1979) showing hospital statistics.

James R Burns

JAMES R. BURNS, ADMINISTRATOR

1979 ANNUAL HOSPITAL SURVEY

ALASKA'S HOSPITALS AND LONG TERM CARE FACILITIES

GENERAL BED AND UTILIZATION STATISTICS (SUMMARY CHARTS)

	ACUTE CARE				LONG TERM CARE				NEWBORN	
	Licensed Beds (1978)*	Admissions	Average Daily Census	Occupancy (percent)**	Licensed Beds (1978)*	Discharges	Average Daily Census	Occupancy (percent)**	Bassinets	Births
SE HSA										
Ketchikan General & Island View Manor	44	1,768	17.6	39.9+	48	27	41.2	85.8	6	289
Petersburg General	13	337	3.2	24.9	12	5	10.8	90.3	4	62
Wrangell General	9	218	1.9	21.6	14	17	11.8	84.0	3	41
Mt. Edgecumbe PHS	66*	1,374	35.8	54.2	16**	70**	7.0**	43.9**	2	86
Sitka Community	24	885	10.9	45.4					4	83
Sitka Pioneers Home					52[1]	--Data not available--				
Bartlett Memorial	67	2,331	31.4	46.9					8	315
St. Ann's Nursing Home					45	42	13.8	30.8+		
SC HSA										
Cordova Community	12[2]	334[2]	3.9[2]	32.5[2]	8[1]	11[2]	6.2[2]	77.6[2]	5[2]	32[2]
Valdez Community	15[2]	379[2]	2.2[2]	14.5[2]					5[2]	38[2]
Harborview Developmental Center					120	15	91.3	76.1		
Seward General	29	495	4.5	15.5					4	36
Wesleyan Nursing Home					64	51	61.7	96.4		
Faith	6	243	1.7	28.8					3	61
Central Peninsula	30	1,257	9.3	31.1					6	320
South Peninsula	13	609	6.1	47.0	4	3	2.8	69.8	4	103
Valley	17	771[3]	10.5	61.6	6	13	N/A	N/A	4	200
Palmer Pioneers Home					56	23	56.0	100.0		
Alaska Hospital and Medical Center	154	6,482	82.4	53.5+					21[4]	1,050
Providence	250	11,349	173.9	71.5+					38[4]	1,786
Alaska Native Medical Center	170*	4,526	121.5	71.5					12	526
Nakoyia Health Care Center					216	286	142.3	65.7		
Careage House Health Care Center					101[1]	101	97.3	96.3		
Ocean Park Cottage					10[1]	--Data not available--				
Hope Park Cottage					21[1]	--Data not available--				

ALASKA'S HOSPITALS AND LONG TERM CARE FACILITIES

GENERAL BED AND UTILIZATION STATISTICS, continued

	ACUTE CARE				LONG TERM CARE				NEWBORN	
	Licensed Beds (1978)*	Admissions	Average Daily Census	Occupancy (percent)**	Licensed Beds (1978)*	Discharges	Average Daily Census	Occupancy (percent)**	Bassinets	Births
SC HSA, continued										
Anchorage Pioneers Home					20	42	N/A	N/A		
Elmendorf USAF	135*	6,041	92.6	68.6					28	859
Lake Otis										
U.S. Coast Guard Dispensary -- Kodiak	*[2]	307[2]	3.2[2]	22.7[2]					N/A	57[2]
Kodiak Island	25	1,129	11.5	46.1	19	--Data not available--			5	111
NavRegMedCen Bremerton, Adak Branch	15*	296	3.2	21.4					5	75
Kanakanak PHS	29*	534	6.4	22.0					N/A	61
Bethel PHS	*[2]	1,563[2]	20.2[2]	48.1[2]					12[2]	N/A
Norton Sound Regional	13**[1]	754	7.1	48.7	6	3	3.2	53.2	4	130
N HSA										
Kotzebue PHS	40*	1,002	13.2	32.9					6	112
Barrow PHS	*[2]	500[2]	4.9[2]	35.0[2]					5[2]	61[2]
Fairbanks Memorial	155**[1]	7,327	99.5	74.9					16[4]	1,134
Carcage North Health Care Center					101	244	73.8	73.0		
Fairbanks Pioneers Home					42	11	42.0	100.0		
Bassett Army	38*	2,090	28.4	74.7					N/A	387
Tanana PHS	*[2]	513[2]	10.8[2]	54.0[2]					N/A	35[2]

*State licensing does not include PHS and military hospitals. For these facilities beds refer to beds set up and in use.

**Percent occupancy is based on licensed beds. Fairbanks Memorial percent occupancy was calculated for 126 licensed beds through October 5, 1978 and 155 licensed beds October 6--December 31, 1978. Norton Sound percent occupancy was calculated for 16 beds through June 30, 1978 and 13 beds July 1--December 31, 1978.

*Percent occupancy is based on licensed beds rather than beds in use. During 1978 St. Ann's Nursing Home had 25 beds in use. Percent occupancy calculated on beds in use would be 55.4%. Ketchikan General had 42 acute care beds in use (41.8% occupancy); Alaska Hospital and Medical Center had 118 beds in use (69.9% occupancy); and Providence had 215 beds in use (83.2% occupancy).

**Mt. Edgecumbe has 6 chronic care and 8 alcoholism treatment beds. The 8 chronic care beds accounted for 507 patient days, 1 discharge and a 17.3% occupancy. The 8 alcoholism treatment beds accounted for 2058 patient days, 69 discharges and a 72.3% occupancy.

[1]Data from Certification and Licensing, Alaska Department of Health and Social Services.

[2]Data from FY 1977 Annual Hospital Survey.

[3]Discharges.

[4]Alaska Hospital and Medical Center bassinet total includes 6 neonatal intensive care beds; Providence includes 14 neonatal intensive care beds; and Fairbanks Memorial includes 3 neonatal intensive care beds.

NORTON SOUND
HEALTH CORPORATION

P.O. BOX 966
NOME, ALASKA 99762
(907) 443-5411

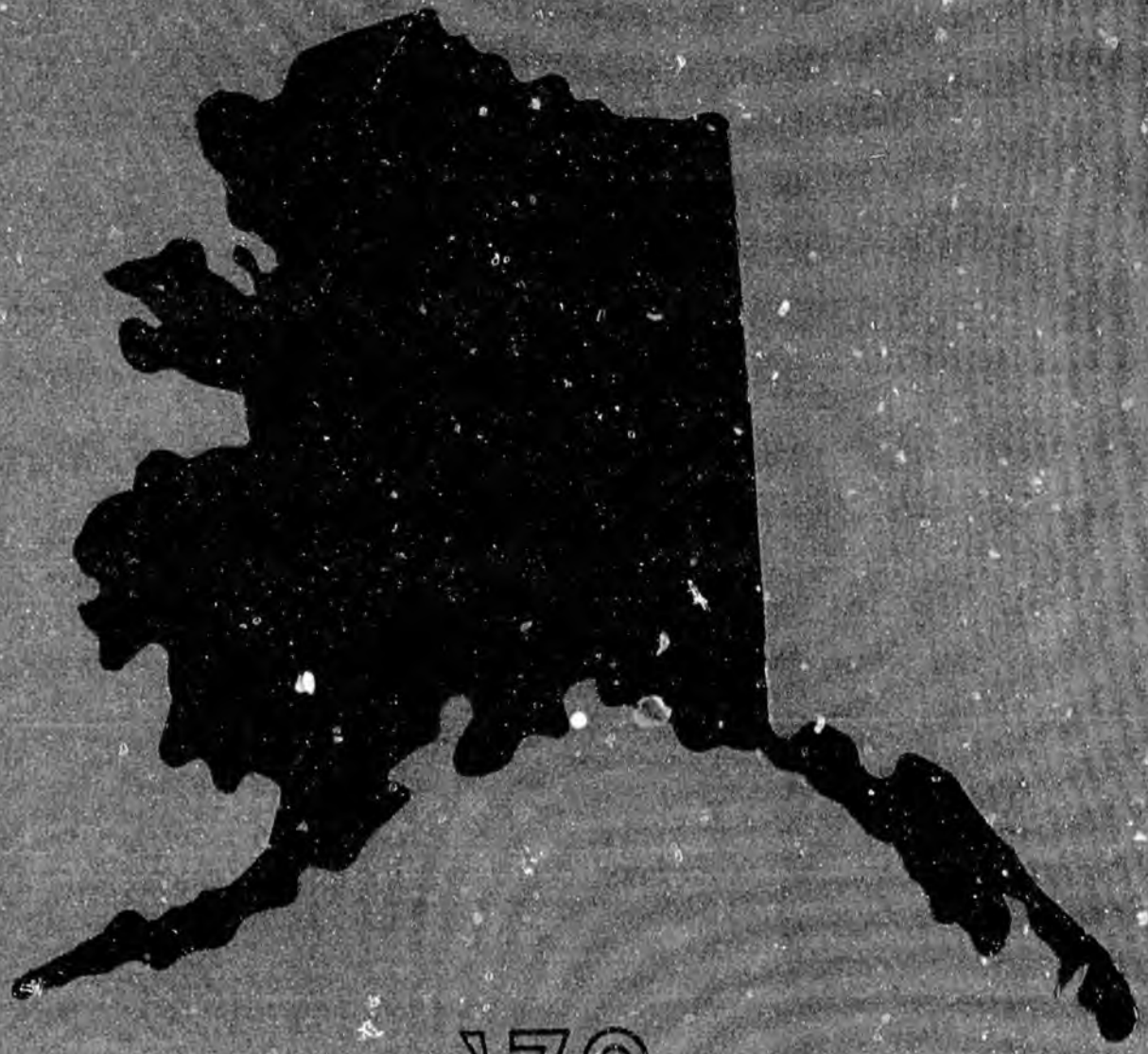
March 28, 1980

Telegram to: Representative Jack Fuller
Senator Frank Ferguson
House Community and Regional Affairs Committee
House Finance Committee

Urge your support of House Bill 974 and 975 to increase State aid to Community Hospitals. The effect in Nome will be to increase our hospital's ability to deal with skyrocketing operating costs. Presently, adjustment of rates to consumers are virtually impossible to make in a timely enough fashion to keep pace with the change in fuel and other operating costs. For the rural hospital with rapid changes in utilization of the hospital this can create very real uncertainties and, or, financial crisis. The added support called for in this legislation will greatly aid all rural hospitals.

William M. Dann
Executive Director

ALASKA STATE HOSPITAL ASSOCIATION
&
LONG TERM CARE DIVISION



'79

COST CONTAINMENT REPORT

'79 Cost Containment Report

The Voluntary Effort

In Alaska 100% Membership

Resolutions of Alaska's Hospitals

Senate Joint Resolution #22 applauds the voluntary cost containment efforts of Alaskan hospitals and requests a progress report to the legislature. The Alaska State Hospital Association, representing its membership, appreciates the opportunity to report on the success in containing the increase of health care costs in Alaska.

The Voluntary Effort, to contain the increase in expenditures and health care costs in the United States, was begun in November, 1977, in all 50 states. This is a cooperative effort of the members of the American Hospital Association, the American Medical Association and the Federation of American Hospitals. The purpose of the Voluntary Effort is to bring together health care providers, insurers, suppliers, business and consumers in a joint program of voluntary action to contain health care costs as an alternative to additional government bureaucracy. The long range goal is to moderate the increase of total health care expenditures, with an immediate target of reducing the rate of increase in health care expenses by two percentage points in 1979, or in range with the Consumer Price Index (CPI), whichever reflects the lower percentage.

The Alaska Voluntary Cost Containment Committee implements and monitors this program in Alaska. This working committee of the Alaska State Hospital Association consists of representatives from the health insurance industry, state governmental agencies, major statewide health care and hospital associations, hospital supply industry, and recognized accounting professionals.

In Alaska, 100% membership participation in this voluntary program has been achieved. In keeping with the national Voluntary Effort, the following resolution has been approved by each member hospital Board.

WHEREAS, the American Hospital Association, the American Medical Association, and the Federation of American Hospitals, in recognition of the need to restrain the rate of increase in health care expenditures, agreed to organize a Voluntary Cost Containment Program and urged each hospital to reassess its operating and capital budgets to see if anything further can be done to reduce these budgets, consistent with sound medical practice, and

WHEREAS, the American Hospital Association, the American Medical Association, and the Federation of American Hospitals have organized a National Steering Committee on Voluntary Cost Containment, which has developed a 15-point program to be implemented through state-level voluntary cost containment committees and through voluntary action of individual hospitals, and

WHEREAS, the Governing Board has thoroughly reviewed these developments with the medical staff and the chief executive officer and is in agreement with the steps that have been taken at the national and state levels, and

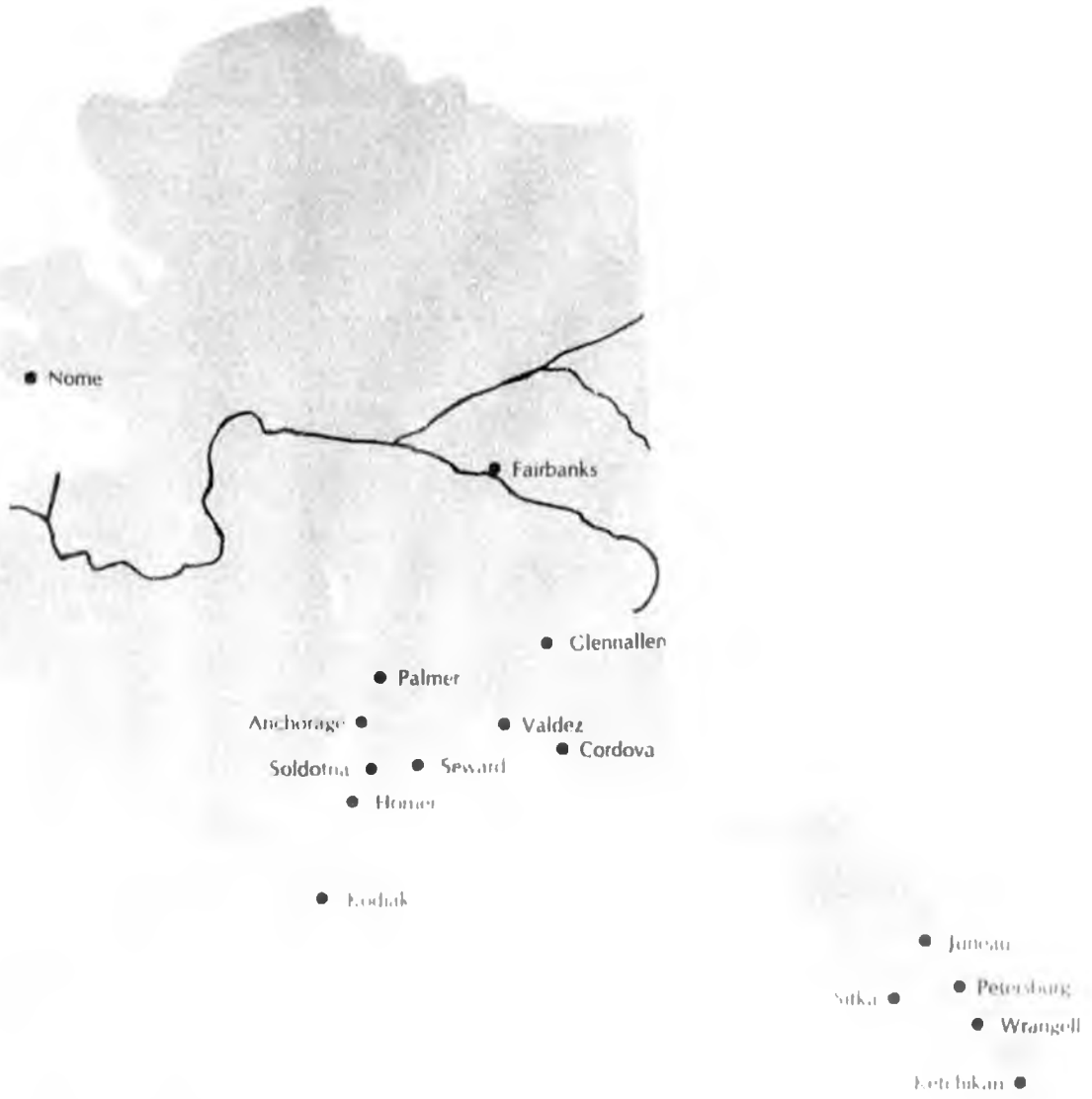
WHEREAS, the Local Governing Board is committed to voluntary action as the key to cost containment and desires to play a leadership role in demonstrating the value of voluntary action in cost containment,

Resolved

THEREFORE, BE IT RESOLVED, that the Local Governing Board supports the program of the National Steering Committee on Voluntary Cost Containment, has reassessed its operating and capital budgets to see if additional reductions or postponements can be made, consistent with sound medical practice, pledges the use of all reasonable means to keep operating expenditures and capital budgets at the lowest levels, consistent with sound medical practice; and seeks provisional certification by the State of Alaska Voluntary Cost Containment Committee.

Endorsing Members

Alaska Hospital & Medical Center
Bartlett Memorial Hospital
Central Peninsula Hospital
Cordova Community Hospital
Fairbanks Memorial Hospital
Faith Hospital
Ketchikan General Hospital
Kodiak Island Hospital
Norton Sound Regional Hospital
Petersburg General Hospital
Providence Hospital
Seward General Hospital
Sitka Community Hospital
South Peninsula Hospital
Valley Hospital
Valdez Community Hospital
Wrangell General Hospital



Participating Facilities in Alaska

Location	Hospital
Anchorage	Providence Hospital
Anchorage	Alaska Hospital & Medical Center
Cordova	Cordova Community Hospital
Fairbanks	Fairbanks Memorial Hospital
Glennallen	Faith Hospital
Homer	South Peninsula Hospital
Juneau	Bartlett Memorial Hospital
Ketchikan	Ketchikan General Hospital
Kodiak	Kodiak Island Hospital
Nome	Norton Sound Regional Hospital
Palmer	Valley Hospital
Petersburg	Petersburg General Hospital
Seward	Seward General Hospital
Sitka	Sitka Community Hospital
Soldotna	Central Peninsula Hospital
Valdez	Valdez Community Hospital
Wrangell	Wrangell General Hospital

National Hospital Standings

Total Beds Per 1,000 Population

Dist. Columbia	7.3	Arkansas	4.7	New Hampshire	4.1
North Dakota	6.8	Pennsylvania	4.7	North Carolina	4.0
Nebraska	6.1	Texas	4.6	Virginia	4.0
Minnesota	6.0	Maine	4.6	California	3.9
Iowa	5.8	Ohio	4.6	South Carolina	3.9
Kansas	5.7	***United States**	**4.5**	Idaho	3.8
West Virginia	5.7	Massachusetts	4.5	Oregon	3.8
Missouri	5.5	Louisianna	4.5	Rhode Island	3.8
South Dakota	5.5	Wyoming	4.4	Arizona	3.7
Wisconsin	5.3	Oklahoma	4.4	Delaware	3.6
Tennessee	5.2	Michigan	4.4	Connecticut	3.5
Montana	5.2	Indiana	4.4	Washington	3.4
Illinois	4.9	Georgia	4.3	Maryland	3.3
Alabama	4.9	Kentucky	4.3	New Mexico	3.3
Florida	4.9	Colorado	4.2	Utah	3.1
Vermont	4.8	Nevada	4.2	Hawaii	3.1
Mississippi	4.7	New Jersey	4.1	**Alaska**	**2.4**
New York	4.7				

Admissions Per 1,000 Population

Dist. Columbia	253	Georgia	169	New Hampshire	151
West Virginia	210	Florida	167	Oregon	149
North Dakota	208	Ohio	167	New York	148
Tennessee	193	Oklahoma	166	South Carolina	146
Iowa	192	Colorado	164	Washington	146
Arkansas	188	Maine	163	Utah	146
Kansas	188	Wisconsin	162	Virginia	143
Nebraska	185	Wyoming	161	California	141
Missouri	184	***United States**	**160**	New Jersey	139
South Dakota	183	Pennsylvania	160	Rhode Island	137
Alabama	181	Indiana	158	Arizona	135
Minnesota	179	Vermont	156	Connecticut	134
Mississippi	179	Nevada	156	New Mexico	134
Montana	178	Idaho	154	Delaware	126
Louisiana	177	Michigan	153	Maryland	115
Texas	174	North Carolina	153	Hawaii	112
Kentucky	172	Massachusetts	152	**Alaska**	**102**
Illinois	170				

Per Capita Personal Income

Alaska	**$10,178**	Pennsylvania	$ 6,466	Montana	$ 5,600
Dist. Columbia	8,648	***United States**	**6,441**	Georgia	5,571
Illinois	7,432	Iowa	6,439	Utah	5,482
Connecticut	7,374	Ohio	6,432	Vermont	5,480
Nevada	7,147	Oregon	6,331	Tennessee	5,432
Delaware	7,060	Wisconsin	6,293	Kentucky	5,423
New Jersey	7,059	Virginia	6,276	North Carolina	5,409
California	7,064	Indiana	6,257	North Dakota	5,400
New York	7,100	Texas	6,243	West Virginia	5,394
Maryland	7,036	Nebraska	6,240	Louisiana	5,386
Michigan	6,994	Minnesota	6,153	Maine	5,385
Hawaii	6,969	Florida	6,108	New Mexico	5,213
Washington	6,772	Missouri	6,005	South Carolina	5,126
Wyoming	6,723	New Hampshire	5,974	Alabama	5,105
Massachusetts	6,585	Arizona	5,817	Arkansas	5,073
Colorado	6,503	Idaho	5,726	South Dakota	4,796
Rhode Island	6,408	Oklahoma	5,667	Mississippi	4,575
Kansas	6,492				

National Hospital Standings

Hospital Expenses Per Capita As % of Per Capita Income

Dist. Columbia	5.65	***United States**	**3.28**	Texas	2.82
Massachusetts	4.65	California	3.27	Oregon	2.80
New York	4.03	Louisiana	3.24	Maryland	2.79
North Dakota	3.83	Wisconsin	3.24	North Carolina	2.77
Missouri	3.75	Nebraska	3.17	New Jersey	2.71
West Virginia	3.72	Mississippi	3.17	New Mexico	2.70
Rhode Island	3.66	South Dakota	3.07	Delaware	2.67
Maine	3.58	Georgia	3.05	South Carolina	2.66
Minnesota	3.52	Oklahoma	2.97	Montana	2.66
Florida	3.49	Colorado	2.97	New Hampshire	2.63
Tennessee	3.48	Iowa	2.96	Virginia	2.60
Michigan	3.44	Connecticut	2.96	Utah	2.55
Ohio	3.43	Nevada	2.95	Washington	2.42
Pennsylvania	3.42	Indiana	2.93	Idaho	2.33
Illinois	3.41	Kansas	2.92	Hawaii	2.06
Vermont	3.40	Kentucky	2.88	Wyoming	1.88
Alabama	3.39	Arkansas	2.84	**Alaska**	**1.39**
Arizona	3.37				

Expenses Per Admission (Adj.)

Massachusetts	$1,703.96	Wisconsin	$1,120.23	Iowa	$ 894.66
New York	1,677.90	Missouri	1,108.45	Tennessee	893.69
Dist. Columbia	1,661.55	Minnesota	1,106.75	New Mexico	891.46
Rhode Island	1,495.96	Hawaii	1,089.21	New Hampshire	888.75
Maryland	1,457.98	Vermont	1,043.15	Alabama	883.71
California	1,403.20	Oregon	1,040.60	Georgia	879.98
Connecticut	1,390.28	Colorado	1,028.83	North Carolina	858.06
Michigan	1,347.96	Virginia	1,015.19	West Virginia	838.83
Illinois	1,332.73	Indiana	1,014.57	South Carolina	830.71
Delaware	1,317.18	Maine	993.73	Utah	815.63
New Jersey	1,245.81	Nebraska	979.70	Kentucky	802.90
Arizona	1,239.16	Washington	973.11	Idaho	751.34
Nevada	1,211.58	North Dakota	929.83	South Dakota	748.76
Pennsylvania	1,189.20	Oklahoma	922.02	Mississippi	739.87
Ohio	1,171.86	Texas	916.49	Montana	735.52
Alaska	**1,170.16**	Kansas	911.55	Arkansas	709.27
***United States**	**1,164.49**	Louisiana	897.67	Wyoming	691.24
Florida	1,152.37				

Compiled by the Department of Health Systems Studies, Hospital Research Center
Sources of Data: American Hospital Association, U.S. Department of Commerce, U.S. Department of Labor

NB Please note the state by state inventory of health care costs and bed ratios. As you will notice, Alaska is at the lower range in all categories.

NB Although some national statistics indicate that Alaska has a higher daily cost, when applied to Alaska's average shorter length of stay, costs per admission are in line with the U.S. average.

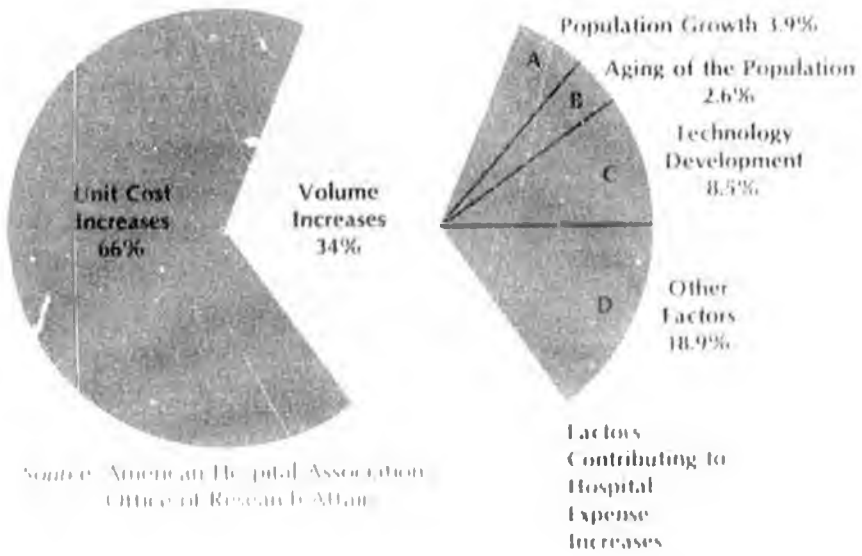
National Overview

Factors contributing to hospital expense increases can be grouped into two major categories: Price increases or inflation affecting unit costs and increases in the volume or quantity of hospital services provided to patients.

An increase in unit cost is due to inflation if there is no change in quantity, quality, and productivity. For example, inflation in hospitals is reflected in unit cost increases resulting from wage increases in excess of productivity gains, increased prices for materials used by hospitals such as fuel and food, increased physician fees, higher insurance premiums, and higher interest rates for borrowed funds. In addition to these factors, increased unit costs have resulted from increased government regulations and improvements in quality, both of which are difficult to measure.

Increases in hospital expenses due to volume have been broken down into four main factors, as noted in the chart below. During the time span of this study, the nationwide quantity of hospital services increased because the population increased, and those aged 65 or over (who require over three times more hospital services than the under 65 category) also increased. Advances in medical science and technology accounted for 8.5 percent of the increase in hospital expenses.

Other factors accounted for approximately 19 percent of the increase in total hospital expenses. These factors include broader health services coverage for more individuals by private health insurance, and expanded governmental programs such as Medicare and Medicaid. Another factor was expanded employee health benefits and higher incomes, allowing individuals to purchase more hospital services.



Factors Contributing to Hospital Expense Increases

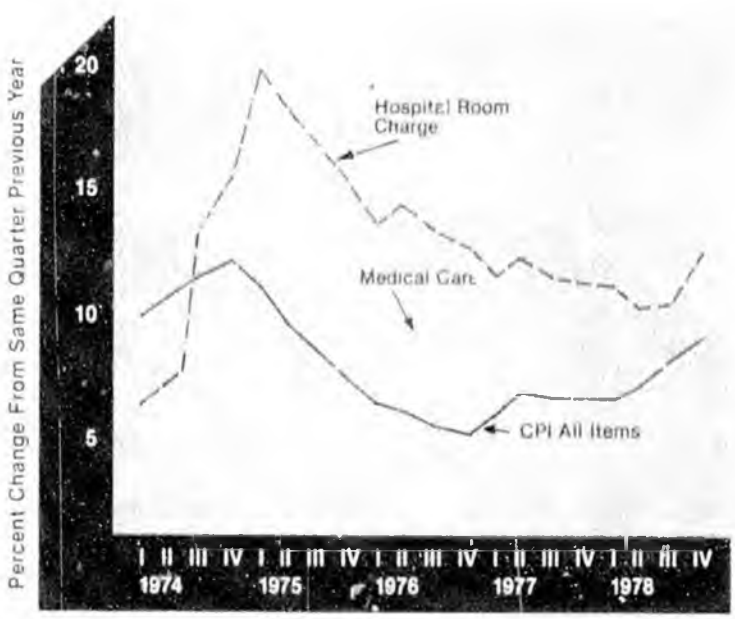
Source: American Hospital Association Office of Research & Affairs

Inflation in the Health Sector

Trends in the growth of prices for the health sector should be compared to trends for the general economy. The health sector is monitored using the Hospital Room Charge and the Medical Care Component of the Consumer Price Index (CPI). Economy-wide inflation is measured using the overall CPI.

Similar growth patterns have occurred over the last five years for the three indicators since the initiation of the Voluntary Effort at the end of 1977, the growth of the three inflation measures has been slowly rising. Since the middle of 1978, however, the general rate of inflation has begun to accelerate. The Medical Care Component of the CPI has shown only a slight increase since the Voluntary Effort began, and is now increasing at a substantially slower rate than the CPI as a whole. During the first quarter of 1979, the Medical Care Component showed a stable rate of increase, while the CPI continued to accelerate. The Hospital Room Charge Component grew steadily and, as in past years, at a higher rate than other measures of inflation until the fourth quarter of 1978 when there was a surge in room prices. During the first quarter of 1979, however, the hospital room index decelerated, despite the continued rapid growth of general consumer prices.

CHART 5



Economy wide Price Inflation vs. Price Inflation in the Health Sector

Source: Bureau of Labor Statistics, U.S. Department of Labor
American Hospital Association
Office of Research Affairs

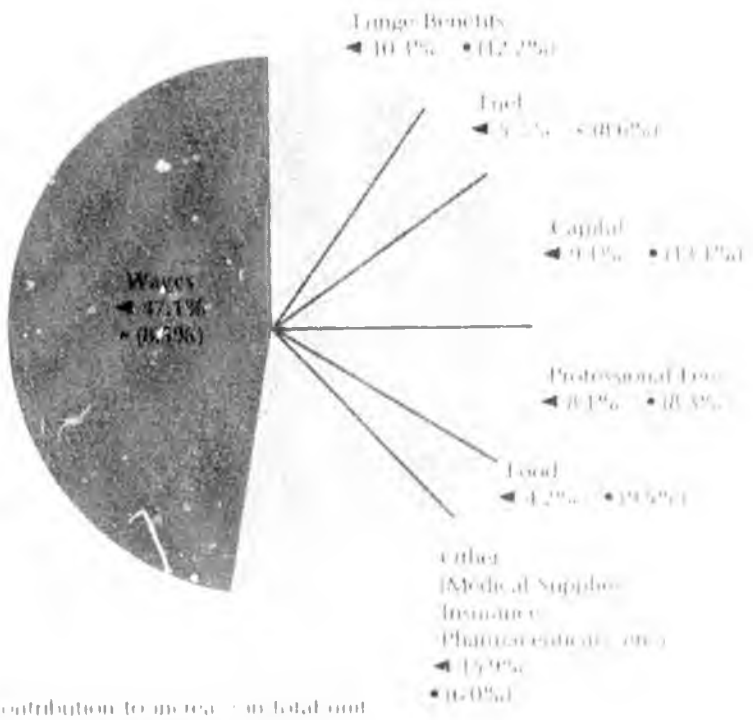
Hospital Market Basket Prices

Both inflation and an increased volume of services contributed to hospital expense increases in 1978.

"Hospital market basket" price increases refer to increases in the unit cost of the goods and services hospitals purchase. Market basket price increases include wage increases and increased acquisition costs (purchase prices) for materials such as fuel, food, professional fees, insurance and borrowed funds.

Approximately two-thirds of the increase in hospital costs has been caused by Hospital market basket price inflation since 1969. The chart below examines some of the elements of the increase in market basket prices, and shows their relative contribution to the overall increase in the cost of the hospital market basket during 1978.

Total hospital expenses for the fourth quarter of 1978 were 12.8 per cent or $1.8 billion higher than total expenses for the fourth quarter of 1977. 45.7 percent or $810 million of this increase was due to growth of services, and 54.3 percent or $962 million was due to market basket price increases.



◄ Contribution to increase in total cost over 1977 levels
• Percent increase in unit cost from 1977-78

Source: American Hospital Association Office of Research Affairs

Hospital Market Basket Components and Their Relative Increase in 1978

Growth in Hospital Service Volume

Nationally since 1973, the total volume of hospital services has increased at an average annual rate of 6.8 percent. Between 1977 and 1978, the total volume of services increased 5.5 percent.

Increasing service intensity accounted for 74 percent of the increase in the total volume of services provided by hospitals during the 1973 to 1978 period. Increasing service intensity reflects:

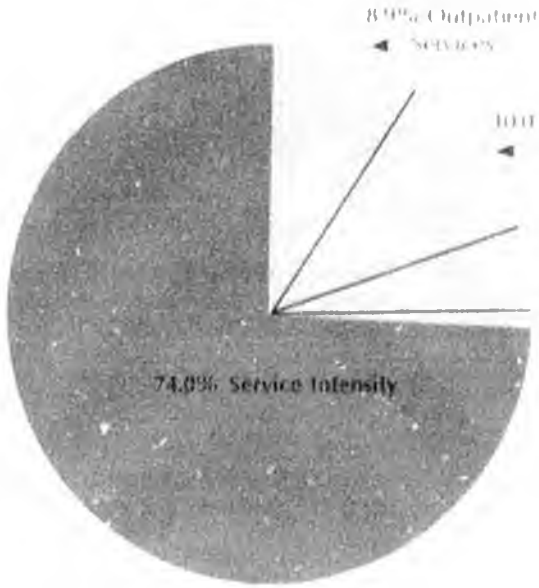
a. Changes in patient mix, particularly increases in the number of patients over-65 years of age.

b. The development of new services.

c. Shorter average length of stay which requires more services to be provided on each day.

d. Regulations requiring hospitals to provide more services, particularly in the administrative area.

Available information indicates that trends in Alaska correspond to the national pattern.



Factors Contributing to Growth of Hospital Service Volume, 1973-1978

Source: American Hospital Association Office of Research Admin.

Note:
The 0.9 percent net increase in under-65 population represents the combined effect of a 3.0% percent growth of population offset by a 2.1% percent decline in the patient day use rate. As population growth outpaced the reduction in the use rate, the volume of services to the under-65 population increased.

Voluntary Effort Commitment in Alaska

Hospital cost containment programs have existed for some time, but the Voluntary Effort gave such efforts nationwide focus which increased the commitment in Alaska. Historically, the hospitals in Alaska have had to maintain a close rein on expenditures due to the higher cost of living, which is reflected in the cost of all supplies and manpower used to keep a hospital operational. During the past several years, our hospitals have been diligent in improving the efficiency of their health delivery, and are continuing to improve management techniques. These efforts are reflected in recognizable savings.

Shared Services

Hospitals throughout Alaska have the opportunity to participate in several shared service programs which help reduce a hospital's operating costs. Through **Group Purchasing**, contract member institutions combine their volume in certain categories of high volume or expensive supplies to receive better pricing and/or services. This coordinated, statewide programs involves approximately 800 acute care beds in Alaska. While savings to members are not always obvious, actual savings are identifiable beginning with the first contract. The "Group Price" becomes the state market price, which fluctuates, but which will always be lower than pre-contract prevailing prices.

Another shared service is our **Circuit-Riding Controller Program** which allows facilities to share controller services to improve their financial capabilities while eliminating the necessity for smaller facilities to hire a full time controller. Presently, five institutions are served by this program.

Shared Services

A unique shared service is the **Audio Visual Library** which has over 500 videocassettes available for use by health services in Alaska. These programs are mailed to the requesting facility, and allow each institution to structure the educational program to fit their needs. New videocassettes are purchased periodically to maintain current quality of the educational material. Facilities share the cost of this central resource, at a great savings over employing full time educational directors or retaining professional consultants periodically.

Health care facilities are mandated by state and federal regulations to maintain medical records in accordance with accepted standards and practices. A continuing shortage of certified medical record technicians makes it extremely difficult for many of our smaller hospitals to successfully fill this position. A traveling **medical record consultant** is available to these hospitals needing this service.

Some hospitals share **laundry services** as well as utilizing **pharmacy** and **dietary consultants.** There are also **energy audit consultant services; shared technical services;** and **continuing education/inservice training programs;** all of which support cost containment.

Consumer Price Index

The unique aspect of the Voluntary Effort is that it has developed a monitoring mechanism to identify and measure the total economic growth in hospital spending over a specific period of time. In the past, hospital spending was frequently measured against the CPI which indicates the relationship between expenses and the inflation rate, but fails to include the unique factors (such as the continuous hours of service, variety of technical/professional, special technological equipment, etc.) which distinguish health care from the general economy.

To remedy this, the Voluntary Effort data will reflect the following areas:

1) inflation experienced in a given period for the cost of goods and services hospitals must purchase;

2) increased expenses related to increased use of services resulting from population growth and aging;

3) technological costs related to improvements in diagnostic and treatment capabilities in medical care.

The Voluntary Effort Today

Where is the Voluntary Effort today? Hospitals during the past year have significantly reduced the rate of increase in health care operational costs. Nationally, in 1976, the rate of increase in hospital annual expenditures was 19.1%. By the end of 1978, that figure had been reduced to 12.8%.

More importantly, the difference between the increase in the GNP and the rate of increase in hospital expenditures has been reduced continually since 1976. **It is important to point out that since February, 1979, the medical index of the CPI has been below the CPI average.**

Some have said that the Voluntary Effort is simply a political response. To the contrary, it is something that has been needed in our country not only in the health care industry, but in all major industries. **By necessity, Alaska's hospitals have been applying cost controls before they became a part of the national program.**

International Comparison

Annual Percentage Increases in Health Care Expenditures, Gross National Product (GNP), and Consumer Price Index (CPI) 1965-1975

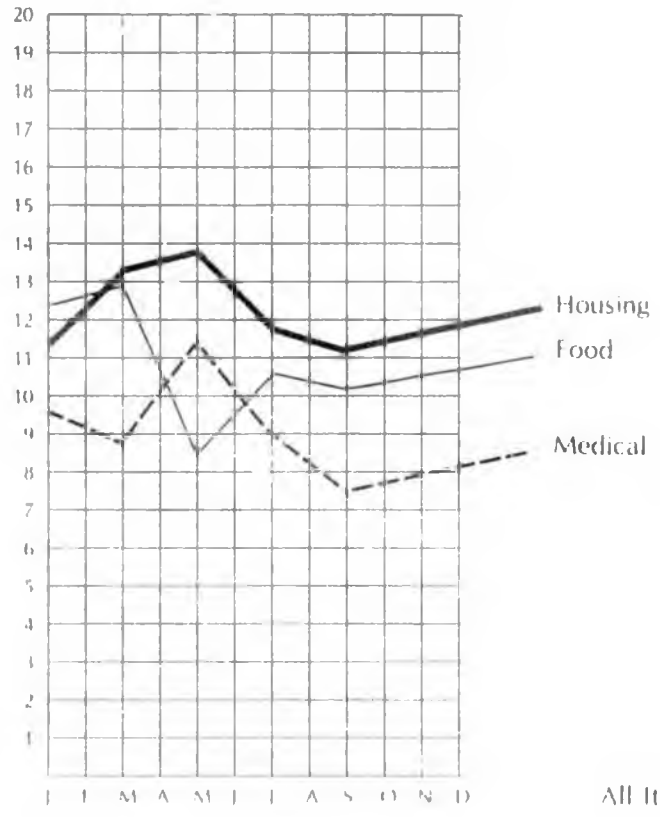
	Health Expenditures[a]	GNP[b]	CPI[b]
Canada	13.45	11.49	5.3
France	14.53	11.05	6.3
Federal Republic of Germany	13.84	8.56	4.2
Netherlands	17.88	11.73	6.5
Sweden	15.04	9.76	6.1
United Kingdom	14.97	11.00	8.5
United States	12.00	8.32	5.2

SOURCES: (a) Simanis, Joseph G., and John R. Coleman, "Health Care Expenditures of Postindustrial Countries," Social Security Bulletin (forthcoming)
(b) International Monetary Fund, International Financial Statistics, Vol. XXXI, No. 5, May 1978. Washington, D.C., 1978.

Cost of Living Statistics

Consumer Price Index Alaska 1979

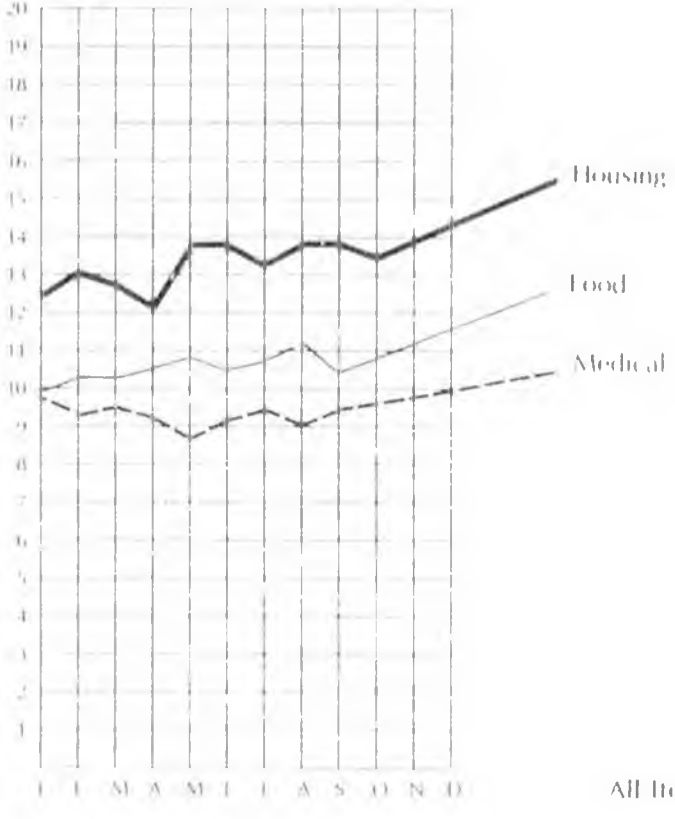
Source: Department of Labor Statistics



All Items 10.4%

Consumer Price Index U.S.A. 1979

Source: Department of Labor Statistics



All Items 12.1%

Regulation Impact on Health Care Costs

Various government entities have shown support and cooperation with the Voluntary Effort. All three Alaskan Congressmen and many of our state legislators have shown support for and endorsed the success of the hospital Voluntary Effort. However, the major threat to the continued success of the Voluntary Effort still comes from government. There are two major areas in which anticipated government action would impede the continued success of the Voluntary Effort.

1. CONTINUED INCREASE OF GOVERNMENT REGULATIONS OF THE HEALTH CARE INDUSTRY. A recent major study indicates that over 25% of hospital costs are attributable to meeting government regulation requirements. Therefore, the most dramatic action to affect hospitals cost savings would be to halt the ever increasing impact of government regulations in the health care industry.

2. THE CARTER ADMINISTRATION HAS PROPOSED AND IS VIGOROUSLY SEEKING **VOLUNTARY** WAGE AND PRICE CONTROLS FOR HOSPITALS WHILE **LEGISLATING LIMITS ON HOSPITAL CHARGES.** (This administration-endorsed bill was defeated in 1978 and 1979 by Congress.)

Such legislation singles out the health care industry by imposing limits upon the ability to generate revenue while allowing labor and other costs to increase. This is ironic since the hospitals are presently the only major industry in the United States to successfully institute a voluntary effort to control their costs. Such mandated controls would be unsuccessful since it would be applied to a single industry, while other industries are allowed to change wages and prices in adjusting to the inflation in the economy. The cost of implementing and maintaining the controls on hospitals would negate the savings achieved by the hospitals and would destroy these private sector institutions that have become the best in the world.