ALASKA LEGISLATURE COMMITTEE FILES 1991-1992 8672
7395 SENATE HEALTH EDUCATION & SOCIAL SERVICES

What is RBRVS à la Medicare or à la SB83 going to do for access to services? For one thing, several large internal medicine practices in Anchorage have already stopped taking new Medicare patients. In my own specialty, Medicare will reimburse me $57.20 for spending half an hour inserting a pair of tiny silicone plugs into the tear drains of people with very dry eyes. The plugs alone cost me $87.50 a pair from the sole manufacturer of the product. So, when I seen this Medicare patient I effectively get paid nothing for my time and have to spend $30 on top of it!

An internist told me the other day that he would have to pay more for a plumber to make a simple repair than he would get paid for admitting a sick, old lady in the middle of the night. Well, like welfare Cadillac stories, I wondered about this one. So I checked it out. I called a few plumbers, and asked what it would cost to replace the circulating pump on my furnace on a Saturday night. The answer: $90.00 an hour, two hours minimum, counting time to and from the shop, plus $77.50 for the pump: $257.50. Then I consulted the RBRVS manual, looked up the code that would apply to spending four hours admitting an old, dehydrated person with pneumonia at 2AM, not counting time to and from home, a total of, say, five hours of doctor time in the middle of the night. I would collect $121.18, no night time differential, and, if I see the patient one or two more times the next day, that's included in the $121.18 as well.

As long as Medicare is the only program paying below its share of costs, providers can still manage to see their elderly Medicare patients because they can still charge their other patients more than Medicare's 34 cents on the dollar: that's called cost-shifting. But if *all* services were reimbursed at Medicare rates, as proposed in a Congressional Budget Office

document, (and this is private medicine's worst nightmare), many, many physicians would have to close their offices because their revenues would fall below their expenses.

This is real, not a threat or a joke. Doctors don't work out of the front room of their houses any more as they did when we were kids. They pay rents, staff salaries, malpractice insurance, business liability insurance, unemployment insurance, phone bills, fax bills, office supply expenses, accounting expenses, computer costs, business property taxes, just like everyone else. No doctor could survive seeing 100% Medicare patients unless he ran them through his office at the rate of one every three minutes, which is no certainly no way to practice medicine. And in states where Medicaid pays even less than Medicare, notorious "medicaid mills" have been in existence for years, which *do* practice like that.

This rather lengthy explanation reveals why doctors are so incredibly wary of government price controls and government promises to "trust us." Once burned, twice shy. That's why, in our CHIPRA proposal, we employ market-based mechanisms to control rising costs.

Overall, the opinion of most health economists clearly indicates that rate-setting cannot be used as the sole method of cost containment and health system reform. Doing so will lead to profound and sometimes unanticipated dysfunctions elsewhere in the system. Yet this is precisely what SB83 is designed to do.

As far as I can see, the principal virtue of SB83 is that it caters to the resentments and frustrations that most people have about the high costs of health care; it bashes doctors and hospitals, (two favorite targets); it

sounds simple; and it's easy to find people to testify for it, just as it would be easy to find people to testify in support of a bill that cuts in half plumbers' fees, or lawyers' fees or the cost of automobile repairs. Its main defects are that it is a quick fix, it's not adequately tied to any other reform measures, and it will make the entire health care system much, much worse for Alaska's patients and providers alike. ASMA requests that you don't give it your support.

Health Insurance Association of America

STATEMENT OF HIAA

ON

SENATE BILL 83

PRESENTED BY:

JAN ANDREA MEISELS

LEGISLATIVE DIRECTOR

BEFORE THE

ALASKA SENATE COMMITTEE ON HEALTH, EDUCATION AND SOCIAL SERVICES

APRIL 10, 1992

22144 Clarendon Street Suite 220
Woodland Hills, CA 91367-6324
818-704-9274

Madame Chairwoman, Members of the Committee, I am Jan Andrea Meisels, Legislative Director of the Legal/State Affairs Department for the Health Insurance Association of America (HIAA), a trade association of the nation's leading commercial insurance carriers that provide health insurance for approximately 95 million Americans. HIAA is opposed to SB83.

SB83 is an attempt to control health care costs by having the state institute a new bureaucracy to set provider rates through expenditure targets, utilization standards, as the procurer or insurer to provide that health insurance and/or coverage to Alaskans. SB83, if enacted would eventually place the state in the role of single payer in the state, eliminating the private insurance market.

Based on the experience with other government programs, i.e. Medicare, Medicaid, the government set reimbursement rates are inadequate to cover provider costs -- which result in a lesser quality of care, denied access and shifting of utilization and costs to others. These government payer "attributes" are a major factor resulting in increasing costs to the private sector. Both Medicare and Medicaid have resulted in broken promises, budget deficits and with Medicaid, it has fostered arbitrary reductions in eligibility to the poor and payment to providers for services that they are expected to render at inadequate reimbursement rates with the result that many providers will no longer accept Medicaid patients due to the reimbursement rates. Due to its rural nature, Alaska is a state that can ill afford to have

providers so disenfranchised, that they may migrate to "the lower 48". The state is currently experiencing revenue shortfalls, so it is questionable how the state can assure reimbursement levels will not be affected by state budget woes, when the proposal calls for the state to eventually become the single payer for health care for all Alaskans.

The single payer concept subtly embraced by SB83 can be analagized to the Canadian health care system. The Canadian style of health insurance is fraught with negative features -- insurance is rationed by politicians and not by medical necessity, there are long-waiting lists for surgeries denied "as being elective" by government boards -- patients have died while awaiting "elective" surgeries and Canadian citizens benefit from the proximity of the United States medical system which serves as a pressure valve for the government-run system "north of the border". Although most forms of health insurance are illegal in Canada, private spending to enhance an austere government plan still accounts for more than one fourth of all health expenditures.

Advocates of the "single payer" system indicate -- erroneously -- that there will be "savings to the system" because of doing away with numbers of insurance companies and their operating expenses. While the cost may appear to be less, we assert that it is not less costly in the long run. At least three types of insurer operating expenses within the "claims

processing" function result in direct benefits to the consumer. Two of these go directly to reduce the overall expense of the health care system. When claims are filed, insurers verify not only the eligibility of the claimant for benefits; we also verify that the type of services provided and the individual or institution providing them are eligible for reimbursement under the benefit plan. A related "investment" by insurers is the detection of deliberate attempts to defraud insurers -- and thereby to defraud honest plan participants. Maintaining a pluralistic system, enhances competition which serves the public well. Among the advantages of this competition is that it encourages positive technological innovation -- encouragement which is lacking in a single-payer system. In fact, other countries, including Canada, currently rely on and benefit from technological development in the United States. Health insurers also compete vigorously in the area of customer service. This results in several positive developments, including systems innovation and quality service and claims handling.

Perhaps most importantly, competition encourages efficient quality care. Employers and employees demand the allocation of resources to effectively administer the system, including implementing managed care programs. This ensures that care is appropriate and of high quality, and that reimbursement is made only when consistent with terms of the plan. Through these functions, the private sector collectively is working to control increases in health care costs. In contrast, what is being

advocated is to place a cap on expenditures without changing the way medical services are rendered.

One of the most important investments the private insurance system has made is the implementation of managed care features of a benefit plan. Managed care has as its primary objective the delivery of effective, appropriate medical care. When experts agree that 25 to perhaps 40 percent of medical services provided yields no significant medical benefit, and in some cases are actually harmful, it is clear that we need to focus on administrative resources on making sure that the medical care received by our insureds is appropriate and of good quality. By working with patient and provider, managed care plans improve the delivery of health care, by among other things, by reducing instances of unnecessary testing and procedures, and closely coordinating the delivery of care with the needs and desires of the patients.

SB83 advocates the Authority to develop and administer utilization standards. However, government-run systems are notoriously poor at this kind of individual judgement. The Professional Review Organizations (PROs) and their predecessors have been at best marginally effective; and legal requirements make it impossible, for all practical purposes, for government to develop effective managed care systems based on selection of efficient physicians and hospitals, as private insurers are aggressively undertaking to do. Thus, government health

insurance programs in most other countries, such as Canada, typically address cost control by simply limiting physician fees and putting a cap on hospital expenditures without changing the way medical services are rendered. Moreover, while Canadians may claim that their single-payer system is not "socialized medicine", because providers are not directly employed by the government, there is little doubt that the allocation of health care resources is centrally planned, just as it would be in a socialist state: In Canada, all major hospital decisions to invest in new technology or services must be approved by the provincial governments.

It is quite clear that new, high-tech services simply are not adequately available in Canada, and therefore, patients who need them have to wait in line. This "rationing by queue" is the inevitable result of government attempts to control costs by restricting health care budgets while publicly espousing a commitment to universal access. Because anything new represents an additional cost, a bureaucratic budgetary approach to cost control discourages innovation, perpetuates existing inefficiencies, and leads to creeping obsolescence. This is an outcome we must strive to avoid as we seek a uniquely American solution to our cost and access problems.

A pluralistic, private system gives the customer a range of options to choose from -- and trade offs to make. If a customer is unhappy, he can switch his coverage to another insurer.

Choice stimulates competitors to provide good, high quality care and service. Private insurers have the ability and incentive to mold benefit packages to meet the needs of the beneficiaries. These preferences reflect the make up the employer's wor force, budget size, competition, regional variations and the need for employers to retain their work force.

Attached to this statement are several articles from Springfield, Illinois which talk about problems Illinois is having with their state employees program -- which is self-insured and self-administered. Due to the state's fiscal problems, the state employee health insurance plan is being adversely affected due to under funding by $135-150 million in this fiscal year which is resulting in excessive delays in claims payment. The time lag for claim payments effect not only the health care providers, but also the insureds -- the residents of Illinois -- the state employees. Basically, how would Alaskans feel if this happened to them -- considering that this may occur with a single payer -- government controlled -- health care financing system. Excessive delays in claims payments, with the citizens of Alaska potentially facing fiscal adversity due to the state's fiscal problems.

The fiscal note on SB83 has been estimated at $377,000. HIAA believes this is substantially understated. The cost for administering the program will be expensive because the expenditure targets will eventually have to be related to the

individual health care provider -- physician, hospital, pharmacist, laboratory service and other providers. For example, the Maryland Health Care Service Cost Review Commission which approves budgets and rates for 52 acute care hospitals, six psychiatric hospitals and four chronic facilities has a budget in FY 1993 of $2.1 million. We recognize, that Alaska has 24 hospitals and nursing homes -- slightly less than half the number of facilities in Maryland. However, SB83 grants the Authority expenditure target responsibility and the ultimate rate determination for physicians, pharmacists, laboratory services and other health care providers which are not controlled by the Maryland Health Care Service Cost Review Commission. Therefore, we believe the total cost of administering this program, let alone the provision of self insuring for the residents of Alaska will be considerably higher than the $377,000 fiscal note. In addition, calculated into the equation for the cost of the state, should be the loss of premium tax revenues the state generates from insurance companies. With the enactment of SB83, the state would lose the premium tax revenues that commercial health insurance companies pay as the state determines to procure insurance from a single insurer or self insurers and administers and eliminates all private insurers.

Included in SB83 is the requirement that three provider representatives be selected by their constituents to negotiate expenditure targets with the Authority. It may be questionable whether providers may be permitted to do this type of negotiation

without some sort of federal anti-trust clearance. The Committee may wish to obtain a legal opinion as to the legality of the requirement for providers to negotiate rates by themselves so that it does not violate Federal Trade Commission anti-trust requirements.

The proposal for expenditure targets and the resultant individual provider rate setting implications are reminiscent of the current federal Medicare reimbursement system where the rates are reduced, but not the number of services or the eligibility to services. While the proposed Alaska Health Resources Authority is charged with developing expenditure targets for the entire state, a large percentage of that population is covered outside the state's jurisdiction -- people covered by Medicare, Medicaid, CHAMPUS, the military, the Bureau of Indian Affairs, employees under the Federal Employees Health Benefit Act -- to name but a few. The reimbursement, benefit level and eligibility are all decided by the federal government and therefore will not be influenced by the state bureaucracy of the Alaska Health Resources Authority. Therefore, the alleged controls espoused by SB83 is a result of a partial expenditure target i.e. "a house with missing walls", so that there really is no "control". If the proposed expenditure target takes into effect the federal government program revenues, it will result with the remaining non-federal government covered citizens having the "privilege" of subsidizing these underfunded government programs by further

inappropriate and inadequate rates which will result in a negative effect on the health care of all Alaskan residents.

There is a definite need for Alaska to address both access and costs. The insurance industry is strongly committed to successfully addressing both of these issues. SB242 greatly enhances access to the groups that are most in need -- small employers -- as 90 percent of Alaska's employers have 25 employees or less. Further, we strongly believe that the managed care programs which ensure only medically necessary care provided in the most cost efficient setting, by quality health care providers is the way to address health care costs. Private insurance companies have a substantial investment in the development and promotion of effective managed care programs. Private insurance managed programs are not a governmental bureaucratic centralized autocracy such as being advocated in SB83 -- but rather they examine the needs of the individual patient, working with the patient's physician to determine what is most appropriate. Managed care is working both by enhancing health care quality and controlling medical expenditures. We therefore respectfully request that the Senate HESS Committee not approve SB83.

STATE OF MARYLAND

CHARLES O. FISHER, SR.
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EXECUTIVE DIRECTOR

HEALTH SERVICES COST REVIEW COMMISSION

4201 PATTERSON AVENUE — 2ND FLOOR — BALTIMORE, MARYLAND 21215
AREA CODE 410-764-2605
FAX-410-764-5987

April 9, 1992

Ms. Jan Andrea Meisels
Legislative Director
Health Insurance Association of America
22144 Clarendon Street
Suite 220
Woodland Hills, California 91367-6324

Dear Jan:

Enclosed is a copy of the FY93 budget allowance for the Health Services Cost Review Commission (HSCRC). You will note the total expenditure is $2.1 million. Other than salary and fringe benefits, the largest single component is for contractual services which incorporates several contracts for processing the HSCRC data. The total budget is financed through a user fee assessed on hospital patients and included in the rates set by the HSCRC. The industry we regulate includes 52 acute hospitals, six private psychiatric hospitals and four chronic facilities. According to the annual disclosure report for FY91 total revenue is approximately $4 billion. According to AHA statistics for 1990, the state of Alaska had 16 community hospitals with total expenses of only $318 million. Although there are certain fixed costs associated with operating a Commission, I can well imagine a substantially lower budget for accomplishing the same purposes as the HSCRC in a state with one quarter of the hospitals and one tenth of the revenue as in Maryland.

Should you require any additional information, please feel free to contact me.

Sincerely,

John M. Colmers
Executive Director

[illegible]eneral\meisels.409

TDD for the Disabled
Baltimore Area 383-7555

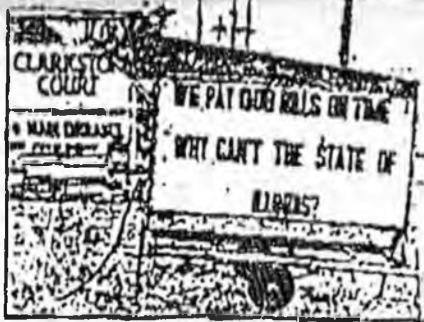
FROM:CENTRAL SERVICES TO: 8187041853 APR 9, 1992 9:04AM P.0

Dept of Budget & Fiscal Planning — BUDGET ESTIMATES — 32160202
Budget Form No. DBFP-DA-3 — FISCAL YEAR 1993

Reg atory Services
Health Services Cost Review Commission
Health Services Cost Review Commission
Health Services Cost Review Commission

Appropriation Statement:

		1991 Actual	1992 Appropriation	1993 Request	1993 Allowance
	Number of Authorized Positions	28.00	28.00	28.00	28.00
01	Salaries Wages and Fringe Benefits....	1,365,689	1,269,706	1,354,136	1,343,655
02	Technical and Special Fees............	8,100	13,284	13,284	13,294
03	Communication.........................	39,880	25,332	40,955	40,955
04	Travel................................	3,544	4,577	3,446	3,446
07	Motor Vehicle Operation & Maintenance.	78	483	725	725
08	Contractual Services..................	487,672	555,791	547,608	687,608
09	Supplies and Materials................	8,060	10,512	9,330	9,330
11	Equipment - Additional................				
13	Fixed Charges.........................	3,240	3,674	4,203	4,203
	Total Operating Expenses...........	542,502	600,569	606,267	746,267
	Total Expenditure.............	1,916,291	1,883,559	1,973,687	2,103,216
	Original General Fund Appropriation...	1,874,420	1,883,559		
	Transfer of General Fund Appropriation	41,871			
	Total General Fund Appropriation......	1,916,291	1,883,559		
	Less: General Fund Reversion/Reduction				
	Net General Fund Expenditure....	1,916,291	1,883,559	1,973,687	2,103,216
	Add : Special Fund Expenditure........				
	Federal Fund Expenditure........				
	Reimbursable Fund Expenditure...				
	Unrestricted Fund Expenditure...				
	Restricted Fund Expenditure.....				
	Total Expenditure.........	1,916,291	1,883,559	1,973,687	2,103,216
	Direct Local (Unappropriated)..				
	Total Expenditure	1,916,291	1,883,559	1,973,687	2,103,216



State Journal-Register/Rich Saal

This sign outside Clarkston Court in Springfield admonishes the state for being so far behind on paying its bills.

Between a doc and a hard place

Late medical insurance payments are a problem for state employees, too

By DOUG FINKE
STAFF WRITER

For Jack and Diane, two state employees, state government's credit rating isn't the issue. Their own is.

The General Assembly will convene in Springfield Wednesday to hear Gov. Jim Edgar's plan for fixing at least a $350 million hole in the state's budget.

When Edgar is finished, lawmakers will debate the wisdom of tax hikes, budget cuts, borrowing and other ideas (both those that are politically expedient and those that are not) for mending the budget hole.

Jack and Diane — a husband and wife who asked that their real names not be used — have little interest in whether Edgar or the legislature, Republicans or Democrats, come out ahead politically when the budget dust settles.

They're wondering how they're going to keep up with the medical bills when their first child is born this spring.

"The baby is due about a month after the state is projected to stop paying its bills," said Jack. "The doctors have been fine so far. (But) we've had indications the hospital may insist on a payment plan. It's going to be very, very difficult times for us."

Like most other bills owed by the state, payments for state employee health insurance claims are far behind the normal 60-day schedule. Lynn Calamo, benefits manager for the Department of Central Management Services, said the state is current for medical bills through Oct. 9, meaning some bills nearly three months old haven't been paid.

Three months isn't the longest backlog in the state's portfolio, but the impact of late medical insurance payments is just as acute for employees as late payments are for hospitals, nursing homes and pharmacies.

Calamo said there is just about an even split be-

See LATE on page 4

LATE

From page 1

tween medical providers who will wait for payments from the state health insurance program and those who are demanding that patients pay upfront.

When a physician requires a payment at the time a service is delivered, it's the employee who, in effect, is carrying the state until money is available to pay the claim.

Compounding the problem for state employees, though, is that Edgar and the legislature underfunded this year's health insurance program by an estimated $100 million. Projections now are that the state will simply run out of money for state workers' health insurance claims in late February or March — perhaps four months before the end of the fiscal year.

That's what has Jack and his wife extremely worried right now. He estimates he faces $3,000 in out-of-pocket medical expenses if the state doesn't accelerate payments.

"When we decided to start the family, we didn't expect to pick up the (entire) cost of the doctors and the hospital," Jack said.

On top of the medical outlay, Jack's wife will not have a state paycheck during most of her maternity leave. Add to that the possibility that state employees may be asked to take furloughs to help balance the budget and the couple's financial squeeze draws tighter.

"We both sat down and looked at the private sector," Jack said. "We looked at whether we can afford to stay on with the state."

Late payment of medical bills is doing nothing for already low state employee morale. That's particularly true since most state employees began making contributions to their health insurance plan this month, for the first time ever.

The provision was part of the contract negotiated with the American Federation of State, County and Municipal Employees. In return, the state this month began to assume employee pension contributions. That provides more take-home pay without a traditional pay raise.

The state sought the employee contribution to health insurance costs in hopes that, if employees bore part of the medical care burden, they would be more careful to seek medical help only when needed.

"I had a $4,000 medical bill in October that the state hasn't paid a dime on," responded one disgruntled secretary of state's employee. "If that was a regular insurance company not

> *"We both sat down and looked at the private sector. We looked at whether we can afford to stay on with the state."*
>
> **Jack**
> State worker

paying bills, the state would shut them down. They're taking money for a product I'm not getting. I'm getting hounded by creditors."

Calamo said the employee contributions should generate about $1.8 million a month for medical, dental and dependent charges. That will provide a little relief for the cash-strapped program, but those contributions will make up only a minuscule portion of the $100 million shortfall in the health insurance program.

Many medical providers are working with their state employee patients to come up with suitable payment plans until state checks arrive.

"We're trying to be as understanding with our patients as we can," said Jill Guinan, business office director for Springfield Clinic. "We encourage them to make monthly payments."

Those monthly payments sometimes include expenses covered by insurance, in which case the clinic reimburses the patient once the state pays up.

The clinic does "a significant portion of our business" with state employees, Guinan said.

While Edgar is expected to address the state's overall budget mess on Wednesday, he is not expected to single out employee health insurance claims for special consideration. However, a group of House Democrats is preparing its own solution to the budget problem, which will address health insurance.

Rep. Mike Curran, D-Springfield, said about a dozen Democrats have hatched a plan "that we feel is a very good solution," although he declined to outline it prior to Edgar's budget speech.

Curran said it is clear that something must be done about the underfunded health care program.

"These are people who are paying for their own health insurance," Curran said. "I'm hearing a lot of frustration from them. State government isn't (the legislature), it's the employees."

FY92

[illegible] for cutting health benefits

By Jean Latz Griffin
Public health writer

Anthony Frye, 29, has tuberculosis. He needs to take medication regularly for at least a year. Otherwise, not only will he get sick but he will become infectious and able to pass the disease on to others.

Frye receives his medical care from Freedom Center, a satellite clinic of Cook County Hospital at 1515 W. Monroe St. Cook County is reimbursed for part of the cost of Frye's care through the Illinois Department of Public Aid's General Assistance program.

But that reimbursement will stop if the cuts proposed in Gov. Jim Edgar's budget are approved by the General Assembly.

The Senate Appropriations Committee will hold hearings on the cuts at 11 a.m. Monday at Illinois Masonic Hospital, 836 W. Wellington Ave.

Medical benefits for people receiving General Assistance, usually single adults, along with many health benefits for the working poor and dental and eye care for women and children, will be dropped. Extra funds paid to hospitals that treat large numbers of poor will be reduced.

City and county clinics like Freedom Center could become overwhelmed, public health providers say, and private hospitals that continue to treat the poor will lose millions of dollars.

"Reductions in the medical benefits of the General Assistance program would hurt all of us," said Dr. Richard Bick, medical director for the Chicago Department of Health.

"In treating tuberculosis, for example, it's not the medication that is expensive, but the staff to make sure that all the patients take their medication. Also we have to test all the people they have had close contact with."

Because Frye is homeless and spends his days at drop-in centers and his nights in shelters, he routinely comes in contact with hundreds of other poor people. Allowing him to again become infectious would be likely to cost much more than continuing to treat his tuberculosis.

Refusing to pay to treat Frye's tuberculosis is just one example of the kind of cost-shifting and "penny-wise and pound-foolish" proposals that public welfare activists say abound in the budget cuts.

"If the medical benefits for GA are eliminated, sure the men can go to Cook County Hospital," said Doug Dobmeyer, executive director of the Public Welfare Coalition. "But County will already be losing money on the GA patients it already serves, and now it will have more of them and they will probably be sicker when they get there."

County Hospital projects it will lose $19 million if the budget cuts go through. Other West Side hospitals and their projected losses are Loretto, $3 million; Bethany, $3.5 million; Mt. Sinai, $8 million; and St. Anthony, $1 million, said Jackie Reed, head of the West Side Health Authority.

"Our community cannot afford to lose these hospitals, and if these cuts go through, it will be just that much harder for them to stay open," she said.

Tribune 4/15/91

6, 1992

March 5, 1992 - Sun-Times

Unions: State slow to pay worker health-care claims

By Charles N. Wheeler III
Chief, Springfield Bureau
Chicago Sun-Times

SPRINGFIELD—Two unions filed contract grievances with the state Wednesday, contending health care for 7,000 state workers they represent is being curtailed by long delays for insurance claim payments.

Union officials said the move was intended to pressure Gov. Edgar and the Legislature to plug a $160 million shortfall in funding for the state's health insurance program.

Because of the shortfall, the state has fallen months behind in paying medical bills for its workers, with claims dating back to last fall just now being paid, according to state officials.

Legislation pending in the House would appropriate the needed funds for the program, but the proposal has had a cool reception from Edgar.

"The governor continues to be concerned about delays in paying medical bills of state employees," said Mike Lawrence, his press secretary. "However, we're in a very tough budget situation. The options would be to either raise taxes or borrow money without having a plan to repay the money. Both of these options are unacceptable to the governor."

But officials of the unions—the Illinois Federation of Teachers and the Teamsters—argued that the payment delays are causing grave harm.

Many state employees must pay immediately for medical services by doctors, pharmacies, hospitals and other providers tired of waiting months for benefit checks, said Gary Leach of the Illinois Federation of Teachers.

"We are certain some members are in the early stages of serious illness but will not be able to verify this because they are forced to cancel doctor's visits," he said.

Some workers are being hounded by collection agencies while others have been sued by providers seeking payment, Leach said.

The grievances by state employee locals of the teachers federation and the Teamsters were similar to ones lodged by Council 31 of the American Federation of State, County and Municipal Employees, the state's largest employee union.

The latest reminder of the state's budget woes, the complaints came on the heels of a bleak report from state Comptroller Dawn Clark Netsch, who said revenues remained "dead in the water" through February.

Most ominously, the comptroller said, sales tax receipts in February totaled $253 million, $57 million less than the $310 million collected in February, 1990.

"If there has been an economic turnaround, it's not showing up in our revenues to date," said Netsch.

Through the first seven months of the 1992 fiscal year, income and sales tax receipts have been "essentially flat," she said, causing her to lower her office's estimates of revenue for the fiscal year by about $100 million.

As a result of the cash crunch, Netsch said, the state faced a near $600 million backlog of unpaid bills at the end of February.

SUN-TIMES/Jon Batt

Sharing Chicago's birthday

People born on March 4 line up Wednesday—Chicago's 155th anniversary—to shake hands with Mayor Daley at the Cultural Center, Washington and Michigan. The city celebrated with a chocolate cake created by pastry chef Eric Burkey of the Sheraton Chicago Hotel & Towers.

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1992 Legislation
FY92 budget

MARKETPLACE INSIDE
For the record/page 12
Police beat/page 12
Obituaries/page 12

CITY/STATE

FRIDAY
FEBRUARY 21, 1992
THE STATE
JOURNAL-REGISTER
SPRINGFIELD, ILLINOIS
PAGE 10

AFSCME to call for health insurance measure

Curran, union join to ask money for cash-strapped fund

By DOUG FINKE
STAFF WRITER

Rep. Mike Curran and the largest state employee union will join forces today to call for more money for the cash-strapped state employee health insurance fund.

The Edgar administration Thursday said it will support tapping various specialized funds for $15 million to help pay employee health-insurance claims. However, the administration so far is not proposing additional funding for the employee health insurance fund.

Curran, a Springfield Democrat, and the American Federation of State, County and Municipal Employees union will hold a news conference this morning calling for a $150 million supplemental appropriation for state employee health insurance.

Curran said he wants the state to borrow the money, just as it did to pay bills owed to nursing homes and Medicaid providers.

"We were willing to borrow for that," Curran said. "Now employees have to borrow to pay the state's bills. We're still a deadbeat, only now with a different group of people."

The employee health insurance fund is underfunded by $135 million to $160 million this fiscal year, meaning some medical bills will be left unpaid for months. On Feb. 1, the state began setting priorities on health-care bills — and simply stopped paying some of them.

As a result, some state employees are being hounded by creditors seeking payment for medical expenses. Others have had to postpone treatment.

"We've been told of signs in some medical offices saying employees have to pay up front," said AFSCME spokesman Steve Trossman. "Our members can't afford that."

Mike Lawrence, a spokesman for Gov. Jim Edgar, said the administration is willing to replenish about $15 million of the health insurance fund by tapping other state accounts. That will cover $15 million cut from health insurance funding as part of the January budget-cutting agreement.

"There was an agreement with the (legislative) leaders at that time to take money from other funds," Lawrence said.

"We are not ready to propose any more supplementals, but we have not ruled out that possibility," he added.

Lawrence said the administration remains reluctant to borrow additional funds unless a repayment plan is part of the deal, as was the case when the state borrowed $500 million to speed up payments to Medicaid providers.

Rick Davis, a spokesman for Comptroller Dawn Clark Netsch, said the state's contribution to employee health insurance effectively ran out Feb. 1. The only money left in the fund comes from employee payroll deductions for their own and dependent coverage. Davis said that comes to about $13 million a month. If fully funded, the insurance fund would have about $50 million available per month.

"This will drastically slow down (payments), because funding is relying solely on employee contributions," Davis said. "The bills will be paid as (funds) trickle in."

Health Insurance Association of America

10A
File 1 SB83

March 4, 1991

Senator Arliss Sturgulewski
Chairperson
Senate Health, Education and Social Services Committee
Alaska State Legislature
P. O. Box V
Juneau, AK 99811

Dear Senator Sturgulewski:

Thank you very much for meeting with me during my recent visit to Juneau and discussing SB83 and its companion bill HB71 as well as HIAA's alternative for affordable, available and cost-effective health insurance, "Financing Health Care for All Americans." If you have any further questions regarding HIAA's opposition to SB83/HB71 or our alternative approach, please do not hesitate to contact me or Gordon Evans.

Sincerely,

Jan Andrea Meisels

Jan Andrea Meisels
State Affairs Associate

JAM:mlp

cc: Gordon Evans

6052 Hackers Lane Agoura Hills, CA 91301-1410 818/991-6817 Telecopier 818/991-0722

ALASKA STATE
HOSPITAL & NURSING HOME
ASSOCIATION

April 15, 1992

MEMO TO: CHAIR & MEMBERS
SENATE HESS COMMITTEE

FROM: Harlan R. Knudson, President/CEO
Alaska State Hospital & Nursing Home Assn.

SUBJECT: Opposition - SB 83, Health Care Authority

Community hospital and nursing home members of this Association had the opportunity to review SB 83 at a meeting here in Juneau on April 6.

These facilities, who must work everyday with commercial insurance companies, Medicaid, Medicare, CHAMPUS and the Veterans Administration are unanimously opposed to SB 83.

We recommend that SB 83 and CHIPRA, the Comprehensive Health Insurance and Payment Reform Act be referred to the citizens of Alaska for thorough public debate and that the Legislature make "comprehensive" health care reform a number one priority for 1993.

Our opposition to SB 83 is based on:

1. Sections 1-8, Pages 1 to 4
   - refers issue of health care limits, access to care, quality controls, utilization controls rather than spell out in legislation how this is done.
   - adds another level of administration to CON process
   - places Health Resource Authority in Department of Administration when experienced personnel are in Department of Health & Social Services.
2. Page 7, Sec. 44.87.060, Line 1 -- Duplicates data program of Department of Health & Social Services
3. Page 7, Sec. 44.87.070 - develop a statewide healthcare budget and expenditure limit. There is serious question if this can even be done, but it is certain the cost to do this will be very expensive.
4. Page 8, Sec. 44.87.080, health care provider negotiations. Besides the very serious anti-trust question of having all health providers join together to negotiate fees, the negotiation process appears unworkable.
5. Page 9, Section 44.87.090 reimbursement schedules. The fiscal note ignores the cost of appeals and litigation. With all providers, easily several millions of dollars a year.
6. Page 10, Section 44.87.100, We understand compliance with reimbursement schedules but have no comprehension of how you comply with expenditure limits.

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(More)

7. Page 10, Section 44.87.110. Mandate providor provide information. Who pays for gathering the information?

8. Page 10, Section 44.87.120, Procurement of Insurance. If the state should self insurer, there needs to be an answer as to federal tax liability.

9. Page 11, Section 44.87.130. We have heard that the Authority will eventually be budget neutral, but have not found where they are authorized to tax or charge fees.

In conclusion we consider SB 83, a costly administrative nightmare that will do little to insure all Alaskans access to cost effective, affordable health care.

#####

ALASKA HOSPITAL COUNCIL

P. O. Box 34035 • Juneau, AK 99803-4035

April 9, 1992

Senator Arliss Sturgulewski, Chair
Senate Health , Education, & Social Services Committee
Alaska State Legislature
Room 427, Capital Building
P. O. Box V
Juneau, AK 99811

Subject: Senate Bill 83, "An Act establishing the Alaska State Health Resources Authority; . . ."

Dear Senator Sturgulewski:

We have reviewed the significant changes in the latest version of Senate Bill 83. While we recognize the tremendous amount of effort involved in the preparation and attempts to address and resolve such complex issues, we have several comments and questions on this particular legislation.

<u>Rate Controls</u>

The bill relies heavily on rate controls. Whether called "expenditure limits" or "reimbursement schedules" this reliance on rate controls is likely to add to the complexity, frustration, and inefficiency than is present in the existing system. Much has been written about the problems and hazards of government imposition of rate controls. Rate controls which favor too heavily the buyer or payor tend to either lower the supply of the service or cause a decline in the quality of the service. If rate controls favor the seller or provider too much, they can lead to inefficiency. In either case the potential exists to create a system which neglects the needs and desires of the consumer or patient.

Rate controls create under-investment in capital expenditures and a lack of ongoing expenditures for repairs and maintenance. With the rapid expansion of technology in the medical field, a system that relies only on rate controls has the potential of not offering

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the technology needed and desired by patients. Again, a system that is not responsive to the consumer or patient.

Please consider the following quote: "Some States have tried rate controls on hospitals for more than a decade. A recent study comparing hospital expenditures...revealed that expenditures in the regulated states rose an average of 9.5 percent from 1986-1989, compared with 7.1 percent in the competitive states. Increases in the regulated states exceeded the national average of 8.5 percent". (Lewin/ICF, April 1991).

We need to carefully weigh the impact on providers, payors, and patients of a system that would rely so heavily on rate controls and expenditure controls. It appears to contain many hazards.

Certificate of Need

In 1982 the Federal Government removed its CON requirements. This left states free to abolish their CON laws. Attached is a map showing the large number of states that have repealed CON laws. In addition, a number of states have scheduled CON laws to sunset. Why are so many states eliminating CON requirements?

In March of 1988 the Federal Trade Commission commented on "... the overall effectiveness of the Certificate of Need process...". Below are all of the headings and subheadings of these FTC "comments". They point out many of the problems with CON laws:

"I. Interest and Experience of the Federal Trade Commission.

II. CON Regulation is Ineffective and Possibly Counterproductive in Promoting Efficiency in Health Care Markets

A. CON Regulation is Unnecessary to Remedy Deficiencies in Health Care Reimbursement

B. CON Regulation is Ineffective as a Cost-Containment Mechanism

C. CON Regulation Interferes with Competition in Health Care Markets.

D. CON Regulation is not a good Mechanism for Addressing Concerns Related to Access for Indigent Patients.

> III. If the CON Process is Retained, the Thresholds should be Raised and the Scope of Coverage should be Restricted in order to Reduce the Negative Effects of CON on the Competitive Process."

Since the goal is to improve many if not all of the features of the system (including access, quality, and costs) it seems from this information that an easing or even elimination of CON restrictions is the best way to achieve of this common goal.

Effect of CON on the Cost of Group Health Insurance

There is a provision of the bill which states that: "A certificate of need may not be issued, except for a temporary or emergency certificate under AS 18.07.071, unless the office has received a determination from the Alaska State Health Resources Authority regarding the effect of the certificate of need on the cost of group health insurance" (Page 3, Line 3). Frankly, this provision is difficult to understand but it appears to involve a task tremendously complicated and time consuming.

Creation of additional Bureaucracy (Alaska State Health Resources Authority)

In assessing the potential addition of a new bureaucracy to State Government to control and limit rates, we can only draw on our existing/previous experience for guidance. There is already in the state a mechanism for setting facility (Hospital and Nursing Home) payment rates. It is known as the Medicaid Rate Advisory Commission. All, including the State, who are associated with this system are frustrated and are working to replace it with something less cumbersome. It should be understandable then that there is concern at the proposed addition of another rate setting body. The rates established by the current MRAC seem to result in an increasing number of appeals and litigation. This means that issues from a given Fiscal Year wait many months, even years, to be resolved. The addition of ASHRA would likely add more forms, more time and the potential for more appeals and litigation. Providers are already needing to expend an increasing proportion of scarce resources on activities to satisfy rate setting bodies. SB 83 creates another one.

Bureaucracies such as that proposed here are expensive to set up and maintain. The FY 1993 budget request for the Medicaid Rate Advisory Commission is $622,600. In addition, there is a separate budget request of $687,000 for the unit that conduct audits of Hospitals and Nursing Homes. The total annual cost of these two functions is in excess of $1.3 million. Since the Alaska State Health Resources Authority would be setting rates for all providers of Health Care not only Hospitals and Nursing Homes it would appear

that the total budget to operate ASHRA would need to be several times larger than the $1.3 million needed to establish and monitor Medicaid rates.

ASHRA is directed in the legislation to develop state-wide health care budget and expenditure limits. There appears to be no mechanism to assist providers in managing ever increasing costs with which they must deal.

The proposals presented in SB 83 only generally and briefly, if at all, reference other key factors impacting the increasing cost of health care. The impact of ever increasing Medical Liability insurance costs and the need for Malpractice reform to slow the growth in these costs is not addressed. The importance of providing access to care for the uninsured and under-insured is briefly mentioned but no specific proposals are brought forward. No one in need of medical care is refused treatment, but the costs associated with the provision of care to those who are in need, but who are unable to pay, has a major impact on the health care system and remains to be addressed.

We appreciate the opportunity to comment.

Sincerely,

The Alaska Hospital Council

STATES WITHOUT HOSPITAL CON PROGRAMS

Repealed Hospital CON Programs

CON Sunset Dates

CON Programs in Operation

February 25, 1991
Alaska State Hospitals & Nursing Homes
Contact: Harlan Knudson, President, 586-1790, Juneau

FACT SHEET FOR RESPONSE TO:
*** The State of Alaska's Health Care Cost Containment Task Force Report**
and
*** Senate Bill No. 83 (HB No. 71), a bill creating the Alaska State Health Resources Authority.**

Introduction:

The Health Care Cost Containment Task Force Report was released this February. The task force was formed originally to consider ways to cut the cost to the state of providing health insurance for its employees. Its duties were extended last year to cover all uninsured and under-insured Alaskans.

The report's major recommendation is creation of the Alaska State Health Resources Authority, as described by legislation sponsored by Sen. Jim Duncan (D-Juneau). The authority would set up a rate and reimbursement payment schedule for health care providers in Alaska, and dictate that schedule be followed by all public employers. It would also allow establishment of insurance pools by groups of smaller employers in search of available and affordable health insurance.

Hospital concerns with the task force and its recommended legislation:

* The task force's view of health care was extremely limited -- there was no representation from the business community, health providers or consumers on the task force. **All its members, but one union representative, were state employees or legislators.**

* There is little hard data to back up the task force report's findings. For example, it cites "overbuilt health care facilities" as one reason for the increasing cost of health care, but **fails to indentify one facility that it considers overbuilt.**

* Much of the hard data is does provide is questionable at best. **There is no analysis of its statement that Alaska health care costs have been increasing at 20 percent for the last five years.** Even if correct, this figure is influenced by such factors as the increase in health care provided in the state, instead of outside the state, and an increase in the number of people eligible for Medicaid because of new federal guidelines.

* The U.S. Dept. of Labor, in fact, has released data on the Anchorage consumer price index showing medical care to have among the smallest increases of any cost-of-living component between the

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second half of 1989 and the second half of 1990. (Medical care showed a 4.2 percent increase; motor fuel was 21 percent, food was 5.9 percent and the consumer price increase overall was 7 percent.)

* There is no analysis of the report's conclusion that there are 90,000 uninsured and underinsured, or that that number will increase to 25 percent of Alaska's population by the year 2000. While we recognize there is an increase in the number of uninsured and underinsured, it is essential that that figure be as accurate as possible before it is used to drive changes to the health care delivery system.

* There is no acknowledgement given of the vast improvement in medical care and delivery in Alaska in recent years, or of cost-saving measures taken by hospitals. These include flexible staff scheduling, group purchasing of supplies and a marked emphasis on outpatient, versus inpatient care.

* There is no acknowlegement of the costs hospitals can't control, but must deal with. These include the cost of fuel oil, wages driven by staff shortages and renovation and maintainence of facilities.

Why we like Senate Concurrent Resolution No. 10 and House Concurrent Resolution No. 5, legislation also introduced by task force members.

* They acknowledge and address the problem of the uninsured and underinsured, an issue all health care providers in Alaska struggle with daily.

* They recommend collecting the information needed to deal with this problem including uniform medical data from health care providers and opens the door to addressing the individual responsibility of every citizen to help control health costs.

* While the basis (the whereas portion) of the legislation is bassed on unsubstantiated data, the resolutions would, for the first time, provide Alaska policy makers with the necessary information to establish a fair and equitable program or programs to control health costs while assuring all Alaskans have access to health care.

* They recommend creation of a Health Resources and Access Task Force -- a group drawn from a broad representation of interests that would delve more thoroughly into the issue of health care costs and access.

* They bring a cross-section of Alaskans, including legislators, members of the administration, health consumers, private employers, health care providers and organized labor to the table to resolve a major issue facing every state in the nation -- controlling costs while assuring all citizens access to care.

# # #

FEB 25 1991

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

February 22, 1991

Senator Drue Pearce
Chair, Labor & Commerce Committee
P. O. Box V
Juneau, AK 99811

RE: SB 83

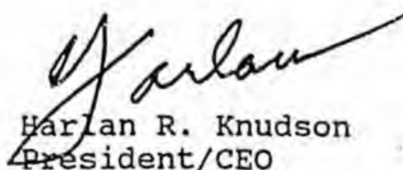
Dear Senator Pearce:

The Alaska State Hospital & Nursing Home Association would like to recommend that the report of the Health Care Cost Containment Task Force, along with SB 83, recommended by that Task Force be referred to the proposed Health Resources and Access Task Force. (SCR 10)

SB 83 is opposed in its current form because it creates yet another untried, undefined payment system for hospitals, and physicians. Simply telling hospitals and doctors what you will pay for their services will escalate shifting the costs of health care to other payors (if there are any left) and do nothing to improve access to care or control the overall cost of care.

The Task Force on Cost Containment was a public employee task force that did a good job in addressing state employee health costs and controlling those costs. It also opened the door to the serious problem of those who do not have health insurance. But, any long range solutions must be developed by a cross section of our provider, legislative, consumer community. This is done under SCR 10

Sincerely,



Harlan R. Knudson
President/CEO

HRK/ma

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April 2, 1992

VIA TELECOPIER--ORIGINAL TO FOLLOW

Harlan R. Knudson, Executive Director
Alaska State Hospital & Nursing Home Association
319 Seward Street, Suite 11
Juneau, Alaska 99801

Re: Senate Bill 83

Dear Harlan:

You have asked me to review the new version of Senate Bill 83 (Work Draft, Ford, 3/23/92). My review has revealed at least two potential legal problems with the bill.

1. Potential federal income tax liability: The bill authorizes the new Alaska State Health Resources Authority to exercise the powers of an insurer. (Page 5, line 20; page 10, line 20) If the Authority did operate as an insurer, it would be required to pay federal income taxes. There may be an assumption that, since the Authority will be "non-profit," it will be eligible for an exemption from federal income taxes. There is, however, no such exemption for insurers. The Internal Revenue Service is quite sensitive about efforts by states to perform functions of private business. The Medical Indemnity Corporation of Alaska encountered this problem with the Internal Revenue Service, and it led to the sale and dissolution of MICA. It is my understanding that the Internal Revenue Service may have raised a similar issue about other Alaska public corporations. The Alaska Railroad is exempt from federal income taxes only because the federal legislation that authorized the sale of the Railroad to the state includes an express exemption specifically for the Railroad. (Dave Walsh, the Director of Insurance, was involved in the Railroad purchase and with MICA and is familiar with the issue.)

Liability for federal income taxes clearly could affect the financial situation of the Authority. Even more seriously, however, attempts to avoid such liability, through litigation or otherwise,

could result in needless expenditures of funds. On the other hand, if the Authority were to concede that it had an obligation to pay federal income taxes, it could establish a dangerous precedent for other public corporations that may have similar exposure.

2. Potential antitrust issues: The bill requires groups of health care providers to "negotiate" recommendations for reimbursement schedules. (Page 9, line 12) On its face, such "negotiations" raise questions about potential violations of the antitrust laws. Specifically, it might be alleged that such "negotiations" were a conspiracy in restraint of trade. Such allegations may be subject to the "state action" defense, since the "negotiations" would be required by state law. Without conducting legal research on this issue, I cannot evaluate how the federal antitrust laws might apply to this situation. The issue requires clarification, however, because, if there is any possibility of exposure to federal antitrust liability, including the provision for treble damages, it is unlikely that any health care providers would be willing to serve on the negotiating teams.

I hope these comments are helpful I will be out of the State until Wednesday, April 8, but my office can reach me if you have any questions before then.

Very truly yours,

ATKINSON, CONWAY & GAGNON

By Susan Wright Mason
Susan Wright Mason

SWM
LTR0492:27/5951.3

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3200 PROVIDENCE DRIVE
P.O BOX 196604
ANCHORAGE, ALASKA 99519-6604
PHONE (907) 562-2211

SISTERS OF PROVIDENCE
SERVING IN THE WEST SINCE 1856

April 14, 1992

Senator Arlis Sturgulewski, Chair
Senate HESS Committee
Members of Senate HESS Committee

Dear Senator Sturgulewski and Committee Members:

Thank you for the opportunity to present CHIPRA at the April 7, 1992, Committee Meeting. We healthcare providers are grateful.

I would entreat you to continue to work with us to develop a total healthcare reform approach for our State. Providers are concerned about healthcare costs. That is why we have come forward with the CHIPRA proposal. We have identified very specific cost containment mechanisms: prices and fees not exceeding the CPI, a base set at 1991 Medicaid charges, publication of prices and fees.

However, we know that in order to make a difference, the pieces of reform should be implemented as a package. If this is not possible, the first steps need to assist providers in keeping their costs down and relieving cost shifting to uncompensated care. This can be done by insurance reform and medical liability reform. To implement cost controls such as SB83 will not solve the problem.

The CHIPRA proposal requires all participate in a solution to healthcare reform. It is the only way that we can truly change the situation. Attachment I describes the areas of participation.

These sacrifices from all will result in a system that provides access to a basic health plan for Alaskans.

Thank you for your interest and leadership in this key issue.

Sincerely,

Sister Dona Taylor

Sister Dona Taylor
Administrator

SDT:lp.0834D
cc: Harlan Knudson

OPPORTUNITIES TO ESTABLISH HEALTH CARE ACCESS AND COST CONTAINMENT

HEALTH CARE FACILITIES

1. Provide Commission/Health Board with prescribed data.
2. Hospitals of over 45 beds to establish in-house utilization and outcome monitoring system.
3. Hospitals to be at risk financially for prescribed utilization standards and prohibited from balance billing for defined excess utilization.
4. Must establish a uniform charge schedule for all patients unless separate schedules required by law or established with an entity (not individual or family) contracting for health care for a population group.
5. Must post understandable charge schedules for the public.
6. Must accept fee schedule assignment.
7. Must submit to annual rate information if rates exceed CPI.
8. Federal and state facilities must comply with same regulations as private sector (licensure and Certificate of Need).

OPPORTUNITIES TO ESTABLISH HEALTH CARE ACCESS AND COST CONTAINMENT

PHYSICIANS

1. Reimbursement schedules based on 1991 charge schedule provided for Medicaid reimbursement available to patients upon request.
2. Stay within CPI or limitations will be set.
3. Participate in expedited Medical Malpractice Settlements and Alternative Disputes Resolution Procedures.
4. Must comply with same licensure and Certificate of Need guidelines as other providers.

OPPORTUNITIES TO ESTABLISH HEALTH CARE ACCESS AND COST CONTAINMENT

INSURANCE COMPANIES

1. Provide purchaser with packages which include incentives for wellness.
   - Incentives for use of primary care physician, disincentives for inappropriate use of specialists and emergency rooms
2. Participate in, and fund, single claims clearing house, universal standard claim form.
3. Establish rates utilizing community rating.

JO/0163b

OPPORTUNITIES TO ESTABLISH HEALTH CARE ACCESS AND COST CONTAINMENT

INDIVIDUAL CONSUMER

1. Must provide proof of health care coverage in order to qualify for Permanent Fund Dividend.

2. Purchase/participate in CHIPRA if no other plan available, utilizing PFD to purchase (on sliding fee scale) if no other options available.

3. Commitment to healthier lifestyles:

   - Utilize insurance coverage for wellness approaches (following national recommendations age/sex physicals, and screenings).

   - Select and utilize personal primary care physicians for all family members (to avoid unnecessary use of specialists and emergency room care).

   - Follow easily available guidelines for better health. Appropriate weight, exercise, eating habits, use of seat belts and other safety equipment, no smoking, etc.

OPPORTUNITIES TO ESTABLISH HEALTH CARE COST ACCESS AND COST CONTAINMENT

STATE GOVERNMENT

1. Set up a reimbursement and benefits review commission to:
   - establish a Basic Health Plan (CHIPRA)
   - establish insurance pool and negotiate discounts.
   - establish centralized claims clearing house.
   - manage the provider data reporting system.
   - make public provider fee schedules for standard procedures.
2. Assure adequate and appropriate capitalization of the health care delivery system.
3. Establish medical liability reform as part of CHIPRA.

CHIPRA HIGHLIGHTS

1. All Alaskans must have at least basic health coverage. If they have no other resource and don't qualify for Medicaid, they use their Permanent Fund -- on a sliding fee scale – to apply towards the purchase of a CHIPRA Policy.

2. All Alaskans must provide proof of health coverage to obtain PF Dividend. ("Coverage" includes programs such as Indian Health Systems, Medicare, VA, etc.)

3. Preventive care covered 100% in CHIPRA. This offsets high deductibles of $1,000 individual, $5,000 family. (Benefit plan is not finalized.)

4. All CHIPRA members and all public employees in same insurance pool. Latter would continue to maintain and negotiate "CHIPRA PLUS" benefits (keeping current levels such as lower deductibles, expanded coverage etc. in place) Other CHIPRA participants could also select "PLUS" benefits, if they were willing to pay the extra cost.

5. Insurance rate would be Community, not Group rated.

6. Insurance premium and hospital/physician price control tied to CPI and rate review by authority.

7. Sets a System (Reimbursement and Benefits Review Commission or Health Board) and Standards in place, then allows market to drive the process.

8. Streamlines the system:

   - Single claim form and clearing house for all insurance companies doing business in the state.

9. Reforms medical liability process.

10. Establishes funding mechanisms for universal access by asking all parties to assume some responsibility. (Providers, large and small business, insurors, government, legal community, individuals.)

0160b

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SISTERS OF PROVIDENCE
SERVING IN THE WEST SINCE 1856

Xcle of SB 83 no resp.

March 22,1991

Dear Senator Sturgulewski,

Since Providence Hospital falls within your district, I wish to note that I am opposed to Senate Bill 83 which would create the Alaska Health Care Authority and Reimbursement System. My colleagues in health care and I truly wish to work with Senator Duncan in resolving the state's health care needs. We recognize and accept that all parties must be willing to make concessions and compromises for the good of all our citizens.

Basically, our concerns are not with the concepts of SB83 but with the prioritization - or order - in which it proposes change. The bill essentially places the problem of the uninsured on the back burner. I believe, however, that unless this issue is addressed it will be the Achilles heel in all other attempts to solve the puzzles of the health care delivery system.

Historic attempts at health care reform in the U.S. indicate the dilemma cannot be solved a <u>piece at at time</u>. All aspects must be addressed simultaneously.

SCR10 calls for a task force which would include <u>all</u> the players in the delivery system - Legislature/Business/Insurance and Providers. I would support this legislation. It provides an opportunity for all concerned to develop a solution.

I would be happy to talk with you further on these issues.

Sincerely,

Sister Dona Taylor

Sister Dona Taylor
Administrator

Health Insurance Association of America

STATEMENT OF HIAA

STATEMENT

of the

HEALTH INSURANCE ASSOCIATION OF AMERICA

on

HEALTH CARE FINANCING FOR ALL AMERICANS

and

SENATE BILL 83

Presented by

JAN ANDREA MEISELS

State Affairs Associate

Before the

ALASKA SENATE COMMITTEE ON LABOR AND COMMERCE

FEBRUARY 28, 1991

6052 Hackers Lane
Agoura, California 91301
818-991-6817

I am Jan Andrea Meisels, State Affairs Associate, Health Insurance Association of America. HIAA is a trade association of 300 private health insurance companies which provide health insurance for 95 million Americans.

The escalating spiral of health care costs continues to plague our society. The members of this committee are familiar with the effects on the Medicaid and Medicare programs. The private health insurance market has been no less immune to its deleterious effects.

The small employer market provides one of the most vivid examples of how health care cost inflation continues to afflict our financing system. Faced with unrelenting demands to hold health care costs down, insurers and employers have intensified the search for ways to moderate premium increases. Leaving high-risk individuals out of group coverage has been one such response. The "excessive employer churning" that newspaper accounts often bring to our attention is largely a function of employers seeking the lowest available rate. We, too, constantly hear the charge by small employers that the presence of a high-risk individual in their group has made it impossible to obtain coverage at any price.

This dynamic is complicated further by the tumultuous labor market of the small employer. Small employers are far more likely than larger organizations to go in and out of business. Our own annual employer survey suggests that employees of small firms also are more likely to change jobs. Employee turnover among small, insured firms is about 23 percent annually and is twice that level for small employers without coverage. These factors contribute to the reluctance of such employers to offer coverage as well as the difficulties of serving the market.

As the complexities of the small employer market have grown and the likelihood of individuals' being separated from the financing system has increased, there is a growing perception that even if they have coverage, they stand a reasonable chance of losing it if they change employers, or if they have poor claims experience.

Madam Chairperson, we have now reached the point where substantial small employer market changes are needed if we are to serve the longer-term interests of small employers and meet the concerns of policy makers. Last year the HIAA Board adopted a comprehensive set of recommendations that we believe can be achieved in the context of a viable private marketplace. Last week the HIAA Board overwhelmingly approved the final details of this proposal. The essence of our proposal is to make certain changes in the market so that it provides substantially more predictability and protection to the purchasers of coverage. Let me emphasize that, to work, these changes will have to apply to all players in the small employer market. All competing entities in the small employer market, including non-insured benefit plans, would have to be bound by the same rules in order to prevent any company or segment of the market from being placed at a disadvantage.

The small employer market precepts we recommend are:

1. <u>GUARANTEED AVAILABILITY</u>

   All small employer groups would be able to obtain private health insurance regardless of the health risk they present.

2. <u>COVERAGE OF WHOLE GROUPS</u>

   If a carrier chooses to cover an employer group, it would be required to accept the whole group. Individuals could not be excluded from coverage within the group for health reasons.

3. <u>RENEWABILITY OF COVERAGE</u>

   At renewal time, employer groups and/or individuals within these groups would be assured that their coverage would not be canceled because their health had deteriorated.

4. <u>CONTINUITY OF COVERAGE</u>

   Given the frequency with which small employers change carriers and employees in this market change jobs, individuals should have greater protection when making such moves. Therefore, when individuals are covered in the system, they would not have to face new preexisting condition restrictions, once those requirements have been fulfilled, in the event that they change jobs or their employer changes carriers.

5. <u>PREMIUM PRICING LIMITS</u>

   There should be meaningful limits on how much an insurance carrier's rates could vary for employer groups of similar composition (similar demography, geography, benefit design and industry). This also would involve limits on how much a carrier could raise its rates for a specific group above and beyond general increases in trend factors.

   Insurance carriers would retain the right to medically underwrite for purposes of assessing risk and setting rates but not to exclude individuals from coverage in a group plan.

6. <u>VIABILITY OF A PRIVATE MARKETPLACE</u>

   Finally, a major objective of these reforms should be to ensure a viable private marketplace over the long term.

These precepts were adopted by the Board with the understanding that they will exact some pain for the industry in the short term, but are critical for coverage of the small employer over the longer term. They represent our industry's

commitment to meeting the needs of the small employer community by providing a responsive insurance marketplace.

To give effect to these proposals, government must authorize a private not-for-profit reinsurance organization. Otherwise, these reforms are not achievable. This organization would allow carriers to pay a premium in exchange for having the reinsurer bear the risk for reinsured individuals. Consistent with the small employer market changes, the proposal does not envision breaking up groups for purposes of reinsurance. Rather, insurers would treat all individuals in a group the same way; all members would have the same benefits. The reinsurer would stand behind the carrier and simply reimburse for claims associated with reinsured individuals. This will allow us to assure that high risks are spread, broadly through the private market rather than concentrated in one small employer group.

The reinsurance mechanism naturally would sustain financial losses or shortfalls, since carriers would reinsure only persons whose claims are expected to exceed the price of reinsurance. The intent of the proposal is that losses be financed privately. Losses first would be spread across carriers in the small employer market up to four percent of premium. If losses were not absorbed fully by the small employer market, a second tier of losses would be spread across health benefit plans of small and large employers, up to one percent of premium and premium equivalent.

These proposals will assure that no small employer, and no employee of a small employer, will be turned down for health insurance because of poor health. They will restore the concept of pooling risk across large groups, greatly limiting how much of the cost of poor health must be borne by the individual employer. Further they will moderate significantly the sometimes dramatic premium increases now experienced by small employers at renewal time and thereby reduce the incentive to change carriers frequently.

With our recommended market changes in place, the small employer will stand to benefit greatly from our rapidly evolving cost management capacity. These reforms will encourage competition based on efficiency rather than just selection. Competitors would no longer be allowed to draw business away from more efficient health benefit plans by offering temporarily low prices that skyrocket once an employee gets sick. Insurers that reduce inefficient administrative costs and that offer cost-effective financing systems and delivery networks will gain a larger share of what is an extremely price-sensitive market.

Another factor affecting high insurance costs for insured employers is the amount of mandated benefits and services the legislatures have required insured plans to include. Collectively across the United States the state legislatures have required 800 different mandates to be included in the insured product. While many of the mandates may have merits on their own it is the

cumulative effect of the mandates that increase the cost of insurance. The effect of the mandated benefits result in making the employer chose between a "cadillac plan" and no plan at all. A study by a respected health economist at the University of Illinois estimates that as many as 16 percent of uninsured small employers fail to offer coverage because of the added cost of state mandates.

It is ironic that the federal tax code forces employers to incorporate in order to get a 100 percent deduction for their health insurance plan. Self-employed individuals who also provide protection to their employees are only allowed to deduct a 25 percent deduction for their health plan. We have testified before Congress several times requesting the tax deduction for these individuals be increased and extended as the 25 percent deduction ends this year.

These small employers are the groups with the most working uninsured -- yet they are given the burden of mandated benefits and a reduced tax benefit to provide coverage to their employee. U.S. Department of Human Services Current Population Survey has indicated that nationally 66 percent of the uninsured are employed full-time work for businesses with 25 or fewer employees -- 46 percent work for employers with 10 or less employees.

The government has an important role to play in addressing affordable and available coverage to those who are at or below poverty level. While we are very pleased that in 1990 Congress adopted many of the HIAA recommendations expanding Medicaid coverage, we still believe there is more to be accomplished -- expanding Medicaid to all people who are at or below poverty level.

I want to emphasize that it is definitely not business as usual in the insurance industry. Besides the small group market insurance reforms which I have already discussed, the nation's insurers are moving on their own against what we know to be the root cause of so many of our problems, the ever spiralling cost of health care. There is a sea change under way in how insurers do business. Our companies are making, and have already made, major investments in managed care. They are no longer solely in the role of risk-spreading and claims processing. They are actively taking on the role of health care managers, devoting major efforts to the goal of getting better value for the health care dollar. The information technology that becomes more sophisticated each day increases our ability to make sound health care judgments on value, on quality, on under utilization as well as over utilization, on efficacy and outcomes. This role is a very different one from that of the traditional health insurer our companies previously fulfilled.

We recognize that there is no magic bullet to solve the egregious problem of unacceptable health care cost escalation. However, we in the private sector recognize that there is a substantial problem and have developed a very effective private sector tool which is just beginning to be used.

Escalating health care costs are not due to a single factor, but a multitude of factors: cost-shifting from government programs, such as Medicare and Medicaid and the uninsured; an aging population; new technology; increased consumer demand; proliferation of health care providers; and inappropriate services. Some of these factors are beyond anyone's control, i.e. the aging of the population. Other factors can be and are being addressed aggressively by the insurance industry. Eliminating inappropriate services which may account for 25 percent or more of medical expenditures is a critical objective, both as a way of reducing costs and improving quality of care. Managed care is increasingly recognized as the best mechanism for carrying our such improvements.

The key objective of managed care is to assure that patients receive appropriate care, that is of high quality care, efficiently provided in the least costly setting. Will it work? Our nation's business leaders think so. According to a survey of Fortune 1000 senior executives conducted by the Roper Organization, Inc., more than two-thirds (68 percent) believe that managing health costs through networks such as health maintenance organizations and preferred provider organizations is, or could be, effective; 89 percent of the executives polled have made changes in their corporate health plans, targeted at containing costs; and an overwhelming 94 percent oppose national health insurance as a solution for the escalating health financing crisis. The vast majority clearly think the private sector should take responsibility for solving their health care financing crisis.

SB 83

Much of the premise of SB 83 is based on the belief that expanding upon the Maryland Health Cost Services Commission model to all Alaskan health care providers will affect reductions in the overall rate of increase in health care costs. The Maryland Commission is a hospital rate setting commission. However, Maryland has a unique aspect -- which no other state currently enjoys, nor will another state enjoy -- a Medicare waiver. This waiver granted by the Health Care Financing Administration (HCFA) allows the state program to determine what rate Medicare will pay hospitals, rather than HCFA. This phenomenon has basically eliminated cost-shifting from the governmental payers, a very critical aspect as to why health care costs continue to spiral in other states, especially in the private market.

Other eastern states have hospital rate setting commissions, but do not have Medicare waivers. New Jersey which lost their Medicare waiver several years ago is currently undergoing a severe crisis, as the uncompensated care trust fund has not been renewed and if it was renewed 24 percent of each hospital bill would have been added as for uncompensated care. Currently some hospitals with high levels of uncompensated care are adding 60 percent of the bill to the New Jersey Commission approved

hospital rate to account for the uncompensated care. Clearly Medicare's under reimbursement is accounting for at least one-third of this add on, with Medicaid and the uninsured uncompensated costs making up the difference.

New York's hospital rate setting program has caused the hospitals $1 billion in operational losses. New York also had a waiver from 1983-1985. New York's uncompensated care is 40-45 percent of hospital bills.

Maryland, New York and New Jersey hospitals still are fighting the battle of uncompensated care as many people are uninsured and when they become ill and seek treatment, their unreimbursed costs become a factor in the rates of people with insurance.

Attached to this statement is a copy of a letter from John Colmers, executive director of the Maryland Health Services Cost Review Commission, indicating the budget of the commission for FY 1992 -- $1.885 million. This is the cost for only the operation of the commission's rate setting for 52 acute care hospitals, and six psychiatric facilities. Alaska would have to spend considerably more for the administration of such a Commission as the intent of SB 83 is to set maximum allowable rates for all health care providers -- individual and institutional.

The Maryland system does not address the issue of accessibility to health care, affordability of health insurance or health care nor does the system address appropriateness of care or quality of providers. Hospitals in a protected regulated environment lose incentives to be more cost effective. The HIAA program of Financing Health Care for All Americans, including managed care does effectively address all these issues, and therefore, the HIAA program will be more effective in assisting individual Alaskans, Alaskan employers and labor organizations to increase affordability of health insurance and health care, increase accessibility to those without insurance and foster cost effective, quality health care.

Phase II of SB 83 would essentially eliminate the private insurance market and develop a state health insurance program. We strongly believe that the private insurance market is a much more viable and effective entity than a government administered program. Both Medicare and Medicaid are government programs that have resulted in broken promises, budget deficits and both arbitrary reductions in eligibility to the poor and payments to providers for services they are expected to render at inadequate reimbursement rates resulting in many providers who will not accept Medicaid patients.

For all the reasons expressed above, we believe the HIAA proposal does more for containing costs, increased accessibility and effectiveness of health delivery systems.

CHARLES O. FISHER, SR.
CHAIRMAN
SUSAN R. GUARNIERI, M.D.
VICE CHAIRMAN
RICHARD G. FRANK
BARRY A. KUHN

STATE OF MARYLAND

C. JAMES LOWTHERS
WILLIAM B. RUSSELL, M.D.
JAMES R. WOOD
JOHN M. COLMERS
EXECUTIVE DIRECTOR
KURT F. PRICE
DEPUTY DIRECTOR

HEALTH SERVICES COST REVIEW COMMISSION

4201 PATTERSON AVENUE—2ND FLOOR—BALTIMORE, MARYLAND 21215
AREA CODE 301-764-2605
FAX-301-764-5987

February 15, 1991

Ms. Jan Meisels
HIAA
6052 Hackers Lane
Agoura Hills, California 91301

Dear Jan:

Enclosed, as requested, is a copy of the Annual Disclosure Report released by the Commission at its February 6, 1991 public meeting. You have also asked for information regarding the budget of the Commission. The proposed FY92 budget for the Commission is $1,885,385. Health General Article Section 19-207.1 authorizes the Commission to include two-thirds of this budget amount in the rates approved by the Commission. Hospitals collect this money from the payors and reimburse the state annually.

Should you have any additional questions, please feel free to contact me.

Sincerely,

John M. Colmers
Executive Director

enc.

general\meisels

TTY for The Deaf
Baltimore Area 383-7555
D.C. Metro Area 565-0451

NEA-ALASKA

AFFILIATED WITH THE NATIONAL EDUCATION ASSOCIATION

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JUNEAU OFFICE
105 MUNICIPAL WAY, SUITE 302
JUNEAU, ALASKA 99801
(907) 586-3090

FAIRBANKS REGIONAL OFFICE
2118 CUSHMAN STREET
FAIRBANKS, ALASKA 99701
(907) 456-4435

February 11, 1991

To: **Senator Pearce, Chair**
Members, Senate Labor and Commerce Committee

Re: **SB 83;** *"An Act relating to the Alaska State Health Resources Authority; relating to the delivery, quality, and financing of health care for residents of the state, and to the issuance of certificates of need; and providing for an effective date."*

NEA-Alaska supports and encourages your favorable consideration of SB 83. It represents a sound and viable alternative to the cost, quality, and utilization of health care services, especially as it may pertain to public school district employees.

Currently, school district employees are covered by a variety of health care plans with a broad range of benefits at differing levels of premium costs.

Many districts are disadvantaged in their ability to maximize benefit coverages at reasonable costs and have seen these costs increase at alarming rates in recent years.

Access to utilization standards, more efficient administrative and provider reimbursement systems, and the opportunity for reducing premium costs and for improving benefits through participation in expanded group pools represents substantial opportunity for employers and employees alike.

Implementation of the provisions in SB 83 is a critical step if we are to effectively deal with health care costs in Alaska.

Thank you for your consideration of our recommendation.

Respectfully submitted,

Bob Manners
Executive Director

Don Oberg
President

cc: Senator Duncan

ALASKA STATE AFL-CIO

2501 Commercial Dr
Anchorage, Alaska 99501
(907) 258-6284

319 1st Ave
Fairbanks, Alaska 99701
(907) 456-2030

MANO FREY
Executive President

February 27, 1991

Senator Jim Duncan
P.O. Box V
Juneau, AK. 99811

Dear Senator Duncan:

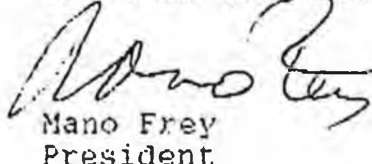
On Thursday, February 21, the Executive Board of the Alaska AFL-CIO voted its unanimous support for SB-83, a measure introduced to decelerate the cost spiral of health care for Alaskans.

The unchecked increases in health care costs is of grave concern to all Alaskans. It has priced insurance right out of the market for many small businesses, resulting in a drastic increase in the percentage of uninsured/ underinsured citizens. This in turn has dumped a greater proportion of the costs on those of us who are fortunate enough to enjoy comprehensive insurance coverage. Alaskans can no longer afford to leave this problem unresolved.

SB-83 is the most comprehensive, reasonable, and effective legislation we have ever seen introduced in this area. It would provide a long-term policy rather than a short-term fix.

With regard to health care cost containment and access questions, all too often public officials are quick to agree that someone else should do something about it. The Alaska AFL-CIO applauds your leadership in the field of health care quality and access through your introduction of SB-83 and urges its passage.

Yours in Progress,



Mano Frey
President

ALASKA STATE EMPLOYEES ASSOCIATION

AFSCME Local 52, AFL-CIO

February 11, 1991

Hon. Jim Duncan, State Senator
Pouch V
Juneau, Alaska 99811

Dear Senator Duncan:

On behalf of the Alaska State Employees Association and its 9,000 members statewide, I want to thank you for introducing Senate Bill 83, which seeks to establish an Alaska State Health Resources Authority to help cap the state's increasing health care costs.

As you know from your experience with the Alaska Health Care Cost Containment Task Force, health care costs to Alaskans exceeded $1.5 billion in 1989 and have been rising at a rate of more than 20% each of the past five years. These cost increases have concommittantly increased the costs of health insurance premiums for all Alaskan employers, including the State of Alaska, making it more and more difficult for them to continue health care coverage for their employees.

Clearly, something needs to be done to bring down or, at the very least, check Alaska's spiraling health care costs and SB 83 takes the right approach.

For its part, ASEA/AFSCME Local 52 has agreed to a defined contribution to health care costs in its collective bargaining agreement with the state, but this is only a step in what should be a comprehensive attept to contain costs throughout Alaska.

Furthermore, SB 83 makes inherently good public policy. Such an approach benefits union's, such as ASEA, by mitigating their health care costs; it benefits the State by lowering its operating costs; and it benefits private sector employers by reducing their cost of doing business with the state.

Again, my thanks to you and your colleagues on the Health Care Cost Containment Task Force for tackling a complex, difficult and controversial subject.

Respectfully yours,

Buddy Maupin

Buddy Maupin, Business Manager
ASEA/AFSCME Local 52, AFL-CIO

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NFIB Alaska

National Federation of
Independent Business

February 11, 1991

The Honorable Jim Duncan
Alaska State Senate
Pouch V
Juneau, Alaska 99811

Dear Senator Duncan:

The legislative agenda of NFIB/Alaska is determined by our ballot. The ballot is our annual poll of our membership on a series of issues deemed critical to small business. A majority vote, of the members in response to the poll, sets our policy and position on legislative issues.

I have previously shared the results of the entire poll with your office. Now that you have introduced SB 83 - Alaska State Health Resource Authority - the objective of this letter is to share with you some thoughts on the bill.

The idea of a voluntary health insurance program appears to be a viable means of providing health insurance to the uninsured population in Alaska. Small businesses are willing to provide health insurance to employees, as long as the cost is not prohibitive. A voluntary pooling approach is a more acceptable alternative than a legislative mandate that all employers must provide health insurance coverage for their employees.

The key elements to NFIB/Alaska members support of the concept of pooling are: the program would be voluntary, administered by private insurance companies and affordable.

For your records the following are the results of the 1991 NFIB/Alaska ballot questions regarding health insurance:

State Office
9159 Skywood Lane
Juneau, AK 99801
(907) 789-4278

Should legislation be passed in order to create a voluntary health insurance plan which would be administered by private insurance companies and which would pool small businesses together so they could purchase employee health insurance at group rates?

Yes 72.2% No 17.0% Undecided 10.8%

a. If this pooling of employers in order to purchase health insurance was available, would you participate?

Yes 50.2% No 19.3% Undecided 30.5%

The Guardian of
Small Business

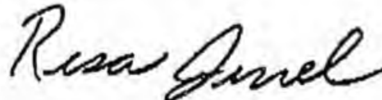
b. Should employers be allowed the option of having their employees pay part of the premium cost of health insurance purchased through the above pooling plan?

Yes 90.0% No 5.2% Undecided 4.8%

NFIB/Alaska hopes this information regarding the views of small business owners on this issues will be useful to you. If you have any questions regarding this information, please do not hesitate to contact me.

I look forward to working with you on SB 83 and other issues of importance to the small business members of NFIB/Alaska.

Sincerely,



Resa Jerrel
NFIB/Alaska
State Director

RESOLUTION

BE IT RESOLVED BY THE JUNEAU FORUM ON THE 1991 ALASKA CONFERENCE ON AGING:

WHEREAS health care expenditures in Alaska have risen from $480 million in 1979 to over $1.5 billion in 1989, a per capita increase of $1327.00 per person per year; and

WHEREAS the number of uninsured or underinsured Alaskans is now estimated at over 90,000 persons; and

WHEREAS a large number of the uninsured and underinsured are senior citizens; and

WHEREAS the Alaska State Health Care Cost Containment Task Force was created early in 1989 to find ways to control the ever increasing cost of health care in Alaska; and

WHEREAS the Alaska State Health Care Cost Containment Task Force has as a result of its research and investigation identified ways to control the rising cost of health care in Alaska; and

WHEREAS the Task Force has endorsed Senate Bill 83 and the changes proposed therein necessary to rising health care cost; and

WHEREAS the Juneau Forum of the 1991 Alaska Conference on Aging has reviewed the findings and recommendations of the Alaska State Health Care Cost Containment Task Force;

BE IT RESOLVED by the Juneau Forum of the 1991 Alaska Conference on Aging that the rising cost of health care is a serious problem for senior citizens; and be it

FURTHER RESOLVED that the Juneau Forum of the 1991 Alaska Conference on Aging strongly supports the cost containment measures proposed in Senate Bill 83; and be it

FURTHER RESOLVED that the Juneau Forum of the 1991 Alaska Conference on Aging strongly supports the Legislatures passage Senate Bill 83, creating the Alaska State Health Resources Authority.

Adopted:

JUNEAU FORUM
1991 ALASKA CONFERENCE ON AGING

By: Juneau Commission on Aging

Chairperson: Lauris S. Parker
Lauris S. Parker

AASB

ASSOCIATION OF ALASKA SCHOOL BOARDS

1990 CORE RESOLUTIONS

passed by the membership

1990 ANNUAL STATEWIDE CONFERENCE

ASSOCIATION OF ALASKA SCHOOL BOARDS

TUESDAY, NOVEMBER 13, 1990

SUBJECT: ADMINISTRATION
90-36
HEALTH INSURANCE

WHEREAS, the Alaska Legislature through the work of the Health Care Cost Containment Task Force is looking at measures to control the rate of increase in the cost of health care for all Alaskans; and

WHEREAS, the cost of health insurance has increased sharply in recent years and shows no signs of stabilizing; and,

WHEREAS, school districts are required to operate within a fixed budget and need to stabilize costs as much as possible to allow for reasonable planning for a sound educational program; and,

WHEREAS, the increasing cost of providing health insurance to school employees has a significant impact on the operating budget of school districts in Alaska; and,

WHEREAS, Alaska school districts have demonstrated that insurance pooling has been an effective means of stabilizing insurance costs for their types of coverage;

NOW THEREFORE BE IT RESOLVED that the Association of Alaska School Boards aggressively investigate the feasibility of pooling for school district employee health insurance as a viable alternative for providing cost containment on a significant budget item.

Health Consumers Of Alaska, Inc.
P.O. Box 91539
Anchorage, Ak. 99509
(907) 277-6219

Senator Jim Duncan
AK. State Legislature
Pouch V
Juneau, Ak. 99801

3-18-91

Testimony SB 83 + 84

Dear Senator Duncan,

This letter is a follow up on The Public opinion message of support sent to you last week. I also talked directly with your staff and offered to provide testimony by members as well as by myself.

Truly your efforts to help control the ever escalating prices of Health care services are sincerely appreciated. The present condition is unacceptable to the Public and to the health consumers.

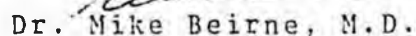
We all recognize I'm sure that there is no single cause for the rapid price increases; on the other hand, some of the causes are more outstanding than others and need to be dealt with now. The providers are simply not entitled to raise prices without adequate justification, and this would be the responsability of a price review board or authority. The consumer would not be required to pay for errors by the management of the provider organization.

While we may all agree that we have many fine providers in Alaska, and in my opinion we certainly do, none the less we should not hesitate to express concern about high prices and their causes. A check and balance system is absolutely necessary in our opinion.

We want to expressly thank you for having the courage to confront the problem, for demanding a solution, and then for offering a realistic solution.

We have reviewed your Bills. We have heard " the tree fall in the forest." We stand ready to work with you in any way we can.

Sincerely,



Dr. Mike Beirne, M.D.
President

The Health Consumers Of Alaska is an Alaskan non-profit corporation organized in 1987. An informed consumer is our goal.

NORTH SLOPE BOROUGH

OFFICE OF THE MAYOR

P.O. Box 69
Barrow, Alaska 99723

Phone: 907-852-2611

Jeslie Kaleak, Sr., Mayor

April 10, 1991

Senator Sturgulewski
Chairperson, Health, Ed. & Social Services Committee
P.O. Box V
Juneau, Alaska 99811-3100

Dear Senator Sturgulewski,

I recently received a letter from Senator Duncan, along with its enclosures of the Alaska State Health Care Cost Containment Task Force Report and the drafts of the associated House and Senate Bills, requesting my support for certain pieces of legislation he is sponsoring. More specifically, the bills are SB 83 & 84. I want to commend the members of the Task Force for their hard work in attempting to find solutions to the overwhelming problem of health care cost containment.

After lengthy review by myself and my staff, I feel it is necessary to draw your attention to some of our primary concerns regarding the proposed legislation. The specific areas of concern include, but are not limited to, 1) Procurement of Coverage, 2) Administration of Coverage, 3) Pricing of Coverage and Cost of the Program, 4) Provider Rate Setting, 5) Eligibility Criteria, 6) Definition of Group Health Insurance, 7) Certificates of Need, and, 8) Evaluation of need for mandatory participation. Until these concerns are specifically addressed, the North Slope Borough cannot support the proposed legislation. In fact, we find the bills both unacceptable and unnecessary.

1) **Procurement of Coverage:** It is unclear in the legislation as to the Alaska State Health Resources Authority's actual ability to contract with insurers, the number of insurers or consultants it would contract with, and how the costs of such services would be distributed to the participants. We are curious as to who will do, and when will, a cost-benefit analysis be completed with respect to the costs of procuring and maintaining a state-sponsored healthcare authority?

2) **Administration of Coverage:** The legislation is also unclear with regard to who would administer insurance claims. It appears to give the Health Resources Authority the power to administer claims but it is unlikely this would occur, even if the state elects to self-insure. The state of Alaska has seen several private insurance carriers attempt to maintain local claims processing office. Economics has proved this venture to be a

costly undertaking. The metropolitan areas of Anchorage, Fairbanks and Juneau cannot seem to maintain a large enough, or skilled enough, pool of labor to efficiently process a large number of claim transactions. We offer as examples Aetna and Travelers who both found it not cost effective to maintain local claims adjudication offices.

In addition, we understand that the Health Authority would have the power to administer the plan eligibility and implementation, and utilization standards, but, the Health Authority does not possess the information to do so. The three insurance carriers who do most of the business in the state have spent several years establishing their databases. Utilization standards are often considered proprietary information, not for sale or outside use. How would the Health Authority overcome this problem?

3) **Pricing of Coverage and Cost of the Program:** The bills are not clear with respect to how exactly coverage would be priced for the participants. Under the proposed bills, SB 83 and HB 71, the Health Authority would establish a pool or pools of eligible employees, for the purposes of providing health coverage. It is not stated whether this eligibility definition would involve the use of community rating for the group or groups, or, whether groups would be specifically established based upon risk categories.

If Alaska's state pool becomes solely high risk health insurance, the costs associated with this program will be extremely high. As rates increase due to poor risks, the pool will be left only with the least healthy of the population as they must accept all applicants in the absence of pre-existing exclusions. High losses associated with this will be paid by the carrier(s) or, in the worst case, by the state if the Authority elects to self insure. Without a reinsurance mechanism, carriers will leave, or never participate in, this market because they cannot afford these types of expected high losses.

Also, even without high losses, the establishment and administration of the program will be costly for the state. Current budget projections for Alaska predict deficits in future years. In addition, the Alaska economy is an unstable one which cannot count on a consistent level of income from year to year.

4) **Provider Rate Setting:** Experience in six states which utilize a statewide hospital rate setting system (CT, MA, NY, NJ, MD, WA) has shown that between 1980 and 1989, states with rate setting arrangements have no clear cost advantage over states without rate setting. In fact, in recent years, some rate setting states have experienced growth rates for hospital costs in excess of the national average. For example, in 1988, five out of six rate setting states had growth rates for costs per admission above the national growth rate; in 1989 three of the six states had growth rates 2-6 percent above the national average.

The rate setting system used in Maryland is often cited as one which has been successful at consistently controlling hospital costs. Between 1980 and 1989, Maryland was the only one of the six rate setting states which had a cost per admission growth rate below

the national average for every year. However, the spread between Maryland's rate of growth and that for the nation has significantly narrowed in recent years. More importantly, on a per capita basis, in 1988 Maryland had a higher percentage increase in its costs than the average for either the five other regulated states or the national average.

Alaska, which is not currently a regulated state, has had a rate of growth for hospital costs which is not out of line with that for the regulated states over the past ten years. In 1989, Alaska's per admission hospital costs rose almost five percent less than the national average, and were between 2 and 11 percent lower than any of the six regulated states, including Maryland. The North Slope Borough has experienced per hospital admission costs between 4 and 9 percent below those of the six regulated states.

5) **Eligibility Criteria:** The proposed legislation is not clear in the area of defining who is eligible for the state's coverage or what criteria would be used to determine eligibility. If current eligibility language from either employers or insurers is used, the problems of "uninsured", "underinsured", and "uninsurable" individuals remain unaddressed. These people will continue to fall outside of the affordable health care providing arena. All public employers appear to be eligible (along with all employees of this group); other (i.e., private) employers (or their employees) can elect to join the pool (or use only the rate setting and utilization standards), yet no more specific criteria (i.e., pre-existing conditions language) is given.

Because of the vagueness of the definition of "eligible", we are prone to believe that ***adverse selection*** will occur. If the state allows all employer groups or any of their employees to join the pool, only the high risk individuals or groups will elect this coverage. The ramifications of this language will create a pool with a similar demographic cross section to that of COBRA participants. Small employers will act in their own best interest and sign up their unhealthy (i.e., high risk) employees for the pool when they need coverage and then withdraw them (take them out of the pool, back to their own plan) when they get healthy. Even if coverage is not community rated, this would be a problem since there are no pre-existing exclusions included in this Bill, thus, all could sign up.

If the plan is community rated, adverse selection poses a more severe problem. State employees pose no selection problems since all will join, not just the high risk cases. Under pure community rating, state employees will face much higher rates since the bad risks from the private employers will drive up rates for all. If coverage is not community rated, rates will still need to be higher since the good risks will need to subsidize the bad.

6) **Definition of Group Health Insurance:** Senate Bill 83 and House Bill 71 define group health insurance as including " life insurance, accidental death and dismemberment, medical care and treatment, dental care, eye care, and other group health coverage as determined by the authority". We are very concerned that these bills do not address life insurance and accidental death and dismemberment coverages when

discussing rate setting and administration. The North Slope Borough has better-than-average life and AD&D experience and would undoubtedly see additional benefit cost increases.

7) **Certificates of Need:** With respect to the requirement of Certificates of Need, Sec. 3, SB 84, and the definition of a "health care facility" in, Sec. 16, SB 84, we will need some additional clarification. As you may know, the North Slope Borough and several of the other rural Borough's have municipal powers in the Health area.

We have a Health Department that has satellite health aide facilities in each of our eight villages and the two primary urban centers, Fairbanks and Anchorage. The definitions of a health care facility and the requirements for Certificates of Need could greatly affect the services this department provides to our entirely rural population. In fact, the requirement of Need Certificates justifying an addition of services in the rural areas could be very restrictive. Such a requirement will also affect our only hospital, the Barrow Public Health Service Hospital. Adding services in an area that has few or no services currently can only save us money in the short and long run.

8) **Evaluation of need for mandatory participation:** Requiring participation of public entities in the group health insurance offerings of the Alaska State Health Resources Authority would cost the North Slope Borough a great deal of money in both the long- and short-term.

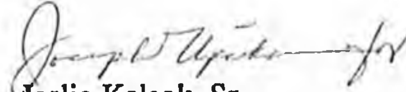
If group insurance costs were mandated at the rate the state currently spends for health care, the North Slope Borough would immediately find its health care costs increase approximately 35%, or, $1,000,000 per year. If coverage is not mandated, but remains voluntary, and since all public and private employers and employees are permitted to use the rate setting agreement, those who choose not to would have costs shifted onto them. (This scenario is unlikely unless the state allows only those in the pool (or puts some other condition on the use of the rate setting) to use the rate setting arrangement.) It appears that either way costs will increase for us, but, they will increase the least with a completely voluntary participation clause for public entities.

Also, given that all providers would have the state set rates for them, hospitals would lose a substantial amount of revenue, thus reducing the dollars available to purchase new equipment, hire skilled physicians, etc. Between the services the Borough currently provides, those services that PHS provides, and our exempt status under the IHC Act, we could only see cost increases through mandated participation.

Senator Stugulewski, we do realize that health care cost containment is one of the primary issues that both the public and private sectors must work together on for solutions. We again acknowledge the hard work the Task Force has put into their report and thank you for including us in your informational search. Please feel free to contact

my office if you need clarification of any of our concerns, or have any comments regarding our information.

Sincerely,



Jeslie Kaleak, Sr.
Mayor

cc: Rep. Eileen MacLean
Sen. Al Adams
Sen. Fischer, Vice-Chairman, HES
Sen. Cotten
Sen. Hoffman
Sen. Menard

AVCP

Association of Village Council Presidents
Pouch 219 • Bethel, Alaska 99559
(907) 543-3521

April 6, 1992

Senator Lyman Hoffman
Pouch V
Juneau, Alaska 99811

RE: S.B. 83, Alaska State Health Resources Authority

Dear Senator Hoffman:

Thank you for the opportunity to comment on S.B. 83. As Mike Smith pointed out in our telephone conversation last week, I had written last year in opposition to the bill. However, after I read the latest (3-27-92) version (which your office faxed to me), I have learned that this is a very different bill.

After having discussed S.B. 83 with Senator Duncan's office (Dale Staley) and with Dave Mather (Health Resources and Access Task Force), as well as others who oppose the bill, I am ready to urge your support of the bill. It may not be perfect, but I believe it is worthy of support.

As I understand the latest version, the rate setting is designed to limit health care expenditures for all state residents and will not only apply to those whose insurance is procured through the Authority. Therefore, there is no opportunity for cost-shifting, such as occurs with medicare.

Other features of the bill, such as the data-gathering elements, should provide useful information in order that future decisions can be made based on accurate and comprehensive information.

There is probably some degree of risk of "quality-flight" and access reduction (i.e., the best health care providers leaving the state) with this bill. Ideally, for this reason, I would probably rather support a national solution, such as a Canadian-style single-payer system. However, no such national solution appears imminent and I believe it is necessary for Alaska to do what it can to help its citizens deal with sky-rocketing health care costs and not wait for the Federal government. Other states are moving forward, thus limiting the risks of health care shortages in Alaska that could be caused if "looser" requirements exist in many other states. Hopefully, the negotiation aspects of the bill will also prevent this from being a serious problem.

I realize my support of this legislation puts me at odds with the stated position of the TIPSA trust, of which AVCP is a member and I am a trustee. However, as I stated above, this version of S.B. 83 is a very different piece of legislation than what was originally introduced.

Sincerely,

ASSOCIATION OF VILLAGE COUNCIL PRESIDENTS
Myron Naneng, President

Lee Olson, Vice President of Finance

cc: Senator Jim Duncan
Senator Al Adams
Senator Fred Zharoff
Representative Ivan M. Ivan
Representative Richard Foster
Representative Georgiana Lincoln
Representative Jerry Mackie

4421 E. Huffman Road
Anchorage, AK 99516
March 27, 1991

Senator Arliss Sturgulewski
Alaska State Legislature
P.O. Box V (MS 3100)
Juneau, AK 99811

Dear Senator Sturgulewski:

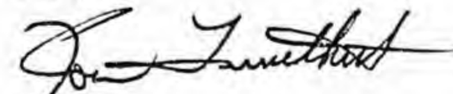
I'm deeply concerned that Alaska Senate Bill 83, sponsored by Juneau Senator Jim Duncan, is the wrong approach for solving the problems of access and rising cost of health care. These problems are complex and require careful study before we embark upon a set of solutions that could bring even greater turmoil to our already troubled health care system.

For example, the Duncan proposal would impose price controls on services. Providers would be limited to what they could charge. On the surface, this may sound like a good idea, but over a period of time, the quality of services will surely decline and many health care professionals will relocate to places where their earnings potential is not controlled by government. Since the program is voluntary for private employers, the bill does nothing to improve access for the thousands of individuals who cannot afford health insurance.

The proposal also calls for creation of a state government agency to administer a government authorized insurance program. Not only does the insurance pool arrangement described in the bill have several financial and underwriting difficulties, it will mean additional cost for taxpayers of the state.

I believe a better option would be to improve upon our existing public/private system rather than creating an expansive government bureaucracy. Yes, we all would like to stop the rapid escalation of health care cost, but Duncan's approach won't work!

Very truly yours,



Ronald J. Trevithick

Alaska State Legislature

Please enter into the record my testimony to the Senate H.E.S.S.
committee name

committee on Health Task Force, dated 3/25/92.
bill/subject

March 25, 1992

TO: Senate H.E.S.S. Committee

FROM: Rose Palmquist 376-2274
president, O.P.A.G.
POB 870294
Wasilla, 99687

RE: COMPREHENSIVE HEALTH COVERAGE AND COSTS

Dear Chairman of Health Task Force,

Your testimony on 3-25-92 was very impressive and acceptable as a beginning towards health care for all.

The task Force obviously addressed the concerns.

Signed: ______________________

Name	Rose Palmquist	Phone (H)	376-2274
Title	Pres OPAG	Phone (O)	
Address	Box 870294- Wasilla AK	ZIP	99687

____
Address

____
Phone No.

1/14/92

Dear Senator,

I understand that Senate Bill 83 (Jim Duncan) deals with some form of state health insurance.

I am totally and unequivocally AGAINST a state (and a national) health care insurance system. Let's keep it in the FREE enterprise system that gives us the world's best health care. Government participation will not improve the situation but exacerbate it.

I hope you'll vote AGAINST S.B. 83.

Sincerely
Jim Dore

J. DORE
11301 PYRAMID DR. #21
ANCHORAGE, AK 99516

344-2761

UNINSURED ALASKA POPULATION

Total Uninsured Population *(Excluding Native Population)*	**76,627**	
Uninsured earning less than 300% of poverty level:	61.47%	(47,106)
Uninsured earning more than 300% of poverty level:	38.53%	(29,521)
Uninsured Children Under Age 19 *(300% of Federal Poverty Level and below)*	**15,694**	**(20.48%)**

less than 100% of poverty level:	4,284 children
100 - 200% of poverty level:	4,888 children
200 - 300% of poverty level:	6,522 children

Uninsured Small Business Family Members — **16,025** **(20.91%)**

- Firms with 25 employees
- Include full-time/full-year workers
- Does *not* include full time/part-year workers

Medically Uninsurable *(i.e. "high risk" individuals)* — **4,000** **(5.22%)**

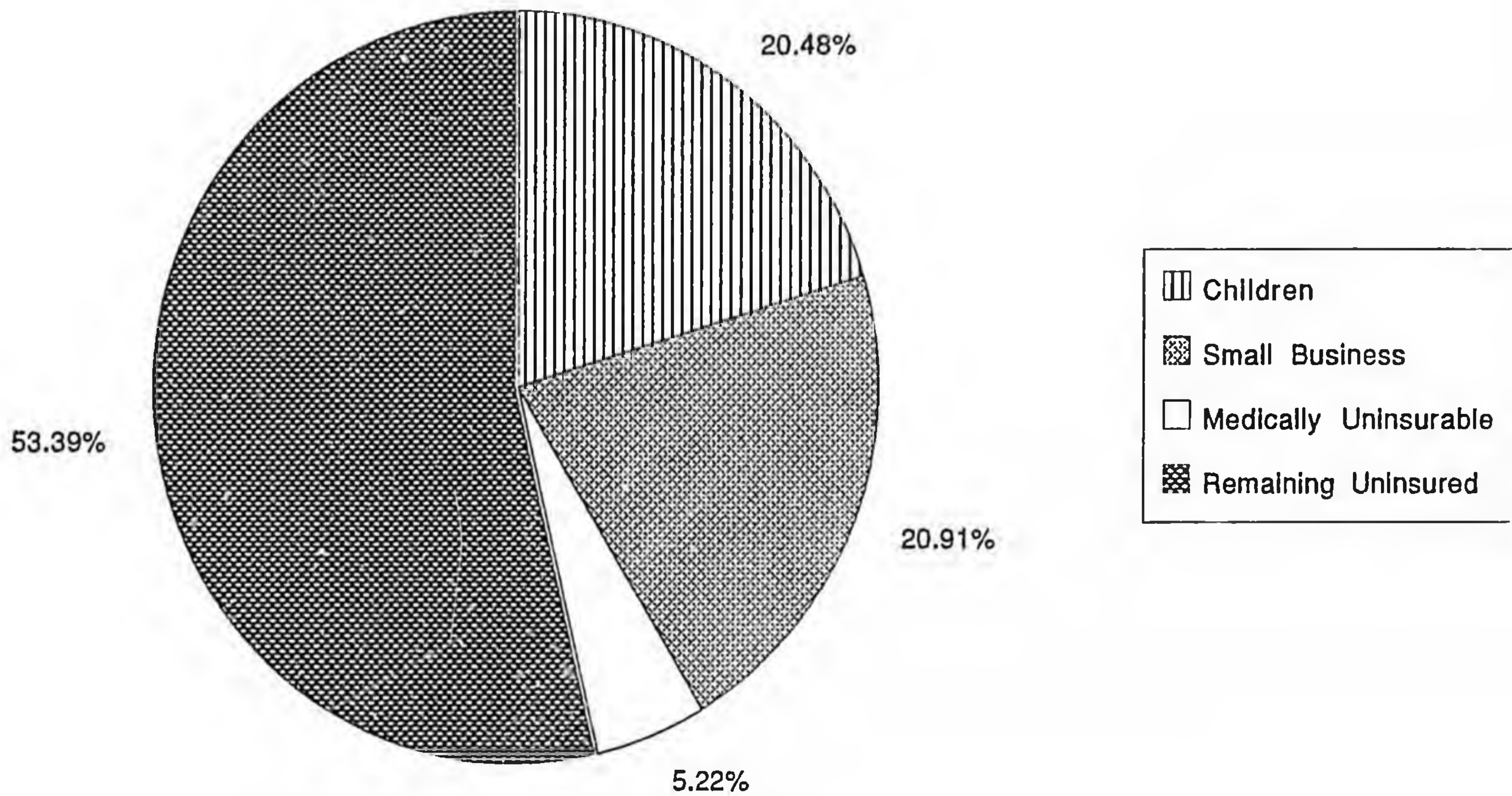
Above figures represent potential size of enrollee participant group for coverage provided under the terms of SB 74, SB 242 and SB 290. Actual enrollment will depend on specific benefit levels offered, participant premium/contribution levels, and participant cost-sharing provisions.

1992 Poverty Guidelines for Alaska

Size of family Unit	*Poverty Guideline (100%)*
1	$8500
2	$11,480
3	$14.460
4	$17,440
5 and above	extra $2,980 per member

Data Sources: Health Systems Research, Inc. February 7, 1992 report; Aetna estimates

UNINSURED ALASKAN POPULATION



COMPARISON OF SELECTED HEALTH REFORM PROPOSALS[1]

FEATURES	PROPOSAL												
	AHA	Pepper	Kennedy	AMA	Stark	NGA	USCC	BRT	HLC	NAM	ACP	AFL-CIO	NLC
OVERVIEW OF PLAN													
Approach													
pluralistic	X	X	X	X		X	X	X	X	X			X
unitary					X[2]						X[3]	X	
Access Assured													
universal	X	X	X	X	X	X		X[4]			X	X	X
not universal							X[5]		X	X			
PRIVATE PROGRAM													
Individual Mandates	X	X	X										X
Employer Mandates	X	X	X	X								X	X
phase-in	X	X	X	X									X
small employers permanently exempt													
minimum % of premium paid for full-time employees	50	80	80										75
minimum % of premium paid for dependents	50	80	80										
premium participation for part-time	X	X	X										X
Subsidies/Tax Incentives	X	X	X	X			X	X	X	X			
employer	X	X	X	X			X	X	X	X			
individual	X	X	X	X			X	X	X				
Cap on Tax Deductible Premium				X[6]									

AHA = American Hospital Association
Pepper = Pepper Commission
Kennedy = Kennedy's Basic Health Benefits for All Americans Act
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COMPARISON OF SELECTED HEALTH REFORM PROPOSALS (cont.)

FEATURES	PROPOSAL												
	AHA	Pepper	Kennedy	AMA	Stark	NGA	USCC	BRT	HLC	NAM	ACP	AFL-CIO	NLC
Insurance Market Reform	X	X		X		X	X	X	X	X		X	
reinsurance mechs./pools	X	X		X			X	X	X				
elim. pre-existing condition clauses	X	X	X	X			X						
required community rating		X	X[7]										
PUBLIC PROGRAM(S)													
Organization													
single program	X										X	X	
separate for different populations		X	X	X	X	X	X	X	X	X			X
Eligibility/Basic													
everyone					X						X	X	
poor	X	X	X	X			X	X	X	X			X
elderly/disabled	X		X[8]	X			X[8]	X[8]	X[8]	X[8]			X[8]
others on buy-in	X	X	X				X	X		X			X
Eligibility/Catastrophic													
everyone	X												
public program enrollees only		X			X[9]								
Funding													
federal	X	X	X	X	X	X	X	X	X	X	X		X
state		X	X	X	X	X	X	X	X	X	X		X
premiums	X	X	X		X	X				X	X		X
individual income-related	X	X	X		X	X				X	X		X
service specific	X[10]												

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COMPARISON OF SELECTED HEALTH REFORM PROPOSALS (cont.)

FEATURES	PROPOSAL												
	AHA	Pepper	Kennedy	AMA	Stark	NGA	USCC	BRT	HLC	NAM	ACP	AFL-CIO	NLC
employer	X	X			X								X
Administration													
federal	X	X			X							X	
federal/state		X[11]	X	X			X	X	X	X			X
private as TPA	X	X[11]		X	X		X	X	X	X			
private as underwriters				X									
BENEFITS													
Federal Definition Of Minimum Benefit	X	X	X	X	X	X[12]			X	X	X	X	X
applies to public plan	X	X[13]	X	X[13]	X	X			X	X	X	X	X
applies to private plans	X	X	X	X		X						X	X
Preemption or elim. of state mandates	X	X	X	X			X	X[14]	X[15]	X[16]			
Scope													
basic	X	X	X	X	X	X			X	X	X	X	X
catastrophic	X	X	X		X[17]								
preventive	X	X			X	X				X	X		X
long-term care	X	X[18]		X[19]	X	X							
Limits													
quantitative limits on services		X			X[17]					X			
dollar limits													
marginal services excluded	X												
medically necessary & reasonable	X	X	X		X						X		
high front-end deduct. and copays	X	X			X[20]								

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COMPARISON OF SELECTED HEALTH REFORM PROPOSALS (cont.)													
FEATURES	PROPOSAL												
	AHA	Pepper	Kennedy	AMA	Stark	NGA	USCC	BRT	HLC	NAM	ACP	AFL-CIO	NLC
IMPROVED AFFORDABILITY													
Federally-Administered Controls on Prices or Total Expenditures					X							X	
State-Administered Controls on Provider Prices or Total Expenditures						X							
Optional Use Of Public Program Rates By Private Insurers													X
Incentives Operating Among Purchasers, Providers, And Consumers With Negotiated Payment	X								X	X			
Required Management Of Care	X	X								X			
all care	X												
only selected services (e.g., long-term care) or selected populations		X			X					X			
Promotes Management of Care		X						X	X				
Disclosure Of Provider Cost And Quality Data	X	X						X	X	X		X	X
Guidelines On Technology And Special Services	X	X				X		X				X	
Use Of Medical Practice Parameters	X	X		X		X	X	X				X	X
Tort Reform	X	X		X		X	X	X	X	X	X	X	X
Anti-trust and Other Legal Reforms to Promote Cost Containment	X									X			
Promotion Of Living Wills And Advance Directives	X												

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Endnotes

1. Some of the proposals are at the "principles" stage and may change significantly. Please refer to the attached summaries for the source and status of the information reflected in this chart.
2. Rep. Stark's proposal calls for public program coverage of all Americans for basic coverage, but it also mandates that employers supplement basic coverage with private coverage if they currently provide more than MediPlan's benefit package. Consequently, this "maintenance of effort" provision takes on some of the character of a pluralistic system. MediPlan LTC is completely public.
3. ACP's position paper presents a national universal financing plan as its long-term goal, but concedes that the immediacy of current access problems may make it necessary to suppport incremental expansions in insurance coverage through Medicaid expansions and, perhaps, an employer mandate. The recommendations presented in their paper are limited to the long-term goal.
4. While BRT's principles call for universal access, the program elements reflected in the principles would not provide for universal access.
5. The USCC adopted a long-term goal of universal access through a pluralistic system, but its proposal is limited to an expanded Medicaid program and a series of provisions designed to improve access to affordable private insurance.
6. Also includes tax-exempt rebates to employees selecting insurance plans with premiums less than those of employer's other plans.
7. Community rating would be required only for the system of regional insurers who would provide insurance to small businesses.
8. Does not propose any alterations of the Medicare program.
9. Catastrophic protection provided only for low-income enrollees.
10. Premiums would be service specific only for expanded benefits to current Medicare beneficiaries whose premium and cost-sharing levels for current services would be grandfathered under the new public program.
11. Presented as one of several options.
12. NGA splits this responsibility between federal and state governments: the federal government would establish guidelines for minimum benefits, while state governments would be responsible for establishing a process to develop, determine, and define the specific benefit package.
13. Enriched package under public plan.
14. BRT would eliminate any federal or state mandated benefit laws.
15. Exemption from state mandated benefit laws would appear to apply only to small employers.
16. Provides exemption from state mandated benefit laws only for basic catastrophic plans.
17. Quantitative limits for hospital care benefits and cost-sharing are eliminated for low-income individuals, thereby providing for some catastrophic coverage for the poor.
18. Means-tested.
19. Asset protection plan.
20. High front-end deductibles and copayments would apply only to long-term care coverage.

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© American Hospital Association February 1991.

AB 83 L+C

LP. AB 84 HCS [illegible]

Mary,

Plz hold 10K

bill file

(will prob[illegible])

be introduced

Mon

or

Tues

Alaska State Legislature

SENATOR JIM DUNCAN

P.O. BOX V JUNEAU, ALASKA 99811-3100

(907) 465-4766

COMMITTEES:
FINANCE
VICE CHAIR – HEALTH EDUCATION & SOCIAL SERVICES
BUDGET & AUDIT
BANKING & ECONOMIC DEVELOPMENT

January 17, 1991

MEMORANDUM

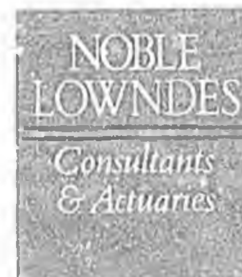
To: All members
Health Care Cost Containment
Task Force

From: D. Gray, Staff

Re: Task Force meeting Friday, January 18.

Note that the Task Force meeting place has been changed to the Governor's Conference Room on the third floor of the Capitol building.

Attached is the meeting agenda and material relating to the agenda. The draft report is yet to be completed. Two legislative proposals are included for your review. One relates to the certificate of need process and the other establishes the Alaska State Health Resources Authority.



JEFF MALEK

MEETING AGENDA

HEALTH CARE COST CONTAINMENT TASK FORCE

January 18, 1991

Governor's Conference Room

10:00 a.m.

1. Review of interim activities.
2. Recent developments.
3. Status of Task Force report. Resolution: [illegible]
4. Proposed legislation.
5. Other business.

HEALTH CARE COST CONTAINMENT

TASK FORCE

Interim activities of the Task Force

1. Public hearings in Fairbanks, Juneau, and Anchorage (teleconferenced to all other sites).

2. Information surveys of municipalities, school districts, health facilities, and health care providers.

3. Alaska health care funding and expenditures analysis.

4. Additional meetings and communications:

   A. Alaska School Board Association.
   B. Alaska Municipal League.
   C. Alaska Municipal Finance Officers Association.
   D. Alaska Hospital and Nursing Home Association.
   E. Alaska State Medical Association.
   F. Anchorage Medical Association.
   G. Alaska business group.
   H. NEA Alaska.
   I. Alaska State Employees Association.
   J. National Governors' Association.
   K. AFSCME Washington, D.C.
   L. Families USA (Senior citizen advocacy group).
   M. National Leadership Commission on Health Care.
   N. Physicians Payment Review Commission.
   O. State of Maryland.
   P. State of Washington.
   Q. State of Louisiana.
   R. State Alliance for Universal Health Care.

HEALTH CARE COST CONTAINMENT

TASK FORCE

REPORT TO THE LEGISLATURE

Draft Outline

I. Introduction

  A. History of Task Force.
    1. Beginnings
    2. Purpose
    3. Accomplishments

  B. Extension.
    1. Finish investigation of long range solutions.
    2. Effects of uninsured/underinsured residents' health care.

II. Investigation and work plan.

  A. Determine the nature and extent of rising health care costs in Alaska

  B. Work Plan
    1. Research.
    2. Surveys.
    3. Public hearings.

III. Findings: Nature of health care in Alaska.

  A. Funding sources (Fed., State, local govt., and private).
  B. Alaska population health care payment and accessibility demographics
  C. Health care provider demographics.

IV. Findings: Sources of health care cost increases.

A. Previous capital expenditures
B. Labor availability and cost.
C. Technology.
D. Uncompensated care.
E. Costs associated with litigation.
F. Inefficient delivery and reimbursement systems
G. Cost shifting from other programs
H. Federal program changes.
I. Health care market place competition issues

V. Long term cost containment proposals.

VII. Recommendations

VIII. Future considerations for Health care in Alaska

STATE OF ALASKA

HEALTH CARE COST CONTAINMENT

TASK FORCE REPORT

TO

THE SEVENTEENTH LEGISLATURE

SUMMARY OF FINDINGS AND RECOMMENDATIONS

DISCUSSION DRAFT -I

CONFIDENTIAL . FOR TASK FORCE MEMBERS USE ONLY

FEBRUARY 1991

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE
REPORT TO THE SEVENTEENTH LEGISLATURE

INDEX

SECTION

EXECUTIVE SUMMARY....................i

OVERVIEW....................1

TASK FORCE WORK PLAN AND OBJECTIVES....................2

STATE EMPLOYEE AND RETIREE HEALTH PLAN UPDATE / RESULTS....3

HEALTH CARE EXPENDITURES IN ALASKA & U.S. 4

CAUSES OF RISING HEALTH CARE COSTS IN ALASKA 5

HEALTH CARE DELIVERY SYSTEM FINDINGS AND SURVEY RESULTS....6

POTENTIAL SOLUTIONS TO SLOW MEDICAL INFLATION....................7

TASK FORCE RECOMMENDATIONS 8

TASK FORCE LEGISLATIVE CONSIDERATIONS 9

OPEN/UNRESOLVED ALASKA HEALTH CARE DELIVERY ISSUES 10

APPENDICES 11

EXECUTIVE SUMMARY

The purpose of this section of the report is to give an overall perspective of the problems facing Alaska with rapidly rising health care costs and propose solutions to stem this problem.

OVERVIEW

Health care costs in Alaska are rising at a pace two and three times the inflation rate for all other goods and services. In 1989, total Alaska health care expenditures are estimated to be in excess of 1.5 billion dollars up from 250 million in 1979, with no substantial change in the states population.

Health care expenditures have been rising at a rate of over 20% each of the last five years in Alaska. These trends are not unique to Alaska alone. Nationally, the Federal Government and virtually all other states are seeking ways to reduce these expenditures or slow the health care inflation rate to be in line with the market basket CPI.

These rapidly rising costs further exacerbate the uninsured population in Alaska, which recent estimates indicate that more than 90,000 Alaska residents are uninsured. This increase in costs have substantially driven up health insurance premiums for all employers , making it very difficult if not impossible, to continue coverage.

The Health Care Cost Containment Task Force initially was charged with the task of investigating , analyzing and recommending ways to reduce or stabilize the health insurance costs for State of Alaska employees, retirees and their dependents. With this work completed and showing favorable results, the Task Forces' charge was expanded during the last session to include reviewing the health care costs for all Alaska residents.

The Task Force, in its expanded role, has investigated the problem of rapidly increasing health care costs in Alaska through public testimony, surveys, research (statewide and nationally) and a detailed analysis of options available to the state.

During this review the Task Force has identified not a sole culprit but numerous contributing factors that must be reviewed in a all encompassing manner to provide the best long term solutions. The contributing factors identified by the Task Force Include:

* Inefficient Medical Care Delivery Systems
* Overbuilt Health Care Facilities
* Cost Of New Medical Technology
* Malpractice Insurance Costs and Protective Measures
* Limited competition For Providers/Insurers
* Health Care delivery System Waste, Overhead And Administrative Costs
* Limited Wellness Promotion And Resources
* Large population of Under/Uninsured Residents
* Cost Shifting Between Public and Private Health Plans
* Life Style diseases and injuries
* Mandated Benefit Coverage
* Limited Access to Private Health Plans
* No Managed Care Delivery Systems IN Place

Although a long and far reaching list each item must be comprehensively addressed to achieve the stated goal of stabilized medical costs in Alaska and basic Health coverage for all Alaskans'.

FINDINGS

The Health Care Cost Containment Task Force has been reviewing the causes for the rapidly rising costs in the State Of Alaska not only for State sponsored plans, but health care costs statewide.

1. Health care expenditures in Alaska have increased 157.2% over the last 10 years, the second highest in the nation[1][2]

1

2 Families USA Foundation Report Nov.1990