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that their dream of a national health plan is unlikely to be realized any time soon. He likens the struggle to an old religious tradition: "I'm half Jewish and at Passover, we always say, 'Next year in Jerusalem.' The problem is, we've been saying it for 2000 years, and it's never quite next year." At the seminar, he said that he told Kennedy, "Just in case you don't get there next year, how about loosening the reins on the states so that we can make modest progress at our parochial level while the grand plan is forged here in Washington?" The response? "Next year in Jerusalem," he laughed.

Despite the lack of flexibility, Ogren said he is convinced that the states can, on their own, make a significant difference in solving the problems of the uninsured. "Those states that throw up their hands and say 'We can't afford it, Washington has to do it,' are dreamers. A dollar is a dollar, whether it's raised by the states or the federal government," he asserted.

Interim Steps

There are "some short-term benefits coming out of the scrutiny of the insurance sector," Ogren noted. While states may not be able to regulate companies that choose to self-insure, "they can certainly institute community rating and eliminate discrimination on the basis of age, sex and preexisting conditions, and really take health insurance back to where it was 20 years ago, when the young and the old, men and women, the healthy and the ill, were blended into a single comprehensive pool.

"I don't know if it will go as far as full-fledged community rating," the lawmaker said, "but we're going to come closer to the roots of what insurance is presumably all about."

A problem with what most states are now doing, he continued, "is that there is little pretense of health care reform. There is quite a bit of insurance reform, but as [states] pick their enemies, they're looking at only half of the equation. They're looking almost exclusively at the administrative cost component, and I don't think it's as simple as that."

Short of moving to a single-payer system, the states can also set for themselves the goal of coordinating various health programs. On average, Ogren said, "the states administer about a half dozen different health care programs, often in a half dozen different agencies, with a half dozen different reimbursement mechanisms. If they can streamline all of those programs, wrap them into a single state-administered program that incorporates the uninsured ... the program would also be a competitor in the marketplace." It would encompass not only the poor enrolled in Medicaid and the uninsured but also would attract people who are now buying insurance individually and would give it up gladly because of preposterous rates."

A principal aim of the Alliance is to coordinate independent state efforts. "There are lots of mistakes that won't have to be replicated because we'll have the chance to see what works and what doesn't. Now, state legislators largely work in a consummate vacuum."

A parallel aim is "to see what our collective voice can mean here in Washington." NCSL has "a very diffused voice. It cannot advocate for a specific position because it must encompass all positions."

Outside Reaction

Since it was formed, the Alliance has attracted a small cadre of legislators who share Ogren's belief. Also on the board are Sens. John Kitzhaber (OR), Paula Hollinger (MD) and Stanley C. Walker (VA) and Reps. James Shon (HI), Dennis Braddock (WA), John Timmer (SD), John McDonough (MA), Gene Davis (UT) and Gail Chatfield (MO). All but Timmer are Democrats.

Clearly not all legislators embrace the Alliance's mission statement. Delaware Rep. Jane Maroney (R), a self-described "states' rights person" – said she believes that states can and should solve their own problems, "so I have an argument conceptually" with the need for federal intervention. Even so, Maroney said, "there is no reason not to debate a system such as the one in place in Canada. We need dialogue. The chemistry of good will takes time to develop."

Not even those who agree with the goal of universal care are necessarily convinced that the Alliance is an ideal vehicle for reaching it. Ogren and his board are "senior, credible people," but they are appealing only to a subset of legislators. They are committed to specific, fundamental change, but there is no evidence that they have swayed some of their more mainstream colleagues," an attendee at the December seminar noted. "They don't seem to feel that they have to market their position. Their audience seems to be people who are already committed to the goal and who need information to translate it into program changes."

Ogren reiterated that the Alliance -- which he termed "truly political, not at all policy-oriented" -- was not created to dictate a common tool or model program for achieving universal access but rather to facilitate the exchange of information among the states.

The Alliance, Hagan asserted, does have room for other viewpoints, provided potential members are committed to three major principles: universality of coverage; cost containment; and a belief that health care is a right.

StateSide ... Discussions with Health Policymakers is a periodic feature of State Health Notes, Published by the Intergovernmental Health Policy Project. The views expressed in StateSide belong to those who are interviewed.

SENATE BILL NO. 83

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATORS DUNCAN, Zharoff, Rodey

Introduced: 1/23/91
Referred: L&C, HES and Finance

A BILL

FOR AN ACT ENTITLED

"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."

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

* **Section 1.** PURPOSE. The purpose of this Act is to

(1) by July 1, 1992, create and begin implementation of a statewide health care provider reimbursement system and utilization standards;

(2) after July 1, 1992, provide comprehensive group health insurance for the state, municipalities, school districts, other employers in the state who elect to participate, and all eligible employees of the state, a municipality, a school district, or other employer in the state who elect to participate in the group insurance offered by the Alaska State Health Resources Authority;

(3) expand the pool of subscribers and maximize the opportunities for health care cost management and economies of scale when purchasing group health insurance;

(4) maintain an efficient provider reimbursement system to reduce the administrative cost

to providers who are serving employees of participants;

(5) maintain a statewide health care data base and utilization standards to control inappropriate or improper utilization practices and to reduce the rate of inflation in the cost of health care in the state;

(6) create the most comprehensive, cost-effective, and efficient method of providing a variety of types of health care insurance necessary to meet the coverage requirements of a participant resulting from negotiated employee contracts;

(7) realize the potential savings that will result if approximately 135,000 active and retired state, municipal, and school district employees and their dependents participate in the group health insurance program offered by the authority;

(8) evaluate the need for mandatory participation in the group health insurance offered by the authority; and

(9) evaluate the need for group health insurance for residents of the state who are uninsured or underinsured.

* **Sec. 2.** AS 18.07.035 is amended to read:

Sec. 18.07.035. APPLICATION AND FEES. Application for a certificate of need shall be made to the department upon a form provided by the department and must contain the information the department requires to reach a decision under AS 18.07.041 - 18.07.111. Each application for a certificate of need must be accompanied by an application fee established by the department by regulation. **A copy of each application for a certificate of need, except an application for a temporary or emergency certificate issued under AS 18.07.071, shall be provided to the Alaska State Health Resources Authority.**

* **Sec. 3.** AS 18.07.041 is amended to read:

Sec. 18.07.041. STANDARD OF REVIEW FOR APPLICATIONS FOR CERTIFICATES OF NEED. The office shall grant a sponsor a certificate of need or modify a certificate of need if the availability and quality of existing health care resources or the accessibility to those resources is less than the current or projected requirement for health services required to maintain the good health of Alaska citizens. **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.**

* Sec. 4. AS 21 is amended by adding a new chapter to read:

CHAPTER 77. STATE INSURANCE.

Sec. 21.77.010. AUTHORITY CREATED; REQUIRED REIMBURSEMENT SYSTEM AND UTILIZATION STANDARDS. (a) There is established within the Department of Administration a nonprofit incorporated legal entity known as the Alaska State Health Resources Authority.

(b) The authority shall, by July 1, 1992, establish and begin implementation of a health care provider reimbursement system and utilization standards. The state, a municipality, or a school district shall use the health care provider reimbursement system and utilization standards established by the authority for eligible employees of the state, a municipality, or a school district. With the approval of the authority, other employers in the state may use the health care provider reimbursement system and utilization standards established by the authority.

(c) The authority shall, no earlier than July 1, 1992, establish a group health insurance pool or pools of eligible employees of the state, a municipality, or a school district if the employer has elected to participate in the group health insurance obtained by the authority and may provide group health insurance to employees of other groups that elect to participate in the group health insurance pool provided by the authority. Employees of other groups that elect to participate shall use the reimbursement system and utilization standards established by the authority.

(d) Upon application by an eligible state program, the authority may, beginning July 1, 1992, allow the eligible state program to participate in the group health insurance pool provided by the authority.

Sec. 21.77.015. REQUIRED COOPERATION BY STATE AGENCIES. An agency of the state that provides health care or that provides funds to purchase health care shall, to the maximum extent possible, cooperate in the development of the use of the health care provider reimbursement system and utilization standards established by the authority, including sharing relevant information.

Sec. 21.77.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The authority shall be managed by a board of directors composed of nine members appointed by the governor. The governor shall appoint at least one but not more than two members as representatives from each of the following:

(1) the executive branch;

(2) labor organizations;

(3) school districts;

(4) municipalities;

(5) private sector employers;

(6) health care providers.

(b) Members of the board serve staggered terms of four years. The board shall elect from its membership a president, vice-president, and secretary. Members of the board serve without compensation but are entitled to receive per diem and travel expenses authorized for boards and commissions under AS 39.20.180. Members of the board are subject to AS 39.50.

Sec. 2. 77.030. GENERAL POWERS. The authority may

(1) beginning July 1, 1992, exercise the powers granted to insurers under the laws of the state; if the authority acts as an insurer, the authority shall comply with the requirements applicable to insurers under this title;

(2) sue or be sued;

(3) enter into contracts or agreements;

(4) establish administrative or accounting procedures;

(5) collect, invest, and disburse funds;

(6) charge fees for providing administrative services;

(7) establish appropriate levels of reserves to cover the expenses of the authority;

(8) adopt necessary regulations and procedures for implementation of this chapter.

Sec. 21.77.040. DUTIES OF BOARD; ANNUAL REPORT. The board shall

(1) in providing group health insurance required under this chapter, provide comprehensive coverage at the lowest possible cost per eligible employee;

(2) provide to the governor and to the legislature an annual report covering the previous fiscal year's activities of the authority;

(3) review each application for a certificate of need under AS 18.07.041 and within 60 days after receiving a copy of the application determine the effect of issuing the certificate on the cost of the group health insurance required under this chapter; a copy of the determination shall be provided to the office of planning and research in the Department of Health and Social Services;

(4) every third fiscal year, include in the annual report a cost and benefit analysis of the activities of the authority.

Sec. 21.77.050. STAFF AND PROFESSIONAL SERVICES CONTRACTS. The authority shall employ an executive director who serves at the pleasure of the authority as its chief administrative officer. The executive director may, with the approval of the authority, select and employ additional staff as necessary. Employees of the authority are in the exempt service under AS 39.25.110. In addition to its staff of regular employees, the authority may contract for the services of consultants and professional, technical, and financial advisors the authority considers necessary for the purpose of developing information, conducting hearings, studies, investigations, or other proceedings, or otherwise exercising its powers.

Sec. 21.77.060. PROCUREMENT OF INSURANCE. (a) The authority shall, after July 1, 1992, obtain a policy or policies of group health insurance covering eligible employees of an employer that has elected to participate, from an insurer authorized to transact business in the state under AS 21.09, or act as a self-insurer if the authority determines that self-insurance can provide the desired insurance coverage and benefits at a lower cost per eligible employee.

(b) Except when acting as a self-insurer, the authority shall obtain group health insurance in compliance with the provisions of AS 36.30 and shall make available bid specifications for desired group health insurance benefits to all insurance carriers licensed in the state and qualified to provide the desired benefits. The specifications shall be made available at least once every five years.

Sec. 21.77.070. ALASKA STATE HEALTH RESOURCES FUND. The Alaska state health resources fund is created in the general fund. The fund consists of money appropriated by the legislature. The fund shall be managed and invested by the board. The board may expend money from the fund to carry out the provisions of this chapter.

Sec. 21.77.080. INSURANCE PREMIUMS. The authority shall provide that sufficient funds are collected to provide authorized benefits, reserves, and to pay the expenses of the authority. Reserves remaining at the termination of an insurance contract shall be invested by the authority in the same manner as retirement funds are invested under AS 14.25.180.

Sec. 21.77.090. PARTICIPATION; WAIVER. (a) The state, a municipality, a district, or other employer in the state may participate in the group insurance coverage provided by the authority. If the state, municipality, district, or other employer elects to participate, the state,

municipality, district, or other employer shall continue to participate unless a waiver is granted by the board.

(b) In determining whether a waiver should be granted, the board shall establish minimum benefit and financial standards for the desired group health insurance coverage. The minimum benefit and financial standards and the proposed time schedule for responsive offers shall be sent to all participants at the time the request for proposal for the desired group health insurance coverage is issued. A participant seeking a waiver of coverage shall match the minimum benefit and financial standards set out in the request for proposal for the desired group health insurance coverage. Participants shall submit documentation of their insurance coverage matching the board's minimum benefit and financial requirements before the deadline established by the board. The board may approve or disapprove a waiver of participation based on the documentation submitted by the participant regarding the benefit and financial standards established by the board.

(c) A participant may separately provide for health insurance coverage additional to that offered by the authority.

Sec. 21.77.100. DEFINITIONS. In this chapter,

(1) "authority" means the Alaska State Health Resources Authority;

(2) "board" means the board of directors of the Alaska State Health Resources Authority;

(3) "district" has the meaning given in AS 14.17.250;

(4) "eligible employee" means an employee of a participant who qualifies for group health benefits as determined by the participant;

(5) "eligible state program" means a program in which an agency of the state provides health care or provides funds to purchase health care for persons who are not employees of the state;

(6) "employer" means the state, a municipality, a district, a collective bargaining unit, the board of a public corporation of the state created within a principal executive department, a self-employed person, or a person employing one or more persons in a business or industry;

(7) "fund" means the Alaska state health resources fund;

(8) "group health insurance" means coverage that may include life insurance,

accidental death and dismemberment, medical care and treatment, dental care, eye care, and other group health coverage as determined by the authority;

(9) "municipality" includes a public corporation established by a municipality;

(10) "participant" means the state, a municipality, a district, or other employer in the state;

(11) "reimbursement system" means a system or method that streamlines or results in cost efficient payments to health care providers, and includes schedules of maximum allowable reimbursement for health care related services based on geographic regions, actual provider costs, and availability of services;

(12) "state" means the executive, legislative, and judicial branches of state government, and includes the University of Alaska and a public corporation of the state created within a principal executive department;

(13) "utilization standards" means a system to monitor, track, and verify patterns of treatment by health care providers that assures that cost efficient and cost effective care is provided within accepted medical standards without reducing the quality of care.

* **Sec. 5.** AS 37.07.030 is amended to read:

Sec. 37.07.030. RESPONSIBILITIES OF THE LEGISLATURE. The legislature shall

(1) provide for a budget review function;

(2) analyze the comprehensive operating and capital improvements programs and financial plans recommended by the governor;

(3) adopt legislation to authorize implementation of the governor's comprehensive operating and capital improvements programs and financial plans or appropriate alternatives to those plans;

(4) provide for a post-audit function to cover financial transactions, program accomplishment, and compliance with legislative intent;

(5) adopt or revise the estimate of receipts required to balance the succeeding fiscal year's budget in order that proposed expenditures do not exceed estimated receipts for that fiscal year;

(6) adopt, revise, or initiate revenue measures in order to balance the succeeding fiscal year's budget and the capital improvements section of the budget for the succeeding six years;

(7) appropriate funds for the operation of the Alaska State Health Resources Authority.

* **Sec. 6.** AS 39.25.110 is amended by adding a new paragraph to read:

(30) employees of the Alaska State Health Resources Authority.

* **Sec. 7.** AS 39.50.200(b) is amended by adding a new paragraph to read:

(52) Alaska State Health Resources Authority (AS 21.77).

* **Sec. 8.** REPORT. The Alaska State Health Resources Authority shall report to the Alaska State Legislature by March 1, 1992, on the progress made by the authority in establishing a health care provider reimbursement system and utilization standards.

* **Sec. 9.** This Act takes effect immediately under AS 01.10.070(c).

SENATE BILL NO. 84

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATOR DUNCAN

Introduced: 1/23/91
Referred: HESS and Finance

A BILL

FOR AN ACT ENTITLED

"An Act relating to state coordination of health planning and development; abolishing the Statewide Health Coordinating Council; and providing for an effective date."

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

*** Section 1.** AS 18.07 is amended by adding a new section to read:

Sec. 18.07.005. LEGISLATIVE PURPOSE. It is the purpose of this chapter to create a rational framework for the planning and development of all health care services in the state to ensure promotion and protection of public health, provide equitable access to health services, and avoid unnecessary increases in health care costs.

*** Sec. 2.** AS 18.07.021 is amended to read:

Sec. 18.07.021. STATE HEALTH PLANNING AND DEVELOPMENT [AGENCY]. The [OFFICE OF PLANNING AND RESEARCH IN THE] department is **responsible for** [THE] state health planning and development, [AGENCY DESIGNATED UNDER 42 U.S.C. 300m(b)(3). THE OFFICE] shall [PERFORM THE FUNCTIONS ENUMERATED UNDER 42 U.S.C. 300m-2,] administer the certificate of need program outlined in **AS 18.07.031 - 18.07.111**

[AS 18.07.041 - 18.07.111], and **shall perform** other functions prescribed in this chapter.

*** Sec. 3.** AS 18.07.031 is repealed and reenacted to read:

Sec. 18.07.031. CERTIFICATE OF NEED REQUIRED. (a) Unless authorized under the terms of a certificate of need issued by the department, a person may not

(1) make a capital expenditure of $1,000,000 or more for construction of a health care facility;

(2) convert a building, in whole or in part, for use as a health care facility if the fair market value of the converted part of the building is greater than $500,000 and the sum of the fair market value plus additional capital expenditures made to facilitate the conversion equals or exceeds $1,000,000;

(3) alter or redistribute the bed capacity of a health care facility by more than 10 beds or 10 percent of the number of beds in the facility, whichever is fewer;

(4) add or eliminate a category of health services to or from those provided by the health care facility; or

(5) acquire a health care facility at a cost of $1,000,000 or more.

(b) The dollar thresholds in (a) of this section apply to total anticipated costs. Costs of constructing or acquiring a health care facility may not be artificially divided, fragmented, or structured to circumvent the requirements of this section.

*** Sec. 4.** AS 18.07.035 is amended to read:

Sec. 18.07.035. APPLICATION AND FEES. Application for a certificate of need shall be made to the department upon a form provided by the department and must contain the information the department requires to reach a decision under **AS 18.07.031 - 18.07.111** [AS 18.07.041 - 18.07.111]. Each application for a certificate of need must be accompanied by an application fee established by the department by regulation.

*** Sec. 5.** AS 18.07.051 is amended by adding a new subsection to read:

(b) A certificate of need is valid only for the defined scope, physical location, and person stated in the certificate.

*** Sec. 6.** AS 18.07.061 is amended to read:

Sec. 18.07.061. MODIFICATION AND TERMINATION OF ACTIVITIES. The certificate holder shall apply to the **department** [OFFICE] for a modification of the certificate [BEFORE TERMINATING PART OF THE ACTIVITIES AUTHORIZED BY THE TERMS OF

ISSUANCE, BUT THE CERTIFICATE HOLDER IS NOT REQUIRED TO OBTAIN THE ACQUIESCENCE OF THE OFFICE] before **transferring the certificate or modifying or** terminating all **or part of** the activities authorized by the certificate. If a certificate holder **intends to terminate** [TERMINATES] all of the activities authorized by a certificate, the certificate holder is required to **apply to** [NOTIFY] the **department** [OFFICE] 60 days before termination and to surrender the certificate to the **department** [OFFICE] within 30 days **after** [OF] termination.

* **Sec. 7.** AS 18.07.061 is amended by adding new subsections to read:

(b) An application for transfer of a certificate shall be made on forms provided by the department and must contain

(1) evidence, of the type the department may require by regulation, that the transferee is able to assume ownership or operation of the health care facility and to provide the appropriate health services;

(2) evidence that the transferee is acquiring the health care facility at no more than its current fair market value; and

(3) other information that the department may require.

(c) Transfer of a certificate is subject to conditions the department considers necessary.

* **Sec. 8.** AS 18.07.071 is repealed and reenacted to read:

Sec. 18.07.071. EMERGENCY CERTIFICATES. (a) The department shall expedite review of an application for a certificate of need under AS 18.07.031(a)(1) that is required to

(1) eliminate or prevent imminent safety hazards as defined by a federal, state, or local fire, building, or life safety code or regulation;

(2) comply with state licensure standards; or

(3) comply with accreditation standards, compliance with which is required to receive federal reimbursement.

(b) An application approved under (a) of this section may be approved only to the extent that the capital expenditure is required to eliminate or prevent the hazards or to comply with the standards described in (a) of this section.

* **Sec. 9.** AS 18.07 is amended by adding a new section to read:

Sec. 18.07.079. FINAL DECISION. (a) Within 150 days after it determines that it has received a complete application, the department shall take one or more of the following actions:

(1) approve part or all of the application and issue a certificate of need that includes conditions that the department considers appropriate; the conditions must be directly related to the activities for which the application was made;

(2) deny a certificate of need;

(3) recommend modifications to the application; if the applicant agrees to modify the application, the department may defer a final decision on the application for 30 days after receiving the modified application and all additional information to support the modifications; deferral for more than 30 days under this paragraph may be made by the department only after written findings that there is good cause for deferring the decision and that deferral is in the public interest.

(b) The department shall send the final written findings and decision to the applicant and to other persons who request a copy of the findings and decision. If the final decision is to approve an application, the department shall issue a certificate of need to the applicant.

* **Sec. 10.** AS 18.07.081(a) is amended to read:

(a) The **department** [OFFICE], a member of the public who is substantially affected by activities authorized by the certificate, [OR] another applicant for a certificate of need**, or a health care facility that either provides services similar to the proposed activity or has indicated to the department in writing within the year preceding the decision to grant the certificate an intention to provide similar services to a health service population that includes all or part of the health service population served under the certificate of need** may **request** [INITIATE] a hearing to obtain modification, suspension or revocation of an existing certificate of need by filing an accusation with the **department** [COMMISSIONER] as prescribed under AS 44.62.360. A revocation, modification, or suspension of an outstanding certificate may not be undertaken unless it is in accordance with AS 44.62.330 - 44.62.630.

* **Sec. 11.** AS 18.07.081(c) is amended to read:

(c) A certificate of need shall be suspended if an accusation is filed before the commencement of activities authorized under **AS 18.07.079** [AS 18.07.041] that charges that factors upon which the certificate of need was issued have changed [,] or new factors have been discovered that significantly alter the need for the activity authorized. [A SUSPENSION OF A CERTIFICATE MAY NOT EXCEED 60 DAYS. AT THE END OF THIS PERIOD OR SOONER, THE OFFICE SHALL REVOKE OR REINSTATE THE CERTIFICATE].

* **Sec. 12.** AS 18.07.081(d) is amended to read:

(d) A certificate of need may be revoked if

(1) the **certificate holder** [SPONSOR] has not shown continuing progress toward commencement of the activities authorized under **AS 18.07.079 within one year after** [AS 18.07.041 AFTER SIX MONTHS OF] issuance;

(2) the **certificate holder** [APPLICANT] fails, without good cause, to complete activities authorized by the certificate;

(3) the **certificate holder** [SPONSOR] fails to comply with the provisions of this chapter or regulations adopted under this chapter;

(4) the **certificate holder** [SPONSOR] knowingly misrepresents a material fact in obtaining the certificate;

(5) the facts charged in an accusation filed under (c) of this section are established; or

(6) the **certificate holder** [SPONSOR] fails to provide services authorized by the terms of the certificate.

* **Sec. 13.** AS 18.07.081(e) is amended to read:

(e) A person **who files** [MAY NOT FILE] an accusation seeking suspension or revocation of a certificate of need under this section, knowing that the charges stated in the accusation are untrue or that the charges do not constitute grounds for revocation or suspension under this chapter**, is guilty of a class B misdemeanor**.

* **Sec. 14.** AS 18.07.091 is repealed and reenacted to read:

Sec. 18.07.091. REPORTING REQUIREMENTS, PENALTIES, AND INJUNCTION. (a) The department shall require all health care facilities operating in the state to periodically file reports required by the department by regulation.

(b) The department shall require a certificate holder to file with the department, periodically during the development stage and annually after that until completion of the activity authorized under AS 18.07.031, a report demonstrating that the activity is in compliance with all provisions of the certificate of need.

(c) If the department finds that a person has substantially failed or refused to comply with AS 18.07.031 - 18.07.111 or a regulation adopted under those sections, the department may take one or more of the following actions:

(1) issue an order directing the person to stop the questioned activity;

(2) deny, suspend, revoke, or modify a construction license required under AS 18.20.020 as related to the questioned activity;

(3) suspend a payment to be made by the department to the person for capital and operating expenses relating to the questioned activity;

(4) deny, suspend, revoke, or modify a certificate of need; or

(5) issue an order against a person who violates a provision of AS 18.07.031 - 18.07.111 or a regulation adopted under those sections imposing a civil penalty of not more than $20,000.

(d) Before imposing a sanction listed in (c) of this section, the department shall give reasonable notice of and an opportunity for a hearing.

(e) Notwithstanding AS 44.62.330 - 44.62.630, if the department finds that there will be a significant and adverse effect upon the public interest caused by substantial failure or refusal of a person to comply with AS 18.07.031 - 18.07.111 or a regulation adopted under those sections, the department may issue an order that does one or more of the following:

(1) directs the person to stop the questioned activity;

(2) suspends a construction license required under AS 18.20.020 as related to the questioned activity; or

(3) suspends a payment to be made by the department to the person for capital and operating expenses relating to the questioned activity.

(f) Notwithstanding AS 44.62.330 - 44.62.630, an order under (e) of this section takes effect immediately upon service by the department and remains in effect pending the decision after any hearing that may have been requested unless the person served can demonstrate to the department's satisfaction that the questioned activity is not subject to the application and review requirements of AS 18.07.031 - 18.07.111, or that the person would likely prevail on the merits and that allowing the activity to continue is in the public interest.

(g) Injunctive relief against a violation of AS 18.07.031 - 18.07.111 or a regulation adopted under those sections may be obtained from a court of competent jurisdiction by the department, a certificate holder who is adversely affected by the violation, or a member of the public substantially and adversely affected by the violation.

* **Sec. 15.** AS 18.07.101 is amended to read:

Sec. 18.07.101. REGULATIONS. The **department** [COMMISSIONER] shall adopt, in accordance with the Administrative Procedure Act (AS 44.62), regulations that establish procedures under which **a person** [SPONSORS] may **apply** [MAKE APPLICATION] for **a certificate** [CERTIFICATES] of need required by this chapter, **establish the amount of variation that may occur in an activity authorized by a certificate of need without requiring a modification of the certificate,** [AND THAT] govern the review of those applications by the **department** [OFFICE], establish requirements for a uniform statewide system of reporting financial and other operating data, **establish reasonable fees for applications and other services,** and otherwise carry out the purposes of this chapter.

* **Sec. 16.** AS 18.07.111 is repealed and reenacted to read:

Sec. 18.07.111. DEFINITIONS. In this chapter

(1) "category of health services" means a service that is recognized as a distinct service for the purposes of health care facility licensure and certification under regulations adopted under AS 18.20.010 - 18.20.130, except that "service" does not include the lawful practice of a profession or vocation conducted independently of a health care facility and in accordance with applicable licensing laws of the state;

(2) "certificate" means a certificate of need;

(3) "certificate of need" means a written order of the department that sets out the affirmative findings that a proposed activity sufficiently satisfies the plans and criteria prescribed for such an activity by this chapter and by department regulations and that permits the certificate holder to proceed with the activity;

(4) "commencement of activities" means, with the intent to continue until it is completed,

(A) the visible commencement of actual operations, on the ground, which is readily recognizable as such, for the construction of a building, the alteration of the bed capacity of a health care facility, or the provision for or deletion of an existing category of health services to consumers; or

(B) a significant step toward acquisition of a health care facility;

(5) "complete activities" means the substantial performance of the work required to comply with the terms of issuance of the certificate of need that all parties participating in those activities have obligated themselves to perform;

(6) "construction" means excavation, erection, alteration, modification, reconstruction, modernization, improvement, extension, or other development by or on behalf of a health care facility and includes the lease or purchase of equipment;

(7) "department" means the Department of Health and Social Services;

(8) "health care facility" means an institutional health service provider licensed in whole or in part by the state under AS 18.20.010 - 18.20.130, whether public or private, whether a partnership or corporation, whether organized for profit or not, and includes a hospital, psychiatric hospital, substance abuse hospital, tuberculosis hospital, skilled nursing facility, kidney disease treatment center (including freestanding hemodialysis units), intermediate care facility, ambulatory surgical facility, freestanding emergency care facility, osteopathic facility, independent diagnostic laboratory, and central service facility; "health care facility" does not include

(A) an Alaska Pioneers' Home administered by the Department of Administration under AS 44.21.020(10) and AS 47.55;

(B) the offices of private physicians or dentists, whether in individual or group practice, occupied on a regular basis to perform the range of diagnostic and treatment services usually performed by physicians and dentists on an outpatient basis;

(C) office buildings built or leased by or on behalf of a health care facility for the exclusive use of physicians, dentists, and other practitioners of the healing arts, or other investments made by or on behalf of a health care facility, unless capital expenditures or operating expenses will be charged or reimbursed in the future as costs for providing patient services offered by the health care facility; and

(9) "person" means an individual, corporation, company, partnership, firm, association, organization, business trust, estate, or government entity, and includes a health care facility.

* **Sec. 17.** AS 18.20.050 is amended to read:

Sec. 18.20.050. DENIAL, SUSPENSION, OR REVOCATION OF LICENSE. The department may deny, suspend, or revoke a license in a case in which it finds that there has been a substantial failure to comply with the requirements established under AS 08.64.336, **AS 18.07.031 - 18.07.111,** or AS 18.20.060 - 18.20.080. The license of a nursing facility, as defined in AS 18.20.390, also may be suspended or revoked by the department under

AS 18.20.310(a)(5).

* **Sec. 18.** AS 44.29.100 is amended to read:

Sec. 44.29.100 ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE. There is established in the Department of Health and Social Services an advisory board on alcoholism and drug abuse. [THE BOARD SHALL FUNCTION AS A STANDING COMMITTEE OF THE STATEWIDE HEALTH COORDINATING COUNCIL ESTABLISHED UNDER AS 18.07.011.]

* **Sec. 19.** AS 47.30.475(b) is amended to read:

(b) Money available under this section shall be awarded by the department to applicants on the basis of community need, but only if the award is consistent with the annual implementation plan developed under 42 U.S.C. 300l-2(b)(2) (National Health Resources Planning and Development Act of 1974) by the health systems agency for the health system area in which the applicant is located [AND THE STATE HEALTH PLAN DEVELOPED BY THE STATEWIDE HEALTH COORDINATING COUNCIL UNDER 42 U.S.C. 300m-3(c)(2)(A),] and only after consideration of comment and advice of the Advisory Board on Alcoholism and Drug Abuse. In awarding grants, the department shall further consider the amount of money that is available for all applications and whether an application would contribute to the wise development of a comprehensive program of alcoholic and drug abuse rehabilitation and prevention.

* **Sec. 20.** AS 18.07.011, 18.07.041, 18.07.081(b); AS 18.08.020(2), 18.08.090(11); and AS 18.26.030(a)(4)(B) are repealed.

* **Sec. 21.** This Act takes effect immediately under AS 01.10.070(c).

SENATE CONCURRENT RESOLUTION NO. 10

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATORS DUNCAN, Kerttula, Pourchot, Menard

Introduced: 2/13/91
Referred: HESS and Finance

A RESOLUTION

Establishing a Health Resources and Access Task Force.

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

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

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

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

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

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

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

ways to manage health care expenditures in the state;

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

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

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

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

FURTHER RESOLVED that the task force shall

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FURTHER RESOLVED that the task force shall consist of 14 members and two alternates as follows:

(1) three members of the Senate appointed by the President of the Senate, one of whom shall be designated as an alternate;

(2) three members of the House of Representatives appointed by the Speaker of the House, one of whom shall be designated as an alternate;

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

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

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

FURTHER RESOLVED that, within funds made available for the purpose, the task force may hire staff and contract for services to perform its duties; and be it

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

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

HOUSE BILL NO. 69

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVES BOYER, Navarre

Introduced: 1/23/91
Referred: Health, Education and Social Services, Judiciary, Finance

A BILL

FOR AN ACT ENTITLED

"An Act relating to state coordination of health planning and development; abolishing the Statewide Health Coordinating Council; and providing for an effective date."

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

*** Section 1.** AS 18.07 is amended by adding a new section to read:

Sec. 18.07.005. LEGISLATIVE PURPOSE. It is the purpose of this chapter to create a rational framework for the planning and development of all health care services in the state to ensure promotion and protection of public health, provide equitable access to health services, and avoid unnecessary increases in health care costs.

*** Sec. 2.** AS 18.07.021 is amended to read:

Sec. 18.07.021. STATE HEALTH PLANNING AND DEVELOPMENT [AGENCY]. The [OFFICE OF PLANNING AND RESEARCH IN THE] department is **responsible for** [THE] state health planning and development, [AGENCY DESIGNATED UNDER 42 U.S.C. 300m(b)(3). THE OFFICE] shall [PERFORM THE FUNCTIONS ENUMERATED UNDER 42 U.S.C. 300m-2,] administer the certificate of need program outlined in **AS 18.07.031 - 18.07.111**

[AS 18.07.041 - 18.07.111], and **shall perform** other functions prescribed in this chapter.

* Sec. 3. AS 18.07.031 is repealed and reenacted to read:

Sec. 18.07.031. CERTIFICATE OF NEED REQUIRED. (a) Unless authorized under the terms of a certificate of need issued by the department, a person may not

(1) make a capital expenditure of $1,000,000 or more for construction of a health care facility;

(2) convert a building, in whole or in part, for use as a health care facility if the fair market value of the converted part of the building is greater than $500,000 and the sum of the fair market value plus additional capital expenditures made to facilitate the conversion equals or exceeds $1,000,000;

(3) alter or redistribute the bed capacity of a health care facility by more than 10 beds or 10 percent of the number of beds in the facility, whichever is fewer;

(4) add or eliminate a category of health services to or from those provided by the health care facility; or

(5) acquire a health care facility at a cost of $1,000,000 or more.

(b) The dollar thresholds in (a) of this section apply to total anticipated costs. Costs of constructing or acquiring a health care facility may not be artificially divided, fragmented, or structured to circumvent the requirements of this section.

* Sec. 4. AS 18.07.035 is amended to read:

Sec. 18.07.035. APPLICATION AND FEES. Application for a certificate of need shall be made to the department upon a form provided by the department and must contain the information the department requires to reach a decision under **AS 18.07.031 - 18.07.111** [AS 18.07.041 - 18.07.111]. Each application for a certificate of need must be accompanied by an application fee established by the department by regulation.

* Sec. 5. AS 18.07.051 is amended by adding a new subsection to read:

(b) A certificate of need is valid only for the defined scope, physical location, and person stated in the certificate.

* Sec. 6. AS 18.07.061 is amended to read:

Sec. 18.07.061. MODIFICATION AND TERMINATION OF ACTIVITIES. The certificate holder shall apply to the **department** [OFFICE] for a modification of the certificate [BEFORE TERMINATING PART OF THE ACTIVITIES AUTHORIZED BY THE TERMS OF

ISSUANCE, BUT THE CERTIFICATE HOLDER IS NOT REQUIRED TO OBTAIN THE ACQUIESCENCE OF THE OFFICE] before **transferring the certificate or modifying or** terminating all **or part of** the activities authorized by the certificate. If a certificate holder **intends to terminate** [TERMINATES] all of the activities authorized by a certificate, the certificate holder is required to **apply to** [NOTIFY] the **department** [OFFICE] 60 days before termination and to surrender the certificate to the **department** [OFFICE] within 30 days **after** [OF] termination.

* Sec. 7. AS 18.07.061 is amended by adding new subsections to read:

(b) An application for transfer of a certificate shall be made on forms provided by the department and must contain

(1) evidence, of the type the department may require by regulation, that the transferee is able to assume ownership or operation of the health care facility and to provide the appropriate health services;

(2) evidence that the transferee is acquiring the health care facility at no more than its current fair market value; and

(3) other information that the department may require.

(c) Transfer of a certificate is subject to conditions the department considers necessary.

* Sec. 8. AS 18.07.071 is repealed and reenacted to read:

Sec. 18.07.071. EMERGENCY CERTIFICATES. (a) The department shall expedite review of an application for a certificate of need under AS 18.07.031(a)(1) that is required to

(1) eliminate or prevent imminent safety hazards as defined by a federal, state, or local fire, building, or life safety code or regulation;

(2) comply with state licensure standards; or

(3) comply with accreditation standards, compliance with which is required to receive federal reimbursement.

(b) An application approved under (a) of this section may be approved only to the extent that the capital expenditure is required to eliminate or prevent the hazards or to comply with the standards described in (a) of this section.

* Sec. 9. AS 18.07 is amended by adding a new section to read:

Sec. 18.07.079. FINAL DECISION. (a) Within 150 days after it determines that it has received a complete application, the department shall take one or more of the following actions:

(1) approve part or all of the application and issue a certificate of need that includes conditions that the department considers appropriate; the conditions must be directly related to the activities for which the application was made;

(2) deny a certificate of need;

(3) recommend modifications to the application; if the applicant agrees to modify the application, the department may defer a final decision on the application for 30 days after receiving the modified application and all additional information to support the modifications; deferral for more than 30 days under this paragraph may be made by the department only after written findings that there is good cause for deferring the decision and that deferral is in the public interest.

(b) The department shall send the final written findings and decision to the applicant and to other persons who request a copy of the findings and decision. If the final decision is to approve an application, the department shall issue a certificate of need to the applicant.

* **Sec. 10.** AS 18.07.081(a) is amended to read:

(a) The **department** [OFFICE], a member of the public who is substantially affected by activities authorized by the certificate, [OR] another applicant for a certificate of need**, or a health care facility that either provides services similar to the proposed activity or has indicated to the department in writing within the year preceding the decision to grant the certificate an intention to provide similar services to a health service population that includes all or part of the health service population served under the certificate of need** may **request** [INITIATE] a hearing to obtain modification, suspension or revocation of an existing certificate of need by filing an accusation with the **department** [COMMISSIONER] as prescribed under AS 44.62.360. A revocation, modification, or suspension of an outstanding certificate may not be undertaken unless it is in accordance with AS 44.62.330 - 44.62.630.

* **Sec. 11.** AS 18.07.081(c) is amended to read:

(c) A certificate of need shall be suspended if an accusation is filed before the commencement of activities authorized under **AS 18.07.079** [AS 18.07.041] that charges that factors upon which the certificate of need was issued have changed [,] or new factors have been discovered that significantly alter the need for the activity authorized. [A SUSPENSION OF A CERTIFICATE MAY NOT EXCEED 60 DAYS. AT THE END OF THIS PERIOD OR SOONER, THE OFFICE SHALL REVOKE OR REINSTATE THE CERTIFICATE].

* Sec. 12. AS 18.07.081(d) is amended to read:

(d) A certificate of need may be revoked if

(1) the **certificate holder** [SPONSOR] has not shown continuing progress toward commencement of the activities authorized under **AS 18.07.079 within one year after** [AS 18.07.041 AFTER SIX MONTHS OF] issuance;

(2) the **certificate holder** [APPLICANT] fails, without good cause, to complete activities authorized by the certificate;

(3) the **certificate holder** [SPONSOR] fails to comply with the provisions of this chapter or regulations adopted under this chapter;

(4) the **certificate holder** [SPONSOR] knowingly misrepresents a material fact in obtaining the certificate;

(5) the facts charged in an accusation filed under (c) of this section are established; or

(6) the **certificate holder** [SPONSOR] fails to provide services authorized by the terms of the certificate.

* Sec. 13. AS 18.07.081(e) is amended to read:

(e) A person **who files** [MAY NOT FILE] an accusation seeking suspension or revocation of a certificate of need under this section, knowing that the charges stated in the accusation are untrue or that the charges do not constitute grounds for revocation or suspension under this chapter**, is guilty of a class B misdemeanor**.

* Sec. 14. AS 18.07.091 is repealed and reenacted to read:

Sec. 18.07.091. REPORTING REQUIREMENTS, PENALTIES, AND INJUNCTION. (a) The department shall require all health care facilities operating in the state to periodically file reports required by the department by regulation.

(b) The department shall require a certificate holder to file with the department, periodically during the development stage and annually after that until completion of the activity authorized under AS 18.07.031, a report demonstrating that the activity is in compliance with all provisions of the certificate of need.

(c) If the department finds that a person has substantially failed or refused to comply with AS 18.07.031 - 18.07.111 or a regulation adopted under those sections, the department may take one or more of the following actions:

(1) issue an order directing the person to stop the questioned activity;

(2) deny, suspend, revoke, or modify a construction license required under AS 18.20.020 as related to the questioned activity;

(3) suspend a payment to be made by the department to the person for capital and operating expenses relating to the questioned activity;

(4) deny, suspend, revoke, or modify a certificate of need; or

(5) issue an order against a person who violates a provision of AS 18.07.031 - 18.07.111 or a regulation adopted under those sections imposing a civil penalty of not more than $20,000.

(d) Before imposing a sanction listed in (c) of this section, the department shall give reasonable notice of and an opportunity for a hearing.

(e) Notwithstanding AS 44.62.330 - 44.62.630, if the department finds that there will be a significant and adverse effect upon the public interest caused by substantial failure or refusal of a person to comply with AS 18.07.031 - 18.07.111 or a regulation adopted under those sections, the department may issue an order that does one or more of the following:

(1) directs the person to stop the questioned activity;

(2) suspends a construction license required under AS 18.20.020 as related to the questioned activity; or

(3) suspends a payment to be made by the department to the person for capital and operating expenses relating to the questioned activity.

(f) Notwithstanding AS 44.62.330 - 44.62.630, an order under (e) of this section takes effect immediately upon service by the department and remains in effect pending the decision after any hearing that may have been requested unless the person served can demonstrate to the department's satisfaction that the questioned activity is not subject to the application and review requirements of AS 18.07.031 - 18.07.111, or that the person would likely prevail on the merits and that allowing the activity to continue is in the public interest.

(g) Injunctive relief against a violation of AS 18.07.031 - 18.07.111 or a regulation adopted under those sections may be obtained from a court of competent jurisdiction by the department, a certificate holder who is adversely affected by the violation, or a member of the public substantially and adversely affected by the violation.

* **Sec. 15.** AS 18.07.101 is amended to read:

Sec. 18.07.101. REGULATIONS. The **department** [COMMISSIONER] shall adopt, in accordance with the Administrative Procedure Act (AS 44.62), regulations that establish procedures under which **a person** [SPONSORS] may **apply** [MAKE APPLICATION] for **a certificate** [CERTIFICATES] of need required by this chapter, **establish the amount of variation that may occur in an activity authorized by a certificate of need without requiring a modification of the certificate,** [AND THAT] govern the review of those applications by the **department** [OFFICE], establish requirements for a uniform statewide system of reporting financial and other operating data, **establish reasonable fees for applications and other services,** and otherwise carry out the purposes of this chapter.

*** Sec. 16.** AS 18.07.111 is repealed and reenacted to read:

Sec. 18.07.111. DEFINITIONS. In this chapter

(1) "category of health services" means a service that is recognized as a distinct service for the purposes of health care facility licensure and certification under regulations adopted under AS 18.20.010 - 18.20.130, except that "service" does not include the lawful practice of a profession or vocation conducted independently of a health care facility and in accordance with applicable licensing laws of the state;

(2) "certificate" means a certificate of need;

(3) "certificate of need" means a written order of the department that sets out the affirmative findings that a proposed activity sufficiently satisfies the plans and criteria prescribed for such an activity by this chapter and by department regulations and that permits the certificate holder to proceed with the activity;

(4) "commencement of activities" means, with the intent to continue until it is completed,

(A) the visible commencement of actual operations, on the ground, which is readily recognizable as such, for the construction of a building, the alteration of the bed capacity of a health care facility, or the provision for or deletion of an existing category of health services to consumers; or

(B) a significant step toward acquisition of a health care facility;

(5) "complete activities" means the substantial performance of the work required to comply with the terms of issuance of the certificate of need that all parties participating in those activities have obligated themselves to perform;

(6) "construction" means excavation, erection, alteration, modification, reconstruction, modernization, improvement, extension, or other development by or on behalf of a health care facility and includes the lease or purchase of equipment;

(7) "department" means the Department of Health and Social Services;

(8) "health care facility" means an institutional health service provider licensed in whole or in part by the state under AS 18.20.010 - 18.20.130, whether public or private, whether a partnership or corporation, whether organized for profit or not, and includes a hospital, psychiatric hospital, substance abuse hospital, tuberculosis hospital, skilled nursing facility, kidney disease treatment center (including freestanding hemodialysis units), intermediate care facility, ambulatory surgical facility, freestanding emergency care facility, osteopathic facility, independent diagnostic laboratory, and central service facility; "health care facility" does not include

(A) an Alaska Pioneers' Home administered by the Department of Administration under AS 44.21.020(10) and AS 47.55;

(B) the offices of private physicians or dentists, whether in individual or group practice, occupied on a regular basis to perform the range of diagnostic and treatment services usually performed by physicians and dentists on an outpatient basis;

(C) office buildings built or leased by or on behalf of a health care facility for the exclusive use of physicians, dentists, and other practitioners of the healing arts, or other investments made by or on behalf of a health care facility, unless capital expenditures or operating expenses will be charged or reimbursed in the future as costs for providing patient services offered by the health care facility; and

(9) "person" means an individual, corporation, company, partnership, firm, association, organization, business trust, estate, or government entity, and includes a health care facility.

* Sec. 17. AS 18.20.050 is amended to read:

Sec. 18.20.050. DENIAL, SUSPENSION, OR REVOCATION OF LICENSE. The department may deny, suspend, or revoke a license in a case in which it finds that there has been a substantial failure to comply with the requirements established under AS 08.64.336, <u>AS 18.07.031 - 18.07.111,</u> or AS 18.20.060 - 18.20.080. The license of a nursing facility, as defined in AS 18.20.390, also may be suspended or revoked by the department under

AS 18.20.310(a)(5).

* **Sec. 18.** AS 44.29.100 is amended to read:

Sec. 44.29.100. ADVISORY BOARD ON ALCOHOLISM AND DRUG ABUSE. There is established in the Department of Health and Social Services an advisory board on alcoholism and drug abuse. [THE BOARD SHALL FUNCTION AS A STANDING COMMITTEE OF THE STATEWIDE HEALTH COORDINATING COUNCIL ESTABLISHED UNDER AS 18.07.011.]

* **Sec. 19.** AS 47.30.475(b) is amended to read:

(b) Money available under this section shall be awarded by the department to applicants on the basis of community need, but only if the award is consistent with the annual implementation plan developed under 42 U.S.C. 3001-2(b)(2) (National Health Resources Planning and Development Act of 1974) by the health systems agency for the health system area in which the applicant is located [AND THE STATE HEALTH PLAN DEVELOPED BY THE STATEWIDE HEALTH COORDINATING COUNCIL UNDER 42 U.S.C. 300m-3(c)(2)(A),] and only after consideration of comment and advice of the Advisory Board on Alcoholism and Drug Abuse. In awarding grants, the department shall further consider the amount of money that is available for all applications and whether an application would contribute to the wise development of a comprehensive program of alcoholic and drug abuse rehabilitation and prevention.

* **Sec. 20.** AS 18.07.011, 18.07.041, 18.07.081(b); AS 18.08.020(2), 18.08.090(11); and AS 18.26.030(a)(4)(B) are repealed.

* **Sec. 21.** This Act takes effect immediately under AS 01.10.070(c).

HOUSE BILL NO. 71

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVES BOYER, Navarre

Introduced: 1/24/91
Referred: Labor and Commerce, Health, Education and Social Services, Finance

A BILL

FOR AN ACT ENTITLED

"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."

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

* **Section 1.** PURPOSE. The purpose of this Act is to

(1) by July 1, 1992, create and begin implementation of a statewide health care provider reimbursement system and utilization standards;

(2) after July 1, 1992, provide comprehensive group health insurance for the state, municipalities, school districts, other employers in the state who elect to participate, and all eligible employees of the state, a municipality, a school district, or other employer in the state who elect to participate in the group insurance offered by the Alaska State Health Resources Authority;

(3) expand the pool of subscribers and maximize the opportunities for health care cost management and economies of scale when purchasing group health insurance;

(4) maintain an efficient provider reimbursement system to reduce the administrative cost

to providers who are serving employees of participants;

(5) maintain a statewide health care data base and utilization standards to control inappropriate or improper utilization practices and to reduce the rate of inflation in the cost of health care in the state;

(6) create the most comprehensive, cost-effective, and efficient method of providing a variety of types of health care insurance necessary to meet the coverage requirements of a participant resulting from negotiated employee contracts;

(7) realize the potential savings that will result if approximately 135,000 active and retired state, municipal, and school district employees and their dependents participate in the group health insurance program offered by the authority;

(8) evaluate the need for mandatory participation in the group health insurance offered by the authority; and

(9) evaluate the need for group health insurance for residents of the state who are uninsured or underinsured.

*** Sec. 2.** AS 18.07.035 is amended to read:

Sec. 18.07.035. APPLICATION AND FEES. Application for a certificate of need shall be made to the department upon a form provided by the department and must contain the information the department requires to reach a decision under AS 18.07.041 - 18.07.111. Each application for a certificate of need must be accompanied by an application fee established by the department by regulation. **A copy of each application for a certificate of need, except an application for a temporary or emergency certificate issued under AS 18.07.071, shall be provided to the Alaska State Health Resources Authority.**

*** Sec. 3.** AS 18.07.041 is amended to read:

Sec. 18.07.041. STANDARD OF REVIEW FOR APPLICATIONS FOR CERTIFICATES OF NEED. The office shall grant a sponsor a certificate of need or modify a certificate of need if the availability and quality of existing health care resources or the accessibility to those resources is less than the current or projected requirement for health services required to maintain the good health of Alaska citizens. **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.**

* Sec. 4. AS 21 is amended by adding a new chapter to read:

CHAPTER 77. STATE INSURANCE.

Sec. 21.77.010. AUTHORITY CREATED; REQUIRED REIMBURSEMENT SYSTEM AND UTILIZATION STANDARDS. (a) There is established within the Department of Administration a nonprofit incorporated legal entity known as the Alaska State Health Resources Authority.

(b) The authority shall, by July 1, 1992, establish and begin implementation of a health care provider reimbursement system and utilization standards. The state, a municipality, or a school district shall use the health care provider reimbursement system and utilization standards established by the authority for eligible employees of the state, a municipality, or a school district. With the approval of the authority, other employers in the state may use the health care provider reimbursement system and utilization standards established by the authority.

(c) The authority shall, no earlier than July 1, 1992, establish a group health insurance pool or pools of eligible employees of the state, a municipality, or a school district if the employer has elected to participate in the group health insurance obtained by the authority and may provide group health insurance to employees of other groups that elect to participate in the group health insurance pool provided by the authority. Employees of other groups that elect to participate shall use the reimbursement system and utilization standards established by the authority.

(d) Upon application by an eligible state program, the authority may, beginning July 1, 1992, allow the eligible state program to participate in the group health insurance pool provided by the authority.

Sec. 21.77.015. REQUIRED COOPERATION BY STATE AGENCIES. An agency of the state that provides health care or that provides funds to purchase health care shall, to the maximum extent possible, cooperate in the development of the use of the health care provider reimbursement system and utilization standards established by the authority, including sharing relevant information.

Sec. 21.77.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The authority shall be managed by a board of directors composed of nine members appointed by the governor. The governor shall appoint at least one but not more than two members as representatives from each of the following:

(1) the executive branch;

(2) labor organizations;

(3) school districts;

(4) municipalities;

(5) private sector employers;

(6) health care providers.

(b) Members of the board serve staggered terms of four years. The board shall elect from its membership a president, vice-president, and secretary. Members of the board serve without compensation but are entitled to receive per diem and travel expenses authorized for boards and commissions under AS 39.20.180. Members of the board are subject to AS 39.50.

Sec. 21.77.030. GENERAL POWERS. The authority may

(1) beginning July 1, 1992, exercise the powers granted to insurers under the laws of the state; if the authority acts as an insurer, the authority shall comply with the requirements applicable to insurers under this title;

(2) sue or be sued;

(3) enter into contracts or agreements;

(4) establish administrative or accounting procedures;

(5) collect, invest, and disburse funds;

(6) charge fees for providing administrative services;

(7) establish appropriate levels of reserves to cover the expenses of the authority;

(8) adopt necessary regulations and procedures for implementation of this chapter.

Sec. 21.77.040. DUTIES OF BOARD; ANNUAL REPORT. The board shall

(1) in providing group health insurance required under this chapter, provide comprehensive coverage at the lowest possible cost per eligible employee;

(2) provide to the governor and to the legislature an annual report covering the previous fiscal year's activities of the authority;

(3) review each application for a certificate of need under AS 18.07.041 and within 60 days after receiving a copy of the application determine the effect of issuing the certificate on the cost of the group health insurance required under this chapter; a copy of the determination shall be provided to the office of planning and research in the Department of Health and Social Services;

(4) every third fiscal year, include in the annual report a cost and benefit analysis of the activities of the authority.

Sec. 21.77.050. STAFF AND PROFESSIONAL SERVICES CONTRACTS. The authority shall employ an executive director who serves at the pleasure of the authority as its chief administrative officer. The executive director may, with the approval of the authority, select and employ additional staff as necessary. Employees of the authority are in the exempt service under AS 39.25.110. In addition to its staff of regular employees, the authority may contract for the services of consultants and professional, technical, and financial advisors the authority considers necessary for the purpose of developing information, conducting hearings, studies, investigations, or other proceedings, or otherwise exercising its powers.

Sec. 21.77.060. PROCUREMENT OF INSURANCE. (a) The authority shall, after July 1, 1992, obtain a policy or policies of group health insurance covering eligible employees of an employer that has elected to participate, from an insurer authorized to transact business in the state under AS 21.09, or act as a self-insurer if the authority determines that self-insurance can provide the desired insurance coverage and benefits at a lower cost per eligible employee.

(b) Except when acting as a self-insurer, the authority shall obtain group health insurance in compliance with the provisions of AS 36.30 and shall make available bid specifications for de red group health insurance benefits to all insurance carriers licensed in the state and qualified to provide the desired benefits. The specifications shall be made available at least once every five years.

Sec. 21.77.070. ALASKA STATE HEALTH RESOURCES FUND. The Alaska state health resources fund is created in the general fund. The fund consists of money appropriated by the legislature. The fund shall be managed and invested by the board. The board may expend money from the fund to carry out the provisions of this chapter.

Sec. 21.77.080. INSURANCE PREMIUMS. The authority shall provide that sufficient funds are collected to provide authorized benefits, reserves, and to pay the expenses of the authority. Reserves remaining at the termination of an insurance contract shall be invested by the authority in the same manner as retirement funds are invested under AS 14.25.180.

Sec. 21.77.090. PARTICIPATION; WAIVER. (a) The state, a municipality, a district, or other employer in the state may participate in the group insurance coverage provided by the authority. If the state, municipality, district, or other employer elects to participate, the state,

municipality, district, or other employer shall continue to participate unless a waiver is granted by the board.

(b) In determining whether a waiver should be granted, the board shall establish minimum benefit and financial standards for the desired group health insurance coverage. The minimum benefit and financial standards and the proposed time schedule for responsive offers shall be sent to all participants at the time the request for proposal for the desired group health insurance coverage is issued. A participant seeking a waiver of coverage shall match the minimum benefit and financial standards set out in the request for proposal for the desired group health insurance coverage. Participants shall submit documentation of their insurance coverage matching the board's minimum benefit and financial requirements before the deadline established by the board. The board may approve or disapprove a waiver of participation based on the documentation submitted by the participant regarding the benefit and financial standards established by the board.

(c) A participant may separately provide for health insurance coverage additional to that offered by the authority.

Sec. 21.77.100. DEFINITIONS. In this chapter,

(1) "authority" means the Alaska State Health Resources Authority;

(2) "board" means the board of directors of the Alaska State Health Resources Authority;

(3) "district" has the meaning given in AS 14.17.250;

(4) "eligible employee" means an employee of a participant who qualifies for group health benefits as determined by the participant;

(5) "eligible state program" means a program in which an agency of the state provides health care or provides funds to purchase health care for persons who are not employees of the state;

(6) "employer" means the state, a municipality, a district, a collective bargaining unit, the board of a public corporation of the state created within a principal executive department, a self-employed person, or a person employing one or more persons in a business or industry;

(7) "fund" means the Alaska state health resources fund;

(8) "group health insurance" means coverage that may include life insurance,

accidental death and dismemberment, medical care and treatment, dental care, eye care, and other group health coverage as determined by the authority;

(9) "municipality" includes a public corporation established by a municipality;

(10) "participant" means the state, a municipality, a district, or other employer in the state;

(11) "reimbursement system" means a system or method that streamlines or results in cost efficient payments to health care providers, and includes schedules of maximum allowable reimbursement for health care related services based on geographic regions, actual provider costs, and availability of services;

(12) "state" means the executive, legislative, and judicial branches of state government, and includes the University of Alaska and a public corporation of the state created within a principal executive department;

(13) "utilization standards" means a system to monitor, track, and verify patterns of treatment by health care providers that assures that cost efficient and cost effective care is provided within accepted medical standards without reducing the quality of care.

* Sec. 5. AS 37.07.030 is amended to read:

Sec. 37.07.030. RESPONSIBILITIES OF THE LEGISLATURE. The legislature shall

(1) provide for a budget review function;

(2) analyze the comprehensive operating and capital improvements programs and financial plans recommended by the governor;

(3) adopt legislation to authorize implementation of the governor's comprehensive operating and capital improvements programs and financial plans or appropriate alternatives to those plans;

(4) provide for a post-audit function to cover financial transactions, program accomplishment, and compliance with legislative intent;

(5) adopt or revise the estimate of receipts required to balance the succeeding fiscal year's budget in order that proposed expenditures do not exceed estimated receipts for that fiscal year;

(6) adopt, revise, or initiate revenue measures in order to balance the succeeding fiscal year's budget and the capital improvements section of the budget for the succeeding six years;

(7) appropriate funds for the operation of the Alaska State Health Resources Authority.

* Sec. 6. AS 39.25.110 is amended by adding a new paragraph to read:

(30) employees of the Alaska State Health Resources Authority.

* Sec. 7. AS 39.50.200(b) is amended by adding a new paragraph to read:

(52) Alaska State Health Resources Authority (AS 21.77).

* Sec. 8. REPORT. The Alaska State Health Resources Authority shall report to the Alaska State Legislature by March 1, 1992, on the progress made by the authority in establishing a health care provider reimbursement system and utilization standards.

* Sec. 9. This Act takes effect immediately under AS 01.10.070(c).

HOUSE CONCURRENT RESOLUTION NO. 5

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY REPRESENTATIVES ELLIS, Boyer, Navarre, Koponen, Ulmer

Introduced: 2/13/91
Referred: Health, Education and Social Services, Finance

A RESOLUTION

Establishing a Health Resources and Access Task Force.

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

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

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

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

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

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

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

ways to manage health care expenditures in the state;

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

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

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

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

FURTHER RESOLVED that the task force shall

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FURTHER RESOLVED that the task force shall consist of 14 members and two alternates as follows:

(1) three members of the Senate appointed by the President of the Senate, one of whom shall be designated as an alternate;

(2) three members of the House of Representatives appointed by the Speaker of the House, one of whom shall be designated as an alternate;

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

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

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

FURTHER RESOLVED that, within funds made available for the purpose, the task force may hire staff and contract for services to perform its duties; and be it

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

The same health-care mess, but two opposing solutions

Controlling costs is the key

Sen. Jim Duncan

By SEN. JIM DUNCAN

Alaska's health-cure system is seriously ill.

The cure is comprehensive reform with three necessary components: Increased access to services, cost containment and quality care. Health-care spending in Alaska has increased over 300 percent since 1970. About 90,000 Alaskans, or 16 percent of our population, have no health-care coverage. Without reform, costs will soar from the $1.5 billion we spend now to $10 billion by the year 2000 and our uninsured will grow to 25 percent of the population.

Recommendations by the Health Care and Access Task Force, that I co-chair, provide an opportunity to enact meaningful health-care reform.

The plan's initial goals are to help people who can afford to help themselves but who aren't presently being served by the insurance industry, make health-care available to low-income pregnant women and children, and slow down increasing costs.

The ultimate goal is universal health care all Alaskans can afford.

Please see Page F-6, **DUNCAN**

Alaska's health-care system is breaking down as costs soar and insurance premiums move ever higher. More and more employers are cutting back on health-care benefits or dropping coverage altogether. As many as 90,000 Alaskans have no insurance, and a heart attack, stroke or other serious illness can wipe out a lifetime of savings.

A new Alaska consensus has emerged for changing the system. But the reform movement has split on how to fix the system.

In one corner, we have a coalition of doctors, hospitals and nursing homes with their proposed Comprehensive Health Insurance and Payment Reform Act. It stresses now programs to make insurance more affordable.

In the other corner is Sen. Jim Duncan, a Juneau Democrat whose pending bill emphasizes limiting health costs through government regulation.

Everyone gives up something

By DR. OLIVER M. KORSHIN

Dr. Oliver M. Korshin

Alaska's physicians and hospitals recently released a plan for comprehensive health reform. Its premise is that the players in the health-care arena — providers, hospitals, patients, insurance companies, employers, malpractice attorneys — share responsibility for the health-care crisis and must each give up something to achieve a solution.

The plan proposes:

- Health insurance for everyone who wants it.
- Expanding health-insurance benefits so that patients don't have to pay for routine physicals, prenatal care and other services that keep people healthy.
- Returning health insurance to its original purpose of spreading risks throughout a community instead of excluding people needing it most —the sick.
- Pegging increases in the cost of medical services, as well as health-insurance premiums, to the average rise in the inflation rate.
- Requiring physicians and hospitals to discount services

Please see Page F-6, **KORSHIN**

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TO ASSURE LEGIBILITY

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

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

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- Requiring physicians and hospitals to discount services

Please see Page F-6, **KORSHIN**

DUNCAN: Cost containment is key

Continued from Page F-1

The task force made a number of recommendations to provide the protection of health insurance to more Alaskans. These access recommendations include:

- A National Association of Insurance Commissioners' reform plan. The result should be improvement in the availability of insurance coverage for small employers.
- Establishment of a state high-risk pool. This involves making insurance available at a higher rate than normal to people who previously were rejected from obtaining insurance coverage for medical reasons.
- A program to ensure low-income pregnant women and children have availability to health care.
- Establishing a state authority, with members appointed by the governor, that can pool together individuals or groups into purchasing groups to procure or provide insurance at lower prices.

In the area of cost containment, the task force embraced a bold and innovative method. It recommended a global spending limit — which would set the allowable total health-care spending in Alaska — to slow down the annual increase in expenditures.

The $1.5 billion expended in Alaska on health care last year is identified as the base year for this spending limit. The limit is subject to adjustment to reflect the annual rate of inflation and other factors.

Provider groups — including dentists, doctors, hospitals and laboratories — each would have a recognized target budget. Representatives from each group negotiate with the authority to establish reimbursement schedules and acceptable standards of service to provide quality care but guard against unnecessary care. This method will work to contain costs. If we can slow down the inflationary spiral 1 to 2 percent a year, we will be successful in reducing health-care costs while greatly increasing access.

"This method will work to contain costs. If we can slow down the inflationary spiral 1 to 2 percent a year, we will be successful in reducing health-care costs while greatly increasing access."

Providers representatives on the task force voted for this approach. It is disappointing now to examine a new proposal from the provider community that only addresses access. They want to use your permanent fund dividend and large state appropriations, and mandate employers to pay for health insurance.

Their proposal won't work because it ignores cost containment. In 1974, Hawaii enacted a program for universal access to insurance without cost controls. Major problems with their system still exist; most notably uncontrolled costs.

☐ Sen. Jim Duncan, D-Juneau, is co-chairman of a state task force exploring ways to change Alaska's health-care system.

KORSHIN: Let players share responsibility

Continued from Page F-1

for those insured through the new program.

• Reforming malpractice laws to reduce costly medical services that doctors and hospitals use to help bolster their defense if sued. This cost is estimated at $225 million in Alaska in 1990.

Yes, our plan requires every Alaskan who receives a permanent fund dividend to have health insurance or coverage through a program like Medicare, Medicaid or the Native Health Service. Those who don't now have coverage would use their dividend to buy basic health insurance provided by the program. Those less well off would pay less for their policies.

Yes, our plan requires employers pay 50 percent of a basic insurance plan for employees. But this makes insurance an affordable benefit.

These features are controversial, but you can't provide services to 90,000 uninsured Alaskans without spending more money. With no income tax and an annual dividend, Alaska is uniquely positioned to solve its health-care crisis.

This crisis is more complex than most social and economic problems. Its solution must be comprehensive. A quick fix that addresses only part of the equation will make it worse.

Sen. Jim Duncan's bill, SB83, to solve the crisis is one-dimensional, mandating government price controls for physicians and hospitals under a "global budget" approach that's never been tried. That's the whole plan. The rest of the bill's plan is merely vague options. In contrast, all of our plan's components are mandated. Our plan is *not* slick election-year salesmanship.

Proposing price controls on doctors and hospitals caters to widespread resentment about the high costs of health care. But, as a sole reform measure, it will drive physicians from Alaska, particularly from rural areas. Hospitals on the brink will close.

The senator says his bill adopts the recommendations of a state-funded task force. Incorrect.

None of the task force recommendations about insurance reform, improved access to health care, and malpractice reforms are mandated in the bill.

The senator claims other bills before the legislature complement his bill and comprise a comprehensive reform package. Also incorrect. Taken together they still don't approach comprehensive reform because they don't adequately address health insurance reform, access for the uninsured or malpractice reform. Besides, none of these bills are linked. Any one could pass in a piecemeal fashion.

SB83 was totally revised shortly after publication of the Duncan task force's report, whereas our plan has evolved through a series of a dozen drafts over the last year. If a radically altered, "all new" SB83 can be introduced this late in the legislative session, our plan can, too. We challenge the legislature to introduce the plan so it can be openly debated.

□ Dr. Oliver M. Korshin is an Anchorage ophthalmologist. He worked in the federal government administering various health programs before entering private practice in 1985.

OPINION

TWO VIEWS

Alaska's health care system needs fixing, but question is how

Global spending limit needed

By JIM DUNCAN


Duncan

The health care system in Alaska is seriously ill. The cure is comprehensive reform that includes three necessary components: increased access, cost containment and quality care.

Health care expenditures in Alaska have increased over 300 percent since 1979. Approximately 90,000 Alaskans have no health care coverage. Small and large businesses have seen insurance premiums increasing by 20 percent to 30 percent a year.

Alaskans have filed for bankruptcy because they became ill and could not pay their medical costs. No one should become too comfortable because those of us who enjoy the protection of health insurance today may be without it tomorrow.

It was clear to the Alaska Health Resources and Access Task Force, which I co-chaired, that we invite a complete collapse of our health care delivery system without comprehensive reform. Task force recommendations call for an innovative and comprehensive approach that I am confident will work.

To increase access, the Task Force recommended the following action:

- Passage of legislation recommended by the National Association of Insurance Commissioners to bring about insurance regulation reform. The result should be improvement in the availability of private coverage for small employers.
- Establishment of a state high-risk pool.
- Immediately provide incentives to ensure low-income pregnant women and children have access to preventive care.
- Establishment of an authority with an ability to pool together individuals or groups into pools to procure or provide insurance.

In the area of cost containment, the task force embraced a bold and innovative method. It recommended a global spending limit to slow down the annual inflationary increase in total health care expenditures in Alaska.

The $1.5 billion expended in Alaska on health care in 1991 is identified as the base for the spending limit.

The limit will be adjusted to reflect annual Consumer Price Index increases and other factors that may increase or decrease health care costs such as changes in population and medical technology.

Subgroups of providers, including hospitals, physicians, dentists and others are recognized with their own budget targets. Each group will appoint representatives to negotiate with the authority to establish reimbursement systems and utilization standards to maintain total expenditures under the global limit and to ensure quality care. This method will work to contain costs.

If we can slow down the inflationary spiral 1 percent to 2 percent a year, we will have taken giant steps in reducing health care costs while greatly increasing access.

There is not any one culprit we can blame for our sick health care system. Medical providers, the insurance industry and consumers all share in the responsibility and all must share in the solution. This is why the task force was composed of a cross section of Alaskans. Membership included lawmakers, administration officials, consumers, a representative of the insurance industry and two medical providers.

I find it surprising that medical providers are now flatly rejecting the task force recommendations on cost containment after voting for the recommendations as members of the task force. Instead, the providers have submitted a proposal that will do little to slow down the approximate 20-percent annual increase in health care costs.

The providers' proposal wants to use your Permanent Fund dividend. It also requires large state appropriations and mandates employers to offer and pay at least 50 percent of insurance premiums. Under the providers' proposal, everyone participates in the solution except providers.

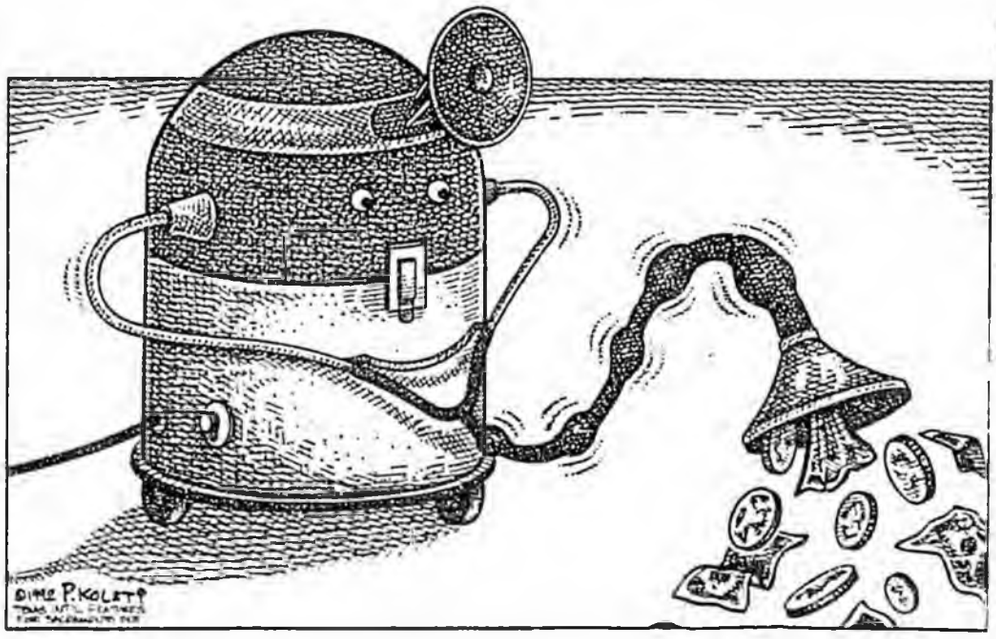
Simply providing access as the providers recommend and ignoring the need to contain costs does not work. Hawaii in 1974 enacted a program for universal access without cost controls. Hawaii officials indicate that major problems with their system still exists; most notably uncontrolled costs growing between 10 percent and 20 percent a year.

Combining access with cost controls, as recommended by the task force, provides an opportunity to bring about meaningful health care reform. The initial goal is to provide access to Alaskans who can help themselves, access to low income pregnant women and children, and to slow down increasing costs.

The ultimate goal is universal access and health care all Alaskans can afford.

We should enact the prescribed medicine and put our health care system on the road to recover. The Task Force has provided a workable solution, so let's proceed with the business of health care reform. Alaskans can't afford to wait any longer. We need to implement comprehensive care reform now.

Jim Duncan represents Juneau in the state Senate.



Universal access for Alaskans

By OLIVER M. KORSHIN


Korshin

The health care crisis in Alaska, as elsewhere in the United States, is multifaceted, more complex than most social and economic problems. Its solution must be comprehensive, including, at a minimum, improved access and cost reduction.

It cannot be cured with a quick fix that addresses only part of the equation. Such a "solution" will likely worsen the crisis.

Alaska's physicians and hospitals have spent over a year developing a plan for comprehensive health care reform, called CHIPRA (Comprehensive Health Insurance and Payment Reform Act of 1992).

One premise of CHIPRA is that the players in the health care arena — providers, hospitals, patients, insurance companies, employers, malpractice attorneys — need to acknowledge their share of responsibility for the health care crisis and give up something to achieve a workable solution.

Many physicians would accept reduction in their practice incomes in exchange for less government intrusion between them and their patients, timely payment, less paperwork and reduced fears of being sued.

CHIPRA proposes the following:

- Universal access to basic health insurance for all Alaskans.
- Preventive care free of deductibles and co-payments.
- Return health insurance to its original purpose of spreading risks throughout a community instead of excluding people from coverage precisely because they need it!
- Peg fee increases for doctors and hospitals, as well as increases in health insurance premiums, to the Consumer Price Index.
- Physicians and hospitals must discount their services for CHIPRA enrollees.
- Reform malpractice statutes to reduce or eliminate costly defensive medicine.
- Administrative simplification by requiring a central claims clearing house and a single claims form.

Yes, CHIPRA does require Alaskans to have health insurance or coverage through a program such as the Veterans Administration, Medicare or the Native Health Service in order to receive a Permanent Fund dividend. But CHIPRA mandates sliding-scale premiums, so that everyone pays a fair share of the cost of coverage.

Yes, CHIPRA does require employers pay 50 percent of the cost of basic insurance for employees. That's the contribution employers must make to solve the crisis. It permits insurance to become an affordable benefit.

We're not attempting to conceal these controversial features of CHIPRA. After all, if we really care about Alaska's uninsured, we have to face the fact that bringing them into the system is going to cost money.

And, with no state income tax and an annual dividend besides, Alaska is in a unique position to fix its own health care crisis.

Sen. Duncan's plan, SB83, offers a one-dimensional solution for this complex problem. SB83 mandates that state government manage the costs of all doctors and hospitals — private, state, federal — under a "global health budget."

Global budgeting for all health services is an untested approach that's never been tried in any state.

But the only tool SB83 gives the state under this global budget scheme is price controls on private sector doctors and hospitals. No insurance reform. No malpractice reform. No improved access for the uninsured.

Placing price controls on private doctors and community hospitals caters to widespread popular resentment and frustration about the high cost of health care, but, if enacted, SB83 will drive physicians from Alaska and make recruitment difficult. Community hospitals will be driven closer to the brink or have to close their doors.

Sen. Duncan says that SB83 incorporates the recommendations of his task force, but that's not accurate.

The senator's task force made some important recommendations — about true insurance reform, access for the uninsured, malpractice reform and administrative simplification, but only price controls got into the mandated language of SB83. The rest of the task force's recommendations are missing or optional.

Sen. Duncan claims other bills before the Legislature complement SB83, and together make a comprehensive reform "package." Also inaccurate.

We support the concepts in several of them, but all these bills taken together still don't constitute comprehensive reform. In particular, there is no bill that gives coverage to the uninsured or that broadly reforms either health or malpractice insurance.

Besides, all these bills are independent, none are linked legislatively. Passage of one is not contingent on passage of all. This is not a health system reform package.

SB83 underwent a hasty, total revision within two days after publication of the Duncan Task Force's report, whereas CHIPRA has painstakingly evolved through a series of about a dozen drafts over more than a year.

If the "all new" SB83 can be re-introduced in its radically altered form this late in the session, there's no compelling reason CHIPRA cannot be introduced, too.

We challenge Sen. Duncan to allow introduction of CHIPRA so it can be debated before all Alaskans.

Oliver M. Korshin, M.D., is in private practice in ophthalmology in Anchorage.

HEALTH CARE: ROUND 2

A continuing dilemma

ON THE OPPOSITE page are two views on proposed changes needed in Alaska's health care system. Both cases are well stated — though poles apart.

Sen. Jim Duncan, D-Juneau, is one of the few members of the Legislature with the grit to tackle this tangled issue head-on. He writes about his bill, originally introduced last year, and now revised, which is currently being discussed in the Legislature.

Dr. Oliver Korshin, an Anchorage ophthalmologist, writes about a health care reform proposal called the Comprehensive Health Insurance and Payment Reform Act of 1992 (CHIPRA). This monumental piece of draft legislation resulted from a team of Alaska physicians and providers meeting for over a year.

Both sides agree there is a problem, but neither so far has presented a plan that is workable.

HERE ARE some of the many reasons why we feel this way. Sen. Duncan's bill creates a board that would regulate fees charged by physicians and hospitals. To practitioners, that sounds a lot like government price controls, which they understandably fear. In fact it *is* price controls. It also sets up a bureaucracy, and who needs another one of those during these days of budget deficits?

The CHIPRA plan, however, also errs on the side of mandates. Among other things, it orders all employers to provide health insurance coverage (a "basic benefits policy"), and says employers must pay at least 50 percent of the premium. This version of "pay or play" has been widely criticized nationwide (as other states grapple with soaring health care costs) as unworkable and yet another burden on already over-burdened businesses.

The CHIPRA plan also mandates that everyone in the state who gets a Permanent Fund dividend carry health insurance. Premiums would be paid for from individual's dividends if they had no other insurance. In a land of fiercely independent souls, who want to make their own decisions on how to spend their dividend, this suggestion will be as popular as, well, as doing away with the dividend altogether.

ONE OF the most appealing aspects of Sen. Duncan's approach is its bold (perhaps too bold) attempt to contain costs. The CHIPRA proposal addresses the troubling area of malpractice in an attempt to curtail "defensive" medicine, with the implication being that doing so would also contain costs now passed on to the patient. Both have positive and negative aspects that need more evaluation.

The important thing is both agree that change is needed. And both agree that the best system would enable Alaskans to have access to basic health care in a way that doesn't break the bank.

A start has been made, thanks to Sen. Duncan and the folks who worked so hard on CHIPRA. The task now is to take the best of both and combine into a workable plan that's fair to all.

5/10/91 ALL ALASKA WEEKLY

Fairbanks dental costs among highest in nation

BY SCOTT J. MCCREA
ALL- ALASKA WEEKLY

According to statistics recently released by the American Chamber of Commerce Researcher's Association, the price of dental care in Fairbanks is 63 percent higher than the national average.

The latest ACCRA index, which surveys the cost of living in 293 participating cities nationwide, lists the average price of an oral examination and teeth cleaning in Fairbanks at $104.28. The price makes Fairbanks as being the second highest in the nation, with Juneau and Kodiak taking top honors at the price of $113. According to the survey, the average cost of the same dental work nationwide is $41.15.

"It's (the index) a price survey," said Leslye Korvola, manager of the borough's Community Research Center. "It does not reflect consumption or expenditures."

Still, said Korvola, the controversy over the cost of dental care in Fairbanks has been a "very sensitive" issue.

"A lot of dentists feel they are providing a service that is more than just dollars and cents," said Korvola.

Korvola said that even though the cost of dental care is higher than the national average, what people end up paying is actually much less.

"The expenditures are much lower because we don't pay out of our own pocket," said Korvola. "Many people are covered by health care insurance or receive government benefits."

The survey has created an uproar in the past among dentists who felt that the

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DENTAL CARE

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research was not accurately done. Fairbank's dentists argued that the random sampling of only five dentists was not adequate enough information with which to determine an average cost on. Korvola said that while the research center surveys on the average of five dentists each time the index is compiled, it is a different five dentists each time. This year, she said, the center surveyed nine dentists.

Another past controversy surrounding the survey was that Fairbanks' dentists were not pricing the same services as dentists in the Lower 48 were. The survey used to ask for a cost on a visual examination and simple cleaning. However, the critics argued, what exactly entails a visual examination might differ from dentist to dentist.

Korvola said that as a result, the survey now specifically asks for a price quote on cited code numbers for procedures used by the American Dental Association. The new survey began in 1987, and since then the cost of dental work has fluctuated from $113.60 in 1986 to $93 in 1988 to the latest figures of $104.28. But despite the reduction in cost from the first survey in 1986, the current statistics still show Fairbanks as being more than twice as high as the average cost.

Dr. Eric Buetow, a North Pole dentist who is the president of the Alaskan Northern Central District Dental Society, said that that one of the main reasons the price of dental care isso high is that "it's an incredibly expensive business to run."

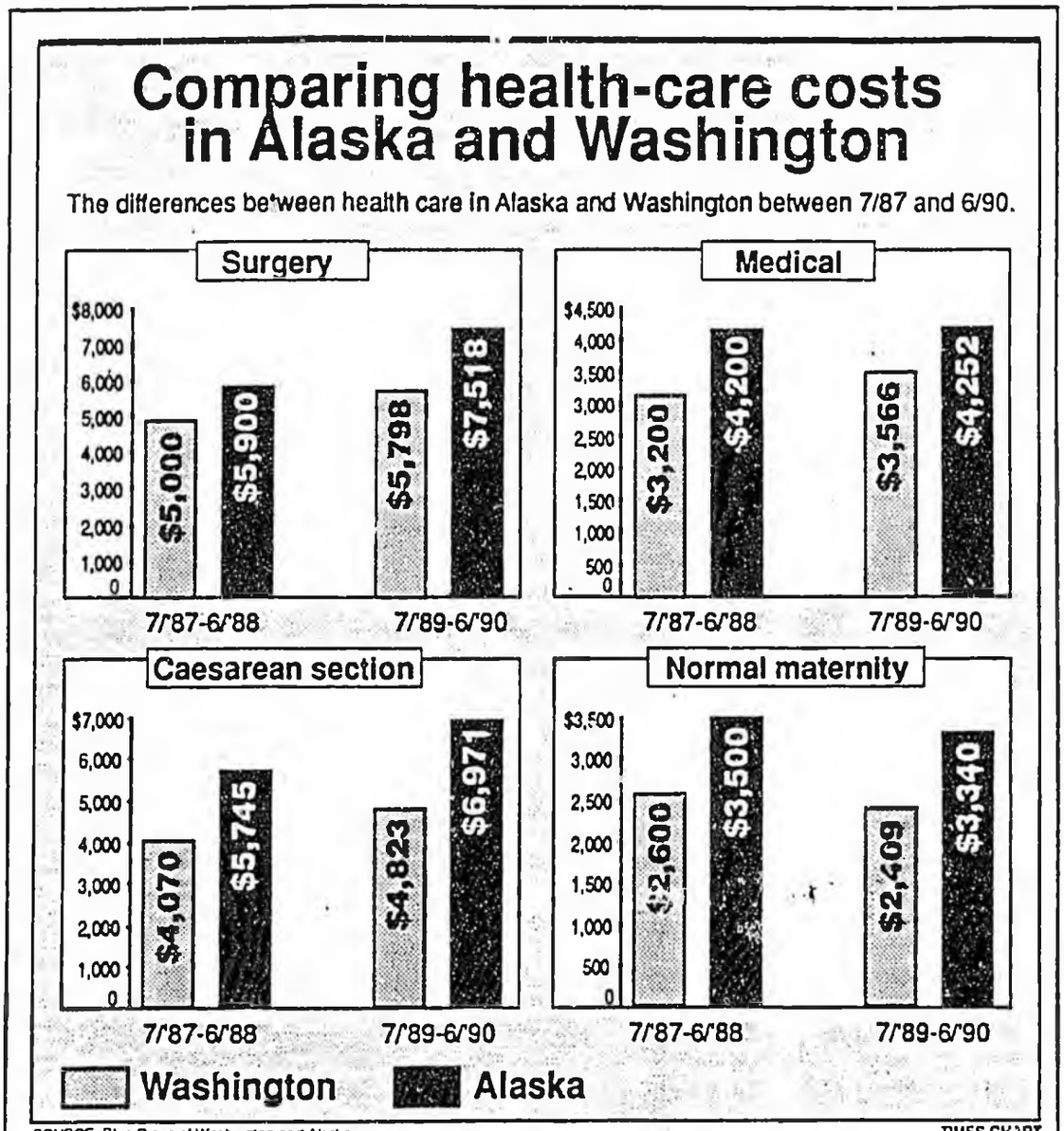
"I have to make a lot of money before I can put a dollar in my pocket," said Buetow, who runs his own business. The cost of supplies for Fairbanks' dentists is high because they often have to order them out of the Lower 48.

"I would guess you would see more of a fluctuation in prices between here and the Lower 48," said Buetow. "I'm sure they will be high, but I'm darn sure in some places on the East Coast you'll find similar fees for the same service."

"It's a tough competition out there," said Buetow. He added that in many metropolitan areas in the Lower 48 there are a larger number of dentists per capita.

"It's tougher to get people in the door out there (Lower 48)," he said. Many dentists often turn to advertising and often turn to free examinations to lure prospective customers, Buetow said.

"Fairbanks has been free and clear of that problem," he added. "No dentists have been forced to leave due to a lack of business."



SOURCE: Blue Cross of Washington and Alaska

TIMES CHART

3-1-91

New insurance plan puts lid on physician charges

New insurance plan puts lid on physician charges

By PATRICIA SOLOVEICHIK

TIMES BUSINESS WRITER 3-1-91

Alaska health care providers took another step toward controlling skyrocketing medical costs this year with the creation of a Blue Cross participating provider agreement that limits physician fees, said Eric Rohlman, vice president for group marketing at Blue Cross.

The program gives patients the option of choosing among 94 participating doctors. These physicians are not allowed to charge fees higher than what Blue Cross is willing to pay for medical services.

Patients who choose a Blue Cross physician in the program, which is called "Participating Provider Network," would avoid "balance billing," Rohlman said. Balance billing occurs when a doctor charges a fee higher than the insurance company has agreed to pay and the patient has to pay the difference, above and beyond the percentage of fees patients already pay.

The program also requires participating physicians to handle the insurance company's paperwork in billing their services.

Although the new physicians network is not expected to reduce costs dramatically, Rohlman said over time it will slow down inflation in medical costs and make Alaska consumers more accountable.

Blue Cross currently provides 81,547 enrollees, or 23 percent of Alaska residents, with health care coverage.

Anchorage Blue Cross customers say the program will help in controlling the rise in group health-care premiums.

"It's a convenience to our employees," said Kathy Steckman, personnel manager for National Bank of Alaska. "This will help because physicians will charge only reasonable and customary costs. That should help hold down costs."

NBA's Blue Cross health insurance is self-funded, which means employee premiums are placed in a trust fund, along with NBA contributions and claims are paid from that fund.

Warren DeVorak, personnel administrator with the Anchorage School District, said he has known about Blue Cross' efforts for some time and has supported it as a way to hold down costs.

"We've had insurance premium increases of 12 to 15 percent a year. This program won't exactly stem that, but it will hold it down significantly in the future," he said. "And it's a win-win situation for employees."

Chris Ulmann, a market analyst for the state Division of Insurance in Anchorage who oversees the Blue Cross arrangements, said "it took quite some time to sign up the participating doctors in the program."

"Signing up 94 physicians is a true success. Doctors are more independent here than they are in other states," Ulmann said.

He said some physicians had charged that

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Blue Cross coerced physicians into signing on with the program by threatening to write out checks to patients instead of sending payment directly to the non-participating doctor.

Under a new Alaska law, non-participating physicians risk having claim payments made directly to their patients. Physicians participating in the new program, however, would be paid directly, Rohlman said.

He said the program offered advantages to doctors, such as improved cash flow and reduced credit risks.

Dr. Charles Aarons, a family practice physician in Anchorage, said his clinic signed up for the program because the clinic's fees were actually lower than the Blue Cross fee schedule.

"But I'm still vehemently opposed to it. They gradually tighten the screws after they suck you in," Aarons said. "I will be interested to see what happens when we try to drop out."

He said fee freezes or minimal inflationary compensation is the rule with such programs in the Lower 48, and he expects similar conditions in Alaska.

"Price controls in a free economy don't work because they eventually lead to rationing," Aarons said.

Rohlman said Blue Cross has not asked physicians to scale down fees and predicts that few will have to do so to participate.

"The vast majority (of physicians fees) are reasonable, but a few set reimbursements by codes that are extremely unreasonable. Our goal is not to come in and reduce reasonable charges," but to identify those doctors who will not gouge patients, he said.

"We shouldn't have to pay the high end, and certainly not three times the average," he said.

However, he said insurers are willing to recognize Alaska's unique situation has given rise to costs 40 percent higher than those in Washington state.

A small, isolated population, boom and bust economy, higher labor and supply costs and a fragmented health-care system contribute to the extraordinary medical inflation in Alaska, according to Blue Cross.

A limited office visit is 40 percent more costly in Alaska than in Washington. A hysterectomy is 32 percent higher, while a mammography costs about the same, Rohlman said.

"We cannot look to the hospitals and doctors as the solutions. As consumers, we have to be part of it," he said.

Anchorage Daily News
3-18-91

Health-care woes

Sen. Duncan offers a timely cure

Anyone who thinks Alaska's health-care system is healthy hasn't been paying attention. For those fortunate enough to have health care, costs are spiraling out of control. And those escalating costs are putting health care beyond the reach of more and more Alaskans.

Perhaps as many as 90,000 state residents have no health insurance or government medical aid, according to a recent legislative study. Because the uninsured must pay out of their own pockets, they skimp on routine care that helps prevent costly illnesses. When they do fall sick, treatment for major conditions can easily push them into poverty or bankruptcy.

For more than a decade, the Alaska Legislature has been happy to confine its concern about health care to mere talk. Despite a decade of oil-boom affluence, the state did almost nothing to control costs to patients or help those without insurance.

At long last, though, there's fresh hope the legislature may do something meaningful. Proposals pushed by Juneau Sen. Jim Duncan may not be perfect, but they give the legislature a good place to start.

Sen. Duncan's package involves two major initiatives. First, it aims to slow the endless cost escalation for health insurance and medical care. Second, it offers tens of tnousands of uninsured Alaskans hope of obtaining health insurance.

On the cost control front, Sen. Duncan's idea has been attacked as a recipe for counterproductive government meddling. In reality, though, it's an exercise in common-sense economics.

State government is one of the largest buyers of medical care in Alaska. When you buy in bulk, you have the power to negotiate a better price. Sen. Duncan would take advantage of that buying power to try to hold down both the cost of care and the cost of health insurance. The idea is similar to the cost-control initiative recently begun by one of the state's largest insurers, Blue Cross.

Sen. Duncan would go a step further and have the state more closely watch investments in costly medical facilities. Overbuilding hospital capacity can drive up overhead costs for all patients. So can instances where numerous facilities each obtain their own expensive but rarely used equipment, instead of agreeing to share.

To expand health-insurance coverage, Sen. Duncan would also capitalize on the state's buying power. Employers would be invited to join with the state in a single health-insurance pool. The larger pool would offer a way to help cut both the cost of insurance and the cost of medical care.

In the longer term, Sen. Duncan would have the state look at creating a pool for those who don't have or aren't wealthy enough to buy their own insurance.

Sen. Duncan's cost-control proposals have given the state's medical establishment apoplexy. Their resistance makes it unlikely that anything resembling his package will pass this year. Instead, the legislature will probably resort to that tried and true time-buying technique, the task force.

Taken seriously, the task force can be a useful way to build consensus. But if the legislature substitutes a task force for legislation, the burden will be on those who reject Sen. Duncan's approach to offer an alternative that better serves the same worthy goals.

Editorial

HEALTH INSURANCE: TIME FOR ACTION

It's time to stop talking and do something about the crisis in health insurance and costs of medical care. Alaska health delivery costs have soared 20 percent annually over the last five years, the second highest rate of any state. The costs of health insurance has become so burdensome that many businesses are having to skinny down on employee coverage.

Many Alaskans are simply slipping out of the safety net, and today are uninsured. This compounds the problem, because their emergencies, if uncollectable by hospitals and doctors, wind up being paid by all of us in higher rates, which further aggravates insurance premiums.

State Sen. Jim Duncan has an ambitious approach, a state medical authority that will negotiate pre-approved rates with health providers and, pooling all public employees with private employers who wish to join, negotiate bulk insurance packages. Alternatively, there is Sen. Jay Kerttula's more modest proposal to offer a kind of safety-net coverage for Alaskans too high-risk to get insurance.

The medical establishment is lobbying hard against Duncan's bill in Juneau. We don't know whether his approach is best, but it's urgent that we do something, not just appoint another task force to study the problem.

HEALTH-CARE COSTS TOO HIGH, ALL AGREE

By Margaret Bauman
Alaska Journal of Commerce

Everyone agrees that Alaska's major health problem is cost, but the cure — that's another matter.

The only thing various factions agree on is something has to be done about the cost, which has left thousands of residents unable to afford health insurance.

"The unchecked increases in health care costs is of grave concern to all Alaskans," said Mano Frey, president of the Alaska State AFL-CIO, in a letter to Sen. Jim Duncan, D-Juneau. "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."

Duncan is the author of a proposal for a state health authority that would set rates for medical services and seek group coverage for some 135,000 state and local public employees.

Legislators hope to slow rising medical costs which they say now run at 20 percent annually, while making health insurance more affordable for public institutions and eventually businesses and Alaskans now without adequate medical coverage.

According to Frey, Duncan's Senate Bill 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."

Frey said the national AFL-CIO is interested in the legislation as well. "They really are positive about this legislation. It could very well develop, if it works, into something other states and the United States in general could adopt," he said.

Frey said he would think individual physicians would be supportive of the plan too, because potentially it could expand the numbers of people that should get some primary car instead of just catastrophic. "People wait until they are seriously ill before they seek help and that's not right," he said.

Ray Schalow, executive director of the Alaska State Medical Association, also voices concern over the current cost of health care. "Our biggest complaint is nobody seems to care about the uninsured," he said.

"You have to deal with all these issues at the same time. We need to sit down at the table and address the total issue.

"I don't question where Duncan's heart is. We've looked at his task force report," Schalow said. But Schalow said physicians and hospitals are already working together, through a cost containment council, to address the issue of costs.

Schalow said he also is concerned that Duncan's proposal would add another layer to the administrative costs that already eat up 20 percent of the cost of health care today.

But the state medical society does want good health care for all residents, he said. "There are enough dollars that flow into Alaska to take care of every man, woman and child in the state."

Schalow also points to a report from

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Stratton

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allow for denying projects in areas where other resources are far more valuable than gold.

And third, where mines are permitted to go ahead, there must be stronger environmental protections. Reclamation must be a condition of the initial permit and bonds must be secured to ensure that reclamation is a reality. Recent water quality laws have cleaned up a lot of dirty water discharge, but these laws need much stronger enforcement. Without the threat of traffic cops, we'd all become speeders. Without strong enforcement of environmental laws, miners do little or nothing to protect the environment.

The conference taught me a lot about the mining industry. I hope the mining industry participants learned a thing or two about us. As more citizens learn the ecological impacts of mining and understand the archaic controls which guide mine development, the more pressure there will be to change the status quo. Miners cannot continue to live in the 19th century as we prepare for the 21st. They can kick and scream and quote their interpretation of the Constitution all the way to defeat, which will happen, or they can accept that the world has changed since 1872. They may even learn to like cornbread and beans.

Jim Stratton is a leader in the Alaska environmental movement.

Industry

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Eastern United States hardwood in lumber, log and recently chip form, has stepped into this change to become a major supplier to Pacific rim users during the 1980s.

These developments present new opportunities for the interior forest of Alaska which has a large percentage of hardwood in the timber mix. In the past, that hardwood had been a significant liability, hindering development of the forest products industry in the mixed stands of the Alaska boreal forest (of Southcentral and Interior Alaska,) and significantly in the Mat-Su area. That birch, and to a lesser degree cottonwood, that was a drag on the potential for harvesting the white spruce in the Susitna forest ten years ago now has a market opportunity in the Pacific rim and the west coast of the U.S.

The major national markets for Mat-Su forest products are Japan and other growth countries on the Pacific rim. The west coast furniture and flooring markets of the U.S. could also use interior Alaska hardwood lumber products. The most significant competitors for this potential industry are British Columbia, Washington, Oregon, and Siberian Russia. Mat-Su cannot compete in volume for them, but they do have products in meeting market niche requirements if Alaska processors play smart in the new market-driven forest products industry. Twenty seven people in three groups of high level buyers of Alaska forest products viewed the Interior forests in 1985 and 1986 and indicated that commercial value appeared to be present.

Due to market developments the past few years, Alaska birch should be able to realize a long-term future market niche if it is developed in reasonable volume and as a dependable supply for the users.

In the next decade, many of the Pacific rim countries besides Japan will become not only major importers of Alaska forest products, but also substantial users of value-added forest products that Alaska is, or is capable of, producing.

Opportunities for development of a resource does not mean income to resource owners. It is the offering and the prudent development of the resource in a timely manner than turns opportunity into jobs and income.

Frank Seymour is timber marketing specialist for the Division of Business Development, Alaska Department of Commerce and Economic Development.

Health

Continued from Page 10

the Alaska State Hospital & Nursing Home Association which concludes the task force out of which Duncan's legislation emerged had an extremely limited view of health care. The report was issued Feb. 25.

"There was no representation from the business community, health providers or consumers on the task force," the report said.

"All its members, but one union representative, were state employees or legislators."

The association also challenges cost figures cited by the task force. "There is no analysis of its statement that Alaska health care costs have been increasing at 20 percent for the last five years," the association said. "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.

"There is no analysis of the report's conclusion that there are 90,000 uninsured and underinsured, or that

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Health

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that number will increase to 25 percent of Alaska's population by the year 2000," the association said. "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."

The association favors 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," the association said. "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."

Individual citizen responsibility is a point also raised by the insurance industry.

"It is the responsibility of the consumer to get involved, to ask how much a procedure will cost and why," said Mick Brogan, a veteran insurance broker.

"Until the consumer gets involved, that equalization of costs is only half complete. A higher priority right now is the uninsured and uninsurables. We are giving them risks they have no business handling all by themselves."

Brogan feels the state would be better off taking care of the underinsured and uninsurables before coming up with a "grand master plan to rewrite basic insurance. They are talking about results. If you are going to control costs you have to go to the consumer and the provider," Brogan said. "Those are the only two that can really control the cost. The point is, with respect to co-insurance, that you can't engage the consumers in participation unless you have them paying part of the bill.

"Unless consumer are participating in the costs, you really don't have much hope that costs will be held down. There is no reason for utilization to be reduced," he said.

Not content to wait until legislators decide what they want to do, Blue Cross of Washington and Alaska has been promoting a participating provider agreement that puts a ceiling on physician fees.

So far, the program has signed up 95 physicians in Alaska, said Eric Rohlman, vice president of group marketing for Blue Cross.

Blue Cross of Washington and Alaska has over 35,000 subscribers in Alaska, through individual and group policies, with more than double that number of residents actually covered through the policies.

That group represents about 22 percent of all physicians with $1 million or more in malpractice insurance, Rohlman said.

A participating physician is one who agrees to accept the Blue Cross payment as the payment in full. "In return, Blue Cross directly pays the physician and improves the physician's cash flow," Rohlman said. "Under this plan, the subscriber does not have to pay anything up front."

"This should be a win-win situation," Rohlman said. "If someone doesn't want to go to a participating doctor, they don't have to, but there is a benefit of not having to pay up front and you will not be balance billed," he said.

"We have collected bills for over 40 years in Alaska, so we think we ought to know what average charges are," Rohlman said. Blue Cross is finding well over 75 percent of charges are at or below the ceiling set by Blue Cross, he added.

One physician who chose not to participate said he wrote to Blue Cross several months ago to ask if the ceiling on charges would be kept in pace with the physician's rising expenses.

He said he is still waiting for a reply.

Blue Cross is optimistic that more physicians will sign up as participants. "Recruiting will continue," he said. "We are in for the long term."

"Blue Cross benefits because they can tell perspective customers they can offer lower rates," Brogan said. "The physician benefits because theoretically he would be a preferred provider for Blue Cross participants. Participants would theoretically pay less in the short run, but that cost advantage can only be passed on to the consumer until the providers figure out basically in their billing practices how to bill around it."

While physicians are signing up for the participating physician plan, they aren't necessarily content with it.

"Our clinic has signed up for it," said Dr. Charles Aarons.

"Our clinic actually will get more for this plan than we have been charging previously. I"ll be making more money from Blue Cross for a while, so my opinions are not tainted by financial self-interest at the moment.

"But Blue Cross because of its position in the market can act as a monoposony. The typical behavior of Blue Cross is they get doctors signed up, then start tightening down.

"They won't actually cut, but in a short period of time they get the cost increases down where they want," Aarons said.

MISSES MARK

2.26.91

Unhealthy health plan

Tues

A LEGISLATIVE task force on health care costs last week estimated that 90,000 Alaskans are in need of affordable, adequate health insurance. There is no reason to dispute the finding of the task force, which is the pet project of Sen. Jim Duncan of Juneau. But there is reason to question the senator's recommendations on how to solve the problem.

His solution is to ensure that all government employees receive good health benefits at low cost by placing additional limits on the fees that health care providers can charge government employees.

Unfortunately, it's a proposal that will exacerbate, not relieve, the health cost crisis.

According to Mr. Duncan, the state should create a new state agency, a health resources authority, that would control rates for medical services charged by doctors, hospitals, pharmacists and other care providers who wish to do business with the state.

With an estimated 135,000 Alaskans covered under state, local or school district union contracts for guaranteed health care, Sen. Duncan intends to leverage their business to get doctors and hospitals to participate in the state price control scheme. He intends to later extend the system to cover private sector employees as well.

THE THOUGHT of yet another government bureaucracy spending millions of more public dollars is frightening enough, but the proposal is much more serious than just creating more government.

The approach ignores the complexity of the health care cost problem itself.

For doctors there's malpractice insurance approaching rates of $100,000 per year. For hospitals there's uncompensated care — those thousands of Alaskans who come in for care and can't pay for it.

Then there's federal government programs like Medicare, Veterans Administration and Champus that reimburse providers according to a set formula, which nets health providers barely 60 cents on the dollar for the cost of care.

THE PROVIDER is expected to just eat the unreimbursed costs, which means to stay in business raising rates for private payers. Sen. Duncan's proposal will only produce additional losses for the health care industry in Alaska.

While there is nothing wrong with wanting to provide good health benefits for government employees, the Legislature should be looking at the total system to develop a health plan that addresses all citizens' needs.

That plan should consider issues like uncompensated care, availability and access to new technology, society's expectations for care, and major health problems like AIDS. A public debate should cover questions like whether we want to ration medical care — as is done in Canada and other countries that have a form of socialized medicine.

The Legislature should work closely with providers and consumers to improve and pay for health care in Alaska. The goal should be to provide the greatest good for the greatest number.

Mr. Duncan's aim misses that mark.

DEEDLE DUMB

2.26.91

Tues

Half-time Legislature

THE NEWS report from Juneau last week said the Legislature has scheduled floor sessions to take place only every other day. One day off, one day on, deedle, deedle dumpling my son John.

Perhaps lawmakers want to rest up for the final two days of the session when all the work takes place.

More likely, they're on a part-time schedule because there just isn't very much going on, and it would be a little boring to just sit around in the House or Senate chamber looking at each other. So they take off half the time.

It didn't used to be that way. During the first 10 years of statehood, the people's representatives could gather in Juneau, do all they had to do, and get back home in two or three months' time. Legislative sessions lasted between 60 and 90 days during the 1960s.

Then came the Prudhoe Bay lease sale, and $900 million to light up the eyes of lawmakers who couldn't count the many ways to spend it. Sessions began dragging on in length beginning in 1970. By 1984 they were lasting almost a half-year. That's when the public said "no more."

A constitutional amendment that year limited the legislature to three-month sessions.

But the 121-day limitation isn't sufficient, as the current half-time Juneau schedule shows. It should be trimmed back even further. Gov. Hickel's proposed 75-day session limit would be a good start. A 60-day limit, with exceptions for emergencies, would make better sense.

Rather than part-time schedules, legislators should put in a full week's work, get the job done, and come back home to live with the people who elect them to be their representative. That's the way the system is designed to work.

THREE PERSPECTIVES

Finding ways to limit healtl

One solution from Legislature to control costs

Sen. Jim Duncan

A tree falls in the forest. There is no one there to hear it fall. Is there a sound? I draw this analogy to The Anchorage Times editorial of Feb. 26 regarding legislation I introduced to help control the inflationary spiral of health care costs in Alaska.

Prior to the publication of the editorial, I had an in-depth discussion with The Anchorage Times editorial board to explain this legislative proposal. After reading the editorial, I had to wonder if I was making a sound when I spoke, or if there was no one around to hear. The editorial missed the mark and the facts entirely.

No one can deny the existence of a problem with rapidly increasing health care cost. However, a notable deficiency in The Anchorage Times editorial was the absence of an alternative solution. The attitude seems to be that there are no solutions. It is the same attitude I've encountered from some health care providers in the state.

The Anchorage Times editorial leaves you with the impression that my proposal is directed solely at public employees. It isn't! It invites and encourages participation from the private sector on a voluntary basis. It can serve as a viable vehicle that will offer all Alaskans affordable quality health care.

The rising cost of health care in our state is one of the most critical problems facing all Alaskans. Total health expenditures in Alaska during 1990 are estimated at $1.5 billion, up 300 percent from the $480 million expended in 1979. It is estimated 80,000 Alaskans are either uninsured or underinsured. If the current inflationary trend continues unchecked, it is estimated health care expenditures will increase to at least $10 billion with over 25 percent of the state's population uninsured by the year 2000.

The problem is not restricted to Alaska. The federal government and virtually all states are grappling with ways to control health care costs. The National Governors Association, AFL-CIO, American Association of Retired Persons and other national groups have identified it as a principal issue of concern. Seventeen states, including Alaska, have established approaches to containing costs and report encouraging results. The Alaska Health Care Cost Containment Task Force, which I chaired, investigated this serious problem for two years and determined it is time for our state to act.

Our private employers want a solution. The Task Force met with a number of Alaska's largest private employers and found many are paying higher premiums for less benefits than the state. Other private employers have found it difficult, if not impossible, to continue coverage thus adding to the ranks of uninsured and underinsured Alaskans.

Increases in health care are also attributed to uncompensated costs incurred by providers. The Anchorage Times asserts the legislation would simply increase uncompensated care losses. On the contrary, losses can be reduced by cutting down on uncompensated claims by providing all Alaskans with the protection of health insurance.

Senate Bill 83 creates a Health Resources Authority. It is charged with establishing a system that results in cost efficient payments to providers.

This system includes schedules of maximum allowable reimbursement for services based on actual provider costs, geographic regions and availability of care. It is also directed to create a statewide utilization standards system to monitor, track and verify patterns of treatment by providers to assure cost effective care is delivered without reducing the quality of medical care. The reimbursement schedules and utilization standards will be used by all public employers and be available for use by all private employers.

After July 1, 1992, the authority may procure or provide a comprehensive group plan to all private and public employers who elect to participate. This will expand the pool of subscribers, maximize the opportunities for cost management, and should realize significant savings.

While editorials need not be objective and impartial, they should be based on fact. I'm assuming The Times provides health insurance coverage for its employees. It should investigate the increase in premiums it pays, the reduction in benefits offered in its policy, or costs it has shifted to employees over the years. It should conduct exhaustive conversations with private and public employers. This may prove to be an ear opener.

I encourage all Alaskans, especially The Anchorage Times, to listen for falling trees. I hear the trees falling as 11 more Alaskans become uninsured on a daily basis as our private employers struggle to keep up with ever increasing health care costs. This legislation recognizes the problem and puts forth a solution. In this regard, it does not miss the mark. It is absolutely right on target!

Jim Duncan represents Juneau in the Alaska state Senate. Opinions expressed in this column do not necessarily reflect the editorial policy of The Anchorage Times. 3-10-91

Patients without insurance create burden for hospitals

Fixing health costs for state employees won't solve problem

Harlan Knudson

Next time you see a young motorcyclist driving down the road at 80 miles an hour without a helmet, you should know that if he ends up in the hospital with thousands of dollars worth of injuries, you're probably going to be the one paying the bill.

The problem of the thousands of uninsured and underinsured Alaskans is not a simple one, and won't be solved easily.

There are a lot of reasons many Alaskans don't have adequate health insurance. They include our lifestyle, especially substance abuse, hazardous jobs and recreation activities; the increasing cost of health insurance; employment that doesn't offer insurance at all; and the lack of blanket supplemental coverage for those with partial insurance.

Sen. Jim Duncan, D-Juneau, is making an admirable attempt to address this compelling problem with legislation he has introduced to establish a health authority.

But his approach has some problems.

The two major components of Duncan's bill are the creation of a rate schedule for health providers that public employers would use, and a provision for creation of insurance pools for groups of private employers.

Duncan's legislation grew out of recommendations by the Health Care Cost Containment Task Force. The task force was originally formed to consider ways to cut down on the amount the state was paying to insure its own employees. Last year, its duties were extended to look into health care cost containment for all Alaskans.

We believe this is no way to go about looking at what is probably the largest health care problem facing Alaska — affordable care for all.

All but one of the task force members were state employees or legislators — there was one union representative. There were no representatives of health providers, consumers or the business community.

In addition, the information the task force relied upon in making its recommendations, specifically the rate of increase in health care costs and the number of Alaskans needing more insurance, is open to question.

While it's one thing to contain the cost of health care by controlling a population insured by a single company — state employees — it is quite another to contain the cost of health care for all Alaskans.

In reducing the cost of health insurance for state employees, the state as purchaser of the insurance and employer of its beneficiaries could dictate or negotiate some cost-cutting measures.

That approach quite obviously will not work on the entire population; a population with health coverage from dozens of different sources or no coverage at all.

The Alaska State Hospital & Nursing Home Association would rather the patients — uninsured and underinsured Alaskans — be diagnosed before treatment by a health authority or any other means.

That diagnosis should be based on adequate information from the state's health providers and consumers, as well as on thoughtful discussion about what the state can and should provide all its citizens when it comes to basic health care.

We believe another bill Duncan has introduced, Senate Concurrent Resolution No. 10 (HCR No. 5 has been introduced in the House by Rep. Johnny Ellis, D-Anchorage) will go a long way toward that diagnosis.

This bill would establish a task force — one that would include providers, consumers and legislators. This task force would be directed to look at the issue of cost containment, the number of uninsured and underinsured Alaskans and health service coordination, among other tasks. It would make recommendations to the legislature in 1992 and 1993.

Those reports, when added to the information already gathered, should tell us the right treatment to cure the ill of too many Alaskans who can't afford adequate health care.

Harlan Knudson is president of the Alaska State Hospital and Nursing Home Association. Opinions in this column do not necessarily reflect the editorial policy of The Anchorage Times 3-10-91

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Physicians have bills too

Raymond Schalow

Why does medical care cost so darn much?

That's a question we ask our physicians, our hospitals, our friends, and our politicians. Everyone will tell you it's a complicated question, and it is. But let me give you two tragic examples that illustrate some of the causes that contribute to rising costs and their effect on our urban and rural communities.

The Anchorage Neighborhood Health Center is the only health facility in Alaska that provides care to those who can least afford it. Its mission statement declares, "ANHC is to be responsive to the needs of the community, especially those who most likely lack access to services because of financial barriers, language barriers, lifestyle barriers, health status barriers, or cultural barriers."

In 1984 ANHC used to do that! In 1990, however, they could only treat 25 percent of the over 48,000 low income persons in Anchorage.

Beginning in 1984, the quantity of service delivered to the Anchorage community began to rapidly decrease. In fact, by 1988 ANHC delivered $275,000 less in services than it did in 1984. Incredible as it sounds, this loss of health care had absolutely nothing to do with state and federal budget cutting.

It's called malpractice insurance! Even though the ANHC physicians were salaried and had never been sued, the cost of their malpractice insurance increased from $16,350 in 1984 to $287,775 in 1988, and rose even higher in 1989, while their primary income (government funding) remained constant.

In other words, $275,000 that could have been spent on hiring additional physicians, purchasing better equipment, or maintaining dental care services had to be used to pay malpractice insurance premiums.

That simply means that members of the community who can least afford medical care now receive $275,000 less than they received in 1984.

This ANHC story is tragic, but it's not the only tragic story that adds to our high cost of health care. Let's take rural Alaska.

Dr. Stanley Jones is a family [illegible] who provided care for the citizens of Haines, Alaska, for more than 26 years. But in 1989 he packed his bag and quit!

Haines is a rural community with no hospital and only one medical office. In addition to Haines, Dr. Jones provided care for Skagway at a personal cost of $100 or more for each round trip ticket.

For all of those 26 years, these two communities had a physician on call 24 hours a day, 365 days a year. Because there was no hospital, Dr. Jones had to have an inventory of drugs, supplies and equipment that exceeded $130,000.

Nurses and administrative staff were also on call 24 hours a day, and their wages had to be guaranteed. Due to the freeze of Medicare and Medicaid payment schedules, Dr. Jones' fees were reimbursed at a substantially lower rate than the cost of his service. Although Dr. Jones had never been sued, his malpractice insurance jumped from $1,000 in 1984 to $69,500 in 1987.

Finally, he was forced to cease the delivery of babies because he could no longer cover the cost of his insurance. Expecting mothers had to travel to Juneau two or three weeks prior to their expected delivery date. Soon thereafter, Dr. Jones retired from active practice entirely.

In a 1989 Senate hearing, Dr. Jones in emotional testimony stated that he could no longer earn a reasonable living in the community he called home. To illustrate his plight, he submitted his 1988 tax return that detailed a personal income loss of $10,000.

The high cost of health care is a complicated issue, and some of the best minds in the country are struggling with the problem. We must provide health care for every one of our citizens, and as the cost of charitable care continues to grow, it is shifted to those who can afford to pay. However, if a large segment of our society cannot, or will not contribute its fair share, then costs will continue to soar.

Some members of society want to ratchet down on health care providers as though they are the problem. But this only adds to the confusion, and ... yes, to the cost. This is a serious social problem that can only be solved when physicians, hospitals, government, large and small businesses, and the public itself finally decide to sit down together, as equal partners and discuss the issues.

Band-Aids are only temporary. What we need is reconstructive surgery.

Raymond Schalow is executive director of the Alaska State Medical Association. Opinions expressed in this column do not necessarily reflect the editorial policy of The Anchorage Times. 3-10-4

Senior Voice OPAG

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WASHINGTON REPORT

Labor unions back national health care reforms

The AFL-CIO Executive Council has unanimously adopted a resolution to push for universal access to health care, significant cost containment, quality care and progressive financing, according to a report in International Teamsters Retiree News.

The group called on all affiliated unions to mobilize their 14.2 million members in a grass-roots campaign and an all-out lobbying effort to win national reforms for the health care industry, said the Teamster newsletter.

There has been "a major underlying climactic change in our society in terms of the perceptions of this issue and its sense of urgency," AFL-CIO president Lane Kirkland said. He cited employers facing "extraordinary uncontrolled costs and the extraordinary shifts with the American Medical Association now recognizing access to health care as a basic human right."

The urgency of the health problem lead the labor group to "support measures that can be enacted," the newsletter said. Among those measures are bills introduced by Sen. Edward M. Kennedy (D-Massachusetts) and Rep. Henry Waxman (D-California) to extend insurance coverage to 37 million Americans lacking insurance.

Other legislation labor will support, according to the newsletter, would:

- Guarantee all Americans the right to health care by establishing a national social insurance program to include workers, the unemployed and others not in the work force. The program would incorporate Medicare and Medicaid.
- Continue labor's goal of a social insurance national health care program "while recognizing that reform may come about in stages."
- Create a national cost containment program that includes a cap on health spending, a capital budget to manage the currently uncontrolled duplication of technology, and a better allocation of resources. A federal authority that negotiates uniform reimbursement rates with hospitals and doctors would be used by all payers.
- Create a national commission of consumers, labor, management, government and providers to run the program.
- Guarantee a core package of benefits, which could be supplemented voluntarily or by collective bargaining.
- Contain progressive financing that requires all employers to contribute.
- Overhaul the existing structure by standardizing claim forms, improving care delivery and assuring that "no individual will be denied coverage regardless of age, income, job status, or health history."
- Reduce job-based retiree health costs by lowering Medicare eligibility to age 60, thus putting the program in line with the average retirement age.
- Improve quality through "practice guidelines" for physicians, create a system for technology assessment, and build a national data base on cost and quality.
- Encourage physicians to avoid unnecessary tests and procedures, while developing a better system to handle malpractice disputes.

Devise a strategy to provide all Americans access to long-term care and to make home care available for the chronically ill.

The group called on all affiliated unions to mobilize their 14.2 million members in a grass-roots campaign to win national reforms for the health care industry.

Jack Lindberg →
Oct 11 – New Eng. Journal of Medicine

For the Health of a Nation

by Henry Simmons, M.D., from the Report of the National [redacted]

The National Leadership Commission on Health Care identified four major problems in our health care system and proposed a major restructuring of the nation's health care system to resolve them. The commission's proposal provides universal access to a basic level of health services; it controls escalating costs through use of economic leverage in the purchase of care, financing and systems reforms, economic incentives including cost sharing, and practice guidelines to encourage appropriate care and eliminate unnecessary care. The commission believes that reducing unnecessary procedures will help contain costs and improve the quality of health care. Its malpractice reform recommendations will also help contain costs and improve quality.

The commission agreed on a vision of a better health care system in the twenty-first century, one that promotes preventive care and healthy lifestyles, and established an innovative, efficient health care system. The system would encourage personal responsibility for choosing good health and appropriate treatment, support a strong doctor-patient relationship, and establish and utilize a public-private partnership to control costs, assure universal access, and improve the quality of care.

Problems with the Current Health Care System

America's health care system is in crisis. Costs are out of control, millions of Americans face difficulty gaining access to needed care, there is a malpractice crisis, and there are serious problems in the quality and appropriateness of much of the medical care being rendered. These problems are interrelated, systemic, and growing worse. It seems clear that they cannot be solved without a long-term, comprehensive strategy. Awareness of these problems has led to a strong shift in public attitudes to broad dissatisfaction with our health care system.

The rate of health care cost escalation is of major concern to both government and the private sector. Unless we act soon to change America's health care system, by the year 2000 the United States could be spending a quarter of the GNP—$2.5 trillion—on health care. That number is more than double the federal government's entire budget for 1990. It is also $1 trillion more than recent estimates for U.S. spending on health care at the turn of the century. National health care spending of $2.5 trillion translates to almost $10,000 per year for every man, woman, and child in this country.

Government is concerned because it is increasingly clear that the federal deficit and rising health care costs are inextricably intertwined. Business and labor are concerned because rising health care costs are now considered a major threat to industry's economic viability and its ability to compete and to provide jobs. The American people are concerned because more and more of the costs are borne directly by individuals, and there is no end in sight.

A systemic problem of this magnitude cannot be solved with a piecemeal strategy. Nor can it be solved by any one segment of society, including government, alone. We all share some of the blame for this complex societal problem, and therefore we share the responsibility for resolving the problem. Costs must be contained, quality and access must be assured, the malpractice problem must be resolved, and, to the extent possible, the American system of freedom of choice, "pluralism," and competition must be preserved. But this will not be possible without comprehensive, long-term structural reform. Such reforms will require creation of a new public-private partnership and a coordinated effort of business, labor, government, providers, insurers, and consumers. Otherwise, costs and problems will only be shifted, and our situation will grow more severe, to the detriment of all.

The growing seriousness of the problems and public concerns have combined to create a new opportunity and need for effecting major change in our health care system. There is now a clear and compelling case for comprehensive reform.

Summary of the Commission's Proposal

The National Leadership Commission on Health Care's final report, *For the Health of a Nation: A Shared Responsibility*, proposes a major restructuring of the nation's health care system. The central feature of the commission's proposal is the notion that none of the problems besetting the nation's health care system—lack of access for millions, poor quality, inefficiency, soaring costs, and a malpractice insurance crisis—can be solved in isolation. The problems are interconnected; the solution must also be. The plan is based on seven fundamental principles and has four interrelated parts—a universal access proposal, a national quality improvement initiative, a cost containment strategy, and a malpractice reform package.

Fundamental Principles of the Commission's Proposal

The commission's proposal is based on seven fundamental principles.

1. *Principle of Universal Access.* There should be no financial barrier separating Americans in need of health care from access to care.
2. *Principle of Fair Compensation.* Every provider of health services in America should be adequately compensated for services rendered to patients.
3. *Principle of Clinical and Economic Freedom.* To the maximum extent possible, without unduly compromising other important principles, health policy ought to restore clinical freedom in rendering health services and economic freedom in financing these services, within the context of adequate countervailing market power from those who ultimately pay for health care in America.
4. *Principle of Shared Responsibility.* Financial responsibility for health care for those too poor to afford it should be shared by government, individuals, and employers.
5. *Principle of Individual Responsibility.* To help achieve the goal of universal access to health care, the individual has a duty to have adequate insurance coverage for himself or herself and dependents.
6. *Principle of Basic Benefits Guarantee.* The design of a basic package of health service benefits to which all Americans should have reliable access is ultimately a federal responsibility.
7. *Principle of a Strong Doctor-Patient Relationship.* Any health care system should foster the goal of protecting the integrity of the doctor-patient relationship.

In light of the federal deficit, the commission proposes building upon the American tradition of providing private health insurance through the workplace. The proposal is designed to encourage continued extensive reliance on that approach, without mandating that employers provide such coverage. The commission also noted that universal access could be funded out of general revenues.

The Commission's Proposal

The Universal Access (UNAC) Plan. UNAC would provide universal access to basic health care for all Americans without insurance. Medicaid recipients would become part of this program. There would be an incentive for more employers to offer health insurance to employees, since both would pay a fee to UNAC if employees were not offered insurance. Financing for this public program would be paid for through a health insurance premium of 0.6 percent of income up to the social security maximum, paid by everyone with incomes over 150 percent of the federal poverty level and their employers, with special provisions for new and small businesses and part-time workers. The funds would be collected nationally; the UNAC program would be administered in a decentralized fashion by the states.

A National Quality Improvement Initiative. This provision would improve the quality, appropriateness, and efficiency of care by establishing a national program of increased technology assessment and outcomes research that would result in national practice guidelines for all the major procedures. Since seventy major procedures account for about half of our total national health expenditures, this is an important way to eliminate unnecessary care. Up to $500 million a year from the UNAC funds would support this ongoing program, designed to assess technology, develop guidelines and standards, and compare new procedures, as they become available, with those already in use.

A Cost Containment Strategy. The elimination of much unnecessary care could potentially cut back up to 20 percent to 30 percent of all procedures performed today. UNAC will have economic leverage, because it will negotiate payment rates for 60 million to 70 million people. Under UNAC, cost shifting of charity care will end and there will be greater inter-employer equity. UNAC will also encourage intervention. The new ability through research and guidelines to make more informed purchasing decisions, combined with cost sharing, will increase individual responsibility. The commission called for increased use of organized systems of care, such as PPOs, by private employers and for physician payment reform with expenditure targets.

A Malpractice Reform Package. This six-part proposal, based on successful programs in some states, calls for strict criteria for expert witnesses; strengthened standards of negligence; punitive damages limited to a grave dereliction of professional responsibility with damages going to the state; limited contingency fees; a fast track through the court system for malpractice cases; and increased use of arbitration. If the states do not move expeditiously to make these changes, there should be consideration of federal preemption of state malpractice laws.

NATIONAL LEADERSHIP COALITION FOR HEALTH CARE REFORM

AT&T
Amalgamated Clothing and Textile Workers Union
American Academy of Pediatrics
American Association of Retired Persons
American College of Physicians
American Federation of State, County, and Municipal Employees
American Federation of Teachers
American Nurses' Association, Inc.
Ameritech
Association of Academic Health Centers
Association of Minority Health Professional Schools
Bell Atlantic
BellSouth
Bethlehem Steel
Chrysler Motors Corporation
Communications Workers of America
DuPont
Eastman Kodak
Equifax
Families USA Foundation
Ford Motor Company
General Electric
Georgia-Pacific Corporation
W.R.Grace & Co.
International Association of Machinists and Aerospace Workers
International Brotherhood of Electrical Workers
International Union of Electrical Workers
Lincoln Telephone & Telegraph Co.
Lockheed Corporation
Meredith Corporation
National Leadership Commission on Health Care
National Small Business United
Northern Telecom Limited
Northwest Airlines
NYNEX Corporation
Pacific Gas & Electric
Pacific Telesis Group
Pioneer Seed
Rochester Telephone Corporation
Rubbermaid
Service Employees International Union
W.C.Smith Inc.
Southern California Edison Company
Southwestern Bell Telephone
3M
Time Warner Inc.
U S WEST
United Steelworkers of America
United Way of America
Westinghouse Electric Corporation
Weyerhaeuser Company
Xerox Corporation

September 21, 1990

From: Beverly Long / Alex

Hawaii an innovator in public health care

HONOLULU — Dr. John Lewin is a spare-time marathon runner with a long distance vision of a nation in which everyone receives prepaid health care.

"I think basic health care is a fundamental human right," says Lewin, the state director of health in Hawaii.

But this former family physician and health officer for the Navajos is convinced this right can best be realized not through a Canadian-style government health service but by vigorous American style competition among health care providers. What Lewin wants the government to do is provide the incentives — or the mandates — that will require this kind of competition.

Hawaii has long been an example in the art of providing health care for working people at a price even the smallest employer can afford. Since 1974 it has been the first (and only) state requiring employers to provide health insurance to all their full-time employees. While businesses can require employees to pay half the cost of this insurance and coverage of dependents is optional, the coverage is mandatory for full-time workers. In practice, most dependents are covered by some health insurance plan.

LOU CANNON

The results of this experiment have been significant. Life expectancy in Hawaii has increased by nearly five years to 78. Infant mortality, which had the high rate of 16 per 1,000 in 1974, is now down to 8.4 — one of the best rates in the nation. And while the rates of cancer and heart disease are similar in Hawaii to those of other states, the death rates from these diseases are lower in Hawaii. Because of its law requiring health coverage for workers, Hawaii has by far the nation's lowest "gap group" -- the term applied to those insufficiently old for Medicare, insufficiently poor for Medicaid and unfortunate to work for an employer who lacks an insurance program.

And last April, at the urging of Lewin and the state's progressive Democratic Gov. John Waihee, Hawaii passed another first-of-its-kind law extending health insurance to the 35,000 persons (a little more than 3 percent of the population) who formed its gap group: the self-employed, part-time and seasonal workers, homeless unemployed and some dependent children. When this State Health Insurance Program (SHIP) was passed, some insurers argued it would be prohibitively expensive. Lewin took the view that the group as a whole (the homeless were an exception) would be healthy and that insurers would find it worthwhile to compete for their business. The results so far suggest Lewin was right.

In comparison with other visionary health programs, notably one in Massachusetts, the emphasis in Hawaii has been on prevention through regular physical examinations, mammograms and prenatal care. The result has been not only a healthier population but low costs that have prompted competitive bids from insurance companies.

Hawaii's health care has become nearly universal at a time when most of the country is heading in the opposite direction. The number of Americans who lack any health insurance is increasing. By and large, these are people who rely on hospital emergency rooms for their medical care.

According to some estimates, as many as 40 million Americans, nearly 20 percent of the population, are lost in this health-coverage gap. The numbers are particularly high in states such as California, which have a high percentage of young workers, immigrants and service industries that tend not to extend health care to employees.

Both in human and economic terms, America pays a tremendous cost for the health-care gap. In inner cities throughout the nation, hospitals and trauma centers are closing down or limiting care because of the high cost of providing uncompensated care in an emergency room. Uninsured Americans tend to wait until a health problem is life threatening — and perhaps incurable — before they seek medical care.

In 1974, Hawaii overcame the reservations of small business men about health-insurance costs by establishing a "community rating." This meant that all the small employers in the state were treated as one risk pool, enabling them to obtain the rate breaks routinely available to big business.

Larger states have balked at such community ratings, although the idea is a way of enticing competitive bids from insurers that would keep costs down and improve long-range health care.

Hawaii's example ought to prove particularly tempting to governors such as Pete Wilson of California, a farsighted Republican who wants to improve preventive health care. Wilson ought to talk to Waihee and especially to Lewin. It is time to provide health care for everyone.

[ ] Lou Cannon is a Washington Post columnist and reporter.

Falling through the net

90,000 Alaskans lack means to pay huge medical bills

By HAL BERNTON
Daily News reporter

Emmett Walton's lung collapsed on a nightmarish flight from Anchorage to Ketchikan. One minute, the 56-year-old Anchorage security guard was relaxing with his wife, Margaret, in the seat of an Alaska Airlines jet, the next he was gasping for precious oxygen through a collapsing lung rapidly filling with fluid. The date was June 16, 1989, a day that for the Waltons marked a turning point in struggles against both a severe physical disability and a crippling financial burden.

Walton was rushed to Ketchikan Memorial, then Providence Hospital in Anchorage for a difficult recovery period in which he slipped in and out of consciousness. Walton, a career Army veteran, fell back on a military benefits program to pick up more than 70 percent of the medical bills from more than two dozen creditors.

But Walton didn't have any supplementary insurance. And his life savings of $2,000 wasn't enough to pay his share of the bills and still keep current on an old batch of medical bills resulting from his wife's stay in a Las Vegas hospital.

At an age when many couples are busying planning their retirements, the Waltons sold their trailer, moved in with Margaret's mother in Mountain View and filed for protection from creditors. The bankruptcy petition filed earlier this year lists assets of $3,639 and debts — almost all of them medical — of $22,944.

"We get phone call after phone call from the hospitals," said Margaret Walton. "Naturally, they want their money. I can't blame them for that. But we just don't have it."

The Waltons are part of an increasing

PAUL SOUDERS / Anchorage Daily News

A collapsed lung and no supplementary insurance put Emmett and Margaret Walton in Bankruptcy Court.

The Waltons are part of an increasing number of Alaskans who run the risk of financial ruin if they get seriously sick or injured. They are among the unfortunates in an Alaska health-care system that is out of control.

For more than a decade, the costs of state medical care have leaped ahead at rates frequently exceeding 20 percent a year. Today, Alaska health care carries an annual price tag of more than $1.5 billion, according to one state study.

Insurers have been raising their rates to match the medical costs. That has made it harder and harder for employers to offer — or self-employed people to purchase — good medical coverage. Today, an estimated 90,000 Alaskans — nearly double the number of a decade ago — lack adequate medical insurance or don't have any insurance at all, according to a state legislative task force study.

"There's a huge gaping hole" in the medical safety net, said Heidi Thomas, a counselor for homeless women at the Clare House in Anchorage. For the women who seek refuge at the Clare House, just getting in the front door of a doctor's office can be a challenge. "The homeless have medical needs but often no insurance to cover them," Thomas said.

Doctors and hospital officials say they try not to turn away those who can't pay. As proof, they point to bad debt that continues to mount even as the economy improves.

Providence Hospital, for example, recorded $4 million in bad debt in 1987, near the height of a severe recession. In 1990, a red-hot year for the state economy, bad debt increased to $9.1 million.

The more bad debt increases, the more the hospital raises prices to help compensate for the costs of the unpaid care, said Dave Hennigan, a Providence Hospital financial officer.

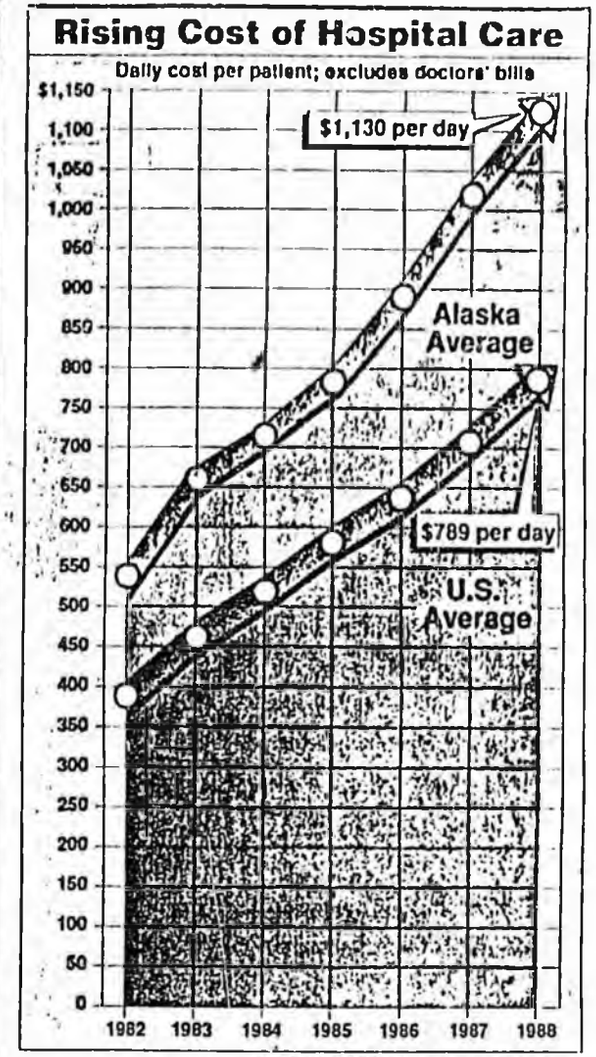
Doctors often do the same, and many have been able to keep earning more money each year.

Anchorage doctors' incomes have risen at roughly the same 6 percent annual rate noted in a national survey by the American Medical Association, according to Ray Schalow, executive director of the Alaska State Medical Association.

PAUL SOUDERS / Anchorage Daily News

A collapsed lung and no supplementary insurance put Emmett and Margaret Walton in Bankruptcy Court.

FRAN DURNER / Anchorage Daily News



RON ENGSTROM / Anchorage Daily News

Sonja Javier, who had no insurance from her seasonal job, sought and eventually found help to fix a painful infection of her teeth. "I can't believe I live in a state that has so much money it pays you to live here but none for my teeth," said Javier. Others without insurance depend on a patchwork of state aid and charity.

The national survey reported that the average U.S. physician's net income before taxes rose from $104,100 in 1983 to $144,700 in 1988, the last year in which statistics were available.

Schalow said Anchorage doctors are willing to tighten their belts to help keep costs under control.

"I can tell you we are willing to come to the table and take our hits like anybody else," said Schalow.

But there is no consensus about how to address the twin problems of rising numbers of uninsured patients and skyrocketing costs.

Doctors and hospitals want to attack the mounting bad debt by creating some sort of universal health insurance — possibly through a state-subsidized insurance pool — that would be available to all Alaskans. They are forming a private task force to develop draft legislation.

Meanwhile, insurer and and employers are pressing proposals to help limit costs. One bill introduced by Sen. Jim Duncan, D-Juneau, would attempt to clamp down on medical costs with a rate-setting board roughly akin to the public utilities commission.

That bill — in its present form — is certain to be fought by the health care industry officials.

"It's fair to say they're not real pleased with this," Duncan said.

□

Alaska's health-care problems are part of a national crisis that has triggered a soul-searching debate — in Congress, the health-care industry and academia — about the costs of medicine and who should bear it.

In Alaska, those costs have soared higher and often faster than those of almost any other state.

Spend a day in an Anchorage private hospital, and your bill will average more than $1,500, according to Medicaid statistics. That's more than double the daily cost of 1983.

That's also over 25 percent higher than the national average, according to American Hospital Association statistics.

Visit an Anchorage doctor for a checkup, and you'll pay an average of $46.17 compared to the national average of $34.76, according to Runzheimer International, a Wisconsin-based consulting firm.

Drop by an Anchorage dentist for teeth cleaning and you'll pay an average of $64.50, about 31 percent more than the national average, according to the Runzheimer survey.

Last year, more than $340 million of the health-care spending came straight out of the state budget. That spending included $263 million for Medicaid and other entitlement programs and $78 million for child health, mental health and other services.

On a per capita basis, state health-care spending topped $2,800 in 1990 and if left unchecked would exceed $18,000 per capita by the year 2000, according to Jeff Malek, a San Francisco-based health consultant who has been studying Alaska health costs for a state task force.

Please see Page F-4, **BILLS**

BILLS: Insurers, doctors ha

Continued from Page F-1

What forces push up the cost of Alaska health care?

Hospitals and doctors point to the state's higher-than-average wage costs in an extremely labor-intensive health-care industry. Much of the labor is highly skilled and often in short supply.

"I could go down to Kentucky and get a dental assistant for $5 an hour," said Ken Wynne, an Anchorage dentist. In Alaska, such help is hard to find and "makes anywhere from $9 to $15 an hour," Wynne said.

Doctors also cite malpractice insurance costs that for some specialties have more than tripled since 1986.

An Alaska obstetrician, for example, may pay $70,000 for a year's malpractice insurance, nearly 90 percent higher than in California, according to Ron Neupauer, underwriting manager for the Medical Insurance Exchange of California, which writes policies in Alaska.

"It's not that there are so many claims in Alaska," Neupauer said. "But my goodness, when there is one it's in the multimillion-dollar range, and there's not that many obstetricians to spread the risk around," he said.

The state task force, in a draft report, cited other reasons for rising costs of Alaska health care.

Alaska doctors, for example, lack the competition from health maintenance organizations and other discount health-care systems common in the Lower 48. Such systems may offer a 25 percent savings from traditional fee-for-service care, according to a Rand Corp., study in Seattle.

The state task force also pointed to the overexpansion by hospitals in the 1980s. That has pushed up operating expenses and might force administrators to charge more for services, Malek said.

Humana Hospital-Alaska, for example, opened a $23.5 million wing in 1986. The new tower increased Humana's capacity from 199 beds to 238, according to the American Hospital Association.

But Humana has had a hard time bringing in patients to help pay off the expansion. In 1989, the hospital association reported Humana had a 37 percent occupancy. That's substantially below the 70 percent national average.

Despite the low occupancy rate, Humana reported a 1989 profit of $4.5 million on revenues of $61 million.

Lyn Whitley, a Humana spokeswoman, said the expansion is a long-range project and the beds will be needed. In the meantime, the hospital has cut costs by staffing less than 160 of the hospital's beds.

The upward spiral of health care has left both insurers and employers scrambling to find ways to keep costs under control.

One major push has been aimed at people who are insured.

The state, for example, has offered one of

"It's fair to say (health care officials) are not real pleased with this."

— Sen. Jim Duncan
on his attempt to start a rate-setting board

Alaska's most comprehensive health-insurance packages. But the cost jumped from $218 a month in 1984 to $425 a month in fiscal year 1989.

Then, in May 1989, the state signed an agreement with the employees' union calling for precertification of surgery, auditing of medical bills, modest reductions in certain coverage limits and other cost-cutting steps. The new policy booklet developed from that agreement also advised — much to the dismay of Alaska hospital officials — for subscribers to shop around and check rates of Lower 48 hospitals.

Since the new plan went into effect, the cost of insuring state workers has declined to $385 a month.

But policy restrictions aren't always painless to employees. Some businesses make their workers pay much larger shares of monthly premiums and much higher deductibles. And sometimes the policies don't cover the really big bills the employee desperately needs paid.

Rolinda Standridge, for example, has a

ıve different ideas on costs

Veterans Administration job that comes with a family health-insurance package that promises to pay 85 percent of all bills, once a deductible is met. But it won't cover pre-existing medical conditions. And that means the insurance won't pay a penny to help treat the heart ailment of Ron Standridge, her husband of one year.

Ron is a self-employed jeweler who hasn't been able to afford his own insurance. He has had several serious heart operations and may need more surgery.

But the couple can't pay off Ron's old medical bills, much less take on any new ones, according to Rolinda. Earlier this year, the couple filed for bankruptcy, listing debts to hospitals and doctors of more than $20,000.

"I'm not sure what will happen," Rolinda said. "We'll be going to our first meeting of creditors soon."

Other workers, struggling to survive on part-time or seasonal employment, find they can't work enough hours to qualify for insurance benefits.

Sonja Javier is a 41-year-old Anchorage woman who has worked in the housekeeping division of the Anchorage Holiday Inn. She had steady hours during the summer tourist season but said she was asked to come into work only a few times in the lean fall and winter months.

Javier said she didn't have enough time on the job to qualify for health insurance offered through her local union.

She wanted that coverage to help finance treatment of rotting teeth that were infecting her body.

"The infection has really been spreading. At one point last June I had blue streaks traveling all the way up my neck," said Javier.

Javier has less than half or her original 32 teeth, and the survivors perch unsteadily on the soft flesh of the sickly gums.

"Right now, it embarrasses me to even to go out and look for another job. When I keep my mouth closed, I'm OK. But when I open my mouth, forget it. When I talk, I start foaming at the mouth."

The pain had been building for more than a year.

Javier first sought help from the Anchorage Neighborhood Health Center, the only center set up to aid low-income people. She said she couldn't secure an appointment from the dental clinic, which later shut down due lack of funds.

Then she sought help from several dentists but says she was refused treatment because she had no money to pay for the costly job of pu''ing her teeth, treating the gums and fitting dentures.

"I wasn't asking for something unreasonable. I said, 'Give me a payment plan.' " Javier said. "If that's crazy, I'm sorry. But I can't believe I live in a state that has so much money it pays you to live here but none for my teeth."

The infection kept getting worse, and Javier resorted to begging antibiotics from friends to help keep the pain in check. Two weeks ago, after a trip to the Providence Emergency Room and several telephone calls to the Southcentral Dental Society, Javier finally found Wynne, the Anchorage dentist.

"She had three badly abscessed teeth that were really terrible," Wynne said. "She was in real pain."

Wynne pulled the three infected teeth on Feb. 7 and has agreed to see Javier for follow-up treatment and worry about the billings later. He said most Anchorage dentists attempt to do at least some charity work, and many participate in a rotating weekly on-call roster. Those signed on to the roster agree to treat emergencies, no matter what the patient's ability to pay.

But for the first six months of this year, no dentists have signed up for the on-call roster. So Wynne found himself unexpectedly drafted to treat Javier. "It's a highly unusual situation. We'll have to do something about the roster at the next dental society meeting," Wynne said.

□

Employees aren't the only ones feeling the bite of cost-control efforts.

Insurers and others who pay medical bills also are targeting hospitals, doctors and others who provide medical services.

The strongest thrust so far has come from the federal government, which has developed programs to help finance the care of the elderly, disabled and poor. In recent years, the government, sometimes working with the state, has set tough new limits on reimbursements. Due largely to these restrictions, Providence Hospital has seen its unreimbursed costs for contract care skyrocket from $8.1 million in 1987 to $30 million in 1990.

Providence, in turn, increases its rates to help compensate for the loss of federal payments, Hennigan said.

Thus the hospital — despite the rising tide of bad debt and payment shortfalls — was able to earn a net income of $8.2 million from revenues of $119.3 million, according to a hospital financial statement.

But Alaska insurers don't want to get stuck with subsidizing the government care. They are attempting to curb their medical costs with contract agreements in which hospitals and doctors agree to limit fees to amounts approved by the companies.

The most aggressive, has been launched by Blue Cross of Washington and Alaska, which this month announced a new "participating provider" network of 94 state doctors.

The doctors won't charge more than what Blue Cross considers "customary and reasonable." The program is designed in part to eliminate any surprises subscribers get when their medical costs are higher than the norm.

Doctors have long fought such price-control efforts, and so far, only 22 percent of the state's eligible doctors have opted to join the new network. "Once they get a hold, they'll ratchet down, or try to freeze rates," said Doug G. Smith, an

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BILLS: Insurers, doctors have different ideas on cutting costs

Continued from Page F-1

orthopedic surgeon who refused to join the network. "These programs have happened all the time in the Lower 48 but we're a little more independent up here and resistant to being herded around."

Doctors, as well as hospitals, also are preparing to fight Duncan's bill to set up a much more wide-ranging price-control system.

Duncan's bill would establish a nine-member board composed of public, labor and private sector representatives including at least one person from the health-care industry. The board would set maximum rates that doctors, hospitals and pharmacists could charge for their services. Those charges would vary from region to region and could increase only when approved by the authority.

Doctors might not like those rates, but the proposed legislation would forbid them from trying to collect more money by billing subscribers for a balance due.

The rate schedule would initially cover the 135,000 Alaskans insured by state municipal and school district insurance plans. But Duncan hopes many state businesses would choose to join the program to help keep down employee health-insurance costs.

The legislation includes several other provisions, including one measure that would create insurance pools that small employers could join to try and get better rates.

"With this bill, Alaska would come out of the dark ages and to the forefront of national cost-control efforts," said Malek, the California consultant who helped draft the legislation.

But doctors and hospital officials think the legislation unfairly singles their operations out as the cause of the state's health-care crisis.

"We cannot support any legislation that has, as its primary method of health-care cost controls, regulating reimbursements to physicians and hospitals," said Harlan Knudson, executive director of the Alaska State Hospital & Nursing Home Association.

"It's crazy, unless we address the whole damn (health care) problem," said Schalow, of the state medical association.

Health-care industry officials, in a recent policy paper, declare the need for a comprehensive state health plan. Some technologies, they say, may have to be rationed because there's just not enough money to pay for their routine use.

They also seek universal health insurance so more of their patients could pay for treatment.

Such a plan may be developed by a state health-care task force, then submitted to the legislature. But Schalow said the doctors don't have enough representation on the task force, and will develop their own plan.

Doctors and hospitals also are seeking further reforms of state liability laws to help curb the cost of malpractice insurance.

"Liability insurance premiums for malpractice have reached levels that physicians can no longer afford nor can their patients afford through increased fees," the policy paper stated.

Duncan said he knows his legislation may face a tough fight from the health-care industry. But he hopes for allies among major state employers hurt by the rising cost of health-care insurance.

"Our goal is not to reduce the quality of health care, or put people out of business. We just want to make this whole system work," Duncan said.

Uninsured Alaskans, health costs on increase, says state task force

Saying that health care costs are out of control at the same time the number of people who can't afford health care is growing by leaps and bounds, Sen. Jim Duncan (D-Juneau) has introduced a bill that would dramatically change the way care is paid for.

Duncan, who chaired the state's Health Care Cost Containment Task Force, presented the report to the legislature in February, along with his bill aimed at reforming health care.

The task force was created last year. Its original job had been to find ways to cut back on the cost of health care insurance paid by the state for its employees. Members include legislators Duncan, who chaired the task force;

"Without substantial reform or an organization that can focus on the problem and bring these pieces together, we will never affect a solution."

Rep. Mike Navarre (D-Soldotna), vice chairman; Sen. Drue Pearce (R-Anchorage); and representatives of state departments and labor organizations.

The task force's report bases most of its recommendations on its findings that health care expenditures are the fastest growing component of the whole budget, $385.5 million in fiscal year 1990, and that the number of uninsured and under-insured Alaskans is 16.5 percent of the population, or 90,000.

Much of the task force's findings are based on some 300 surveys it sent out to groups in Alaska, including public employers, health care providers and private sector employers.

It also examined health care plans in other states and held three public hearings.

In addition, the report describes the results of its earlier task -- to control the cost of health insurance paid by the state for is employees.

Jeffrey Malek; the consultant who worked on the report, and Duncan described the task force's findings and Duncan's consequent legislation to legislative committees in February.

Photo by Mark Kelley

At left, Sen. Jim Duncan (D-Juneau) testifies on health legislation he is introducing before the House Labor and Commerce Committee. Rep. Mark Boyer (D-Fairbanks), who introduced similar legislation in the House, is at right.

Malek said the number of uninsured, new medical technology, malpractice costs and cost shifting are behind much of the increase in health care costs. The factor most responsible for the rise in costs is the increasing number of people who can't afford health care, forcing hospitals and providers to shift the cost of paying for their care to others, he said.

"Without substantial reform or an organization that can focus on the problem and bring these pieces together, we will never affect a solution," Malek told the Senate Labor and Resources Committee.

Under the legislation introduced by Duncan, Senate Bill No. 83 (It's been introduced in the House by Rep. Mark Boyer), would create an Alaska State Health Resources Authority.

The authority, composed of nine volunteers, would include representatives of the executive branch, labor organizations, school districts, municipalities, private sector employers and health care providers.

It would perform a number of tasks, including reviewing all certificate of need requests, but its most controversial task would be to set rate reimbursement schedules for Alaska health care providers, said Duncan.

Those schedules would be followed by public employers and any private employers who choose to do so, said Duncan. The authority would also allow the creation of insurance pools by private employers. This proposal is especially aimed at employers, such as fishermen, who may have difficulty obtaining commercial insurance on their own.

"I believe if we're going to address health care costs in the state and do it comprehensively, this is the vehicle," said Duncan.

Duncan told the Senate Labor and

Continued on next page

Task force report ...

Continued from page 3

Resources Committee that the reimbursement schedule would take into account the actual costs felt by providers, saying the point of the legislation is to "control the inflationary rise" of health care, not cut the current cost.

Response from committee members to the legislation was mixed. Sen. Richard Eliason (D-Sitka), questioned the amount of money the task force says is being spent on health care. The task force says Alaskans spend $2,850 a minute on health care, and that figure is increasing by $534 a minute.

Sen. Virginia Collins (R-Anchorage) expressed concern about subsidizing health care, as long as the number of people who can't buy their own health care increases.

"As long as we continue to subsidize health care, we're going to continue to increase the cost of health care, and not necessarily increase the quality of health care," she said.

This bill by Duncan is not the only piece of legislation associated with the task force's report.

Also introduced in both House and Senate is a resolution that would establish a Health Resources and Access Task Force.

This task force would perform some of the same duties performed by the task force chaired by Duncan -- namely, it would examine the cost of health care and access to health care.

Its responsibilities, however, would extend to much more information gathering than was undertaken by the Health Care Cost Containment Task Force.

It would seek data on these issues from the medically indigent, health care consumer groups, the insurance industry, health care providers, labor organizations, emergency service workers, businesses, the Medical Care Advisory Committee, the Alaska Native Health Service and the public.

Its membership would also be different from the earlier task force. Members would include six legislators, two representatives of the executive branch and eight representatives of the medically indigent, private employers, health care providers, nonprofit organizations, health consumers and labor organizations.

This task force would make two reports to the governor and legislature, in 1992 and 1993.

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Calendar

March	
	National Nutrition Month
	Mental Retardation Month
	National Social Workers Month
18-24	**National Poison Prevention Week**
21-22	**American Hospital Association Region 9 Policy Board Meeting, Carmel, Calif.**
26-27	**American Health Care Association Board of Directors, Washington, D.C.**
30	**Doctor's Day**
April	
	National Alcohol Awareness Month
	National Child Abuse Prevention Month
	National Sexually Transmitted Diseases (STDs) Education and Awareness Month
	National Occupational Therapy Month
	Cancer Control Month
7-9	**Alaska State Hospital & Nursing Home Association Mid-year Legislative Conference, Juneau**
21-23	**Healthcare Forum 61st Annual Meeting -- Breakthrough Leadership; Building High Performance Organizations, San Francisco**
22-25	**Conference on Aging, Anchorage**
May	
	National Arthritis Month
	National Mental Health Month
	National High Blood Pressure Month
6-12	**National Nurses Week**
12-18	**National Hospital Week**
	National Nursing Home Week
19-22	**14th Annual National Rural Health Association Conference, Seattle**
June	
9-12	**American Health Care Association Congressional Conference, Washington, D.C.**
17-18	**American Hospital Association Region 9 Policy Board Meeting, Seattle**

A legislative viewpoint

Basic health services top lawmakers' lists

Health care issues are continuing to gather supporters among the Alaska State Legislature, although this session the focus may be more on fending off cuts to health care budgets, rather than creating new programs, say some key legislators.

"What I'm hearing from legislators this session is that basic health care is one of the priorities," said Rep. Georgianna Lincoln, co-chair with Rep. Pat Carney of the House Health, Education and Social Services Committee.

Lincoln, a freshman Republican representative from Rampart, said she has been struck by the high number of Alaskans without basic health care coverage, and the high cost of health care.

Lincoln, however, said she thinks the legislature is going to be reluctant to spend much new money on the problem of health care, a view shared by Sen. Arliss Sturgulewski (R-Anchorage) chair of the Senate Health, Education and Social Services Committee.

Sturgulewski said she thinks her committee will have to spend a lot of time trying to find funding for programs cut under the governor's budget. These include the homemaker service and portions of the childcare budget.

Rep. Georgianna Lincoln

"Most of us are in a state of shock right now because of program cuts ... and a lack of funding," said Sturgulewski.

Sturgulewski also mentioned concern about comments by Health and Social Services Commissioner Ted Mala regarding cuts to or elimination of Medicaid.

"I see no way the state could possibly move into coverage of these programs," said Sturgulewski. Medicaid is funded in equal parts by the state and federal governments.

There is a bright side to the budget cuts, said Lincoln. "I think what it's [the cuts] doing is to analyze what we've got and how we can make that better."

"The state should be able to deliver the health care much better than it is, but I don't think it will cost any more," she said.

Drawing from her background in resource development, Sturgulewski sees the settlement of the mental health lands dispute as a major issue to be tackled by her committee.

Once settled, the mental health lands dispute has the potential of giving more than $1 billion in funds for health programs serving the mentally ill.

Sturgulewski, a 13-year legislator who has not before chaired the HE&SS Committee, said there has so far been little leadership from the new administration on major health issues. With the lack of leadership from the governor's office, the legislature has stepped in, she said.

"We do have to take a very close look at how we're providing health care and how we're delivering it because of the tremendous cost involved," she said.

She complimented Sen. Jim Duncan (D-Juneau) on his attempt to address the problem of Alaska's under-insured and uninsured with a health authority.

"I think the approach and leadership Sen. Duncan is taking is excellent ... but it too won't go very far if the administration doesn't buy into it," she said.

Both legislators hedged on the question of capital dollars for health facility renovation and construction. Sturgulewski said it's too early to tell what will happen, while Lincoln said she gets the feeling anything not considered a "basic service" will have trouble getting funded.

Sturgulewski and Lincoln said they see a need for a statewide health policy, but expressed doubt about finding a lot of money for such a plan.

"We have been studied and studied and studied to death. Now we need to dust off all these studies that have been done and see what we can use," said Lincoln.

Sen. Arliss Sturgulewski

Sturgulewski said the key to a statewide health policy is coordination between the administration and the legislature.

"We're still serving [health care] out of little boxes, a mental health box, a social services box ..." said Sturgulewski.

Lincoln said she is particularly concerned about coordinating health care for Alaska's rural areas.

"When you ask me about health, it's difficult for me to talk just about health. I want to talk to you about no jobs in the village, that is health. I want to talk to you about children who are dropping out of school, that is health," said Lincoln. "If any one of those things don't click in your life, it affects your health, whether that's mental or physical health."

From KETCHIKAN Daily News
4/30/91

Health insurance

The United States' system of paying for health care is breaking down. Fixing it is one of the most formidable challenges of the 1990s. With no federal leadership on this issue, the states will have to blaze the trail.

Few people actually pay for health care directly. Insurance, mainly provided by employers or the government, pays most doctor and hospital bills. Thus the cost of periodic illnesses or emergencies is spread widely. But the cost has grown so high — 11.6 percent of the nation's output goes to pay for health care — that it's painful to bear even when it's distributed through insurance.

Rising costs push more employers to limit or suspend health insurance benefits and force the government to restrict coverage. Caring for the growing number of uninsured people — 32 million nationwide — forces doctors and hospitals to shift more costs onto the shoulders of those who can pay. ...

People will not continue to accept a system that leaves so many without any protection at all.

— The Register-Guard, Eugene, Ore., April 18

Title
SB 83

3-8-91

Bill upsets insurers, medical industry

Law would put lid on medical fees charged state employees

By PATRICIA SOLOVEICHIK
TIMES BUSINESS WRITER

A proposal introduced in the state Legislature last month that would require the state of Alaska to set fees that doctors and other health-care providers charge patients has insurers, the medical community and some businesses in an uproar.

Sen. Jim Duncan, D-Juneau, author of the proposal, said Senate Bill 83 and companion legislation would create the Alaska State Health Resources Authority. If enacted, it would establish by July 1992 reimbursement rates and treatment standards that insurers must use in paying health-care providers who serve state employees.

After July 1992, ASHRA would offer comprehensive group health insurance to public employees and to businesses in Alaska that want to participate.

The legislation requires all health-care providers hoping to do business with the state's 135,000 public employees could not charge fees higher than those established by the state and would be required to meet state guidelines for treating patients, Duncan said.

Duncan said his legislation is the result of two years of study by the state Health Care Cost Containment Task Force, of which the senator was chairman.

Duncan said he hopes the state's private employers would join the program using participating physicians and medical facilities, particularly small businesses that would be provided group coverage for their employees.

"We met with large corporate employers in December to discuss this legislation, and they indicated that without this legislation they would need to either reduce benefits or ask employees to pay more," Duncan said.

"The business community is very interested in a solution, but they have not made a definitive statement on S.B. 83," he said.

Several large local employers testified before the task force about their concerns, including

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Insure

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BP Exploration (Alaska) Inc. BP Exploration officials could not be reached for comment late Thursday.

Resa Jerrell, state director of the National Federation of Independent Businesses, said she favors the legislation as a "viable means of providing health insurance to the uninsured population in Alaska."

She said a voluntary pooling is a more acceptable alternative than a legislative mandate that all employers must provide health insurance coverage for their employees.

But she said NFIB members are adamant that the program be voluntary and administered by private insurance companies. Duncan has said Alaska would self-insure those without coverage if insurance companies could not meet state cost expectations.

Insurers in Alaska are not pleased with state regulatory intervention. They say they would prefer to take care of the problem through the free enterprise system.

"Sen. Duncan is able, through state government, to bring a much larger solution faster," said Eric Rohlman, vice president of group marketing for Blue Cross of Washington and Alaska.

"But I think its better to look to private enterprise. We hope we can be part of the solution and still believe in competition," Rohlman said.

"The disappointing part of S.B. 83 is that many feel we haven't moved fast enough," Rohlman said.

Duncan believes Alaskans do not have the time to wait for private enterprise solutions.

"If the system goes unchecked, it's in danger of collapse. As costs continue to rise, more people will drop out of insurance coverage. Those people will still go to hospitals, but the cost will be picked up by those who are able to pay.

"As the number of uninsured people rises, so will the cost of health care, which will cause more people to drop out. It's a circle that continues until at some point it collapses on us," Duncan said.

Harlan Knudson, chairman of the Alaska State Hospital and Nursing Home Association, agreed that the cost-shifting would occur, but he pointed the finger at Duncan's bill as the issue that is most disconcerting.

"The state will push down the reimbursement that hospitals now get for state employment and public employee insurance. That cost will be shifted to other buyers of health care," Knudson said.

He also charged that the program will become a "tremendously expensive undertaking."

And he said he is concerned that this bill will get the go-ahead because of public pressure on the Legislature to take some strong action on health-care costs.

In Resolution No. 5, which Knudson said he supports, Duncan said the imposition of fee schedules is necessary to get a handle on the 200 percent rise over the last 10 years in Alaska's annual expenditures for health care. The outlays have gone from $680 million to more than $1.6 billion.

And the state's uninsured have reached 90,000 people, or 18 percent of the total population. Duncan said a continuation of current trends would mean 25 percent of the state's residents will be unable to get insurance.

Under S.B. 83, ASHRA would be managed by a board of directors composed of nine members appointed by the governor from the executive branch, organized labor, school districts, municipalities, private sector employers and health-care providers.

The Associated Press

JUNEAU — The House approved a $606 million spending plan for education on Tuesday, but the governor's chief budget official says he intends to fight the bill in the Senate.

Representatives passed House Bill 5 by a 38-2 vote. The plan would spend almost $54 million more than proposed by Gov. Walter Hickel on pupil transportation, student lunch programs and the state's contribution toward school operating costs.

The House measure would fund the state's share of operating costs at last year's

level. The governor has asked for a 7.3 percent cut.

"The House definitely intends to send a message to the governor," said House Speaker Ben Grussendorf, D-Sitka. "Our commitment is to education."

Anchorage Republican Reps. Terry Martin and Loren Leman cast the only votes against the bill.

Shelby Stastny, director of Hickel's Office of Management and Budget, last week called the House bill irresponsible and said the governor would likely veto it.

Stastny said he was not surprised by the wide margin of Tuesday's vote.

"We still have the Senate to go through," he said. "The Senate's indicated they're going to be more deliberate. We hope that the Senate will slow down and allow us to look at it a little bit."

The House passed the education spending bill in just two weeks. Legislators normally take most of the 19-week session to iron out state spending plans.

The bill now goes to the Senate, where it likely will take the place of a nearly identical bill introduced by Sen. Paul Fischer, R-Soldotna. Fischer said he would support the House bill and would like to see quick approval.

Sen. Pat Pourchot, D-Anchorage, has said the measure would move slower in the Senate, but the group would not miss "the strategic deadline" for overriding a Hickel veto.

It would be easier for the legislature to pass a bill and then face a possible gubernatorial veto while still in session. If the measure passes at the end, lawmakers would have to call a special session to consider a veto override.

Missing from the House bill is almost $129 million to help offset school construction costs.

Lawmakers wanted the bond debt money taken out so it could be lumped in with the rest of the state construction budget later during the session.

Health cost Rx

A ray of hope for controlling costs

Alaskans pride themselves on being first in many national comparisons, but one top ranking is a first-class pain in the pocketbook. Hands down, Alaska has the highest medical costs in the country.

According to statistics from the Anchorage planning department, the city's 1989 medical cost index was 28 percent higher than Boston, the highest Outside city cited. Anchorage topped New York by 35 percent and Los Angeles by 46 percent. And within Alaska, Anchorage is a low-budget location. Costs in Fairbanks, Ketchikan and Juneau are even higher.

Fortunately, a large number of Alaskans may soon enjoy at least a small measure of relief from these high costs. The giant health insurance firm Blue Cross is starting to use its clout to hold down doctors' fees. The insurer has persuaded some 22 percent of Alaska's eligible doctors to charge only what Blue Cross considers reasonable. Some doctors have been charging more, leaving Blue Cross patients to pay whatever exceeds the firm's cost cap, on top of the usual co-payments and deductibles.

Blue Cross' arrangement is good news for the 80,000 Alaskans it insures. The deal should exert powerful pressure to limit ever-increasing doctors' fees. Unlike some cost-control measures that force patients to use certain doctors, however, Blue Cross clients remain free to see the physician of their choice.

Alaska doctors are less enamored of the change — even though the arrangement is common in the Lower 48. For them, health insurance becomes more of a mixed blessing. Until now, insurance has enabled them to charge prices with little regard for how they affect most patients. Now, they're being asked to make some price concessions in return for the good financial fortune insurance allows them to enjoy.

Sounds like a fair trade to us.

LIMITS: 94 doctors agree to Blue Cross health insurance plan to set rates

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ka doctors have agreed to work for fees set by private insurers, according to state and industry officials. Such cost-containment efforts are common in the Lower 48, but Alaska doctors have often viewed these programs with distrust and outright hostility.

So far, Blue Cross has signed up about 22 percent of Alaska doctors who had enough malpractice insurance to meet insurer requirements. In Anchorage, the program includes 50 doctors, about 14 percent of qualifying area physicians. The Anchorage network includes more than 15 family practitioners, nine psychiatrists, two obstetrician-gynecologists and six podiatrists.

Blue Cross officials hope the network will rapidly expand, but some doctors — even some who joined the program — are angered by what they view as Blue Cross's strong-arm recruiting tactics.

Blue Cross told doctors that if they declined to join the network, the insurer would stop sending them direct payment of medical bills, according to a copy of an Oct. 12 letter Blue Cross sent to state doctors. Instead the check would be made out to both the doctor and the subscriber, then sent to the subscriber, who would be responsible for forwarding it on to the doctor. Doctors fear that would slow an already cumbersome collection process.

But as long as the subscriber approves direct payment to the doctor, Blue Cross appears to have no legal authority to deny those payments, according to Dave Walsh, director of the state Division of Insurance.

"We have asked Blue Cross for additional information as to why they think they ought to do this," Walsh said.

Ford, in an interview Friday, said the company has decided to hold off on imposing the new payment system. "We decided the time was not right."

In the meantime, some doctors say they will fight the Blue Cross program.

"We don't appreciate having someone come in with heavy-handed scare tactics," said Doug G. Smith, an orthopedic surgeon who refused to join the program. "Once they get a hold, they'll ratchet down, or try to freeze rates. These programs have happened all the time in the Lower 48 but we're a little more independent up here and resistant to being herded around."

And one doctor who joined the program isn't sure how long he'll stay in.

"They agreed upon our fee schedule and did not try to discount us, but I do not have any illusions about their long-term objective," said Bruce Klessling, an Anchorage family practitioner. "We will withdraw from the program if they don't allow for the normal cost increases we have to incur to keep our office open."

Blue Cross officials say about 75 percent of Alaska's doctors charge acceptable rates. The rest charge anywhere from 5 percent to roughly 20 percent more.

Doctors who participate in the network will be free to raise their rates. But if those increases exceed what Blue Cross considers reasonable, they may be kicked out of the network, Rohlman said.

94 doctors agree to limit fees to what Blue Cross says is fair

By HAL BERNTON
Daily News reporter

Blue Cross, the giant health insurer, has created a network of 94 Alaska doctors who will limit subscriber fees to amounts approved by the company.

Officials of Blue Cross view the network as a "milestone agreement." They say it can put an end to their subscribers' getting stuck with surprise bills because doctors charge more than the insurer allows for a given service.

Alaska subscribers will have no obligation to use doctors on the insurer's new list. But if they do, they may save on medical bills.

"It will be a consumer choice," said Dave Ford, a Blue Cross vice president. "If he goes to the doctor who has signed up, then he will have the protection."

Once a deductible is met, Blue Cross policies typically pay from 80 percent to 100 percent of a subscriber's medical bills, as long as the doctor's fee doesn't exceed rates Blue Cross considers reasonable. But in recent years, doctors' fees have risen faster than the Blue Cross rates, saddling subscribers with a growing share of medical costs.

"As carriers have reduced their payments to doctors, doctors, in many instances, have simply recouped that from the consumer," said Eric Rohlman, a Blue Cross vice president. "This (network) addresses that problem."

Seattle-based Blue Cross of Washington and Alaska is one of the state's largest insurers, with policies covering nearly 80,000 Alaskans.

"I hope it works," said Bill Purrington, an Anchorage health insurance broker. "The problem is there's been such a huge increase in the cost of health care in the last 10 years."

The new network appears to mark the first time Alas-

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