

ALASKA LEGISLATURE COMMITTEE FILES 1991-1992 8672

7535 SENATE LABOR & COMMERCE

SB 83 AMENDMENTS

- 1) HAVE SMALL BUSINESSES COME ONLINE AT SAME TIME AS STATE & 3 MUNIS.
- 2) REQUIRE OUTLYING AREAS TO BE BROUGHT ONLINE AT A DATE CERTAIN IN THE FUTURE. *Dec 31, 1994. - DUNCAN ASKED 1995*
- 3) PG 5 LN 31 CHANGE [AND] TO OR .
- 4) PG 9 LN 19 - 21 CHANGE TO REQUIRE APPROVAL.
- 5) PG 5 SEC (B) (2) ADD ADDITIONAL CRITERIA TO RATE AND UTILIZATION STANDARDS.
- 6) PG 5 LN 12 DELETE [COST] INSERT CHARGES.

Page 5, alter line 14:

Insert new subsections to read:

"() Analyze the Alaska population that is uninsured or underinsured for health care."

"() Provide recommendations to the Legislature no later than February 15, 1992, for a systematic approach or plan with alternatives including liabilities and financing alternatives that may be considered to assure access to affordable quality health for all Alaskans, and report on annually on its progress."

"() Provide recommendations to the Legislature no later than February 15, 1993, for the design of a program with alternatives including liability and financing alternative to provide health care insurance to Alaska residents who:

- (a) are not covered by health insurance, and
- (b) have been refused health insurance coverage by two or more health insurance carriers in the last twelve months, or
- (c) have been deemed uninsurable for health coverage, or
- (d) are unable to pay for basic health care protection and do not qualify for any other health care protection program or plan.

Change "employer" in the definitions to "Public Employer" and write a definition for "Private Employer" as all other.

1) have small businesses come on line at same time

MAURICE

2) require outlying areas be brought in at same date certain (delayed)

- check w/ insurance companies on this one.

3) p5, line 31 change and to or

4) p9, lines 1-21 change to require approval.

5) p5, section (b) (2) -. additions to list?
(were suggested at hearing)

plus reword (c) to not be cost - there has to be some profit. charges

AMENDMENT

CSSB-83 AMENDMENT SERIES III

(placement from CSSB 83L&C)

PAGE 3 LINE 29

REPLACE

Post-It™ brand fax transmittal memo 7671		# of pages ▶ 1
To <i>1111</i>	From <i>1111</i>	
Co. <i>1111</i>	Co. <i>1111</i>	
Dept.	Phone # <i>1111</i>	
Fax # <i>1111</i>	Fax # <i>1111</i>	

(b) THE AUTHORITY SHALL BY JULY 1, 1992, CREATE AND BEGIN A PHASED IMPLEMENTATION OF STATEWIDE GEOGRAPHIC SPECIFIC HEALTH CARE PROVIDER REIMBURSEMENT SYSTEMS, AND UTILIZATION STANDARDS.

NO LATER THAN DECEMBER 31, 1993 THE AUTHORITY SHALL HAVE OPERATIONAL REIMBURSEMENT SYSTEMS AND UTILIZATION STANDARDS FOR HEALTH PROCEDURES PERFORMED WITHIN THE BOUNDARIES OF AN INCORPORATED MUNICIPALITY OR BOROUGH WITH A POPULATION BASE IN EXCESS OF 20,000 AS DETERMINED BY THE 1990 US CENSUS REPORT.

All reimbursement schedules and utilization standards considered necessary by the authority shall be operational by June 30, 1995.

THE AUTHORITY SHALL ESTABLISH THE REIMBURSEMENT SYSTEM AND UTILIZATION STANDARDS PROSPECTIVELY, UTILIZING THE THE MOST ACCURATE INFORMATION AVAILABLE TO THE AUTHORITY USING DEFINED RELIABLE COMPONENTS, THE DEFINED COMPONENTS FOR THE REIMBURSEMENT SYSTEM SHALL INCLUDE BUT ARE NOT LIMITED TO:

1. EFFORT AND TIME BY PROVIDER (E&T),
2. FACILITIES AND PRACTICE EXPENSE (FPE),
3. PROFESSIONAL LIABILITY INSURANCE (PLI),
4. GEOGRAPHIC MODIFIER (GEO),
5. AVAILABILITY OF SERVICES MODIFIER (ASM),
6. UNCOMPENSATED CARE NET COST (UCNC),
7. ACTUAL PROVIDER COST AS OF JANUARY 1 1991 (APC);

THE AUTHORITY SHALL FURTHER DEFINE THE COMPONENTS AND ASSIGN RELATIVE WEIGHTING TO EACH COMPONENT ²
 THE AUTHORITY WILL PUBLISH NO LATER THAN JULY 1, 199~~2~~² AND UPDATE ANNUALLY A GUIDE FOR HEALTH CARE PROVIDERS, INSURERS AND PARTICIPANTS THAT DESCRIBES THE SCHEDULES AND STANDARDS SYSTEMS ALONG WITH AN EXPLANATION OF HOW TO UTILIZE THE SCHEDULES AND STANDARDS

All Providers and claims payor shall use these health care provider reimbursement schedules and utilization standards when billing for services provided to public employers or public employees and private employers may elect to use these schedules and standards by application to the authority.

THE AUTHORITY AS SOON AS FEASIBLE, SHALL ESTABLISH HEALTH CARE QUALITY, UTILIZATION, PROVIDER COST/ BILLING INFORMATION AND DATA COLLECTION PARAMETERS INCLUDING REPORTING PROCEDURES, IN COOPERATION WITH REPRESENTATIVES OF THE HEALTH CARE PROVIDER AND INSURANCE COMMUNITY, ONCE ESTABLISHED ALL HEALTH CARE PROVIDERS AND INSURERS OPERATING IN THE STATE SHALL COMPLY WITH THE HEALTH CARE INFORMATION AND DATA REPORTING PROCEDURES.

REPLACE "PROCURE OR PROVIDE" WITH:

PROCURE OR WHEN PROCUREMENT OF INSURANCE IS NOT REDLY OR ECONOMICALLY AVAILABLE, PROVIDE ~~INSURANCE~~

REPLACE SEC44.87.060 PROCUREMENT OF INSURANCE

(a) THE AUTHORITY MAY AFTER JULY 1, 1992 BEGIN THE PROCUREMENT OF A COMPREHENSIVE GROUP HEALTH INSURANCE PROGRAM FOR INDIVIDUALS, GROUPS OF INDIVIDUALS OR EMPLOYERS THAT THE AUTHORITY DETERMINES DO NOT HAVE HEALTH INSURANCE OR FOR WHOM HEALTH INSURANCE COULD BE MORE COST EFFECTIVE IF PROCURED BY THE AUTHORITY, THE AUTHORITY MAY ALSO HEALTH INSURANCE TO EMPLOYERS WHO ELECT TO PARTICIPATE IN THE GROUP HEALTH INSURANCE ~~PROGRAM~~ BY THE AUTHORITY; EMPLOYER GROUP HEALTH INSURANCE MAY INCLUDE COVERAGE FOR ELIGIBLE EMPLOYEES AND DEPENDENTS;

THE AUTHORITY MAY NOT PROVIDE OR ACT AS A SELF INSURING ENTITY UNTIL THERE IS SUBMITTED A REQUEST FOR PROPOSAL TO LICENSED HEALTH INSURANCE CARRIERS IN THE STATE THAT ARE DEEMED BY THE AUTHORITY QUALIFIED TO PROVIDE THE DESIRED BENEFITS AND MEET THE SPECIFICATIONS OUTLINED IN THE REQUEST FOR PROPOSAL.

Provided or Procured

IF AFTER AND ONLY AFTER THIS REQUEST FOR PROPOSAL PROCESS HAS BEEN COMPLETED THE AUTHORITY DETERMINES THAT THE DESIRED COVERAGES OR BENEFITS ARE NOT REDLY AVAILABLE AND OR THE AUTHORITY CAN PROVIDE THE DESIRED COVERAGES AND BENEFITS AT A LOWER COST PER ELIGIBLE PERSON,CAN THE AUTHORITY SUBMIT ITS PLAN TO THE LEGISLATURE TO ACT AS A PROVIDER OF COVERAGE OR BENEFITS.

" THE AUTHORITY WHEN PROCURING OR PROVIDING INSURANCE MAY, CREATE POOLS OR SUB POOLS OF PARTICIPANTS TO ACCURATELY TRACK PREMIUM, EXPERIENCE AND EXPOSURE BY CATAGORY, THE AUTHORITY MAY ALSO EMPLOY RISK SHARING MECHANISIMS TO LIMIT THE AUTHORITIES OR PARTICIPANTS TOTAL EXPOSURE AND PREMIUM CLAIM VOLATILITY

February 15,

" NOT LATER THAN ~~1993~~ 1993 THE AUTHORITY SHALL DESIGN AND PROCURE OR PROVIDE A BASIC HEALTH INSURANCE PROGRAM FOR ALASKA EMPLOYERS WHO ELECT TO PARTICIPATE AND WHO:

- a. HAVE FIFTY OR LESS EMPLOYEES and,
- b. WHO HAVE BEEN REFUSED COVERAGE BY TWO OR MORE HEALTH INSURANCE CARRIERS. IN THE LAST TWELVE MONTHS AND
- c. EMPLOYERS WHO HAVE NOT PROVIDED HEALTH INSURANCE COVERAGE TO THEIR EMPLOYEES IN THE LAST TWELVE MONTHS.
- d. THIS PLAN SHALL EMPHASIZE PREVENTATIVE AND PROTECTIVE HEALTH SERVICES
- e. THIS PLAN WILL BE EXEMPT FROM MANDATED COVERAGE PROVISIONS OUTLINED IN SEC---- EXCEPT WHERE THE AUTHORITY DEEMS IT APPROPRIATE AND MORE COST EFFECTIVE TO OFFER CERTAIN COVERAGES..
- f. THE AUTHORITY WILL SUBMIT RECOMMENDATIONS TO THE LEGISLATURE FOR CONSIDERATION. A WAY TO PROVIDE FINANCIAL INCENTIVES FOR EMPLOYERS TO PROVIDE HEALTH PROTECTION FOR THEIR EMPLOYEES AND DEPENDENTS.
- g. THE PLAN MUST HAVE PROVISIONS TO STREAMLINE MARKETNG, PAYMENT OF CLAIMS TO PROVIDERS/PARTICIPANTS, AND ADMINISTRATION
- h. THE PLAN MUST INCLUDE HEALTH CARE COST MANAGEMENT PROVISIONS AND USE THE PROVIDER REIMBURSEMENT SYSTEM AND UTILIZATION UTILIZATION STANDARDS OUTLINED IN SEC.--
- i. THE AUTHORITY MAY UTILIZE ALASKA LICENSED INSURANCE AGENTS/BROKERS TO ASSIST IN THE MARKETING AND SERVICING OF THIS PLAN

~~1993~~

A M E N D M E N T

OFFERED IN THE SENATE BY THE SENATE LABOR AND COMMERCE COMMITTEE
TO: CSSB 83(L&C)

Page 6, after line 11:

Insert a new subsection to read:

"(c) If the authority elects to act as a self-insurer, the authority shall submit a plan of the intended insurance coverage and benefits to the legislature. The authority may not begin acting as a self-insurer until 60 days after the authority submits the intended plan of insurance to the legislature."

A M E N D M E N T

OFFERED IN THE SENATE BY THE SENATE LABOR AND COMMERCE COMMITTEE
TO: CSSB 83(L&C)

Page 2, after line 31:

Insert a new bill section to read:

** Sec. 4. AS 24.20.206 is amended to read:

Sec. 24.20.206. DUTIES. The Legislative Budget and Audit Committee shall

- (1) report to the legislature its recommendations relating to the confirmation of appointees to the Board of Trustees of the Alaska Permanent Fund Corporation;
- (2) annually review the long-range operating plans of all agencies of the state which perform lending or investment functions;
- (3) review periodic reports from all agencies of the state which perform lending or investment functions;
- (4) present a complete report of investment programs, plans, performance, and policies of all agencies of the state which perform lending or investment functions to the legislature within 30 days after the convening of each regular session;
- (5) present to the legislature within 30 days after the convening of each regular session a review of the report of the governor under AS 37.07.020(d) with recommendations for needed legislation;
- (6) in conjunction with the finance committee of each house recommend annually to the legislature the investment policy for the general fund surplus and for the income from the permanent fund;
- (7) provide for an annual post audit and annual operational and performance evaluation of the Alaska Permanent Fund Corporation investments and investment programs;
- (8) provide for an annual operational and performance evaluation of the Alaska Housing Finance Corporation and the Alaska Industrial Development and Export Authority; the performance evaluation shall include, but is not limited to, a comparison of the effect on various sectors of the economy by public and private lending, the effect on resident and nonresident

employment, the effect on real wages, and the effect on state and local operating and capital budgets of the programs of the Alaska Housing Finance Corporation and the Alaska Industrial Development and Export Authority;

(9) provide for an annual post audit and annual operational and performance evaluation of the Alaska State Health Resources Authority."

Renumber the following bill sections accordingly.

A M E N D M E N T

OFFERED IN THE SENATE BY THE SENATE LABOR AND COMMERCE COMMITTEE
TO: CSSB 83(L&C)

Page 3, line 29:

Delete "implementation of a"

Insert "a phased implementation of a statewide geographic specific"

Page 3, line 30, after "standards.":

Insert "The authority shall establish the reimbursement system and utilization standards prospectively utilizing the most accurate information available to the authority regarding defined reliable components of the reimbursement system and utilization standards. By July 1, 1993, the authority shall establish and operate at least 50 percent of the reimbursement system and utilization standards. By June 30, 1994, the authority shall complete establishment and implementation of the reimbursement system and utilization standards."

Page 4, after line 13:

Insert a new subsection to read:

"(e) At least 60 days before implementing a phase of the reimbursement system and utilization standards, the authority shall provide public notice and accept public comments on that phase of the reimbursement system and utilization standards."

Page 5, line 23, after "(4)":

Insert "establish a grievance procedure to resolve disputes between the authority and participants;
(5)"

Page 6, line 3:

Delete "obtain"

Insert "procure or provide"

Page 6, line 7:

Delete "obtain"

Insert "procure or provide"

A M E N D M E N T

OFFERED IN THE SENATE BY THE SENATE LABOR AND COMMERCE COMMITTEE
TO: CSSB 83(L&C)

Page 1, lines 6 - 11:

Delete all material and insert:

"(1) by July 1, 1992, create and begin a phased implementation of statewide geographic specific health care provider reimbursement systems and utilization standards;

(2) after July 1, 1992, begin the procurement or provision of a comprehensive group health insurance program for individuals, groups of individuals, or employers that the authority determines do not have health insurance or for whom health insurance could be more cost effective if offered by the authority to employers who elect to participate; the authority may also procure or provide health insurance to employers who elect to participate in the group health insurance offered by the authority; employer group health insurance may include coverage for eligible employees and dependents;

(3) assure financial protection for participants and beneficiaries, provide equitable payment to health care providers, and slow the increase in health care expenditures;"

Reletter the following paragraphs accordingly.

Page 2, line 11:

Delete "offered"

Insert "procured or provided"

Page 2, line 13:

Delete "evaluate the need for group health insurance for residents of the state who are"

Insert "continue to evaluate and where feasible offer a health insurance program for those sectors of the state that remain"

7-LS0305J /
Ford
4/18/91

CS FOR SENATE BILL NO. 83 ()
IN THE LEGISLATURE OF THE STATE OF ALASKA
SEVENTEENTH LEGISLATURE - FIRST SESSION

BY
Offered:
Referred:

Sponsor(s): SENATORS DUNCAN, Zharoff, Rodey

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to the Alaska State Health Resources Authority; relating to the delivery,
2 quality, and financing of health care for residents of the state, and to the issuance of
3 certificates of need; and providing for an effective date."

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

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

6 (1) by July 1, 1992, create and begin a phased implementation of geographic specific
7 health care provider reimbursement systems and utilization standards;

8 (2) after July 1, 1992, begin the procurement or provision of a comprehensive group
9 health insurance program for individuals, groups of individuals, or employers that the authority
10 determines do not have health insurance or for employers who elect to have the authority procure or
11 provide insurance on the employer's behalf; employer group health insurance may include coverage for
12 eligible employees and dependents;

13 (3) assure financial protection for participants and beneficiaries, provide equitable
14 payment to health care providers, and slow the increase in health care expenditures;

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

3 (5) maintain efficient provider reimbursement systems to reduce the administrative cost
4 to providers who are serving employees of participants;

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

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

11 (8) realize the potential savings that will result if approximately 135,000 active and
12 retired state, municipal, and school district employees and their dependents participate in the
13 reimbursement systems and utilization standards offered by the authority; and

14 (9) continue to evaluate and where feasible offer a health insurance program for those
15 sectors of the state that remain uninsured or underinsured.

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

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

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

25 Sec. 18.07.041. STANDARD OF REVIEW FOR APPLICATIONS FOR CERTIFICATES
26 OF NEED. The office shall grant a sponsor a certificate of need or modify a certificate of need
27 if the availability and quality of existing health care resources or the accessibility to those
28 resources is less than the current or projected requirement for health services required to maintain
29 the good health of Alaska citizens. A certificate of need may not be issued, except for a
30 temporary or emergency certificate under AS 18.07.071, unless the office has received a
31 determination from the Alaska State Health Resources Authority regarding the effect of the

- 1 (1) provide for a budget review function;
- 2 (2) analyze the comprehensive operating and capital improvements programs and
3 financial plans recommended by the governor;
- 4 (3) adopt legislation to authorize implementation of the governor's comprehensive
5 operating and capital improvements programs and financial plans or appropriate alternatives to
6 those plans;
- 7 (4) provide for a post-audit function to cover financial transactions, program
8 accomplishment, and compliance with legislative intent;
- 9 (5) adopt or revise the estimate of receipts required to balance the succeeding
10 fiscal year's budget in order that proposed expenditures do not exceed estimated receipts for that
11 fiscal year;
- 12 (6) adopt, revise, or initiate revenue measures in order to balance the succeeding
13 fiscal year's budget and the capital improvements section of the budget for the succeeding six
14 years;

15 **(7) appropriate funds for the operation of the Alaska State Health Resources**

16 **Authority.**

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

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

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

20 (52) Alaska State Health Resources Authority (AS 44.87).

21 * Sec. 8. AS 44 is amended by adding a new chapter to read:

22 **CHAPTER 87. STATE INSURANCE AUTHORITY.**

23 **Sec. 44.87.010. AUTHORITY CREATED; REQUIRED REIMBURSEMENT SYSTEMS**
24 **AND UTILIZATION STANDARDS.** (a) There is established within the Department of
25 Administration a nonprofit incorporated legal entity known as the Alaska State Health Resources
26 Authority.

27 (b) The authority shall

28 (1) by July 1, 1992, create and begin a phased implementation of geographic
29 specific health care provider reimbursement systems and utilization standards (A) within the
30 boundaries of municipalities that have a population of 20,000 or more as reflected by the 1990
31 United States census and (B) for interested and eligible businesses that have 50 or fewer

1 employees; the health care provider reimbursement systems and utilization standards required
2 under this paragraph shall be in operation by December 31, 1993;

3 (2) create and begin a phased implementation of geographic specific health care
4 provider reimbursement systems and utilization standards within the boundaries of communities
5 that have a population of less than 20,000 as reflected by the 1990 United States census; the
6 health care provider reimbursement systems and utilization standards required under this
7 paragraph shall be in operation by July 1, 1995;

8 (3) establish the reimbursement systems and utilization standards prospectively
9 utilizing the most accurate information available to the authority regarding defined reliable
10 components of the reimbursement systems and utilization standards; components for the
11 reimbursement systems must include but are not limited to

- 12 ✓(A) effort and time by provider;
- 13 (B) technological advances resulting in new equipment, staff, or training;
- 14 ✓(C) facilities and practice expense;
- 15 (D) training as a specialist that expands or improves service;
- 16 ✓(E) professional liability insurance;
- 17 (F) resolution of rate disputes and associated expenses;
- 18 ✓(G) geographic modifier;
- 19 (H) uncollectible debt expenses;
- 20 ✓(I) availability of services modifier;
- 21 (J) charity caseload modifier;
- 22 ✓(K) uncompensated care net cost;
- 23 (L) long-term elder care expenses;
- 24 (M) employee expenses resulting from competition with state employee
- 25 salaries;
- 26 (N) specialist recruitment expenses;
- 27 (O) capital costs;
- 28 (P) Medicaid rates;
- 29 ✓(Q) actual provider charges as of January 1, 1991;

30 (4) assign relative weight to each component specified in (3) of this subsection
31 and may further define each component;

1 (5) publish, not later than July 1, 1992, a guide for health care providers, insurers,
2 and participants that describes and explains how to use the reimbursement systems and utilization
3 standards;

4 (6) establish health care information and data reporting procedures; the procedures
5 shall be established in cooperation with health care providers and insurers.

6 (c) A health care provider and a person paying a claim shall use the health care provider
7 reimbursement systems and utilization standards established by the authority when billing for
8 services provided to a public employer or a public employee. Other employers may elect to use
9 the reimbursement systems and utilization standards, if the use is approved by the authority.

10 (d) Upon application by an employer or an eligible state program, the authority may,
11 beginning July 1, 1992, allow the employer or the eligible state program to participate in a group
12 health insurance pool established by the authority.

13 (e) Not later than February 15, 1993 the authority shall design and procure or provide
14 a basic health insurance program for employers who elect to participate and who have

15 (1) 50 or fewer full-time employees;

16 (2) been refused coverage by two or more health insurance carriers in the last 12
17 months; or

18 (3) not provided health insurance coverage to their employees in the last 12
19 months.

20 (f) A plan required under (e) of this section

21 (1) must emphasize preventative and protective health services;

22 (2) must include provisions to streamline marketing and payment of claims to
23 providers and participants;

24 (3) must include the reimbursement systems and utilization standards described
25 in (b) of this section;

26 (4) may utilize insurance agents or brokers licensed in this state to assist in the
27 marketing and servicing of the plan.

28 (g) The authority shall submit recommendations to the legislature for providing financial
29 incentives for employers to provide health protection for their employees and dependents.

30 (h) At least 60 days before implementing a phase of the reimbursement systems and
31 utilization standards, the authority shall provide public notice and accept public comments on that

1 phase of the reimbursement systems and utilization standards.

2 Sec. 44.87.015. REQUIRED COOPERATION BY STATE AGENCIES. An agency of
3 the state that provides health care or that provides funds to purchase health care shall, to the
4 maximum extent possible, cooperate in the development of the use of the health care provider
5 reimbursement systems and utilization standards established by the authority, including sharing
6 relevant information.

7 Sec. 44.87.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The authority shall
8 be managed by a board of directors composed of nine members appointed by the governor. The
9 governor shall appoint at least one but not more than two members as representatives from each
10 of the following:

- 11 (1) the executive branch;
- 12 (2) labor organizations;
- 13 (3) school districts;
- 14 (4) municipalities;
- 15 (5) private sector employers;
- 16 (6) health care providers.

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

21 Sec. 44.87.030. GENERAL POWERS. The authority may

- 22 (1) beginning July 1, 1992, exercise the powers granted to insurers under the laws
23 of the state; if the authority acts as an insurer, the authority shall comply with the requirements
24 applicable to insurers under AS 21;
- 25 (2) sue or be sued;
- 26 (3) enter into contracts or agreements;
- 27 (4) establish administrative or accounting procedures;
- 28 (5) collect, invest, and disburse funds;
- 29 (6) charge fees for providing administrative services;
- 30 (7) establish appropriate levels of reserves to cover the expenses of the authority;
- 31 (8) adopt necessary regulations and procedures for implementation of this chapter.

1 Sec. 44.87.040. DUTIES OF BOARD; ANNUAL REPORT. The board shall

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

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

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

11 (4) establish a grievance procedure to resolve disputes between the authority and
12 participants;

13 (5) every third fiscal year, include in the annual report a cost and benefit analysis
14 of the activities of the authority;

15 (6) analyze the health care needs of the state population that is uninsured or
16 underinsured;

17 (7) provide recommendations to the legislature not later than February 15, 1992,
18 for a systematic approach or plan with alternatives including liabilities and financing alternatives
19 that may be considered to assure access to affordable quality health insurance for all state
20 residents; the recommendations must be updated each year;

21 (8) provide recommendations to the legislature not later than February 15, 1993,
22 for the design of a program with alternatives including liability and financing alternatives to
23 provide health care insurance to state residents who

24 (A) are not covered by health insurance;

25 (B) have been refused health insurance coverage by two or more health
26 insurance carriers in the last 12 months;

27 (C) have been considered uninsurable for health coverage; or

28 (D) are unable to pay for basic health care protection and do not qualify
29 for any other health care protection program or plan;

30 (9) beginning January 1, 1994, periodically review and update the reimbursement
31 systems and utilization standards established by the authority, and evaluate the need for

1 reimbursement systems and utilization standards in other areas of the state.

2 Sec. 44.87.050. STAFF AND PROFESSIONAL SERVICES CONTRACTS. The
3 authority shall employ an executive director who serves at the pleasure of the authority as its
4 chief administrative officer. The executive director may, with the approval of the authority,
5 select and employ additional staff as necessary. Employees of the authority are in the exempt
6 service under AS 39.25.110. In addition to its staff of regular employees, the authority may
7 contract for the services of consultants and professional, technical, and financial advisors the
8 authority considers necessary for the purpose of developing information, conducting hearings,
9 studies, investigations, or other proceedings, or otherwise exercising its powers.

10 Sec. 44.87.060. PROCUREMENT OF INSURANCE. (a) The authority may, after
11 July 1, 1992, begin to procure a policy or policies of comprehensive group health insurance
12 covering an individual or an employer that the authority determines does not have health
13 insurance or for whom health insurance could be more cost effective if procured by the authority.
14 The authority may procure or, if procurement of insurance is not economically feasible, provide
15 group health insurance to employers who elect to participate. Group health insurance may
16 include coverage for eligible employees and dependents. The authority shall procure the
17 insurance from an insurer authorized to transact business in the state under AS 21.09, or the
18 authority may elect to act as a self-insurer if the authority determines that self-insurance can
19 provide the desired insurance coverage and benefits at a lower cost per eligible employee and the
20 authority complies with (c) of this section.

21 (b) The authority, no earlier than July 1, 1992, may establish a group health insurance
22 pool or pools of eligible employers that elect to participate in the group health insurance obtained
23 by the authority. Coverage provided under this subsection must include eligible employees and
24 dependents. Employers that elect to participate shall use the reimbursement systems and
25 utilization standards established by the authority.

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

31 (d) Before the authority elects to act as a self-insurer, the authority shall solicit proposals

1 for the required coverage from insurers licensed in this state to offer health insurance. If after
2 the proposal process has been completed, the authority determines that the desired coverage or
3 benefits are not available from insurers licensed in this state or the authority can provide the
4 desired coverage and benefits at a lower cost per eligible person, the authority may submit a plan
5 of the intended self-insurance coverage and benefits to the legislature. The authority may not
6 begin acting as a self-insurer until the legislature has approved the self-insurance plan submitted
7 by the authority.

8 (e) The authority, when procuring or providing insurance, may create pools or subpools
9 of participants to accurately track premium, experience, and exposure by category. The authority
10 may employ risk sharing mechanisms to limit the total exposure and premium claim volatility
11 of the authority or a participant.

12 Sec. 44.87.070. ALASKA STATE HEALTH RESOURCES FUND. The Alaska state
13 health resources fund is created in the general fund. The fund consists of money appropriated
14 by the legislature. The fund shall be managed and invested by the board. The board may expend
15 money from the fund to carry out the provisions of this chapter.

16 Sec. 44.87.080. INSURANCE PREMIUMS. The authority shall provide that sufficient
17 funds are collected to provide authorized benefits, reserves, and to pay the expenses of the
18 authority. Reserves remaining at the termination of an insurance contract shall be invested by
19 the authority in the same manner as retirement funds are invested under AS 14.25.180.

20 Sec. 44.87.090. PARTICIPATION; WAIVER. (a) The state, a municipality, a district,
21 or other employer in the state may participate in the group insurance coverage provided by the
22 authority. If the state, municipality, district, or other employer elects to participate, the state,
23 municipality, district, or other employer shall continue to participate unless a waiver is granted
24 by the board.

25 (b) In determining whether a waiver should be granted, the board shall establish
26 minimum benefit and financial standards for the desired group health insurance coverage. The
27 minimum benefit and financial standards and the proposed time schedule for responsive offers
28 shall be sent to all participants at the time the request for proposal for the desired group health
29 insurance coverage is issued. A participant seeking a waiver of coverage shall match the
30 minimum benefit and financial standards set out in the request for proposal for the desired group
31 health insurance coverage. Participants shall submit documentation of their insurance coverage

1 matching the board's minimum benefit and financial requirements before the deadline established
2 by the board. The board may approve or disapprove a waiver of participation based on the
3 documentation submitted by the participant regarding the benefit and financial standards
4 established by the board.

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

7 Sec. 44.87.900. DEFINITIONS. In this chapter,

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

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

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

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

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

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

21 (7) "full-time employee" means a person who works 30 or more hours in a week;

22 (8) "fund" means the Alaska state health resources fund;

23 (9) "group health insurance" means coverage that may include medical care and
24 treatment, dental care, eye care, and other group health coverage as determined by the authority;

25 (10) "health care provider" has the meaning given in AS 21.88.900;

26 (11) "municipality" includes a public corporation established by a municipality;

27 (12) "participant" means a person who participates in the group health insurance
28 procured or provided by the authority;

29 (13) "reimbursement systems" means systems or methods that streamline or result
30 in cost efficient payments to health care providers, and includes schedules of maximum allowable
31 reimbursement for health care related services based on geographic regions, actual provider costs,

1 and availability of services;

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

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

8 * Sec. 9. REPORT. The Alaska State Health Resources Authority shall report to the Alaska State
9 Legislature by March 1, 1992, on the progress made by the authority in establishing a health care
10 provider reimbursement systems and utilization standards.

11 * Sec. 10. This Act takes effect immediately under AS 01.10.070(c).

ADOPTED

CS FOR SENATE BILL NO. 83 ()
IN THE LEGISLATURE OF THE STATE OF ALASKA
SEVENTEENTH LEGISLATURE - FIRST SESSION

BY
Offered:
Referred:

Sponsor(s): SENATORS DUNCAN, Zharoff, Rodey

(Handwritten mark)
A BILL
FOR AN ACT ENTITLED

1 "An Act relating to the Alaska State Health Resources Authority; relating to the delivery,
2 quality, and financing of health care for residents of the state, and to the issuance of
3 certificates of need; and providing for an effective date."

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

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

6 (1) by July 1, 1992, create and begin a phased implementation of geographic specific
7 health care provider reimbursement systems and utilization standards;

8 (2) after July 1, 1992, begin the procurement or provision of a comprehensive group
9 health insurance program for individuals, groups of individuals, or employers that the authority
10 determines do not have health insurance or for employers who elect to have the authority procure or
11 provide insurance on the employer's behalf; employer group health insurance may include coverage for
12 eligible employees and dependents;

13 (3) assure financial protection for participants and beneficiaries, provide equitable
14 payment to health care providers, and slow the increase in health care expenditures;

PROVIDERS & USERS

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

3 (5) maintain efficient provider reimbursement systems to reduce the administrative cost
4 to providers who are serving employees of participants;

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

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

11 (8) realize the potential savings that will result if approximately 135,000 active and
12 retired state, municipal, and school district employees and their dependents participate in the
13 reimbursement systems and utilization standards offered by the authority; and

14 (9) continue to evaluate and where feasible offer a health insurance program for those
15 sectors of the state that remain uninsured or underinsured.

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

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

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

25 Sec. 18.07.041. STANDARD OF REVIEW FOR APPLICATIONS FOR CERTIFICATES
26 OF NEED. The office shall grant a sponsor a certificate of need or modify a certificate of need
27 if the availability and quality of existing health care resources or the accessibility to those
28 resources is less than the current or projected requirement for health services required to maintain
29 the good health of Alaska citizens. A certificate of need may not be issued, except for a
30 temporary or emergency certificate under AS 18.07.071, unless the office has received a
31 determin. n from the Alaska State Health Resources Authority regarding the effect of the

1 certificate of need on the cost of group health insurance.

2 * Sec. 4. AS 24.20.206 is amended to read:

3 Sec. 24.20.206. DUTIES. The Legislative Budget and Audit Committee shall

4 (1) report to the legislature its recommendations relating to the confirmation of
5 appointees to the Board of Trustees of the Alaska Permanent Fund Corporation;

6 (2) annually review the long-range operating plans of all agencies of the state
7 which perform lending or investment functions;

8 (3) review periodic reports from all agencies of the state which perform lending
9 or investment functions;

10 (4) present a complete report of investment programs, plans, performance, and
11 policies of all agencies of the state which perform lending or investment functions to the
12 legislature within 30 days after the convening of each regular session;

13 (5) present to the legislature within 30 days after the convening of each regular
14 session a review of the report of the governor under AS 37.07.020(d) with recommendations for
15 needed legislation;

16 (6) in conjunction with the finance committee of each house recommend annually
17 to the legislature the investment policy for the general fund surplus and for the income from the
18 permanent fund;

19 (7) provide for an annual post audit and annual operational and performance
20 evaluation of the Alaska Permanent Fund Corporation investments and investment programs;

21 (8) provide for an annual operational and performance evaluation of the Alaska
22 Housing Finance Corporation and the Alaska Industrial Development and Export Authority; the
23 performance evaluation shall include, but is not limited to, a comparison of the effect on various
24 sectors of the economy by public and private lending, the effect on resident and nonresident
25 employment, the effect on real wages, and the effect on state and local operating and capital
26 budgets of the programs of the Alaska Housing Finance Corporation and the Alaska Industrial
27 Development and Export Authority;

28 (9) provide for an annual post audit and annual operational and performance
29 evaluation of the Alaska State Health Resources Authority.

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

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

- 1 (1) provide for a budget review function;
- 2 (2) analyze the comprehensive operating and capital improvements programs and
- 3 financial plans recommended by the governor;
- 4 (3) adopt legislation to authorize implementation of the governor's comprehensive
- 5 operating and capital improvements programs and financial plans or appropriate alternatives to
- 6 those plans;
- 7 (4) provide for a post-audit function to cover financial transactions, program
- 8 accomplishment, and compliance with legislative intent;
- 9 (5) adopt or revise the estimate of receipts required to balance the succeeding
- 10 fiscal year's budget in order that proposed expenditures do not exceed estimated receipts for that
- 11 fiscal year;
- 12 (6) adopt, revise, or initiate revenue measures in order to balance the succeeding
- 13 fiscal year's budget and the capital improvements section of the budget for the succeeding six
- 14 years;

15 **(7) appropriate funds for the operation of the Alaska State Health Resources**

16 **Authority.**

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

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

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

20 (52) Alaska State Health Resources Authority (AS 44.87).

21 * Sec. 8. AS 44 is amended by adding a new chapter to read:

22 **CHAPTER 87. STATE INSURANCE AUTHORITY.**

23 Sec. 44.87.010. AUTHORITY CREATED; REQUIRED REIMBURSEMENT SYSTEMS
 24 AND UTILIZATION STANDARDS. (a) There is established within the Department of
 25 Administration a nonprofit incorporated legal entity known as the Alaska State Health Resources
 26 Authority.

27 (b) The authority shall

28 (1) by July 1, 1992, create and begin a phased implementation of geographic
 29 specific health care provider reimbursement systems and utilization standards within the
 30 boundaries of municipalities that have a population of 20,000 or more as reflected by the 1990
 31 United States census; the health care provider reimbursement systems and utilization standards

80% EXPENDITURES AT THIS AREA

1 required under this paragraph shall be in operation by December 31, 1993;

2 (2) establish the reimbursement systems and utilization standards prospectively
3 utilizing the most accurate information available to the authority regarding defined reliable
4 components of the reimbursement systems and utilization standards; components for the
5 reimbursement systems must include but are not limited to

- 6 (A) effort and time by provider;
- 7 (B) facilities and practice expense;
- 8 (C) professional liability insurance;
- 9 (D) geographic modifier;
- 10 (E) availability of services modifier;
- 11 (F) uncompensated care net cost;

What ABOUT UPGRADES

12 *C.H. Anders?* → (G) actual provider ^{charges} cost as of January 1, 1991;

13 (3) assign relative weight to each component specified in (2) of this subsection
14 and may further define each component;

15 (4) publish, not later than July 1, 1992, a guide for health care providers, insurers,
16 and participants that describes and explains how to use the reimbursement systems and utilization
17 standards;

18 (5) establish health care information and data reporting procedures; the procedures
19 shall be established in cooperation with health care providers and insurers.

20 (c) A health care provider and a person paying a claim shall use the health care provider
21 reimbursement systems and utilization standards established by the authority when billing for
22 services provided to a public employer or a public employee. Other employers may elect to use
23 the reimbursement systems and utilization standards, if the use is approved by the authority.

24 (d) Upon application by an employer or an eligible state program, the authority may
25 beginning July 1, 1992, allow the employer or the eligible state program to participate in
26 health insurance pool established by the authority.

27 (e) Not later than February 15, 1993, the authority shall design and procure or provide
28 a basic health insurance program for employers who elect to participate and who have

- 29 (1) 50 or fewer full-time employees;
- 30 (2) been refused coverage by two or more health insurance carriers in the last 12
31 months; and

1 (3) not provided health insurance coverage to their employees in the last 12
2 months.

3 (f) A plan required under (e) of this section

4 (1) must emphasize preventative and protective health services;

5 (2) must include provisions to streamline marketing and payment of claims to
6 providers and participants;

7 (3) must include the reimbursement systems and utilization standards described
8 in (b) of this section;

9 (4) may utilize insurance agents or brokers licensed in this state to assist in the
10 marketing and servicing of the plan.

11 (g) The authority shall submit recommendations to the legislature for providing financial
12 incentives for employers to provide health protection for their employees and dependents.

13 (h) At least 60 days before implementing a phase of the reimbursement systems and
14 utilization standards, the authority shall provide public notice and accept public comments on that
15 phase of the reimbursement systems and utilization standards.

16 Sec. 44.87.015. REQUIRED COOPERATION BY STATE AGENCIES. An agency of
17 the state that provides health care or that provides funds to purchase health care shall, to the
18 maximum extent possible, cooperate in the development of the use of the health care provider
19 reimbursement systems and utilization standards established by the authority, including sharing
20 relevant information.

21 Sec. 44.87.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The authority shall
22 be managed by a board of directors composed of nine members appointed by the governor. The
23 governor shall appoint at least one but not more than two members as representatives from each
24 of the following:

- 25 (1) the executive branch;
- 26 (2) labor organizations;
- 27 (3) school districts;
- 28 (4) municipalities;
- 29 (5) private sector employers;
- 30 (6) health care providers.

31 (b) Members of the board serve staggered terms of four years. The board shall elect

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INDUSTRY*

1 from its membership a president, vice-president, and secretary. Members of the board serve
2 without compensation but are entitled to receive per diem and travel expenses authorized for
3 boards and commissions under AS 39.20.180. Members of the board are subject to AS 39.50.

4 Sec. 44.87.030. GENERAL POWERS. The authority may

5 (1) beginning July 1, 1992, exercise the powers granted to insurers under the laws
6 of the state; if the authority acts as an insurer, the authority shall comply with the requirements
7 applicable to insurers under AS 21;

8 (2) sue or be sued;

9 (3) enter into contracts or agreements;

10 (4) establish administrative or accounting procedures;

11 (5) collect, invest, and disburse funds;

12 (6) charge fees for providing administrative services;

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

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

15 Sec. 44.87.040. DUTIES OF BOARD; ANNUAL REPORT. The board shall

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

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

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

25 (4) establish a grievance procedure to resolve disputes between the authority and
26 participants;

27 (5) every third fiscal year, include in the annual report a cost and benefit analysis
28 of the activities of the authority;

29 (6) analyze the health care needs of the state population that is uninsured or
30 underinsured;

31 (7) provide recommendations to the legislature not later than February 15, 1992,

1 for a systematic approach or plan with alternatives including liabilities and financing alternatives
2 that may be considered to assure access to affordable quality health insurance for all state
3 residents; the recommendations must be updated each year;

4 (8) provide recommendations to the legislature not later than February 15, 1993,
5 for the design of a program with alternatives including liability and financing alternatives to
6 provide health care insurance to state residents who

INDICATES H. H. RISK, ETC.

7 (A) are not covered by health insurance;

8 (B) have been refused health insurance coverage by two or more health
9 insurance carriers in the last 12 months;

10 (C) have been considered uninsurable for health coverage; or

11 (D) are unable to pay for basic health care protection and do not qualify
12 for any other health care protection program or plan;

13 (9) beginning January 1, 1994, periodically review and update the reimbursement
14 systems and utilization standards established by the authority, and evaluate the need for
15 reimbursement systems and utilization standards in other areas of the state.

16 Sec. 44.87.050. STAFF AND PROFESSIONAL SERVICES CONTRACTS. The
17 authority shall employ an executive director who serves at the pleasure of the authority as its
18 chief administrative officer. The executive director may, with the approval of the authority,
19 select and employ additional staff as necessary. Employees of the authority are in the exempt
20 service under AS 39.25.110. In addition to its staff of regular employees, the authority may
21 contract for the services of consultants and professional, technical, and financial advisors the
22 authority considers necessary for the purpose of developing information, conducting hearings,
23 studies, investigations, or other proceedings, or otherwise exercising its powers.

24 Sec. 44.87.060. PROCUREMENT OF INSURANCE. (a) The authority may, after
25 July 1, 1992, begin to procure a policy or policies of comprehensive group health insurance
26 covering an individual or an employer that the authority determines does not have health
27 insurance or for whom health insurance could be more cost effective if procured by the authority.
28 The authority may procure or, if procurement of insurance is not economically feasible, provide
29 group health insurance to employers who elect to participate. Group health insurance may
30 include coverage for eligible employees and dependents. The authority shall procure the
31 insurance from an insurer authorized to transact business in the state under AS 21.09, or the

1 authority may elect to act as a self-insurer if the authority determines that self-insurance can
2 provide the desired insurance coverage and benefits at a lower cost per eligible employee and the
3 authority complies with (c) of this section.

4 (b) The authority, no earlier than July 1, 1992, may establish a group health insurance
5 pool or pools of eligible employers that elect to participate in the group health insurance obtained
6 by the authority. Coverage provided under this subsection must include eligible employees and
7 dependents. Employers that elect to participate shall use the reimbursement systems and
8 utilization standards established by the authority.

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

14 (d) Before the authority elects to act as a self-insurer, the authority shall solicit proposals
15 for the required coverage from insurers licensed in this state to offer health insurance. If after
16 the proposal process has been completed, the authority determines that the desired coverage or
17 benefits are not available from insurers licensed in this state or the authority can provide the
18 desired coverage and benefits at a lower cost per eligible person, the authority may submit a plan
19 of the intended self-insurance coverage and benefits to the legislature. The authority may not
20 begin acting as a self-insurer under the plan until the legislature has been in regular session for
21 60 calendar days after the plan was submitted.

22 (e) The authority, when procuring or providing insurance, may create pools or subpools
23 of participants to accurately track premium, experience, and exposure by category. The authority
24 may employ risk sharing mechanisms to limit the total exposure and premium claim volatility
25 of the authority or a participant.

26 Sec. 44.87.070. ALASKA STATE HEALTH RESOURCES FUND. The Alaska state
27 health resources fund is created in the general fund. The fund consists of money appropriated
28 by the legislature. The fund shall be managed and invested by the board. The board may expend
29 money from the fund to carry out the provisions of this chapter.

30 Sec. 44.87.080. INSURANCE PREMIUMS. The authority shall provide that sufficient
31 funds are collected to provide authorized benefits, reserves, and to pay the expenses of the

1 authority. Reserves remaining at the termination of an insurance contract shall be invested by
2 the authority in the same manner as retirement funds are invested under AS 14.25.180.

3 Sec. 44.87.090. PARTICIPATION; WAIVER. (a) The state, a municipality, a district,
4 or other employer in the state may participate in the group insurance coverage provided by the
5 authority. If the state, municipality, district, or other employer elects to participate, the state,
6 municipality, district, or other employer shall continue to participate unless a waiver is granted
7 by the board.

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

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

21 Sec. 44.87.900. DEFINITIONS. In this chapter,

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

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

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

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

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

31 (6) "employer" means the state, a municipality, a district, a collective bargaining

1 unit, the board of a public corporation of the state created within a principal executive
2 department, a self-employed person, or a person employing one or more persons in a business
3 or industry;

4 (7) "full-time employee" means a person who works 30 or more hours in a week;

5 (8) "fund" means the Alaska state health resources fund;

6 (9) "group health insurance" means coverage that may include medical care and
7 treatment, dental care, eye care, and other group health coverage as determined by the authority;

8 (10) "health care provider" has the meaning given in AS 21.88.900;

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

10 (12) "participant" means a person who participates in the group health insurance
11 procured or provided by the authority;

12 ~~DELETED~~ (13) "public employer" means the state, a municipality, a district, or a public
13 corporation of the state created within a principal executive department;

14 (14) "reimbursement systems" means systems or methods that streamline or result
15 in cost efficient payments to health care providers, and includes schedules of maximum allowable
16 reimbursement for health care related services based on geographic regions, actual provider costs,
17 and availability of services;

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

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

24 * Sec. 9. REPORT. The Alaska State Health Resources Authority shall report to the Alaska State
25 Legislature by March 1, 1992, on the progress made by the authority in establishing a health care
26 provider reimbursement systems and utilization standards.

27 * Sec. 10. This Act takes effect immediately under AS 01.10.070(c).

1 unit, the board of a public corporation of the state created within a principal executive
2 department, a self-employed person, or a person employing one or more persons in a business
3 or industry;

4 (7) "full-time employee" means a person who works 30 or more hours in a week;

5 (8) "fund" means the Alaska state health resources fund;

6 (9) "group health insurance" means coverage that may include medical care and
7 treatment, dental care, eye care, and other group health coverage as determined by the authority;

8 (10) "health care provider" has the meaning given in AS 21.88.900;

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

10 (12) "participant" means a person who participates in the group health insurance
11 procured or provided by the authority;

12 (13) "reimbursement systems" means systems or methods that streamline or result
13 in cost efficient payments to health care providers, and includes schedules of maximum allowable
14 reimbursement for health care related services based on geographic regions, actual provider costs,
15 and availability of services;

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

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

22 * Sec. 9. REPORT. The Alaska State Health Resources Authority shall report to the Alaska State
23 Legislature by March 1, 1992, on the progress made by the authority in establishing a health care
24 provider reimbursement systems and utilization standards.

25 * Sec. 10. This Act takes effect immediately under AS 01.10.070(c).

CS FOR SENATE BILL NO. 83 (L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY THE SENATE LABOR AND COMMERCE COMMITTEE

Offered:

Referred:

Sponsor(s): SENATORS DUNCAN, Zhzroff, Rodey

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to the Alaska State Health Resources Authority; relating to the delivery,
2 quality, and financing of health care for residents of the state, and to the issuance of
3 certificates of need; and providing for an effective date."

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

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

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

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

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

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

1 to providers who are serving employees of participants,

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

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

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

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

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

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

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

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

24 Sec. 18.07.041. STANDARD OF REVIEW FOR APPLICATIONS FOR CERTIFICATES
25 OF NEED. The office shall grant a sponsor a certificate of need or modify a certificate of need
26 if the availability and quality of existing health care resources or the accessibility to those
27 resources is less than the current or projected requirement for health services required to maintain
28 the good health of Alaska citizens. A certificate of need may not be issued, except for a
29 temporary or emergency certificate under AS 18.07.071, unless the office has received a
30 determination from the Alaska State Health Resources Authority regarding the effect of the
31 certificate of need on the cost of group health insurance.

1 * Sec. 4. AS 37.07.030 is amended to read:

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

3 (1) provide for a budget review function;

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

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

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

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

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

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

18 Authority.

19 * Sec. 5. AS 39.25.110 is amended by adding a new paragraph to read:

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

21 * Sec. 6. AS 39.50.200(b) is amended by adding a new paragraph to read:

22 (52) Alaska State Health Resources Authority (AS 44.87).

23 * Sec. 7. AS 44 is amended by adding a new chapter to read:

24 CHAPTER 87. STATE INSURANCE AUTHORITY.

25 Sec. 44.87.010. AUTHORITY CREATED; REQUIRED REIMBURSEMENT SYSTEM
26 AND UTILIZATION STANDARDS. (a) There is established within the Department of
27 Administration a nonprofit incorporated legal entity known as the Alaska State Health Resources
28 Authority.

29 (b) The authority shall, by July 1, 1992, establish and begin implementation of a health
30 care provider reimbursement system and utilization standards. The state, a municipality, or a
31 school district shall use the health care provider reimbursement system and utilization standards

1 established by the authority for eligible employees of the state, a municipality, or a school
2 district. With the approval of the authority, other employers in the state may use the health care
3 provider reimbursement system and utilization standards established by the authority.

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

11 (d) Upon application by an eligible state program, the authority may, beginning July 1,
12 1992, allow the eligible state program to participate in the group health insurance pool provided
13 by the authority.

14 Sec. 44.87.015. REQUIRED COOPERATION BY STATE AGENCIES. An agency of
15 the state that provides health care or that provides funds to purchase health care shall, to the
16 maximum extent possible, cooperate in the development of the use of the health care provider
17 reimbursement system and utilization standards established by the authority, including sharing
18 relevant information.

19 Sec. 44.87.020. BOARD OF DIRECTORS: ORGANIZATION. (a) The authority shall
20 be managed by a board of directors composed of nine members appointed by the governor. The
21 governor shall appoint at least one but not more than two members as representatives from each
22 of the following:

- 23 (1) the executive branch;
- 24 (2) labor organizations;
- 25 (3) school districts;
- 26 (4) municipalities;
- 27 (5) private sector employers;
- 28 (6) health care providers.

29 (b) Members of the board serve staggered terms of four years. The board shall elect
30 from its membership a president, vice-president, and secretary. Members of the board serve
31 without compensation but are entitled to receive per diem and travel expenses authorized for

1 boards and commissions under AS 39.20.180. Members of the board are subject to AS 39.50.

2 Sec. 44.87.030. GENERAL POWERS. The authority may

3 (1) beginning July 1, 1992, exercise the powers granted to insurers under the laws
4 of the state; if the authority acts as an insurer, the authority shall comply with the requirements
5 applicable to insurers under AS 21;

6 (2) sue or be sued;

7 (3) enter into contracts or agreements;

8 (4) establish administrative or accounting procedures;

9 (5) collect, invest, and disburse funds;

10 (6) charge fees for providing administrative services;

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

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

13 Sec. 44.87.040. DUTIES OF BOARD; ANNUAL REPORT. The board shall

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

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

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

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

25 Sec. 44.87.050. STAFF AND PROFESSIONAL SERVICES CONTRACTS. The
26 authority shall employ an executive director who serves at the pleasure of the authority as its
27 chief administrative officer. The executive director may, with the approval of the authority,
28 select and employ additional staff as necessary. Employees of the authority are in the exempt
29 service under AS 39.25.110. In addition to its staff of regular employees, the authority may
30 contract for the services of consultants and professional, technical, and financial advisors the
31 authority considers necessary for the purpose of developing information, conducting hearings,

1 studies, investigations, or other proceedings, or otherwise exercising its powers.

2 Sec. 44.87.060. PROCUREMENT OF INSURANCE. (a) The authority shall, after
3 July 1, 1992, obtain a policy or policies of group health insurance covering eligible employees
4 of an employer that has elected to participate, from an insurer authorized to transact business in
5 the state under AS 21.09, or act as a self-insurer if the authority determines that self-insurance
6 can provide the desired insurance coverage and benefits at a lower cost per eligible employee.

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

12 Sec. 44.87.070. ALASKA STATE HEALTH RESOURCES FUND. The Alaska state
13 health resources fund is created in the general fund. The fund consists of money appropriated
14 by the legislature. The fund shall be managed and invested by the board. The board may expend
15 money from the fund to carry out the provisions of this chapter.

16 Sec. 44.87.080. INSURANCE PREMIUMS. The authority shall provide that sufficient
17 funds are collected to provide authorized benefits, reserves, and to pay the expenses of the
18 authority. Reserves remaining at the termination of an insurance contract shall be invested by
19 the authority in the same manner as retirement funds are invested under AS 14.25.180.

20 Sec. 44.87.090. PARTICIPATION; WAIVER. (a) The state, a municipality, a district,
21 or other employer in the state may participate in the group insurance coverage provided by the
22 authority. If the state, municipality, district, or other employer elects to participate, the state,
23 municipality, district, or other employer shall continue to participate unless a waiver is granted
24 by the board.

25 (b) In determining whether a waiver should be granted, the board shall establish
26 minimum benefit and financial standards for the desired group health insurance coverage. The
27 minimum benefit and financial standards and the proposed time schedule for responsive offers
28 shall be sent to all participants at the time the request for proposal for the desired group health
29 insurance coverage is issued. A participant seeking a waiver of coverage shall match the
30 minimum benefit and financial standards set out in the request for proposal for the desired group
31 health insurance coverage. Participants shall submit documentation of their insurance coverage

1 matching the board's minimum benefit and financial requirements before the deadline established
2 by the board. The board may approve or disapprove a waiver of participation based on the
3 documentation submitted by the participant regarding the benefit and financial standards
4 established by the board.

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

7 Sec. 44.87.100. DEFINITIONS. In this chapter,

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

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

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

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

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

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

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

22 (8) "group health insurance" means coverage that may include life insurance,
23 accidental death and dismemberment, medical care and treatment, dental care, eye care, and other
24 group health coverage as determined by the authority;

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

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

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

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

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

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

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

**1991 LEGISLATION
POSITION PAPER
DEPARTMENT OF ADMINISTRATION**

Division Labor Relations

Bill Number CSSB 83

Bill Title Act relating to the Alaska State Health Resources Authority

Position Statement: Explain briefly what bill does, its impacts and Department's position, i.e., a) support, b) do not support, c) neutral or d) oppose.

We oppose this legislation for budgetary reasons.

This bill would establish the Alaska State Health Resources Authority as a nonprofit incorporated legal entity, within the Department of Administration; the authority is to be managed by nine (9) uncompensated directors appointed by the Governor.

The Alaska State Health Resources Authority would be charged with three (3) primary responsibilities:

1. Issuing recommendations on the effect of certificates of need (AS 18.07.071) on group insurance costs, effective immediately.
2. By July 1, 1992, implement a health care provider reimbursement system and utilization standards; these are mandatory for all public employers and may be voluntarily utilized by other employers.
3. By July 1, 1992, establish a voluntary health insurance pool designed to purchase or provide affordable health insurance.

State agencies involved in health care/health insurance are to cooperate in developing the reimbursement system and utilization standards, through the sharing of information. The authority is to report its progress to the legislature by March 1, 1992, and annually thereafter.

While we support the objectives proposed in this legislation, we must oppose the bill's proposed effective dates because immediate implementation will increase our FY 92 operating budget beyond the level we believe appropriate. The bill is otherwise meritorious. We believe the bill should be given budgetary support in FY 93, along with a cost reduction justification offset.

APPROVED:

Director Bruce Cummings

Division Labor Relations

Signature 

Date 4/1/91

Commissioner Millett Keller

Signature 

Date 4/3/91

(For more information, call Barbara Pritchett 465-2200)

Rev. 01/28/91

1991 LEGISLATION
POSITION PAPER
DEPARTMENT OF ADMINISTRATION

Division Retirement and Benefits Bill Number SB 83

Bill Title An Act relating to the Alaska State Health Resources Authority...

Position Statement: Explain briefly what bill does, its impacts and Departments' position,
i.e. a) support, b) do not support, c) neutral or d) oppose.

This bill creates an Authority within the Department of Administration managed by a Board of Directors. By July 1992, the Authority will create utilization standards and reimbursement systems that will be used by participating groups on a statewide basis. After July 1992, the Authority will provide group health insurance to various public employers throughout the State should they choose to elect to participate.

The bill does not require the State to participate in the insurance pool. The State may elect to do so. It is anticipated the Division of Retirement and Benefits would continue to perform similar administrative functions regarding the health plan, whether the State decided to participate in the pool or not.

Since the bill has no clear adverse impact on this division and could provide more accessible and more affordable health insurance coverage for employers, the Department supports this bill.

APPROVED:

Director Gary M. Bader Division Retirement and Benefits

Signature *Gary M. Bader* Date February 12, 1991

Commissioner Millett Keller

Signature *Millett Keller* Date 2/13/91

**1991 LEGISLATION
POSITION PAPER
DEPARTMENT OF ADMINISTRATION**

Division Labor Relations **Bill Number** SB 83

Bill Title Act relating to the Alaska State Health Resources Authority

Position Statement: Explain briefly what bill does, its impacts and Department's position, i.e., a) support, b) do not support, c) neutral or d) oppose.

This bill would establish the Alaska State Health Resources Authority as a nonprofit incorporated legal entity, within the Department of Administration; the authority is to be managed by nine (9) uncompensated directors appointed by the Governor.

The Alaska State Health Resources Authority would be charged with three (3) primary responsibilities:

1. Issuing recommendations on the effect of certificates of need (AS 18.07.071) on group insurance costs, effective immediately.
2. By July 1, 1992, implement a health care provider reimbursement system and utilization standards; these are mandatory for all public employers and may be voluntarily utilized by other employers.
3. By July 1, 1992, establish a voluntary health insurance pool designed to purchase or provide affordable health insurance.

State agencies involved in health care/health insurance are to cooperate in developing the reimbursement system and utilization standards, through the sharing of information. The authority is to report its progress to the legislature by March 1, 1992, and annually thereafter.

We support this legislation as a potential vehicle to curb escalating health care/health insurance costs. However, we recognize that the bill may require technical amendments for clarity or to improve organizational efficiency (e.g., statutory placement of authority, frequency and nature of reports to legislature, etc.). We do not anticipate any change in position as a result of such amendment, but will modify our position as necessary on bill substitutes.

APPROVED:

Director Bruce Cummings **Division** Labor Relations

Signature *Bruce Cummings* **Date** 2/13/91

Commissioner Millett Keller

Signature *Millett Keller* **Date** 2/13/91

(For more information, call Barbara Pritchett 465-2200)

Rev. 01/28/91

MEMORANDUM

State of Alaska

TO: Senator Drue Pearce
Chairperson
Senate Labor & Commerce Committee
Alaska State Senate


DATE: March 1, 1991

FILE NO.:

THRU:

TELEPHONE NO.: (907) 465-2515

SUBJECT: CSSB 83

FROM: Dave Walsh 
Director
Division of Insurance
Department of Commerce
and Economic Development

We have reviewed the following documents and they appear to respond to the points and concerns noted in the February 22, 1991 Position Paper from the Department of Commerce and Economic Development attached. The reviewed documents are:

CS for Senate Bill No. 83 (L&C)	Work Draft 7-LS0305\G, Ford, 2/28/91
Amendment to CSSB 83 (L&C)	Work Draft 7-LS0305\G.1, Ford, 2/28/91
Amendment to CSSB 83 (L&C)	Work Draft 7-LS0305\G.2, Ford, 2/28/91
Amendment to CSSB 83 (L&C)	Work Draft 7-LS0305\G.3, Ford, 2/28/91
Amendment to CSSB 83 (L&C)	Work Draft 7-LS0305\G.4, Ford, 2/28/91
Amendment to CSSB 83 (L&C)	Work Draft Page 3 Line 29, Ford, no date

STATE OF ALASKA

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

OFFICE OF THE COMMISSIONER

FEB 25 1991
WALTER J. HICKEL, GOVERNOR

P. O. BOX D
JUNEAU, ALASKA 99811-0800
PHONE: (907) 465-2500

February 25, 1991

Honorable Drue Pearce
Alaska State Senate
P.O. Box V
Juneau, AK 99811

Dear Senator Pearce:

Please accept this letter as a formal retraction of the position paper on SB 83 dated 2/19/91. The most current position paper, dated 2/22/91, is attached.

The original bill analysis was not affected.

Please excuse our ignorance on this procedure. If the Department of Commerce and Economic Development can be of any assistance to you in the future, please do not hesitate to ask.

Sincerely,



Larry Galloway
Special Assistant

LG/wfd4188W-1
.22591a
Enclosure
cc: Senator Jim Duncan

what, pray
tell, u he
apologizing for?
Call + say
everyone
who gives
in to Jim
only reinforces
his behavior!
Larry works for
Hickel not
Duncan - and these
are so different he
should be careful about
letting Jim scare him.

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

This department is in favor of this legislation with the changes noted below.

SB 83 would create a Health Resources Authority in the Department of Administration which would become the purchasing entity or may become the provider of health insurance coverage for state employees, municipal employees, school district employees and other groups electing to participate.

The department recommends the following changes to SB 83.

1. Move Section 4 of the bill from Title 21 to another title.

This would avoid conflict with the content and purpose of Title 21. Title 21 is designed for the regulation of the business of insurance. Section 4, on the other hand, is designed for the purchase or provision of coverage. These two roles tend to be in conflict with each other. Further, Title 21 is administered and regulated within the Department of Commerce and Economic Development while Section 4 is an authority administered under the Department of Administration.

2. Eliminate regulatory oversight of the authority by the Division of Insurance.

The regulation of one agency in the executive branch by another agency in the executive branch is not workable. The potential for interagency squabbles is substantially increased and other conditions beyond the regulatory scheme may control and prevail. This arises if the authority elects to become a direct provider of coverage. To a large extent, that should be part of the responsibility of the authority Board of Directors.

3. Provide for legislative oversight of any move to provider status.

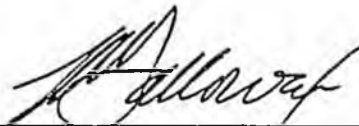
If the authority elects to become a direct provider of coverage, it basically enters an area that has been a subject for private enterprise. Such a move must, therefore, be subject to a process that assures that conditions warrant such a move. This should be done only after appropriate hearings on the specific move and the Legislature has had an opportunity to review the proposal.

4. Expand the report required in page 4 to include complaints against the authority as an element for review.

The fiscal activities of the authority are a reasonable measure of the financial activities and rate activities of the authority. An equally important activity is one that deals with how the authority treats those it serves. Complaints are one measure of a firm's success in its relations with the public. It should also serve to let the authority and the Legislature know how the public perceives the authority and the coverage it provides.

5. Change the cost-benefit analysis to biannual rather than triannual.

A greater frequency of cost-benefit analysis is desirable. A two-year period would assure that each Legislature has an opportunity to see and review such information. The three-year approach would skip every other Legislature.

 Spec. Asst. II

Glenn A. Olds, Commissioner

Date: 2-22-91

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


This department is not in favor of this legislation as presently written.

SB 83 would create a Health Resources Authority in the Department of Administration which would become the purchasing entity or may become the provider of health insurance coverage for state employees, municipal employees, school district employees and other groups electing to participate.

We believe that this legislation effectively puts the state in the insurance business as either an agent or as an insurer. It will adversely impact competition, and tends to create a monopoly either way. If the authority further concentrates insurance coverage in a single insurer as an agent or elects to become an insurer itself, other private insurers will be unable to continue to provide coverage at a reasonable expense level, thus resulting in higher costs of coverage. The remaining market will be too small to support more than a very few insurers, thus limiting choice and competition. It is unlikely they will be able to compete with the state.

The legislation will adversely impact insurance agents currently making a living at selling health insurance. No data is available to quantify this impact.

- Move AS 21 provisions to another title.
- Expand the report required in page 4 to include complaints as an element for review.
- Change the cost-benefit analysis to biannual rather than triannual.
- Provide for legislative oversight of any move to provider status.
- Eliminate regulatory oversight of the Authority by the Division of Insurance.


Glenn A. Olds, Commissioner

Date: 2-19-91

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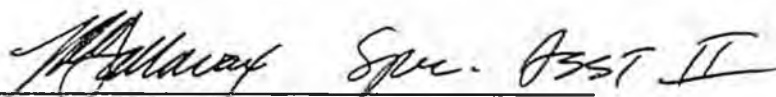
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- Eliminate regulatory oversight of the Authority by the Division of Insurance.


Glenn A. Olds, Commissioner

Date: 2-19-91

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF ADMINISTRATIVE SERVICES

WALTER J. HICKEL, GOVERNOR

P.O. Box H
Juneau, Alaska 99811-0650
Phone: (907) 465-3082

June 27, 1991

JUL 05 1991

*Red
CJ*

Dear Health Care Interest,

As you may know, Senate Concurrent Resolution 10, creating the Health Resources and Access Task Force, recently passed the Legislature. This Task Force combines the missions of the Universal Health Care Task Force and the Health Care Cost Containment Task Force. However, the future of this project remains uncertain due to recent budget cuts. The entire fiscal note for SCR 10 which included funding for project staff, travel, and contractual services was zeroed out.

The primary purpose of the Health Resources and Access Task Force is to recommend to the Governor and Legislature a health care program covering all Alaskans and a strategy to contain health care costs. The Task Force is made up of 17 members, with three each from the Senate, the House, and the Executive Branch. These nine members select the remaining eight public members. The Senate members are Senators Duncan, Collins and Kerttula. The House members are Representatives Ellis, Boyer, and Navarre. The Executive Branch members are Commissioner Theodore Mala (Department of Health and Social Services), Commissioner Millet Keller (Department of Administration), and Commissioner Glenn Olds (Department of Commerce and Economic Development). For the purposes of getting the Task Force started, Senator Duncan and Representative Ellis have agreed to serve as temporary co-chairs until, as according to SCR 10, the Task Force members can choose a chair from among themselves.

The Health Resources and Access Task Force is soliciting applications for the eight public members. Please review the announcement on the back of this letter and reply by July 12 if you are interested in being considered.

The mailing address for the Task Force is:

Health Resources and Access Task Force
P.O. Box Y
Juneau, Alaska 99811

If you would like further information, please call either Senator Jim Duncan at 465-4766 or Representative Johnny Ellis at 561-7628. It has been my pleasure to work on this project.

Sincerely,

Nancy Cornwell

Nancy Cornwell
Project Director, Universal Health Care Task Force

APR 15 1991

Health Access & Cost Containment Council

April 12, 1991

Honorable Drue Pearce
Alaska State Legislature
P.O. Box V (MS 3100)
Juneau, Alaska 99811

RE: Senate Bill 83

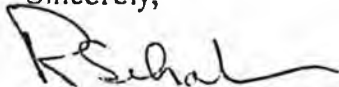
Dear Senator Pearce:

The Alaska Hospitals & Nursing Homes Association, the Alaska Hospital Council, and the Alaska Medical Association have joined together to address the issues of health care cost and access.

Part of our effort has been the analysis of Senate Bill 83. (enclosed)
But more important, we offer our Council as a resource to the legislature on these complex and serious issues.

The Council will continue to meet over the summer with experts and participants alike, in an attempt to assist the legislature in solving these problems.

Sincerely,



Ray Schalow

CORRECTION

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

STATE OF ALASKA

DEPT. OF HEALTH AND SOCIAL SERVICES

DIVISION OF ADMINISTRATIVE SERVICES

WALTER J. HICKEL, GOVERNOR

P.O. Box H
Juneau, Alaska 99811-0650
Phone: (907) 465-3082

June 27, 1991

JUL 05 1991

*Red
S.J.*

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Sincerely,

Nancy Cornwell

Nancy Cornwell
Project Director, Universal Health Care Task Force



HEALTH RESOURCES AND ACCESS TASK FORCE

SOLICITS PUBLIC MEMBERS

The Health Resources and Access Task Force was created by the Legislature to recommend to the Governor and Legislature a health care program covering all Alaskans and a strategy to contain health care costs.

The Task Force is soliciting applications for eight public members representing the following interests:

- (1) medically indigent
- (1) private employers (not health care providers)
- (2) health care providers
- (1) health insurer that offers health insurance in Alaska
- (1) nonprofit organizations
- (1) consumer of health services, not an employer or provider
- (1) labor organizations

If you are interested in being considered, send a resume (MAXIMUM OF 2 PAGES) TO:

Health Resources and Access Task Force
P.O. Box Y
Juneau; Alaska 99811

Resume must be postmarked by July 12, 1991. Note on the resume which of the public member categories listed above you believe you best represent. For further information, call 465-2933.

APR 15 1991

Health Access & Cost Containment Council

April 12, 1991

Honorable Drue Pearce
Alaska State Legislature
P.O. Box V (MS 3100)
Juneau, Alaska 99811

RE: Senate Bill 83

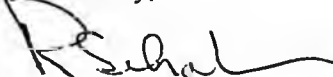
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Sincerely,



Ray Schalow

Health Access & Cost Containment Council

POSITION PAPER

in re: SB 83

by

Joint Health Access and Cost Containment Council

Alaska Hospital & Nursing Home Association

Alaska Hospital Council

Alaska State Medical Association

We do not support Senate Bill 83, and would like to lay out the reasons for our opposition in a joint response by our three organizations, representing Alaska's hospitals, nursing homes and physicians. Our comments concern both the Health Care Cost Containment Task Force Report (or, HCCC Report) to the 17th Legislature, and its outgrowth legislation, SB 83.

We share a deep concern about the crisis of the uninsured and the increasing costs of health care. We have formed a working group to deal with the issues, the Joint Health Access and Cost Containment Council. Health care providers represented by this Council are committed to help solve the problem of ensuring access to health care for all Alaskans; we are equally committed to help find ways to contain health care costs and maximize effectiveness of health care dollars. In our judgment, SB 83 does not adequately address either of these broad commitments.

Before we comment on Senate Bill 83, we must first review the Health Care Cost Containment Task Force Report of February 1991 on which SB 83 is based. The report's major contentions are that Alaska health care costs are skyrocketing, and will be almost \$10 billion by the year 2000; and that, the cause of this inflation is provider charges. SB 83 consequently proposes a reduction of those charges as the primary method of controlling health care expenditures. It also proposes, without saying how, to establish utilization standards to reduce the volume of services.

The HCCC Report is so poorly done that it is difficult to critique without redoing all the work. Throughout the report, statements are made without adequate data, sources are not referenced, the method selected for multiple data "adjustments" is not specified, the questionnaires used and the response rates are not shown. The report has an obvious slant, driven by alarmist costs for the year 2000, extrapolated from scanty data using unstated statistical methodology. *Since these projections are central to the HCCC Report's conclusions, it is imperative that the methodology used be fully revealed and completely justified.*

The projections seem to have been made by taking the rate of increase from a single year --1979-80-- and projecting forward for 20 years of compounded increases. However, the rate of increase on which the projections are based is in marked disagreement with the health care cost inflation rate given by the U.S. Bureau of Labor Statistics in the Consumer Price Index (CPI) for 1985-89. (See attached). These CPI figures actually show that the rate of increase in Anchorage is approximately one-half that shown in the Task Force's Report. It also shows that Alaska's rate is in line with the rate of medical inflation nationwide. *In fact, as the CPI shows, Alaska's rates in the recent past have increased more slowly than U.S. rates.*

The report fails to address other Alaska-specific factors impinging on cost increases. For example, during the 1970's and 1980's Alaska medicine was intent on catching up with the rest of the country in order to create the medical and technological infrastructure already in place elsewhere in the United States. In response to strong public demand, the health care community built coronary and intensive care units, developed an adequate emergency medical services and transport system, built newborn and pediatric intensive care units, acquired CT scanners and so on. Further the state greatly expanded the Pioneer Home system, nursing homes and schools, public health nursing and village aide programs; and thereby created increased expectations in rural and bush Alaska for high quality local services. These represented huge capital outlays and have clearly driven the costs of medical care upwards in Alaska.

Had these expenditures not been made, Alaskans would now be complaining loudly that our medical system is backward and inadequate, and that we need to spend the money immediately to improve it. *The money was spent, and it should have been spent--Alaska was a medically underdeveloped territory. These expenditures severely skew the Alaska cost increase curve.* The skewing is not automatically bad--it's just a reality of what it costs to cease being a medical backwater of Seattle. As the CPI figures show, now that we have made our initial investment, our rate of cost increases has slowed to keep step with the rest of the nation.

One of the most significant developments in health care insurance costs in Alaska is almost completely ignored by the HCCC Report: namely, that \$20 million was saved in 1990-91 for state employee health insurance expenditures without any legislation at all and without the development of a huge state bureaucracy. During this period, some common modes of controlling costs were instituted: pre-admission review, effective case management and some increase in employee financial participation. Yet the report fails to take this decrease into account in making its alarmist extrapolations about state employee health costs in the year 2000. In fact, if we use the report's simplistic projection model, and take the very latest percentage change in rates, then project it linearly forward to 2000, we find predicted health care costs for 2000 *lower* than those of 1990! *An unlikely event, but the result of simplistic statistical modeling.*

The HCCC Report only gives lip service to other factors impinging on health care cost increases, even though these overshadow by far the effect of provider charges. Some of these other factors include: ever-growing social expectations -- and patient demands -- for the full use of every resource on every problem, coupled with capital-intensive technological breakthroughs; professional liability and defensive medicine issues; the huge resources spent to preserve life born too soon and to put off death for the mortally ill; and the unanticipated and massive health care expenditures resulting from the AIDS, violence and cocaine epidemics. These are all given only perfunctory attention, even though we providers see these as the real drivers of health care costs increases.

Purported to be a response to the problems identified in the HCCC Report, SB 83 does not meaningfully address the problem the Task Force identified as highest priority: the paramount question of access to care for the uninsured and underinsured. This is surprising, since the HCCC Report claims growth in this group from 40,000 to 90,000 in the last few years. And furthermore, publicity about SB 83 implies that the bill addresses this problem. In fact, SB 83 specifies neither how nor when this group will have health insurance, only that the problem will be addressed after July 1, 1992.

Despite the report's stated interest in reducing cost shifting, SB 83 will actually exacerbate the problem. It will further erode access and quality of care by further jeopardizing the economic viability of Alaska's rural hospitals. Already, many of these hospitals are serving a small number of patients, and barely make ends meet. Rural physicians depend on the existence of rural hospitals and nursing homes for a substantial part of their practice activity. Every patient without insurance generates costs for the hospitals and physicians, which are either included in charges to other patients who can pay, or are taken as losses by the hospitals and physicians.

The pool of employees covered under SB 83's Health Resources Authority (HRA) would be the last major group which can help bear the costs of care for the uninsured. *Medicaid and Medicare reimbursement already is at or below real cost.* If the HRA lowers the rate it pays for care of its beneficiaries, the costs for taking care of the uninsured cannot be passed along to others, nor made to vanish. The costs will be there, and will increase the losses taken by the hospitals, and by the physicians. The losses will reduce the margin of free care which health care providers will be able to provide to those with no resources, or even tip the fragile balance of financial viability of small hospitals and their physicians. These obviously make the problem of access even worse.

The HCCC Report's reference to the importance of controlling the costs of defensive medicine is ignored in SB 83. There is nothing in the way of tort reform, or any other solution. Some individual physicians are paying more than \$100,000 a year for professional liability insurance. A family practitioner who agrees to deliver babies may pay more than \$1000 per baby delivered for the obstetrical portion of his/her malpractice insurance. Some authorities estimate that the cost of medical care is inflated by as much as one-third by defensive medicine, which is further encouraged with each huge judgement or settlement. And the spiral of medical costs continues upwards.

The heart of SB 83 is fixing provider charges and establishing "utilization standards." Careful historical analysis of the establishment of fee schedules reveals almost nothing but failures. The establishment of fee ceilings invariably results in further inflationary pressures, as the ceiling automatically becomes the new "floor" which all providers will automatically charge, even those whose charges were originally lower than the ceiling. *We have cited source articles in our bibliography.* The establishment, maintenance and periodic revision of a fee schedule is a complex and costly undertaking, requiring a sizeable bureaucracy.

Our experience with fee schedules has been unpleasant. Fee schedules under other programs which at first appeared fair, and based on fair market rates, increasingly have become provider's-cost-based, and then payor's-budget-based, and so paper-laden, complicated and slow that no payment is sometimes better than the costs of collection. Fee schedules exacerbate access to care because some providers choose not to participate.

What would the establishment and implementation of utilization standards really mean? First, there currently *are* no generally accepted standards -- medicine is not an exact science. Some work has begun in this area, but it is early and largely untested. Second, assuming that such standards can be developed, then a bureaucracy must be established and hired to implement and enforce them. Due process for beneficiaries and providers must be developed and maintained. A large professional and paralegal bureaucracy will have to be established, which will likely cost more to sustain than whatever minimal savings may be realized.

Finally, SB 83 creates a government-run insurance bureau, whether or not the state actually gets into the direct insurance business of receiving premiums, reviewing claims, and making payments.

In short, SB 83 certainly will create a large bureaucracy and in our opinion is unlikely to reduce the cost of medical care in Alaska at all.

Health care providers in Alaska oppose SB 83. So what do we support?

- * First, and foremost, we support and pledge to continue our participation in the establishment of a coherent health policy for Alaska. This must address access to health care as one of the basics. It must set goals for health status and spell out the skeleton of a health care system to which federal, state, and local government programs, as well as private health care providers can contribute. How can we know whether we have succeeded if we don't know where we are trying to go?
- * Secondly, we support a high quality analysis of the Alaska health care system, using standardized methodology and uniform medical data. The discrepancies between the HCCC Task Force Report and our analysis must be resolved prior to the adoption of any legislation enacting changes.
- * Third, we support watchful analysis and thoughtful observation of other state and federal proposed solutions to the problem of providing health care to all Americans at reasonable cost. We are a small state and can ill-afford to be out "on point" when larger states with more resources have been unable as yet to demonstrate a successful solution.
- * Fourth, we support continued implementation of those cost-saving measures which have been demonstrated to reduce cost *without* increased regulation or the creation of state bureaucracies -- measures such as those which have already reduced the increase in health care insurance costs for state employees by \$20 million in FY 1990 and frozen them in place for FY 1991.
- * Fifth, we support immediate and concrete measures to deal with Alaska's uninsured that could include the establishment of basic medical benefits packages, mandated risk pooling for currently uninsurable individuals, and state subsidies of premiums for certain individuals.

- * And finally, we support a mechanism that provides a forum for cooperation, dialogue and consensus among all levels of government, business, the uninsured, providers, Natives, and the general public.

For all of the reasons cited in previous pages, the Joint Health Access and Cost Containment Council and its constituent organizations representing Alaska's hospitals, nursing homes and physicians, respectfully request that the legislature not pass Senate Bill 83. We stand willing and ready to assist in whatever way we can with a thoughtful, careful analysis of Alaska's health needs and its current health system. We believe that the broadest base of agreement possible is the place to start, and that sound public policy will more certainly follow if we agree where we are trying to go.

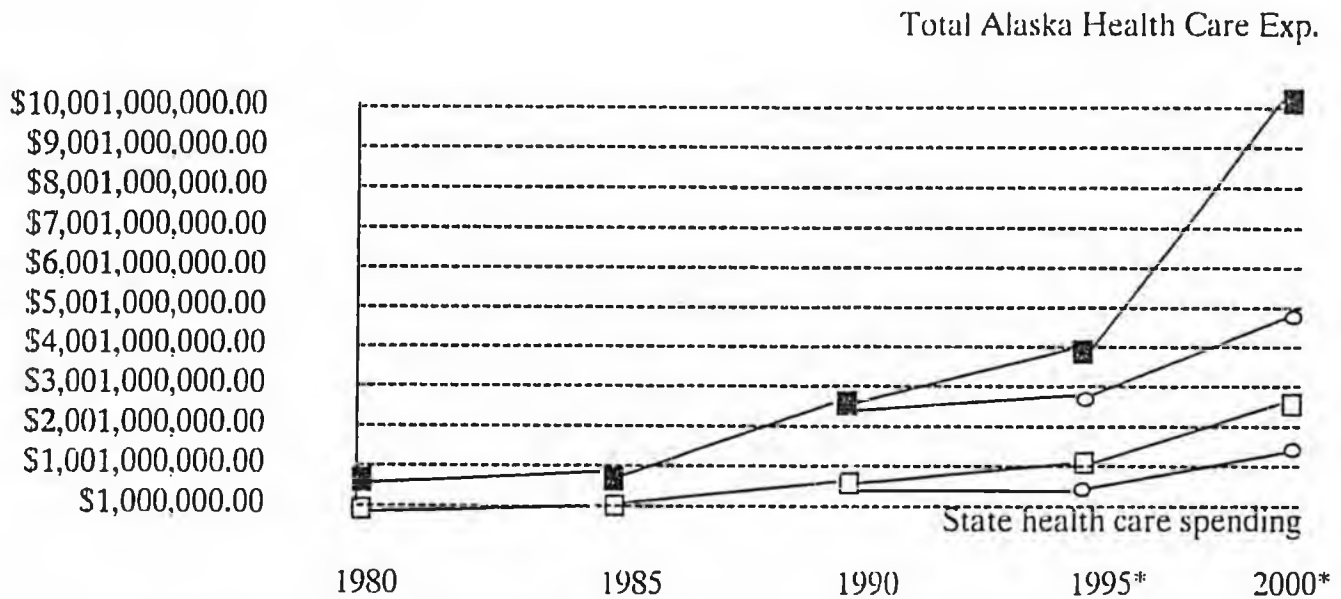
Respectfully submitted on behalf of the Joint Health Access and Cost Containment Council.

April 12, 1991

Health Cost Containment Task Force Exhibit

Source - Noble Lowndes

This exhibit demonstrates the rise in health care spending in Alaska from 1980 through the year 2000.



- Illustrates total health care expenditures in Alaska

1980 = \$576. million, 1985 = \$852. million, 1990 = \$1.608 billion
 1995 = \$4.0 billion*, 2000 = \$10.0 billion*

- Illustrates health care spending by the State

1980 = \$75. million, 1985 = \$175. million, 1990 = \$350 million
 1995 = \$1.068 billion*, 2000 = \$3.26 billion*

- Revised to reflect corrected rate of increase

* estimate

Health Access & Cost Containment Council

January 9, 1992

The Honorable Jim Duncan & Johnny Ellis
Co-Chair
Health Resources & Access Task Force
P.O. Box Y
Juneau, Alaska 99811

Gentlemen:

The Alaska Physician/Hospital Health Access and Cost Containment Council (APHHACCC) looks forward to presenting and discussing with you on January 9, the following:

- A) A proposed "Comprehensive Health Insurance and Payment Reform Act of 1992" (CHIPRA), and
- B) The APHHACCC comparison of CHIPRA with SB 83, the Alaska Health Resources Authority Act.

We strongly urge you to support legislation that reflects the Task Force's combined concerns in simultaneously assuring access to care for all Alaskans and fiscal responsibility.

Please keep in mind that the current CHIPRA proposal is the work of the council's members and administrators. It needs your review and input, and it needs the review and input of health providers around the state. Working together, we can achieve meaningful health care reform in Alaska.

Sincerely,

Jennifer Christian, M.D.
Co-Chair, APHHACCC

Health Access & Cost Containment Council

THE COMPREHENSIVE HEALTH INSURANCE AND PAYMENT REFORM ACT OF 1992 (CHIPRA): AN OUTLINE FOR MODEL HEALTH CARE REFORM LEGISLATION

JANUARY 6, 1992

DRAFT

- I: INTRODUCTION: The Comprehensive Health Insurance and Payment Reform Act of 1992 (CHIPRA) establishes access by the people of Alaska to a program of basic health care benefits that utilizes market forces to restrain spiralling costs. CHIPRA creates an insurance pool and a broad-based preferred provider organization through which providers agree to discount fees to pool members. Creation of the PPO is predicated upon fundamental tort reform, prompt payment of claims, uniformity of utilization review standards and use of a standard health claims form.

CHIPRA does not replace existing insurance programs, which remain free to compete with CHIPRA policies in the marketplace. CHIPRA can be utilized by the currently insured as well as by the uninsured and uninsurable. Small businesses may also participate.

Participation in the insurance pool is open to individuals and groups of employees on an elective basis. A single premium structure, based on sex and age, will be mandated regardless of group size. Funding will be by a combination of individual contributions, use of the Permanent Fund dividend on a sliding-scale based on income, and by a sales tax on the purchase of products associated with a high risk of disease or injury. A special tax on companies selling health insurance in Alaska but not offering CHIPRA policies is included as an additional revenue enhancement option. Insurance policies will be sold by private insurance agents or, in the case of large employee groups, can be purchased directly from the carrier. Any carrier may offer, and any insurance agent market CHIPRA policies, in much the same fashion that Alaska lending institutions market home mortgages sponsored by the Alaska Housing Finance Corporation in competition with traditional mortgage instruments.

CHIPRA's coverage provisions contain strong financial incentives for promoting preventive health services.

A reimbursement and benefits review commission is established in order to negotiate fee discounts; recommend and publish reasonable, voluntary reimbursement schedules; publish a list of services or procedures that are not covered by the program; establish a set of uniform utilization review standards; and set payment ceilings for providers who increase charges in excess of the annual rate of increase of the Consumer Price Index, unless such increases can be justified to the Commission. Publication of the reimbursement schedule, coupled with mandatory disclosure of individual provider fee schedules upon patient request, will exert potent market pressures to eliminate "outlier" fees.

II: PROVISIONS

A. CREATION OF A REIMBURSEMENT AND BENEFITS REVIEW COMMISSION:

An independent commission shall be established and shall, on a defined, regular basis: review and amend the basic health benefits package; negotiate the provider discount; establish and publish a voluntary fee schedule for procedures; review and define non-covered services; review and define inefficient services; establish a uniform set of utilization review standards; and collect, review and evaluate data on the performance and effectiveness of the program. The Commission shall be empowered (and funded) to hire nationally recognized expert consultants to assist it in these determinations. The results of these determinations shall be published and distributed to all Permanent Fund dividend recipients on an annual basis, along with the Permanent Fund dividend application.

Should the rate of increase in some providers' charges exceed the rate of increase of the Consumer Price Index for the most recent 12-month period, the Commission shall be authorized to invoke limiting charge levels on the providers involved, unless the increases can be justified to the Commission. This provision applies equally to individual and institutional providers.

The Commission shall consist of two representatives of each of the following interest groups: hospitals, physicians, employers, the health insurance industry and the public. Method of selection, terms of appointment, salaries, supporting staff and means of enforcing its decisions are to be defined.

B. DEFINITION OF HEALTH BENEFITS PLAN:

A basic but comprehensive health plan would be defined and adopted. The waiting period for pre-existing conditions shall not exceed one year. The plan shall be defined as the covered services currently provided to State of Alaska retirees, modified as follows:

1. Basic inpatient and outpatient services are covered according to the scope of coverage defined below. These include indicated laboratory and radiological studies.
 2. The deductible and co-insurance shall be waived for approved routine preventive services to adults and for prenatal, well-baby and well-child care. Limits shall be imposed on the number of "waivered" services per calendar year.
 3. Non-covered services:
 - a: Dental care other than emergency extractions and repair of trauma.
 - b: Corrective lenses other than after ocular surgery or for conditions other than myopia, hyperopia, presbyopia and regular astigmatism.
 - c: Cosmetic surgery other than for major congenital deformities, trauma, cancer and related conditions.
 - d: Inpatient care for substance abuse, other than for the immediate, life-threatening consequences thereof (lifetime benefit of one covered inpatient recreational drug overdose episode).
 - e: Experimental treatments or procedures.
 - f: Chiropractic services.
 - g: Homeopathic and naturopathic services.
 - h: Treatments or procedures defined by the Reimbursement and Benefits Review Commission as inefficacious or of doubtful value for the preservation of or improvement in the quality of life.
- C. SCOPE OF COVERAGE: A deductible of \$1000 per participant per year shall apply, with a maximum out-of-pocket limit of \$5,000 per family. The plan will pay 80% of the balance after the deductible has been met. The deductible and co-insurance shall be on sliding scale for those receiving other low-income benefits and shall be waived for approved routine preventive care for adults and for routine prenatal and well-baby and well-child care. An annual limit shall be established for these "waivered" services. Participants may opt for lower deductibles and co-insurance, but the costs of such additional premiums shall be borne by the participant and/or the employer, and not by the pool. There will be a lifetime annual benefit limit of \$1,000,000 per subscriber.
- D. CREATION OF INSURANCE POOL AND PREFERRED PROVIDER ORGANIZATION:
PAYMENT OF PREMIUMS; ELIGIBILITY:
1. An insurance pool is created to obtain coverage for its members at an initial discount of 5% below providers' charges to the Alaska Medicaid program for 1991. A participating provider may not collect more than 95% of such charges from all sources. New providers will be reimbursed at 95% of the average 1991 Alaska Medicaid charges for their geographic areas.
 2. Individuals, employees and groups of employees are eligible to participate.

3. There shall be a waiting period of no more than one year for pre-existing conditions. Premiums will be based on age and sex, (no experience rating) although discounts shall be granted to non-smokers.
 4. Premiums may be paid by a combination of employee/employer contributions, individual payments, or assignment of all or part of the Permanent Fund dividend. A sales tax on the purchase of products associated with a high risk of disease or injury shall be levied if actuarial studies or experience with the program reveal a shortfall. A tax may also be levied on companies selling health insurance in Alaska who do not offer policies under the CHIPRA program.
 5. Any person wishing to participate in the program must be eligible to receive a Permanent Fund dividend.
 6. All insurance carriers must pay, deny or challenge in writing claims within 15 working days of receipt by the all-payor claims clearing house (cf. item M), with interest penalties payable thereafter, provided the claim form is fully completed.
- E. PROVIDER CHARGES: Providers shall maintain a single fee or charge schedule for services, except when separate schedules are a requirement of law or regulation, or when separate schedules are negotiated with an entity (not an individual or a family) purchasing or contracting for health services to a population group. This (these) schedule(s) shall be made available upon request to members of the group(s) to which they apply.
- F. GENERAL HEALTH INSURANCE PROVISIONS (for CHIPRA and non-CHIPRA policies). All health insurance carriers doing business in Alaska shall:
1. Accept the 1992 revised HCFA 1500 form as the standard form for all claims.
 2. Adopt the utilization review standards as defined by the Reimbursement and Benefits Review Commission.
 3. Adhere to the same standards for claims payment as CHIPRA participants.
- G: MEDICAL LIABILITY REFORM: Based on the uniform standards for medical malpractice cases outlined in the Health Equity and Access Improvement Act of 1991, central elements of malpractice reform under CHIPRA shall be:
1. Expedited medical malpractice settlements
 2. Alternative dispute resolution,
 3. Mandatory periodic payments of awards,
 4. Caps on non-economic damages,
 5. Limitation on attorney fees.
 6. Several liability for non-economic damages
 7. Uniform statute of limitations.
 8. Protection for certain high-risk specialties (e.g., obstetrics).

- H: STANDARDIZED UTILIZATION REVIEW MONITORING SYSTEM: All hospitals with a bed capacity in excess of 100 would be required to establish a multidisciplinary team whose purpose is to implement a utilization and outcome oriented approach to hospitalization, based on uniform guidelines established by the Commission. The hospital will provide annual reporting data to the Commission. The hospital will be at risk financially for prescribed standards of utilization and will be prohibited from billing any third party or patient for defined excess utilization. Third party utilization will be eliminated for large hospitals under this approach.
- I: EMPLOYER PROVIDED COVERAGE: All employers having five or more full-time employees would be required to provide basic health insurance coverage to employees and their dependents through the basic health plan pool if they are not already providing other health insurance with the same basic benefits. Employers already providing other insurance may switch to a CHIPRA policy; differences in deductibles, co-insurance, etc. (if any) will then have to be settled between employer and employees on the same basis as any change in employee benefits.
- J: COMPLIANCE BY ALL STATE AND FEDERAL AGENCIES: All federal and state agencies who are providing health care in Alaska shall comply with the same rules and regulations that apply to the private sector. This includes licensure and certificates of need, as examples. The intent of this provision is to begin the process of levelling the playing field as the Commission attempts to reduce rate of increase in health care spending.
- K: CERTIFICATE OF NEED REFORM: The certificate of need law will be amended to require *all* institutional providers of health services to be in compliance with it.
- L: HOSPITAL PRICE REVIEW: All hospitals will be required to submit annual rate information. The information will be in a prescribed format and will enable the Commission to measure the actual increase in rates proposed. Any hospital increasing its rates faster than the CPI must request a rate review hearing before the Commission. The results of the review will be made available to the public, in sufficient detail and clarity to justify the increase. An appeal mechanism shall be established.
- M: ALL PAYOR CLAIMS CLEARING HOUSE: All claims for services provided under all insurance programs doing business in the state shall be submitted [electronically] to a single claims paying clearing house. The clearing house will process claims and remit payment within 15 days of entry into the system. In addition, the clearing house shall abstract claims data for routine submission to the Commission. Insurance companies operating in the state will bear the cost of the clearing house and will be prohibited from incorporating the costs into the group rating process.

- N: MEDICAID ELIGIBILITY TECHNICIANS: All hospitals with more than 100 beds will be required to employ eligibility technicians for the purpose of providing assistance to the population; the technicians shall be deputized by the state to make eligibility determinations for Medicaid and GRM. The hospital will be required to adhere to all state requirements in the conduct of this activity. The intent of this provision is to provide greater access to the Medicaid and GRM programs, possibly increasing the number of enrollees and reducing the uninsured population.
- O: LICENSURE: All institutional health care providers determined by the authority to be essential to the cost efficiency of the health care system will be required to obtain a state license. The state will establish minimum licensure standards for each type of institutional health care provider, and will require evidence that the provider, prior to being granted a new or renewal license, has conformed to the applicable certificate of need laws.

HEALTH ACCESS AND COST CONTAINMENT COUNCIL (HACCC)
JANUARY 4, 1992

COMPARISON OF HACCC'S COMPREHENSIVE HEALTH INSURANCE AND PAYMENT
REFORM ACT (CHIPRA) WITH SB83

OVERVIEW: Health care reform is rapidly becoming the leading political issue in the U.S. Costs are growing rapidly. Many Americans are afraid to change jobs for fear of losing their coverage. Still others, as many as 37 million, are uninsured, and fear financial ruin in the event of a serious illness or injury. In Alaska, however, according to recent opinion polls, health care does not yet occupy first place. The purpose of HACCC's proposal, known as the Comprehensive Health Insurance and Payment Reform Act of 1992 (or CHIPRA) is to embark on comprehensive health care reform now, rather than when health care has reached true crisis proportions in Alaska as it already has elsewhere in the country. CHIPRA is based partly on previous legislative initiatives and on the recommendations of various work groups and task forces. CHIPRA assumes that all the participants in the health care debate will be willing to address objectively the multitude of problems that exist and be willing to achieve a workable compromise.

The HACCC's proposal is truly comprehensive, whereas SB83 represents a fragmented approach that deals only with provider price control and utilization review standards, mandated for a single segment of the already-insured: State employees. SB83 addresses real insurance reform, as well as the issue of coverage for all Alaskans other than State and other public employees on a "might do" basis. *In other words, SB83 mandates limited reforms only for services to public employees, while reform for services to everyone else, even limited reform, is contingent upon unspecified conditions.* The likelihood is that none of SB83's provisions will ever be applied to other Alaskans.

SB83 has been vigorously promoted as dealing with the uninsured, yet a careful reading of the bill reveals that this unfortunate part of our population is, in fact, left in the political never-never land of "maybe." To use the uninsured as a banner behind which to rally support for SB83, while in fact giving them little more than a political promise to perhaps do something in the future is less than forthright.

CHIPRA, on the other hand, makes the uninsured, underinsured and uninsurable its first priority. The Council believes that their needs take priority over the needs of State employees who already have more-than-adequate coverage. State employees are neither at risk of losing their health benefits nor of being financially ruined by illness or injury.

CHIPRA also provides insurance relief to small business as an integral part of its program, whereas SB83 addresses the needs of small business, like those of the uninsured, as a lower priority, to be accomplished only on a conditional basis.

What follows is a comparison of the two proposals detail by detail in tabular form.

UNDERLYING PURPOSE:

Comprehensive health care reform affecting all Alaskans, universal access, market-based price controls. CHIPRA advocates system-wide reform, with individualized price controls and utilization review standards being only two facets of a solution to a very complex problem.

Implementation of government price controls and utilization review standards for health services to public employees. SB83 advocates price controls as a precursor to system-wide reform, which the bill does not address.

WHAT IS PROPOSED:

CHIPRA proposes comprehensive health care, health insurance, utilization review, provider payment and tort reform affecting *all* Alaskans. In so doing it assures universal access to a basic health benefits package.

SB83 proposes control of provider reimbursements, insurance reform and imposition of an additional utilization review system only for State of Alaska and other public employees. Extension of reforms to others is purely discretionary. It does not assure universal access. In fact, the "must do" sections of the bill deal only with "public employees" and their dependents. Everything else is a "maybe." (Sec. 8, 1c-e).

The second major difference between CHIPRA and SB83 is that CHIPRA provides coverage for the uninsured, underinsured and uninsurable as an essential element, not as a contingency to be addressed after the costs of insurance for State employees is controlled. State employees already have excellent health insurance, for which they pay no part of the premium.

A third difference is that CHIPRA provides relief for small businesses as another essential element, not as a contingency

BASIC PRINCIPLES OF HEALTH CARE REFORM:

CHIPRA defines a set of basic principles as an essential element in health care reform, as follows:

SB83 offers no clear definition of principles. This is a critical omission in any plan to reform the health care system.

ACCESS: Each Alaskan should have access to high quality basic health care, defined later in the proposal.

CHOICE: Consumers should have free choice of providers

RESPONSIBILITY: Consumers must take responsibility for their lifestyle choices and be aware of the costs of these choices. Any health care reform must provide incentives to avoid abusive life styles and to obtain preventive care.

COST SHARING: Consumers should share in meeting some of the costs of health care.

MARKET ENVIRONMENT: A free market environment, with appropriate restraints on cost increases, allows alternative approaches and stimulates innovation, research and competition.

CAPITALIZATION: Adequate capitalization of the health care delivery system must be assured

STANDARDS: Covered services must be based on scientifically based, nationally recognized standards of acceptability and efficacy.

PREVENTION: Successful reform must provide tangible financial incentives for seeking and obtaining preventive care

DEFINITION OF BENEFITS PACKAGE:

CHIPRA defines a basic health care benefits package. It says up front what is and is not covered.

No definition of a basic health care benefits package is provided.

ELIGIBILITY:

All Alaskans who qualify for the Permanent Fund dividend.

Only "public employees" and their dependents. "Other employers may elect to use the reimbursement system and utilization review standards, if the use is approved by the authority."

THE UNINSURED & SMALL BUSINESSES:

CHIPRA provides coverage for the uninsured, underinsured and uninsurable as a first step. This provides true universal access.

CHIPRA provides affordable insurance to small businesses as an essential ingredient of true health system reform.

The Health Authority "may begin to procure" insurance after July, 1, 1992 for the uninsured and for those not falling into the category of public employees. This provision leaves everyone outside the public sector--including the uninsured and small businesses--to the vicissitudes of political and budgetary contingencies.

In other words, SB83's first priority is to take care of the needs of those who already have excellent health insurance.

MEDICAL LIABILITY REFORM:

CHIPRA mandates comprehensive tort reform as an essential element of health care delivery reform.

SB83 not only does nothing to reform medical liability, it actually *reinforces* the current liability system by factoring the costs of malpractice insurance into the new reimbursement system.

FUNDING:

CHIPRA has a specific funding mechanism, utilizing a combination of the Permanent Fund Dividend program, employer and individual contributions, and a new sales tax on the purchase of products associated with a high risk of disease or injury.

SB83 has no specific funding provision. It mentions "potential savings if approximately 135,000 [public employees and dependents] participate" in the program. Monies for supporting the new State bureaucracy, the Alaska State Health Resources Authority, will be appropriated by the legislature.

CREATION OF A NEW STATE BUREAUCRACY:

CHIPRA creates a Reimbursement and Benefits Review Commission. Its membership will be from the public, insurance industry, providers and employers. On a regular basis it shall publish a voluntary fee schedule which shall be readily available to consumers; negotiate and renegotiate provider discounts; review and redefine, if necessary, covered and non-covered services and establish a unitary utilization review program for all health insurance programs in the state. The Commission will be authorized to fix fees should they rise faster than the Consumer Price Index. Even including staff, the Commission's size will be limited.

PROVIDER PAYMENT REFORM:

Under CHIPRA each provider would be required to maintain a single, uniform fee schedule for all patients, initially defined as that provider's fees charged to the Alaska Medicaid program in 1991. The fee schedule would be available to patients upon request. Reimbursements under the CHIPRA insurance program would be at a negotiated discount from this fee schedule, initially set at 5%, but renegotiable annually.

Should the rate of increase in some providers' charges exceed the rate of increase of the Consumer Price Index (CPI) for the most recent 12-month period, limiting charge levels will be imposed on the providers involved unless the rate of increase can be justified.

SB83 creates the Alaska State Health Authority (ASHRA) within the Department of Administration. It will develop and implement a fee schedule and utilization review standards that apply only to its beneficiaries. It has the authority to act as self-insurer, which gives it the potential for becoming a truly enormous bureaucracy. SB83's approach adheres to the philosophy that government can fix any problem, and that more and bigger government is better.

No provision is made for publishing and disseminating the ASHRA fee schedule.

The insurance pool created by SB83 would set a standard fee schedule for all providers, by geographic area. There is no provision for negotiation or appeal of ASHRA's decisions. SB83, while citing economy of scale in purchasing group health insurance--a market mechanism--mandates complete government setting of provider reimbursements, with not even a token involvement of providers. A 60 day public comment period is provided initially, but there is no provision for future comments, much less negotiations. Even national health programs, such as Canada's, provide for regular negotiations with providers.

CHIPRA

The rate of increase in charges by institutional providers will be subject to a similar mechanism if the rate exceeds the increase in the CPI.

PROVIDER DATA REPORTING:

CHIPRA and SB 83 are in agreement on the need for more information. CHIPRA wants data to judge efficacy of services and to restrain increases in costs.

UTILIZATION REVIEW:

CHIPRA mandates a single utilization review program for *all* health insurers doing business in Alaska. This would replace the current multitude of different, and sometimes contradictory utilization review programs.

BROAD INSURANCE REFORM:

CHIPRA mandates community rating and ends exclusions for pre-existing conditions under its insurance programs; mandates the use of a single claim form for *all* insurers in the state; and speeds up processing of claims by imposing penalties for late payment on *all* insurers.

SB83

SB83 contains no provision for a uniform charge schedule nor for mandatory availability of the schedule upon patient request.

CHIPRA and SB 83 are in agreement on the need for more information. But SB83's language suggests that ASHRA will utilize data as a sanctioning mechanism rather than as an equitable evaluation tool.

SB83 introduces a new set of utilization review standards, *in addition to* all those already in place in the state.

SB83's reforms apply only to public sector employees and their dependents. No mention is made of community rating, exclusion of pre-existing conditions, or a standard claims form.

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

FOR IMMEDIATE RELEASE:
January 9, 1992

Contact: Harlan Knudson
Juneau 586-1790

A coalition of Alaska physicians and health care facilities has proposed a reform packages aimed at providing universal health coverage in the state.

The Health Access & Cost Containment Council, which includes representatives of the Alaska State Medical Association and the Alaska State Hospital & Nursing Home Association, has been working on the reform package for almost a year. Its proposal was unveiled today before the state's Health Resources and Access Task Force meeting in Juneau.

"We feel this plan offers Alaskans what they need most -- accessible, affordable, basic health insurance coverage," said Dr. Jennifer Christian, Anchorage, co-chair of the council.

"This proposal makes the uninsured, underinsured and uninsurable its first priority; other proposals have no concrete provision for uninsured Alaskans," said Dr. Christian.

Key parts of the Comprehensive Health Insurance and Payment Reform Act of 1992 (or CHIPRA) are formation of a reimbursement and benefits review commission to review fees charged by physicians, hospitals and other health providers.

The physicians' plan would be open to Alaskans with pre-existing conditions, and for all businesses employing three or more people. CHIPRA provides a basic plan for all Alaskans, enabling employers to build on the plan to maintain current levels of

(More)

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coverage if they are higher than the basic plan. CHIPRA provides affordable insurance to small businesses as an essential ingredient of true health system reform. Eligibility would be based on qualifications for the Permanent Fund Dividend.

Funding for this pool would come from individual contributions, a portion of the Permanent Fund Dividend based on income, sales taxes on products associated with a high risk of disease or injury, and contributions from insurance companies and other providers.

CHIPRA promotes preventive care by fully covering routine preventive care, such as well baby check-ups.

The bill would require hospitals to have a single price or charge schedule for all patients, CHIPRA and otherwise.

Other parts of the proposal include an annual hospital price review, and a medical liability reform package which incorporates alternative dispute resolutions, expedited medical malpractice settlements and other concepts which have been introduced in national reform proposals. It streamlines claims processing by creation of both a single claim form to be used statewide, and a central claims clearing house.

"It's important to realize that, in order to arrive at this proposal, all of those in the arena of health care had to give up something," said Dr. Christian. "Hospitals and physicians will submit to control of the rates they may charge, and limit rate increases to consumer price index levels or face penalties; employers may have some additional costs. Community rather than employee group-rating will be required of insurance companies."

"But the end result is well worth it, and we hope that by seeking compromises from everyone, we have a workable package that will be approved by the Legislature."



Health Insurance Association of America

April 8, 1991

Senator Drue Pearce
Chairperson, Senate Labor and Commerce Committee
Alaska State Senate
P.O. Box V
State Capitol
Juneau, Alaska 99811

By facsimile

Dear Senator Pearce:

Gordon Evans has relayed to me your request for HIAA input on the impact of several proposed amendments to SB 83. HIAA is opposed to SB 83 and we do not believe the proposed amendments improve the bill, in fact several of the proposed amendments intensifies our opposition toward the bill. The following is our interpretation of the impact of the proposed amendments. The working draft dated March 19 was used as the basis of the areas to be discussed.

1. Page 1, lines 6-7 Phased-in geographic specific health care provider reimbursement systems and utilization standards.

HIAA is unable to give you the specific dates for each of the phased-in geographic regions, and the impact on the different Alaskan regions. The impact on the provider communities would be best obtained from the provider organizations themselves. However, the impact on the insurance companies which would be required to use these systems for their Alaskan policyholders would be substantial. Each insurance company has invested millions of dollars in their own systems. Requiring an Alaskan-unique reimbursement and utilization systems to be implemented will require major modifications to the various systems resulting in substantial financial investments.

2. Page 5 lines 6-12 Components that the reimbursement systems must include as a minimum.

Subsections (A), (B), (C), (D) and (G) are all part of the proposed Medicare Resource-based Relative Value System (RBRVS). To the best of our knowledge subsections (E)--availability of the services modifier--and (F) uncompensated care net cost are not included in the program being developed by HCFA. The creation of an Alaskan-unique system, i.e. variation from the Medicare RBRVS will further delay the implementation time, not only for the Authority but also for insurance companies which will be required to modify their computer reimbursement and utilization systems. A minimum of 12 months will be required for the modifications once

the Authority develops the system and disseminates the information. This time frame may well be inadequate for many small and medium sized companies. The RBRVS has 7,000 different procedures for which values must be assessed. If these are to vary by geographic regions this will require multiplying the 7,000 procedures by the number of different regions. We are still uninformed as to the number of geographic regions Medicare plans to have nationwide, let alone the number of regions planned for Alaska, either by HCFA or by the Authority.

I believe the intent of SB 83 is to set rates and utilization standards for all health care providers, not just physicians and hospitals. The RBRVS does not cover providers other than physicians. If the Authority is to set rates for allied health practitioners, i.e., chiropractors, dentists, podiatrists, psychologists, etc. this will take additional time and an immense effort by the Authority staff.

The RBRVS is supposed to begin phased-in implementation as of January 1, 1992. The five-year phased-in approach is based on phasing in the Medicare fee schedule from the current payment system over a period of time to soften the impact of the different reimbursement approach. The phase-in is not based on geography, i.e. urban areas before rural areas. The final regulations were expected to be published in the Federal Register on April 1. As of the date of this letter the regulations were not published. In addition, the Physician Payment Review Commission annual report to Congress was also supposed to be available by April 1 as it is to^{be} based on the final regulations. This report has also not been released. For additional information on the RBRVS and Physician Payment Review Commission I have attached a copy of an HIAA 1990 descriptive bulletin to our members.

3. Page 5, line 31 The Authority's authority to design and procure or provide a basic health insurance program.

There are major negative implications of making the Authority's authority additive by allowing it to design and procure or provide a basic health insurance program for employers who elect to participate and (1) who have 50 or fewer full-time employees; (2) have been refused coverage by two or more health insurance carriers within the past 12 months; and (changing to or) (3) have not provided health insurance coverage to their employees in the past 12 months. The additive effect makes the Authority's area of responsibility all that more encompassing as any one of the three conditions need to be met rather than all three as originally proposed. This puts the Authority in direct competition with the private insurance market.

The purpose of SB 242, HIAA's small group market reform proposal is to assure that small employers will no longer be denied access to coverage. With SB 242 no employer, even those

Senator Drue Pearce
April 9, 1991
Page 3

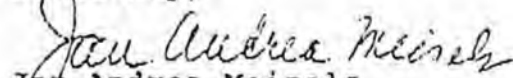
with high risk employees would be denied access to the private insurance market. Under Section 21.55.120 guaranteed issue carriers would insure these higher risk groups and would have a private not-for-profit reinsurance mechanism standing behind it. Any small employer group who went to a non-guaranteed issue carrier, and it did not want to insure the group, they are required to provide the employer with the list of the guaranteed-issue carriers, produced by the board of the Small Employer Health Reinsurance Association (section 21.55.030). Nationally, two-third's of the uninsured are employed by or are a dependent of someone employed by an employer with 25 or fewer full-time employees. We would assume this would be the same or greater for Alaska. SB 242 is structured for employers with 25 or fewer employees. To keep the cost of these small employer plans affordable, SB 242 includes various provisions for rate bands allowing for specific maximum variance from the individual insurance company's midpoint as well as variances between industries and year-to-year increases (section 21.55.050). To further make the health plans affordable SB 242 also includes various cost containment provisions, including a provision allowing the plans not to include any state imposed mandated coverages or provider except for those included in the Act; and prevents any impediments to managed care components within the small employer health plan.

4. Page 9 lines 19-21. Legislative affirmation prior to the Authority becoming the provider of insurance.

We are encouraged by the amendment requiring the legislature to affirmatively approve any proposal by the Authority prior to its becoming the provider of insurance. However, the concept of the state becoming the insurer is one we strongly oppose whether or not the legislature gives prior approval. We strongly believe the private insurance sector can do a better job than another state bureaucracy to provide accessible, affordable, quality, health coverage to the people of Alaska. SB 242 is the better vehicle to achieve that objective.

I hope these comments are of assistance to you. If I may be of any further assistance please do not hesitate to contact me.

Sincerely,


Jan Andrea Meisels
State Affairs Associate

JAM/bhs

cc: Gordon Evans

attachment



Health Insurance Association of America

INSURANCE, MANAGED CARE AND PROVIDER RELATIONS BULLETIN

#2-90 - March 23, 1990

MEDICAL RELATIONS

PHYSICIAN PAYMENT REFORM LEGISLATION

SUMMARY

As part of the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239), Congress enacted comprehensive reform of Medicare physician payment. The reform includes four components that are interrelated both politically and substantively.

- o Medicare's reasonable charge method of determining payment amounts will be replaced by a resource-based fee schedule in 1992.
- o To provide financial protection to beneficiaries, the cumbersome and complex system of maximum actual allowable charge (MAAC) limits will be replaced by a uniform charge limit that is a percentage of the fee schedule amount.
- o The fee schedule conversion factor, which attaches dollar amounts to relative values, will be updated on the basis of Medicare Volume Performances Standards (MVPS).
- o Finally, the legislation created a program for research on effectiveness of medical services and development and dissemination of practice guidelines and a new Agency for Health Care Policy and Research (AHCPR) to administer it.