ALASKA LEGISLATURE COMMITTEE FILES 1991-1992 8672
7536 SENATE LABOR & COMMERCE

MEDICARE FEE SCHEDULE

In January 1992, the Medicare program will begin to replace the current payment system that bases fees on what physicians charge with a fee schedule that reflects the resources used in efficiently providing services to patients. That policy is intended to realign payments that, under a charge-based system, have come to overvalue most surgical and technical procedures relative to visits and consultations. Over a five-year transition period, the fee schedule will play an increasingly important role in determining what physicians are paid.

Relative Value Scale

The relative value scale (RVS) indicates the value of each service relative to other services. The RVS is translated into a schedule of fees when it is multiplied by a dollar conversion factor and a geographic adjustment factor that indicates how fees should vary from one locality to another. The fee schedule does not include specialty differentials.

The resource basis of the Medicare Fee Schedule is embodied in the relative value scale. The RVS will have three cost components: "physician work" that reflects the time and intensity of the physician's effort in providing a service; a "practice expense" that includes costs such as office rent, salaries, equipment and supplies; and "malpractice" that reflects professional liability premium expenses. While the proportion of a relative value represented by each component varies by service, on average physician work accounts for slightly more than half the relative value.

Coding

When physicians submit claims for payment from the Medicare program, they use a system of codes to describe the services they provided. The use of these codes by both the Medicare carriers who process the claims and physicians who file them has varied widely. Differences in the interpretation of codes theoretically can be accommodated under the current charge-based system since it is possible for fees to vary to reflect those differences. But a fee schedule places different requirements on the coding system. With a single relative value assigned to each service nationally, coding definitions must be standardized and widely understood so that codes are applied uniformly by all who use them.

Two areas that have been particularly problematic are standardizing coding policies for surgical procedures and clarifying the definitions of codes used for physician visits and consultations. The legislation recognizes the need for coding reform by calling for HHS to develop a uniform coding system. It specifies that payment for surgical procedures should reflect a global service definition that encompasses pre- and post-operative services. It also instructs HHS to establish a coding structure for visits and consultations that allows for accurate assignment

of relative values, especially with regard to time spent, in the fee schedule. Within this framework, Congress has left the design of the coding policies to HHS, directing the Department to consult with the Physician Payment Review Commission (PPRC).

In addition to analyzing data from the Hasio study and conducting its own survey of physicians, the PPRC has relied heavily on consensus panels of surgeons and medical directors of Medicare carriers, to develop recommendations for coding reform. Over the next year, it will continue its work to apply that definition to each surgical procedure and to assign relative work values that accurately reflect the policy.

Recently, the PPRC, in collaboration with the American Medical Association, began a consensus process involving physicians, insurers, other health professionals and consumers to take up the issues raised in the legislation about reforming the coding system for office visits and consultation. The Commission expects to draw on this work in consulting with HHS and in developing recommendations to Congress.

Transition to the Medicare Fee Schedule

The legislation calls for a five-year transition from the current payment system to the Medicare Fee Schedule, the first step of which is particularly significant. Fees for services in a locality whose 1991 payments, as defined by the legislation, are within 15 percent of the fee schedule will shift to the fee schedule amounts in that first step.

For services whose payments do not move to the fee schedule in the first year, the remaining differences between their recognized payment amounts during the transition and the fee schedule amount will be reduced by 25 percent in 1993, 33 percent in 1994 and 50 percent in 1995. In 1996, all payments will be based on the fee schedule.

Conversion Factor

In the first year of the transition, the conversion factor is to be set so that estimated expenditures under the fee schedule for 1992 equal estimates of what expenditures would have been if the current payment system had continued. Assumptions made about physicians' responses to these changes will be a key factor in determining what the conversion factor will be. The research upon which to make these assumptions is limited. Available studies do suggest, however, that the impact on physicians from both increases and reductions in fees will be partially offset by changes in the volume of services.

In subsequent years, the fee schedule will be adjusted for inflation and other factors through annual updates. The Medicare Volume Performance Standard policy described below outlines the factors to be considered and the process for updating fees.

BENEFICIARY FINANCIAL PROTECTION

Medicare has always allowed physicians to charge patients more than the approved Medicare payment amount--often called "balance billing." The payment reform legislation continues that policy, while placing stricter and clearer limits on what physicians can charge. The policy standardizes the percentage by which charges can exceed the fee schedule amount, replacing a complicated system of physician-specific charge limits know as maximum allowable actual charges (MAACs). In 1991, physicians will no longer be able to charge patients more than 125 percent of the Medicare fee. This will decline to 120 percent in 1992 and 115 percent in 1993 and thereafter.

This policy is expected to reduce the number and size of balance bills substantially.

MEDICARE VOLUME PERFORMANCE STANDARDS (MVPS)

The MVPS policy is the major component of the payment reform to address the problem of aggregate costs. The fee schedule conversion factor will be updated on the basis of how expenditure increases compared to a previously determined goal. This policy draws heavily on the expenditure target (ET) proposal developed by the PPRC.

MVPS policy expresses Congress' determination to slow the growth of expenditures to an affordable rate. By basing fee updates on how expenditure growth compares to a target, the medical profession is given a collective incentive to constrain costs. While these incentives are not intended to influence the decisions of individual practitioners directly, they are likely to spur physician organizations, such as the American Medical Association, national specialty societies, and state medical associations, to focus on cost containment.

The MVPS will be the federal government's principal tool to control aggregate spending on physician services in Medicare. Once a specific target for the rate of increase in expenditures is adopted, fee increases two years later will be adjusted up or down. The ability to set a target does not imply long-term control over costs, however. If expenditure growth is slowed more through reduced fee updates than through slower growth in service volume, the increasing divergence between Medicare fee levels and those of private insurers could limit the federal government's ability to control growth in spending without compromises of access to care.

The specifics of the MVPS policy are complex because Congress decided to leave very little discretion to HHS in the implementation of the policy. The legislation calls for the Congress to make annual decisions on the performance standard (the target rate of increase in expenditures) and on the conversion factor update. But leaving these decisions to Congress requires provisions about concerning what will happen if Congress does not

act. Thus, the legislation contains a series of formulas that HHS will use to determine the standard and the update if Congress does not specify it each year.

While those who drafted the legislation envision that Congress will act each year, the default formulas are very important. First, they signal Congress' current thinking about the appropriate level of the performance standard and how the subsequent conversion factor update will depend on it. Second, the presence of a default option will influence deliberations as various parties weigh potential options in comparison to the default formulas.

A number of significant decisions about MVPS were left for the future. One concerns whether there should be subnational performance standards and updates. The legislation takes a step in this direction by calling for HHS to recommend a separate standard each year for surgery, but the default formulas specify only national standards and updates. A separate performance standard has a theoretical advantage of providing additional impetus to surgical specialty societies to contain costs, but it risks causing the relative values between surgery and other services to diverge from the resource basis of the fee schedule. In addition, the ability to set differential performance standards in an objective manner is questionable. While the legislation provides an avenue to move to subnational performance standards based on type of service, the key decisions will be made in 1990 or 1991.

Performance standards could be set at the state level as well. State standards would emphasize the role of state-level organizations.

RESEARCH AND DISSEMINATION TO IMPROVE CLINICAL PRACTICE

The third component of the payment reform legislation expanded federal support and dissemination of health care research. It established the Agency for Health Care Policy and Research (AHCPR) and gave it a broad charge to conduct and support research on the quality, appropriateness, effectiveness and cost of health care services, and to use the results of this research to promote improvements in clinical practice and in the organization, financing and delivery of health care services.

The new agency, a component of the Public Health Service that reports directly to the Secretary of Health and Human Services, assumes the responsibilities of the National Center for Health Services Research and Health Care Technology Assessment (NCHSR), which was abolished. While many of the programs are similar to those carried out by NCHSR, the scope is greater, the funding higher and the emphasis different. Effectiveness and outcomes research are more prominent, and there is a specific program to develop and analyze large clinical data bases such as those generated through Medicare claims. There is much greater emphasis on disseminating information generated through research on

clinical practice, especially a program to develop and disseminate practice guidelines, clinical standards, review criteria and performance measures. The attached bulletin describes in detail the new agency's activities.

IMPLICATIONS OF THE REFORM

If the payment reform were to be described in one phrase, it might be "rationalization" of fee-for-service practice. The fee schedule seeks to rationalize the pattern of payment by making incentives to physicians more neutral. For example, physicians now have financial incentives to perform procedures rather than to provide evaluation and management services and to specialize in the more procedurally-oriented components of medicine. With payment based on relative resources, physicians do not have an economic incentive to go in one direction or the other.

Effectiveness and outcomes research generate a second force to rationalize care. As understanding of effective and appropriate practice increases, it can be translated into medical practice guidelines. While most physicians will respond to this opportunity to improve their practices, education will be reinforced by utilization and quality review using improved criteria. Utilization review will also provide a financial incentive to eliminate medically unnecessary or inappropriate services. Volume performance standards provide the government some measure of control over outlays and give the medical profession a collective incentive to take steps to increase the appropriateness of medical practice.

The reform attempts to enable fee-for-service medicine to continue by diminishing its tendency to significantly increase costs. Rather than engineer a 180-degree change in incentives to physicians, as capitation for all Medicare beneficiaries would, the reform seeks to stimulate increased professional activity to define efficient medical practice and encourage physicians to practice that way. Administrative activities, such as utilization review, are used as reinforcement.

While the orientation of the reform is toward improving fee-for-service care, it does not discourage alternative delivery systems, such as HMOs, which will continue to compete with fee-for-service and benefit from the effectiveness research and practice guidelines. The competition between fee-for-service and HMO payment will continue, based on factors such as which sector can do a better job of controlling costs in a manner that satisfies both patients and physicians.

While some believe that the reform provisions are revolutionary, many aspects of the policy are logical extensions of policy changes enacted over the past five years. For example, departures form charge-based relative values began in 1986 with reductions in payment for cataract surgery. Restrictions on physician charges began in 1984 when charges were frozen along with Medicare payments.

Basing fee updates on comparisons of expenditure increases with what is judged affordable has been pursued on an ad hoc basis ever since. A number of specialty societies have developed and disseminated practice guidelines. The payment reform policy builds on these relatively fragmented efforts by combining them and pursuing them with greater determination and purpose.

Implementation of these policies over the next few years will require effort as well as further policy decisions. While major decisions about fee schedule have been made, much analysis remains to be done, MVPS policy is the least developed. Congress will not only have to confront issues such as subnational targets but is likely to hear disparate advice from private payers concerning how MVPS affects them and whether the fee schedule and MVPS should apply to their payment policies.

Cost shifting to private insurers is likely to occur. However, its impact may not be severe because insurers will be able to anticipate the phase-in of the RBRVS system by adopting parts of the relative value scale or the whole package, and tightening utilization review and management programs by using practice guidelines to define and identify appropriate care for policyholders.

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For further information, contact:

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(202) 223-7836

GORDON EVANS

SB 83/HB 71 - State Health Insurance Pool. Introduced 1/23 by Duncan and Zharoff, SB 83 is intended to implement recommendations of the Health Care Cost Containment Task Force (HB 71, the House version, was introduced on 1/24 by Representative Boyer and Navarre). The bill would create an Alaska State Health Resources Authority to provide the "lowest cost comprehensive health insurance" on a group basis, report annually on its activities, and review certificates of need for new or expanded health facilities.

The legislation would:

1. Create an independent state corporation, the Alaska State Health Resources Authority, with a board of nine members appointed by the Governor with at least one but no more than two members representing: the executive branch, labor organizations, school districts, municipalities, private sector employers and health care providers;

2. Require the authority to establish mandatory "health care provider reimbursement system and utilization standards" for the state, municipalities, and school districts by July 1, 1992;

3. Require the authority, "no earlier than July 1, 1992," to establish a group health insurance pool to provide health insurance to eligible employees of the state, a municipality, or a school district if the employer has elected to participate; the authority may provide health insurance to other (private) employers if they elect to participate and use the reimbursement and utilization standards; and

4. Require that if the state, municipality, district or other employer elects to participate in the group insurance coverage, then it must continue to participate unless a waiver is granted by the authority; a waiver may be granted if the employer can document by a time certain that it can match the "minimum benefit and financial standards set by the authority."

The intent of the legislation is to address a significant problem faced by many employers, including municipalities - the growing cost of health care and insurance for their employees. The Task Force, as stated in its draft report, found that:

- Health care expenditures in Alaska have increased 157.2 percent over the last 10 years, the second highest in the nation.

- The health care expenditures portion of the State of Alaska budget is the fastest-growing component of the whole budget, $385.5 million in FY 90 and, at this pace, will exceed $2 billion in FY 95.

- The number of uninsured residents in Alaska has increased at an alarming rate to an estimated 90,000 uninsured residents, representing 16.5 percent of the total population in Alaska.

- The cost of providing health coverage for state employees and their dependents has been reduced and stabilized at $385.00 for FY 90 and 91.

Some concerns:

1. **Mandatory payment and utilization schedules:** Although participation in the health insurance pool is not required, use of payment and utilization schedules for medical procedures, etc. set by the authority is. This means presumably that the state will provide a list of doctors, hospitals, and insurers which agree to the rates set by the state. If you use one of these for medical services, you will be fully reimbursed up to the limits of your coverage. The legislation does speak to setting the rates based on "geographic regions, actual provider costs and availability of service."

Even with the estimated potential of 135,000 employees, is the pool large enough to affect the cost of care? Are there enough health care providers to make them want to participate?

2. **Alternatives:** What is the impact on municipalities and their ability to negotiate with a private insurer if the rates are set by the state but they elect not to participate in the state system? How does the system set up in the legislation affect collective bargaining? Will the "minimum benefit and financial standards" negotiated meet the needs and the budgets of all potential employers that do or want to participate, using the current state health benefits as an example?

3. **Representation:** Why does the definition of "employer" include "a collective bargaining unit"? The legislation states that the Board of the authority shall be made up of representatives of the executive branch, municipalities, school districts etc. but it does not specify "employers" versus "employees."

4. **Getting out of the pool:** What is the timeline to "match" the state program when applying for a waiver? Can an employer get an "apples to apples" quote? Should there not be the provision (added to the legislation last year at our request) to at least allow an employer to get out of the pool if it could no longer provide <u>any</u> health care benefit?

HIAA

ON HEALTH CARE FINANCING FOR ALL AMERICANS

HOW REINSURANCE WORKS

For more than two years, the Health Insurance Association of America (HIAA) has been developing the components of a reform package designed to address the unique requirements of the small employer market. These reforms, when taken as a whole, will ensure fair access to and continuation of coverage for small employers and their employees. These reforms constitute a meaningful basis for enhancing and expanding health care coverage.

Small employers, unlike their larger counterparts, are likely to go into and out of business frequently. Similarly, their employees tend to move from job to job frequently. Finally, small employers change insurance carriers more often in an attempt to obtain more favorable rates. All of these factors, combined with growing health care cost pressures, make it exceedingly difficult for insurance carriers to provide coverage to the small employer and they also make it more likely that individuals within this market will lose health care coverage at some point. HIAA's small employer market reforms tackle these problems in a reasonable and workable manner.

The HIAA proposal would ensure that any small employer may obtain coverage (regardless of the health condition of its employees or the inherent administrative burdens they pose). The following examples illustrate how this would work.

SITUATION: Tom's Tree Trimmers opens for business with a full-time work force of five employees. With workers engaged in dangerous work, where statistics suggest that personal injury is far more likely to occur than in, say, a computer sales and repair outlet, obtaining affordable health insurance may be difficult. Let us suppose that two employees, Harry and Sam, have serious health problems, which insurance companies term **pre-existing conditions**. To obtain coverage, the president of Tom's Tree Trimmers could face the following options: terminate Harry's and Sam's employment, insure everyone except Harry and Sam, or provide no insurance for any of the employees.

SOLUTION: Under the HIAA reform proposal, Tom's Tree Trimmers would not be excluded from coverage because it is engaged in dangerous work or because two of its employees, Harry and Sam, have pre-existing conditions. Also, the carrier selling insurance to the company would be permitted to reinsure Harry and Sam, the high risk employees (unbeknownst to Harry, Sam, and their employer), by paying a reinsurance premium. In exchange for the reinsurance premium, the reinsurer would agree to reimburse the insurer for Harry's and Sam's costs.

SITUATION: During the course of the year a third employee at Tom's Tree Trimmers, George, becomes seriously ill. Will his condition threaten coverage for himself or his coworkers?

Health Insurance Association of America

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SOLUTION: Under HIAA's reform proposal, insurance coverage would be maintained for all employees, regardless of any of the employees' conditions. Tom's Tree Trimmers' insurance carrier would be obligated to renew the contract (unless the company failed to pay its premiums in a timely fashion or was dishonest with the carrier).

SITUATION: George, who has had several months of poor health, is on the road to recovery. He decides to leave Tom's Tree Trimmers to gain experience at a small computer sales and repair outlet, the Corner Computer Company. He is concerned that he will not be able to obtain coverage with his new employer because of his health record with Tom's Tree Trimmers. He is aware that, prior to the reforms in the small employer market, employees who changed jobs or employers that changed carriers could face recurring pre-existing condition limitations. George realizes that this could leave him without health care coverage.

SOLUTION: Under the HIAA proposal, George would be guaranteed continuity of coverage and would not be subject to any new pre-existing condition limitations if he changes jobs or his employer switches carriers, since he satisfied those while employed by Tom's Tree Trimmers (this assumes that George did not allow his coverage to lapse for a sustained period of time).

SITUATION: Both Tom's Tree Trimmers and the Corner Computer Company are concerned that their health premiums will rise inordinately if one or more employees is found to be seriously ill.

SOLUTION: Under the HIAA proposal, an insurance carrier would have to limit how much its rates, based upon the group's health history, varied. Carriers could vary their rates for similar small employer groups (those with similar demographics, plan type, and geographic area) by no more than 35 percent above or below their midpoint rate (the midpoint rate is halfway between the carriers lowest and highest rate). Carriers would also have to limit their industry rating adjustment to 15 percent. Finally, the year-to-year premium increase for a group could be no more than 15 percent above the carriers "trend" (defined as the increase in the lowest new business rate). To reflect cost differentials between managed care and non-managed care products, carriers could establish separate trends.

SITUATION: A new firm, Tree Doctors, Inc., opens for business in the same community as Tom's Tree Trimmers. Like its competitor, Tree Doctors employs five employees. At the time it opens for business, all of its employees are healthy. The president of Tree Doctors, Inc. knows that he is in stiff competition with Tom's Tree Trimmers. He is concerned that he may be at a competitive disadvantage if any of his costs are higher than those of Tom's Tree Trimmers. Since Tom's Tree Trimmers has been in business for some time, the owner of Tree Doctors, Inc. is concerned that he may not be able to purchase health insurance coverage at a rate that will be similar to the rates charged to his competitor.

SOLUTION: Under the HIAA proposal, the availability of reinsurance combined with the premium rate limits would moderate the premium difference between groups. The HIAA plan would ensure that Tree Doctors, Inc. did not incur inordinately high premiums relative to demographically similar firms.

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SIMPLIFIED NUMERICAL RATING LIMIT ILLUSTRATIONS

Year 1990

(1) **Typical Employer**[1] - Carrier XYZ is selling a health plan to a typical employer at a midpoint premium rate which amounts to $200 per month, per employee (i.e., this figure would be an average of the premiums for some single persons and some families). The employer pays, on average, 80 percent of the premium ($160); the employee pays 20 percent of the premium ($40).

Low Risk Employer - While a second employer has similar demographic, area and industrial composition as the typical employer, it has, on, average a very low health risk. Because the employer is low risk, Carrier XYZ agrees to sell coverage at a rate which is 35 percent below the midpoint rate of $200 per employee. In this instance, the health plan would cost $130 per month, per employee. Of this amount, 80 percent ($104) is contributed by the employer and 20 percent ($26) is contributed by the employee.

(3) **High Risk Employer** - A third employer has demographic, area, and industrial compositions similar to the above employers but has a very high medical risk. Carrier XYZ may charge this employer no more than $270 per month, per employee for the same health plan (35 percent above the midpoint rate of $200). Of this amount, $216 (80 percent) is contributed by the employer and $54 (20 percent) is contributed by the employee.

Year 1991

Assumption: Carrier XYZ's "trend" (the percentage increase in their lowest new business rate[2] from 1990 to 1991) is 12 percent.

(4) **Typical Employer** - Although the typical employer's workforce remained the same, a number of employees became seriously ill during 1990 and submitted major claims. From 1990 to 1991, carrier XYZ may increase the typical employer's rates by no more than 15 percent above "trend." Therefore, the rate charged to the typical employer in 1991 would be nc more than $254 per employee (12 percent+15 percent above the midpoint rate of $200). Of this amount, $51 is contributed by the employee and $203 is contributed by the employer.

(5) **High Risk Employer** - While the high risk employer's workforce also remained the same, several additional employees became seriously ill and submitted major claims. Since the high risk employer is already at the top of carrier XYZ's rating limit, XYZ can increase the high risk employer's rates by no more than the trend. Therefore, the rate charged to the high risk employer in 1991 could be no more than $302 per month, per employee for the health plan (35 percent above the group's 1991 mid-point rate of $224), which amounts to an increase from 1990 to 1991 of no more than trend (12 percent). Of this amount, $60 is contributed by the employee and $242 is contributed by the employer

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[1] By "typical" we mean a small employer group that does not contain an unusually large number of cases with high or low medical risk. For example, a small employer group that has been covered by a carrier for several years is often going to be a typical employer. On the other hand, a small employer group that is newly covered is more apt to be considered low risk since in the first year or so health plan costs are often lower (due to preexisting condition limits, for example).

[2] This is believed the best measure of a carrier's general yearly increase in premiums.

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October 1990

HEALTH SERVICES COST REVIEW COMMISSION
4201 PATTERSON AVENUE—2ND FLOOR—BALTIMORE, MARYLAND 21215
AREA CODE 301-764-2605
FAX-301-764-5987

February 15, 1991

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

Dear Jan:

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

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

Sincerely,

John M. Colmers
Executive Director

enc.

generalkmeisels

THE AMERICAN HOSPITAL ASSOCIATION

AHA Hospital Statistics

A Comprehensive Summary of U.S. Hospitals

1990-1991

AHA

Table

5C (Continued) Alaska

Utilization, Personnel, and Finances in States

Excludes AHA nonregistered hospitals (see Table 14, page 230).

CLASSIFICATION	HOSPITALS	BEDS	ADMISSIONS	INPATIENT DAYS	ADJUSTED PATIENT DAYS	OCCUPANCY, percent	AVERAGE DAILY CENSUS	ADJUSTED AVERAGE DAILY CENSUS	AVERAGE STAY, days	SURGICAL OPERATIONS	OUTPATIENT VISITS			NEWBORNS	
											Emergency	Other	Total	Bassinets	Births
ALASKA	27	1,932	57,630	399,539		52.4	1,012			37,224	220,076	1,024,160	1,244,236	207	10,537
6-24 beds	6	110	2,567	14,883		36.4	40			1,459	13,750	75,315	89,065	25	52
25-49	8	274	6,712	46,161		46.0	126			2,714	32,517	138,493	171,010	33	1,35
50-99	8	551	18,536	100,622		50.1	275			9,628	85,067	516,172	601,239	69	3,07
100-199	3	419	11,272	100,734		65.9	276			11,004	29,808	219,074	248,882	33	2,04
200-299	1	238	6,210	31,614		36.6	87			5,314	24,253	43,294	67,547	18	1,32
300-399	1	340	12,303	75,619		60.9	207			7,075	34,681	31,812	66,493	24	2,24
400-499	0	0	0	0		00.0	0			0	0	0	0	0	0
500 or more	0	0	0	0		00.0	0			0	0	0	0	0	0
Psychiatric	3	274	2,147	67,185		67.2	184			0	831	6,295	7,126	0	0
Hospitals	3	274	2,147	67,185		67.2	184			0	831	6,295	7,126	0	0
Institutions for mentally retarded	0	0	0	0		00.0	0			0	0	0	0	0	0
General	24	1,658	55,483	332,448		49.9	828			37,224	219,245	1,017,865	1,237,110	207	10,53
Hospitals	24	1,658	55,483	332,448		49.9	828			37,224	219,245	1,017,865	1,237,110	207	10,53
Hospital units of institutions	0	0	0	0		00.0	0			0	0	0	0	0	0
TB and other respiratory diseases	0	0	0	0		00.0	0			0	0	0	0	0	0
Obstetrics and gynecology	0	0	0	0		00.0	0			0	0	0	0	0	0
Eye, ear, nose, and throat	0	0	0	0		00.0	0			0	0	0	0	0	0
Rehabilitation	0	0	0	0		00.0	0			0	0	0	0	0	0
Orthopedic	0	0	0	0		00.0	0			0	0	0	0	0	0
Chronic disease	0	0	0	0		00.0	0			0	0	0	0	0	0
All other	0	0	0	0		00.0	0			0	0	0	0	0	0
Federal	7	395	16,712	77,299		53.4	211			10,801	67,243	726,861	814,104	74	3,088
Psychiatric	0	0	0	0		00.0	0			0	0	0	0	0	0
General and other special	7	395	16,712	77,299		53.4	211			10,801	67,243	726,861	814,104	74	3,088
Nonfederal	20	1,537	40,918	297,334		52.5	801			26,423	132,833	297,299	430,132	133	7,447
Psychiatric	3	274	2,147	67,185		67.2	184			0	831	6,295	7,126	0	0
Hospitals	3	274	2,147	67,185		67.2	184			0	831	6,295	7,126	0	0
Institutions for mentally retarded	0	0	0	0		00.0	0			0	0	0	0	0	0
TB and other respiratory diseases	0	0	0	0		00.0	0			0	0	0	0	0	0
Long term general and other special	0	0	0	0		00.0	0			0	0	0	0	0	0
Short-term general and other special	17	1,263	38,771	225,149		48.9	617			26,423	132,002	291,004	423,006	133	7,447
Hospital units of institutions	0	0	0	0		00.0	0			0	0	0	0	0	0
Community hospitals*	17	1,263	38,771	225,149	310,393	48.9	617	850	5.8	26,423	132,002	291,004	423,006	133	7,447
6-24 beds	4	80	1,157	10,665	16,939	36.3	29	46	9.2	915	3,462	15,574	19,036	18	336
25-49	5	209	5,019	36,926	61,926	48.3	101	171	7.4	1,820	19,634	57,319	76,953	37	1,114
50-99	6	275	9,458	48,825	69,454	48.7	134	190	5.8	4,300	37,002	50,975	87,977	25	1,309
100-199	1	121	5,584	29,500	30,839	48.8	59	84	3.9	6,398	17,970	92,050	110,020	18	1,119
200-299	1	238	6,210	31,614	38,414	36.6	87	105	5.1	5,314	24,253	43,294	67,547	18	1,325
300-339	1	340	12,303	75,619	92,871	60.9	207	254	6.1	7,075	34,681	31,812	66,493	24	2,244
400-499	0	0	0	0	0	00.0	0	0	0.0	0	0	0	0	0	0
500 or more	0	0	0	0	0	00.0	0	0	0.0	0	0	0	0	0	0
Nongovernment not-for-profit	5	780	26,836	156,136	218,930	54.9	426	599	5.8	18,389	92,534	211,740	304,274	75	5,070
Investor-owned (for profit)	1	238	6,210	31,614	38,414	36.6	87	105	5.1	5,314	24,253	43,294	67,547	18	1,325
State and local government	8	245	5,725	37,399	53,049	41.6	107	146	6.5	2,720	15,215	35,970	51,185	40	1,052

(See Table 44 through 60, pages 14 through 17.)

Table 5C (Continued) Alaska

CLASSIFICATION	FULL-TIME EQUIVALENT PERSONNEL					FULL-TIME EQUIVALENT TRAINEES			EXPENSES						
									LABOR				TOTAL		
	Physicians and Dentists	Registered Nurses	Licensed Practical Nurses	Other Salaried Personnel	Total Personnel	Medical and Dental Residents	Other Trainees	Total Trainees	Payroll (in thousands)	Employee Benefits (in thousands)	Total (in thousands)	Percent of Total	Amount (in thousands)	Adjusted, per Admission	Adjusted, per Inpatient Day
ALASKA	256	1,851	217	4,390	6,314	7	15	22	$ 213,275	$ 42,665	$ 255,940	57.3	$ 446,996		
6-24 beds	27	70	13	282	392	3	0	3	10,171	1,851	12,023	60.7	19,796		
25-49	26	186	23	585	810	1	0	1	23,646	4,539	28,185	59.2	47,637		
50-99	123	357	94	1,438	2,012	2	0	2	58,196	10,560	68,756	64.0	107,396		
100-199	79	371	31	833	1,314	0	15	15	51,055	9,971	61,026	65.8	92,697		
200-299	1	127	30	330	488	1	0	1	23,486	5,015	28,501	42.5	66,997		
300-399	0	360	26	912	1,298	0	0	0	46,721	10,728	57,449	51.1	112,464		
400-499	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
500 or more	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
Psychiatric	10	105	7	360	492	0	0	0	14,498	4,215	18,713	61.9	30,238		
Hospitals	10	105	7	360	482	0	0	0	14,498	4,215	18,713	61.9	30,238		
Institutions for mentally retarded	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
General	246	1,346	210	4,030	5,832	7	15	22	198,777	38,450	237,227	56.9	416,748		
Hospitals	246	1,346	210	4,030	5,832	7	15	22	198,777	38,450	237,227	56.9	416,748		
Hospital units of institutions	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
TB and other respiratory diseases	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
Obstetrics and gynecology	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
Eye, ear, nose, and throat	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
Rehabilitation	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
Orthopedic	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
Chronic disease	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
All other	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
Federal	218	404	83	1,437	2,142	5	15	20	67,533	10,099	77,632	72.1	107,629		
Psychiatric	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
General and other special	218	404	83	1,437	2,142	5	15	20	67,533	10,099	77,632	72.1	107,629		
Nonfederal	38	1,047	134	2,953	4,172	2	0	2	145,742	32,566	178,307	52.5	339,357		
Psychiatric	10	105	7	360	482	0	0	0	14,498	4,215	18,713	61.9	30,238		
Hospitals	10	105	7	350	487	0	0	0	14,498	4,215	18,713	61.9	30,238		
Institutions for mentally retarded	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
TB and other respiratory diseases	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
Long term general and other special	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
Short term general and other special	28	942	127	2,593	3,690	2	0	2	131,244	28,351	159,595	51.6	309,119		
Hospital units of institutions	0	0	0	0	0	0	0	0	0	0	0	0.0	0		
Community hospitals*	28	942	127	2,593	3,690	2	0	2	131,244	28,351	159,595	51.6	309,119	$5,858.53	$ 995.90
6-24 beds	0	41	7	130	178	0	0	0	5,207	1,021	6,228	57.4	10,856	5,687.19	640.89
25-49	7	127	18	279	531	1	0	1	16,464	3,549	20,013	56.4	35,483	4,437.05	573.06
50-99	20	375	34	550	779	0	0	0	22,529	4,485	27,014	55.1	49,008	4,007.51	705.62
100-199	0	112	12	292	416	0	0	0	16,807	3,553	20,360	59.4	34,307	4,282.57	1,112.46
200-299	1	127	30	330	488	1	0	1	23,486	5,015	28,501	42.5	66,997	8,678.47	1,744.08
300-399	0	360	26	912	1,298	0	0	0	46,721	10,728	57,449	51.1	112,464	7,429.25	1,711.62
400-499	0	0	0	0	0	0	0	0	0	0	0	0.0	0	0.00	0.00
500 or more	0	0	0	0	0	0	0	0	0	0	0	0.0	0	0.00	0.00
Nongovernment not-for-profit	27	710	65	1,876	2,678	1	0	1	90,674	19,616	110,290	53.6	205,720	5,563.90	939.66
Investor owned (for-profit)	1	127	30	330	488	1	0	1	23,486	5,015	28,501	42.5	66,997	8,678.47	1,744.08
State and local government	0	195	32	387	524	0	0	0	17,084	3,719	20,804	57.1	36,403	4,415.68	686.21

*For information on community hospitals that includes nursing home-type data, refer to Hospital Units columns in tables 4A through 4D, pages 14 through 17.

(continued on next page)

HEALTH SERVICES COST REVIEW COMMISSION
4201 PATTERSON AVENUE—2ND FLOOR—BALTIMORE, MARYLAND 21215
AREA CODE 301-764-2605
FAX-301-764-5987

For further information call: * For release 1:30 p.m.

John M. Colmers * February 6, 1991

PRESS RELEASE

For the fifteenth consecutive year, the cost of a hospital admission in Maryland rose at a rate below the national average, according to Charles O. Fisher, Sr., Chairman of the Health Services Cost Review Commission, the state agency that regulates hospital rates.

The Commission's Annual Disclosure revealed that cost per admission rose 8.70% in Maryland last year, while the national average was 8.96%. Based on these figures, Marylanders saved an estimated $5.3 million in hospital costs in 1990.

Chairman Fisher noted that in 1976 the cost of an admission to a Maryland hospital was more than 25% above the national average, and that in 1990 it was 8.11% below the national average. (See Chart 1). Since the cost per admission in Maryland has not risen at the national rate since 1976, the increased cost to Marylanders would have been approximately 34% or $1.1 billion in 1990 alone.

While hospital costs per admission rose 8.7%, hospital charges per admission rose 10.04%. Hospitals' uncompensated care rose in 1990 from approximately $246 million or 7.8% of revenue to $271.9 million or 7.7% of revenue. (See Chart 2).

Hospital profits decreased from $78.3 million in 1989 to $67.0 million in 1990. (See Chart 3). Nineteen hospitals (Memorial at Cumberland, Key Medical Center, Franklin Square, Frederick, GBMC, Good Samaritan, Harbor Medical Center, Holy Cross, Johns Hopkins, Johns Hopkins Oncology, Peninsula General, Physician Memorial, Sacred Heart, St. Agnes, St. Joseph's, Sinai, Suburban, University and Washington Adventist) had profits exceeding $2,000,000, while two hospitals (Homewood Medical Center and AMI Doctors Hospital) had losses exceeding $2 million. In total, 42 acute hospitals showed profits while 12 hospitals posted losses.

Mr. Fisher noted the Commission's continued monitoring of the financial condition of Maryland hospitals. Hospital profits fell slightly despite an increase in revenue per admission of 10.04% compared to an 8.24% increase in revenue per admission the previous year. Simultaneous with the release of this disclosure statement, the Commission released the second annual report measuring hospital financial and operating characteristics relative to industry-wide standards. This report was developed through a cooperative effort of the Commission, the hospitals, third party payers, and the business community. Mr. Fisher renewed the commitment on the part of the Commission to continue to adjust the rate setting system as circumstances warrant. The Commission modified the rate system last year by tying continued growth to the ability of the system to match the rate of growth in hospital costs nationally. Mr. Fisher, an attorney from Westminster said, "The success of hospital rate setting in Maryland is the result of the continued commitment on the part of all the participants to the goals of cost containment, stability, and financial access. Our ability to continue this program will depend on the joint response of the Commission, the hospitals, and the payers to respond to the challenges of continued cost containment, particularly for

Medicare cases."

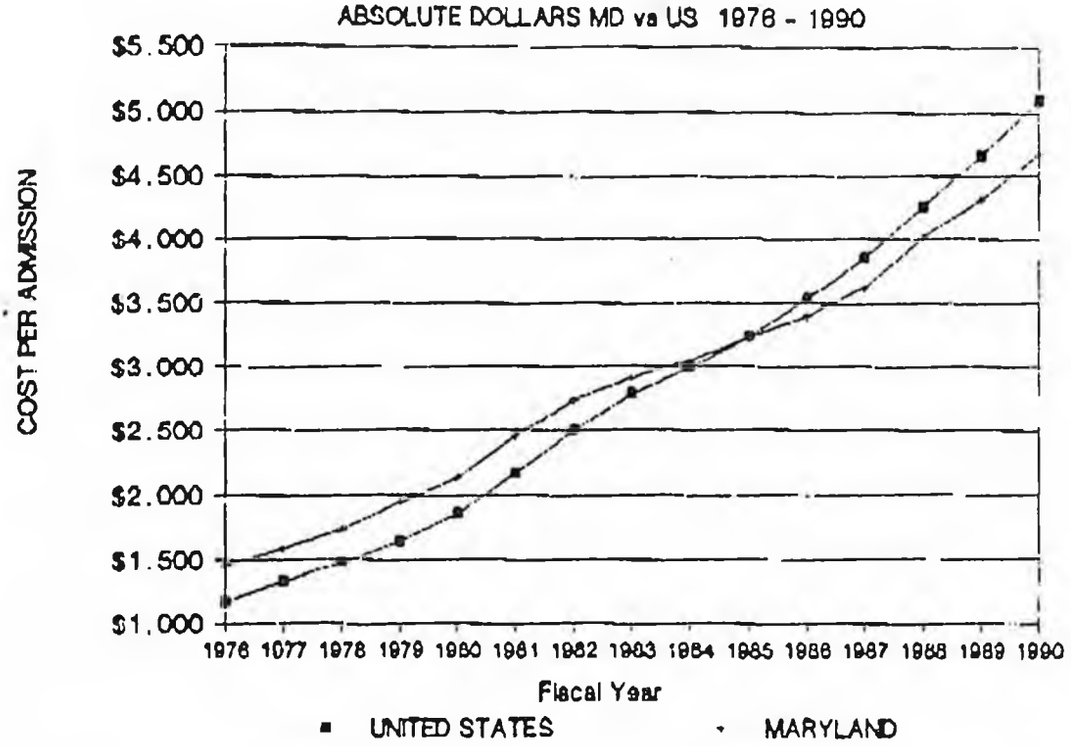
Net patient revenue increased by 11.53% as the combined result of a 1.00% increase in the number of admissions, the increase in the charge per admission, the change in case mix, and a growth in outpatient activity. There was also a slight increase in equivalent patient days of 84,695 or 1.9%.

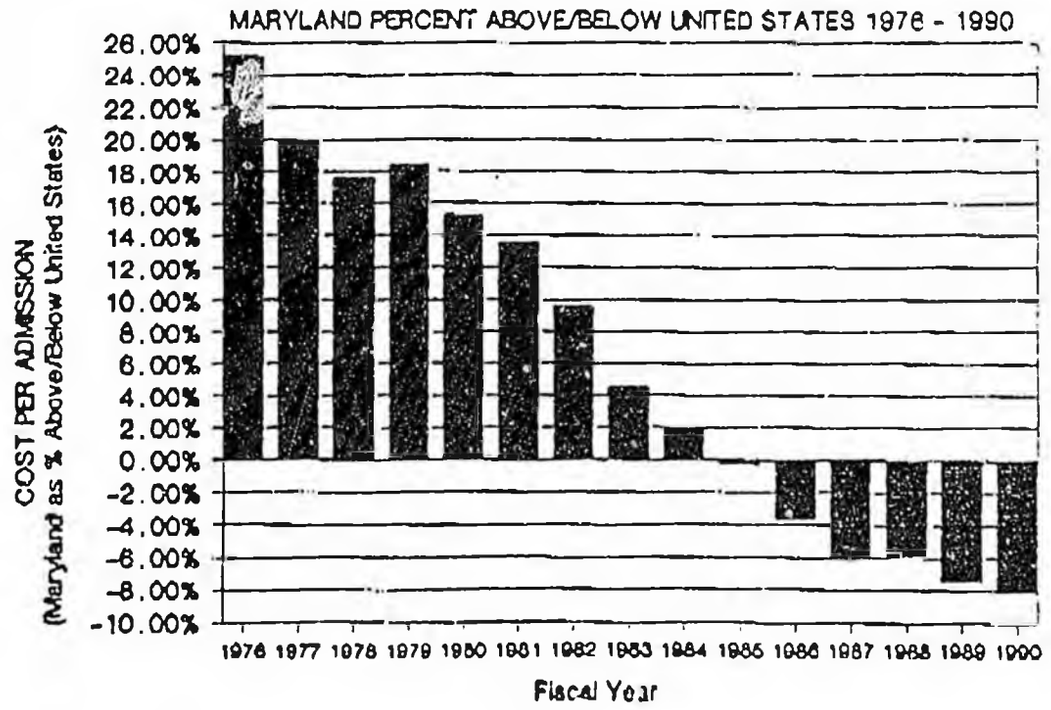
Hospital uncompensated care increased in absolute terms but decreased in relative terms in FY 1990. Total hospital uncompensated care rose to $271.9 million, an increase of 10.51% over the previous year. This represents 7.72% of gross patient revenue, a slight decrease from the 7.79% experienced the previous year.

Mr. Fisher concluded by noting that while Maryland's cost per admission has fallen from 25% above the national average to 8.11% below the national average, there is no reason to be complacent. Hospitals are facing increasing pressures that lead to increased costs. These can only be controlled by the continuation of the cooperative effort associated with Maryland's hospital regulatory structure coupled with increased involvement by business and labor, the ultimate payers.

The Commission expects to face continued challenges as it attempts to balance the legitimate needs of Maryland hospitals with the actions necessary to maintain the all payer system and its inherent equity and financial access.

CHART 1
COMPARISON - COST PER ADMISSION

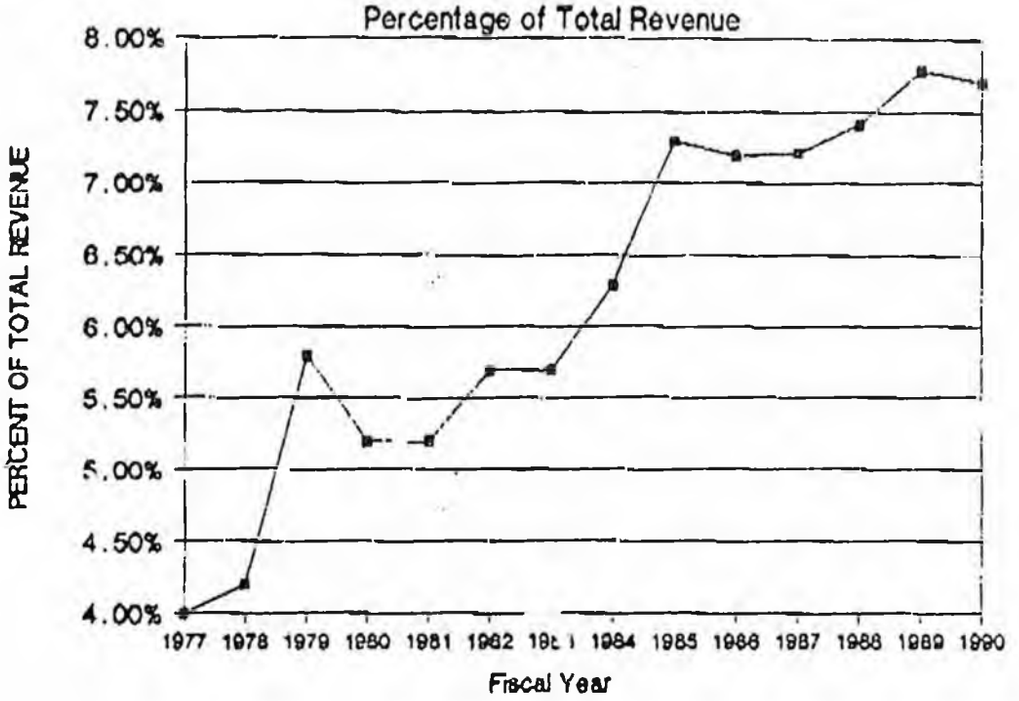


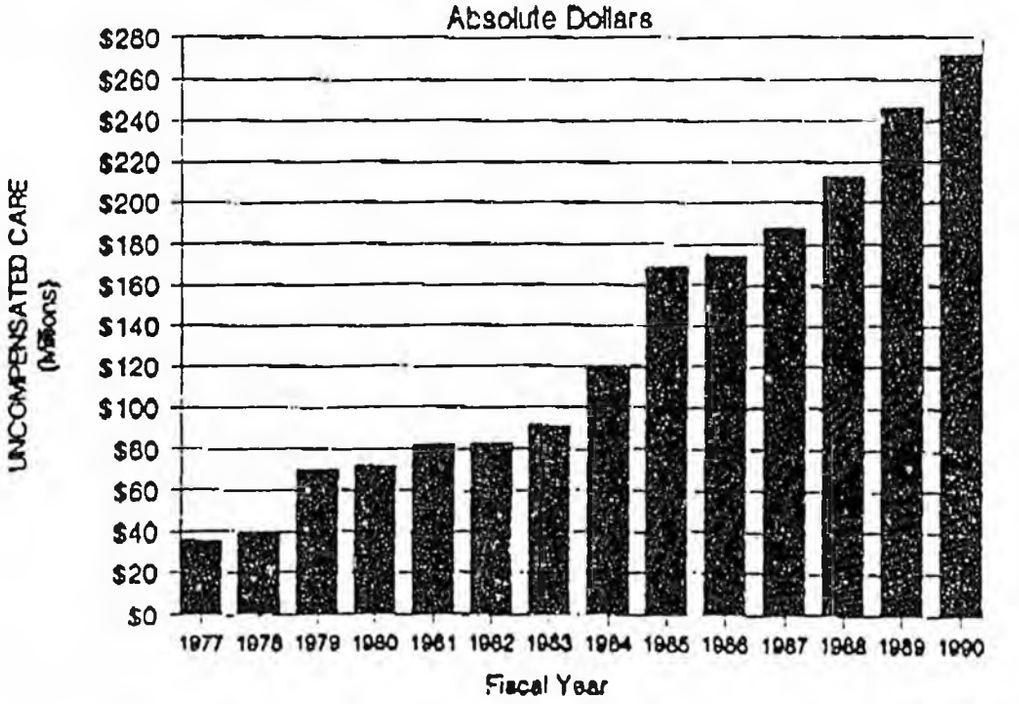


Source HSCRC Annual Disclosure Reports

CHART 2

UNCOMPENSATED CARE
MARYLAND HOSPITALS 1977 - 1990

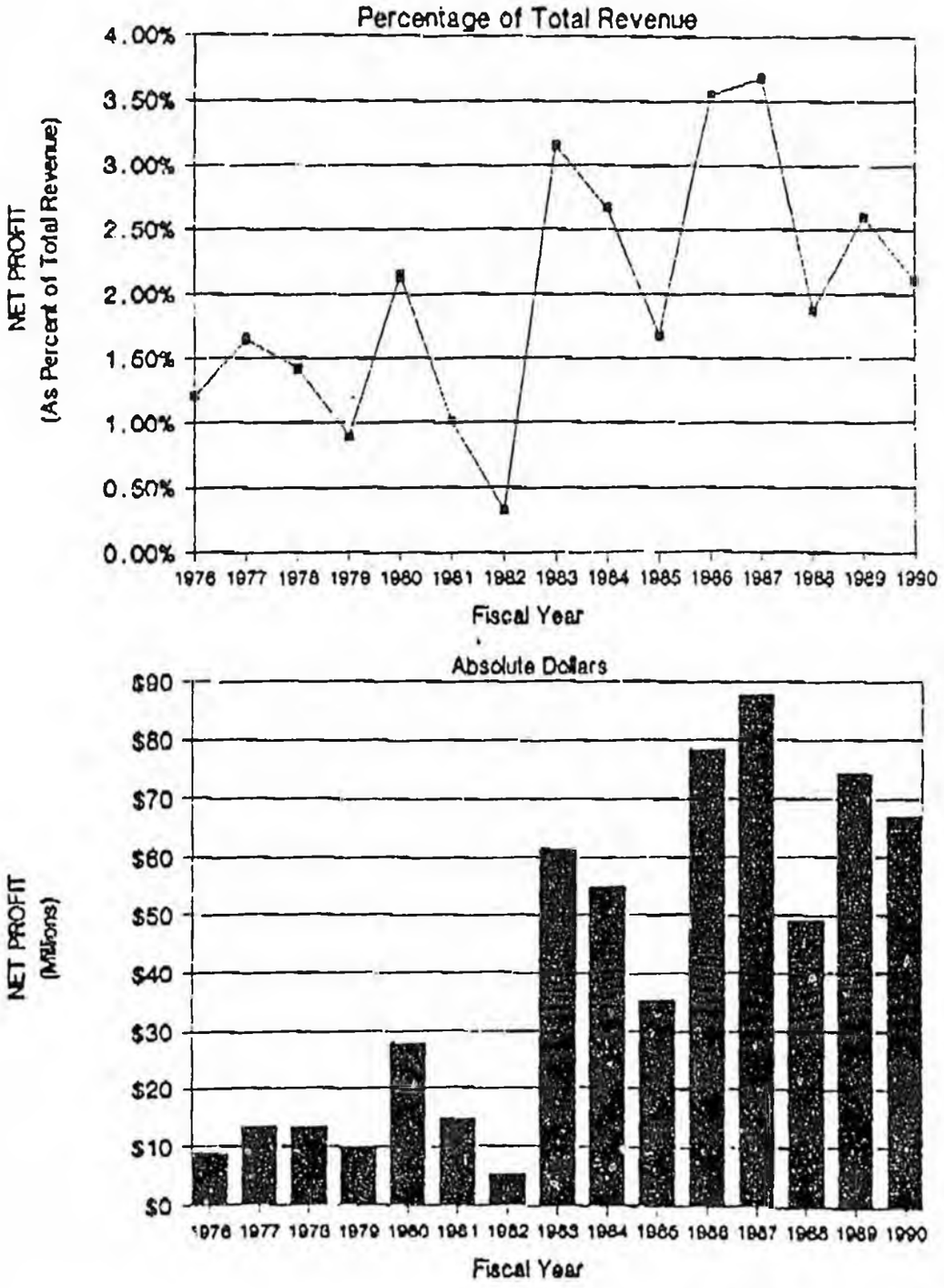




Source HSCRC Annual Disclosure Reports

CHART 3

NET PROFITS
MARYLAND HOSPITALS 1976 - 1990



Source HSCRC Annual Disclosure Reports

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

March 22, 1991

Senator Drue Pearce
P.O. Box V
Juneau, Alaska 99811

Dear Senator Pearce:

In preparation for the hearing on SB 83 at 3:30 p.m. Friday, March 22, Senator Duncan has been good enough to share with us his proposed committee substitute bill dated March 19.

Hospitals greatly appreciate Senator Duncan's attempt to work with them, and the efforts in the proposed committee substitute bill to provide a more timely process to the implementation of a hospital/physician rate system.

We still have these concerns with SB 83 and the proposed committee substitute:

1. Insurance pooling is needed now, not in 1993. It should be administered by the Division of Insurance, provide coverage for the uninsurable, as well as individuals and small employers, and a basic health plan should be adopted that reduces health insurance costs.

2. SB 83, and the proposed committee substitute, provides a major buyer of health care the right to set the rates they will pay for that care. This will save money for public employees, but increase costs (through cost shifting) to other buyers of health care.

3. The certificate of needs provisions in CSSB 83 are unnecessary, duplicate the work of the Department of Health & Social Services, and will add to the time and cost it takes a facility to receive the CON.

4. There is still no realistic fiscal note on CSSB 83. The Medicaid Rate Advisory Commission, setting rates for less than 30 hospitals and nursing homes spends over $600,000 per year.

Enacting insurance pooling legislation this session will deal with the issue of the uninsurable and those without insurance. It will take the best efforts of the Task Force on Health Care Resources and Access (SCR 10) to bring us equitable and realistic solutions to controlling health care costs for all Alaskans.

Sincerely,

Harlan R. Knudson
President/CEO

319 SEWARD STREET #11 • JUNEAU, AK 99801 • (907) 586-1790 • FAX (907) 463-3573

ALASKA STATE
HOSPITAL & NURSING HOME
ASSOCIATION

Rod

March 15, 1991

Senator Drue Pearce, Chair
Senate Labor & Commerce Committee
Attn: Rod Mourant
P.O. Box V
Juneau, AK 99811

Dear Senator Pearce:

We greatly appreciate the early notice of the hearing on SB 83, creating the Alaska Health Care Authority for 3:30 p.m. Friday, March 22.

Hospitals in the following communities would appreciate being included in the teleconference: Soldotna, Cordova, Fairbanks, Dillingham, Ketchikan, Kodiak, Anchorage, Seward, Sitka, Homer, Valdez, Wrangell.

This Association continues to seriously question whether or not SB 83 will have a positive impact on controlling health care costs. We believe you will hear from health providors and businesses that the results will more than likely be the shifting of public employee health costs to the other buyers of health care.

Another concern is the administrative and legal costs of a state reimbursement system. We are hopeful there will be a hard look at the fiscal note for SB 83 on March 22. We are asking Senator Collins to help in requesting data from the Department of Health & Social Services on the cost of administering the Medicaid Rate Advisory Commission. The 1992 budget request is over $700,000 and that does not include the cost of several lawsuits and the appeals process.

Thank you very much for your very careful review of this very major piece of health care legislation.

Sincerely,

Harlan R. Knudson
President/CEO

P.S. This Association has spent close to $100,000.00 during the past eighteen months in a lawsuit with the Department over a very arbitrary cap on long term care rates by the Medicaid Rate Advisory Commission.

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ALASKA STATE
HOSPITAL & NURSING HOME
ASSOCIATION

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

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

Introduction:

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

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

Hospital concerns with the task force and its recommended legislation:

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

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

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

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

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

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

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

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

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

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

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

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

* They recommend creation of a Health Resources and Access Task Force -- a group drawn from a broad representation of interests that would delve more thoroughly into the issue of health care costs and access.
* They bring a cross-section of Alaskans, including legislators, members of the administration, health consumers, private employers, health care providers and organized labor to the table to resolve a major issue facing every state in the nation -- controlling costs while assuring all citizens access to care.

# # #

ALASKA STATE
HOSPITAL & NURSING HOME
ASSOCIATION

February 22, 1991

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

RE: SB 83

Dear Senator Pearce:

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

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

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

Sincerely,

Harlan R. Knudson
President/CEO

HRK/ma

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Ray Gillespie
Gillespie & Associates
Lobbying & Governmental Affairs

Reg - fyi
Leep

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November 14, 1990

The Honorable Drue Pearce
Alaska State Senate
3111 "C" Street, Suite 535
Anchorage, Alaska 99503

Re: SB 550, Certification of Utilization Review Providers

Dear ~~Senator Pearce~~ Drue:

As the Task Force begins to draft its report to the legislature, I would like to take this opportunity to share thoughts on certification/accreditation of utilization review providers (SB 550).

As you know, the Task Force has taken testimony from numerous health providers that standardization of utilization review is necessary given the proliferation of review firms. This type of legislation helps ensure that utilization review firms do not unfairly restrict access to medical care, promotes uniformity of review standards, paperwork and procedures with which health care providers must deal, and promotes cooperation between the providers and the review organizations. In addition, legislation such as SB 550 tends to protect the rights of the patient and ensure that private review agents are fully qualified to perform the utilization review. In addition it ensures confidentiality of patient medical records.

At least 10 states have enacted legislation regulating the practice of private utilization review agents. In the past year alone, Georgia, Kentucky, Maryland, Mississippi, South Carolina and Virginia have enacted such legislation. Typically the legislation requires companies conducting utilization review to obtain a certification either from the State Department of Health or the Commissioner of Insurance. Generally, in order to be certified, a utilization review firm must submit certain information to show:

1. the critera and procedures used in evaluating hospital and medical care;

2. the type and qualifications of personnel performing utilization review;

3. procedures and policies ensuring that a private review agent is reasonably accessible to patients and providers during normal business hours;

4. submit policies and procedures ensuring the applicable state and federal laws protecting confidentiality are followed; and

5. procedures that ensures providers may seek reconsideration of adverse decisions.

Please consider this information and the testimony provided to the Task Force concerning the need for utilization review legislation. Should you need other or further information or have questions concerning SB 550, please feel free to call upon me.

Again, we urge the Task Force to seriously consider a favorable recommendation to the Legislature for utilization review legislation such as SB 550.

Sincerely,

Raymond A. Gillespie

NEA-ALASKA

AFFILIATED WITH THE NATIONAL EDUCATION ASSOCIATION

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February 11, 1991

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

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

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

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

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

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

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

Thank you for your consideration of our recommendation.

Respectfully submitted,

Bob Manners
Executive Director

Don Oberg
President

cc: Senator Duncan

ALASKA STATE EMPLOYEES ASSOCIATION

AFSCME Local 52, AFL-CIO

February 11, 1991

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

Dear Senator Duncan:

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

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

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

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

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

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

Respectfully yours,

Buddy Maupin

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

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MANO FREY
Executive President

February 27, 1991

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

Dear Senator Duncan:

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

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

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

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

Yours in Progress,

Mano Frey
President

MAR 14 19

Hi!

I had fun
with this!
Thanks for dinner -
Love you!

John

my doctor

good grief!

fyi -
then keep
hidden

NORTHWEST MEDICAL
PROFESSIONAL CORPORATION
2841 DeBarr Road, Suite 22 • Anchorage, Alaska 99508
Phone: (907) 276-6301

Vernon A. Cates, M.D.
General Practice
John W. Gerster, M.D.
Internal Medicine
Robert D. Hanek, M.D.
Family Practice
Alexandor T. Baskous, M.D.
Family Practice

11-Mar-91

To: Editor, The Anchorage Times

I can't believe it! Senator Jim Duncan has once again demonstrated the short-sightedness of the petty little bureaucratic mind. His idea to solve the increasing costs of medical care is to simply create another commission so that the State Government can set all the rates. Price controls do not work! What, you think milk costs too much? Why, let's just pass a law saying that Carrs cannot charge more than 10¢ a quart. Flying outside is too expensive? We'll just pass a law that Alaska Airlines cannot charge more than 10$ to fly to Seattle. Do you really think that shortly there would be any more milk or airlines in Alaska? Sen. Duncan flunks Economics I: In a free society, prices are determined by costs, not fiat, and health care is no different. East Germany has been the perfect example that government-controlled prices do not work. Can you really imagine the Alaska Legislature, that paragon of fiscal responsibility, knowing more about prices than the free market economy? Health Care is expensive for three reasons: the stratospheric explosion of expensive technology, the boom in malpractice insurance costs, and the perception that everyone is entitled to a perfect outcome. It's a little like the public insisting that every auto manufacturer make only Rolls-Royces and wondering why they are so expensive. We have the best Rolls-Royce of medical care in the world, but no one wants to pay for it. Let us ask the legislature to work on the roots of the problem in meaningful insurance and tort reform, and not embark on this ill-advised experiment in Northland Socialism.

John W. Gerster M.D.

JWG/hs

OLIVER M. KORSHIN, M.D.
6920 CROOKED TREE DRIVE
ANCHORAGE, ALASKA 99516
907-346-1946

MAR 2 8 1991

March 22, 1991

Drue Pearce, Chairman
Senate Labor and Commerce Committee
P.O. Box V
Juneau, Alaska 99811

Dear Senator Pearce:

This is a personal note to accompany my written testimony on SB 83.

Of course I remember that you are a patient of mine. It's been at least two years, and you're due for a follow-up!

A number of us were at a disadvantage at the hearing because Senator Duncan had made major changes to the bill which we could not fully absorb because we had not been aware of them until hearing time. Of course, our prepared testimony was based on the earlier version.

Nonetheless, the revisions, as I understand them, don't alter the fact that the primary purpose of the bill is to establish a fee schedule for health providers and to develop and implement utilization standards. Better minds than Senator Duncan's have tried to do the same and have consistently failed to control rising costs, because rising costs aren't driven by inflation in provider charges, but by other, more potent factors discussed both in the Task Force report and in my testimony.

It's like having an elevator stuck on the top floor of a highrise, and you're on the ground floor trying to get it to come down. You can't find the right button, but the fire alarm is handy, so you pull that. You'll get some immediate and spectacular results—the occupants will flee the building, the sprinklers may go off and the fire engines will arrive, but the elevator will stay on the top floor.

I trust you and the members of the committee have all actually read the Health Care Cost Containment Task Force report. I know you were on the Task Force, so I'm probably treading on thin ice here. It's not just that the report is poorly done, it's *so* poorly done that it's embarrassing. It looks like a high school junior effort at best; it surely doesn't reflect the workings of a powerful intellect or one well-versed on the issues of health care delivery or health economics. But it's done with a word processor on a laser printer, so it's immediately "acceptable," I suppose.

What did the State actually pay its consultant to produce that report? You should ask for your money back, as the product is so flimsy and reflects poorly on the mem-

bership and efforts of the task force. As I said in my testimony, the least prestigious scientific journal would not even consider such a report. As physicians, we are accustomed to much more rigorous presentation and analysis of data than what the Task Force's consultant has produced.

Anyway, I hope the bill is defeated. I'd be grateful for anything you can do to help.

Best regards,

Oliver Korshin

enclosure

TESTIMONY ON SB 83
MARCH 22, 1991

OLIVER M. KORSHIN, M.D.
ANCHORAGE, ALASKA

I'm an ophthalmologist engaged in solo private practice here in Anchorage for the last five years. Prior to that, I worked 17 years for the U. S. Public Health Service; eleven of those years I spent as a medical care administrator, part of that time in the Medicare program. So I'm intimately familiar with the workings of the health care bureaucracy, both from the bureaucrat's and provider's standpoint. I'm also representing the Alaska State Medical Association today. So that I don't keep you in suspense, I am here to tell you that Alaska's physicians oppose SB 83, and request it be defeated.

Now, to take a step in a positive direction, I must also tell you that Alaska's physicians are committed to help solving the problem of ensuring access to health care for all Alaskans. We are equally committed to help find ways to reduce health care costs and maximize effectiveness of health care dollars.

We do not believe that SB 83 adequately addresses either of these broad commitments. Specific proposals which do deal with them will be presented at the end of this testimony.

SB 83 is based in large measure on the Health Care Cost Containment Task Force Report of February 1991. So, to discuss SB 83, one must first review the Task Force report. The report identifies a number of "contributing factors" to health care cost inflation, but its underlying thesis, completely unsupported by hard data, is that the principal cause of the inflation is spiralling provider charges. SB 83 consequently proposes a reduction of those charges as the principal method of controlling health care expenditures. It also proposes, without saying how, to establish "utilization standards" to reduce the volume of services.

The report itself is so poorly done that it is difficult to critique without redoing all the work. The sources of the data are not referenced, the questionnaires used are not shown, the response rates to the questionnaires are not given, nor is the statistical methodology of projecting the alarmist costs for the year 2000 described. *As*

these projections are central to the plan's conclusions, and therefore to the raison d'être *for SB 83, it is imperative that the methodology used be fully revealed and completely justified.* To all appearances, the projections seem to have been made by simply taking the very latest rate of increase and assuming that this will hold unabated for the next ten years. That is rather like projecting that the Dow Jones Average will hit 17,910 by December 31 because it was 2900 on January 1 and rose 18% in January alone.

These simplistic cost projections are presented with all the calculated zeal of a burglar alarm salesman trying to frighten homeowners into buying a home security system by reciting residential crime figures. One four-point graph even purports to project health care expenditures in Alaska in 2000 "without ASHRA[1] " and with the "impact of ASHRA," as if a health authority that doesn't even exist yet, whose bureaucratic complexities and costs have not yet even been determined, much less projected forward nine years, were a mathematical variable that can be factored into an equation or a graph, or as if ASHRA were some sort of secret toothpaste ingredient that will make teeth "twice as white." Finally, a few obligatory and lackluster testimonials from interested constituent groups and organizations are appended supporting the Task Force's mission.

No medical journal would accept such a poorly done article purporting that a given treatment is effective for a given disease. And the legislature shouldn't buy SB 83's "cure" for containing health costs based on this Task Force report. It would be like buying "Engine Overhaul in a Can" based on ad copy in a J. C. Whitney catalogue.

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 playing a serious game of catch-up with respect to the rest of the country in order to create the medical-technological infrastructure taken for granted elsewhere in the United States during those decades. This meant building coronary and intensive care units, developing an adequate emergency medical services and transport system, building newborn and pediatric intensive care units, acquiring CT scanners and so on. 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 lots of money right away to improve it. So of course lots of money was spent, and it *should* have been spent—Alaska was medically unde-

[1] Alaska State Health Resources Authority

veloped territory. These expenditures severely skewed the Alaska cost increase curve and make comparison with other states, which started from a more sophisticated infrastructure, a precarious affair. This skewing is not automatically bad—it's just a reality of what it costs to cease being a medical backwater of Seattle.

One of most important significant developments in health care costs in Alaska, however, is almost glossed over by the report: namely, that $20 million was saved in 1990-91 for state employee health expenditures *without any legislation at all and without the development of a huge state bureaucracy.* This was probably done by effective care management and preadmission review—by now accepted modes of controlling costs. Yet the report fails to take this decrease into consideration in making its alarmist extrapolations about state employee health costs in the year 2000. In fact, using the report's simplistic projection methodology of taking the very latest percentage increase in rates and projecting it linearly forward to 2000, the $20 million savings would result in *lower* costs in 2000 than in 1990. At any rate, the report's authors chose to downplay both the savings and their implications, because they don't harmonize with their preconceptions that doctors and hospitals are the main culprits for the health care cost crisis.

And the report gives only lip service to the other factors impinging on health care cost increases, even though these overshadow by far the effect of provider charges. Ever-growing expectations and demands for the instant availability of high-tech medicine, coupled with spiralling technology; the problem of the *overinsured,* the malpractice/defensive medicine issue; the fact that huge resources are spent during the first and last few weeks of life; the massive health care expenditures mandated by the AIDS and cocaine epidemics—these are all given only perfunctory attention.

Finally, the Task Force report is so full of grammatical and punctuation errors, verbatim repetition of entire paragraphs, misspellings and so on, that it raises the question of the author's depth of preparation and underlying competence to buttress facts in support of a coherent thesis. Substantial state funds were apparently spent to hire someone, supposedly an expert in the field of health care delivery and health economics, who had many months to devote to the report's preparation and writing. The report's almost juvenile quality makes us wonder at the care and skill employed in researching and analyzing the data on which the report's conclusions are based.

Now to the bill: SB 83 does not even address the problems the Task Force identified as those of highest priority, and instead concentrates on reducing fees and creating

utilization standards. Regarding the paramount question of the uninsured and underinsured, the bill proposes merely to "evaluate the need" for health insurance for these individuals. This is surprising, as the report loudly protests that the ranks of these unfortunate people have jumped from 40,000 or 50,000 to 90,000 in a few short years. So it's clear that this issue is only being used as a smoke screen—the bill's authors really aren't concerned with the uninsured or underinsured right now. They wish to protect the job perks of their constituents—the *overinsured* state employees.

SB 83 places the burden of cost control exclusively on the shoulders of providers, with no provision to restrict or reduce consumer demand by streamlining benefits, increasing deductibles or co-insurance rates. In other words, it doesn't address at all the problems of *overinsurance.* It looks like a bill to protect the Cadillac benefits, 1960's-level deductibles and minimal co-insurance rates of state employes, who appear to be the principal constituents of the bill's authors, as well as the bill's principal beneficiaries.

Despite all the lip service given in the report to improving access, the bill utterly fails to propose anything at all in this regard. It is, as we said, silent on the issue of the uninsured except to "evaluate" their needs. It would seem that 90,000 uninsured or underinsured Alaskans constitute the real crisis, not whether state employees can continue to have $100 deductible health insurance policies, be hospitalized for 30 days to break their cigarette habit (or their kid's habit), or get one pair of eyeglasses a year whether or not they need them.

Despite the report's stated interest in reducing cost-shifting, SB 83 will exacerbate the problem, and it will further erode the continued access and quality of care by jeopardizing hospitals' ability to operate or even to remain open, in the case of Alaska's smaller hospitals.

Despite the report's reference to the importance of controlling the costs of defensive medicine—estimated by some authorities to constitute as much as *one-third* of all health care costs—SB 83 proposes nothing in the way of tort reform. Some providers are paying more than $100,000 a year for professional liability insurance; defensive medicine intensifies throughout the medical community with each huge judgement or settlement, and the spiral of medical costs continues upwards.

Now to get to the heart of the bill—the fixing of provider charges and the establishment of "utilization standards." Any careful historical analysis of the estab-

lishment of fee schedules reveals almost nothing but failures. In fact, 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. I refer you to the work of Alain Enthoven and other eminent health economists. And the establishment, maintenance and revision of a fee schedule is a complex and costly undertaking, requiring a sizeable bureaucracy. Many refinements and exceptions will be necessary. Reviews, denials and appeals will have to be dealt with, and this doesn't take into account what will be needed if the state actually starts writing its own insurance—an option provided by SB 83.

Regarding the establishment and implementation of utilization standards, what does this really mean? First, there *are* no generally accepted standards—medicine is not an exact science. Second, assuming that such standards do exist, or can be defined by 1992, then a bureaucracy must be established and hired to implement and enforce these standards. Such a bureaucracy must obtain the services of skilled individuals, possessing at least a nursing degree. And legitimate exceptions to standards *always* arise, and with great frequency: the patient with hypertension is "allowed" three visits a year to the doctor, but this particular patient has an unusual and uncontrollable form of hypertension, and needs monthly visits. A hospital stay must be extended because of complications. A way to obtain legitimate exceptions to the standard must be available, which predicates creation of a review mechanism. An appeals process must also be established for reviews that are denied, and so on.

All this requires a higher level staff to review the applications for exceptions and the appeals of denials, and this means obtaining the services of general physicians, specialists and even subspecialists. Due process for beneficiaries and providers must be developed and maintained—after all, this is a government program. In short order, a large professional and paralegal bureaucracy will have been established, which, as health economists will point out, often costs more to sustain than whatever savings—if any—may be realized.

When these standards are applied to hospital care, the costs of applying, reviewing, enforcing and modifying them becomes astronomical, as whole patient charts must be abstracted and computerized.

Finally, one of our central criticisms of SB 83 is that it creates a government-run insurance bureau, whether or not the state actually gets into the direct insurance

business of receiving premiums, reviewing claims, making payments and so forth. In 1965 another legislative body, the U. S. Congress, created a government insurance program—Medicare, the crown jewel of the Great Society package of legislation. It established a government agency, called the Bureau of Health Insurance, to establish payment rates, review and control the utilization of services and purchase insurance for its beneficiaries at the lowest possible cost. But not even the Congress made SB 83's mistake of actually giving the government the option to run the insurance program directly—it contracted with private insurance companies, known as fiscal intermediaries, to handle claims and pay out benefits.

Even with the contracting mechanism, the Bureau of Health Insurance had grown so large that within a decade it could no longer be contained within the massive Social Security Administration, and so a new, separate bureaucracy was created—the Health Care Financing Administration (HCFA).

By 1990 HCFA and its various insurance and non-insurance contractors (who perform utilization review and quality of care review functions) had become one the largest, most complex and costliest of all the Federal bureaucracies, and one that is thoroughly loathed by beneficiaries, providers and legislators alike. And costs were not—and still are not—controlled. Nor was the volume of services curtailed, but instead has continued to grow unabated. And all the dollars sunk into this gigantic bureaucracy are no longer available for providing services to patients.

The authorizing legislation for Medicare, HCFA, and the burgeoning mandated utilization review and cost containment mechanisms now occupy thousands of pages, with many more thousands of pages of regulations. The documentation is as complex as the Internal Revenue Code and its regulations. Don't take my word for it—request all the Medicare amendments to Title XVIII of the Social Security Act, and the regulations, wait for the cartons to arrive and see for yourselves. I know firsthand, because my first job as a federal physician in 1968 was as a consultant to the then infant Medicare program, and even then it was a highly complex program which resisted efforts to be effectively administered.

Medicare has proven to be a social, political, bureaucratic and fiscal tar baby for legislators, taxpayers, old people and providers alike. Americans over 65 are now paying a larger percentage of their income on health care than before Medicare existed. Is this what Alaska wants to duplicate? We don't think so. SB 83 will grow (it's already increased from eight to eleven pages in just a few days), and so will the bu-

reaucracy it creates, and it won't reduce the costs of medical care in Alaska by one dime.

SB 83 would ultimately create the same kind of monster, helpless bureaucracy as Medicare. And it's not only that the dead hand of bureaucracy will blight any part of the medical care system it grasps, (think of your last visit to a VA hospital)—it's also a very expensive proposition. The authors of SB 83 haven't yet calculated the costs, or, if they have, they haven't yet shared them with the public. The important difference between SB 83 and Medicare, as far the the Alaska legislature is concerned, is that *you'll* be appropriating money for it, not the federal government, and *you'll* be grappling with it at every legislative session for the next 50 years.

SB 83 is poor legislation based on an almost childishly crafted report, and poor legislation is worse than no legislation. Don't pass it.

Organized medicine in Alaska doesn't support this bill. We don't want to end on such a negative note. So what *do* we support?

- We support establishment of a coherent health care policy for Alaska—we don't have one.

- We support a complete redoing of the Health Care Containment Task Force report based on professional—not amateur—analysis of the health care situation in Alaska, with standardized, above-board and even-handed methodology and with the full cooperation of physicians and hospitals in supplying data. Hire a team of respected health care economists from a leading university or public policy think tank.

- We support watchful analysis and observation of other states' and national proposed solutions to the problem of providing equitable 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—intellectual, fiscal and infrastructure—have been unable as yet to demonstrate a successful solution.

- We support full implementation of those current cost-saving measures which have been demonstrated to reduce cost *without* legislation or the creation of state bureaucracies—measures such as those which have already reduced health care costs for state employees by $20 million in FY 1990 and frozen them in place for FY 1991.

- And finally, we support immediate and concrete measures to deal with Alaska's uninsured and underinsured through the establishment of streamlined benefits packages, care management systems, mandated risk pooling for currently uninsurable individuals and state subsidies of premiums for certain individuals. SB 73 and SB 74, by Senator Kerttula, contain such provisions.

Thank you.

ADDENDUM

When I arrived to give this testimony at the Anchorage Legislative Information Office, Senator Duncan was in the middle of reading a new substitute for the bill, which contained "substantial changes." The substitute was telefaxed to Anchorage about an hour later, and could not be adequately reviewed before the testimony. These changes mostly have to do with (1) stressing the need to contract with a private insurance company before allowing the state to become an insurer; (2) introducing a cost-based methodology for arriving at the fee schedule, (a virtual copy of the as-yet untried Resource Based Relative Value System cost methodology being phased in by Medicare in 1992); and (3) implementing (rather than evaluating the need for) an insurance scheme for the underinsured and uninsured by 1993.

These changes don't alter the basic character of the bill, nor our objections to it. Senator Duncan told the hearing that by these changes he was moving the issue of the uninsured "off the back burner." Perhaps he's moved it to the front of the stove, but it's clearly still on slow simmer.

The "improved" SB 83 now seems to blend old SB 83 with facets of Senator Kerttula's SB 73 and SB 74, which deal exclusively with the underinsured, uninsured and uninsurable and which I support. The result is an unwieldy hybrid or omnibus bill, which, in trying to become all things to all people, will result in an even more complex and unworkable bureaucracy under the auspices of the proposed Health Resources Authority.

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SISTERS OF PROVIDENCE
SERVING IN THE WEST SINCE 1856

March 22,1991

Dear Senator Pearce,

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

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

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

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

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

Sincerely,

Sister Dona Taylor
Administrator

Table 1

Consumer Price Index – Urban Consumers
All Items and Selected Components
U.S. & Alaska

Year	All Items				All Items Less Shelter				Housing		Medical		Food & Beverage	
	U.S. annual average	Percent change	Anchorage annual average	Percent change	U.S. annual average	Percent change	Anchorage annual average	Percent change	U.S. annual average	Anchorage annual average	U.S. annual average	Anchorage annual average	U.S. annual average	Anchorage annual average
1960	29.6		34.4											
1965	31.5	6.4%	35.3	2.6%										
1970	38.8	23.2	41.1	16.4										
1975	53.8	38.7	57.1	38.8										
1980	82.4	53.2	86.5	48.7	82.9		84.7		81.1	85.9	74.9	76.6	88.7	89.7
1981	90.9	10.3	92.4	6.8	91.0	9.8%	92.0	8.6%	90.4	92.5	82.8	86.9	93.6	94.3
1982	96.5	6.2	97.4	5.4	96.2	5.7	96.3	4.7	96.9	98.2	92.5	94.8	97.3	97.2
1983	99.6	3.2	99.2	1.8	99.8	3.7	99.9	3.7	99.5	99.0	100.6	99.7	99.5	99.7
1984	103.9	4.3	103.3	4.1	103.9	4.1	103.8	3.9	103.6	102.7	106.8	105.5	103.2	103.2
1985	107.6	3.6	105.8	2.4	107.0	3.0	107.5	3.6	107.7	103.0	113.5	110.9	105.6	106.2
1986	109.6	1.9	107.8	1.9	108.0	0.9	111.2	3.4	110.9	102.6	122.0	127.8	109.1	110.6
1987	113.6	3.6	108.2	0.4	112.6	3.3	115.1	3.5	114.2	97.5	130.1	137.0	113.5	113.1
1988	118.3	4.1	108.6	0.4	115.9	3.9	117.8	2.3	116.5	95.4	138.6	145.6	118.2	113.8
1989	124.0	4.8	111.7	2.9	121.6	4.9	122.3	3.8	123.0	96.3	149.3	7.0 154.4	7.6 124.9	117.2
1st half 1988	116.8		108.4		114.4		117.0		117.2	95.8	136.5	143.0	116.5	113.5
1st half 1989	122.7	5.1	110.9	2.3	120.4	5.2	121.4	3.6	121.7	95.8	146.3	9.8 153.1	10.1 123.6	116.4
1st half 1990	128.7	4.9	116.9	5.4	126.2	4.8	126.5	4.2	128.6	102.2	159.1	12.8 160.1	7.0 131.0	122.5

Notes: The most current Consumer Price Index data available for Alaska is for the first half of 1990.
For comparability, data for the first half of 1988 and 1989 are given to show the percentage change over the year.

Source: U.S. Department of Labor, Bureau of Labor Statistics.

MAR 2 6 1991
Ales

Alaska State Legislature

SENATOR JIM DUNCAN

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

(907) 465-4766

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

MEMORANDUM

TO: SENATE LABOR AND COMMERCE COMMITTEE MEMBERS

FROM: SENATOR JIM DUNCAN
PRIME SPONSOR SENATE BILL 83

DATE: MARCH 25, 1991

SUBJECT: SENATE BILL 83

Please find attached a letter from Dr. Mike Beirne, M.D. concerning SB 83 and SB 84. I am sure you will recognize Dr. Beirne not only as an Anchorage physician but also as a former legislator.

I wanted you to have this information about a provider and a consumers group supporting the concepts proposed in SB 83.

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

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

3-18-91

Testimony SB 83+84

Dear Senator Duncan,

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

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

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

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

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

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

Sincerely,

Dr. Mike Beirne, M.D.
President

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

APR 2 1991

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

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

Dear Senator Pearce:

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

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

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

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

Very truly yours,

Ronald J. Trevithick

APR 1 6 1991

NORTH SLOPE BOROUGH

OFFICE OF THE MAYOR

P.O. Box 69
Barrow, Alaska 99723

Phone: 907-852-2611

Jeslie Kaleak, Sr., Mayor

April 10, 1991

Senator Drue Pearce
Chairperson, Labor & Commerce Committee
P.O. Box V
Juneau, Alaska 99811-3100

Dear Senator Pearce,

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

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

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

2) **Administration of Coverage**: The legislation is also unclear with regard to who would administer insurance claims. It appears to give the

Health Resources Authority the power to administer claims but it is unlikely this would occur, even if the state elects to self-insure. The state of Alaska has seen several private insurance carriers attempt to maintain local claims processing office. Economics has proved this venture to be a costly undertaking. The metropolitan areas of Anchorage, Fairbanks and Juneau cannot seem to maintain a large enough, or skilled enough, pool of labor to efficiently process a large number of claim transactions. We offer as examples Aetna and Travelers who both found it not cost effective to maintain local claims adjudication offices.

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

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

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

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

4) **Provider Rate Setting**: Experience in six states which utilize a statewide hospital rate setting system (CT, MA, NY, NJ, MD, WA) has shown

that between 1980 and 1989, states with rate setting arrangements have no clear cost advantage over states without rate setting. In fact, in recent years, some rate setting states have experienced growth rates for hospital costs in excess of the national average. For example, in 1988, five out of six rate setting states had growth rates for costs per admission above the national growth rate; in 1989 three of the six states had growth rates 2-6 percent above the national average.

The rate setting system used in Maryland is often cited as one which has been successful at consistently controlling hospital costs. Between 1980 and 1989, Maryland was the only one of the six rate setting states which had a cost per admission growth rate below the national average for every year. However, the spread between Maryland's rate of growth and that for the nation has significantly narrowed in recent years. More importantly, on a per capita basis, in 1988 Maryland had a higher percentage increase in its costs than the average for either the five other regulated states or the national average.

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

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

Because of the vagueness of the definition of "eligible", we are prone to believe that ***adverse selection*** will occur. If the state allows all employer groups or any of their employees to join the pool, only the high risk individuals or groups will elect this coverage. The ramifications of this language will create a pool with a similar demographic cross section to that of COBRA participants. Small employers will act in their own best interest

and sign up their unhealthy (i.e., high risk) employees for the pool when they need coverage and then withdraw them (take them out of the pool, back to their own plan) when they get healthy. Even if coverage is not community rated, this would be a problem since there are no pre-existing exclusions included in this Bill, thus, all could sign up.

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

6) **Definition of Group Health Insurance:** Senate Bill 83 and House Bill 71 define group health insurance as including " life insurance, accidental death and dismemberment, medical care and treatment, dental care, eye care, and other group health coverage as determined by the authority". We are very concerned that these bills do not address life insurance and accidental death and dismemberment coverages when discussing rate setting and administration. The North Slope Borough has better-than-average life and AD&D experience and would undoubtedly see additional benefit cost increases.

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

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

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

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

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

Senator Pearce, we do realize that health care cost containment is one of the primary issues that both the public and private sectors must work together on for solutions. We again acknowledge the hard work the Task Force has put into their report and thank you for including us in your informational search. Please feel free to contact my office if you need clarification of any of our concerns, or have any comments regarding our information.

Sincerely,

Jeslie Kaleak, Sr.
Mayor

cc: Rep. Eileen MacLean
Sen. Al Adam
Sen. Collins, Vice-Chairman L & C
Sen. Eliason
Sen. Halford
Sen. Kerttula

APR 2

3531 West 31st Avenue
Anchorage, Alaska 99517

April 20th, 1991

Senator Drue Pearce
P.O. Box V
Juneau, Alaska 99811

Dear Drue,

As an agent involved in insurance sales, I have almost daily contact with Alaskans who are either unable to afford health insurance or, because of a disqualifying condition, can not get coverage at any price.

It will not be news to you that the health care system in this country is in crisis. Periodically, we hear leaders in the health care and insurance industries (and politicians of all flavors) making noises about doing something about it. To date, I see no progress nor any prospects for progress. The health care providers blame the insurance industry and insurance people blame the medical profession. The pot is kept boiling by union demands and by frequent government action to shift the costs of federal and state health programs to the private sector.

In my opinion, nothing constructive will be achieved until government, medical, insurance, union and business people meet to decide what each can contribute to control the spiralling costs of health care. I believe that unilateral efforts by these parties to solve the problems are doomed to failure.

The National Association of Life Underwriters published a special edition of the Life Association News in February. Its focus is on The Health Care Crisis and I am enclosing a copy for you. I hope you will find it informative.

Sincerely,

Frank Keen

MAY 8 1991

PEDIATRIC CONSULTANTS OF ALASKA, INC.

Clinton B. Lillibridge, M.D., F.A.A.P.

April 21, 1991

Senator Drue Pearce
Chairman
Labor and Commerce Committee
Alaska State Legislature
Pouch V
Juneau, AK 99811

RE: **Senate Bill 83**

Dear Senator Pearce:

Let me tell you why Senate Bill 83 will not provide cost containment.

Approximately 90 percent of my billing is for overhead. My hourly room pay is $15.73. Many other pediatricians, family physicians, and internists have a similar high overhead rate. To regulate costs downward requires reducing salaries for nurses, reducing the amount paid to lawyers, dropping medical liability insurance, not paying rent, or other utilities. NINETY PERCENT OF EVERY DOLLAR PAID TO OFFICES GOES TO THE COMMUNITY. SIMPLY CUTTING PROFESSIONAL FEES WILL HAVE SEVERE EFFECTS THROUGHOUT THE COMMUNITY.

Sincerely,

CLINTON B. LILLIBRIDGE, M.D.
Pediatric Gastroenterologist

CBL/bw

COMMUNITY
CHIROPRACTIC CLINIC

550 EAST TUDOR ROAD
ANCHORAGE, ALASKA 99503
TELEPHONE (907) 562-5366

Dear Senator Pearce,

Again, I would like to thank you for taking the time to visit with us the other day. It was very enjoyable to meet you and we are very happy to support you. Enclosed, please find a couple of pamphlets illustrating the effectiveness and cost effectiveness of Chiropractic versus Medical care for the treatment of musculo-skeletal injuries (the most common type of injury). Also please remember that while Chiropractic is indeed better and cheaper, we also do not expose our patients to the risks of drugs or surgeries. An added benefit of conservative care.

If you have any questions or would like to chat about this a bit, I'll be glad to be available at your convenience.

Hoping you have a successful and enjoyable session.

Most Truly Yours,

David Mulholland D.C.

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE
INFORMATIONAL SURVEY

BACKROUND

This survey is designed to give the Health Care Cost Containment Task Force additional insight into the complexities of health care delivery and associated costs to Alaskans. This information will be supplemented by public testimony from interested parties later this year.

PLEASE DESCRIBE YOUR PRACTICE :

1. Scope and Specialties of your practice: _____
   _____

2. Year started_____

3. Organizational structure (Corp., Sub. S, Non-Profit, etc.)
   _____

4. Total Number Of Employees_____, Full-Time_____,
   Part-Time _____, Seasonal _____, Other _____

5. Your position _____

EMPLOYEE BENEFITS

6. Does your firm offer health insurance to employees and their dependents? _____

6a. If so, of the total number of employees listed above, how many are covered ? _____, Are any groups not covered ? _____

6b. Which categories? (part-time, seasonal, etc.)_____
   _____

7. Is your health plan provided by an insurance company? _____

7a. If so, which company?_____ how long ? _____

EMPLOYEE BENEFITS CONT.

8. How much are your monthly health insurance premiums?

	1990	1985	1980
Single -	$		
Family-	$		

9. How much do your employees pay towards the cost?

Single- $

Family- $

10. Please describe your health plan?

Annual deductible $ _____

Co-payment percentage _____

Lifetime maximum benefit $_____

Chiropractic benefit limit $ _____

Psychiatric benefit $ _____

Substance abuse limit $ _____

Well child care coverage ? _____

Prescription drug card ?_____

Vision care coverage? _____

Dental coverage ? _____

11. Which of the following health care management techniques have you included in your health plan ?

_____ Preferred provider networks

_____ Pre-certification for hospital stays

_____ Pre-admission testing

_____ Outpatient surgeries

__ ___ Utilization review

_____ Benefit plan changes

_____ Others - Please list _____
_____
_____
_____

12. Which of these have been **most effective** in containing your health care costs? _____
_____
_____

13. Which of these have been **least effective** in containing your health care costs?_____
_____
_____

14. What do you think is the biggest contributor to the rapidly rising health care costs in Alaska ?

_____

_____

_____ _____

15. What suggestions do you have for the Task Force that could help slow medical inflation in Alaska? _____

_____

_____

_____

16. What percentage of your practice/service is providing care to :

Medicare Recipients _____
Medicade Recipients _____
State Employees _____
Federal Employees _____
Uninsured/underinsured _____

17a. How much medical care/service did you provide during 1989 for which you were not reimbursed $_____

17b. What percentage is this of your total practice/service_____%

17c. Approximately how has 17a and 17b changed since 1985?

a. +/- _____%
b. +/- _____%

18. How much have your fees/rates increased :

1989 to 1990 _____%
1985 to 1990 _____%
1980 to 1990 _____%

19. What would you say is the major contributor (s)to increases in your cost of providing health care to Alaskans _____

_____

_____

_____

_____

_____

20.. Would you be interested in testifying before the Health Care Cost Containment Task Force on this issue? ____

If so, Please furnish the following information:

NAME:_____

TITLE:__ _____

REPRESENTING:_____

ADDRESS:_____

_____

_____

THANK YOU FOR YOUR TIME AND INFORMATION. PLEASE FORWARD COMPLETED SURVEY IN THE ENVELOPE PROVIDED.

FINDINGS

The results support the findings of many of the earlier studies of workers' compensation claims: When compared with standard medical care, chiropractic care evidences greater cost-effectiveness in the management of work-related back injuries.

1. The specific findings from the present study that support this conclusion are: The duration of temporary total disability represented by the average length of the com-pensation period, and the indemnity payments for work days lost, were substantially less for claimants treated by chiropractors compared with those treated by medical doctors. In the group of claimants that excluded surgery patients, the period of disability was 48.7 percent shorter for chiropractic patients; for the claimant group that included patients who underwent surgery, the duration of disability was 51.3 percent shorter for chiropractic patients. Interestingly, the magnitude of the difference in duration of disability between patients of chiropractors and medical doctors is similar to that found by other investigators.

2. The average cost of chiropractic physician services and prescribed procedures was significantly less than the corresponding cost for medical doctors. In both claimant groups analyzed in this study, the cost of chiropractors' services and prescribed procedures was over 50 percent less than that of medical doctors (55.3 percent less in claimant group A and 58.8 percent less in claimant group B).

3. Claimants treated by medical doctors were hospitalized at a much higher rate than claimants treated by chiropractors and incurred significant additional costs due to hospitalization services. Only 20.3 percent of chiropractic patients in each claimant group were hospitalized; 51.3 percent of medical patients in claimant group A and 52.2 percent of medical patients, coupled with a higher average cost of hospitalization, resulted in a substantial impact on the overall cost of care attributable to medical doctors.

4. The estimated average total cost of care, computed across all major categories of treatment costs, was substantially higher for medical patients compared with chiropractors' patients: 83.8 percent higher in the claimant group that excluded surgery patients and 95.3 percent higher in the claimant group that included surgery patients. The present study's methodology, in accounting for the total treatment costs of *managing* a work-related back injury, more accurately reflects the cost-effectiveness of chiropractic care over standard medical care.

The study confirms the findings of earlier literature: the chiropractic approach to the management of work-related back injuries and illnesses minimizes the impact of such injuries on prolonged absence from work and excessive treatment costs.

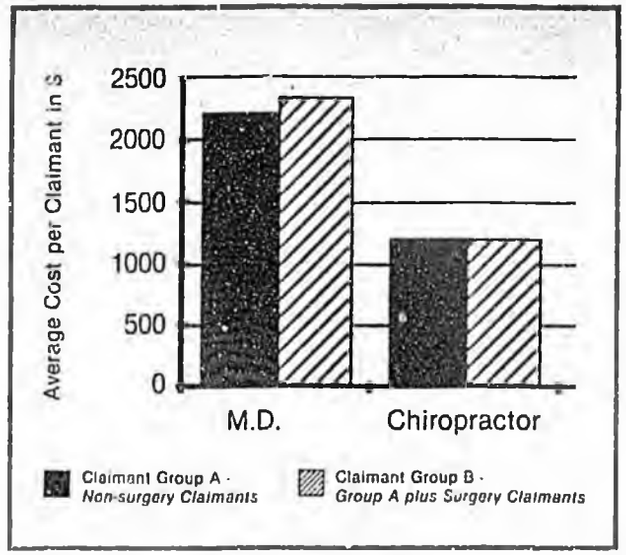

Figure 5. Estimated Total Cost Of Care

ACKNOWLEDGEMENTS

Permission to print the highlights of the Florida report has been granted to the American Chiropractic Association by the Foundation for Chiropractic Education and Research, Publisher.

For more information, contact: Foundation for Chiropractic Education and Research, 1701 Clarendon Boulevard, Arlington, Virginia 22209.

Commission On Insurance
American Chiropractic Association
1701 Clarendon Boulevard • Arlington, VA 22209

Printed in the United States of America

CHIROPRACTIC VERSUS MEDICAL CARE

A Cost Analysis of Disability and Treatment for Back-Related Workers' Compensation Cases.

HIGHLIGHTS OF THE FLORIDA REPORT

A STUDY DESIGNED TO SHOW THE TOTAL COST OF MANAGEMENT OF A CLAIMANT'S TREATMENT

Presented here are some of the highlights of the Florida report. The statistics summarized in the report were compiled by the Office of Medical Services, Florida Division of Workers' Compensation, at the request of the Foundation for Chiropractic Education and Research. The statistics were compiled during the period April-June, 1988. The complete report is available by writing to either the Foundation for Chiropractic Education and Research or the American Chiropractic Association (addresses are given on the back of this folder.)

The annual cost of work-related injuries is a major concern within the health-care profession. Work-related injuries translate into costs not only for treatment and rehabilitation, but costs to employers and insurance carriers for work days lost. Health-care researchers have paid particular attention to workers' compensation claims for back-related injuries, which are one of the most disabling types of injuries.

Because of the debilitating nature of most back injuries, researchers continue to analyze the efficacy and cost-effectiveness of alternate treatment approaches. In light of chiropractic's unique focus on the treatment of the neuromusculoskeletal system and, specifically, the spine, comparisons in workers' compensation literature are often made between chiropractic care and standard medical care.

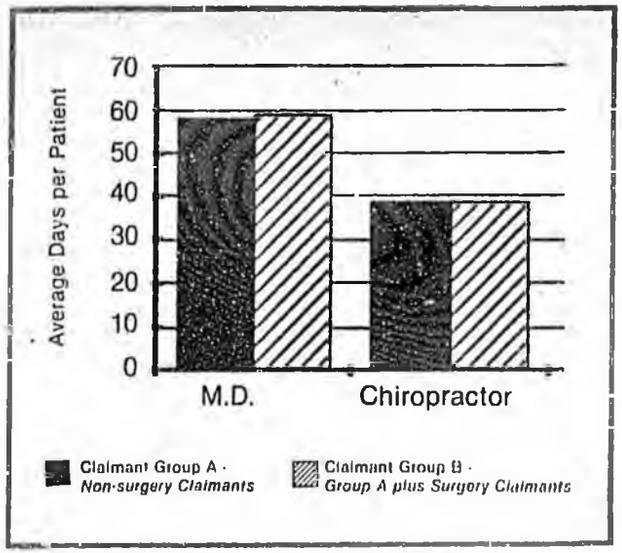

Figure 1. Length Of Compensation Period

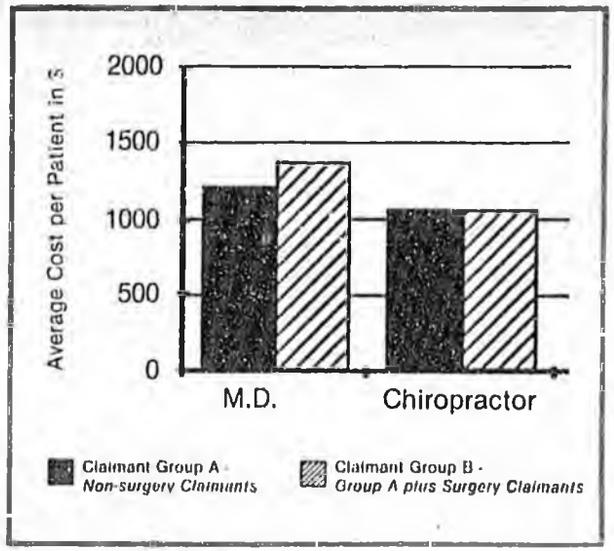

Figure 3. Hospital Services' Costs

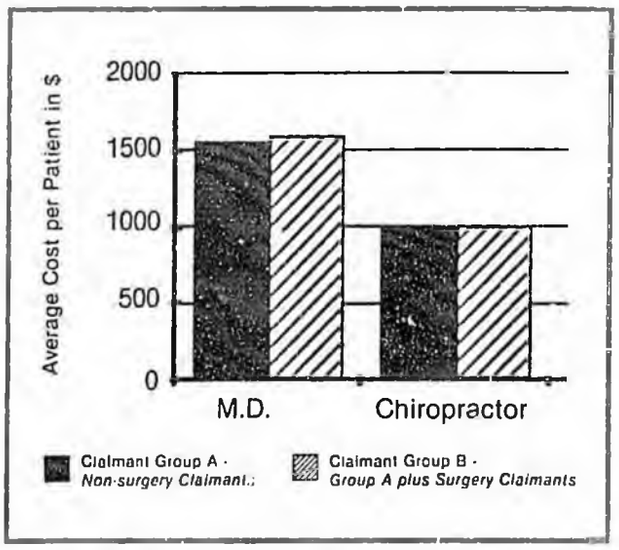

Figure 2. Physician And Prescribed Services' Costs

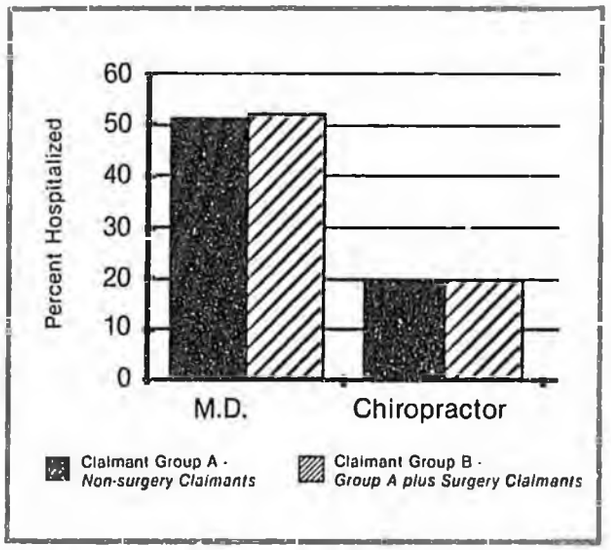

Figure 4. Percent Hospitalized Of All Closed Cases

The purpose of the Florida report is to compare chiropractic and medical care for back-related injuries and illnesses stemming from closed workers' compensation claims. The comparative analysis covers the following major variables: duration of disability; cost of indemnity payments for work days lost; cost of all physician services and physician prescribed procedures (such as occupational and physical therapy and radiological examinations and interpretations); cost of hospital services and procedures, both in-patient and out-patient costs; drug and supply costs; transportation costs; and miscellaneous treatment costs.

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A Bulletin for ALEC Leaders
About State, Federal and Local Issues

February 22, 1991

IN THIS ISSUE...

HEALTH CARE

Three States Confront Universal Health Care: Proponents of Canadian-style universal health care are mounting major efforts in three states, California, Minnesota, and Missouri. Action in these states over the next few weeks may be vital to averting the enactment of such costly and dangerous socialist-style health care system.

In California, Senator Nicholas Petris has introduced legislation, SB 36, that would establish a one-payor universal health care system for all Californians. The government-funded and operated system would provide coverage for a comprehensive package of medical benefits, including hospitalization, preventive care, primary and tertiary care for acute and chronic conditions, rehabilitative care, long-term care, mental health services, dental care, and prescription drugs. Provider rates would be set by the state and all capitol expenditures subject to state control. The program would be funded through a 10% gross payroll tax on all employers (the tax would be phased in over three years for certain small businesses), a 2% tax on gross wages for employees and the self-employed, an unspecified tax on gross receipts, and an increase in the tax on unearned income.

Only slightly less dangerous is legislation, AB 14, by Assemblyman Bert Margolin, powerful Chairman of the Assembly Committee on Insurance. Assemblyman Margolin's proposal would establish a "play or pay" mandate for insurers, similar to Massachusetts failed universal health care law. All employers, regardless of size, would be required to provide qualifying health insurance coverage for all employees working more than 25 hours per week and their dependents. Companies with more than 50 employees that fail to comply will be assessed a "contribution" equal to the highest annual premium charged in the geographic area for group coverage. Employers with less than 50 workers would have to pay an 8% gross payroll tax. Employees of small businesses would be subject to a 2% tax on wages. Qualifying insurance plans must cover hospitalization and attendant services, radiology and other diagnostic services, physician visits, pap smears and mammograms, sterilization, comprehensive maternity and perinatal care, emergency care, reconstructive surgery, preventive care for minors, prescription drugs, and certain mental health services. Qualifying plans would be severely restricted in their ability to require cost-sharing and deductibles could be no more than $250 annually per individual or $500 annually per family.

In Minnesota, new Governor Arne Carlson, in a stunning about-face, now indicates he may not oppose a universal health care program being pushed by Representative Paul Ogren. That legislation, HF 2, is based on recommendations of the Minnesota Health Care Access Commission. Under the proposal the state would establish a basic health care package, to be offered through existing health maintenance organizations (HMO's) and preferred provider organizations (PPO's). The benefit package would include preventive, primary, and outpatient care, prescription drugs, mental health care, and chemical dependency care. Limits on physician visits and hospitalization benefits would be imposed to hold down costs. The state would subsidize purchase of the new insurance through a sliding scale based on family income. The total cost of the program is estimated to exceed $290 million per year. Governor Carlson had said the state could not afford such a program. However, the Governor now says that at least a pilot program would be acceptable.

Missouri legislators are nearing a vote on Representative Gail Chatfield's $6 billion per year proposal for a one-payor universal health care system. That legislation, H 28, has been the subject of a carefully orchestrated campaign by organized labor and other liberal special interests. A vote could come as early as next week.

For additional information, contact Michael Tanner, Director of ALEC's Task Force on Health Care, at (202) 547-4646.

TAX AND FISCAL POLICY

Balanced Budget Amendment Rescission Fails key Vote in New Hampshire: Despite a well coordinated effort to convince New Hampshire legislators to reverse the state's long-held position for fiscal discipline in the federal budget process, the House State-Federal Relations Committee, Chaired by ALEC member, Representative Garret Cowenhoven, recently voted 10-5 against passage of a resolution (HCR 1) to rescind the state's call for a

limited constitutional convention to *propose* a federal balanced budget amendment. New Hampshire is one of twenty-nine states with an effective resolution calling on the Congress to either *propose* a federal balanced budget amendment or to convene a limited constitutional convention to *propose* such an amendment.

Groups supporting the rescission effort in New Hampshire, featuring an amazing cross-section of left- and right-wing extremists -- labor unions, social-welfare spending advocates, the John Birch Society, and Liberty Lobby -- continue to spread the discredited argument that a constitutional convention could not be limited to *proposing* a balanced budget amendment, and that it would somehow develop into a "runaway" convention that could scrap the Bill of Rights and lead to a host of other changes in our form of government. Fortunately, the vast majority of legislators in New Hampshire have read the U.S. Constitution, as well as numerous other historical documents and in-depth studies on Article V and the process for amending the Constitution. Legislators in New Hampshire also realize that Congress is unlikely to *propose* a balanced budget amendment unless and until the requisite number of states (34) exercise their Constitutional prerogative for such an amendment.

The rescission resolution in New Hampshire now goes to the full House of Representatives. However, in the weake of the vote by the State-Federal Relations Committee, it is unlikely that the resolution will pass. The rescission effort also faces strong bipartisan opposition by Legislative Leaders in the state, including ALEC members, House Speaker Harold Burns and Representative Beverly Rodeschin, and by U.S. Congressman Dick Swett.

Similar rescission efforts have been launched so far this year in Idaho, Kansas (HCR 5010), Nebraska (LR 2), South Carolina (H 3353, 3365, S 606, S 611) and Utah (HJR 8).

ALEC supports a federal balanced budget amendment and the unquestionable right of the states under Article V of the U.S. Constitution to call for a constitutional convention to *propose* a balanced budget amendment. ALEC does not take this issue lightly. However, the numerous safeguards built into the amending process are quite clear and distinct. In addition, a *proposed* amendment, either from Congress or a convention, does not become part of the Constitution until it is ***ratified*** by 38 states.

For more information, contact Duane A. Parde, Director of ALEC's Task Force on Tax & Fiscal Policy, at (202) 547-4646, or Senator....

ALEC to Host California Budget Reform Workshop: On Wednesday, March 13, ALEC will sponsor a California Budget Reform Workshop. The Workshop, being held at the request of ALEC State Chairman, Senator Bill Leonard, will address such issues as the effects of mandating and earmarking on state budgets, privatization, and solutions to budget problems from other states. Speakers will include Larry McCarthy, President of the California Taxpayers Association; Steven Haywood, Director of the Claremont Institute's Golden State Project; Wendell Cox, nationally known consultant on public transportation policy; Representative

Joseph Petrilli, Majority Leader of the Delaware House of Representatives and Chairman of ALEC's Task Force on Tax and Fiscal Policy; ALEC National Chairman, Delegate Ellen R. Sauerbrey, Minority Leader of the Maryland House of Delegates; and Senator Kelly Mader, Chairman of the Wyoming Senate Appropriations Committee.

For additional information, contact Senator Leonard at (?16) 445-3688, or Duane Parde, Director of ALEC's Task Force on Tax and Fiscal Policy, at (202) 547-4646.

BANKING AND FINANCIAL SERVICES

Credit Cards Face Increased Regulation: Credit cards have been the focus of a plethora of bills in the current session. Legislation setting interest rate caps for credit card purchases has been introduced in Arizona, New Hampshire, New York, Ohio, Oklahoma, Rhode Island, Texas, and West Virginia. States continue to try to cap interest rates despite overwhelming evidence that such action results in reducing credit availability to minorities and low-income people.

In an interesting counterpoint, six states (Maine, New Hampshire, New Jersey, New York, Rhode Island, and South Carolina) have introduced legislation to establish a state-sponsored credit card. Revenue generated would be used for a variety of purposes, including educational financial aid and environmental projects.

There have also been a flurry of privacy bills introduced which prohibit the use of credit cards as required identification for check cashing. States introducing this type of privacy bill include Arizona, Connecticut, Georgia, Illinois, Indiana, Massachusetts, Minnesota, North Dakota, New Hampshire, New Jersey, Ohio, Oklahoma, South Carolina, Tennessee, Wisconsin, and West Virginia. In conjunction with this issue of privacy, the following states have introduced bills which prohibit a vendor from requiring the credit card holder's telephone number as a condition of sale: Arizona, Connecticut, Delaware, Georgia, Minnesota, New Hampshire, Pennsylvania, Texas, and Washington.

For additional information, contact Patricia Finn, Director of ALEC's Task Force on Banking and Financial Services, at (202) 547-4646.

ENVIRONMENT

Crossborder Transit of Wastes Triggers Civil War Among States: The controversy over out-of-state waste disposal has flared anew recently after several U.S. District Court decisions finding state barriers to crossborder waste disposal an unconstitutional infringement on interstate commerce. Battles between the states are raging in three areas; hazardous waste disposal, low-level radioactive waste disposal, and solid waste disposal.

Hazardous Waste

The controversy over interstate hazardous waste erupted after the North Carolina Council of State (composed of the state's top elected officials) vetoed the construction of a regional hazardous waste incinerator in Butner. The move violated commitments made to other southern states which signed a regional hazardous waste disposal pact with North Carolina in late 1989. Alabama and South Carolina quickly retaliated by banning North Carolina waste from their disposal facilities and recycling centers as of January 1. The move by Alabama and South Carolina (the destination for 71 million pounds of North Carolina's hazardous waste, 64 percent of all hazardous waste shipped out of North Carolina annually) forced hundreds of businesses to store wastes on-site until new contract could be negotiated with facilities in other states. Meanwhile, Tennessee and Kentucky, the other two signatories to the regional pact, indicated that disposal facilities in their states could not be counted on to meet capacity assurances required of North Carolina by the federal government.

A federal district court judge on January 11, however, ruled that several of South Carolina's laws restricting out-of-state hazardous waste disposal were unconstitutional infringements on interstate commerce (*Hazardous Waste Treatment Council v. State of South Carolina, et al, DC SC, No. 3:90-14020-0, 1/11/91*). A similar decision was reached by federal courts last summer, which rejected a ban of certain out-of-state wastes enacted by Alabama. Given the scarcity of case law in this area, these two rulings set a potentially strong precedent and should give pause to those states contemplating similar prohibitions. Both Alabama and South Carolina are appealing these rulings to federal district courts.

In the meantime, South Carolina has threatened to sue the EPA if it fails to penalize North Carolina for its lack of a federally approved hazardous waste management plan. EPA indicated this month that it would likely draft a "tiered" enforcement program out of reluctance to impose harsh penalties mandated under federal law.

The Comprehensive Environmental Response, Compensation & Liability Act (CERCLA) requires that states adopt plans (subject to EPA approval) ensuring 20 years of future capacity for the disposal of all generated hazardous waste. Failure by states to adopt an approved plan could lead to the cutoff of federal "Superfund" cleanup assistance. North Carolina is the home of 22 contaminated sites eligible for Superfund assistance. Analysts estimate that approximately $286 million will be necessary to clean-up these sites in order to meet federal standards.

Other states which are challenging the interstate disposal of hazardous wastes included Louisiana, which has enacted stringent taxes on out-of-state hazardous waste, and New York, which has proposed to modify private disposal licenses in order to set limits on the amount of out-of-state hazardous waste that a facility may accept legally.

The National Solid Waste Management Association recently reported that all states export some hazardous waste to out-of-state facilities and all but two states (Alaska and Montana) received some out-of-state hazardous waste for disposal. Approximately 35 states are net exporters of waste, while 15 states are net importers of waste. Of the 236 million tons of hazardous waste generated each year, however, 96 percent is treated or disposed of at the industrial facility which generated the waste.

Low-Level Radioactive Waste

The controversy over low-level radioactive waste disposal is similar to that regarding hazardous waste. The 1985 Low-Level Radioactive Waste Policy Amendments Act require states to assume responsibility for providing either by itself or in cooperation with other states for the disposal of Class A, B & C low-level radioactive waste. Most of this waste is generated by electric utilities, other industry, government, and university and medical research by-products such as diagnostic and treatment procedures. This waste typically includes contaminated towels, mops, gloves and protective clothing, machinery parts, laboratory equipment, animal carcasses, and various liquids.

Since 1985, most states have chosen to form regional compacts, with one state designated to provide for disposal. Yet little progress has been made in facility siting -- only 3 disposal facilities exist (those in South Carolina, Nevada, and Washington) to handle 1.4 million cubic feet of waste annually. Only Illinois, Nebraska, California, and Texas, and Washington are making progress (albeit slow and amidst serious political opposition) in siting new facilities, leading many analysts to believe that when the three existing facilities close in January, 1993, the nation will face a serious capacity crunch that could devastate certain industries.

New York, one of the few states not part of a regional compact, filed suit against the federal government last year, arguing that the original Low-Level Radioactive Waste Act of 1980 is constitutional because it requires states to take title to privately-generated waste that it did not generate.

State officials which host the three existing disposal facilities are frustrated at the lack of progress by many states in meeting federal mandates for disposal capacity and are prepared to exercise authority to bar interstate disposal of radioactive waste granted them by the 1985 Act. Nevada, South Carolina, and Washington last November prohibited the disposal of radioactive waste generated in Michigan (the designated host state for a facility in the midwest compact). In response, generators of Michigan radioactive waste filed suit against the three states and the state attorney general filed suit against other members of the midwest regional compact (Indiana, Iowa, Minnesota, Missouri, Ohio, and Wisconsin). Michigan argues that these states are not forthcoming with promised financial assistance in the state's search for an acceptable site.

Michigan may be the first of many states excluded from disposal rights in the near future. Washington, South Carolina, and Nevada have similarly warned Massachusetts and New Jersey this month that, unless those states speed up their own siting process, they to will be prohibited from using the nation's only three low level radioactive waste disposal sites. In the meantime, Washington has unilaterally prohibited the disposal of radioactive waste generated in Rhode Island, Vermont, New Hampshire, Puerto Rico, and Washington, D.C.

Solid Waste

The ongoing controversy regarding interstate solid waste disposal recently came to a head over Indiana's recently adopted House Enrolled Act 1240.

The Indiana statute would (1) require transporters of interstate waste to certify the origin and non-hazardous content of the solid waste based upon inspections by officials in the state where the trash originated, and (2) mandate that out-of-state waste disposal fees equal the fee for dumping the waste at a site closest to the waste's point of origin minus the fee actually charged for disposal by the Indiana disposal facility.

A U.S. District Court, however, ruled on December 27 that both provisions of the bill violate the commerce clause of the U.S. Constitution (*Government Suppliers Consolidating Services Inc. v. Indiana*, DC SInd, No. IP 90-303-C, 12/27/90). Although Indiana argued that the law was an attempt to protect the health and safety of its citizens, the court found that that no such evidence existed to prove that it would do so and that, moreover, was more interested in economic protectionism and political posturing. A similar ruling was issued last summer regarding the unconstitutionality of an Alabama waste ban statute.

Arkansas, Delaware, Ohio, Michigan, Wisconsin, Montana, and Rhode Island have similar provisions on the books which restrict the disposal of out-of-state waste and are thus subject to legal challenge.

An October, 1990 report issued by the National Solid Waste Management Association found that only 8 percent of the nation's solid waste is transported for disposal across state lines, and that 83 percent of all such shipments are either between contiguous states or states in nearby, non-contiguous regional wastesheds. All told, fully 38 states are both importers and exporters of solid waste, 5 states are exporters only, 4 states and importers only, and 1 state (Montana) is neither.

Clearly, a political Lebanon is being waged between states who have enshrined NIMBY -- Not-In-My-Back-Yard -- as the central objective of all state waste policy. This is not only destructive economically (waste flows to the cheapest disposal fees and thus ensures affordable disposal) but environmentally as well. Waste should be disposed of in the most environmentally sensible facility available, regardless of location. Statutes which close down disposal options will increase costs to the economy and in many cases direct wastes to obsolete facilities for lack of better recourse. Finally, small communities willing to host such facilities are unduly penalized by limiting the means by which they can build-up their tax base and provide local jobs. State legislators would be well-advised to resist the political temptation afforded by such policies and pursue a balanced waste agenda that protects the environment and the economy.

For further information, contact Jerry Taylor, director of ALEC's National Task Force on Energy, Environment & Natural Resources, at (202) 547-4646.

<u>CONEG Falls Apart Over Packaging Restrictions</u>: The Coalition of Northeast Governors (CONEG) fragmented last month when environmental groups pulled-out of the Coalition's Source Reduction Council (SRC) over protests that anti-packaging efforts were being stalled by lack of political commitment by the Governors and procedural changes in the organization's operating procedures. CONEG is composed of state executives, individual businesses, trade associations, and environmental

groups charged with reaching consensus recommendations on various solid waste policy issues.

CONEG gained national notoriety last year when it issued model toxics-in-packaging legislation that was subsequently adopted by 8 states, thus becoming a *de facto* national standard. Yet CONEG's Source Reduction Council was charged with a more ambitious agenda which included sweeping product regulations. Although business interests were dubious about SRC's direction, they believed that yet-another attempt at "dialogue" and "consensus building" with the environmentalists was preferable to being the target of bad press and green boycotts. These earlier fears were confirmed, however, when environmental groups within SRC -- led by the Environmental Defense Fund and the Natural Resources Defense Council -- demanded that the group endorse a goal of 50 percent reduction in consumer packaging over 5 years. When the debate reached a deadlock, CONEG officials changed the procedural rules which provided environmentalists veto-power over SRC recommendations. Miffed, the greens picked-up there marbles and went home. Although the governors represented by CONEG have sent letters to the environmentalists pleading for their return, analysts believe that CONEG's influence in the solid waste debate will decline dramatically.

Policy analysts believe that CONEG's absence won't be missed much. CONEG's toxics-in-packaging bill will have more political impact than environmental consequence, given the essentially trivial nature of the risks addressed. The real significance of CONEG was the belief invested in its potential by the business community, which lended credibility to the group's recommendations with many state legislators. The fact that American business would walk so far down this policy road and court such economic disaster is distressing in itself. Modern packaging is a significant contributor to our nation's standard of living, a benefit to consumers, and a key factor in reducing America's solid waste stream through the well-documented reduction in food waste, broken products in transit, and efficient product use. CONEG was built upon the false premise that packaging was a solid waste problem in need of state action. Thus, no economic or environmental good could possibly come from the organization.

For further information, contact Jerry Taylor, Director of ALEC's National Task Force on Energy, Environment & Natural Resources, at (202)547-4646.

California Court Curbs Initiative Process by Overturning Proposition 105: Proposition 105, enacted by California voters in 1988, was overturned this month by a state appeals court which found that the initiative violated the state's constitutional requirement for single-subject ballot initiatives (*Chemical Specialties Manufacturers Association, Inc., et al. v. Deukmejian et al,.* Cal CTApp San Fransisco, No. A04089). Proposition 105, the "Public's Right to Know Act," required businesses advertising household products with toxic constituents to provide warnings that the product should not be disposed of in the trash, among other things. The law, in the opinion of Appeals Court Judge Robert Merrill, "Seeks to reduce toxic pollution, protect seniors from fraud and deceit in the issuance of insurance policies, raise the health and safety standards in nursing homes, preserve the integrity of the election process and fight

Apartheid," which might be "well-intentioned" but not reasonably related to one another.

Political analysts note the California leftists have become experts at grouping vague, warm-sounding policies together in an unbeatable combination of mom-and-apple-pie propositions linked only to the extent that a *Jeopardy* category is linked by the moniker "Things Beginning with the Letter R." This dishonest practice will undoubtedly be difficult to continue if the Appeals Court ruling stands.

For further information, contact Jerry Taylor, Director of ALEC's National Task Force on Energy, Environment & Natural Resources, at (202)547-4646.

Federal Court Rules Municipalities Can Be Responsible Parties for Superfund Cleanup & Liability: A U.S District Court ruled last month that household waste is not automatically exempt from federal Superfund law and the municipalities can be held legally liable for trash sent to landfills requiring cleanup (*B.F. Goodrich Co. V. Murtha, DC Conn,* No. N-97-52-PCD, 1/8/91). A similar ruling last December (*Transportation Leasing Co. v. California,* No. CV-87-7368-WMB, DC, Calif, 12/4/90) leads policy experts to conclude that massive cleanup costs stemming from the federal Comprehensive Environmental Response, Compensation, And Liability Act (CERCLA) will soon threaten taxpayers who may be responsible for at least 22 percent of the disposal facilities on the Superfund National Priority List.

Perhaps the realization that what the government defines as hazardous waste -- requiring billions of dollars for cleanup -- includes items stored routinely, without hysteria, in most every household in America will lead municipal officials to the conclusion that Superfund cleanup mandates amount to environmental overkill, are economically ridiculous, and potentially ruinous to a multitude of parties -- including taxpayers. It's unfortunate that this realization may come only when public officials, as opposed to industry, are faced with its mandates.

For further information, contact Jerry Taylor, Director of ALEC's National Task Force on Energy, Environment & Natural Resources, at (202)547-4646.

EDUCATION

Vouchers Achieving Popularity in School Choice Battles: The most far reaching form of choice in education is one that provides parents with a certificate or voucher which can be used at any public or private school in the state. The passage of a Wisconsin bill in 1990 that provides low income parents in Milwaukee a voucher with a value of $2500 redeemable at any non-assigned public or participating private school opened the floodgates for variations of voucher legislation in 1991.

Legislation in Tennessee would grant all parents a voucher equal to the annual per student cost of public education redeemable at any non-assigned public or participating private school. In Florida legislation, HB 385, has been introduced that would grant all parents a voucher with a value equal to 80% of the annual per student cost of public

education if redeemed at a non-assigned public school or 60% of the annual per student cost of public education if redeemed at a private school. A bill in Kansas, S 199, would provide all parents in the county encompassing Wichita a voucher with a value equal to the annual per student cost of public education. And, in Maryland, legislation, H 598, would grant low income parents with children in "academically bankrupt" elementary schools in Baltimore a voucher with a value equal to the annual per student cost of public education.

Similar public/private choice legislation is currently being drafted by ALEC members Representative Grusendorf in Texas, Senator Salvatore in Pennsylvania, and Representative Bugielski in Illinois. It is also likely that the Louisiana Association of Business and Industry will be pushing for the introduction of a public/private choice bill in Louisiana this year.

A less effective but more common form of choice is "open enrollment" which allows parents to send their children to any public school in the state. Open enrollment bills have been introduced this year in Michigan, H 4107, South Carolina, H 3087, and Oklahoma, S 40, and are expected to be introduced in Alabama, Massachusetts and North Carolina. Since 1987, some form of open enrollment has been enacted in Minnesota, Ohio, Utah, Idaho, Washington, Iowa, Nebraska, Colorado, and Arkansas.

For additional information, contact Timothy Beauchemin, Director of ALEC's Task Force on Education, at (202) 547-4646.

CRIMINAL JUSTICE

Electronic Home Monitoring Expanding as Sentencing Option: Legislation to expand the use of electronic home monitoring has been introduced in Massachusetts (H 1931 and S 622), Montana (H 148), Nevada (A 314), New York (A 1345 and S 2156), and Virginia (H 1380). The Virginia bill, which has passed the legislature and is awaiting the Governor's signature, would allow probation and parole officers in addition to sheriffs and jail administrators to assign offenders to electronic home monitoring.

Although judges or corrections officials in each of these states currently have authority to sentence some offenders to electronic home detention, such an alternative is rarely used. For example, according to a 1988 National Institute of Justice survey, less than 200 convicts in the states mentioned above combined were being electronically home monitored compared to over 1,000 in Florida and Michigan each.

For more information, please contact Timothy Beauchemin, the Director of ALEC's Task Force on Criminal Justice at (202) 547-4646.

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HEALTH CARE REFORM: Rx FOR A HEALTHY AMERICA

WASHINGTON, D.C. -- The nation's Governors have made health care reform their number one priority this year for several reasons:

- Health care costs have risen so dramatically that states -- who finance health care for the needy, directly provide services through public health and other programs, and pay for health benefits as employers -- find it increasingly difficult to fund other critical state priorities.

- Despite the expenditure of ever-increasing amounts of money, access to health care services is limited and may become increasingly limited.

- The shifting of costs and responsibilities from one payor to another in the system is exacerbating the problems of both cost and access and is contributing to an inefficient system.

- The current health care system is not structured to encourage the delivery of preventive health care services, which Governors increasingly understand is critical to a healthy and productive citizenry.

Health care in the United States is nearing a state of crisis. In 1983, the United States spent $357 billion, or 10.5 percent of the gross national product (GNP) on health care. By 1989, those figures had climbed to more than $599 billion, or 11.5 percent of GNP -- that's $2,400 for every man, woman, and child in the country. Left unchecked, health care costs are projected to rise to $1.5 trillion, or 15 percent of the GNP, by the year 2000.

Yet, millions of Americans have limited or no access to the health care services they need. Based on insurance statistics alone, the figures are appalling. Approximately 31 million people are uninsured annually, and 37 million are uninsured in any given month. Governors, who are responsible for the health and welfare of their citizens, understand clearly that having health insurance or Medicaid coverage does not ensure access to services, particularly for poor and rural citizens.

-more-

Because there are so many other factors that make a difference in whether people actually have access to health care services, Governors must address the following kinds of issues: adequately funding public health efforts; meeting the transportation needs of poor and rural citizens; coordinating the outreach efforts that result in people using health care services more effectively; and screening and licensing health care personnel and facilities.

Employers, the traditional source of insurance coverage for workers and their families, are experiencing double-digit increases in their employee health insurance premiums. Their responses have ranged from dropping coverage for their workers' dependents to decreasing coverage for their employees. For most small businesses, increasingly expensive health insurance is simply beyond their financial reach.

Governors are employers too. In fact, in some states, government is the largest single employer. And as employers, Governors suffer the same premium increases and face the same draconian choices as any other employer.

Where Does Medicaid Fit?

While the Governors are taking an expansive view of health care reform in their initiative, "Rx for a Healthy America," it is clear that the genesis of their interest is their concern and frustration with the current direction of the Medicaid program.

Since its inception in 1965 as a program designed to provide health care services to women and children eligible for Aid to Families with Dependent Children (AFDC) and to the aged, blind, and disabled covered by federal Supplemental Security Income (SSI), Medicaid has grown to include a wide variety of special populations and services. This growth has created problems both in the states' ability to fund and effectively administer the program.

For instance, in 1980, Medicaid spending accounted for 9 percent of a state's budget; in 1990, it accounted for nearly 14 percent of all state spending. Further, the rapid expansion of mandated populations and federal micro-management of services has created an administrative nightmare.

The NGA Task Force on Health will consider and discuss a variety of conceptual options for restructuring the Medicaid program when it meets in Washington, D.C., on February 3, 1991. Although Medicaid is but one piece of a larger puzzle, it is a very large piece.

Wide-reaching and thoughtful discussion about Medicaid could lead to the creative use of its resources.

What Are the Governors Doing?

To provide the larger context for Medicaid and the other critical and interlocking issues in health care, National Governors' Association Chairman Booth Gardner of Washington established the Task Force on Health. The task force is working on two products that will be completed by August 1991: a report on state options in health care reform and a policy on health care.

Task Force Report. The task force report will detail state options to both increase access to health care and control costs throughout the health care system. The options in the report will both identify incremental steps states have already taken successfully and describe comprehensive ways states can restructure their health care financing and delivery.

The report will guide states in reorienting their health care systems to emphasize preventive and primary care. It also will discuss how to overcome the barriers to the provision of preventive and primary care; barriers that riddle the current structure of the health care system.

The report will outline steps Governors can take to help the working uninsured. Constructive guidance will be offered to Governors interested in working with their business community to help small businesses obtain affordable health insurance for their employees. It will offer suggestions to help stabilize the insurance situation for businesses that now provide health insurance coverage but are finding it increasingly difficult to do so.

A variety of options for expanding access to health care for the non-working population will also be covered. The options will range from expanded use of Medicaid and Medicare to the development of a totally new publicly funded health insurance program for non-working people.

Because the Governors know that without significant new cost controls, the goal of increasing access to care will never be realized, the report will contain a wide range of options for cost containment.

The report will describe a series of incremental and discrete cost control strategies, such as the expanded use of managed care programs, administrative reform, and medical tort reform. It will also suggest bold and innovative strategies, such as a state-level all-payor system and global budgeting for the control of capital expansion.*

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* All-Payor System: A system in which association of purchasers come together to negotiate payment with an association of providers.

Global Budgeting: The idea of defining limits on the total amount of health care expenditures. Allocations are then made within that amount.

Managed Care: The concept of managing the access to health care, the utilization of services, and the cost of care.

Finally, although the focus of the report will clearly be on state action, the report will contain suggestions for federal action that would help the states implement the strategies.

Policy on the Federal Role. To complement the report, the task force will develop a policy for consideration during their annual meeting in August 1991. The policy will focus on the key issues that would require federal action to restructure the health care system. The policy will focus on recommendations on the future of the Medicaid program, changes in insurance practices, and small market reforms to enhance increased access to health insurance.

How Are the Governors Reaching Out?

The Governors began the process of reaching out to a wide variety of people when they hosted a national conference on health care reform in September 1990. During the two-day conference, some of the best health policy analysts and experts in the country participated in roundtable discussions. The participants and Governors explored issues ranging from ensuring the delivery of quality care to helping business find affordable, stable insurance policies; from insurance practice reforms to the individual's responsibility for health care. That conference gave the task force valuable information and insight with which to begin its work.

As the report is developed, Governors will seek extensive feedback and "reality-testing" from the wider community. This spring, Governors will hold a series of regional meetings to elicit comments on drafts of the report from business, labor, the insurance industry, and the provider community.

Further, the Governors will host a working meeting of state health policy analysts and health and human service executives to invite review and comment on the report as it moves to its final form. By involving the widest variety of interested people, Governors believe the strategies in the report will be tested for "workability" and will have benefitted from the best thinking of those involved in the health care system.

What Happens Beyond the Task Force?

Although the formal work of the task force will conclude in August 1991, the issue of health care reform will remain a high priority for the nation's Governors. As the Governors begin to implement the recommendations contained in the report, policymakers at all levels of government will have the opportunity to learn more about what works and what does not.

The Governors want to have the participation and cooperation of their federal partners in fashioning innovative approaches to health care reform. As the Governors and their federal partners evaluate these approaches, there will be opportunities to develop an informed national consensus about how best to move the nation's health care system toward a day when access to health care can be ensured for everyone at prices all can afford.

. . . FEDERAL UPDATE . . .

National Conference of State Legislatures **Vol. V, No. 5 05/24/91**

* **FISCAL YEAR 1992 BUDGET RESOLUTION**: With House and Senate Appropriations Committees anxiously awaiting the go-ahead to start moving the 13 regular appropriations bills, senior members of the House and Senate Budget Committees have begun final deliberations on the Fiscal Year 1992 budget resolution. The conference committee is expected to be fairly short because there are only a small number of differences between House and Senate spending priorities. The biggest disagreements are in the areas of education, transportation, administration of justice, science, space, and technology. Most of these disputes will be resolved by simply "splitting the difference" between House and Senate recommendations.

The most contentious issue between House and Senate budgeteers will be the so-called "Brown Amendment" that is attached to the Senate version of the budget resolution. Under the Brown proposal, any new or expanded entitlement spending can only be financed through spending cuts in other entitlement programs. Under last year's budget agreement, which instituted new "pay-as-you-go" budget rules, new entitlement spending could be off-set by either spending cuts or new tax increases.

Many Senate Democrats are strongly opposed to the Brown Amendment as they believe it will "hand-cuff" Congress in its ability to finance new domestic initiatives. It is expected that Sen. James Sasser (D-Tennessee), Chairman of the Senate Budget Committee, will work with House Democrat conferees to strike the Brown proposal from the final version of the budget.

NCSL continues to encourage budget conferees to increase transportation spending to the level supported by highway user fees and Highway Trust Fund balances, provide sufficient funding for Unemployment Insurance administration, and express support for the Bush Administration's new $15 billion block grant for the states.

NCSL STAFF CONTACT: SUSAN WOLFE

* **CHILD CARE**: Among key programs contesting for limited domestic discretionary funding is the Child Care and Development Block Grant. NCSL and many other groups labored hard in the 101st Congress to enact this state grant program that carries no federal mandates or standards. At issue in the FY92 appropriations process is whether to fund this new program at its fully authorized amount of $825 million. The President's proposed budget and House and Senate budget resolutions call for increases over the FY91 appropriation -- but not full funding.

> **ACTION**: Contact members of the House and Senate Appropriations Committees and urge them to support a $825 million FY92 appropriation for the Child Care and Development Block Grant. A secondary issue regards the disbursement date for these funds that the Administration has recommended as September, 1992 (or one month before the federal fiscal year ends). An earlier disbursement date of March 1, 1992 should be sought in communications with Congress.

NCSL STAFF CONTACT: SHERI STEISEL

* **FOSTER CARE**: NCSL, governors, and state welfare administrators are seeking appropriations language that would end the perennial effects of HHS' underestimating of states'

claims for Title IV-E foster care and adoption assistance administrative costs. With the exception of the FY91 appropriation that provided $536 million of 1989 and 1990 back claims, annual Title IV-E appropriations have failed to cover both current costs and prior year claims. Complicating matters are statutes prohibiting payment for prior year claims from current year appropriations.

> **ACTION**: State legislators should call House and Senate Appropriations Committee members and urge: (1) the addition of budget neutral language that would make "such sums as may be necessary" available for unanticipated Title IV-E costs -- making this program similar to AFDC and Medicaid; (2) full funding of Title IV-E; and (3) funding for prior year claims (only $118 million recommended by Administration and House/Senate budget resolutions when several hundred million is owed).
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> *NCSL STAFF CONTACT: SHERI STEISEL*

* **BANKING REFORM**: The House Subcommittee on Financial Institutions has begun consideration of amendments to the Administration's proposal to reform the nation's banking system. Over the next couple weeks, the Subcommittee will be considering various proposals that would authorize, by federal law, nationwide interstate branching by banks; preempt state banking laws; and threaten the future of the nation's dual banking system. NCSL has been working aggressively to preserve the states' ability to control entry into banking markets and adapt banking policy to the needs and characteristics of local markets, businesses, and communities.

With the support of NCSL and other groups, the Subcommittee has already rejected the Administration's proposal to limit the number of insured accounts per person per institution. However, an NCSL-supported effort to permit well-capitalized state banks to participate in activity not permitted by a national bank failed to garner Subcommittee approval.

The key vote in Subcommittee will be on an amendment offered by Rep. Bruce Vento (D-Minnesota) that will preserve states' ability to permit interstate branching. NCSL strongly supports the Vento amendment and a close vote is expected.

> **ACTION**: Contact your House delegations, especially those members on the House Banking Committee, and urge support for the Vento Amendment. In addition, urge support for any legislative proposals that preserve state banking powers and the resulting positive impact such regulation has on community development and small business growth.
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> *NCSL STAFF CONTACT: BILL WAREN*

* **HIGHWAY REAUTHORIZATION**: The Senate Environment and Public Works Committee has taken the lead on surface transportation reauthorization legislation, S. 965. This proposal, which is being sponsored by Sens. Daniel Moynihan (D-New York), Quentin Burdick (D-North Dakota), Frank Lautenberg (D-New Jersey), John Chafee (R-Rhode Island), and Steve Symms (R-Idaho), would spend $105 billion for highways and mass transit over the next five years.

The most controversial provisions are: 1) the consolidation of most categorical programs into an omnibus $45 billion grant to the states; 2) greater planning and programming responsibilities for metropolitan planning organizations (MPOs); and 3) guaranteeing each state an apportionment equal to the average of federal funds received during 1987-1991. The legislation continues funding for Interstate completion and maintenance, but stresses overall transportation efficiency and integration, by rewarding the improvement of existing facilities with a higher federal matching rate.

At press time, the Environment and Public Works Committee has scheduled a meeting for May 22 to consider amendments to S. 965. It is expected that a number of changes to the state apportionment and MPOs sections will be considered. At this point, there appears to be no interest by Senators to propose an increase in the federal excise tax on motor fuels.

The House Public Works and Transportation Committee has yet to introduce its highway reauthorization proposal, as there appears to be no consensus among committee members regarding the future of the federal highway-aid program. Legislation may be drafted by early June and a 5-10 cent increase in the federal gas tax may be assumed. House Democrat leadership has expressed support for an increase in the excise tax. Additional hearings are expected after the introduction of the House committee bill.

NCSL STAFF CONTACT: REBECCA BRADY

* **SOLID AND HAZARDOUS WASTE**: Legislation waiving federal sovereign immunity and permitting states to assess fines and penalties against federal facilities continues to move ahead. H.R. 2194 (Reps. Denn.. Eckart, D-Ohio and Dan Schaefer, R-Colorado) is headed for a full House Energy and Commerce Committee hearing on June 4, while its Senate companion, S. 596 (Sen. George Mitchell, D-Maine), was voted unanimously out of the Senate Environmental Protection Subcommittee. Despite bipartisan cosponsorship, Administration support is limited to support for the "objectives" of the legislation only.

Meanwhile, Sen. Max Baucus (D-Montana) unveiled the Senate's bipartisan legislation, S. 976, intended to reauthorize the Resource Conservation and Recovery Act. Hearings are scheduled to commence in June. House legislation will not emerge until September as the Hazardous Materials and Transportation Subcommittee continues preliminary hearings.

> **ACTION**: NCSL continues to encourage legislators to contact their delegations to urge cosponsorship of and support for S. 596 as drafted and cosponsorship for and support for H.R. 2194. NCSL opposes section 2(c) of H.R. 2194 which preempts state authority to use fine and penalty proceeds as states determine by earmarking such proceeds exclusively for environmental purposes.

NCSL STAFF CONTACT: JON FELDE

* **MEDICAID**: The Administration has launched a major offensive against states' use of provider taxes and voluntary contributions to enhance state Medicaid matching funds. Almost half the states have enacted or have under consideration one or both of these financing options to expand access, improve provider reimbursement, and to pay for recently enacted federally mandated program expansions. Last year, the Health Care Financing Administration (HCFA) published proposed regulations that would have restricted the use of both financing options, but Congress enacted a statutory prohibition on the promulgation of regulations on provider taxes and placed a moratorium on regulations on voluntary contributions that expires December 31, 1991.

Legislation (H.R. 1457, S. 833) to extend statutory protection similar to that enacted last year regarding provider taxes, has been introduced by Congressman Jim Cooper (D-Tennessee) and Senator Wyche Fowler (D-Georgia). HCFA is preparing new regulations that are likely to prohibit the use of voluntary contributions and may also restrict the use of provider taxes by redefining what constitutes a tax.

> **ACTION**: Write your Congressional delegation and urge cosponsorship of H.R. 1457 and S. 833 which provides statutory authority for states to produce up to 10 percent of their total state