

ALASKA LEGISLATURE COMMITTEE FILES 1991-1992 86/2

7539 SENATE LABOR & COMMERCE

Plan #	Payout					Preexisting illness													Comments	Telephone
	Quality index	Single	Family	Catastrophic claims	Lifetime maximum	Maternity coverage	Renewability	Rate	Waiting period, mo.	Look-back period, mo.	Available to anyone	Exclusion riders	Higher rates	Other coverage						
69	74%	60%	—	\$1-million	○	Conditional	—	12	No limit	No	Yes	No	a	—	800-522-4075					
68	66	65	—	1-million	●	Conditional	●	12	No limit	Yes	No	No	a,c	K	800-553-3164					
68	66	65	—	1-million	●	Conditional	●	12	No limit	No	No	No	a,c	K	800-553-3164					
68	70	62	—	1-million	●	Conditional	●	24	24	No	Yes	Yes	a,c,d,h	E	305-596-7600					
68	74	61	—	1-million	●	Conditional	○	12	12	No	Yes	No	a,d	—	800-752-6663					
67	70	58	●	1-million	○	Conditional	●	12	No limit	No	Yes	No	a	—	800-868-2500					
57	70	67	—	1-million	●	Optional	●	8	No limit	No	Yes	No	—	M	913-232-1622					
67	71	68	—	1-million	●	Conditional	●	9	No limit	No	Yes	No	a,c,h	M	502-423-2011					
65	62	51	●	1-million	○	Conditional	—	24	60	No	Yes	Yes	a	—	212-578-2211					
64	75	64	●	None	●	Conditional	●	24	24	No	Yes	Yes	a,g	—	312-777-7000					
64	65	53	●	1-million	○	Conditional	●	24	24	No	Yes	Yes	a	—	205-832-1850					
63	65	53	—	2-million	●	Conditional	●	12	12	No	Yes	No	a,c,d	—	800-624-5150					
63	72	60	●	2-million	○	Conditional	●	24	24	No	Yes	Yes	a,d,e	—	913-722-1110					
62	74	60	●	1-million	○	Conditional	●	12	24	No	Yes	No	a	—	817-297-4123					
61	62	51	—	1-million	●	Conditional	○	11	No limit	No	Yes	No	c	—	800-543-2944					
61	63	55	○	None	○	Optional	●	24	24	No	Yes	Yes	—	G,H	201-802-2642					
61	71	59	●	2-million	○	Conditional	○	24	12	No	Yes	Yes	a	—	708-570-5500					
81	77	80	●	None	●	Conditional	●	12	12	Yes	No	No	c,d	C	727-255-0820					
77	76	77	●	None	●	Conditional	○	12	12	Yes	No	No	c	C	215-564-2100					
76	70	70	—	None	●	Conditional	●	6	6	Yes	No	No	c	B,L	313-225-8000					
76	76	75	—	None	●	Conditional	●	12	No limit	Yes	No	No	f	B,H	800-847-1200					
71	63	66	—	None	●	Conditional	●	9	12	Yes	No	No	—	B,H,K	205-988-2200					
70	71	75	—	500,000	●	Optional	—	12	6	No	Yes	No	c	B,H	405-841-9797					
68	58	50	●	none	●	Guaranteed	●	24	60	No	Yes	Yes	—	B,G,H	212-578-2211					
67	55	53	—	none	●	Conditional	●	12	No limit	Yes	Yes	No	f	B,G,H	207-775-3536					
67	59	59	—	1-million	●	Conditional	—	12	12	No	No	No	c	F	406-444-8210					
66	62	66	—	1-million	●	Optional	●	12	No limit	No	No	No	a,i	B,G,I,N	216-687-7218					
62	65	67	○	None	●	Conditional	●	12	12	No	No	No	f	B,H	201-822-4500					
61	63	66	○	None	●	Conditional	●	12	12	Yes	No	No	f	C,H	201-822-4500					
58	52	45	●	None	●	Conditional	●	24	24	No	Yes	Yes	—	—	312-777-7000					
58	52	45	●	None	●	Conditional	●	24	24	No	Yes	Yes	—	—	312-777-7000					
58	52	45	●	None	●	Conditional	●	24	24	No	Yes	Yes	—	—	312-777-7000					
53	55	45	●	1-million	●	Optional	—	24	24	No	Yes	Yes	—	—	309-766-2311					
50	52	45	●	None	●	Conditional	●	24	24	No	Yes	Yes	—	—	312-777-7000					
42	35	30	●	2-million	○	Conditional	—	24	24	No	Yes	Yes	j	B,G,H	913-722-1110					
67	68	72	●	None	●	Conditional	●	11	24	Yes	No	No	d	B	212-430-4757					

f-Participating physicians for families below some income levels  
g-\$50/year for preventive care per person.  
h-Well-child care  
i-Major-medical coverage after \$2500 deductible is met.  
j-Major-medical coverage after \$25,000 of covered expenses are incurred.

#### Key to Comments

A-Coinsurance on hospital and \$10 copayments

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for physicians' visits.  
B-No coinsurance.  
C-Coinsurance only for certain services.  
D-Less coinsurance after the first year.  
E-If PPO doctors not used, coinsurance and coinsurance maximums are higher.  
F-30 percent coinsurance.  
G-Pays a set amount for hospital room and board.  
H-Surgical-fee schedule  
I-Pays set amount for all services for each day in the hospital.

J-Routine maternity rider offered only with family policies.  
K-Routine maternity coverage is included as part of policy only with family policies.  
L-Maternity coverage only for delivery and hospital stays—no doctor visits covered.  
M-Routine maternity coverage and coverage for maternity complications offered only with family policies.  
N-No maternity coverage even for complications unless rider is purchased.

# THE CRISIS IN HEALTH INSURANCE

## PART 2

Last month, in the first part of this series, we looked at the problems millions of Americans have in obtaining and keeping health insurance. We evaluated 71 individual health-insurance policies sold by 40 commercial carriers and Blue Cross and Blue Shield organizations, and discussed other alternatives for people who lose their group insurance.

This month, we go beyond the short-term remedies to examine the various solutions to the health-insurance crisis that have been proposed by insurance companies, physician organizations, and the business community. We also visit Canada to look at how that nation pays for its health care. The Canadian example is considered by some as a model for the U.S.

## HEALTH INSURANCE FOR ALL?

The American health-care system is the costliest in the world. The U.S. spends 171 percent more on health care per person than Great Britain; 124 percent more than Japan; 88 percent more than West Germany; and 38 percent more than Canada.

Over the last five years, the cost of health care in the U.S. has risen 42 percent, faster than the cost of food, housing, or transportation. In 1990, the nation's medical bill will total some \$666-billion, or about \$2664 for every man, woman, and child. Health-care spending now consumes 11½ percent of Gross National Product; by the end of the decade, it could account for as much as 15 percent.

Not all of those dollars pay for medical treatment. The cost of administration, claims handling, and insurance-company bureaucracy eats up at least \$65-billion, almost 10 per-

cent of the total. "We waste more of our medical dollars on bureaucracy and paper pushing than any other country," says Dr. David Himmelstein, national coordinator of Physicians for a National Health Program.

Despite the vast sums poured into health care, the U.S. ranks 12th in life expectancy, behind Japan, Italy, France, and the Scandinavian countries. It ranks 21st in the number of deaths of children under age 5; 22nd in infant mortality; and 24th in the percentage of babies born with an adequate birthweight (Bulgaria, Hong Kong, and the Soviet Union all do better on that last measure).

Among industrialized nations, only the U.S. and South Africa fail to provide access to health care for all their citizens.

### A joint venture

The U.S. health-care system is built on a lucrative partnership of

fee-for-service medicine and private insurance. For years, doctors and hospitals had *carte blanche* to set their own fees and pass the cost of their services along to private insurance carriers or to their patients. Insurance companies (and patients) rarely questioned the amount of those bills. "No one ever paid us to go fight with doctors," says one insurance executive.

If fees rose higher than the premiums the insurance companies needed to pay claims and turn a profit, the insurers simply raised the price of coverage. Policyholders could either pay the higher premiums or go uninsured.

The cost of medical care has now forced insurance premiums so high that millions of people *are* going uninsured. "The whole system keeps pricing more and more people out of it," admits Howard Bolnick, president of Celtic Life, a seller of health insurance. The mar-

ket is working efficiently, but it's less than optimum from society's point of view."

### Decades of debate

As more people are squeezed out of the American health-care system, and as basic public-health statistics underline the system's comparative inauquacies, a decades-old debate over public-health policy has been rekindled. The debate has been simmering for some 80 years.

In the years before World War I, in the 1930s, in 1949, in 1965, and again in the 1970s, the U.S. seemed on the verge of establishing universal health insurance. A 1939 issue of CONSUMER REPORTS noted: "There is now no doubt of the growing wave of popular sentiment in favor of an efficient public health program. It has become obvious that the people of the country intend to see to it that the whole population shall benefit from the discoveries of modern medical science. The only question before the country now is 'how soon?'"

A decade later, in 1949, we reported: "As the new Congress meets, prospects for national health insurance have never looked better. There are a number of reasons why 1949 may see a Federal insurance law passed at last. The American public has overwhelmingly demonstrated its approval of health insurance in many surveys, in legislative programs of consumer, civic, and labor groups, in government policy reports, and in endorsements by political leaders. Soaring prices have made the cost of medical care even more difficult for most families to afford."

Sixteen years later, a national health-insurance program still hadn't come to pass, despite the committed leadership of President Lyndon Johnson. In 1965, after powerful lobbying against national health insurance by organized medicine, Congress voted to authorize it only for the elderly, in the form of Medicare. (At the same time, it established Medicaid, a new government program for the poor.)

Even then, the Medicare Act was tailored to the economic demands of the American Medical Association and Blue Cross and Blue Shield, the primary insurance carrier of the day. Fee-for-service medicine and the Blue Cross method of reimbursing health-care providers became part and parcel of Medicare. They laid the foundation for

today's towering health-care costs. (Blue Cross and Blue Shield also got the job of paying Medicare claims for the Government.)

Again in the 1970s, there was serious talk of universal health insurance. But President Jimmy Carter could not muster the political backing needed to fulfill his campaign pledge to implement it.

How has a system that costs so much and still falls short managed to survive and resist reform?

### The power of the AMA

Fearful that universal health insurance will lower the incomes of its 271,000 members, the American Medical Association has for years denounced national health insurance as "socialized medicine." More to the point, the AMA has paid politicians handsomely to view national health insurance in the same light.

The AMA is one of the largest contributors to political campaigns, appearing near the top of almost every list of the big money raisers, the big contributors, and the big trade association political action committees (PACs) compiled by the Federal Elections Commission.

During a 15-month period ending in March 1990, the AMA ranked second on the election commission's list of the top 50 PACs in amount of receipts, second in total spending (which includes funds for advertising and mailings as well as contributions), and seventh in the amount of cash on hand, with some \$2-million in reserve to bankroll future campaigns.

In the 1988 Congressional elections, the AMA spent \$5.3-million, including \$2.3-million in direct contributions to House and Senate candidates. From January 1989 through March of this year, it has given money to 348 members of Congress, including eight of the 12 Congressional members of the Pepper Commission, a bipartisan group composed of members of Congress and industry representatives that was established to study health-care financing and recommend changes. The Commission was chaired by Sen. John D. Rockefeller IV, D-W.Va.

To replenish its coffers, the AMA embarked on a special effort last year to discredit the Canadian health-care system, often viewed as a model for reform in the U.S. In what it called its "Strengthening the U.S. health-care system" campaign, the AMA wrote to member physicians: "We need your help to con-

tinue reaching millions of Americans. We must tell them the facts about the dangers in a Canadian-type health-care system—before it's too late. Help us continue publishing our messages in leading magazines and newspapers . . ." Enough doctors sent checks that the AMA was able to buy ads disparaging the Canadian system in major magazines. (For one example, see the illustration on page 610.)

The AMA's national political program is reinforced by the efforts of state medical associations. From early 1989 to the end of March, state medical associations in 10 states spent some \$4.1-million on behalf of political candidates.

### Insurance doubt

The insurance industry's stake in the battle is the \$175-billion it collects each year in health-insurance premiums. In a letter sent to member companies last summer, Carl Schramm, president of the Health Insurance Association of America (HIAA), warned that "a move in the United States to a Canadian approach to health-care financing is antithetical to our interests." Schramm subsequently told CU: "We'd be out of business. It's a life-and-death struggle."

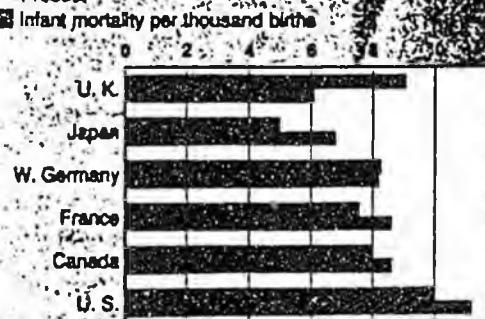
The insurance industry also shovels money at politicians. American Family Corp., the fifth-largest seller of health insurance, particularly dread-disease and cancer policies, ranks eighth on the election com-

**Doctors on the picket line**  
Just as organized medicine in the U.S. has opposed universal medical insurance, many Canadian physicians were none too fond of the notion. When Saskatchewan became the first province to adopt universal medical coverage, doctors there went on strike. When Quebec followed suit in 1970, its doctors also staged a short strike.

### HIGH COSTS, POOR RESULTS

Though the U.S. spends a higher percentage of its Gross Domestic Product on health care than these five industrialized nations, its record on infant mortality is poorest of the group. (Gross Domestic Product is monetary value, at market prices, of all goods and services created in a country in a given year. Infant mortality is a commonly used measure of the overall health of a nation, reflecting how well medical services are delivered throughout its population.)

■ Health expenditures as a percentage of Gross Domestic Product  
■ Infant mortality per thousand births



Sources: Health Care Financing Review, 1988, Annual Supplement; UN Children's Fund, State of the World's Children, 1989; Organization for Economic Cooperation and Development, Health Data Bank.

mission's list of the top 50 corporate campaign contributors, ahead of such giant corporations as Boeing, Citicorp, and Ford Motor Co. It donated some \$250,000 from the beginning of 1989 through March of this year. Three other large sellers of health insurance—The Travelers, Metropolitan, and Prudential, all of which collect well over \$1-billion in health-insurance premiums each year—are also among the top 50 corporate contributors.

But the insurers don't limit themselves to campaign contributions. Their forte is "educational" lobbying. "We produce lots of research bulletins that are classy little numbers," HIAA president Schramm told CU. When the Pepper Commission issued its report last March, its recommendations for reforming sales practices in the small-employer market were strikingly similar to those of the HIAA. "The Pepper Commission basically ceded the small-group issues to us," Schramm says. "The [the commission's recommendations] are our proposals."

### Changes in the wind

But public dissatisfaction with the current system has once again brought health insurance onto the

national agenda. Poll after poll shows that the American people are unhappy with the way their health care is financed. A 1988 poll conducted by Louis Harris and Dr. Robert Blendon, chairman of the Department of Health Policy and Management at the Harvard School of Public Health, found that 61 percent of Americans would prefer a system of national health insurance like the one in Canada, in which "the government pays most of the cost of care for everyone out of taxes, and the government sets all fees charged by doctors and hospitals." This year, a Los Angeles Times poll asking a similar question found that 66 percent of Americans would prefer a health-insurance system similar to Canada's. "People are far ahead of the political leadership on this issue," says Susan Sherry, an official at Families USA, a senior citizens health-advocacy group.

The business community has also become vocal on the issue. Some corporate leaders are calling for changes that they would have considered unthinkable a few years ago. "We need fundamental reform. Whether we have the courage to move forward remains to be seen," says Walter Maher, a lobbyist for Chrysler Corp. Chrysler says that workers' health insurance adds \$700 to the cost of every car it builds in the U.S.—an amount that must come down if the company is to remain competitive.

Not all doctors side with the AMA. The 68,000-member American College of Physicians is calling for reforms that would guarantee all Americans access to medical services and reduce the waste and inefficiency in the present system: The 3000 members of Physicians for a National Health Program have a similar goal. (Those groups, however, don't back their programs with political contributions.)

Privately, even some insurance-industry executives recognize that universal health insurance is probably inevitable, and they have been preparing for their eventual role in it. "Some companies are saying, 'If we can survive until there's national health insurance, we have a shot at administering it,'" says an official at one Blue Cross and Blue Shield organization.

### Solving the crisis

A number of remedies for the health-insurance crisis have been proposed by various interest

groups. Some are limited; others are more far-reaching. Some deal only with controlling costs of the health-care system. Others confront the more basic question of providing access to care for everyone. Among the proposals likely to be part of the public debate in the coming months are these:

1. **Encourage people to use fewer medical services by writing higher deductibles into policies.** The theory behind this proposal is that when people pay a greater share of their bills, they'll use health care more frugally. As a result, the argument goes, health-care costs will decrease, premiums will rise more slowly, and more people will be able to afford coverage.

Such a notion assumes that people prescribe their own medical care. Most of the time they don't; their doctors do.

Health-care providers also stimulate much of the demand for elective medical care. Hospitals now advertise in magazines, on television, and on billboards—drumming up business for their inpatient psychiatric services, for example, when such cases might be handled more appropriately on an outpatient basis. As part of its corporate-image promotion, General Electric advertises magnetic resonance imaging machines (MRIs) on television. "It doesn't hurt to have people aware of MRIs," says a GE spokesperson. If people ask for MRIs instead of ordinary X-rays, hospitals will have no choice but to shell out \$1.4-million to \$2-million for a machine.

Higher deductibles may indeed make some people think twice before seeking care in the first place. While discouraging unnecessary services is a reasonable goal, there's an obvious danger that people will postpone necessary treatment. Then more costly procedures may be necessary, or it may be too late.

There is even some doubt as to whether any savings would result from a switch to higher deductibles. "Our experience has shown that higher deductibles have not prevented our [claim] costs from going up," says Andy Perkins, a vice president at The Travelers.

2. **Do away with state-mandated benefits.** Each state requires that health-insurance policies sold there include certain coverages. These so-called state mandates vary among states, but many require insurers to cover newborn babies, adopted children, prenatal care, and

In Some Countries She Could Wait Months For Her Surgery.

The American Medical Association is launching a national advertising campaign in 1989. This ad ran in Newsweek.

**On the offensive** To counteract positive media portrayals of universal health insurance programs in Canada and elsewhere, the American Medical Association launched a national advertising campaign in 1989. This ad ran in Newsweek.

# CRISIS IN HEALTH INSURANCE

mammographic screening. They may also offer employees the option of continuing their coverage when they leave a job.

The insurance industry contends that some mandated benefits, such as coverage for visits to psychologists, podiatrists, chiropractors, and social workers, are of questionable value and unnecessarily raise the price of insurance. However, the industry has no estimate of the overall premium savings that would result.

In CU's view, repealing mandated coverage moves in the wrong direction—toward less access to care. To shave a few dollars off premiums, more women would lose their prenatal care, more newborns and children would go without preventive treatment, and more employees would have no coverage when they left their jobs.

**3. Design stripped-down policies.** Some insurance-company and Blue Cross and Blue Shield executives have suggested designing policies with limited benefits that they can sell for about half the price of more comprehensive coverage.

While such basic policies might improve the overall statistics on the uninsured, they, too, would result in less coverage for individuals. We reported on some of them last month. An "affordable" basic policy from Blue Cross and Blue Shield of Oklahoma, for instance, covers only 21 days of hospital care. That might be enough for most sicknesses, but a catastrophic illness or injury would leave a policyholder uninsured and possibly on the road to bankruptcy. A person whose serious heart attack cost almost \$50,000 would have been left \$10,000 in debt by an affordable hospital-surgical policy sold by Pyramid Life, the policy that ranked at the bottom of our Ratings last month.

**4. Institute "managed care."** Under the rubric of "managed care," insurance companies are belatedly paying attention to what their dollars are buying. Managed care includes formal programs for monitoring the quality of treatment and determining whether it's appropriate for the patient's condition. Some programs require policyholders to seek second opinions before undergoing surgery, to use hospital outpatient facilities for specified procedures, to use certain doctors and hospitals, and to obtain approval from insurance companies before starting a proposed course of treatment.

Managed care attempts to put controls on doctors—ironically some of the same controls doctors have feared from a national health-insurance program. In the process, it is creating a brand-new profession, health-care cost management, one of the fastest growing segments of the health-care industry. Health-care cost management firms are expected to generate some \$7-billion in revenue in the next few years—revenue that will, of course, come from insurance premiums.

Whether the savings in the cost of health care will be greater than the money spent to "manage" it remains to be seen. "None of this stuff has done anything to make the fundamental health-care system cost less and [be] more efficient," says Curt Fuhrmann, president of the individual health division of Washington National. And even if managed care eventually reduces the nation's health-care bill, it will do nothing to expand access to medical services for people who currently have no insurance coverage.

**5. Establish risk pools.** The insurance industry wants each state to set up a high-risk pool that would provide policies for people the companies don't want to insure. Such pools are yet another way for the industry to shed a group of policyholders who are not profitable. The HIAA further proposes that the states pick up the tab for pools' losses; that is, make up the difference between what the pools collect in premiums and what they pay out in claims.

Last spring, when we surveyed the risk pools that had been organized in 19 states, we found that they covered only about 55,500 people in total, and all the pools were operating at a loss. Pool administrators estimated that at least 413,000 people in those states needed pool coverage but couldn't obtain it. In Illinois, for example, the waiting list was so long that people have to wait at least a year for coverage.

**6. Expand Medicaid coverage.** When Medicaid was first established in the mid-1960s, it covered some 70 percent of those with incomes below the poverty line. Today Medicaid covers just 38 percent, because states and the Federal government have raised their eligibility standards.

The insurance industry and the American Medical Association want to reverse that trend by requiring Medicaid to cover anyone whose

income falls below the official poverty line, currently \$12,675 for a family of four; \$8075 for a couple; and \$6314 for a single person.

Under some proposals, people whose incomes are as high as twice the poverty level could "buy" Medicaid benefits. Under other proposals, these people would have to turn to the private market for their coverage. It's hard to see how any family whose income is around \$13,000—or even \$26,000—can afford some of the policies we rated last month. Premiums for families of four ranged from about \$2000 to more than \$6000 a year.

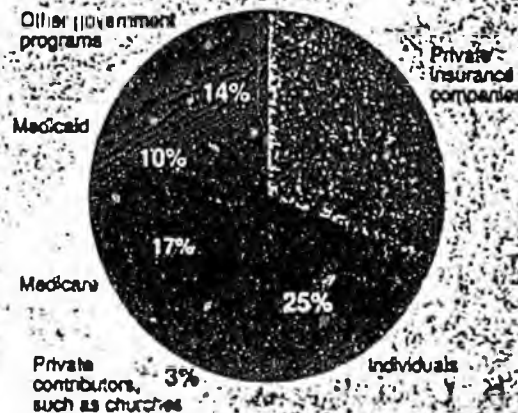
Expanding Medicaid is an easy solution for doctors and insurance companies. It costs them nothing. The burden will be borne by state and local treasuries, whose Medicaid budgets are already stretched to the limit.

Putting Medicaid cards into the hands of more people wouldn't necessarily assure them access to health care. Many doctors refuse to treat Medicaid patients because reimbursement rates are low. Reforming Medicaid would expand coverage for some, but it would also increase the government bureaucracy needed to determine eligibility. It is at best a stopgap measure that will do little to curb waste in the health-care system.

**7. Reform insurance-company practices.** One plan proposed by insurers themselves would excuse people who were once covered under a small employer's group policy from satisfying a new waiting period for pre-existing illnesses

## WHO WRITES THE CHECKS?

As costly as the private insurance system is, it pays only 31 percent of the U.S. health-care bill. At least 25 percent comes directly out of Americans' pockets.



Source: Paying More, Getting Less. From U.S. Health Care Measures Up, National Health Care Campaign, 1988



**Signs of the times** Hospitals in some parts of the country now advertise to fill their beds, partly because of recent insurance-company rules requiring that more procedures be done on an outpatient basis. These two billboards beckon motorists along a New Jersey highway.

**Paying for long-term care**  
The Pepper Commission has recommended a publicly funded program to pay for nursing-home expenses and for home care needed by people of all ages. That would eliminate the need for most nursing-home insurance. CU supports this approach.

when their employers change carriers or when they change jobs. In those cases, people with health problems would have immediate coverage. This proposal would also prohibit insurers from excluding coverage for certain health conditions or parts of the body by means of exclusion riders.

But insurers still don't want to take on any unnecessary risk. So their proposal also calls for the establishment of a reinsurance agency (essentially a company that insures insurance companies) to assume the risk of waiving pre-existing conditions clauses and eliminating exclusion riders. Insurers themselves would fund the reinsurance program through assessments, but if assessments proved to be inadequate, the government could be called on to make up the difference.

Another industry-sponsored proposal would limit the sometimes huge annual increases experienced by employees who work for small firms—to no more than 15 percent above an insurance company's general yearly rate increase for all its policyholders.

Both of those proposals would help people already safely inside the insurance loop. But they won't help people with health problems who are outside the system or who must buy their own coverage.

**8. Require all employers to offer coverage.** The main proponent of this approach is Senator Edward Kennedy. He is sponsoring

a bill that would require all employers to offer insurance to employees who work at least 17½ hours a week. Under Kennedy's bill, employers would also have to pay 80 percent of the cost of a basic package of benefits for their full-time employees.

Others have proposed variations on Kennedy's plan. These so-called pay-or-play approaches to health care coverage would require employers to offer insurance to their workers or pay into a special government-operated fund that would provide the coverage. In other words, employers would either "play" by providing coverage or "pay" into the special fund. The Pepper Commission recommended such a plan.

To win support of the AMA, Kennedy's bill does not address cost containment. More people would be covered, but most doctors and hospitals would still have a blank check. That omission, a serious one in CU's view, has also given employers and the insurance industry reason for opposing this approach.

Lobbyists for small business argue that the costs of providing coverage are too great for many marginal firms. Unless small businesses received tax relief in exchange for providing coverage, this approach could give them a powerful incentive to hire employees to work fewer than 17½ hours a week. Seasonal and part-time workers could still be left without insurance.

Congress is likely to give pay-or-play proposals serious consideration in the next few years. At

best, these proposals can expand insurance coverage for some people. At worst, they fail to offer a way to curb health-care costs. They also perpetuate the current system of private insurance with all its administrative waste. In fact, they would add another layer of administrative bureaucracy in creating the special government fund for workers whose employers would still not provide coverage.

**9. Introduce universal health insurance.** This is the approach Canada has taken to fund medical care for its citizens. Under this system, everyone is entitled to health care, and the public pays the bills through tax dollars rather than through insurance premiums.

Providers of health care charge a fee for their services, just as in the U.S. But their fee schedules must be negotiated with the government, which has an incentive to control costs, since tax increases are as politically unpopular in Canada as in the U.S.

In CU's view, the first eight of these proposals fall short of the goal of affordable health care for all Americans. They would still limit employment options—forcing some people to stay on a job that may otherwise be unsatisfactory simply to keep their health insurance. They could still force a person to spend as much as \$12,000 a year to cover a family under a conversion policy. Some sick people would still have to settle for an inferior hospital-indemnity policy just because it is better than nothing. Worst of all, many Americans would still be denied proper health

care simply because they couldn't afford to buy insurance.

## Recommendations

The few reforms that were won in the past were simply bargains struck with doctors and insurance companies. People who could least afford the cost of medical care or insurance were sleighed off onto

public programs. The public assumed the cost of health care for those patients through Medicare and Medicaid while health-care providers and insurance companies kept control of the system and retained for themselves the ability to profit from those who could pay.

Meaningful reform must provide for universal access to health care;

cost containment; mechanisms to ensure quality of care; elimination of administrative waste; and long-term care for the elderly and disabled.

The only model for reform that attempts to meet those criteria is the Canadian system. It is not a system

## DOCTORS VS. INSURERS THE BATTLE OVER FEES

Insurance companies and the Federal government say they're trying to control health-care costs. And in the process, they're going head to head with the medical establishment.

Insurers are now requiring many policyholders to obtain approval before beginning a course of treatment. They require that policyholders have certain types of surgery done in hospital outpatient facilities and that they obtain second opinions before having any surgery performed. They are also establishing preferred-provider organizations, PPOs, in which doctors agree to reduce their fees to the insurer in exchange for more patients; the insurer lowers deductibles and coinsurance as an inducement for policyholders to use PPO doctors.

Since 1984, the Federal government has limited the fees it pays to doctors who treat Medicare patients. It will soon implement a new way of paying doctors based on the relative value of the various services they perform. This new system is aimed at reducing the fees of some highly compensated specialists such as anesthesiologists and radiologists, and increasing the fees of others, such as family doctors. The system also includes limits on billing and on the number of services performed.

So far, all these efforts at taming health-care costs have been about as successful as trying to squeeze a balloon. When insurers or the Federal government clamp down on costs in one area, costs expand rapidly in another. "We pay less per claim, but we pay for more claims," says Curt Fuhrmann, president of the individual health division of Washington National, a seller of health insurance. "A lot of this stuff works initially, but after a while the system adjusts and finds a way around it." Nowhere is that more evident than in the war over bills that has erupted between doctors and insurance companies.

### The fine art of bill coding

Pressure from insurance carriers to limit physician payments, as Medicare does, has spawned a new industry devoted to teaching doctors how to bill for their services and maximize reimbursement. Firms in the business of "doctor reimbursement and coding" sell thick books and sponsor seminars that tell physicians how to beat the system.

"Reimbursement guaranteed. You'll improve your reimbursement, or you'll get your money back," reads an advertisement for one such company, Medbooks. "Start now to bill for all of the services you provide—and receive all of the payments you're entitled to!" reads a flyer for St. Anthony Publishing Inc., a company that proclaims it has grown into an industry leader in "five short years."

The primers sold by these new firms tell physicians how to choose certain billing codes over others that would net them less income. There are some 7000 codes representing all the services physicians perform, and doctors customarily list the

codes on the bills they present to patients and their insurance companies.

For example, one newsletter reported that insurance companies are not paying if doctors use the code for "hospital discharge day management" when they discharge hospital patients. It advised doctors to use either the code for "medical conference by physician regarding medical management with patient and/or relative, guardian, or other, approximately 25 minutes" or a code for a higher level of daily hospital visit. The newsletter recommended that doctors use both codes for a while and see which one insurance companies will go for.

A physicians' newsletter from St. Anthony Publishing carried this headline: "Updating superbill brings financial rewards." Superbills are the detailed bills that patients receive for the procedures doctors perform. St. Anthony advised doctors in family practice that adding and billing separately for such services as minimal [office] visits, brief [office] visits, injections such as tetanus and DPT, new patient office visits, supplies, and brief follow-up consultations could bring an increase in weekly revenue of \$845, or \$40,560 a year (based on 48 weeks).

The books and newsletters also offer guidance on "unbundling"—that is, charging separately for services that were once priced together or "bundled." Unbundling almost invariably means more income.

Another newsletter from St. Anthony Publishing described one medical office in which doctors were performing dilatation and curettage procedures 10 to 15 times a week. When the doctors were shown how to charge separately for dilatation and for curettage, and even for sterile surgical dressings, the average payment from insurance companies increased from \$300 to \$535, and the practice increased its revenue some 78 percent.

### Insurers strike back

To combat these practices, insurance companies are now hiring firms to "rebundle" the bills that come into their claims departments. Indeed, a rival industry has sprung up to scrutinize bills for evidence of the billing practices promoted by the coding and reimbursement firms.

For instance, ERISCO, a subsidiary of Dun and Bradstreet, offers "medical claims editor" computer software that will rebundle a \$2500 bill for performing an appendectomy (\$1500) with a laparotomy (\$1000), the latter being simply an incision in the abdomen. Once the computer program has rebundled the bill, the doctor will receive only \$1500 for the appendectomy and nothing extra for making the incision.

No one knows yet whether insurers or doctors will win this war. What is certain is that the battles are costly and the money being spent on books, seminars, and software is doing little to improve the health of Americans.

of "socialized medicine," in which doctors and hospitals work for the government and patients are assigned to clinics. Canadians are free to pick their doctors and hospitals. The Canadian health-care system costs less than the U.S. system and delivers more, mostly because it spends less on administration and bureaucracy. Canada spends about 1 to 2½ percent of every health-care dollar on administering health claims, compared with 10 to 11 percent spent by private insurers in the U.S.

A move to a universal health-care system modeled on Canada's would save money in other ways. Because medical care would be available to everyone, there would be no need for medical-payments coverage under workers' compensation insurance or automobile-insurance policies, or for the liability portion of homeowners insurance that goes to cover injury claims.

As we explain in the report that begins below, Canada has by no means found the ideal system. It is

facing the same cost pressures on medical care as the U.S. and European countries, and, like those nations, it is examining ways to contain them. But public debate there has long since moved away from reforming insurance practices and toward targeting the country's resources to improve the health of its people.

The U.S. should take the best of the Canadian system and add to it the techniques that have shown the most promise for controlling health-care costs and curbing the overuse of health-care services that occurs in both countries. Those techniques include establishing "practice guidelines" for physicians (which define procedures that are effective under various circumstances) and assessing whether new technologies are effective in treating disease. Borrowing the best from Canada and adding effective cost containment would produce a uniquely American system that would serve all citizens.

It may be that the American

model will evolve first in one of the states. (The Canadian system was patterned after universal hospital coverage introduced in the province of Saskatchewan in the 1940s.)

Some states are already looking for ways to improve access to health care for their residents. In California, for instance, there is a serious proposal in the legislature for the state to pay for health care, including long-term care, for all Californians. In New York, the state legislature recently passed a state-subsidized insurance plan for young children of the working poor, a step some see as a move in the direction of universal health insurance.

"In the next decade, if you don't have a national health system, the insurance companies will continue to selectively deinsure. No matter how many premiums you've paid, you'll never know if you'll be next," says Dr. Jane Fulton, a professor of health policy at the University of Ottawa. "That risk should be intolerable to Americans."

## A LOOK AT THE CANADIAN ALTERNATIVE

**N**ear downtown Montreal, a pregnant woman arrives at a *centre local de services communautaires*. Here at the CLSC, as the center is called, she receives regular checkups and counseling on the right foods to eat during her pregnancy.

When it's time for her to deliver,

she will go to a local hospital. One of the two doctors who has been caring for her will deliver the baby. After the baby is born, she can bring it back to the CLSC for immunizations and follow-up care.

A social worker at the center will help her adjust to the demands of motherhood if she needs help, and a staff nurse will visit two weeks after the baby is born to give breastfeeding advice and answer other questions.

If the nurse finds that the mother lacks the skills to care for her baby, or detects more serious problems such as child abuse or neglect, more intensive counseling, either in the mother's home or at the CLSC, will be scheduled. When the mother needs a break, she can take the baby to the CLSC's day-care center, where women from the surrounding community drop off their children for a few hours each week.

The woman will pay nothing for these services. She simply presents her orange-and-yellow health card, issued by the government of Quebec. That card entitles her to free medical care at any of the 158 CLSCs in the province or from any

doctor or hospital she chooses.

The CLSCs in Quebec, as well as similar community health centers in other provinces, represent an attempt at integrating medical care and social services within the framework of Canada's universal health-care system.

CLSCs help community residents find housing or day care for elderly or sick parents. Some offer smoking-cessation clinics. At others, elderly residents from the surrounding community can come by for a hot lunch at noon or for flu shots. A few CLSCs function as mini-hospitals where patients are admitted and kept overnight for observation and treatment.

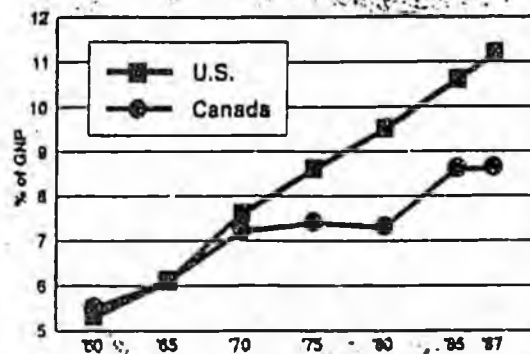
"The CLSC is an example of how policy is moving toward improving the overall health of the population," says Dr. Michael Rachlis, a Toronto physician who has studied his country's health system.

### How the system evolved

Twenty-five years ago, just before Canada began phasing in universal insurance for medical services, the U.S. and Canadian health-care systems were on parallel tracks. Both

### THE ROAD NOT TAKEN

Canada and the U.S. were spending about the same percentage of their Gross National Products on health care in 1965, just before Canada established its publicly funded insurance system for medical services. Since then, the U.S., which has retained private insurance, has spent a greater portion of GNP on health care.



Source: Paying More, Getting Less: How U.S. Health Care Measures Up, National Health Care Campaign, 1988.

countries were spending about 6 percent of Gross National Product on health care. By 1987, as health-care costs increased throughout the industrialized world, Canadians were spending 8.6 percent, while Americans were spending 11.2 percent.

But by then, the two countries were already on very different tracks. In 1966, Canada passed its Medical Care Act, entitling all residents to medical care funded through the tax system. (Free hospital care had been established in 1957.) About the same time in the U.S., the president of the American Medical Association declared that health care was a privilege, not a right—an issue still not fully resolved in the U.S. today.

### No private insurance

Canada outlawed private insurance for any services covered by its universal programs. Insurance companies there can sell health policies only to pay for uncovered services, such as private rooms in hospitals, medical expenses incurred in foreign countries, and dental care. When Canadians go to a hospital or see a doctor, they simply show their medical card, issued by the provincial government. The doctor then bills the government and is reimbursed according to fee schedules negotiated earlier. (Hospitals receive an annual budget that covers virtually all patient costs. They are paid one-twelfth of their budget each month.)

Since the billing forms used by doctors are standardized and only the government pays the bills, processing costs are low and providers receive payment in about 30 days. Patients don't have to cope with the deductibles, coinsurance, coinsurance maximums, or out-of-pocket expenses that are part of virtually every American health-insurance policy. Nor do they have to fill out complicated forms. There are no user fees, and doctors cannot "balance bill"—that is, charge more than the negotiated fee. (In the U.S., doctors can bill patients for more than the insurance company's allowable charge.)

Canada's program covers most medical services. However, eyeglasses, prescription drugs for people under 65, out-of-hospital dental care for adults, and cosmetic surgery are usually not covered in most provinces. Some provincial governments also pay for a few



**Prenatal care** At a clinic near downtown Montreal, Dr. Stephen DiTommaso examines Sandra Gail Dabovich while her son Anjoine watches. Pregnant women are closely monitored at Canadian clinics and offered services ranging from nutritional counseling to home visits after their babies are born.

Photo: CYNTHIA JOHNSON

nonphysician services, such as physiotherapy, podiatry, and chiropractic treatments.

### Fee-for-service doctors

Although Canada replaced private insurance policies with a public-insurance system, it retained fee-for-service medicine; that is, most doctors receive fees for the services they perform, rather than a salary. Today physicians' incomes are among the highest in Canada—four to five times higher than the average industrial wage. (In the U.S., the average physician in private practice earns five to six times the average industrial wage.)

Each year, medical associations and the provincial governments negotiate an overall increase in the fee schedule. The associations then allocate the increases among various specialties and services.

The negotiated fees, however, tend to be lower than in the U.S. (where doctors also care for patients who can't pay). In Quebec, for instance, medical groups have negotiated a fee of \$217 for doctors who perform cesarean sections (they receive \$87 more if there are complications and \$109 more if the delivery is at night or on the weekend). They receive a fee of \$174 for performing an appendectomy. (Here and elsewhere in this report, all Canadian figures are given in U.S. dollars.) In the U.S., the average physician fee for delivering a baby by cesarean is \$1222, and the

surgeon's fee for performing an appendectomy averages \$846.

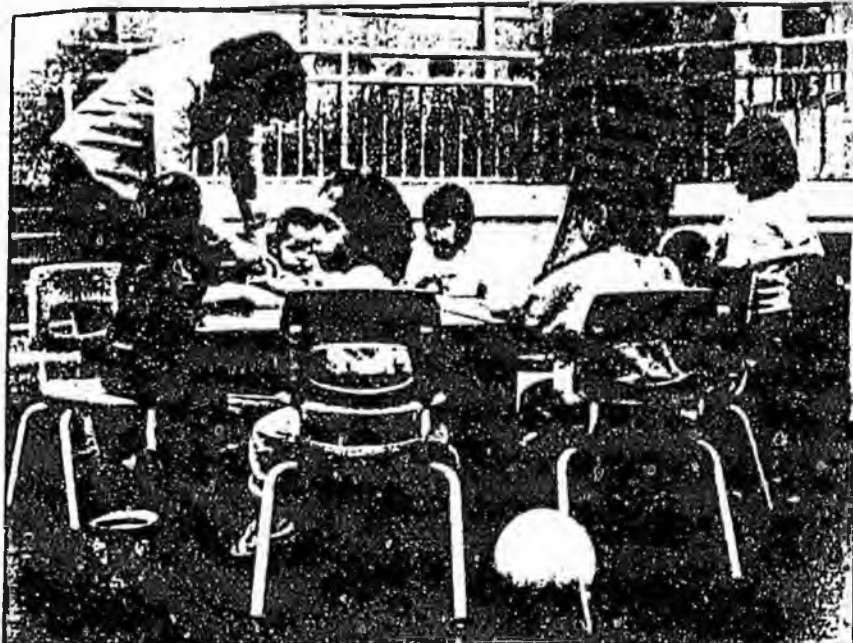
The cost of malpractice insurance in the U.S. is higher than in Canada, and U.S. doctors maintain they must practice defensive medicine to avoid malpractice suits. Nevertheless, the money spent on malpractice premiums still accounts for only a tiny fraction of the differences in cost between the two health-care systems, according to Dr. David Himmelstein of Physicians for a National Health Program.

Compared with the U.S., Canada spends much less on health care, but its system is still the second most expensive in the world, a statistic some trace to an oversupply of doctors who bill for too many services and to overutilization of medical services by patients. The government gives Canadian doctors considerable autonomy in their practice of medicine. And they have no insurance companies looking over their shoulders as do doctors in the U.S.

### Hospital budgets

Hospitals also negotiate their budgets with the provincial ministries of health. Budgets are based on a baseline amount that the hospital spent in 1969. Each year, the ministries grant increases for inflation, for new programs, and for increased activity in the hospital's services.

Because the ministries have tended to hold increases to less than the actual rate of inflation, hospitals



**Child's play** Pierrette Croteau, a child-care worker at the Montreal clinic, helps toddlers and preschoolers at the facility's day-care center. Each day the center looks after 10 to 20 neighborhood children whose parents drop them off either for half-day or full-day care.

have had to redistribute their funds internally to live within their budgets. Ottawa Civic Hospital, for instance, closed 82 beds in 1989 but was able to serve more people than the previous year by shifting patients to outpatient care and surgical day-care centers, eliminating overnight stays for preadmission testing, and shortening the length of stays. Canadian health-policy planners say that reducing the number of days patients spend in hospitals is vital if the system is to get its costs under control.

In the U.S., hospitals in states without limits on hospital rates can simply raise their daily charges and pass them along to insurance companies that pay the bills for patients who are not on Medicare. Insurers then pass them along to policyholders. (For Medicare patients, the Government pays a fixed amount based on the diagnosis.)

### **New technology**

Provincial governments also control the introduction of expensive new technology like magnetic resonance imaging machines, which take sharp pictures of internal organs, and lithotripters, which crush kidney stones and gallstones with sound waves. A hospital can raise private funds to buy an MRI, but since the money to operate it comes from the government, hospitals generally don't do that. Further-

more, doctors can't bill the government for use of the equipment unless it is authorized.

The introduction of new technology has, therefore, gone more slowly than in the U.S. Critics of the system, mostly doctors and hospitals, contend that as a result, some people are being deprived of state-of-the-art treatment. But other Canadians, including health-policy planners and government officials, say there is a benefit in introducing new technology more slowly. They argue that by waiting for reasonable evidence that new technology really works they can make a more informed decision about whether to commit scarce resources to it.

In the U.S., when a new machine comes on the market, its use tends to spread rapidly throughout the medical community—often before there has been time to assess the technology's effectiveness. Once a hospital or a group of doctors buys a new machine, the incentive to use it to recoup the investment exists side by side with the need to use it to improve medical care. That inevitably drives up health-care costs.

No Canadian who is acutely ill is denied prompt medical care. If patients need emergency care and the local hospital has no facilities or equipment to provide it, they are transported to the nearest hospital that does. If necessary services are available only in another province,

or in the U.S., the patient goes there, and his or her provincial government pays the entire bill.

The slower implementation of technology sometimes means waiting lists for some procedures, however. A person complaining of headaches doesn't immediately receive a CAT scan and may have to wait several weeks for one. But if doctors suspect the person has a life-threatening ailment such as a brain tumor, a CAT scan will be done right away. The same is true of such costly procedures as coronary-artery bypass surgery.

"None of my patients has ever suffered or been deprived of medical care because of this system," says Dr. Philip Berger, a physician who treats AIDS patients in downtown Toronto. "I treat the poorest and the sickest, and they get everything they need." Even the costly drug AZT is supplied free to AIDS patients by the Ontario government.

### **Who pays the bill?**

The Canadian federal government pays part of the health bill for each province. It pays more of the cost for poorer provinces and less for wealthier ones. The provinces themselves fund the rest of their health-care budgets, which usually account for about one-third of their total annual spending.

At both the federal and provincial level, the money to pay for health care is raised through a combination of personal income taxes; corporate taxes; excise taxes on gasoline, tobacco, and alcohol; and lottery profits.

In Alberta and British Columbia, residents also pay a special insurance premium earmarked for health care. In Alberta, a family of any size pays \$552 a year; a single person pays \$276. Ontario did away with insurance premiums earlier this year and replaced them with an employer health tax. In Ontario, employers with a payroll greater than \$347,826 (U.S.) would pay a rate of 1.95 percent. Employers with smaller payrolls pay less. (Quebec and Manitoba levy a similar tax.) Unlike U.S. payroll taxes, the employee does not pay a matching amount.

A Canadian with a taxable income of \$26,086 (U.S.) living in Ontario would pay about \$7184 a year in Federal and provincial taxes. Of that, roughly \$1340, or about 19 percent, goes to fund health care.

In the U.S., a person with \$26,086



**A place for the elderly** The Montreal center feeds about 100 elderly men and women from the surrounding community each noon. The cost of lunch is nominal—the U.S. equivalent of \$2.39. The 158 clinics across the province of Quebec tailor their programs to the needs of the communities they serve.

in taxable income would pay \$4776 in Federal income taxes and perhaps another \$1304 in state taxes, bringing his or her total income tax to about \$6080. None of that money would pay for his or her health care. The person would also pay Social Security taxes, of which about \$378 would go to fund Medicare.

The American (or his or her employer) would pay for his or her medical care through private insurance; that typically costs \$1500 to \$2000 a year. In addition, he or she would have to pay out of pocket the deductibles, coinsurance, and other expenses not covered by the insurance policy. Together, those out-of-pocket costs can easily run between \$500 and \$1000 per year.

### Looking ahead

There's virtually no debate in Canada about whether there should be a publicly funded insurance system or whether all people should have access to health care. There is plenty of debate, however, about whether the dollars the country spends on health care are spent in the right place.

Like other industrialized countries, Canada is also experimenting with ways to control costs. In Quebec, for example, there are caps on doctors' incomes. When a general practitioner's gross quarterly income (before taxes and practice expenses) reaches the U.S. equivalent of \$37,102, the government will pay him or her only 25 percent of the usual fee for the rest of the quarter. In effect, then,

Quebec has put a damper on the ability of general practitioners to gross much more than \$148,000 a year. (In the U.S., the typical general practitioner earns about \$216,900 before taxes and practice expenses. But high practice expenses, including the cost of dealing with the fragmented private and public insurance systems and the cost of malpractice insurance, reduced that to a mean net income of about \$95,000 in 1988.)

In Canada, as elsewhere, doctors and the medical establishment have been vocal in demanding more resources. The community health centers are controversial, for example, because traditional medical practitioners see them as diverting health-care dollars from new equipment, more operating rooms, and larger fees.

Most Canadians like their health-care system, and would dispute the American Medical Association ad in U.S. magazines last year that characterized their system (without actually naming it) as "underfinanced, overextended, and ill-equipped."

Dr. Eugene Vayda, a U.S. and Canadian citizen who is a professor of medicine at the University of Toronto, has practiced under both the Canadian and U.S. health-care systems. "It's a pleasure to practice in a system where everyone has the same buying power," he says. "It allows you to focus on the patients and their needs. The Canadian system is so much better than the U.S., you can't even speak of them in the same breath." ■

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## JAMES GANNON



### Sick state of health-care costs

**T**HE RISING cost of health care in the United States is enough to make a healthy person sick.

Americans are spending staggering amounts on health care and finding that the more they spend, the faster costs rise. Between 1970 and 1989, health care spending climbed from \$950 a person annually to \$2,354 — after adjusting for inflation.

Per-person spending on health care in the United States is about double that of Japan and Germany and nearly three times the average in Britain.

Health care spending is a monster gobbling up an alarming share of the federal budget and the nation's total income. National health spending totaled \$675 billion in 1990 — more than double U.S. spending on national defense.

For what we spend on health care, we could fight 10 Persian Gulf Wars each year and have enough left over to gold-plate the Pentagon.

If all that spending assured quality health care to everyone who needs it, there would be little complaint. But the nation's health care system leaves a massive number of Americans shut out.

About 33 million Americans have no health insurance. And contrary to popular belief, these are not the poor (who are covered by Medicaid) but largely the working class; more than three-fourths of the uninsured are employed men and women and their dependents.

"The health care crisis is no longer a matter of the poor — it is a middle class issue, a family issue, a small business issue, and a federal government issue," said Sen. John D. Rockefeller, D-W.Va., one of the Senate's leading experts on health care. "The system is imploding — collapsing in on itself."

**T**HE CRISIS Rockefeller senses is changing the political dynamics of the issue and forcing Congress to get serious about major reform. It is uniting old adversaries — organized labor, huge corporations, small business interests — into powerful coalitions demanding federal action to control costs and expand access to health care.

"Now, for the first time, we find ourselves in broad alliance with many of our traditional opponents on this issue," AFL-CIO President Lane Kirkland told a Senate hearing on health care reform last week.

"The health care tragedy is no longer confining itself to the fringes of our society; it is striking at millions of solid, working, taxpaying families."

Kirkland and others testified at a hearing called by Chairman Lloyd Bentsen, D-Texas, of the Senate Finance Committee, who cited polls showing that more voters are worried about the rising cost of health care than about "taxes or interest rates or even about losing their jobs."

Bentsen, the Democrats' 1988 vice presidential nominee and a prospective opponent to President Bush in 1992, has begun a series of hearings he hopes will focus attention on the issue and point toward some solutions.

There is a growing sense in Democratic circles that the long-simmering problem is reaching the kind of critical mass that could make it an important 1992 presidential campaign issue.

But the Democrats are no more certain than Bush is on the question of what to do. Piecemeal remedies — such as cost controls applied to Medicare and Medicaid and promotion of health maintenance organizations — have had limited effect, and radical surgery on the system is politically scary and extremely costly.

Some Democrats propose to replace the current private-insurance system with one big government-run national health plan.

There's virtually no chance any major legislation will reach a vote this year. But, with the heat rising, look for the lid to blow in the campaign of 1992.

*James P. Gannon is Washington bureau chief for the Detroit News.*

# Falling through the net

## 90,000 Alaskans lack means to pay huge medical bills

By HAL BERNTON

Daily News reporter

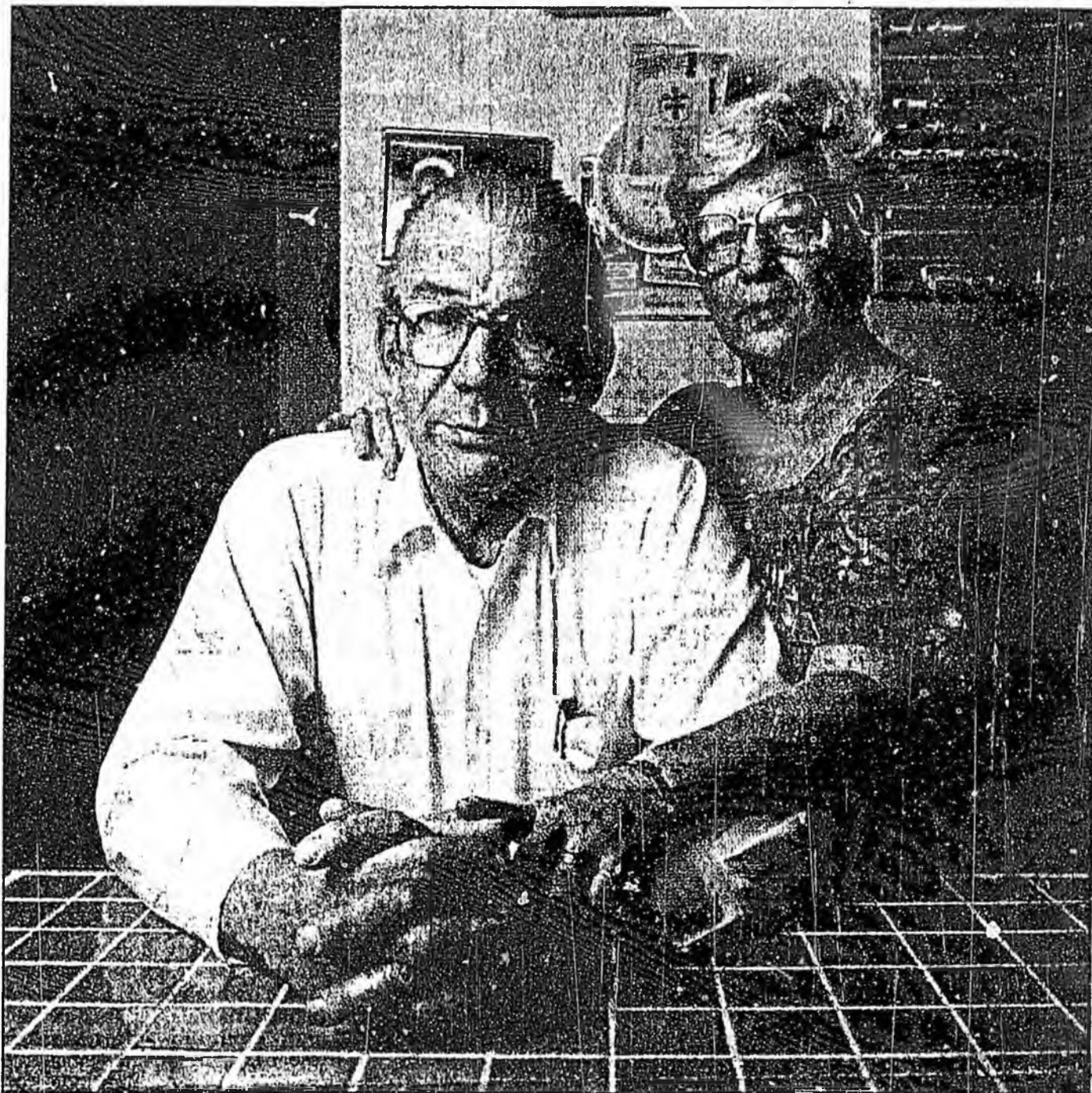
Emmett Walton's lung collapsed on a nightmarish flight from Anchorage to Ketchikan. One minute, the 56-year-old Anchorage security guard was relaxing with his wife, Margaret, in the seat of an Alaska Airlines jet, the next he was gasping for precious oxygen through a collapsing lung rapidly filling with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

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

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

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

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



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

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

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

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

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

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

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

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

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

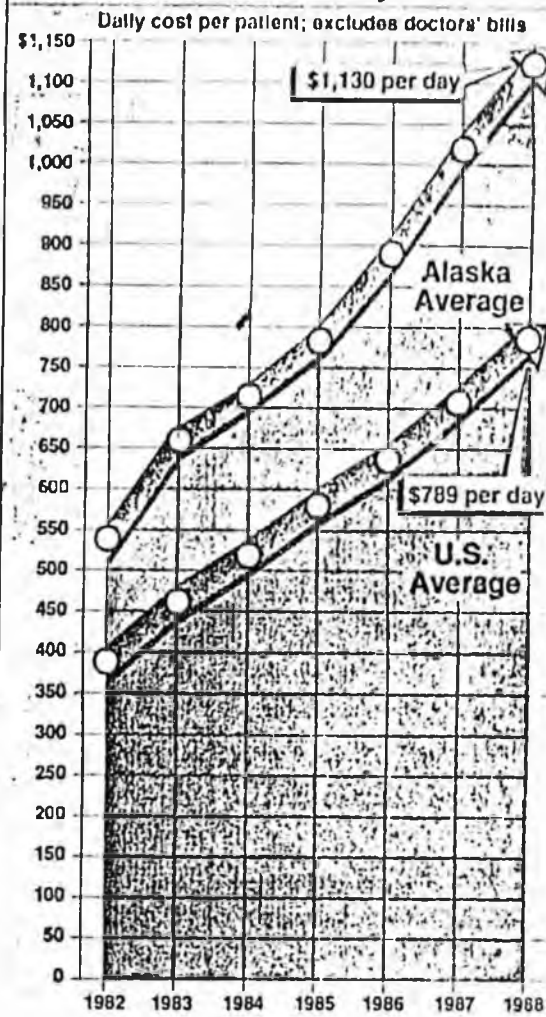
A collapsed lung and no supplementary insurance put Emmett and Margaret Walton in Bankruptcy Court.



FRAN DURNER / Anchorage Daily News

PAUL SOUDERS / Anchorage Daily News

## Rising Cost of Hospital Care



RON ENGSTROM / Anchorage Daily News

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

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

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

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

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

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

Meanwhile, insurer and employers

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

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

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

□

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

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

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

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

Association statistics.

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

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

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

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

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

# BILLS: Insurers, doctors ha

Continued from Page F-1

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The state, for example, has offered one of

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

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



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

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

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

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

Rolinda Standridge, for example, has a

# Five different ideas on costs

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

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

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

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

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

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

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

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

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

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

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

The pain had been building for more than a year.

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

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

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

The infection kept getting worse, and Javier resorted to begging antibiotics from friends to help keep the pain in check. Two weeks ago, after a trip to the Providence

Emergency Room and several telephone calls to the Southcentral Dental Society, Javier finally found Wynne, the Anchorage dentist.

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

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

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

□

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

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

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

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

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

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

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

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

Doctors have long fought such price-control efforts, and so far, only 2 percent of the state's eligible doctors have opted to join the new network. "Once they get a hold, they'll ratchet down, or try to freeze rates," said Doug G. Smith, an

## **BILLS:** Insurers, doctors have different ideas on cutting costs

Continued from Page F-1

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

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

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

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

The rate schedule would initially cover the 135,000 Alaskans insured by state,

municipal and school district insurance plans. But Duncan hopes many state businesses would choose to join the program to help keep down employee health-insurance costs.

The legislation includes several other provisions, including one measure that would create insurance pools that small employers could join to try and get better rates.

"With this bill, Alaska would come out of the dark ages and to the forefront of national cost-control efforts," said Malek, the California consultant who helped draft the legislation.

But doctors and hospital officials think the legislation unfairly singles their operations out as the cause of the state's health-care crisis.

"We cannot support any legislation that has, as its primary method of health-care cost controls, regulating reimbursements to physicians and hospitals," said Harlan Knudson, executive director of the Alaska State Hospital & Nursing Home Association.

"It's crazy, unless we ad-

dress the whole damn (health care) problem," said Schalow, of the state medical association.

Health-care industry officials, in a recent policy paper, declare the need for a comprehensive state health plan. Some technologies, they say, may have to be rationed because there's just not enough money to pay for their routine use.

They also seek universal health insurance so more of their patients could pay for treatment.

Such a plan may be developed by a state health-care task force, then submitted to the legislature. But Schalow said the doctors don't have enough representation on the task force, and will develop their own plan.

Doctors and hospitals also are seeking further reforms of state liability laws to help curb the cost of malpractice insurance.

"Liability insurance premiums for malpractice have reached levels that physicians can no longer afford nor can their patients afford through increased fees," the policy paper stated.

Duncan said he knows his legislation may face a tough fight from the health-care industry. But he hopes for allies among major state employers hurt by the rising cost of health-care insurance.

"Our goal is not to reduce the quality of health care, or put people out of business. We just want to make this whole system work," Duncan said.



W. R. R. 1967  
The Miami Herald

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Consistent as always, he always said that the lands act is about preserving our culture and our land," said John Shively, vice president at NANA Regional Corp. of Kotzebue. "We didn't set out saying, 'Give me my corporations.'"

money is an item that contradicts the very essence of cultural survival for Native people, which is the concept of sharing," said Ross Schaeffer, president of NANA.

"The challenge I see is

Native values."

### THE BOTTOM LINE

Other corporations have been willing — at times eager — to trade Native land

Cook Inlet Region Inc., an Anchorage corporation representing a polyglot mix of 6,553 Indian, Aleut and Eskimo shareholders, had traded away 600,000 acres for the bidding rights on developed federal

Kodiak has sought to trade 112,000 acres locked within a wildlife refuge for a sliver of potentially oil-rich land in the Arctic National

Please see Page E-2, ANCSA

groups.

But while conditions are better today, Inupiat leaders have reason to be

Please see Page E-6, BRADNER

# Layoffs, corporate maneuvers strip millions of health insurance

By DONALD L. BARTLETT and JAMES B. STEELE  
Knight-Ridder Newspapers

Bobby Jean McLaughlin of Charleston, W.Va., mother of six and grandmother of six, is a multiple statistic in America's new economic order.

McLaughlin lost it all.

She lost her job, her health insurance, her pension, her savings and, in the end, her husband.

She lost her job as a \$6.20-an-hour department store manager, after 18 years, as a result of the prevailing corporate financial craze.

With it, she lost the health insurance that had paid the family medical bills.

And she lost her pension when she took the lump sum payment set aside for her retirement and was obliged to use it instead to pay hospital and doctor bills.

She had little choice. Her husband of more than 35 years, Joseph, worked in a small bakery in Charleston that did not provide health insurance for its employees.

He was suffering from emphysema, his condition deteriorating with each passing day. When he no longer could breathe without the aid of a ventilating machine, he was forced to quit.

Recalled McLaughlin:

"It just wiped out my savings. I

## The DEATH of the MIDDLE CLASS



couldn't tell you the amount of money we put out. He was using those tanks (of oxygen). And it was just breaking us up, 'cause they were \$38.50 every time they came with one.

### SERIES AT A GLANCE

□ NOV. 24: Two decades of economic rule changes by a succession of Congresses and presidents are causing the dismantling of America's middle class and the further enriching of the rich.

□ NOV. 24: Through a variety of corporate tax breaks, Congress has systematically shifted the federal income tax burden from businesses to individuals.

■ DEC. 1: Foreign-owned companies in the U.S. can eliminate fringe benefits, such as health insurance, and pay lower U.S. taxes. And foreign ownership of American business is growing.

□ DEC. 8: Deregulation of the airline, trucking and S&L industries has eliminated middle-income jobs and will end up costing workers hundreds of billions dollars in taxes and lost wages.

□ TODAY: As more companies are bought, sold, merged, restructured or go bankrupt, a growing number of middle-class workers are being forced to go without health insurance protection.

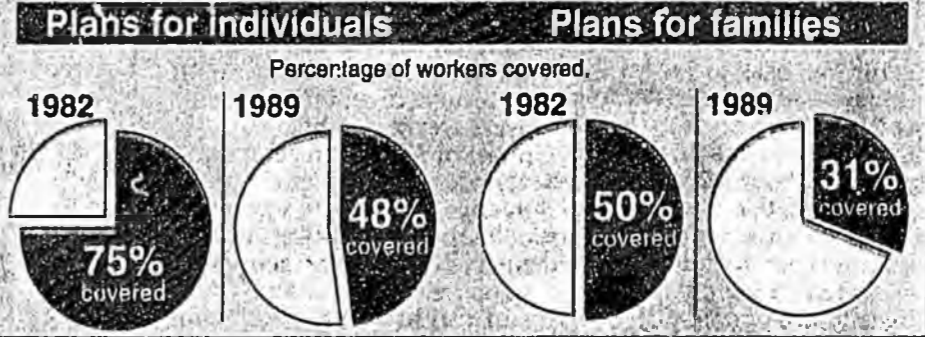
□ DEC. 22: Come retirement, millions of Americans will discover to their dismay that the pension they thought was there isn't.

"I tried to get help with the medical bill, but they look at you like you are dirt under their feet. We were always kind of independent. He worked at the bakery 30 years. He worked even after the

### What went wrong

In just seven years, health care benefits paid by companies have been stripped from millions of employees.

Figures are for workers at companies employing 100 or more people.



doctor told him his lungs were bad enough he could get disability."

Last December, Joseph McLaughlin died.

No one, not in the federal government, not in private industry, keeps an accurate count of the Bobby Jean McLaughlins.

But their numbers already are in the millions. They are the anonymous middle-class health-care casualties of high-stakes corporate finance in America, the victims of a government rule book that looks after the demands of deal-makers and ignores the needs of ordinary citizens.

They are not poor enough to qualify for state or federal health-

assistance programs.

They are not affluent enough to be able to afford the cost of private medical insurance.

And so they go without — joining the ranks of an estimated 40 million Americans who have no medical insurance. That does not take into account more millions who are underinsured.

Those numbers are bound to grow — unless the U.S. government reverses policies.

Consider:

• U.S. Labor Department surveys of large and medium-sized companies that offer health insur-

Please see Page E-7, INSURANCE

# INSURANCE: Corporate maneuvers cheat millions of benefits

Continued from Page E-1

ance for 31 million employees show that the percentage of those employees with fully paid coverage for themselves alone fell from 75 percent in 1982 to 48 percent in 1989, the latest period studied. (Large and medium-size companies employ 100 or more people.)

- At those same companies, the percentage of employees with fully paid coverage for themselves and members of their families fell from 50 percent in 1982 to 31 percent in 1989.

- The average monthly employee contribution for individual health-care protection rose from \$9 in 1982 to \$25 in 1989, an increase of 178 percent. During that same period, the average weekly paycheck went up 25 percent.

- The average monthly employee contribution for combined individual and family health-care protection rose from \$27 in 1982 to \$72 in 1989, an increase of 167 percent.

- Because part-time workers seldom receive fully paid fringe benefits such as health insurance and pensions, their numbers are growing exponentially. Companies like this arrangement because it reduces costs. At Wal-Mart, now the nation's largest retailer, 40 percent of the workforce is part-time. At K mart Corp., it is 47 percent. At Sears, Roebuck & Co., it is 55 percent.

- As a result of the largest increase in corporate bank-

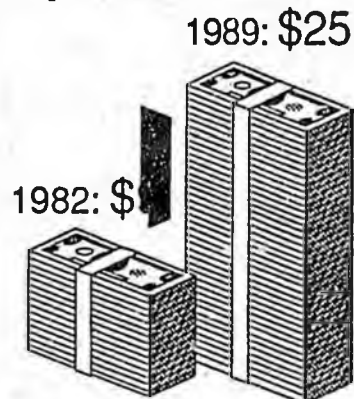
## What went wrong?

Employees are forced to pay more for their health insurance

Average monthly employee contribution for health care.

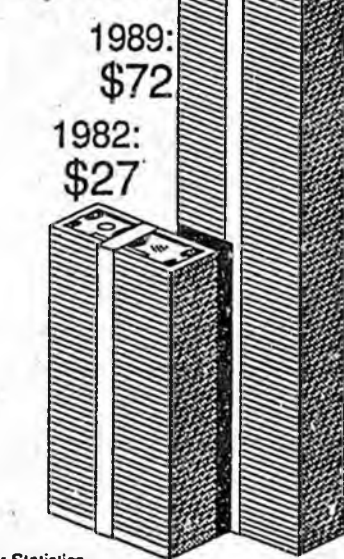
### Plans for individuals

Up 167%



### Plans for families

Up 178%



SOURCE: Philadelphia Inquirer, Bureau of Labor Statistics

losing their health-care protection grows daily as one company after another dismisses employees to trim expenses, eliminates jobs while seeking to reorganize in Bankruptcy Court, or goes out of business.

For a lucky few workers across the country in that situation, the government rule book — as crafted by a succession of lawmakers and presidents, Democrats and Republicans — offers some relief.

Call it the hospital legal lottery.

ble for all those medical bills.

If you are among the lucky few, you will win and recover, if not your health, at least the money you lost.

But the process can be expensive and time-consuming.

Ask Roy Mahon Jr.

In 1984, Mahon went to work as a salesman in Garden City, Kan., for Massey-Ferguson Ltd., the Canadian company that was one of the world's largest manufacturers of agricultural tractors, combine harvesters and other farm equipment.

A year later, Massey-Ferguson executives followed a course charted by so many U.S. corporations. They reorganized the business, as they put it at the time, to "achieve profitable growth through acquisition."

First, in May 1986 they created a new company called Massey Combines Corp., which took over the money-losing combine operations, including the dealership that employed Mahon in Kansas.

The rest of the business operations stayed with the old Massey-Ferguson, which gave itself a new name, Varsity Corp., and sold stock. The proceeds were earmarked for the acquisition of businesses.

The new Massey Combines got more than just the depressed combine business. It got:

About \$200 million in debt; about 1,500 employees, including Roy Mahon, and the financial obligation to pay the medical claims and

other benefits of retirees and the widows of retirees of the original Massey-Ferguson.

On March 4, 1988, Massey Combines Corp. went into receivership in Canada, the equivalent of Bankruptcy Court. The company fired all its employees and notified retirees that their health and other benefits were being terminated.

Roy Mahon remembers that time well.

Earlier in the year, he said, "I was working on a new parts counter on our building. I stood up and I thought I had sprained something real bad. Turned out I had an aneurysm and it gave way.

"That night I was in the hospital. Two days later I had my leg taken off. Consequently, they found out I had an aneurysm in each groin and my aorta was about to blow. ...

"So basically the operations were the amputation of the left leg, then aorta surgery, and they went in and rebuilt the area on the right leg. ... (The sur-

geon) spent 7½ hours on that leg."

Soon after Mahon returned home to recuperate, he discovered something amiss at Massey Combines.

"I was wondering what was happening because one of my claims went to the administrator and they sent it back not paid," he said.

"The next thing I knew I got a telephone call from my former boss who said the company went belly up. They were bankrupt and everything was gone. ...

"That was it. I was left hanging with about \$65,000 to \$75,000 in hospital bills."

Eventually, Mahon said, Kansas Medicaid paid all but \$18,000 to \$20,000 of the bills. He had to pay the rest.

"I had to cash in my IRA account to survive," he said. "I sold one of my cars. In August 1988, I sold my house to get what I could get out of " because I had to have funds to live on. I had to get these bills down.

"But consequently I have absolutely no credit whatsoever. ... Financially, I'm now at the bottom."

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growing exponentially. Companies like this arrangement because it reduces costs. At Wal-Mart, now the nation's largest retailer, 40 percent of the workforce is part-time. At K mart Corp., it is 47 percent. At Sears, Roebuck & Co., it is 55 percent.

As a result of the largest increase in corporate bankruptcies since the Great Depression, millions have lost their health insurance protection. The bankruptcy surge is continuing unabated.

Faced with steadily rising expenditures for the health-care costs of retirees, companies are curtailing or eliminating a benefit once promised for life. Millions of future retirees will see their coverage disappear. The government's General Accounting Office estimates that companies paid \$9 billion in retiree medical costs last year, but should have set aside \$32 billion for future payments. They did not.

The number of workers

goes out of business.

For a lucky few workers across the country in that situation, the government rule book — as crafted by a succession of lawmakers and presidents, Democrats and Republicans — offers some relief.

Call it the hospital legal lottery.

If you win, your medical bills are paid.

If you lose, you pay your own medical bills.

But very few win.

Here is how it works:

Let's say the company where you have been employed so many years decides to restructure itself to cut its costs. As a part of the realignment, your job is terminated.

Suddenly, you lose the health insurance that has been paying your medical bills.

You hire a lawyer and sue the company.

If you are like most workers, you will lose, which means you will be responsi-

But the process can be expensive and time-consuming. employees, including Roy Mahon, and the financial obligation to pay the medical claims and

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TAKING A STAND

TIMES 12/12/91

## Alaska health care ideas workable, in line with national proposals

Attempting to get The Anchorage Times to understand my health care reform proposal, Senate Bill 83, is much like my trying to teach a pig to sing. It annoys the pig and it wastes my time.

The Times editorial of Dec. 12 shows a complete lack of understanding of SB83 as did its previous editorial on this issue earlier in 1991. This despite the voluminous information I provided The Times as well as a personal visit with its editorial board.

The Times continues to insist that my approach in SB83 is designed "... to help the state's estimated 135,000 government employees to have cheaper coverage." Well, it does that, but if The Times editorial writers would read on they would find that it also will provide cheaper coverage for the private sector employers



Jim Duncan

and employees who presently have insurance, as well as providing improved access for the estimated 90,000 Alaskans who are either uninsured or underinsured.

The key to successful health

care reform is a comprehensive approach. That means you not only provide universal coverage but also enact a tough, no-loop-hole strategy to bring health care costs, system wide, under control. Without cost containment measures, the inflationary spiral of nearly 20 percent annually in health care costs will continue and any reform proposal will be doomed to failure. SB83 proposes this comprehensive approach.

The cost containment steps in SB83 of rate setting and utilization standards are controversial and I guess for that reason The Times believes the proposal is only trying to focus blame. To the contrary, SB83 recognizes that all parties: consumers, health care providers and the insurance industry have to participate if health care reform is to work.

SB83 does not place blame. It proposes a cure.

It is interesting to note that many national proposals embrace rate setting as a necessary cost control strategy, as does SB83.

- The National Leadership Coalition for Health Care Reform endorses rate setting. The coalition is comprised of unions, associations of health care professionals, consumers and businesses including AT&T, Bethlehem Steel, Chrysler, Ford, Eastman Kodak, General Electric, Lockheed, 3M, Westinghouse and Xerox. Former presidents Gerald Ford and Jimmy Carter have endorsed the coalition plan.

- The National Planning Association, in a report titled, "Curing U.S. Health Care Ills," endorses a global spending limitation and fee

schedules for provider reimbursement.

- The national AFL-CIO recently endorsed health care reform that includes a national cost containment program with a cap on health care spending and uniform reimbursement rates for all providers.

- The National Governors Association staff in a briefing paper, "Strategies for Controlling Health Care Costs," favors a single public agency to negotiate health care payments with health care providers.

- Congress is considering legislation that proposes a federal agency to set spending targets and negotiate rates between providers and consumers.

It is clear that major health care reform will happen and it

will include universal coverage and cost containment. However, as SB83 proposes, I believe it is preferable to have Alaskans solving Alaska's problem than to turn it over to a federal authority.

The Times editorial concludes by stating, "It is time to stop the hand-wringing and turf protecting and to focus on a cure." I agree. I stopped wringing my hands by introducing SB83. It's not turf protection, and it proposes a cure.

The Anchorage Times, like the pig, can be annoyed at learning how to sing, but I am sure many other Alaskans will continue to sing the tune for comprehensive health care reform like SB83.

*Jim Duncan represents Juneau in the state Senate. Opinions expressed in Taking a Stand do not necessarily reflect the editorial position of The Anchorage Times.*

MONDAY  
January 6, 1992

TIMES

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# State working to heal health insurance woes

ASSOCIATED PRESS

JUNEAU — Alaska lawmakers are trying to find a cure for the rising cost of health insurance, but any treatment is bound to be costly.

There are more than a dozen bills regarding health insurance pending from the 1991 session, and more are expected to be introduced in the final session of the 17th Legislature, which begins Jan. 13.

A legislative report says Alaskans pay as much as \$2 billion annually to doctors, hospitals, clinics, pharmacies and other health-care suppliers — an increase of 300 percent over the past decade.

Many people are finding they cannot afford health insurance and are foregoing basic medical treatment.

An estimated 90,000 Alaskans — 16 percent of the state's population — are without health insurance but make too much money to qualify for welfare.

If costs increase at the current pace, which is more than double the inflation rate, Alaskans could be faced with a \$10 billion-a-year bill for health care by next decade. And the number of uninsured Alaskans could total one-quarter of the state's population, experts estimate.

The cost of the Medicaid program also is on the rise. Lawmakers last year appropriat-

ed about \$102 million toward Medicaid. The program pays for medical care of poor, aged, blind or disabled people, and for nursing-home care. The cost is split between the state and federal governments.

This year the Legislature and Gov. Walter J. Hickel approved \$108 million for the state's share of Medicaid. But based on current costs, that will not be enough, said Janet Clarke, director of administrative services for the state Department of Health and Social Services.

The state also pays out tens of millions of dollars a year to insure its employees. The \$385-a-month premium pays for medical, dental and vision coverage for the employee, his or her spouse and children. Unlike most private-sector health plans, the employees contribute nothing toward the premium.

Lawmakers are considering several bills to solve or at least ease the health-care cost dilemma. A legislative task force also is looking for solutions.

The most comprehensive and controversial proposal has been offered by Sen. Jim Duncan, D-Juneau. It would create a state authority to set guidelines for the cost of medical services throughout Alaska.

Rep. Mark Boyer, D-Fairbanks, has introduced a similar bill. See Health, page B3

# Health

Continued from page B1

lar measure in the House.

The legislation also would pool Alaska employers, possibly including the state, to create a larger policyholder group with more leverage to negotiate lower insurance premiums.

Duncan's plan is opposed by some doctors, hospitals and other health-care suppliers. "They have this fear this will lead to a state insurance company," Duncan said.

One version of the plan would allow the authority to serve as a self-insurer, bypassing the insurance industry.

Duncan said his legislation would try to control the escalating cost of medical care, create a larger pool of employees and employers to help bring down premi-

ums, and educate consumers on choices in medical care.

"We don't think you control costs by merely controlling hospital charges," said Harlan Knudson of the Alaska State Hospital and Nursing Home Association. "You can't just set arbitrary fee schedules, which he would do in his bill."

The association supports creating a state health authority. But Knudson said detailed information on health-care costs and who pays the bill should be collected before legislators lock the state into a comprehensive health-care law. Such an exhaustive research project could take between two to six years, he said.

Meanwhile, Sen. Virginia Collins, R-Anchorage, has two bills pending that she says will tide the state over until a comprehensive health-care law can be approved.

She has proposed creating a

non-profit corporation comprised of Alaska insurers to pool small businesses' insurance needs and spread the risk among many employers.

"People who are uninsured are working, but have no insurance through their employers," Collins said.

If a small firm employs someone with a high risk of needing medical care, finding insurance often can be impossible. The idea behind pooling is to spread the risk out among a large group of smaller businesses.

Another Collins bill would create a non-profit corporation charged with offering low-cost health insurance to schoolchildren. Her proposal would set premiums based on parents' income.

Sen. Jay Kerttula, D-Palmer, is sponsoring a bill that would set up a new state authority to determine basic health-care services, and then offer state-subsidized in-

urance plans to small businesses and uninsured Alaskans.

Another Kerttula bill would require insurers and hospitals to join an association charged with providing insurance to people with high medical risks and those who cannot afford standard insurance.

There also is talk of reviving the state catastrophic illness fund which helped pay for high medical costs incurred by patients without insurance or adequate coverage.

It used to serve about 200 people a year to the tune of about \$3 million, but the fund has received no money from lawmakers since 1987.

The fund was mostly used to pay the high cost of premature births and infants with severe medical problems, said Rep. Niilo Koponen, D-Fairbanks. People had to pay some of their own money toward their medical bills

before they could qualify for the state aid.

Whether lawmakers can agree on major changes governing health care and insurance before they adjourn next May is doubtful. Collins, a member of the state task force studying the problem, said she does not expect lawmakers to have the time to pass a comprehensive bill this session. ---

Some say the state should wait and see if Congress can come up with a national solution to the health-insurance problem. But Duncan and Koponen say that may take too long.

"We can make a beginning here and assist people in Alaska, which is what we tried to do with the catastrophic illness fund," Koponen said.

Duncan said the states must show initiative and creative thinking in facing the problem. "The states are going to have to be the laboratories."

# States mull bills tinkering with health care

By HAL SPENCER 1/2/92  
ASSOCIATED PRESS

Weighing experiments that could lead to national health care reforms, at least 18 state legislatures will consider bills this year that range from expanding services to the poor to providing insurance for all.

The Washington and Minnesota legislatures are among several that will consider multimillion-dollar proposals financed by new taxes and fees to replace private medical insurance with state-operated insurance pro-

■ Descriptions of health legislation facing state lawmakers in '92. A8

grams much like Canada's national health insurance system.

Alaska will look at ways to pool health insurance for small businesses so they can afford to provide basic coverage to workers. Kentucky legislators will decide whether to broaden Medicaid coverage for the poor, and Michigan will continue debate on a Senate-passed plan to provide subsidized insurance to the working poor.

The growing involvement of the states in health care is another measure of the "desperate need" to reform the nation's health care system, said Washington state Rep. Dennis Braddock.

"It's too bad it has to come from the states and not the Congress, but it looks like that's what will happen," said Braddock. He is the sponsor of a measure that would collect taxes and fees from employers and individuals and use the money to administer health care and pay providers.

Congress is expected to take up health care reform this year. Nearly 35 million Americans are uninsured and the number is rising along with health care costs. Those costs, increasing at twice the inflation rate, are expected to reach \$738 billion this year, the Advisory Council on Social Security said recently.

"It is likely, however, that some state or states will show the way" to a national health care system, said Sidney Wolfe, a physician and director. See Health, back page

## Health

Continued from page A1

of the liberal Public Citizen Health Research Group in Washington, D.C.

Robert Moffit of the conservative Heritage Foundation agreed.

"There is a real deep sense of desperation. The states are excellent laboratories of social experimentation. Some are going in the wrong direction on this issue, but that's all right, too, because we can learn from their mistakes," said Moffit, deputy director of the foundation's Domestic Policy Studies in Washington.

Significant health care reforms by the states seem unlikely this year because legislative budgets have been hit hard by recession, said Joy Wilson, a health care expert with the National Conference of State Legislatures in Washington.

"There is a lot of discussion, but really, with the recession and budget deficits, that's about all it

## Health legislation facing some state legislatures in 1992

ASSOCIATED PRESS

**Alaska:** Several measures, ranging from state-run health insurance for all through a Canadian-style "single-payer" system to pooling small businesses so they can afford to provide insurance.

**California:** Several proposals, including "pay or play" and Canadian-style single-payer plans under which business and government would finance health care insurance for all.

**Florida:** Governor's commission preparing recommendations for more health care access. Legislation includes a state-run, Canadian-style insurance system.

**Hawaii:** Measures to improve the state's unique system under which 98 percent of residents already have some form of health care coverage.

**Idaho:** A health care access study committee expected to make recommendations for possible legislative action. A Canadian-style system could be on the table.

**Kansas:** Measure for business pay or play insurance coverage for all to be financed through new taxes.

**Kentucky:** Proposals to broaden Medicaid coverage for the poor through cost controls and other steps.

**Michigan:** State Senate-passed measure to provide subsidized insurance to the working poor facing House action. Businesses and individuals could get tax credits for buying the insurance.

**Minnesota:** Legislative proposal, vetoed by governor last year but still being negotiated, to raise the cigarette tax to help finance health care for an increasing num-

ber of people. Eventually, the legislature would create and fund in some form a state-subsidized health care system for all.

**Nebraska:** Modest proposals to cover more poor people and control medical costs for all.

**New Jersey:** Preparing regulations to enact 1991 law providing "bare bones insurance policy" to 1 million uninsured residents. Legislature will consider fund sources including a payroll tax.

**New York:** Several proposals, including a pay or play proposal requiring employers either to provide basic insurance or pay a tax which would pay basic health care costs of the uninsured.

**Ohio:** Proposals include a Canadian-style "universal care" plan, and more modest bills seeking to improve current system through cost containment and other

steps.

**Utah:** Modest proposals to broaden Medicaid coverage, and to make it easier for some citizens, such as young people, to get or keep private insurance.

**Vermont:** A single-payer health care plan similar to Canada's.

**Virginia:** Proposal to provide state-funded health insurance to poor children not covered by Medicaid.

**Washington:** Proposals for Canadian-style system and a pay or play approach with a payroll tax on businesses. Also would expand a state subsidized health insurance program now serving 21,000 working poor.

**Wisconsin:** Several proposals including a Canadian-style plan.

is right now," she said.

But the discussion contains an edge of urgency.

Republican state Sen. John Holmgren of Bear River City, Utah, told of a farmer-friend who has no health insurance and is dying of cancer. Medical bills "will

spend him down to poverty. He'll have nothing to leave his family. When you've paid your way all your life, something like this can leave you with not much dignity," Holmgren said.

Utah is among at least nine states proposing modest legisla-

tion tinkering with the current system to make health care available to more people.

At least another nine states, with varying enthusiasm, are pursuing major health care reform that one way or another would give virtually every citizen

access to basic medical care.

The proposals are taking two basic forms. One, the "pay or play" approach, would preserve the private insurance industry. Employers would be given the option of providing affordable health insurance to workers or paying

into a state fund from which health care for the uninsured would be financed.

The other, a "single-payer" system modeled after Canada's system, would eliminate the industry in favor of one big state insurance program. Business and individuals, through taxes and fees, would pay into a state fund from which health insurance for all would be administered and financed.

In some states, including California and Washington, both proposals are in the hopper.

Some versions of these plans include various cost control mechanisms. Washington's pay-or-play measure, proposed by Democratic Gov. Booth Gardner, would set up a regulatory commission with the power to control medical costs.

Any real reform must include the ability to control Medicaid costs as well, state officials said. Several states will seek federal permission, or waivers, to bypass federal rules controlling Medicaid in order to reduce the cost and increase service.

# 18 states consider health-care reform

By HAL SPENCER

THE ASSOCIATED PRESS

Weighing experiments that could lead to national health-care reforms, at least 18 state legislatures will consider bills this year that range from expanding services to the poor to providing insurance for all.

The Washington and Minnesota legislatures are among several that will consider multimillion-dollar proposals financed by new taxes and fees to replace private medical insurance with state-operated insurance programs, much like Canada's national health-insurance system.

Alaska will look at ways to pool health insurance for small businesses so they can afford to provide basic coverage to workers. The bill, submitted by Juneau's Sen. Jim Duncan, might also include the state in the pool, to create a larger policyholder group with more leverage to negotiate lower rates.

Duncan's legislation also would create a state authority to set guidelines for the cost of medical services throughout Alaska.

Kentucky legislators will decide whether to broaden Medicaid coverage for the poor, and Michigan will continue debate on a Senate-passed plan to provide subsidized insurance for the working poor.

The growing involvement of the states in health care is another measure of the "desperate need" to reform the nation's health care system, said Washington state Rep. Dennis Braddock.

"It's too bad it has to come from the states and not the Congress, but

## Don't look for help from Washington

By WALTER R. MEARS

THE ASSOCIATED PRESS

**WASHINGTON** — While the issue won't wait in 1992, the answer to the problem probably will because there's little chance the government will be able to write a new national health-insurance policy in an election year.

But with costs and concern rising, the health-care crisis and rival ideas to deal with it are going to be fixtures in every campaign — from the White House to Congress to state house.

By President Bush's count, there already are 31 varying proposals before Congress. He'll be adding his own in the State of the Union message on Jan. 28.

"I do think the time has come

### AP NEWS ANALYSIS

for the administration to come forward with a comprehensive program," he said. "We will capitalize on and learn from some of those programs that are floating around up there."

Until Bush made that commitment, almost offhandedly, answering questions at the Kiwanis and Rotary Clubs in Ontario, Calif., on Dec. 6, the White House had seemed willing to let the issue ride with a limited, holding-action proposal.

It looks like that's what will happen," said Braddock. He is the sponsor of a measure that would collect taxes and fees from employers and individuals and use the money to administer health care and pay providers.

Congress is expected to take up health-care reform this year. Nearly 35 million Americans are uninsured and the number is rising along with health-care costs. Those costs, increasing at twice the inflation rate,

are expected to reach \$738 billion this year, the Advisory Council on Social Security said recently.

"It is likely, however, that some state or states will show the way" to a national health-care system, said Sidney Wolfe, a physician and director of the liberal Public Citizen Health Research Group in Washington, D.C.

Robert Moffit of the conservative Heritage Foundation agreed.

But the numbers are getting worse, the soaring cost of medical care is a drag on the faltering economy, and the question has climbed the roster of voter concerns.

National health insurance was one of the issues Sen. Harris Wofford pushed in Pennsylvania in winning his Democratic upset in November.

The Commerce Department reports an 11 percent increase in U.S. spending on health care during 1991, to a total of \$738 billion in 1991, and forecasts annual increases of 12 percent to 13 percent for the next five years.

That report says health spending will reach 14 percent of the

Please turn to Congress, Page 8

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Significant health-care reforms by the states seem unlikely this year because legislative budgets have

been hit hard by recession, said Joy Wilson, a health-care expert with the National Conference of State Legislatures in Washington.

"There is a lot of discussion, but really, with the recession and budget deficits, that's about all it is right now," she said.

But the discussion contains an edge of urgency.

Republican state Sen. John Holmgren of Bear River City, Utah, told of a farmer-friend who has no health insurance and is dying of cancer. Medical bills "will spend him down to poverty. He'll have nothing to leave his family. When you've paid your way all your life, something like this can leave with with not much dignity," Holmgren said.

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At least another nine states, with varying enthusiasm, are pursuing major health-care reform that one way or another would give virtually every citizen access to basic medical care.

The proposals are taking two basic forms. One, the "pay-or-play" approach, would preserve the private insurance industry. Employers would be given the option of providing affordable health insurance to workers or paying into a state fund from which health care for the uninsured would be financed.

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Please turn to States, Page 8

## States...

**Continued from Page 1**  
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Any real reform must include the ability to control Medicaid costs as well, state officials said. Several states will seek federal permission, or waivers, to bypass federal rules controlling Medicaid in order to reduce the cost and increase service.

Medicaid costs are shared about

50-50 between the federal treasury and the states.

Oregon is still awaiting federal approval of a controversial plan to make Medicaid available to more poor people by putting limits on access to certain expensive medical services, such as organ transplants.

Wolfe said the time is ripe for change.

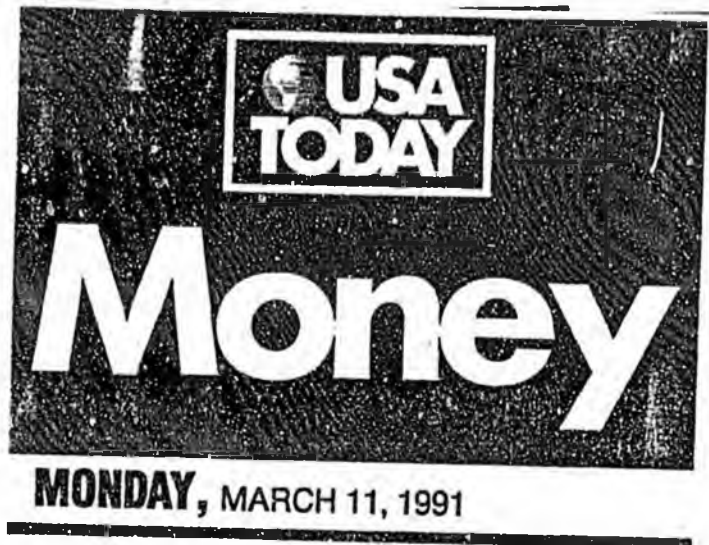
"The time has come when the middle class is medically indigent," he said. "People are hurting."

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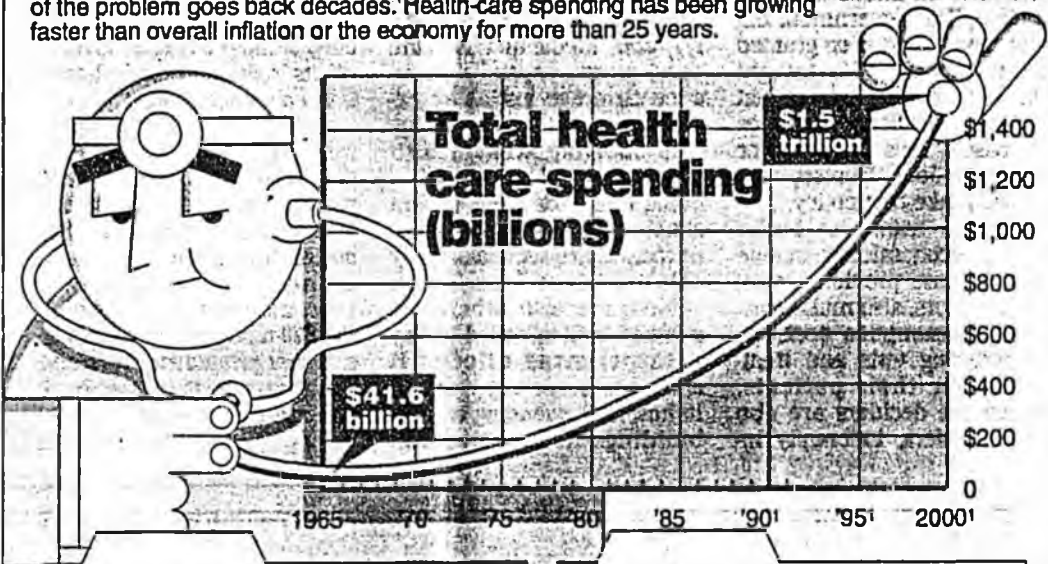
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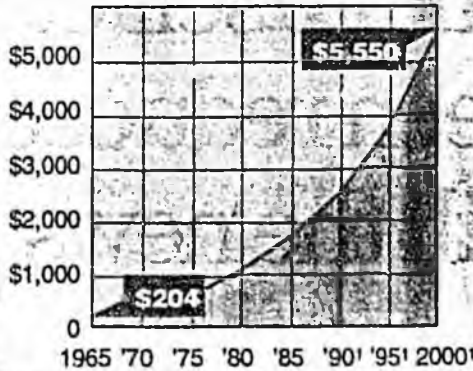
### SPECIAL REPORT

## Health-care ills

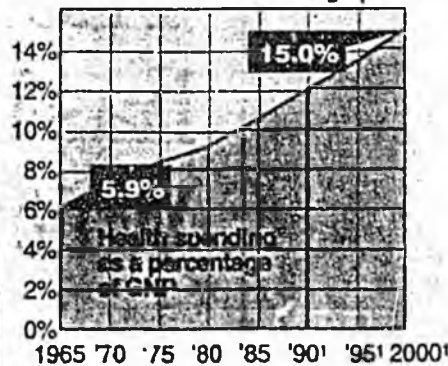
Widespread fears about the cost of health care may be fairly recent, but the root of the problem goes back decades. Health-care spending has been growing faster than overall inflation or the economy for more than 25 years.



### Health costs per person



### Health care's growing bite of the economy



1 - estimate

Source: Health Care Financing Administration

By Marty Baumann, USA TODAY

## HEALTH MONEY

A continuing series



No other part of the U.S. economy seems less understood than health care. Few realize why health-care costs are so stubbornly high (\$2,700 per American this year) or why health care seems to defy free-market economics — why, for example, increases in the supply of hospitals and doctors only increase prices.

What a growing number of people are coming to know is dissatisfaction with a health-care system that absorbs ever-soaring sums of money while letting more and more people fall through the cracks.

Health & Money, a continuing series beginning today, will explore how the health-care system works, why it sometimes fails and what's being done to change it.

## COVER STORY

# Health care costs more, serves fewer

On 3B:

► Technology

vs. cost

► Reform plans

By Kevin Anderson  
USA TODAY

The U.S. health-care system made a dream come true for Priscilla Brewer's family in 1976. Doctors at Norton Children's Hospital in Louisville, Ky., knocked her daughter's leukemia into

remission. Between the hospital's leukemia research grant and Brewer's insurance, the family paid nothing.

Today, however, both the grant and the insurance coverage are gone, and Brewer's dream is tarnished. The textile worker says that her employer "changed insurers a number of times, and our rates went up with each change." Her truck-driver husband's employer provides no insurance coverage. By last year, her share of the premium for family coverage was eating up 44% of her take-home pay. A search for a cheaper alternative was fruitless: Although her daughter's leukemia has been dormant for 15 years, no insurance company would touch them because of it. "Finally, I had no choice but to drop coverage," Brewer says. "We couldn't afford it."

Mark Carlson has no such problem. As a middle manager at Du Pont, the Newark, Del., man has no worries that his health insurance will protect his family's finances in cases of catastrophic illness. But Carlson's insurance covers less of the routine care his family needs. When the Carlsons' first child was born in 1983, out-of-pocket costs came to \$25. Those costs were \$650 for the second baby in 1986, \$1,200 for the third in 1988 and \$2,700 for the fourth last year.

Of all the cold showers of reality falling on the USA as the '90s dawn, none is as chilling as this: The health-care system in this country is in deep, deep trouble.

To those it serves best, it offers the most sophisticated, innovative and effective medical care in the world. But it is an expensive welter of inefficiency that excludes more and more people even as it consumes an ever growing chunk of

Please see COVER STORY next page ►

# The health-care dollar

## Where it comes from

Private health insurance and care plans	32%
Direct payments from patients	21%
Medicare	17%
Other government payments	15%
Medicaid	10%
Other private payments	5%

## ...and what it buys

Hospital care	34%
Physician care	20%
Nursing-home care	8%
Drugs and supplies	6%
Dental care	5%
Public health	3%
Other	17%

1—includes other professional services, personal and home care, private insurance profits, non-commercial research and construction.

Source: Census Bureau and Employee Benefit Research Institute, 1988 studies, latest available data

USA TODAY

## COVER STORY

# Health-care malady

Continued from 1B

our national resources. There is growing agreement that unless there is fundamental change, the U.S. will be in danger of sacrificing other important national priorities — education, environment, competitiveness — for health care.

Forces are building for such change. CEOs of corporations, reeling from 20%-plus annual increases in health insurance costs, proclaimed health care the No. 1 challenge facing American business in the '90s. Labor, noting that worker-paid insurance costs have risen 70% in two years — and that 80% of recent strikes are over health benefits — has embraced health care as its No. 1 issue. So have congressional Democrats.

We'll spend an estimated \$700 billion this year on health care, nearly 8% more than last year, 144% more than 10 years ago. We'll spend as much on health care this year as on cars and trucks, plus gasoline and parts — plus our entire military. Health care accounts for 12% of our total economy, vs. 9.1% of gross national product in 1980.

At the current rate, the nation's health-care bill will top \$1.5 trillion and 15% of GNP by the year 2000, and few see current cost-control efforts changing that forecast.

Yet gaps are widening. There are an estimated 37 million Americans with no health insurance. That's 15% of the population, or more than one person in seven who must rely on a shrinking charity-care establishment. An additional 30 million to 50 million are believed to lack adequate coverage.

The crisis atmosphere may be new, but the problems are not. Real health-care costs (with general inflation factored out) have been growing at a steady 4% to 5% a year since the 1960s. The ranks of the uninsured have been growing since 1980, when they numbered about 25 million.

What is pushing the health-care mess to the forefront of middle-class consciousness may have less to do with tragic cases like the Brewers' and more with nagging situations like Carlson's. Since 1988, one employer in six has cut or limited health benefits. Carlson doesn't blame Du Pont. "The company is paying a hell of a lot more for health," he says.

And though shrinking benefits don't have Carlson worried about handling a major medical problem financially, they do have millions worried. In a recent

poll by Northwestern Mutual Life, 60% said they had no confidence their insurance would cover a major illness a few years from now.

Money is now the biggest health-care worry. In a separate poll by the Gallup Organization last August, 19% named out-of-pocket costs their No. 1 worry when it comes to their health; 30% named fear of losing their insurance.

Those fears are well-founded, if a projection by Harvard University's School of Public Health is right: It foresees 28% of all workers losing health coverage by 1993 because they change jobs or their employer changes insurers.

Access to health insurance — with its dramatic stories of suffering and its blatant inequities — is a hot political issue. But it is merely a symptom of rampant health-care inflation. "I don't know who's to blame for this situation in our country," Brewer says. "What happened to make it so expensive?"

The glib answer: everything. "We never tried to put together a systematic arrangement on health care in this country, unlike probably every other country you can think of," says John Dunlop, former U.S. Secretary of Labor. "What we have today is the result of a series of pragmatic decisions made over time to meet narrow questions." (See story, above right.)

The good intentions behind those decisions paved the road to inflation — a built-in inflation that defies efforts to bring it down across the board. Government efforts to curb the growth of Medicare and Medicaid spending succeeded — for those programs. For the health-care system as a whole, the effect was that of squeezing an inner tube in one place only to have it balloon in another.

What has ballooned, as hospitals shifted costs, is private health-insurance rates. For larger employers, rates have doubled since 1986. For those small employers who provided insurance in the first place, rates are rising even faster, sometimes doubling or tripling in a single year.

Small employers have often responded by eliminating coverage for employees or for dependents. Roughly two-thirds of the uninsured are small-business employees and their families. Larger employers have responded by cutting benefits, raising employee premiums and shared payments, and shifting to alternatives: prepaid group care; utilization review (UR), in which nurses and doctors hired by the insurer screen hospitalization requests; and preferred provider organizations (PPOs), which limit employees to certain doctors and hospitals with whom the insurer has negotiated discount fees.

These approaches are controlling some cost growth, but not in any way that holds much promise for systemwide change. Southern California Edison's PPO cut its health-care cost growth in half, from 25% a year to 12%, still far above general inflation. "There are limitations to having discount medicine be the only way to save money," says Wally Maher, Chrysler Corp.'s former benefits chief and current health policy leader.

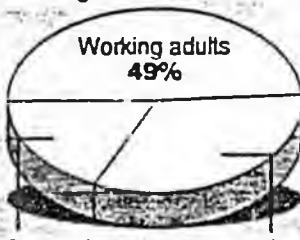
Roadblocks to reform abound. Some hope to cut the 15% to 30% of all medical tests and procedures believed to be of little or no medical benefit. But medicine is art as well as science, and doctors note that what looks unnecessary on statistical charts seems necessary when considering specific patients. That aside, there's a dearth of comprehensive national data on medical outcomes, without which tackling unnecessary care "is like taking a step in a dark room full of trap doors," says William Cutler of the Employee Benefit Research Institute.

Insurance administration costs, which eat up about 15% of health spending vs. 5% in Canada, are another promising target. But ironically, administrative overhead is rocketing as private cost-cutting efforts mount. And while the aging of the population has accounted for only about 10% of excess health-care inflation, demographics indicate higher costs in 20 years or so, when the baby boomers start to retire.

Despite the clamor for change, there's no agreement on what change to pursue. "A huge segment of the business community has a vested interest in the status quo. Consensus is fractured, despite the problems," Maher says. "But inaction is tantamount to deciding as a nation that we'll keep spending more and more of our GNP for health care, leaving less and less for the education and investment we need to compete in the 21st century."

## Who's not covered

Of 37 million people in the USA without health insurance, nearly half are working adults.



Source: Employee Benefit Research Institute

USA TODAY

# How the cost spiral started

## Indemnity plans 'doomed to fail'

Health insurance in the USA traces its history to 1798, when Congress established the Marine Hospital Service for merchant sailors, a pre-paid care system funded by wage deductions.

We might be better off today had we stuck with pre-paid care as our main form of coverage. But indemnity health insurance — reimbursement for unexpected costs — began to supplant it in the late 1800s. It exploded into widespread use during World War II, when employers were in stiff competition for workers, yet couldn't raise wages because of wartime controls. So they began offering health insurance en masse as an incentive. The government encouraged it, and even granted tax incentives. "We thought health-care increases might not be as inflationary as wage increases," says former labor secretary John Dunlop, who helped make that policy.

But the nature of health care is economically unique in that those providing most care, doctors, also make most of the consumption decisions by ordering tests and treatments for their patients. "Since the deciders are also the providers, indemnity in-

surance was doomed to fail" because it shields the deciders from having to weigh a procedure's benefits against its cost, says Dr. Arnold Reiman, former editor of the *New England Journal of Medicine*.

Bad economics such as that made for good medicine, however. Freed from having to be gatekeepers of resources, American physicians trained themselves to be advocates for their patients. The USA led the world in medical science. "You can get the best health care in the world here, but it depends on circumstances," says Dr. Glen Aukerman, president of the American Academy of Family Physicians. "We don't have a system. We have a lot of random moving parts."

Those moving parts didn't meld into an inflation machine until the mid-1960s, when Medicare (for the elderly) and Medicaid (for the poor) greatly expanded insurance coverage just as an explosion in medical technology was boosting what health economists call "intensity" — doing more for each patient simply because physicians-as-advocates are technologically able to do more to help them.

Medicare also ushered in another well-intended policy with perverse effects: It agreed to cover any shortfall in hospitals' spending on new buildings and equipment.

"Hospital capital spending took off," says Carl Schramm, president of the Health Insurance Association of America, fueling health-care inflation.

After numerous failed efforts to slow health-care inflation in the '70s, drastic change came in 1985, when Medicare changed from an indemnity basis to the Prospective Payment System — paying hospitals a flat fee based on a patient's diagnosis. If the patient's care costs more than the fee, the hospital eats the difference, but keeps the surplus if the care costs less.

Real growth in Medicare spending fell from nearly 7% a year in the '70s (vs. 5% for overall health spending) to 3% since 1985 (vs. 4% for overall spending). Average hospital occupancy dropped from about 80% in 1983 to 60% by 1988. Meanwhile cuts in Medicaid eligibility pushed 60% of those living in poverty off its rolls, adding to hospitals' charity-care load.

Since those changes put hospitals in a financial squeeze, hospitals have passed the burden on to privately insured patients. That cost-shifting is what has hospital room rates rising 12% a year, has aspirin tablets costing \$20 on some hospital bills, and has private insurers and employers passing the buck one more time — to you.

— Kevin Anderson

## A SPECIAL MONDAY REPORT ON YOU AND YOUR MONEY

# Why health-care costs are tough to cure

## ABOUT THIS REPORT

The stories on this page and page 1B launch Health & Money, a continuing series of special reports on the USA's health-care system: how it's paid for, where it succeeds and fails and what forces are building within it for sweeping change. In coming months, Health & Money will take you inside hospitals, doctors' offices, medical schools and companies for a look at how finance and economics shape decisions that affect your health care.

## HEALTH MONEY

A continuing series



By Kevin Anderson  
USA TODAY

For the roots to the reasons why U.S. health-care costs have stubbornly outpaced general inflation for three decades, look in the mirror.

Our crazy-quit health-care system has been shaped not by a master blueprint, but by countless isolated decisions — each made in keeping with American attitudes and values.

To be sure, we got some unintended consequences, such as the growing legions of uninsured. But by and large, we built high inflation into our health-care system by molding it to our national character. Ours is a system that leans heavily toward technology. It is biased toward action. Most important, it is a system that someone else seems to pay for.

Dr. Elizabeth Korte sees our expensive attitudes in action every week. "Patients will walk in and say, 'I think I should have an MRI scan,'" or some other fancy test or treatment gleaned from a news story or heard from a neighbor. Before ordering an \$850 trip to a magnetic resonance imaging scanner, Korte uses the diagnostic skills honed in 32 years of practice in Carthage, Ill.

But in the end, "whether I think an MRI will show us anything or not, if the patient insists on one, I go along." Part of the reason, she allows, is that she exposes herself to legal risk if she doesn't. But Korte urges her patients to be equal partners in caring for their health, and she hesitates to say no, even when her "partner" forgets which of them holds the M.D. "I think overall, it's nice that people are informed about medical technology and treatments. But they need to be informed about when they're indicated and when they're not."

Our love of technology and faith in science has played an especially strong role in building high inflation into the health-care system.

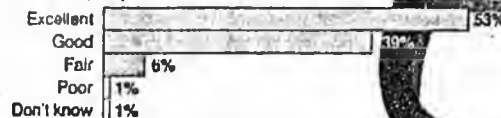
"We are to medical-care technologies what the French are to wines," says Robert Blendon, chairman of Harvard's department of health policy. Like our military, our

## Attitudes in conflict

Nothing has shaped U.S. health care so much as our peculiarly American attitudes toward medicine, science and government. Often these attitudes clash.

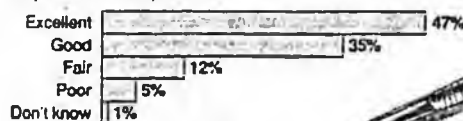
### We love our doctors . . .

Three out of four adults say they have a doctor they consider to be their family's physician. How they rated the quality of their doctors' care:



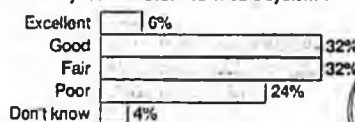
### . . . and hospitals . . .

One in four were hospitalized in the past year. How they rated their hospital care:



### . . . but dislike the system

How they rate the U.S. health-care system<sup>1</sup>:



1 - Doesn't total 100% due to rounding.  
Source: Employee Benefits Research Institute poll by the Gallup Organization of 1,000 adults conducted in November and released March 5.

health-care establishment is dominated by sophisticated technology — dazzlingly effective in given situations, but very costly. (See page 1B, left.)

But techno-just wouldn't be such a powerful engine of health inflation were it not that we pay for health care in ways that shield consumers from costs. Our reimbursement insurance system has developed into a blank-check approach to health-care financing.

Health-care consumption decisions — 75% to 80% of which are made by doctors on their patients' behalf — traditionally haven't been made with an eye toward weighing cost and benefit. That's why Korte can order that MRI scan for her insis-

tent patient. Without cost-shielding health-care inflation wouldn't be such a problem. With it, a host of other native values and attitudes play into inflation's hand:

► We value the individual over society, and we cherish miracles and heroic efforts against daunting odds. Countless thousands are alive here that might not be in other countries. In Sweden, doctors seldom try to save premature babies weighing less than 27 ounces. Here, doctors routinely try to save preemies weighing as little as 18 ounces; they succeed one time in four — generally for a hospital bill well into six figures. Britain's national health system bars transplant

surgery, hemodialysis and other costly treatments beyond certain ages and health conditions. Roughly a third of the average American's lifetime health expenditures will be spent in the last year of life, half of that in the final two months. Health-policy people call this the "\$100,000 funeral" problem.

► We hate to wait or to travel long distances for necessities. That has meant an insatiable market for closer hospitals, more surgeons and operating rooms, more machines, more costly treatments to allay smaller and smaller discomforts. All consideration to convenience, little to costly duplication of facilities and services.

► We are quick to sue. The

malpractice-suit explosion since the early '70s permeates every treatment decision and hospital policy. That leads to so-called defensive medicine — excess testing to document a lawsuit defense. "These days, we have to prove what's not wrong with a patient," says Dr. Ed Langston of Indianapolis.

► We favor action over patience. The don't-just-sit-there-do-something mind-set is present in a fair number of health-care decisions in the USA. Doctors in the USA are biased toward trying a test or treatment — just in case, just to be safe — although it's not clearly indicated. Patients are biased toward demanding it and letting insurance pay.

► We are optimists. The dark side of that attitude is a penchant for self-denial. Much is made of the costly overuse of health care. But underuse is an expensive problem, too: Not seeking care when you should can let a problem get more serious and thus more expensive to treat. And it's not just the uninsured who underuse the system. A 1987 study in *Health Affairs* noted this among people who had insurance and did see a doctor for some reason in the past year. A startling 41% said although they had experienced one of seven serious symptoms that always require attention (unexplained bleeding, chest pain during exercise, etc.), they did not see a doctor for it.

Cost-shielding has led to a culture of entitlement — of high expectations and little idea of costs," says Dallas Salisbury, president of Employee Benefits Research Institute. EBRI polls show that 34% of adults with health insurance had no idea what the total bill was for their last hospitalization; 78% had no idea what their employer pays for their insurance.

Yet for all its expense, waste and inefficiency, the U.S. health-care system works very well for a large majority — which poses a public-attitude hurdle for reformers. "We are very dissatisfied with the health-care system," says Blendon, "but we like our own doctors and hospitals. So reforms can't really dramatically change those relationships."

USA TODAY

# Reform plans focus on access, cost of care

The widening debate over how to fix the USA's health-care system doesn't suffer from a lack of reform proposals. The count is around three dozen and climbing.

Two types of plans predominate: those that focus on access — providing health insurance for the 37 million who lack it and those, mostly national health plans, that address soaring costs. A sampling:

**Labor:** Last year, the AFL-CIO adopted 10 principles to guide the drafting of any blueprint for health reform — concepts such as universality, accountability and portability. And it kicked off a massive grassroots campaign to build support for reform.

But instead of unveiling a blueprint three weeks ago as some expected, the AFL-CIO chose to be a power broker, agreeing to back any idea that moves health care in the direction it wants. Insiders say it's a pragmatic way to get first-step legislation this year.

**Insurers:** Three years ago, before the access problem became a national issue, the Health Insurance Association of America began moving to preempt the assaults it saw coming. Final details of its pro-

## Picking up the health-care tab

For decades, people have long paid lip service to the idea of a national health program, but support erodes when a specific price tag is mentioned.

### Good idea . . .

Percent favoring government-financed national health program



### . . . but no big tax hike

1990 poll question

Would you support a comprehensive national health-insurance program if it cost more than \$200 a year per person in added taxes? **22%**

Source: *New England Journal of Medicine*, July 1990

USA TODAY

posal came just two weeks ago. An access plan, the HIAA would institute small market reforms — including tax incentives, looser coverage requirements, risk pools, reinsurance funds, and prohibitions against dropping or excluding high-risk individuals from coverage — to enable its members to offer affordable coverage to small business. The plan doesn't address costs, opposes mandates and is meant to be

adopted by state legislatures with some variations. Connecticut begins operating under the first version in May. The HIAA plan stands out in that it goes its own way: It makes health insurance a less profitable business. But it wouldn't be abolished, as many plans advocate.

**Business:** The National Leadership Commission on Health Care, which includes businesses and unions, advo-

cates a national pay-or-play system in which the "pay" goes to a Universal Access Program that would supplant Medicare. The National Association of Manufacturers is pushing HIAA-style reforms, including risk pools and tax incentives, to expand voluntary insurance coverage. It opposes mandates.

**Doctors:** The American Medical Association's Health Access America plan would expand Medicaid, federally mandate employer coverage and risk pools, limit tax deductions for employers and drastically reform the malpractice system. The 2,000-member Physicians for a National Health Program calls for a Canadian-style free care system: 100% tax funded, basing levies on what's now paid for health care; and state run, with pre-set hospital budgets and salaries or fixed fees for doctors.

**Others:** The Heritage Foundation, a conservative think tank, would mandate coverage but would put the mandate on the individual, not the employer. Employees would get what employers now pay for health as added wages and would be taxed on it but would get tax credits on what they spend for coverage. Health

economists Alain Enthoven and Richard Kronick of Stanford University devised Consumer Health Choice. It requires government and employers to offer many coverage choices and "manage the competition" among them for cost-effectiveness.

**Congress:** Most plans require changes that would have to be passed by Congress, which has already embraced elements of several plans in its own thinking. From some members' rhetoric, you'd think sweeping reform was about to burst forth from Capitol Hill in a matter of weeks. Senior staff experts on health policy counsel, however, say this will be another year of debate; a few bills might see floor votes, but real reform is three to five years away. Among proposals:

► In the Senate, the focus is on access plans. Sen. Jay Rockefeller (D-W.Va.) chaired Congress' biggest effort on health care, the joint, bipartisan Pepper Commission, which developed the pay-or-play concept. Legislation based on the Pepper Commission's March 1990 final report is expected this month.

Sen. Ted Kennedy (D-Mass.), chairman of Labor and Human Resources, remains

## GLOSSARY

Terms you should know in the continuing health-care debate:

**Capitation:** Paying doctors and hospitals a fixed amount in advance per person covered to provide all needed health care.

**Mandates:** Requiring employers by law to provide basic health-insurance coverage to employees.

**Pay-or-play:** Giving employers the choice of either "playing" by providing a re-

quired level of insurance coverage or paying into a state program that will provide it.

**Risk pools:** Statewide entities funded by taxes, employers and insurers to provide coverage for otherwise uninsurable people.

**Small-market reforms:** Changing the rules governing health insurance to make it more affordable for small employers, small groups and individuals.

Capitol Hill's leading figure on health care. His current proposal was co-sponsored in each of the past two Congresses with Rep. Henry Waxman (D-Calif.), health subcommittee chairman of the House Energy and Commerce Committee. Also an access bill, it relies on national mandates rather than pay-or-play, making health coverage a right of employment like the minimum wage. Expect Kennedy-Waxman to be reintroduced this spring.

► In the House, national health programs predominate — so far. In January, Rep. Pete Stark (D-Calif.), chairman of the Ways and Means subcommittee, introduced MedPlan, a universal national program that would supplant private insurance and Medicaid, adopt Medicare's payment

methods for doctors and hospitals, and cost everyone except the poor \$1,000 a year in premiums plus limited out-of-pocket expenses. Last week, Stark's fellow subcommittee member, Rep. Marty Russo (D-Ill.), introduced a Canadian-style national health plan.

Some bills from the last Congress drew widespread attention and may be reintroduced. Rep. Mary Rose Oaker (D-Ohio) called for a government-run national system that would pay employer, public and group insurance plans, on a capitation basis, enough to cover 80% of all care costs, with caps on individual out-of-pocket spending. Rep. David Obey's (D-Wis.) plan was unique in requiring each state to design its own reform plan, then going with those that work best.

# Technology fuels health-care inflation

Every aspect of our health-care system seems designed to lock in high inflation. But what are the main engines driving costs? Which features contribute most to keeping health-care inflation a consistent 4 to 5 percentage points above general inflation? USA TODAY asked a number of health economists and policy experts. Their consensus:

**Technology:** There's widespread agreement that technology is the largest engine of health-care inflation. We spend vastly more on health care simply because we have vastly more things to spend it on. Treatments and procedures developed just since 1975 — total body scanners, transplants, implants, less-invasive surgery, artificial enzymes, genetically engineered drugs — now account for more than a third of the estimated \$275 billion we'll spend on hospital care this year and most of the \$8 billion we'll spend on prescription medicines.



Developing and perfecting technology is hugely expensive. It's an expense the USA shoulders for much of the planet by supporting more than half the world's total medical research. And medical technology, by its very nature, expands the overall health market — and thus overall health spending — even while making things easier, cheaper and safer for each patient. Pinpointing a problem by a magnetic resonance imaging scanner rather than exploratory surgery is fast, painless, safe, more accurate and costs less per patient. But because of this, hundreds more MRI scans are done than were exploratory operations.

The technologies of the future — gene therapy, fetal surgery, tissue cloning — promise to eclipse the boom of the past 15 years, both in miracle power and cost. The dilemma: We still lack a way to measure the benefits of medical technology against the overall cost. "Not knowing exactly what we're getting for what we spend is the conundrum that has frozen health policy," says William Cutler, research chief for the Employee Benefit Research Institute.

**Workforce:** Health care is hugely labor intensive. The payroll makes up more than 70% of the average hospital's budget. Hospitals must raise wages to compete with wages in non-health-care jobs. "But non-health wages are being driven by productivity gains that hospitals, by their very nature, have trouble matching," says Henry J. Aaron, a senior Brookings Institution economist. Machines can't give nursing care.



Also, the machines hospitals do buy have a perverse effect on labor, compared with other economic sectors: An expensive new machine going into a factory will reduce labor needs; an expensive machine going into a hospital increases labor needs. The more sophisticated the machine, the more schooling, skill — and pay — its operators need.

Another workforce-related engine of health-cost inflation is the makeup of the medical profession. Two-thirds of the USA's 585,000 physicians practice a medical subspecialty, twice the proportion of most Western countries. Technological dominance accounts for part of that. But the health-insurance system rewards doctors far more for doing the procedures of specialty medicine than for the counseling, listening and preventive services of primary-care medicine. There's a bitter chicken-or-egg dispute over whether the payment bias evolved in response to the prestige and clout specialists wield or whether the profession grew lopsided because of a biased reward system. But both factors long ago knitted into a vicious cycle. Result: Average U.S. physician income, a record \$137,000 last year, is 65% higher than in the second-best paying country, Canada.

— Kevin Anderson

# Demanding Mercedes care for VW prices

*Robert J. Blendon has amassed the largest storehouse of data on how Americans feel about health care — the results of nearly every poll question on the subject asked since the 1940s. Blendon, professor and chairman of the department of health policy and management at Harvard University's School of Public Health, discussed some of what he's learned in a recent interview:*

**Q. Are our values and attitudes also shaping health-care reform efforts?**

A. One of the major ways we're trying to rein in costs is outcomes research, which has a lot to do with our attraction toward scientific answers to difficult questions. In this country, we don't want to set a budgetary limit on health spending. We still want to say that everybody who could benefit by anything should get it. So all the people who'll be doing outcomes research over the next few years are trying to scientifically search out those tests and treatments of little or no benefit to patients by amassing huge computer databases.

The idea is we'll just be able to take kind of a Patriot missile to knock out un-



By Tim Dillon, USA TODAY

**BLENDON:** People don't trust budgets.

needed procedures, surgically striking with no collateral damage, no one having to give up anything. To believe in that, you have to have a unique faith in science. Other countries don't. They

have a unique faith in budgets.

**Q. Meaning?**

A. Meaning they don't go trying to figure out a computer program that says this patient should get that help under these circumstances. Instead, they give doctors and hospitals the money they got last year, plus a little, and ask them to do the best they can. A lot of discretion is left to the physician, but there are pressures on the resources available to him. Americans are very uncomfortable with that. People don't trust anyone to set budgets. The U.S. is unique in its general distrust of government.

**Q. Then why do polls consistently show that most Americans favor a national health program?**

A. Roughly two-thirds of Americans, every time you poll them, say they want a national health plan, but they really have two different things in mind. To about half of Americans, a national health plan essentially requires government coming in with the National Guard or something to make your employer provide you with private insurance, with the government taking care

of the unemployed and the poor. In the other half of American minds, it means Medicare for everybody.

**Q. What reforms can we realistically make given the constraints of our attitudes and values?**

A. We can make sure that nobody is without basic insurance. Secondly, we can put in some restraints on procedures and facilities to eliminate waste and duplication where there's a lot of consensus things aren't necessary. That's not going to sound very good to people who think we need to adopt really tough rationing choices if we are to save big dollars. They're correct — if we want to save big dollars. I don't believe we're going to do that. We'll go after administrative waste, put some budgetary pressures in for doctors and hospitals and maybe slow growth 10% or 15%. But the underlying pressures from our value system will always keep health care very expensive. No one in America really wants a Volkswagen health-care system — basic cheap care for all. They say they want it in the abstract. But they don't want it in practice.

\* DELIVER TO: LIOCJAM

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\* SENT: 02/27/91 TIME: 15:50

\* FROM: LIOCMIL

\* SUBJECT: 91-02-107; PL2; SB82, 83; 2/27

\* PRINT DATE: 02/27/91 TIME: 15:50

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SUBJECT LINE TO READ: TC NO.; PL FS; SHORT SUBJECT; DATE

T/C NO: 91-02-107  
DATE: 02-27-91  
SPONSOR: S LABOR & COMMERCE  
SUBJECT: SB 82, SB 83  
MODERATOR: JUDY  
SITE: ANCHORAGE

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✓	NAMES/REPRESENTING	ADDRESS	PHONE	BILL NO.
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2.	DAVID HENNIGAN	PROVIDENCE HOSPITAL		SB 83
3.	CHARLES HERNDON			SB 83

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1.	DEBRA GRAYO AAT			HB 83
2.	EMMITT WILSON/HUMANA	HOSPITAL		HB 82
3.	DIANE KAPLAN/APRN			HB 82
4.	CHARLES NORTHRUP/APBC			HB 82
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MODERATOR: CHARLENE  
SITE: HOMER

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	NAME/REPRESENTING	ADDRESS	PHONE	BILL NO.
1.	MARTHA ELLEN ANDERSON,	617 W. FAIRVIEW	235-6831	SB83
2.	MARY RAYMOND,	BOX 2335, HOMER 99603	235-7942	SB83
3.	DONNA L. LIBAL,	4136 BARTLETT ST., HOMER	235-6127	SB83
4.	VELMA ELLYSON,	3935 SVEDLUND, HOMER	235-7655	SB83
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1.	CLIFFORD L. JENSON,	BOX 71, HOMER 99603	235-8538	SB83
2.	PEARL JENSON,	BOX 71, HOMER 99603	235-8538	SB83
3.	J. E. CAPPOCK,	617 W. FAIRVIEW, HOMER	235-8831	SB83
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\* FROM: LIOCPSG \*  
\* SUBJECT: PART. LIST FOR 91-02-107 \*  
\* PRINT DATE: 02/27/91 TIME: 15:45 \*  
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PARTICIPANT LIST 91-02-107 CHARITABLE GAMING

PETERSBURG

- 1. MATT HOLMES KFSK
- 2. DAN CALLAWAY KRSA

IS IT POSSIBLE FOR US TO LEARN WHEN SB 83 IS GOING TO BE DISCUSSED??

DOROTHY

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* DELIVER TO: LIOCDAR
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* ORIGINAL
* SENT: 02/13/91 TIME: 15:54
* FROM: LIOCMIL
* SUBJECT: 91-02-038; PL; SB83; 2/13
* PRINT DATE: 02/13/91 TIME: 16:04
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SUBJECT LINE TO READ: TC NO.; PL FS; SHORT SUBJECT; DATE

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T/C NO: 91-02-038
DATE: 2/13
SPONSOR: S LABOR AND COMMERCE
SUBJECT: SB 83 HEALTH CARE COST CONTAINMENT
MODERATOR: JUDY
SITE: ANCHORAGE

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~~TO TESTIFY~~

NAMES/REPRESENTING	ADDRESS	PHONE	BILL NO.
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TO OBSERVE

NAME/ REPRESENTING	ADDRESS	PHONE	BILL NO.
1. LISA WOLF/PROVIDENCE HOSPITAL			
2. JANET OATES/PROVIDENCE HOSPITAL			
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\* DELIVER TO: LIOCBL5 \*  
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\* ORIGINAL \*  
\* SENT: 03/22/91 TIME: 15:36 \*  
\* FROM: LIOCPSG \*  
\* SUBJECT: T/C 91-03-081 HEALTH RES \*  
\* PRINT DATE: 03/22/91 TIME: 15:36 \*  
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T/C 91-00-000

PARTICIPANT LIST FROM PETERSBURG

TO TESTIFY:

- ~~1.~~ GARY GRANDY
- 2.
- 3.+
- 4.+

TO OBSERVE ONLY:

- 1.+
- 2.+
- 3.+
- 4.+

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* ORIGINAL
* SENT: 03/22/91 TIME: 15:35
* FROM: LTCCSOL
* SUBJECT: 91-03-081; PL#1-SB83; 3-22
* PRINT DATE: 03/22/91 TIME: 15:35
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SUBJECT LINE TO READ: TC NO.; PL/FS; SHORT SUBJECT; DATE

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T/C NO: 91-03-081
DATE: 3-22-91
SPONSOR: SENATE LABOR AND COMMERCE
SUBJECT: SB83
MODERATOR: ALYSON
SITE: SOLDOTNA

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NAME/REPRESENTING	ADDRESS	PHONE	BILL NO.
1. RANDY NICHOLS/	CENTRAL PEN. GENERAL HOSP	ITAL	
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NAME/RERESENTING	ADDRESS	PHONE	BILL NO.
1. RICHARD CAMPBELL/KP	BOROUGH 144N BINKLEY	262-4441	
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\* SENT: 03/22/91 TIME: 16:11 \*  
\* FROM: LTCCKTN \*  
\* SUBJECT: 91-03-081;PL1;HEALTH RES;3-22 \*  
\* PRINT DATE: 03/22/91 TIME: 16:11 \*  
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SUBJECT LINE TO READ: TC NO.;FL/FS;SHORT SUBJECT;DATE

T/C NO: 91-03-081  
DATE: MARCH 22, 1991  
SPONSOR: SENATE LABOR AND COMMERCE  
SUBJECT: SB 33, STATE HEALTH RESOURCES AUTHORITY  
MODERATOR: JUNE ROBBINS  
SITE: KETCHIKAN

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NAME/REPRESENTING	ADDRESS	PHONE	BILL NO.
1. ROGER STONE, KETCHIKAN GENERAL HOSPITAL	3100 TONGASS AVE, KETCHIKAN 99901	225-5171	SB 83
2. DAVID JOHNSON, AK STATE MEDICAL ASSN.	3612 TONGASS AVE, KETCHIKAN 99901	225-5145	SB 83

had to leave - ↓ access.

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NAME/REPRESENTING	ADDRESS	PHONE	BILL NO.
1. ED MAHN, KETCHIKAN GENERAL HOSPITAL	3100 TONGASS AVE, KETCHIKAN 99901	225-5171	SB 83
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WRANGELL HOSPITALS

Also - BILL ADAMS - Adv. X from home

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SUBJECT LINE TO READ: TC NO.; PL FS; SHORT SUBJECT; DATE

T/C NO: 91-03-081  
DATE: 03-22-91  
SPONSOR: S LABOR & COMMERCE  
SUBJECT: SB 83  
MODERATOR: JUDY  
SITE: ANCHORAGE

PARTICIPANT LIST

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NAMES/REPRESENTING	ADDRESS	PHONE	BILL NO.
1. O. KORSHUM MD/AK ST MED ASSN	1200 AIRPORT HTS	276-8838	SB 83
2. BRUCE MOORE	3261 AMBER BAY LP	257-6138	SB 83
3. DAVE HENNIGAN/PROVIDENCE HOSP.		261-3002	SB 83

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TO OBSERVE:

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BACK UP NUMBER: 561-1199  
EMAIL ADDRESS: LIOCMIL

T/C NO: 91-03-081  
DATE: MARCH 21, 1991  
SPONSOR: SENATE LABOR & COMMERCE  
SUBJECT: SB83:  
MODERATOR: FRAN  
SITE: FAIRBANKS

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2. MIKE POWERS - FMH			
3. GORDON DEFUE			
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* SENT: 03/22/91 TIME: 16:29
* FROM: LIOCMIL
* SUBJECT: 91-03-081; PL#2; SB83; 3/22
* PRINT DATE: 03/22/91 TIME: 16:29
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SUBJECT LINE TO READ: TC NO.; PL FS; SHORT SUBJECT; DATE

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T/C NO: 91-03-081
DATE: 03-22-91
SPONSOR: S LABOR & COMMERCE
SUBJECT: SB 83
MODERATOR: JUDY
SITE: ANCHORAGE

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PARTICIPANT LIST

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TO TESTIFY

NAME/REPRESENTING	ADDRESS	PHONE	BILL NO.
1. D. KORSHUM MD/AK ST MED ASSN	1200 AIRPORT HTS	276-8838	SB 83
2. BRUCE MOORE	3261 AMBER BAY LP	257-6138	SB 83
3. DAVE HENNIGAN/PROVIDENCE HOSP.		261-3002	SB 83

4. DAVID FRAZIER	1600 A ST	258-1139	SB 83
5. MITCH GRAVO	2550 DENALI	272-6474	SB 83

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TO OBSERVE:

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1. JANET OATES/PROVIDENCE HOSPITAL		261-3145	SB 83
2. KENDALL THOUZ	5350 LITTLE TREE	563-7675	SB 83
3. SHARON ANDERSON/HUMANA HOSPITAL		264-1713	SB 83
4. CHARLES STOKES/HUMANA HOSPITAL		264-1703	SB 83
5. NONI BALDWIN	2525 BLUEBERRY#107	276-4849	SB 83
6. JEFF DUZENBERY	1079 POTLATCH CIR		
7. JAN BOMHOFF	1400 W BENSON #200	257-5236	
8. TOM TURNER	1400 W BENSON STE 350	257-5216	

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STATE OF ALASKA  
THE LEGISLATURE

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Copies of minutes listed below were originally included in this file. The minutes are available on the STAIRS database CMPR. In order to save space copies of minutes have not been left in the files.

Mary Van Nimwegen

*Senate Labor and Commerce 3-22-91 3:30 pm*

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SENATE LABOR & COMMERCE COMMITTEE  
BILL FILE

BILL NUMBER: SB 92

BILL TITLE: LEADING AUTHORITY IN LOANS COMM FISH & AL BANK

SPONSOR: ZILKOFF

RECEIVED: 1/30/91

WRITTEN REQUEST TO SCHEDULE: DATE \_\_\_\_\_ FROM \_\_\_\_\_  
SECTIONAL ANALYSIS RECEIVED: DATE \_\_\_\_\_ FROM \_\_\_\_\_  
FISCAL NOTE REQUESTED: DATE \_\_\_\_\_ FROM \_\_\_\_\_  
FISCAL NOTE RECEIVED: DATE \_\_\_\_\_ FROM \_\_\_\_\_  
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FIVE DAY NOTICE GIVEN:  
COMMITTEES OF REFERRAL: FIRST: L & C SECOND: Res THIRD: FIN

DATE	COMMITTEE ACTION
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HEARING NOTIFICATION LIST

- |            |           |
|------------|-----------|
| 1. SPONSOR | 6. _____  |
| 2. AGENCY  | 7. _____  |
| 3. _____   | 8. _____  |
| 4. _____   | 9. _____  |
| 5. _____   | 10. _____ |

**STATE OF ALASKA**  
**1991 LEGISLATIVE SESSION**

**BILL NO. SB 92**

Revision Date: \_\_\_\_\_ Department Affected: Commerce & Economic Dev.  
 Title: An Act relating to the lending authority and loans of CFAB BRU: Banking, Securities & Corporations  
 Component: Banking & Securities  
 Sponsor: Sen. Zharoff  
 Requestor: \_\_\_\_\_ COMPONENT SERIAL NO. 

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**Expenditures/Revenues: (Thousands of Dollars)**

OPERATING	FY 82	FY 83	FY 84	FY 85	FY 86	FY 87
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
<b>TOTAL OPERATING</b>	0	0	0	0	0	0

<b>CAPITAL</b>	0	0	0	0	0	0
----------------	---	---	---	---	---	---

<b>REVENUE</b>	0	0	0	0	0	0
----------------	---	---	---	---	---	---

**FUNDING: (Thousands of Dollars)**

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
<b>TOTAL</b>	0	0	0	0	0	0

**POSITIONS:**

FULL-TIME	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

**Estimate of current year impact:**

**ANALYSIS: (Attach a separate page if necessary.)**

Prepared By: Willis F. Kirkpatrick, Director Phone: 465-2521  
 Division: Banking, Securities & Corporations Date: 3/26/91  
 Approved by Commissioner: Glenn A. Olds *[Signature]* Asst Comm  
 Agency: Department of Commerce & Economic Development Date: 3-26-91

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impacted Agency(ies).



SENATOR FRED F. ZHAROFF  
ALASKA STATE LEGISLATURE

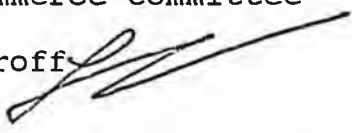
P. O. BOX 405, KODIAK, ALASKA 99815 (907) 488-5259  
DURING SESSION:  
P. O. BOX V, JUNEAU, ALASKA 99811 • (907) 465-3473 • 465-3474

DISTRICT N

ALASKA PENINSULA • ALEUTIAN CHAIN • BRISTOL BAY • KODIAK ISLAND • LAKE CLARK/LAKE ILIAMNA • PRIBILOF ISLANDS • SHUMAGIN ISLANDS

MEMORANDUM

TO: Senator Drue Pearce  
Chair  
Senate Labor and Commerce Committee

FROM: Senator Fred F. Zharoff 

DATE: March 8, 1991

RE: Senate Bill 92 - "An Act relating to the lending authority and loans of the Commercial Fishing and Agriculture Bank; and providing for an effective date."

I respectfully request that Senate Bill 92 be scheduled for a hearing before the Senate Labor and Commerce Committee at the committee's earliest convenience.

SB 92 would allow the Alaska Commercial Fishing and Agriculture Bank to develop a small loan program specifically targeted at rural commercial fishermen.

CFAB is a cooperative lending institution that was created by the Alaska Legislature in 1978 to serve Alaska's commercial fishing and agriculture industries. In recently evaluating CFAB's effectiveness, the officers concluded the institution was not doing as good a job as it could in Western Alaska and the Arctic-Yukon-Kuskokwim area. The commercial fishermen in these regions generally are engaged in relatively low income fisheries in which a relatively small capital investment is required for participation.

Financing for these fisheries operations, in general, has been difficult to obtain because of the regions' remoteness (all business must be transacted by phone or mail), language difficulties, less exposure to financial systems and institutions, the fishermen's lack of alternate income, and the annual fluctuations in salmon returns and income.

To serve these people, CFAB plans to start a program for small loans of less than \$25,000. CFAB envisions establishing relationships with rural businesses and agencies (village corporations, Native associations, etc.) for originating and servicing these small loans.

CFAB could set up the program for small loans without legislation. The program is included in the bill so the legislature will have a full understanding of what is being proposed. The operative change CFAB requires in statute to go forward with its plans is in (b)(1) of Section 1, an exemption from CFAB's membership requirement.

As a cooperative, CFAB requires its borrowers to become members/owners. This involves the purchase of capital stock, extensive documentation, and a recordkeeping/communication burden. The administrative requirements are complicated and costly for both CFAB and its borrowers, and an impediment to small loans.

Through SB 92, CFAB is requesting the legislature to make the small loans program more feasible -- both for CFAB and the borrowers -- by granting a membership exemption under the limited circumstances proposed in the bill.

SB 92 also makes clarifying changes in CFAB's existing statute by confirming that using permits for collateral, nominating another person to assume a note, and instituting legal action to recover deficiencies applies to CFAB loans for fishing-related needs as well as loans for the purchase of entry permits.

The Department of Commerce and Economic Development prepared a position paper in support of the House companion version of this bill, HB 111. SB 92 has no fiscal cost for the state government.

The following backup information is attached:

1. A sectional analysis.
2. CFAB's 1990 annual report.
3. CFAB statutes.



## SENATOR FRED F. ZHAROFF

### ALASKA STATE LEGISLATURE

P. O. BOX 405, KODIAK, ALASKA 99615 (907) 486-5250

DURING SESSION:

P. O. BOX V, JUNEAU, ALASKA 99811 • (907) 465-3473 • 465-3474

DISTRICT N

ALASKA PENINSULA • ALEUTIAN CHAIN • BRISTOL BAY • KODIAK ISLAND • LAKE CLARK/LAKE ILIAMNA • PRIBILOF ISLANDS • SHUMAGIN ISLANDS

## SECTIONAL ANALYSIS

### SENATE BILL 92

"An Act relating to the lending authority and loans of the Commercial Fishing and Agriculture Bank; and providing for an effective date."

#### SECTION 1

Adds a new section to statutes, AS 44.81.225, authorizing the Alaska Commercial Fishing and Agriculture Bank (CFAB) to make small loans to qualified borrowers who are not bank members.

- (a) Explains the reason for the program.
- (b) (1) Allows the small loan borrower to be exempt from the CFAB membership requirement.
- (b) (2) Limits the amount that may be loaned to each borrower under this program to no more than \$25,000.
- (c) Limits the total amount of money that may be used for small loans to no more than eight percent of CFAB's total capital. CFAB's capital is presently about \$37 million, so the amount available for small loans at the present time would not exceed \$2,960,000.
- (d) Allows CFAB to contract with a public agency or legal entity to service small loans.

#### SECTION 2

Amends 44.81.230(a) to include a reference to 41.81.225. 44.81.230(a) is an existing requirement for the Commercial Fisheries Entry Commission to certify that a fisherman who borrows for the purchase of a limited entry permit qualifies as a permit transferee under the limited entry statutes and regulations.

#### SECTION 3

Amends 44.81.230(b) -- which lists the requirements for pledging an entry permit as collateral for a loan -- to include a reference to 44.81.225. Also, by including a reference to 44.81.235, confirms that a permit lien can apply to loans made for fishing-related needs other than the purchase of limited entry permits.

SECTION 4

Amends 44.81.230(f) -- which allows a loan debtor to avoid foreclosure on an entry permit by nominating another person to assume the note -- to include a reference to 44.81.225. Also, by including a reference to 44.81.235, confirms that this method of avoiding foreclosure is applicable to CFAB loans for other fishing-related needs.

SECTION 5

Amends 44.81.250(d) -- which allows CFAB to institute legal action to recover deficiencies -- to include a reference to 44.81.225, thereby extending this section to cover the small loans program. Also, by including a reference to 44.81.235, confirms this section applies to loans for other fishing-related needs.

SECTION 6

Immediate effective date.

SB 92: "An Act relating to the lending authority and loans of the Commercial Fishing and Agriculture Bank; and providing for an effective date."

The department encourages the intent to foster further development of our commercial fisheries industry, especially geographic areas which may discourage normal lending sources. It is our understanding that this type of development activity is the foundation upon which CFAB was built.

We do question, but are not opposed to, the exemption provisions of membership to be qualified for a loan. One of the fundamental elements in the well-being of any cooperative is the support of its members and, in turn, the coop's membership service. It may be in the best interest of not only the success of CFAB but fisheries development to expand membership rather than dilute it.

The department encourages passage of SB 92.

  
Glenn A. Olds, Commissioner

Date: 3-24-91

Identical companion bill to SB 92

HB 111: "An Act relating to the lending authority and loans of the Commercial Fishing and Agriculture Bank; and providing for an effective date."

The department encourages the intent to foster further development of our commercial fisheries industry, especially geographic areas which may discourage normal lending sources. It is our understanding that this type of development activity is the foundation upon which CFAB was built.

We do question, but are not opposed to, the exemption provisions of membership to be qualified for a loan. One of the fundamental elements in the well-being of any cooperative is the support of its members and, in turn, the coop's membership service. It may be in the best interest of not only the success of CFAB but fisheries development to expand membership rather than dilute it.

The department encourages passage of HB 111.

*Glenn A. Olds* Spec. Asst. H  
\_\_\_\_\_  
Glenn A. Olds, Commissioner

Date: 2-28-91

FISCAL NOTE

STATE OF ALASKA  
1991 LEGISLATIVE SESSION

BILL NO. HB 111

Revision Date: \_\_\_\_\_ Department Affected: Commerce & Economic Dev.  
 Title: An Act relating to the lending BRU: Banking, Securities & Corporations  
authority and loans of CFAB Component: Banking & Securities  
 Sponsor: Rep. Navarre  
 Requestor: \_\_\_\_\_ COMPONENT SERIAL NO. 

1	2	3	3
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Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
<b>TOTAL OPERATING</b>	0	0	0	0	0	0

CAPITAL	0	0	0	0	0	0
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REVENUE	0	0	0	0	0	0
---------	---	---	---	---	---	---

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
<b>TOTAL</b>	0	0	0	0	0	0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

Estimate of current year impact: \_\_\_\_\_

ANALYSIS: (Attach a separate page if necessary.)

Prepared By: William F. Kirkpatrick, Director Phone: 465-2521  
 Division: Banking, Securities & Corporations Date: 2/28/91  
 Approved by Commissioner: Glenn A. Olds *See Asst IT*  
 Agency: Department of Commerce & Economic Development Date: 2-28-91

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OM3, & Impacted Agency(ies).



2550 Denali Street, Suite 1201  
P. O. Box 92070  
Anchorage, Alaska 99509-2070  
(907) 276-2007

February 19, 1991

Senator Drue Pearce  
Chair, Senate Labor and Commerce Committee  
Alaska State Legislature  
Post Office Box V (M.S. 3100)  
Juneau, Alaska 99811

Dear Senator Pearce,

We have been told that among the casualties of current budget reduction efforts in the Department of Commerce's Division of Business Development is an amount of about \$200,000 which had been provided annually in the recent past to partially fund activities of the Alaska Business Development Center, Inc., and the Fairbanks Native Association.

We cannot, and do not, presume to be in a position to second-guess the individuals who must make cost-cutting decisions, and that is not the spirit of this letter. We would like to say for the record, however, that -- if the \$200,000 number is accurate -- it appears to be an extremely effective expenditure in terms of making valuable services available to needful rural Alaskans.

I suspect that at CFAB we see only the tip of the iceberg with regard to the work of ABDC; we have considered about 20-30 loan applications in the past year from fishermen who had sought counseling assistance from ABDC. We have also referred a number of rejected applicants and other inquirers to the Center for counseling, and we do so with great confidence. In addition, CFAB officers frequently encounter Center personnel taking an active and constructive part in seminars, workshops, panels, etc., in rural Alaska. Our loan officers are unanimous in the collective view that the Alaska Business Development Center has been a consistently positive force in helping individuals and small businesses confront the often formidable challenges of financial planning and orderliness.

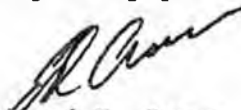
The cash-flow patterns and pressures of life in rural Alaska are clearly much more daunting than anything faced by those of us who are blessed by a salaried consumer lifestyle, and the services of Alaska Business Development Center in that area seem to be totally consistent with

*Alaska Commercial Fishing and Agriculture Bank*

Senator Drue Pearce  
February 19, 1991  
Page 2

Governor Hickel's expressed desire to spend public money in ways which can maximize the private sector's contribution to Alaska. In summary, we respectfully urge that this item be objectively and comprehensively considered as the Department's budget priorities are established.

Very truly yours,



Edward E. Crane  
President

EEC:dmv

cc: Dr. Glenn Olds, Commissioner  
Department of Commerce and Economic Development  
Jamie Parsons, Director  
Division of Business Development  
Gary Selk, President  
Alaska Business Development Center, Inc.

March 22, 1991

Senator Fred Zharoff  
Post Office Box V  
Juneau, Alaska 99811

Dear Senator Zharoff,

For the Community Enterprise Development Corporation of Alaska and its members, I wish to voice our support for Senate Bill No. 92. This Bill, if passed, would allow the Alaska Commercial Fishing & Agriculture Bank to make \$25,000 commercial fishing loans.

Please allow me to tell you something about Community Enterprise Development Corporation of Alaska (CEDC). CEDC, formed by the Federal Government in 1968, is a non-profit organization designed to promote economic development in rural Alaska. We have 168 rural organizations who are members of CEDC, and the geographic areas which our members come from range from Sitka to Barrow.

One of the programs which we have, and is perhaps the most visible one in rural Alaska is our EDA Boat Loan Program. CEDC inherited this program from the Alaska Native Foundation in 1983. It is now the most creditable Federal Loan Program in rural Alaska. This program gives Western Alaska Fishermen, who otherwise could not qualify for a commercial bank loan, alternative financing for their boats. Since 1983, ninety four fishermen received financing worth \$1,123,973 for boats and gear from CEDC.

Our program has, and will continue to have a positive economic impact in Western Alaska. However, we do have restrictions with this program, and this is why we support Senate Bill No.92.

Our loan fund is small, and on an average we can only make 10 new boat loans per year. We cannot make loans outside of Western Alaska. Also, because we can not take fishing permits as collateral, we do not make permit loans. Within our service area the average fishing permit is worth from \$12,000-\$25,000.



**CEDC**


Community Enterprise Development Corporation of Alaska  
1577 'C' Street Plaza, Suite 304/Anchorage, Alaska 99501, 907-274-5400

Based on the number of inquiries that we get from fishermen outside of our service area. And due to limitations in our program. We can see there is adequate need for small fishing boats, and fishing permit financing in and outside of our service area.

CEDC and CFAB share a common interest with commercial fishermen. We both would like to see fishermen meet their goal of self-sufficiency. If this bill passes, this goal will be more attainable for the small boat fishermen.

Sincerely,

COMMUNITY ENTERPRISE DEVELOPMENT  
CORPORATION OF ALASKA



Perry R. Eaton  
President & CEO



*Alaska Commercial Fishing  
and Agriculture Bank*

*1990 Annual Report*

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For more information contact:

Alaska Commercial Fishing and  
Agriculture Bank  
2550 Denali Street, Suite 1201  
Anchorage, Alaska 99503  
1907/ 276-2007 or (800) 544-2228

## **Executive Message to Members**

---

May 31, 1990, marked the end of the 11th year of CFAB operations. We believe that in some respects, though, it's appropriate to view Fiscal 1990 as the first year of "normal" operations. From 1980 on into 1984, CFAB's activities and results were influenced in part by its immaturity, by both internal and external exuberance in implementation of a unique concept, and by an aggressiveness in keeping with the inflationary trends of the time and with the trend of Alaska's economy in general.

The mid-80's were marked by the effects of crippling loan losses to CFAB; policies, practices, and financial results were dramatically influenced by the need to retrench and recover. At best, those years can be characterized as a "holding period."

Fiscal 1988 and 1989 were brighter. The significant distortions to CFAB's activities and financial results were generally favorable, reflecting recoveries which were the results of prior years' efforts. Fiscal 1989 was a particular example of that with over 50 percent of its gross income and about 80 percent of its net proceeds attributable to the efforts and events of prior years.

There were very few elements such as the above, and none which were extreme, affecting operations and financial results in Fiscal 1990. We are pleased by the short-term trends and inferences which can be drawn from such limited experience.

### **New Loan Activity**

There were 102 new members of CFAB in Fiscal 1990, the largest number, by far, in any twelve-month period since 1983. These are individuals, partnerships, and corporations who turned to CFAB for the first time to meet their respective financing needs.

Excluding seasonal loans to processors (to avoid confusing distortions), CFAB made 171 new loans in Fiscal 1990; they involved advances of over \$14.0 million. One hundred of those loans, totaling about \$8.8 million, were to new members. The remaining 71 were repeat loans to "old" members and involved about \$5.5 million.

Neither CFAB's Board of Directors nor its management are inclined to guide the institution on a course of "bigness for bigness' sake." Nevertheless, we are heartened by the indications that CFAB is providing service to new segments, or new generations, in the Alaska seafood industry; by the gradually reducing average loan balance (which tends to limit CFAB's vulnerability to localized adverse developments); and by the continuing diversity of its loan portfolio among major fisheries.

### **Financial Condition**

We invite your attention to CFAB's financial statements, and its independent auditors' opinion letter, elsewhere in this Annual Report. CFAB's total assets increased about \$10.8 million during the year, slightly less than the \$11.2 million increase in net loans and receivables outstanding. Further analysis of the latter change, aided by a review of NOTE B to the financial statements, discloses that CFAB's gross earning loans and receivables increased by about \$12.9 million. This increase, offset in part by an increase of only \$9.2 million in interest-bearing debt, implies an enhancement of future opportunities for net proceeds. This in turn made possible a reduction in the interest rate charged on all variable rate loans; that reduction was made effective June 1, 1990.

CFAB's net equity increased about \$1.8 million in Fiscal 1990. Much of that increase is related to the retention of net proceeds, but over \$700,000 is the result of new borrowers' direct investment in Class B Preferred Stock. There was a small net reduction of about \$3,000 in outstanding Class A Membership Stock. This arose through the retirement of the Class A Stock of about 400 members who had been inactive for three or more years. In most cases, the \$10 par value was paid to those members; in the few instances involving members who had previously defaulted on obligations to CFAB, the par value was transferred to CFAB's unallocated surplus account.

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### **Financial Results of Operations**

CFAB's statement of net proceeds for Fiscal 1990 shows some major changes from the prior year, primarily in the areas of gross revenues and net proceeds. As mentioned earlier, this is because in Fiscal 1989 CFAB received large amounts of long-overdue interest income while Fiscal 1990 was essentially a "normal" operating year.

There are several categories of operating expenses, as reported, which reflect relatively large increases from the prior year and which merit comment. "Salaries and benefits" increased nearly \$95,000. That amount does in fact include modest and "normal" increases in compensation to CFAB's employees as well as significantly higher health insurance costs. The majority of the increase, however, is related first to the recording of the cash value of accrued vacation leave (\$35,000) at May 31, 1990, to conform with accounting rules; and, second, to the fact that Fiscal 1989's reported expenses had been reduced by receipt of proceeds (\$40,200) from termination of a supplemental retirement plan.

There was an increase of about \$35,000 in "Advertising and promotion" expenses. This arose primarily from (1) the one-time expense of CFAB's 10th Anniversary Open House, (2) the introduction of radio advertising, (3) broader use of newspaper advertising, and (4) increased participation in trade shows, etc. Evaluation of the effectiveness of the latter three activities is ongoing, and related expenditures are likely to fluctuate in amount. We do believe that increased loan activity in Fiscal 1990 was due — at least in part — to CFAB's promotional efforts.

"Professional fees" were about \$25,000 greater than in Fiscal 1989. Most of that arose from CFAB's defense of a lawsuit emanating from a 1982 personnel action. We believe that suit has no merit. In fact, CFAB has been granted summary judgment, but the matter is still embedded in the appeal process.

### **Member Note Program**

In CFAB's 1989 Annual Report, and in subsequent newsletters, the Member Note Program was announced. That program makes it possible for members to effectively utilize short-term funds through the purchase of unsecured CFAB notes. To date, the program has not been used by a wide range of CFAB members. For those members who have participated, though, it seems to be an attractive arrangement — over the 9-month course of its availability, notes totaling \$1,008,000 were sold.

### **CFAB Staff**

There were no changes in CFAB's 18-person fulltime employee group during Fiscal 1990. We are pleased with the staff's stability and commitment, which result in clear and definite benefits to existing member-borrowers and which contribute to the growth trends as well.

### **Board Changes**

At CFAB's 1989 Annual Meeting, Bristol Bay fisherman Glenn Gustafson of Anchorage and Prince William Sound fisherman C. Ross Mullins of Cordova were elected to CFAB's Board of Directors. They replaced Harvey Samuelsen and Bob Waldrop, each of whom had declined to seek reelection. Mr. Samuelsen was one of CFAB's original Directors (and the last to serve as an active Director), and he and Mr. Waldrop together represented over 17 years' experience with CFAB. All of CFAB's members have benefitted from the dedication and contributions of these longtime Directors.

### **1990 Annual Meeting**

One three-year Director's term is subject to election in 1990, and a call for nominations will have been issued prior to distribution of this Annual Report. In addition, it will be necessary to seek candidates for completion of the unexpired term of CFAB's "farmer" Director.

---

The number and percentage of eligible members voting in Director elections and on other CFAB business have continued to increase in recent years. However, actual attendance at Annual Meetings has continued to be minimal even though a variety of approaches — including sectional meetings in coastal communities — has been attempted. Therefore, the Board has concluded to hold the 1990 Annual Meeting on Friday, October 26, in CFAB's own quarters and with limited special features in order to minimize the cost. Official notices will be mailed in September.

#### *Statewide Fishermen's Conference*

CFAB has been invited to participate with a broad group of Anchorage and Southcentral businesses to present a trade show and conference for Alaska fishermen in late November at Anchorage's Egan Convention Center. We have taken particular interest in the conference itself, which is being structured to give fishermen insight into the dramatically changing market forces which affect Alaska seafood, especially salmon. Fishermen tend naturally to focus their attention and energies on production and production-related factors. We believe the direct effects on fishermen's incomes from competitive market developments are equally worthy of attention and understanding, and we expect to vigorously promote and support CFAB member attendance at the November conference.



Gil Gunderson  
Chairman, Board of Directors



Edward E. Crane  
President

---

**Independent Auditor's Report**

Board of Directors  
Alaska Commercial Fishing  
and Agriculture Bank  
Anchorage, Alaska

We have audited the balance sheets of Alaska Commercial Fishing and Agriculture Bank as of May 31, 1990 and 1989, and the related statements of net proceeds, changes in capital and patronage, and cash flows for the years then ended. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such financial statements present fairly, in all material respects, the financial position of Alaska Commercial Fishing and Agriculture Bank as of May 31, 1990 and 1989, and the results of its operations and its cash flows for the years then ended in conformity with generally accepted accounting principles.

*Deloitte & Touche*

Certified Public Accountants  
June 14, 1990

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**Balance Sheets**

	May 31,	
	1990	1989
<b>Assets:</b>		
Cash .....	\$ 21,890	\$ 126,752
Loans and other receivables, net of allowance for loan losses of \$1,205,648 and \$1,471,399, respectively .....	45,300,534	34,107,728
Accrued interest receivable .....	1,944,488	1,661,180
Deferred income tax benefits .....	426,203	239,912
Investment in National Bank for Cooperatives .....	4,549,247	5,374,626
Bank premises, furniture and equipment, net .....	118,382	155,413
Acquired assets held for sale .....	133,395	133,406
Other assets .....	42,813	20,336
Prepaid income taxes .....	140,000	
	<u>\$ 52,676,952</u>	<u>\$ 41,819,353</u>
<b>Liabilities:</b>		
Accounts payable and accrued expenses .....	\$ 193,395	\$ 91,655
Accrued interest payable .....	229,367	186,449
Class B preferred stock subscriptions .....	99,077	28,249
Notes payable .....	16,359,128	7,190,780
Dividend payable .....	48,600	37,328
Income taxes payable .....		363,547
	<u>16,929,567</u>	<u>7,898,008</u>
Commitments and Contingent Liabilities (Note H)		
<b>Capital:</b>		
<b>Share capital -</b>		
Class C special preferred stock, \$10,000 par value, authorized 4,000 shares, outstanding 3,130 shares .....	31,800,000	31,800,000
Class B preferred stock, \$100 par value, authorized 400,000 shares, outstanding 28,187 and 26,261 .....	2,818,700	2,626,100
Loans receivable on Class B preferred stock .....	(442,700)	(955,900)
Class A membership stock, \$10 par value, authorized 10,000 shares, outstanding 843 and 1,147 .....	8,430	11,470
	<u>34,184,430</u>	<u>33,481,670</u>
Capital in excess of par value .....	111,600	102,420
Contributed capital .....	144,626	144,626
Unallocated surplus .....	1,306,729	192,629
	<u>35,747,385</u>	<u>33,921,345</u>
	<u>\$ 52,676,952</u>	<u>\$ 41,819,353</u>

See notes to financial statements.

**Statements of Net Proceeds**

	Year ended May 31,	
	1990	1989
<b>Gross Loan Revenues:</b>		
Interest and fees on loans and other receivables .....	\$ 4,701,341	\$ 8,103,810
Provision for allowance for loan loss .....	<u>204,500</u>	<u>132,300</u>
<b>Net Loan Revenues</b> .....	4,496,841	7,971,510
<b>Interest expense</b> .....	900,648	1,308,357
<b>Net proceeds before other income, operating expenses,     income tax expense and extraordinary credit</b> .....	3,596,193	6,663,153
<b>Other Income:</b>		
Interest on temporary investments .....	2,379	231,113
Gain on sale of assets .....	798	425
Net income from acquired assets .....	<u>13,659</u>	<u>10,000</u>
	<u>16,836</u>	<u>241,538</u>
	3,613,029	6,904,691
<b>Operating Expenses:</b>		
Salaries and benefits .....	1,229,207	1,135,476
Occupancy expense .....	157,665	162,328
Advertising and promotion .....	119,014	83,937
Professional fees .....	93,829	68,679
Travel, lodging and meals .....	65,687	57,365
Office operations .....	47,783	46,807
Depreciation and amortization .....	46,116	75,142
Telephone and postage .....	31,822	30,184
Directors' fees .....	22,375	16,650
Miscellaneous .....	<u>25,581</u>	<u>22,612</u>
	<u>1,839,079</u>	<u>1,699,180</u>
<b>Net proceeds before income tax expense and extraordinary credit</b> .....	1,773,950	5,205,511
<b>Income tax expense</b> .....	<u>784,000</u>	<u>2,100,000</u>
<b>Proceeds before extraordinary credit</b> .....	989,950	3,105,511
<b>Extraordinary credit — Utilization of net operating loss carryforward</b> .....	<u>172,000</u>	<u>1,970,000</u>
<b>Net Proceeds</b> .....	<u>\$ 1,161,950</u>	<u>5,075,511</u>

See notes to financial statements.

**Statements of Changes in Capital and Patronage**

	<u>Share capital</u>	<u>Capital in excess of par value</u>
<b>Balance, May 31, 1988</b> .....	\$ 32,864,080	\$ 95,310
Allocation to unallocated undistributed loss .....		
Issuance (redemption) of stock during the year:		
Class B preferred stock, 5,026 shares, net .....	(502,600)	
Class A stock, 79 shares .....	790	7,110
Reduction in loans receivable on Class B preferred stock .....	1,119,400	
Net proceeds .....		
Amortization of unallocated patronage deficit .....		
Dividends declared .....		
Unallocated surplus .....		
<b>Balance, May 31, 1989</b> .....	33,481,670	102,420
Issuance (redemption) of stock during the year:		
Class B preferred stock, 1,926 shares, net .....	192,600	
Class A stock, 229 shares, net .....	(2,290)	9,180
Class A stock, 75 shares, cancelled .....	(750)	
Reduction in loans receivable on Class B preferred stock .....	513,200	
Net proceeds .....		
Dividends declared .....		
Unallocated surplus .....		
<b>Balance, May 31, 1990</b> .....	<u>\$ 34,184,430</u>	<u>\$ 111,600</u>

See notes to financial statements.

<u>Contributed capital</u>	<u>Unallocated surplus</u>	<u>Allocated undistributed patronage</u>	<u>Net proceeds</u>	<u>Unallocated patronage earnings (deficit)</u>	<u>Total</u>
\$ 144,626	\$ —	\$ 825,691	\$ —	\$ (5,671,245)	\$ 28,258,462
		(825,691)		825,691	
					(502,600)
					7,900
					1,119,400
			5,075,511		5,075,511
			(4,845,554)	4,845,554	
			(37,328)		(37,328)
	192,629		(192,629)		
144,626	192,629	—	—	—	33,921,345
					192,600
					6,890
	750				513,200
			1,161,950		1,161,950
			(48,600)		(48,600)
	1,113,350		(1,113,350)		
<u>\$ 144,626</u>	<u>\$ 1,306,729</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ —</u>	<u>\$ 35,747,385</u>

**Statements of Cash Flows**

	<u>Year ended May 31,</u>	
	<u>1990</u>	<u>1989</u>
<b>Cash flows from operating activities:</b>		
Interest received . . . . .	\$ 4,208,059	\$ 8,441,456
Fees received . . . . .	212,353	234,178
Payments for operating expenses . . . . .	(1,748,486)	(1,677,811)
Interest paid . . . . .	(857,730)	(1,556,634)
Income taxes paid . . . . .	(1,301,838)	(6,365)
<b>Cash Provided by Operating Activities . . . . .</b>	<b>512,358</b>	<b>5,434,824</b>
<b>Cash Flows from Investing Activities:</b>		
Loan originations, net of undisbursed funds and principal repayments on member loans . .	(11,362,521)	5,323,534
Required investment in National Bank for Cooperatives . . . . .	(102,988)	(122,516)
Proceeds from retirement of investment in National Bank for Cooperatives . . . . .	928,367	274,519
Proceeds from lease of acquired assets . . . . .	13,659	10,000
Proceeds from sale of equipment . . . . .	798	425
Satisfaction of lien on acquired assets held for sale . . . . .	12	(47,817)
Payments for purchase of equipment . . . . .	(9,085)	(1,749)
<b>Net Cash Provided by (used in) Investing Activities . . . . .</b>	<b>(10,531,758)</b>	<b>5,436,396</b>
<b>Cash Flows from Financing Activities:</b>		
Additions (repayment) of notes payable, net . . . . .	9,161,097	(11,508,891)
Repayment of capital lease . . . . .	(12,749)	(8,872)
Proceeds from issuance of Class B stock . . . . .	705,800	616,800
Proceeds from issuance of Class A stock, net . . . . .	6,890	7,900
Proceeds from subscription for Class B stock . . . . .	70,828	22,549
Payment of dividends to members . . . . .	(37,328)	
Proceeds from member notes, net . . . . .	20,000	
<b>Net Cash Provided by (used in) Financing Activities . . . . .</b>	<b>9,914,538</b>	<b>(10,870,514)</b>
<b>Net Increase (Decrease) in Cash . . . . .</b>	<b>(104,862)</b>	<b>706</b>
<b>Cash, beginning of year . . . . .</b>	<b>126,752</b>	<b>126,046</b>
<b>Cash, end of year . . . . .</b>	<b>\$ 21,890</b>	<b>\$ 126,752</b>

See notes to financial statements.

	<u>Year ended May 31,</u>	
	<u>1990</u>	<u>1989</u>
<b>Reconciliation of Net Proceeds to Net Cash Provided by Operating Activities:</b>		
Net Proceeds.....	\$ 1,161,950	\$ 5,075,511
Adjustments to reconcile net proceeds to cash provided by operating activities -		
Depreciation.....	46,116	75,142
Deferred tax benefit.....	(186,291)	(239,912)
Provision for loan losses.....	204,500	132,300
Lease income from assets held for sale.....	(13,659)	(10,000)
Gain on sale of assets.....	(750)	(425)
Foreclosure costs.....	(34,786)	(144,398)
Changes in assets and liabilities:		
Accrued interest receivable.....	(283,308)	340,711
Other assets.....	(22,477)	(6,947)
Accounts payable and accrued expenses.....	101,740	(46,827)
Accrued interest payable.....	42,918	(103,878)
Income taxes payable.....	(363,547)	363,547
Prepaid income taxes.....	(140,000)	
<b>Total Adjustments.....</b>	<b><u>(649,592)</u></b>	<b><u>359,313</u></b>
<b>Net Cash Provided by Operating Activities.....</b>	<b><u>\$ 512,358</u></b>	<b><u>\$ 5,434,824</u></b>
<b>Supplemental Schedule of Noncash Investing and Financing Activities:</b>		
Addition of a capital lease obligation for equipment.....		<u>\$ 58,840</u>

See notes to financial statements.

## Notes to Financial Statements

Year Ended May 31, 1990 and 1989

### Note A — Summary of Significant Accounting Policies:

**Operations:** The Alaska Commercial Fishing and Agriculture Bank (CFAB) was incorporated on May 4, 1979 to promote growth of Alaska agriculture and fishing by providing debt financing to resident-owned businesses engaged in harvesting, processing or marketing, and to promote its own growth as a strong user-oriented institution through cooperative ownership and self-governance.

**Interest on loans:** The accrual of income is suspended on loans for which the payment of interest is contractually past due more than 90 days.

**Investment in National Bank for Cooperatives:** The investment in National Bank for Cooperatives (NBC) is stated at cost plus noncash patronage notifications. No ready market exists for this investment. Patronage dividends from NBC reduce interest expense to NBC in the year declared.

**Allowance for loan losses:** The allowance for loan losses is based upon review and evaluation of nonaccrual loans, other delinquent loans, and large loans as well as application of a potential loss factor consistent with CFAB's experience.

**Acquired assets held for sale:** Acquired assets held for sale include those assets acquired through foreclosure. These assets are carried at the lower of fair value or the recorded investment in the related loan. Holding costs are expensed when incurred unless such costs increase the fair value of the asset.

**Bank premises, furniture and equipment:** Bank premises, furniture and equipment are stated at cost less accumulated depreciation and amortization. Depreciation and amortization are charged to operations by use of the straight-line method over estimated useful lives of three to ten years. Expenditures for maintenance and repairs are charged to operating expense as incurred. Expenditures for renewals or improvements which extend the life of an asset are capitalized at cost and depreciated as stated above. Upon sale, retirement or other dispositions of property, the cost and accumulated depreciation are removed from the respective accounts and the resulting gain or loss recorded.

**Income taxes:** CFAB qualifies as a cooperative taxable under Subchapter T of the Internal Revenue Code.

**Deferred loan fees:** Statement of Financial Accounting Standards (SFAS) No. 91, "Accounting for Nonrefundable Fees and Costs Associated with Originating and Acquiring Loans and Initial Direct Costs of Leases," became effective for loan originations beginning January 1, 1988. SFAS No. 91 requires loan origination fees and direct loan origination costs, if material, to be capitalized and the net fee or cost to be amortized over the life of the related loan as an adjustment to yield. SFAS No. 91 was not applied because the effects were not material to the financial position or results of operations.

**Net reporting of cash receipts and payments:** Statement of Financial Accounting Standards (SFAS) No. 104, "Net Reporting of Certain Cash Receipts and Cash Payments and Classification of Cash Flows from Hedging Transactions," becomes effective June 15, 1990. SFAS No. 104 amends SFAS No. 95 to permit banks to report net amounts of cash receipts and cash payments for loans made to customers and principal collections of loans, and deposits accepted and repayments of deposits. As permitted, CFAB has elected early adoption of SFAS No. 104 and the 1989 financial statements have been restated.

**Reclassification:** Certain items in the 1989 financial statements have been reclassified to conform to 1990 presentation.

### Note B — Loans:

CFAB's loan portfolio by major category is as follows:

	May 31,	
	1990	1989
Seafood harvesters	\$ 30,170,321	\$ 27,080,586
Fish processors	11,902,245	7,116,742
Agriculture and timber	3,409,048	588,386
Other receivables	1,457,268	1,749,313
	<u>46,948,882</u>	<u>36,535,027</u>
Less loans receivable on Class B preferred stock	442,700	955,900
	<u>46,506,182</u>	<u>35,579,127</u>
Less allowance for loan losses	1,205,648	1,471,399
	<u>\$ 45,300,534</u>	<u>\$ 34,107,728</u>

In accordance with its statutory mandate and authority, CFAB's financing activity is limited to the Alaskan commercial fishing and agriculture industries. This concentration of loans in resource-based industries results in an unusual level of risk exposure.

**Notes to Financial Statements** *continued*

The loan portfolio includes loans which have been classified as nonaccrual. Nonaccrual loans by major category are as follows:

	May 31,	
	1990	1989
Seafood harvesters	\$ 1,341,632	\$ 2,500,981
Fish processors	898,882	1,498,416
Agriculture and timber		233,385
Other receivables		129,352
	<u>2,240,514</u>	<u>4,362,134</u>
Less loans receivable on Class B preferred stock	<u>10,600</u>	<u>156,000</u>
	<u>\$ 2,229,914</u>	<u>\$ 4,206,134</u>

Activity in the allowance for loan losses is as follows:

	May 31,	
	1990	1989
Balance at beginning of year	\$ 1,471,399	\$ 2,197,140
Charged to expense	204,500	132,300
Recoveries on loans previously charged off	<u>317,950</u>	<u>27,400</u>
	1,993,849	2,356,840
Less loan amounts charged off	<u>788,201</u>	<u>885,441</u>
Balance at end of year	<u>\$ 1,205,648</u>	<u>\$ 1,471,399</u>

The allowance for loan losses is periodically evaluated by management and changes are recorded through the current period provision for loan losses.

*Loans to Directors:* To qualify for election to the CFAB Board of Directors, an individual must be a borrowing member or be an officer or principal of a corporation, partnership, or joint venture which is a borrowing member. Loans to these directors or their interests totalled \$323,485 and \$215,605 at May 31, 1990 and 1989, respectively.

**Note C – Bank Premises, Furniture and Equipment:**

Bank premises, furniture and equipment consists of the following:

	May 31,	
	1990	1989
Furniture, fixtures and equipment	\$ 902,865	\$ 897,781
Leasehold improvements	<u>147,202</u>	<u>147,202</u>
	1,050,067	1,040,983
Less accumulated depreciation and amortization	<u>931,685</u>	<u>885,570</u>
	<u>\$ 118,382</u>	<u>\$ 155,413</u>

**Note D – Notes Payable:**

Notes payable consists of:

	May 31,	
	1990	1989
NBC long-term notes with interest rate of 11.28%, maturing in January, 1993	\$ 5,000,000	\$ 5,000,000
NBC short-term notes and seasonal loan with interest rates ranging from 9.11% to 10.0%, maturing May 1, 1991	11,301,440	2,140,766
Member note with interest rate of 8.5% maturing August 26, 1990	20,424	
Other - Capital lease	<u>37,264</u>	<u>50,014</u>
	<u>\$ 16,359,128</u>	<u>\$ 7,190,780</u>

The NBC notes are secured by substantially all CFAB assets.

Principal payments required on notes payable are as follows:

Year ending May 31,	Amount
1991	11,333,632
1992	11,768
1993	5,011,768
1994	1,960

**Notes to Financial Statements** *continued***Note E — Employee Benefit Plans:**

CFAB has an employee benefit plan as defined under Section 401(k) of the Internal Revenue Service Code covering substantially all employees.

An employee is allowed to contribute up to 15% of his/her earnings to the maximum limit allowed by the Code. Contributions by CFAB to the plan are at the discretion of the Board of Directors. Contributions by CFAB for the years ended May 31, 1990 and 1989 were \$56,279 and \$54,018, respectively.

**Note F — Capital:**

*Share capital:* Shares owned by the State of Alaska must be repurchased by CFAB on or before July 20, 2000.

Preferential shareholders' rights on dissolution are attached in the order of Class C, Class B and Class A.

The following rights apply to the three categories of stock:

**Class C** - No voting or dividend rights. May only be issued to the State of Alaska.

**Class B** - No voting rights. Class B stock may only be held by members of CFAB. Prior to December 31, 1985, all loans required a purchase of Class B stock in an amount equal to 10% of the loan balance; however, this purchase was not funded but was evidenced by notes. On loans made subsequent to December 31, 1985, each borrower is required to make a cash purchase of Class B stock in an amount equal to 5% of the total loan. This investment will remain in place until retired by the Board of Directors.

**Class A** - No dividend rights. Each member of CFAB must own one share of Class A stock. Each share of stock carries one vote. To vote, a member must be a current borrower or have borrowed from CFAB during the preceding two years or have minimum retained membership earnings and/or Class B stock with CFAB of \$2,500.

**Note G — Income Taxes:**

The provision for income taxes consists of the following:

	Year ended May 31,	
	1990	1989
Current payable - Federal	\$ 798,000	\$ 369,912
Deferred benefit - Federal	(186,000)	(239,912)
	<u>\$ 612,000</u>	<u>\$ 130,000</u>

The deferred income tax benefit relates principally to the timing difference arising from the effect of the Tax Reform Act of 1986 on the allowance for loan losses. For Alaska State income tax calculation purposes, CFAB has \$1,908,000 net operating loss carryforward available as of May 31, 1990, to offset future taxable earnings. The net operating loss carryforward expires May 31, 1998.

**Note H — Commitments and Contingent Liabilities:**

*Commitments:* CFAB leases office space under a non-cancelable operating lease agreement which expires in 1992 and for which the remaining lease obligation is \$265,609. Rental expense under this lease totalled \$151,844 and \$156,872 for the years ended May 31, 1990 and 1989, respectively.

*Contingencies:* CFAB is a litigant in several legal actions arising from normal business activities, primarily related to delinquent loans and foreclosures. CFAB reserves for potential losses on delinquent loans as described in Note A. As to litigation outside of delinquencies and foreclosures, management believes that those actions are without merit or that the ultimate liability, if any, resulting from them will not materially affect CFAB's financial position or its results of operations.

## ***Board of Directors and Staff***

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### **Board of Directors**

Gilbert Gunderson, Chairman  
Juneau

Alan Otness, Vice Chairman  
Petersburg

Dean Paddock, Secretary-Treasurer  
Juneau

Glenn Gustafson, Director  
Anchorage

Hyoung "Henry" Kim, Director  
Anchorage

C. Ross Mullins, Director  
Cordova

Charles W. Trowbridge, Director  
Palmer

### **Staff**

Iver H. Amundsen  
Assistant Vice President

Karl D. Barnard  
Vice President

Dan A. Berkshire  
Vice President

Cynthia D. Blush  
Bookkeeper

Darleen S. Church  
Senior Vice President

Robert H. Clark  
Vice President

Wendy M. Clark  
Administrative Secretary

Edward E. Crane  
President

Elton E. Engstrom  
Loan Officer Trainee

A. W. Hall  
Business Development Officer

Lela F. Hart  
Vice President

Isabelle R. Kautzky  
Receptionist

Sharon A. Morgan  
Administrative Support Secretary

Mary B. Ober  
Documentation Assistant

David G. Rogers  
Senior Vice President

Douglas W. Sindt  
Data Processing Supervisor

Lora C. Smith-Thilmony  
Senior Bookkeeper

Deborah A. Tosch-Price  
Documentation Paralegal

Godelieve C. Van Lint  
Administrative Support Clerk

DeLories M. vonGemmingen  
Executive Secretary

**Office Address:** 2550 Denali St., Suite 1201 (Denali Towers), Anchorage

**Mailing Address:** P.O. Box 92070, Anchorage, AK 99509-2070

**Telephone:** (907) 276-2007; (800) 544-2228 (Outside Anchorage)

**FAX:** (907) 279-7913

## **What is CFAB?**

Alaska Commercial Fishing and Agriculture Bank (CFAB) began operations in 1980. Its sole mission is to provide financing of all kinds to the commercial fishing industry and the agriculture industry (including timber) in Alaska.

## **What kinds of loans and repayment programs are available from CFAB?**

CFAB can make loans for almost any fishing-related or farming-related purpose. The most common purposes are the purchase, modification, or refinancing of a vessel; purchase of a limited entry permit; gear, engine, or equipment replacement or upgrade; general operating capital; and fish processing, etc. There are no "standard" repayment terms or programs — we work with each applicant to determine a repayment schedule appropriate to that particular loan transaction.

## **Who may borrow from CFAB?**

In order to be eligible for consideration as a CFAB borrower, an applicant must be commercially involved in one of the industries mentioned earlier. An individual applicant must be a bona fide Alaska resident. A partnership must be comprised of Alaska residents. If the applicant is a corporation, the majority ownership and control must rest with Alaskans. There are some exceptions to the latter rule for companies which are involved in shorebased fish processing.

Eligibility, however, is only a first step. To obtain a CFAB loan, an applicant must be found by CFAB to be capable and creditworthy within the context of the specific loan request. The standards used by CFAB are essentially the same as those of any responsible lender. However, CFAB's specialized purposes, and the experience we have gained, may permit us to consider a broader range of applicants than do most other lenders.

## **Who owns CFAB?**

CFAB is a cooperative. This means that each borrower becomes an owner through a modest purchase of CFAB stock when a loan is made. The State of Alaska is also an owner. CFAB was established by a special Alaska statute, and the State made an initial investment of "seed money" — that money is expected to be returned to the State as borrowers' ownership grows.

## **Does that mean the State operates CFAB?**

CFAB's statute provides for it to be operated as a private cooperative rather than as a State agency. Its basic policies and directions are established by a seven-person Board of Directors, which hires professional management and staff to operate the business. Five of the Directors must be borrower-owners of CFAB and are elected by the total borrower-ownership. The other two Directors are appointed by the Governor of Alaska. All Directors' terms are for three years. CFAB holds an ownership meeting each year - borrower-owners have the opportunity to vote on important matters, to receive reports from Directors and management, and to elect Directors. The State's stock is non-voting, although CFAB provides periodic reports to State officials.

## **Where does CFAB get its money to loan?**

CFAB is not limited as to its source of funds. Since its inception, CFAB has borrowed funds for re-lending from the Federal Farm Credit System.

## **What is CFAB's interest rate and how is it set?**

Although CFAB occasionally makes fixed rate loans, the vast majority of its loans are on a variable rate basis. That is, the rate will change — up or down — as CFAB's costs change. There is no single initial rate — the initial rate is based on the kind of loan involved. Most important, we use a procedure to objectively analyze the credit-worthiness of each individual applicant, which permits us to offer the most favorable interest rates to the most desirable risks. CFAB's interest rates overall are set to provide sufficient income to pay its own interest costs and operating expenses and to provide a small margin. Since CFAB is a cooperative, any margin which is actually produced is either returned to the borrower-owners or otherwise used to their benefit.

— EXCERPTED FROM A CFAB BROCHURE. —