ALASKA LEGISLATURE COMMITTEE FILES 1993-1994 8672

8266 SENATE HEALTH EDUCATION & SOCIAL SERVICES

THE STATE OF ALASKA
HEALTH RESOURCES AND ACCESS TASK FORCE

FINAL REPORT

to

the Governor and Legislature

January 1993

Alaska State Legislature
Health Resources and Access Task Force
State Capitol
Juneau, Alaska 99801-1182

HEALTH RESOURCES AND ACCESS TASK FORCE

MEMBERS

Legislative Branch

Senator Jim Duncan
Co-Chair

Senator-Elect Johnny Ellis
Co-Chair

Representative Mark Boyer

Senator Jalmar Kerttula

Representative Mike Navarre

Senator Robin Taylor

Executive Branch

Commissioner Nancy Bear-Usera
Department of Administration

Commissioner Theodore Mala, MD, MPH
Department of Health & Social Services

Commissioner Glenn Olds
Department of Natural Resources

Public Members

Mano Frey
Representing Labor Organizations

Roxanna Horschel
Representing Private Employers

David Mather, Dr. P.H.
Representing Non-Profit Organizations

Jerry Near
Representing Health Insurers

Patricia O'Gorman
Representing Medically Indigent

Karen Perdue
Representing Consumers

Sister Dona Taylor
Representing Providers

Rodman Wilson, M.D.
Vice Chair
Representing Providers

STAFF

Nancy Cornwell
Project Director

Bonnie Gruening
Administrative Assistant

CONSULTANT

Lawrence Bartlett, Ph.D.
Director
Health Systems Research, Inc.

ACKNOWLEDGEMENTS

The Health Resources and Access Task Force wishes to acknowledge the assistance of many people and organizations.

We would like to recognize the 17th Alaska State Legislature for creating the Task Force and for dedicating the necessary resources for our work. We also offer our appreciation to Senator Virginia Collins who served as an original member of the Task Force until she resigned in September 1992 and Senator Arliss Sturgulewski who attended and participated in many of our meetings.

Several members of the Executive Branch actively participated in the Task Force meetings, including Deputy Commissioner of Health and Social Services Jay Livey, Deputy Commissioner of Administration Roberley Waldron, and Director Dave Walsh and Deputy Director Thelma Snow Walker of the Division of Insurance. In addition, numerous Executive Branch staff provided important information to the Task Force, including Kim Busch, Deb Erickson, Gordon Landes, Peter Nakamura, M.D., Jack Nielson, Larry Streuber, Chris Ulmann, and Brad Whistler. Both Janet Clarke and Larry Streuber deserve a special thanks for assisting the Task Force in securing initial resources for our office and for the services of the Institute of Social and Economic Research.

Many private organizations including the twenty-nine which made brief presentations to the Task Force deserve our recognition. Several made considerable contributions to our process including Steve LeBrun of Aetna Life Insurance Company, Harlan Knudson and Garrey Peska of the Alaska State Hospital and Nursing Home Association, and well as many representatives of the American Association of Retired Persons, the Green Party, and the League of Women Voters who consistently followed our deliberations and asked questions of us.

Worthy of special acknowledgement are the hundreds of member of the public who participated in our community meetings and public hearings, submitted written comments, and completed our surveys. Their stories reminded us of the personal struggles people face in trying to gain access to health care. We would also like to thank the Anchorage Daily News for publishing our public opinion survey on their editorial page. As a result, hundreds of Alaskans responded.

We are grateful to Lawrence Bartlett, Ph.D., Director of Health Systems Research, Inc. who served as our consultant and provided us with invaluable research and guidance throughout our process. We would also like to thank Scott Goldsmith, Ph.D., with the Institute of Social and Economic Research for the reports he prepared for us.

And finally, a special thanks to Nancy Cornwell, our project director, whose dedicated assistance with all facets of our work added immensely to our success, and to Bonnie Gruening, our administrative assistant, who responded to many, many requests and kept all the information coming.

TABLE OF CONTENTS

EXECUTIVE SUMMARY ii

CHAPTER ONE: BACKGROUND AND PURPOSE OF THE TASK FORCE 1

CHAPTER TWO: TASK FORCE FINDINGS 3

CHAPTER THREE: GUIDING PRINCIPLES 37

CHAPTER FOUR: TASK FORCE RECOMMENDATIONS 39

A. OVERVIEW 39

B. TASK FORCE RECOMMENDATIONS 41

C. IMPLEMENTATION TIMETABLE 75

REFERENCES 79

LIST OF APPENDICES 83

EXECUTIVE SUMMARY

The Health Resources and Access Task Force was created in 1991 by the Alaska State Legislature and charged with the responsibility for developing a strategy that would provide health care coverage for all Alaskans and that would contain rising health care costs. Over the past sixteen months, the Task Force has labored diligently to thoroughly examine the health care financing and delivery problems that exist in the state and to identify the appropriate strategies for making quality health care available and affordable to all Alaskans. In carrying out its responsibilities, the Task Force carefully examined a significant amount of data and research on health care issues both in and outside of Alaska, held numerous community meetings and public hearings, conducted surveys of the Alaskan public, and received and reviewed written comments from numerous individuals and organizations across the state.

The Task Force found the health care financing and delivery systems in Alaska to be in a state of crisis. Specifically, the Task Force found that:

- Over the past dozen years, health care costs have grown out of control, far outstripping the growth in the overall economy. Unless steps are taken to address this problem, future costs can be expected to continue to spiral upward.

- Despite the significant amount of health care dollars spent in Alaska, a significant portion of the state's population--over 76,000 persons--have no health care coverage. Not only does this lack of coverage have a negative impact on the health of these persons, but it also results in higher health care costs to those of us who do have insurance.

- There are many problems inherent in our current health care financing system that result in so many uninsured Alaskans. For example, many insurers who sell coverage to small businesses will refuse to insure or charge unaffordable rates to those businesses and individuals who most need health care protection.

- Significant problems exist within the state's health care delivery system. For example, in some areas of the state people lack access to even the most basic of health services, while in other areas a lack of coordination among providers results in the unnecessary duplication of services.

- The State does not have the proper policies in place to assure a strong and stable public health infrastructure.

- The manner in which we resolve medical malpractice claims is in need of improvement.

As a result of the above problems, the Task Force also found that:

- The health status of Alaska's population is among the worst in the nation; and

- A significant portion of the state's population believes that fundamental reform is necessary to correct the problems in the state's health care financing and delivery systems.

The Task Force agrees with the message it received from the Alaska public calling for a significant overhaul of the state's existing health care financing and delivery systems. We recommend the implementation of a comprehensive health care reform strategy designed to improve the health of the Alaskan people by making health care coverage available and affordable to all. The specific components of this strategy include:

- The establishment of a statewide health care expenditure limit to bring skyrocketing costs under control and make health care affordable once again;

- The establishment of a single payer system under which health care coverage will be available to all Alaskans <u>at no additional increase in total spending</u>. While a single payer system is being developed and implemented, the Task Force has also recommended a series of interim measures designed to provide an immediate increase in access to care for many uninsured and underinsured Alaskans;

- A series of measures designed to improve the availability, efficiency and coordination of health care services throughout the state;

- A commitment to provide a strong public health infrastructure; and

- Improvements in medical malpractice claims resolution.

The Task Force firmly believes that enactment of these recommendations will improve the availability, affordability and quality of health care provided in Alaska. As a result, Alaskans will live healthier, happier, and more productive lives.

CHAPTER ONE: BACKGROUND AND PURPOSE OF THE TASK FORCE

During the 1991 legislative session, the Alaska State Legislature passed Legislative Resolve 45 which created the Health Resources and Access Task Force. The primary purposes of the Task Force were:

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

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

3. To define a strategy for implementing a health care program covering all Alaskans and a strategy to contain the costs of health care in the state.

(The resolution creating the Task Force includes fourteen specific tasks related to these primary purposes. See Appendix A for resolution.)

The Health Resources and Access Task Force consists of seventeen members including three members of the Senate, three members of the House, three members representing the executive branch, and eight public members representing health care providers (two members), the medically indigent, employers, health insurers, nonprofit organizations, consumers, and labor organizations.

The Task Force, created in May 1991, sunsets on February 1, 1993. The Task Force held fourteen two-day meetings between September 1991 and November 1992. During these meetings, we developed an understanding of the health care access and cost problems facing Alaskans by reviewing relevant health services research and related scientific information. Task Force members also drafted "guiding principles" which we followed in the development of our recommendations. In addition, we reviewed the full array of possible approaches for addressing identified problems, including the relevant experience of other states and countries with health care reform measures. For many of these approaches, we explored how, if implemented in Alaska, they would change our current health care system.

As a means of getting public input from Alaskans on their health care problems and recommendations for reform, the Task Force heard brief presentations from twenty-nine organizations including advocacy groups, professional service and other provider organizations, private and public sector employers, and business groups. We also held community meetings and public hearings in Anchorage, Bethel, Cordova, Delta Junction, Dillingham, Fairbanks, Glenallen, Haines, Homer, Juneau, Kenai,

Ketchikan, Kodiak, Kotzebue, Nenana, Nome, Palmer, Petersburg, Seward, Skagway, Soldotna, Sitka, Tok, Unalaska, Valdez, Wasilla, and Wrangell. In addition, 495 Alaskans responded to two separate public opinion surveys distributed by the Task Force. And finally, many Alaskans provided invaluable written comments to us. (Written comments from interest groups and individuals, summaries of the community meetings/public hearings, and the survey results are published in a separate document.)

One important part of Alaska's health care system which we excluded from our recommendations was long-term care. During our early meetings, we discussed the daunting scope of the Task Force's charge. We also noted that the financing problems for primary, preventive and acute care are significantly different from those for long-term care. The Task Force felt that our principal charge was to address the problems of spiraling health care costs and lack of health care coverage for primary, preventive and acute care services. However, our decision to exclude long-term care from our recommendations should not be interpreted as our believing that this problem is insignificant. On the contrary, the Task Force concluded that the long-term care problems facing Alaskans are so significant, and the effort required to address them so large, that the State should pursue those issues in an arena dedicated solely to that subject.

The Task Force published an interim report of our findings in January 1992 and interim recommendations in March 1992. This report represents our final findings and recommendations.

Chapter Two of this report presents the Task Force's major findings and sub-findings. Chapter Three contains our guiding principles, and Chapter Four describes both the Task Force's short-range and long-range recommendations for health care reform in Alaska.

CHAPTER TWO: TASK FORCE FINDINGS

Between September 1991 and November 1992, the Task Force examined the health care access and cost problems facing Alaskans. Our examination led us to a number of important findings, which we have summarized in this chapter. We also highlight and discuss a number of important subfindings within each of these areas. And finally, throughout the chapter we have included excerpts from the letters and testimony we received that illustrate in very human and personal terms the problems that Alaska's health care financing system has created for many of its people.

Finding #1: In the 1980s, health care costs in Alaska grew at a rate far above other measures of the state's economy.

- **In the twelve-year period from 1979 to 1991, total health care spending in Alaska more than tripled, rising from $479.7 million to $1.598 billion.**

Details on 1979 expenditures can be found in Malhotra and Wills (1981). Table 2-1 below identifies the sources of health care spending in Alaska in 1991 by major payer category. Table 2-2 on the following page provides further detail on the sources of 1991 spending, while Appendix B to this report describes the data upon which this estimate was developed.

Table 2-1
1991 Health Care Spending in Alaska by Payer Category

PAYER	AMOUNT	PERCENT OF TOTAL
Federal Government	$ 549 million	34%
Individuals	377 million	24%
State Government	318 million	20%
Businesses	235 million	15%
Local Governments	118 million	7%
Total 1991 Spending	$1.598 billion	100%

Table 2-2
ESTIMATED 1991 HEALTH SPENDING IN ALASKA
BY SOURCE OF FUNDS
(In Thousands of Dollars)

Detail	Individual	Business	Local	State	Federal	TOTAL
Employment-Based:						$460,121
Insurance Premiums	$61,164	$121,418	$39,906	$47,929	$35,402	28.80%
Self-Insured Plans	$30,861	$65,379	$48,774	$9,290		
Subtotal/Employment-Based	$92,024	$186,796	$88,681	$57,218	$35,402	
Other Private						$77,547
Individual Policies and Coverage through Fraternal Orgs and Auto Liability Insurance	$29,458					4.85%
Workers' Compensation		$48,089				
Out-Of-Pocket:						$255,602
Expenses of Uninsured	$255,602					16.00%
Co-payments/Deductibles						
Non-covered Services						
Medicare:				$964	$90,000	$90,964 5.69%
Medicaid:						$214,550
Federal					$109,248	13.43%
State				$95,326		
Medicaid Administration				$4,276	$5,700	
Other Public						
Federal:						$308,561
IHS/AANHS					$206,153	19.32%
Veterans' Affairs					$46,476	
CHAMPUS payments					$14,647	
Military Support					$41,284	
State:						$160,455
Pioneers' Homes				$12,436		10.04%
Youth Corrections Health Care				$662		
API, Harborview				$19,270		
Grants to Regional Health Corporations				$7,066	$313	
Selected state health services				$27,977		
Revenue Sharing for Health				$5,026		
Other grants for health				$21,799		
Community Mental Health Grants				$27,995		
Fisherman's Fund				$1,230		
General Relief Medical				$7,672		
Other State Health Spending				$29,009		
Local:						$29,713
Local Taxes in Support of Hospitals						1.86%
Other Local Health Spending (net of state grants)			$29,713			
Total	$377,084	$234,885	$118,394	$317,926	$549,223	$1,597,513
As a % of total spending	23.60%	14.70%	7.41%	19.90%	34.38%	

Source: Data originally compiled by ISER, UAA from various sources. Selected entries updated by Health Systems Research, Inc.

- **Per capita health care spending in Alaska increased nearly two and one-half fold over the past twelve years, growing from $1,160 in 1979 to $2,783 in 1991.**[1]

A certain portion of the growth in overall health spending in Alaska is due to an increase in the size of the state's population. The Task Force found that even after accounting for population growth, 1991 per capita health care spending in Alaska was roughly two and one-half times greater than in 1979.

- **In Anchorage, while consumer prices for all goods and services grew 28.9 percent since the early 1980s, medical costs grew 81.5 percent (Anchorage Daily News 1992), or nearly three times the rate of inflation.**

The Task Force found that increases in the prices charged for health care services contributed significantly to the growth in health care spending. For example, during the last decade, health care prices in the United States increased at nearly twice the rate of general inflation. Although comparable data is not available for the entire state, an analysis of Anchorage consumer prices indicates that medical costs there increased three times faster than overall inflation.

Finding #2: Alaska's per capita health care spending, which is higher than the national average, is expected to continue to grow at a fast pace.

In 1991, Alaska's per capita health care spending was roughly equal to the national average. However, this comparison does not take into account the fact that Alaska's population is much younger than the nation as a whole. As discussed below, after adjusting for these age differences, health care spending per person in Alaska was found to be much higher than the national average.

- **Alaska's 1991 age-adjusted per capita health care spending was 27 percent above the national average.**

U.S. and Alaska 1991 per capita health care spending was estimated to have been roughly the same, at $2,872 and $2,783, respectively. However, these figures

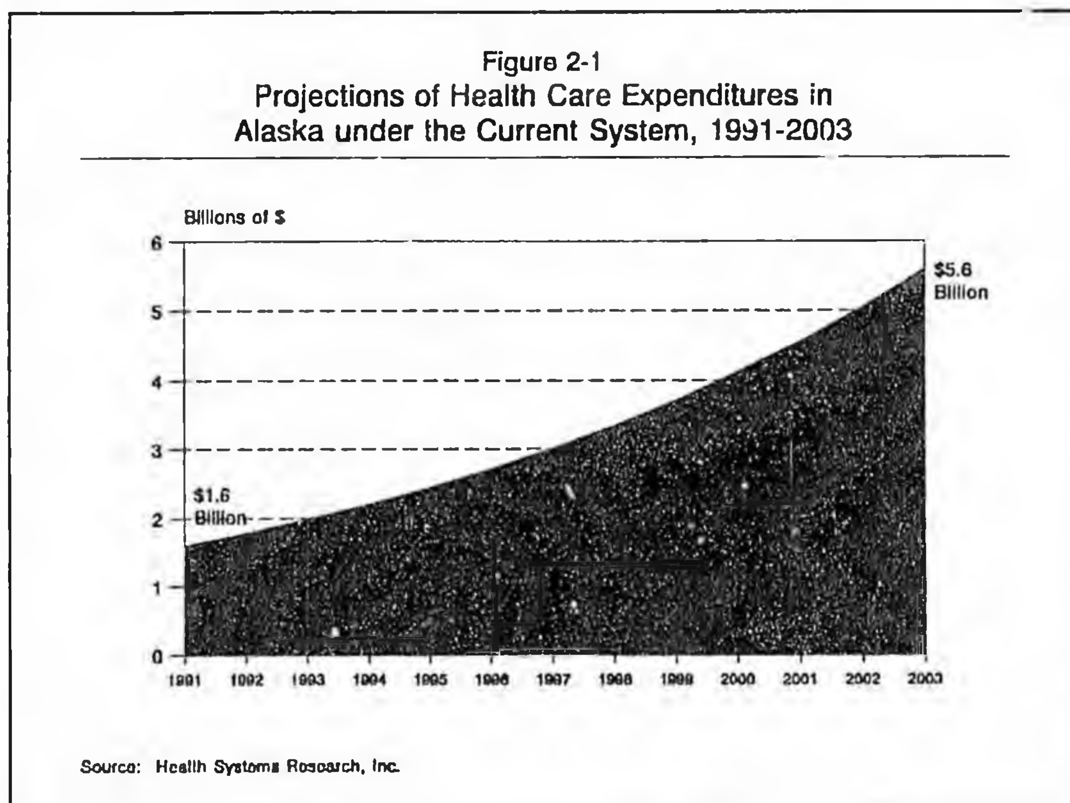
[1] According to the Alaska Department of Labor, the state's population in 1979 was 413,700. The 1991 population was projected by the Department to be 574,000, see middle series projections in Alaska Population Projections, November 1991.

are not adjusted to reflect differences in the age composition of the populations. Because Alaska's population is younger than the nation as a whole, and because the young have lower health care costs than the elderly, the age distribution of Alaska's population would be expected to result in lower health care costs overall than for the U.S. When per capita costs are adjusted for age, Alaska's 1991 per capita health spending is estimated to have been twenty-seven percent higher than the national average.[2]

- **Total health care spending in Alaska under our current system is projected to more than double over a seven year period, increasing from slightly below $1.6 billion in 1991 to nearly $3.34 billion in 1998. By the year 2003, health care spending in the state will be nearly $5.6 billion.**[3]

While the historical rates of growth in health care spending were of great concern to the Task Force, they found that projections of future health care spending, which assume "business as usual," were even more alarming. Statewide health care spending is expected to more than triple over the next twelve years, reaching nearly $5.6 billion in the year 2003.

Figure 2-1
Projections of Health Care Expenditures in Alaska under the Current System, 1991-2003



Source: Health Systems Research, Inc.

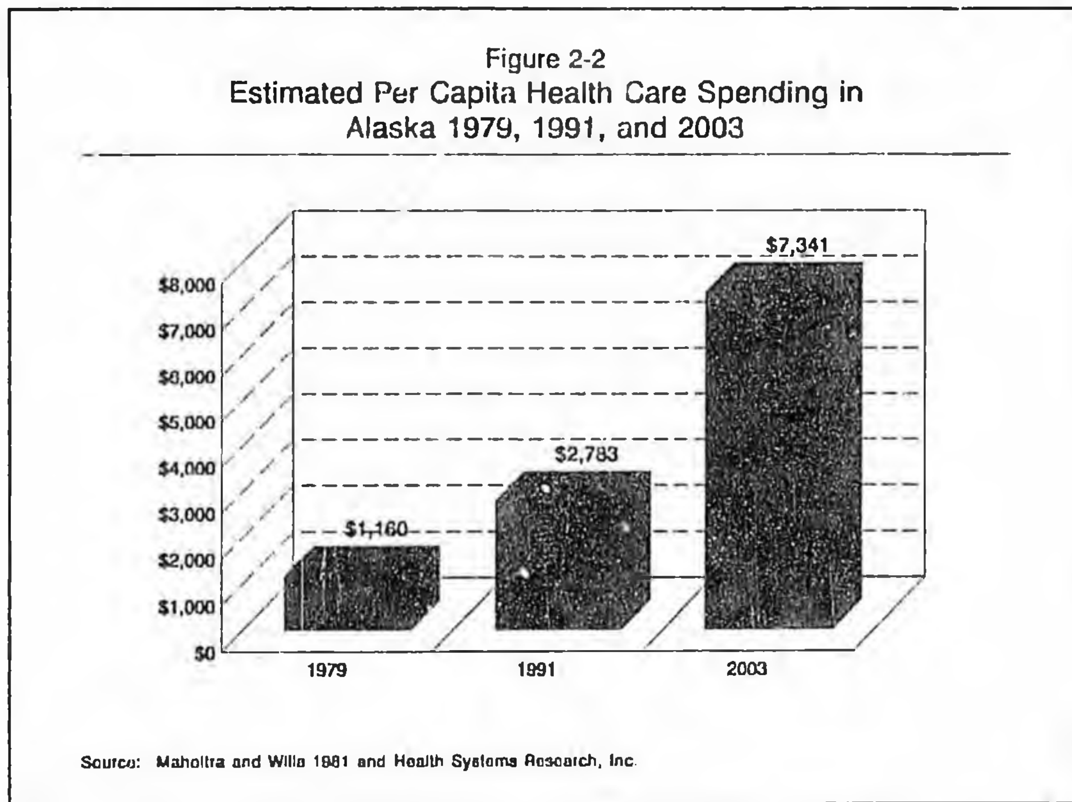
---

[2] Bartlett, L., Health Systems Research, Inc. For expenditures by age groups, see CRS 1991.

[3] See Chapter Four for a fuller discussion of the Task Force's projections of future health care spending in Alaska.

- **Between 1991 and 2003, per capita health care spending under the current system in Alaska is expected to increase over two and one-half fold to $7,341, up from $2,783 in 1991.**

Figure 2-2
Estimated Per Capita Health Care Spending in
Alaska 1979, 1991, and 2003



Source: Maholtra and Wills 1981 and Health Systems Research, Inc.

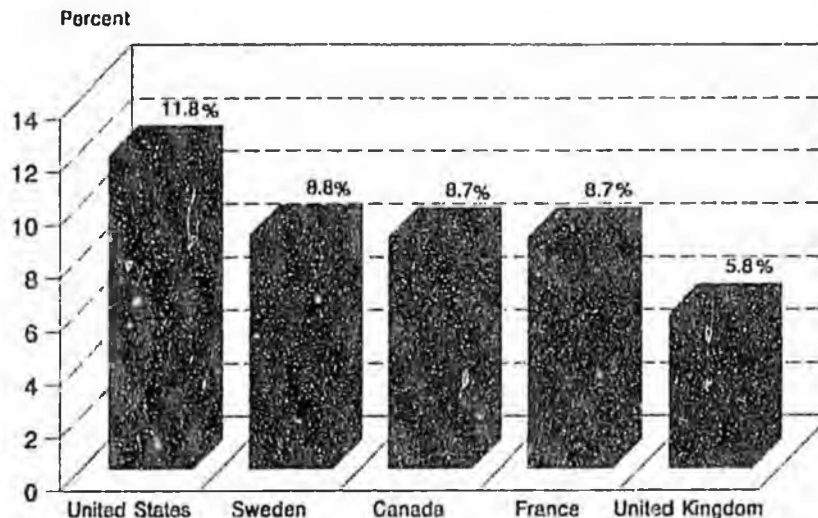
In considering projections of health care spending in Alaska, the Task Force took special note of the proportion of health care spending that is likely to be consumed by the elderly. During the 1980s, Alaska's elderly population grew at a faster rate than the U.S. elderly population, and faster than Alaska's population as a whole (Appendix C, Section IV). Such population growth, together with the fact that per capita health care costs for the elderly are three times greater than average (CRS 1991), suggests that the elderly will consume an even greater share of health care spending in future years. This was of great concern to Task Force members, since services for the elderly are financed disproportionately by the public sector, principally through Medicare and Medicaid.

Finding #3: Health care costs are having an increasingly negative effect on Alaska's employers, including both private businesses and governments, as well as on workers and their families.

As health care spending has grown, it has absorbed a larger percentage of the Gross Domestic Product, business profits, payroll, and family incomes.

- **The U.S. spends a larger share of its Gross Domestic Product on health care than any other industrialized country (see Figure 2-3). As a result, U.S. industries find it increasingly difficult to compete in the world's economy (CRS 1991).**

Figure 2-3
Health Care Spending as a Percent of Gross Domestic Product, Selected Countries, 1989



Source: Congressional Research Service

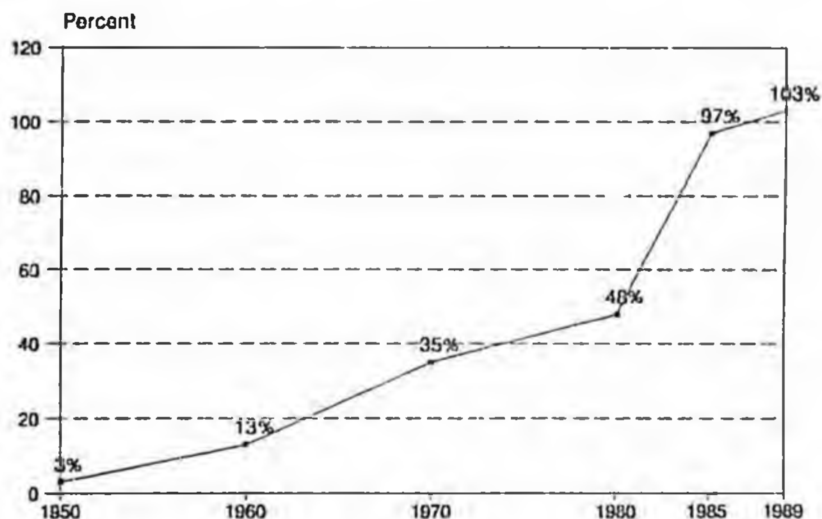
- **Rapidly rising health care costs have had a negative impact on the profitability of most businesses.**

According to the Employee Benefits Research Institute, in 1970, health care benefits paid for by businesses were equivalent to about 35 percent of after-tax profits for corporations. By 1980, health benefit payments, as a business expense, were equal to about 48 percent of after tax profits, and by 1989, they had reached roughly the same level (103 percent) as after-tax profits (see Figure 2-4).[4]

---

[4] Employee Benefit Research Institute tabulations of data from the U.S. Department of Commerce, Bureau of Economic Analysis, Survey of Current Business, selected years.

Figure 2-4
Employer Spending on Health Insurance
as a Percentage of Corporate After-Tax Profits



Source: Employee Benefit Research Institute tabulation of U.S. Department of Commerce data.

- **Rapidly rising health care costs have meant less take-home pay for Alaska workers.**

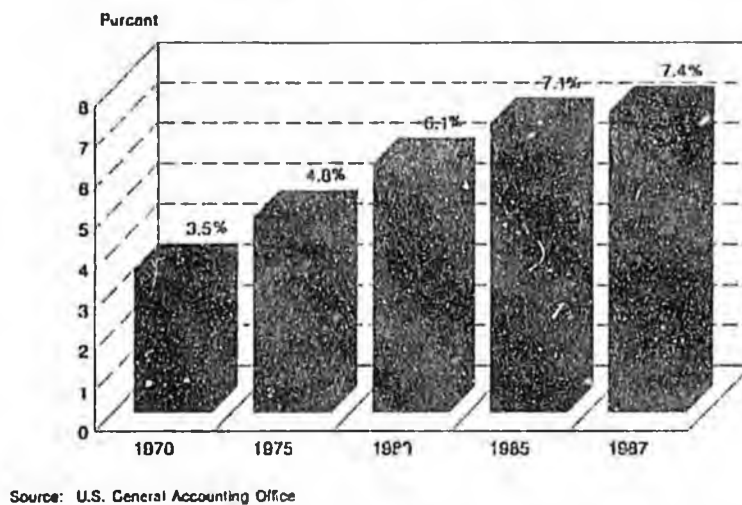
Health care benefits as a percent of payroll have been the fastest growing component of labor compensation over the last two decades, limiting employers' ability to increase real wages. As shown in Figure 2-5 on the following page, in 1970, health care spending by U.S. businesses represented 3.5 percent of total wages and salaries. By 1987, business health care spending had increased to 7.4 percent of wages and salaries (GAO 1990).

PERSONAL STORIES . . .

"I am a 31 year old, lifelong Alaskan, who has not had the luxury of being covered by a health care plan via the work place. For seven years, I went without any coverage at all. Fearing financial ruin due to escalating health care costs, I obtained a private policy in March 1990. My monthly premium, with a $500 deductible, was $55. Today my premium is $98. My premium increased four times in 24 months. For certain, I can expect more increases. I would also like to mention that this policy contains three riders for excluded coverage for pre-existing conditions."

-- Anchorage Resident

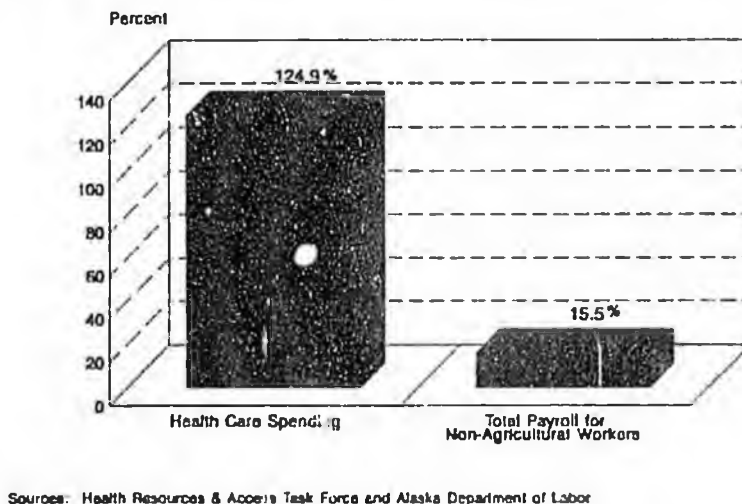
Figure 2-5
Business Health Expenditures as a
Percentage of Wages and Salaries, 1970 - 1987



Source: U.S. General Accounting Office

In Alaska, the disparity between growth in health care spending and growth in wages has been especially great. Between 1984 and 1991, health care spending in Alaska is estimated to have grown by 125 percent, while total wages and salaries for workers have increased by only 16 percent (see Figure 2-6 below).[5]

Figure 2-6
Growth in Total Health Spending and in Total Payroll
for Non-Agricultural Workers in Alaska, 1984 to 1991



Sources: Health Resources & Access Task Force and Alaska Department of Labor

---

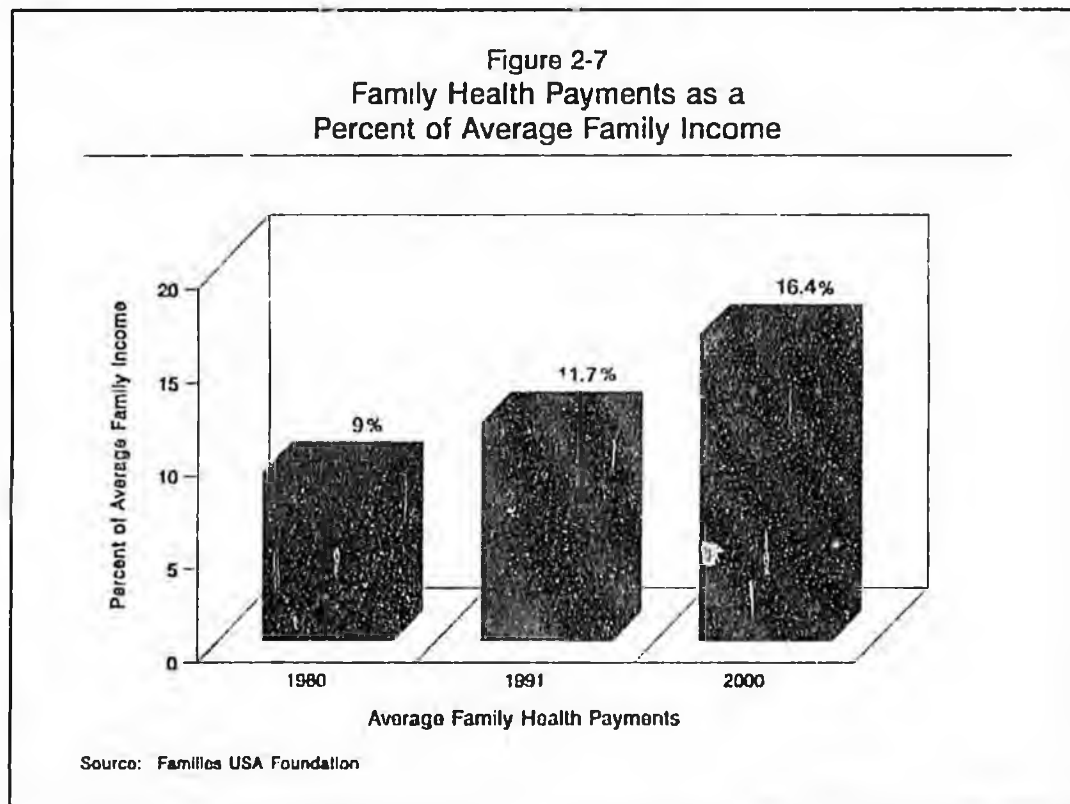
[5] Total yearly payroll (nonagricultural earnings) in Alaska were $6,360,017,668 in 1984 and $7,347,053,592 in 1991, see Alaska Department of Labor, Employment and Earnings Report: 2nd Quarter 1991 and Alaska Statistical Quarterly: 2nd Quarter 1985. Total health care spending in Alaska is estimated to have been $710.3 million in 1984 (Noble Lowndes estimate) and $1.598 billion in 1991 (ISER and Health Systems Research, Inc. estimate).

- **In an attempt to offset rising health care costs, businesses have increasingly required their employees to pay a greater portion of their health care premiums and often have increased the levels of copayments and deductibles in their plans. This trend, along with rising provider rates, has meant that families are spending a larger percentage of their income on health care.**

During the 1980s, both the percentage of plans requiring premium cost-sharing and the dollar amounts contributed by employees increased. According to the Bureau of Labor Statistics, between 1982 and 1988 the proportion of workers required to contribute to the cost of their coverage increased from 21 to 46 percent for workers with individual coverage, and from 51 percent to 65 percent for those with family coverage. In addition, over the same time period the average monthly premium cost increased from $31 to $72 for workers with individual coverage, and from $171 to $320 for those with family coverage (Short 1988).

As a result of the trend toward requiring larger contributions from employees, as well as the overall growth in health care spending, the burden that health care costs have placed on families has increased. In 1980, average family spending on health care accounted for 9 percent of family income. By 1991, average family health spending had increased to 11.7 percent. If these trends continue, out-of-pocket health care expenditures for an average family can be expected to absorb over 16 percent of annual income by the year 2000 (Families USA Foundation 1991).

Figure 2-7
Family Health Payments as a
Percent of Average Family Income



Source: Families USA Foundation

Not surprisingly, rising health care costs also have been at the core of many disputes between employers and their workers. In 1989, nearly two-thirds of forty-three major labor walkouts in the United States were disputes over health benefits (New York Times 1991).

PERSONAL STORIES . . .

"Our own health care system has changed dramatically since I started working here in 1980. At first my employer paid all the premiums. Now, every year, we have to pay more and more and the benefits are less and less."

-- Eagle River Resident

Finding #4: In spite of significant spending on health care, many Alaskans lack coverage for even the most basic health care services.

While $1.6 billion (the estimated total health care spending in Alaska in 1991) seems like it should be sufficient to provide a basic level of care to all Alaskans, the Task Force observed that:

- **In the late 1980s, over 76,000 non-elderly Alaskans had no health care coverage.**

An analysis of Alaska-specific data from the 1988 through 1991 Current Population Surveys revealed that approximately 76,000 non-elderly Alaskans had no health care coverage. That means that they had no coverage for any service, whether it be private insurance, Medicaid, Medicare, Indian Health Service coverage, or any other type of third-party health care coverage.[6]

---

[6] The Current Population Survey is a national survey conducted each year by the U.S. Bureau of the Census. While the number of persons included in the CPS from states with relatively low populations (such as Alaska) is small, most states nonetheless rely on CPS data to provide rough estimates of the number of uninsured because better estimates are expensive and difficult to generate. One technique used to compensate for the small sample size is to analyze survey results over a several year period. This approach was used in the analyses conducted for the Task Force. We would also note that in the Task Force's Interim Report (January 11, 1992), 90,000 Alaskans were reported as being uninsured. This number included a certain number of Alaska Natives who responded in the survey that they had no health care coverage, despite the fact that they are eligible to receive care through the AANHS/IHS system. Dr. Bartlett of Health Systems Research, Inc., in response to the Task Force's request to develop an estimate using the "assumption that all Alaska Natives have health care coverage through the Indian Health Service system," removed the Alaska Native respondents from the sample and reanalyzed the data. This reduced the estimate of the number of uninsured Alaskans from 90,000 to 76,000. For complete results of Dr. Bartlett's analyses, see Appendix D.

- **Over 21,000, more than one in every four, uninsured Alaskans are under the age of 18.**[7]

Figure 2-8 presented below displays the distribution of Alaska's non-elderly uninsured population by age. Because of the nearly universal coverage provided by Medicare to the elderly population, our analysis focuses on the characteristics of the non-elderly uninsured population. As can be seen from this chart, over a quarter (28 percent) of uninsured persons in the state are children, while another 15 percent are young adults aged 18 - 24. The remainder of the state's uninsured population are adults aged 25 - 49 (48 percent) and older adults aged 60 - 64 (9 percent).

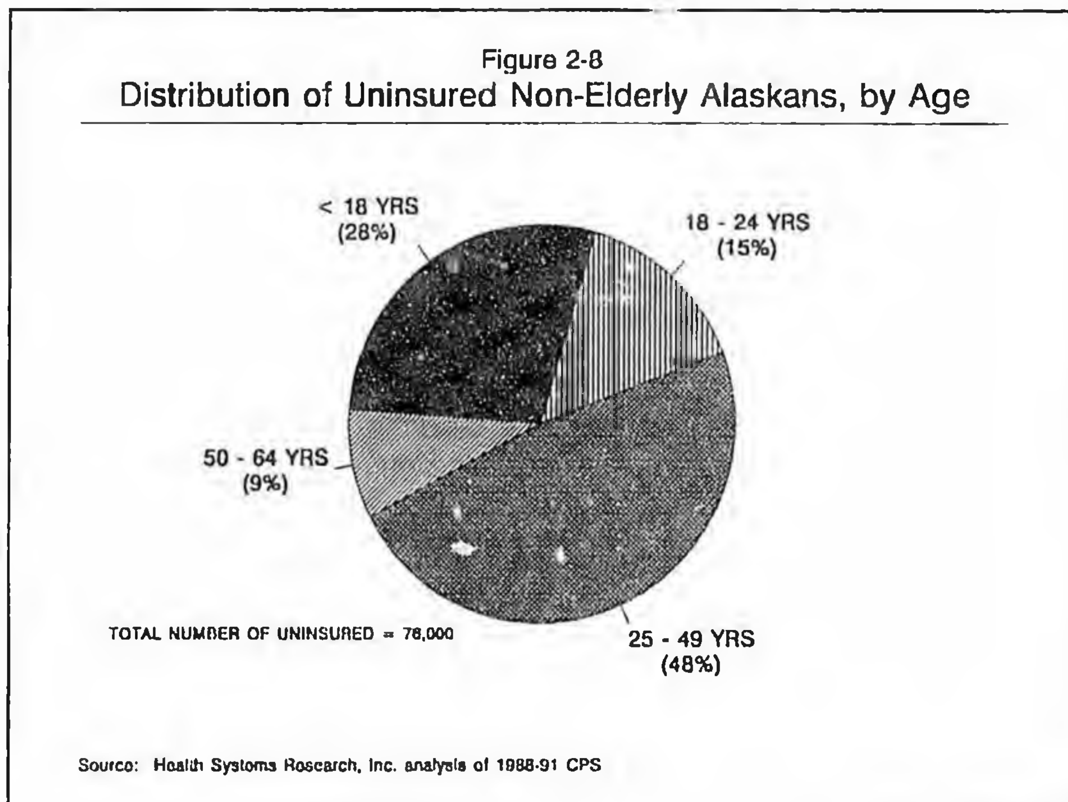


Figure 2-8
Distribution of Uninsured Non-Elderly Alaskans, by Age

Source: Health Systems Research, Inc. analysis of 1988-91 CPS

- **In the late 1980s, many uninsured Alaskans did not have sufficient income to purchase health care coverage on their own.**

A 1989 study by the National Health Care Campaign found that, in most states, it is only when families earn more than 250 percent of the poverty level that they begin to accumulate the disposable income required to contribute toward a portion of

---

[7] In the Task Force's Interim Report, we reported that there were 28,000 uninsured children. When Dr. Bartlett removed Alaska Native respondents from the CPS sample, the estimate of the number of uninsured children was reduced to 21,000. See Appendix D.

premium costs (Appendix D). When the Task Force compared this finding to its analysis of the incomes of uninsured Alaskans, it discovered that a significant portion of the state's uninsured population could not afford to purchase coverage on their own. For example, the Task Force realized that even though the federal and State governments together spent over $214 million in 1991 in Alaska for the Medicaid program, more than 13,500 uninsured Alaskans lived in households in the late 1980s with incomes below the federal poverty level.[8] An additional 16,000 uninsured Alaskans lived in households with incomes between 100 and 200 percent of poverty (with incomes between $15,120 and $30,240 for a family of four).

PERSONAL STORIES . . .

"When my daughter and son-in-law were expecting their first child, my daughter was unable to work . . . Our son-in-law was making just enough to pay for essentials. The state welfare system declined their request for medical coverage claiming our son-in-law's income was too high, wasn't making more than $6 per hour . . . I was informed that (a particular) hospital would help. The hospital charged according to income. They paid all of the hospital bill."

-- Anchorage Resident

Of particular concern to the Task Force was the fact that so many thousands of low income children were without basic health care coverage. We found that of the more than 21,000 uninsured Alaskan children, about 3,900 lived in households with incomes below the federal poverty level, while another 4,500 were in families with incomes between one and two times the poverty level.

Given the financial risks of being uninsured, the Task Force also found it disturbing that nearly 30,000 uninsured Alaskans were in families with incomes in excess of 300 percent of poverty. Of these, roughly 18,000 were employed full-time for the entire year. The Task Force concluded that, under the current system, there may be a number of reasons why persons with adequate incomes are without coverage. Some may be uninsured because they wish to avoid the expense or consider themselves to be "immortal." Others have significant health care needs and cannot find an insurer who will offer them a policy at an affordable price. The Task Force further recognized that as long as some Alaskans remain uninsured and continue to incur health care expenses which they cannot afford, providers will continue to shift the costs of caring for the uninsured and underinsured to employers who provide health care benefits to their employees.

PERSONAL STORIES . . .

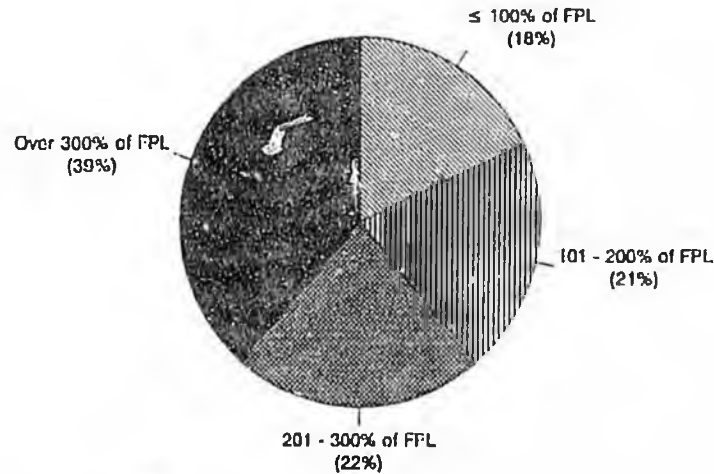
"I can't get health insurance because I have been diagnosed recently with MS. I was working in a full-time position (for a large employer), I was pregnant at the time I was diagnosed. Unfortunately, the employer is here in the state and felt a need to lay me off, when I was pregnant and recently diagnosed. I have contacted several health insurance companies in the private sector and to my disbelief, people with tuberculosis, any form of cancer within the last ten years, diabetes, overweight, MS, AIDS, or even having open heart surgery cannot obtain health insurance in the private sector, even though we are willing to pay the premium, we are unable to get health insurance."

– Anchorage Resident

---

[8] The 1989 federal poverty level for a family of four in Alaska was $15,120.

Figure 2-9
Distribution of Uninsured Non-Elderly Alaskans, by Poverty Status



TOTAL NUMBER OF UNINSURED = 76,000

Source: Health Systems Research, Inc. analysis of 1988-91 CPS

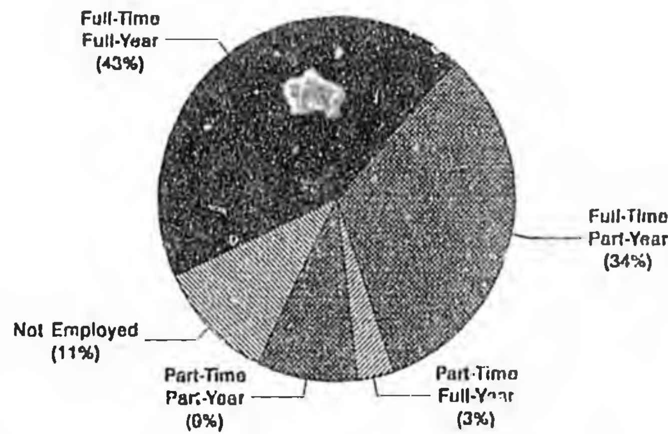
Finding #5: Nearly nine out of ten Alaskans without health care coverage are "working uninsured" Alaskans and their dependents.

- **Contrary to what many believe, the vast majority of uninsured Alaskans are workers or dependents of workers.**

Analysis of Alaska's uninsured population also revealed that in the late 1980s, over 68,000 uninsured non-elderly Alaskans, or 89 percent of uninsured Alaskans, lived in a household where the head of household worked some or all of the year (see Figure 2-10 on the following page). Only 8,000 uninsured Alaskans lived in households where the head of household was unemployed for the entire year (Appendix D).

- **Nearly half of all uninsured Alaskan workers and their dependents are in families where the head of household worked in seasonal job. Given the Task Force's charge to design a program to provide access to health care for all Alaskans, we concluded that efforts to tie health care coverage to employment would not readily achieve our goal of "universal access."**

Figure 2-10
Distribution of Uninsured Non-Elderly Alaskans,
By Employment Status of Head of Household



TOTAL NUMBER OF UNINSURED = 76,000

Source: Health Systems Research, Inc. analysis of 1988-91 CPS

Of the 68,000 uninsured Alaskans who lived in a household where the head of household worked some or all of the year, 26,000 were in households in which the family head had a full-time (but not full-year) seasonal job, while another 6,800 uninsured Alaskans were in families in which the head of household had a part-time seasonal job (Appendix D).

The Task Force felt it likely that, even if employers were required to provide coverage to their employees, the seasonally-employed and uninsured in Alaska would still be without coverage while they were unemployed. Further, this group would create considerable "churning" in the health insurance market as they gained coverage when they worked and lost it when they did not. The large number of uninsured Alaskans who have a link to the state's significant seasonal economy raised doubts within the Task Force about relying on employment-based coverage as a viable approach for achieving universal coverage. This issue is discussed in greater detail in Chapter Four.

PERSONAL STORIES . . .

"You go to an insurance company, and as soon as they find out you are a diabetic, which is my case, or a number of other diseases, they slam the door in your face . . . I ran the Iditarod a few years ago, I had diabetes then too. They don't come much healthier than me, I'd like to think. And the fact that I can't get any sort of insurance is absolutely disgusting . . . There is very blatant discrimination that takes place, on a regular basis throughout the insurance industry, and if there is a way that the government can somehow overcome that or create a system where the people can take the place of the insurance company, let's do it . . . I have had a job for years, it's full-time (full-year) this year (its usually seasonal), anyway, it's even with the federal government, but it's considered temporary . . . there is no coverage involved.

-- Anchorage Resident

Finding #6: Hard hit by the problems of our current health care financing system are Alaska's small businesses and their workers.

- **Small businesses must purchase coverage in an insurance market which includes high and unpredictable premium increases and onerous underwriting practices.**

As health care spending has increased, so has competition among small group insurers. Today, insurers commonly reduce their exposure against losses by excluding some groups, some individuals, and some health conditions from the coverage offered.

The rating approaches used by small group insurers can also result in high and unpredictable rate increases, particularly when pre-existing condition limitations expire. As a means of attracting groups, insurers have been known to offer groups low rates in the first year only to raise them dramatically in subsequent years. Additionally, insurers charge higher premiums for small groups particularly those with groups with high health needs, women, and older workers, as well as for certain "higher risk" industries (Butler et al. 1991).

- **For comparable benefit packages, small employers (defined as employers with fewer than twenty-five employees) pay 10 to 40 percent more in health premiums than large employers (ICF Incorporated 1987). Because benefits packages for small employers are more expensive, it is not surprising that small business owners overwhelmingly cite the cost of coverage as the most important reason for not offering health care benefits (Butler et al. 1991; Formisano 1988; Hall and Kuder 1990). In Alaska, nearly half of all of the uninsured adults or 26,000 workers were employed by small businesses in the late 1980s.[9]**

PERSONAL STORIES . . .

"An uninsured woman I know can only afford going to a neighborhood health clinic where she can pay a sliding fee for only the very basic of services. When she or her children need a specialist, because she is uninsured, the doctors refuse to see her without cash up front. It is humiliating to her to try to beg for medical care for her family and this makes me furious."

-- Anchorage Resident

---

[9] In the Task Force's Interim Report, we reported that there were 28,000 uninsured Alaskans who worked for small businesses. When Dr. Bartlett removed Alaska Native respondents from the sample, the estimate of the number of uninsured Alaskans who worked for small businesses was reduced to 26,000. See Appendix D.

One of the reasons why health premiums are significantly higher for small groups than for large groups is the administrative costs of insurers. As illustrated in Table 2-3, one national study reported that the smallest groups may pay as much as 40 percent of their incurred claims toward administrative costs while the largest groups pay as little as 5.5 percent (CRS 1990).[10]

Table 2-3
Breakdown of Insurance Company Administrative Expenses

(Percentage of Incurred Claims)

Number of Employees			General*	Profit & Risk	Commission	Total
1	to	4	23.1	8.5	8.4	40.0
5	to	9	21	8.0	6.0	35.0
10	to	19	17.5	7.5	5.0	30.0
20	to	49	14.9	6.8	3.3	25.0
50	to	99	10.0	6.0	2.0	18.0
100	to	499	8.9	5.5	1.6	16.0
500	to	2,499	7.8	3.5	0.1	12.0
2,500	to	9,999	5.9	1.8	0.3	8.0
10,000	or	more	4.3	1.1	0.1	5.5

* Includes claims administration, general administration, interest credit, and premium taxes.

Source: Congressional Research Service

- **In January 1991, the Division of Insurance estimated that there were only nine insurers that were significantly active in Alaska's small group market. Alaska's small businesses purchasing coverage therefore not only face onerous underwriting practices and higher premiums than large groups, but they do so in a market with relatively limited competition.**[11]

---

[10] The Health Insurance Association of America also reports administrative expenses. Their data reflect a similar distribution in the types of administrative expenses, but a smaller range for employers of different sizes (25 percent of incurred claims for groups with fewer than 25 employees and 6 percent for groups of 2,500 or more employees), see Health Insurance Association of America, 1991. Statement of HIAA on Health Care Reform and Insurers' Operating Expenses. Presented Before the Subcommittee on Education and Health, Joint Economic Committee, U.S. Congress. Washington, D.C. (October 16).

[11] Chris Ulmann, Alaska Division of Insurance, January 15, 1992.

Alaska's health insurance market can be divided into two segments, self-insured plans and conventionally-insured plans. Alaska, like all states, is prohibited by the federal Employment Retirement Income Security Act (ERISA) from regulating self-insured plans. Therefore, we know very little about this market. The conventionally-insured market, made up of both commercial and nonprofit insurers, is dominated by two large insurers, AETNA Life Insurance Company and Blue Cross of Washington and Alaska. Together, AETNA and Blue Cross wrote 70 percent of total premiums in the Alaska private insurance market in 1990.[12] The remaining 30 percent of the market included over 400 insurers, of which only twenty companies had over one-half of one percent of the market, and many of whom sold few if any policies. Of these twenty additional insurers, only nine were significantly active in the small group market.

Finding #7: The lack of adequate health care coverage can have a negative effect on the health of uninsured and underinsured.

The Task Force discovered that the health of the uninsured often suffers because they delay seeking care for medical problems.

- **The uninsured report a lower health status than the insured (Freeman et al. 1987) and use fewer services overall than the insured. When the uninsured do use services, it is more likely to be late in the course of an illness and occur in costly institutional settings such as emergency rooms (The Robert Wood Johnson Foundation 1987; CRS 1988).**

Cost is an obvious factor that deters the uninsured from receiving care. Indeed, over a third of uninsured Alaskans reported that "within the last year, there was a time that they needed to see a doctor, but could not because of the cost," compared to only one in ten insured Alaska. Not surprisingly, uninsured Alaskans also report waiting longer periods than the insured for routine preventive

PERSONAL STORIES . . .

"I am one of many Alaskans who has no health insurance. I have a partner who is in private business who cannot afford health insurance. I am unemployed and have been without insurance for two years. My two children are without insurance also. We all have medical conditions which should be treated, but we cannot afford to go the doctor. Our lives are challenged often by this fact. A major or emergency illness would be catastrophic to us."

– Nenana Resident

[12] Total health insurance premiums written in 1990 were $297 million, of which AETNA wrote $127 million and Blue Cross wrote $82 million.

checkups with a doctor.[13] The fact that the uninsured often do not receive needed preventive care increases overall health care costs because when the uninsured do seek care, they may be sicker and incur greater costs in treating their illness--costs that could have been avoided with adequate preventive care.

Finding #8: The uninsured and underinsured generate unpaid medical bills the costs of which are ultimately paid in the form of higher provider charges by persons with health care coverage.

As health care expenditures have increased, there has been an increase in the amount of "uncompensated" care that providers must cover, which they do by increasing their charges to those who have health insurance. Data provided by the Alaska State Hospital and Nursing Home Association was used to estimate the costs associated with charity care, bad debt, and Hill-Burton free care. In 1990, ten hospitals, representing 86 percent of the acute care community hospital beds in Alaska, provided $16.8 million in charity care, care which resulted in bad debt, and Hill-Burton free care (Appendix E).[14] To remain financially viable, these facilities had to "cost-shift," that is, increase their charges to insured patients in order to cover these unpaid or "uncompensated" expenses.

This $16.8 million figure may actually understate the magnitude of cost-shifting by Alaska's acute care community hospitals. Industry representatives have stated that reimbursement from public payers such as Medicare and Medicaid do not cover the cost of delivering services to those clients. If this is the case, then the losses associated with the delivery of services to Medicare and Medicaid patients must also be shifted to private payers.

The net result is that to recover uncompensated care costs and insufficient payments from public programs, Alaska hospitals must set their charges to privately insured patients at levels that are 15 to 20 percent, or more, above the actual cost of caring for these patients.

Although of no less interest to the Task Force, we were unable to obtain information on cost-shifting associated with physician services.

PERSONAL STORIES . . .

"The cost of health care prohibits routine health visits, therefore my family's health care suffers. I can only hope that my family will not be affected by an illness before comprehensive and affordable health care can be provided to them."

-- Anchorage Resident

---

[13] Preliminary results from the 1991 Behavioral Risk Factor Surveillance Survey, Alaska Division of Public Health, November 1992.

[14] The costs associated with this care may have been offset by the $3.7 million in revenues from state and local governments.

Finding #9: Many Alaskans who currently have health care coverage fear that it will not provide adequate protection for them if they develop a serious medical problem.

The Task Force asked Alaskans to express their views about our current health care system by circulating a survey. Four hundred and sixty-two (462) surveys were returned to the Task Force. They included 124 from our community meetings/public hearings, 243 from the Anchorage Daily News (who put the survey in their editorial column), 79 from the Anchorage Neighborhood Health Center, 6 from the Anchorage Rescue Mission, and 10 from Bean's Cafe. Obviously, the survey results were not generated using a random method, but nonetheless, they did give the Task Force some indication of the concerns of certain Alaskans about our health care system. (Complete survey results are published in a separate document.)

PERSONAL STORIES . . .

"My insurance has become too costly and next month I will have to do without . . . I am endangering my life daily and the financial future of my family. No one should have to live in this fear that grows daily."

-- (signed) "Helpless," Anchorage

Of those Alaskans who returned our survey the vast majority expressed significant concern about the adequacy and stability of their health care coverage and their ability to pay for out-of-pocket medical expenses. Specifically:

- **85 percent of respondents worry "a great deal" or "quite a lot" that their out-of-pocket costs for medical bills will increase rapidly over the next few years.**

- **82 percent worry "a great deal" or "quite a lot" about having to pay very expensive medical bills which are not covered by health insurance.**

- **75 percent worry "a great deal" or "quite a lot" that the benefits under their current health care plan will be cut back substantially.**

- **75 percent worry "a great deal" or "quite a lot" that they will have to pay a much larger premium for their current health care plan.**

- **67 percent worry "a great deal" or "quite a lot" that they will lose health insurance which they now have.**

PERSONAL STORIES . . .

"As my health declined, I wasn't able to work . . . The constant hassles concerning medical coverage were overwhelming. My credit was scarred as I was unable to continue minimal payments.."

-- Kenai Resident

> ***Finding #10:*** *In spite of the significant amount it spends on health care, the health status of Alaska's population is among the worst in the nation.*

Although Alaska's age-adjusted per capita health care spending is 27 percent above the national average, the Task Force found that this higher spending has not translated into a better health status.

- **A 1992 study by Northwestern National Life Insurance Company (NWNL) ranked the "general health of Alaska's population" the 46th worst among the 50 states (Eckstein, T.E., and Associates, Inc. 1992).**

Rankings such as those in the NWNL study are used by insurers to establish premiums. For each state, the population's overall health is measured using seventeen criteria in five major areas: disease, lifestyle, access to health care, occupational safety and disability, and mortality. Examples of Alaska's rankings for specific criteria include:

Selected Health Criteria	Ranking
Support for Public Health Care	50
Infectious Disease	49
Occupational Fatalities	48
Unemployment	45
Access to Primary Care	43
Premature Death	40
Prevalence of Smoking	40
Violent Crime	28
Infant Mortality	25

- **The American Public Health Association recently published a state-by-state report of the health of each state's population. Alaska ranked higher in this report than in the NWNL ranking in part because of the indexes chosen.[15] Even so, Alaska ranked lower than might have been expected,**

---

[15] The American Public Health Association (APHA) examined statistics on twenty-five measures of health for each state. These measures were the basis for the five categories for which APHA developed composite rankings. There were several measures where Alaska ranked high. Some of these high rankings reflect Alaska's unique service delivery system, while others suggest high levels of government spending for health and other services. Alaska ranked relatively high in the following measures: primary care physicians per capita, adequate prenatal

given the higher than average level of age-adjusted per capita health care spending (APHA 1992).

APHA tabulated statistics for five health categories and ranked each state. Alaska's rankings were as follows:

Category	Ranking
Healthy Behaviors	44
Healthy Environment	36
Medical Care Access	25
Healthy Neighborhoods	23
Community Health Services	3

The Task Force also examined additional data on the health of Alaskans at several meetings. We found that age-adjusted death rates in Alaska for certain preventable diseases were substantially higher than the national average. Alaskans have above average death rates for unintentional injuries (primarily occupation-related), for chronic obstructive pulmonary disease (primarily attributable to smoking), for chronic liver disease (primarily attributable to alcohol), and for suicide (Alaska Bureau of Vital Statistics 1992).

Finding #11: ***A strong public health program based on disease prevention, health promotion, and public health protection is essential to controlling health care costs and to achieving a healthy populace. The State of Alaska does not have a policy that assures the presence of a strong, fully-functioning public health program.***

Given the overall poor health of Alaskans described under Finding #10, and the fact that effective public health programs can improve health status, the Task Force felt it was particularly important to examine the state's public health system.

---

care, fluoridated water, average public assistance payment per family, education spending per capita, childhood poverty rate, government health spending per capita, sanitation and sewerage spending per capita, and public health workers per capita.

Several public health officials briefed the Task Force on the roles and responsibilities of public health providers in Alaska. While we were reminded of the State's responsibility to provide health assessment, health policy development, and to assure the presence of essential, effective public health services, the Task Force nonetheless found that:

- **The capability of the Division of Public Health to carry out the State's public health responsibilities continues to be diminished at a time when program responsibilities are increasing.**

In the last decade, the level of per capita public health spending by the State of Alaska from the General Fund has remained flat after being adjusted for inflation ($48.99 in 1982 vs. $49.15 in 1992). This has occurred despite the fact that during this period, the Division of Public Health's program responsibilities have grown substantially due to new technologies and changing patterns of disease (e AIDS, drug-resistant tuberculosis, substance abuse) (Appendix F). Unfortunately, the Task Force fears that State funding for public health programs will be further diminished unless there is greater recognition of the role they play in protecting and maintaining the health of the state's population.

Finding #12: The financial access issue aside, basic health care services are not available to many Alaskans because of transportation problems and problems with the mix, distribution, and coordination of the state's health care resources.

The Task Force observed that Alaska has access and cost problems because of the maldistribution of health care resources. Many Alaskans live in areas where health care services are not available or where there are shortages of health care personnel. In other areas, there is more capacity in the system than is needed. While sufficient resources exist in some communities, Alaskans will often go outside of those communities for care. Finally, even though Alaska Natives have access to health care through the Alaska Area Native Health Service, their health needs far outstrip available resources.

- **Alaskans living in remote and rural areas often find that only the most basic health care services are available in their communities. Access to advanced services requires travel, frequently hundreds of mile by air. Many cannot afford to travel and defer their medical treatment.**

Alaskans living in remote and rural areas of the state often travel great distances at significant cost to obtain health care. The Alaska Native Health Board reported the unmet need for patient travel was $4.9 million in Fiscal Year 1990. Forty percent of all their patients who need to travel for medical care defer treatment because they lack money for airfare (Alaska Native Health Board 1991).

- **Alaska has an inadequate supply and maldistribution of primary care practitioners.**

Alaska is directly affected by the nationwide shortage of primary care practitioners. Alaska currently has twenty federally designated Health Professional Shortage Areas and ten designated Medically Underserved Areas. Together, these areas include nearly a third of the population and cover two-thirds of the state (ADHSS 1992). in many Alaskan communities, the population base is too small to support a financially viable physician practice. The State of Alaska, recognizing this aspect of Alaska's health care system, has liberal practice standards that allow mid-level practitioners, such as nurse practitioners and physician assistants, to practice with minimal supervision and to write prescriptions (ADHSS 1992). Although many communities rely on mid-level practitioners for care, Alaskans still encounter serious difficulties in receiving needed primary care, and additional primary care physicians are still needed.

The Task Force was advised, on a number of occasions, that:

- **Difficulties in recruiting and retaining health care professionals in Alaska contribute to the lack of access to appropriate, cost-effective health care for Alaskans, particularly in rural areas.**

Alaskan providers have the greatest difficulty retaining adequate numbers of nurses, physical therapists, occupational therapists, and diagnostic technicians. Other categories of health care professionals which are difficult to find are administrators, physicians, bio-medical technicians, and workers in the areas of patient billing, medical records, personnel, social work, and alcohol and mental health counseling (Rural Alaska Health Education Center 1992).

Further, individual Alaskan health care practitioners, particularly in rural areas, experience high rates of turnover. In Alaska's many small, isolated communities, health care professionals do not have a peer support group and must be on-call 24 hours a day, 7 days a week. In addition, the undersupply of health care professionals, cultural and social barriers, isolation, and limited transportation and communication systems all contribute to "burnout" among practitioners.

Recruitment has become increasingly difficult as salary expectations have increased. Salaries, particularly those offered in rural Alaskan communities, have

become less competitive than those offered outside of Alaska over the past decade (ADHSS 1992).

Efforts to recruit health care practitioners in Alaska are limited by the lack of data on such items as the characteristics of professionals who are most likely to want to practice in Alaska (particularly rural Alaska), factors that increase the number of applicants for positions in these areas, and provider characteristics most important to employers and consumers (ADHSS 1992).

Recruiters have found an important factor in getting practitioners to locate and practice in rural areas is their exposure to rural settings during their medical education. Alaska lacks formalized in-state clinical sites for primary health care students. In addition, there are only rudimentary free-standing medical residency programs in the state, and none for family practitioners (ADHSS 1992).

While there are significant shortages of health care professionals:

- **It is estimated that nearly one quarter of the hospital beds in Alaska's acute care community hospitals represent excess capacity, yet it costs Alaska's health care payers as much as $21 million annually to maintain them.**

There has been a lack of direction from the State of Alaska regarding standards for hospital size. Further, there were some major renovations and new construction of community hospitals when Alaska's revenues from oil peaked in the early 1980s. These projects were based on occupancy rates using the rapid rate of population growth experienced in the state at that time. As population growth rates diminished, the recession hit in the mid- to late 1980s, and a national trend toward decreasing utilization of care for patients in "inpatient" settings was realized, it became apparent that the State had overestimated the need for hospital beds.[16]

Also in the mid-1980s, the State significantly reduced its health planning efforts and has not issued a state health plan since 1984. The Certificate of Need process continues in Alaska and achieves some savings but without the goals and standards that a state health plan could provide. Capital grants continue to be provided to some individual communities for facility construction without a clear policy from the State.

Alaska's acute care community hospitals are on the average much smaller than U.S. hospitals as a whole. Using the national average as the benchmark, the Institute of Social and Economic Research (ISER) found that twelve of Alaska's sixteen acute

---

[16] Anchorage projects were more justified, but some projects in smaller communities created significant excess capacity. Not all the projects which were proposed were built however as State funding declined in the 1980s.

care community hospitals had excess capacity in 1989. At the U.S. average occupancy rate, 229 (or 22 percent) of the 1,027 acute care beds in Alaska were surplus. The total annual cost to Alaskans to pay for surplus beds was estimated to range from $5.8 to $11.6 million or 2 to 4 percent of the total annual acute care facility costs. However, applying a more rigorous standard, and what some consider a more reasonable goal for occupancy, 75 percent,[17] and a fixed cost assumption of 20 percent, the annual cost of excess capacity in Alaska's acute care facilities was found to be as high as $20.8 million. (The complete analysis is in Appendix C, Section 1.)

Compounding this excess capacity problem, the Task Force observed that:

- **Even as Alaska's small communities continue to maintain fully-licensed hospitals, many residents leave their communities to go to a larger hospital for care.**

The Task Force found that many of Alaska's small hospitals have very low occupancy rates.[18] However, because residents of communities with small, under-utilized hospitals often go to larger hospitals in other areas to receive care instead of to their local hospitals, the Task Force felt that these facilities will find it difficult to substantially reduce their surplus capacity.

The Task Force reviewed approaches taken in rural communities in other states when faced with the possibility of closing under-utilized, financially troubled community hospitals.[19] Often, these hospitals are converted and licensed as "alternative" facilities, thus maintaining some type of medical facility presence in the community. Many different models for converting hospitals to alternative facilities exist, but in general they involve changing the mix of services, limiting the length of stay, providing only certain core services, and establishing transfer policies with more advanced facilities. For example, a "converted" hospital might continue to provide only emergency services, routine obstetrical care, and outpatient services.

The Task Force was concerned to find that instead of moving towards an "alternative facility" model, many Alaskan hospitals with low occupancy rates are

---

[17] In the 1970s, the occupancy rate for mid-sized hospitals in the U.S. approached 75 percent. In addition, Alaska's 1984 State Health Plan established occupancy rate goals of 80 percent for Level IV communities (population between 40,000 and 750,000) and 65 percent for Level III communities (populations between 1,500 and 60,000).

[18] Examples of small Alaskan hospitals with low occupancy rates, based on 1989 figures, include: Cordova Hospital, with 13 beds and a 15 percent occupancy rate; Petersburg Hospital, 8 beds and 12 percent occupancy; Wrangell General Hospital, 9 beds and 11 percent occupancy; and Seward General Hospital, 32 beds and 11 percent occupancy. (See Appendix C, Section 1.)

[19] The Task Force reviewed models from the States of Montana, California, Washington, Colorado, and Kansas for converting hospitals into alternative inpatient facilities.

moving in the opposite direction. In order to attract patients who may currently be seeking care at larger hospitals, some small hospitals are seeking to duplicate costly, high-tech services offered in Alaska's tertiary care centers.

Finally, the Task Force found that the State of Alaska has not created incentives to encourage the conversion of under-utilized hospitals into alternative facilities. Indeed, the ability and willingness of Alaskan communities to convert under-utilized hospitals to alternative facilities is restricted by State licensure standards, Medicare's conditions of participation, and Alaska's revenue sharing statute (AS 29.60.120) which greatly favors hospitals of ten beds or more (Appendix G; Agency for Health Care Policy Research 1991).

- **Alaska does not presently have excessive amounts of expensive high-tech medical equipment. However, in recent months, physicians and physician groups in Alaska's urban areas have shown increasing interest in offering high-tech services that will duplicate services offered at hospitals in these areas. Small community hospitals have also shown an increased interest in acquiring high-tech equipment.**

It is widely recognized that the increased use of high-tech medical equipment and services has improved the quality of health care in the United States. However, at the same time the proliferation of new technology has been a driving factor behind escalating health care costs.

In October 1991, the Department of Health and Social Services reported to the Task Force that the current levels of high-tech medical equipment and services available in Alaska were not excessive (see Appendix I). However, recent interest by physicians in providing high-tech services in their offices may change this situation.

In Alaska, a Certificate of Need (CON) is currently required for new medical services or equipment located in a hospital setting and costing $1 million or more. Because current CON law does not apply to projects in non-hospital-based settings, many of the high-tech projects under consideration by private physicians and physician groups would not require review or approval by the State. Even purchases of such equipment by small hospitals may avoid the Certificate of Need process if they obtain used equipment that costs less than $1 million. The excessive proliferation of medical technology could thus become an additional factor contributing to rising health care expenditures in Alaska.

- **A lack of effective coordination between the four principal health care systems in Alaska, the private sector, the Alaska Area Native Health Service (AANHS), the State of Alaska, and the military, has contributed to excess capacity in some rural communities and a lack of access to**

facilities and some services for some segments of the population in others.

In some Alaska communities, services are duplicated at facilities run by different segments of the health care system because of insufficient coordination of health care resources. For example, Sitka, with a population of 9,000, has two general acute care hospitals, one operated by the local government and the other by a tribal organization under contract to the AANHS. Both hospitals, which offer virtually identical services, are under-utilized.

Other communities suffer from the opposite problem--facilities whose services are needed by the community are unable to offer those services to some segments of the population due to restrictions on who is eligible for treatment. The Task Force has noted recent progress in this area, however. For example, in the western and northern regions of the state, four out of the five general acute care facilities are federally-owned, and have historically been restricted to serving only Alaska Natives. Contracts to operate three of these hospitals--in Dillingham, Bethel and Kotzebue--have recently been awarded by the AANHS to local organizations that are attempting to expand services to all residents of these communities.

- **By nearly all measures, the health status of Alaska Natives is significantly lower than other Alaskans. The health needs of Alaska Natives far outstrip the resources available through the Alaska Area Native Health Service and its tribal contractors. Many villages do not have basic water and sanitation services which are essential to the control of disease.**

As part of the their trust responsibility, the federal government is required to provide health care to all Alaska Natives. This is accomplished through the Alaska Area Native Health Service and its tribal contractors. Funding for this system in Alaska, which serves approximately 90,000 Alaska Natives, has not kept pace in recent years with the growth of the Alaska Native population and health care spending trends. Providers in this system have been encouraged to enhance collections from Medicaid, Medicare, and other third-party payers in an effort to make up for the shortfall in funding. Yet, as a group, Alaska Natives' health needs are greater than other Alaskans. Their HIV infection rate is the highest in the state and death rates for suicide and homicide continue to be three to four times the national average. Substance abuse problems, including fetal alcohol syndrome/effect and brain damage associated with inhalant abuse are still on the rise. Alaska Natives have one of the highest age-adjusted mortality rates from cancer in the U.S. and diabetes is increasing. Water and sanitation services, which are taken for granted in urban Alaska, are not available in many Alaska Native villages (see Appendix H).

Finding #13: The way in which we handle claims of injury arising from medical care is unsatisfactory to almost everyone. It compensates only a few of the victims, is slow, costly, and agonizing to both claimants and providers.

The Task Force recognized that there is considerable disagreement over how much our system of resolving claims of medical malpractice contributes to rising health care expenditures and inappropriate patterns of practice. We also acknowledged that our current system is not necessarily the best way to resolve such claims. Many of the Task Force's observations of our system of handling claims are based on national studies and studies in other states, although there is considerable documented experience on the subject in Alaska (Weeks 1992).

Every year, patients in Alaska are injured by medical care. Comprehensive data on the numbers of medical injuries are not available. Two landmark studies, one in New York and one in California, showed that 3.7 percent and 4.65 percent, respectively, of large samples of hospitalized patients are injured by medical care. About one quarter of those patients are injured because of negligent care - 1.0 percent in the New York study and 0.8 percent in California. The majority of adverse events were minor and transient, but many were serious, and some caused or contributed to death (Harvard Medical Practice Study 1990; Danzon 1985). It is reasonable to assume that the age-adjusted rate of injury in Alaska is roughly the same as in New York and California.

- **Most medical injuries caused by negligence do not result in lawsuits.**

The New York study (Harvard Medical Practice Study) found that for every eight hospitalized patients egligently injured, only one patient filed a medical malpractice claim. In the California study, at most one in ten patients negligently injured filed a claim.

- **Many lawsuits alleging medical malpractice are without medical foundation.**

The New York study also found that more than eight of ten medical records of those who file claims show "no evidence of negligence or even injury".

- **On several occasions, the Task Force was advised that because the costs of bringing a case to trial are high, plaintiff attorneys in Alaska generally are reluctant to take a case unless they expect a settlement or award of at least $100,000 (Weeks 1992).**

A significant part of the high cost of pursuing a medical malpractice lawsuit is the high cost of engaging expert witnesses. One plaintiff attorney says it is impossible to bring a medical malpractice case to trial in Alaska for less than $75,000 (Weeks 1992). By the same token, NORCAL, which insures about 240 Alaskan physicians, reports that the "average cost of defending a case through trial is around $60,000" (Appendix J).

- **Nationwide, studies have shown that fewer than half of all medical malpractice claims result in any payment to the claimant.**

Studies of closed claims found that payments to the claimant were paid in only 40 - 50 percent of cases (40 percent, Danzon 1985; 41 percent, Appendix J (NORCAL); 43 percent, GAO 1987b; "no more than half," Harvard Medical Practice Study 1990).

- **Less than half of the medical malpractice premium dollar goes to the patient in settlements and awards.**

A 1987 Rand Corporation study found that only 43 percent of every dollar spent on "higher-stakes" litigation, including medical liability, reaches the injured parties as compensation. A.M. Best estimated that the "total cost of medical malpractice direct losses paid" were $2.29 billion or 41 percent of the $5.6 billion paid in malpractice insurance premiums in 1989. The rest is spent on attorneys' fees for both sides, litigation expenses, and administrative expenses of insurers (Hensler et al. 1987; Lembo 1992).

- **Medical malpractice claims take a long time to be resolved.**

The 1987 GAO study also reported that the median length of time from injury to claim was 13 months (range <1 to 229 months), from injury to closing for claims without any payment was 17 months (range <1 to 132 months), and from injury to closing for claims closed with payment was 23 months (range <1 to 132 months) (GAO 1987b). In a study of only obstetrical malpractice cases, the average time from event to resolution was 33 months (Bovbjerg, Tancredi, and Gaylin 1991).

- **On numerous occasions, the Task Force voiced concern about the costs of and practices associated with defensive medicine. We found that the estimates of the costs of defensive medicine are inconclusive.**

Defensive practices include, in order of frequency as established in a 1983 study: (1) maintaining more detailed records, (2) referring more cases to other physicians, (3) ordering additional diagnostic tests, (4) spending more time with

patients, (5) not accepting certain types of cases, (6) increasing fees, and (7) providing additional treatments (Zuckerman 1984).

The American Medical Association (AMA) estimated in 1989 that the cost of the practice of "defensive medicine" by physicians was nearly $21 billion. Of that, $5.6 billion was spent by physicians for malpractice insurance premiums and $15.1 billion on defensive medicine practices (AMA 1991). In 1989, $21 billion represented about 18 percent of the total expenditures for physician services. Although the AMA's estimate appears to be made based on a thoughtful analysis, it is important to note that the core of the study was a physician survey. In addition, the AMA's estimate includes only costs associated with physicians' services and not other providers, most notably, hospitals. Therefore, it understates the total cost of defensive medicine in the U.S.

Other estimates of the cost of defensive medicine exist but the AMA's estimate is the most frequently cited. All the estimates are controversial, in part because of the difficulty in defining defensive medicine. The Office of Technology Assessment, a bipartisan research agency of the Congress, is currently developing its own estimates.

While the Task Force was concerned about costs associated with defensive medicine, we were also concerned how these practices can effect the quality of care provided and the level of trust between the physician and patient. For example, some tests and treatments can be detrimental to the health of the patient.

- **While total malpractice insurance premiums represented only 5 percent of total expenditures for physician services, individual physician premiums represent a significant cost of practicing medicine in Alaska.**

Medical Indemnity Exchange of California reports that the current annual rates for a $1 million/$3 million (most commonly purchased) professional liability insurance policy in Alaska are: $79,948 for obstetrics, neurosurgery, orthopedics with spinal surgery; $42,328 for general surgery, orthopedics without spinal surgery, ENT (ear, nose, and throat) with more than 5 percent plastic surgery; $26,456 for ENT with less than 5 percent plastic surgery; $13,524 for ophthalmology; $11,760 for internal medicine and pediatrics; $10,584 for family practice, no surgery; and, $6,468 for psychiatry. NORCAL rates for a $1 million/$3 million policy for obstetrics are: $64,519 for OB/GYN and $37,751 for family practitioners with obstetrics (Appendix K).

- **The system for resolving claims of injury from medical care generates considerable uneasiness and disgruntlement among providers (Charles et al. 1985).**

The threat of litigation is perceived by providers to be ever-present. It colors virtually everything they do with respect to patients. While providers agree that their undivided attention should be focused upon what is best for their patients, physicians and other providers continually consider what is safest for themselves. This legal milieu influences clinical decisions when it should not, warps decisions on where to practice and whom to see, and shortens careers. For example, 29 percent of physicians practicing obstetrics stop delivering babies before age 45 and 67 percent before age 55 (Institute of Medicine 1989). Studies show that over 79 percent of practitioners of obstetrics report that they have been sued at least once during their careers (American College of Obstetricians and Gynecologists 1992).

- **Obstetricians in Alaska pay between $65,000 and $80,000 annually and family practitioners delivering babies between $35,000 and $40,000 annually for professional liability insurance. Nationally, practitioners of obstetrics and gynecology are sued more frequently than any other specialty (U.S. DHHS 1987). The average damage award paid by an obstetrician in 1984 was $178,000, more than double the average paid by other specialties (Gehshan 1991). Nationally, one million dollar-plus awards are frequent in birth-injury cases (Nocon et al. 1987). Several have been awarded in Alaska.**[20]

No group or specialty class of physicians is inherently more negligent than another, but some groups, such as obstetricians are sued more often than other providers (GAO 1987a). Settlements tend to be high and award by juries are typically high because the consequences of serious injury at birth are usually lifelong. Physicians who have practiced obstetrics and discontinued indicate professional liability issues as a primary cause including both the expectation for increased malpractice premiums and the fear of lawsuits (Rosenblatt and Wright 1987; Nesbitt et al. 1992).

- **Under the state's statute of limitations, malpractice cases involving injury to children can be filed up to two years after the age of 19. This requires physicians to have "tail" insurance to protect against claims filed many years after an alleged event. However, virtually all residua from birth or early-life injury or illness are obvious by the time a child is eight years old.**[21]

---

[20] Rodman Wilson, MD, December 2, 1992.

[21] "Virtually all sequelae of birth injuries and illnesses early in life should be apparent by the time a child is eight years old", statement made by Marianne von Hippel, MD, behavioral pediatrician, November 6, 1992, Anchorage. "Most major residua of birth injuries and early life illnesses will be clearly apparent by six to eight years of age", statement made by Ron Brennan, MD, neurodevelopmental pediatrician, November 10, 1992, Anchorage.

- **Alaska law requires interest on civil judgments to be paid at rate of 10.5 percent per year from the date of notification of a lawsuit (AS 9.30.070). The accrued interest can add substantially to medical malpractice and other awards.**

The Task Force learned that the pre-judgement interest rate of 10.5 percent currently used in Alaska has not been adjusted since 1980. In contrast, federal courts use an approach that is more responsive to changing economic conditions, awarding pre-judgement interest using the yield of the 52-week U.S. Treasury bills (3.75% in November, 1992) as the rate of interest (Title 28, U.S. Code, 1961).

Pre-judgement interest is designed in part to deter casualty insurance companies from delaying settlement.[22] However, interest payments can add significantly to medical malpractice awards. For example, if it takes five years to reach a verdict and make an award of $500,000 in a case of injury from negligent medical care, an additional $262,500 is added in accrued interest, making the total award $762,500. In addition, it is possible that interest rates that are high may provide an incentive for plaintiffs' attorneys to delay in order to increase potential awards and thereby their contingency fees.

Finding #14: Most Alaskans believe that fundamental changes are needed in our health care system in order to make things work better. They also believe health care reform is an important issue that State government should address.

- **Nearly 90 percent of respondents to the Task Force's public opinion survey indicated that Alaskans want substantial change to our health care system.**

Of those Alaskans who returned the survey, 60 percent responded that "there were some good things in our health care system, but fundamental changes are needed to make it work better," while an additional 28 percent indicated "that so much is wrong with it, that we need to completely rebuild it."

- **Nearly all respondents indicated that health care reform is one of several important issues, if not the single most important issue, for State officials.**

---

[22] Testimony by Dan Hensley to the Health Resources and Access Task Force, November 13, 1992.

Seventy-six percent of survey respondents indicated "that reform of Alaska's health care system should be one of several important issues for State officials" while an additional 21 percent believe that it is "the single most important issue for State officials."

- **Respondents overwhelmingly believe that the State government should play a role in controlling health care costs and ensuring access to basic health services for all Alaskans.**

Ninety-four percent of Alaskans who answered the Task Force's survey responded that "in the absence of national health care reform, the Alaska State government should play a more active role in controlling rising health care costs" while 96 percent indicated that "the State government should play a more active role in ensuring access to basic health services for all Alaskans."

* * *

These fourteen findings, together with principles used by the Task Force to guide their policy decisions, are the basis upon which the Task Force made its recommendations. The Task Force's guiding principles are described in the next chapter.

CHAPTER THREE: GUIDING PRINCIPLES

At our September 1991 meeting, the Health Resources and Access Task Force developed guiding principles to be followed in the development of public policy. Our original principles were further refined in September and October 1992. The Task Force used these principles to evaluate alternative health care reform strategies.

PREAMBLE

The Alaska Constitution provides that the State of Alaska is responsible for the public health. However, each Alaskan bears individual responsibility to maintain and improve his or her own physical, mental, and emotional health and to pursue a healthful lifestyle. This fundamental responsibility lies with the individual--not the family, not schools, not churches, not employers, not health care providers, and not the government.

The vision of health care reform for Alaska must go beyond the issues of access, financing, and cost containment. It must include a health care program that merges the personal health care delivery system with a population-oriented public health program based on the principles of health promotion, health protection, and disease prevention.

Health care costs can best be contained by an educated public, committed to wellness. The state must take an aggressive role in working with all Alaskans on health and safety education and the prevention of illness.

ACCESS

All Alaskans should have access to timely and appropriate health care without regard to personal financial means.

A health care plan should include prevention, primary care, early diagnosis and treatment, and incentives for healthful lifestyles.

FINANCING

All Alaskans have a responsibility to obtain and pay for health care for themselves and their dependents. It is the responsibility of society at large to finance care for those unable to pay.

Responsibility for the financing of care should be equitably distributed among payers.

COST CONTAINMENT

Health care services can be extended to everyone only if overall costs are contained. Duplicate coverage should be avoided.

Cost sharing requirements may be considered as a way of controlling excessive utilization but should take into account ability to pay.

Health care should be provided in the most efficient and cost effective manner and location and may include contractual arrangements for patient management and utilization controls.

Payments to providers should be reasonable and fair.

Health services based on disease prevention, health promotion, and health protection must be promoted as a major way to lower costs.

GENERAL

Individuals should have an informed and reasonable choice in selecting health care providers. However, they may be restricted to certain providers in cases where such arrangements are more cost-effective.

Systems to maintain and expand access and to control costs should be as simple to administer as possible.

Design of programs should be sensitive to cultural differences and community needs, including the special problems in rural areas of access and availability of providers.

A public health system based on the core functions of assessment, policy development, and assurance of essential public health services must be established and maintained as the foundation of an effective health program for Alaska.

The Task Force's recommendations, which draw upon these guiding principles, are presented in Chapter Four.

CHAPTER FOUR: TASK FORCE RECOMMENDATIONS

A. OVERVIEW

This chapter presents the Task Force's recommendations for improving the financing and delivery of health care in the State of Alaska. In developing these recommendations, the Task Force recognized the skill and dedication of the hundreds of health care providers working throughout the state to improve the health status of its residents. However, the Task Force also has come to realize that these efforts are hampered by many aspects of the Alaskan health care system itself. In fact, to call the current method of health care delivery and financing in the state a "system" is inappropriate. The existing structure could more aptly be described as a "non-system" that allows health care costs to continue to spiral out of control, that leaves even the most basic health care coverage unaffordable for a large number of Alaskans, and that leaves an even greater number of Alaskans worried about the possible financial consequences of a serious illness in the family.

Given this situation, the Task Force agrees with the view expressed by the vast majority of Alaskans responding to its health care survey, who believe that fundamental changes must be made to the current structure of our health care system (see Finding #13). In our view, minor tinkering with the current structure is not sufficient to address the current health care crisis in Alaska. This conclusion is based upon our review of a considerable body of evidence indicating that, although a wide variety of incremental approaches and piecemeal solutions have been attempted over the past several decades, none has succeeded in controlling health care costs or providing access to basic health services to all Alaskans.

The Task Force has thus come to the unavoidable conclusion that "business as usual" approaches to dealing with the problems of our health care system will no longer suffice. We therefore propose a comprehensive strategy designed to:

1. Bring runaway health care costs under control and make health care affordable for all Alaskans;

2. Move to a unified health care financing system that will provide financial access to needed care for all Alaskans and eliminate the concerns and fears that many Alaskans have with our current health insurance system;

3. Increase the effectiveness and efficiency of the current health care delivery system by increasing the availability and coordination of health services throughout the state;

4. Improve the health status of Alaskans by ensuring adequate support for vital public health activities and emphasizing the importance of healthy lifestyles and access to preventive care; and

5. Make improvements in the way in which we resolve medical malpractice disputes.

The recommendations developed by the Task Force to achieve these objectives are as bold and as ambitious as the charge given to us by the Alaska State Legislature. They are based upon a careful assessment of the full array of possible approaches for addressing identified problems, a review of the relevant health services research and related scientific information, and the examination of the relevant experience of other states and countries that have enacted health care reform measures. We believe that they reflect Alaska's unique environment and the concerns and values of its residents. At the same time, they are also consistent with many of the major health care reform proposals being discussed at the national level.

The Task Force strongly believes that our proposed strategy represents the best way to improve the health of the state's population and to provide access to affordable, high quality health care to all Alaskans. We recognize, however, that our recommended solutions may be considered quite controversial. There are several reasons this may occur. The first is that our strategy includes a number of concepts or terms that may be unfamiliar to or misunderstood by the Alaskan public. The second reason is that, because our strategy calls for significant changes in the way in which the health care system currently operates, there may be certain individuals or groups who may feel threatened by these reforms and seek to paint an unrealistic picture of their implications.

For these reasons, the Task Force recognizes that the enactment of meaningful health care reform in Alaska may require a significant public education effort. We have begun this effort by documenting Alaska's health care problems in earlier chapters of this report. In this chapter, we will describe in detail our recommendations for addressing these problems. In doing so, we have attempted to further the public's understanding of this important issue by describing: the range of options we considered in many areas; why we selected certain alternatives; and what the impacts of our recommendations on health care costs and coverage are expected to be.

The Task Force proposes a comprehensive health care reform strategy that will:

1. *Bring runaway health care costs under control and make health care affordable for all Alaskans.*
2. *Move to a unified health care financing system that will provide financial access to needed care for all Alaskans.*
3. *Improve the health status of Alaskans by ensuring adequate support for vital public health activities.*
4. *Make improvements in the way we resolve medical malpractice disputes.*

B. TASK FORCE RECOMMENDATIONS

The Task Force's recommendations, which together provide a comprehensive strategy for improving the health of all Alaskans, can be broken down into the following major components:

- Cost Containment Efforts
- Health Care Access Improvements
- Public Health/Service Delivery System Enhancements
- Medical Malpractice Reform

Our recommendations in each of these areas are presented below.

COST CONTAINMENT RECOMMENDATIONS

RECOMMENDATION # 1:

The Task Force recommends the establishment of a statewide health care expenditure limit that would bring increases in health care spending in Alaska down to acceptable levels.

Because spiralling health care costs have had a negative economic impact on Alaskan individuals and businesses and have been an important factor contributing to the growing number of uninsured persons, the Task Force spent considerable time reviewing possible approaches to bring health care costs under control. Unfortunately, none of these approaches was found to be completely effective in controlling costs.[1] Among the approaches examined were:

- Utilization controls, such as prior authorization, second surgical opinion programs, etc. In general, these measures do decrease utilization, but have not brought overall costs under control.

- Managed care. More formal managed care systems, such as health maintenance organizations (HMOs), have not been accepted in Alaska and are therefore virtually non-existent. In other areas of the country where HMOs are more prevalent, they have resulted in initial reductions in health care spending, although over time, their health care spending grows at essentially the same rate as overall health care costs.

---

[1] For a good review of the experiences associated with different cost containment approaches, see Congressional Research Service. 1990. Controlling Health Care Costs. Washington, D.C. (January).

- Government price setting. Governmental price regulation, particularly in the area of hospital rate setting, has been shown in a number of cases to reduce the growth in health care spending. However, price setting approaches that focus on controlling the growth in unit prices (e.g., charges for physician office visits) may cause providers to increase the amount of services they provide to offset the effects of the price controls.

- Market-oriented competitive strategies. These efforts may enable larger purchasers to reduce their costs by negotiating discounts from providers. However, unless overall cost levels are reduced, the revenues lost to providers from these discounts may be recovered by charging higher prices to smaller purchasers, such as individuals or small business policy holders. in addition, in many ares of the state where the numbers of providers are limited, competitive strategies are likely to be ineffective.

Based upon this review of possible cost containment options, the Task Force concluded that any effective strategy to bring costs under control and make health care affordable to all Alaskans must include the establishment of an overall limit on health care spending in Alaska. Such expenditure limits or "global budgets" have succeeded in keeping increases in health care spending in a number of other countries, including Canada and West Germany, at levels that are more in line with growth in other segments of their economies.

Within the United States, a global budgeting approach for hospitals has also been used with considerable success by the State of Maryland and by the Rochester, New York community to control the growth in hospital spending without diminishing either the quality of or access to care. The establishment of statewide health care expenditure limits covering all services has also been the centerpiece of major health care reform legislation recently passed in the States of Minnesota and Vermont. At the national level, the concept of global budgeting, including the establishment of state-specific expenditure limits, has been a key component of a number of major health care reform proposals and was an important element of the health care reform strategy put forth by President-elect Bill Clinton during his campaign.

How Would a Statewide Health Care Expenditure Limit Work?

Under a global budgeting approach, an overall limit would be established for health care spending within the State of Alaska. This limit would not be set so as to cut health care spending below current levels, but would rather be designed to reduce its current rate of growth, which far outstrips the growth in inflation and in other sectors of the economy (see Finding #1 in Chapter Two). The Task Force believes that the objective of global budgeting should be to limit annual increases in health care spending to the overall rate of inflation, as reflected in the growth in the Consumer Price Index (CPI). We recommend that the limits be phased in over a three-year period beginning in 1994, with the data collection efforts initially required to establish the limits to be conducted in 1993. Annual adjustments to the target rate of growth could be made, as appropriate, to reflect such factors as:

- Changes in the size and/or demographic characteristics (e.g., age distribution) of the state's population that may affect the need/demand for health care in the future;

- Changes in technology and health care delivery that may increase or decrease health care costs;[2]

- The identification and reduction of the provision of unnecessary health care;

- Desired changes in some segments of the population's (e.g., the uninsured's) access to adequate health care services;

- Increases or decreases in the costs associated with medical malpractice premiums and awards as appropriate;

- Reductions in administrative costs; and

- Other such factors as a newly established Alaska Health Care Authority (AHCA) (to be described later in this chapter) may determine to be appropriate (e.g., changes in the burden of disease, epidemics, disasters, etc.).

To the extent possible, the overall statewide health care expenditure target should be subdivided, with separate subtargets established, at a minimum, for such major services as hospital care, physician services, etc. The Task Force also believes that it may be appropriate to establish a separate subtarget for capital expenditures, and to link the State's Certificate of Need policies to the global budgeting process to ensure that this target is not exceeded.

Once expenditure targets for different services have been established, reimbursement rates for health care providers would be set at levels that are expected to result in expenditures that fall within the limit for each provider type. This does not necessarily mean that the State would unilaterally set rates for each class of provider. Instead, the Task Force envisions that after establishing the expenditure targets for different services, the newly established Alaska Health Care Authority would then work with designated representatives of the various provider groups (e.g., the state medical

---

[2] The Task Force recognizes that the introduction of new health technologies has been a significant contributor to the rapid growth in health care costs. And while some technologies can improve patient outcomes, we also recognize that in many instances new technologies and procedures may be utilized inappropriately and may not necessarily have demonstrated a positive impact on health care outcomes. For these reasons, the Task Force felt that upward allowances for technology changes should be incorporated into the expenditure limits judiciously and be limited to technologies whose effectiveness has been clearly demonstrated through scientific study and for which utilization standards have been developed in a similarly scientific manner.

association and the state hospital and nursing home association) to identify a mutually acceptable set of reimbursement rates.

These reimbursement rates can initially be developed entirely by the provider community and could vary across providers of similar services. From the State's perspective, these reimbursement structures must meet the following basic requirements:

1. Given reasonable assumptions concerning anticipated utilization levels, reimbursement rates should result in total expenditures which will fall within the expenditure limit;

2. Different rates may not be charged to different payers by a provider;

3. For health care facilities overall, the base for the statewide expenditure goal will be actual costs in a base year. Actual base year costs will also be the basis for reimbursement levels for individual facilities;

4. For hospitals, the unit of payment will be on a DRG-specific per discharge basis. Price or charge levels will be increased above cost levels to account for uncompensated care and/or rates from any public payers (e.g., Medicare) that are not sufficient to cover costs;[3]

5. For physician services, the reimbursement schedules will utilize a resource-based relative-value scale (RBRVS); and

6. For other services, the Authority will work with the provider community to develop the specific reimbursement schedules as appropriate.

Only if (a) a provider group fails to initially propose an equitable reimbursement structure that can reasonably be expected to result in expenditures that fall within predetermined targets, and (b) subsequent negotiations between the State and that provider group fail to reach agreement on such a reimbursement schedule, will the State as a last resort establish and put into effect its own reimbursement schedule for their services.

If expenditures exceed the target in a given year without good cause, the Authority will be able to take appropriate measures to ensure compliance with the expenditure targets, including reducing the subsequent year's reimbursement levels to bring spending back within the expenditure limit. For example, if the target annual rate of growth for total hospital expenditures is 7.5 percent, but overall hospital spending in a given year increases by 9 percent, the Authority could bring hospital

---

[3] It is the Task Force's expectation that the State of Alaska would request the necessary federal waivers to ensure that all payers comply with the reimbursement rates established as part of the global budgeting process.

spending back into line with the budget by allowing an increase of only 6 percent in the following year.

A key feature of the expenditure limit process will be the establishment of mechanisms through which detailed information on health care spending will be furnished to the various provider groups. This information will enable these groups to analyze spending patterns and assist them in identifying and addressing problems, such as inappropriate utilization or price increases in their own areas.[4] The Task Force recommends that the State take the appropriate steps to provide the necessary anti-trust protections to providers participating in negotiations with the Authority or working with data from the Authority to address problems that are identified.

The State's involvement in data-related activities is discussed further in the next recommendation.

What are the Anticipated Impacts of Establishing Statewide Health Care Expenditure Limits?

It is the Task Force's view that the establishment of these expenditure limits will be effective in bringing skyrocketing health care costs under control. We believe this can be achieved without harming health care quality or causing health care to be "rationed." Rather, we would expect these limits to provide incentives for improving the efficiency of the state's health care delivery system and reducing the utilization of inappropriate and unnecessary services. The Task Force believes that the potential reductions in unnecessary utilization could be significant. For example, national research has found that a substantial portion of a growing number of expensive high-technology procedures have been found to be "medically inappropriate."[5]

The Task Force further anticipates that the establishment of expenditure limits would provide incentives for existing health care organizations or groups of health care providers to form new coordinated health care systems that would offer to provide comprehensive quality care to patients on a prepaid capitated basis. An incentive for the establishment of such managed care plans would be to exempt them from any reduction in their subsequent year's rates if they came in within their budget, even if fee-for-service providers exceeded their expenditure targets. These managed care systems would achieve their efficiencies through internal patient care management rather than through heavy-handed "over the shoulder" government regulation. Where the population base was sufficient to support several of these coordinated care plans,

---

[4] For an interesting discussion of the use of information feedback to providers, see Lasker, R. et al. 1992. Realizing the Potential of Practice Pattern Profiling. Inquiry 29 (Fall): 287-297.

[5] See, for example, Chassin, M. et al. 1987. Does Inappropriate Use Explain Geographic Variations in the Use of Health Care Services? Journal of the American Medical Association 258:2533-37.

competition between different managed care plans would provide a further incentive to holding down costs. These plans would be able to compete on the basis of price, quality, and patient satisfaction, but not on the basis of selecting only healthy patients and avoiding those with significant illness.

While the Task Force does not anticipate that the availability or the quality of health care services would be diminished by expenditure limits, as noted earlier, we do anticipate that the affordability of health care in Alaska would be substantially improved. The following analysis illustrates this point by assessing anticipated future growth in health care spending with and without an expenditure limit.

> **THE IMPACT OF STATEWIDE HEALTH CARE EXPENDITURE LIMITS**
>
> *The establishment of statewide health care expenditure limits would:*
>
> - *Bring runaway health care costs under control;*
> - *Not harm quality of care or result in health care rationing;*
> - *Provide incentives for the development of coordinated health care systems that provide comprehensive quality care; and*
> - *Significantly improve the affordability of health care in Alaska.*

As indicated in Chapter Two (see Finding #1), health care spending in Alaska is estimated to have reached nearly $1.6 billion in 1991. To estimate the cost impact of establishing spending limits, the Task Force developed projections of health care spending in Alaska, both with and without the limits, through the year 2003. Our projections reflect anticipated changes in the state's population and increases in health care spending due to other factors.

Based upon population projections developed by the Alaska Department of Labor, the growth in the state's population can be expected to cause aggregate health care spending to rise by approximately 2.76 percent per year from 1991 through the year 2003. The aging of Alaska's population is expected to result in increases of approximately 0.4 percent per year during the same period. In addition, we assume that other factors, such as increases in prices, utilization levels, or intensity of care, would increase health care spending by another 8 percent per year. The combined effect of these three factors, when compounded, is an 11.4 percent annual rate of growth in health care spending. As indicated in Table 4-1, under this scenario health care spending in Alaska would increase from roughly $1.6 billion in 1991 (column 1) to nearly $5.6 billion by the year 2003 (see column 13), an increase of over 275 percent. That translates to approximately $7,340 in health care spending per Alaskan in 2003.

The lower half of Table 4-1 presents projections of health care spending in Alaska under a system with expenditure limits. Under this scenario, the increases in health care spending due to population growth and aging remain unchanged. However, the target rate of growth due to factors other than population changes is reduced from 8 percent per year to 4 percent, which is assumed to be the average

Table 4-1
A COMPARISON OF PROJECTED HEALTH CARE EXPENDITURES IN ALASKA
UNDER THE CURRENT SYSTEM AND A SYSTEM WITH EXPENDITURE LIMITS, 1991 - 2003
(In Billions of $)

	(1) 1991	(2) 1992	(3) 1993	(4) 1994	(5) 1995	(6) 1996	(7) 1997	(8) 1998	(9) 1999	(10) 2000	(11) 2001	(12) 2002	(13) 2003	(14) CUMULATIVE
ALTERNATIVE A: Current System														
Baseline/Prior Year Expenditures	$1.598	$1.598	$1.787	$1.983	$2.202	$2.446	$2.712	$3.008	$3.339	$3.706	$4.117	$4.559	$5.051	
1. Increase Due to Popula. .n Growth		$0.053	$0.043	$0.048	$0.053	$0.057	$0.064	$0.071	$0.080	$0.090	$0.086	$0.096	$0.108	
2. Increase Due to Aging of Population		$0.004	$0.006	$0.008	$0.009	$0.009	$0.010	$0.011	$0.013	$0.015	$0.019	$0.022	$0.025	
3. Increase Due to Other Factors @ 8.0%	____	$0.132	$0.147	$0.163	$0.181	$0.201	$0.223	$0.247	$0.275	$0.305	$0.338	$0.374	$0.415	
TOTAL: Projected Net Cost/Current System	$1.598	$1.787	$1.983	$2.202	$2.446	$2.712	$3.008	$3.339	$3.706	$4.117	$4.559	$5.051	$5.599	$42.107
ALTERNATIVE B: System With Expenditure Limits														
Baseline/Prior Year Expenditures	$1.598	$1.598	$1.787	$1.983	$2.175	$2.356	$2.516	$2.687	$2.872	$3.070	$3.283	$3.502	$3.736	
1. Increase Due to Population Growth		$0.053	$0.043	$0.048	$0.052	$0.055	$0.059	$0.064	$0.069	$0.074	$0.068	$0.074	$0.080	
2. Increase Due to Aging of Population		$0.004	$0.006	$0.008	$0.009	$0.008	$0.009	$0.010	$0.011	$0.013	$0.015	$0.017	$0.019	
3. Increase Due to Other Factors under Expenditure Limits	____	$0.132	$0.147	$0.136	$0.119	$0.097	$0.103	$0.110	$0.118	$0.126	$0.135	$0.144	$0.153	
TOTAL: Net Cost of System With Expenditure Limits	$1.598	$1.787	$1.983	$2.175	$2.356	$2.516	$2.687	$2.872	$3.070	$3.283	$3.502	$3.736	$3.988	$35.552
ADDITIONAL COST (SAVINGS) OF SYSTEM WITH EXPENDITURE LIMITS	$0.000	$0.000	$0.000	($0.027)	($0.090)	($0.196)	($0.321)	($0.467)	($0.636)	($0.833)	($1.057)	($1.315)	($1.611)	($6.555)

annual economy-wide inflation rate during this period.[6] The information presented in Table 4-1 assumes that the 8 percent annual increase due to non-population changes is reduced to the target rate of 4 percent over the course of three years, beginning in 1994 and reaching the 4 percent per year level in 1997. As a result, once the expenditure limits are fully implemented, annual health care spending is projected to increase a total of 7.3 percent per year, rather than the 11.4 percent anticipated without the limits.

Based upon these assumptions, the establishment of expenditure limits would result in aggregate health care spending of $3.988 billion in the year 2003 (column 13). This translates to a per capita cost of slightly less than $5,000 per Alaskan in the year 2003, or about a third less than what it would have been without expenditure limits.

Further, cumulative health care spending over the period from 1991 through 2003 would total $42.1 billion without expenditure limits (column 14), compared to less than $35.6 billion with expenditure limits in place. This represents cumulative savings of $6.55 billion statewide over the period in which the expenditure limits are in place. This represents cumulative savings of over $8,500 per Alaskan. This difference in the growth in health care spending is depicted in Figure 4-1.

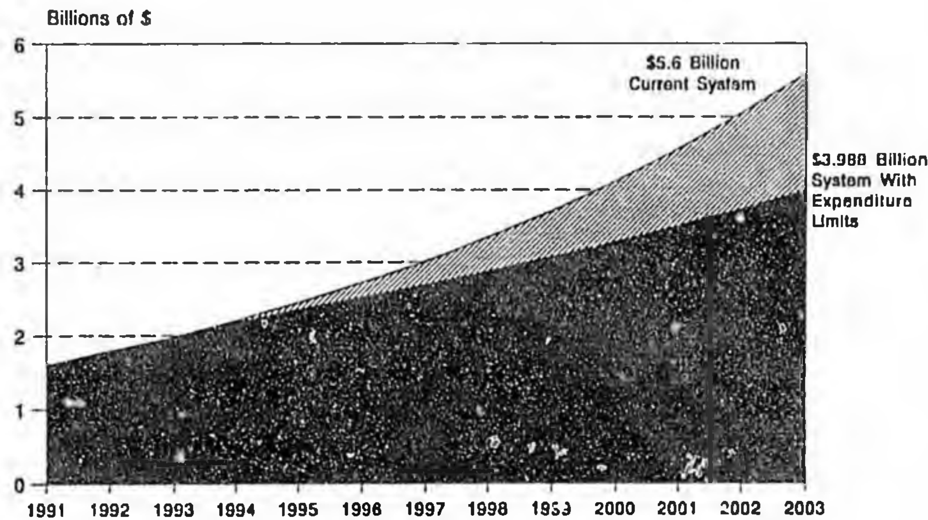
HEALTH CARE EXPENDITURE LIMITS: ANTICIPATED SAVINGS

During the first ten years of operation, statewide health care expenditure limits could result in $6.55 billion in statewide health care savings. That translates to over $8,500 per Alaskan.

---

[6] The target growth rate used in this analysis is consistent with that included in the State of Minnesota's health care reform legislation, which calls for increases in spending to be reduced to half of what they would otherwise have been. An earlier draft of this report used slightly higher assumptions for non-population based growth in health care spending in the absence of expenditure limits and for overall inflation (10% and 5%, respectively). In this analysis the assumptions concerning projected non-population-based health care spending increases and overall inflation rates have been reduced to 8% and 4%, respectively, to make them consistent with those used in federal projections of future health care spending. See Sonnefeld, S. et al. 1991. Projections of National Health Expenditures through the Year 2000. Health Care Financing Review 13 (Fall). To the extent that non-controlled growth in health care spending and inflation would exceed our assumptions, the savings resulting from the expenditure limits would increase.

Figure 4-1
Projected Health Care Expenditures in
Alaska under Alternative Systems, 1991 - 2003



Source: Health Systems Research, Inc.

RECOMMENDATION # 2:

The Task Force supports the passage of legislation to establish a single administrative entity to oversee the State's health care cost containment and access initiatives.

The Task Force recommends the establishment of the Alaska Health Care Authority (AHCA) at the State level, which would have responsibility for overseeing the development, implementation, and enforcement of the statewide expenditure limits, as well as other cost containment and access initiatives discussed later in this chapter. To ensure that it is able to carry out its significant responsibilities as effectively as possible, the Task Force further recommends that the Authority be structured to:

- Function as independently as possible;
- Be staffed by the most qualified individuals available; and
- Not include representation from provider groups, since the Authority will be responsible for negotiating with these groups.

The AHCA will be responsible for implementing the expenditure limits, which will include the conduct of negotiations with provider groups concerning reimbursement arrangements that will meet expenditure targets. The collection and analyses of comprehensive data on health care utilization and expenditures are also essential elements of the proposed global budgeting process. The AHCA must have the authority and capacity to collect and analyze all health care data necessary for the development, implementation, and monitoring of the health care expenditure limit process. As discussed under the prior recommendation, the Authority must also be able to share data on cost and utilization with the provider community in a timely manner through some form of feedback mechanism. Sharing information on utilization and expenditures with provider groups will assist in identifying possible problem areas and in making adjustments in their activities, as appropriate.

In addition to its responsibilities in the area of global budgeting, the Authority will also be charged with implementing other initiatives designed to reduce costs by increasing the efficiency of the current health care financing system. These initiatives include:

- The development of uniform billing and common claims forms which are to be used by all payers and providers;
- The development of uniform utilization review standards and criteria; and
- The establishment of requirements for the timely payment of claims by all payers, with the goal of providing payment within fifteen working days of receipt of an error-free or "clean" claim.

As a complement to the development of uniform utilization review standards by the proposed Alaska Health Care Authority, the Task Force also recommends the passage of legislation requiring the registration of utilization review agents operating in Alaska and the development of regulations by the Department of Commerce and Economic Development (DCED) to ensure their competency and their use of the uniform standards developed by the Authority.

Additional responsibilities of the Authority will be discussed in later recommendations.

RECOMMENDATION # 3:

The Task Force supports expanding the State's authority to review and approve or disapprove rates filed by health insurers.

In addition to establishing the Alaska Health Care Authority, the Task Force also supports expanding the authority of the State Director of Insurance to allow him

or her to approve or disapprove rate requests filed by all health insurers, both non-profit and commercial, that sell group and/or individual health insurance policies in Alaska. Currently the Director of Insurance does review rate filings submitted by insurance carriers. However, his ability to deny a rate filing is quite limited, even if it determined that the rates requested are excessively high in relationship to the benefits to be paid. This expanded authority will provide the State with the ability to deny rate requests in such instances and will improve the State's ability to ensure that insurance premiums charged by all health insurers in Alaska are reasonable.

HEALTH CARE ACCESS RECOMMENDATIONS

The cost containment measures called for in the previous recommendations will slow the erosion in health care coverage caused by rapidly escalating costs. However, these efforts alone cannot be expected to remove the health care access barriers faced by the tens of thousands of Alaskans who lack health care coverage. To address the very real needs of uninsured Alaskans and to meet our mandate from the Legislature to design a program that will provide universal coverage to all of the state's residents, the Task Force believes that a major, fundamental change to our current health care financing structure is required.

As will be discussed in greater detail later in this section, after a careful assessment of the Alaskan environment as well as pros and cons associated with alternative approaches to providing universal coverage, including pay-or-play proposals and employer mandates, the Task Force has concluded that a single payer financing system is the most efficient, equitable, and appropriate model for Alaska.

The Task Force is committed to the belief that all Alaskans will benefit from a single payer system. Nonetheless, as noted earlier, we also recognize that the benefits of a single payer system may not be immediately evident to the Alaska public and to policymakers. Programs must be put in place to educate the public concerning the benefits of moving to such a system and to stimulate an expanded public dialogue on the issue. However, such a public education process may require time for it to have an effect.

Unfortunately, during the period in which this public education process and public debate will take place, the problems that exist within our current financing system will continue. Uninsured persons will die or be admitted for expensive hospital care for problems that could have been avoided through access to adequate primary care. Children without access to preventive care may develop lifelong limitations due to conditions that could have been treated if detected early. And thousands of Alaskans will continue to live with the fear that their current insurance may not be there when they need it.

Given this situation, the Task Force felt that, in spite of its commitment to a single payer system, it should also put forth recommendations for making incremental improvements to the existing financing system that have already been adopted in many other states and that could be enacted immediately by the Alaska State Legislature. The first four of the Task Force's access-related recommendations (Recommendations 4 through 7) focus on this short term strategy. Our final recommendation describes the Task Force's rationale for proposing a single payer system as the preferred approach for providing universal coverage.

RECOMMENDATION # 4:

The Task Force recommends the enactment of legislation establishing regulatory reform measures in the small group health insurance market.

As described in Chapter Two (see Finding #6), a significant proportion of uninsured Alaskans are either employees in small firms or dependents of these employees. As was also noted, a number of serious problems in the current small group health insurance market are likely to make health care coverage unattractive to many small businesses. These problems include:

- The refusal by some insurers to provide coverage to certain small businesses because of the type of work in which they are involved or the health status of their employees or their dependents;

- Premium levels charged by the same insurer that may vary widely across firms with similar employee characteristics;

- Premium setting practices that result in many small businesses being offered very attractive first year rates, but then being hit by double--or even triple--digit increases in their premium costs in the following years. These staggering increases cause many businesses not to enter the market in the first place, to drop their coverage, or to switch to another carrier;

- High administrative costs due to medical underwriting activities and the frequent switching of insurers that is promoted by insurer practices; and

- The dropping of some small businesses without notice or refusing to renew their coverage because of their claims experience.

A number of organizations, including the National Association of Insurance Commissioners (NAIC) have worked to develop a package of regulatory reform measures that would enable states to address these problems. The NAIC has developed a Small Employer Health Insurance Availability Model Act that incorporates many desired reform provisions. These provisions, which would apply to policies sold to employers with fewer than twenty-five employees, include:

- Guaranteed Issue and Renewability: All small group insurers must provide coverage to all eligible firms applying for coverage and may not terminate such coverage for other than good cause, such as non-payment of premiums.

- Whole Group Coverage: Insurance policies sold to small groups must provide coverage to all eligible employees and their dependents and cannot exclude certain individuals based upon their health status.

- Elimination of Multiple Waiting Periods for Pre-existing Conditions: Waiting periods for individuals with pre-existing conditions are to be waived if these individuals have previously fulfilled a waiting period and maintain continuous coverage.

- Development of Standardized Plans: To allow comparison shopping by small employers, each small group insurer must offer two standardized plans, one of which is to be a "bare bones" plan.

- Premium Rating Restrictions: Premium rate "bands" or restrictions would be established to limit variation in:

    - annual premium increases faced by individual small businesses; and

    - premium rates charged to different types or classes of small businesses.

- Reinsurance Pool: A statewide reinsurance pool should be established to spread the risk associated with the guaranteed issue requirements in the small group market.

- Data and Disclosure: Small group insurers must disclose their premium rating practices and renewability provisions to small businesses. Insurers must also maintain their records in proper order and submit an annual statement certifying that the rates they charge small businesses are actuarially sound and comply with all the above requirements.

Over half of the states have already enacted small group health insurance market reforms similar to those included in the NAIC Model Act. The Task Force believes that enactment of such regulatory reform efforts could reduce many problems that Alaska's small businesses encounter in attempting to obtain or maintain health care coverage for their workers. The Task Force therefore recommends that the Legislature enact the NAIC model statute as part of a short term strategy to improve access to health care coverage in the state. The Task Force further recommends that the elimination of multiple waiting periods for pre-existing conditions should also apply to persons moving from group to non-group coverage.

RECOMMENDATION # 5:

The Task Force recommends that the State of Alaska require insurers to move toward community rating in establishing premiums in the small group insurance market.

With respect to the development of premiums to be charged in the small group insurance market, the Task Force viewed the provisions in the NAIC Model Act calling for the use of specific rate bands to limit variations in premium rates as a starting point, rather than the endpoint, for reform in this area. To further reduce the variations in premiums in this market, the Task Force calls for the phased-in use of quasi-community rates in the small group marketplace. Specifically, the Task Force recommends:

- The use of health status/medical underwriting and gender as factors in the setting of premium rates should be phased out over a three- to five-year period.

- At the end of the phase-in period, the only allowed variations in premiums charged to small businesses in a given geographical region of the state (to be defined by the State Director of Insurance), would be for differences in age composition and occupation/industry among small groups, as well as for differences in the family status of group members (i.e., single vs. family coverage).

- Limits should be placed on the maximum variation allowed in a geographic region due to age and industry differences across small groups. In reviewing the approaches of several other states that recently passed legislation calling for the use of some form of community rating, the Task Force viewed favorably an approach incorporated in a Massachusetts statute, which specified that no small business could be

charged a premium greater than twice that of the lowest small group premium within a given geographical area. During the phase-in of this 2:1 rate band requirement, the statute requires that renewal rates not exceed the trend for the class, plus allowable adjustments, plus 10 percent.

- Within this quasi-community rate setting structure, the Task Force recommends that insurers be allowed to offer discounts for non-smoking and for participation in wellness programs.

While this shift to community rating will mean lower premiums for some higher risk groups, the Task Force recognizes that it may also mean, at least initially, higher premiums for some lower risk groups. However, the Task Force believes that the enactment of the expenditure limits described in an earlier recommendation will reduce the magnitude of these premium increases. We also recognize that other aspects of our recommendations--including prohibiting insurers from cancelling policies because of changes in health status or use and the gradual elimination of medical underwriting--mean that the higher premiums that may be paid by some groups will provide them with much more predictable and stable health care coverage than they had in the past.

It also should be noted that the Task Force's recommendations with respect to community rating are directed at the small group market, which we defined as including firms with two to twenty-five employees. At this time, we did not extend our recommendations concerning community rating to larger firms because of the concern that this requirement might spur them to drop coverage or to self-insure, thereby avoiding the State's regulatory requirements completely.[7] However, the Task Force does recommend that the State Director of Insurance explore the feasibility and implications of extending these community rating requirements to firms with up to fifty employees.

The Task Force was also interested in extending its recommendations to the individual, non-group market. However, because of the significant potential for adverse selection that exists in the individual market, unless otherwise specified, our recommendations do not extend to that segment of the insurance marketplace.

---

[7] The provisions of the federal Employee Retirement and Income Security Act of 1974 (ERISA) do not allow state governments to regulate self-funded employee health benefit plans.

RECOMMENDATION # 6:

The Task Force recommends the establishment of State-sponsored health insurance pooling arrangements.

During its deliberations, the Task Force reviewed information indicating that nationwide as much as 40 percent of premiums charged to very small businesses may be attributable to administrative costs. While the small group market reform provisions included in earlier recommendations are expected to reduce the administrative costs associated with providing coverage to small businesses, the Task Force also considered it appropriate for the State, through the newly established Health Care Authority, to establish one or more pooling arrangements through which both individuals and businesses, small and large, could purchase health care coverage. It is anticipated that certain additional efficiencies and economies could accrue to the members of these pool arrangements that would further reduce their premium costs. In designing these pools, the Task Force noted the importance of considering their medical underwriting and premium setting practices in relation to those of other insurers governed by the small market reform proposals to ensure that these State-sponsored pools are not damaged by the adverse selection that would result from other insurers subtly "dumping" undesirable risks into these pools.

RECOMMENDATION # 7:

The Task Force recommends the passage of legislation providing for publicly-subsidized coverage of uninsured low-income pregnant women and children who are not eligible for Medicaid.

Even with the recommendations concerning cost containment, market reform, and pooling measures in place, the Task Force recognizes that it would be necessary to provide some level of public subsidy to certain low-income uninsured persons if they are to be able to afford health care coverage (see Finding #4).

The Task Force determined that the populations to be given highest priority for receiving subsidized coverage should be low income pregnant women and children in families with incomes too high to be eligible for Medicaid but too low to be able to

purchase private health insurance on their own.[8] Priority was given to these groups because of the documented improvements in birth outcomes and the cost savings associated with the receipt of prenatal care by pregnant women and the positive lifelong benefits associated with providing adequate primary and preventive care to children. The Task Force also determined that the positive health improvements resulting from public health care subsidies for these populations could be maximized by providing coverage of comprehensive services (e.g., prenatal and other preventive services, plus other ambulatory and inpatient care) for low income pregnant women and ambulatory care services for low income children.

Given these priorities, the Task Force recommends that legislation be enacted to establish a program providing State-subsidized insurance coverage for low-income children who are not eligible for Medicaid or Indian Health Service coverage and who are in families with incomes below 300% of the federal poverty level. In order to make the program more affordable at the outset, coverage would be provided for primary and preventive and/or ambulatory care services, but not for inpatient care.

Experience in other states has shown similar programs to be more attractive to families if they were perceived to foster self-sufficiency and were similar to private insurance in design. Therefore, the Task Force recommends that the program be given an identity apart from Medicaid, particularly the eligibility system. This would not preclude the Medicaid agency from administering the program if it proves most cost-effective, however serious consideration should be given to having a private insurer administer the program under contract to the State. The Task Force was heartened by expressions of interest from two major carriers in Alaska in being involved in such a program.

While coverage would be substantially subsidized by the State, premium sharing requirements in the range of $50 - $300 per year per child should be established on an income-related sliding scale basis. This premium sharing will not only reduce the required level of State subsidy, but also will give parents of enrolled children a sense of involvement and participation in contributing to coverage for their children.

As illustrated in Table 4-2 on the following page, approximately 14,600 uninsured Alaskan children would be eligible for coverage under this program. The Task Force estimates that roughly 8,200 children would actually enroll in the program, with nearly 90 percent of these children having no previous health care coverage. The remaining enrollees are expected to be children with private insurance that provides inadequate coverage of primary and preventive care. The annual cost of the program is estimated to be $6.1 million, of which $4.2 million would be financed by State subsidies. The remaining $1.9 million would be paid by families in the form of premium contributions.

---

[8] It should be noted that the Task Force identified high-risk individuals as another high priority population and in our interim recommendations we endorsed the establishment of a statewide high-risk insurance pool for this population. Legislation establishing such a pool was enacted last year by the Alaska State Legislature.

Table 4–2
ESTIMATES OF ENROLLEES AND COSTS UNDER SUBSIDIZED AMBULATORY CARE PROGRAM FOR LOWER INCOME ALASKAN CHILDREN NOT ELIGIBLE FOR MEDICAID OR IHS COVERAGE

Income	Number of Uninsured Children	Number of Enrollees	Costs (in millions of $)		
			State	Family	TOTAL
Under Poverty	3,900	300	$0.2	$0.0	$0.2
100–200% Poverty	4,500	2,900	$1.8	$0.4	$2.2
200–300% Poverty	6,200	5,000	$2.2	$1.5	$3.7
TOTAL	14,600	8,200	$4.2	$1.9	$6.1

Source: Health Systems Research, Inc.

With respect to the coverage of low income pregnant women, the Task Force recognizes that, while federal laws enable the State of Alaska to extend Medicaid eligibility to pregnant women and infants in families with incomes up to 185% of poverty, the State currently has elected to provide coverage only to pregnant women and infants in families with incomes below 133% of poverty. The Task Force recommends that the State expand its Medicaid coverage for pregnant women and infants up to 185% of poverty. The FY 1994 cost of this expansion to the State is estimated to be $3.8 million, which will be matched by an equal amount from the federal government. For uninsured women with incomes above this income level but below 300% of poverty, the Task Force recommends the establishment of a publicly-subsidized private insurance program providing comprehensive services.

RECOMMENDATION # 8:

The Task Force recommends the enactment of legislation establishing a single payer health care financing system to provide universal health care coverage for all Alaskans.

While the previous recommendations can be expected to result in short-term improvements in the availability and affordability of health care coverage, even with their enactment, tens of thousands of Alaskans will remain without health care coverage. After considerable examination of alternative approaches to provide health care coverage for all Alaskans, the Task Force concluded that the most appropriate model for achieving such a goal in Alaska is through the establishment of a single payer financing system. Our rationale for selecting this model is described below.

Why a Single Payer System?

In considering what financing structure would be the most appropriate for providing universal health care coverage in Alaska, the Task Force carefully considered a range of different models for achieving this goal. They included three of the major approaches that have been considered both in other states and at the national level:

- Mandated employment-based health care coverage;
- "Pay or Play" coverage requirements; and
- A single payer system.

Each of these approaches is described below.

- Mandated employment-based health care coverage.

  Under this approach, all Alaska employers would be required to provide health care benefits for at least their full time workers. This requirement could also be extended to the dependents of these workers, and to part time workers, with employer premium contributions for this latter group adjusted on a sliding scale basis depending on the number of hours that they work.

  To implement such a requirement, the State of Alaska would require a federal waiver of the Employee Retirement and Income Security Act of 1974, known as ERISA. This federal statute precludes states from regulating employee benefit programs and would preclude Alaska from requiring the provision of health care benefits. Only one state in the nation, Hawaii, has received a waiver of ERISA, because its employer mandate was established prior to ERISA's passage. Under this approach, a publicly subsidized health insurance plan also would have to be created to provide coverage for low income individuals and families not tied to the work force.

- "Pay or Play" approaches.

  In an attempt to avoid the need for an ERISA waiver, a number of states have enacted legislation that does not directly require employers to provide health care benefits for their workers, but Instead exempts employers that provide such coverage from newly established payroll taxes. The States of Massachusetts and Oregon have enacted these "Pay or Play" employer requirement, but have delayed their implementation to 1995. The State of Florida also has enacted legislation proposing a "pay or play" requirement if employers do not voluntarily extend coverage to their workers.

  Like the employer mandated coverage approach, a pay or play approach would require the establishment of state-sponsored coverage for persons not linked to the work force or workers whose employer elected to pay the payroll tax rather than provide health benefits.

- A single payer system.

  By a "single payer" system we mean a system under which all Alaska residents would be provided constant health care coverage through a unified funding mechanism. This would be in contrast to our current system under which whether or not a person has coverage is dependent upon whether his or her employer provides health benefits, whether or not their income is below a certain level to qualify for Medicaid, whether they are old enough to qualify for Medicare, or whether they would qualify for coverage under the Indian Health Service.

A single payer systems does not mean that all health care providers would end up being government employees or that all health care facilities would be government owned. Under a single payer system, the current mix of private and public health care providers could continue to provide services and Alaskans would still have the ability to select the provider of their choice.

After a careful consideration of each of these possible approaches, the Task Force concluded that the most appropriate approach for providing universal coverage in Alaska is a single payer system. There are several important reasons why a single payer system is preferred to either an employer mandate or a "pay or play" approach, both of which are based upon our current system. They are the following:

1. The current mix of public, employer, and individual financing inevitably creates coverage gaps for some people, particularly when their employment status changes.

   Linking health care coverage to employment is particularly difficult in Alaska. Given the seasonal nature of many of its industries, there are considerable fluctuations in employment during the course of the year. For example, an analysis of all but the state's very largest firms conducted by the Alaska Department of Labor found that employment in the "average" business fluctuated by 24 percent from the lowest employment month to the highest. In the very seasonal industries, those fluctuations were even greater. In seafood processing, for example, the highest monthly employment averaged over 300 percent higher than in the lowest month. The lumber and wood products, utilities, and construction industries were also found to have fluctuations of from 66 to 87 percent.[9]

2. Health care financing approaches that require all businesses to provide health care benefits or that levy additional taxes on those businesses that do not may threaten the economic viability of many small businesses in Alaska.

   As discussed in Chapter Two, a significant proportion of uninsured Alaskans are workers employed by small businesses or the dependents of these workers. While many of the businesses that employ these uninsured workers might be able to afford to provide coverage for these workers, particularly in a system in which effective cost containment measures are in place, the financial status of some of these businesses might be jeopardized by the burden that either a health benefit mandate or a "pay or play" requirement would place upon them. The Task Force believes that a single payer approach offers greater flexibility to identify

[9] Rae, B. 1991. Alaska's 13,476 Other Employers. Alaska Economic Trends (August).

funding sources and develop financing arrangements that will be less of a threat to the state's small businesses.

3. Multiple payer systems would not necessarily address the problems of cost shifting that exist in our current system.

Unless there was a requirement that all payers would pay the same amount to providers for comparable services, multiple payer approaches to providing universal coverage would not necessarily solve the problem of cost shifting, which places an inequitable burden on some payers. Under such a system, larger payers might be able to negotiate significant discounts in charges from providers, with losses in revenues being made up through higher charges to other, smaller payers. To the extent that public programs reduce their reimbursement levels below costs due to budgetary constraints, this source of cost shifting can also exist. Under a single payer system, by definition, a single rate would be paid to a given provider for a given service, so that no one's cost would be artificially increased.

4. Systems that are built upon the existing public-private financing arrangements can be expected to inherit its inefficiencies.

These inefficiencies exist because there are considerable administrative costs associated with conducting eligibility determinations for public program coverage, enrolling individuals in employment-based plans, and re-enrolling them when they change jobs and are lucky enough to obtain coverage at their second job. Given the seasonal fluctuations in employment discussed above, these costs are likely to be particularly high in Alaska.

There also are significant costs associated with having multiple insurers provide coverage. These administrative costs include not only insurer overhead, but also the cost to providers of filling out different forms and responding to varying requests from different insurers. In its study of the Canadian health care system, the U.S. General Accounting Office concluded that nationwide there would have been administrative cost savings of approximately $67 billion in 1991 if the U.S. had adopted a Canadian-style single payer system--more than enough to cover the increased cost associated with covering all currently uninsured Americans.[10] While the magnitude of GAO's estimates of administrative cost savings have been questioned by some analysts, most conclude that the administrative savings would nonetheless be significant.[11]

---

[10] General Accounting Office. 1991. Canadian Health Insurance: Lessons for the United States. Washington, D.C. (June).

[11] See Gauthier, A. et al. 1992. Administrative Costs in the U.S. Health Care System: The Problem or the Solution? Inquiry 29 (Fall).

What Would be the Impact of a Single Payer System on Health Care Costs in Alaska?

An analysis of the cost of moving to a single payer health care financing system that provides coverage to all Alaskans is presented in Table 4-3. This analysis assumes that a single payer system providing universal access is implemented in 1995, one year after the beginning of the phase-in of the expenditure limits. To the projections of health care expenditures in Alaska under a system with expenditure limits (see Table 4-1 in Recommendation #1) are added the following:

- The marginal costs associated with providing health care coverage to Alaska's currently uninsured population. These costs are based upon analyses which indicate that per capita health care costs for insured individuals are approximately 40 percent higher than for persons without health care coverage.[12]

- Anticipated administrative savings associated with a single payer system, which is based on a low-end estimate of 4 percent savings of total expenditures.[13]

As can be seen from Table 4-3, the administrative savings associated with the single payer system are estimated to exceed the anticipated marginal cost of covering Alaska's uninsured population. As a result, cumulative expenditures under this alternative scenario for the period 1991 to 2003 total $34.9 billion (see column 14). This figure is significantly less than the cumulative cost of $42.1 billion for maintaining the current system without expenditure limits or universal access, which is presented as Alternative A in Table 4-3. It is also less than the estimated $35.55 billion in cumulative health care spending under a system under in which there are expenditure limits, but neither universal access nor a single payer system (see Table 4-1, Alternative B, column 14).

> The savings in administrative costs that result from a single payer system would be enough to provide coverage to all uninsured Alaskans.

How Could a Single Payer System be Financed?

As the analysis presented above illustrates, the difficulty in restructuring our current health care financing system to one that is more equitable, efficient, and rational is not that it will cost more money. Rather, the problems are due to the fact that the public may have certain misconceptions about a single payer system, it may not be aware of the savings that could accrue from moving to such a system, and the

---

[12] Needleman, J. et al. 1990. The Health Care Financing System and the Uninsured. Submitted to the Office of Research, Health Care Financing Administration, DHSS (April 4).

[13] For a fuller discussion of alternative estimates of administrative cost savings associated with a single payer system, see Gauthier et al. 1992.

Table 4-3
A COMPARISON OF PROJECTED HEALTH CARE EXPENDITURES IN ALASKA
UNDER THE CURRENT SYSTEM AND A SINGLE PAYER SYSTEM WITH EXPENDITURE LIMITS, 1991 – 2003
(In Billions of $)

	(1) 1991	(2) 1992	(3) 1993	(4) 1994	(5) 1995	(6) 1996	(7) 1997	(8) 1998	(9) 1999	(10) 2000	(11) 2001	(12) 2002	(13) 2003	(14) CUMULATIVE
ALTERNATIVE A: Current System														
Baseline/Prior Year Expenditures	$1.598	$1.598	$1.787	$1.983	$2.202	$2.446	$2.712	$3.008	$3.339	$3.706	$4.117	$4.559	$5.051	
1. Increase Due to Population Growth		$0.053	$0.043	$0.048	$0.053	$0.057	$0.064	$0.071	$0.080	$0.090	$0.086	$0.096	$0.108	
2. Increase Due to Aging of Population		$0.004	$0.006	$0.008	$0.009	$0.009	$0.010	$0.011	$0.013	$0.015	$0.019	$0.022	$0.025	
3. Increase Due to Other Factors @ 8.0%		$0.132	$0.147	$0.163	$0.181	$0.201	$0.223	$0.247	$0.275	$0.305	$0.338	$0.374	$0.415	
TOTAL: Projected Net Cost/Current System	$1.598	$1.787	$1.983	$2.202	$2.446	$2.712	$3.008	$3.339	$3.706	$4.117	$4.559	$5.051	$5.599	$42.107
ALTERNATIVE C: Single Payer System w/Expenditure Limits														
Baseline/Prior Year Expenditures	$1.598	$1.598	$1.787	$1.983	$2.175	$2.352	$2.505	$2.666	$2.836	$3.016	$3.207	$3.397	$3.598	
1. Increase Due to Population Growth		$0.053	$0.043	$0.048	$0.052	$0.054	$0.059	$0.063	$0.068	$0.073	$0.067	$0.072	$0.077	
2. Increase Due to Aging of Population		$0.004	$0.006	$0.008	$0.009	$0.008	$0.009	$0.010	$0.011	$0.012	$0.015	$0.016	$0.018	
3. Increase Due to Other Factors under Expenditure Limits		$0.132	$0.147	$0.136	$0.119	$0.097	$0.103	$0.110	$0.117	$0.124	$0.132	$0.139	$0.148	
Savings Due to Expenditure Limits				($0.027)	($0.090)	($0.201)	($0.333)	($0.490)	($0.674)	($0.891)	($1.139)	($1.427)	($1.759)	
4. Additional Costs of Universal Access					$0.094	$0.098	$0.102	$0.106	$0.110	$0.114	$0.119	$0.124	$0.128	
5. Administrative Savings of Single Payer System					($0.098)	($0.104)	($0.111)	($0.118)	($0.126)	($0.134)	($0.142)	($0.150)	($0.159)	
TOTAL: Net Cost of Single Payer System	$1.598	$1.787	$1.983	$2.175	$2.352	$2.505	$2.666	$2.836	$3.016	$3.207	$3.397	$3.598	$3.810	$34.928
ADDITIONAL COST (SAVINGS) OF SINGLE PAYER SYSTEM WITH EXPENDITURE LIMITS	$0.000	$0.000	$0.000	($0.027)	($0.094)	($0.208)	($0.343)	($0.502)	($0.690)	($0.910)	($1.162)	($1.453)	($1.789)	($7.178)

fact that there would be major shifts in the distribution of responsibility for the financing of health care.

For example, with respect to this latter issue, the establishment of a non-employment-based single payer financing system would relieve both private and public employers--including private businesses, school districts, municipal governments, etc.--of the significant costs that most currently incur in providing employee health benefits. At the same time, however, it would require the identification of new sources of revenues to replace these expenditures. In addition, under a single payer system, other sources of health care dollars currently financing care in Alaska, such as Medicare, federal Medicaid funds, IHS, VA, etc., would continue to come into the state on a block grant-like basis but would go into a Statewide Universal Access Fund rather than be used to support individual facilities or finance care for specific program recipients.

The Task Force realizes that federal waivers will be required to integrate these federal health care funding streams into a single payer financing system. We also recognize that bringing these different programs into a single payer system must be done carefully and sensitively. For example, the Task Force recommends that the newly created Alaska Health Care Authority negotiate with Alaska Natives and the federal government to bring the IHS/tribal health care system within the single payer system. These negotiations will require changes to federal law and must recognize and address the following issues:

- Recommendations for change which affect the IHS/tribal health care delivery system in Alaska must recognize and support the federal trust responsibility to provide health care to Alaska Natives.

- Recommendations for universal coverage must provide the same rights for Alaska Natives as for all other Alaskans and must support at least the level of care currently available to Alaska Natives.

- Recommendations for cost control should capture and, if possible, enhance the direct federal appropriations currently going to the Alaska Area Native Health Service.

- Other issues regarding copayments and deductibles (prohibited by law in the IHS system), native preference in employment, etc. must be addressed.

As discussed above, employment-based and individually purchased health care coverage would be eliminated under a single payer system. Table 4-4 uses the estimates of 1991 health care spending in Alaska originally presented in Table 2-1 to estimate the need for new revenue sources to replace these private health insurance payments.

Table 4–4
SOURCES OF HEALTH CARE SPENDING IN ALASKA, 1991
(In Thousands of $)

SOURCES	ESTIMATED 1991 EXPENDITURES
1. Private Businesses	
■ Insurance premiums	$121,418
■ Self–insured payments	$65,379
2. Local Government	
■ Insurance premiums	$39,906
■ Self–insured payments	$48,774
■ Local taxes to support hospitals/local spending	$29,713
3. State Government	
■ Premium contributions for state employees	$47,929
■ Self–insured payments	$9,290
■ Medicaid	$99,602
■ Other health programs	$161,106
4. Federal Government	
■ Premium contributions for civilian employees	$35,402
■ Medicare	$90,000
■ Medicaid	$114,948
■ IHS/AANHS	$206,153
■ Veterans' Affairs	$46,476
■ CHAMPUS and military	$55,931
■ Other	$313
5. Workers' Compensation	$48,089
6. Individual	
■ Premium contributions for employment–based coverage	$92,024
■ Individual policies and policies through fraternal orgs and auto liability insurance	$29,458
■ Service–related cost sharing (copayments, deductibles), excess out–of–pocket expenses of uninsured	$255,602
TOTAL, ALL EXPENDITURES:	$1,597,513
TOTAL, EXPENDITURES IN SHADED AREAS:	$537,668

Source: Data originally compiled by ISER, UAA from various sources. Selected entries updated by Health Systems Research, Inc.

If a single payer system had been put in place in 1991, the sources of health care spending that would not have been available are identified in the shaded boxes in Table 4-4. Expenditures for employment-based and non-group coverage, including the premium contributions made by businesses and individuals, are estimated to total $489.6 million. If workers' compensation health care payments were included under the single payer system, which would eliminate this cost to employers, the total is $537.7 million.

While the Task Force is not recommending a specific revenue source to replace these dollars, it recognizes that funds could come from a number of existing sources. These include:

- Payroll taxes;
- Income taxes;
- Sales taxes;
- Excise taxes; and
- Permanent Fund earnings.

Table 4-5 provides estimates of the amount of 1991 revenues that theoretically could have been available from a number of these different sources. As can be seen from this table, certain of these potential revenue sources, such as sales taxes on specific items or "sin" taxes on cigarettes and alcohol, would not raise revenues sufficient to replace group and non-group insurance premiums. However, several of these revenue sources, such as payroll tax, income tax, or Permanent Fund earnings, either alone or in combination with other revenue sources, could replace current premium contributions.

It should again be emphasized that these new revenue sources would not represent additional spending on health care, but would instead replace existing expenditures being made by Alaskan employers and individuals. For example, because employers would no longer have to make health care contributions on behalf of their workers and their dependents, it is expected that these savings would be passed on to the Alaskan workers in the form of higher wages, which in turn might be subject to a new payroll or income tax. It is this understanding of the need to redistribute, rather than increase, spending under a single payer system that must be communicated to the public if this model of universal access is to be accepted.

Table 4-5
POSSIBLE SOURCES OF REVENUES TO REPLACE GROUP AND NON-GROUP HEALTH PREMIUMS/BENEFITS

A. <u>PAYROLL TAX</u>

(Based upon 1991 Non-agricultural Payroll of $7.347 billion)

Rate	Revenue
@ 3%	$ 220 million
@ 5%	$ 367 million
@ 7%	$ 514 million
@ 8%	$ 588 million
@ 9%	$ 661 million

B. <u>INCOME TAX</u>

(Based upon 1990 Federal Taxable Income)

Rate	Revenue
@ 1%	$ 66.5 million
@ 3%	$ 199 million
@ 5%	$ 332 million
@ 10%	$ 664 million

C. <u>SALES TAX</u>

1. General Tax on Retail Items

Rate	Revenue
@ 1%	$ 34 million
@ 6%	$ 216 million

2. Sales Tax on Hotel and Lodging

Rate	Revenue
@ 1%	$ 1.9 million
@ 5%	$ 9.0 million
@ 10%	$ 18.6 million

D. <u>EXCISE TAXES</u>

1. Cigarette Tax

   - Increasing tax per pack by 10¢ would raise about $4.5 - $5 million

2. Alcoholic Beverage Tax

   - Equaling tax rate on alcoholic beverages: $4.28 million
   - Increasing tax to highest rate in other states: $8.26 million

E. <u>PERMANENT FUND EARNINGS (7/1/90 - 6/30/91)</u> .... $ 1.03 billion

Estimates for C. based upon: Alaska Department of Revenue, <u>Revenue Potential of a General Sales Tax</u>, January, 1989. Revenues from a 6% sales tax estimated by ISER, Fiscal Policy Paper No. 6, April 1991. Estimates for D. based upon: Alaska Department of Revenue, <u>Revenue Alternatives</u>, January, 1989.

PUBLIC HEALTH/SERVICE DELIVERY SYSTEM RECOMMENDATIONS

While the recommendations presented to this point address the problems with the affordability of health care services and problems with health care coverage faced by many Alaskans, as described in Chapter Two, the Task Force also identified significant problems with respect to the availability of needed health care services, particularly in many rural areas in the state, as well as problems associated with the lack of adequate public health interventions and the fragmentation of the existing health care delivery system. To address these problems, the Task Force developed recommendations concerning:

- The retention and recruitment of health care personnel;
- The creation of more flexible licensure standards;
- The expansion of the scope of the State's Certificate of Need program; and
- The strengthening of public health efforts.

The Task Force's recommendations for each of these areas are presented below.

RECOMMENDATION # 9:

The Task Force recommends that the State of Alaska develop initiatives to attract and retain qualified health care professionals in medically underserved areas of the state.

To address the need for qualified health care professionals in many underserved areas of the state, the Task Force recommends the development and implementation of a multi-faceted strategy designed to ensure an adequate supply of appropriately trained health care professionals in the state. Within this overall strategy, the Task Force specifically recommends that:

- The Alaska State Legislature should create a state student loan forgiveness program that provides for forgiveness of a specified loan amount each year for health practitioner service in an area designated as underserved by the Department of Health and Social Services.

- The State of Alaska and Alaska State Legislature should support the development of an Alaska-based family practice residency program. The State should stipulate a condition requiring rotations in rural and underserved areas.

- The State of Alaska and the Alaska State Legislature should support the development and maintenance of Alaska-based training and rotations for mid-level practitioners, nurses, and other health professionals. They should also provide incentives for the development and maintenance of continuing education particularly targeted to professionals that practice in underserved areas. Particular attention should be paid to recruiting local residents, especially Alaska Natives, into health care professions.

- The Task Force supports continued efforts by the State and the Rural Alaska Health Professions Foundation to analyze the specific recruitment and retention problems experienced in Alaska.

RECOMMENDATION # 10:

The Task Force supports the development of more flexible facility licensure standards.

In addition to the development of a statewide strategy for recruiting and retaining qualified health care professionals, the Task Force also believes that flexibility must be incorporated into the State's current facility licensure standards if needed health care resources are to be made available throughout the state in the most appropriate and cost efficient manner. To this end, the Task Force has developed the following specific recommendations:

- The State of Alaska, in conjunction with the provider community, should explore the creation of more flexible facility licensure standards that allow communities to choose from a broader range of levels and types of care. Facility licensure that provides the ability of mid-level clinics to expand their capabilities without becoming hospitals ought to be explored for rural communities, along with study of ways to give communities options to change the role of their existing hospitals or co-located systems. The Task Force wishes to stress that communities need to be given the responsibility for deciding levels of care and that communities that currently have plans for capital improvements to their facilities should not be impacted by this effort. This effort should be undertaken in the near future.

- The State of Alaska should join in national efforts to ensure that public programs, such as Medicare and Medicaid, acknowledge that the cost of delivering care in rural areas is different from the costs in urban areas and should be compensated accordingly.

- The Task Force supports the development of reimbursement systems which create incentives for increasing the number of primary care providers as well as the availability of primary care.

- Because Alaska lacks a primary care clinic system which can assist in meeting the primary health care needs of those who are uninsured or underinsured, the State of Alaska should continue to promote these models of care in their long-range planning and funding and should help communities become aware of federal funding opportunities that promote the availability of primary care.

RECOMMENDATION # 11:

The Task Force recommends the strengthening and expansion of the State's Certificate of Need program.

The Task Force supports strengthening the State's Certificate of Need process. To this end, it recommends that the Department of Health and Social Services be directed to promulgate in regulation standards establishing "need" and the criteria for determining when a Certificate of Need will be awarded. The Task Force also recommends that the requirements for Certificate of Need be extended to all health facilities, including Pioneers' Homes, Veterans Homes, and to expensive medical equipment to be located in any setting. The Task Force further recommends that federal facilities voluntarily comply with Certificate of Need requirements and file impact statements with the Department of Health and Social Services. It is estimated that it will take the Department approximately a year to develop standards once given the authority to do so.

RECOMMENDATION # 12:

The Task Force recommends that adequate resources be devoted to maintaining a strong public health infrastructure in Alaska.

In seeking to broaden access and improve the financing of health care in Alaska, the Task Force is aware that these efforts must be considered in a broader

context that reaffirms the primacy of public health as the cornerstone of community and personal health. Indeed, the twin goals of universal access to health care and containment of costs cannot be achieved without reshaping health care into a rational system based on prevention of disease and violence, promotion of healthful personal habits, and paying for diagnostic and treatment measures only if they are known to be effective. Indeed, the Task Force recognized the importance of prevention, the promotion of healthful lifestyles, and population-based public health services by integrating all of these into our guiding principles (see Chapter Three).

In addition, the Task Force also recognizes that clean air, clean land, clean water, and clean food are basic to good health. It is the responsibility of government to assure these basics exist and to engage as well in other core public health functions, such as the collection and analysis of vital data, the formulation of public health policy, and assuring the availability of essential health services to address problems such as infant mortality, drug and alcohol abuse, suicide, and domestic violence.

Because adequate public health services are paramount to the cost-effectiveness and efficiency of a reformed personal health care system, the Task Force strongly recommends that sufficient resources be devoted to maintaining a strong public health infrastructure in Alaska.

MEDICAL LIABILITY RECOMMENDATIONS

The Task Force developed several recommendations in an effort to address the problems identified in Chapter Two with the existing process for handling medical liability claims. These recommendations are described below.

RECOMMENDATION # 13:

The Task Force recommends reducing the statute of limitations for birth-related injuries from current law to the eighth birthday of the child.

Under the State of Alaska's current statute of limitations, malpractice cases involving injury to children can be filed up to two years after the age of nineteen. However, the Task Force has been informed that virtually all residua from birth or early-life injury or illness are obvious by the time a child is in school, and that subtle learning defects appearing after roughly age eight are almost always genetic. Nonetheless, "tail" insurance to protect against claims filed many years after the fact,

including those involving injuries to infants and children, is very expensive. Given these findings, the Task Force, in an effort to make obstetrical and pediatric care more available and affordable in Alaska, supports a change in the statute of limitations for medical malpractice claims, reducing it for birth-related injuries to the eighth birthday of the child.

RECOMMENDATION # 14:

The Task Force recommends that the State's existing pre-trial screening process for medical malpractice suits be replaced with a court ordered non-binding arbitration process.

The Task Force believes that because medical malpractice litigation is so cumbersome, costly, and unpredictable, alternative ways of resolving claims of injury by medical care that are quicker, fairer, and less disruptive are needed.

Several types of "alternative dispute resolution" (ADR) systems are currently being proposed or tested across the nation. Some are "no-fault" systems which, like workers' compensation laws, require only that the cause of injury be proved, not whether negligent care occurred. Another approach, called "accelerated compensation events," would pay awards for pre-selected, ordinarily avoidable poor outcomes without determination of cause or fault.

Another approach, arbitration, is frequently used to settle contractual disputes but has been used only infrequently in medical malpractice cases. Recently, however, its application to this area of litigation has received increased attention.

Arbitration can take various forms. Some states, including Alaska, have statutes allowing providers and patients to enter into binding arbitration agreements. However, as in the case of Alaska, overly restrictive statutory provisions--such as those that preclude providers from requiring patients to enter into agreements to arbitrate as a condition of care, that allow the unilateral revocation by the patient of the agreement to arbitrate, or that add the cumbersome requirement of having a panel of three arbitrators--have limited the use of this ADR process Many proponents of arbitration propose eliminating such obstacles in order to provide broad flexibility to voluntary binding arbitration. Others suggest that non-binding arbitration be ordered by the courts every time a lawsuit is filed as a way to get quicker and more consistent resolution of medical malpractice lawsuits. It is not known whether mandatory non-binding arbitration will reduce overall costs associated with malpractice claims.

The Task Force recommends that a mandatory, court-ordered non-binding arbitration process be enacted in Alaska for all medical malpractice cases. The

process would entail the submission of all disputes to a neutral arbitrator with known skill in malpractice or other personal injury claims. The arbitrator would be selected from a panel developed by the courts with input from all parties. The arbitrator would conduct a hearing after each affected party had been provided reasonable opportunity (discovery) to investigate the claim. Either party would have the right to reject the arbitrator's decision and proceed to trial.

It is further recommended that the current three-person expert panel review system be replaced by having a single court-appointed physician or other provider serve as a neutral expert as an integral part of the proposed non-binding arbitration process. This expert should be adequately compensated and should have duties and responsibilities similar to those currently given to the expert advisory panel under AS 09.55.536, but should also be asked to render an opinion as to liability and to answer specific questions posed by the arbitrator.

In addition, the following time limits and requirements should be applied to the arbitration process:

- Parties to the suit will be allowed not more than 120 days from the date upon which the defendant files an answer to the complaint for discovery;
- The arbitration hearing may last no more than three days;
- The arbitrator will produce a decision in writing, admissible at trial, within thirty days;
- The entire arbitration process must be completed within 300 days from the date of filing of the lawsuit.

Lastly, the Task Force recommends that this court-ordered process be installed for an experimental period of five years, and that a study be conducted to assess: (1) litigant satisfaction with the process; (2) disposition rates to ensure that the process leads to timely resolution of claims; and (3) costs to litigants.

RECOMMENDATION # 15:

The Task Force recommends that the Legislature adjust the level of pre-judgement interest charged in medical malpractice cases from 10.5% to the prevailing interest rate.

As its final recommendation in the area of medical malpractice, the Task Force suggests that the Alaska State Legislature examine the reasonableness of the current

statutory requirement for the payment of pre-judgement interest in malpractice cases at the set annual rate of 10.5 percent (see Finding #13). The Task Force believes that a more reasonable approach to determining the pre-judgement interest rate would be to follow the federal courts in using the prevailing rate of yield of short-term U.S. Treasury bills.

C. IMPLEMENTATION TIMETABLE

The Task Force strongly encourages the Alaska State Legislature's prompt enactment of all of the recommendations presented in this chapter. The timetable for actual implementation of these recommendations is presented in Table 4-6 on the following page. As shown on this table, the Task Force also calls for immediate implementation of nearly all its recommendations following passage of the required legislation. The only exceptions to this are the following:

- Several steps will be involved in the implementation of the statewide health care expenditure limits. First and foremost will be the establishment of the Alaska Health Care Authority, which will have responsibility for implementing these limits. Assuming that legislation is enacted and the Authority established in the first half of 1993, during its first year of operation the Authority's activities will be focused on collecting the necessary data to establish the initial expenditure limits and obtaining the necessary federal waivers to ensure that payments made under federal programs to Alaska health care providers are consistent with those established through the Authority's negotiation process. Following this initial data collection period, the expenditure limits would be phased in over a three-year period, beginning in 1994 and ending in 1996. The statewide expenditure limits would be in full effect beginning in 1997.

- All but one of the Task Force's interim short term recommendations for improving access should be implemented immediately. For example, as indicated in Table 4-6, small group market reform would be implemented in 1993. However, as discussed earlier, the Task Force calls for the use of community rating in the small group market to be phased in over a three to five period. The small group market reforms would provide the basis for moving to the community ratings, with the rating bands established as part of this reform gradually tightened from 1994 through 1996 until the desired community rates are achieved.

- Finally, as discussed earlier, the Task Force strongly believes that a single payer financing system is the most appropriate model for providing coverage to all Alaskans. We recognize however, that while it is hoped that a single payer system will be enacted by the Alaska State Legislature in 1993, the possibility exists that further public education and

Table 4-6
Timetable for Implementation of Task Force Recommendations

	RECOMMENDATION	TIMEFRAME
1.	Establish Alaska Health Care Authority	Immediate
2.	Establish Statewide Expenditure Limits	
	▪ Collect/analyze data to establish initial limits	1993
	▪ Obtain necessary federal waivers	1993
	▪ Phase-in expenditure limits	1994 - 1996
	▪ Expenditure limits in full effect	1997
3.	Expand State's authority to approve/disapprove insurer rate filings	Immediate
4.	Small market insurance reform	1993
5.	Phase-in community rating in small group market	1994 - 1996
6.	Establish State-sponsored health insurance pooling arrangements	1993
7.	Establish program to cover low-income uninsured children and pregnant women	1993
8.	Establish a single payer health care financing system	
	▪ Conduct program of public education/dialogue on issue	1993 - 1994
	▪ Negotiate and obtain necessary federal waivers to bring all payers into the system	1993 - 1994
	▪ Implement single payer financing system	1995
9.	Develop initiatives to attract and retain health professions in underserved areas	1993
10.	Develop more flexible licensure standards	1993
11.	Strengthen/expand Certificate of Need program	1993
12.	Devote adequate resources to maintain a strong public health infrastructure	1993 onward
13.	Reduce the statute of limitations for medical malpractice claims for birth-related injuries	1993
14.	Replace existing pre-trial screening process with court ordered non-binding arbitration on a demonstration basis	1993 - 1998
15.	Adjust the level of pre-judgement interest charged to the prevailing interest rate	1993

community-based dialogue will be required to generate the public support necessary for passage of this legislation. For this reason, the timetable presented in Table 4-6 calls for the conduct of a broad-based public education program designed to increase community awareness and discussion about the benefits of the single payer system. During the same time period, the Alaska Health Care Authority should be charged with the responsibility for developing detailed specifications for the single payer system, and engaging in discussions and negotiations with the federal government and representatives of the Alaska Native population to secure their participation in the system. Legislation should also be enacted authorizing the AHCA to submit requests for the federal waivers necessary to implement a single payer system.[14] Based upon this timeframe, implementation of a single payer financing system in the state would begin in 1995.

With respect to the public education efforts directed at increasing Alaskans' awareness of the benefits of a single payer system, the Task Force recognizes that our authorization expires on February 1, 1993. Because we believe these public education efforts may be critically important to the successful establishment of the single payer system, we are extremely concerned that there be a single entity assigned responsibility for coordinating these education and outreach efforts and given sufficient resources to do so. We therefore strongly recommend that the legislation establishing the Alaska Health Care Authority also charge the Authority with the responsibility for coordinating efforts to increase the public's understanding and awareness of the benefits of a single payer system.

---

[14] The Task Force recognizes that prior to the establishment of such a program in Alaska, legislation designed to provide universal coverage for all Americans may be enacted at the national level. If the approach to achieving universal coverage embodied in the federal statute is not a single payer model (i.e., it involves an employer mandate or a "pay or play" approach), given the Alaska environment and the problems associated with linking health care coverage and employment, the Task Force further urges that the Legislature authorize the Authority to request the necessary federal waivers to implement a single payer system in lieu of any other approaches that might be embodied in the federal statue.

REFERENCES

Agency for Health Care Policy Research. 1991. Delivering Essential Health Care Services in Rural Areas: An Analysis of Alternative Models. Rockville, MD: U.S. Department of Health and Human Services (May) No. 91-0017.

Alaska Bureau of Vital Statistics. 1992. 1988-1989 Annual Report. Juneau (July).

Alaska Department of Health and Social Services. 1992. Practice Sites: State Primary Care Development Strategies. Juneau: Division of Public Health, proposal to the Robert Wood Johnson Foundation (October 5).

Alaska Division of Insurance. 1990. 53rd Annual Report: 1990 Calendar Year.

Alaska Department of Labor. 1991. Alaska Population Projections. Juneau (November).

Alaska Native Health Board. 1991. Access to Care: Crisis for Alaska Natives. Anchorage (January).

American College of Obstetricians and Gynecologists. 1992. Professional Liability and Its Effects: Report of a 1992 Survey of ACOG's Membership. Washington, D.C.

American Medical Association. 1991. Advocacy Briefs: The Impact of Professional Liability on Access to Health Care. Chicago: American Medical Association, Office of Policy, Communication, and Advocacy Support. The brief references: Reynolds, R. 1990. The Cost of Medical Professional Liability in the 1980s. Chicago: Center for Health Policy Research, American Medical Association. The 1989 estimate of the cost of defensive medicine is based on earlier estimate, see: Reynolds, R.A., Rizzo, J.A., and Gonzales, M.S. 1987. "The Cost of Medical Professional Liability" Journal of the American Medical Association 257:2776-2781.

American Public Health Association. 1992. America's Public Health Care Report: A State-by-State Report on the Health of the Public. Washington, D.C. (November).

Anchorage Daily News. 1992. Anchorage's Cost of Living Up 3.2 Percent. (August 14).

Bovbjerg, R., Tancredi, L., and Gaylin, D. 1991. Obstetrics and Malpractice: Evidence on the Performance of a Selective No-Fault System. Journal of the American Medical Association 265:2836-2843.

Butler, P. et. al. 1991. Access and the Uninsured: A Guide for States. Portland, Maine: National Academy for State Health Policy (March).