ALASKA LEGISLATURE COMMITTEE FILES 1993-1994 8672

8274 SENATE HEALTH EDUCATION & SOCIAL SERVICES

		FY 95	FY 96	FY 97	FY 98
	Fee Reporting				
8	Document Processing Clerk III R-10 @$36.9	295.2	295.2	295.2	295.2
3	3 Clerk III R-8 @$33.3	99.9	99.9	99.9	99.9
1	Investigator III R-18 @$58.2	58.2	58.2	58.2	58.2
2	Investigator II R-16 @$51.2	102.4	102.4	102.4	102.4
1	Publication Specialist II R-16 @$51.2	51.2	51.2	51.2	51.2
1	Analyst/Programmer III R-17 @$54.5	54.5	54.5	54.5	54.5
16	Total:	661.4	661.4	661.4	661.4
	Travel:	25.0	25.0	25.0	25.0
	Contractual- $10.6 per position	169.6	169.6	169.6	169.6
	Office space per position-				
	12 mths/$1.80/sq ft/175 sq ft = $3.8				
	Miscellaneous contractual- $6.8				
	Supplies: $1.0/position	16.0	16.0	16.0	16.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after	193.6	16.0	16.0	16.0
	Printing Annual Provider Price List	15.0	15.0	15.0	15.0
	(assuming $.5 per copy, 30 copies printed)				
	Public Health Improvement Plan				
1	Health & Soc Ser Planner III R-21 @$70.1	70.1	70.1	70.1	70.1
1	Health & Soc Ser Planner I R-17 @$$54.5	54.5	54.5	54.5	54.5
0	Clerk-Typist III R-8 @$33.3	0.0	0.0	0.0	0.0
2	Total:	124.6	124.6	124.6	124.6
	Travel:	20.0	20.0	20.0	20.0
	Contractual- $10.6 per position	21.2	21.2	21.2	21.2
	Office space per position-				
	12 mths/$1.80/sq ft/175 sq ft = $3.8				
	Miscellaneous contractual- $6.8				
	Supplies: $1.0/position	2.0	2.0	2.0	2.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after	24.2	2.0	2.0	2.0
	Contract Funds:	63.5	63.5	63.5	63.5

DRAFT

		FY 95	FY 96	FY 97	FY 98
	Federal Medicaid Waiver				
	Contract w/Dept. of Law for representation				
	in Washington D.C.	100.0	100.0	100.0	100.0
	NOTE: These figures are estimates. The actual number could be significantly higher.				
	Develop Incentives to Attract Health Care Providers				
	Forgiveness of Student loans: A loan forgiveness program would require legislation in order				
	to be enacted, so no expense amounts for this are included in this fiscal note. As an				
	estimate, a 1992 bill, CSHB 442 (HES) carried a fiscal note with costs ranging from $26.7				
	in the second year to $347.5 in the sixth.				
	Enrollment				
2	Chief, R-22 @$74.5	0.0	0.0	0.0	149.0
2	Eligibility & Qual Ctrl Tech II R-18 @$58.2	0.0	0.0	0.0	116.4
2	Eligibility Tech IV R-16 @$51.2	0.0	0.0	0.0	102.4
14	Eligibility Tech II R-12 @$41.0	0.0	0.0	0.0	574.0
1	Analyst Programmer V R-21	0.0	0.0	0.0	70.5
1	Analyst Programmer IV R-19 @$61.9	0.0	0.0	0.0	61.9
2	Investigator III R-18 @$58.2	0.0	0.0	0.0	116.4
1	Acct Tech II, R-14 @$45.2	0.0	0.0	0.0	45.2
1	Data Entry Center Supervisor, R 14 @$45.2	0.0	0.0	0.0	45.2
1	Document Processor IV, R-12 @$41.0	0.0	0.0	0.0	41.0
2	Document Processor III, R-10 @$36.9	0.0	0.0	0.0	73.8
1	Document Processor II, R-8 @$33.3	0.0	0.0	0.0	33.3
49	Document Processor I, R-7 @$31.8	0.0	0.0	0.0	1,558.2
1	Accounting Clerk III, R-10 @$36.9	0.0	0.0	0.0	36.9
2	Clerk Typist III, R-8 @$33.3	0.0	0.0	0.0	66.6
82	Total:	0.0	0.0	0.0	3090.8
	Travel	0.0	0.0	0.0	0.0
	Contractual: $10.6/position	0.0	0.0	0.0	869.2
	Office space per position-				
	12 mths/$1.80/sq ft/175 sq ft = $3.8				
	Miscellaneous contractual- $6.8				
	Enrollment booklet				
	350,000 copies/$450/1000 copies				157.5
	Supplies: $1.0/position	0.0	0.0	0.0	82.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after	0.0	0.0	0.0	992.2
	Capital Expenditure:				
	Microfilm Equipment				175.9
	(This unit is designed to be very comparable to the PFD division)				

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		FY 95	FY 96	FY 97	FY 98
	Develop Long-Term Health Care Plan				
1	Health & Soc Serv Planner III R-21 @$70.1		70.1	70.1	70.1
1	Health & Soc Serv Planner II R-19 @$61.9		61.9	61.9	61.9
1	Health & Soc Serv Planner I R-17 @$54.5		54.5	54.5	54.5
1	Clerk-Typist III R-8 @$33.3		33.3	33.3	33.3
4		0.0	219.8	219.8	219.8
	Travel:		20.0	20.0	20.0
	Contract Funds:	0.0	????	????	????
	Contractual- $10.6 per position	0.0	42.4	42.4	42.4
	Office space per position-				
	12 mths/$1.80/sq ft/175 sq ft = $3.8				
	Miscellaneous contractual- $6.8				
	Supplies: $1.0/position	0.0	4.0	4.0	4.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after	0.0	48.4	48.4	48.4
	Miscellaneous supplies:	20.0	20.0	20.0	20.0
	General office equipment:				
	Recording equipment $.2	0.2	0.0	0.0	0.0
	3 Fax @ $3.0 = $9.0	9.0	0.0	0.0	0.0
	Conference Table $4.0	4.0	0.0	0.0	0.0
	Conference chairs 25 @ $220	5.5	0.0	0.0	0.0
	Storage cabinets 10 @ $.3	3.0	0.0	0.0	0.0
	File cabinets 50 @ $.6	15.0	15.0	0.0	0.0
	Telephone system @$1.3/position	71.5	26.0	42.9	508.3
	Photocopier @$90.0	90.0	0.0	0.0	0.0
	Photocopier mid size 2 @ 7.0	14.0	0.0	0.0	0.0
	Photocopier desktop 2 @$1.2	2.4	0.0	0.0	0.0
	Typewriters 10 @$.5	5.0	0.0	0.0	0.0
	Reception chairs 3 @$220 =	0.7	0.0	0.0	0.0
	Mailing equipment $.5	0.5	0.5	0.5	0.5
	Total Number of Positions:	55.0	75.0	108.0	499.0
	Total Salary Cost:	2,654.5	3,641.7	5,502.7	18,581.7
	Total Cost other than Salary:	15,437.4	4,614.1	5,344.2	12,930.2
	Grand Total:	18,091.9	8,255.8	10,846.9	31,511.9
	4 year total:	68,706.5			
	NOTE: These estimates do not take into account 1) any costs to the workers' compensation system resulting from the merger of occupational and non-occupational health care, nor 2) the impact of this plan on premium tax receipts by the general fund.				

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FISCAL NOTE

STATE OF ALASKA
1994 LEGISLATIVE SESSION

BILL NO. SB 284

Revision Date: 3/22/94
Title: Comprehensive Health Insurance Act

Sponsor: Senate HESS
Requestor:

Department Affected: Commerce and Economic Development
BRU: Alaska Health Insurance Corporation
Component:

COMPONENT SERIAL NO.

Expenditures/Revenues:

OPERATING EXPENDITURES	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
PERSONAL SERVICES	2,306.7	3,293.9	3,293.9	6,384.7		
TRAVEL	579.6	372.4	388.8	331.8		
CONTRACTUAL	1,811.7	1,223.4	1,320.7	2,144.6		
SUPPLIES	67.0	87.0	87.0	169.0		
EQUIPMENT	779.1	330.5	111.9	1,317.3		
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	5,544.1	5,307.2	5,202.3	10,347.4		
CAPITAL EXPENDITURES	*500.0	*500.0	*500.0	*11,332.9		
CHANGE IN REVENUES ( )						
FUND SOURCE						
1002 Federal Receipts						
1003 GF Match						
1004 GF	6,044.1	5,807.2	5,702.3	21,680.3		
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	6,044.1	5,807.2	5,702.3	21,680.3		

Estimate of current year (FY 94) cost: $

POSITIONS						
FULL-TIME	47.0	67.0	67.0	231.0		
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary.)
Please see attached.
*The capital costs are based upon information provided by the Department of Health and Social Services.

Prepared by: David J. Walsh
Division: Insurance
Phone: 465-2515
Date: 3/22/94

Approved by Commissioner: Paul Fuhs
Agency: Commerce and Economic Development
Date:

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						FY 95	FY 96	FY 97	FY 98
	SB 284 Fiscal Note for the Alaska Health Insurance Corporation								
	Board of Directors: (See Attached Charts)								
		7 members $400/day honorarium				280.0	123.2	117.6	98.0
		FY95 100 days $280.0							
		FY96 44 days $123.2							
		FY97 42 days 117.6							
		FY98 35 days 98.0							
		Travel				204.6	134.2	156.2	118.8
	Staff:								
# positions									
1	Executive Director PX R-28					95.6	95.6	95.6	95.6
1	Deputy Director R-23					79.3	79.3	79.3	79.3
1	Administrative Officer III R-21					70.5	70.5	70.5	70.5
1	Secretary R-10					36.9	36.9	36.9	36.9
2	2 Clerk-Typist III R-[illegible] @$[illegible].3					66.6	66.6	66.6	66.6
1	Accounting Clerk III R-10					36.9	36.9	36.9	36.9
1	Information Officer R-17					54.5	54.5	54.5	54.5
1	Paralegal Assistant II R-16					51.2	51.2	51.2	51.2
1	Administrative Asst III R-16 @$51.2					51.2	51.2	51.2	51.2
1	Publication Specialist II R-16 @$51.2					51.2	51.2	51.2	51.2
1	Acct Tech I R-12 @$41.0					82.0	82.0	82.0	82.0
1	Acct Clerk III R-10 @36.9					36.9	36.9	36.9	36.9
13					Total:	712.8	712.8	712.8	712.8
		Travel:				50.0	50.0	50.0	50.0
	Contractual costs per person:			10.6		137.8	137.8	137.8	137.8
	12 mths/$1.80/sq ft/175 sq ft = $3.8								
	Miscellaneous contractual- $6.8								
	Contract w/Dept. of Law for legal support								
	services (1 AAG & 1 secretary)					140.0	140.0	140.0	140.0
	Supplies: 1.0/position					13.0	13.0	13.0	13.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after					157.3	13.0	13.0	13.0

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		FY 95	FY 96	FY 97	FY 98
	Public Involvement Process:				
	Advertising (2 time newspaper ads Juneau,	45.0	24.0	36.0	11.0
	Anchorage, Fairbanks, & Ketchikan)				
	$1.0/hearing 45 hearings (FY95)				
	24 hearings (FY96)				
	36 hearings (FY97)				
	11 hearings (FY98)				
	Teleconference hearings via LIO sites	945.0	168.0	252.0	77.0
	Full service set-up for 4-6 hr mtg.				
	$25/hr/LIO site plus toll costs.				
	LIO has 22 sites, $4,400 plus toll costs				
	of $2,600 per 8 hr conference.				
	$7,000/8hr 45 hearings/3 days = 135 days (FY95)				
	24 hearings/1 day = 24 days (FY96)				
	36 hearings/1 day = 36 days (FY97)				
	11 hearings/1 day = 11 days (FY98)				
	This assumes no transcription of hearings or minutes.				
	Printing handouts for hearings/meetings	5.0	2.7	4.0	1.2
	7000 copies of 2 back-to-back pages = $650				
	$650/7000 = $.093/item rounded to $.10				
	Assuming 50,000 copies x $.10 = $5,000 (FY95)				
	24/45 = 53% $5,000 x 53% = $2,666 or $2.7 (FY96)				
	36/45 = 80% $5,000 x 80% = $4,000 or $4.0 (FY97)				
	11/45 = 24% $5,000 x 24% = $1,222 or $1.2 (FY98)				
	Data Collection/Analysis and Claims:				
1	Chief R-22 @ $74.5	74.5	74.5	74.5	74.5
1	Analyst/Programmer IV R-19 @$61.9	61.9	61.9	61.9	61.9
1	Analyst/Programmer III R-17 @$54.5	54.5	54.5	54.5	54.5
1	Secretary R-10 @$36.9	36.9	36.9	36.9	36.9
	Fees and premiums Section				
1	Economist II R-20 @ $65.8	65.8	65.8	65.8	65.8
2	Research Analyst III R-18 @ $58.2	116.4	116.4	116.4	116.4
2	Research Analyst II R-16 @ $51.2	102.4	102.4	102.4	102.4
3	Statistical Tech I R-12 @ $41.0	123.0	123.0	123.0	123.0
3	Statistical Tech II R-14 @ $45.2	135.6	135.6	135.6	135.6
1	Statistical Clerk R-10 @ $36.9	36.9	36.9	36.9	36.9

						FY 95	FY 96	FY 97	FY 98
	Operational Expense Section (start in FY 1996)								
1	Economist II R-20 @ $65.8						65.8	65.8	65.8
4	Statistical Tech I R-12 @ $41.0						164.0	164.0	164.0
3	Statistical Tech II R-14 @ $45.2						135.6	135.6	135.6
2	Statistical Clerk R-10 @ $36.9						73.8	73.8	73.8
3	Research Analyst II R-16 @ $51.2						153.6	153.6	153.6
3	Research Analyst III R-18 @ $58.2						174.6	174.6	174.6
32					Total:	807.9	1,575.3	1,575.3	1,575.3
	Note: (This unit is comparable to the Research and Analysis								
	section in the department of Labor with 38 positions)								
	Contractual- $10.6 per position					169.6	339.2	339.2	339.2
	Office space per position-								
	12 mths/$1.80/sq ft/175 sq ft = $3.8								
	Miscellaneous contractual- $6.8								
	Supplies: $1.0/position					16.0	32.0	32.0	32.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after					193.6	209.6	32.0	32.0
	Capital Expenditure:								
	Contractual Claims Handling/Data Collection costs:					500.0	500.0	500.0	11,157.0
	The amounts for '95 to '97 assume that data is downloaded from computer files								
	maintained by hospitals, insurers, etc. Not all of the data required by the bill								
	will be included in these computer files. This amount also assumes that data								
	from IHS, self-insurers, etc will not be included until the appropriate waivers								
	can be obtained.								
	The '98 amount assumes a decreasing per claim rate equal to what Medicaid is currently paying.								
		Claims volume (,000):	Cost per claim						
		up to 650	$6.23						
		650 to 675	$4.75						
		675 to 700	$3.50						
		over 700	$2.25						
	4.712 claims per person/ 500,000 non-medicaid people in Alaska = 2.356 million claims per								
	year. Plus 1.411 million claims from medicaid people = 3.767 million total claims.								
	While it is likely that the cost per claim would decrease with the additional number of claims,								
	the required data collection system would be expanded from what is currently in use for								
	Medicaid. We assumed that the increases and decreases will cancel out.								

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		FY 95	FY 96	FY 97	FY 98
	Fee Reporting				
8	Document Processing Clerk III R-10 @$36.9	295.2	295.2	295.2	295.2
3	3 Clerk III R-8 @$33.3	99.9	99.9	99.9	99.9
1	Investigator III R-18 @$58.2	58.2	58.2	58.2	58.2
2	Investigator II R-16 @$51.2	102.4	102.4	102.4	102.4
1	Publication Specialist II R-16 @$51.2	51.2	51.2	51.2	51.2
1	Analyst/Programmer III R-17 @$54.5	54.5	54.5	54.5	54.5
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	Office space per position-				
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	Equipment: 12.1/position 1st yr, 1.0/pos. after	193.6	16.0	16.0	16.0
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	(assuming $.5 per copy, 30 copies printed)				
	Public Health Improvement Plan				
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1	Health & Soc Ser Planner I R-17 @$$54.5	54.5	54.5	54.5	54.5
0	Clerk-Typist III R-8 @$33.3	0.0	0.0	0.0	0.0
2	Total:	124.6	124.6	124.6	124.6
	Travel:	20.0	20.0	20.0	20.0
	Contractual- $10.6 per position	21.2	21.2	21.2	21.2
	Office space per position-				
	12 mths/$1.80/sq ft/175 sq ft = $3.8				
	Miscellaneous contractual- $6.8				
	Supplies: $1.0/position	2.0	2.0	2.0	2.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after	24.2	2.0	2.0	2.0
	Contract Funds:	63.5	63.5	63.5	63.5
	Federal Waivers for Medicaid etc				
	Contract w/Dept. of Law for representation				
	in Washington D.C.	100.0	100.0	100.0	100.0
	NOTE: These figures are estimates. The actual number could be significantly higher.				

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		FY 95	FY 96	FY 97	FY 98
	Develop Incentives to Attract Health Care Providers				
	Forgiveness of Student loans: A loan forgiveness program would require legislation in order to be enacted, so no expense amounts for this are included in this fiscal note. As an estimate, a 1992 bill, CSHB 442 (HES) carried a fiscal note with costs ratinging from $26.7 million in the second year to $347.5 million in the sixth.				
	Enrollment				
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2	Eligibility Tech IV R-16 @$51.2	0.0	0.0	0.0	102.4
14	Eligibility Tech II R-12 @$41.0	0.0	0.0	0.0	574.0
1	Analyst Programmer V R-21	0.0	0.0	0.0	70.5
1	Analyst Programmer IV R-19 @$61.9	0.0	0.0	0.0	61.9
2	Investigator III R-18 @$58.2	0.0	0.0	0.0	116.4
1	Acct Tech II, R-14 @$45.2	0.0	0.0	0.0	45.2
1	Data Entry Center Supervisor, R 14 @$45.2	0.0	0.0	0.0	45.2
1	Document Processor IV, R-12 @$41.0	0.0	0.0	0.0	41.0
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1	Document Processor II, R-8 @$33.3	0.0	0.0	0.0	33.3
49	Document Processor I, R-7 @$31.8	0.0	0.0	0.0	1,558.2
1	Accounting Clerk III, R-10 @$36.9	0.0	0.0	0.0	36.9
2	Clerk Typist III, R-8 @$33.3	0.0	0.0	0.0	66.6
82	Total:	0.0	0.0	0.0	3090.8
	Travel	0.0	0.0	0.0	0.0
	Contractual: $10.6/position	0.0	0.0	0.0	869.2
	Office space per position-				
	12 mths/$1.80/sq ft/175 sq ft = $3.8				
	Miscellaneous contractual- $6.8				
	Enrollment booklet				
	350,000 copies/$450/1000 copies				157.5
	Supplies: $1.0/position	0.0	0.0	0.0	82.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after	0.0	0.0	0.0	992.2
	Capital Expenditure:				
	Microfilm Equipment				175.9
	(This unit is designed to be very comparable to the PFD division)				

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		FY 95	FY 96	FY 97	FY 98
	Develop Long-Term Health Care Plan				
1	Health & Soc Serv Planner III R-21 @$70.1		70.1	70.1	70.1
1	Health & Soc Serv Planner II R-19 @$61.9		61.9	61.9	61.9
1	Health & Soc Serv Planner I R-17 @$54.5		54.5	54.5	54.5
1	Clerk-Typist III R-8 @$33.3		33.3	33.3	33.3
4		0.0	219.8	219.8	219.8
	Travel:		20.0	20.0	20.0
	Contract Funds:	0.0	????	????	????
	Contractual- $10.6 per position	0.0	42.4	42.4	42.4
	Office space per position-				
	12 mths/$1.80/sq ft/175 sq ft = $3.8				
	Miscellaneous contractual- $6.8				
	Supplies: $1.0/position	0.0	4.0	4.0	4.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after	0.0	48.4	48.4	48.4
	Miscellaneous supplies:	20.0	20.0	20.0	20.0
	General office equipment:				
	Recording equipment $.2	0.2	0.0	0.0	0.0
	3 Fax @ $3.0 = $9.0	9.0	0.0	0.0	0.0
	Conference Table $4.0	4.0	0.0	0.0	0.0
	Conference chairs 25 @ $220	5.5	0.0	0.0	0.0
	Storage cabinets 10 @ $.3	3.0	0.0	0.0	0.0
	File cabinets 50 @ $.6	15.0	15.0	0.0	0.0
	Telephone system @$1.3/position	61.1	26.0	0.0	213.2
	Photocopier @$90.0	90.0	0.0	0.0	0.0
	Photocopier mid size 2 @ 7.0	14.0	0.0	0.0	0.0
	Photocopier desktop 2 @$1.2	2.4	0.0	0.0	0.0
	Typewriters 10 @$.5	5.0	0.0	0.0	0.0
	Reception chairs 3 @$220 =	0.7	0.0	0.0	0.0
	Mailing equipment $.5	0.5	0.5	0.5	0.5
	Total Number of Positions:	47.0	67.0	67.0	231.0
	Total Salary Cost:	2,306.7	3,293.9	3,293.9	6,384.7
	Total Cost other than Salary:	3,737.4	2,513.3	2,408.4	15,295.6
	Grand Total:	6,044.1	5,807.2	5,702.3	21,680.3
	4 year total:	39,233.9			

NOTE: These estimates do not take into account 1) any costs to the workers' compensation system resulting from the merger of occupational and non-occupational health care, nor 2) the impact of this plan on premium tax receipts by the general fund.

DRAFT

Alaska State Legislature

Legislative Research Agency

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Phone: (907) 465-3991
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February 25, 1994

MEMORANDUM

TO: Senator Jim Duncan

FROM: Maureen Weeks MW
Legislative Analyst

RE: **Comparison of Senate Bill 284 and Senate Bill 270**
Research Request 94.157

You asked us to compare two health care reform bills before the legislature this year. Senate Bill 284/House Bill 451 and Senate Bill 270/House Bill 414. The comparison is attached.

We chose our questions from the topics covered in side-by-side comparisons of health care reform plans by the American Association of Retired Persons and the Intergovernmental Health Policy Project at the George Washington University. For your convenience, here is a table of contents.

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I hope this is useful for your purposes. If you have any questions would like additional information, please call.

Attachment

Summary Statement

SB 284/HB 451	SB 270/HB 414
Comprehensive reform using a market-based single-payer system with health care coverage for every legal Alaska resident	Commission analyzes health care reform proposals, makes changes in current health care systems, and recommends long-term reform

Definition:

"'Market based single payer system' means a system in which a single entity provides health insurance to all residents of the state and the insurance is based on market forces, including provider defined fees, defined patient copayments, sliding scale copayments for the indigent, provider fees that are posted or made otherwise available at the point of services, published or disseminated fees in comparative lists that allow fee comparison by consumers, voluntary expenditure targets, provider peer review and control of volume, utilization, and quality of health services, and a regularly published description of the various types of providers licensed to provide services in the benefit package." (Sec. 21.58.400(9))

Market Forces:

A "market-based" system uses market forces to make consumers more aware of the actual costs of health services and provides consumers with information enabling them to make more informed purchasing decisions. (Sec. 1 (b)(2).

Analysis of Cost-Benefits:

The commission is "not intended to be viewed as a comprehensive reform proposal." Instead, it would analyze cost-benefit of elements of reform proposals (Governor's transmittal letter, p. 1; and N. Usera, personal communication)

Does the Plan Describe a Benefits Package?

SB 284/HB 451	SB 270/HB 414
No. the corporation is to develop a package by December 31. 1995	No. the commission is to analyze and make recommendations on "defining a range of potential benefit packages" by January 1. 1996

Mandate to Develop Benefits Package:

The Alaska Health Insurance Corporation "shall" develop a "benefits package of health care services that enrollees in the state health insurance plan are entitled to receive" (21.58.110) "The corporation shall adopt regulations specifying the health care services required to be covered by the state health insurance plan . . ." (21.58.170(a))

"By December 31, 1995, the corporation shall . . . determine the health care services required under AS 21.58.170 . . ." (Sec. 12(3))

Public Participation:

The Alaska Health Corporation shall allow the public an "ongoing opportunity" to participate in decisions made by the board of directors about health care services residents want included in the benefit package. (Sec. 21.58.320)

Annual Review:

"The corporation shall . . . at least annually, review the health care benefits package and revise it as determined by the corporation, taking into consideration the health needs of the state, available funding, and other relevant factors as determined by the corporation . . . " (21.58.100(10))

Defining a Range of Potential Benefit Packages:

The Alaska Health Commission is to analyze health care reform proposals; recommend proposals to the governor and the legislature; and make recommendations on "defining a range of potential benefit packages for universal health care coverage for Alaskans -- on or before January 1, 1996" (Sec. 44.19.621(a)(5)(A) The commission would analyze plans placed before it, including universal coverage plans (N. Usera, personal communication).

Does the Bill Offer a Financing Plan?

SB 284/HB 451	SB 270/HB 414
No, the corporation is to present financing options to the governor and legislature by January 1, 1997	No, the commission is to analyze and make recommendations on "determining financing plans for recommended proposals" by January 1, 1996

Financing Options:

"[B]y January 1, 1997, the corporation shall . . . present options to the governor and the legislature on how to finance a state health insurance plan under a market based single payer system." Sec. 12 (6)

Public Participation in Decisions:

The Alaska Health Insurance Corporation "shall" give the public "an ongoing opportunity" to participate in the corporation's board of directors' decisions regarding financing options and revenue sources that should be used to finance the health plan. (Sec. 21.58.320)

Determining Financing Plans:

The Alaska Health Commission is to analyze health care reform proposals; recommend proposals to the governor and the legislature; and make recommendations on "determining financing plans for recommended proposals -- on or before January 1, 1996." 44.19.620(a)(5)(D)

Summary Statement

SB 284/HB 451	SP 270/HB 414
Comprehensive reform using a market-based single-payer system with health care coverage for every legal Alaska resident	Commission analyzes health care reform proposals, makes changes in current health care systems, and recommends long-term reform

Definition:

"'Market based single payer system' means a system in which a single entity provides health insurance to all residents of the state and the insurance is based on market forces, including provider defined fees, defined patient copayments, sliding scale copayments for the indigent, provider fees that are posted or made otherwise available at the point of services, published or disseminated fees in comparative lists that allow fee comparison by consumers, voluntary expenditure targets, provider peer review and control of volume, utilization, and quality of health services, and a regularly published description of the various types of providers licensed to provide services in the benefit package.' (Sec. 21.58.400(9))

Market Forces:

A "market-based" system uses market forces to make consumers more aware of the actual costs of health services and provides consumers with information enabling them to make more informed purchasing decisions. (Sec. 1 (b)(2).

Analysis of Cost-Benefits:

The commission is "not intended to be viewed as a comprehensive reform proposal." Instead, it would analyze cost-benefit of elements of reform proposals (Governor's transmittal letter, p. 1; and N. Usera, personal communication)

Does the Plan Provide for Universal Coverage?

SB 284/HB 451	SB 270/HB 414
Yes, by Jan. 1, 1998	No, it promotes access to affordable care

Universal Coverage:

"The purpose of this Act is to . . . create a market based single payer state health insurance system that provides health insurance to all residents of the state . . ." (Sec. 1(b)(2))

"By January 1, 1998, the corporation shall . . . begin to provide health insurance coverage for state residents . . . " (Sec. 12(7))

Access to Affordable Care:

"It is the intent of the legislature to promote access to affordable, quality health care for Alaskans . . . " (Sec. 2).

Governor's transmittal letter states. "This bill addresses improvements to the delivery, quality, access, cost and financing of health care services. The bill is not intended to be viewed as a comprehensive reform proposal." (1/28/94, p. 2)

Does the Plan Describe a Benefits Package?

SB 284/HB 451	SB 270/HB 414
No. the corporation is to develop a package by December 31. 1995	No. the commission is to analyze and make recommendations on "defining a range of potential benefit packages" by January 1. 1996

Mandate to Develop Benefits Package:

The Alaska Health Insurance Corporation "shall" develop a "benefits package of health care services that enrollees in the state health insurance plan are entitled to receive" (21.58.110) "The corporation shall adopt regulations specifying the health care services required to be covered by the state health insurance plan . . ." (21.58.170(a))

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The Alaska Health Commission is to analyze health care reform proposals: recommend proposals to the governor and the legislature; and make recommendations on "defining a range of potential benefit packages for universal health care coverage for Alaskans -- on or before January 1, 1996" (Sec. 44.19.621(a)(5)(A) The commission would analyze plans placed before it, including universal coverage plans (N. Usera, personal communication).

How is the Plan to be Administered?

SB 284/HB 451	SB 270/hb 414
By the Alaska Health Insurance Corporation	By the Alaska Health Commission
Membership: 7 directors appointed by the governor to 4-year terms	Membership: 3 members appointed by the governor to six-year terms
Meetings: at least quarterly	Meetings: at least quarterly
Compensation: $400 per meeting day plus travel and per diem	Compensation: Range 26C

Make-up of the Board:

The majority of directors are to be expert in health care issues; consumers and providers are to be "fairly represented"; geographic and gender composition are to approximate that of the state.

Committees of Experts:

The commission "shall" establish committees of experts to make recommendations.

Comparison to Permanent Fund Board:

In testimony before the legislature, the bill's authors compare it to "arm's length" entities such as the Alaska Permanent Fund Board.

Advisory Committees:

The commission "may" establish advisory committees to conduct research or investigation (committees must include at least one commission member) and "may" adopt regulations establishing fees for services provided by the commission.

Comparison to Public Utilities Commission:

In testimony before the legislature, the Governor's representative compared the commission to a public utilities commission.

Does the Bill Offer a Financing Plan?

SB 284/HB 451	SB 270/HB 414
No, the corporation is to present financing options to the governor and legislature by January 1, 1997	No, the commission is to analyze and make recommendations on "determining financing plans for recommended proposals" by January 1, 1996

Financing Options:

"[B]y January 1, 1997, the corporation shall . . . present options to the governor and the legislature on how to finance a state health insurance plan under a market based single payer system." Sec. 12 (6)

Public Participation in Decisions:

The Alaska Health Insurance Corporation "shall" give the public "an ongoing opportunity" to participate in the corporation's board of directors' decisions regarding financing options and revenue sources that should be used to finance the health plan. (Sec. 21.58.320)

Determining Financing Plans:

The Alaska Health Commission is to analyze health care reform proposals; recommend proposals to the governor and the legislature; and make recommendations on "determining financing plans for recommended proposals -- on or before January 1, 1996." 44.19.620(a)(5)(D)

How Does the Plan Control Costs?

SB 284/HB 451	SB 270/HB 414
Sets health care expenditure target, with annual review	Simplifies administration with uniform procedures
Uses a monitoring system: physicians voluntarily regulate health care costs (followed by mandatory regulation if necessary)	Requires state approval for rates charged by insurers
Posts and publishes provider prices for consumer comparison shopping	Sets up pools to share risks
Requires providers to provide health care data	Establishes mandatory non-binding arbitration in medical malpractice suits, with arbitrator's decision admissible in court
Uses copayments to encourage shopping	Considers altering hospital licensing to lower use of expensive acute care
Simplifies administration with uniform claims forms and claims clearinghouse	
Uses preventive and wellness programs	
Promoting effective medical treatments	
Identifying the best provider mix and encouraging effective medical treatments	

How Does the Plan Control Costs? (Continued)

SB 284/HB 451	SB 270/HB 414
General Statement: "The purpose of this Act is to . . . increase access to health care by containing the rate of increase of health care expenditures . . . " (Sec. 1(b)(1) Expenditure Target: "The corporation shall prescribe by regulation a statewide health care expenditure target . . . [T]he base year . . . shall be calendar year 1993 . . . The corporation annually shall adjust the . . . target . . . to reflect changes in the Consumer Price Index" as well as changes in demographics, medical technology, access to services, the burden of disease, elimination of unnecessary care, liability insurance costs, administrative costs and utilization patterns. (Sec. 21.58.270(a) and (b)) Voluntary Physician Compliance with Target: The expenditure target adopted by the corporation [is] a recommended target for expenditures within each specified category or subcategory of health care services or products . . . [P]roviders may voluntarily comply with the expenditure target and may take all appropriate steps not prohibited by law to attempt to ensure that annual expenditures for health care in the state do not exceed the expenditure target . . . " (Sec. 21.58.280)	General Statement "The analysis to be provided by the commission, particularly with regard to the cost, financing and implementation of health care reform, is critical, given the current fiscal circumstances facing the state. It is essential that the fiscal impact of health care reform be fully considered before further action is taken." (Governor's transmittal letter, 1/28/94, p. 2.) Uniform Procedures: No later than July 31, 1996, the director of the division of insurance, after considering the advice of the commission, shall adopt by regulation uniform claims forms, uniform standards and uniform procedures for the processing of data relating to billing for and payment of health care services provided to Alaskans." (44.19.628(a)) Rate Approval: Health insurance "rates, fees and payments . . . may not be excessive, inadequate or unfairly discriminatory" and "rates [paid] to providers . . . must be fair and reasonable." (Sec. 21.87.190(a)) A health insurer or health maintenance organization "shall" file rates or fees with the commission and the division of insurance (including changes). The division "shall" review the filing within 45 days and recommend approval or disapproval to the commission in writing. The commission shall hold a public hearing for comment on the filing." (Sec. 44.19.625 and 21.51.350 and 21.86.075)

How Does the Plan Control Costs? (Continued)

SB 284/HB 451	SB 270/HB 414

Mandatory Physician Compliance:

The corporation "shall" monitor the success of voluntary compliance. If the corporation determines (after three years) that voluntary compliance has "failed substantially" to meet the target, the corporation "shall" impose a mandatory expenditure limit, by regulation. (Sec. 21.58.300)

The corporation "may" regulate compliance by: imposing a mandatory limit on one or more subcategories or on specific items; establishing mandatory price and utilization controls; monitoring expenditures; and establishing cost-sharing recommendations. It may also directly assume all or part of cost-control functions (deductibles and copayments, information on provider fees, and the expenditure target). (Sec. 21.58.300(b))

Copayments:

After seeking input from the public, the corporation shall establish deductible and copayment amounts. (Sec. 21.58.170 and 21.58.180) In testimony before the legislature, the bill's authors have characterized the copayments as "substantial" and said the purpose would be to encourage consumers to "shop" for the best price.

Uniform Claims:

By June 31 (sic), 1995, the corporation "shall" complete and implement a uniform claims form (Sec. 21.58.110(4) and Sec. 12(2))

Pools:

The purpose of the commission is to [promote] the creation of pools for the purpose of sharing risks or purchasing insurance for health care services . . ." (Sec. 44.19.621(a)(4))

After consulting with the Alaska Health Commission, the director "shall" adopt regulation to create pools "for the purpose of sharing risks or purchasing insurance." (Sec. 21.87.285 and 21.86.320 and 21.87.285)

Mandatory Arbitration:

A person who files an action against a health insurer or a medical malpractice action against a health care provider shall submit the claim to the court for arbitration. Either party may reject the arbitrator's decision. The decision is admissible in court. (Sec. 09.55.535(a)-(e) and Sec. 09.55.565)

Hospital Licensing:

The commission is to analyze and make recommendations to the governor and legislature on "investigating alternatives to existing hospital licensing requirements to allow for less use of [expensive] acute care facilities." Deadline: January 1, 1997. (Sec. 44.19.622(a)(5)(H))

How Does the Plan Control Costs? (Continued)

SB 284/HB 414	SB 270/HB 414
Claims Clearinghouse: By December 31, 1995, the corporation "shall" establish a claims clearinghouse. A provider "shall" submit all claims for payment under the state health insurance plan to the claims clearinghouse. Subject to appropriation, the claims clearinghouse shall pay claims approved for payment by the corporation. (Sec. 21.58.220(a) and (b) and Sec. 12(3))	
Prevention and Wellness: The purpose of the Act is to . . . [use] preventive and wellness programs to reduce health care costs (Sec. 1(b)(3)(B)).	
Effective Treatments, Provider Mix: The corporation "shall" establish committees of experts to recommend how to control health care costs. The recommendations are to include: a greater emphasis on healthful lifestyles, prevention of disease and injury, promoting effective medical treatments, and identifying the optimal provider mix within the state. (Sec. 21.58.110(18))	

Does the Plan Allow Public Participation?

SB 284/HB 414	SB 270/HB 414
The Alaska Health Insurance Corporation sets up an "extensive" public involvement process allowing Alaskans to participate in decisions made by the board of directors	The Alaska Health Commission collects and analyzes data from public hearings. Except when adopting regulations or acting on rate filings, the Alaska Health Commission is exempt from the Open Meetings Act

Public Involvement Process:

"The corporation shall design, implement and maintain an extensive community based public involvement process [to allow] residents . . . to participate in decisions made by the corporation's board of directors regarding: health care services residents want included in the benefit package; financing options; revenue sources that should be used to finance the health plan; cost-sharing options; and administration of the health care plan." (Sec. 21.58.320)

"The [Alaska Health Insurance] Corporation shall . . . create and implement the formal public involvement process . . . for the purpose of gathering broad input on the state health insurance plan, options for financing the cost of coverage, cost-sharing of the health insurance plan, and the cost of the plan . . ." (Sec. 21.58.110(2)

"The corporation shall conduct a comprehensive public involvement process designed to solicit information and opinions regarding [health care services] required to be covered . . ." (Sec. 21.58.170(b)

Public Participation:

"The commission shall . . . collect and analyze data and information from public, private or other sources relating to the cost, delivery, or financing of health care services provided to Alaskans." The term "public" here refers to public hearings (N. Usera, personal communication)

Open Meetings Exemption:

"[M]eetings of the Alaska Health Commission, except for meetings concerning the adoption of regulations or actions on filings," are exempt from AS 44.62.310 (the Open Meetings Act). (Sec. 44.62.310(d)(6))

Rate and Filings Public Hearings:

"The commission shall hold a public hearing for comment on [rate] filing[s] and for verifying the basis for the filing[s]." (Sec. 44.19.629(b)(3)

Does the Plan Allow Public Participation? (Continued)

SB 284/HB 414	SB 270/HB 414
Regulations Take Public Requests Into Account: "The corporation shall adopt regulations specifying the health care services required to be covered by the state health insurance plan, taking into consideration the services requested by the public . . ." (Sec. 21.58.170(a)	

Does the Plan Include Data Collection?

SB 284/HB 451	SB 270/HB 414
Yes. plan sets up a health care data system to begin collecting data by December 31. 1994; invalidates licenses of providers who do not comply	Yes. plan sets up a system to collect and analyze health care data; providers and insurers must submit that data.

Comprehensive Data Collection:

"The corporation shall . . . establish [a] comprehensive health care data system . . ." Sec. 21.58.110(3)

The corporation "shall . . . establish the [health care data] system . . . and begin collecting data by December 31, 1994." (Sec. 12(1).

List of Data to be Collected:

"The corporation shall develop and periodically update a health care data system [based on] calendar year 1993 and [including] health care expenditures, including [the following]: capital expenditures associated with receiving health care; demographic data; clinical information, including patient diagnosis, type of provider, type of service, location and length of care, referral patterns, quality of care, and result of care; billing and payment data; and public health data, including vital statistics and health status. (Sec. 21.58.260(a))

Providers Must Submit Data . . .

Providers "shall" comply with requirements to submit claims data for the health care data system, including regulations adopted by the Alaska Health Insurance Corporation. (Sec. 21.58.260(b) and Sec. 08.02.025)

Commission Shall Collect Data:

"The purpose of the commission is to [establish and implement] a system for collecting and analyzing information and data relating to health care needs of and services provided to Alaskans." (Sec. 44.19.621(a)(1))

"The commission shall . . . collect and analyze data and information from public, private, or other sources relating to the cost, delivery, or financing of health care services provided to Alaskans." (Sec. 44.19.625(b)(2))

Providers and Insurers Must Provide Data:

"All persons and entities providing or insuring health care services to Alaskans shall provide, upon request or order of the commission, reports, data, health information, insurance schedules, statistics, and other information, as determined necessary by the commission, by regulation . . . " (Sec. 44.19.631(a)

Mechanism to Collect and Analyze Data:

"It is the intent of the legislature to [establish] a mechanism for the . . . collection and analysis of information and data concerning health care services and the making of recommendations based on that data . . . " (Sec. 2)

Does the Plan Include Data Collection? (Continued)

SB 284/HB 451	SB 270/HB 414
. . . Or Invalidate Their Licenses A provider's license "is not valid" unless the health care provider submits required data. (Sec. 08.02.025)	
Federal Waivers: The corporation "shall" apply for federal waivers to "incorporate . . . claims data . . . into the corporation's data system . . . " (Sec. 21.58.110(14))	
Data Used to Monitor Voluntary Compliance: Based on the data compiled through the health care data system, the corporation "shall" monitor the success of voluntary provider compliance with the health care expenditure target (Sec. 21.58.270(a))	

Does the Plan Include Preventive Care?

SB 284/HB 451	SB 270/HB 414
Yes, one goal of the corporation is to prevent illness and promote wellness	The bill does not mention prevention or wellness

Preventive and Wellness Programs:

"The purpose of the Act is to . . . provide a structure for addressing the health care needs of the state, including . . . use of preventive and wellness programs to reduce health care costs" (Sec. 1(b)(3)(B)

Benefits Include Prevention and Wellness Goal:

"The corporation shall adopt regulations specifying the health care services required to be covered by the state health insurance plan, taking into consideration . . . the goal of prevention of illness and promotion of wellness . . ." (Sec. 21.58.170(a))

Expert Committees Consider Health and Prevention:

The corporation shall . . . establish committees of experts . . . to make recommendations to the corporation regarding how to contain the cost of health care, including incorporating a greater emphasis on healthful lifestyles [and] prevention of disease and injury . . ." (Sec. 21.58.110(18))

Commission Does Not Endorse Particular Approach:

The commission performs a "market anaiysis" on health care reform proposals (or elements of those proposals) brought to it by the governor or by others; it does not endorse a particular approach. (M. Usera, personal communication)

Does the Plan Include Public Health?

SB 284/HB 451	SB 270/HB 414
The corporation establishes a public health improvement plan and requires recommendations for specific legislative action for that plan	Public health is not included in the bill

Need to Focus on Public Health:

"The legislature finds that . . . there is a compelling need for a strong, clear focus on public health issues . . . ." (Sec. 1(5))

Public Health Improvement Plan:

"The corporation shall . . . develop and update [a] public health improvement plan for the state" (Sec. 21.58.110(3) and 21.58.310(a))

Plan Includes:

The plan required under this section must include: an analysis of health status in Alaska; an assessment of appropriate government roles; standards for assessment, development and quality assurance; documentation of the extent to which the current public health system implements or achieves these standards; identification of interjurisdictional issues involved in health care access and delivery; [and] recommendations . . ." (Sec. 21.58.310(b)

Required recommendations for specific legislative action include: strategies, time lines, financial needs and specific sources of stable revenue . . .; local, regional, state and federal [sharing of responsibility] to deliver public health care services . . .; integration of the public health care system with state and national health care reform efforts; the corporation's estimate of the optimal share [expressed as a percent] that public health should represent in the total health care delivery system of the state." (Sec. 21.58.310(b)(6))

Intent to Include Public Health Issues:

The authors of the bill intend to amend the bill to include public health issues (N. Usera, personal communication)

Does the Plan Include Long-Term Care?

SB 284/HB 451	SB 270/HB 414
Yes. the Alaska Health Insurance Corporation must develop a long-term care plan by January 1. 1997	No. the plan does not include long-term care

Developing Long-Term Care Plan:

"The purpose of this Act is to . . . provide a structure for addressing the health care needs of the state. including . . . developing a comprehensive long-term care plan that integrates support services and that promotes human dignity." (Sec. 1(b)(3)(A))

By January 1. 1997. the corporation shall develop a long-term care plan that comprehensively addresses the needs of Alaska residents. (Sec. 21.58.110(19) and Sec. 12(6)

Long-Term Care Is Public Health Component:

The bill's authors consider long-term care as one component on the continuum of care that must be considered in addressing public health (N. Usera. personal communication)

Does the Plan Consider Primary Care?

SB 284/HB 451	SB 270/HB 414
Yes. the corporation must give incentives to primary care physicians to practice in Alaska. especially in rural areas	No. the plan does not discuss primary care

Design an Incentive Program:

The corporation "shall" design a program to give incentives to primary care providers to practice in Alaska. "especially in rural and under-served areas of the state. (Sec. 21.58.110(16))

Incentives:

Incentives "may" include "added premiums" on prices for primary care providers; student loan forgiveness, in-state family practice residency, and training and "rotations" for "midlevel practitioners." (Sec. 21.58.110(16)

Commission Does Not Endorse a Particular Approach:

The commission performs a "market analysis" on health care reform proposals (or elements of those proposals) brought to it by the governor or by others; it does not endorse a particular approach. (N. Usera, personal communication)

What is the Federal Role in the Plan?

SB 284/HB 451	SB 270/HB 414
The state must apply for waivers from federal laws before it can require claims data and redirect revenue The bill does not mention the need to study the effects of federal health care reform laws on Alaska	The commission is to analyze the effects on Alaska of new federal health care reform laws The plan does not mention the possible need to apply waivers to federal laws (such as ERISA)

Federal Waivers:

By December 31, 1994, the corporation shall determine the federal waivers necessary to set up the Alaska Health Insurance Corporation. (Sec. 12(1))

The corporation shall . . . pursue necessary federal waivers from applicable federal law or other federal health care payers in order to incorporate both claims data and revenue streams into the corporation's data system and additional revenue into the state health insurance fund. (Sec. 21.58.110(14))

New Federal Laws?

The bill does not mention how the plan would "dovetail" with new federal health care reform laws.

Requirements Imposed by New Federal Laws:

The Alaska Health Commission is to analyze health care reform proposals; recommend proposals to the governor and the legislature; and make recommendations about "requirements imposed on [Alaska] by [health care reform] measures passed by Congress." (Sec. 44.19.621(a)(5)(B))

ERISA Waiver?

The plan requires all providers and insurers of health care to Alaskans -- including self-insurers -- to submit "reports, data, health information, insurance schedules, statistics and other information." The state may need a waiver from the federal Employee Retirement Income Security Act (ERISA) before it can force self-insurers to comply.

Does the Plan Discuss Medical Malpractice Liability?

SB 284/HB 451	SB 270/HB 414
No. it suggests separate legislation	Yes. the plan requires non-binding arbitration of medical malpractice claims. with the arbitrator's decision admissible in court
Separate Legislation: "Because the state constitution's single subject rule precludes the consideration of comprehensive tort reform in the same legislative enactment as health care reform. tort reform should be addressed in a separate legislative enactment." (Sec. 1(8))	Arbitration Required: "A person who files an action for damages against a health care provider resulting from medical malpractice shall also submit the claim to the court for arbitration." (Sec. 09.55.535(a)) Arbitrator's Decision Not Binding: "The decision of the arbitrator may be rejected by a party." (Sec. 09.55.535(d)) Arbitrator's Decision Admissible in Court: "If the decision . . . is rejected . . ., the action may proceed in . . . court. The arbitrator's decision is admissible evidence in that action . . ." (Sec. 09.55.535(e)) Action against a health insurer (including a health maintenance organization) must also go to non-binding arbitration and the arbitrator's decision is admissible in court (Sec. 09.55.565)

Anchorage Chamber of Commerce
Resolution On Health Care Reform
93/94-7

WHEREAS quality, access, and the costs of health care are all critical to Alaskans; and

WHEREAS the cost of health care is being born by the state, the federal government, public and private sector employers and individuals collectively; and

WHEREAS certain legislation is pending which could significantly alter health care and the allocation of costs to pay for health care for Alaskans.

BE IT RESOLVED that the Anchorage Chamber of Commerce urges Alaska Legislators and the Governor to:

1. To clearly identify the cost implications (to the state, residents, public & private sector employers) of health care reform;
2. Avoid a single payor system;
3. Increase access to coverage for small employers through insurance company reform;
4. Address coverage for non-residents employed in seasonal industries in the state;
5. Thoroughly review entitlement to benefits if provided through taxes, assessments or premiums through employment;
6. Allow freedom of choice of employers to participate or not participate in any state mandated health care plan;
7. Address in advance how school districts, municipalities, boroughs or other public sector employers would have to increase budgets to cover any costs increase associated with health care reform;
8. Address how premiums will be paid by unemployed individuals and if premiums are not paid, who shares the burden of health care costs for those individuals;
9. Adopt a level of benefits which establishes the base benefit payment for all health care providers and allows residents to seek care from any provider in the state recognizing however, some providers will charge an amount greater than allowed by the plan which must be paid by the resident;
10. Address the number of employees/persons covered;
11. Address impact on collective bargaining agreements;
12. Address impact on national employers doing business in Alaska;
13. Address plan sponsors who currently give retiree welfare benefits to non-residents.

Be it further resolved that health care reform and the payment of health care costs should address all of the above areas and town meetings should be held to discuss the ramification of any proposed amendments or changes prior to voting on reform; and

While the current health care system may need to be fine tuned and some changes made, it does not need to be dismantled.

George Wuerch
Chairman 1993-94

Carol Heyman
President

February 18, 1994

HEALTH SYSTEM REFORM WORK GROUP
ALASKA PROPOSAL

SB 284/HB 451

February 9, 1994

Provided by Senator Jim Duncan

ISSUE	WORK GROUP PROPOSAL SB 284/ HB 451
1. **Universal Coverage/Access**	The corporation is required by law to purchase and/or directly provide a health plan for all Alaska residents.
2. **Financing Universal Coverage**	The corporation either contracts or directly pays for the health plans through a "market-driven single-payer system." The system would use market forces to insure appropriate consumption (i.e., published fees, appropriate copayments and deductibles, and incentives to use preventive services). The legislature would decide from among a variety of revenue sources which should be used to finance the health plans. Federal contributions added to fund.

ISSUE	WORK GROUP PROPOSAL SB 284/ HB 451
3. **Cost Containment**	Cost containment is necessary. There will be a set target budget. There is a base year set for the global/target budget. The corporation will set both the "target" budget and sub-budgets. Total expenditures would be under voluntary control (peer review/sanctions). If <u>not</u> successful in a three year period of time, mandatory control would be put in place, and corporation assumes cost control functions. (See also Provider Mix)
4. **Data Collection**	Single claim form through single entity. All claims data + IHS, VA, CHAMPUS (non-fee-for-service) expenditures. Other health data (which data still to be resolved) Confidentiality protected. Annual/periodic reports.

ISSUE	WORK GROUP PROPOSAL SB 284/ HB 451

5. **Establish Alaska Health Insurance Corporation**

General

The group would be as independent as possible from politics. It would be housed in a state agency as a public corporation with a board of directors.

It would be a policy making entity, compensated (but not full time employment), have regularly scheduled meetings and a professional staff. The Directors must be residents of Alaska.

The Directors would have staggered terms, longer than four years such that no single governor would be able to appoint all members. (However, given the constitution, a governor can remove directors.) There should be no vacancies.

Members confirmed by the Legislature.

Advisory groups to report to corporation.

Functions

Responsible for implementation of policy as well as development of future policy/alternatives. This includes such items as setting the benefit package, developing and establishing an expenditure target, getting federal waivers, etc.

ISSUE	WORK GROUP PROPOSAL SB 284/ HB 451

5. **Establish Alaska Health Insurance Corporation** (continued)

Membership Criteria

Fair geographical representation of the directors. Uncertain how to assure this feature.

Gender balance.

General categories of membership with fair representation of consumers and providers. If physicians on board of directors, allied health professionals should also be represented.

6. **Provider Mix**

Expenditure data used to establish current provider mix, used by corporation in future years to adjust mix.

Allied health professionals included in same type of peer review/cost control activities as physicians.

Allied health professionals allowed to practice full range of what they are licenses to practice and not constrained by reimbursement mechanisms (as long as such services are included in the benefit package).

Allied health professionals involved in making recommendations to corporation on desired or expected changes in types/intensity of services, increase/decrease in numbers of providers. Recommendations from various peer groups consolidated at structural level between corporation and peer groups. This lateral integration of peer groups will focus on developing "incentives" rather than controls in making recommendations to the corporation.

ISSUE	WORK GROUP PROPOSAL SB 284/ HB 451
6. **Provider Mix** (continued)	Incentives to attract/retain health care professionals in medically underserved areas...student loan forgiveness. Alaska based family residency program, training for mid-level practitioners, RAHEC to analyze retention and recruitment.
7. **Utilization**	Utilization needs to be controlled. Utilization is a factor to be examined and factored into establishing targets. Specialty groups will examine utilization and make recommendations to the corporation. If corporation "target" is not met and utilization's target has been determined to be inappropriate, corporation will examine other means of controlling utilization. Specialty groups given the opportunity to deal with excesses by imposing across-the-board cuts before corporation imposes mandatory sub-budgets. Quality of care is another factor that must be factored into budget/sub-budgets.
8. **Access to Care (both coverage and physical access).**	Appropriate transportation costs must be included in expenditure target budget, plus a factor for adjusting the target. Data collected should include transportation costs. Authority responsible for analyzing current service delivery system and recommending changes to the system as a means of improving access.

ISSUE	WORK GROUP PROPOSAL SB 284/ HB 451
9. **Health Insurance Reform**	Community rating. Coverage of pre-existing conditions. Guaranteed renewal. Insurers must offer basic plan. Single claims form/electronic claims system. Claims clearinghouse. Minimum benefit package. Director of Division of Insurance should have corporation to review and approve or disapprove health insurance rates; will need adequate staff including actuaries.
10. **Tort Reform**	Statute of limitation at age 8 for injury before age 6. Prejudgement interest floats with federal discount rate. Universal coverage assures future medical care for the negligently injured. Mandatory non-binding arbitration of **all** lawsuits; one neutral expert. Arbitration of all small claims; threshold of $100,000-$200,000; if appealed, losing party would have to pay 100% of all costs; eliminate panel, one medical expert per side; limit on attorney fees, both sides; arbitrator is a friend of the court; Rule 11 strengthened.

Provided by Senator Duncan

2/8/94

Report of the
Health System Reform Work Group

PURPOSE AND MEMBERSHIP OF THE HEALTH SYSTEM REFORM WORK GROUP

At the suggestion of several legislators, sponsors of Senate Bill 114 and representatives of the Health Access and Cost Containment Council, who authored Senate Bill 205, began meeting during the legislative interim. It was recognized that there were a number of areas of agreement in the two pieces of legislation.

Members of the work group included legislators, physicians, hospital and nursing home administrators, representatives of the insurance industry, the Administration, and the Alaska Native Health Board.

In addition, many other individuals representing a wide range of interests participated in the meetings. The group met bimonthly through December 1993. This documents reports areas of agreement among all but a few members of the work group. It also suggests a time line for implementation.

The report does not attempt to describe the extent of health care problems facing Alaska nor does it analyze the feasibility or cost of implementing proposed reforms.

This report presents the work group's areas of agreement in the following sequence:

I. creation of a corporation
II. cost control and utilization
III. universal coverage
IV. financing universal coverage
V. access to care and mix of providers
VI. data collection

VII. a public health improvement plan
VIII. tort reform
IX. health insurance reform

I. CREATION OF A CORPORATION

Successful health care reform demands ongoing coordination, integration, and monitoring of the various elements of any comprehensive reform package. The work group agreed that a single administrative and policy-making entity is best suited to coordinate, integrate, and monitor the various elements of their reform proposal.

Areas of Agreement

Section A: Creation of a corporation. A health care corporation will be created to provide a health plan for all Alaskan residents and to monitor and control all health care expenditures in the state.

The corporation will be within a department of the state government but will operate as independently as possible.

Section B: Board of Directors. The operations of the corporation will be directed by a board of directors whose responsibilities are defined below.

Section C: Corporation's responsibilities. The corporation's board of directors will:
(1) hire an executive director who serves at the pleasure of the board; the executive director hires other staff as necessary;
(2) design a public involvement process for the purpose of gathering public input on the benefit package, options for financing, cost-sharing, and plan administration;
(3) establish a comprehensive health care data system and begin collecting and analyzing health care expenditure data, demographic data, clinical information, billing and payment data, and health status, vital statistics, and other public health data;
(4) design and adopt uniform claims forms and implement their use;

(5) develop a public health improvement plan for the state of Alaska;
(6) create a claims clearinghouse in Alaska to process all claims made to the corporation;
(7) define the benefit package and eligibility requirements;
(8) establish a voluntary cost control system including:

(a) establish and adopt a voluntary state-wide health care expenditure target;

(b) annually monitor health care expenditures and determine whether they have exceeded the voluntary expenditure target, how expenditures and patterns of utilization have changed, what factors have contributed to any changes, and report to the legislature and governor;

(c) prospectively collect and publish descriptions of provider types and lists of provider prices for frequently billed services and procedures;

(d) establish appropriate cost-sharing requirements for all residents under the corporation's health care plan;

(e) contract with an agency or agencies of Alaskan providers to perform peer volume, quality and appropriateness control;
(9) present options to the governor and legislature on how to finance a health plan for all Alaskans;
(10) with funds appropriated by the legislature, provide or purchase health care coverage (a health plan) for all Alaskan residents through a market-based single-payer system;
(11) pursue waivers from the Employee Retirement Income Security Act and federal health care payers in order to capture both their claims data and revenue streams;
(12) develop incentives to attract, train and retain a broad array of health care providers in underserved areas of the state;
(13) through the claims clearinghouse, pay claims submitted by licensed providers for services that are in the benefit package;
(14) at any time beginning three years after the voluntary expenditure target has been in effect, if the corporation concludes that voluntary compliance has failed substantially to achieve the adopted voluntary expenditure target:

(a) the corporation may, by regulation, impose a mandatory expenditure budget or limit;

(b) the corporation may, by regulation, impose mandatory expenditure budget or limits on one, some, or all subcategories of the budget;

(c) the corporation may, by regulation, directly assume some or all previously contracted cost control functions;

(d) the corporation may, by regulation, establish new price, volume and quality control guidelines;

In addition, the corporation will continue to:

(e) annually monitor health care expenditures and determine if they excceded the mandatory budget, how expenditures and patterns of utilization have changed, what factors contribute to those changes, and report to the legislature and governor;

(f) establish appropriate cost-sharing requirements for all residents under the corporation's plan.

(15) establish committees of experts and others as needed to make recommendations regarding preventive measures, efficacy of health care modalities, provider mix within the state, and other matters; and,

(16) hold public meetings and make annual reports to beneficiaries, the governor, and the legislature.

Section D: Composition and appointment of board of directors. The board of directors will not exceed nine members. They will be appointed to staggered terms by the governor and confirmed by the legislature. A member will serve until replaced by the governor.

A majority of the board will be experts in health issues and fairly represent the interests of the general public in having access to quality and affordable health care. Interests of health care providers and purchasers will be fairly represented on the board. All directors will be residents of the state of Alaska. Their sex and geographical representation will approximate that of the state's population.

Section E: Board compensation,meetings, and staff. Directors will be compensated for the time they serve. This is expected to be part-time. The board will meet at least quarterly and will be supported by professional staff.

II. COST CONTROL AND UTILIZATION

Historical experience with utilization controls, managed care, and hospital rate setting have resulted in little, if any, significant decline in the rate of growth of health care spending. Market-oriented competitive strategies, for which there is almost no experience in Alaska, are unlikely to be effective at controlling costs in many areas because of chronic provider shortages and sparse population.

Areas of Agreement

The work group agrees that health care expenditures will for at least three years be controlled using a voluntary cost-control system as outlined in sections (A) through (E) below:

Section A: Establishing and adopting a voluntary state-wide health care expenditure target. The work group agrees that the management of limited health care resources in Alaska will best be accomplished by annually establishing and adopting a voluntary state-wide health care expenditure target. The corporation will establish the expenditure target from a base year of historical expenditures (the year prior to enactment of enabling legislation) and adjust it in future years, as appropriate by the following factors:

-changes in the general Consumer Price Index (for Alaska) plus a factor as follows:

-in the first year, CPI plus 1.5 percent;
-in the second year, CPI plus 1.0 percent;
-in the third year, CPI plus 0.5 percent; and,
-in the fourth year and years thereafter,
CPI with no additional factor;

-changes in the size and other demographic characteristics in the population such as aging;

-changes in the burden of disease resulting from epidemics, disasters, and reduction or elimination of diseases;

-elimination of unnecessary care;

-changes in technology;

-increases or decreases in the costs associated with medical malpractice premiums and awards;

-changes in administrative costs;

-changes aimed at improving access to care; and,

-changes in the patterns of utilization.

In designing the expenditure target, the corporation will take into consideration and, where possible, include all current sources of payment for health care services in Alaska including:

-all public and private employers and other groups that provide insurance or self-insured plans;

-individual plans and out-of-pocket expenses;

-federal, state, and local government sources, such as Medicare, the military, CHAMPUS, the Department of Veterans Affairs, the Indian Health Service, federal employee plans, Medicaid, General Relief Medical, grants to other governments and non-profit organizations, and other state and local government direct-service health programs;

-transportation costs associated with getting to and from health services; and,

-capital costs of health care facilities.

Section B. Monitoring the expenditure target. The corporation will monitor and make an annual report to the legislature and governor on:

(1) changes in total expenditures, (2) whether expenditures have exceeded the expenditure target, (3) how expenditures and patterns of utilization have changed, and (4) what factors have contributed to those changes.

Section C. Publish Provider Prices. Providers will post or make their price lists available upon request at their place of business. They will list their most frequently billed services.

Annually and prospectively, providers will submit a list of their prices to the corporation. The corporation will publish a description of types of providers licensed to provide services in the benefit package as well as comparative lists of provider prices for frequently billed services.

Section D. Cost-sharing with consumers. After seeking input from the public, the corporation will establish levels of deductibles and copayments.

Section E. Peer volume and quality control. The corporation will contract with an agency or agencies of Alaskan providers to perform peer volume, quality, and appropriateness control. This agency will establish peer specialty groups whose charge will be to control excesses within their discipline by reducing volume of care or by other mechanisms.

Peer specialty groups may also recommend through the agency expected or desired changes in the types and intensity of services or the types of providers best suited to furnish them. The agency may laterally organize various peer groups as a way of consolidating information from the groups. The agency may make this information and other recommendations available to the corporation. Recommendations developed by this agency will focus on developing incentives rather than controlling patterns of care.

Specific state action to require one or more cost control agencies will be necessary in order to forestall Federal Trade Commission antitrust action against providers.

Section F: The possibility of a mandatory cost control system. By the end of the third year of a voluntary cost control system, the corporation will determine if total health care expenditures have exceeded the expenditure target. If the corporation concludes that voluntary compliance has failed substantially to achieve the adopted voluntary expenditure target, the corporation may establish a mandatory state-wide health care expenditure budget. The corporation will not have to seek approval from the governor or legislature in order to implement a mandatory budget. The corporation may also establish new price, volume, and quality controls and guidelines.

The corporation may also annually establish mandatory sub-budgets as a means of controlling costs and making desired changes in the service delivery system.

The corporation may assume some or all of the previously contracted cost control functions or decide to contract with appropriate agencies for some cost control functions.

The corporation will continue to monitor expenditures and patterns of utilization.

III. UNIVERSAL COVERAGE

Areas of Agreement

Section A: Universal Coverage for all Alaskan Residents. The work group agrees on the goal of universal health care coverage for all Alaskans. They further agree that the corporation will be required by law to provide or purchase a health plan for all Alaskan residents.

IV. FINANCING UNIVERSAL COVERAGE

Areas of Agreement

Section A. A market-based single-payer system. The work group agrees that the corporation will provide or purchase health plans for all residents of the state. The corporation will design a system which utilizes market forces to encourage consumers to make more informed and appropriate purchasing decisions. Employers, unions, and individuals may purchase health benefit plans which cover services not included in the corporation's benefit package.

Section B. Market forces/appropriate utilization. The corporation will rely on market forces to control inappropriate utilization. Patterns of utilization will be influenced through appropriate deductibles and copayments and through incentives aimed at appropriate care. The corporation will publish comparative lists of provider prices. Each provider will post or provide upon request their prices at his or her place of business.

Section C. Health Fund. The corporation will undertake an extensive public involvement process for the purpose of gathering public input on the benefit package, options for financing, cost-sharing, and plan administration.

By January 1, 1997, the corporation will present options for financing the health plan for all Alaskans to the legislature. The legislature will decide, from among a variety of revenue sources, which should be used to finance the health plans for Alaskan residents. Potential revenue sources include: payroll taxes, income taxes, sales taxes, excise taxes, permanent fund earnings and dividends, and contributions to premiums. The legislature will appropriate funds to the corporation to pay for the health plan for Alaskans. As federal waivers are granted, existing federal and state revenue streams will be allocated to the corporation's fund.

IV. ACCESS TO CARE AND MIX OF PROVIDERS

In addition to access problems associated with inadequate health care coverage, the current distribution of health care resources in the state impedes some Alaskans from physically getting to health care services.

Areas of Agreement

Section A. Transportation costs. Transportation costs associated with receiving appropriate health care, particularly in a state like Alaska with few roads, must be considered a legitimate health care expense. In addition, reasonable changes in the distribution of health care providers and other resources must be made in the current system in order to alleviate some of the physical access problems. Therefore, valid transportation expenses should be included in the expenditure target.

Section B. Incentives to change the provider mix. The corporation will develop incentives to attract, train and retain health care providers in underserved areas. Incentives may include creating a student loan forgiveness program, supporting the development of an Alaska-based family residency program, developing and maintaining Alaska-based training and rotations for mid-level practitioners, and continuing efforts to analyze specific recruitment and retention problems in the state.

Section C. Scope of practice and reimbursement for services. Allied health professionals, like physicians, will be reimbursed by the claims clearinghouse for services rendered which are in the corporation's benefit package. For services within the benefit package, the corporation shall not restrict reimbursements for a particular provider and a particular service without making similar restrictions for all providers. That is, the corporation may not control health care expenditures by reimbursing only certain providers for a particular service. If the corporation chooses to control health care expenditures by reducing the benefit package, the elimination of certain services in the benefit package must be for all classes of providers.

To help attract and retain primary care providers to the state and in particular to underserved areas, the corporation may vary the rates of reimbursement to providers.

Section D. Allied health professionals. Allied health professionals ask to be included in the same type of peer volume and quality control activities as physicians and health care facilities. The work group agrees that they should be involved in these activities as long as they make the same commitment physicians and health care facilities have made to: (a) provide their fee schedules to the corporation, and (b) limit increases in prices to the CPI plus factors defined in Section II.

V. DATA COLLECTION

Areas of Agreement

Section A. Data collection. The corporation will establish a comprehensive health care data system to collect and analyze the following health care data elements:

(a) health care expenditures including capital expenditures and transportation expenditures associated with receiving care;

(b) demographic data;

(c) clinical information including diagnoses, use of services (provider type, type of services and procedures, location of care, length of care, and referral patterns), quality of care, and health outcomes;

(d) billing and payment data; and,

(e) health status, vital statistics, and other public health data.

The above data elements are essential to the corporation's ability to carry out its functions.

The best source of information for most of these data elements is claims data collected by third-party payers. Additional expenditure data will need to be collected from health care agencies such as the Indian Health Service, the Department of Veterans Affairs, and the military, which do not provide indemnity (insurance) plans but rather provide health services directly.

Sources of data on health status, health outcomes, quality of care, and transportation costs, are more difficult to identify. The corporation will have to develop these data bases.

Section B. Uniform claims forms and single claims clearinghouse. The corporation must take two important additional steps in order to develop a comprehensive data system. They are: (1) design and adoption of uniform claims forms for use by all providers and payers, and (2) establishment of a claims clearinghouse in Alaska to process all claims submitted to the corporation.

These steps are necessary even as we transform from our multiple-payer system to a market-based single-payer system.

Another step in the development of a comprehensive data system is to pursue a federal waiver from the Employee Retirement Income Security Act. Without it, the state will not be able to compel self-insured employer plans to provide their claims data to the corporation.

VII. A PUBLIC HEALTH IMPROVEMENT PLAN

Areas of Agreement

The work group discussed Representative Joe Sitton's proposal to create a public health commission with the charge of developing a public health improvement plan. The work group agrees that such a plan is essential and that all public health providers in the state should participate in its development.

Section A. A public health improvement plan. The corporation shall direct the development of a public health improvement plan for the state of Alaska. The plan will identify core public health services and the roles and responsibilities of each federal, state, regional and local public health agency. The work group recognizes that a sound public health infrastructure is

essential to maintaining and improving the health of Alaskans and to controlling the growth in personal health care spending.

VIII. TORT REFORM

Areas of Agreement

The work group agrees that the following tort reform changes are warranted.

Section A. Statute of limitation at age 8 for injury before age 6. The current statute of limitations will be reduced from age 23 so that an action based on alleged professional negligence may not be brought against a health care provider on behalf of a person less that six years of age unless it is brought before the eighth birthday. Exceptions include fraud, intentional concealment of facts, or an undiscovered inappropriate foreign body within the person.

Section B. Floating or pre-judgment interest rates. Pre-judgment interest on medical malpractice claims should be linked to the federal discount rate in effect on January 1 of the year in which judgment or decree is entered.

Section C. Mandatory non-binding arbitration of all lawsuits. As specified in both Senate Bills 123 and 204, all lawsuits alleging medical malpractice will be submitted to non-binding arbitration. The state's three person pre-trial screening process will be replaced with one neutral expert. The arbitration process, including discovery, will be completed within 6 months. The arbitrator's written decision is admissible in court.

Section D. Limitation on recoverable damages. The work group agrees that a limitation on the amount of recoverable damages should be established either through a cap on non-economic damages or through a proposal made by the trial lawyers.

The work group was unable to decide between a cap of $250,000 on non-economic damages as included in Senate Bill 204 and a new system proposed

by the trial lawyers that would replace the existing way in which medical malpractice lawsuits are adjudicated in Alaska.

Under the trial lawyers' proposal, a (state) authority will issue each health care provider a standardized liability package with a $5 million limit on coverage. Every provider will be required to purchase professional liability insurance from the corporation. Premiums will reflect type and location of practice, and in the case of financial hardship, income. A risk pool may be established. The corporation will be the only named defendant in a medical malpractice action.

All cases asking compensatory damages of less that $200,000 will be arbitrated with the cost of arbitration borne equally by both sides and limited to no more than one medical expert for each side. The arbitration hearing will be concluded within two days' time. If a case proceeds to a jury trial, the arbitrator will be the first witness as a friend of the court. The witness fee of the arbitrator will be borne by the party bringing the appeal.

The work group was intrigued by the trial lawyers' proposal but were unable to reach agreement.

Pending Issues

The work group was unable to reach agreement on changing the collateral source rule as presented in Senate Bill 204.

IX. HEALTH INSURANCE REFORM

Interim reform of the health insurance market was not of great interest to the work group, presumably because these potential access improvements are known to be marginal. The work group found some similarities between Senate Bills 114 and 205.

Since these bills were introduced in the legislature, Senate Bill 173 was enacted. It provides for some improvements in the small group insurance market. Insurers can no longer use claims experience, health status, and

length of coverage to set premium rates. It also requires that at least a basic plan be offered if an insurer has been denied coverage on the basis of health status or claims experience.

Under the work group's proposal, a health plan uniformly providing benefits to all Alaskan residents would eliminate the need to further regulate the health insurance industry. However, until the corporation begins providing a health plan to all residents, significant concerns remain.

Areas of agreement

Section A. Rating Practices. Senate Bill 114 and 205 both require insurers or a state pool to set their premium rates based on a quasi-community rate and to issue and renew plans to all groups that make such a request. Insurers may deny coverage for pre-existing conditions for only a limited period of time (one year in SB 114; corporation determines by regulation in SB 205). In all cases, however, insurers or the state pool must offer a basic plan to all who apply.

Section B. Rate review authority. The work group agrees that rate changes filed by all health insurers that sell group or individual insurance policies in Alaska will be subject to review and approval by the state director of insurance. The director must be given appropriate actuarial staff to perform this new function.

Pending Issues

The work group agrees and both bills require that insurers use a quasi-community rate. Both bills allow rates to vary by age and family composition/status. Senate Bill 114 also allows rates to vary by occupation and industry but requires that all rates fall within an established range or band. Insurers may not vary rates among similar businesses within a given geographical regional. Senate Bill 205 allows rates to vary by sex and other "generic factors". Rates must be set on a state-wide basis.

Suggested Timetable

(assumes enactment in 1994 and adequate staffing)

Functions of Corporation

	Begin Date
(1) Create corporation	July 1994
(3) Design public involvement system/begin process	Dec. 1994
(2) Establish data system and begin collecting data	Dec. 1994
(4) Design claims forms	June 1995
implement their use	Dec. 1995
(5) Develop a public health improvement plan	Dec. 1994
(6) Create clearinghouse	Dec. 1995
(7) Establish benefit package and eligibility requirements	1995
(8) Establish voluntary cost control system	Dec. 1996*
Establish Year One expenditure target	1997
(Year Three expenditure target)	1999
Monitor expenditures/patterns of utilization	1995
Collect and publish fees	Dec. 1995
Establish cost-sharing	Jan. 1997
Contract w/peer volume/control agency	Jan. 1996
(9) Present options to the legislature and governor on how to finance the health plans for all Alaskans	Jan. 1997
(10) Legislature begins funding health plans for all Alaskans (date received by corporation)	Jan. 1998
(11) Pursue federal waivers	Dec. 1994
(12) Initiatives to attract, train, and retain providers	Dec. 1994
(13) Claims clearinghouse begins paying claims	Dec. 1996

*If voluntary cost controls are successful at keeping expenditures within the expenditure target, this function will continue.

Continued. Suggested Timetable

Functions of Corporation	Begin Date
If the voluntary cost control system does not succeed in keeping expenditures within the expenditure target, at the end of the third year, the corporation may:	
(14) Establish a mandatory cost control system	2000
Establish a mandatory budget	2000
May assume all or some cost control functions	2000
Establish new price, volume, and quality controls	2000
Establish mandatory sub-budgets	2000
(15) Establish committees of experts	As needed
(16) Hold public hearings/report to legislature and governor	Annually

From Donald Fritz
7120 Henderson Loop
Anchorage AK 99507
349-8034

to: Senator Jim Duncan
attn: Roxanne Stewart
State Capital, Juneau, Alaska
99801-1182

Dear Senator,

Thank You for your time and attention, I will be brief. On January 12 1994 at about 7P.M. I had an accident at my home which resulted in a deep cut on the bridge of my nose: actually, a flap of skin and underlying tissue was cut loose (and flapping), and there was profuse bleeding. I was taken by a friend to my girl friend's home where we first tried to figure out where to go that could clean and stitch the wound and hopefully not charge too much, since I have no insurance. We finally settled on Providence Emergency Room, since it was after normal business hours.

At the hospital we waited for about an hour, filling in forms and relaxing. A very pleasant and efficient doctor then cleaned and stitched the flap down and prescribed antibiotics. This took about an hour. I remained in the emergency room another hour receiving intravenous antibiotics and resting up from the general trauma of the event. Then I went home.

The next day I called the hospital and asked about the bill for services rendered, and they told me that they had no idea what the charges were, and they would not begin to guess. How much does a dozen stitches on the nose cost?

Well, Sirs, 2 hours in the emergency room costs $350.00 (that's for the real estate), and 1 hour of the doctor's time cost $727.00. Add a few miscellaneous items and you're up to $1200.

Anybody that has received a minor medical bill like that recently has a very good idea why we have a health care crisis: THE AVERAGE GUY CAN'T AFFORD IT.

We can't get sick. We can't get hurt.

When your assembled body considers health care reform, asking Alaskans to collect together somehow to secure health care, please carefully consider your opening option of calling for an independent audit to rollback the cost of non-elective health care at such facilities as present themselves as general to-the-public health care providers. The time to control non-elective health care costs is RIGHT NOW, before we all sign on the dotted line.

I modestly suggest a commission such as the Public Utilities Commission to govern basic rates at the basic care givers.

As an alternative, perhaps the State might organize and fund basic care facilities to compete in a no-frills way with the higher priced services presently being offered (in a market too small to cause competition to function as a greed control).

Thank You for your attention and good luck in your earnest search for a much needed solution.

Sincerely,

Donald Fritz

HGI # A

CYCLE 01/17/94
OUTP

PROVIDENCE HOSPITAL
PO BOX 196604
ANCHORAGE , AK 99519-6604
907 261-3005
FEI # 920016429N

PAGE NO 1

HOSP NO 061

BIRTH-DATE 02/20/49

8 E PATIENT NAME	PATIENT NUMBER	SEX	AGE	ADMISSION DATE	DISCHARGE DATE	DAYS	
FRITZ ,DONALD E.	52177656	M		01/12/94			

GUARANTOR NAME AND ADDRESS

DONALD E. FRITZ
7120 HENDERSON LP
ANCHORAGE,AK 99507

C.O.B.	INSURANCE COMPANY NAME	GROUP NUMBER	POLICY NUMBER
1	SELF PAY S01#		.
	MERCHANT MD CLIFFORD		

PLEASE RETURN THIS PORTION WITH YOUR PAYMENT.

AMOUNT OF PAYMENT $

ATE OF ERVICE	DESCRIPTION OF HOSPITAL SERVICES	SERVICE CODE	TOTAL CHARGES	EST. COVERAGE INS. CO. NO. 1	EST. COVERAGE INS. CO. NO. 2	EST. COVERAGE INS. CO. NO. 3	EST. COVERAGE INS. CO. NO. 4	PATIENT AMOUNT
DETAIL OF CURRENT CHARGES, PAYMENTS AND ADJUSTMENTS								
1/12	001 CATH-INTRA	0861375	6.00					6.00
1/12	002 SUTURE EXTRA	0865370	22.60					22.60
1/12	001 TRAY-SUTURE/P	0865425	45.50					45.50
1/12	002 DRESSING PACK	0866462	11.40					11.40
1/12	001 IV START PACK	0866502	5.70					5.70
1/12	002 MEDICATION I	0866300	4.60					4.60
1/12	004 MEDICATION I	0866300	9.20					9.20
1/12	001 MEDICATION II	0866301	12.60					12.60
1/12	001 COMPREHENSIV	0862427	350.00					350.00
1/12	001 BARD INFUSOR	0863900	5.25					5.25
1/12	001 LAC/RED/COMP/	0891225	727.00					727.00
SUMMARY OF CURRENT CHARGES								
	MED-SUR SUPPLIES		91.20					91.20
	PHARMACY		26.40					26.40
	ER PHY FEE		727.00					727.00
	EMERGENCY ROOM		355.25					355.25
SUB-TOTAL OF CURR. CHARGES			1199.85					1199.85

PAYMENT IS DUE WITHIN 15 DAYS

Outpatient services are on a cash basis only. If you are unable to pa account in full within 15 days, please contact the Patient Acco Department for payment arrangements.

CYNTHIA BACON — NO PAY TIL RECEIVED 1/21/94

Thank you.
261-3005 -3.

PH 8532-6 (1/91) NS

IT IS OUR PLEASURE TO SERVE YOU
THANK YOU FOR SELECTING PROVIDENCE

TOTALS	1199.85					1199.8

PATIENT NUMBER 52177656

PLEASE REFER TO PATIENT NUMBER ON ALL INQUIRIES AND CORRESPONDENCE.

ADDITIONAL PATIENT BILLING MAY BE NECESSARY FOR ANY CHARGES NOT POSTED WHEN THIS BILL WAS PREPARED, OR IF INSURANCE CARRIERS DO NOT PAY ANY PART OF THE AMOUNT SHOWN UNDER ESTIMATED INSURANCE COVERAGE.

PAY THIS AMOUNT 1199.8

PROVIDENCE HOSPITAL
ANCHORAGE , AK

PHOTO OF TOM FRITZ showing
HEALING FACE WOUND (NOSE AREA)
TAKEN 12/94

• Kurt Kristensen • HCO # 1 • Box 945 • Kenai • Alaska • 99611 •
Phone • 907-776-8591 • Fax • 907-776-8594

January 7, 1994

Honorable Senator Jim Duncan
Alaska State Senate
Juneau, Alaska 99801-1182

Dear Mr. Duncan & Staff:

Thank you for your courteous and prompt correspondence on the health insurance compromise efforts you have sponsored so capably.

I have reviewed **the action document** and have a few comments:

1. The document is very sketchy and I would appreciate follow-up documents as this evolves into a bill during this session.

2. I support a completely insurance company free concept; even in Hawaii the monopoly insurance carriers are managing a 35% profit margin. The only acceptable level of involvement would be as a super-risk carier for excess costs for catastrophic illnesess (but here too it should be a non-patient contact role)

3. I hope cost containment will be accompanied by real preventative health provisions; options as well as penalties (taxes and higher deductibles).

4. I hope members of the council could possibly be appointed from existing borough committees (local health committees).

5. I am concerned that chiropractors, naturopaths and like health professionals be allowed to operate unrestricted by current medical establishment.

6. Utilization limits and allocation should be (first) considered by local health committees.

7. I am really leery about a "minimum coverage plan" and allowing the insurance companies to continue to limit and harass patients:

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continued-page 2

and doctors; if unavoidable, let the Authority provide several additional, options for families to choose, **cafeteria style,** what they need. With full coverage available for no more than the amount of the permanent dividend amount per person, per year. Should you need additional r evenues it should, in my opion, come from general revenues raised through an income tax/employment tax-with employees paying 2% of gross income and employers paying 4% of gross payroll.

8. Finally I would like to make a case for **abandoning the separate system of paying for injured workers' medical treatment under the Alaska Workers' Compensation coverage:**

As I indicated to you, in our discussion in Kenai, in my own injury resolution, the treatment and limitations given to me has been far worse than the actual injury.

For every doctor my primary physician would send me to (that would confirm original diagnosis and treatment plan) the workers' compensation carrier would find a physician that would say the opposite. In my opinion they have spent more money fighting treatment than they would have needed to spend had they listened to my primary physician.

I propose that you consider rolling all medical care for injured workers into the new universal care plan and leave the rehabilitation to a new arbitration authority consisting of a hearing officer and the first two doctors that treat the injured worker.

I believe savings in workers compensation rates will drop in such a no-fault system.

In conclusion, Mr. Duncan, my proposal (# 8) may contain the silver lining that will convince employers to participate in a constructive single-payer universal health-care plan. In return for the employee contribution to the universal plan and the employer retaining current immunity to employee law suits it would be possible to consider covering non-employment coverage of rehabilitation and retraining.

I believe that is a win-win-situation.

• Kurt Kristensen • HCO # 1 • Box 945 • Kenai • Alaska • 99611 •
Phone • 907-776-8591 • Fax • 907-776-8594

continued-page 3

Should you consider this idea, please go one step further and confer with Mr Kerttula and Mr. Navarre about my proposal for a Governor's Council on Safety and Workers' Compensation.

I am taking the liberty of including a copy of my letter to Senator Kerttula regarding the Governor's Council concept.

Sincerely,

Kurt

LEGISLATIVE PROPOSAL FOR 1994 SESSION

PROPOSAL

FOR

A GOVENOR'S COUNCIL ON WORKERS' COMPENSATION AND SAFETY

Whereas Alaska has the Nation's highest commercial injury rates. and

Whereas the Alaska Workers Compensation Division opens approximately 30,000 cases each year. and

Whereas Alaska private industry lost 133,050 workdays in 1990 a 21% increase over 1989, and

Whereas injured workers are denied a fair and timely resolution of their claims. and

Whereas commercial carriers have become the primary deliverers of services to injured workers, and are unable to separate their employer/profit relationship from their care and obligation to secure equitable resolution for injured workers. and

Whereas in recent years the average of settlements for injured workers have fallen below $ 20,000, and

Whereas a need exists to link the Alaskan Workers' right to a safe and healthy work environment with an equitable and no-fault system for returning injured workers to a level of competence and income potential not less than 2/3 of pre-injury income and benefits, and

Whereas events have proven that the system cannot be allowed to become politicized, be it herewith known that an impartial committee of well-intentioned individuals from all areas and aspects of the process should be created as a Permanent Commission with a basic staff, budget and mission to hold public deliberations on these issues and advise the Governor and the Legislature on effective and fair ways of insuring a safe workers' environment in Alaska and an equitable and efficient manner of rehabilitating injured workers in a cost-effective and no-fault fashion.

Whereas the credibility of this Council is paramount, be it resolved that the Council shall have 17 members, and that an impartial State Hearing Officer shall be assigned as the presiding officer of all meetings.

Be it resolved that the members shall hold 5 year terms and that 3 members shall be replaced each year, and

Be it resolved that the members shall be appointed in the following manner:

4 injured workers--selected by attorney groups for injured workers
1 attorney for injured worker--selected by trade group
1 attorney for employer--selected by trade group
1 Rehabilitation Provider-selected by trade group
1 Social Case Worker for injured workers-selected by trade group
1 employee physician--selected by trade group
1 employer physician--selected by trade group
1 private union representative--selected by trade group
1 public union representative--selected by trade group
1 legislative House member or staff--Republican
1 legislative Senate member or staff--Democrat
1 state OSHA Division Chief
1 state Workers Compensation Division Chief
1 governor's representative

AFSCME/Alaska Office P.O. Box 93330 Anchorage, AK 99509-3330
(907) 277-5218 AK Toll Free 1-(800) 478-5215 FAX (907) 277-5206

Senator Steven Rieger 2/17/94
Health, Education, and Social Services Committee Chair
State Capital
Juneau, Ak. 99801

Dear Senator Rieger,

I would like to express my support for Senate Bill 284 (health care reform). The bill features many concepts which the American Federation of State, County, and Municipal Employees supports. The concept of universal coverage is necessary and fair, and the single payer system appears to be the best of the available options. As a representative of public employees, I have seen the numerous problems our current health system has created for our members, and I welcome health care reform.

S.B. 284 is desirable now because it allows Alaska to create a system tailored to our specific needs, before we find ourselves under a federal mandate which might not work here.

I support S.B. 284 and the Senate's effort at reforming Alaska health care. I particularly commend Senator Duncan's tireless efforts on this important issue. The time for health care reform is now.

Sincerely,

Steven Larsen
International Union Representative
American Federation of State County and Municipal Employees

cc Senators Sharp; Leman; Miller; Duncan, Ellis; Salo

Post It™ brand fax transmittal memo 7671 | # of pages ▸
To Senator Steve Rieger | From Steve Larsen

Alaska State Legislature

Please enter into the record my testimony to the SEN. HESS
committee name

committee on SB 284, dated 2/17/94.
bill/subject

I represent the Christian Science Churches in Alaska. I would like to take this opportunity to share with you a need we feel is very important. As you may know, Christian Science includes as a part of the religion, the practice of spiritual healing. The treatment of disease and illness in Christian Science is done solely through the means of prayer. Alaska's constitution protects the right of the individual to practice his religion. Alaska state statutes currently recognize and accommodate treatment solely by spiritual means, through prayer, in accordance with the tenets and practices of a recognized church or religious denomination by an accredited practitioner of the church or denomination. See AS 11.51.120(b), AS 47.10.080(k), AS 47.10.085, AS 47.17.020(d), AS 47.17.290(13).

In some instances it may become necessary for a Christian Scientist to enter a Christian Science sanatorium while receiving Christian Science treatment. Christian Science sanatoriums are already providers as "hospitals" in the Medicare law, and most probably would be included in a federal national health program as providers in a federal law. Most major insurance companies accept claims for stays in Christian Science sanatoriums. Therefore, I would like to offer the following suggestion as an amendment. It would be to the definition of "health care provider" on page 18 line 29. Please add at the end of line 29:

> "and a sanatorium as included in the definition of 'hospital' in title XVIII of the federal Social Security Act and treatment and care compatible with such services."

I feel that this is a very reasonable and important amendment, and one that is necessary, if you are to achieve your stated intent to "preserve the individual's choice of health care provider" (p. 2).

Signed: Donald A. Mangelsdorf
Testifier

CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR ALASKA
Representing (Optional)

P.O. Box 873452 WASILLA, AK 99687
Address

376-7413
Phone No.

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

February 18, 1994

Senator Steve Reiger, Chair
Senate Health, Education & Social
Services Committee
Capitol Building
Juneau AK 99801

Re: SB 284, Health Reform

Dear Senator Reiger:

ASHNHA, representing community hospitals and nursing homes from across the state supports SB 284, drafted by the Health System Reform Work Group, as a "work in progress" towards health reform.

By "work in progress" we mean that individual hospitals and nursing home members and their trustees are in the process of reading and responding to the final version of SB 284 as introduced on February 9.

SB 270, the Governor's health reform proposal is under similar review.

Community hospitals were represented with the other organizations, professions and agencies in the drafting of SB 284 by the Work Group. They now stand ready to work with the Legislature and Administration in building on SB 284 and SB 270 to assure all Alaskans access to cost effective, quality health care.

Sincerely,

Harlan Knudson

Harlan R. Knudson
President/CEO

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

AKPIRG

ALASKA PUBLIC INTEREST RESEARCH GROUP

Post Office B
(907) 2

Post-it™ brand fax transmittal memo 7671	# of pages ▸ 2
To SENATOR RIEGER	From SCONA
Co. FOR YOUR	Co. AKPIRG
Dept. COMMITTEE	Phone # 2785661
Fax # 465-2069	Fax # 278-9300

Quality and affordable health care is an inalienable right of all Alaskans and the promotion and protection of that right is a responsibility of the state.

All pre-existing conditions result in discrimination, inequality, prevent "portability," and must be abolished.

Consumer involvement and consumer control are of vital public interest in health policy reform. Because of the complexity and potential impact of health reform, noone with a vested interest should be appointed to any new Board / Commission / Authority / Corporation.

Mandatory utilization review (volume control) and enforcement of the rates and fees of insurors and health providers is a responsibility of the state.

Mandatory review and enforcement of minimum/appropriate standards of care are a responsibility of the state.

The U.S. Public Interest Research Group as well as the Congressional Budget Office have reported that on the national level the single payor financing proposal has been the only proposal that can result in equitable universal health care as well as reduce costs.

There can be no free riders. There has to be a shared sacrifice. Women, children the elderly and people with disabilities want to pay their fair share; but that fair share should not be more than what is paid by hospital administrators, legislators or President Clinton. Mandatory coverage at an affordable premium rate will be necessary in order to assure low deductibles and co-payments. The sick, injured and persons with disabilities must have affordable benefit packages to independently participate in a world where they can work or own their own business.

There must be an application of waivers from federal regulations so that Alaska can implement a comprehensive benefit package as good or better than what the citizens of Canada or any other country have, and to assure that Alaska dollars stay in Alaska and federal dollars committed to Alaska health programs continue to come to Alaska.

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There must be a state plan to coordinate both private and public facilities and programs so as to assure more efficient delivery of services.

A 1992 Legislative Report demonstrated that malpractice is a problem in Alaska, but that there has been no proof that reducing benefits to those injured due to negligence would in fact reduce costs to taxpayers. ANHSO's research instead shows that current proposals for tort reform protect wrong doers at the expense of civil rights to citizens, especially women, children, the elderly, people with disabilities and subsistence users.

By Bonnie Nelson
Consumer Advocate

AKPIRG
ALASKA PUBLIC I
Post Office Box 10-1093 / A

Post-it™ brand fax transmittal memo 7671 | # of pages ▸ 5

To SENATOR RIEGLE	From S CONN
Co FOR YOUR	Co AKPIRG
Dept. COMMITTEE	Phone # 2785661
Fax # 465 2069	Fax # 2789300

Prepared Testimony for Presentation to the Health Resources and Access Task Force by Alaska Public Interest Research Group.
September 26, 1992

Task Force Members:

Alaska Public Interest Research Group, a 6,000 member non-profit research and consumer advocacy group has been asked to address " what recommendations AkPIRG has for reforming the health care system" and "how the current health care system creates problems for our organization's interests."

We have decided to focus on our comments directly on the Health Care Reform Final Recommendations to the Governor and the Legislature, adopted March 14, 1992.

AkPIRG applauds the decision to endorse a single payor system by the Health Resources and Access Task Force. It is in that spirit of appreciation that we hope you will examine these comments and distribute them to all interested parties. They are intended to spark renewed debate and begin a process of serious public examination of this important subject.

A. Global budgeting in the sense that it is commonly used, as in Canada, can only work if there is a single payor system. The most efficient single payor system is operated by the public sector. Nowhere in the final recommendations does it state categorically that Alaska will become the single health insuror, and that private health insurance will be abolished. If private health insurance is simply to be funneled through a new state agency, this is really no better than the current system in terms of wasted private insurance overhead and administrative costs.

In Canada physicians with negotiated fees simply do [illegible] procedures to amass the income they desire. What will prevent that under this system?

A key issue is WHO will be on the authority/commission that regulates rates and other important features of Alaska's heath care system? It should not be a hegemony of health care providers and others with a financial interest in the health care system. Consumers and others from grass roots organizations must have a very significant and central role in this all important regulatory body, and all of their work must be public and open to public scrutiny and review.

If medical care prices are not frozen the first year, or rolled back to the previous year immediately after this legislation is enacted, health care entrepreneurs will massively increase prices.

in anticipation of regulation years down the road. Additional data collection will be important and useful.

B. Regulation of Utilization Review Agents is extremely important since they are totally unregulated nationally. Health care consumers should be a central part of the board or other mechanism established to regulate UR agents.

C. Authority to review rates filed by health insurers. We understand that legislation to do this was killed by a massive lobbying effort of the health insurance industry. This legislation would be a very important step. This demonstrated political power will certainly be used to kill other key aspects of the Task Force recommendations without work to organize grassroots support for this legislation.

D. Small Group Market Reform has generally been a failure ascross the country as a means of expanding access. State initiatives along these same lines have been ignored by the targeted small businesses.

E. State High-Risk Pool Enacted by Law. While such pools have been implemented in many states across the county, they have been of very limited effectiveness because either the premiums are too high to help all but the wealthy, or the state rapidly runs out of funds to subsidize pool insurance.

F. Community rating/minimizing medical underwriting. If you contemplate a private health insurance system, then the concepts of community rating and the minimization of medical underwriting are laudable goals. The point, of course, is to abolish private health insurance and eliminate the need altogether for medical underwriting and individual payment for coverage.

G. State incentives. These are only necessary if premiums are paid by all to private health insurers, guaranteeing inequality of access. In the case of a single public payor financed by progressive taxation, there is obviously no need to offer " state incentives."

H. Pay -or-play approach is a very bad idea for a number of reasons. It builds upon the flawed historical approach of providing health care at the place of employment. It knocks out small business and favors big business. It short changes retired people, the unemployed and all those not associated with a workplace. It is administratively far more difficult than progressive taxation to finance a single payor. It keeps the private insurance industry and guarantees its stranglehold on the inequities of health care.

THE
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I. Medical malpractice insurance. There is little research evidence that the Task Force's approach on this issue will in any way result in the lowering of medical malpractice payments, but it is very likely to take away the civil liberties of a class of people. Furthermore, it will encourage those physcians who apparently engage in malpractice to continue doing so. If we are to encourage reform in this area, we must abolish the old boy peer review networks enjoyed by physicians and their licensing boards and replace them with predominantly consumer review boards. Since the malpractice premiums would need to be rigidly controlled and companies forced to follow actuarial and not cash flow accounting, a better idea might be to have the state take over malpractice insurance.

J. Health Planning/Certificate of Need. While this is an excellent idea, once again there must be a predominance of people on the regulating board who are not health care providers, and who otherwise have no conflict of interest. Furthermore, the regulating body must have the legal teeth to implement what they recommend.

Further commentary:

Health care reform in Alaska will confront problems that are not yet seriously acknowledged, problems that will challenge the state under any implemented system.

The future of the Indian Health Care System, even as an inadequate, ultimate safety net for indigenous peoples, both rural and urban, who do not otherwise qualify for medical care will be seriously challenged, both by falling Federal support for Indian health programs and, ironically, by the state's persistent legal challenge to the legal concept of tribal sovereignty. This irrational attack on the proposition that underlies continued Congressional support of a Federal program for native peoples in Alaska will also seriously impact programs delivered by regional nonprofit health organizations who depend on this same source of funds.

As to unmet needs which will generate massive health problems in the future, one need look no further than the just completed newspaper series on water and sewage problems in Alaska native villages to anticipate epidemics that will flow from the bush to urban Alaska. Finally, the persistent failure of Federal agencies to disclose historical contamination of Alaska lands and wildlife has been coupled with the serious misinterpretation of health data that has concealed generational afflictions caused, not by life styles, but by environmental poisoning of the lands, water and wildlife. The recent rediscovery of a radioactive dump is but the first indication of this vile legacy long buried in the data and

long misinterpreted or ignored because the victims are predominantly native people served by the IHS.

Although its charge may be otherwise, the Health Resources and Access Task Force should look carefully at these "time bombs" and direct its considered expertise to remediation that will force Federal acknowledgement of this serious problem and redirect state energy to consumer protection and not to attacks on the legal proposition of tribalism that now requires Federal support of a supplementary managed health system. That system of Indian health care must be seriously expanded and improved.

Thank you for this opportunity to begin what is hoped will be public discussion and debate on health care reform.

Stephen Conn
Executive Director

Dr. Lawrence D. Weiss, AkPIRG Health Reform Volunteer Consultant.

ALASKA NATIVE HEALTH BOARD

STATE LEGISLATIVE PRIORITIES FOR FISCAL YEAR 1995

I. *PUBLIC POLICY LEGISLATION PRIORITIES*

A. State health care reform

B. Public health services enhancement

C. Mandatory school health education

D. An increase in tobacco taxes

E. Loan forgiveness for health professionals

II. *CAPITAL PROJECT APPROPRIATIONS PRIORITIES*

A. Rural village water and sanitation facilities

B. Village clinic construction and replacement

III. *HEALTH PROGRAM PRIORITIES*

A. Home and community based services

B. Health promotion and disease prevention

C. Mental health and substance abuse services

D. Support for physician assistant training and compensation

E. UAA Masters in Social Work degree

SUMMARY OF RECOMMENDATIONS
ALASKA NATIVE HEALTH BOARD
STATE LEGISLATIVE PRIORITIES FOR FISCAL YEAR 1995

I. PUBLIC POLICY LEGISLATION PRIORITIES

A. State health care reform

It is essential that the State of Alaska enact legislation in 1994 to establish the framework for health care reform in Alaska. Alaska has the opportunity to provide for universal coverage and cost containment in a manner that will fit Alaska's unique health care system and needs. The Alaska Native Health Board supports the authorization in 1994 of an "Alaska Health Authority" to be charged with developing a plan of action for the state. This plan should be based on a single-payer system. It should leave intact the Indian Health Service system for the provision of health services to Alaska Natives, while involving the Alaska Native health community in the design of the state's overall health system.

B. Public health services enhancement

The Alaska Native Health Board endorses the legislation introduced by Representative Joe Sitton (H.B.332) and its companion bill (S.B.259) to describe in statute the public health responsibilities of the state of Alaska, to create a public health commission, and to develop a comprehensive plan for providing public health services for the residents of Alaska.

C. Mandatory school health education curriculum

The 1993 legislature was successful in securing passage of legislation urging all school districts in the state to implement a comprehensive school health education curriculum. Despite the Governor's veto, the need remains to ensure that all school-age children in the state receive the basic information essential to maintain personal hygiene, respond to emergency medical conditions, prevent disease, and develop healthy lifestyles. Failure to implement such a curriculum on a mandatory basis will be more costly over the long run than the expense of providing this effort. The Alaska Native Health Board supports passage of H.B.320.

D. Supporting an increase in state tobacco taxes

Alaska has the sixth highest smoking rate in the United States, and the highest level of use of smokeless tobacco. Cancer has outstripped heart disease as the top killer of Alaskans. Raising tobacco taxes has the double benefit of raising revenues for the state while reducing the demand for tobacco, especially among younger Alaskans. The Alaska Native Health Board endorses the Governor's initiative, but recommends that the tax be increased to $1.00 per pack of cigarettes.

E. Loan forgiveness for health professionals

Alaska continues to experience a serious need to recruit and maintain an adequate number of health care professionals statewide. Special needs exist in rural Alaska, where recruitment and retention are more difficult and the need for Alaska Native health professionals is well-demonstrated. We support Senator Ellis' bill (S.B.235) authorizing the forgiveness of state loans to health professionals in exchange for service in the state.

II. CAPITAL PROJECT APPROPRIATIONS PRIORITIES

A. Rural village water and sanitation facilities

For the third year in a row, the Alaska Native Health Board considers the construction and rehabilitation of village water and sanitation systems to be the highest priority for capital projects legislation. In 1993 significant progress was made in improving coordination with federal and state agencies and securing a long-term committment of funding from both sources to address rural Alaska's $1 billion unmet need. The Alaska Native Health Board endorses the recommendation of the Department of Environmental Conservation to maintain an annual commitment of at least $25 million for construction projects in rural Alaskan villages.

B. Village clinic construction and replacement

The Alaska Native Health Board maintains the vision that all villages in Alaska will have adequate community health clinics. We endorse appropriations in response to needs identified by individual rural communities for clinic construction and rehabilitation as an overall capital improvement budget priority. Renewal of a special $500,000 appropriation to the Department of Environmental Conservation will ensure that all village clinics will have piped water and sewer service before the year 2000.

III. HEALTH PROGRAM OPERATIONS PRIORITIES

A. Home and community-based services

In 1993 the Department of Health and Social Services was successful in securing federal waivers to allow the use of Medicaid funds for providing home and community based services in Alaska. Unfortunately, Medicaid funding limitations have delayed the implementation of these new authorities. The Alaska Native Health Board recognizes that, in the long run, home and community based care will reduce the need for institutional services and result in dramatic cost savings for the state. We urge the legislature to provide the Medical Assistance funding necessary for the enhancement of these services in FY1995, and to support the Governor's bill (S.B.249 and H.B. 377) for assisted living services.

B. Health promotion and disease prevention

While health promotion and disease prevention initiatives are responsible for less than one percent of health expenditures in the state, they hold the greatest promise for long-term reduction of mortality, illness, and injury for Alaskans. Through such efforts as passage of the public health legislation and school health education legislation identified above, and through the maintenance and enhancement of funding for current Department of Health and Social Services initiatives, the legislature will provide a strong foundation for long-term health status improvement and medical care cost containment.

C. Mental health and substance abuse services

The State of Alaska made great strides in the late 1980s to develop a comprehensive array of community mental health and substance abuse facilities and services throughout Alaska. It is essential to continue efforts to resolve the Mental Health Lands Trust so that sustained state funding remains available for the services currently provided. Of particular concern is the provision of adequate resources to reduce dependency on the Alaska Psychiatric Institute by allowing rural hospitals to provide inpatient psychiatric services without financial risk.

D. Physician assistant training and compensation

Alaska has become increasingly reliant on physician assistants for providing comprehensive ambulatory care services, especially in many rural communities which lack physician services. The Alaska Native Health Board endorses legislation (S.B.231

and H.B. 341) which will allow and enhance reimbursement for physician assistant services.

Over the past two years the Southeast Alaska Regional Health Corporation has been successful in establishing the first program for training physician assistants in Alaska in conjunction with the University of Washington. The Alaska Native Health Board urges the legislature to provide the financial support necessary to maintain this effort.

E. Masters in Social Work degree at University of Alaska

The University of Alaska Anchorage has been successful in securing support for beginning a Masters in Social Work degree program in Anchorage. The Alaska Native Health Board endorses approval by the legislature of $260,000 for implementing this program in FY1995.

BRIEFING PAPER: ALASKA HEALTH CARE REFORM

Alaska needs to join the growing number of states undertaking the reform of their health care systems. Alaska's health care costs are increasing at staggering rates, and over 75,000 Alaskans have no source of health care coverage.

While most Alaska Natives are included in the benefits system of the Indian Health Service, there are many health services that the Indian Health Service does not provide (such as long-term care) or does not adequately cover. The facilities operated by the regional Alaska Native non-profit health organizations are impacted by service demands of non-insured Alaskans in rural areas, and our resources for purchase of specialized care in the private sector cannot keep up with the increasing costs of such services.

Consequently, the Alaska Native Health Board has been an active participant throughout 1993 in the discussions designed to develop an Alaska-specific solution to our health care crisis.

We concur with both the findings of the ad-hoc committee and the governor that Alaska must put in place its own system of health care reform before a federal mandate is imposed. We urge the Alaska State Legislature to act this session to establish an "Alaska Health Authority" empowered to develop the specifics of a reformed system for consideration in the 1995 legislative session.

We support the concept of a single-payer system which recognizes the need to retain the separate federal medical programs of the Veterans Administration, CHAMPUS, and the Indian Health Service.

The Alaska Native health community is prepared to actively participate with the new Health Authority to ensure that the Alaska Native health system is efficiently and effectively coordinated with the system designed by the state in conjunction with the private sector medical community, the insurance industry, business, and labor.

The Alaska Native Health Board will be submitting specific recommendations concerning the bills which come before the legislature as the session progresses.

BRIEFING PAPER: ENHANCING PUBLIC HEALTH SERVICES

The Alaska Native Health Board was actively involved in a series of meetings in 1993 devoted to the promotion and protection of public health services in Alaska. These included the public health policy conference at the University of Alaska-Fairbanks, the Alaska Health Summit at the Egan Center in Anchorage, and several follow-up meetings with the State of Alaska and other public health agencies.

We share the concern of Representative Joe Sitton that, although the Alaska State Constitution mandates the protection of the health of the public, there has never been formal action to address this protection through state statutes. Furthermore, the essential public health services required by Alaskans should be clearly defined and well-coordinated through a long-term services plan.

The Alaska Native Health Board supports the concept of the formation of a permanent state board or commission to oversee this planning process and address coordination of services. Public health services in Alaska are provided through multiple agencies including the State Department of Health and Social Services, the Indian Health Service, borough and city health departments, and the regional Alaska Native health organizations. The efficiency of these services will be enhanced through proper oversight and coordination.

The reform of the health care system in Alaska must provide for the maintenance of essential public health services.

The Alaska Native Health Board endorses passage of S.B. 259 and H.B. 332 during this legislative session, and is prepared to actively participate in the formation of the commission and the development of a long-term public health services plan.

BRIEFING PAPER: MANDATORY COMPREHENSIVE SCHOOL HEALTH EDUCATION

Health services in Alaska are based to a large extent on crisis intervention and the medical model, which waits until problems become serious before resources are committed. The result is unnecessary suffering, a huge financial burden on individuals and society, and self-destructive patterns of behavior that are resistant to change.

Alaska's primary health problems are behavior-based. They include substance abuse, mental health disorders, suicide, tobacco use, sexually transmitted diseases, unintentional injury, drownings, child abuse, domestic violence, and increasingly HIV.

Whereas we have greatly expanded the availability of clinical services throughout Alaska, medical personnel alone cannot reverse the trends of these diseases and conditions. The Alaska Native Health Board beleives in the old adage that "an ounce of prevention is worth a pound of cure."

One important key to success in addressing behavioral problems in our society lies in the education system. Positive behaviors learned at an early age will have life-long benefits. While a health education emphasis is applied in Headstart programs in Alaska, our elementary and high schools generally fail to provide comprehensive education for our youth regarding personal and family health.

School districts complain that the resources are not adequate and that other curricula must be prioritized, yet our school spending levels outstrip any other state. While conservative parents argue that sex education should not be taught in schools, our STD and teen pregnancy rates are among the highest in the country.

Health education focuses on many non-controversial areas, including personal hygiene, personal safety and injury prevention, knowledge of diseases, first aid and CPR. Sex education can be modified to meet parental concerns in each school district.

Health education is inexpensive relative to many other curricula, and will save millions of dollars in long-term medical care and other societal costs if implemented. School districts will not institute more than cursory programs unless mandated by the State of Alaska. Your mandate is requested.