

**ALASKA LEGISLATURE COMMITTEE FILES 1993-1994 8672**

**8275 SENATE HEALTH EDUCATION & SOCIAL SERVICES**

## BRIEFING PAPER: SUPPORTING AN INCREASE IN TOBACCO TAXES

An Anchorage Daily News headline in October, 1993 delivered a chilling message that has become all too common throughout the United States of America: "Cancer top killer in state: Officials blame tobacco for rise." This should come as no surprise in Alaska, with the sixth highest smoking rate in the U.S. The previous "top killer" in Alaska was heart disease, which is often attributable to smoking as well. Rates of smokeless tobacco use in Alaska are the highest in the United States, leading to early nicotine addiction among hundreds of youth each year and placing users at high risk for cancer of the mouth and other disease.

The good news about tobacco-related death and disease is that they are entirely preventable. In addition, lawmakers have at their disposal a powerful tool to significantly reduce demand for tobacco while actually raising revenues: that is, raising tobacco taxes.

Governor Hickel is to be commended for his recent proposal to raise Alaska's cigarette tax by 14 cents a pack (to 42 cents). However, consideration of the magnitude of the problem, the effectiveness of taxation, and levels of taxation in Alaska as compared to other states and countries quickly reveals that a 14 cent increase is not nearly enough. Consider the facts:

- Smoking claims more lives in the U.S. each year than alcohol, cocaine, heroin, auto accidents, homicide, and suicide combined.
- Smoking is seldom an informed choice. Almost all new users are children and teens who are most susceptible to advertising. Most adults smoke not by choice but from addiction.
- Tobacco is the only consumer product that kills when used exactly as prescribed.
- More Americans will die from second-hand smoke this year than from AIDS. Children whose parents smoke are at high risk of asthma, bronchitis, pneumonia, otitis media, and sudden infant death syndrome.
- Smoking causes approximately one out of every six deaths in Alaska. Alaska's health care costs attributable to smoking in 1989 were estimated at \$34.1 million for persons 35 and older. Alaskans spend over \$105 million each year on tobacco.

- Alaska Natives have one of the highest smoking rates in the nation, averaging nearly 50% among both men and women.
- Rates of smokeless tobacco use in Alaska are also highest among Alaska Natives.
- Alaska Natives have the highest cancer death rate of any Native group in the country. The most common cancer is lung cancer.

Since Canada raised its cigarette taxes in the late 1980s from an average of 46 cents per pack to \$3.27 per pack, teen smoking has been reduced by two-thirds and total cigarette consumption has fallen faster than anywhere in the world.

A recent Gallup poll revealed that most smokers want to quit, and 86 percent said they would try to quit if cigarette prices rose to \$5.00 per pack.

-- - With our current tax of 29 cents per pack, Alaska ranks 23rd out of the 50 states in taxation levels, while the United States ranks last among 18 developed nations in cigarette taxes.

The Alaska Native Health Board strongly urges the legislature to raise Alaska's cigarette tax to \$1.00 per pack or higher. We also urge the state to use a portion of the revenues to fund a permanent Office of Tobacco Control within the Division of Public Health.

## BRIEFING PAPER: LOAN FORGIVENESS FOR HEALTH PROFESSIONALS

The regional Alaska Native health organizations currently constitute a \$150,000,000 industry in rural Alaska. These organizations are responsible for the operation and management of six hospitals, numerous health centers, and a wide spectrum of community health programs.

The success of these organizations is critically dependent on their ability to attract and retain qualified health care professionals, including physicians, mid-level practitioners, dentists, nurses, pharmacists, radiology and laboratory technicians, and sanitarians. Many of the individuals currently employed were recruited from outside of the state and have a tenure of two years or less.

Alaska Natives currently represent less than 10 percent of the health care professionals serving with these organizations. While this number is increasing, one of the most significant barriers to successful placement of Alaska Natives in health professions is the high cost of medical education.

Often Alaska Natives who successfully complete courses of study in the lower 48 states end up practicing outside of Alaska or in urban areas because of the need to generate an adequate income to repay student loans.

The Alaska Native Health Board believes that more Alaskans will pursue the health professions, and that more Alaskan health professionals will return to serve in rural Alaska if the onus of repayment is relieved.

Passage of the legislation submitted by Senator Johnny Ellis, S.B.235, will provide the relief that is needed. This will ensure that Alaska's investment in health professional education is rewarded by attracting and retaining Alaskans in service to essential health programs throughout the state.

## BRIEFING PAPER: RURAL VILLAGE WATER AND SANITATION FACILITIES

1994 marks the third year that the Alaska Native Health Board has placed village water and sanitation facilities at the top of its priority list for capital appropriations by the Alaska State Legislature.

We commend the legislature for the landmark actions of the 1993 session in approving nearly \$44 million for construction and rehabilitation of facilities in rural communities.

We believe that substantial progress was made administratively in 1993 in addressing the \$1 billion unmet need in these areas. The Departments of Environmental Conservation and Community and Natural Resources participated in a year-long joint effort with federal agencies to clearly substantiate the needs, improve coordination on construction prioritization and implementation, improve protocols for working with city and tribal governments, provide training for community system operators, and address such difficult issues as the need for subsidizing operational costs.

The Alaska Native Health Board in turn has taken the lead in organizing a Rural Alaska Sanitation Coalition, which will bring together rural health agency representatives and community government representatives to work cooperatively with state and federal agency personnel to continue this work in 1994 and 1995. We will be co-sponsoring a sanitation summit meeting in conjunction with the Alaska State Rural Development Council in Anchorage March 14-18, 1994, and urge attendance by legislators.

The most important ingredient in the long-range solution is a commitment by the State of Alaska to a ten-year schedule of construction equally matched by federal funds. The Department of Environmental Conservation is recommending an FY1995 capital appropriation of \$25 million to address the needs in the communities highest on its priority listing. While a ten-year schedule will require a commitment of \$50 million per year, we applaud DEC's initiative and urge the legislature's support.

Over 100 communities in rural Alaska still use honeybuckets for their waste management. Many sewage lagoons and community solid waste sites are out of compliance with federal and state standards. Rural Alaska will continue to face sanitation-related diseases such as Hepatitis A and meningitis until piped water and sewer are available in these communities.

## BRIEFING PAPER: VILLAGE CLINIC CONSTRUCTION AND REPLACEMENT

Over 400 Community Health Aides serve as the backbone of rural Alaska's health care program. Substantial improvements in the numbers, compensation, and training levels of Community Health Aides have been accomplished in the past three years as the result of increased program support by the Indian Health Service. However, many community clinics continue to be substandard, lacking adequate equipment, heating sources, handicapped access, adequate lighting, storage space, and, most importantly, access to safe water and sanitation.

Most community health clinics in rural Alaska are owned and operated by local governments through leases with the Indian Health Service. The only source of financing for replacing or upgrading these facilities is through DCRA grant sources or designated capital appropriations.

The Alaska Native Health Board ~~applauds the~~ Alaska State Legislature for the appropriations made in 1993 for the upgrade of many facilities. Community governments which prioritize the safety and adequacy of their community health clinics deserve the continuing support of the legislature in meeting these needs.

The Alaska Native Health Board also requests the continuation of the annual appropriation of \$500,000 begun two years ago to address the need to provide for piped water and sewer service to all village health clinics. Over the past two years this allocation has met approximately one-half of the needs identified by the state and the Indian Health Service. We need to fulfill the objective of safe water supply in all rural clinics by the year 2000.

## BRIEFING PAPER: HOME AND COMMUNITY BASED SERVICES

Last year the Alaska Native Health Board urged the State of Alaska to secure waivers from the U.S. Department of Health and Human Services to implement Project CHOICE. We are pleased that these waivers have been granted and that the program is now underway. The costs of institutional care for elderly and disabled Alaskans are the highest in the United States. Alaska's elderly population will continue to grow at an accelerating rate (94 percent in the last decade). It is essential that the State of Alaska undertake every effort to seek means for providing for the health and social needs of our elderly and disabled through non-institutional approaches in the coming years.

The technology for de-institutionalization is rapidly improving through the investments being made in home health care in the lower 48 states. This technology must be replicated in Alaska, and special efforts must be made to make it available in rural areas. Many of the regional Alaska Native health organizations are investing in the identification and training for home health aides and personal care providers and are seeking to convert available facilities for extended care services. Many rural Alaska communities are proposing low-cost alternatives through the offering of such programs as home-delivered or group meal programs, respite care, personal care/chore services, adult day care and group homes, case management, and assisted living services.

Investments by the State of Alaska in programs such as these will ensure that elderly and disabled rural Alaskans can stay in their home communities where their quality of life is better and their longevity will be enhanced. Such an investment will reduce the demand for the construction of higher-cost facilities in both urban and rural Alaska, and reduce the burden on Medicaid, GRM, and private insurance resources for financing these services.

It should be the goal of state policy makers to ensure a full continuum of care to meet the needs of all Alaskans, regardless of income or Medicaid eligibility. We encourage close scrutiny of the September 1993 reports released by the Older Alaskans Commission, entitled "A Blueprint for Home-Based Long-Term Care for the Elderly in Alaska" and "Long-Term Care Alternatives for Alaska's Elderly: 1993 and Beyond." The Alaska Native Health Board urges full funding for the Division of Medical Assistance appropriation for these services, and support the Governor's bill for assisted living (S.B.249 and H.B. 377). We urge the Legislature to work with the Older Alaskans Commission and regional Alaska Native health organizations to help close the large gaps in services to rural and Alaska Native elders. Such efforts will ultimately benefit not only our elders, but all Alaskans.

## BRIEFING PAPER: HEALTH PROMOTION AND DISEASE PREVENTION

A dramatic shift in causes of death among Alaska Natives has been seen in the last 50 years. In 1950, almost 46 percent of Alaska Native deaths were from infections, while 11.3 percent were due to suicides, homicides, and unintentional injuries. Today, infections account for only 1.2 percent of deaths while suicides, homicides, and unintentional injuries (including drownings, aircraft and motor vehicle accidents, fires, and injuries related to alcohol and other drugs) now account for almost one-third of all Native deaths. Deaths from heart disease and cancer have increased from 12.4 percent of the total in 1950 to 31.8 percent today. Like suicide, homicide, and injury, cancer and heart disease are largely preventable through healthy lifestyle choices.

The 1993 report of the Alaska Health Resources and Access Task Force is unequivocal in its call for greater State investment in health promotion and disease prevention to address these behavioral health issues. This report cited the American Public Health Association's ranking of Alaska as 44th among the states in healthy behaviors.

The Department of Health and Social Services initiated an Office of Prevention under the Cowper administration; unfortunately this initiative was cancelled by Dr. Ted Mala. This administration has also reduced the number of public health nurses located in rural Alaska. The few programs that are currently in place need to be maintained and strengthened, including the BRU grant awards to the regional non-profit Alaska Native health organizations.

The Alaska Native Health Board strongly endorses the community health promotion grant program administered by the Division of Public Health using the federal Preventive Health and Health Services block grant. Programs such as the Rural Human Services Project and the Community Suicide Prevention grant program are essential to turning around rural Alaska's behavioral health problems. Programs which provide family counseling, alcohol-free community activities, aftercare services from persons returning from treatment, FAS and AIDS education and prevention, parenting skills training, smoking cessation services, and nutrition education are in critical need in most rural Alaska communities.

The resources of the Indian Health Service alone are not adequate to provide these programs. Continued support from the State of Alaska will ensure that future generations of Alaskans will be healthier and more productive citizens.

## BRIEFING PAPER: MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

The investment made by the State of Alaska over the past ten years in the establishment and growth of comprehensive mental health and substance abuse treatment facilities and services is finally paying off.

The Alaska Native Health Board believes that sustained education efforts regarding these problems, combined with an increased commitment on behalf of the Alaska Native leadership, is resulting in a growing desire to address these problems by families and communities to seek assistance and change in their lives.

Rural and Alaska Native organizations have invested more of our available resources to establish the types of programs which are proving successful, including recovery camps, halfway houses, and youth treatment programs. Alaska Natives have increasingly become committed to receiving the training necessary to provide these services for ourselves in our communities: —

Now that the state revenue crisis is intensifying, the pressures to reduce funding for these programs will increase. Because of the nature of the problems they address, the need to sustain these programs over a ten to 20-year time frame is essential. If Alaska is to reduce the long-term demand for corrections facilities and programs, for psychiatric institutions, and for inpatient medical facilities, community-based prevention and treatment programs must be sustained.

The revenue stream required for their support is available through the Mental Health Lands Trust settlement. We urge the Alaska State Legislature to undertake all necessary actions to ensure the conclusion of this settlement in 1994. We further recommend close consideration of the recommendations of the Alaska Mental Health Board and the new strategic plan of the Division of Alcoholism and Drug Abuse for other approaches to resolving these difficult issues.

The Alaska Native Health Board requests that these community mental health and substance abuse programs be maintained at current levels in FY1995, and allowed to become successful in achieving our objectives of sobriety and wellness in the Alaska Native community.

## BRIEFING PAPER: SUPPORT FOR PHYSICIAN ASSISTANT TRAINING AND COMPENSATION

In 1992 the Alaska Native Health Board endorsed the proposal by the Southeast Alaska Regional Health Corporation to initiate an in-state training program for physician assistants. In 1993 this program became a reality, and has helped increase the availability of Alaska-trained mid-level practitioners.

Physician assistants are in increasing demand throughout Alaska and are becoming an essential feature of the rural Alaska health care system.

Physician assistants meet the need for outpatient services in communities which are too large to be served by Community Health Aides but are too small to attract physicians as local health care providers. Under the preceptorship of urban-based physicians, they can provide a more comprehensive array of pharmaceuticals, coordinate medical evacuations, diagnose and refer more complex medical cases, and provide clinical support for Community Health Aides in surrounding communities. It is also substantially less expensive for rural communities to support physician assistants than physicians.

The University of Washington and the WAMI Medical Education Program have demonstrated that physician assistants who are trained in Alaska are more likely to return to practice in Alaska. In addition, the in-state training offered in Sitka is generally preferred by Alaska Natives over lower-48 based training.

State funding for continuation of the SEARHC physician assistant training program at Sitka is essential to maintain this program in future years of operation.

The Alaska Native Health Board also endorses legislation extending Medicaid reimbursement for more of the services provided by physician assistants in rural Alaska (S.B.231 and H.B. 341). Such reimbursement will increase the viability of subregional health centers operated by local governments and reduce the demand on Medicaid for payment of travel costs for referral to treatment in urban facilities.

**BRIEFING PAPER: SUPPORTING THE MASTERS IN SOCIAL WORK PROGRAM  
AT THE UNIVERSITY OF ALASKA-ANCHORAGE**

Last year the Alaska Native Health Board encouraged the Alaska State Legislature to support the development of a Masters in Social Work Degree Program at the University of Alaska in Anchorage. This program has now been authorized and has enrolled 30 students.

There is a high demand for social workers throughout the state. Our regional health and social services organizations require MSW degree social workers to be in compliance with federal and state regulations for program operations. Other agencies demanding qualified MSW candidates include the Division of Family and Youth Services and community mental health centers.

The availability of an Alaska-based program increases the ability of Alaska Natives to secure this degree both in terms of affordability and access. Eleven percent of the University of Alaska's Bachelors in Social Work graduates are Alaska Natives, and many seek to achieve a masters degree.

The program increases the tuition revenues of the University of Alaska system, capturing resources that would otherwise go to outside educational institutions.

The program includes the requirement for students to provide 14,800 hours per year of voluntary placement in Alaska health and social service agencies, enhancing the services of these agencies and increasing the familiarization of the students with Alaska's unique program demands.

The UAA Masters In Social Work degree program needs a second year commitment of \$260,000 from the Alaska State Legislature to maintain its operations. The Alaska Native Health Board strongly endorses this investment.



# Alaska State Legislature

Please enter into the record my testimony to the SENATE H.E.S.S.  
committee name

committee on SB 270 & 284, dated MARCH 2, 1994  
bill/subject

Attached please find a copy of the current Health Care Financing Administration - 1500 medical services billing form (dated 12/90, in lower right corner). This standardized form is one of the things your proposed legislation would mandate. I thought you might like to know that one already exists. Also attached is the previous H.C.F.A.-1500 form (dated 1/84) which was replaced by the current version. I no longer have any copies of the H.C.F.A.-1500 designed in the 1970's.

The preceding is but one example from SB 270 and 284 showing that the bills were not researched well. Also not the attached copy of a page from Time Magazine: The graph shows the cost of U.S. medical care began increasing dramatically in 1987. The article (see underlined paragraph) never noted that in 1986 Congress enacted C.O.B.R.A., which forced hospital emergency rooms to treat all patients whether or not they paid. This is one of those "unfunded liabilities" that governments imposes on lesser governments and the private sector.

However, notice on the graph that in 1990 the medical care inflation started to decrease dramatically. This was prior to the Clinton campaign's cry of "health care crisis". There was no great increase in HMO's that year that turned things around. The graph after 1990 shows the resourcefulness and responsiveness of the private sector: Medicine took a hit from Congress and still found a way to cut costs and maintain quality of care in only 3 years. And all this without a huge bureaucracy telling Medicine what to do! Has government ever cut costs and improved services at the same time?

Signed: *Marlene M. Leak* MARLENE M. LEAK  
Testifier

SELF  
Representing (Optional)

771 8th AVE. FAIRBANKS 99701  
Address

452-1015  
Phone No.

PLEASE DO NOT STAPLE IN THIS AREA



HEALTH INSURANCE CLAIM FORM

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (DDN or ID) <input type="checkbox"/> FICA - E.R. LUNG (SSA) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID)				13. INSURED'S ID NUMBER (FOR PROGRAM IN ITEM 1)	
2. PATIENT'S NAME (Last, First, Middle Initial)				3. PATIENT'S BIRTH DATE (MM DD YY) SEX (M <input type="checkbox"/> F <input type="checkbox"/>	
4. PATIENT'S ADDRESS (No. Street)				5. PATIENT RELATIONSHIP TO INSURED (Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>	
6. CITY		STATE		7. INSURED'S ADDRESS (No. Street)	
8. ZIP CODE		TELEPHONE (Include Area Code)		9. CITY	
10. OTHER INSURED'S NAME (Last, First, Middle Initial)		11. IS PATIENT'S CONDITION RELATED TO:		12. INSURED'S POLICY (GROUP OR PLAN) NUMBER	
13. OTHER INSURED'S POLICY OR GROUP NUMBER		14. EMPLOYMENT (CURRENT OR PREVIOUS): YES <input type="checkbox"/> NO <input type="checkbox"/>		15. INSURED'S DATE OF BIRTH (MM DD YY) SEX (M <input type="checkbox"/> F <input type="checkbox"/>	
16. OTHER INSURED'S DATE OF BIRTH (MM DD YY) SEX (M <input type="checkbox"/> F <input type="checkbox"/>		17. AUTO ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/> PLACE (State)		18. EMPLOYER'S NAME OR SCHOOL'S NAME	
19. EMPLOYER'S NAME OR SCHOOL'S NAME		20. OTHER ACCIDENT? YES <input type="checkbox"/> NO <input type="checkbox"/>		21. INSURANCE PLAN NAME OR PROGRAM NAME	
22. INSURANCE PLAN NAME OR PROGRAM NAME		23. RESERVED FOR LOCAL USE		24. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, refer to and complete item 5 & 6	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (Authorized the release of any medical or other information necessary to process this claim. Also required payment of government benefits either to myself or to the party who pretests equipment before.)				13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (Authorize payment of medical benefits to the undersigned and/or supplier to services described below.)	
14. DATE OF CURRENT ILLNESS (First symptom or injury (accident or pregnancy) or MP)		15. PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE (MM DD YY)		16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM (MM DD YY) TO (MM DD YY)	
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE		18. ID NUMBER OF REFERRING PHYSICIAN		19. HOSPITALIZATION DATES RELATED TO CURRENT SERVICE FROM (MM DD YY) TO (MM DD YY)	
20. RESERVED FOR LOCAL USE		21. RESERVED FOR LOCAL USE		22. OUTSIDE LAB? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES	
23. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (APPROPRIATE ITEMS TO FILL IN TO FILL IN BY LINE)				24. MEDICAID REIMBURSEMENT COOP. ORIGINAL Ref. No.	
25. RESERVED FOR LOCAL USE				26. PRIOR AUTHORIZATION NUMBER	
27. DATE(S) OF SERVICE FROM (MM DD YY) TO (MM DD YY)		28. PROCEDURE(S) SERVICES OR SUPPLIES (Specify Disease, Circumstances, or Modifier)		29. CHARGES (DATE, ICD-9, CPT, ICD-10, ICD-9-CM, ICD-9-PCS, ICD-9-CM, ICD-9-PCS)	
30. FEDERAL TAX ID NUMBER SSN EIN		31. PATIENT'S ACCOUNT NO.		32. AGENT ASSIGNMENT? For gov't claims, see back YES <input type="checkbox"/> NO <input type="checkbox"/>	
33. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (Do not treat the statements on the reverse as part of this bill and do not make a bill thereon)		34. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than date of office)		35. PHYSICIAN'S SUPPLIER'S BILLING NAME ADDRESS ZIP CODE & PHONE	
36. FEDERAL TAX ID NUMBER SSN EIN		37. PATIENT'S ACCOUNT NO.		38. TOTAL CHARGE \$	
39. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (Do not treat the statements on the reverse as part of this bill and do not make a bill thereon)		40. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than date of office)		41. AMOUNT PAID \$	
42. FEDERAL TAX ID NUMBER SSN EIN		43. PATIENT'S ACCOUNT NO.		44. BALANCE DUE \$	
45. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (Do not treat the statements on the reverse as part of this bill and do not make a bill thereon)		46. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (if other than date of office)		47. PHYSICIAN'S SUPPLIER'S BILLING NAME ADDRESS ZIP CODE & PHONE	

CARRIER PATIENT AND INSURED INFORMATION PHYSICIAN OR SUPPLIER INFORMATION

EASE DO NOT STAPLE IN THIS AREA



HEALTH INSURANCE CLAIM FORM

FORM APPROVED DMB NO. 0838-0008  
 READ INSTRUCTIONS BEFORE COMPLETING OR SIGNING THIS FORM (CHECK APPLICABLE PROGRAM AT CHECK BELOW)

MEDICARE (MEDICARE NO.)     MEDICAID (MEDICAID NO.)     CHAMPUS (SPONSOR'S SSN)     CHAMPVA (VA FILE NO.)     FECA BLACK LUNG (SSN)     OTHER (CERTIFICATE SSN)

PATIENT AND INSURED (SUBSCRIBER) INFORMATION

1. PATIENT'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)		2. PATIENT'S DATE OF BIRTH		3. INSURED'S NAME (LAST NAME, FIRST NAME, MIDDLE INITIAL)	
4. PATIENT'S ADDRESS (STREET, CITY, STATE, ZIP CODE)		4. PATIENT'S SEX MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>		6. INSURED'S ID NO. (FOR PROGRAM CHECKED ABOVE, INCLUDE ALL LETTERS)	
7. PATIENT'S RELATIONSHIP TO INSURED SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> CHILD <input type="checkbox"/> OTHER <input type="checkbox"/>		8. INSURED'S GROUP NO. (OR GROUP NAME OR FECA CLAIM NO.)		<input type="checkbox"/> INSURED IS EMPLOYED AND COVERED BY EMPLOYER HEALTH PLAN	
9. OTHER HEALTH INSURANCE COVERAGE (ENTER NAME OF POLICYHOLDER AND PLAN NAME AND ADDRESS AND POLICY OR MEDICAL ASSISTANCE NUMBER)		10. WAS CONDITION RELATED TO A. PATIENT'S EMPLOYMENT YES <input type="checkbox"/> NO <input type="checkbox"/> B. ACCIDENT AUTO <input type="checkbox"/> OTHER <input type="checkbox"/>		11. INSURED'S ADDRESS (STREET, CITY, STATE, ZIP CODE)	
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (READ BACK BEFORE SIGNING) I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I ALSO REQUEST PAYMENT OF GOVERNMENT BENEFITS EITHER TO MYSELF OR TO THE PARTY WHO ACCEPTS ASSIGNMENT (IF) (X).		13. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO UNDERSIGNED PHYSICIAN OR SUPPLIER FOR SERVICE DESCRIBED BELOW.		11A. CHAMPUS SPONSOR'S STATUS ACTIVE DUTY <input type="checkbox"/> DECEASED <input type="checkbox"/> RETIRED <input type="checkbox"/> BRANCH OF SERVICE	
SIGNED _____ DATE _____		SIGNED _____		SIGNED _____	

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF ILLNESS (FIRST SYMPTOM) OR INJURY (ACCIDENT) OR PREGNANCY (LMP)	15. DATE FIRST CONSULTED YOU FOR THE CONDITION	16. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS OR INJURY, GIVE DATES	16A. IF EMERGENCY CHECK HERE <input type="checkbox"/>
17. DATE PATIENT ABLE TO RETURN TO WORK	18. DATES OF TOTAL DISABILITY FROM _____ THROUGH _____	19. DATES OF PARTIAL DISABILITY FROM _____ THROUGH _____	
19. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE (E.G., PUBLIC HEALTH AGENCY)		20. FOR SERVICES RELATED TO HOSPITALIZATION GIVE HOSPITALIZATION DATES ADMITTED _____ DISCHARGED _____	
21. NAME AND ADDRESS OF FACILITY WHERE SERVICES RENDERED (IF OTHER THAN OFFICE)		22. WAS LABORATORY WORK PERFORMED OUTSIDE YOUR OFFICE? YES <input type="checkbox"/> NO <input type="checkbox"/> CHARGES	

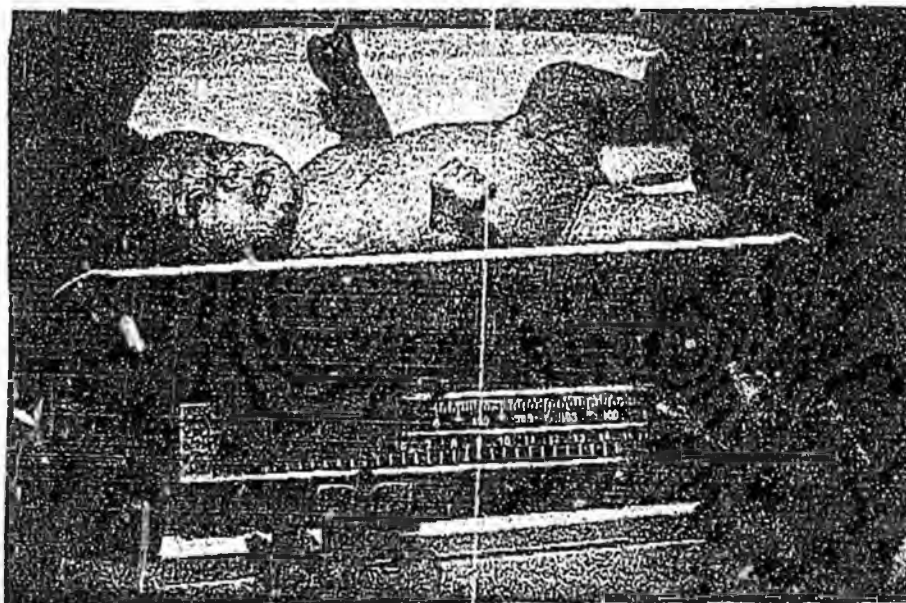
23A. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY: RELATE DIAGNOSIS TO PROCEDURE IN COL. D BY REFERENCE NOS. 1, 2, 3, ETC. OR ICD CODE: B.

1.	EPSONI YES <input type="checkbox"/> NO <input type="checkbox"/>
2.	FAMILY PLANNING YES <input type="checkbox"/> NO <input type="checkbox"/>
3.	
4.	

24. DATE OF SERVICE FROM TO	25. PLACE OF SERVICE	26. FULLY DESCRIBE PROCEDURES, MEDICAL SERVICES OR SUPPLIES FURNISHED FOR EACH DATE GIVEN PROCEDURE CODE (IDENTIFY) (EXPLAIN UNUSUAL SERVICES OR CIRCUMSTANCES)	27. DIAGNOSIS CODE	28. PRIOR AUTHORIZATION NO.			
				29. CHARGES	30. DAYS OR UNITS	31. T.O.S.	32. LEAVE BLANK

25. SIGNATURE OF PHYSICIAN OR SUPPLIER (INCLUDING DEGREE) ON CREDENTIALS. (I CERTIFY THAT THE STATEMENTS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART THEREOF.)	26. ACCEPT ASSIGNMENT (GOVERNMENT CLAIMS ONLY) (SEE BACK) YES <input type="checkbox"/> NO <input type="checkbox"/>	27. TOTAL CHARGE	28. AMOUNT PAID	29. BALANCE DUE
30. YOUR SOCIAL SECURITY NO.	31. PHYSICIAN'S, SUPPLIER'S, AND/OR GROUP NAME, ADDRESS, ZIP CODE AND TELEPHONE NO.			
32. YOUR PATIENT'S ACCOUNT NO.	33. YOUR EMPLOYER ID NO.	ID NO.		

FORM BUBBLED WITH CHAMPUS



This infant's HMO in California helps keep a lid on medical-cost inflation

■ HEALTH CARE

# Crisis? What Crisis?

As medical inflation eases, so does the sense of urgency that Clinton needs to push his revolutionary plan

By ADAM ZAGORIN WASHINGTON

**T**HE LATEST ASSAULT ON BILL CLINTON's top domestic goal began with 10 words on a Sunday-morning talk show last week. "We do not have a health-care crisis in America," declared Daniel Patrick Moynihan, the Senate Finance Committee chairman. His words sent shivers through the White House, where creating a national sense of urgency about health care is regarded as critical to propelling the President's reforms through Congress. As the week progressed, things only got worse. The American Medical Association, it was disclosed, is preparing a plan to lobby for 37 significant changes in Clinton's plan, including the elimination of proposed limits on doctors' fees. Then came a letter, signed by 565 economists, warning about fallout from the price controls contained in the Clinton proposal.

Administration officials quickly tried to dampen the rising rebellion. Senior economic advisers led a hushed but urgent campaign to prevent the influential Business Roundtable from endorsing a more modest alternative to the President's 1,300-page plan. White House economics chief Robert Rubin and Deputy Treasury Secretary Roger Altman telephoned insurance-company CEOs at Prudential, Chubb, American International Group

and CNA to urge them not to endorse the rival plan, backed by Representative Jim Cooper of Tennessee and Senator John Breaux of Louisiana. But the Administration's pre-emptive strike met with resistance. Late Friday an informal straw poll of the Roundtable's policy committee turned up broad support for Cooper-Breaux.

On his return from Europe this week, Clinton aims to launch an all-out campaign for passage with his Jan. 25 State of the Union speech. But attitudes about health-care reform have shifted in the months since Clinton unveiled his plan in September. The economy has rebounded smartly, and a growing number of legislators have been denying the existence of a national medical emergency. Certainly one aspect of the crisis: the skyrocketing cost of care, has abated. Medical inflation fell from an annual rate of 6.3% in the first half of last year to 4.4% in the second half, according to the consumer price index. New projections indicate that the Federal Government will spend \$120 billion less on Medicare and Medicaid through 1998 than was estimated only a year ago.

Behind the slowdown lie aggressive steps by several states including Maryland, Oregon and Florida to contain medical costs. Many private companies are taking their own measures. Typical is Intel, the microchip manufacturer, which suffered 20% annual increases in health-insurance premiums until the introduction of a managed-care program in 1990 that covers 20,000 U.S. employees. Now costs are edging up only 5% a year.

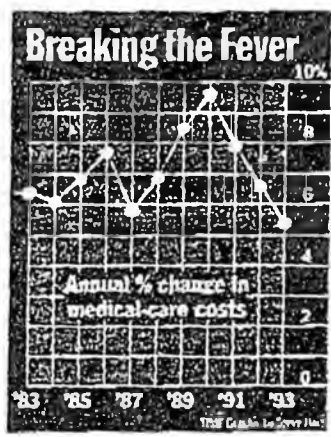
Another ingredient of medical-cost containment involves the decision by many hospitals, pharmaceutical companies and other providers to stabilize or lower their prices, perhaps in hopes of heading off congressional action on health-care reform.

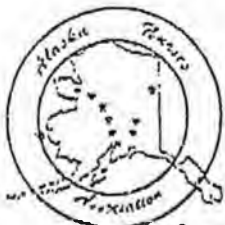
This, at least, is the argument advanced by Administration experts who caution that decelerating costs could prove illusory and that only a full-scale, Clinton-style reform with mandatory price restraints can tackle the job in the long run. "Medical inflation slowed in the late 1970s just in time to defeat a previous effort at cost containment," recalls Laura Tyson, chairman of the Council of Economic Advisers. "Later on, prices resumed their former upward spiral."

Moreover, advocates of reform argue, inflation is only one of many health-care problems that need fixing, most notable among them the lack of coverage for 37 million Americans, which the Clinton plan is designed to remedy. Warns Paul Begala, a senior Clinton political adviser: "The American people believe something serious must be done in a country where any one of us could lose our medical insurance tomorrow."

The sentiment among critics of Clinton's plan leans toward proposals that are more incremental, with less ambitious financing and lower costs. The one claiming the most support so far is the Cooper-Breaux plan, also known as "Clinton Lite." The proposal matches many features of the President's proposal but does not put limits on insurance premiums and will not yield universal coverage.

Several Republican legislators have developed their own, mostly incremental plans, hoping to avoid the awkward choice between opposing reform altogether and voting for some variation of the Clinton plan, for which the President will get most of the political credit. But, as the saying goes, you can't beat something with nothing. And the Republicans have yet to agree on an alternative that isn't Democratic in design. —With reporting by Michael Duffy and Dick Thompson/Washington





# ALASKA NURSES ASSOCIATION

237 E. 3rd Avenue #3 Anchorage, AK 99501-2523  
(907) 274-0827 FAX: (907) 272 0292

March 2, 1994

Senator Steve Rieger  
Room 516-C  
Capitol Building  
Juneau, Alaska 99801-1182

Dear Senator Rieger:

On behalf of the Alaska Nurses Association (ANA) I thank you for the opportunity to testify on today SB 284, an act establishing the Alaska Health Insurance Corporation. The Alaska Nurses Association commends the legislature for the leadership demonstrated on this issue.

The Alaska Nurses Association strongly supports universal coverage for all Alaskans. We believe this is the single most important aspect of health care reform. The Association, knowing the value of guaranteed coverage to primary care services, would support a single payer approach to ensuring a basic set of benefits for every citizen of this state.

Under SB284, we salute the development of a corporation which will control costs, increase coverage, and provide a structure for addressing the health care needs of the state. We applaud the bill's recognition for a strong public health care system. As an organization that has long advocated the principles of disease prevention and health promotion, we are gratified to see that wellness and prevention have been recognized as appropriate strategies to achieve the goals of cost containment and improved health outcomes.

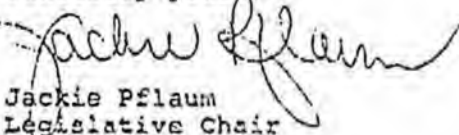
We are concerned that the bill as written does not clearly prevent the exclusion of coverage for any reason, particularly pre-existing conditions, employment, family situations or other reasons now often used as reasons to exclude coverage. We ask your careful consideration and any necessary amendments to assure universal and comprehensive coverage.

The Alaska Nurses Association applauds your efforts to include all appropriate providers in the cost reimbursement mechanisms which will occur in the reformed health care system. We strongly support the incentives for primary care providers which have been suggested. The inclusion of all primary care providers will significantly impact the accessibility of rural populations to access primary care.

The Association is committed to the belief that strong consumer presence needs to be an inherent component of the Alaska Health Insurance Corporation. While we recognize the need for expert representation on the Corporation Board, we also are convinced that it is only by empowering more consumers that the system will become more responsive to the concerns of those directly impacted by that system. You have addressed the need for required public involvement in Sec 21.58.320. However, we believe there needs to be significant consumer representation on the Board of Directors itself and urge you to add language to the bill which will demonstrate a commitment to greater consumer representation.

The Alaska Nurses Association endorses SB284 and looks forward to continuing opportunity to provide input and engage in dialogue about health care reform in the State of Alaska. Thank you.

Sincerely yours,



Jackie Pflaum  
Legislative Chair

TASKTIME.

State of Alaska Division of Insurance Senate Bill 284 House Bill 451 Pert Chart of Implementation Tasks and Times		Effective date: July 1, 1994												1997	1998	1999	2000
AS 21 58 Reference	Footnotes	30-Sep 1994	31-Dec 1994	31-Mar 1995	30-Jun 1995	30-Sep 1995	31-Dec 1995	31-Mar 1996	30-Jun 1996	30-Sep 1996	31-Dec 1996						
AS 21 58 010	Appoint Alaska Health Ins Corp Board, 7 Members	.....															
AS 21 58 060	Determine duties of Chair, Vice Chair by Reg (1)																
	Write Job description for Executive Director (2)																
AS 36 30.015	Appoint Executive Director	.....															
	Adopt procedures for procurement of supplies, services, prof svcs, construction																
	Write job description for administrative officer and other classified staff members (2)																
	Hire administrative Officer	.....															
	Hire clerical	.....															
	RSA with Dept of Law for legal services																
	Cost:																
	Office Space																
	Office furniture, equipment																
	Travel Expense																
	Expense for preparation of regulation																
	• RSA																
AS 21 58 320	Implement public involvement process	.....	.....														
AS 21 58 110(2)	Develop extensive community based public involvement process																
	Public Hearing - Teleconference - 5 days/hearing (3)	1 per mo	1 per mo	1 per mo	1 per mo	1 per mo	1 per mo										
	Publications, advertising																
	Write job description for information officer (classified)																
	Hire information officer																
	Cost:																
	Information Officer																
	Public Hearing space rental																

DRAFT

		TASKTIME													
		30-Sep	31-Dec	31-Mar	30-Jun	30-Sep	31-Dec	31-Mar	30-Jun	30-Sep	31-Dec	1997	1998	1999	2000
		1994	1994	1995	1995	1995	1995	1996	1996	1996	1996				
	Printing, mailing, advertisement cost Travel Expense for Board Teleconference														
AS 21.58.260	Establish data system, begin collecting data	.....	.....	(4)											
AS 21.58.110(3)	Select computer equipment, obtain Hire computer specialists, programmers														
AS 21.58.260(a)	Determine process for obtaining summary data from claim system, population stats, public health														
AS 21.58.260(b)	Adopt regulations for system of obtaining claims info from providers paid by others outside of claim clearinghouse/until clearinghouse on line Cost: Office Space Office furniture equipment Computer hardware Computer software-programming Contract funds														
AS 21.58.310	Begin first public health improvement plan Hold public hearings for input into plan Construct plan Hold public hearings for comment on plan written Determine information sources Develop recommendations for legislative action	.....	.....	(4)											
As 21.59.110(5)	Annually update plan Write job description for planners (classified emp) Hire specialist/expert planner for health care Hire assistant planner for health care Cost: Hearing space Advertising Publication of proposed plan Teleconference Salaries														
AS 21.58.110(6)	Determine federal waivers necessary to implement	.....	.....	(4)											

10/13/94

Footnotes	TASKTIME											1998	1999	2000
	30-Sep 1994	31-Dec 1994	31-Mar 1995	30-Jun 1995	30-Sep 1995	31-Dec 1995	31-Mar 1996	30-Jun 1996	30-Sep 1996	31-Dec 1996	1997			
AS 21.58 110(14)	Research info needed for waivers Determine, obtain legal assistance Prepare plan for requesting waive RSA to Dept of Law for Wash, DC representation Cost: Legal fees (research and representation) Travel to Washington DC Printing cost RSA													
AS 21.58 110(16)	Develop incentives to attract health care providers Determine options available - rural Public Hearings for comment - teleconference Test incentives, make adjustments Write job description for 1/2 time staff (classified) 1/2 time staff - hearings, reporting Cost Public Hearing Space Cost of plan, subsidy (student loan forgiveness, clinics, housing, staff, location, etc) Teleconference													
AS 21.58 110(4)	Complete uniform claims form Initial public hearing for input- teleconference Determine necessary info on form Determine codes needed to gather info from forms Coordinate with others (Feds, states) Determine users (providers, insureds) of forms Determine data capture needs (equip, staff) Final public hearing on form - teleconference Write job description for Dept of Ins staff (classified) One Dept of Ins staff, support person (1 year) Computer facilities Cost Printing Distribution Education of user (pamphlets, advertising, etc)													

DRAFT

		TASKTIME														
		Footnotes	30-Sep 1994	31-Dec 1994	31-Mar 1995	30-Jun 1995	30-Sep 1995	31-Dec 1995	31-Mar 1996	30-Jun 1996	30-Sep 1996	31-Dec 1996	1997	1998	1999	2000
	Travel for coordination with other jurisdictions Computer Salaries															
AS 21.58.220	Establish claims clearinghouse				.....											
AS 21.58.110(1)	Develop regulations on system for paying claims Determine data system needed Write job descriptions for staff (classified) Determine and hire staff to input data Determine and hire staff to review data, test check data Determine and hire staff to investigate fraud Determine legal staff to prosecute fraud/RSA Determine review, complaint procedure Determine system for payment of health care outside of Alaska															
AS 21.58.110(9)	Reg to define acceptable reasons for denial of claims Cost: Computer system Office and computer space Office equipment, phone system Salaries (Legal, Computer, Clerical) Adoption of regulations (hearings, pub notice) File space RSA															
AS 21.58.170	Determine health care services required	(5) (6) (7)			.....											
AS 21.58.110(7)	for health care plan benefits package Develop list of minimum services based on need, cost, funds available Public Hearing to get comment on list Adopt regulations giving minimum services						1 per mo	1 per mo	1 per mo	1 per mo						
AS 21.58.110(10)	Determine impact on waiver from Feds Review list annually Write job description for staff person (classified) Hire staff person for initial list and annual review RSA to Dept of Law for legal assistance Cost:															

DRAFT

		TASKTIME														
		Footnotes	30-Sep 1994	31-Dec 1994	31-Mar 1995	30-Jun 1995	30-Sep 1995	31-Dec 1995	31-Mar 1996	30-Jun 1996	30-Sep 1996	31-Dec 1996	1997	1998	1999	2000
		Research assistance														
		Adoption of regulations (hearings, publication)														
		Office space														
		Office furniture, equipment														
		Salary														
		RSA														
AS 21	58.230	Begin monitoring health care expenditures, utilization patterns, begin collecting fee information (8)			.....		.....	.....								
		Develop monitoring interval, end product														
		Develop summary reports from claims system														
AS 08	02.025	Develop system for collecting fee info from providers														
		- develop codes, common names for procedures														
		- determine system for summarizing, computer needs, publication needs														
		- develop system for requiring participation by providers in submitting fee information														
		- develop review, complain handling system														
		Develop summary reports for utilization data														
		Adopt regulations														
		Write job description of staff (classified)														
		Determine and hire necessary staff (prof. clerical)														
		Determine computer needs, obtain equipment														
AS 21	58.240	Annual publication of types of providers & prices														
AS 21	58.250	Annual comparative list of common services, prices based on claims														
		Cost:														
		Salaries														
		Office space														
		Office furniture, equipment														
		Adoption of Regulations (hearing, publication)														
		Computer														
		Printing, Distribution														
AS 21	58.330	Implement peer review system for utilization, c u i. (8)			.....		.....	.....								
		Develop peer specialty groups to control utilization														
		Determine system for evaluating quality of peer reviewers														

		TASKTIME														
		Footnotes	30-Sep 1994	31-Dec 1994	31-Mar 1995	30-Jun 1995	30-Sep 1995	31-Dec 1995	31-Mar 1996	30-Jun 1996	30-Sep 1996	31-Dec 1996	1997	1998	1999	2000
	Determine documentation needed to support peer review conclusions Determine system for review, complaints Determine publication of peer review info Cost: Travel Printing Public Hearing															
AS 21.58.110(7)	Adopt regulations to establish eligibility criteria for enrollment, define resident Determine criteria based on AK law and judgments Determine enrollment information needed, form Determine enrollment period, sign up			.....	.....	.....	.....	.....	.....							
AS 21.58.110(8)	Determine premium and sliding scale based on ability to pay, annually															
AS 21.58.190	Develop process for determining ability to pay Develop process for collecting fees Develop process for cancelling coverage Determine review, complaint process Determine system for detecting fraud Determine system for prosecuting fraud/RSA															
AS 21.58.140	Adopt regulations for processes and procedures															
AS 21.58.160	Determine disclosure procedure for medical, financial data															
AS 21.58.210	Disseminate info regarding plan and enrollment Write job descriptions for staff (classified) Determine and hire necessary staff (professional, clerical, investigators) Cost: Salaries Printing, distribution of forms Advertising - education RSA File space (secure)															
AS 21.58.280	Voluntary cost control system											.....	.....	.....	.....	.....

		TASKTIME												1998	1999	2000	
		Footnotes	30-Sep 1994	31-Dec 1994	31-Mar 1995	30-Jun 1995	30-Sep 1995	31-Dec 1995	31-Mar 1996	30-Jun 1996	30-Sep 1996	31-Dec 1996	1997				
AS 21.58.110(11)	Determine system for reviewing provider charges Determine summary info from data system (claims.etc) Determine summary info from provider fee lists Determine interval of review of costs Compare infra to expenditure target by category Determine when voluntary system is not working																
AS 21.58.110(17)	Adopt regulations for mandatory system if voluntary system fails to achieve target expenditures Determine system for enforcing mandatory cost Determine recommendations on containing cost of health care Write job description of staff (classified) Determine and hire necessary staff for review																
AS 21.58.110(18)	Develop committees of experts to review Costs: Salaries Office space Office furniture and equipment Compensation to experts Adopt regulations (hearings, publication)																
AS 21.58.110(19)	Develop long-term health care plan Determine needs of AK residents Determine system of attaching costs to needs Costs: Public Hearing Space																
AS 21.58.180	Establish deductible, copayment amounts Determine costs, premiums Costs: Advertising Public Hearing																
AS 21.58.110(12)	Present options to governor, legislature. - how to finance state health ins plan under market based single payer system																

	Footnotes	TASKTIME										1997	1998	1999	2000		
		30-Sep 1994	31-Dec 1994	31-Mar 1995	30-Jun 1995	30-Sep 1995	31-Dec 1995	31-Mar 1996	30-Jun 1996	30-Sep 1996	31-Dec 1996						
AS 21.58.110(13)	Determine if Corp is insurer or coverage procured from one or more companies (9)																
AS 21.58.270	Establish statewide health care expenditure target Determine change in demographics, medical tech access to health care, catastrophe, elimination of unnecessary care, chg in cost of liability ins, chg in admin cost, chg in utilization Annually adjust expenditure target													*****/			
AS 21.58.110(15)	Begin to provide health ins coverage for state residents													*****/			
AS 21.58.110(20)	Annually report to enrollees, governor, legislature Hold public meetings Cost: Teleconference Printing, distribution Travel																
AS 24.20.206	Legislative Budget and Audit provide annual post audit and operational and performance evaluation of Corp																

FOOTNOTES

All time lines are based on best case scenerios or specific times for implementation included in legislation.

(1) It has not been determined who will write regulations for determining duties of the chair and vice chair of the corporation board.

(2) It is unclear who will be preparing job descriptions prior to Executive Director coming on board.

(3) Assumes public hearing will not be transcribed.

(4) We do not anticipate that this time line can be met.

(5) The providers list in the bill at AS 21.58.400 does not match the provider list in As 21.36.090.

(6) The affect this bill may have on workers compensation coverages, disability coverages has not been taken into consideration.

(7) The affect of this bill on the total amount of premium taxes collected from insurers writing accident and health insurance has not been taken into consideration.

(8) The complete evaluation of this requirement is beyond the expertise of the staff of the Division of Insurance.

(9) If Corporation becomes the insurance company additional staff and costs will be undertaken such as an insurance company would incur.

## Responsibilities of Board of Directors of Health Insurance Corporation

Section	Working hours for each board member	Due by:	3Q 94	4Q 94	1Q 95	2Q 95	3Q 95	4Q 95	1Q 96	2Q 96	3Q 96	4Q 96	1Q 97	2Q 97	3Q 97	4Q 97	98
See hearing worksheet	Attending hearings (assume 8 hours each day, member attends half the hearings hearings in FY 95 are 3 days each, hearings thereafter are one day each)	varies	180	156	96	120	52	8	8	28	60	20	32	32	44	0	0
See hearing worksheet	Prepare for and summarize hearings (2 hour. for each hearing)	varies	30	26	16	20	26	4	4	14	30	10	16	16	22	0	0
AS 21.58.060	Determine duties of chair and vice chair & elect them	ASAP	4														
AS 21.58.070	Meet quarterly (assume 1 day each quarter)	quarterly	8	8	8	8	8	8	8	8	8	8	8	8	8	8	32
AS 21.58.090	Prepare job description for executive director; advertise	ASAP	2														
AS 21.58.090	Interview four candidates for executive director	ASAP	8														
AS 21.58.090	Meet to select executive director	ASAP	4														
AS 21.58.100(12)	Present options to legislature for financing of plan	Annually ?				2				2				2			2
AS 21.58.100(16)	Meet with universities, doctors, etc to encourage primary care physicians (assume 4 hours a week for 12 weeks)	12/31/94		48													
AS 21.58.100(18)	Establish and work with committees of experts regarding cost containment, etc (assume 2 hours per month)	7/1/94 and ongoing	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
AS 21.58.100(20)	Hold public meetings to report to enrollees, governor, & legislature	Annually after 1998															2
AS 21.58.130	Review proposals from insurers to provide health insurance to Alaskans (two week's work, assuming that background work done by staff)	1/1/97 ? and every three years								80							
AS 21.58.130	Select insurer to provide coverage, or decide to form own insurer	1/1/1997 and every three years								8							
AS 21.58.280	Work with providers in meeting voluntary expenditure target (assume 1day per month)	1998 and ongoing															96
AS 21.58.290	Report to the governor and legislature on health care expenditures, etc	Annually				2				2				2			2
AS 21.58.320	Assist in the "extensive community based public involvement process" (assume 2 hours per month)	12/31/94 and ongoing	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
AS 21.58.330	Set up peer review of quality (assume 2 hours per month)	1/1/96 and ongoing					6	6	6	6	6	6	6	6	6	6	6
AS 24.20.206	Meet with the Legislative Budget and Audit Committee following their annual audit (one day meeting)	12/31/94			8				8				8				8
Total Hours Worked in Fiscal Year:			802				348				332				278		
Total Days worked in Fiscal Year (rounded):			100				44				42				35		

This worksheet calculates the total number of hours that A SINGLE BOARD MEMBER will spend doing various tasks.

NOTE: These numbers do not consider any time spent in the event that the board decides to form their own insurer. Such a decision will greatly increase the participation required by the board.

## Hearings required to implement The Alaska Health Insurance Corporation

Section	Hearings (some for regs, some not)	Due by:	Hearings to be held in:															
			3Q 94	4Q 94	1Q 95	2Q 95	3Q 95	4Q 95	1Q 96	2Q 96	3Q 96	4Q 96	1Q 97	2Q 97	3Q 97	4Q 97	98	
AS 21.54. 25	Set out criteria for insurers' claims grievance procedures	7/1/94	2															
AS 21.58. 060	Prescribe duties for director's chair and vice-chair	7/1/94	1															
AS 21.58. 110(4)	Develop a uniform claims form	7/1/95			2	2												
AS 21.58. 110(7)	Develop eligibility requirements for enrollees	1/1/96			3	3	3											
AS 21.58. 110(9)	List acceptable reasons for denying claims	7/1/97 ?										3	3					
AS 21.58. 110(16)	Create program to encourage primary care physicians	12/31/94	2	2														
AS 21.58. 110(19)	Develop long term care plan	1/1/97							2	2	3							
AS 21.58. 170(a)	Specifying the health benefits to be included	12/31/95			3	3	3											
AS 21.58. 110(10)	Review the health benefits in plan	Annually after 1995										2				2		
AS 21.58. 160	Establish standards for confidentiality of medical and financial information on enrollees	12/31/94 ?	3	3														
AS 21.58. 180	Setting the deductibles and copayments	1/1/97								2	2							
AS 21.58. 190 & 110(8)	Establishing the premiums and enrollee fees	7/1/97 ?									3	3	3					
AS 21.58. 190	Set out method for enrollees to submit financial info	7/1/97 ?										2	2					
AS 21.58. 220	Require providers to submit claims to clearinghouse	1/1/98 ?														2		
AS 21.58. 220	Set out clearinghouse's claims grievance procedures	1/1/98 ?												2	2			
AS 21.58. 230(a)	Set out contents of provider price list	12/31/95					2	2										
AS 21.58. 230(b)	Set date for providers to submit price list	12/31/95					1											
AS 21.58. 260(a)	Set out types of data to be collected in data system	12/31/94	3	3														
AS 21.58. 260(b)	Require providers to submit claims data to data system	12/31/94		1														
AS 21.58. 270(a)	Prescribe initial statewide health care expenditure target	1/1/98												3	3			
AS 21.58. 270(b)	Adjust statewide health care expenditure target	Annually after 1998																
AS 21.58. 280	Establish voluntary cost control system and method for evaluation	12/31/96								3	3							
AS 21.58. 300(b)	Impose a mandatory expenditure limit (if voluntary fails)	Optional after 2001																
AS 21.58. 300(b)	Establish mandatory price guidelines	Optional after 2001																
AS 21.58. 300(b)	Establish cost sharing recommendations relevant to expenditure limit	Optional after 2001																
AS 21.58. 300(d)	Establish procedures for monitoring compliance with cost control provisions	Optional after 2001																
AS 21.58. 300(d)	Establish procedures for providing notice to overcharged person	Optional after 2001																
AS 21.58. 310	Develop initial public health improvement plan	12/31/94	3	3														
AS 21.58. 310	Update public health improvement plan	Annually after 1994					2				2				2			
AS 21.58. 320	Design community based public involvement process	12/31/94		1														
AS 21.58. 330	Set up peer review system for quality controls	1/1/96				2	2											
AS 36.30 015(e)	Adopt procedures to govern procurement	12/31/94	1															
Total Hearings in the quarter:			15	13	8	10	13	2	2	7	15	5	8	8	11	0	0	
Total Hearings in FY:			45				24				36				11			

This sheet calculates the number of hearings that will need to be held to implement the programs in the bill  
Assume that hearings in FY 95 each last 3 days, hearings in later FYs average one day each



## Number of Trips Taken by Directors of Alaska Health Insurance Corporation

Section	Purpose of Trip	Due by:	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q	3Q	4Q	1Q	2Q	3Q	4Q	
			94	94	95	95	95	95	96	96	96	96	97	97	97	97	98
See hearing worksheet	Attending hearings (assume 8 hours each hearing, member attends half the hearings)	varies	30	26	16	20	26	4	4	14	30	10	16	16	22	0	0
See hearing worksheet	Prepare for and summarize hearings (2 hours for each hearing)	varies	30	26	16	20	26	4	4	14	30	10	16	16	22	0	0
AS 21.58.060	Determine duties of chair and vice chair & elect them	ASAP	4														
AS 21.58.070	Meet quarterly (assume 1 day each quarter)	quarterly	4	4	4	4	4	4	4	4	4	4	4	4	4	4	16
AS 21.58.090	Prepare job description for executive director; advertise	ASAP	4														
AS 21.58.090	Interview four candidates for executive director	ASAP	4														
AS 21.58.090	Meet to select executive director	ASAP	4														
AS 21.58.100(12)	Present options to legislature for financing of plan	Annually ?				4				4				4			4
AS 21.58.100(16)	Meet with universities, doctors, etc to encourage primary care physicians (assume 4 hours a week for 12 weeks)	12/31/94		48													
AS 21.58.100(18)	Establish and work with committees of experts regarding cost containment, etc (assume 2 hours per month)	7/1/94 and ongoing	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12
AS 21.58.100(20)	Hold public meetings to report to enrollees, governor, & legislature	Annually after 1998															4
AS 21.58.130	Review proposals from insurers to provide health insurance to Alaskans (two week's work, assuming that background work done by staff)	1/1/97 ? and every three years								4							
AS 21.58.130	Select insurer to provide coverage, or decide to form own insurer	1/1/1997 and every three years								4							
AS 21.58.280	Work with providers in meeting voluntary expenditure target (assume 1 day per month)	1998 and ongoing															48
AS 21.58.290	Report to the governor and legislature on health care expenditures, etc	Annually				4				4				4			4
AS 21.58.320	Assist in the "extensive community based public involvement process" (assume 2 hours per month)	12/31/94 and ongoing	12	12	12	12	12	12	12	12	12	12	12	12	12	12	12
AS 21.58.330	Set up peer review of quality (assume 2 hours per month)	1/1/96 and ongoing					4	4	4	4	4	4	4	4	4	4	4
AS 24.20.206	Meet with the Legislative Budget and Audit Committee following their annual audit (one day meeting)	12/31/94			4				4				4				4
<b>Total Number of Trips in FY:</b>			<b>372</b>				<b>244</b>				<b>284</b>				<b>216</b>		
<b>Total Travel Cost in FY:</b>			<b>\$204,600</b>				<b>\$134,200</b>				<b>\$156,200</b>				<b>\$118,800</b>		
Number of Directors who must travel each time:			4														
Plane fare per trip:			400														
average 1 1/2 nights per trip at \$100 per night:			150														
Average cost per trip:			550														

This worksheet calculates the total number of trips to be taken by directors for various reasons. It assumes that 4/7 of the members must travel for any given meeting/hearing/etc.

**FISCAL NOTE**

**STATE OF ALASKA**  
**1994 LEGISLATIVE SESSION**

**BILL NO. SB 284**

Revision Date: \_\_\_\_\_  
 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	3,402.5	4,389.7	6,250.7	19,329.7		
TRAVEL	684.6	557.4	583.8	616.8		
CONTRACTUAL	2,037.0	1,448.7	1,546.0	5,125.9		
SUPPLIES	90.0	110.0	143.0	452.0		
EQUIPMENT	1,087.3	353.5	577.1	4,415.1		
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
<b>TOTAL OPERATING</b>	<b>7,301.4</b>	<b>6,859.3</b>	<b>9,100.6</b>	<b>29,939.5</b>		

<b>CAPITAL EXPENDITURES</b>	12,000.0	2,500.0	2,500.0	2,675.9		
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<b>CHANGE IN REVENUES ( )</b>						
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**FUND SOURCE**

1002 Federal Receipts						
1003 GF Match						
1004 GF	19,301.4	9,359.3	11,600.6	32,615.4		
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
<b>TOTAL</b>	<b>19,301.4</b>	<b>9,359.3</b>	<b>11,600.6</b>	<b>32,615.4</b>		

Estimate of current year (FY 94) cost: \$ -0-

**POSITIONS**

FULL-TIME	70.0	90.0	123.0	514.0		
PART-TIME						
TEMPORARY						

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

Please see attachments.

Prepared by: David J. Walsh, Director  
 Division: Insurance

Phone: 465-2515  
 Date: 2/28/94

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

Date: \_\_\_\_\_

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					FY 95	FY 96	FY 97	FY 98
<b>SB 284 Fiscal Note for the Alaska Health Insurance Corporation</b>								
<b>Board of Directors: (See Attached Charts)</b>								
	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
	<b>Staff:</b>							
<b># positions</b>								
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-8 @\$33.3				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	Accounting Tech III R-16 @\$51.2				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	Accountant IV R-20 @\$65.8				65.8	65.8	65.8	65.8
1	Acct Supervisor I R-16 @\$51.2				51.2	51.2	51.2	51.2
2	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
1	Personnel Officer I R-18 @\$58.2				58.2	58.2	58.2	58.2
1	Supply Officer II R-16 @\$51.2				51.2	51.2	51.2	51.2
2	Mail Clerk Carrier II R-9 @\$35.1				70.2	70.2	70.2	70.2
21				<b>Total:</b>	<b>1,060.6</b>	<b>1,060.6</b>	<b>1,060.6</b>	<b>1,060.6</b>
	Travel:				50.0	50.0	50.0	50.0
	Contractual costs per person: 10.6				222.6	222.6	222.6	222.6
	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				21.0	21.0	21.0	21.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after				254.1	21.0	21.0	21.0

					FY 95	FY 96	FY 97	FY 98
<b>Public Involvement Process:</b>								
Advertising (2 time newspaper ads Juneau, Anchorage, Fairbanks, & Ketchikan)					45.0	24.0	36.0	11.0
\$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 4-8 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)								
<b>Data Collection:</b>								
Computer equipment					10,000.0	2,000.0	2,000.0	2,000.0
(Estimated based on the current value of the equipment owned by Blue Cross of WA and AK)								
Software Development (contracted out)*					2,000.0	500.0	500.0	500.0
*This assumes waiver of procurement process and that contractor is able to modify existing system to the corporation's use. The Division of Insurance is not aware of any off-the-shelf software available. Software cannot be finalized until regulations are adopted which specify the data to be collected.								
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	Actuary R-27 @\$92.8				92.9	92.9	92.9	92.9
1	Secretary R-10 @\$36.9				36.9	36.9	36.9	36.9

## HEALTH1.XLS

					FY 95	FY 96	FY 97	FY 98
	Fees and Charges 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
	Demographics Section							
1	Economist II R-20 @ \$65.8				65.8	65.8	65.8	65.8
2	Research Analyst II R-16 @ \$51.2				102.4	102.4	102.4	102.4
1	Research Analyst III R-18 @ \$58.2				58.2	58.2	58.2	58.2
3	Statistical Tech I R-12 @ \$41.0				123.0	123.0	123.0	123.0
2	Statistical Tech II R-14 @ \$45.2				90.4	90.4	90.4	90.4
1	Statistical Clerk R-10 @ \$36.9				36.9	36.9	36.9	36.9
	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
43				Total:	1,377.5	2,144.9	2,144.9	2,144.9
	Note: (This unit is comparable to the Research and Analysis section in the department of Labor with 38 positions)							
	Contractual- \$10.6 per position				286.2	455.8	455.8	455.8
	Office space per position- 12 mths/\$1.80/sq ft/175 sq ft = \$3.8							
	Miscellaneous contractual- \$6.8							
	Supplies: \$1.0/position				27.0	43.0	43.0	43.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after				326.7	220.6	43.0	43.0

					FY 95	FY 96	FY 97	FY 98
	<b>Claims Clearinghouse:</b>							
1	Director R-26*				0.0	0.0	90.0	90.0
1	Claims Administrator R-21*				0.0	0.0	70.5	70.5
1	Data Processing Manager II R-22 *				0.0	0.0	74.5	74.5
2	Analyst Programmer V R-21 @\$70.5*				0.0	0.0	141.0	141.0
4	Analyst Programmer IV R-19 @\$61.9*				0.0	0.0	247.6	247.6
4	Analyst Programmer IV R-19 @\$61.9				0.0	0.0		247.6
4	Analyst Programmer III R-17 @\$54.5				0.0	0.0		218.0
1	Analyst Programmer II R-15 @\$48.0				0.0	0.0		48.0
1	Physician Assistant R-20*				0.0	0.0	65.8	65.8
1	Investigator IV R-20 @\$65.8*				0.0	0.0	65.8	65.8
4	Nurse IV R-18 @\$58.2				0.0	0.0		232.8
3	Nurse III R-16 @\$51.2				0.0	0.0		153.6
4	Investigator III R-18 @\$58.2				0.0	0.0		232.8
3	Investigator II R-16 @\$51.2				0.0	0.0		153.6
6	Eligibility & Qual Ctrl Tech II R-18 @\$58.2*				0.0	0.0	349.2	349.2
24	Eligibility Tech IV R-16 @\$51.2				0.0	0.0		1,228.8
12	Eligibility Tech IV R-16 @\$51.2*				0.0	0.0	614.4	614.4
48	Eligibility Tech III R-14 @\$45.2				0.0	0.0		2,169.6
108	Eligibility Tech II R-12 @\$41.0				0.0	0.0		4,428.0
22	Data Processing Clerk III R-10 @\$36.9				0.0	0.0		811.8
3	Mail Clerk Carrier II R-9 @\$35.1*				0.0	0.0	105.3	105.3
2	Mail Clerk Carrier I R-7 @\$31.8				0.0	0.0		63.6
1	Secretary R-10 @\$36.9*				0.0	0.0	36.9	36.9
260				Total:	0.0	0.0	1,861.0	11,849.2
	* Means that this person starts in FY 97, everyone else starts in FY 98							
	Staffing in this unit is based on the staffing currently in Aetna's claims office							
	Travel:				0.0	0.0	10.0	100.0
	Contractual- \$10.6 per position				0.0	0.0	0.0	2,756.0
	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	0.0	33.0	260.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after				0.0	0.0	399.3	2,779.7
	Note: The utilization review unit does not include physicians or other medical specialists. This may result in some friction with affected disciplines.							
	Note: The bill requires that the claims clearinghouse be established by 12/31/95.							
	We understand from the author of the bill this means that the claims clearinghouse would be organized by that date but will not be doing any work before 7/1/97. The cost of organizing the section would be part of the data collection set-up.							

## HEALTH1.XLS

				FY 95	FY 96	FY 97	FY 98
	<b>Fee Reporting</b>						
2	Research Analyst III R-16 @\$51.2			102.4	102.4	102.4	102.4
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 I R-13 @\$42.7			42.7	42.7	42.7	42.7
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
19			<b>Total:</b>	<b>806.5</b>	<b>806.5</b>	<b>806.5</b>	<b>806.5</b>
	<b>Travel:</b>			<b>50.0</b>	<b>50.0</b>	<b>50.0</b>	<b>50.0</b>
	Contractual- \$10.6 per position			201.4	201.4	201.4	201.4
	Office space per position-						
	12 mths/\$1.80/sq ft/175 sq ft = \$3.8						
	Miscellaneous contractual- \$6.8						
	Supplies: \$1.0/position			19.0	19.0	19.0	19.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after			229.9	19.0	19.0	19.0
	Printing Annual Provider Price List			15.0	15.0	15.0	15.0
	(assuming \$.5 per copy, 30 copies printed)						
	<b>Public Health Improvement Plan</b>						
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
1	Clerk-Typist III R-8 @\$33.3			33.3	33.3	33.3	33.3
3			<b>Total:</b>	<b>157.9</b>	<b>157.9</b>	<b>157.9</b>	<b>157.9</b>
	<b>Travel:</b>			<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>
	Contractual- \$10.6 per position			31.8	31.8	31.8	31.8
	Office space per position-						
	12 mths/\$1.80/sq ft/175 sq ft = \$3.8						
	Miscellaneous contractual- \$6.8						
	Supplies: \$1.0/position			3.0	3.0	3.0	3.0
	Equipment: 12.1/position 1st yr, 1.0/pos. after			36.3	3.0	3.0	3.0
	<b>Contract Funds:</b>			<b>45.0</b>	<b>45.0</b>	<b>45.0</b>	<b>45.0</b>

DRAFT

## HEALTH1.XLS

					FY 95	FY 96	FY 97	FY 98
	Federal 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				????	????	????	????
	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
	Microfilm Equipment							175.9
	(This unit is designed to be very comparable to the PFD division)							

## HEALTH1.XLS

				FY 95	FY 96	FY 97	FY 98
	<b>Develop Long-Term Health Care Plan</b>						
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:				100.0	100.0	100.0
	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			91.0	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:			70.0	90.0	123.0	514.0
	Total Salary Cost:			3,402.5	4,389.7	6,250.7	19,329.7
	Total Cost other than Salary:			15,898.9	4,969.6	5,349.9	13,285.7
			Grand Total:	19,301.4	9,359.3	11,600.6	32,615.4
			4 year total:	72,876.7			
	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.						

**FISCAL NOTE**

**STATE OF ALASKA**  
**1994 LEGISLATIVE SESSION**

**BILL NO. SB 284**

Revision Date: \_\_\_\_\_  
 Title: Comprehensive Health Insurance Act  
 \_\_\_\_\_  
 Sponsor: Senate HESS  
 Requestor: \_\_\_\_\_

Department Affected: Commerce and Economic Development  
 BRU: Insurance  
 Component: Operations  
 \_\_\_\_\_  
**COMPONENT SERIAL NO.** 354

**Expenditures/Revenues:**

<b>OPERATING EXPENDITURES</b>	<b>FY 95</b>	<b>FY 96</b>	<b>FY 97</b>	<b>FY 98</b>	<b>FY 99</b>	<b>FY 00</b>
PERSONAL SERVICES	351.1	292.9	292.9	292.9		
TRAVEL	55.0	25.0	25.0	25.0		
CONTRACTUAL	74.2	63.6	63.6	163.6		
SUPPLIES	7.0	6.0	6.0	6.0		
EQUIPMENT	84.7	6.0	6.0	6.0		
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
<b>TOTAL OPERATING</b>	<b>572.0</b>	<b>393.5</b>	<b>393.5</b>	<b>493.5</b>		

<b>CAPITAL EXPENDITURES</b>						
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<b>CHANGE IN REVENUES ( )</b>						
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**FUND SOURCE**

1002 Federal Receipts						
1003 GF Match						
1004 GF	572.0	393.5	393.5	493.5		
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
<b>TOTAL</b>						

Estimate of current year (FY 94) cost: \$ -0-

**POSITIONS**

FULL-TIME	7.0	6.0	6.0	6.0		
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary.)

Please see attachments.

Prepared by: David J. Walsh, Director  
 Division: Insurance

Phone: 465-2515  
 Date: 2/28/94

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

Date: \_\_\_\_\_

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<b>SB 284 Division of Insurance Fiscal Note for the Alaska</b>				
<b>Health Insurance Corporation</b>				
	FY95	FY96	FY97	FY98
<b>Develop Uniform Claim Form by 6/30/95</b>				
Insurance Analyst III R-18 @\$58.2	58.2	0.0	0.0	0.0
Travel: For instate meetings and to Washington, DC to interface with Health Care Financing Administration (HCFA) which is working on a national uniform claim form.	30.0	0.0	0.0	0.0
Contractual: 1 position X \$10.6	10.6	0.0	0.0	0.0
Office space per position- 12 mths/\$1.80/sq ft/175 sq ft = \$3.8				
Miscellaneous contractual- \$6.8				
Supplies: \$1.0/position	1.0	0.0	0.0	0.0
Equipment: \$12.1/position 1st yr, \$1.0 after	12.1	0.0	0.0	0.0
<b>Rate Approval</b>				
Insurance Analyst III R-18@\$58.2	58.2	58.2	58.2	58.2
3 Consumer Complaint Specialists R-14 @\$45.2	135.6	135.6	135.6	135.6
Travel: Instate	5.0	5.0	5.0	5.0
Contractual: 4 position X \$10.6	42.4	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				
Contract w/consulting actuary	0.0	0.0	0.0	100.0
Supplies: \$1.0/position	4.0	4.0	4.0	4.0
Equipment: \$12.1/position 1st yr, \$1.0 after	48.4	4.0	4.0	4.0

Division Liaison				
Program Coordinator R-20 @\$65.8	65.8	65.8	65.8	65.8
Clerk-Typist III R-8 @\$33.3	33.3	33.3	33.3	33.3
Travel:	20.0	20.0	20.0	20.0
Contractual: 2 position X \$10.6	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	24.2	2.0	2.0	2.0
Total Costs:	572.0	393.5	393.5	493.5

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Memo to: Dave Walsh, Director

Date: February 24, 1993

From: Gene Furman CPA AFE  
Insurance Financial Examiner

Subject: Structure of a health  
insurer and manning thereof

When the fiscal note working group gets to the point of costing out the structure of the Alaska Health Insurance Corporation ("AHIC") it is likely that the appropriate model to use for this costing process will be the to elect the option to have the AHIC act as a health insurance provider. This option is most attractive in terms of job creation in that a significant number of jobs will be moved from outside to inside the state. Further, AHIC thus has the potential to become an incubator for a new alaskan industries. Spin off jobs such as training required employees at University of Alaska and increased bush employment when direct medical service providers are created are important examples of the indirect benefits of AHIC.

We need to review the organizational structure of a life and health insurer to be certain that we have an accurate picture of the costs required. Accordingly, I have outlined below organizational elements which the fiscal note working group should consider. It can be utilized as a checklist to determine that we have considered all AHIC costs.

#### Health Insurer Organization

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##### A) Levels of authority

- 1) Board of Directors - Covered in AS 21.58.020 to .080 (\*)  
The Board should be divided into at least the following committees:
  - a) Executive committee -
    - 1) Executive Director, Senior Deputy Executive and various Directors
    - 2) Deal with matters which bear a vital relation to the general business policy of AHIC. (\*)
  - b) Insurance committee -
    - 1) Various Deputy or Assistant Executive Directors and Directors
    - 2) Deals with decisions under
      - AS 21.58.310 - public health improvement plan
      - AS 21.58.110 - federal waivers (\*)
      - AS 21.58.110 - incentives for bush health care providers (\*)
      - AS 21.58.220 - claims clearing house (\*)
      - AS 21.58.110 - acceptable reasons for denial of claims (\*)
      - AS 21.58.170 - determine health care services required (\*)

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AS 21.58.110 - annual review (\*)

AS 21.58.230 - monitoring health care  
expenditures utilization (\*)

- c) Compensation committee - deals with matters of employee compensation and benefits
  - d) Audit committee - receives and follows up on the reports of the internal audit department and the independent auditors
  - e) Government relations - liasons with the state legislature and federal government
- 2) Executive Officers - An Executive Director and Deputy or Assistant Executive Directors are provided for in AS 21.58.090. (\*)
  - 3) Managerial Officers - Directors and Deputy or Assistant Directors will be needed to be responsible for the day to day functions of departments. These subordinate officers will be engaged in the following relationships
    - a) line,
    - b) staff, or
    - c) functional.

#### B) Departmentalization

- 1) Actuarial department - establishes the company's premium rates, reserve liabilities and generally handles all the mathematical operations of the company, designs new policies and forms, files rates and forms with regulator for approval, preforms frequency and cost studies.
- 2) Marketing department - responsible for placing new coverage, service to policyholders, supervises the activities of agents, preforms market analysis, trains agents and controls sign up costs.
- 3) Accounting department - responsible for company's accounting procedures and report preparation including the company's annual report to its regulators.
- 4) Auditing department - establishes and supervises the company's auditing function.
- 5) Investment department - handles the company's investment program under policies laid down by the board of directors, collects the interest and dividends on the company's investments and reinvestment of same.
- 6) Treasury department - manages the company's cash flow and banking relationships.
- 7) Legal department - handles the conduct of court cases

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growing out of contested claims, sufficiency and correctness of policy forms, agency contracts and analysis and interpretation for the benefit of the company of both state and federal statutory and court law governing health insurance.

- 8) Underwriting department - responsible for establishing standards of selection and for passing judgment on applicants for health insurance.
- 9) Medical department - supervises the company's medical examiners and the final authority on services and procedures to be covered.
- 10) Administration department - issues new coverage certificates, premium and commission accounting, policy changes, claims and similar functions of policyholder service; personnel administration, official company correspondence, minutes of meetings, corporate governance, government relations and planning.

C) Functionalization - as multiple health insurance products are developed costs from each function will be required to implement and service the product.

(\*) These costs exist in both the independent procurement and the acting as an insurer options.

Source: Life Insurance, Black & Skipper, eleventh edition, Prentice Hall, 1987.

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DRAFT FOOTNOTE REGARDING COST CONTROL PROGRAMS

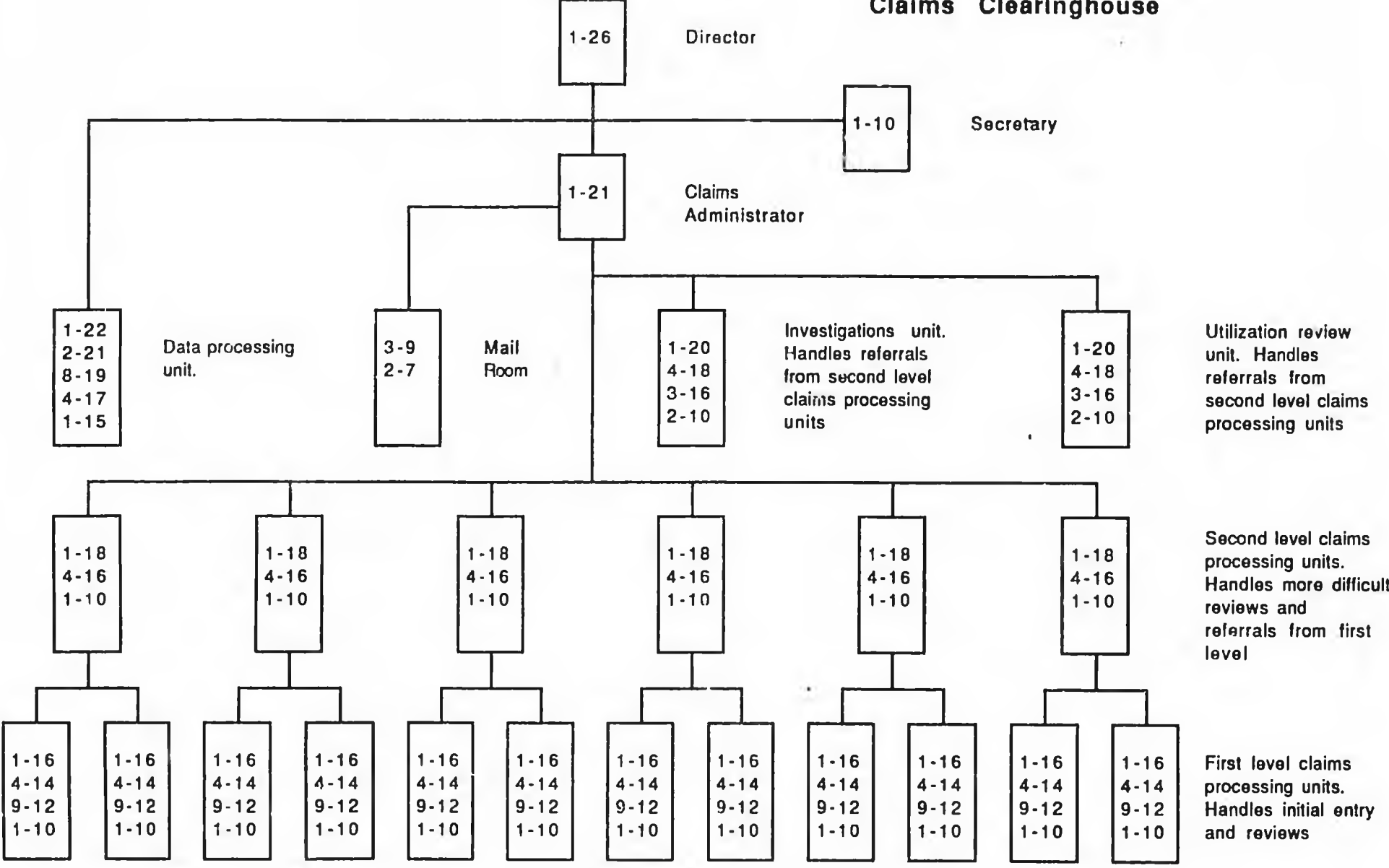
AS 21.58.260 requires the collection of health care data from which the corporation shall, under .270, prescribe by regulation a statewide health care expenditure target which shall, under .280, constitute a recommended target for expenditures within each specified category or subcategory of health care services or products. AS 21.58.290 and .300 require the monitoring of the voluntary health care provider compliance program of .280, the reporting of this effort to the legislature and the imposition by regulation of mandatory expenditure limits on one or more subcategories should voluntary compliance not produce the desired affect.

We can and have provided costs for adopting a regulation and a section of people to monitor and report to the legislature. What we have not included are costs of enforcement for the mandatory compliance of cost controls. Cost and product controls have been adopted at various times in our country's history. Examples would be the price controls of the second world war, Prohibition in which the sale of alcohol was banned and President Carter's recent attempt at price controls to bring the inflation of the seventies under control. Each ended in a country worse off than before the remedy. Accordingly, we are unable to identify a successful model after which to pattern a system of effective price or product controls which would not result in black market activities or a refusal of medical service providers to provide a product at the mandated price. Examples of this pattern of behavior would be the government controlled health care systems of Canada, Germany and India.

Also, we have no information regarding the political will of the legislature to enforce the mandatory cost control program. Without enforcement there will be no cost or product control programs. Judges, prosecutors, state troopers, investigators, paralegal and clerical support personnel therefore are some of the most expensive employees in state government. Enforcement quickly becomes expensive. An identification of the willingness of the legislature to accept the political backlash which even moderate enforcement will produce will be required before it is possible to calculate a cost.

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**Claims Clearinghouse**



DRAFT

LIST OF CONTACTS RELATING TO THE  
FISCAL NOTE FOR SB 284

Becky, Juneau.....Legislative Information Office

Madeline Kellyhouse.....PFD  
Tom Williams.....PFD  
Mike McGee.....PFD  
Randy Moore.....PFD

Larry Kemp.....Dept. of Commerce & Economic Dev.  
Judy Weske.....Dept. of Commerce & Economic Dev.  
Occupational Licensing

Brad Whister.....Dept. of Health & Soc. Serv.

Phyllis.....Blue Cross  
Lorraine Manger.....Blue Cross

Chuck Caldwell.....Dept. of Labor/Research & Analysis

Jim Coates.....Dept. of Labor/Unemployment Ins.

Barbara Saunders.....Aetna

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mailed to  
Bonnie by  
me 3/1/94



Betty -  
I spoke w/  
Bonnie right  
after the mtg  
& I was sure  
she told me.  
4 people came  
to this mtg  
only 4

# LEGISLATIVE TELECONFERENCE NETWORK SIGN-IN SHEET

URA CHUGACH/EAGLE  
RIVER  
CAMPUS

SPONSOR: SENATE HESS  
SUBJECT: Health Reform  
START/END TIME: 1:30 DATE: 02/18/94

PLEASE

	Name/Representing	Address	Zip	Phone No.	Testify	Observe	Bill No.
1.	Bonnie Nelson	20615 White Birch Rd	99567	688-3012	✓		
2.	Daryl Nelson	" " "	"	"	✓		
3.	Janet Oates	HC 85 9291 Heland Rd. ER	99577	696-2345	✓		
4.	RUTH CALLAN	22424 71. Birchwood	99567	688-9047	✓		
5.	JESSIE YEARSLEY	22424 N Birchwood Ln	99567	688-5446	✓		
6.	Wole PARSON	3677 College Rd	99709	479-3800		✓	
7.	Kim Adams	P.O. Box 2425, Palmer, AK	99645	746-6202			
8.	Julie Oates	9151 W Pkwy Terr Ln AK	99577	696-3779			
9.	Karin Williams	Box 878901 Wasilla, AK 99687	99687	696-3279		✓	
10.							
11.							
12.							
13.							
14.							
15.							

mailed to Jana  
by Bonnie Nelson  
re 3/1/94



# LEGISLATIVE TELECONFERENCE NETWORK

## SIGN-IN SHEET

UAA CHUGACH/EAGLE  
RIVER  
CAMPUS

SPONSOR: SENATE HESS

SUBJECT: Health Reform

START/END TIME: 1130 DATE: 02/14/94

**PLEASE PRINT**

	Name/Representing	Address	Zip	Phone No.	Testify	Observe	Bill No.
1.	Bills Johnston	Box 770334 Eagle River AK	99577	694-9766			284
2.	Ruth Callan	22424 N Birchwood	99567	688-9047			284
3.	Daryl Nelson	20619 White Birch	99567	699-3017			284
4.	Bonnie Nelson	LL	LL	LL			284
5.							
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TESTIMONY ON HEALTH CARE REFORM LEGISLATION

BEFORE THE

ALASKA SENATE COMMITTEE ON

HEALTH, EDUCATION AND SOCIAL SERVICES

February 28, 1994

My name is Gordon Evans and I represent the Health Insurance Association of America ("HIAA"), which is a trade association of the nation's leading commercial health insurance companies which provide health insurance for approximately 55 million Americans.

I am here today to present HIAA's view on the issue of "health care reform". HIAA supports enactment of Senate Bill 270 with some modification as the best way to approach the problems in our health care system.

HIAA wholeheartedly embraces many of the building blocks upon which comprehensive health care is based: measurable quality and outcomes standards, physician choice, and administrative simplification. Reform must include a shift in emphasis away from sickness and repair, and toward health and wellness.

However, we disagree with the sponsors of Senate Bill 284 that the government is the most appropriate mechanism for delivering health coverage to all Alaskans. HIAA advocates that government should be an "enabler" not a "doer."

The system must be streamlined and be made more "user friendly." Our health care system is awash in a sea of paperwork. HIAA supports standard guidelines for electronic data processing and a nationally uniform claim form to achieve an efficient and paperless system. Collecting and disseminating appropriate outcomes data and practice guidelines should be a component of any health care reform package.

HIAA also believes that all Alaskans, indeed all Americans, are entitled to health care coverage. To achieve this goal, we should build on the employer-based system to create a consumer-responsive, prevention-focused, affordable, and cost effective health system. We do not believe that a government-run, single-payer type system would provide the service or access to technology that most Americans expect and deserve.

All of us -- including the insurance industry -- are concerned about the more than 37 million Americans, including an estimated 76 thousand Alaskans, who do not have health care coverage. However, adopting Canadian-style, single-payor public health insurance -- everybody is covered and it appears to be cheaper -- unfortunately is not the magic solution.

For one thing, it's not that simple. There is no free lunch, as the economists like to say. If you try to provide free health care to everybody on a fixed government budget, eventually something's got to give -- and the consequences are very clear from the Canadian experience.

Everybody has access in Canada, the advocates say. Well, yes, but access to what? Can every Canadian get to see a doctor when they have the flu or their child has an earache? Does every Canadian have prompt access to medically necessary care?

Studies by the Vancouver-based Fraser Institute estimate that, across Canada, more than 177,000 people are waiting for surgery. Average waiting times vary by type of surgery and by province for certain kinds of medical care. For example:

- \* On average, it takes almost seven weeks to see a gynecologist in New Brunswick.
- \* Patients in British Columbia wait up to a year for routine procedures such as prostatectomies, hip replacements, and surgery for hemorrhoids and varicose veins.
- \* In Ontario, patients wait up to six months for a CAT scan, up to a year for eye surgery and orthopedic surgery, up to a year and four months for an MRI scan, and up to two years for other treatment.
- \* All over Canada, patients wait for coronary bypass surgery.
- \* On average, it takes about five weeks to see a specialist in all 10 Canadian provinces.

Is this the type of access we want?

As the waiting lines grow for virtually every type of treatment in every Canadian province, America serves as Canada's safety valve. In increasing numbers, Canadians are crossing the U.S. border to get care they cannot get at home.

Health care budgets have gotten particularly tight in the Canadian provinces in the last few years. Health spending now consumes about a third of provincial budgets. The government in Ottawa has frozen its per capita contribution at the 1989-90 level for the foreseeable future. The result has been turmoil at the provincial level as the provinces struggle to keep health spending from breaking the budget.

The essence of the American health care system is its ability to adapt quickly to changing needs and to develop and rapidly employ new and better ways of treating illness and maintaining health. Such responsiveness is clearly not possible when all major resource allocation decisions are made by the government.

One of the major rationales given by advocates for a government-run health insurance system for their claim that such a publicly run system will be cheaper than our current system is that administrative costs are lower. This may appear to be the case on the surface, but there is no reason to assume that the government will show the needed fiscal restraint in health care when it has failed to restrain other government programs.

In closing, let me emphasize that it has not been HIAA's intent to defend the current U.S. health care financing system as perfect, nor to portray the Canadian system as inept. Clearly, we must develop and adopt improvements that will extend affordable health care coverage to all Alaskans and all Americans.

The question is not whether we should address the problem. We should. Rather, the question is whether we should pursue a solution that builds upon what is good about America's health care financing and delivery system, or adopt an approach that would abruptly sweep away ~~our~~<sup>our</sup> present structure and substitute a radically different approach.

HIAA appreciates the opportunity to appear today and we would be happy to work with the committee and the Legislature to seek a resolution of this problem.

# Public Opinion Message

Title First Name Middle Name Last Name Suffix  
    
 Mailing Address Zip  
   
 Home Address Zip  
    
 Telephone Affiliation City

House Members		
Barnes*	Hoffman*	Olbergs
Bride*	Hudson	Parnell*
Brown*	James*	Phillips
Bunde*	<input checked="" type="checkbox"/> Kott*	Porter*
Carney*	Larson*	Sanders*
Davidson	Mackles	Sitton*
Davis*	MacLean*	Therrell*
Davis, B*	Martin*	Toohy <input checked="" type="checkbox"/>
Davis G	Menard*	Ulmer
Finkelstein*	Moses*	Vezey*
Fosters	Mulder*	Williams*
Green*	Navarre*	Willis*
Grussendorf	Nichols*	
Hanley	Nordlund*	

Senate Members	
Adams	Lincoln*
Donley*	Little
Duncan	Miller*
Ellis*	Pearce*
Frank*	Phillips*
Halford**	Rieger* <input checked="" type="checkbox"/>
Jackos	Salo*
Kelly*	Sharp*
Kerttula**	Taylor
Leman	Zharoff*

Caucuses
Anchorage Caucus*
Fairbanks Caucus*
Mat-Sui Caucus*
Bush Caucus*

Committees
C&RA
Finance
HESS <input checked="" type="checkbox"/>
Judiciary
Labor & Comm
Rules
State Affairs
Trans

Bill #  
 Support  Oppose  Amend  
 Not Related

Subject: Alaska Health Insurance Corporation

50 Word Maximum Message

1	2 oppose	3 these	4 bills	5 because
6 they	7 will	8 eliminate	9 personal	10 choice
11 by	12 creating	13 a	14 state	15 run
16 health	17 care	18 monopoly,	19 These	20 bills
21 also	22 have	23 to	24 cost	25 estimate
26 nor	27 any	28 provision	29 for	30 financing
31 the	32 cost	33 of	34 health	35 care.
36 Please	37 do	38 not	39 support	40 SB-284
41 or	42 HB-451.	43	44	45
46	47	48	49	50

Post-It brand fax transmission number 7671 of pages 1  
 465-2069

**PUBLIC OPINION TELECONFERENCE ON SENATE  
BILL #284-MARCH 2, 1994**

1. THE FINDINGS AND THE PURPOSES OF SENATE BILL 284 REFLECT THE BELIEF THAT THERE ARE A GROWING NUMBER OF CITIZENS WHO ARE UNABLE TO OBTAIN HEALTH INSURANCE OR PAY FOR THE NEEDED CARE.
  - A. I CANNOT HELP BUT WONDER WHETHER THE SOLUTION PROPOSED FOR THOSE WITHOUT MEDICAL COVERAGE IS SIGNIFICANTLY LARGER THAN THE PROBLEM???
  - B. DO WE REALLY HAVE ANY MEANS OF DETERMINING HOW MANY PEOPLE IN FACT DO NOT HAVE AFFORDABLE ACCESS TO HEALTH CARE COVERAGE?? THE INFORMATION AVAILABLE DOES NOT APPEAR TO TRULY ANSWER THAT QUESTION. PERHAPS A SERIES OF QUESTIONS ON THE PERMANENT FUND APPLICATION DETAILING THE REASONS PEOPLE DO NOT HAVE COVERAGE WOULD GIVE US A MORE ACCURATE FIGURE.
2. THE FINDINGS AND PURPOSES OF SENATE BILL 284 STATE THAT HEALTH CARE SERVICES AND HEALTH INSURANCE IN THE STATE ARE BECOMING PROHIBITIVELY COSTLY.
  - A. I QUESTION WHETHER OR NOT THE PROPOSED ALASKA HEALTH INSURANCE CORPORATION WOULD BE ABLE TO PROVIDE COVERAGE AT A MORE REASONABLE RATE IN LIGHT OF THE FACT THAT THERE DOES NOT APPEAR TO BE ANY ESTIMATE OR PLAN FOR ESTIMATION BEFORE ENACTMENT.
3. SENATE BILL 284 DOES NOT OFFER A PLAN OR AN ESTIMATE FOR FUNDING THE INSURANCE CORPORATION UNTIL "AFTER" CLAIMS HAVE BEGUN TO BE PAID. THE POLICY OF PASSING A BILL AND FIGURING OUT HOW TO FUND IT LATER IS IRRESPONSIBLE.
4. OF MAJOR CONCERN IS THE FACT THAT THE CORPORATION DOES NOT REQUIRE PUBLIC INPUT VIA THE VOTING PROCESS TO CHANGE MANY OF THE SIGNIFICANT AREAS OF ITS OWN OPERATION AS WELL AS THE FUNDING OF SUCH. THE POWERS OVER PROVIDERS OPERATING IN OUR STATE ARE TOTALLY OFEN ENDED AS WELL.

# NEWS

American Medical Association

FEBRUARY 28, 1994

## Surgeons back single payer

### ACS says national plan would protect patients' choice of doctor

By Sharon McIlrath  
AMNEWS STAFF

WASHINGTON — Sending shock waves through the health world, the American College of Surgeons has become the first major medical organization to back a single-payer health plan in the United States.

The position was adopted by the college's board of regents Feb. 4 and revealed to the world six days later at a congressional hearing.

ACS Chairman David Murray, MD, said the 60,000-member group acted out of frustration with insurer-run managed care plans and a desire to bring about reforms that permit "patients to select the physician or surgeon of their choice." He emphasized that the college had not endorsed any of the single-payer bills introduced in Congress to date, and had a number of quarrels with a leading contender introduced by Rep. Jim McDermott, MD (D, Wash.), and Sen. Paul Wellstone (D, Minn.).

The single-payer endorsement came at a fairly low-key hearing of a House Education and Labor subcommittee and had not been included in a written statement delivered to the commit-

tee earlier. It caught committee members as well as other medical groups completely off guard and caused some grumbling among surgical subspecialties, which now must decide whether to follow the ACS or break ranks.

For the moment, the National Medical Assn. and the American Medical Women's Assn. are the ACS's only medical company in the single-payer camp. Other major physician groups say there are pockets of support for a Canadian-type plan among their colleagues as well, and some surgical groups are reserving judgment until they've held further discussions with ACS.

But experience with Medicare and Medicaid has left many doctors wary of a plan that AMA President-elect and Maine surgeon Robert McAfee, MD, said would take "medical decisions out of the hands of doctors and patients and give it to faceless government bureaucrats." Also, as Dr. Murray told reporters at the hearing, the ACS board has not polled its members, and there may be some dissension with the single-payer endorsement within the college's ranks.

The ACS endorsement came on the heels of a visit from Dr. McDermott, who also traveled at his own expense to plead his case before the AMA and the American College of Physicians. Despite the ACS's reservations about his proposal, the Washington psychiatrist was plainly elated with their decision and said he'd willingly make some changes to meet ACS objections and bring other medical groups aboard.

"These groups are all fractured," he said. "But with the surgeons going, you might be surprised what happens. . . . The importance of what they've said is that managed competition takes away from decisions between doctors and patients and puts it in the hands of insurance companies. . . . Differences between us are easily bridgeable."

One of ACS's chief complaints about the McDermott-Wellstone proposal is its reliance on states to administer the program, Dr. Murray said. Surgeons fear that would be a "replay of Medicaid," which varies from state-to-state but is widely regarded as poorly administered and underfinanced.

Dr. McDermott said his plan, which requires the same benefits and pay structure in all states, avoids Medicaid mistakes. But he said Ways and Means health subcommittee Chairman Rep. Pete Stark has introduced another plan that extends Medicare to all Americans and suggests that this might be the basis for a compromise with surgeons.

#### Inside: more on reform

CBO: Mixed marks  
for Clinton plan  
budget . . . . . [1]

ACP exec, a vocal  
reform advocate,  
resigns . . . . . [2]

AMA to Congress:  
No retreat on  
coverage . . . . . [3]

Update: Reform  
in the states . . . [4]

Flash points:  
abortion, mam-  
mography . . . . [5]

MAR 1 9 1994 MED 13:34 PK HOSP & NURSING HOME BOT 46305515 P. 10

Moreover, he said, if surgeons and other doctors want assurances that they'll have a place at the bargaining table, he'd have "no problem" with adding "a guaranteed mechanism for negotiation" to his bill.

Although the White House did not return repeated phone calls, several medical leaders said they thought that rather than boosting the chances of a single-payer plan, the new ACS position might improve the prospects for the Clinton bill instead.

That proposal — which creates regional purchasing alliances, requires employers to pay for worker health benefits and caps annual increases — has been depicted by opponents as bureaucratic, expensive and radical. But with ACS supporting a single-payer plan, the president's plan may seem more "moderate," postulated American Society of Internal Medicine Executive Vice President Alan Nelson, MD.

"McDermott's got some company now," added American Academy of Family Physicians Executive Robert Graham, MD. He can say that besides 90 co-sponsors, he's also got "this very learned physicians group, which says this is not a bad way to do it." This "makes the president look more moderate" and shows that he's positioned his plan "midstream" in the debate.

#### 'No' to single payer

While AAFP is backing the president's plan as a "starting point," ASIM has said only that it likes some elements of the plan and disapproves of others. But like the AMA's Dr. McAfee, Drs. Graham and Nelson are firmly opposed to the single-payer concept.

To a large degree, all three men say the government itself is to blame. "The history of government-run medical programs does not inspire confidence that our patients' medical needs will be the government's top priority," observed Dr. McAfee.

"Our members have had 30 years experience with a single payer called HCFA, and it really hasn't been all that satisfactory," Dr. Graham agreed.

"When you have a single payer with the ability to impose price controls, the viability of the system rests on government's intention to deal in good faith," and the track record with Medicare and Medicaid "isn't reassuring," added Dr. Nelson.

Nor is Dr. McAfee the only surgeon unhappy with the ACS's new position. Durham, N.C., surgeon and former AMA President James E. Davis, MD, recently founded the American Society of General Surgery, which unlike the ACS will make policy chiefly through a house of delegates. He predicts that ACS's action will prove "very troubling to many, many surgeons throughout the country" and may "make democratically-based organizations such as ours more attractive."

That doesn't keep the medical profession's single-payer backers from hoping. Representatives of the Physicians for a National Health Program, which backs a Canadian-style plan, were overjoyed at the latest turn of events. "It's a highly important and dramatic breakthrough," said Quentin Young, MD, PNHP past president.

"We've seen an increasing physician awareness that the only reform that preserves patient choice and physician autonomy is single payer," the Chicago internist continued. "We didn't think the ACS would be the first major break out of the kennel. But I think this is a harbinger of what we can expect from other places in the house of medicine."

#### Secret support

Privately, representatives of most physician organizations say they've seen some upturn in the number of members who see a single-payer plan as preferable to those that hasten the

drive to managed care.

One medical executive was shocked when the Canadian approach beat out managed competition and incremental reforms in a straw vote among Oregon members. A family physician in Wisconsin says it no longer takes several drinks to get physicians in that state to speculate that a single-payer plan might not be any worse than managed care.

But primary care representatives say they think single payer support is concentrated mainly among surgeons and medical subspecialists, who fear managed care will put them out of business.

It boils down to economics, said AAFP's Dr. Graham. For family physicians, managed care does create some frustrations but their specialty's in short supply, so "there's no threat to their livelihood."

In a community with 50 cardiologists and three big managed care organizations using 10 cardiologists each, however, 20 cardiologists are going to be left with nothing to do, he added. And in that scenario, "I've heard an increasing number of people say I'd rather have single payer."

Whether its economics or autonomy that drives them, many subspecialists would prefer to practice in a system where patients don't need a primary care gatekeeper's or insurers' permission to seek treatment from a specialist. And, Dr. Murray told the House subcommittee, many do find a Medicare-type system preferable.

"We can take care of a Medicare patient as we see fit," he told the panel. "But we take care of our other patients

the way the insurance company sees fit. . . . These conditions are becoming increasingly onerous and in some cases are affecting quality of care."

But while they're inclined to agree with Dr. Murray's assessment of managed care, some surgical subspecialties are dubious about the ACS strategy. The American Academy of Orthopaedic Surgeons wants to meet with ACS regents to "decipher their reasons" before deciding whether to jump on the single-payer bandwagon, said AAOS President Bernard Rineberg, MD.

"Managed care is moving ahead at its own rate of speed," he noted, however. It already is being pushed for Medicare and is likely to be "layered on" whatever health plan is eventually enacted by Congress, including those that have only one payer.

RECEIVED FEB 22 1994

John J. Shaffer  
303 Kimsham Street  
Sitka Alaska 99835-7124

February 18, 1994

Senator Steve Rieger, Chair  
Senate HESS Committee  
Alaska State Legislature  
State Capitol (MS 3100)  
Juneau AK 99801-1182

Dear Senator Rieger:

Thank you for giving me a few personal minutes yesterday to let you know about my concern for the passage of a good bill focusing on Health Care Reform.

As you may have noticed today, the power went out in Sitka just after I gave my name for the record at the teleconference. Some of my Sitka friends teased me about that situation. Hope it didn't cause too much confusion on your end.

Please let members of your committee know the essence of my testimony, which would have been similar to this:

"My name is John J. Shaffer of Sitka and I am speaking on behalf of the State Legislative Committee of the American Association of Retired Persons.

For several years, we have placed the area of health care as the number one priority in our legislative program. This priority has been consistently endorsed by members of our organization, which relates to more than 42,839 individuals in the State of Alaska.

Our concern is not just for Senior Citizens, but for everyone in our state: children, youth and adults. We are concerned for those who are insured and for those who are not insured. Increased health care costs affects all of us.

The State Legislative Committee has just endorsed the concepts of Health Care Reform which are contained in Senate Bill No. 284.

Now that the Legislature and the Governor have received the Final Report of the Health Resources and Access Task Force, much of the ground work for this issue has been done.

It is not the time for more study, it is the time for action."

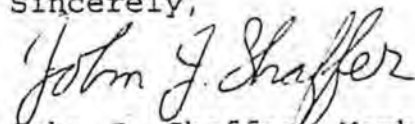
Setting up a Corporation with a board of directors that would be "compensated, but with less than full time employment", would be a positive step in the direction of action.

Senator Rieger, you are to be commended for holding hearings on this promptly and I hope you are able to move the bill on to the next committee quickly.

When you have additional hearings, perhaps the power source in Sitka will be more cooperative.

I think it would be exciting for Alaska to be ahead of the curve on health care reform, making us "in charge" of the changes that may be coming from the federal level, rather than just being reactive.

Sincerely,



John J. Shaffer, Member  
State Legislative Committee  
American Association of Retired Persons

cc: Mary Lou Meiners, Chair  
AARP State Legislative Committee

# Raven Causes Power Outage

By SHANNON HAUGLAND  
Sentinel Staff Writer

All of Sitka lost power for about an hour this afternoon when a raven electrocuted itself in some high-voltage conductors at the Marine Street substation.

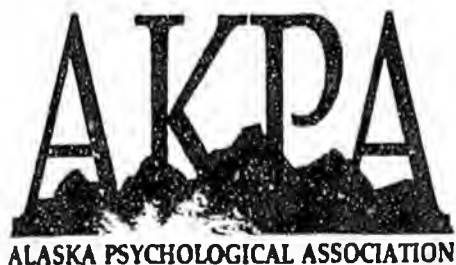
City Electrical Superintendent Dick Wilson said it was "an easy fix" and there was no damage to the system.

He said it appeared that the raven was sitting on one of the buses — a high voltage conductor — and then touched another bus that crossed overhead with its head or beak. The resulting short circuit opened protective breakers and shut down power to the distribution network.

He said the bird's insides "exploded" outside its body all over the immediate area, leaving only feathers and a skeleton.

"It was so instantaneous, he probably never knew what hit him," said Wilson.

Sentinel  
2/18/94



TESTIMONY GIVEN TO THE ALASKA SENATE HEALTH, EDUCATION & SOCIAL SERVICE COMMITTEE  
2/18/94

My name is Dr. Sally Schliesmann, and I am a licensed psychologist in private practice in Anchorage. I am also President of the Alaska Psychological Association. I am here today to talk about the importance of including psychological services in state health care reform.

Last fall, I had the opportunity to participate in the Health Care Reform Work group meetings crafting a joint health care proposal. Today there are several issues I want to bring to your attention, the first of which is access to service. Many people who seek therapy use insurance to cover some of the expense, BUT not all insurance packages include payment for therapy. Most people cannot afford to pay out-of-pocket. In my own business, 50% of my clients use insurance, 50% do not. 10% are on a sliding scale, which means I offer them service at a reduced fee. Many people drop out of therapy due to financial struggles. I do my best, ethically and reasonably, to accommodate this. I estimate that I get 5-10 calls a month from people who want to make an appointment and then discover they can't afford it. Most of these people will probably not get help. One alternative for them is Southcentral Counseling Center, a state-funded mental health center, which currently has a five-week waiting list.

I see this as a health care crisis. I am one practitioner. In our state, there are 170 licensed psychologists and psychological associates available to provide services to those in need. There are many in need who aren't able to afford to get the help they need.

The next issue of importance is early intervention. What does this mean? It means getting to the problems when they're small so they don't get worse, and before they cause deeper emotional problems and greater financial setbacks. A young married couple recently came to see me for marriage counseling. They sought help when their problems were new, and with hard work, came to some resolutions in six weeks and now feel stronger in their marriage and more able to face future problems. A young college student recently came to see me to get help with bulimia. She had bulimic symptoms for six months. She sought help early enough and her prognosis is good because of this. It doesn't take much to imagine the worse-case scenario of either of these examples: the psychological and financial costs will be high if problems go untreated.

Page 2  
Senate HESS Testimony  
Dr. Schliesmann  
2/18/94

National health reform has emphasized the importance of primary and preventive health care in contrast to specialized treatment. I encourage you to consider, and as the health care reform debates continue, to think of psychological services as primary care and preventive service. Mental health is an essential component of total health care.

Did you know that

- personal and family problems are the number one workplace threat?
- 30-60% of physician visits are made by patients with no diagnosable physical illness. Anxiety and depression are among the six most common conditions seen in family medical practice.
- alcohol treatment for one family member subsequently reduces the health care costs of the whole family
- psychological intervention enables surgery and heart attack patients to recover more quickly

There is an accumulating body of research showing the significance of behavior and psychology on the body's immune system. In addition, psychologists provide interventions to help with hypertension, cancer, and gastrointestinal disorders, to name a few health concerns.

The more access to and availability of psychological services that people have, the more mentally healthy people are, the better individuals will be, communities will be and, as a whole, both individuals and communities will spend less on overall health services.

I have more information and statistics on these and many other issues of concern to psychologists. I am happy to provide you with more information at your request. I look forward to offering you more input regarding state health care reform.

Thank you.

OK

DAN WAYNE HAS STEPPED OUT

WOMEN WHITE BELIEF, EMULATION & SOCIAL PERMANENCE  
SCHEDULED FOR 10:30 TO 12:30  
APR 1968

LEGISLATIVE TELECONFERENCE NETWORK SYSTEM  
IN JUNEAD

APR  
1968



LEGISLATIVE TELECONFERENCE NETWORK SYSTEM  
MESSAGE FROM LIGGERS IN JUNEAU

1981/04  
AND

RE: COM: 403AW SCHEDULED FOR 02/18/94 13:30 TO 14:30

MONITOR SENATE HEALTH, EDUCATION & SOCIAL SERV PURPOSE: PUBLIC HEARING

MESSAGE TEXT: ~~ONE SOMEONE WOULD ALSO LIKE TO TEST.~~



02/18/94 13:20:30 LEGISLATIVE TELECONFERENCE NETWORK SYSTEM  
MESSAGE FROM: LIOCELM IN HOMER LTC

LTN1150  
AND

RE TCU: 48569 SCHEDULED FOR 02/18/94 13:30 TO 15:30  
SPONSOR: SENATE HEALTH, EDUCATION & SOCIAL SERVICES/PT. PUBLIC HEARING

MESSAGE TEXT: HOMER STANDING BY. NO PARTIC. YET THX.

02/18/94  
13:23:43

LEGISLATIVE TELECONFERENCE NETWORK SYSTEM  
PARTICIPANT LIST (ALL PARTICIPANTS)

LTN1150  
BY: JTT  
FOR: JTT

TCU: 48569 SCHEDULED FOR 02/18/94 13:30 TO 15:30  
PUBLIC HEARING SENATE HEALTH, EDUCATION & SOCIAL SERV

LOCATION: SITE A  
ALL ITEMS  
ALL ITEMS

~~OFFERED  
10/11~~

~~DELIVERED  
10/11~~

TESTIFY  
TESTIFY

02/18/94  
3:34:42

LEGISLATIVE TELECONFERENCE NETWORK SYSTEM  
PARTICIPANT LIST (ALL PARTICIPANTS)

LINE 154  
BY FBI  
FOR FBI

TCN 40509 SCHEDULED FOR 02/18/94 13:30 TO 15:30  
PUBLIC HEARING SENATE HEALTH, EDUCATION & SOCIAL SERVICE

LOCATION FAIRBANKS  
35 284

~~SR~~

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HANCHETT ENT

TESTIFY

02/18/94  
15:34:55

LEGISLATIVE TELECONFERENCE NETWORK SYSTEM  
PARTICIPANT LIST (TESTIFIERS ONLY)

LINE 155  
BY MAT  
FOR MAT

TCN 40509 SCHEDULED FOR 02/18/94 13:30 TO 15:30  
PUBLIC HEARING SENATE HEALTH, EDUCATION & SOCIAL SERVICE

LOCATION MATSU  
58 284

~~SR~~

~~CON~~

~~MARGEL & DUFF~~

TESTIFY

02/18/94  
13:30:57

LEGISLATIVE TELECONFERENCE NETWORK SYSTEM  
PARTICIPANT LIST (ALL PARTICIPANTS)

LTN1150  
BY SOL  
FOR: SOL

TCN 40309 SCHEDULED FOR: 02/18/94 13:30 TO 15:30  
PUBLIC HEARING SENATE HEALTH, EDUCATION & SOCIAL SERVICES

LOCATION: KEN STE  
20 797

MR

MIKE

LOCKWOOD

CPG

TESTIFY

02/18/94 13:40:11 LEGISLATIVE TELECONFERENCE NETWORK SYSTEM  
MESSAGE FROM: LIGCERT IN JUNEAU

LTN1120  
AND

RE TCN: 40309 SCHEDULED FOR: 02/18/94 13:30 TO 15:30  
SPONSOR: SENATE HEALTH, EDUCATION & SOCIAL SER/PURPOSE: PUBLIC HEARING

MESSAGE TEXT: ZENS, DUNCAN, ELLIS, SAID ARE 1/2 JOU

Additional people in Eagle River

- 1) Ruth ~~Call~~ Allen
- 2) ~~Jessie Ayrault~~
- 3) ~~Cole Carson~~
- 4) ~~Kim Ayrault~~ friends

Sitka has  
power outage  
and will call  
back as soon  
as they have  
power again.

258/1241



# LEGISLATIVE TELECONFERENCE NETWORK SIGN-IN SHEET

SPONSOR: Senate Mess  
SUBJECT: SB 270 & SB 274  
START/END TIME: 1:30 DATE: 2/12/94

PLEASE PRINT

	Name/Representing	Address	Zip	Phone No.	Testify	Observe	BTI No.
1.	Thelma Langdon Elder Persons Action Group	2363 Surf. Cook Dr Anchorage	99517	347-0134	✓		
2.	DAVID MALTMAN Gov Control	3601 C ST # 740		563-5355		✓	
3.	Willow Arrow " " "	" " "		"		✓	
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							

Govmans Council Office 3601 C ST # 740

Offsets

Governor's Council on Disabilities

~~1) Thelma Langdon to testify~~

2 observers

Eagle River —

Testify

~~1) Janet Oates~~

~~2) Daryl Nelson~~

~~3) Bonnie Nelson~~

Cordova

Jarman

Kelchkin

Sitka

Tair

Mat

Soldatna



Testimony  
3 min limit

# LEGISLATIVE TELECONFERENCE NETWORK SIGN-IN SHEET

40309

pg 2

SPONSOR: Senate HESS  
SUBJECT: SB 270 Health Care SB 284. Nevada Jones Act  
START/END TIME: 1:30 DATE: 2-17

PLEASE PRINT

	Name/Representing	Address	Zip	Phone No.	Testify	Observe	Bill No.
1.	<del>Mary Ellen Goodland</del>	<del>2616 Newberry Anchorage AK</del>	<del>99507</del>	<del>522-1466</del>	<input checked="" type="checkbox"/>		<del>SB 284</del>
2.	<del>MARS FSC AIRTEL CO.</del>	<del>2501 COMMERCIAL DR</del>	<del>99501</del>	<del>272-4571</del>	<input checked="" type="checkbox"/>		
3.	<del>Richard Lee &amp; Associates (Tombston)</del>	<del>PO Box 107072</del>	<del>99511</del>	<del>214-4722</del>	<input type="checkbox"/>		
4.	<del>Ken [unclear]</del>	<del>MCA/IDHITS/CO + Acc VA</del>	<del>99519</del>	<del>343-4623</del>	<input checked="" type="checkbox"/>		
5.	<del>William C. [unclear]</del>	<del>MCA/IDHITS/PC Box 196157 Anch. AK</del>	<del>99519</del>	<del>343-4622</del>		<input checked="" type="checkbox"/>	
6.	<del>Michael A. Brogan</del> Had to leave	<del>1435 'N' ST.</del>	<del>99501</del>	<del>257-5260</del>	<input checked="" type="checkbox"/>		
7.							
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*Testimony  
3 min time  
limit*

# LEGISLATIVE TELECONFERENCE NETWORK SIGN-IN SHEET

40309

SPONSOR: Sen. HESS

SUBJECT: SB 276 - Hunter Care SB 284 - Hunter Ins Act

START/END TIME: 1:30 DATE: 2-17

**PLEASE PRINT**

	Name/Representing	Address	Zip	Phone No.	Testify	Observe	Bill No.
1.	<del>William ASMA</del>	1200 Airport Hts #310	99508	276-8878	✓		
2.	<del>STEPHAN CONN</del>	AK FIRE P.O. BOX 101093	99509	276-3661	✓		284
3.	<del>DR SALLY SCHLIESMANN</del>	2100 DENALI SUITE 701 Anchorage	99503	275-1200	✓		
4.	<del>Barbara Wingo</del>	11411 Lone Tree Dr. Anch. AK	99514	503-4308 346-1525	✓		284
5.	<del>Ed BURGHAN</del>	9960 WINE TREE DR	99512	346-1001	✓		284
6.	<del>Ken Taylor - highway committee</del>	4116 W. 11th St Anchorage	99506	563-1000	✓		
7.	David Wachter / Spirit House		99501	277-0782		✓	284
8.	Charles E. McKee	1505 W 43rd #7	99504		✓		284
9.	Theba Pittman	4720 Eagle #1 Anch	99503	561-0515		✓	
10.	Martine C. Leonard	1032 W. 11th St	99501	272-9152		✓	284
11.	DAVID G ALEXANDER MD	9601 PROSPECT DR	99516	346-2444	✓		
12.	Roni Zobel	3431 ILLIAMNA	99517	248-4544	✓		
13.	MARTORIE T. LINDER	P.O. Box 230029	99523	346-3611	✓		284
14.	JAMES DELROSS	2348 Leander Cir - Anch	99515	374-8524	✓		<del>284</del> 270
15.							



## Aleutian/Pribilof Islands Association, Inc.

401 E. Fireweed Lane, Suite 201  
Anchorage, Alaska 99503-2111  
Phone (907) 276-2700

April 22, 1994

HD-379-94

Alaska State Senate  
The Honorable Senator  
Steve Rieger, Chairman  
Health, Education & Social Services Committee  
MS 3100  
Juneau, Alaska 99811

Dear Chairman Rieger:

The Aleutian/Pribilof Islands Association, Inc. urges your support for the preservation of two vital rural health manpower development programs that Alaska is about to lose: The Alaska Center for Rural Health and the Alaska Physician Assistant Training Project.

The Alaska Center for Rural Health (formerly know as RAHEC) is a non-profit corporation which has been working furiously to ensure adequate health manpower for Alaska. As you know, we have a very hard time recruiting and retaining adequate health manpower to the more remote areas of our state. The Center, through its ability to establish communications between the far-flung parts of our rural health system and sources of training and health center development, has begun to mobilize us towards growing our own health profession's resources.

They have also conducted systematic study of our health manpower problems and provides timely connection to educational resources. By doing so, it has begun to show us ways to achieve health career development. Further, the Center has been designated as Alaska's Office of Rural Health by the Governor, and has over the past two years been assisting rural communities to more effectively plan for the health services. The Center requires \$250,000 to maintain its core operations. If historical success is any indication, the Center should be able to nearly double that amount each year in obtaining federal funds for our state.

The Alaska PA Project, three years in the making under a federal demonstration grant, is now graduating twelve Alaska-trained physician's assistants per year. The Center has taken on the

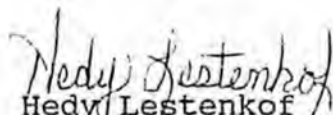
HD-379-94  
April 22, 1994  
Steve Rieger, Chairman

responsibility for administering the PA project without asking for administrative expenses since it represents an important part of its mission. Therefore, the \$500,000 that is needed to support the PA Project will go totally to the training of students.

We strongly urge that you appropriate the amount of \$750,000 to the Center to provide core funding for these two programs.

Thank you for your interest and assistance in improving the delivery of health services in Alaska.

Sincerely,

  
Hedy Lestenkof  
Health Director

cc: Bert M. Sharp, Vice-Chairman  
Loren Lemman, Committee Member  
Mike Miller, Committee Member  
Jim Duncan, Committee Member  
Johnny Ellis, Committee Member  
Judy Salo, Committee Member  
Alaska Center for Rural Health