ALASKA LEGISLATURE COMMITTEE FILES 2001-2002 8672

10528 SENATE HEALTH EDUCATION & SOCIAL SERVICES

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Interview Protocol

1. What do you see are the current trends in accessing health care?
2. How do you see the current situation of access to health care in Anchorage?
3. What are the barriers to accessing health care in Anchorage?
4. What resources do the uninsured have that allow them to access health care?
5. What improvements would you like to see in the access to health care for the uninsured?
6. Who should be involved in solving the problem of providing better access to health care in anchorage?

Appendix D

Research Participants Wanted

Are you working more than half time with no medical coverage? The Anchorage Access to Health Care Coalition wants to hear about your health care access problems and concerns. If you are interested in joining a small group of people like you for one hour to discuss these issues, please call 272-6131 (Alaska Primary Care Association). Your ideas are valuable.

PUBLIC TESTIMONY

State of Alaska Senate Health, Education and Social Services Committee: Subcommittee on Health Care and Welfare

Testimony Presented at the
Mat-Su Legislative Information Office
November 8-9, 2001
By Daniel J. Winkelman, Legal Counsel
Yukon-Kuskokwim Health Corporation

Good afternoon Chair and Subcommittee members. My name is Dan Winkelman, I am Legal Counsel for the Yukon-Kuskokwim Health Corporation located in Bethel. Thank you for this opportunity to participate at this Subcommittee meeting, to discuss the future of our State's health care and welfare.

YKHC is comprised of 58 federally recognized tribes operating pursuant to Compact with the federal government under the Indian Self-Determination Education and Assistance Act. We operate the only hospital in Bethel as well as 49 village-based clinics staffed with community health aide practitioners; and 3 sub-regional clinic's staffed with community health aide practitioners, registered nurses and mid-level practitioners.

YKHC urges this Subcommittee, that when considering Medicaid cost-containment measures for the next fiscal year, to understand that under the Indian Health Care Improvement Act, the Federal government subsidizes 100% of the cost of providing medical services to Medicaid-eligible Alaska Native patients through Alaska Native tribe or tribal health organization facilities.[1] Alaska's Federal Match Percentage, otherwise known as the Federal Medical Assistance Percentage or "FMAP", is 100% for health care services provided to Medicaid-eligible Alaska Native patients.[2] Indeed, when Congress

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[1] *See* 25 U.S.C. 1601 *et seq.*(2001); *see also* S. REP. NO. 101-508 (1990).
[2] *Id.*

enacted this law, the U.S. Senate Select Committee on Indian Affairs stated in its Senate Report, and I quote:

> Thus, the Federal Government would pay for 100% of the reimbursements to tribally-owned health facilities for services provided to Medicaid-eligible Indian patients. *This, in turn, would reduce the states' current share of Medicaid expenditures to 0% for these same facilities.* As a result, Native Americans will have better access to health care services and will be able to more fully utilize third party resources to which they are entitled.[3]

Therefore, 100% of Medicaid costs for Alaska Native patients is 100% Federal pass-through monies resulting in a State Medicaid experditure of 0%. Accordingly, any reduction in Medicaid rates proposed by this Subcommittee would be a reduction of Federal, not State monies for Medicaid eligible Alaska Native patients resulting in a decrease of health care services to Alaska Natives and contrary to Congress' intent. For the foregoing reasons, YKHC strongly urges this Subcommittee to *not* reduce the State's Medicaid Program.

Lastly, I would like to invite the Subcommittee to personally tour YKHC and meet with your rural constituent's *before* the Subcommittee proposes health care legislation that would negatively effect rural Alaska.

Thank you.

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[3] S. REP. NO. 101-508 (emphasis added).

Alaska Native Health Board

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Written Testimony for the
Healthcare and Welfare Reform Subcommittee

Presented by: Cynthia J. Navarrette, PHR

November 8, 2001
Wasilla, Alaska

My name is Cynthia Navarrette. I am the President and CEO of the Alaska Native Health Board (ANHB). ANHB is a statewide non-profit corporation that was established more than 30 years ago for the purpose of "promoting the spiritual, physical, mental, social and cultural well-being and pride of Alaska Native people." The Board of Directors of ANHB include Alaska Native regional and village health providers from across the State. In most cases, these organizations are the only health care providers for their region, serving both Alaska Natives and non-Natives who would otherwise have virtually no access to health care services.

I am going to provide my testimony in ~~three~~ 4 parts: 1) An overview of the Alaska Native Statewide Health Care Delivery System; 2) An overview of the funding provided for operating the programs, functions, services, and activities throughout the health care delivery system; 3) An overview of Medicaid, and; 4) The effects of IHS Beneficiaries use of the Medicaid Program.

Overview of The Alaska Native Statewide Health Care Delivery System

The heart of the Alaska Native Health System is the 468 Community Health Aides working in 178 village clinics throughout rural Alaska. The IHS beneficiaries in remote villages do not have daily access to physician care. They rely on the medical attention of the Health Aide.

There are six regional hospitals operated by the following Native regional organizations.

- Maniilaq, Inc. located in Kotzebue, Yukon-Kuskokwim Health Corporation located in Bethel, Norton Sound Health Corporation located in Nome, Bristol Bay Area Health Corporation located in Dillingham, Arctic Slope Native Association located in Barrow, and Southeast Alaska Regional Health Consortium located in Sitka.

The Alaska Native Health Care Delivery System consists of both consortiums and individually operated service units. A typical consortium infrastructure includes village clinics, possibly several sub-regional clinics, and a regional hospital. The rural health organizations typically serve areas as sole community providers. They may also serve the entire population, regardless of race.

The Alaska Native Medical Center (ANMC) is located in Anchorage and provides essential tertiary care, acute care and specific statewide health services for all Indian Health Service beneficiaries. The Alaska Native Tribal Health Consortium and Southcentral Foundation jointly manage the facilities that provide the full continuum of care within the Alaska Native Health Campus.

The AK Native Health System reflects levels of care available within the village, the regional hospitals, and the Alaska Native Medical Center (ANMC), located in Anchorage. The Medivac is essential to receive the next step up of care from the village to the regional hospital. If the case is deemed serious enough, a Medivac can be directed from the village straight to ANMC. There are

Medivac call-outs from Regional Hospitals to ANMC, and also from ANMC to more specialized hospitals in the lower-48.

Overview Of Funding

With the construction of the new Alaska Native Medical Center and the Primary Care Center, there is a perception that Alaska Native Health Services are amply funded. The reality is that the system is significantly under-funded. Indian people have long experienced disproportionately low health status and a large gap in health care resources compared to other Americans. Recently, Congress requested a health status and resource deficiency report for each Indian tribe or service unit. The IHS charged a Level of Need Funded (LNF) Workgroup to develop the necessary methodology. This report, published April 2001, states that Alaska is only funded at 61% of the total need compared to the Federal Employee Health Benefits Package. It is important to know that the Medicaid reimbursement funding is included in this percentage.

Overview of Medicaid

The Medicaid Program is not out of control. It is a large cost in every State, second only to Public Schools. To save the Alaska Legislature money by reducing the Medicaid Program would actively harm people receiving care – either by eliminating services for adults, or cutting reimbursement to providers, which will reduce access. Medicaid provides insurance to individuals and families that have no other access to health care services. Reducing the program would be a huge detriment to the health of Alaskan citizens.

Additionally, there is the economic impact that would be imposed on private health care providers to consider. 17% of the employees within the private sector are funded due to the Medicaid Program. Realistically, Medicaid within the State of Alaska is not a comparatively generous

program. Other States in our nation provide more services and that should be the direction in which the Alaska Legislature heads as well.

The Effects of IHS Beneficiaries Use of the Medicaid Program

IHS Beneficiaries are a large user of the Medicaid Program. However, the fiscal reality this imposes on the Medicaid Program is not what one would think. The State of Alaska receives 100% reimbursement from the Federal Government for IHS Beneficiaries that utilize Medicaid. This results in broader user access to a non-IHS Beneficiary population. Additionally, the IHS Beneficiary who utilizes the Medicaid Program actually has a positive impact on our States economy. The federally reimbursed dollars create jobs in the private health care sector that may not be otherwise available.

The Alaska Native Health Care Delivery System encourages the Alaska State Legislature not to cut the Medicaid Program and lower the wellness of Alaskans for the benefit of fiscal conservation.

Bill Hogan, Lifequest & Alaska Mental Health Board

Alaska Mental Health Board

Talking Points
Senate HESS Subcommittee on Health Care and Welfare
November 2001

Welfare

Programs such as the Alaska Temporary Assistance Program, Adult Public Assistance, and General Relief provide basic support for many Alaskans, helping them to meet fundamental expenses such as food, shelter, clothing, and transportation. Whether transitional or long-term in nature, these programs allow participants to live as independently as possible and with dignity in their community of choice. These programs also help Alaskans avoid homelessness and minimize higher cost, more restrictive settings, including hospitalization, nursing home placement, and incarceration. As the subcommittee reviews these programs, the AMHB requests that it keep in mind the following principles:

- All Alaskans have the basic human need to achieve and maintain the highest possible level of independence.
- The State has a responsibility to address the basic human needs of individuals who do not have other means to meet those needs on either a short or long-term basis.
- Support levels should to be sufficient to allow individuals to live with dignity in the community.
- Support levels should be consistent and predictable to provide stability for individuals as well as for the service providers.
- Programs should be readily accessible to eligible applicants.
- All eligible individuals should be treated on a fair and equitable basis.
- Programs should be flexible enough to respond to the evolving needs of recipients and should not impose unnecessary and rigid barriers to support and community integration.
- Programs and services should be managed to promote efficiency and maximize resources.

Review of these programs should be conducted in a thoughtful manner. At a minimum, this process should include the following features:

- No changes should be made that negatively impact the ability of participants to meet basic living needs.
- Review of these programs should be on a program-by-program basis.
- No major changes should be made without meaningful input from program recipients.
- Any review or revision of a program must consider the full impact of the program and any proposed changes on recipients. The impact of reductions to other programs and services (grant programs, revenue sharing, etc.) on the ability of Alaskans to meet basic life needs must also be carefully considered.

Health Care

Review of health care programs, such as Medicaid and other publicly funded health care programs, aimed at cost containment, access, and coverage is appropriate and necessary periodically. The review should involve a broad group of those affected by possible changes, including the Alaskans these programs directly serve. Some points to consider:

- The subcommittee has limited time to address a number of complex issues.
- Access to health care should be carefully considered. Publicly funded programs represent the only source of health care for many Alaskans, providing vital services unavailable elsewhere. Private insurance has historically provided limited and lesser coverage for persons with mental illness (and substance abuse disorders) compared to coverage for other health conditions. The U.S. Senate recently passed a comprehensive mental health parity measure that, if it becomes law, will help reduce reliance on Medicaid and other forms of public assistance (many with mental illnesses would work if their illnesses were covered by private insurance).
- Public health care and welfare costs represent a relatively small portion of the State's direct budget costs and attract significant amounts of matching Federal funds. Our rough estimate is that State General Fund expenditures for health care and welfare totals about 7% of all FY 2002 State expenditures (including the Permanent Fund).
- The U. S. Surgeon General's 1999 report on Mental Health and subsequent supplements assessed the nation's response to mental illness and called for positive, proactive engagement. We urge that the Legislature to take leadership in addressing mental health issues:
  - ✓ Mental health and physical health are inseparable.
  - ✓ Mental disorders are real health conditions that can be disabling—more years of life are lost to mental illness in our society than all forms of cancer combined.
  - ✓ Mental health treatment works! Many forms of treatment now effectively address the symptoms of mental illness with fewer ill affects.
  - ✓ Up to 50% of those with severe mental illnesses do not seek treatment as consequence of stigma - fear, stereotyping, and discrimination.

  We must increase efforts to reduce and eliminate barriers to effective treatment of mental illness by eradicating stigma, educating others and ourselves about mental illness, and ensuring that mental health services are available when and where people need them.

OUR PRINCIPLES

Zero tolerance for fraud -- America's hospitals and health systems are rooted in a tradition of ethics and caring. We're committed to preventing, uncovering, and eliminating health care fraud and abuse. Hospitals across the nation are voluntarily adopting plans to ensure compliance with complex and confusing Medicaid laws and regulations.

However, Medicaid billing errors often result from confusing and conflicting regulations and instructions that are part of the Medicare reimbursement system. These are not intentional acts. Yet some would have you believe that mistakes and fraud are the same.

Providers who make billing mistakes after attempting to comply with the complicated and frequently changing rules of Medicaid payment should be treated in a fair, equitable and civil manner and granted appropriate due process rights -- rights that are guaranteed to all Americans.

Compliance -- The AHA Board of Trustees recently issued a statement urging all hospitals and health systems to voluntary adopt regulatory compliance programs "as a way to minimize errors in conforming to highly technical and complicated rules," and urged hospitals and health systems to "develop and implement or strengthen a formal compliance program to ensure that regulations are accurately followed."

THE SOLUTION

To solve this problem, we need to return to the partnership we once had with the government. By rebuilding this partnership, we can go a long way toward ensuring compliance and fairness.

We would propose:

- imposing a "de minimus" standard. Under the standard, as defined by the American Institute of Certified Public Accountants, Medicaid overpayments to providers of less than a specified percentage would result in penalties of no more than the amount of the claim plus interest.
- establishing a "safe harbor" for hospitals that submit a claim based on advice given by fiscal intermediaries and carriers. Such hospitals would be subject to fines limited to actual damages and interest.
- raising the burden of proof from a "preponderance of the evidence" standard to a "clear and convincing evidence" standard.
- establishing a "safe harbor" for hospitals that have adopted effective, good-faith compliance plans in which they are, if found in violation, subject only to actual damages plus interest.

Rebuilding the hospital/government partnership -- Hospitals and health systems want a new partnership with the State. Working together, we can do more to prevent hospital billing errors, and to prevent government over-reaching as it tries to account for those errors.

The AHA is willing to help find other ways in which the State government can make the billing system more workable. We have proposed a "best practices" process. Under this process, the AHA would identify vague laws, regulations, carrier instructions, etc., and go to the State with our best view on how they can be implemented. The State in turn would consider the problem and our suggestions, and get back to us with proper guidance. Through this process, disputes related to interpretation of laws, or individual concerns, could be solved without antagonism.

In addition, we have talked to the Attorney General's office about a mechanism that would give us an "early warning" about potential areas of concern. We respectfully disagree with the Attorney General's office that our members have received reasonable notice of problems in the past.

Also, we need to look at a dispute resolution system that could remove some of the adversarial relationship between the government and the hospital field. If we can develop an administrative mechanism to resolve disputes over both broad policies and specific disagreements, we can diffuse a potentially volatile situation.

At a minimum, we need to return to a system in which [***the Alaska Medicaid payment authority***] exercises its authority to review and discuss billing disputes with hospitals. Only after the failure of those efforts should Attorney General's office become involved.

- ✓ Develop clear and objective standards that differentiate between a regulatory overpayment and a civil/criminal fraud and publish these standards so that the AHA may advise its members on the standards.

The DOJ needs to speak clearly and precisely to retain its enforcement credibility, which is now at risk as it tries to stretch its enforcement resources with collection efforts of this sort.

- ✓ develop a self-disclosure program for regulatory overpayments that encourages compliance and not fear of unreasonable claims of penalties and damages, and would not require payment of penalties beyond standard interest penalties absent specific evidence of fraud or reckless disregard of overbilling.
- ✓ develop a "safe harbor" treatment for hospital overpayments that occur as a result of inaccurate or incomplete fiscal intermediary/carrier instructions.

CONCLUSION

We understand and agree with the government's determination to investigate and punish those who would abuse the system.

But the government is doing the right thing in the wrong way.

The overwhelming majority of Alaska's hospitals and health systems work hard to comply with the mountain of rules and regulations that govern Medicaid payment. When a mistake is made, it should not be treated as fraud. It should be treated as a mistake.

Through a rebuilding of the health care field's partnership with the government, we can make things fair again -- for hospitals and health systems and the people they serve, and for the government as well.

Note: based on "Testimony of the American Hospital Association before the Subcommittee on Immigration and Claims of the Committee on the United States House of Representatives on Health Care Initiatives Under the False Claims Act which Impact Hospitals April 28, 1998" delivered by Gordon Sprenger

http://www.aha.org/ar/testimony/test980428a.asp

November 8, 2001

Senator Green,

I would like to take this opportunity to speak to the issue of Denali Kid Care. I was introduced to the Denali Kid Care program through a personal heartbreak. My son attempted suicide through cutting his wrists and forearms. After a series of events I eventually had to place him in Providence Hospital's Adolescent Mental Health Unit. After 12 days of treatment, medication and counseling it was their recommendation that he be placed in a long-term residential treatment program.

We are a family of 5, my husbands health care program through his employer does not provide for residential treatment. I was consumed by panic. How could I bring my son home under his current frame of mind? How do you explain his actions to my other 2 daughters, of 6 and 4 years of age? It was impossible to fund something of this magnitude on my husband's salary and fall ultimately into bankruptcy. If I brought him home would I wake up one morning to find him dead in his bed? Or maybe even one of his sisters finds him that way.

Why wasn't the birth of my son followed by an owner's manual that would allow me to prepare for something so tragic that even foreknowledge could not ease or truly prepare you for? My thoughts were my adversary, my terrorist within. Until the staff caring for my son at Providence introduced me to Denali Kid Care. I had never considered this as an option for our family because my husband carried insurance through his employer for us, however because of my son's situation and other factors he qualified for this coverage. He has been in a residential facility in Utah for 14 months, as there were no facilities available for him in Alaska. After nearly 8 months of complete indescribable torment and anguish, for myself as well as him, the wonderful person I knew he could be, is emerging. It is unimaginable what our lives would be like today had Denali Kid Care not been there for us.

Respectfully,

Carolyn Sue Drouce

OCT 19 2001

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DENALI COMMISSION HEALTH CARE STEERING COMMITTEE
Recommendations for Restructuring
October 11, 2001

The De ommission Health Care Steering Committee was formalized by action of the Commission in the Sept r er 14, 2000 quarterly meeting. Prior to being formalized, the Steering Committee was established on an ad-hoc basis to assist the Commission in completing a statewide needs assessment and prioritization process for primary health care facilities.

Over the past year the formalized Steering Committee has been instrumental in helping the Commission to get the Health Care Program into operation. Now that the Program is in the operational phase, we believe it is time to sharpen the focus of the Steering Committee and to refine the Committee organization to best achieve the defined purposes.

Steering Committee Functions:

1. Provide general policy advice to the Commission
2. Provide advice on funding guidelines and funding allocations
3. Establish objectives for outreach and constituent input and actively facilitate both
4. Provide advice on approaches necessary to ensure sustainability of facilities and services
5. Provide direction regarding assessment and training needs relative to health care delivery and facility issues

Current make-up of the Steering Committee:

1. Director of Department of Health and Social Services Division of Public Health (DHSS-DPH) serves as chairperson
2. Representative of Alaska Native Tribal Health Consortium (ANTHC)
3. Representative of Indian Health Services (HIS)
4. Representative of USDA Rural Development Agency (USDA-RD)
5. Representative of Alaska Mental Health Trust (AMHT)
6. Representative of Alaska Center for Rural Health
7. Representative of Alaska Primary Care Association (APCA)
8. Representative of the DHSS-DPH
9. Representativ , the Denali Commission

Proposed restructuring of Steering Committee:

1. Chairperson would remain the same
2. ANTHC – representative would be the President or board member
3. IHS – representative would be Deputy Director and Chief Medical Officer
4. AMHT– representative would be the Executive Director
5. University of Alaska – Vice President for Health and Social Services
6. APCA – representative would be the Executive Director
7. Alaska Native Health Board (ANHB) – represented by the Executive Director or board member

Proposed sub-committee for funding agencies:

1. USDA-RD
2. Housing and Urban Development

Alaska Division of Insurance
Presentation to the
Senate Health Education and Social Services Committee
Subcommittee on Health Care and Welfare

Who is writing health insurance in Alaska?

- Self-funded employer plans (i.e. most large employer plans) are preempted under federal law from state regulation and therefore the Alaska Division of Insurance is not able to collect information on these plans
- There is not a competitive health insurance market in Alaska
- Results of the Division's 2000 health insurance survey indicate that
  - 1 insurer (Blue Cross) writes almost 90% of individual health insurance in Alaska and 1 other insurer (Mutual of Omaha) writes about 9%
  - 3 insurers (Blue Cross, Principal and Aetna) write over 85% of the small employer health insurance in Alaska
- Very limited choice of insurers and health plans

What are the barriers to insurers writing health insurance in Alaska?

- Small remote population: small base over which to spread administrative costs making it difficult to be competitive and make money
- Alaska's health insurance market represents less than .2% of the indemnity market in the U.S.
- Difficult to establish relationships and contracts with health care providers making the cost of health care even more expensive and more risky for insurers to write in Alaska
- On a national level and in Alaska insurers are pulling out of the individual and small group markets because they are not profitable for the them

What are the barriers to the purchase of health insurance by Alaskan's?

- Alaskans with health conditions are guaranteed coverage through the CHIA however many are not able to afford the premiums
- Healthy Alaskans would be able to purchase coverage in the standard market however their choices are limited to basically two insurers and many are not able to afford the premiums
- Cost of individual and small employer health insurance is high. Individual and Small employer premiums are high due to the high cost of health care, higher risk nature of the individuals insured (smaller pool and anti-selection) and administrative costs for both the insurer and the small employer. Therefore, many small employers can not afford to cover even a portion of the premium.
- **COST**

What can the state do to decrease the number of uninsured Alaskans?

- According to the latest US Census Bureau survey data the number of uninsured in Alaska is growing (at 19% in 2000)
- Lack of affordability appears to be the reason
- Direct or indirect premium subsidies or assistance programs
- Create a pool for lower income individuals and small employers currently without insurance and subsidize premiums or provide funds to cover excess losses of the pool

CORRECTION

THE FOLLOWING DOCUMENT(S)
HAVE BEEN REFILMED TO
ASSURE LEGIBILITY OR PAGINATION

OCT 19 2001

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1. USDA-RD
2. Housing and Urban Development

3. IHS
4. State of Alaska
5. MHTB
6. Other organizations at discretion of Committee Chairperson

Rationale for restructuring:

The intent is to reorganize the Steering Committee so it is able to accomplish its purposes more effectively and expeditiously. Subcommittees, both standing and ad-hoc, established at the discretion of the chairperson, would support the restructured committee in dealing with technical and procedural issues. (At this point it is clear that a funding agency subcommittee is needed to assist in the allocation and integration of the various funding streams and preliminary discussions are underway regarding a data committee.) The Steering Committee can then focus on providing policy level advice and reviewing and acting on recommendations from the subcommittees. The proposed make up of the new Committee reflects this policy level focus.

The proposal to include the University of Alaska Vice President for Health and Social Services will allow us to continue to tap the input of the Alaska Center for Rural Health, which is a unit of the University of Alaska, as well as other expertise contained within the University system, by having this representative of the University President.

We believe that USDA-RD can serve best as a member of the funding agencies subcommittee, and may be utilized in other subcommittees as appropriate.

The DHSS-DPH and Denali Commission will continue to provide staff support to Steering Committee.

Concurrence with recommendation:

Jeffery B. Slaser, Federal Co-chair

Fran Ulmer, State Co-chair

Alaska Division of Insurance
Presentation to the
Senate Health Education and Social Services Committee
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The Right Way to Replace Welfare

By Marvin Olasky

Policy Review
March-April 1996, Number 76

Over the past few decades, government welfare programs have been designed to lift the burden of caring for the poor from ordinary people, by allowing them to write a check to pay the professionals who would solve problems. It is time for government to reassert a healthy pressure on the American people: Congress should phase out federal-assistance programs and push states to develop ways for individuals and community-based groups to take over poverty-fighting responsibility.

Our predecessors understood the Constitution's charge to provide for the common defense but to promote the general welfare -- by ensuring an environment in which individual and community action could flourish. When, for example, Congress in 1854 passed a bill for federal construction and maintenance of mental hospitals, President Franklin Pierce vetoed the bill. "Should this bill become law, that Congress is to make provision for such objects, the foundations of charity will be dried up at home," he said.

Pierce's veto was sustained. His concern about "dried up" charity was typical of the era: Municipal aid to the poor could dry up private charity; state relief could dry up city aid; federal programs could dry up state efforts. Hardly the way to promote the general welfare.

But the mood of that era -- not to mention the Constitutional vision for addressing social needs -- has been lost. The concept of the modern welfare state placed responsibility for fighting poverty not at the lowest level but the highest. National entitlement programs came to dominate the social-services scene. The reversal of Pierce's doctrine was so complete that even conservatives in the 1980s, who favored reducing the growth of welfare programs, still talked of the importance of maintaining a federal safety net. They did not understand that the federal safety net was not only inefficient, but conceptually mistaken.

What? Criticize the safety net itself? Yes. When I took my children to the circus recently, I realized how infrequently the Ringling Brothers safety net is used. For an acrobat, a fall to the safety net is a failure; if he falls stunt after stunt, he will be fired. Most people during the Depression had the psychology of the acrobat: The newly installed federal safety net was to be used only when the choice was between it and a hole in the ground. But over time, as attitudes soften[illegible] welfare programs expanded, that desire to avoid using the safety net was often lost. The destigmatizing of welfare in the 1960s meant that the acrobats no longer needed to strain for those extra inches, because the audience would still applaud even if they fell into the safety net every time.

What America needs is not a safety net but a vast variety of small trampolines, suited to individual needs, movable so as to be present for individual crises, and providing a level of bounce fitted to the skill level and psychology of the individuals they are designed to save. Government's role under such a plan is clear: Get rid of constraints on the construction and movement of trampolines, and -- if it does not appear that enough trampolines will be produced -- provided incentives to get more. In that way, government can promote the general welfare.

What would this mean in terms of practical policy? Nothing short of a revolutionary proposal: We must place in the hands of state officials all decisions about welfare and the financing of it, and then press

them to put welfare entirely in the hands of church- a... ...ity- based organizations.

Under this radically decentralist proposal, Congress would acknowledge that even the block-grant concept violates common sense -- far better to leave the money in the states in the first place. Congress would acknowledge that block grants reduce accountability, for the goal of block grants is to free state governments from centralized control, but it also tends to free them from taxpayer control because the funds are viewed as "free money" blown in from Washington; Congress would acknowledge that block grants tend to breed scandal; without real accountability to either the national capital or the state's citizenry, funds are wasted and pressure mounts for Congress to attach not just strings but ropes to hold the sides of the box together.

In this scenario, a bold Congress, pushed hard by the newcomers of 1994 and 1996, would not fall into the same old trap and recentralize. Instead, Congress would pass, effective at the end of the block-grant era, a massive tax cut, with federal taxes decreasing by the amount no longer block-granted. (A side benefit: If Congress moves toward a flat tax, the tax rate could be set lower than is currently anticipated.)

States would then use their own taxing authorities to implement new programs, or duplicate the old ones if they choose to do so. If a new Congress were to make that decision in 1997, states would have four years to plan for the post-federal welfare era. They could tax residents adequate amounts to care for the poor, but provide incentives for citizens to contribute sizable amounts of time or money to local poverty-fighting charities by providing exemptions to the ... ...

It is not as if a dollar-for-dollar replacement for the $350 billion annual cost (in 1994) of federal and state welfare spending (70 percent of it coming from Washington) is necessary: We know that much money is wasted and worse than wasted, actually causes harm. Yet, if more trampolines are needed, we should not be opposed theoretically to governments, once they have worked to reduce barriers, also working to promote the general welfare.

The best way for legislatures to do this would be to offer the average taxpayer a deal as follows: "Come the year 2001, under the Welfare Replacement Act of 1997, your federal tax burden will be reduced by an average of $3,000. We certainly do not want to be accused of being cruel or mean-spirited, so we will raise state taxes by an average of $2,500. However, we also want to promote personal involvement with community-based organizations that offer effective compassion to the poor, and if you provide to such an organization a combination of money and time totaling at least $3,000 -- thus leaving the quantity of societal commitment to the poor unchanged -- you will be exempt from the new tax."

This would obviously represent a sweeping change from the current system. Now, taxpayers who itemize can deduct from their taxable income the contributions they make to a wide range of religious, charitable, and educational organizations, at their marginal tax rate (the lowest is 15 percent, the highest is 39.6 percent). This is helpful, but not good enough, and movement toward a flat tax might eliminate that deduction anyway. Under the new system proposed here, states would push taxpayers in a massive way to become involved with groups that provide direct social services to the poor, and offer exemption from taxation for such purposes to those who were helping others in their own way.

At least 11 critical questions about such a revolutionary departure from current practice immediately arise:

Q: ***What percentage of taxpayers would choose to support local charities and thereby gain exemption?*** That is very difficult to predict, but with four years of preparation it is likely that many would, resulting in

a tremendous boost to nonprofit finances and a large increase of citizen involvement. Those who did not become involved would pay the new tax, and states could use that fund to pay for any missing trampolines.

Q: ***Would church-based and community-based organizations be ready to expand or replicate themselves in order to make use of their new resources in a new century?*** They would have time to prepare, and the encouragement of a new system would ... the "compassion fatigue" that has built up over the years.

Q: ***Would acceptance of exemption-creating contributions force poverty-fighting charities to accept governmental control?*** At the moment, charitable organizations that seek government grants come under government oversight; some church-related programs have gained financially but lost their souls in the process. Even nonreligious charities accepting public funds have been forced to treat all of their clients bureaucratically, within the parameters set by law and regulation, rather than dealing with each human being on an individual basis.

The advent of "new tax" exemptions would not automatically free up religious groups and other community-based institutions to participate as equals in the social services sector. Despite precedents set by the GI Bill and other programs that allowed consumer choice, the ACLU would not be amused by the removal of secular liberalism from its established, privileged place.

Still, the offer of an exemption (signifying a right not to pay because of other services rendered) is as clear a hands-off statement as a legislature can make. Exemptions offer a greater degree of protection than deductions, credits, or especially vouchers, since the latter requires government not only to overlook revenue but to send out checks. A political coalition strong enough to obtain tax exemptions should be strong enough to keep them from being abused by antireligious zealots.

Q: ***Wouldn't some exemptions from taxation go for funds sent to phony, needless, or simply ineffective projects? Wouldn't these cases be cited by partisans of the welfare state as reasons for opposing the exemption system?*** Certainly, and those cases would make an impact on people who are startled to find that some among their fellow human beings are foolish, incompetent, or gullible.

Markets work not because everyone exercises perfect judgment, but because, on balance, most people make good judgments most of the time. Even with all the anticipated human error, a charitable sector in which the funds are allocated by individual private decisions is likely to be less wasteful than the current system. Besides, with more resources at stake, more careful analysis of charitable effectiveness is likely to become common. Publications that examine charities the way a Consumer Reports examines products would emerge.

Q: ***Wouldn't acceptance of volunteer time as part of the exemption-creating contribution open the door to fraud?*** It is true that proof regarding the giving of money tends to be clearer than that concerning time, the valuation of which can be complicated. Still, emphasis on the crucial meaning of compassion -- suffering with -- is vital, and a plan that provides incentives for contribution of money but not time is incomplete.

Many groups already keep records of volunteer hours, so bookkeeping would not be an insurmountable problem. Corruption could be kept to a ... keeping the general credit for exemption purposes at the level of the minimum wage -- enough to provide a bit of compensation for work time lost and to signify societal commitment to compassionate action, but not enough to promote

widespread cheating.

Q: ***What would happen to health care for the poor?*** Medicaid is the single biggest element of current federal and state welfare expense; of the $324 billion that federal and state agencies spent on welfare in 1993, $132 billion went for that one program. And yet, many cities have free or sharply-reduced-price clinics where some dedicated doctors and nurses volunteer their time. What can governments do to help such organizations?

In Jackson, Mississippi, the Voice of Calvary Family Health Center sees about 8,000 patients each year, and would like to expand its operations or start other clinics like it. Center director Lee Harper contrasts her clinic with higher-budgeted state operations and concludes, "When you have more money, you tend to waste more." Still, she needs more funds. Job one, however, is getting more hours from volunteer doctors, dentists, and nurses. "If we get the health professionals, we'll get the money."

Such an urgent need translates into a specific proposal that could be implemented at the federal level in lieu of all the macro-reform proposals of the 1990s: Give medical professionals tax credits for hours regularly worked at clinics. If a typical doctor, dentist, or nurse worked one day every two weeks at a clinic or in a similar way spent time to provide health care to poor individuals, billions of dollars in medical expenses could be saved. Participating health personnel, in return, could receive a tax credit equivalent to 10 percent of their salaries. Such a credit could be the cornerstone of the personal alternative to bureaucratic health-care plans that are rightly regarded with skepticism.

Q: ***Why substitute a state tax (with exemptions) for a federal one? Why not simply reduce taxes and allow individuals to spend the money as they see fit?*** Advocates of individual rather than governmental responsibility have the personal emphasis right, but will a reliance merely on individual goodwill and effort lead to the production of enough trampolines? For those who emphasize original sin rather than natural goodness, there is a middle ground between government and individual: Call it societal responsibility, within which government requires payment but leaves to the individual taxpayer how the money shall be spent.

Q: ***Will it be possible to restrict tax-exempting contributions to those organizations that are actually engaged in fighting poverty and its associated pathologies?*** In some cases the correct category will be obvious, but in others careful judgment will be required. For example, it would seem that general donations to a college or a private school should not be used for exemption purposes, but donations to a college or school scholarship fund for poor students should be. General donations to a church should not produce an exemption, but those to the church's specific poverty-fighting endeavors (an anti-addiction program for example) should be. General donations to a hospital should not; donations to a free or reduced-rate clinic for the poor should.

Such categorization would be necessary, even though it could cut into the individual flexibility that straightforward tax reduction would allow. No matter how carefully state legislatures define the new tax category for poverty-fighting organizations, officials would have to write and apply regulations implementing the new tax. That authority potentially could allow a state agency to exclude organizations that it did not favor for ideological, theological, or political reasons. Some organizations might change what they do and the way they do it in order to conform to the regulatory standards.

Such a threat does not mean that the new system could not work. It does mean that eternal vigilance will continue to be the price of liberty.

Q: ***Why not rely on pure voluntarism to do what is necessary?*** The seeds of welfare replacement are already planted; if we wish to move quickly enough to save a generation of children during the first decade of the 21st century, those seeds need lots of water. If men were angels, no incentives for goodness would be necessary, but devolution to the states and further devolution through an exemption system is a good way for human beings to shift resources from the public sector to the private sector. Such a shift would provide a pool of capital for worthy charities to use in replicating themselves and thus replacing the welfare state.

The stimulation of voluntarism through tax exemption is an impure tactic, but our predecessors in this country, with their realistic view of human nature, were not above using impure motives to promote virtue. Colonial settlers who took in a poor person received compensation from the township, and some of them may occasionally have profited a bit (although that would be more than made up for by the time they spent mentoring the needy person). A farm family that adopted an orphan gained a farm hand, though the economic advantage was outweighed by the hard task of being new parents to someone who had grown up under tough conditions.

Q: ***Why require $3,000 to receive the exemption from payment of $2,500?*** If some people hesitate to give (in money or minimum-wage time) the greater amount necessary to receive an exemption, that is fine; the quality of their giving would probably be low. Some personal contribution by the taxpayer is important to build a sense of involvement with and responsibility for the work of the charitable organization. The goal is to have as many taxpayers as possible think through their giving, and not merely respond to direct-mail appeals.

Q: ***Why would taxpayers be expected to make better decisions on groups to support than government officials have?*** Competition has made the American economy the strongest in the history of humanity, and the American political system the envy of the world. The American people have proven themselves capable, on average and over the long haul, of making good economic and political judgments. Taxpayers who invested $500 of their own money and time in order to direct $2,500 to satisfying projects would be likely to make equally good judgments in the charitable sphere.

Decisions about where funds shall go would no longer be a function of political struggles over the budgets of government agencies, but would result from the decisions of millions of individual donors. Independent charitable organizations would for the first time in generations be on a level playing field with those groups favored by government. Some errors would occur, but there is every reason to expect this system of delivering assistance to the needy to be far more effective than the current model of top-down government monopoly.

Yes, some innovators would fall, but isn't it better to win a football game 50-14 than to play so defensively as to fall into a 3-3 tie? Given the growing number of damaged children and ruined adults under our current regime, isn't it better to take the rational risks that could liberate millions, rather than suffer constant winter without Christmas?

In general, decentralization offers the best shot for each state to innovate in the way that is right for its unique population and specific problems. Since we do not know precisely which legislative plan would best promote the offering of individual compassion, an emphasis on state-level action maximizes the opportunity to find out for sure which tactics work best. Furthermore, there may be greater opportunity to move quickly in some states than in Washington.

While each state would have to sort out its particular problems, all must face, for example, rising

rates of illegitimacy. Abstinence programs are a start. When pregnancy nevertheless results and marriage does not, states should foster group-living arrangements for women while pregnant and during the year or two afterwards, so that those who would otherwise be alone will have a support network. States should challenge biases against adoption, and stress the advantages to the child of adoption at birth (or up to age two, at the latest). Having a baby out of wedlock should not bring with it the reward of any governmental cash payments.

No public-policy measure can take the place of the personal changes that are necessary to raise high the standard of American compassion. With supportive laws and rules compassionate individuals can make real progress toward reducing some of our most serious social pathologies, but the crucial change is still the one that goes on in each individual soul, not in the federal or state capitols.

Marvin Olasky is a professor of journalism at the University of Texas at Austin and the author of The Tragedy of American Compassion. *This article is excerpted from* Renewing American Compassion *by Marvin Olasky. Copyright 1996 by Marvin Olasky. Reprinted by permission of the Free Press, an imprint of Simon & Schuster, Inc.*

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Karen Lynn McNaught
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My Name is Karen Mcnaught, I have been a resident of Alaska for the past 11 years. My Husband and I have a one year old daughter called Isabel.

Whilst I was pregnant with Isabel we lived in a remote area behind Denali State park. We both worked for princess hotels.

In the 19th week of my pregnancy I slipped on ice and fell causing a placenta abruption and internal bleeding.

I was taken to hospital where I was told the bad news that there was only a 6% chance that I would carry Isabel to term.

They felt that I would either miscarry or have to be induced at 23 weeks.

I was referred to a perinatologist that specialize in high risk pregnancies. There are only 2 in the state

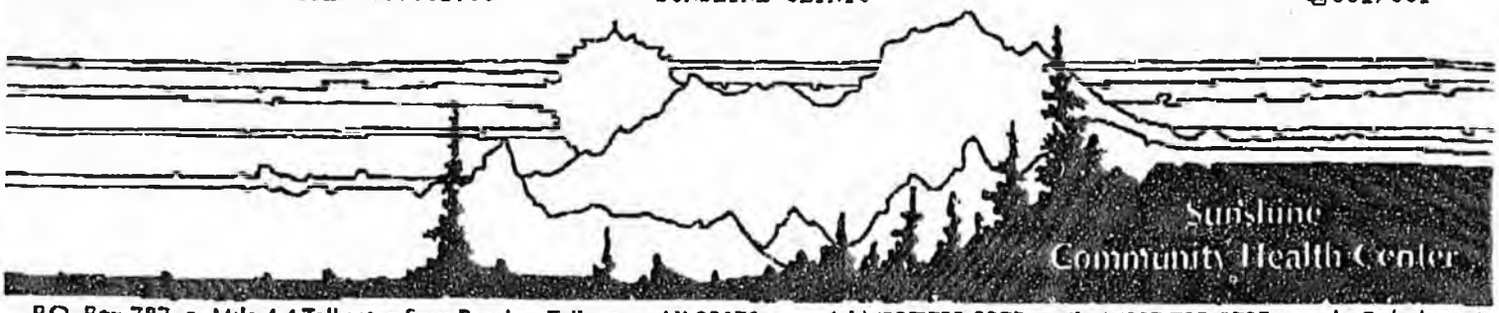
My Husband and I have what we thought was good medical insurance. That covered maternity, we where shocked to find that it only covered the perfect pregnancy.

Thankfully I had denali kid care that helped pay for what the insurance company did not cover.

I was underdose observation my whole pregnancy with numerous doctor appointment, ultra sounds and test monitoring me and Isabel.
The last 6 weeks of pregnancy where spent staying next to the hospital at providence house all of what was paid for by denali kid care.
on oct 1st Isabel was born by C. section.
(not covered by insurance)
She is the Joy of our life, we daily thank the Grace of God, providence hospital and Denali kid care for her.
I am one of many people who have such stories to tell of the importance of denali kid care
The children of Alaska are it most precious asset, more so the all to God. We need to protect them with all we can as they are our future.

Thank you for taking the time to hear my comment.

Nov. 9. 2001.



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PUBLIC TESTIMONY FOR LEGISLATIVE HEARING ON STATE MEDICAID THURSDAY AND FRIDAY, NOVEMBER 8, 9 2001

Testifying for Sunshine Community Health Center

Sunshine Community Health Center is a non-profit, federally qualified health center serving the residents of the Upper Susitna Valley. We provide comprehensive primary care services regardless of ability to pay. We have recently received a federal expansion grant to extend our services via a mobile clinic, to Willow and Trapper Creek.

We are a critical safety net provider for the northern region of the MatSu. Census 1990 data indicate that 35% of Willow and 26% of Trapper Creek residents lived below 200% of the poverty level. Analysis of our patient data indicates that fully 40%-50% of our patient population have no medical insurance. We also have an increasing number of patients who are "under-insured," meaning that they only have catastrophic insurance coverage or their deductibles are so high (over $1500) that they are virtually without insurance. Approximately 20% of our patients have Medicaid, 10% have Medicare.

Obviously, with a payor analysis such as the above, most private providers are not interested or able to locate a viable practice in this area. This is a critical and growing problem for rural Alaska. Safety net providers play a crucial role in the overall health care of Alaskans. Medicaid coverage, based on reasonable costs, for safety net providers such as rural health clinics and FQHC's (federally qualified health centers) is a key component of our survival.

I applaud this committee's commitment to ensuring careful and comprehensive planning for our State Medicaid plan. I would urge you to carefully consider potential negative impacts to safety net providers of any cutbacks to Medicaid coverage.

OPENING STATEMENTS FOR PCA VIDEO

Hi. I'm Bonnie Johnson. I am a Registered Nurse who has practiced for over 30 years in Alaska. Because I am concerned with long term care issues, I became a member of the "Gaps in Health Care Task Force". The task force is a group of nurses, social workers and health care providers who identify gaps in health care and find solutions that will better meet the needs of our clients. There are many problem areas that contribute to gaps in health care, and one key improvement for the State of Alaska will be enhancing the Personal Care Attendant (PCA) Program. This program, in existence for those eligible for Medicaid since 1987, provides services by trained health care paraprofessionals in a client's home, with supervision by a registered nurse. The State PCA Redesign Committee is working to improve the program. Perhaps videotaped testimony from clients may best express their needs to the Committee and the legislature.

Long term care is an important subject for Alaska.

- Alaskans are aging. The fastest growing population in Alaska is the 65+ age group.
- Aging successfully-Alaskans love their independence. Most of us want to stay in our homes as we age.
- The need for long term care is complex, increasing, and expensive.
- We need a system that allows for a continuum of care from complete independence to full dependency.
- The PCA program is an important program in this continuum.

The PCA program provides direct personal care services to individuals in their home. Although many have needs that would qualify them for placement in a long-term care facility, they prefer to stay at home and receive this care. These services help the client remain as independent as possible, and provide support to the families.

Claudia Andersen, a Registered Nurse with many years of experience, will be interviewing several clients with the PCA program to familiarize you with the service. These are the fortunate ones, as they have PCA service.

CLOSING SUMMARY OF PCA VIDEO

The GAPS in Health Care Committee has identified the following concerns as those that need to be addressed to increase the effectiveness and safety of the PCA program.

1) Recruitment and Training of PCA's: **The PCA is responsible for the cost** of training, as well as a State and Federal background check via fingerprints(some contract companies reimburse after 6 mos of employment). The minimum training required is 75 hours, the cost : $450.00-$1,200.00

Recommendation:

- More funding saurces to support the cost of training.
- Childcare to allow training; and/or a pay-back system.

2) **Retention of PCA's: There are currently no benefits for the PCA.**

Recommendation:

- The State contract could require a benefit package that might include : health insurance, vacation time, overtime, transportation cost reimbursement, pay raises, a career ladder. e.g. progressive "ranks" according to experience and hours of continuing education.

Continuing Education opportunities would increase knowledge base, skills, confidence, pride in vocation, and of course improve the quality of care for Alaskans.

3) Accessibility: **The current waiting list for PCA services is 153 names** long. These are our disabled and/or elderly Alaskans who simply ask to be maintained in their homes as long as possible. The cost of this care is less than any other option our state provides.

Recommendation:

- The program focuses on Medicaid eligible clients. We need to expand services to include non-Medicaid clients, with a sliding fee scale.

- Dual diagnosis clients are not accepted. We need a service that will accept and provide services to those with mental health diagnoses.
- The time between referral, paper ssment, approval, and delivery of services is 6-10 weeks long. The paperwork process is outdated and redundant.
- We need efficient tools, an application could be e-mailed, signatures fax'd, a minimum approval time respected.
- We need to attract and hire more PCA's.

4) **Safety: The PCA works with little supervision.** Currently, after the initial RN assessment, there are provisions for a second visit in a year, and one telephone call in 6 months.

Recommendation:

- Nursing visits, mentoring, and supervision need to be increased. The lowest paid, least trained PCA is working with our most frail and vulnerable population.
- There needs to be an agency back-up plan to provide services to clients when the PCA is unavailable.

The PCA program can preserve and support Independence and safety of Alaskans. It can provide quality care in a cost effective manner to Alaskans in their homes. Our priority must be to provide this service in a system that protects Alaskans from abuse, neglect or exploitation.

November 9, 2001

To whom it may concern.

I want to take a moment of your time to write about the benefits of Denali Kid Care for my family. I am the single working mother of two small children, Joseph who is 4 and Megan who is almost 3. I have recently looked into the cost of health care for my family. For my children and I it would be $150.00 per month plus a $350.00 deductible per family member. As for me the cost of health care is very expensive. But, I would like you all to know how fortunate I am. My children are extremely healthy and I contribute a lot of that to Denali Kid Care. I believe in preventative medicine. My children are up to date on their shots and on their physical check ups. My son for the first time went to the dentist to get his teeth cleaned and checked. Without Denali Kid care this would not have been possible. It is also the piece of mind that if one of my children were to get sick or injured, that there is some help out there to cover the costs of outrageous medical expenses. In conclusion, I would like to personally thank everyone involved in the Denali Kid Care program. They have given many parents the opportunity to provide preventative health measures to their children and piece of mind knowing that in the case of an emergency that there is someone to help. I would like to say thank you again for keeping our children happy and healthy, especially mine ☺.

Thank you,
Joleen M. Adair

Joleen M. Adair

THE
FOLLOWING
DOCUMENT(S)
ARE
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A Resolution of the Alaska State Hospital and Nursing Home Association (ASHNHA) concerning Medicaid Funding

Directed to: Alaska Legislature Subcommittee on Healthcare and Welfare—Senator Lyda Green Chair

Whereas: The ASHNHA member organizations provide multiple services to the state's Medicaid beneficiaries, and

Whereas: ASHNHA members have worked closely with the legislature and administration to secure new programs including Denali Kid Care and Breast Cancer treatment among other worthwhile endeavors, and

Whereas: ASHNHA members are concerned about potential decreases in the Federal matching funds as well as the significant changes to federal Pro-share, and

Whereas: A part of the increased cost of health services relates to the shortage of trained staff including Licensed Nurses, Allied Health Professionals, Certified Nursing Assistants, IT professionals and other health professionals, and

Whereas: The DHSS and ASHNHA have worked cooperatively in the past 2 years to develop new methodologies to stabilize the rate setting process

Therefore Be It Resolved, That:

ASHNHA strongly encourages the subcommittee to fully fund the incremental increases in Medicaid in the SFY 2002 budget, and

Further Be It Resolved, That:

ASHNHA asks that the Legislature address the shortage of Alaskans trained in health professions by:

a) Prioritizing technical/vocational education in the funding of K-12
b) Supporting the development of a second accredited program for RN nursing utilizing UAS as the distance delivery expert and expansion of UAA's LPN, RN and BSN programs at the Anchorage campus
c) Provide student loan forgiveness for those who complete LPN-RN training in Alaska and work in Alaska facilities.
d) Expand Certified Nursing Assistant and Allied Health professional training throughout UA with a focus on distance delivery models

Approved this _____ of _____ 20__ by the ASHNHA membership

Attest:

Dennis Murray, Chair

Charles Franz, Secretary

cc. Alaska State Legislature, Governor Tony Knowles, Jay Livey, DHSS

November 9, 2001
To the HESS Committees of the Legislature:

Tomorrow is my 57th birthday and I received a birthday present from my health insurance company—a notice that as of December I will be paying $830.88/month in premiums for a policy with a $2500 deductible, an increase in rates since May of 2000 of $293.57! My rates each month are more than my daughter pays for rent. They are quadruple the amount of my car payment. They are twice as much as my monthly food allowance. They have had the effect of limiting my retirement contributions and savings. I have been outside on a pleasure trip one in the past five years. My insurer will collect from me $12,470.56 per year before they will have to pay an extra dime in claims from me.

There is a silent insurance crisis in this state in the individual health insurance market. Those in my age bracket are particularly hard hit, but there are many younger people who are self-employed, RIFFED, or work for small employers who offer no health insurance. Our plight affects ALL Alaskans who

Alaskans who face the rising cost of health care, in part caused by unpaid medical bills from non-insured and underinsured people.

I have lived and worked in Alaska since 1978. I try to keep myself healthy. To try to avoid additional medical bills, I have to take shortcuts. My internist prescribes my asthma medication telephonically. My gynecologist prescribes anti-inflammatories for my shoulder. That is what happens when my premiums are too high for me to utilize my insurance correctly and pay for it at the same time.

It all began when Principal Mutual suckered me into a particular pool at a reasonable rate in or about 1993. I don't have a record of those rates but I can tell you that in May 1996, I paid only $188.13 per month. In April 1997 I paid $226.79/month when Mutual of Omaha bought Principal Mutual's book of business and closed my pool. Mutual of Omaha then placed the next group of health insurance buyers during another short timeframe in a different pool. With no new blood coming in, my pool began to age. The healthier members of my pool, who had no pre-existing conditions, switched to cheaper policies with other

insurers. The people who could find no alternative insurance companies willing to honor their pre-existing conditions, remained in my pool and so the pool shrank and had a larger percentage of people with health problems. While average claims increased, premiums skyrocketed. (I've prepared a handout to show you the increases in my premiums. You will note that my insurance premium was raised 30% over the previous year in 1999 when medical care costs in this state rose only 2%! You will note that by December 15, 2001, my premiums will be 441% of what they were in 4/96!)

These raises have had the effect of drastically reducing the number of policyholders in the pool. According to Mutual of Omaha, there were 12,591 policies in force in my pool in 1997. By the year 2000, there were 5,757 policyholders. Today, the number in my pool is probably even smaller.

When I complained about my rates, Mutual of Omaha cavalierly invited me to "shop in the open market" for other insurance. **As I found out, in Alaska, there is no "open market" for individual health insurance.** No insurer will

cover my pre-existing conditions—asthma and an arthritic shoulder—the two conditions for which I need ongoing treatment!

Moreover, I found out that there is no regulatory body on rates here. The Alaska Division of Insurance has no authority to oversee this price gouging that particularly affects middle-aged Alaskans.

Thus, **my only recourse is to turn to the Alaska Comprehensive Health Insurance Association (ACHIA) for coverage.** It will mean a waiting period of six months for my pre-existing conditions to be covered, but I'll have to take that chance.

Unfortunately, **the health of ACHIA is also at risk. You see, ACHIA has become the dumping ground for persons who are in my boat and age group and who are being priced out of the market.** As I understand it, ACHIA operates on premiums from its policyholders and assessments on large insurance companies doing business in this state. Self-insured plans are exempted from these assessments. Before the State became self-insured, its

insurer, Aetna, was contributing to ACHIA. Now, one insurer, Blue Cross, is bearing the majority of the load of subsidizing this federally mandated program.

Obviously, ACHIA needs additional mechanisms for its funding. One representative wants the State to pay an assessment. Other folks have suggested that the self-insured employers also contribute.

Thus, I implore you. Please put preserving ACHIA on the front burner this legislative year! While you are at it, please, please do something about the price gouging by and limited access to individual health insurance plans. Investigate other ways of sharing the risks so the pools for individual/non-employer sponsored health insurance plans are larger and not so age and time-sensitive and exclusive. Consider having the state plan for all non-employer insured people to purchase and have an insurer bid to insure that large group.

PREMIUM HISTORY
$2500 Deductible
One Person Insured

Age 51	4/30/96	188.13	Percent change of monthly premium costs from 4/96	Percent change of previous monthly premium	Percent change of medical care costs from previous year
Age 51	5/31/96	231.08	122%	22%	9.2%
Age 52	4/1/97[1]	226.79	121%	-2%	
Age 52	6/16/97	263.56	140%	16%	7.7%
Age 53	6/15/98	292.74	156%	11%	2.7%
Age 54	6/15/99	380.95	202%	30%	2.0%
Age 55	6/15/00	537.31	285%	41%	4.3%
Age 56	6/15/01	764.89	406%	42%	unknown
Age 57	12/15/01	830.88	441%	8%	unknown

[1] Date Mutual of Omaha purchased book of business from Principal Mutual

when the housing market is in flux. When rental or housing prices are changing fast, the inflation rate for the housing portion of the CPI may be exaggerated. This occurs because many homeowners have long-term fixed interest rate mortgages, which reflect past housing market conditions. So in times when the local housing market became overheated and prices rose rapidly, property owners with fixed rate mortgages were not affected. In such an environment, the rate of inflation would be overstated. The opposite scenario develops in a down market.

To evaluate the influence of the housing market on the CPI, the bureau produces an index that excludes housing. It is referred to as the CPI-U All Items Less Shelter component. (See Exhibit 4.) Using the All Items Less Shelter index for comparison between Anchorage and the nation shows that the difference of the indexes over the years is much smaller.

Medical care costs rose the fastest

Although medical care costs are a fairly small component of the CPI and are unable to push the overall index around very much, their meteoric rise in Anchorage over time has caught people's attention. (See Exhibit 5.) No other component of the CPI has come close to matching the increases in health care prices. The national experience has been similar to Anchorage's. During the past decade medical care costs in Anchorage have grown by 68.8%, much faster than the overall index, which increased by 27.2%. In 1998 and 1999 health care cost increases fell below three percent, but in 2000 this index regained its former momentum. As the state and national population continues to age and the need for health care expands, ever-rising costs will continue to challenge affordability for these services.

Selected Components CPI-U Anchorage and U.S. City Annual Averages 1983-2000 (continued) 4

	TRANSPORTATION				MEDICAL CARE				APPAREL & UPKEEP			
Year	U.S Avg.	Percent Change from Prev. Yr	Anch. Avg	Percent Change from Prev. Yr	U.S Avg	Percent Change from Prev. Yr	Anch. Avg	Percent Change from Prev. Yr	U.S. Avg.	Percent Change from Prev. Yr	Anch Avg.	Percent Change from Prev. Yr.
1983	99.3	2.4	98.5	1.6	100.6	8.8	99.7	5.2	100.2	2.5	101.6	5.2
1984	103.7	4.4	104.6	6.2	106.6	6.2	105.5	5.8	102.1	1.9	101.7	0.1
1985	106.4	2.6	108.2	3.4	113.5	6.3	110.9	5.1	105.0	2.8	105.8	4.0
1986	102.3	-3.9	107.8	-0.4	122.0	7.5	127.8	15.2	105.9	0.9	109.0	3.0
1987	105.4	3.0	111.3	3.2	130.1	6.6	137.0	7.2	110.6	4.4	116.6	7.0
1988	108.7	3.1	113.0	1.5	138.6	6.5	145.6	6.4	115.4	4.3	119.1	2.1
1989	114.1	5.0	116.7	3.3	149.3	7.7	154.4	5.9	118.6	2.8	125.0	5.0
1990	120.5	5.6	120.7	3.4	162.8	9.0	161.2	4.4	124.1	4.6	127.7	2.2
1991	123.8	2.7	121.7	0.8	177.0	8.7	173.5	7.6	128.7	3.7	126.6	-0.9
1992	126.5	2.2	123.3	1.3	190.1	7.4	183.0	5.5	131.9	2.5	130.2	2.8
1993	130.4	3.1	128.8	4.5	201.4	5.9	189.6	3.6	133.7	1.4	131.2	0.8
1994	134.3	3.0	136.9	6.3	211.0	4.8	197.8	4.3	133.4	-0.2	128.9	-1.8
1995	139.1	3.6	143.8	5.0	220.5	4.5	211.6	7.0	132.0	-1.0	130.0	0.9
1996	143.0	2.8	147.2	2.4	228.2	3.5	231.1	9.2	131.7	-0.2	128.7	-1.0
1997	144.3	0.9	147.0	-0.1	234.6	2.8	248.9	7.7	132.9	0.9	127.0	-1.3
1998	141.6	-1.9	144.9	-1.4	242.1	3.2	255.7	2.7	133.0	0.1	125.6	-1.1
1999	144.4	2.0	143.7	-0.8	250.8	3.5	260.8	2.0	131.3	-1.3	125.8	0.2
2000	153.3	6.2	150.5	4.7	260.8	4.1	272.1	4.3	129.6	-1.3	124.5	-1.0

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

Food costs around the state

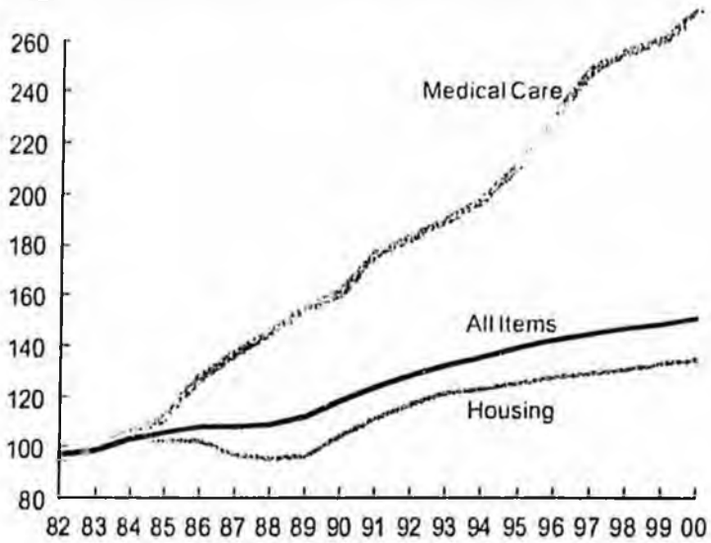
Four times a year, the University of Alaska Fairbanks Cooperative Extension Service posts results from its *Cost of Food at Home* survey for 20 communities around the state. (See Exhibit 6.) This food basket assembles items that contain minimum levels of nutrition for an individual or family at the lowest possible cost. In addition, the survey includes information on utility and fuel costs. The geographic coverage of the study is its biggest strength. No other survey in the state covers as many communities. Another strength is that it has been produced consistently for many years. The survey's biggest weakness is that it is largely limited to food, which is only a small component in the cost-of-living picture.

Other problems surface with the food cost study because many items that can be purchased in urban Alaska are not available in rural communities. The study also assumes that the market basket consists of identical items in all of the communities even though the buying habits of residents in the different places may vary dramatically. Recently the study included cost calculations of the widespread rural habit of ordering grocery items via mail from urban merchants; but other items entering the rural areas by barter or imported as baggage or private cargo are not included. Moreover, the local grocery list of base nutritional items also ignores the substitution of subsistence-harvested meats, fowl, fish, berries, and other foods for store-bought items.

According to the December 2000 *Cost of Food at Home* study, a family of four in Alaska enjoyed the lowest food costs in urban areas such as Anchorage, Fairbanks, and Juneau. The highest costs tended to be in remotely situated communities which are serviced by air and where the marketplace is small. Dillingham and Bethel belong in this category. Other high cost areas also exist in small places that lie on a major transportation system such as highways or the Alaska Marine Highway System. Grocery prices in these places often fall between the urban and remote-rural price ranges. Examples of such places are Petersburg, Tok, Delta, and Homer. But location is not everything. The size of the market, the level of competition, and the relative proximity to a larger urban area are other major determinants of food costs.

5 Medical Costs Increase Most

Anchorage CPI-U for selected components 1982-2000



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

Rents are high in Juneau and Kodiak

Because housing gobbles up such a large slice of household income it often is a good proxy for an area's cost of living. The Alaska Housing Finance Corporation contracts with the Alaska Department of Labor and Workforce Development to collect rental housing data for 10 communities around the state. Exhibits 7 and 8 display monthly rental costs for two-bedroom apartments and three-bedroom single-family homes.

Like food and other items, the cost of housing varies dramatically among areas. The supply of housing, vacancy rates, quality of housing, condition of the local economy, building costs, and local demographics are factors that help

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News Release

STUDY SHOWS INDIVIDUAL HEALTH INSURANCE MARKET IS FAILING OLDER ADULTS, RAISING QUESTIONS ABOUT TAX CREDITS

Losing Employer-Based Coverage Leaves Adults in Midlife Years Vulnerable to High Expenses and Access Problems

back

July 10, 2001

For more information, please call:
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Public Information Officer
TEL 202-408-6889

ANDREA ZUERCHER
at *Health Affairs*
TEL 785-842-2611

Washington, D.C.—Early retirement because of poor health or loss of a job may be risky business if you lose your employer or group health insurance coverage. A new study shows that adults ages 50 to 64 who buy individual coverage are likely to pay much more out-of-pocket for a limited package of benefits than their counterparts who are covered via their employers.

The study, which appears in the July/August issue of the policy journal *Health Affairs*, makes clear that older working-age adults could face financial and access problems if they lose their employer-based health plan. The authors conclude that today's individual health insurance market "does not work well" for adults in the age 50-to-64 range who lack access to group premium rates.

The findings, based on an analysis by researchers at The Commonwealth Fund's Task Force on the Future of Health Insurance, illuminate the potential problems of implementing a tax credit system for the purchase of health insurance among certain populations. A number of legislative proposals, including one put forward by President Bush, would provide tax credits in the $500 to $1,200 range for individuals. Based on their analysis, the researchers say these would be insufficient to help older adults buy coverage. An analysis of premium costs in 15 cities showed a median cost of nearly $6,000 for a 60-year-old. "Even in states with community rating [which limits what insurers can charge], credits in the $1,000 range would pick up at most one-third of premium costs," the study finds. At a minimum, "tax credits would need to be adjusted by age and region to reflect market realities," the authors say.

The study examines the viability of tax credits to help adults without employer or public group coverage in purchasing private health insurance. The study was authored by Elisabeth Simantov, former senior research analyst at The Commonwealth Fund; Cathy Schoen, vice president of research and evaluation; and Stephanie Bruegman, a program associate, both also at the Fund. The analysis was based on a survey of 1,523 persons ages 50 to 64 between August and November 1999. The authors also analyzed a variety of premium and benefit data in the nongroup health insurance market from 15 cities.

Highlights of their findings:

- Out-of-pocket premium costs were higher in the nongroup market. Nearly half with individual coverage reported annual out-of-pocket premiums of at least $2,000. In contrast, only 16 percent of adults insured through their employer paid that much.
- Annual premium costs climb steeply with age in the nongroup market; 55-year-olds were quoted rates twice as high as those for a 25-year-old seeking comparable benefits; rates were three-to-four times higher for a 60-year-old.
- Older adults with low incomes or who are in fair or poor health are more likely to have insurance through a public program or to be uninsured. The majority of older adults who have employer-sponsored coverage or who buy individual coverage are healthy and have higher incomes.

- The currently proposed tax credits of $500 to $1,200 to encourage health insurance purchase for individuals are small relative to premium rates quoted midlife adults in the nongroup market. Even with a tax credit, low-income adults in this group would still spend one-quarter to two-fifths of their income for health insurance in the open market

- Near-elderly persons are at high risk of access problems and financial burdens if not well insured. They rely heavily on prescription medications but do not always have coverage for them.

- Nongroup coverage leaves adults in this group especially vulnerable to high out-of-pocket medical expenses. One of four adults with individual coverage had annual out-of-pocket medical expenses of at least $1,000. In contrast, only 15 percent of those with employer coverage reported comparable expenses.

The authors conclude that their study reflects the importance of risk pooling and broad-based participation to keep individual insurance markets accessible to all. For tax credits to be viable for all age groups, the authors say they must be implemented in concert with access and rating reforms that minimize or bar discrimination or that provide group coverage options.

Health Affairs, published by Project HOPE, is a bimonthly multidisciplinary journal devoted to publishing the leading edge in health policy thought and research. Copies of the July/August 2001 issue will be provided free to interested members of the press. To obtain a copy, contact Jackie Graves at *Health Affairs* at 301/652-7401, ext. 255 or via email, press@healthaffairs.org. This article and selected others are available free on the journal's Web Site, www.healthaffairs.org.

###

- Marriages: 5,373
- Divorces: 2,647

Source: Unpublished data from National Vital Statistics Reports, Vol. 48, No. 19

Health Insurance

- Percent of private establishments offering health insurance to their employees: 46.2 (1993)
- Percent of private sector employees eligible for their employer's health plans: 61.2 (1993)
- Percent of private sector employees participating in their employer's health plans: 51.7 (1993)

Source: Employer-Sponsored Health Insurance: State and National Estimates DHHS Publication No. (PHS) 98-1017

- Employer-Sponsored Health Insurance: State and National Estimates. (PHS) 98-1017.

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Related Links

- **Alaska Department of Health and Social Services**
- **Healthy People 2000 State Data**

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This page last reviewed September 11, 2001

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Disease Control and Prevention
National Center for Health Statistics
Division of Data Services
Hyattsville, MD
20782-2003

(301) 458-4636

November 9, 2001

Thank you for giving me the opportunity to speak before your legislative committee regarding health insurance. Health insurance is what most employees look for when taking an employment position, even if they have to contribute some amount towards the premium. As a small non-profit that contracts with the State of Alaska to provide Substance Abuse Treatment for Alaskan's citizens, Nugen's Ranch only benefit for full time employees is health insurance. Due to raising cost of health insurance, the employees must now contribute to the premium. In October of this year our health insurance premium increase by $346.16 per month. At the present time the health insurance premium is $999.01 per employee. This was a 52% increase over last year premium. The reason given the Ranch for this increase were: the age of my employees, there use of the health insurance, the employee health problems, and the general increase in the insurance industry.

Nugen's Ranch is looking for other health insurance companies to provide our health coverage, but there are only a limited number of companies, and with a small group it is almost impossible to find a carrier. Even with the State's insurance program for person that have been denied coverage, the premiums for some of my staff would be even higher then what is being paid under our current health plan.

Nugen's Ranch is on the verge of losing health insurance coverage to do the increase in premium. Losing this coverage would mean that 15 employee would not have coverage, and could not afford to purchase health insurance coverage on their own. I myself am considered a high-risk person due to my heart condition, and the fact that four years ago, I had to have open-heart surgery. For the rest of my life I must take a drug call coumindan, due to the fact that stroke risk from my surgery.

There is a Health Insurance crisis in the State, for small to median size businesses. Somehow, there needs to be away to increase the number of companies that are doing business in the state. I am aware that Alaskan uses their health insurance if they have it and the high cost of medical care in Alaska. But there needs to be some kind of program for the average citizen to afford health insurance coverage, so that they are not at risk of losing everything if they have a major medical problem.

Karen Nugen-Logan
P. O. Box 871545
Wasilla, AK 99687

Date: November 8, 2001

To: Subcommittee on Health Care and Welfare

From: Angela Gonzalez, Member, Medical Care Advisory Committee

I am Angela Gonzalez. I am a consumer member of the Medical Care Advisory Committee. As you know, the committee advises the Commissioner of the Department of Health and Social Services on all aspects of the Medicaid program. My three children have been on Denali KidCare. DKC was important to my family because.....

I have some comments that I want to read. They are unsolicited comments from a survey of mothers of recent newborns whose children were on Denali KidCare. I believe these comments reflect how many mother s feel about Denali KidCare.

Comment #1. "The best thing that helped us have a healthy baby was Denali Kid Care. I did not put off prenatal care for fear of bills. It made it a lot less stressful for us. Denali Kid Care saved my sons life. When he was 2 months old. He got RSV and I took him to the ER to be seen. It turned out he was in respiratory distress and was taken by ambulance to Providence New Born Intensive Care Unit. He stayed 6 days. I don't think I would have taken him to the ER if I thought I would have to pay the 20% of my insurance because we were so broke. The doctor said that his respiratory rate was so high at the ER that he could have stopped breathing at anytime. He quit breathing once in the ER. Please help continue this program I feel it is one of the most important programs available to parents. "

Comment #2. "My pregnancy was not planned and even with my job and medical insurance, I would not have been able to go to doctor' appointments if it weren't f or Denali KidCare because of the cost of travel in and out of the village and the cost of what my insurance does not cover. It is very expensive and hard to make ends meet in Rural Alaska, especially when you don't have the capabilities of keeping up with the rest of the world's costs--medical and such, especially unplanned happenings. I know my baby is healthy because of Denali Kid Care and they continue to keep her healthy. Thank you."

Comment #3. "I had to quit my job due to problems during my Pregnancy and lost all benefits that went with it. I then was informed abo.. Denali Kid Care" who helped out. My husband and I appreciate the services they gave us in the labor & delivery of our baby. Thank you so much!!"

Comment #4. "Denali Kid Care is the best thing that happened in our lives. Without it my kids won't get their annual check up done because we don't have insurance. With our limited income, we can't afford each ones' dental and medical check ups. Thank you Alaska DKC."

Comment #5. "Denali Kid Care is a wonderful program. Without it, I may not have had a healthy baby. I suffered from pre-term labor and stayed at the Providence House in Anchorage for 3 months."

Thank you.

As a Catholic Social Services employee I'd like to share a story about a former family I served. She is a single mom of 2 boys one a teen and the other almost 10. She is currently pregnant with her third child. She has an in-home child care facility and earns close to $1500-$2000 per month depending on the number of children she cares for each month. She make enough money to cover her household fixed expenses and day to day expenses as they come up. She does not make enough to cover the cost of a private insurance carrier and is presently on Denali KidCare. She recently found out that this third child she is caring has an 84% chance of having down syndrome. She is still needing to undergo amniocentesis testing which she is scheduled for this Monday. If this would not be such an emotional issue she would be here to testify. She is very concerned that without the Denali KidCare she would not be able to afford the testing. She has so much trauma she is faced with and the future unsure but she is willing to deal with it. Her question to you is are you willing to deal with knowing that cutting the DKC program you could be hurting so many unborn children. Are you ready to deal with it???

Angela Gonzalez
276-3046

Jerry Nick

Greetings to panel members and other participants.

I am not here to defend the part the Health Insurance plays in the Health care picture. As student of this issue, I do not support the multi-million dollar compensation packages Insurance company executives extract and other elaborate entitlements. But, if insurance is to continue as a means of paying medical bills it needs to revert to sound insurance principles. Mandates override the basic elements that make insurance workable. That is the distillation of risk and reliance on actuarially sound costs. Ignoring these elements drive the costs and hence approach the affordability limit.

The issue of health care costs and it's continuing spiral upwards has been with us for some time. In this State Jay Kertula broached the idea of solving the problem with State and local participation I believe in the early 80's Subsequent to his initiatives, other studies and task force efforts with legislative intent and participation have been undertaken. The first of these projects commencing close to 15 years ago.

As we are all aware, no workable long range solution ever evolved either in Alaska or for that matter natioh wide based on reform efforts of the late 80's and early 90's. Efforts have divided into two fronts, either more money which expands the problem, or shaving the domain of any of the now participants in the industry. Any suggestion of change begins to raise the hackles of those that might perceive challenges to their piece of the pie.

Around the nation others have also challenged the problem of high medical costs without success Nationally and within States, various creative ideas have patched the problem c[illegible] could be described as temporary fixes. In Alaska the latest being Denali Kid Care. But one of the reasons for this meeting today is that the cost of the fixes is escalating. We all know that more and more patients are being squeezed out of decent health care because of cost. The ranks of the uninsured is continuing to rise increasingly. Hence the impact on social programs attempting to provide a safety net for those being left out is continuing to balloon the costs of the programs. That's what is happening to Medicaid.

So, here we are back at the table wondering and considering what to do about this onerous problem. Is there an answer. Probably, but not in the context of contemporary approaches which have been tried before. Most all reform efforts have involved the major players in the Health care industry,

from providers, insurers, government, and some private sector representatives. When all players contribute their interests in the solutions, nothing has changed. Everyone's economic survival dictates the design of solutions and we end back at square one. Today 15 plus years later we are still grappling with escalating health care costs.

In any public forum, especially when the legislature is involved; the goals, desires, and participation of all citizens must be weighed. That brings us back to the square one mentioned above. The elements/players of the system admit that change must be necessary; but not the part they play.

Any further task force development with the goal of reform must have an autonomous mission. Politics will be a liability to it's success. It must have a well defined mission based on a broad input from the many different players. It must be insulated from special interests and have the charge of developing a patient centered, efficient, centralized administrative design. We should be looking towards a consolidation of the many overlapping, competing, duplicative delivery systems we now have in Alaska, most of which are tax payer supported. We need to develop criteria which helps stem health care dollars exiting the state. There needs to be some real teeth in the Certificate of need process so that excess capacity which we now have big time. Mandates and their impact on costs must be understood. As I write this, the Federal Government if cooking up some more, the latest on mental health benefits. Anthrax which has infected 17 with 4 dying has prompted the American hospital assn. To ask for billions to counteract the threat. More money expands the system which we already are claiming to be too expensive. What ever is built out to counter the Anthrax threat will remain to be supported in the future. Scores of other issues could be listed here and this could go on and on. I mention few here to make the point that many options for improvements are available. And not everyone is going to like them. When we finally make the decision to make the changes and stand the heat, And I cannot tell you who we is, but it will probably come from the legislature. This whole issue is going to take some tough decisions, Only then will the beginning of reform come.

Currently within Alaska are dozens of talented knowledgeable people available to begin the process many of which have been through this whole exercise before. Margaret Mead said that all it takes to change the world is a handful of committed people. The legislature needs to empanel such a body with appropriate guidelines to start the process. It may take some funding to

meets the costs, but consider the 1.2 billion we are already spending on health and social services, and more than that on Health Care in this state over all, any costs here will be a meager contrast.

The suggestion is that the final product as a result of reform must stand on it's own merit and be owned by the people it is to serve citizens of Alaska. It must protected from special interests which will kill any effort to effect change unless it meets their vision.

In closing, if we cannot embrace change, then it is back to more money or cutting out someone's program to lower costs which is where we are today.

CATHOLIC SOCIAL SERVICES

ST. FRANCIS HOUSE
3710 E. 20TH AVE., SUITE 1
ANCHORAGE, ALASKA 99508-3418
907-276-5590 • FAX 258-1091

November 8, 2001

Senator Lyda Green
And members of the
Subcommittee on Health Care and Welfare
600 East Railroad Avenue
Wasilla, AK 99654

Fax: (907) 376-3157

Greetings:

I am the manager of St. Francis House, a program of Catholic Social Services that has been providing basic emergency services to economically struggling families in Anchorage for over forty years. In addition to my experience in working with the families that come to St. Francis House for assistance; I help answer the 24-hour, statewide, information and referral hotline, AKINFO. St. Francis House contracts with the state of Alaska to answer the AKINFO line during the day. My conversations with the callers to AKINFO give me an even greater familiarity with the unmet health care needs of Alaskans across the state.

I am a member of the Anchorage Access to Health Care Coalition because I believe, based on my experiences, that there is a very high correlation between inadequate access to health care and poverty. I am committed to working to increase access to basic health care for everyone in Alaska.

In light of the increased spending on National Defense, I am very concerned that Medicaid and Denali Kidcare might be in jeopardy of being compromised. I would like to plead with the committee to do everything in its power to protect the minimal health programs we have in place. We need to build upon these programs, not cut back.

As it is, these programs are woefully inadequate and there are thousands of working Alaskans who do not have access to affordable health insurance and only receive health care in hospital emergency rooms after their condition has become acute. Many of the people who are treated in this way have no means to fill the prescription they receive. This is an expensive and ineffective way to deal with health needs. At least, right now, since the advent of Denali Kidcare, thousand more of our children are receiving the preventative and consistent health care that they need to thrive.

In this time of national crisis, economic upheaval and biological warfare, it is more important than ever to keep our kids as healthy and strong as possible.

Sincerely,

Sara J Jackson

Sara J. Jackson
Program Manager

Senate Health, Education and Social Services Committee
Nov 8-9, 2001

Dear Senator Green:

Please add me to the group list interested in working on the insurance issues. I would like to be part of the solution. Thanks.

Marilyn Kasmar
Alaska Primary Care Association
907. 272. 6131

3009 Northwood Street
Anchorage, Alaska 99517

November 9, 2001

Senator Lyda Green
Senate District N
600 East Railroad Avenue
Wasilla, Alaska 99654

FAX: 907 376 3157

Dear Senator Green,

Thank you for providing an opportunity for written testimony to the Senate Health, Education and Social Services Subcommittee on Health Care and Welfare.

I understand your concern for the cost of the Medicaid Program in Alaska; however, it is very important for providing minimal health care to Alaskans. As has been noted, Alaska only pays 40% of the cost of this program.

AARP has joined other Alaska organizations to encourage the Alaska Legislature to include Alzheimers and related disorders under Medicaid. Presently, Alzheimers patients must present other physical problems before they can receive Medicaid assistance.

The Medicaid Waiver Program in Alaska has reduced the cost of care by allowing many patients to receive in-home and community care instead of nursing home care. This program could provide assistance to Alzheimer patients in their home for an extended time before they would need nursing home placement.

Thank you for allowing me to present this information to your committee.

Sincerely,

Marguerite Stetson
AARP Alaska Executive Committee Member

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

November 2, 2001

Senator Lyda Green, Chair
Subcommittee on Health Care and Welfare
600 First Railroad Avenue
Wasilla, Alaska 99654

Dear Senator Green:

The Alaska State Hospital and Nursing Home Association, as you know, is comprised of all the nursing facilities and all but two of the hospitals (except Norton Sound and Samuel Simmons) in the state. Medicaid on average is approximately 20% of the hospitals business and about 85% of the nursing facilities. As you are aware from all the letters you have received from members, Medicaid is a very big concern to us. We have a wealth of information that we would be happy to share with you and are willing to work with you on all of the issues.

The Henry J. Kaiser Family Foundation recently distributed a report, "Medicaid Budgets Under Stress: Survey Findings for State Fiscal Year 2000, 2001, and 2002." In that report, Alaska's top factors for contributing to Medicaid Expenditures in 2001 were:

- Home & community-based services (HCBS) waivers and other non-institutional LTC programs — 43% cost increase
- Pharmacy — 19% cost increase
- Hospital payments — 14% cost increase

In FY 2002, the top factors were:

- Pharmacy — 21.5% cost increase
- Home & community based services (HCBS) waivers and other non-institutional LTC programs — 19.3% cost increase
- Enrollment — 10% cost increase
- Continuing rise in disabled population
- Potential reduction in FMAP due to CPI formula changes

426 MAIN STREET • JUNEAU, AK 99801 • (907) 586-1790 • FAX (907) 463-3573

The Medicaid program is an important factor in the local economy, bringing in at least $2 in federal dollars for each state dollar spent. Medicaid is designed to be counter-cyclical: as unemployment rises and incomes drop, more people become eligible for Medicaid. If the program operates as intended, states and the federal government spend more on Medicaid as a result, easing the negative effects of the economic downturn. If states respond to their difficult fiscal situations by cutting Medicaid in the months ahead, it not only will make it more difficult for newly unemployed workers to secure coverage, but it also could deepen the negative effects of the economic downturn. On average for every $1 that states cut from their Medicaid general fund budgets, the total amount of spending on the program drops by $2.33 because of the even greater loss of federal Medicaid matching funds.

ASHNHA promotes and advocates for quality care within nursing and hospital facilities where more than 80% of the patients in long-term care nursing facilities are funded by Medicaid. Many small communities within the state are highly dependent on Medicaid funding long-term care beds to support hospital and clinic services. Without Medicaid funds many small communities would not have any medical services at all.

ASHHNHA appreciates the effort you and committee are taking to understand and improve the Medicaid program in Alaska and are very willing to assist you in any way that we can,

Sincerely,

Linda Fink

Linda Fink
Assistant Director

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

ASHNHA Resolution Supporting Current Certificate of Need Legislation

WHEREAS, the Alaska State Hospital and Nursing Home Association is strongly committed to developing a coherent and comprehensive network of health care services within the State of Alaska, and

WHEREAS, the State of Alaska shares these objectives with ASHNHA,

WHEREAS, the State has developed a CON review process that seeks to ensure that new health care facility construction projects or equipment purchases are cost effective, not duplicative, are adequately planned and involve the public, and improve accessibility and quality of health care services; and

WHEREAS, the CON review process encourages adequate access to healthcare through geographical dispersion of health care facilities and services which might not otherwise be expected to develop; and

WHEREAS, the CON provides a mechanism whereby provider initiatives may be evaluated against alternatives for meeting state priorities for improving the health status of its citizens; and

WHEREAS, the need to provide health care services to an expanding population with increasingly limited funds places a premium on effective and efficient deployment of these limited resources, and

WHEREAS, the demography and geography of Alaska limit the effectiveness of unregulated competition as a means of ensuring socially appropriate supply and demand of healthcare services, being culturally diverse, geographically dispersed and predominately rural; and

WHEREAS, the CON helps Alaskan health care providers meet the larger objectives of society, particularly with regard to understanding and addressing the needs of under-served and indigent patients; and

WHEREAS, the CON ensures these extra-institutional objectives are adequately addressed regarding healthcare facility and program planning, and that decisions to expand or contract the health services capacity are economically sound and medically necessary; and

WHEREAS, similar programs function in the majority of other States to good effect, to the extent that several States have found it necessary to re-instate CON when it has been allowed to lapse in order to correct market imbalances arising in its absence; and

WHEREAS, the future structure of health care delivery is uncertain and repeal or significant alteration of CON legislation would threaten the ability of our members to fulfill their commitments to access, community-based health services, improved quality, continuity of care, and cost containment; and

426 MAIN STREET • JUNEAU, AK 99801 • (907) 586-1790 • FAX (907) 463-3573

WHEREAS, market competition is a necessary but insufficient mechanism to achieve all of these objectives and should be supplemented by reasonable State oversight; and

WHEREAS, the shared challenge to our members and the State of Alaska is to develop a socially responsible and economically viable healthcare marketplace.

THEREFORE, BE IT RESOLVED that the Alaska State Hospital and Nursing Home Association endorses the current Certificate of Need Program, without significant alteration, as an effective way to maintain an affordable, accessible and high quality healthcare delivery system responsive to the needs of Alaskans; and

BE IT FURTHER RESOLVED that ASHNHA opposes any and all attempts to repeal or weaken the CON; and

BE IT FURTHER RESOLVED that ASHNHA remains willing to work with interested parties and the State of Alaska to improve the CON process in order that it respond to the evolving needs of the health care environment in Alaska and that it shall remain effective and efficient in meeting its stated goals.

No matter how hard hospitals try to comply with complex, cumbersome, and confusing payment rules and regulations, it is impossible to be error-free. But they are, in fact, astonishingly accurate.

We have seen accusations of pervasive fraud leveled before. Several years ago the Federal government undertook a massive investigation under the False Claims Act into the Medicare "DRG three-day window."

How did the government's 72-hour window investigation affect hospitals?

In **Maine**, 24 hospitals settled with the DOJ. The Maine Hospital Association studied those hospitals, and found some interesting things:

- The total number of Medicare billing errors over a 5-year period was fewer than 1,000.
- Billing errors per hospital over the 5-year period ranged from 3 to 200.
- There were 2.9 million Medicare claims submitted by the 24 hospitals in the 5-year period. This represents an error rate of just .034 percent of total claims.
- During the same period only $139,000 in claims for all of the hospitals were found to be in error; this represents .005 percent of their $2.6 billion in total Medicare claims

In **Vermont**, 11 hospitals made payments to the federal government to settle $83,816 in reported Medicare billing errors that occurred between 1990 and 1995. During that period, Vermont hospitals billed Medicare for $1.5 billion. So the amount demanded by the government translates into an error rate of 1/200th of one percent. One Vermont hospital's data makes the point even clearer: the Medicare caseload at the hospital is roughly 20,000 cases a year. Of the 200 cases reviewed, the government came up with only ***one*** dispute. The government should be applauding hospitals like that, not prosecuting them.

In **Connecticut**, 34 hospitals were given demand letters on the 72-Hour Window Rule. During the period of investigation, 1990-1995, Connecticut hospitals handled more than 10 million Medicare claims. Of that total, fewer than 3,000 claims were cited by DOJ in the investigation -- an error rate of less than three one-hundredths of one percent. The government identified less than $1 million worth of payment errors out of a total of $6 billion in payments.

And here in **Alaska**, DOJ investigated two hospitals and found no errors. Still, those hospitals were assessed federal penalties. The penalties were small -- $69 and $289 -- but the hospitals' letters asking DOJ for an explanation about why they were fined have not been answered.

Most accounting firms' standards include expected error rates -- human and otherwise -- that generally fall between three and five percent. Clearly, the Federal DOJ based its investigation on a zero-tolerance-for-errors rule that is unfair and unrealistic, which raises serious questions about their purpose.

Another example: The physicians at teaching hospitals (PATH) audit. Teaching hospitals and medical schools were investigated to determine whether physician instructors billed Medicare for work performed by medical residents they supervise.

Mary Hitchcock Memorial Hospital in Lebanon, NH, spent more than $1 million in staff time and fees for attorneys, consultants and accounting assistance to perform a self audit on Medicare billing. Why? The government demanded the audit as part of its PATH investigation. What did the audit find? An error rate of zero.

The result of the Federal government's campaign? Millions of dollars are being spent on lawyers' and accountants' fees instead of patient care. Is the government finding fraud? On the contrary. In the majority of cases, hospital error rates are proving to be minuscule.

OUR PRINCIPLES

Zero tolerance for fraud – America's hospitals and health systems are rooted in a tradition of ethics and caring. We're committed to preventing, uncovering, and eliminating health care fraud and abuse. Hospitals across the nation are voluntarily adopting plans to ensure compliance with complex and confusing Medicaid laws and regulations.

However, Medicaid billing errors often result from confusing and conflicting regulations and instructions that are part of the Medicare reimbursement system. These are not intentional acts. Yet **some** would have you believe that mistakes and fraud are the same.

Providers who make billing mistakes after attempting to comply with the complicated and frequently changing rules of Medicaid payment should be treated in a fair, equitable and civil manner and granted appropriate due process rights -- rights that are guaranteed to all Americans.

Compliance -- The AHA Board of Trustees recently issued a statement urging all hospitals and health systems to voluntary adopt regulatory compliance programs "as a way to minimize errors in conforming to highly technical and complicated rules," and urged hospitals and health systems to "develop and implement or strengthen a formal compliance program to ensure that regulations are accurately followed."

THE SOLUTION

To solve this problem, we need to return to the partnership we once had with the government. By rebuilding this partnership, we can go a long way toward ensuring compliance and fairness.

We would propose:

- imposing a "de minimus" standard. Under the standard, as defined by the American Institute of Certified Public Accountants, Medicaid overpayments to providers of less than a specified percentage would result in penalties of no more than the amount of the claim plus interest.
- establishing a "safe harbor" for hospitals that submit a claim based on advice given by fiscal intermediaries and carriers. Such hospitals would be subject to fines limited to actual damages and interest.
- raising the burden of proof from a "preponderance of the evidence" standard to a "clear and convincing evidence" standard.
- establishing a "safe harbor" for hospitals that have adopted effective, good-faith compliance plans in which they are, if found in violation, subject only to actual damages plus interest.

Rebuilding the hospital/government partnership -- Hospitals and health systems want a new partnership with the State. Working together, we can do more to prevent hospital billing errors, and to prevent government over-reaching as it tries to account for those errors.

The AHA is willing to help find other ways in which the State government can make the billing system more workable. We have proposed a "best practices" process. Under this process, the AHA would identify vague laws, regulations, carrier instructions, etc., and go to the State with our best view on how they can be implemented. The State in turn would consider the problem and our suggestions, and get back to us with proper guidance. Through this process, disputes related to interpretation of laws, or individual concerns, could be solved without antagonism.

In addition, we have talked to the Attorney General's office about a mechanism that would give us an "early warning" about potential areas of concern. We respectfully disagree with the Attorney General's office that our members have received reasonable notice of problems in the past.

Also, we need to look at a dispute resolution system that could remove some of the adversarial relationship between the government and the hospital field. If we can develop an administrative mechanism to resolve disputes over both broad policies and specific disagreements, we can diffuse a potentially volatile situation.

At a minimum, we need to return to a system in which [***the Alaska Medicaid payment authority***] exercises its authority to review and discuss billing disputes with hospitals. Only after the failure of those efforts should Attorney General's office become involved.

- ✓ develop clear and objective standards that differentiate between a regulatory overpayment and a civil/criminal fraud and publish these standards so that the AHA may advise its members on the standards.

The DOJ needs to speak clearly and precisely to retain its enforcement credibility, which is now at risk as it tries to stretch its enforcement resources with collection efforts of this sort.

- ✓ develop a self-disclosure program for regulatory overpayments that encourages compliance and not fear of unreasonable claims of penalties and damages, and would not require payment of penalties beyond standard interest penalties absent specific evidence of fraud or reckless disregard of overbilling.
- ✓ develop a "safe harbor" treatment for hospital overpayments that occur as a result of inaccurate or incomplete fiscal intermediary/carrier instructions.

CONCLUSION

We understand and agree with the government's determination to investigate and punish those who would abuse the system.

But the government is doing the right thing in the wrong way.

The overwhelming majority of Alaska's hospitals and health systems work hard to comply with the mountain of rules and regulations that govern Medicaid payment. When a mistake is made, it should not be treated as fraud. It should be treated as a mistake.

Through a rebuilding of the health care field's partnership with the government, we can make things fair again -- for hospitals and health systems and the people they serve, and for the government as well.

Note: based on "Testimony of the American Hospital Association before the Subcommittee on Immigration and Claims of the Committee on the United States House of Representatives on Health Care Initiatives Under the False Claims Act which Impact Hospitals April 28, 1998" delivered by Gordon Sprenger

http://www.aha.org/ar/testimony/test980428a.asp

ALASKA STATE

HOSPITAL & NURSING HOME

ASSOCIATION

ASHNHA Resolution Supporting Current Certificate of Need Legislation

WHEREAS, the Alaska State Hospital and Nursing Home Association is strongly committed to developing a coherent and comprehensive network of health care services within the State of Alaska, and

WHEREAS, the State of Alaska shares these objectives with ASHNHA,

WHEREAS, the State has developed a CON review process that seeks to ensure that new health care facility construction projects or equipment purchases are cost effective, not duplicative, are adequately planned and involve the public, and improve accessibility and quality of health care services; and

WHEREAS, the CON review process encourages adequate access to healthcare through geographical dispersion of health care facilities and services which might not otherwise be expected to develop; and

WHEREAS, the CON provides a mechanism whereby provider initiatives may be evaluated against alternatives for meeting state priorities for improving the health status of its citizens; and

WHEREAS, the need to provide health care services to an expanding population with increasingly limited funds places a premium on effective and efficient deployment of these limited resources, and

WHEREAS, the demography and geography of Alaska limit the effectiveness of unregulated competition as a means of ensuring socially appropriate supply and demand of healthcare services, being culturally diverse, geographically dispersed and predominately rural; and

WHEREAS, the CON helps Alaskan health care providers meet the larger objectives of society, particularly with regard to understanding and addressing the needs of under-served and indigent patients; and

WHEREAS, the CON ensures these extra-institutional objectives are adequately addressed regarding healthcare facility and program planning, and that decisions to expand or contract the health services capacity are economically sound and medically necessary; and

WHEREAS, similar programs function in the majority of other States to good effect, to the extent that several States have found it necessary to re-instate CON when it has been allowed to lapse in order to correct market imbalances arising in its absence; and

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Care Connections

Care Coordination • Social Services

P.O. Box 318
Palmer, Alaska 99645
(907) 746-2037
Fax (907) 746-2031

To: The Chair and Members of Health, Education, and Social Services Subcommittee

From: Lourdette Diamond Neuburg

Date: 11/9/01

Thank you for holding these hearings in Wasilla. I am the director of Care Connections, a small, for-profit care coordination agency located in Palmer. Our agency provides care coordination services in the Mat-Su Valley, Eagle River, and Chugiak for individuals who meet nursing home level of care. We arrange home- and community-based services to prevent or postpone nursing home placement.

Care Connections serves 61 adults, 85 % of whom reside in their own home either alone or with family members. The services provided through the Medicaid Waiver (CHOICE) program allow the individuals to continue to remain as independent as possible. As the care coordinators for these individuals, we are able to advocate for and arrange services, assess the situation and needs, plan the care, provide information and referral. Services provided may include Lifeline, chore service, respite, adult day services, transportation, meals, modifications to the home, and some equipment and supplies as well as regular Medicaid services.

There is a chance that the individual may not meet either physical or financial criteria for the CHOICE program. We realize this when we begin services; consequently, care coordination agencies may provide services and support, which are not reimbursable. Individuals must qualify for CHOICE both financially and physically. This takes time. All providers in the CHOICE program are in this situation and must decide whether or not to provide service to particular clients. However, what is unique to care coordinators is that we are the only providers who do not have the ability to negotiate our reimbursement rates and we have not had an increase in pay, cost of living or otherwise, since the inception of the CHOICE program approximately eight years ago.

Care coordinators provide a vital service for clients on the Waiver programs. I am proud to work in a program that benefits individuals and families, and saves Alaska money by preventing or postponing nursing home placement. Please continue to support care coordination and the Waiver programs. Thank you.

Lourdette Diamond Neuburg

Bartlett Regional Hospital

3260 Hospital Drive • Juneau • Alaska 99801 • 907-586-2611

November 2, 2001

Senator Lyda Green
State Capitol, Room 125
Juneau, AK 99801-1182

Dear Senator Green:

I understand you are chairing a committee to pursue reducing Medicaid expenditures in our State. While I agree with the concept of looking for efficiencies in the administration of the Medicaid program, I do not support the reduction of services covered under Medicaid.

I know of numerous low-income families and individuals in my community who would not otherwise have access to healthcare services if it were not for Medicaid. Healthcare is not a luxury; it is not an option; it is a necessity that all members of our communities should have access to.

Expansion of Medicaid coverage in recent years to include Breast Cancer Detection and Children's health care to families who otherwise wouldn't qualify for Medicaid will reduce Medicaid costs in the long run. I applaud the State for these efforts. Furthermore, the current Medicaid reimbursement system is modeled to ensure that the State always pays less for health care services than insurance companies or individuals who pay privately. I believe the State already pays the least amount for the most healthcare that it possibly can.

Please consider, very carefully, the long-term effects of any actions you may take in your efforts to reduce Medicaid expenditures.

Sincerely yours,

J Brian Barnes

Bartlett Regional Hospital
3260 Hospital Drive • Juneau • Alaska 99801 • 907-586-2611

November 2, 2001

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State Capitol, Room 125
Juneau, AK 99801-1182

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Sincerely yours,

Shawn M. Cobb

Sitka Community Hospital

209 Moller Avenue, Sitka, Alaska 99835 Phone (907) 747-3241 Fax (907) 747-1794

November 2, 2001

Senator Lyda Green:
600 East Railroad Avenue
Wasilla, AK 99654

Dear Senator Green:

I would like to offer a few comments before your Subcommittee meeting next week at the Mat-Su LIO. I share your concern regarding Medicaid spending but my perspective is quite different. I suggest that the discussion needs to be broader than just "how can we save money." Looking for ways to make the current system more efficient or cost effective is just one part of the discussion that needs to take place.

As a health care administrator, I am well aware that the Medicaid program fails to pay its fair share. In an effort to adjust for the Medicaid related underpayments, providers shift the unfunded cost of care to individuals who have insuranc '. Most providers, physicians, and insurance companies will tell you that the insured population covers the shortcomings of the Medicaid program.

As a nation, our funding priorities are not aligned with our care expectations. We want the best in health care, whenever we need it, regardless of our ability to pay. Such expectations have been translated into federal and state regulations that have put providers at odds with patients and residents.

Although most Americans view health care as a right, there is no universal agreement as to societies obligation to fund the required facilities and services. Limiting the discussion to "ways to save money" will at best provide a short-term band-aide and at worst will jeopardize the existing safety net of providers, many of whom are struggling financially.

Healthcare funding goes against ordinary business practices and certainly does not pass the "common sense" test. Reduction of cumbersome and costly regulation/oversight, elimination of most of the paperwork we are required to complete, and coordination of state/federal inspections to reduce the number of times we are inspected would produce immediate savings.

The bottom line is: pay for what you require and do not require what you will not pay for.

Sincerely,

Bill Patten

Bill Patten, MA, NHA
CEO/Administrator

Bartlett Regional Hospital

3260 Hospital Drive • Juneau • Alaska 99801 • 907-586-2611

November 2, 2001

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Sincerely yours,

Kathryn Callahan

Bartlett Regional Hospital

3260 Hospital Drive • Juneau • Alaska 99801 • 907-586-2611

November 2, 2001

Senator Lyda Green
State Capitol, Room 125
Juneau, AK 99801-1182

Dear Senator Green,

It has come to my attention that you are seriously looking to reduce Medicaid spending. I could not disagree more! You should be looking at ways to increase spending and ways to make the current system more efficient.

At this point, Medicaid fails to pay their share of the cost of care. As a result, providers are forced to shift the cost to individuals who have insurance. Talk to any provider, physician or insurance company and they will tell you that the insured population has to cover for the shortcomings of the Medicaid program.

Let me offer the following suggestions. Please look for ways to increase spending on preventative care (breast cancer detection, low birth weight, mental health, programs that help people reduce their drinking or help them to stop smoking.)

Please take the time to listen to the stories of the people who have been helped by Denali Kid Care. The vast majority is trying to become self-reliant, but life has gotten in the way.

Visit with a family who has a loved one in a long-term care facility. There is no way the family could provide the level of care that is required. There is also no possible way that a family could pay for the care of someone who lives in a facility for a long period of time.

Please pick up any article that focuses on the shortage of nurses and read about what is going to occur in healthcare in the years ahead. Make every effort to find a way to increase the programs for educating nurses.

Please look at all of the money being spent pushing paper. Look for ways to computerize and automate.

We don't need you to cut spending; we need you to look at where we need more funding.

Sincerely,

Sheryl Washburn, MSN, RN
Patient Care Administrator

Bartlett Regional Hospital

3260 Hospital Drive • Juneau • Alaska 99801 • 907-586-2611

November 2, 2001

Senator Lyda Green
State Capitol, Room 125
Juneau, AK 99801-1182

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Sincerely,

Michelle E. Casey
Manager, Staff Development & Patient Education

Providence Alaska Medical Center

November 1, 2001

Senator Lyda Green
600 East Railroad Ave.
Wasilla, AK 99654

Dear Senator Green,

As another legislative session kicks off and budgets are discussed, I wanted to share my concerns with you about the continued Federal changes to the Medicaid program which tend to shift costs to the State of Alaska and force some people out of medical care. The Medicaid program has great value for all Alaskans, and I ask for your help in preserving these critical monies for those in need in our state. Unfortunately, what some people propose as cost savings are really only cost deferrals and the costs tend to increase the longer they are deferred.

As you are aware, Alaska has one of the highest populations of uninsured and underinsured people in the nation. For this reason alone, Medicaid funding is imperative to ensure all Alaskans have access to appropriate healthcare services when they need it. But most importantly, Medicaid dollars help ensure those who would normally fall between the cracks have access to services.

One key program that serves this purpose is Denali Kid Care. Denali Kid Care provides excellent health insurance coverage for children and teens through age 18 for both working and non-working families, and for pregnant women who meet income guidelines. **Funding cuts in this program would cost the state substantially more in the long term as primary prevention for these key populations would then be limited.** For that reason, any cuts to Medicaid that would affect this essential program should be avoided at all costs.

I would also discourage cuts in any program that gives access to mental health, women's, or home health care services; assisted living homes; or long-term care facilities. Children, women and the elderly are our most vulnerable populations and as a community we have a responsibility to make sure they have access to health care, especially preventive care that prevents costly treatment in the future. I would urge you and the committee to work with the health care providers in Alaska to find innovative ways to more effectively use what federal and state dollars are available and try to offset some of the shortfalls with increased efficiency in our health care system. This will be challenging work but working together, we can sometimes surprise ourselves.

Your support of health care programs in Alaska throughout the years has been greatly appreciated, and I hope that you will continue to show your support by ensuring Medicaid monies remain available to those in need. Spending money now invests in our future and shows that as a state we remain committed to taking care of those most in need.

Sincerely,

Gene L. O'Hara
Chief Executive

Bartlett Regional Hospital
3260 Hospital Drive • Juneau • Alaska 99801 • 907-586-2611

November 2, 2001

Senator Lyda Green
State Capitol, Room 125
Juneau, AK 99801-1182

Dear Senator Green:

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Bartlett Regional Hospital

3260 Hospital Drive • Juneau • Alaska 99801 • 907-586-2611

November 2, 2001

Senator Lyda Green
State Capitol, Room 125
Juneau, AK 99801-1182

Dear Senator Green:

I am concerned about the unintended consequences of ceasing the Medicaid funding for Denali Kids, Breast Cancer Detection, Mental Health, and Long Term Care. I can understand how the savings in the short term would be quite appealing, but please consider the long-term ramifications of such a decision.

This decision targets those people who are least likely to have the means and skills to fend for themselves. What could end up being very expensive for the taxpayers might have been able to be nipped in the bud had funding been available for prevention.

As a nurse, I have seen long and painful hospital stays because the individual lacked the means to seek health care. The hospitalization cost is far more than what an office visit with follow-up treatment would have cost. Where is the sense in this?

Sincerely,

Valerie McCormick, RN, MS
Acute Care Manager

Bristol Bay Area
Health Corporation
6000 Kanakanak Road
P.O. Box 130
Dillingham, AK 99576
(907) 842-5201
800-478-5201
FAX (907) 842-9354

Bristol Bay Area Health Corporation is a tribal organization representing 34 villages in Southwest Alaska:

Aleknagik
Chignik Bay
Chignik Lagoon
Chignik Lake
Clark's Point
Dillingham
Egegik
Ekuk
Ekwok
Goodnews Bay
Igiugig
Iliamna
Ivanof Bay
Kanatak
King Salmon
Kokhanok
Koliganek
Levelock
Manokotak
Naknek
New Stuyahok
Newhalen
Nondalton
Oleonville
Pedro Bay
Perryville
Pilot Point
Platinum
Port Heiden
Portage Creek
South Naknek
Togiak
Twin Hills
Ugashik

To promote health with competence, a caring attitude & cultural sensitivity

November 7, 2001

Senator Lyda Green
600 East Railroad Avenue
Wasilla, AK 99654

BY FAX AND E-MAIL

Dear Senator Green:

I'm the Clinical Director of the Bristol Bay Area Mental Health Center in Dillingham. I write this, however, not as their representative but as a Clinical Psychologist, licensed by the State of Alaska, who has practiced as a professional for over 30 years in 8 different community mental health settings. I just learned of this hearing today so my comments will be briefer, more discursive, than they would have been had I had more time.

Our clinic serves 33 Native Alaskan and Native American villages spread over an area of 40,000 square miles. These villages are essentially accessible only by air. Because of the nature of psychotherapy, geography and the culture of our clients, any number of Medicaid regulations rob them of services and us of revenue. Since this is an eleventh hour submission, I'll only discuss three issues. Also, I'll only discuss them from the standpoint of how they affect psychotherapy. Clearly there are many more counterproductive rules that affect psychiatric and case management services as well as psychotherapy.

Simply put, the problems are: (a) We take the client's time filling out irrelevant forms with him or her rather than using the time to provide services. (b) We don't receive reimbursement for critical services we do provide. (c) The rules don't take into account our geography.

We Waste the Client's time with Meaningless Activities

Medicaid requires that upon entering treatment and then every six months after that, we perform an assessment for each client.. This is a lengthy formal process done with the client that can take as much as an hour. In addition, for clients who are severely or chronically mentally ill, there is a second formal assessment as well that's done initially and then every six months. This one takes a minimum an hour of the clients time.

would like to make and what services the therapist will provide to help him/her make these changes. Like the two assessments, this has to be done initially and then every six months.

There are any number of problems with these requirements. Two of the most obvious are: (a) Study after study has shown half of all clients drop out of therapy before their fifth appointment. (I don't have the statistics for my clinic but a related measures suggests it's probably the same for us as well.) This means anywhere from twenty five to over fifty percent of a client's time is spent doing something other than treatment. (b) So far as I can tell, what they are doing is to complete documents that are totally unnecessary for treatment. The assessment that matters is done by each therapist in his or her own way; it's less invasive and time consuming than Medicaid requirements. In terms of treatment plans, my best guess is that most clients couldn't tell you their contents two weeks after they're done. I do know that many react with annoyance at having their time taken with this quasi-legal procedure. It seems out of place in what, at best, is a human relationship, rather like a prenuptial agreement is.

We can't Bill for Vital Services We Provide.

Medicaid only allows us to charge for traditional client-in-office service. For the people we serve, however, there are a large number of activities that provide a more natural context for psychotherapy. While we provide services in these settings, we can't bill for them. Steaming and berry picking are examples. We also can't bill for psychotherapy over the telephone even though we do a lot of this with people in the villages and for those suicidal people who call us in crisis, often in the middle of the night, who are too emotionally disabled to wait for bankers' hours to come to our office.

Medicaid Regulations are Geographically Unfriendly

We aren't Anchorage or Austin. We're bush Alaska with very few professionals attempting to help people in very isolated small villages spread over an area the size of Ohio. This means the problems I've discussed so far are magnified ten-fold. For example, our professionals can only visit the villages every three months and for a brief time. This further means each client can only be seen for an hour or so each visit. Simple math then shows that half of our contact hours are spent doing treatment plans or formal assessment and only half are devoted to therapy. If we see a client, say, four hours a year at least two are spent filling out forms. As another example, in the harsh and close living conditions of the villages, crises predictably occur. These crises must be dealt with immediately and not when the next visit is scheduled. This means extensive telephone work which isn't reimbursed.

None of these problems are unsolvable but all require a somewhat different

mind-set. That is, all can be solved if you don't assume providers are trying to cheat the system or would waste money were they not subjected to stringent oversight. These problems could be solved were you to assume: (a) Those of us in the field know better than bureaucrats what services and procedures are needed. (b) Rather than trying to cheat the system, we're dedicated professionals who work for wages much less than we would make in the private sector because we care deeply about what we do. (c) The problem with mental health services isn't that they're overused and therefore need stringent oversight (assessments, elaborate and detailed treatment plans, etc.) to eliminate waste. The problem is that these services are underused. Epidemiology tells us many more people are disabled than seek services. Our own research, over and over, shows people leave treatment prematurely, within a month, rather than staying too long. Everything we know suggests that tax dollars would be saved if instead of subsidizing an army of bureaucratic overseers, we took that money and paid for services our clients needed.

Sincerely,

Bruce Allen, Ph.D.
Clinical Director

Alaska Women's Resource Center
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Medicaid Reduces Other Costs

During fiscal year 2001, Medicaid allowed over 150 Alaskan women and their children to access substance abuse treatment with the Alaska Women's Resource Center. Approximately 151 children received "drug free focused" activities and services, developmental screenings, health care, and mental health services. Without Medicaid assisting these families with their treatment costs, 140 children would be in the foster care system today at an annual cost of over 6 million dollars.

Denali KidCare

During fiscal year 2001, the Alaska Women's Resource Center assisted 900 uninsured and/or low-income families with applying for Medicaid through the Denali KidCare Program. It is important to note that the entire family was uninsured prior to Denali KidCare.

Privatization of Medicaid

Regarding privatization of Medicaid, the Alaska Women's Resource Center encourages an analysis of the existing costs including the costs associated with the current private processing of claims.

Senator Green and other members of the Senate HESS Subcommittee on Health Care

- I'm DGA MD, a pediatrician in Anchorage. I am a member of the Medicaid Physicians Advisory Committee with representatives from the state medical ass'n and medicaid officials that has been meeting for about 8 years, and I am the physician representative to the Medical Care Advisory Committee or MCAC

- We pediatricians (and the other pediatricians at our recent annual meeting agreed to let me speak for them on this) do deeply appreciate the Alaska Medicaid and Denali Kid Care Programs

- Our patients appreciate Medicaid and love DKC with it's 6 month effectiveness and the use of an ID card rather than coupons.

- Physicians have been taught to strongly believe in cost effective care. It may not be cheap, but it must not be wasteful

- Health Care costs for healthy individuals is really very inexpensive. 85% of your Medicaid dollars are spent on those 15% of the Alaskan Medicaid clients who spend more than $5000 per year. These are mostly the elderly in nursing homes or the chronically handicapped. Few, if any, of these expensive patients will ever get off the Medicaid rolls. The other 85% of recipients receive medical care that is not only less expensive, but also very cost effective because the majority of those 85% will become productive members of society.

- The state Medicaid program has been closely reviewed by your MCAC and that comittee's recommendation first and foremost is, to quote an old saying, "it's not broken, don't fix it". A couple of areas to look at in our opinion would be first, since the state pays for disaster dental care for adults it really makes sense to also fund some preventive care. It is cheaper and therefore more cost effective. And second, the payment for transportation charges needs a total review. Like, why are we "fiscal conservatives" insisting on paying top dollar for air flights because there is some obtuse policy that tickets can only be purchased if they are totally refundable. There are also problems with cabs, buses, and other conveyances.

- Now the federal government is proposing cost neutral Health Insurance Flexibility and Accountability (HIFA) wavers that would allow coverage for more adults, but only by subtracting the amount available to children and other current beneficiaries. There will even be less total money to go around because the cost of developing this rather complex program will also have to come out of the current Medicaid payments.

- We pediatricians would say this is robbing from Peter to pay Paul. Give a little to the kids two years ago, and take a lot of it back. Adding a co-pay or deductible will mean many will go bare. This will not affect the non-working families, they will continue to get full coverage. It will only affect the families who have succeeded in working and earning enough to be above the poverty level. Working at jobs with no family health insurance.

- Bottom line, health care is expensive, but the current Medicaid/DKC program IS cost effective, the patients ARE appreciative of what they get, and the ones who benefit from DKC seem to be trying to get off all state support. But they do have to take one step at a time in order to successfully get to the finish line. This group needs a pat on the back not a slap in the face and not anyone reaching into the pocketbook.

- Do you have any questions?

David B Alexander MD

Sheri Mayer
257-1120

To whom it may Concern

My name is Sheri Mayer and I have three children ages 11, 9, 5.

Denali Kid Care has been such a positive thing in my family. Two of my children have had day surgery and I was absolutly unable to pay those bills. I have no worry when my child becomes sick or needs to visit the dentist. Without this coverage a simple office visit may very well be our familys food budget I know many families on Denali Kid Care and simply paid without it may be a child not getting the proper care of the dentist or even not going to the doctor when they are ill due to lowinc

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