HEALTH CARE
Finding an Alaskan Prescription

A Report by Commonwealth North

Dear Reader:

Commonwealth North believes that information and education are the foundation of meaningful policy debate, and are of particular importance in an issue the magnitude of health care reform -- an issue that directly affects all of our lives, many of our livelihoods, and a significant portion of the national economy. If Alaskans are uninformed, we run the risk of decisions being made without us. Even a decision to maintain the status quo has consequences. If health care costs continue to rise, an increasing burden will be placed on families, businesses, and taxpayers.

All analysts who have studied health care deem the available data to be incomplete. Nonetheless, legislative debate on the issue is prominent at state and federal levels and change can be expected. Commonwealth North believes it is important to synthesize and present in a cogent way information that will help readers focus on what additional data they need and to draw their own conclusions about changes in our health care system.

Unique conditions in Alaska warrant special consideration. Commonwealth North concludes that reform of some type is inevitable, but Alaskans could get caught in a well-intended, but ill-founded solution, or one that does not address Alaskans' needs. Therefore, it is incumbent upon all of us to become part of the process by making our views known. If this report advances the reform debate in Alaska, it will have achieved its purpose.

Bill McHugh, President
Commonwealth North

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HEALTH CARE: Finding an Alaskan Prescription

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EXECUTIVE SUMMARY

The adequacy of the nation's health care system has been a topic of national discussion since at least the 1992 presidential campaign. Political consensus on whether system reforms are needed and what shape any reform should take has not been reached.

In January 1993, following numerous public hearings and considerable study and debate, the Alaska Health Resources and Access Task Force proposed a series of reforms. Legislation (Senate Bill 284) reflecting a compromise between the Task Force's proposal and a proposal put forward by the Alaska State Medical Association and the Alaska State Hospital and Nursing Home Association was considered by the state legislature during the 1994 session, but the legislature adjourned without enacting it or any other major reform legislation.

In Congress, five major committees have considered a multitude of health care reform bills. Although the timeline for action on reform has been extended a number of times during the past year, Congress is expected to act by the end of the 1994 Congressional session.

Commonwealth North has not attempted to reach a consensus on health care reform. Rather, this report synthesizes and presents in a cogent way information that will help readers understand the health care reform debate and draw their own conclusions about the health care system. Commonwealth North has, however, reached a number of conclusions about the effort to achieve consensus on health care reform.

- The health care reform debate is complex and controversial. Multiple players with competing interests, large philosophical and ethical questions, and the magnitude of the issue -- one that directly affects all of our lives, many of our livelihoods and a significant portion of the national economy -- contribute to the complexity and controversy.

- There are significant factual disputes about the health care system. Not enough data exists to allow analysts to predict accurately the full effect of the various approaches to reform. Will managed competition control costs? Will an employer mandate result in lost jobs? No one knows for sure.

- Every approach to health care reform creates winners and losers by redistributing the burden of who pays for health care. Our current health care system relies on a mix of government, business, and individual financing. If the system is expanded to cover more people or more services, who will bear the additional cost?

Perhaps the most important conclusion is that the involvement of Alaskans in the health care debate is vital. Commonwealth North believes that health care reform of some type is inevitable. If reform goals are to be achieved in Alaska, Alaskans must work to ensure that reform is responsive to the unique Alaska conditions listed below.

- Alaska's geographical area is large and its population is relatively small and widely dispersed. Access to health care in Alaska is a function not only of cost and coverage, but of the actual existence and proximity of services.

- Alaska has twenty federally designated Health Professional Shortage Areas and ten Medically Underserved Areas, which together include nearly one-third of the population and cover three-fourths of the state. The designations are based on an inadequate number of health care providers in these areas.

- Precise numbers of Alaskans who are uninsured (including those not eligible for government-sponsored health coverage) and a complete understanding of why some Alaskans are uninsured are not available. Estimates of who the uninsured are indicate that a majority live in households in which the head of household works at least part of the year, and in which household income is at least 200% of the federal poverty level.

- Government spending (federal, state and local spending combined) accounts for over 60% of total health care spending in Alaska, compared with 44% nationally. Federal government spending alone accounts for over one-third of total health care spending in Alaska. Over 40% of Alaskans are eligible for coverage through a federal program.

- The proportion of Alaskans employed in the public sector is 30%, nearly twice the national average.

- Alaska has a preponderance of small businesses. The proportion of private sector employees in Alaska working in firms with fewer than twenty employees is 39%, compared to 27% nationally.

- Alaska has a large number of seasonal workers. Employment in all but our largest firms fluctuates an average of 24% from the lowest employment month to the highest employment month. In addition, Alaska has a comparatively high unemployment rate.

- No HMOs (health maintenance organizations) operate in Alaska, although they are widely available in most of the country.

The information presented in this report was gathered from a variety of sources, including several speakers who presented their views to Commonwealth North at forums and briefings from late 1993 through June 1994. The speakers and their topics were as follows:

- Mr. Robert Brand, President, Solutions for Progress, Inc., spoke on the single-payer approach to health care reform.

- Stuart Butler, Vice President and Director of Domestic and Economic Policy Studies, The Heritage Foundation, spoke on the Consumer Choice Act, which would replace employer-provided health insurance with tax credits or government vouchers.

- Bernard Craighead, Congressional Liaison, National Health Care Campaign, Democratic National Committee, spoke on President Clinton's Health Security Act.

- Senator Jim Duncan (D-Juneau) and Dr. Oliver Korshin spoke on Alaska Senate Bill 284, a single-payer, market controls approach to health care reform.

- W. David Helms, President, The Alpha Center, spoke on reform efforts in other states.

- Karen Perdue, President-elect of the Alaska Public Health Association, spoke on conditions unique to Alaska that should be considered in any health care reform effort.

- Betty Woods, President and CEO, Blue Cross of Washington and Alaska, spoke on the insurance industry's perspective on health care reform.

The report is written in five parts.

Part I looks at how well the health care system is meeting the objectives of affordability, accessibility and quality, both nationally and in Alaska.

Part II describes factors that affect the system's ability to adequately meet its objectives.

Part III reviews efforts undertaken over the last several years to improve the health care system's ability to meet its objectives.

Part IV summarizes the major approaches to reform currently under consideration at the state and federal levels.

Part V discusses how well each approach is suited to Alaska.

Tables 1 and 2, which follow this Executive Summary, outline the major approaches to health care reform under consideration at the state and national levels.

TABLE 1 -- Approaches to Increase Affordability

	Summary	Relies on Market Reforms	Relies on Govt. Regulation	Considerations in Alaska	Examples
Consumer Participation	Increase consumer interest in what health care costs through increased copayments, elimination of health benefit deductions, vouchers, etc.	X		Unlikely to be effective in communities with limited number of providers.	Heritage Foundation (Nickles), Chafee
Managed Competition	Regulate networks of insurance companies, physicians and hospitals competing for the business of consumers organized into large groups.	X	X	Alaska's small dispersed population will not support managed competition.	Clinton, Cooper, Washington, Florida, Minnesota
Managed Care	Induce physicians and hospitals to increase efficiency through financial incentives and utilization controls.	X		No HMOs currently operate in Alaska. PPOs and utilization controls are increasingly common.	Widespread. Oregon mandates. Clinton, Chafee offer incentives
Global Budgeting	Limit flow of funds into health care system through premium caps, annual health budget, etc.		X	Would require extensive cooperation with federal government; feds. purchase one-third of all health care in Alaska.	McDermott, Clinton, Washington, Minnesota
Service Coordination	Eliminate duplication of services and facilities through coordination of multiple payers.		X	IHS, VA, DOD, Medicaid, Medicare are all major payers in Alaska. Over 40% of Alaskans are eligible for coverage through a public program.	SB 284
Malpractice Reforms	Reduce defensive medicine through capping noneconomic damages, mediation, etc.		X	Proposed legislative actions have been controversial.	Widespread, including SB 284
Admin. Efficiences	Reduce complex paperwork requirements.	X		Alaska law amended 1994 to require use of uniform claims forms.	Widespread, including Alaska

Source: Compiled by Commonwealth North

TABLE 2 -- Approaches to Increase Accessibility

	Summary	Universal Coverage	Considerations in Alaska	Examples
Individual Mandate	Require all individuals to have health insurance.	Yes	Alaska affected similarly to other states.	Clinton, Heritage Foundation (Nickles), Chafee, Washington
Single Payer	Government pays for all health care.	Yes	Large portion of Alaskans receive health coverage through a federal program; single payer would require extensive cooperation with federal government.	SB 284, McDermott
Employer Mandate	Requires all employers to provide health insurance to at least their full-time workers.	No	Alaska has a large number of small businesses and seasonal workers; comparatively high unemployment and self-employment rates.	Clinton, Kennedy, Hawaii, Washington
Insurance Market Reforms	Increase access to health insurance by eliminating pre-existing condition exclusions and using community rating to set premium amounts.	No	Alaska recently created high risk pool. Quasi-community rating and modified preexisting condition exclusion will take effect 9/94.	Widespread
Rural Initiatives	Address noneconomic access barriers to health care, such as provider shortages and transportation costs.	No	Alaska has 20 Health Professional Shortage Areas and 10 Medically Underserved Areas, covering nearly 1/3 of the population and 3/4 of the state.	Widespread, including SB 284

Source: Compiled by Commonwealth North

INTRODUCTION

Some say that the nation's health care system is "in crisis" and in need of fundamental change. Is this so? Or is our system suffering from lesser problems, correctable through a series of incremental changes? If so, what are these problems? What has been done to address them and what more might be done? And most important, how might different solutions work in Alaska?

To explore these questions, Commonwealth North (CWN) identified three primary objectives of an effective health care system, examined how well the objectives are being met both nationally and in Alaska, and reviewed proposals for meeting the objectives. The objectives identified -- affordability, accessibility, and quality -- have been recognized by almost every health care professional, policy maker, and think tank that has studied the health care system. Betty Woods, President and CEO of Blue Cross of Washington and Alaska, in her presentation to Commonwealth North, described these three objectives as the proverbial three-legged stool, and stressed that equal attention must be paid to each of them.

This report does not attempt to forge a consensus on whether reform is needed, but to synthesize and present in a cogent way information that will help readers draw their own conclusions about the health care system. The information presented is based on the best data available, with the caveat that all analysts who have studied the health care system deem the data to be incomplete.[1]

While CWN's primary interest is Alaska's health care system, attention is also given to the health care system nationwide and to federal efforts to change the system. The federal government, as an employer and a provider of health care, is by far the largest single source of health care spending in Alaska. Federal spending accounts for over a third of total health care spending in the state, and more than 40% of all Alaskans are eligible for coverage through a federal program.[2] Therefore, any analysis of the health care system in Alaska must take into account the federal government's role.

In addition, the national debate on health care reform is being driven by national statistics. If Congress passes a reform plan, it is likely that the states will receive federal mandates to change their health care systems. Studying the various reform proposals under debate in Congress will allow Alaska to better anticipate any mandates, and to understand how to fulfill them in a way that best serves Alaskans. In addition, many argue that acting now will pre-position the state in a way that will allow it more flexibility in dealing with federal mandates.

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[1] Uniform data collection and development of a health database were features of the reform bills considered by the Alaska legislature in 1994; the bills failed to pass. The most comprehensive document published on the health care system in Alaska is the January 1993 report of the State of Alaska Health Resources and Access Task Force (HRATF). The HRATF was created in 1991 by the State legislature to develop a strategy that would provide health care coverage for all Alaskans and contain rising health care costs. The work of the task force is cited throughout this report.

[2] See Figures 1 and 2.

PART I: ARE THE OBJECTIVES BEING MET?

To evaluate how well the health care system is working, CWN reviewed information on the affordability, accessibility, and quality of the system both in Alaska and nationwide.

Affordability

For purposes of this report, affordability is broadly defined to mean the cost of health care and the impact of the cost on government budgets, on business, and on individuals and families.

Rising Costs

The U.S. spends a larger share of its gross domestic product (GDP) on health care than any other industrialized country. Spending has grown from 8.4% of GDP (or $133 billion) in 1975 to 13.2% of GDP (or $752 billion) in 1991, a rate of increase in the last several years of nearly 15% per year.[3] In Alaska, health care spending has tripled over the past decade, rising from $480 million in 1979 to $1.6 billion in 1991. Per capita spending during this time increased nearly two and one-half fold, growing from $1,160 per capita in 1979 to $2,783 in 1991.[4]

The rapid increase in health care expenditures is not without economic benefits. For example, hospitals and nursing homes have become a growth industry in older cities, employing low-income, low-skilled people whose traditional sources of employment have disappeared. In 1960, health care ranked ninth among New York City's employers; today it ranks first.[5]

However, a concern has developed over the past several years that spending this amount of money on health care diminishes the opportunity for investment in other programs and crowds out other means of economic growth. As illustrated in Figure 1, the cost of health care is shared by government, businesses, and individuals.

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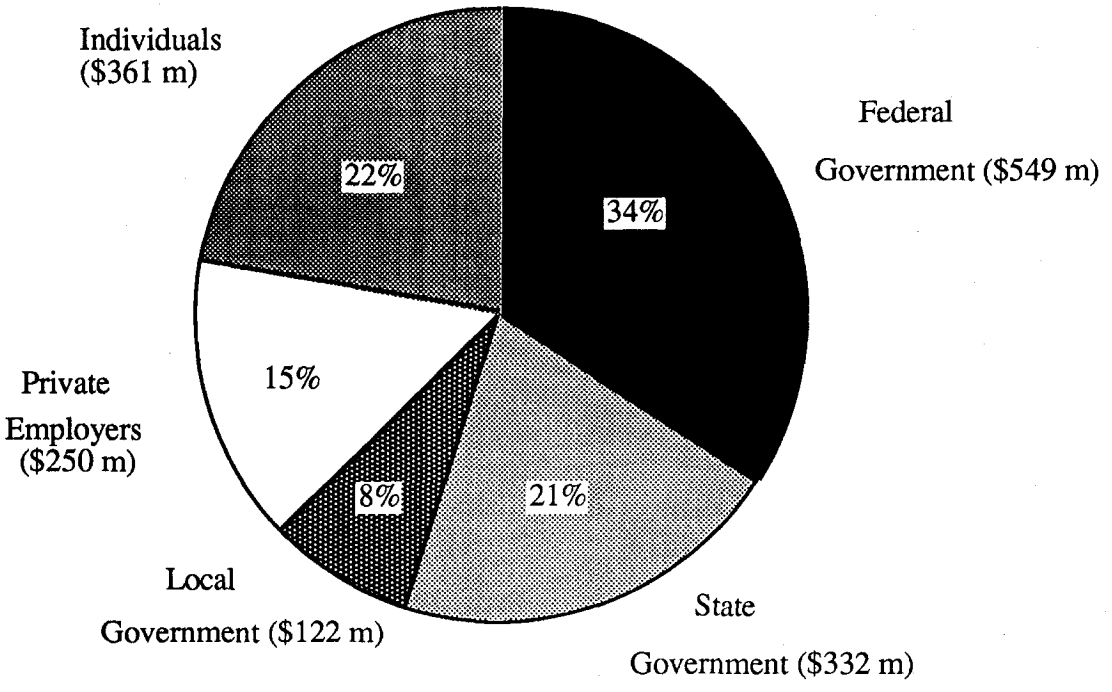
[3] Letsch, S.W., et al, *National Health Care Expenditures 1991*, Health Care Financing Review, Winter 1992, 14 (2) at p. 1, 9. U.S. Department of Health and Human Services, Baltimore, MD. GDP (gross domestic product) measures the U.S. economy as the value of output produced within the geographic boundaries of the U.S. by U.S. or foreign citizens or companies. GDP has been adopted internationally as the measure of domestic health care resource allocation.

[4] Health Resources and Access Task Force, *Final Report to the Governor and Legislature* at p. 5 and 7, January 1993, Juneau, AK.

[5] Gladwell, M., *To the Community's Good Health*, Washington Post Weekly, 3/7-3/13/94.

FIGURE 1 -- Who Pays for Health Care in Alaska[6]



Impact on Federal, State, and Local Budgets

Nationally, federal, state and local governments together pay approximately 44% of all health care expenditures.[7] In Alaska, federal, state and local governments pay over 60% of all health care expenditures. Because government has a finite amount of money, the money must be divided among competing programs. A decision to spend on health care results in a decision not to spend on other needs or services.

Impact on Business

A majority of Americans with health insurance receive it through their employer.[8] The tradition of employer-provided insurance began during World War II as a means of increasing workers' benefits while wages were frozen. It is reinforced today through the U.S. tax code, which allows employers to deduct the cost of employee health insurance, a deduction that is not permitted to the self-employed or to individuals who purchase insurance directly. In addition, health benefits paid for by employers are not counted as taxable income to employees.

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[6] Institute of Social and Economic Research, *The Cost of Health Care in Alaska*, Research Summary No. 53, December 1992, University of Alaska Anchorage. FY91 data. Federal spending consists of Indian Health Service ($206 million), Department of Veteran Affairs ($46 million), Medicare ($90 million), Medicaid ($115 million), military personnel and dependents ($56 million) and federal employees ($35 million). State spending consists of Medicaid ($100 million), state employees ($84 million) and other ($148 million; includes grants to local governments, Pioneers' Homes, Alaska Psychiatric Institute, General Relief Medical program, etc.). Local spending includes hospitals ($30 million) and municipal employees ($92 million).

[7] Letsch, *supra* note 3 at p. 7.

[8] There is no consensus on how many insured Americans receive insurance through their employer. Estimates in the literature vary from at least 73% (American Medical Association, Public Opinion on Health Care Issues at p. 2, March 1994) to at least 89% (Employee Benefit Research Institute, *Source of Health Insurance and Characteristics of the Uninsured*, Special Report and Issue Brief No. 133 at Table 1, January 1993).

The cost of health benefits to employers has grown dramatically in recent years. In 1970, health care benefits as an expense to corporate employers nationally amounted to 35% of after-tax profits. By 1989 they equalled after-tax profits. Health care benefits as a percent of payroll have been the fastest growing component of labor compensation over the past two decades, increasing from roughly 3.5% to 7.4% of total wages and salaries.[9]

This growth in costs has limited employers' ability to increase wages. In Alaska, health care spending is estimated to have grown 125% between 1984 and 1991, while total wages and salaries grew only 16%.[10] Employers pay 32% of total health care expenditures in Alaska (17% is paid by government employers; 15% is paid by private employers).[11]

Impact on Individuals and Families

The Henry J. Kaiser Family Foundation determined that, in 1993, the average American had $909 in medical bills not covered by insurance, and the average adult contributed $86 per month toward insurance premiums, for a total annual expenditure of nearly $2000.[12] In 1980, average family spending on health care accounted for 9% of family income; by 1991, it accounted for 11.7% of family income.[13] The percentage spent by older Americans is even higher. In 1994, the average older American is expected to spend 23% of household income on health care, twice what was spent in 1987.[14]

The trend over the last several years has been for employers to turn to workers and their families to pay a larger share of insurance bills. During the past five years, the average family premium for employer-based group insurance doubled from $2500 to $5200.[15] From 1982 to 1988, the proportion of workers required to contribute to the cost of their coverage increased from 21% to 46% for workers with individual coverage, and from 51 to 65% for workers with dependent coverage.[16]

In Alaska in 1991, individuals and families paid 22% of all health care costs.

Accessibility

Accessibility is influenced by both economic and non-economic factors. For purposes of this report, accessibility is defined in terms of the ability to acquire health care coverage (whether private insurance or through a governmental program) and the availability, even if covered, of health services.

Economic Access

A majority of Americans, and a majority of Alaskans, have health coverage. However, an estimated 37 million Americans, and an estimated 76,000 Alaskans, are uninsured at any one time.[17] This includes persons who do not have private insurance, as well as persons who are neither poor under Medicaid's rules nor aged or disabled under Medicare's rules and who do not

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[9] Health Resources and Access Task Force, *supra* note 4 at p. 9 (citing GAO 1990).

[10] Health Resources and Access Task Force, *supra* note 4 at p. 10.

[11] Institute of Social and Economic Research, *supra* note 6.

[12] Rosenthal, E., *Patients Share Bigger Burden of Rising Health Care Costs*, New York Times 5/12/94 at A1.

[13] Health Resources and Access Task Force, *supra* note 4 at p. 11 (citing Families USA Foundation 1991).

[14] Rosenthal, *supra* note 12 (citing American Association of Retired Persons 1994).

[15] New York Times, *Navigating the Health Swamp: A Primer*, 6/12/94 at p. HR3.

[16] Health Resources and Access Task Force, *supra* note 4 at p. 11 (citing US Bureau of Labor Statistics).

[17] For national data, Employee Benefits Research Institute national survey, March 1993, as reported in the Washington Post (12/15/93) and New York Times (12/15/93). For Alaska data, see Footnotes 19 and 20.

qualify for any other government program. (Figure 2 provides information on where Alaskans get their health coverage.)

The estimate of the number of uninsured Alaskans was developed by the Health Resources and Access Task Force (see Footnote 1). Based on the Current Population Survey for 1988-91, a national survey conducted annually by the U.S. Bureau of the Census, the Health Resources and Access Task Force estimated that 13% of Alaskans (approximately 76,000 individuals) have no health coverage.[18] This estimate is roughly consistent with the findings of the Behavioral Risk Factor Surveillance System (BRFSS) survey, also a national survey, administered annually by the Alaska Division of Vital Statistics in cooperation with the U.S. Centers for Disease Control. The BRFSS found that in 1991 and 1992, 12-15% of adult Alaskans were without health coverage. Of those without coverage, 77% indicated that they could not afford to purchase insurance, 4.5% indicated that they were uninsurable because of a poor medical history and 9% indicated that they "did not believe in health insurance."[19]

The uninsured do not necessarily go without health care. Some uninsured persons pay for health services out of their own pockets; many of the uninsured receive "free" care at hospitals or clinics that is in fact paid for through the rates charged insured patients (a phenomenon known as cost shifting, discussed later). However, research has shown that the uninsured see physicians only two-thirds as often as do the insured, make greater use of emergency rooms and as a group average only three-quarters as many days in the hospital. A large nationwide study that attempted to control for clinical status found that uninsured individuals compared to privately insured patients had conditions of higher risk when admitted to hospitals.[20] Overall, the uninsured report a lower health status than the insured.[21]

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[18] Health Resources and Access Task Force, *supra* note 4 at p. 12-17. Results were analyzed over a four year period to compensate for Alaska's small sample size.

[19] Alaska Bureau of Vital Statistics, *Health Care Coverage in Alaska: A Survey Look*, Vital Signs, Vol. 4, No. 1, 1994, Alaska Division of Public Health, Juneau, AK.

[20] Greenberg, W., Competition, Regulation, and Rationing in Health Care at p. 56, Health Administration Press, Ann Arbor, MI, 1991.

[21] Health Resources and Access Task Force, *supra* note 4 at p. 19 (citing Freeman, et al 1987).

FIGURE 2 -- Where Do Alaskans Get Their Health Coverage?

Program	Who is Eligible	# Alaskans	Note
IHS	All Alaskan Natives and American Indians	85,698	Funded by fed. govt. Number eligible based on 1990 census.
Department of Veteran Affairs	Veterans with service-connected disability or illness. All other veterans who fall below income threshold ($19,800 single vet., $23,400 with one dependent).	8,000	Funded by federal government. Number served FY93. There are 72,000 veterans in Alaska; most are not eligible. (Source: Telephone conversation 7/7/94 with Mike Veil, DVA, Anchorage, AK)
Department of Defense	All active duty military personnel.	20,012	Funded by federal government. Number enrolled 1994
CHAMPUS	Children and spouses of active duty military; retired active duty military.	48,621	Funded by federal government. Number enrolled 1994. (Source: Telephone conversation 7/11/94 with Capt. Clapsaddle, Elmendorf AFB
Medicare	All persons who are over age 65, disabled or who have end-stage renal disease.	29,972	Funded by federal government. Number enrolled 1993. (Source: Telephone conversation 7/14/94, HCFA, USDHHS, Baltimore, MD
Medicaid	State discretion. Generally, women, children and aged/blind/disabled who meet income threshold. Not covered are single persons, childless persons and families with two able-bodied parents regardless of income.	85,374	Funding shared by state and federal governments. Number eligible FY94. (Source: Telephone conversation 7/5/94 with Gretchen Mannix, DHSS, Juneau, AK)
Federal Government Employees	Full-time federal employees and their dependents; retirees and their dependents.	N/A	Federal government purchases private insurance for employees. Total 15,897 federal employees in Alaska; number of dependents and retirees not available. (Source: Telephone conversation 7/8/94 with Carole Sheldon, BLM, Anchorage, AK)
State Government Employees	Full-time state employees and their dependents; retirees and their dependents.	71,700	State government purchases private insurance for employees. Number eligible 7/94: 13,750 active employees (with 27,500 dependents); 13,850 retirees (with 16,600 dependents). (Source: Telephone conversation 7/5/94 with Janet Parker, DOA, Juneau, AK)
Local Government Employees	Municipal and certain other local government employees and their dependents; retirees and their dependents.	N/A	Local governments generally purchase private insurance for employees. Number of employees not available.
Private Empl/Indiv.		N/A	Numbers not available.
Uninsured		76,000	Number developed by Health Resources and Access Task Force.

NOTE: Some individuals are eligible for and may be counted in more than one program.
Source: Compiled by Commonwealth North

Figure 3 identifies the uninsured in Alaska. These estimates are based on the 1988-91 Current Population Surveys as analyzed by the Health Resources and Access Task Force. (Creation of a high risk insurance pool enacted in 1993 may have changed these numbers somewhat.) According to the survey, most of the uninsured are working or in families in which the head of household works all or part of the year (43% work full-time, full-year compared to 52% nationally). Nearly half the working uninsured work seasonally only (43% compared to 32% nationally). Many of the uninsured work for small businesses. A majority of the uninsured have incomes above the federal poverty level (82% compared to 70% nationally). Nationally, half of the uninsured are without insurance for four months or less; only 15% are uninsured for more than two years.[22]

FIGURE 3 -- Who in Alaska is Uninsured?

BY EMPLOYMENT STATUS OF HEAD OF HOUSEHOLD	Number of Uninsured	Percent of Uninsured
Families in which the head-of-household works full-time, full-year	32,800	43%
Families in which the head-of-household works part-time, full-year	2,300	3%
Families in which the head-of-household works seasonally (either full-time or part-time)	32,800	43%
Families in which the head-of-household is unemployed all year	8,000	11%
Families in which the head-of-household is employed by small business (fewer than 25 employees)	26,000	34%

BY INCOME STATUS OF HEAD OF HOUSEHOLD	Number of Uninsured	Percent of Uninsured
Households with income below the federal poverty level ($15,120 for family of four in Alaska)	13,600	18%
Households with income of 101-200% of the federal poverty level ($15,121 to $30,240)	15,900	21%
Households with income of 201-300% of the federal poverty level ($30,241 to $45,360)	16,700	22%
Households with income in excess of 300% of the federal poverty level (in excess of $45,361)	30,000	39%

SOURCE: Health Resources and Access Task Force, supra note 4 at p. 15-17, based on analysis of 1988-91 Current Population Survey.
Some individuals are counted in more than one category.
Federal poverty level figures are for a family of four in Alaska in 1989.

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[22] Greenberg, *supra* note 20 at p. 56; Albright, J. et al, Health Care in the U.S.: What We Should Keep and What We Should Change , Hoover Institution on War, Revolution and Peace, Stanford University, 1994; Glavin, M., *Health Care and a Free Society*, Imprimus 22 (11), November 1993, Hillsdale College, Hillsdale, MI.

Non-Economic Access

Health care coverage does not eliminate all barriers to health care. A large number of Alaskans are eligible for coverage by government health care programs, but the provision of needed services is often limited by resource availability. For example, the Alaska Native population's demand for health services is greater than can be met by the Indian Health Service.

The central health care problem for many rural communities is an inadequate supply of providers. The nationwide shortage and maldistribution of primary care providers is particularly pronounced in rural and inner-city areas. In many Alaskan communities the population base is too small to support a financially viable physician practice. Alaska currently has twenty federally designated geographic Health Professional Shortage Areas and ten designated Medically Underserved Areas. Together, these areas include nearly a third of the population and cover three-fourths of the state.[23]

In addition, Alaska's large geographic area and rural nature create physical access problems. The Alaska Native Health Board reported that in 1991 40% of all Alaska Native patients who needed to travel for medical care deferred treatment because they lacked money for airfare.[24]

Quality

For purposes of this report, quality is broadly defined in terms of the health of the general population. The U.S. may offer the finest health care in the world, but not every American benefits from this high quality care. The general health status of Alaskans, and particularly of Native Alaskans, ranks comparatively low by several standard indicators.

For example, the infant mortality rate for Alaska in 1991 was 10.1 deaths per 1,000 live births, compared to a national rate of 8.9 deaths per 1,000 births; the rate was 7.9 among white Alaska infants and 16.0 among Alaska Native infants. Alaskans suffer a high rate of fetal alcohol syndrome and fetal alcohol effect.[25] Alaska's suicide rate is twice the national average; the suicide rate of Alaska Native males ages 20-24 is 13 times the national average.[26] A 1992 study by Northwestern National Life Insurance Company ranked the "general health of Alaska's population" 46th worst among the fifty states. Examples of Alaska's rankings for specific items include: 49th in infectious disease, 40th in premature death, and 25th in infant mortality.[27]

Social issues (Alaska consistently ranks among the top four states in per capita consumption of alcohol), the large number of high risk occupations (unintentional injury accounted for 15.4% of all Alaskan deaths in 1991, compared to 4% of all deaths nationally[28]), and the lack of water and sanitation facilities in many Alaska Native villages contribute to Alaska's health status and health care needs.

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[23] Alaska Department of Health and Social Services, *Healthy Alaskans 2000: Charting the Course of Public Health for the Decade* at p. 168, February 1994, Juneau, AK. The Health Professional Shortage Area designation is based on the ratio of primary care physicians to the population, and qualifies primary care physicians, physician assistants, and nurse practitioners practicing or willing to practice in the designated area to receive scholarships and education loan repayment. The Medically Underserved Area designation is based on the provider to population ratio, the number of elderly residents, the infant mortality rate, and the poverty level. Areas so designated are eligible for federal community health center grants. A lack of resources has allowed the federal government to fund very few community health centers -- Alaska has only one, located in Anchorage.

[24] Health Resources and Access Task Force, *supra* note 4 at p. 25.

[25] Alaska Bureau of Vital Statistics, 1991 Annual Report, at p. 25, 27, 36, Juneau, AK.

[26] Hlady, W.G. and Middaugh, J., *Suicides in Alaska: Firearms and Alcohol*, American Journal of Public Health, 1988; 78 (2) at p. 179-180.

[27] Health Resources and Access Task Force, *supra* note 4 at p. 22.

[28] Alaska Bureau of Vital Statistics, *supra* note 25.

PART II: WHAT FACTORS HAVE CONTRIBUTED TO THE COST INCREASES AND ACCESS PROBLEMS?

Alaska-Specific Factors

CWN identified four important factors that contribute to the cost of and complicate access to health care in Alaska.

- *Current system's reliance on employment-based health coverage.* Many Alaskans are employees of small businesses and/or are seasonal employees, two groups which traditionally have not received health insurance through their employers. Small businesses overwhelmingly cite the cost of health coverage as the most important reason for not providing it; small businesses are reportedly charged more than larger businesses for the same coverage, primarily because of the high administrative cost associated with small group plans. It is estimated that 34% of uninsured Alaskans are employed by small business.[29]

  In addition, a large number of Alaskans are seasonal workers. An analysis by the Alaska Department of Labor found that employment in all but the state's largest firms fluctuated an average of 24% from the lowest employment month to the highest. In seafood processing, for example, the highest month's employment averaged 322% higher than the lowest month's employment. The lumber and wood products, utilities, and construction industries were found to have fluctuations of over 70%.[30] It is estimated that 43% of uninsured Alaskans are seasonal workers.[31]

- *Rural nature of state and low population density.* Alaska's per capita personal health care expenditures (adjusted for age) are 54% above the national average. This is much higher than our 15-35% cost-of-living adjustment would suggest.[32] Although economists have not been able to fully explain this high cost, it is believed that the small size of Alaska's markets is a contributing factor. Small markets preclude economies of scale and may allow providers to hold monopoly control.

  Alaska's rural nature creates access problems. Many communities are not large enough to support a viable physician practice. In addition, the nature of being a sole practitioner in an isolated community makes the recruiting of providers difficult. Travel to receive medical care outside the community is expensive.

- *Low health status of Alaskans.* The comparatively low health status of Alaskans, discussed earlier, affects the insurance rates charged in the state (rankings such as those in the Northwestern National Life Insurance Company study, discussed earlier, figure into insurers' calculation of premium rates) and creates a need for health care services.

- *Lack of coordination of services.* Alaskans receive their health care through a variety of programs (see Figure 2). Although some cooperation is ongoing, there is, in general, poor integration of health programs in the state. Lack of integration contributes to duplication of services and access problems in some communities.

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[29] Health Resources and Access Task Force, *supra* note 4 at p. 17-18.

[30] Rae, B., *Alaska's 13,467 Other Employers,* Alaska Economic Trends at p. 10, August 1991.

[31] Health Resources and Access Task Force, *supra* note 4 at p. 17-18.

[32] Institute of Social and Economic Research, *supra* note 6.

General Factors

Analysts have identified a number of additional factors that contribute to cost and access problems both nationally and in Alaska.

- *Role of insurance.* Originally designed to spread large unpredictable risk, health insurance now generally pays for routine doctor visits, some preventive care, and hospitalization. The presence of insurance as a primary payer in the health care system makes the patient less sensitive to the prices charged by providers. Insured patients' out-of-pocket payments are far less than the actual cost of their medical care -- after meeting the deductible, most patients "buy" medical care for twenty cents or less on the dollar.[33] Economic theory suggests that, to stimulate competition and lower prices, consumers must search for the best bargains, that is, the best value for their money. In a system in which the patient is removed from the watchdog consumer role by third parties who pay the bills, most patients have little interest in the cost of their medical care. Consequently, providers are unlikely to gain market share by lowering prices and so have little incentive to lower prices.

  In addition, health insurance involves "moral hazard", defined as the increased use of services by an insured party because the services are covered by insurance.[34] One study showed that a better-insured group consumed 40% more health care services than a less-insured group.[35]

- *Cost shifting.* Experts agree that one of the biggest factors driving medical cost inflation is "cost shifting" of unpaid bills of the uninsured to those who can pay. When providers care for those with no health care coverage and who cannot afford to pay, or care for those who are covered by a program that does not fully reimburse providers for their costs (e.g., many Medicaid and Medicare reimbursement rates do not represent the actual cost of procedures), they offset their losses by raising their fees to full-pay patients.[36] Health insurance companies pass along the higher fees to employers and individuals in the form of higher premiums. This creates a spiral effect: higher premiums cause more businesses to trim covered benefits, and more businesses and individuals to drop insurance benefits altogether, creating a bigger pool of uninsured and more unpaid bills. This pushes costs even higher.

- *Payment methods.* Although payment policies have changed over the last decade, many fee-for-service insurance plans still exist, reimbursing physicians and hospitals for each procedure and diagnosis they perform. This payment method provides no incentive for efficient behavior.

- *Complex paperwork requirements.* Estimates of the annual administrative costs associated with health care nationwide run as high as $80-100 billion.[37] One national study found that,

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[33] Albright, *supra* note 22 at p. 3.

[34] Greenberg, *supra* note 20 at p. 45.

[35] Newhouse, J., *An Iconoclastic View of Health Cost Containment*, John F. Kennedy School of Government Bulletin at p. 16, Winter 1994, Cambridge, MA.

[36] According to the Alaska State Hospital and Nursing Home Association, the largest category of uncompensated care is "contractual adjustments", which is the difference paid by large health consumers such as Medicaid and what the care actually costs. This category of costs grew in Alaska from $51 million in 1989 to $90 million in 1992. The amount written off as charity care grew from $7 million in 1989 to $10 million in 1992. Bad debt grew from $17.5 million in 1989 to $21 million in 1992. Source: *Uncompensated Care Continues to Grow at State's Community Hospitals*, Alaska Health Care News at p. 7, April 1994, Juneau, AK.

[37] Albright, *supra* note 22 at p. 4.

for groups of one to four individuals, as much as forty cents of every dollar paid for insurance goes to administrative costs.[38]

- *Excess hospital beds.* Over the last decade, the average length of hospital stay has declined and many services that once required hospitalization are now performed on an outpatient basis. Some consolidation of hospitals has occurred, but many hospitals must now spread their fixed costs across a smaller patient population than they once did.

  The average hospital occupancy rate nationwide in 1990 was 67%.[39] The average Alaska hospital occupancy rate in 1989 was 49%. Many of Alaska's small hospitals had very low occupancy rates (for example, 15% at Cordova Hospital, 11% at Seward General Hospital).[40] Recently, Providence Hospital in Anchorage reported a 59% occupancy rate.[41]

- *Malpractice claims resolution.* Few empirical studies have been done on the effect of malpractice reform on the frequency and cost of defensive medicine (that is, care that does not benefit, or only marginally benefits, the patient and is provided predominantly to avoid malpractice claims). Lewin-VHI, Inc. estimated the cost of defensive medicine nationally at slightly over $4 billion annually, or less than one percent of total annual health care spending.[42] The American Medical Association estimated the cost at $15.1 billion annually.[43] According to the Alaska State Hospital and Nursing Home Association, the amount paid by physicians and hospitals for liability insurance in Alaska increased from $781,000 in 1976 to $13.4 million in 1992.[44]

- Additional factors cited in the literature include:

  Increased longevity. The elderly need and use medical services more than any other group of Americans, accruing medical costs of nearly four times the national average. Nationally, the percentage of the population age 65 and over has grown from 8% of the population in 1950 to 12.3% of the population in 1990.[45] The proportion of Alaska's population over age 65 is much smaller than the national average (4%), but growing quickly. During the 1980s, the state's population age 65 and over grew twice as fast as the state's total population.[46]

  Induced demand. Some analysts assert that physicians induce demand for their services. Between 1965 and 1985, the total number of physicians nationwide increased 89.2%, while the nation's population increased only 23.1%.[47] Included within this increase is a disproportionate number of physician specialists. In Alaska, the number of physicians has

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[38] Health Resources and Access Task Force, *supra* note 4 at p. 18.
[39] Letsch, *supra* note 3 at p. 12.
[40] Goldsmith, O.S., Report to Health Resources and Access Task Force: January 1992, Institute of Social and Economic Research, UAA, Anchorage, AK (contained in Appendix D of HRATF Final Report).
[41] Comment from Dave Hennigan, Assistant Administrator of Finance, Providence Hospital, Anchorage, AK, at 6/14/94 Commonwealth North Roundtable with Robert Brand.
[42] Lewin-VHI, Inc., Estimating the Costs of Defensive Medicine at p. 2, prepared for MMI Companies, Inc., 1/27/93.
[43] Health Resources and Access Task Force, *supra* note 4 at p. 32.
[44] Alaska State Hospital and Nursing Home Association, 7/8/94 statement of Harlan Knudson, President, on HB 292.
[45] Newhouse, *supra* note 35 at p. 16.
[46] Goldsmith, *supra* note 40 at p. 55.
[47] Greenberg, *supra* note 20 at p. 15.

nearly doubled since 1982. The number of physicians' assistants has increased from 42 to 194.[48] The state's population increased only 19% during this time.[49]

Increased utilization. Analysts have found that Americans go to the doctor more often, and get more medical attention for the same problem, than they would have ten to twenty years ago. Americans often see specialists for illnesses that general practitioners could handle.[50] Some analysts also cite cultural traits that make it difficult for Americans to accept human mortality and cause us to look to heroics to prolong life.

Technology. The introduction of expensive technology almost always raises costs. Researchers have suggested that as much as 50% of the increase in hospital costs over the last several years stems from new technology.[51]

Not enough emphasis on preventive care and lifestyle issues, and an increase in violence.

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[48] Telephone conversations 6/17/94 with Leslie Haywood and Nancy Ferguson, Alaska State Medical Board, Department of Commerce and Economic Development, Juneau, AK.

[49] Alaska Department of Health and Social Services, *supra* note 23 at p. 27.

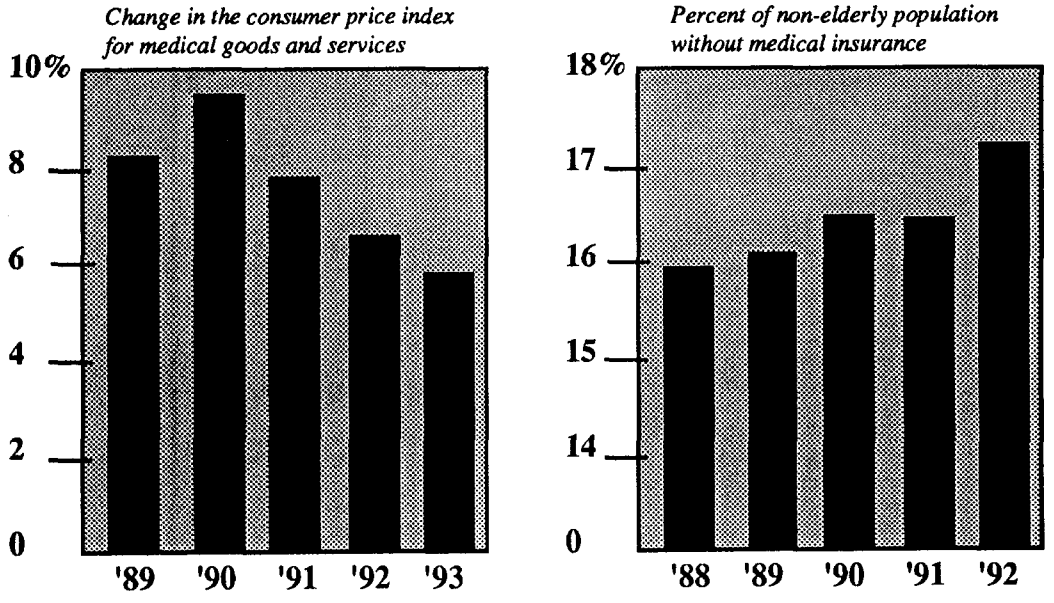
[50] Institute of Social and Economic Research, *supra* note 6.

[51] Greenberg, *supra* note 20 at p. 139, 143.

PART III: WHAT HAS BEEN DONE TO INCREASE ACCESS AND REDUCE COSTS?

Concerns about the rising cost of health care have led to a variety of efforts to restrain costs, and there is some evidence that these efforts are having an effect. The inflation rate for medical prices hit a twenty year low in 1993. Although some health care executives and analysts argue that this trend obviates the need for major reform, there is also evidence that as health inflation has decreased, the percentage of the population that is uninsured has increased.[52]

FIGURE 4 -- As Health Inflation has Decreased, the Number of Uninsured has Increased



Sources: Bureau of Labor Statistics, Employee Benefit Research Institute

The unintended consequences of incremental reform efforts point to the complexity of the health care system. For example:

- Government's efforts to reduce its health care expenditures have resulted in costs being shifted to other payers. For example, both the Medicare program and the Medicaid programs in many states have changed from passive payers of their enrollees' medical costs to active controllers of costs through the use of prospective reimbursement systems. However, in many cases the reimbursement rates do not represent the actual cost of the care provided; these costs are shifted to full-pay patients. An additional consequence has been a decrease in the number of

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[52] Hilzenrath, D., *The Medical Business Says It's Taking Care of Itself*, Washington Post Weekly, 2/7-2/13/94 at p. 22, citing US Bureau of Labor Statistics and Employee Benefit Research Institute data. According to Betty Woods, President and CEO of Blue Cross of Washington and Alaska, trend factors in Alaska, which are a function of projected utilization and cost increases, have taken a significant downturn in the past year. In June 1993, the trend factor for a $100 deductible, 80% coverage medical plan was 17.5% more than the previous year. In June 1994, the trend factor for the same plan was 10%.

physicians willing to serve Medicaid patients (some sources indicate that as many as 35% of physicians refuse Medicaid patients[53]).

- Employers' efforts to reduce their health care expenditures have resulted in costs being shifted to employees through higher deductibles and copayments, and through higher employee contributions to the premium. Some employers have terminated coverage for employees' dependents or terminated coverage altogether. For example, the State of Alaska, which provides insurance to over 41,000 employees and their dependents and more than 30,000 retirees and their dependents, was able to reduce its monthly premium per enrollee from $501 to $423 by increasing the health plan's deductible from $100 to $250, decreasing the share of each medical bill the state pays from 90% to 80%, increasing the maximum amount an enrollee would have to pay in any given year from $1,950 to $5,000, and implementing certain utilization review and hospital precertification procedures.[54]

  Other employers have calculated that it is cheaper to pay workers' health care expenses directly than to pay insurance premiums. Nationwide, more than 50% of employers now self-insure.[55] In Alaska, the proportion of private sector employees who receive insurance coverage through a self-insured plan is estimated to be as high as 70%.[56] Most of Alaska's largest employers (for example, Carr's, Alyeska, British Petroleum, and Enstar) are self-insured. Self-insured businesses are regulated by the federal government and are exempt from state mandated coverage requirements and the 1% state premium tax.

- Private health insurers' efforts to reduce their liability for health care expenditures have resulted in decreased access to health coverage. Insurers have increased the number of exclusions from insurance coverage, especially for persons who are in a high-risk category because of prior or existing diseases or who work in selected industries.[57] In addition, insurance companies are monitoring physicians' fees and utilization patterns more closely, causing physicians to complain that the insurance industry is taking the control of medical care out of the hands of doctors and patients.

- Insurers have also sought to reduce their financial exposure through the establishment of health maintenance organizations (HMOs). A capitated HMO offers specific health services for a fixed price per enrollee per month. The HMO hires or contracts with physicians and hospitals, and accepts the financial risk of providing health services. Acceptance of risk by the provider organization creates an incentive for providers to be cost conscious -- in contrast to the fee-for-service system, providers in an HMO make profits from keeping costs down rather than by the volume of work they perform. There is concern that the incentive to consider cost over care is in fact an incentive to provide as little care as possible. There is also concern that the PPO (preferred provider organization) form of managed care, in which physicians and hospitals agree to discount their prices to large groups of enrollees, shifts costs to those not in the PPO group.

- Many insurers have successfully reduced administrative costs. Betty Woods of Blue Cross indicated in her presentation to Commonwealth North that in 1990 her organization was

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[53] Glavin, *supra* note 22 at p. 4.

[54] Telephone conversation 7/5/94 with Janet Parker, Alaska Division of Retirement and Benefits, Department of Administration, Juneau, AK.

[55] Institute of Social and Economic Research, *supra* note 6.

[56] Swagel, W., *Pay Less, Feel Better: Self Funding of Health Benefits*, Alaska Business Monthly, June 1994 at p. 20.

[57] Albright, *supra* note 22 at p. 19.

spending nearly fourteen cents of every dollar of revenues on administrative costs. Presently that cost is less than ten cents.

Other reforms that have been undertaken include:

- *Insurance market reforms.* Alaska is one of several states that has created a high risk pool for persons who would otherwise be medically uninsurable. In addition, to address the concern of people losing or changing jobs, federal law requires employers to offer departing employees the option of purchasing their employment-related health insurance for up to eighteen months.[58]

- *Malpractice litigation reform.* Alaska is one of several jurisdictions that has capped awards for noneconomic damages and taken other steps to discourage medical malpractice claims. There is to date little evidence on whether such efforts have been effective.

- *Community efforts.* For example, the City and Borough of Juneau, which is self-insured, operates a health education and wellness program for its employees. As a result, the City and Borough's health care expenditures have declined. To reward employees for their efforts, savings are shared with the employees; in 1993, each full-time employee was awarded $482. An effort by the Kenai Peninsula Borough to create a regional health maintenance organization was defeated by voters in 1993.

[58] Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

PART IV: WHAT ELSE MIGHT BE DONE TO INCREASE ACCESS AND REDUCE COSTS?

This section describes approaches under consideration at the state and federal levels to improve the health care system's ability to meet its objectives of affordability, accessibility, and quality. The different approaches reflect varying practical and political perspectives, as well as different philosophical views on the role and responsibility of government. Each approach should be viewed as a possible building block. The three objectives are highly interrelated, and most of the reform proposals consist of a combination of approaches.

To Improve Affordability

To improve affordability, reform proposals rely primarily on two mechanisms: market competition and government regulation. Both approaches acknowledge that the current health care system lacks the competition necessary to control prices. The market-oriented approach attempts to instill market incentives into the health care system. The regulation-oriented approach argues that competition cannot work in the health care sector and that government must therefore intervene.

It is not possible to say which of the many reform proposals would be the most effective at controlling costs. All of the proposals purport to reduce the projected growth in the amount of money spent each year on health care. However, there is no consensus on how much any of the proposals might cost, and therefore no consensus on how much they might save. For example, the Congressional Budget Office calculated that Congressman Cooper's managed competition proposal would cost at least $150 billion more over six years than Cooper had estimated.[59]

All of the proposals would redistribute the burden of who pays for health care. For example, imposing an employer mandate would provide a cost advantage to those firms that currently offer employee health insurance over those that do not. Lewin-VHI has predicted that Clinton's employer mandate would shift nearly $30 billion from firms that currently pay to those that do not by eliminating cost shifting.[60] Ending the tax exclusion for employer-provided health benefits would increase the tax burden on individuals. The Congressional Budget Office has estimated that taxing employer-provided benefits that exceed $4,000 per family per year would likely increase the average family's annual tax payment $100 to $600.[61] Requiring community rating of health insurance premiums would be less costly for people who are paying high premiums because of high health risk, and more costly for those who are paying lower premiums because they are young and healthy.

Seven major approaches to improving affordability are summarized below. (See also Table 1)

Increasing the Consumer's Participation in the Marketplace

Active consumer participation is an essential element of a competitive marketplace. In the current health care market, the presence of insurance as the primary payer relieves consumers of the need to search for the best value for their money (that is, to make consumers care about what their health care costs). Similarly, the prominent role of employers in purchasing health insurance relieves consumers of the need to search for the best insurance bargains. In addition, markets do not function well if consumers cannot make fully informed purchasing decisions. Access to good information about health care has been poor, partly because the information is costly to gather,

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[59] Priest, D. and Rich, S., *Someone Find a Calculator*, Washington Post Weekly, 4/25-5/1/94 at p. 11.

[60] Pearlstein, S., *Win Some and Lose Some on Health Care Reform*, Washington Post Weekly, 3/7-3/13/94 at p. 20.

[61] *Id.*

analyze and interpret. The consumer-oriented reform proposals aim generally to increase consumer interest in what health care costs and to increase consumer knowledge of the health care system.

To develop the informed consumers necessary to a competitive market, many of the reform proposals call for the publication of health industry data (e.g., prices, outcomes research, consumer and provider satisfaction).

To encourage health care consumers to search for the best value for their money, the proposals generally increase the consumer's responsibility for the purchase of health care services or health insurance. The proposals include increased co-payments and deductibles, the elimination of insurance except for catastrophic coverage, and the imposition of a "health benefits tax" through capping the amount of health benefits employees can receive tax-free from their employers.

Some of the proposals focus on enabling consumers to directly purchase health care services or health insurance. The Heritage Foundation proposal, which Stuart Butler presented to Commonwealth North, would replace employer-provided insurance with tax credits or government vouchers to all individuals for the purchase of health insurance and the payment of out-of-pocket medical expenses. The Medical Savings Account approach would require employers to make monthly payments into a tax-free account for each employee in lieu of purchasing health insurance. Employees would use the money in the account to purchase medical services directly.

Support is widespread for increasing consumers' knowledge of the costs and quality of health care services. A concern with increasing consumer responsibility for health care purchasing is that health care may be too costly for some, and the necessary use of health services will therefore be discouraged.

Managed Competition

Managed competition is theorized to control costs through market competition among insurers. It is characterized by the organization of health care consumers into purchasing groups (commonly referred to as alliances) and by networks of insurance companies, physicians, and hospitals who compete for these consumer groups' business (commonly referred to as health plans). The grouping is designed to give consumers more leverage in negotiating prices and to pool risks. The proposals differ on whether participation in alliances would be mandatory or voluntary. Opponents of the voluntary approach argue that it will result in costly premiums, as the young and healthy will choose not to participate in order to avoid sharing the costs of the elderly and unhealthy.

As the name suggests, under this approach competition would be managed, or regulated, by the government. For example, under President Clinton's proposal, each health plan would be required to publish data on its prices and quality, offer a specific basic benefit package, accept all enrollees and limit spending to an amount set annually by the government.

The ability of managed competition to control costs is uncertain. The approach relies on the premise that in order to compete, health plans will need to be cost conscious. This raises the concern that incentives to cut costs will also serve as incentives to cut care.

Capitated HMOs and Other Managed Care Arrangements

Managed care is theorized to control costs through incentives to physicians and hospitals to reduce waste and inefficiency. While many studies have found that, over the long term, the rate of cost increases in managed care plans is about the same as the rate of increase in fee-for-service plans, managed care is nonetheless viewed as a viable mechanism for controlling health care costs. Several of the reform proposals provide incentives for the creation of capitated HMOs or other managed care arrangements.

In a capitated HMO, the financial risk traditionally borne by insurance companies is borne by the providers of care. This creates an incentive for physicians and hospitals to manage each patient's health efficiently. Unlike the traditional delivery system, in which insurance companies pay providers for each procedure or diagnosis, managed care networks of hospitals and doctors provide all care to large groups of patients for a flat fee. Typical cost control measures utilized by HMOs include controlling patients' access to medical specialists through the use of "gatekeepers" (primary care physicians or nurses), eliminating unnecessary surgery and reducing the length of hospital stays. In addition, HMOs commonly emphasize preventive care on the basis that it is cheaper to keep patients well than to treat them later.

HMOs' detractors are concerned that the incentive to consider cost over care is in fact an incentive to provide as little care as possible, and that HMOs are biased toward covering only healthy people who are not likely to have extensive medical needs. Physician specialists are concerned that HMOs shift power to the primary care physicians who serve as gatekeepers. Managed care also raises concerns over the consumer's ability to choose his or her own physician, as HMOs generally cover only those services provided by designated physicians.

In the preferred provider form of managed care (PPO), organizations contract with a set of providers (practicing in their separate offices or institutions, as a rule) in order to achieve lower costs; the providers discount their fees in return for the organization steering patients their way. There is some evidence that the discounts, rather than reflecting efficiencies in the system, are cost-shifted to other privately insured persons.[62]

Global Budgeting

Global budgeting is the most direct way to control health care costs. Under this approach, government limits the flow of funds into the health care system, theoretically forcing providers to be more efficient in the provision of health care. Global budgeting can take many forms. Proposals under consideration include limiting annual increases in private insurance premiums and establishing annual national and/or statewide health budgets.

While global budgets might squeeze some waste and inefficiency out of the system, there is concern that they would result in the rationing of health care, either through denying some medical services to some consumers or creating long waiting lists for services.

Improved Coordination of Services

What is commonly referred to as the health care "system" is in fact a patchwork of multiple providers and payers. Improving the coordination of health services would contain costs by eliminating the duplication of services and facilities and allowing for a more efficient distribution of resources. Although several of the proposals fold Medicaid into the general reform plan, most, including some of the single-payer proposals, leave the Medicare, DVA, IHS and military plans intact. Reorganizing health care in the U.S. into a truly coordinated system would be very difficult, both politically and practically.

Malpractice Litigation Reforms

Lewin-VHI, Inc. has estimated the potential defensive medicine savings nationwide from comprehensive malpractice reform at $4.3 billion, or less than one percent of total annual health care spending.[63] The American Medical Association estimated the savings at $15.1 billion

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[62] A recent analysis of patients at Georgetown University Hospital who underwent coronary bypass surgery found that PPO and fee-for-service patients spent almost the same length of time in the hospital, and that the hospital's average cost of caring for the two groups was nearly the same ($16,904 for PPO patients and $16,939 for fee-for-service patients). However, the average payment to the hospital was $11,252 for the PPO patients, compared with $30,501 for the fee-for-service patients. Source: Hilzenrath, D., *Does Managed Care Really Save Money?*, Washington Post Weekly, 6/20-6/26/94 at p. 8.

[63] Lewin-VHI, Inc., *supra* note 42 at p. 2.

annually.[64] Malpractice reforms contained in the various proposals include promoting settlement through alternative dispute resolution, limiting attorneys' fees, capping noneconomic damages, shortening statutes of limitation and capping malpractice premiums. The development of national practice guidelines has also been proposed as a means of reducing the number of unnecessary medical procedures.

Malpractice reforms have been enacted in several states. Many health care providers and analysts assert that further reforms are needed.

Administrative Efficiencies

Essentially all of the reform proposals seek to reduce the administrative costs associated with health care through mandating more efficient administrative practices, such as use of a uniform claims form and electronic billing. Steps to increase administrative efficiency have been taken in several states. However, establishment of a national standardized claim form and billing system is unlikely to occur without a federal mandate.

To Improve Accessibility

Proposals to improve accessibility can be classified into those that would ensure universal coverage and those that would not. Most experts agree that universal coverage can be achieved in only one of two ways: government can pay the full cost of everybody's health care (the single-payer approach) or government can require all individuals to purchase health insurance (the individual mandate approach).

Advocates of universal coverage maintain that cost shifting will continue as long as people are outside the insurance system. Without a mandate there will be "free riders," individuals who choose not to participate in the system but in times of need prevail upon the legal and moral obligation of the system to serve them. In the health care system, these free riders (both those who have access to affordable health insurance but choose not to buy it and those who do not have access to health insurance) contribute largely to the cost shifting/cost escalation spiral.

In addition to the economic rationale for universal coverage, many advocates maintain that health care is a "merit good," a good that should be provided regardless of one's ability to pay for it because of its social benefits. The benefit of good health accrues not only to the healthy individual but to all of society -- when workers are healthy, productivity increases; when children are vaccinated against communicable disease, others are less likely to contract disease. This view is reflected in our current health care system, in which government subsidizes the cost of care for the indigent.

Opponents of universal coverage argue that the marginal cost of covering each and every individual is too high, both in terms of financial expense and the amount of government involvement that would be required. Several of the reform proposals would make insurance more accessible but stop short of ensuring universal coverage. These proposals rely on the premise that, as health insurance becomes more accessible, most of the currently uninsured population will buy it and the remaining pool of uninsured will be too small to create significant cost shifting or cost escalation. It should also be pointed out that universal coverage addresses only economic access to health care. Noneconomic access barriers, such as transportation and provider availability, might still prevent individuals from receiving needed care.

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[64] Health Resources and Access Task Force, *supra* note 4 at p. 32.

Five major approaches to improving accessibility are summarized below. (See also Table 2)

Individual Mandate

An individual mandate is one of the two means identified by experts to achieve universal coverage. It is simply a requirement that all individuals have health insurance. The proposals vary in how they enable individuals to obtain insurance. Some proposals rely on an employer mandate and subsidies to small businesses and low income individuals. The Heritage Foundation proposal would provide tax credits or government vouchers to all individuals.

The individual mandate approach requires an enforcement mechanism. Under the Heritage Foundation proposal, for example, all individuals would be required to show proof of health insurance on their federal income tax returns.

Single-Payer

Single-payer is the other sure means of achieving universal coverage. Under this approach, all individuals could go to the doctor or hospital of their choice and the government would pay the bill. (Deductibles and copayments are features of some single-payer proposals.) The role of private insurance companies would be eliminated except perhaps to administer plans or to provide supplemental coverage for services the government chose not to pay for.

In the single-payer proposals under debate, private providers would continue to deliver health services. Providers would not be government employees and health care facilities would not be government owned. One proposal would simply enroll all Americans in Medicare.

Under the single-payer approach, the basic benefits package -- what services government will and will not pay for -- is central. Opponents of single-payer argue that it will result in rationing of health care, as government cannot afford to pay for all the services that everybody needs and wants. Advocates of single-payer argue that it is superior to proposals that continue the current mix of employer and individual financing. Severing the link between employment and health insurance provides security to the consumer in terms of uninterrupted insurance coverage. In addition, the single-payer approach is administratively simple.

Employer Mandate

Under an employer mandate, all employers would be required to provide health care benefits for at least their full-time workers. In some proposals, this requirement is extended to workers' dependents and to part-time workers. Washington State recently extended its mandate to seasonal workers.[65] Typically, the employer mandate proposals include government subsidies for small, low-wage businesses and lower-income workers.

An employer mandate builds on the existing health care system. Advocates argue that it would be difficult to find a way to replace the dollars that employers currently contribute to health care. Opponents argue that an employer mandate alone cannot achieve universal coverage. Another program would need to be created to provide coverage for individuals not tied to the workforce. In addition, the mobility of today's workforce makes this approach administratively complex.

Economists routinely point out that a mandate on employers to provide insurance adds to labor costs, and that higher labor costs translate into higher prices for consumers or reduced compensation for employees, either in wages or benefits. Most economists agree that job loss would occur under an employer mandate -- estimates of job loss under a federal mandate range

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[65] Telephone conversation 6/9/94 with Tom Ansart, Washington State Health Services Commission. The provision regarding seasonal employees has not yet been implemented.

from 150,000 to 1.5 million jobs.[66] Advocates argue that employers who do not now provide health insurance operate at an advantage over employers that do provide health insurance, and that an employer mandate would level the playing field.

Currently, Hawaii is the only jurisdiction with an employer mandate. States are prohibited from regulating employee benefit programs by the federal Employee Retirement Income Security Act of 1974 (ERISA). Hawaii's employer mandate existed prior to the passage of ERISA, and so was grandfathered in. Today, approximately 97% of all Hawaiians are insured.

A variation of the employer mandate would require employers to offer health coverage but would not require them to pay for it. Another variation, "play-or-pay," would provide incentives for employers to pay for health care benefits by imposing new payroll taxes on employers who fail to provide health benefits. An ERISA exemption would not be required for either of these approaches.

Insurance Market Reforms

Nearly all of the proposals include insurance market reforms. Although insurance reforms would not achieve universal coverage, they would increase access to health insurance. Community rating and elimination of the pre-existing condition exclusion are the reforms for which there seems to be the widest support; these reforms have been adopted in several states.

- Community rating is designed to reduce the prohibitively expensive premiums currently charged some individuals and small groups. Today, insurance companies use "experience rating" to determine premium rates. The rates are based on the age, gender, lifestyle and medical history of the individuals that are covered and, in the case of employer-provided insurance, on the size of the firm and the industry. Under this system, rates vary widely. For example, a 64-year old may pay four to six times as much as a twenty-year old for the same basic plan.[67] Small employers (those with fewer than 25 employees) generally pay ten to forty percent more than large employers for the same basic plan.[68] By contrast, under community rating, the same rate would be charged for comparable benefits to all people in a geographic area.

  The proposals under consideration vary in their implementation of community rating. Some would require health plans to charge the same premiums regardless of an individual's age, gender, or health status; others would allow age and gender rating of premiums. Many proposals would allow discounts for non-smokers and for participants in wellness programs.

  The effect of community rating would be that companies with older, less healthy workers (coal mining firms, oil refiners, etc.) would likely save as much as $1,000 per year per employee. In contrast, service firms (department stores, large accounting firms, etc.) would likely see premiums increase by $1,000 or more per employee.[69] In addition, males would subsidize females, the young would subsidize the old, and the healthy would subsidize the sick. Overall, the fewer healthy people there are in the community pool to counterbalance the sick, the higher the premium rates would be. To prevent healthy people from dropping out of

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[66] Lewin-VHI, Inc. estimates the range of job losses at 155,000 to 349,000 (Heritage Foundation, *Issue Bulletin No. 188*, 4/11/94, Washington, D.C.). CONSAD Research Corporation estimates the range of job losses at 900,000 to 1.5 million (Heritage Foundation, *The Jobs Impact of Health Care Reform*, F.Y.I., 7/6/93, Washington, D.C.).

[67] Pear, R., *Pooling Risks and Sharing Costs in Effort to Gain Stable Insurance Rates*, New York Times, 5/22/94 at A14.

[68] Health Resources and Access Task Force, *supra* note 4 at p. 17.

[69] Brookings Institution economist Henry Aaron, reported in Pearlstein, *supra* note 59.

the pool, some proposals mandate participation, an approach which would work much like Clinton's proposed alliances.

Since April 1993, the state of New York has required community rating for individuals and small businesses. According to the Superintendent of Insurance for New York, premiums have increased under the new law for nearly two-thirds of enrollees and doubled for 5% of enrollees. Enrollment has dropped slightly -- analysts have concluded that 1% of young New Yorkers have opted to drop their coverage rather than pay the higher premiums.[70]

- Eliminating insurers' ability to deny health care coverage because of pre-existing conditions would increase the number of people eligible to purchase health insurance. Viewed by many as discrimination, pre-existing condition exclusions may also be viewed as rational business practice. Opponents argue that the classic purpose of private insurance of all sorts is to insure against unknown risks, not known ones.

Rural Initiatives

To address non-economic barriers to access, most proposals provide funds for rural initiatives or task forces to address the concerns of rural residents. Various proposals would provide grants for transportation programs and enhanced funding for rural public health services. Some proposals seek to reduce the shortage of primary care practitioners in underserved areas by expanding the National Health Service Corps or by providing tax incentives and government repayment of education loans to providers who practice in underserved areas.

To Improve Quality

Basic Benefits Package

Quality, defined in terms of the general health of the population, is largely a reflection of the affordability and accessibility of health care. Several of the reform proposals seek to define the basic level of health care which all individuals should be guaranteed -- a level which, if received by all, would theoretically improve the overall health status of the population. A basic benefits package is a detailed list of health care services that would be required to be included in every health plan. Such a requirement could benefit not only the currently uninsured, but the underinsured as well -- those whose current policies lack coverage of needed services.

Many of the reform proposals contain fairly comprehensive benefit packages, which typically include medically necessary hospital visits, physician visits, prescription drugs, and preventive care. Some of the proposals also include mental health and alcoholism services, and home and nursing home care.

The basic benefits package is a major determinant of a health plan's costs. This raises two concerns. A parsimonious package would transfer costs to individuals; a comprehensive package would be very expensive. In addition, defining a basic benefits package would require answers to difficult philosophical and ethical questions, such as those regarding neonatal intensive care and high-technology measures at the end of life. Oregon's health plan is the first public attempt to define a benefit package by clinical effectiveness and social value. The Oregon Medicaid program does not cover conditions which get better on their own (like colds) or for which no useful treatment exists.

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[70] Pear, *supra* note 66 and Scism, L., *New York Finds Fewer People Have Health Insurance a Year After Reform*, Wall Street Journal, 5/27/94 at A2.

PART V: WHAT ABOUT ALASKA?

Regarding Affordability

Due to its small, widely dispersed population, Alaska would find it difficult to meet the market share requirements of **managed competition**. According to the literature, a minimum of three health plans is required in an area to ensure efficient competition among plans, and a minimum of 300,000 alliance members is required to support three health plans offering physician and hospital services.[71] Therefore, even Anchorage is not large enough to support efficient managed competition. A minimum of 10,000 alliance members is required to support three health plans offering physician services only. Most communities in Alaska are not large enough to support managed competition on even this narrower range of services.

Increasing consumer participation in the marketplace is a competition-based approach that is less dependent on large population groups than is managed competition. However, in communities with a limited number of providers even this approach is likely to be ineffective. Empowering individuals to purchase health care directly and informing consumers of the costs and quality of health care may have little influence on the prices charged by a sole practitioner in a community, but may be a useful strategy in Alaska's larger communities.

Legislation requiring that providers make their prices available to the public and establishing an authority to analyze comprehensive data on health care utilization and expenditures was considered by the State legislature in 1994 but failed to pass. At least one insurer in the state offers a Direct Reimbursement Plan, under which the employee pays the health care provider directly for his or her medical costs and is then reimbursed by the employer for 50% (or some other agreed to percentage) of the cost. Employees who incur no medical costs during the year are given a cash payment by the employer at the end of the year.[72]

Managed care plans rely on utilization controls and incentives to providers rather than market competition to control costs. The capitated health maintenance organization (HMO) form of managed care is widely available in most of the country. Enrollment in HMOs grew from 9.1 million individuals nationwide in 1980 to 45 million individuals in 1993.[73] The owners of Alaska's largest hospital (Sisters of Providence) and its two largest private insurers (Aetna Life Insurance Co. and Blue Cross of Washington and Alaska) offer HMO plans in the Lower 48. However, there are no HMOs in Alaska. David Helms, President of the Alpha Center, asserted in his presentation to CWN that HMOs would work in Alaska. He suggested that the large number of state employees could serve as the base population for an HMO, with small businesses and others invited to buy in.

PPOs (preferred provider organizations) are increasingly common in Alaska. In addition, many Alaskan employers rely on utilization controls such as pre-admission review and mandatory second opinions to contain costs. For example, effective July 1, 1994, the Teamsters Local 959 began requiring its enrollees to obtain pre-authorization for all medical care, even office visits, through a toll-free call to a designated Primary Care Nurse. Exxon, Fred Meyer, Dresser Industries, Alascom, and Honeywell are among the other companies in Alaska that use utilization controls.

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[71] Kronick, et al (New England Journal of Medicine, 1/14/93), cited in *Analysis of Managed Competition and Its Application in Alaska, 3/7/94 Issue Paper*, prepared by KPMG Peat Marwick for the Alaska Department of Health and Social Services.

[72] Telephone conversation 6/2/94 with William A. Barnes, Anchorage, AK.

[73] Hilzenrath, *supra* note 52.

Based in part on the limitations of competition in a state with our small population, the Health Resources and Access Task Force (HRATF) recommended **global budgeting** as an effective strategy to reduce the rate of growth of health care spending in Alaska. The HRATF recommended limiting annual increases in health care spending to the overall inflation rate, adjusted for factors such as changes in population size and technological developments, and estimated that such a limit would hold spending to $6.55 billion less than was otherwise projected for the period 1991 through 2003.[74]

Senate Bill 284, a compromise between the HRATF recommendation and a proposal put forward by the Alaska State Medical Association and the Alaska State Hospital and Nursing Home Association, would set target expenditure limits. The limit would become mandatory after three years only if targets were exceeded. The 1994 legislature adjourned without taking action on SB 284.

Because of the presence of the federal government as a major payer in Alaska's health care system, global budgeting would require extensive cooperation between the state and federal governments.

Improving the coordination of health services delivery would allow health care dollars and resources to be more efficiently allocated. As discussed, health care dollars in Alaska come from a variety of sources and Alaskans receive health services through a variety of programs. The HRATF recommended that the state seek federal waivers to allow federal health care dollars to come into the state as a block grant rather than being designated for individual facilities or specific program recipients.[75]

Some coordination is ongoing. Indian Health Service (IHS) hospitals throughout the state, established to serve Alaska Natives and American Indians, serve some non-Native patients as well (IHS facilities are authorized to collect funds from Medicaid, Medicare, and private insurance to pay for these services, as well as to accept money directly from patients). Community health aides, physician assistants, and other health care providers who work under contract to the IHS also serve (and are authorized to collect payment for) non-Native Alaskans.[76] In addition, due largely to the initiative of state public health nurses and IHS community health aides, the state and the IHS share a data system for patient records. (DHSS is applying to the Robert Wood Johnson Foundation for grant funds to expand the shared system.) The Army, Air Force, IHS, and DVA are in the process of forming a coalition to share patients, providers, and resources, and to negotiate agreements with civilian providers for discounted rates.

Further integration of services is needed. For example, Sitka, with a population of 9,000, has two general acute care hospitals, one operated by the local government and the other by the IHS. Both hospitals are under-utilized.[77] On a smaller scale, federal, state, and local government programs all promote prenatal care. Many families with two employed members are eligible for health coverage by more than one program.

Coordination of health care services would likely result in a reallocation of resources. For example, Bassett Army Community Hospital at Fort Wainwright in Fairbanks recently assumed financial responsibility for the CHAMPUS program (which provides health coverage for military retirees and the dependents of military personnel). This resulted in a significant increase in the number of CHAMPUS recipients receiving care at Bassett rather than at other hospitals. In FY 92,

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[74] Health Resources and Access Task Force, *supra* note 4 at p. 42.
[75] *Id.*, at p. 65.
[76] Telephone conversation 7/8/94 with Dr. Thomas Nighswander, Director of Community Health Services, Alaska Native Medical Center, Anchorage, AK.
[77] Health Resources and Access Task Force, *supra* note 4 at p. 29.

Bassett paid Providence Hospital $1.2 million for CHAMPUS patient care; in FY 93, that amount fell to $500,000.[78]

Any system reforms affecting the IHS must recognize and support the federal trust responsibility to provide health care to Alaska Natives. For example, copayments and deductibles are prohibited by law in the IHS system. Negotiations currently underway between Native American tribes (the Native Corporations in Alaska) and the IHS over service delivery may significantly impact financing arrangements, as Native Corporations seek to become the direct recipient of federal health funds (bypassing the IHS). At least three Alaska Native Corporations are expected to have entered into these financing "compacts," as they are called, by October 1, 1994.

No **malpractice reforms** of consequence have been enacted in Alaska since 1988, when the voters approved a ballot initiative requiring the court to hold each party liable only for that party's percentage of fault (several liability). Significant reform also occurred in 1986, when noneconomic damages (for intangible losses such as pain and suffering) were capped at $500,000 except in the case of disfigurement or severe physical impairment. According to the Legislative Research Agency, it is not possible to obtain the historical data needed to measure the effectiveness of these past reforms.[79]

A proposal to reduce the noneconomic damage cap to $250,000, limit punitive damages to $200,000, reduce pre-judgment interest, and require that malpractice lawsuits claiming birth injury be brought by age eight was considered by the Legislature during the 1994 session, but failed to pass.

Regarding **administrative efficiencies**, legislation passed in 1994 will require all insurers operating in Alaska to use a uniform claims form. The larger insurance companies in the state are moving toward electronic billing.

Regarding Accessibility

The health reform proposal advanced by the Alaska State Medical Association and the Alaska State Hospital and Nursing Home Association contained an **individual mandate**. Under the proposal, proof of health insurance would have been required in order to receive the Alaska Permanent Fund Dividend. The dividend could be used as partial payment for insurance by checking a box on the dividend application. To enable people to obtain insurance, the proposal, known as CHIPRA (Comprehensive Health Insurance Payment Reform Act), mandated employer participation through the play-or-pay approach, with government subsidies for the poor.

The Health Resources and Access Task Force (HRATF) recommended **single-payer** as the most suitable health care reform approach for Alaska. The HRATF envisioned a system in which the current mix of private and public providers would continue to provide health services, and in which funds from all sources would flow to one repository from which they would be redistributed to pay for health care. The proposal relied on expenditure limits to control costs.

The HRATF proposal was superseded by SB 284, which represents a compromise with the Alaska State Medical Association and the Alaska State Hospital and Nursing Home Association. Described by Senator Jim Duncan and Dr. Oliver Korshin in their presentation to Commonwealth North as a "market-driven single-payer approach," SB 284 maintains the single-payer concept but

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[78] Alaska Hospital and Nursing Home Association, *supra* note 36 at p. 6.

[79] Weeks, M., *State Approaches to Medical Malpractice*, Research Request 91.222, Legislative Research Agency, March 1992, Juneau, AK.

relies on providers to voluntarily curb prices and volume of services. Government would set expenditure limits only if the voluntary effort failed.

The HRATF projected that administrative savings from a single-payer system would be slightly greater each year than the cost of insuring the currently uninsured.[80] Robert Brand of Solutions for Progress, Inc. (a Pennsylvania health care consulting firm commissioned by Senator Duncan to analyze a single-payer system in Alaska), in his presentation to Commonwealth North, projected savings from a single-payer system of $3.4 billion by the year 2000. Savings would be achieved through shifting of certain costs to the federal government, global budgeting, utilization controls, and administrative simplification.[81] Implementing a comprehensive single-payer system in Alaska would require an extensive amount of cooperation among the multiple payers in our health care system, particularly the state and federal governments.

An **employer mandate** has been more or less ruled out by the major groups studying reform in Alaska. Because of the nature of employment in the state, an employment-based system would likely leave many Alaskans uninsured. Many of our industries are seasonal in nature. An analysis conducted by the Alaska Department of Labor found that employment in all but our largest firms fluctuated an average of 24% from the lowest employment month to the highest. In seafood processing, for example, the highest month's employment averaged 322% higher than the lowest month's employment. The lumber and wood products, utilities, and construction industries were found to have fluctuations of over 70%.[82] Washington State recently extended its employer mandate to seasonal workers, with the employer contribution to the insurance premium based on the number of hours worked.

In addition, 39% of private sector employees in Alaska work in firms with fewer than twenty employees, compared to 27% nationally.[83] In Hawaii, where 97% of all individuals are covered through an employer mandate, 97% of businesses employ fewer than 100 persons and account for 51% of the jobs in the state; 94% of businesses employ fewer than 50 persons.[84]

Alaska also has a larger proportion of self-employed individuals (17.5%) than does the U.S. as a whole (14.4%)[85] and a relatively high unemployment rate. Alaska's statewide unemployment rate in May 1993 was 8.4%. The comparable national unemployment rate was 6%. Unemployment in some parts of rural Alaska was nearly double the state rate -- the highest rate was 18.2% in the Yukon-Koyukuk region.[86]

However, the proportion of Alaskan workers employed in the public sector, in which health insurance is provided, is twice the national average.[87]

	AK	U.S.
Military	9.2%	2.0%
Federal Government (civilian)	5.7%	2.4%
State and Local Government	15.1%	11.1%
	30.0%	**15.4%**

[80] Health Resources and Access Task Force, *supra* note 4 at p. 64.

[81] Solutions for Progress, Inc., Single-Payer Financing for Universal Health Care in Alaska: Costs and Savings, A Study Prepared for Senator Jim Duncan, 6/13/94, Philadelphia, PA.

[82] Rae, *supra* note 30 at p. 49.

[83] Goldsmith, *supra* note 40 at p. 49.

[84] Lewin, J. and Sybinsky, P., *Hawaii's Employer Mandate and Its Contribution to Universal Access*, Journal of the American Medical Association, 269 (19) at p. 2540, 5/19/93.

[85] Goldsmith, *supra* note 40 at p. 48.

[86] Alaska Department of Labor, Alaska Economic Trends at p. 16, August 1993.

[87] Goldsmith, *supra* note 40 at p. 48.

Regarding insurance market reforms, Alaska law was amended in 1993 to require some **community rating** of small group plans. Under the new law, when using health status, claims experience, and duration of coverage in determining premium rates, small group insurers must limit the rate to no more than 115% of that which would be charged if these factors were not considered. Rates may also be adjusted based on age, gender, industry, geographic area, family composition, and group size.

In addition, the 1993 amendments prevent insurers from denying health coverage to small employers whose employees have **pre-existing conditions**. A 12-month waiting period is allowed for specified conditions. However, new waiting periods may not be imposed on workers changing jobs if they satisfied waiting periods in their previous employer's plan. The premiums charged under this provision may not be more than 35% higher than the premiums paid by others with similar coverage.[88] The small group amendments will take effect September 19, 1994.

Since January 1, 1994 the State Division of Insurance has operated a high risk pool for individuals unable to obtain private insurance because of a pre-existing condition. As of May 1994, 108 persons were participating in the pool. Premium rates were roughly 175% of the average rate charged in the state (the law caps the rate at 200% of the average).[89]

Rural initiatives are essential to improving access to health care in a state as geographically large and rural as Alaska. As mentioned, Alaska currently has twenty Health Professional Shortage Areas and ten Medically Underserved Areas, which together include nearly a third of the population and cover three-fourths of the state.[90] Attracting providers to rural communities and ensuring that transportation is available to services not provided in the community are critical access issues in rural Alaska. Other proposals for improving access include more flexible facility licensing standards, increased use of health care paraprofessionals, and modification of Medicaid and Medicare reimbursement rates to reflect the higher cost of delivering care in rural Alaska.

Regarding Quality

The comparatively poor health status of Alaskans, and particularly Native Alaskans, suggests that many Alaskans are not receiving all the health services they need. There has been little public debate in Alaska over what a **basic benefits package** might include. Reform proposals considered by the legislature during the 1994 session would have established a public authority to develop and cost out a basic benefits package; the proposals did not pass.

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[88] AS 21.56

[89] Telephone conversation 6/13/94 with Ross Blaker, Aetna Life Insurance Co.

[90] Alaska Department of Health and Social Services, *supra* note 23 at p. 168.

CONCLUSION

This report identifies problems with the health care system -- costs are rising, some costs are being shifted, and not every American is able to receive the health care he or she needs or wants. How significant these problems are and whether they rise to a level requiring reform of the current system continue to be topics of wide-ranging debate.

Commonwealth North reached the following conclusions about the effort to achieve consensus on health care reform:

- The involvement of Alaskans in the health care debate is vital. Unique situations in Alaska warrant special consideration if health care reform goals are to be achieved. For example, even the provision of health insurance to all Alaskans would not necessarily ensure adequate health care. The large geographical area and small, widely dispersed population have resulted in provider shortages and infrastructure inadequacies. Requiring employers to provide or offer health insurance to their employees is also problematic. Any reform must be responsive to Alaska's large number of small businesses and large seasonal fluctuations in employment.

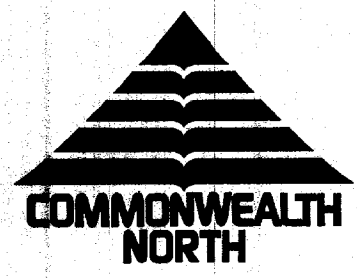
- The health care reform debate is complex and controversial. Multiple players with competing interests, large philosophical and ethical questions, and the magnitude of the issue -- one that directly affects all of our lives, many of our livelihoods and a significant portion of the national economy -- contribute to the complexity and controversy.

- Every approach to health care reform creates winners and losers. For example, the working uninsured would "win" if employers are required to purchase health insurance for them; employers would consequently "lose" as they would bear the financial burden of purchasing the health insurance. However, even within employer groups there are factions and controversies. Employers who currently provide coverage have different interests than employers who do not currently provide coverage. From the currently-insuring employer's perspective, requiring all employers to provide coverage would "level the playing field," and likely reduce overall costs as cost-shifting is eliminated.

- Even maintaining the status quo creates winners and losers. Without some reform that contains health care costs, costs will likely continue to rise, placing an increasing burden on families, businesses and taxpayers.

- Significant factual disputes contribute to the controversy. Clearly, more information is needed. As noted, the data on uninsured Alaskans presented in this report came from a limited number of sources and has been questioned by some groups as being inaccurate or incomplete. Without more information on why some Alaskans are uninsured, the data is open to different interpretations and therefore not as useful as it could be in developing a solution. For example, data cited in this report estimates that 39% (or approximately 30,000) of the uninsured in Alaska live in households with incomes in excess of $45,000. To some, this suggests that a large number of our uninsured can afford health insurance and are simply choosing not to buy it. To others, it suggests that specific circumstances (competing household expenses, pre-existing conditions that make the family "uninsurable," etc.) must exist.

Information and education are the foundation of meaningful policy debate. It is hoped that this report will advance the debate on health care reform in Alaska.



Commonwealth North is a non-profit corporation, organized and existing under the laws of the State of Alaska. It addresses state and national public policy issues and involves approximately 400 of Alaska's leaders and concerned citizens representing business, labor, education, public service and the Alaska Native community. It was founded in 1979 on a bipartisan basis by Governor William A. Egan and Governor Walter J. Hickel.

The goals of the organization include: Strengthening the private sector of our economy; Understanding Alaska's role in the larger world; Educating members on major issues affecting our state and nation; Influencing state and national public policy decisions by providing a forum for nationally recognized speakers and conducting studies of critical issues facing the state and the nation.

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