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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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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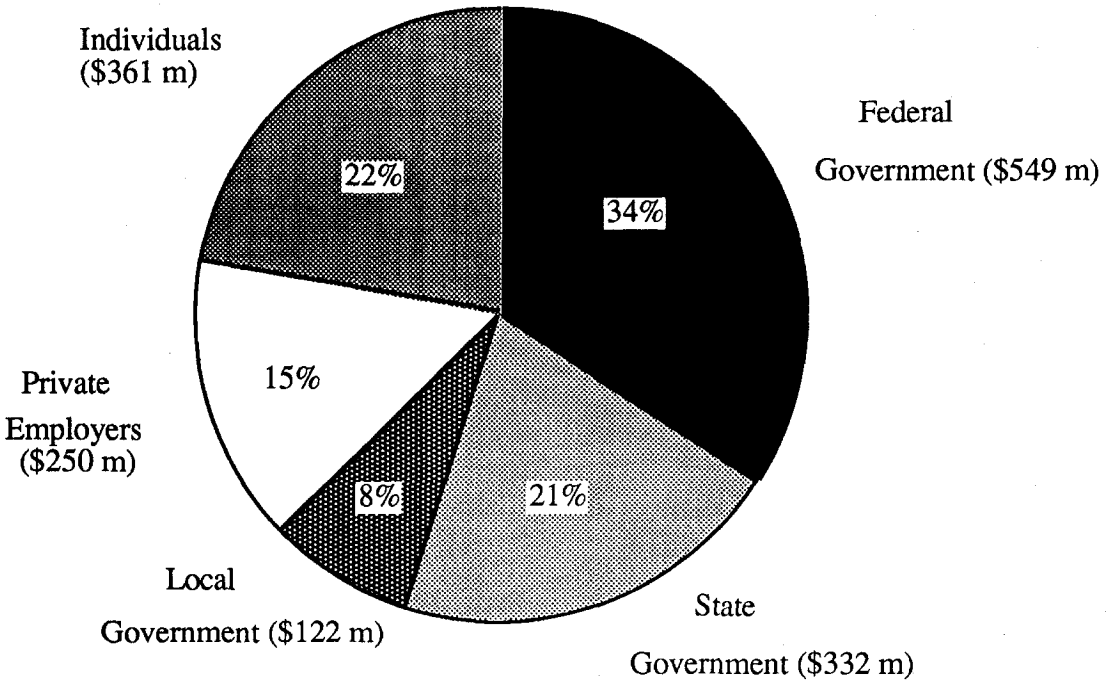
[3] Letsch, S.W., et al, *National Health Care Expenditures 1991*, Health Care Financing Review, Winter 1992, 14 (2) at p. 1, 9. U.S. Department of Health and Human Services, Baltimore, MD. GDP (gross domestic product) measures the U.S. economy as the value of output produced within the geographic boundaries 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.