HB 264

HOUSE COMMITTEE REPORT

(21)
Date Referred: March 31, 1989 FURTHER REFERRALS:

Date of Committee Action: 4/10/89

The FINANCE Committee considered: HB 264

HOUSE BILL NO. 264 [STATE PREMIUM TAX EXEMPTION]
"An Act relating to the state exemption from certain insurance premium taxes; and providing for an effective date."

RECOMMENDATIONS:
[ ] be replaced with _____ [ ] the same title [ ] a new title
[ ] have attached amendment(s)
[X] do pass
[ ] do not pass
[ ] no recommendation
[ ] individual recommendations
[ ] additional referral to the _____ Committee

ADOPTS: _____ letter of intent

ATTACHES NEW FISCAL NOTE(s): (Dept) APPROVES PREVIOUS: (Date/Dept)

[ ] fiscal impact _____ [ ] fiscal note(s) _____
(2) [X] zero fiscal note HESS/Commerce [ ] zero fiscal note(s) _____
[ ] zero with analysis _____ [ ] zero fn/analysis _____

SIGNING DO PASS:	SIGNING: (Check approp. column)	Do Not Pass	No Rec	Amend
HOFFMAN				
LARSON				
KOPONEN				
ULMER				
BARNES				
WALLIS				
SHULTZ				
RIEGER				
BROWN				

Ronald J. Larson
Co-Chairman's Signature
Bruce Hoffman

STATE OF ALASKA
1989 LEGISLATIVE SESSION

BILL VERSION: HB 264
PUBLISH DATE: _____

FISCAL NOTE

REQUEST: _____

Revision Date: _____
Title: An Act...state exemption from certain insurance premium taxes....
Sponsor: Health Care Cost Containment Task Force
Requestor: _____

Agency Affected: Health & Social Services
BRU: _____
Components: _____

Adopted

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
PERSONAL SERVICES	-0-	-0-	-0-	-0-	-0-	-0-
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
REVENUE	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS:

FULL-TIME	-0-	-0-	-0-	-0-	-0-	-0-
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

Prepared by: _____ Phone: _____
Division: _____ Date: _____

Approved by Commissioner: Myra M. Munson Date: 4-5-89
Agency: Department of Health & Social Services

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

STATE OF ALASKA
1989 LEGISLATIVE SESSION

BILL VERSION: HB 264
PUBLISH DATE: _____

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: State exemption from certain insurance premium taxes
Sponsor: Rules (Health Care Cost
Requester: House Finance /Containment Task Force)

Agency Affected: Commerce & Econ. Dev.
BRU: Insurance
Components: _____

Adopted

EXPENDITURES / REVENUES: (Thousands of Dollars)

OPERATING	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	0	0	0	0	0	0

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary.)

Prepared by: Paul Roller, Director
Division: Insurance
Phone: 465-2515
Date: 4-5-89

Approved by Commissioner: Larry Merculieff /W Rank, for
Agency: Department of Commerce & Economic Development
Phone: 465-2500
Date: 4/6/89

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

3753D/040689a

Introduced: 3/31/89
Referred: Finance

BY THE RULES COMMITTEE BY REQUEST (For the Health Care Cost Containment Task Force)

IN THE HOUSE

HOUSE BILL NO. 264

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to the state exemption from certain insurance premium taxes; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 21.09.210(i) is amended to read:

(i) Premiums paid by the state for insurance policies and contracts purchased under the provisions of AS 39.30 are exempt from taxation under this section. An insurer may not include the tax imposed under this section in a premium charged on an insurance policy or contract purchased by the state under the provisions of AS 39.30. An insurer may claim the [CLAIMS FOR] exemption [SHALL BE MADE] on forms provided by the division of insurance.

* Sec. 2. This Act takes effect immediately under AS 01.10.070(c).

HB 264

STATE OF ALASKA HEALTHCARE COST CONTAINMENT TASK FORCE

Provided by: Arthur J. Gallagher & Co.
Aetna Life Insurance Company

April 3, 1989

At its March 29, 1989 meeting, the Healthcare Cost Containment Task Force requested additional information on three financial issues. The following material provides Arthur J. Gallagher's and Aetna's comments on the three issues.

1. Premium Taxes. There is a great deal of confusion on the Premium Tax issue. Currently, premium taxes are paid to the State on the Health plans and then Aetna files for a refund of the taxes. Thus, the net effect on the plan should be zero. In determining the State's premium rates it is assumed there is no tax liability.

   In order to recover the 1987 tax credit of $1,700,000 ($1,300,000 active and $400,000 retirees) the following needs to occur:

   1. Combine plan financials at year end. This allows Aetna to cross apply Premium Stabilization Account Funds.

   2. The State Revenue Department has to issue 1988 premium tax refund to Aetna prior to July 1, 1989.

   3. Section 1 AS21.09210 (i) is amended effective January 1, 1989.

Aetna will credit $1,700,000 as directed by administration.

2. Extended Liability Reserves. Under the State's plan there is an extension of benefits which continues Medical coverage for up to 12 months for employees who are totally disabled at contract termination. This is deferred liability which cannot be measured while the plan is active.

   Aetna provides for this liability by establishing reserves at each renewal. The extended liability reserves established as of the July 1, 1988 renewal are as follows:

	Extended Liability	Extended Maturity	Total	80%
Actives	$2,178,045	$857,139	$3,035,184	$2,400,000
Retirees	1,162,282	27,189	1,189,471	900,000

   Note: These reserves were outlined on page 18A of Arthur J. Gallagher's March 29, 1989 Report on the Task Force.

Aetna would be agreeable to transferring the extended liability to the State in the event of contract termination. With the transfer of liability, 80% of the reserves would no longer be required. The remaining 20% of the reserves would be required to provide for extended liabilities while the contract is in force.

To accomplish the transfer of liability, Aetna would need to make a change to the contract with the State. Also, a notice would need to be provided to employees indicating that the State has assumed this liability.

If the State wishes to proceed with this change we would need an effective date. Once implemented, Aetna would credit the State for that portion of the reserves. Aetna will credit Extended reserves of $3,300,000, as directed by Administration.

3. Minimum Premium. Aetna has a minimum premium product available called the Split Funded Group Plan (SFGP). There are two types of SFGP available: one where Aetna retains terminal liabilities and reserves, and one where terminal liabilities and reserves are transferred to the State. All further discussion will assume the State is responsible for terminal liabilities and reserves.

The following table outlines the reserves available to the State:

	Actives	Retirees
July 1, 1988 Reserves:		
Unpaid claim	$ 7,808,469	$4,127,414
Extended Liability	3,035,184	1,189,471
Total	$10,843,653	$5,316,885
Estimated Float Claims	-2,175,000	-925,000
	$ 8,668,653	$4,391,885
Reserve Release Charge	-346,746	-175,675
Net Reserve Release	$ 8,321,907	$4,216,210

Note: SBS Option I benefits are combined with basic benefits to avoid producing two separate claim transactions and the expenses associated with two transactions. It is assumed that Option I would also convert to SFGP to continue these expense savings.

Aetna would need to retain a portion of the reserves to cover "float" claims outstanding on the conversion date. Float claims are those claims where a claim check has been issued but not recorded as paid. The liability is estimated to be approximately two weeks of claims.

In addition, if the reserves are released in a lump sum there is a charge made to cover the opportunity costs associated with the conversion of assets to cash. Currently, the charge is equal to 4% of the lump sum payment. The charge would be waived if the reserves were released in 12 installments.

Upon the conversion to SFGP, Aetna's costs would increase as follows:

	Actives	Retirees
Lost Interest	$ 867,492	$125,351
Banking and Administration	86,000	37,000
Additional Risk	54,218	26,584
TOTAL	$1,007,710	$488,935

Currently, Aetna is crediting interest to the State on the claim reserves at an annual rate in the range of 7.5% to 8.5%. This interest is used to offset some of the expenses under the plan. Once released, the net expenses increase by the amount of the lost interest. Aetna has assumed 8% in this illustration.

The banking and administration charges cover the added costs associated with SFGP. Although terminal liabilities and reserves shift to the State, Aetna guarantees payment of these liabilities in the event the State cannot provide the funds. Aetna assesses an additional risk charge for this guarantee. The risk charge could be waived if there is Letter of Credit for 120% of the reserves.

It would be necessary to increase the "conventional " premium rates to provide for these additional expenses.

Under a SFGP arrangement, the following additional documents are required to implement SFGP:

- The Letter of Intent (Exhibit A) outlines the State's desire to implement SFGP and accepts in principal the various Agreements.
- The Banking Agreement (Exhibit B) sets up the wire transfer of funds between the State and Connecticut National Bank.
- The Split Funded Agreement (Exhibit C) amends the insurance contract and outlines the various terms and conditions of the arrangement.
- The Retrospective Premium Agreement (Exhibit D) provides for the call on any unused Claim Liability Limit to fund an accounting deficit.
- The Termination Liability Fund (Exhibit E) is necessary to assure that adequate reserve funding is available at all times.

In addition to these documents, a notice needs to be sent to the employees announcing the change to SFGP.

Under SFGP, the conventional premium would be split into two components. A basic premium component equal to the estimated expenses would be developed and paid to Aetna monthly. The basic premium level is not guaranteed and would be "trued up" at year end based upon actual plan costs. The remainder of the conventional premium would be retained by the State's for claim payment.

Due to associated costs and ease of administration, it is recommended that the State review Split Funding where Aetna retains terminal liabilities and reserves. The net impact of this on FY 89, 90 depends upon the actual claims paid and the State's accounting practices.

It is further recommended that the Task Force continue to pursue Cost Containment measures to be implemented in FY 90.

Jeffrey A. Malek
Assistant Area Vice President
Employee Benefits
Arthur J. Gallagher & Co.

Philip B. French
Assistant Vice President
Western Home Office
Aetna Insurance Co.

THE FOLLOWING DOCUMENT HAS

NOT BEEN FILMED BUT IS

AVAILABLE IN THE ORIGINAL

FILE

STATE OF ALASKA

HEALTH CARE COST CONTAINMENT TASK FORCE

CONFIDENTIAL

Arthur J. Gallagher & Company Inc.
Gallagher Heffernan Insurance Brokers
160 Spear Street, Suite 1100
San Francisco, CA 94120
1-800-877-9300

March 29, 1989

AK3/891

March 29, 1988

Dear Task Force Members:

We are pleased to present our findings regarding Cost Containment, Financial Review and Alternate Funding options affecting the State health plan insured by Aetna.

This report is divided into six sections as follows:

1.00 Cost Containment
2.00 Financial Review
3.00 Alternate Funding
4.00 Recommendations
5.00 Future Cost Containment Considerations
6.00 Estimated Financial Impact of Task Force Recommendations on FY 89, 90

Following these sections are supporting documents and literature.

The information contained in this report covers many options and variables. All of these are potential cost saving ideas if the State and participants agree to them.

Please keep in mind that these alternatives are the first step in managing health care costs. The State must take a proactive position from here forward.

We would like to thank all of the people involved in providing information to prepare this report, especially the State entities and Aetna Insurance Company. The task force's timeframe could not have been met without everyones' complete cooperation.

Arthur J. Gallagher is committed to working with you on Health Care Cost Containment, keeping benefits intact and retaining as much money in the State of Alaska as possible.

Sincerely,

Jeffrey A. Malek
Area Vice President
Employee Benefits

Ronald C. Johnson
Area Vice President
Employee Benefits

cc: Janice Fried

AK3/892

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT TASK FORCE
INDEX

1.00 COST CONTAINMENT

The purpose of this section is to identify components of Health Care Cost Containment provisions that the State could implement in order to control escalating costs while not compromising medical necessity and quality of care on an incentive basis to the employees and covered dependents.

Many major Alaska employers have implemented cost containment provisions, which generally would shift costs to employers plans who do not have cost containment. It is our recommendation that the State take a leading position in managing their health care. Aetna and Arthur J. Gallagher & Company are ready to work with the State on standard cost containment programs along with development of some prototype plans that would make the State a leader in the country, delivering cost effective, participant sensitive health care benefits.

Cost containment has several components: employee communication, systems, plan design, fixed costs and potential savings. We have attempted to outline each of the components and cost savings in this section. The administration of cost containment provisions (i.e., precert, U/R etc.) is available from firms other than Aetna, and could be contracted through the RFP process. However, in the interest of time and knowledge of the situation in Alaska, we feel Aetna is in the best position to show results quickly.

The fixed costs, estimated by Aetna, appear to be on the high side and the savings to be under estimated. Through negotiations, the fixed cost may be lowered and the actual savings may be higher due to positive employee acceptance.

We have not reviewed plan design changes, state contribution caps, or cost containment measures, as these do not contain the cost but merely shift the cost. The pricing of plan design changes are available if you should require them.

1.01 UTILIZATION REVIEW - HEALTHLINE

SCOPE

HEALTHLINE (basic) combines consumer advisory services with pre-admission certification, continued stay review, focused psychiatric review, expanded individual case management and utilization review services.
(Attachment A)

EFFECT ON PARTICIPANTS

Through the toll-free telephone number for Aetna's HEALTHLINE, employees have access to health care information ranging from claim status inquiries to advance review of planned hospital stays. This enables them to make informed health care decisions about the appropriateness of the care they receive and help control costs for both the State and the employee. A $400 reduction is suggested for non-compliance.

EFFECT ON PLAN

Claims are managed on a prospective basis by reviewing care prescribed and recommending alternatives for the participant to make informed decisions and control plan costs.

EFFECT ON ADMINISTRATION

The State must communicate the change in procedures to employees and retirees.

ACTION REQUIRED

The State must enter into an agreement for Aetna to provide these services, and pay service charges.

ASSOCIATED COSTS

$2.08 per employee per month
Plus the Cost of running new I.D. cards
Actives 12,600 X $2.08 = $26,208 per month
Retirees

ESTIMATED NET EFFECT ON PLAN	FY89	FY90
PERCENTAGE SAVINGS:	6%*	6%*
Actives	$3,131,000	$3,131,000
Retirees	1,224,817	
Total	4,355,817	

NOTES:

Aetna needs sixty (60) day minimum lead time from date of signed agreement.

RECOMMENDED ACTION

* of medical costs

1.02 OUTPATIENT PRECERTIFICATION

SCOPE

Outpatient Precertification operates similarly to a typical hospital precert system. **(Attachment A and B)**

EFFECT ON PARTICIPANTS

Employees have a financial incentive (a suggested $400 reduction for noncompliance) to call Aetna's **HEALTHLINE** before having specific tests or procedures on an outpatient basis.

EFFECT ON PLAN

The **HEALTHLINE** nurse identifies those cases where the test or procedure may not be medically necessary.

EFFECT ON ADMINISTRATION

The State must communicate to employees/retirees the change in procedures.

ACTION REQUIRED

The State must enter into an agreement for Aetna to provide these services and pay service charges.

ASSOCIATED COSTS

$1.55 per employee per month
Actives 12,600 employees X $1.55 = $19,530 per month
Retirees

ESTIMATED NET EFFECT ON PLAN	FY89	FY90
PERCENTAGE SAVINGS:	3%*	3%*
Actives	$1,252,000	$1,252,000
Retirees	607,409	
Total	1,859,409	

NOTES:

RECOMMENDED ACTION

* of medical costs

1.03 MANAGED SECOND SURGICAL OPINION

SCOPE

Managed Second Surgical Opinion operates similarly to a typical hospital precert system. The program is expected to be available the third quarter of 1989. **(Attachment B and C)**

EFFECT ON PARTICIPANTS

Employees have a financial incentive (a suggested $400 reduction for noncompliance) to call Aetna's HEALTHLINE before having specific surgical procedures.

EFFECT ON PLAN

The HEALTHLINE nurse identifies those cases where a second surgical opinion is necessary.

EFFECT ON ADMINISTRATION

The State must communicate the changes in procedures to the employees and retirees.

ACTION REQUIRED

The State must enter into an agreement for Aetna to provide this service and pay service charges.

ASSOCIATED COSTS

To Be Determined

ESTIMATED NET EFFECT ON PLAN	FY89	FY90
PERCENTAGE SAVINGS:	1 - 1.5%*	1 - 1.5%*

NOTES:

RECOMMENDED ACTION

* of medical costs

1.04 MANAGED MENTAL HEALTH

SCOPE

Managed Mental Health is a prototype program offered by Aetna utilizing an Employee Assistance Program to act as a gatekeeper, providing counseling, referrals and pre-authorization.
(Attachment B and C)

EFFECT ON PARTICIPANTS

The employee either calls the EAP directly or is referred by the HEALTHLINE nurse to the EAP.

EFFECT ON PLAN

The claim is managed on a prospective basis by reviewing and recommending alternatives to standard inpatient treatment resulting in lower plan costs.

EFFECT ON ADMINISTRATION

The State must communicate the changes in procedure to employees and retirees.

ACTION REQUIRED

The state must enter into an agreement with Aetna to provide these services, and pay service charges.

ASSOCIATED COSTS

To Be Determined

ESTIMATED NET EFFECT ON PLAN	FY89	FY90
PERCENTAGE SAVINGS:	TBD	TBD

NOTES:

RECOMMENDED ACTION

1.05 HIGH RISK PREGNANCY MANAGEMENT

SCOPE

This program is currently under development and is designed to lower the incidence of low birth weight (LBW) infants born to female employees and dependents. (Attachment D)

EFFECT ON PARTICIPANTS

All female employees and dependents are encouraged to call the Aetna HEALTHLINE nurse.

EFFECT ON PLAN

Care is managed on a prospective basis emphasizing the need for early prenatal care, compliance with the provider instructions, awareness of risk factors and behavioral changes.

EFFECT ON ADMINISTRATION

The State must communicate the changes in procedures to employees.

ACTION REQUIRED

The State must enter into an agreement with Aetna to provide these services and pay service charges.

ASSOCIATED COSTS

To Be Determined

ESTIMATED NET EFFECT ON PLAN	FY89	FY90
PERCENTAGE SAVINGS:	TBD	TBD

NOTES:

RECOMMENDED ACTION

1.06 ON-SITE CONCURRENT REVIEW

SCOPE

The On-Site Concurrent Review program is designed to assure that medically necessary care is being provided in an efficient manner. A registered nurse visits hospitalized patients daily and reviews the patients hospital charts.
(Attachment E)

EFFECT ON PARTICIPANTS

Patients have daily interface with the nurse.

EFFECT ON PLAN

Daily telephone contact between the review nurse and an Aetna Area Medical Director enables the review nurse to negotiate for alternative care, identify ICM necessity early on, interacts with social services and discharge planning departments, to insure maximum benefit of these services.

EFFECT ON ADMINISTRATION

The State must communicate the changes of procedure to employees and retirees.

ACTION REQUIRED

The State must enter into an agreement with Aetna in order for Aetna to provide these services.

ASSOCIATED COSTS

$130,000 - $150,000 per site

ESTIMATED NET EFFECT ON PLAN	FY89	FY90
DOLLAR SAVINGS:	$260,000 - 450,000 per site	$260,000 - 450,000 per site

NOTES:

RECOMMENDED ACTION

1.07 R & C PROFILES

SCOPE

Reasonable & Customary (R & C) Profiles represent the prevailing charge made by Health Care providers of similar expertise for a similar procedure in a particular geographic area. These are currently set every six months for the State. Aetna states they are paying 85% of R & C.

EFFECT ON PARTICIPANTS

If the provider charges more than the R & C Profile, the employee will have to pay the excess amount.

EFFECT ON PLAN

Health Care expenses will usually be within the prevailing R & C Profiles for the geographic area. By using an alternative to the current month of date, the plan could save some inflationary increases.

EFFECT ON ADMINISTRATION

The State may communicate the changes in procedure to employees and retirees.

ACTION REQUIRED

The State must enter into an agreement with Aetna and pay the associated costs.

ASSOCIATED COSTS

If R & C Profiles are determined on an annual basis: $50,300 - $68,000.
If R & C Profiles revised to the Seattle area (+25%): $100,000

ESTIMATED NET EFFECT ON PLAN	FY89	FY90
SAVINGS		
• Annualized R & C		
per employee per month	$3.57	$3.57
annualized	$540,000	$540,000
• Revised Seattle		
per employee per month	$3.14	$3.14
annualized	$475,000	$475,000

NOTES:

RECOMMENDED ACTION

1.08 WELLNESS PROGRAMS

SCOPE

Wellness Programs are comprised of topics designed to promote safety and good health among employees. Many include physical fitness programs.
(Attachment F)

EFFECT ON PARTICIPANTS

To increase worker morale and productivity and lower absenteeism.

EFFECT ON PLAN

This program is a long-term investment in the employees of the State of Alaska which will in the long run reduce the cost of: accidents, ill health (absenteeism), lower productivity, and health care.

EFFECT ON ADMINISTRATION

The State needs to regularly communicate the program to its employees and retirees.

ACTION REQUIRED

Aetna has a Wellness Program available called the Wellness Video Tape Library, where appropriate topics are addressed. The State must enter into a contract with Aetna and pay the associated charges.

ASSOCIATED COSTS

To Be Determined

ESTIMATED NET EFFECT ON PLAN	FY89	FY90
LONG TERM SAVINGS:	Minimum of 2 1/2 years before savings are realized.	

NOTES:

RECOMMENDED ACTION

1.09 MAIL ORDER DRUG PROGRAM

SCOPE

The Mail Order Drug Program offers a cost saving, convenient service for obtaining prescription drugs through the mail. Drugs are dispensed up to a 90 day supply instead of a 30 day supply. This program is ideal for patients receiving maintenance treatment, which account for up to 70% of all prescription drug costs. Additional savings may be realized by substituting generic drugs for brand name drugs.
(Attachment G)

EFFECT ON PARTICIPANTS

The plan participants must submit a patient profile form and mail in their prescriptions. The patient profile is maintained on computer to protect against adverse interaction with other drugs. Medications are mailed within two business days of receipt.

EFFECT ON PLAN

The plan can be added without altering the present medical plan, and can be integrated with other health benefits provisions (including deductibles and coinsurance maximums). Coordination of benefits can be administered as well.

EFFECT ON ADMINISTRATION

The State needs to communicate the program to the actives and retirees as benefit enhancements and encourage participation in order to maximize savings.

ACTION REQUIRED

The State must complete the mail order drug program application, enter into an agreement with Aetna and pay the appropriate charges.

ASSOCIATED COSTS

To Be Determined

ESTIMATED NET EFFECT ON PLAN	FY89	FY90
PERCENTAGE SAVINGS:	up to 1%	up to 1%

NOTES:

RECOMMENDED ACTION

PRESCRIPTION DRUG TREND

Over the past few years, the trend experience on prescription drugs has exceeded the overall medical trend average. In part, this stems from earlier hospital discharges and the corresponding transfer of post treatment pharmaceuticals from an inpatient (Hospital Ancillary) basis to an outpatient (Prescription Drugs) classification. It is also due in part to new life-saving drugs with excessive price tags.

Contributing to this development are orphan drugs. Orphan drugs get their name from the Orphan Drug Act which was signed into law in 1983. The purpose of the Act was to encourage drug companies to develop treatments for rare diseases by rewarding such companies with a seven year monopoly on the sale of the drug. Because of the monopoly, drug companies can charge virtually any amount they want. Examples of orphan drugs include Pentam (an inhalant version of pentamidine used to prevent a pneumocystic pneumonia infections in AIDS victims–cost $100 per vial) and Human Growth Hormone (used to prevent dwarfism in children–cost $8,000 - $30,000 per year).

Because of the highly complex technology or biotechnology associated with their development, many other new drugs enjoy a monopoly type status. This status is often furthered by competitors who remove their less advantageous drugs from the market for fear of being sued for marketing an unsafe product. Given that many of these drugs deal with life-threatening situations, the consumer is often faced with the choice of pay or die. Examples of such drugs include Factor VIII (speeds blood clotting in hemophiliacs without the risk of AIDS, hepatitis, or other diseases that are present with other treatments–cost $25,000 per year), TPA (dissolves blood clots in the treatment of heart attacks–cost $2,200 per treatment), AZT (treatment of AIDS–cost $8,000 per year), and Cyclosporine (suppresses the rejection of new organs in organ transplants–cost $5,000 - $7,000 per year). Provided by Aetna Insurance Company.

1.10 SUPPLEMENTAL BENEFIT SYSTEM REVIEW

SCOPE

The Supplemental Benefit System (SBS) is available to all eligible active employees of the State of Alaska, where the employee can choose coverage and pay premiums out of The Alaska Social Security Fund. SBS covers the deductible, and Wellness or Preventative Care Programs. Open enrollment occurs in October for the plan year effective the following February.

EFFECT ON PARTICIPANTS

Participants generally perceive the SBS benefits as first dollar coverage. Typically this provides no real incentive for the participant to control the cost of their own health care. This in turn drives up the cost of the plan.

EFFECT ON PLAN

Prior to January 1, 1989 SBS experience was combined with all other plan experience, so that it was impossible to determine what effect the SBS had on the total cost of the plan. It is possible that the SBS may be driving utilization higher on the base plan due to the perceived first dollar coverage discussed above.

EFFECT ON ADMINISTRATION

As of January 1, 1989, the coding of claim data has changed to separate SBS experience from the rest of the plan.

Without separate experience to calculate the premium rates, the premium was an estimated guess. With the changes in coding, SBS experience can be tracked to help identify trends and patterns in utilization, and accurate premium rates can be determined.

ACTION REQUIRED

The State needs to look at experience on an ongoing basis to gain an understanding of the effect of SBS on the true cost of the plan and how it is effecting the base plan.

ASSOCIATED COSTS

To Be Determined

NOTES:

RECOMMENDED ACTION

1.11 ELIGIBILITY/ENROLLMENT VERIFICATION

SCOPE

The active and retired employees of the State need to meet the eligibility requirements (conditions that the employee must satisfy) of the State's Health Insurance Plan in order to participate in the plan and obtain plan benefits. All pertinent data is maintained on magnetic tape by the state via the payroll system and is transferred to Aetna, where Aetna pays claims directly from that information.

AREAS OF CONCERN

At the present time there are several areas of concern to the consultant:

- **Accuracy of the eligibility data.** Is Aetna paying claims on persons who are no longer eligible for coverage, persons who have never been eligible for coverage, or in duplicate (paying claims twice)? Are employees who are eligible for COBRA and who choose COBRA transferred from active status to COBRA continuation status and is this communicated to Aetna, all on timely basis.

- **Timeliness of Data Transfer.** Even under the best scenario (accurate eligibility data for the current month), the timeliness of the data transfer from the State of Alaska is of utmost importance. Untimely transfer of data combined with inaccurate data compounds the accuracy of the eligibility data further.

EFFECT OF INACCURACIES ON THE PLAN

It is more likely that the State is paying claims on ineligible persons and in duplicate. The amount overpaid is difficult to determine without further investigation.

EFFECT ON ADMINISTRATION

Initially, there would be more work for the State to develop a system. However, the results should show substantial savings.

ACTION REQUIRED

We recommend that the State take immediate action to examine these issues, and subsequently initiate a new enrollment process in order to generate current, accurate and verifiable data.

ASSOCIATED COSTS

To Be Determined

NOTES:

RECOMMENDED ACTION

1.12 MANAGEMENT REPORTS/PARTICIPANT DEMOGRAPHICS

SCOPE

Management Reports provide the necessary information for the effective management of the health care program. Effective reports help to identify trends and patterns in charges and utilization; pinpoint specific sources of expense; design plan changes; and monitor the results of plan changes.
(Attachment H)

CURRENT REPORTING

Currently, the State receives a minor recap of claim data which is provided by Aetna's Experience Monitoring Reports (which are available in many combinations). Experience Monitoring Reports includes three report types: Basic Year-To-Date (premium and claim tracking data); Monthly summary (rolling 12 month basis); and Statistical Data Report (an overview of current year experience, claim activity, and prior year run off).
(Attachment H1)

ADDITIONAL AETNA REPORTING AVAILABLE

Aeccess II (Computerized Claim Extract System)

This system provides a look at inpatient utilization, the most expensive type of care, including hospital charges, physician and other inpatient expenses.
(Attachment H2)

Aeccessor

This is a PC based data reporting and analysis system, offering pre-programmed basic and menu reports, and custom reports as well.

EFFECT ON PLAN MANAGEMENT

Administration

Administration would be responsible for utilizing management reporting to effectively manage the health care program.

Plan

By monitoring plan experience and identifying trends and patterns, management can make informed decisions regarding changes in the plan design to contain costs and monitor the results of those changes.

One result of a change in plan design is cost shifting. As the plan design change contains cost in one area, the cost differential is shifted to another area. A good example of cost shifting internal to the plan is inpatient hospitalization to outpatient surgery. An example external to the plan occurs when public programs cut down reimbursement levels and hospitals shift costs to private payors.

Participant

One result of the analysis of management reports might shift some of the costs from the employer to the employee by changing the deductible and/or coinsurance level (cost sharing).

RECOMMENDATIONS

We recommend that the State obtain the most comprehensive reporting available, and be reviewed by the State and the consultant (Arthur J. Gallagher).

The State should implement a system to track participant demographics and relate it to claim and eligibility data.

ACTION REQUIRED

The State must sign an agreement with Aetna to receive the necessary reports.

ASSOCIATED COSTS

Will be determined based on reports chosen.

ESTIMATED NET EFFECT ON THE PLAN

This will be determined once reports are selected and analyzed.

NOTES:

RECOMMENDED ACTION

2.00 FINANCIAL REVIEW

We have reviewed the financial information on the State plan and have found several areas that need further consideration. These are outlined in sections 2.01 - 2.04.

Regarding the administration charges listed by Aetna, we did not attempt to value them as they are contractually agreed upon and do not come up for review until the end of the calendar year 1989.

It is important to note that the administration charges are broken into two parts.

1) Retention charges are made up of the following:

   Administrative, Claim Settlement, Risk and Profit Charges;
   Premium Taxes;
   Non-Recurring Charges;
   Less Interest Credits;
   Less Premium Tax Credit;

2) Direct Charges are made up of the following:

   Printing Charges;
   Watts Line Charges;
   Management Reports;
   Tape Charges;
   Consulting Charges;
   COBRA, Direct Billing;
   Miscellaneous.

The total of these two were $5,363,319 or 7.42% during the 1987 policy year. These charges as a percent of premium appear to be in line with the current market place, especially when you consider Aetna is processing roughly twice as many claims per insured for the State of Alaska versus other Alaska plans. Employee education would lower the volume by suggesting employees batch bills and submit them on one claim form. The State is charged on a sliding scale per explanation of benefits (E.O.B.) regardless how many bills are attached.

The areas that did concern us, were premium tax credits (section 2.01) and the that State bills back through the plan consulting fees worth $161,424 for the 1987 plan year. If this is an expense, it should be paid separately, and not added to the total cost of the plan.

In addition, it is confusing that the financials are calculated on a July 1st - June 30th basis; and the premium changed on February 1, 1989.

STATE OF ALASKA
EXPERIENCE SUMMARY
AETNA

POLICY PERIOD
JULY 1, 1987 - JUNE 30, 1988

GROUP	CREDITED PREMIUM	PAID CLAIMS	INCURRED CLAIMS	RETENTION*	1987 POLICY YEAR BALANCE	CUMULATIVE BALANCE	CLAIM RESERVES AS OF JULY 1988
ACTIVE	47,044,042	46,253,424	47,386,626	3,415,729	(3,758,313)	(5,876,190)	10,843,653
RETIRED	16,849,557	18,400,148	19,881,727	1,311,701	(4,343,871)	5,558,415	5,316,885
TOTAL	63,893,599	64,653,572	67,268,353	4,727,430	(8,102,184)	(317,775)	16,160,538

*Interest credits of $1,466,940 and taxes of $1,610,974 are included in the retention figures.

POLICY PERIOD
JULY 1, 1986 - JUNE 30, 1987

GROUP	CREDITED PREMIUM	PAID CLAIMS	INCURRED CLAIMS	RETENTION*	1986 POLICY YEAR BALANCE	CUMULATIVE BALANCE	CLAIM RESERVES AS OF JULY 1987
ACTIVE	39,484,110	43,359,389	44,123,343	1,526,215	(6,165,448)	(2,117,877)	9,710,451
RETIRED	15,500,815	12,322,670	12,621,468	568,806	2,310,541	9,902,286	3,835,306
TOTAL	54,984,925	55,682,059	56,744,811	2,095,021	(3,854,907)	7,784,409	13,545,757

*Interest credits of $2,108,878 and taxes of $31,725 are included in the retention figures.

STATE OF ALASKA
AETNA
1987 Retention Charge

Paid Claims	$ 72,314,057
Incurred Processed Claims Transactions	556,158
Average Lives	21,833
Processed Claim Transactions per Employee/Retiree per month	$ 2.12
Claims Cost per Member/Retiree per month	$ 276.01

Retention	Dollars	Paid Claims
Ongoing Administrative, Claim Settlement, Risk & Profit Charges	$4,849,698 *	6.71%
Cash Fund Accounting Interest Credits	-1,656,235	-2.29%
Sub Total (1)	$3,193,463	4.42%
Non-Recurring Items:		
Revisionary Admin. Charges	6,900	
Direct Charges	340,234	
Premium Taxes	1,822,722	
Premium Tax Refund	0	
Sub Total (2)	$2,169,856	3.00%
Net Retention (1+2)	$5,363,319	7.42%

	No. PCT's		Matrix Multiplier		
*	556,158	x	$8.72	=	$4,849,698

STATE OF ALASKA

AETNA

1987 Policy Year Direct Charges

I.	Printing Charges	$19,407
II.	Watts Line Charges	

Month	Total
July, 1987	$ 5,201
August	15,283
September	6,423
October	6,022
November	6,685
December	5,375
January, 1988	5,351
February	4,926
March	324
April	5,000
May	0
June	$ 4,956

		$65,546
III.	PRO Charges	$47,434
IV.	Experience Monitoring Reports	$ 1,248
V.	Custom Access Reports	$19,888
VI.	Delegate Tape	$ 6,000
VII.	Consulting Fees	$161,474
VIII.	Special I.D. Cards	$ 3,520
IX.	COBRA Direct Billing	$15,606
X.	Custom requested Eligibility Information	$ 111
	TOTAL DIRECT CHARGES	$340,234

State of Alaska

AETNA

Interest and Rate History

Interest Received All Groups

July 1, 1987 to June 30, 1988 $ 1,656,235
The interest rate applied to the positive cash balance is 7.5%.

July 1, 1986 to June 30, 1987 $ 2,350,177
The interest rate applied to the positive cash balance is 9.0%.

The interest rate applicable for the 1988 policy year will be between the range of 7.5% to 8.5%.

Rates

Rates effective February 1, 1989

Active Medical

$431.72 per eligible General Government employee, PSEA employee, IBU employee, and those employees not covered by a collective bargaining agreement;

$448.78 per eligible Supervisor or Confidential employee, and Masters, Mates and Pilots employee;

$484.97 per eligible MEBA employee;

$442.84 per eligible Local 71 employee;

$12.13 per participating employee of Option 1; and

$32.99 per participating employee and family for Option 1

Retiree Medical

$252.83 per eligible benefit recipient for health care coverage

Rates

Effective Date	Active Medical	Retiree Medical
February 1, 1989	+5.0%	+19.7%
July 1, 1988	+33.3%	+50.6%
November 1, 1987	-1.0%	-15.0%
July 1, 1987	+27.0%	Pass

(S1)

STATE OF ALASKA
(ALL PLANS COMBINED)

AETNA GROSS RETENTION COST AS A CHARGE PER PROCESSED CLAIM TRANSACTION

RETENTION GUARANTEE FOR NOVEMBER 1, 1987 - JUNE 30, 1988
MEDICAL, DENTAL, VISION, AUDIO AND SUPPLEMENTAL HEALTH

11/1/87 - 6/30/88 PAID CLAIMS COST PER EMPLOYEE/RETIREE PER MONTH	PROCESSED CLAIM TRANSACTIONS PER EMPLOYEE/RETIREE PER MONTH FOR 11/1/87 - 6/30/88						
	0 - 1.64	1.65-1.69	1.70-1.74	1.75-1.79	1.80-1.84	1.85-1.89	1.90 & UP
$ 0.00 - $249.99	$9.02	$8.95	$8.88	$8.80	$8.74	$8.67	$8.60
$250.00 - $259.99	$9.06	$8.99	$8.92	$8.84	$8.78	$8.71	$8.64
$260.00 - $269.99	$9.10	$9.03	$8.96	$8.88	$8.82	$8.75	$8.68
$270.00 - $279.99	$9.14	$9.07	$9.00	$8.93	$8.86	$8.79	$8.72
$280.00 - $289.99	$9.18	$9.11	$9.04	$8.97	$8.90	$8.83	$8.76
$290.00 - $299.99	$9.22	$9.15	$9.08	$9.01	$8.94	$8.87	$8.80
$300.00 AND UP	$9.26	$9.19	$9.12	$9.05	$8.98	$8.91	$8.84

NOTE: These retention charges exclude interest credits, premium taxes, and direct expense items (i.e., printing, toll-free telephone lines, and premium tax for Political Subdivisions). These factors will be incorporated at final accounting.

2.01 PREMIUM TAXES

Currently, required by State Law (AS 39.30), Aetna charges a premium tax based upon the total premium collected, applies for a tax refund at the end of the year, and then credits the retention charge.

During our review, it was discovered that Aetna had collected the 1987 calendar year refund, but it had not been credited. The 1988 refund has not been applied for as of yet (estimated 1987 credit $1,650,000, estimated 1988 credit $1,750,000, for a total of $3,400,000).

It is recommended that Aetna reduce the premiums due during remaining year 1989 by the amount of the 1987 & 1988 tax credit.

2.01A AS 39.30

This law should be amended to exempt the State from paying this premium tax. It would simplify the administration and retain the money in Alaska.

2.02 RESERVES

Per the agreement between the State and Aetna, Aetna is required to establish reserves for incurred but unreported claims. This also allows Aetna to pay claims after termination of a contract.

A reserve development spread sheet is attached for your review. We feel that the reserves established by Aetna are slightly overstated (Aetna agrees the reserve levels are "conservative"). The fact that the plan may be slightly over reserved does not present a problem because the State earns interest credits on the money and it keeps the plan in a healthy position.

One consideration is to have the State hold the reserves in a separate account. This would keep the money in the State, and if the State's investment performance is better than Aetna's, this would result in an immediate credit.

The reserves as of June 30, 1989 (Excluding Extended Liability)	= $14,317,095
Aetna's estimated required reserves	= $12,761,685
Estimated over reserve	= $ 1,555,410 (+11%)

STATE OF ALASKA

ERG - 392675
AETNA
Reserve Development

ERG		(A) Runoff 7/88 - 9/88	+	(B) Runoff 7/87 - 9/87	x	(C) Runoff 7/87 - 7/88	=	(D) Reserve	Actual Runoff 7/1/88 - 3/1/89
A	Actives								
	Comp. Medical	4,900,657		4,362,820		5,956,475		6,690,774	6,492,100
	Extended Liability							2,178,045 ✓	
	Maternity							857,139	
	Comp. Dental	698,872		727,610		881,740		846,914	827,702
	Vision	218,196		223,679		277,585		270,781	268,508
B	Supplemental Benefits Systems								
	Comp. Medical	54,911		38,739		47,211		66,920	77,182
	Extended Liability							16,413 ✓	
	Maternity							12,750	
C	PoliticalSubdivision								
	Comp. Medical	651,714		544,969		726,162		868,398	793,861
	Extended Liability							249,999 ✓	
	Maternity							122,634	
	Comp. Dental	112,564		81,037		102,849		142,862	129,984
	Vision	29,062		27,498		37,360		39,485	36,594
D	Retiree Medical								
	Comp. Medical	2,563,098		1,903,897		3,065,888		4,127,414	3,772,585
	Extended Liability							1,162,282 ✓	
	Maternity							27,189	
E	Retiree D/V/A								
	Comp. Dental	182,300		117,518		156,875		243,353	228,014
	Vision	64,676		38,617		53,847		90,183 ✓	87,178
F	Polysubs Option II								
	Comp. Medical	2,847		0		471		0	2,977
	Extended Liability							802 ✓	
	Maternity							482	

2.03 EXTENDED LIABILITY

As a part of Aetna's standard operating procedure, a separate reserve is established for "extended liability". Extended liability is for claims incurred by an individual on disability at the time of contract termination (Aetna's). Most plans eliminate the extended liability reserve. If they change from one carrier to another, the new carrier usually accepts the liability.

If a plan is self funded, extended liability is calculated as part of the regular reserve.

Currently, Aetna holds $3,697,724 for extended liability. By issuing a contract change, this money could be released to the State and reduce premiums for the fiscal year 1989 by this amount.

2.04 CLAIM FLUCTUATION MARGIN - PREMIUM STABILIZATION ACCOUNT

In all insured medical plans, the carrier provides for the ability to recover deficits and usually has a vehicle to pay dividends to policyholders in lower utilization years.

Aetna's procedure is to establish a claim fluctuation margin as a part of the premium calculation (1989 = 3%). The margin is used to cover unexpected claim activity. If there is a surplus or deficit on the plan at the end of a plan year, it is posted on a cumulative basis to the premium stabilization account (P.S.A.).

The premium stabilization account balance as of July 1, 1988 = $279,636.

Aetna's Maximum P.S.A = $706,000.

In previous years the P.S.A. had a substantial positive balance. The State has never requested this credit, instead it lets the monies grow with interest, and uses it to reduce future premium increases.

STATE OF ALASKA

ACTIVE EMPLOYEE EXPERIENCE

Policy Year	Paid Premium	Incurred Claims	Retention	Policy Year Surplus (Deficit)	Cumulative Balance
7/82 - 7/83	27,729,375	25,312,455	1,586,818	830,102	830,102
7/83 - 7/84	27,857,503	23,619,520	684,501	3,553,482	4,383,584
7/84 - 7/85	34,763,000	32,223,711	770,849	1,768,440	6,152,024
7/85 - 7/86	36,756,000	38,378,681	871,457	(2,494,138)	3,657,886
7/86 - 7/87	39,484,110	44,113,812	1,526,215	(6,155,917)	(2,498,031)
* 7/87 - 7/88	47,004,042	47,386,626	2,210,804	(2,593,388)	(5,091,419)

RETIRED EMPLOYEE EXPERIENCE

Policy Year	Paid Premium	Incurred Claims	Retention	Policy Year Surplus (Deficit)	Cumulative Balance
7/82 - 7/83	6,440,213	8,146,246	377,676	(2,083,709)	(2,083,709)
7/83 - 7/84	10,274,521	7,275,641	258,989	2,739,891	656,182
7/84 - 7/85	13,848,779	9,456,773	254,484	4,137,522	4,793,704
7/85 - 7/86	14,011,340	11,092,724	353,460	2,565,156	7,358,860
7/86 - 7/87	15,500,815	12,621,468	568,806	2,310,541	9,669,401
* 7/87 - 7/88	17,296,636	19,881,727	869,340	(3,454,431)	6,214,970

* Estimated figures for the 1987 policy year.

3.01 PREMIUM DELAY

Premium Delay is basically a fully insured plan where the plan sponsor pays the premium thirty (30), sixty (60,) or even ninety (90) days after the original due date. This program is a pure cash flow mechanism. However, it must be understood, if the State changes carriers, the premium deferred would have to be paid up, usually shortly after cancellation.

Also, the carrier charges interest on the amount of premium on delay. The next page is one example of the cash flow advantage and associated charges.

An estimated net first year cash float of $13,360,114 could result from implementing premium delay.

STATE OF ALASKA

Premium Delay

Actives	60 Day Lag	90 Day Lag
Amount Deferred	5,485,724	10,971,448
Total Charge	658,287	1,316,574

Retirees		
Amount Deferred	2,105,250	4,210,500
Total Charge	252,630	505,260

Annualized Interest Rate - 12%

3.02 MINIMUM PREMIUM/SFG FUNDED - NON-FUNDED

One step closer to self funding employee benefits would be minimum premium (split funded).

Minimum premium is a vehicle by which the State would pay the fixed costs of the plan on a monthly basis and claims as they are presented to the bank. This affords the State the ability to hold the reserves, pay claims as they are presented, while the maximum cost of the plan would not exceed the fully insured premium level.

This is a popular way for plan sponsors to receive cash flow, retain reserves, earnings, usually lower costs and not increase overall liability or impair the "insured perception" to employees.

Minimum premium plan design prevents the State from paying two whole premiums on dual covered individuals.

An illustration of the fixed costs associated with minimum premium plans, is included in 3.03.

3.03 SELF FUNDING A.S.O - A.S.C

The State could consider a self funded plan (A.S.O./A.S.C.) whereby the State hires a claims administrator (could be an insurance company or a T.P.A.) and funds the claims as they are presented. Also, most plans purchase aggregate reinsurance to limit their total exposure not to exceed 125% of the insured premium.

In good years, the State would retain the surplus and reserves. In a bad year, they could pay up to 25% more than an insured or minimum premium plan would cost.

Most plans of this size are self funded in some fashion. The State should consider this as a future option.

However, the bargaining units may express concern if the plan is self funded, that is to say there is no insurance company fronting the risk as in insured or minimum premium plans.

1987 Retention Charges

Comparison of Funding Arrangements

Credited Premium	$ 63,893,599
Paid Claim	$ 64,653,472
Average Lives	19,733

Retention	Conventionally Insured	SFGP Funded	SFGP Unfunded	ASC
Ongoing Administrative, Claim Settlement, Risk and Profit Charges	$ 4,187,517	$ 4,187,517	$ 4,187,517	$ 3,924,185
Cash Fund Accounting Interest Credits	$ (1,466,940)	$ (1,466,940)	$ (451,000)*	$ (584,000)*
Banking and Admin. Charges	$ 0	$ 101,000	$ 230,284	$ 101,000
Sub Total	$ 2,720,577	$ 2,821,577	$ 3,966,801	$ 3,441,185
Direct Charges	$ 395,879	$ 395,879	$ 395,879	$ 395,879
Total Retention	$ 3,116,456	$ 3,217,456	$ 4,362,680	$ 3,837,064

Taxes have been excluded due to the Tax exemption status for the State of Alaska.

* Interest earned due to funds in the Premium Stabilization Reserve.

3.04 POOLING CONCEPT

Pooling is basically a self funded plan that has expanded to cover more than one entity. Examples are state, university and municipal employees.

Pooling of employee benefits and property and casualty insurance has become very popular with public entities in the last ten years.

Pooling of coverages is usually undertaken to improve cost effectiveness, provide coverage when they are not available or uncompetitive in the standard insurance markets, and to retain premium money in the state.

Our firm successfully established the JIA for the Alaska Municipal League last year. Although it originally drew criticism, a year later it looks to be a huge success. It has provided coverage that was previously unaffordable or very expensive at competitive rates and has kept $7,000,000 in the State that would have normally been sent to out of State insurance companies.

3.04A POOLING LEGISLATURE

In order to proceed with pooling, legislation has to be enacted to allow combining employee benefits plans. We recommend that the State take pooling under further consideration as a long range cost management technique.

3.05 AS 21.89.030 AMENDMENT

Alaska State Law requires that an insurance company use a negotiable bank check to settle a claim or pay a judgment. This means that Aetna issues checks on a funded account. Usually minimum premium or self funded plans issue drafts that are funded upon presentation. This change from checks to drafts would result in an additional ten day float on the money, resulting in a net interest credit of approximately $2,500,000 per year. There are some administrative and banking arrangements that need to be established to take advantage of this.

State Law AS 21.89.03 should be interpreted or modified to allow the State to use drafts for benefit payments.

Additional Issues

Alaska law (Section 21.89.030) requires that an insurance company use a negotiable bank check to settle a claim or pay a judgement. This is interpreted to mean that the check requirement pertains to claims or judgements against the insurance company. That is why we currently issue checks on this account. Benefit payments under split-funded or self-funded plans are made by drawing drafts, with the contractholder as payer, against a Connecticut National Bank (CNB) account in which all such contractholders participate. This is not an Ætna account. Therefore, we believe that Alaska law allows the use of drafts for these special arrangements. The State should concur with this interpretation.

In order to implement a split-funded or self-funded arrangement the State must execute a banking agreement enabling CNB to advance funds on their behalf and promising to reimburse CNB for such advances. (Ætna's normal procedures result in a one day delay.) The State should confirm that they are empowered with the right to enter into such a "loan" agreement.

Under the present check arrangement the State of Alaska does not participate in Ætna's bulk payment process. Under this process providers are paid bulk on a scheduled basis. On average the bulk payments are "aged" an additional ten days. If the State converts to a Split-Funded or Self-Funded arrangement and converts from checks to drafts, the State would be eligible for the bulk payment process recognize an additional cash flow advantage of ten days. Ths cash flow advantage represents approximately $2,586,139 in claims for the Active and Retirees. If checks are used, however, Ætna would need to establish a separate bank routing number, and build an interface print and maintain a separate supply of checks that would differentiate between the State of Alaska's checks and other policyholder's drafts, an additional cost to the State would be generated. These charges are approximately:

Start-up charges	$ 25,000
Operating (annual charge)	$ 50,000

4.00 RECOMMENDATIONS

Action

_____1.00 Cost Containment
_____1.01 Utilization Review - Healthline (Basic)
_____1.02 Outpatient Precertification
_____1.03 Managed Second Surgical Opinion
_____1.04 Managed Mental Health
_____1.05 High Risk Pregnancy Management
_____1.06 On Site Concurrent Review
_____1.07 R & C Profiles
_____1.08 Wellness Programs
_____1.09 Mail Order Prescription Drug Plan
_____1.10 Supplemental Benefit System
_____1.11 Eligibility/Enrollment Verification
_____1.12 Management Reports/Participant Demographics
_____2.00 Financial Review
_____2.01 Premium Taxes
_____2.01A Premium Tax Amendment
_____2.02 Reserves
_____2.03 Extended Liability
_____2.04 Claim Fluctuation Margin - Premium Stabilization Account

_____3.00 Alternate Funding
_____3.01 Premium Delay
_____3.02 Minimum Premium/Funded - Unfunded
_____3.03 Self Funding A.S.O. - ASC.
_____3.04 Pooling Concept
_____3.04A Pooling Legislation
_____3.05 AS 21.89.030 Amendment

5.00 FUTURE COST CONTAINMENT CONSIDERATIONS

_____ Preferred Provider Organizations: Medical and Dental
_____ Managed Care
_____ Prescription Drug Network
_____ Plan Design Alternatives
_____ Flexible Benefit Plans
_____ Education for Plan Participants
_____ Employee Assistance Plans
_____ Electronic Plan Processing

6.00 ESTIMATED FINANCIAL IMPACT OF TASK FORCE RECOMMENDATIONS FY 89, 90

FISCAL YEAR 1989 IMPACT

Effective Date	Project Premium Paid	$110,000,000
ASAP	Premium Tax Credit	(3,450,000)
7/1/89	Cost Containment	0
7/1/89	Interest Credit on Drafts	(225,000)
ASAP	Reserve Release	0
ASAP	Extended Liability Amendment	(3,697,724)
	Total	$ 7,372,724
	Net Effect	-6.7%

FISCAL YEAR 1990 IMPACT

Project Premiums Paid	$123,200,000
Premium Tax Credit or Amendment	(1,700,000)
Cost Containmment	(6,500,000)
Interest Credit on Drafts	(2,700,000)
Reserve Release Interest Credits	(1,360,000)
Extended Liability Amendment	0
Total	$ 12,260,000
Net Effect	-8.84%
Total Fiscal Years 1989 - 1990	**-$19,632,724**

Section 2 Objectives of The HEALTHLINE Program

The objectives of Ætna's HEALTHLINE Program are to aggressively promote cost-effective hospital utilization and informed health care consumer behavior through:

- Direct interaction with providers
- Consumer Counseling and advocacy

We recognize that most consumers do not have the knowledge and experience necessary to prudently purchase health care services. They are not familiar with the options available, the questions to ask their doctors, etc. We also recognize that the advice and assistance of independent experts can be most beneficial with helping consumers find their way through the complexities of the healthcare delivery system. Ætna's HEALTHLINE Program is designed to fill these important needs by combining counseling, pre-certification, second surgical opinion, continued stay review and discharge planning into one comprehensive program.

Resources in Support of the HEALTHLINE Program

Ætna's HEALTHLINE Program is fully integrated, system supported and administered by specially trained nurse and physician advisors.

- Specially trained HEALTHLINE Nurses and dedicated support staff in the Seattle, WA Claim Office.
- Home Office Management and Professional Staffs to manage the programs and assure consistency. This includes our staff of registered nurses, social workers and physicians to provide support as necessary.
- Home Office based Focused Psychiatric Review staff which includes a board certified psychiatrist, a licensed clinical psychologist and 25 masters level psychiatric clinicians (MSN's and MSW's) each of whom has extensive clinical experience in direct patient care.
- Personnel experienced in discharge planning and patient placement are available as Home Office resources.

Resources in Support of the Program (Continued)

- Professional protocols which address the need for admission, length of stay, candidates for ambulatory surgery, candidates for Individual Case Management, etc.

- Reference guides for nurses to assist with the application of protocols, second opinion referral, computerized notice of certification, etc.

- Network of 310 Nurses in Ætna Claim offices throughout the country to draw upon as a resource with knowledge of community programs, facilities, etc.

- Quality Assurance Program administered by medical professionals which ensures that Healthline components are consistently administered in accordance with established procedures and applicable plan provisions.

- Physician advisor network which includes board certified practitioners in all major specialties.

- Outside peer review organizations for impartial advice and on-site review of selected cases.

- Ætna's national directory of 15,000+ Board Certified Physicians for second surgical opinion referrals.

- The insurance industry's largest provider profile database profiling hospital costs for common causes of admission, (i.e., 50 most common admitting diagnoses by hospital, 50 most common surgical procedures resulting in admission by hospital.

- System support through Æcclaims (Ætna's Computerized Claim System).

- Computerized monitoring and reporting of activity and results through Æccess (Ætna's Computerized Claim Extract System).

Section 3 — Message to Employees

In order to receive maximum benefits, the employees of STATE OF ALASKA and their family members must notify the Ætna HEALTHLINE Nurse Consultant of each hospital admission. Compliance with this pre-notification requirement will assure full benefits, assuming the patient remains covered at the time of admission. Notifying the HEALTHLINE Nurse Consultant is required within the following time frames:

Non-Emergencies/Non-Urgent Admissions: Two weeks Prior to Admission

- Admission that is not an urgent or emergency admission.

Maternity Admission: Within 60 days prior to expected date of delivery.

Emergency Admissions: Within 48 Hours Following Admission

- Admission for a disease or injury severe enough to require immediate confinement.

Within two days after the patient notifies the HEALTHLINE Nurse, a system-generated "Notice of Certification" is automatically mailed to the patient's home, physician's office, and hospital. The confirmation will indicate the number of certified hospital days, as well as remind the patient of the need to recertify if an extended hospital stay is anticipated. Refer to Exhibit II to review a sample Notice of Certification.

Pre-certification will not be required for employees and/or their dependents if Medicare provides primary coverage.

The employees of STATE OF ALASKA, their family members, and attending physicians are advised to always contact the HEALTHLINE Nurse under the following conditions:

- Before all surgery
- Before ordering private duty nursing services
- Prior to a hospital discharge which involves transferring the patient to a convalescent facility or providing for home health care

This telephone call will trigger discussion of a second surgical opinion, assistance in identifying a qualified board certified specialist from Ætna's second surgical opinion consultant listing, and consideration of ambulatory care alternatives. The HEALTHLINE Nurse also has authority to waive a mandatory second opinion requirement when it is determined, based on established criteria, that surgery is clearly the treatment of choice.

Additionally, this telephone call will trigger discussion about the extent of coverage and the criteria applied for assessing the medical necessity for private duty nursing, convalescent facility and home health care.

Section 4 Workflow

Telephone System

STATE OF ALASKA employees and their family members will contact the Seattle, WA Ætna Claim Office via Toll-Free Telephone Service. The telephone service will be available for both customer relations inquiries which involve claim status or denial questions and HEALTHLINE calls which include pre-admission certification, second surgical opinion assistance, outpatient surgery, plan features and other healthcare related questions.

Review Recent Claim History

The HEALTHLINE Nurse will scan recent claim activity to identify significant recent events, (i.e., prior hospital admissions) and diagnostic-related information. If necessary, claim history screens can also be accessed.

Identify Type of Activity: Pre-Certification or Consumer Advice

Telephone calls will be classified into one of three categories: Pre-certification, Consumer Advice or Both. This will be done by interviewing the caller.

If Pre-Certification

- HEALTHLINE Nurse obtains information from the caller and enters it into Ætclaims Terminal: (See Section 5 for Focused Psychiatric Review)
- Proposed surgical operation (if any)
- Name, address, and phone number of attending physician
- Hospital name and address
- Scheduled admission date
- Number of inpatient days requested
- The Nurse Consultant will gather any missing medical information by telephoning the attending physician's office.

Section 4 Workflow

If Pre-Certification (Continued)

- HEALTHLINE Nurse applies severity of illness/intensity of service criteria to determine the necessity of inpatient admission. Hospital certification will be refused if the patient can be safely and adequately treated in an ambulatory surgical or other outpatient setting.

- If the hospital admission is necessary, the Nurse Consultant will add additional information into the Æclaims System to determine if:

  - The hospital or physician is a "red flag" provider.

  - A Preferred Provider Arrangement is in effect and if so, identify the applicable network and determine what services are eligible for preferred benefits.

  - The surgical procedure requires a second surgical opinion.

  - Weekend admission criteria and pre-admission testing edits must be applied.

- If the hospital admission is necessary, the HEALTHLINE Nurse certifies a specific number of hospital days. The emphasis is on certifying an appropriate length of stay based on the individual's medical situation and established utilization review criteria.

- If a second surgical opinion is required, the HEALTHLINE Nurse can provide the caller with the names of three board certified specialists whom they may seek for second surgical opinions.

- A system-generated Notice of Certification will be mailed within two days after the telephone call is received.

- Except for routine maternity admissions, the Nurse Consultant will diary all confinements for concurrent stay review and discharge planning.

If Pre-Certification (Continued)

Based on system editing of certain diagnoses and his/her own medical judgement, the Nurse Consultant identifies potential candidates for Individual Case Management.

- Potential denials of pre-certification or reductions in requested lengths of stay are referred to a Physician Advisor. The Physician Advisor will discuss this matter with the patient's attending physician and if necessary, bring in a board certified specialist for consultation. When the final certification period is decided, a Notice of Certification is issued with copies to the employee, physician, and hospital, and a diary date is established for follow up review.

- Attending physicians are encouraged to request certification for extended hospital stays by telephone using the HEALTHLINE Toll-Free Number. If approved, an amended "Notice of Certification" will be issued.

- The Æcclaims System will issue a daily list for continued stay review and discharge planning. In all cases, the Nurse Consultant will telephone the hospital and/or attending physician the day before the certification expires to determine if the patient is still confined. Additional follow up diaries will be established as necessary.

- When the hospital and surgical claims are submitted for payment, the Æcclaims System will automatically display the number of certified hospital days to ensure accurate claim payment.

If Consumer Advice

The HEALTHLINE Nurse is fully prepared to discuss various treatment philosophies, alternate delivery care sites and provide resources for additional health and medical information.

- Inform participants about less costly alternatives to hospitalization, such as ambulatory surgical facilities, home health care, hospices, and birthing centers.

- Encourage the use of other cost containment measures, such as pre-operative outpatient testing, second surgical opinions, and generic drugs.

- Identify candidates for Individual Case Management.

- Provide names of Board Certified Physicians and criteria for physician selection.

- Encourage participants to be more assertive in expressing and defining their health care needs. (Suggest questions callers can ask their physician.)

- Provide addresses and telephone numbers of local chapters of national organizations devoted to specific disease entities, e.g., American Cancer Society, American Diabetic Association, etc.

- Discuss "wellness"/general health issues.

- May steer participants to local suppliers of durable medical equipment, home health care agencies and hospice care which provide high quality care and discount offers, when appropriate.

- The nurse consultant will document the results of all telephone conversations:

    - Telephone calls will be diaried for 90 days. Estimated savings are assigned to each call based on the treatment alternative elected by the patient as a result of the HEALTHLINE advice. Additionally, Ætna will conduct random surveys to monitor consumer satisfaction with the program.

- A list of candidate likely for Individual Case Management will be maintained and the associate savings achieved will be documented.

Determining the Medical Necessity of the Admission

To determine if confinement in an acute care hospital is necessary, or if the proposed treatment could be performed in an alternate less costly setting, the Nurse Consultant reviews the diagnosis and justification for admission against the Severity of Illness/Intensity of Service (SI/IS) criteria.

The ISD-A Review System consists of utilization review and management criteria designed to screen hospital admissions, continued hospitalization, and services provided to patients for medical necessity and appropriateness of level of care. The ISD criteria address the question of medical necessity in terms of the severity of the patient's condition, the intensity of treatment the patient is receiving, the indications that discharge can be safely accomplished. These criteria were developed by Interqual, Inc., a provider consultant organization. They were subsequently tested for validity and reliability at Boston University Medical Center and adopted for the Appropriateness Evaluation Protocol (AEP) criteria used to evaluate acute care for federally funded patients.

Severity of Illness/Intensity of Service-Discharge (SI/IS-D) Criteria

The criteria consist of the following three components:

- Severity of Illness (SI) Criteria - SI criteria are a list of major physiological conditions and signs of acute illness which are sufficiently severe to justify the patient being admitted to an acute care hospital.

- Intensity of Service (IS) Criteria - IS criteria are diagnostic and therapeutic services which generally are available only in an acute care hospital setting.

There are both generic and thirteen body system sets of SI/IS criteria that are diagnoses independent. The two questions answered by the use of these criteria are:

  - Why is the patient hospitalized?

  - What diagnostic and/or therapeutic services will be rendered?

- Discharge Screening Criteria - Discharge screens which are specific indications of patient stability are included with each criteria set. When these screens are met, a patient generally no longer belongs in the hospital.

If surgery is to be performed, the system will edit the procedure code to determine if the procedure is on Ætna's ambulatory surgery list. If so, the nurse consultant will determine if there are any medical reasons why the surgery could not be performed in an outpatient setting.

In general, a hospital admission is considered appropriate and is certified as medically necessary if at least one SI or IS criterion is met and the procedure cannot be safely performed in an outpatient setting. If neither an SI or IS criterion is met and the procedure can be performed in an outpatient setting, a

recommendation for denial of certification is made. Physician review is then required. However, the HEALTHLINE Nurse may override the criteria, but must provide documentation of conclusions, if either of the following occur:

- No objective criteria have been met, but other clinical factors or a combination of marginal findings make the admission necessary or,

- One or more objective criteria have been met, yet the appropriateness of the admission is not justified.

Preoperative Day Guidelines

Generally, preoperative days are not considered medically necessary and should not be certified. This includes pre-op days requested solely due to the patient's distance from the hospital or due to hospital policy. However, a preoperative day may be certified when specific medical criteria are met.

Ambulatory Surgery Guidelines

Generally, an inpatient hospital confinement is not medically necessary and should not be certified for any procedure on the ambulatory/outpatient surgery list or the office surgery list. However, an admission for postoperative overnight care for a procedure on the ambulatory surgery list may be certified based on specific medical criteria.

Assigning a Length of Stay

If it is determined that confinement is necessary, the following is then assessed:

- Can the required testing be performed prior to admission if scheduled on an inpatient basis, and does the explanation clearly indicate the medical necessity for an inpatient workup?

- If the admission is scheduled for Friday or Saturday, does the explanation clearly indicate medical necessity? (i.e., Are the proposed services available over the weekend?)

- If a surgical admission is not scheduled for early in the morning on the day of surgery, does the explanation clearly indicate the medical necessity for the pre-operative stay?

Days are not certified for the preceding situations unless medical necessity is clearly documented. For DRG cases, the Healthline Nurse addresses the medical necessity for the hospital stay but does not assign a length of stay.

Length of Stay (LOS) norms are used as a guideline in the review process. They are derived from actual hospital stays of patients treated for specific conditions. Characteristics such as patient age, single or multiple diagnoses, and surgical intervention are factored in to establish the LOS. Norms used are taken from the Professional Activity Study (PAS) prepared by the Commission on

Professional and Hospital Activities (CPHA). The PAS data library contains information on approximately 250 million hospitalizations and increases at the rate of about 10 million cases annually.

When the nurse consultant determines that an admission is medically necessary, the Western PAS LOS at the 50th percentile for the admitting diagnosis is used as the guideline in assigning a length of stay.

If a patient is not quite meeting criteria, but it is clear to the nurse that the patient will require inpatient care, the nurse should certify the day without physician review. The nurse should do this only in cases where (s)he can clearly document the medical rationale for certifying, and (s)he feels that this rationale would be upheld if audited. If the nurse is not totally comfortable with a decision to certify, the case should be referred for physician review.

Physician Review - Physician review is required if:

1. Any applicable discharge screens are met and discharge is not scheduled for that day; or

2. Any applicable discharge screens are not met, any applicable IS criteria are also not met, and discharge is not scheduled for that day.

Disagreements

Disagreements will occasionally arise between the Ætna Nurse Consultant and the attending physician about the need for a hospital admission or length of stay. In such cases, the nurse will immediately refer the case by telephone to a Physician Advisor who will determine whether (s)he is qualified to render an opinion or whether the case is of a complex nature requiring an opinion from a specialist. If the physician advisor determines that (s)he has the necessary expertise to give a professional opinion, (s)he will discuss the case with the attending physician. Based on the results of this discussion, the physician advisor will certify a specified number of days and verbally communicate this information to the attending physician at that time. The physician advisor will then contact the referring nurse consultant who will document the file and process a system generated Notice of Certification.

If the case cannot be resolved between the attending physician and the physician advisor, and the attending physician requests a review at a higher level, the physician advisor will refer the case to a second level review by a specialist who will further discuss the case directly with the attending physician.

If there is still disagreement, the physician specialist will refer the case to the Ætna Home Office Regional Medical Director for review and direct discussion with the attending physician. Based on the results of the discussion, the Home Office Regional Medical Director will certify a specified number of days and verbally communicate this information to the attending physician at that time. The Home Office Regional Medical Director will also contact the referring nurse consultant who will document the file and process a system generated Notice of Certification.

Requests for Reconsideration

All Notices of Certification contain detailed instructions to provide the employee an opportunity for review of our precertification determination. All requests for reconsideration involving a question of medical necessity are reviewed at the physician level.

Section 5: Focused Psychiatric Review

OBJECTIVES

In response to the concern expressed by employers regarding the utilization and cost increases in this area, Ætna has developed a Focused Psychiatric Review Program (FPR).

The primary objective of the program is to assure that employer benefit dollars purchase only necessary, appropriate and cost effective high-quality inpatient psychiatric care.

Psychiatric disorders, and services to treat them, are considerably more varied than other areas of medicine. Diagnosis is not an adequate predictor of the need for inpatient services. Stabilizing an episode of an extremely serious mental illness in one patient may occur very rapidly and lead to a quick and successful discharge. A much less profound mental illness diagnosis may be complicated by symptoms (such as persistent suicidal thinking) and require much more extended inpatient care.

The unique case by case nature of psychiatric disorders and their complications has defied specific categorization or easily understood criteria. The problem of psychiatric care presents an on-going challenge to cost containment techniques and strategies.

Ætna's FPR Program addresses this problem by using a collaborative clinical consulting approach.

Focused Psychiatric Review involves a person to person review process between a Psychiatric Review Specialist (PRS) and the treating practitioner that begins prior to a non-emergency admission or within 48 hours of an emergency confinement. The review focuses on the specific problems that require inpatient care and prompts providers to crystallize their treatment goals and therapeutic strategies to achieve them. The key to achieving the objective is a collaborative participation with the provider of care rather than compliant or adversarial participation.

PROGRAM DETAILS

As a psychiatric case becomes active, the process of concurrent review begins immediately.

Computer system inquiries are made to check information relating to past psychiatric claim hospitalization dates and locations.

During the initial call to the attending physician, the need for inpatient care is discussed in light of the patient's psychiatric history, specific symptoms and proposed treatment. The initial assessment confirms the diagnosis, including possible differential diagnoses, prior psychiatric treatment, pertinent history and findings, and the specific problems for which hospitalization is requested. The practitioner is asked to assess the severity of impairment for each defined problem. Treatment goals are discussed and all aspects of the treatment plan are considered for their potential effectiveness in achieving the maximum therapeutic benefit.

During each subsequent telephone conference, the PRS reviews and analyzes the ongoing degree of severity of each problem that was present upon admission and documents any new issues. The impact of each treatment modality on the desired goals is assessed. If progress is demonstrated, questions are directed, when appropriate, toward influencing possible changes in the choice of treatment. Current trends in psychiatric care, published research results and pertinent case examples are discussed when relevant. The PRS works closely with the practitioner to encourage proactive discharge planning so that it occurs as soon as the maximum benefits of inpatient care have been achieved. Once the patient's discharge status is confirmed, the PRS discusses aftercare arrangements with the attending physician. This process helps to assure continuity of care and also presents an opportunity to influence cost effective treatment alternatives/case management.

Provider attitude is of major importance. Although reviewers cannot control this variable, it can be and will be influenced by the reviewer's attitudes, skills and qualities of interaction. As the provider's attitude becomes more participatory and collaboratively inclines, cost containment becomes a reality.

FPR AS PART OF ÆTNA'S HEALTHLINE PROGRAM

Claimants covered by HEALTHLINE have the FPR process initiated by HEALTHLINE as they follow standard procedures for hospital admissions. A call must be made to the HEALTHLINE nurse consultant by the patient/family member/attending physician/hospital before a non-emergency admission or within 48 hours following an emergency admission. The HEALTHLINE nurse consultant will obtain details pertaining to the proposed mental health or substance abuse admission in the same manner as other proposed admissions. Preliminary case information is entered into the HEALTHLINE subsystem and the caller is advised that a psychiatric clinician from Ætna's Home Office will be calling the treating practitioner within 24 hours of the initial contact. At that point, referral of all pertinent information is made by the servicing claim office to the Home Office who performs the necessary follow-up. STATE OF ALASKA will be notified as appropriate and <u>always</u> prior to implementation of an ICM case or a benefit reduction.

Individual Case Management

Some illnesses or injuries require prolonged and/or expensive care. In these cases, cost savings, as well as more effective care, may be provided through Ætna's Individual Case Management (ICM) program.

ICM is a creative approach to health care treatment and financing. Specifically, ICM is a flexible program in which Ætna's staff of doctors and nurse consultants work closely with patients, their doctors, their families, and our customers to arrange for quality care in alternative settings.

Alternative settings can include skilled nursing facilities, residential treatment facilities, or even a patient's own home. These alternatives offer emotional advantages for patients and their families, because patients are able to leave the hospital and receive an appropriate level of care in less stressful (and more cost-effective) settings. However, the patient's attending physician always makes the final decision on the treatment plan.

Potential ICM claims are identified as early as possible by a number of sources and evaluated by Ætna personnel. The ICM program is coordinated by the nurse consultant, who is assisted by physicians in Ætna's Home Office and a network of physician consultants, representing a variety of specialties.

Recommendations often involve specially authorized reimbursement for noncovered medically necessary expenses or the use of alternative medical management techniques or procedures. It is estimated that nearly 50% of ICM cases involve coverage beyond that traditionally provided by health benefit plans - coverage for such services as special medical equipment, home modifications, nurses, attendants and even special training for family members.

Each case is continually reviewed to assure that the site and mode of treatment remain appropriate.

ICM savings are usually substantial and can be greater than $20,000 per month, per case. ICM savings have significantly increased each year since the program began in 1982. In 1987, the savings amounted to over $122 million and in 1988 ICM saved Ætna customers over $180 million.

We are constantly seeking opportunities to apply this program. For example:

- Through Ætna's Healthline precertification program including Continued Stay Review and Focussed Psychiatric Review.
- Through the claim offices' Outreach Program - a program designed to increase the provider community's awareness of ICM and encourage earlier identification of potential cases.
- Through customer identification of a potentially serious medical problem.
- Through employee education about our program.

Examples:

The following cases are just two of the hundreds of ICM success stories:

- Following an automobile accident, a teenager became a quadriplegic. After a lengthly hospital hospital stay, he had progressed to the point where hospital services could be duplicated in his home. ICM provided coverage for the construction of wheelchair ramps, an extended bedroom, enlarged doors and a redesigned bathroom - at a cost significantly less than continued hospitalization.

- A teenaged girl was to be confined to a psychiatric hospital for one year or more. The attending psychiatrist felt that a day-hospital treatment program would meet the patient's needs and be more cost effective. Her parents, however, could not afford to pay the 50 percent co-insurance for outpatient therapy. ICM arranged for 80 percent coverage and the patient was able to start day care, and to remain in her own home.

Section 6 Quality Control

Ætna has established procedures to assure that HEALTHLINE Nurses follow established utilization review criteria. Cases handled by each HEALTHLINE Nurse are subject to random audits by the nurse's supervisor and monthly audits by the Ætna's Home Office professional staff. The audits include a review of a representative sampling of cases to make certain that the appropriate length of stay and Severity of Illness/Intensity of Service guidelines are applied.

- The review also assures that necessary cases are referred to a physician advisor by the HEALTHLINE Nurse, hospital inpatient confinements are really necessary, other treatment alternatives have been considered, turn-around time objectives are met, and correct diagnosis and procedure codes are being used.

Healthline Personnel Credentials

Those individuals who would be responsible for the day-to-day operations of the HEALTHLINE Program, including determining appropriateness of care, will be the HEALTHLINE Nurse(s) in the Seattle, WA Ætna Claim Office supported by local and Home Office Physician Consultants. These full time Nurse Consultants will be dedicated to servicing employees.

Nurse Consultants

The hiring criteria for HEALTHLINE Nurses include the following: the HEALTHLINE Nurse must be a registered nurse who has worked in at least two different provider settings for a minimum of five years. Personal qualifications are as important as professional ones. Clearly, the HEALTHLINE Nurse must have the ability to listen, draw out, empathize, counsel and patiently respond.

An essential requirement is at least six months experience in utilization review or discharge planning. Ætna's pre-admission certification and length of stay authorization program involves determining medical necessity as well as applying and reviewing medical data as necessary. An individual's knowledge of diagnostic and corresponding treatment protocols is essential to conduct the initial review process.

Prior to working as a HEALTHLINE Nurse, the individual must undergo an extensive utilization review and pre-certification training program.

PATIENT NAME	CLAIM ACCT.	DIAGNOSIS	CARE IN ABSENCE OF ICM AND COST	ICM CARE CHOICE AND COST	DATE ICM STARTED	EST. SAVINGS TO DATE	ACTIVE
Matthew	10-001	Substance Abuse	Charter North $39,220	Milam $12,605	12/14/88	$26,615	No
Margaret	10-007	Pulmonary Disease	Hospital $53,200	Rehabilitation $24,874	10/12/88	$28,326	No
Richard	10-100	Lung Cancer	Hospital $24,333/month	Comp Homecare $9,927/month	11/22/88	$10,261	No
Denise	10-001	Substance Abuse	Care Unit $24,575	Milam $12,605	12/8/88	$11,970	No
David	10-001	Substance Abuse	Hospital $13,890/month	Provo Canyon School $4,390/month	9/22/88	$30,853	Yes
Jeffrey	14-001	Substance Abuse	Charter North $31,030	Milam $6,605	11/23/88	$24,530	No
Wendy	10-001	Substance Abuse	Charter North $39,720	Milam $13,105	11/8/88	$26,615	No
Nicole	10-003	Substance Abuse	Charter North $39,720	Milam $12,720	12/2/88	$27,115	No
Richard	14-001	Renal Cancer	Hospital $12,045	Skilled Nursing Fac. $6,912	10/20/88	$12,045	No
Cheryl	10-002	Renal Failure	Convalescent Facility $2,190/month	Residential Care $1,388/month	9/30/88	$32,612	Yes
Ryan	10-020	Substance Abuse	Charter North $30,768	Milam $10,084	9/29/88	$20,684	No
John	12-001	Substance Abuse	Charter North $26,300	Milam $9,288	10/24/88	$17,012	No
Scott	10-009	Substance Abuse	Charter North $33,375	Milam $12,605	10/17/88	$20,770	No
Calvin	10-001	Substance Abuse	Charter North $38,960	Milam $12,605	10/13/88	$26,355	No

PATIENT NAME	CLAIM ACCT.	DIAGNOSIS	CARE IN ABSENCE OF ICM AND COST	ICM CARE CHOICE AND COST	DATE ICM STARTED	EST. SAVINGS TO DATE	ACTIVE
Melinda	10-001	Head Injury	Hospital in AK $26,102 per month	Hospital in NJ $12,874 per month	12/2/87	$171,964	Yes
Andrea	10-003	Substance Abuse	Hospital $12,440 per month	Provo Canyon School $4,500 per month	1/13/88	$100,172	Yes
Curtis	10-001	Substance Abuse	Hospital $11,077 per month	Provo Canyon School $4,350 per month	6/15/88	$46,391	Yes
Benita	10-006	Substance Abuse	Hospital $10,091 per month	Provo Canyon School $5,741 per month	7/8/88	$76,718	Yes
Jeremy	10-001	Arthritis	Hospital $27,922 per month	Comp. Home Care $4,300 per month	6/16/88	$85,657	Yes
Georgette	10-006	Psychiatric	Hospital $12,440 per month	Spring Creek Conv. $2,500 per month	7/4/87	$172,104	Yes
Bobby	10-001	Head Injury	Hospital $11,558 per month	Comp Home Care $5,418 per month	5/23/88	$29,798	No
Karma	10-002	Psychiatric	Hospital $29,626 per month	Comp. OP Program $12,400 per month	4/14/87	$292,315	No
Robert	10-001	Cerebral Aneurism	Anchorage Rehab $11,186 per month	Seattle Rehab $7,720 per month	4/88	$24,262	No
Rayna	10-001	Substance Abuse	Hospital $7,286 per month	Provo Canyon School $4,350 per month	7/28/88	$15,348	Yes
Kirsten	10-001	Substance Abuse	Charter North $39,220	Residential $21,292	12/1/88	$4,482	Yes
Angela	10-001	Severe Burns	Hospital $49,800	Rehabilitation $23,320	10/27/88	$25,654	No
Kathleen	10-001	Substance Abuse	Charter North $39,220	Milam $13,705	11/14/88	$25,615	No
Jason	10-009	Substance Abuse	Charter North $39,220	Milam $12,605	11/11/88	$26,615	No

PATIENT NAME	CLAIM ACCT.	DIAGNOSIS	CARE IN ABSENCE OF ICM AND COST	ICM CARE CHOICE AND COST	DATE ICM STARTED	EST. SAVINGS TO DATE	ACTIVE
Rachel	10-001	Substance Abuse	Charter North $38,460	Milam $12,605	11/2/88	$25,855	No

Psychiatric Review Specialists

Focused Psychiatric Review activity will be administered by the Home Office Medical and Claim Departments by Psychiatric Review Specialists and physician consultants. Psychiatric Review Specialists are uniquely prepared and experienced professionals. PRS's are Masters-level educated psychiatric nurse clinicians (MSN's) or psychiatric social workers (MSW's) with a minimum of two years post graduate experience in psychiatric inpatient care and management. The Psychiatric Review Specialist has a detailed knowledge of psychiatry, its concepts, practice, intent, limitations and alternatives and is trained in insurance principles. Clinical expertise and insurance knowledge are applied through the process of concurrent clinical review. Additionally, they must exhibit interpersonal qualities which enable them to work comfortably and effectively with health care professionals in discussing and influencing treatment, overall patient management decisions within professional boundaries, and the plan provisions.

Additionally, PRS's are knowledgeable about the full range of psychiatric and substance abuse coverage available under the STATE OF ALASKA benefit plan. The clinicians work collaboratively as members of Ætna's professional team which includes psychiatrists and doctoral level clinical psychologists. Clinicians expert in various psychiatric subspecialities provide ongoing consultation at periodic case conferences.

Physician Consultant

In order to qualify as a Physician Consultant, the physician must:

- Be board certified in his/her specialty.
- Have local medical society membership, including county and state medical societies.
- Be familiar with the goals of Ætna's utilization management program.
- Be familiar with the criteria sets used by the utilization review coordinators to assess the medical necessity of admission to the hospital and continued stay.
- Be knowledgeable about facilities and different levels of care available in the community.
- When necessary, seek the opinion of a qualified specialist.
- When necessary, telephone the patient's attending physician to discuss our recommendation concerning the need for admission and appropriate length of stay.

HEALTHLINE Program Evaluation

STATE OF ALASKA will be provided with reports reflecting pre-certification activity and savings achieved through the HEALTHLINE Program. Please refer to EXHIBIT III and IV.

Pricing

Cost for administering the HEALTHLINE Program through the 1989 calendar year are as follows:

- Full Healthline/FPR: $2.08 per employee per month.
- Precert Only: $1.56 per employee per month.
- Consumer Advisory Only: $.71 per employee per month.

Pre-Installation Activity

It is in the employee's best interest to have one source for all questions on claim handling and Healthline. Accordingly, we propose to operate the Ætna Healthline Program out of the Seattle, WA claim office where the healthcare claims are currently processed.

Prior to the effective date, the following must be accomplished;

- Distribute employee descriptive literature announcing the program and the associated benefit provisions.

- Commence the employee educational campaign which includes the use of a videotape, payroll stuffers, and other educational materials. It is recommended that the educational campaign continue after the effective date in order to reinforce the availability and understanding of the program.

- Consider the need to issue employee identification cards bearing a toll-free Ætna Healthline number, highlights of the program, and an initial supply of the Ætna Healthline Pre-Admission Certification Checklist. Refer to Exhibit I.

- Establish Ætna system records to reflect the purchase and coverage of the Ætna Healthline Program.

- Consider the need to provide staffing, telephone lines, and information systems necessary to support the program. A lead time of 90 days is suggested for this purpose.

Recommendation

We believe that an effective cost containment program should focus on pre-certification and the evaluation of confinement which might lead to unnecessarily costly and inappropriate use of the hospital setting. Ætna's HEALTHLINE Program puts the emphasis where experience shows it belongs - education, information and informed choice before the patient enters the medical care system followed by appropriate discharge planning and case management after admission.

In conclusion, Ætna is prepared to offer HEALTHLINE to STATE OF ALASKA and assure a smooth and successful start-up period.

SAMPLE
PRECERTIFICATION ACTIVITY
BY THE TYPE OF HOSPITAL ADMISSION
EMPLOYEES AND DEPENDENTS, ÆTNA PRIMARY

Prepared 6/1/87

PH NO. STATE OF ALASKA Page 1 TA
04/01/86 - 04/01/87

PH TOTALS

TYPE OF ADMISSION	ADMISSIONS TOTAL	DAYS REQUESTED	DAYS CERTIFIED	DAYS USED	DAYS GREATER THAN CERTIFIED USED	REQUESTED	PERCENT OF DAYS CERT	SAVINGS
PRECERTIFIED	623	4,276	3,795	3,612	41	387	9	106,820
NOT PRECERTIFIED	20	N/A	N/A	93	93	N/A	N/A	9,300
OTHER	44	N/A	N/A	357	N/A	N/A	N/A	0
TOTAL	687	4,276	3,795	4,062	134	387	N/A	116,120

STANDARD SAVINGS CALCULATIONS:

1) 41 NON CERTIFIED DAYS CONSIST OF:

21 HOSPITAL DAYS WERE USED ON 3 ADMISSION WHERE 0 DAYS WERE CERTIFIED. SAVINGS ARE CALCULATED AS THE SUM OF THE ROOM & BOARD CHARGES FOR THESE ADMISSION. SAVINGS = $ 4,200

20 HOSPITAL DAYS WERE USED IN EXCESS OF DAYS CERTIFIED ON 15 ADMISSIONS. SAVINGS ARE CALCULATED BY MULTIPLYING THE NUMBER OF EXCESS DAYS TIME THE AVERAGE DAILY ROOM & BOARD CHARGE FOR EACH ADMISSION TIMES THE 50% STANDARD BENEFIT PENALTY. SAVINGS = 2,000

387 DAYS WERE REQUESTED IN EXCESS OF DAYS CERTIFIED ON THE REMAINING CERTIFIED ADMISSIONS. SAVINGS ARE CALCULATED BY MULTIPLYING THE AVERAGE NUMBER OF DAYS REQUESTED IN EXCESS OF CERTIFICATION TIMES THE AVERAGE DAILY ROOM & BOARD CHARGE FOR EACH ADMISSION PLUS 30% TO ACCOUNT FOR ANCILLARY CHARGES. SAVINGS = 100,620

$106,820

2) 93 DAYS WERE USED FOR 20 NON PRECERTIFIED ADMISSIONS. SAVINGS ARE CALCULATED BY MULTIPLYING THE NUMBER OF DAYS USED TIMES THE AVERAGE ROOM & BOARD CHARGE PER DAY TIMES 50%. SAVINGS = 9,300

SAMPLE
INTEGRATED COST CONTAINMENT SAVINGS
ALL EMPLOYEES AND DEPENDENTS

Prepared 6/1/87
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PH NO. STATE OF ALASKA

	CURRENT QUARTER	1ST PRIOR QUARTER	2ND PRIOR QUARTER	3RD PRIOR QUARTER
REASONABLE AND CUSTOMARY CHARGE SAVINGS	$ 4,984	$ 12,527		
COORDINATION OF BENEFIT SAVINGS	$ 80,474	$ 146,634		
HOSPITAL PRECERTIFICATION SAVINGS	$ 150,750	$ 124,620		
INDIVIDUAL CASE MANAGEMENT SAVINGS	$ 164,866	$ 0		
TOTAL SAVINGS FROM ÆTNA COST CONTAINMENT	$ 401,074	$ 283,781		

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