SB

254

STATE OF ALASKA
THE LEGISLATURE

POUCH Y · STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

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Mary Van Nimwegen

SB 254

H HESS	4/25/90
H HESS	4/26/90
H HESS	4/27/90

HOUSE COMMITTEE REPORT

(7)
Date Referred: April 9, 1990 FURTHER REFERRALS:

FINANCE

Date of Committee Action: 4/27/90

The HESS Committee considered: CSSB 254(FINANCE)

CS SB NO. 254 (Fin) STATE INSURANCE AUTHORITY

"An Act relating to group health insurance and to health care provided by the state; and providing for an effective date."

RECOMMENDATIONS:
[X] be replaced with HCS CSSB 254 (HESS) [X] the same title [ ] a new title
[ ] have attached amendment(s)
[ ] do pass
[ ] do not pass
[ ] no recommendation
[X] individual recommendations
[ ] additional referral to the _____ Committee

ADOPTS: _____ letter of intent

ATTACHES NEW FISCAL NOTE(s): (Dept)
[ ] fiscal impact _____
[ ] zero fiscal note _____
[ ] zero with analysis _____

APPROVES PREVIOUS: (Date/Dept)
[X] fiscal note(s) 3/30/90 / DOA
[X] zero fiscal note(s) 3/20/90 / DCED
[ ] zero fn/analysis _____

SIGNING DO PASS:

K D Kerr
Mark Boldt

SIGNING: (Check approp. column)

	Do Not Pass	No Rec	Amend
		X	
		X	

J Ellis
Chairman's Signature

Rick Urion
ASMA

failed

April 26, 1990 #5

PROPOSED AMENDMENTS TO CSSB 254 (FIN)

This amendment is offered to prevent misunderstandings and unintended adverse effects on health care providers. Three amendments are necessary.

I. CHANGE "RATE SCHEDULES" TO "BENEFIT SCHEDULES" #5

It is proposed that the term "rate schedules" be changed to "benefit schedules." Currently the term "rate schedules" appears in the following locations in the bill:

1. Page 1--paragraph (1);

2. Page 2--heading of AS 21.77.010;

3. Page 2--subsection (b) of AS 21.77.010 (twice);

4. Page 3 (top)--AS 21.77.015;

5. Page 7--AS 21.77.100(11); and

6. Page 8--Section 6.

COMMENT: "Benefit schedule" more accurately reflects the intended meaning of the phrase, since the Authority will be dealing with the level of benefits to be paid for services rendered to insured employees and will not be dealing with the rates charged by the health care providers. Proposed Amendment II below proposes a definition of this term.

II. DEFINITION OF "BENEFIT SCHEDULES"

It is proposed that the definition in proposed new AS 21.77.100(11) (page 7) (now pertaining to "rate schedules") be revised as follows:

> (11) "benefit [RATE] schedules" means lists [SCHEDULES] of the amounts the authority's group health insurance will pay [ALLOWABLE PAYMENTS] for covered health care related services based on geographic regions, actual provider costs, usual and customary provider charges, and availability of services;

COMMENTS: The proposed revisions are intended to clarify that the "benefit schedules" pertain only to how much the Authority's insurance will pay. The schedules would not affect the amount a health care provider may charge for services or prevent a provider from billing the insured employee for the balance, if the insurance benefit did not cover the entire charge for the service. The phrase "usual and customary provider charges" is added because this term is commonly used in private insurance policies as a limit on the benefits that will be paid. Its inclusion in the definition clarifies that the amount of the benefit payment may not be determined solely by the provider's costs.

III. NO PROHIBITION OF BALANCE BILLING

It is proposed that new AS 21.77.030(b) (top of page 4) be revised as follows:

> (b) In exercising its powers under this chapter, the authority may not:
>
> (1) participate directly or indirectly in a collective bargaining agreement; or[.]
>
> (2) require that health care providers, as a condition of receiving payment under the authority's group health insurance, agree to accept payment from the authority's group health insurance as payment in full or agree to otherwise forego their rights to collect from the insured employee any balance due after payment of the group health insurance benefits.

COMMENTS: The proposed amendment is intended to make clear that the Authority may not prevent health care providers from collecting from the patient any unpaid balance that remains after the Authority's group health insurance has paid the authorized benefits.

6-0623Jd ✓
Ford

AMENDMENT #1

OFFERED IN THE HOUSE

TO: CSSB 254 (Finance)

Page 2, line 16, after "authority":

Insert "for eligible employees of the state, municipality, or school district"

Page 7, line 8, after "care":

Insert "for persons who are not employees of the state"

4/26/90

6-0623Je
Ford

AMENDMENT #2

adopted

OFFERED IN THE HOUSE

TO: CSSB 254 (Finance)

Page 3, after line 23:

Insert a new subsection to read:

"(c) Members appointed under (a)(5) of this section shall be employees of a school district that has elected to participate in the group health insurance obtained by the authority. Members appointed under (a)(6) of this section shall be employees of a municipality that has elected to participate in the group health insurance obtained by the authority."

Page 8, line 8, after "TERMS":

Insert "; INITIAL APPOINTMENTS"

Page 8, line 14, after "years.":

Insert "AS 21.77.020(c), enacted in sec. 2 of this Act, does not apply to members appointed to the initial board of directors of the Alaska State Group Health Insurance Authority."

6-0623Jc
Ford

AMENDMENT #3

adopted

OFFERED IN THE HOUSE

TO: CSSB 254 (Finance)

Page 6, lines 16 - 18:

Delete "Once the board awards the insurance contract, a participant may not be granted a waiver during the term of the contract."

4/26/90

6-0623Jb
Ford

AMENDMENT #4

adopted

OFFERED IN THF HOUSE

TO: CSSB 254 (Finance)

Page 7, after line 8:

Insert a new paragraph to read:

"(6) "employer" means the state, a municipality, a district, a collective bargaining unit, or the board of a public corporation of the state created within a principal executive department;"

Renumber the following paragraphs accordingly.

4/26/90

STATE OF ALASKA

STEVE COWPER, GOVERNOR

DEPT. OF HEALTH AND SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

P.O. BOX H
JUNEAU, ALASKA 99811-0601
PHONE: (907) 465-3030

April 26, 1990

Honorable Johnny Ellis, Chair
House Health, Education, and Social Services
Alaska State Legislature
P.O. Box V
Juneau, Alaska 99811

Dear Representative Ellis:

I wish to clarify several points as they relate to CSSB 254(Fin) currently before you. The Department supports two pending amendments to clarify the sponsor's intent to exclude certain state programs from mandatory participation. These two amendments are (1) in sec. 21.77.010(b), "for its employees," and (2) the definition of eligible state program to include "for persons who are not employees."

State programs which simply provide or pay for health care services for Alaskans differ greatly from those which provide health care services for their employees. Much of the health care provided by State programs are to clients who are indigent, children who are in the custody of the State, or have another special need. Virtually all of these programs are payors of last resort, so if other coverage exists, i.e., through employment, it will be used first. Many of these programs, such as the Medicaid program, have federally mandated rules that govern their operation.

It is not feasible to use similar rate schedules, payment systems, and utilization standards for these programs as for employee benefit programs. For instance, deductibles or co-payments would not be feasible for programs that are income-based, and in fact, in the Medicaid program deductibles are not allowable. In addition, existing mechanisms in State statute already exist to set facility rates for purposes of Medicaid.

In conclusion, we support Senator Duncan's intent to clarify that State programs which provide health care or provide funds to purchase health care for persons who are not employees are exempt from participation in this measure. We also support the existing language in AS 21.77.010(d), which allows the option for eligible state programs to apply and participate in a group health insurance plan if they so desire and if the authority approves such an application.

Thank you.

Sincerely,

Karen Perdue
Deputy Commissioner

KP/cb
cc: Honorable Jim Duncan
Alaska State Senate

Municipality of Anchorage

P.O. BOX 196650
ANCHORAGE, ALASKA 99519-6650
(907) 343-4425

TOM FINK,
MAYOR

DEPARTMENT OF EMPLOYEE RELATIONS

April 17, 1990

Representative Johnny Ellis
Rm 104, Capitol
P O Box V
Juneau, AK 99811

Dear Representative Ellis:

We have been following the progress of SB 254 relating to Group Health and to Health Care Provided By the State with some concern. Our primary issue with this proposed legislation is that it goes far beyond the stated scope of State group health insurance or health care provided by the State. Currently this bill mandates that all public employees in Alaska must either: (1) participate in the State's group insurance program or (2) use whatever provider payment systems, rate schedules and utilization standards the State establishes for itself. The net effect is that the State of Alaska will determine group health benefits for all public employees in Alaska and will determine the costs for such benefits for all public employers.

In its current form (CSSB 254), this legislation will have a major negative impact on the Municipality in the following areas:

- Negotiated labor agreements which afford specific levels of coverage. Scope and cost would be mandated, while not guaranteeing current levels.
- Participation of Municipal employees in Taft-Hartley plans. Inability to continue such participation.
- At worst, removal of major term and condition of employment from the realm or collective bargaining.
- At best, establish threshold for bargaining where employer can only bargain more coverage at a higher cost.

The result for local governments and school districts will be the exact opposite from the stated objective to lower group health costs.

There is considerable merit to the pooling concept for group health coverage as a means of reducing costs. Those in the pool should, however, first have the opportunity to assess the pool and determine if it meets their particular needs and fiscal capabilities. We believe these concerns can be effectively met and the objective of benefit pooling can be positively obtained by modifying Section 21.77.010 (b) as follows:

(b) The authority shall, by February 1, 1992, establish and maintain a health care provider payment system, rate schedules, and utilization standards. The state [,] and a municipality who elects to participate, or a school district who elects to participate shall use the health care provider system, rate schedules and utilization standards established by the authority.

Section 21.77.010 (c) should also be modified slightly to require that municipalities or school districts who elect to participate shall do so by resolution. This will enable the affected citizens the opportunity to be heard prior to participation.

Finally, 21.77.020 should have two minor modifications to insure appropriate representation of the Board of Directors. Those changes should be as follows:

(5) two members representing participating school districts;
(6) two members representing participating municipalities;

These changes are minor and do not adversely impact the pooling objectives of this legislation. They do, however, have significant impact for local government employers throughout Alaska by enabling us to make informed public decisions concerning whether or not it is in our best interests to join the pool established under the proposed authority. We strongly urge you to incorporate these proposed amendments and would welcome the opportunity to testify before your committee regarding our concerns.

Sincerely,

Glenn Lundell

Glenn Lundell
Director, Employee Relations

GL/sw/SB254

SENATE BILL 254 BY SENATOR DUNCAN
Finance

ALASKA STATE GROUP HEALTH INSURANCE AUTHORITY
"An Act relating to group health insurance and to health care provided by the state; and providing for an effective date."

Section 1.

PURPOSE

The purpose of this act is to establish the Alaska State Group Health Insurance Authority. By February 1, 1990 the Authority has the responsibility to create and maintain:

(a) a rate schedule to be used in Alaska which will reflect the vast geographic differences and availability of services in rural and urban areas;
(b) statewide utilization standards to control inappropriate or improper utilization practices to reduce the rate of inflation in the cost of health care in Alaska; and
(c) an efficient provider payment system to reduce the cost to providers who are serving employees of the participants in the authority.

The state, municipalities, and school districts will benefit by using the provider payment system, rate schedule, and utilization standards established by the Authority.

Section 2.

CREATION OF THE AUTHORITY

The authority is established in the Department of Administration. It has a 15 member board of directors appointed by the Governor with the general powers provided to quasi government agencies including the hiring of staff and enter into contracts for professional services. In addition, after February 1, 1992, the Authority may exercise the powers granted to other insurers licensed in the state.

BOARD OF DIRECTORS

The board of directors will be composed of 15 members representing:

(1) one nonvoting member of the legislative branch;
(2) one nonvoting member of the judicial branch;
(3) two members representing the executive branch;
(4) two members representing labor organizations;
(5) two members representing school districts;
(6) two members representing municipalities;
(7) two members representing the Department of Health and Social Services;
(8) two members representing health care providers;
(9) one member representing the University of Alaska.

These appointees serve for a five year term and elect officers from the board membership. They are entitled to per diem and travel expenses but may not otherwise be compensated for their services as a board member.

POWERS OF THE AUTHORITY

The Authority may:
(1) after February 1, 1990 exercise the powers granted to insurers under the laws of the state, and shall comply with the requirements applicable to insurers under this title;
(2) sue or be sued;
(3) enter into contracts for agreements;
(4) establish administrative and accounting procedures;
(5) collect, invest, and disburse funds;
(6) adopt necessary regulations and procedures for implementation of this chapter.

The authority may not participate in collective bargaining activities.

ANNUAL REPORT, STAFF AND PROFESSIONAL SERVICES

The board shall annually report to the governor and the legislature on its previous fiscal year's activities and every third year include a cost benefit analysis of the health insurance required under this chapter.

The authority shall employ an executive director, who with the approval of the authority may select and employ additional staff as necessary. The authorities employees are in the exempt service. The authority may contract for professional and technical services it determines necessary to exercise its powers.

PROCUREMENT OF INSURANCE

After February 1, 1990 the authority shall purchase a policy or policies of group health insurance covering eligible employees of the state, a municipality, or a district if the employer has elected to participate. The authority may act as a self-insurer if it is determined that self-insurance will provide the desired insurance coverage and benefits at a lower cost per eligible employee.

When purchasing group health insurance the authority shall comply with the provisions of Title 36 and shall make bid specifications available, once every five years, to all insurance carriers licensed in Alaska and qualified to provide the desired benefits.

STATE GROUP HEALTH INSURANCE FUND AND PREMIUMS

The state group health insurance fund is created in the general fund. It consists of appropriations and premiums collected under this title. Money in the fund shall be managed and invested by the board and the board may expend funds from the fund to carry out its operations.

The authority shall collect sufficient premiums to provide the required insurance coverage and to pay the expenses of the authority.

PARTICIPATION AND WAIVER

The authority may also grant a waiver of participation to the state, a municipality or a school district who has elected to participate. The board may approve or disapprove a waiver when the participant can document the ability to match the minimum benefit and financial standards established by the board for the desired group health coverage. A waiver may be granted when a participant certifies that its' employees will not have health care coverage from the authority or other carrier.

Participants may separately provide for health insurance in addition to that provided by the Authority.

DEFINITIONS

(1) authority, means the Alaska State Group Health Insurance Authority;
(2) board, means the board of directors of the Alaska Group Health Insurance Authority;
(3) district, means a school district or REAA;
(4) eligible employee, means an employee qualified for group health insurance benefits as determined by the participant;
(5) fund, means the state group health insurance fund;
(6) group health insurance, means coverage that may include life insurance, accidental death and dismemberment, workers' compensation, medical care and treatment including Medicare and Medicaid, dental care, eye care, and other group health coverage as determined by the authority;
(7) municipality, includes a public corporation established by a municipality;
(8) participant, means the state, a municipality, or a district;
(9) state, means the executive, legislative, and judicial branches of state government, or an organizational unit of a branch, and includes the University of Alaska, and a public corporation of the state created within a principal executive department.
(10) payment system, means a system or method to streamline and effect cost efficient payments to health care providers.
(11) rate schedule, means a schedule of allowable payments for health care related services rendered based on geographic regions actual provider cost and availability of services.
(12) utilization review, means a system to monitor, track and verify patterns of treatment by health care providers to assure that the most efficient and cost effective care is delivered within accepted standards with out reducing quality of care.

Section 3.

Places employees of the authority in the exempt service.

Section 4.

Requires board members of the authority to comply with the conflict of interest statutes.

Section 5.
Provides that terms of the board members will be staggered.

Section 6.
The Authority is required to make a progress report to the Legislature by March 1, 1991. The report covers the Authorities efforts in establishing the health care provider payment system, rate schedule, and utilization standards.

Section 7.
Provides for an immediate effective date.

Health Insurance Authority

SB 254 by Senator Duncan

Purpose:

To provide a vehicle that enables cost effective health care delivery to all participants of State health plans (including active/retirees of State, Municipal and Education), in order to help curb escalating health care costs.

Currently each entity purchases health care from a number of health insurance providers for their plans. By creating a health insurance authority each participating entity would in effect have the ability to realize the cost economies of a much larger group (134,000 participants vs 24,000). This would enable the authority to negotiate payment rates and utilization factors with health care providers and provide for appropriate care delivery at an appropriate cost. The authority could be expanded to include medicaid and workers compensation benefit systems.

The authority could phase in responsibilities over a period of time

Phase I

Authority Created -

Establish provider payment and utilization standards for use by participating entities with their current health plans.

Phase II

Start to pool purchasing of coverage voluntarily by entities.

Phase III

Pool all entities to give maximum cost efficiencies.

Health Insurance Authority

SB 254

Background

* Supplemental Request FY 89 of 21.8 million to cover increased Health Care premiums.
* Increasing costs of Health Care in Alaska from 75 million in FY 80 to in excess of 300 million in FY 90.
* Health Insurance premiums for employees increasing from $217.65 in FY 84 to $431.72 in FY 89 an increase of 98% in five years. The national average in 1989 was $216.00
* Health Care Task Force Creation
    * Short term - ways to reduce supplemental requests
    * Mid term - ways to reduce FY 90 costs
    * Long term - ways to reduce health care costs in Alaska.

Health Insurance Authority

* Coordinate buying power of State plans to reduce health care costs in Alaska.
* Lower cost of plan administration
* Realize trends in health care delivery and adjust accordingly.

Recently I received a copy of a letter sent by Michael Hurst to G.G.U. members citing the "actual" cost for employees health care.

As you are aware I am quite concerned about rising Health care costs in the state and the cost to employees. As a member of the Health Care Cost Containment Task Force we have reviewed the costs under the Aetna plan and have made recommendations that would reduce costs but not reduce benefits. The task force has made recommendations that allowed for the recovery of past due refunds and cost containment savings totaling over 10 million dollars.

The letter may mislead G.G.U. members as it outlines a 9.6 million dollar surplus at the end of the plan accounting period ending June 30, 1989, when in fact the balance was actually 7.2 million. In past years the plan was in a deficit position.

This surplus was used (along with cost containment provisions) to reduce the premium from $431.72 to $384.59 per employee per month and to guarantee this premium level until January 31, 1991.

It must be noted that the 7% health care inflation pointed out in Hurst's letter is not a realistic projection when health care inflation in the State's plan has been tracking at 19.98% per year for the last five years.

If health care costs continue to rise at 20% per year the current $385.00 premium will increase substantially unless we can find ways to slow or stop this pace. The Task Force is evaluating long term ways to curb health care inflation in the State and will be reporting these findings.

ASSOCIATION OF ALASKA SCHOOL BOARDS
316 W. 11th St. • Juneau, Alaska 99801-1510 • (907) 586-1083

MEMO

TO: House HESS Committee Members

FROM: Carl F.N. Rose, Executive Director

RE: Senate Bill 254 - Group Health Insurance Authority

DATE: April 26, 1990

The Association of Alaska School Boards is keenly aware of the financial hardship experienced by school districts which is due in large measure to rapidly escalating health coverage costs. We recognize the value of looking for alternative means to alleviate this burden.

While we concur with the concept of the Alaska State Health Group Authority, which is set forth in SB 254, we do have some concerns.

One of those concerns would be the possibility of a future determination that the program should be mandatory, and would require *all* school districts to participate. It has been our experience in forming and administering a cooperative property insurance program for school districts that some of the larger districts, such as Anchorage, Fairbanks and Juneau, were able to either negotiate lower rates on their own or participate in a self-insurance arrangement with their municipal governments. We suspect this might also be true in the area of health coverage.

We believe that if the program is truly beneficial then it will follow that districts will voluntarily join. However, a mandated program may not prove to be in everyone's best interest, and would put an additional burden on a school district (or municipality) to demonstrate why they should be allowed to pursue other options.

Another concern regards the governance of the Authority. The make-up of the governing board currently specifies "two members representing school districts". We would like to have it made clear that those two representatives should represent school district *management*, since it is already specified that labor organizations will be represented.

ALASKA STATE MEDICAL ASSOCIATION

4107 Laurel Street • Anchorage, Alaska 99508-5334 • (907) 562-2662

JIM

April 12, 1990

Honorable Johnny Ellis
Chairman
Health, Education and Social Services
P.O. Box V
Juneau, Alaska 99811

Re: Senate Bill 254

Dear Representative Ellis:

Is creating a government-run insurance program the solution for restraining the costs of health care?

In 1965 the U.S. Congress amended the Social Security Act by adding Title 18 - Medicare. Like Senate Bill 254 it established a government agency - the Bureau of Health Insurance - to establish payment rates, review utilization of services, and purchase insurance at the lowest possible cost for its beneficiaries, in this case, Americans over 65. It contracted with private insurance companies, known as Fiscal Intermediaries, to pay out benefits. Within a decade the Bureau of Health Insurance had grown so large that it could no longer be contained within the Social Security Administration, so a new separate bureaucracy was created - the Health Care Financing Administration, or HCFA.

By 1990 HCFA and its non-insurance contractors (who perform utilization review and quality care review functions) had become one of the largest, most complex and costliest of the Federal bureaucracies, and one that is equally mistrusted by providers and beneficiaries alike. Since 1965 health care expenditures have risen to consume 12% of GNP, a higher proportion than almost any country.

Medicare has proven to be a political, social and fiscal tarbaby for legislators, providers and consumers. Yet, Senate Bill 254 recreates in miniature the same mistakes Title 18 made almost a generation ago. Senate Bill 254 even goes a step farther, by giving the Insurance Authority the option to actually operate the insurance program itself - collecting premiums and paying benefits. Does the State of Alaska really want to become caught in this scenario?

Organized medicine in the US - and in Alaska - has been firmly committed to accessible, affordable health care, but we don't believe that having government enter the insurance business is a good answer.

Rather, we believe in using the marketplace to restrain the utilization of services, by introducing higher deductibility and/or greater co-insurance. By making patients partially responsible for health care costs, frivolous utilization of services will diminish without question.

We also believe in reviewing the entire benifit package, and re-examining the meaning of the term "comprehensive care." The benifit package available to Alaska state employees and retirees is certainly one of the most generous in the country.

Finally, we believe that the passage of House Bill 581 will provide a better forum to examine a number of issues and offer a program for stabilizing inflation of health care expenditures.

Therefore, we believe Senate Bill 254 to be a proposed "quick fix" for a much larger problem and we sincerely oppose this legislation.

Sincerely,

Ray Schalow
Executive Director

WCCA
Workers' Compensation Committee of Alaska

Tuesday, April 24, 1990

Johnny Ellis, Chairman
House Health, Education, and Social Services Committee
Alaska State Legislature
P.O. Box V (MS 3100)
Juneau, AK 99811

Re: CSSB 254

Dear Representative Ellis:

I understand that this bill has passed in the Senate and has now been referred to your committee for consideration. As president of the Workers' Compensation Committee of Alaska, representing some 450 employers throughout Alaska for workers' compensation concerns, and also as Benefits Manager of the Anchorage School District with over 35 years experience in the group insurance and employee benefits field, I must convey to you my total opposition to CSSB 254, both as to its intent and construction. At first glance, it may appear to offer reduced health care cost for employees of the State and its political subdivisions, but as written, I am afraid it would do just the opposite.

The bill purports to call for voluntary participation by the various eligible entities, but then provides for requiring mandatory participation. It requires the creation of fee schedules and utilization standards for health care providers without addressing any realistic basis for establishing, or enforcing of them. It would allow for entirely different levels of benefits and plan designs from one entity to another. Unless practical parameters or guidelines for the benefits to be provided are established in the bill itself, the entire program would be unmanageable and costs would run wild. Finally, enactment of this bill will require the creation of a large state bureaucracy which will greatly increase the overall cost of providing health coverage to public employees. The $0 fiscal note given to the Senate Finance Committee, was very misleading that was only for FY 90. Starting with FY 91, the fiscal impact will be significant.

The concept of a statewide Group Health Coverage Authority could be made to work and might contain, or even reduce the future cost of health benefits for public sector employees if:

P.O. Box 200631
Anchorage, Alaska 99520

1. The Legislature establishes a uniform health plan providing for basic medical, dental, and vision benefits with reasonable deductibles, and co-payments for all plan participants, and declares that only employer contibution amounts, and not specific health care benefits, are subject to collective bargaining;

2. All state mandates of specific health benefits currently in effect are repealed;

3. Participation in the State Plan is made mandatory for all employees of the state and its political subdivisions in the same manner as the state retirement systems;

4. The Legislature establishes a self-funded health care authority for paying benefits under the basic state health plan and provides for annual appropriations to the fund based on annual actuarial assessments of the claims experience of the plan and appropriate reserve and expense requirements; and

5. Risk sharing contracts are established with a statewide network of healthcare providers and hospitals establishing rate and fee schedules.

Should CSSB 254 pass as written, it would increase cost for those political entities which now effectively manage their health benefit plans. It does not seem at all fair for the state to attempt to reduce its current high employee health plan cost at the expense of other political subdivisions. The California consultant's contention, in his report to the state Health Task Force, that combining all public sector employees under one state health authority will save large amounts of money for all public entities is plain wrong under existing conditions in Alaska.

I urge you and your committee not to recommend passage of CSSB 254 Thank you for your consideration.

Sincerely,

Warren L. Dvorak, President

WLD/mse

cc: Mark Boyer, Vice-Chairman
Cheri Davis
Walt Furnace
Peter Goll
Max F. Gruenberg, Jr.
George G. Jacko, Jr.

NEA-ALASKA

AFFILIATED WITH THE NATIONAL EDUCATION ASSOCIATION

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FAIRBANKS REGIONAL OFFICE
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April 25, 1990

To: Rep. Johnny Ellis, Chair
Members, House HESS Committee

Re: CS for SB ~~245~~ 254 (Finance)
"An Act relating to group health insurance and to health care provided by the state; and providing for an effective date."

NEA-Alaska supports and encourages your favorable consideration of SB 254.

At the school district level employees are covered by a wide variety of plans, some good and many not so good, with a broad range of premium costs. All are regularly faced with substantial premium cost increases and frequently diminished benefit coverage.

Many school districts, by virt : of their relatively small size, don't have any advantage or leverage in negotiating premium rates and benefit coverage with insurance carriers or health care providers.

Through Phase I SB 254 makes critical information and systems available to school districts lacking the resources necessary to acquire this information on their own.

More importantly, SB 254 will eventually provide school districts with viable options to those currently available to them and represents the real potential for increased benefit coverage, meaningful cost containment, and lower premium rates for all public employees.

The attached data sheet which is currently being updated reflects the broad range of premium costs and benefit coverages currently available to school district employees.

SB 254 is a way to better address the health care concerns of school districts and all of their employees. We urge your favorable response.

Thank you for your consideration of o r position.

Respectfully submitted,

Bob Manners
Executive Secretary.

NEA-ALASKA TABLE TALK

MARCH 1989
VOL. 1, NUMBER 5

MONTHLY NEWSLETTER (EXCEPT DECEMBER)
FOR LOCAL NEGOTIATORS, LOCAL PRESIDENTS
AND OTHER INTERESTED MEMBERS

HERE ARE THE LATEST HEALTH INSURANCE COMPARISONS:

In February NEA-Alaska began a statewide health insurance comparison study. This is a summary of the preliminary responses.

There are 57 Districts. We contacted 55 Districts and have had 50 responses. The cooperation of the Districts has been excellent. Not all of the responses have included all information however, so use the summary for indications of trends and refe. to the study itself for specific information about specific Districts. Request the study from your field staff representative.

Premiums

Monthly premiums for employees only range from a low of $105. 44 to a high of $160.93.

Monthly premiums for family range from a low of $156.12 to a high of $473.02.

Monthly "composite" premiums - one cost per employee regardless of marital or family status - range from a low of $203.20 to a high of $417.85.

Amount of Premium Paid By District

The standard in Alaska is 100% premium paid by the employer. Four Districts pay 90% of the premium. One District pays 80%.

Deductibles

15 Districts have $50/$150 for ind/fam deductible
1 has $50. for each person covered.
1 has $50/$200.
26 Districts have $100/$300
2 have $100/$100
1 has $150/150
1 has $200/$600

Co-Insurance

11 pay 80%
27 pay 90%
We have some info on caps on co-insurance but it is not yet complete.

Lifetime Maximums on Major Medical

20 Districts have a $250,000 maximum.
9 Districts have a $500,000 maximum.
15 Districts have a $1,000,000 maximum.

Primary/Secondary Coverage

Most Districts provide coordination of benefits if two spouses work for the District. Thirteen Districts do not provide primary/secondary coverage.

Alcoholism and Drug Abuse Benefit

13 Districts provide a benefit less than that now set by AK Statu atute may not dictate under certain conditions. The statutory minimum is $7,000 over 2 years/Lifetime max of $14,000 - No special requirements added over and above requirements for other medical conditions.

Dental

3 Districts provide Orthodontia.
5 Districts provide less than 80% coverage for class B routine care.
8 Districts provide more than $1,000 coverage annually.

Vision

8 Districts have an eye exam benefit that is less than 90% of one exam per year.

Audio

6 Districts do not have audio coverage.

STATE OF ALASKA

HEALTH CARE COST CONTAINMENT TASK FORCE

CONSULTANTS REPORT

JANUARY 4, 1990

JUNEAU, ALASKA

Jeffrey A. Malek
Area Assistant Vice President
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SECTION I

CONTINUED DISCUSSION REGARDING

POOLING CONCEPTS

I. CONTINUED DISCUSSION REGARDING POOLING CONCEPTS

Several states have enacted pooling legislation for a variety of reasons. Two case summaries, one for Hawaii and the other for Utah are presented below to gain an understanding as to how and why other states have exercised pooling for their benefit plans. Hawaii and Utah were chosen for this initial study because they both have been utilizing pooling for a number of years, Utah for 13 years and Hawaii for 28 years). We recommend that you accept the invitations from Hawaii and Utah to personally experience the benefits of pooling.

Utah Public Employee Health Plan

The State of Utah's Public Employee Health Plan was established in 1977 by the state legislature to help reduce and control health care costs. The plan provides coverage to over 70,000 (23,000 primary insureds) state, county, city, and school district employees, retirees and their dependents. All public entities must participate in the plan. The fund is governed by legislation, directed by a board of trustees and a full time director. It requires 35 state employees to run the required operation.

Currently, the fund offers one plan design to all entities with separate rating based on each entities experience. The fund provides Dual Choice Medical and Dental, Two - H.M.O.'s, Life and Long-Term Disability coverage. The coverages are self-funded with in-house administration and claim payors. Substantial savings have been realized by creating a buying group that is cohesive and proactive in cost containment and non-payment. One problem that has surfaced is that the fund has been setting rates 18 20 months in the future, and medical inflation has required increases in contributions earlier than originally anticipated.

The Utah Public Employee Fund has extended an invitation to the Task Force an on site look at their operation and answer any further questions you may have regarding their "pooling" experience.

Hawaii Public Employees Health Fund

The Hawaii Public Employee Health Fund was established in 1962 under Chapter 87 (revised) as a method to purchase and distribute employee benefit coverage for over 110,000 (65,000 primary insureds) state, county, city and school employees, retirees and their dependents. All public entities must participate in the fund.

The fund started in 1962 with the base benefit plan and added, dependent care in 1966, group life in 1968 and Dental, Vision (V.S.P.) and Prescription Drug plans effective January 1, 1990.

Currently, the fund offers a indemnity medical plan with Blue Cross, utilizing minimum Premium Funding, three - H.M.O.'s (Kaiser, Community Health Plan, Island Care Plan). Dental, Vision, Prescription Drug and Life Insurance are currently fully insured with the option of utilizing alternate funding methods. All plans are free standing and have separate rating and experience.

The fund currently negotiates with carriers on a two year rate guarantee basis that coincides with the labor agreements. All contracts are negotiated with the negotiating committee which usually occurs every two years.

Hawaii Public Employees Health Fund does not presently employ cost containment methods (ie: pre-certification and utilization review) or a preferred provider organization. Hawaii is currently experiencing medical inflation 4% to 5% lower than the mainland. The plan design includes higher deductibles and co-payments and the employees pay 40% of the medical premium.

Legislation governs the operations and power of the fund which is directed by a board of trustees and has of full-time director with a staff of eight. Hawaii utilizes the fund to purchase and distribute benefit coverages using outside vendors, however, they could self-fund and/or self-administrator the program.

The fund is currently investigating the ability to add Long-Term Care to the benefit package for their covered employees.

The Hawaii Public Employee Health Fund has offered to assist the Task Force in understanding the operation of their fund, and have extended an invitation to the Task Force to send a delegation to Hawaii for further on site discussions.

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

POUCH V STATE CAPITOL
JUNEAU ALASKA 998
907 465 3

MEMORANDUM February 12, 1990

SUBJECT: Group health insurance - CSSB 254( )

TO: Senator Jim Duncan

FROM: Michael F. Ford MFF
Legislative Counsel

The attached draft raises a constitutional issue you should consider. Under Sec. 21.77.020(a), members of the legislative and judicial branches of state government will serve on the board of the Alaska State Group Health Insurance Authority. Having legislative and judicial members on the board of an executive agency may violate the separation of powers doctrine. This doctrine requires that government powers not be blended, unless there is an express constitutional provision allowing the mixture. See Bradner v. Hammond, 553 P.2d 1 (Alaska 1976). If you believe you must have legislative and judicial representatives on the board, the separation of powers issue would be minimized if the legislative and judicial members were not voting board members, but were members who only acted in an advisory capacity.

Please contact me if you have further questions.

MFF:pl
WKP2/031

Enclosure

ESTIMATED POPULATIONS OF ALASKANS WHOSE HEALTH CARE COSTS ARE DIRECTLY, INDIRECTLY, OR PARTIALLY PROVIDED FOR BY THE STATE

Employee/Retiree	Dependents	Totals
1. State Active Employees		
13,000	17,500	30,500
2. Retirees (State, Muni, School)(PERS & TRS).		
10,500	9,800	
Up to 60% reside in state		
6,300	5,900	12,200
3 Local Govt. Active Employees (PERS)		
13,600	18,400	32,000
$. Teacher Actives (TRS)		
8,200	11,000	19,200
Medicaid/Medicare Eligibles. Div. Of Medical Assistence		
41,000		41,000
		(134,900)

a) Some of the people appearing in item 2 will be counted in item 5.

b) Estimates of dependents in items 3 and 4 assume that the groups exhibit the same age and sex characteristics as in group 1

ARTHUR J. GALLAGHER & CO.

CONSULTANTS' REPORT

TO THE

STATE OF ALASKA

HEALTH CARE COST CONTAINMENT TASK FORCE

JUNEAU, ALASKA

JANUARY 29, 1990

Jeffrey A. Malek
Area Assistant Vice President
Arthur J. Gallagher & Company
160 Spear Street, Suite #1100
San Francisco, California 94105
1 (800) 546-9300, Ext. #427

SECTION IV

POOLING

POOLING FINDINGS UPDATE

There are several items discussed at the last Task Force meeting that we would like to clarify.

Hawaii Premium Rates

For fiscal year 1990, Hawaii's monthly premium rate for Medical, Vision, Prescription Drug and Dental are:

Single Coverage - State pays $ 52.88; Employee pays $ 35.28 = $ 88.16

Family Coverage - State pays $154.02; Employee pays $102.70 = $256.72

There was a misunderstanding on how Hawaii calculates the composite rate, creating the confusion on the $500.00 monthly rate.

Hawaii's health benefit agreements with Labor.

Approximately 90% of the 65,000 active participants in the Hawaii pool are covered by labor agreements. Hawaii's pool provides standard level of benefits for all participants and sets the premium rate. In labor negotiations, the units negotiate for the contribution provided by the State. The difference is (if any) paid by the employee. Hawaii also operates with a "me too" clause with its labor group resulting in similar state/employee contributions for all groups.

At the last Task Force meeting, it was requested additional information on pooling specifically, advantages, savings and long-term effect on health care cost containment. Included in this report is a closer look at the savings realized by UTAH's Public Employee Health Plan (PEHP).

Utah Public Employee Plan (PEHP)

The State of Utah's Public Employee Plan (PEHP) was established in 1977 by the state legislature to help reduce and control health care costs. The plan provides coverage to over 70,000 (23,000 primary insureds) state, county, city, and school district employees, retirees and

their dependents. All public entities must participate in the plan. The fund is governed by legislation, directed by a board of trustees and a full-time director. It requires 35 state employees to run the plan's operation.

Currently, the fund offers one plan design to all entities with separate rating based on each entities experience. The fund provides Dual Choice Medical and Dental, Two - H.M.O.'s, Life and Long-Term Disability coverage. The coverages are self-funded with in-house administration and claim payors.

PEHP has realized savings in three main areas. Lower cost of administration, negotiated provider payment, utilization standards and plan design including wellness programs. These findings are verified by UTAH's Legislation Auditor General's report dated February 2, 1989. (Included in attachment.)

ADMINISTRATIVE COSTS

UTAH's PEHP compared favorably in the audit report with five self-insured carrier administrative rates. The average was 6.8% compared to PEHP at 3.5%. Aetna, currently, charges the State of Alaska 6.5% to process claims totalling $5,656,424 for the 1989 plan year. If Alaska could effect similar savings in administrative costs, the savings would be $2.5 million per year, just for active and retiree plans.

Comparison of Administrative Cost Between Self-Insured Carriers for Health Care Source UTAH Legislative Audit Report

Carrier	Administration Costs As A Percent of Total Costs
Company A	6.3*
Company B	7.0
Company D	6.4*
Company E	9.3
Company F	5.1
Simple Average	6.8
Alaska (Aetna)	6.5
PEHP	3.5

*These companies also administer a 401(K) plan to employees as well as other programs.

Negotiated provider payment and utilization standards

PEHP has been able to reduce health care costs through negotiated discounts in preferred provider arrangements. In the comparison of PEHP's reimbursement of Seven Common procedure reimbursements (Page 3, Table I, Utah Legislative Audit Report) the savings ranged from 6% - 8% from usual carrier reimbursements. Claims payors (carriers) in Utah use a "Med Index" to ascertain usual and reasonable rates. In a comparison of Ten Common health care procedures (see Utah Legislation Audit Report, Page 4, PEHP, Table II), PEHP was reimbursing providers at a lower rate than the med index resulting in savings of 11% to 25%.

These similar savings could be achieved in Alaska's plan by using combination of preferred providers, revised usual, reasonable and customary (UCR) and provider payment schedules. In the 1989 plan year, $80,318,125 was paid for claims if savings similar to Utah's experience are realized, the State of Alaska would save between $6.4 million and $20.0 million per plan year.

Plan Design and Wellness Programs

PEHP has implemented plan design charges to incorporate cost containment and wellness plans.

Cost containment provisions that have been implemented include:

- Second Surgical Opinion
- Utilization Review
- Pre-Certification
- Managed Mental Health and Substance Abuse
- Alternate Care Settings (Home Health)
- Pharmacy P.P.O.
- Outpatient Surgery
- Preferred Provider Network
- Flex Plan (See Attachment)
- Three Phase Wellness Plan (See Attachment)

That Includes:

- Screening
- Education and Assistance
- One-On-One Guidance, If Necessary

These several plan designs, cost containment and funding arrangements have demonstrated reduced plan inflation. The Table below illustrates that PEHP has been able to hold costs at about the overall medical CPI level (6.7%) versus Alaska's plan increasing at 19.98%.

Comparison of Rate Increases For Family Premiums By Other Western States

State	Annual Premium Growth Rate For Last Five Years	Estimated Increased FY'90
Arizona	17.2%	N/A
Colorado	6.4	N/A
Idaho	4.0	30%
Montana	5.5	26
Nevada	4.6	15
New Mexico - Plan A	23.8	30
New Mexico - Plan B	9.6	30
Wyoming	6.7	52
Average	9.7	31
Alaska (Aetna 3 years)	19.98	0 (Revised)
Utah	6.6	23-31*
Medical CPI	6.7	N/A

*PEHP is requesting a 21% increase and a one-time appropriation of $2.4 million to rebuild its reserves. To fund the $2.4 million appropriation over time could increase premiums from 2% to 10%. PEHP also will reduce benefits by 10%.

Source: Utah Legislation Audit Report

Additionally, PEHP has been able to hold premium increases at 6.6% versus the insurance carriers average in Utah of 12.2% over the last 5 years.

Currently, PEHP is requesting a supplemental appropriation in funding for the plan from $308.00 to $325.00 to cover short funding in the last session and rebuild reserves.

In previous good years when a surplus was generated, it was returned to the Utah State general fund.

Conclusion

By utilizing a pooling concept for Alaska's health plans, the following savings could be generated for the Active and Retiree Plan. Savings could be significantly greater by including total health care paid for by the state programs.

Estimated Savings:

Administration	$ 2.0 - $3.0 million
Provider Arrangements	6.4 - $20.0 million
Slowing Premium Increase	T.B.D.
Recognize Trends/Adjust	2.0 - $10.0 million
Total Estimated Savings for active and retiree plans	$10.4 - $33.0 million

2.4.

STATE OF UTAH
Office of the Legislative Auditor General

412 State Capitol • Salt Lake City, Utah 84114 • (801) 538-1033

WAYNE L. WELSH, CPA
AUDITOR GENERAL

February 2, 1989
ILR-89-D

Senator K. S. Cornaby
Representative Rob W. Bishop
Members of the Interim Retirement Committee

Subject: Public Employees' Health Plan

Dear Legislators:

This report has been provided to give the Legislature some additional background information on rising public employee health insurance costs. The review is limited in its scope since many factors are affecting health care costs and were not explored in detail. It is also difficult to directly compare each health care provider because of the great variety among the programs. For example, several companies have started health maintenance or preferred provider organizations but each organization is set up differently in an attempt to control costs or make a profit. Finally, several areas were not completely examined due to the time constraints of providing this report to the Legislature. However, even with this limited review, we hope the information in this report will be helpful to the Legislature.

Three main areas are briefly presented: 1) a comparison of Public Employees' Health Plan (PEHP) customary and reasonable reimbursement rates with five local insurance companies and the Utah Med-Index, 2) a comparison of PEHP premium increases with increases in seven intermountain states and five local insurance companies, and 3) a comparison of PEHP administrative costs to five local health care providers with self-insurance programs. PEHP appears to be slightly below average for customary and reasonable reimbursement rates compared to five other insurance carriers and below the

50th percentile of the Med-Index for Utah's market. PEHP premium increases appear to be slightly lower than other groups over the past five years and the current request appears justified. PEHP administrative costs are low compared to other self-insurance groups. This report does not discuss policy issues nor draw any solid conclusions but tries to provide some comparative data.

Customary and Reasonable Reimbursement Rates

PEHP reimbursement rates for seven selected medical procedures are in the middle range when compared to rates of five local insurance companies. The reimbursement rates are negotiated or accepted by insurance companies with health care providers for standard medical procedures. Insurance companies establish these rates to help control costs and to speed up reimbursements to health care providers. The rate is set as a maximum reimbursement for each procedure so each claim paid will not exceed this amount. Since rates are renegotiated or estimated from health care costs, the rates are constantly changing. Our review was only limited to current rates paid and did not examine historical trends. For example, the carrier at the high end for reimbursement rates may or may not have been at the high end four or five years ago. Also, one company may have recently established new rates while another company is using older rates accounting for some disparity between rates.

Our review looked at established reimbursement rates for seven high frequency and high dollar volume medical practices based on claims filed with Public Employees Health Plan (PEHP). We compared the total allowed cost of the seven procedures under traditional and preferred care with five other insurance companies. Table I shows how PEHP rates compare to other insurance groups operating in the state.

TABLE I

Comparison of Customary and Reasonable Reimbursements
For Seven Common Procedures For Health Care
(For Detail See Attachment A)

Company	Allowed Costs For Seven Procedures Under A Traditional Program	Allowed Costs For Seven Procedures Under A Preferred Program
Company A*	$6,940	$5,925
Company B**	5,560	5,560
Company C	7,903	7,903
Company D	6,451	6,451
Company E***	6,888	N/A
Average (A-E)	6,749	6,460
PEHP	6,384	5,965

* This company has a preferred provider network.
** This company common reimbursement rate was used although it does operate some health maintenance groups to try to keep costs lower.
*** This company uses a combination of health maintenance organization and preferred providers.

As Table I shows, PEHP traditional rates are lower than four of the five companies. Attachment A includes a more detailed chart of the procedures and the various reimbursement levels. Company B is able to maintain lower rates than the other companies because of its relative strength in the market place and has a broad base of health care providers. PEHP preferred rates are higher than three of the five companies. The rates are also higher than the one company (Company A) which uses some type of preferred provider network. It is difficult to directly compare Company E's preferred rates since it will reimburse at the set rate but will also reimburse additional funds later as an incentive to control utilization. Thus, the rates for Company E were not available to compare with the PEHP's preferred plan.

PEHP tries to reduce overall claims by using a global fee schedule which may include other procedures which other companies would pay separately. For example, PEHP's global fee for a normal child delivery would include any ultra-sound examination during pregnancy where another company may be billed separately for the ultra-sound usage. Thus, it is difficult to say conclusively which company has negotiated the best rates. Also, the majority of

PEHP claims are paid at the preferred rate rather than the higher traditional rate. Although PEHP's largest membership is in the traditional program, many traditional members use PEHP's preferred provider network. These claims are reimbursed at the preferred rate rather than the traditional rate which lowers the claims costs to PEHP.

Several insurance companies use what is called the Med-Index in establishing customary and reasonable rates. The Med-Index for Utah is a based on billings submitted for each medical procedure and is issued twice yearly. We sampled PEHP's various reimbursement codes to determine ten frequently reimbursed procedures incurring large dollar claims at PEHP. Table II shows PEHP's fees for these ten procedures compared to the Med-Index's fall of 1988, 50th and 80th percentiles for health care costs in Utah.

TABLE II

Comparison of Customary and Reasonable Reimbursements
For Ten Common Procedures For Health Care

Procedure	PEHP Traditional	PEHP Preferred	Med. Index 50 Percentile	Med. Index 80 Percentile
Procedure A	$1,008	$ 950	$1,160	$1,181
Procedure B	1,204	1,150	1,400	1,600
Procedure C	938	905	1,098	1,271
Procedure D	1,064	1,008	1,277	1,427
Procedure E	1,190	1,065	1,260	1,385
Procedure F	700	627	664	717
Procedure G	280	259	275	322
Procedure H	28	22	25	30
Procedure I	9	8	10	12
Procedure J	47	42	52	58
Totals	6,468	6,036	7,221	8,003

The PEHP traditional and preferred rates do compare favorably with the 50th percentile of the Med-Index for Utah's market. The total cost of the ten procedures for PEHP traditional program was $6,468 or approximately 12 percent lower than the $7,221 for the 50 percentile of the Med-Index. PEHP preferred program total cost was $6,036 or approximately 20 percent lower than the 50th percentile. PEHP tries to maintain its rates slightly below the 50th percentile. The index serves as a indicator of what range health care providers bill for each procedure. Two of the five companies we surveyed use the Med-Index to set their maximum reimbursement rates.

Premium Increases

Our review showed that PEHP's rate increases are within the range experienced in the health insurance industry. Our review consisted of two tests on premium increases. First, we compared PEHP's increases over the past five years and requested increase for fiscal 1990 with some western states plans for state employees. Second, we compared PEHP's increase with other insurance companies within the state. In both cases, it appears PEHP's requests for rate increases are consistent with the industry trend. PEHP's request may also be influenced by some additional factors which should be considered by the Legislature.

Although a review of premium increases was completed, the review is only one half of the picture. Cost of premiums depends on benefits offered and how benefits can be modified. For example, changing a benefit package can reduce the increase in premium rates from year to year. In the short time we were given it was not possible to determine how much benefit changes affected premium increases in other states or in Utah insurance companies. Table III shows how PEHP's premium increases compare to other western states.

TABLE III

Comparison of Rate Increases For Family Premiums By Other Western States

State	Annual Premium Growth Rate For Last Five Years	Estimated Increase FY-90
Arizona	17.2%	N/A
Colorado	6.4	N/A
Idaho	4.0	30%
Montana	5.5	26
Nevada	4.6	15
New Mexico-Plan A	23.8	30
New Mexico-Plan B	9.6	30
Wyoming	6.7	52
Average	9.7	31
Utah	6.6	21-31[a]

[a] PEHP is requesting a 21 percent increase and a one time appropriation of $2.4 million to rebuild its reserves. To fund the $2.4 million appropriation over time could increase premiums from 2 to 10 percent. PEHP also will reduce benefits by 10 percent.

Table III shows Utah's premium increases have been lower on average than the western states we surveyed. PEHP's requested premium increase, when the benefit reduction is excluded, is close to 31% or the average premium increase being projected by other western states in Table III.

Additionally, we compared selected Utah insurance companies against PEHP's rate experience. Table IV shows premium increases within Utah.

TABLE IV

Comparison of Rate Increases by Carriers Located in Utah

Company	Annual Premium Growth Rate For The Past Five Years	Estimated Increase FY 90	Benefits Modified
Company A	7.5%	N/A	Yes
Company B	24.7	15-40%	No
Company C	9.7	15	No
Company D	10.1	21	Yes
Company E	8.8	N/A	Yes
Average	12.2	21	
PEHP	6.6	21*	Yes
Medical CPI	6.7	N/A	

* This figure does not include the one time appropriation requested and the decrease in benefits.

Several companies have recently experienced significant increases making the average higher when compared to PEHP. However, the data show PEHP's premium increase experience is similar to the premium increases being experienced in the local market. For example, one major Utah insurance company informed us that the average premium increase over the past few months for the companies it insures has been increasing approximately 30 to 31 percent without changes in benefits. Most insured groups are modifying the benefit package to keep the 30 to 31 percent increase down in the 20 to 21 percent range.

Company B reported the highest growth even though it reports a low reimbursement rate schedule shown on Table I and in the Appendix. This would suggest that other factors than just a low reimbursement rate will impact increases in premium rates. It appears that low reimbursement rates may result in additional utilization increasing the amount of claims paid by an insurance company.

Company B reported the highest premium rate increases even though it reports the lowest reimbursement rate schedule shown on Table I and in the Appendix. This would suggest that other factors than just a low reimbursement rate will impact increases in premium rates. It appears that low reimbursement rates may result in additional utilization or more expensive procedure codes billed, increasing the amount of claims paid by an insurance company rather than lowering costs. A company B official said the company experienced higher utilization than expected resulting in the need to increase premiums.

Several factors have contributed to the large rate increases. Utilization of health care services, technology advancements, medical inflation, and the growth in psychiatric hospitals have all been cited as causes for Utah's increasing health costs. Also, most of the literature and professionals in the field said the growth in health care costs may continue for a few more years.

PEHP has two major factors to consider when comparing premium costs. First, it is the only self-administered and self-insured program among the western states. Some of the other western states are self-insured but are administered through an established insurance company. Self-insurance supposedly lowers premium costs since the group accepts the risk of controlling utilization and claim expenses.

Second, PEHP has experienced past losses due mainly to claim expenses exceeding premiums collected. PEHP, along with several other companies, needs to rebuild reserves which were lost during the past two years. The Legislatures decision will determine the length of time PEHP is given to rebuild reserves and will directly impact the level of the premium increase required this year.

Administrative Costs

PEHP administrative costs are low when compared to other self-insured plans. Our review only focused on administrative costs associated with other self-insured programs. Although we focused on just self-insured programs, the other programs have wide variations in the types of programs they administer. Thus, it is difficult to directly compare administrative costs. A more detailed analysis of costs is needed to determine why PEHP administrative costs are low compared to other companies. Table V compares the administrative costs as reported by various companies.

TABLE V

Comparison of Administrative Costs Between
Self Insured Carriers For Health Care

Carrier	Administrative Costs as a Percent of Total Costs
Company A	6.3*
Company B	7.0
Company D	6.4*
Company E	9.3
Company F	5.1
Simple Average	6.8
PEHP	3.5

* These companies also administer a 401K plan to employees as well as other programs.

PEHP average is below the reported administrative cost of all the other companies with self-insurance programs. Actuaries in the field of health care indicate any administrative cost below six percent is considered very good in the self-insurance area. However, we did not determine if additional administrative costs would result in overall savings to PEHP in claims paid. For example, additional staff to conduct more pre-and post-audits could potentially reduce claims but would increase administrative costs. This type of study would take several months to complete accurately and might not be conclusive even then.

We hope this letter provides you with the information you need on these issues. If you have any questions or need additional information, please let us know.

Sincerely,

Wayne L. Welsh
Auditor General

WLW:CF/syg

ATTACHMENT A

TABLE VI

Comparison of Customary and Reasonable Reimbursements
For Ten Common Procedures For Health Care

Procedure	PEHP Traditional	Average (A-E)	Company A	Company B	Company C	Company D	Company E
Proc. A	$1,008	$1,001	$1,125	$ 800	$1,181	$ 950	$ 950
Proc. B	1,204	1,340	1,500	1,000	1,600	1,300	1,300
Proc. C	938	1,075	938	890	1,271	1,075	1,200
Proc. D	1,064	1,212	1,207	990	1,427	1,188	1,250
Proc. E	1,190	1,170	1,190	1,020	1,385	1,063	1,190
Proc. F	700	668	700	600	717	625	700
Proc. G	280	282	280	260	322	250	298
Proc. H	28	24	N/A	20	30	22	23
Proc. I	9	9	N/A	7	12	8	8
Proc. J	47	46	N/A	45	58	N/A	35

Table VII

Comparison of Customary and Reasonable Reimbursements
For Ten Common Procedures For Health Care

Procedure	PEHP Preferred	Average (A-E)	Company A	Company B	Company C	Company D	Company E
Proc. A	$ 950	$ 967	$ 956	$ 800	$1,181	$ 950	$ 950
Proc. B	1,150	1,295	1,275	1,000	1,600	1,300	1,300
Proc. C	905	1,009	800	890	1,271	1,075	N/A
Proc. D	1,008	1,160	1,034	990	1,427	1,188	N/A
Proc. E	1,085	1,122	1,020	1,020	1,385	1,063	N/A
Proc. F	590	636	600	600	717	625	N/A
Proc. G	255	268	240	260	322	250	N/A
Proc. H	22	23	19	20	30	22	23
Proc. I	8	8	6	7	12	8	8
Proc. J	42	43	32	45	58	N/A	35

RESPONSE TO AUDIT

REIMBURSEMENT RATES

Although the comparison shows that both Traditional and Preferred Care have negotiated good reimbursement rates for physicians, analysis shows that the reimbursement rate for the Preferred Care's global fee includes many diagnostic fees that are normally billed as separate procedures to other carriers.

An important consideration is the facility charges in conjunction with surgical procedures. Preferred Care has *profiled physicians* and selected them based on quality issues and how well they have utilized the system in the past. A recent analysis of many procedures shows that this system is working well. For example, when comparing our Preferred providers with non-Preferred providers for caesarean section, the average facility charge for our Preferred providers was $386 less. Our Traditional Care program restricts the length of stay for in-patient hospitalization for many high volume procedures. For example, an uncomplicated hysterectomy is limited to three days for females less than 50 years of age. It is not uncommon for our Preferred physicians to limit the in-patient stay to two days. Total charges for hysterectomies for our Preferred providers are over $1000 less than non-Preferred providers.

PREMIUM INCREASES

Although the Public Employees Health Program compares favorably with both private carriers in Utah and other Western states, there are other factors that are important to recognize. In the past, the Public Employees Health Program has made lump sum payments to the State general fund from surplus generated; therefore, adjustments would be necessary for past premium increases. Refund adjustments would show lower past premium increases.

At the present time, there are 1,186 early retirees in the Traditional Care system. Because they are included in the risk pool with active employees, there is a subsidy from active employees. This group's experience has contributed to the size of the premium increase being requested.

ADMINISTRATIVE COSTS

Although the Public Employees Health Program compares very favorably with other self-insured carriers, and even more favorably with indemnity carriers, the year that was used for the comparison includes many one time start up expenditures.

These resulted when Salt Lake County, Salt Lake City and all Utah Local Governments Trust groups joined the system. Examples of one time expenditures included in the costs presented are a new computer system, office furniture, equipment, and supplies for 20 new employees.

SECTION C

REVIEW OF POOLING

PART ONE

OVERVIEW OF THE POOLING CONCEPTS

PART ONE

OVERVIEW OF POOLING CONCEPTS

Pooling enables entity(ies) to employ a mechanism that provides benefits (or coverages) that may not be available, are too costly, and/or helps to contain overall costs of the program. Generally, legislation is enacted (see Section C Part 2 for a Review of SB254) to create an entity that provides the coverages needed, and oversees the operations of those coverages effectively and cost efficiently.

Many states have enacted pooling legislation either for their employees/retirees uninsurable/uninsureds coverages. States that have enacted legislation include:

Connecticut	Maine	Oregon
Florida	Minnesota	Tennessee
Hawaii	Montana	Utah
Illinois	Nebraska	Washington
Indiana	New Mexico	Wisconsin
Iowa	North Dakota	

A pool provides many benefits not currently available under the arrangement utilized in Alaska, whereby each subgroup may have a separate plan(s).

Some of the advantages of pooling:

- **Economy of scale**

  Eliminate duplicate or multiple plan costs

- **Provide for plan Flexibility/Plan Rates**

  Each sub-group could have a different plan design and rates

- **Premium rates based upon sub-group experience**

  Sub-group pays their proportioned share of expenses

- **Data collection**

  Allows an easy system for tracking trends, abnormalities or impacts on health care expenditures, instead of having to get information from many different (possibly inaccurate) sources.

- **Projection futures costs/trends**

  The data base that would be available would be invaluable in projecting future costs/trends as you could identify changes immediately.

- **Predict/act on cost shifting**

  Effectively you could determine when there was any potential of actual cost shifting.

- **Could still utilize third party vendors for service**

  This would retain the integrity and cost economies that are necessary in these types of programs.

CONCLUSIONS

By utilizing the pooling concept you would have the best of all worlds, including centralized information, substantial savings, predict future cost/trends and probably improve service to all parties involved. Other states have investigated and implemented pooling for these very reasons. Now is the time for Alaska to be able to benefit from pooling also.

SECTION C

REVIEW OF POOLING

PART TWO

REVIEW OF SB254

AN ACT RELATING TO GROUP HEALTH INSURANCE

PART TWO

REVIEW OF SB254

"AN ACT RELATING TO GROUP HEALTH INSURANCE"

Following this section is a copy of the bill (SB254) and two sections.

The bill in its submitted version would create the Alaska State Group Health Insurance Authority to provide group health insurance benefits to all state employees, including: retired, municipal, and school district employees on a cost effective basis. The bill would give the authority the power to arrange for health coverage on the most economical basis while "spreading" the risk over a larger base of enrollment, affording the most favorable payment schedules to providers and vendors for the state.

COMMENTS ON SB254

- The Authority should have the option to be expanded to include Workmens' Compensation, Health and Social Services, medical coverages and payments, and uninsurable/uninsured benefits as sub-groups of the pool (Sec. 21.77.010).

- Revise bill to remove requirement to be licensed as an insurer under AS21, remove the Authority from title 21 (see 21.77.030.).

- Revise purchase of insurance requirement to remove clause "that it has to be sent to all licensed insurers - (at least every 5 years)" rather to use an RFP notification process where by qualified bidders are maintained on a list or by request (section 21.77.050.).

- Required participation may be revised to clarify/simplify the requirements to evaluate whether or not a sub-group has an eligible waiver, while not undermining the necessity of as many eligible groups feasible to participate. (See 21.77.080.)

- Pool should have the ability to ~~access~~ assess members and or issue bonds to fund benefits or establish adequate reserves. (See 21.77.070.)

SECTION C

REVIEW OF POOLING

PART THREE

FEASIBILITY OF POOLING IN ALASKA

PART THREE

FEASIBILITY OF POOLING HEALTH CARE IN ALASKA

As a long term cost management strategy of health care costs, pooling provides the best vehicle, this has been proven by Hawaii, Utah, New Mexico, California (schools) and others.

Pooling has proven effective in areas outside of just health coverages, one example is the Alaska Municipal Leagues - Joint Insurance Association (AML-JIA) that is providing property, workers' compensation and liability coverage that previously was unavailable or not available at a reasonable cost.

There are a number of hurdles to be crossed in getting any pool in place and effective Alaska will be no exception to these.

- **Passage of Bill**

  The bill must gain support from legislature, administration, judicial, municipalities and participants in order to pass. This can only be accomplished through an effective communication campaign.

- **Challenges of Authority**

  In the past these bills have received some challenges (legal) after being enacted. However, the bill in its current form has been proven to be effective in answering these challenges.

- **Set up and operation of Authority**

  The success of the Authority will be measured by the effectiveness of its membership and participants. The Authority will have to rely on the expertise not only within, but also outside consultants, actuaries, administrators and providers. Only as a complete partnership will it be a successful venture.

It is our estimate that following the initial set up costs and associated fixed costs, the state could realize the following savings (as a percent of total health care expenditures outside of the pool):

1 - 3%	Simplification of Administration
13 - 40%	Provider payment schedules/agreements
5 - 7%	Recognize trends adjust quickly
1 - 3%	General economics of scale savings (misc.)
22 - 53%	Total savings estimate: up to 50-100+ million dollars.

This does not include the sentinel effect that would generally slow medical inflation for the state plan.

SECTION C

REVIEW OF POOLING

PART FOUR

SUGGESTED TIME LINE FOR IMPLEMENTATION OF POOLING

PART FOUR

SUGGESTED TIME LINE FOR IMPLEMENTATION OF POOLING

- Passing of SB254 creating "authority"

  "Alaska State Group Health Insurance Authority"

1. First Month
   - Selection of members
   - Organization of Authority/1st meeting
2. Second through Fourth Month
   - Evaluation of services required - (RFP those Services)
   - Selection of certain service providers (actuarial/consulting etc.)
   - Review of current plans and arrangements to be included in pools
   - Provider Payment options evaluation
3. Fifth through Eighth Month
   - Meetings with eligible sub-group participants
   - Develop pro form a benefit and cost analysis (actuarial study)
   - Outline to sub-groups the impact to their group(s)
   - Select provider payment strategy
4. Eighth through Twelfth Month
   - RFP Third party vendors
   - Determine/Evaluate required participation by sub-group or issue warriors
   - Establish final rates/benefit plans for each sub-group
   - Finalize providers payment arrangements
   - Finalize third party vendors arrangements
   - Notify participants

5. **Thirteenth through Sixteenth Month (Ongoing)**

Begin pool operations, i.e., premium collection, claim payments, etc.

- Evaluate pools operations/effectiveness
- Provide communication to sub-group and participants
- Review/settle disputes (claims)
- Analyze experience/trends
- Compare pool results to others "like organizations"
- Measure actual cost savings
- Monitor provider relations/payment schedule
- Advise on state/federal law change impacts

NEW MEXICO'S PUBLIC SCHOOL INSURANCE AUTHORITY

New Mexico schools have found a way to reduce group health insurance premiums while increasing everyone's benefits.

How was this accomplished? Through passage of legislation creating a statewide Insurance Authority to provide insurance for all school districts. The resulting group size and stability created insurance company interest which had never existed before. Also, the greatly increased technical expertise, which is affordable to a large group, meant school districts were no longer at the mercy of insurance companies.

In 1984, after several years of rapidly escalating group insurance premiums, the New Mexico education community made an assessment of its situation and possible solutions. For many years, the NEA-New Mexico had been sponsoring a voluntary group in which about 70 of the state's 88 school districts participated. The largest districts generally did not participate. The group had little stability since many districts would leave the group when their claims experience was good enough to secure a lower premium standing alone and would return to the group when claims experience was poor. Both the NEA group and the districts, which obtained their insurance coverage independently, felt they were at the mercy of insurance companies with insufficient technical expertise to adequately deal with company actuaries and insufficient means to curb rapidly increasing medical costs. The state School Boards Association and a group of superintendents had also spent much of the previous year investigating solutions.

The solutions identified were a joint powers agreement among those districts willing to participate or legislation which would contain some mandates for participation. Representatives of school districts voted on these two options plus a status quo option and overwhelmingly chose the legislative route because of the strength and stability it was hoped that would provide to the group.

Because the state was facing a financial crisis, it was not possible to secure funding to support the Authority during its first year of existence. Funding for subsequent years was handled by using part of the interest earned from premiums held by the

Authority prior to transmittal to insurance carriers under a partial self funding procedure called minimum premium.

Through the Governor's office, the Authority was able to secure the services of a loaned executive, who was the employee benefits manager for a large government contractor. This individual lobbied the bill through the legislature, wrote insurance specifications negotiated with insurance companies and performed general staff responsibilities for the Authority. Each education organization represented on the Authority financed the attendance of its representatives to Authority meetings during the first year. Office expenses were provided by the Office of Education to which the Authority was attached during its first year.

There were seven members on the original Authority board - - three representatives from labor, three from management and the director of the State Office of Education. The labor and management board members represented organizations and were chosen by those organizations to serve on the board. Because the Authority decided to cover retirees and other educational institutions, the board was expanded in the second year to include a representative from the New Mexico Educational Retirees Association and a representative nominated by participating higher education institutions.

The three coverages tackled by the Authority in the first year were health, including a $10,000 life coverage for employee only; dental and vision. Draft specifications were prepared for each and were circulated to all school districts and employee organizations. Written comments were requested and hearings were conducted prior to development of final specifications. These specifications were sent to potential bidders in the form of requests for proposals in order to allow maximum flexibility when negotiating with bid finalists.

Seven major insurance companies submitted bids for the health insurance. This compared to only one bidder that had been interested in the NEA-New Mexico sponsored program the last time it was bid. These companies stated that the reason for their increased interest was the stability of the group which was assured by the legislation.

A waiver system was provided in the legislation in order to allow districts which could secure equal benefits at less cost to opt out of the group. This has been a controversial feature and is included primarily to make the concept salable to the legislature and reluctant school districts. Districts must receive the Authority's permission to opt out. They cannot re-enter the plan for three years and if a district opts out for one coverage, it must petition for any other coverages and its retirees are not eligible for coverage.

The benefit plans which were bid are better than any school district previously had. Despite this, the rates from the successful bidder were sufficiently lower that nearly every school district was able to add vision and dental coverage for no more cost than it had budgeted for health insurance alone.

Once the employee group plans were in place, the Authority was entering its second year and preparing itself to enter the world of risk-related insurance. The first task was to broaden the statute which created the Authority so that property, casualty, liability, and other coverages could be bid. Many other changes to the law were also made to reflect the experience the Authority had undergone during its first year of existence. The waiver procedure was modified and the Albuquerque Public Schools removed from coverage by the statute.

In its second year, the Authority secured an amendment to the original law which removed the administrative attachment to the Office of Education and made the Authority an independent public body. Except for being represented by the Attorney General's Office for purposes of litigation, the Authority purchases all its services from the private sector in accordance with the State Purchasing Act. This has been accomplished through issuing Requests for Proposals which allow for negotiations with those submitting the best proposals. At this time, the Authority has service contracts with two third-party administrators, one for group insurance and one for risk-related insurance; a lease counsel; a secretarial service and a bank.

The Authority has been in court twice. The Albuquerque Public Schools appealed its denial of a health insurance waiver to the Court of Appeals which held that the law, which required school districts to certify that they could obtain equal coverage at lower cost, did not allow the Authority to question the accuracy of the claim. The law was amended in the next legislative session to require proof of the certification and to remove Albuquerque from coverage by the Act. A group of independent insurance agents currently has the Authority in court questioning the validity of the law which created the Authority.

The strength of the Authority comes from the unity of the education community behind the concept and the extreme necessity for some sort of solution to controlling insurance costs and securing insurance coverage in some of the risk areas. Seldom has the education community ever been as united as it has been around this issue.

COST CONTROLS

One of the methods used to control costs was the employment of some cost containment features designed to limit or eliminate hospital

stays. These include second-opinions for elective surgery, 100% payment for out-patient surgery and pre-admission and concurrent review of the length of hospital confinement.

These features have not had the effect of limiting benefits. They, instead, have helped make school employees better health care consumers through a plan which is the state-of-the-art in health insurance at this time. One reason for the selection of the Prudential Insurance Company to handle the Authority's plan was that Prudential was a pioneer in the field of cost containment.

Previous attempts at controlling costs in other plans had involved cost shifting features such as higher deductibles, higher stop losses and lower surgical schedules. These plans merely shifted costs from the insurance company to school employees.

The Authority's insurance plans have also involved alternative funding approaches designed to maximize cash flow and reduce net cost. These have included a minimum premium feature in which the Authority retains the premium collected and allocates it to the insurance company on a weekly basis as it is needed to pay claims. Partial self insurance is being used in the risk related area to reduce net cost. Complete self insurance is the ultimate goal when a sufficiently large cash reserve is accumulated. A method of creating that cash reserve immediately through a borrowing plan called certificates of participation is being investigated. If it can be demonstrated that this will result in net savings to school districts, the plan will be pursued.

BENEFITS

The following are some of the benefits gained from creation of the Authority:

A. What had been a proposed ten to thirty percent group insurance premium increase was not implemented on September 1, 1985, creating a savings of approximately three million six hundred thousand to nine million dollars.

B. Health insurance premiums decreased by four million one hundred thousand dollars, yet overall benefits were improved.

C. Dental insurance premiums decreased by one and one half million dollars, yet overall benefits were improved.

D. An affordable vision care benefit plan was implemented.

E. School districts, which had never been able to afford dental and vision insurance were able to implement programs.

F. School districts which were in danger of losing their property, casualty or liability insurance were able to retain their coverage.

G. Many retired school employees, who had lost their group insurance at retirement, were able to get coverage again.

H. A group was created, which had the size and stability to create insurance company interest which had never existed before.

I. Risk-related insurance premiums which had increased an average of 53% in 1985-86 and which had been projected to increase by an average 27% for the 1986-87 school year were held to no increase and many programs which school districts were going to have to reduce or eliminate in 1986-87 could be reinstated.

ACKNOWLEDGEMENTS

The Legislature, which had been most cooperative while passing the legislation creating the Authority, remained very cooperative during the second year. This is attributed to the show of strength by a united education community and the extraordinary success experienced by the Authority during its first year of operation.

The contribution of the loaned executive must be recognized as the most important factor in the success of the Authority. Undoubtedly, the project would never have gotten off the ground without his determination, expert guidance, firmness and vision.

The contribution of the Office of Education must also be recognized. The original legislation attached the Authority to the Office of Education for purposes of administrative support. All secretarial and business management services were performed by the Office of Education. In addition, the director of the Office of Education served as President of the Authority since its inception. His background, expertise, resources and the status of his office have helped immeasurably in making this effort a success.

Credit also goes to the Attorney General's Office for representing the Authority in its court battles; to the Legislative Finance Committee and the Legislative Education Study Committee staff for keeping their committees informed and assuring that the committees hear both sides of issues involving the Authority; to the Risk Management Division for its moral support, information and expertise; to Governor Anaya for supporting the Authority in the face of criticism from detractors; to Representative Ben Lujan for carrying our legislation in 1985 and 1986 and to the State Purchasing Office for helping us achieve the greatest possible flexibility in dealing with insurance companies while complying with the Purchasing Act.

The organizations which comprise the Authority Board must also be recognized. These organizations funded all the expenses of their representatives during the first year. These organizations and the school districts by which their representatives are employed have provided much release time for Authority Board members to attend committee and Board meetings.

An added benefit which has resulted from all this cooperative effort has been an increased trust and respect among labor and management organizations. Hopefully, these healthy relationships will lead to future cooperative efforts in other areas.

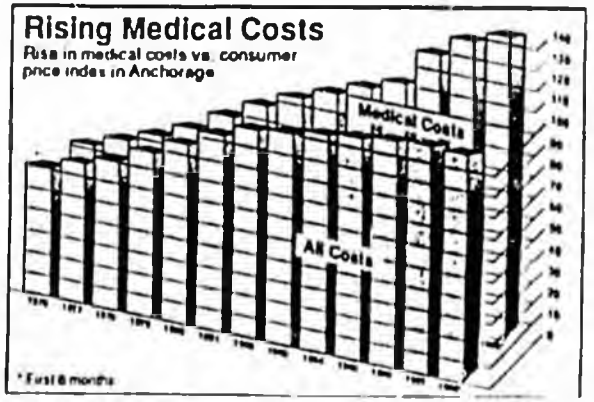
■ **MONEY MARKETS:** Weekly listings / B-4 ■ **MALLWATCH:** Merchants join forces / B-5 ■ **PLASTIC POWER:** Holiday bills / B-6

BUSINESS

SUNDAY
SECTION B Jan. 22, 1989

Health insurance costs rise feverishly

Workers at a loss as employers cut back on benefits

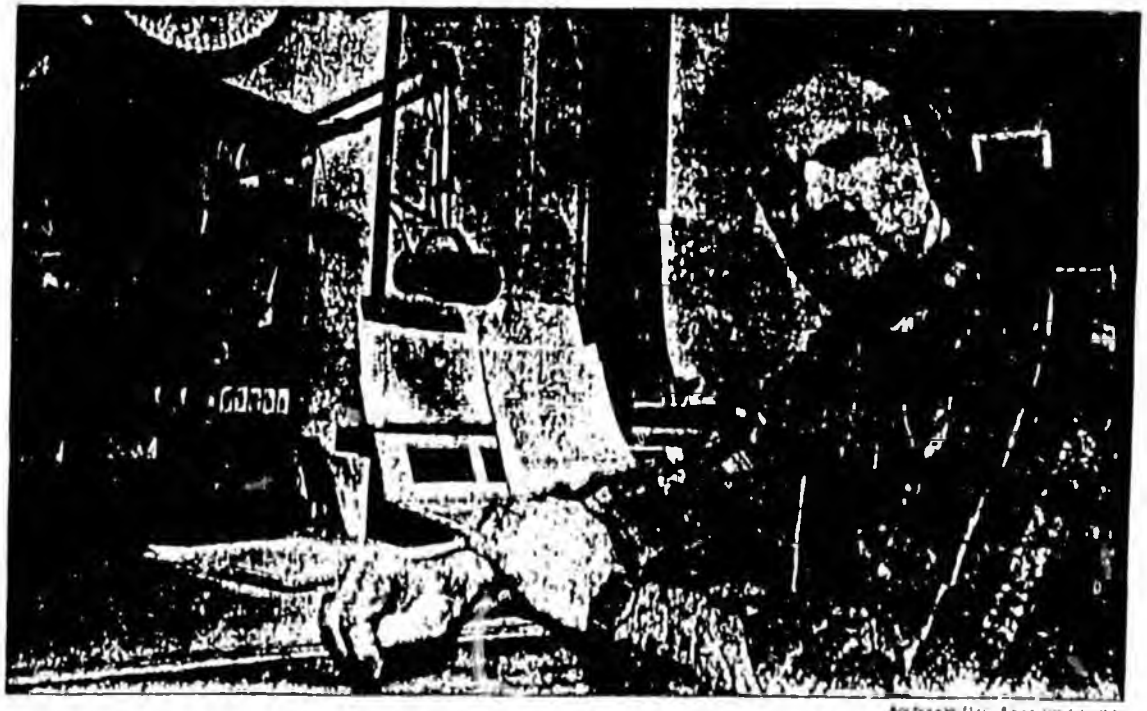


By HAL BERNTON
Daily News reporter

Lester Snow has worked as an Alaska disc jockey for 19 years, and one benefit he always counted on was health insurance. That meant a lot to Snow because his wife, Jennifer, has a serious heart condition that requires medication and close monitoring.

Then last February, Snow got bad news from his employer, Sourdough Broadcasters Inc. Owner Patty Harpel said she couldn't afford the 70 percent price increase demanded by the company's insurer, and couldn't find a cheaper alternative. Group insurance for the station's 15 employees would be dropped.

Snow fell back on a Veterans Administration policy to cover his own ailments but he also needed a family policy for his wife and two teen-age children. He found Jennifer's heart condition drove the cost of that policy out of sight. "My family has nothing," Snow says. "If we have a catastrophic accident or ill



Anchorage Daily News (or Lauren)

Disc jockey Lester Snow was left scrambling when his employer was forced to drop health benefits for employees.

"You just don't get good [illegible] appears to be particularly

100 percent, according to brokers Walt Baldwin, Bill Purrington and Dave Stratton.

Those rate increases have pushed the cost of many Alaska policies far above the national average. For an Alaska Railroad union worker and family, for example, the total cost of annual insurance is $5,845, more than double the national average.

In years past, employers tried to dodge rate increases by changing to another insurer. But this year, the market's tightened and finding another insurer is much harder to do, says Baldwin.

Employee exams often are required before new insurers agree to write the policies, and if they don't like what they find, then they back away or refuse to insure already existing conditions.

The cost of individual policies — a fall back for those whose employers don't offer insurance — also is soaring. Blue Cross of Washington and Alaska, a major state insurer, is seeking an average 70 percent

disc jockey for 19 years, and one benefit he always counted on was health insurance. That meant a lot to Snow because his wife, Jennifer, has a serious heart condition that requires medication and close monitoring.

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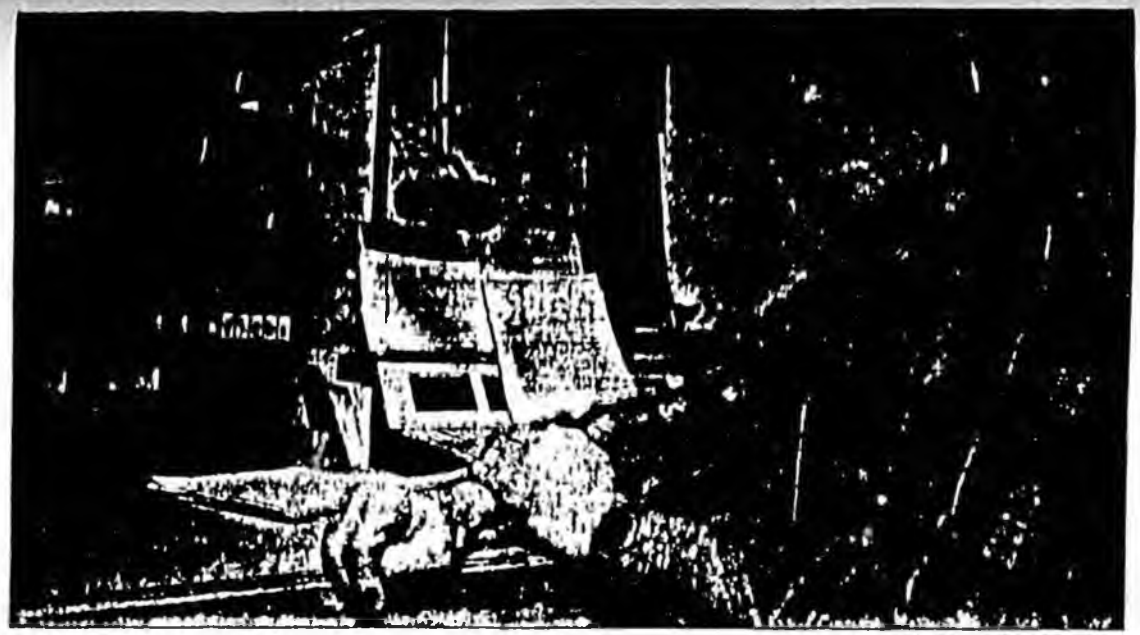
Snow is experiencing the harsh edge of a new Alaska business trend — the slashing of employee health-care benefits.

Throughout the state — and particularly in Anchorage — employers already reeling from several years of recession are being shell-shocked by huge annual increases in the cost of health-care benefits.

They're responding by cutting back on these benefits and forcing employees to share more of the costs, and in some cases dropping such coverage altogether. And they're joining a debate already in progress among insurers, those who offer medical services and state officials about why rates are skyrocketing and just what can be done to control them.

Often hit hardest by increases are small employers already operating on thin profit margins.



Anchorage Daily News/Jim Lavrakas

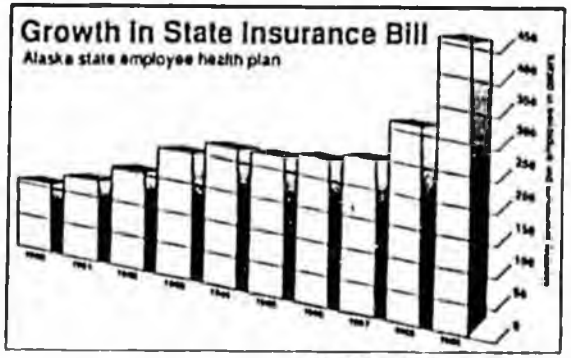
Disc jockey Lester Snow was left scrambling when his employer was forced to drop health benefits for employees.

"You just don't get good rates if you have anyone with medical problems," says Harpel, the station manager. "And you never know how long you will be able to keep a policy before it's canceled and you're out on the big wide ocean looking for another lifesaver."

A state survey estimated that 40,000 working Alaskans and their dependents lack any type of health insurance — either from private or public sources.

The state's shrinking health-care coverage represents a sharp reversal from the boom years of the early '80s, when Alaska employers — both public and private — developed some of the nation's best health benefits to help recruit workers from the Lower 48. Many policies were what insurance agents call "cadillacs," featuring minimal out-of-the pocket expenses for employees.

But many of the "cadillacs" are turning into humble Fords and Chevys, or worse, as employers struggle to cope with the rising insurance costs. That has made health insurance a major issue in state, municipal and private sector union negotiations, and in Juneau, where politicians already have drafted bills to create a new state health insurance corporation.



Anchorage Daily News chart/Tom Kingsbury

"It's a serious problem, and one that we're going to face for the rest of our lives," says Bill Quinn, a union leader who serves on an Alaska Railroad Corp. health insurance committee. "Those of us in the baby boom may not be faced with what kind of health insurance we want when we retire, but whether we'll be able to afford it."

The Alaska health-care inflation parallels a nationwide surge in benefit costs, but premium inflation here appears to be particularly acute.

Three nationwide surveys reported by Business Insurance, The Wall Street Journal and Health Week cited average 1989 increases of 11 to 25 percent for group health plans.

In Alaska, a few companies contacted by the Daily News report they've managed to hold the line on health costs. Alaska Commercial Co., for example, an Anchorage-based merchandising chain employing 450 people, this year reports no increase in its policy premium.

"We manage the benefits very carefully," says Sam Salkin, Alaska Commercial's president. "We have (medical) authorization procedures, second opinions."

But Alaska Commercial is the exception, not the norm.

Three major Alaska insurance brokers indicated average 1989 increases of 30 to 60 percent are the norm.

And some increases top

Those rate increases have pushed the cost of many Alaska policies far above the national average. For an Alaska Railroad union worker and family, for example, the total cost of annual insurance is $5,845, more than double the national average.

In years past, employers tried to dodge rate increases by changing to another insurer. But this year, the market's tightened and finding another insurer is much harder to do, says Baldwin.

Employee exams often are required before new insurers agree to write the policies, and if they don't like what they find, then they back away or refuse to insure already existing conditions.

The cost of individual policies — a fall-back for those whose employers don't offer insurance — also is soaring. Blue Cross of Washington and Alaska, a major state insurer, is seeking an average 70 percent jump in the cost of individual insurance policies.

"The point is not just that it's expensive, but whether it will even be available," said Paul Roller, director of the state Division of Insurance. "People just cannot afford those rates."

The debate over Alaska's rising health costs is often dominated by discord.

Doctors say their Alaska costs are high, because overhead is much higher, and they point the finger at insurance companies.

"I think a lot of the problems, from the physician's perspective, are generated by the insurance companies," says Richard Neubauer, an Anchorage internist. "They set up a lot of obstacles for prompt payment of bills, and maximize the amount of paperwork.

Please see Page B 3, HEALTH

Harvard MBAs take ethics to heart

By PAUL WILKES
The New York Times

BOSTON — At the Harvard Business School earlier this year, a group of students gath-

"I have to agree. This is a business decision, pure and simple. We're paid to make the most profit possible. When you start getting into sociology and all that, you lose sight of what

Office space market closes in on recovery

The latest office space

HEALTH INSURANCE: Employers cut benefits in face of rising costs

Continued from Page B-1

"They set up quality insurance programs, review types of things, and call for justification."

Broker Purrington accuses Blue Cross, a major — and non-profit — Alaska insurer, of predatory pricing — cutting rates when major competition shows up, then jacking them up once that competition's gone. In 1985, for example, Blue Cross cut many of its group rates to help fend off an unsuccessful attempt by Humana Care Plus to grab a piece of the Alaska market.

Stephen Clark, executive vice president of Blue Cross, says the problem doesn't lie with the insurance companies. He says Alaska doctors and hospitals charge much more than in the Lower 48, and their company just passes through the ever-inflating costs. Alaska laboratory tests, for example, averaged 72 percent higher in Alaska than Washington, according to Blue Cross data.

"If we are to contain the excessive costs of health care in Alaska, we've got to work in unison with the physicians, hospitals, employers and individual subscribers," Clark says.

State officials don't keep detailed financial data on all of the more than 30 insurers selling health insurance in Alaska. But they do monitor Blue Cross, due to its special status as a non-profit medical service corporation. And in 1987, the last year in which financial information is available, state records indicate Blue Cross roughly broke even in Alaska, paying out $61 million in claims and administrative costs and taking in the same amount in premiums.

Aetna Life & Casualty, in a report to a state task force, indicated that since 1985, the insurance plan covering state employees lost more than $10 million.

State insurance division officials cite several major national trends forcing up the cost of Alaska health insurance. They include:

- The use of ever-more-costly technology to examine, treat and prolong the life of patients, including victims of AIDS and other terminally ill patients.

"Our society hasn't reached the point yet where we say we can't afford to absorb the cost of a heart transplant for a 60-year-old guy who's been smoking six packs of cigarettes all his life," says Warren Dvorak, benefits manager for the Anchorage School District.

- Increased salaries to help hospitals and other institutions deal with an ever more severe shortage of nurses and other medical personnel.
- Cost shifting. As the federal government cuts back on Medicare and other medical payments, hospitals are trying to compensate by raising rates for patients with private insurance.
- Recent federal laws requiring employers to extend temporary health benefits to former employees and full benefits to some seasonal and temporary employees.

Regional trends also fuel the inflation, according to the state insurance division, industry officials and a draft report of the Governor's Interim Commission on Health Care.

- Huge increases in the cost of Alaska malpractice insurance — both for doctors and hospitals — have been passed on to health care consumers. And the threat of damage suits has prompted more defensive medicine. Doctors order additional, at times unnecessary, tests and exams to help protect them from patients who might later decide to sue.
- With the past three years, a major increase in the use of an ever-expanding array of Alaska health care services. Last year, for example, Charter North Medical Corp. opened an expensive new facility for in-patient treatment of disturbed children. That prompted a more than doubling of admissions from state employees and their families. And hospital charges to the state's insurance program soared from $320,446 in fiscal year 1987 to $1.2 million in fiscal year 1988.

The increased use, industry officials say, also results from shiftish workers who — in a down economy — fear for job security, and want to make sure any health problems are dealt with while they still have coverage.

- The sagging economy also has caused a big increase in free medicine by the hospitals. Within the past three years, Providence Hospital's unreimbursed medical services jumped from $7 million to $17 million. During that same time period, Humana's jumped from $5 million to $12 million, the hospitals say.

That tends to drive up the cost of services for those who can afford to pay, state officials say.

□

In the Lower 48, the struggle to gain control of health care costs — and often intense competition for patient dollars — has triggered a revolution in health care delivery. In many major urban areas, employers can choose from a wide range of programs, such as pre-paid health-care plans in which doctors and hospitals guarantee services for a fixed fee. Other programs involve doctors and hospitals who team up to offer employers discount services in exchange for large volumes of business.

In the health-care industry, such programs are known as "managed care," and many view them as the wave of the future.

"An increasingly high percentage of people who are insured receive some sort of managed care," says Doug Hastings, a Washington, D.C., attorney specializing in hospital and health care issues. "And most experts predict that growth will continue."

But in Alaska, such programs are in their infancy. That's due, in part, to the state's isolation and sparse population, which make it difficult to organize large-volume health care programs profitably.

Another obstacle to their development is the state's doctors, many of whom view such programs with distrust and outright hostility. "I'm extremely happy that those things have not come here," said Neubauer, the internist. "Maybe the cost of insurance will go down, but so will the quality of care and I'm not sure it's worth it."

Neubauer said the managed care systems tend to screen out those who are really sick, since they may need lots of expensive treatment that will cut away the profits from a pre-paid or discount plan.

Other Alaska doctors say managed care means more insurance company bureaucracy and inferior care for everyone. Doctors withholding treatment for fear the next test — or the next operation — will erode the profit from a pre-determined fee.

Insurance companies disagree and are frustrated by the Alaska doctors' reluctance to embrace the new systems. "You're opening a very interesting and very sensitive area," says Robert Simons, a physician employed as Aetna's medical director. Simons said he sent letters to state physicians asking them to join in new managed care program with Aetna, and found "no real interest."

Blue Cross says it will attempt to impose health-care management on physicians by drafting new discount policies that only reimburse patients for the average cost of a physician's service. The average broken arm, for example, costs $67 to set in Alaska, but some doctors charge $150.

If a doctor's cost is way over the average — and there are no special complications to justify that, then the new policy would prod the patient to a cheaper doctor, said Clark, the Blue Cross vice president.

Aetna and Blue Cross have had more success dealing with hospitals.

Aetna has convinced Humana to offer a 30 percent discount in services, according to Simons, in return for helping fill the hospital's beds with a steady stream of its insured.

Blue Cross has teamed up with Providence in a similar program. And Providence recently struck out on its own to offer such discounts directly to Alyeska Pipeline Service Co. and several other large employers.

The employers who purchase such discounted services use an economic hammer to insure their employees go to the right hospital. Employees pay a low deductible if they attend the preferred hospital, a much higher deductible if they attend the com[illegible].

Such plans were introduced to Anchora[illegible] mid '80s, and as rates rise, their appeal grows, both to employers and employees.

The Alaska Railroad, for example, after months of tough bargaining reached a 1987 union agreement that included a three-year freeze on employer payments toward health benefits. At the time, it looked like a good settlement because those payments covered all the costs of a gilt-edged medical plan jointly insured through the railroad and Aetna.

But last year, Aetna hit the railroad with a 40 percent rate increase for the standard plan. Then they offered a more modest alternative, a 14 percent rate increase for those employees who would join a "preferred hospital" plan with Humana.

Under that plan, employees who chose Providence would have to pocket 40 percent — rather than the standard 20 percent — of initial hospital costs.

Other cost management efforts included insurance company approval of non-emergency surgery and a financial penalty for not obtaining a second opinion on prospective surgery.

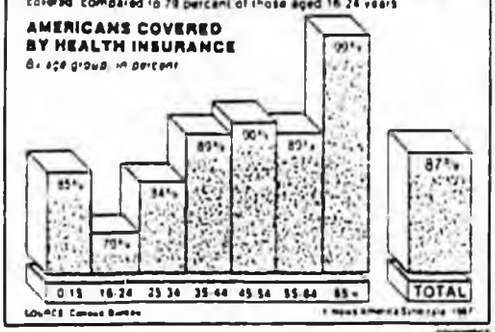
Non-union railroad employees chose to sign up for the preferred plan, but union workers opted against it. Then this year, facing another 32 percent increase, the unions decided to go with the preferred option.

Even with the preferred plan, the new insurance doesn't come cheap. A family policy will cost each union member $2,049 out of pocket.

Quinn, the union leader, said he's talked with the rank and file. About cutting benefits to try to bring that expense down farther. But for the moment, his members say no. "The employees still want the plan they have. They aren't willing to downscale it — yet."

Most Americans have health insurance

Most Americans – 87 percent – have private or government health insurance. By age group, 99 percent of those 65 years and older are covered, compared to 78 percent of those aged 18-24 years.



> *"You just don't get good rates if you have anyone with medical problems. And you never know how long you will be able to keep a policy before it's canceled."*
>
> — Patty Harpel

Trad susp souq

Los Angeles T

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ANCHORAGE, ALASKA, WEDNESDAY, FEBRUARY 16, 1989 PRICE 25 CENTS

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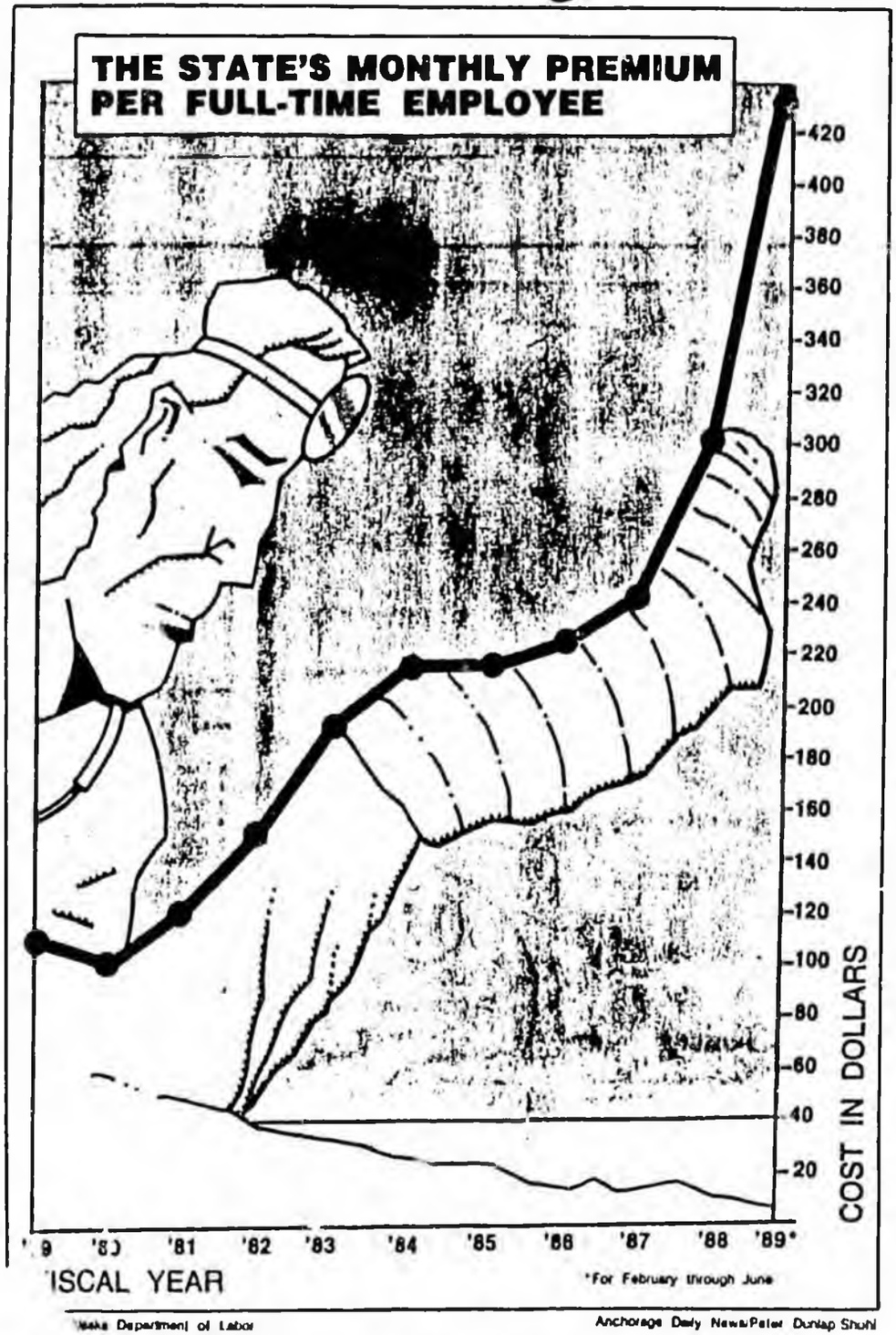

State health insurance: $104 million

Cowper seeks more money for state workers' coverage

By DAVID POSTMAN
Daily News reporter

JUNEAU — State employees' top-of-the-line health insurance policy will cost $104 million this year, $20 million more than the state has budgeted to pay for it.

The plan costs the state an average of $431 a month per employee, 520 percent more than it did a dozen years ago. It covers 90 percent of the costs of everything from plastic surgery to year-long stays in mental hospitals.

"We have the best plan. Everything is covered," said Chuck Taylor, deputy commissioner of the Department of Administration.

Because the policy costs more money than the state has appropriated for it, Gov. Steve Cowper is asking for a special appropriation of about $20 million to pay for this year's increases. But Cowper, Taylor and legislative leaders say the health coverage may be too expensive for these days of limited money.

The state is locked into the plan through contracts with its labor unions. Those contracts call for the state to provide the same level of coverage even if the costs go up or there is less money to pay for the policy.

"There's not any consideration for what happens in a down economy," Cowper said at last week's budget summit with legislative leaders. "I think it's fair to say that this is just a situation nobody ever anticipated. If everything had kept going up it would have worked just fine."

But as costs skyrocketed, state income dropped and the state is now stuck with a boom-time health plan.

All full-time employees, including legislators, are

Please see Back Page, INSURANCE

INSURANCE: For state workers

Continued from Page A-1

covered by the policy at no cost. Part-time employees can buy into the plan at about half the state's cost, according to Taylor.

Under the policy, Taylor said:

• 90 percent of all medical costs are paid. Only 8 percent of public employee insurance policies in the country have 90 percent coverage.

• 100 percent of the premium for dependent coverage is paid. Alaska is one of 12 states with that provision.

• State employees have a $100 deductible and pay less out-of-pocket medical expenses than all but 3 percent of public employees nationwide.

As medical costs have gone up, so have insurance costs. But Alaska's public employees' plan, issued by Aetna Life Insurance Company, has also gotten more expensive because of its extremely liberal terms and because people are going to the doctor a lot more often, according to Taylor.

The biggest increases have been for chiropractic care and psychiatric and substance abuse treatment, according to a survey of state employee insurance claims filed during the past two years. Charges for chiropractic care went up 27 percent in the past year. But that is not due so much to higher costs as it is to people going to the chiropractor more often.

State figures show employees visited chiropractors 25 percent more often in the past year.

A Juneau chiropractic clinic, Davis Valley Chiropractic, is No. 9 on the list of payments made to doctors and clinics, receiving $315,620 from Aetna.

Treatment for mental illness and substance abuse accounts for 40 percent of all hospital stays paid for by the plan. For Aetna's other Alaska insurance policy holders, mental illness and substance abuse accounted for just 16 percent of all hospital stays.

And the state pays for people to go to whatever hospital they want and to stay as long as they want. Five of the 14 most expensive hospital stays paid for from July 1986 to June 1987 were for mental disorders. One 16-year-old boy, the son of a state worker, spent more than a year in Camelback Hospital in Phoenix, Ariz., at a cost of $131,000, for neurotic depression. Another 15-year-old spent 350 days at the same hospital for what insurance records show as "childhood mental disorders."

Charter North Hospital, which specializes in mental illness and substance abuse treatment, had the highest charges per hospital admission of any hospital used by state employees last year. Charter North charged an average of $15,441 per admission compared to Providence Hospital at $6,115 and Humana Hospital-Alaska at $5,487.

Taylor said some of the high costs of treatment for mental illness and substance abuse are due to high alcoholism and divorce rates in Alaska and the fact that many people do not have family here and more readily turn to professionals for help.

"It's also my opinion that you are seeing the impact of television advertising," Taylor said. "Turn on the tube and what do you see, 'Problems with your kid? Send them here. Cocaine problems, come see us.'"

Taylor also said the rise in chiropractic costs might also be attributed to heavy television advertising.

Whatever the reason, state leaders say something must be done to at least slow the rising costs. But since the insurance is part of union contracts, there is little that can be done.

Any change would have to be negotiated with the unions or the legislature would have to amend state labor relation laws to allow Cowper to make changes in the benefit package.

Cowper, House Speaker Sam Cotten and Senate President Tim Kelly agree they will "take a look at" the benefit package, but because of the contract requirements they stop short of saying they will take action to cut the plan.

"If something was to appear before us magically maybe we could take a look at it," Kelly said at last week's budget summit.

But this week Kelly said in an interview that the costs were clearly out of control.

He said it is unfair to the Alaskans that do not share in the plan to keep paying out more and more money to insure state employees. "It comes down to creating an elite class of people who are living better than the people they are working for."

Cotten said that to balance next year's budget it might be necessary to cut services, raise some taxes and repeal an oil-company tax break, and that state employees should not be exempt from taking a hit, too.

But even with changes this year, the cost of the plan will keep going up, according to Taylor. "If I cut the plan and contain costs, I still have to deal with 20 and 30 percent increases each year."

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: CSSB 254 (Fin)
PUBLISH DATE: 3/30/90 (a)

FISCAL NOTE

REQUEST:

Revision Date:
Title: An Act relating to group health insurance
Sponsor: Duncan
Requestor: Senate Finance

Agency Affected: Commerce & Economic Dev.
BRU:

Components:

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
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)
As the Senate Finance Committee substitute places the Alaska State Group Health Insurance [illegible] within the Department of Administration, this fiscal note is z..

Prepared by: Guy Bell, Director
Division: Administrative Services
Phone: 465-2505
Date: 3/29/90

Approved by Commissioner: Larry Merculieff
Agency: Department of Commerce & Economic Development
Date: 3/29/90

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

LW/dg16408D-1/32990b

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: CSSB 254 (Financ
PUBLISH DATE: 3/30/90 (b)

FISCAL NOTE

REQUEST:

Revision Date:
Title: An Act relating to group health insurance; ef date
Sponsor: Senator Duncan
Requestor: Senate Finance Committee

Agency Affected: Dept of Administration
BRU: Retirement & Benefits
Components: Retirement & Benefits

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	85.5	102.6				
TRAVEL	40.8	43.2				
CONTRACTUAL	140.2	145.3				
SUPPLIES	4.5	2.0				
EQUIPMENT	21.0					
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	292.0	293.1	*	*	*	*
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND	292.0	293.1	*	*	*	*
FEDERAL FUNDS						
OTHER						
TOTAL	292.0	293.1	*	*	*	*

POSITIONS:

FULL-TIME	2	2				
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary) See page 2 for FY 91 detail.

*After February 1, 1992, the authority shall provide that sufficient premiums are collected to provide the required insurance coverage and to pay the expenses of the authority.

Prepared by: Senator Rick Uehling, Co-Chairman
Division: Senate Finance Committee
Phone: 465-4821
Date: 3/29/90

Approved by Commissioner:
Agency:
Date:

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

CSSB 254: "An Act relating to group health insurance; and providing for an effective date."

Personal Services:		
Executive Director 24A $73.2/10 months	$61.0	
Clerk Typist III 8B $29.4/10 months	24.5	
Total Personal Services		$ 85.5
Travel:		
Assume board meetings every two months for 15 board members at an average cost of $400 per trip.		
$400 x 15 x 6	$36.0	
Staff travel for Executive Director:		
Board meetings $400 x 4	1.6	
One meeting per month $400 x 8	3.2	
Total Travel		$ 40.8
Contractual:		
Office Space - 500 sq. ft. @ $1.75 x 8	$ 7.0	
Telephone - $200 x 8 months	1.6	
Postage $200 x 8 months	1.6	
Advertising and Printing	5.0	
Professional Services Contract(s)	125.0	
which may include:		
Rate studies		
Utilization research		
Financial systems analysis		
Total Contractual Services		$140.2
Supplies:		
$1000 per employee	$ 2.0	
Software	1.5	
Total Supply		$ 4.5
Equipment:		
2 PC's and a printer	$11.0	
Bookcases and file cabinets	1.2	
Desks and chairs	4.0	
Photocopier	2.0	
Phone system	.8	
Miscellaneous	2.0	
Total Equipment		$ 21.0
Total Operating		$292.0

STATE OF ALASKA
1990 LEGISLATIVE SESSION

Bill Version: CSSB 254 (FIN)
Publish Date:

FISCAL NOTE

REQUEST:

Revision Date:
Title: An Act relating to group health.
Sponsor: Duncan
Requestor:

Agency Affected: Administration
BRU:
Components:

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	129.6	129.6				
TRAVEL	52.0	52.0				
CONTRACTUAL	310.6	300.6				
SUPPLIES	3.3	3.3				
EQUIPMENT	33.3	0				
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	528.9	485.5	*	*	*	*
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND	528.8	485.5				
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

FULL-TIME	3	3				
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

* Due to the nature of the authority, it is not possible to predict costs for subsequent fiscal years. See attached for further analysis.

Prepared by: Mike Campbell for Sally Smith
Phone: 465-4470
Division: Retirement and Benefits
Date: 4/23/90

Approved by Commissioner: Gary M. Baxter for Frank S. Baxter
Date: 4/23/90
Agency: Department of Administration

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

7/6K2/042001-0/1&2

Rev: 11/89

CS for CSSB 254 (Fin)
Analysis of the Fiscal Implications
Prepared by the Division of Retirement and Benefits
Department of Administration

Analysis: This bill creates the Alaska State Group Health Insurance Authority in the Department of Administration. This independent agency would have specific powers as outlined, including regulatory power. Using appropriate staff and contractual services, it would establish and maintain a statewide provider payment system, rate schedules and utilization standards by 2/1/92. Various public entities would be required to implement these in their group insurance plans.

The Authority would offer voluntary participation in a comprehensive group health insurance plan to various public agencies throughout the State after 2/1/92. This coverage would be procured by the Authority or self-insured if this was shown to be less expensive.

This bill allows voluntary participation in the Authority's group plan. It is assumed that the State would take advantage of this plan if appropriate coverage was provided less expensively than through competitive bidding and renewals. It is not expected that this bill would increase the cost of health insurance for the State and could result in a decrease in cost. Upon participation, a public entity would be required to continue participation unless granted a waiver by the Authority.

This analysis is for the estimated administrative costs of the proposed Authority. The analysis does not consider the actual cost of health insurance.

Personal Services

Executive Director (Range 24A, 11 mos.)	$68.6
Administrative Assistant II (14A, 10.5 mos.)	34.9
Clerk Typist III (8B, 10.5 mos)	26.1
Total Personal Services	$129.6

Travel

Assume 7 Board meetings for FY 91 and every 2 months thereafter at an average cost of $400 per member per trip.

$400 X 15 X 7 =		$42.0	
Administrative travel for Director:			
Board Meetings	$400 X 7 =	2.8	
Organizational meetings	$600 X 12=	7.2	
Total Travel			**$52.0**

Contractual

Office Space--500 sq. ft. @$1.75 X 11 mos.	$9.6	
Telephone--$300 X 11 mos.	3.3	
Courier services--$200 X 11 mos.	2.2	
Postage--$500 X 11 mos.	5.5	
Advertising and Printing	10.0	
Professional Services Contract(s).	280.0	
which could include:		
*carrier surveys and analysis		
* provider data collection		
* provider meetings		
* rate studies and analyses		
* financial consulting		
* self vs fully insured analyses		
* development of plan design		
Total Contractual Services		**$310.6**

Supplies:

$500 per employee	$1.5	
Software	1.8	
Total Supplies		**$3.3**

Equipment:

3 PCs and printer		$15.0	
Phone system		2.6	
Photocopier		1.3	
Fax machine		1.8	
Office furniture:			
1 management unit	4.0		
2 support workstations	5.0		
3 chairs	1.2		
3 side chairs	.8		
2 file cabinets	.9		
bookcase	.1		
storage cabinet	.6		
Total furniture		12.6	
Total Equipment			33.3