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STATE OF ALASKA
HEALTH CARE COST CONTAINMENT
TASK FORCE
CONSULTANTS' REPORT
NOVEMBER 28, 1989

Jeffrey A. Malek
Area Assistant Vice President
Arthur J. Gallagher & Company
160 Spear Street, Suite #1100
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November 22, 1989

Senator Tim Kelly
Chairman Health Care Cost Containment
Task Force
Alaska State Senate
3111 "C" Street, Suite #550
Anchorage, AK 99503

Dear Senator Kelly:

Attached is our report for the November 28, 1989 Task Force meeting in Juneau. Per the Task Force's request, this report covers four major areas:

- A. Trends in State of Alaska Health Care;
- B. Alternate Funding of Aetna Plan - Update;
- C. Review of Pooling Concepts;
- D. Health Care Payment Alternatives.

As the Task Force focuses on long range health care cost containment issues, I would like to illustrate the savings gained so far to date.

\$ 1,270,189.00	Premium Tax Refund (Actives)
339,120.00	Premium Tax Refund (Retirees)
2,428,147.00	Extended Liability Reserve (Actives)
7,558,709.00	Cost Containment Measures (Actives)*
<u>\$11,596,165.00</u>	Total Hard Dollar Savings Identified By Health Care Cost Containment Task Force, To Date.

This represents a net savings of over 11% not including the full impact of savings to the Retiree program or the long term sentinel effect on health care inflation.

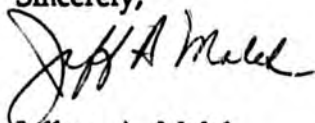
These measures also helped provide the state with a favorable renewal from Aetna whereby the revised rate* would hold until February 1, 1991. This is important when medical inflation in Alaska is predicted at least 23% this year without these steps (and good experience) the legislature would have to appropriate approximately an additional 25 million for February 1, 1990 to January 31, 1991.

Senator Tim Kelly
November 22, 1989
Page Two

- * Cost containment measures net effect on premium rate.
Rate effective February 1, 1989 = 431.72 rate effective December 1, 1989 after cost
containment 384.59 = 47.13 per active employee per month savings x 13,365 average
enrollment.

Please do not hesitate to call if you have any questions.

Sincerely,



Jeffrey A. Malek
Area Assistant Vice President

JAM/jyi

cc: H.C.C.C. Task Force
Dave Gray
Janice Fried

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SECTION A
TRENDS IN HEALTH CARE
TRENDS AND STATE EXPENDITURES

PACIFIC REGION TRENDS

**ALASKA
CALIFORNIA
HAWAII
OREGON
WASHINGTON**

HIAA STATISTICS ON HOSPITAL COSTS AND CHARGES, PHYSICIAN POPULATION

Every year, the Health Insurance Association of America publishes health insurance statistics. The following data is from the HIAA's 1987 update of the *Source Book of Health Insurance Data*.

The \$460.19 average cost to community hospitals in 1985 represents a 11.9 percent increase over the 1984 figure. In 1985, the average length of time a patient remained in a community hospital was 7.1 days, down from 7.6 days just two years earlier. The cost for the average stay increased 16 percent to reach \$3,244.74 in 1985.

On a state-by-state basis, the average cost per day in 1985 ranged from a low of \$282.05 in South Dakota to a high of \$693.44 in Alaska. Of the Pacific Region states studied, the semiprivate room charge was highest in Alaska for both January 1987 and January 1988, and the change in charges during the same time period was the highest at 13.9 percent. The average length of stay varied by area, from a low of 5.1 days in Utah to a high of 9.4 days in New York. The average length of stay in Alaska was 5.4 days.

As of January 1987, the national average cost to the patient for a semiprivate room was \$243.90, a 7.5% increase over January 1986. The highest average rate was in the West, and the lowest average rate was in the South.

The following three tables illustrate Community Hospital Statistics - 1985; a Comparison of Hospital Semi-Private Room Charges By State, from January 1986 and 1987; and The Number And Rate Per 100,000 Population of Active Physicians, Pharmacists, And Dentists, By State, 1984.

1986 HOSPITAL DAILY SERVICE CHARGES FOR PACIFIC STATES

The following tables illustrate the 1986 average hospital daily service charges and average length of stay for the Pacific states: Alaska, California, Hawaii, Oregon, and Washington.

These 1986 daily hospital charges, which include room and board and ancillary charges were compiled by Equicor-Equitable HCA Corporation. The data was provided by 1,863 hospitals nationwide for the year ending December 1986.

Hospitals Surveyed

To assure as much consistency as possible, all hospitals surveyed were listed by the American Hospital Association as "general medical and surgical." Hospitals were non-federal government, private nonprofit, and for-profit.

Surveyed hospitals were requested to exclude geriatric, nursery, pre- or post-natal, and infant care; and beds reserved for psychiatric, rehabilitation, and extended care.

Data Evaluation

Average room and board charges, ancillary charges, and length of stay have been weighted by the total number of patient days, and have not been separated by room category. The data has been calculated according to Metropolitan Statistical Area (MSA), non-MSA counties, state, and nationally.

National Averages

The average room and board charge for the nation was \$257, in Anchorage it was \$346. The national average ancillary charge was \$439, in Anchorage it was \$335. The average charge per patient day was \$697, compared to \$680 in Anchorage. The average length of stay for the hospitals surveyed was 6.5 days, while in Anchorage it was 3.8.

Rhode Island hospitals reported the lowest average daily service charges (\$425), while Nevada hospitals reported the highest average charges (\$1,204).

The largest number of states (16) reported average hospital service charges ranging from \$600 to \$700.

According to the Equicor data, on average, hospital beds in 35 states were empty at least 150 days a year.

**A SURVEY OF
STATE EMPLOYEE HEALTH
BENEFIT COSTS**

STATE EMPLOYEE HEALTH BENEFIT COSTS

The cost of providing health care to state employees increased in the year that ended January 1988, according to data collected by Martin E. Segal Company. This finding contrasts sharply with the findings of surveys taken for the two previous years, when the rise in health care costs was below the national inflation figure for medical costs.

After two years of contained costs, states experienced dramatic increases in their employee health plan expenditures in 1988. About one-fifth of state plans reported cost increases of more than 20 percent, and costs jumped by more than 35 percent in three states.

During the year ending in January 1988, the average cost increase of state employee health benefit plans was more than twice the rise in the Consumer Price Index medical care component.

The average per employee cost for health care rose to \$93.15 in 1988, a 14.1 percent increase over the \$81.62 average monthly cost in 1987. National medical costs rose 6.2 percent during that time.

In 1987, 21 states showed no increase, and six states showed reduced costs. Total 1988 costs remained the same in seven states and increased in 43 states.

There was some variance in 1988 inflation figures for the states' health benefits. Total cost increases for single coverage ranged from less than 19 percent in 18 states to more than 25 percent in eight states. Two states--New York and California--experienced cost increases in excess of 45 percent.

Managing Costs

Of the 50 states, 31 paid 100 percent of the cost for 1988 employee-only coverage, and 12 required no contribution for family coverage. Although most states pay for single coverage, the survey found a slight shift toward paying a smaller share of employee health costs. The number of states paying less than 80 percent of the cost for employee-only coverage doubled from four states in 1987 to eight states in 1988.

Slightly less than one-fourth of the states (12 of the 50) paid for the full cost of health benefits for employees and their dependents. As of January 1988, 28 states were paying less than 80 percent of the total cost for employee and family coverage, and ten states were paying less than half.

Participation in health maintenance organizations varied widely. The number of HMO's offered ranged from zero in six states to ten or more in 15 states and 25 or more in six states. More than 30 percent of the 31.1 million state employees were enrolled HMOs. Seven states had more than 50 percent participation in HMOs, with Wisconsin leading with 77 percent participation. In 14 states, however, participation was less than 10 percent.

Cost management provisions used by state plans included precertification and preadmission review; length-of-stay assignments, concurrent review, and discharge planning; second surgical opinion programs; incentives for outpatient services; bill audits; hospice and home health benefits; and wellness programs. Cost management incentives have played a major role holding down the rate of increase for state health cost. Despite the high 1988 increase, the average three-year increase was approximately the same percentage as the CPI medical care component.

Retiree Benefits

Both the 1987 and 1988 studies found that half of the states made a contribution to the health care costs of retirees over age 65, and 16 states paid the full cost of coverage for some or all retirees. Two states--Indiana and Nebraska--do not allow retirees age 65 or older to continue participation in the state plan.

Among the 48 states that make coverage available to retirees, the average monthly cost for single retirees with Medicare was \$61.97 in January 1988, an 11.3 percent increase over January 1987.

Political pressures may lead to future expansion of retiree coverage. While states may be increasing their share of the retiree costs, more states are likely to authorize studies of their actuarial liabilities, fund retiree health benefits on a level cost actuarial basis during the employees' working years, and relate the state contribution to years of credited service.

State Health Plan Costs

Percentage Increases (Jan. 1986 to Jan. 1988)

Year Ended January	CPI Medical Care Component	<u>Average Total Cost--50 State Plans</u>		
		Employee Only	Employee & Family	Retiree Over 65
1988	6.2%	14.1%	12.8%	11.3%
1987	7.5	5.3	4.8	4.6
1986	6.9	3.5	2.8	1.7

Source: Martin E. Segal Company

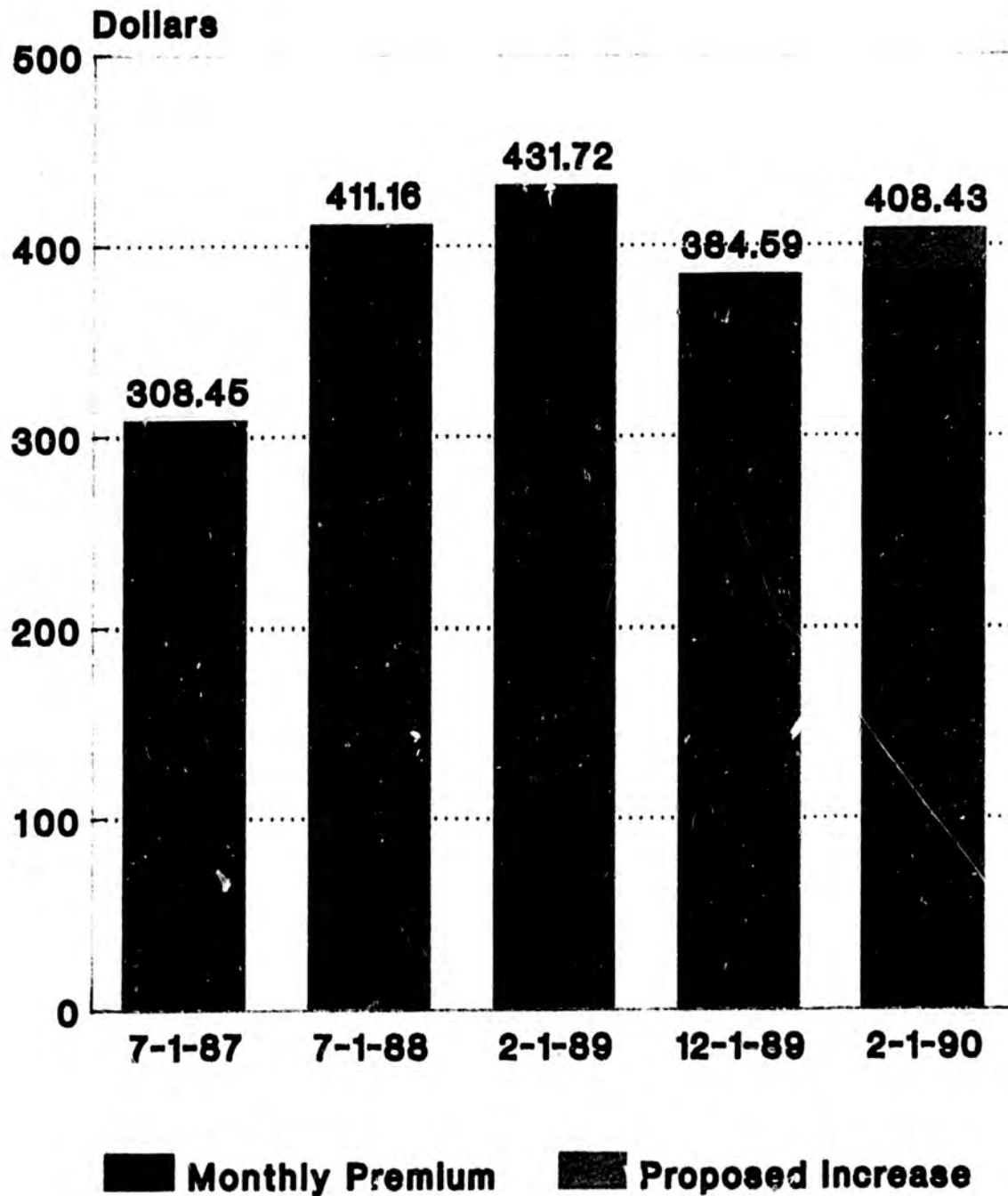
State of Alaska Premium Rates with Percent Change

July 1987	July 1988	Feb 1989	Dec 1989	Feb 1990
\$308.45	\$411.16	\$431.72	\$384.59	\$408.43
Base Year	+33.30	+5.00	-10.90	+6.20

Source: Aetna Life Insurance Company

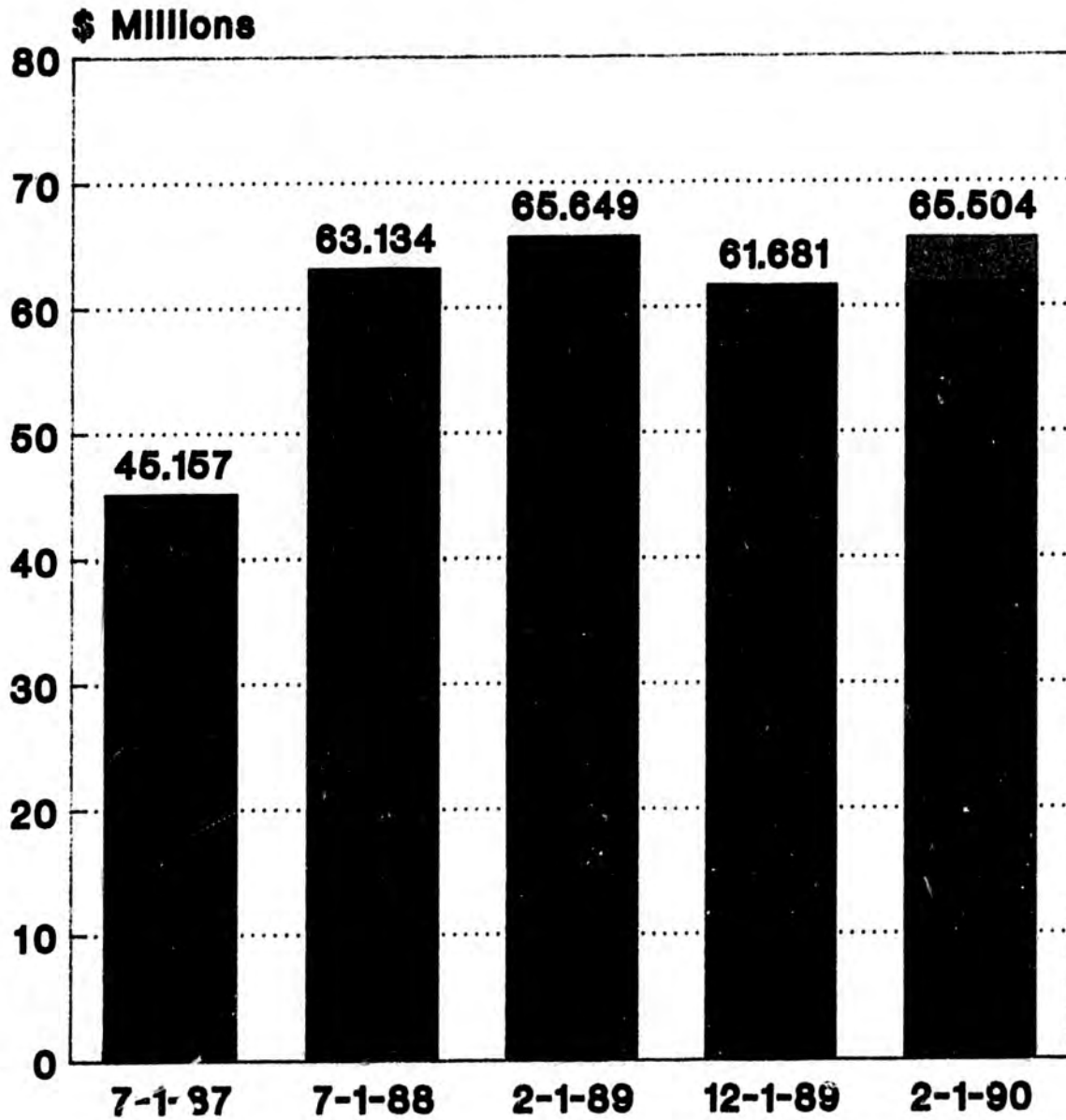
STATE OF ALASKA

MONTHLY HEALTH PREMIUM



STATE OF ALASKA

TOTAL ANNUALIZED HEALTH PREMIUM •



■ Monthly Premium ■ Proposed Increase

• Based on number of employees at each point in time

ARTHUR J. GALLAGHER & CO.

CONSUMER PRICE INDEX

CONSUMER PRICE INDEX

The Consumer Price Index, published by the Department of Labor's Bureau of Labor Statistics, is a standard measure for the rate of U.S. inflation.

The CPI is based on prices of food, clothing, shelter, fuel, transportation fares, medical services, drugs, and other goods and services that people buy for day-to-day living. All taxes directly associated with the purchase and use of the purchase are included in the index.

Since 1913, the Bureau of Labor Statistics (BLS) has been compiling the Consumer Price Index, which measures changes in the cost of living. The CPI is published for two population groups:

1. CPI-U

The CPI for All Urban Consumers covers approximately 80% of the total noninstitutional civilian population. In addition to wage earners and clerical workers, the CPI-U includes such groups as professional, managerial, and technical workers; self-employed and short-term workers; and persons not in the labor force such as retirees and the unemployed.

2. CPI-W

The CPI for Urban Wage Earners and Clerical Workers represents about one-half the population covered by CPI-U.

Prices of most goods and services are obtained by personal visits from the Bureau's representatives or by mail questionnaires. Local data collected in 91 urban areas is combined to obtain a U.S. city average, regional averages, and averages for 27 major local areas. Area indexes do not measure differences in the level of prices among cities; they measure the average change in prices for each area since the base period.

In calculating the index, price changes for the items in each location are averaged together with weights, which represent their importance in the spending of all wage earners and clerical workers.

Revisions: 1987, 1988

Beginning in January 1987, the BLS revised the CPI to reflect changes in the "market basket," incorporating factors such as technological changes and shifts in spending patterns and population. The changes, part of periodic revisions made for greater accuracy, are based on information from the 1980 population census and the 1982-84 Consumer Expenditure Survey.

Many item definitions, including those for medical care, have been altered to more accurately show consumer spending trends. The publication schedule, expenditure weighting, and geographic designations have also been altered.

Beginning in January 1988, the base year for most categories and areas was changed from 1967=100 to 1982-84=100. Only indexes with a base later than December 1981 have maintained their bases. The 1982-84 period was chosen to coincide with updated expenditure weights. CPI data was last rebased in February 1971, when the 1967 base was substituted for the former 1957-59 base.

Medical Care Component

The medical care component includes services and commodities, which are also published separately for medical insurance.

The medical services component is made up of charges for physicians' services, dental services, services by other medical professionals (includes services rendered by therapists, nurses, and other practitioners), hospital and related services, other inpatient services (includes nursing and convalescent home services), outpatient services (includes emergency room services, laboratory fees, and X-rays), and hospital rooms.

Commodities include prescription drugs, non-prescription drugs, and medical supplies. Before 1987, the *CPI Detailed Report* broke down prescription drugs into anti-infective drugs; tranquilizers and sedatives; circulatories and diuretics; hormones; diabetic drugs, biologicals and prescription medical supplies; pain and symptom control drugs; supplements, cough and cold preparations, and respiratory agents. These are now grouped under one category. The nonprescription drugs and medical supplies component is broken down into internal and respiratory over-the-counter drugs and nonprescription medical equipment and supplies. The cost of eyeglasses, formerly included under "prescription drugs and other medical supplies," is under a new classification that covers all expenses for eye care services and commodities.

Health Insurance

"Health insurance," an item figured in the CPI total but not delineated in the published reports, includes only the portion of premiums not paid out in benefits. Before the revisions, the item was total premium cost, both the portion paid out for claims and the portion retained for operating expenses and profit. Starting with January 1987, the portion paid out by insurance companies for claims is included along with consumer out-of-pocket expenses.

The amount paid by insurance is included under the medical service or commodity that is consumed, i.e., physicians' services, prescription drugs, hospital room. This change alters the expenditure weights of directly priced medical care and of health insurance.

Due to the change in weighting, the number of medical care classifications has been increased to assure greater accuracy. The CPI classification "other medical care services" has been discontinued and more specific classifications have been added. The reallocation of items was based on spending patterns in the 1982-84 Consumer Expenditure Survey. All previously priced items continue to be priced, but with smaller samples.

Area Indexes

The CPI includes 27 local areas. An area is generally the Consolidated Metropolitan Statistical Area (CMSA), provided by the DOL Office of Management and Budget. The U.S. Index and those for the four largest urban areas are published monthly. Indexes for other areas are published bi-monthly or semi-annually (in January and July).

The BLS advises that local area indexes are subject to substantially more statistical error and variability than the national index. As a result, the local indexes should not be used in escalation provisions. Beginning in 1987, the population samples are based on the 1980 census, and the CPI publication schedule for some regions was changed.

Regional Indexes

Regional CPIs, which are cross-classified by population size, enable users in local areas for which an index is not published to get a better approximation of the CPI for their area by using the appropriate population-size class measure for their region. The classifications were altered in 1987.

The population size classes are aggregations of areas that have urban populations as follows:

For 1981-1986:

A-1 = More than 4,000,000
 A-2 = 1,250,000 to 4,000,000
 B = 385,000 to 1,250,000
 C = 75,000 to 385,000
 D = Less than 75,000

For 1987-1988:

A = More than 1,200,000*
 B = 500,000 to 1,200,000
 C = 50,000 to 500,000
 D = Less than 50,000

* For the largest size class (A), the reference base is December 1986=100.

Calculating Index Changes

The index measures price changes from a designated reference date, which equals 100. An increase of 22%, for example, is shown as 122.0. This change can also be expressed dollars: the price of a "market basket" of goods and services would have risen from \$10 in the base period to \$12.20.

Seasonally Adjusted Data

For analyzing general price trends in the economy, seasonally adjusted changes are usually preferred because they eliminate the effect of changes that normally occur at the same time and in the same magnitude every year. This includes price movements resulting from changing climatic conditions, production cycles, holidays, and sales.

The unadjusted data is of primary interest to consumers concerned about the prices they actually pay.

Reliability

Since the CPI is rounded to one decimal place, some ambiguity may arise in interpreting small index changes. Although a month-to-month change of 0.1% in all items is significant, a change of this size might result from a much smaller change in the unrounded value.

ANNUAL CPI-U AVERAGES 1983-1987 IN SELECTED CITIES

All items, medical care expenditures, and medical care services of the Consumer Price Index for All Urban Consumers (CPI-U). 1982-1983, 1983-1984, 1984-1985, 1985-1986, and 1986-1987 annual increases and averages by selected cities. 1967 = 100 for pre-1987 averages, unless otherwise noted. For 1987 averages, 1982-84 = 100.

Area	All Items		Medical Care		Medical Care Services	
	Annual Average	Percent Change	Annual Average	Percent Change	Annual Average	Percent Change
U.S. City Average						
1983	298.4	3.2	357.3	8.7	387.0	8.7
1984	311.1	4.3	379.5	6.2	410.3	6.0
1985	322.2	3.6	403.1	6.2	435.1	6.0
1986	328.4	1.9	433.5	7.5	468.6	7.7
1987*	113.6	3.6	130.1	6.6	130.0	6.6
Anchorage, Alaska (1)						
1983	264.8	1.8	359.2	5.1	393.6	5.0
1984	275.6	4.1	380.3	5.9	416.4	5.8
1985	282.3	2.4	399.8	5.1	437.2	5.0
1986	287.8	1.9	460.7	15.2	510.0	16.7
1987*	108.2	0.4	137.0	7.2	139.4	8.0
Honolulu, Hawaii						
1983	273.5	2.2	357.6	10.3	375.1	10.7
1984	284.8	4.1	379.7	6.2	398.2	6.2
1985	294.1	3.3	400.6	5.5	418.8	5.2
1986	301.1	2.4	432.8	8.0	452.7	8.1
1987*	114.9	5.0	127.9	4.6	128.1	4.9
Los Angeles-Long Beach, Anaheim (1)						
1983	292.7	1.8	381.8	7.0	407.7	6.7
1984	306.1	4.6	398.8	4.5	424.5	4.1
1985	320.2	4.6	428.0	7.3	455.2	7.2
1986	330.7	3.3	458.2	7.1	488.4	7.3
1987*	116.7	4.3	129.5	7.1	129.7	7.5
Portland, Oregon-Washington						
1983	290.1	1.1	363.0	7.5	398.6	7.2
1984	301.0	3.8	381.6	5.1	416.6	4.5
1985	312.4	3.8	401.2	5.1	434.8	4.4
1986	316.8	1.4	429.8	7.1	463.1	6.5
1987*	110.9	2.5	126.8	6.5	123.7	5.7
San Diego, California						
1983	334.6	2.9	335.6	8.2	359.9	8.0
1984	354.2	5.9	353.8	5.4	375.2	4.3
1985	373.2	3.4	366.9	3.7	388.0	3.4
1986	383.7	2.8	393.9	7.4	418.7	7.9
1987*	117.5	3.5	129.4	9.5	128.8	9.5
San Francisco-Oakland, Cal.						
1983	302.5	0.8	348.2	6.9	378.6	7.3
1984	319.8	5.7	363.1	4.3	395.1	4.4
1985	333.1	4.2	384.1	5.8	417.5	5.7
1986	343.2	3.0	413.8	7.7	450.5	7.9
1987*	115.4	3.4	128.7	7.5	128.4	7.0

ANNUAL CPI-U AVERAGES 1983-1987 IN SELECTED CITIES
(Continued)

Area	All Items		Medical Care		Medical Care Services	
	Annual Average	Percent Change	Annual Average	Percent Change	Annual Average	Percent Change
Seattle-Everett, Washington						
1983	304.0	2.1	346.8	7.9	375.3	7.9
1984	313.9	3.7	362.9	4.6	390.8	4.1
1985	321.9	2.5	385.6	6.3	414.2	6.0
1986	325.2	1.0	404.2	4.8	432.4	4.4
1987*	109.2	2.3	124.6	6.0	123.4	6.0

* 1987 indexes on 1982 - 84 = 100 base

(1) Indexes on 1985 - 1986 on an October 1967 + 100 base

ANNUAL CPI-W AVERAGES 1983-1987 IN SELECTED CITIES

All items, medical care expenditures, and medical care services of the Consumer Price Index for All Urban Consumers (CPI-U). 1982-1983, 1983-1984, 1984-1985, 1985-1986, and 1986-1987 annual averages and increases by selected cities. 1967 = 100 for pre-1987 averages, unless otherwise noted.

Area	All Items		Medical Care		Medical Care Services	
	Annual Average	Percent Change	Annual Average	Percent Change	Annual Average	Percent Change
U.S. City Average						
1983	297.4	3.0	355.1	8.6	384.1	8.7
1984	307.6	3.4	377.7	6.4	407.9	6.2
1985	318.5	3.5	401.2	6.2	432.7	6.1
1986	323.4	1.5	431.0	7.4	465.7	7.6
1987*	112.5	3.6	130.2	6.7	130.3	6.7
Anchorage, Alaska (1)						
1983	257.5	0.7	349.3	5.2	377.7	5.0
1984	267.7	4.0	368.4	5.5	397.7	5.3
1985	275.4	2.9	386.8	5.0	416.8	4.8
1986	280.3	1.8	438.5	13.4	478.1	14.7
1987*	107.9	0.2	133.6	6.6	135.8	7.4
Honolulu, Hawaii						
1983	278.8	4.0	365.2	9.8	385.9	10.3
1984	291.3	4.5	386.3	5.8	407.8	5.7
1985	301.4	3.5	406.7	5.3	428.0	5.0
1986	308.2	2.3	437.6	7.6	460.3	7.5
1987*	115.9	5.1	126.7	4.6	126.9	5.1
Los Angeles-Long Beach, Anaheim (1)						
1983	293.5	0.8	376.1	7.0	400.9	6.6
1984	301.9	2.9	392.8	4.4	417.4	4.1
1985	314.8	4.3	421.6	7.3	447.9	7.3
1986	323.7	2.8	450.7	6.9	480.0	7.2
1987*	114.0	4.1	129.0	6.9	129.4	7.3
Portland, Oregon-Washington						
1983	285.8	0.4	326.7	7.5	352.2	7.2
1984	294.2	2.9	341.4	4.5	365.8	3.9
1985	302.9	3.0	359.8	5.4	383.2	4.8
1986	305.5	0.9	384.6	6.9	407.6	6.4
1987*	108.5	2.4	126.4	6.5	123.6	5.8
San Diego, California						
1983	319.2	0.4	342.6	8.1	371.0	7.9
1984	327.9	2.7	362.1	5.7	388.9	4.8
1985	337.0	2.8	376.8	4.1	403.9	3.9
1986	345.8	2.6	405.0	7.5	436.6	8.1
1987*	111.1	3.6	130.4	9.7	130.5	9.9
San Francisco-Oakland, Cal.						
1983	298.9	0.0	345.2	6.9	373.9	7.4
1984	315.8	4.7	361.7	4.8	392.5	5.0
1985	328.3	4.0	383.6	6.1	416.4	6.1
1986	337.2	2.7	413.5	7.8	449.8	8.0
1987*	114.3	3.3	130.0	7.9	130.1	7.4

ANNUAL CPI-W AVERAGES 1983-1987 IN SELECTED CITIES
(Continued)

Area	All Items		Medical Care		Medical Care Services	
	Annual Average	Percent Change	Annual Average	Percent Change	Annual Average	Percent Change
Seattle-Everett, Washington						
1983	294.2	0.1	349.6	7.9	374.7	7.8
1984	302.8	3.3	367.1	5.0	391.6	4.5
1985	309.1	2.1	390.5	6.4	415.7	6.2
1986	311.3	0.7	410.9	5.2	436.2	4.9
1987*	107.4	2.3	126.2	6.6	124.8	6.2

* 1987 indexes on 1982 - 84 = 100 base

(1) Indexes for 1985 - 1986 on an October 1967 = 100 base

CPI ANNUAL INCREASES, 1989 AVERAGES BY POPULATION SIZE CLASS
50,000 to 500,000*

Population Size Class*	All Items	Medical Care	Medical Care Commodities	Medical Care Services	Professional Medical Services
CPI-U					
Annual Average 1988	116.8	138.0	138.4	137.9	137.8
Percent Change					
1981-1982	6.4%	12.5%	10.3%	13.0%	8.7%
1982-1983	2.8	8.7	8.3	8.8	7.0
1983-1984	4.1	5.3	7.9	4.7	6.4
1984-1985	3.4	6.0	6.6	5.9	6.3
1985-1986	1.6	7.6	6.9	7.8	6.9
1986-1987	3.5	6.9	6.1	7.0	6.6
1987-1988	3.7	6.5	6.1	6.6	6.9
CPI-W					
Annual Average 1988	117.1	138.6	138.6	138.6	138.2
Percent Change					
1981-1982	6.2%	11.2%	10.3%	11.4%	8.5%
1982-1983	2.6	8.4	8.4	8.4	6.8
1983-1984	4.1	5.5	7.8	5.1	6.4
1984-1985	4.1	6.0	6.7	5.9	6.3
1985-1986	1.3	7.6	7.0	7.8	7.0
1986-1987	3.5	7.1	6.2	7.2	6.6
1987-1988	3.6	6.7	6.1	6.9	7.1

* Population of Anchorage falls within this category.

**SEMIANNUAL AVERAGES, INCREASES BY U.S. CITY AVERAGE
AND POPULATION SIZE CLASS 50,000 TO 360,000***

All items and medical care expenditure categories of the Consumer Price Index for All Urban Consumers (CPI-U), by region and population size class. Indexes 2nd half (July - December) 1988 and percent changes from 2nd half 1987 and 1st half 1988. 1982-84 = 100, unless otherwise indicated.

Region*/Population Size Class**	All Items	Medical Care	Medical Care Commodities	Medical Care Services	Professional Medical Services
CPI-U					
U.S. City Average	119.7	140.8	142.4	140.5	139.6
% Change from 2nd half 1987	4.2	6.7	6.9	6.7	6.7
% Change from 1st half 1988	2.5	3.2	3.6	3.2	3.9
50,000 to 360,000	118.2	139.9	140.4	139.8	139.6
% Change from 2nd half 1987	3.9	6.2	6.0	6.3	6.2
% Change from 1st half 1988	2.4	2.9	2.9	2.9	2.6
CPI-W					
U.S. City Average	118.4	141.2	141.3	141.2	139.7
% Change from 2nd half 1987	4.1	6.8	6.7	6.8	6.9
% Change from 1st half 1988	2.5	3.3	3.4	3.3	2.9
50,000 to 360,000	118.5	140.7	140.5	140.7	140.0
% Change from 2nd half 1987	3.8	5.9	7.9	5.5	5.7
% Change from 1st half 1988	2.3	3.1	4.2	2.8	2.4

ARTHUR J. GALLAGHER & CO.

STATE EXPENDITURES

SCOPE

The purpose of this section is threefold. First, to address the general economic conditions in Alaska tracing from just prior to the petroleum windfall in 1979, through the oil price crash of 1986, and finally through fiscal 1988. Second, to examine general state spending patterns throughout this period. And third, to look more specifically at state spending patterns on health related items. By briefly examining the economics and demographics and areas other than health expenditures, we hope to create a broader perspective for the readers.

The source of much of the information in this section is from two recently published research reports by the University of Alaska, Institute of Social and Economic Research titled *"Where Have All The Billions Gone?"* which was published in February, 1987 and updated in February, 1989. The first report describes state general fund spending (annual expenditures) from fiscal 1979 through 1986, and the update summarizes spending from fiscal 1979 through 1988. (The expenditures are general fund expenditures as reported in the Alaska Department of Administration's Annual Financial Reports and its supplements.)

Although determining how much money the state spent and for what purposes is a difficult task, the authors of the above research report are confident that the report provides a "useful reliable picture" of where the state has spent its money. The report illustrates specifically where the money went (to state agency budgets, to local governments and school districts, etc.) to help determine who is dependent on state money, and therefore who is most vulnerable as state spending declines.

GENERAL ECONOMIC AND DEMOGRAPHIC CONDITIONS

During the 1981 to 1986 period, Alaska's population and cost of living increased dramatically. Alaska's population increased by more than 30 percent from 414,000 to 542,000 from 1979 to 1986. According to the Anchorage consumer price index, between 1979 and 1986, prices increased 35 percent.

The state's general fund reserves were quite small before the trans-Alaska pipeline was built and before the Prudhoe Bay field began oil production. But, as Prudhoe Bay's oil production steadily increased in the late 1970's and early 1980's (from 1.2 million to 1.6 million barrels daily), bonus payments, royalties, severance and taxes levied on the oil companies amounted to billions of dollars in petroleum revenues collected by the state.

Alaska's general fund revenues triple between 1979 and 1982 (from \$1.5 billion to \$4.5 billion). From 1981 through 1986, the petroleum revenues made up more than 80 percent of all state general fund revenues (56 percent in 1979; and 13 percent in 1972).

With the high price of oil, consumers used less while oil exploration and production continued to increase. With supply up and demand down, world oil prices decreased from approximately \$27 per barrel to less than \$10 per barrel by the spring of 1986. Alaska lost more than \$1 billion in anticipated revenues within a six month period.

Since the crash of 1986, state revenues continue to decline as the volatile price of oil remains at low levels.

GENERAL FUND EXPENDITURES

Most of the state's income goes into and is appropriated from the general fund, except for the share of petroleum revenue that goes directly to the Permanent Fund. Total state expenditures are divided into operating and capital expenditures. Operating expenditures is money spent for daily government operations. Capital expenditures is money spent on tangible items that have lives in excess of a year.

Expenditures are made with the state's own petroleum and non-petroleum money and federal money that the state receives. The majority of federal money that goes into the general fund is for specific health and social service programs and highway construction projects. These items are paid for through a combination of federal and state matching funds.

State expenditures are broken out into two categories: standard and special. Special expenditures are composed of items that are not customary kinds of government spending. Between 1981 and 1986, special expenditures accounted for almost a third of general fund spending. Standard expenditures are composed of traditional government functions and can be examined either by program category or recipient.

Our research efforts will concentrate on standard expenditures because within the standard program categories is the item we want to isolate, health. The standard categories include health, education, social services, public protection, natural resource management, administration of justice, transportation, development, and general government.

Health expenditures include the cost of Medicaid and other medical aid programs, costs of operating and building state hospitals and other medical facilities, and grants to municipalities or non-profit groups for emergency medical services or other health services.

Direct recipients of standard expenditures are state agencies, local governments, school districts, the university system, and persons collecting welfare, retirement, and other transfer payments.

From fiscal 1981 through 1986, state general fund expenditures amounted to \$26.1 billion of which \$23.4 billion was spent and \$2.7 billion was deposited into the Permanent Fund.

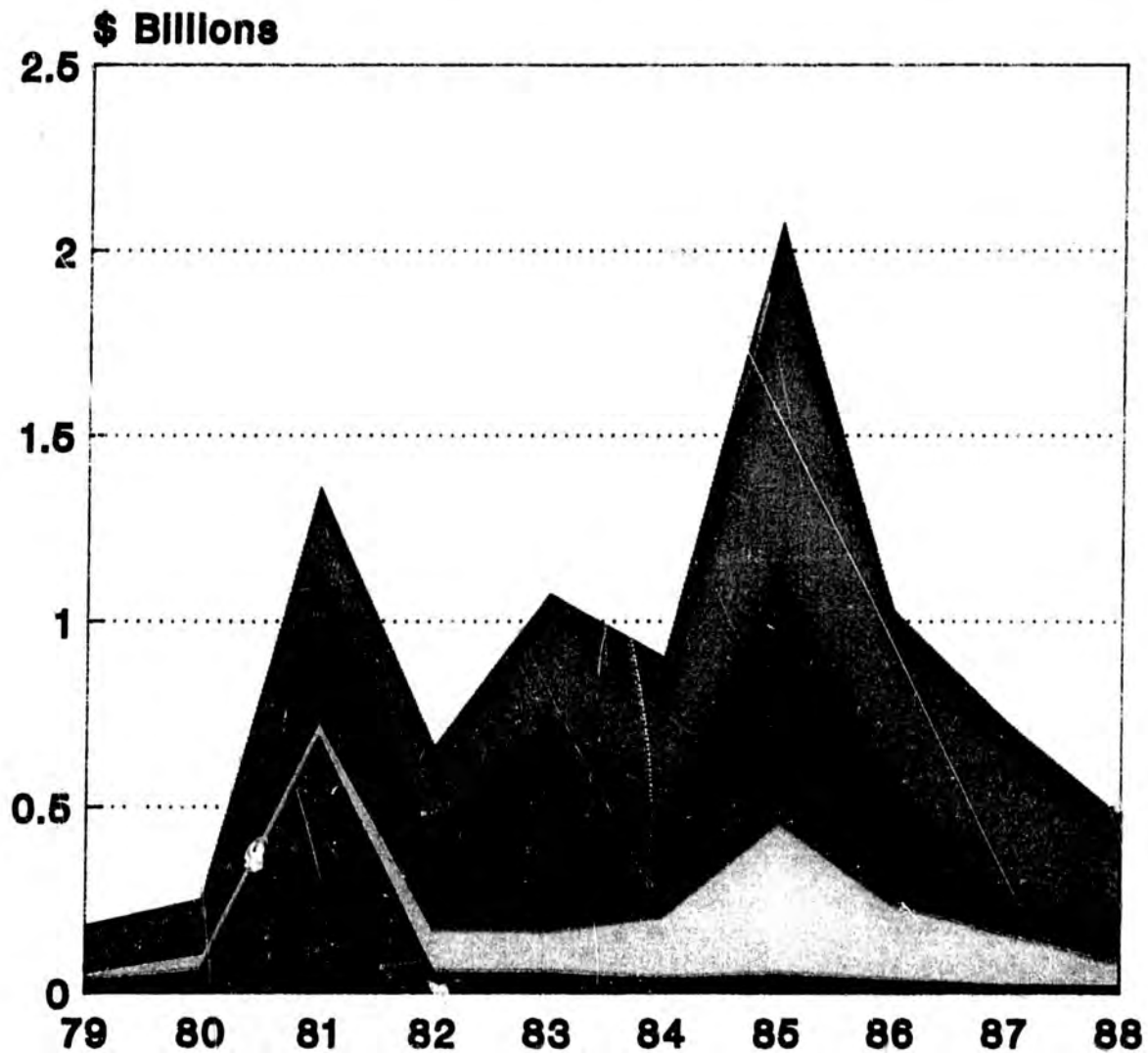
Standard expenditures amount to \$18.4 billion (70.5 percent) while special expenditures amounted to \$7.7 billion (or 29.5 percent). State general fund spending peaked in 1985, three years after revenue peaked.

In fiscal 1987 and 1988, standard and special expenditures amounted to \$6.8 billion of which special spending made up approximately \$750 million (or 11 percent) of total state spending. Most of the special spending consisted of Permanent Fund dividends.

The following exhibits describe patterns of standard general fund expenditures by program category, by operations spending and by capital spending, and finally by operating and capital expenditure for health. For a full disclosure of the State of Alaska Operations and Capital Expenditures from 1979 through 1988, see Appendix.

STATE OF ALASKA

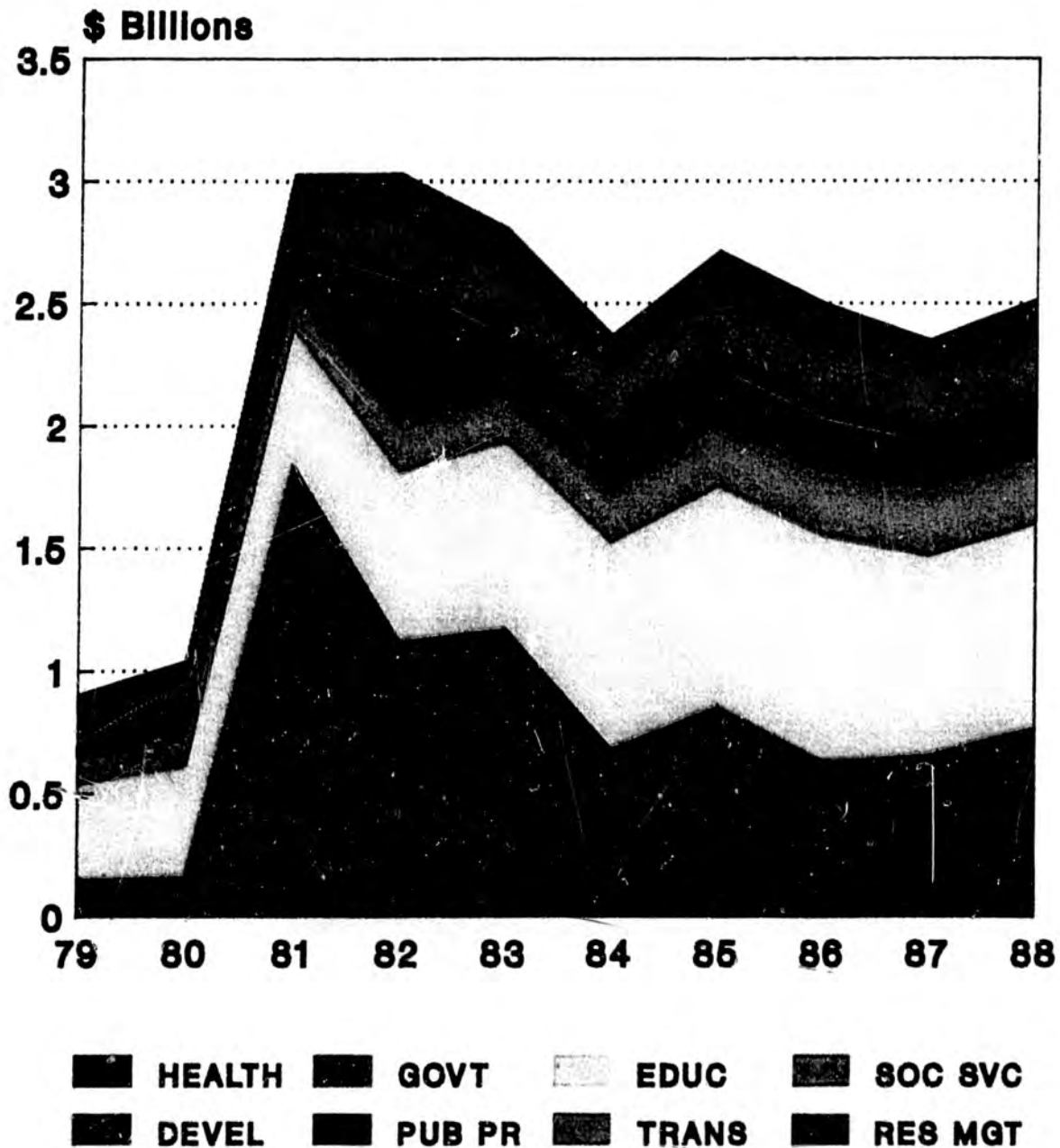
STANDARD GENERAL FUND CAPITAL SPENDING 1979-1988



HEALTH	GOVT	EDUC	SOC SVC
DEVEL	PUB PR	TRANS	RES MGT

STATE OF ALASKA

STANDARD GENERAL FUND OPERATION SPENDING 1979-1988



• Excludes Administration of Justice

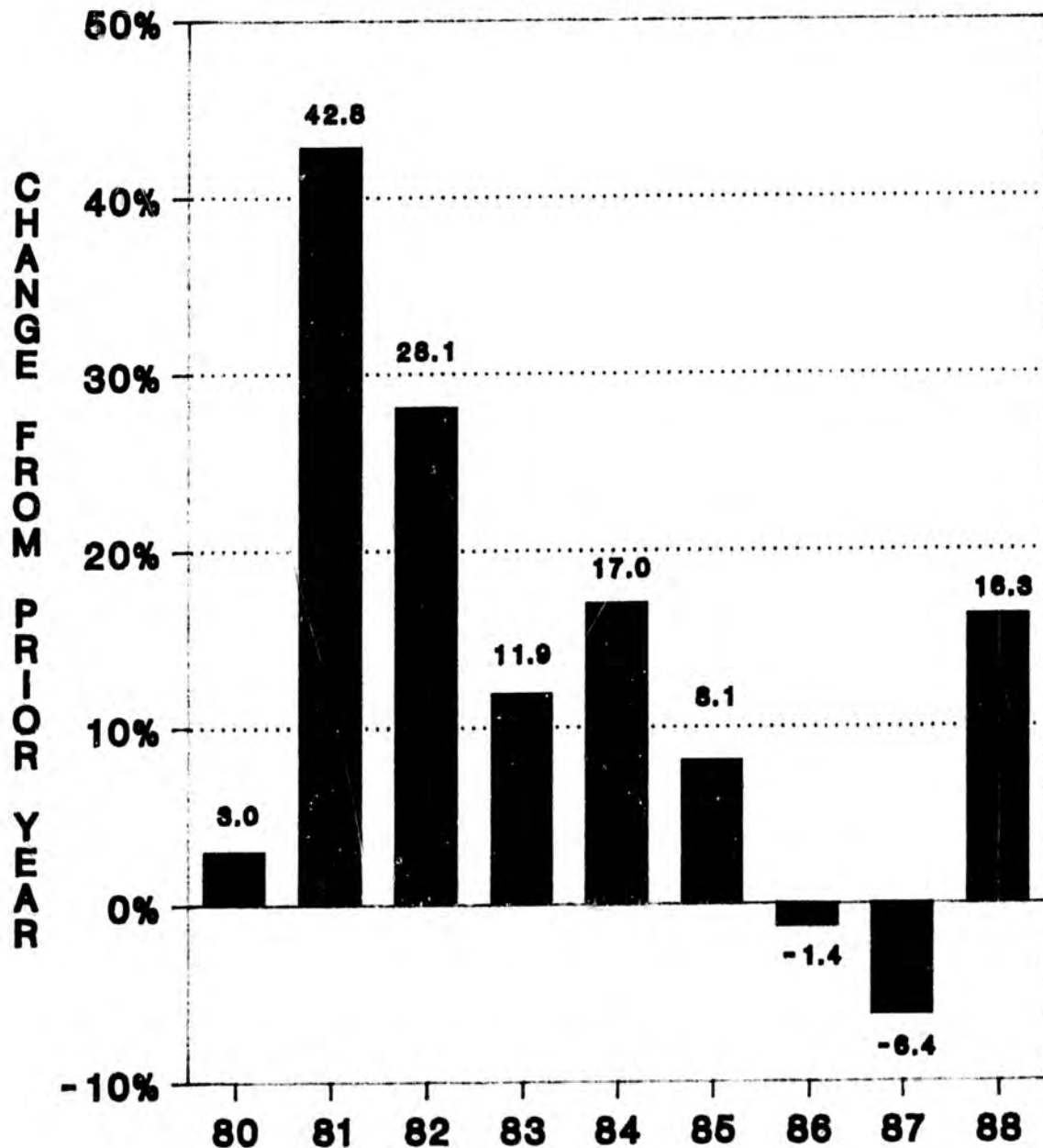
HEALTH EXPENDITURES

Operating and capital expenditures on health during fiscal 1981 through 1986 amounted to \$950 million (or 5 percent) of standard expenditures, an average of \$153 million per fiscal year. Using fiscal 1979 and 1980 as a point of reference, an average of \$74 million was spent in each year. By fiscal 1987 total expenditures on health amounted to just over \$177 million, a 6 percent decrease from the previous year. By fiscal 1988, state spending increased more than 16 percent, to over \$206 million.

During the 1986 through 1987 period, health expenditures decreased at a decreasing rate (-6.4 percent) compared to total expenditures (-12.4 percent). From 1987 through 1988, health expenditures substantially increased (+16.3) compared to a 2.5 percent decrease in total expenditures. See ILLUS. for a complete comparative analysis of expenditures from 1979 through 1988.

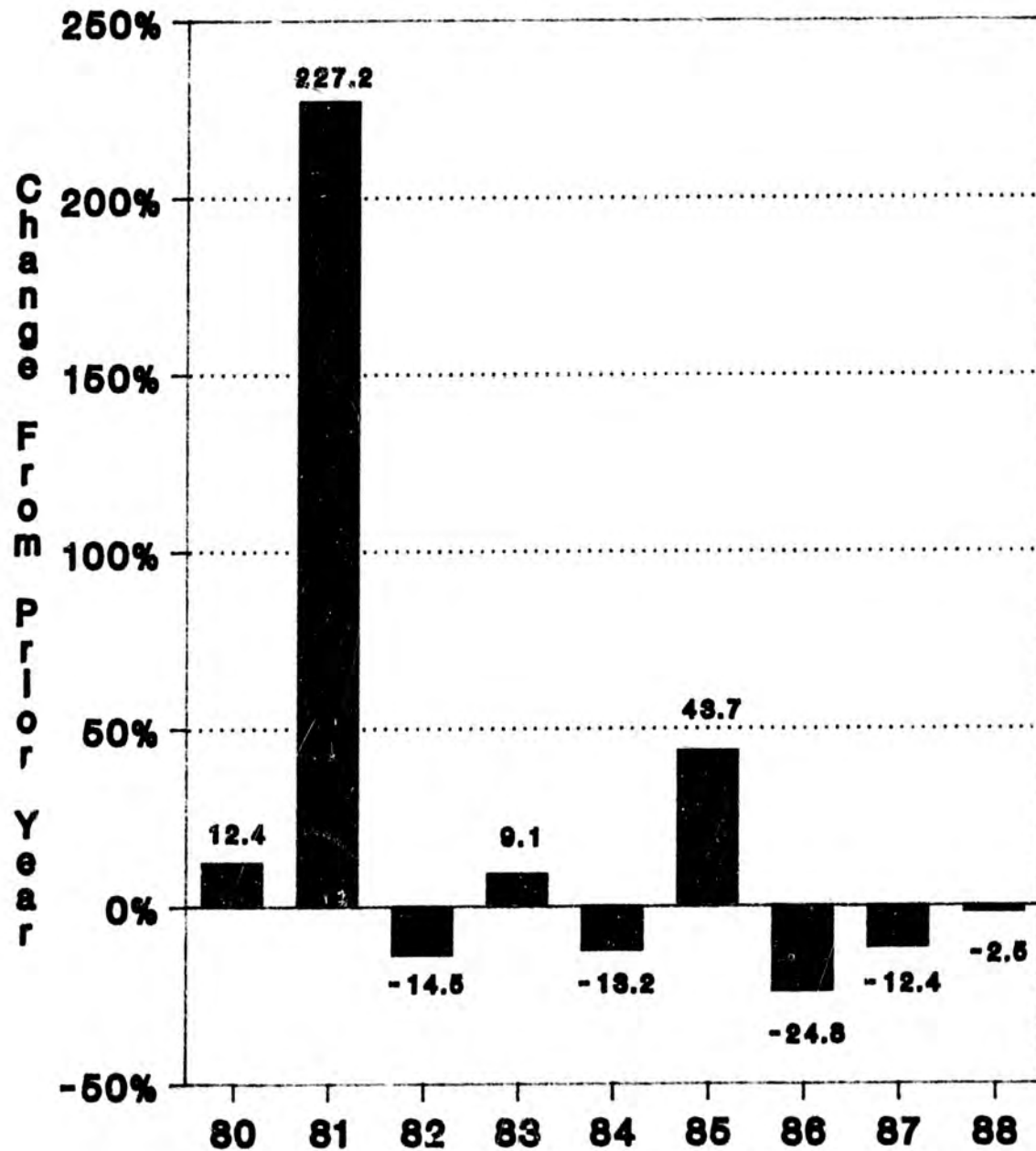
STATE OF ALASKA

PERCENT CHANGE IN HEALTH EXPENDITURES 1979-1988



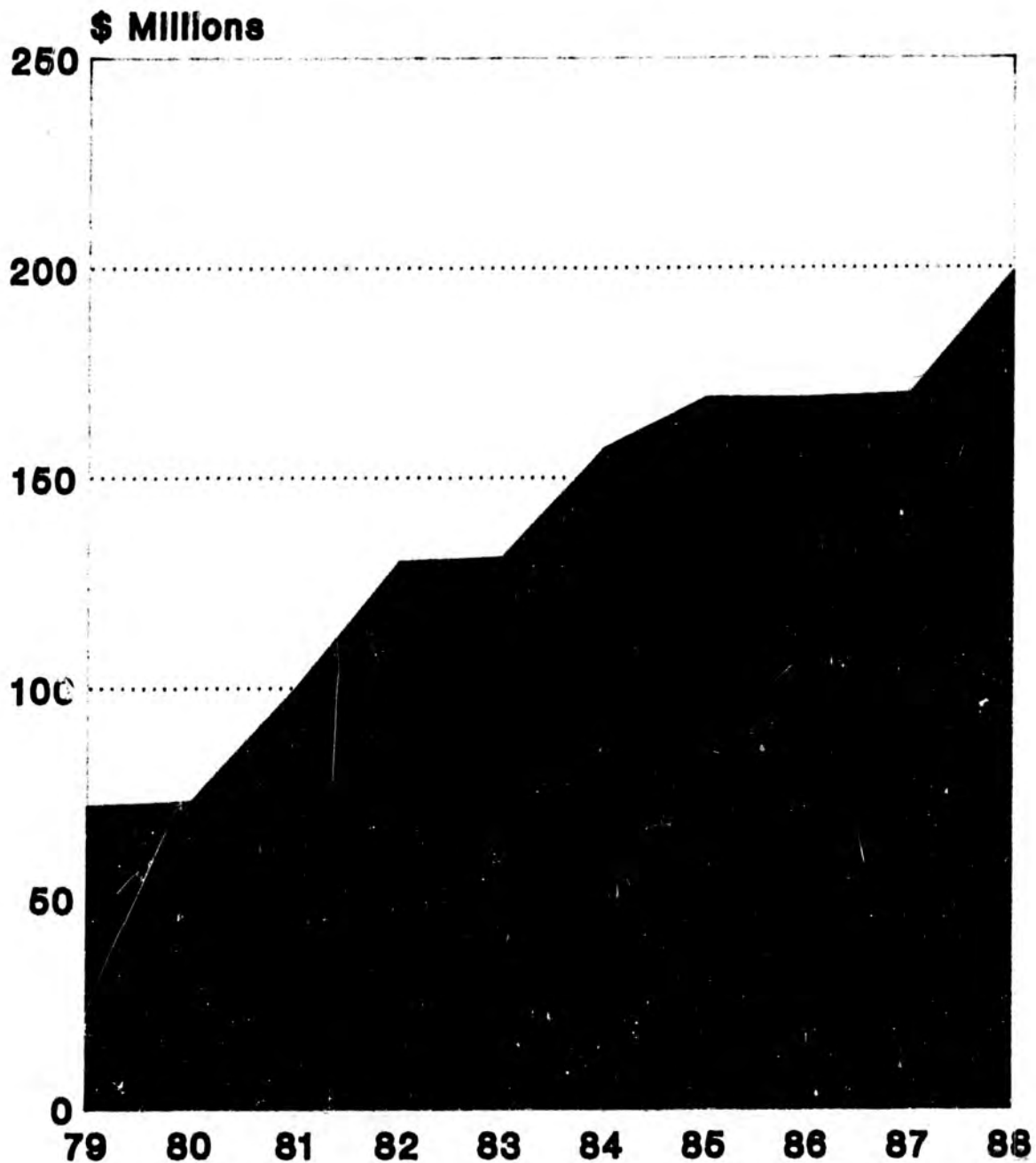
STATE OF ALASKA

PERCENT CHANGE IN TOTAL EXPENDITURES 1979-1980



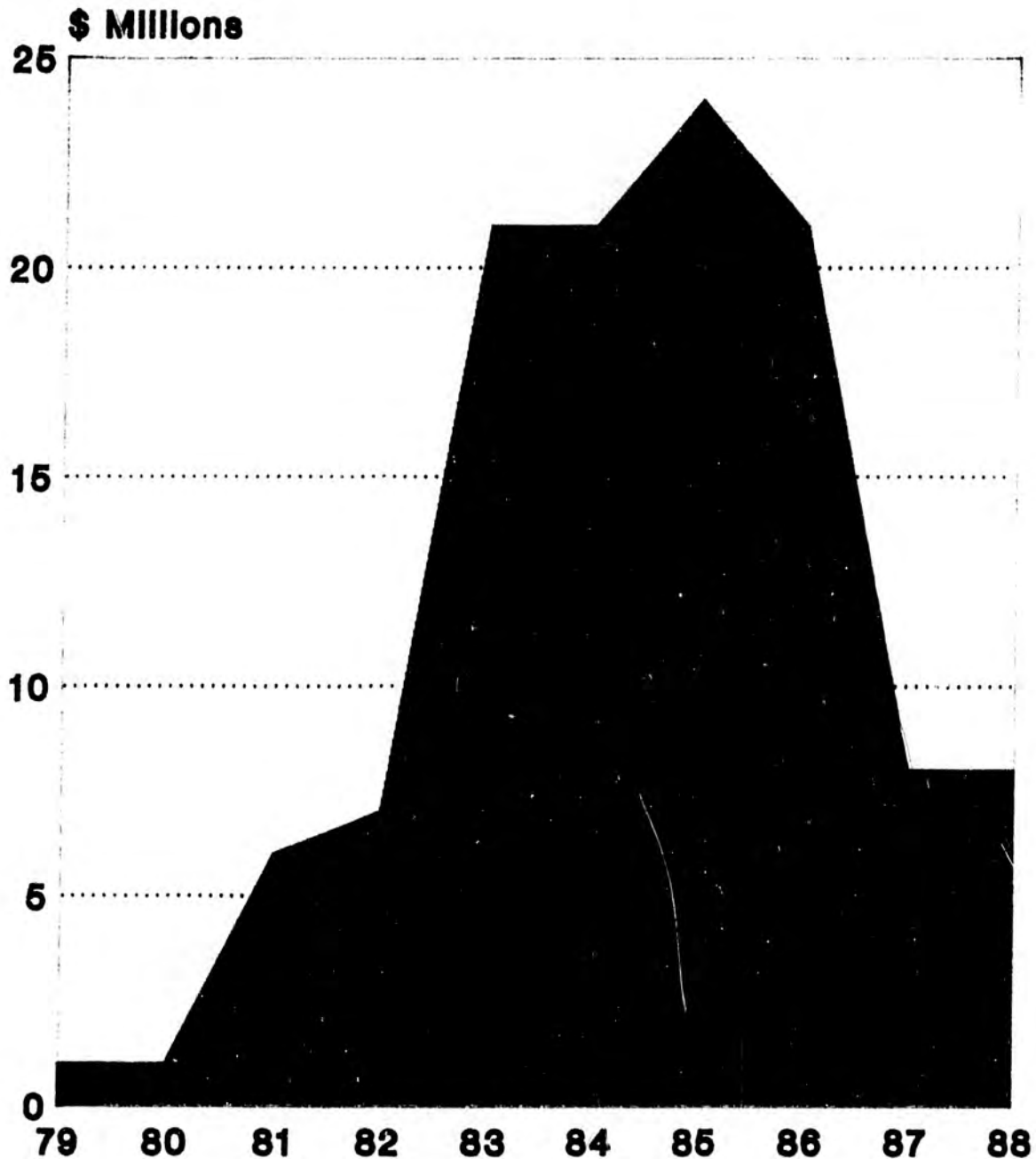
STATE OF ALASKA

STANDARD GENERAL FUND OPERATION SPENDING HEALTH ONLY



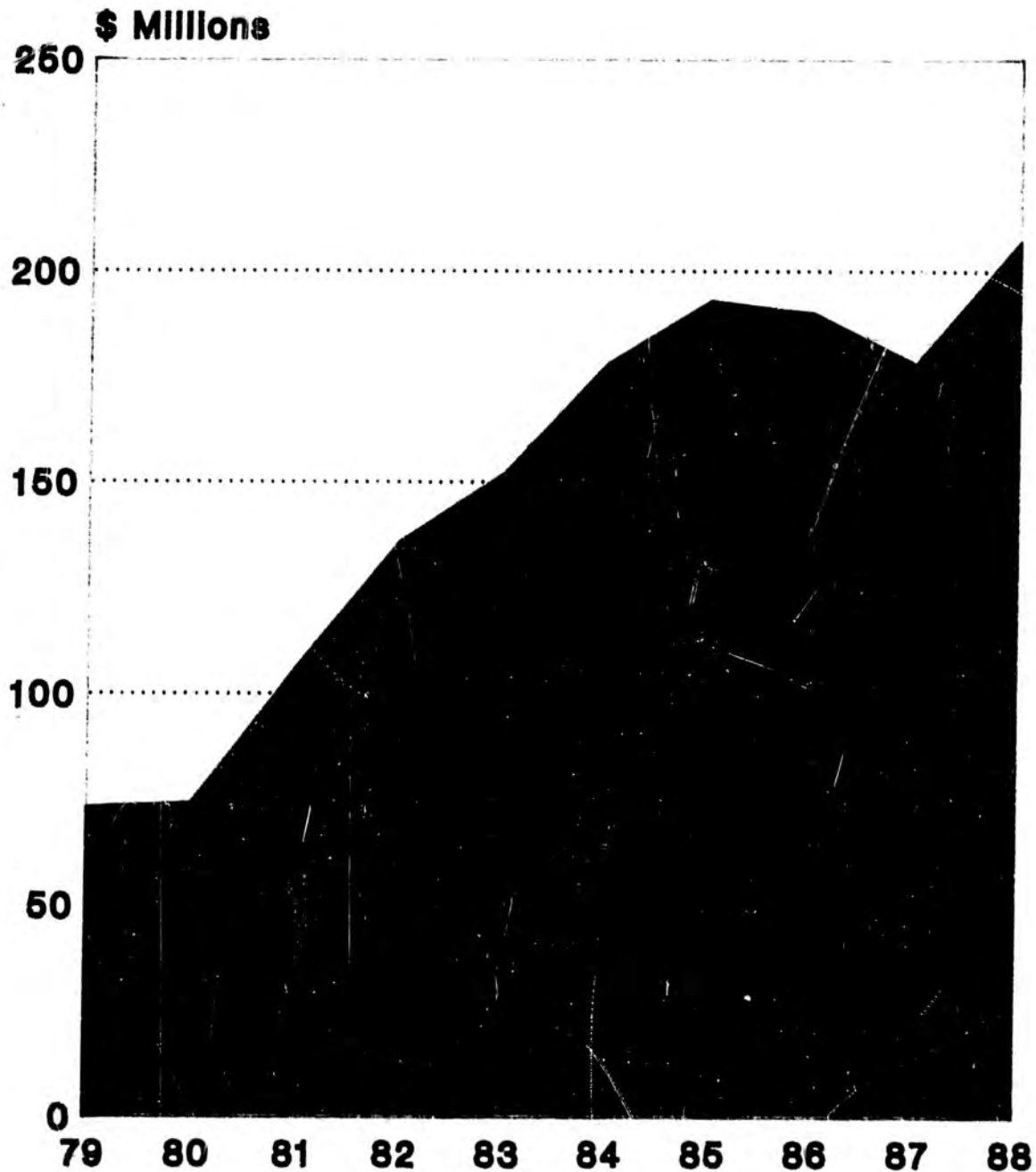
STATE OF ALASKA

STANDARD GENERAL FUND CAPITAL SPENDING HEALTH ONLY



STATE OF ALASKA

STANDARD GENERAL FUND TOTAL SPENDING HEALTH ONLY



SECTION B

**ALTERNATE FUNDING UPDATE
(ACTIVE/RETIRES AETNA PLAN)**

ALTERNATE FUNDING UPDATE
(ACTIVE/RETIREE PLAN)

Previously, the Health Care Cost Containment Task Force had identified alternate funding options under the Aetna plan as a technique to provide the state with plan savings, cash flow advantages and potentially greater returns on reserves.

The following alternate funding methods were identified by the task force:

- Premium Delay
- Retrospective premium calculation
- Minimum premium plans (partially self-funded)
- A.S.O. (self-funded)

ALTERNATE FUNDING UPDATE

During the October 1989 task force meeting, the task force requested that the Department of Administration review the feasibility of implementing an alternate funding (ie: minimum premium) mechanism that were identified by the task force and report back to the task force.

The commissioner reviewed some of the alternative options some time ago and that at that time it was determined that implementation was not acceptable possibility.

However, if the task force requested, they could direct their "consultant, A.J. Gallagher & Co." to review the feasibility.

In fact, A. J. Gallagher & Co. reviewed the feasibility and impact of alternate funding in our report in March 1989. We continue to believe that alternate funding of the state plan would provide many advantages that would for outweigh the disadvantages.

Some of the advantages are:

- Reserves would remain in the state (resulting in a potentially higher rate of return)
- Claims would be paid as presented versus prepaid as they currently are paid (more money would remain in the state)
- Cash flow advantages
- Potentially overall lower plan cost
- The insurance risk of the state plan would be more attractive to other health care providers (at RFP time)
- Greater plan design flexibility

RECOMMENDATION

We can review this issue, however, administration is in a better position because they are aware of their system's limitations. With the continually rising costs of these plans any strategies that contain health care costs should be reviewed and implemented immediately. It is highly unusual to see a plan of this size fully insured, this long.

OFFICE OF THE PRESIDENT

MEMBER

TENTH ALASKA LEGISLATURE
ELEVENTH ALASKA LEGISLATURE
TWELFTH ALASKA LEGISLATURE
THIRTEENTH ALASKA LEGISLATURE
FOURTEENTH ALASKA LEGISLATURE
FIFTEENTH ALASKA LEGISLATURE
SIXTEENTH ALASKA LEGISLATURE



SENATOR TIM KELLY

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ANCHORAGE, ALASKA 99521
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October 9, 1989

John Andrews, Commissioner
Department of Administration
P.O. Box C
Juneau, Ak 99811

Re: Request for information pertaining to health care costs.

Dear Commissioner ^{Take} Andrews,

The Health Care Cost Containment Task Force applauds the initiative and efforts of your department and ASEA to implement cost containment measures in the State's health plans. The attention of the Task Force itself is now primarily directed to other areas of potential cost savings. These include self insurance concepts, pooling with other entities, and buying power mechanisms (e.g., HMO and PPO) to affect favorable health provider costs.

At the October 5 meeting, the Task Force requested the assistance of the Division of Retirement and Benefits for information important to our efforts. Specifically requested were:

- A. Analyze the implementation of alternate funding concepts under the Aetna contract as part of the renewal process. The analysis should include the costs/savings, advantages and disadvantages of the following formats:
 - Premium delay
 - Retrospective Premium Arrangement
 - Minimum Premium
 - Administrative Services Only (ASO)
- B. Review and recommend advantages and disadvantages of having the renewal action by Aetna coincide with the fiscal year. Secondly, could the SBS plan also be on the same basis?
- C. Provide information on the extent to which cost containment measures may be applied to the retiree health plan, e.g.:
 - a. How are benefits set and changed if necessary?

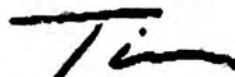
Com. Andrews
Oct. 9, 1989
Page 2

- b. Which of the recent cost containment measures implemented for the actives could be applied to the retirees' health plan unilaterally?
- c. What happens if the retirees' health premium cost plus the retirement payments exceed the pension funds?

The next meeting of the Task Force is tentatively set for November 20. If possible, it would be most useful if the information could be provided at that time. In this regard, our consultant is available in clarifying and assisting in this work effort.

Thank you for your attention to this request.

Sincerely,



TIM KELLY
Chair
Health Care Cost Containment
Task Force

STATE OF ALASKA

DEPARTMENT OF ADMINISTRATION**OFFICE OF THE COMMISSIONER****STEVE COWPER, GOVERNOR**

P.O. BOX C
JUNEAU, ALASKA 99811-0200
PHONE: (907) 485-2200

October 25, 1989

The Honorable Tim Kelly
Alaska State Legislature
P.O. Box V
Juneau, AK 99811

Dear Senator Kelly:

The Health Care Cost Containment Task Force has requested assistance on a number of issues. I have addressed these requests in the same order as in your letter of October 9.

- A. The Department of Administration reviewed the issue of limited self insurance through the use of a third party claims payer in April 1988. It did not appear to be a desirable alternative at that time. It may be that an examination of the different formats you suggest would be worthwhile at this time. The limitation on our resources at this time makes it difficult to undertake a detailed study of the subject in any detail.

We would be happy to work with the Task Force's consultant, Mr. Malek, or the Legislature's Research Agency in providing any facts and figures from the administration that would assist in preparing a report to your Task Force. I would of course recommend that they contact Aetna for any possible financial considerations and Touche Ross, the health consultant for Retirement and Benefits regarding their perspective on alternate funding.

- B. The beginning of the SBS year, February 1, was designed to put employee deductions and annuity contributions to employee accounts on a calendar or tax year basis. Annuity contributions are based on the social security wage base which is also based on a tax year. While it is possible to change the beginning of the SBS year and its renewal action, the administrative effort and employee confusion would be considerable.

The Honorable Tim Kelly
October 25, 1989
Page 2

The renewal date for the active group plan was changed to a February 1 basis to put all renewals with the health carrier on a common date. While the renewal of the group medical contracts have become somewhat less complicated, it can be confusing when a single fiscal year incorporates two health insurance premiums. The actual date of the renewal has no effect on the budgeting for health insurance premiums.

If the Task Force has recommendations for contract renewals on either the SBS or the group plan, I would be happy to consider these recommendations.

C. Health Cost Containment for the retiree medical plan.

a. Retiree medical benefits are provided for in statute for all retirees under any of the State's retirement systems. They are provided at no cost to the retiree and are paid from the respective retirement funds.

The actual level of benefits for retirees is set by the administrator of the retirement systems, the Commissioner of Administration. Retirement health benefits have come to be recognized as an accrued benefit and something that cannot legally be diminished. Any changes to the retiree medical plan must avoid diminishment of benefits to existing retirees. I believe there are a number of changes that could be made to the retiree health plan that would significantly reduce premiums and at the same time, not be considered a diminishment of benefits.

b. I have asked the Department of Law to review the recently signed agreement with the Alaska State Employees Association to determine which of the benefit changes could be implemented in the retiree medical plan. I would plan on making any possible changes to the retiree coverage effective on July 1, 1990.

c. The health premiums for retirees are paid directly to the health carrier from the appropriate retirement funds. All employees and employers who participate in the retirement systems contribute to the funds. The contribution rate for all employees is set in statute at a constant rate. The contribution rate for employers changes annually and is affected by such things as legislation, employee demographics and actuarial

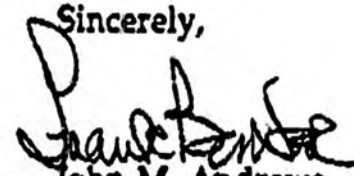
The Honorable Tim Kelly
October 25, 1989
Page 3

assumptions. Generally, as health costs have continued to increase, employer contributions have increased due to actuarial assumptions necessary to maintain adequate funding of the systems.

The contribution rates are set each year to amortize known and projected costs into the future. As long as the retirement funds continue to be adequately funded as they are now, all benefits that are due to retirees will be funded when the time comes to pay this liability.

We do not plan on having Touche Ross attend the November Task Force meeting unless there is some specific purpose in having them attend. I hope that Mr. Malek can work with Touche Ross in preparing the report that you have requested.

Sincerely,


John M. Andrews
Commissioner

JMA/MBC/ksl

Nationwide, 8% of all employment-related health plans were self-insured in 1984, which translates into more than 175,000 self-insured plans, according to a 1986 study conducted by the Health Care Financing Administration, Division of National Cost Estimates. The study, written by Patricia McDonnell, Abble Guttenberg, Leonard Greenberg, and Ross H. Arnett, and published in the winter 1986 issue of *Health Care Financing Review*, also notes that among the largest organizations, as many as 80% are self-insured.

The study analyzes which companies do and do not self-insure. The propensity of an organization to self-insure, according to the study, differs primarily by its size, with large establishments more likely to self-insure. In the overwhelming majority of cases, the self-insured benefit was hospital and/or medical coverage.

This report excerpts the study, entitled *Self-Insured Health Plans*. For reprints of the entire study, write to Carol Pearson, L1, 1705 Equitable Building, 6235 Security Blvd., Baltimore, MD 21207.

The number of employment-related health plans that are self-insured has increased so dramatically in the past decade that the vast majority of large establishments now use some form of self-insurance, and the practice is growing among smaller establishments. It is estimated that 67% will have self-funded in 1986.

Even though only 8% of all employment-related health plans are self-insured, more than 50% of all employees with health insurance participate in these self-insured plans. Some reasons employers do not offer health insurance coverage to employees may be because they consider it to be too expensive a benefit, most employees are covered under a relative's plan, or most employees are part-time workers. The low percentage of self-insured health plans may be misleading, because more than 90% of employers have less than 100 employees and rarely self-insure. However, among the remaining organizations with 100 or more employees in 1984, the proportion of employers who self-insured increased rapidly with size—in 1984, one-third of those with 100 or more employees, more than one-half of those with 250 or more employees, three-fourths of those with 1,000 or more employees, and four-fifths of those with 5,000 or more employees offered a benefit that was self-insured. In the overwhelming majority of cases, the self-insured benefit was hospital and/or medical; in more than one-third of the cases, the self-insured benefits included dental and/or vision.

Definitions

For the most part, the terms "self-insurance" and "self-funding" mean essentially the same thing and are often substituted for one another. Occasionally, however, there are definitional difficulties in using these terms interchangeably because plans that are self-funded are not necessarily self-insured. For example, employers might self-fund a retrospective premium agreement on a conventional group insurance contract, but there is no effective risk shift because employers are liable for additional premiums. Funding implies setting aside money to pay for future claims. Insurance implies the assumption of risk by accepting responsibility for reimbursing providers for employees' health claims. Plans that self-insure must also self-fund by setting aside money on an unfunded basis through a general asset plan or by establishing a 501(c)(9) trust, also known as a voluntary employee beneficiary association (VEBA).

Substantial growth of VEBAs occurred in the 1950s when jointly administered plans, under the Labor Management Relations Act of 1947, began using tax-exempt trusts. In addition, because VEBAs are able to restrict membership according to "objective conditions reasonably related to employment," they are able to influence their aggregate claims costs, thereby making them attractive to employers. Currently, however, unfunded plans are more common than funded plans.

partly as a result of the 1984 Deficit Reduction Act (DEFRA) that limited the amount of assets that could be held tax-free in a trust.

The Wyatt Company found that 27% of the employers it surveyed in 1986 were unfunded because they had not established a 501(c)(9) trust for their self-insured medical plans, and 22% were funded because they had established a 501(c)(9) trust.

Partial Self-Insurance

Not all health plans are totally self-insured to totally fully insured. Increasingly, they combine elements of fully insured and self-insured plans, as in the case of minimum-premium plans, stop-loss coverage, and administrative-services-only agreements.

Employers who partially self-insure may limit their risk exposure by engaging a third-party insurer to provide stop-loss coverage beyond a certain dollar threshold or by purchasing a minimum-premium plan. Stop-loss coverage is a reinsurance policy in that it protects the self-insured policyholder against excessive claims on either an aggregate-plan basis or specific-individual basis. As with a purely self-insured plan, the employer assumes all responsibility for the financial risk of random claim fluctuations below the stop-loss threshold.

Stop-loss coverage, when it is purchased as an accompaniment to self-insurance, is more expensive than pure self-insurance on the average. However, it protects the employer against large unforeseen claims and random claim fluctuations while still minimizing premiums, taxes, and reserves.

Responsibility for payment in a minimum premium plan is allocated between the employer and the insurer, with the employer liable for paying up to 90% of expected claims and with the insurer liable for paying anything in excess of the 90% figure. This arrangement retains for the carrier the full complement of underwriting, claims processing, claims review, and administrative services. In addition, the carrier usually establishes reserves for the full risk of the account. Under a minimum-premium plan arrangement, employers may avoid paying premium taxes on 90% of claims funds.

The term "partially self-insured" is sometimes used to describe an employer who self-insures for some benefits and purchases commercial insurance for other benefits.

Self-Insurance Findings

Findings on the rate of self-insurance among all employer organizations, including business establishments, unions, religious organizations, governments,

and schools are presented in Figure 1 (next page). On a nationwide basis, it was found that 8% of all organizations that provide health insurance coverage for their employees did so, in full or in part, through some form of self-insurance. Although only 6% of the more than 2.2 million organizations with one to 99 employees that offer health plans are self-insured, that percent rises rapidly with organization size. This translates into coverage by more than 175,000 self-insured health plans for more than 50% of the work force.

Nationwide percents and totals in Table 1 (next page) were derived from a random sample of approximately 28,500 business establishments, unions, religious organizations, post-secondary schools, and governmental units. The sample findings were then weighted to account for the fact that not all types and sizes of organizations were sampled (or responded) with equal probability.

Organization Size

In this section, all employees (full-time and part-time) are included in the data. Findings support the theory that the more employees in the organization, the greater the propensity to self-insure. Fewer than one out of every ten organizations with less than 100 employees self-insure compared with four out of every five organizations with more than 5,000 employees.

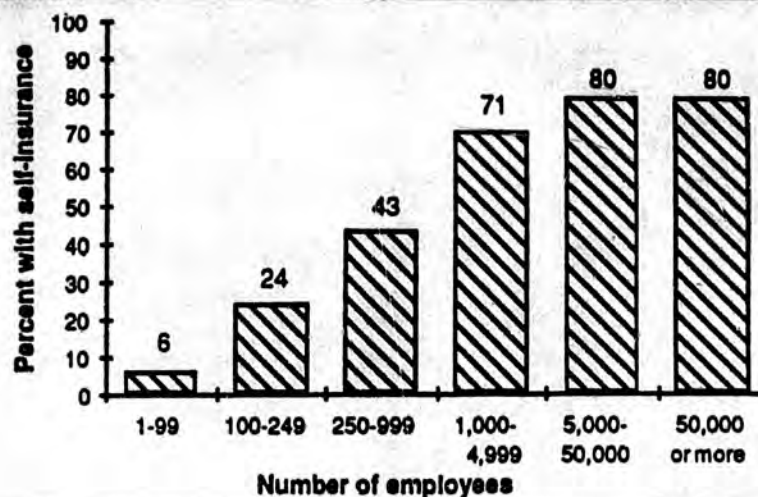
The most likely explanation for high rates of self-insurance among large establishments is that their risk pools are large and actuarially enable them to better predict their employees' health expenses. The size at which organizations seem to be risk indifferent as to how they insure (self versus purchased) is the 250 to 1,000 employee range. This corresponds with the minimum group size in which health benefits are actuarially predictable with a reasonable degree of confidence.

To assess the quality and validity of our results, we compared the 8% self-insurance rate with previously reported findings by other organizations that study self-insurance. At first glance, our results appeared too low. For example, both Coopers and Lybrand (1984) and the Wyatt Company (1984) reported self-insurance rates of approximately 60% for the organizations in their respective studies.

When examined more closely, however, this statistic is wholly consistent with our findings (see Table 1) that 53% of organizations with more than 250 employees and 74% of organizations with more than 1,000 employees self-insure.

continued on next page

Figure 1. Percent of organizations with self-insured health plans, by size: 1984



Note: The total of all organizations with self-insured health plans was 8%.

Table 1. Number and percent of organizations with self-insured health plans, by type of organization and size: 1984

Type of organization	Number of employees						
	Total	1-99	100-249	250-999	1,000-4,999	5,000-49,999	50,000 or more
All organizations							
Total with health plans	2,344,335	2,234,875	59,610	30,700	12,180	4,030	230
Number of self-insured	176,424	136,881	14,190	13,266	8,655	3,238	184
Percent of self-insurance	8	6	24	43	71	80	80
Cumulative percent ¹	—	6	36	55	74	80	—
Business establishments							
Total with health plans	2,286,810	2,197,000	48,600	24,300	10,500	3,530	180
Number of self-insured	163,626	132,000	11,000	10,100	7,500	2,880	146
Percent of self-insurance	7	6	23	41	71	82	81
Cumulative percent ¹	—	7	36	54	74	82	—
Unions							
Total with health plans	3,672	620	700	1,290	815	220	17
Number of self-insured	2,227	200	330	810	685	175	17
Percent of self-insurance	61	32	47	63	84	80	100
Cumulative percent ¹	—	61	66	72	83	81	—
Religious organizations							
Total with health plans	780	470	100	110	70	30	—
Number of self-insured	184	36	25	51	50	22	—
Percent of self-insurance	24	8	25	46	71	73	—
Cumulative percent ¹	—	24	51	59	72	—	—
Governmental units²							
Total with health plans	49,111	35,600	9,000	3,950	440	110	6
Number of self-insured	9,446	4,490	2,590	2,020	265	78	3
Percent of self-insurance	19	13	29	51	60	68	50
Cumulative percent ¹	—	19	37	52	62	67	—
Post-secondary schools							
Total with health plans	3,962	1,185	1,210	1,050	355	135	27
Number of self-insured	941	155	245	285	155	83	18
Percent of self-insurance	24	13	20	27	44	61	67
Cumulative percent ¹	—	24	28	35	50	62	—

¹ Cumulative percent for a given cell is the percent of organizations of that size or greater that are self-insured

² Governmental units include counties, municipalities, townships, and school districts

³ Based on a very limited number of observations (5 or fewer)

⁴ Statistically unreliable

SOURCE: Health Care Financing Administration, Office of the Actuary. Data from the Division of National Cost Estimates

As Many As 80% Of Largest Firms Self-Fund Health Care, Says Health Care Financing Administration Study

Wyatt Company's results were further similar to ours in that 75% of their respondents with 7,501 to 10,000 employees self-funded their health plans in 1984.

[Ed. Note: Surveys of insurance companies done by Charles D. Spencer & Associates confirm the high rate of self-funding. In 1986, among 43 large insurance companies surveyed, self-funded and minimum premium plans represented approximately 68% of all health insurance in force among these insurers. In other words, more than two-thirds of health coverage provided by major insurers in 1986 was not insured health care. The complete insurance company survey may be found at RR 311.-69.]

The difference in the overall self-insurance rate is because the other surveys were designed to encompass a relatively limited range of firms, most of which had more than 100 employees, including a preponderance of firms with more than 500 employees.

Organization Type

When organizations are compared by type, business establishments and unions show the greatest disposition toward self-insurance. Among business establishments, 74% of all firms with more than 1,000 employees self-insure.

Unions have an even greater penchant for self-insurance. As shown in Table 1, 83% of unions with greater than 1,000 employees have some form of self-insurance. Even unions with less than 100 employees are moderately likely to be self-insured. Possible explanations for these high rates among union health plans are that unions have traditionally been involved in employee benefit innovation and their aim to deliver comprehensive benefit packages is bolstered when the same level of benefits can be delivered more economically.

As depicted in Table 1, religious organizations, governments, and schools with large numbers of employees are somewhat less likely than either businesses or unions with large numbers of employees to self-insure. These organizations usually have fixed incomes and therefore, in many instances, prefer to purchase insurance with the knowledge that there is no potential for cost overruns.

It is important when comparing self-insurance rates of different types of organizations against one another to compare similar size categories. If one compares only totals, those organizations with a disproportionate number of small establishments will tend to have a lower overall self-insurance rate—17% of unions have one to 99 plan participants, 32% of schools have one to

99 plan participants, 61% of religious organizations have one to 99 plan participants, 85% of governmental units have one to 99 plan participants, and 96% of business establishments have one to 99 plan participants.

Self-Insured Benefits

Findings on those benefits for which an organization is most likely to self-insure are shown in the following Table 2. Survey respondents were asked to indicate whether they self-insured for hospital and/or medical benefits, dental and/or vision benefits, or both. Organizations that do not self-insure for one or both benefit groups may still provide these benefits through purchased insurance.

As shown in the table, business establishments, religious organizations, and governments are approximately twice as likely to self-insure for hospital and/or medical benefits than for dental and/or vision benefits. The propensity of an organization to self-insure for one or both of these benefit groups generally increases as organization size increases. Unions, if they self-insure, are more inclined than other types of organizations to self-insure for dental and/or vision benefits; post-secondary schools are less inclined to self-insure for these benefits. ■

Table 2

Percent of self-insured health plans that self-insure for hospital and/or medical, dental and/or vision, or both, by organization type and size: 1984

Organizations type and size	Self-insured for—	
	Hospital and/or medical	Dental and/or vision
	Percent	
All types and sizes combined	91	49
Type		
Business establishments	91	48
Unions	93	77
Religious organizations	93	45
Governmental units ¹	99	51
Post-secondary schools	98	30
Size²		
1 or more	91	49
100 or more	98	52
250 or more	98	59
1,000 or more	99	74
5,000 or more	99	81

¹ Governmental units include counties, municipalities, townships, and school districts.

² Number of employees of that size or greater that are self-insured.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Division of National Cost Estimates.

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
- **Provides 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 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**

15 - 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 forma 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

Senate Bill 254

BY SENATOR DUNCAN

ALASKA STATE GROUP HEALTH INSURANCE AUTHORITY

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

Section 1.**PURPOSE**

The purpose of this act is to provide comprehensive group health insurance for all eligible employees of the state, a municipality, or a school district. It will also expand the pool of subscribers to provide the maximum opportunity for cost containment when purchasing group health insurance.

Section 2.**CREATION OF THE AUTHORITY**

The Alaska State Group Health Insurance Authority is created within the Department of Commerce and Economic Development as a nonprofit corporation to provide group health insurance to eligible state, municipal, and school district employees.

BOARD OF DIRECTORS

The board of directors will be composed of 16 members representing:

- (1) the commissioner of administration;
- (2) the commissioner of health and social services;
- (3) the director of the division of insurance;
- (4) 13 members appointed by the governor representing the following:
 - (A) one member representing local governments;
 - (B) one member representing school boards;
 - (C) two members representing public school teachers;

SB 254
page 2

- (D) one member representing the public who is not a state or municipal employee;
- (E) two members from the permanent public employees in the classified service of the state;
- (F) one member from the permanent employees of the University of Alaska;
- (G) two members from the permanent employees of school districts;
- (H) two members from the permanent employees of municipalities; and
- (I) one member representing health care providers.

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) exercise the powers granted to insurers under the laws of the state;
- (2) sue or be sued;
- (3) enter into contracts or agreements;
- (4) establish administrative and accounting procedures;
- (5) collect, invest, and distribute funds;
- (6) adopt necessary regulation and procedures for the operation of the Authority.

FIDUCIARY RESPONSIBILITY

The board is responsible for obtaining group health insurance that provides comprehensive coverage at the lowest

SB 254
page 3

possible cost to eligible employees.

PROCUREMENT OF INSURANCE

The Authority shall purchase an insurance policy or policies from companies licensed to sell insurance in Alaska. This insurance shall cover eligible employees of the state, municipalities, and school districts. In addition the Authority may act as a self-insurer if it finds that self-insurance is a cost effective way to provide insurance coverage to eligible employees.

Except when acting as a self-insurer the Authority shall comply with the State Procurement Code and make bid specification for the desired group health insurance available to all qualified carriers. The specifications shall be available at least once every five years.

STATE GROUP HEALTH INSURANCE FUND

The Fund is an account in the state general fund that consist of money appropriated by the Legislature and insurance premiums collected by the Authority. The board is responsible for the management and investment of money in the Fund and has the authority to use money from the Fund for operation of the Authority.

INSURANCE PREMIUMS

Premiums are collected from participating agencies, municipalities, and school districts in amounts sufficient to provide the required insurance coverage and to cover the operating expenses of the Authority. All premiums are deposited in the State Group Health Insurance Fund.

SB 254
page 4

REQUIRED PARTICIPATION

The state, each municipality, and each school district shall purchase Group Health Insurance from the authority.

WAIVER

A waiver of the requirement to purchase group health insurance from the Authority may be granted. The Authority shall establish minimum benefit and financial standards for desired group health insurance coverage. A participant seeking a waiver of coverage shall provide documentation before the deadline established by the board that their insurance coverage matches or is better than the minimum benefit and financial standards established by the Authority. The board may approve or disapprove the request for a waiver. Once the board has contracted for insurance coverage no waivers can be granted.

Participants may purchase additional coverage beyond that available from the Authority.

DEFINITIONS

- (1) "authority" means the Alaska State Group Health Insurance Authority (ASGHIA);
- (2) "board" means the board of directors of ASGHIA;
- (3) "district" means school district including REAAs;
- (4) "eligible employee" an employee of a participant who qualifies for group health insurance benefits as determined by the participant;
- (5) "fund" means the state group health insurance fund;
- (6) "group health insurance" means insurance coverage that includes life insurance, accidental death and dismemberment, medical care and treatment, dental care,

SB 254
page 3

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 school 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, the Alaska State Building Authority, and the Alaska Railroad Corporation.

Section 3.

Provides that the Department of Administration shall obtain the group health insurance from the Alaska State Group Health Insurance Authority for the retirement programs it administers.

Section 4.

The Alaska State Group Health Insurance Authority is included under the state Conflict of Interest statutes.

Section 5.

The terms of office of the initial members of the board of directors of the Authority shall be staggered by the governor.

Section 6.

Provides for an immediate effective date.

1 IN THE SENATE

BY DUNCAN

2

SENATE BILL NO. 254

3

IN THE LEGISLATURE OF THE STATE OF ALASKA

4

SIXTEENTH LEGISLATURE - FIRST SESSION

5

A BILL

6

For an Act entitled: "An Act relating to group health insurance; and

7

providing for an effective date."

8

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

9

* Section 1. PURPOSE. The purpose of this Act is to

10

(1) provide comprehensive group health insurance for the state,

11

municipalities, school districts, and all eligible employees of the state,

12

a municipality, or a school district; and

13

(2) expand the pool of subscribers and maximize the opportuni-

14

ties for cost containment when purchasing group health insurance.

15

* Sec. 2. AS 21 is amended by adding a new chapter to read:

16

CHAPTER 77. STATE INSURANCE.

17

Sec. 21.77.010. AUTHORITY CREATED. There is established within

18

the Department of Commerce and Economic Development a nonprofit incor-

19

porated legal entity known as the Alaska State Group Health Insurance

20

Authority. The authority shall provide group health insurance to

21

eligible state, municipal, and school district employees.

22

Sec. 21.77.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The

23

authority shall be managed by a board of directors composed of 16

24

members as follows:

25

(1) the commissioner of administration;

26

(2) the commissioner of health and social services;

27

(3) the director of the division of insurance;

28

(4) 13 members appointed by the governor as follows:

29

(A) one member representing local governments;

1 comprehensive coverage at the lowest possible cost to eligible employ-
2 ees.

3 Sec. 21.77.050. PROCUREMENT OF INSURANCE. (a) The authority
4 shall obtain a policy or policies of group health insurance covering
5 eligible employees of participants, from an insurer authorized to
6 transact business in the state under AS 21.09, or act as a self-
7 insurer if the authority determines that self-insurance can provide
8 the desired insurance coverage and benefits at a lower cost to eligi-
9 ble employees.

10 (b) Except when acting as a self-insurer, the authority shall
11 obtain group health insurance in compliance with the provisions of
12 AS 36.30 and shall make available bid specifications for desired group
13 health insurance benefits to all insurance carriers licensed in the
14 state and qualified to provide the desired benefits. The specifica-
15 tions shall be made available at least once every five years.

16 Sec. 21.77.060. STATE GROUP HEALTH INSURANCE FUND. The state
17 group health insurance fund is created in the general fund. The fund
18 consists of money appropriated by the legislature, and premiums col-
19 lected under AS 21.77.070. The fund shall be managed and invested by
20 the board. The board may expend money from the fund to carry out the
21 provisions of this chapter.

22 Sec. 21.77.070. INSURANCE PREMIUMS. (a) The authority shall
23 provide that sufficient premiums are collected to provide the re-
24 quired insurance coverage and to pay the expenses of the authority.
25 All premiums shall be deposited in the fund.

26 (b) Reserves remaining at the termination of an insurance con-
27 tract shall be invested by the authority in the same manner as retire-
28 ment funds are invested under AS 14.25.180.

29 Sec. 21.77.080. REQUIRED PARTICIPATION; WAIVER. (a) The state,

1 State Group Health Insurance Authority;

2 (3) "district" has the meaning given in AS 14.17.250;

3 (4) "eligible employee" means an employee of a participant
4 who qualifies for group health insurance benefits as determined by the
5 participant;

6 (5) "fund" means the state group health insurance fund;

7 (6) "group health insurance" means coverage that includes
8 life insurance, accidental death and dismemberment, medical care and
9 treatment, dental care, eye care, and other group health coverage as
10 determined by the authority;

11 (7) "municipality" includes a public corporation estab-
12 lished by a municipality;

13 (8) "participant" means the state, a municipality, or a
14 district;

15 (9) "state" means the executive, legislative, and judicial
16 branches of state government, or an organizational unit of a branch,
17 and includes the University of Alaska, the Alaska State Building
18 Authority, and the Alaska Railroad Corporation.

19 * Sec. 3. AS 39.30.090 is amended to read:

20 Sec. 39.30.090. PROCUREMENT OF GROUP INSURANCE. (a) The De-
21 partment of Administration may obtain a policy or policies of group
22 insurance covering state employees, persons entitled to coverage under
23 AS 14.25.168, AS 22.25.090, AS 39.35.535 or former AS 39.37.145, [OR
24 EMPLOYEES OF OTHER PARTICIPATING GOVERNMENTAL UNITS,] subject to the
25 following conditions:

26 (1) A group insurance policy shall provide one or more of
27 the following benefits: life insurance, accidental death and dismem-
28 berment insurance, weekly indemnity insurance, hospital expense insur-
29 ance, surgical expense insurance, dental expense insurance, audio-

1 BENEFIT OF THE EMPLOYEES.

2 (7)] A person receiving benefits under AS 14.25.110,
3 AS 22.25, AS 39.35, or former AS 39.37 may continue the life insurance
4 coverage that was in effect under this section at the time of termina-
5 tion of employment with the state [OR PARTICIPATING GOVERNMENTAL
6 UNIT].

7 (5) [(8)] A person electing to have insurance under (4)
8 [(7)] of this subsection shall pay the cost of this insurance.

9 (6) [(9)] For each permanent part-time employee electing
10 coverage under this section, the state shall contribute one-half the
11 state contribution rate for permanent full-time state employees, and
12 the permanent part-time employee shall contribute the other one-half.

13 (7) [(10)] A person receiving benefits under AS 14.25,
14 AS 22.25, AS 39.35, or former AS 39.37 may obtain auditory, visual,
15 and dental insurance for that person and eligible dependents under
16 this section. The level of coverage for persons over 65 shall be the
17 same as that available before reaching age 65 except that the benefits
18 payable shall be supplemental to any benefits provided under the
19 federal old age, survivors, and disability insurance program. A
20 person electing to have insurance under this paragraph shall pay the
21 cost of the insurance. The commissioner of administration shall adopt
22 regulations implementing this paragraph.

23 (8) [(11)] A person receiving benefits under AS 14.25,
24 AS 22.25, AS 39.35, or former AS 39.37 may obtain long-term care
25 insurance for that person and eligible dependents under this section.
26 A person who elects insurance under this paragraph shall pay the cost
27 of the insurance premium. The commissioner of administration shall
28 adopt regulations implementing [TO IMPLEMENT] this paragraph.

29 (b) In this section



STATE OF ALASKA
OFFICE OF THE GOVERNOR
BILL ANALYSIS

DEPARTMENT Commerce & Econ. Dev.	DIVISION Insurance	BILL NUMBER SB 254	SPONSOR Senator Duncan
SHORT TITLE OF BILL An Act relating to Group Health Insurance			
DEPARTMENT POSITION Neutral			
PREPARED BY Jim Jordan, Deputy Director	DATE 4-7-89	COMMISSIONER'S SIGNATURE 	DATE 4/

SUMMARY

OTHER AGENCIES AFFECTED BY BILL Department of Administration Department of Health and Social Services Department of Education and University of AK	CONSTITUENT GROUPS AFFECTED BY BILL State Employees Municipal Employees School District Employees
ORGANIZATIONAL SUPPORT FOR BILL Unknown	ORGANIZATIONAL OPPOSITION TO BILL Unknown

FISCAL IMPACT: ☐ NONE ☐ FISCAL NOTE ATTACHED

BACKGROUND/LEGISLATIVE INTENT

SB 254 establishes the Alaska State Group Health Insurance Authority (Authority) comprised of 16 members. The Authority is required to purchase the group health insurance or to self-insure in order to provide the health care financing benefits provided to state employees, municipality employees and school district employees. Unless granted a waiver by the Authority, the state and each municipality or school district must have its health insurance benefits purchased through the Authority (Section 1).

ANALYSIS OF BILL/PROGRAM EFFECTS

See attached.

AMENDMENTS PROPOSED

See attached.

3788D-1/041089a

PLEASE ATTACH A SEPARATE SHEET FOR ADDITIONAL COMMENTS OR ANALYSIS.

ANALYSIS OF BILL/PROGRAM EFFECTS:

Section 2

AS 21.77.010-.020. Authority Created

The Alaska State Group Health Insurance Authority (Authority) is established as a nonprofit, incorporated legal entity. The Authority is to be comprised of 16 members which include the Commissioner of Administration, the Commissioner of Health and Social Services, the Director of the Division of Insurance, and 13 members appointed by the Governor which include one member representing local governments, one member representing school board, two public school teachers, one person from the general public, two permanent classified state employees, one permanent University of Alaska employee, two school district permanent employees, two permanent municipal employees, and one member representing health care providers. The Authority is to elect a president, vice president, and secretary. Members' compensation is limited to per diem and travel expense reimbursement.

AS 21.77.030. Powers

The Authority is granted certain powers to carry out its duties. Those duties are the ability to exercise powers granted to insurers; to sue or be sued; to enter into contracts; to establish administrative and accounting procedures; to manage funds; and to promulgate regulations.

It is not clear what is exactly intended by the ability to exercise powers granted to insurers. Because the Authority can either purchase the health insurance coverage from admitted insurers or can self-insure the health care benefits, it is assumed the intent is to allow the Authority to act as a self-insurer even though, because it is an entity separate from the state, a municipality, or school district, it would otherwise need to be formed and licensed as an insurer under AS 21.

AS 21.77.040. Fiduciary Duty

This provision requires the Authority to provide the coverage at the lowest possible cost to the covered employees.

AS 21.77.050. Purchase of Insurance

The Authority is required to purchase group health insurance coverage from authorized insurers. However, the Authority is allowed to self-insure the benefits if it can be done at a lower cost. The Authority, if it purchases insurance coverage, must bid the program at least every five years and the request for proposals must go to all licensed insurers authorized to write health insurance (which would be in excess of 500 insurers).

AS 21.77.060. Health Insurance Fund

A segregated fund is created within the general fund which consists of funds appropriated by the Legislature and premium funds collected. The premium funds collected would assumedly be comprised of any state employee premium contributions and those premiums remitted by the various municipalities and school districts for the coverage for their employees.

AS 21.77.070. Insurance Premiums

The Authority is required to assure that sufficient premiums are collected to provide the group health coverage and to pay the expenses of the Authority. This would appear to mean that the per diem costs and travel costs of the Authority's board members need to be refunded by the state, municipalities, and the school districts.

Funds remaining at the termination of an insurance contract are required to be invested in the same manner as retirement funds. This provision would appear to place health insurance premium funds on par with retirement funds in order not to encounter dedicated funding, constitutional problems.

AS 21.77.080. Required Participation

This section requires that the state, each municipality, and each school district obtain their health insurance benefits through participation in the Authority provided coverage. However, a waiver to the required participation can be granted by the board of the Authority.

The waiver criteria are that the waiver applicant's group health insurance match the benefits provided by the Authority and the financial standards set by the board. It would appear the benefit match would be satisfied by a benefit plan being the actuarial equivalent or better than the benefit plan provided by the Authority. Assumedly, the financial standards criteria would entail the premium rates for the covered employees being equal to or less than the premium rates for an actuarial equivalent benefit plan provided by the Authority and that, if the plan was insured, the insurer providing the group health insurance contract was as financially strong as the insurer providing the Authority's group health insurance contract. The financial standards criteria would be complex and difficult if the comparisons involved a self-insured plan with an insured plan.

AS 21.77.090. Definitions

The operative terms found in the Act we defined in this section.

Section 3

AS 39.30.090. Department of Administration Duties

This section amends AS 39.30.090 so that the Department of Administration must obtain the group health insurance contract covering state employees from the Authority. Additionally, the language is removed which provided discretionary participation by other governmental units (e.g., municipalities and school districts) in the state employee group health insurance plan. It would appear that the requirement in this section that the health insurance coverage for state employees be obtained from the Authority would preclude the state from seeking a waiver under AS 21.77.080.

Section 4

AS 39.50.200(b). Conflict of Interest

This section makes the Authority's board members subject to the state's conflict of interest law.

Section 5

AS 21.77.020(b). Staggered Initial Board Terms

The initial 13 board members are to be appointed by the Governor to varying terms of office with two members serving one year; three members for two years; four members for three years; and four members for four years.

Section 6

Effective Date

This Act is to take effect immediately upon signature of the Governor.

Amendments Proposed

1. It is recommended that this Authority be created within a title other than Title 21. Title 21 is the section of Alaska law which regulates the business of insurance. An inherent conflict arises when provisions pertaining to the purchase of insurance are mixed with regulatory provisions.
2. AS 21.77.030(1) needs to be clarified so that it exempts the Authority from having to be formed and licensed as an insurer under AS 21 if that is the intent. If the intent is to allow the Authority to act as the administrator for self-insured plans sponsored by the state, municipalities and school districts, then this provision should be amended to reflect that power.

GAO

United States General Accounting Office

Briefing Report to the Committee on
Labor and Human Resources, U.S. Senate

April 1988

HEALTH INSURANCE

Risk Pools for the Medically Uninsurable



**International
Foundation
Information
Center**

368.38
Un38d

The six programs insured about 20,000 individuals. Middle-aged individuals appear most likely to enroll in risk pools. Enrollees incur higher medical expenses than the general population. The data available indicate that their expenses are higher for treatment of heart conditions, cancer, and diabetes specifically. Insurance industry and advocacy group officials believe that risk pools can also help finance the cost of treating patients with acquired immunodeficiency syndrome (AIDS). State officials expressed concern that AIDS patients could increase program costs, but did not know the extent to which persons infected with the virus that causes AIDS have enrolled in risk pools.

The six states we reviewed have not determined the extent to which persons who cannot obtain insurance because of poor health are enrolling in risk pools. State officials generally believe, however, that their programs are not serving all eligible individuals.

As arranged with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to other congressional committees having jurisdiction over the matters discussed in this report and other interested parties.

If you have any questions, please call me on (202) 275-6195.



for Michael Zimmerman
Senior Associate Director

12	Subsidy Percentage by Income and Number of Persons Assisted by the Wisconsin Program	22
13	Comparison of Age Distribution of Risk Pool Enrollees to the National Population as of December 31, 1986	24
14	Average 1986 Claims Expenses per Policyholder for State Risk Pool Programs	25
15	Comparison of 1986 Claims Expenses Incurred, by Medical Condition, for Three State Risk Pool Programs, to Company's 1986 Average Claims Expense	26

ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome
BLS	Bureau of Labor Statistics
GAO	General Accounting Office
HCFA	Health Care Financing Administration

To help the medically uninsurable, 15 states have passed legislation establishing health insurance risk pool programs.¹ Typically, the states create associations to operate the programs and require all insurers doing business in the state to be members. The associations offer insurance to eligible individuals and establish premiums. If premiums do not cover expenses, deficits are generally shared among association members. Table 1 shows the states that have enacted legislation, and the effective dates.

**Table 1: Effective Dates of Risk Pool
Authorizing Legislation^a**

<u>State</u>	<u>Effective date</u>
Connecticut	Apr. 1976
Minnesota	July 1976
Wisconsin	Jan. 1981
North Dakota	July 1981
Indiana	Sept. 1981
Florida	July 1982
Montana	July 1985
Tennessee	July 1986
Nebraska	Sept. 1986
Iowa	Jan. 1987
New Mexico	Apr. 1987
Washington	May 1987
Illinois	Apr. 1987
Maine	Sept. 1987
Oregon	Sept. 1987

^aRhode Island established a risk pool in 1975. However, Blue Cross and Blue Shield of Rhode Island offers open enrollment. According to a state official, no more than 10 or 12 persons have been enrolled in the risk pool at any time. Because of its small size, we did not examine the Rhode Island program.

In addition, according to a study conducted by the Intergovernmental Health Policy Project, legislatures in 12 states considered, but did not enact, legislation authorizing a risk pool during 1987. Appendix II lists these states.

OBJECTIVES, SCOPE, AND METHODOLOGY

On March 23, 1987, the Chairman and the Ranking Minority Member of the Senate Committee on Labor and Human Resources asked us to obtain information on health insurance risk pools. In later discussions with their offices, we agreed to obtain information on

¹Blue Cross and Blue Shield Plans in the 15 states with risk pools we examined do not offer open enrollment.

and interviewed program administrators, risk pool association representatives, and state insurance officials. Except for Wisconsin, which surveyed risk pool enrollees in 1982, 1984, and 1986, limited information on the characteristics of the insured was available. Moreover, the results of Wisconsin's surveys may not accurately represent the characteristics of enrollees in that state's risk pool because many of those surveyed did not respond, and state officials did not analyze the characteristics of nonrespondents to determine whether differences existed between them and respondents.

To obtain information on how well the programs have met the expectations that led to their creation, we examined authorizing legislation and reviewed legislative histories and program evaluations where available. We also discussed the programs' effectiveness with program administrators, state insurance officials, and representatives of private groups interested in risk pools.

Our fieldwork was conducted between April and November 1987 in accordance with generally accepted government auditing standards. We obtained oral comments from the Department of Health and Human Services, and have revised the report to reflect these comments where appropriate.

RISK POOL PROGRAM CHARACTERISTICS

Risk pools provide health insurance that is comprehensive, but costly, to persons who can afford, but have difficulty obtaining, health insurance. Risk pool insurance covers a broad range of health services comparable to those covered through group health insurance plans offered by large and medium-sized employers.

Deductibles, or the covered medical expenses an enrollee pays before the plan pays, are usually higher under risk pool insurance than under typical group plans. Further, premiums charged for risk pool insurance are normally 25 to 50 percent higher than rates private insurers charge for an individual policy. The premiums that risk pools charge do not cover claims expenses. Risk pool operating losses are generally shared among private insurers doing business in the state. Most states, however, allow insurers to offset these losses through state tax credits.

Risk Pool Management

The organizational structures of the 15 state risk pools are essentially the same. The risk pool is operated by an association consisting of health insurance providers doing business in the state, including commercial health insurance companies and Blue Cross and Blue Shield Plans. Twelve states also require health maintenance organizations to be association members. While

**Table 2: Eligibility Requirements for
State Risk Pool Programs^a**

<u>Individuals are eligible if they</u>				
<u>State</u>	<u>Are refused coverage by (number of insurers)</u>	<u>Are offered limited coverage by other insurers</u>	<u>Are offered high premiums by other insurers</u>	<u>Suffer from specified diseases</u>
Florida	Two	Yes	Yes	No
Illinois	One	No	Yes	Yes
Indiana	Two	Yes	Yes	Yes
Iowa	One	Yes	Yes	Yes
Minnesota	One	Yes	Yes	Yes
Montana	Two	Yes	No	No
Nebraska	One	Yes	Yes	Yes
New Mexico	One	Yes	Yes	No
North Dakota	One	Yes	No	No
Oregon	One	No	No	Yes
Tennessee	One	Yes	Yes	Yes
Washington	One	Yes	Yes	No
Wisconsin	One	Yes	Yes	No

^aConnecticut and Maine do not have these eligibility requirements.

Insurance Benefits

Risk pool insurance covers a comprehensive range of medical services and is comparable to the coverage that large and medium-sized employers make available through their group health plans. Table 3 provides examples of medical services typically covered or excluded under risk pool insurance policies.

**Table 3: Medical Services Typically Covered
or Excluded Under Risk Pool Insurance Policies**

<u>Covered</u>	<u>Excluded</u>
Hospital services	Experimental treatments
Physician services	Cosmetic treatments
in-hospital and	Eyeglasses and hearing aids
out-of-hospital	Dental care
Prostheses	Routine physical
Durable medical	examinations
equipment	Expenses payable under
Physical therapy	other insurance or under
Oral surgery	government programs
	Custodial care

- waiting periods during which expenses to treat medical conditions diagnosed before the policy was issued, referred to as preexisting conditions, are not covered; and
- limitations on the maximum amount of medical expenses that will be paid during the enrollee's lifetime.

Cost Sharing Provisions

Risk pool deductibles for medical expenses are generally higher than deductibles under the group health plans that large and medium-sized employers offer. According to risk pool officials, high deductibles discourage unnecessary use of medical services and help control costs. With one exception, Wisconsin, the programs allow enrollees to select from among two or more deductible amounts. BLS found that group health plans covering 78 percent of employees at large and medium-sized firms have medical expense deductibles of \$150 or less and that plans covering 93 percent of the employees have deductibles of \$200 or less. Table 5 shows the range of medical expense deductible amounts under state risk pool programs.

**Table 5: Deductible Amounts for
State Risk Pool Programs**

<u>State</u>	<u>Medical expense deductibles for an individual</u>	
	<u>Lowest</u>	<u>Highest</u>
Connecticut	\$400	\$1,500
Florida	1,000	2,000
Illinois	250	1,000
Indiana	200	1,000
Iowa	500	1,000
Maine	500	1,000
Minnesota	500	1,000
Montana	500	1,000
Nebraska	250	1,000
New Mexico	500	1,000
North Dakota	150	1,000
Oregon	a	a
Tennessee	500	2,000
Washington	500	1,000
Wisconsin	1,000	1,000

^aAs of January 1988, Oregon had not established a deductible for its program.

Risk pool coinsurance requirements were generally comparable to those required under group health plans that large and medium-sized employers offer. Thirteen of the 15 states require enrollees to pay 20 percent of covered medical expenses after meeting

**Table 6: Benefit Limitation Provisions of
State Risk Pool Programs**

<u>State</u>	<u>Preexisting condition provisions</u>			<u>Maximum lifetime benefit</u>
	<u>Condition period (months)</u>	<u>Waiting period (months)</u>	<u>Waiver provision</u>	
Connecticut	6	12	a	\$1,000,000
Florida	6	6	None	500,000
Illinois	6	6	b, c	500,000
Indiana	6	6	None	None
Iowa	6	6	b	250,000
Maine	3	3	a, b	500,000
Minnesota	3	6	a	250,000
Montana	60	12	b	250,000
Nebraska	6	6	d	500,000
New Mexico	6	6	b	None
North Dakota	3	6	b	250,000
Oregon	6	6	d	1,000,000
Tennessee	6	6	None	500,000
Washington	6	6	b	500,000
Wisconsin	6	6	None	500,000

^aWaiting period may be waived or reduced under certain limited circumstances.

^bWaiting period will be waived if the applicant had other health insurance in force before enrolling in the risk pool.

^cWaiting period will be reduced if the applicant also pays a premium surcharge.

^dWaiting period will be waived if the applicant had other health insurance in force before enrolling in the risk pool and pays a 10-percent premium surcharge.

Cost-Containment Provisions

Private insurers have included a number of cost-containment features in their health insurance policies. In general, these features discourage individuals from seeking unnecessary medical treatment or encourage them to use less costly treatment alternatives. BLS surveyed large and medium-sized firms to determine whether their health plans included any of nine common

Table 7: Rate Limits and Examples of Annual Premium Rates Charged by State Risk Pool Programs

State	Rate limit ^a (percent)	1987 annual premium rates for coverage with a \$1,000 medical expense deductible for a			
		40-year-old		55-year-old	
		Male	Female	Male	Female
Connecticut	150	\$1,156	\$1,538	\$2,077	\$2,486
Florida	200	1,924	1,924	3,153	3,153
Indiana	150	1,162	1,597	2,130	2,363
Minnesota	125	641	641	999	999
North Dakota	135	945	945	1,383	1,383
Wisconsin	150	996	1,320	1,784	1,660

^aBased on rates charged for private health insurance in the state.

Financing Program Deficits

Risk pool authorizing legislation generally prescribes how program operating deficits will be financed. In 12 of the 15 states, deficits are shared among risk pool association members through assessments voted by the association's governing body. These states distribute assessments in proportion to each member's share of total premium income⁴ in the state except in Connecticut, which assesses members according to their share of total claims paid, and in Washington, which assesses members according to their share of total health insurance subscribers. Maine plans to finance deficits through a tax on hospital revenues, while Illinois will subsidize its risk pool from general revenues. Tennessee will provide up to \$2 million a year from general revenues to cover deficits, with any remaining deficits made up from assessments to association members. Oregon assessed association members for startup costs, but state legislation does not address how operating deficits will be financed.

Nine of the 12 states that assess deficits against association members allow them to credit the assessments against their state taxes. Allowing a tax credit results in reduced tax collections and has much the same effect as subsidizing risk pool losses from general revenues. In the other three states, assessments are considered a cost of doing business that the state insurance department may consider when approving rates the companies propose for their health insurance plans.

⁴Premium income is the revenue an insurer earns from the sale of insurance.

significant percentage growth, but from a low base. Table 8 summarizes the number of policies in force at the end of 1983 and 1986.

**Table 8: Risk Pool Insurance Policies in Force
as of December 31, 1983, and December 31, 1986**

<u>State</u>	<u>Policies in force as of</u>		<u>Change (percent)</u>
	<u>December 31, 1983</u>	<u>December 31, 1986</u>	
Connecticut	3,419	2,315	-32
Florida	49	1,036	2,014
Indiana	2,288	2,998	31
Minnesota	6,043	10,842	79
North Dakota	245	1,279	422
Wisconsin	<u>1,798</u>	<u>2,075</u>	15
Total	<u>13,842</u>	<u>20,545</u>	48

Because of turnover in the enrollee population, the number insured through risk pools has been greater than indicated by the table. Excluding North Dakota, for which data were not readily available, there were about 23,000 policies written and in force during the 3-year period in addition to the 19,266 policies in force on December 31, 1986.

Wisconsin was the only state that has surveyed former enrollees to determine why they had canceled their policies. In 1982 Wisconsin surveyed 562 former enrollees and received responses from 208, or about 37 percent of those surveyed. About 23 percent canceled because they could not afford the insurance premiums. The other cancellations resulted from enrollees obtaining group health insurance coverage, becoming eligible for Medicare, dying, or moving out of the state.

Fiscal Experience

Risk pools in the six states we reviewed have consistently operated at a loss. The six programs incurred an aggregate net operating loss of about \$18.1 million in 1986--about three times the 1983 level. Minnesota, with by far the largest enrollment, experienced the greatest loss, \$9,024,228 in 1986. Table 9 compares program operating results for calendar years 1983 and 1986.

Administrative Expenses

Risk pools in the six states we reviewed reimburse the company that administers their programs for expenses incurred in issuing policies, processing claims, and paying benefits. This reimbursement, however, is generally subject to limits. Three states reimburse the program administrator for reasonable costs incurred, but Minnesota and North Dakota limit the reimbursement to 12.5 percent of claims expenses. Indiana and Wisconsin pay the administrator a basic monthly fee plus additional fees related to the volume of activities, such as processing insurance applications and insurance claims. Florida, which has the highest rate of administrative expenses, reimburses the administrator for all direct costs incurred, pays a monthly fee for indirect costs, and additional activity-related fees. Administrative expenses ranged from about 3.7 percent of claims expenses in Connecticut and Indiana to about 14.9 percent of claims in Florida.

Assessments

Risk pool association members share in operating losses through assessments voted by the association's governing board. Because the association normally maintains a cash reserve, assessments are not necessarily equal to operating losses for any given year. Table 11 shows the 1986 assessments in the six states.

**Table 11: Assessments Levied on Members of State
Risk Pool Associations--1986**

<u>State</u>	<u>Assessment</u>
Connecticut	\$1,490,387
Florida	0
Indiana	4,683,662
Minnesota	9,054,432
North Dakota	1,509,780
Wisconsin	750,000
Total	<u>\$17,488,261</u>

Despite concerns expressed that risk pool losses will significantly increase insurance costs, assessments to date have been modest compared to the total volume of insurance business in the states. For the three states that did not permit tax credits, risk pool assessments represented less than 1 percent of the total volume of premium income in those states.

**Table 12: Subsidy Percentage by Income and Number of
Persons Assisted by the Wisconsin Program**

<u>Household income</u>	<u>Subsidy as a percentage of premium</u>	<u>Number of policies</u>
Under \$9,000	33.3	253
\$9,000-\$11,999	29.0	151
\$12,000-\$14,999	23.0	138
\$15,000-\$16,499	17.0	57
Total		<u>599</u>

Participants in this program represented about 29 percent of risk pool enrollees as of December 31, 1986. Wisconsin officials estimated that \$433,000 was spent for premium subsidies in 1987. In 1988, the state will introduce a program to also subsidize deductibles for low-income individuals.

Provisions to waive the waiting period for coverage of preexisting medical conditions have proven costly. In 1983, Indiana authorized a waiver for enrollees who paid a 10-percent premium surcharge. Losses increased sharply during 1983 and 1984, and program officials attributed the increase to the waiver provision. Similarly, North Dakota introduced a waiver in 1985 to attract enrollment. According to North Dakota officials, the additional revenue gained from the 50-percent premium surcharge did not cover the sharp increase in claims expenses. The state has since terminated this waiver provision.

Demographics of Risk Pool Enrollees

Risk pool enrollees are more likely to be between the ages of 40 and 64 than the general population. Five of the six states reviewed maintained data on the age and sex of enrollees. Table 13 compares the age distribution of enrollees in the five states as of December 31, 1986, to that of the U.S. population in 1986. About 54 percent of the enrollees in these states were females, compared to about 52 percent of the national population.

**Table 13: Comparison of Age Distribution of Risk Pool
Enrollees to the National Population
as of December 31, 1986^a**

<u>Age category</u>	<u>Percent distribution</u>	
	<u>Risk pool enrollees</u>	<u>National population</u>
Under 30	22	47
30-39	14	16
40-49	15	11
50-59	26	9
60-64	19	5
Over 64	4	12

^aThe Census Bureau does not publish age distribution estimates for individual states for age categories comparable to those the risk pools maintain. Analysis of Census Bureau state-level data shows that differences between age distribution in the five states and the nation are not significant.

Insurance officials described various factors that influence the makeup of risk pool enrollment. First, women are less likely to participate in the labor force than men and are more likely to depend on their spouse for access to employer-sponsored group insurance plans; and as a result, women are at greater risk of losing access to group insurance because of divorce or death of a spouse. Second, middle-aged workers who lose coverage under group plans because of layoffs or terminations are more likely than younger workers to be in poor health and to experience difficulty in obtaining commercial health insurance. Finally, large numbers of persons 65 and older may not be enrolled because they are generally covered by Medicare.

Wisconsin has conducted periodic surveys to obtain demographic information on its program enrollees. In 1986, Wisconsin surveyed 1,919 enrollees and received responses from 1,101, or about 57 percent. The results of this survey may not accurately represent the characteristics of all enrollees in that state, but do provide information on the respondents. Wisconsin found that

treatment of heart and circulatory diseases, cancer, and diabetes than national averages for all persons the company insures. Table 15 shows the data from the three states.

Table 15: Comparison of 1986 Claims Expenses Incurred, by Medical Condition, for Three State Risk Pool Programs, to Company's 1986 Average Claims Expense

<u>Medical condition</u>	<u>Percent of claims expenses paid</u>			
	<u>Company average</u>	<u>Florida</u>	<u>Indiana</u>	<u>Wisconsin</u>
Heart and circulatory diseases	12	12	15	23
Cancer	7	15	18	13
Abdominal conditions	10	18	10	7
Diabetes	1	5	3	6
Blood disease	1	5	1	6
All other	69	45	53	45

In its periodic surveys, Wisconsin asks enrollees about the health conditions that prevented them from obtaining private insurance. In 1986, about 22 percent of those who responded reported that heart-related diseases prevented them from obtaining insurance. About 11 percent cited hypertension; 14 percent, diabetes; and 9 percent, cancer.

Impact of AIDS on Risk Pool Programs

Both insurance industry and advocacy group officials have indicated that risk pools can help finance the cost of treating AIDS patients. The president of the Health Insurance Association of America, for example, has written that no institution by itself can bear the burden of "the alarming medical bill for AIDS." Likewise, the executive director of the Gay Men's Health Crisis, an organization interested in AIDS-related health care issues, has acknowledged that insurance companies have legitimate concerns about the catastrophic cost of treating AIDS patients. Both have endorsed risk pools as part of the solution to the problem of financing AIDS care.

Program officials in the six states reviewed expressed concern about the potential impact of AIDS-related costs on their risk pool program. None of the states limit coverage of AIDS, and four states--Indiana, Iowa, Minnesota, and Nebraska--specifically make individuals diagnosed with AIDS eligible for their programs. None of the states, however, had studied whether individuals likely to develop AIDS were enrolled in their programs or whether enrollees were being treated for the disease. In two states, officials noted that the types of medical services being provided certain enrollees appeared to be consistent with an AIDS diagnosis.

STATES IN WHICH BLUE CROSS AND BLUE SHIELD
PLANS OFFER OPEN ENROLLMENT

District of Columbia
Maryland
Massachusetts
Michigan
New Hampshire
New Jersey
New York
North Carolina
Pennsylvania
Rhode Island
Vermont
Virginia

PRIVATE GROUPS AND ORGANIZATIONS
CONTACTED TO OBTAIN INFORMATION ON RISK POOLS

American Diabetes Association
Washington, D.C.

Blue Cross and Blue Shield Association
Washington, D.C.

Center for Health Affairs
Chevy Chase, Maryland

Communicating for Agriculture
Minneapolis, Minnesota

Employee Benefits Research Institute
Washington, D.C.

Health Insurance Association of America
Washington, D.C.

Intergovernmental Health Policy Project
Georgetown University
Washington, D.C.

National Association of Insurance Commissioners
Kansas City, Kansas

National Governors' Association
Washington, D.C.

National Health Policy Forum
George Washington University
Washington, D.C.

The Center for Study of Social Policy
Washington, D.C.

Urban Institute
Washington, D.C.

Washington Business Group on Health
Washington, D.C.

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SECTION D
HEALTH CARE PAYMENT ALTERNATIVES

PART ONE
P.P.O. / BUYING GROUP

PREFERRED PROVIDER ORGANIZATIONS/BUYING GROUPS

Currently the State of Alaska is paying full retail for Medical/Dental services as opposed to negotiating with providers for a discounted rate, just as you would do with any product or service you use in quantity.

These are several ways for the state to take advantage of negotiated discounts, they include:

- A. Utilize current/expanded P.P.O. arrangement in place available through Aetna
- B. Contract with an outside firm (P.P.O)
- C. Have state of Alaska negotiate its own contracts, possibly in conjunction with options A&B above.

Option C offers the most flexibility for the state where by the state established the agreements and relationship regardless of the claim paying operations, this could also be part of a pooling authorities scope.

ESTIMATED SAVINGS

15-40% depending on service or on total estimated savings during the first 12 months, or 15-25,000,000 for active and retirees. This of course would have to be discounted for expenses.

The arrangement must take into account utilization/ambulatory review, per diem rating and length of stay protocols to be effective.

Generally, health care providers will embrace this type of arrangement as a trade-off - they contract their services at a discounted rate and they receive more patients.

Obviously, in certain rural areas without competition the advantage would be minimized.

Employers and community leaders in the Milwaukee, Wis., area joined forces in late 1985 and established the Greater Milwaukee Health Care Purchasing Plan to curtail the rise of health care costs. At the Midwest Business Group on Health Eighth Annual Conference in late February 1988, Richard Salzetti, corporate benefits supervisor of the Miller Brewing Company, described how the plan works. This research report summarizes Mr. Salzetti's presentation.

In 1985, a Blue Cross/Blue Shield user group and other employers, a total of 34 employers, formed the Milwaukee Chapter of the Midwest Business Group on Health. Richard Salzetti, corporate benefits supervisor of the Miller Brewing Company, described the group's purchasing plan at the Midwest Business Group on Health 1988 Conference. Their goal was to represent the business community in purchasing health care, act as a major purchaser of health care services, and improve the cost effectiveness of high quality health care.

At the same time as the Milwaukee Chapter was developing local purchasing plan specifications, Milwaukee area community leaders created a health care task force. The groups shared goals: methods to curtail rising medical plan costs. So they joined forces in the Greater Milwaukee Health Care Purchasing Plan and developed its own preferred provider organization, Health Care Network of Greater Milwaukee.

The Milwaukee Purchasing Plan enlisted a health care purchasing consultant, Community Care Network, Inc. (CCN) of San Diego. A model purchasing plan, the group determined, should include price and quality control principles and change the health care marketplace. Under such a plan, employers and employees become "buyers" of health care.

Mr. Salzetti explained some of the major features of the Purchasing Plan and the Health Care Network:

- A board of directors composed of employer and benefit managers from major local employers.
- Its own purchasing agent to manage the day-to-day operation and contract with providers (CCN).
- Identification of the good quality providers and the poor quality providers. The Milwaukee Purchasing Plan used information from Medicare Title 19, other government sources, and employers. In addition, the

Plan's Physician Advisory Committee gives some advice on what to look for and practice patterns. The Plan received 600 physicians' applications, and 55 were eliminated.

- A network of 13 local hospitals and, effective March 1, 1988, 450 physicians, including primary care physicians.

- A Physician Advisory Committee (PAC), which aids the Board in physician evaluation and selection, through established criteria.

- Quality assessment components developed by the purchasing agent and the PAC.

- Predetermined payments for services. Participating providers agree to accept the scheduled fees offered by the plan. Per diem rates are negotiated with the hospitals, and physician rates are based on the California Relative Value Scale adjusted for Milwaukee area rates.

- Each employer maintains its own medical plan, whether comprehensive or basic and major medical.

Claims generally are submitted first to the employer's claim administrator for verification of eligibility. The administrator then forwards Network claims to the Health Care Network for pricing and return to the administrator for payment.

- Employees and dependents are encouraged, through incentives, to use selected providers.

- Each hospital in the Network is responsible for its own preadmission review. All participating providers assume the financial risk for unnecessary care.

Utilization review is a basic element of the program and includes preadmission review, concurrent hospital review, second opinion, discharge planning, and individual case management. There are reviews at the provider and plan levels. Providers' performance is measured using non-acute profiles and other quantitative criteria.

Greater Milwaukee Health Care Purchasing Plan: Employer, Community Coalition Contains Costs

Data Collection

The next step for the program is data collection and management. To this end, the Purchasing Plan plans to hire a database manager to develop a database, including specific inpatient/outpatient hospital and physician data. Once the data is in place, Mr. Salzetti observed, the local data may be compared to national and specific illness standards. In addition, the physician data may help measure the quality of care and monitor use.

The source of data will be providers' bills that are sent to a central data collection pool.

Employees are primarily concerned that the purchasing plan maintain the existing level of benefits, provide high level of financial protection, and offer an advisor hotline.

Employers, on the other hand, are concerned with encouraging employees to use the purchasing plan providers either through rewards with higher benefits or "punishment" with lower benefits. Communications are important in this process, perhaps through use of identification cards and explanation of benefits statements.

Other employer concerns are whether the administrative costs of the program (the insurer and third party administrator) are cost-effective, whether to continue using the present administrator, and negotiations and discussions with union representatives.

Future Holds Expansion

The Purchasing Plan aims to expand its contracted provider network to include dental, vision, and chiropractic care; prescription drugs; nursing services; and medical supplies.

Other goals are to identify the best providers, increase the number of plan participants, and use cost and quality data to ease cost negotiations.

Thus far, the Purchasing Plan has contracts with 13 employers, all self-insured, covering 30,000 employees. Negotiations are proceeding with an insurer to include in the network its entire book of business in the Milwaukee area.

Save \$2 Million First Year

The Purchasing Plan's cost savings ratio overall is 1 to 3.8 and it is expected to save more than \$2 million the first year, Mr. Salzetti said. Other positive outcomes are that it allows the "buyer" to obtain more control in health services, and that the continuous review of providers will improve quality, monitor charging patterns, and allow development of data for evaluations.

How much did it cost to put the program together? Initially, 12 Milwaukee Purchasing Plan employers contributed \$10,000 each, Mr. Salzetti said. Currently, each member employer contributes annually \$1.50 per employee and a percent of the savings realized.

■

Direct Contracting With Hospitals: Alternative Payment Arrangements

by Douglas G. Cave

Large self-insured employers are realizing the advantages of direct contracting with hospitals on a per diem or per case basis, and therefore are moving away from per service financial arrangements. The *per diem* system of reimbursement pays the hospital a predetermined amount for each day a patient is in the hospital, while the *per case* system pays a predetermined amount for each patient admitted. Employers can use their power of numbers to obtain favorable day- and case-based rates in exchange for giving employees an economic incentive to use contracted hospitals.

In the past, some employers and third party insurers tried to control hospital costs by negotiating discounts on billed charges. However, discounts are not much better than straight charge arrangements because providers have a strong incentive to increase the volume of services to compensate for the discounts. In other words, hospitals are rewarded for providing more units of service as long as the marginal revenue of the last unit provided exceeds the marginal cost of providing that unit. Some hospitals may also offset the discounts by increasing their initial service charges.

To remove many of the perverse effects of discounted charge arrangements, employers are now turning to alternative hospital payment systems — per diem and per

case. These systems transfer more financial risk to the hospital for the services they deliver. Hospitals are usually more willing to negotiate per diem contracts because they can negate some of the financial risk transferred to them simply by keeping patients in the hospital longer.

Providers have an incentive to increase the length of stay because the first days of patient care are the most resource-intensive and costly. The final days of care are relatively inexpensive, so profit (total revenue minus total cost) from a patient may significantly increase as length of stay increases (up to a point).

This conclusion is supported by evidence from past state rate setting programs based on per diem reimbursements (New York and New Jersey). In both systems, hospitals significantly increased their occupancy rates by increasing the average length of stay (ALOS), rather than by increasing the admission rate.^[1] The states implemented volume-related penalties to address the length-of-stay changes; that is, hospitals did not receive the fully approved per diem rates for days provided in excess of a budgeted volume. Even strong financial penalties, however, were not very effective in offsetting the perverse incentives to increase day volume. This suggests that hospitals gained more by increasing ALOS than they lost from volume-related penalties.

To correct this deficiency of per diem reimbursement, employers should try to negotiate a case-based payment system (although, as will be discussed, this system has some of its own perverse incentives). Because most hospitals are willing to negotiate on a per diem basis, establishing a day-based payment system may be a necessary first step to arranging a per case reimbursement system.

Negotiating Per Diem Rates

The hospital and employer need to develop per diem values before negotiations can take place. Both must decide whether negotiations will be based on one all-inclusive per diem rate or on many broad-based per diem rates (such as medical, surgical, maternity, mental health, and alcohol and drug abuse).

An all-inclusive per diem rate may not benefit either the employer or hospital because both the case mix and severity of illness level of employee and dependent admissions may change over time, significantly changing the agreed per diem rate. *Case mix* refers to a classification system that categorizes patients according to their inpatient resource requirements. For example, one case mix system places patients into high intensity service categories and low intensity categories. *Severity*

of illness, on the other hand, refers to the probability of death or loss of function over the natural history of a disease. Thus, measures of severity of illness define a disease-specific clinical condition at one point in time. For each case mix category, patients will have a somewhat different severity of illness.

The case mix and severity of illness of employees seeking care from a particular hospital may change significantly after the employer introduces strong financial incentives for employees to use providers under contract. As more employees are channeled to contracted hospitals, the actual health risk level of employees seeking care from these hospitals may change. On the other hand, an all-inclusive per diem rate gives hospitals the perverse incentive to admit only patients who are less seriously ill and require less resource-intensive care (i.e., of lower average case mix). In general, these patients are inexpensive to treat, which allows hospitals to increase profits for each day of care provided.

If case mix or severity of illness level dramatically fluctuates, especially during the first year of contract negotiation, broad based per diem rates should help minimize large losses or gains incurred by the hospital or employer. For instance, Table I shows that the all-inclusive per diem rate for Employer A using Hospital X is \$965. This is based on a day mix of 47.8% medical patients (501 days/1,048 days) and 15.5%

Table I
Employer A's Calculated 1988 Per Diem Rates for Hospital X

Case Mix Classes	Inpatient Days	Total Paid Charges	Charge/Day
Medical	501	\$ 382,569	\$ 764
Surgical	162	321,264	1,983
Cardiovascular	7	44,716	6,388
Other surgery	155	276,548	1,784
General maternity	138	183,692	1,331
Normal delivery	47	78,646	1,673
Other obstetric	91	105,046	1,154
Mental health	81	46,146	570
Alcohol and drug	166	77,984	470
Totals	1,048	\$1,011,655	\$ 965

surgical patients (162 days/1,048 days). Let's assume that, after negotiations, the mix moves more toward medical cases (that is, those patients who require less intensive per day resources). The all-inclusive per diem value of \$965 is now an overestimate. Therefore, the employer may lose money on this per diem contract — at least during the first year. If Employer A had negotiated a broad based per diem contract, the hospital would have less incentive to change its current day mix toward treating more medical cases.

Alternatively, a negotiated stop-loss arrangement may help alleviate large losses or gains by either party — although most stop-loss arrangements are negotiated in favor of the

hospital. Under a stop-loss provision, hospitals are financially responsible for only a certain amount of billed patient charges; stop-loss, therefore, protects hospitals from very high cost patients, who are called *outliers*. For example, assume the billed charges for a patient are \$15,500. The all-inclusive per diem rate without a stop-loss provision is negotiated at \$965. The patient stayed in the hospital for nine days. Under per diem arrangements without stop-loss, the employer owes the hospital only \$8,685 (\$965/day × 9 days). The employer would save 44% of billed charges ($1 - [\$8,685 / \$15,500]$).

Now assume a \$10,000 stop-loss threshold is implemented. This affects the negotiated all-inclusive per diem rate because outliers are eliminated from the per diem calculation. The new all-inclusive per diem rate should be negotiated around \$915. (This is the average per diem value after the high cost outlier patients are eliminated.) With a \$10,000 stop-loss provision, the employer owes the hospital \$13,735 ($[\$915/\text{day} \times 9 \text{ days}] = \$8,235$; $[\$15,500 - \$10,000] = \$5,500$; $[\$8,235 + \$5,500] = \$13,735$). The employer would save only 11.4% of billed charges ($1 - [\$13,735 / \$15,500]$).

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The employer may transfer more risk to the hospital by negotiating broad based per diem rates with a much higher stop-loss level. We will turn to the issue of stop-loss provisions later.

Hospital X should calculate Employer A's broad based per diem rates based on: (1) the experience of all patients admitted to its facility; and (2) the experience of the Employer A employees admitted over the past several years. Rates based on the experience of *all* patients will give the hospital the most statistically valid per diem values. The hospital should, however, also have a good idea of Employer A's inpatient costs per diem; these rates can be calculated if the hospital's claim system uses an identifier that tracks employer group. Were the employer's broad based per diems greater than, equal to or less than Hospital X's overall per diem values? This comparison gives the hospital some baseline information on the severity of illness and case mix of Employer A's employees. Also, by capturing several years of experience data, Hospital X can determine whether employees seeking care have increased or decreased their overall severity of illness and case mix composition over time.

After obtaining an experience claims tape, Employer A also calculates broad based hospital per diem rates (refer to Table I). The medical per diem is \$764, surgical is \$1,983, general maternity is \$1,331, mental health is \$570, and alcohol and drug abuse is \$470. Several of these broad based categories are divided into more refined subcategories. For example, surgery is divided into cardiovascular operations (\$6,388/day) and other surgical operations (\$1,784/day).

The employer compares its calculated broad based per diem values with those calculated by the hospital. These two rates are expected to be somewhat different because the employer and hospital calculated their values based on different databases. Therefore, the employer's negotiated group-specific per diems

Case Mix Classes	Inpatient Admissions	ALOS	Total Paid Charges	Charge/Case
Medical	67	7.5	\$ 382,569	\$5,710
Surgical	31	5.2	321,264	10,363
Cardiovascular	1	7.0	44,716	44,716
Other surgery	30	5.2	276,548	9,218
General maternity	42	3.3	183,692	4,374
Normal delivery	22	2.1	78,646	3,575
Other obstetric	20	4.6	105,046	5,252
Mental health	8	10.1	46,146	5,768
Alcohol and drug	10	16.6	77,984	7,798
Totals	158	6.6	\$1,011,655	\$6,403

should fall somewhere between the hospital's per diem values and its own calculated values.

Negotiating Per Case Rates

The day-volume response caused by per diem payment systems can be corrected by moving to per case reimbursement. Under per case payment, hospitals are reimbursed a fixed predetermined amount based on a patient's resource requirements — and not on the actual costs or charges of resources used during diagnosis and treatment. This gives hospitals an incentive to reduce both length of stay and the amount of ancillary resources used to treat each case.

Before the Medicare prospective payment system (PPS) was implemented on October 1, 1984, ALOS of Medicare patients was declining at an annual rate of about 2%. For example, between 1981 and 1982 the ALOS for pre-PPS states decreased from 9.7 days to 9.5 days (a change of 2.1%). In 1984, however, the ALOS for PPS states declined 9.8% (from 9.2 days to 8.3 days); the decline continued in 1985.[2]

Other evidence suggests that the PPS also has had an effect on the use of diagnostic and therapeutic tests conducted in a hospital. In

1984, there were major reductions in routine serology and blood chemistry tests as well as declines in well-established hospital procedures, such as electrocardiograms and transurethral cystoscopy.[3] These facts support the hypothesis that per case payment systems should reduce length of stay and the number of ancillary services.

Case-based systems may use one all-inclusive per case rate (such as that used by the California Medical system from 1980 to 1982) or broad based per case rates. The most common example of a broad based system is diagnosis-related groups (DRGs), which classify an admission into one of 23 major diagnostic categories based on principal diagnosis. Each admission then is assigned to one of over 460 DRGs based on patient age, procedures performed and comorbidity or complications.

Employers should not negotiate an all-inclusive per case rate for much the same reason they should not negotiate an all-inclusive per diem rate: all-inclusive rates encourage hospitals to admit only those patients who require less intensive resources. Returning to Employer A, Table II shows that the all-inclusive rate for Hospital X is \$6,403/case. On average, charges for medical

Table III

1988 Per Case Rates for Hospital X at Different Threshold Levels

Case Mix Classes	STOP-LOSS THRESHOLDS							
	Total		< \$10,000		< \$15,000		< \$25,000	
	Total Inpatient Admissions	Case Rate Payment	Total Inpatient Admissions	Case Rate Payment	Total Inpatient Admissions	Case Rate Payment	Total Inpatient Admissions	Case Rate Payment
Medical	67	\$5,710	56	\$2,968	60	\$3,593	65	\$4,931
Surgical	31	10,363	19	5,191	26	7,096	29	8,395
Cardiovascular	1	44,716	0	0	0	0	0	0
Other surgery	30	9,218	19	5,191	26	7,096	29	8,395
General maternity	42	4,374	40	4,013	42	4,374	42	4,374
Normal delivery	22	3,575	22	3,575	22	3,575	22	3,575
Other obstetric	20	5,252	18	4,548	20	5,252	20	5,252
Mental health	8	5,768	8	5,768	8	5,768	8	5,768
Alcohol and drug	10	7,798	8	7,137	10	7,798	10	7,798
Totals	158	\$6,403	131	\$4,035	146	\$4,848	154	\$5,661

cases were \$5,710/case, while charges for surgical cases were \$10,363. By negotiating an all-inclusive case rate of \$6,403/case, Hospital X can increase profits by changing its current case mix away from treating surgical and toward treating medical cases.

Also, Employer A should not attempt to negotiate per case rates based on DRGs because it cannot establish statistically valid per case values — there are too many DRGs and too few patients. The hospital, on the other hand, should have a good idea of its overall costs and charges for each DRG category; this gives Hospital X a competitive advantage in the negotiation process.

Employer A should calculate broad based per case rates using similar categories to those it established for negotiating per diem rates. Table II indicates that the medical per case rate is \$5,710, surgical is \$10,363, general maternity is \$4,374, mental health is \$5,768 and alcohol and drug abuse is \$7,798. The employer then uses these values to negotiate case-based rates with Hospital X.

Because per case systems transfer more risk to the hospital than per

diem systems, most hospitals will require some type of stop-loss provision to reduce their financial liability for outlier cases. PPS (a system designed to pay a predetermined amount per DRG case) defines outliers in several ways. For instance, a *length-of-stay outlier* is defined as a case whose length of stay exceeds the mean DRG length of stay by 20 or more days. A *cost outlier* is one whose costs exceed the average cost by 1.5 times the established DRG rate. Outliers usually represent about 3% of all Medicare cases and account for between 5% and 7% of Medicare's total payments to hospitals. Many recently adopted state case-based systems use similar outlier criteria.[4]

Table III shows three different possible stop-loss thresholds set by Employer A for Hospital X: \$10,000, \$15,000 and \$25,000. Over 17% of the cases exceeded a \$10,000 threshold. These cases accounted for 47.8% of total payments to Hospital X. After eliminating the outliers from the analysis, the overall case rate was reduced from \$6,403 to \$4,035; the medical case rate was reduced from \$5,710 to \$2,968; and the surgical case rate

was reduced from \$10,363 to \$5,191. Surgical cases had the greatest percentage — almost 39% — excluded at the \$10,000 threshold level.

About 7.6% of the cases had payments greater than \$15,000, accounting for 30% of total hospital payments. After excluding the outliers, Table III shows that the overall case rate decreased to \$4,848. Only 2.5% of the cases exceeded a \$25,000 threshold; they accounted for 13.8% of total payments to Hospital X. Excluding the outliers, the overall case rate now was \$5,661. The employer and hospital may decide to implement one of these stop-loss thresholds, or they may use an even higher threshold level. This depends largely on the degree of financial risk the hospital is willing to assume.

Other Effects of Per Case Payment Systems

Case-based payment systems give hospitals an incentive both to perform fewer tests and treatments and to reduce ALOS. Per case systems, however, also are susceptible to their own perverse utilization responses. For instance, hospital occu-

pancy rates are a function of ALOS, admission rate and number of hospital beds. Decreasing ALOS reduces a hospital's occupancy rate and, therefore, its total revenues. This gives the hospital a strong incentive to increase its admission rate to fill empty hospital beds. The hospital's other alternative to increase its occupancy rate is to close beds; however, this does not produce revenue.

Evidence from Medicare's PPS shows that from 1980 to 1983 the discharge rate in pre-PPS states was slightly increasing (from 380 discharges/1,000 to 403 discharges/1,000); this was an annual increase of about 2%. In the first year of PPS, however, the Medicare discharge rate in PPS states declined for the first time (3.5%).^[2] This trend continued in subsequent years.^[5]

New Jersey introduced a case-based payment system in 1980. Data released from the New Jersey Department of Health showed that the introduction of the per case program resulted in decreases in ALOS and cost per case. There was, however, no significant increase in the admission rate over the first several years of system implementation.^[4]

These facts do not support the hypothesis that case-based payment systems will generate more hospitalizations. Other forces may have been operating, however, to oppose incentives to increase admissions, such as utilization review (UR) firms developing more objective and stringent admission criteria and physicians moving away from inpatient treatment toward less costly ambulatory care. Without a clearer

understanding of why admission rates decreased in the PPS and New Jersey systems, employers should assume that a strong prospective UR program is necessary to counteract provider incentives to admit more patients.

As a hospital's occupancy rate declines, it has at least two other alternatives to increase its total revenue base. First, a reduction in revenues could motivate staff physicians to admit a more profitable patient case mix (e.g., more patients who require low resource-intensive care). Moreover, profits per case can be further enhanced by admitting only the least severely ill patients in the low resource-intensive categories. An employer's UR firm should continually monitor and evaluate admitted cases to protect the employer from these perverse incentives.

Second, the hospital may decide that treating some patients in an outpatient setting will provide more revenue than treating them on an inpatient basis. Negotiated rates under many case-based systems do not apply to a hospital's outpatient departments, so hospitals continue to bill charges for these patients. Outpatient charges for a given procedure, therefore, are often greater than when the same procedure is performed on an inpatient basis.

These hospitals have successfully "gamed" the per case payment system in an effort to maintain their revenue base. This has a dramatic effect on an employer's ability to contain hospital costs — considering that, in 1986, over 40% of all hospital operations were performed in outpatient settings (as compared to only 16% in 1980).^[6,7]

To correct for deficiencies in the per service and per diem payment systems, large employers will increasingly turn to direct contracting with hospitals on a per case basis. UR firms will have to use stringent admission guidelines to control, monitor and evaluate hospitalizations. They also will need to verify that the hospital is not withholding necessary medical services to increase its profit margin. This could affect the hospital's quality of care — an issue beyond the scope of this paper. Employers should also develop a payment strategy for outpatient services to ensure that the case-based payment system controls hospital costs as effectively as possible.

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With 608 operational preferred provider organizations identified and the growth of multi-state PPOs, many states have started to develop legislation to monitor PPO development. The American Medical Care and Review Association (AMCRA) has surveyed all 50 states to determine the current status of legislation on PPOs.

The following is a brief summary and is not intended for any purpose other than for basic information. Additional information may be obtained by contacting the insurance commissioner and/or the department of health in each state.

Alabama—No PPO legislation.

Alaska—Currently, Alaska insurance law contains no provisions that specifically relate to PPOs. Any PPO desiring to operate in the state needs to be authorized as either a "commercial insurer" or as a hospital or medical service corporation (e.g., Blue Cross).

Arkansas—The Arkansas Insurance Department Bulletin 9-85 states its official opinion that insurers may form and/or participate in PPOs.

Arizona—No PPO legislation.

California—"True" PPOs (those that do not assume risks) are not licensed by the state, nor are they regulated per se. Entities that call themselves PPOs, but which assume risks, are subject to licensing either as health care service plans regulated by the cited agency, or as insurers subject to Department of Insurance jurisdiction. §10133 and §10401, §11512 of the California Insurance Code (Deering 1977 & Supp. 1986).

Colorado—No PPO legislation.

Connecticut—A PPO is an arrangement existing between an individual insurance company and participating physicians and, as such, is not required to be licensed by the state.

Delaware—No PPO legislation.

District of Columbia—No PPO legislation.

Florida—As follows:

1. Third-party administrator (TPA)—regulated by Department of Insurance (DOI), Chapter 626, Part VI, Florida Statutes.

2. Self-insurer—either: (a) single employer—regulated under ERISA, U.S. Department of Labor; or (b) multiple employer trust—regulated under ERISA and by DOI, Section 624.436 and 624.440, Florida Statutes.

3. Insurance company—regulated by DOI - Insurance Code.

Note: Self-insurer, insurance company, or TPA can administer health benefit plan. If self-insurer does administration, the self-insurer does not have to be licensed as a TPA.

Enabling PPO legislation Senate Bill 28B-1983. Amending 626.9541(25); 627.6371(1), (2); 627.6691(1), (2). Fla.Stat. Ann. §627.6375 and 627.6695 (West Supp. 1986).

Georgia—No enabling legislation permitting insurers to establish PPOs.

Hawaii—No PPO legislation.

Idaho—No PPO legislation, but some action on PPOs is pending.

Illinois—Senate Bill 1311 and House Bill 2089 signed into law on Sept. 19, 1985, requires registration of administrators of preferred provider programs and clarifies certain insurance statutes with respect to the ability of insurance companies to issue policies with preferred provider options. The Illinois PPO Statute is Article XX-1/2, Chapter 73 (1985), paragraph 982 f to g.

Indiana—The PPO law simply provides specific authority of insurers to operate such plans. Ind.Code. Ann. §27-8-11-1, -2, -3, -4 (West Supp. 1985).

Iowa—House Bill No. 570 (1985) amended sections 508.29 and 515.48(5)(a) of the Iowa Code to provide that insurers may contract with health care service providers.

Kansas—Senate Bill No. 19 (1985). This bill amends statute §40-231 to allow insurance-company-sponsored PPOs. Kan. Ins. Dept. Bill 1985-16. PPO filing requirements.

Kentucky—No PPO legislation.

Louisiana—In 1984, the legislature enacted PPO legislation under its Health Care Control Chapter. They define PPOs and authorize group purchasers to enter

to contracts with health care providers at alternative rates of payments. La. Rev. Stat. Ann. §40:2201-2204 (West Supp. 1986).

Maine—PPO legislation was passed on March 31, 1986 (1986 Me. Legis. Serv. 288.). It calls for registration and minimum solvency requirements. It also lists duties such as provider lists, contracts, utilization experience, etc., in the form prescribed by the superintendent.

Maryland—In 1985, the legislature enacted PPO legislation that is applicable to nonprofit health service plans (§354EE), health insurers (§470X), and group and blanket health insurers (§477FF) (Supp. 1985).

Massachusetts—No PPO legislation.

Michigan—The general statutory provisions concerning PPOs are contained in the Prudent Purchaser Act, Mich. Comp. Laws. Ann. §550.51-550.63 (West Supp. 1985). They call for written standards for all agreements, institute or review for quality of health care, filing annual reports with the commissioner of insurance, etc.

Minnesota—PPO legislation was passed in 1983 that allows group health insurers to pay different amounts to insureds who elect to receive health care goods or services from providers designated by the insurer. Minn. Stat. Ann. §72A.20(15)(4) (West. Supp. 1986).

Mississippi—No PPO legislation.

Missouri—No PPO legislation.

Montana—No PPO legislation.

Nebraska—No PPO regulations. Neb. Rev. Stat. §44-4101e to 44-4113 (1984 and Supp. 1985). Applies to preferred provider insurance arrangements.

Nevada—Senate Bill No. 286 (1985) provides that an insurer shall include provisions in a policy of health insurance encouraging an insured's use of services and facilities that are efficient and that tend to control or reduce the cost of health care.

New Hampshire—Enacted PPO legislation in House Bill No. 80 1985 entitled "Accident and Sickness Insurance - Reimbursement Agreements" which amends the insurance law by adding Chapter 420-C. N.H. Rev. Stat. Ann. §420-C:1.

New Jersey—No PPO legislation.

New Mexico—No regulations on PPOs.

New York—No legislation that specifically recognizes PPOs. A PPO, which does not have an established definition in the state, may need to obtain insurance or health department licensure, depending upon its structure. Any entity that is doing the business of insurance is required to be licensed by the state.

North Carolina—Currently in the process of developing regulations under the new statutes that went into effect in October 1985 (H.B.1037) N.C. Gen. Stat. §7-1, 57-16.1, 58-260.5, 58-260.6 (Supp. 1985).

North Dakota—No regulation on PPOs.

Ohio—No regulations on PPOs.

Oklahoma—No regulations on PPOs.

Oregon—Passed PPO legislation in House Bill 2031 (71) (1985) appointing the Oregon Health Council to consider cost containment issues and to develop a policy consistent with the legislative intent of fostering new types of cost containment health care services. Ore. Rev. Stat. §743.531 (1985).

Pennsylvania—Senate Bill No. 935 (11-13). Amends Pa. Ins. Code §621.2© and 626 and add §630 (1986) PPO legislation.

Rhode Island—No PPO legislation.

South Carolina—No PPO legislation.

South Dakota—No PPO legislation.

Tennessee—No PPO legislation.

Texas—Tex. Admin. Code Tit. 28, §3.3701 et. seq. (1986). PPO authorizing regulations.

Utah—Senate Bill No. 91(181-182) amending Code §31A-22-617 and 31A-22-618 (1986). Authorizes preferred health care provider contracts.

Vermont—No PPO legislation.

Virginia—PPOs are considered insurance policies or contracts, and they are not specifically regulated. Va. Code §38.1-347.2, 38.1-813-4 (Supp. 1985).

Washington—The legislation is very specific as to the requirements to become registered as a health care contractor under Chapter 48.44RCW, but otherwise, there is no specific PPO legislation. An organization looking into setting up a PPO in the state should contact the state insurance commissioner for a copy of the law and regulations. If prepayment is involved, the PPO must obtain a certificate of registration.

West Virginia—No PPO legislation. But the PPOs are reviewed on a case-by-case basis to determine if an insurance mechanism is present.

Wisconsin—PPO legislation is part of the Wisconsin Administrative Code Section Insurance 3.48 and Chapter 609. All PPOs should review these laws to insure that they meet these guidelines. The state does not license PPOs.

Wyoming—The Health Care Reimbursement Reform Act of 1985 allows preferred provider arrangements. Wyo. Stat. §26-22-501 to 503 (Supp. 1985).



Preferred provider organizations (PPOs) are the fastest growing alternative delivery system. This Research Report discusses the structure of PPOs and how to assess the efficiency of the providers, and overall quality of services.

In general, a preferred provider organization (PPO) is a health care delivery system that tries to combine the best elements of the fee-for-service and HMO systems. Common characteristics of PPOs are as follows:

- limited group of physicians and hospitals,
- fee schedule negotiated in advance,
- utilization controls or claims review,
- consumer choice of providers,
- rapid claims payment, and
- flexible benefit levels.

PPOs can be organized in several ways. Insurance companies or third-party administrators can negotiate contracts directly with providers. In some cases, insurance carriers have enough claims history to target lower cost providers. Sometimes PPOs are marketed by insurers to current policyholders as an extension of their existing business; providers can tap into the insurers' claims administration system. Hence, the easier the administration of the PPO, the more beneficial to the employer, due to lower administrative expenses.

PPOs can also be developed by the providers themselves. If a hospital is the nucleus in the formation of the health service delivery system, it could enlist its existing medical staff or extend privileges to other physicians in order to expand its service area. If a medical group is the focus, hospitals where physicians have admitting privileges would be included. These provider-oriented organizations then make their services available to carriers, unions, and self-funded employers.

Negotiated Fee Schedule

Initially, the most attractive feature of PPOs may be their negotiated fees, which are almost always discounted. The ability to negotiate a PPO arrangement often depends on who and where the employer is and with whom it is negotiating.

Few rules guide the negotiations between PPOs and health care providers. There is no prepayment or capitation amount paid to providers; all services are paid for on a fee-for-service basis, and physicians may ac-

cept some percentage of the local area's "usual and customary" determination as full payment. This can be viewed as a discount, but it is actually a standardization of payments made to physicians.

Through a PPO, consumers maintain freedom of physician choice with incentives, such as waiving copayments or deductibles, to use PPO providers. Subscribers can still choose to go to nonparticipating providers, but at additional out-of-pocket expenses. Other PPOs offer subscribers additional benefits that might include coverage of some preventive or specialized services (psychiatric or substance abuse) that may not be covered under the employer's existing health plan.

On the hospital side, hospital payments may be determined through straight discounts, incremental discounts based on volume, or some kind of prospectively determined reimbursement. The ability to negotiate significant concessions may be limited if the company is in an area served by a single hospital. Since most of the employees probably use the hospital already, the cost of discounts or other concessions probably won't be offset by increased admissions. On the other hand, if there are two or three hospitals, an employer might be able to make a favorable arrangement with one of them.

Utilization Management

To assure that cost reduction efforts do not reduce the quality of care, utilization review and quality assurance programs are incorporated in the structure of a PPO. An effective utilization review program should include:

- Pre-admission review and certification in non-emergency cases to be sure that hospitalization is necessary.
- Admission and continued-stay review of all inpatient days to be sure they are medically necessary.
- Appropriateness evaluation to decide whether admissions and hospital days are medically necessary.
- Non-acute profiling, a variety of utilization review results to identify physicians who prescribe more or

more expensive treatment than protocols indicate is needed. Once identified, physicians are counseled or removed from the PPO.

- Denial process, which notifies physician, patient, and payor when an admission or inpatient day is considered not medically necessary.
- Dispute resolution or appeals process, which allows physicians, patient, and payor to appeal review results.
- Discharge planning to determine if complications in a case may make prompt discharge from the hospital difficult.
- Effective reporting process, which provides employers with providers' overall utilization statistics and specific statistics on their employees.

Adding A PPO Option

Two approaches are prevalent when adding a PPO option:

1. Adding a PPO's discounted fees and health care utilization control to an existing benefit plan. Employees are encouraged to use preferred providers, but essentially benefits remain unchanged.
2. Installing a completely new plan that combines redesigned benefits, strict utilization management, and changes in reimbursement to direct employees and providers toward less expensive health care services.

An overlaid PPO is easier to put into effect than a redesigned benefit plan, but a new benefit plan can control health care costs over the long term by encouraging employees to change the way they use health care services, while at the same time giving providers incentives to provide care more efficiently.

Evaluation

Before a PPO proposal can be evaluated, the employer needs to know the cost of current medical benefits and be able to estimate what costs will be under the PPO.

Evaluating the providers associated with the PPO can be done by reviewing the selection criteria of the PPO. Some PPOs are not particularly selective initially but weed out poor performers as data becomes available. Employers will have to withstand the potentially adverse employee relations that result from this approach. The PPO may rely on the judgment of a group of community physicians to review the practice patterns of participating physicians. Another method is review of utilization profiles from third-party payors or other organizations. Also, the PPO may identify a series of common procedures and compare the costs for individual providers for these procedures.

To evaluate hospitals, Medicare cost reports offer a convenient, and largely untapped, data source. They are available from state or local fiscal intermediaries, local planning agencies, or coalitions. They provide hospital-specific data on average cost and charges per case, or per admission, for all patients, not just those on Medicare.

Care must be used in evaluating hospitals based on raw data, however. The main problem when this data is used for comparison purposes is that one hospital may have a higher cost per case, not because it is less efficient, but because it treats more seriously ill patients. Although the case mix index published by the federal government is derived using only Medicare patients, it is reasonable to assume that a hospital having a complicated case mix for Medicare patients would also have a complicated case mix for non-Medicare patients.

Adjusted cost data will allow the employer to make reasoned first-cut judgments not only about PPOs, but also about the efficiency of the hospitals their employees use.

Evaluating Quality

PPO quality can be measured in several ways. A PPO's facilities must be located where most employees can reach them conveniently, and it must provide access to the kinds of care needed. Generally this means primary care physicians, a range of specialists, and access to both general care and specialty hospital facilities.

If the PPO cannot provide services directly, it must be able to supply them through agreements with other providers. Otherwise, the employer must make sure employees aren't penalized for not using PPOs in these situations.

The finances of a PPO should be analyzed like the finances of any other potential business partner. Employers should be aware of the PPO's internal reimbursement procedures. The arrangement the PPO has with a contracting employer for reimbursement may be different from the way it reimburses providers. Employers should be sure these internal arrangements encourage efficient health care while providing sufficient financial incentives to retain quality hospitals and physicians.

Plans marketed by the large organizations may offer more financial stability and comprehensive services than a plan negotiated with local providers. That stability is often desirable, but it may require an employer to accept a standard plan instead of one tailored to its individual requirements.

The 1987 Directory of PPOs, issued by the American Medical Care and Review Association, lists 646 operating plans in 43 states and Puerto Rico and the District of Columbia. Some 71 plans are operated by 23 organizations that have multiple state locations. Provider contracts have been signed with 2,571 hospitals and 194,420 physicians.

The directory discusses, among other things, the growth and development of PPOs, state legislative measures, as well as administration and operation practices industry-wide. The bulk of the Directory is devoted to profiles of the 646 plans. Individual copies of the Directory are available from AMCRA at a prepaid cost of \$50. For further information, contact AMCRA, 5410 Grosvenor Lane, Suite 210, Bethesda, MD 20814, (301) 493-9552.

The 1987 *Directory of PPOs* lists 646 plans, of which 38 are in preoperational status. PPOs are located in 43 states and Puerto Rico and the District of Columbia (see Table 1). Physicians, hospitals, and joint ventures between physicians and hospitals comprised the main force behind the early PPO growth. According to the 1987 survey their sponsorship has declined from 49.4% reported last year to 44.6% (288 plans). Insurance companies sponsor 157 plans and physician-hospitals, 114. Physician-sponsored plans total 104, and hospitals sponsor 70 plans. Other sponsors include Blue Cross/Blue Shield Plans (67), investors (36), third-party administrators (30), HMOs (25), self-funded employers (12), and sponsorship by others (31).

Administration

Most plans (602) do not have lock-in arrangements that require members to use their services. Such arrangements involve specific providers, such as dental and mental health, or specific payors, such as unions or schools. Only 44 plans have a lock-in feature and these plans tend to be classified as exclusive provider organizations.

Most of the 646 PPOs operate on a for-profit basis (444 or 69%) and operate mostly in the Western region (136, of which 75 are in California). For profit plans in the other regions total 118 in the Southeast, 96 in the Midwest, and 94 in the Northeast.

Staffing depends on the comprehensiveness of services directly provided by the PPO. According to the 1987 survey, 23 plans have from 11 to 15 staff members and only four plans have a staff of more than 100

persons. Most plans have their own provider base (physicians and hospitals) and marketing staff. Functions such as utilization review and claims processing, are sometimes contracted to third-party administrators, insurance companies, and professional review organizations. A breakdown of contracted out services provided by the PPO include the following:

	PPO	Others
Physician/hospital contracting	254	11
Marketing	231	40
Claims processing	172	95
Preadmission certification	202	55
Utilization review/peer review	231	41
Provider payment	146	112
Consumer/provider grievances	244	32
Cost analysis and reporting	231	52

Provider Contracting

PPOs reported 506,938 physicians and 11,504 hospitals under provider contracts, representing approximately one-third of all providers in the country. Many providers have signed contracts with more than one PPO, as in California, Ohio, Florida, and Pennsylvania, where more than one PPO operates in the same metropolitan area.

The 61 PPOs reporting from the Northeast region have 1,322 hospitals under contract. In the Southeast, where 59 PPO reported, there are 1,069 participating hospitals. Sixty-five plans in the Midwest have participating contracts with 1,357 hospitals, and in the West, 5,244 hospitals have signed contracts with 386 plans.

1987 AMCRA Survey Of PPOs Lists 646 Plans Covering More Than 21 Million Lives

Table 1
PPOs By State

State	Operational	Pre-Operational
Alaska	1	
Alabama	16	
Arizona	20	
Arkansas	2	
California	109	1
Colorado	22	1
Connecticut	4	
District Of Columbia	9	
Florida	43	1
Georgia	16	2
Hawaii	3	
Illinois	33	1
Indiana	10	2
Iowa	3	
Kansas	8	1
Kentucky	8	3
Louisiana	12	2
Maryland	10	
Massachusetts	10	1
Michigan	15	3
Minnesota	9	1
Mississippi	3	2
Missouri	21	1
Nebraska	2	
Nevada	7	
New Jersey	4	1
New Mexico	5	
New York	11	1
North Carolina	10	1
Ohio	48	2
Oklahoma	11	
Oregon	7	1
Pennsylvania	30	1
South Carolina	4	
South Dakota		1
Tennessee	17	2
Texas	18	2
Utah	6	
Vermont	1	
Virginia	8	
Washington	19	3
West Virginia	2	1
Wisconsin	9	
Wyoming	1	
Puerto Rico	1	1
Total Number	608	38

continued on next page

**Table 2
Number Of Physician Contracts**

	North East	South East	Mid- West	West	California	Total	%
Family Practice	10,181	5,155	3,159	4,455	10,559	33,509	12.4
Internal Medicine	13,069	7,069	3,685	3,190	12,063	39,076	14.4
Pediatrics	6,234	3,705	1,788	1,790	5,823	19,340	7.1
OB/GYN	6,053	3,535	1,929	2,045	6,902	20,464	7.6
General Surgery	6,706	3,530	1,869	1,781	5,769	19,655	7.3
Others	43,466	27,007	11,949	12,911	43,268	138,601	51.2
Subtotal	85,709	50,001	24,379	26,172	168,473	270,645	100.0
No. Physicians	30,871	6,316	29,623	1,010	168,473	236,293	
Grand Total	116,580	56,317	54,002	27,182	252,857	506,938	
No. of PPOs							
Reporting	46	46	40	37	39	208	
Average Per PPO	2,534	1,224	1,350	735	6,483	2,437	

Table 2, above, shows the number of physician contracts by region and by specialty.

Membership

Total membership in the 295 PPOs reporting this data is 21,623,817, an average of 73,301 members per PPO. AMCRA was able to identify 46 PPOs with 100,001 or more members. PPO membership by plan size is as follows:

PPO Membership	Total Plans
0 - 5,000	65
5,001 - 10,000	34
10,001 - 15,000	32
15,001 - 20,000	16
20,001 - 40,000	57
40,001 - 60,000	22
60,001 - 100,000	23
100,001 - 200,000	25
200,001 - 300,000	5
300,001 - 400,000	5
400,001 - 500,000	2
500,001 and up	9

Benefits Provided

Many PPOs are single benefit plans, providing psychiatric, pharmacy, physician therapy, and other specialized services. These plans work in cooperation with other PPOs and health maintenance organizations to supplement the basic core of services provided by a PPO. Benefits plans vary with each employer and the

deductibles and copayments differ for each plan depending upon the contractual relationship the employer and PPO have with the providers.

Table 3, on the next page, shows the benefits offered by the PPOs.

Utilization Review

The participating provider agreements give the PPO a provider base to deliver necessary services, but utilization review provides the PPO with appropriate use of those services. The procedures for hospital inpatient utilization was reported by 258 PPOs. They include pre-admission certification (249 plans), admission certification (206 plans), concurrent length of stay review (238 plans), mandatory second surgical opinion (186 plans), retrospective inpatient services review (223 plans), mandatory ambulatory or outpatient service review (143 plans), and retrospective ambulatory service review (152 plans).

Data Collection/Reporting

Some 255 PPOs reported the data collection programs they have in place. Physician specific data is collected by 234 plans, average length of stay by 239 plans, lab usage by 172 plans, and 238 plans collect data on total charges.

Fully 251 plans provide reports to groups contracting with the plan. Reports include cost (207), UR (on exception basis) (134), general UR statistics comparison (160), and 84 plans provide other reports.

1987 AMCRA Survey Of PPOs Lists 646 Plans Covering More Than 21 Million Lives

Table 3
Benefits Offered By The PPOs

	Totals		North East		South East		Mid West		West		Calif.	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Unlimited Inpatient Hospitalization	171	56	33	13	35	12	35	10	39	8	29	13
Limited Inpatient Hospitalization	93	108	18	24	16	26	21	19	16	27	22	12
Psychiatric Inpatient Care	211	17	45	1	37	11	42	2	47	1	40	2
Alcoholic Drug Inpatient Care	203	23	44	1	35	13	40	3	45	3	39	3
Emergency Room Coverage	222	6	46		45	3	43	2	47		41	1
Physician Outpatient Office Visits	224	5	45	1	46	2	42	2	48		43	
Mental Health Outpatient Visits	208	22	43	4	38	11	42	2	47	1	38	4
Outpatient X-Ray Services	221	8	45	1	44	4	45		46	1	41	2
Outpatient Lab Services	219	9	45	1	46	2	45		43	4	40	2
Routine Injections	184	42	36	10	37	10	36	8	40	7	35	7
Podiatry Services	159	65	35	12	24	21	33	10	33	14	34	8
Chiropractic Services	123	103	23	24	20	25	24	18	29	20	27	16
Pharmacy Services	192	42	44	5	36	12	38	8	40	8	34	9
Prescription Eye Exams and Glasses	85	140	19	28	11	36	16	28	21	24	18	24
Dental Services	96	123	20	24	14	31	20	22	19	27	23	19

Marketing

Direct contact by personal visit and mail are the most popular methods of contracting PPOs used with employers and recruiting providers. Some 616 plans used direct personal contact, 418 made contact through direct

mail, 348 advertised in newspapers, 135 on radio, and 77 on television. Flyers or brochures were handed out by 398 PPOs and 109 plans used other marketing methods.



This Research Report is an edited version of a speech given at a symposium jointly sponsored by the Society of Actuaries and the American College of Hospital Administrators by David V. Axene, principal consulting actuary, Milliman & Robertson, Seattle.

Mr. Axene listed factors to be taken into account when developing cost estimates to establish rates for merged health care systems (i.e., health maintenance organizations or preferred provider organizations).

Hospitals and physicians in a merged health care system (i.e., health maintenance organizations, preferred provider organizations) frequently agree to provide services for enrollees at discounted prices in return for increased volume. These discounted prices are usually expressed in terms of percentages; that is, 10% or 20% lower than the providers' usual charges.

It is necessary that the rates contracted for be adequate to cover expenses and yet also competitive. Therefore, it is necessary to actuarially project costs for the providers before quoting rates.

Identify Rating Variables

Rating variables must be identified. In order to set a rate, the actuary must ask questions such as the following:

1. What kind of people will be using the services? Are they a Medicare or Medicaid group? Are they an employee group?
2. What kind of providers are there in the community, and what are their charge levels?
3. What kind of utilization levels will develop?
4. What is the benefit design of the plan that will be offered?
5. What administrative costs and margins are anticipated?

Type Of People

In rating, one must consider the kind of people who will be using the PPO, demographic characteristics, health status characteristics, marketing methods, and relationships to other parties.

Demographic characteristics include age-sex distribution. How many people are there by various family status—that is, employee, spouse, and child(ren). How old are they? How many are married? What is the average number of dependents?

Health status of the group is difficult to ascertain because there is no working definition of health status.

If a large part of the potential enrollees work at an occupation with high risk, these adverse health characteristics would have to be factored into the rate.

A PPO attracting employed people will develop much different risk characteristics (i.e., costs) than a PPO marketed on an individual basis to people who otherwise would not have health coverage.

Marketing Considerations

Is the PPO going to be marketed to employer groups? Will the employees have free choice or will there be participation requirements? Will brokers be used? Depending on the marketing method, the costs will be different.

Consider the relationship to other parties: Do the employees constitute a group? Were the members patients of the physicians before they became participating providers? Depending on how many people were existing patients of the providers in the program, the costs will be different.

Look At Providers

Next, look at what kind of providers are going to be included in the network. What kinds of physicians are in the community? Are they associated with a medical school? Are they just solo practitioners? How were they chosen? How much can you negotiate? Are their offices empty?

How big is the provider group—can they provide all the care in the area? Do you have to have another group to provide tertiary care?

Are the physicians cooperative—do they really want to make the PPO work?

A thorough fee analysis or charge survey is recommended. Take a selective sample of about 100 charges that reflect about 75% of all physician charges. Com-

Milliman & Robertson Lists Variables To Be Identified When Setting Rate For Preferred Provider Organization

Compare the surveyed charges sent in by prospective providers with the community norms. Without this information, it may not be feasible to go any further because the PPO might be dealing with the most expensive providers in the community.

Reimbursement Method

The PPO reimbursement method is important. An actuary cannot accurately figure out costs until the reimbursement method is known. What will be used, a prenegotiated fee schedule, 80th percentile, capitation?

The reimbursement method also affects utilization levels which in turn affects the cost.

Extent of discounts and other risk arrangements also are important to know, along with provider incentives. In many cases, 50 bed days can be taken off from the inpatient hospital assumptions if certain physician incentives are included in the plan design. With the right provider incentives, projected costs can be reduced.

Cost Per Service

Find out the cost per service. Look at each unit, such as an inpatient day, a doctor visit, a surgery, and find out how much would it typically cost if it were on a fee-for-service basis.

The sources for this information are many. For hospital costs, look at Medicare filings, DRG rate filings, hospital budgets, hospital financial statements, HIAA data, AHA data, DRG weights. For professional fees use fee surveys, claims data from carrier, HIAA data, relative value studies.

Utilization Levels

It may be difficult determining the community utilization level. Utilization controls, plan design, type of provider, and incentives affect utilization.

Utilization rates are determined by taking the number of services performed and dividing by the number of eligible persons. This results in data such as bed days per 1,000, physician visits per 1,000, admissions per 1,000. The product of utilization rate and cost per service is the projected health care cost.

Value Of Copays, Deductibles, Etc.

Next, subtract the actuarial value of deductibles and copayments from the projected cost, keeping in mind that deductibles and copayments may affect utilization. Competitive restraints and regulatory requirements also affect these numbers. Regulatory requirements usually add costs; competition may lower costs.

Expense Considerations

Finally, take into consideration administrative expenses and margins, investment income, reinsurance, marketing expenses. Expense margin and profit can be loaded in as a percent of premium.

You may want to develop variations to reflect age/sex mix, benefits, size of group, etc. The final results should be compared to competitive rate levels to be assured of a competitive product.

Assuming the product can be effectively marketed with both health care and administrative costs managed, the program can be successful.



This Research Report provides general guidelines for those who wish to solicit providers for participation in a preferred provider organization. The basis of this report is a Request for Proposal (RFP) sent by Blue Cross and Blue Shield of Northern Ohio to hospitals in the area. The Blue plan used responses to the RFP to select hospitals to participate in its new method of reimbursement.

Blue Cross and Blue Shield of Northern Ohio invited hospitals in its area to enter a competitive bidding program in order to be included in direct reimbursement of hospital services provided to Blue Cross and Blue Shield members. The Blue plan sent out a Request for Proposal (RFP) to the hospitals from which this report was taken.

Many aspects of the RFP can be used by an entity seeking bids in order to set up a preferred provider organization.

Cover Letter

The cover letter accompanying the RFP may contain the following information:

Your office (hospital) is invited to submit a bid for the preferred provider organization to be formed by _____ Company. Bids must be submitted in accordance with the requirements of the enclosed Request for Proposal. Bids must be submitted no later than _____. Bids must be mailed or delivered to:

Name
Address
City, state, zip

Questions related to the Request for Proposal cannot be answered by telephone. All questions should be submitted in writing to the above address no later than _____. Written answers to questions will be provided to all potential bidders. A bidders' conference will be held on _____.

Introduction

The introduction is used to explain the preferred provider organization concept and the plans for establishing a PPO in the area.

The corporate structure, history, and financial backing of the entity requesting the bids should be disclosed.

Terms of the contracts to be offered to the selected providers should be explained, as well as the reimbursement structure and utilization review requirements. The

deadline for responses should be given and implementation date of the PPO should be estimated.

The number of proposal copies needed should be stated.

Proposal Specifications

This section identifies the information the sender needs to evaluate proposals from medical service providers for participation in the PPO. Respondents should be advised that each question must be answered, and that they are free to include additional information.

Proposal Amendments And Withdrawals

No amendments, revisions, or alterations to proposals will be accepted after the due date. Prior to the due date, a submitted proposal may be withdrawn upon written notification. Any submitted proposal shall remain valid for 180 days after the due date.

Alternate Proposals

Bidders must submit proposals that meet the requirements of the RFP. In addition, alternate proposals from bidders will be considered, provided that a clear designation of all differences between proposals is made and that the proposal responsive to the RFP's requirements is clearly identified.

Proposal Format

The proposal should include a transmittal letter, the completed application, and all applicable attachments.

The transmittal letter should be signed by an individual authorized to legally bind the bidder. The letter should include:

1. A statement indicating the bidder is a legal entity.
2. A statement that no attempt has been made or will be made by the bidder to induce any other provider to submit or not to submit a proposal.
3. An explanation of deviations from the specifications of the RFP.

Guidelines Of A Request For Proposal From Providers When Selecting Participants For A Preferred Provider Organization

4. A statement that the bidder certifies that the prices proposed have been arrived at independently, without consultation, communication, or agreement, for the purpose of restricting competition, as to any matter relating to such prices with any other bidder or with any competitor, and unless otherwise required by law, the prices quoted have not been knowingly disclosed by the bidder prior to the award, directly or indirectly, to any other bidder or to any competitor.

Each person signing the proposal certifies that he/she is the person in the bidder's organization responsible for, or authorized to make, decisions as to the prices quoted.

Bids

Providers should consider the following factors in establishing their bids:

The need to operate efficiently and cost-effectively and the elimination of duplicative or unnecessary services and facilities.

The expectation of increased volume.

Competitiveness of the bidding process.

Availability of opportunities to reduce current costs.

Other Bid Requirements

In addition to the bid itself, providers should submit service mix information. Cases that the provider believes should be treated as outliers must be identified.

Evaluation Criteria

Some of the evaluation criteria to be used to select preferred providers include:

1. price,
2. quality,
3. use by prospective subscribers of the network,
4. ability to submit proper data for utilization review,
5. location, and
6. service availability.

Selection Process

A four-step selection process can be used.

First, the criteria chosen should be evaluated as to primary and secondary importance, and so weighted.

The second step is to rank providers by price bid and prospective subscriber use. Separate rankings are prepared for each criterion. A composite ranking is found.

The third step in the selection process is the review of composite rankings to identify duplication of services within locations.

The fourth step is the review of selections to determine whether a sufficient range of services is available within locations.



Sample Preferred Provider Organization Contract Between Sponsoring Agency And Providers

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This Research Report is a sample contract between a sponsoring agency and a participating provider pursuant to establishment of a participating provider organization.

The sponsoring agency in this contract is the health plan administrator. PPOs can be sponsored by other entities as well. The contract has language for agreements with either a hospital or a physician. The language would have to be modified for a dental PPO.

THIS AGREEMENT, made this ____ day of ____, by and between ____ (herein referred to as "SPONSOR") and ____ (herein referred to as "PROVIDER")

WITNESSES:

WHEREAS, PROVIDER agrees to provide covered (health, hospital) services to persons who are covered individuals under group health (policies, plans) (issued, administered, underwritten) by SPONSOR; and

WHEREAS, PROVIDER agrees to accept as payment in full the scheduled benefits specified herein for the provision of covered (health, hospital) services to covered individuals; and

WHEREAS, SPONSOR agrees to remit scheduled benefits directly to PROVIDER if a covered individual executes a valid assignment of the right to payment of a scheduled benefit in favor of PROVIDER;

Now, therefore, the parties agree as follows:

I. DEFINITIONS

A. *Covered (health, hospital) services.* Those (health, hospital) services for which benefits are payable under the terms of a group health (policy, plan), subject to the exclusions and limitations described therein. These services are described in the appendix to this agreement.

B. *Covered individual.* A person certified by SPONSOR as eligible for benefits under a group health (policy, plan) (issued, administered, underwritten) by SPONSOR.

C. *Group health (policy, plan).* A contract between SPONSOR, and respectively, a policyholder (if the contract is issued on an insured basis) or an employee benefit planholder (if the contract calls for SPONSOR to provide only certain administrative services) under which SPONSOR provides reimbursement of covered (health, hospital) services for covered individuals designated by the (policyholder, planholder).

D. *Practitioner.* A licensed practitioner of the healing arts acting within the scope of the license.

E. *Scheduled benefit.* The maximum amount payable by SPONSOR under the terms of a group health (policy, plan) for the rendering (by a practitioner of a covered health service, of a covered hospital service) to a covered individual. These scheduled benefits appear in the attached appendix.

II. REPRESENTATIONS AND WARRANTIES

A. SPONSOR warrants and represents that it is a corporation duly organized and existing under the laws of the state of ____ and is authorized to transact the business of ____ in the state of ____.

B. If PROVIDER is a hospital, PROVIDER warrants and represents that it is a hospital licensed by the state of ____ and accredited by the Joint Commission on Accreditation of Hospitals and that all persons who will render covered hospital services to covered individuals shall be practitioners and/or employees of PROVIDER.

If PROVIDER is practicing individually, PROVIDER warrants and represents that he/she is a practitioner and maintains an office for the full-time practice of ____ in the state of ____ and that he/she has not been suspended from professional practice or publically reprimanded by any court or agency of competent jurisdiction within the past five years. PROVIDER further agrees that all health services under this agreement shall be performed in strict accordance with all generally accepted legal and ethical standards of the ____ profession.

If PROVIDER is a legally constituted—partnership or a professional corporation, PROVIDER warrants and represents that only practitioners will perform services pursuant to this agreement, that it is involved in and maintains an office for the full-time practice of ____ in the state of ____, and that no partner, member, or

Sample Preferred Provider Organization Contract Between Sponsoring Agency And Providers

person associated with PROVIDER has been suspended or publically reprimanded by any court or agency of competent jurisdiction within the past five years. PROVIDER further agrees that all health services rendered to a covered individual shall be performed in strict accordance with all generally accepted legal and ethical standards of the _____ profession.

C. PROVIDER agrees not to reject any covered individual as a patient for a covered (health, hospital) service by reason of the alleged inadequacy of any scheduled benefit.

D. PROVIDER enters into this agreement as an independent contractor and not otherwise. Nothing herein shall be construed to create the relationship of employer and employee between PROVIDER, its agents or employees and SPONSOR.

E. PROVIDER shall operate in complete accordance with all laws and/or rules and/or requirements of the state of _____, including the filing of any necessary reports.

F. PROVIDER shall not promote or publicize his/her/its status under this agreement without the prior written consent of SPONSOR. PROVIDER agrees not to use SPONSOR'S name or service marks in any way to advertise or promote the business of PROVIDER or any of its affiliates unless the material making use of such name or service marks has been specifically approved in writing by SPONSOR.

G. SPONSOR shall cause PROVIDER'S name and address to be disseminated to covered individuals and to (policyholders, planholders). SPONSOR does not guarantee in any way that PROVIDER will be engaged by any covered individuals or any number of covered individuals.

H. SPONSOR shall deliver to PROVIDER a list of those entities which are (policyholder, planholders) under which covered individuals are eligible for covered (health, hospital) services pursuant to a group health (policy, plan).

SPONSOR shall update said list periodically. PROVIDER may rely upon the accuracy of the information contained in said list and shall not be held responsible in any way for any errors in such lists.

I. PROVIDER shall keep accurate and current medical files and records concerning each covered individual. PROVIDER shall make such files and records available to SPONSOR during normal business hours. Nothing contained herein shall require PROVIDER to reveal any physician-patient confidential information which is not subject to disclosure pursuant to SPONSOR'S standard claim form authorization.

J. Neither SPONSOR nor PROVIDER shall utilize or disclose any of either's proprietary processes and/or procedures without written consent of the other party.

K. SPONSOR shall have the right during the term of this agreement, without the consent of the PROVIDER, to modify the number of covered (health, hospital) services. SPONSOR shall have the right to determine the scheduled benefit to be assigned any added service and also shall have the right to increase the scheduled benefit for any existing covered (health, hospital) service. Any modifications granted under this subpart will take effect _____ days after written notice to PROVIDER.

L. In consideration of covered (health, hospital) services performed by PROVIDER, SPONSOR shall promptly make payments to PROVIDER following actual receipt of an itemized account of charges, provided covered individual has executed a valid assignment of the right to payment of a scheduled benefit in favor of PROVIDER. Payment will be made as established under this agreement.

III. AUDITS

A. SPONSOR shall, at its own cost and expense, have the right to investigate and audit the covered (health, hospital) services provided to covered individuals under the agreement. PROVIDER shall cooperate by making available all necessary files and records as may be reasonably requested by SPONSOR. Any such audit or investigation shall be carried out without requiring PROVIDER to reveal any physician-patient confidential information not otherwise subject to disclosure pursuant to SPONSOR'S standard claim form authorization.

B. SPONSOR agrees that all files relating to the rendering of covered (health, hospital) services for covered individuals by PROVIDER are the property of PROVIDER. In the event of termination of this agreement, said files shall remain with PROVIDER, subject, however, to the right of any covered individual to request that his/her file be transmitted elsewhere in accordance with his/her instructions.

IV. INDEMNIFICATION AND HOLD HARMLESS

A. PROVIDER shall be solely responsible for services performed for or rendered to covered individuals by PROVIDER.

B. PROVIDER shall indemnify and hold SPONSOR harmless from any and all claims, lawsuits, settlements, judgments, costs, penalties, expenses, attorneys fees, or

continued on next page

liabilities incurred as a result of medical services provided or failed to be provided by PROVIDER to any covered individual.

C. PROVIDER shall maintain, at its sole cost and expense, in full force and effect during the term of this agreement a valid current policy or policies of insurance with an insurer acceptable to SPONSOR, which acceptance shall not be unreasonably withheld, insuring PROVIDER against any liabilities for any services provided or failed to be provided, any negligence, and/or judgment.

The coverage shall be in amounts not less than \$ _____ per occurrence, \$ _____ in aggregate claims per year, which minimum amounts SPONSOR retains the right to adjust annually on the anniversary of this agreement. Evidence of such insurance shall be provided to SPONSOR on request. PROVIDER hereby warrants that such insurance is now, and will be, continuously in effect so long as (health, hospital) services are being rendered by PROVIDER to covered individuals.

If the policy or policies described above are issued to a medical partnership or professional corporation of which PROVIDER is a member, or if PROVIDER is a medical partnership or professional corporation, the required minimum coverage shall be multiplied by the number of partners or members who are practitioners.

V. TERMINATION

A. Either party may terminate this agreement upon the giving of _____ days prior written notice by registered mail, return receipt requested, to the other party. Notices to PROVIDERS shall be sent to the last address on file with SPONSOR.

B. Except as may be precluded by law, PROVIDER shall complete the performance of covered (health, hospital) services for covered individuals in progress at the time of termination in accordance with this agreement provided covered individuals consent.

VI. ASSIGNMENTS

PROVIDER will not assign its rights, duties, or obligations under this agreement either in whole or in part without the written consent of SPONSOR; provided, however, that any assignment by SPONSOR to any of its affiliates or subsidiaries shall be permissible at any time.

VII. MODIFICATIONS

No changes in this agreement shall be effective unless they are in writing and signed by both parties.

APPENDIX

I. Physician services.

(All surgical and medical services commonly performed by the physician will be payable at the rate of _____ % of SPONSOR'S usual and prevailing fee schedule.)

All surgical services commonly performed by the physician will be payable (at the rate shown in the 1964 CRVS surgical schedule using a conversion factor of \$ _____, at _____ % of the physician's normal charges, at _____ % of the SPONSOR'S usual and prevailing fee schedule, which will be updated annually).

All medical services commonly performed by the physician will be payable (at the rate shown in the 1964 CRVS medical schedule using a conversion factor of \$ _____, at _____ % of the physician's normal charges, at _____ % of the SPONSOR'S usual and prevailing fee schedule, which will be updated annually).

For the following surgical procedures performed in the physician's office, ambulatory surgical center, or hospital outpatient department where no inpatient confinement results, an incentive payment of % greater than the surgical reimbursement shown above will be paid.

II. Hospital services.

A. Inpatient and outpatient services will be reimbursed on the basis of (_____ % of the SPONSOR'S usual and prevailing fee schedule, _____ % of the hospital's normal charges, the following table of diagnostic related groupings), adjusted annually.

B. Emergency room services will be reimbursed at _____ % of the (SPONSOR'S usual and prevailing fee schedule, hospital's normal charges), adjusted annually.

C. Outpatient surgeries will be reimbursed at the incentive rate of _____ % of the hospital's normal charges, adjusted annually, for the surgeries listed below when performed on an outpatient basis in lieu of an inpatient confinement.

The art and science of negotiating as a health care purchaser was discussed at the Midwest Business Group on Health's Eighth Annual Conference at the end of February 1988 by Michael Rode, regional manager of Community Care Network of San Diego; David Redfield, vice-president of the DePaul Health Corporation; and Roger Freitag, manager of headquarter employee benefits for Allen-Bradley Company; all based in Milwaukee, Wis. Another workshop also dealt with purchasing health care for the small employer. A summary of these presentations follows.

"Preferred provider organizations represent providers' interests, and are weak in utilization review, while insurance companies do not always have the consumer's interest at heart," Michael Rode, Milwaukee regional manager for Community Care Network (CCN) of San Diego and administrator of Health Care Network of Greater Milwaukee (a business coalition's preferred provider organization), told the Midwest Business Group on Health's 1988 conference. The conference theme was "The Science of Health Care Purchasing."

"A purchaser system has an advantage in that it is controlled by the employer and it is the most effective way to put the purchaser's interest first." Mr. Rode and David Redfield, vice-president of DePaul Health Corporation in Milwaukee, discussed negotiating prices and services with health care providers.

A strong utilization review component is vital to the success of a contract provider arrangement, Mr. Rode emphasized. "If medically unnecessary days are identified by UR, the hospital must eat the cost."

Mr. Rode identified some steps the purchaser must take before it approaches negotiations with hospitals.

Initial Steps

1. How will the hospital be reimbursed? Some possibilities include:

- a. A straight discount of billed charges—but rates continue to rise.
- b. A discount off billed charges with some sort of cap.
- c. Diagnosis related groups (DRGs) approach (such as Medicare's)—not the most effective because of coding inaccuracies, DRG creep, and their not accommodating.
- d. Per diem approach, and very limited, with global rates for medical/surgical, physical rehabilitation, and psychiatric services, for example. CCN feels that this is the most effective way of controlling costs. To discour-

age shifting from inpatient to outpatient charges, hospital amounts must be capped.

e. Stratified per diem for pediatrics, obstetrics/gynecology, oncology.

f. A combination of the previous approaches.

2. Establish a deadline for contract negotiations.

3. Give the hospital an idea of who you are, what you do, and how many lives are covered by the plan.

4. Have a bid structure in mind.

5. Determine selection criteria by identifying the following factors:

a. What kind of discount are you getting? Understand that hospital's historic costs in relation to other hospitals.

b. Geography.

c. Services and range of services needed. Get all possible services in the community.

d. Historically, where have your employees gone for hospital care?

e. Quality—the Joint Commission on Accreditation of Healthcare Organizations is one source of information.

Physician Contracting

The following factors should be taken into consideration with physician contracting.

1. Reimbursement mechanism. For example, the Greater Milwaukee Health Care Purchasing Plan used the California Relative Value Studies adjusted for the area and did not allow any fee negotiations. The plan sent a fee schedule to physicians and invited them to join the network.

2. Doing the research, selecting physicians, using the following criteria.

- Geography
- Specialty
- Board certification
- Staff privileges to network hospitals

Negotiating Prices And Services With Health Care Providers: A Guide For Employers

• Medical advisory committee, a local peer review organization, to help identify quality criteria. One of the biggest challenges, Mr. Rode observed, was to enlist into the network the best quality physicians.

3. Identify your organization, who you are, what you do and how many lives you control.

Providers' Perspective

Ideally, from the provider's perspective, how should the employer/purchaser approach provider negotiations? Mr. Redfield described the process.

1. First you seek the request for proposal. Seek information; providers want to tell you how good they are. Ask about the following:

a. Quality assurance plan, peer review, report of the Joint Commission or other specialized evaluator.

b. Outcome evaluation and consumer satisfaction.

c. Length of stay for a variety of procedures, practice pattern.

d. Experience and approach to, and dealing with managed care (current affiliations).

2. Give information about your organization, including experience, utilization review expectations (specific, if you wish), patient volume, and utilization for a variety of specialized benefits.

As far as pricing is concerned, Mr. Redfield said, providers would prefer graduated pricing. For example, the first \$x thousand worth of business at one price, and a reduced price beyond that. "A percent discount is not useful because the provider can just adjust prices," Mr. Redfield said. "It is important to establish a partnership relationship, a win-win atmosphere."

3. Discuss non-cost issues, such as quality assurance. Emphasize that you are looking at more than just costs.

4. "If the deal is too good to be true, it is too good to be true."

Implementation, Administration

Members of the Milwaukee coalition promote the providers in the network, Mr. Rode explained. One company had a health fair. Mr. Rode also suggested that employer purchasers eliminate providers who are not in the network from access to employees. "Monitor and enforce incentives, or disincentives such as deductibles and copays," he encouraged.

It is important to communicate with your providers regularly, the speakers agreed, to keep them informed about any problems, issues, or concerns.

Milwaukee is making the health care purchasing network available to small employers, insurance carriers, and multiple employer trusts, Mr. Rode concluded. And employees are being pushed into managed care.

Small Employers

How can small employers also obtain health care savings such as those negotiated by large employers or employer health care coalitions? It is a very difficult and sometimes long process, but it can be done, panelists at a purchasing workshop for small employers agreed. Frequently, the local Chamber of Commerce and the Small Business Association provide opportunities to get group rates, Carol Greenberg, executive director of the Worcester (Mass.) Area Systems For Affordable Health Care suggested.

Two ways of obtaining more favorable health care rates are through community-based purchasing groups and through insurance carrier programs. Other possibilities include joining a benefit trust (companies that band together to provide benefits) or participating in a buyers' group through a credit union. "Community-rated pre-paid plans are a good value for smaller employers," Ms. Greenberg said, and reiterated that "there's safety and opportunity in numbers."

For example, groups can influence health care costs and systems by "encouraging" the elimination of some "excess" hospitals or reduction of hospital beds, Peter Lardner, president of Rock Island, Ill.-based Bituminous Casualty Corporation, emphasized.

Definitely, insurance carriers should be encouraged to become more involved in negotiating lower rates for their clients, some conferees said. The insurance industry is not very amenable to changes; larger employers get the rate breaks but smaller employers pay the difference, conferees complained.

What incentive does a small employer have to push for rate negotiations when it is fully insured through a commercial carrier? That incentive is to ultimately lower health care costs in the community.

Questions For Evaluation

Roger Freitag, manager of headquarter employee benefits for Allen-Bradley Company, offered the following questions for employers to consider when evaluating health care purchasing programs.

• Are they flexible to meet the needs of your company's environment?

• Are they compatible with your company's health program objectives?

• Will they fit in with employee relations policy?

• What are the legal implications?

• Do the systems now available deal effectively with quality of care and establish control for the employer?



ISER RESEARCH SUMMARY

Institute of Social and Economic Research, University of Alaska

February 1989, R.S. No. 41

Appendix to "Where Have All The Billions Gone? - Part II"
State of Alaska Operations and Capital Expenditures by Program Category and Department
FY 1979-1988
(\$ Thousands)

OPERATIONS	1979	1980 [6]	1981	1982	1983	1984	1985	1986	1987	1988
EDUCATION	388,490	445,393	556,044	688,230	760,560	838,384	897,399	918,888	813,111	825,623
Governor's Office	1,336	2,437	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]
Alaska Historical Commission	181	292	to DOE after '80		[1]	[1]	[1]	[1]	[1]	[1]
Alaska Arts Council-grts & admin	1,155	2,145	to DOE after '80		[1]	[1]	[1]	[1]	[1]	[1]
Dept. of Administration										
Teacher's retirement	11,912	11,458	12,160	23,805	25,099	30,353	34,480	32,152	23,374	0
Dept. of Education	277,635	317,478	403,526	507,635	585,027	645,203	693,941	717,204	645,332	679,080
Foundation Program	181,966	204,748	255,384	345,257	409,424	428,772	466,735	492,279	415,155	437,438
Foundation Program-RSA	0	0	0	0	7,902	0	0	0	0	0
Financial Support Programs	51,715	53,860	52,118	62,007	62,461	66,410	54,182	45,597	52,873	53,592
P.L. 81-874 Settlement	0	0	0	0	0	0	0	0	0	12,215
Gen. admin. and Program Support(e)	6,612	1,602	8,923	10,665	11,307	22,149	30,144	28,507	29,024	27,971
Student Financial Aid	[1]	9,194	(in Post Secondary Ed.)		[2]	[2]	[2]	[2]	[2]	[2]
Scholarship Loan Program	3,600	8,120	23,277	19,300	[5]	[5]	[5]	[5]	[5]	[5]
Grants and admin	671	[2]	[2]	385	3,548	3,082	3,272	3,183	2,672	551
Post Secondary Education, adult ed., and voc ed. (& rehab. after 80)	4,255	3,011	14,334	17,462	21,066	22,240	30,977	22,813	17,016	21,918
WICHE	715	(in Post Secondary Ed.)		1,240	1,555	1,646	1,848	1,676	1,197	1,293
Museums and Libraries	2,982	3,463	3,967	5,800	5,556	5,465	7,001	6,609	5,535	5,837
Public Broadcasting Commission	2,846	4,056	4,559	(in gen govt)		[1]	[1]	[1]	[1]	[1]
Mt. Edgecombe	0	0	0	0	0	0	0	3,359	2,848	2,939
Other operations	0	5,424	0	0	0	0	0	39	0	0
Alaska Historical Commission	[1]	[1]	369	356	425	477	492	511	85	0
Alaska Arts Council	[1]	[1]	2,445	5,300	5,783	4,962	5,247	4,385	2,604	1,759
Grants	0	0	150	1,401	0	0	69	1,207	243	3,036
Misc RSAs	[3]	[3]	[3]	[3]	[3]	[3]	861	723	217	1,058
School Bond Debt Retirement	22,273	24,000	38,000	38,262	56,000	90,000	93,113	106,316	115,863	109,473
Municipal Grants	0	0	267	2,060	1,903	4,696	764	115	344	7
University of Alaska	74,561	86,378	109,723	128,144	148,531	158,132	168,214	169,417	144,061	146,536
Statewide Admin & Regents	7,220	6,699	9,360	9,630	12,503	16,514	14,921	14,231	11,470	12,725
Organized Research	7,506	7,942	11,370	13,755	(in Fairbanks)		15,381	13,674	11,760	[1]
Fairbanks	21,728	23,004	31,982	38,608	58,614	62,041	51,358	49,913	45,367	73,593
Anchorage	10,988	10,474	14,452	17,824	20,074	22,795	24,263	24,031	21,305	50,816
Juneau	2,341	3,841	5,486	7,286	9,133	9,757	10,308	9,934	8,568	9,377
Community colleges	17,829	17,829	26,886	37,319	39,725	39,563	43,469	41,770	38,404	25

APPENDIX
State of Alaska Operations and Capital Expenditures by Program Category and Department
FY 1979-1988
(\$ Thousands)

OPERATIONS	1979	1980 [6]	1981	1982	1983	1984	1985	1986	1987	1988
Cooperative Extension Svc	0	0	2,645	3,347	4,301	4,164	4,570	4,397	3,956	[1]
Rural education	3,618	3,257	1,859	0	3,176	3,106	3,379	3,251	2,664	[2]
Student loans, scholarships	75	76	77	[2]	[2]	[2]	[2]	[2]	[2]	[2]
Other operations-spec expend. (salary increase)	3,256 (2,721)	13,256 (11,496)	3,106 0	175 0	1,005 0	192 0	565 0	857 7,359	567 0	0
Working capital	0	0	2,500	0	0	0	0	0	0	0
Grants	0	0	0	200	0	0	0	0	0	0
State Bond Comm.-Debt Service	23,046	27,642	30,368	26,586	[4]	[4]	[4]	[4]	[4]	[4]
SOCIAL SERVICES	114,701	131,127	167,238	185,720	198,251	216,020	260,944	274,557	277,512	289,876
Governor's Office-grants	200	350	400	0	0	0	0	0	0	0
Dept. of Administration	22,463	23,703	32,428	42,938	53,971	58,548	73,985	75,527	77,878	81,274
Longevity Bonus	12,348	13,388	19,546	25,796	27,758	29,414	43,574	44,382	47,227	50,352
Pioneers Homes	10,115	10,315	12,882	14,188	18,454	20,580	20,676	21,929	21,277	21,856
Older Alaskans Commission	0	0	0	131	565	1,053	1,039	864	9,374 [p]	9,066
Aging Grants (in DHSS 1979-1982)			[1]	2,823	7,194	7,493	8,696	8,352	[1]	[1]
Dept. of Revenue-Child Support Enf	1,488	1,896	2,216 (in General Govt.)			[1]	[1]	[1]	[1]	[1]
Dept. of Education	4,475	118	64	[1]	[1]	[1]	[1]	[1]	[1]	[1]
Vocational Rehabilitation	4,446	(in education category)		[1]	[1]	[1]	[1]	[1]	[1]	[1]
Youth Employment Svcs	29	118	64 (in DHSS-Admin of Justice category)				[1]	[1]	[1]	[1]
Dept. of Health & Social Services	52,437	61,586	83,649	96,652	97,299	106,098	125,581	136,048	143,424	152,078
Public Assistance	25,202	29,602	36,959	39,542	37,996	42,462	55,955	63,186	73,668	80,221
PFD Hold Homeless	0	0	0	0	4,138	2,871	3,471	2,938	3,207	7,329
Public Assistance Eligibility	3,531	4,324	6,078	7,188	9,112	9,702	10,289	10,713	10,585	11,140
Public Assistance admin.	(in admin. and misc. below)		(in health)		2,654	4,145 [f]	5,944	4,595	5,133	5,345
Energy Assistance Program	0	0	2,922	4,619	6,591	6,513	7,817	6,254	6,445	5,316
Program Services	7,480	9,742	4,515	6,091	6,076	5,725	5,644	5,802	4,445	21,219
Juvenile Custody (in Admin of Justice)			10,651	14,386	13,932	16,390	16,730	16,475	15,800	
Social Svcs and Social Svcs Admin.	5,778	6,783	7,803	8,366	8,716	9,215	10,274	12,533	11,949	12,411
Contract social & health svcs	0	0	0	0	1,532	2,571	4,126	7,745	7,121	6,249
WIN	303	355	476	478	475	585	574	496	[2]	[2]
Administration and misc.	3,590	3,413	4,142	593	(in Public Assistance Admin.)			[1]	1,952	[2]
Office on Aging	508	3,972	6,114	0	0	0	0	0	0	0
Aging Grants	3,093	(in Ofc on Aging)		7,187	(in DOA-Social Services)			[1]	[1]	[1]

APPENDIX
State of Alaska Operations and Capital Expenditures by Program Category and Department
FY 1979-1988
(% Thousands)

OPERATIONS	1979	1980 [6]	1981	1982	1983	1984	1985	1986	1987	1988
Old Age Assistance	2,952	3,395	3,989	4,558	6,077	5,919	(in Public Assistance)		[1]	[1]
Domestic Violence-grants	0	0	0	3,444	0	0	0	0	0	0
Grants	0	0	0	200	0	0	3,650	1,070	261	0
Misc RSAs	[3]	[3]	[3]	[3]	[3]	[3]	1,107	[3]	[3]	[3]
Anch SS Block Grant	0	0	0	[2]	[2]	[2]	[2]	2,500	2,411	2,411
Fbks SS Block Grant	0	0	0	[2]	[2]	[2]	[2]	500	437	437
Longevity Bonus-new legis.	0	0	0	0	0	0	0	1,241	0	0
Dept. of Labor	18,493	22,498	27,361	25,237	28,132	29,641	32,258	35,804	34,338	32,003
Employment Security	14,258	18,812	22,425	20,303	23,469	25,204	26,402	27,386	26,618	25,465
WIH	[2]	841	905	844	645	927	1,005	874	737	784
Admin.	4,235	2,845	4,031	4,056	4,018	3,510	4,851	7,544	6,983	5,754
Grants	0	0	0	34	0	0	0	0	0	0
Dept. of Commerce & Economic Dev.	62	62	107	0	0	0	0	0	0	0
Dept. of Community & Regional Affair	13,634	18,775	17,398	17,535	18,563	21,733	28,859	27,140	21,853	24,316
Senior Citizens Tax Exemption	1,864	2,158	2,558	2,014	2,424	3,458	4,442	4,357	3,087	3,071
Child Assistance	1,734	2,168	3,005	8,219	9,678	10,514	12,775	13,247	10,975	12,082
CETA/JPTA	9,677	13,952	11,637	6,915	6,375	7,123	7,069	8,147	7,791	9,243
Displaced Homemakers	0	0	0	0	0	540	591	434	[2]	[2]
Senior Citizen Housing Dev.	64	75	59	73	86	98	0	0	0	0
Sr. Citizen Hang-Chugach Facility	0	0	0	0	0	0	1,000	0	0	0
Other operations	55	422	139	99	0	0	0	0	0	0
Grants	0	0	0	215	0	0	0	0	0	0
Winterization	240	[2]	[2]	[2]	[2]	[2]	[2]	[2]	[2]	[2]
Misc RSAs	[3]	[3]	[3]	[3]	[3]	[3]	2,982	955	[3]	[3]
Municipal Grants	0	0	751	0	286	0	261	38	19	205
State Bond Comm.-Debt Service	1,449	2,139	2,864	3,358	[4]	[4]	[4]	[4]	[4]	[4]
HEALTH X	71,565	73,486	99,990	129,599	131,196	157,216	169,134	168,918	170,262	199,326
Dept. of Health & Social Services	69,687	71,310	97,040	126,334	129,008	157,092	167,695	168,852	170,252	199,285
Nursing	4,543	4,870	5,926	7,503	7,818	8,135	8,091	8,393	7,356	8,582
CDC/Laboratories	2,448	2,624	2,855	3,485	4,266	4,762	4,539	4,186	4,009	3,369
Environmental Health	1,181	1,180	355	139	[2]	[2]	[2]	[2]	[2]	[2]
Health & Safety	0	0	0	0	0	91	[2]	[2]	[2]	[2]
Child & Family Health	2,681	2,896	3,966	4,620	5,580	6,902	6,970	6,163	6,141	6,446

APPENDIX
State of Alaska Operations and Capital Expenditures by Program Category and Department
FY 1979-1988
(\$ Thousands)

OPERATIONS	1979	1980 [6]	1981	1982	1983	1984	1985	1986	1987	1988
Public Health Administration	993	1,593	1,283	2,130	2,145	1,568	1,485	3,326	2,093	2,013
Grant to MOA	600	0	846	939	939	1,230	[2]	[2]	[2]	[2]
Grant to Fairbanks	[2]	[2]	[2]	[2]	80	50	80	[2]	[2]	[2]
Emergency Medical Services	994	1,097	1,825	1,857	2,422	2,220	0	0	0	0
Medicaid	25,418	23,887	31,678	36,045	35,627	58,183	63,255	63,460	74,458	97,528
General Relief-Medical	5,776	5,435	6,741	9,857	9,208	9,824	10,249	10,442	6,430	8,173
Catastrophic Illness	0	0	0	0	0	5,344	2,132	1,061	874	[2]
Med Asstc admin	[2]	[2]	[2]	[2]	[2]	[2]	[2]	3,345	3,631	3,791
Alcohol and Drug Abuse	633	4,878	4,283	1,956	1,515	1,539	1,152	1,237	1,370	2,050
Grants	3,570	[2]	9,284	15,784	14,322	12,184	13,638	13,850	11,525	11,736
API	7,082	7,826	8,978	10,847	11,880	13,186	13,680	14,187	13,082	13,509
Harborview	4,619	4,929	5,459	6,483	7,202	7,305	7,427	7,037	7,016	7,060
Community Ment. Health Svcs Grants	2,682	2,938	3,905	4,446	5,034	5,680	6,150	7,258	8,505	12,435
Other mental health	3,259	3,916	4,803	4,743	7,001	6,420	9,928	8,105	7,329	7,842
Other planning and admin.	2,110	2,345	3,331	10,476	11,476	8,525	8,017	7,790	7,427	7,011
Grants	192	[2]	[2]	1,711	1,417	2,336	8,027	8,608	8,376	6,733
Public assistance admin & coll.	898	896	1,517	1,805	(in soc svcs)		[1]	[1]	[1]	[1]
Health Clinics	0	0	0	716	1,076	1,608	2,248	[2]	[2]	[2]
Other programs	0	0	0	792	0	0	257	0	0	418
Misc RSAs	[3]	[3]	[3]	[3]	[3]	[3]	370	404	630	589
Municipal Grants	0	0	0	0	2,188	124	1,439	66	10	41
State Bond Comm.-Debt Service	1,878	2,176	2,950	3,265	[4]	[4]	[4]	[4]	[4]	[4]
NATURAL RESOURCE MANAGEMENT	68,192	82,587	118,145	161,246	176,227	137,776	156,458	152,275	134,442	147,054
Governor's Office-CZM	2,367 [h]	3,504	2,258	15	0	0	0	0	0	0
Dept. of Administration	0	0	0	480 [a]	0	0	0	0	0	0
Dept. of Revenue	297	264	0	0	0	0	0	0	0	0
Dept. of Commerce & Economic Dev. (oil & gas bd. in DNR)			1,268	2,070	2,287	[2]	[2]	[2]	[2]	[2]
Dept. of Natural Resource	22,283	29,807	32,950	50,126	82,302	45,737	53,349	51,646	45,031	53,282
Management and admin. ion	6,018	7,375	8,933	11,604	13,176	13,050	18,444	17,338	12,118	7,954
Oil & gas cons & mgmt. pipeline su	1,500	1,851	4,938	4,679	129	0	0	0	0	0
Land, water, forest management	5,472	8,396	12,293	24,694	20,564	17,562	20,831	20,157	16,708	30,872
Minerals & energy	2,736	3,462	2,641	3,441	6,873	9,580	6,300	6,843	10,540	8,126

APPENDIX
State of Alaska Operations and Capital Expenditures by Program Category and Department
F / 1979-1988
(\$ Thousands)

OPERATIONS	1979	1980 [6]	1981	1982	1983	1984	1985	1986	1987	1988
Dept. of Administration	824	[2]	390	416	580	433	3,062	3,716	3,965	4,373
Public Offices Commission	0	0	390	416	580	433	523	544	545	551
Office of Public Advocacy	0	0	0	0	0	0	2,539	3,172	3,420	3,822
Dept. of Labor	3,753	6,016	6,931	7,923	9,516	10,729	11,415	14,425	13,484	13,335
OSHA	1,909	2,156	2,030	1,736	2,035	2,350	2,504	2,572	2,607	2,539
Other	1,844	3,860	4,901	6,187	7,481	8,379	8,911	11,853	10,877	10,796
Dept. of Law	446	434	585	706	742	796	778	865	410	317
Dept. of Revenue	405	462	530	562	608	692	659	655	571	634
Dept. of Commerce & Economic Dev.	6,292	8,041	8,459	9,785	12,455	15,596	14,699	13,267	12,250	12,973
Dept. of Military Affairs	5,427	5,949	6,984	8,999	14,022	10,025	18,925	13,735	17,715	22,949
Search and rescue	304	336	398	651	832	810	695	[2]	[2]	[2]
Alaska Disaster Office	747	1,406	1,583	1,908	1,208	1,312	9,380	4,560	9,310	13,392
Alaska National Guard	3,725	4,207	4,404	5,176	7,091	6,290	6,387	6,724	6,552	7,939
AK N.G. retirement	282	[2]	599	1,264	507	1,613	1,918	1,835	1,298	991
Other	369	0	0	0	4,384 [k]	0	545	616	555	627
Dept. of Natural Resources-Ag insp.	724	834	(to DEC-Environmental Health)			[1]	[1]	[1]	[1]	[1]
Dept. of Public Safety	6,852	5,687	7,309	7,680	8,222	7,152	8,940	9,872	8,416	8,350
Dept. of Environmental Cons.-Env Hea	0	0	1,815	1,183	2,003	1,800	2,196	3,284	2,758	3,009
Dept. of Community & Regional Affair	0	0	56	130	0	0	0	0	0	0
Municipal Grants	0	0	1,048	255	1,260	601	287	304	600	231
State Bond Comm.-Debt Service	972	1,479	2,376	3,879	[4]	[4]	[4]	[4]	[4]	[4]
ADMINISTRATION OF JUSTICE	80,331	84,412	100,702	140,715	158,205	180,718	198,228	205,762	193,693	205,138
Governor's Office [i]	6,412	6,356	1,398	1,596	1,649	1,706	1,610	1,674	1,563	1,644
grants	2,406	1,477	703	123	59	0	0	0	0	0
Dept. of Administration	[1]	[1]	2,938	3,672	4,261	4,952	6,265	5,925	5,802	6,137

APPENDIX
State of Alaska Operations and Capital Expenditures by Program Category and Department
FY 1979-1988
(\$ Thousands)

OPERATIONS	1979	1980 [6]	1981	1982	1983	1984	1985	1986	1987	1988
Historic resource mgmt	367	297	305	299	0	0	0	0	0	0
Park mgmt & operations	5,964	8,153	3,709	4,467	5,325	5,545	6,183	7,120	5,290	5,508
Youth Conservation Corps	226	273	131	363	0	0	0	0	0	0
Grants	0	0	0	579	0	0	1,415	0	43	0
Marathon/Union Oil	0	0	0	0	36,235	0	0	0	0	0
Misc. RSAs	[3]	[3]	[3]	[3]	[3]	[3]	176	188	332	822
Dept. of Fish and Game	24,490	25,722	47,057	62,128	65,428	66,381	74,326	74,786	66,219	69,621
Commercial fish	9,473	9,667	13,613	17,760	19,036	19,248	19,613	22,049	18,918	21,686
Fisheries Rehab. Enhancement Dev.	8,344	7,576	9,812	12,553	12,567	12,864	14,738	15,473	13,168	14,631
Comm. Fisheries Entry Commission	0	0	1,750	2,238	2,600	2,082	2,057	2,445	2,031	1,965
Game	905	807	7,586	10,053	11,759	11,478	11,570	11,747	10,463	10,235
Subsistence Division	158	860	1,162	1,369	2,096	2,614	2,925	2,898	2,426	2,237
Habitat Protection	936	1,690	2,614	2,887	2,469	2,328	3,013	3,599	3,075	3,005
Bd. of Fisheries & Game	282	289	467	510	817	1,090	1,309	1,089	929	963
Administration & support	3,875	4,784	3,765	5,815	4,669	4,807	5,043	5,089	4,457	4,088
Pipeline monitoring	263	[2]	(in DNR as of 1981)		[1]	[1]	[1]	[1]	[1]	[1]
Sport Fish	0	0	4,451	6,270	7,470	7,994	9,081	6,729	7,322	7,293
Other operations	254	49	1,837	1,917	1,945	1,876	1,775	1,554	272	19
Grants	0	0	0	756	0	0	257	0	0	0
Special Items	0	0	0	0	0	0	1,063	1,635	2,887	2,943
Misc RSAs	[3]	[3]	[3]	[3]	[3]	[3]	674	479	271	556
Susitna-APA	0	0	0	0	0	0	1,208	0	0	0
Dept. of Public Safety (F&W)	6,953	7,467	9,727	12,406	13,312	12,904	13,143	13,031	10,986	11,473
Dept. of Environmental Cons.	4,819	5,436	7,917	12,093	12,843	12,554	15,640	12,812	12,203	12,678
Administration & support	2,583	1,407	944	1,146	1,097	2,444	3,352	2,347	1,798	1,506
Village Safe Water	375	(in Capital)	[5]	[5]	[5]	[5]	[5]	[5]	[5]	[5]
Grants	0	0	0	624	1,330	300	2,159	306	94	[2]
Other operations	1,861	4,029	258	546	620	1,136	800	1,631	1,709	2,134
Environmental Qual. Operations	[2]	[2]	4,670	6,828	7,055	6,114	6,570	6,184	5,715	6,921
Environmental Management	[2]	[2]	2,045	2,949	2,741	2,560	2,759	2,344	2,887	2,117
Municipal Grants	0	0	0	633	55	200	0	0	3	0
State Bond Comm.-Debt Service	6,983	10,387	16,968	21,295	[4]	[4]	[4]	[4]	[4]	[4]
PUBLIC PROTECTION	25,695	28,902	36,483	41,518	49,408	47,824	60,961	60,123	60,169	66,171

APPENDIX

[illegible]

APPENDIX
State of Alaska Operations and Capital Expenditures by Program Category and Department
FY 1979-1988
(\$ Thousands)

OPERATIONS	1979	1980 [6]	1981	1982	1983	1984	1985	1986	1987	1988
ASHA-operations	369	[2]	[2]	[2]	239	[2]	[2]	[2]	[2]	[2]
Tourism	1,457	1,828	2,928	9,721	7,568	6,092	7,911	6,531	5,754	13,789
Energy and Power Development	310	2,830	3,980	9,692	3,489	11,720	0	0	5,863	0
E & P Dev.-Spec. Items	0	0	0	88	2,663	0	0	0	0	0
APA	324	518	2,399	1,432	9,706	[2]	6,127	5,105	4,124	6,820
Loan fund administration	760	878	1,312	1,327	2,398	2,967	2,462	2,780	2,868	2,497
Business loans	[2]	[2]	655	[2]	[2]	[2]	[2]	[2]	[2]	[2]
Other programs	0	3	0	140	336	0	357	9	0	0
Fisheries-related econ. dev.	0	0	0	2,272	2,903	2,585	2,503	3,448	4,804	4,419
Agricultural Action Council [c]	0	0	0	583	5,346	1,068	(to DNR-Capital)	[1]	[1]	[1]
Energy-related grants	0	0	0	152	2,484	0	0	0	0	0
Power Cost Equalization	0	0	0	0	0	0	(in Capital)	[5]	13,787	15,060
Oil & Gas Board [b]	0	0	0	131	144	[2]	[2]	[2]	[2]	[2]
Alaskan Seafood Mktg Institute	0	0	0	2,050	6,905	3,733	3,784	3,515	3,005	4,514
Alaska Resources Corp.	[1]	[1]	[1]	[1]	358	236	(to DOR)	[2]	[2]	[2]
AIDA	[2]	[2]	[2]	650	695	746	808	830	731	897
AK Railroad Corp.	0	0	0	0	0	0	1,840	[2]	[2]	[2]
Grants	0	0	0	0	0	0	72	101	0	0
Dept. of Natural Resources-agric.	653	645	14,107	2,510	1,825	2,033	2,597	3,007	2,144	2,246
Ag Revolving Loan Fund	0	0	0	0	0	0	0	758	[2]	[2]
Other	653	645	14,105	2,510	1,825	2,033	2,597	2,249	2,144	2,246
Dept. of Fish and Game	225	232	270	0	0	0	0	0	0	0
Dept. of Community & Regional Affairs	23,671	32,622	66,283	82,543	87,227	94,202	88,369	158,868	128,898	111,154
Local Gov't. Assistance	621	994	1,650	2,276	2,394	5,302	4,210	3,684	2,948	2,690
Statewide Assistance	0	0	0	0	0	0	2,232	2,063	1,658	1,946
Revenue Sharing	19,663	28,050	51,409	55,603	55,465	57,781	60,333	59,569	47,845	40,124
Community Assistance Grants	0	0	4,416	6,016	6,535	4,816	3,866	2,448	1,918	2,592
Community and Rural Dev.	1,368	1,372	[2]	[2]	[2]	552	796	575	510	494
Community Planning Svcs	1,043	1,403	2,141	2,810	2,477	2,821	20	(in Capital)	[1]	[1]
Community Svcs-Housing	[2]	[2]	5,112	[2]	[2]	[2]	[2]	[2]	[2]	[2]
Rural Housing Loans	0	0	0	4,471	855	[1]	[1]	[1]	[1]	[1]
Hsgng Loan Admin	0	0	0	907	1,301	1,953	1,963	2,068	1,757	1,961
Housing Constr Dev	0	0	0	0	0	0	0	72	76	165
Housing Development Grant	0	0	0	4,303	5,114	1,697	[2]	[2]	[2]	[2]
Supplemental Housing Grants	0	0	0	0	1,047	1,199	4,306	0	0	0
Home Ownership Asst. Fund	0	0	0	0	0	5,706	[2]	[2]	[2]	[2]
Other admin. and assistance	871	803	1,356	1,260	1,660	1,577	2,951	2,578	1,966	1,647

APPENDIX
State of Alaska Operations and Capital Expenditures by Program Category and Department
FY 1979-1988
(\$ Thousands)

OPERATIONS	1979	1980 (6)	1981	1982	1983	1984	1985	1986	1987	1988
Coastal Zone Management	(in NRM, Governor's Ofc)			1,610	3,377	[2]	[2]	[2]	[2]	[2]
Other special projects & grants	0	0	0	2,106	4,151	9,045	2,093	1,742	1,785	151
Municipal Lands Trustee	105	[2]	199	231	272	264	243	267	257	273
Community Block Grants	0	0	0	0	150	1,489 [1]	1,628 [m]	70	77	75
Uninc. community grants	0	0	0	950	2,429	[2]	457	78	[2]	[2]
Energy Programs	0	0	0	0	0	0	3,203	2,406	1,158	1,327
Misc RSAs	[3]	[3]	[3]	[3]	[3]	[3]	68	[3]	1,194	1,625
Municipal Assistance	0	0	[1]	[1]	[1]	[1]	[1]	81,248	65,749	56,084
Municipal Aid	0	0	0	111,773	[5]	[5]	[5]	[5]	[5]	[5]
Municipal Grants	0	0	118	1,825	14,327	10,430	5,564	927	1,367	233
State Bond Comm.-Debt Service	3,260	3,527	3,738	5,926	[4]	[4]	[4]	[4]	[4]	[4]
TRANSPORTATION	113,068	130,446	151,585	241,168	233,282	232,956	271,795	270,377	233,059	250,203
Dept. of Public Safety (mts & mess)	[1]	874	1,727	2,215	(to DCED in Public Protection)			[1]	[1]	[1]
Dept. of Transportation	91,813	103,026	114,357	205,723	229,790	230,031	271,442	270,377	233,059	250,203
Admin	8,357	9,241	11,475	11,772	13,707	13,465	31,174	29,195	26,934	28,763
Maintenance and operations	45,318	49,633	52,722	81,045	87,095	89,543	85,770	86,983	66,002	81,305
Marine transportation	36,285	42,198	47,098	56,024	59,281	61,802	65,417	65,742	59,751	59,170
Design and Construction	1,853	1,954	3,062	46,610	58,853	50,065	50,665	52,608	45,949	45,221
Right of Way	[2]	[2]	[2]	1,152	[2]	[2]	[2]	[2]	[2]	[2]
Standards & Technical Services	0	0	0	0	0	4,968	5,432	4,752	4,026	3,917
Planning & Programming	[1]	[1]	[1]	9,120	10,854	10,188	6,445	4,219	1,587	965
Anchorage Int'l Airport	0	0	0	0	0	0	15,331	16,798	17,537	[1]
Fairbanks Int'l Airport	0	0	0	0	0	0	6,126	6,837	6,889	[1]
International Airports	0	0	0	0	0	0	[1]	[1]	[1]	26,307
Other operations	0	0	0	0	0	0	80	33	[2]	[2]
Misc RSAs	[3]	[3]	[3]	[3]	[3]	[3]	5,002	3,210	4,384	5,135
Municipal Grants	0	0	0	16	3,492	2,925	353	0	0	0
State Bond Comm.-Debt Service	21,255	26,546	35,501	33,214	[4]	[4]	[4]	[4]	[4]	[4]
GENERAL GOVERNMENT	71,479	86,451	1,736,148	986,580	1,037,306	522,064	684,111	457,602	482,538	568,205

APPENDIX
State of Alaska Operations and Capital Expenditures by Program Category and Department
FY 1979-1988
(\$ Thousands)

OPERATIONS	1979	1980 [6]	1981	1982	1983	1984	1985	1986	1987	1988
Governor's Office	8,513	8,535	12,601	20,640	34,708	38,375 [d]	20,691	56,413 [n]	13,956 [o]	16,193
Dept. of Administration (Public Broadcasting Comm)	23,637 (in Dept. of Education)	25,311	30,895	86,571 (8,070)	109,577 (6,993)	108,232 (7,363)	114,650 (7,456)	110,601 (7,792)	98,604 (6,561)	96,138 (6,657)
Dept. of Law RSAs	5,421 [3]	6,386 [3]	12,529 [3]	16,424 [3]	15,194 4,135	22,449 [3]	28,243 [3]	26,744 [3]	24,191 [3]	28,152 [3]
Dept. of Community & Regional Affairs Legal Services	[2]	[2]	[2]	[2]	[2]	[2]	250	[2]	[2]	[2]
Dept. of Revenue	7,931	9,232	1,630,756	835,557	846,666	320,432	485,841	232,961	317,777	398,740
Child Support Enforcement	[1]	[1]	[1]	2,406	3,089	3,729	3,463	4,354	4,788	5,530
Permanent Fund Corp.	0	0	0	357	2,385	2,594	0	0	0	0
Permanent Fund Transfer	0	0	900,000	800,000	400,000	300,000	300,000	0	0	0
Permanent Fund Dividends Operation	0	0	0	467	0	0	2,094	2,494	2,901	2,936
Permanent Fund Payments '82	0	0	0	16,101	418,343	119	92	0	(31)	(121)
Permanent Fund Dividend-'82 Reopen	0	0	0	0	0	52	0	0	0	0
Permanent Fund Dividend-'82 Supple	0	0	0	0	0	0	1,102	0	0	0
Permanent Fund Dividend-'83 Reopen	0	0	0	0	0	0	2,480	0	0	0
Permanent Fund Dividend-'83	0	0	0	0	0	0	1,279	0	13	(26)
Permanent Fund Dividend-'84	0	0	0	0	0	0	158,558	169	102	(12)
FY 86 Permanent Fund Div.	0	0	0	0	0	0	0	207,749	0	0
FY 87 Permanent Fund Div.	0	0	0	0	0	0	0	0	294,530	0
FY 88 Permanent Fund Div.	0	0	0	0	0	0	0	0	0	375,155
AHFC	[2]	[2]	556,955	[1]	[1]	[1]	0	0	0	0
Refundable Credits & tax refunds	0	0	162,064	4,005	5,370	1,750	1,056	1,648	380	0
Operations & admin.	7,931	9,232	11,737	12,221	16,188	11,951	14,738	15,186	13,850	14,336
U of A Settlement	0	0	0	0	4,200	0	0	0	0	0
Oil & gas litigation	0	0	0	0	180	237	979	1,361	1,244	942
Dept. of Education	26	0	0	0	0	0	0	0	0	0
Dept. of Public Safety (F&W)	183	175	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]
Dept. of Transportation-public facil	14,699	19,033	25,391	(to capital expenditures)			[5]	[5]	[5]	[5]
Legislature	11,069	16,862	22,880	26,279	31,161	32,576	34,686	30,883	27,910	28,982

APPENDIX
State of Alaska Operations and Capital Expenditures by Program Category and Department
FY 1979-1988
(\$ Thousands)

OPERATIONS	1979	1980 [6]	1981	1982	1983	1984	1985	1986	1987	1988
Office of Ombudsman	(in Leg.)	917	1,096	1,109	(in Leg.)	[1]	[1]	[1]	[1]	[1]
Total Debt Service	59,825	75,052	97,475	102,359	142,519	165,994	175,139	166,236 [q]	162,406	156,545
TOTAL OPERATIONS [7]	983,671	1,125,813	3,128,543	3,170,890	3,112,237	2,718,929	3,092,375	2,875,347	2,707,028	2,879,618

[a] Office of Science and Technology.

[b] In DNR under Natural Resource Management in 1979.

[c] In 1982 was in capital expenditures in development category, DCED.

[d] \$20,000 for "Appropriation Project."

[e] Includes boards and commissions in addition to program support, design and delivery, and administration.

[f] Several support services moved here from Social Services Administration.

[g] Includes only Youth Correctional Services; the remainder is now in new Department of Corrections.

[h] Includes Limited Entry, Fisheries Commission, CZM, pipeline surveillance(79-80); CZM & OCS (81); NOAA (82).

[i] 79-80 Public Defender, Prosecution, Human Rights Commission, Status of Women, Police Standards Council, Criminal Justice Planning; 81-Due Process; 82-Status of Women, Human Rights Commission.

[j] 80-Prosecution; 81-Added Criminal Justice Planning.

[k] Special Items-Emergency Services Program and Land Acquisition.

[l] Some of this may be Social Services block grant money.

[m] Community Service BG+Community Development BG.

[n] \$28,238 = salary and benefits increase; \$12,842 = non-covered employee compensation.

[o] \$416=salary & benefits increase

[p] Administration and grants not separated.

[q] 1986 Debt Service and Total revised from January-February 1987 documents.

APPENDIX
State of Alaska Operations and Capital Expenditures by Program Category and Department
FY 1979-1988
(\$ Thousands)

CAPITAL	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988
EDUCATION	25,135	49,841	50,551	114,898	110,597	165,755	409,175	207,206	143,641	68,903
Governor's Office	0	0	0	1	72	2	0	0	0	0
Dept. of Administration	0	0	0	127	42	0	0	0	0	0
Department of Education	2,473	3,236	4,514	21,696	31,715	71,271	159,616	118,588	107,100	42,256
Transfers to local gov'ts & districts										
Rural Education	0	0	0	11,497	6,992	3,462	1,353	134	771	
Other	910	[2]	[2]	6,854	21,537	64,581	89,995	44,274	42,653	25,811
Libraries and museums	279	286	391	389	777	2,503	3,275	3,091	871	600
Public Broadcasting Commission	134	324	440	(in General Govt-DOA)			[1]	[1]	[1]	[1]
Grants	0	0	0	0	0	0	1,180	0	0	0
Student Loan Prog	[1]	[1]	[1]	[1]	[1]	[1]	60,341	63,600	61,000	15,000
Teacher Loan Program	0	0	0	0	0	0	0	600	0	0
Other	1,150	229	3,683	2,956	2,409	725	3,472	1,557	518	667
BIA Transfer School	0	0	0	0	0	0	0	5,332	1,287	178
Continuations,supplements,revisions	0	2,397	0	0	0	0	0	0	0	0
Dept. of Transportation	14,618	40,875	33,181	46,743	11,842	7,562	72,964	3,963	1,107	137
Local gov't transfers AND transfers to REAAs	14,176	6,953	28,215	6,661	11,842	7,562	72,964	3,963	1,107	137
Continuations,supplements,revisions	0	33,922	0	0	0	0	0	0	0	0
Other-unspecified	442	0	4,966	82	0	0	0	0	0	0
University of Alaska	8,044	5,730	7,925	18,729	26,412	48,928	101,064	46,766	11,352	22,078
Fairbanks	4,775	[1]	2,293	4,252	5,748	15,901	32,775	8,923	2,092	7,591
Anchorage	2,175	[1]	1,833	3,399	7,932	15,948	16,543	12,503	2,961	1,770
UAA/ACC	0	0	0	0	0	361	11,137	7,698	361	0
Juneau	200	[1]	262	1,349	5,667	4,562	13,220	7,526	436	3,937
Community colleges	667	[1]	2,676	4,167	2,172	3,725	10,247	3,148	1,571	3,952
Cooperative Extension	[2]	[2]	8	34	58	6	[2]	[2]	[2]	[2]
Organized Research	[1]	[1]	481	342	37	47	[1]	[1]	[1]	[1]
Statewide	22	[1]	[2]	3,189	3,823	8,136	10,553	4,038	3,382	1,614
Agriculture Exp Station	123	[1]	[2]	278	232	240	49	[1]	[1]	[1]
Other-unspecified	0	5,730	278	0	0	0	0	0	0	0
Other	82	[1]	94	1,719	743	2	75	225	117	472
Intl Bus Center	0	0	0	0	0	0	0	0	0	2,500
GO Bond Issue-74,78,80	[2]	[2]	[2]	[2]	[2]	[2]	6,465	2,705	432	242
Municipal Grants	0	0	4,911	27,602	40,514	37,992	75,531	37,889	24,082	4,432

APPENDIX
State of Alaska Operations and Capital Expenditures by Program Category and Department
FY 1979-1988
(\$ Thousands)

CAPITAL	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988
Dept. of Community & Regional Affairs municipal grants	0	0	0	0	180	0	0	0	0	0
State Bond Committee-Debt Service	0	0	20	0	0	0	0	0	0	0
SOCIAL SERVICES	700	1,885	6,372	13,810	18,368	16,069	37,042	20,597	23,052	20,896
Dept. of Administration-pioneers home	70	1,107	265	3,650	3,110	1,141	4,710	2,706	7,041	5,074
Dept. of Health & Social Services	620	728	254	2,246	609	0	3,711	18	260	616
Grants	620	728	15	1,716	0	0	3,711	0	260	616
Other	0	0	239	530	609	0	0	18	0	0
Dept. of Labor	0	50	121	572	271	524	713	605	340	436
Dept. of Community & Regional Affairs	10	0	2,000	1,214	11,393	12,358	24,318	16,340	14,565	12,246
Senior Citizen Housing Development	0	0	0	1,184	5,567	1,249	1,426	984	25	34
Senior Citizen Housing Dev. Grants	0	0	0	0	571	6,411	1,709	1,120	4,954	2,808
Senior Citizen Housing Projects	0	0	0	0	4,104	3,224	2,174	250	[2]	[2]
Senior Citizen Housing Needs Assessm	0	0	0	0	125	0	0	0	0	0
Other	10	0	0	30	0	0	0	0	0	0
Manilaq Services	0	0	2,000	0	0	0	0	0	0	0
Weatherization & Energy Conservation	0	0	0	0	0	1,474	8,894	5,111	4,006	3,627
Suppl Housing Dev	0	0	0	0	0	0	2,993	3,567	3,450	3,297
Low Inc MultiFam Hsing Dev	0	0	0	0	0	0	(1)	1,402	[2]	[2]
Grants	0	0	0	0	0	0	7,202	3,906	2,130	2,480
municipal grants	0	0	0	0	1,026	0	(1)	0	0	0
Municipal Grants	0	0	3,732	6,128	2,985	2,046	3,401	928	846	2,524
HEALTH	820	1,040	6,400	6,684	21,247	21,121	23,578	21,026	7,522	7,514
Department of Education	48	0	0	0	0	0	0	0	0	0
Dept. of Health & Social Services	772	1,040	1,611	2,710	9,370	16,668	18,850	17,493	4,643	5,590
Clinics;Health Centers,Health Corps.	582	524	767	24	213	21	579	623	[2]	[2]
API	177	[2]	116	192	114	406	478	243	167	150
Harborview	13	[2]	0	171	11	103	71	63	[2]	[2]
API/Harborview	0	0	60	0	0	0	443	86	0	0
Hospitals	0	0	0	0	5,340	11,413	9,383	7,667	608	1,263

APPENDIX
State of Alaska Operations and Capital Expenditures by Program Category and Department
FY 1979-1988
(\$ Thousands)

CAPITAL	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988
Dept. of Fish and Game	2,520	1,594	4,666	9,923	12,407	8,896	11,231	11,484	5,910	2,532
Dept. of Public Safety	99	92	627	404	741	135	0	0	0	0
Dept. of Environmental Cons.	430	60	1,583	10,514	3,229	5,869	27,521	14,613	13,122	20,131
Water,sewers,solid waste-local commu	430	60	[2]	10,514	2,444	[2]	[2]	[2]	5,129	6,731
Water & Sewer Projects-local cnties	0	0	0	0	0	4,483	18,988	11,563	3,890	2,723
Water quality mgmt,air & solid waste	0	0	1,500	0	785	[2]	[2]	[2]	839	3,256
Municipal Grants	0	0	0	0	0	0	8,448	3,050	3,264	7,421
Other	0	0	83	0	0	1,386	85	0	0	0
Municipal Grants	0	0	6,533	14,341 (a)	23,350	85,912	95,961	31,852	58,619	21,095
PUBLIC PROTECTION	3,313	1,852	3,431	9,841	15,158	11,869	21,162	10,203	13,241	3,773
Dept. of Labor	0	0	93	197	0	0	0	0	0	0
Dept. of Commerce & Economic Dev. (APUC, weights & measures)	1,924	30	1,715	129	53	501	184	137	250	2
Dept. of Military Affairs	1,376	1,728	543	584	2,172	1,610	3,343	1,161	7,755	1,222
Dept. of Public Safety	13	94	1,028	2,648	741	1,354	5,609	2,912	1,177	1,544
Local transfers for fire& rescue equ	0	0	380	1,661	601	0	0	0	0	0
Other	13	94	648	987	140	1,354	5,609	2,912	1,177	1,544
Dept. of Community & Regional Affairs	0	0	0	1,278	1,002	730	0	0	0	0
Local transfers for fire& rescue equ	0	0	0	1,278	1,002	730	0	0	0	0
Dept. of Transportation	0	0	0	0	0	0	5,585	0	0	0
Municipal Grants	0	0	52	5,005 (b)	11,190	7,674	12,026	5,993	4,059	1,005
ADMINISTRATION OF JUSTICE	570	729	8,710	16,052	14,491	23,888	62,887	34,225	14,610	8,892
Dept of Law	0	0	14	411	33	25	5	33	36	7
Dept. of Health & Social Services	415	391	2,961	3,032	8,584	7	3,365	3,597	4,442	1,343
Dept. of Public Safety	101	58	1,466	3,760	2,983	2,276	(in Public Protection)		[1]	[1]

APPENDIX
State of Alaska Operations and Capital Expenditures by Program Category and Department
FY 1979-1988
(\$ Thousands)

CAPITAL	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988
Emergency Medical Services	0	160	134	1,306	730	995	834	568	502	261
Continuations, supplements, revisions	0	356	0	0	0	0	0	0	0	0
Public Health	[2]	[2]	482	14	152	146	88	17	4	[2]
Mental health	0	0	0	0	1,089	1,735	0	0	0	0
Other unspec.	0	0	42	0	0	0	0	0	0	0
Other	0	0	0	1,003	1,174	151	9	0	0	0
Admin. and Support	0	0	10	0	547	1,698	1,937	1,416	600	1,820
Grants	0	0	0	0	0	0	5,028	6,810	2,762	2,096
Dept. of Community & Regional Affairs	0	0	0	396	680	63	0	325	114	8
Health clinics	0	0	0	396	626	63	0	325	114	8
EMS equipment	0	0	0	0	54	0	0	0	0	0
Municipal Grants	0	0	4,789	3,578	11,197	4,390	4,728	3,208	2,765	1,916
NATURAL RESOURCES MANAGEMENT	7,862	17,789	42,133	58,406	64,855	120,410	155,351	69,989	87,649	51,160
Dept. of Administration										
(Nat'l Land Leg. Campaign)	745	[1]	[1]	0	0	0	0	0	0	0
AK Council on Science & Technology	0	0	0	973	1,489	16	0	0	0	0
Governor's Office										
(Nat'l Land Leg. Campaign)	0	1,518	1,091	0	0	0	0	0	0	0
Other	0	0	0	0	66	0	0	0	0	0
Dept. of Natural Resources	4,068	14,525	27,633	22,251	23,573	19,582	20,638	12,040	9,998	7,402
Parks and recreation	602	4,542	4,164	3,535	3,478	3,640	4,564	2,840	2,330	1,418
Land and Water Cons. Apport. Fund	3,197	[2]	2,617	1,663	1,348	639	1,642	749	1,039	692
Historical Preservation	269	[2]	562	607	309	480	968	219	314	319
Land Administration & mgmt	0	6,971	7,932	1,611	65	21	0	0	0	0
Forest/Land/Water Mgmt	0	0	0	97	401	1,034	5,384	3,344	1,720	1,465
Minerals & energy	0	[2]	144	134	6,563	7,064	1,793	1,370	1,149	168
Management & admin	0	[2]	11,737	11,151	11,323	6,654	4,472	1,680	1,747	2,747
Other	0	0	435	188	86	0	0	47	0	0
Continuations, supplements, revisions	0	3,012	0	0	0	0	0	0	0	0
Cook Inlet Regional Corp	0	0	0	1,228	0	0	0	0	0	0
Kepler-Bradley Lake Acquisition	0	0	0	2,037	0	0	0	0	0	0
Grants	0	0	42	[2]	[2]	50	476	0	0	0
Municipal grants	0	0	0	0	0	0	130	136	0	43
RSAs	[3]	[3]	[3]	[3]	[3]	[3]	1,209	1,655	1,699	550

APPENDIX
State of Alaska Operations and Capital Expenditures by Program Category and Department
FY 1979-1988
(\$ Thousands)

CAPITAL	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988
Courts	54	280	264	4,258	1,801	1,314	1,530	886	1,107	4,657
Municipal Grants	0	0	537	1,279	0	2,005	1,082	0	0	0
Dept. of Transportation	0	0	3,468	3,267 [c]	446	1,648	24,283	2,304	87	100
Dept. of Corrections	0	0	0	0	0	16,613	32,622	27,405	8,938	2,785
Dept. of Community & Regional Affairs grant	0	0	0	45	644	0	0	0	0	0
DEVELOPMENT	7,869	39,492	403,276	201,162	530,676	253,218	608,325	297,564	62,111	81,995
Dept. of Revenue-mun bond bank	500	7,446	22,351	0	150,054	0	4,177	996	0	
Municipal Bond Bank	500	7,446	5,500	0	54	0	4,000	750	[2]	[2]
AK Renewable Resources Dev. Corp.	0	0	16,851	0	0	0	0	0	0	0
ANFC	[2]	[2]	[2]	[1]	150,000	[1]	0	0	0	0
Other	0	0	0	0	0	0	177	246	0	0
Com. Fish & Forest Prod Asstc. Funds	0	0	14,312	0	0	0	0	0	0	0
Governor's Office	0	5,433	3,768	2,182	14,428	58	0	0	0	0
Dept. of Environmental Cons.	0	91	0	0	0	0	0	0	0	0
Dept. of Commerce & Economic Dev.	766	11,938	307,579	144,203	212,831	142,477	363,664	200,618	1,558	57,327
Hydro and Power Projects	589	[2]	[2]	[2]	[2]	[2]	[2]	[2]	[2]	[2]
Grants	28	[2]	0	0	0	0	301	402	0	0
Energy & Power Dev	0	[2]	1,393	1,774	1,438	256	40	18	135	924
Economic development	0	0	863	123	96	[2]	212	326	386	935
Fisheries-related	[2]	[2]	1,725	1,568	594	157	5,056	122	105	1,181
APA										
Susitna	[2]	[2]	4,610	12,730	23,408	25,159	32,213	31,669	(839)	0
Pwr Dev Revolving Loan Fund	[2]	[2]	[2]	[2]	[2]	[2]	210,000	0	0	0
Power Cost Equalization [1]	0	0	0	5,698	768	18	11,496	21,700	[1]	[1]
Other	[2]	[2]	35,194	100,473	162,630	111,397	55,335	137,649 [g]	1,641	53,754
AK Energy Policy	0	0	0	0	0	0	0	75	0	0
Business Loans	0	0	79,721	[2]	[2]	[2]	[2]	[2]	[2]	[2]
Mining Loan Fund	0	0	9,935	[2]	0	0	[2]	[2]	[2]	[2]
AIDA	0	[2]	173,049	8,000	0	0	0	0	0	0
Local projects	0	[2]	246	336	1,050	54	2,630	329	0	0
Agriculture-related	149	[2]	549	1,187	998	3,607	3,057	[2]	[2]	[2]

APPENDIX
State of Alaska Operations and Capital Expenditures by Program Category and Department
FY 1979-1988
(\$ Thousands)

CAPITAL	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988
Tourism	0	0	0	200	97	156	0	0	0	0
Alaska CD Notes to AIDA	0	0	0	0	21,330	0	0	0	0	0
Agricultural Action Council	0	0	[1]	9,001	315	1,414	(to DNR)	[1]	[1]	[1]
AK Railroad										
Aquisition	0	0	0	0	0	0	22,271	0	0	0
Other	0	0	0	0	0	0	11,000	0	0	0
Investment Loan Fund										
Alt Tech & Energy	0	0	[2]	[2]	0	[2]	1,000	845	[2]	[2]
Comm Fishing	0	0	[2]	[2]	0	[2]	4,000	3,710	[2]	[2]
Fisheries Enhancement	0	0	[2]	[2]	0	[2]	5,000	812	[2]	[2]
Rural Elect Rev Loan Fund	0	0	0	[2]	0	[2]	[2]	1,000	[2]	[2]
Livestock Facilities Loan	0	0	0	2,650	0	0	[2]	[2]	[2]	[2]
Admin	0	0	0	0	0	0	53	21	26	2
Other	0	0	294	463	107	259	0	0	150	450
Misc RSAs	[3]	[3]	[3]	[3]	[3]	[3]	[3]	1,940	(46)	81
Dept. of Natural Resources-agri	761	8,547	7,921	1,243	1,005	2,809	11,121	4,551	1,121	659
Agri-misc	761	8,547	7,921	1,243	1,005	2,855	4,460	1,038	878	450
Agricultural Action Council	0	0	[1]	[1]	[1]	[1]	511	363	243	209
Livestock Facility Loan	0	0	0	[1]	[2]	[2]	650	150	[2]	[2]
Ag Revolving Loan	0	0	[2]	[2]	0	[2]	5,000	2,500	[2]	[2]
Grain Reserve Loan	0	0	0	0	0	58	500	500	0	0
Dept. of Environmental Cons	0	0	1,496	0	0	0	0	0	0	0
Dept. of Community & Regional Affairs	247	2,154	5,820	4,794	5,491	10,139	64,529	13,540	7,106	7,964
Municipal Grants [d]	230	2,154	5,820	3,495	3,880	6,155	3,913	2,379	1,045	9
Special projects/grants	0	0	0	1,299	1,528	2,159	2,021	542	669	569
Other	17	0	0	0	0	86	2,344	0	0	0
Unincorporated Community Grants	0	0	0	0	0	1,739	9,642	4,838	2,934	2,798
Housing Revolving Loan	0	0	0	0	0	0	45,000	4,000	[2]	[2]
HAD Loan Reserve	0	0	0	0	0	0	1,000	0	0	0
Community Planning Svcs (in oper.)	0	0	0	0	83	263	306	766	524	230
Local Gov't Asstc.(in oper.)	0	0	0	0	0	0	303	0	0	0
Community Block Grants	0	0	0	0	0	0	0	275	1,934	4,358
Misc RSAs	[3]	[3]	[3]	[3]	[3]	[3]	[3]	740	[3]	[3]
Dept. of Transportation	5,595	3,884	2,298	802	0	0	0	0	0	0
Harbors	5,285	[2]	2,078	802	0	0	0	0	0	0
Admin	310	[2]	220	0	0	0	0	0	0	0
Municipal Grants	0	0	35,088	47,938	55,442	52,821	140,682	67,667	35,066	15,873

APPENDIX
State of Alaska Operations and Capital Expenditures by Program Category and Department
FY 1979-1988
(\$ Thousands)

CAPITAL	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988
Municipal Aid	0	0	0	[1]	91,425	44,914	24,152	10,192	17,260	172
TRANSPORTATION	103,756	81,704	172,819	211,153	281,916	299,902	798,439	395,593	386,514	239,374
Dept. of Transportation	103,756	81,704	147,762	139,820	190,741	199,688	662,533	320,131	338,012	190,272
Marine	602	[2]	3,817	2,502	7,369	9,043	18,395	16,667	17,324	4,961
Airports	1,261	12	9,299	11,642	13,399	12,688	135,432	54,380	74,724	34,390
Highways	351	26	30,532	18,876	34,748	53,411 [f]	202,253	96,233	116,565	82,564
Harbors	[1]	[1]	8,696	11,676	11,893	24,627	51,818	19,548	13,309	3,243
Local Service Roads	2,931	[2]	[2]	42,910	54,790	46,810	118,811	46,268	37,398	18,994
Statewide Transportation & Facil.	804	743	2,213	9,829	13,472	19,768	44,063	34,484	39,276	30,105
Facilities Planning & Programming	[1]	[1]	[1]	734	2,683	5,082	971	295	248	1,230
Regions [h]	[1]	8,482	12,332	[1]	[1]	[1]	[1]	[1]	[1]	[1]
Facilities	347	[2]	[2]	261	4,788	4,721	37,335	7,544	7,426	3,744
Administration	0	0	2,334	0	222	89	3,507	0	591	45
Grants-Iditarod Hdqtrs	0	0	0	0	0	0	285	285	[2]	[2]
Anch Pioneer Home Overruns	0	[2]	[2]	1,300	0	0	0	0	0	0
North Slope Haul Road	1,608	[2]	[2]	0	0	0	4,132	0	0	0
Capital Improvement Federal Aid	95,524	[2]	[2]	9,992	[2]	[2]	[2]	[2]	[2]	[2]
RSAs	328	[3]	[3]	29,440	47,074	23,168	43,237	44,132	31,151	10,996
Other	0	0	0	658	303	280	2,294	295	[7]	[2]
Other-unspecified	0	0	78,539	0	0	0	0	0	0	0
Continuations, supplements, revisions	0	72,441	0	0	0	0	0	0	0	0
Dept. of Public Safety	0	0	0	12	0	0	0	0	0	0
Dept. of Community & Regional Affairs	0	0	0	954	2,179	1,027	0	0	0	0
Municipal Grants [e]	0	0	0	954	2,179	1,027	0	0	0	0
Municipal Grants	0	0	25,057	70,367	88,996	99,187	135,906	75,462	48,502	49,102
GENERAL GOVERNMENT	28,055	54,936	677,142	44,788	29,801	13,889	23,180	8,076	5,035	2,102
Governor's Office	1,145	532	2,290	6,157	1,489	1,167	1,078	1,001	283	105
Dept. of Administration	632	625	2,345	14,089	19,357	11,783	22,001	7,005	4,700	1,927
Dept. of Law	0	0	27	279	20	13	0	0	0	0
Dept. of Revenue	13	27	642,585	8,857	243	508	0	0	15	5
Native Land Claims	0	0	292,585	0	0	0	0	0	0	0

APPENDIX
State of Alaska Operations and Capital Expenditures by Program Category and Department
FY 1979-1988
(\$ Thousands)

CAPITAL	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988
Emergency Op. Exp.	0	0	350,000	0	0	0	0	0	0	0
Sitka Green Lake Hydro	0	0	0	8,600	0	0	0	0	0	0
Admin	13	27	0	0	243	0	0	0	15	5
Fish Tax Refund	0	0	0	0	0	508	0	0	0	0
Dept. of Transportation	26,162	53,078	29,410	12,869	(in Transportation Category)			[1]	[1]	[1]
Legislature	103	674	457	298	507	380	101	70	37	65
Municipal Grants	0	0	28	2,239	8,185	38	0	0	0	0
TOTAL CAPITAL EXPENDITURES [7]	178,080	249,268	1,370,834	676,794	1,087,109	926,121	2,144,421	1,064,479	743,374	484,609

[a] Grants for water/sewer, solid waste disposal, utilidors, other infrastructure and parks and recreation equipment and facilities.

[b] Grants for fire and rescue equipment.

[c] Corrections capital projects cost overrun.

[d] Not labeled as municipal grants, but listed by election district. For electrification, community centers, equipment, fuel tanks, planning, etc.

[e] Not labeled as municipal grants, but listed by election district. For road improvements.

[f] Includes some expenditures for local roads in 1984-1986.

[g] \$111,618 is for Bradlely Lake.

[h] In 1980 and 1981, some expenditures for highways and mosts for local roads were in this category.

[i] "Power Cost assistance Fund" in 1982-1984.



ISER RESEARCH SUMMARY

Institute of Social and Economic Research, University of Alaska Anchorage Feb. 1989, R. S. No. 41

Where Have All The Billions Gone? — Part II

In the early 1980s, Alaska's legislators and administrators had the pleasant job of spending more and more oil revenue as it flooded into the state treasury. Over the past three years, they've faced the less enviable work of cutting the budget as oil income recedes. Which kinds of spending have declined and which have continued to grow even as low oil prices reduce state revenues?

This research summary updates a 1987 ISER publication that describes how Alaska spent its money during the first half of the 1980s, when high oil prices and the state government's ownership of the huge Prudhoe Bay oil field combined to bring the State of Alaska tens of billions of dollars.¹ This publication adds spending in fiscal 1987 and 1988 — the years since the crash and subsequent instability of oil prices.²

An important point to remember is that these figures include spending done with the state's own revenues and with federal grants.³ Federal aid is mainly restricted to transportation projects, welfare programs, and some education programs. The major — and the most volatile — part of state revenue is oil revenue.

Table 1 shows annual state spending by category from fiscal 1979 through 1988. Figure 1 shows how much spending in each category increased from 1980 to the peak in the mid-1980s, and how much each has declined since. Figure 2 illustrates how the patterns of state spending looked before the advent of big oil revenues, during the boom, and after the crash.

Changes in State Spending, 1986-1988

• *Money for construction projects and special transfers to public corporations, to loan funds, and to the Permanent Fund were the first things to be cut as revenues fell. (See Table 1 and Figure 1.)*

¹"Where Have All the Billions Gone?" *Alaska Review of Social and Economic Conditions*, February 1987, Institute of Social and Economic Research, University of Alaska Anchorage.

²The current fiscal year is 1989; it will end June 30, 1989. Spending information for that year won't be available until December 1989.

³In fiscal 1987 and 1988, the State of Alaska received \$456 million and \$443 million in federal grants-in-aid. Total general fund revenues for those years were \$2.3 billion and \$2.8 billion. Almost all spending described in this summary was done through the general fund; some education, transportation, and other spending came through special funds.

• *By fiscal 1988, state capital spending was less than one-quarter of what it had been in 1985 — and much of that capital money was federal aid for transportation projects. In the peak spending year of fiscal 1985, state agencies, municipalities, school districts, and the University of Alaska spent \$1.6 billion in state capital money, as compared with about \$400 million in fiscal 1988.*

• *Transfers to public corporations like the Alaska Housing Finance Corporation (AHFC) and the Alaska Power Authority (APA) all but disappeared in the past two years. The exception was \$50 million transferred to APA in fiscal 1988 for construction of the Bradley Lake dam. Such corporations received \$1.9 billion in state money between fiscal 1981 and 1986.*

• *State transfers to loan funds have dwindled sharply. The student loan program received the largest infusions of general fund money in the past two fiscal years — \$61 million in fiscal 1987 and \$15 million in 1988. The state legislature in 1988 reduced state spending for student loans by creating a corporation to raise loan money through bond sales.*

State loan programs got \$1.2 billion in general fund money from fiscal 1981 through 1986. The money that went to public corporations and loan funds in the early 1980s was not simply spent in the same way, for instance, that state operating money is spent. Much of the money was used to create assets and reserves that continue to be of significant economic value to the state; it's beyond the scope of this review to try to assess that value.

• *Special deposits — beyond those required by law — in the Permanent Fund were discontinued after 1985. Between fiscal 1981 and 1985, the legislature made \$2.7 billion in special deposits in the Permanent Fund. Those special deposits substantially increased the principal of the Permanent Fund and its earning potential.*

• *The heaviest percentage cuts in the state operating budget have been in revenue sharing and other aid to municipalities. Those appropriations have dropped steadily since fiscal 1985 and by 1988 were more than 30 percent less than they had been three years earlier: \$166 million as compared with \$112 million.*

● Some operations spending decreased between fiscal 1986 and 1987, and then increased in fiscal 1988. State agency spending and operating aid to schools increased about 5 percent between 1987 and 1988, and the appropriation for the University of Alaska increased about 1 percent.

● Despite the increases in 1988, spending for state agencies and for education remained below the 1986 highs. The biggest percentage cut after aid to municipalities was in operating money for the University of Alaska, which in fiscal 1988 was 14 percent less than it had been in 1986. Operating aid for Alaska's school districts—which includes the huge foundation program and other kinds of financial aid as well as reimbursement for school construction debt—was about 5 percent less in 1988 than it had been in 1986. Operating budgets of state agencies were down 7 percent from their 1986 levels.

● Cash payments to individuals, and in-kind benefits or services that have cash value to the recipients, have continued to grow throughout the 1980s. Those kinds of state spending—which we collectively call "distributions to individuals" in Table 1 and Figure 1—are of two kinds: those that are based on the need of the recipient, and those that are not. Those programs based on need include public assistance, Aid to Families with Dependent Children, Medicaid, and unemployment benefits. You would expect spending under such programs to increase during a recession, when more people are out of work. Medical costs have climbed rapidly in recent years, which also increases the costs of the Medicaid program.

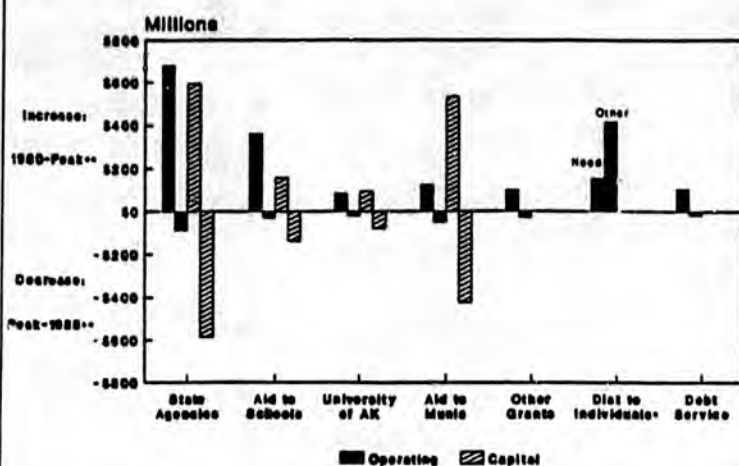
● Cash distributions unrelated to need have grown the fastest in the past two years. Spending for those programs has grown more than spending for welfare and unemployment programs in the past several years. (Figure 1.) The biggest of these is of course the Permanent Fund Dividend program, which in 1988 paid Alaskans \$375 million from the earnings of the Permanent Fund. A much smaller but still substantial distribution program is the Longevity Bonus program, which pays \$250 a month to all those over 65 who have lived in Alaska at least a year. That program paid out \$50 million in fiscal 1988. Another program that does not make payments to individuals but which has cash value to them is the Power Cost Equalization program, which subsidizes the cost of electricity for rural Alaskans. That program cost the state about \$15 million in fiscal 1988.

● Even taking inflation into account, state spending in fiscal 1988 was still nearly double spending in 1980. (See Table 1, last line, "Total Spending in 1988 \$.")

Spending Patterns, 1979-1988

● The distribution of state spending is becoming more like it was before 1981. (Figure 2.)

Figure 1. Growth and Decline of State Expenditures 1980-1988 (Dollar Change)



*Distributions to individuals based on need include primarily welfare and unemployment programs; other distributions include Permanent Fund Dividends, Longevity Bonus payments, and others.

**Most operating expenditures peaked in fiscal 1986, most capital expenditures in fiscal 1985. Distributions to individuals have increased throughout the 1980s and therefore show no decline.

● Special spending made up about 11 percent of state spending in fiscal 1987 and 1988—but almost all that special spending consisted of Permanent Fund dividends. If we exclude Permanent Fund dividends, which didn't exist before fiscal 1983, special spending in recent years would be just about the same as it was in 1979 and 1980—less than one percent of total spending. During the years of high revenues, special spending made up 30 percent of total spending. (We define special spending as spending for items outside traditional government functions—transfers to public corporations and loan funds, extra deposits in the Permanent Fund, large one-time expenditures, and Permanent fund dividend payments.)

● State agencies accounted for about 40 percent of total spending in fiscal 1987 and 1988. Between fiscal 1981 and 1986, when special spending was soaring, spending by state agencies themselves accounted for only about 30 percent of total spending. In 1979 and 1980, before the advent of big oil revenues, state agency spending made up more than half of all spending.

● Aid to municipalities—both operating and capital—is on the decline. It made up 8 percent of state spending in the two most recent fiscal years, as compared with 11 percent between 1981 and 1986. Still, aid to municipalities remains almost three times higher than it was at the start of the 1980s, when it made up just 3 percent of state spending.

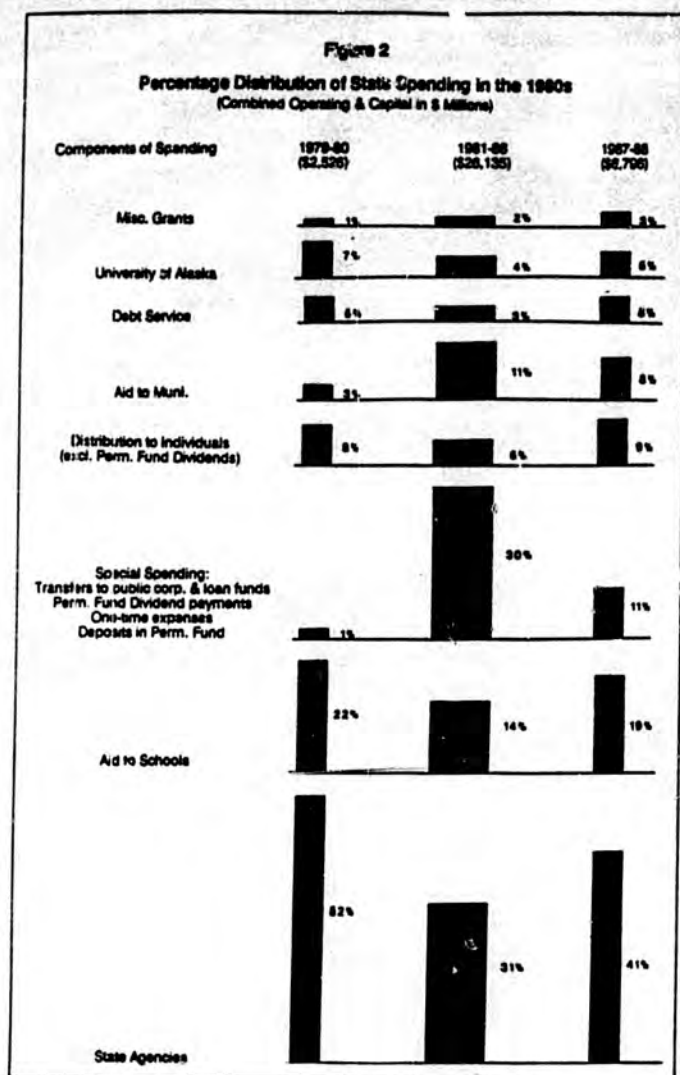
Table 1
State Expenditures,^a Standard and Special, FY 1979-1988
(Operating and Capital, \$millions)

	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988
State Agencies^b										
Operating	\$431	\$493	\$647	\$868	\$996	\$1041	\$1146	\$1175	\$1033	\$1089
Capital	152	226	295	251	293	289	820	416	399	234
Total	\$583	\$719	\$942	\$1119	\$1289	\$1330	\$1966	\$1591	\$1432	\$1323
Aid to Schools^b										
Foundation Program	181	205	255	345	409	423	467	492	415	437
Bond Debt Reimb.	22	24	38	38	56	90	93	106	116	109
Other Financial Support	52	54	52	62	62	66	54	46	53	66
Capital Aid	15	7	28	65	42	76	164	48	45	26
Total	\$270	\$290	\$373	\$510	\$569	\$655	\$778	\$692	\$629	\$638
University of Alaska^b										
Operating	75	86	108	128	148	158	168	169	144	146
Capital	8	6	8	19	26	49	101	46	11	22
Total	\$83	\$92	\$116	\$147	\$174	\$207	\$269	\$215	\$155	\$168
Aid to Municipalities^b										
Operating	32	41	117	164	166	166	166	155	121	112
Capital	4	6	89	310	347	353	539	257	208	116
Total	\$36	\$47	\$206	\$474	\$513	\$519	\$705	\$412	\$329	\$228
Other Grants & Programs^b	\$18	\$16	\$23	\$69	\$74	\$84	\$116	\$99	\$86	\$86
Transfers to and Other GF Expenditures for Public Corporations^c										
APA	-	-	14	120	196	137	95	173	5	61
AHFC	4	4	557	265	150	-	-	-	-	-
AIDA	-	-	173	9	22	1	1	1	1	1
Alaska Railroad	-	-	-	-	-	-	35	-	-	-
Total	\$5	\$12	\$768	\$395	\$369	\$140	\$135	\$175	\$6	\$62
Loan Fund Transfers^c										
Enterprise	4	15	145	236	66	205	330	76	61	18
Other	-	-	96	4	-	-	2	2	-	-
Total	\$4	\$15	\$240	\$240	\$66	\$205	\$332	\$78	\$61	\$18
Distrib. to Individuals Perm. Fund Dividends^c										
Other ^b	99	107	143	177	478	187	160	210	295	375
Total	\$99	\$107	\$143	\$177	\$667	\$418	\$439	\$504	\$587	\$680
Deposits in Perm. Fund & Other GF Expenditures for Permanent Fund^d	-	-	\$900	\$801	\$402	\$303	\$301	\$3	\$3	\$4
Debt Service^b	\$60	\$70	\$97	\$94	\$143	\$166	\$175	\$164	\$162	\$157
One-Time Expenditures^b										
ANCSA Payment			293							
Rainy Day Acct			350							
Income Tax Refund & Other Refunds			162	4	5	2	1	2		
Other					\$40				<1	
Total			\$805	\$4	\$45	\$2	\$1	\$2	\$<1	
Total Spending (current \$)	\$1158	\$1368	\$4613	\$4030	\$4311	\$4029	\$5217	\$3935	\$3450	\$3364
Total Spending (1988 \$)	\$1619	\$1735	\$5416	\$4484	\$4711	\$4231	\$5343	\$3958	\$3456	\$3364

^aConsists almost entirely of general fund expenditures. Includes some transportation and education expenditures from other funds. Includes expenditures made with the state's own revenues and federal revenues the state receives.

^bStandard expenditures are spending for traditional government functions.

^cSpecial expenditures include spending for items outside the usual kinds of government spending.



● *Aid to schools, by contrast, rose as a proportion of total spending in 1987 and 1988. It made up 19 percent of spending in the most recent years, as compared with 14 percent in the first half of the 1980s. This doesn't mean that the amount of state money going to school districts was shrinking during the years of high spending—quite the opposite was true. What it means is that as overall spending increased and new kinds of spending were added, the very substantial state aid to schools made up a smaller proportion. The State of Alaska has always provided big support for education; in 1979 and 1980, aid to schools made up 22 percent of state spending.*

● *State money for the University of Alaska moved up to 5 percent of total spending in the past two fiscal years. That compares with 4 percent in the years of high revenues. Nevertheless, state spending for the university remained below the 7 percent of total spending it had been at the start of the 1980s.*

● *Grants to non-profit organizations and others have increased steadily as a share of state spending in the 1980s. Such grants increased from 1 percent in 1979 and 1980 to 2 percent in the mid-1980s and 3 percent in the most recent fiscal years.*

Editor's note: More detailed information on state spending is available from ISER. Call 786-7710 or write ISER at the address below and ask for the technical appendix to this Research Summary.

RESEARCH SUMMARY (No. 41)
Institute of Social and Economic Research
University of Alaska Anchorage
E. Lee Gorsuch, Director
3211 Providence Drive
Anchorage, Alaska 99508

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September 30, 1989

State of Alaska
Division of Retirement and Benefits
Department of Administration
Pouch CR
Juneau, Alaska 99811

RE: GROUP INSURANCE POLICIES - 392675

Gentlemen:

We have reviewed the premiums and claims under your Group Insurance program in order to determine the required premium levels to become effective February 1, 1990.

The renewal rates for the political subdivisions became effective July 1, 1989. At this time we have reviewed separately the experience results for the Actives, SBS, Retiree-Medical and Retiree-Dental/Vision/Audio plans.

The incidence of claims is quite high for Health coverages. Accordingly, we believe the most recent experience is a reasonable indication of future claim costs. Individual monthly experience for the groups is outlined on the enclosed exhibits labeled A, B, C, and D. The following table provides the starting loss ratio for each group. The development of these loss ratios is provided on exhibits E, F, G and H.

	<u>Incurred Loss Ratio</u>
Actives and SBS Option I	75.0%
Supplemental Benefits Option II	63.3%
Retiree Medical	73.1%
Retiree-Dental/ Vision/Audio	74.7%

The premiums are adjusted to reflect the rate changes effective February 1, 1989. We have based the starting loss ratios on the relationships between incurred claims for the period September 1, 1988 to September 1, 1989 and adjusted premium for the same period.

State of Alaska
September 28, 1989
Page 2.

We believe that the loss ratios outlined on the first page are a reasonable estimate of the claims which can be expected to emerge during the forthcoming year.

The development of the required Health Insurance rate levels on the basis of the prior experience results for your programs are illustrated on exhibits E, F, G and H.

The trend adjustment is based upon a blending of annual trend factors of 23%, 11% and 11% for the Medical, Dental and Vision coverages respectively.

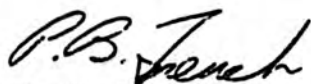
The trend factors have been projected for the 17 month period extending from the mid-point of the experience period to the mid-point of the billing period and adjusted by the individual loss ratios. The adjusted trend is developed on Exhibit I.

Also included in the required premium structures are expense adjustments estimated at 4.7% of the adjusted expected claim ratios. The claim fluctuation margin is equal to 5% of the required premium for the Actives and Retiree Medical groups and 10% for the SBS II and Retiree D/V/A groups. As available, PSR balances can be used to offset the margin.

Exhibit J outlines the existing and renewal rates effective February 1, 1990. The Actives and SBS option I rates have been further adjusted to reflect the plan changes effective December 1, 1989.

Please let Ms. Withrow know if you have any questions regarding this renewal.

Very truly yours,



P. B. French, Asst. Vice President
Western Home Office
Aetna Life Insurance Company

EAK/lg

Encl.

C: Lynn Withrow, Seattle - EBD

STATE OF ALASKA
 ACTIVES AND SBS OPTION I
 SUMMARY OF PREMIUMS AND CLAIMS
 COMBINED HEALTH

MONTH	CREDITED PREMIUM	ADJUSTED PREMIUM*	PAID CLAIMS	QUARTERLY LOSS RATIO
Sep-88	\$5,590,256	\$5,879,518	\$3,881,278	
Oct-88	5,498,453	5,783,126	4,639,998	74.7%
Nov-88	5,485,724	5,769,760	4,503,963	
Dec-88	5,393,869	5,673,313	4,107,018	
Jan-89	5,357,924	5,635,570	4,958,739	76.7%
Feb-89	5,702,618	5,702,618	3,984,840	
Mar-89	5,799,269	5,799,269	4,337,447	
Apr-89	5,796,603	5,796,603	4,245,787	74.9%
May-89	5,918,653	5,918,653	4,542,824	
Jun-89	5,953,431	5,953,431	4,305,703	
Jul-89	5,992,939	5,992,939	4,108,504	71.2%
Aug-89	6,048,617	6,048,617	4,403,960	
	-----	-----	-----	
	\$68,538,358	\$69,953,419	\$52,020,061	74.4%

	AVERAGE CLAIMS/MONTH
LATEST 12 MONTHS	\$4,335,005
LATEST 9 MONTHS	\$4,332,758
LATEST 6 MONTHS	\$4,324,038
LATEST 3 MONTHS	\$4,272,722

* Adjusted to reflect 5% rate increase for the Actives and 10% rate increase for SBS option I effective February 1, 1989.

STATE OF ALASKA

SBS OPTION II

SUMMARY OF PREMIUMS AND CLAIMS

COMPREHENSIVE MEDICAL

MONTH	CREDITED PREMIUM	ADJUSTED PREMIUM*	PAID CLAIMS	QUARTERLY LOSS RATIO
Sep-88	\$30,074	\$33,081	\$30,841	
Oct-88	27,577	30,335	49,690	91.0%
Nov-88	45,315	49,847	22,511	
Dec-88	50,020	55,022	30,321	
Jan-89	43,361	47,697	21,649	57.3%
Feb-89	40,500	40,500	30,162	
Mar-89	43,000	43,000	26,080	
Apr-89	43,000	43,000	20,983	67.9%
May-89	43,000	43,000	40,471	
Jun-89	43,000	43,000	36,579	
Jul-89	43,000	43,000	26,639	59.2%
Aug-89	43,000	43,000	13,145	
	\$494,847	\$514,482	\$349,071	67.8%

AVERAGE CLAIMS/MONTH

LATEST 12 MONTHS	\$29,089
LATEST 9 MONTHS	\$27,337
LATEST 6 MONTHS	\$27,316
LATEST 3 MONTHS	\$25,454

* Adjusted to reflect 10% rate increase effective February 1, 1989.

STATE OF ALASKA
RETIREE
SUMMARY OF PREMIUMS AND CLAIMS
DENTAL/VISION/AUDIO

MONTH	CREDITED PREMIUM	ADJUSTED PREMIUM*	PAID CLAIMS	QUARTERLY LOSS RATIO
Sep-88	\$284,783	\$202,196	\$184,709	
Oct-88	283,076	200,984	199,104	94.0%
Nov-88	284,039	201,668	184,471	
Dec-88	281,561	199,909	144,701	
Jan-89	282,117	200,303	215,595	86.6%
Feb-89	233,022	233,022	188,066	
Mar-89	234,780	234,780	163,925	
Apr-89	233,301	233,301	159,485	68.5%
May-89	233,190	233,190	157,215	
Jun-89	233,205	233,205	149,992	
Jul-89	233,991	233,991	146,300	61.6%
Aug-89	234,942	234,942	136,202	
	\$3,052,008	\$2,641,491	\$2,029,765	76.8%

	AVERAGE CLAIMS/MONTH
LATEST 12 MONTHS	\$169,147
LATEST 9 MONTHS	\$162,387
LATEST 6 MONTHS	\$152,187
LATEST 3 MONTHS	\$144,165

* Adjusted to reflect 29% rate decrease effective February 1, 1989.

EXHIBIT E

STATE OF ALASKA
ACTIVES & SBS OPTION I

EXPERIENCE PERIOD 9/1/88-9/1/89

	PAID CLAIMS	+	ESTIMATED UNR	-	PRIOR RUNOFF	=	INCURRED CLAIMS	LOSS RATIO
MEDICAL	\$42,813,867		\$6,931,834		\$6,579,111		\$43,166,590	
DENTAL	7,207,756		933,281		845,251		7,295,786	
VISION	1,998,438		271,552		274,565		1,995,425	
	-----		-----		-----		-----	
	\$52,020,061		\$8,136,667		\$7,698,927		\$52,457,801	75.0%
					PREMIUM =		\$69,953,419	

SUMMARY OF RATE ACTION

1.	Expected Loss Ratio		75.0%
2.	Trend - See Exhibit	+	22.2%

3.	Expected Loss Ratio 2/90 - 2/91		97.2%
4.	Expenses @4.7% of Expected Claims x		104.7%

			101.8%
5.	Claim Fluctuation Margin	÷	95.0%

6.	Net Required Premium		107.1%
7.	Indicated Net Change	Billed +	7.1%

STATE OF ALASKA

SBS OPTION II

EXPERIENCE PERIOD 9/1/88-9/1/89

	PAID CLAIMS	+	ESTIMATED UNR	-	PRIOR RUNOFF	=	INCURRED CLAIMS	LOSS RATIO
MEDICAL	\$349,071		\$54,911		\$78,500		\$325,482	63.3%
					PREMIUM =		\$514,482	

SUMMARY OF RATE ACTION

1. Expected Loss Ratio		63.3%
2. Trend - See Exhibit	+	20.6%

3. Expected Loss Ratio 2/90 - 2/91		83.9%
4. Expenses @4.7% of Expected Claims x		104.7%

		87.8%
5. Claim Fluctuation Margin	÷	90.0%

6. Net Required Premium		97.6%
7. Indicated Net Change		Pass

STATE OF ALASKA

RETIREE

EXPERIENCE PERIOD 9/1/88-9/1/89

	PAID CLAIMS	+	ESTIMATED UNR	-	PRIOR RUNOFF	=	INCURRED CLAIMS	LOSS RATIO
D/V/A	\$2,029,765		\$264,314		\$321,815		\$1,972,264	74.7%
					PREMIUM =		\$2,641,491	

SUMMARY OF RATE ACTION

1. Expected Loss Ratio		74.7%
2. Trend - See Exhibit	+	11.6%

3. Expected Loss Ratio 2/90 - 2/91		86.3%
4. Expenses @4.7% of Expected Claims x		104.7%

		90.4%
5. Claim Fluctuation Margin	÷	90.0%

6. Net Required Premium		100.4%
7. Indicated Net Change		Pass

STATE OF ALASKA

TREND

ACTIVES	WEIGHT	TREND FACTOR	WEIGHTED TREND
MEDICAL	82.3%	23.0%	18.9%
DENTAL	13.9%	11.0%	1.5%
VISION	3.8%	11.0%	0.4%
	-----		-----
	100.0%		20.9%

Experience Period

Billing Period

Sep-88

Mar-89

Sep-89

Feb-90

Aug-90

Feb-91

17 MONTHS

	WEIGHTED TREND		PERIOD		LOSS RATIO		ADJUSTED TREND
ACTIVES & SBS I	20.9%	*	17/12	*	75.0%	=	22.2%
SBS II	23.0%	*	17/12	*	63.3%	=	20.6%
RETIREE	23.0%	*	17/12	*	73.1%	=	23.8%
RETIREE D/V/A	11.0%	*	17/12	*	74.7%	=	11.6%

STATE OF ALASKA

RETIREE

EXPERIENCE PERIOD 10/1/88-10/1/89

	PAID CLAIMS	+	ESTIMATED UNR	-	PRIOR RUNOFF	=	INCURRED CLAIMS	LOSS RATIO
MEDICAL	\$21,318,858		\$4,024,997		\$3,900,576		\$21,443,279	71.9%
							PREMIUM =	\$29,805,013

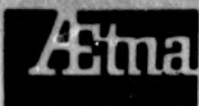
SUMMARY OF RATE ACTION

1. Expected Loss Ratio		71.9%
2. Trend - See Exhibit	+	22.0%

3. Expected Loss Ratio 2/90 - 2/91		93.9%
4. Expenses @4.7% of Expected Claims x		104.7%

		98.3%
5. Claim Fluctuation Margin	÷	95.0%

6. Net Required Premium		103.5%
7. Indicated Net Change	Billed +	3.5%



Employee Benefits Division
Western Home Office
P.O. Box 8092
Walnut Creek, CA 94596-8092
(415) 932-7200

October 30, 1989

Mr. Pat Pachacek
Touche Ross & Co.
1600 Landmark Towers
345 St. Peter Street
Saint Paul, MN 55102-1656

Dear Pat:

Attached are the revised exhibits for the Retiree Medical coverage. We have re-rated this coverage using the September 1989 premium and adjusting the premium for the additional premium payment received in October 1989 for this coverage. Apparently, an audit was performed by the State on the Retiree Medical Premiums and they discovered that they had not paid the additional premium necessary for the rate increase on February 1, 1989. Using these additional premium figures, I develop a 3.5% increase including a 5% margin and a 1.7% decrease if we exclude the margin requirement. Please call Phil French at (415)932-7270 if you have any questions or if there is anything else you need.

Sincerely,

Betsy Killius

Betsy Killius
Account Coordinator
Western Home Office
Aetna Life Insurance Company

CC: Phil French
Lynn Withrow
Steve LeBrun

Aetna
LIFE & CASUALTY
STATE OF ALASKA
SUMMARY OF RATES

SUPPLEMENTAL BENEFITS OPTION I

Existing Rates

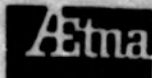
Employee	\$12.13
Dependent	\$20.86

Rates Effective February 1, 1990

Employee	\$18.62
Dependent	\$32.02

ACTIVES

Existing	\$431.72
Effective December 1, 1989	\$384.59
Effective February 1, 1990	\$408.43



STATE OF ALASKA

SUPPLEMENTAL BENEFITS OPTION I

CLAIMS (1/1/89 - 9/15/89)	\$1,119,428	
RESERVE	\$335,838	
INCURRED CLAIMS		\$1,455,266
PAID PREMIUM (1/1/89 - 9/15/89)		\$1,657,500
LOSS RATIO		87.8%

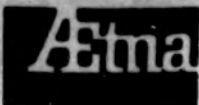
1. Expected Loss Ratio		87.8%
** 2. Trend		34.5%

3. Expected Loss Ratio 2/90-2/91		122.3%
4. Expenses	x	104.7%

		128.1%
5. Claim Fluctuation Margin	+	90.0%

6. Required Premium		142.3%
7. Indicated Change	Billed +	42.3%
8. Adjustment for Plan Change effective 12/1/89		11.2%
9. Net Required Premium		153.5%
10. Indicated Net Change	Billed +	53.5%

** Includes adjustment for expected increased utilization by employees enrolled in the SBS plan



Employee Benefits Division
Western Home Office
P.O. Box 8092
Walnut Creek, CA 94596-8092
(415) 932-7200

October 16, 1989

Mr. Pat Pachacek
Touche Ross & Co.
1600 Landmark Towers
345 St. Peter Street
Saint Paul, MN 55102-1656

Dear Pat:

Enclosed are the revised exhibits for the SBS Option I rating. After correcting the reserve and premium and adjusting the trend, the indicated change before any plan changes is +42.3%. The plan change is worth an additional \$13,482/month in SBS Option I premium. This is an additional 9.6% annually. Since the plan change is effective December 1, 1989 and the rates don't go into effect until February 1, 1990, I added an additional two months of premium bringing the additional cost for the plan change to +11.2%. The net increase then becomes Billed + 53.5%. Please call me at 415-932-7293 should you have any questions.


cc: Lynn Withrow
Phil French

The seven states presented as case studies in the National Governors' Association's overview of state health care plans were chosen because they demonstrate a variety of approaches toward health care cost containment. For more details on the plan design and funding of the state plans, see RR 308.3.-1 and following.

Florida. Florida's state employee benefit program covers approximately 211,000 employees, retirees, and dependents in FY 1983-84, at a cost to the state of close to \$87,800,000.

Cost containment strategies began in 1978, when the plan became self funded with an ASO contract. Since then, it also has pursued traditional approaches to holding down costs.

Coordination of benefits, coordination with Medicare, and subrogation rights saved the plan an estimated \$10,232,777 in 1983.

A maximum fee schedule for physician services saved the state an estimated \$9,889,485 in 1983.

An estimated \$15,519,947 was saved in 1983 through claims review.

New and pilot programs include:

The health incentive program. This is modeled on the Mendocino County plan (see RR 330.-15). The three-year pilot project began in January 1982 as a voluntary option for state employees in Dade County. A financial incentive is paid to members whose annual claim submissions are \$500 or less. Members are also offered a health education/risk reduction workshop and educational material on self treatment, cost containment, and health promotion. Based on first-year data, the state has recommended not to expand the program statewide because of adverse selection affecting the insurance base of the other options.

Hospice care. The state began offering hospice care as a benefit in August 1983.

The patient-auditor program. Beginning March 1, 1984, the state plan began a patient-auditor program to encourage patient awareness of the financial aspect of illness by offering incentives to verify charges on medical bills. If a reported overcharge is verified, the patient-auditor is eligible for an incentive award of up to 50% of the overcharge, not to exceed \$1,000.

HIGHLIGHTS

This report capsules cost containment aspects of seven state employees' health care programs. These cost containment initiatives range from preferred provider arrangements to incentives aimed at modifying health utilization behavior in a variety of ways.

The information is from a report titled, "Harnessing State Expertise to Contain Health Care Costs: The Potential of Employee Health Benefit, Medicaid, and Health Planning Programs," prepared by the National Governors' Association, Center for Policy Research, Health Policy Studies.

Copies of the complete report may be obtained from the Publications Office, National Governors' Association, 444 North Capitol Street, N.W., Washington, DC 20001.

Changes in the Florida program must first be agreed to in collective bargaining and then recommended in the governor's budget and approved by the Florida legislature.

New options being researched by the plan for possible inclusion in FY 1984-85 include a preadmission certification program for screening nonemergency hospital admissions; a mandatory second opinion program for elective surgery; development of a preferred provider network; expanded use of alternative providers, such as nurse practitioners; alternatives to increase the cost savings from HMOs; and increased deductibles.

Illinois. In 1983, Illinois' total health care bill for its 225,000 employees and their dependents was \$118 million.

In 1981, the governor limited the acceptable health care cost increase to 15%. As a result, policies implemented in 1981 included mandatory ambulatory surgery for 67 procedures, preadmission testings, and a \$50 deductible for each emergency room visit.

A pilot utilization review program in Springfield has had measurable success. The program is based on the days of inpatient care on which no acute services are rendered.

(CONTINUED)

It was designed to identify practice patterns such as delays in discharge and early or unnecessary admissions, which can be measured in terms of the incidence of nonacute hospital days. The percentage of nonacute days was reduced from 23.1% of all days reviewed in 1981 to 8.7% in 1983, a reduction of more than 60%. This represented an annual savings of approximately 3,450 hospital days. Illinois officials believe that possible reasons for the reduction of hospital days in Springfield may be the sentinel effect, peer pressure on area physicians, and general excess utilization in the system. As a result of the success in Springfield, utilization review will be expanded in Illinois.

Another approach under consideration is implementation of a Medical Services Advisory program, based on an initiative by the Zenith Corporation (see RR 335.64.-5).

Illinois assesses the cost impact of its alternative delivery system options--in this case, HMOs. Because of the problems of adverse selection, the state has asked all HMOs to experience rate with the state.

Critical to all of Illinois' cost containment activities has been and continues to be the collection and analysis of data. Data are critically important to such activities as identifying specific cost escalation problems, assessing the cost impact of increasing employee enrollment in HMOs, and monitoring the effectiveness of implemented programs.

Kentucky. Kentucky provides health benefits to approximately 90,000 active and retired state employees and teachers, plus 70,000 dependents.

Kentucky in 1982 opened its plan to competitive bidding. The request for proposals for the bid included specifications pursuant to cost containment strategies. Blue Cross won the contract to continue as the state's insurance carrier. The state was granted a \$1.2 million rate credit by Blue Cross for the cost containment provisions in the new contract.

A number of cost containment initiatives have been implemented since the new contract went into effect. There is a second surgical opinion program. The employee will be reimbursed only 50% if a second opinion is not obtained for a selected list of fifteen elective procedures. The state estimated savings of \$820,000 in 1982-83 as a result of this program.

The Kentucky plan also has an incentive program for ambulatory surgery. The state has established a schedule of 45 procedures that can be performed safely on an outpatient basis. An employee is reimbursed only 50% of the cost if a procedure listed on the schedule is performed on an inpatient basis, with certain exceptions. Exceptions to the ambulatory surgery requirement are granted based on the type of procedure and the health status of the employee. Savings attributable to the ambulatory surgery program totaled \$991,000 from 1982 to 1983.

Kentucky also provides incentives for short maternity stays. Women who leave the hospital within two days of giving birth receive \$75; if they leave within one day they receive \$125. In addition, they receive \$100 for in-home services, which will not be considered as income on state taxes. This program has resulted in cost savings of \$27,500 in the first year of operation.

The state program includes a 24-hour limit on hospital admissions prior to surgery and a program of preadmission certification for nonemergency hospital admissions, except maternity and psychiatric admissions. Physicians are required to get prior approval for admissions from a utilization review board, except for an emergency, when review takes place after admission. The state realized savings of \$98,000 attributed to limiting hospital admissions prior to surgery.

A number of additional cost containment initiatives were added recently. In October 1983, the state started an employee audit for hospital bills. Employees who find overcharges on their bills receive 25% of the money recovered by the state, up to \$125. Kentucky also is expanding the range of benefits covered--hospice care and birthing centers were added in January 1984, and home health care will be covered later in 1984.

In the future, Kentucky plans to develop programs to promote employee wellness. As a first step, employees will be administered risk assessment questionnaires. Results will be analyzed and employees given specific suggestions to improve their health status by altering their lifestyles.

North Carolina. In October 1982, North Carolina changed to a self-funded program incorporating traditional cost containment features and a performance-based administrative services contract.

(CONTINUED)

Although operational for only one year, self funding has proved to be a financial success. The investment earnings for the first 12 months have covered the costs of administering the plan.

North Carolina's contract with its administrator has a performance clause that holds the administrator fiscally accountable for inefficiencies and provides fiscal rewards for achieving cost savings. There are three elements to the performance contract:

1. If the claims processing error rate exceeds 5% of total plan dollars, as determined by an outside auditor, the administrator must pay a penalty.

2. If the administrator can reduce hospital days per thousand below a targeted number, through improved utilization review, education of providers, etc., the administrator receives 10% of the savings.

3. If coordination of benefits does not save between 4.5% and 6.5% of total paid claims, a sliding scale final penalty is imposed on the administrative agency.

Plan design features for cost containment include:

Second surgical opinion. For five selected procedures, the plan will pay its normal rate of contribution only if a second opinion has been sought. Without the second opinion for these five procedures, the plan will pay only 80% of the fee up to a cap of \$1,000.

Ambulatory Surgery. For any procedure done on an outpatient basis, the plan waives the deductible and coinsurance rates for the surgeon's and facility's fees.

Preadmission testing. The plan will pay 100% of the charges for tests performed on an outpatient basis within 14 days of a scheduled admission to a hospital. If the tests are performed on an inpatient basis unnecessarily, the plan will not pay the room and board costs.

Incentive for early discharge. For maternity cases receiving the approval of the attending physician, the plan will pay 100% of the first two newborn visits and the cost of the infant DPT and polio vaccines if the maternity stay for a normal delivery is two days or less, or if the stay is five days or less for a Caesarean-section.

Ohio. From 1980 to 1983, Ohio's expenditures for employee health benefits increased by 77%, while total enrollment of active state employees declined slightly. During the same time period, state employees' enrollment in HMOs rose from 15% to 40%.

Unfortunately, this shift to prepaid health plans appears to have created a problem of adverse selection. This problem became so great by 1981 that the insurance company refused to renew its contract with the state. As a result, Ohio determined that self funding with an ASO agreement was the most cost-effective arrangement for the state.

The Bureau of Insurance and Risk Management, which coordinates health insurance for Ohio's state employees, is developing a proposal that would offer employees a choice between two state health plans. One plan would be essentially the same as the current plan. The second plan would have a level of benefits that is similar to the existing plan but would alter the way in which employees use the benefits. The alternative plan would contain a mandatory ambulatory surgery program, increased coinsurance and deductibles, second opinions for surgical procedures, and economic incentives for low-volume utilization of health services, including a "pay-back" provision. The attractiveness of this alternative plan is that the Bureau believes it can offer employees a high level of benefits at a significantly reduced premium because of the cost-containment features. The plan would then be attractive to a broad cross-section of employees, be competitive with the HMOs, and reduce the effects of adverse selection.

Utah. The Utah plan became self funded and self administered in 1976. In 1983, the plan cost the state \$16,000,000 and covered 9,500 employees and their families. Cost containment programs include:

Incentives for shortened stays. When the inpatient hospital stay for 12 selected procedures is reduced one or more days from state-established norms, a \$50 incentive is issued to the insured when the claim is processed. Reductions in stay must have the consent of the attending physician.

Ambulatory surgery. The state will reimburse 100% of R&C charges for outpatient surgery for 100 identified procedures. If the procedures are done on an inpatient basis without medical necessity, the state requires 20% coinsurance on the full hospital bill (otherwise paid at 100%).

(CONTINUED)

5-84
FLORIDA, ILLINOIS, KENTUCKY, NORTH CAROLINA, OHIO, UTAH, WISCONSIN PROFILED

Preadmission testing. The state will pay 100% for preadmission tests performed within ten days of an inpatient admission. The tests are done on an inpatient basis, the normal coinsurance rate of 30% is required.

Second surgical opinion. The program pays R&C charges in full for the consulting physician's exam, and for ten identified procedures will pay the insured a \$25 bonus for obtaining the second opinion.

Lifestyle programs. All employees are eligible to participate in a state-paid fitness and nutrition profile and risk assessment program. Additionally, the program offers cash rebates to employees who quit smoking, lose weight, or engage in regular exercise programs.

Wisconsin. Tremendous increases in the cost of state employee health insurance benefits provided the impetus for cost containment. Expenditures have increased from approximately \$44.3 million in 1980 to \$75.5 million in 1983.

In 1983, Wisconsin enacted legislation to provide incentives for employees to choose low-cost alternative health care plans, primarily HMOs. These changes are an effort to change the behavior of health care consumers and providers. The state's contribution rate is based on the price of the lowest cost plan offered to employees.

This program has had a number of immediate impacts. First, the number of HMOs offered to employees increased from eight to 16. Second, the percentage of state employees enrolled in HMOs increased from about 15% to more than 66% in one enrollment period. The state intends to share the cost savings with employees.

Wisconsin plans to continue efforts to contain the costs of employee health benefits. Next on the agenda is to develop incentives for the administrator of the fee-for-service plan to do more to restrain costs. One proposal under consideration would share saving accrued from audits of large hospital bills with the administrator.

* * * * *

The rising cost of health care has caused employers to adopt a wide range of measures to manage and control medical benefit expenses. Public sector employers do not seem to be as aggressive as their counterparts in the private sector in using cost management techniques. This is one of the findings in a survey of 336 public employers conducted by William M. Mercer-Meidinger, in cooperation with the Public Risk and Insurance Management Association.

Most of the respondents (61%) were city or town agencies; 19% were county or parish agencies; 8% were school boards or districts; and 3% were state agencies.

The median population of the agencies' jurisdictions in the Mercer-Meidinger study was 57,000. The median number of employees of the responding agencies was 520. About 26% of the agencies cover more than 1,000 employees in their medical plans; 19% between 500 and 1,000 employees; 29% cover fewer than 250. In 40% of the agencies, medical benefits are negotiated in labor agreements.

Plan Design

Among the respondents, the most commonly used medical plan is basic medical/surgical plus major medical, which was offered by 60% of the agencies to their salaried employees, with 29% offering first-dollar coverage on hospitalization. Half of the agencies continue to offer basic coverage for their hourly employees, with 23% offering first-dollar coverage on hospitalization.

Thirteen percent of the public employers in the survey have recently changed to comprehensive plans for their salaried employees, compared to 26% a year ago, and another 11% said they are considering such a change.

Deductibles

About 13% of the agencies have recently increased deductibles for salaried employees, and 11% increased deductibles for hourly employees. By contrast, deductibles were increased by 30% for salaried and 24% for hourly employees. For most of the agencies, however, these amounts are still relatively low. Deductibles are \$150 in 70% of the salaried plans and 68% in the hourly plans.

Other changes in plan design the survey respondents have made or are considering:

--increasing maximum out-of-pocket limits. About 15% have changed, 15% are considering. In 29% of the salaried plans and 27% of the hourly plans, the

HIGHLIGHTS

This Research Report is taken from a William M. Mercer-Meidinger study of public employers' health care plan cost containment features.

Copies of the survey report are available at no charge by writing William M. Mercer-Meidinger, Incorporated, marketing department, 2600 Meidinger Tower, Louisville, KY 40202-3415.

out-of-pocket limit is \$500 or less; 38% of salaried plans and 41% of hourly plans have \$1,000 limits.

--increasing or adding employee contributions for medical coverage. About 9% have contributions for salaried employee coverage, almost 11% have contributions for dependent coverage.

--using a flexible spending account for health care expenses. Only 7% have actually made the change, but about 13% are considering doing so.

Retiree Medical Benefits

Several forces have created significant liabilities for private sector employers offering health care benefits to retirees. According to the Mercer-Meidinger survey, 73% of the survey respondents provide medical benefits for retired employees. Of these, 46% supplement Medicare and 45% provide identical benefits received by active employees.

More than 75% of the cost is paid by the retiree in 63% of the agencies, while in 24%, the retiree pays nothing.

Some 68% of the responding agencies provide medical benefits for dependents of retirees, and 14% absorb the entire cost of dependent coverage.

In an effort to contain costs, survey respondents overwhelmingly (78%) indicated that they are planning to pass on future cost increases to retirees.

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HMOs And PPOs

Forty percent of the survey respondents said they were interested in health maintenance organizations because of their ability to reduce health care costs. However, 54% felt that adverse selection might lead to an increase in the costs of traditional plans.

More than half (54%) of the agencies surveyed offer HMO options. Of these, 61% offer more than one HMO. In 1985, 52% of the surveyed employers offered HMO plans, and only 30% offered more than one.

The most important feature in evaluating an HMO is the quality and number of hospitals and physicians available, according to 62% of the respondents. Many respondents (41%) considered the full service aspect of the HMO benefit schedule important, and 34% said geographic location was important.

PPOs have become more aggressive in their marketing of the public sector. About 22% of the respondents offered PPOs in 1986, compared to only 13% in 1985.

Employers currently without PPO options seem receptive to offering such options in the future: 27% said they would offer a PPO from a quality organization; another 49% said they might. Only 23% said that they would consider a PPO attractive if they thought they would save 11% or less.

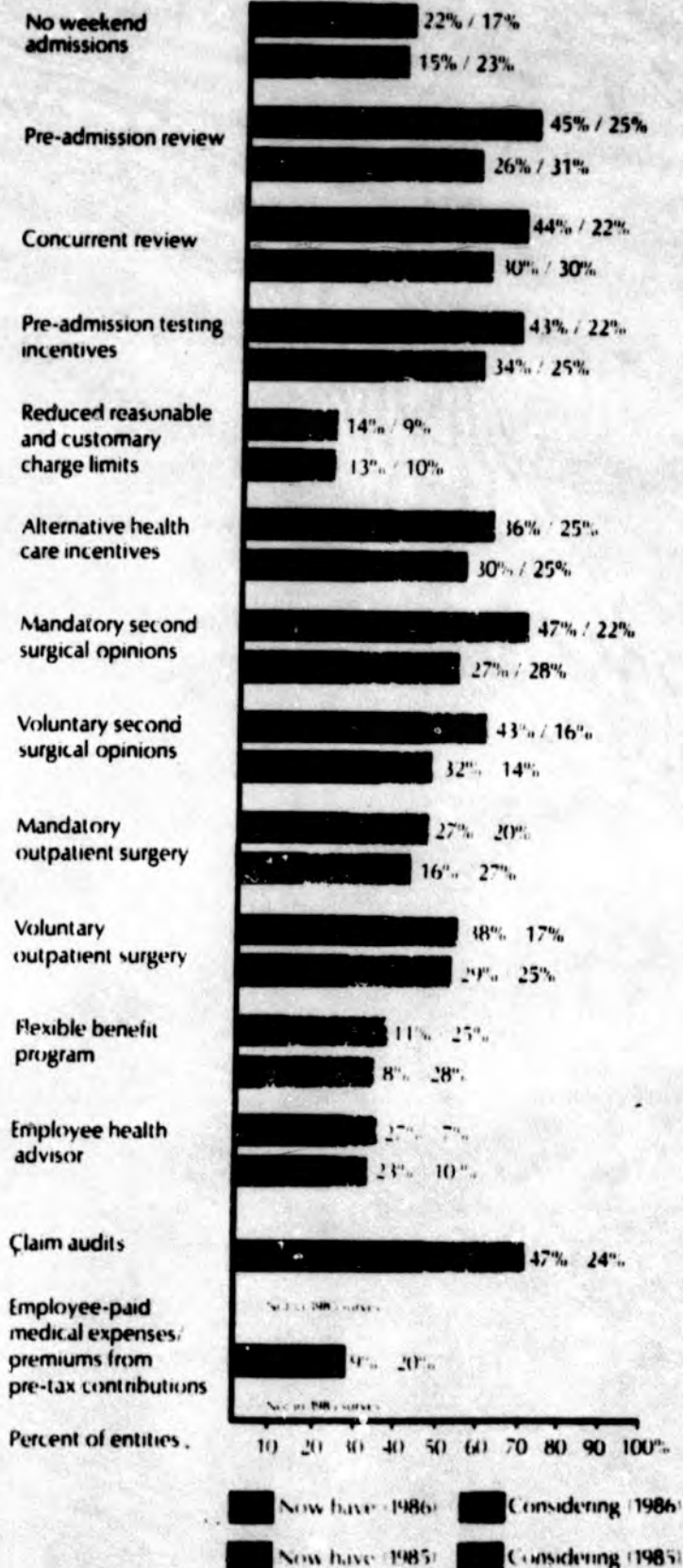
The most important features of a PPO, according to the survey respondents, are quality of providers, discounts on service, and accessibility to employees. The most serious criticism, on the other hand, was employee resistance to limited choice of provider (58% of respondents, compared to 68% last year).

Communications

Twenty-eight percent of the respondents said that a good communication program can have significant impact on helping reduce costs; another 56% said it can have a moderate impact.

About half of the agencies in the survey have put in special communication programs to deal with various aspects of health care--52% to introduce changes in benefit plans, 35% to enhance employees' understanding of their roles as purchaser, 50% to increase general health awareness, 49% for specific health education programs, and 31% to enlist employees' help in containing costs.

Cost containment features in medical plans



Claims Administration

While 58% of the agencies said information provided by their claims payors was helpful in managing costs, only 45% have made any changes in their plans based on such information. Seventy-six percent said their claims reports are not compared to norms such as national, regional, local, or industry.

In 41% of the agencies, health plans are fully insured. Of those, 26% are fully experienced rated (down from 56% last year) and 8% are pooled (down from 35% last year). Twenty-four percent have ASO arrangements and 22% of those have stop-loss coverage, compared with 91% in 1985.

Blue Cross/Blue Shield is used by 37% of the agencies, 24% use independent TPAs, 27% use commercial carriers, and 4% are self-administered. During the past year, 21% have changed their administration arrangements.

More than half of the survey respondents (55%) thought employee lifestyle had only a moderate effect on medical costs, while 39% thought it had a significant effect.

About 24% thought they could do little or nothing to change employees' lifestyles, while nearly two-thirds thought they could have a moderate effect, and 12% thought they could have a significant effect.

The most popular program was alcohol and drug abuse treatment (offered by 52% of the agencies), followed by blood pressure screening (45%) and employee assistance (48%). The greatest leap in wellness programming was in the area of physical fitness. Programs emphasizing fitness are now offered by 27% of the agencies, compared to 21% last year.

As shown in the chart on the previous page, public sector employers increased their use of virtually every medical intervention feature in 1986, compared to last year.

Asked which groups can and should act to bring health care costs under control, the agencies first named coalitions of employers and providers. Hospitals ranked second. Despite these opinions, only 23% of the agencies belong to any local employer cost containment group.

As shown in the chart, the survey employers have adopted a number of cost-containment features in their medical plans.

* * * * *

Cost management policies will work only if they control the costs of those who use the health care system most often, declares the Equitable. To get a profile of these "heavy users," Louis Harris and Associates questioned 32 million patients—nearly one in five American adults—who had been hospitalized at least once or had visited their doctors at least ten times in the past 12 months.

The overall object of the survey was to provide policymakers in both the public and private sector with information relevant to the design of future health insurance programs and health plans. The survey examines ways to manage the high cost of providing health care services to those who use them the most without preventing or inhibiting them from getting the services they need.

This Research Report summarizes the findings of the fifth comprehensive survey conducted by the Harris agency on the state of the health care system in America. For additional information about this and previous surveys in the series, contact Andrew Plesser at (212) 489-6900.

A newly released study of the state of health care in America suggests that some of the steps taken to curb spiraling health care costs may not be as successful as is being reported.

Despite a slower rate of inflation, increased cost sharing, reduced benefits, and the growth of health maintenance organizations and preferred provider organizations, medical prices continue to rise about three times faster than the Consumer Price Index.

Louis Harris and Associates suggests in a comprehensive study on the state of the American health care system that policymakers may need to reevaluate their cost containment strategies. The researchers conclude that "any policy which seeks to change the behavior of health care consumers must change the behavior of the heavy users. These people use most of the available services and incur most of the costs." But, they caution, "heavy users will be hurt first, and hit hardest, by any policy that reduces access to or the quality of care."

The Equicor Survey of Hospital Patients and Other Heavy Users of Health Care Services is the fifth in a series of health care studies conducted by Louis Harris and Associates for The Equitable. To identify the heavy users, the Harris firm interviewed a nationwide cross-section of 8,400 individuals in 3,900 households during May and June of 1986. The heavy users, who represent 18% of the population, were comprised of

966 patients (12%) who had been hospitalized, and 548 people (6%) who had visited a doctor at least 10 times during a 12-month period.

As shown in the chart on the following page, the profile of heavy users of health care services differs from the general population in these ways: twice as many females (69%) as males are heavy users; they are older; they have worse health status; and they are more likely to be disabled and covered by Medicare.

Heavy users are similar to the general population in terms of income levels with the largest percentage having incomes of less than \$15,000. Two-thirds, or 69%, of heavy users are covered by health plans provided by employers or unions; 5% have no health insurance.

Health Status

In terms of health status, one-quarter (26%) of all heavy users suffered from hypertension during the previous 12 months, 14% suffered from heart disease, 11% were victims of accidents or injuries requiring hospitalization, and 9% have diabetes. In addition, 18% of all female heavy users had given birth in the previous 12 months.

All of the above conditions (except maternity and accidents) are highly correlated with age. Age becomes a factor also when multiple conditions are present as shown below.

PROFILE OF HEAVY USERS OF HEALTH CARE SERVICES

	<u>All Heavy Users</u>	<u>Number Of Nights In Hospital</u>					<u>Nonmaternity Heavy Users</u>	<u>All Adults* (Total Public)</u>
		<u>0</u>	<u>1-2</u>	<u>3-5</u>	<u>6-10</u>	<u>11 Or More</u>		
Base	1,514	548	238	291	223	198	1,338	Varies
Sex								
Male	31%	30%	22%	26%	37%	46%	35%	47%
Female	69%	70%	78%	74%	63%	53%	65%	54%
Age								
18-29 years	23%	19%	36%	30%	16%	14%	18%	29%
30-39 years	23%	27%	27%	25%	14%	13%	20%	21%
40-49 years	14%	14%	13%	15%	12%	14%	15%	13%
50-64 years	20%	20%	14%	14%	28%	29%	23%	20%
65 and over	20%	20%	9%	16%	28%	30%	23%	17%
Household Income								
\$15,000 or less	31%	34%	24%	25%	28%	41%	32%	32%
\$15,001 to \$25,000	19%	18%	22%	18%	19%	16%	18%	20%
\$25,001 to \$35,000	19%	19%	17%	23%	17%	16%	18%	15%
\$35,001 to \$50,000	14%	13%	19%	14%	11%	11%	13%	14%
\$50,001 or more	10%	10%	13%	10%	11%	7%	11%	12%
Health Status								
Excellent	27%	27%	44%	40%	21%	15%	22%	44%
Good	41%	45%	39%	42%	36%	35%	43%	46%
Fair or poor	31%	34%	17%	18%	40%	50%	35%	10%
Disabled								
Yes	28%	31%	12%	16%	31%	52%	31%	15%
No	72%	69%	88%	84%	67%	48%	68%	85%
Number Of Nights In Hospital In Last Year								
0	36%	100%	—	—	—	—	41%	88%
1-2	16%	—	100%	—	—	—	13%	3%
3-5	19%	—	—	100%	—	—	15%	4%
6-10	15%	—	—	—	100%	—	16%	3%
11 or more	13%	—	—	—	—	100%	14%	2%
Health Insurance								
Through work or union	69%	68%	73%	74%	70%	60%	64%	68%
Through self, family, or group	40%	40%	37%	37%	42%	46%	36%	46%
Medicare A or B	25%	24%	13%	20%	32%	41%	27%	20%
Medicaid	7%	8%	6%	4%	7%	8%	7%	6%
No health insurance	5%	5%	7%	4%	5%	5%	5%	5%
Sources Of Care								
Have usual source of care	85%	84%	85%	85%	88%	88%	85%	88%
Have one personal physician	76%	73%	—	—	—	—	76%	80%
Marital Status								
Single	14%	17%	13%	11%	11%	16%	15%	22%
Married	64%	57%	75%	77%	62%	57%	62%	58%
Divorced/separated	10%	23%	8%	6%	11%	9%	10%	11%
Widowed	11%	13%	4%	5%	16%	17%	13%	9%

* Notes: (1) Some of these tables add to less than 100% because of "not sure" responses and refusals.
(2) The "All public" data come not from this survey but from a variety of other Harris surveys.

continued on next page

	Ages				
	18-29	30-39	40-49	50-65	65+
One condition	25%	30%	48%	59%	67%
Two conditions	3%	4%	11%	26%	28%

Hospital Choice

Until recently, noted the Harris firm, it was assumed that doctors, not patients, determined the choice of hospitals. The results of the survey reveal, however, that the doctor chooses the hospital for only 43% of the heavy users. A further 6% said the decision was made jointly by doctor and patient.

The tendency to let the doctor choose the hospital increases steadily with age: from 34% among those age 18-29 to 47% for those age 50-64 and 47% for those age 65 and over.

In terms of criterion used in choosing hospitals, the survey findings show that "very few patients shop around to compare hospital prices." A hospital's reputation for providing quality care is the principle criterion used by 74% of heavy users in choosing hospitals. Also considered, by 58% of heavy users, are the hospital's location (presumably close to the patient's home) and previous experience at the hospital. All three of these factors were considered more important than the out-of-pocket costs, which only 38% of heavy users singled out as "very important" in their choice-making.

The importance of out-of-pocket expense in choosing a hospital differ by age and income. Higher income groups are less likely to cite this as a "very important" reason for choosing a hospital compared to only 8% of heavy users with incomes of \$15,000 or less.

Health care payors have placed emphasis on the price competition among hospitals as a determinant in their selection of "preferred" hospitals. These findings show that "if price competition is to grow, it will be the buying power of the third-party payors, not the consumers," perhaps because hospital price information is not readily available to consumers.

How long a patient stays in the hospital has been greatly influenced by the Medicare prospective payment system. The medium number of nights heavy users were hospitalized was four; this number embraces the 11% who stayed one night and 20% who stayed 20 or

more nights.

Length Of Stay Varies

Length of stay varied by income group (highest and lowest spend more time than those earning between \$15,000 and \$50,000), sex (men stayed longer than women), and by age (those over age 50 spend more nights than those under age 50).

The impact of this findings should be tempered, according to the Harris firm, by the fact that this is the first national survey to ask whether DRGs and other cost containment mechanisms are causing more patients to be discharged "quicker and sicker" than they were in the past. Therefore, these findings "do not provide a definitive answer." However, 12% of the heavy users believe they were hospitalized for "too short a time," a finding that is, according to the Harris firm, "large enough to cause concern."

What was the consequence of being discharged at a time perceived as being "too early?" A 59% majority of those who believe they were discharged too early say their condition got worse; 18% said there was no effect, while 3% said the condition got better by itself. Three of every 10 (32%) said they were readmitted sometime during the year because they were still ill.

Employers instituted specific policies to control costs that included increased deductibles and cost sharing as well as preadmission, concurrent, and retrospective reviews. The pollsters conclude that "any substantial increases in cost-sharing and preadmission reviews are likely to be widely unpopular among the heavy users. Many health plans have probably reached the limit to which they can shift costs to health care consumers without triggering negative backlash or reducing access."

This conclusion was based on the large differences between the replies of heavy users and those of employees, relating to cost-sharing. Heavy users indicate that increased cost-sharing is viewed very critically. They, of course, tend to be affected more adversely than the rest of the population.

Access/Quality

The Harris firm observed that in terms of access and quality of care, the "policymakers and health care providers have every reason to be pleased with these findings: Heavy users were "satisfied" with these aspects of health care services:

- ability to see a doctor when necessary (90%)
- quality of their doctors (89%)
- health insurance policy (74%)
- quality of hospital care (82%).

How many heavy users are slipping through the safety net of the current health care system? Only 7% of the heavy users said they failed to get the care they needed. But the pollsters injected this fact: "that 7% represent more than two million people."

The proportion of those who fail to get needed care was somewhat higher among the lowest income group (12%), those who are disabled (13%), those on Medicaid (15%), and those without health insurance (16%). The two most common reasons why people failed to get the health care services they needed are that services cost too much (33%), or they do not have adequate insurance coverage (25%).

Doctor/Patient Relationship

The pollsters note that "the inability of patients to see their own doctor has often been given as a criticism of HMOs." However, this survey indicates that "for the majority of Americans this is not particularly important."

Findings show also that "substantial economies may be possible through the use of lower cost health care professionals in the treatment of some patients." Less than one-third (29%) of all heavy users said they "mind a great deal" if they are treated by a medically trained nurse-practitioner or a physician's assistant, when a doctor is not available.

As in the selection of hospitals, consumers are less likely than employers or other third-party payors to allow a doctor's fee to influence their choice. "These data show conclusively that even with increased cost-sharing in many health plans, most patients cannot, or do not, shop around between doctors on the basis of price." The survey showed that only one in ten of all heavy users chose their doctors because their fees were

lower. Younger heavy users were slightly more likely to do this. And, only a 16% minority said that the fees were an important reason in their choice of physician. Those eligible for Medicaid (24%), those currently without health insurance (19%), and those in the lowest income group (21%) are more likely than are other heavy users to say that fees are important.

Alternative Treatments

While HMO membership has undoubtedly been growing among heavy users, no more than 9% of them have joined an HMO. Membership ranges from 14% in the West, 11% in the Midwest, and 6% in the South and in the East.

At the time of the survey, 5% of all heavy users were PPO members. The pollsters noted that when responses to questions about PPOs are compared with those about HMOs, "it is clear that the restrictions which both place on patients' choices are not fundamental barriers." It should be noted, they added, that "HMO growth has been fueled by employee and public support, an increased understanding among employers that a capitation-based payment system fundamentally changes the motivation of health care providers. Discounted fee-for-service methods such as PPOs do not do so."

Lifestyle

There is no evidence that heavy users of health care services have less healthy lifestyles, or higher risk factors. A previous survey conducted by the Harris firm for *Prevention* magazine showed that there is a tendency for many people to change their behaviors and reduce their risk factors only after they have suffered a health problem. "The challenge," then "is how to persuade those who are fit and healthy to adopt healthy behaviors and reduce their risk factors—and so reduce their chances of becoming heavy users." ■