SB

254

SENATE FINANCE COMMITTEE REPORT

DATE: 3/12/90 FURTHER:

DATE TURNED INTO OFFICE: 3/29/90

The Finance Committee considered SB 254

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

and recommended:

[✓] replace with _____ CS SB 254 (Finance) [ ] same title [✓] new title
[ ] or adopt _____ CS _____ [ ] technical title change (HB only)

[ ] attached amendment(s)
[ ] _____ letter of intent adopted

[ ] do pass

[ ] do not pass

[ ] no recommendation

[✓] individual recommendations

[ ] further referral to _____

ATTACHES NEW FISCAL NOTE(S): Dept/Date:

[✓] fiscal note(s) _____
SFC: DOH 292.0 3/29/90

[✓] zero fiscal note(s) _____
DCCED 0 3/29/90

[ ] appropriation-no fiscal note

APPROVES PREVIOUS: Dept/Date:

[ ] fiscal note(s) _____

[ ] zero fiscal note(s) _____

SIGNING DO PASS:

OTHER RECOMMENDATIONS:

Paul Fink (Do not pass with present fiscal note)

1. _____ 2. _____

Co-Chairs: Signatures and Recommendations

R/O SFC- 3-29-90

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: CSSB 254 (Finance)
PUBLISH DATE: _____

FISCAL NOTE

REQUEST:

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

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

EXPENDITURES/REVENUES: (Thousands of Dollars)

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

FUNDING: (Thousands of Dollars)

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

POSITIONS:

FULL-TIME	2	2				
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary) See page 2 for FY 91 detail.
*After February 1, 1992, the authority shall provide that sufficient premiums are collected to provide the required insurance coverage and to pay the expenses of the authority.

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

Approved by Commissioner: _____ Date: _____
Agency: _____

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

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

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

R/O SFC 3-29-90

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: CSSB 254 (Fin)
PUBLISH DATE:

FISCAL NOTE

REQUEST:

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

Agency Affected: Commerce & Economic Dev.
BRU:
Components:

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

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

POSITIONS:

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

ANALYSIS: (Attach a separate page if necessary)

As the Senate Finance Committee substitute places the Alaska State Group Health Insurance Authority within the Department of Administration, this fiscal note is zero.

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

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

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

LW/dg16408D-1/32990b

R/O SFC 3-29-90

6-0623J
Ford
3/28/90
Adopted
by SFC
3/29/90
JD

Original sponsor(s): SEN. DUNCAN

IN THE SENATE BY THE FINANCE COMMITTEE

CS FOR SENATE BILL NO. 254 (Finance)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - SECOND SESSION

A BILL

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

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

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

(1) by February 1, 1992, create a statewide health care provider payment system, rate schedules, and utilization standards;

(2) after February 1, 1992, provide comprehensive group health insurance for the state, municipalities, school districts, and all eligible employees of the state, a municipality, or a school district who elect to participate in the group insurance offered by the Alaska State Group Health Insurance Authority;

(3) expand the pool of subscribers and maximize the opportunities for cost containment when purchasing group health insurance;

(4) maintain an efficient provider payment system to reduce the cost to providers who are serving employees of participants;

(5) maintain statewide utilization standards to control inappropriate or improper utilization practices and to reduce the rate of inflation in the cost of health care in the state;

(6) create the most comprehensive, cost-effective, and efficient method of providing a variety of types of health care insurance necessary to meet the coverage requirements of a participant resulting from negotiated employee contracts;

(7) realize the potential savings that will result if

approximately 135,000 active and retired state, municipal, and school district employees and their dependents participate in the group health insurance program offered by the authority; and

(8) determine the need for mandatory participation in the group health insurance offered by the authority.

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

CHAPTER 77. STATE INSURANCE.

Sec. 21.77.010. AUTHORITY CREATED; REQUIRED PAYMENT SYSTEM, RATE SCHEDULE, AND UTILIZATION STANDARDS. (a) There is established within the Department of Administration a nonprofit incorporated legal entity known as the Alaska State Group Health Insurance Authority.

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

(c) The authority shall, beginning February 1, 1992, provide group health insurance to eligible employees of the state, a municipality, or a school district if the employer has elected to participate in the group health insurance obtained by the authority and may provide group health insurance to employees of other groups that elect to participate in the group health insurance obtained by the authority.

(d) Upon application by an eligible state program, the authority may, beginning February 1, 1992, allow the eligible state program to participate in the group health insurance obtained by the authority.

Sec. 21.77.015. REQUIRED COOPERATION BY STATE AGENCIES. An agency of the state that provides health care or that provides funds to purchase health care shall, to the maximum extent possible,

cooperate in the development of the use of the health care provider payment system, rate schedules, and utilization standards established by the authority, including sharing relevant information.

Sec. 21.77.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The authority shall be managed by a board of directors composed of 15 members appointed by the governor as follows:

(1) one nonvoting member representing the legislative branch;

(2) one nonvoting member representing the judicial branch;

(3) two members representing the executive branch;

(4) two members representing labor organizations;

(5) two members representing school districts;

(6) two members representing municipalities;

(7) two members representing the Department of Health and Social Services;

(8) two members representing health care providers;

(9) one member representing the University of Alaska.

(b) A member of the board serves for a term of five years. The board shall elect from its membership a president, vice-president, and secretary. Members of the board serve without compensation but are entitled to receive per diem and travel expenses authorized for boards and commissions under AS 39.20.180. Members of the board are subject to AS 39.50.

Sec. 21.77.030. GENERAL POWERS. (a) The authority may

(1) beginning February 1, 1992, exercise the powers granted to insurers under the laws of the state; if the authority acts as an insurer, the authority shall comply with the requirements applicable to insurers under this title;

(2) sue or be sued;

(3) enter into contracts or agreements;

(4) establish administrative or accounting procedures;

(5) collect, invest, and disburse funds;

(6) adopt necessary regulations and procedures for implementation of this chapter.

(b) In exercising its powers under this chapter, the authority may not participate directly or indirectly in a collective bargaining agreement.

Sec. 21.77.040. DUTIES OF BOARD; ANNUAL REPORT. The board shall, in obtaining group health insurance required under this chapter, provide comprehensive coverage at the lowest possible cost per eligible employee. The board shall provide to the governor and to the legislature an annual report covering the previous fiscal year's activities of the authority. Every third fiscal year the authority shall include in the annual report a cost and benefit analysis of the health insurance required under this chapter.

Sec. 21.77.050. STAFF AND PROFESSIONAL SERVICES CONTRACTS. The authority shall employ an executive director who serves at the pleasure of the authority as its chief administrative officer. The executive director may, with the approval of the authority, select and employ additional staff as necessary. Employees of the authority are in the exempt service under AS 39.25.110. In addition to its staff of regular employees, the authority may contract for the services of consultants and professional, technical, and financial advisors the authority considers necessary for the purpose of developing information, conducting hearings, studies, investigations, or other proceedings, or otherwise exercising its powers.

Sec. 21.77.060. PROCUREMENT OF INSURANCE. (a) The authority shall, after February 1, 1992, obtain a policy or policies of group

health insurance covering eligible employees of the state, a municipality, or a district, if the employer has elected to participate, from an insurer authorized to transact business in the state under AS 21.09, or act as a self-insurer if the authority determines that self-insurance can provide the desired insurance coverage and benefits at a lower cost per eligible employee.

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

Sec. 21.77.070. STATE GROUP HEALTH INSURANCE FUND. The state group health insurance fund is created in the general fund. The fund consists of money appropriated by the legislature, and premiums collected under AS 21.77.080. The fund shall be managed and invested by the board. The board may expend money from the fund to carry out the provisions of this chapter.

Sec. 21.77.080. INSURANCE PREMIUMS. (a) The authority shall provide that sufficient premiums are collected to provide the required insurance coverage and to pay the expenses of the authority. All premiums shall be deposited in the fund.

(b) Reserves remaining at the termination of an insurance contract shall be invested by the authority in the same manner as retirement funds are invested under AS 14.25.180.

Sec. 21.77.090. PARTICIPATION; WAIVER. (a) The state, a municipality, or a district may participate in the group insurance coverage provided by the authority. If the state, municipality, or district elects to participate, the state, municipality, or district shall

continue to participate unless a waiver is granted by the board.

(b) In determining whether a waiver should be granted, the board shall establish minimum benefit and financial standards for the desired group health insurance coverage. The minimum benefit and financial standards and the proposed time schedule for responsive offers shall be sent to all participants at the time the request for proposal for the desired group health insurance coverage is issued. Except as provided in (d) of this section, a participant seeking a waiver of coverage shall match the minimum benefit and financial standards set out in the request for proposal for the desired group health insurance coverage. Participants shall submit documentation of their insurance coverage matching the board's minimum benefit and financial requirements before the deadline established by the board. The board may approve or disapprove a waiver of participation based on the documentation submitted by the participant regarding the benefit and financial standards established by the board. Once the board awards the insurance contract, a participant may not be granted a waiver during the term of the contract.

(c) A participant may separately provide for health insurance coverage additional to that offered by the authority, and may provide for marketing and servicing to be done by licensed insurance agents.

(d) The board shall grant a waiver to a participant who elects not to provide group health insurance to employees. A waiver granted under this subsection takes effect at the expiration of the existing health insurance coverage.

Sec. 21.77.100. DEFINITIONS. In this chapter

(1) "authority" means the Alaska State Group Health Insurance Authority;

(2) "board" means the board of directors of the Alaska

State Group Health Insurance Authority;

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

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

(5) "eligible state program" means a program in which an agency of the state provides health care or provides funds to purchase health care;

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

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

(8) "municipality" includes a public corporation established by a municipality;

(9) "participant" means the state, a municipality, or a district;

(10) "payment system" means a system or method that streamlines or results in cost efficient payments to health care providers;

(11) "rate schedules" means schedules of allowable payments for health care related services based on geographic regions, actual provider costs, and availability of services;

(12) "state" means the executive, legislative, and judicial branches of state government, or an organizational unit of a branch, and includes the University of Alaska and a public corporation of the state created within a principal executive department;

(13) "utilization standards" means a system to monitor, track, and verify patterns of treatment by health care providers that assures that cost efficient and cost effective care is provided within

accepted medical standards without reducing the quality of care.

* Sec. 3. AS 39.25.110 is amended by adding a new paragraph to read:

(30) employees of the Alaska State Group Health Insurance Authority.

* Sec. 4. AS 39.50.200(b) is amended by adding a new paragraph to read:

(50) Alaska State Group Health Insurance Authority (AS 21.-77).

* Sec. 5. STAGGERED INITIAL TERMS. Notwithstanding AS 21.77.020(b), enacted in sec. 2 of this Act, the terms of the initial members of the board of directors of the Alaska State Group Health Insurance Authority who are appointed under AS 21.77.020(a), enacted in sec. 2 of this Act, shall be staggered by the governor. Three members shall serve for one year, four members for two years, four members for three years, and four members for four years.

* Sec. 6. REPORT. The Alaska State Group Health Insurance Authority shall report to the Alaska State Legislature by March 1, 1991, on the progress made by the authority in establishing a health care provider payment system, rate schedules, and utilization standards.

* Sec. 7. This Act takes effect immediately under AS 01.10.070(c).

SENATE BILL 254 BY SENATOR DUNCAN
State Affairs

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 establish the Alaska State Group Health Insurance Authority. By February 1, 1990 the Authority has the responsibility to create and maintain:

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

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

Section 2.

CREATION OF THE AUTHORITY

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

BOARD OF DIRECTORS

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

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

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

- SPONSOR'S BACKGROUND MATERIAL -

POWERS OF THE AUTHORITY

The Authority may:

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

The authority may not participate in collective bargaining activities.

ANNUAL REPORT, STAFF AND PROFESSIONAL SERVICES

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

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

PROCUREMENT OF INSURANCE

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

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

STATE GROUP HEALTH INSURANCE FUND AND PREMIUMS

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

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

PARTICIPATION AND WAIVER

The authority may also grant a waiver of participation to the state, a municipality or a school district who has elected to participate. The board may approve or disapprove a waiver when the participant can document the ability to match the minimum benefit and financial standards established by the board for the desired group health coverage.

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

DEFINITIONS

(1) authority, means the Alaska State Group Health Insurance Authority;
(2) boar[illegible] means the board of directors of the Alaska Group Health Ins[illegible]ance Authority;
(3) distri[illegible], means a school district or REAA;
(4) eligible employee, means an employee qualified for group health insurance benefits as determined by the participant;
(5) fund, means the state group health insurance fund;
(6) group health insurance, means coverage that may include life insurance, accidental death and dismemberment, workers' compensation, medical care and treatment including Medicare and Medicaid, dental care, eye care, and other group health coverage as determined by the authority;
(7) municipality, includes a public corporation established by a municipality;
(8) participant, means the state, a municipality, or a district;
(9) state, means the executive, legislative, and judicial branches of state government, or an organizational unit of a branch, and includes the University of Alaska, and a public corporation of the state created within a principal executive department.

Section 3.
Places employees of the authority in the exempt service.

Section 4.
Requires board members of the authority to comply with the conflict of interest statutes.

Section 5.
Provides that the authority will sunset on June 30, 1995.

Section 6.
Provides that terms of the board members will be staggered

[illegible]tion 7.
The Authority is required to make a progress report t[illegible]
[illegible]ature by March 1, 1991. The report covers the Aut[illegible]
in establishing the health care provider paymer[illegible]
[illegible]ule, and utilization standards.

[illegible]or an immediate effective date.

By Senator Duncan

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

Personal Services:		
Executive Director 24A $73.2/10 months	$61.0	
Clerk Typist III 8B $29.4/10 months	24.5	
Total Personal Services		$ 85.5
Travel:		
Assume board meetings every two months for 15 board members at an average cost of $400 per trip.		
$400 x 15 x 6	$36.0	
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Postage $200 x 8 months	1.6	
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Professional Services Contract(s)	125.0	
which may include:		
Rate studies		
Utilization research		
Financial systems analysis		
Total Contractual Services		$140.2
Supplies:		
$1000 per employee	$ 2.0	
Software	1.5	
Total Supply		$ 4.5
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Desks and chairs	4.0	
Photocopier	2.0	
Phone system	.8	
Miscellaneous	2.0	
Total Equipment		$ 21.0
Total Operating		$292.0

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

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

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

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

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

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

Health Insurance Authority

SB 254

Background

* Supplemental Request FY 89 of 21.8 million to cover increased Health Care premiums.

* Increasing costs of Health Care in Alaska from 75 million in FY 80 to in excess of 300 million in FY 90.

* Health Insurance premiums for employees increasing from $217.65 in FY 84 to $431.72 in FY 89 an increase of 98% in five years. The national average in 1989 was $216.00

* Health Care Task Force Creation

    * Short term - ways to reduce supplemental requests

    * Mid term - ways to reduce FY 90 costs

    * Long term - ways to reduce health care costs in Alaska.

Health Insurance Authority

* Coordinate buying power of State plans to reduce health care costs in Alaska.

* Lower cost of plan administration

* Realize trends in health care delivery and adjust accordingly.

Health Insurance Authority

SB 254 by Senator Duncan

Purpose:

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

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

The authority could phase in responsibilities over a period of time

Phase I

Authority Created -

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

Phase II

Start to pool purchasing of coverage voluntarily by entities.

Phase III

Pool all entities to give maximum cost efficiencies.

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

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

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

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

My name is Barbara Huff, I am the President of the Anchorage Municipal Employees Association (AMEA). I represent approximately 575 Municipality of Anchorage employees. I am also a member of the Anchorage Municipal Coalition Unions and the State's Health Care Cost Containment Task Force.

Senate Bill 254, an Act relating to group health insurance or the pooling concept of public employee health benefit plans, is of great importance to my members and the Municipality of Anchorage.

The Municipality of Anchorage over at least the last 5 years has seen a drastic increase in the cost of health benefits which it provides for it's employees. The Anchorage School District has seen a similar dilemma.

Recently an agreement was reached between the Anchorage Municipal Employees Association and the Municipality of Anchorage which, in effect, reduced health benefits to offset a projected 22 percent cost increase for 1990.

There is just so much cost containment and cost shifting that can be accomplished. We have reached that point in the municipality and I can only anticipate that future insurance premium increase will result in two things happening: 1. Costs to the individual employee will reach the point where the family can't afford the protection and 2. The benefits will come down at the same time rendering what coverage is left virtually useless in certain common medical emergencies.

Post-it™ brand fax transmittal memo 7671	# of pages ▸
To LARRY GRAY	From BARBARA HUFF
Co.	Co. AMEA
Dept. Senator Kelly's Office	Phone # 276-4236
Fax # 463-4867	Fax # 337-6668

Senate Bill 254 would establish a mechanism whereby the State, Municipality of Anchorage and various school districts and Universities could pool their numbers and use this economy of size to the advantage of all public employees in purchasing a basic health care plan. This large group of people could also jointly operate a cost containment program that, again, would realize significant savings by way of the economy of scale principle.

In an ideal situation each group of public employees would prefer to select it's own health care coverage. Unfortunately, the cost trends are making this impossible. The proposed legislation would allow pooling of numbers for basic coverage while still allowing individual employee groups to enhance the coverage depending on their own priorities and ability to pay.

This compromise, to me, seems to allow the employee to retain options while still benefiting from a far greater purchasing power than his own group could exercise.

I recommend the bill be adopted.

ARTHUR J. GALLAGHER & CO.

CONSULTANTS' REPORT

TO THE

STATE OF ALASKA

HEALTH CARE COST CONTAINMENT TASK FORCE

JUNEAU, ALASKA

JANUARY 29, 1990

Jeffrey A. Malek
Area Assistant Vice President
Arthur J. Gallagher & Company
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SECTION IV

POOLING

POOLING FINDINGS UPDATE

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

Hawaii Premium Rates

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

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

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

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

Hawaii's health benefit agreements with Labor.

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

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

Utah Public Employee Plan (PEHP)

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

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

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

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

ADMINISTRATIVE COSTS

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

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

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

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

Negotiated provider payment and utilization standards

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

These similar savings could be achieved in Alaska's plan by using combination of preferred providers, revised usual, reasonable and customary (UCR) and provider payment schedules. In the 1989 plan year, $80,818,125 was paid for claims if savings similar to Utah's experience are realized, the State of Alaska would save between $6.4 million and $20.0 million per plan year.

Plan Design and Wellness Programs

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

Cost containment provisions that have been implemented include:

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

That Includes:

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

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

Comparison of Rate Increases For Family Premiums By Other Western States

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

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

Source: Utah Legislation Audit Report

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

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

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

Conclusion

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

Estimated Savings:

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

2.4.

STATE OF UTAH
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WAYNE L. WELSH, CPA
AUDITOR GENERAL

Audit Subcommittee of the Legislative Management Committee
Senator Wilford R. Black, Jr., Chairman • Senator Dix H. McMullin
Representative Jack F. DeMann • Representative Beverly J. White

February 2, 1989
ILR-89-D

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

Subject: **Public Employees' Health Plan**

Dear Legislators:

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

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

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

Customary and Reasonable Reimbursement Rates

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

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

TABLE I

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

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

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

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

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

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

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

TABLE II

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

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

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

Premium Increases

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

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

TABLE III

Comparison of Rate Increases For Family Premiums By Other Western States

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

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

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

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

TABLE IV

Comparison of Rate Increases by Carriers Located in Utah

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

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

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

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

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

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

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

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

Administrative Costs

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

TABLE V

Comparison of Administrative Costs Between
Self Insured Carriers For Health Care

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

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

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

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

Sincerely,

Wayne L. Welsh
Auditor General

WLW:CF/syg

ATTACHMENT A

TABLE VI

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

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

Table VII

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

Procedure	PEHP Preferred	Average (A-E)	Company A	Company B	Company C	Company D	Company E
Proc. A	$ 950	$ 967	$ 956	$ 800	$1,181	$ 950	$ 950
Proc. B	1,150	1,295	1,275	1,000	1,600	1,300	1,300
Proc. C	905	1,009	800	890	1,271	1,075	N/A
Proc. D	1,008	1,160	1,034	990	1,427	1,188	N/A
Proc. E	1,065	1,122	1,020	1,020	1,385	1,063	N/A
Proc. F	590	636	600	600	717	625	N/A
Proc. G	255	268	240	260	322	250	N/A
Proc. H	22	23	19	20	30	22	23
Proc. I	8	8	6	7	12	8	8
Proc. J	42	43	32	45	58	N/A	35

RESPONSE TO AUDIT

REIMBURSEMENT RATES

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

An important consideration is the facility charges in conjunction with surgical procedures. Preferred Care has *profiled physicians* and selected them based on quality issues and how well they have utilized the system in the past. A recent analysis of many procedures shows that this system is working well. For example, when comparing our Preferred providers with non-Preferred providers for caesarean section, the average facility charge for our Preferred providers was $336 less. Our Traditional Care program restricts the length of stay for in-patient hospitalization for many high volume procedures. For example, an uncomplicated hysterectomy is limited to three days for females less than 50 years of age. It is not uncommon for our Preferred physicians to limit the in-patient stay to two days. Total charges for hysterectomies for our Preferred providers are over $1000 less than non-Preferred providers.

PREMIUM INCREASES

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

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

ADMINISTRATIVE COSTS

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

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

STATE OF ALASKA

HEALTH CARE COST CONTAINMENT TASK FORCE

CONSULTANTS REPORT

JANUARY 4, 1990

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SECTION I

CONTINUED DISCUSSION REGARDING

POOLING CONCEPTS

I. CONTINUED DISCUSSION REGARDING POOLING CONCEPTS

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

Utah Public Employee Health Plan

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

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

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

Hawaii Public Employees Health Fund

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

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

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

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

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

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

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

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

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.

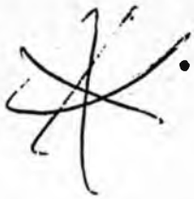
COMMENTS ON SB254

- 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 form a benefit and cost analysis (actuarial study)
   - Outline to sub-groups the impact to their group(s)
   - Select provider payment strategy
4. **Eighth through Twelfth Month**
   - RFP Third party vendors
   - Determine/Evaluate required participation by sub-group or issue warriors
   - Establish final rates/benefit plans for each sub-group
   - Finalize providers payment arrangements
   - Finalize third party vendors arrangements
   - Notify participants

5. Thirteenth through Sixteenth Month (Ongoing)

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

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

NEW MEXICO'S PUBLIC SCHOOL INSURANCE AUTHORITY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COST CONTROLS

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

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

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

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

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

BENEFITS

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

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

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

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

D. An affordable vision care benefit plan was implemented.

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

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

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

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

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

ACKNOWLEDGEMENTS

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

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

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

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

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

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

United States General Accounting Office

GAO

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

April 1988

HEALTH INSURANCE

Risk Pools for the Medically Uninsurable

GAO/HRD-88-66BR

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-230452

April 13, 1988

The Honorable Edward M. Kennedy, Chairman
The Honorable Orrin G. Hatch, Ranking Minority Member
Committee on Labor and Human Resources
United States Senate

This report responds to your March 23, 1987, request concerning state-administered health insurance risk pool programs. You asked that we determine the programs' characteristics, enrollment, and financial experience; the characteristics of the persons they insure; and their success in meeting expectations. We agreed with your offices to focus on the programs in Connecticut, Florida, Indiana, Minnesota, North Dakota, and Wisconsin. These six state programs had been in operation for 3 or more years and, therefore, had sufficient experience to permit analysis. We also obtained information on programs in the other nine states that have more recently enacted risk pool legislation. We obtained oral comments on this report from the Department of Health and Human Services and have incorporated them where appropriate.

Risk pool programs provide health insurance to individuals who cannot obtain it because their health conditions make them unacceptable risks to private insurers. The programs provide comprehensive insurance coverage similar to that of employer-sponsored group health plans. Costs to the insured are relatively high because of generally large deductibles and premiums that are usually 25 to 50 percent more than those paid by individuals with private health insurance.

Despite high premiums, the programs require a subsidy. Two states subsidize their risk pools directly from state revenue, while most of the 15 states that have enacted risk pool legislation assess risk pool deficits against insurers doing business in the state. In the majority of these states, however, insurers may credit their full share of risk pool deficits against state premium or corporate income taxes. Allowing a tax credit results in reduced tax collections and has much the same effect as financing the risk pool from general revenues.

The six programs we reviewed have consistently operated at a loss, paying an average of $1.60 in claims for each dollar of premium income in 1986. According to estimates prepared by the Health Care Financing Administration (HCFA), private insurers nationally paid $0.87 in claims per dollar of premium income during that year.

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.

Thomas Dowdy

for Michael Zimmerman
Senior Associate Director

Contents

ABBREVIATIONS

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

HEALTH INSURANCE: RISK POOLS FOR THE MEDICALLY UNINSURABLE

INTRODUCTION

About 63 percent of the population is covered by health insurance that is related to employment, normally a group insurance plan. Persons not covered by a group plan may purchase an individual plan. When writing an individual policy, insurance companies normally obtain information on the individual's medical condition to assess the risks involved in providing coverage. Occasionally companies either refuse to provide coverage to, or limit coverage for, persons who have chronic medical conditions that are costly to treat. These persons are commonly referred to as the medically uninsurable.

An estimated 37 million Americans lack health insurance coverage. Researchers believe that from 1 to 2 million of these persons cannot obtain insurance because of medical conditions that make them unacceptable risks to private insurers. Researchers also believe that this group is growing because (1) an increasingly competitive insurance market has led insurers to adopt more restrictive health insurance standards; (2) increasing health care costs, and resulting increased insurance premiums, have discouraged some employers from providing group health insurance as an employee benefit; and (3) advances in diagnostic testing have enabled insurers to identify individuals who have potentially costly illnesses.

In the past, Blue Cross and Blue Shield Plans have been a source of insurance for the medically uninsurable. During the 1930s, when the plans pioneered health insurance, all group and individual subscribers paid a uniform rate regardless of their health status. Enrollment in the plans was open to all, and individuals who were at risk of incurring high medical costs benefited because their premiums were subsidized by lower risk individuals. Commercial companies entered the field in the 1940's, and a competitive for-profit health insurance industry developed.

In this competitive environment, Blue Cross and Blue Shield Plans began to base premiums for large group policies wholly or partly on the group's health experience, rather than on the experience of all their subscribers. Therefore, the plans had fewer lower risk individual subscribers to subsidize health care costs for high-risk individuals. Not all Blue Cross and Blue Shield Plans continue to offer individual insurance coverage without regard to health status, referred to as open enrollment. As of October 1987, Plans in 11 states and the District of Columbia offered open enrollment. Appendix I lists the states in which Plans offer open enrollment.

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]

State	Effective date
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

[a]Rhode 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

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

-- the programs' characteristics, including eligibility requirements, covered medical services, deductibles, and coinsurance requirements;

-- the programs' experience concerning enrollment, premium income, claims expenses, and subsidy requirements;

-- enrollees' characteristics, including age, gender, primary illness, and the types and costs of medical services they have received; and

-- the extent to which the programs have met the expectations that led to their creation.

As agreed with the Senators' offices, our review focused on the programs in Connecticut, Florida, Indiana, Minnesota, North Dakota, and Wisconsin. These six state programs had been in operation for 3 or more years and, therefore, had sufficient experience to permit analysis. We also obtained information on programs in the nine other states that have more recently established risk pools.

In the six states, we spoke with and obtained and reviewed appropriate documentation from (1) risk pool program administrators, (2) officials of state insurance departments, and (3) representatives of private groups interested in the programs. For the other nine states, we interviewed and obtained documents from program administrators. We also interviewed representatives of national organizations interested in risk pools. Appendix III lists the groups and organizations we contacted.

To obtain information on program characteristics, we analyzed authorizing legislation, reviewed program administrative policies and procedures, and examined risk pool insurance policies. We compared program characteristics to data on employer-sponsored group insurance plans reported by the Bureau of Labor Statistics (BLS) in its June 1987 Survey of Employee Benefits in Large and Medium Firms, 1986. We discussed program characteristics with program administrators, state insurance department officials, and representatives of private groups interested in risk pools to obtain their views of how program characteristics affect program operations.

To obtain information on the programs' enrollment and financial experience, we analyzed program financial and operating reports prepared by program administrators and state insurance departments. We also discussed enrollment and financial trends with these officials.

To obtain information on the insured, we analyzed reports prepared by program administrators and state insurance departments,

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

legislation in six states provides for self-insured organizations[2] to be association members, U.S. district courts have held that, under the provisions of the Employee Retirement Income Security Act of 1974, employers with self-insured health plans are exempt from state insurance regulation and therefore cannot be required to participate in a risk pool.

The risk pool association manages the program through its governing body, which generally includes health insurance industry officials, state government officials, and consumer representatives. The association recommends premium rates and changes in program benefits within the framework of authorizing legislation. The association contracts with an insurance company to administer the program, issue policies, collect premiums, process claims, and maintain financial records.

State insurance departments oversee program operations--they review and approve program operating plans, premium rates, and changes in program benefits. The departments also review program performance.

Eligibility Requirements

To be eligible for risk pool enrollment, individuals must normally have been rejected for health insurance by one or more insurers. Ten states also grant eligibility to persons who either hold or have been offered a policy with premiums higher than risk pool premiums. Eleven states permit enrollment if an individual was offered a policy that excluded coverage of specific medical conditions. Seven states allow applicants with specified diseases--such as cancer, acquired immunodeficiency syndrome (AIDS), or juvenile diabetes--that generally make it difficult to obtain insurance to enroll without meeting other requirements. Table 2 summarizes the eligibility requirements of the various state programs.

[2]Self-insured organizations directly bear the risk and cost of providing health care coverage rather than purchasing coverage from an insurance company.

Table 2: Eligibility Requirements for State Risk Pool Programs[a]

State	Individuals are eligible if they: Are refused coverage by (number of insurers)	Are offered limited coverage by other insurers	Are offered high premiums by other insurers	Suffer from specified diseases
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

[a]Connecticut 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

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

The programs also protect enrollees from extraordinary medical costs by limiting the out-of-pocket expenses that they must pay during the year. Table 4 shows the out-of-pocket medical expense limits under the state risk pool programs.

Table 4: Out-of-Pocket Medical Expense Limits of State Risk Pool Programs

State	Out-of-pocket limit	
	Individual	Family
Connecticut	$2,000	$4,000
Florida[a]	2,500	5,000
Illinois	1,500	3,000
Indiana[a]	1,000	2,000
Iowa[a]	1,500	3,000
Maine	1,500	3,000
Minnesota	3,000	b
Montana	5,000	b
Nebraska	5,000	b
New Mexico[a]	1,500	2,500
North Dakota	3,000	b
Oregon	c	c
Tennessee[a]	1,500	2,000
Washington[a]	1,500	3,500
Wisconsin	2,000	4,000

[a]The program also offers a higher out-of-pocket limit at a reduced premium.

[b]Limit on out-of-pocket medical expenses is applied "per covered person." No family limit is provided.

[c]As of January 1988, Oregon had not established an out-of-pocket expense limit for its program.

Cost-Sharing and Benefit Limitation Provisions

Risk pool insurance policies contain a number of cost sharing and benefit limitation provisions. These features, which are traditional mechanisms that have long been used in the insurance industry, include

- deductibles, or the amount of covered medical expenses, either for a calendar year or per hospital admission, an enrollee must pay before the plan provides coverage;
- coinsurance, or the fixed percentage or amount of covered medical expenses an enrollee must pay after satisfying deductible requirements;

-- 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

State	Medical expense deductibles for an individual	
	Lowest	Highest
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

[a]As 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

deductible requirements. Nebraska requires a 10-percent coinsurance payment, and, as of January 1988, Oregon had not established a coinsurance percentage. BLS found that group health plans covering 86 percent of employees at large and medium-sized firms also contained a 20-percent coinsurance feature.

Benefit Limitation Provisions

Risk pool insurance policies exclude preexisting medical conditions from coverage for a period of time. Preexisting conditions are those that have been diagnosed or treated during a specified period before the effective date of the policy--referred to as the condition period. Costs of treating preexisting conditions are not covered for a period after the effective date of the policy--referred to as the waiting period. Insurers have traditionally used waiting periods for preexisting conditions to prevent persons in poor health from purchasing insurance only when they plan to seek treatment.

Nine programs will waive or reduce the preexisting condition waiting period if the individual had other insurance in force before enrolling. Two of these states require enrollees requesting a waiver to pay a 10-percent premium surcharge. One state will also reduce the waiting period for enrollees who pay a surcharge, whether they had other insurance or not.

Thirteen state risk pool programs limit the maximum amount in benefits payable during an enrollee's lifetime. The limits were generally similar to those of the group health plans that large and medium-sized employers offer. BLS found that group health plans covering about 43 percent of the employees at large and medium-sized firms were covered by a plan that limited lifetime benefits to $500,000 or less.

Table 6 shows the benefit limitation provisions of the state risk pool programs.

Table 6: Benefit Limitation Provisions of State Risk Pool Programs

State	Preexisting condition provisions: Condition period (months)	Waiting period (months)	Waiver provision	Maximum lifetime benefit
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

[a]Waiting period may be waived or reduced under certain limited circumstances.

[b]Waiting period will be waived if the applicant had other health insurance in force before enrolling in the risk pool.

[c]Waiting period will be reduced if the applicant also pays a premium surcharge.

[d]Waiting 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

cost-containment measures.[3] BLS found that 68 percent of the employees at large and medium-sized firms were covered by a plan that included at least one of the nine cost-containment features.

Like private insurers, risk pool programs include cost-containment features in their insurance policies. Eight of the state programs have implemented one or more of the provisions covered in the BLS survey. The most common provision, a requirement that decisions to hospitalize enrollees be reviewed by the program administrator, has been adopted by seven states. Three states require enrollees to obtain a second opinion before nonemergency surgery, three states require enrollees to use generic rather than more expensive brand-name drugs, and three states require that routine laboratory tests before hospitalization be performed on an outpatient basis.

Risk Pool Premiums

The basis for setting risk pool insurance premiums is normally prescribed in authorizing legislation. Premiums are usually established based on the rates charged for private health insurance in the state and vary based on age and, sometimes, sex and geographic area. The legislation generally provides for premiums to be adequate to cover anticipated claims expenses, but it limits rates to a multiple of the rates charged by private insurers. Legislation in 12 states provides for multiples between 125 and 150 percent. Three states provide for higher multiple limits, including Montana, which provides a 400-percent limit. Program administrators in the six states we reviewed survey private insurers to determine the average rates they charge for health insurance as a basis for setting risk pool rates. Table 7 shows the rate limits and examples of premiums charged in the six states reviewed.

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[3]The cost containment measures covered in the BLS survey included (1) incentives to encourage a second surgical opinion before nonemergency surgery, (2) incentives to encourage use of outpatient surgery, (3) incentives to use generic rather than more expensive brand-name drugs, (4) limits on reimbursement for nonemergency weekend hospital admissions, (5) separate deductibles for hospital admissions, (6) incentives to have routine laboratory tests done on an outpatient basis before hospitalization, (7) higher payment for delivery at a birthing center, (8) incentives to audit the hospital's statement, and (9) preadmission certification requirements.

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 Male	40-year-old Female	55-year-old Male	55-year-old 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	1,764	1,660

[a]Based 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 income[4] 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.

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

As stated earlier, legislation in six states provides for self-insured organizations to be risk pool association members. The courts, however, have held that because employers with self-insured health plans are exempt from state insurance regulation under the Employee Retirement Income Security Act of 1974, they cannot be required to participate in risk pools.

Insurance industry officials and program administrators in the states we reviewed believed that exempting self-insured organizations from risk pool participation can unfairly increase the burden on persons who obtain private insurance from risk pool association members. Even in states where tax credits relieve insurers from subsidizing risk pools, officials were concerned because of the possibility of the tax credit being repealed. Minnesota, for example, repealed its tax credit provision in 1987.

RISK POOL ENROLLMENT AND FINANCIAL EXPERIENCE

In five of the six programs we reviewed, enrollment has increased since 1983. For the six programs, total enrollment increased 48 percent to 20,545 persons. However, the Minnesota risk pool, with 10,842 insured, has 53 percent of the six-state total.

The risk pools in the six states have consistently operated at a loss. In 1986 the programs paid an average of $1.60 in claims for each dollar of premium income. According to estimates prepared by HCFA, private insurers nationally paid about $0.87 in claims per dollar of premium income during the same period. To date, however, assessments to risk pool association members in the three states that do not permit tax credits have been modest when compared to the total volume of insurance business in the states.

State officials have found that often a conflict exists between the objectives of (1) increasing enrollment by enhancing the attractiveness of the risk pool plan and (2) reducing deficits through higher premiums or reduced coverage.

Enrollment

Enrollment in risk pool programs has increased since 1983, but growth in the programs has not been uniform. Between the end of 1983 (the first year all six were offering policies) and the end of 1986, the number of insured grew from 13,842 to 20,545.[5] About half of the insured at the end of 1986 were in Minnesota. Two newer programs, those in Florida and North Dakota, experienced

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[5]The number of policies in force is virtually equivalent to the number of insured persons, according to program officials, since almost all risk pool policies are for individuals rather than families.

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

State	Policies in force as of December 31, 1983	Policies in force as of December 31, 1986	Change (percent)
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	1,798	2,075	15
Total	13,842	20,545	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.

Table 9: Comparison of Risk Pool Deficits for Calendar Years 1983 and 1986

State	Deficit or (surplus) 1983	1986	Change (percent)
Connecticut	$508,721	$885,375	74
Florida	(6,276)[a]	681,157	[b]
Indiana	177,657	5,160,982	2,805
Minnesota	3,972,634	9,024,228	127
North Dakota	230,896	1,633,219	607
Wisconsin	1,609,052	678,806	-58
Total	$6,492,684	$18,063,767	178

[a]The Florida risk pool was in operation only during the last 4 months of 1983 and, according to program officials, had a surplus primarily because of the 12-month waiting period for coverage of preexisting medical conditions.

[b]Percentage change not calculated.

From calendar year 1983 to calendar year 1986, premium income for the six programs increased by 178 percent, while claims expense increased by 190 percent. Meanwhile, the loss ratio--the ratio of claims expenses to premium income--increased from $1.54 in claims per dollar of income in 1983 to $1.60 in 1986. In comparison, the loss ratio for health insurers nationally, according to HCFA estimates, was $0.87 per dollar of premium income during 1986. Table 10 shows the loss ratios for the six states for calendar years 1983-86.

Table 10: Risk Pool Loss Ratios for Calendar Years 1983-86

State	Claims paid per dollar of premium income 1983	1984	1985	1986
Connecticut	$1.10	$1.28	$1.39	$1.19
Florida	[a]	0.28	1.79	1.25
Indiana	0.83	1.56	1.30	1.70
Minnesota	1.87	1.65	1.49	1.76
North Dakota	2.49	2.32	1.91	2.17
Wisconsin	3.02	2.07	1.35	1.19

[a]The Florida risk pool was in operation only during the last 4 months of 1983 and, according to the pool's audited financial statements, did not incur claims expense during the period.

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

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

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.

Program Features That Have Affected Operations

Officials in the six states have adjusted program requirements and benefits to achieve two sometimes conflicting objectives--increasing enrollment and controlling costs. Efforts to make the programs more attractive to potential enrollees, mainly involving improved benefits, tend to increase operating losses. Program officials have found that, in particular, reductions in and waivers of preexisting condition waiting periods contribute to increased program losses. However, when program administrators have attempted to control costs through premium increases and benefit restrictions, enrollment has either decreased or increased at a lower rate.

State program officials have not made a detailed analysis of how various changes have affected program operations. According to officials, many factors affect the operations of a risk pool, and it is difficult to isolate the impact of a change or event from the impact of the other factors. Nonetheless, program officials told us that the programs' enrollment history and fiscal experience can provide insight into the impact policy changes are likely to have on program operations.

Efforts to Increase Enrollment

Minnesota has the largest enrollment of the six risk pool programs reviewed, and that enrollment has grown steadily since 1983. Minnesota law limits risk pool premium rates to 125 percent of comparable private insurance rates. However, despite significant loss increases, the state insurance department has not authorized an increase in premium rates since 1985 even though the law would have permitted it. As a result, the program has the lowest premium rates of the six programs reviewed.

Wisconsin has taken several steps to boost enrollment. In 1985 it implemented a program, financed by state revenues, to subsidize risk pool premiums for low-income individuals. Persons with a household income of less than $16,500 are eligible for the premium subsidy, which varies with income. Table 12 shows the percentage of premium subsidies and the number of policyholders assisted as of December 31, 1986.

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

Household income	Subsidy as a percentage of premium	Number of policies
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		599

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 expen. The state has since terminated this waiver provision.

Efforts to Control Costs

The Connecticut program experienced sharply increased losses in part due to court action that required the program to provide unlimited coverage for mental and nervous conditions. To moderate losses, Connecticut increased premiums and doubled both deductibles and out-of-pocket expense limits for enrollees in 1985. Enrollment declined by about 20 percent between December 31, 1984, and December 31, 1985. Program officials identified the changes as a major factor in the enrollment decline. The state's robust economy and federal legislation extending health benefits to laid-off workers also contributed to the decline, according to the officials.

In 1983, Wisconsin took various steps to reduce risk pool losses. It raised the limit on risk pool premiums from 130 to 150 percent of comparable private premiums, extended the waiting period for coverage of preexisting medical conditions from 30 days to 6 months, and increased the enrollee's liability for out-of-pocket medical expenses from $1,500 to $2,000. Growth in program participation has been modest, despite the previously noted premium subsidies provided to low-income enrollees.

To reduce losses that occurred as a result of waiving the waiting period for coverage of preexisting medical conditions, Indiana increased base premiums significantly and, in January 1986, increased the waiver surcharge from 10 to 25 percent. Despite this action, losses continued to increase. Program officials believe that the higher premiums resulted in only those with the most costly health conditions enrolling or continuing their enrollment. Average claims paid per policyholder were $3,713 in 1986, the highest of the six programs reviewed. Program officials believe that enrollees paid the higher premiums and the 25-percent waiver surcharge because they had an immediate need for medical care. Indiana has since eliminated the waiver provision.

ENROLLEE CHARACTERISTICS

Risk pool enrollees are most likely to be middle aged. The limited data available suggest that enrollees incur higher medical costs generally and incur higher costs for heart and circulatory diseases, cancer, and diabetes specifically than does the population at large. State officials are concerned about, but have little information on, the potential cost impact on their programs concerning the treatment of AIDS patients.

Researchers who have studied risk pools believe that from 0.5 to 1 percent of the population is medically uninsurable. Their estimates, however, are rough approximations, not supported by detailed research on the size and demographic makeup of this population.

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]

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

[a]The 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

-- 61 percent were not employed, and 13 percent were employed part time; and

-- 88 percent of those who were employed worked for firms employing 25 or fewer people--firms less likely to provide group health insurance.

Cost and Nature of Medical Services Used

The six states we reviewed did not gather consistent data on the health care costs risk pool enrollees incur. Available information on medical expense reimbursements made to enrollees, however, indicates that the costs they incur are higher than those of the average person. Table 14 presents 1986 claims expenses per policyholder, based on the average number of policies outstanding for the year in the six states. The states did not maintain consistent data on claims expenses per insured person, and these figures may slightly overstate average annual expenses for an individual to the extent that more than one person was insured under a policy.

Table 14: Average 1986 Claims Expenses per Policyholder for State Risk Pool Programs

State	Average claims expense per policyholder
Connecticut	$1,742
Florida	2,504
Indiana	3,713
Minnesota	1,804
North Dakota	2,495
Wisconsin	1,555

As the table shows, average claims expense per policyholder, not including deductible and coinsurance expenses paid by the policyholder, varied considerably. The weighted average for the six states was $2,140. In comparison, according to estimates prepared by the Department of Health and Human Services, per capita health care expenses, including deductible and coinsurance payments, averaged about $1,620 nationally in 1986.

Three states have gathered information on the conditions that enrollees suffer from, and one state has gathered information on the conditions that made it difficult for them to obtain insurance in the private market. The company that administers the Florida, Indiana, and Wisconsin programs summarizes claims expenses by the health conditions that led enrollees to seek treatment. These data indicate that enrollees in these states incur more expenses for the

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

	Percent of claims expenses paid			
Medical condition	Company average	Florida	Indiana	Wisconsin
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.

HAVE THE PROGRAMS MET EXPECTATIONS?

The six states we reviewed have not formally assessed risk pool program performance. Risk pool legislation emerged in response to a perception that opportunities to purchase health insurance were decreasing for persons with serious health problems. According to state officials and insurance industry representatives, the legislation generally was a compromise response to other approaches that would have required all insurers to offer open enrollment. Legislators concluded that the risk pool would distribute the burden of persons with chronic or costly medical conditions among insurers more equitably. Legislation authorizing the risk pools did not establish specific goals but rather contained general statements about assisting the medically uninsurable. Legislative histories of the programs generally offered limited insight into what legislators expected the programs to accomplish.

The information that would be needed to evaluate program performance generally has not been developed. Officials in the six states reviewed have not estimated the size of the medically uninsurable population in their states. Consequently, program officials do not know what portion of this population their programs serve. Further, the states generally do not compile information on the makeup of the enrollee population. As a result, program officials do not know which population segments find the programs most attractive or, more importantly, which segments to target in order to bring coverage to those in need. Officials in the six states reviewed generally believe that their programs are not serving all the medically uninsurable in their states.

SUMMARY

Risk pools provide subsidized health insurance to that segment of the uninsured population that cannot obtain it because of poor health. The six programs that we reviewed have assisted a limited number of persons. As of February 1988, conclusive evidence to show that risk pools are or are not effective, and data that would allow comparison of risk pools to other mechanisms for financing health care for the uninsured, had not been developed.

APPENDIX I

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

APPENDIX II

STATES THAT CONSIDERED, BUT DID NOT ENACT, LEGISLATION AUTHORIZING A RISK POOL DURING 1987

Alaska
California
Georgia
Mississippi
Missouri
New York
Ohio
South Carolina
South Dakota
Texas
Vermont
West Virginia

APPENDIX III

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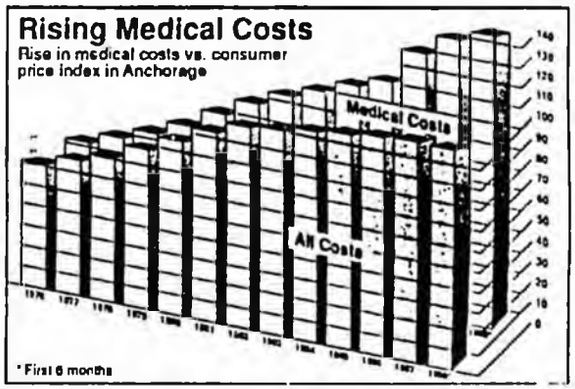
■ **MONEY MARKETS:** Weekly listings / B-4 ■ **MALLWATCH:** Merchants join forces / B-5 ■ **PLASTIC POWER:** Holiday bills / B-6

BUSINESS

SUNDAY
SECTION B Jan. 22, 1989

Health insurance costs rise feverishly

Workers at a loss as employers cut back on benefits



By HAL BERNTON
Daily News reporter

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

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

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

Anchorage Daily News/Jon Lasseter

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

[illegible] don't get [illegible]

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

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

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

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

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

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

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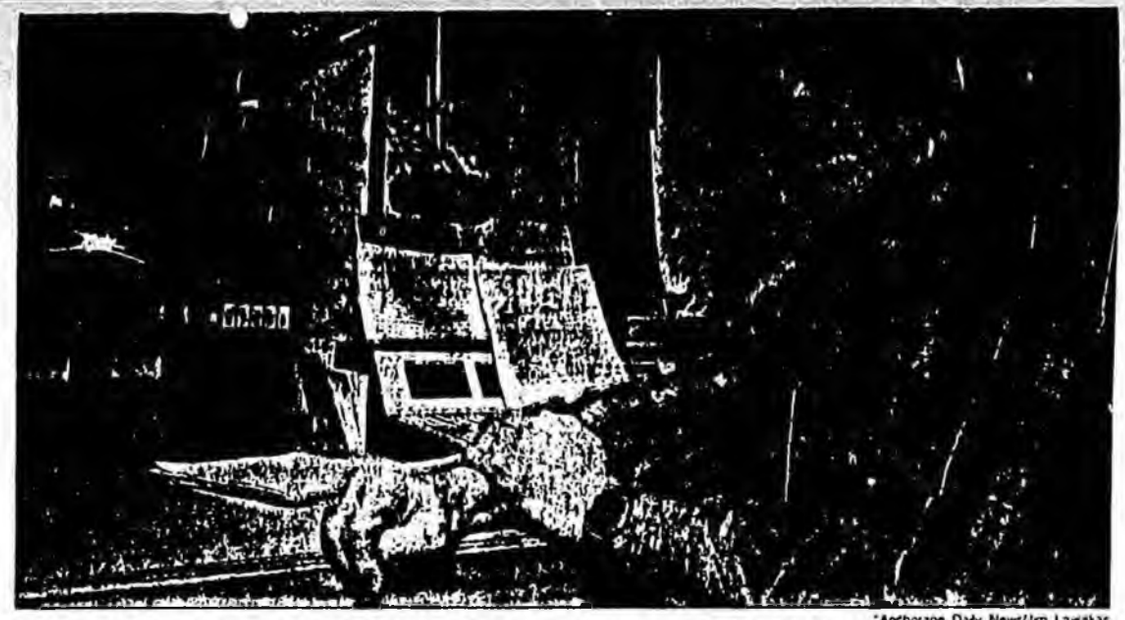
Snow fell back on a Veterans Administration policy to cover his own ailments but he also needed a family policy for his wife and two teen-age children. He found Jennifer's heart condition drove the cost of that policy out of sight. "My family has nothing," Snow says. "If we have a catastrophic accident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

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

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

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

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



*Anchorage Daily News/Jim Lavrakas

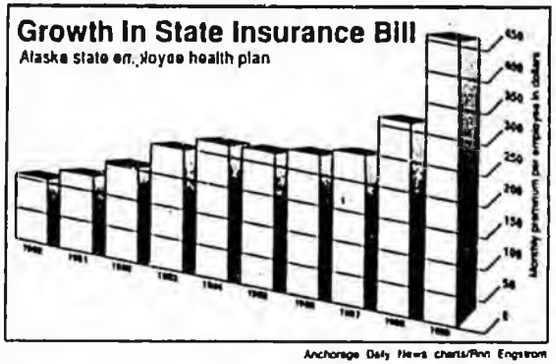
Disc jockey Lester Snow was left scrambling when his employer was forced to drop health benefits for employees.

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

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

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

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



Anchorage Daily News charts/Ann Engstrom

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

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

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

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

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

But Alaska Commercial is the exception, not the norm.

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

And some increases top

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

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

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

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

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

□

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

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

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

Please see Page B-3, HEALTH

Harvard MBAs take ethics to heart

By PAUL WILKES
The New York Times

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

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

Office space market closes in on recovery

The latest office space market study documents the

HEALTH INSURANCE: Employers cut benefits in face of rising costs

Continued from Page B-1

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

□

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Such plans were first introduced to Anchorage in the mid '80s, and as rates rise, their appeal grows, both to employers and employees.

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

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

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

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

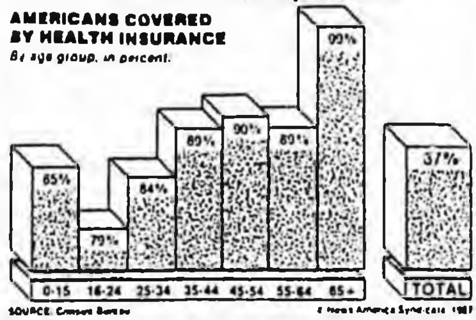
Non-union railroad employees chose to sign up for the preferred plan, but union workers opted against it. Then this year, facing another 32 percent increase, the unions decided to go with the preferred option.

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

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

Most Americans have health insurance

Most Americans – 87 percent – have private or government health insurance. By age group, 99 percent of those 65 years and older are covered, compared to 79 percent of those aged 16-24 years



Infographics

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

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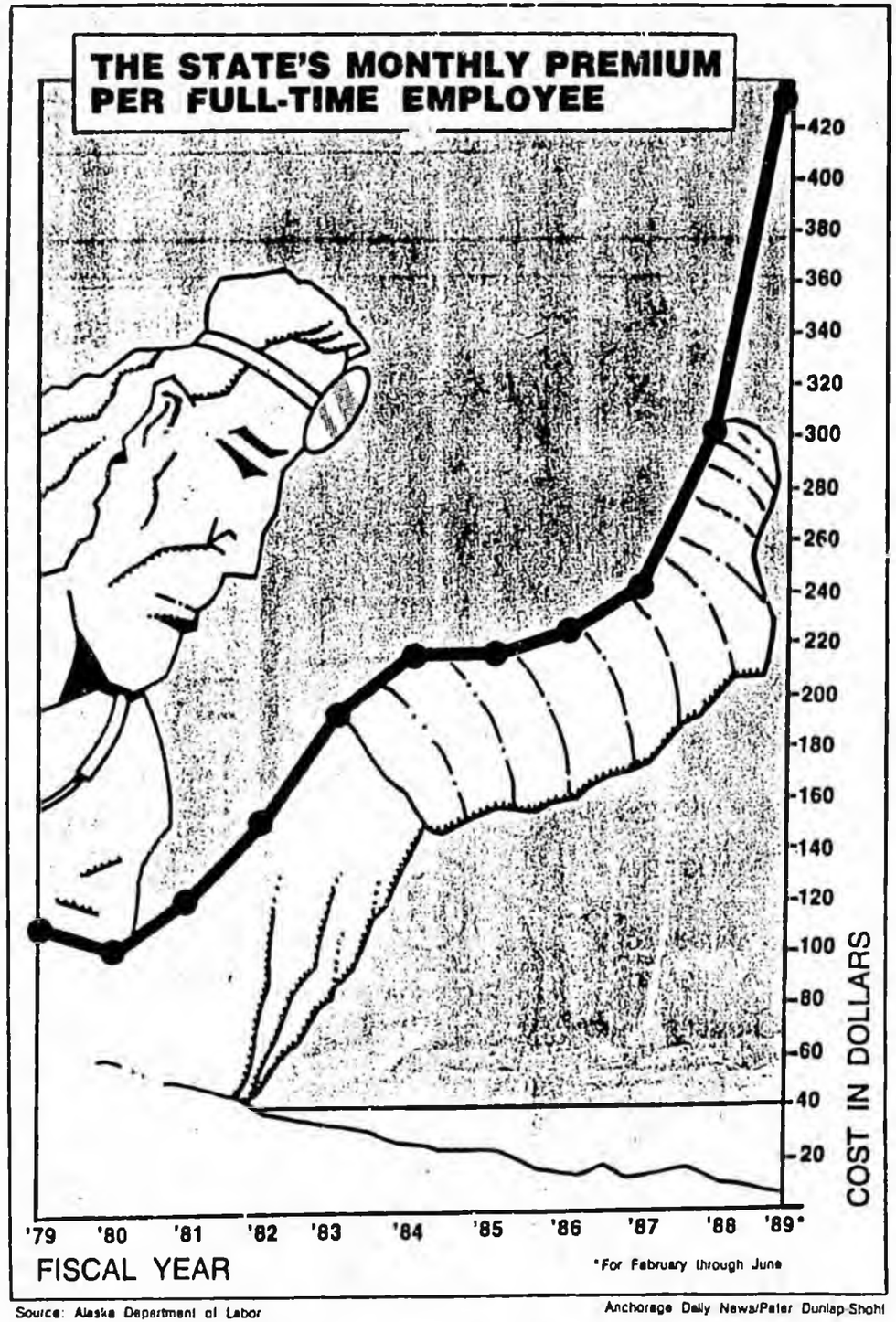
ANCHORAGE, ALASKA, WEDNESDAY, FEBRUARY 15, 1989 PRICE 25 CENTS

Anch Daily News



State health insurance: $104 million

Cowper seeks more money for state workers' coverage

By DAVID POSTMAN
Daily News reporter

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

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

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

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

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

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

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

All full-time employees, including legislators, are

Please see Back Page, **INSURANCE**

INSURANCE: For state workers

Continued from Page A-1

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

Under the policy, Taylor said:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3/29/90
SFC

Anchorage, Alaska
March 22, 1990

Memorandum

To: Larry Houle

From: Director, Personnel

Subject: SB254 - An Act Relating to the State Insurance Authority

Per your request for a position paper on this bill, the ARRC opposes this bill for the following reasons:

- The ARRC has its own health care program which seems to work well at this time.
- To help control costs, the management and union have established a cost containment committee to deal with plan changes to cut costs.
- The ARTA requires the railroad to be in a position to sell the ARRC. The health plan should remain separate from the state's for this purpose.
- The ARRC is not included in state personnel plans under AS39; the health care plan should not be either.
- Pursuant to AS42.20.010, the ARRC is a state instrumentality which has a legal existence independent and separate from the state. The health and life insurance plans should also be separate.

If you need any additional information, please let me know.

Ronald W. Stocker

(WPPER1/11)

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: SB 254
PUBLISH DATE: _____

FISCAL NOTE

REQUEST: _____

Revision Date: _____
Title: Group Health Insurance

Agency Affected: Education
BRU: _____

Sponsor: Duncan
Requestor: Duncan

Components: _____

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

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

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

The increased cost to the Department of Education for health coverage of part time employees cannot be anticipated at this time. Any increase or decrease in cost to school districts must be absorbed within local districts budgets.

Prepared by: Mary Hakala
Division: Commissioner's Office
Phone: 465-2800
Date: 1/29/90

Approved by Commissioner: William G. Demmert
Agency: Education
Date: 1/29/90

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

This fiscal note did not accompany the bill.

Bill does not relate to nor impact DOE

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: ____________
PUBLISH DATE: ____________

FISCAL NOTE

REQUEST:

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

Agency Affected: Admin
BRU: [illegible]
Components: [illegible]

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	[illegible]	129.6				
TRAVEL	52.0	52.0				
CONTRACTUAL	[illegible]	[illegible]				
SUPPLIES	[illegible]	[illegible]				
EQUIPMENT	33.3	0				
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING						
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND	528.[illegible]	485.5				
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

3/29/90

Draft FN submitted by DOA by Mike Coughlin. No formal FN submitted, per Senator Duncan

Prepared by ____________ Phone: ____________
Division: ____________ Date: ____________

Approved by Commissioner: ____________ Date: ____________
Agency: ____________

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

page ___ of ___

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

DRAFT

Analysis: This bill creates the Alaska State Group Health Insurance Authority in the Department of Administration. The authority, using appropriate staff and contractual services, would establish and maintain a statewide provider payment system, rate schedules and utilization standards by 2/1/92. Various public entities would be required to implement these in their group insurance plans.

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

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

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

Personal Services

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

DRAFT

Travel

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

$400 X 15 X 7 =		$42.0

Administrative travel for Director:

Board Meetings	$400 X 7 =	2.8
Organizational meetings	$600 X 12=	7.2

Total Travel **$52.0**

Contractual

Office Space--500 sq. ft. @$1.75 X 11 mos.	$9.6
Telephone--$300 X 11 mos.	3.3
Courier services--$200 X 11 mos.	2.2
Postage--$500 X 11 mos.	5.5
Advertising and Printing	10.0
Professional Services Contract(s) which could include:	280.0

* carrier surveys and analysis
* provider data collection
* provider meetings
* rate studies and analyses
* financial consulting
* self vs fully insured analyses
* development of plan design

Total Contractual Services **$310.6**

Supplies:

$500 per employee	$1.5
Software	1.8

Total Supplies **$3.3**

DRAFT

Equipment:

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

STATE OF ALASKA
1990 LEGISLATIVE SESSION

Bill Version: CSSB 254 (SA) (b)
Publish Date: 3/12/90

FISCAL NOTE

REQUEST:

Revision Date:
Title: An Act relating to group health insurance
Sponsor: Duncan
Requestor: Sen. State Affairs

Agency Affected: Administration
BRU: Retirement and Benefits
Components: Retirement and Benefits

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

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

POSITIONS:

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

ANALYSIS: (Attach a separate page if necessary)

Based on assumptions outlined on page 2, it is estimated that there will be no increase to either the operating expense of the division or the group insurance premiums for the State of Alaska.

Prepared by: Sally Smith for Mike Coughlin
Division: Retirement and Benefits
Phone: 465-4460
Date: 1/29/90

Approved by Commissioner: Frank S. Baxter
Agency: Department of Administration
Date: 1/30/90

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

Changes in CSSB 254 (SA) have no fiscal impact. This fiscal note is appropriate.

Rev. 1/88

Senate Bill 254
Analysis of the Fiscal Implications for Employee Benefits
Prepared by the Division of Retirement and Benefits
Department of Administration

Analysis: This bill would create the Alaska State Group Health Insurance Authority. The Authority would be required to purchase group insurance for the State of Alaska, municipalities and school districts. Unless granted a waiver, all entities must purchase their group insurance benefits through the Authority. The State would not be allowed a waiver. It is understood the intent of the bill is to create economies of scale and provide low cost group insurance for public organizations throughout the state.

With this purpose in mind, it is estimated that the State of Alaska would not suffer any increase in premiums as a result of this bill based on the following assumptions:

1. that the level of benefits offered by the authority would be no greater than that offered by the State of Alaska now;

2. that each entity would be separately underwritten and the State of Alaska would not be subsidizing higher costs of other, smaller employers;

3. that the administrative costs in support of the Authority would not increase the current overall premium costs;

4. that the administrative and premium costs would be borne equally by each employer and not allocated by employee numbers;

5. that the Authority's selected claims payor would perform as favorably (e.g. financial accounting) as the State's current arrangement; and

6. that staff costs, whether contracted out or through additional State employees, will be borne by the Authority.

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: CSSB 254 (SA) (a)
PUBLISH DATE: 3/12/90

FISCAL NOTE

REQUEST:

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

Agency Affected: Commerce & Economic Dev.
BRU: Alaska State Group Health Insurance Authority
Components:

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	141.9	141.9				
TRAVEL	50.4	50.4				
CONTRACTUAL	283.1	283.1				
SUPPLIES	4.5	4.5				
EQUIPMENT	32.0					
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	511.9	479.9	*	*	*	*
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND	511.9	479.9				
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

FULL-TIME	3.0	3.0				
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

*Given the nature of this organization, it is not possible to predict the costs for the subsequent fiscal years.

Prepared by: Guy Bell, Director
Division: Administrative Services
Phone: 465-2505
Date: 3/5/90

Approved by Commissioner: Larry Merculieff
Agency: Department of Commerce & Economic Development
Date: 3/5/90

Distribution (by preparer):
Legislative Finance
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64080-1/3590a

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

Personal Services:

Executive Director	24A	$73.2	
Administrative Assistant II	14A	39.3	
Clerk Typist III	8B	29.4	
Total Personal Services			$141.9

Travel:

Assume board meetings every two months for 17 board members at an average cost of $400 per trip.

$400 x 17 x 6 = $40.8

Staff travel for Executive Director:

Board meetings	$400 x 6	$2.4	
One meeting per month	$600 x 12	$7.2	
Total Travel			$ 50.4

Contractual:

Office Space - 500 sq. ft. @ $1.75 x 12 months	$10.5	
Telephone - $300 x 12 months	3.6	
Courier Services - $250 x 12 months	3.0	
Postage - $500 x 12 months	6.0	
Advertising and Printing	10.0	
Professional Services Contract(s) which may include:	250.0	
- Assessment of insurance availability and affordability		
- Rate studies		
- Financial Advisor		
- Options analysis		
Total Contractual Services		$283.1

Supplies:

$1,000 per employee	$3.0	
Software	1.5	
Total Supply		$ 4.5

Equipment:

3 PC's and a printer	$15.0
3 bookcases with 3 shelves @ $120	.4
3 file cabinets/5 drawers legal @ $525	1.6
Management Workstation	4.0
Technician Workstation	2.5
Support Workstation	2.5
Phone system	1.0
1 calculator desk	.5
1 chair, executive swivel with arms	.4
2 chair posture tilt with arms @ $425	.9
2 side chairs @ $275	.6
Photocopier	2.0
Telecopier	.6
Total Equipment	$ 32.0

STATE OF ALASKA
1990 LEGISLATIVE SESSION

Bill Version: SB 254 (b)
Publish Date: 3/12/90

FISCAL NOTE

REQUEST:

Revision Date:
Title: An Act relating to group health insurance
Sponsor: Duncan
Requestor: Sen. State Affairs

Agency Affected: Administration
BRU: Retirement and Benefits
Components: Retirement and Benefits

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

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

POSITIONS:

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

ANALYSIS: (Attach a separate page if necessary)

Based on assumptions outlined on page 2, it is estimated that there will be no increase to either the operating expense of the division or the group insurance premiums for the State of Alaska.

Prepared by: Sally Smith for Mike Coughlin
Phone: 465-4460
Division: Retirement and Benefits
Date: 1/29/90

Approved by Commissioner: Frank S. Baxter
Date: 1/30/90
Agency: Department of Administration

Distribution (by preparer):
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Legislative Sponsor
Requestor
Office of Management and Budget
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Rev: 11/89

Senate Bill 254
Analysis of the Fiscal Implications for Employee Benefits
Prepared by the Division of Retirement and Benefits
Department of Administration

Analysis: This bill would create the Alaska State Group Health Insurance Authority. The Authority would be required to purchase group insurance for the State of Alaska, municipalities and school districts. Unless granted a waiver, all entities must purchase their group insurance benefits through the Authority. The State would not be allowed a waiver. It is understood the intent of the bill is to create economies of scale and provide low cost group insurance for public organizations throughout the state.

With this purpose in mind, it is estimated that the State of Alaska would not suffer any increase in premiums as a result of this bill based on the following assumptions:

1. that the level of benefits offered by the authority would be no greater than that offered by the State of Alaska now;

2. that each entity would be separately underwritten and the State of Alaska would not be subsidizing higher costs of other, smaller employers;

3. that the administrative costs in support of the Authority would not increase the current overall premium costs;

4. that the administrative and premium costs would be borne equally by each employer and not allocated by employee numbers;

5. that the Authority's selected claims payor would perform as favorably (e.g. financial accounting) as the State's current arrangement; and

6. that staff costs, whether contracted out or through additional State employees, will be borne by the Authority.

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: SB 254 (a)
PUBLISH DATE: 3/12/90

FISCAL NOTE

REQUEST:

Revision Date:
Title: Regarding Group Health Insurance

Agency Affected: Commerce & Economic Dev.
BRU: Insurance

Sponsor: Senator Duncan
Requestor: Senate State Affairs

Components:

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

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

POSITIONS:

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

ANALYSIS: (Attach a separate page if necessary) No fiscal impact for FY 90.

Prepared by: James J. Jordan, Acting Director
Division: Insurance
Phone: 465-2515
Date: 1/26/90

Approved by Commissioner: Larry Merculieff
Agency: Department of Commerce & Economic Development
Date: 1/29/90

Distribution (by preparer):
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LW/dg16208D/12990a