SB

254

SENATE STATE AFFAIRS COMMITTEE

BILL NUMBER SB 254

SPONSOR Duncan_Dale

BILL TITLE Group health insurance

DATE REFERRED 3-31-89

HEARING SCHEDULED

FISCAL NOTE PREPARED - Guy Bell_2505

SPONSOR CONTACTED - DUNCAN REQUESTED. (1 31 90 Hearing)

INTERESTED PARTIES CONTACTED

- ✓ Reed Staops_463-3223 Address
- ✓ Jeff Malek_ (of Arthur Gallagher Co) Contact
- Admin: / Mike Coughlin_4470
- Commerce: Linda Wild
  HESS_Jay Livey_3030...
  DOE:
- ✓ UofA: Wendy Redman: (Baronof) 474-7582 (Fax 474-7570)
  OAC: Fran Toland
- Barbara Huff: (FAX 337-6668) # 269-4236
- Scott Burgess: AK. Muni League_ 586-1325
- NEA_Bob Manner 586-3090

OTHER

Fiscal Notes:

- ✓ Commerce. Linda Wild
- ✓ Admin: Sioux Plummer_2200_Mike
- ✓ HLESS: Jay Livey -3030
- ✓ DOE: Steve Hole
- ✓ University: John Rogh_ left message
  Wendy Redman: 474-7582

STATE OF ALASKA
THE LEGISLATURE

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

LEGISLATIVE AFFAIRS AGENCY

LEGISLATIVE REFERENCE LIBRARY

Copies of minutes listed below were originally included in this file. The minutes are available on the STAIRS database CMPR. In order to save space copies of minutes have not been left in the files.

Mary Van Nimwegen

SB 254

Senate State Affairs 1/31/90

SB 254.txt FRIDAY, MARCH 2

Proposed CS for SB 254, Duncan, GROUP HEALTH INSURANCE

TELECONFERENCE; Anchorage, Fairbanks, others welcome.

TO TESTIFY;

Senator Duncan
Jeff Malek: Arthur J. Gallagher Co./Health Care Cost Containment Consultant
Bruce Cummings: Director, Labor Relations
Michelle Castanedo: ASEA
Bob Stalnaker: Division of Retirement and Benefits

NOTIFIED; *indicates would like to testify

Wendy Redmond: University faxed CS
Reed Stoops: Aetna lobbyist delivered CS
Scott Burgess: Municipal League Mailed CS
NEA: Bob Manners, Mailed CS
School Board Association
Division of Insurance:

HESS: Jay Livey
DOE: Steve Hole

NOTES;

*The CS is structured on the Phase-In concept which reflects both the Health Care Cost Containment Task Force recommendations to set rate schedules and utilization standards prior to providing health insurance and committee concerns on researching the state's ability to negotiate discounted rates, provider payment system in both rural and urban areas and requires a report to Legislature prior to providing health insurance.
It also contains the statement of intent that nothing in this act affects collective bargaining; HOWEVER, LANGUAGE REFERS TO PAST AGREEMENTS. SEE PROPOSED AMENDMENT, Yellow page.

1. In the Bill Analysis by Jim Jordan, Division of Insurance, they recommend that the Group Health Authority be created within another title other than Title 21. He sees conflict in mixing purchasing with regulating. Response: Neither Legal nor Duncans' office can suggest a better title in that it is important not to override current insurance statutes.

concern: becomes "self regulating"

2. Division of Insurance also recommends that Sec. 21.77.030 (Page 3, Line 12) GENERAL POWERS, needs clarification so as to exempt the Group Health Authority from having to be formed and licensed as an insurer. If the intent is to allow the Authority to act as the administrator for self-insured plans sponsored by the state, municipalities and school districts, then this section should be amended to reflect that. Jeff Malek agrees with this revision. Response: Dealt with in CS, Page 4, beginning Line 8 states option to purchase or provide.

3. Jeff Malek recommends that Sec. 21.77.050 be revised to allow RFP notification process. Response: Dealt with in CS Page 4, beginning Line 15.

4. Jeff Malek recommends that Sec. 21.77.070 (Page 4, Line 27) be revised to allow the pool to access members and/or issue bonds to fund benefits or establish reserves. Response: Not included in CS as unnecessary at this time. Could be added to Purpose section as task for authority to determine. SEE AMENDMENT #2, yellow page.

5. Self-Insurance issue, Jeff Livey of HESS states that the only advantage is if the state actively manages health care costs or contracts with a company to actively manage. No response as no track record.

CS SB 254 PROPOSED AMENDMENTS;

AMENDMENT 1:
Page 7, Lines 11,12 amended to read:

*Sec. 7. Nothing in this Act affects a contract or collective bargaining agreement. (in effect on the effective date of this Act)

AMENDMENT 2:
Add language Page 2, Starting line 5 (Under Section 1. Purpose)
(9) Determine the need for the Authority to have access to members and/or issue bonds to fund benefits or to establish reserves.

Alaska State Legislature

SENATOR JIM DUNCAN

P. O. BOX V JUNEAU, ALASKA 99811-3100

(907) 465-4766

COMMITTEES:
FINANCE
VICE CHAIR – HEALTH EDUCATION & SOCIAL SERVICES
BUDGET & AUDIT
BANKING & ECONOMIC DEVELOPMENT

M E M O R A N D U M

TO: Senator Pat Pourchot
Chairman, Senate State Affairs Committee

FROM: Senator Jim Duncan

DATE: January 9, 1990

SUBJECT: Hearing schedule for SB 254 "An Act relating to group health insurance; and providing for and effective date."

I would like to have a hearing scheduled for Senate Bill 254 to be brought before your committee at your on Wednesday, January 31, 1990. The reason for requesting a specific date is to provide an opportunity for the Health Care Cost Containment Task Force consultant to testify to the committee. Jeff Malek of Arthur J. Gallagher and Company of San Francisco scheduled to be in Juneau on that date for another meeting. I believe his testimony is very important as we begin considering the legislation.

Please let me know if I can provide you with any additional information that may be necessary to get SB 254 scheduled for a hearing before your committee on January 31.

SB 343 _ March 31st window

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

POUCH Y STATE CAPITOL
JUNEAU ALASKA 99811
907 465 3800

MEMORANDUM February 12, 1990

SUBJECT: Group health insurance - CSSB 254( )

TO: Senator Jim Duncan

FROM: Michael F. Ford
Legislative Counsel

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

Please contact me if you have further questions.

MFF:pl
WKP2/031

Enclosure

1.31.90 STATE AFFAIRS

EO's NO COMMENT

SB 5 Kelly Grandfather comment

SB 254

Duncan:
300 m/l FY 89 Health Costs
Increase of 98% in 5 years
Health care Cost Containment

Add
Medicaid / Workman's Comp
Phase IN Authority Responsibilities
GET LANGUAGE OF PHASE
(passed out)
REVISE BOARD MAKE-UP handed out at hearing

PAT: Could it include non-governmental groups
Response: Possible options.

Malek:
Rural NEEDS/URBAN NEEDS
Problem • Purchase System vs Delivery System
Est 134,000 est. in Alaska.
• 5% saving at a minimum

Malek

Phase 1 _ create the vehicle

- How do we fund an authority?

LINN Baker

Focus

Provider _ good record
Price _ good price

Group

11% less than traditional program, Utah has proven that they have given business to hospital, thus able to negotiate lower price

KELLY Unions?

Baker response: None in plan _ No collective bargaining public employee unit in Utah.

Kelly: Employer contribution?

Baker: was 80% - 20% ← employee
now 90% - 10%

Pat: Numbers? State/Local

Resp: 23,000 Active 3,500 Retired - 65
4000 + 65

Kelly: Does Utah self-insure

Resp: Yes _ pay all claims _ do not reinsure with other carrier.
5 Risk Pools.

Kelly: How many / much to administer

Rasp. 3 to 5 emps (or) 35 employees.
3½% cost of premium

Dept. of Admw: Bruce Cunnings
Interested
Concerns as originally proposed.
A. Collective Bargaining — is an insurance policy a negotiable item under Pool concept.
B. Labor Union Trusts — Pooling Trust SB 254 may exclude joining trust

Div. of R;B: Mike Coughlin
Supports
O Fiscal Note based on assumptions (noted in fiscal note)
1. No operating increase to division.

Pat: COST SAVINGS?
Response: doubts whether larger group will incur cost savings.
State has had trouble negotiating discounted program.
SHORT TERM SAVINGS

KELLY — would work if run perfectly.
Why would some i.e. UAA want to join?

DUNCAN:
Bill as is — has some problems.

KELLY: supports phasing concept

Malek: restructure payment to physicians (Fed. gov. plan)
1. Balance .... Harvard School has provided. Shifts emphasis back to GP.
shift cost to State.

KELLY: Watch fed guidelines as set in 1992 — follow suit?

George Matson:
Risk standpoint — probably won't help
Purchasing Power — may be effective, Study Ratio of providers to population
Discount — 15% discount may not reflect cost saving — increase in # of visits

Don Valesco: Loc. 71
Tailoring (services/insurance) to small groups.
Pro-collective bargaining
Garth Henblin — Bartlett
Annual Rate: 20% increase in Premiums - Bartlett - 8%

Bob Manners_ NEA
encourage/supportive
especially for small school districts:

Sitka School District: Beckfort
left state pool__
joined Blue Cross_ comparable coverage
at lower premium.
Concerns mandatory plan
AK very different from Utah__
one provider
Kelly: ~~Kelly~~_ Cap on Premium.
Response _ set cap at $4800
split 50% at 50%
Duncan: Political Subdivision of State Plan
Muni/Sch. District

Alaska State Legislature

Sen. Pat Pourchot, Chairman

Sen. Jan Faiks, Vice Chairman
Sen. Al Adams
Sen. Tim Kelly
Sen. Rick Uehling

P.O. Box V
State Capitol
Juneau, Alaska 99811

907-465-3712

Senate State Affairs Committee

MEMORANDUM

TO: Senate State Affairs Committee Members

FROM: Senator Pat Pourchot

RE: Wednesday, January 31 Committee Hearing

DATE: January 30, 1990

TELECONFERENCE: Anchorage, Fairbanks, Barrow, Sitka

On Wednesday, January 31 at 1:30 p.m. in the Beltz Room the Senate State Affairs Committee will hear the following bills:

SB 254, An Act relating to group health insurance; and providing for an effective date.
SB 254, sponsored by Senator Duncan, establishes the Alaska State Group Health Insurance Authority, comprised of 16 members. The Authority is required to purchase group health insurance or to self-insure to provide coverage at the lowest possible cost to the pool of state, municipal and school district employees. Unless granted a waiver, state, municipal and school districts must have their health insurance benefits purchased through the Authority. Jeff Malek, Health Care Cost Containment Task Force consultant with Arthur Gallagher and Co. will testify on the pooling concept. This is the first hearing for SB 254.

SB 366, An Act relating to the Dalton Highway.
SB 366, sponsored by Senator Frank, would open the entire Dalton Highway for year-round public travel from the Yukon River to a terminus near the Arctic Ocean. Individuals, groups and municipalities from the areas along the Dalton Highway will be testifying.

SB 254.txt Wednesday, March 7

Proposed CS for SB 254, Duncan, GROUP HEALTH INSURANCE

TO TESTIFY;

*Jeff Malek: Arthur J. Gallagher Co./Health Care Cost Containment Consultant

*Jeff is prepared to defend the omission of the sunset clause from the CS.

NOTES;

Changes from the previous CS that may need some explanation:

← P.2 Non-voting members

Page 3, Lines 14,15,16: provide clarification that if the authority self-insures they are required to comply with all laws in the state, including being licensed and regulated.

Page 3,Lines 23,24,25: moved the collective bargaining wording to restriction under general powers.

Page 3, starting line 29 and continues on Page 4: establishes review process in place of sunset clause.

ALERT; Jim Baldwin called after packets went out with a recommendation for an amendment to the wording under state on Page 7, line 1,2. See last page in this notebook.

Sunset amendment is second to last page.

SB 254.txt

SB 254, Duncan, GROUP HEALTH INSURANCE

TELECONFERENCE; Anchorage, Fairbanks,Barrow, Sitka and Linn Baker will be calling in from Utah. Please clarify at beginning of hearing that we will hear SB 254 (Group Health) for approximately one hour and then hear SB 366, Dalton Highway.

SCHEDULED TESTIMONY;

Senator Duncan
Jeff Malek: Arthur J. Gallagher Co./Health Care Cost Containment Consultant
Linn Baker: Administrator/Utah State Retirement
He will be calling in from Utah.

NOTIFIED; *indicates would like to testify
Lynn withrow: Aetna (Seattle) available for questions
Reed Stoops: Aetna lobbyist
Scott Burgess: Municipal League
NEA
School Board Association
Division of Insurance: Don Koch (available for questions)
University: Wendy Redman
HESS: Jay Livey
DOE: Steve Hole

NOTES;

1. In the Bill Analysis by Jim Jordan, Division of Insurance, they recommend that the Group Health Authority be created within another title other than Title 21. Conflict in mixing purchasing with regulating.

2. Division of Insurance also recommends that Sec. 21.77.030 (Page 2, Line 19) GENERAL POWERS, needs clarification so as to exempt the Group Health Authority from having to be formed and licensed as an insurer. If the intent is to allow the Authority to act as the administrator for self-insured plans sponsored by the state, municipalities and school districts, then this section should be amended to reflect that. Jeff Malek agrees with this revision.

3. Jeff Malek's report recommends that Sec. 21.77.010 (Page 1, Line 17) be expanded to include Workman's comp, Health and Social Services, medical coverages and payments and uninsurable/uninsured benefits as sub-groups of the pool.

4. Jeff Malek recommends that Sec. 21.77.050 (Page 3, Line 3) be revised to allow RFP notification process.

5. Jeff Malek recommends that Sec. 21.77.080 (Page 3, Line 29) be revised to 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.

6. Jeff Malek recommends that Sec. 21.77.070 (Page 3, Line 22) be revised to allow the pool to access members and/or issue bonds to fund benefits or establish reserves.

7. The University raised the question: Would we be required to participate if we could prove we have a lower cost per employee program?

8. Question posed by Admin: How does collective bargaining fit into the group health authority picture.

9. Self-Insurance issue, Jeff Livey of HESS states that the only advantage is if the state actively manages health care costs or contracts with a company to actively manage.

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: SB 254
PUBLISH DATE:

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

LW/dg16208D/12990a

STATE OF ALASKA
1990 LEGISLATIVE SESSION

Bill Version: SB 254
Publish Date:

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 by 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)

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: CSSB 254 (SA)
PUBLISH DATE:

FISCAL NOTE

DRAFT

REQUEST:

Revision Date: 3/1/90
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
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

6408D-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

6408D/3590a

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: CSSB 254 (SA)
Publish Date:

FISCAL NOTE

REQUEST:

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

This bill has no FY 90 impact. It is not expected to affect either the operating budget of the division or the State's group health insurance premium.

Prepared by: Sally Smith, Director
Division: Retirement and Benefits
Phone: 465-4460
Date: 3-9-90

Approved by Commissioner: Frank S. Baxter
Agency: Department of Administration
Date: 3/13/90

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

15/6K1/030901-0/1&2

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 immediately create the Alaska State Group Health Insurance Authority in the Department of Commerce. 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.

Upon participation, a public entity would be required to continue participation unless granted a waiver by the Authority.

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. For that reason, it is not expected to increase the cost of health insurance for the State and could result in a decrease in cost.

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: CSSB 254 (SA)
PUBLISH DATE:

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
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

6408D-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

6408D/3590a

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

SENATE COMMITTEE REPORT

FIRST COMMITTEE OF REFERRAL

Date of 5-DAY NOTICE ____________
IN ACCORDANCE WITH UNIFORM RULE 23

FURTHER FIN

**FISCAL NOTE(S) MUST BE ATTACHED
IN ACCORDANCE WITH AS 24.08.035

DATE TURNED INTO OFFICE ____________

3/31/89
Mr. President:

STATE AFFAIRS Committee considered SB 254

group health insurance; efd

and recommended:

[X] replace with (CS) SB 254 [] same title [] new title

[ ] attached amendment(s) and

[ ] ____________ letter of intent adopted

[ ] do pass

[ ] do not pass

[ ] no recommendation

[X] individual recommendations

[ ] further referral to ____________

FISCAL NOTE(S) attached [ ] zero [X] fiscal impact
[ ] appropriation no FN attached [ ] Gov. FN introduced w/ bill

MEMBERS SIGNING DO PASS

Tim Kelly
Ed Adams
~~Rick Uehling~~

OTHER RECOMMENDATIONS

Rick Uehling (No Rec)
Jan Faiks (fiscal not absurd) No Rec
Pat Pourchot do pass

Chair : signature and recommendation

[ ] Committee backup attached

CS SB 254

6-0623H
Ford
3/1/90

Original sponsor(s): SEN. DUNCAN

CHANGES From SB 254 highlighted:

IN THE SENATE

CS FOR SENATE BILL NO. 254 ( )

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 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 Commerce and Economic Development 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 schedule, and utilization standards. The state, a municipality, or a district shall use the health care provider payment system, rate schedule, 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.

Sec. 21.77.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The authority shall be managed by a board of directors composed of 17 members appointed by the governor as follows:

(1) two members representing the legislative branch who are not legislators;

(2) two members 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. The authority may

(1) beginning February 1, 1992, exercise the powers granted to insurers under the laws of the state;

(2) sue or be sued;

(3) enter into contracts or agreements;

(4) establish administrative or accounting procedures;

(5) collect, invest, and disburse funds;

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

NEW SECTION

Sec. 21.77.040. 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. 21.77.050. FIDUCIARY DUTY OF BOARD. In obtaining group health insurance required under this chapter, the board shall provide comprehensive coverage at the lowest possible cost per eligible employee.

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 ~~to~~ per eligible employees.

(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. 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.

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) "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, the Alaska State Housing Authority, and the Alaska Railroad Corporation, & other corporations established by the state.

* 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, five members for three years, and five members for four years.

* Sec. 6. REPORT. The Alaska State Group Health Insurance Authority shall report back 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 schedule, and utilization standards.

* Sec. 7. Nothing in this Act affects a contract or collective bargaining agreement in effect on the effective date of this Act.

* Sec. 8. This Act takes effect immediately under AS 01.10.070(c).

6-0623H
Ford
3/6/90

Original sponsor(s): SEN. DUNCAN

IN THE SENATE BY THE STATE AFFAIRS COMMITTEE

CS FOR SENATE BILL NO. 254 (State Affairs)

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 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 Commerce and Economic Development 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 schedule, and utilization standards. The state, a municipality, or a district shall use the health care provider payment system, rate schedule, 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.

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. 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.

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) "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, the Alaska State Housing Authority, and the Alaska Railroad Corporation.

* 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 schedule, and utilization standards.

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

6-0623Ha
Ford

A M E N D M E N T

OFFERED IN THE SENATE BY SEN. POURCHOT

TO: CSSB 254 (State Affairs)

Page 7, after line 8:

Insert a new bill section to read:

"* Sec. 5. AS 44.66.010(a) is amended by adding a new paragraph to read:

(17) Alaska State Group Health Insurance Authority (AS 21.-77.010) -- June 30, 1995."

Renumber the following bill sections accordingly.

3/6/90

CS SB 254 PROPOSED AMENDMENTS;

AMENDMENT 1: (Per Jim Baldwin, Asst. Attorney General)
Page 7, Lines 1,2 amended to read:

and includes the University of Alaska, (the Alaska State Housing Authority, and the Alaska Railroad Corporation) and a public corporation of the state created within a principal executive department.

SB 254 → Group Health 3-5-90

Phase 1 : mandates all in

→ Sunset Commission:

FAILS _ July 1, 1995 _ report back

→ Malek:

Bonds _ Task Force Rec's

(NO)

Bruce Cummings
changed statement — Now supports

Brian Rogers — Supports changes

→ Definition of Group Health —
(language should be optional)
Page 6

→ Scott Burgess:

→ Political Subdivision — other instruments of the State,

Muni. League — pools on Worker's Comp.

→ Rec — delete worker's comp.

→ Mnimum benefit and financial standards

Page 5 — Concern over waiver process

Sen. Duncan
A collective bargaining can optin or opt out.

Financial extingency clause

Falks: 3 year contract but financial crisis at year 2 — What if Muni has to give up 25% of employees

Disenrollment

ADAMS: Sunset

KELLY

6-0623H
Ford
3/6/90

Original sponsor(s): SEN. DUNCAN

IN THE SENATE BY THE STATE AFFAIRS COMMITTEE

CS FOR SENATE BILL NO. 254 (State Affairs)

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 providing for an effective date."

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

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(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;

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employees and their dependents participate in the group health insurance program offered by the authority; and

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Sec. 21.77.010. AUTHORITY CREATED; REQUIRED PAYMENT SYSTEM, RATE SCHEDULE, AND UTILIZATION STANDARDS. (a) There is established within the Department of Commerce and Economic Development 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 schedule, and utilization standards. The state, a municipality, or a district shall use the health care provider payment system, rate schedule, 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.

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(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.

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(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;

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(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.

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(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. 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.

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(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;

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(9) "state" means the executive, legislative, and judicial branches of state government, or an organizational unit of a branch,

and includes the University of Alaska, the Alaska State Housing Authority, and the Alaska Railroad Corporation.

* 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 schedule, and utilization standards.

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

A M E N D M E N T

OFFERED IN THE SENATE BY SEN. POURCHOT

TO: CSSB 254 (State Affairs)

Page 7, after line 8:

Insert a new bill section to read:

"* Sec. 5. AS 44.66.010(a) is amended by adding a new paragraph to read:

(17) Alaska State Group Health Insurance Authority (AS 21.-77.010) -- June 30, 1995."

Renumber the following bill sections accordingly.

CS SB 254 PROPOSED AMENDMENTS;

AMENDMENT 1: (Per Jim Baldwin, Asst. Attorney General)
Page 7, Lines 1,2 amended to read:

and includes the University of Alaska, (the Alaska State Housing Authority, and the Alaska Railroad Corporation) and a public corporation of the state created within a principal executive department.

Legal opinion - ~~(1)~~ preference of new governor - to appointees
(2) political

6-0623H
Ford
3/1/90

Original sponsor(s): SEN. DUNCAN

CHANGES FROM SB 254 highlighted:

IN THE SENATE

CS FOR SENATE BILL NO. 254 ( )

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 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 Commerce and Economic Development 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 schedule, and utilization standards. The state, a municipality, or a district shall use the health care provider payment system, rate schedule, and utilization standards established by the authority.

(c) The authority shall, beginning February 1, 1992, provide grou. 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.

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

(1) one- two members representing the legislative branch ~~who are not legislators~~; one each NON voting

(2) one NON-voting two members 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. The authority may

(a) (1) beginning February 1, 1992, exercise the powers granted and comply with requirements. to insurers under the laws of the state;

(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) will not participate in collective bargaining agreements.

Sec. 21.77.040. STAFF AND PROFESSIONAL SERVICES CONTRACTS. NEW SECTION 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. 21.77.050. FIDUCIARY DUTY OF BOARD. In obtaining group health insurance required under this chapter, the board shall provide comprehensive coverage at the lowest possible cost per eligible employee.

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 employees.

(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. 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.

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) "fund" means the state group health insurance ~~fund~~;

Amend (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;

apply to setting rate schedules

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

(8) "participant" means the state, a municipality, or a districts

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

and all political subdivisions

Ask Jim o Baldwin

and public corporations (Kelly-PF?

* 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, five members for three years, and five members for four years.

* Sec. 6. REPORT. The Alaska State Group Health Insurance Authority shall report back 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 schedule, and utilization standards.

* Sec. 7. Nothing in this Act affects a contract or collective bargaining agreement in effect on the effective date of this Act.

* Sec. 8. This Act takes effect immediately under AS 01.10.070(c).

* Sec. 9
Sunset — July 1, 1995

List of Changes to SB 254_CS 3.6.90

Page 2, Line 24, 25, 26 — 1. Changed to one non-voting member: legislative and judicial

Page 3, Line 14, 15, 16 — 2. Addressed Dept. of Commerce concern: requiring authority to comply with all insurance requirements i.e. to be licensed.

Page 3, Line 23, 24, 25 — 3. Clarified that Authority can not participate in collective bargaining

Page 3, Line 29 onto Page 4 Lines 1, 2, 34 — 4. Instead of "sunset clause", CS requires ~~three~~ annual report to governor and legislature with a cost & benefit analysis of the health insurance every 3 years

Page 4, Line 23 — 5. Technical change from "to" to "per"

Page 6 Line 19 — 6. Changed definition of group health insurance to optional wording "may"

AMENDMENTS

1. Language for definition of ~~STATE~~ — Did Not pass

2. Sunset Clause passed

6-0623H
Ford
3/6/90

Original sponsor(s): SEN. DUNCAN

IN THE SENATE BY THE STATE AFFAIRS COMMITTEE

CS FOR SENATE BILL NO. 254 (State Affairs)

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 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:

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Sec. 21.77.010. AUTHORITY CREATED; REQUIRED PAYMENT SYSTEM, RATE SCHEDULE, AND UTILIZATION STANDARDS. (a) There is established within the Department of Commerce and Economic Development 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 schedule, and utilization standards. The state, a municipality, or a district shall use the health care provider payment system, rate schedule, 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.

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(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;

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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.

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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.

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

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

(6) "group health insurance" means 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, the Alaska State Housing Authority, and the Alaska Railroad Corporation.

* 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 schedule, and utilization standards.

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

6-0623Ha
Ford

passed

AMENDMENT

OFFERED IN THE SENATE BY SEN. POURCHOT

TO: CSSB 254 (State Affairs)

Page 7, after line 8:

Insert a new bill section to read:

"* Sec. 5. AS 44.66.010(a) is amended by adding a new paragraph to read:

(17) Alaska State Group Health Insurance Authority (AS 21.-77.010) -- June 30, 1995."

Renumber the following bill sections accordingly.

3/6/90

did not pass

CS SB 254 PROPOSED AMENDMENTS;

AMENDMENT 1: (Per Jim Baldwin, Asst. Attorney General)
Page 7, Lines 1,2 amended to read:

and includes the University of Alaska, (the Alaska State Housing Authority, and the Alaska Railroad Corporation) and a public corporation of the state created within a principal executive department.

Proposed Amendments: see last page, this document.

STATE OF ALASKA

OFFICE OF THE GOVERNOR

BILL ANALYSIS

DEPARTMENT	DIVISION	BILL NUMBER	SPONSOR
Commerce & Econ. Dev.	Insurance	SB 254	Senator Duncan

SHORT TITLE OF BILL
An Act relating to Group Health Insurance

DEPARTMENT POSITION
Neutral

PREPARED BY	DATE	COMMISSIONER'S SIGNATURE	DATE
Jim Jordan, Deputy Director	4-7-89		4/

SUMMARY

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

FISCAL IMPACT: ☐ NONE ☐ FISCAL NOTE ATTACHED

BACKGROUND/LEGISLATIVE INTENT

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

ANALYSIS OF BILL/PROGRAM EFFECTS

See attached.

AMENDMENTS PROPOSED

See attached.

3788D-1/C41089a

PLEASE ATTACH A SEPARATE SHEET FOR ADDITIONAL COMMENTS OR ANALYSIS

ANALYSIS OF BILL/PROGRAM EFFECTS:

Section 2

AS 21.77.010-.020. Authority Created

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

AS 21.77.030. Powers

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

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

AS 21.77.040. Fiduciary Duty

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

AS 21.77.050. Purchase of Insurance

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

AS 21.77.060. Health Insurance Fund

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

AS 21.77.070. Insurance Premiums

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

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

AS 21.77.080. Required Participation

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

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

AS 21.77.090. Definitions

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

Section 3

AS 39.30.090. Department of Administration Duties

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

Section 4

AS 39.50.200(b). Conflict of Interest

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

3788D

Section 5

AS 21.77.020(b), Staggered Initial Board Terms

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

Section 6

Effective Date

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

Amendments Proposed

1. It is recommended that this Authority be created within a title other than Title 21. Title 21 is the section of Alaska law which regulates the business of insurance. An inherent conflict arises when provisions pertaining to the purchase of insurance are mixed with regulatory provisions.

2. AS 21.77.030(1) needs to be clarified so that it exempts the Authority from having to be formed and licensed as an insurer under AS 21 if that is the intent. If the intent is to allow the Authority to act as the administrator for self-insured plans sponsored by the state, municipalities and school districts, then this provision should be amended to reflect that power.

3788D

– phasing authority

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.

1-31-90 Senator Duncan

ALASKA STATE GROUP HEALTH INSURANCE AUTHORITY

Board of Directors; Organization

The Board would be composed of 17 members representing the following:

2 members from the Legislative Branch;

2 members from the Executive Branch;

2 members from the Judicial Branch;

2 members representing Labor Organizations;

2 members representing School Districts;

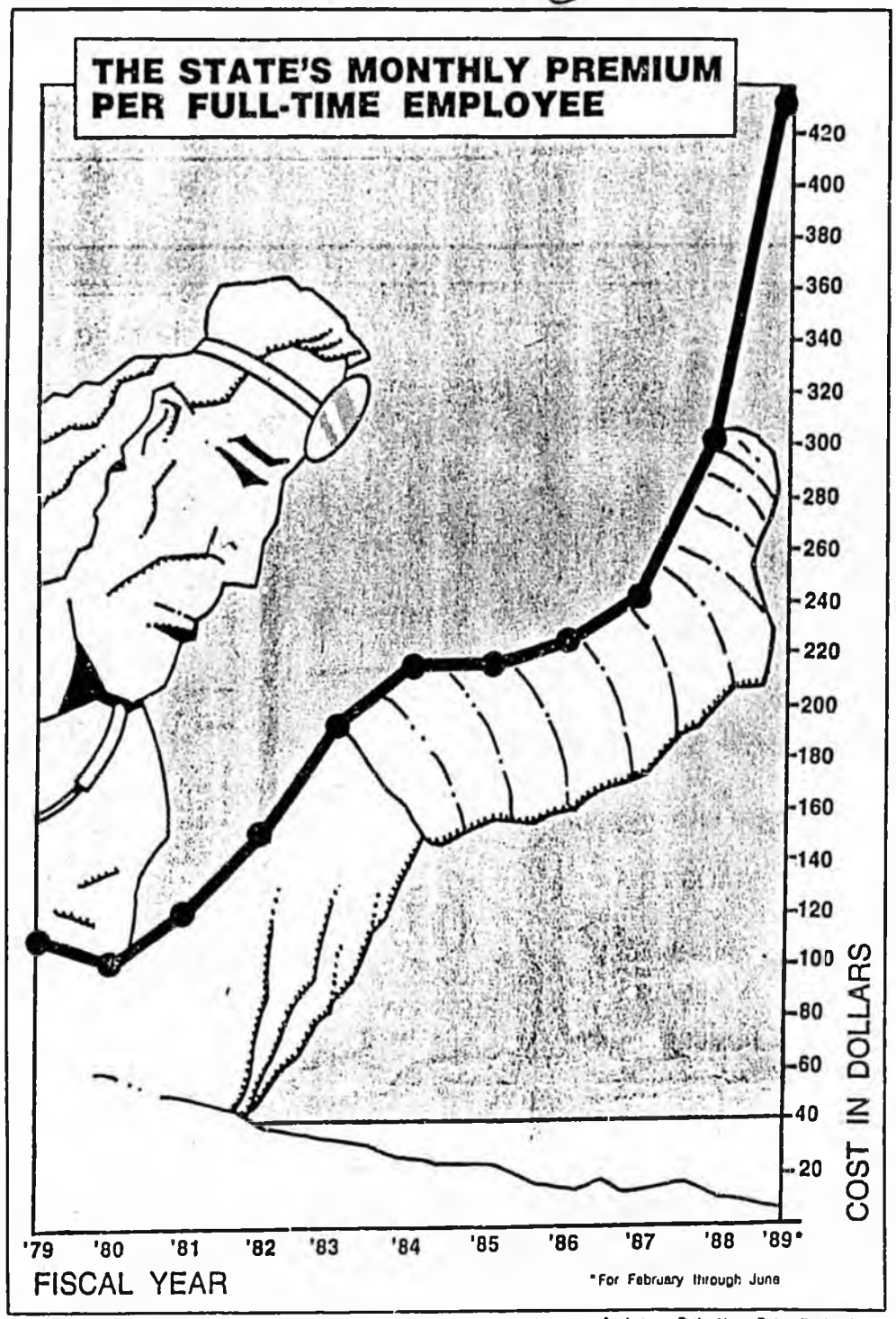
2 members representing Municipalities;

2 members representing the Department of Health and Social Services;

2 members representing Health Care Providers; and

1 member representing the University of Alaska.

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

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INSURANCE: For state workers

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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."

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 [illegible] greement among those districts willing to participate or [illegible] .on 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

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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]

	Individuals are eligible if they			
State	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	1,784	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	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 expenses. 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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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 $386 less. Our Traditional Care program restricts the length of stay for in-patient hospitalization for many high volume procedures. For example, an uncomplicated hysterectomy is limited to three days for females less than 50 years of age. It is not uncommon for our Preferred physicians to limit the in-patient stay to two days. Total charges for hysterectomies for our Preferred providers are over $1000 less than non-Preferred providers.

PREMIUM INCREASES

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

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

ADMINISTRATIVE COSTS

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

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

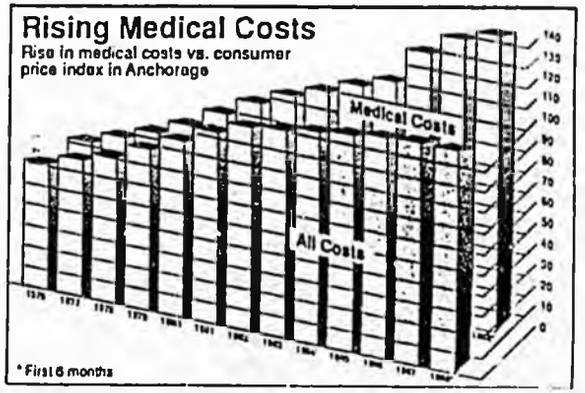
■ **MONEY MARKETS:** Weekly listings / B-4 ■ **MALLWATCH:** Merchants join forces / B-5 ■ **PLASTIC POWER:** Holiday bills / B-6

BUSINESS

SUNDAY
SECTION B Jan. 22, 1989

Health insurance costs rise feverishly

Workers at a loss as employers cut back on benefits

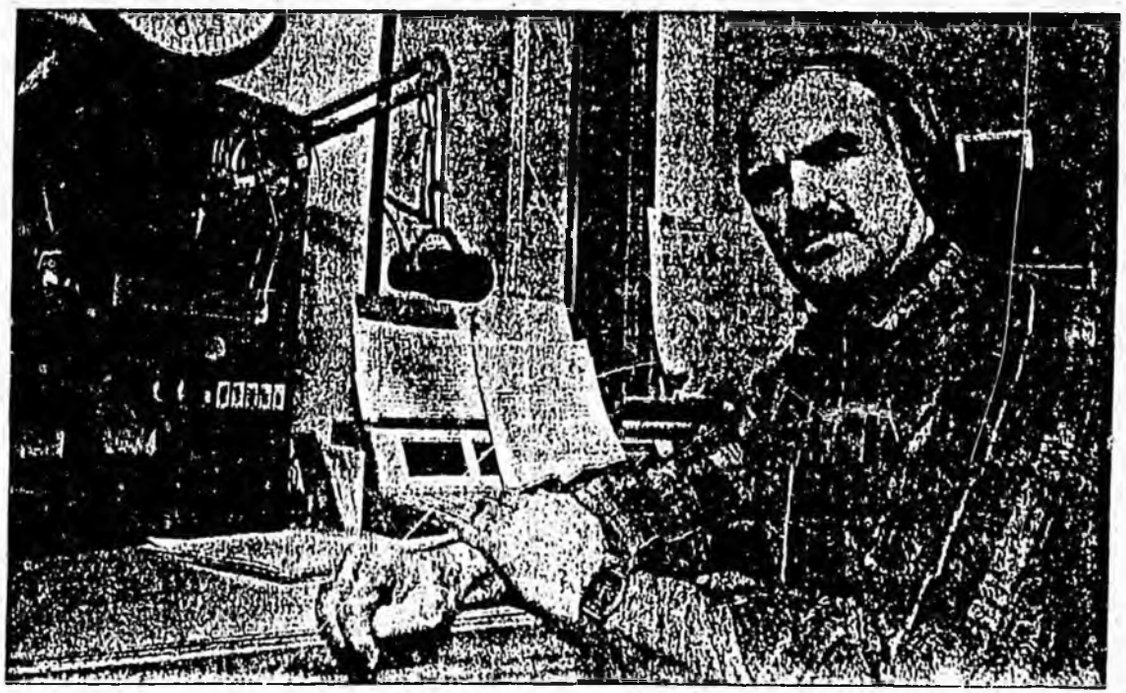


By HAL BERNTON
Daily News reporter

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

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

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



Anchorage Daily News/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 ... appears to be particularly ... 100 percent, according to brokers Walt Baldwin, Bill Purrington and Dave Stratton.

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

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

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

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

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

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

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

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

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

*Anchorage Daily News/Jim Lavrakas

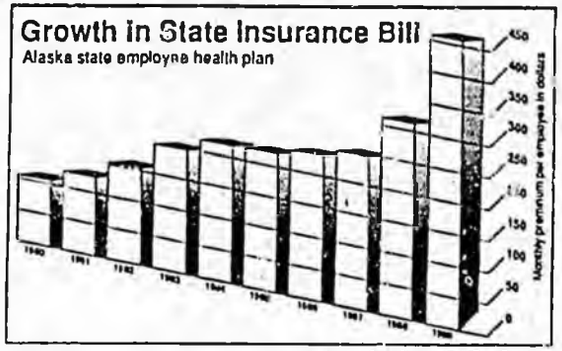
Disc jockey Lester Snow was left scrambling when his employer was forced to drop health benefits for employees.

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

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

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

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



Anchorage Daily News charts/Ron 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 100.

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 gathered around a table on the spacious

"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 piece of the Alaska market.

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

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

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

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

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

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

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

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

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

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

The increased use, industry officials say, also results from 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.

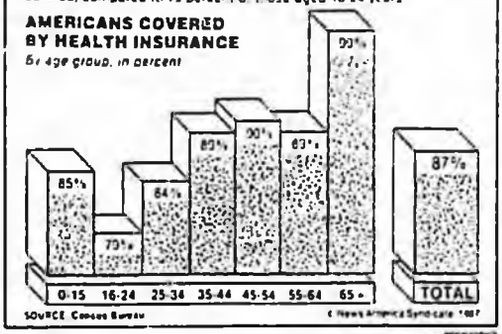
Non-union railroad employees chose to sign up for the preferred plan, but union workers opted against it. Then this year, facing another 32 percent increase, the unions decided to go with the preferred option.

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



> *"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."*
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> — Patty Harpel

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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.

1-31-90 Senator Duncan

ALASKA STATE GROUP HEALTH INSURANCE AUTHORITY

Board of Directors; Organization

The Board would be composed of 17 members representing the following:

2 members from the Legislative Branch;

2 members from the Executive Branch;

2 members from the Judicial Branch;

2 members representing Labor Organizations;

2 members representing School Districts;

2 members representing Municipalities;

2 members representing the Department of Health and Social Services;

2 members representing Health Care Providers; and

1 member representing the University of Alaska.

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

See D Addendum

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

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

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

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

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

- A board of directors composed of employee benefit managers from major local employers.
- Its own purchasing agent to manage the day-to-day operation and contract with providers (CCN).
- Identification of the good quality providers and the poor quality providers. The Milwaukee Purchasing Plan used information from Medicare Title 19, other government sources, and employers. In addition, the Plan's Physician Advisory Committee gives some advice on what to look for and practice patterns. The Plan received 600 physicians' applications, and 55 were eliminated.
- A network of 13 local hospitals and, effective March 1, 1988, 450 physicians, including primary care physicians.
- A Physician Advisory Committee (PAC), which aids the Board in physician evaluation and selection, through established criteria.
- Quality assessment components developed by the purchasing agent and the PAC.
- Predetermined payments for services. Participating providers agree to accept the scheduled fees offered by the plan. Per diem rates are negotiated with the hospitals, and physician rates are based on the California Relative Value Scale adjusted for Milwaukee area rates.
- Each employer maintains its own medical plan, whether comprehensive or basic and major medical.

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

- Employees and dependents are encouraged, through incentives, to use selected providers.
- Each hospital in the Network is responsible for its own preadmission review. All participating providers assume the financial risk for unnecessary care.

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

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

Data Collection

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

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

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

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

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

Future Holds Expansion

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

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

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

Save $2 Million First Year

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

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

Direct Contracting With Hospitals: Alternative Payment Arrangements

by Douglas G. Cave

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

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

To remove many of the perverse effects of discounted charge arrangements, employers are now turning to alternative hospital payment systems — per diem and per case. These systems transfer more financial risk to the hospital for the services they deliver. Hospitals are usually more willing to negotiate per diem contracts because they can negate some of the financial risk transferred to them simply by keeping patients in the hospital longer.

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

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

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

Negotiating Per Diem Rates

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

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

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

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

If case mix or severity of illness level dramatically fluctuates, especially during the first year of contract negotiation, broad based per diem rates should help minimize large losses or gains incurred by the hospital or employer. For instance, Table I shows that the all-inclusive per diem rate for Employer A using Hospital X is $965. This is based on a day mix of 47.8% medical patients (501 days/1,048 days) and 15.5% surgical patients (162 days/1,048 days). Let's assume that, after negotiations, the mix moves more toward medical cases (that is, those patients who require less intensive per day resources). The all-inclusive per diem value of $965 is now an overestimate. Therefore, the employer may lose money on this per diem contract — at least during the first year. If Employer A had negotiated a broad based per diem contract, the hospital would have less incentive to change its current day mix toward treating more medical cases.

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

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

Table I

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

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

The Author

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

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

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

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

Table II

Employer A's Calculated 1988 Per Case Rates for Hospital X

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

Negotiating Per Case Rates

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

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

Other evidence suggests that the PPS also has had an effect on the use of diagnostic and therapeutic tests conducted in a hospital. In 1984, there were major reductions in routine serology and blood chemistry tests as well as declines in well-established hospital procedures, such as electrocardiograms and transurethral cystoscopy.[3] These facts support the hypothesis that per case payment systems should reduce length of stay and the number of ancillary services.

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

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

Table III

1988 Per Case Rates for Hospital X at Different Threshold Levels

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

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

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

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

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

Table III shows three different possible stop-loss thresholds set by Employer A for Hospital X: $10,000, $15,000 and $25,000. Over 17% of the cases exceeded a $10,000 threshold. These cases accounted for 47.8% of total payments to Hospital X. After eliminating the outliers from the analysis, the overall case rate was reduced from $6,403 to $4,035; the medical case rate was reduced from $5,710 to $2,968; and the surgical case rate was reduced from $10,363 to $5,191. Surgical cases had the greatest percentage — almost 39% — excluded at the $10,000 threshold level.

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

Other Effects of Per Case Payment Systems

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

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

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

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

These facts do not support the hypothesis that case-based payment systems will generate more hospitalizations. Other forces may have been operating, however, to oppose incentives to increase admissions, such as utilization review (UR) firms developing more objective and stringent admission criteria and physicians moving away from inpatient treatment toward less costly ambulatory care. Without a clearer understanding of why admission rates decreased in the PPS and New Jersey systems, employers should assume that a strong prospective UR program is necessary to counteract provider incentives to admit more patients.

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

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

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

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

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Summary Of State Legislation Governing PPOs: Survey Of The American Medical Care And Review Association

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

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

Alabama—No PPO legislation.

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

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

Arizona—No PPO legislation.

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

Colorado—No PPO legislation.

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

Delaware—No PPO legislation.

District of Columbia—No PPO legislation.

Florida—As follows:

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

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

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

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

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

Georgia—No enabling legislation permitting insurers to establish PPOs.

Hawaii—No PPO legislation.

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

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

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

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

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

Kentucky—No PPO legislation.

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

Summary Of State Legislation Governing PPOs: Survey Of The American Medical Care And Review Association

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

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

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

Massachusetts—No PPO legislation.

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

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

Mississippi—No PPO legislation.

Missouri—No PPO legislation.

Montana—No PPO legislation.

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

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

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

New Jersey—No PPO legislation.

New Mexico—No regulations on PPOs.

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

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

North Dakota—No regulation on PPOs.

Ohio—No regulations on PPOs.

Oklahoma—No regulations on PPOs.

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

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

Rhode Island—No PPO legislation.

South Carolina—No PPO legislation.

South Dakota—No PPO legislation.

Tennessee—No PPO legislation.

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

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

Vermont—No PPO legislation.

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

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

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

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

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

Structure, Operation Of Preferred Provider Organizations: How To Assess Program Efficiency, Quality Of Services

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

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

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

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

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

Negotiated Fee Schedule

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

Few rules guide the negotiations between PPOs and health care providers. There is no prepayment or capitation amount paid to providers; all services are paid for on a fee-for-service basis, and physicians may accept some percentage of the local area's "usual and customary" determination as full payment. This can be viewed as a discount, but it is actually a standardization of payments made to physicians.

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

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

Utilization Management

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

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

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

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

Adding A PPO Option

Two approaches are prevalent when adding a PPO option:

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

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

Evaluation

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

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

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

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

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

Evaluating Quality

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

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

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

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

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

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

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

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

Administration

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

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

Staffing depends on the comprehensiveness of services directly provided by the PPO. According to the 1987 survey, 23 plans have from 11 to 15 staff members and only four plans have a staff of more than 100 persons. Most plans have their own provider base (physicians and hospitals) and marketing staff. Functions such as utilization review and claims processing, are sometimes contracted to third-party administrators, insurance companies, and professional review organizations. A breakdown of contracted out services provided by the PPO include the following:

	PPO	Others
Physician/hospital contracting	254	11
Marketing	231	40
Claims processing	72	95
Preadmission certification	202	55
Utilization review/peer review	231	41
Provider payment	146	112
Consumer/provider grievances	244	32
Cost analysis and reporting	231	52

Provider Contracting

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

The 61 PPOs reporting from the Northeast region have 1,322 hospitals under contract. In the Southeast, where 59 PPO reported, there are 1,069 participating hospitals. Sixty-five plans in the Midwest have participating contracts with 1,357 hospitals, and in the West, 5,244 hospitals have signed contracts with 356 plans.

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

Table 1
PPOs By State

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

continued on next page

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

Table 2
Number Of Physician Contracts

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

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

Membership

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

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

Benefits Provided

Many PPOs are single benefit plans, providing psychiatric, pharmacy, physician therapy, and other specialized services. These plans work in cooperation with other PPOs and health maintenance organizations to supplement the basic core of services provided by a PPO. Benefits plans vary with each employer and the deductibles and copayments differ for each plan depending upon the contractual relationship the employer and PPO have with the providers.

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

Utilization Review

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

Data Collection/Reporting

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

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

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Table 3
Benefits Offered By The PPOs

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

Marketing

Direct contact by personal visit and mail are the most popular methods of contracting PPOs used with employers and recruiting providers. Some 616 plans used direct personal contact, 418 made contact through direct mail, 348 advertised in newspapers, 135 on radio, and 77 on television. Flyers or brochures were handed out by 398 PPOs and 109 plans used other marketing methods.

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

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

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

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

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

Identify Rating Variables

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

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

Type Of People

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

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

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

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

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

Marketing Considerations

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

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

Look At Providers

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

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

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

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

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

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

Reimbursement Method

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

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

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

Cost Per Service

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

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

Utilization Levels

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

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

Value Of Copays, Deductibles, Etc.

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

Expense Considerations

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

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

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

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

This Research Report provides general guidelines for those who wish to solicit providers for participation in a preferred provider organization.

The basis of this report is a Request for Proposal (RFP) sent by Blue Cross and Blue Shield of Northern Ohio to hospitals in the area. The Blue plan used responses to the RFP to select hospitals to participate in its new method of reimbursement.

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

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

Cover Letter

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

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

Name
Address
City, state, zip

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

Introduction

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

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

Terms of the contracts to be offered to the selected providers should be explained, as well as the reimbursement structure and utilization review requirements. The deadline for responses should be given and implementation date of the PPO should be estimated.

The number of proposal copies needed should be stated.

Proposal Specifications

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

Proposal Amendments And Withdrawals

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

Alternate Proposals

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

Proposal Format

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

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

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

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

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

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

Bids

Providers should consider the following factors in establishing their bids:

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

The expectation of increased volume.

Competitiveness of the bidding process.

Availability of opportunities to reduce current costs.

Other Bid Requirements

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

Evaluation Criteria

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

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

Selection Process

A four-step selection process can be used.

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

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

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

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

Sample Preferred Provider Organization Contract Between Sponsoring Agency And Providers

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

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

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

WITNESSES:

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

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

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

Now, therefore, the parties agree as follows:

I. DEFINITIONS

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

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

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

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

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

II. REPRESENTATIONS AND WARRANTIES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

III. AUDITS

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

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

IV. INDEMNIFICATION AND HOLD HARMLESS

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

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

continued on next page

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

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

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

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

V. TERMINATION

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

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

VI. ASSIGNMENTS

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

VII. MODIFICATIONS

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

APPENDIX

I. Physician services.

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

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

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

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

II. Hospital services.

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

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

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

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

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

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

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

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

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

Initial Steps

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

a. A straight discount of billed charges—but rates continue to rise.

b. A discount off billed charges with some sort of cap.

c. Diagnosis related groups (DRGs) approach (such as Medicare's)—not the most effective because of coding inaccuracies, DRG creep, and their not accommodating.

d. Per diem approach, and very limited, with global rates for medical/surgical, physical rehabilitation, and psychiatric services, for example. CCN feels that this is the most effective way of controlling costs. To discourage shifting from inpatient to outpatient charges, hospital amounts must be capped.

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

f. A combination of the previous approaches.

2. Establish a deadline for contract negotiations.

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

4. Have a bid structure in mind.

5. Determine selection criteria by identifying the following factors:

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

b. Geography.

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

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

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

Physician Contracting

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

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

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

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

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

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

Providers' Perspective

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

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

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

b. Outcome evaluation and consumer satisfaction.

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

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

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

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

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

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

Implementation, Administration

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

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

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

Small Employers

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

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

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

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

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

Questions For Evaluation

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

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

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

• Will they fit in with employee relations policy?

• What are the legal implications?

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

Plan to provide all Americans with health insurance studied

By NANCY BENAC
THE ASSOCIATED PRESS

WASHINGTON – A draft proposal to spend $65 billion on two of the nation's biggest health care problems is running into behind-the-scenes White House opposition even before it comes up for a vote.

The U.S. Bipartisan Commission on Comprehensive Health Care planned to vote today on a proposal to provide health insurance to more than 31 million uninsured Americans and help 9 million Americans pay the high cost of long-term care.

Several sources said Thursday that approval was not guaranteed, noting that the White House had been pressuring Republicans on the 15-member commission to withhold their support.

Rep. Fortney "Pete" Stark, a California Democrat who is a member of the commission, predicted its recommendations to Congress would be a "dead letter" because of opposition from the White House.

"The postmaster in this case is President Bush and ... they don't want a plan which would embarrass them in the next election," Stark said.

The commission's draft plan would require all businesses with more than 100 employees to provide private health insurance to their workers, or to contribute to a public plan for employees and non-working dependents.

When fully implemented, all Americans would be provided health insurance through their employer or the public plan.

It also would offer all Americans coverage for long-term care in their homes and for the first three months in a nursing home. Federal benefits for additional time spent in a nursing home would be greatly improved.

The draft plan did not recommend how to pay for the benefits, saying "the commission is committed to raising whatever additional revenues are necessary."

The commission – including 12 members of Congress and three White House appointees – was created by Congress in 1988 to tackle the thorny questions of how to ensure quality, affordable care for the uninsured and for those devastated by the high costs of long-term care.

The panel is commonly known as the Pepper Commission in honor of its first chairman, the late Rep. Claude Pepper, D-Fla., an outspoken advocate for the elderly and disadvantaged.

Stark criticized the draft plan, saying it would not guarantee health coverage for all Americans, particularly those employed by small businesses. He noted it provided extended nursing home protection only to those of limited income and assets, and complained that it failed to recommend how to pay for the $65 billion program.

But two advocacy groups for the elderly said the proposed plan recommended important improvements in the nation's health care system.

John Rother, legislative director for the American Association of Retired Persons, called it "a promising start."

Ronald Pollack, executive director of the Families USA Foundation, a non-profit advocacy group for the elderly, said the plan "meets the crucial goals of health-care reform – protection from the devastation of long-term care costs at home or in a nursing home as well as affordable health care for all Americans, regardless of income or job status."

Rec'd from Dale - 1-9-90

Senate Bill 254 BY SENATOR DUNCAN

ALASKA STATE GROUP HEALTH INSURANCE AUTHORITY

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

Section 1.

PURPOSE

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

Section 2.

CREATION OF THE AUTHORITY

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

BOARD OF DIRECTORS

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

(1) the commissioner of administration;

(2) the commissioner of health and social services;

(3) the director of the division of insurance;

(4) 13 members appointed by the governor representing the following:

(A) one member representing local governments;

(B) one member representing school boards;

(C) two members representing public school teachers;

(D) one member representing the public who is not a state or municipal employee;

(E) two members from the permanent public employees in the classified service of the state;

(F) one member from the permanent employees of the University of Alaska;

(G) two members from the permanent employees of school districts;

(H) two members from the permanent employees of municipalities; and

(I) one member representing health care providers.

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

POWERS OF THE AUTHORITY

The Authority may:

(1) exercise the powers granted to insurers under the laws of the state;

(2) sue or be sued;

(3) enter into contracts or agreements;

(4) establish administrative and accounting procedures;

(5) collect, invest, and distribute funds;

(6) adopt necessary regulation and procedures for the operation of the Authority.

FIDUCIARY RESPONSIBILITY

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

possible cost to eligible employees.

PROCUREMENT OF INSURANCE

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

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

STATE GROUP HEALTH INSURANCE FUND

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

INSURANCE PREMIUMS

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

REQUIRED PARTICIPATION

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

WAIVER

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

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

DEFINITIONS

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

(2) "board" means the board of directors of ASGHIA;

(3) "district" means school district including REAAs;

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

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

(6) "group health insurance" means insurance coverage that includes life insurance, accidental death and dismemberment, medical care and treatment, dental care,

eye care, and other group health coverage as determined by the Authority;

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

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

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

Section 3.

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

Section 4.

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

Section 5.

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

Section 6.

Provides for an immediate effective date.

re: CS SB 254

STATE OF ALASKA

HEALTH CARE COST CONTAINMENT

TASK FORCE

REPORT TO THE LEGISLATURE

By

Senator Tim Kelly, Chair
Representative Mike Navarre, Vice Chair
Senator Jim Duncan
Representative Mark Boyer
Michelle Castanedo
Bruce Cummings
Barbara Huff
Don Hitchcock
Karen Perdue
Greg O'Claray

January 31, 1990

LONG RANGE CONSIDERATION OF THE

HEALTH CARE COST CONTAINMENT TASK FORCE

While the Task Force has achieved particular success in reducing the supplemental funding request and reducing the FY 90 cost of the State's health plan, the inflationary trends of medical costs in Alaska portend future increases for the State. Indeed, the State will be paying in excess of $300 million in FY 90 for health care payments of all types. This is an increase from $75 million in 1980, a 300 percent increase over the past 10 years. Aetna's calculation of cost trend factors for the last three years has ranged from 14 percent to 23 percent.

It is with this view and concern that the Task Force identified several considerations to affect long-term strategies of minimizing medical inflation. These strategies are for the most part directed at the health provider industry itself. They utilize the State's size in both numbers and funding to health care providers to restrain or control medical inflation. These considerations also attempt to reduce direct cost shifting to the State from mandated benefit changes and federal program changes.

The following areas have been determined by the Task Force as needing further study and consideration in developing recommendations to the State.

1. Self-Insured Plan Options

Currently, the State purchases its State health care on a fully insured basis. The Task Force is presently investigating the funding alternatives, whereby the State could employ a variety of financing options in order to reduce the cost of the plan and keep premium dollars in Alaska until claims are paid. Exhibit E

illustrates the self-insured options that are available to the State at this time.

By utilizing alternate funding methods, the State could increase the flexibility by which it funds and pays benefits to participants. However, it must be noted that there would be some administrative expenses incurred as some of the record-keeping for the accounts would have to be handled internally by the State instead of the carrier.

The Task Force expects to issue a complete report regarding the advantages, disadvantages, and associated costs, with an estimate of the savings generated by alternate funding methods.

2. Health Care Purchasing Groups

The Task Force has determined that by utilizing buying groups, the State could effect substantial savings to its health care plans.

Currently, the State of Alaska is paying full retail price for medical and dental services. Just as the State does with other goods and services purchased in quantity, the State could negotiate with providers for a discounted rate.

The State can take advantage of current negotiated discounts by utilizing the P.P.O. arrangement through Aetna. There are several ways that the State can negotiate a discount. They include: contracting with a third party organization to negotiate on the State's behalf; or have the State of Alaska negotiate its own contracts, possibly in conjunction with the P.P.O. arrangement and contracting with a third party organization. These arrangements should include all forms of health care purchasing within Alaska, not just the employee benefit plan (e.g. Medicaid and Medicare).

If the State negotiates its own contracts, this generally offers the most flexibility. The State would establish the agreement and the relationship regardless of the claims paying operations. This could also be part of the pooling authorities scope.

Estimated Savings. Generally, negotiated discounts, have generated gross savings (before expenses) of 5 percent to 20

percent, depending on the service, locality and competition in the given area. Such arrangements could generate savings on the employee benefit plan alone of 1.7 million to 7.5 million dollars per year. The Task Force believes that negotiated discounts is an important consideration for containing the cost of medical care. The Task Force will continue to review the alternatives to determine feasibility of this important buying power. Necessarily, the feasibility will depend to an important degree on unique aspects of Alaska's health provider market, wherein many communities are served by one or few providers.

The Task Force recognizes that it is imperative that quality care is delivered to the participant on a cost efficient basis through the plan with negotiated discounts.

3. Provider Payment Schedules

The Task Force has identified provider payment schedules as a proven method effective in controlling health care costs and constraining long-term medical cost inflation. This strategy has been employed by the federal government through the Diagnostic Related Group System (DRG) and the Resource Based Relative Value System (RBRVS) which will be implemented in 1992.

In a further step to control costs, a payment schedule could also be employed by the State. This would be either a modified DRG, a RBRVS or a schedule specifically tailored to the State of Alaska's health care marketplace.

Essentially, under the DRG a schedule is predetermined for each procedure based on the diagnosis of the patient. Under RBRVS schedule, type of care, necessity of care, geographic area, and training of the physician are all taken into account. A system of this nature takes considerable lead time to implement. These payment schedules can only be effective, if:

- The schedule is set on a realistic basis;
- Modifiers are used to control cost shifting; and
- If utilization review is in place;
- Quality of care is assured; and
- Cost savings objectives are met.

Unless the payment system is carefully designed, cost shifting is likely to occur which would minimize overall savings.

The Task Force continues to review and consider alternatives in the way providers are paid (other than the customary, usual and reasonable basis). The Task Force will determine the savings generated by utilizing a provider payment system, and will make specific recommendations as to the type of system most appropriate and its overall operations and implementation.

4. Pooling Concepts

The Task Force is reviewing a cost containment strategy employed by many states called pooling. The purpose of pooling is to provide comprehensive group health insurance to a larger base of enrollment so that: the risk is spread out; health coverage is provided on the most economical basis; provides the maximum opportunity for cost containment when purchasing group health insurance through favorable payment schedules of providers and vendors; entity(ies) can employ a mechanism that provides benefits or coverages that may not be available or are too costly.

Generally, legislation is required to create an entity that provides the coverages needed and oversees the operation of those coverages effectively and in a cost efficient manner. Senate Bill 254, authored by Senator Duncan, has been introduced into legislation. This bill would create the Alaska State Group Health Insurance Authority which would enable the State of Alaska to offer pooled group health coverage to eligible state, municipal and school district employees.

Some of the advantages of pooling are:

- Economy of scale. Eliminate duplicate or multiple plan costs.

- Provides for plan flexibility, plan rating and risk sharing. Each sub-group could conceivably have a slightly different plan design and could be individually rated based on their experience.

However, the risk of large claims occurring could be shared within the pool to eliminate wide swings in experience.

- Data collection - Allows a simplified system for tracking claims, abnormalities or impacts on health care expenditures, instead of obtaining information from many different sources.

- Projection of future cost and trends. The data base would be valuable in projecting future costs and trends, so that the State could be proactive rather than reactive in the management of its health plans.

Pooling enables the State to combine many advantages including self-funding, utilizing the State's purchasing power to help negotiate and control health care cost, and provide benefits on a cost efficient and manageable basis.

The Task Force is currently reviewing other states that have enacted these programs in order to determine the advantages and disadvantages and complexities involved in setting up a pool for the State. It is anticipated that the savings would be generated in several areas:

- Simplification of administration could save 1% to 3%.

- Provider Payments Schedules and P.P.O. Agreements, 5% to 20%.

- Recognize trends and adjust quickly, 5% to 7%.

- In general, economies in a scale of 1% to 3%.

The greatest savings generated would be from the State becoming a cohesive buying group for health care. By increasing the size of the group, the State is better able to negotiate with providers of the service to afford the best possible care, proper utilization, and the maximum benefit to participants without impacting the plan negatively. It would also isolate the plan from an additional cost shifting from other sources, which have become a significant

CONSULTANTS' REPORT

TO THE

STATE OF ALASKA

HEALTH CARE COST CONTAINMENT TASK FORCE

JUNEAU, ALASKA

JANUARY 29, 1990

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

SECTION IV

POOLING

POOLING FINDINGS UPDATE

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

Hawaii Premium Rates

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

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

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

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

Hawaii's health benefit agreements with Labor.

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

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

Utah Public Employee Plan (PEHP)

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

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

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

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

ADMINISTRATIVE COSTS

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

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

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

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

Negotiated provider payment and utilization standards

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

These similar savings could be achieved in Alaska's plan by using combination of preferred providers, revised usual, reasonable and customary (UCR) and provider payment schedules. In the 1989 plan year, $80,818,125 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 tc 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

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

STATE OF ALASKA

HEALTH CARE COST CONTAINMENT TASK FORCE

CONSULTANTS REPORT

JANUARY 4, 1990

JUNEAU, ALASKA

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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.

1.29.90
Dave Gray

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

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To LAVE GRAY	From Barb HUFF
Co.	Co. AMEA
Dept. Senator Kelly's Office	Phone # 279-4236
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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.