

LEGISLATIVE FINANCE - HOUSE / SENATE FINANCE COMM. FILES 8879

HB 581 cont. 1937 1937 554 145

TABLE I

**XYZ Capital Management: Actual and Annualized Equity Performance Versus S&P 500
Category of Accounts: Tax-Exempt Client Portfolios
Annualized Percentage Returns for N Years Through Year X**

Year	Standard Deviation ⁽⁹⁾	Actual Return (%)	2 Yrs.	3 Yrs.	4 Yrs.	5 Yrs.	6 Yrs.	7 Yrs.	8 Yrs.	9 Yrs.	10 Yrs.	11 Yrs.	12 Yrs.	13 Yrs.	14 Yrs.	15 Yrs.	16 Yrs.	17 Yrs.
'87	1.2%	10.72	14.30	19.80	15.51	16.07	17.47	14.28	17.58	18.19	17.39	15.06	15.08	15.44	12.75	10.78	13.25	12.25
		5.24	11.75	18.05	15.00	16.47	17.30	13.82	16.00	16.29	15.28	13.03	13.90	15.55	11.88	9.88	10.42	10.65
'86	3.0%	17.99	24.62	17.15	17.44	18.87	14.89	18.59	19.16	18.15	15.51	15.48	15.84	12.91	10.79	11.84	12.35	
		18.67	25.04	18.45	19.46	19.87	15.33	17.62	17.75	16.45	13.84	14.73	16.45	12.41	10.21	10.78	11.00	
'85	1.9%	31.61	16.73	17.26	19.09	14.28	18.70	19.32	18.17	15.23	15.24	15.64	12.50	10.25	11.41	11.99		
		31.75	18.34	19.72	20.18	14.66	17.45	17.61	16.18	13.32	14.34	16.25	11.90	9.59	10.24	10.50		
'84	3.0%	3.54	10.68	15.18	10.31	16.27	17.40	16.36	13.34	13.55	14.17	10.91	8.64	9.99	10.70			
		6.29	14.13	16.55	10.75	14.78	15.42	14.11	11.21	12.55	14.31	10.25	7.92	8.73	9.12			
'83	2.8%	18.32	21.49	12.67	19.69	20.38	18.66	14.80	14.86	15.40	11.67	9.11	10.55	11.27				
		22.55	22.05	12.28	17.01	17.34	15.48	11.92	13.36	15.79	10.66	8.07	8.94	9.34				
'82	6.8%	24.75	9.94	20.15	20.90	18.72	14.24	14.27	15.04	10.95	8.23	9.87	10.70					
		21.54	7.47	15.21	16.07	14.11	10.25	12.10	14.98	9.41	6.72	7.78	8.31					
'81	3.5%	- 3.10	17.92	19.65	17.26	12.24	12.74	13.72	9.34	6.54	8.48	9.51						
		- 4.97	12.18	14.29	12.32	8.12	10.61	14.06	7.98	5.19	6.49	7.18						
'80	4.4%	43.50	32.96	24.95	16.44	16.20	16.80	11.24	7.81	9.85	10.86							
		32.42	25.35	18.75	11.66	14.02	17.60	9.96	6.53	7.85	8.48							
'79	3.1%	23.19	16.60	8.61	10.23	12.08	6.63	3.49	6.24	7.72								
		18.65	12.46	5.29	9.83	14.83	6.61	3.27	5.12	6.19								
'78	2.4%	10.37	1.98	6.22	9.47	3.59	0.53	4.02	5.93									
		6.59	- 0.53	7.04	13.90	4.36	0.91	3.31	4.63									
'77	2.4%	- 5.77	4.21	9.17	1.96	-1.33	2.99	5.31										
		- 7.17	7.26	16.44	3.80	-0.19	2.78	4.35										
'76	2.5%	15.24	17.51	4.67	- 0.19	4.84	7.29											
		23.94	30.42	7.74	1.64	4.89	6.40											
'75	2.9%	19.82	- 0.24	- 4.85	2.39	5.76												
		37.23	0.46	- 4.87	0.60	3.21												
'74	3.0%	-16.94	-15.21	-2.83	2.51													
		-26.46	-20.80	- 9.28	- 3.89													
'73	2.7%	-13.45	5.10	9.96														
		-14.69	0.75	5.08														
'72	3.2%	27.62	23.94															
		19.00	16.62															
'71	3.1%	20.37																
		14.30																

**XYZ CAPITAL MANAGEMENT COMPOSITE
OF ALL CLIENTS (BOLD)**

S&P 500 INDEX

Characteristic Line⁽¹⁰⁾

Beta = .89

Annual Alpha = +2.6%

R² = 90.3%

This performance presentation of XYZ Capital Management conforms to the standards set by the Financial Analysts Federation (standards dated 1979).

In addition to the information presented herein, such standards include:

- 1) Returns from all cash reserves and equivalents and/or bonds used by the manager in place of equities are included in performance calculations.
- 2) Figures include accounts under our management from their respective inception dates, including those clients no longer with the firm.
- 3) No selective periods of performance have been utilized. Results from all accounts have been continuous from their inception to the present or to the cessation of the client relationship with the firm.
- 4) The composite calculation has been appropriately weighted for the size of each account.
- 5) Results are presented before management and related custodial fees. XYZ Capital fee schedule is attached.
- 6) Convertible securities have been included in these equity results.
- 7) No alterations of composites as presented here have occurred due to changes in personnel or other reasons at any time.
- 8) The composites have been audited as of 3/3/88 (statement attached).
- 9) Approximately two-thirds of all portfolios had returns equal to the composite "actual return" +/- one standard deviation.
- 10) The characteristic line is a regression of manager composite performance versus S&P 500 over the full performance history (17 years).

TABLE II

XYZ Capital Management Equity Account Summary
Category: Tax-Exempt Client Portfolios

<u>Year</u>	<u>Composite Assets (\$000)</u>		<u>% Equiv. Equity Assets ⁽⁹⁾</u>	<u>% XYZ's Total Equities Managed</u>	<u># of Clients</u>	<u>Average Account Size (\$000)</u>	<u>Median Account Size (\$000)</u>
	<u>Reg. Yr.</u>	<u>Yr. End</u>					
1987	5,506,550	5,881,173	100%	96%	65	80,580	40,813
1986	4,456,012	5,506,550	100	90	62	77,557	28,726
1985	3,463,639	4,464,521	100	92	57	65,655	38,975
1984	3,253,627	3,439,790	100	93	55	52,118	25,926
1983	2,486,902	3,253,627	100	91	56	48,562	20,608
1982	1,840,726	2,480,485	100	89	52	42,042	20,933
1981	1,749,541	1,840,726	100	90	51	31,737	19,262
1980	1,133,875	1,749,541	100	91	45	35,705	26,285
1979	850,993	1,133,875	100	92	42	23,622	12,882
1978	645,561	850,993	100	90	41	18,500	11,268
1977	677,257	645,561	100	85	42	14,345	7,510
1976	540,736	677,257	100	87	44	13,822	7,588
1975	343,959	540,736	100	88	43	11,265	6,058
1974	317,764	343,959	100	90	40	8,000	4,801
1973	179,007	317,764	100	98	33	8,362	6,795
1972	78,626	179,007	100	98	21	7,459	1,997
1971	28,205	78,626	100	98	14	4,914	927

This composite presentation of XYZ Capital Management conforms to the standards set by the Financial Analysts Federation (standards dated 1979).

In addition to the information presented herein, such standards include:

- 1) All cash reserves and equivalents and/or bonds used by the manager in place of equities are included in composite presentations.
- 2) Figures include accounts under our management from their respective inception dates, including those clients no longer with the firm.
- 3) No selective periods for presentation have been utilized. Data from all accounts have been continuous from their inception to the present or to the cessation of the client relationship with the firm.
- 4) The composite calculation has been appropriately weighted for the size of each account.
- 5) Results are presented before management and related custodial fees. The average fee charged for each period appears in the presentation.
- 6) Convertible securities have been included in these equity composites.
- 7) No alterations of composites as presented here have occurred due to changes in personnel or other reasons at any time.
- 8) The data have been audited as of 3/3/88 (statement attached).

Table III

*FAF Investment Manager Performance
Presentation Standards Checklist*

Following is a checklist for investment managers, their clients and prospects, and for consultants—to assure proper conformance to the Financial Analyst Federation "Performance Presentation Standards of January 12, 1989."

I. Performance calculations.

- A. Performance results have been calculated on a time-weighted basis.*
- B. Returns combine income and current market valuations (thus, presenting so-called total returns).*
- C. Manager's fee levels have been disclosed along with performance records so that after-fee results can be measured.*
- D. Performance results of broad security classes such as equities or fixed income have been calculated with cash or substitute securities included. If cash has been excluded in the calculations, returns with cash have also been presented, along with the statement that FAF standards consider performance with cash as most representative of managerial results and most representative for comparisons with other managers.*

E. All exclusions from performance calculations and presentation by manager have been disclosed.

F. The method of linking interim performance results (daily, monthly, quarterly) has been explained. (FAF standard is for monthly linking.)

G. Balanced account performance.

1. Manager has assigned cash and substitute securities to the specific asset category to which it belongs, thereby allowing a clear division of the performance record for each asset managed.

2. If cash and substitute securities are not assigned to a separate asset, comparisons should not be made against other managers' performance figures for assets where cash returns have been included.

3. Manager has supplied information on risk, volatility and/or other measures which allow for reasonable performance evaluation.

H. *Convertible securities have been consistently assigned to either equities or fixed income, and have not been shifted without notice being given to clients concurrent or prior to such shift.*

J. *Managers have provided the indexes against which their submitted performance records have normally been compared.*

K. *If managers' assets have been leveraged, and performance returns calculated on this basis, results on an all-cash (unleveraged) basis have been provided.*

II. *Investment manager composites of performance results.*

A. *Manager has submitted a composite of all accounts managed for each period submitted; the composite includes results from any and all accounts no longer clients of the firm.*

B. *If a manager has separate composites, all have been submitted. A prospect should be able to account for the performance of all of the manager's assets managed.*

C. *Composites are not "survivors only" compilations; they include results of all accounts ever managed, including those of clients no longer with the firm.*

D. *All performance results contained in the composite include cash and substitutable securities, as per I.D. above.*

E. *All individual years and cumulative performance results for all periods have been supplied. The composite covers every year of the past 10 years, along with longer term results if the manager has been in business this long.*

F. *Compound annualized returns have also been provided for all periods.*

G. *A clear statement from manager indicates that no selectivity of account results for partial periods exists.*

H. *Composite or other data have not been altered for reasons of personnel changes or any other reasons.*

I. *Composite results are:*

1. *Weighted for the dollars under management (the FAF standard).*

2. *Presented on a median (unweighted) basis (recommended only as additional information, not as the primary disclosure).*

- J. *Data includes:*
 - 1. *Number of client relationships in the composite.*
 - 2. *Assets under management for each period.*
 - 3. *Average and median size of accounts in the composite have been presented.*
 - 4. *Assets included in the composite presented are shown as a percentage of the manager's total accounts which share very comparable investment guidelines and risks; and as a percentage of the manager's total funds under management. All clients and related performance data for this asset type can be accounted for.*

- K. *Fee information is clear, so that pre- and post-fee results can be determined.*

- L. *Composites include typical indexes against which manager has been judged.*

- M. *Alpha, Beta, Standard Deviation of Returns and other measures of risk, quality, variability, etc. within the composite for each year have been indicated.*

- N. *Other information provided:*

III. *Verification of performance data.*

- A. *Results have been audited by reputable auditors.*

- B. *Results are not audited, but include statements that calculations and presentation of individual accounts and composites conform to FAF performance presentation standards.*

- C. *Neither of A. or B. above.*

PERS AND TRS FINANCIAL PROJECTIONS

FEBRUARY 21, 1989

WILLIAM M.
MERCER MEIDINGER HANSEN
INCORPORATED

PERS AND TRS FINANCIAL PROJECTIONS

FEBRUARY 21, 1989

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WILLIAM M.
MERCER MEIDINGER HANSEN
INCORPORATED

February 21, 1989

Mr. James R. Wilson
Statement Investment Officer
State of Alaska
Department of Revenue
Treasury Division
P.O. Box SB
Juneau, AK 99811

Re: PERS and TRS Financial Projections

Dear Jim:

Enclosed you will find our actuarial projections of financial results for both PERS and TRS for the next 15 years. As always, care should be exercised in using these long-term financial projections.

For both PERS and TRS, we provide projections based upon four different sets of actuarial assumptions. The first table for each retirement system is based upon the current actuarial assumption which assumes an investment return rate of 9% per year and salary increases of 6.5% for the first five years of employment and 5.5% for later years of employment. Then, for each retirement system, we provide three additional projections. The first one assumes a 1% higher investment return with no change in the salary increase assumption; the second one assumes no change in the investment assumption but a 1% lower rate of salary increase assumption; the last one, which provides the most optimistic scenario, bases its projections upon a 1% higher rate of investment return with the 1% lower salary increase assumption.

For both PERS and TRS, there were actuarial losses during FY88. These losses led to lower funding ratios and increases in employer contribution rates. There were three major deviations from actuarial assumptions during the year. Of greatest importance was the substantial increase in the monthly premiums for retiree medical insurance. The monthly rate is currently \$250 per month per benefit recipient. After a few years of declining retiree medical insurance premiums, the rates have once again shot skyward.

There were actuarial losses from less-than-anticipated investment return rates during the year. Even with the three-year smoothing approach used on valuation assets, the dramatic drop in equity values on October 19, 1987 still had an affect on the total investment performance for the year. Based upon valuation assets, both PERS and TRS had investment performance rates during the year which were about 3% less than our 9% interest assumption.

William M. Mercer Meidinger Hansen, Incorporated

Mr. James R. Wilson
February 21, 1989
Page Two

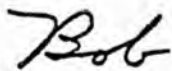
Partially dampening the affects of these two actuarial losses were the less-than-anticipated salary increases during the year. Both PERS and TRS experienced actuarial gains in this area.

The projections this year, when compared with last year's projections, all show slightly lower funding ratios and slightly higher employer contributions at all durations. More than anything else, this reflects the impact of the higher cost of post-retirement medical insurance. Also, this year's projections include additional employer contributions for the Retirement Incentive Program.

Summary

Despite actuarial gains from less-than-anticipated salary increases during FY88, actuarial losses from a dramatic rise in retiree medical insurance premiums, as well as less-than-anticipated investment performance, led to a decrease in funding ratios for both PERS and TRS. Nevertheless, both plans are still extremely well funded and are projected to remain so in the ensuing years.

Sincerely,



Robert F. Richardson, ASA, EA, MAAA
Principal

RFR:js

State of Alaska TRS
Financial Projections ('000 omitted)

As of June 30	Investment Return 9.00% (nominal)			Salary Increases 6.04% (6.5/5.5 assumed)							Ending Asset Valuation
	---Valuation Total Assets	Amounts on July 1-- Accrued Liability	Surplus* (Deficit)	-----Flow Total Salaries	Employer Contribs	Employee Contribs	Total Contribs	Benefit Payments	Net Contribs	Investment Earnings	
1988	1,331,905	1,348,677	(16,772)	413,556	59,004	37,085	96,859	78,902	17,987	126,075	1,475,967
1989	1,475,967	1,482,362	(6,395)	438,535	59,519	37,723	99,242	83,548	15,694	139,521	1,631,182
1990	1,631,182	1,628,457	2,725	465,022	57,897	38,667	96,564	88,385	8,179	153,781	1,793,142
1991	1,793,142	1,784,918	8,224	493,110	57,715	37,723	95,438	93,429	2,009	168,735	1,963,887
1992	1,963,887	1,932,792	11,094	522,893	60,979	39,897	100,876	98,692	2,183	184,802	2,150,872
1993	2,150,872	2,136,494	14,378	554,476	64,418	41,196	106,614	104,192	2,421	202,398	2,355,692
1994	2,355,692	2,337,571	18,121	587,967	68,040	44,627	112,667	109,943	2,722	221,675	2,580,089
1995	2,580,089	2,557,711	22,378	623,480	71,855	47,197	119,052	114,812	4,240	242,848	2,827,177
1996	2,827,177	2,799,971	27,206	661,138	75,870	49,916	125,786	125,013	773	265,931	3,093,880
1997	3,093,880	3,061,206	32,675	701,071	80,095	52,791	132,886	129,756	3,130	291,120	3,388,130
1998	3,388,130	3,349,291	38,839	743,415	84,542	55,830	140,372	138,434	1,938	318,741	3,708,810
1999	3,708,810	3,663,024	45,786	788,318	89,218	59,124	148,342	146,321	2,021	348,904	4,059,725
2000	4,039,735	4,006,144	33,591	835,932	94,136	62,695	156,831	151,330	5,501	382,066	4,447,302
2001	4,447,302	4,384,959	62,343	886,422	99,307	66,482	165,789	155,844	9,944	418,716	4,875,962
2002	4,875,962	4,803,804	72,158	939,962	104,740	70,497	173,237	165,218	10,019	459,035	5,345,017
2003	5,345,017	5,261,848	83,169	996,736	110,445	74,755	185,200	172,835	12,366	503,255	5,860,638

* Surpluses reduce employer contributions over 5 years
* Deficits increase employer contributions over 25 years

PERCENTAGE RATIO RELATIONSHIPS OF ABOVE DATA

As of June 30	Funding Ratio	-----As % of Salaries-----				--As % of Assets--	
		Employer Contribs	Employee Contribs	Total Contribs	Benefit Payments	Net Contribs	Investment Earnings
1988	98.8	14.27%	9.16%	23.43%	19.08%	1.28%	9.00%
1989	99.6	13.57%	9.06%	22.63%	19.05%	1.01%	9.00%
1990	100.2	12.45%	8.32%	20.77%	19.01%	0.48%	9.00%
1991	100.5	11.70%	7.65%	19.35%	18.95%	0.11%	9.00%
1992	100.6	11.66%	7.63%	19.29%	18.87%	0.11%	9.00%
1993	100.7	11.62%	7.61%	19.23%	18.79%	0.11%	9.00%
1994	100.8	11.57%	7.59%	19.16%	18.70%	0.11%	9.00%
1995	100.9	11.52%	7.57%	19.09%	18.41%	0.16%	9.00%
1996	101.0	11.48%	7.55%	19.03%	18.91%	0.03%	9.00%
1997	101.1	11.42%	7.53%	18.95%	18.51%	0.10%	9.00%
1998	101.2	11.37%	7.51%	18.88%	18.62%	0.05%	9.00%
1999	101.2	11.32%	7.50%	18.82%	18.56%	0.05%	9.00%
2000	101.3	11.26%	7.50%	18.76%	18.10%	0.13%	9.00%
2001	101.4	11.20%	7.50%	18.70%	17.58%	0.21%	9.00%
2002	101.5	11.14%	7.50%	18.64%	17.58%	0.20%	9.00%
2003	101.6	11.08%	7.50%	18.58%	17.34%	0.22%	9.00%

Table 2
State of Alaska IRS
Financial Projections (000 omitted)

As of June 30	Investment Return 10.00% (nominal)			Salary Increases 6.04% (6.5/5.5 assumed)				Ending Asset Valuation			
	--Valuation Total Assets	Amounts on Accrued Liability	July 1-- Surplus* (Deficit)	-----Flow Amounts During Following 12 Months-----							
			Total Salaries	Employer Contribs	Employee Contribs	Total Contribs	Benefit Payments	Net Contribs	Investment Earnings		
1988	1,331,705	1,348,677	(16,772)	413,556	59,004	37,885	96,889	78,902	17,987	140,749	1,490,641
1989	1,490,641	1,482,362	8,279	438,535	57,237	39,723	96,960	83,548	13,413	157,188	1,661,242
1990	1,661,242	1,628,457	32,785	465,022	55,090	38,667	93,757	88,385	5,372	174,699	1,841,313
1991	1,841,313	1,784,918	56,394	493,110	53,216	37,723	90,939	93,429	(2,490)	193,213	2,032,036
1992	2,032,036	1,952,792	79,244	522,893	54,614	39,897	94,511	98,692	(4,181)	213,155	2,241,009
1993	2,241,009	2,136,494	104,515	554,476	56,000	42,196	98,195	104,142	(5,997)	235,006	2,470,018
1994	2,470,018	2,337,371	132,448	587,967	57,363	44,627	101,989	109,945	(7,956)	258,954	2,721,016
1995	2,721,016	2,557,711	163,306	623,480	58,692	47,197	105,890	114,812	(8,922)	285,261	2,997,355
1996	2,997,355	2,799,771	197,384	661,138	59,976	49,916	109,892	125,013	(15,122)	313,966	3,296,199
1997	3,296,199	3,061,206	234,994	701,071	61,199	52,791	113,990	129,756	(15,766)	345,313	3,625,746
1998	3,625,746	3,349,291	276,455	743,415	62,349	55,830	118,180	138,434	(20,254)	379,691	3,985,182
1999	3,985,182	3,663,024	322,159	789,318	63,406	59,124	122,530	146,321	(23,791)	417,255	4,378,646
2000	4,378,646	4,006,144	372,501	835,932	64,351	62,695	127,046	151,330	(24,284)	458,544	4,812,905
2001	4,812,905	4,584,759	427,946	886,422	65,161	66,482	131,643	155,844	(24,202)	504,145	5,292,848
2002	5,292,848	4,803,804	489,044	939,962	65,804	70,497	136,302	165,218	(28,917)	554,303	5,818,235
2003	5,818,235	5,261,848	556,386	996,736	66,248	74,753	141,003	172,835	(31,831)	609,323	6,395,726

- * Surpluses reduce employer contributions over 5 years
- * Deficits increase employer contributions over 25 years

PERCENTAGE RATIO RELATIONSHIPS OF ABOVE DATA

As of June 30	Funding Ratio	-----As % of Salaries-----				--As % of Assets--	
		Employer Contribs	Employee Contribs	Total Contribs	Benefit Payments	Net Contribs	Investment Earnings
1988	98.8	14.27%	9.16%	23.43%	19.08%	1.28%	10.00%
1989	100.6	13.05%	9.06%	22.11%	19.05%	0.85%	10.00%
1990	102.0	11.85%	8.32%	20.16%	19.01%	0.31%	10.00%
1991	103.2	10.79%	7.65%	18.44%	18.95%	-0.13%	10.00%
1992	104.1	10.44%	7.63%	18.07%	18.87%	-0.20%	10.00%
1993	104.9	10.10%	7.61%	17.71%	18.79%	-0.26%	10.00%
1994	105.7	9.76%	7.59%	17.35%	18.70%	-0.31%	10.00%
1995	106.4	9.41%	7.57%	16.98%	18.41%	-0.31%	10.00%
1996	107.0	9.07%	7.55%	16.62%	18.91%	-0.48%	10.00%
1997	107.7	8.73%	7.53%	16.26%	18.51%	-0.46%	10.00%
1998	108.3	8.39%	7.51%	15.90%	18.62%	-0.53%	10.00%
1999	108.8	8.04%	7.50%	15.54%	18.56%	-0.57%	10.00%
2000	109.3	7.70%	7.50%	15.20%	18.10%	-0.53%	10.00%
2001	109.8	7.35%	7.50%	14.85%	17.58%	-0.48%	10.00%
2002	110.2	7.00%	7.50%	14.50%	17.50%	-0.52%	10.00%
2003	110.6	6.65%	7.50%	14.15%	17.34%	-0.52%	10.00%

Table 3
State of Alaska TRS
Financial Projections ('000 omitted)

As of June 30	Investment Return 9.00% (nominal)			Salary Increases 5.04% (5.5/4.5 assumed)						Ending Asset Valuation	
	--Valuation Total Assets	Amounts on July 1-- Accrued Liability	Surplus* (Deficit)	-----Flow Total Employer Salaries Contris		Amounts During Following 12 Months----- Employee Contris Total Benefit Payments Net Contris Investment Earnings					
1983	1,331,905	1,348,677	(16,772)	409,656	58,541	37,584	96,126	73,590	17,536	126,055	1,475,495
1989	1,475,495	1,476,121	(626)	430,303	57,181	39,090	92,272	82,889	13,383	139,373	1,628,251
1990	1,628,251	1,614,564	13,687	451,990	55,328	37,468	92,995	87,343	5,653	153,391	1,787,295
1991	1,787,295	1,761,762	25,532	474,770	53,923	36,320	90,243	91,961	(1,718)	168,018	1,953,594
1992	1,953,594	1,918,539	35,056	498,699	55,872	38,051	93,922	96,757	(2,834)	183,608	2,134,368
1993	2,134,368	2,089,059	45,309	523,833	57,895	39,864	97,759	101,741	(3,982)	200,558	2,330,944
1994	2,330,944	2,274,591	56,353	550,234	59,995	41,763	101,757	106,927	(5,169)	218,993	2,544,767
1995	2,544,767	2,470,514	68,252	577,966	62,172	43,752	105,924	111,171	(5,247)	239,099	2,778,619
1996	2,778,619	2,697,541	81,078	607,096	64,429	45,836	110,265	120,690	(10,425)	260,860	3,029,054
1997	3,029,054	2,934,142	94,912	637,693	66,766	48,018	114,784	124,686	(9,901)	284,437	3,303,589
1998	3,303,589	3,193,767	109,822	669,833	69,185	50,304	119,490	132,547	(13,057)	310,115	3,600,647
1999	3,600,647	3,474,741	125,906	703,592	71,687	52,769	124,456	139,543	(15,087)	337,962	3,923,522
2000	3,923,522	3,780,270	143,252	739,053	74,272	55,429	129,701	143,580	(13,879)	368,303	4,278,026
2001	4,278,026	4,116,064	161,962	776,302	76,943	58,223	135,165	147,035	(11,869)	401,814	4,667,971
2002	4,667,971	4,485,809	182,162	815,427	79,696	61,157	140,853	155,255	(14,402)	438,375	5,091,944
2003	5,091,944	4,887,449	203,995	856,525	82,531	64,239	146,771	161,618	(14,847)	478,229	5,555,326

* Surpluses reduce employer contributions over 5 years
 * Deficits increase employer contributions over 25 years

PERCENTAGE RATIO RELATIONSHIPS OF ABOVE DATA

As of June 30	Funding Ratio	-----As % of Salaries-----				--As % of Assets--	
		Employer Contris	Employee Contris	Total Contris	Benefit Payments	Net Contris	Investment Earnings
1988	98.8	14.29%	9.17%	23.46%	19.18%	1.25%	9.00%
1989	100.0	13.29%	9.08%	22.37%	19.26%	0.86%	9.00%
1990	100.8	12.24%	8.33%	20.57%	19.32%	0.33%	9.00%
1991	101.4	11.36%	7.65%	19.01%	19.37%	-0.09%	9.00%
1992	101.8	11.20%	7.63%	18.83%	19.40%	-0.14%	9.00%
1993	102.2	11.05%	7.61%	18.66%	19.42%	-0.18%	9.00%
1994	102.5	10.90%	7.59%	18.49%	19.43%	-0.21%	9.00%
1995	102.8	10.76%	7.57%	18.33%	19.23%	-0.20%	9.00%
1996	103.0	10.61%	7.55%	18.16%	19.88%	-0.36%	9.00%
1997	103.2	10.47%	7.53%	18.00%	19.55%	-0.31%	9.00%
1998	103.4	10.33%	7.51%	17.84%	19.79%	-0.38%	9.00%
1999	103.6	10.19%	7.50%	17.69%	19.83%	-0.40%	9.00%
2000	103.8	10.05%	7.50%	17.55%	19.43%	-0.34%	9.00%
2001	103.9	9.91%	7.50%	17.41%	18.94%	-0.27%	9.00%
2002	104.1	9.77%	7.50%	17.27%	19.04%	-0.30%	9.00%
2003	104.2	9.64%	7.50%	17.14%	18.87%	-0.28%	9.00%

Table 4
State of Alaska TRS
Financial Projection: ('000 omitted)

As of June 30	Investment Return 10.00% (nominal)			Salary Increases			5.04% (5.5/4.5 assumed)			Ending Asset Valuation	
	--Valuation Total Assets	Amounts on Accrued Liability	July 1-- Surplus* (Deficit)	-----Flow Total Salaries	Employee Contribs	Amounts During Employee Contribs	Following Total Contribs	Benefit Payments	Net Contribs		Investment Earnings
1988	1,331,905	1,348,677	(16,772)	409,656	58,541	37,584	96,126	78,590	17,536	140,727	1,490,167
1989	1,490,167	1,476,121	14,046	430,303	55,722	39,090	94,812	82,889	11,923	157,064	1,659,255
1990	1,659,155	1,614,564	44,590	451,990	52,441	37,668	90,109	87,343	2,766	174,350	1,836,270
1991	1,836,270	1,761,762	74,508	474,770	49,349	36,320	85,669	91,961	(6,293)	192,494	2,022,472
1992	2,022,472	1,918,539	103,933	498,699	49,439	38,051	87,489	96,757	(9,267)	211,896	2,225,101
1993	2,225,101	2,087,059	136,042	523,833	49,421	39,864	89,284	101,741	(12,456)	233,013	2,445,657
1994	2,445,657	2,274,591	171,066	550,234	49,281	41,763	91,044	106,927	(15,883)	256,000	2,685,773
1995	2,685,773	2,476,514	209,259	577,966	49,003	43,752	92,755	111,171	(18,417)	281,085	2,948,442
1996	2,948,442	2,697,541	250,901	607,096	48,568	45,836	94,404	120,690	(26,286)	308,272	3,230,428
1997	3,230,428	2,934,142	296,286	637,693	47,958	48,018	95,976	124,686	(28,709)	337,760	3,539,479
1998	3,539,479	3,193,767	345,711	669,833	47,154	50,304	97,458	132,547	(35,089)	369,891	3,874,281
1999	3,874,281	3,474,741	399,540	703,592	46,130	52,769	98,900	139,543	(40,643)	404,767	4,238,405
2000	4,238,405	3,780,270	458,135	739,053	44,861	55,429	100,292	143,580	(43,288)	442,868	4,637,985
2001	4,637,985	4,116,064	521,921	776,302	43,324	58,223	101,546	147,035	(45,488)	484,714	5,077,211
2002	5,077,211	4,485,809	591,402	815,427	41,475	61,157	102,632	155,255	(52,624)	530,476	5,555,063
2003	5,555,063	4,887,949	667,114	856,525	39,277	64,239	103,517	161,618	(58,101)	580,377	6,077,339

* Surpluses reduce employer contributions over 5 years
 * Deficits increase employer contributions over 25 years

PERCENTAGE RATIO RELATIONSHIPS OF ABOVE DATA

As of June 30	Funding Ratio	-----As % of Salaries-----				--As % of Assets--	
		Employer Contribs	Employee Contribs	Total Contribs	Benefit Payments	Net Contribs	Investment Earnings
1988	98.8	14.29%	9.17%	23.46%	19.18%	1.25%	10.00%
1989	101.0	12.95%	9.08%	22.03%	19.26%	0.76%	10.00%
1990	102.8	11.60%	8.33%	19.94%	19.32%	0.16%	10.00%
1991	104.2	10.39%	7.65%	18.04%	19.37%	-0.33%	10.00%
1992	105.4	9.91%	7.63%	17.54%	19.40%	-0.44%	10.00%
1993	106.5	9.43%	7.61%	17.04%	19.42%	-0.53%	10.00%
1994	107.5	8.96%	7.59%	16.55%	19.43%	-0.62%	10.00%
1995	108.4	8.48%	7.57%	16.05%	19.23%	-0.66%	10.00%
1996	109.3	8.00%	7.55%	15.55%	19.88%	-0.85%	10.00%
1997	110.1	7.52%	7.53%	15.05%	19.55%	-0.85%	10.00%
1998	110.8	7.04%	7.51%	14.55%	19.79%	-0.95%	10.00%
1999	111.5	6.56%	7.50%	14.06%	19.83%	-1.00%	10.00%
2000	112.1	6.07%	7.50%	13.57%	19.43%	-0.98%	10.00%
2001	112.7	5.58%	7.50%	13.08%	18.94%	-0.94%	10.00%
2002	113.2	5.09%	7.50%	12.59%	19.04%	-0.99%	10.00%
2003	113.6	4.59%	7.50%	12.09%	18.87%	-1.00%	10.00%

Table 5
State of Alaska PERS
Financial Projections ('000 omitted)

As of June 30	Investment Return 9.00% (nominal)			Salary Increases 6.04% (6.5/5.5 assumed)					12 Months		Ending Asset Valuation
	--Valuation Amounts on July 1--			-----Flow Amounts During Following					Net	Investment	
	Assets	Accrued Liability	Surplus* (Deficit)	Total Salaries	Employer Contribs	Employee Contribs	Total Contribs	Benefit Payments	Contribs	Earnings	
1988	2,088,428	2,246,583	(158,155)	945,136	128,539	64,553	193,092	97,859	95,233	200,702	2,384,364
1989	2,384,364	2,511,963	(127,597)	1,002,222	126,601	68,452	195,053	106,870	88,183	228,218	2,700,764
1990	2,700,764	2,801,804	(101,039)	1,062,756	123,924	72,586	196,510	116,504	80,006	257,607	3,038,378
1991	3,038,378	3,118,259	(79,881)	1,126,946	122,858	76,970	199,829	125,883	73,946	289,087	3,401,411
1992	3,401,411	3,464,631	(63,221)	1,195,014	125,211	81,619	206,831	135,955	70,875	323,092	3,795,378
1993	3,795,378	3,843,567	(48,189)	1,267,193	128,328	86,549	214,877	148,046	66,832	359,963	4,222,172
1994	4,222,172	4,256,607	(34,435)	1,343,731	132,148	91,777	223,925	160,809	63,116	399,936	4,685,224
1995	4,685,224	4,706,881	(21,658)	1,424,893	136,626	97,320	233,946	175,544	58,402	443,273	5,186,899
1996	5,186,899	5,196,490	(9,591)	1,510,956	141,724	103,198	244,922	191,787	53,135	490,219	5,730,253
1997	5,730,253	5,728,256	1,997	1,602,218	147,698	109,431	257,130	209,342	47,788	541,081	6,319,122
1998	6,319,122	6,305,512	13,610	1,698,992	155,546	116,041	271,587	228,844	42,743	596,237	6,958,102
1999	6,958,102	6,931,281	26,820	1,801,611	163,784	123,050	286,834	247,363	39,471	656,186	7,653,758
2000	7,653,758	7,611,981	41,776	1,910,428	172,431	130,482	302,913	269,379	33,534	721,345	8,408,636
2001	8,408,636	8,349,986	58,650	2,025,818	181,505	138,363	319,869	293,243	26,625	792,030	9,227,292
2002	9,227,292	9,149,673	77,619	2,148,178	191,027	146,721	337,748	318,446	19,302	868,695	10,115,290
2003	10,115,290	10,016,415	98,874	2,277,928	201,018	155,582	356,601	344,013	12,587	951,909	11,079,787

* Surpluses reduce employer contributions over 5 years
 * Deficits increase employer contributions over 25 years

PERCENTAGE RATIO RELATIONSHIPS OF ABOVE DATA

As of June 30	Funding Ratio	-----As % of Salaries-----				---As % of Assets---	
		Employer Contribs	Employee Contribs	Total Contribs	Benefit Payments	Net Contribs	Investment Earnings
1988	93.0	13.60%	6.83%	20.43%	10.35%	4.27%	9.00%
1989	94.9	12.63%	6.83%	19.46%	10.66%	3.48%	9.00%
1990	96.4	11.66%	6.83%	18.49%	10.96%	2.80%	9.00%
1991	97.4	10.90%	6.83%	17.73%	11.17%	2.30%	9.00%
1992	98.2	10.48%	6.83%	17.31%	11.38%	1.97%	9.00%
1993	98.7	10.13%	6.83%	16.96%	11.68%	1.67%	9.00%
1994	99.2	9.83%	6.83%	16.66%	11.97%	1.42%	9.00%
1995	99.5	9.59%	6.83%	16.42%	12.32%	1.19%	9.00%
1996	99.8	9.38%	6.83%	16.21%	12.69%	0.98%	9.00%
1997	100.0	9.22%	6.83%	16.05%	13.07%	0.79%	9.00%
1998	100.2	9.16%	6.83%	15.99%	13.47%	0.65%	9.00%
1999	100.4	9.09%	6.83%	15.92%	13.85%	0.54%	9.00%
2000	100.5	9.03%	6.83%	15.86%	14.10%	0.42%	9.00%
2001	100.7	8.96%	6.83%	15.79%	14.48%	0.30%	9.00%
2002	100.8	8.89%	6.83%	15.72%	14.82%	0.20%	9.00%

Table 6
State of Alaska PERS
Financial Projections ('000 omitted)

As of June 30	Investment Return 10.00% (nominal)			Salary Increases 6.04% (6.5/5.5 assumed)					Ending Asset Valuation		
	--Valuation Amounts on July 1--			-----Flow Amounts During Following 12 Months-----							
	Assets	Accrued Liability	Surplus* (Deficit)	Total Salaries	Employer Contribs	Employee Contribs	Total Benefit Payments	Net Contribs	Investment Earnings		
1988	2,088,428	2,246,583	(158,155)	945,136	128,539	64,553	193,092	97,859	95,233	224,047	2,407,708
1989	2,407,708	2,511,963	(104,255)	1,002,222	121,095	68,452	189,547	106,870	82,677	256,943	2,747,328
1990	2,747,328	2,801,804	(54,475)	1,062,756	112,941	72,586	185,527	116,504	69,024	291,921	3,108,273
1991	3,108,273	3,118,259	(9,987)	1,126,946	106,373	76,970	183,343	125,883	57,460	329,242	3,494,974
1992	3,494,974	3,464,631	30,343	1,195,014	107,466	81,619	189,085	135,955	53,130	369,629	3,917,733
1993	3,917,733	3,843,567	74,166	1,267,193	110,035	86,549	196,584	148,046	48,539	413,789	4,380,060
1994	4,380,060	4,256,607	123,453	1,343,731	112,496	91,777	204,273	160,809	43,464	462,080	4,885,604
1995	4,885,604	4,706,881	178,722	1,424,893	114,826	97,320	212,146	175,544	36,602	514,818	5,437,024
1996	5,437,024	5,196,490	240,533	1,510,956	116,996	103,198	220,195	191,787	28,408	572,308	6,037,739
1997	6,037,739	5,728,256	309,483	1,602,218	118,980	109,431	228,411	209,342	19,070	634,914	6,691,725
1998	6,691,725	6,305,512	386,213	1,698,992	120,746	116,041	236,787	228,844	7,943	703,058	7,402,696
1999	7,402,696	6,931,281	471,415	1,801,611	122,260	123,050	245,310	247,363	(2,053)	777,180	8,177,824
2000	8,177,824	7,611,981	565,842	1,910,428	123,485	130,482	253,967	269,379	(15,412)	857,901	9,020,312
2001	9,020,312	8,349,986	670,326	2,025,818	124,377	138,363	262,740	293,243	(30,503)	945,608	9,935,417
2002	9,935,417	9,149,673	785,743	2,148,178	124,891	146,721	271,611	318,446	(46,834)	1,040,877	10,929,459
2003	10,929,459	10,016,415	913,044	2,277,928	124,977	155,582	280,560	344,013	(63,454)	1,144,421	12,010,426

* Surpluses reduce employer contributions over 5 years
 * Deficits increase employer contributions over 25 years

PERCENTAGE RATIO RELATIONSHIPS OF ABOVE DATA

As of June 30	Funding Ratio	-----As % of Salaries-----				---As % of Assets---	
		Employer Contribs	Employee Contribs	Total Benefit Payments	Net Contribs	Investment Earnings	
1988	93.0	13.60%	6.83%	20.43%	10.35%	4.25%	10.00%
1989	95.8	12.08%	6.83%	18.91%	10.66%	3.22%	10.00%
1990	98.1	10.63%	6.83%	17.46%	10.96%	2.36%	10.00%
1991	99.7	9.44%	6.83%	16.27%	11.17%	1.76%	10.00%
1992	100.9	8.99%	6.83%	15.82%	11.38%	1.44%	10.00%
1993	101.9	8.68%	6.83%	15.51%	11.63%	1.17%	10.00%
1994	102.9	8.37%	6.83%	15.20%	11.87%	0.94%	10.00%
1995	103.8	8.06%	6.83%	14.89%	12.32%	0.71%	10.00%
1996	104.6	7.74%	6.83%	14.57%	12.69%	0.50%	10.00%
1997	105.4	7.43%	6.83%	14.26%	13.07%	0.30%	10.00%
1998	106.1	7.11%	6.83%	13.94%	13.47%	0.11%	10.00%
1999	106.8	6.79%	6.83%	13.62%	13.73%	-0.03%	10.00%
2000	107.4	6.46%	6.83%	13.29%	14.10%	-0.18%	10.00%
2001	108.0	6.14%	6.83%	12.97%	14.48%	-0.32%	10.00%
2002	108.6	5.81%	6.83%	12.64%	14.82%	-0.45%	10.00%

Table 7
State of Alaska PERS
Financial Projections ('000 omitted)

As of June 30	Investment Return 9.00% (nominal)			Salary Increases 5.04% (5.5/4.3 assumed)						Ending Asset Valuation	
	--Valuation Amounts on July 1--			-----Flow Amounts During Following 12 Months-----							
	Assets	Accrued Liability	Surplus* (Deficit)	Total Salaries	Employer Contri	Employee Contri	Total Benefit Payments	Net Contri	Investment Earnings		
1988	2,088,428	2,246,583	(158,155)	936,223	127,717	63,944	191,661	97,502	94,159	200,654	2,383,240
1989	2,383,240	2,497,668	(114,428)	983,408	121,758	67,167	108,925	106,061	82,864	227,873	2,693,977
1990	2,693,977	2,770,007	(76,030)	1,032,972	115,276	70,552	185,828	115,134	70,694	256,550	3,021,221
1991	3,021,221	3,065,357	(44,136)	1,085,034	110,559	74,108	184,666	123,829	60,837	286,884	3,368,942
1992	3,368,942	3,386,586	(17,645)	1,139,719	109,358	77,843	187,201	133,080	54,121	319,284	3,742,347
1993	3,742,347	3,735,867	6,480	1,197,161	109,893	81,766	191,659	144,194	47,465	354,104	4,143,915
1994	4,143,915	4,114,220	29,696	1,257,498	113,294	85,887	199,181	155,808	43,373	391,687	4,578,975
1995	4,578,975	4,524,205	54,770	1,320,876	116,802	90,216	207,017	169,179	37,818	432,354	5,049,148
1996	5,049,148	4,967,303	81,845	1,387,448	120,417	94,763	215,180	183,882	31,298	476,281	5,556,726
1997	5,556,726	5,445,658	111,069	1,457,376	124,142	99,539	223,681	199,637	24,044	523,697	6,104,462
1998	6,104,462	5,961,862	142,600	1,530,827	127,977	104,556	232,532	217,073	15,460	574,820	6,694,743
1999	6,694,743	6,518,135	176,608	1,607,981	131,922	109,825	241,747	233,228	8,519	630,024	7,333,285
2000	7,333,285	7,120,015	213,270	1,689,023	135,978	115,360	251,338	252,553	(1,214)	689,641	8,021,712
2001	8,021,712	7,768,923	252,789	1,774,150	140,144	121,174	261,319	273,361	(12,043)	753,900	8,763,570
2002	8,763,570	8,468,197	295,372	1,863,567	144,420	127,282	271,702	295,108	(23,406)	823,160	9,563,325
2003	9,563,325	9,222,083	341,242	1,957,491	148,806	133,697	282,502	316,776	(34,274)	897,888	10,426,939

* Surpluses reduce employer contributions over 5 years
 * Deficits increase employer contributions over 25 years

PERCENTAGE RATIO RELATIONSHIPS OF ABOVE DATA

As of June 30	Funding Ratio	-----As % of Salaries-----				---As % of Assets---	
		Employer Contri	Employee Contri	Total Benefit Payments	Net Contri	Investment Earnings	
1988	93.0	13.64%	6.83%	20.47%	10.41%	4.22%	9.00%
1989	95.4	12.38%	6.83%	19.21%	10.79%	3.27%	9.00%
1990	97.3	11.16%	6.83%	17.99%	11.15%	2.48%	9.00%
1991	98.6	10.19%	6.83%	17.02%	11.41%	1.91%	9.00%
1992	99.5	9.60%	6.83%	16.43%	11.68%	1.53%	9.00%
1993	100.2	9.18%	6.83%	16.01%	12.04%	1.21%	9.00%
1994	100.7	9.01%	6.83%	15.84%	12.39%	1.00%	9.00%
1995	101.2	8.84%	6.83%	15.67%	12.81%	0.79%	9.00%
1996	101.6	8.68%	6.83%	15.51%	13.25%	0.59%	9.00%
1997	102.0	8.57%	6.83%	15.35%	13.70%	0.41%	9.00%
1998	102.4	8.36%	6.83%	15.19%	14.18%	0.24%	9.00%
1999	102.7	8.20%	6.83%	15.03%	14.50%	0.12%	9.00%
2000	103.0	8.05%	6.83%	14.88%	14.95%	-0.02%	9.00%
2001	103.3	7.90%	6.83%	14.73%	15.41%	-0.14%	9.00%
2002	103.5	7.75%	6.83%	14.58%	15.84%	-0.26%	9.00%

Table 8
State of Alaska PERS
Financial Projections ('000 omitted)

As of June 30	Investment Return 10.00% (nominal)			Salary Increases 5.04% (5.5/4.5 assumed)							Ending Asset Valuation
	--Valuation Amounts on July 1--			-----Flow Amounts During Following 12 Months-----							
	Assets	Accrued Liability	Surplus* (Deficit)	Total Salaries	Employer Contribs	Employee Contribs	Total Benefit Contribs	Payments	Net Contribs	Investment Earnings	
1988	2,088,428	2,246,583	(158,155)	936,223	127,717	63,944	191,661	97,502	94,159	223,993	2,406,579
1989	2,406,579	2,497,668	(91,089)	983,408	116,253	67,167	183,420	106,061	77,359	256,559	2,740,497
1990	2,740,497	2,770,007	(29,509)	1,032,972	104,304	70,552	174,856	115,134	59,722	290,738	3,090,957
1991	3,090,957	3,065,357	25,601	1,085,034	97,758	74,108	171,865	123,829	48,036	326,952	3,465,946
1992	3,465,946	3,386,586	79,360	1,139,719	97,784	77,843	175,627	133,080	42,547	366,052	3,874,544
1993	3,874,544	3,735,867	138,678	1,197,161	97,546	81,766	179,312	144,194	35,118	408,583	4,318,246
1994	4,318,246	4,114,220	204,026	1,257,498	97,012	85,887	182,899	155,808	27,091	454,770	4,800,107
1995	4,800,107	4,524,205	275,902	1,320,876	96,149	90,216	186,364	169,199	17,165	504,869	5,322,142
1996	5,322,142	4,967,303	354,838	1,387,448	94,921	94,763	189,683	183,882	5,801	559,115	5,887,058
1997	5,887,058	5,445,658	441,400	1,457,376	93,290	99,539	192,829	199,637	(6,808)	617,801	6,498,050
1998	6,498,050	5,961,862	536,188	1,530,827	91,217	104,556	195,773	217,073	(21,300)	681,230	7,157,981
1999	7,157,981	6,518,135	639,846	1,607,981	88,657	109,825	198,482	233,228	(34,746)	749,851	7,873,085
2000	7,873,085	7,120,015	753,070	1,689,023	85,562	115,360	200,923	252,553	(51,630)	824,192	8,645,548
2001	8,645,548	7,768,923	876,625	1,774,150	81,880	121,174	203,055	273,361	(70,307)	904,267	9,479,508
2002	9,479,508	8,468,197	1,011,311	1,863,567	77,554	127,282	204,836	293,108	(90,272)	990,835	10,380,071
2003	10,380,071	9,222,083	1,157,988	1,957,491	72,524	133,697	206,221	316,776	(110,556)	1,084,380	11,353,895

* Surpluses reduce employer contributions over 5 years
 * Deficits increase employer contributions over 25 years

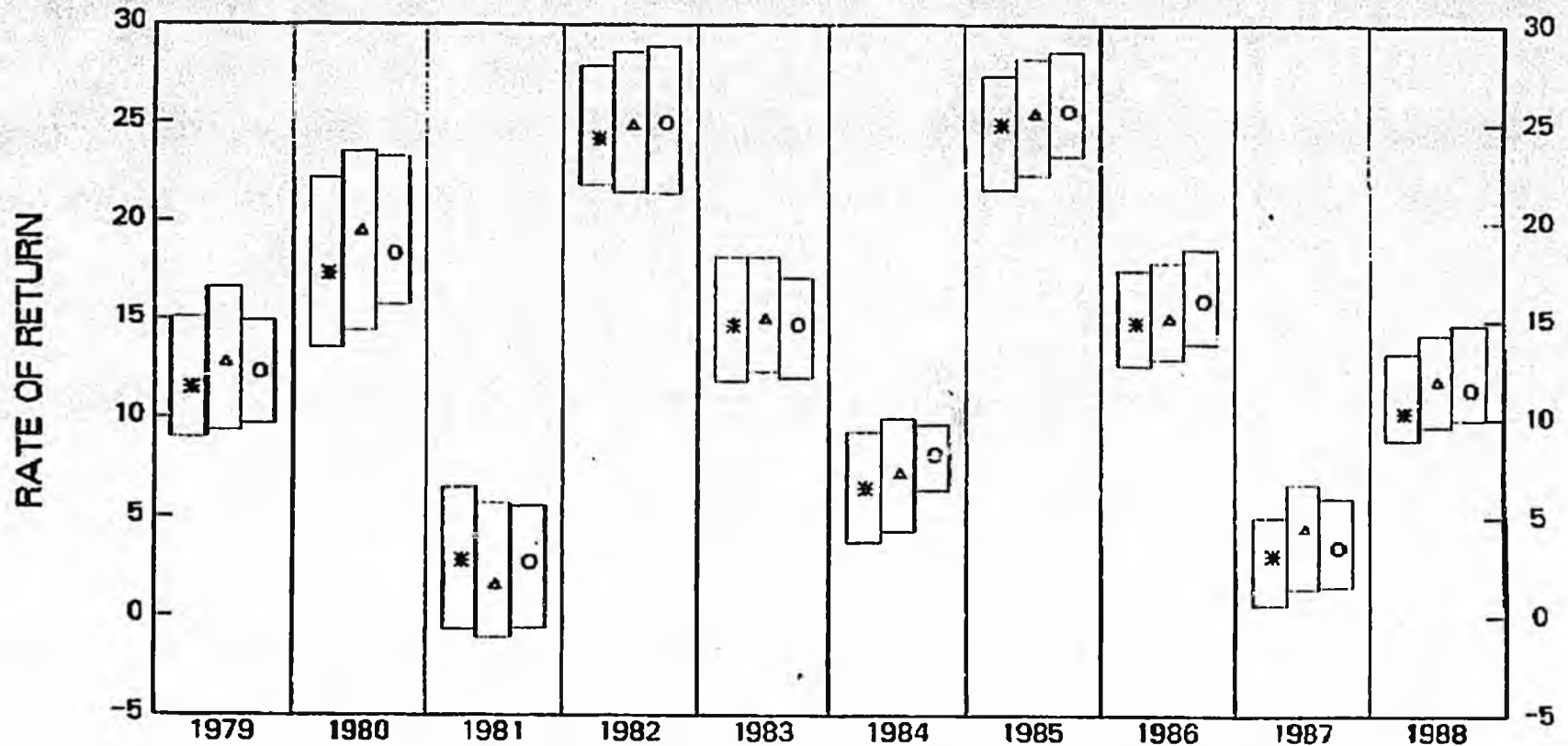
PERCENTAGE RATIO RELATIONSHIPS OF ABOVE DATA

As of June 30	Funding Ratio	-----As % of Salaries-----				---As % of Assets---	
		Employer Contribs	Employee Contribs	Total Contribs	Benefit Payments	Net Contribs	Investment Earnings
1988	93.0	13.64%	6.83%	20.47%	10.41%	4.20%	10.00%
1989	96.4	11.82%	6.83%	18.65%	10.79%	3.02%	10.00%
1990	98.9	10.10%	6.83%	16.93%	11.15%	2.05%	10.00%
1991	100.8	9.01%	6.83%	15.84%	11.41%	1.47%	10.00%
1992	102.3	8.58%	6.83%	15.41%	11.68%	1.16%	10.00%
1993	103.7	8.15%	6.83%	14.98%	12.04%	0.86%	10.00%
1994	105.0	7.71%	6.83%	14.54%	12.39%	0.60%	10.00%
1995	106.1	7.28%	6.83%	14.11%	12.81%	0.34%	10.00%
1996	107.1	6.84%	6.83%	13.67%	13.25%	0.10%	10.00%
1997	108.1	6.40%	6.83%	13.23%	13.70%	-0.11%	10.00%
1998	109.0	5.96%	6.83%	12.79%	14.18%	-0.31%	10.00%
1999	109.8	5.51%	6.83%	12.34%	14.50%	-0.46%	10.00%
2000	110.6	5.07%	6.83%	11.90%	14.95%	-0.63%	10.00%
2001	111.3	4.62%	6.83%	11.45%	15.41%	-0.78%	10.00%
2002	111.9	4.16%	6.83%	10.99%	15.84%	-0.91%	10.00%



TOTAL FUND: RATES OF RETURN BY ASSET SIZE

FOR PERIODS ENDING DECEMBER 31.



BARS REPRESENT THE RANGE OF RETURNS BETWEEN THE FIRST AND THIRD QUARTILE

ANNUAL MEDIAN RETURNS

	(*)	1979	1980	1981	1982	1983	1984	1985	1986	1987	1988
UNDER \$10 MILLION	(*)	11.7	17.5	3.0	24.4	14.9	6.6	25.1	15.0	3.2	10.5
\$10 TO \$50 MILLION	(Δ)	12.9	19.6	1.7	25.0	15.1	7.3	25.6	15.2	4.6	12.0
OVER \$50 MILLION	(O)	12.5	18.5	2.8	25.2	14.9	8.3	25.8	16.1	3.7	11.7

ANNUALIZED LINKED MEDIAN RETURNS

	1979-88	1980-85	1981-88	1982-88	1983-88	1984-88	1985-88	1986-88	1987-85	1988
UNDER \$10 MILLION	12.9	13.1	12.5	14.0	12.3	11.8	13.2	9.4	6.8	10.5
\$10 TO \$50 MILLION	13.6	13.7	13.0	14.7	13.1	12.7	14.1	10.5	8.2	12.0
OVER \$50 MILLION	13.7	13.8	13.3	14.8	13.2	12.9	14.0	10.4	7.6	11.7

MEMORANDUM

STATE OF ALASKA

DEPARTMENT OF REVENUE

TO: The Honorable Hugh Malone
Commissioner of Revenue

DATE: November 1, 1988

FROM: Milton B. Barker *MB*
Deputy Commissioner

SUBJECT: Foreign Equity
Investment
Accounting

End-of-period valuation reports in investment accounting are computed based on reported market values for marketable securities. If the investments and the domicile of the investor are in the same country (and, therefore, denominated in the same currency), then the books of account are probably kept in the country's currency. However, if the investments are located in another country and are denominated and traded in a foreign currency, then the market valuation at the end of a period is denominated in the foreign currency. In order to provide a valuation report in terms of the investor's domestic currency and books of account, the foreign denominated value is converted to domestic value by applying the momentary foreign exchange rate prevailing at the end of the period between the domestic currency and the foreign currency. This is an entirely appropriate methodology for valuation reports, but it is not appropriate for reporting foreign investment activity or for recording foreign investment transactions on the investor's domestic books of account.

If investments are made in different countries having different currencies, then purchases, sales, gains, losses, and income transactions should not be converted into U.S. dollar books of account. The value is not fixed in terms of U.S. dollars and will not become fixed until the foreign currency is sold and the proceeds are used to buy U.S. dollars which are repatriated. When the U.S. dollars are repatriated, that is when events should be recognized on the U.S. dollar books of account.

Over the last five years the retirement funds have been investing in foreign markets through our two contract managers, Citibank and Morgan Guaranty, both of London, England. The funds' domestic book values should reflect the amount of U.S. dollars we advanced to the managers for investment purposes and not foreign transactions which are arbitrarily valued at a presumably appropriate exchange rate somewhere near that point in time. By attempting to convert all foreign investment activity into recordable U.S. dollar equivalents, we are essentially marking up the funds' book values to market values (albeit on a lagging basis). Such actions destroy the historical nature of book value in keeping track of the net U.S. dollar amount which was invested in the securities, creates a book value which is inconsistent with the other book values on the domestic books of account, and misleads users of the data.

The foreign investing through managers is analogous to buying stock in a single foreign company or a mutual fund. The book value is the U.S. dollars used to acquire the stock. If the company or mutual fund buys or sells some

The Honorable Hugh Malone
Page 2
November 1, 1988

of its assets, it does not affect book value. If the company or mutual fund retains income for investment in the business or fund or uses it to buy other assets, it does not change book value. The only things which could change book value would be investing more U.S. dollars to buy more of the stock or selling some of the stock for foreign currency and then exchanging the foreign currency for U.S. dollars. The fact that the book value of the company's assets are increasing or decreasing does not change the book value of the retirement funds' investment. It does, however, change the market values.

Even dividend or interest income earned in foreign currencies should not be ascribed as U.S. dollar income. As long as the income remains in foreign currency investments, its amount in U.S. dollar terms is not fixed and varies with each transitory change in the exchange rates. If the income is remitted in U.S. dollars, then its amount is fixed and then we can recognize it as U.S. dollar income on accounting reports.

Attached is Chapter 16 of the Miller Comprehensive GAAP Guide 1988 which discusses FASB-52, the statement of the Financial Accounting Standards Board that establishes generally accepted accounting principles for foreign operations and exchange. FASB-52 requires recognition in U.S. dollars of the book value of the income, gains, and losses realized in foreign currencies but not converted into U.S. dollars.

There are several aspects of FASB-52 that suggest this is a less than satisfactory treatment of the accounting problem.

1. For one thing, FASB-52 was highly controversial and was adopted by only a 4-3 vote.
2. Significantly, any foreign currency exchange gain or loss that results from translating (but not converting) income, gains, and losses realized in foreign currencies into U.S. dollars is not recorded as income on the U.S. dollar books of account, but is instead to be posted directly to a separate component of shareholder equity and realized as income only on partial or complete liquidation of the foreign investment. This seems rather arbitrary since not only the gain or loss component but also the original book value of the investment is just as much at risk to fluctuations in foreign exchange rates.
3. Along these lines, it is interesting to note that on page 22 Miller suggests that if it is not possible to compute meaningful exchange rates (in his examples, owing to foreign strife or exchange restrictions), "it is best to include earnings of a foreign operation only to the extent that cash has been received in unrestricted funds." Similarly, on page 24 Miller states "disclosure of exchange rate changes. . .that occur subsequent to the balance sheet date should be disclosed, if the effects are material." Given that the retirement funds investments are of a

The Honorable Hugh Malone
Page 3
November 1, 1988

long-term nature, the exchange rate as of the balance sheet date is not meaningful. Partial or complete liquidations of these foreign investments are highly infrequent.

Perhaps the basic problem is that FASB-52 is oriented toward business activities in foreign countries that generate liabilities in foreign currencies. (The second model which FASB-52 addresses (page 4), a business which conducts operations in U.S. dollars, is certainly not relevant.) The retirement systems are a misfit in that they operate in foreign currencies yet all their liabilities are in U.S. dollars. Indeed, this would be true of any foreign investment, as opposed to business activity. The examples and language of FASB-52 do not explicitly address investment activities.

MBB/gb

Attachments

ANNUAL RATES OF RETURN (a)
ON EXTERNALLY MANAGED EQUITIES
OF ALASKA RETIREMENT FUNDS

MANAGER AND INCEPTION DATE	03-31-89 to 06-30-89	06-30-88 to 06-30-89	Inception to 06-30-89
R.E. Equity Managers:	MANAGER R of R	MANAGER R of R	MANAGER R of R
Aetna (09-30-80)	N/A	4.77% (b)	6.19% (b)
Hancock (09-30-80)	N/A	-0.42 (b)	3.24 (b)
Equitable (12-31-80)	8.67	8.00	8.39
Sentinel (03-05-84)	N/A	6.54 (b)	7.02 (b)
JMB (04-12-84)	3.49	11.57	8.92
Morgan (06-01-84)	10.50	9.27	12.08
Karsten (12-26-84)	N/A	4.82 (b)	6.74 (b)
<u>Group Average</u>		<u>7.64%</u>	<u>7.54%</u>
<u>Domestic Equity Managers:</u>			
Alger (06-14-84)	47.58%	10.12%	10.81%
Invesco (06-14-84)	33.64	1.90	13.88
Lehman (06-14-84)	32.09	18.99	17.27
IDS (01-12-89)	37.24	28.21	28.21
Loomis, Sayles (01-12-89)	31.37	31.31	31.31
Miller Anderson (01-12-89)	26.20	27.74	27.74
United Capital (01-12-89)	27.35	22.13	22.13
<u>Active Group Average*</u>	<u>32.51%</u>	<u>17.69%</u>	<u>15.06%</u>
State Street (07-13-88)	29.21	17.40	17.40
Treasury (11-02-87)	11.22	8.56	7.98
<u>Domestic Group Average</u>	<u>32.24%</u>	<u>17.59%</u>	<u>15.15%</u>
<u>International Equity Managers:</u>			
Citicorp (11-01-83)	-18.59	7.77	24.83
Morgan Guaranty (11-01-83)	-7.71	10.74	25.56
<u>Group Average</u>	<u>-13.27%</u>	<u>9.26%</u>	<u>25.20%</u>
<u>ALL EQUITY MANAGER AVERAGE</u>		<u>14.55%</u>	<u>15.08%</u>

* - Not net of fees of approximately .31%.

a - Pure internal rate of return weighted by amount and date of deposits.

b - Used 03-31-89 value because 06-30-89 was not available.

Portfolio Management, Treasury Division
August 16, 1989

ANNUAL RATES OF RETURN (a)
ON INTERNALLY MANAGED FIXED INCOME INVESTMENTS
AND ON THE TOTAL FUNDS OF ALASKA RETIREMENT FUNDS
Fiscal Years 1985 through June 30, 1989

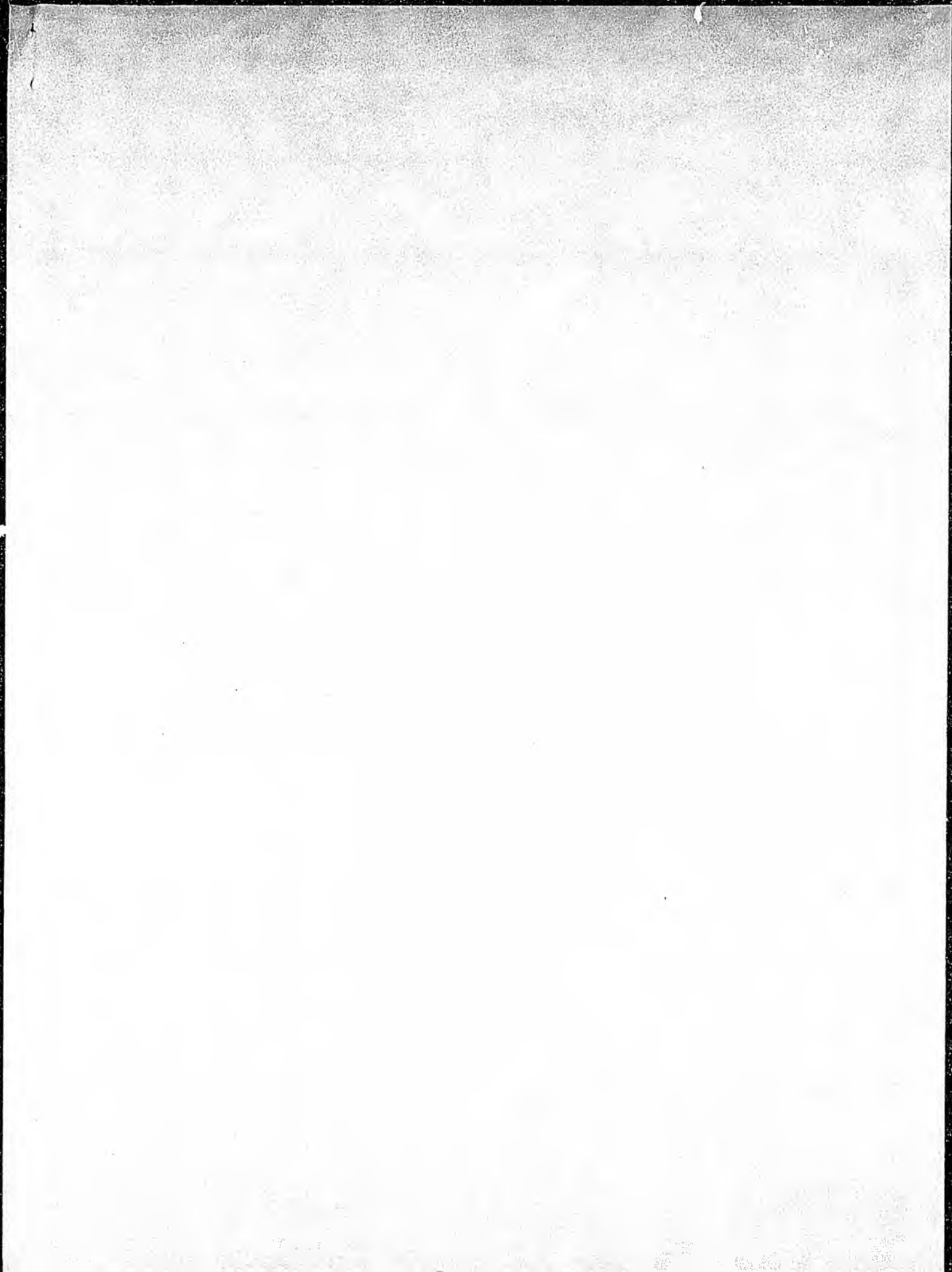
	<u>Fiscal Year 1989</u>		<u>Fiscal Year 1988</u>		<u>Fiscal Year 1987</u>		<u>Fiscal Year 1986</u>		<u>Fiscal Year 1985</u>		<u>Fiscal Year 1985 Through June 30, 1989</u>	
	<u>Rates of Return at Cost (c)</u>	<u>Market</u>	<u>Rates of Return at Cost (c)</u>	<u>Market</u>	<u>Rates of Return at Cost (c)</u>	<u>Market</u>	<u>Rates of Return at Cost (c)</u>	<u>Market</u>	<u>Rates of Return at Cost (c)</u>	<u>Market</u>	<u>Rates of Return at Cost (c)</u>	<u>Market</u>
R. E. Mortgages	9.08%	11.81%	10.63%	8.60%	13.38%	4.05%	11.74%	17.96%	13.05%	26.61%	12.07%	16.45%
Bonds and Reserves (b)	<u>9.68</u>	<u>15.04</u>	<u>9.48</u>	<u>7.67</u>	<u>10.43</u>	<u>4.87</u>	<u>11.61</u>	<u>23.24</u>	<u>9.75</u>	<u>29.65</u>	<u>10.14</u>	<u>15.18</u>
Total Fixed Income	9.62%	14.72%	9.63%	7.79%	10.98%	4.71%	11.64%	21.67%	10.83%	28.62%	10.55%	15.44%
Total Equities	<u>14.55%</u>	<u>14.55%</u>	<u>-5.12%</u>	<u>-5.12%</u>	<u>20.39%</u>	<u>20.39%</u>	<u>37.80%</u>	<u>37.80%</u>	<u>21.54%</u>	<u>21.54%</u>	<u>15.08%</u>	<u>15.08%</u>
TOTAL FUND	<u>11.58%</u>	<u>14.65%</u>	<u>2.73%</u>	<u>1.93%</u>	<u>14.94%</u>	<u>10.90%</u>	<u>19.74%</u>	<u>26.59%</u>	<u>13.27%</u>	<u>26.84%</u>	<u>12.14%</u>	<u>15.31%</u>

a - Internal rates of return under simplifying assumption of mid-month flows for fixed income investments.

b - Net of gains, losses, and amortizations.

c - Cost returns for fixed income investments; but market returns on equities. The returns for total fund approximate actuary's calculation of returns.

Portfolio Management, Treasury Division
August 18, 1989



H B

5 8 1

HOUSE COMMITTEE REPORT

File

(11)

Date Referred: April 9, 1990

FURTHER REFERRALS:

Date of Committee Action: 4/28/90

The FINANCE Committee considered:

HB 581

HOUSE BILL NO. 581

UNIVERSAL HEALTH CARE TASK FORCE

"An Act creating a universal health care task force; and providing for an effective date."

RECOMMENDATIONS:

- [] be replaced with CS HB 581 (FIN) [] the same title
- [] have attached amendment(s) [] a new title
- [] do pass
- [] do not pass
- [] no recommendation
- [] individual recommendations
- [] additional referral to the _____ Committee

ADOPTS: _____ letter of intent

ATTACHES NEW FISCAL NOTE(S):
(Dept)

APPROVES PREVIOUS: (Date/Dept)

- [] fiscal impact DHSS
- [] zero fiscal note _____
- [] zero with analysis _____

- [] fiscal note(s) _____
- [] zero fiscal note(s) _____
- [] zero fn/analysis _____

SIGNING DO PASS:

SIGNING:
(Check approp. column)

Do Not Pass No Rec Amend

[Signature] Brown

[Signature] Koponen

[Signature] _____

Name	Do Not Pass	No Rec	Amend
<u>[Signature]</u> Hoffman	+		
<u>[Signature]</u> Larson	+		
<u>[Signature]</u> Barnes	X		
<u>[Signature]</u> Shultz	X		
<u>[Signature]</u> Phillips	✓		
<u>[Signature]</u> Rieger	✓		
<u>[Signature]</u> Wallis	✓		

[Signature] Larson
CU Chairman's Signature

[Signature] Hoffman

FISCAL NOTE

REQUEST: _____

Revision Date: _____ Agency Affected: DHSS
 Title: "An Act creating a universal health care task force & providing for an effective date." BRU: Administrative Services
 Sponsor: by the HESS Committee Components: Planning and Development
 Requestor: by the House Finance Committee

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	73.3	105.9				
TRAVEL	17.5	26.5				
CONTRACTUAL	87.8	7.1				
SUPPLIES	0.9	0.5				
EQUIPMENT	-0-	-0-				
LAND & STRUCTURES	-0-	-0-				
GRANTS, CLAIMS	-0-	-0-				
MISCELLANEOUS	-0-	-0-				
TOTAL OPERATING	179.5	140.0	-0-	-0-	-0-	-0-

CAPITAL	0	0	0	0	0	0
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REVENUE	0	0	0	0	0	0
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FUNDING: (Thousands of Dollars)

GENERAL FUND	179.5	140.0				
FEDERAL FUNDS						
OTHER						
TOTAL	179.5	140.0	0	0	0	0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY	3	3				

ANALYSIS : (Attach a separate page if necessary)

See attached assumptions and calculation analysis.
No fiscal impact in FY 1990.

Prepared by: House Finance Committee Phone: 465-3727
 Division: Co-Chairman Ron Larson Date: _____

Approved by Co-Chairman Lyman Hoffman Date: _____
 Commissioner: _____ Agency: _____

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

PERSONNEL	FY 91	FY 92
RAIII 20 months = \$ 84,740	\$ 33,896	\$ 50,844
RA II 16 months = 54,912	24,024	30,888
CTIII 18 months = 39,564	15,386	24,178
Total personnel \$179,216	\$ 73,306	\$105,910
<hr/>		
TRAVEL	FY 91	FY 92
Task Force travel:		
8 meetings, 5 members, 3 days per diem	\$ 10,500	17,500
Evenings will be public meeting & discussion		
Next day is education/work session		
Avg. fare \$400; per diem \$90; misc. \$30		
Total per meeting, per member \$550		
Staff travel for research and meetings:	7,000	9,000
Total travel	\$17,500	\$26,500
<hr/>		
CONTRACTUAL	FY 91	FY 92
Printing		-0-
3 X \$5,000 for expert testimony & task force education	14,000	-0-
Advertizing (display ads)	3,500	6,500
Telephone long distance calls	350	650
Office Space	-0-	-0-
Employer survey (phone)	20,000	
Characteristics survey (phone, interview and observation)	50,000	
Total contractual	\$87,850	\$ 7,150
<hr/>		
SUPPLIES	FY 91	FY 92
Paper goods, office supplies	\$ 600	450
Reference books	300	
Total supplies	\$ 900	\$ 450
<hr/>		
EQUIPMENT	FY 91	FY 92
Personal Computer	-0-	-0-
<hr/>		
TOTAL FOR PROJECT	\$179,556	\$140,010

Assumptions:

1. Written work of the task force in providing program description and supportive documentation will be provided by legislative research agency, including any report printing.
2. Teleconferencing of public meetings will be provided at no cost through the legislative network or other comparable arrangement.
3. Reimbursement for services of those appointed by the Governor will be limited to travel and per diem.
4. Advisory committee members will provide funding for travel and other costs for their participation from their respective budgets.
5. Office space to be provided within existing legislative offices or by other donated arrangement.
6. Computer used for staff research work will be donated. page 2 of 2

Original sponsor(s): HESS Committee

1 IN THE HOUSE

BY THE FINANCE COMMITTEE

2 OS FOR HOUSE BILL NO. 581 (Finance)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 SIXTEENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act creating the Universal Health Care Task
7 Force; and providing for an effective date."

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

9 * Section 1. FINDINGS. The legislature finds that

10 (1) over 50,000 residents of the state cannot afford to pay
11 their medical bills, are not covered by a group health insurance plan, do
12 not qualify for public assistance programs, and cannot afford to pay indi-
13 vidual health insurance premiums; a vast majority of the uninsured are
14 either employed or are dependents of employed state residents;

15 (2) many state residents with high risk, preexisting health
16 conditions are unable to obtain health insurance and must deplete their
17 personal resources in order to obtain care;

18 (3) many state residents do not receive certain kinds of crit-
19 ical care due to exclusions in their health insurance policies;

20 (4) the health insurance coverage for many state residents does
21 not cover costly illnesses or injuries causing catastrophic financial
22 consequences to them and their families;

23 (5) due to the lack of health insurance coverage, many state
24 residents do not obtain necessary preventive care, and this leads to dra-
25 matically higher remedial care and an additional incidence of disease and
26 illness in the state;

27 (6) the cost of providing health care to those who are unable to
28 pay is shifted to those who are taxpayers or participants in a health
29 insurance plan;

1 (7) it would enhance the ability of Alaska businesses to remain
2 competitive if they had better access to affordable health care coverage
3 for their employees;

4 (8) the Governor's Interim Commission on Health Care recommended
5 that "a state working group should explore and develop health insurance
6 plans for medically uninsured Alaskans";

7 (9) every state resident should be guaranteed a basic level of
8 health care regardless of income and should not become financially desti-
9 tute before obtaining health care; access to health care should be univer-
10 sal, including those state residents with preexisting health conditions;

11 (10) the issues of medical indigency and universal health care
12 are complicated, complex issues requiring review by an authoritative group
13 for a certain period of time.

14 * Sec. 2. PURPOSE. The purpose of the Universal Health Care Task Force
15 created by this Act, is to

16 (1) design a cost-efficient program that allows access to health
17 care, through insurance or other means, to all state residents, and that
18 provides a basic level of health care services;

19 (2) define the best strategy for implementing a universal health
20 care program, including consideration of the redistribution of existing
21 funds spent on health care in the state in order to provide for a more
22 rational and equitable health care system.

23 * Sec. 3. UNIVERSAL HEALTH CARE TASK FORCE. (a) The Universal Health
24 Care Task Force is created in the Department of Health and Social Services.
25 The task force is composed of five individuals appointed by the governor
26 with a significant and demonstrated expertise or interest in health care.
27 As a nonvoting technical advisory committee to assist the task force, the
28 governor shall also assign one representative each from the Department of
29 Health and Social Services, the division of insurance, the division of

1 retirement and benefits, and the Office of the Governor, and the presiding
2 officer of each house of the legislature shall assign a member from that
3 house.

4 (b) The members of the task force are entitled to receive per diem
5 and travel expenses authorized for boards and commissions under AS 39.20.-
6 180.

7 (c) The task force shall select a chair and a vice-chair from among
8 the members of the task force.

9 * Sec. 4. DUTIES OF THE TASK FORCE. The task force shall

10 (1) solicit advice and information from health care consumer
11 groups, the insurance industry, health care providers including the State
12 Medical Association, the Alaska Psychiatric Association, the Alaska Psycho-
13 logical Association, the Alaska Mental Health Board, the State Health
14 Association, the Alaska Pharmaceutical Association, the Alaska Public
15 Health Association, the Alaska Dental Association, the Alaska Academy of
16 Physicians Assistants, the Alaska Nurses Association, the United States
17 Department of Veterans Affairs, the United States Department of Defense,
18 the Civilian Health and Medical Program of the Uniformed Services, public
19 employee unions, representatives of the medically indigent, emergency
20 services personnel, large and small businesses, the Medical Care Advisory
21 Committee, the Alaska Native Health Service, actuaries, public relations
22 experts, the public, and the technical advisory committee created in sec. 3
23 of this Act;

24 (2) analyze all the relevant information necessary to recommend
25 a program of universal health coverage, including 1990 census data and the
26 study done in 1954 for the United States Department of the Interior by
27 Thomas Parran, titled "Alaska Health: A Survey Report";

28 (3) update the information in the "Alaska Comprehensive Health
29 Care Financing Study" done by the Battelle Human Affairs Research Center in

1 1982;

2 (4) make an accurate estimate of the number of people who are
3 unable to receive necessary health care services in the state, which pa-
4 tients are generating unpaid medical bills, which state residents are
5 uninsured or lack adequate insurance, which health care providers are
6 providing uncompensated care, who is paying for the cost of uncompensated
7 care, and the total cost of uncompensated care in the state;

8 (5) identify those health care services necessary to achieve an
9 acceptable minimum level of health care for all state residents and to
10 examine those health care services that provide the most care for the most
11 people at the least cost, including prevention services; the Oregon Basic
12 Health Services Act shall be examined by the task force;

13 (6) recommend ways to coordinate services between nonprofit
14 health care providers, profit making health care providers, the state
15 division of public health, the United States Department of Veterans Af-
16 fairs, the United States Department of Defense, and the Alaska Native
17 Health Service in order to achieve a more efficient and effective health
18 care delivery system;

19 (7) consider possible delivery systems for a universal health
20 care program, including using a single, comprehensive statewide system or
21 changing existing health care services to yield an integrated system of
22 health care coverage; options that shall be considered include

23 (A) expanding the use of private health insurance to pro-
24 vide coverage to the uninsured and underinsured;

25 (B) continuing or reinstating government programs, includ-
26 ing the Medicaid medically needy option or the catastrophic illness
27 program, if private insurance is not the best way to provide coverage;

28 (C) sponsoring the pooling of small employers into a single
29 organized health care purchasing group;

1 (D) mandating coverage in the workplace for employers with
2 a certain threshold number of employees;

3 (E) mandating a minimum basic level of health services to
4 be included in a health insurance plan, with a special emphasis on
5 important preventive services and children's health services;

6 (F) requiring that health care programs include residents
7 who are unable to obtain insurance due to a high risk or a preexisting
8 medical condition;

9 (G) requiring that health care programs include coverage
10 for costly medical services that have a catastrophic financial impact
11 on patients and their families, including making the state the payor
12 of last resort before a family becomes destitute;

13 (H) requiring that the University of Alaska provide health
14 coverage for all students;

15 (I) combining the workers' compensation system with a
16 universal health care program;

17 (J) establishing or lengthening the time for continuation
18 or conversion of health insurance coverage after a state resident
19 leaves employment;

20 (K) using the unemployment insurance program to also cover
21 health care services for the unemployed;

22 (L) examining the ability of the state to self-insure under
23 a universal health care program;

24 (M) making charity care a requirement as part of the li-
25 censing or certificate of need process;

26 (N) having special programs designed to ensure that chil-
27 dren have adequate health coverage, such as the child health care
28 programs established in Minnesota;

29 (8) consider a means of financing a universal health care

1 program including the following:

2 (A) the use of a payroll tax for full or partial financing
3 of a small employer insurance pool;

4 (B) a Medicaid waiver requesting a block grant from the
5 federal government to subsidize a universal state program;

6 (C) using the permanent fund dividend program to finance
7 coverage for some residents;

8 (D) using reasonable deductibles and co-payments to dis-
9 courage frivolous use of health programs;

10 (E) using the unemployment tax to cover the costs of insur-
11 ance for the unemployed or uninsured;

12 (F) a Medicaid buy-in for the medically uninsured;

13 (G) streamlining coverage so that families are not covered
14 under two separate insurance programs;

15 (9) pursue financial support from other sources, including
16 private foundations like the Robert Wood Johnson Foundation, for the work
17 of the task force and for implementation of a universal health care pro-
18 gram;

19 (10) coordinate with the community health planning efforts des-
20 cribed in Senate Bill 326 of the Sixteenth Alaska State Legislature;

21 (11) solicit actuarial data and other technical information and
22 assistance from the health care insurer providing coverage to the state;

23 (12) utilize information provided by the Health Care Cost Con-
24 tainment Task Force established by the Sixteenth Alaska State Legislature.

25 * Sec. 5. REPORT. The task force shall, by March 1, 1992, provide a
26 preliminary report, and by June 30, 1992, provide a final report to the
27 legislature and the governor that recommends a program for providing uni-
28 versal health care, including recommendations for implementing the program
29 in phases in an expeditious, yet orderly manner.

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* Sec. 6. This Act is repealed June 30, 1992.

* Sec. 7. This Act takes effect February 1, 1991.

Amendment #1

By Rieger

To: CS HB 581 (HESS)

Page 2, Lines 17-19 Delete all material after "residents," and replace with "and that provides a basic level of health care services."

Page 2, Line 22, after "provide for a" insert "more"

Page 2, Lines 23-24. Delete all material after "system" add "

Page 3, Line 3, after "benefits," insert "a member selected by"

Technical

Page 3, Line 3, after "representatives," insert "a member selected by"

Page 3, Line 8, delete "governor" and replace with "task force"

+ Page 4, Line 29 through Page 5, Line 3: Delete all material and re-letter accordingly

+ Page 6, Lines 10-14: Delete all material and re-letter accordingly

Page 4, Lines 26-28: Delete all material and re-letter accordingly

Am #2

presiding ^{officer} ~~member~~ of each house of the legislature shall assign a member from that house.

page 2, line 28: after "care." insert "The governor shall consider, to the greatest extent possible, making appointments that represent a broad cross section of Alaskans interested in health care."



HEALTH CARE COALITION OF ALASKA

March 16, 1990

REC'D MAR 19 1990

Honorable Johnny Ellis
Chairman
Health, Education and Social Services Committee
Alaska State Legislature
P.O. Box V (MS3100)
Juneau, Alaska 99811

Jim

Dear Representative Ellis:

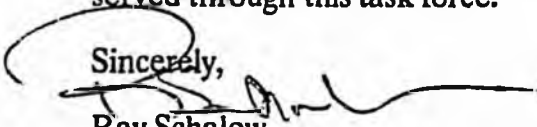
On behalf of the health care industry in this state, I commend you and your colleagues for recognizing and responding to the need for a universal health care task force. I believe this to be the most significant piece of health legislation this session.

The entire issue of cost and access is impacted by the medically indigent, native health delivery system, veterans care, CHAMPUS, Medicare, Medicaid, military delivery system, the public and the private sector. There are no easy answers to our current dilemma, but unless we pull ALL the players into the game, we will never find a solution.

I have two requests that I sincerely ask you to consider. The first request is to consider adding health industry members to the task force. Apart from providing the educational expertise, I believe they would be objective and honest in their assessments. But most importantly, it would be helpful for them to participate in any final resolutions. Secondly, I have enclosed an overview of what many believe is the problem facing society today. I realize how busy you are, but I strongly urge you to read this document. Hopefully it summarizes the need, and possibly the direction you might consider for the Task Force.

Again, thank you for recognizing the urgent need for this kind of a group. You might suggest to Senator Kelly that his cost containment group might be best served through this task force.

Sincerely,


Ray Schalow
Chairman

ALASKA ACADEMY OF PHYSICIANS ASSISTANTS • ALASKA PHARMACEUTICAL ASSOCIATION • ALASKA PUBLIC HEALTH ASSOCIATION
ALASKA STATE MEDICAL ASSOCIATION • HEALTH ASSOCIATION OF ALASKA • ALASKA NATIVE HEALTH BOARD • ALASKA NURSES ASSOCIATION • ALASKA DENTAL SOCIETY

working together . . . caring together

4107 Laurel Street Anchorage, AK 99508 (907) 562-2662 Fax 561-2063

Alaska State Medical Association

4107 Laurel Street Anchorage, Alaska 99508 (907) 562-2662 (Fax) 561-2063

Dr. John Kitzhaber, an Oregon physician and current president of the Oregon State Senate offers a clear and cogent presentation on the issue of uncompensated care in America. I have taken the liberty of paraphrasing his comments and urge you to read them thoroughly. It speaks to an issue that we in the health industry are just now beginning to understand, and it points out the need for greater dialogue between provider and legislator in order to address a critical social problem.

Let me begin by stating to you that unequivocally the most serious threat facing the health industry today is uncompensated care. If left unresolved, it will erode the health of our society and in turn will lead to an erosion of the clinical autonomy of physicians and other providers. It will also undermine some of the very principles on which our health care system has been built and will lead to increased regulation of the practice of medicine and probably to a government controlled health care delivery system.

To understand the threat and challenge it poses, we must first consider the evolution of our American health care system. Our health care system was founded on the principle of universal access, the idea that all Americans, regardless of their income, should have access to the health care system and to all the services it has to offer. We were able to deliver on this social objective because of our fee-for-service reimbursement system and the ability to cost shift. So when the poor came for treatment, the service was rendered and the cost was merely shifted to someone who could pay through an incremental increase in their bill or in their insurance premium.

This policy was no accident, but was the result of conscious decisions in both the public and private sector. In the public sector, we enacted Medicare and Medicaid in 1986 extending coverage to the poor and the elderly. At the same time, we had a rapid expansion of private policies funded primarily through employment. This rapid growth of third-party insurance coverage led to the belief that health care for the poor in this country was free, when in fact it being subsidized primarily by the government and by the business community. We created what we felt to be an ideal health care system. It was a system with no financial restraints, where individuals had access to as much health care as they wanted or needed. Physicians could practice pure medicine, viewing their patients primarily from their health needs without concerning themselves over income. But this system also led to, and encouraged utilization. It led to the deeply held social belief in this country that health care is a right. That resulted, understandably, in a dramatic increase in

expenditures. The amount we spent on health care grew from \$75 billion in 1980 to nearly \$500 billion in 1988 and it still continues to grow. An more telling, is the growth of health care expenditure as a percent of the Gross National Product. We spent 7.4 cents on the dollar in 1970 and we spend about 12 cents today. If this rate continues, by the turn of the century we will be spending 20 percent of the Gross National Product on health care, and by about 2020, we will be spending 40 cents out of every dollar on health care.

This, of course, will not happen. It makes a great deal of sense in terms of a social policy, but makes little sense in terms of an economic policy. No single set of expenditures can grow at a rate faster than the growth of the Gross National Product.

The prosperity we have enjoyed in the 1st 20 years has allowed us to absorb these rapid increases and has masked the underlying fallacy of the way we finance health care in this country. A number of factors occurred that have brought our ideal health care system into collision with economic realities. New medical technologies were being developed and being used because there was no financial restraint on the system, and at a tremendous cost. Secondly, the population was aging. There has been a significant increase in the elderly as a percent of the population, and they use more health care services. They have a larger incidence of chronic diseases, both of which increase the financial strain on the system. These factors brought the people who had been traditionally subsidizing the cost of health care for the poor, the business community and the government, to a position where they had to reevaluate their willingness to continue to do that. The economic stagnation that we experienced at the beginning of this decade could no longer absorb the rapid increases in the cost of health care. Our annual productivity growth was 3% a year in the sixties and seventies, but fell to half a percent a year by 1979, and was actually negative in the early eighties.

Our federal budget deficit increased from about \$73 to \$211 billion in five years. We liquidated all our foreign assets and became the largest debtor nation in the world. The government in the first part of this decade recognized that they could no longer continue an open-ended subsidy of the cost of care for the poor without raising taxes, increasing the deficit or making deep cuts in other domestic programs. At the same time, this country entered the world market. We began recognizing that we were not competing just among ourselves like the auto industry once did, but were competing with mainland China, West Germany, Japan, etc. They realized that cutting costs, particularly labor-related costs, had to be done in order to remain competitive with cheap labor industries abroad. They couldn't pass the cost of health care on to their consumers and still remain competitive; particularly when American business has to carry the cost of health care on the books as necessary expense and are competing with countries that do not carry health care as a cost, because they have nationalized health care programs.

The business community now became interested in cost containment in order to remain competitive. The government became interested in cost containment to balance the budget. The object of business and government was simply to reduce the exposure to the cost shift, and to reduce their funding and subsidy of the cost to care for the poor. The subsidy was not taken out of the system, it was merely shifted on to individuals and

providers. How did they do it?

In 1983, the federal government enacted the DR'G's, which is a prospective reimbursement system that shifted economic risk on to providers. They began requiring first-day hospital deductible for Medicare, increases in the Part B monthly Medicare premium. This shifted costs on to the individuals. With Medicaid, the program for the poor, they cut their match rate and shifted that to the states. The first thing the states did was cut provider reimbursement rates, so that now we get 45 to 50 cents on the dollar for taking care of someone on welfare. That pushed costs and responsibility to the individuals. We have had 800,000 women and children squeezed off Medicaid in the last ten years. That program, which used to cover 65 percent of the poor, now covers less than 38 percent of the poor.

The private sector reacted exactly in the same way with an increased involvement in HMO's, PPO's, and other prospective managed care plans that put the providers at risk. They increased co-payments and deductible for their employees then shifted costs on to individuals. The important thing to remember is that cost containment reflected absolutely no social policy beyond cutting costs for the government and the business community. There was recognition that the amount of health care that could be spent on the poor was limited. There was no consideration of the implications of those decisions on access to health care. They reduced the funding in the system, but didn't reduce what the public expected from the system.

Today we find ourselves in a situation of transition. We are still ostensibly committed to the principle of universal access; but now the system is driven by economic factors, not by the social factors that drove it in the Sixties and Seventies. Providers are now at economic risk, and we are losing our ability to cost shift.

Our ability to deliver on the concept of universal access has depended on cost shifting and the willingness of business and government to subsidize the cost of care for the poor. But what we are seeing today, while we are still supposedly committed to universal access, is a progressive shifting of the responsibility to pick up that cost. Remember that between 1965 and 1980 that subsidy was borne by government and business which spread it out over taxpayers in general. So society was paying for the social responsibility to have universal access in this country.

Because of the cost containment measures that have occurred, the subsidy has now been shifted to providers. Physicians have far less ability to absorb this shift and what formerly was subsidized care for the poor is now showing up as uncompensated care. As physicians reach a point where they can't absorb additional uncompensated care and still pay the bills, they push the costs on to individuals. So today, if you don't have insurance coverage or money, you are increasingly likely to lose access to the health care system - either because the provider won't take in any additional indigent patients, or you delay treatment because you are afraid you can't afford it.

This has changed how we finance health care in this country. Our health care system now has a bifurcated financing mechanism. On one side

is the public system, which is Medicare and Medicaid; and on the other side is the private system which is mostly employment based policies and some individual policies. There has always been a little gap in between where some people slip through the cracks. But as long as government and the business community were willing to subsidize the cost of care for the poor, that gap has been very narrow and has really contained only society's truly downtrodden.

Today as those two-third party payers are trying to escape from the subsidy, we've seen a reduction in government expenditures, co-payments and deductible in Medicare and increases for Medicaid eligibility, so people spill of the public side into that gap. As competition in the world market increases, we shift from a manufacturing to a service based economy with large numbers of low paid, non-unionized workers without health insurance coverage, and as premium rates continue to climb, people spill off the private side into that gap. Today that gap is no longer narrow, it has 37 to 40 million Americans in it. They are no longer just society's downtrodden. Seventy percent of those people are working full time or part time or are dependents of someone who is working. But it's those in that gap that are generating 75 percent of the uncompensated care. Why should we be concerned about this? Because there are some serious consequences in the shifting of responsibility to pay for the care of the poor, and there are some social and professional consequences that affect providers.

The first social consequence is an erosion in our commitment to universal access. Because there is a physician surplus in the country, and because care for the poor is no longer subsidized but is uncompensated, we have a very competitive, market-driven system in the provider community. Since market systems were not designed to foster social responsibility, it shouldn't be surprising that no one is competing for the poor. Public health clinics are closing and we are seeing patient dumping from hospital to hospital, physician to hospital and between physicians. There are treatment delays and a growing number of people in the gap.

That leads to the second consequence, which is a very real and measurable deterioration of health for a growing number of Americans. We have 40,000 neonatal deaths each year from the complications of low birth weight. Two-thirds of those mothers do not receive adequate prenatal care. Forty percent of the poor in America are children and only one-third of them are covered by Medicaid, the other two-thirds are in the gap and are losing access to basic preventive services. We are seeing an increase in pertussis and pediatric nutritional problems. There is case after case of people actually dying because of lack of access to the system. People are dying from strokes because they couldn't get in to get their blood pressure medication refilled. People are dying of heart failure and having MI's because of lack of routine checkups. People are dying of perforated ulcers because of treatment delays.

The third consequence is that we are mortgaging our own future. Remember, that 40 percent of the poor in this country are children, and two-thirds of them are in the gap. Also in that gap are tens of millions of young working Americans. These people constitute a large part of the shrinking workforce of tomorrow that we're expecting to fuel the economy and pay for

a growing retired population. How are we going to do that in the face of \$170 billion owed to foreign governments and nearly a three trillion dollar national debt; a ten trillion dollars unfunded liability, the difference between what we expect them to make and what we are planning to take out of their paychecks to pay for Medicare, Social Security and federal pensions, most of which are automatically indexed and have no income eligibility requirements. What we're asking these people to do is be more productive than any other generation. We are asking them to do something that we have all refused to do, and that is recognize that increases in personal consumption have to be balanced with increases in productivity.

In the last ten years, American workers have averaged a \$3200 increase per capita in personal consumption and only \$950 of that has been paid for by increases in what each one produces. The remaining \$2200 has been paid for by cuts in domestic spending and investment and by foreign debt. We are asking this group of people to be more productive than anyone in the history of this country, and probably take a reduction in their standard of living. Having asked them that, we are crippling them going in by denying them access to the basic health care services they need to be healthy, productive members of the workforce. You cannot have an increase in productivity unless your workforce is health and well educated. This is a very, very serious implication.

There are also some disturbing professional implications. The first is the growing problem of uncompensated care that is catching physicians and providers between what society expects from our health care system, and economic realities. When the government and the business community move to limit their subsidy of the cost of health care for the poor, they could do so without denying access to individuals, and they could do so without publicly or explicitly abandoning the idea of universal access, because they shifted that subsidy on to the providers. But when physicians move to limit their exposure to this for exactly the same reasons, they have to deny access to individuals. When a physician reaches a point where he or she cannot absorb any additional uncompensated care, they either have to reduce the number of indigent patients they see or reduce the services they provide to those patients. In either case, that means rationing. Increasingly, physicians in this country are being forced to become the rationing instruments for a society that refuses to recognize that rationing is occurring. That puts physicians in direct conflict not only their professional ethics, but with social expectations for the health care system. It casts them in a very unfavorable light as many people still view physicians as they were in the halcyon days of the 1960's or 1970's, when the economy was booming and incomes were rising. Most physicians do not understand the relationship between cost shifting and subsidizing care for the poor, and they don't understand the implications of taking cost shifting away from providers. The thought that a wealthy profession would be denying access to the poor is unacceptable to them. It puts them in a very vulnerable position politically. As the problems of the poor intensify, state legislatures are going to begin to react and they are going to say: If physicians are not going to take care of the poor voluntarily, we are going to force you to do that. There are a lot of ways that are designed to force physicians to assume the responsibility for taking care of the poor, but they ignore the fact that society, while paying lip serve to universal access, has

made a decision to limit the amount of money that they're going to spend on it. When someone convinces corporate America that a government sponsored health care program will put them in a better position in terms of competition in the world market; then we will be looking at a nationalized health care program. But in the short run, we are looking at increased regulation, reduction, and erosion in physician clinical autonomy.

What can we do about this problem? To solve this crisis in uncompensated care, we have got to start by accepting three very hard realities. The first reality is that resources are limited and that's a difficult reality. But it should be obvious to anybody who looks at the need in this country and looks at the available dollars. As we said, we have a national debt approaching three trillion dollars that must be reduced. We have a huge defense budget that has been traditionally hard to pare down, and we spend \$450 billion a year on Medicare, Social Security and other federal pensions. At the same time, we are cutting aid to education, we are also cutting investments in road, sewers, and infrastructure; and civilian research and development. All of those things we need to increase the productivity in this country.

No one wants their personal health care expenditures cut, but at the same time, we want to reduce government spending. We want good road and schools, safe streets, criminals behind bars, a comfortable retirement, police protection, fire protection, clean air, clean water; and we want to do all that, of course, with lower taxes and higher wages.

Obviously that doesn't work. There is a finite amount of money that this country can invest in health care versus the other things we also have to invest in. Once we come to grips with the fact that there is a finite health care budget in America, then we have to decide who is going to get the service and how much service each person is going to get.

That brings us to the second reality. The rich are always going to have access to more health care than the poor. That's all right if what the poor get is adequate and if they're all getting it. After all, one of the hallmarks of a capitalistic system is that goods and services are distributed on the basis of income, not necessarily on need or merit. We readily accept that in most instances. We don't expect public housing to look like the Ritz and we don't expect food stamps to be redeemed in very expensive restaurants. But because of our system, our concept of universal access, we take for granted that the poor should have access to all the health care services that are available to the rich.

This is the only part of our system that operates on this open-ended economic principle. What we've done is reject a multi-tiered system based on income. But actually we already have that kind of a system in place. The rich have always been able to fly to other states and other countries for diagnostic and therapeutic modalities not available near home. They have had consultations and elective surgeries that the poor have not had access to. We would all agree that everyone should have a right to prenatal care. You may argue whether or not the public should pay for a face lift electively for everybody on welfare, but it becomes much more difficult when you are trying to balance a transplant versus prenatal care.

What we need is a better definition of adequate health care to address that question. If we know resources are limited, if we know people with high incomes can buy more health care than people of lower incomes, and if we know that society can't buy everything for everyone who might benefit from it, we must consciously and responsibly decide what level of health care everybody should get, that means the definition of adequate health care.

That brings us to the last reality, the inevitability of rationing. This is very difficult for physicians and providers to come to terms with. But when you define adequate health care, you also define what's more than adequate. That leads to the basis for explicit rationing of health care. I suggest that rationing already exists in our system. We ration by income and transportation barriers. But more importantly, we ration through a lack of any policy to guide how we spend our health care dollars. We ration inadvertently by legislative decision. If we have a limited amount of money in the health care budget and you spend it on one thing, it's not available to be spent on something else.

Consider how we are doing this today. We spend almost \$2000 per capita on health care in America. That is more than any other country in the world and yet our wellness as measured by morbidity and mortality statistics is not significantly higher than in England, which spends half as much, or even Singapore which spends a fourth as much. Why is that? Because we have no policy to guide how we spend our health care dollars. We are spending huge sums on some and none on others. We spend more per capita than any country in the world, yet 37 million Americans have no coverage and many of them are losing access to the system. We spend three billion dollars a year on neonatal intensive care while we're denying prenatal care to hundreds of thousands. We spend \$50 billion a year on people in the last six months of their lives, while we are closing pediatric clinics. That's like having someone in charge of a truck fleet for your corporation who adopts a policy that he won't change the oil in the trucks until the blocks melt. You certainly wouldn't hire that guy to work for you. But that's exactly how we spend health care dollars in this country. We don't spend it on prenatal care, we spend it on neonatal intensive care. We don't treat hypertension, we treat people who have stroked out. We are rationing by default. It's guided by no social policy and it's not equitable. We are wasting millions of dollars and thousands of lives. The reason we are rationing implicitly as opposed to explicitly is because we don't want to come to grips with our own limits.

To solve this problem of uncompensated care with of the ominous implications for society and for physicians, we have to recognize that our health care system is indeed in flux and that we have to build a new system that is based on the three realities that we've just discussed: limited resources, acceptance of the fact that the rich will always be able to buy more health care than the poor, and that we're going to have to ration. We have to recommit ourselves to universal access, but not universal access for everyone to everything. Universal access for everyone to an adequate level of health care. This will put our system back on a sound economic foundation, and means we are going to have a three tiered system of delivery in this country. We already have a non-defined sort of implicit multi-tiered system. But this would mean a

government sponsored tier for the poor. It would mean a tier that the business community funds for those who are working, and a traditional fee-for-service tier for those who wish to buy additional health care services. It's at that bottom tier that we have to come to grips with rationing.

The government has a responsibility to pay for the poor, not for the elderly. The government should pay for the poor regardless of age and there is no reason Lee Iacocca needs Medicare. We should put an income eligibility requirement on it.

It's the bottom tier that we have to come to grips with rationing. It's this tier that we have to set the socially acceptable minimum level of health care for this country, and how do we get there? I suspect there are three elements to resolving this. We must have a clear social policy and we need to define adequate health. Then we need a universal insurance system to insure that people get access to that care. The social policy we had in the Sixties, Seventies, and Eighties, was universal access. One of the reasons we are in trouble today is because we were able to cover everybody for almost everything. But unless you define what it is you're covering people for, you still have an open-ended system that we can't afford. Politically it's far more difficult to deal with the question of adequate health care than to design and politically adopt a position to deal with the universal insurance coverage question.

We must have a clear social policy because we need a framework to guide how we spend those health care dollars in a way that is efficient and equitable. We must make an attempt to recognize our limits and adopt such a policy. Should we discontinue funding for heart, bone marrow and liver transplants for people on welfare or should we take that money and extend it out to buy preventive and prenatal services for a far larger group of people who have been in the gap? The question is not whether transplants have merit. The question is not whether, in the short run, we could find some additional money to buy a few more transplants for people on public assistance. The issue is, does it make more sense and is it a better use of public dollars if we we're going to spend more on health care to buy high tech services for a group of people who already had access to virtually everything in the private sector; or should we extend services to a larger number of people who currently do not have access to any health care whatsoever. Should universal access to adequate health care be the first priority for spending additional dollars?

Once we get a definition of adequate health care and array our health care services on a priority basis, we are changing, in a very fundamental way, the nature of the rationing debate. The rationing debate traditionally has an individual focus. It goes like this: You have one heart and three potential recipients. Do you give that heart to the 17-year-old unwed mother of three on welfare or do you give it to a 40-year-old corporate executive? This raises the kind of imponderable ethical and moral question that society, almost by definition, can't resolve on an individual basis. But when you develop a definition of adequate, and array your health care services in a priority order, you shift that debate from the individual focus to a social focus. You are no longer debating which service should be given or denied to which individual, you are debating which priority funding should be given to

each service, given the reality of limited resources. Society has made the decision to limit the amount of money it's spending on health care. Society needs to make the decisions on how to spend that money. That takes physicians out of the squeeze and they can now continue to be patient advocates. They can continue to do everything they can possibly do for their patients within the context of the resources that society has made available.

How do we get to this definition of adequate? There are really three steps. The first and probably the most difficult is building a consensus. A group of dedicated providers and health experts should break down every dollar spent on health care. A list should be made of the number of people getting the service and the cost; the number of people not getting the service and the economic as well as health implications of not giving them that service; and the cost to extend the service to cover everybody in giving them that service; and then the cost to extend the service to cover everybody in the unmet need population. Arrange this list in a tentative priority order and begin presenting it at town hall meetings where citizens are actually getting involved in working through the trade-offs and choices that are necessary to set up a priority list of health care choices. Bring this information together and generate a final list that will be submitted to the legislature. Once the health care resources are arrayed in that kind of a list, you have to integrate it with the budget process. You must, then, require that the funding go to the first item on your priority list for everyone in the population for whom the state has responsibility. You go down and fund the second, third, etc., until you run out of money.

What that does is, put accountability in the system. If our state legislature decided to cut \$20 million out of our health care budget, it would not be an abstract accounting exercise. It would mean the deletion of very specific services for very specific individuals off the bottom of the priority list and then the debate becomes far more focused. If you want to come in and refund the transplant program, it's very clear that you either have to knock something else off your priority list - you have to make a choice, a clinical choice and a political choice between those two health services, or you have to rob another program, or raise more money.

The final point with this type of system is that, if it's done on the basis of sound clinical grounds, you can actually save money in the system. A study done in California suggested that the cost of treating a low birth weight infant was \$28,000 up to six figures. The study suggested that if you provided that care to all the indigent women who needed it, you could save \$22 million a year in your health care system. That's money that can be used to add services on your priority list. It could be used to raise provider reimbursement levels to a reasonable point where people are not trying to avoid dealing with that population.

What is the role of physicians in resolving this problem? The most significant role they plan is to come to grips with their own limits. They have got to recognize that health care resources in America are in fact limited. How can we expect the public to accept the limits or expect state legislatures to recognize the limits if physicians are not willing to recognize them themselves. We are inviting all of the ominous

consequences that uncompensated care is bringing our way. We have to do that as a first item and express that publicly, physicians must discuss it with each other and with their patients.

Secondly, professional organizations need to adopt a policy, a statement on how to expend limited health care dollars. Something that says the first priority is to extend the basic level of health care coverage, and then we can fight about the budget. But to do that, we have to get involved in the definition of "adequate". Physicians are really the only group in this country that have the qualifications to provide sound clinical input to the state legislature. We need to say, yes, we are going to have to ration health care in this country. It's inappropriate and unethical for physicians to do it, society needs to do it. If the legislature is going to ration health care, then offer a list of clinically wise priorities. This makes sense in terms of marginal costs and marginal benefits. We have to provide that input and then support the legislative decisions that make responsible resource allocation decisions. We have to do that publicly, in our community and at the legislative level.

Uncompensated care requires a partnership solution between public policy makers at the state legislative level and leadership in the medical community. If left unresolved, the problem of uncompensated care is going to result in an erosion in our social commitment to universal access, a deterioration of health for a growing number of Americans with very serious social and economic consequences. It is going to put physicians in conflict with their professional ethics and with what society expects from the health care system. This will lead to regulation, an erosion of clinical autonomy, and very likely a nationally controlled health care delivery system. We cannot accept this outcome as in the final analysis, physicians are patient advocates.

I hope this will assist your understanding concerning the health care industries dilemma and crystallize societies dilemma as well.

Sincerely,

Ray Schalow
Executive Director

AB 581

MEDICAL
INDIGENCY

ProjectNotes



National Conference of State Legislatures

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HEALTH CARE FOR THOSE WHO CANNOT ALWAYS AFFORD CARE

The headlines of the nation's newspapers and periodicals mark the absence of a national health care assurance policy: "US Must Cure Health Care Ills;" "State Health Care Funding Criticized;" "Can You Afford to Get Sick?: The Battle Over Health Benefits;" "US Rations Health Care;" and "Deciding What Medical Care the Poor Can Have: Lists Are Drawn Up." State and federal efforts to better the health care system are fragmented and often work at cross purposes. The lack of agreement on a solution begs the unanswered question: who is responsible?

Health care expenditures have escalated astronomically in the last 25 years. Health care costs consumed 5.9 percent of the Gross National Product (GNP) in 1965. The U.S. Department of Commerce has reported that the nation's health care tab was \$600 billion in 1989, or 11.5 percent of the GNP. Those billions, up 10 percent from 1988 total health care expenditures, translate into approximately \$2,400 per person. 1990 health spending is expected to reach \$661 billion. At the same time, the number of uninsured has grown substantially.

Medical indigency and health insurance are top priority issues for the 1990 legislative sessions. Health insurance issues are explicitly tied to medical indigency policy. Improving access to health care is of concern to medical indigency policymakers as millions of uninsured people report financial barriers to receiving needed care. Mandating health insurance benefits, establishing financial incentives for employer-paid coverage, and creating state-sponsored insurance plans are a few of the key issues facing state lawmakers today.

INSURANCE STATUS

Recent efforts to help solve the problems of medical indigency and uncompensated care focus on the "insurance status" of the population. Lack of insurance leads to an abundance of problems for individuals and health care providers alike. If they can't afford to pay cash or the insurance deductible, the 37 million Americans without health insurance must rely on the goodwill of hospitals, doctors, and other providers. Lack of health insurance or insufficient insurance coverage is not an exclusive problem of the unemployed, the elderly, or persons living in rural areas.

- o A decade ago, approximately 25 million Americans under age 65 did not have health insurance. Today, 37 million Americans, approximately 16 percent of the nation's population, have no health insurance coverage at all, more people than the combined populations of New York, New Jersey, and Illinois.
- o Of the uninsured and increasingly underinsured Americans, the majority have ties to the workplace. Twenty-three million "working poor" have jobs or are dependents of workers.
- o Almost one third of uninsured employees work for employers who do not offer insurance. More than one-third of uninsured workers do not participate in their employer's health insurance plan even if they are eligible. Approximately one-third of uninsured workers do not qualify for their employer's health plans.¹
- o Underinsured people are those who cannot pay for their share of insurance deductibles or copayments or for medical care not covered by their insurance policies. Fifty million Americans are covered only part of the year, and millions more are covered by inadequate plans for catastrophic illness or accident. Nearly every health care consumer has the potential of facing medical expenses for which he or she cannot pay because insurance policies generally have a cap on expenditures.
- o The uninsurable or "high risk" population consists of an estimated one to two million people with high health risks, such as heart disease, diabetes, or acquired immunodeficiency syndrome (AIDS). Many are refused health insurance coverage and others cannot afford to purchase an individual policy, which usually is offered for a much higher premium.
- o Researchers believe that the uninsurable population is growing and attribute the increase to the following factors: insurers are adopting more restrictive health insurance standards due to an increasingly competitive insurance market; not as many employers are providing health insurance benefits because of escalating costs; and advances in technology enable insurers to identify people who have potentially costly illnesses.
- o Others presumably can pay for their care but do not. For example, some people who have insurance do not pay their deductible or copayment amount. It is unclear how many insured people have difficulty paying these costs.

- o Seventeen percent, representing 9.5 million women of child-bearing age (15 to 44), have no private or public health insurance.² Researchers have concluded that 9 percent of women who have private insurance have policies that provide inadequate coverage for maternity care.³
- o Between the ages of 15 and 44, women's need for health services is substantially higher than men's because of reproductive health needs, including perinatal care and contraception. Furthermore, the reproductive years are the time period when women's health most affects society as a whole, by determining the health of the next generation.
- o Burdens of inadequate and incomplete insurance coverage weigh heavily on minority women. A disproportionate burden of illness falls on ethnic minorities, especially African-American women, giving rise to a greater need for health care.

Among the factors contributing to the growth in the uninsured population are the following: a smaller percentage of poor people are covered by Medicaid, because states have limited eligibility over the years to help control costs; most new jobs in the past 10 years are in the service sector, where employees are less likely to be covered by health insurance; and work-based dependent coverage appears to be declining. For this reason many state initiatives focus on expanding work-based insurance coverage, either by giving employers incentives or by requiring them to make insurance available.

¹ Irene Fraser, *Promoting Health Insurance in the Workplace: State and Local Initiatives to Increase Private Coverage* (Chicago: American Hospital Association, 1988).

² Kay Johnson, Director, Health Division, Children's Defense Fund, quoted in *Hunger Action Forum*, Vol. 2, No. 8, August 1989.

³ Paula Braveman, MD, et al., "Women Without Health Insurance: Links Between Access, Poverty, Ethnicity, and Health," *The Western Journal of Medicine*, 1988 December: 149: 708-11.

FINANCING INSURANCE COVERAGE

"A major reason why so many people lack health insurance is that state government regulations are increasing the costs of insurance and pricing millions of people out of the market for insurance. Freedom of choice in health insurance means being able to buy a health insurance policy tailored to individual and family needs. This is a freedom that is rapidly vanishing from the health insurance marketplace." John E. Goodman and Gerald L. Musgrave, Freedom of Choice in Health Insurance, National Center for Policy Analysis

All 50 states have mandated benefit laws which typically require employers that offer group health plans to include specific benefits. During the past 20 years, states across the U.S. have imposed nearly 700 of these mandates. This approach has become increasingly more controversial when employers are mandated to provide insurance coverage. The National Center for Policy Analysis estimated that in 1986, between 14 percent and 25 percent, or 5.2 million to 9.3 million of the people without health insurance, had no insurance because state governments imposed special interest regulations that mandated expensive coverage.

States are struggling with the financial realities of health care mandates. States are not always in a financial position to respond to urgent health care needs. The vagaries of funding a multitude of state programs sometimes require states to mandate employer-based expansions of health care services. Financing programs at times is simply beyond the capabilities of current state budgets. However, employer-based mandates are not the only alternative available, a variety of state approaches are presented below:

- o One approach to insuring the employed uninsured population is to expand the number of employers who offer health benefits.
- o Another approach is to develop mechanisms that enable employees who cannot afford their share of the premium for work-based insurance, especially for dependents, to purchase insurance at affordable rates.
- o Unemployed uninsured people also may benefit from programs that enable more workers to purchase insurance, if they are allowed to participate.
- o The problems facing the underinsured may require insurance policies to provide coverage for more services, such as mental health benefits, mammography screenings, and maternity care.
- o Another approach is to exempt certain covered services from cost-sharing requirements.

In 1990 many states will consider these approaches as well as state risk pools for the one to two million Americans deemed uninsurable.

- o At least 15 states have insurance risk share pools to help provide access to insurance for high risk individuals who otherwise would have trouble obtaining coverage.
- o The costs to risk pool participants are usually 25 to 50 percent higher than premiums paid by persons with private insurance.
- o Even with the high contributions paid by covered people, risk pool programs must be subsidized to cover their costs.

State legislatures and the federal government are considering a variety of other financing mechanisms. Alternatives include using funds from general revenues, changing the estate and gift tax laws, increasing tobacco and alcohol taxes, creating tax incentives for expanding health coverage, enacting state risk pool arrangements, mandating benefits, and Medicaid expansions.

WHOSE RESPONSIBILITY?

STATE

State governments are faced with increasing health care costs for the medically indigent and are under pressure to find more adequate and equitable means to finance health care. The following state examples illustrate the innovative ways in which states address these issues:

COLORADO

The Colorado Health Care Access Act (HB 1034) was introduced by Representative Carol Taylor-Little and Senator Sally Hopper in January of this year. The legislation, patterned after the 1989 Oregon Basic Services package, proposes to address the access problem in two ways: first, by guaranteeing basic health coverage for everyone with incomes under the federal poverty line and committing not to reduce eligibility or provider payment due to budget constraints; and second, by giving small employers a tax incentive to provide health insurance for their employees, a strategy intended to help the working poor. The act would add as many as 170,000 Coloradans with incomes below the federal poverty line to the expanded Medicaid program, many of whom would be children. Up to 245,000 Colorado workers and their families in thousands of small firms also are expected to benefit.

Under the proposal, an independent, objective commission comprised of health care providers, consumers, and experts in health care financing, delivery, and ethics would develop a list of health care services in order of priority, according to the benefits and costs of each service. The proposal requires the commission to consult with the Joint Review Committee for the Medically Indigent, the Joint Budget Committee, and the House and Senate health committees.

Sponsors of the legislation hope to benefit business in three ways: by giving small employers access to low-cost health insurance through a state pool; by providing a tax credit to small employers who purchase insurance through the pool; and by giving all employers valuable information on the effectiveness and appropriateness of services prioritized by the commission, which employers can use in designing more cost-effective benefit packages, thus helping them to control costs.

GEORGIA

In 1989 Representative E.M. Childers, chair of the House Health and Ecology Committee, authored a resolution in the Georgia General Assembly creating the Access to Health Care Commission (1989 Georgia Laws, p. 1749, HR 162). The commission is charged with studying factors that limit access to health care in Georgia and making recommendations concerning programs and policies to improve access in the state. The commission is composed of 30 members: six representing the state General Assembly (health, insurance, and appropriations committees); health providers (hospitals

physicians, nurses, and health centers); health consumers; business; insurers; and state organizations.

A comprehensive solution to the problem of medical indigence is the goal. Georgia has one of the highest infant mortality rates in the United States. Eighteen percent of the population under age 65 is uninsured, including 55 percent of families with income between 50 and 100 percent of the federal poverty level. Of particular concern are the following rural health issues: 40 percent of the state's population are located in rural areas; 50 percent of the population aged 65 and above are located in rural areas; and problems exist with the financial instability of the state's rural hospitals.

INDIANA

Legislation enacted in 1989 (1989 Indiana Acts, P.L. 327, SEA 385) established a Commission on State Health Policy. The commission is intended to improve the effectiveness of programs financed by the state and the effectiveness and delivery of health care services in the state. A study and recommendations are to include research on access to health care, the cost of health care and its underlying factors, preventive health care, and the role of healthy lifestyles. The act also creates a State Health Policy Advisory Committee to provide information and assist the commission in the performance of its duties. The commission is to submit an interim report to the governor and the General Assembly before November 1, 1990, and a final report before November 1, 1991.

The Steering Committee on Health Care for the Medically Underserved, a coalition of health care providers, business, government, and consumer representatives, issued a report calling for state-supported demonstration projects to test private financing mechanisms for uninsured and underinsured residents. The projects are intended to help the state develop an overall policy for financing the delivery of health care services to the working poor. The committee recommended that the state expand its Medicaid program to cover more women, children, and infants who cannot afford health care. It also recommended that the state study ways to develop other public programs to increase health coverage for the indigent.

MISSOURI

In December 1989, Representative Gail L. Chatfield proposed sweeping legislation to create the Missouri Universal Health Assurance Plan (HB 1127). The sponsor emphasized that the intent of the legislation is to provide increased health care coverage to citizens who are currently uninsured by restructuring the state's financing mechanisms so that individuals, businesses, and providers of health care may all benefit. The proposed legislation would cover a range of options, including: mandatory employer coverage, direct state subsidies of individual premiums, and expansions of Medicaid. The basic premise behind the bill is to establish a Canadian style comprehensive health program with three guiding principles: universal access, cost containment, and quality assurance.

The Canadian system mentioned above is perceived to have one of the best health care systems in the developed world. The model is best described as a single-payer public system providing affordable, universal coverage. Each province has its own system, although all provinces conform to basic rules of universality and accessibility.

The Missouri plan is intended to replace the patchwork of private and public insurance with a single state insurance program for which everyone is eligible and within which every resident will have access to a basic package of health care services. The proposed plan would consolidate all of the money presently being paid by private companies and individuals, as well as the state, federal, and local governments into a single fund. Finally, the plan contains quality assurance provisions for constant monitoring and improvement of the quality of care.

OTHER

Nearly 1.8 million residents of North Carolina either have no health insurance or inadequate coverage. A task force of the North Carolina Institute of Medicine has proposed creation of a comprehensive health-benefits plan that would represent the minimum level of insurance coverage to which all citizens would have access. The plan would include comprehensive coverage for primary care, particularly preventive services, but would provide for only 10 days of inpatient care in order for the coverage to remain affordable. The gross cost of the plan would be \$1.4 billion, but institute officials contend that the net cost would be much lower -- about \$700 million -- because of savings resulting from reductions in cost shifting and out-of-pocket expenditures by the medically indigent.

In Washington state, a bill introduced late in 1989 would create the Universal Health Access Program, based on the Canadian health care system. Nearly 700,000 people -- 15 percent of the population -- remain uninsured and unable to afford health services. Representative Dennis Braddock hopes that a universal health system will enable the state to combine and streamline the various health care programs currently operated by the state with a price tag of \$3 billion a year.

FEDERAL

Federal proposals also have addressed the issue of how to better protect uninsured, underinsured, and uninsurable Americans.

The Pepper Commission, created by the now-repealed Medicare Catastrophic Coverage Act of 1988, is currently formulating recommendations on how to deal with the insurance crisis, curb costs, and widen access to care. Among the issues being discussed are the following: implementation of employer-paid health insurance for workers and dependents coupled with a new payroll tax to buy coverage for those lacking insurance; creation of a single government agency empowered to set rates for Medicaid and Medicare; and expansion of Medicaid. The "play or pay" option already

has been embraced or proposed in some states, e.g., Massachusetts, Colorado, Oregon, and Washington. However, critics fear it would hurt small firms and trigger unemployment.

The Social Security Advisory Council, a private sector panel studying the system, has until July 1990 to draft a report, with a final report on the health care system due to the Department of Health and Human Services by January 1991. The Council, unlike the Pepper Commission, has no congressional mandate, and no major changes or restructuring are expected to be suggested.

Congress has passed several initiatives to expand Medicaid coverage. The current trend is to expand Medicaid whereby states are able to address the health care needs of pregnant women, infants, and children in low-income families. Forty-one states have raised Medicaid income eligibility to at least the full federal poverty level. Of these, nine have increased their eligibility levels to the maximum allowed -- 185 percent of federal poverty.

LABOR/BUSINESS

The U.S. Chamber of Commerce, the National Association of Manufacturers, and other business groups are pushing for government action. Business representatives maintain that they "have done all we can do" to manage health care costs. Employers realize that if they do not insure workers they pay dearly. They subsidize the cost of care provided to workers whose employers do not provide health care. The issue of health care costs is one of the most bitterly fought at the bargaining table, e.g., "Baby Bell" contract, Pittston Coal Company strike.

Unions have played a major role in developing employer-based health care coverage for working families. Until recently, such coverage provided access to care for most working Americans and their families. But the health insurance system has evolved during the past decade because of the shifting economy. Over the years, organized labor has fought to protect workers from increased health care costs. However, only 29 percent of employers today offer 100 percent reimbursement for health care, compared with 53 percent just five years ago. A growing number of workers are no longer provided family coverage or cannot afford high monthly premium contributions to insure spouses and children. Working families are now paying more for their health care, if they can afford to pay for it all.

In order to control skyrocketing costs, an AFL-CIO grassroots campaign seeks to develop a five-point national health care program that would: place a cap on all health care expenditures, assure all Americans access to basic health care services, invest in technology assessment, develop guides for physicians to consult in treating various conditions, and inform consumers about cost and quality of health care services by making materials available to all consumers. Federation President Lane Kirkland has stressed that the AFL-CIO's objectives are to launch a "combined federal-state program that will control health care inflation, require all businesses to do their fair share in providing health care protection to employees, provide coverage for the poor and unemployed, effectively monitor the quality of health care,

and eliminate unnecessary procedures."

"Results of the 1987 National Medical Expenditure Survey indicate that many employees would prefer alternatives to costly, high-option traditional insurance, although many employers do not offer them. Furthermore, employees seem willing to trade some reductions in deductibles and copayments for additional protection against catastrophic medical expenses. But the appeal of more traditional high-option benefits, such as first-dollar coverage for hospital stays, will lead many employees to choose the high-option plans, no matter how financial incentives are changed to favor low-option plans and HMOs." Pamela Farley Short and Amy K. Taylor, National Center for Health Services Research.

More Americans are paying more for their own health costs, according to the Employee Benefit Research Institute. Of 1,000 Americans surveyed, about 43 percent paid higher monthly premiums in the last two years; another 32 percent paid more for deductibles; and about 40 percent paid more copayments and dependent-coverage costs. Critics argue that what we do not need are programs that are little more than "band-aids," stop-gap measures that moderate the inequities individuals now experience in the distribution and provision of medical care in our nation.

The question remains, where will responsibility lie? Policymakers at both the state and federal level continue to struggle with these issues. Is a national legislative solution the answer? Some argue that only a federal solution is equitable. On the other hand, federal proposals are often characterized as preemptive of state authority. States are wary of federal interventions that strip state flexibility and displace state plans to deal with the problem. Are individual state solutions the answer? States are in varying degrees of fiscal health. Many contend that piecemeal state solutions will further hamper efforts at "universality." The debate continues, and states retain the authority to address their own needs and develop service systems designed to best respond to their unique circumstances.



FYI



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COMING IN APRIL

ALTERNATIVE FUNDING SOURCES FOR CARE OF THE MEDICALLY INDIGENT

Medical indigency issues continue to dominate health care agendas across the nation. Legislators feel pressure from a variety of sources to address the problem, including health care advocates, business leaders, physicians, and hospitals, most notably public hospitals. The last few years have witnessed a shift in public policy approaches to meeting the needs of the medically indigent. The goal of presenting state information in ProjectNotes has been to inform state legislators of these approaches.

A variety of approaches have been proposed and implemented to help solve the problem and legislators are keenly aware that what works for one state may not be acceptable or feasible in another. Proven and promising strategies states have used to control health care costs while seeking alternative revenue sources to fund care for the medically indigent are highlighted in the April edition of ProjectNotes.

TECHNICAL ASSISTANCE UPDATE

The Medical Indigency Project has sponsored state technical assistance programs in Alaska, Colorado, Kansas, Nevada, Oklahoma, South Carolina, and Wisconsin. The April edition of ProjectNotes recaps these programs and tracks legislative activity surrounding the issue of medical indigency in the state since the program presentation.

1989 HEALTH CARE LEGISLATION REVIEW

The Health Services Program is currently compiling the seventh in a series of NCSL publications summarizing significant health care laws passed by the 50 states, commonwealths, and territories in 1989. The section on Medical Indigency will be previewed in the April edition of ProjectNotes.

MEDICAL
INDIGENCY ProjectNotes

MEDICAL INDIGENCY PROJECT

The National Conference of State Legislatures (NCSL) has a strong commitment to assisting state legislatures with a variety of medical indigency issues. NCSL is assembling a consortium of funders to address the problems of medical indigency. The Colorado Trust and American College of Emergency Physicians are the first to support the Medical Indigency Project. NCSL received a two-year grant from the Colorado Trust to assist state legislators in developing policies on health care for the medically indigent. The Colorado Trust is a private foundation established in 1985. Its primary mission is to promote and enhance the health and well-being of all people, particularly the citizens of Colorado. The American College of Emergency Physicians strives to provide a unifying direction of purpose in the field of emergency medicine. The college provides information regarding the practice of emergency medicine and encourages training of emergency physicians, with the aim of improving emergency room care.

The project conducts on-site technical assistance, publishes periodic reports, and maintains an information clearinghouse on innovative state programs of care for the medically indigent. The project also will produce three newsletters on issues concerning the medically indigent. ProjectNotes is the first in a series of reports on access to care, financing, and the quality of health care for the medically indigent.

TECHNICAL ASSISTANCE

Technical assistance services offer legislatures programs tailored specifically to their state's situation. Assistance in the past has included special workshops, assistance with drafting legislation, and special testimony.

A number of states have expressed an interest in technical assistance for 1989 - 1990 on a variety of topics related to the issue of medical indigency. Requests for technical assistance come from states with large medically indigent populations and states that have experienced a recent increase in this group. States chosen to receive technical assistance are determined according to state need, issue area, potential impact on the legislative process, and legislative interest. If your state legislature is interested in more information on technical assistance programs concerning issues affecting the medically indigent, please contact project staff.

PUBLICATIONS

The Medical Indigency Project has produced a variety of publications and other information resources on major medical indigency health policy issues. One copy of each publication is provided upon request at no cost to state legislators, legislative staff, and state legislative libraries. Please contact NCSL's Book Order Department at the number listed in the FYI section.

INFORMATION CLEARINGHOUSE

The Medical Indigency Project and other health projects have developed an extensive information clearinghouse on a variety of health topics. The information clearinghouse guarantees legislators and legislative staff a quick, reliable, and knowledgeable source of information when research reports and legislation are being formulated. NCSL's Health Services Program fields over 1,000 information requests a year from legislative offices, health departments, other health care professionals, and the media.

Requests cover a broad range of medical indigency topics, including: uncompensated care, Medicaid eligibility and expansion, funding sources, health insurance regulation, risk pools, mandated health benefits, and state programs for the medically indigent. The resources of the Medical Indigency Project information clearinghouse may be accessed by contacting project staff.

MEETINGS AND SEMINARS

NCSL's Annual Meeting and other seminars and conferences provide an opportunity to reach a large number of interested legislators. Health issues are always among the most important sessions at these meetings and draw large audiences. Information on upcoming workshops will be included in future editions of ProjectNotes.

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**FINANCING HEALTH CARE FOR ALASKA'S
UNINSURED AND UNDERINSURED**

**A Technical Assistance Program
for the Alaska State Legislature**

March 30 - 31, 1990

**Health Care Financing Project
Medical Indigency Project**

**Health Services Program
Human Services Department**

**National Conference of State Legislatures
1050 17th St., Suite 2100
Denver, CO 80265
303/623-7800**

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The Arizona Health Care
Cost Containment System

ARIZONA'S
HEALTH
CARE

ACCESS

PROGRAM
FOR
THE
INDIGENT

Overview

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The Arizona Health Care Cost Containment System is now in its eighth year as a Medicaid demonstration project, and changes in the health care industry promise to make it yet another year of challenges. AHCCCS has already demonstrated that it costs less than traditional Medicaid in other states -- an independent study by SRI International, a nationally known research organization, shows a substantial cost savings (see Page 20) -- and that the partnership between the public and private sectors is working.

The program began Oct. 1, 1982, and is now serving almost 290,000 needy Arizonans, mostly mothers, children and elderly persons. Among these are 11,417 people who have qualified for services under the Arizona Long Term Care System, a major new program for the developmentally disabled, elderly and physically disabled that started in January 1989.

BACKGROUND

Before 1982, Arizona was the only state not participating in the federal Medicaid program, which began in the mid-1960s. Since 1864, health care for Arizona's low-income population was provided by the counties through county hospitals and clinics, or through contracted providers.

A statewide county government fiscal crisis in 1980-81, due in part to

escalating health care costs and a new law that limited county budget increases, compelled the Legislature to propose a Medicaid demonstration project funded by federal, state and county governments.

In the spring of 1982, AHCCCS was approved as a three-year demonstration project (under Section 1115 of the Social Security Act) by the Health Care Financing Administration, the federal agency that oversees the program. AHCCCS officially began Oct. 1, 1982. HCFA has since given the program repeated extensions to continue operating and receiving federal funds as a demonstration project. In late November 1988, HCFA approved a five-year extension until 1993. Arizona, on the other hand, gave AHCCCS permanent status in 1987.

The goal of the AHCCCS project was to develop and test a new delivery and payment system for providing health care services, facilitate cost containment, improve patient access and, at the same time, encourage quality care and efficient treatment.

The original program design called for a private contractor to serve as the day-to-day administrator. The administrator's responsibilities included enrollment functions, health plan oversight, audit and compliance functions, claims processing, medical quality assurance, and grievance and appeals.

The program was implemented with very little time for planning and development. Virtually every review of the early years of AHCCCS cites an inadequate amount of time for planning.

During its first 18 months the program was beset with a number of administrative and budgetary problems, which resulted with the termination of the private administrator's contract less than halfway through the term. There was a tremendous amount of negative press about the program, resulting

in a lack of confidence by elected officials, the medical community and the public at large.

After having received a notice of contract termination from the private administrator in March 1984, the state assumed the administration of the program. A task force was appointed to manage the transition from the private sector to the state.

Within 30 days, the state successfully took over the operation. It hired 150 employees, transferred the private administrator's computer software system to state computers, and brought on-line a new computer center.

The AHCCCS program was mobilized to assume a strong, regulatory position. New challenges included:

- Performing financial and contractual compliance reviews of 19 contracting health plans.

- Quality control review of the county eligibility systems.

- Medical quality-of-care audits of the health plans, some of the most thorough medical reviews of any Medicaid program.

- Increased staffing for the audits, compliance and utilization review functions.

After the state assumed administration of the program, two health plan contracts were terminated due to plan insolvency and another plan with new management was successfully reorganized under the federal bankruptcy statutes. AHCCCS was then, and remains today, the only statewide prepaid Medicaid system in the country.

FUNDING

AHCCCS is funded by a combination of state, county and federal contributions. The chart on Page 5 shows the AHCCCS budgets by revenue source since Fiscal Year 1982-83. Before FY 1988-89, the percentage of funds contributed by the state continued to grow partly because of the addition of the Children's Care Program, which is 100 percent state-funded. Because the counties' contribution is fixed and the federal government's risk-sharing is limited, the State General Fund has absorbed a number of program cost increases. There have been increases in the federal percentage over the past three years, which can be attributed to two factors. First, the AHCCCS Administration has more aggressively pursued more federal matching funds. Second, more federal funds have become available as Congress has expanded federally matched eligibility under Medicaid for more pregnant women and children.

AHCCCS differs from traditional Medicaid programs in that its "match" of federal funds is in the form of capitation payments (fixed rates based on AHCCCS population numbers) rather than being based on services rendered. The state is capitated by the federal government on a prepaid basis per its Section 1115 waiver agreement for the categorically eligible, and therefore it is at financial risk for containing health care costs.

Capitation rates were established according to actuarial estimates and represent 95 percent of the estimated cost of services that would have been provided under a fee-for-service arrangement. The actuarial study, conducted by Actuarial Research Corporation (contracted by HCFA), was based on utilization and cost data obtained from several surrounding states. The

AHCCCS BUDGETS
by fiscal year

(000)

	<u>State</u>	<u>Federal</u>	<u>Other*</u>	<u>Total</u>
1982/83	22,050	37,800	55,300	115,150
1983/84	81,270	57,063	80,457	218,790
1984/85	124,621	66,772	65,272	256,664
1985/86	141,311	70,120	62,912	274,343
1986/87	127,822	87,148	72,162	287,132
1987/88	187,193	111,983	78,050	377,226
1988/89**	245,216	311,402	123,906	680,524
1989/90**	320,293	452,026	159,475	931,794

* Primarily county funds

** Includes long term care

amount paid the state has been based on the estimated number of enrollees in each eligibility category multiplied by the respective capitation rate. Quarterly adjustments are made for the actual number of enrollees. Having established the capitation rate, HCFA then pays the state based on a federal matching rate of about 62 percent of that rate.

The annual county contributions for the acute care portion of the program are fixed by statute at 50 percent of the lesser of what they budgeted or spent on health care in FY 1980-81 which resulted in an annual contribution of \$63,073,476. A change was made to Pima County's contribution in 1986 based on a re-evaluation of their 1980-81 indigent health care expenditures by the Auditor General. The only change made to the statutory formula since the inception of the program also reduced Pima County's contribution. That change to the county contribution formula (per Laws 1986, Chapter 380, Section 19) limited the amount of county contributions beginning with FY 1987 to 33 percent of the amount that AHCCCS expended in that county for FY 1984. That change affected only Pima County's contribution, which was reduced by \$3,403,130 to \$12,737,224.

The chart on Page 7 shows the history of the counties' annual contributions to the acute care AHCCCS program. The chart illustrates that while the AHCCCS program has grown significantly, the county contribution to acute care has actually decreased.

It is important to note that the startup of the long term care program in FY 1988-89 increased the counties' contribution to the program. The counties' contribution is to cover the entire local share of the long term care program costs for the elderly and the physically disabled. However, as discussed later, the counties' contribution to long term care was capped

ANNUAL COUNTRY CONTRIBUTIONS
TO AHCCCS ACUTE CARE PROGRAM

	FY 84 FY 85 CONTRIBUTION	FY 86 CONTRIBUTION	FY 87 FY 88 FY 89 FY 90 CONTRIBUTION
APACHE	\$ 262,476	\$ 262,476	\$ 262,476
COCHISE	2,161,200	2,161,200	2,161,200
COCONINO	724,956	724,956	724,956
GILA	1,379,280	1,379,280	1,379,280
GRAHAM	523,044	523,044	523,044
GREENLEE	186,108	186,108	186,106
LA PAZ	207,000	207,000	207,000
MARICOPA	32,933,076	32,933,076	32,933,076
MOHAVE	1,207,956	1,207,956	1,207,956
NAVAJO	302,964	302,964	302,964
PIMA	17,378,112	16,140,357	12,737,224
PINAL	2,649,756	2,649,756	2,649,756
SANTA CRUZ	471,288	471,288	471,288
YAVAPAI	1,393,260	1,393,260	1,393,260
YUMA	<u>1,293,000</u>	<u>1,293,000</u>	<u>1,293,000</u>
	\$63,073,476	\$61,835,721	\$58,432,588

according to statute for the first two years of the program. The Legislature must now re-address the counties' funding of Medicaid long term care.

ELIGIBILITY GROUPS

AHCCCS provides services to several different groups of people. These include categoricals and the Medically Needy/Medically Indigent. Categoricals are those people who enter AHCCCS through a program for which federal matching funds are available. Examples are persons who are receiving Aid to Families with Dependant Children (through the Department of Economic Security) or Supplemental Security Income (through the Social Security Administration). Other eligible groups that are defined by Arizona statute only -- such as the Medically Needy/Medically Indigent who come to AHCCCS through the counties -- receive no federal matching funds. A chart showing the income levels for each eligibility group can be found in Appendix A.

Eligibility groups are briefly described below:

1. Categorically eligible

By federal law, these groups must be covered by AHCCCS. A person may qualify for AHCCCS benefits through the Aid to Families with Dependent Children (AFDC) program, through the AFDC-related Medical Assistance Only (MAO) group, or through the Supplemental Security Income (SSI) program and SSI-related MAO groups. Federal regulations define these groups. The Arizona Department of Economic Security (DES) performs eligibility determinations for AFDC-related applications. The Social Security Administration, a federal agency, performs eligibility determinations for the aged, blind and disabled

**EXPANDING ACCESS TO HEALTH CARE
FOR CALIFORNIA'S
UNINSURED POPULATION**

Prepared by:

The Senate Office of Research
Elisabeth Kersten, Director
March, 1990



484-S

C A L I F O R N I A L E G I S L A T U R E



SENATE OFFICE OF RESEARCH

Elisabeth K. Kersten, Director

March 9, 1990

Dear Friend:

Over 5 million persons in California do not have health insurance and consequently face limited access to health care services.

Lack of health insurance and lack of access to health care are growing problems for California. Between 1979 and 1986 the number of persons without health insurance increased by 50 percent. Due to current population and immigration trends, the number is likely in excess of 6 million today. Especially vulnerable are low income working and nonworking persons, children, and minorities.

As a group, the uninsured frequently forego necessary medical treatment for economic reasons; often the only route to medical care is via the emergency room where the costs of intervention are high and overcrowding problems severe.

The 1989-90 Session is likely to see a number of legislative proposals for expanding access to health for the uninsured.

To assist in the review of these proposals, SOR has produced the attached briefing paper, entitled "Expanding Access to Health Care for California's Uninsured Population". The report is designed to provide background on the extent and nature of problems of lack of health insurance and uncompensated care and to outline options the Legislature has for responding. It is not designed to advocate any particular proposal or idea.

SOR welcomes your comments on the report and is available to provide further assistance in reviewing proposals for expanding access to health care. Peter Hansel is SOR's consultant on health care financing and health insurance issues and can be reached at (916) 445-1727 (ATSS 8-485-1727).

Sincerely,

A handwritten signature in cursive script that reads "Elisabeth Kersten".

ELISABETH KERSTEN

EK:gd

**EXPANDING ACCESS TO HEALTH CARE
FOR CALIFORNIA'S
UNINSURED POPULATION**

Prepared by:
Peter Hansel, Consultant
Senate Office of Research
March, 1990

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Executive Summary

In the period since World War II health insurance has become the primary means of access to health care services for most Americans. Currently, over three-fourths of the U.S. population has private health insurance of some kind. Medicare and Medicaid, public insurance programs designed to assist elderly, disabled, and low income persons, provide coverage for an additional 8-10 percent of the population.

Historically, a relatively small percentage of the population (10-15 percent) has had neither private or public insurance coverage. Generally, this residual population has relied on charity care by providers and/or public health safety net programs for access to necessary health care and the costs of providing this care have been easily absorbed by the health care delivery system.

Since the late 1970s the number of persons without either private health insurance or eligibility for Medicaid has risen sharply. Between 1977 and 1985, the percentage of Americans without private insurance or Medicaid or Medicare coverage increased from 13 to 17.6 percent, or 37 million Americans.¹ In California the number of nonelderly persons without either private health insurance coverage or eligibility for Medi-Cal or Medicare increased from 3.5 to 5.2 million persons between 1979 and 1986, a 50 percent increase.² Given current population and immigration trends it is likely that the number of Californians without health insurance has increased to in excess of 6 million persons.

The rise in the number of uninsured Californians is placing severe demands on the state's private and public health care delivery system, including rising burdens of uncompensated care and burdens on the county health care safety net. Without measures to increase health insurance availability and access to health care services these impacts will become increasingly severe in future years.

This issue brief examines the problem of the growing number of Californians without health insurance and discusses options the state has for expanding access to health care for this growing population.

The report:

- Summarizes recent data on the composition of the uninsured population, recent trends in coverage, and examines economic and demographic changes that are contributing to the rise in the number of uninsured.
- Examines impacts associated with the growth of the uninsured population, including reduced access to health care services by uninsured persons and declining health status as a result of lack of access, rapid growth of uncompensated care expenditures of health care providers, the growing cost shift to private payors of health care, and the overburdening of the county health care system, including growing backlogs for clinic, emergency, and inpatient services.
- Presents a variety of options for expanding access to health care by the uninsured population, including comprehensive reform proposals that would change the manner in which health care is delivered to all persons in the state as well as incremental proposals targeted at segments of the uninsured population such as employees and their dependents. Where possible, the report references proposals adopted or being experimented with in other states.

In addition, the report contains an appendix summarizing major pending or recently introduced proposals for expanding access to health care services by uninsured persons including the Health and Welfare Agency's proposal contained in its report of the AB 350 task force.

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Colorado's Indigent Care Program

Background

In 1974, the State of Colorado initiated a program to fund health care services to Colorado's non-Medicaid poor. The program was officially authorized by statute in 1983. The University of Colorado Health Sciences Center has managed the program since July 1982.

The Indigent Care Program is comprised of five separate line item appropriations. For fiscal year 1988-89, the total appropriation of \$41,922,273 included:

Community Maternity Program	\$ 3,349,705
Denver Indigent Care Program	16,059,496
Out-State Indigent Care Program	6,858,474
Specialty Indigent Care Program	1,389,078
Health Sciences Center Indigent Care Program	14,265,520
<hr/>	
Total	\$ 41,922,273
<hr/>	

Providers

The MI statute establishes that Denver Health and Hospitals is the designated primary provider for health care for Denver County residents. The statute further designates the Health Sciences Center as the primary provider for non-Denver County residents within the Denver Metropolitan Statistical area. The Health Sciences Center, additionally, is designated as the specialty care provider where services may not be available throughout the state.

By statute, providers must be licensed by the State Department of Health as a general hospital, a community clinic, or a maternity hospital. Health Maintenance Organizations, issued a certificate of authority, may also be providers in the Out-State and Specialty Indigent Care Programs. To be eligible to apply as a provider, applicant institutions must provide at least 3% of their annual costs as charity care. Open enrollment for the program occurs each Spring prior to the State's new fiscal year.

The Out-State Indigent Care Program has received 57 applications for participation in the 1988-89 program year. Of the 57 providers, 42 were hospitals and 15 were community clinics. For the Specialty Indigent Care Program, 2 hospitals applied.

Providers are required, at a minimum, to provide emergency care to indigent patients up to the capacity of their physical, staff, and financial capabilities.

Patient Eligibility

The MI statute clearly states that the program as established is not an entitlement program. The medically indigent patients accepting services under this program are subject to limitations and requirements.

It is the responsibility of the individual patient to apply for eligibility under the program and provide the necessary documentation. Patients eligible for Medicaid do not qualify under the MI program. Other third party insurance coverage must be exhausted, prior to coverage under the MI program.

To determine a patient's eligibility, each provider uses the guidelines published in the 1988-89 Ability-to-Pay Manual. The ability-to-pay formula considers family size, income, assets, and liabilities to determine an indigent rating.

Services Covered

The services covered vary by provider and are established as part of the contractual process. A priority is placed on emergency acute care services. Although the MI statute has established target percentages for utilization of inpatient, outpatient, emergency and transportation services, these requirements may be waived by the Indigent Care Program Administration.

Provider Payment

For all programs, with the exception of the Community Maternity Program, providers are paid on the basis of percentage of costs within appropriation limitations. The 1988-89 projected reimbursement rate for Out-State providers is 29.5% of costs.

Reporting Requirements

Provider hospitals and clinics are required to report patient and financial data. The instructions on the reporting requirements are contained in the 1988-89 Uniform Data Reporting System Manual.

For further information on the Indigent Care Program, contact:

Ms. Laurie Shroyer
Manager, Indigent Care Program
University of Colorado Health
Sciences Center
4200 East 9th Ave., Box A019
Denver, Colorado 80262
(303) 393-2072

SCOPE
(Shared Cost Option for Private Employers)

Purpose The purpose of SCOPE is to provide low-cost health insurance for employees of small businesses, many of whom do not now have health benefits.

Sources of Funds The Robert Wood Johnson Foundation of Princeton, New Jersey, has provided grant funds under the auspices of its "Health Care for the Uninsured" Program for the development of SCOPE. The Colorado Trust, a Colorado philanthropic foundation, has provided matching funds for the project, as have The Piton Foundation and The Hill Foundation. The Denver Department of Health and Hospitals is also providing matching support for the project. The insurance plan, once developed, will be self-supporting.

Participants The SCOPE grant, which was awarded to the Denver Department of Health and Hospitals, is a collaborative effort; the other participating entities are University Hospital, the Colorado Business Coalition for Health and the Denver Medical Society.

SCOPE Plan Characteristics Preventive and primary care will be covered. Preventive care will be free, while a physician's office visit will require a nominal copayment. Inpatient hospital care will require a significant deductible and coinsurance which, for low-income patients, may be absorbed by the State's medical indigency program. There will be limitations on the physicians and hospitals whose services may be used by plan enrollees. The premium price will be modest, lower than any other comprehensive health plan offered in the Denver market. Specific information on premium prices, copayments and deductibles and participating providers will be available in July, 1989.

Project Tasks The first task was to determine the size, composition and location of the potential market for low cost health insurance. A survey of 776 small employers in the Denver metropolitan area was undertaken to determine the extent of insurance coverage, the characteristics of employees, and the location of the small employer population. This has been invaluable in the process of benefit design, pricing, and location of physician and hospital providers.

Detailed benefit design, actuarial analysis, and determination of prices, deductibles, and copayment levels are complete.

Development of a network of participating physicians and hospitals has been completed.

The insurance package has been bid to existing insurers. United States Life Insurance Company is the underwriter. The plan will be marketed through agents and brokers as well as directly.



**USLIFE CARE
S.C.O.P.E. PLAN OF BENEFITS**

This plan requires that insureds take full advantage of the convenience and cost savings which are afforded when medical treatment, services or supplies are provided by a Participating Physician. See EXCEPTIONS below.

SCHEDULE OF BENEFITS

MEDICAL CARE MUST BE PROVIDED THROUGH A PARTICIPATING PHYSICIAN (See Exceptions Below)	
Cash Deductibles:	<ul style="list-style-type: none"> • \$250 per person, per calendar year, for hospital confinement in a Participating Hospital (but not for Well Baby Care) • \$50 per person, per calendar year, for prescribed drugs obtained while not hospitalized
Coinsurance:	50% of the first \$5,000 of all covered charges, 100% thereafter, EXCEPT as provided below.
Co-Payment:	<ul style="list-style-type: none"> • \$15 per visit at a physician's office or for a physician's visit at home for evaluations and examinations. (but not for preventive care) <p><i>(an additional \$15 co-payment will not be required if as a result of the visit you are referred by a participating physician to a lab or hospital for outpatient diagnostic tests)</i></p> <p><i>after the payment of the co-payment the remaining covered charges will be paid at 100%</i></p>
Pregnancy:	benefits are paid as for a sickness
Well Baby Care: (Routine Nursery Care)	100% of covered charges
Accident:	100% of the first \$500 of covered charges before the cash deductible or co-payment is satisfied
Preventive Care:	100% of the covered charges for services shown on page 5
Maximum Benefit For Each Person While Insured * :	<ul style="list-style-type: none"> • Unlimited for persons under age 70 • \$50,000 for persons age 70 and over

EXCEPTIONS: Medical Care Provided By A Nonparticipating Physician

- **Accident (In Service Area or Out of Service Area)** 100% of the first \$500 of covered charges
- **Hospital Confinement** If an insured person is admitted to a Participating Hospital by a Participating Physician, all expenses for services provided by a Non-Participating Physician which are incurred in connection with that admission will be covered as if they were provided by a Participating Physician.

*Limited benefits are payable for treatment of alcoholism, drug addiction and psychiatric disorders (see page 3)

DEFINITIONS

PARTICIPATING PHYSICIAN means a physician listed in the List of Participating Physicians, as periodically updated.

PARTICIPATING HOSPITAL means a hospital listed in the List of Participating Hospitals, as periodically updated.

COINSURANCE means the amount United States Life will pay each calendar year after the insured satisfies the cash deductible or co-payment requirement, as appropriate.

DEPENDENT means the employee's legal spouse, and each unmarried child who is under age 19 (or under age 25 if a full-time student) and is supported by the employee. "Child" includes a stepchild or an adopted child.

SERVICE AREA means the geographical area served by all the participating physicians listed in the List of Participating Physicians and the List of Participating Hospitals.

FAMILY DEDUCTIBLE

In no event will the insured members of a family, in combination, have to satisfy more than 2 times the cash deductible for hospital confinement, shown on page 1.

BENEFITS FOR PERSONS ELIGIBLE FOR MEDICARE

The benefits to be paid by the group policy will be reduced by the amount of Medicare benefits to which the person is entitled.

United States Life will presume that a person is entitled to all Medicare benefits on the date he is eligible for them, even though he may not apply for them on time.

For groups subject to COBRA, this "carve-out" wording will not apply.

PREGNANCY BENEFITS

Benefits for pregnancy, and complications of it, are provided to all insured persons on the same basis as those to be paid for a sickness.

WELL BABY CARE

Charges incurred for routine nursery care of a child will be considered covered charges under the major medical benefit plan if:

- the child is born while the mother is insured, and
- the charges are incurred while the mother is hospitalized having been admitted or referred for admission by a participating physician.

CONTINUATION OF DEPENDENTS' INSURANCE WITHOUT PREMIUM PAYMENT (SURVIVORS' BENEFIT)

At the employee's death, the spouse may not be eligible to continue his or her medical insurance in accordance with state law, or he or she may choose not to do so even if they are eligible. In either case, insurance will be continued for the spouse and dependent children if they were insured for such benefits when the employee died. Premium payment is not required. Insurance will continue for up to 12 months, but will end on the date:

- the spouse remarries
- the child no longer qualifies as a dependent, or
- the Employer's plan ends.

This benefit is not available to dependents who are eligible to continue their insurance under a COBRA continuation right.

MAJOR MEDICAL BENEFITS

COVERED CHARGES

The charges covered by the plan are those listed below. Any amount of such charges which exceeds reasonable and customary charges will not be covered.

REASONABLE AND CUSTOMARY CHARGE means a charge not more than the usual charge for medical treatment in the locality where it is received. The nature and severity of the injury or sickness involved will be taken into account.

Covered Charges Include Charges For:

- hospital room and board, up to the hospital's highest charge for a semi-private room; hospital services and supplies; physician's diagnosis, treatment and surgery; anesthesia and its administration; private duty nursing (but not by a member of the insured's immediate family or household); professional ambulance service (up to \$100); prescription drugs; physiotherapy; x-ray and lab services; artificial limbs or crutches.
- confinement in a convalescent home, up to 50% of the amount to be paid for hospital room and board, limited to 50 days for all confinements due to related causes.
- hospice care for the terminally ill with 6 months or less to live, including services of registered nurses and home health aides, occupational, speech or respiratory therapy, medical social services, nutritional and family unit counseling and respite care; for each 3 month period, benefits will be paid up to \$5,000, with a per diem maximum of \$55, and up to \$500 for bereavement support services for the family unit; the maximum benefit duration will be 9 months.
- home health care, including services of registered nurses and home health aides, occupational or speech therapy, medical social work and special meals and nutritional services; benefits will be paid up to 100 visits per calendar year.

Covered charges for treatment of alcoholism and drug addiction include:

1. charges incurred while hospitalized in a Participating Hospital for treatment, up to 45 days per calendar year.
2. charges incurred while not hospitalized, if made by:
 - a Participating Hospital
 - a facility licensed by the department of health to treat alcoholics/addicts
 - a mental health facility approved as such by the department of institutions.

Benefits for item 2 will be paid up to \$500 per calendar year.

Covered charges for psychiatric treatment include:

1. charges incurred while hospitalized in a Participating Hospital, up to \$25,000 for each person while insured.
2. charges incurred while not hospitalized, if made by:
 - a Participating Hospital
 - a Participating Physician
 - a comprehensive health care service corporation
 - a community mental health center or mental health clinic approved by the department of institutions.

Benefits for item 2 will be paid up to \$1,000 per calendar year.

PREAUTHORIZATION

The plan will pay the benefits described above for inpatient treatment of alcoholism, drug addiction and psychiatric treatment *only* if the insured person gets authorization from United States Life's designated utilization review organization (URO) prior to treatment.

LIMITED BENEFITS ARE PAYABLE FOR:

Dental care, treatment or surgery, temporomandibular joint dysfunctions (TMJ), eye exams and cosmetic treatment or surgery.

MAJOR MEDICAL BENEFITS (Continued)

PRE-EXISTING CONDITIONS

PRE-EXISTING CONDITION means an injury or sickness for which a person:

- incurred charges
- received medical treatment
- consulted a physician, or
- took prescription drugs

within 3 months before he became insured under this plan.

No charges incurred for a pre-existing condition will be considered covered charges under this plan until:

1. the person has not:

- incurred charges
- received medical treatment
- consulted a physician, or
- taken prescription drugs

for such condition, or any complication of it, for 3 continuous months, while insured:

2. the employee stays insured under this plan as a full-time employee for 6 continuous months; or
3. the employee or dependent stays insured under this plan for 12 continuous months.

CHARGES NOT COVERED

1. Charges to buy or rent:

- air conditioners
- air purifiers
- motorized transportation equipment
- escalators or elevators in private homes
- eye glass frames or lenses
- hearing aids
- swimming pools or supplies for them
- general exercise equipment.

2. Charges incurred after a person's insurance ends, regardless of when the injury or sickness occurred. However, major medical benefits may be provided as described in the BENEFITS AFTER INSURANCE ENDS provision.

3. Charges for a routine physical exam, except as provided on Page 5.

BENEFITS AFTER INSURANCE ENDS

If a person's insurance ends while he is totally disabled, benefits will be paid for covered charges if:

- they are incurred to treat the injury or sickness which caused the total disability
- they are incurred within 12 months after insurance ends
- total disability is continuous from the day insurance ends to the day the charge is incurred, and
- the person is not covered for the total disability under another group plan.

GENERAL EXCLUSIONS FOR ALL MEDICAL CARE BENEFITS

No medical care benefits will be paid for treatment which:

- would be given free of charge if the person was not insured
- results from war or an act of war or intentional self-inflicted injury
- is for a job-related injury or sickness for which a person is entitled to benefits from a workers' compensation or similar law.

The benefits to be paid by this plan will be coordinated with benefits to be paid by other group plans.

PAYMENT FROM A THIRD PARTY

Medical benefits paid under the group policy must be returned to United States Life if the insured recovers from a third party for the same injury or sickness. No medical benefits will be paid under the group policy to an insured who has received payment from a third party for past or future medical care as the result of the negligence or intentional act of a third party.

If an insured makes a claim for medical benefits under the group policy prior to receiving payment from a third party, he must agree to repay United States Life from any payment received from a third party to the extent of the benefits paid by United States Life.

Repayment is required regardless of whether the payment received from the third party is the result of a legal judgment, an arbitration award, a compromise settlement, or any other arrangement.