

ALASKA LEGISLATURE SPECIAL COMMITTEE / SUBJECT FILE 8672
1714.1 SCOMM 68: HEALTH CARE COST CONTAINMENT TASK FORCE, 1989-91



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

Jeffrey A. Malek
Area Assistant Vice President
Arthur J. Gallagher & Company
160 Spear Street, Suite #1100
San Francisco, California 94105

November 22, 1989

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

Dear Senator Kelly:

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

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

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

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

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

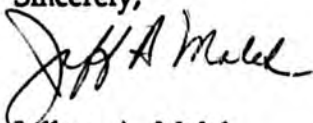
These measures also helped provide the state with a favorable renewal from Aetna whereby the revised rate* would hold until February 1, 1991. This is important when medical inflation in Alaska is predicted at least 23% this year without these steps (and good experience) the legislature would have to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

Senator Tim Kelly
November 22, 1989
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- * Cost containment measures net effect on premium rate.
Rate effective February 1, 1989 = 431.72 rate effective December 1, 1989 after cost
containment 384.59 = 47.13 per active employee per month savings x 13,365 average
enrollment.

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

Sincerely,



Jeffrey A. Malek
Area Assistant Vice President

JAM/jyi

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

STATE OF ALASKA
HEALTH CARE COST CONTAINMENT
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NOVEMBER 28, 1989

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San Francisco, California 94105

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"Direct Contracting with Hospitals: Alternative Payment Arrangements," Employee Benefits Journal, June 1989.

Summary of state legislation governing P.P.O.s. Survey of the American Medical Care and Review Association

SECTION A
TRENDS IN HEALTH CARE
TRENDS AND STATE EXPENDITURES

PACIFIC REGION TRENDS

**ALASKA
CALIFORNIA
HAWAII
OREGON
WASHINGTON**

HIAA STATISTICS ON HOSPITAL COSTS AND CHARGES, PHYSICIAN POPULATION

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

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

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

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

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

1986 HOSPITAL DAILY SERVICE CHARGES FOR PACIFIC STATES

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

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

Hospitals Surveyed

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

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

Data Evaluation

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

National Averages

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

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

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

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

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

STATE EMPLOYEE HEALTH BENEFIT COSTS

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

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

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

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

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

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

Managing Costs

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

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

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

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

Retiree Benefits

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

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

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

State Health Plan Costs

Percentage Increases (Jan. 1986 to Jan. 1988)

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

Source: Martin E. Segal Company

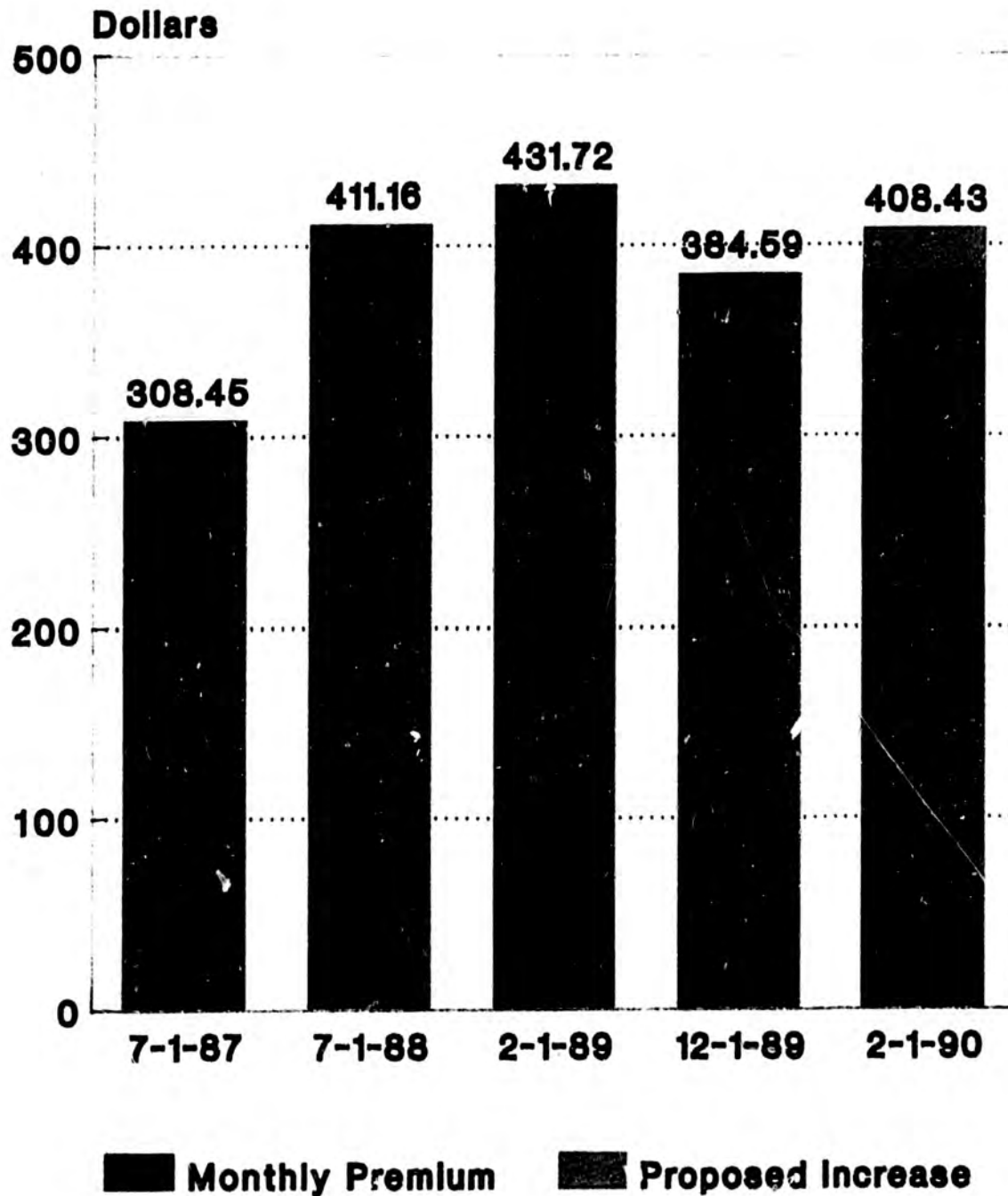
State of Alaska Premium Rates with Percent Change

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

Source: Aetna Life Insurance Company

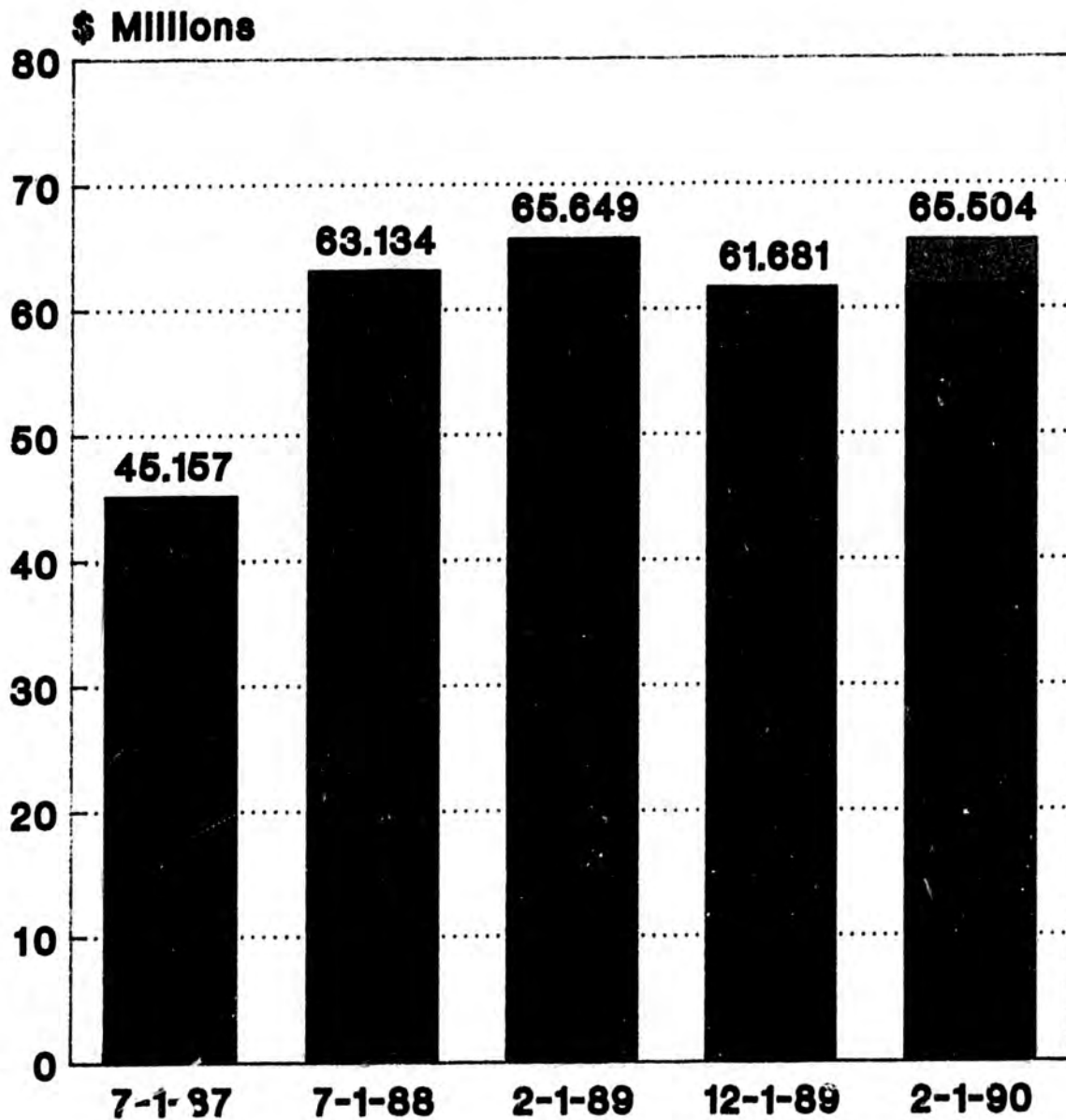
STATE OF ALASKA

MONTHLY HEALTH PREMIUM



STATE OF ALASKA

TOTAL ANNUALIZED HEALTH PREMIUM •



■ Monthly Premium ■ Proposed Increase

• Based on number of employees at each point in time

ARTHUR J. GALLAGHER & CO.

CONSUMER PRICE INDEX

CONSUMER PRICE INDEX

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

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

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

1. CPI-U

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

2. CPI-W

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

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

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

Revisions: 1987, 1988

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

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

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

Medical Care Component

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

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

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

Health Insurance

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

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

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

Area Indexes

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

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

Regional Indexes

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

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

For 1981-1986:

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

For 1987-1988:

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

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

Calculating Index Changes

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

Seasonally Adjusted Data

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

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

Reliability

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

ANNUAL CPI-U AVERAGES 1983-1987 IN SELECTED CITIES

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

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

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

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

* 1987 indexes on 1982 - 84 = 100 base

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

ANNUAL CPI-W AVERAGES 1983-1987 IN SELECTED CITIES

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

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

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

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

* 1987 indexes on 1982 - 84 = 100 base

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

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

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

* Population of Anchorage falls within this category.

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

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

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

ARTHUR J. GALLAGHER & CO.

STATE EXPENDITURES

SCOPE

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

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

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

GENERAL ECONOMIC AND DEMOGRAPHIC CONDITIONS

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

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

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

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

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

GENERAL FUND EXPENDITURES

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

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

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

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

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

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

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

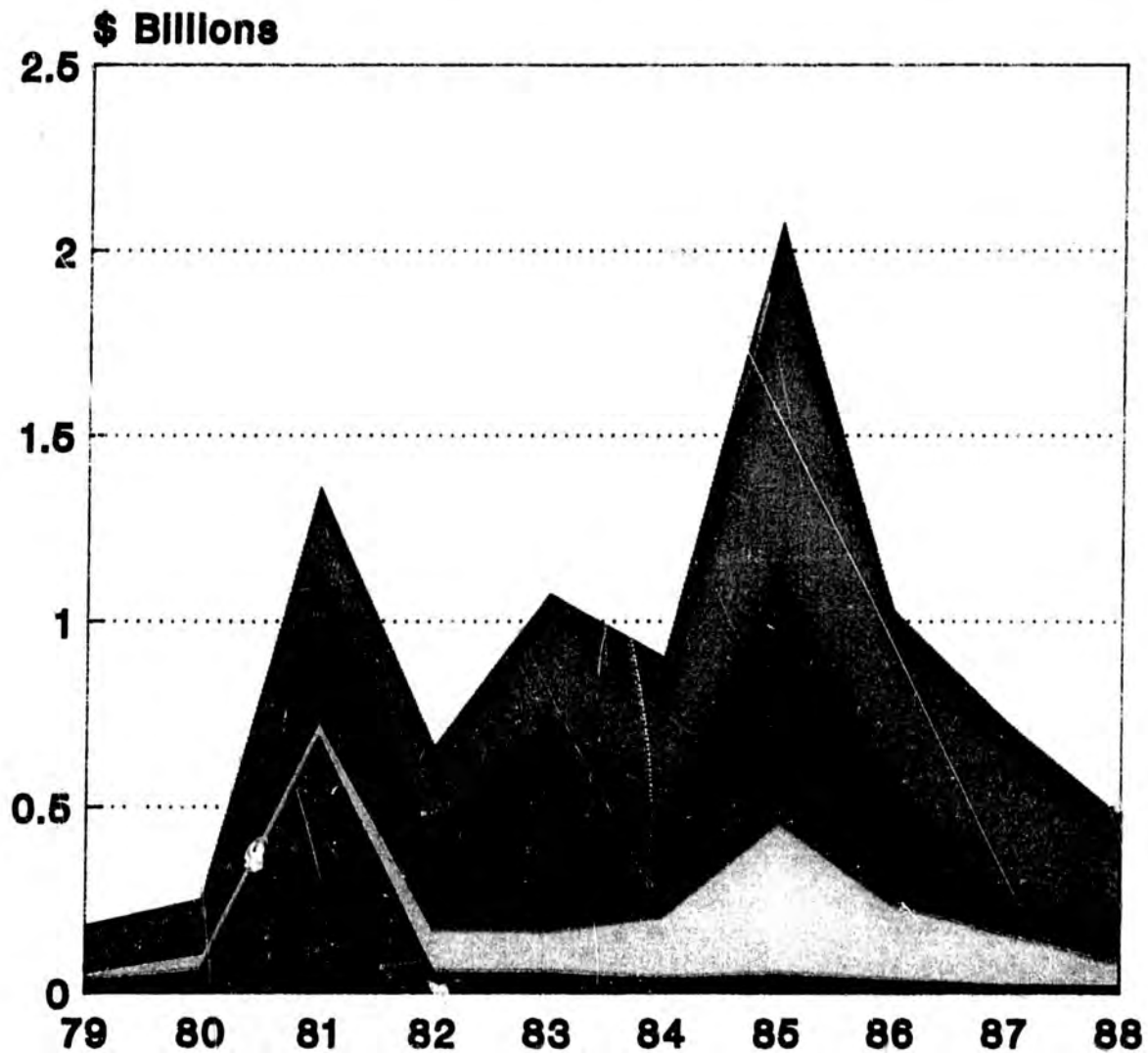
Standard expenditures amount to \$18.4 billion (70.5 percent) while special expenditures amounted to \$7.7 billion (or 29.5 percent). State general fund spending peaked in 1985, three years after revenue peaked.

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

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

STATE OF ALASKA

STANDARD GENERAL FUND CAPITAL SPENDING 1979-1988

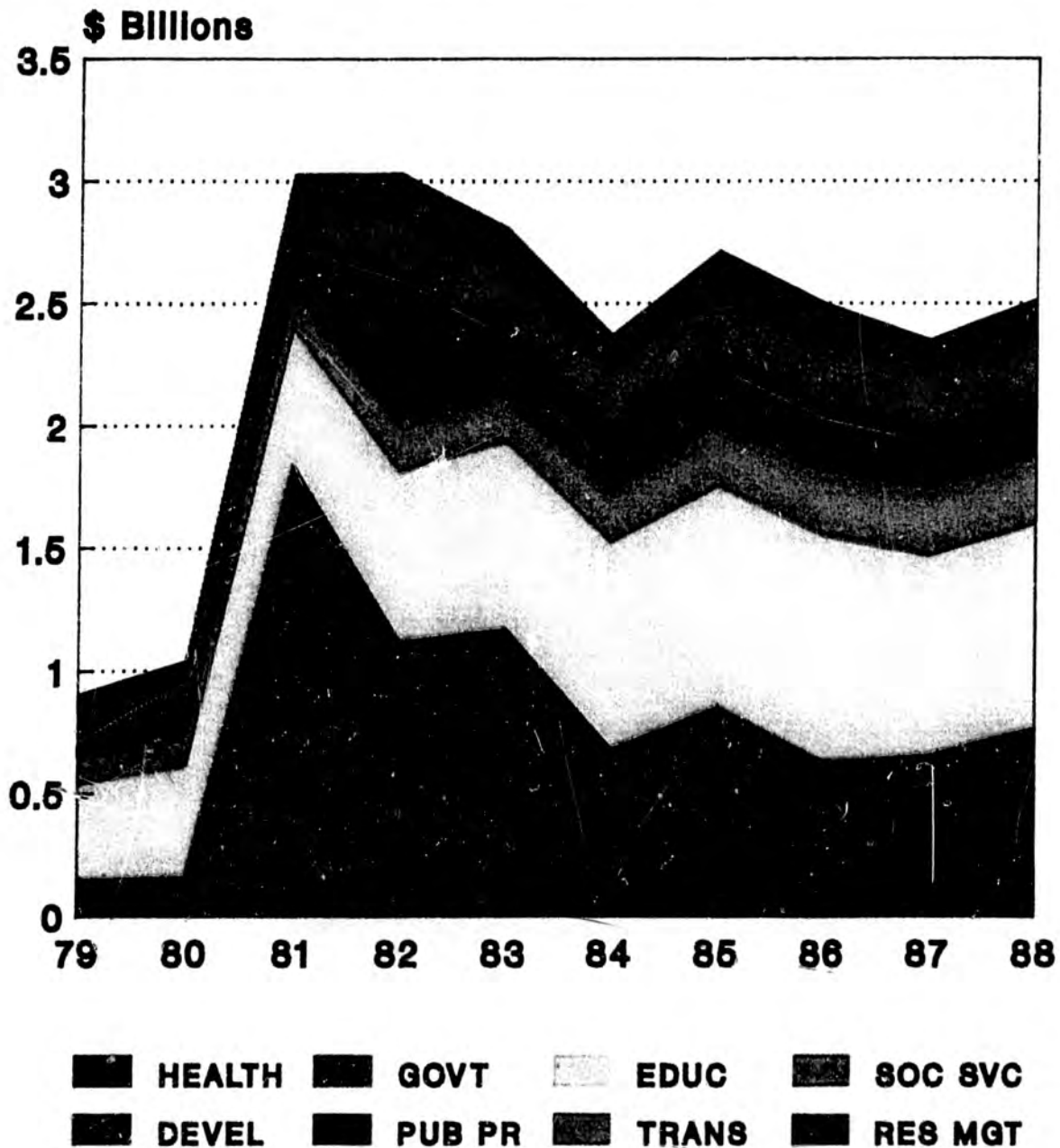


HEALTH	GOVT	EDUC	SOC SVC
DEVEL	PUB PR	TRANS	RES MGT

STATE OF ALASKA

STANDARD GENERAL FUND OPERATION SPENDING

1979-1988



• Excludes Administration of Justice

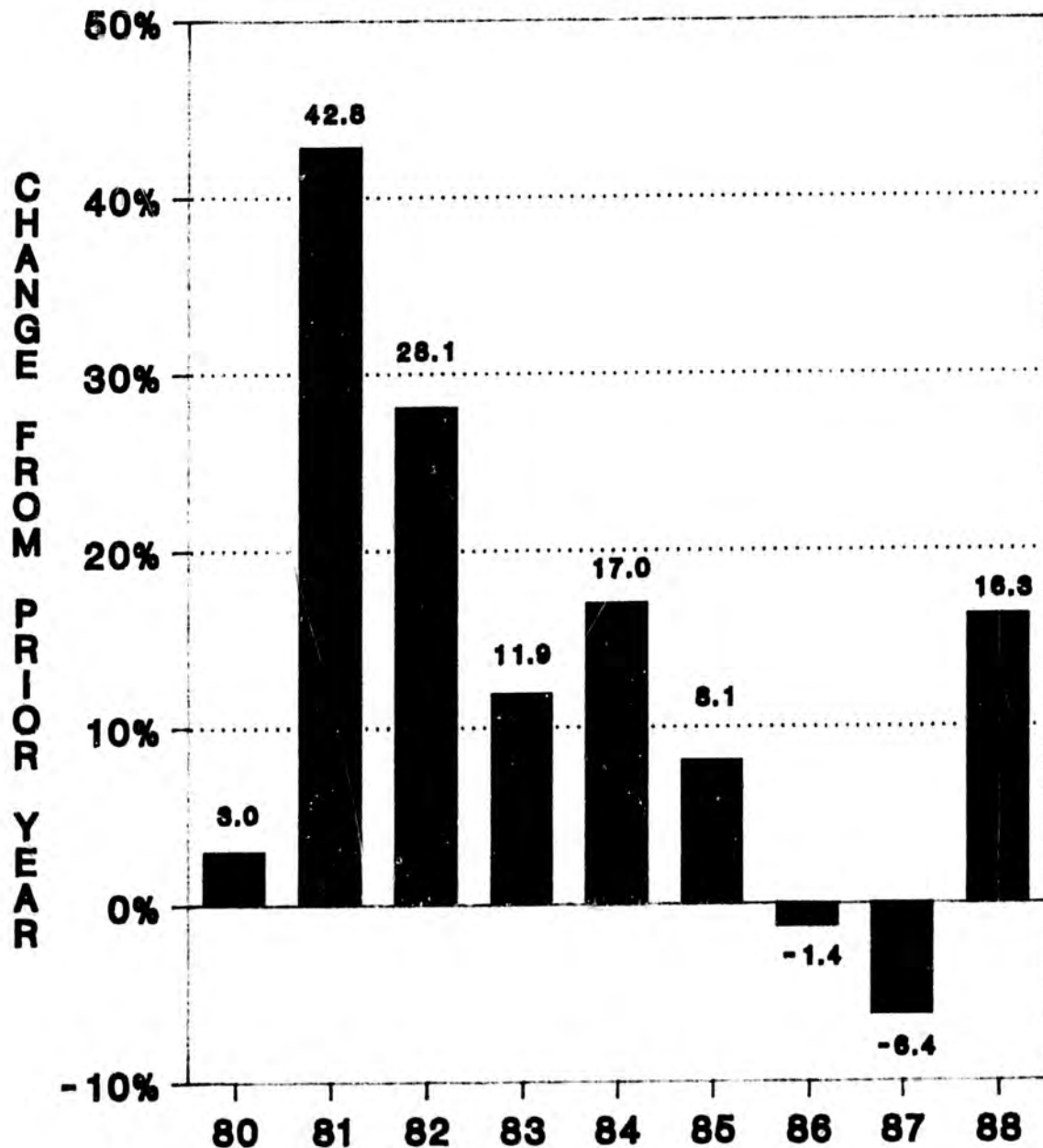
HEALTH EXPENDITURES

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

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

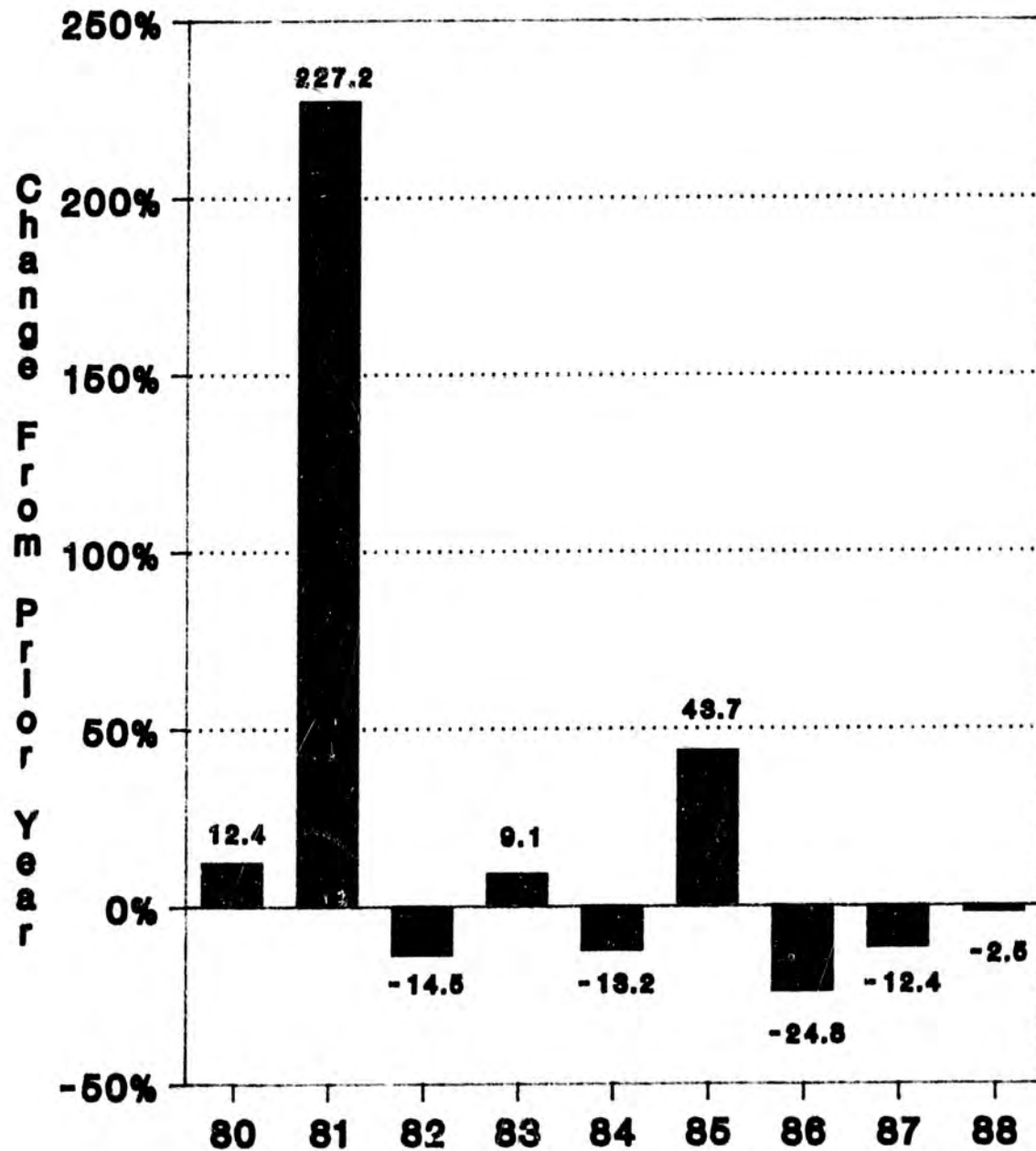
STATE OF ALASKA

PERCENT CHANGE IN HEALTH EXPENDITURES 1979-1988



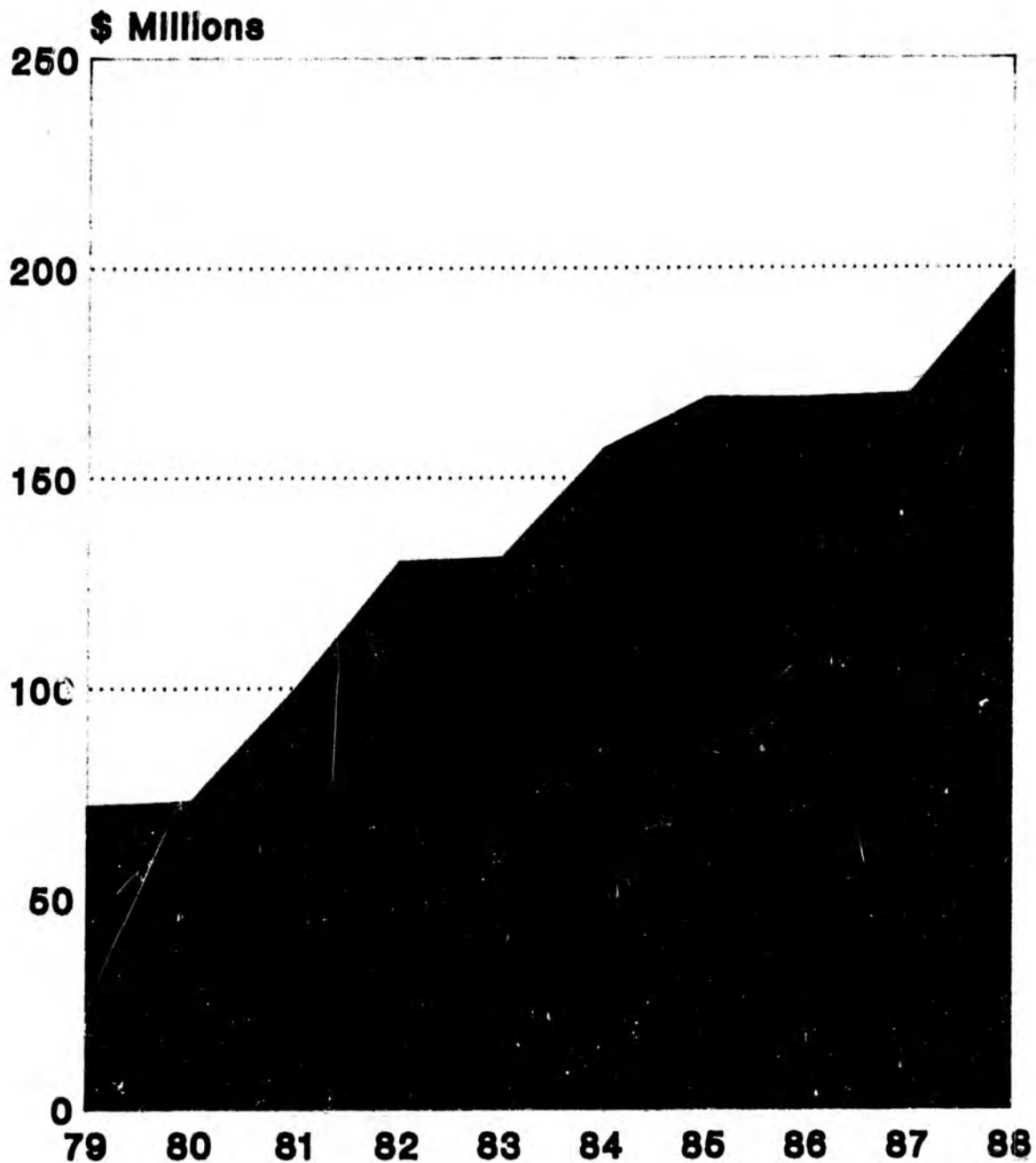
STATE OF ALASKA

PERCENT CHANGE IN TOTAL EXPENDITURES 1979-1980



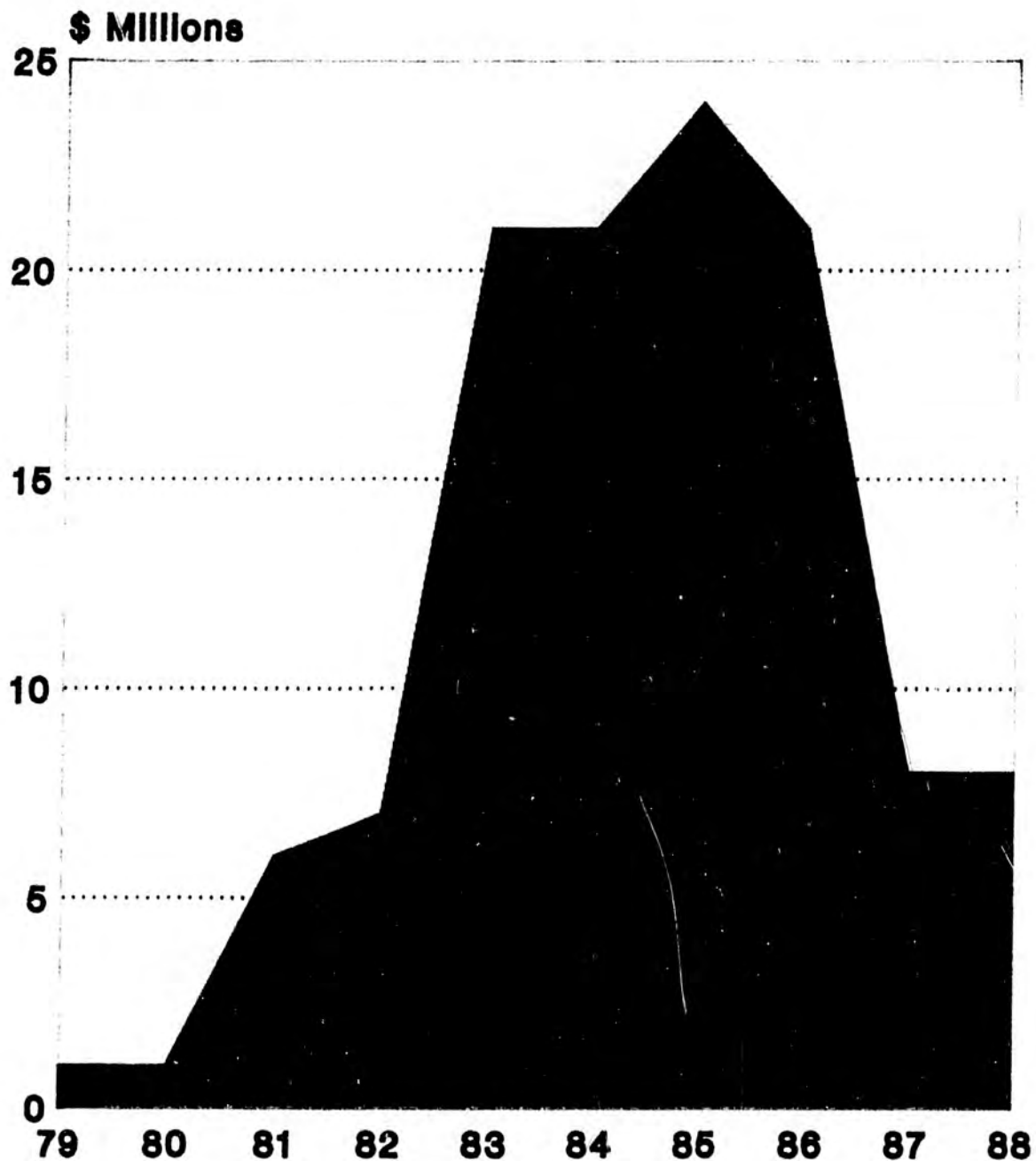
STATE OF ALASKA

STANDARD GENERAL FUND OPERATION SPENDING HEALTH ONLY



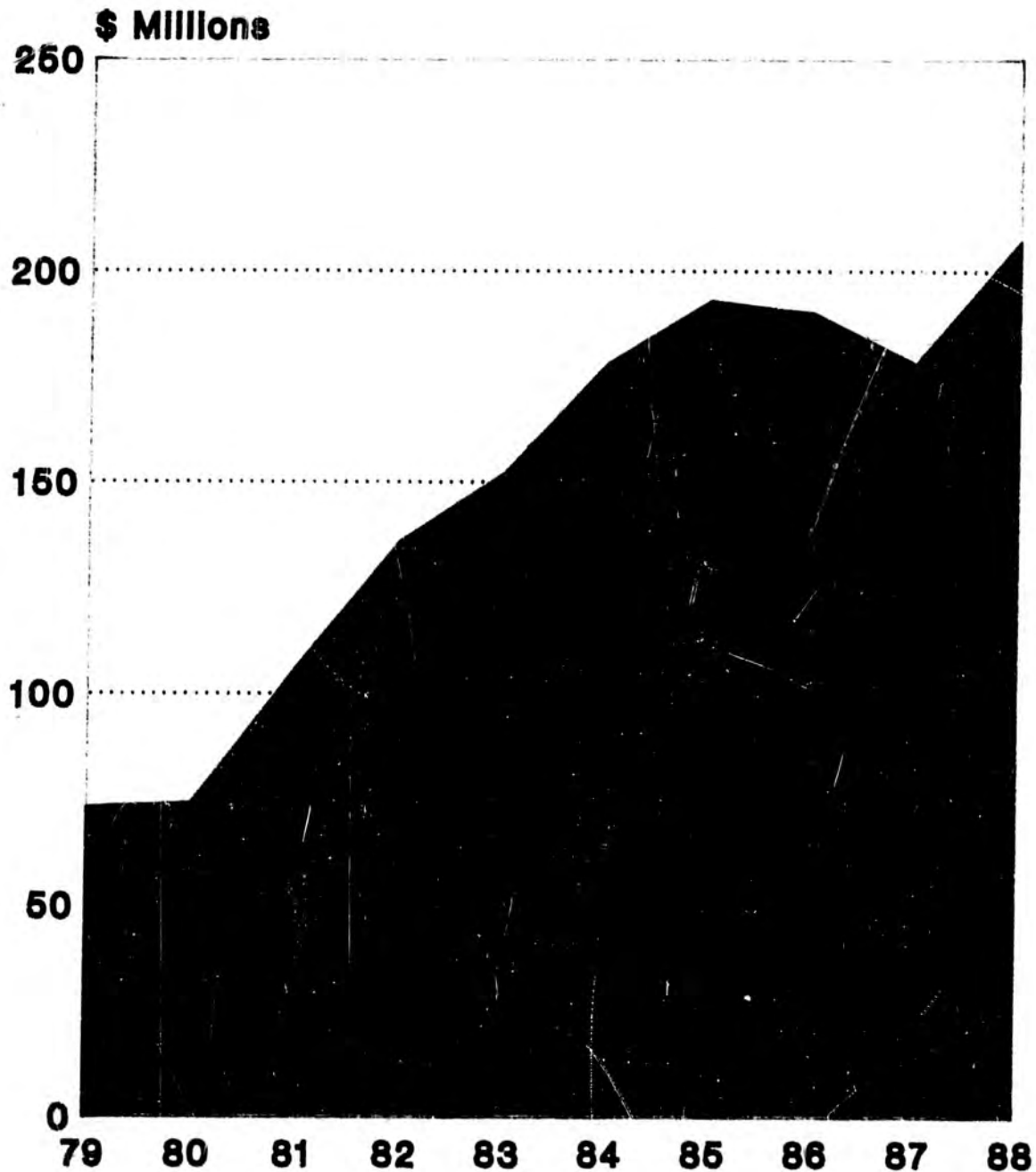
STATE OF ALASKA

STANDARD GENERAL FUND CAPITAL SPENDING HEALTH ONLY



STATE OF ALASKA

STANDARD GENERAL FUND TOTAL SPENDING HEALTH ONLY



SECTION B

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

ALTERNATE FUNDING UPDATE
(ACTIVE/RETIREE PLAN)

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

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

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

ALTERNATE FUNDING UPDATE

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

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

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

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

Some of the advantages are:

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

RECOMMENDATION

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

OFFICE OF THE PRESIDENT

MEMBER

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



SENATOR TIM KELLY

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ANCHORAGE, ALASKA 99521
(907) 561-7612

October 9, 1989

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

Re: Request for information pertaining to health care costs.

Dear Commissioner ^{Jahr} Andrews,

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

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

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

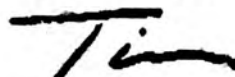
Com. Andrews
Oct. 9, 1989
Page 2

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

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

Thank you for your attention to this request.

Sincerely,



TIM KELLY
Chair
Health Care Cost Containment
Task Force

STATE OF ALASKA

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

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

October 25, 1989

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

Dear Senator Kelly:

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

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

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

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

The Honorable Tim Kelly
October 25, 1989
Page 2

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

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

C. Health Cost Containment for the retiree medical plan.

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

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

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

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

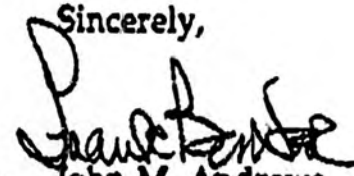
The Honorable Tim Kelly
October 25, 1989
Page 3

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

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

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

Sincerely,


John M. Andrews
Commissioner

JMA/MBC/ksl

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

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

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

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

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

Definitions

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

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

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

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

Partial Self-Insurance

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

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

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

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

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

Self-Insurance Findings

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

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

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

Organization Size

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

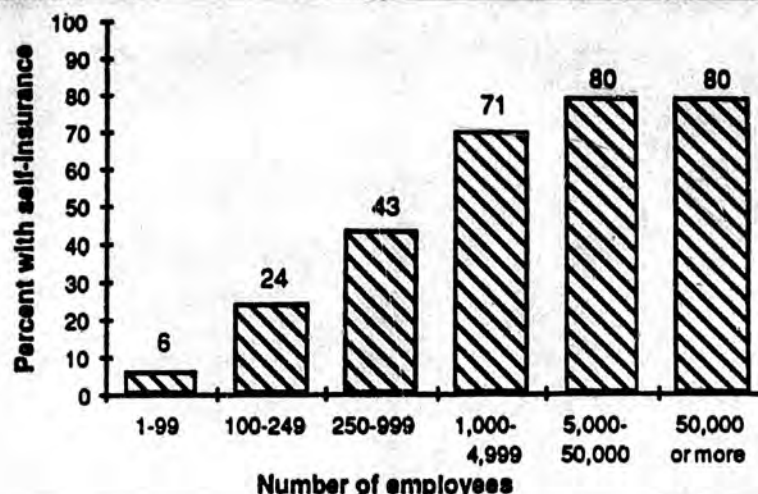
The most likely explanation for high rates of self-insurance among large establishments is that their risk pools are large and actuarially enable them to better predict their employees' health expenses. The size at which organizations seem to be risk indifferent as to how they insure (self versus purchased)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

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

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

continued on next page

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



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

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

Type of organization	Number of employees							0 or missing
	Total	1-99	100-249	250-999	1,000-4,999	5,000-49,999	50,000 or more	
All organizations								
Total with health plans	2,344,335	2,234,875	59,610	30,700	12,180	4,030	230	2,710
Number of self-insured	176,424	136,881	14,190	13,266	8,655	3,238	184	10
Percent of self-insurance	8	6	24	43	71	80	80	(¹)
Cumulative percent ¹	—	6	36	55	74	80	—	(¹)
Business establishments								
Total with health plans	2,286,810	2,197,000	48,600	24,300	10,500	3,530	180	2,700
Number of self-insured	163,626	132,000	11,000	10,100	7,500	2,880	146	0
Percent of self-insurance	7	6	23	41	71	82	81	0
Cumulative percent ¹	—	7	36	54	74	82	—	(¹)
Unions								
Total with health plans	3,672	620	700	1,290	815	220	17	10
Number of self-insured	2,227	200	330	810	685	175	17	10
Percent of self-insurance	61	32	47	63	84	80	² 100	(¹)
Cumulative percent ¹	—	61	66	72	83	81	—	(¹)
Religious organizations								
Total with health plans	780	470	100	110	70	30	—	—
Number of self-insured	184	36	25	51	50	22	—	—
Percent of self-insurance	24	8	25	46	71	73	—	—
Cumulative percent ¹	—	24	51	59	72	—	—	—
Governmental units²								
Total with health plans	49,111	35,600	9,000	3,950	440	115	6	—
Number of self-insured	9,446	4,490	2,590	2,020	265	78	3	—
Percent of self-insurance	19	13	29	51	60	68	³ 50	—
Cumulative percent ¹	—	19	37	52	62	67	—	—
Post-secondary schools								
Total with health plans	3,962	1,185	1,210	1,050	355	135	27	—
Number of self-insured	941	155	245	285	155	83	18	—
Percent of self-insurance	24	13	20	27	44	61	³ 67	—
Cumulative percent ¹	—	24	28	35	50	62	—	—

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

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

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

⁴ Statistically unreliable

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

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

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

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

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

Organization Type

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

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

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

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

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

Self-Insured Benefits

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

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

Table 2

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

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

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

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

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

SECTION C
REVIEW OF POOLING

PART ONE
OVERVIEW OF THE POOLING CONCEPTS

PART ONE
OVERVIEW OF POOLING CONCEPTS

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

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

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

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

Some of the advantages of pooling:

- **Economy of scale**
Eliminate duplicate or multiple plan costs
- **Provides for plan Flexibility/Plan Rates**
Each sub-group could have a different plan design and rates
- **Premium rates based upon sub-group experience**
Sub-group pays their proportioned share of expenses
- **Data collection**
Allows an easy system for tracking trends, abnormalities or impacts on health care expenditures, instead of having to get information from many different (possibly inaccurate) sources.
- **Projection futures costs/trends**
The data base that would be available would be invaluable in projecting future costs/trends as you could identify changes immediately.
- **Predict/act on cost shifting**
Effectively you could determine when there was any potential of actual cost shifting.

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

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

CONCLUSIONS

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

SECTION C
REVIEW OF POOLING

PART TWO
REVIEW OF SB254
AN ACT RELATING TO GROUP HEALTH INSURANCE

PART TWO**REVIEW OF SB254****"AN ACT RELATING TO GROUP HEALTH INSURANCE"**

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

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

COMMENTS ON SB254

- The Authority should have the option to be expanded to include Workmens' Compensation, Health and Social Services, medical coverages and payments, and uninsurable/uninsured benefits as sub-groups of the pool (Sec. 21.77.010).
- Revise bill to remove requirement to be licensed as an insurer under AS21, remove the Authority from title 21 (see 21.77.030.).
- Revise purchase of insurance requirement to remove clause "that it has to be sent to all licensed insurers - (at least every 5 years)" rather to use an RFP notification process where by qualified bidders are maintained on a list or by request (section 21.77.050.).

- Required participation may be revised to clarify/simplify the requirements to evaluate whether or not a sub-group has an eligible waiver, while not undermining the necessity of as many eligible groups feasible to participate. (See 21.77.080.)
- Pool should have the ability to access members and or issue bonds to fund benefits or establish adequate reserves. (See 21.77.070.)

SECTION C
REVIEW OF POOLING

PART THREE
FEASIBILITY OF POOLING IN ALASKA

PART THREE**FEASIBILITY OF POOLING HEALTH CARE IN ALASKA**

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

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

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

- **Passage of Bill**

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

- **Challenges of Authority**

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

- **Set up and operation of Authority**

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

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

1 - 3% **Simplification of Administration**

15 - 40% **Provider payment schedules/agreements**

5 - 7% **Recognize trends adjust quickly**

1 - 3% **General economics of scale savings (misc.)**

22 - 53% **Total savings estimate: up to 50-100+ million dollars.**

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

SECTION C
REVIEW OF POOLING

PART FOUR
SUGGESTED TIME LINE FOR IMPLEMENTATION OF POOLING

PART FOUR

SUGGESTED TIME LINE FOR IMPLEMENTATION OF POOLING

- Passing of SB254 creating "authority"
"Alaska State Group Health Insurance Authority"

1. First Month

- Selection of members
- Organization of Authority/1st meeting

2. Second through Fourth Month

- Evaluation of services required - (RFP those Services)
- Selection of certain service providers (actuarial/consulting etc.)
- Review of current plans and arrangements to be included in pools
- Provider Payment options evaluation

3. Fifth through Eighth Month

- Meetings with eligible sub-group participants
- Develop pro forma benefit and cost analysis (actuarial study)
- Outline to sub-groups the impact to their group(s)
- Select provider payment strategy

4. Eighth through Twelfth Month

- RFP Third party vendors
- Determine/Evaluate required participation by sub-group or issue warriors
- Establish final rates/benefit plans for each sub-group
- Finalize providers payment arrangements
- Finalize third party vendors arrangements
- Notify participants

5. Thirteenth through Sixteenth Month (Ongoing)

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

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

Senate Bill 254

BY SENATOR DUNCAN

ALASKA STATE GROUP HEALTH INSURANCE AUTHORITY

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

Section 1.**PURPOSE**

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

Section 2.**CREATION OF THE AUTHORITY**

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

BOARD OF DIRECTORS

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

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

SB 254
page 2

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

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

POWERS OF THE AUTHORITY

The Authority may:

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

FIDUCIARY RESPONSIBILITY

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

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page 3

possible cost to eligible employees.

PROCUREMENT OF INSURANCE

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

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

STATE GROUP HEALTH INSURANCE FUND

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

INSURANCE PREMIUMS

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

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page 4

REQUIRED PARTICIPATION

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

WAIVER

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

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

DEFINITIONS

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

SB 254
page 3

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

- (7) "municipality" includes a public corporation established by a municipality;
- (8) "participant" means the state, a municipality, or a school district;
- (9) "state" means the executive, legislative, and judicial branches of state government, or an organizational unit of a branch, and includes the University of Alaska, the Alaska State Building Authority, and the Alaska Railroad Corporation.

Section 3.

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

Section 4.

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

Section 5.

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

Section 6.

Provides for an immediate effective date.

1 IN THE SENATE

BY DUNCAN

2

SENATE BILL NO. 254

3

IN THE LEGISLATURE OF THE STATE OF ALASKA

4

SIXTEENTH LEGISLATURE - FIRST SESSION

5

A BILL

6

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

7

providing for an effective date."

8

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

9

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

10

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

11

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

12

a municipality, or a school district; and

13

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

14

ties for cost containment when purchasing group health insurance.

15

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

16

CHAPTER 77. STATE INSURANCE.

17

Sec. 21.77.010. AUTHORITY CREATED. There is established within

18

the Department of Commerce and Economic Development a nonprofit incor-

19

porated legal entity known as the Alaska State Group Health Insurance

20

Authority. The authority shall provide group health insurance to

21

eligible state, municipal, and school district employees.

22

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

23

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

24

members as follows:

25

(1) the commissioner of administration;

26

(2) the commissioner of health and social services;

27

(3) the director of the division of insurance;

28

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

29

(A) one member representing local governments;

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

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

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

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

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

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

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

1 State Group Health Insurance Authority;

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

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

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

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

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

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

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

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

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

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

1 BENEFIT OF THE EMPLOYEES.

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

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

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

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

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

29 (b) In this section



STATE OF ALASKA
OFFICE OF THE GOVERNOR
BILL ANALYSIS

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

SUMMARY

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

FISCAL IMPACT: ☐ NONE ☐ FISCAL NOTE ATTACHED

BACKGROUND/LEGISLATIVE INTENT

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

ANALYSIS OF BILL/PROGRAM EFFECTS

See attached.

AMENDMENTS PROPOSED

See attached.

3788D-1/041089a

PLEASE ATTACH A SEPARATE SHEET FOR ADDITIONAL COMMENTS OR ANALYSIS.

ANALYSIS OF BILL/PROGRAM EFFECTS:

Section 2

AS 21.77.010-.020. Authority Created

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

AS 21.77.030. Powers

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

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

AS 21.77.040. Fiduciary Duty

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

AS 21.77.050. Purchase of Insurance

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

AS 21.77.060. Health Insurance Fund

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

AS 21.77.070. Insurance Premiums

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

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

AS 21.77.080. Required Participation

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

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

AS 21.77.090. Definitions

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

Section 3

AS 39.30.090. Department of Administration Duties

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

Section 4

AS 39.50.200(b). Conflict of Interest

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

Section 5

AS 21.77.020(b). Staggered Initial Board Terms

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

Section 6

Effective Date

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

Amendments Proposed

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