ALASKA LEGISLATURE COMMITTEE FILES, 1989-1990 8672
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Table III shows Utah's premium increases have been lower on average than the western states we surveyed. PEHP's requested premium increase, when the benefit reduction is excluded, is close to 31% or the average premium increase being projected by other western states in Table III.

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

TABLE IV

Comparison of Rate Increases by Carriers Located in Utah

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

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

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

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

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

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

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

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

Administrative Costs

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

TABLE V

Comparison of Administrative Costs Between
Self Insured Carriers For Health Care

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

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

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

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

Sincerely,

Wayne L. Welsh
Auditor General

WLW:CF/syg

ATTACHMENT A

TABLE VI

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

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

Table VII

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

Procedure	PEHP Preferred	Average (A-E)	Company A	Company B	Company C	Company D	Company E
Proc. A	$ 950	$ 967	$ 956	$ 800	$1,181	$ 950	$ 950
Proc. B	1,150	1,295	1,275	1,000	1,600	1,300	1,300
Proc. C	905	1,009	800	890	1,271	1,075	N/A
Proc. D	1,008	1,160	1,034	990	1,427	1,188	N/A
Proc. E	1,085	1,122	1,020	1,020	1,385	1,063	N/A
Proc. F	590	636	600	600	717	625	N/A
Proc. G	255	268	240	260	322	250	N/A
Proc. H	22	23	19	20	30	22	23
Proc. I	8	8	6	7	12	8	8
Proc. J	42	43	32	45	58	N/A	35

RESPONSE TO AUDIT

REIMBURSEMENT RATES

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

An important consideration is the facility charges in conjunction with surgical procedures. Preferred Care has *profiled physicians* and selected them based on quality issues and how well they have utilized the system in the past. A recent analysis of many procedures shows that this system is working well. For example, when comparing our Preferred providers with non-Preferred providers for caesarean section, the average facility charge for our Preferred providers was $386 less. Our Traditional Care program restricts the length of stay for in-patient hospitalization for many high volume procedures. For example, an uncomplicated hysterectomy is limited to three days for females less than 50 years of age. It is not uncommon for our Preferred physicians to limit the in-patient stay to two days. Total charges for hysterectomies for our Preferred providers are over $1000 less than non-Preferred providers.

PREMIUM INCREASES

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

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

ADMINISTRATIVE COSTS

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

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

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

- **Provide 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~~ assess 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
13 - 40%	Provider payment schedules/agreements
5 - 7%	Recognize trends adjust quickly
1 - 3%	General economics of scale savings (misc.)
22 - 53%	Total savings estimate: up to 50-100+ million dollars.

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

SECTION C

REVIEW OF POOLING

PART FOUR

SUGGESTED TIME LINE FOR IMPLEMENTATION OF POOLING

PART FOUR

SUGGESTED TIME LINE FOR IMPLEMENTATION OF POOLING

- Passing of SB254 creating "authority"

  "Alaska State Group Health Insurance Authority"

1. First Month
   - Selection of members
   - Organization of Authority/1st meeting
2. Second through Fourth Month
   - Evaluation of services required - (RFP those Services)
   - Selection of certain service providers (actuarial/consulting etc.)
   - Review of current plans and arrangements to be included in pools
   - Provider Payment options evaluation
3. Fifth through Eighth Month
   - Meetings with eligible sub-group participants
   - Develop pro form a benefit and cost analysis (actuarial study)
   - Outline to sub-groups the impact to their group(s)
   - Select provider payment strategy
4. Eighth through Twelfth Month
   - RFP Third party vendors
   - Determine/Evaluate required participation by sub-group or issue warriors
   - Establish final rates/benefit plans for each sub-group
   - Finalize providers payment arrangements
   - Finalize third party vendors arrangements
   - Notify participants

5. **Thirteenth through Sixteenth Month (Ongoing)**

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

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

NEW MEXICO'S PUBLIC SCHOOL INSURANCE AUTHORITY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

COST CONTROLS

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

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

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

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

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

BENEFITS

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

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

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

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

D. An affordable vision care benefit plan was implemented.

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

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

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

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

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

ACKNOWLEDGEMENTS

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

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

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

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

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

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

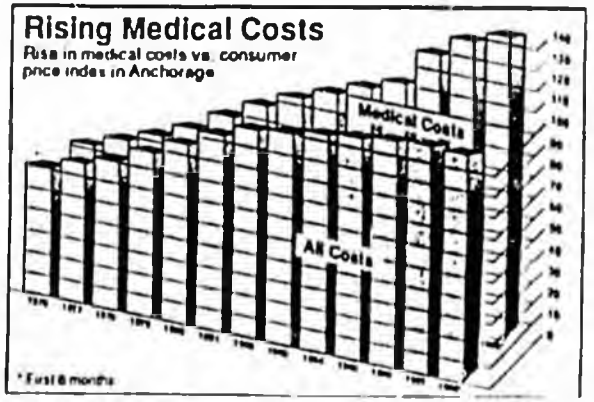
■ **MONEY MARKETS:** Weekly listings / B-4 ■ **MALLWATCH:** Merchants join forces / B-5 ■ **PLASTIC POWER:** Holiday bills / B-6

BUSINESS

SUNDAY
SECTION B Jan. 22, 1989

Health insurance costs rise feverishly

Workers at a loss as employers cut back on benefits

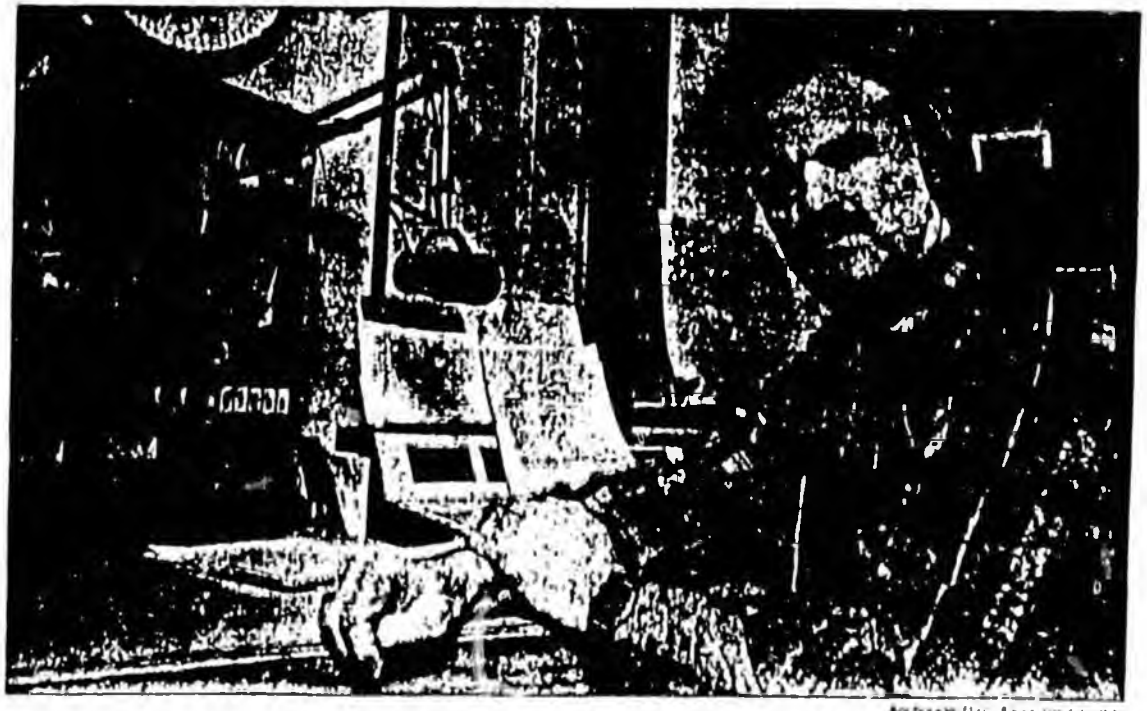


By HAL BERNTON
Daily News reporter

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

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

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



Anchorage Daily News (or Lauren)

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

"You just don't get good [illegible] appears to be particularly

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

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

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

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

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

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

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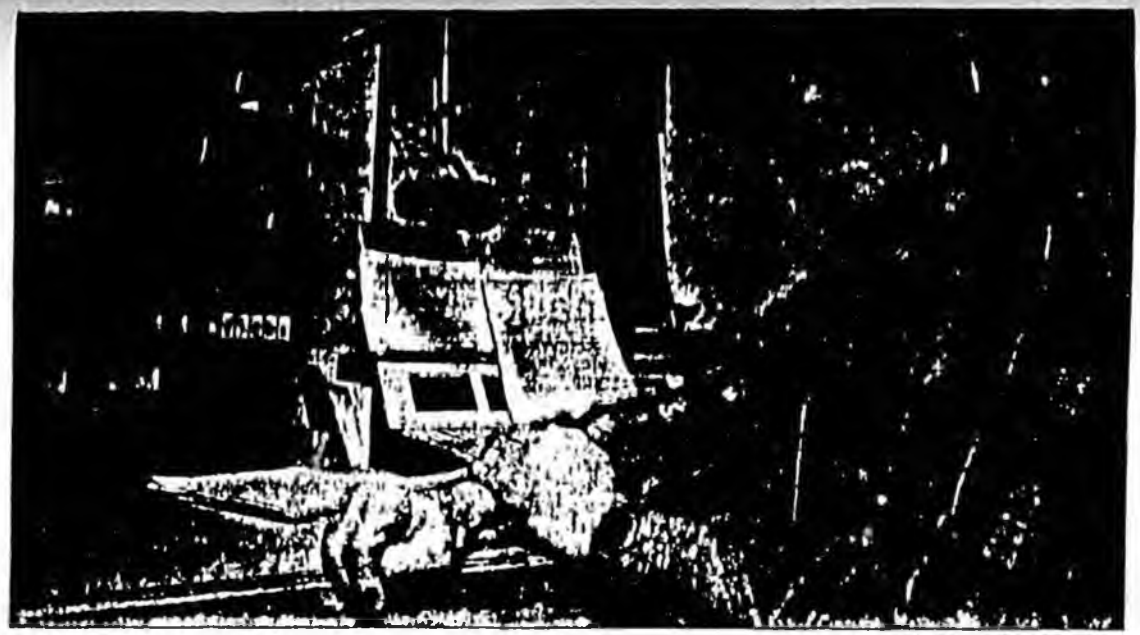
Snow is experiencing the harsh edge of a new Alaska business trend — the slashing of employee health-care benefits.

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

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

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



Anchorage Daily News/Jim Lavrakas

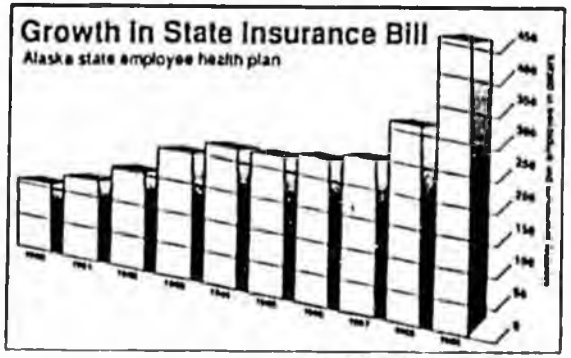
Disc jockey Lester Snow was left scrambling when his employer was forced to drop health benefits for employees.

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

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

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

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



Anchorage Daily News chart/Tom Kingsbury

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

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

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

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

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

But Alaska Commercial is the exception, not the norm.

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

And some increases top

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

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

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

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

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

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

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

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

Please see Page B 3, HEALTH

Harvard MBAs take ethics to heart

By PAUL WILKES
The New York Times

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

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

Office space market closes in on recovery

The latest office space

HEALTH INSURANCE: Employers cut benefits in face of rising costs

Continued from Page B-1

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

□

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Such plans were introduced to Anchora[illegible] mid '80s, and as rates rise, their appeal grows, both to employers and employees.

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

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

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

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

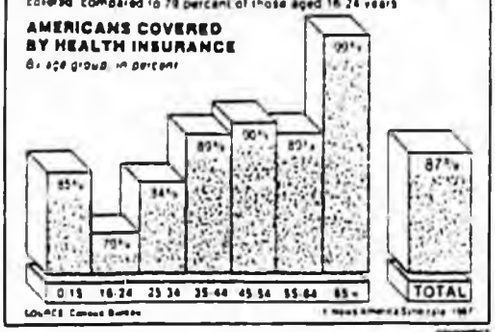
Non-union railroad employees chose to sign up for the preferred plan, but union workers opted against it. Then this year, facing another 32 percent increase, the unions decided to go with the preferred option.

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

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

Most Americans have health insurance

Most Americans – 87 percent – have private or government health insurance. By age group, 99 percent of those 65 years and older are covered, compared to 78 percent of those aged 18-24 years.



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

Trad susp souq

Los Angeles T

CHICAGO cutor in th investigatic fraud in Chi lion-dollar c tures inc door-to-door ing to press cooperate agents.

Departme veteran Ira who is heac gation, and pressed rac provide ev others who trading pits Board of Tra cago Mercan

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But its su servers said more on wha next several what went or three years work.

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For examp brokers who — and in electronically five undercov posing as tra markets hav of relatively tions, but it carry relative ties.

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"If you ar break ope undercover and go doo time to do it the good law are out of former Depa tice attorney senting suspe

CD RATES FOR THE SERIOUS INVESTOR.

Maturity	Rate
60 Days	8.75%
[illegible]	[illegible]

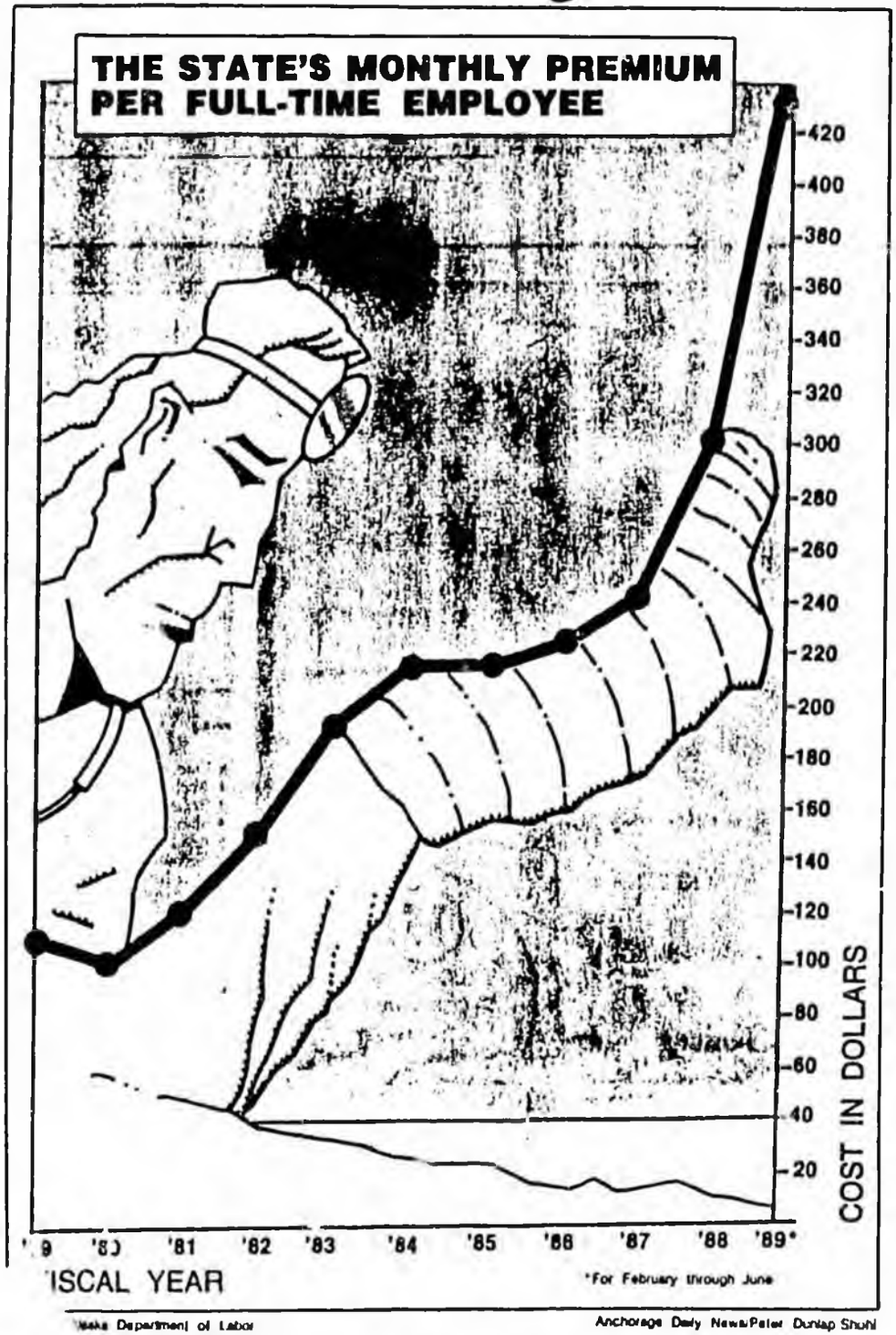
New Year's Clearanc

Christmas sales have dropped off, and our year-end inventories are far too high! To reduce our stock we'v drastically cut prices on all popular computer systems. All units must go, but prices are limited to stock on hand. save now during the largest inventory clearance in our his

The Apple III

ANCHORAGE, ALASKA, WEDNESDAY, FEBRUARY 16, 1989 PRICE 25 CENTS

Anch Daily News



State health insurance: $104 million

Cowper seeks more money for state workers' coverage

By DAVID POSTMAN
Daily News reporter

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

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

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

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

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

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

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

All full-time employees, including legislators, are

Please see Back Page, INSURANCE

INSURANCE: For state workers

Continued from Page A-1

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

Under the policy, Taylor said:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: CSSB 254 (Fin)
PUBLISH DATE: 3/30/90 (a)

FISCAL NOTE

REQUEST:

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

Agency Affected: Commerce & Economic Dev.
BRU:

Components:

EXPENDITURES/REVENUES: (Thousands of Dollars)

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

FUNDING: (Thousands of Dollars)

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

POSITIONS:

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

ANALYSIS: (Attach a separate page if necessary)
As the Senate Finance Committee substitute places the Alaska State Group Health Insurance [illegible] within the Department of Administration, this fiscal note is z..

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

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

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

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STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: CSSB 254 (Financ
PUBLISH DATE: 3/30/90 (b)

FISCAL NOTE

REQUEST:

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

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

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	85.5	102.6				
TRAVEL	40.3	43.2				
CONTRACTUAL	140.2	145.3				
SUPPLIES	4.5	2.0				
EQUIPMENT	21.0					
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	292.0	293.1	*	*	*	*
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

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

POSITIONS:

FULL-TIME	2	2				
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary) See page 2 for FY 91 detail.

*After February 1, 1992, the authority shall provide that sufficient premiums are collected to provide the required insurance coverage and to pay the expenses of the authority.

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

Approved by Commissioner:
Date:
Agency:

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

STATE OF ALASKA
1990 LEGISLATIVE SESSION

Bill Version: CSSB 254 (FIN)
Publish Date:

FISCAL NOTE

REQUEST:

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

Agency Affected: Administration
BRU:
Components:

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	129.6	129.6				
TRAVEL	52.0	52.0				
CONTRACTUAL	310.6	300.6				
SUPPLIES	3.3	3.3				
EQUIPMENT	33.3	0				
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	528.9	485.5	*	*	*	*
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND	528.8	485.5				
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

FULL-TIME	3	3				
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

* Due to the nature of the authority, it is not possible to predict costs for subsequent fiscal years. See attached for further analysis.

Prepared by: Mike Conway-Klein for Sally Smith
Phone: 465-4470
Division: Retirement and Benefits
Date: 4/23/90

Approved by Commissioner: Doug M. Bogden for Frank S. Baxter
Date: 4/23/90
Agency: Department of Administration

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

7/6K2/042001-0/162

Rev: 11/89

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

02-576(2/77)

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: CSSB 254 (Financ
PUBLISH DATE: 3/30/90 (b)

FISCAL NOTE

REQUEST:

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

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

EXPENDITURES/REVENUES: (Thousands of Dollars)

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

FUNDING: (Thousands of Dollars)

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

POSITIONS:

FULL-TIME	2	2				
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary) See page 2 for FY 91 detail.

*After February 1, 1992, the authority shall provide that sufficient premiums are collected to provide the required insurance coverage and to pay the expenses of the authority.

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

Approved by Commissioner:
Agency:
Date:

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

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

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

STATE OF ALASKA
1990 LEGISLATIVE SESSION

Bill Version: CSSB 254 (FIN)
Publish Date:

FISCAL NOTE

REQUEST:

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

Agency Affected: Administration
BRU:
Components:

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	129.6	129.6				
TRAVEL	52.0	52.0				
CONTRACTUAL	310.6	300.6				
SUPPLIES	3.3	3.3				
EQUIPMENT	33.3	0				
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	528.9	485.5	*	*	*	*
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND	528.8	485.5				
FEDERAL FUNDS						
OTHER						
TOTAL						

POSITIONS:

FULL-TIME	3	3				
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

* Due to the nature of the authority, it is not possible to predict costs for subsequent fiscal years. See attached for further analysis.

Prepared by: Mike Campbell for Sally Smith
Phone: 465-4470
Division: Retirement and Benefits
Date: 4/23/90

Approved by Commissioner: Gary M. Baxter for Frank S. Baxter
Date: 4/23/90
Agency: Department of Administration

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

7/6K2/042001-0/1&2

Rev: 11/89

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

Analysis: This bill creates the Alaska State Group Health Insurance Authority in the Department of Administration. This independent agency would have specific powers as outlined, including regulatory power. Using appropriate staff and contractual services, it would establish and maintain a statewide provider payment system, rate schedules and utilization standards by 2/1/92. Various public entities would be required to implement these in their group insurance plans.

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

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

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

Personal Services

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

Travel

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

$400 X 15 X 7 =		$42.0	
Administrative travel for Director:			
Board Meetings	$400 X 7 =	2.8	
Organizational meetings	$600 X 12=	7.2	
Total Travel			**$52.0**

Contractual

Office Space--500 sq. ft. @$1.75 X 11 mos.	$9.6	
Telephone--$300 X 11 mos.	3.3	
Courier services--$200 X 11 mos.	2.2	
Postage--$500 X 11 mos.	5.5	
Advertising and Printing	10.0	
Professional Services Contract(s).	280.0	
which could include:		
*carrier surveys and analysis		
* provider data collection		
* provider meetings		
* rate studies and analyses		
* financial consulting		
* self vs fully insured analyses		
* development of plan design		
Total Contractual Services		**$310.6**

Supplies:

$500 per employee	$1.5	
Software	1.8	
Total Supplies		**$3.3**

Equipment:

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

SB

297

STATE OF ALASKA
THE LEGISLATURE

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

LEGISLATIVE AFFAIRS AGENCY

LEGISLATIVE REFERENCE LIBRARY

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

Mary Van Nimwegen

CSSB 297

H HESS 4/6/90

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: CSSB 297 (Fin)(a)
PUBLISH DATE: 2/5/90

FISCAL NOTE

REQUEST:

Revision Date:
Title: Licensing, sale, transportation, importation, & Possession of alcoholic beverages; local option ballots
Requestor: Sen. Finance Comm.
Sponsor: Sen. Binkley

Agency Affected: Dept. of Revenue
BRU: Alcoholic Beverage Control Boa:
Components:

EXPENDITURES/REVENUES: (Thousands of Dollars)

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

FUNDING: (Thousands of Dollars)

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

POSITIONS:

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

ANALYSIS: (Attach a separate page if necessary)

Depending on the number of local option elections to ban sale and importation or possession of alcoholic beverages, this legislation would produce postage cost reductions under (b)(1) in Section 9.
Mailing to licensees under current law - 444 licensees
Mailing under this legislation - 39 licenses

Prepared by: Patrick L. Sharrock, Director
Division: Alcoholic Beverage Control Board
Phone: 277-8638
Date: 12/14/89

Approved by Commissioner: Hugh Malone
Agency: Department of Revenue
Date: 12/14/89

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

Changes in CSSB 297 (Fin) have no fiscal impact. This fiscal note is appropriate. 2/2/90 mmc

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: CSSB 297 (Fin) (b)
SBU28X
PUBLISH DATE: 2/5/90

FISCAL NOTE

REQUEST:

Revision Date: 12/7/89
Title: An act relating to licensing, sale, importation, importation, and possession of alocoholic ages
Sponsor: Binkley
Requestor: Labor & Commerce

Agency Affected: Office of the Governor
BRU: Division of Elections
Components: 1 -Elections

EXPENDITURES/REVENUES: (Thousands of Dollars)

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

FUNDING: (Thousands of Dollars)

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

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS : (Attach a separate page if necessary)

Prepared by: Linda Edgeworth
Division: Division of Elections
Phone: 465-4611
Date: 12/7/89

Approved by Commissioner: (Acting)
Agency: Division of Elections
Date: 12.11.89

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

Changes in CSSB 297 (Fin) have no fiscal impact. This fiscal note is appropriate. 2/2/90 mew

HOUSE COMMITTEE REPORT

(7)
Date Referred: February 16, 1990 FURTHER REFERRALS:
LABOR & COMMERCE

Date of Committee Action: 4/6/90

The HESS Committee considered: CSSB 297(FINANCE)

CSSB NO. 297 (Finance) LIQUOR LICENSES:LOCAL OPTION LAWS

"An Act relating to licensing, sale, transportation, importation, and possession of alcoholic beverages; local option election ballots; possession of products designed for brewing or distilling; and providing for an effective date."

RECOMMENDATIONS:
[ ] be replaced with _____ [ ] the same title [ ] a new title

[ ] have attached amendment(s)

[X] do pass

[ ] do not pass

[ ] no recommendation

[ ] individual recommendations

[ ] additional referral to the _____ Committee

ADOPTS: _____ letter of intent

ATTACHES NEW FISCAL NOTE(s): (Dept)

[ ] fiscal impact_____

[ ] zero fiscal note_____

[ ] zero with analysis_____

APPROVES PREVIOUS: (Date/Dept)

[ ] fiscal note(s) _____

[X] zero fiscal note(s) 2/5/90 \ Gov.

[X] zero fn/analysis 2/5/90 \ Rev.

SIGNING DO PASS:

J. Ellis

Mack Banfa

J. Greenberg

SIGNING: (Check approp. column)

	Do Not Pass	No Rec	Amend
Wm Munnerlyn		X	
Cheri Davis		X	

J. Ellis
Chairman's Signature

REC'D FEB 17 1990

Senator Johne Binkley

Senate Finance Committee
P.O. Box V • Juneau, Alaska 99811 • (907) 465-4985

Finance Committee
Co-Chairman

MEMORANDUM

February 21, 1990

TO: Representative Johnny Ellis, Chairman
House Health, Education and Social Services Committee

FROM: Senator Johne Binkley

RE: SB 297, amendments to local option statutes

The above-referenced bill has been referred to your committee. I'd like to take this opportunity to give you a synopsis of the legislation. A more complete sectional analysis is enclosed as well.

The most substantive change made to Title 4 by this bill is that all five local option questions are reworded and made more straight forward. I have heard from many people around the state who have been involved in some way with a local option election that the ballot questions are confusing, particularly to those people for whom English is a second language. Current statute also allows for more than one question to appear on a single ballot. This compounds the confusion of the question in a couple of ways. First, some questions allow for certain kinds of sale; other questions prohibit any kind of sale, importation or possession. The final outcome of an election in which opposing options were passed is unknown. SB 297 limits the local option ballots to one question per election.

The reworded questions also change the effect of a "yes" or "no" vote. Therefore, many of the changes in the bill are technical in nature, switching "yes" and "no" where needed throughout the statute.

The bill also would allow an established village where the Division of Elections was running the election to request that the ballots be printed in the resident's Native language in certain circumstances. We anticipate that the Division will, through the regulatory process, go ahead and prepare these ballot questions in the languages where local options are more commonly held. Municipalities may already prepare the ballots in other languages. However, the bill does contain a provision which clarifies this point.

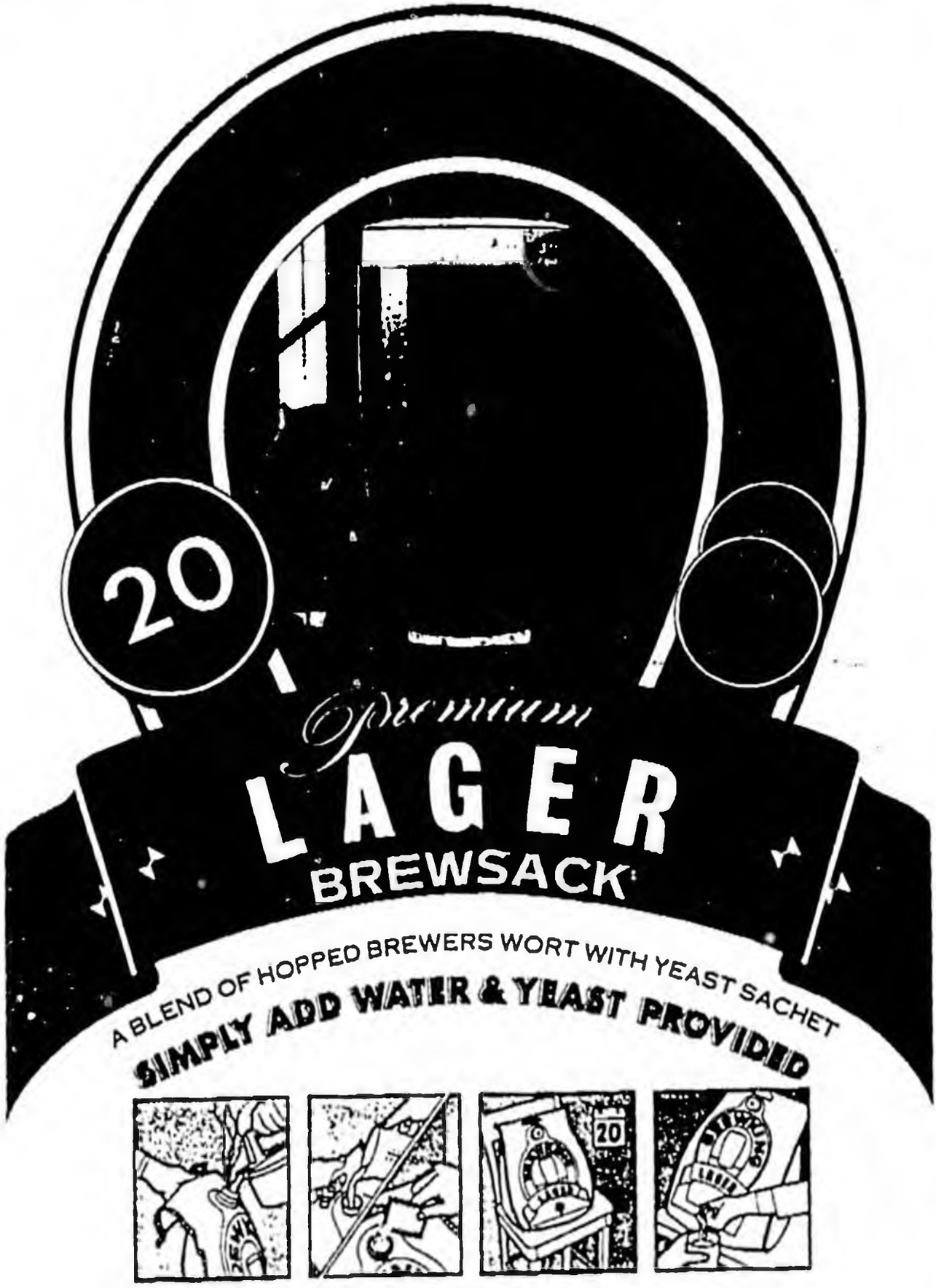
The bill also requires that package store licensees notify the ABC Board of their intent to sell alcohol by mail. This consists of a box on the license renewal or application form which the licensee simply checks. Whenever there is a local option election in which an option is adopted, the Board will send notice only to those

lincensees who are selling by mail, rather than the current requirement of sending notification to every package store licensee in the state.

Finally, the bill clarifies that possession of products designed solely for brewing alcohol is not allowed by people under 21 or in a local option area. I've attached for your reference an advertisement of a product called a "brewsack." You just add water and the yeast which is provided and wait two weeks then bingo! You have 20 pints of beer.

I would appreciate your scheduling of this bill at the earliest convenience. Please let Janice Adair in my office (4985) know when that might be. Thank you.

THE NEW WAY TO DRINK BEER AT HOME



IT'S IN THE BAG

BREWKING

The great innovation in Beer at home

THE PRODUCT

1. Produces 20 pints of NATURALLY SPARKLING BREWKING Lager.
2. Easy and convenient to make in just 3 weeks
3. No additional equipment required.
4. Highly distinctive pack gives maximum on-shelf impact.
5. Made from genuine Brewers Raw Materials without additives.

WHAT HAS BREWKING IN IT FOR YOU?

1. Excellent Margins.
2. Incremental business.
3. Builds customer traffic.
4. High sales value per square foot.

Brewsacks are available from:

CONTROL BOARD
RECEIVED
ALCOHOLIC BEVERAGE

Look out for Brewking Bitter, available soon

Senator Johne Binkley

Senate Finance Committee
P.O. Box V • Juneau, Alaska 99811 • (907) 465-4985

Finance Committee
Co-Chairman

MEMORANDUM February 19, 1990

TO: Members, House Health, Education & Social Services Committee

FROM: Senator Johne Binkley

RE: Sectional Analysis of CSSB 297 (Finance),
Local Option Amendments to Title 04

Section One. This section would require ABC Board authorization before a package store can sell in response to a written order and that authorization is only good for only year at a time. Whenever there is a local option adopted by a community, the board is required to notify all holders of a package store license of the election. This section ties in which section 26 which limits the notification only to those package store licensees which told the board of their intent to sell by mail. The Board has revised its license renewal forms so that those package store licensees who want to sell by mail need only check a box.

Section Two. This would bring the amount of distilled spirits that can be sent by mail order to an area with restricted sales into compliance with the presumption provision. There was an amendment to SB 371 on the floor of the House at the end of the 1988 session which increased the mail order amount to 18 liters but the presumption amount was not changed. This would drop it back down to 12. (Tab #1)

There have been a number of problems with people understanding the effects of a local option election. This bill attempts to assist the local governing bodies and the Division of Elections by simplifying the ballot language and requiring certain explanations. Many of the changes in this bill are technical in nature resulting from the changes made to the ballot language. It was necessary to change the effect of a "yes" vote and of a "no" vote.

Section Three. This clarifies that on a vote for a community liquor license, only one type of license may be voted on in any one election.

Section Four. A technical change switching the effects of a "yes" vote and a "no" vote on the question of allowing the sale of alcoholic beverages.

Section Five. This changes the wording of the local option ballot for the prohibition of liquor sales to read "Shall the sale of alcoholic beverages be allowed in

the city of *Bethel*?" It also makes another technical change to the effects of a "yes" or "no" vote.

Section Six. This changes the wording of the local option ballot for a community liquor license election and makes technical changes so that only one type of community liquor license may be voted on in any one election as in Section Three, above. The questions would read: "Shall alcoholic beverages be sold in the city of Bethel only by a bar operated by the city of *Bethel*?" or "Shall alcoholic beverages be sold in the city of Bethel only by a liquor store operated by the city of *Bethel*?" The current language is attached. (Tab # 2)

Sections Seven and Eight. Both of these sections make technical changes to provisions regarding community liquor licenses which reflect the changes in Section Three, above which limits a vote on a community liquor license to one type of license in any one election.

Section Nine. Adds the provision that an explanation must follow the community liquor license question which explains how alcohol may be sold by a bar which means "beverage dispensary license" and by a liquor store which means "package store license."

Section Ten. This changes the wording of the local option ballot for banning the sale and importation of alcohol. The question would read "Shall the sale and importation of alcoholic beverages be allowed in the city of *Bethel*?" It also makes technical changes to the effects of a "yes" or "no" vote.

Section Eleven. This changes the wording of the local option ballot for banning the possession of alcohol to read "Shall the possession of alcoholic beverages be allowed in *Bethel*?" It also makes technical changes to the effects of a "yes" or "no" vote.

Sections Twelve. These section make additional technical changes to the effects of a "yes" or "no" vote on the question of allowing the sale and importation of alcohol in an established village.

Section Thirteen. This change will allow the ban on possession to take effect 60 days following certification of the election IF there are no licensed premises in the established village. If there is a licensed premises, then the effective date remains 90 days after certification of the election. It also includes a technical change to the effects of a "yes" or "no" vote.

Sections Fourteen and Fifteen. Makes the same changes as Sections 12 and 13, above as they relate to municipalities.

Section Sixteen. This is a technical change to the effects of a "yes" or "no" vote on sale and importation.

Section Seventeen. This changes the wording of the local option ballot which would allow the sales of alcohol only by selected licensees and specifies that only one kind of license can be voted on at a time. It would read "Shall alcoholic beverages be sold in the city of *Bethel* only by (bar) (liquor store) (restaurant)?" A copy of an actual ballot from the city of Bethel asking this question as it is currently required to be stated is attached. (Tab #3)

Sections Eighteen and Nineteen. These are technical changes relating to the clarification that on a vote for selected liquor license, only one type of license may be voted on in any one election.

Section Twenty. This section relates to selected licensee elections (Section 17, above) and is one of the more confusing parts of the bill. It requires some backgrcund information.

Under current law at AS 04.11.320, the ABC Board may not issue a license in an established village where there is no licensed premises UNLESS there has first been a local option election on either prohibiting sales and the vote was no OR on the question of a selected licensee and the vote was YES. (Tab #4)

Because the local option laws are complex, many villages which propose to have a vote on a selected licensee have not realized that voting NO on the type of licensee would not allow them to have another kind of licensee instead. A NO vote on this question when there is no licensed premises does not allow the Board to issue another kind of license.

Subparagraph (d) of this section would require the Lieutenant Governor's office (the Division of Elections) to make this known to the residents of a village which is going to have an election on one of these questions. The Division would have to post written notice of the requirements of AS 04.11.320 in two different public locations within the village. They already post notice of the election itself.

Subparagraph (e) would require the ballot give an explanation of the types of liquor sales allowed if the ballot were to pass.

Section Twenty-One. Deletes the reference to a "combination of questions" on a local option ballot for a municipality. This clarifies that only one question may be voted during an election.

It also provides that the local governing body may prepare the election ballots in English and a second language specified by the body. This does not give a municipality any additional powers but simply spells out in statute that they have this ability.

Section Twenty-Two. Makes the same deletion of "combination of questions" for established villages.

Section Twenty-Three. Makes the same deletion of "combination of questions" under the provisions in statute governing the petitions for a local option election.

Section Twenty-Four. This subsection would allow the governing body of an established village to request that the local option ballot be written in both English and another language. The request would have to be made to the Lt. Governor's office within 15 days of the filing of the petition in order to give his office time to prepare the ballots. However, it is envisioned that the ballot questions would be set out in regulation for those languages most common to the areas where the local option elections generally take place.

Section Twenty-Five. This makes technical changes to the effects of a "yes" or "no" vote on the questions of sale, sale and importation and possession.

Section Twenty-Six. This section makes technical changes to the effects of a "yes" or "no" vote. It also expands the notice requirements of a community that has adopted a local option. Under current law, if a community bans the sale and importation, it is required to post notice of the ban within the community. This section extends that notice requirement to the ban on possession.

It also includes a change in (b)(1) to the notice requirements for the ABC Board and ties into Section One, above. Under current law, the Board must send notice to every package store licensee by registered mail of the adoption of a ban on importation. This amendment would expand that notification to include the ban on possession. The Board would only have to send by certified mail a notice to those licensees authorized to sell in response to a written order.

Section Twenty-Seven. This clarifies what was probably an oversight in current statute. It provides that persons under 21 or persons within a local option area which has restricted the sale and importation or possession of alcohol may not possess products designed to brew or distill alcohol.

Section Twenty-Eight. In 1988, we passed SB 371 where it was required that alcohol being shipped into a community which had restricted the sale of alcohol be labeled and have an itemized invoice on the outside of the box. However, air carriers were not given any responsibility for checking to see if people were shipping alcohol. This section states that a carrier may not knowingly ship unlabeled alcohol.

In order to make that requirement workable, it was necessary to revise the itemized invoice requirement. The ABC Board had interpreted the language from last year as allowing only the licensee to prepare the invoice. This section will allow the purchaser to provide the invoice. This could be the sales receipt.

Section Twenty-Nine. This section makes the bill effective on July 1, 1990.

(2) procedures for the issuance, denial, renewal, transfer, revocation, and suspension of licenses and permits;

(3) terms and conditions of licenses and permits issued;

(4) fees for licenses and permits issued for which no fees are prescribed by statute;

(5) conduct of regular and special meetings of the board;

(6) delegation to the director of routine administrative functions and powers;

(7) the temporary granting or denial of issuance, transfer, and renewal of licenses;

(8) manner of giving any notice required by law or regulation when not provided for by statute;

(9) requirements relating to the qualifications of licensees, the conditions upon which a license may be issued, the accommodations of licensed premises, and board inspection of those premises;

(10) making of reports by wholesalers;

(11) purchase of fidelity bonds by the state for the director and the employees of the board;

(12) prohibition of possession of alcoholic beverages by drunken persons and by minors;

(13) required reports from corporations licensed under this title, including reports of stock ownership and transfers and changes of officers and directors;

(14) creation of classifications of licenses or permits not provided for in this title;

(15) establishment and collection of fees to be paid on application for a license or permit;

(16) required reports from partnerships and limited partnerships licensed under this title, including reports of transferred interests of 10 percent or more.

Sec. 04.06.110. Peace officer powers. The director and the persons employed for the administration and enforcement of this title may, with the concurrence of the commissioner of public safety, exercise the powers of peace officers when those powers are specifically granted by the board. Powers granted by the board under this section may be exercised only when necessary for the enforcement of the criminally punishable provisions of this title, regulations of the board, and other criminally punishable laws and regulations governing the manufacture, barter, sale, consumption, and possession of alcoholic beverages in the state.

Chapter 10. Licensing.

[Repealed. For current law, see AS 04.11.]

Chapter 11. Licensing.

Article 1. Licensing and Reporting Requirements.

Sec. 04.11.010. License or permit required. (a) Except as provided in AS 04.11.020, a person may not manufacture, sell, offer for sale, possess for sale or barter, traffic in, or barter an alcoholic beverage unless under license or permit issued under this title.

(b) A person may not solicit or receive orders for the delivery of an alcoholic beverage in an area where the results of a local option election have, under AS 04.11.490 - 04.11.500, prohibited the board from issuing, renewing or transferring one or more types of licenses or permits under this title, unless the person is licensed under this title and the order is actually received by that person from the purchaser of the alcoholic beverage. A person who violates this subsection is punishable upon conviction under AS 04.16.200(a) or (b).

(c) In a criminal prosecution for possession of alcoholic beverages for sale in violation of (a) of this section, the fact that a person possessed more than 12 liters of distilled spirits, 24 liters or more of wine, or 45 liters or more of malt beverages in an area where the sale of alcoholic beverages is prohibited under AS 04.11.490, 04.11.492, 04.11.496, or 04.11.500 creates a presumption that the person possessed the alcoholic beverages for sale.

Sec. 04.11.015. Purchase from nonlicensee prohibited. (a) A person may not purchase alcoholic beverages from a person who is not a licensee, permittee, or an agent or employee of a licensee or permittee.

(b) A person who violates this section is guilty of a violation.

Sec. 04.11.020. Exceptions: License or permit not required. (a) A license or permit is not required to authorize sales made by a person under a judgment and decree of foreclosure, under the bankruptcy law of the United States, or under order of the board or a court under AS 04.16.220.

(b) A license or permit is not required to serve alcoholic beverages in exchange for valuable contributions at a private gathering of a bona fide group of co-workers or of a professional, social, or fraternal organization if equal contributions are made by all in attendance and only the amount required to purchase the alcoholic beverages is contributed. All other applicable provisions of this title and regulations under this title shall be observed at these private gatherings.

Sec. 04.11.492. Community liquor license; complete prohibition on sales. (a) The following question, appearing alone, may be placed before the voters of a municipality in accordance with AS 04.11.502: "Shall the sale of alcoholic beverages be prohibited in .....(name of municipality) unless sold by a .....(either a beverage dispensary or package store, or both, operated under a community liquor license)? (yes or no)."

(b) If a majority of the voters vote "yes" on the question set out in (a) of this section, the board shall be notified immediately after certification of the results of the election and thereafter may not issue, renew, or transfer between holders or locations a license for licensed premises located within the boundaries of a municipality and in unincorporated areas within five miles of the boundaries of the municipality, with the exception of a beverage dispensary or package store operated under a community liquor license held by the municipality. Licenses in effect are void 90 days after the results of the election are certified. A license that will expire during the 90 days after the results of a local option election under this section are certified may be extended, until it is void under this subsection, by payment of a prorated portion of the annual license fee.

(c) If a majority of the voters vote "no" on the question set out in (a) of this section or vote "yes" on a question set out in AS 04.11.490, 04.11.496, or 04.11.500 in an election conducted in accordance with AS 04.11.502 after an election in which the voters voted "yes" on the question set out in (a) of this section, the board shall be notified immediately after a certification of the results of the election. The prohibitions imposed under (b) of this section on the issuance, renewal, or transfer of licenses between holders and locations as a result of the earlier election are removed 90 days after the results of the election are certified except insofar as those prohibitions are imposed in accordance with the results of the subsequent election.

Sec. 04.11.496. Prohibition of sale and importation of alcoholic beverages. (a) The following question, appearing alone, may be placed before the voters of a municipality or an established village in accordance with AS 04.11.502: "Shall the sale and importation of alcoholic beverages be prohibited in .....(name of municipality or village)? (yes or no)."

(b) If a majority of the voters vote "yes" on the question set out in (a) of this section, a person, beginning on the first day of the month following certification of the results of the election, may not knowingly send, transport, or bring an alcoholic beverage into the municipality or established village, unless the alcoholic beverage is sacramental wine to be used for bona fide religious purposes based on tenets or teachings of a church or religious body, is limited in quantity to the amount necessary for religious purposes, and is dispensed only for religious purposes by a person authorized by the church or religious body to dispense the sacramental wine. The board shall be notified immediately after certification of the results of the election and thereafter may not issue, renew, or transfer between holders or locations a license for licensed premises located within the boundaries of the municipality and within unincorporated areas within five miles of the

(f) If a majority of the voters vote "no" on the question set out in (a) of this section or vote "yes" on the questions set out in AS 04.11.492 or 04.11.500 in an election conducted in accordance with AS 04.11.502 after an election in which the voters voted "yes" on the question set out in (a) of this section, the prohibition on the possession of alcoholic beverages is removed effective 90 days after the results of the election are certified except as those prohibitions continue to be imposed in accordance with the results of the subsequent election.

(g) For the purposes of this section, "possession" means having physical possession of or exercising dominion or control over alcoholic beverages, but does not include having alcoholic beverages within the digestive system of a person.

Sec. 04.11.500. Prohibition of the sale of alcoholic beverages except by selected licenses. (a) The following question, appearing alone, may be placed before the voters of a municipality or an established village in accordance with AS 04.11.502: "Shall the sale of alcoholic beverages be prohibited in .....(name of municipality or village) except by .....(listing of the types of licenses which premises would be exempted from the prohibition on the sale of alcoholic beverages if the measure passes)? (yes or no)."

(b) If a majority of the voters vote "yes" on the question set out in (a) of this section, the board shall be notified immediately after certification of the results of the election and thereafter may not issue, renew, or transfer between holders or locations a license for licensed premises located within the boundaries of the municipality and in unincorporated areas within five miles of the boundaries of the municipality or within the perimeter of the established village, except those types of licenses listed on the ballot. Licenses in effect within the boundaries of the municipality or perimeter of the established village, and in an unincorporated area outside of but within five miles of the boundaries of the municipality, except those types of licenses listed on the ballot, are void 90 days after the results of the election are certified. A license that will expire during the 90 days after the results of a local option election under this section are certified may be extended, until it is void under this subsection, by payment of a prorated portion of the annual license fee.

(c) If the majority of the voters vote "no" on the question set out in (a) of this section or vote "yes" on the questions set out in AS 04.11.490, 04.11.492, 04.11.496, or this section if different types of licenses are listed on the ballot in an election conducted in accordance with AS 04.11.502 after an election in which the voters voted "yes" on the question set out in (a) of this section, the board shall be notified immediately after certification of the results of the election. Licenses in effect in the municipality, in the unincorporated area outside of but within five miles of the boundaries of the municipality or established village that were excepted from the prohibition on sale in accordance with the results of the earlier election are void 90 days after the results of the election are certified. Thereafter the board may not issue, renew, or transfer between holders or locations a license for licensed premises located within the boundaries of the municipality or within the perimeter of an established village, or in an unincorporated area within five miles of the boundaries of the municipality, except a license that may be issued to a municipality or to one of the types of licenses listed on the ballot as a result of a majority of the voters voting "yes" on the question set out in AS 04.11.492 or this section, respectively. A license that will expire during the 90 days after the results of a local option election under this section are certified may be extended, until it is void under this subsection, by payment of a prorated portion of the annual license fee.

04 11.320

(3) the application has not been completed in accordance with AS 04.11.260;

(4) issuance of the license would violate the restrictions pertaining to the particular license imposed under this title;

(5) issuance of the license is prohibited under this title as a result of an election conducted in accordance with AS 04.11.502;

(6) the requirements of AS 04.11.420 - 04.11.450 relating to zoning, ownership and location of the license, and the identity and financing of a licensee have not been met;

(7) the licensed premises are to be located in a municipality, the type of license sought is a beverage dispensary or package store license, and that type of license is already in effect in the municipality under a community liquor license, unless the new license is to become effective after the community liquor license is no longer effective, whether as the result of a local option election or otherwise;

(8) the authority sought is authority to operate a beverage dispensary or package store under a community liquor license for premises to be located in a municipality where the authority sought is already held by a private licensee under a beverage dispensary or package store license, unless the community liquor license is to become effective after the privately held license is no longer effective, whether as the result of a local option election or otherwise;

(9) issuance of the license is prohibited under AS 04.11.400(a) or prohibition of issuance of the license is found necessary under AS 04.11.400(b);

(10) the application contains false statements of material fact;

(11) the license is sought for the sale of alcoholic beverages in a first or second class city in which there are no licensed premises at the time of application unless a majority of the voters in a local option election conducted in accordance with AS 04.11.502 have voted "no" on the question set out in AS 04.11.490, or have voted "yes" on a question set out in AS 04.11.492 or 04.11.500;

(12) the license is sought for the sale of alcoholic beverages in an established village in which there are no licensed premises at the time of application unless a majority of the voters in a local option election conducted in accordance with AS 04.11.502 have voted "no" on the question set out in AS 04.11.490 or have voted "yes" on the question set out in AS 04.11.500.

(b) An application requesting issuance of a new permit shall be denied if

(1) the board finds, after review of all relevant information, that issuance of the permit would not be in the best interests of the public;

(2) the board finds that any of the statements made in the application are untrue;

(3) the application has not been completed in accordance with AS 04.11.260;

(4) the permit is sought for the sale of alcoholic beverages in a first or second class city or established village in which there are no licensed premises at the time of application unless a majority of the voters in a local option election conducted in accordance with AS 04.11.502 have voted "no" on the question set out in AS 04.11.490.

Sec. 04.11.330. Denial of license or permit renewal. (a) An application requesting renewal of a license shall be denied if

(1) the board finds, after review of all relevant information, that renewal of the license would not be in the best interests of the public;

(2) the license has been revoked for any cause;

(3) the applicant has not operated the licensed premises for at least 30 eight-hour days during the immediately preceding calendar year, unless the board determines that the licensed premises are under construction or cannot be operated through no fault of the applicant;

(4) the board finds that issuance of an existing license under AS 04.11.400(g) has not encouraged tourist trade;

(5) the requirements of AS 04.11.420 - 04.11.450 relating to zoning, ownership of the license, and financing of the licensee have not been met;

(6) renewal of the license would violate the restrictions pertaining to the particular license under this title;

(7) renewal of the license is prohibited under this title as a result of an election conducted in accordance with AS 04.11.502;

(8) the application has not been completed in accordance with AS 04.11.270;

(9) the license was issued under AS 04.11.400(j), and the board finds that the public convenience does not require renewal.

(b) An application for renewal of a license may be denied if the applicant is delinquent in the payment of taxes if the tax liability arises in whole or in part out of the licensed business.

(c) An application requesting renewal of a conditional contractor's permit shall be denied if

(1) the board finds, after review of all relevant information, that issuance of the permit would not be in the best interests of the public;

(2) the application has not been completed in accordance with AS 04.11.270.

(d) Notwithstanding (a)(3) of this section, a recreational site license issued under AS 04.11.210 may be renewed if the license was exercised at least once during the immediately preceding calendar year.

Sec. 04.11.340. Denial of request for relocation. An application requesting approval for the relocation of licensed premises shall be denied if

(1) the board finds, after review of all relevant information, that relocation of the license would not be in the best interests of the public;

(2) the relocation is prohibited under AS 04.11.400(a) or (b);

(3) the license would be relocated out of the established village, incorporated city, unified municipality, or population area established under AS 04.11.400(a) within which it is located;

(4) transfer of ownership is to be made concurrently with the relocation of the licensed premises and a ground for denial of the transfer of ownership under AS 04.11.360 is presented;

(5) the application has not been completed in accordance with AS 04.11.290;

(6) relocation of the license would result in violation of a local zoning law;

SB

315

STATE OF ALASKA
THE LEGISLATURE

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

LEGISLATIVE AFFAIRS AGENCY

LEGISLATIVE REFERENCE LIBRARY

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

Mary Van Nimwegen

SB 315

S HESS 3/30/90

H HESS 4/4/90

HOUSE COMMITTEE REPORT

(7)
Date Referred: March 15, 1990 FURTHER REFERRALS:
LABOR & COMMERCE

Date of Committee Action: 4/4/90

The HESS Committee considered: CSSB 315(LABOR & COMMERCE)

CS SENATE BILL NO. 315 (L&C) LONG-TERM CARE DISABILITY INSURANCE

"An Act relating to long-term care insurance; and providing for an effective date."

RECOMMENDATIONS:
[ ] be replaced with _____ [ ] the same title [ ] a new title
[ ] have attached amendment(s)
[ ] do pass
[ ] do not pass
[X] no recommendation
[ ] individual recommendations
[ ] additional referral to the _____ Committee

ADOPTS: _____ letter of intent

ATTACHES NEW FISCAL NOTE(s): (Dept)
[ ] fiscal impact _____
[ ] zero fiscal note _____
[ ] zero with analysis _____

APPROVES PREVIOUS: (Date/Dept)
[ ] fiscal note(s) _____
[X] zero fiscal note(s) 2/28/90 DED
[X] zero fn/analysis 2/28/90 Admin

SIGNING DO PASS:

SIGNING: (Check approp. column)

	Do Not Pass	No Rec	Amend
		X	
		—	
		X	

Chairman's Signature

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: CSSB 315 (L&C) @
PUBLISH DATE: 2/28/90

FISCAL NOTE

REQUEST:

Revision Date:
Title: An Act relating to long-term care disability insurance; and providing for an effective date
Sponsor: HESS Committee
Requestor: HESS Committee

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

EXPENDITURES/REVENUES: (Thousands of Dollars)

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

FUNDING: (Thousands of Dollars)

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

POSITIONS:

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

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

Prepared by: Don Koch, Acting Deputy Director Phone: 465-2577
Division: Insurance Date: 2/6/90

Approved by Commissioner: Larry Merculieff Date: 2/7/90
Agency: Department of Commerce & Economic Development

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

Changes in CSSB315 (L&C) have no fiscal impact. This fiscal note is appropriate.

6264D/2690a

STATE OF ALASKA
1990 LEGISLATIVE SESSION

Bill Version: CSSB 315 (Z4C) (b)
Publish Date: 2/28/90

FISCAL NOTE

REQUEST:

Revision Date:
Title: An Act relating to long-term disability insurance
Sponsor: Senate HESS
Requestor:

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

EXPENDITURES/REVENUES: (Thousands of Dollars)

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

FUNDING: (Thousands of Dollars)

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

POSITIONS:

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

ANALYSIS: (Attach a separate page if necessary)

The long-term care insurance coverage offered to retirees under the Public Employees', Teachers', Judicial, or the Elected Public Officers' Retirement systems are not affected by this bill.

Prepared by: Sally Smith
Division: Retirement and Benefits
Phone: 465-4470
Date: 2/12/1990

Approved by Commissioner: Frank S. Baxter
Agency: Department of Administration
Date: 2/12/90

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

Changes in CSSB 315 (L4C) have no fiscal impact. This fiscal note is appropriate.

4/6X3/012217-0/112

Department of Commerce & Economic Development / POSITION PAPER

CSSB 315 (HESS): "An Act relating to long-term care disability insurance; and providing for an effective date.

The department supports this legislation. This bill establishes a specific regulatory framework for insurance contracts that provide for long-term care benefits. It establishes certain standardized contract provisions in order to require certain minimum benefits and to facilitate public understanding and comparison shopping.

Funding of long-term care is a critical issue throughout the nation that impacts all third-party and out-of-pocket payers of medical care for older persons. "Long-term care" is the term that pertains to a continuum of care that ranges from some assistance in the home to the extreme of 24-hour skilled care in a medical facility. Our average population is getting older and is living longer, thus, increasing the likelihood of more people requiring some form of long-term care. Medicare currently provides almost no coverage for long-term care. Medicaid provides the majority of the funding for long-term care nationwide and provides for nearly all of the funding for skilled nursing service care in Alaska. Most Americans are not financially prepared to meet the cost of long-term care in their later years. This results in those people spending down both assets and income in order to qualify for public assistance primarily through Medicaid.

The insurance industry has been slow to develop insurance products to cover this risk. The most important reason for this is the lack of reliable statistical data on which to base rates, coupled with the fact that correct projection of costs far into the future is required and is extremely difficult to accomplish. Although this attitude is changing, the general population has held the misperception that there is little or no need for such coverage and also that, if long-term care is needed, Medicare would provide the necessary benefits.

Without mechanisms such as insurance products to prefund long-term care, publicly-funded care is expected to increase, perhaps to a point beyond that which public resources can readily bear. It is important to encourage the growth of insurance products to help finance long-term care needs. However, this needs to be done in a manner that provides appropriate elements of consumer protection.

SB 315 is based on the National Association of Insurance Commissioners (NAIC) Model Long-Term Care Act. The NAIC is encouraging the adoption of this model by the various states in lieu of federal intervention. Abuses have occurred in other states with a large senior population. These abuses have received Congressional scrutiny, with indications that the federal government should regulate long-term care if the states do not.

L. Merculieff

Larry Merculieff, Commissioner

Date: 2/7/90

LM/LW/dg16266D
2690a

Alaska State Legislature

SENATOR PAUL FISCHER, Chairman
SENATOR JIM DUNCAN, Vice Chairman
SENATOR AL ADAMS
SENATOR LLOYD JONES
SENATOR TIM KELLY

PO BOX V
ROOM 508
STATE CAPITOL
(907) 465-3762

Senate Committee on Health, Education and Social Services

TO: REPRESENTATIVE JOHNNY ELLIS, CHAIRMAN, HOUSE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE.

FROM: SENATOR PAUL FISCHER, CHAIRMAN, SENATE HEALTH, EDUCATION AND SOCIAL SFRVICES COMMITTEE. PF.

DATE: MARCH 16, 1990

RE: SB 315 - LONG TERM CARE INSURANCE.

THIS BILL IS BASED UPON A MODEL ACT DEVELOPED BY THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS. IT ESSENTIALLY ALLOWS PROVIDERS TO DELIVER LONG TERM CARE INSURANCE IN THE STATE OF ALASKA. TO DATE, 38 STATES HAVE DEVELOPED SIMILAR VERSIONS OF THIS MODEL ACT. SEVERAL OTHER STATES HAVE SIMILAR MEASURES UNDER CONSIDERATION.

ESSENTIALLY, THIS BILL PROVIDES A METHOD FOR OUR CITIZENRY TO MEET THE NEEDS OF AN AGING POPULATION. MEDICARE CURRENTLY PROVIDES ALMOST NO COVERAGE FOR LONG TERM CARE. MOST COVERAGE FOR LONG TERM CARE COMES OUT OF MEDICAID. THIS BILL PROVIDES A PRIVATE SECTOR ALTERNATIVE FOR INDIVIDUALS IN NEED OF LONG TERM CARE. IT WOULD ALSO HELP REDUCE PRESSURES ON THE MEDICAID BUDGET.

THIS BILL ENJOYS THE SUPPORT OF THE DEPARTMENT OF COMMERCE, THE HEALTH INSURANCE ASSOCIATION OF AMERICA, AND THE AMERICAN COUNCIL OF LIFE INSURANCE.

I RESPECTFULLY REQUEST THAT YOU CONSIDER THIS BILL FOR SCHEDULING AT YOUR EARLIEST POSSIBLE CONVENIENCE.

THANK YOU.

LONG TERM CARE EDUCATION COALITION

WHAT IS LONG-TERM CARE?
Why You Need to Know

This is the first in a series of newsletters produced by the Coalition for Long-term Care Education. The Coalition is comprised of a variety of organizations, cooperating in this endeavor to respond to the need for educational information on the subject of long-term care. This issue introduces the concept of long-term care and explains why it should be of concern to you. Subsequent issues will be produced periodically on such topics as long-term care options, paying for long-term care, what to look for when selecting long-term care services, and others.

There's a great deal of talk these days about "the graying of America" and something called "the long-term care issue."

What's it all about? Why should you care?

America is getting older. More and more of us are moving into our senior years. And our life expectancy is increasing.

In the year 2000, about 35 million Americans will be aged 65 and over—more than twice the number in 1960. Since 1960, the population aged 65 and over has grown more than twice as fast as the U.S. population in general. The number of Americans aged 80 and over totals almost six million today; in the year 2030, that number is expected to have almost tripled.

These statistics tell the story behind the phrase, "the graying of America."

This growth in the elderly population will be reflected, among other things, in an increased demand for long-term care services. But what is "long-term care" and why do you need to know about it?

The Challenge of Living Longer

We Americans are healthier than ever—and living longer. And because so many Americans will live into their eighties and nineties—perhaps even to age 100—we all need to do some looking ahead.

While many millions of "young-old" Americans lead healthy, active lives, others are not so fortunate. Two out of five persons aged 65 and over risk needing nursing home care. By the year 1990, about 7.7 million Americans over age 65 are expected to need some form of long-term care. And as we get into our eighties, the chances increase considerably that we will face health problems or frailty. Statistics show that, at any given time, 22 percent of those aged 85 or older are in a nursing home.

Many of us are concerned that our health might deteriorate as we get older and we worry about our financial ability to handle disability or illness. Still, few of us make preparations that would help us handle these situations. Why? Partially it has to do with widespread misunderstanding about long-term care and how it is paid for.

Getting the Facts Straight

Many Americans deny their own possible future need for long-term care, associate long-term care only with nursing homes and believe that Medicare will pay for most long-term care services—all misconceptions.

The purpose of this newsletter is to help clear up some of the confusion for you about long-term care—to help you learn about the issue and to prepare yourself and other family members for a possible need for long-term care services.

What Is Long-term Care?

Simply stated, long-term care refers to a person's need for a wide range of medical, nursing, and social services over a prolonged period of time. This is generally called "chronic" care, as distinct from more intensive medical treatment for a short-term illness called "acute" care. The need for long-term care can result from chronic illness or disability or from a sudden accident or stroke.

Long-term care does NOT take place only in a nursing home, nor is it needed only by the elderly. Care might be provided to people of any age in the home, in community facilities, or in nursing homes. Relatives, friends and neighbors, and those working for community services often provide assistance with the normal activities of daily living such as eating, bathing, and dressing. Or, those who need care could be living in a community for senior citizens which might meet all of their health and social needs—commonly known as a continuing care community.

If you do not have these support systems or if you need skilled nursing or rehabilitative care on a daily basis, you may find your only option to be an institution such as a nursing home.

AFSCME Retiree Program
American Council of Life Insurance
American Nurses' Association, Inc.
Blue Health Women
Extension Service, USDA
General Federation of Women's Clubs
Health Insurance Association of America
National Association of Area Agencies on Aging
National Consumers League
National Council of Catholic Women
Public Voice for Food & Health Policy
The National Council on the Aging, Inc.

Social services are as important a part of long-term care as are medical and nursing services, particularly in helping you remain in the community if you need care. They include services provided in one's own home such as homemaker or "chore" services, "meals on wheels" and those provided in a community setting such as an adult day care center. Some of these services may also provide "respite care," which is time off for family members caring for an elderly relative.

Future newsletters will cover the types of services available for long-term care in more detail.

Thinking about the Options

If you are elderly and need help with day-to-day tasks, you may already have had to think about your need for long-term care. You have perhaps wondered how much longer you will be able to remain in your home and what kinds of help you will need to do that. Here are two things you can do: (1) Explore community programs in your area. (2) Find out the cost of these different programs to determine how far your savings or insurance will go to meeting those costs.

If you are the middle-aged child of an elderly parent, you've probably been considering similar questions about your parent's future. And then there's your own future—it's very possible that you have been so busy raising and educating your children and worrying about your parents that you've devoted little time to plans for your own older years.

The Role of Government Programs

Surveys show that millions of older persons mistakenly believe that Medicare covers most long-term care services. This is a dangerous misunderstanding because it leads to a false sense of security, thinking we already have coverage for the expenses of a chronic illness or disability.

Medicare does not cover **any** long-term care expenses. It is intended to help pay for short-term "acute" care in a hospital.

It also pays for care in a Medicare-certified skilled nursing home that provides daily nursing and rehabilitative care for a patient following hospitalization. Medicare offers coverage for only 100 days of skilled nursing home care annually and pays in full for only the first 20 days of such care.

Medicare pays for care in your home only if you are homebound and need, for a limited period of time, part-time nursing or speech therapy or physical therapy.

And while private supplemental health insurance (commonly referred to as "Medigap" insurance) is designed to help cover some of the gaps that Medicare covers, it does not include long-term care.

Medicaid, the government program for people with very low incomes, **does** cover the cost of long-term nursing home care. But if you have savings, you literally have to impoverish yourself to qualify for the program, which means first "spending down" or exhausting all of your own assets (although you do not have to sell your house).

Understanding the limitations of these programs is important when you are beginning to explore choices for yourself or for a family member. Costs vary considerably depending on the range of services needed and where those services will be provided. Home care may be the least expensive if only limited support is needed and if family members are the primary caregivers. On the other hand, an institution such as a skilled nursing home might be very expensive, costing between $20,000 and $40,000 a year.

Medicaid and private savings are the two major ways to finance long-term care today. Various government financing options are being considered by Congress, major studies on financing long-term care will soon be released, and private insurance is becoming more widely available. We'll tell you more about these developments in another newsletter.

Summing Up

We all need to think about our older years—whether we want to—or will be able to—stay in our homes, move to retirement communities or continuing care communities, or arrange for nursing home care. These decisions depend, of course, on the state of our health and the degree to which we are independent.

Millions of family members today continue a long American tradition of caring for elderly relatives. Family caregivers provide between 75 and 90 percent of the personal care, household maintenance, transportation and shopping for older persons.

But the reality is that many of us are living to very old ages and are being taken care of by relatives who themselves may be elderly or who may also be juggling jobs and other family responsibilities. Many people who are caring for elderly relatives find it very difficult to bear the entire burden alone. It is important that we all get as much help for ourselves or elderly relatives and have as many options as possible.

Obviously, the sooner you begin thinking and planning for a time when you or a relative may require long-term care, the better prepared you will be if a need arises. A crisis develops only when we don't plan.

Anticipating long-term care needs can mean, for example, checking into all of the resources available in your community, such as home care, adult day care, continuing care communities, and nursing homes. It means investigating the costs of these services and facilities and determining what resources you have to cover those costs. It means looking into government programs, private long-term care insurance, and their costs and coverage. And it means following federal and state legislative proposals that offer new solutions to meet long-term care needs.

Ask questions. Find out what is available. Become a knowledgeable consumer. Check out all your options. And look for the next in this series of educational newsletters.

To obtain additional copies, please write to:

American Council of Life Insurance
Health Insurance Association of America
Company Services
1001 Pennsylvania Avenue, N.W.
Washington, D.C. 20004-2599

CONSUMER NOTES . . . FROM THE LIFE AND HEALTH INSURANCE INDUSTRY

Long-term Care Insurance

Many people want to know how to buy insurance coverage that will protect them from the potentially catastrophic expenses related to long-term care. However, most people do not know what their chances are of ever needing long-term care services, how expensive these services can be or whether their present health insurance coverage will take care of them.

What Is Long-term Care?

Long-term care refers to the kind of help that you might need should you develop a chronic illness or disability that makes it impossible for you to care for yourself. You may never need lengthy care in a nursing home, but it's possible that some day you will need help at home with daily activities such as dressing, bathing, or walking.

To meet a range of long-term care needs, there are many kinds of long-term care services in addition to the care associated with lengthy stays in a nursing home or health care you may need at home. Other services include: adult day care; respite care (which helps family members cope with caring for older persons at home); care given in senior citizens or congregate housing; aide or chore services; and friendly visiting services.

Some or all of these services may be available where you live now or plan to retire. However, this issue of **Consumer Notes** deals mainly with the two kinds of long-term care covered by private long-term care insurance policies that are currently available: nursing home and home health care.

In addition, it will help you gauge whether long-term care insurance policies can help you meet future expenses related to chronic illness or disability.

Medicare and Long-term Care

The fact is that neither Medicare nor private Medicare supplement insurance (or the health insurance you have through your employer) will pay for most long-term care expenses.

Medicare supplement (Medigap) insurance is private insurance that is designed to help cover some of the gaps in Medicare coverage. It will not cover long-term care costs. Some retirees are covered by their group health plan which complements Medicare, but these plans generally do not cover long-term care either.

Although you may have Medicare as well as other health insurance, you will be covered for expenses related to only a limited amount of skilled nursing care. Skilled nursing care refers to the kind of daily nursing and rehabilitative care that can be performed only by, or under the supervision of skilled medical personnel. The care received must also be based on a doctor's orders.

This means you will not be covered if you need the kind of extended, intermediate or custodial care associated with long-term nursing home stays or if you need prolonged home health care on a daily basis.

Intermediate care refers to occasional nursing and rehabilitative care that must be based on a doctor's orders and can only be performed by, or under the supervision of skilled medical personnel. Custodial care is care that is primarily for the purpose of meeting personal needs such as help in walking, bathing, dressing, eating or taking medicine. It can usually be provided by someone without professional medical skills or training.

Home health care may include care received at home such as part-time skilled nursing care, speech therapy, physical or occupational therapy, part-time services of home health aides or help from homemakers or choreworkers.

At present, there are a limited number of long-term care insurance products available that do cover these kinds of expenses. However, insurance companies are developing more products as the demand for this kind of coverage increases.

Will You Need Long-term Care?

By the year 1990, about 7.7 million Americans over age 65 will likely need some form of long-term care.

But those aged 85 or older are the most at risk for needing long-term care services. In fact, statistics show that, at any given time, 22 percent of those aged 85 or older are in a nursing home.

At the same time, it is estimated that two out of five people aged 65 or older risk entering a nursing home. More than half of those will need to stay 90 days or fewer; yet about 40 percent will need to stay on average 2½ years. Only a small number ever stay over five years.

While you may never need nursing home care, home health care or other long-term care services, you still may wish to consider purchasing insurance that covers many of these services because of the risks posed by the need for long-term care and the costs involved.

Insurance, by definition, is a way for you to share the costs of possible economic loss by contracting with an insurance company to assume the risk of such a loss in exchange for a premium.

How Expensive Is Long-term Care?

Long-term care can be very expensive. In 1986, a year in a nursing home cost an average of $20,000 to $30,000 (the cost often depending on the area in which the

home is located) or about $2,000 per month. At the most expensive nursing homes, the annual cost could be as much as $50,000.

Home health care provided on an unskilled basis (help with grooming or dressing) by a home health aide three times a week for a year can easily cost $440 a month or $5,300 a year. Skilled nursing home care visits can cost even more with three visits per week for a year running as much as $680 a month or $8,200 a year.

It's difficult to know what kind of care you may need or what the costs will be, but knowing you will be responsible for the majority of expenses, you can begin to consider what kind of insurance coverage you need to buy.

Who Pays for Long-term Care?

In 1987, over half of nursing home care expenses alone were paid out-of-pocket by individuals or families. Medicare paid for less than two percent of the nation's $41.6 billion annual nursing home bill and private insurance paid even less.

In fact, Medicare will only help pay for:

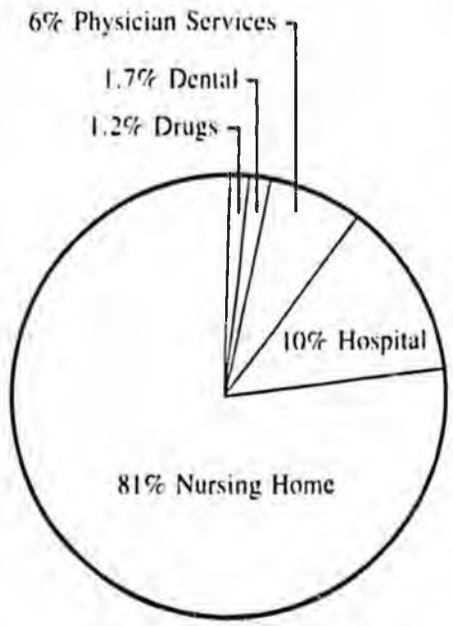
- Skilled nursing care up to 100 days, and your admission to a facility must be within 30 days of a three-day hospital stay. A physician must show that your admission is necessary.*
- Part-time skilled home health care (but only if you are homebound, a physician certifies the care is necessary and provides a treatment plan and the agency is Medicare participating). This is a very limited benefit and does not cover services you may need on a daily basis over an extended period of time.*

The other primary payer of nursing home care expenses (over 42 percent) is Medicaid, the government program that is meant to provide help with medical expenses to the poor. To qualify for Medicaid, you (or your family) either must already be "poor" or literally impoverish yourself—by spending virtually all of your assets (except your house). That happens to about one half of the people who enter nursing homes as "private-pay" patients. A recent study showed that those who pay for nursing home care out of their own pockets are often impoverished within six months to a year. They then must turn to Medicaid (public assistance) to pay part or all of their expenses.

For those over the age of 60, expenses for some home care services, such as Meals on Wheels, homemaker and home health aides, are available on a limited basis under the Federal Older Americans Act. If you need such services, contact the local Area Agency on Aging, listed in your telephone directory, for more information about eligibility requirements. Area Agencies on Aging are not direct providers of services, but they do operate an information and referral service to help older adults identify and access needed assistance within their communities.

*Legislation currently pending in Congress is expected to change Medicare's present skilled nursing care and home health care benefits. All Medicare beneficiaries will be receiving details from insurers and the federal government once the law goes into effect.

Elderly Out-Of-Pocket Expenses over $2,000 Per Year



What Kind of Insurance Is Available?

You can buy private insurance that helps to cover major expenses for long-term care. (See the "Who Offers Long-term Care Insurance" section for where to write about available policies.) There are a limited number of policies on the market today, but at least one is available in each state. These policies help pay expenses that may pose the highest risk to you.

Almost all available policies are "indemnity" policies, meaning they pay a set amount (usually a certain dollar figure per day) for care in a nursing home or for home health care. No policy, however, provides blanket coverage for all expenses and most policies on the market today do not automatically adjust for inflation. This means a policy's benefits are not necessarily tied to future increases in the costs of long-term care.

Each policy is priced differently. In 1986, costs ranged from about $100 a year in premiums to more than $2,500, depending on several factors:

Age—In general, the younger you are when you buy a policy, the lower the premium will be.

Elimination or Deductible Periods—These periods are defined as the number of days you must be confined in a facility or the number of home care visits you must have received before policy benefits begin. Usually, the longer the elimination or deductible period is, the lower the premium will be.

Amount Paid and Duration of Benefits—These vary from policy to policy, but in general, the more money the policy will pay or the longer the benefit period is, the more you will pay for the policy. For example, a policy that pays $100 a day for up to five years of nursing home care will cost more than a policy that pays $50 a day for three years.

What Kind of Care Is Provided?

Long-term care policies may pay for skilled, intermediate or custodial care in a nursing home. Each policy

may define these levels of care differently and the definitions are not the same as Medicare's.

Some policies require you to be hospitalized first before covering nursing home care, and many require that you receive skilled or intermediate care before they will pay for custodial care expenses.

Policies generally pay only for expenses in facilities that:

- Are licensed by the state and participate in Medicaid and/or Medicare; and
- Meet the policy's definition of skilled, intermediate or custodial care

This is why it's very important for you to find out the kinds of nursing homes in the area in which you live or plan to receive care before you buy a policy. Check the nursing homes in your area to make sure they fit policy definitions. If they don't, you may not be eligible for benefits.

Also, policies often cover home health care services such as skilled or non-skilled nursing care, and homemaker and home health aides. Some policies, however, require a prior nursing home or hospital stay before they will cover home health care benefits.

What Kinds of Limits Are There?

All policies contain limitations and exclusions in addition to age, elimination or deductible periods, or the amount and duration of benefits. Others you should study before making a purchase are:

Pre-existing conditions—When you apply for long-term care insurance, you may be asked questions about the previous and current state of your health. This is because an insurance company generally requires that a certain period of time pass before the policy pays for care related to a health problem you may have had when you applied. Such health problems are called pre-existing conditions. At this time, most companies use a six-month pre-existing condition limitation period. In some cases, you may be denied coverage because of your health status.

Eligibility—After a certain age, you will be unable to buy a policy. Each company sets its own age limit—usually around age 79. Most policies are only available to those over the age of 55. It's possible that both age limits may change in the future, as new policies are developed and sold.

Renewability—This policy provision is normally found on the first page of the policy. It tells you under what circumstances the policy can be cancelled by the insurance company or how premiums can be raised. Most policies are guaranteed renewable and cannot be cancelled.

Exclusions—Policies may not pay for long-term care related to mental or nervous conditions, alcoholism, mental retardation, or certain other health conditions or situations. However, Alzheimer's disease, and other organic disorders, leading causes of nursing home admissions, are generally covered.

What Kinds of Questions Should You Ask?

Before you consider buying long-term care insurance, you should determine what kinds of resources you have or plan to have to take care of your long-term care needs. For example, do you have savings, life insurance, or a pension that would help pay for them? Would other family members help you, if necessary, or would you qualify for community services that are income-related?

Be sure to read policies you are considering carefully and compare them. Don't be afraid to ask an insurance agent about anything that doesn't seem clear in the policy. There is no one solution for everyone in planning for the future, but your financial plans should include consideration of your long-term care needs.

The following questions will help you compare and evaluate policies you may wish to consider. Use them as a basis for discussion with an insurance agent or for asking questions about promotional literature you may receive in the mail.

What Does Long-term Care Cost?

1. What kinds of nursing homes are there in your area and how much do they charge per month for:
   - skilled nursing care?
   - intermediate nursing care?
   - custodial/personal care?
2. What do home health care agencies in your area charge per month for:
   - unskilled care?
   - skilled care?

How Much Does the Policy Pay?

3. What is the maximum amount the policy will pay for:
   - skilled nursing care?
   - intermediate nursing care?
   - custodial nursing care?
   - home health care?

How Much Does the Policy Cost?

4. How much will the policy cost you over time (i.e., 1, 5, 10, or 15 years)?
5. Can the company raise your premium over time or under other circumstances? If so, what are the circumstances?

What Are the Benefits?

6. Does the policy provide benefits for:
   - skilled nursing care?
   - intermediate care?
   - custodial care?
   - home health care?
7. How long will the policy pay benefits for:
   - skilled nursing care?
   - intermediate nursing care?
   - custodial nursing care?
   - home health care?
   - all of the above services?
8. Does the policy cover Alzheimer's disease if you developed it after you purchased the policy?
9. Does the policy provide benefits if you need care away from the area in which you live or if you move to another state?
10. Will the policy provide benefits if you have similar coverage with another policy?

What are the Limits?

11. What is the elimination or deductible period before benefits begin for:
    - nursing home care?
    - home health care?
12. What is the pre-existing condition limitation period?
13. Can the company cancel or refuse to renew the policy? If there are conditions, what are they?
14. a. Is a prior hospital stay required before the policy will pay for:
        - skilled nursing care?
        - intermediate nursing care?
        - custodial nursing care?

    b. Is a prior skilled nursing home stay required before the policy will pay for:
        - intermediate care?
        - custodial care?

    c. Is a prior nursing home stay required before the policy will pay for:
        - home health care?
15. Are there other limitations or exclusions that concern you? If so, what are they?

Who Offers Long-term Care Insurance?

There are policies available now in every state and many companies are in the process of developing policies.

You may wish to contact your state insurance department or insurance agent for more information. To obtain a list of private insurers offering products in your state, write to:

Health Insurance Association of America
Information Services
1001 Pennsylvania Avenue, N.W.
Washington, D.C. 20004-2599

Additional Reading

Publications about long-term care, health care coverage, and other subjects of interest to older Americans are available free or at a low cost from the following organizations:

American Association of Homes for the Aging
1129 20th Street, N.W.
Washington, D.C. 20036
Telephone: 202/296-5960

Brochures describing continuing care communities.

American Association of Retired Persons
Health Advocacy Services
1909 K Street, N.W.
Washington, D.C. 20049
Telephone: 202/872-4700

Brochures about long-term care, home care, housing options, health care, and health maintenance organizations.

American Health Care Association
1200 15th Street, N.W.
Washington, D.C. 20005
Telephone: 202/833-2050

Brochures about long-term care facilities.

Council of Better Business Bureaus
1515 Wilson Boulevard
Arlington, VA 22209
Telephone: 703/276-0100

Brochures about home care and long-term care facilities.

Health Insurance Association of America
1001 Pennsylvania Avenue, N.W.
Washington, D.C. 20004-2599
Health Insurance Hotline 1-800-423-8000

Brochures about health insurance, in general, and how private health insurance works with Medicare. Health insurance hotline.

National Consumers League
Suite 516
815 15th Street, N.W.
Washington, D.C. 20005
Telephone: 202/639-8140

Brochures about life care communities, home health care, hospice care, ambulatory care, and health maintenance organizations.

The National Council on the Aging, Inc.
West Wing 100
600 Maryland Avenue, S.W.
Washington, D.C. 20024
Telephone: 202/479-1200

Brochures about long-term care and Medicaid, Medicare, community resources, housing options and long-distance caregiving.

State Insurance Departments

Some have consumer education programs for older Americans about a range of insurance-related topics, including Medicare, Medicaid, Medigap, and long-term care insurance. Contact the department in your state for further information.

Social Security District Office

Several brochures, including **Your Medicare Handbook**, as well as information on Medicaid and other government programs for the elderly. To find the office nearest you, check the government listings in your telephone directory.

Other **Consumer Notes** include:

A326 *Choosing Financial Advisers*
C326 *Staying Well, Your Responsibility*
D326 *Group Health Insurance Continuation*
E326 *IRAs: An Investment in Your Future*
F326 *Medicare Supplemen. Insurance*
G326 *Help for the Working Caregiver*
H326 *Checklist for Change: Financial Planning for Life's Transitions*

All issues of **Consumer Notes** *may be obtained free-of-charge in single or bulk quantities by writing to the following address. Please be sure to include the name and booklet number of the issues you are ordering.*

American Council of Life Insurance
Health Insurance Association of America
Company Services
1001 Pennsylvania Avenue, N.W.
Washington, D.C. 20004-2599

States Adopt NAIC Model Act, Related Legislation For Long-Term Care Insurance Policies

In addition, no policy which "provides benefits only following institutionalization shall condition such benefits upon admission to a facility for the same or related conditions within a period of less than 30 days after discharge from the institution."

An outline of coverage is required for both individual and group policies. The outline should include (1) a description of the principal benefits and coverage provided; and (2) a statement of the principal exclusions, reductions, and limitations. Individual policies must contain a statement of the renewal provisions, including any reservation of a right to change premiums, and that the policy should be consulted to determine governing contractual provisions. Group policies must contain a statement that the group master policy determines governing contractual provisions.

Arizona—Rev. Stat. Ann. 20-1691 to 20-1691.6 (1987)

California—Model pending (1988)

Colorado—Rev. Stat. 10-19-101 to 10-19-104 (1986); Admin. Ins. Reg. 86-5 (1986)

Connecticut—Gen. Stat. 38-174m (1986) (Commissioner shall develop regulations to implement)

Florida—HB 478 pending (1988)

Georgia—HB 1748 (1988)

Hawaii—SB 545 model adopted (1987)

Idaho—Code 41-4601 to 41-4606 (1988)

Illinois— HB 1491 model pending (1987)

Indiana—Code 27-8-12-1 to 27-8-12-16 (1987) See also Code 12-1-25-1 to 12-1-25-9 (1987)

Iowa—Code 514G.1 to 514G.8 (1987)

Kansas—Stat. Ann. 40-2225 to 40-2228 (1988)

Kentucky—Model pending (1988) Rev. Stat. 304.17-314 (1987)

Maine—Rev. Stat. Ann. tit. 24A 5505I to 55053 (1986; authorizes commissioner to develop regulations)

Maryland—Ann. Code art. 48A 354FF, 477GG (1986; authorizes commissioner to develop regulations)

Minnesota—Stat. 62A.46 to 62A.56 (1986/1987)

Nebraska—LB 416 model adopted (1987)

New York—Ins. Law 1117 (1986)

North Carolina—Gen. Stat. 58-540 to 58-546 (1987)

North Dakota—Cent. Code 26.1-45-01 to 26.1-45-10 (1987)

Ohio—HB 611 pending (1988)

Oklahoma—Stat. tit. 36; 4421 to 4427 (1987)

Oregon—Rev. Stat. 743.138 (1987)

Pennsylvania—SB 1023 model pending (1988)

Rhode Island—HB 9178 pending (1988)

South Carolina—Model awaiting governor's signature (1988)

Tennessee—SB 1926 model pending (1988)

Texas—Ins. Code Ann. art. 370.1(F)(5) (1987; authorizes commissioner to develop regulations)

Virginia—Code 38.2-5200 to 38.5208

Washington—Rev. Code Ann. 48.84.010 to 48.84.910 (1988)

Wisconsin—Stat. 146.91 (1987)

Wyoming—Stat. 26-38-101 to 26-38-106 (1988)

No Action As Of July 1988

Alabama	Montana
Alaska	Nevada
Arkansas	New Hampshire
Delaware	New Jersey
District of Columbia	New Mexico
Guam	Puerto Rico
Louisiana	South Dakota
Massachusetts	Utah
Michigan	Vermont
Mississippi	Virgin Island
Missouri	West Virginia

States Adopt NAIC Model Act, Related Legislation For Long-Term Care Insurance Policies

The National Association of Insurance Commissioners (NAIC) drafted the Long-Term Care Insurance Model Act in July 1987. Thirty-two states have reported action in regard to long-term care insurance, having either adopted the NAIC Model Act, enacted similar or related legislation, or devised pending legislation.

This report summarizes the provisions under the NAIC Long-Term Care Insurance Model Act and lists the action by the various states.

The Long-Term Care Insurance Model Act was drafted by the National Association of Insurance Commissioners to establish standards for the design of long-term care insurance policies. The NAIC model has been adopted or used as a guide by states to promote the availability of individual and group insurance coverage for long-term care.

Following is a summary of the provisions under the NAIC Model Act:

Section 1. Purpose. The intent of the act is to protect the public while recognizing the need to permit flexibility and innovation with respect to coverage.

Section 2. Scope. Clarifies the entities subject to the act notwithstanding any other applicable state insurance legislation that may be in conflict with the act. The act is intended to apply to group and individual policies, contracts, and certificates issued either by insurers, fraternal benefit societies, non-profit health, hospital, and medical service corporations, prepaid health plans, health maintenance organizations, or any similar organization.

Section 3. Title. The Long-Term Care Insurance Act.

Section 4. Definitions. The definition of "long-term care insurance" means any insurance policy or rider advertised, marketed, offered; or designed to provide coverage for not less than 12 consecutive months for each covered person on an expense incurred, indemnity, prepaid, or other basis; for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital.

The act further clarifies "other than an acute care unit of a hospital" is intended to allow payment of benefits when "a portion of a hospital has been designated for, and duly licensed or certified as, a long-term care provider or swing bed."

"Applicant" means the person who seeks to contract for benefits under an individual policy or the proposed certificate holder in the case of a group policy.

Section 5. Limits of group long-term care insurance. No group insurance coverage may be offered to a resident (of this state) under a group policy issued in another state, unless this state or another state has statutory and regulatory long-term care insurance requirements substantially similar to those adopted in this state.

Section 6. Disclosure and performance standards. This subsection permits the adoption of regulations establishing disclosure standards, renewability, and eligibility terms and conditions, and other performance requirements. Regulations should recognize the developing and unique nature of long-term care insurance and the distinction between group and individual policies.

No long-term care insurance policy may:

(1) Be cancelled, nonrenewed, or otherwise terminated because of age or deteriorating mental or physical health of the insured;

(2) Contain a provision establishing a new waiting period in the event existing coverage is converted to or replaced by a new or other form within the same company, except when the insured voluntarily selects increased benefits;

(3) Contain coverage for skilled nursing care only or provide significantly more skilled care in a facility than is covered for lower levels of care.

In terms of preexisting conditions, an insurer is not prohibited from using an application form to determine a preexisting condition; however, no policy, other an employer's group policy, may define "a preexisting condition" more restrictive than "a condition for which medical advice or treatment was recommended by, or received from, a provider of health care services, within six months preceding the effective date of coverage."

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STATE LEGISLATION ON LONG-TERM CARE INSURANCE
(as of March 1989)

NAIC MODEL BILL	LEG/REG MORE STRINGENT THAN MODEL BILL	OTHER	LEGISLATION PENDING	AMENDMENTS PENDING
Arizona	California	Colorado	Arkansas Passed	Arizona
Florida	Connecticut	Kentucky	Delaware	California
Georgia	Maine	New York	Hawaii*	Connecticut
Hawaii*	Minnesota		Maryland	Florida
Idaho	Washington	3 STATES	Massachusetts	Georgia
Illinois	Wisconsin		Michigan	Iowa
Indiana			Montana	Kansas
Iowa	6 STATES		New Hampshire	Maine
Kansas			New Jersey	Missouri
Nebraska			New Mexico	Nebraska
Nevada			Oregon	North Dakota
North Carolina			Pennsylvania	Oklahoma
North Dakota			South Dakota	Tennessee
Ohio			Utah	
Oklahoma			Vermont	13 STATES
Rhode Island				
South Carolina			15 STATES	
Tennessee				
Virginia				
Wyoming				
20 STATES				

*Inadvertently repealed in 1988; has been re-introduced in 1989.

SB

326

HOUSE COMMITTEE REPORT

(7)
Date Referred: April 28, 1990 FURTHER REFERRALS: FINANCE

Date of Committee Action: 4/30/90

The HESS Committee considered: CSSB 326(FINANCE)

CS SB NO. 326 (Fin) GRANTS FOR COMMUNITY HEALTH PLANNING

"An Act relating to grants for health planning; and providing for an effective date."

RECOMMENDATIONS:
[ ] be replaced with _____ [ ] the same title [ ] a new title
[ ] have attached amendment(s)
[X] do pass
[ ] do not pass
[ ] no recommendation
[ ] individual recommendations
[ ] additional referral to the _____ Committee

ADOPTS: _____ letter of intent

ATTACHES NEW FISCAL NOTE(s): (Dept)
[ ] fiscal impact _____
[ ] zero fiscal note _____
[ ] zero with analysis _____

APPROVES PREVIOUS: (Date/Dept)
[X] fiscal note(s) 4/26/90 / DHSS
[ ] zero fiscal note(s) _____
[ ] zero fn/analysis _____

SIGNING DO PASS:
J Ellis
W Furnace
M Luna
Chris Dallis
Mark Boyer

SIGNING: (Check approp. column)

	Do Not Pass	No Rec	Amend

J Ellis
Chairman's Signature

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: CSSB 326 (Fin)
PUBLISH DATE: 4/26/90

FISCAL NOTE

Corrected Note

REQUEST:

Revision Date: April 26, 1990
Title: Grants for community health planning
Sponsor: Senator Jones
Requestor: Senate Finance

Agency Affected: Health & Social Services
BRU: Administrative Services
Components: Planning

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	37.1	26.0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	150.0	150.0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	187.1	176.0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	187.1	176.0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	0	0	0	0	0
TOTAL	187.1	176.0	0	0	0	0

POSITIONS:

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

ANALYSIS: (Attach a separate page if necessary)

Prepared by: Senator Rick Uehling, Co-chairman
Division: Senate Finance Committee
Phone: 465-4821
Date: April 26, 1990

Approved by Commissioner: _____ Date: _____
Agency: _____

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

HEALTH ASSOCIATION OF ALASKA

STATEMENT OF SUPPORT
April 28, 1990
CSSB 326 -- Grants for Community Health Planning

Community hospitals and nursing homes across the state support CSSB 326 as it provides an opportunity for communities and/or regions within the state to measure the cost and the effectiveness of their local health system.

CSSB 326 provides:

1. That the Department of Health & Social Services establish a grant program under which up to 12 municipalities, Native service areas or rural government entities may receive a grant of up to $50,000.00 to:

   A. Conduct a comprehensive analysis of the local health care delivery system;

   B. Review coordination and cooperation of community, regional, state and federal health care services and programs;

   C. Review adequacy of health care facilities;

   D. Identify the uninsured and the under insured;

   E. Recommend to local, state, regional and federal agencies ways to coordinate and maximize the delivery of health care services.

2. Communities or regional areas applying for grants must:

   A. Have broad community or regional participation;

   B. Provide cash and in-kind contributions totaling in value of up to 1/3 of the grant applied for.

3. The fiscal note is:

   1991 -- $150,000 grants; $37,100 administration = $187,100.00.

   1992 -- $150,000 grants; $26,000 administration = $176,000.00.

   The program is repealed July 1, 1992.

FOR MORE INFORMATION CONTACT:

Harlan Knudson - 586-1790
Health Association of Alaska
319 Seward Street, #11
Juneau, AK 99801

# # #

140-SC-117-M

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: CSSB 326 (Fin)
PUBLISH DATE: _____

FISCAL NOTE

Corrected Note

REQUEST: _____

Revision Date: April 26, 1990
Title: Grants for community health planning
Sponsor: Senator Jones
Requestor: Senate Finance

Agency Affected: Health & Social Service:
BRU: Administrative Services

Components: Planning

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	37.1	26.0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	150.0	150.0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	187.1	176.0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	187.1	176.0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	0	0	0	0	0
TOTAL	187.1	176.0	0	0	0	0

POSITIONS:

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

ANALYSIS: (Attach a separate page if necessary)

Prepared by: Senator Rick Uehling, Co-chairman
Division: Senate Finance Committee
Phone: 465-4821
Date: April 26, 1990

Approved by Commissioner: _____
Agency: _____
Date: _____

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

[redacted]

- Fiscal Note and Fiscal Note Analysis -

FISCAL NOTE ANALYSIS (continued)

CSSB 326 (FIN) BY JONES
5/6/89

"An Act relating to grants for community health planning; and providing for an effective date."

Contractual funding is based upon the following assumptions:

PURPOSE	FY 1991	FY 1992
Grant administrator	$21,000	$21,000
Advertising of RFP	600	
Printing	500	
Technical assistance work sessions	15,000	5,000
	37,100	26,000

It is estimated that a half-time grant administrator will be needed to organize and administer the grant program. Funding for this purpose is shown in the contractual line to facilitate a reimbursable services agreement for use of an existing position if such an arrangement proves feasible and efficient. Two year funding of the half-time position reflects the spread of grants over two fiscal years.

Advertizing cost is for notices in major newspapers and by mail.

Printing costs are estimated for publishing a Request for Proposal and for application forms.

Technical assistance work sessions would be held in 5 regional locations to assist with initial application completion. Additional on-site assistance, grant administration, monitoring and evaluation would occur as funding allows.

Grant funding assumes a maximum grant amount of $50,000 for each grantee in FY 91 and a maximum grant amount of $50,000 for each grantee in FY 92. The sum of all grant funding would be limited to $150,000 each fiscal year. The total number of grants would be limited to up to twelve.

SB 326 - Grants for Community Health Planning

Introduction

Through the work of the Governor's Interim Commission on Health Care, certain principles were developed and commended to the Governor and legislature to guide the development of health policy. One principal focused on ensuring access to basic health care services for all Alaskans. Another principal emphasized community responsibility for health care and health promotion. This bill allows for several communities, regions, or combination of municipalities, non-profit agencies, etc., to apply for a grant.

Senate bill 326 focuses directly on local responsibility to ensure health care access for Alaskans. The bill makes it possible for local health leaders to identify health care priorities and to coordinate future efforts in reaching those goals.

Background

Changes in the cost of health services, in reimbursement policies for public and private purchasers, in the economic and demographic conditions in rural areas, in the availability of health care providers, and other trends, threaten the availability of health care services in many Alaskan communities.

In addition, many factors inhibit necessary changes in the delivery of health services to Alaska, including:

- inappropriate and outdated regulatory laws
- aging and inefficient health care facilities
- the absence of local planning and coordination of rural health services
- the lack of community understanding of the costs and benefits of supporting hospitals and other health service providers
- the lack of state or regional assistance to assure access to care that cannot be provided in every community, and
- the lack of clarity of state health policy objectives.

The Program

This program is designed to utilize a method for strengthening health services in Alaska by working directly with communities. The model program, developed by the University of Washington School of Medicine Rural Health Office, includes four phases:

- **Community selection:** Any community desiring to participate in this program may initiate a request to the administrator of the program, designated by the State.

- **Community analysis**: A thorough and intensive study will be made of the health services system in each participating community. This will include a management and financial study of the community hospital and/or nursing home; a market survey; a needs assessment; and other community analysis that may be deemed important.

- **Strategic planning**: A strategic plan will be developed for the community, involving all elements of the health services delivery system.

- **Implementation of the plan**: Problems indentified in the planning process and changes in service configuration will be implemented.

Each grantee will develop a long-range plan covering the local spectrum of health services. It will be the grantees' responsibility to involve all major health care providers, business leaders, public officials and other community leaders, to develop the project design and to oversee and implement the program. Grantees will also participate in the financial support of the program with a one-third match in cash or in-kind contributions.

Appropriation

In this act, the state of Alaska will appropriate $187.1 in FY91 to support the program, $176.0 in FY92. Grantees will receive up to $50,000 each. The bill allows for one-half of the grants awarded by the Department of Health and Social Services to go to rural areas with special needs, as defined by the department.

Other costs include funding a half-time grant administrator, advertising of the RFP, printing and technical assistance work sessions. Communities will be expected to contribute 33-percent of the total grant appropriation in cash or in-kind contributions (see attached fiscal note analysis).

Administration

The Department of Health and Social Services shall establish the Alaska Rural Health Systems Project. The Department may contract with a third party to carry out the implementation of the legislation where this makes most effective use of available expertise, avoids duplication of efforts and promotes economy of resources. The Department will develop a list of appropriate resources and consultants to assist the grantees.

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Community Health Systems

The Community Health Services Development (CHSD) strategy for assisting rural communities is a product of the University of Washington Rural Hospital Project (PHP). This four-year demonstration project was designed to develop approaches to stabilize and improve health services in a sample of six rural communities in the states of Washington, Alaska, Montana and Idaho (WAMI). The RHP emerged out of a recognition that the stability of rural health systems in the WAMI states was being threatened and one symptom was the increasingly tenuous status of rural hospitals that exist in the majority of rural communities in the four-state region. The basic premise of the RHP was that the hospital could be used as a point of entry into the community, a way to engage community leadership in a fundamental attack on the issues threatening health services in that rural community.

Although the community hospital is often the focal point for community agreement ("contract") to work with University of Washington/AHEC staff, the CHSD strategy includes strengthening all elements of the community health care system. The Community Health Services Development cycle has been completed in all six initial communities, and a formal evaluation of outcomes is currently underway. The CHSD

approach has been used in an additional 14 communities in the WAMI region.

Seward, Alaska was one of the original six RHP communities. A discussion of why Seward applied to participate, the issues the community was facing and a review of its accomplishments can serve to demonstrate the potential for this community-oriented approach.

Why Seward applied as a Rural Hospital Project Demonstration Community:

All participating communities were rural with hospitals under 50 beds. The hospital had to be experiencing financial distress in order to be selected.

In 1984, at the time communities were polled for their interest in partnering with the University of Washington School of Medicine, Seward faced the following problems:

- The small population base in Seward created severe limits on the range of health services and financial resources available to support those services; in addition, there was substantial out-migration by the service area population for hospital, physician, dental and other health services.

- The hospitals long-term financial viability was a major concern. The loss from operations for FY's 1982 and 1983 totalled $650,000.

- The hospital facility had significant structural deficiencies in building, equipment and safety, with no capital reserve to modernize.

- Physician recruitment and retention had been a problem for many years. The number of physicians the small population could support was so small that physician stress and burnout was a recurring problem.

- The hospital board of trustees had not conducted a strategic planning process and was generally feeling overwhelmed by the responsibilities for stabilizing hospital and health services for the community.

- Public satisfaction surveys of health care in the community revealed major problems with confidence and quality. This clearly contributed to patient out-flow to other communities for services.

- A lack of cooperation and coordination among the

major health care providers in the community was noted.

- Various hospital financial practices and policies and practices are inadequate, including a very high accounts receivable.

- There was a high level of dissatisfaction with pharmacy services in the community.

- There was substantial dissatisfaction with alcoholism and mental health services, with massive out-migration to Anchorage for these services.

- The scope of medical services provided at the hospital was smaller than many hospitals of similar size. No surgery was being performed at that time, and a large portion of obstetrical patients were leaving the community for care.

In summary, approximately 40 significant problems, including those listed above, were documented by the Rural Hospital Project team when health services in Seward were analyzed carefully. Not surprisingly, the small cadre of health care leaders in the community was experiencing immense