

**ALASKA LEGISLATURE COMMITTEE FILES 1991-1992**

**7389**

**SENATE HEALTH EDUCATION & SOCIAL SERVICES**

**8672**



Kodiak Island Hospital and Care Center

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Kodiak, Alaska 99615  
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January 18, 1991

Senator Lloyd Jones  
Attn: Glenda Carino  
P.O. Box V  
Juneau, AK 99811

Via FAX: 465-3922

Dear Senator Jones:

Enclosed is a brief summary of the Kodiak Island Hospital & Care Center's replacment facility plan including estimated financial needs.

If you have any questions, please feel free to contact me.

Sincerely,

N. Campeau  
Interim Administrator

NC/dr  
Enclosures

Post-It™ brand fax transmittal memo 7671		# of pages ▶ 5
To Glenda Carino	From N. Campeau	
Co. Senator Jones	Co. KIH/CC	
Dept.	Phone # 486-3281	
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cc: Senator Fred Zharoff  
Harlan Knudson, ASHNHA

# KODIAK ISLAND (BOROUGH) HOSPITAL AND CARE CENTER

## HISTORICAL PERSPECTIVE

Kodiak Island (Borough) Hospital and Care Center has been trying for nine years to achieve funding for a badly needed modern health care facility. The State of Alaska has not funded rural health care facility construction for the past seven years.

During this nine years, several studies have been completed. They have studied the needs of the Borough, the present facilities, the need for either remodeling/additions to the present facility, or a replacement facility; the projected health care needs of Kodiak Island Borough; and the respective costs of remodeling/additions versus a replacement facility.

In 1982, the State of Alaska contracted with ECI-Hyers, Architects and Planners, to study the existing need in the state. Their conclusions were that replacement of the present facility would be the most cost effective methods of providing needed health care.

In 1985, Mills, John & Rigdon Architects determined that the most prudent method of providing the needed health care was a replacement facility. Their findings were that the present facility's problems in the areas of asbestos control, mechanical systems, air handling systems, traffic flow, earthquake protection and multiple code violations made a replacement facility the only choice.

In May of 1986, the Health System Agency came to the conclusion as the two previous studies: replacement is the only cost effective and realistic approach to the problems of health care delivery in Kodiak Island Borough.

The present facility has 66 deficiencies under Federal Codes, 19 deficiencies under the Handicapped Code, 4 major deficiencies under Life Safety Code, and it does not meet the state requirements for earthquake protection.

When the hospital was built in 1968, it met the medical needs of that time. Then, we had 2,300 outpatient visits a year; now, we have over 9,000. Then, we had about 10 patients a day in the hospital; now, we have over 15 a day. Then, we had one x-ray machine; now, we need three machines and our CT Scanner is going to have to be put in a building outside the hospital because there is no room inside. Then, we had three laboratory machines performing 1,500 tests a year; now, we have five state-of-the-art machines performing over 9,000 tests. But we are still in the same building with the same 22-year-old mechanical, ventilation and electrical system.

The State of Alaska appropriated \$200,000 to Kodiak Island Borough for planning of a new facility. Kodiak Island Hospital and Care Center has donated over \$2,000,000 to the Borough for site acquisition, architect's drawings and specifications, and site preparation. There are currently plans, specifications and documents ready for construction. Due to a lack of funding, the Certificate of Need which was granted, and extended twice in anticipating of funding, has expired. The Certificate of Need has been resubmitted to the State for review.

The Kodiak Island Borough and the City of Kodiak have both made the replacement of the present hospital with a new facility their number one priority again this year.

To date, the Kodiak Island Borough and Hospital have spent \$1,813,962.00 in preparation for the new hospital. There is over \$1,000,000 in reserves dedicated for the construction of the new hospital. We are currently researching the possibility of a fund developing program to further assist ourselves and the state in providing the necessary health care for our borough.

Over the nine years of waiting, we have spent large sums of money studying the problem and developing the most economical solution and the plans and specifications to implement the replacement facility. The delays have increased the cost of construction, through inflation and increasing technology, from \$11,500,000 in 1982 to \$19 million in 1991. These are costs that are directly born by the hospital, borough, citizens and State of Alaska.

KODIAK ISLAND HOSPITAL REPLACEMENT

COST ESTIMATE

1. New Construction	\$ 14,000,000
2. Site Work	484,500
3. Site Acquisition	495,000
4. Landscaping	250,000
5. Mechanical Balancing	40,000
6. Movable Equipment	450,000
7. Architectural/Engineering Fees	1,200,000
8. Site Survey/Soils & Materials Testing	50,000
9. Special Inspections	42,000
10. Administrative Expense	250,000
11. Contingency	<u>1,738,500</u>

TOTAL PROJECT COST (1991) \$ 19,000,000

LOCAL FUNDING \$ 4,000,000

BALANCE REQUESTED FROM STATE OF ALASKA \$ 15,000,000

Alaska Hospitals and Nursing Homes

Certificate of Need Information<sup>1</sup>

for the

Senate Special Committee on Health Care Facility Assessment

Ketchikan General Hospital and Island View Manor \$17.8 - \$19.3 Million

A Certificate of Need was issued on June 15, 1990 to Ketchikan General Hospital and Island View Manor authorizing a maximum capital expenditure of \$17,800,000 for a single phased project and the alternative amount of \$19,300,000 for a three phased project. A three phased approach, even though more expensive, was approved as a viable alternative in the event that project funding was not achieved in a single lump sum. The Certificate of Need authorizes the correction of all life/safety code violation, remodel and enlarge outpatient and ancillary support areas, a bed capacity of 39 acute care beds and 35 long-term care bed, and no change in services offered. The Certificate of Need expires on July 30, 1995. The City of Ketchikan currently has no funds to complete this project.

Seward General Hospital - \$9.5 Million

A Certificate of Need was first issued to Seward General Hospital for a remodeling and replacement project in May of 1985, and was modified on September 9, 1989, to reduce the authorization from \$10.5 million to \$9.5 million. The Certificate of Need authorizes remodeling in the existing building and a replacement project. The replacement portion of the project will consist of new construction on a site adjacent to the existing hospital. The project will include no more than ten double rooms for acute patient care and involves no change in services currently attended by the facility. The Certificate of need expires on April 30, 1994.

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<sup>1</sup> The amounts supplied in this report are only the amounts authorized by Certificate of Need. The Certificate of need regulations allow for 15% increase in cost above inflation, before additional Certificate of Need approval is required. As a result the actual amounts need by hospitals may be greater then what is listed in this report. For actual amounts needed, it is suggested that the individual hospitals be contacted.

### Kodiak Island Hospital - Cost Unknown

A Certificate of Need was granted to Kodiak Island Hospital in August of 1986 for a replacement facility at a cost of up to \$18.2 million. Upon completion of the design phase of the project, the estimated cost had gone up to \$22.8 million. The Hospital Administration was very displeased with the high cost overrun. In addition, the Hospital Administration was very displeased with the architectural plans, feeling that in addition to being very expensive, they were not very efficient or effective. Kodiak Island Hospital was granted 2 extension to their Certificate of Need; the last of which expired on August 25, 1990. The Hospital Administration has decided that the present architectural plans are too expensive, as well as inefficient, and are starting over on the design phase. Therefore, Kodiak Island will be submitting a new Certificate of Need application for a replacement facility. They are possibly going to pursue a "design-build" approach rather than a traditional design process, in anticipation that this will save a significant amount of money. An informal conversation with the Hospital Administration indicated that an initial guess estimated the replacement cost with a designer build approach at approximately \$12 - \$14 million.

### Denali Nursing Home

As reported in the press last year, Denali Nursing Home in Fairbanks is in a very deteriorated condition without sufficient funds to ensure remedy to these problems and assure ongoing operations. Total scope of the physical plant needs and costs are unknown. They have also talked about possibly replacing the building. Last year they indicated that \$8.2 million would be needed for replacement. No Certificate of Need has been applied for.

### Wesleyan Nursing Home \$3.83 Million

A Certificate of Need was issued in 1985 for \$3.83 million to Wesleyan Nursing Home in Seward. The activities approved included the construction of a new wing, and extensive renovations, with no charge in the licensed capacity of 66 beds. The Certificate of Need expired in May 1, 1990. Undoubtedly, the cost for these activities has risen due to inflation. The last information received from Wesleyan indicated that the cost has gone up to \$4.45 million.

### Unalaska Health Clinic/Infirmary

Over the past few years, Unalaska has sought help to upgrade and expand their health facility. The latest request indicated a need for approximately \$4.5 to \$5.0 Million. The need is basically for a trauma care center. As proposed this will not be subject to Certificate of Need review as it does not meet the definition of a health care facility set out in the Certificate of Need statute.

### Alaska Psychiatric Institute

A Certificate of Need application is anticipated to replace the current 162 bed state mental health hospital, the Alaska Psychiatric Institute (API). In FY 91, the Governor requested funds to continue planning and undertake Certificate of Need processes to replace API. This was not funded in FY 91 but will be requested again in FY 92. API is in a badly deteriorated condition after 28 plus years of continuous operation. Mechanical, electrical, plumbing, building and other systems have or are failing. Repair, renovation and ongoing staff and patient safety is potentially compromised by the large amount of asbestos contained behind walls and above ceilings. Estimated replacement cost in 1989 was \$70.8 million.

### Bartlett Memorial Hospitals 6 Million

Bartlett Memorial Hospital in Juneau received a Certificate of Need in 1986 approving an expenditure of \$11.2 million for extensive renovations. These renovation were mostly completed, but the Hospital Administrators has indicated they would like to modify the Certificated of Need to allow for an expenditure of another \$6 million for additional renovations.

SB67

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PMS

SENATOR ARLISS STURGELEWSKI

PO BOX U

JUNEAU AK 99811

PETERSBURG GENERAL HOSPITAL SUPPORTS SB67 AND SUPPORTS HAVING  
PROVIDENCE AND HUMANA HOSPITALS ELIGIBLE TO PARTICIPATE IN  
STATE MATCHING GRANTS.

GARY GRANDY, ADMINISTRATOR

REPORT ON RURAL ALASKA HOSPITALS AND NURSING HOMES  
INVENTORY AND EVALUATION  
SURVEY

PREPARED FOR  
ALASKA LEGISLATURE

BY

DIVISION OF STATE HEALTH PLANNING AND DEVELOPMENT  
DEPARTMENT OF HEALTH AND SOCIAL SERVICES  
HELEN D. BEIRNE, COMMISSIONER

MARCH 8, 1982

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## INTRODUCTION

Ensuring access to and availability of care is an important planning responsibility of the State of Alaska. The needs for and adequacy of health care facilities, manpower, services and equipment are all important considerations in determining an appropriate health care delivery system for Alaska.

With the support of a 1981 legislative appropriation, the Department of Health and Social Services has conducted an inventory of 15 rural hospitals and nursing homes and a survey of more than 200 clinics in the State to assess their physical plant condition and functional adequacy. This report describes the inventory design and process, the findings, and alternative construction funding sources. In a separate effort, the Department surveyed all health clinics in the State and has provided an initial report on the needs for clinic construction to the legislature.

Information provided in these reports is intended to serve as a guide in determining an appropriate level of State support for health facility construction, since the number and size of construction aid requests and/or appropriations are increasing each year. Cost estimates are provided to outline the dimension of construction need, but cannot be interpreted as a recommended level of State support.

### I. HEALTH FACILITY INVENTORY DESIGN AND IMPLEMENTATION

#### The Need for a Health Facility Inventory

The Department of Health and Social Services has become increasingly aware that many health care facilities, particularly rural hospitals and nursing homes,

are in need of renovation or replacement. This awareness has sharpened as the Department fulfills its responsibilities for review and approval of facility construction plans, for issuing construction licenses, for annual operational licensure surveys, for certification for Medicare and Medicaid reimbursement and in analyzing applications for certificate of need. Knowledge that there were significant needs for upgrading facilities was accompanied by an awareness that many communities were unable to undertake hospital or nursing home renovations because the community's economic base could not support the total costs. The Department initially outlined its concerns related to health facility construction and operation in a 1981 report to the Legislature on health facility revenue sharing.

#### Designing the Inventory

As a result of an appropriation by the 1981 Legislature to inventory health facilities, the Department defined its scope as those rural hospitals and nursing homes designated as Level III facilities in the State Health Plan. This designation includes communities with sufficient population and health care services, manpower, equipment and facilities to provide basic hospital services and long term care services. The inventory was limited to these communities because construction, licensing and certification staffs had identified major deficiencies in these facilities which communities had been unable to correct. These deficiencies included:

- Building, fire and life safety code violations;
- Lack of adequate mechanical ventilation to patient care areas;
- Mechanical and electrical inadequacies resulting from acquisition and use of modern equipment which places higher demands on original mechanical and electrical systems;

- Structural constraints which inhibit facility flexibility to respond to changes in health care practices, patterns of use, medical technology and community attitudes;
- Space shortages resulting from increased complexity of information processing and records storage requirements;
- Space shortages resulting from more medical equipment;
- Storage shortages related to greater use of disposables rather than reusable items.

Changes in service area populations (growth or decreases) modifying needs for space.

To determine interest in participating in the survey, the Department contacted all rural hospitals and nursing homes to advise them of the survey and to request their participation. Anchorage and Fairbanks hospitals were not included as they are not considered rural facilities and were not experiencing code compliance correction issues faced by rural facilities. For-profit facilities such as Nakoyia Health Care Center in Anchorage and Careage North in Fairbanks were also excluded since they are not eligible for State assistance. All rural hospitals and nursing homes elected to participate in the inventory with the exception of Valley Hospital in Palmer, since financing had been secured for renovation/replacement of the facility and project design was in progress. Sitka Community Hospital also declined to participate since construction of a replacement facility was underway.

## Conducting the Inventory

Once the listing of facilities to be inventoried had been finalized, the Department of Health and Social of Services issued a Request for Proposal to architectural firms for the completion of an on-site inventory and evaluation survey of fifteen rural health care facilities in the State.

The purpose of the survey is two-fold: 1) to develop a detailed record of the current condition of each subject facility, emphasizing physical condition and functional adequacy; and, 2) based on an analysis of those current conditions and any anticipated future developments (expressed in long-range plans, and certificate of need applications, for example), to formulate recommended activities for the correction of noted deficiencies and provide preliminary cost estimates for the recommended activities.

The inventory and condition survey was organized into three basic phases:

### Phase One: Pre-inventory Activity

The first phase consisted of pre-inventory activity including:

- preparation of request for proposals
- selection of architectural firm
- initial consultation with selected firm
- collection and review of available documents/plans
- confirmation of site visit schedule
- development of forms and questionnaires
- final coordination meeting between architectural firm and DHSS

## Phase Two: On-site Inventory

The second phase included all the on-site inventory activity. To accomplish this portion of the work in the limited time available, two survey teams were formed, each with a hospital systems planner, an architectural investigator, a mechanical investigator, and an electrical investigator. The facilities surveyed were divided into an eastern region and a western region with one survey team assigned to each region. Pre-determined survey formats were used to assure consistency between the two regions.

Each site survey consisted of the following steps:

### Document Review:

Examination of existing documents including plans, code reviews, pertinent facilities board actions, pending physical plant changes, fire marshal reports, licensing agency recommendations and long-range plans.

### Staff Interview:

An interview session including representatives from the facility's administration and medical staff (as deemed appropriate by the facility's administrator).

### Facility Examination:

The survey team inspected all portions of the facility to gather first-hand information on all systems. Standardized forms and checklists were used to assure thorough investigation and standardized reporting. Field notes were used to itemize deficiencies not covered by the standardized forms and checklists.

### Final Meeting:

A final meeting was held with the facility's administrator to communicate the results of the facility examination, preliminary findings of the team, and to discuss the nature of the report.

### Phase Three - Evaluation of Reports

The third phase of the inventory and condition survey included the evaluation of collected data, and preparation and submission of draft reports. The Health Resources Development Section of the Division of State Health Planning and Development, DHSS analyzed several drafts and worked with the consulting architectural firm toward the completion and printing of the report.

## II. OVERVIEW OF SURVEYED FACILITIES

During its evaluation of the physical facilities of each hospital/nursing home the architectural team discovered a number of serious deficiencies. Generally, the deficiencies result from advances and changing techniques in the medical field, coupled with more stringent building, fire and life safety codes which have been adopted over the years since construction of the facilities. Space and flexibility limitations in the facilities were also judged to be important deficiencies and were considered in arriving at the recommendations for corrective measures.

The majority of nursing units were found to lack required electrical capacity, mechanical ventilation systems and nurse call systems. Surgical units

in some hospital facilities were found not to meet minimum area requirements and to be poorly ventilated. Often the surgical areas were laid out in a manner providing undesirable circulation patterns which created cross-contamination problems.

Advanced laboratory and treatment equipment is increasingly being placed in service at the facilities. Usage of the radiology and laboratory units of the facilities is also increasing. These areas require large amounts of mechanical and electrical service to accommodate these increases. Most of the facilities surveyed were drastically short on space in these areas. Most of the older facilities provide insufficient waiting areas for outpatients, causing the use of corridors, foyers, and other access areas for waiting areas. These conditions result in Life Safety Code violations.

Many facilities have found it necessary to store medical equipment in corridors due to the lack of storage space, thus compounding circulation problems.

New obstetrical practices such as "birthing rooms" and "rooming in" have become popular in recent years causing changes in space requirements for obstetrical areas.

Administration areas in most facilities are cramped, with records storage space lacking. As these facilities convert to the use of computerized data storage systems, this problem will increase due to the sophisticated mechanical and electrical requirements for this equipment. Retrofitting most facilities to handle this type of equipment will be costly and difficult.

Bringing some of the surveyed facilities into compliance with the governing

mechanical and electrical codes is expected to be more costly than new construction. This is due, in part, to a lack of physical space in which to install the required systems. Examples of this are:

The existence of concrete floor slab-on-grade construction, where the floor would have to be removed to install new plumbing or mechanical systems; and,

Buildings that have little or no space between ceilings and the roof framing for the installation of mechanical systems.

Although, in some instances the report recommends facility replacement based upon the conclusion that it would not be cost-efficient to attempt to bring the facility up to current hospital construction standards by remodeling or renovation, many of those facilities may still be useful for non-hospital programs.

The reports do not recommend the correction of noted deficiencies when the costs involved appear to outweigh the benefits. In such instances replacement is suggested. In other instances the reports recommend immediate remedial action to correct hazards even though the final conclusion is for replacement of the facility.

### III. PRIORITIZATION OF SURVEY FACILITIES

In conducting the inventory and evaluation study of the fifteen hospitals and long-term care facilities, the architectural consultants identified six facilities which are in greater need of immediate attention than others, due

to their more severe physical and functional deficiencies. To arrive at a ranking of all surveyed facilities based upon relative need for construction to correct noted deficiencies, the Department assembled a committee to review the report. This committee consisted of one member of:

The Alaska Medical Facility Authority;  
The Alaska State Hospital Association  
Southeast Alaska Health Systems Agency, Inc;  
South Central Health Planning and Development, Inc.;;  
The Medical Care Advisory Committee, and  
The Statewide Health Coordinating Council.

The ranking provided by this committee was based only upon the relative severity of all physical and functional deficiencies found at each facility and did not consider other factors such as facility utilization or population trends: The committee ranking was as follows:

- 1.) Cordova Community Hospital and Long-Term Care Facility
- 2.) Petersburg General Hospital and Long-Term Care Facility
- 3.) Seward General Hospital
- 4.) Kodiak Island Hospital and Long-Term Care Facility
- 6.) Wesleyan Nursing Home
- 7.) Wrangell General Hospital
- 8.) South Peninsula General Hospital and Long-Term Care Facility
- 9.) Ketchikan General Hospital and Island View Manor
- 10.) Central Peninsula General Hospital
- 11.) Bartlett Memorial Hospital
- 12.) Valdez Community Hospital

13.) St. Ann's Nursing Home

14.) Norton Sound Regional Hospital

To develop a construction plan for addressing the need for correcting the noted deficiencies, the Department considered the recommendations given in the report and the recommended ranking provided by the review committee in light of factors other than physical characteristics such as occupancy rates, population trends, accessibility, and alternative sources of health care. The construction plan (attached as an appendix) recognizes the need for an orderly progression for each facility on a year to year basis from preparation of long-range planning to design and then to construction. The plan also recognizes the fact that some of the facilities have completed the planning phase or design phase and are prepared to proceed with the correction of deficiencies. For these reasons the construction plan is not entirely consistent with the prioritized listing which was based only upon the severity of deficiencies. The plan also spreads the estimated costs for planning and construction over a five year period.

For some facilities the consultants report provided estimated costs for correcting deficiencies. For other facilities where estimated costs were more difficult to assess the report recommended long-range planning before establishment of cost estimates. Readers of this report should note that the estimated costs have been proposed without the benefit of detailed long-range planning and should only be viewed as guidelines. The costs shown in the report and construction plan are estimated 1982 values without projection for inflation and do not include other project costs such as fees, equipment, or site acquisition. More accurate figures have been presented for the Petersburg facility since that facility is nearing the end of the design phase.

The estimated costs shown are provided as a guideline in determining the dimensions of a given community's need. No estimates have been made or indeed can be made from this inventory as to the level of State assistance appropriate to any one community.

The construction plan emphasises the need for long-range planning prior to construction. The consultant report indicates that sufficient long-range planning was not done before construction of several of the facilities surveyed. The Department recommends a requirement for formal long-range planning for those facilities which have not begun or have not have adopted a long-range plan before any State funding is provided. One important aspect of long-range planning is to identify possible future expansion and thereby, avoid "boxing in" service areas which can reasonably be expected to require more space in future years. Long-range planning and State policy development should also consider both Pioneers and non-Pioneers requiring long-term nursing care. The expected growth of the age group of Alaskans eligible for Pioneer services, which include skilled nursing care, make this an important consideration.

#### IV. ALTERNATIVE SOURCES OF CONSTRUCTION FUNDS

Possible sources for construction funds are limited and apparently do not meet the needs of most of the surveyed facilities. Existing sources are:

##### Revenue Sharing

Under AS 29.90 municipalities or other hospital or health facilities sponsors may receive reimbursement for up to 25% of total project costs. This partial reimbursement is available only to those facilities which have successfully secured financing and have completed a health facility construction project. Most rural facilities do not have the capacity for debt required to secure

financing for completion of a facility. For this reason access to the partial reimbursement is essentially denied to those facilities.

#### Alaska Medical Facility Authority

Under AS 18.26 medical facilities may apply to the Alaska Medical Facility Authority for State backing relative to the sale of tax-exempt bonds for the purpose of financing medical facility construction. One project has been financed through this program to date -- a 1978 Fairbanks Memorial Hospital expansion project in the amount of approximately \$12 million. Alaska Hospital and Medical Center, Anchorage, is presently working with the Authority for the refinancing of that facility and the acquisition of the adjacent professional office building.

One determination which the Authority must make before bonds may be issued under this statute is that the lease or operator agreement for the medical facility being financed by that issue is at least sufficient to meet all obligations in connection with the lease or operator agreement, including all costs necessary to service the bonds. This prerequisite essentially disallows / use of the program by rural facilities, most of which do not have more than a minimal capacity for servicing bonds.

#### Federal Funding

Federal funding for health facility construction provided under the Hill-Burton program is no longer available.

Congress has approved a program which may provide construction funds for the purpose of converting existing hospitals and long-term care facilities to

other uses. The intent of this program is to provide for an orderly closure of an unneeded hospital or long-term care facility. This program has not been funded and would not serve the needs of Alaskan facilities which are seeking funds for renovation or replacement.

The only Federal funds which are available for health facility construction are essentially limited to construction or renovation of Federally owned facilities such as Public Health Service hospitals or Veterans hospitals.

#### Municipal or Borough Bonds

The issuance of municipal or borough bonds is a possible source of funds for community hospitals. Most of the surveyed facilities are, however, located in municipalities or boroughs which do not have the bond capacity necessary to meet more than a portion of estimated construction costs.

#### Direct Legislative Funding

Direct legislative funding through the sale of bonds or from general funds has been an important source of State support for health facility construction, particularly for rural facilities. There are, however, several problems which may result from a direct legislative appropriation to a named recipient. This method of funding has provided excess funding in some instances, and insufficient funding in other instances, since, under this method, funding levels are necessarily set before reliable cost estimates are available. An excess of funds usually results in additions to the original building concept such as additional administrative space, another operatory or another feature which may not be essential. Insufficient funding either causes delays

in project construction, incomplete projects, or the construction of a facility which is reduced in scope from the original design.

#### Conventional Loans

Conventional loans from lending institutions may be another source of construction dollars for hospitals; however, lending institutions usually have more stringent requirements and higher interest rates than previously mentioned alternatives.

### V. DETERMINING A STATE ROLE IN HEALTH FACILITY CONSTRUCTION

The question of the appropriate state role in assisting construction needs of existing facilities is a complex one. This report has noted that the State and Federal Government have previously had roles in establishing and/or assisting with the construction of many health care facilities. With the discontinuation of Federal funds which had previously supported construction of health care facilities, the State's role has become less clear and in need of further exploration and definition. Regardless of the extent of the State's role, the fact remains that many of Alaska's health care facilities, which are deemed to be needed facilities by virtue of access to the services they provide, are in need of renovation, modernization or replacement in order to continue to make quality health care reasonably accessible to Alaskans as well as to the many visitors to this State.

Health facility construction funding is presently limited to the aforementioned alternatives. The likelihood of Federal assistance for which Alaska facilities would be eligible any time in the near future is remote. Health facility construction need not be bound by current programs if it is determined that the State has a role in assisting with systematic health facility upgrading and construction.

Two legislative proposals address the need for a statutorily established health facility construction program. House Bill 844 and the identical Senate Bill 782 pose one possible format for a program addressing health facility construction. These bills would create a fund within the Department of Health and Social Services for plant improvements and maintenance at rural health facilities. The bills provide that the Statewide Health Coordinating Council will make recommendations to the Commissioner of the Department of Health and Social Services as to the prioritization of projects. Under these bills the prioritization of projects would be based upon:

- 1) The condition of the existing physical plant of a rural health facility (as determined by an annual inventory prepared by the Department of Health and Social Services);
- 2) The ability of the rural health facility to continue to provide quality health services;
- 3) The need in the community for additional services; and
- 4) The ability of the rural health facility to meet current licensure standards.

Although the concept of providing state assistance to rural health facilities as outlined in these bills appears valid, the bills do have some shortcomings. The bills apparently provide for total State funding of construction of rural health facilities. It can be argued that the State has a responsibility for ensuring access to quality health care facilities by its citizens by providing

grant funds when other sources of funding are non-existent or insufficient; however, the Department does not believe the State has a responsibility to totally fund health facility construction. Some level of local support for health facility construction is essential.

The Department has historically supported the establishment of a formalized health facility construction program in Alaska to better guide the allocation of limited resources. The completed rural hospital and nursing home inventory and condition survey and the committee's review comments described in this report are viewed as the first step in the development of a systematic approach to state assistance for health facility construction. Such an approach should include the following components as well:

- a Statewide Medical Facilities Plan
- certificate of need review
- a funding mechanism
- construction progress assessments

A proposed format and discussion of these components follows:

#### Statewide Medical Facilities Plan

A hospital construction assistance program should be based upon a Statewide Medical Facilities Plan which sets out the future needs for medical facilities in the State. This plan may be included as a part of the State Health Plan prepared on a regular basis by the Department of Health and Social Services and the Statewide Health Coordinating Council. The purpose of the Statewide Medical

Facilities Plan would be to orderly set forth and prioritize the need for construction of health facilities. The format of such a plan should be determined by the Department of Health and Social Services; however, the development and approval of the plan would involve the individual hospital, the Statewide Health Coordinating Council, the Alaska State Hospital Association, the State Health Planning and Development Agency, and the health systems agencies or successor organizations. To provide a data base for the plan, each facility would be requested to submit, on a voluntary basis, a long-range plan. The long-range plan would, at a minimum, anticipate the facility's program needs and construction needs for the current year and the next five years. These institution-specific plans would be included and prioritized in the Statewide Medical Facilities Plan by the Division of State Health Planning and Development and approved by the Statewide Health Coordinating Council (SHCC). In its consideration for approval of the Statewide Medical Facility Plan the SHCC would consider public input, certification and licensure reports, the State Health Plan, and other pertinent information.

#### Funding Mechanism

The funding mechanism should allow sufficient flexibility to permit non-grant financing to be used in conjunction with grant funds. Planning and design of a hospital construction project should be completed to the degree necessary to establish reliable construction cost estimates before construction funding levels are determined. The mechanism might also serve to reduce the inaccuracy of funding levels by providing separate allocations for 1) planning and design, and 2) construction. Although some adjustments to cost estimates will occur during construction this method of determining funding levels

will reduce the excess funding and funding shortfalls which have resulted from current methods of funding hospital construction.

The first step in any building program is the perception that a need exists. Typically, the perception of the need for a building program results from observable facility inadequacies: The facility is too small, too old, does not provide sufficient space for a recently perceived need such as birthing room, long-term care rooms, ultra-sound services, for example. As such, the need for a building program is generally perceived on a local level by physicians, facility staff, the community served by the facility and is subsequently brought before the facility's board of directors for approval. The State may point out the need for a building program as a result of licensure or architectural surveys; however, it is essential that the people who work in the facility and are served by the facility be involved in the development of a solution to an identified need if the solution is to be acceptable.

Once a need has been perceived, active planning begins with a need survey and feasibility evaluation. The work required by the need survey will depend upon the specific points of the perceived need. If the perceived need is to meet a code requirement, the need survey may simply be a statement of the facts. If the perceived need is for a new facility, the need survey would be more extensive, identifying what services the community desires, what services may reasonably be offered in the community, and workloads for those services. The most important point to determine with the need survey is whether the perceived need is an actual need.

## Certificate of Need Review

The certificate of need review is essential to any process whereby State funds are provided for hospital and nursing home construction. It is this review which offers a safeguard against the proliferation of health care beds, avoids unnecessary duplication of facilities, and gives assurance that the size and cost of facilities are reasonable.

The above noted need survey and feasibility evaluation are the major components of a certificate of need application. A positive indication by the need survey and feasibility evaluation usually result in the issuance of a certificate of need approving the requested construction project. (When a negative indication results from the need survey or feasibility study the facility's board generally does not proceed with the submission of an application for a certificate of need. As such, few certificate of need applications are disapproved.)

Where construction of a health facility is proposed the certificate of need review addresses considerations such as:

1. The relationship of the project to the State Health Plan;
2. The relationship of the proposed project to the long-range plan of the facility;
3. The relationship of the proposed project to the Health Systems Plan and Annual Implementation Plan of the Health Systems Agencies;

4. The need of the population to be served served by the facility;
5. The availability of less costly or more effective alternative methods of meeting the needs of the area to be served by the facility;
6. The immediate and long-term financial feasibility of the proposed facility;
7. The relationship of the facility to other existing health care facilities in the area;
8. The availabilitly of resources including health manpower, management personnel and the availability of funds needed for construction or those funds needed for operating costs;
9. The probable impact of the construction project on the cost of providing health services to the citizens to be served.

#### Level of State Assistance

Assuming certificate of need approval, one major decision regarding a proposed health facility project would remain: the appropriate level of state assistance for the project. The appropriate level could be determined in a simple and straight forward manner by the provision of a ratio of State assistance to local assistance, such as 70% State funding and 30% local match. Obviously several variations in the ratio are possible. An important consideration which this simple formula would overlook is the capability of the community served to provide the matching funds. The discontinued Federal Hill-Burton program for health facility construction worked on this basis: however, in Alaska the local match was provided by the State.

It may be more appropriate to establish an application process by which the facility would request an amount of State assistance with accompanying justification to support the request. Department of Health and Social Services staff or an advisory committee would review the application for State assistance and provide to the Commissioner a recommended level of State participation in the form of a grant, loan, loan guarantee or a combination. In this model a procedure would be established to coordinate the expenditure of grant funds with lenders, the Alaska Medical Facility Authority, and other possible funding sources.

Once any level of State funding has been established, the recipient should be required to demonstrate the availability of total construction funds necessary for the completion of the project before the expenditure of State funds. Such a demonstration will help avoid situations where funding is depleted before the project is completed or where the scope of a project is reduced to the point where the completed facility will be inadequate to fulfill needs and requirements for which it was originally planned.

#### Construction Progress Assessments

To give further assurance that funds will be sufficient to complete the project, it is advisable for the disbursement of funds to be made in phases according to the percentage of work completed. The Department of Health and Social Services currently reviews plans and specifications for hospital construction and intermittently visits construction sites to assure that the completed facility meets codes and it is acceptable for Medicare and Medicaid certification and State licensure. Under this program the Department of

Health and Social Services representatives would have the added responsibilities of verifying the percentage of project completion and reporting that percentage to the disbursement officer in charge of State funds for each project.

APPENDIX

FIVE-YEAR CONSTRUCTION PLAN FOR STATE HEALTH PLAN LEVEL III

HOSPITALS AND NURSING HOMES

## Notes to Five-Year Construction Plan for State Health Plan Level III

### Bartlett Memorial Hospital

A long-range plan has recently been completed. Preparation of plans and specifications for the correction of deficiencies may begin once the facility's board has assessed the long-range plan. The five year plan indicates \$2,000,000 for design during FY 85 with construction costs determined thereby in FY 86. The source of financing has not been identified.

### Central Peninsula General Hospital

Facility operations have recently expanded into a major addition for outpatient and administration departments. Another addition for needed beds and surgery department improvements is in the contracting phase. A borough bond issue has been approved for the purpose of financing the project and a certificate of need has been issued.

### Cordova Community Hospital and LTC Facility

Has recently completed a certificate of need application for a new structure. A bill for funding of the design phase is currently before the legislature. A decision regarding this application is expected in late March. The five-year plan indicates an estimated \$1,000,000 for design during FY 83 and \$13,000,000 toward construction in FY 84.

### Faith Hospital

Has completed preliminary drawings for an addition and renovation project. Funding has not been arranged. This facility's board has in the past indicated reluctance to accept State funding. The five-year plan suggests a sum of \$1,200,000 as needed for this project.

### Ketchikan General Hospital and Island View Manor Nursing Home

Has recently completed an extensive addition and renovation project. Funds shown anticipate future needs of \$50,000 in FY 84 for planning and \$1,000,000 in FY 85 for design. Construction costs as determined during these phases would follow in FY 86.

### Kodiak Island Hospital and LTC Facility

Is currently completing long-range planning and program work and has submitted a certificate of need application. \$1,000,000 for design and \$10,000,000 for construction are estimated for FY 84 and FY 85.

### Norton Sound Community Hospital

Recently occupied a new hospital wing and remodeled facility. \$50,000 for formal long-range planning is estimated for FY 85 with funds required for subsequent phases to follow in succeeding years. Long-range planning should consider both Pioneer and non-Pioneer long-term nursing care.

### Petersburg General Hospital and LTC Facility

\$10,000,000 is before the legislature. Planning and design has ben completed with funds provided from previous state grants.

### Seward General Hospital and Wesleyan Nursing Home

Should be encouraged to join in cooperative planning at an early date in order to maintain quality standards consistent with recognized goals. Long-range planning funds of \$40,000 for each facility are scheduled in FY 84 and design funds of \$1,500,000 in FY 85. Approximate construction costs for joint usage are shown at \$15,000,000 in FY 86. Long-range planning should consider both Pioneer and Non-Pioneer long-term nursing care.

### Sitka Community Hospital

A new Facility is under construction.

### South Peninsula Hospital

Has completed some preliminary planning and has been granted a certificate of need for an addition. A bill for funding has been introduced into the legislature to provide \$4,000,000 for construction in FY 83.

### St. Ann's Nursing Home

Occupies quarters which were remodeled and expanded in the late 1970s. Establishment of a Pioneer Home providing other nursing home services in Juneau would profoundly affect this facility. The five-year plan schedules long-range planning funds of \$40,000 in FY 84 and design funds of \$500,000 in FY 85. Construction funds as necessary would be designated in FY 86 following the design phase.

### Valdez Community Hospital

Is deficient in certain respects and should be studied particulary in regard to overall Harborview Developmental Center relationship and future need. Long-range planning funds of \$50,000 in FY 85 would establish probable costs to be considered in FY 86 and 87.

### Valley Hospital

Is currently completing construction drawings in accordance with the certificate of need issued. Construction is expected to begin in early summer of 1982

### Wrangell General Hospital and LTC facility

Has expressed a need for additional space to satisfy current standards and goals. Design funds of 1,000,000 are indicated for FY 83 with construction funds of \$8,000,000 in FY 84.

FIVE-YEAR CONSTRUCTION PLAN FOR STATE HEALTH PLAN LEVEL III

HOSPITALS AND NURSING HOMES

FACILITY	FY 1983	FY 1984	FY 1985	FY 1986	FY 1987
Bartlett Memorial Hospital Juneau	long-range plan is complete		\$2,000,000 for design	const. cost to be determined during design phase	
✓ Central Peninsula General Hospital Soldotna	Addition & remodel design is complete and construction to begin in 1982	construction is to be completed in FY 84 with borough funds			
Cordova Community Hospital & LTCF Cordova	\$1,000,000 for design of new facility	\$13,000,000 for construction of new facility			
Faith Hospital Glennallen	Addition & remodel \$1,200,000 for construction of new facility				
Ketchikan General Hospital and Island View Manor Ketchikan	new addition & remodeling has been completed	\$50,000 for long-range planning	\$1,000,000 for design	construction costs to be determined during design phase	
Kodiak General Hospital & LTCF Kodiak		\$1,000,000 for design	\$10,000,000 for construction		
Horton Sound Hospital & LTCF Nome			\$50,000 for long range planning	design costs to be determined in planning phase	construction costs to be determined in planning
✓ Petersburg General Hospital & LTCF Petersburg	\$10,000,000 for construction design to be comp. w/state grant fund				
Seward General Hospital Seward		\$40,000 for long range planning	\$1,500,000 for design	\$15,000,000 for construction	
Weselyan Nursing Home Seward		\$40,000 for long range planning (cooperative program)			
Sitka Community Hospital Sitka	A new facility is under construction				
✓ South Pen. General Hospital & LTCF Homer	\$4,000,000 for construction				
✓ St. Ann's Nursing Home Juneau		\$40,000 for planning	<sup>200,000</sup> \$500,000 for design	Construction costs to be determined in design phase	
✓ Valley Hospital & LTCF Palmer	Addition & remodel design is complete to be under construction in 1982				
Valdez Community Hospital Valdez			\$50,000 for long-range planning	design costs to be determined in planning phase	const. costs to be determined in design phase
Wrangell General Hospital & LTCF Wrangell	\$1,000,000 for design	\$8,000,000 for construction			
OTHER				unknown	unknown
<b>TOTAL</b>	<b>\$17,200,000</b>	<b>\$22,170,000</b>	<b>\$15,100,000</b>	<b>\$15,000,000 plus</b>	<b>\$15,000,000 plus</b>

\* LTCF = Long-Term Care Facility

APPROXIMATE COSTS SHOWN ARE ESTIMATED 1982 VALUES WITHOUT PROJECTIONS FOR FUTURE INFLATION AND DO NOT INCLUDE OTHER PROJECT COSTS SUCH AS FEES, EQUIPMENT, SITE ACQUISITION, ETC. THE ESTIMATED COSTS SHOWN ARE PROVIDED AS A GUIDELINE IN DETERMINING THE DIMENSIONS OF A GIVEN COMMUNITY'S NEED. NO ESTIMATES HAVE BEEN MADE OR INDEED CAN BE MADE FROM THIS INVENTORY AS TO THE LEVEL OF STATE ASSISTANCE APPROPRIATE TO ANY ONE COMMUNITY.

File

# Humana tries to block access to funds

4.12.91

By PATRICIA SOLOVEICHIK

TIMES BUSINESS WRITER

Humana Hospital—Alaska is working hard in the state Legislature this week trying to eliminate competing Providence Hospital from eligibility in a program designed to prioritize requests for millions of dollars in state aid on hospital construction projects.

Senate Bill 67, sponsored by Sen. Lloyd Jones, R-Juneau, is now in the Senate Finance Committee, where lobbyists for Humana are tussling over how to best "level the playing field" for the two Anchorage hospitals.

As the bill is written, Humana is excluded from receiving state grant money for health care facility con-

struction because it is a for-profit facility, while Providence is eligible for the aid as a non-profit organization.

Charles P. Stokes, Humana's executive director, said he backs amendments that would channel state aid to the smaller, rural hospitals and keep the larger facilities from the grant money.

"Humana or other large facilities should not have access to that money. I support giving it to the hospitals that need it," he said Thursday.

He said he is not convinced that the "basis of need" criteria set forth in the bill would weed out Providence Hospital as a beneficiary of state monies.

"I just want a level playing field," he said. "I have no problem with anyone getting the money if they need it."

Sen. Jones said the bill was born of a task force created to investigate the problems of rural hospitals in need of state aid for improvements. The small hospitals had little political backing and so were unsuccessful in getting state financial aid.

The proposal under discussion would create a board to prioritize requests on the basis of objective criteria, including need, and make recommendations to the Legislature, he said.

"Then we got into a problem with Humana. They didn't want to be in See Humana, page C5

## Humana

Continued from page C1

the process, but they wanted to hold Providence out," Jones said. He said the Humana lobbyist is pushing for an amendment sponsored by Sen. Albert Adams, D-Juneau, that would limit state aid to facilities with less than 200 beds.

"We decided to go back to the level playing field that they want by allowing for-profits to apply for state aid. Humana doesn't want it, but I can't see limiting access to the funds by statute. Down the road, there may be a 200-bed hospital that may really need the help," he said.

Humana's Stokes said he does not believe the state would allow

his facility to apply for funds because of its for-profit status.

Finance committee members were expected to submit at least two amendments for consideration today to address the perceived skewing of competition in favor of Providence, Jones said.

Janet Oates, spokeswoman for Providence, said the hospital

favors a bill that would open up the application process for all health care facilities, but added that Providence would not likely apply for the state money.

"We're leaving it up to the state Hospital and Nursing Home Association to settle this. We're trying to keep out of it," Oates said.

SB

74

FISCAL NOTE

No. 3

STATE OF ALASKA  
1992 LEGISLATIVE SESSION

J.A. Bill Version: SB 74

(S) Publish Date: 4-17-92

Revision Date: 12/27/91 1.3.92

Department Affected: Commerce & Econ. Dev.

Title: Relating to pooled health insurance who are uninsured or denied adequate coverage

BRU: Insurance

Sponsor: Senator Kerttula

Component: Operations

Requestor: Senator Kerttula

COMPONENT SERIAL NO. 

0	3	5	4
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EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
PERSONAL SERVICES						
TRAVEL	1.9	.6	.6	.7	.7	.8
CONTRACTUAL	7.5					
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	9.4	.6	.6	.7	.7	.8
CAPITAL	0	0	0	0	0	0
REVENUE FUND RESOURCE:	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	9.4	.6	.6	.7	.7	.8
FEDERAL FUNDS						
OTHER FUND SOURCE:						
TOTAL	9.4	.6	.6	.7	.7	.8

POSITIONS:

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

Estimate of current year impact: \_\_\_\_\_

ANALYSIS (Attach a separate page if necessary.)

SEE ATTACHED

Changes in C55374 (YES) have no fiscal impact. This fiscal note is appropriate.

15A12970 date MA Fouse Comte Aide (initial)

Prepared By: Don Koch, Chief of Market Surveillance Phone: 465-2577

Division: Insurance Date: 1/2/92

Approved by Commissioner: Glenn A. Olds Date: 1.10.92

Agency: Department of Commerce & Economic Development

Distribution (by preparer): Leg. Fin., Legislative Sponsor, Requestor, OMS/DBR, Gov. Legis. Off., and Impacted Agency(ies). Page 1 of 2

## FISCAL NOTE - SB 74

### ANALYSIS:

This legislation creates a health insurance pool for individuals who are uninsured or denied adequate coverage. It creates an association in which all insurers writing health insurance must participate as a condition to doing business. This fiscal note assumes that the full faith and credit will not be exposed by the association. It also assumes that the formation of the association will require the director's presence for three meetings. It also assumes that contractual assistance will be needed for the writing of any necessary regulations and review of plan of operation. Subsequent activity by the division should be contained by one annually after formation.

9052D

FISCAL NOTE

STATE OF ALASKA  
1992 LEGISLATIVE SESSION

JAN 28 1992 LL NO. SB 74

Revision Date: 12/27/91

Department Affected: Commerce & Econ. Dev.

Title: Relating to pooled health insurance  
who are uninsured or denied adequate coverage

BRU: Insurance

Sponsor: Senator Kerttula

Component: Operations

Requestor: Senator Kerttula

COMPONENT SERIAL NO. 

0	3	5	4
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EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
PERSONAL SERVICES						
TRAVEL	1.9	.6	.6	.7	.7	.8
CONTRACTUAL	7.5					
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	9.4	.6	.6	.7	.7	.8
CAPITAL	0	0	0	0	0	0
REVENUE FUND RESOURCE:	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	9.4	.6	.6	.7	.7	.8
FEDERAL FUNDS						
OTHER FUND SOURCE:						
TOTAL	9.4	.6	.6	.7	.7	.8

POSITIONS:

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

Estimate of current year impact: \_\_\_\_\_

ANALYSIS (Attach a separate page if necessary.)  
  
SEE ATTACHED

Prepared By: Don Koch, Chief of Market Surveillance

Phone: 465-2577

Division: Insurance

Date: 1/2/92

Approved by Commissioner: Glenn A. Olds

Asst. Comm.

Agency: Department of Commerce & Economic Development

Date: 1.10.92

Distribution (by preparer): Leg. Fin., Legislative Sponsor, Requestor, OMB/DBR, Gov. Legis. Ofc., and Impacted Agency(ies).

JAN 28 1992

FISCAL NOTE - SB 74

ANALYSIS:

This legislation creates a health insurance pool for individuals who are uninsured or denied adequate coverage. It creates an association in which all insurers writing health insurance must participate as a condition to doing business. This fiscal note assumes that the full faith and credit will not be exposed by the association. It also assumes that the formation of the association will require the director's presence for three meetings. It also assumes that contractual assistance will be needed for the writing of any necessary regulations and review of plan of operation. Subsequent activity by the division should be contained by one meeting annually after formation.

9052D/122691c

FISCAL NOTE

BILL NO. SB 74

STATE OF ALASKA  
1992 LEGISLATIVE SESSION

Revision Date: \_\_\_\_\_  
Title: An Act relating to pooled health insurance for individuals who are uninsured;

Department Affected: All State  
BRU: All State

Sponsor: Kerttula  
Requestor: Senate Finance

Component: All State

COMPONENT SERIAL NO. \_\_\_\_\_

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
PERSONAL SERVICES	116.6	270.5	2031.2	2031.2	2031.2	2031.2
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	116.6	270.5	2031.2	2031.2	2031.2	2031.2

CAPITAL	0	0	0	0	0	0
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REVENUE FUND SOURCE:	0	0	0	0	0	0
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FUNDING: (Thousands of dollars)

GENERAL FUND	116.6	270.5	2031.2	2031.2	2031.2	2031.2
FEDERAL FUNDS	0	0	0	0	0	0
OTHER FUND SOURCE	0	0	0	0	0	0
TOTAL	116.6	270.5	2031.2	2031.2	2031.2	2031.2

POSITIONS

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

Estimate of current year impact: none

**ANALYSIS: (attach a separate page if necessary.)** Passage of this bill will also increase personal services cost to political subdivisions and school districts by approximately \$1,640.1 in FY 95 and each year thereafter. See attached analysis for details.

Prepared By: Gary Bader *Nancy M. Bader*  
Division: Retirement and Benefits

Phone: 465-4470  
Date: April 27, 1992

Approved by Commissioner: Nancy Bear Usera  
Agency: Department of Administration

Date: 4/20/92

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB & Impacted Agency(ies).  
Rev 10/90 Page 1 of 5

Senate Bill 74  
 Analysis of Financial Impact  
 Prepared by the Division of Retirement and Benefits  
 Department of Administration  
 April 27, 1992  
 Page 2 of 5

Passage of this bill would require operating losses incurred by the Comprehensive Health Insurance Association to be shared by members of the Association. The Association may provide for assessments against individual members to meet these losses. This analysis is based on estimates of operating losses and the resulting assessments to the State's plans. These estimates have been developed by the State's health insurance carrier, Aetna.

For purposes of this analysis it is assumed that annual losses in the first year of operation of the insurance pool (FY 93) would be \$187,000. The second and third year losses would be \$432,120 and \$826,316 respectively. It is assumed that losses would become level after the third year.

The costs on page 1 of this fiscal note consist of two components-- active employees and retirement system contributions. These components are discussed separately below:

State of Alaska Costs

Active Employees

These operating losses when allocated to the State's plan for active employees would result in a \$.72/employee/month increase in cost for health insurance in the first year, \$1.67/employee/month in the second year and \$3.18/employee/month in the third and following years. The costs for active employees are calculated as follows:

FY 93		
13,500 employees X 12 months X \$.72 increase=		\$116.6
FY 94		
13,500 employees X 12 months X \$1.67 increase=		\$270.5

FY 95 (and following fiscal years)  
13,500 employee X 12 months X \$3.18 increase= \$515.2

Retirement System Contributions

The operating losses outlined above that are allocated to the State's retiree health plan will result in an increase to employer contributions to the Public Employees' (PERS) and Teachers' Retirement Systems (TRS). These increases will not become effective until FY 95. The increase in funding to both the Judicial Retirement System and the Elected Public Officers Retirement System is insignificant and not considered here.

The bill is estimated to increase the State's contributions by .20% of the Public Employees' Retirement System (PERS) payroll, and .16% of the Teachers' Retirement System (TRS) payroll. The FY 95 State PERS payroll, including the University of Alaska, is estimated to be \$707,802,127 (State \$626,535,254 and University of Alaska \$81,266,873). It is assumed payroll will remain level each year thereafter.

The FY 95 State TRS payroll, including the University of Alaska, is estimated to be \$482,697,507 (Department of Education/Legislature \$5,857,379 and the University of Alaska \$56,901,980). TRS salaries are also assumed to remain level each year thereafter.

The estimated FY 95 increase in contributions for the State of \$1,516.0 is calculated as follows:

Estimated State PERS FY 95 payroll	\$626,535,254	
PERS contribution rate increase	x <u>0.20%</u>	
State total PERS cost .....		\$1,253.1
Estimated University of Alaska PERS FY 95 payroll	\$81,266,873	
PERS contribution rate increase	x <u>0.20%</u>	
U of A total PERS cost .....		\$ 162.5
Estimated Department of Education/ Legislature TRS FY 95 payroll	\$5,857,379	
TRS contribution rate increase	x <u>0.16%</u>	
DOE/Leg total TRS cost.....		\$ 9.4
Estimated U of A TRS FY 95 payroll	\$56,901,980	
TRS contribution rate increase	x <u>0.16%</u>	
U of A total TRS cost .....		\$ 91.0

FY 95 increased retirement system costs..... \$1,516.0

TOTAL FY 95 STATE COSTS  
INCLUDING ACTIVE HEALTH COSTS \$2,031.2

Political Subdivision and School District Costs

Political subdivisions throughout the state will also see their costs increase in the same manner as the State, that is in two components- active employees health costs and increased contributions to the retirement systems.

Political Subdivision/School District Active Employees

FY 93  
1200 employees X 12 months X \$.72 increase= \$10.4

FY 94  
1200 employees X 12 months X \$1.67 increase= \$24.0

FY 95 (and following fiscal years)  
1200 employee X 12 months X \$3.18 increase= \$45.8

Political Subdivision/School District Retirement System Contributions

In addition to the State's costs above, political subdivision costs would increase by \$922.4 in FY 95 calculated as follows:

Estimated Political Subdivision		
PERS FY 95 payroll	\$461,219,955	
PERS contribution rate increase	<u>X</u> .20%	
Political Subdivision PERS cost.....		\$922.4

Estimated School District TRS		
FY 95 payroll	\$419,938,149	
TRS contribution rate increase	<u>X</u> .16%	
School District TRS cost.....		\$671.9

FY 95 increased retirement system costs for  
political subdivisions..... \$1594.3

TOTAL FY 95 POLITICAL SUBDIVISIONS COSTS  
INCLUDING ACTIVE EMPLOYEE HEALTH COSTS..... \$1,640.1

Passage of this bill would result in a .3% decrease in the PERS funding ratio and increase the present value of the unfunded liability of the PERS by \$9,532,000. The TRS funding ratio would decrease by .2% and the present value of its unfunded liability would increase by \$3,605,000.

FISCAL NOTE No. 4

Bill Version: SB 74

**STATE OF ALASKA  
1992 LEGISLATIVE SESSION**

BILL NO. : (S) Publish Date: 4-17-92

Revision Date: 4/7/92

Department Affected: Health & Social Services

Title: An Act relating to pooled health insurance.....

BRU: Medicaid

Component: Medicaid Non-Facility

Sponsor: Kertulla

Requestor: Senate HESS

COMPONENT SERIAL NO. 

2	2	9	
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**EXPENDITURES/REVENUES: (Thousands of Dollars)**

OPERATING	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
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 FUND SOURCE:	0	0	0	0	0	0

**FUNDING (Thousands of Dollars)**

GENERAL FUNDS	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER FUND SOURCE:	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

**Estimate of current year impact:**

ANALYSIS: (Attach a separate page if necessary.)

See attached note

Changes in CSSM 4 (HE) have no fiscal impact. This fiscal note is appropriate.  
Kimberly B. Busch date April 7, 1992  
Comte Aide (initial)

Prepared by: Kimberly B. Busch  Phone: 465-3355

Division: Medical Assistance Date: April 7, 1992

Approved by Commissioner: Theodore A. Mala, MD, MPH 

Agency: Health and Social Services Date: April 7, 1992

Distribution (by Preparer): Leg. Fin., Legislative Sponsor, Requestor, OMB/DBR, Gov. Legis. Ofc., & Impacted Agency(ies)

## FISCAL NOTE

### STATE OF ALASKA 1992 LEGISLATIVE SESSION

BILL NO. SB No. 74

Revision Date: 4/7/92 Department Affected: Health & Social Services  
 Title: An Act relating to pooled health insurance..... BRU: Medicaid  
 Component: Medicaid Non-Facility

Sponsor: Kertulla  
 Requestor: Senate HESS

**COMPONENT SERIAL NO.**

2	2	9	
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**EXPENDITURES/REVENUES: (Thousands of Dollars)**

OPERATING	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
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
<b>TOTAL OPERATING</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

<b>CAPITAL</b>	0	0	0	0	0	0
<b>REVENUE FUND SOURCE:</b>	0	0	0	0	0	0

**FUNDING (Thousands of Dollars)**

GENERAL FUNDS	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER FUND SOURCE:	0	0	0	0	0	0
<b>TOTAL</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>

**POSITIONS:**

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

**Estimate of current year impact:**

ANALYSIS: (Attach a separate page if necessary.)

See attached note

Prepared by: Kimberly B. Busch Phone: 465-3355  
 Division: Medical Assistance Date: April 7, 1992

Approved by Commissioner: Theodore A. Mala, MD, MPH   
 Agency: Health and Social Services Date: April 7, 1992

Distribution (by Preparer: Leg. Fin., Legislative Sponsor, Requestor, OMB/DBR, Gov. Legis. Ofc., & Impacted Agency(ies))

FISCAL NOTE ATTACHMENT

4/7/92

SB 74

We believe it is the intent of SB 74 in proposing 21.55.300(b) that coverage under the plan presented in this bill would cease when Medicaid eligibility was found to exist. We recommend, if this is correct, that this section be amended to specifically exclude Medicaid recipients from coverage in order to prevent confusion on this point. In our view, it would make little fiscal sense not to exclude the few Medicaid recipients who would qualify as "high risk" state plan eligibles, as each person who has, if even for a short period of time, overlapping dual coverage would result in the state plan making some payments in lieu of Medicaid payments. This would produce small Medicaid program savings, but would result in the loss of the 50% federal funds employed in the Medicaid program.

Even if this assumption is correct, there may be a very small number of persons, possibly fewer than 200 per year, for whom the plan may pay for medical expenses which could have been paid for by Medicaid. Medicaid provides for coverage of unpaid medical bills for a period of up to three months prior to the month of application, provided that the recipient would have been eligible in any of those months and that unpaid bills exist for covered services provided in that month. Anyone who had bills paid by the plan during this retroactive Medicaid period would not have Medicaid payment for these bills.

The Medicaid application provides none of the information that is necessary to determine whether a recipient would be a plan eligible, and even if it did, we would be unable to accurately assess the average costs such potential dual eligibles might shift from Medicaid to the plan. Therefore, this fiscal note presents no calculation of potential savings from this cost shift.

FISCAL NOTE

STATE OF ALASKA  
1991 LEGISLATIVE SESSION

BILL NO. SB No. 74

JAN 28 1992

Revision Date: \_\_\_\_\_ Department Affected: Health and Social Services  
 Title: An Act Relating to Pooled health Insurance for individuals who BRU: Medicaid  
are uninsured or denied adequate coverage; and providing for an effective date. Component: Medicaid Non-Facility  
 Sponsor: Kertulla  
 Requestor: \_\_\_\_\_ COMPONENT SERIAL NO 2-2-9

Expenditures/Revenues: Thousands of Dollars

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
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	0.00	0.00	0.00	0.00	0.00	0.00

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

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	0	0	0	0	0
TOTAL	0.00	0.00	0.00	0.00	0.00	0.00

POSITIONS:

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

Estimate of current year impact: None

ANALYSIS: (Attach a separate page if necessary.)

See attached note

Prepared By: Kimberly B. Busch Phone: 465-3355  
 Division: Medical Assistance Date: 2-25-91

Approved by Commissioner: [Signature] Date: \_\_\_\_\_  
 Agency: Health and Social Services

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impact Agency(ie

## SB 74

We believe it is the intent of SB 74 at Sec. 21.55.300(b) that coverage under the plan proposed by this bill would cease when Medicaid eligibility was found to exist. We recommend, if this is correct, that this section be amended to specifically exclude Medicaid recipients from coverage in order to prevent confusion on this point. In our view, it would make little fiscal sense not to exclude the few Medicaid recipients who would qualify as "high risk" state plan eligibles, as each person who has, if even for a short period of time, overlapping dual coverage would result in the state plan making some payments in lieu of Medicaid payments. This would produce small Medicaid program savings, but would result in the loss of the 50% federal funds employed in the Medicaid program.

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# Alaska State Legislature

## SENATE

Official Business


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

**TO:** Senator Arliss Sturgulewski  
Chair, Senate HESS Committee

**FROM:** Senator Jay Kerttula

**SUBJECT:** Senate Bill 74  
High Risk Health Insurance Pool

**DATE:** January 28, 1992



I would appreciate your scheduling Senate Bill 74, relating to high-risk health insurance pools.

High risk pools are pools of **insurers**. States will ask insurance companies to share the costs of medical care for people with high risk medical problems - individuals whom insurance companies have rejected.

To create a high risk pool, a state generally forms an association of all health insurance companies doing business in the state. The enabling language creates a board of directors and the board is responsible for developing the authorizing legislation's intent about benefits, eligibility and pricing. The legislature sets the premium rate (somewhere between 125 to 150 percent of the standard individual premium in the state)

Senate Bill 74 is based on model legislation which has been approved by 24 states. Senate Bill 74 would require all health insurance companies, hospitals and medical service corporations (that offer subscriber contracts for major medical coverage) to join a high risk pool.

All state residents who are "high risk" would be eligible for insurance through this pool at a "reasonable rate." In addition, Senate Bill 74 also provides for a Medicare supplement plan for state residents who are high risks and 65 years of age or older.

*With Assoc. of Health Ins.*

Additionally, Alaskans who have had their health insurance terminated once they have become "high risk", would be eligible for this health insurance plan.

According to the 1988 GAO report, approximately 1% of the population was estimated to be medically uninsurable in 1986. Based on these "rough" figures, 5,000 plus Alaskans would qualify for high risk insurance.

Senate Bill 74 sets a cap on a premium of 125 percent of the average of five instate rate estimates.

In theory, premiums cover the majority of claims paid by the pool. In practice, however, premiums are generally insufficient because of a premium cap and because the high risk participants in the pool are likely to create more costs than the premium will cover.

A 1988 GAO study concluded that for every \$1.00 received in premiums by the current operating pools, \$1.60 is paid out in claims. Senate Bill 74 takes the approach taken in most states with pools; it assesses the pool members for the excess costs in proportion to their share of the state health insurance market.

Experience in most states indicates that plans lose money over the cost of a year. While losses can at times be large, the cost has been in the range of 1 percent of the total amount of premiums collected from all health insurance policies sold in those states.

High-risk pools may be the only way that individuals with severe or chronic health conditions can obtain adequate major medical coverage. While Senate Bill 74 in no way solves the problem of ensuring that all Alaskans have adequate health coverage, it is one piece of the puzzle and a most necessary one.

JK:pt  
attachments

# Alaska State Legislature



Sen. Jay Kerttula, Co-Chairman  
Sen. Pat Pourchot, Co-Chairman

Sen. Al Adams  
Sen. Jim Duncan  
Sen. Lyman F. Hoffman  
Sen. Dick Shultz  
Sen. Rick Uehling

State Capitol  
Juneau, AK 99801-1182  
(907) 465-1200  
(907) 463-3066 Fax

Box 1009  
Palmer, AK 99645  
(907) 376-2675  
(907) 376-0315 Fax

## Senate Finance Committee

### CONTENTS OF SB 74 PACKET

#### SENATE HEALTH EDUCATION AND SOCIAL SERVICES COMMITTEE

- 1) SPONSOR STATEMENT
- 2) SECTIONAL ANALYSIS AND COPY OF BILL AND FISCAL NOTE
- 3) LEGISLATIVE RESEARCH ANALYSIS OF FINANCIAL IMPACT OF SENATE BILL 74 AND REDUCTION OF BAD DEBT
- 4) LETTER OF SUPPORT FROM SOUTHERN ALASKA LIFE UNDERWRITERS ASSOCIATION
- 5) NEWS ARTICLES
- 6) HEALTH BENEFITS LETTER ON HIGH RISK POOLS IN OTHER STATES

# Alaska State Legislature



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Palmer, AK 99645  
(907) 376-2675  
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## Senate Finance Committee

### Sponsor Statement

#### Senate Bill 74

SB 74 is a bill to establish a high risk insurance pool for those who are deemed medically uninsurable due to a preexisting condition which makes it impossible for them to buy insurance on the open market.

All state residents who are deemed "high risk" would be eligible for insurance through this pool at a "reasonable rate". In addition, Senate Bill 74 also provides for a Medicare supplement plan for state residents who are high risks and 65 years of age or older. Approximately 5,000 Alaskan residents would be eligible under this plan.

Senate Bill 74 does not require a subsidy from the general fund.

More and more Alaskans are finding they cannot get health insurance even if they can pay for it. Insurance company practices, in Alaska, and nationally, shifted away from health insurance plans that were open to all, to a practice

of selectively deinsuring individuals the company thinks have risks of experiencing claims.

The health insurance industry practice of skimming off the the low risk healthy populations and individuals has recently become significantly more aggressive.

Small employers cannot get health insurance if one employee, or the employee's child has asthma or another pre-existing condition. Nationally, commercial carriers do not sell policies to individuals that have heart disease, cancer, diabetes, stroke, adrenal disorders, epilepsy or ulcerative colitis. Even asthma and mild hypertension are now likely to cause a rejection. Treatment for depression or a visit to a marriage counselor or a psychiatrist are also likely to trigger a rejection.

If you are rejected or dropped from coverage, that fact is recorded at the Medical Information Bureau in Boston, an industry clearing house. The next company to which you apply is likely to check your file with the Bureau and also deny you coverage.

If individuals have a less serious condition, they may get coverage with an exclusion rider. The company may offer policies to exclude coverage for conditions such as

glaucoma, recent knee operation, migraine headaches, varicose veins, arthritis, a caesarian delivery, or even a chronic ear infection in a child.

Between 1/4 and 1/2 of all policies carry these exclusion riders. Even if your health is perfect, you may be denied coverage because you are in a profession that is more likely to file claims, switch jobs frequently, or because you do hazardous work. Those who fall into this category are barbers, florists, medical practitioners, miners, commercial fishermen, waiters, maids, railroad workers, lawyers, fry cooks, house painters, car wash operators, loggers, pilots - to name just a few.

Blue Cross and Blue Shield used to offer policies that anyone could buy. Today, because of the skimming practices of other carriers, even the Blues decline coverage of health problems and use exclusion riders and higher premiums.

26 other states have created risk pools known as comprehensive health insurance associations. Many other states are considering such legislation.

Senate Bill 74 reflects the model legislation created by the National Association of Insurance Commissioners.

In brief, SB 74 creates a nonprofit health insurance association made up of all health insurance carriers who write major health insurance in the state. The Association also includes hospital and medical services corporations that offer subscriber contracts. Members must participate as a condition of doing business in the state.

Subject to the approval of the Director of the Division of Insurance, DCED, the Association organizes itself, uses its Board of Directors and offers major medical insurance to those who have been rejected by two carriers in the previous six months, or who have had a restrictive rider placed on a subscriber contract. The association will contract with one of its members to administer the plan.

The premiums are capped at 125% of the rate charged for standard coverage for a similar plan in the state. For example, if the standard coverage for a similar plan were \$100, the premium under this plan would be \$125.

Senate Bill 74 complements other remedies and health care options which have been reviewed and recommended by the Health Cost Containment Task Force. It is one piece of the health insurance puzzle that the legislature is looking to resolve. It can stand alone and can be moved forward

without waiting for other legislation. It would provide relief for an important group of individuals who are presently unable to get insurance.

What happens when goals can't come  
speeding health insurers of document

notary affect for

that in SB 83 - Should not be in Health Authority

Nationally 1% of premiums.

How much would standard policies increase

What will impact on bad debt.

SB 74

A HIGH RISK POOL FOR THE UNINSURABLE

SB 74 Creates a mechanism to make health insurance available to those who are unable to obtain health insurance on the open market.

COMPREHENSIVE HEALTH INSURANCE ASSOCIATION

The bill creates a Comprehensive Health Insurance Association which is a non-profit incorporated legal entity

MEMBERSHIP

Membership in this association is mandatory for all health insurers as a condition of doing business in Alaska.

BOARD OF DIRECTORS

A board of 7 directors is chosen by the members from the membership subject to the approval of the Director of the Division of Insurance. The Director of the Division of Insurance will serve as a non-voting ex-officio member of the board. (To be amended)

POWERS AND PROCEDURES

The association, exercising the powers granted to an insurer, establishes administrative and accounting procedures to administer the state high risk health insurance plan. These procedures will be used to contract with a carrier to administer the state plan. The association may sue or be sued.

PLAN OF OPERATION

The plan of operation is approved and may be modified by the Director of the Division of Insurance.

The association is exempt from the Administrative

Procedure Act and exempt from state taxes.

#### TYPES OF HIGH RISK INSURANCE:

Two types of plans must be offered;

1. an individual state plan of health insurance covering major medical for high risk individuals, or
2. medicare supplement policy for those over 65 years of age who are high risk

#### ELIGIBILITY

TO QUALIFY FOR HIGH RISK COVERAGE one must be able to show that the individuals have been state residents for six months who;

1. have been rejected by two health insurance carriers in the previous 6 months for medical reasons, or
2. have a policy but an exclusion rider has been placed on a medical condition.

#### BENEFITS

The high risk policy covers major medical services like that available to groups that are not high risk. There is a lifetime maximum of \$1,000,000 for usual, customary and prevailing charges. The covered services are detailed in SB 74. Coverage includes hospital services, professional services, laboratory and X-ray services, and prescription medications among others. Please see SB 74 for details.

#### COPAYMENT AND DEDUCTIBLE

The high risk plan other than the Medicare supplement plan may require deductibles of \$200, \$500, and \$1000 and copayments of 20% to a limit of \$2000 after which payment is at 100%. Mental Health services require a 50% copayment to a limit of \$4000 per year.

#### PREEXISTING CONDITIONS

Preexisting conditions can be excluded from coverage for a period of 6 months if the condition became evident within the previous three months.

However, there is a waiver of the preexisting condition waiting period if the preexisting condition waiting period has been satisfied while the person was covered by a policy from which they have been involuntarily terminated.

#### PREMIUMS

The premium charged the individual is capped at 125% of the average premium paid by those of standard risk. The premium will vary only on the basis of age and the geographical location of the insured.

#### ADMINISTRATION OF THE PLAN

The selection of the writing carrier to administer the state plan will be based on the carrier's efficiency, ability and estimate of total charges.

Members are assessed for losses in excess of premiums in proportion to the proportion of the premiums written in the state.

Each member insurer of the association shall share the losses due to claims and administrative costs and the costs of the administration of the association that are in excess of the income from premiums. The loss is shared among all insurers in proportion to the proportion of premiums written in the state by that insurer. (Experience in other states is that the assessment to insurers does not exceed 1% of the total premiums written. Thus premiums state-wide should not increase more than 1% as a result of this assessment.)

Net gains shall be held at interest and used by the association to offset future losses.

#### ENROLLMENT

Provides that a state resident at high risk is eligible to enroll in the state insurance plan. It prohibits enrollment if other coverage exists.

#### WRITING CARRIER'S RESPONSE

Requires the plan to accept or reject an application for enrollment within 30 days.

#### EFFECTIVE DATE OF POLICIES

The policy is effective from the date of the application if the first quarterly premium has been received and the applicant qualifies for the policy.

#### TRANSITION FROM PREVIOUS POLICY

If a person is involuntarily dropped from coverage, is denied coverage by one other carrier, and if the person applies to the plan within 60 days of termination and pays the premium, their coverage applies retroactively to the date they were terminated from coverage.

#### SOLICITATION OF ELIGIBLE PERSONS

Requires the association to solicit eligible persons for enrollment through use of the press, radio, and television. Insurers and HMOs that reject a person from coverage, or apply underwriting restrictions shall notify the applicant of the existence of the state plans, the requirements for being accepted, and the procedure for applying.

#### DUTIES OF THE DIRECTOR

The Director of the Division of Insurance must approve the association's plan, the association's contract with the writing carrier including the coverage and premiums to be charged, and pass regulations to administer the chapter.

#### STATE NOT LIABLE

Provides that the state is not liable for acts of the association.

**PROPOSAL BY SENATOR KERTTULA  
FOR EXPANDED AVAILABILITY OF  
HEALTH INSURANCE FOR ALASKANS**

**HIGH RISK POOL  
SENATE BILL 74**

*(Montana's plan is used to give an idea of potential impact in Alaska. Montana's plan is more restrictive than proposed in SB 74. Montana's 1990 population was 803,655 compared to Alaska's 1990 population of 551,947.*

**EXISTING  
PLAN**

\$1,000 Deductible

**SB 73/74  
PLAN**

\$200, \$500 & \$1,000 deductibles. Premium Cap of 125%. \$1 million lifetime benefit.

**PROJECTED  
STATE COST**

\$30,000 Admin. start-up costs

**PROJECTED  
PREMIUMS**

*(Montana's prem. schedule + 35 % added costs)*

<17: 100.60  
<24: 150.05  
<29: 161.87  
<34: 179.46  
<39: 202.18  
<44: 229.51  
<49: 255.67  
<54: 284.27

**PROJECTED  
INS. IND. COST**

No more than 1 % of total health ins. premiums sold.

**PROJ.  
HOSP/DR.**

0

**SENATE BILL 73**

*(The SCOPE plan offered in Denver is used to give an idea of the potential impact in Alaska. The SCOPE plan does not have a public subsidy, the proposal in SB 73 would include a sliding scale for the low income. The cost projections are based on a pilot project in a community of 2,110 with 30% uninsured; an average premium cost of \$65 per month, an average state subsidy of \$20 per month, per participant.*

\$250 Deductible for hospital care. 0 deductible for preventative care. 50% copay. of first \$5,000 for hospital care, 100% thereafter. \$15 copayment for Dr. visit, not a preventative visit. 0 copay. for Dr. preventative visit. Unlimited lifetime benefit for under 70, \$50,000 lifetime benefit for over 70.

Emphasize prev. care/ nominal copay. deemphasize hosp. care with a large deductible & copayment.

\$200,000

*(Premiums based SCOPE premiums + 35 percent)*

<30: 44.31  
<34: 55.37  
<39: 65.58  
<44: 78.66  
<49: 94.58  
<54: 114.47  
<59: 139.39  
<64: 171.95

0

20 % discount

# DIVISION OF LEGAL SERVICES

## LEGISLATIVE AFFAIRS AGENCY STATE OF ALASKA

P.O. Box Y, Juneau, Alaska 99811  
(907) 465-3867 or 465-2450  
FAX (907) 465-2029

Deliveries to: 240 Main Street  
Court Plaza, Room 500  
Mail Stop 3101

### MEMORANDUM

January 24, 1991

SUBJECT: Pooled Health insurance - SB 74

TO: Senator Jay Kerttula

FROM: Michael F. Ford *M.F.*  
Legislative Counsel

The following is a sectional analysis of SB 74:

#### Section 1 - Purpose.

#### Section 2

Sec. 21.55.010 - Establishes the comprehensive health insurance association and provides that membership in the association consists of certain insurers.

Sec. 21.55.020 - Establishes the board of directors of the health insurance association and provides for voting rights of members.

Sec. 21.55.030 - Establishes the general powers of the association.

Sec. 21.55.040 - Requires the association to submit a plan of operation. Establishes specific items that the plan of operation must include.

Sec. 21.55.050 - Exempts the association from the Administrative Procedure Act.

Sec. 21.55.060 - Provides that the association is exempt from taxation, except for taxes on real or personal property.

Sec. 21.55.100 - Requires the association to make insurance available to residents who are high risks. Specifies the type of deductible to be offered and requires that a medicare supplement plan also be provided to certain residents.

Senator Jay Kerttula  
January 24, 1991  
Page 3

Section 3 - Requires the association to make insurance available to eligible residents by January 1, 1992.

Section 4 - Effective date.

MFF:pl  
91-024.plm

# Alaska State Legislature

Legislative Research Agency



130 Seward Street, Suite 218  
Juneau, Alaska 99801-2196

Phone: (907) 465-3991  
Fax: (907) 463-3351

March 19, 1992

## MEMORANDUM

TO: Senator Jay Kerttula

FROM: Paul Engelman *PE*  
Legislative Analyst

RE: Financial Impact of Senate Bill 74: High Risk Insurance Pool  
Research Request 92.179

As requested in your memorandum of February 14, 1992 we have estimated the financial impact of the high risk health insurance pool created by Senate Bill 74 (SB 74). In this memorandum we discuss the assumptions needed to make the estimates, estimate the impact of the legislation on bad debts incurred by medical providers, and estimate the effect the bill will have on Medicaid payments.

The approach taken in this analysis was to be as actuarially conservative as possible. As a result, the cost estimates may be higher than those developed previously. The alternative that would generate the highest rate was used wherever a choice was presented. The only exception to this was choosing between Alaska information and information from other regions. In these cases the Alaska data was used.

The analysis yielded a monthly rate of \$181 per insured for the "high risk" pool, a monthly rate increase of \$3.30 for the "main" pool members, and a maximum potential monthly savings of \$1.12 for the "main"-pool members because of bad debt reduction. The attached table shows how computations were made.

3.30  
1.12  
2.18

## Assumptions

Rates: The Alaska rates are based on the experience of nine states with high risk pools that have been in existence for three or more years.<sup>1</sup> Since all but one of these states has a cap on participant premiums that is greater than the 25 percent cap proposed in SB 74, the premiums in each state are adjusted down to reflect the income they would earn with a 25 percent cap on premiums.

<sup>1</sup>Health Benefits Letter, Scandlen Publishing, Inc. Alexandria, October 23, 1991. The original source is *Communicating for Agriculture*.

Senator Kerttula  
March 19, 1992  
Page 2

**Pool Participants:** Two insurance pools are associated with SB 74. A "main" pool consists of Alaskans who have private health insurance and are not in "ERISA" programs.<sup>2</sup> This pool is based on Alaska enrollments in Aetna (86,200 subscribers) and Blue Cross of Washington and Alaska (71,900 subscribers), who underwrite the bulk of this business (75 percent) according to Chris Ulmann of the Division of Insurance. The number qualified for the pool is adjusted to include other commercial health insurers in Alaska. The final estimate is 209,500.

The size of the second or "high risk" pool is based on the Minnesota experience and is estimated to have 3,180 participants in Alaska. The nine-state average could be used and would result in a lower estimate of 703 participants; however the higher number is used because it is the one that yields the maximum potential liability for the program.

Two estimates identifying the cost of the high risk insurance premiums were considered. The first estimate uses the premium revenue and enrollment from the nine-state "high risk" pool. The premiums are adjusted to reflect a 25 percent cap in each state then the average rate based on total enrollment is determined. This rate reflects costs in the "lower forty-eight" and was adjusted to reflect Alaska medical costs.<sup>3</sup> This resulted in a capped rate of \$192.

The second approach uses an average rate for the "main" pool as identified by the Division of Insurance.<sup>4</sup> This rate, \$145, was increased by 25 percent to reflect the cap on the high risk pool. This resulted in a rate of \$181 for the "high risk" pool. The lower rate of \$181 is used since it directly reflects the Alaska insurance experience.

**Claims/Expenses:** Because the claims figures are provided on a paid rather than an incurred basis resulting in an understatement of total liability, 3 percent

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<sup>2</sup>"Self-insured firms are exempt under the Employee Retirement Income Security Act (ERISA)." Source :*Focus On*, Office of Intergovernmental Affairs, Health Care Financing Administration. DHHS, February, 1988

<sup>3</sup>Costs were adjusted using the ACCRA cost of living index for health expenditures produced by the American Chamber of Commerce Researchers Association.

<sup>4</sup>Personal communication with Chris Ulmann.

is added to the paid claims to adjust to an incurred claim amount.<sup>5</sup> Another 5 percent is added to the loss ratio to cover the incremental administrative costs of claims payments. With these two adjustments, the "fully funded" loss ratio (the ratio of the sum of claims and administrative costs to premiums) is estimated to be 220 percent. That is, costs are estimated to be 120 percent higher than the premiums if the rate cap is 25 percent.

#### Estimating the Impact

Estimating the effects of SB 74 using this information is uncomplicated. The annual high risk premium is equal to the monthly premium multiplied by the number of high risk pool participants times 12 months. This yields premium income of \$6,916,500. Multiplying the premium income by the loss ratio of 220 percent yields claims and operating expenses of \$15,216,300. Subtracting the claims and operating expense from the premium income yields a loss of \$8,299,800. This is the amount that must be distributed among the "main" pool. Based on these calculations, each member of the "main" pool will be assessed an additional premium of \$3.30 per month or 1.82 percent of the base premium amount.

One of the effects of the pool is the reduction of bad debts incurred by doctors, hospitals, and other health care providers. The effect of the pool on bad debts is also uncomplicated once an amount of the high risk claims that would have been bad debts has been determined. Based on discussions with Larry Bartlett of Health Systems Research, Inc. of Washington, D.C., bad debts are assumed to be equal to 50 percent of the total high risk claims. Since the "main" pool of 209,500 constitutes 38 percent of the current population and assuming that the health care utilization rate by the "main" pool is the same as the total population, if all of the benefits of the bad debt reduction experienced by the providers were passed along to the pool members, the maximum benefit that the "main" pool could receive would be \$1.12 or 0.62 percent of the base premium. The balance of the benefits are distributed to other

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<sup>5</sup>Paid claims usually understate the liability that corresponds to the premiums earned for two reasons. 1) there is a lag in the payment of claims: the claims paid at the beginning of the current period reflect claims incurred in the previous period (as much as 90 percent of the claims paid in January were incurred in December) and the claims paid at the end of the period do not reflect the full amount of claims incurred (these claims will be paid in the next period). Since costs are generally increasing the claims incurred at the end of the period will be more costly than those that are paid at the end. By estimating the amount of payment lag, an adjustment to the paid claims to reflect the difference in costs at the beginning of the period and the end of the period can be made. 2) If the insured group is increasing or decreasing in size the number of claims will increase or decrease, respectively. Adjusting to an incurred amount of claims will also reflect the change in claims due to changes in group size.

Senator Kerttula  
March 19, 1992  
Page 4

Alaskans not in the pool. If either the hospitals or insurance companies do not pass the full amount of the benefit to the public or members of the pool the benefit will be less.

The estimate of the effect of distributing the losses of the "high risk" pool to the "main" pool can change significantly depending on the size of the pools. For example, a decrease of 10 percent in the number of people in the "main" pool will result in a cost increase of \$0.37 per individual when the losses from the high risk pool are charged back.

#### The Effect on Medicaid Payments

After contacting several individuals in the agency that determines which individuals qualify for Medicaid, we were unable to develop an estimate of the impact of the high risk pool on Medicaid, although it is likely to be quite small. Those individuals contacted felt the number of people who "spend down" in order to qualify for these programs is very small (1 percent or less).<sup>6</sup> In addition, it is highly unlikely anyone with sufficient discretionary cash income to be able to afford the premiums for this program would qualify for Medicaid benefits (a young mother living with someone was the only specific instance mentioned). If this is the case, the impact of the high risk pool on Medicaid recipients would be very small. Unfortunately none of the individuals who were contacted could do more than talk in broad generalizations; as a result, we did not feel comfortable developing a rate. None of the individuals contacted knew of any study of individuals "spending down" to qualify for Medicaid.

The agency staff indicated an interest in the pool as a way to insure some of their low income high risk individuals (Medicaid would pay the premiums). My understanding is Medicaid qualified individuals would not be eligible for the "high risk" pool the way it is now structured. However if they were determined to be eligible, these individuals would reduce the benefits to the State by shifting money away from federal Medicaid dollars to Alaska insurance dollars.

We hope this information is useful to you. If you have any questions or would like additional information, please contact this agency.

Attachment

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<sup>6</sup>Most of the information was supplied by Chris Aschenbrenner, Gordon Landes and Curt Lomas.

## Impact and Rating Information for SB 74

### High Risk Health Insurance Pool Experience Selected States - 1990 (From Health Benefits Letter)

<u>State</u>	<u>Enrollment</u>	<u>Premium Cap</u>	<u>Premiums Paid</u>	<u>Claims Paid</u>	<u>Loss Ratio</u>	<u>1990 Population</u>	<u>Enrollment % of Pop.</u>
Connecticut	2,200	150%	\$4,496	\$10,438	232%	3,296	0.07%
Florida	5,934	300%	\$12,444	\$17,425	140%	13,003	0.05%
Indiana	3,080	150%	\$8,377	\$16,978	203%	5,564	0.06%
Iowa	1,971	150%	\$4,574	\$5,054	110%	2,787	0.07%
Minnesota	25,272	125%	\$25,735	\$49,470	192%	4,387	0.58%
Montana	304	400%	\$629	\$570	91%	804	0.04%
Nebraska	2,904	165%	\$4,423	\$6,760	153%	1,585	0.18%
North Dakota	1,303	135%	\$2,571	\$4,312	168%	541	0.20%
Tennessee	4,121	150%	\$10,775	\$17,121	159%	4,897	0.08%
<b>Total / Average</b>	<b>47,089</b>	<b>158%</b>	<b>\$74,024</b>	<b>\$128,128</b>	<b>173%</b>	<b>36,964</b>	<b>0.13%</b>
Experience Adjusted to a 125 percent cap =			\$60,366	\$128,128	212%		

1) Average Monthly Premium Paid **\$131**  
 Adjusted to a 125 percent Cap **\$107**  
 Adjusted to Alaska Costs Using  
 ACCURA Cost Index **\$192**

2) Average Monthly Premium Based  
 on Division of Insurance Data **\$145**  
 Adjusted to 125 percent Cap **\$181**

#### Alaska Enrollment in High Risk Pool

1) Based on Nine State Average **703**  
 2) Based on Minnesota Experience **3180**

## Estimating the Effects of SB 74

### Assumptions

Number of insured's in Main Pool*	209,500
Number of Insured's in High Risk Pool	3,180
Premium with a 125 Percent Cap	\$181
Paid Loss Ratio	212%
Factor to Adjust Paid Claims to Incurred	3%
Incremental Claims Payment Cost	5%
<b>Fully Funded Loss Ratio</b>	<b>220%</b>

Annual Income (Premium x pool x 12 months)	\$6,916,500
Annual Claims Expense (Income x Loss Ratio)	\$15,216,300
Losses to be Covered by Main Pool	\$8,299,800
Annual Cost per Main Pool Member	\$39.62
Monthly Cost per Main Pool Member	\$3.30

### **Effect on Bad Debts**

Assume 50 percent of the estimated claims amount would have ended up as bad debt (probably would be less)

Estimated bad debt reduction                      \$7,435,238

Savings to insurance pool members (assumes that the insurance pool covers 38 percent of the population).                      \$2,825,390

Maximum possible reduction of premiums ( insurance companies transfer full savings)  
\$1.12                      0.62%

\*Based on 86,200 Aetna + 71,900 Blue Cross = 75% Main Pool  
Source: Division of Insurance (Chris Ulmann)

Prepared by Legislative Research, March 1992 (92.179)

MEMORANDUM

14 April 1992

TO: Senate HESS Committee Members

FROM: Senator Arliss Sturgulewski, Chair

Following are recommendations regarding the amendments proposed by the division of insurance and others.

**DO NOT RECOMMEND ADOPTION:**

Pages 1-6 of amendments offered by div of insurance.  
These amendments combine the associations of SB 74 & SB 242

**RECOMMEND ADOPTION:**

Page 7 of amendments offered by div of insurance.  
Provides additional options for deductibles. Clarifies Medigap coverage available only to high risk residents covered by Medicare. Clarifies state plan coverage must be made available to eligible high risk residents.

**DO NOT RECOMMEND ADOPTION:**

Page 8-12 of amendment offered by division of insurance.  
Establishes a benefit committee to decide benefits offered by pool rather than outlining benefits to be covered in statute.

**DO NOT RECOMMEND ADOPTION:**

Page 13 of amendments offered by division of insurance.  
This amendment is a clarifying amendment following adoption of amendments on pages 8-13.

**RECOMMEND ADOPTION:**

Page 14 of amendments offered by division of insurance.  
prohibits coverage where workers' compensation policy is available.

**DO NOT RECOMMEND ADOPTION:**

Page 15 of amendments offered by division of insurance.  
This amendment is a clarifying amendment following adoption of  
amendments on pages 8-13.

**RECOMMEND ADOPTION**

Pages 16 & 17 of amendments offered by division of insurance.  
clarifies that persons eligible for other health benefits are ineligible  
for this program.

Page 18 is a duplicate.

**RECOMMEND ADOPTION**

Page 19 of amendments offered by division of insurance.  
Clarifying amendment regarding licensed persons.

**RECOMMEND ADOPTION**

Page 20 of amendments offered by division of insurance.  
Clarifying amendment.

**RECOMMEND ADOPTION**

Page 21 of amendments offered by division of insurance  
Provides guidance as to what may constitute a medical condition.

**RECOMMEND ADOPTION**

Page 22 of amendments offered by division of insurance.  
Sets out requirements for legislative review of plan.

**OTHER SUGGESTIONS:**

**RECOMMEND ADOPTION:**

Page 2, Line 5.

after "division of Insurance, add: "at least two board members  
shall be consumers appointed by the director of the division of  
insurance"  
(offered by Kerttula)

**RECOMMEND ADOPTION:**

Page 2, line 17 through 23:

The association should have the power to receive funds from other sources.

RECOMMEND ADOPTION

Page 8, Line 17:

HIAA, Aetna, and the division of insurance all agree that the percentage amount that can be charged for premiums should be higher than 125% and probably should be 150%. (HIAA - 200%)

MEMORANDUM

10 April 1992

TO: Senator Arliss Sturgulewski

FROM: Staff

Following is a list of suggested changes or amendments to Senate Bill 74:

Page 2, Line 5.

OK after "division of Insurance, add: "at least two board members shall be consumers appointed by the director of the division of insurance" amendment by Kerttula

OK Staff recommends that it be the commissioner of the department of commerce who appoints members.

Page 2, line 17 through 23:

the division of insurance feels that the association should have the power to receive funds from other sources

Staff concurs

OK Page 2, line 28:

OK this section provides that if the association fails to act on a plan of operation, the director may adopt regulations. This provision was in the original SB 242 and it was felt that it was not

the duty of the director to act if the association dropped the ball.

*Staff recommends that the association be responsible for the plan of operations.*

Page 3, lines 4 through 17:

the division of insurance recommends that language be added to provide that the association establish standards for cost containment.

*Staff concurs.*

Page 3, lines 27 through 29:

the division of insurance and the HIAA both recommended removal of this section, division of insurance says it is redundant, and probably ok to leave in.

*Staff recommends it be left in.*

Page 4, line 5:

HIAA recommends reduction of lifetime maximum from \$1,000,000 to \$500,000.

*Staff recommends it be left at \$1,000,000*

Page 4, Line 12:

this section excludes dental services from the services offered under this plan.

*Staff recommends dental services be included.*

Page 5, Line 25 through 31:

HIAA recommends that the amount of the deductible be raised from the current amount in the bill of \$200, \$500, & \$1000 to \$1000 and \$5000.

*Staff has no recommendation, although \$1000 and \$5000 seems high.*

Page 6, Lines 17 through 31;

HIAA and the division of insurance both feel that the 6 month preexisting condition exclusion is too short and recommend it be lengthened.

Page 8, line 15:

the division of insurance feels that the estimate of rates should be submitted annually

*Staff concurs*

Page 8, Line 17:

HIAA, Aetna, and the division of insurance all agree that the percentage amount that can be charged for premiums should be higher than 125% and probably should be 150%. (HIAA - 200%)

Page 9, line 26:

HIAA & Aetna both feel there should be a prohibition against employers taking an employee out of the regular insurance policy and putting that employee into this insurance pool ("dumping").

*the insurance companies say that SB 242 will take care of the problem of high risk employees - this bill, however, is a much better deal for high risk persons, whether or not the employer is paying the premiums. The policy question is if the legislature feels that high risk persons should be subsidized, or run the risk of getting the boot from their employers because of the high insurance premiums an employer has to pay (SB 242 allows for 5x the premium base rate to be charged for high risk employees).*

Page 10, Line 28 through 31:

the division of insurance believes that there should be an exclusion in this section for persons who are able to obtain insurance through COBRA or conversion policies

Page 11, Line 1 & 2:

the division of insurance suggests that the director, by regulation, be able to add eligibility requirements.<sup>1</sup>

Page 12, Lines 6 through 14

here again, the director is responsible for duties that may be more appropriately assigned to the association itself.

Page 14, Line 5

Sen. Kerttula offered amendment deleting "for medical reasons" from this line. Both HIAA and Aetna object to this deletion on the grounds that the purpose of this legislation is to ensure that unhealthy individuals can get insurance. Sen. Kerttula's position is that persons are often denied insurance because of the class of persons they belong to.

*Staff has no recommendation.*

Page 14, Line 10:

add: (c) have been refused by two insurers to issue insurance except at a rate exceeding the state high risk plan rate (offered by Kerttula ) HIAA objects to adoption of this amendment.

*Staff has no recommendation.*

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<sup>1</sup> NOTE: the association itself is exempt from the administrative procedures act, but there are several references in the legislation to the ability of the director of the division of insurance to promulgate regulations affecting the operation of the association. There should be a policy decision made as to how much control the director has over the association.

**SUMMARY OF COMMENTS BY MEISELS RE: SB 74**

- 2000-01-10*
- ✓ Recommends the premium be 150 percent (rather than 125 percent) of average premium. Goes on further to suggest that it be 175-200 percent.
  - ✓ Recommends allowance of a credit against premium taxes (2.7%) *Policy discussion*
  - ✓ Recommends increase in deductibles (current bill = \$200, \$500, and \$1000)(recommendation=\$1000 & \$5000.)
  - ✓ Recommends removal of medicare eligible persons so that this will not act as medicaid supplement coverage.
- Recommends reduction of lifetime maximum from \$1,000,000 to \$500,000.
- Recommends extension of pre-existing condition exclusion from three months to 10 months.
- ✓ Recommends barring employers from paying premiums for that person so as to avoid "dumping" (goes on to say that SB 242 will eliminate the need)
- Recommends listing in the legislation of persons ineligible for coverage.
- Recommends deletion of section allowing persons to purchase insurance retroactively within 60 days of termination of previous coverage after making application.
- ✓ Recommends no adoption of amendment proposed by sponsor which deletes "for medical reasons" within the definition of high risk resident.
  - ✓ Recommends no adoption of amendment that would allow persons who have been refused by two insurers to issue insurance except at a rate exceeding the state high risk plan rate.

**SUMMARY OF COMMENTS BY MFISELS RE: SB 74**

✓ Recommends the premium be 150 percent (rather than 125 percent) of average premium. Goes on further to suggest that it be 175-200 percent. *could have a range 125-150%*

✓ Recommends allowance of a credit against premium taxes (2.7%)

Recommends increase in deductibles (current bill = \$200, \$500, and \$1000)(recommendation=\$1000 & \$5000.)

✓ Recommends removal of medicare eligible persons so that this will not act as medicaid supplement coverage. *Needs further discussion*

✓ Recommends reduction of lifetime maximum from \$1,000,000 to \$500,000.

✓ Recommends extension of pre-existing condition exclusion from three months to 10 months.

*6 months is 3 mo "lookback" provision*  
Recommends barring employers from paying premiums for that person so as to avoid "dumping" (goes on to say that SB 242 will eliminate the need)

*pg 9  
1/20*  
Recommends listing in the legislation of persons ineligible for coverage.

Recommends deletion of section allowing persons to purchase insurance retroactively within 60 days of termination of previous coverage after making application. *There - actually = continuity*

Recommends no adoption of amendment proposed by sponsor which deletes "for medical reasons" within the definition of high risk resident. ~~Amendment~~

Recommends no adoption of amendment that would allow persons who have been refused by two insurers to issue insurance except at a rate exceeding the state high risk plan rate.

PROPOSED AMENDMENTS TO SB 74

*Drafted by  
Senator Kistler*

*Rec. on  
medical cost  
state*

Page 2 line 5 after "division of insurance." Add:

"In addition at least 2 board members shall be consumers appointed by the Director of the Division of Insurance".

*removed fetal  
code  
model code  
5*

Page 14 line 4 delete "[for medical reasons]"

Page 14 between line 10 and line 11 Add:

"(C) have been refused by two insurers to issue insurance except at a rate exceeding the state high risk plan rate".

*NAAC model*

CARVE-OUTS FROM EMPLOYER GROUPS

This amendment addresses the potential problem of insurers' carving out unhealthy employees and dependents from employer groups and "dumping" such individuals into the high-risk pool. It is taken from the Connecticut statute governing that state's individual high-risk plan (Conn. Gen. Stat. Ann. §38a-556(c) (West Supp. 1992)).

Page 10, line 27 - Insert after the period:

"No member [of the association] shall be permitted to select out individual lives from an employer group to be insured by or through the association."

Page 9, lines 26-27 - Delete the entire subsection and re-letter the remaining subsections accordingly. This section contemplates employers' carving out unhealthy employees from the employer group and sending those risks to the high-risk plan. Such carve-outs by employers, as well as by insurers, are contrary to the purpose of the high-risk pool, will produce an excessively large pool, and should be illegal.

ELIGIBILITY FOR THE HIGH-RISK PLAN

This amendment clarifies that persons possessing or eligible for substantially similar coverage under other health plans are not eligible for the high-risk plan. It is taken from the NAIC's MODEL HEALTH INSURANCE POOLING MECHANISM ACT.

Page 10, lines 28-29 - Delete everything up to the period. Insert the following:

"A person shall not be eligible for coverage under the plan if the person has or obtains health insurance coverage substantially similar to or more comprehensive than a plan policy, or would be eligible to have coverage if the person elected to obtain it. Persons otherwise eligible for plan coverage may, however, solely for the purpose of having coverage for a preexisting condition, maintain other coverage only while satisfying any preexisting condition waiting period under a plan policy."

#### PREMIUM LEVEL

Page 8, line 17 - Delete "125" and insert "150". Setting the premiums as low as Minnesota's will push Alaska's pool into the same deficit situation as Minnesota is now facing (\$28 million). A low premium will unduly raise assessment levels for insurers and cause severe cost-shifting from the high-risk population to other insureds in Alaska.

#### REJECTION FOR MEDICAL REASONS

Page 14, line 4 - Reject the proposed amendment to delete "for medical reasons". The whole purpose of a high-risk plan is to enable unhealthy individuals who cannot get coverage to obtain it. Thus, the only rational basis for accepting otherwise rejected individuals under this plan is that they were rejected for medical reasons.