ALASKA LEGISLATURE COMMITTEE FILES 1991-1992 8672

7497 SENATE LABOR & COMMERCE

51

7/11/90 (4)

DISCUSSION DRAFT

Dear----------,

The Health Care Cost Containment Task Force has been reviewing the costs and availability of health care in ALASKA since March 1989. And has identified a number of cost management techniques for short and long range results. The short range measures have already been implemented and are showing positive results.

In order to properly evaluate long range health care cost management techniques the Task Force will be holding public hearings to gather additional information and perspectives.

I would like to extend an invitation for (you, your group) to attend and provide us with your input.The hearings will be held during September 1990.

Enclosed is some background information on the health care economy in Ålaska You will receive additional information as to the specific concern before the Task Force.

If you have any questions or comments please contact Dave Gray at 465-3822 or myself.

Sincerely,

WELLNESS PROGRAMS

Employer-sponsored wellness programs aim to improve and maintain the health of employees, and controls the rising cost of employer-provided health insurance by reducing the number of employee claims.

The varied wellness program offerings by employers range from education classes or seminars to complex fitness programs in sophisticated company exercise facilities. The goal of these programs is to encourage healthier life-styles for employees. "Wellness" concentrates on the "whole health" and well-being of the individual employee, and wellness programs promote better health habits to positively affect both the employee's work life and private life. The introduction of wellness programs in the workplace complements the more traditional health care system that treats illnesses as and after they occur. Generally, the programs are employer funded because few group insurance plans offer preventive programs.

Programs may involve smoking cessation, stress management, employee fitness, annual physicals, health risk appraisals, nutrition, weight control, hypertension, and back care. Overall health promotion programs may incorporate substance abuse programs, such as employee assistance programs, and screening programs for high blood pressure, early cancer detection, AIDS, glaucoma, and diabetes.

The challenge is to design a wellness/fitness program that matches the health care needs of the employees with the resources available. It doesn't have to be an elaborate, expensive program to be effective. There are several options available varying in cost and complexity that can bring positive, long-term health benefits. The first step is to evaluate the types of health problems most prevalent among employees, what staff resources are available to design and oversee the program, and how much money there is to spend.

Until recently, evidence suggests that there is very little concern on the part of the sponsors for measuring the effectiveness of their programs, particularly from a financial perspective. The sponsors' commitment to health promotion program evaluation and to the development of efficient evaluation strategies to measure their program returns is essential.

Recent Tax Reform Act provisions (which emphasize the economic viability of corporate investments as opposed to their tax sheltering characteristics) and increased competitive pressures from foreign corporations only serve to underscore the necessity for saving from program investment to be documented with sound empirical evidence.

FEDERAL GOALS

In listing its national health and disease prevention objectives for the year 2000, the federal government has targeted as its goal an increase in the proportion of worksites offering employer-sponsored fitness program.

According to a U.S. Department of Health and Human Services survey, nearly 66 percent of worksites with more than 50 employees had at least one health promotion activity in 1987, with smoking topping the popularity list.

Recognition of the need for wellness programs has also been acknowledged by the federal government in legislation. Although the law has provided for health services for federal employees since 1946, in 1986 the government clarified that the "health services" prescribed include physical fitness programs and facilities designed to promote and maintain employee health. As the nation's largest employer, the federal government actively encourages federal agencies to implement wellness programs to promote good health.

WELLNESS PROGRAMS

RESULTS

As reported by Business Insurance, April 17, 1989
Between 1986 and 1987, the "Taking Care" program introduced by Travelers in 1986 reported savings of 0.33 to 0.77 on doctor visits per employee; measured health behavior improvements in smoking, alcohol consumption, set belt use, relaxation practices, exercise and eating habits; a decrease in the projected death rate per 1,000 employees of 0.17 per year; and a perception of the program as a valued health care benefit for 81% of the employee population.

As reported by The American Journal of Health Promotion, November/December 1989
Between 1985 and 1986, the "TriHealthalon", a wellness voluntary program introduced by General Mills, Inc. reported that the percent of participants that smoke decreased form 21 to 16 percent. Sear belt usage increased from 44 to 71 percent. Improvements in lifestyle habits among TriHealthalon participants during the first two years of the program suggests it has increased lifestyle and health awareness among the participant group. It was also determined that there is a $3.10 to $3.90 payback for each dollar spent in developing the TriHealthalon program.

As reported by Health Care Promotion, November 1989

- DuPont's program, which includes fitness facilities, smoking cessation, health education, and counseling, has resulted in a 37 percent reduction in heart attacks among salaried employees and an 18 percent reduction among hourly employees.

- Health-care expenses for San Diego's school employees and firefighters average $548 a year less per employee for fitness program participants than nonparticipants.

- SpeedCall Corporation's smoking cessation and fitness program resulted in a 50 percent decrease in the number of insurance claims among employees who quit smoking.

- At Tenneco, the average medical claim for a non-exercising female employee was more than twice the average for women who participated in the in-house exercise program ($1,536/$639). For men, the average claim for non-exercisers was $1004 compared with $562 for exercisers.

- Lockheed Missiles and Space Company saved an estimated $1 million in life insurance costs through its wellness program.

- Absenteeism among exercising employees at Lockheed was 60 percent lower than for nonexercisers-and turnover was 13 percent lower among regular exercisers.

- A daily before-work aerobics class significantly reduced the number of on-the-job injuries among Marriott Hotel's housekeepers.

- Control Data in Minneapolis now pays $1.8 million less for health care each year because of its ten-year Stay Well program.

- Based on the results of its two-year wellness program AT&T estimates it will save $10 million or more in 10 years just from reducing the risk of cancer and heart disease among its workforce.

- A five-year study of Johnson & Johnson's Life for Life program revealed that hospital costs for participating employees were half that of nonparticipants. The reduction of hospital-related medical insurance costs alone more than pays for the $200 per employee spent annually on the wellness program.

RESULTS - CONTINUED

- For every dollar spent on its Stay Alive & Well program, which is provided to all employees, spouses, and retirees, **Blue Cross-Blue Shield of Indiana saves $1.45 million in health-care costs.**

As reported by Topics in Total Compensation, Summer 1989

Control Data Corporation has been keeping track of both specific employee health habits and medical costs, and is one of the few corporations that has conclusively matched the two. Control Data found that employees who smoke a pack of cigarettes a day generate 18% higher medical claims than nonsmokers; sedentary employees have claims 14% higher than individuals who exercise vigorously at least three times a week for a minimum of 20 minutes at a time; hypertensive and overweight (30% over ideal) employees have costs 11% higher for each group than healthy employees; and using seat belts less than 25% of the time while driving translates into 13% higher medical claims costs than when they are used more frequently.

As reported by Health Care Promotion, November 1989

- People who don't exercise have 36% higher health care costs and 54% longer hospital stays than people who exercise. Overweight people have 7% higher health care costs and 85% longer hospital stays than people who are thin. Companies with wellness/fitness programs report that employees who participate in these programs are absent half as much as nonparticipants, and their morale and productivity is markedly higher than nonparticipating employees.

- **Bank of America's Corporate Health Programs called "Be Your Best"** includes featured the monthly "Challenge" along with other components, which included the following: take your children, spouse or friend out for a walk at least three times a week; eat one generous serving of fresh fruit or salad, drink six glasses of water; and drink two glasses of low-fat milk every day. Complete a seven-minute stretching exercise every workday for a month. Every workday for a month find one cartoon or joke that made you laugh and share it with someone else at work. In the year before Bank of America trained 250 managers in their pilot program, stress-related workers' compensation claims in that region dropped from $124,000 to $29,000.

- **Bank of America's workers' compensation claims related to back injury exceed $1.3 million annually**, where the claims are concentrated in only a few departments. These departments were targeted for a program developed and implemented by a registered physical therapist on staff. The results after the first six months were substantial, not only in the reduction of the number of injuries, but also in days lost and workers' compensation claims. If the trends continue, Bank of America expects 245 fewer workdays will have been lost and $44,000 will have been saved in workers' compensation claims for the full year.

- **24% of Bank of America's employees smoke.** (The national average is 27%.) Studies have found that smokers cost their companies at least $400 more annually than nonsmokers in terms of increased medical care, absenteeism, etc. A pilot group of employees using an intervention program designed for physicians to help their patients stop smoking called **"Quit for Life"** enabled 22% of the pilot group to stop smoking.

As you can see the companies referred to above report significant savings in health care costs and marked improvements in employee productivity, morale, absenteeism, and retention. There are many low cost methods to provide employee health education, individual assistance, early detection, and exercise programs.

FEDERAL LEGISLATION

The Omnibus Reconciliation Act of 1989 (OBRA 1989). Congress passed on November 22, 1989 and signed into law on December 19, 1989. Designated as P.L. 101-239. A number of significant provisions affect employee benefits. Most are contained in Title VII of the Act, which is called the Revenue Reconciliation Act of 1989, of which the following is a summary:

Employee Stock Ownership Plans (ESOPs); changing the method of calculating the Social Security wage base; addition of ERISA Section 502 which levies a civil penalty for a breach of fiduciary duty; interest on employee mandatory contributions to defined benefit plans; quarterly contribution provisions apply on to single-employer defined benefit plans and do not apply to money purchase pensions; annual valuations of defined benefit plans rather than every three years; and the definition of normal retirement age.

This law also contained changes to the health care continuation law, COBRA, the changes follow:

o **Disabled Employees.**
Effective for plan years beginning on or after December 19, 1989, coverage extends 29 months (from 18 months) for qualified beneficiaries with a disability at the time of termination of employment or reduction in hours of employment. This amends IRC Section 4980(f)(2)(B). The disability could have occurred prior to the qualifying event. In order to be entitled to the extended continuation coverage, the qualified beneficiary must be determined under title II or XVI of the Social Security Act to have been disabled at the time of the termination of employment or reduction in hours.
Allowable premium charged to the beneficiary for the 19th through the 29th month form 102% to 150%.

o **Preexisting Conditions.**
COBRA coverage must be provided if the qualified beneficiary is covered under other health plans that do not provide coverage for pre-existing conditions. This provision is effective for qualifying events occurring after December 31, 1989 and for qualified beneficiaries electing COBRA coverage after December 31, 1988.

o **Premium Payment.**
Plan administrators may not require any premium payment until 45 days after the qualified beneficiary makes the initial election of COBRA coverage. This provision is effective for plan years beginning after December 31, 1989.

o **New Definition of Covered Employee.**
Covered employees entitled to COBRA coverage include independent contractors, partners and self-employed individuals covered under a group health plan. This provision is effective for plan years beginning after December 31, 1989.

o **Dependents' Eligibility.**
Dependents' eligibility for COBRA coverage is extended to a period of 36 months when the employee or former employee becomes entitled to Medicare benefits.

Physician Payment Reform (resource based relative value scale, or RBRVS) restructures the way Medicare reimburses physicians and is designed to contain Medicare's costs for physician payments as well as to reduce the perceived inequities in payment to primary care givers as compared to surgeons and other specialists. Volume performance standards were established. Effective in 1992, physicians will be compensated by Medicare based on RBRVS which will be phased in over a five year period. During the phase-in period, the physician will be paid in a combination of current payment methods and the fee schedule.

FEDERAL LEGISLATION

On Wednesday, December 13, President Bush signed into law H.R. 3607, the Medicare Catastrophic Coverage Repeal Act of 1989. Designated as P.L. 101-234. The repeal is effective January 1, 1990. Expanded hospital benefits, a new prescription drug benefit, and a cap on out-of-pocket doctor expenses have now been eliminated from the Medicare program. The Medicare surtax, which would have applied in 1989, was retroactively repealed. Congress retained provisions of the Act that improved coverage for certain low-income individuals and protected individuals from being forced into poverty when a spouse must be cared for in a nursing home.

On November 7, 1989, Congress repealed IRC Section 89. On November 11, 1989, President Bush signed the 1989 debt limit legislation into law. The debt ceiling bill essentially repeals the present law regarding nondiscrimination and minimum qualification standards and reinstates nondiscrimination rules in effect before the Tax Reform Act of 1986.

A SURVEY OF THE 101st CONGRESS ON HEALTH CARE LEGISLATION

Metropolitan Life conducted a survey of the priority key issues of the 101st Congress on health care legislation. Virtually all of the Congressional respondents surveyed say they regard health-care as either a "top priority" or "very important." 43% of the legislators surveyed think the nation's health-care system is in "a state of crisis."

Legislators reviewed a list of health care issued of concern to corporations and then name the main issue on the list facing the 101st Congress. For each of the issues listed, respondents were also asked to predict whether some form of related legislation will be enacted over the next two years. The results follow:

	Top Health Care Issues	Chances for Legislation
Long-term care for the elderly	33%	50%
Drug abuse	20%	56%
Modification of existing funding for Medicare catastrophic coverage	14%	35%
Insuring the uninsured	14%	12%
Infant mortality rate	5%	36%

Congress will assign priority to containing health care costs and extending health care coverage to all segments of society. Congress also has an eye on AIDS care research as well as the nursing shortage, Medicare reimbursement to physicians and hospitals, rural health care problems, Medicare/Medicaid funding, prenatal and pediatric care, and medical malpractice and liability.

STATE OF ALASKA

EXPENSE/UTILIZATION SUMMARY
ACTIVE EMPLOYEES--1ST QUARTER 1990

Gross Submitted Expenses

1st Quarter 1990 Versus 1989 Quarterly Average	0.0%
1st Quarter 1990 Versus 1st Quarter 1989	-7.5%

Net Paid Expenses

1st Quarter 1990 Versus 1989 Quarterly Average	-9.9%
1st Quarter 1990 Versus 1st Quarter 1989	-12.5%

Hospital Admissions

1st Quarter 1990 Versus 1989 Quarterly Average	-12.3%
1st Quarter 1990 Versus 1st Quarter 1989	-15.3%

Hospital Patient Days

1st Quarter 1990 Versus 1989 Quarterly Average	-22.3%
1st Quarter 1990 Versus 1st Quarter 1989	-33.5%

Average Hospital Length Of Stay

1st Quarter 1990 Versus 1989 Quarterly Average	-10.9%
1st Quarter 1990 Versus 1st Quarter 1989	-23.0%

(**Note:** ALOS For 1989=6.4 days; 1st Q 1989=7.4; 1st Q 1990=5.7)

Outpatient Surgical Procedures

1st Quarter 1990 Versus 1989 Quarterly Average	+5.1%
1st Quarter 1990 Versus 1st Quarter 1989	+3.1%

Inpatient Surgical Procedures

1st Quarter 1990 Versus 1989 Quarterly Average	+2.1%
1st Quarter 1990 Versus 1st Quarter 1989	-5.9%

PER EMPLOYEE PLAN EXPENSE BY TYPE OF CARE 1ST QUARTER 1990 VS. 1ST QUARTER 1989

Inpatient Hospital	**-18.6%**
Inpatient Surgical	**-8.3%**
Outpatient Surgical	**+5.7%**
Outpatient Physician (Non-Surgical)	**-3.8%**
Chiropractic	**-33.9%**
Outpatient Mental/Nervous Substance Abuse	**-12.0%**

HOSPITAL INPATIENT PRECERTIFICATION

Condition	Confinements Certified	Confinements Not Certified	% Not Certified
Medical/Surgical	950	93	8.9
Maternity/Pre-Natal	272	11	3.8
Adolescent Psychiatric	15	12	44.4
Alcohol Abuse	33	6	15.3
All Other Psychiatric/ Substance Abuse	143	10	6.5
Total	**1413**	**132**	**8.5%**

OUTPATIENT PRECERTIFICATION

	Total Certified	Total Not Certified	% Not Certified
Managed 2nd Opinion	124	13	6.4%
Outpatient Precert	323	22	9.5%

ESTIMATED POPULATIONS OF ALASKANS WHOSE HEALTH CARE COSTS ARE DIRECTLY, INDIRECTLY, OR PARTIALLY PROVIDED FOR BY THE STATE

Employee/retiree/other	Dependents	Totals
1. State Active Employees		
13,070	18,925	31,995
2. Retirees (State, Muni, School) (PERS & TRS).		
10,500	9,800	
Up to 60% reside in state.		
6,300	5,900	12,200
#. Local Govt. Active Employees (PERS).		
13,600	18,400	32,000
4. Teacher Actives (TRS).		
8,200	11,000	19,200
5. Univ. of Alaska.		
3,035	3,204	6,239
6. Corrections (prisioners).		
2,516		2,516
7. Medicaid/Medicare Eligibles. Division of Medical Assistence		
41,000		41,000
		(144,150)

Notes:

A. Some of the people appearing in item 2 will be counted in item 7.

B. Estimates of dependents in items 3 and 4 assume that the groups exhibit the same age and sex characteristics as in group

From: Div. R&B

STATE OF ALASKA
Family Demographics
March 1990

Age	Employee Only	EE + spouse	EE + 1 child	EE + 2 or more children	EE + spouse + 1 child	EE + spouse + 2 or more children	Total
16-20	17	1	1	0	1	0	20
21-25	196	37	15	7	21	10	286
26-30	569	170	52	35	96	151	1073
31-35	855	283	82	93	227	544	2084
36-40	996	382	129	156	328	928	2919
41-45	866	355	152	155	350	917	2795
46-50	594	410	96	90	297	478	1965
51-55	379	360	29	22	144	147	1081
56-60	219	222	12	3	55	34	545

61-65	114	110	3	0	14	4	245
66-70	22	24	1	1	3	1	52
71-80	2	2	0	0	0	0	4
81-85	0	1	0	0	0	0	1
TOTAL	4829	2357	572	562	1536	3214	13070

STATE OF ALASKA
Spouse Demographics
March 1990

Age	*Number*
15-20	4
21-25	91
26-30	492
31-35	1180
36-40	1610
41-45	1487
46-50	1094
51-55	600
56-60	306
61-65	147
66-70	43
71-80	24
81-85	5
86+	3
TOTAL	7086

STATE OF ALASKA
Dependent Demographics
March 1990

Age	*Number of Dependent Children*
0-5	2250
6-10	2895
11-15	2969
16-19	2346
20-23	1299
24+	80
TOTAL	11839

ASSOCIATION OF ALASKA SCHOOL BOARDS
316 W. 11th St. • Juneau, Alaska 99801-1510 • (907) 586-1083

February 7, 1990

Senator Tim Kelly
Alaska State Legislature
P.O. Box V
Juneau, Alaska 99811

RE: SCHOOL DISTRICT HEALTH CARE COSTS

Dear Senator Kelly:

Annually, when we conduct our Salary and Benefit Surveys, we ask questions relating to health care costs for various categories of employees.

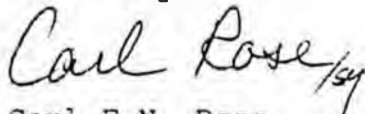
The enclosed information shows, by district, what kind of premiums are currently being paid for single employees and employees with families.

In the past we have asked for total health care costs for teachers and administrators, but have overlooked asking that question for *classified employees*. We are quickly surveying districts so that we can provide you with that additional piece of information -- to complete the overall picture of total health care costs for *all* employees. Hopefully we can get that information back from districts fairly quickly.

Like you, we have a real interest in helping school districts find ways to control the rapidly increasing costs of health insurance. We are also concerned that any proposed solutions will actually provide a real benefit to districts.

If we can assist you further in this regard, please don't hesitate to let us know.

Sincerely,



Carl F.N. Rose
Executive Director

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STATEWIDE: SCHOOL DISTRICT MEDICAL EXPENDITURES FOR TEACHERS

DISTRICT	REGION	ADM	FTE CERT STAFF	MED PREM S	MED PREM F	TOT DISTRICT COST
ADAK	SW	655	43	$1,873		$71,200
ALASKA GATEWAY	INT	458	40	$1,274	$3,848	$103,182
ALEUTIAN REGION	SW	112	13	$2,200	$6,000	$36,200
ANCHORAGE	SC	37,176	2,355	$2,438		$5,981,395
ANNETTE ISLANDS	SE	419	39	$1,266	$3,835	$90,124
BERING STRAIT	NW	1,261	128	$760(SI)	$1,986(SI)	$554,000
BRISTOL BAY	SW	249	25	$1,260		$31,500
CHATHAM	SE	321	39	NA	NA	
CHUGACH	SC	94	14	$1,392	$4,217	$45,052
COPPER RIVER	INT	591	45	$4,680	$4,680	$210,600
CORDOVA	SC	425	35	$1,303	$3,949	$113,767
CRAIG	SE	227	17	NA	NA	
DELTA/GREELY	INT	897	60	$1,883	$5,691	$276,000
DILLINGHAM	SW	445	40	$1,931	$5,489	$151,804
FAIRBANKS	INT	13,696	863	Self Insured	$4,069	$3,511,256
GALENA	INT	145	19	NA	NA	$47,947
HAINES	SE	331	32	$1,894(SI)	$5,692(SI)	$156,000
HOONAH	SE	255	19	$1,883	$5,690	$59,348
HYDABURG	SE	100	11	$1,368(SI)	$2,748(SI)	$61,884
IDITAROD	INT	389	40		$4,300	$164,160
JUNEAU	SE	4,575	295	$3,324		$980,580
KAKE	SE	183	19	$4,320(SI)	(SI)Self Insure	$79,920
KASHUNAMIUT	SW	165	17	$3,109(SI)	$6,011(SI)	$47,000
KENAI	S[illegible]	8,438	569	$4,529(SI)	$4,529(SI)	$2,432,277
KETCHIKAN	SE	2,498	170	$1,820	$5,018	$608,677
KLAWOCK	SE	203	16	$537(SI)	$1,871(SI)	$40,935
KODIAK	SW	2,341	160	$1,693	$5,129	$481,182
KUSPUK	SW	384	45		$5,235	$237,958
LAKE & PENINSULA	SW	357	41	$1,392	$4,218	$104,282
LOWER KUSKOKWIM	SW	2,768	241	$2,210(SI)	$2,210(SI)	$552,500
LOWER YUKON	SW	1,264	125	$911	$2,763	$165,479
MAT-SU	SC	8,744	508	$4,664	$4,664	$2,391,840
NENANA	INT	194	18	$1,524	$4,392	$53,998
NOME	NW	753	51	$1,319	$4,164	$169,936
NORTH SLOPE	NW	1,246	145	(SI)Self Insure	$2,550	$400,000
NW ARCTIC	NW	1,632	123	$1,800	$1,800	$235,000
PELICAN	SE	41	6	$1,783	$5,691	$25,640
PETERSBURG	SE	657	46	$1,873	$5,676	$156,445
PRIBILOF	SW	151	13	$1,876	$5,691	$26,663
RAILBELT	INT	336	30	$1,873	$5,676	$110,516
SANDPOINT	SW	152	15	$1,399	$2,400	$29,312
SE ISLANDS	SE	502	52	$1,465	$4,424	$139,863
SITKA	SE	1,685	106	$1,660	$5,000	$398,664
SKAGWAY	SE	146	12	$1,896	$5,700	$51,552
ST. MARY'S	SW	111	12	$1,265	$3,542	$28,548
SW REGION	SW	461	59	$1,265	$3,834	$152,537
TANANA	INT	93	8	$1,922	$5,876	$42,036
UNALASKA	SW	181	17		$4,533	$78,874
VALDEZ	SC	750	61	$1,460(SI)	$4,424(SI)	$231,056
WRANGELL	SE	518	41	$1,260	$3,828	$121,705
YAKUTAT	SE	129	14	$1,873	$5,676	$49,726
YUKON FLATS	INT	338	37	(Self Insured)	(SI)	$432,000
YUKON-KOYUKUK	INT	512	49		$4,380	$214,620
YUPIIT	SW	306	28	$1,560	$3,000	$44,208
						$22,980,946 *

LEGEND Σ = 7,026 →( )

ADM–Student Enrollment (Average Daily Membership–a half time student counts as .5)
FTE CERT STAFF–Number of certificated staff (teachers) using Full Time Equivalency
MED PREM S–Indicates the Medical Premium paid annually by the district for a Single individual
MED PREM F–Indicates the Medical Premium paid annually by the district for a Family
TOT DISTRICT COST–Total costs to the district for medical insurance coverage of this group of employees
NA–Not Available   SI–Self-Insured   * NOTE: Figure does not include Chatham, Craig school districts.

ASSOCIATION OF ALASKA SCHOOL BOARDS • 1988-89 SCHOOL YEAR

STATEWIDE: SCHOOL DISTRICT MEDICAL EXPENDITURES FOR ADMINISTRATORS

DISTRICT	REGION	ADM	FTE ADMIN	SUPT MEDICAL PREMIUM	CO MEDICAL PREMIUM	PRIN MEDICAL PREMIUM	TOT MEDICAL COSTS
ADAK	SW	655	6	$5,888	$3,900	$4,000	$14,688
ALASKA GATEWAY	INT	462	7	$3,832	$3,632	$3,832	$21,999
ALEUTIAN REGION	SW	112	5	$1,873	$5,620		$16,701
ANCHORAGE	SC	37,176	119	$2,438	$2,438	$2,438	
ANNETTE ISLAND	SE	419	5	$2,750	$7,670	$5,101	$15,501
BERING STRAIT	NW	1,261	24	$1,986	$1,986	$1,986	$30,700
BRISTOL BAY	SW	249	3	$4,440	$1,260	$1,260	$6,960
CHATHAM	SE	321	6	$5,600	$5,600	$5,600	$22,400
CHUGACH	SC	94	7	$1,905	$4,548		$7,498
COPPER RIVER	INT	591	6	$4,680	$4,680	$4,680	$28,080
CORDOVA	SC	425	4	$3,949	$3,949	$3,949	$15,796
CRAIG	SE	227	3	$3,025	$2,605		$8,635
DELTA/GREELY	INT	897	6	$1,884	$1,884	$1,884	$32,520
DILLINGHAM	SW	445	8	$1,931	$1,931	$1,931	$33,240
FAIRBANKS	INT	15,696	52	$3,767	$3,767	$3,767	$380,831
GALENA	INT	145	3	$2,770	$3,854	$3,854	$6,624
HAINES	SE	331	3	$1,884			$17,085
HOONAH	SE	255	4	$1,784	$1,784	$1,784	$1,262
HYDABURG	SE	100	3	$4,104		$4,104	$8,208
IDITAROD	INT	389	12	$4,320	$4,320		$51,840
JUNEAU	SE	4,575	19	$3,240	$3,240	$3,240	$61,560
KAKE	SE	183	3	$4,320	$4,320	$4,320	$12,960
KASHUNAMIUT	SW	165	2	$1,902		$1,902	$3,804
KENAI	SC	8,438	50	$4,529	$4,529	$4,529	$322,946
KETCHIKAN	SE	2,498	14	$1,995	$1,995	$1,995	$69,236
KLAWOCK	SE	203	2	$3,948		$3,948	$7,896
KODIAK	SW	2,341	17	$1,693	$1,693	$1,693	$59,914
KUSPUK	SW	INFO NA	0				
LAKE & PENINSULA	SW	357	22	$4,224	$4,224	$4,224	$31,904
LOWER KUSKOKWIM	SW	2,768	34	$2,210	$2,210	$2,210	$75,140
LOWER YUKON	SW	1,264	19	$2,763	$2,763	$2,763	$35,571
MAT-SU	SC	8,744	38	$4,664	$4,664	$4,664	$177,232
NENANA	INT	194	3	$4,388	$4,388	$4,388	$13,164
NOME	NW	753	7	$4,164	$4,164	$4,164	$27,179
NORTH SLOPE	NW	1,246	27	SELF INSURE	SELF INSURE	SELF INSURE	$110,000
NORTHWEST ARCTIC	NW	1,632	31	$1,920	$1,920	$1,920	$49,920
PELICAN	SE	41	1	$1,873			$1,873
PETERSBURG	SE	657	3	$5,676		$2,972	$11,620
PRIBILOF ISLANDS	SW	151	2	$1,883		$1,883	$5,690
RAILBELT	INT	336	4	$5,676	$1,873	$5,676	$18,997
SAND POINT	SW	152	2	$1,399		$4,200	$5,599
SITKA	SE	1,685	8	$3,688	$5,000	$3,688	$32,376
SKAGWAY	SE	146	1	$1,872			$5,700
SOUTHEAST ISLAND	SE	502	7	$1,465	$1,465	$1,465	$23,340
SOUTHWEST REGION	SW	461	12	$959	$959	$959	$32,899
ST. MARY'S	SW	111	2	$2,750		$3,542	$6,292
TANANA	INT	93	1	$4,218			$4,218
UNALASKA	SW	181	2	$4,533			$7,253
VALDEZ	SC	750	6	$4,424	$4,424	$4,424	$32,425
WRANGELL	SE	518	4	$1,260		$1,260	$14,290
YAKUTAT	SE	129	2	$5,676		$5,676	$11,352
YUKON FLATS	INT	338	9	$4,644	$4,644	$4,644	$37,152
YUKON/KOYUKUK	INT	512	19	$4,380	$4,380	$4,380	$83,220
YUPIIT	SW	306	7	$3,100	$1,600	$3,100	$12,600
							$2,125,890 *

Σ= 666

LEGEND

ADM–Student Enrollment (Average Daily Membership–a half time student counts as .5)
FTE ADMIN–Number of administrators using Full Time Equivalency–a half time administrator counts as .5
MEDICAL PREMIUM–Indicates the Medical Premium paid annually by the district for SUPERINTENDENTS, CENTRAL OFFICE staff, and PRINCIPALS
TOT MEDICAL COST–Total costs to the district for medical insurance coverage.

* NOTE: Figure does not include Anchorage, Kuspuk school districts.

STATEWIDE: SCHOOL DISTRICT MEDICAL EXPENDITURES FOR CLASSIFIED STAFF

DISTRICT	REGION	ADM	FTE CLASS	MED PREM S	MED PREM F	TOT DISTRICT COST
ADAK	SW	655	32.80	$1,922		
ANNETTE ISLANDS	SE	419	23.00	$1,512	$4,584	
BERING STRAIT	NW	1,261	209.72	$816	$2,484	
BRISTOL BAY	SW	249	13.87	$1,332		
CHATHAM	SE	321	32.00	$2,520	$6,960	
COPPER RIVER	INT	591	25.50		$4,920	
CORDOVA	SC	425	20.00	$1,560	$4,728	
DELTA/GREELY	INT	897	35.00	$1,932	$5,892	
DILLINGHAM	SW	445	25.50		$4,200	
FAIRBANKS	INT	13,696	425.50		$3,768	
GALENA	INT	145	10.00	$1,523	$4,595	
HAINES	SE	339	9.00	$1,884		
HOONAH	SE	255	13.50	$1,512		
HYDABURG	SE	100	10.35	$1,920		
IDITAROD	INT	389	49.61		$4,296	
JUNEAU	SE	4,575	143.85		$3,288	
KAKE	SE	183	12.33		$4,392	
KENAI	SC	8,438	320.80		$3,600	
KETCHIKAN	SE	2,498	96.00	$1,620	$4,812	
KLAWOCK	SE	203	7.00	$1,308		
KODIAK	SW	2,341	132.02	$1,608	$4,872	
KUSPUK	SW	384	41.25	$588		
LAKE & PENINSULA	SW	357	42.66	$1,392		
LOWER KUSKOKWIM	SW	2,768	212.02			
LOWER YUKON	SW	1,264	102.00	$1,764	$5,256	
MAT-SU	SC	8,744	328.32		$4,980	
NENANA	INT	194	9.61	$1,524	$4,392	
NORTH SLOPE	NW	1,246	350.00	$672	$2,628	
NORTHWEST ARTCTIC	NW	1,632	151.00			
PELICAN	SE	41	3.07	$1,688	$5,040	
PETERSBURG	SE	657	19.40	$1,740	$4,740	
RAILBELT	INT	336	19.06	$1,872	$5,676	
SITKA	SE	1,685	46.00	$1,656	$4,980	
SKAGWAY	SE	146	6.00		$5,676	
SOUTHEAST ISLAND	SE	502	67.10	$1,452	$4,416	
SOUTHWEST REGION	SW	461	54.00	$1,260	$3,840	
ST. MARY'S	SW	111	7.32	$1,260		
UNALASKA	SW	181	10.80		$4,536	
VALDEZ	SC	750	54.00	$1,200	$3,660	
WRANGELL	SE	518	20.00	$1,260	$3,840	
YAKUTAT	SE	129	12.50	$1,872		
YUKON FLATS	INT	338	44.00		$2,640	
YUKON/KOYUKUK	INT	512	79.00		$4,320	
YUPIIT	SW	306	104.00	$516	$1,896	

NOT AVAILABLE – CURRENTLY BEING SURVEYED

Σ = 3,780.46

LEGEND

ADM–Student Enrollment (Average Daily Membership–a half time student counts as .5)
FTE CLASS–Number of classified employees using Full Time Equivalency–a half time employee counts as .5
MED PREM S–Indicates the Medical Premium paid annually by the district for a Single individual
MED PREM F–Indicates the Medical Premium paid annually by the district for a Family
TOT DISTRICT COST–Total costs to the district for medical insurance coverage.

NOTE: Bering Strait, LKSD, North Slope are self insured.

TOTAL HEALTH CARE COSTS FOR SCHOOL DISTRICT EMPLOYEES BY CATEGORY FY 89

DISTRICT	TOT DIST COST ADMIN	TOT DIST COST TCHRS	TOT DIST COST CLASSIFIED *	ALL DISTRICT TOT
ADAK	$14,688	$71,200	($25,201.00)	$111,089.00
ALASKA GATEWAY	$21,999	$103,182	($73,185.94)	$198,366.94
ALEUTIAN REGION	$16,701	$36,200	($18,605.90)	$71,506.90
ALEUTIANS EAST				$180,000.00
ANCHORAGE		$5,981,395		$14,508,000.00
ANNETTE ISLANDS	$15,501	$90,124	($96,315.00)	$201,940.00
BERING STRAIT	$30,700	$554,000	($80,027.00)	$664,727.00
BRISTOL BAY	$6,960	$31,500	($63,431.31)	$101,[illegible]1.31
CHATHAM	$22,400			$209 394.91
CHUGACH	$7,498	$45,052	($30,437.18)	$8[illegible],987.18
COPPER RIVER	$28,080	$210,600	($91,323.56)	$330,003.56
CORDOVA	$15,796	$113,767	($1,552.68)	$131,115.68
CRAIG	$8,635			$75,579.49
DELTA/GREELY	$32,520	$276,000	($177,276.00)	$485,796.00
DILLINGHAM	$33,240	$151,804	($129,956.00)	$315,000.00
FAIRBANKS	$380,831	$3,511,256	($1,021,757.00)	$4,913,844.00
GALENA	$6,624	$47,947	($40,380.00)	$94,951.00
HAINES	$17,085	$156,000	($37,240.00)	$210,325.00
HOONAH	$1,262	$59,348	($50,661.00)	$111,271.00
HYDABURG	$8,208	$61,884	($4,072.00)	$74,164.00
IDITAROD	$51,840	$164,160	($171,636.79)	$387,636.79
JUNEAU	$61,560	$980,580	($287,276.00)	$1,329,416.00
KAKE	$12,960	$79,920	($73,184.00)	$166,064.00
KASHUNAMIUT	$3,804	$47,000	($14,526.00)	$65,330.00
KENAI	$322,946	$2,432,277	($550,964.00)	$3,306,187.00
KETCHIKAN	$69,236	$608,677	($342,710.00)	$1,020,623.00
KLAWOCK	$7,896	$40,935	($12,169.00)	$61,000.00
KODIAK	$59,914	$481,182	($150,232.00)	$691,328.00
KUSPUK		$237,958		$446,561.12
LAKE & PENINSULA	$31,904	$104,282	($67,200.19)	$203,386.19
LOWER KUSKOKWIM	$75,140	$552,500	$627,640	1,225,280.00
LOWER YUKON	$35,571	$165,479	($646,792.00)	$847,842.00
MAT-SU	$177,232	$2,391,840	($1,561,419.00)	$4,130,491.00
NENANA	$13,164	$53,998	($40,138.00)	$107,300.00
NOME	$27,179	$169,936	($37,218.00)	$234,333.00
NORTH SLOPE	$110,000	$400,000	($370,809.00)	$880,809.00
NW ARCTIC	$49,920	$235,000	($174,938.00)	$459,858.00
PELICAN	$1,873	$25,640	($6,870.00)	$34,383.00
PETERSBURG	$11,620	$156,445	($81,088.00)	$249,153.00
PRIBILOF	$5,690	$26,663	($36,246.90)	$68,599.90
RAILBELT	$18,997	$110,516	($49,965.44)	$179,478.44
SE ISLANDS	$32,376	$139,863	($6,066.00)	$178,305.00
SITKA	$5,700	$398,664	($183,764.33)	$588,128.33
SKAGWAY	$23,340	$51,552	($2,036.00)	$76,928.00
ST. MARY'S	$32,899	$28,548	($42,553.00)	$104,000.00
SW REGION	$6,292	$152,537	($65,254.00)	$224,083.00
TANANA	$4,218	$42,036	$46,254.00	92,508
UNALASKA	$7,253	$78,874	($40,832.00)	$126,959.00
VALDEZ	$32,425	$231,056	($150,717.00)	$414,198.00
WRANGELL	$14,290	$121,705	($45,368.00)	$181,363.00
YAKUTAT	$11,352	$49,726	($24,347.88)	$85,425.88
YUKON FLATS	$37,152	$432,000	$42,593.31	$426,558.69
YUKON-KOYUKUK	$83,220	$214,620	($150,400.04)	$448,240.04
YUPIIT	$12,600	$44,208	($108,639.29)	$165,447.29
	2120291	22951636		$40,961,368.64

* CLASSIFIED TOTAL IS AN ESTIMATED FIGURE

Total = $41,680,262.64

Total [(# Adm) + (# Teach) + (# class)] = 11,472

University of Alaska

TO: Dave Grey

FROM: Bob Warren

DATE: February 20, 1990

RE: YOUR REQUEST FOR EMPLOYEE BENEFIT PROGRAM INFO

3,035 employees covered in Basic Health Plan.

3,204 dependents covered.

1989 cost/employee/month ($305.00) = $11,108,100/year.

STATE EXPENDITURES ON HEALTH CARE SERVICES

	(Millions)
1. Dept. of Health & Social Services.	236.3
2. Elementary & secondary schools.	41.7
3. Dept. of Corrections.	8.0
4. U. of A.	11.1
5. Dept. of Community & Regional Affairs.	5.0
6. Dept. of Administration.(employees).	50.0
7. Dept. of Administration (retirees).	21.0
8. Dept. of Administration.(other).	12.4
	$385.5

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
DIRECT MEDICAL EXPENSES-FY90

	General Fund	Federal Funds	Other	Total	Recipients Served	Notes
Medicaid Non-facility	25,891.0	25,654.2		51,545.2	16,949	
Medicaid Facilities	46,524.4	46,060.9		92,585.3		
Indian Health Services		9,403.9		9,403.9		
Medicaid - PFD Hold Harmless			1,300.0	1,300.0		
Medicaid - ALB Hold Harmless	1,236.6			1,236.6		
General Relief Medical	6,385.1			6,385.[illegible]		
Medicaid State Programs		4,687.1		4,687.1		
Foster Care	390.0			390.0	925 FTE's	Povided by DFYS staff.
Residential Care	73.3			73.3	310	Povided by DFYS staff.
McLaughlin Youth Center	106.4			106.4		
Fairbanks Youth Facility	60.7			60.7		
Nome Youth Facility	7.0			7.0		
Johnson Youth Center	0.5			0.5		
Bethel Youth Facility	23.8			23.8		
Maniilaq - Public Health				0.0		
Nursing	305.3			305.3		
Eye Care	48.7			48.7	1,000	
EMS	124.7			124.7		
Audiology	29.5			29.5		
Maniilaq-Mental Health & DD	156.3			156.3		Does not include Developmental Disabilities.
Norton Sound-Public Health				0.0		
Nursing	518.2			518.2		
EMS	149.2			149.2		
Health Clinic	52.6			52.6	1,600	
Eye Care	43.9			43.9	1,500	
Audiology	46.4			46.4	1,250	
EMS Ambulance Support	2.0			2.0		
Norton Sound-Mental Health	124.7			124.7	235	Does not include Developmental Disabilities or Chronically Mentally Ill.
TCC-Public Health						
Clinic	8.7			8.7		
TCC-Mental Health	168.3			168.3	94	Does not include Chronically Mentally Ill.
YKHC-Public Health				0.0		
Health Care Svcs	334.7			334.7		
EMS	126.4			126.4		
Anchorage Block Grant	628.4			628.4		Based on FY90 subgrantee awards provided by Municipality of Anchorage.

LFD 3/6/90

DEPARTMENT OF ADMINISTRATION PIONEER HOME HEALTH CARE EXPENSES — PIONHEALTH$ 3/5/90

FIGURES ARE BASED ON FY91 GOVERNOR REQUEST

FUNDING: GENERAL FUNDS AND GENL FUNDS PROGRAM RECEIPTS

	SITKA	FAIRBANKS	PALMER	ANCHORAGE	KETCHIKAN	JUNEAU	CENTRAL OFC	TOTAL
PERSONAL SERVICES								
NURSING AIDE	$844,875	$843,356	$873,395	$1,939,605	$430,112	$448,442		$5,379,785
NURSE I	$54,085	$15,311	$16,007	$4,106		$8,003		$97,512
NURSE II	$258,058	$257,431	$309,987	$631,844	$85,858	$256,824		$1,800,002
NURSE III	$175,742	$169,217	$208,270	$210,792	$157,902	$151,361		$1,081,284
NURSE IV	$64,376	$66,758	$53,471	$173,687	$62,248	$53,471		$474,011
PROGRAM NURSE CONSULTANT							$60,035	$60,035
NURSING DIRECTOR				$70,377				$70,377
LICENSED PRACTICAL NURSE	$134,328	$135,220	$39,543	$508,403	$158,258			$975,750
PHYSICAL THERAPIST I	$63,869	$53,144	$61,742	$4,273		$36,714		$219,742
PHYSICAL THERAPIST II				$52,964				$52,964
ACTIVITY THERAPIST I				$41,085				$41,085
ACTIVITY THERAPIST II		$60,035	$56,335	$51,544	$46,643	$47,891		$262,448
OCCUPATIONAL THERAPIST II	$46,024							$46,024
MEDICAL RECORDS TECH				$43,607				$43,607
LABORATORY ASST	$34,749							$34,749
PIONEER HOME AIDE	$108,690	$135,265	$79,787	$332,184	$61,773	$58,792		$776,491
SOCIAL WORKER III	$48,006	$58,401	$45,115	$70,623	$45,115	$48,006		$321,266
TOTAL	$1,832,800	$1,794,138	$1,743,652	$4,149,094	$1,047,909	$1,109,504	$60,035	$11,737,132
VACANCY %	2.22%	2.00%	2.00%	2.98%	2.00%	2.63%	2.89%	
LINE 100 PERSONAL SERVICES	$1,792,112	$1,758,255	$1,708,814	$4,025,368	$1,026,951	$1,080,324	$58,300	$11,450,124
CONTRACTUAL-PROFESSIONAL SVCS								
PHYSICIAN	$27,000	$60,000	$40,000	$61,000	$28,500	$26,500		$243,000
PHARMACY	$23,600	$14,700	$15,000	$34,000	$4,000	$13,000		$104,300
DENTIST	$1,700	$4,000	$1,100	$2,500	$1,000	$4,000		$14,300
OCCUPATIONAL/SPEECH THERAPY	$14,400		$20,600	$55,000				$90,000
MEDICAL RECORDS		$1,200						$1,200
LABORATORY				$2,000	$1,900			$3,900
PHYSICAL THERAPY					$40,000			$40,000
MEDICAL DIRECTOR					$5,000			$5,000
TOTAL	$66,700	$79,900	$76,700	$154,500	$80,400	$43,500		$501,700
SUPPLIES AND MATERIALS								
PROFESSIONAL & SCIENTIFIC SUPPLIES	$60,900	$70,500	$44,600	$200 000	$45,100	$63,500		$484,600
TOTAL WITH VACANCY	$1,919,712	$1,908,655	$1,830,114	$4,379,868	$1,152,451	$1,187,324	$58,300	$12,436,424

NOTES TO ACCOMPANY PIONEER HOME HEALTH COST ANALYSIS

1. Figures related to the Governor's FY91 budget request.

2. The items on the spreadsheet represent costs that can be isolated easily from the budget documents. No attempt was made to isolate specialized housekeeping, laundry or equipment that might be more expensive for nursing than for other home residents.

3.Several other items are not enumerated on the spreadsheet which relate to health care costs. These include specialized travel, training, certain health related grants and laboratory expenses. Year to date figures for FY90 indicate these expenses are in the $50-60,000 range.

4. Calculations from Occupancy Reports provided by the agency for the past 12 months suggest that these expenses are attributable to an average of about 283 residents. This average is composed of full time nursing residents, temporary infirmary patients and residential patients requiring short term nursing care.

DEPARTMENT OF CORRECTIONS
PROJECTED MEDICAL COSTS
FY90

Major Medical Component

	Authorized	Projected	Variance
100	1,110.0	1,257.8	< 147.8>
200	4.0	44.3	< 40.3>
300	3,484.0	4,647.0	<1,163.0>
400	269.0	478.3	< 209.3>
500	0.0	17.7	< 17.7>
TOTAL	4,867.0	6,445.1	<1,578.1>*

*Note: Historically, the major medical budget has been underfunded and has received a supplemental legislative appropriation each year to cover essential health care costs.

Medical Personnel Costs Within Institutional Budgets

Component	Number of Positions	Budgeted Costs
Fairbanks Correctional Center	3	$ 178.0
Yukon-Kuskokwim Correctional Center	2	134.4
Palmer Correctional Center	4	226.1
Mat-Su Pre-Trial	2	86.2
Hiland Mountain Correctional Center	2	106.1
Cook Inlet Pre-Trial	3	135.6
Anchorage Annex Correctional Center	3	158.5
Wildwood Correctional Center	4	184.8
Spring Creek Correctional Center	3	145.0
Lemon Creek Correctional Center	3	132.2
Ketchikan Correctional Center	1	68.5
TOTAL	30	$1,555.4

Total Projected Medical Costs

Major Medical	$6,445.1
Institutional Medical Costs	1,555.4
Total Projected Cost	$8,000.5

Number of Inmates Served

All inmates booked into state correctional centers receive, at a minimum, a physical and mental health screening. In addition, ongoing health care services, as mandated by the court, are provided to pre and post-convicted inmates.

Projected bookings for FY90	32,000
Daily institutional population capacity	2,516
Average daily medical cost for FY89 (excluding institution medical costs)	$7.14

Walter Majoros
2/16/90

FY90 SRS DAT
for HEALTH

Revenue Sharin

FY90

COMMUNITY	Actual Amount	Formula Amount
ANCHORAGE	1,044,005	$2,121,000
FAIRBANKS:CITY	410,644	$834,264
JUNEAU CITY & BORO	396,732	$806,000
NOME	283,825	$576,619
KENAI PENINSULA	264,914	$538,200
KODIAK ISLAND	240,542	$488,686
SEWARD	210,872	$428,407
SITKA	172,610	$350,675
KETCHIKAN	171,294	$348,000
VALDEZ	164,493	$334,184
CORDOVA	156,273	$317,484
PALMER	148,098	$300,875
BETHEL	142,735	$289,980
PETERSBURG	139,927	$284,275
WRANGELL	135,841	$275,975
NORTH SLOPE	87,753	$178,278
KENAI:CITY	59,341	$120,557
SOLDOTNA	51,923	$105,487
MATANUSKA SUSITNA	49,025	$99,600
NORTHWEST ARCTIC	38,392	$77,997
HOMER	25,432	$51,667
GALENA	21,938	$44,570
EMMONAK	17,181	$34,905
CRAIG	15,751	$32,000
UNALASKA	15,285	$31,054
ANIAK	10,969	$22,285
KOTZEBUE	10,969	$22,285
McGRATH	10,969	$22,285
SELDOVIA	8,477	$17,222
HAINES:CITY	8,477	$17,222
WASILLA	8,171	$16,600
KLAWOCK	7,876	$16,000
COLD BAY	7,643	$15,527
TELLER	5,485	$11,142
KIANA	5,485	$11,142
KOYUKUK	5,485	$11,142
TANANA	5,485	$11,142
WALES	5,485	$11,142
NULATO	5,485	$11,142
GAMBELL	5,485	$11,142
LOWER KALSKAG	5,485	$11,142
SAINT MICHAEL	5,485	$11,142
ANDERSON	5,485	$11,142
GOLOVIN	5,485	$11,142
STEBBINS	5,485	$11,142
GRAYLING	5,485	$11,142
KOBUK	[illegible] 485	$11,142
SELAWIK	485	$11,142
UPPER KALSKAG	485	$11,142
HOLY CROSS	[illegible],485	$11,142
SHUNGNAK	5,485	$11,142
WHITE MOUNTAIN	5,485	$11,142

KALTAG	5,485	$11,142
KIVALINA	5,485	$11,142
BUCKLAND	5,485	$11,142
SHAKTOOLIK	5,485	$11,142
KOYUK	5,485	$11,142
NOORVIK	5,485	$11,142
HUGHES	5,485	$11,142
UNALAKLEET	5,485	$11,142
AMBLER	5,485	$11,142
ELIM	5,485	$11,142
HUSLIA	5,485	$11,142
BREVIG MISSION	5,485	$11,142
DEERING	5,485	$11,142
SHAGELUK	5,485	$11,142
CHUATHBALUK	5,485	$11,142
ALAKANUK	5,286	$10,740
KOTLIK	5,286	$10,740
KWETHLUK	5,286	$10,740
MEKORYUK	5,286	$10,740
GOODNEWS BAY	5,286	$10,740
SHELDON POINT	5,286	$10,740
NUNAPITCHUK	5,286	$10,740
MOUNTAIN VILLAGE	5,286	$10,740
EEK	5,286	$10,740
NIGHTMUTE	5,286	$10,740
CHEVAK	5,286	$10,740
NAPAKIAK	5,286	$10,740
CHEFORNAK	5,286	$10,740
SCAMMON BAY	5,286	$10,740
PILOT STATION	5,286	$10,740
QUINHAGAK	5,286	$10,740
SAINT MARY'S	5,286	$10,740
RUSSIAN MISSION	5,286	$10,740
NEWTOK	5,286	$10,740
NAPASKIAK	5,286	$10,740
MARSHALL	5,286	$10,740
TULUKSAK	5,286	$10,740
AKIAK	5,286	$10,740
KASIGLUK	5,286	$10,740
TUNUNAK	5,286	$10,740
ATMAUTLUAK	5,286	$10,740
PLATINUM	5,286	$10,740
TOKSOOK BAY	5,286	$10,740
DILLINGHAM	5,095	$10,351
CLARK'S POINT	5,095	$10,351
BRISTOL BAY BOROUGH	5,095	$10,351
PORT HEIDEN	5,095	$10,351
EKWOK	5,095	$10,351
NEW STUYAHOK	5,095	$10,351
TOGIAK	5,095	$10,351
SAINT GEORGE	5,095	$10,351
KING COVE	5,095	$10,351
NEWHALEN	5,095	$10,351
NONDALTON	5,095	$10,351
ALEKNAGIK	5,095	$10,351
SAND POINT	5,095	$10,351

MANOKOTAK	5.095	$10,351
CHIGNIK	5.095	$10.351
WHITTIER	4,563	$9,270
PELICAN	4,239	$8,611
HOONAH	4,239	$8,611
YAKUTAT	4,239	$8,611
SKAGWAY	4,239	$8,611
KAKE	4,085	$8,300
ANGOON	4,085	$8,300
THORNE BAY	3,938	$8,000
KASAAN	3,938	$8,000
ALLAKAKET	0	$0
BETTLES	0	$0
SHISHMAREF	0	$0
ANAKTUVUK PASS	0	$0
BARROW	0	$0
AKHIOK	0	$0
FORT YUKON	0	$0
KAKTOVIK	0	$0
LARSEN BAY	0	$0
POINT HOPE	0	$0
TENAKEE SPRINGS	0	$0
KUPREANOF	0	$0
ANVIK	0	$0
ATKA	0	$0
PORT LIONS	0	$0
WAINWRIGHT	0	$0
OUZINKIE	0	$0
DELTA JUNCTION	0	$0
AKUTAN	0	$0
SAVOONGA	0	$0
NENANA	0	$0
SAXMAN	0	$0
HAINES	0	$0
NUIQSUT	0	$0
RUBY	0	$0
NORTH POLE	0	$0
PORT ALEXANDER	0	$0
DIOMEDE	0	$0
ALEUTIANS EAST BOROU	0	$0
FAIRBANKS NORTH STAR	0	$0
NIKOLAI	0	$0
ATQASUK	0	$0
OLD HARBOR	0	$0
EAGLE	0	$0
KACHEMAK	0	$0
KODIAK	0	$0
HOUSTON	0	$0
HOOPER BAY	0	$0
SAINT PAUL	0	$0
HYDABURG	0	$0
	$4,936.863	$10,131,308

1989 DISTRIBUTION OF ALASKAN HEALTH CARE PROVIDERS AND FACILITIES

	PROVIDERS*																			FACILITIES**	
LOCATION	AUD	CHI	CSW	DEN	D.HYG	PHYS	PARA	OSTE	POD	OPT	PHAR	O.THR	P.THR	PSY A	PSY	LPN	RN	ANP	TOTAL	ACB	LTCB
Southeast																					
Angoon																1			1		
Coffman Cove																	1		1		
Craig				2		1											1		4		
Gustavus																	3		3		
Haines			1	2	1	3							1			1	7		16		
Juneau	1	7	16	20	17	48	2		1	5	17	4	12	2	8	41	221	4	426	51	92
Kake																	1		1		
Ketchikan		3	3	8	5	19				3	14	1	9		4	31	132	6	238	46	76
Metlakatla				1													1		2		
Petersburg		2	1	2		3					1		2		1	2	29		43	11	16
Pelican																		1	1		
Sitka	1	1	3	6	3	21	1			1	10	3	6	1	2	19	126	1	205	102	47
Thorne Bay																1	5		6		
Wrangell		1	1	3	1	2					1					2	18		29	9	18
SUB-TOTAL	2	15	25	45	27	97	3	0	1	9	43	8	31	3	15	99	544	12	976	219	249
Southcentral																					
Anchor Pt. & area						2					1					1	8		12		
Anchorage	17	57	90	169	117	445	55	23	6	33	127	48	100	14	57	358	2075	60	3851	806	706
Cordova		1		1		3					1		1		2	3	19		31	13	12
Homer		4	2	4	3	10				2	2	1	4		3	14	89	2	140	20	18
Kenai & area	1	10	1	9	9	20	16	3		3	14	5	8	1	3	33	129	2	267	46	49
Palmer		3	2	4	5	19	7	1			5	2	12			17	138	7	222	36	59
Seldovia						1					1						1		3		
Seward		1	1	2	2	3					1	1	1		1	16	31	3	63	32	68
Talkeetna								2				1				1	6		10		
Valdez		1	1	2		3					2	4				3	25		41	15	84
Wasilla & area	1	7	1	14	5	7	2	1		3	8	5	8		1	31	114	3	211		
Whittier																1	1		2		
SUB-TOTAL	19	84	98	205	141	513	80	30	6	41	162	67	134	15	67	478	2636	77	4853	968	996

AUD = Audiologist
CHI = Chiropractor
CSW = Clinical Social Worker
DEN = Dentist
D.HYG = Dental Hygienist
PHYS = Physician
PARA = Paramedic
OSTE = Osteopath
POD = Podiatrist
OTP = Optometrist
PHAR = Pharmacist
O.THR = Occ. Therapist
P.THR = Phys. Therapist
PSYA = Psycologist Asst.
PSY = Psycologist
LPN = Lic. Pract. Nurse
RN = Registered Nurse
ANP = Adv. Nurse Pract.
ACB = Acute Care Beds
LTCB = Longer Term Care Beds

	PROVIDERS																		FACILITIES	
LOCATION	AUD	CHI	CSW	DEN	D.HYG	PHYS	PARA	OSTE	POD	OPT	PHAR	O.THR	P.THR	PSY A	PSY	LPN	RN	ANP	TOTAL	ACB	LTCB
Southwest & Yukon D.																					
Adak																	1		1	15	
Aklak																	1		1		
Bethel	1		4	6	1	5	1	1		1	1		1			4	60	6	92	51	
Cold Bay																	1	1	2		
Dillingham		1		2	1	8	1			1	2			1	1	2	33	1	54	28	
King Cove																	3	2	5		
Kodiak		2	3	8	6	13		3		2	6		6		2	16	71		138	25	23
McGrath																		1	1		
Mekoryuk																	1		1		
Naknek & K.Salmon																2	4	3	9		
Old Harbor																	1	1	2		
Sand Point			1														1		2		
St. Paul Is.							1												1		
Togiak																	1	1	2		
Unalaska & Dutch H.																2	4		6		
SUB-TOTAL	1	3	8	16	8	26	3	4	0	4	9	0	7	1	3	26	180	16	317	119	23
Interior																					
Central																	1		1		
Delta Junction				1			1	1						1		4	7		15		
Eagle																	1		1		
Fairbanks	3	10	18	35	18	116	13	4	1	11	36	8	28		21	98	398	9	827	177	155
Ft. Yukon																	3		3		
Galena																	4		4		
Glennallen & area		2		1							1					3	21		27		
Healy to Cantwell			1				1						1			1	9		13		
Nenana & Anderson																	3		3		
North Pole & Eielson				5	2	4		2	2	1	4	1	2	1	1	24	107	1	157		
Tanana																	5	3	8		
Tok & Dot Lake																	5		5		
SUB-TOTAL	3	12	19	42	20	120	15	7	3	12	41	9	31	1	22	130	564	13	1064	177	155

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LOCATION	PROVIDERS																			FACILITIES	
	AUD	CHI	CSW	DEN	D.HYG	PHYS	PARA	OSTE	POD	OPT	PHAR	O.THR	P.THR	PSY A	PSY	LPN	RN	ANP	TOTAL	ACB	LTCB
Northwest & Arctic																					
Atqasuk																	1		1		
Barrow	1		1	1	1	4	2	1		1						1	20	5	38	14	
Gambel																	1	1	2		
Kotzebue			2	1		3				1	1					6	27		41	31	22
Nome	1		5	6	2	5	2	1		1	4		1			4	42	1	75	15	15
Nuiqsut																	2		2		
Unalakleet																1	2		3		
SUB-TOTAL	2	0	8	8	3	12	4	2	0	3	5	0	1	0	0	12	95	7	162	60	37
TOTAL	27	114	158	316	199	768	105	43	10	69	260	84	204	20	107	745	4019	125	7372	1543	1460

* This information is consolidated from the Division of Occupational Licensing lists of current licensees and their residence addresses.

1. It cannot be assumed that all are actively practicing.
2. It does not include all military or Indian Health Service medical personnel.

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DEN=Dentist
D.HYG = Dental Hygienist
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Alaska State Legislature

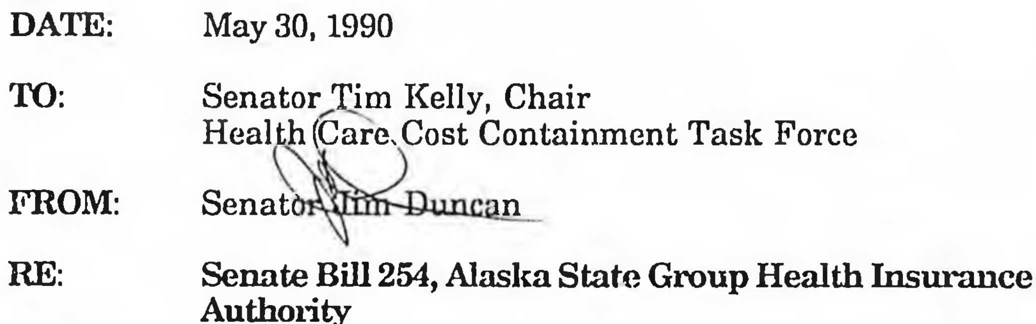
SENATOR JIM DUNCAN

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

(907) 465-4766

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

MEMORANDUM



DATE: May 30, 1990

TO: Senator Tim Kelly, Chair
Health Care Cost Containment Task Force

FROM: Senator Jim Duncan

RE: **Senate Bill 254, Alaska State Group Health Insurance Authority**

I provide the following information on SB254 for the use of the Health Care Cost Containment Task Force. This bill passed the Senate, was slightly modified in the House HESS Committee, but failed to move out of House Finance this session. Attached is a copy of the latest version of the bill and a sectional analysis.

Attachments

Duncan will prefile.

SENATE BILL 254
House HESS Version

BY SENATOR DUNCAN

ALASKA STATE GROUP HEALTH INSURANCE AUTHORITY

"An Act relating to group health insurance and to health care provided by the state; and providing for an effective date."

<u>Section 1.</u> **PURPOSE**

The purpose of this act is to establish the Alaska State Group Health Insurance Authority. By February 1, 1990 the Authority has the responsibility to create and maintain:

(a) a rate schedule to be used in Alaska which will reflect the vast geographic differences and availability of services in rural and urban areas;

(b) statewide utilization standards to control inappropriate or improper utilization practices to reduce the rate of inflation in the cost of health care in Alaska; and

(c) an efficient provider payment system to reduce the cost to providers who are serving employees of the participants in the authority.

The state, municipalities, and school districts will benefit by using the provider payment system, rate schedule, and utilization standards established by the Authority.

<u>Section 2.</u> **CREATION OF THE AUTHORITY**

The authority is established in the Department of Administration. It has a 15 member board of directors appointed by the Governor with the general powers provided to quasi government agencies including the hiring of staff and enter into contracts for professional services. In addition, after February 1, 1992, the Authority may exercise the powers granted to other insurers licensed in the state.

BOARD OF DIRECTORS

The board of directors will be composed of 15 members representing:

(1) one nonvoting member of the legislative branch;

(2) one nonvoting member of the judicial branch;

(3) two members representing the executive branch;

(4) two members representing labor organizations;

(5) two members representing school districts;

(6) two members representing municipalities;

(7) two members representing the Department of Health and Social Services;

(8) two members representing health care providers;

(9) one member representing the University of Alaska.

These appointees serve for a five year term and elect officers from the board membership. They are entitled to per diem and travel expenses but may not otherwise be compensated for their services as a board member. Directors representing districts and municipalities appointed after the initial appointees are to be participants in the group health insurance obtained by the Authority.

POWERS OF THE AUTHORITY

The Authority may:

(1) after February 1, 1990 exercise the powers granted to insurers under the laws of the state, and shall comply with the requirements applicable to insurers under this title;

(2) sue or be sued;

(3) enter into contracts for agreements;

(4) establish administrative and accounting procedures;

(5) collect, invest, and disburse funds;

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

The authority may not participate in collective bargaining activities.

ANNUAL REPORT, STAFF AND PROFESSIONAL SERVICES

The board shall annually report to the governor and the legislature on its previous fiscal year's activities and every third year include a cost benefit analysis of the health insurance required under this chapter.

The authority shall employ an executive director, who with the approval of the authority may select and employ additional staff as necessary. The authorities employees are in the exempt service. The authority may contract for professional and

technical services it determines necessary to exercise its powers.

PROCUREMENT OF INSURANCE

After February 1, 1990 the authority shall purchase a policy or policies of group health insurance covering eligible employees of the state, a municipality, or a district if the employer has elected to participate. The authority may act as a self-insurer if it is determined that self-insurance will provide the desired insurance coverage and benefits at a lower cost per eligible employee.

When purchasing group health insurance the authority shall comply with the provisions of Title 36 and shall make bid specifications available, once every five years, to all insurance carriers licensed in Alaska and qualified to provide the desired benefits.

STATE GROUP HEALTH INSURANCE FUND AND PREMIUMS

The state group health insurance fund is created in the general fund. It consists of appropriations and premiums collected under this title. Money in the fund shall be managed and invested by the board and the board may expend funds from the fund to carry out its operations.

The authority shall collect sufficient premiums to provide the required insurance coverage and to pay the expenses of the authority.

PARTICIPATION AND WAIVER

The authority may also grant a waiver of participation to the state, a municipality or a school district who has elected to participate. The board may approve or disapprove a waiver when the participant can document the ability to match the minimum benefit and financial standards established by the board for the desired group health coverage. A waiver may be granted when a participant certifies that its' employees will not have health care coverage from the authority or other carrier.

Participants may separately provide for health insurance in addition to that provided by the Authority.

DEFINITIONS

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

(2) board, means the board of directors of the Alaska Group Health Insurance Authority;

(3) district, means a school district or REAA;

(4) eligible employee, means an employee qualified for group health insurance benefits as determined by the participant;

(5) eligible state program, is a program with which a state agency provides health care or funds to purchase health care for persons not employed by the state;

(6) employer, means the state, a municipality, a district, a collective bargaining unit, or the board of a public corporation of the state created within a principal executive department;

(7) fund, means the state group health insurance fund;

(8) group health insurance, means coverage that may include life insurance, accidental death and dismemberment, workers' compensation, medical care and treatment including Medicare and Medicaid, dental care, eye care, and other group health coverage as determined by the authority;

(9) municipality, includes a public corporation established by a municipality;

(10) participant, means the state, a municipality, or a district;

(11) payment system, means a system or method to streamline and effect cost efficient payments to health care providers.

(12) rate schedule, means a schedule of allowable payments for health care related services rendered based on geographic regions actual provider cost and availability of services.

(13) state, means the executive, legislative, and judicial branches of state government, or an organizational unit of a branch, and includes the University of Alaska, and a public corporation of the state created within a principal executive department.

(14) utilization review, means a system to monitor, track and verify patterns of treatment by health care providers to assure that the most efficient and cost effective care is delivered within accepted standards with out reducing quality of care.

Section 3.

Places employees of the authority in the exempt service.

Section 4.

Requires board members of the authority to comply with the conflict of interest statutes.

Section 5.

Provides that terms of the board members will be staggered.

Section 6.

The Authority is required to make a progress report to the Legislature by March 1, 1991. The report covers the Authorities efforts in establishing the health care provider payment system, rate schedule, and utilization standards.

Section 7.

Provides for an immediate effective date.

Offered: 4/28/90 6-0623D
Referred: Finance

Original sponsor(s): SEN. DUNCAN, Kerttula

1 IN THE SENATE BY THE HESS COMMITTEE

2 HOUSE CS FOR CS FOR SENATE BILL NO. 254 (HESS)

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 SIXTEENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act relating to group health insurance and to
7 health care provided by the state; and providing for
8 an effective date."

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

10 * Section 1. PURPOSE. The purpose of this Act is to
11 (1) by February 1, 1992, create a statewide health care provider
12 payment system, rate schedules, and utilization standards;
13 (2) after February 1, 1992, provide comprehensive group health
14 insurance for the state, municipalities, school districts, and all eligible
15 employees of the state, a municipality, or a school district who elect to
16 participate in the group insurance offered by the Alaska State Group Health
17 Insurance Authority;
18 (3) expand the pool of subscribers and maximize the opportuni-
19 ties for cost containment when purchasing group health insurance;
20 (4) maintain an efficient provider payment system to reduce the
21 cost to providers who are serving employees of participants;
22 (5) maintain statewide utilization standards to control inappro-
23 priate or improper utilization practices and to reduce the rate of infla-
24 tion in the cost of health care in the state;
25 (6) create the most comprehensive, cost-effective, and efficient
26 method of providing a variety of types of health care insurance necessary
27 to meet the coverage requirements of a participant resulting from negoti-
28 ated employee contracts;
29 (7) realize the potential savings that will result if

1 approximately 135,000 active and retired state, municipal, and school
2 district employees and their dependents participate in the group health
3 insurance program offered by the authority; and
4 (8) determine the need for mandatory participation in the group
5 health insurance offered by the authority.
6 * Sec. 2. AS 21 is amended by adding a new chapter to read:
7 CHAPTER 77. STATE INSURANCE.
8 Sec. 21.77.010. AUTHORITY CREATED; REQUIRED PAYMENT SYSTEM, RATE
9 SCHEDULE, AND UTILIZATION STANDARDS. (a) There is established within
10 the Department of Administration a nonprofit incorporated legal entity
11 known as the Alaska State Group Health Insurance Authority.
12 (b) The authority shall, by February 1, 1992, establish and
13 maintain a health care provider payment system, rate schedules, and
14 utilization standards. The state, a municipality, or a school dis-
15 trict shall use the health care provider payment system, rate sched-
16 ules, and utilization standards established by the authority for
17 eligible employees of the state, municipality, or a school district.
18 (c) The authority shall, beginning February 1, 1992, provide
19 group health insurance to eligible employees of the state, a munici-
20 pality, or a school district if the employer has elected to partici-
21 pate in the group health insurance obtained by the authority and may
22 provide group health insurance to employees of other groups that elect
23 to participate in the group health insurance obtained by the author-
24 ity.
25 (d) Upon application by an eligible state program, the authority
26 may, beginning February 1, 1992, allow the eligible state program to
27 participate in the group health insurance obtained by the authority.
28 Sec. 21.77.015. REQUIRED COOPERATION BY STATE AGENCIES. An
29 agency of the state that provides health care or that provides funds

1 to purchase health care shall, to the maximum extent possible, cooper-
2 ate in the development of the use of the health care provider payment
3 system, rate schedules, and utilization standards established by the
4 authority, including sharing relevant information.
5 Sec. 21.77.020. BOARD OF DIRECTORS; ORGANIZATION. (a) The
6 authority shall be managed by a board of directors composed of 15
7 members appointed by the governor as follows:
8 (1) one nonvoting member representing the legislative
9 branch;
10 (2) one nonvoting member representing the judicial branch;
11 (3) two members representing the executive branch;
12 (4) two members representing labor organizations;
13 (5) two members representing school districts;
14 (6) two members representing municipalities;
15 (7) two members representing the Department of Health and
16 Social Services;
17 (8) two members representing health care providers;
18 (9) one member representing the University of Alaska.
19 (b) A member of the board serves for a term of five years. The
20 board shall elect from its membership a president, vice-president, and
21 secretary. Members of the board serve without compensation but are
22 entitled to receive per diem and travel expenses authorized for boards
23 and commissions under AS 39.20.180. Members of the board are subject
24 to AS 39.50.
25 (c) Members appointed under (a)(5) of this section shall be
26 employees of a school district that has elected to participate in the
27 group health insurance obtained by the authority. Members appointed
28 under (a)(6) of this section shall be employees of a municipality that
29 has elected to participate in the group health insurance obtained by

1 the authority.

2 Sec. 21.77.030. GENERAL POWERS. (a) The authority may

3 (1) beginning February 1, 1992, exercise the powers granted
4 to insurers under the laws of the state; if the authority acts as an
5 insurer, the authority shall comply with the requirements applicable
6 to insurers under this title;

7 (2) sue or be sued;

8 (3) enter into contracts or agreements;

9 (4) establish administrative or accounting procedures;

10 (5) collect, invest, and disburse funds;

11 (6) adopt necessary regulations and procedures for imple-
12 mentation of this chapter.

13 (b) In exercising its powers under this chapter, the authority
14 may not participate directly or indirectly in a collective bargaining
15 agreement.

16 Sec. 21.77.040. DUTIES OF BOARD; ANNUAL REPORT. The board
17 shall, in obtaining group health insurance required under this chap-
18 ter, provide comprehensive coverage at the lowest possible cost per
19 eligible employee. The board shall provide to the governor and to the
20 legislature an annual report covering the previous fiscal year's
21 activities of the authority. Every third fiscal year the authority
22 shall include in the annual report a cost and benefit analysis of the
23 health insurance required under this chapter.

24 Sec. 21.77.050. STAFF AND PROFESSIONAL SERVICES CONTRACTS. The
25 authority shall employ an executive director who serves at the plea-
26 sure of the authority as its chief administrative officer. The execu-
27 tive director may, with the approval of the authority, select and
28 employ additional staff as necessary. Employees of the authority are
29 in the exempt service under AS 39.25.110. In addition to its staff of

1 regular employees, the authority may contract for the services of
2 consultants and professional, technical, and financial advisors the
3 authority considers necessary for the purpose of developing informa-
4 tion, conducting hearings, studies, investigations, or other proceed-
5 ings, or otherwise exercising its powers.
6 Sec. 21.77.060. PROCUREMENT OF INSURANCE. (a) The authority
7 shall, after February 1, 1992, obtain a policy or policies of group
8 health insurance covering eligible employees of the state, a munic-
9 ipality, or a district, if the employer has elected to participate,
10 from an insurer authorized to transact business in the state under
11 AS 21.09, or act as a self-insurer if the authority determines that
12 self-insurance can provide the desired insurance coverage and benefits
13 at a lower cost per eligible employee.
14 (b) Except when acting as a self-insurer, the authority shall
15 obtain group health insurance in compliance with the provisions of
16 AS 36.30 and shall make available bid specifications for desired group
17 health insurance benefits to all insurance carriers licensed in the
18 state and qualified to provide the desired benefits. The specifica-
19 tions shall be made available at least once every five years.
20 Sec. 21.77.070. STATE GROUP HEALTH INSURANCE FUND. The state
21 group health insurance fund is created in the general fund. The fund
22 consists of money appropriated by the legislature, and premiums col-
23 lected under AS 21.77.080. The fund shall be managed and invested by
24 the board. The board may expend money from the fund to carry out the
25 provisions of this chapter.
26 Sec. 21.77.080. INSURANCE PREMIUMS. (a) The authority shall
27 provide that sufficient premiums are collected to provide the re-
28 quired insurance coverage and to pay the expenses of the authority.
29 All premiums shall be deposited in the fund.

1 (b) Reserves remaining at the termination of an insurance con-
2 tract shall be invested by the authority in the same manner as retire-
3 ment funds are invested under AS 14.25.180.
4 Sec. 21.77.090. PARTICIPATION; WAIVER. (a) The state, a munic-
5 ipality, or a district may participate in the group insurance coverage
6 provided by the authority. If the state, municipality, or district
7 elects to participate, the state, municipality, or district shall
8 continue to participate unless a waiver is granted by the board.
9 (b) In determining whether a waiver should be granted, the board
10 shall establish minimum benefit and financial standards for the de-
11 sired group health insurance coverage. The minimum benefit and finan-
12 cial standards and the proposed time schedule for responsive offers
13 shall be sent to all participants at the time the request for proposal
14 for the desired group health insurance coverage is issued. Except as
15 provided in (d) of this section, a participant seeking a waiver of
16 coverage shall match the minimum benefit and financial standards set
17 out in the request for proposal for the desired group health insurance
18 coverage. Participants shall submit documentation of their insurance
19 coverage matching the board's minimum benefit and financial require-
20 ments before the deadline established by the board. The board may
21 approve or disapprove a waiver of participation based on the documen-
22 tation submitted by the participant regarding the benefit and finan-
23 cial standards established by the board.
24 (c) A participant may separately provide for health insurance
25 coverage additional to that offered by the authority, and may provide
26 for marketing and servicing to be done by licensed insurance agents.
27 (d) The board shall grant a waiver to a participant who elects
28 not to provide group health insurance to employees. A waiver granted
29 under this subsection takes effect at the expiration of the existing

1 health insurance coverage.

2 Sec. 21.77.100. DEFINITIONS. In this chapter

3 (1) "authority" means the Alaska State Group Health Insur-
4 ance Authority;

5 (2) "board" means the board of directors of the Alaska
6 State Group Health Insurance Authority;

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

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

11 (5) "eligible state program" means a program in which an
12 agency of the state provides health care or provides funds to purchase
13 health care for persons who are not employees of the state;

14 (6) "employer" means the state, a municipality, a district,
15 a collective bargaining unit, or the board of a public corporation of
16 the state created within a principal executive department;

17 (7) "fund" means the state group health insurance fund;

18 (8) "group health insurance" means coverage that may in-
19 clude life insurance, accidental death and dismemberment, medical care
20 and treatment, dental care, eye care, and other group health coverage
21 as determined by the authority;

22 (9) "municipality" includes a public corporation estab-
23 lished by a municipality;

24 (10) "participant" means the state, a municipality, or a
25 district;

26 (11) "payment system" means a system or method that stream-
27 lines or results in cost efficient payments to health care providers;

28 (12) "rate schedules" means schedules of allowable payments
29 for health care related services based on geographic regions, actual

1 provider costs, and availability of services;

2 (13) "state" means the executive, legislative, and judicial
3 branches of state government, or an organizational unit of a branch,
4 and includes the University of Alaska and a public corporation of the
5 state created within a principal executive department;

6 (14) "utilization standards" means a system to monitor,
7 track, and verify patterns of treatment by health care providers that
8 assures that cost efficient and cost effective care is provided within
9 accepted medical standards without reducing the quality of care.

10 * Sec. 3. AS 39.25.110 is amended by adding a new paragraph to read:

11 (30) employees of the Alaska State Group Health Insurance
12 Authority.

13 * Sec. 4. AS 39.50.200(b) is amended by adding a new paragraph to read:

14 (50) Alaska State Group Health Insurance Authority (AS 21.-
15 77).

16 * Sec. 5. STAGGERED INITIAL TERMS; INITIAL APPOINTMENTS. Notwithstand-
17 ing AS 21.77.020(b), enacted in sec. 2 of this Act, the terms of the ini-
18 tial members of the board of directors of the Alaska State Group Health
19 Insurance Authority who are appointed under AS 21.77.020(a), enacted in
20 sec. 2 of this Act, shall be staggered by the governor. Three members
21 shall serve for one year, four members for two years, four members for
22 three years, and four members for four years. AS 21.77.020(c), enacted in
23 sec. 2 of this Act, does not apply to members appointed to the initial
24 board of directors of the Alaska State Group Health Insurance Authority.

25 * Sec. 6. REPORT. The Alaska State Group Health Insurance Authority
26 shall report to the Alaska State Legislature by March 1, 1991, on the
27 progress made by the authority in establishing a health care provider
28 payment system, rate schedules, and utilization standards.

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

DONALD W. SEILER

3456 Kant Court Juneau, Alaska 99801 (907) 789-2495

PROFESSIONAL EXPERIENCE

1989-present **JUNEAU RACQUET CLUB, JUNEAU, ALASKA**
General Manager

Manage all aspects of programming and operations at a full service health/fitness facility. I am accountable for all financial management including budget, accounts receivable, accounts payable, and cash management. I write and update the business and marketing plans and am responsible for their implementation.

ACCOMPLISHMENTS

Developed, marketed, and supervised implementation of a health promotion program for 700 municipal employees.
Developed a marketing program that resulted in the highest new member enrollment in 12 years.

1987-1989 **ST. JOSEPH'S HOSPITAL, TAMPA, FLORIDA**
Director of Health Promotion

Managed all health promotion activities at a 750 bed metropolitan hospital. Responsibilities include management of a 14,000 square foot fitness center. Was accountable for all aspects of fitness center operation, including marketing, a $950,000 budget and a staff of 22 FTE's. Additional health promotion responsibilities included preparation of proposals and program development for corporate clients. I served as behaviorist in weight management program for moderate and morbidly obese patients and taught nutrition, smoking cessation, stress management, and other disease prevention programs.

ACCOMPLISHMENTS

Supervised development of a 12 week cholesterol control program.
Developed smoking cessation program with 56% quit rate on 1 year follow-up..
Supervised health promotion program for 2,700 hospital employees.
Conducted all start-up activities of fitness center from opening to one year membership of 1325 members.
Fiscal year 1989-90 ended with a 28% return on sales.

1986-1987 **ST. JOSEPH'S HOSPITAL, TAMPA, FL**
Health and Sports Institute Director

Total responsibility for all aspects of health promotion programming at a major destination resort. Developed customized educational programs for visiting corporations including stress management, health risk appraisal, and lifestyle management for health promotion.

ACCOMPLISHMENTS

Developed weight training program for preadolescent gymnasts.
Certified by Johnson and Johnson Health Management Inc. to deliver stress management, weight control, nutrition, and smoking cessation programs.
Served as nutrition consultant to the Tampa Bay Buccaneers professional football team.

1984-1986 **UNIVERSITY OF HOUSTON AT CLEAR LAKE, HOUSTON, TEXAS**
Health Promotion Coordinator

Responsibility for development and delivery of health promotion programs for corporate clients. Conducted testing in the human performance lab using treadmill, hydrostatic weighing, skinfold calipers, and spirometry. Prepared individual exercise prescriptions based on test results. Using Cybex equipment, conducted strength assessments for astronaut selection. Implemented special events including weight loss competitions, walkfests, and blood pressure survey programs. Instructed Employee Fitness Exercise Classes for ages 16-70. Developed and implemented instructor training workshop for new instructors. Conducted physical abilities testing for prospective employees on job related skills and gross motor skills.

ACCOMPLISHMENTS

Developed Fitness Instructor Workshop with total enrollment of 75 participants.
Edited and wrote monthly newsletter which included current information on health related topics.
Developed and conducted blood pressure screening program for 4000 school district employees.

Other significant work experiences:

1979-1984 Commercial Helicopter Pilot
Houston, TX and Anchorage, AK

Flew in support of fire suppression, biological surveys, and offshore oil and gas production.

1978-1979 Fitness Facility Manager
Nautilus of Texas, Houston, TX

1976-1978 Park Caretaker
Champion Papers, Pasadena, TX

1970-1976 Maintenance Manager/Combat Helicopter Pilot
U.S. Army

EDUCATION

UNIVERSITY OF HOUSTON at CLEAR LAKE: MA, May 1986
Major: Human Performance
Minor: Psychology

UNIVERSITY OF HOUSTON at CLEAR LAKE: BS, May 1985
Major: Health, Leisure and Sports
Minor: Business Administration

PROFESSIONAL ASSOCIATIONS

American College of Sports Medicine
National Strength and Conditioning Association
Association for Fitness in Business - Book Reviewer

PROFESSIONAL CERTIFICATIONS

American College of Sports Medicine - Health and Fitness Instructor
American Red Cross - CPR, Basic First Aid, Advanced Lifesaving

PERSONAL

Happily married, wife: Kim
Four children: Tara 12, Andy 4, Ryan 2, Merideth 4 months
Excellent physical condition

An Overview Of:

Corporate Health Promotion Programs

Presented To:

The State of Alaska Health Care Cost Containment Task Force

Presented By:

Positive Health Options

a division of the

Juneau Racquet Club

Rising Health Care Costs - The Problem

Health care costs are growing at a rate much higher than the consumer price index. Total health care costs in the U.S. were:

*1973 - $200 billion

*1983 - $360 billion

*1993 - expected to be $1 trillion!

At the same time, employer contributions have grown from 6% to an anticipated 40% of total expenditures.

*Chrysler estimates that approximately $220 of the cost of each automobile is due to employee health care costs

*General Motors spent more on employee health care costs than on steel for its automobiles

There are many causes for increased health care costs:

*Increased use of expensive technology

*Expensive drug therapies

*Rising cost of mental health services

*Larger and more frequent claims for catastrophic illnesses

*Reduced Medicare payments

The National Center for Health Statistics reported that approximately 70% of all health care expenditures are a result of lifestyle choices:

*Of the 10 leading causes of death, heart disease and cancer account for 6% of all those fatalities

*53% of all cardiovascular deaths and 60% of all cancer deaths are due to the effects of lifestyle

*The National Chamber of Commerce estimates that businesses lose 52 million work days due to heart disease

Cost-Containment Efforts

American businesses are trying a variety of cost containment techniques, including:

- *Expense Management
  - *Prospective Review
  - *Concurrent Review
  - *Retrospective Review
- *Benefit Reduction
- *Alternative Delivery Systems
  - *Health Maintenance Organizations
  - *Preferred Provider relationships
  - *Ambulatory Surgery
  - *Utilization Education
- *Utilization Reduction
  - *Health Promotion
  - *Employee Assistance

Health Promotion Programs

Comprehensive health promotion programs have achieved impressive results:

*Johnson & Johnson - $378 per employee cost savings

*NASA - 52% improvement in job performance

*Kennecott Copper - 58% reduction in absenteeism

*General Motors - 60% decrease in sickness and accident payments within 1 year of implementing an employee assistance program

Components of a comprehensive health promotion program are:

*Awareness - Media campaigns, newsletters

*Assessment - Health Risk Appraisals, blood pressure

*Lifestyle Change - Smoking cessation programs, weight loss programs

*Environmental Support - Smoking policies, flex-time, exercise facilities

The Products

There are many levels of corporate health promotion programming. The following descriptions detail some of the options that are available:

Level 1 - Awareness and Education

Quarterly campaigns to increase awareness of selected area of health concern. Each campaign will include:

1. On-site posters to create interest in program and encourage attendance.
2. Reproducible hand-outs to increase awareness and provide education.
3. 1/2 hour to 1 1/2 hour lectures about the selected topics.

The number of sessions depends upon the number of shifts and employees.

Level 2 - Appraisal, Awareness, and Education

This quarterly campaign is similar to the above program,but includes the addition of some form of health screening (such as cholesterol screening, hypertension screening, etc.). Costs are determined by test selection, number of employees, and number of shifts.

Level 3 - Off-site Program Management

Following a complete analysis of needs, including management assessment and employee assessment, a system will be designed to provide on-going health promotion activities. The specific needs of the corporation will be addressed in a mutually agreed upon program. A Health Promotion Coordinator will be on-site 2-3 days per week, depending upon current needs. The Positive Health Options Health Promotion Manager will maintain contact with the client's representative to insure quality of programming and to identify new program needs.

Level 4 - On-site Program Management

Following a complete analysis of needs, including management assessment and employee assessment, a system will be designed to provide on-going health promotion activities. The specific needs of the corporation will be addressed in a mutually agreed upon program. A Health Promotion Coordinator will be based on-site. The Health Promotion Manager will maintain contact with the client's representative to insure quality of programming and to identify new program needs.

In addition to the above health promotion systems, Positive Health Options can provide the following lifestyle intervention programs:

*Smoking Cessation

*Stress Management

*Weight Management

*Exercise

The experts at Positive Health Options can help an organization design programs and facilities, including site selection, personnel selection, and equipment selection.

The Organization

In addition to purchasing a product and services, you are also buying an organization. The Juneau Racquet Club opened in 1978 as an indoor racquet and exercise facility. Always on the leading edge of fitness and recreation, the club was among the first in Alaska to offer group aerobic classes (1980), fitness testing (1982), and wellness programs (1984).

Positive Health Options began as a division of the Juneau Racquet Club in 1989. At that time Positive Health Options began the management of a comprehensive health promotion program for the City and Borough of Juneau. This program is the first comprehensive municipal wellness program and serves as a model for those to come.

The staff of Positive Health Options as highly qualified and experienced in management of Corporate Health Promotion Programs as well as delivery of behavioral intervention programs. Their expertise includes exercise physiology, behavioral science, business management.

Advantages of choosing Positive Health Options are:

*Responsive to employee and management needs

*Confidentiality for participants is assured, improving response

*Integration of all aspects of programming

*Single source for all health promotion needs

*Experienced, qualified staff

*Expertise available in the private sector

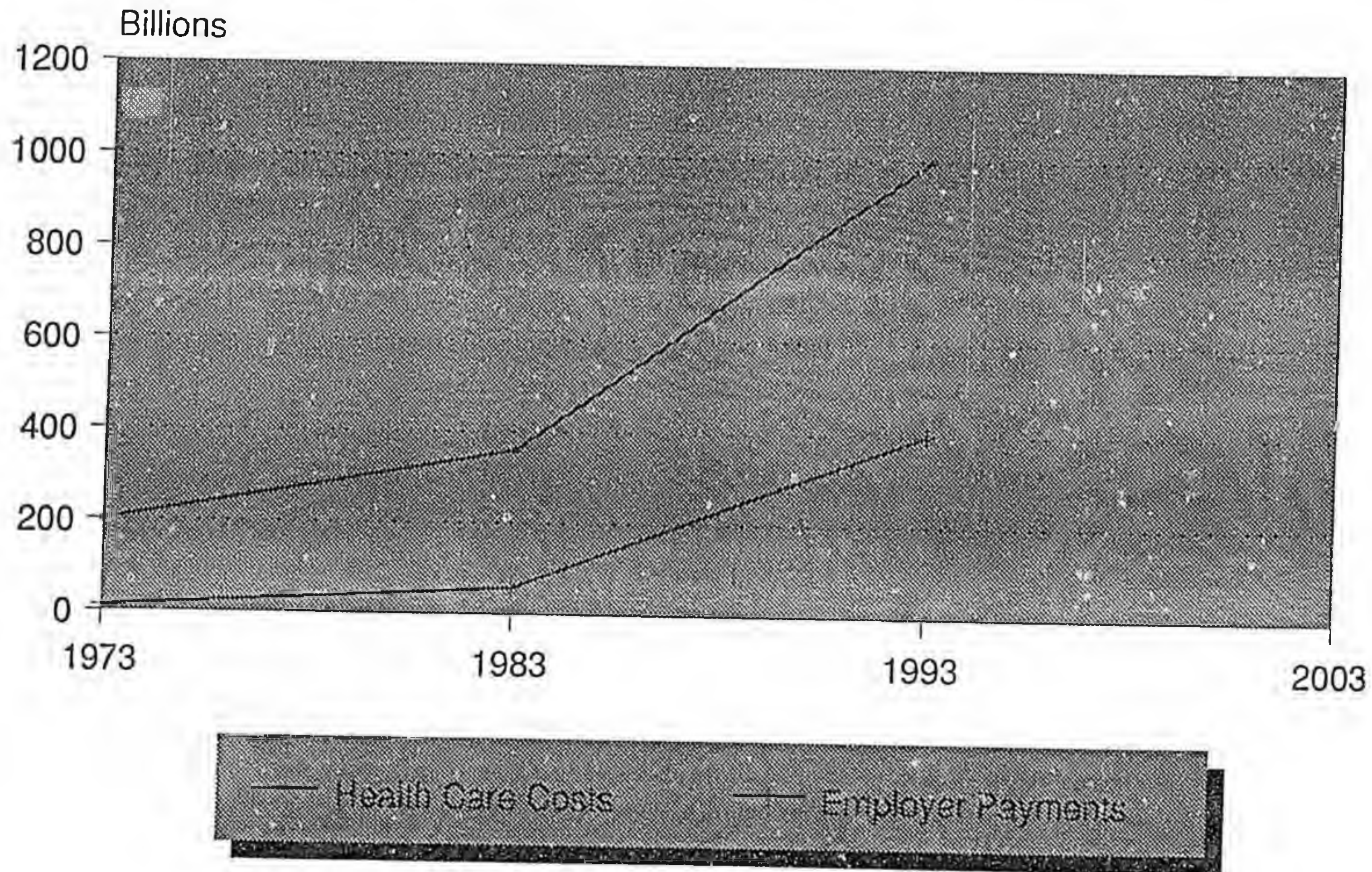
*Full time staffing

Worksite Health Promotion: An Alaskan Perspective

Positive Health Options

a division of the
Juneau Racquet Club

American Health Care Costs
and Employer Contributions



Solutions To Rising Costs

- Expense Management
  - Prospective Review
  - Concurrent Review
  - Retrospective Review
- Reduced Benefits
- Alternative Delivery Systems
- Co-Payments
- Utilization Reduction
  - Health Promotion
  - Employee Assistance

Results of Health Promotion Programs

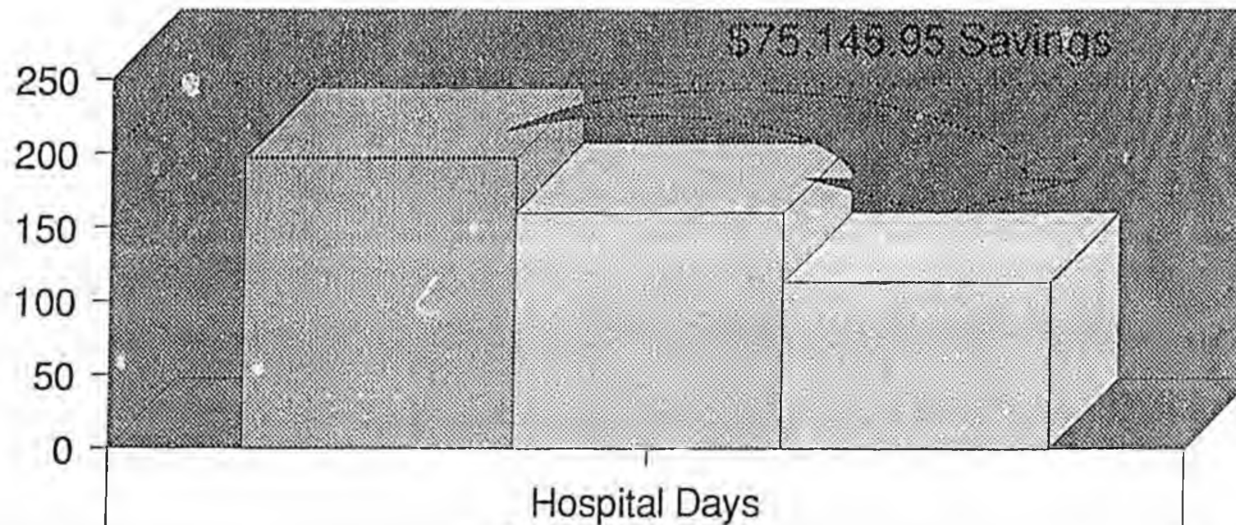
- Johnson & Johnson - $378 per employee cost savings
- New York Telephone - $2,700,000 cost savings
- NASA - 52% improvement in job performance
- Kennecott Copper - 58% reduction in absenteeism and 55% reduction in medical costs
- General Motors - 60% decrease in sickness and accident payments in one year

HEALTH PROMOTION PROGRAM COMPONENTS

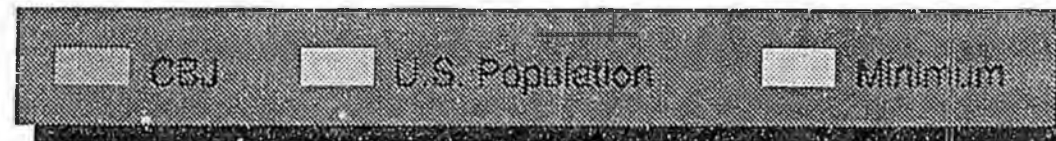
Component	Examples
Awareness	Media Campaigns Newsletters Health Screenings
Assessment (Monitoring & Follow-up)	Health Screenings with monitoring and follow-up Employee Assistance Program
Lifestyle Change (Education & Skill Building)	Smoking Cessation Programs Weight Loss Programs Stress Management Programs
Environmental Support	Smoking Policies Cafeteria Programs Vending Machine Programs Exercise Breaks Flex-Time

Health Yourself

Reduction in Hospital Days

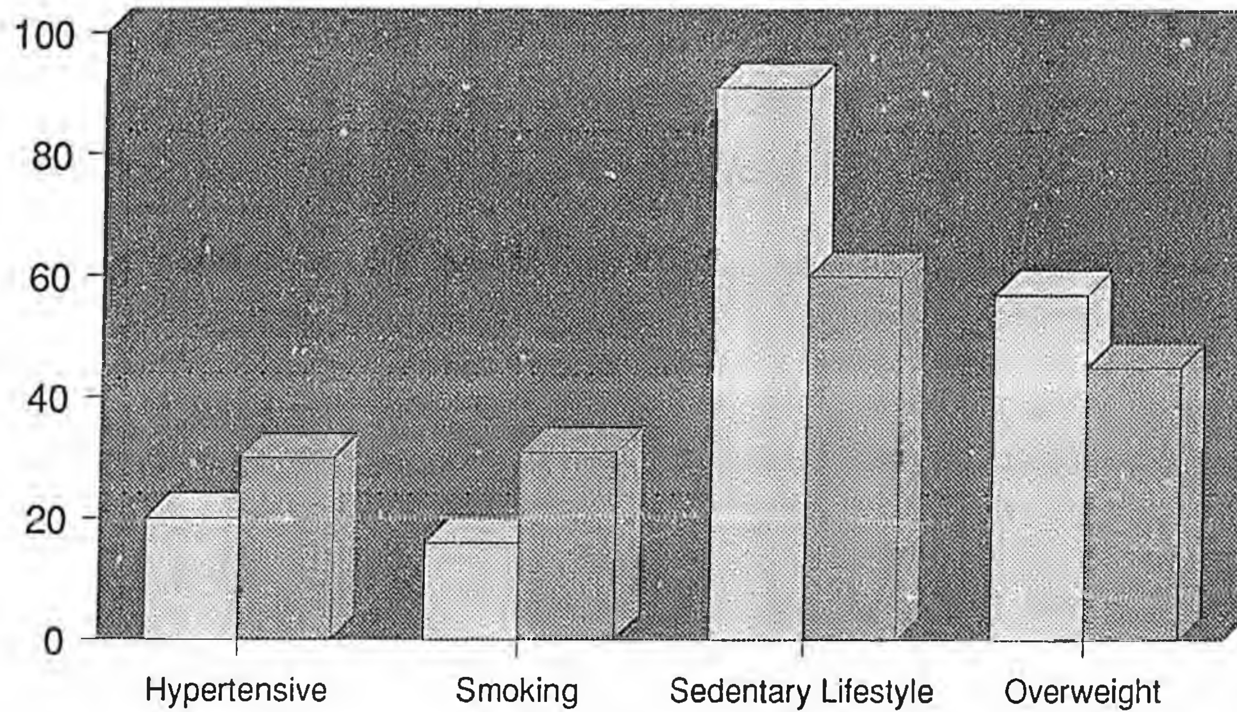


	Hospital Days
CBJ	197.17
U.S. Population	160.15
Minimum	112.92



Health Yourself 1990

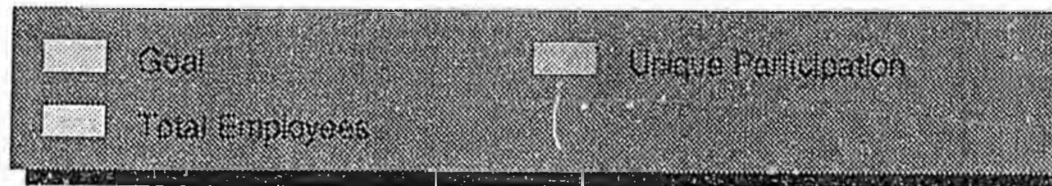
Health Yourself

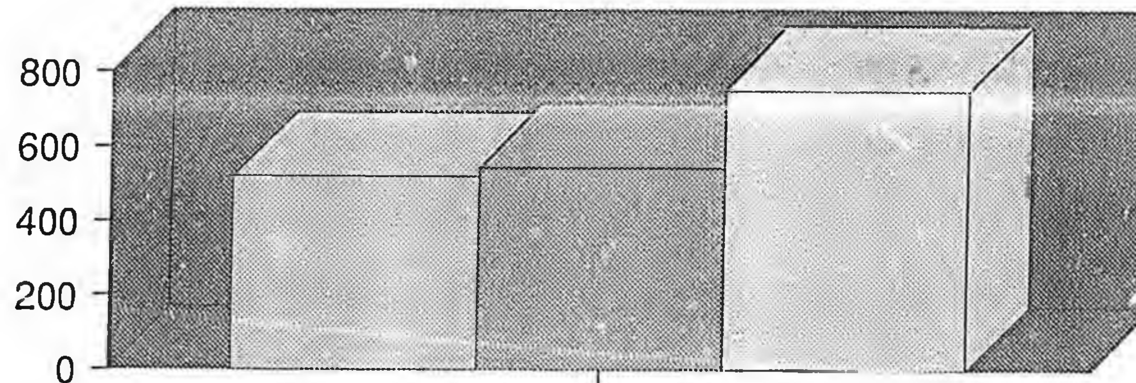


	Hypertensive	Smoking	Sedentary Lifestyle	Overweight
CBJ	20	16	91	57
U.S. Population	30	31	60	45

CBJ U.S. Population

Health Yourself
Unique Participation





Goal	521	70%	of Total Employees
Unique Participation	545	72%	of Total Employees
Total Employees	753		

Positive Health Options
Advantages

- Responsive to employee and management needs
- Confidentiality for participants is assured, improving response
- Integration of all aspects of programming
- Single source for all health promotion needs
- Experienced, qualified staff
  - Expertise available in private sector
  - Full time staffing

COORDINATION OF BENEFITS AND "DOUBLE COVERAGE"

In today's society, families in which both adults are employed are common. If the employers of both adults provide their workforce with medical/dental insurance, it is possible for one or both to have "double coverage."

When a covered employee or dependent has insurance from two insurance carriers, "coordination of benefits" provisions set the rules for the payment of claims. Under these provisions, one plan is "primary" and one plan is "secondary." The primary plan pays regular benefits in full. The secondary plan pays a reduced amount which, when added to the benefits paid by the primary plan, will equal no more than 100% of the medical/dental expense.

A plan that does not coordinate benefits is always the primary plan. Subject to variances mandated by some states, if both plans coordinate, the primary plan is determined as follows:

...The plan which covers the patient as an employee, rather than as a dependent, is primary.

...If a child is a covered dependent under both plans, a plan covering the parent whose birthday falls earlier in the year determines its benefits before a plan covering the parent whose birthday falls later in the year. (In some states the father's plan is primary) However, if the parents are legally separated or divorced, benefits will be payable under the plan of the parent with custody of the child, except as follows: if a court decree has established financial responsibility for the child's covered expenses, benefits will first be payable under the plan of the parent who has that responsibility, and that parent's plan is primary.

...A plan covering a person as an employee (or dependent of such employee) who is not laid-off or retired determines its benefits before a plan covering a person as a laid-off or retired employee (or dependent of such employee).

Assuming a situation in which the plans of both adults pay benefits on an 80%/20% basis after the deductible and in which both deductibles have been met, one plan will pay an 80% benefit and one will pay a 20% benefit. <u>Both insurance carriers receive a 100% premium</u>.

Employers in the private sector have found that requiring an employee to contribute even a token amount of his or her own premium <u>and</u> the dependents' premium motivates employees to responsibly evaluate the need for "double coverage."

There is a potential danger for an employee who elects not to enroll himself/herself or dependents in an employer's plan when the opportunity to do so is first available. If coverage under one plan terminates because of lay-off, termination of employment or retirement, the persons now without coverage will be "late entrants" if they apply for coverage under the (remaining) other plan.

Late entrants must provide evidence of insurability when applying for coverage. This must usually be provided at no expense to the insurance carrier and it will be subjected to close scrutiny. Late entrants may be declined, approved with exclusions for pre-existing conditions or approved with no restrictions. In

PREMIUM REDUCTION

Health Insurance plan changes which should result in reductions in premiums include the following:

...Increase individual deductible

...Increase family deductible maximum

...Increase individual coinsurance maximum*

...Increase family coinsurance maximum*

...Delete first dollar accident coverage

...Delete first dollar hospital coverage

...Delete routine maternity care coverage**

...Require preauthorization for hospital confinement

...Add inpatient hospital deductible

...Enter into a preferred provider arrangement

...Require a second surgical opinion

...Delete coverage for specified charges:
_Dental
_Vision
_Rx Drugs
_Mental Health
_Alcoholism
_Drug abuse
_Chiropractic

* Coinsurance is that part of a covered charge (often 20%) above the deductible which is payable by the insured person. Most health insurance plans limit an insured person's coinsurance liability to a specific calendar year maximum. Some plans feature a family maximum.

** Federal law requires employers with 15 or more employees who have a group insurance plan to provide coverage for pregnancy on the same basis as coverage for any other medical condition. The law does not require that the employer provide this benefit within the group insurance program.

NOTE: Adoption of some of the changes listed above may violate laws of a given jurisdiction. Employers are advised to seek legal counsel when making reductions in coverage.

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

02-576(2/77)

COORDINATION OF BENEFITS AND "DOUBLE COVERAGE"

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Assuming a situation in which the plans of both adults pay benefits on an 80%/20% basis after the deductible and in which both deductibles have been met, one plan will pay an 80% benefit and one will pay a 20% benefit. <u>Both insurance carriers receive a 100% premium</u>.

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Late entrants must provide evidence of insurability when applying for coverage. This must usually be provided at no expense to the insurance carrier and it will be subjected to close scrutiny. Late entrants may be declined, approved with exclusions for pre-existing conditions or approved with no restrictions. In

some plans, late entrants may be subject to waiting periods before some coverages take effect. Some insurance carriers liberalize late entrant penalties if the applicant can show that a change in the availability of "other coverage" has taken place and that application is being made within 30 days of this event.

COBRA (Consolidated Omnibus Budget Reconcilliation Act) regulations ameliorate the loss of coverage from a group plan maintained by an employer with 20 or more employees. Employees terminating from a firm subject to this law may continue coverage for themselves and their dependents for up to 18 months at their own expense. COBRA offers a short term solution to terminating employees. Those returning to the workforce with a firm that provides group insurance without an "evidence of insurability" requirement and those doing this early enough to satisfy the new firm's probationary period before COBRA's 18 months have expired will not have a problem. Uninsurable persons who lose coverage for any reason may regret an earlier decision not to elect "double coverage."

It does not appear to be unethical to motivate an employee (by asking him or her to pay an affordable part of the premium) to responsibly evaluate the need for double coverage for himself/herself and/or his or her dependents.

PREMIUM REDUCTION

Health Insurance plan changes which should result in reductions in premiums include the following:

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...Increase family deductible maximum

...Increase individual coinsurance maximum*

...Increase family coinsurance maximum*

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...Delete first dollar hospital coverage

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...Require preauthorization for hospital confinement

...Add inpatient hospital deductible

...Enter into a preferred provider arrangement

...Require a second surgical opinion

...Delete coverage for specified charges:
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- _Vision
- _Rx Drugs
- _Mental Health
- _Alcoholism
- _Drug abuse
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Health costs not evident to consumer

By David Stratton

As a broker in the health insurance field I am constantly asked to explain why this coverage is so expensive. All too often the coverage is not available at any price. What has happened to bring us to this crossroads today?

Medical services are more in demand today than ever before. Many services in America experience a decline in demand as their price increases, however, this does not seem to be the case with medical services. As a matter of fact, the demand doesn't seem to be slowed at all by the spiraling price increases. Just the opposite appears to be true. Why is this?

Who pays for most the medical services provided today? If you need food and shelter you will purchase groceries at the store and look for a home to rent or purchase. You actually look for what you can afford because you will be paying according to what is charged. This creates an informed and cautious shopper.

But who pays for most of the medical services the consumer uses? A third party payor is most often present in the payment for medical services. This allows the consumer to pay little or nothing of the total cost of health care.

Many times the billing for these services is sent directly to the third party and the consumer has no idea of the accuracy or the quantity of the billing. This puts many consumers totally out of touch with the cost of the medical services which they are using.

There can be little hope of curtailing the increasing spiral of costs until the end user of these products becomes involved in the cost portion of the program. Currently the premium for the insurance is mostly paid by the employer and the employee pays a small portion of the medical bills.

Possible solutions to this problem of cost include government sponsored plans with no direct cost to the consumer.

Large employers have found that a distinct relationship exists between the use of a plan and out-of-pocket expense to the employee. The higher the out-of-pocket costs, the lower the use of the plan benefits.

In addition these employees and their dependents are not going without needed medical care. In fact they are using the plan benefits when needed and changing their life styles as well. Many employees had quit smoking and limited their drinking habits. Exercise had also become a part of their lives on a regular basis.

All in all, the employees discovered what the actual costs of medical were and took the option of improving their health and reducing their dependance on plan benefits.

These results may well point to one of the main culprits of the price spiral in employee health benefits. Possibly we can all see that culprit by taking a long look deeply into the bathroom mirror.

The author is a member of the Alaska Association of Independent Agents and Brokers, president of the Alaska Associatio of Life Underwriters, and president of the Alaska Chapter of the Society of CLU and ChFC.

• Recourse

Continued from Page 9

condition," he added.

Other people share the same problem. Those who have had drug or alcohol treatment and older individuals fit into similar categories.

Other than a little bit of cancer, I'm in fairly decent health (a little high blood pressure maybe). While I feel like an old man (the name is not Erma by the way — it's Hungarian and probably developed during the era of Conan) at 28, most tell me I've got a way to go.

But I would have some recourse. I could fall into the uninsured category or get into a group plan (thank god I'm already in one) and become its high-risk centerpiece. In that case, the other healthy members of the group would pick up the costs.

This also opens up another issue — that of an increasing trend (albeit small) by employers requiring a physical and medical history prior to hiring prospective employees. Many employers are already letting medical coverage be an individual thing.

It makes me worry. But what the hell, at least I have a plan now and the cancer said later on for the time being.

• Increasing competition

Continued from Page 15

sured. The task force found it could amount to a possible 5.4 percent savings if instituted on the state's health care plan based on programs in other areas.

Clark said the idea of a built in fee system is to increase the competition level in the industry. He said he'd also like to see it reduce the amount of what he called "defensive" costs where a doctor orders second and third tests that tell him essentially the same data due to malpractice worries.

Of cost shopping, Clark says, "Everybody's entitled to transportation but not everybody's entitled to drive a BMW."

In some cases, Blue Cross is allowing patients to receive care in the home in lieu of costlier hospital care where applicable.

Roller said the state looked at the option of going self insured for its employees and found that it wouldn't do any good. The finding further reinforced his perception that the insurance companies weren't out to make a killing but just out to cover costs incurred.

• Health: insurers have little control

Continued from Page 9

can peg on one scapegoat, but a number of serious factors contribute, he added.

"In the old days, you picked one guy and called it a hospital problem," he said. "You can't do that anymore. Employers, unions, the medical profession, the insured ... they all have to get involved as well. If we are to contain the excessive costs of health care in Alaska, we've got to work in unison with the physicians, hospitals, employers and individual subscribers to reach a consensus on how to remedy a situation where individuals are being priced out of health care benefits. Everybody involved has to be willing to make changes."

He admitted his request for a rate increase won't solve the problem.

"It just finances it for one more year," Clark said while on a trip through Alaska last month.

Blue Cross, as well as Aetna, has studied the problem in depth. Aetna shared its findings with the governor's Health Insurance Task Force underlining some of the causes for increases and the severity of the situation facing the state. Blue Cross reviewed claim histories to come up with a picture of the industry. Its study suggests measures must be taken to contain cost increases or more individuals will fall in that uncovered realm.

"Something is seriously amiss," Roller said. "We're obviously spending an adequate amount but it's not being distributed equally. As people start to drop out of the health insurance area, that in turn drives up costs even higher and that spreads risks among a smaller and smaller pool."

Roller said many tend to blame the insurers but that's not the case.

"They don't have much control," he said.

According to figures researched by Hewitt Associates, 33 percent of the projected increases in health care premiums could be attributed to medical inflation, 29.5 percent to cost shifting from cut federal programs, 16 percent to utilization of services, 11 percent to technology with the rest going to catastrophic and malpractice cases.

Roller points to cost shifting as one of the more overlooked causes which is primarily due to the result of the federal government capping programs that provide coverage. Because of that, Medicare and other government subsidies pay a set amount for certain illnesses and services. As a result, insurance carriers pay more and shift the increased costs that fall on them to the rest of their subscribers.

"That point needs to be brought home," Roller said. "It's not just hitting Alaska but it's endemic throughout the country."

He also says health insurance is really a misnomer. Insurance companies act more and more like administrators. They pay the bills which come in at a predictable rate. At the end of the year, reviewers with doctorates calculate the costs and schedule rates accordingly.

"It's kind of like insuring yourself for buying gasoline," he said. "You know you're going to need it."

Dental insurance is a good example. Most people can expect a couple of routine visits a year, he adds.

Wagstaff said medical insurance is very service oriented and provides it chiefly because his clients require it and because it's part of business insurance planning. His firm specializes in all forms of employee benefits insurance products.

Solutions are being sought after by the state as well as a number of carriers. As a first step, Blue Cross is building a what it calls a realistic fee schedule and assisting its clients in finding the most cost-effective care. Clark calls it putting more power back into the hands of the consumer.

"We don't have the answers yet," he said. "We're getting back to the basics."

Roller said the Health Insurance Task Force looked into setting up a utilization review middleman to recommend low-cost services to the in-

See INCREASING, Page 20

INSURANCE UPDATE

Part 1 PERSONAL COVERAGE

Health insurance rates will go higher

By IMRE NEMETH

Health insurance rates are high and projected to escalate further with no real end in sight. The reasons for this are debatable, of course, but contributing factors pegged are medical inflation, user cost apathy, federal program cutbacks, technology and catastrophic cases.

Stephen Clark, vice president and chief operating officer at Blue Cross of Washington and Alaska, proposed a 70 percent increase on certain Alaska plans just to cover costs. Two of four of its individual health plans are targeted for the hefty hike with others planned for smaller increases.

Paul Roller, director of the state Division of Insurance, says other carriers are proposing increases as high as 102 percent. While the proposals may appear high, Roller figures his market analysts will probably find many justified and allow increases similar to those proposed.

There's a trend by health-care providers to move subscribers into plans with higher deductables and limits on service. The riders of the past and even the so-called "Cadillac" plans are being trimmed. It's not to the level of a 1968 Volkswagon beetle but the new typical plan could very well be likened to the self described sensible Hyundai.

Plans with the lowest deductables — from $100 to $200 — are typically getting the most attention by insurance companies and the lion's share of increases.

Almost like a travel agent who electronically calls up every fare on the planet when tracking the cheapest route between two points, Paul Wagstaff's Northwest Planning Associates computer system digs into the industry for the best plan for a particular client. He estimates the number of plans available at between 1,400 and 1,500 among the as many as 200 different carriers.

Using the data and specifics provided by a typical business shopping for a plan for its employees, he then comes up with a slate of possibilities. The ensuing spectrum of plans comparing cost per month and available coverage then provides the choice.

Wagstaff says the shopping process is a constant. He attributes it to employers routinely looking at a yearly rate increase.

"There's a trend to more skeletal plans," he said. "People are getting down to the basics and deleting options of the cost. What is shaping out of this is a definite trend toward the higher deductable. It's those plans with sizeable deductables that experience the least amount of yearly increase — in the 12 percent to 15 percent range as opposed to 25 percent and up.

Clark is tired of spiraling rates. He'd like to see measures taken that put a cap on the problem.

Moving to the Bahamas and working on a professional tan 12 months out of the year was out, so he went for the next best thing — Clark decided to hammer at the causes. He figures if he can't kick rates in the teeth, he might be able to forestall the continuing trend of astronomic annual hikes.

"It's a national problem," Clark said.

In the United States, health care consumes 11 percent of the gross national product. The country's medical system and quality of care is considered among the best in the world, but there's an increasing number of people who don't have medical coverage. These individuals who slip through the cracks also need attention in case of illness. When they do have something happen and spend time in the hospital, they end up forcing costs higher on those who pay. By contrast, in Japan and most of Western Europe where health care is universally available, health care takes up 3.5 percent of their gross national product.'

Clark said the first step in the battle is calling awareness to the problem and getting everybody involved. It's not just something consumers

See HEALTH, Page 15

So you've a problem

By IMRE NEMETH

In late October of last year, my doctor said, "You've got a tumor, it could be cancerous. I want you on the operating table tomorrow."

I wasn't too impressed.

Nonetheless, two days later, I felt like a 1933 Willys that just had it's roof chopped two inches. Something was missing. Then the doc (who wasn't much for humor) told me this tumor (which I had grown attached to) was malignant and that I could expect treatment.

Not fun. Expensive too. In a few weeks, I racked up nearly $15,000 in bills and I glowed in the dark.

Little did I know then, but I entered the realm of high-risk health care individuals. If I were to ask an insurance carrier today for individual coverage at a good price, the staffer handling the call could conceivably hold up a crucifix and back slowly out of the room. Or they may just say no.

I asked Paul Wagstaff, owner of Northwest Planning Associates, what my chances were.

"You'd have a very difficult time getting insurance," he said simply.

Insurance carriers base plan rates on group or individual claims history. They function as a business much like any other and must make a profit. Risk is not something they consider too cool.

Wagstaff said most would like to wait and see if I developed any more problems. It would probably take five years, he said.

"At best they would rider the

See RECOURSE, Page 14

MAR 16 1989

3531 West 31st Avenue
Anchorage, Alaska 99517

March 14th, 1989

WEST ANCHORAGE LEGISLATORS
Senators Pat Rodey & Drue Pearce
Representatives Alyce Hanley,
Max Gruenberg, Dave Donley & Loren Leman

Jo - Let's plug him into the Task Force - give this to members - let Frank know what's happening.

Dear Drue,

During the March 2nd Turnagain Community Council teleconference I had an opportunity to tell you that, as a life and health insurance salesman:

...I believe we have reached a crisis stage insofar as the availability of affordable health insurance and health care is concerned.

...I have some recommendations for those legislators charged with bringing the cost of health insurance for State of Alaska employees under control.

The costs for health care and health insurance, the usage rate for health services, and cost shifting are all factors which must be brought under control. I believe that the State of Alaska must serve as a catalyst in bringing together qualified people from the medical professions, insurance industry, consumer groups and social services organizations to look for solutions. I do not believe they will find any unless (1) they are all really determined to do so, (2) they are all prepared to consider some radically new ideas, and (3) they are all willing to give up some of the things they have become used to. I urge you all to do what you can to establish this forum.

Every day I talk to responsible people who want to stand on their own two feet and fund their future health care expenses through insurance. For many the cost of doing this today has become a serious burden and for others it has become an impossible objective. All are faced with difficult decisions in selecting what they can and should insure. I have spoken to no one in the private sector who does not resent the level of health insurance which the State of Alaska continues to provide its employees. In negotiating an affordable level of benefits with union representatives, the message in the previous sentence should be transmitted loudly and clearly.

I see three areas in which savings may be found in the state group insurance program:

Rate Structure From what I have read in the newspapers, the State of Alaska now pays $431 per month per state employee. This is the rate if the employee is single and it is the rate if the employee has a spouse or a child (or children) or a spouse and a child (or children). This was probably the most cost effective way of rating the entire group at some time in the past but it may not be the best way today. There are any number of ways to "rate out" a group and I think it would be appropriate to ask your carrier to produce rates using different combinations. If changes

are made in the employee contribution level (presently "zero") or the plan design it would be appropriate to (1) communicate these changes to all employees, (2) run a survey to determine the likely level of participation following the changes, and (3) ask your carrier to recalculate the various rating structures using the new census.

Employee Participation in Premium Payments I have enclosed a reprint of three articles from the February 6th edition of the Alaska Journal of Commerce. David Stratton's article - Health Costs Not Evident to Consumer - contains a message that we must all understand. State employees can now insure themselves and their dependents on the group plan whether they need insurance or not. In an enclosed paper "Coordination of Benefits and Double Coverage," I have presented information which may assist you in evaluating a requirement for employee contributions towards the cost of their own and their dependents' insurance.

Plan Design The information in Mr. Stratton's article is also pertinent in developing an appropriate plan design. I will not presume to suggest a plan design for State of Alaska employees. I will suggest that increased participation in the cost of health care through changes in plan design can be as beneficial in eliminating unnecessary expenditures as a requirement to participate in the cost of premiums. I have provided a list of plan features which, if changed, may result in savings. I should add that insurance carriers weigh the cost of a given feature in different ways (usually as a result of their own experience) and that it is unreasonable to expect any carrier to be able to change its plan in all of the ways I have listed.

I hope you find this information useful. If I may provide additional information, please contact me. My phone number at work is 257-5239. At home it is 243-2928.

Thank you all for the efforts you are making on behalf of all of us. I look forward to hearing from you at the future Turnagain Community Council teleconferences.

Sincerely,

Frank Keen

cc. Senator Sturgulewski
Senator Binkley
Senator Uehling
Senator Fischer
Representative Hoffman
Representative Larson
Representative Ellis

STATE OF ALASKA

HEALTH CARE COST CONTAINMENT

TASK FORCE

REPORT TO THE LEGISLATURE

By

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

January 31, 1990

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SECTION I

CREATION OF THE
HEALTH CARE COST CONTAINMENT TASK FORCE

SECTION I

CREATION OF THE

HEALTH COST CARE CONTAINMENT TASK FORCE

Several events occurred at the beginning of the Sixteenth Alaska State Legislature that drew attention to the escalating costs of health insurance for State employees, retirees, and their dependents. The first was the announcement of a substantial mid-year premium increase in order to cover the increased costs and utilization of State health care plans. The supplemental appropriation bill introduced to pay the additional premium costs for the fiscal year (FY 89) budget alone was $21,800,000.

Particularly alarming was the aspect that the additional premium needed followed large premium increases in the preceding two years with essentially no changes to the health plans. In effect, the cost of State employee health benefit coverage has increased 54% over the last three years. Legislative finance committees had earlier expressed their concern by requesting the Division of Retirement and Benefits to make recommendations that the Legislature could take to limit costs. The initial reaction of many finance committee members to the new funding request was negative or confrontational.

State employee union representatives had also expressed concern. Several of the bargaining units were in negotiations with the State over wages and benefits, wherein, the health care cost increases presented a complicating factor. From their perspective, rising health care costs was a continuing problem throughout the nation that has been confronted successfully in the private and other public sectors with appropriate cost management of health plans. Furthermore, they expressed a willingness to assist the Administration and the Legislature in determining cost containment provisions that could readily and effectively apply to the State's health care situation.