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7498 SENATE LABOR & COMMERCE

With consenting agreement between the Governor and the House and Senate leadership, Senate Concurrent Resolution 23 was introduced on February 23, 1989 to create a task force made up of legislators, public employee representatives, and representatives of the Administration. Their task was to review all aspects of health care cost containment and make recommendations that would reduce the supplemental funding request.

Secondly, the task force was to determine actions that would contend with health cost inflation in the long term. Testimony before the Senate Finance Committee on February 24, 1989 asserted that there was in fact means to help reduce the costs of the State health care plan. Possible areas of savings that were outlined included: cost containment provisions could be incorporated into the plan without changing existing benefits, review of the plan's financial status, alternate funding of the plan, and provider payment schedules. Several items could be implemented to impact the FY 89 budget, with the remainder to reduce health care costs in FY 90 and beyond.

On March 10, 1989, SCR 23 had passed both houses of the Legislature and became Legislative Resolve 8. Appointments to the Task Force were quickly made and the Task Force began work on March 22, 1989. The Task Force retained A.J. Gallagher & Co. to provide health care consulting and actuarial services.

The following is a report of the work and activities of the Health Care Cost Containment Task Force. This report describes the findings, results, and recommendations designed to achieve a more cost efficient State of Alaska Health Care Benefit System for employees, retirees and their dependents.

SECTION II

HEALTH CARE COST CONTAINMENT TASK FORCE

GOALS AND OBJECTIVES

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HEALTH CARE COST CONTAINMENT TASK FORCE

GOALS AND OBJECTIVES

SHORT RANGE

The Task Force was charged with the responsibility of identifying ways to reduce the FY 89 health care cost supplemental funding request. The Task Force looked at ways to immediately reduce the cost to the State and, in return, reduce the supplemental funding request to cover premium increases. The short range review focused on three specific areas:

- Funding of the plan.
- Plan Design.
- Procedural or legislative changes that would reduce costs.

MID-RANGE

The Task Force was charged with determining appropriate cost containment measures that could be implemented, without interfering with collective bargaining prerogatives, to reduce health care cost to the State for FY 90 and beyond. The mid-range review focused on several areas:

- Cost containment measures that would monitor and assure that the most cost beneficial health care delivered to participants.

- Methods to revise the health plan designs to keep it in line with general trends and changes in the health care delivery systems.

- Educational and wellness programs to effect long-term health improvement strategies and identify long range cost containment goals.

LONG RANGE

The Task Force sought to identify ways to control or curb rising health care provider charges, assure quality of care, and restrict actions that shift additional costs to the State plan. The Task Force has identified means to reduce or slow medical inflation of State health plans over the long term. The areas that have been determined to require further study are:

- Alternate financing of the plan (partially self-funded, etc.).

- Purchasing groups (i.e., Preferred Provider Organization-P.P.O.-or buying coalitions) to coordinate the health care purchasing power of the State in order to assure appropriate costs and proper benefit delivery to participants.

- Provider payment schedules in lieu of the current, usual, customary and reasonable schedules (UCR).

- Pooling or trusting of health care benefit plans.

- Impact of state or federal legislation that dictates cost shifting from other programs to State plans.

SECTION III

OVERVIEW OF STATE HEALTH BENEFIT PLANS

(ACTIVES AND RETIREES)

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OVERVIEW OF STATE HEALTH BENEFITS PLANS

(ACTIVEES AND RETIREES)

The base medical plan covers approximately 13,000 active employees, and an estimated 17,500 dependents for medical, dental, vision and audio coverage. Prior to December 1, 1989, there were nine plan designs for each of the separate bargaining units all covered under one master contract with the Aetna Insurance Company.

Effective December 1, 1989, all of the plans have come under one common plan design, including non-bargained and union employees. Cost containment measures were implemented on December 1, 1989. This was accomplished utilizing Task Force recommendations, collective bargaining negotiations between the State and the Alaska State Employees' Association (ASEA), along with the "me too" clause in other labor contracts. A summary of the new plan is presented in Exhibit A. It should be noted that the new plan is still subject to a ratification vote of ASEA employees.

Under a separate plan design, approximately 10,500 retirees and an estimated 9,800 dependents are covered for medical only. Retirees can be former members of the Public Employees' Retirement System (PERS), the Teacher's Retirement System (TRS), the Judicial Retirement System (JRS), or the Elected Public Officer's Retirement System (EPORS).

Retirees have the option of having dental, vision and audio coverage with the premium being deducted from their retirement checks, if they elect to do so following 60 days of their retirement. A description of coverages provided to retirees is outlined in Exhibit B.

The Supplemental Benefits System (SBS) is available to all eligible active employees of the State of Alaska, where the employee can choose additional

coverage and pay premiums out of the Alaska Social Security Fund. SBS covers the deductible and the wellness or prevention care programs. Open enrollment occurs in October for the plan year effective the following February. There are two SBS coverage options (Exhibit C). Currently, 8,900 employees are enrolled in Option I and slightly over 400 enrolled in Option II.

DESCRIPTION OF AETNA SERVICES

Aetna Insurance Company provides a fully insured plan for both the active and the retiree plans. Although, the two plans are governed under separate contract, there appeared to be a financial link between the two plans upon termination of the Aetna contracts. The link was a provision that allowed the cross application of deficits or surpluses between the two plans. Upon recommendation of the Task Force, the State and Aetna agreed to keep the two plans completely separate.

Aetna Insurance Company services the State's plan from Seattle, Washington, where the claim processors, cost containment and service of the plan are handled on a day-to-day basis. There are currently 46 Seattle-based Aetna employees dedicated exclusively to the State of Alaska plan. They include: claim processors, nurses, cost containment specialists, customer service representatives, clerical, supervisors, and account executives.

Financial and accounting services for the State of Alaska plan are handled out of the Aetna western home office, located in Walnut Creek, California. The Walnut Creek office provides for renewals, financial projections and costing of revisions as necessary for the plan.

The home office of the Aetna Insurance Company (based in Hartford, Connecticut) receives the eligibility and premium payments. Aetna then allocates the funds to the appropriate accounts and verifies coverage for the eligible individuals.

Under the fully insured plans, the State pays a fixed premium to Aetna, where Aetna assumes the risk and settles claims for the participants. The plan is fully experience-rated, whereby future rates are based on claims paid under the State's plan. It should be noted that the financial accounting for the plan is run on a fiscal year basis coinciding with the State's fiscal year; however, the rates change on February 1st of each year. Originally, the rate change and the financial accounting coincided; however, due to prolonged and

proposed plan changes over the past several years, the actual rate change has been shifted to February 1st of each year. Aetna is required to produce rate changes and financial accounting to the State during the month of October, preceding the proposed renewal date in February. This leads to some confusion as the claims and accounting data are on a slightly different basis than when the premium is collected. In years when there is no premium increase, it has less of an effect than in years when there is a substantial increase projected. The increases lag the claims data by seven months.

Aetna has been under contract with the State of Alaska since 1981. The contract was rebid in 1987 for a three year duration with the possibility of two one-year extensions. In 1987, the rebid attracted only one respondent, Aetna.

COST EXPERIENCE

Tables I and II display the monthly premium cost over the years for each entity covered under the medical plans. Please note that the financial accounting period and the fiscal year of the State do not coincide; therefore, the discrepancy for two rates in a single year. The aggregate of claims experience is presented in Table III.

INPATIENT AND OUTPATIENT BENEFITS

Total inpatient and outpatient benefits payable increased 12.95 percent from policy year 1987 to 1988. The detailed breakdown of these increases is presented in Exhibit D.

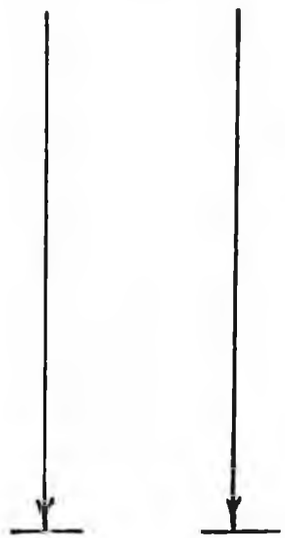
Inpatient benefits payable (regular benefits payable by the plan, after deductibles and coinsurances) increased 11.12 percent from 1987 to 1988 of which hospital room and board increased 14.57 percent. Mental and nervous benefits payable increased 27.34 percent during this period, which represents 10.6 percent and 12.14 percent of inpatient benefits payable in 1987 and 1988, respectively.

Outpatient benefits payable increased 14.57 percent from 1987 to 1988. Benefits payable for outpatient facilities increased 72.22 percent during the same period, while ancillary increased 22.97 percent. (See Percent Changes in Benefits Payable). Mental and nervous/substance abuse increased 8.69 percent.

TABLE I

MONTHLY HEALTH INSURANCE PREMIUMS BY COVERED ENTITY (ACTIVE EMPLOYEE PLAN)

	FY84	FY85	FY86	FY87	FY88	FY89	2/89 a	12/89 b	2/90 c
General Gov't Unit	$217.65	$217.65	$224.20	$242.15	$307.53	$411.16	$431.72	$384.59	$384.59
Non-Covered Employees	217.65	217.65	224.20	242.15	307.53	411.16	431.72		
Local 71	186.51	230.84	237.75	256.80	326.14	421.75	442.84		
IBU (begin 11/83)	184.57	184.57	224.20	242.15	307.53	411.16	431.72		
MMP (begin 7/85)	N/A	N/A	237.75	256.80	326.14	427.41	448.78		
MEBA	234.84	234.84	250.45	270.50	343.54	461.88	484.97		
CCSEA	217.65	217.65	224.20	242.15	307.53	411.16	431.72		
Supervisory	230.84	230.84	237.75	256.80	326.14	427.41	448.78		
Confidential	230.84	230.84	237.75	256.80	326.14	427.41	448.78		
PSEA	216.12	216.12	222.60	240.90	305.94	411.16	431.72		



(a) Renewal
(b) Cost Containment Implementation
(c) Renewal with Cost Containment

TABLE II

MONTHLY HEALTH INSURANCE PREMIUMS
RETIREES

FY84	FY85	FY86	FY87 7/86-10/87	FY88 11/87-6/88	FY89 7/88-1/89	FY90 2/89-1/90	FY90/91 2/90-1/91
$156.07	$191.85	$175.00	$165.00	$140.25	$211.22	$252.83	$243.98

TABLE III

STATE OF ALASKA

ACTIVE EMPLOYEE EXPERIENCE

Policy Year	Paid Premium	Incurred Claims	Retention	Policy Year Surplus (Deficit)	Cumulative Balance
7/82 - 7/83	$27,729,375	$25,312,455	$1,586,818	$ 830,102	$ 830,102
7/83 - 7/84	27,857,503	23,619,520	684,501	3,553,482	4,383,584
7/84 - 7/85	34,763,000	32,223,711	770,849	1,768,440	6,152,024
7/85 - 7/86	36,756,000	38,378,681	871,457	(2,494,138)	3,657,886
7/86 - 7/87	39,484,110	44,113,812	1,526,215	(6,155,917)	(2,498,031)
7/87 - 7/88	47,004,042	48,171,397	2,210,804	(3,378,159)	(5,876,190)
7/88 - 7/89	67,580,599	49,502,164	2,185,030	17,603,865*	4,279,836

RETIRED EMPLOYEE EXPERIENCE

Policy Year	Paid Premium	Incurred Claims	Retention	Policy Year Surplus (Deficit)	Cumulative Balance
7/82 - 7/83	$ 6,440,213	$ 8,146,246	$ 377,676	$(2,083,709)	$(2,083,709)
7/83 - 7/84	10,274,521	7,275,641	258,989	2,739,891	656,182
7/84 - 7/85	13,848,779	9,456,773	254,484	4,137,522	4,793,704
7/85 - 7/86	14,011,340	11,092,724	353,460	2,565,156	7,358,860
7/86 - 7/87	15,500,815	12,621,468	568,806	2,310,541	9,669,401
7/87 - 7/88	17,296,636	19,881,727	869,340	(3,454,431)	5,558,415
7/88 - 7/89	27,078,313	21,257,624	1,042,751	5,656,150	11,214,565

*Includes refund of $3,698,336.

Hospital ancillary (which includes mental and substance abuse disorders) continues to represent the largest percentage of inpatient and total benefits payable for plan years 1987 and 1988, at 42.56 percent and 43.19 percent, respectively.

On an outpatient basis, ancillary benefits represent 18.99 percent and 10.06 percent of outpatient and total benefits payable, respectively.

Medical benefits is the most significant outpatient service at 20.28 percent of outpatient and 10.74 percent of total benefits payable, respectively.

RANGE OF EXPENSE REPORT

Generally, the occurrence of claimants within the various cost ranges are relatively consistent from one year to the next.

During the calendar years 1987, 1988 and 1989, the majority of claims (between 66.65 percent and 69.94 percent) fall within the $10,000 to $20,000 range.

In calendar years 1987 and 1988, the number in the $50,000 to $100,000 range increased almost 65 percent from 42 to 69. Based on annualized data for calendar year 1989, this range appears to normalize back to approximately the 1987 level.

INPATIENT CONFINEMENTS IN EXCESS OF $50,000

Benefits payable for inpatient confinements in excess of $50,000 as a total impatient benefits payable increased slightly from plan year 1987 to plan year 1988 (11.15 percent to 12.14 percent), while the actual dollar increased over 20 percent. The most significant increase was in the Son of Participant category, where 11 participants (10 more than the 1987 plan year) had a medical condition that generated over $50,000 in benefits payable, ranging from $51,767 (extreme immaturity) to $145,740 (pre-term infant), and amounting to almost $850,000. During plan year 1987, there was one claim that amounted to just over $62,000.

SECTION IV

FINDINGS, RESULTS AND RECOMMENDATIONS

OF THE

HEALTH CARE COST CONTAINMENT TASK FORCE

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FINDINGS, RESULTS AND RECOMMENDATIONS

OF THE

HEALTH CARE COST CONTAINMENT TASK FORCE

SHORT RANGE -- MARCH 1989 TO MAY 1989

A. **Financial Reviews of Plans.** Premium Taxes --Aetna would charge the State's plan for premium taxes and credit the plan experience once a refund was received from the Department of Revenue. This procedure would not normally effect the State's rates, however, (plan expenses) were overstated by $1.8 million ($1,147,379 for activees and $667,978 for retirees) due to a delay in crediting the refund.

The Task Force requested the Department of Administration to procure a refund from Aetna for this amount. This refund was applied to reduce the supplemental funding request. The active plan received a refund of $1,147,374 and the retiree plan received a $667,978 refund.

B. **Legislation.** The Task Force recommended that the Legislature revise AS 39.30 to exempt the payment of premium taxes on the State's health plan and eliminate the possibility of a future expense charge to the plan expenses.

HB 264 am was enacted on May 8, 1989 effecting this change.

C. **Extended Liability Reserve.** As a part of Aetna's standard operating procedure, a separate reserve is established for "extended liability." The purpose of the extended liability reserve is for claims incurred by an individual on disability at the time of a prospective contract termination (Aetna's). Plans can eliminate the extended liability reserve. If they change from one carrier to another, the new carrier could accept the liability.

Aetna was holding $3,697,724 as of June, 1988 for this liability and agreed to release 80% of the monies to the State, if the State accepted the liability.

The Task Force recommended that the Department of Administration assume the liability and recover $2.4 million to help reduce the supplemental funding request.

D. **Financial Experience.** The State's financial experience was reviewed to determine if the reserves, expenses (retention) and deficit/surplus were in accordance with the contract.

The Task Force found that the reserves were set within actuarially accepted levels.

Plan expenses were running less than 7.0% (before interest offsets). It was, however, found that previous years when the plan was in a surplus position, the rates could have been reduced or a refund could have been generated to the State, as opposed to being held by Aetna.

In 1989, the active employees' plan had a surplus of $4,279,836 (see Table III). The implementation of cost containment provisions and good experience, enabled the State to negotiate the current rate of $384.59 to be guaranteed for an additional 12 months.

The retiree plan has a current surplus of $11,241,565 less the claim fluctuation margin of $1,464,374 for a net balance of $9,750,191. The net balance could be used to reduce premium rates.

E. **Drafts Versus Checks.** Alaska State Law (AS 21.89.03) requires that an insurance company use a negotiable bank check to settle a claim or pay a judgment. This means that Aetna issues checks on a funded account. Usually, minimum premium or self-funded plans issue drafts that are funded upon presen ation. This change from checks to drafts would result in an additional ten day float on the money, resulting in a net interest credit to the State. There are some administrative and banking arrangements that need to be established to take advantage of this.

The Task Force recommended revision of AS 21.89.03. SB 257 and HB 265 were introduced for the State to take advantage of this interest credit.

F. **Supplemental Benefits System (Plans I & II).** Prior to fiscal year 1989, the Supplemental Benefits System experience or (cost) was not maintained separate from general health plan experience. Therefore, it had not been possible to ascertain the actual and appropriate premium rates.

The Task Force recommended separate experience results with the financial accounting period ending June 30, 1989. The plan experience has been separated and the SBS option has been rated much closer to what the actual cost is.

A second concern of the Task Force was that the Supplemental Benefits System raises the level of benefits to the participants and, therefore, may increase utilization. This possibility heightened the importance to separate the experience and limit the shifting of costs to the base plan. Separation of

experience would provide for the SBS and the base medical plan to be responsible for their appropriate share of costs. Effective February 1, 1990, the SBS plan will have a 53% increase, while there was no increase necessary for the regular medical plan.

G. **Audit.** In the nine years that the State plan has been covered by Aetna, there has never been an audit of the carrier's performance. To evaluate the performance and quality assurance factors that are contractually agreed to. The Task Force had recommended that the Division of Retirement & Benefits should institute a complete audit of Aetna's procedures and claims operations. The Division of Retirement & Benefits contracted with Deloitte & Touche to audit Aetna's claims operation. The audit report was delivered in December, 1989.

CONCLUSION

The initial supplemental request for FY 89 ($21,800,000) was subsequently reduced to $12,300,000 through finance committee budget work. The $7,200,000 general fund portion of this latter figure was offset by $3,500,000 through Task Force identified refunds. In effect, the FY 89 general fund requirement for the health care cost increase was reduced to $3,700,000.

An additional $700,000 of refunds was returned to retiree pension funds.

RESULTS AND RECOMMENDATIONS

MID-RANGE -- MAY 1989 THROUGH DECEMBER 1989

The Task Force identified over 20 items that would help reduce health care cost in fiscal year 1990 and beyond.

The most significant areas of potential savings were cost containment provisions in the operation of the health care plan and negotiated fee arrangements with health care providers. The Task Force identified the following cost containment provisions that could be implemented by agreement between labor and management without effecting negotiated benefits.

*__Utilization Review__ - Provides ongoing review for reasonableness of treatment and costs;

*__Pre-admission Certification__ - Requires pre-certification for all hospital admissions, reduces inpatient hospital stays, and provides alternate treatment sites where more cost effective;

*__Outpatient Pre-certification__ - Requires pre-certification for all outpatient surgeries or procedures over a pre-determined level, reduces unnecessary procedures or limits expensive procedures;

*__Managed Mental Health/E.A.P.__ - Helps guide participant to appropriate treatment and intervention/prevention by using an employee assistance program as a referral to treatment;

*__Expanded Large Case Management__ - By knowing about a claim early on (via pre-certification), the Health Care Coordinator can review the claim for possibly more efficient care setting at a lower cost to the plan.

***Consumer Advisory Service** - Provides a health resource to all participants regarding claims, procedures or questions giving the participants an ally in the "system".

***High Risk Pregnancy Management** - This program is designed to lower the incidence of low birth weight (LBW) infants born to female employees and dependents. Can reduce or eliminate high cost of premature deliveries;

***Managed Second Surgical Opinion** - Operates similarly to the pre-certification factor system, whereby listed surgical procedures requires a second opinion to find out whether the surgery is necessary or an alternative method could be used at a lower cost;

***On-Site Concurrent Review** - The On-Site Concurrent Review Program is designed to assure that medically necessary care is provided in an efficient manner. A registered nurse visits hospitalized patients daily and reviews the patient's hospital charts. Provides sentinel effect on hospitals lowering overall inpatient costs;

***Vision Plan P.P.O.** - Provides plan members with the option of receiving care from a preferred provider. The participant receives improved benefits while the plan is billed at a discount for services;

***R & C Profile** - Reasonable and Customary (R & C) profiles represent the prevailing charge made by health care providers of similar expertise for a similar procedure in a particular geographic area. These are currently set every six months for the State. Aetna states they are paying 90% of R & C. The profiles could be revised every 12, 18 or 24 months to slow medical inflation within the plan;

***Wellness Programs** - Wellness Programs are comprised of topics designed to promote safety and good health among employees, including physical fitness programs. A long range approach to controlling medical costs through prevention;

***Mail Order Drug Program** - The Mail Order Drug Program offers a cost saving, convenience service for obtaining prescription drugs through the mail. Drugs are dispensed up to a ninety day supply instead of a thirty day supply. This program is ideal for patients receiving maintenance treatment, which account for up to 70% of all prescription drug costs. Additional savings would be realized by substituting generic drugs for brand names drugs.

***Eligibility/Enrollment Verification** - It was recommended that all participants re-enroll in the plan to ensure that the eligibility of employees, retirees and their dependents and other insurance plan information was current. The last complete enrollment was in 1983.

***Management Reports/Participant Demographics** - Management reports provide the necessary information for the effective management of the health care program. Effective reports help to identify trends and patterns in charges and utilization; pinpoint specific sources of experience; design plan changes and monitor the results of plan changes. Current reports need revisions to accurately track plan experience on a timely basis.

As of December 1, 1989 all recommendations were implemented with the exception of managed mental health, R & C profiles and wellness programs. The total savings generated by these cost containment provisions in conjunction with negotiated benefit changes is approximately $7,000,000 for calendar year 1990 (for active employees). These measures also helped provide the State with a favorable renewal from Aetna, whereby the revised premium rate of $384.59 will be guaranteed until February 1, 1991.

A similar but limited effect could be achieved for the retiree's plan. The limit is the State constitutional treatment of an employee's retirement benefits as a contractual right (from the first day of employment). The State cannot act to reduce or impair that right. It is the impairment question that needs legal

definition. Accordingly, the Task Force has requested an Attorney General's opinion on which cost containment provisions may be implemented and withstand challenge. It is expected that provisions such as utilization review and periodic re-enrollments are acceptable, whereas pre-certification and second surgical opinions require close legal scrutiny.

The Task Force anticipates affecting in the near future some cost containment provisions for the retiree's plan which will reduce the health care cost obligations of the pension funds.

LONG RANGE CONSIDERATION OF THE

HEALTH CARE COST CONTAINMENT TASK FORCE

While the Task Force has achieved particular success in reducing the supplemental funding request and reducing the FY 90 cost of the State's health plan, the inflationary trends of medical costs in Alaska portend future increases for the State. Indeed, the State will be paying in excess of $300 million in FY 90 for health care payments of all types. This is an increase from $75 million in 1980, a 300 percent increase over the past 10 years. Aetna's calculation of cost trend factors for the last three years has ranged from 14 percent to 23 percent.

It is with this view and concern that the Task Force identified several considerations to affect long-term strategies of minimizing medical inflation. These strategies are for the most part directed at the health provider industry itself. They utilize the State's size in both numbers and funding to health care providers to restrain or control medical inflation. These considerations also attempt to reduce direct cost shifting to the State from mandated benefit changes and federal program changes.

The following areas have been determined by the Task Force as needing further study and consideration in developing recommendations to the State.

1. Self-Insured Plan Options

Currently, the State purchases its State health care on a fully insured basis. The Task Force is presently investigating the funding alternatives, whereby the State could employ a variety of financing options in order to reduce the cost of the plan and keep premium dollars in Alaska until claims are paid. Exhibit E

illustrates the self-insured options that are available to the State at this time.

By utilizing alternate funding methods, the State could increase the flexibility by which it funds and pays benefits to participants. However, it must be noted that there would be some administrative expenses incurred as some of the record-keeping for the accounts would have to be handled internally by the State instead of the carrier.

The Task Force expects to issue a complete report regarding the advantages, disadvantages, and associated costs, with an estimate of the savings generated by alternate funding methods.

2. Health Care Purchasing Groups

The Task Force has determined that by utilizing buying groups, the State could effect substantial savings to its health care plans.

Currently, the State of Alaska is paying full retail price for medical and dental services. Just as the State does with other goods and services purchased in quantity, the State could negotiate with providers for a discounted rate.

The State can take advantage of current negotiated discounts by utilizing the P.P.O. arrangement through Aetna. There are several ways that the State can negotiate a discount. They include: contracting with a third party organization to negotiate on the State's behalf; or have the State of Alaska negotiate its own contracts, possibly in conjunction with the P.P.O. arrangement and contracting with a third party organization. These arrangements should include all forms of health care purchasing within Alaska, not just the employee benefit plan (e.g. Medicaid and Medicare).

If the State negotiates its own contracts, this generally offers the most flexibility. The State would establish the agreement and the relationship regardless of the claims paying operations. This could also be part of the pooling authorities scope.

Estimated Savings. Generally, negotiated discounts, have generated gross savings (before expenses) of 5 percent to 20

percent, depending on the service, locality and competition in the given area. Such arrangements could generate savings on the employee benefit plan alone of 1.7 million to 7.5 million dollars per year. The Task Force believes that negotiated discounts is an important consideration for containing the cost of medical care. The Task Force will continue to review the alternatives to determine feasibility of this important buying power. Necessarily, the feasibility will depend to an important degree on unique aspects of Alaska's health provider market, wherein many communities are served by one or few providers.

The Task Force recognizes that it is imperative that quality care is delivered to the participant on a cost efficient basis through the plan with negotiated discounts.

3. Provider Payment Schedules

The Task Force has identified provider payment schedules as a proven method effective in controlling health care costs and constraining long-term medical cost inflation. This strategy has been employed by the federal government through the Diagnostic Related Group System (DRG) and the Resource Based Relative Value System (RBRVS) which will be implemented in 1992.

In a further step to control costs, a payment schedule could also be employed by the State. This would be either a modified DRG, a RBRVS or a schedule specifically tailored to the State of Alaska's health care marketplace.

Essentially, under the DRG a schedule is predetermined for each procedure based on the diagnosis of the patient. Under RBRVS schedule, type of care, necessity of care, geographic area, and training of the physician are all taken into account. A system of this nature takes considerable lead time to implement. These payment schedules can only be effective, if:

- The schedule is set on a realistic basis;
- Modifiers are used to control cost shifting; and
- If utilization review is in place;
- Quality of care is assured; and
- Cost savings objectives are met.

Unless the payment system is carefully designed, cost shifting is likely to occur which would minimize overall savings.

The Task Force continues to review and consider alternatives in the way providers are paid (other than the customary, usual and reasonable basis). The Task Force will determine the savings generated by utilizing a provider payment system, and will make specific recommendations as to the type of system most appropriate and its overall operations and implementation.

4. Pooling Concepts

The Task Force is reviewing a cost containment strategy employed by many states called pooling. The purpose of pooling is to provide comprehensive group health insurance to a larger base of enrollment so that: the risk is spread out; health coverage is provided on the most economical basis; provides the maximum opportunity for cost containment when purchasing group health insurance through favorable payment schedules of providers and vendors; entity(ies) can employ a mechanism that provides benefits or coverages that may not be available or are too costly.

Generally, legislation is required to create an entity that provides the coverages needed and oversees the operation of those coverages effectively and in a cost efficient manner. Senate Bill 254, authored by Senator Duncan, has been introduced into legislation. This bill would create the Alaska State Group Health Insurance Authority which would enable the State of Alaska to offer pooled group health coverage to eligible state, municipal and school district employees.

Some of the advantages of pooling are:

- Economy of scale. Eliminate duplicate or multiple plan costs.

- Provides for plan flexibility, plan rating and risk sharing. Each sub-group could conceivably have a slightly different plan design and could be individually rated based on their experience.

However, the risk of large claims occurring could be shared within the pool to eliminate wide swings in experience.

- Data collection - Allows a simplified system for tracking claims, abnormalities or impacts on health care expenditures, instead of obtaining information from many different sources.

- Projection of future cost and trends. The data base would be valuable in projecting future costs and trends, so that the State could be proactive rather than reactive in the management of its health plans.

Pooling enables the State to combine many advantages including self-funding, utilizing the State's purchasing power to help negotiate and control health care cost, and provide benefits on a cost efficient and manageable basis.

The Task Force is currently reviewing other states that have enacted these programs in order to determine the advantages and disadvantages and complexities involved in setting up a pool for the State. It is anticipated that the savings would be generated in several areas:

- Simplification of administration could save 1% to 3%.

- Provider Payments Schedules and P.P.O. Agreements, 5% to 20%.

- Recognize trends and adjust quickly, 5% to 7%.

- In general, economies in a scale of 1% to 3%.

The greatest savings generated would be from the State becoming a cohesive buying group for health care. By increasing the size of the group, the State is better able to negotiate with providers of the service to afford the best possible care, proper utilization, and the maximum benefit to participants without impacting the plan negatively. It would also isolate the plan from an additional cost shifting from other sources, which have become a significant

factor in medical inflation in the State of Alaska.

5. Trusts

The Task Force is also investigating the feasibility of using a trust to provide benefits to employees of the State. A trust generally collects premiums and pays health and welfare benefits to participants. It is governed by a trust document and a board of trustees, which can be a variety of representation from fully elected to an equal management and union representation.

The State could either create a trust, join an existing trust, or allow the bargaining units to utilize their own trusts. It would operate on a similar basis as an Insurance Authority (pool) would, except that they may not require enabling legislation. They would require collective bargaining agreements. Generally, a trust provides benefits to participants only up to the contribution level of employers. Typically, they use cost containment provisions and preferred provider arrangements to control costs.

6. Wellness and Employee Assistance (EAP) Programs

The Task Force is continuing investigations into the value of wellness programs. Nationally, these types of programs are gaining more recognition as a successful long-term strategy to reduce work force health costs through encouraging health promoting activities and discouraging risk taking (e.g. smoking, excess weight, etc.). Recently, the Municipality of Anchorage and one of its union groups have initiated a wellness program that combines incentives for program participation.

THE IMPACT OF COST SHIFTING TO THE STATE'S HEALTH PLAN DUE TO FEDERAL OR STATE LEGISLATIVE CHANGES

Consistently, over the last 10 years, federal and state law changes have shifted expenses to the various State health plans due to program cutbacks, reallocation of resources, or reducing benefits payable under certain programs. An excellent example is the federal Medicare system. Medicare currently pays 75% for physician services on the basis of "usual, customary and

reasonable" charges. The difference between the amount Medicare pays a provider for his or her services and the actual charge often times is passed on to the non-Medicare paying patients. It is in this manner that the State health plans experience a cost shift to the State's plans from the Medicare program.

In the waning hours of this last session of Congress, substantial changes to the Medicaid/Medicare system were incorporated in the Omnibus Budget Reconciliation Act (OBRA 89). It is difficult to report with certainty all the ramifications. However, there are several features readily apparent:

- A relative value payment schedule (RBRVS) is mandated for Medicare for 1992. Studies to determine geographic area adjustment factors and volume statistics for the schedule will commence this year.

- The State is obliged to an expanded coverage of pregnant women and for children up to six years of age.

- The State is obligated for certain nursing training costs as well as making up the difference of reduced Medicaid expenditures for certain programs and services mandated in the Nursing Home Reform provisions of OBRA 87.

The initial estimates of fiscal impact to the State for the latter two are $7,000,000 and $1,400,000, respectively.

It is imperative that the State of Alaska monitor federal legislative and programmatic changes that would result in a shift or increase in the cost of providing benefits under the State programs. The Task Force recommends that a monitoring function be established to measure and predict the cost of such changes (particularly, the RBRVS implementation) and their effects on the State.

Conclusion

The Task Force recommends that the Legislature extend its existence to February 15, 1991. We recognize that the successes obtained in reducing State employee and retiree health care costs can only be viewed as a beginning. Much work has been done to understand the longer term implications and prospects for controlling medical cost inflation. There is much work remaining before a consensus approach can be creditably advanced. The work needs to be completed. The only questions are when and by whom. The current task force has functioned as a unique and cooperative blend of public employee, administrative and legislative interests that has had real sucess. Building on the existing knowledge base, much more can be achieved.

SECTION V

ATTACHMENTS

EXHIBIT A

BENEFIT SUMMARY FOR ACTIVE EMPLOYEES

(REVISED DECEMBER 1, 1989)

Variations in coverage were provided to the nine active employee groups and collective bargaining units which have been standardized as of December 1, 1989. Standardization of the plan effected certain groups who had orthodontia an "incentive" dental arrangement, and other plan variations relative to the general government group. The following is a summary of the basic health plan that is provided to employees of the State:

DEDUCTIBLE

$100/$300 per family

MEDICAL

The plan pays 90% of the first $3,950, then 100% of covered medical expenses.

LIFETIME MAXIMUM BENEFIT

$250,000; $5,000 Automatic Yearly Restoration

PREEXISTING CONDITIONS

12 month limitation of $1,000 on medical conditions which existed prior to the effective date of coverage.

TRAVEL

The plan reimburses receipted travel/lodging/meal expenses for pre-authorized pre-operation testing when one way travel distance exceeds 100 miles. Reimbursement is available only for the days of actual testing.

ALCOHOL/DRUG ABUSE

The plan pays 90% of these expenses, with a limitation of $7,000 on outpatient services over a two year period.

MENTAL/NERVOUS DISORDERS

The plan pays 90% of inpatient expenses, 50% of counseling services up to $2,500 annually.

EXHIBIT A

(continued)

PRESCRIPTION DRUGS

If a participating pharmacy is utilized, there is a $5 copay per brand name prescription, and no copay or generic prescriptions; if a non-participating pharmacy is used the plan pays 100% after the applicable brand name copay.

MAIL ORDER DRUGS

$2 copay for each brand name prescription, no copay for generic prescriptions. The plan deductible and coinsurance requirements are waived. Copay amounts do not apply either toward the calendar year deductible or the out-of-pocket limit.

DENTAL

$25 annual deductible per covered individual, with a maximum of 3 deductibles per year which is applied to maintenance, and structural services. The plan pays 100% of preventative services (mouth X-rays once per year), 85% of maintenance services, 50% of structural services up to an annual maximum of $1,500. Preauthorization required for dental procedures or treatment in excess of $500.

VISION

$5 copay per examination, $10 copay for materials (lenses, frames). The plan covers one examination and one set of lenses every 12 months, one set of qualified frames every other year. Charges for non-covered items in excess of the maximum allowable limit are paid by the employee.

AUDIO

The plans pays 80% of an annual exam, 80% for hearing aids and services, $800 limit over a three year period, no annual deductible.

CONVALESCENT FACILITY

The plan pays 100%, up to the semi-private room limit after the deductible is satisfied. Precertification is required, no prior hospital confinement is required. The convalescent facility confinement must be certified as being in lieu of acute care hospitalization. No maximum length/days of coverage applies.

HOME HEALTH CARE

After the deductible is satisfied, the plan pays 90% for up to 120 visits per year. Precertification is required, no prior hospital confinement required.

CHIROPRACTIC SERVICES

After the deductible is satisfied, the plan pays a maximum of $750 per year per person.

COORDINATION OF BENEFITS

An accumulated calendar-year-to-date Maintenance of Benefits coordination applies to both the standard "external" Coordination of Benefits situation, where primary coverage is available through another employer's plan, as well as to duplicate coverage for working couples under the State of Alaska Plan. Children will be enrolled only under one parent's plan according to the birthday rule. Spouses will enroll separately, effective January 1, 1990.

PATIENT AUDITOR PROGRAM

A program that encourages patient participation in identifying services for which the patient did not receive treatment. The erroneous charges identified on a single bill or admission total a minimum of $100. If an overcharge is verified, and any overpayment made to the provider are recovered, the patient will be rewarded half of the overcharge, up to $400 per year. Any payments to participants under this program are considered as taxable income.

EXHIBIT A

(continued)

HEALTHLINE

Healthline is a program comprised of precertification requirements under the following situations: a hospital or skilled nursing facility stay; certain elective surgeries (which may also require a second opinion); certain outpatient procedures and treatments; and arranging for home health care or private duty nursing. The penalties for failure to certify medically necessary treatment are as follows: failure to precertify a hospital stay, $400; failure to precertify required inpatient/outpatient surgery or treatment, or to obtain a second surgical opinion when requested, $200; failure to precertify private duty nursing, home health care, or a long stay in a skilled nursing facility, $400. The precertification penalty is not a covered expense under SBS.

EXHIBIT B

BENEFIT SUMMARY FOR RETIREES

(CURRENT PLAN DESIGN)

DEDUCTIBLE

$100/$300 per family

CO-INSURANCE PLAN PAYS

Plan pays 80% of covered medical expenses.

LIFE-TIME MAXIMUM

$1,000,000

PRE-EXISTING CONDITIONS

None

TRAVEL

One way transportation subject to medical necessity and pre-authorization by carrier.

ALCOHOL/DRUG ABUSE

Plan pays 90% of these expenses with a limit of $7,000 outpatient services over a two year period.

MENTAL & NERVOUS DISORDERS

Plan pays $15 per visit with certain limitations.

PRESCRIPTION DRUGS

The plan pays 100% for generic prescriptions, 80% for brand name prescriptions.

EXHIBIT C

SUPPLEMENTAL BENEFIT SYSTEM I & II:

SBS OPTION I

Pays an additional 10% for medical expenses covered under the group plan

Pays 100% for routine physical exams, newborn care for 72 hours after birth, and immunizations

Pays rehabilitative care (100% inpatient for 60 days and 80% outpatient)

Pays 80% for convalescent care

Increases lifetime maximum of the group plan to $1,000,000

SBS OPTION II

$200 deductible; 20% copay, no stop loss

Covers physicians' and hospital services, prescription drugs

Does not cover dental, vision, or audio services

Substance abuse paid at 80%; maximum benefit: $7,000 in a consecutive two year period

Mental and Nervous disorders paid at 50% after deductible; $1,000 per year maximum

Lifetime Maximum $250,000

Maximum of $1,000 paid during the first 12 months for a pre-existing condition

EXHIBIT D

STATE OF ALASKA
CLAIM EXPERIENCE BY TYPE OF CARE
ACTIVE EMPLOYEE GROUP
PERCENT CHANGE IN BENEFITS PAYABLE
PLAN YEARS 1987 TO 1988

INPATIENT

Hospital Room and Board	+14.57%
Hospital Ancillary	+12.65
Surgery	+ 7.33
Assistant Surgery/Anesthesia	- 1.31
Medical	- 0.95
Total Inpatient	+11.12

	Benefits Payable	Number of Admissions	Average Charge Per Admission
Mental and Nervous	27.34 %	7.3 %	13.57 %
Substance Abuse	-1.31	-7.2	4.63
Total	17.61	1.8	9.52

OUTPATIENT

Facilities	72.22%
Ancillary	22.97
Surgery	11.42
Assistant Surgery/Anesthesia	7.89
X-Ray Laboratory	15.69
Pharmacy	20.84
Chiropractic	6.55
Mental & Nervous/Substance Abuse	8.69
Medical	12.76
Other Outpatient	3.17
Total Outpatient	14.57
Inpatient and Outpatient	12.95%

STATE OF ALASKA
CLAIM EXPERIENCE BY TYPE OF CARE
AETNA PLAN - ACTIVE EMPLOYEE GROUP
INPATIENT
JULY 1987 - JUNE 1988

	Submitted Expenses	Percent of Inpatient Benefits Payable	Benefits Payable	Percent of Total Benefits Payable
Hospital Room & Board (1)	$ 7,150,077	34.14%	$ 6,924,519	14.33%
Hospital Ancillary (1)	8,908,267	42.56	8,632,865	17.86
Surgery	2,545,441	12.09	2,452,408	5.07
Assistant Surgery/Anesthesia	893,074	4.25	862,986	1.79
Medical	1,670,981	6.96	1,412,664	2.92
Total Inpatient	**$21,167,750**	**100.00%**	**$20,285,442**	**41.97%**

INPATIENT UTILIZATION & COSTS
MENTAL, NERVOUS & SUBSTANCE DISORDERS

	Submitted Expenses	Benefits Payable	Percent of Inpatient Benefits Payable	Percent of Total Benefits Payable
Mental & Nervous	$2,256,381	$2,149,458	10.60%	4.99%
Substance Abuse	1,141,111	1,105,049	5.45	2.56
Total	$3,397,492	$3,254,507	16.05%	7.55%

	Number of Admissions	Average Charge Per Admission
Mental & Nervous	205	11,007
Substance Abuse	125	9,129

STATE OF ALASKA
CLAIM EXPERIENCE BY TYPE OF CARE
AETNA PLAN - ACTIVE EMPLOYEE GROUP
OUTPATIENT
JULY 1987 - JUNE 1988

	Submitted Expenses	Percent of Outpatient Benefits Payable	Benefits Payable	Percent of Total Benefits Payable
Facilities	$ 138,379	0.50%	$ 114,829	0.27%
Ancillary	4,663,209	18.99	4,336,695	10.06
Surgery	2,706,760	10.90	2,488,070	5.77
Assistant Surgery/Anesthesia	502,031	2.15	490,155	1.14
X-Ray Laboratory	4,038,233	15.33	3,500,042	8.12
Pharmacy	2,770,557	10.38	2,370,830	5.50
Chiropractic	2,562,027	9.92	2,264,807	5.25
Mental & Nervous/ Substance Abuse	1,918,380	4.62	1,054,022	2.44
Medical	6,100,745	20.28	4,631,079	10.74
Other Outpatient	1,765,977	6.93	1,582,487	3.67
Total Outpatient	$27,166,748	100.00%	$22,833,016	–
Total Inpatient	21,167,750		20,285,442	–
TOTAL	$48,334,498		$48,118,458	52.96%

STATE OF ALASKA
RANGE OF EXPENSE REPORT
FAMILY BENEFITS PAYABLE [1]
IN EXCESS OF $10,000
AETNA PLAN - ACTIVE EMPLOYEE GROUP
JANUARY 1987 TO JUNE 1989

RANGE OF EXPENSE	NUMBER OF FAMILIES		
	1/89 - 6/89 [2]	1/88 - 12/88	1/87 - 12/87
$10,000 - $20,000	321	727	719
$20,000 - $35,000	93	207	184
$35,000 - $50,000	32	59	59
$50,000 - $100,000	22	69	42
$100,000 - $150,000	6	23	21
$150,000 +	2	6	3

(1) Benefits Payable is defined as regular benefits payable by the plan after plan provisions, i.e., deductible and coinsurance, but before coordination of benefits.

(2) First six months of experience.

STATE OF ALASKA
INPATIENT CONFINEMENTS IN EXCESS OF $50,000
AETNA PLAN - ACTIVE EMPLOYEE GROUP
JULY 1987 TO JUNE 1988

Claimant Relation	Claimant Age	Submitted Expenses	Benefits Payable	Diagnosis	MDC
Male EE	39	$248,194	$241,442	Aneurysm of Carotid Artery	5
Male EE	47	122,647	113,303	Full-Thickness Skin Loss	22
Male EE	48	118,894	111,284	Intermediate Coronary Syndrome	5
Wife	51	111,447	100,775	Subarachnoid Hemorrhage	1
Male EE	45	102,405	96,918	Intercranial Hemorrhage	1
Daughter	19	101,048	83,035	Intracranial Injury	24
Daughter	0	93,963	92,748	Anomalies of Pulmonary Valve	5
Male EE	45	87,387	85,042	Unspecified Intracranial Hemorrhage	1
Wife	36	82,368	79,193	Gastric Hemorrhage	6
Daughter	19	82,221	83,047	Intracranial Injury	24
Husband	58	78,694	78,604	Respiratory Failure	4
Husband	53	76,664	80,623	Rehabilitation Procedure	23
Male EE	57	76,636	56,191	Rehabilitation Procedure	23
Male EE	35	75,326	65,796	Fracture of Rib	4
Female EE	33	74,602	75,087	Complication of Prosthetic Devise	21
Daughter	18	71,211	71,134	Neurotic Depression	19
Husband	35	70,609	61,076	Fracture of Rib	4
Daughter	0	70,192	70,044	Twin, Mate Liveborn	15
Female EE	39	66,937	60,656	Meningeal Hemorrhage	1
Female EE	54	65,120	65,833	Chronic Lymphoid Leukemia	17
Son	14	65,047	62,564	Adjustment Reaction	19
Wife	49	62,690	53,152	Atrioventricular Excitation	5
Daughter	0	60,966	61,153	Single Liveborn	15
Daughter	10	59,250	58,334	Injury to Pancreas Multiple Sites	7

Daughter	0	57,260	57,360	Pre-Term Infants	15
Wife	34	56,054	50,298	Affective Psychoses	19
Male EE	51	54,987	48,171	Chronic Ischemic Heart Disease	5
Female EE	68	52,835	47,388	Aortic Aneurysm	5
Male EE	52	52,023	49,289	Primary Cardiomyopathies	10

EE = Employee

STATE OF ALASKA
TOP 20 INPATIENT FACILITIES
RANKED BY SUBMITTED EXPENSES
JULY 1987 - JUNE 1988

PROVIDERS	LOCATION	SUBMITTED EXPENSE	PAYABLE
Providence Hospital	Anchorage	$ 3,639,459	$ 3,581,886
Bartlett Memorial Hospital	Juneau	1,640,884	1,163,827
Humana Hospital	Anchorage	1,443,001	1,430,857
Charter North Hospital	Anchorage	1,173,099	1,156,146
Fairbanks Memorial Hosp	Fairbanks	1,156,136	1,141,414
University Hospital	Seattle	380,689	363,694
North Star Hospital	Anchorage	379,365	377,489
Swedish Hospital Med Ctr	Seattle	360,136	357,443
Virginia Mason Hospital	Seattle	322,128	329,363
Valley Hospital Assoc	Palmer	227,113	225,947
Ketchikan General Hosp	Ketchikan	225,688	222,906
Children's Hosp & Med Ctr	Seattle	219,524	206,157
Devereaux Foundation	Philadelphia	180,063	179,886
Lakeside Recovery Ctr	Alaska	153,922	150,216
Central Peninsula Gen	Soldotna	146,520	144,816
Schick Shadil Hosp	Seattle	136,967	135,076
New England Deaconess Hosp	Boston	91,194	90,844
Sitka Community Hosp	Sitka	84,432	81,759
Camelback Hospital	Phoenix	66,312	68,239
Delpelchin Children's Ctr	Houston	65,209	64,639

STATE OF ALASKA
TOP 20 INPATIENT FACILITIES
RANKED BY SUBMITTED EXPENSES
JULY 1988 - JUNE 1989

PROVIDERS	LOCATION	SUBMITTED EXPENSE	PAYABLE
Providence Hospital	Anchorage	$ 3,922,951	$ 3,905,752
Humana Hospital	Anchorage	2,046,073	2,027,433
Charter North Hospital	Anchorage	1,750,962	1,738,634
Bartlett Memorial Hospital	Juneau	1,591,269	1,567,946
Fairbanks Memorial Hosp	Fairbanks	1,265,681	1,250,062
University Hospital	Seattle	490,297	488,952
Swedish Hospital Med Ctr	Seattle	403,408	402,032
North Star Hospital	Anchorage	389,835	383,121
Valley Hospital Assoc	Palmer	311,450	310,050
Virginia Mason Hospital	Seattle	284,520	281,137
Children's Hosp & Med Ctr	Seattle	274,601	274,294
Charter Medical Corp	Provo	215,590	212,576
JFK Medical Ctr	Edison	199,501	199,760
Ketchikan General Hosp	Ketchikan	192,688	189,126
Hartwyck at Oak Tree	Edison	178,336	141,470
Lakeside Recovery Ctr	Alaska	172,794	168,316
Central Peninsula General	Soldotna	164,519	162,664
University Medical Ctr	Tucson	155,431	147,581
Sitka Community Hosp	Sitka	120,347	118,060
Manor West Hosp	Los Angeles	101,387	100,386

STATE OF ALASKA
TOP 20 OUTPATIENT FACILITIES
RANKED BY SUBMITTED EXPENSES
1987

PROVIDERS	PROVIDER TYPE*	LOCATION	SUBMITTED EXPENSE
Providence Hospital	HS	Anchorage	$ 1,595,624
Bartlett Memorial Hospital	HS	Juneau	1,183,900
Humana Hospital	HS	Anchorage	817,321
Fairbanks Memorial Hospital	HS	Fairbanks	720,431
Sitka Community Hospital	HS	Sitka	360,314
Valley Hospital Association	HS	Palmer	273,070
Ketchikan General Hospital	HS	Ketchikan	242,990
University Hospital	HS	Seattle	195,675
Central Peninsula Hospital	HS	Soldotna	172,127
Swedish Hospital Med Ctr	HS	Seattle	137,355
Virginia Mason Hospital	HS	Seattle	125,654
Bartlett Memorial Hospital	HS	Juneau	122,282
Norton Sound Regional Hosp	HS	Nome	104,308
Kodiak Island Hospital	HS	Kodiak	93,749
Petersburg General Hospital	HS	Petersburg	83,890
South Peninsula Hospital	HS	Homer	71,797
Valdez Community Hospital	HS	Valdez	61,298
Lakeside Recovery Center	AT	Bothell	60,581
Cordova Community Hosp	HS	Cordova	59,566
Seward General Hospital	HS	Seward	57,226

* HS - Hospital
* AT - Alcoholism Treatment Facility

STATE OF ALASKA
TOP 20 OUTPATIENT FACILITIES
RANKED BY SUBMITTED EXPENSES
1988

PROVIDERS	PROVIDER TYPE*	LOCATION	SUBMITTED EXPENSE
Providence Hospital	HS	Anchorage	$1,657,284
Bartlett Memorial Hospital	HS	Juneau	1,450,677
Fairbanks Memorial Hospital	HS	Fairbanks	1,011,416
Humana Hospital	HS	Anchorage	966,929
Our Lady of Comp Care Ctr	CF	Anchorage	512,832
Sitka Community Hospital	HS	Sitka	435,684
Valley Hospital Association	HS	Palmer	356,429
Ketchikan General Hospital	HS	Ketchikan	253,381
University Hospital	HS	Seattle	243,503
Virginia Mason Hospital	HS	Juneau	223,973
Central Peninsula Hospital	HS	Soldotna	201,414
Norton Sound Regional Hosp	HS	Nome	186,407
Swedish Hospital Med Ctr	HS	Seattle	177,489
Petersburg General Hospital	HS	Petersburg	93,861
Alaska Treatment Ctr	OT	Anchorage	86,854
South Peninsula Hospital	HS	Homer	74,815
Valdez Community Hospital	HS	Valdez	59,352
Charter North Hosp	HS	Anchorage	56,258
Seward General Hospital	HS	Seward	53,574
Kodiak Island Hospital	HS	Kodiak	45,456

* HS - Hospital
* CF - Convalescent Facility
* OT - Other

STATE OF ALASKA
TOP 20 OUTPATIENT FACILITIES
RANKED BY SUBMITTED EXPENSES
1989

PROVIDERS	PROVIDER TYPE*	LOCATION	SUBMITTED EXPENSE
Bartlett Memorial Hospital	HS	Juneau	$ 1,060,108
Providence Hospital.	HS	Anchorage	975,393
Fairbanks Memorial Hospital	HS	Fairbanks	585,295
Humana Hospital	HS	Anchorage	484,297
Valley Hospital Association	HS	Palmer	206,937
Sitka Community Hospital	HS	Sitka	129,984
Ketchikan General Hospital	HS	Ketchikan	115,751
Central Peninsula Hospital	HS	Soldotna	106,197
University Hospital	HS	Seattle	95,728
Norton Sound Regional Hosp	HS	Nome	91,526
Virginia Mason Hospital	HS	Seattle	74,348
Swedish Hospital Med Ctr	HS	Seattle	68,668
Kodiak Island Hospital	HS	Kodiak	51,329
Search Mt. Edgecombe Hosp	HS	Sitka	50,793
Petersburg General Hospital	HS	Petersburg	48,814
South Peninsula Hospital	HS	Homer	37,694
Seward General Hospital	HS	Seward	34,003
Our Lady of Comp Care Ctr	CF	Anchorage	31,230
Valdez Community Hospital	HS	Valdez	26,983
Deaconess Medical Ctr	HS	Spokane	26,259

* HS - Hospital

EXHIBIT E

HEALTH BENEFIT PLAN

FUNDING ARRANGEMENTS

	Fully Insured	Premium Delay	Retrospective Premium	Minimum Premium	Minimum Premium Reserve Less	Self-Funded w/Ston-Loss	Fully Self-Funded
Claim Fluctuation Margin	Paid To Carrier	Paid To Carrier	State Retains	State Retains	State Retains	State Retains	State Retains
Incurred But Not Report Reserve	Paid To Carrier	Paid To Carrier	Paid To Carrier	Paid To Carrier	State Retains	State Retains	State Retains
Claim Liability	Carrier	Carrier	Carrier	State Up To Deposit Liability(1)	State Up To Deposit Liability(2)	State(3)	State
Expenses	Paid To Carrier	Paid To Carrier	Paid To Carrier	Paid To Carrier	Paid To Carrier	State Retains	State Retains
Who Pays Claims	Carrier	Carrier	Carrier	Carrier	Carrier	Claims Administrator	Claims Administrator
Grace Period	31 Days	90 Days	31 Days	31 Days	31 Days	N/A	N/A

(1,2) - Carrier assumes liability for benefit payments which exceeds policyholder's limit.

(3) - State assumes liability up to stop-loss (reinsurance) point.

4/10/90 (1)

This refers to (1a)

STATE OF ALASKA

ACTIVE EMPLOYEES' HEALTH PLAN

UTILIZATION REPORTS

FIRST QUARTER 1990

STATE OF ALASKA
ACTIVE EMPLOYEES' HEALTH PLAN
UTILIZATION REPORTS
FIRST QUARTER 1990

I. Intent of Reports

A. Track cost savings and other changes due to plan design modifications put in place December 1, 1989:

1. Healthline
2. Inpatient Precertification and Review
3. Outpatient Precertification
4. Managed Second Opinion
5. Onsite Concurrent Review
6. Healthy Beginnings
7. Participating Pharmacy Drug Plan
8. Mail Service Drug
9. Out-of-pocket Maximum Increased
10. Chiropractic Care Maximum
11. Deductible Carry-over
12. Modification to Benefits After $50,000 Lifetime Maximum is Reached.
13. Co-ordination of Benefits Modifications
14. Vision Service Plan
15. Skilled Nursing Facility Care

16. Dental
    - deductible added
    - coinsurance change
    - maximum increased
17. Transportation
18. Third Party Liability Recovery
19. Dependent Eligibility

B. Identify Other Areas of Potential Cost Savings

EXHIBIT A

STATE OF ALASKA

SUMMARY OF BENEFIT CHANGES

HEALTHLINE UTILIZATION MANAGEMENT

A family of programs designed to promote cost-effective utilization of inpatient and outpatient medical services and informed healthcare consumer behavior through direct interaction with providers and through consumer counseling and advocacy.

HOSPITAL, SKILLED NURSING FACILITY, HOME HEALTHCARE AND PRIVATE-DUTY NURSING CARE REVIEW

Proposed confinements or care are reviewed to assess medical necessity, to determine appropriateness of level of care, and to determine length of inpatient stays.

OUTPATIENT PRECERTIFICATION

Sixteen outpatient diagnostic tests and procedures require precertification through Healthline in order to determine medical necessity.

MANAGED SECOND OPINION

Certain elective procedures and treatments (selection based on high frequency of use, high cost and indications of substantial inappropriate use) are reviewed for medical necessity.

ONSITE CONCURRENT REVIEW

The program is designed to assure that medically necessary care is provided in an efficient manner. A registered nurse visits hospitalized patients daily in the Providence and Humana Hospitals in Anchorage and reviews the patient's hospital chart. Based on her daily update of the patient's condition, the nurse negotiates for alternative care modes and venues with the attending physician and can identify individual case management necessity at an early state.

HEALTHY BEGINNINGS

Healthy Beginnings is a prenatal program design to reduce employer costs associated with the birth of premature or low birth weight infants. Covered employees or their dependents are encouraged to call Healthy Beginnings for risk assessment and appropriate intervention activity.

PARTICIPATING PHARMACY DRUG PLAN

State of Alaska family members pay $5.00 for non-generic drugs; generic prescriptions are provided at no cost to employees.

If participating pharmacists are used no filing of claims is necessary and Aetna will pay the pharmacy directly.

MAIL SERVICE DRUG PROGRAM

Brand-name drugs require a $2.00 payment per prescription; there is no cost for generic drugs.

INCREASE IN OUT OF POCKET LIMIT

The per-person calendar stop loss limit increased from $1,950 to $3,950; accordingly, the individual out-of-pocket limit for 90% coinsurance items will be $395 (not including the deductible).

CHIROPRACTIC CARE LIMITATION

Benefits for chiropractic services for spinal subluxation (whether rendered by a chiropractor, physician, osteopath, etc.) are subject to a $750 calendar year maximum per person. The intent of this limitation has been clarified such that it is now more accurately described as a "spinal disorder limitation"; the $750 benefit limit only applies to office visits, exams, consultations and regional manipulations.

DEDUCTIBLE CARRYOVER

Expenses incurred in the last three months of a calendar year, and applied toward that year's deductible will no longer also count toward the succeeding calendar year deductible obligation.

BENEFITS AFTER $50,000 PAID CLAIMS

Individuals exceeding $50,000 in lifetime paid benefits are required to satisfy the annual deductible; in addition, benefits in excess of $50,000 are paid at 90% (rather than 100%) up to the $3,950 out of pocket limit.

COORDINATION OF BENEFITS

The State of Alaska plan, when it is the secondary plan under order of payment rules, will pay the difference between what the primary plan has paid and the regular benefits that would be paid under the State plan in the absence of any coordination of benefits; this "maintenance of benefits" approach no longer automatically provides 100% COB benefits.

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A network of vision care providers and facilities offer services and supplies at negotiated prices.

Employees are responsible for minimal deductible payments for exams and standard eyewear purchases; the additional cost of special options or cosmetic/fashion features is paid in full by the employee.

SKILLED NURSING FACILITY CARE

Benefits for Skilled Nursing/Extended Care Facility confinement expenses for room and board and other medical services and supplies will be paid at 100% after the deductible; this benefit is only available if the skilled nursing facility confinement is a medically necessary alternative to an acute care inpatient hospital stay.

DENTAL EXPENSE COVERAGE

A $25 annual deductible (with a $75 family limit) applies to all restorative and other expenses not preventative in nature; the deductible is <u>waived</u> for expenses in connection with oral exams, x-rays, fluoride applications and cleanings.

Dental expenses such as extractions, periodontics, root canal treatment, oral surgery, and fillings are paid at 85% after the deductible rather than 90%.

Benefits for full mouth x-rays will be provided only once per calendar year per person.

Calendar year maximum increased from $1,000 to $1,500.

TRANSPORTATION BENEFITS

A per diem benefit to defray the cost of meals and lodging for employees or dependents who must travel to have preoperative testing and surgery is available. In addition, travel benefits includes coverage for transportation costs to the extent inpatient treatment in another location is less expensive than costs at the location nearest the employee.

THIRD PARTY RECOVERY

There is a requirement that individuals reimburse Aetna on behalf of the plan to the extent a covered family member recovers medical expenses from a third party wrongdoer or another insurance company. This provision prevents double recovery of expenses resulting from injuries due to an act or omission of a third party.

DEPENDENT ELIGIBILITY

Dependent children between the ages of 19 and 23 must be attending school regularly in order to be covered under the plan, provided they are also unmarried and chiefly dependent of the employee for support.

II. Period Reported

A. Period Covered

1. Incurred Claims Up to March 1990
   - Includes incurred claims from last quarter 1989
2. Claims Paid During First Quarter 1990

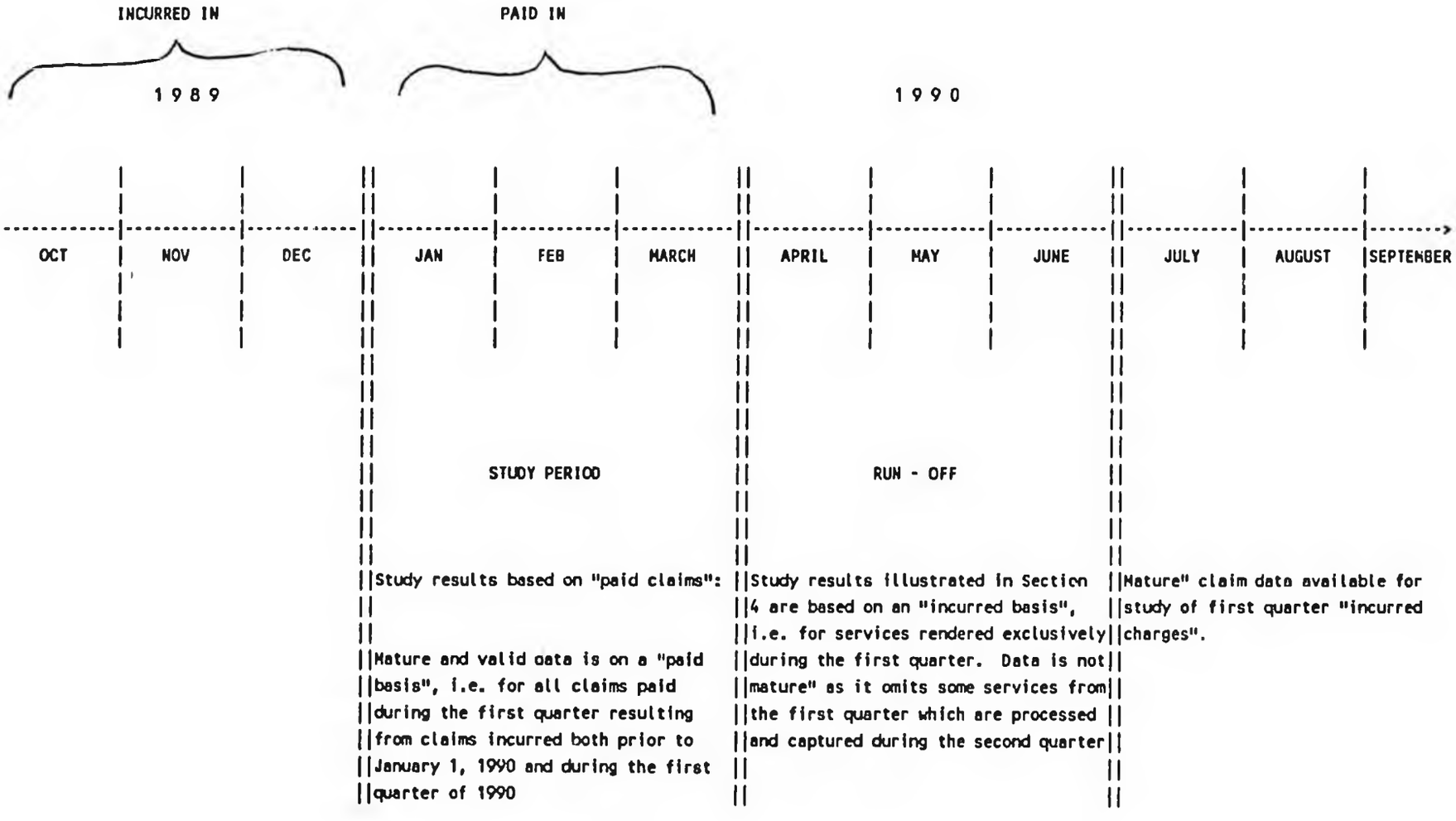
B. Incurred vs. Paid

C. Incurred Basis

- Immature data
- Incurred after January 1, paid through April 30

D. One Quarter is Insufficient For Hard Projections

CLAIM TIMELINE



III. Cost Savings Indicators

A. Healthy Beginnings

- 49 of 64 identified as increased risk
- 3 required physician referral
- Average age 32

B. Per Diem Travel Reimbursement

- 5 cases

C. Third Party Liability Recovery

- 38 cases identified

IV. Estimated Cost Savings Indicators

A. Inpatient Precertification

B. Onsite Concurrent Review

C. Procedure Precertification

D. Outpatient Precertification

E. Managed Second Opinion

F. Home Health Care Precertification

G. Skilled Nursing Facilities

V. Encouraging Trends

A. Overall Costs Were Down for First Quarter 1990

- Total expenses decreased by 8.1% or $84 per employee on paid basis
- Total expenses decreased by 9.7% or $83 per employee on incurred basis

B. Utilization Decreased

- Admission and Patient days (per 1,000 employees)
- Average length of stay unchanged
- Inpatient surgical procedures decreased 3.5%
- Outpatient surgical procedures increased, but not as high as Aetna book of business (18.4%)

C. No change in distribution of services

A. See Green / Blue bar graph.

B. Red / Blue bar graph.

VI. Next Reporting Period

A. Paid Data With Sufficient Run-off Will Correspond With Plan Design Changes

B. Will be Able to Track Actual Dollars Saved

1. Overall plan savings
2. Chiropractic services
3. Vision care claims
4. Prescription drug costs
5. Dental

C. Data Will be Complete

(10)

STATE OF ALASKA

HEALTHCARE EXPERIENCE

FIRST QUARTER 1990

PREPARED BY:

CUSTOMER CONSULTING SERVICES

AETNA LIFE INSURANCE COMPANY

JUNE, 1990

STATE OF ALASKA

HEALTHCARE EXPERIENCE

TABLE OF CONTENTS

EXECUTIVE SUMMARY

The following evaluation provides an initial view of the emerging trends of the State of Alaska's medical and dental healthcare experience through a comparison of first quarter 1989 and first quarter 1990 claim data. All data is presented for the active employee group only. The primary focus of this evaluation is to determine the impact of changes made to the State's health plan in December 1989 and January 1990.

- The State of Alaska's average healthcare benefit per employee for the combined experience of the indemnity plan, Vision Service Plan, Prescription Card Service (PAR Drug) and Mail Order Drug Program (MEDCO) was $951 in the first quarter of 1990 compared to $1,035 in the first quarter of 1989. This represents an 8.1% decrease in cost to the plan.

- The estimated savings to the State of Alaska for the first quarter 1990 was $892,772 or $68 per employee. The $68 savings is the difference between the $1,035 per employee benefit in the first quarter 1989 and the sum of the $951 benefit in first quarter 1990 plus $16 program cost.

- The precertification and other utilization management programs helped to significantly reduce hospital use patterns. Inpatient bed days per 1000 employees declined from 424 days per 1000 employees in the first quarter 1989 to 342 bed days per 1000 employees in the first quarter 1990.

- Hospital benefits paid for treatment of psychiatric disorders and for the treatment of substance abuse disorders declined by 53% and 54%, respectively.

- The cost to the plan for reimbursement of chiropractic expenses was reduced by 36.6% from $509,205 ($41 per employee) in the first quarter 1989 to $335,760 or $26 per employee in first quarter 1990.

- Dental benefits paid by the State of Alaska's healthcare plan decreased from $167 per employee in the first quarter of 1989 to $148 per employee during the comparable period in 1990.

- The Utilization Management program activity indicates 715 requests for precertification of a hospital stay. Eighty of the requested stays (11%) were averted. 6,753 bed days were requested of which 2,903 (43%) were averted. The onsite nurse in Anchorage reviewed 93 cases and 356 bed days were averted.

- There were 482 procedures requested through the procedure protocol program; Outpatient Precertification and Managed Second Opinion. Thirty five (7.3%) of these requests were not certified.

- There are 64 active participants in the Healthy Beginnings Program (high risk pregnancy). Seventy five percent (49/64) of the participants were classified at increased risk for delivery of low birth weight infants and are receiving proactive intervention services from the Healthline nursing staff.

INTRODUCTION & OVERVIEW

In order to help control their escalating health care costs, the State of Alaska implemented a series of Utilization Management Programs and plan design changes on December 1, 1989 and on January 1, 1990. These changes to the health benefit program the State provides to its approximately 13,000 active employees are described in Exhibit A of this section.

The State of Alaska requested that Aetna's Customer Consulting Services Department develop the necessary management reports to monitor program activity and to perform an assessment of the effects of plan design and program changes from utilization and expense perspectives.

Our principal objective in the first phase of this project was to develop management reports which reflect both program activity and results. Initial reports of preliminary overall results are presented in Section 4. Reports on Utilization Management program activity and plan changes are located in Sections 5 and 6.

Exhibit A briefly describes the changes that the State made to its health care program. The majority of these plan design changes and new utilization management programs became effective on December 1, 1989. The optimal method of assessing the impact of these changes calls for the use of patient service data which occurred exclusively on or after January 1, 1990, i.e. for claims "incurred" during 1990 only. Additional discussion on this issue is found in Section 3 - Methodology. Unfortunately, during this initial review, it is not possible to rely exclusively on this approach.

For this initial study, we elected to use the total set of data available, which represents all claim services paid for during the first quarter of 1990 and to compare it to the analogous "paid claim" data which occurred during the first quarter of 1989.

As the program matures, we will make an assessment of the health care program changes using only data for patient services incurred on and after January 1, 1990.

Our recommendations for future reporting and evaluation of the impact of changes on the State of Alaska's healthcare costs is found in Section 7 - Summary.

EXHIBIT A

STATE OF ALASKA

SUMMARY OF BENEFIT CHANGES

HEALTHLINE UTILIZATION MANAGEMENT

A family of programs designed to promote cost-effective utilization of inpatient and outpatient medical services and informed healthcare consumer behavior through direct interaction with providers and through consumer counseling and advocacy.

HOSPITAL, SKILLED NURSING FACILITY, HOME HEALTHCARE AND PRIVATE-DUTY NURSING CARE REVIEW

Proposed confinements or care are reviewed to assess medical necessity, to determine appropriateness of level of care, and to determine length of inpatient stays.

OUTPATIENT PRECERTIFICATION

Sixteen outpatient diagnostic tests and procedures require precertification through Healthline in order to determine medical necessity.

MANAGED SECOND OPINION

Certain elective procedures and treatments (selection based on high frequency of use, high cost and indications of substantial inappropriate use) are reviewed for medical necessity.

ONSITE CONCURRENT REVIEW

The program is designed to assure that medically necessary care is provided in an efficient manner. A registered nurse visits hospitalized patients daily in the Providence and Humana Hospitals in Anchorage and reviews the patient's hospital chart. Based on her daily update of the patient's condition, the nurse negotiates for alternative care modes and venues with the attending physician and can identify individual case management necessity at an early state.

HEALTHY BEGINNINGS

Healthy Beginnings is a prenatal program design to reduce employer costs associated with the birth of premature or low birth weight infants. Covered employees or their dependents are encouraged to call Healthy Beginnings for risk assessment and appropriate intervention activity.

PARTICIPATING PHARMACY DRUG PLAN

State of Alaska family members pay $5.00 for non-generic drugs; generic prescriptions are provided at no cost to employees.

If participating pharmacists are used no filing of claims is necessary and Aetna will pay the pharmacy directly.

MAIL SERVICE DRUG PROGRAM

Brand-name drugs require a $2.00 payment per prescription; there is no cost for generic drugs.

INCREASE IN OUT OF POCKET LIMIT

The per-person calendar stop loss limit increased from $1,950 to $3,950; accordingly, the individual out-of-pocket limit for 90% coinsurance items will be $395 (not including the deductible).

CHIROPRACTIC CARE LIMITATION

Benefits for chiropractic services for spinal subluxation (whether rendered by a chiropractor, physician, osteopath, etc.) are subject to a $750 calendar year maximum per person. The intent of this limitation has been clarified such that it is now more accurately described as a "spinal disorder limitation"; the $750 benefit limit only applies to office visits, exams, consultations and regional manipulations.

DEDUCTIBLE CARRYOVER

Expenses incurred in the last three months of a calendar year, and applied toward that year's deductible will no longer also count toward the succeeding calendar year deductible obligation.

BENEFITS AFTER $50,000 PAID CLAIMS

Individuals exceeding $50,000 in lifetime paid benefits are required to satisfy the annual deductible; in addition, benefits in excess of $50,000 are paid at 90% (rather than 100%) up to the $3,950 out of pocket limit.

COORDINATION OF BENEFITS

The State of Alaska plan, when it is the secondary plan under order of payment rules, will pay the difference between what the primary plan has paid and the regular benefits that would be paid under the State plan in the absence of any coordination of benefits; this "maintenance of benefits" approach no longer automatically provides 100% COB benefits.

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DEPENDENT ELIGIBILITY

Dependent children between the ages of 19 and 23 must be attending school regularly in order to be covered under the plan, provided they are also unmarried and chiefly dependent of the employee for support.

METHODOLOGY

The purpose of this study is to assess the impact of all utilization management programs and plan design changes on the State of Alaska's healthcare experience. In an effort to review activity both before and after benefit changes, we have primarily focussed on data for the first quarter 1989 and the first quarter 1990 to facilitate the comparison of comparable time periods and pre- and post- results.

SOURCE OF DATA

Data analyzed in this study was extracted from AECCLAIMS, Aetna's computerized claim payment system which manages all of Aetna's policyholder's claim submissions. All healthcare expense and utilization statistics were obtained from AECCESS Basic Reports and Aetna's AECCESS database which contains information on all inpatient and outpatient claims processed for the State of Alaska within the past 27 months.

Data on Utilization Management program activity was obtained from Aetna's system resources and records maintained in our Seattle claim office. Additionally, information was provided by Aetna's PAR drug information system, MEDCO, and the Vision Service Plan.

EXPOSURE DATA

To enable accurate comparisons of utilization and expenses between comparable time periods, as well as between the State's and Aetna's normative data, factors have been developed to express utilization in relative terms, such as admissions per 1000 employees, bed days per 1000 employees and expenses per employee.

Numbers of employees used in the calculation of "per 1000 employees" and "per employee" factors were supplied by the State of Alaska. The employee counts provided are as follows:

	JANUARY	FEBRUARY	MARCH	QUARTER AVERAGE
1ST QTR 89'	12,558	12,702	12,936	12,732
1ST QTR 90'	13,017	13,107	13,264	29

SOURCE: State of Alaska

NORMATIVE DATA

The normative data presented for comparison with the State's experience is based on Aetna's Book of Business and so represents average results for employers with all types of health benefit plans.

In all cases the normative values represent the midpoint of an expected range and should not be considered absolute values. Because the State's employee demographics differ from Aetna's Book of Business, these norms are general benchmarks of average results for groups with a wide range of demographics characteristics.

PAID VERSUS INCURRED DATA

For this first evaluation, data represents all claim services paid for during the first quarter of 1990 compared to paid claim data for first quarter 1989, however as previously indicated, this is not the optimal method of assessing the impact of program and plan changes.

In many instances, the time span between the date that patient service occurs and the date that the claim payment is made and recorded in our database is three months. As a result, the total set of data available at the time of this assessment is inclusive of:

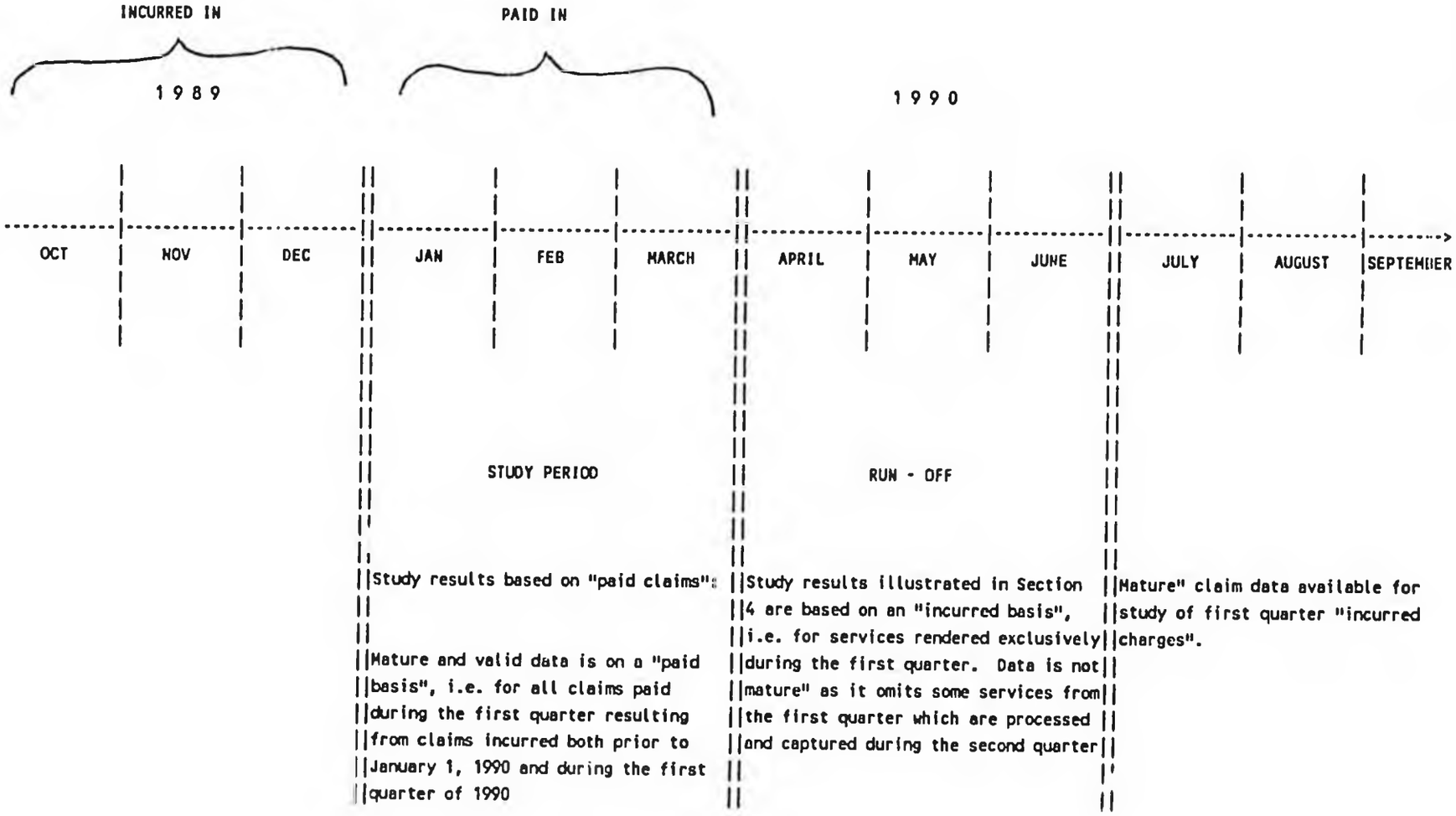
- Patient services rendered prior to January 1st, e.g. December, November and October of 1989, or even earlier, but paid in the first quarter of 1990, and

- omissions for some patient services rendered in January, February and March of 1990 but not yet paid and recorded in the first quarter of 1990.

We were able to isolate data exclusively for claims "incurred" during the first quarter of 1990 and TABLES 4-6 in Section 4 have reflected the results. For the reason noted above, however, it would be inappropriate to consider this data valid as it omits some services which occurred during the later portion of the first quarter, i.e., this data is "immature".

The exhibit on the following page provides a visual display of the impact of claim lag and the value of allowing sufficient time to elapse before the most credible "view" of claim data is undertaken.

CLAIM TIMELINE



FINDINGS

EXPENSE

Total healthcare benefits in the first quarter 1990 including the Vision Service plan, the Mail Order Drug program and the Prescription Card program are $951 per employee. The average benefits paid per employee during the first quarter 1989 were $1,035. This represents an 8.1% reduction in per employee claim costs over time. (TABLE 1)

The first quarter 1990 estimated savings to the State when the cost of Healthline programs is considered is $892,772.

CLAIM COSTS PER EMPLOYEE

1ST QUARTER 1990

Aetna Indemnity	$906
Vision Service Plan	28
Prescription Drug Card	14
Mail Order Drug	3
Utilization Management Programs	16
	$967

1ST QTR 1989		1ST QTR 1990		
$1,035	-	$967	=	$68

$68 X 13,129 employees = $892,772 1st Qtr. Savings

NOTE: 1989 dollars are not adjusted for inflation.

Employees paid $171 or 12.7% in cost sharing plan features, i.e., deductible and coinsurance during the first quarter 1989. In the first quarter of 1990 employees paid $157 or 13.3% of covered charges. Employees paid 8.2% fewer actual dollars, however the portion of covered charges being shared by employees increased.

Although the deductible paid in the first quarter per employee decreased from $91 to $8[illegible], this probably results from the influence of 1989 incurred services included in paid results. When viewed on an incurred basis (TABLE 4), i.e., paid claims for services incurred in the first quarter 1990, the deductible portion remained

the same as 1989 levels. We expect therefore, that when 1990 incurred data is more complete, the positive effects of the plan changes which eliminated the deductible carry-over provision and the deductible waiver on large claims will become more evident.

The amount of savings due to coordination of benefits decreased from $144 to $118 per employee (-18.1%). These are our findings, however, because the savings from the Maintenance of Benefits approach is captured in the NOT COVERED expenses as opposed to COB savings this will involve further study in order to give a better idea of the impact of Maintenance of Benefits.

UTILIZATION

The precertification and other inpatient utilization management programs, i.e. On-Site nurse and Managed Second Opinion, have positively impacted hospital use patterns. The programs have helped to reduce the level of hospital inpatient utilization (patient days per 1000 employees) from 424 days in the first quarter 1989 to 342 days in the first quarter 1990 (-19.3%). (TABLE 2.) This 19.3% decrease was better than Aetna's book of business. The 10% decrease in bed days experienced by Aetna perhaps also reflects the influence of our healthline programs. In addition hospital admission rates per 1000 employees for the State's population declined 18.7%.

This reduction in inpatient hospital services is a major factor in the overall decrease in both submitted charges and healthcare benefits paid by the State of Alaska.

The average length of stay remained virtually unchanged. Utilization Management programs work to avert unnecessary short stay admissions, therefore this result is not unexpected. This is however only a single quarter comparison and results may fluctuate over time.

TYPES OF CARE

HOSPITAL

When benefits paid by the State's health plan are examined by specific types of care (TABLE 3) it is clear that inpatient experience had the greatest impact on the reduction in overall benefits paid. Total inpatient costs per employee decreased 14.9% from $477 per employee in 1989 to $406 per employee in 1990. Outpatient benefits decreased only 5.4%, from $483 to $457.

When per employee benefits for hospital services, i.e., room and board and ancillaries are examined separately from all other inpatient benefits, the decrease is even more dramatic. Psychiatric benefits declined 53% and substance abuse confinement costs are down 54%. The number of inpatient days associated with psychiatric and substance abuse treatment will be examined when paid claim data more closely reflect services incurred after program implementation.

INPATIENT HOSPITAL BENEFITS PER EMPLOYEE

	1ST QTR 89	1ST QTR 90	%CHANGE
Hospital Room & Board and Ancillaries (Medical/Surgical)	$288	$262	-9%
Hospital Room & Board and Ancillaries (Psychiatric)	$60	$28	-53%
Hospital Room & Board and Ancillaries (Substance Abuse)	$28	$13	-54%
TOTAL	$376	$303	-19%

CHIROPRACTIC

Benefits paid for chiropractic services also showed a significant decrease (-36.6%). $509,205 or $41 per employee was paid in the first quarter of 1989 compared to 335,760 or $26 per employee from January 1 through March 31, 1990.

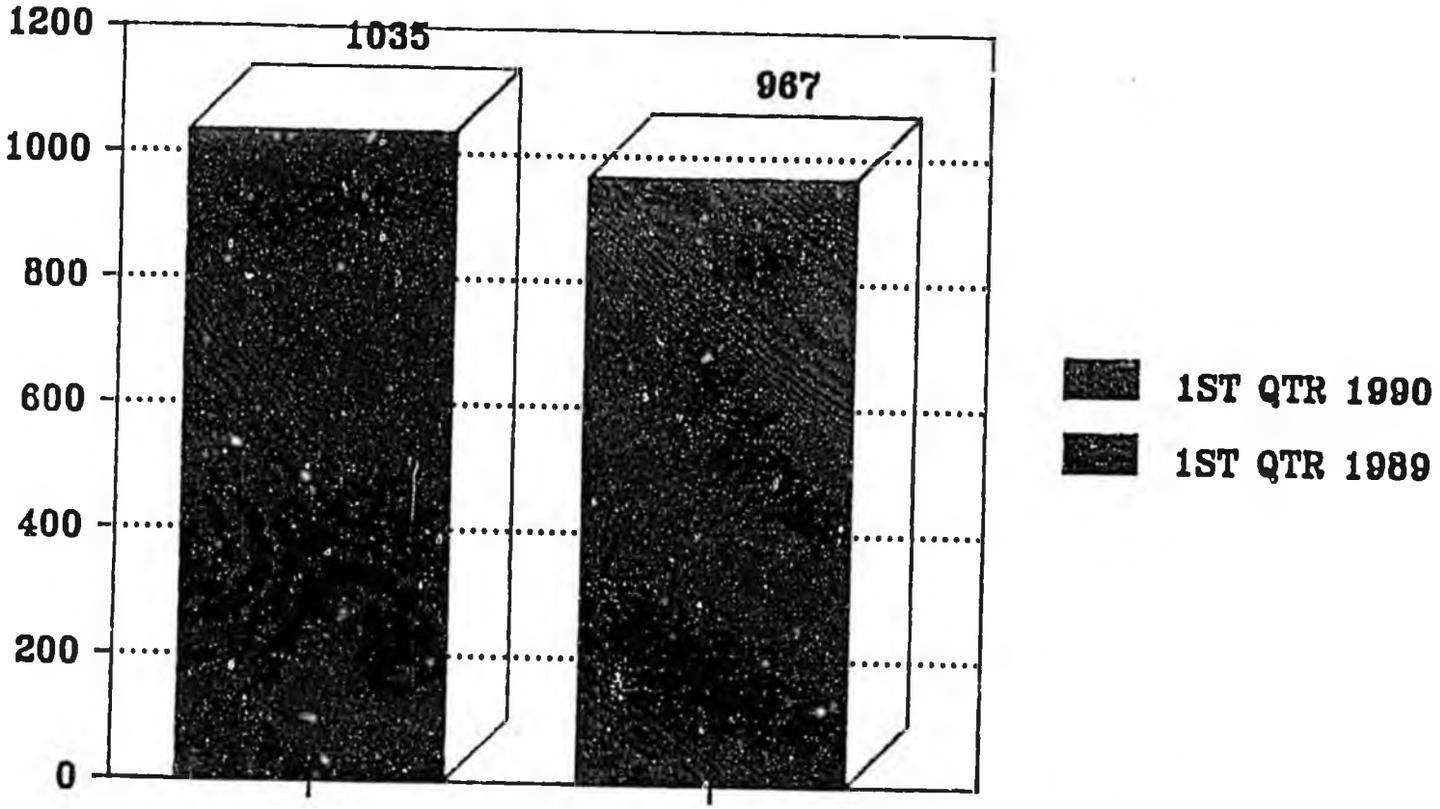
This result was impacted by the $750 calendar year maximum added to the plan. A more detailed view of the chiropractic experience for the first quarter of 1990 is provided on TABLE 18 in Section 6.

DENTAL

The plan also experienced a decrease (-11.4%) in dental benefits over time, from $167 per employee in first quarter 1989 to $148 per employee in first quarter 1990.

The addition of a $25 deductible, the change from 90% coinsurance to 85% for certain services, limitation on full-mouth x-rays and the required pre-treatment authorizations all contributed to this result. The impact of the increase in the annual maximum will become more evident as the year progresses.

STATE OF ALASKA
HEALTHCARE PLAN SAVINGS
PER EMPLOYEE

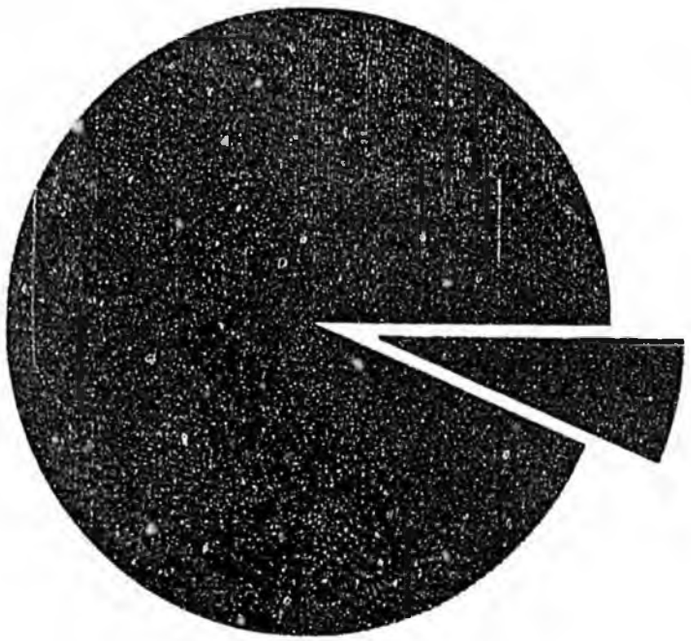


$68 x 13129 = $892,772

(SAVINGS PER ER) (EMPLOYEES) (1ST QTR 90 SAVINGS)

STATE OF ALASKA
TOTAL HEALTHCARE CLAIM COSTS
PER EMPLOYEE

OTHER PLAN COSTS:	
UTILIZATION MGT.	$16
MAIL ORDER DRUG	$ 3
PRESCR DRUG CARD	$14
VISION SERV. PLAN	$28
TOTAL	$61



1ST QUARTER 1990

STATE OF ALASKA
SUMMARY OF EXPENSE
PAID CLAIMS
ACTIVE EMPLOYEE GROUP

TABLE 1

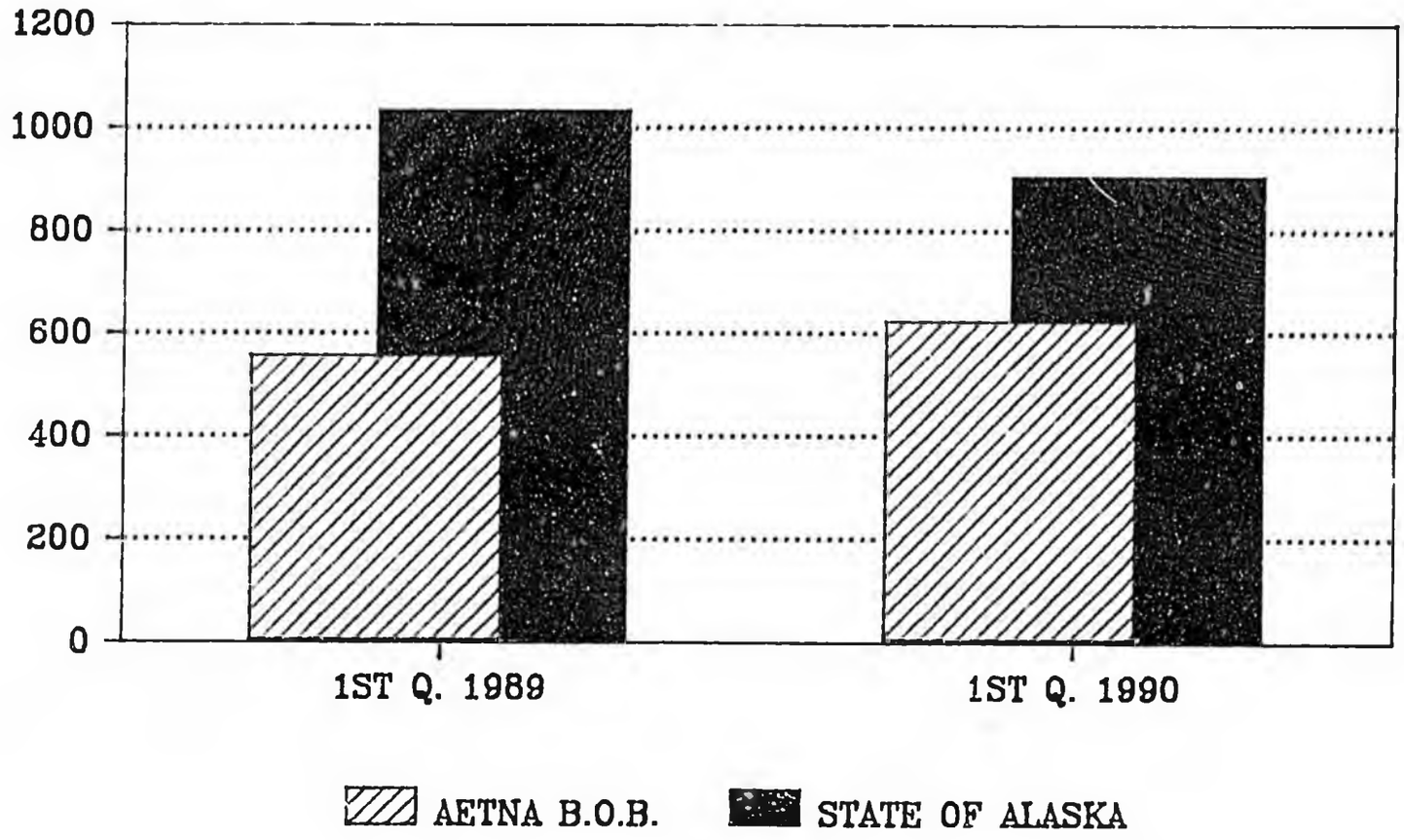
KEY INDICATORS (PER EMPLOYEE)	STATE OF ALASKA 1ST QTR. 1989	STATE OF ALASKA 1ST QTR. 1990	STATE OF ALASKA % CHANGE	STATE OF ALASKA DOLLAR CHANGE	AETNA BOOK OF BUSINESS 1989	AETNA BOOK OF BUSINESS 1990	AETNA BOOK OF BUSINESS % CHANGE
GROSS SUBMITTED EXPENSES	$1,575	$1,457	-7.5	-$118	$881	$958	8.7
CLAIM ADMINISTRATION SAVINGS & OTHER NOT COVERED	$225	$275	22.2	$50	$172	$195	13.4
EXPENSES COVERED	$1,350	$1,182	-12.5	-$168	$709	$763	7.6
EXPENSES PAID BY EMPLOYEES							
DEDUCTIBLE	$91	$85	-6.6	-$6	$55	$60	9.1
CO-PAY	$80	$72	-10.0	-$8	$69	$75	8.7
TOTAL COST SHARING	$171	$157	-8.2	-$14	$124	$135	8.9
COST SHARING AS % OF COVERED	12.7%	13.3%	4.7	-	17.5%	17.7%	1.0
COB	$144	$118	-18.1	-$26	$22	$21	-4.5%
EXPENSES PAID BY PLAN	$1,035	$906	-12.5	-$129	$556	$599	7.7
TOTAL EXPENSES PAID BY PLAN INCLUDING VSP, PAR, MEDCO	$1,035	$951	-8.1	-$84			

NUMBER OF EMPLOYEES: 1ST QUARTER 1989 12,732

1ST QUARTER 1990 13,129

STATE OF ALASKA

NET PAID PER EMPLOYEE
TREND



STATE OF ALASKA
SUMMARY OF HEALTHCARE UTILIZATION
PAID CLAIMS
ACTIVE EMPLOYEE GROUP

TABLE 2

	STATE OF ALASKA			AETNA BOOK OF BUSINESS		
HEALTHCARE UTILIZATION PER 1000 EE'S	1ST QUARTER 1989	1ST QUARTER 1990	% CHANGE	1ST QUARTER 1989	1ST QUARTER 1990	% CHANGE
ADMISSIONS	65	53	-18.7	49	46	-6.1
PATIENT DAYS	424	342	-19.3	300	270	-10.0
AVERAGE LENGTH OF STAY	6.5	6.5	-0.7	6.1	5.9	-3.3
SURGICAL PROCEDURES						
INPATIENT	50	48	-5.5	41	39	-4.9
OUTPATIENT	255	264	3.4	163	166	18.4
% INPATIENT	16.5%	15.3%	-7.3	20.1%	18.9%	-6.0
NUMBER OF EE'S	12,732	13,129	3.1			