ALASKA LEGISLATURE COMMITTEE FILES 1993-1994 8672
8292 SENATE HEALTH EDUCATION & SOCIAL SERVS. - SENATE JUDICIARY

HJR

52

STATE COMMITTEE REPORT

DATE: 4/21/94 FURTHER:

DATE TURNED INTO OFFICE: 4/30/94

HESS Committee considered HOUSE JOINT RESOLUTION NO. 52

Urging the Congress to amend the Social Security Act so that the higher cost of living in Alaska is reflected when the per capita income of the state is used as a factor in determining the federal share of Medicaid costs.

and recommends:

[ ] replace with _____ CS _____(_____)
or [ ] adopt previous_____ CS _____(_____)
[ ] attaches amendment(s)

[ ] same title
[ ] new title
[ ] technical title change (HB only)

[ ] adopts _____Letter of Intent
[ ] further referral to the _____

[ ] do pass
[ ] do not pass
[ ] no recommendation
[ ] individual recommendations

NEW FISCAL NOTES

Department	Date	Zero	Fiscal

PREVIOUS FISCAL NOTES

Department	Date	Zero	Fiscal
Health+Soc Servs	3/4/94	✓	

[ ] Appropriation No Fiscal Note

DO PASS:

Mike Miller
Andrew A. Lemon
Bert Sharp

OTHER RECOMMENDATIONS:

Steve Rieger
Chair: Signature and Recommendation

716 W. Fourth Ave., #240
Anchorage, Alaska 99501-2133
258-8191

While in Session:
Alaska State Capitol
Juneau, Alaska 99801-1182
465-4968

Alaska State Legislature

House of Representatives

District 11:
Sand Lake
Spenard
Taku-Campbell

Representative Jim Nordlund

SPONSOR STATEMENT

HJR 52 urges the amendment of the Social Security Act to increase federal funding for Alaska's Medicaid program. Currently, the federal government sets its medical assistance percentages based on each state's per capita income. Those percentages range from 50% to 79%, with Alaska's matching rate set at only 50%.

We all know that Alaska's per capita income appears high until you consider our high cost of living and medical care. An American Chamber of Commerce study shows that health care costs in Anchorage, Fairbanks, Juneau and Kodiak are between 171 and 190% of the national average.

The federal government already takes into account these higher costs by adjusting our poverty guidelines up 25%. Medicare regulations also recognize the higher cost of health care by providing a funding adjustment of 25% for nursing facilities in Alaska.

Amending the Social Security Act to include a similar 25% adjustment in the federal medical assistance formula would increase the percentage for Alaska's medicaid program to 62%. This would mean an additional $31,000,000 in federal funding and would require no increase in state General Fund dollars. The savings could be used for other state purposes while Alaska residents in need of Medicaid would still receive the care they need.

An increase in the Federal Medical Assistance Percentage would also increase funding for aid to families with dependent children, foster care assistance and the JOBS program (Job Opportunity and Basic Skills).

Since Medicaid eligibility is determined according to each state's poverty level, the 25% federal adjustment to Alaska's poverty guidelines increases the number of people we have to cover. This is unfair. On one hand the feds tell us we have to cover these individuals, and yet they don't give us the additional assistance to make it equitable. Given the state's current financial situation, it seems that now is the time to request our fair share.

FISCAL NOTE

STATE OF ALASKA
1994 LEGISLATIVE SESSION

BILL NO. HJR 52

Revision Date: 01/26/94
Title: Federal share of Medicaid Costs for Alaska
Sponsor: Reps. Nordlund, Brice, Foster, ...
Requestor:

Dept. Affected: Health and Social Services
BRU: Medical Assistance Administration
Component: All components

COMPONENT SERIAL NO. 242, 243, 244, 1226, 1434, 1822, 197

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY95	FY96	FY97	FY98	FY99	FY00
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0

CAPITAL EXPENDITURES						

CHANGES IN REVENUES						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

Estimate of current year (FY94) impact: _____

ANALYSIS: (Attach a separate page if necessary)
Revised Alaska specific formula would increase Federal matching funds for Medicaid. If Congress accepts the Alaska specific federal match rate formula requested in the resolution, Alaska assistance programs that rely on this formula would realize an increase in federal match in excess of 40 million dollars.

Prepared by: Kimberly B. Busch
Division: Medical Assistance
Phone: 465-3355
Date: 01/27/94

Approved by Commissioner: Margaret R. Lowe, M.Ed., Ed.S.
Date: 1-27-94
Agency: Department of Health & Social Services

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POSITION PAPER

STATE OF ALASKA ★ DEPARTMENT OF HEALTH & SOCIAL SERVICES

Position Paper

A resolution urging the Congress to amend the Social Security Act so that the higher cost of living in Alaska is reflected when the per capita income of the state is used as a factor in determining the federal share of Medicaid costs.

POSITION

The Department of Health and Social Services strongly supports House Joint Resolution No. HJR 52 which urges Congress to amend the Social Security Act so that the higher cost of living in Alaska is reflected in the formula used to calculate the federal financial contribution for programs including Medicaid and Aid to Families with Dependent Children.

Historically, the federal law has mandated a formula which uses a cost of living differential to set a higher poverty level for Alaska. This has the effect of mandating a greater number of eligibles for such programs as Medicaid and Aid to Families with Dependent Children. The federal law fails to specify the use of a cost of living differential to establish the match rate for federal financial contributions to these same programs. The result is that Alaska receives in excess of 40 million dollars less in federal dollars every year than the amount that we believe an equitable formula would provide to us.

All of the current health care reform proposals except the Chaffee Bill employ the same federal match rate formula. Passage of these proposals will further exacerbate the financial burden to Alaska. Senator Stevens instigated the inclusion of this Alaska-specific language in the Chaffee Bill. This was a very important step that we believe must be taken further. The Social Security Act must be amended this year to include this Alaska specific language.

We support Representative Nordlund's resolution to encourage this action by our Congressional delegation.

Recommended by: Kimberly B. Busch

Kimberly B. Busch
Director
Division of Medical Assistance

Date: 1-21-94

Approved by: Margaret R. Lowe

Margaree R. Lowe, M.Ed., Ed.S,
Commissioner

Date: 1-27-94

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United States Senate

COMMITTEE ON APPROPRIATIONS
WASHINGTON, DC 20510-6025

February 9, 1993

The Honorable Jim Nordlund
Alaska State Legislature
House of Representatives
Juneau, Alaska 99802-1182

Dear Jim:

Thank you for letting me know of your support for my efforts to amend the Social Security Act and to increase the federal share for the State's Medicaid program.

I was able to attach my Medicaid amendment to the Health Equity and Access Reform Today Act (HEART) prior to its introduction in November. It is my understanding that a member of my staff has already sent you the language for this amendment, but knowing of your interest in health care reform I have attached a copy of the HEART bill, along with some other information on legislation currently being considered by Congress.

With best wishes,

Cordially,

TED STEVENS

Enclosure

Medicaid Services Reduced To Meet Budget Constraints

Reductions in Medicaid services were implemented this fall because FY93 medical payments exceeded projections, the FY94 medicaid budget request was not fully funded by the legislature and, some one time costs were incurred through legal settlements.

Medicaid, an "entitlement program" created by the federal government to provide medical service for low-income citizens, is funded jointly by a state and federal match formula. The program is intended to help those who are elderly, blind, or disabled, and families with dependent children who do not have sufficient money or insurance coverage to pay for health care.

The Division of Medical Assistance is limiting the services it pays for in the following ways:

Increases for inflation adjustments for physicians and dentist fees and for residential psychiatric treatment facility services will not be made; and

payments to doctors who assist in surgery will be reduced;

The amount paid to some transportation providers will be capped;

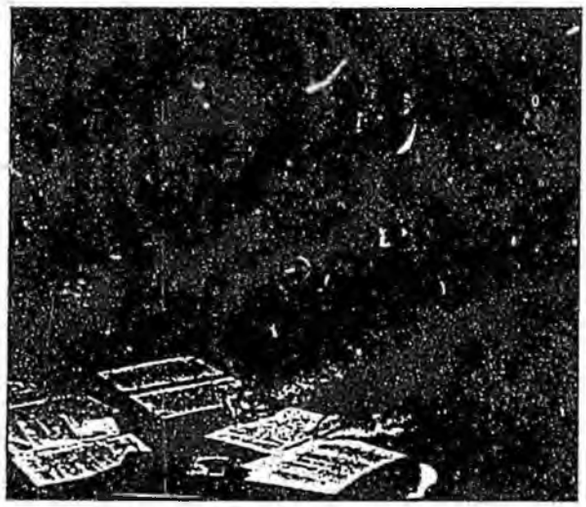
Payment for growth hormones will only be made if the treatment is prescribed by a board-certified endocrinologist to address certain specific medical needs;

The maximum number of chiropractic visits paid for in one year will be reduced from 24 to 12 and payment for x-rays to chiropractors will be limited to one x-ray per year instead of the current three; and,

Prior approval will be required for magnetic resonance imaging (a diagnostic service similar to x-rays).

"In keeping with our mission, we want to ensure access to medical care by low income Alaskans who meet regulatory eligibility and medical need requirements," said Kim Busch, Director of the Division of Medical Assistance. "To that end, the Division reduced expenditures through program changes which limited rather than eliminated optional Medicaid services or eligible groups."

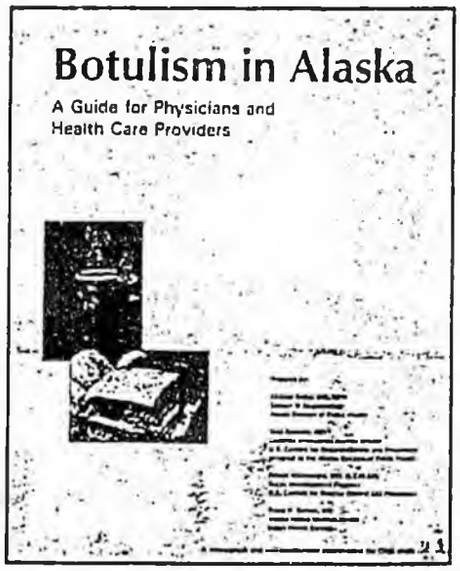
Featured speaker Burdena Pasenelli, Special Agent in charge of the Federal Bureau of Investigations (FBI), Alaska meets with students at McLaughlin during Red Ribbon Week.



Deputy Commissioner Mel Krogseng signing Memorandum of Understanding between the Division of Public Health's Alaska Cancer Prevention and Control Program and the American Cancer Society, Alaska Division Cancer.

Botulism in Alaska: *A Guide for Physicians and Health Care Providers may be obtained by writing Division of Public Health, Section of Epidemiology, P.O. Box 240249, Anchorage, AK 99524-0249.*

The Alaska Division of Public Health, the Arctic Investigations Program of the U.S. Centers for Disease Control and Prevention, and the Alaska Area Native Health Service of the U.S. Indian Health Service have produced this monograph to give Alaska health care providers an up-to-date summary of botulism in Alaska.



FEDERAL MEDICAL ASSISTANCE PERCENTAGE

(FMAP)

- *THE FEDERAL BUDGET FOR THE MEDICAID PROGRAM WAS APPROXIMATELY $121,400,000,000 FOR FEDERAL FY 92.*

- *THE FEDERAL SHARE OF MEDICAID IN ALASKA FOR THAT PERIOD WAS $107,700,000, OR LESS THAN $1 OF EVERY $1000 IN THE FEDERAL BUDGET.*

- *THE PROPOSED ADJUSTMENT TO THE FMAP FOR ALASKA WOULD INCREASE FEDERAL FUNDING FOR MEDICAID IN ALASKA BY ABOUT $30 MILLION, OR 10 CENTS FOR EVERY $230 SPENT BY THE FEDERAL GOVERNMENT FOR MEDICAID NATIONALLY.*

- *THE PROVIDER TAX PROGRAM, WHICH OVER 30 STATES USE AS A FUNDING DEVICE TO INCREASE THE FEDERAL SHARE OF THEIR MEDICAID PROGRAM COSTS, WILL INCREASE FEDERAL MEDICAID SPENDING BY $11,300,000,000 IN FY 93.*

- *THE AMERICAN CHAMBER OF COMMERCE (ACCRA) COST OF LIVING INDEX FOR 1992 SHOWS THE COST OF LIVING FOR 4 COMMUNITIES IN ALASKA WHICH RANGE BETWEEN 130% TO 146% OF THE NATIONAL AVERAGE.*

- *THE ACCRA INDEX FOR HEALTH CARE COSTS IN THE ALASKA COMMUNITIES IS BETWEEN 171% TO 190% OF THE NATIONAL AVERAGE.*

- *MEDICARE REGULATIONS RECOGNIZE THE HIGHER COSTS OF HEALTH CARE IN ALASKA BY PROVIDING A FUNDING ADJUSTMENT OF 25% FOR NURSING FACILITIES IN THE STATE.*

- *ELIGIBILITY FOR MEDICAID IS BASED IN PART ON FEDERAL POVERTY GUIDELINES ESTABLISHED BY THE U. S. DEPARTMENT OF HEALTH AND HUMAN SERVICES.*

- *POVERTY GUIDELINES FOR THE STATE OF ALASKA ARE ADJUSTED UP BY 25% ACCORDING TO THE FEDERAL REGISTER TO REFLECT THE HIGHER COST OF LIVING IN ALASKA.*

- *ANY ADJUSTMENT TO THE ALASKA FMAP WILL IMPACT NOT ONLY MEDICAID BUT ALSO THE AFDC, FOSTER CARE, AND JOBS PROGRAMS.*

- *ADJUSTING THE FMAP FOR ALASKA WILL HAVE NO IMPACT ON THE FMAP FOR OTHER STATES.*

FY 1994 Federal Financial Participation

Proposed FMAP Increase for Alaska

AFDC - Program		
Total Eligible for Federal Match		*$113,600,800*
Federal Match @ Proposed Rate		*70,432,400*
Federal Match @ Current Rate		*56,800,400*
Proposed Federal Fund Increase		*13,632,000*
Medicaid - Program		
Total Eligible for Federal Match		*$258,035,000*
Federal Match @ Proposed Rate		*159,981,700*
Federal Match @ Current Rate		*129,017,500*
Proposed Federal Fund Increase		*30,964,200*
AFDC & Medicaid Increased Federal Funds	*SFY 94 Budget*	*$ 44,596,200*

The $44.5 million dollars represents an increase in federal funds to the State of Alaska Medicaid and AFDC programs. This estimation is based on the state FY 94 budget. If the proposed change to the FMAP calculation would pass and be effective for FY94, it would mean that federal participation for funding the Alaska Medicaid and AFDC programs would increase by the $44.5 million, which would reduce the state portion of the Alaska Medicaid budget by $30.9 million for FY 94 and reduce state expenditures for AFDC by $13.6 million. That is, overall the state budget for the programs would not change, but the federal participation would increase, thereby decreasing the state GF expenditure.

FACT SHEET IN SUPPORT OF THE FMAP ADJUSTMENT

Sections 1101(a)(8)(B) and 1905(b) of the Social Security Act establishes for each state participating in the Medicaid program a federal matching rate known as the "Federal Medical Assistance Percentage" or FMAP. The FMAP is that percentage of the state's Medicaid expenditures paid by the federal government. The matching rate is established on the basis of the ratio between each state's per capita income and the per capita income of the United States. The intent behind these sections is to assure that states that are poorer in relation to other states will be required to bear a lesser share of the burden of their Medicaid expenditures, with the federal government picking up a larger share. Currently, federal matching rates range from 50% to 79%.

Alaska is unfairly disadvantaged by the current statutory formula. For Alaska the current FMAP rate is 50%, a result of the fact that the Alaska per capita income looks very high in comparison to the per capita incomes of the lower 48 states. However, a simple comparison of per capita income fails to take into account the dramatically higher cost of living and of medical care in Alaska.

Currently Medicare regulations recognize the higher costs in Alaska by providing for an adjustment of 25% for nursing facilities in Alaska. Federal poverty guidelines are also adjusted by 25% for Alaska. The statutory provisions that determine federal matching rates by reference to state per capita income should incorporate a similar cost of living adjustment, so that the share of the Medicaid expenditure burden borne by Alaska will be comparable to that of states where residents with lower per capita incomes also benefit from significantly lower living costs.

*The attached legislation to amend sections 1101(a)(8)(B) and 1905(b) would employ an "**adjusted per capita income**" (per capita income divided by 1.25) to compute the federal matching, FMAP, for Alaska.*

FEDERAL MEDICAL ASSISTANCE PERCENTAGE

FMAP BACKGROUND

- *FEDERAL FINANCIAL PARTICIPATION FOR THE MEDICAID PROGRAM IS BASED ON THE FEDERAL MEDICAL ASSISTANCE PERCENTAGE (FMAP).*
- *THE FMAP IS CALCULATED ACCORDING TO A FORMULA BASED ON PER CAPITA INCOME OF THE INDIVIDUAL STATE IN RELATION TO THE PER CAPITA INCOME OF THE UNITED STATES.*
- *THIS FORMULA IS DEFINED IN THE SOCIAL SECURITY ACT UNDER SECTION 1101 (a)(8)(B) AND SECTION 1905 (b).*
- *STATE INCOME IS ESTABLISHED AS A DESIGNATED PORTION OF THE NATIONAL INCOME AS DETERMINED AT THE U.S. DEPARTMENT OF COMMERCE, BUREAU OF ECONOMIC ANALYSIS (BEA). PER CAPITA INCOME OF ALASKA IS DERIVED BY THE BEA AS A PORTION OF NATIONAL INCOME STATISTICS.*

FMAP FORMULA

THE FORMULA IS DEFINED IN THE SOCIAL SECURITY ACT, SECTION 1101(a)(8)(B) AND SECTION 1905(b).

THE FORMULA IS:

$$\frac{(\text{STATE PER CAPITA INCOME})^2}{(\text{NATIONAL PER CAPITAL INCOME})^2} \times 45\%$$

Population figures are from the U.S. Department of Commerce-U.S. Census Bureau.

Income figures are "personal income" which includes income derived from all sources. Data is from the U.S. Department of Commerce-Bureau of Economic Analysis.

THE FMAP IS USED TO DETERMINE THE FEDERAL MATCH TO FUND PROGRAMS SUCH AS:

- ★ *MEDICAID*
- ★ *AFDC*
- ★ *FOSTER CARE*
- ★ *JOBS PROGRAM*

ANY ADJUSTMENTS MADE TO THE FMAP WILL IMPACT THE FEDERAL FUNDING AVAILABLE TO THESE PROGRAMS.

FY 1994 Federal Financial Participation

Proposed FMAP Increase for Alaska

AFDC - Program		
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This letter is to update you with additional information in support of the change we would like to propose to the Social Security Act regarding the Federal Medical Assistance Percentage (FMAP), the federal matching for Medicaid and other programs. At this time we would like to share with you the results of our continued research and other efforts to bring equity to the matching formula for the states of Alaska and Hawaii.

On December 12, 1991 Congress passed the Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991. This law was enacted to establish new limitations on Federal Financial Participation (FFP) when states receive funds donated from providers and revenues generated by certain health care related taxes. This legislation was conceived in response to financing methods developed in some states as a method of shifting the burden of Medicaid financing to increase Federal participation, a practice labeled as "a financing scam" and "sleight of hand" by OMB Director, Richard Darman.

Currently there are at least 29 states operating 34 different provider tax or donation programs which cost the federal government $6.8 billion in FY 92. The George Washington University publication "State Health Notes" begins its June 29 issue with the headlines "Illinois Explores New Provider Tax; Other States May Follow". The lead article states that Illinois Governor Jim Egan has decided to press the issue with the new provider tax legislation by modifying the state's existing assessment program to protect an estimated $735 million in federal matching funds. This exemplifies the magnitude of and tenacity for these programs which are designed to draw Medicaid money from the federal government to subsidize state Medicaid expenditures.

In spite of HCFA's best efforts to demolish this type of federal underwriting of Medicaid, the legislation which Congress finally enacted has been less effective than was hoped for by that agency. Future costs associated with this method of burden-shifting are shown in the current Federal Medicaid baseline spending projections. The following table shows amounts included in the fiscal year 1993 Federal Medicaid budget associated with State tax and donation programs. These projections which were derived from estimates provided by states show projected federal medicaid spending associated with these programs (in billions of dollars)

FY93	11.3
FY94	14.4
FY95	18.0
FY96	22.00

The States of Alaska and Hawaii however, have never used a provider tax "scam" or collected provider donations to "creatively" fund our Medicaid programs. Medicaid in Alaska

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has always been paid for with 50% FFP and 50% State general funds void of any contrived funding mechanism. At this time we still are not initiating a device to finance our Medicaid program through the use of "artificial" provider taxes or donations. All we are seeking is to have our programs funded in terms of dollars that recognize our true costs in these unique settings.

CONSIDERATIONS FOR EQUITY

COST OF LIVING

Alaska is unfairly disadvantaged by the current statutory formula. Alaska's current federal matching rate is 50%, a result of the fact that the Alaska per capita income looks very high in comparison to the per capita incomes of the lower 48 states. However, a simple comparison of per capita incomes fails to take into account the dramatically higher cost of living in Alaska and the even more egregious cost of health care in the state. According to the most recent OPM survey data, residents of Juneau experience a cost of living that exceeds the national standard by more than 32%. The cost of living is even higher in more remote Alaska locations.

These data are confirmed in a study by the American Chamber of Commerce Research Association (ACCRA). Quarterly the association produces the ACCRA Cost of Living Index to provide a reasonably accurate measure of living cost differences among urban areas. The four Alaska communities included in this index all registered current living costs at more than 30% above the average for all participating areas. The Composite Index score for Anchorage was 131%, Fairbanks--130%, Juneau--133%, and Kodiak--146%.

The attached chart displays the ACCRA cost of living data for 34 representative communities when sorted by Health Care Cost standing. The cost of health care in Alaska far exceeds that of any other state. The health care segment of the ACCRA unadjusted composite index reveals the index for Alaska as: Anchorage--179%, Fairbanks--190%, Juneau--182% and Kodiak--171% of the national average.

The ACCRA index reflects cost differentials for a midmanagement standard of living. This standard is set by a weighting structure in which home ownership costs are more heavily weighted than they would be if the index were designed to reflect the average costs for all urban consumers. The remaining charts demonstrate the change in the ranking status of urban areas where the index is recalculated based on a consumer package more in line with a Medicaid eligible's spending ability. That is to say, the mortgage cost has been removed from the calculation. These charts are prepared from ACCRA data for a representative selection of 34 communities: big-small; urban-rural; and nationwide.

When the cost of the mortgage is removed from the composite figure the two Alaska communities included in the 34 immediately come to the top of the list with an even more

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substantial gap between Alaska and the other states regarding consumer prices. (Kodiak is now at 141% and Anchorage at 127% with the next two communities, Washington D.C. and Los Angeles, at nearly 10 and 15 percentage points less than Anchorage in living costs.) This large gap demonstrates that Federal match for Medicaid cannot buy services in Alaska comparable to the lower 48 states.

The principals of benefit adequacy and horizontal equity support cost of living differentials in program funding. A health care program receiving federal funding should provide horizontal equity which means adequate and equal treatment of people in similar circumstances. Uniform benefits seemingly would provide horizontal equity in dollar terms. However, if the cost of living varies substantially, the purchasing power of a given amount of money is higher in areas with lower living costs, and the amount of services purchased in one location would not be affordable in another location with a higher cost of living. Financial adjustment to reflect cost of living differences would equalize the real purchasing power of the programs and produce equal treatment for the Alaska Medicaid population.

PROGRAM ELIGIBILITY AND COSTS

Medicaid in Alaska has several program areas where coverage is based on federal poverty levels as a guiding criteria. These programs probably account for at least half of the Medicaid eligible population and an even greater percentage of people actually served under Medicaid. The poverty level is established for the 48 states by family size; guidelines are updated annually from the Department of Health and Human Services.

As prescribed by Federal regulations, the poverty levels for Alaska are set at 125% of poverty in the 48 states, and poverty levels in Hawaii are 115% of US poverty. The Federal Register states this adjustment simply and clearly, "In view of substantially higher costs of living in Alaska and Hawaii, the OEO Income Poverty Guidelines for determining program eligibility in Alaska will be 25% higher, and in Hawaii 15% higher, than the national guidelines."

Federal financial participation for the Medicaid program is based on the Federal Medical Assistance Percentage (FMAP) which is calculated according to a formula based on per capita income in the state in direct relation to the per capita income of the United States. This formula is defined in the Social Security Act under section 1101(a)(8)(B) and section 1905(b). It is to this formula that we hope to add very simple language which will reflect consideration for our documented higher living costs and higher medical care costs in the states of Alaska and Hawaii only.

The methodology used by the federal government to determine the FMAP available to Alaska and Hawaii for the Medicaid program truly produces inequity and diminishes our two states' abilities to purchase care for our Medicaid populations. Amending the Social Security Act to correct this inequity would have increased the federal match by approximately

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$40,000,000 in SFY 93 in Alaska and $54,000,000 in Hawaii for both the medically indigent people and the health care industry. While significant for these two states, this is an increase of less than 0.2% in federal matching for Medicaid program expenditures. By adjusting the FMAP formula it provides the federal government the opportunity to recognize the true value of per capita income in the financing side of Medicaid for Alaska and Hawaii as it already recognizes our higher living costs in determining who and how many are eligible for program benefits, and still have no impact on the FMAP of other states.

The following is a copy of the language proposed to amend the FMAP formula in a way which will provide relief from the horizontal inequity experienced in the states of Alaska and Hawaii in relationship to our burden of providing higher cost medical care for an expanded Medicaid eligible population. Please contact Kim Busch, Director of Medical Assistance in the Department of Health and Social Services, at 465-3355 for more information regarding the FMAP formula and the proposed amendment to the Social Security Act.

Proposed Amendment to the Social Security Act

Section 1905(b) of the Social Security Act [42 U.S.C. § 1396d(b)] shall be amended to read as follows:

The term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to the 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) for Alaska and Hawaii, the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the adjusted per capita income of such State bears to the square of the per capita income of the 50 states; (2) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum; and (3) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 50 per centum. "Adjusted per capita income" for Alaska shall be determined by dividing the state three year average per capita income by 1.25, and for Hawaii by dividing the state three year average per capita income by 1.15. The Federal medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of section 1101(a)(8)(B) of this title. Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 1603 of Title 25).

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COST OF LIVING ANALYSIS
COL SORT by HEALTH CARE COST STANDING

	Location	Health Care 5%	Composite 100%	Grocery 13%	Housing 28%	Utility 9%	Trans. 10%	Misc 35%
1	Anchorage, AK	178.5	131.0	132.1	141.1	98.5	106.9	131.1
2	Kodiak, AK	171.4	145.7	160.6	156.8	172.8	112.2	130.2
3	Washington, DC	142.2	134.4	118.6	175.8	113.7	130.4	112.4
4	Los Angeles, CA	136.5	132.6	107.7	185.3	80.0	119.6	116.4
5	Springfield, MA	118.4	118.7	109.9	135.8	134.9	111.2	106.3
6	Phoenix, AZ	117.0	100.5	100.0	92.6	100.1	106.8	102.9
7	Klamath Falls, OR	112.6	93.1	96.5	89.6	75.6	105.0	93.0
8	Albany, NY	112.5	114.2	110.8	119.8	128.2	104.4	110.3
9	Pittsburg, PA	111.0	107.3	103.4	97.5	149.7	107.8	104.9
10	Visalia, CA	110.1	114.9	107.8	128.9	118.8	106.5	108.4
11	Dallas, TX	107.3	99.1	100.8	93.1	116.0	103.2	96.5
12	Vermillion, SD	106.7	98.4	100.0	88.8	102.7	90.0	100.0
13	Midland, MI	104.8	109.2	106.0	124.6	87.5	100.1	106.9
14	Charleston, SC	103.5	99.4	93.7	96.7	99.2	90.2	105.9
15	Santa Fe, NM	103.3	107.3	98.2	133.4	84.9	102.3	97.7
16	Gainesville, FL	102.4	101.7	95.9	107.0	82.5	107.7	102.7
17	Springfield IL	102.4	97.8	103.0	92.7	90.6	101.2	100.3
18	Carlsbad, NM	102.3	88.7	102.5	73.8	66.8	106.0	94.1
19	Milwaukee, WI	101.2	104.9	99.5	124.0	95.5	102.1	95.3
20	Sioux Falls, SD	99.4	92.2	97.1	88.7	84.5	99.7	91.9
21	Cincinnati, OH	98.7	106.7	102.7	112.6	94.2	102.6	109.1
22	Cheyenne, WY	97.8	99.2	106.3	95.1	81.1	103.6	103.5
23	Bloomington, IL	96.7	102.7	98.1	98.0	130.1	101.5	102.3
24	Pueblo, CO	96.4	86.0	97.1	73.3	78.5	83.2	93.2
25	Memphis, TN	96.3	94.7	100.0	82.9	89.8	101.5	101.4
26	Tulsa, OK	94.7	88.5	98.3	72.7	90.6	91.4	95.3
27	Macon, GA	94.3	100.1	96.7	94.2	106.6	95.6	106.6
28	Baton Rouge, LA	93.8	97.7	100.5	84.8	117.9	100.7	101.6
29	Birmingham, AL	93.5	99.2	96.2	94.8	121.4	98.7	99.2
30	Bellingham, WA	90.3	93.5	94.3	92.1	84.8	91.0	97.7
31	Lubbock, TX	87.5	94.0	99.3	86.3	83.9	97.3	100.9
32	Louisville, KY	85.2	92.1	88.2	89.2	79.7	92.9	99.7
33	Fort Wayne, IN	83.7	90.6	94.2	89.8	98.3	98.6	86.6
34	Fayetteville, AR	74.9	87.9	94.2	76.4	86.6	95.6	94.8

Prepared using data from the ACCRA COST OF LIVING INDEX, First Quarter 1992 for a representative selection of 34 communities.
The index reflects cost differentials for a midmanagement ($32,000/yr.) standard of living.

COST OF LIVING ANALYSIS
COL SORT by COMPOSITE STANDING

	Location	Composite 100%	Grocery 13%	Housing 28%	Utility 9%	Trans. 10%	Health Care 5%	Misc 35%
1	Kodiak, AK	145.7	160.6	156.8	172.8	112.2	171.4	130.2
2	Washington, DC	134.4	118.6	176.8	113.7	130.4	142.2	112.4
3	Los Angeles, CA	132.6	107.7	165.3	80.0	119.6	136.5	116.4
4	Anchorage, AK	131.0	132.1	141.1	98.5	108.9	176.5	131.1
5	Springfield, MA	118.7	109.9	135.8	134.9	111.2	118.4	106.3
6	Visalia, CA	114.9	107.0	128.9	118.8	106.5	110.1	108.4
7	Albany, NY	114.2	110.8	119.8	128.2	104.4	112.5	110.3
8	Midland, MI	109.2	106.0	124.6	87.5	100.1	104.8	106.9
9	Pittsburg, PA	107.3	103.4	97.5	149.7	107.8	111.0	104.9
10	Santa Fe, NM	107.3	98.2	133.4	84.9	102.3	103.3	97.7
11	Cincinnati, OH	106.7	102.7	112.6	94.2	102.8	98.7	109.1
12	Milwaukee, WI	104.9	99.6	124.0	85.5	102.1	101.2	95.3
13	Bloomington, IL	102.7	98.1	98.0	130.1	101.5	96.7	102.3
14	Gainesville, FL	101.7	95.9	107.0	82.5	107.7	102.4	102.7
15	Phoenix, AZ	100.5	100.0	92.6	100.1	106.8	117.0	102.9
16	Macon, GA	100.1	96.7	94.2	106.6	95.6	94.3	106.6
17	Charleston, SC	99.4	93.7	98.7	99.2	90.2	103.5	105.9
18	Birmingham, AL	99.2	98.2	94.8	121.4	98.7	93.5	99.2
19	Cheyenne, WY	99.2	106.3	95.1	81.1	103.6	97.8	103.5
20	Dallas, TX	99.1	100.8	93.1	116.0	103.2	107.3	96.5
21	Springfield IL	97.8	103.0	92.7	90.6	101.2	102.4	100.3
22	Baton Rouge, LA	97.7	100.5	84.8	117.9	100.7	93.8	101.6
23	Vermillion, SD	96.4	100.0	88.8	102.7	90.0	106.7	100.0
24	Memphis, TN	94.7	100.0	82.9	89.8	101.5	96.3	101.4
25	Lubbock, TX	94.0	89.3	86.3	83.8	97.8	87.5	100.9
26	Bellingham, WA	93.5	94.3	92.1	84.8	91.0	90.3	97.7
27	Klamath Falls, OR	93.1	86.5	89.8	75.6	105.9	112.6	93.0
28	Sioux Falls, SD	92.2	97.1	88.7	84.5	89.7	89.4	91.9
29	Louisville, KY	92.1	88.2	89.2	79.7	92.9	85.2	99.7
30	Fort Wayne, IN	90.6	94.2	89.8	98.3	98.6	83.7	86.6
31	Carlsbad, NM	89.7	102.5	73.8	66.8	108.0	102.3	94.1
32	Tulsa, OK	88.5	98.3	72.7	90.6	91.4	94.7	95.3
33	Fayetteville, AR	87.9	94.2	76.4	88.6	95.6	74.9	94.8
34	Pueblo, CO	86.0	97.1	73.3	78.5	83.2	96.4	93.2

Based on data from the ACCRA COST OF LIVING INDEX, First Quarter 1992
for a representative selection of 34 communities.
The index reflects cost differentials for a midmanagement standard of living.

\FMAP\COL-100%.WK3

COST OF LIVING ANALYSIS
COL SORT by HOUSING

	Location	Composite 100%	Grocery 13%	Housing 28%	Utility 9%	Trans. 10%	Health Care 5%	Misc 35%
1	Los Angeles, CA	132.6	107.7	185.3	80.0	119.6	136.5	116.4
2	Washington, DC	134.4	118.6	175.6	113.7	130.4	142.2	112.4
3	Kodiak, AK	145.7	160.6	156.6	172.8	112.2	171.4	130.2
4	Anchorage, AK	131.8	132.1	141.1	98.5	106.9	178.5	131.1
5	Springfield, MA	116.7	109.9	135.8	134.9	111.2	116.4	106.3
6	Santa Fe, NM	107.3	08.2	133.4	84.9	102.3	103.3	97.7
7	Visalia, CA	114.9	107.8	126.9	116.6	106.5	110.1	108.4
8	Midland, MI	109.2	106.0	124.6	87.5	100.1	104.8	106.9
9	Milwaukee, WI	104.9	99.5	124.0	95.5	102.1	101.2	95.3
10	Albany, NY	114.2	110.8	119.8	128.2	104.4	112.5	110.3
11	Cincinnati, OH	106.7	102.7	112.6	94.2	102.6	98.7	109.1
12	Gainesville, FL	101.7	95.9	107.0	82.5	107.7	102.4	102.7
13	Bloomington, IL	102.7	98.1	98.0	130.1	101.5	96.7	102.3
14	Pittsburg, PA	107.3	103.4	97.5	149.7	107.8	111.0	104.9
15	Charleston, SC	99.4	93.7	96.7	99.2	90.2	103.5	105.9
16	Cheyenne, WY	99.2	106.3	95.1	81.1	103.6	97.8	103.5
17	Birmingham, AL	99.2	98.2	94.8	121.4	98.7	93.5	99.2
18	Macon, GA	100.1	96.7	94.2	106.6	95.6	94.3	106.6
19	Dallas, TX	99.1	100.8	93.1	116.0	103.2	107.3	96.5
20	Springfield IL	97.2	103.0	92.7	90.6	101.2	102.4	100.3
21	Phoenix, AZ	100.5	100.0	92.6	100.1	106.8	117.0	102.9
22	Bellingham, WA	93.5	94.3	92.1	84.8	91.0	90.3	97.7
23	Fort Wayne, IN	90.6	94.2	89.8	98.3	98.6	83.7	86.6
24	Klamath Falls, OR	93.1	96.5	89.6	75.6	105.0	112.6	93.0
25	Louisville, KY	92.1	88.2	89.2	79.7	92.9	85.2	99.7
26	Vermillion, SD	98.4	100.0	88.8	102.7	90.0	108.7	100.0
27	Sioux Falls, SD	92.2	97.1	88.7	84.5	99.7	99.4	91.9
28	Lubbock, TX	94.0	99.3	86.9	83.9	97.3	87.5	100.9
29	Baton Rouge, LA	97.7	100.5	84.6	117.9	100.7	93.8	101.6
30	Memphis, TN	94.7	100.0	82.9	89.8	101.5	96.3	101.4
31	Fayetteville, AR	87.9	94.2	76.4	86.6	95.6	74.9	94.8
32	Carlsbad, NM	88.7	102.5	73.8	66.8	106.0	102.3	94.1
33	Pueblo, CO	86.0	97.1	73.3	78.5	83.2	96.4	93.2
34	Tulsa, OK	86.5	98.3	72.7	90.6	91.4	94.7	95.3

Based on data from the ACCRA COST OF LIVING INDEX, First Quarter 1992
for a representative section of 34 communities.
The index reflects cost differentials for a middlemanagement standard of living.

\FMAP\house-stWK3

COST OF LIVING ANALYSIS
COL SORT by COMPOSITE STANDING
COMPARISON OF LIVING COSTS WITH and WITHOUT MORTGAGE PAYEMNTS

	Location	With Mortgage Composite	Without Mortgage Composite 100%	Grocery 18%	Utility 13%	Trans. 14%	Health Care 7%	Misc 48%
1	Kodiak, AK	145.7	141.0	160.6	172.8	112.2	171.4	130.2
2	Anchorage, AK	131.0	120.7	132.1	98.5	106.9	173.5	131.1
3	Washington, DC	134.4	117.9	118.6	119.7	130.4	142.2	112.4
4	Los Angeles, CA	132.8	111.8	107.7	80.0	119.6	136.5	116.4
5	Springfield, MA	118.7	111.7	109.9	134.9	111.2	118.4	106.3
6	Albany, NY	114.2	111.6	110.8	128.2	104.4	112.5	110.3
7	Pittsburg, PA	107.3	110.7	103.4	149.7	107.8	111.0	104.9
8	Visalia, CA	114.9	109.1	107.8	118.8	106.5	110.1	108.4
9	Bloomington, IL	102.7	104.2	98.1	130.1	101.5	96.7	102.3
10	Cincinnati, OH	106.7	104.1	102.7	94.2	102.6	98.7	108.1
11	Phoenix, AZ	100.5	103.2	100.0	100.1	106.8	117.0	102.9
12	Midland, MI	109.2	102.9	106.0	87.5	100.1	104.0	106.9
13	Baton Rouge, LA	97.7	102.5	100.5	117.9	100.7	93 8	101.6
14	Macon, GA	100.1	102.1	98.7	106.6	95.6	94.3	106.6
15	Dallas, TX	99.1	101.1	100.6	116.0	103.2	107.3	96.5
16	Birmingham, AL	99.2	100.7	98.2	121.4	98.7	93.5	99.2
17	Cheyenne, WY	98.2	100.5	108.3	81.1	103.6	97.8	103.5
18	Charleston, SC	99.4	100.2	93.7	99.2	90.2	103.5	105.9
19	Springfield IL	97.8	99.5	103.0	90.6	101.2	102.4	100.3
20	Gainesville, FL	101.7	99.3	95.9	82.5	107.7	102.4	102.7
21	Vermillion, SD	96.4	99.1	100.0	102.7	90.0	106.7	100.0
22	Memphis, TN	94.7	99.0	100.0	88.8	101.5	96.3	101.4
23	Milwaukee, WI	104.0	97.1	99.5	95.5	102.1	101.2	95.3
24	Santa Fe, NM	107.3	96.9	98.2	84.9	102.3	103.3	97.7
25	Lubbock, TX	94.0	96.7	99.3	83.9	97.3	97.5	100.9
26	Tulsa, OK	96.5	94.4	98.3	90.6	91.4	94.7	95.3
27	Klamath Falls, OR	93.1	94.2	98.5	75.6	105.0	112.6	93.0
28	Carlsbad, NM	96.7	94.1	102.6	66.8	106.0	102.3	94.1
29	Bellingham, WA	93.5	93.7	94.3	84.8	91.0	90.3	97.7
30	Sioux Falls, SD	92.2	93.2	97.1	84.5	99.7	99.4	91.9
31	Louisville, KY	92.1	92.9	88.2	79.7	92.9	85.2	99.7
32	Fayetteville, AR	87.9	92.1	94.2	86.6	95.6	74.9	94.6
33	Fort Wayne, IN	90.9	90.6	94.2	98.3	98.6	83.7	86.6
34	Pueblo, CO	86.0	90.6	97.1	78.5	83.2	98.4	93.2

Prepared using data from the ACCRA COST OF LIVING INDEX, First Quarter 1992
for a representative selection of 84 communities nationwide.
WOH-SCRT 1-43

COST OF LIVING ANALYSIS
COL SORT by COMPOSITE STANDING

COMPARISON OF LIVING COSTS WITH and WITHOUT MORTGAGE PAYMENTS

OBSERVATIONS - How the Housing Cost Factor skews the composite index.

When mortgage payment is removed from the composite cost of living determination, the variance or range of difference between highest and lowest is reduced by 9.4 percentage points.

Prioritizing the communities based on the composite number w/mortgage, there are 12 cities in the range of 100% ± 5.0%.

Prioritizing the communities based on the composite number without mortgage, there are 17 cities, or one-half the population, in the range of 100% ± 5.0%.

The cost of a mortgage is 28% of the composite figure when it is included; this is more than twice the weight of any other single factor accumulated. (Groceries are next high at 13%.)

The range in the mortgage factor is from 185.3 in Los Angeles and 175.8 in Washington DC to 72.7 in Tulsa. This is a difference of 112.6 percentage points.

The one overriding assumption in all these numbers is: this Index reflects cost differentials for a midmanagement standard of living; a family of four with income at $32,000 annually.

The possibility of these AFDC and Medicaid recipients paying a mortgage for housing at this income level is unrealistic. For this reason the mortgage payment was dropped from the COL calculations.

Furthermore, there are several programs which subsidize housing expenses for the poverty and near-poverty income levels, thereby rendering any comparison of housing costs ineffective at this income level.

DEC-15-83 WED 14:47 MEDICAL ASSISTANCE FAX NO. 9074635154 P. 16

HJR

54

SENATE COMMITTEE REPORT

DATE: 4/6/94 FURTHER:

DATE TURNED INTO OFFICE: 4/30/94

HESS Committee considered SSHJR 54

Relating to medical savings account legislation.

and recommends:

[ ] replace with _____ CS _____(_____)
or [ ] adopt previous_____ CS _____(_____)
[ ] attaches amendment(s)

[ ] same title
[ ] new title
[ ] technical title change (HB only)

[ ] adopts _____ Letter of Intent
[ ] further referral to the _____

[ ] do pass
[ ] do not pass
[ ] no recommendation
[ ] individual recommendations

NEW FISCAL NOTES

Department	Date	Zero	Fiscal

PREVIOUS FISCAL NOTES

Department	Date	Zero	Fiscal
none	3/23/94	✓	

[ ] Appropriation No Fiscal Note

DO PASS:

Mike Mutlett
Lorraine Lemon
Bert Harp

OTHER RECOMMENDATIONS:

J. Duncan-Moore

Steve King Du Pass
Chair: Signature and Recommendation

Alaska State Legislature
House of Representatives

COMMITTEES:
HEALTH, EDUCATION
& SOCIAL SERVICES
UDICIARY
STATE AFFAIRS

SPECIAL COMMITTEES:
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JUNEAU, AK 99811
PHONE (907) 465-3777

Representative Pete Kott

SPONSOR STATEMENT

HJR 54 – Supporting Medical Savings Account Legislation

As medical costs nationally and in Alaska continue to rise, the need for innovative approaches to health care cost containment becomes more acute. Medical Savings Accounts (MSAs) offer an approach to reducing health care costs that appeals to market forces and minimizes government intrusion into the market. MSAs allow employers and self-employed individuals to purchase a high-deductible catastrophic medical policy and put the premium savings into a special savings account to pay for routine medical care. The funds in the MSA belong to the insured and, if not spent, accumulate as savings, pre-funding future medical care expenses.

Because MSAs belong to the employee, they are fully portable and are not relinquished when the individual changes employment. Over time, MSAs have the potential of building a substantial savings account for the individual, if the person exercises prudence in use of medical care. MSAs will enable a person to purchase health insurance coverage during periods of unemployment if the person so chooses.

MSAs are an attractive health care option because they encourage individual restraint as a means of containing costs. This is compatible with the free market in that it protects individual freedom and rewards prudent decision-making.

HJR 54 urges Congress to enact legislation that will make Medical Savings Accounts a viable option in the national effort to reduce and contain health care costs. I urge its speedy passage.

STATE OF ALASKA
1994 LEGISLATIVE SESSION

BILL NO. SSHJR 54

F I S C A L N O T E

REQUEST:
Revision Date:
Dept.Affected NONE
Title: RELATING TO MEDICAL SAVINGS ACCOUNT LEGISLATION.
BRU:
Sponsor: REP. KOTT
Components:
Requestor: REP. KOTT

EXPENDITURES/REVENUES: (THOUSANDS OF DOLLARS)

OPERATING	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
Personal Services	0.0	0.0	0.0	0.0	0.0	0.0
Travel	0.0	0.0	0.0	0.0	0.0	0.0
Contractual	0.0	0.0	0.0	0.0	0.0	0.0
Supplies	0.0	0.0	0.0	0.0	0.0	0.0
Equipment	0.0	0.0	0.0	0.0	0.0	0.0
Land & Structures	0.0	0.0	0.0	0.0	0.0	0.0
Grants, Claims	0.0	0.0	0.0	0.0	0.0	0.0
Miscellaneous	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES						

FUNDING: (THOUSANDS OF DOLLARS)

1002 Federal Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1003 GF Match	0.0	0.0	0.0	0.0	0.0	0.0
1004 GF	0.0	0.0	0.0	0.0	0.0	0.0
1005 GF/Program Receipts	0.0	0.0	0.0	0.0	0.0	0.0
1006 GF/MHTIA	0.0	0.0	0.0	0.0	0.0	0.0
Other	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

ESTIMATE OF ANY CURRENT YEAR (FY 94) COST $

POSITIONS:

Full-Time	0	0	0	0	0	0
Part-Time	0	0	0	0	0	0
Temporary	0	0	0	0	0	0

ANALYSIS: (Attach a separate page if necessary)

Prepared By: HOUSE HESS COMMITTEE
Phone: 465-3759
Division:
Date: 3-21-94
Approved By: REP. CON BUNDE, CO-CHAIR
Agency: REP. CYNTHIA D. TOOHEY, CO-CHAIR
HOUSE HESS COMMITTEE
Date: 3-21-94

Medical Savings Accounts: Putting People First in Health Care

By
Victoria C. Craig
Director of Research
The Council for Affordable Health Insurance
February, 1993

Executive Summary

Each of us is mortal — we get sick and we die. And when we do get sick, it is the health care system that reaches out to heal and to comfort us. The health care system will touch each of us at our most vulnerable and intimate moments. How to reform that system is not an abstract exercise, it is a decision that will affect us personally for the rest of our lives. And it is a decision that must put people -- patients -- first, because the only purpose of this or any other health care system must be the care and comfort of the patient.

The Council for Affordable Health Insurance has carefully reviewed the numerous health care reform proposals in the states and at the Federal level. The Council believes that they are all fundamentally flawed because they do not address the real problem in the health care delivery system today — the difference between the person who receives the care, and the person who pays the bill. The Council supports something truly revolutionary for our health care system — a return to market principles through the establishment of medical savings accounts.

Medical savings accounts (MSAs) are tax-deferred accounts set aside for routine medical care and to allow for the build-up of savings to pay for future medical expenses. MSAs would allow employers, self-employed individuals, and others to purchase a high-deductible policy and put the premium savings into a medical savings account to pay for routine medical care. The funds in the MSA belong to the insured, and if not spent, accumulate over time as savings, pre-funding future health care expenses.

MSAs have many unique advantages.

- MSAs is the one idea that has the potential to actually reduce health care costs without resorting to rationing.
- MSAs restore the patient/physician relationship, making the patient a buyer as well as user of care.
- MSAs will create a demand for information about the quality and price of health care.
- MSAs will reduce administrative costs.
- MSAs will put insurance companies back in the business of providing real insurance.
- MSAs will end the struggles over state mandated benefits.

By incorporating medical savings accounts with other concepts that have always been the strength of our country — individual freedom and responsibility, a free market for goods, services, and ideas, a robust competitive environment, and limiting government's involvement to protecting those who are incapable of caring for their own needs; we can fix the current health care delivery system instead of destroying it.

This will in turn best accomplish the purpose of a health care system reform — an optimal balance of quality, affordability, and accessibility.

Overall Costs of an MSA

Question: Will administrative costs of the insurance company increase because they will be writing more individual policies? How will this affect the price of the policy?

Answer: It is not clear that there will be more individual policies since we anticipate joint participation between the employer and employee. In fact, if there were an increase in individual policies, that would probably mean that the cost of administering an individual policy would be less than that of a group policy. It must be recognized that administrative costs of the insurance companies will fall since they will not be handling the small dollar claims. And every dollar saved in administrative expenses is a dollar directly available to increase MSA contributions or reduce the cost of the entire insurance program.

Statement: Proponents claim that insurance costs would go down under their plan because consumers would buy their insurance directly from insurers and not through employers. They claim that getting rid of the "third party in the transaction" would greatly reduce administrative red tape and cost. It could be argued, however, that eliminating the employer would lead to increased administrative costs.

Answer: The statement misses the point. We would encourage employers to incorporate the MSA concept into their program. No one is trying to get rid of the employer, but rather to advocate individual responsibility. That is why we envision joint participation, as it is the most efficient and most effective way to reduce health care costs over a period of time.

Question: Would health insurance premiums be reduced substantially enough to cover the deductible of a catastrophic policy as the medical savings account concept proposes?

Answer: Our actuaries have developed the following estimates based on some of the largest sources of claims data available in the country. These premiums are based on a plan which pays 80 percent of the first $5,000 of expenses after the deductible and 100 percent thereafter, and assumes a 75 percent loss ratio, and a 40-45 year old head of household.

Deductible	Annual Premium Individual	Family of 4
$ 250	$2,108	$6,223
2,500	1,132	3,106
Difference	976	3,117

The MSA arrangement is naturally more attractive for families since children's costs are more heavily weighted toward first-dollar expense than those for adults. For about a 40% increase in premiums, the per person $2,500 deductible can be changed to a per family deductible of $2,500. In this example, the $6,223 currently being spent for the $250 deductible plan could be split as follows:

Premium for a $2,500 per family deductible	$4,348
Contribution to the MSA	$1,875

The maximum out-of-pocket exposure under the $2,500 deductible plan is $3,500 or ($2,500 + (.20 x $5,000)). The maximum out-of-pocket exposure under the $250 deductible plan assuming a maximum imposition of three deductibles and three stop-loss expense amounts per family is $3,750 or (3[$250 + (.20 x $5,000)]). Thus the maximum potential out-of-pocket is actually $250 less under the $2,500 family deductible even before we consider the amount in the MSA. With the MSA contribution, the financial protection for the family has actually increased by $2,125. In this example, the individual may want to increase the deductible further to, say, $5,000. The annual premium for a $5,000 family deductible would be $3,135 and the maximum out-of-pocket expense would be $6,000. Thus, the $6,223 premium for the $250 deductible plan could be split with $3,135 going towards insurance and $3,088 to the MSA. In this case, the increase in maximum out-of-pocket expense would be ($6,000-$3,750) or $2,250 which is more than covered by the MSA contribution.

Question: Would raising the deductible from their typical levels of $100 or $250 up to $3,000 really reduce the premiums by 66 percent, thereby assuring that employees would assume no risk of making out-of-pocket expenses with their own money other than out of the MSA?

Answer: It could be as much as two-thirds, but the $4,500, $3,000, and $1,500 figures are meant to be illustrative only. In some cases, they may be

pretty close to the mark, but they will vary widely depending on location and demographics of a particular group. If we use instead numbers based on the same claims data from above, we get a table:

Deductible	Individual	Family
$ 100	$2,236	$6,726
3,000	1,039	2,844
Premium Savings	$1,197	$3,882
% Reduction	54%	58%

Question: The reduction in health premiums by 66 percent appears to be implausibly large. It implies that employers currently spend $3,000 in premiums to reduce each employee family's deductible by at most $2,900 (from $3,000 to $100). Because many families spend less than $2,900 per year on covered care, the cost of providing low deductible policies ($3,000 per employee) would be far in excess of the expected cost of the extra care the additional premiums cover, right?

Answer: This is precisely the irony. At lower deductible levels, employers may spend more than one dollar for every dollar of added coverage. This is largely due to the increasing certainty of use of benefits as deductible amounts get lower, combined with the administrative add on of processing these small claims through the insurance mechanism. While a typical health insurance loss-ratio is 75 percent (meaning 25 cents of every premium dollar is spent on taxes, administration, and marketing costs), the distribution of these expenses is much heavier in the handling of small claims where third party involvement is both unnecessary and inefficient.

The cost effect is particularly true for family coverage. For instance, using the numbers above, the cost to reduce the deductible for a family of four from $3,000 per person to $100 per person is ($6,726 - $2,844) or $3,882. If we adjust the $3,000 deductible premium so that it applies on a per family basis, we get ($2,844 x 1.40) or $3,982 and the cost of the deductible reduction becomes ($6,726 - $3,982) or $2,744.

This $2,744 of savings realized by increasing the deductible to $3,000 will not be diminished by expense loads — every penny is available to spend on health care services or left in the MSA for the future. Another way to look at it is that the premium savings represent average health care expenses of (.75 x $2,744)

or $2,058, and an average increase in the MSA of $686, which makes the option even more attractive to the consumer.

Question: Is it realistic to think that insurers would be willing to sell high-deductible policies? Would policies be affordable?

Answer: Low-cost, high-deductible policies are available today. What is not available is the ability to invest the premium savings in a tax-free account for the purpose of offsetting medical expenses below the deductible amount. Below the table shows some of the annual premiums for policies available in June, 1992. The premiums are based on a family with two adults, age 35, with one child.

Individual Health Insurance Annual Family Premiums With $2,500 Deductible (June, 1992)

		Washington National	Pyramid Life	Time Insurance	American Community
Cincinnati	City	$1,369	$1,622	$1,310	$1,083
	Suburb	1,369	1,622	1,310	1,032
Indianapolis	City	1,369	1,537	1,404	1,259
	Suburb	1,213	1,451	1,216	1,135
Peoria	City	1,542	1,622	1,572	1,032
	Suburb	1,542	1,622	1,572	1,032
Portland	City	N/A	1,878	1,253	N/A
	Suburb	N/A	1,878	1,164	N/A
Des Moines	City	1,369	1,451	1,123	N/A
	Suburb	1,213	1,281	1,123	N/A
Dallas	City	1,836	2,135	1,872	N/A
	Suburb	1,680	1,281	1,123	N/A
Richmond	City	1,525	1,622	1,497	N/A
	Suburb	1,525	1,537	1,497	N/A

(Cents have been truncated to make the chart easier to read)

Some observations about these figures:

1. These policies are on the market today.

2. They are sold individually, not in groups. Medical savings accounts are intended chiefly as a group insurance program and may save additional premiums through economies of scale and the administrative advantages of mass purchasing.

3. These policies contain a per-person deductible, not a family deductible. Going from a per-person to a single family deductible would raise the premium cost by approximately 40 percent.

4. There are extremely wide variations in health care costs and utilization patterns in the United States. These are somewhat reflected on this table in the premium differences between Des Moines and Dallas, but the truly high cost areas (New York, Boston, Los Angeles, and San Francisco) are not included here. Premiums that are appropriate in Des Moines would be far too low for New York (as would deductible levels), and it is important that any legislation allow for the dramatic differences in regional costs.

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January 20, 1994
FOR IMMEDIATE RELEASE
For further information about the survey, contact Sid Groeneman: (202) 429-6990

Golden Rule Employees Enthusiastic About Medical Savings Account

An early-January survey demonstrates that employees of Golden Rule, an Illinois-based life and health insurer, are very pleased with their new Medical Savings Account (MSA) plan, are using the funds to pay for services not covered previously, and are saving money for themselves and their company. Sixty-five percent of the employees enrolled in the MSA rate their new form of health insurance as "excellent," and another 32% rate it as "good." Only 2% rate it "only fair," and no one rated it "poor." The employees overwhelmingly prefer the MSA to their former plan, by a margin of 82% to 1%.

"By any standard of comparison, these numbers represent a strong endorsement of the Medical Savings Account," according to Sid Groeneman, a Research Manager for Market Facts, Inc., the firm that conducted the January 7-13 survey for Golden Rule.

The Medical Savings Account is a new form of employer-provided health coverage which uses financial incentives to encourage consumers to purchase health care services more carefully, promoting efficient utilization. With "first-dollar coverage" provided by the MSA, employees can minimize their deductibles and copayments, or avoid them entirely. Under Golden Rule's plan, employees not exhausting the money in their account can choose to receive an end-of-year refund or retain the money in an interest-bearing account to pay for next year's expenses. Golden Rule's MSA plan also offers employees more choice in how they can spend their benefits, as the funds can be used for products and services not covered by most traditional plans such as dental care, eye care, and preventive care.

Most Golden Rule employees chose the MSA originally, at least in part, because they believed it might save them money. As it turned out, they were correct: 93% of enrolled employees received a refund check, averaging $602. The refunds applied to the period from May through the end of 1993, and likely would have been higher for a full calendar year.

-- MORE --

MARKET FACTS

The few MSA-plan employees who didn't receive a refund are just as pleased with the plan as those who did receive a check in December: 19 of the 28 who didn't receive a refund rated the MSA plan as "excellent" (68%), and the remaining nine rated it as "good."

"The thing I'm most pleased about with the Medical Savings Account is the benefit it represents for the single mother," said John M. Whelan, president and chief executive officer. "If she has a child that needs to go to the doctor, she now has first dollar coverage, and she isn't penalized with either a deductible or copayment. It makes it easy for her to take her child to a doctor."

The popularity of the plan extends beyond sheer economics, as 29% also gave a coverage-related reason for choosing the MSA. Most of them mentioned that the MSA pays for routine medical care or miscellaneous expenses not covered by traditional insurance, some noted dental expenses or vision care, and a few mentioned prescription drugs or other items. And about 15% of the employees opting for the MSA mentioned choosing it because they think it helps reduce health/medical expenses for the company or the country.

If it becomes more widely adopted, the MSA form of health coverage should make use of health and medical care services more efficient system-wide. And, while saving money, its proponents believe that it can also promote wellness by expanding consumers' options.

Since Golden Rule's Medical Savings Account went into effect in May 1993, one-fifth of enrolled employees started using a medical service they hadn't used before *because of the plan*, while only 3% indicated they stopped using some service they had been using earlier. Looking toward the future, over half (51%) of the employees think they or their family might use a service they hadn't used before, such as vision or dental care, because of the plan; 4% think they might stop using some medical service or health product.

Twenty-one percent reported "shopping around" or "comparing prices" *more* since the plan went into effect; 9% reported shopping or comparing prices *less*.

Since the Medical Savings Account went into effect, employees have changed their patterns of purchasing health care. One employee said she liked the plan because she now has an incentive "to check on the surgeons' fees before any surgery and even with the regular doctors."

-- MORE --

MARKET FACTS

* * *

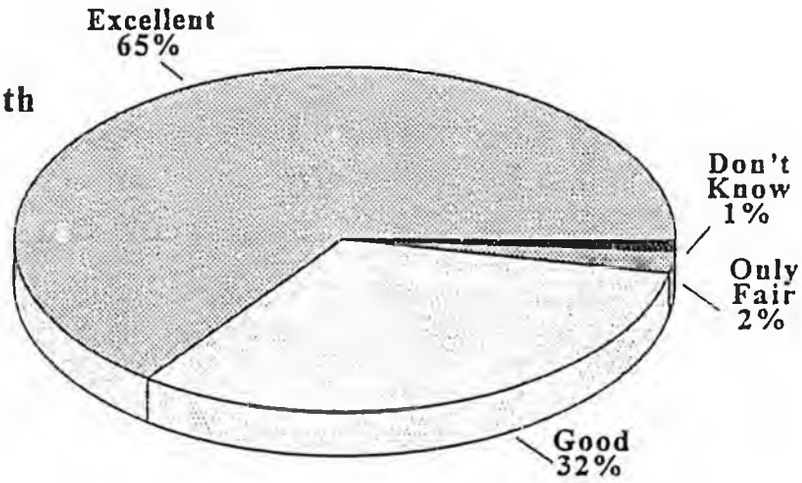
The telephone survey of Golden Rule Insurance employees was conducted by the Washington and Chicago-area offices of Market Facts, Inc., an international survey and market research firm headquartered in Arlington Heights, Illinois Market Facts made three attempts during the week of the survey to reach and interview the 708 Golden Rule employees for whom phone numbers were available. Five hundred twenty employees were interviewed (73% completion rate). Only 28 employees refused to be interviewed (5% of the eligible employees contacted).

Market Facts conducts research for many of the country's leading corporations, associations, non-profits, and government organizations at all levels. The company recently completed its second personnel survey for the U.S. Postal Service (Summer, 1993), and is about to begin a third USPS survey in 1994. This series includes all USPS employees (over 716,000 in 1993) and represents the largest civilian employee surveys ever conducted.

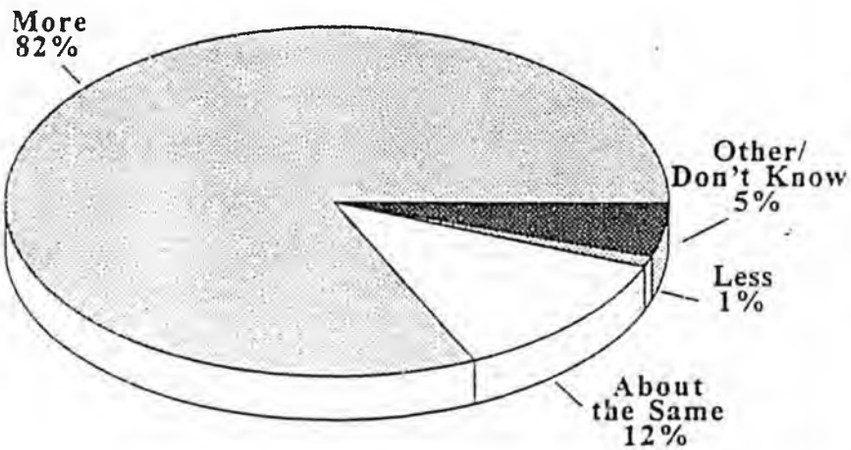
-- GRAPHS ON NEXT PAGE --

Key Findings from Jan. 7-13 Survey of Golden Rule's Employees Enrolled in the Medical Savings Account Plan

"How would you rate the Medical Savings Account health insurance plan overall -- excellent, good, only fair, or poor?"



"Overall, do you like the Medical Savings Account more, less, or about the same as the former Golden Rule plan?"



Provided by Rep. Hoff

MEDICAL COSTS IN ALASKA

Alaska has the highest health care costs in the nation. According to Dr. Rodman Wilson costs in Anchorage are 40% higher than in Seattle. In a newspaper article in March of 1993, Ms. Betty Wood, President of Blue Cross, Washington/Alaska stated that coronary bypass heart operations were three times as expensive in Anchorage as compared to Seattle, The manager of the Alaska Truckers Association said that he inquired about tying into a Washington State group health insurance plan for the trucking industry and he was told that the Alaska participants would pay a 40% surcharge.

The reason for this situation is overinsurance or excessive demand for medical services.. This is caused by the 130,000 Alaskans who are enrolled in group health insurance plans provided by the State of Alaska, by municipal governments, and by school districts.

The model of these plans is the Aetna plan covering 13,500 Employees of the State of Alaska who are in the Alaska State Employees Association which negotiates this plan. As of March of 1993 this plan had a deductible of $100, 90% coinsurance to $3,950, and 100% payment beyond that number.

Suppose that the Union had negotiated a clothing purchase plan instead of the group health insurance plan? State Employees could go to any store that sold clothing and buy as many articles of clothing as they wished. They would be required to have these purchases approved by a Licensed Clothing Advisor who would receive 10% of the purchase as compensation for advice. The participant would be required to pay the first $100 of the transaction and then 10% of the next $3,950. For amounts over this number the State would pay 100%. There would be no restrictions on the cost of the clothing or accessories. They could buy Gucci shoes and Brooks Brothers Suits. These purchases would not be taxed as income by the Internal Revenue Service.

If such a plan were to be put into force, Nordstrums, Pennys, Lamonts and other clothing establishments would be jammed with shoppers. The management would expand the facilities and hire more sales and warehouse people. The stores would raise the prices because with the State of Alaska paying the bills, no one will be concerned about cost.

The only difference between the Clothing Purchase Plan and the Group Health Insurance plan is that medical services are intangible and cannot be stored.

The State of Alaska has more people in the service of State and Local government and school districts than any other state, as a percentage of the population. All the group insurance plans of these lesser governmental entities follow the pattern of the State plan negotiated by the Alaska State Employees Union. For example, the group insurance plan of the Copper River School District which has about 100 employees is a clone of the State plan although it is not administered by the

Aetna. It is my estimate that there are 130,000 participants and their dependents in these plans. Private employers such as the banks and the energy companies must pattern their plans after the State Plan.

In February of 1993, the negotiators for the State of Alaska attempted to make some changes to the plan to moderate an anticipated increase in premiums. Aetna had told the State that rates would increase by 30%. This meant an increase in payments to Aetna of about $20,000,000. The negotiators for the state asked the Union to accept a change in the deductible from $100 to $250.00 and a change in coinsurance from 90% of the first $3,950 to 80% of the first $5,000 of expense. This change was refused by the Union and the matter has gone to an arbitrator to decide whether the State can alter these provisions.

Why did costs double in the years form 1988 to 1992? According to an article in the Anchorage Times in October of 1989, the 13,500 State employees and their dependents made 338,800 claims in 1988. This is 25 claims per participant. In 1992 the employees made 685,000 claims or about double the number of claims.

Dental and Vision claims remained about the same, The increase was in medical claims.

No analysis has ever been made in the State Plan of who makes the claims. Figures in most plans show that 25% of the people make 80% of the claims. Half the people in a plan will make less than 10% of the claims and about 20% of them will not see a physician in the course of a year. Federal Express with 47,000 employees found that 16% of the participants made 80% of claims. I believe that these figures would apply to the State. If my surmise is correct then there are 3.750 participants and their families who made 80% of the claims.

There is no reason why the participants in these governmental plans should not demand as much expensive and extensive health care is available. From the point of view of the doctor he has every reason to supply these services and even urge upon the patient more elaborate and costly procedures. His income and career will benefit by so doing. These fortunate people in the governmental plans have free medical care of the finest quality and this has created unlimited demand and rising costs.

The State will pay $80,000,000 to pay for the medical, dental and vision costs of 13,500 State Employees. This is about $6,000 per participant or $500 per month. We estimate that there are 30,000 people in the plan, including dependents, the cost is about $2,700 per individual.

These government employees have unlimited access at no cost to the finest in health care. On the other hand, there are 60,000 to 90,000 Alaskans who have no access to health care outside of what they can

pay for themselves. Anchorage has 30,000 of these uninsured people.

On February 6, 1993 there was an article in the Anchorage Daily News concerning the financial problem at the Anchorage Neighborhood Health Center. This is a Community Health Center whose expenses are met in part by the Federal government. These centers were established to provide health care to poor people for a modest fee. The center treated 9,400 people in a year at a cost of $4,000,000. The doctors at the center work on salary. The cost per person was $425 per year.

Why does it cost the State $2,700 per person for health care as compared to $425 for the Neighborhood Health Center? A partial explanation is that the Health Center provided basic medical care. We know that hospital charges are about 50% of medical costs so let us double the cost for the Health Center per person to $850. This is 30% of the cost of the State.

The reason for the difference is the State plan is Third Party payments and medicine for a fee with complete choice of physicians available to the participant. The Neighborhood Health Center is direct service with a small payment for service based on the patients ability to pay. It resembles the British System of National Health Service.

The State Group Health Plan could be changed to save millions of dollors. For example a vairible deductable could be used as in the Forbes Plan which is attached. Payments could be made to those who made no claims.

William A. Barnes SR..
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Private Labor Union Membership Continues to Slide

The U.S. Department of Labor Bureau of Labor Statistics has reported another year-to-year decline in the percentage (market share) of private sector workers belonging to labor unions. In 1993, union market share was 11.1 percent, down from 11.4 percent in 1992. In the last five years, 2.2 million new jobs have been created, while private union membership declined by 1.2 million. Private union market share peaked in the middle 1950s when nearly 40 percent of private workers were union members. Since 1955, private employment has doubled, with 45 million new jobs created. At the same time private sector union membership declined by more than 40 percent, with a membership decline of more than seven million. Public sector union membership continues to be comparatively strong, with nearly 38 percent market share, compared to 37 percent in 1989.

Real Estate Value Drop Due to '86 Tax Increases

One trillion dollars have been eliminated from the market value of domestic real estate in response to the tax changes of 1986, according to **Dr. Paul Craig Roberts** of George Washington University, although subsequent tax changes have slightly improved the aggregate environment for real estate. But the normal underlying trend of price changes in domestic real estate are influenced by, among other things, local conditions. One study revealed that approximately 50% of changes in relative real estate prices can be explained in changes in state tax burdens.

Medical Savings Account Introductions Reach Record Level

While the federal health care debate rages on in the nation's capital, often focusing on how much control government should have over the medical care that Americans receive, state legislators are exploring innovative methods for controlling costs by giving people greater decisionmaking power. One such method is through medical savings accounts (MSA), which ALEC has been promoting for several years.

In 1991, medical savings account bills were introduced in three states. In 1992, MSAs were introduced in four states. Then, a remarkable thing happened. Legislators in 15 states introduced MSAs in 1993, and thus far in 1994, 27 states have seen medical savings accounts introduced. (The 27 states are: Ala., Ariz., Calif., Colo., Conn., Ga., Hawaii, Ill., Ind., Idaho, Iowa, Kan., Md., Mich., Miss., N.Y., N.C., Ohio, Okla., Pa., S.C., Utah, Vt., Va., Wash., W. Va., Wisc.)

A recent study prepared by the actuarial consulting firm of **Milliman and Robertson, Inc.** for the **Council for Affordable Health Insurance (CAHI)** determined that the U.S. could save $588 billion over five years if Congress enacted medical savings accounts (for more information on this study, see the November 1, 1993, edition of *FYI*.)

For more information on medical savings accounts, see ALEC's *Individual Medical Account Act* in *Keeping the Promise: A Comprehensive Health Care Plan for the States*, or contact Molly Hering, Legislative Director of the Health Care Task Force.

National Leadership Summit on Economic Growth Set for April in San Antonio

ALEC's 1994 *National Leadership Summit On Economic Growth* will be held in San Antonio, Texas, April 14-17. San Antonio is an ideal site because it is one of the nation's fastest growing economic and cultural centers. The Hyatt Regency Riverwalk is one of the nation's premier meeting facilities, located in the heart of old San Antonio, home of the Alamo. This year's Summit, *Business, Labor and Government Working Together for Economic Growth and Prosperity*, will focus on strategies, policies and fundamental economic principles necessary to promote economic growth in the U.S. as we enter into the new global marketplace.

The areas to be covered include: Principles of Economic Growth; Business and Job Creation; Investment and Technological Innovation; Regulations and Government Mandates; and Public Spending and Competitive Government. State legislatures play a critical role in promoting a sound economy, and the policies developed at the state level will be the difference in future economic prosperity or stagnation. ALEC's National Leadership Summit on Economic Growth will provide up-to-date information and analysis from senior corporate executives, public policy experts and state legislative leaders on this important issue. Some of the speakers tentatively scheduled include: **The Honorable Nelson Wolfe, Mayor of San Antonio; *Wall Street Journal* columnist Robert Bartley; U.S. Senator Kay Bailey Hutchison; and Lawrence Lindsey, member of the Federal Reserve Board of Governors.**

American Legislative Exchange Council

THE INDIANAPOLIS NEWS

"Where the Spirit of the Lord is, There is Liberty."—II Cor. 3:17

MONDAY

DECEMBER 27, 1993

A golden health plan

This Christmas is turning out to be golden for hundreds of Golden Rule employees, thanks to an innovative health program that just could become a model for other employers.

This past year, Golden Rule Chairman J. Patrick Rooney gave his employees a choice between regular, low-deductible health insurance and a new Medical Savings Account plan.

Because low-deductible insurance is so costly, the company devised the new plan: cheaper insurance with a higher deductible, along with a savings account to cover expenses not covered under the old plan.

The old plan for families had a $250 deductible and a co-pay that stopped at $1,000, for a total out-of-pocket employee expense of $1,250.

The new plan set a $3,000 deductible, no co-pay, and thus cost Golden Rule far less, but the company then gave the employee $1,750 to cover the additional deductible expenses.

That made the two plans seemingly equal in merit: In both cases, the employee's out-of-pocket expenses would be the same, $1,250. But there are some important differences.

Not only did Golden Rule save money on the MSA plan, but now, at year-end, employees are being reimbursed any money not spent from their accounts.

The total reimbursement? An incredible $468,000.

Under current law, the MSA proceeds are taxable income, as opposed to the tax-free nature of traditional health benefits. But the MSA plan generally would be the better option for those who are able to keep their health costs down in a given year.

The Medical Savings Account plan has some additional benefits. First, the account could be used to pay insurance premiums between jobs. If an employee loses his or her job or is out on strike, there would be money in the account to continue health insurance.

Too, as Rooney has pointed out, the incentive for employees to be prudent about their health cost spending would be revived under the MSA plan, for employees know they would recoup any unspent money.

In other types of employee health savings accounts, the money reverts back to the employer if it isn't spent by year's end. Thus, especially if it is the employee's own money deducted from his or her paycheck, the employee has a built-in urgency to try to spend the money allocated to the fund, not cut back on health expenditures.

One of the best offshoots of such a plan is that it would encourage more employers to provide health insurance for their employees. People whose companies pay for their insurance often don't realize how much their employers are paying on their behalfs. According to Rooney, annual family premiums in Indianapolis average $4,300. In Cincinnati, the cost is slightly higher, $4,500. In Des Moines, that figure nears $4,700. In Washington, it's closer to $8,200.

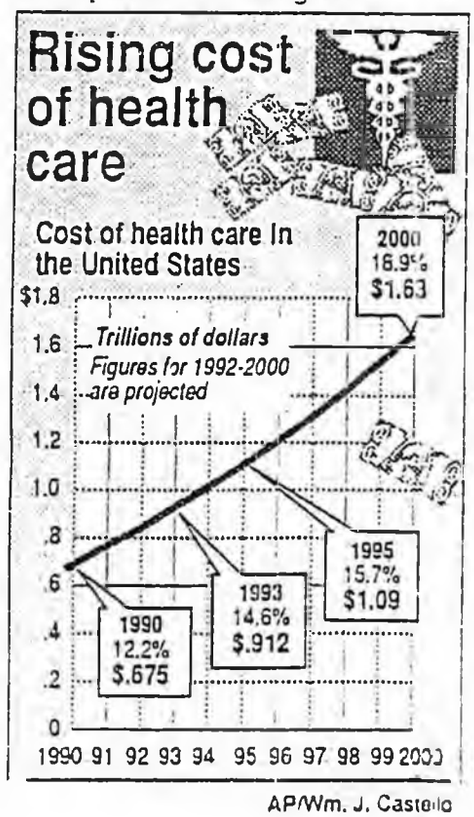
Small businesses often don't provide group insurance, not because they don't care about their employees, but because they can't afford it. That might change if they paid for more reasonably priced high-deductible insurance and employee MSAs.

Congress could get the ball rolling even further by modifying the tax code to allow MSA money to be treated like an Individual Retirement Account, with the fund allowed to accumulate tax-free until it was spent. In fact, Rep. Andy Jacobs, D-Ind., and Sen. Dan Coats, R-Ind., both have introduced legislation to that end.

In particular, Coats' "HealthSave Proposal" would call for participating employers to purchase an umbrella policy for employees for catastrophic medical costs. They then would provide each employee with an MSA of $3,000 per annum, which would remain on account, tax-free, for future medical bills and other limited uses, such as long-term care and education.

Coats also has called for an increase in tax credits for those whose employers do not offer such coverage.

Americans recognize their critical need for affordable health care, but they also want choices. Golden Rule's MSA plan ought to become a prominent player in the debate over health care options before Congress.



AP/Wm. J. Castello

MEDICAL SOCIETY OF THE STATE OF NEW YORK
NEWS OF NEW YORK

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COMMENTARY


Mr. Donald F. Foy

Health Care Reform That Works: Medical Savings Accounts

A former Speaker of the House of Representatives once described some pending legislation by saying: *"An indefinable something is to be done in a way nobody knows how, at a time nobody knows when, that will accomplish nobody knows what."*

How's that for an accurate assessment of today's national health care debate?

An indefinable something is to be done, because the Clinton administration has staked most of its political capital on bringing manifest change to the way we Americans purchase and receive health care.

It is to be done *in a way nobody knows how*, because the administration has kept secret its health care plans not in the name of reform but in the interest of politics.

It is to be done *at a time nobody knows when*, because the administration has discovered that neither Congress nor the nation is thrilled with its economic plan and health care reform involves tinkering with one-eighth of the gross domestic product of the United States.

And it *will accomplish nobody knows what*, because the types of programs, the extent of the government's involvement, and the economic and social costs they will incur have never before been seen, so the results can only be speculated

Supply Side Controls Don't Work

The basis of the problem is this: All of these ideas for health care reform impose controls on the supply side of the economic interchange. But the empirical evidence is that controls on the supply side simply don't work.

Medicaid is an excellent example. Statisticians tell us that the average national medical cost of the normally-insured, non-elderly population, including the deductibles and co-insurance they pay out of their own pockets, is $1,495 per person.

But the average national cost for non-elderly Medicaid patients is $3,313 . . . more than twice as much!

So what are we accomplishing by controlling medical care costs? We are denying low-income people convenient, quality medical care. Instead, we're sending them to emergency rooms—often in ambulances—at a cost many times greater than if those patients were simply able to visit a neighborhood physician.

Unfortunately, it is this same supply side philosophy that drives the administration's most frequently-mentioned idea for controlling medical costs—managed competition.

Demand Side Idea Makes More Sense

While I don't want to deny the Clinton plan a fair hearing, I think we all would profit by examining an idea from the demand side. It's known as the Medical Savings Account and it allows employers to replace conventional insurance plans with individual savings accounts for employees' medical expenses.

Here's how it works: The average employer nationally paid about $4,600 in 1992 for health care coverage on an individual worker and family. Nationwide, the annual deductible averages $212 for one person and $531 for a family. So when the employee co-payment is included, the employee typically has an average out-of-pocket cost of $1,000 to $2,000 for any serious medical expense.

But in most parts of the United States, the employer could buy a catastrophic policy for the worker and his family that will pay all medical expenses above $3,000 for just 35 to 40% of the cost he has been paying.

If the employer puts $2,000 into a Medical Savings Account, that employee is guaranteed the same protection he or she had under the previous insurance programs. Here's the difference: if the employee doesn't spend all of the $2,000, the unspent balance is his to keep.

In a typical American city such as Cincinnati, 23% of all families will spend less than $500 a year on health care. Those families could retain a savings of $1,500 or more—if their employers put at least $2,000 into their Medical Savings Account.

If the employee had a $100,000 heart transplant operation during the next year, his out-of-pocket costs would still be only $1,000— no higher than they are today with conventional insurance. The difference is this: with the Medical Savings Account, the insurance company doesn't get involved until the family's medical expenses exceed $3,000. The employee self-insures the first $3,000.

Each year, the employee will receive $2,000—and, at the end of the year, he would be able to roll over any money remaining in his Medical Savings Account into an IRA.

Practical Solution to Cost Control

Medical Savings Accounts offer the most practical method for getting health care spending under control.

- Individuals would have an incentive to spend their health care dollars wisely— they would be using their money, not someone else's.
- The account could be used to pay for any medical expense recognized by the Internal Revenue Service, including preventive care, eye care, dental care and annual physicals.
- Escalating premium increases for employers would stop.
- The accounts would be fully vested in the employee and portable. They would leave with him when he changes jobs.
- Paperwork would be reduced for providers and insurance companies alike, because there is no insurance claim to fill out and no prior approval to be obtained until the expense exceeds $3,000.
- Medical Savings Accounts would let individuals choose their physicians, rather than have bureaucrats choose for them.
- Medical Savings Accounts would also provide an incentive to stay healthy by allowing individuals to receive preventive care—such as mammograms and pap smears—they might have avoided previously because their insurance didn't cover it or they didn't have the cash.

The Medical Savings Account concept works. At Dominion Resources, Inc., a Virginia utility, a combination of Medical Savings Accounts and other incentives has held health care cost increases to an average of just seven-tenths of one percent over the last three years.

People spending their own money spend it more wisely. So why hasn't a common-sense solution of such obvious merit been adopted nationwide?

Federal Tax Code Presents Obstacle

The primary obstacle is the present federal tax code. When an employer spends a dollar on an employee's health insurance today, that dollar is excluded from the employee's taxable income. But, if the employer wants to establish a Medical Savings Account for the employee, that dollar is subject to federal, state and local taxes—including social security tax. Looking at it another way, today's tax laws encourage us to use health insurance.

The Medical Savings Account would restore competition in the health care marketplace, because the first $3,000 employees spend would be their own money.

A simple revision of our present tax codes would make Medical Savings Accounts economically attractive to more Americans and begin to apply the brakes to our out-of-control health care costs.

But that isn't the only advantage of the Medical Savings Account.

When employees lose their jobs today, the COBRA legislation guarantees them the right to stay insured by paying an insurance premium to their former employer. The reason most employees don't do that is because they don't have the cash available to pay the premiums that are required.

But, if they had a Medical Savings Account, they would have tax-free money in that account that could be used to pay

Continued on Page 17

(Continued from page 5)

the COBRA payment and keep insurance in effect until they got a new job.

Half of all uninsured persons are without coverage for four months or less, and 70% are without coverage for 12 months or less. The Medical Savings Account would permit these people to stay insured.

In other words, 25 million Americans—or 70% of the 37 million uninsured—could stay insured without new costs to employers and without new payroll taxes on the workers. This is possible simply by permitting workers to accumulate money in a Medical Savings Account.

The remaining 12 million uninsured could be accommodated by treating all Americans equally on the tax deduction for health benefits.

It's estimated that tax fairness would bring another 9.8 million Americans into the health insurance system at a net cost to the federal government of only $8 billion a year—small potatoes indeed when compared to the $150 billion the White House plan may cost! Then, if the government would privatize Medicaid for the non-elderly, we could begin to treat the poor with decency and respect. We could let them go to a neighborhood doctor instead of an emergency room, and we could cut the cost of Medicaid by half.

Savings for the American People

A final point is that this proposal provides much-needed savings for the American people. You'll recall that the individual retirement account was one of the most popular tax benefits ever offered the American workers—before it was repealed!

The Medical Savings Account brings that idea back. It embodies the much-ballyhooed tax cut for the middle class—about which we have heard very little lately from our elected leaders in Washington. And it provides each of us with a private-sector solution to our nation's mounting health care crisis.

Instead of waiting for the administration to produce the "indefinable something" in "a way nobody knows how" and "at a time nobody knows when," each of us should tell our representatives in Congress now that we support the Medical Savings Account as the most practical method for getting health care spending under control.

Let me conclude by confiding with you that the Speaker of the House I quoted in the beginning of this article—the man who so succinctly summarized the Clinton administration's jury-rigged approach to health care reform—was Congressman Thomas B. Reed of Maine. He served in Congress between 1877 and 1899!

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A proposal for medical savings

The sense of anticipation in the air is palpable. The adminstration is gearing up its publicity campaign to sell Hillary Rodham Clinton's health care plan, and congressional Democrats tremble at the thought of having to vote for a new round of taxes to pay for it. Meanwhile, the Republicans have been quietly putting together some ideas of their own that could come in handy if the Clinton plan turns out to be so unwieldy and expensive that it sinks under its own weight.

One proposal that holds out a good deal of promise is the medical savings account. According to the National Center for Policy Analysis, which has been working with Republican senators and representatives, the medical savings account plan would have the virtue of cutting costs, simplifying the system and giving consumers more independence in their choice of health care. Here is how it would work:

Currently, the average cost of employment-based family medical insurance plan runs to $4,500 a year. Part of that is paid by the employer and part by the employee. Instead of the money going to an insurance company as a premium, under this proposal, it would be paid into a tax-free medical saving account, to be spent on health care at the discretion of the consumer. Some people would want to buy into the company plan; others might choose a health maintenance organization (HMO); and others again might want simply to buy a catastrophic health-insurance plan, which can make a lot of financial sense.

Currently, such catastrophic insurance policies cost about $1,500 to $1,700 a year. Catastrophic insurance covers most of the costs of hospitalization, which accounts for the majority of the real big-ticket items — major surgery, broken limbs, etc. — that people tend to worry about. By definition, these plans have a high deductible — generally $2,500 to $3,000 for the family. That may sound like a lot, but it more or less corresponds to the amount in the medical saving account when the premium has been paid.

It is in that $3,000 category that real savings can take place. Insurance companies currently find that the vast majority of their claims, over 90 percent, fall into this area. It would be up to the individual consumer to spend the money as each sees fit. If the money is really yours, then chances are you'd want to shop around and compare prices. You would also want to make sure you got the best value for your money. And you would weigh more carefully whether a visit to the doctor is really necessary. An element of competitiveness and accountability would be introduced into the system that is currently lacking, which is one reason that health care costs are zooming out of sight. And, not insignificantly, paperwork for the vast number of minor expenses currently billed directly from the doctor's office to the insurance company would be reduced.

Perhaps the best part for the consumer is that the money not spent would stay in the account from year to year, earning interest. Few people have health care expenses of $3,000 in a year, so most folks would find their balances growing. At retirement, the final sum would be paid out and possibly rolled over into a pension plan.

But how about those who are currently without insurance? An element of tax fairness could be introduced by making health care premiums tax-deductible for the self-employed. In the lower income ranges, a refundable tax credit could help pay for insurance, and those without incomes could be given health care vouchers, much as they are given food stamps today, to pay for catastrophic insurance and out-of-pocket expenses. That would take them out of the vastly expensive Medicare system.

Right now, it does not seem that Mrs. Clinton's task force has much interest in practical and commonsense approaches such as this. But when the dust settles after the health care battle that will surely come, perhaps the medical savings account will look like an idea whose time has come.

The Tax Trap

IT'S NO MYSTERY why our health-care spending has skyrocketed. Under the law, employers can deduct the cost of health insurance for their employees, but employees cannot deduct insurance they buy themselves. That makes it cheaper for employers to buy insurance than for employees to buy their own. Health-policy analyst Eric-Charles Banfield notes that when federal, state and local taxes take 40 percent of an employee's income, the worker must earn $3333 to buy a $2000 insurance policy.

What's more, since employees pay taxes on their salaries but not on their health benefits, they want ever more generous benefits. The result? Today employers offer their workers extravagant coverage for everything from psychological counseling to cosmetic surgery. That makes these services appear free and, says economist John Goodman of the National Center for Policy Analysis, "As long as medical care appears to be free, there will be an unlimited demand for it, driving up costs."

If individuals could deduct the cost of health insurance they bought themselves, many might choose to buy their own—especially if not getting it at the office meant they could earn higher salaries. And if they bought their own, most people would choose more efficient, high-deductible policies. "Insurance should be disaster protection for when the house burns down or the young breadwinner dies," writes Jonathan Kwitny, author of *Acceptable Risks*. "Yet when it comes to health, we send for insurance accountants and adjusters every time we catch cold." The IRS leaves us almost no choice.

Golden Rule®

Representative Cynthia Toohey
Co-Chair, House HESS Committee
House of Representatives
State Capitol
Juneau, AK 99801

March 21, 1994

Dear Rep. Toohey:

Not only do I endorse Representatives Kott and Davis' resolution relating to Medical Savings Account legislation, but I also applaud the Alaska Legislature for considering an "American Solution" to the problem of increased spending for health care.

I am aware that the plight of the oft-mentioned 37 million Americans without health insurance is not a result of lack of access. With the exception of about 1% of the population, uninsurability due to health status is not the problem. Cost is the major deterrent, and "job-lock" is also a significant factor.

As the resolution so succinctly states, Medical Savings Accounts will address those problems by empowering people to make their own decisions and at the same time reducing costs throughout the system.

If I or my associates can be of assistance to you, please feel free to contact me.

J. Patrick Rooney
Chairman of the Board

JPR/js

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HOUSE COMMITTEE REPORT

(9)

Date Referred: March 18, 1994 FURTHER REFERRALS:

Date of Committee Action: 3/22/94

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: SSHJR 54

SPONSOR SUBSTITUTE FOR HOUSE JOINT RESOLUTION NO. 54
SUPPORT MEDICAL SAVINGS ACCT LEGIS

Relating to medical savings account legislation.

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

[ ] have attached amendments(s)

[X] do pass

[ ] do not pass

[ ] no recommendations

[ ] individual recommendations

[ ] additional referral to the _____ Committee

ADOPTS: _____ letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept) APPROVES PREVIOUS: (Dept/Date)

[ ] fiscal impact _____ [ ] fiscal note(s) _____

[X] zero fiscal note House HESS Committee [ ] zero fiscal note(s) _____

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	DNP	NR	AM
Peter Cott	✓	Ron Dunn		✓	
[illegible]	✓	Wade Minter		✓	
[illegible]	✓				
Audrey Olivera	✓				
Betty J. Davis	✓				
Tom Brice	✓				

[illegible]
CHAIRMAN'S SIGNATURE

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Jerry Duncan
Signature of Camera Operator

10/1/97
Date

02-519 (REV 8/78)

SB

1

DIVISION OF LEGAL SERVICES

LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

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130 Seward Street, Suite 409
Juneau, Alaska 99801-2105

MEMORANDUM January 14, 1993

SUBJECT: Sectional analysis of SB 1 (Retirement Incentive Program)

TO: Senator Jim Duncan
Attention: Roxanne Stewart

FROM: Teresa B. Cramer TBC
Legislative Counsel

You have requested a sectional analysis of the above described bill.

As a preliminary matter, note that a sectional analysis or summary of a bill should not be considered an authoritative interpretation of the bill and the bill itself is the best statement of its contents. If you would like an interpretation of the bill as it may apply to a particular set of circumstances, please advise.

Because this bill sets up a time-limited program which is repealed July 1, 1995, it is not placed into the codified statutes. If the bill is enacted, it will be published in the Session Laws and also in the Temporary and Special Acts volume of the Alaska Statutes.

Section 1 states the legislative purpose in adopting a retirement incentive program for public employers and employees.

Section 2 establishes the general requirements for a retirement incentive program. Subsection (a) permits employers to designate organizational units of employees eligible to participate. Subsection (b) sets out criteria for the organization units. Subsection (c) limits which employees are eligible to participate to those who will be qualified to retire after receipt of the retirement incentive.

Subsection (d) sets out requirements for the employer's plan and requires the employer to agree to reimburse the retirement system for the extra costs incurred by the system as a result of participation by the employer's employees.

Subsection (e) sets out the formula for computing how much each member of the Teachers' Retirement System (TRS) who participates in the plan owes in order to

receive the three-year credit. It is based on the annual contribution rate of 8.65% for members of TRS set out in AS 14.25.050. Subsection (f) sets out the formula for computing how much each member of the Public Employees' Retirement System (PERS) who participates in the plan owes in order to receive the three-year credit. It is based on the annual contribution rates of 7.5% for peace officers who are members of PERS and 6.75% for other members of PERS set out in AS 39.35.160.

Subsection (g) provides that the retirement incentive is a credit of three years, to be used either to meet retirement eligibility requirements or, if those are met, to increase the amount of credited service a participant is entitled to when computing benefits. Subsection (h) limits the kinds of credited service that employees retiring under the retirement incentive plan may use when determining whether they are eligible to retire. Note that the subsection does not limit the kinds of credited service that may be considered when computing the employee's benefits.

Subsection (i) permits employees to assume part of the employer's liability in order to become eligible to participate in a retirement incentive plan.

Section 3 authorizes the state to adopt a retirement incentive plan for its employees, to begin July 31, 1993, and ending October 31, 1993. Subsections (b) and (c) limit which employees may participate. Subsection (d) requires that participants be appointed to retirement on or before July 1, 1994.

Section 4 authorizes political subdivisions and public organizations which participate in PERS to adopt a retirement incentive plan for their employees, to begin December 31, 1993, and ending June 30, 1994. Subsection (b) requires that participants be appointed to retirement on or before February 1, 1995.

Section 5 authorizes the University of Alaska to adopt a retirement incentive plan for its employees, to begin June 30, 1993, and ending December 31, 1993. Subsection (b) requires that participants be appointed to retirement on or before August 1, 1994. Subsection (c) addresses participants in the Optional University Retirement Program.

Section 6 authorizes employers in TRS other than the state or the University of Alaska, which are covered in sections 3 and 5 above, to adopt a retirement incentive plan for their employees, to begin June 30, 1993, and ending December 31, 1993. Subsection (b) requires that participants be appointed to retirement on or before August 1, 1994.

Section 7 permits state employee participants to receive credit, for purposes of determining whether the participant satisfies the years of service requirements for retirement under TRS or PERS, for certain employment with political subdivisions or public organizations who did not participate in PERS or TRS at the time of the

employment. The employment may not be counted when the amount of the participant's benefits are calculated.

Section 8 permits the administrative director of the Alaska Court System who is a member of the Judicial Retirement System (JRS) to participate in a retirement incentive program. The section sets out provisions comparable to those that apply to members of the other retirement systems.

Section 9 permits the Department of Administration to take certain actions if employers who are participating in the retirement incentive program become delinquent in the payments they owe the system for the increased benefits paid to their retirees under the program.

Section 10 establishes an indebtedness owed by participants in the retirement incentive program who, after retirement, are reemployed in a position that is covered by PERS, TRS, or JRS.

Subsection (b) prohibits participants from working for a state department or agency for three years after the participant retired. There is an exception for work for the University of Alaska and for employment with the legislature during the session if the employment is on an hourly basis and if the employee is not entitled to retirement, health, or leave benefits. Subsection (c) permits the Board of Regents, in the case of the University of Alaska, and the commissioner of administration, in the case of other employers, to permit employers to enter into personal services contracts with participants during the three-year waiting period if the employer establishes that there is a compelling reason for hiring the participant because of the participant's specialized or extensive experience. Note that while subsections (b) and (c) permit state agencies to hire certain participants, neither subsection excuses the participant from paying the penalty established under subsection (a).

Section 11 directs state agencies to file with the Office of Management and Budget reports showing the expected effect of the program on the agency's personal services cost and operation. Subsection (b) directs OMB to document the net reduction in personal services costs for each agency in the governor's annual budget request. Subsection (c) directs OMB to report to the legislature on the retirement incentive program.

Section 12 states that employees do not have a vested or contractual right to benefits under a retirement incentive program until an agreement is executed with the administrator of the retirement system. The legislature reserves the right to make changes to the program.

Section 13 makes the definitions in TRS and PERS, as appropriate, applicable to the bill.

Section 14 repeals sections 2 - 8 of the Act, which establish and authorize the retirement incentive programs, on July 1, 1995.

Section 15 is an immediate effective date clause.

If I may be of further assistance, please advise.

TC:pl
93-023.plm

FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. SB 1

Revision Date: _____ Dept. Affected: Administration
Title: An Act relating to retirement incentive programs for Public Employees' and Teachers Retirement Systems and certain persons under IRS
BRU: Retirement and Benefits
Component: Retirement and Benefits
Sponsor: Duncan
Requestor: (S) State Affairs
COMPONENT SERIAL NO. 64

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99
PERSONAL SERVICES	701.7	630.3	273.9	273.9	273.9	273.9
TRAVEL	6.0	6.0	2.0	2.0	2.0	2.0
CONTRACTUAL	25.3	24.9	10.9	10.9	10.9	10.9
SUPPLIES	4.8	4.0	1.5	1.5	1.5	1.5
EQUIPMENT	109.0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	846.8	665.2	288.3	288.3	288.3	288.3
CAPITAL	0	0	0	0	0	0
REVENUE FUND SOURCE:	0	0	0	0	0	0
FUNDING:						
1002 Federal Receipts	0	0	0	0	0	0
1003 GF Match	0	0	0	0	0	0
1004 GF	0	0	0	0	0	0
1005 GF/Program Receipts	0	0	0	0	0	0
1006 GF/MHTIA	0	0	0	0	0	0
Other	846.8	665.2	288.3	288.3	288.3	288.3
TOTAL	846.8	665.2	288.3	288.3	288.3	288.3
POSITIONS						
FULL-TIME	6	6	6	6	6	6
PART-TIME	0	0	0	0	0	0
TEMPORARY	12	11	0	0	0	0

Estimate of current year (FY93) impact: $_____ We anticipate the need for a Legislative Revised Program to increase our FY93 authorization, thus allowing the division to hire the FY94 staff prior to July 1, 1993. The FY93 hiring would be needed so that we can properly train the RIP staff prior to the opening of the window periods. These costs would be paid for by participating employers.

ANALYSIS: (attach a separate page if necessary.) The actuarial costs to participating employers due to this program are to be paid up front and no additional costs to the systems are anticipated. See attached detailed analysis.

Prepared By: Robert F. Stalnaker
Division: Retirement and Benefits
Phone: 465-4470
Date: January 14, 1993

Approved by Commissioner: Nancy Bear Usera
Agency: Department of Administration
Date: 1/25/93

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Rev 11/92

Fiscal Note

Senate Bill 1
Analysis of Fiscal Implications to the Retirement Fund
Prepared by Division of Retirement and Benefits
Department of Administration
January 14, 1993

Analysis: This bill would place a temporary retirement incentive provision in statute for the Public Employees' (PERS) and Teachers' (TRS) Retirement Systems. Active PERS and TRS members could retire on an accelerated basis with an increased benefit under the following conditions: as early as age 47, if vested; with 17 years of service as a qualified peace officer, fire fighter or teacher; or with 27 years of credited service in the PERS. Before qualifying for an accelerated benefit, however, the member must pay a lump sum indebtedness payment or take an actuarial reduction from their life time benefit for the indebtedness amount.

We estimate that five permanent full-time positions will be needed in Juneau and one in Anchorage to administer the increased demand for information and services resulting from adding potentially over 4000 new retirees to the PERS and TRS, resulting from prior RIPs and projected for this one. In addition, we estimate that twelve long-term non-permanent employees will also be needed for varying lengths of time over the next two fiscal years. Personnel will handle increased counseling, address and beneficiary changes, account maintenance and other services.

We estimate that we will need to increase our normal number of counseling trips by 5 trips over the next two fiscal years to assure that members understand the options and requirements of the program.

Senate Bill 1
Analysis of Fiscal Implications to the Retirement Fund
Prepared by Division of Retirement and Benefits
Department of Administration
January 14, 1993

The total estimated administrative cost to the division by fiscal year is as follows:

			FY 94	FY 95	FY 96
PERSONAL SERVICES					
FY 94					
2	Retirement Specialist I/II	102.6			
8	Retirement Technician I/II	336.0			
1	Accountant I	45.3			
3	Accounting Clerk III (12 months)	113.4			
2	Clerk II (12 months)	58.2			
1	Retirement Technician I (6 months)	21.0			
1	Accounting Clerk III (8 months)	25.2			
	Total FY 94 Personal Services Cost		$701.7		
FY 95					
2	Retirement Specialist I/II	102.6			
5	Retirement Technician I/II	210.0			
4	Retirement Technician I/II (9 months)	126.0			
1	Accountant I	45.3			
2	Accounting Clerk III (12 months)	75.6			
1	Accounting Clerk III (4 months)	12.6			
2	Clerk II (12 months)	58.2			
	Total FY 95 Personal Services Cost			$630.30	
FY 96					
2	Retirement Specialist I/II	102.6			
3	Retirement Technician I/II	126.0			
1	Accountant I	45.3			
	Personal Services Cost (FY 96 and beyond)				$273.9
TRAVEL					
	Traveling to various locations throughout the state to counsel prospective retirees and give seminars		6.0	6.0	2.0
CONTRACTUAL					
	Computer services for additional PCs, CRT use		16.1	15.7	7.2
	Telephone service for: 6 permanent phones		1.2	1.2	1.2
	Telephone service for: 11 leased phones		5.5	5.5	0.0
	Long distance call expense base on previous RIP		2.5	2.5	2.5
	Total Contractual Costs		25.3	24.9	10.9

Senate Bill 1
Analysis of Fiscal Implications to the Retirement Fund
Prepared by Division of Retirement and Benefits
Department of Administration
January 14, 1993

		FY 94	FY 95	FY 96
SUPPLIES				
Office supplies		4.8	4.0	1.5
EQUIPMENT				
6 Work stations	18.0			
6 Chairs	2.4			
10 Personal computers	55.0			
Other office equipment (calculators, etc.)	5.0			
6 Phones (1100/instrument)	6.6			
5 Microfiche viewers	4.0			
1 Computer Output Printer	18.0			
Total Equipment Cost		109.0	0.0	0.0
TOTAL Operations Cost		$846.8	$665.2	$288.3

The retirement technicians, retirement specialists, accountant and accounting clerks need constant access to the PERS and TRS computer files. We do not have excess terminals, microfiche viewers or calculators. Our equipment request will satisfy our equipment needs for the duration of the program. We propose the purchase of personal computers to be used as terminals because they will be compatible with the division's Local Area Network.

We are also proposing the purchase of an additional computer output printer. The previous RIPs put great demand on our existing two printers, and we were always in a state of backlog. Our current day-to-day printer needs maximize the capacity of our existing printers. After comparing the cost of leasing a printer for two years, coupled with our existing needs, purchasing a new printer would be more cost effective.

All administrative costs of the program will be paid in advance by participating employers as required by the bill.

The Other Funds are comprised of PERS at $453.2, TRS at $370.8 and SBS at $22.8 for FY 94.

FISCAL NOTE

STATE OF ALASKA
1993 LEGISLATIVE SESSION

BILL NO. SB 1

Revision Date: _____

Title: "An Act relating to retirement incentive programs for the public employees . . . effective date."

Sponsor: Senator Duncan

Requestor: Senate State Affairs

Department Affect d: Administration

BRU: Finance

Component: Finance

COMPONENT SERIAL NO. 59

EXPENDITURES/REVENUES:

OPERATING	FY 94	FY 95	FY 96	FY 97	FY 98	FY 99
PERSONAL SERVICES	70.9	7.8	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	70.9	7.8	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE FUND SOURCE:	0	0	0	0	0	0
FUNDING:						
1002 Federal Receipts	0	0	0	0	0	0
1003 GF Match	0	0	0	0	0	0
1004 GF	70.9	7.8	0	0	0	0
1005 GF/Program Receipts	0	0	0	0	0	0
1006 GF/MHTIA	0	0	0	0	0	0
OTHER	0	0	0	0	0	0
TOTAL	70.9	[illegible]	0	0	0	0
FULL-TIME	0	0	0	0	0	0
PART-TIME	4	4	0	0	0	0
TEMPORARY	C	0	0	0	0	0

Estimate of current year (FY93) impact: None

ANALYSIS: (Attach a separate page if necessary.)
See Attached

Prepared by: Don Wanie, Director Rec 1/21/93
Division: Finance
Phone: 465-2240
Date: _____

Approved by Commissioner: Nancy Bear Usera
Agency: Administration
Date: 1/25/93

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Fiscal Note

ANALYSIS: (continued)

The Division of Finance is responsible for verification of employment history and processing of termination pay for all State employees. This includes verifying the length of employment, accounting for all leave without pay during the entire employment with the State,and determining salaries for the three highest years. In addition, final and terminal leave pay must be processed in accordance with contractual agreements.

With implementation of a Retirement Incentive Program (RIP), the workload for these functions would be significantly increased and additional support will be required by the Division of Finance to meet processing deadlines. Approximately 500 employees took advantage of the previous RIP. It is anticipated that a comparable number of employees would participate if a RIP was implemented in the next year. Based on past experience, this would require four additional positions, including one Accountant I and three Accounting Technicians I, for a period of six months. Estimated cost for these positions would be:

		FY 94	FY 95
Accountant I (1)	Range 14A	17.9	3.6
Accounting Technician I (3)	Range 12A	53.0	4.2
		70.9	7.8

Alaska State Legislature

SENATOR JIM DUNCAN

COMMITTEES:
VICE CHAIR – FINANCE
VICE CHAIR – STATE AFFAIRS
RULES
BUDGET & AUDIT
ETHICS REFORM

MEMORANDUM

Date: January 12, 1993

To: Senator Loren Leman, Chair
Senate State Affairs Committee

From: Senator Jim Duncan

Subject: SB 1, relating to retirement incentive programs for the public employees' retirement system and the teachers' retirement system and certain persons under the judicial retirement system.

Please schedule SB 1, establishing the Retirement Incentive Program for a hearing in the Senate State Affairs Committee as soon as possible. The basic configuration of the Retirement Incentive Program as proposed in SB 1 is substantially similar to previous offerings of the program.

The basic provisions of the program remain unchanged. It will again offer a three year retirement credit to qualified individuals to be applied in the following order;

1. to meet the age or service required for eligibility for normal retirement;
2. to meet the age required for early retirement;
3. to reduce the actuarial adjustment required for early retirement; and
4. as years of credited service for calculating retirement benefits.

To qualify, an employee must be within 3 years of early or normal retirement. The increased benefit will vary depending on each individual's length of service and their age. The personal services savings required by the program will again be calculated over a five year period.

The employee is required to pay what they would have paid into the retirement system if they had continued to work for an additional three years. The employer's cost will be the difference between the employee's contribution and the full actuarial cost of the three year incentive. The State's actuaries calculate the full cost for each individual eligible for the

program. This means that all cost incurred because the individual retires three years earlier is fully paid into the respective retirement system. Recent annual reports on both PERS and TRS report that the systems have been adequately compensated for RIP incurred costs.

The window periods in SB 1 are as follows;

Employee Type	Application Period	First Day Employee Can Retire	Employee Must Retire on or Before
Teachers	6/30/93-12/31/93	7/1/93	8/1/94
University	6/30/93-12/31/93	7/1/93	8/1/94
State	7/31/93-10/31/93	8/1/93	7/1/94
Municipal	12/31/93-6/30/94	1/1/94	2/1/95

A November 1991 Legislative Audit reported a total savings of almost $23 million was achieved by public employers through the use of the 1989-90 Retirement Incentive Program. The State of Alaska saved over $6 million, with the largest savings accruing to the Department of Transportation and Public Facilities. The University saved $4.3 million and school districts throughout the state saved almost $9 million. The total number of participants was 1,571. This compares to 2,327 participants in the 1986-87 Retirement Incentive Program and a savings estimated at $73 million.

I appreciate your support for the reenactment of the Retirement Incentive Program, SB 1.

Attachments

Alaska State Legislature

SENATOR JIM DUNCAN

COMMITTEES:
VICE CHAIR – FINANCE
VICE CHAIR – STATE AFFAIRS
RULES
BUDGET & AUDIT
ETHICS REFORM

January 12, 1993

Provided by Senator Jim Duncan

FACT SHEET ON SB 1, 1993-94 RETIREMENT INCENTIVE

I introduced SB 1, establishing the 1993-94 Retirement Incentive Program for public employees on January 4, 1993.

Background: SB 1 includes all the same provisions as SB 337 which was vetoed by the Governor in June, 1992 except the section for which the governor ostensibly vetoed the bill. The "objectionable provision" was added by the House Finance Committee and would have allowed the Commissioner of Administration to implement the program in times of economic crises without requiring legislation.

Economic Benefits: In addition to the required personal services cost savings, the economic benefits of the Retirement Incentiv Program are very compelling; first, personal services savings are realized in operating budgets; second, a high percentage of the new retirees remain in their communities and continue contributing their resources to our economy; and third, the employee with less seniority who is not laid off or is newly hired continues to receive a paycheck and also contributes to Alaska's economy.

Statistics provided by the Department of Administration show that increased percentages of retirees are remaining in Alaska since the first Retirement Incentive Program in 1986. For example, retirees in the Public Employees' Retiremer System remaining in Alaska ros from 60 percent in 1982 to 69 percent in 1986 and reached 71 percent in 1991. Teachers Retirement System retirees remaining in Alaska was at 49 percent in 1982, rose to 54 percent in 1986, and reached 66 percent in 1991. Retention of these retirees and their income is beneficial to Alaska's economy.

The Incentive: The basic configuration of the Retirement Incentive Program remains substantially similar to previous offerings of the program. Individuals will be provided with a three year retirement credit to be applied in the following order;

1. to meet the age or service required for eligibility for normal retirement;

2. to meet the age required for early retirement:

3. to reduce the actuarial adjustment required for early retirement; and

4. as years of credited service for calculating retirement benefits.

The Retirement Incentive Program requires that the employer's

1986-87 R.I.P. Savings - Sources February 1989 Legislative Audit, and Retirement and Benefits Statistics

	# Participants	Savings
State	1,095	$ 14,448,520
School Districts	603	31,182,600
Political Subdivisions	412	4,756,800
University of Alaska	217	22,305,400
Totals	2,327	$ 72,693,320

1989-90 R.I.P. Savings - Source - 1991 Legislative Audit

	# Participants	Savings
State	739	$ 6,033,100
School Districts	748	10,016,000
Political Subdivisions	132	2,617,900
University of Alaska	145	4,317,800
Totals	1,764	$ 22,984,800

Office of the Governor
Office of Management and Budget
February 1, 1993

Position Paper
Retirement Incentive Program Legislation

(SB 1, SB 10, HB 36, HB 42, HB 57)

Several bills have been introduced in the Legislature which would establish another retirement incentive program (RIP) for Alaska state and local government employees. These bills are: SB 1, SB 10, HB 36, HB 42, and HB 57.

The Hickel Administration does not support any of these retirement incentive bills under current circumstances. A similar retirement incentive bill, SB 337, was passed during the 1992 legislative session, and was vetoed by Governor Hickel. The chief reason cited in the Governor's veto message was that the bill would have made the retirement incentive program a permanent feature of the PERS and TRS systems.

This "permanent RIP" provision was the most serious flaw in SB 337 and in itself was sufficient to justify veto of the bill; however, members of the Administration had other concerns about the legislation which have been evaluated in detail since that time. These concerns are serious enough to prevent the Administration from supporting the current RIP bills, even though the "permanent RIP" provision is not included in any of the current bills.

The most important of these concerns are:

1. A third retirement incentive program is unlikely to be cost-effective unless large numbers of layoffs are necessary and most positions are eliminated;

2. Regularly repeated retirement incentive programs — such as one every three or four years — undermine the fundamental purpose of these programs by encouraging employees to delay, rather than accelerate, their retirements in order to take advantage of the next likely incentive program; and,

3. The state should not be encouraging its most experienced, knowledgeable employees to leave state service unless severe fiscal conditions allow no other alternative. The primary purpose of the state's already generous retirement system is to retain experienced employees. In the 1989 RIP, 23 percent of the participants were under age 50, and several retired at age 40.

Cost-Effectiveness of a Third RIP

The Administration's position is that another retirement incentive program is unlikely to save the state money unless large numbers of layoffs are required, and most of the positions are eliminated. The vast majority of retirement incentive programs which have been offered by governments and corporations across the country were established because large layoffs were imminent, and the incentive programs offered a means to reduce the number of layoffs necessary.

In contrast, the most recent RIP offered by the State of Alaska was not established because large layoffs were anticipated. In fact, only three of the 753 state positions affected by the program were expected to be eliminated. Nevertheless, the program was supposed to result in savings to the state by filling the vacated positions with employees at lower salaries. In 1990, the Office of Management and Budget (OMB) projected that the 1989 RIP would result in net savings to the state of over $6 million.

However, this projection did not account for the fact that many of the participants in the RIP would have retired in the near future even if the program had not been available. This issue has been acknowledged by OMB, the Division of Legislative Audit, and others in the past, with a general consensus that the savings estimates were inflated somewhat by omitting the effect of normal retirements. However, the magnitude of this savings inflation was not recognized until OMB recently began quantifying the effect of normal retirements on the projected RIP savings.

The details of these calculations will be included in a separate report to the legislature, but the end result is that when historical retirement rates are incorporated into the estimates of RIP savings, the total savings for the program during the 3-5 year measurement period drop from over $6 million to less than zero.

The primary reason for this dramatic difference is that because only three of 753 positions were expected to be eliminated, the net savings from the RIP were small — averaging about $8,000 per participant — compared to the cost of the RIP to the state to fund the additional retirement benefits — which averaged about $23,000 per employee. According to the state's actuarial data, about 48 percent of the RIP participants would have been expected to retire normally without the RIP. When the relatively small savings per employee are adjusted to reflect these normal retirement statistics, the overall savings originally projected for the program during the measurement period are eliminated.

Advocates for another retirement incentive program may point out that some potential savings under the RIP were not calculated in the original savings estimates. This is true, but these factors are relatively minor in comparison and do not change the basic conclusion supported by OMB's most recent analysis: that successful retirement incentive programs are successful because most, if not all, of the affected positions are eliminated,

and that a RIP which relies primarily on filling positions at lower salaries is likely to be marginal at best and may well result in a net cost to the employer.

Repeating the Retirement Incentive Program Over and Over

Retirement incentive programs were offered by the state and many local governments and school districts in 1986 and 1989, and would have been available again in 1992 if the Governor had not vetoed SB 337. The Administration's position is that retirement incentive programs simply cannot be effective if they are repeated on a regular basis. According to a national retirement consulting firm, very few, if any governments or corporations have offered retirement incentive programs three times in only nine or ten years.

The basic purpose of these programs is to encourage employees to retire earlier than they otherwise would. Yet if employees believe that another RIP may be offered in two or three years, they have a strong incentive to delay their retirements to take advantage of the financial benefits of the next RIP. This effect is difficult to quantify, but it is clear that at some point regularly repeated RIPs simply become an enhancement of an already generous retirement system, with little or no savings to the employer.

Loss of Experienced Employees

The main purpose of the state's retirement system is to encourage experienced, knowledgeable state employees to remain in state service, thereby reducing the costs and loss of productivity associated with rapid turnover in the state work force. Retirement incentive programs are designed to increase turnover and reduce the number of long-term employees. Some advocates of these programs believe that they mainly eliminate the "dead wood" of less productive employees; others opposed to the programs feel they result in a "brain drain" of good employees that leaves agencies less productive.

As noted above, 23 percent of the participants in the 1989 RIP were under age 50, and several retired at age 40. The Administration's view is that the state is not well-served by encouraging experienced, capable employees to leave state service early, and that a program which has this effect should only be implemented if the need for large layoffs leaves no other alternative.

A REPORT ON THE DEPARTMENT OF ADMINISTRATION PUBLIC EMPLOYEES' RETIREMENT SYSTEM RETIREMENT INCENTIVE PROGRAM

May 16, 1986 - October 1, 1987

Audit Control Number

02-1327-89-S

Commissioner, Department of Administration — John M. Andrews

Deputy Commissioners, Department of Administration — Charles E. Taylor, James J. Fox

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STATE OF ALASKA

THE LEGISLATURE

BUDGET AND AUDIT COMMITTEE

AUDIT DIVISION
P.O. BOX W
JUNEAU, ALASKA 99811-3300

February 8, 1989

Members of the Legislative Budget
and Audit Committee:

In accordance with the provisions of Title 24 of the Alaska Statutes, the attached report is submitted for your review.

A REPORT ON THE
DEPARTMENT OF ADMINISTRATION
PUBLIC EMPLOYEES' RETIREMENT SYSTEM
RETIREMENT INCENTIVE PROGRAM

May 16, 1986 - October 1, 1987

Audit Control Number

02-1327-89-S

As stated in the Report Objectives, Scope, and Methodology Section, the Audit primarily involved determining the estimated cost savings to the State of Alaska as a result of state employees enrolled in the Public Employees' Retirement System and participating in the Retirement Incentive Program as enacted by Chapter 26, SLA 1986. This audit was conducted in accordance with generally accepted governmental performance auditing standards.

Randy S. Welker

Randy S. Welker, CPA
Legislative Auditor
Division of Legislative Audit

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REPORT OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with the provisions of Title 24 of the Alaska Statutes, a review was conducted to determine the estimated cost savings resulting from State of Alaska employees participating in the Retirement Incentive Program (RIP). The objectives, scope, and methodology of our review were as follows:

Objectives

Chapter 26, SLA 1986 created a retirement incentive program for members of the Public Employees' Retirement System and Teachers' Retirement System. The stated purpose of this legislation, effective May 16, 1986 was:

> Since it is necessary for state agencies and may be necessary for other employers who participate in the state retirement systems to reduce their personal services costs because of declining state revenue, a program encouraging employees to retire voluntarily may reduce the hardship of layoffs. This program is intended to realize sufficient economies to offset the cost of administration and benefits to the state agencies and other employers resulting from the award of retirement credits and to result in a net reduction in personal services costs to the state or other employer during a period of declining revenue.

The objective of our review was to determine the amount of cost savings as a result of state employees participating in RIP. The scope of our review and methodology used to meet this objective follows.

Scope and Methodology

All executive branch employees (excluding the University of Alaska) enrolled in the Public Employees' Retirement System, participating in RIP between May 16, 1986 to October 1, 1987, and having position control numbers (PCNs) were reviewed.

In order to calculate the estimated cost savings in personal service costs as a result of employees participating in RIP, we obtained a listing of retirees from the Department of Administration, Division of Retirement and Benefits. The listing, dated November 9, 1987 provided us with the retiring employee's name, social security number, and employer's RIP cost by department.