

HOUSE FINANCE COMMITTEE
FOURTH SPECIAL SESSION
May 27, 2016
9:07 a.m.

9:07:00 AM

CALL TO ORDER

Co-Chair Thompson called the House Finance Committee meeting to order at 9:07 a.m.

MEMBERS PRESENT

Representative Mark Neuman, Co-Chair
Representative Steve Thompson, Co-Chair
Representative Dan Saddler, Vice-Chair
Representative Bryce Edgmon
Representative Les Gara
Representative Lynn Gattis
Representative David Guttenberg
Representative Scott Kawasaki
Representative Cathy Munoz
Representative Lance Pruitt
Representative Tammie Wilson

[Note: Representative Pruitt was absent from the morning portion of the meeting.]

MEMBERS ABSENT

None

ALSO PRESENT

Lori Wing-Heier, Director, Division of Insurance, Department of Commerce, Community and Economic Development; Fred Parady, Deputy Commissioner, Department of Commerce, Community, and Economic Development; David Teal, Director, Legislative Finance Division; Sheela Tallman, Premera Blue Cross Blue Shield of Alaska; Jane Pierson, Staff, Representative Steve Thompson; Representative Liz Vasquez.

PRESENT VIA TELECONFERENCE

David Morgan, Self, Anchorage; Jeff Ranf, Alaska Association of Health Underwriters, Anchorage; Jennifer Jolliffe, Self, Anchorage.

SUMMARY

HB 374 REINSURANCE PROGRAM; HEALTH INS. WAIVERS

CSHB 374(FIN) was REPORTED out of committee as amended with a "do pass" recommendation and with one new fiscal impact note from the Department of Commerce, Community and Economic Development.

#hb374

HOUSE BILL NO. 374

"An Act relating to a reinsurance program for residents who are high risks and insurer assessments to cover the costs of the reinsurance program; relating to application for state innovation waivers for health care insurance; relating to definitions of 'residents who are high risks' and 'covered lives'; and providing for an effective date."

[9:07:37 AM](#)

Co-Chair Thompson discussed the agenda.

Representative Wilson referred to a document from the [House] Labor and Commerce [Committee] titled "HB 374 Reinsurance Program; Health Insurance Waivers" from the Department of Commerce, Community and Economic Development (copy on file). She referred to page 2 of the document related to consumer impact. She detailed the document addressed that the existing federal reinsurance program would expire in the current year. She continued the document referred to a 2016 estimated tax of \$30 per member, per month on individual plans, and an \$18 per member, per month charge for individuals in group plans. She asked for verification that the original bill would have maintained the tax; therefore, no one would pay more than they paid currently.

LORI WING-HEIER, DIRECTOR, DIVISION OF INSURANCE, DEPARTMENT OF COMMERCE, COMMUNITY AND ECONOMIC DEVELOPMENT (DCCED), replied in the affirmative. She confirmed a reinsurance fee had been set in 2014, 2015, and 2016 for

the federal government, which would terminate at the end of the current year. She elaborated there was also a tax that would be suspended at the end of the current year. She relayed the state did not know if the tax would be reenacted at some point in the future. She explained it was a percentage - that the tax was equivalent to \$18 on an employee plan or \$30 on an individual plan per month. She clarified the reinsurance was \$2.25 per member, per month and the tax was estimated at \$18 per member, per month (approximately \$20 total). With the knowledge the reinsurance program was expiring, the department was trying to back into a number at \$20 multiplied by 12 [months] and multiplied by the 224,000 in an insured population in Alaska, which resulted in a total of about \$55 million.

Ms. Wing-Heier furthered that within the insured population there was primary and excess or stop-loss insurance. She detailed the stop-loss insurance did not contribute to the tax or contributed at a much lower rate because they were paying at a percentage and because their premiums were much less. She explained that participating employers (e.g. the State of Alaska or another large employer) took a much larger deductible, taking the losses in-house, buying stop-loss insurance, and funding losses internally. For example, instead of paying a \$5 million premium, an employer was funding a \$4 million premium and only purchasing a \$1 million premium. She continued the tax was paid on the \$1 million instead of \$5 million. She communicated that school districts and other employers had been "crying foul" that they did not pay 3 percent on the portion they self-funded and they did not budget for it. She further explained that the employers specified the entities were asked to pay the \$20 per person, per month "time out."

FRED PARADY, DEPUTY COMMISSIONER, DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT, interjected that [the employers in the example specified] it was a new tax.

Ms. Wing-Heier reiterated it was a new tax - the employers specified they had never paid the amount because they self-funded. The employers also emphasized they could not begin to pay the amount because they did not have the funding. She explained Representative Kurt Olson had come out with the committee substitute (CS) to HB 374, which would go with the premium tax. She discussed that related to the fully insured, it was right to say the 3 percent tax equated to \$18 and everyone paid the \$2.25 including the

plans with stop-loss. However, when it came to large employers that self-funded the majority of the program (and with high stop-loss), the percentage was so low, when the \$20 per person, per month was used, employers such as the Kenai Peninsula School District, the North Slope Borough School District, and others had called and sent letters specifying the structure did not work.

[9:13:11 AM](#)

Representative Wilson asked if the amount was the same as the 2.7 percent [tax] under discussion.

Ms. Wing-Heier answered "that amount equated to \$55 million." She explained that \$55 million according to the actuarial study would impact the premium or rates by about 15 to 18 percent.

Mr. Parady added that the 2.7 percent was the state tax.

Ms. Wing-Heier continued that every [insurance] policy in the state (i.e. life and health, workers' compensation, auto, home, and other) paid a tax to the state, which was most often 2.7 percent (there were some exceptions such as title insurance, which paid 1 percent). The bill before the committee assumed that the 2.7 percent tax would come in for the reinsurance program.

Mr. Parady clarified "in this bill." Ms. Wing-Heier agreed.

Representative Wilson asked for verification that the 2.7 percent was currently coming into the General Fund (GF). She asked for verification that the department was asking to have the 2.7 percent designated to DCCED to offset and reduce premiums for everyone (not only the high risk group).

Ms. Wing-Heier answered that the funds did currently go to the General Fund. She deferred to Mr. Parady for further detail.

Mr. Parady replied his best understanding was the tax was collected by the Division of Insurance and at the year-end it lapsed to the GF.

Co-Chair Thompson noted that Mr. Teal would be available for questions.

Representative Wilson directed her question to Co-Chair Thompson. She wondered if the bill was really only related to funding something in the current year. She reasoned the 2.7 percent could be designated to a particular fund to do exactly what DCCED was talking about versus looking at \$55 million out of the GF.

Co-Chair Thompson noted that Mr. Teal would answer the question.

[9:16:19 AM](#)

Representative Guttenberg asked about the statutory references. He referred to Section 1 of the bill that addressed funding the reinsurance program. He mentioned statutory references that were included. He asked for detail on how the structure worked.

Ms. Wing-Heier referred to a statute book for an answer.

Co-Chair Thompson noted that Commissioner Hladick was also available.

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Ms. Wing-Heier answered that the primary tax collected by the division was under AS 21.09.210, which was insurance tax. In FY 15 the tax had brought in \$55,941,000. Additionally, the department had collected \$108,000 for unauthorized insurance premium tax under AS 21.33.055; \$38,000 for independently procured insurance tax under AS 21.33.061; \$2,754,811 for surplus lines insurance under AS 21.44.180; and \$274,847 for title insurance under AS 21.66.110 for a total of \$59,117,449 in premium tax in FY 15. She noted the total did not include the receipts and licensing fees collected by the division.

Representative Guttenberg asked what the funds were currently used for. Ms. Wing-Heier answered that once the funds left the division, it no longer tracked them.

Representative Guttenberg surmised that before leaving the division, the money was used to fund the division.

Ms. Wing-Heier answered in the negative. She clarified the division was funded separately. She elaborated that insurance producers, agents, brokers, adjusters, and finger printing funded the division. The division collected fees for those services, which were responsible for funding the division's operations (the fees were separate from any tax collected by the division).

[9:22:49 AM](#)

Co-Chair Thompson noted that the Legislative Finance Division would address a conceptual amendment.

DAVID TEAL, DIRECTOR, LEGISLATIVE FINANCE DIVISION, discussed that Co-Chair Thompson had asked if there was a way to show the amount as something other than an expenditure of unrestricted general funds (UGF) and to straighten out the fiscal note. In response, the Legislative Finance Division had drafted an amendment that would be included in a CS later in the day. He explained it would establish an Alaska Comprehensive Health Insurance Association (ACHIA) fund; rather than spending UGF premium tax revenue directly to DCCED, the premiums would be deposited into a fund, which would make it designated revenue (very similar to the alcohol and drug treatment money). The state could then specify the fund could be used to make appropriations to DCCED to run the reinsurance program.

Mr. Teal clarified the revenue that would go into the fund was from premium taxes on all insurance lines, not just health insurance. He added it would not include the 2.7 percent workers' compensation fee that was already going into a workers' safety fund. He explained the revenue included penalties and interest on late fees (it was not purely premiums) and was net of refunds, errors, etcetera. The fund would be modeled after the alcohol fund and the premium taxes would be reclassified as designated general funds (DGF) rather than UGF. As the bill was written, it would spend UGF because the premium taxes were UGF revenue. He detailed the taxes were UGF revenue because they were appropriated to DCCED, but lapsed into the GF at the end of the year. The alternative was to create a fund calling the funds designated revenue, which would reclassify the

revenue as DGF (there would be a loss of UGF revenue). He continued there was no change in the deficit - in one case more UGF was spent and in the other case in creating the fund there was a loss of an equivalent amount of UGF revenue. He explained the deficit would still be exactly the same and "there is no free money here."

Mr. Teal detailed the advantages to creating a fund were that there was a lag, so the amount of funds in the account were known. There would be an effective date of FY 16, which would put the premiums collected in 2016 (due to lapse on June 30) into the fund; the funds would be available for appropriation in FY 17, which meant DGF premium taxes would be spent in FY 17. A loss of UGF revenue would be shown in FY 16 because it was reclassified. Second, the current bill would put the expenditures (\$55 million) in the agency operations portion of the budget by direct appropriation and then a grant to ACHIA, which would inflate the DCCED operating budget. The bill did not run the money through DCCED; it would go into a fund under a statewide allocation and would appear in DCCED as DGF. He reiterated there was no new money, it was merely a question of how things were classified. He underscored that the concept was not a "black magic budget trick" and it would operate the exact same way as the alcohol fund. He explained if the legislature was concerned about its FY 17 expenditure level, the way the bill was drafted UGF expenditures would go up by \$55 million, whereas, if the legislature implemented the fund, the UGF expenditures would not change (UGF revenue would simply be lost).

[9:28:40 AM](#)

Co-Chair Neuman summarized his understanding of Mr. Teal's statements. He surmised the state was collecting premium funds of about \$55 million, which currently went into the GF and were used to pay ACHIA. He asked for verification the proposal would collect the premium tax and deposit it directly into the ACHIA fund. He believed it was not new money coming out of the GF and the method would be clear for tracking and budgetary purposes.

Mr. Teal answered in the affirmative. He explained the method would help in a way because (like with alcohol) the legislature would be spending FY 16 money in FY 17 and it would have a fairly good idea about the amount of money

available, which would avoid over-appropriation. Additionally, as the years go by, the legislature may find there was more money in the fund than it had appropriated, which would enable the legislature to increase or decrease the appropriation. He stated it was a matter of providing affordable healthcare to individuals who would have very high premiums and it was a way to avoid premium tax increases for everyone. He explained it would be using state money to make healthcare more affordable.

Co-Chair Neuman asked for verification the state would maintain its ability to increase premiums through regulation to help cover costs if the costs for ACHIA increased.

Mr. Teal answered in the affirmative. He elaborated that if the state raised premiums it would increase premium taxes, which would go to the fund and could be used to pay healthcare costs.

Co-Chair Neuman remarked the method was more self-regulating. Mr. Teal agreed.

[9:30:48 AM](#)

Representative Gattis asked why the taxes on insurance premiums had been instituted in the first place. She elaborated that the money may not be new, but it was a new "spend." She detailed the money had been deposited in the GF in the past for GF purposes. She had spoken with some insurance companies that did not know why they were collecting the funds.

Mr. Teal answered by comparing the taxes to Division of Motor Vehicles fees. He detailed the state charged money for license plates, which exceeded the cost of making and issuing the plates. He explained the tax was a revenue generator.

Representative Gattis stated that it was not new money, but surmised it was clearly a new spend. Mr. Teal answered that it was a loss of \$55 million in GF revenue, which could be characterized as a new spend or a loss in revenue - it amounted to the same thing.

Vice-Chair Saddler understood that the insurance industry model passed on the risk to ever-increasing pools; if one

insurer did not believe they could cover all of their claims, they purchased reinsurance insurance. He furthered the risk was passed along until someone had to pay. He discussed that currently Premera had the risk pool, had determined the cost of fulfilling claims was more than it was collecting, and was trying to pass on its risk to somebody. He surmised the state was not buying more insurance, but it was merely appropriating money to pay for it. He believed the state was the last payer. He asked for the accuracy of his statements.

Mr. Teal believed it was accurate, but deferred to Ms. Wing-Heier for detail. He spoke to insurance and reinsurance in simpler terms and explained subsidizing the cost with state money was making healthcare affordable. He continued that otherwise, premiums would increase for everyone because premiums could not be increased for very high risk people. He did not know it was even fair to classify them as high risk people. He furthered many of the individuals had known conditions and expensive healthcare cost where no one would insure them. For example, he questioned what an insurer would have to charge an individual for healthcare premiums if it was known a person had a medical condition that would cost \$250,000 or \$300,000 per year. He explained the cost would be totally unaffordable. He detailed that normally premiums were spread to everyone; the bill provided a way to pay some of the medical costs out of state funds instead of increasing all Alaskan's premium costs. He saw it as affordable healthcare as opposed to an insurance premium. He added it was not a risk, it was a known expense.

[9:35:00 AM](#)

Ms. Wing-Heier answered that reinsurance was common in the insurance world for health, workers' compensation, auto, and other. She specified insurance companies bought reinsurance in great volumes. For example, Alaska National and American International purchased reinsurance because they only wanted to take a certain amount of loss themselves. She elaborated reinsurance was insurance for an insurance company because they could only afford to take so much risk themselves, particularly for catastrophic loss. She explained an insurance company may take the first \$1 billion or \$100 million of a catastrophic loss and it would then submit a claim to its reinsurer. She detailed the claim may go to the first layer of the reinsurance program

and then to the second layer depending on the loss. The program was attempting to reinsure for the catastrophic claims of the individual market. She reiterated the practice was not uncommon in the industry - she did not know of many insurance companies that took every loss net to their bottom line.

Vice-Chair Saddler stated it was one of the reasons the insurance industry was one of the first industries to use computers to calculate "this kind of stuff." He referred to Ms. Wing-Heier's testimony related to self-funding insurance pools (e.g. school districts and others) that may self-insure for a portion of their risk and then go to reinsurance or different insurance coverage for another portion, which was the source of the inequity of applying the premium tax. He noted the school districts had their own funds to self-insure from. He asked if the money originated from the State of Alaska paying an amount per employee. He stated that contracts were usually negotiated and included health insurance costs. He wondered about the source of funds school districts used to provide the self-insurance coverage.

Ms. Wing-Heier replied that she did not know about the school district funding. She deferred to Mr. Parady.

Mr. Parady answered that he had been the former chief operating officer of the North Slope Borough School District. He detailed that the district had self-insured its 500 employees and 2,000 covered lives for \$7 million and had purchased insurance to cover losses exceeding \$7 million or individual claims exceeding \$150,000. The source of the funds was school district operating funds, which came from the foundation formula.

Vice-Chair Saddler asked for verification the state paid to help populate insurance funds used by school districts to provide self-insurance for health insurance. He surmised the goal was to find a way to equitably share the costs of the high risk insurance pool. He construed the school districts and others were objecting to the imposition of additional premium taxes; however, the state was currently paying most of the cost already.

[9:38:52 AM](#)

Mr. Parady noted that the school district was a political subdivision of the state; therefore, all of its expenses were essentially the state's, absent some federal grants or private fundraising. Secondly, one of the district's objections would be timing and the fact that when the state was looking at the \$20 per person, per month option it included 256,000 insured lives, 150,000 of the individuals were carrying stop-loss insurance. He explained it was not offset by an expiring federal tax; it was a form a new tax that hit districts in a way they were not budgeting for.

Vice-Chair Saddler asked Mr. Parady if the premium tax went through, whether the school districts would ask for more money to cover the cost. Mr. Parady affirmed the districts would look for help with the money.

Representative Gara believed the presenters had sufficiently demonstrated why something like the bill needed to pass. He did not want to increase the premiums for other policy holders and there was a certain amount of compassion reflected in helping people with severe medical conditions. He asked if the \$55 million generated by the premium tax that went into the insurance fund was used for anything else at present. He wondered whether the bill would take money away from other things the legislature was presently funding, meaning the legislature would have to locate alternative funding sources for those items.

Mr. Teal answered that the premium tax receipts went into the GF. Once the money went into the GF it was indistinguishable from royalty proceeds or any other GF receipts. He detailed that the money was definitely being spent on something at present, but he could not identify specifically what that was. The bill would reduce GF revenue by \$55 million, leaving the state with a \$55 million deficit. He explained the scenario would be exactly the same as if the legislature used UGF to make the expenditures.

Representative Gara referred to an earlier statement that the department could change the premium tax through regulation if there was a shortfall in the future. He believed the tax was set by statute. He asked for clarification.

Ms. Wing-Heier answered that it was set by statute.

Representative Gara asked for verification the premium tax could not be changed unless it was changed in statute. Ms. Wing-Heier replied in the affirmative.

9:42:41 AM

Representative Guttenberg did not know what the actuarial chart indicated about the specific group of individuals and rising healthcare costs or how large the group was. Additionally, he did not know whether the group was growing disproportionately to the rest of the population. He spoke to the rest of the insured population and asked if the taxes were based on percentages or a flat fee. He wondered if the percentage or flat fee was able to keep up with rising costs. He asked whether the money that would go into the future designated fund rising as rates rose. He did not imagine a flat fee would keep up with rising healthcare costs of the specific population; however, a percentage would keep up more proportionately. He asked if there was a gap between the two lines.

Ms. Wing-Heier believed Representative Guttenberg was asking whether the \$55 million would be adequate in the future or should the amount be a certain percentage of the claims (e.g. 10 or 20 percent). She did not know whether the answer was known, but the receipts or revenue collected by the division was limited. Only so much insurance would be sold in the state and with a 2.7 percent tax a limited amount would be collected to put towards the program. The bill intended that the legislature may appropriate because the ACA [Affordable Care Act] was in its infancy. Section 3 of the bill also proposed an innovation waiver. She expounded that there may be changes coming from the federal Congressional delegation that may impact how the program looked in two or three years, which could mean the state may not need \$55 million. She believed the term "may appropriate" would depend on how they looked at the issue in 2019 and 2020 in terms of whether \$55 million was the correct number. She detailed the division did not know how successful the innovation waiver would be or the impact it would have on Alaska, but it did want to consider the option to see how it would impact the individual and small group markets in the state. The division also wanted to work with the Congressional delegation. She reiterated the ACA had only been implemented three years earlier and had been passed as a "one size fits all" program. The division believed the ACA would change over time. She relayed the

division had received a notice the previous day that Texas received a rate filing from Blue Cross Blue Shield for 58.6 percent. She underscored the rate was not sustainable even for Texas. She stressed that things would have to change and as things changed the division hoped it was "not sitting here asking you for, just saying, \$75 million. That's not the intent." She concluded the bill language used the term "may appropriate" and the issue would have to be revisited the next year.

Representative Guttenberg spoke to his prior question and asked what portion of the funds were flat fees and how many were percentages of [insurance] policies. Ms. Wing-Heier answered that the funds were all percentages of one point or another.

[9:47:09 AM](#)

Co-Chair Thompson OPENED public testimony.

DAVID MORGAN, SELF, ANCHORAGE (via teleconference), shared that he was an economist and had 30 years of experience working in the healthcare field. He testified that it was a pattern that had been seen throughout the whole process of the ACA, which had originally promised to save money and contain costs. However, he emphasized that costs had exploded in both large and small states; primarily because efforts to contain costs had not been made. He was concerned that the old pool had certain managed care processes that helped contain costs of high cost patients. He detailed that to get into the program there was a process to make sure that everyone who was supposed to pay (i.e. insurance, tribes, and others that had health benefits) paid first and the pool paid last. Second, the act had looked at using Medicare centers equality and negotiated certain prices and purchase of certain services. It had tried to shift patients to a higher volume, bigger quality scenario in order to save money for the pool. He observed that in 2016 Alaska only had the second highest rate increases on average; Minnesota was at 47 percent and Alaska was at 39.1 percent. He relayed that virtually every state had gigantic increases. He understood the process that had been set up and the information being used were changing greatly. He remarked that in six months Medicaid expansion went from a savings of \$32 million for four years to a cost of \$56 million. He stated he agreed with the

director of the Division of Insurance that the state was in a debt spiral.

9:51:16 AM

JEFF RANF, ALASKA ASSOCIATION OF HEALTH UNDERWRITERS, ANCHORAGE (via teleconference), testified in support of the legislation. He explained that the association represented over 100 licensed insurance agents throughout Alaska. He detailed the association's members consulted with individual Alaskans and Alaskan employers on how to purchase, administer, and utilize their health insurance coverage. He provided further detail about the association. He shared the organization had seen first-hand what residents were experiencing as they attempted to purchase insurance to help pay for their medical expenses. He stressed that the situation was very serious. He furthered that health insurance had gone from being expensive to potentially unavailable to a large group of Alaskans. He discussed the bill would amend statute related to ACHIA. He communicated that Alaskans had not heard a significant amount about ACHIA because ACA was supposed to have dealt with the issue; therefore, the focus had been on ACA in Alaska. However, ACA had not worked. The bill would enable the state to put ACHIA back to work, which he supported. He underscored that doing nothing put many more people at risk. The association's concern was that erosion could start to occur in the group market if the individual market was not stabilized. He relayed it would become a more widespread and complicated problem to solve. He asked the committee to support the bill.

SHEELA TALLMAN, PREMIERA BLUE CROSS BLUE SHIELD OF ALASKA, spoke in support of the legislation. She read from a prepared statement:

Premera has operated in Alaska since before statehood in 1952 and provides coverage to over 110,000 Alaskans in all lines of business including the individual and family policy holders, small group, large group, as well as providing services to the larger self-funded employers in the state. The individual health insurance market was in crisis. I would like to start by briefly describing what has got us here, explaining the impacts to the health insurance industry, and most importantly what Alaskan residents are facing in trying to buy individual coverage.

With health reform in 2014 the major change to the insurance market was guaranteed issue to all individuals without preexisting condition exclusions and this provided access to insurance for several thousands of individuals which has been a good thing. Premera and the other insurers priced products, estimating the impact of an uninsured purchasing coverage for the first time. However, we've experienced a significant influx of new enrollees with very high medical costs. Many leaving the high risk pool, ACHIA, which has shrunk by half and the federal preexisting condition pool. Premera lost approximately \$13 million in the individual market in 2014. For 2015 and 2016, Premera had approximately 37 percent and 39 percent average rate increases for the individual metallic plans, but the claims continue to exceed premiums. To break even in 2015 Premera would have needed a 70 percent rate increase.

To say it differently, Premera is taking in on average, \$713 in premium per member, per month, but paying claims at \$919 per member, per month, demonstrating the very high claims costs in this individual pool. In a very small sized market like Alaska there was simply not enough healthy individual purchasers to offset the costs of enrollees with very high claims costs. Today, Alaska's average benchmark plan premium in the individual market is the highest in the country at over \$700 per month. The next highest state is \$468 per month. So while states, you've heard, are experiencing similar increases or even higher percentage rate increases, the impacts in Alaska are more than double since the premium is already so high. While subsidies will help many, there are still over 1,200 individuals that do not qualify for any subsidies and are picking up the full payment of that premium.

We're very concerned that premiums will continue to skyrocket, due to the small size of the individual pool and with fewer people to spread the risk across, the small number of individuals with these conditions are destabilizing the pool, which is resulting in these premium increases. To give you an example, just for the first half of 2015 we had over \$45 million in

claims, \$11 million of those claims came from 47 individuals.

One solution is an approach other insurers have taken already, which is simply to exit the individual market. However, we've been working, Premera and Moda, have been working collaboratively with the Division of Insurance to come up with a sustainable option for Alaskans, which is the reinsurance program we've discussed, administered by ACHIA. That program would cover or reinsure the claims costs for some of the highest cost medical conditions. These are the long-term, chronic conditions such as kidney disease and heart failure that are impacting the pool. The program would help mitigate premium increases for all individual policy holders, but also stabilize the market, which could potentially attract new competitors into this market. It would also provide financial certainty for customers, knowing that health insurance will continue to be available to them in their time of need.

We also support the innovation waiver. We support flexibility at the state level to help Alaskans maintain the coverage they've had and to tailor reforms to meet the unique needs of the Alaska market. The waiver would allow the state to explore longer-term positions and policies to help address the very high cost of care in the state.

What Alaska needs is immediate relief from these year-over-year premium increases and House Bill 374 will help to mitigate these swings and on behalf of the 23,000 individual policy holders in the state, we ask for your support.

[9:58:49 AM](#)

Co-Chair Neuman thanked Ms. Tallman for coming to address the committee in person. He asked how the committee could be assured that the insurance companies would pass the \$55 million to the consumers.

Ms. Tallman answered that the intent of the program was to reduce the rate of the premium increase. She detailed if there was a reinsurance program - much like how the federal reinsurance program had worked - it would be factored into

the rate filings the company would be submitting to the Division of Insurance for review.

Representative Munoz asked about the individuals receiving insurance through federal subsidized plans. She asked how the subsidies were being funded.

Ms. Tallman answered that the entire pool under discussion was individuals purchasing coverage in the federal exchange or outside of the exchange; it was all one pool for each insurer. Federal subsidies through the ACA were paid for under other revenues that went to the federal government and the ACA (e.g. insurer tax, penalties for individuals without insurance, and other revenue sources in the ACA).

Ms. Wing-Heier elaborated that while a significant population received premium tax credit, it were not equal to all constituents. She detailed it was based on income. Approximately 70 percent probably received a subsidy of 1 percent or another, but it was not equal to every member - everyone did not get 90 percent of their premium paid. For example, a family of four with a \$1,000 per month premium who received a 50 percent tax credit, would still responsible for a \$2,000 payment. She reiterated it was based on income and it changed depending on how a member's income varied within a year. She explained the system was complicated and the division tried to work with constituents. She furthered a person learned the amount of their premium tax credit when they filed their taxes with the Internal Revenue Service (IRS).

Representative Munoz asked whether some of the 23,000 under discussion received some subsidy, while others did not. Alternatively, she wondered if the individuals were all unsubsidized.

Ms. Wing-Heier estimated that about 70 percent of the 23,000 individuals were receiving a subsidy. She estimated that about half (or fewer) of the 70 percent received a full subsidy. She reiterated her previous testimony that the credit varied by income. One of the reasons the division supported the innovation waiver was that it had the ability "to soften the cliffs." She detailed that in some of the income levels, if a person earned one cent more, their subsidy could change or go away. She explained it was trued up by the IRS, not by the Centers for Medicare and Medicaid Services (CMS) or the state. She continued

people were more than surprised when they went to pay their taxes and discovered their subsidy had been calculated incorrectly and they ended up owing back their subsidy. She stressed the ACA was in its infancy and had created some problems for many constituents in the calculation of the subsidy.

[10:03:34 AM](#)

Vice-Chair Saddler referred to background information provided by Ms. Tallman that some health insurance companies were responding to the high claim costs by limiting their coverage in specific sections of the state or the entire state (i.e. Eastern Washington versus the whole state). He asked if Premera was considering limiting its scope of coverage in portions of Alaska or all together and if so, he wondered what the decision point was.

Ms. Tallman answered that currently the company was working on its rate filing and was obtaining the claims data from Moda, which would be used in the rate development process. All of the factors were under consideration. The company was committed to the individual market, but it was a tenuous market. She added that each state had its own market and was evaluated on its own.

Vice-Chair Saddler believed the calendar for the rate filing was in approximately six weeks. He asked for verification that a decision would be made by Premera within six weeks to continue as is or to scale back in part or in total.

Ms. Tallman answered in the affirmative.

Vice-Chair Saddler asked if Ms. Tallman believed the proposed funding mechanism would be sufficient for the short-term and long-term.

Co-Chair Thompson believed the question pertained to a corporate decision.

Ms. Tallman answered that based on the analysis looking at the markets, the \$55 million would have a fairly significant impact on individual premiums. She detailed the question could only be answered for year-one. She believed a reinsurance program would help mitigate the premium increases and the rates. She thought the impacts would be

what happened over time to the pool if there were new competitors coming in. She reiterated the \$55 million would have a significant impact and would potentially bring the rate of the increase to the 20 to 25 percent range that had been mentioned the previous day.

Vice-Chair Saddler asked about any experience Ms. Tallman had with the 1332 innovation waivers under ACA. He asked if it would be a good move for the state.

Ms. Tallman answered that Premera did not have direct experience with the 1332 waiver. She explained the waiver was still in the very initial stages and it had not been formally explored by the State of Washington. Given the unique nature of the insurance market and the overall Alaskan market for insurance it would be a very positive way to look at longer-term solutions to address the high cost of healthcare in Alaska.

[10:07:06 AM](#)

Representative Gara referred to a reference to a disappearing federal tax that may be causing some of the problem. He asked if it was worth \$55 million. He wondered if the tax was ending for certain. He asked if other states were erupting over the issue because they were facing the same problem as Alaska.

Ms. Wing-Heier answered that the tax had been suspended for 2017 and the division did not know whether the federal government would reenact it at some point or not; the federal government had not committed one way or another. She explained the reinsurance had been eliminated and had sunset; to reinstate the reinsurance it would have to be passed in federal legislation. She reiterated that the tax had merely been suspended.

Representative Gara asked if it was the origin of the \$55 million new problem.

Ms. Wing-Heier replied in the negative. She explained Alaskans were paying the 3 percent tax and the \$2.25 per member per month fee. The goal was to consider what the net impact would be if both the 3 percent and the \$2.25 went away. She expounded if they took the net impact and put it into a state program so there was no additional cost. She continued the money had previously been paid to the federal

government and would now be paid to the state, which was how the division had come up with a rough number at \$20 per person, per month. The division did not realize the 3 percent was not being paid at the extent to the stop-loss carriers, which was an error in its calculation.

Co-Chair Thompson remarked that the committee was still hearing public testimony.

Representative Gara clarified that he had heard the question earlier but had not received an amount. He referred to the \$55 million.

Mr. Parady answered that it was not \$55 million. The department had arrived at \$55 million by multiplying \$20 per month for 236,000 insured individuals. He clarified that only 150,000 of the total were stop-loss and did not pay the tax. At best, the amount was one-third of the \$55 million.

Representative Gara stated that a number of people who qualified for ACHIA probably qualified for social security disability insurance also. He noted that Medicare was like an exclusive insurance program. He wondered if a person could qualify for social security disability health insurance and ACHIA could pay for any remaining costs.

[10:10:48 AM](#)

Ms. Tallman answered that it was a complex question and issue. She believed to the benefit of individuals who would qualify for both programs, they should certainly have the ability to tap into the program. She was unsure given the complexity of the interplay with the federal program.

Representative Kawasaki asked if Premera also operated in other small markets with very few insurers across the United States.

Ms. Tallman answered that Premera operated in the State of Washington. Additionally, it currently operated in Oregon, but would be leaving that market in 2017. Those states had a number of other competitors in the individual and group markets.

Representative Kawasaki stated it looked like there were 11 in Washington and 11 in Oregon. He observed that the rates

in Washington appeared to have dropped from 2015 to 2016 by 4 percent. He asked if Premera would anticipate a competitor coming into the market if ACHIA took the highest risk pool out of the equation.

Ms. Tallman would anticipate that it would provide some stability to the market and would be more attractive to competitors. She detailed that a program to help stabilize the market meant a company would not be faced with significant swings year-over-year. The program would be available to any insurer and she believed it would make the market more attractive for others.

Representative Wilson asked if any other state had a program like Alaska's ACHIA that helped to compensate for a specific group.

Ms. Tallman answered that the high risk pool, prior to ACA, had been in effect in a number of other states. The goal with the reinsurance program was to utilize the high risk pool and to do a similar thing to what it had been doing before a guaranteed issue. She detailed that Oregon was implementing what had previously been a temporary reinsurance program. She knew that other states were very interested in the program under discussion. She specified that Premera had conversations with other Blue Cross plans in Arizona, Illinois, and Texas, who were very interested to see how the program would work and if it could be applied in their states.

[10:13:57 AM](#)

JENNIFER JOLLIFFE, SELF, ANCHORAGE (via teleconference), shared that she is a small business owner in Anchorage. She was a large fan of having health insurance. She stated if insurance rates continued to increase at the same level they had in the past two years, her annual premium for 2017 could easily be \$16,800 with a \$6,500 deductible. She believed the amount was insane when compared to her income, which was not much over the qualifying rate for a tax subsidy. She asked the committee to consider what it would be like to not have health insurance even though they worked hard and contributed to the social and economic wellbeing of the state's communities. She did not want to be a person looking in the mirror and terrified to go to the doctor because she could not afford it. She implored the committee to think about Alaskans.

Co-Chair Thompson CLOSED public testimony.

Representative Wilson stated that 2.7 percent was going into a fund, which could exceed the \$55 million; however, the money was not specifically designated to one agency - it would be up to the department to utilize. She believed the change could mean increased competition in Alaska because the goal was to try to alleviate some of the high risk. Additionally, everybody on insurance paying the 2.7 percent would be funding the particular issue. She surmised that hopefully most everyone should benefit in some way - individuals may not see a decrease in what they pay, but hopefully the increase would not be as significant as it would be if no action was taken.

10:18:06 AM

Mr. Parady answered in the affirmative. The fund would be available to any insurer providing coverage and it would moderate the rate increase for the individual market.

Representative Wilson stated that the federal government may choose to continue the tax, but it was not yet known. She added the program and waiver could also change. She surmised that it was possible that in one or two years the money may not be needed due to potential federal changes.

Mr. Parady answered that it was the hope.

Vice-Chair Saddler believed the bill was focused at the individual health insurance market. He referred to the previous question related to all of the other policy holders who would pay the cost. He wondered if there were any other lines of insurance in the same dire straits as health insurance. He asked if there was a risk of other people going after the money.

Ms. Wing-Heier answered that at present the small group market, which was the only other market, was performing fairly well. She relayed she could not say it was performing excellently, but at present it was supporting itself.

Vice-Chair Saddler provided scenario that involved "a rash" of marijuana induced auto accidents and there was insufficient money to pay for all of the auto accident

collisions. He asked if the auto insurance industry would have access to the money. Ms. Wing-Heier answered in the negative. The fund was strictly for healthcare insurance through ACHIA.

Co-Chair Thompson relayed that the committee would reconvene later in the day to address a forthcoming CS.

10:20:32 AM

RECESSED

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RECONVENED

Co-Chair Thompson discussed the agenda.

Co-Chair Neuman MOVED to ADOPT the proposed committee substitute for HB 374, Work Draft 29-GH2126\N (Glover/Wallace, 5/27/16). There being NO OBJECTION, it was so ordered.

JANE PIERSON, STAFF, REPRESENTATIVE STEVE THOMPSON, explained the changes in the CS. She directed attention to Section 1, page 2, lines 1 through 5, which was a new section relating to the duties of the director to formulate general policy and adopt regulations to administer "this chapter" and to specify covered conditions that were eligible for payment from the Alaska Comprehensive Health Insurance fund. Under Section 2, page 2, lines 7 through 27 a new subsection was created in AS 21.55.430 that defined the disposition of proceeds from tax on insurance premiums. She detailed that insurance premium taxes collected would be deposited directly into the new Alaska Comprehensive Health Insurance fund. The legislature would then have the ability to appropriate monies from the fund to DCCED to pay claims under the ACHI reinsurance program. Section 2 further defined net proceeds that would be deposited into the fund.

5:19:40 PM

Representative Wilson pointed to page 2 lines 3 through 5 related to specifying covered conditions [eligible for payment through the fund]. She thought the bill was based on high risk individuals who may be outside "of that." She remarked that at present the list was very short. She asked if there would be the same type of list as the one

currently utilized for ACHIA. She asked for verification that even if people were rejected they would still have to be on the list.

Ms. Pierson deferred the question to the department.

Ms. Wing-Heier replied that the current ACHIA, which was a direct payment, had a very specific list of qualifying conditions. The reinsurance program would be different. She detailed that under the ACA everyone was guaranteed issue. The bill looked at taking the top cost drivers and only reinsuring those individuals under the ACA; those differed from what was under the old ACHIA. She explained there would still be a condition list, but only certain conditions would be eligible - it would not include everything under the ACA - otherwise it would assume every claim. She elaborated that under the first 21 months it would be the \$240 million paid. The bill only looked at taking \$55 million or whatever amount was appropriated by the legislature. She relayed that the \$55 million would address the top cost driver claims (shown in the claims data) for the first 21 months of the program started in 2014.

Representative Wilson pointed to the definition of high risk residents on page 2, beginning on line 29. She noted the definition specified an individual would have to be rejected for medical reasons [after applying for a subscriber contract]. She asked if an individual could be rejected, but not fall under the proposed plan.

Ms. Wing-Heier answered that the language had been left for the Medigap/Medsup policies [Medicare Supplemental Insurance]. To pick up the high risk residents or claims under the ACA, only subsection (C) [of Section 3] had been amended in the CS (in order to make it ACA compliant). To pick up the Medicare supplemental insurance payments under the old ACHIA, the language remained as-is in subsections (A) and (B) to keep the condition list in the current ACHIA. She relayed there were still constituents under the policy, there was not a market in Alaska for Medicare patients for pharmaceutical policies.

Representative Wilson wanted to ensure that with the passage of the bill situations would not occur where an individual may be unable to find insurance from the pool and could not qualify under the bill either. She remarked

the situation had happened in the past prior to the ACA where an individual with a high cost disease could not get coverage because they were not in one of the top high risk categories.

Ms. Wing-Heier answered that under the ACA it was guaranteed issue; no one could be rejected. The reinsurance bill was only defining the claims it would seat and pay with state funds.

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Representative Munoz asked if the payments would be made directly from the fund to the claimant or if the claims would go to the insurance company for payment. She asked if the individual purchased insurance through "your organization" or through ACHIA. Alternatively, she wondered if the individuals would still be under the insurance company.

Ms. Wing-Heier answered that people and families in the individual market would go to healthcare.gov, a broker, or a navigator, and would purchase insurance just as they did at present. Additionally, the individuals would submit claims just as they did at present. She noted that all of the mechanics were still being worked out, but in theory, Premera would pay the claims as they came in on a monthly basis. Those claims based on the 10 to 15 (or whatever the cutoff point may be) claims for the \$55 million or appropriated amount would be triggered and sent to ACHIA for payment. She furthered that ACHIA would then reimburse Premera; ACHIA and its administrator would carefully monitor the condition list against what was appropriated against what was submitted by Premera. She added that DCCED would oversee the entire process.

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Representative Gara asked for verification that the bill applied to people who would be covered under a private insurance company, but they would have conditions and the insurance company would go to the ACHIA program for some reimbursement to keep the cost down for the insurance company and hopefully the premiums down for the members. He noted that sometimes the two did not get tied together.

Ms. Wing-Heier replied in the affirmative. She detailed that at the same time reimbursement was sought for the claims, the premium would seat. She expounded that when an individual was diagnosed and the claim was seated, the premium was also seated. She continued that essentially the whole person (claim and premium) was seated to ACHIA for the policy year and the claims were paid by ACHIA.

Representative Kawasaki asked if it would be a negotiation. He remarked there were a very limited number of diseases currently covered under ACHIA. He asked if the issue would be up to the department to decide.

Ms. Wing-Heier answered that the bill focused on the top cost drivers that were causing premiums to see 40 percent increases for the third year in a row - it was not so much a decision, but what was driving the market. The bill was trying to remove the increases from the market through the reinsurance program.

Representative Kawasaki spoke to the mechanics of the program. He referred to the end of Section 1 of the legislation related to high risk residents and the Comprehensive Health Insurance fund. He asked for verification DCCED would be making the decisions. He clarified he was speaking about high cost individuals that the department was either negotiating with or talking to (current insurers) that the department would identify.

Ms. Wing-Heier answered that in January of the current year the division had submitted a "data call" to Assurant, Premera, and Moda. The division had asked the companies to provide the claim data from 2014 and 2015, which it had sent to an independent actuary. The actuary had reviewed all of the losses for the three insurers that were doing business in the individual market. She noted Aetna only had a handful of insurers (103) and had been excused from the data call. The actuary had listed the top claims included in the data provided. She clarified that instead of having the division make the call, it had asked the actuary to aggregate and list the data of the three insurers from the highest cost claims down.

Representative Kawasaki surmised that it could pertain to an individual with multiple complications within a particular list. He asked how the situation would work.

Ms. Wing-Heier answered that the division had gone from a diagnosis code to a fixed code to ensure it was not double counting. The process had dropped the number of claimants in half. For example, the division was looking at individuals as opposed to a person with asthma and cancer. She explained it was the reason the division was looking at the entire treatment of a person and their premium instead of only picking up certain doctor bills or treatments.

[5:30:32 PM](#)

Representative Gara MOVED to ADOPT Conceptual Amendment 1:

Page 1, line 1, following "Act":

Insert "relating to coverage under the Comprehensive Health Insurance Association;"

Page 1, following line 5:

Insert a new bill section to read:

"* Section 1. AS 21.55.320 is amended by adding a new subsection to read:

(b) When a person with a disability that is covered under 42 U.S.C. 1935 - 1935b-10 (Title XVIII of the Social Security Act) is referred by an insurer to a state plan under AS 21.55.310, the plan administrator shall request that the Department of Health and Social Services provide information to the person about applying for the federal benefits."

Page 1, line 6:

Delete "Section 1"

Insert "Sec. 2"

Renumber the following bill sections accordingly.

Page 3, line 24:

Delete "Section 2"

Insert "Section 3"

Page 3, line 25:

Delete "Sections 1 and 3 - 5"

Insert "Sections 1, 2, and 4 - 6"

Co-Chair Thompson OBJECTED for discussion.

Representative Gara explained there was social security disability insurance that was disability-based as opposed to asset or income-based. He noted it was a determination about whether or not a person could work. He explained there were a number of conditions covered by ACHIA (e.g. end-stage liver disease, acute liver failure, cystic fibrosis, and other). He relayed that many of the individuals could not work and qualified for the definition of disability. Currently if a person was receiving social security disability they could not be on the ACHIA plan. He discussed the bill's substantial cost. He had worked with DCCED and the Department of Health and Social Services (DHSS) and the departments would like to help refer people to get the federal insurance they were entitled to because of their condition. He elaborated it would mean the individuals and the state would not have to pay for the insurance. He believed it was a win-win scenario. The amendment specified the departments should help individuals through the process to apply for the disability insurance when eligible.

Representative Wilson believed a lawyer was needed to go through the social security disability [application process]. She remarked it was not merely about filling out a form. She asked if a person could get the insurance without actually qualifying and being put into social security disability. She did not believe so.

Ms. Wing-Heier answered that when a person applied in the marketplace at healthcare.gov, they were asked if they had a disability. In theory the application was then sent to Medicare or Medicaid and CMS sent it to the state agency. She furthered that in theory what Representative Gara was suggesting should be taken care of. However, in the event that someone was not taken care of, the amendment was asking the departments to double check to ensure the proper benefits were being applied when the departments sent the claim on to Medicare or Medicaid.

Representative Wilson spoke to social security disability. She believed there were disabled people who could be on the list and qualify for ACHIA who were working and did not want social security disability because it could "mess with everything else" a person had. She thought the amendment would require individuals to go through the process because there was a chance they would qualify for social security, which would provide insurance. She agreed it would work,

but she believed a person who was working and had a disability would have to go after social security disability even if they did not want to or they would not be covered.

Representative Gara countered that the amendment did not do what Representative Wilson thought it did. He pointed to line 11 and explained the amendment did not require individuals to get on social security disability. He added there were other related laws the amendment did not address. He clarified the amendment would ask the departments to provide individuals with the information about how to apply [for social security disability]; it did not require a person to apply. He stated that individuals in the condition often did not have much money and often did not know their way through the federal bureaucracy. He underscored the amendment would only specify that individuals would be given information about how to apply. He furthered it was insurance the individuals were entitled to at no cost. He believed the individuals should not be stuck paying high premiums because they did not know about a program they could apply for. He emphasized a lawyer was not needed to get social security disability; however, if a person was denied the benefit they may need an attorney to help them with the appeal process.

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Co-Chair Thompson stated that based on personal experience, social security was not that difficult to deal with. He shared that his wife had gone through chemotherapy for two years and had been unable to work. He furthered that social security had requested a letter from her doctor and she was able to immediately begin drawing social security benefits at 52 years of age. He stated that it was not a big process that required an attorney. He added the amendment pertained to slightly different situations; his wife had drawn social security payments like she had retired.

Representative Wilson understood the amendment slightly better. She surmised the amendment specified the departments would merely provide individuals with the paperwork needed to apply [for social security disability]. She initially thought the amendment would force individuals to apply for the benefit. She read from the amendment and surmised the departments would merely provide the

application information to individuals to use if they chose.

Ms. Wing-Heier answered in the affirmative.

Representative Wilson clarified that it was not possible to just get a federal insurance without being qualified as disabled. She reiterated her understanding of the amendment and relayed she was fine with its action. She wanted to ensure the state was not forcing working individuals who had a disability into a federal system they did not want to use.

Co-Chair Thompson noted that Representative Liz Vasquez was in the audience.

Representative Gattis stated she did not know any specifics on how a person received social security disability insurance benefits. She remarked that because the amendment was only about providing information to individuals, she did not need further information about the process.

Co-Chair Thompson WITHDREW his OBJECTION to Conceptual Amendment 1. There being NO OBJECTION, Conceptual Amendment 1 was ADOPTED.

Vice-Chair Saddler addressed the fiscal note from the Department of Commerce, Community and Economic Development, which called for an appropriation of \$55 million in FY 17 in the grants and benefits line and included no changes in positions.

Representative Wilson wanted to ensure the \$55 million was not GF and would be funds collected with the 2.7 percent tax.

Mr. Teal explained that the premium tax collections went into the fund. The premium taxes were currently classified as UGF, but as soon as the legislature specified the revenue was directed to a specific fund for a specific purpose they became DGF. He provided a scenario where the premium taxes generated totaled \$65 million, which he noted may be more accurate than \$55 million. He explained it did not matter how much was collected. The collections would go into the fund and the legislature could appropriate money from the fund to the Division of Insurance. He explained under the scenario \$55 million could be allocated to the

division and would put a cap on the amount the department could spend for the program.

Representative Wilson asked if the \$55 million would be a cap "from here on out." Mr. Teal answered in the negative. He explained the cap would be whatever the legislature decided upon. He furthered if it turned out that insurance premiums continued to rise, taxes rose, and there was \$70 million collected in FY 17, the \$70 million would go into the fund and the legislature would decide how much of the amount it wanted to appropriate. He elucidated that any flow to the fund and the appropriations from the fund were not necessarily connected. He added they were connected in a way because the legislature could not appropriate more money than it had.

Co-Chair Neuman MOVED to REPORT CSHB 374(FIN) as amended out of committee with individual recommendations and the accompanying fiscal note.

Representative Kawasaki OBJECTED. He recognized that the legislation was a stopgap bill. He referred to a 37 percent increase in September of 2014 and another 38 percent in 2014 and surmised the bill represented a "Band-Aid on a bullet hole." He stressed the importance of solving the healthcare cost increase problem in Alaska. He hoped it was a project the committee could undertake over the interim. He expressed hope that the \$55 million would go a long way in the coming year, but he believed it was "looking down the barrel of a gun."

Representative Kawasaki WITHDREW his OBJECTION.

Vice-Chair Saddler noted that Section 4 of the legislation gave the Division of Insurance director the authority to apply for the innovation waiver. He encouraged Ms. Wing-Heier to do so.

Ms. Wing-Heier confirmed the division would apply for the waiver.

There being NO further OBJECTION, CSHB 374(FIN) was REPORTED out of committee as amended with a "do pass" recommendation and with one new fiscal impact note from the Department of Commerce, Community and Economic Development.

Co-Chair Thompson addressed the schedule for upcoming meetings.

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ADJOURNMENT

5:45:13 PM

The meeting was adjourned at 5:45 p.m.