HB

5889

STATE OF ALASKA
THE LEGISLATURE

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May, 1986

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Jeanie Henry

House Judiciary	4/18/86	8:00 Am
" "	4/22/86	8:00 Am

HOUSE

COMMITTEE REPORT

(7)

Date referred: 4/8/86

FURTHER REFERRALS: FINANCE

DATE: _____

The JUDICIARY Committee has considered HB 589

"An Act relating to participation in the state group life and health insurance policies by residents; and providing for an effective date."

and recommends:

[ ] do pass

[ ] do not pass

[ ] do pass with attached amendment(s)

[ ] no recommendation

[ ] replace with _____ [ ] same title

[ ] new title

and recommends _____

[ ] further referral to the _____ Committee

and attaches: [ ] letter of intent
[ ] first fiscal note
[ ] new fiscal note
[ ] zero fiscal note

SIGNING DO PASS:

SIGNING OTHER RECOMMENDATIONS:

Max Sturnberg Jr No Rec

do not pass

Chairman

Version #2
Lauterbach
4/21/86

Original sponsors: Sund, M.M.Miller,
Hurley, et al

IN THE HOUSE BY THE JUDICIARY COMMITTEE

CS FOR HOUSE BILL NO. 589 (Judiciary)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to disability insurance; and providing for an effective date."

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

* Section 1. AS 21 is amended by adding a new chapter to read:

CHAPTER 55. STATE DISABILITY INSURANCE.

ARTICLE 1. COMPREHENSIVE DISABILITY INSURANCE ASSOCIATION.

Sec. 21.55.010. CREATION; MEMBERSHIP. There is established a nonprofit incorporated legal entity to be known as the Comprehensive Disability Insurance Association. Membership consists of all licensed hospital or medical service corporations in the state that offer subscriber contracts for major medical coverage and all insurers licensed to transact disability insurance in the state that offer policies for major medical coverage on an expense incurred basis. All members shall maintain membership in the association as a condition of doing disability insurance business, or being able to offer subscriber contracts, in the state.

Sec. 21.55.020. BOARD OF DIRECTORS; ORGANIZATION. The board of directors of the association shall be made up of seven individuals selected by participating members, subject to approval by the director of the division of insurance. The director or the director's designee shall serve as a nonvoting ex officio member of the board. In determining voting rights at members' meetings, a member is entitled to vote in person or proxy. The vote shall be [illegible]

coverage on an expense incurred basis, or the member's subscriber fees, derived from or on behalf of state residents in the previous calendar year, as determined by the director. In approving members of the board, the director shall consider, among other things, whether all types of participating members are fairly represented. Members of the board other than the director or the director's designee may be reimbursed from the association for expenses incurred by them as members, but may not otherwise be compensated by the association for their services. The costs of conducting meetings of the association and its board of directors shall be borne by members of the association.

Sec. 21.55.030. GENERAL POWERS. The association may

(1) exercise the powers granted to insurers under the laws of the state;

(2) sue or be sued;

(3) enter into contracts with insurers, similar associations in other states, or with other persons for the performance of administrative functions;

(4) establish administrative and accounting procedures for the operation of the association.

Sec. 21.55.040. PLAN OF OPERATION. (a) The association shall submit to the director a plan of operation and any amendments necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation and amendments become effective upon approval in writing by the director. If the association fails to submit a suitable plan of operation by a date that is 180 days after the effective date of this Act, or if at any subsequent time the association fails to submit suitable amendments to

regulations necessary or advisable to effectuate the provisions of this chapter. These regulations shall continue in force until modified by the director or superseded by a plan submitted by the association and approved by the director.

(b) All members of the association shall comply with the plan of operation.

(c) The plan of operation shall

(1) establish the procedures whereby all the powers and duties of the association under this chapter will be performed;

(2) establish procedures for handling assets of the association;

(3) establish the amount and method of reimbursing members of the board of directors under AS 21.55.020;

(4) establish regular places and times for meetings of the board of directors;

(5) establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;

(6) provide that any member insurer aggrieved by a final action or decision of the association may appeal to the director within 30 days after the action or decision;

(7) establish the procedures whereby selections for the board of directors will be submitted to the director;

(8) contain additional provisions necessary or proper for the execution of the powers and duties of the association.

Sec. 21.55.050. ADMINISTRATIVE PROCEDURE ACT. The association is exempt from the Administrative Procedure Act (AS 44.62).

Sec. 21.55.060. TAX EXEMPTION. The association is exempt from

political subdivisions except taxes levied on real or personal property.

ARTICLE 2. STATE DISABILITY INSURANCE PLANS.

Sec. 21.55.100. TYPES OF INSURANCE PLANS. (a) The association shall make available to residents who are high risks an individual state plan of disability insurance. The association shall offer three alternatives related to deductibles as described in AS 21.55.120.

(b) The association shall make available to residents who are high risks and 65 years of age or older a medicare supplement plan that meets the minimum policy standards and minimum benefit standards established by regulations adopted by the director under AS 21.89.060.

(c) The association may not deny coverage under a state plan to a resident who satisfies the requirements of AS 21.55.300 - 21.55.310. The association shall determine whether a person is a high risk in accordance with AS 21.55.500(9) and the director's regulations.

Sec. 21.55.110. MINIMUM BENEFITS OF STATE DISABILITY INSURANCE PLAN. Except as provided in AS 21.55.120 - 21.55.140, the minimum standard benefits of a disability insurance plan offered under AS 21.-55.100(a) shall be benefits with a lifetime maximum of $1,000,000 per individual, for usual, customary, reasonable, or prevailing charges or, when applicable, the allowance agreed upon between a provider and the writing carrier for charges, for the following medical services performed for an individual covered by the plan for the diagnosis or treatment of nonoccupational disease or nonoccupational injury:

(1) hospital services;

(2) subject to the limitations of AS 21.36.090(d). professional services that are rendered by a physician or by a registered nurse at the physician's direction, other than services for mental or

(3) the diagnosis or treatment of mental conditions, as defined in regulations of the director, rendered during the year on other than an inpatient basis, up to a yearly maximum benefit of $4,000;

(4) legend drugs requiring a physician's prescription;

(5) services of a skilled nursing facility for not more than 120 days in a policy year;

(6) home health agency services up to a maximum of 270 visits in a calendar year if the services commence within seven days following confinement in a hospital or skilled nursing facility of at least three consecutive days for the same condition, except that in the case of an individual diagnosed by a physician as terminally ill with a prognosis of six months or less to live, the home health agency services may commence irrespective of whether the covered person was previously confined or, if the covered person was confined, irrespective of the seven-day period, and the yearly benefit for medical social services may not exceed $200;

(7) hospice services for up to six months in a calendar year;

(8) use of radium or other radioactive materials;

(9) outpatient chemotherapy;

(10) oxygen;

(11) anesthetics;

(12) nondental prosthesis and maxillo-facial prosthesis used to replace any anatomic structure lost during treatment for head and neck tumors or additional appliances essential for the support of the prosthesis;

(13) rental, or purchase if purchase is more cost effective

the absence of the condition for which it was prescribed;

(14) diagnostic x-rays and laboratory tests;

(15) oral surgery for excision of partially or completely unerupted impacted teeth or excision of a tooth root without the extraction of the entire tooth;

(16) services of a licensed physical therapist rendered under the direction of a physician;

(17) transportation by a local ambulance operated by licensed or certified personnel to the nearest health care institution for treatment of the illness or injury and round trip transportation by air to the nearest health care institution for treatment of the illness or injury if the treatment is not available locally; if the patient is a child under 12 years of age, the transportation charges of a parent or legal guardian accompanying the child may be paid if the attending physician certifies the need for the accompaniment;

(18) confinement in a licensed or certified facility established primarily for the treatment of alcohol or drug abuse or in a part of a hospital used primarily for this treatment, for a period of at least 45 days within any calendar year;

(19) alternatives to inpatient services as defined by the association in the state plan benefits;

(20) second surgical opinions;

(21) other services that are medically necessary in the treatment or diagnosis of an illness or injury as may be designated or approved by the director.

Sec. 21.55.120. DEDUCTIBLES AND COPAYMENTS. (a) A state plan other than a medicare supplement plan may require deductibles of $200 a person $500 a person, or $1,000 a person. The amount of the deduc-

basis than when that service is offered on an inpatient basis. Expenses incurred during the last three months of a calendar year and actually applied to an individual's deductible for that year shall also be applied to that individual's deductible in the following calendar year. The $200 maximum, the $500 maximum, and the $1,000 maximum may be adjusted yearly to correspond with the change in the medical care component of the consumer price index, as adjusted by the director. The base year for the computation shall be the first full calendar year of operation of the association.

(b) A state plan other than a medicare supplement plan shall require a maximum copayment of 20 percent for charges for all types of health care in excess of the deductible and 50 percent for services described in AS 21.55.110(3) in excess of the deductible.

(c) The sum of the deductible and copayments required in any calendar year under a plan may not exceed a maximum limit of $2,000 per covered individual. Covered expenses incurred after the applicable maximum limit has been reached shall be paid at the rate of 100 percent of usual, customary, reasonable, or prevailing charges, except that expenses incurred for treatment of mental and nervous conditions shall be paid at the rate of 50 percent. The $2,000 maximum shall be adjusted yearly to correspond with the change in the medical care component of the consumer price index as adjusted by the director.

(d) In this section, "consumer price index" means the consumer price index for all urban consumers for the Anchorage Metropolitan Area compiled by the Bureau of Labor Statistics, United States Department of Labor.

Sec. 21.55.130. PREEXISTING CONDITIONS. (a) A preexisting condition exclusion in a state plan may not exclude coverage of a preexisting condition unless

(1) the condition first manifested itself within the period of three months immediately before the effective date of coverage in a manner that would cause a reasonably prudent person to seek diagnosis, care, or treatment; or

(2) medical advice or treatment was recommended or received within the period of three months immediately before the effective date of coverage.

(b) A policy may not exclude coverage for a loss due to pre-existing conditions for a period greater than six months following the effective date of coverage.

(c) A state plan issued to a person whose previous subscriber contract, disability policy, or medicare supplement policy was involuntarily terminated shall credit the time covered under the previous contract or policy toward an exclusion for preexisting conditions under the state plan if the previous contract or policy had a similar preexisting condition exclusion and the person applies for a state plan within 31 days after termination of the previous contract or policy. If a person covered by this subsection is accepted by the writing carrier and pays a specified premium for retroactive coverage, the state plan is effective retroactively to the date on which the person's previous contract or policy terminated.

Sec. 21.55.140. CARE AND SERVICES NOT COVERED. A state plan may not provide benefits for charges for the following:

(1) care for an injury or disease either

(A) arising out of and in the course of an employment subject to a workers' compensation or similar law or where the benefit is required to be provided under a workers' compensation policy to a sole proprietor, business partner, or corporation officer; or

(B) to the extent benefits are payable without regard to fault under a coverage statutorily required to be contained in a motor vehicle or other liability insurance policy or equivalent self-insurance;

(2) treatment for cosmetic purposes other than surgery for the prompt repair of an accidental injury sustained while covered or for replacement of an anatomic structure removed during treatment of tumors;

(3) travel, other than transportation covered under AS 21.-55.110(17);

(4) private room accommodations to the extent it is in excess of the institution's most common charge for a semiprivate room;

(5) services or articles to the extent that the charge exceeds the reasonable charge in the locality for the service;

(6) services or articles that are determined not to be medically necessary, except for the fabrication or placement of the prosthesis as specified in AS 21.55.110(12) and (2) of this section;

(7) services or articles the provision of which is not within the scope of the license or certificate of the institution or individual rendering the services or articles;

(8) services or articles furnished, paid for or reimbursed directly by or under any law of a government, except as otherwise provided in this chapter;

(9) services or articles for custodial care or designed primarily to assist an individual in the activities of daily living;

(10) service charges that would not have been made if no insurance existed or for which the covered individual is not legally obligated to pay;

(11) eyeglasses, contact lenses, or hearing aids or the

fitting of them;

(12) dental care not specifically covered by this chapter;

(13) services of a registered nurse who ordinarily resides in the covered individual's home, or who member of the covered individual's family or the family of the individual's spouse;

(14) experimental procedures; and

(15) services and supplies for which the patient was not charged.

Sec. 21.55.150. STATE PLAN PREMIUMS. (a) The association may not charge a rate for coverage issued by or through the association that is excessive, inadequate, or unfairly discriminatory.

(b) The association shall use separate scales of premium rates based on age and geographic location of the insured.

(c) The five members of the association that insure, or have subscriber contracts with, the largest number of individuals in the state under plans with benefits substantially equivalent to the state plan benefits shall submit to the association an estimate of the rate that would be actuarially sound for a person who is a standard risk for coverage substantially equivalent to the state plan. The premium for a state plan may not exceed 150 percent of the average of those five estimates.

ARTICLE 3. ADMINISTRATION OF PLANS.

Sec. 21.55.200. SELECTION OF WRITING CARRIERS. The association shall develop bid specifications for members that wish to be selected as a writing carrier to administer a state plan. The selection of the writing carrier shall be based upon criteria including the member's proven ability to handle a large number of disability insurance cases or subscriber contracts, efficient claim paying capacity, and the estimate of total charges for administering the plan.

Sec. 21.55.210. DUTIES OF WRITING CARRIERS. (a) The writing carrier shall perform the administrative and claims payment functions required by this section. The writing carrier shall provide these services for a period of three years, unless a request to terminate is approved by the director. The director shall approve or deny a request to terminate within 90 days of its receipt. A failure to make a final decision on a request to terminate within the specified period shall be considered an approval. Six months before the expiration of each three-year period, the association shall invite submissions of policy forms from members of the association, including the writing carrier. The association shall follow the provisions of AS 21.55.210 in selecting a writing carrier for the subsequent three-year period.

(b) The writing carrier shall provide to all eligible persons enrolled in a state plan an individual policy or certificate, setting out a statement of the insurance protection to which the person is entitled, with whom claims are to be filed, and to whom benefits are payable. The policy or certificate must indicate that coverage was obtained through the association.

(c) The writing carrier shall submit to the association and the director on a quarterly basis a report on the operation of the state plans. Specific information to be contained in the report shall be determined by the association.

(d) Claims shall be paid by the writing carrier and shall indicate that the claim was paid under a state plan. A claim payment shall include a telephone number that can be used for inquiries regarding the claim.

(e) The writing carrier shall be reimbursed from the state plan premiums received for its direct and indirect expenses for administer-

reimbursement for that portion of the writing carrier's administrative, printing, claims administration, management and building overhead expenses that are assignable to the maintenance and administration of the state plans. The association shall approve cost accounting methods to substantiate the writing carrier's cost reports consistent with generally accepted accounting principles. Direct and indirect expenses may not include costs directly related to the original submission of policy forms before selection as the writing carrier.

(f) The writing carrier shall at all times when carrying out its duties under this chapter be considered an agent of the association.

Sec. 21.55.220. OPERATION OF THE PLAN. (a) Upon notification as an eligible person under AS 21.55.320, a person may enroll in a state plan by payment of the appropriate state plan premium to the writing carrier.

(b) An employer that has in its employ one or more eligible persons enrolled in a state plan may make all or a portion of a state plan premium payment directly to the writing carrier.

(c) Each member of the association shall share the losses due to claims expenses of the state plans for plans issued or approved for issuance by the association, and shall share in the operating and administrative expenses incurred or estimated to be incurred by the association incident to the conduct of its affairs. Claims expenses of the state plan that exceed the premium payments allocated to the payment of benefits shall be the liability of the members. Each member shall share in the claims expense of the state plans and operating and administrative expenses of the association in an amount equal to the ratio of the member's total fees for subscriber contracts or total disability insurance premiums, received from or on behalf of

disability insurance premiums received by all members from or on behalf of state residents, as determined by the director.

(d) The association shall make an annual determination of each member's liability, if any, and may make an annual fiscal year end assessment if necessary. The association may also, subject to the approval of the director, provide for interim assessments against the members as may be necessary to assure the financial capability of the association in meeting the incurred or estimated claims expenses of the state plans and operating and administrative expenses of the association until the association's next annual fiscal year end assessment. Payment of an assessment is due within 30 days of receipt by a member of a written notice of a fiscal year end or interim assessment. Failure by a member to tender to the association the assessment within 30 days shall be grounds for revocation of a member's certificate of authority. A member that ceases to do disability insurance business in the state, or ceases to offer subscriber contracts in the state, due to revocation, suspension, or voluntary surrender of its certificate of authority remains liable for assessments through the calendar year during which the disability insurance business ceased. The association may decline to levy an assessment against a member if the assessment would not exceed $10. Assessments paid by a member are a general expense of the member.

(e) Net gains, if any, from the operation of the state plans shall be held at interest and used by the association to offset future losses due to claims expenses of a state plan or allocated to reduce state plan premiums.

ARTICLE 4. ENROLLMENT IN THE STATE DISABILITY INSURANCE PLAN.

Sec. 21.55.300. ELIGIBILITY FOR STATE DISABILITY INSURANCE. (a) Except as provided in (b) of

high risk is eligible to enroll in a state plan described in AS 21.-55.100.

(b) A person may not be covered by the state plan while covered by another disability policy or subscriber contract. Upon ceasing to be a resident a person is not eligible to purchase or renew coverage under a state plan, but previously purchased coverage remains in effect for the period covered by payments made while a resident.

(c) Additional eligibility requirements may not be imposed by the director, the association, or a writing carrier.

Sec. 21.55.310. ENROLLMENT BY AN ELIGIBLE PERSON. A person may enroll in a state plan by applying to the writing carrier. The application must include the following:

(1) name, address, age, and length of time at residence of the applicant;

(2) a designation of the plan desired, including deductible option chosen;

(3) information relevant to whether the person is a high risk.

Sec. 21.55.320. WRITING CARRIER'S RESPONSE. Within 30 days after receiving the certificate described in AS 21.55.310, the writing carrier shall either reject the application for failing to comply with the requirements of AS 21.55.300 and 21.55.310 or forward the eligible person a notice of acceptance and billing information.

Sec. 21.55.330. EFFECTIVE DATE OF POLICIES. (a) Except as provided in (b) of this section and AS 21.55.130(c), insurance under a state plan is effective immediately upon receipt of the first quarterly premium, and is retroactive to the date of the application, if the applicant otherwise complies with the requirements of this

(b) Insurance under a state plan is effective retroactively to the date on which the person's previous contract or policy terminated if the person

(1) applies for a state plan within 60 days after the previous contract or policy terminated;

(2) is accepted by the writing carrier; and

(3) pays a specified premium for the period of retroactive coverage.

Sec. 21.55.340. SOLICITATION OF ELIGIBLE PERSONS. (a) The association, under a plan approved by the director, shall disseminate appropriate information to the residents of the state regarding the existence of the state plans and the means of enrollment. Means of communication may include use of the press, radio, and television, as well as publication in appropriate state offices and publications.

(b) The association shall devise and implement means of maintaining public awareness of the provisions of this chapter regarding the state plans and shall administer this chapter in a manner that facilitates public participation in the state plans.

(c) Selling or marketing of qualified state plans is limited to licensed disability insurance agents.

(d) An insurer or hospital or medical service corporation that rejects or applies underwriting restrictions to an applicant for a subscriber contract, a disability insurance policy, or a medicare supplement plan in the state shall notify the applicant of the existence of the state plans, the requirements for being accepted, and the procedure for applying.

ARTICLE 5. GENERAL PROVISIONS.

Sec. 21.55.400. DUTIES OF DIRECTOR. The director may

association and approve the association's contract with the writing carrier including the coverages and premiums to be charged;

(2) contract with the federal government or another unit of government to ensure coordination of the state plans with other governmental assistance programs;

(3) undertake directly or through contracts with other persons studies or demonstration programs to develop awareness of the benefits of this chapter; and

(4) adopt regulations necessary to administer this chapter.

Sec. 21.55.410. STATE NOT LIABLE. The state is not liable for acts or omissions of the association or a writing carrier under this chapter, nor is the state liable for payment of a claim under a state plan issued by a writing carrier.

Sec. 21.55.500. DEFINITIONS. In this chapter

(1) "association" means the Comprehensive Disability Insurance Association created in AS 21.55.010;

(2) "copayment" means the portion of the eligible expenses, in excess of the deductible, for which the insured is responsible;

(3) "deductible" means the portion of eligible expenses for which the insured is responsible in each calendar year under AS 21.-55.120(a);

(4) "home health agency services" means any of the following services provided upon recommendation of a licensed physician as part of a treatment plan:

(A) intermittent or part-time nursing services of a registered professional nurse or a licensed practical nurse, that are provided to a person under the continued direction of the person's physician and within the limitation of the nurse's

(B) nursing services that are provided to a person at the person's residence, including a residential care facility or adult boarding home; a hospital, skilled nursing facility or intermediate care facility is not considered a residence;

(C) home health aide services that are prescribed by and under the continued direction of a physician and supervised by a professional nurse;

(D) home health aide services that are provided to a person at the person's residence, as described in (B) of this paragraph;

(E) physical and occupational therapy services, speech pathology, and audiology services that are prescribed by a physician and provided to a person by or under the supervision of a qualified practitioner; these services may be provided to a person who is a patient in an intermediate care facility or skilled nursing facility;

(5) "hospice services" means services provided under a coordinated comprehensive program of palliative and supportive care on a 24-hour, seven days per week basis for persons who have been diagnosed as terminally ill and their families by an interdisciplinary team of professionals or volunteers under an incorporated central administration that has a physician as medical director;

(6) "major medical coverage" means a disability insurance contract, or a subscriber contract, that provides benefits for hospital and medical care with potential lifetime maximum benefits per insured of at least $10,000;

(7) "medical social services" means services rendered the patient under the direction of a physician by a qualified social

work, including assessment of the social, psychological and family problems related to or arising out of the covered person's illness and treatment, appropriate action and utilization of community resources to assist in resolving the problems, and participation in the development of treatment for the covered person;

(8) "resident" means a person who is physically present in the state, has lived in the state for at least the six consecutive months immediately preceding application for a state plan, and intends to remain permanently in the state; "resident" also includes a person who is not physically present in the state if the person lived in the state for at least six of the nine months immediately preceding application for a state plan and the person's absence from the state is for medical treatment; a person ceases to be a resident if the person is absent from the state for more than 90 consecutive days for reasons other than for medical treatment or education;

(9) "residents who are high risks" means residents who

(A) have been rejected for medical reasons after applying for a subscriber contract, a policy of disability insurance, or a medicare supplement policy by at least two association members within the six months immediately preceding the date of application for a state plan; or

(B) have had a restrictive rider placed on a subscriber contract, a disability insurance policy, or a medicare supplement policy;

(10) "state plan" means a policy of insurance offered by the association through a writing carrier;

(11) "usual, customary, reasonable, or prevailing charge" means the charge for a medical care procedure, service, or supply item

(A) the billed amount for the medical service provider's actual charge;

(B) the charge usually made by that provider for performing that procedure or service or for providing the supply item; or

(C) the customary charge, based on a profile of charges made for the same medical procedure, service, or supply item in the same geographical area by other providers that have performed the same procedure or service or can provide the same supply item;

(12) "writing carrier" means the insurer or insurers selected by the association and approved by the director to administer a state plan.

* Sec. 2. The association established by sec. 1 of this Act shall make available to residents the plans required by AS 21.55.100, enacted in sec. 1 of this Act, by July 1, 1987.

* Sec. 3. This Act takes effect immediately in accordance with AS 01.-10.070(c).

CORRECTION

Discard HB 589 & Replace with New one

and retain this corrected version.

Introduced: 2/14/86
Referred: Labor & Commerce
Judiciary and Finance

IN THE HOUSE

BY SUND,M.M.MILLER,HURLEY, DUNCAN,NAVARRE,AND DAVIS

HOUSE BILL NO. 589

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to participation in the state group life and health insurance policies by residents; and providing for an effective date."

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

* Section 1. AS 39.30.090 is amended to read:

Sec. 39.30.090. PROCUREMENT OF GROUP INSURANCE. The Department of Administration may obtain a policy or policies of group insurance covering state employees, persons entitled to coverage under AS 14.-25.168, AS 22.25.090, AS 39.35.535 or former AS 39.37.145, [OR] employees of other participating governmental units, or eligible residents, subject to the following conditions:

(1) A group insurance policy shall provide one or more of the following benefits: life insurance, accidental death and dismemberment insurance, weekly indemnity insurance, hospital expense insurance, surgical expense insurance, dental expense insurance, audio-visual insurance, or other medical care insurance.

(2) Each eligible employee of the state, the spouse and the unmarried children chiefly dependent on the eligible employee for support, and each eligible employee of another participating governmental unit shall be covered by the group policy, unless exempt under regulations adopted by the commissioner of administration.

(3) A governmental unit may participate under a group policy if

(A) its governing body adopts a resolution authorizing

participation, and payment of required premiums;

(B) a certified copy of the resolution is filed with the Department of Administration; and

(C) the commissioner of administration approves the participation in writing.

(4) The Department of Administration shall obtain the insurance policy from an [ANY] insurer authorized to transact business in the state under AS 21.09 and AS 21.90.

(5) The Department of Administration shall make available bid specifications for desired insurance benefits to all insurance carriers licensed in the state and qualified to provide the desired benefits. The specifications shall be made available on or before July 1, 1965, and at least once every succeeding five years. The lowest responsible bid submitted by an insurance carrier with adequate servicing facilities shall govern selection of a carrier under this section.

(6) If the aggregate of dividends payable under the group insurance policy exceeds the governmental unit's share of the premium, the excess shall be applied by the governmental unit for the sole benefit of the employees.

(7) A person receiving benefits under AS 14.25.110, AS 22.25, AS 39.35, or former AS 39.37 may continue the life insurance coverage that was in effect under this section at the time of termination of employment with the state or participating governmental unit.

(8) A person electing to have insurance under (7) of this section shall pay the cost of this insurance.

(9) For each permanent part-time employee electing coverage under this section, the state shall contribute one-half the state contribution rate for permanent full-time state employees, and the

permanent part-time employee shall contribute the other one-half.

(10) A person receiving benefits under AS 14.25, AS 22.25, AS 39.35, or former AS 39.37 may obtain auditory, visual, and dental insurance for that person and eligible dependents under this section. The level of coverage for persons over 65 shall be the same as that available before reaching age 65 except that the benefits payable shall be supplemental to any benefits provided under the federal old age, survivors, and disability insurance program. A person electing to have insurance under this paragraph shall pay the cost of the insurance. The commissioner of administration shall adopt regulations implementing this paragraph.

(11) An eligible resident may participate if the resident applies on forms provided by the department, pays the cost of the insurance and the administrative fee set by the department, and the commissioner of administration approves the application in writing.

* Sec. 2. AS 39.30.095(a) is amended to read:

(a) The commissioner of administration shall establish the group health and life benefits fund as a special account in the general fund to provide for group life and health insurance under AS 39.30.090 and 39.30.160. The commissioner shall maintain accounts and records for the fund. The fund consists of employer contributions, employee contributions, resident contributions, appropriations from the legislature, and interest earned on investment of the fund as provided in (d) of this section.

* Sec. 3. AS 23.30.095(b) is amended to read:

(b) After obtaining the advice of an actuary, the commissioner of administration shall determine the amount necessary to provide benefits under AS 39.30.090 and 39.30.160 and shall set the rate of employer contribution, resident contribution, and employee contri-

bution, if any. The commissioner of administration shall pay premiums and claims in accordance with the insurance policies in effect under AS 39.30.090 and 39.30.160 with money in the fund.

* Sec. 4. AS 39.30.100 is amended by adding a new paragraph to read:

(4) "eligible resident" means a person who is a resident and who has been a resident, except for absences from the state for military service or necessary medical care, for the 12 consecutive months immediately preceding the date of application.

* Sec. 5. By January 1, 1987, the commissioner of administration shall secure a group health and life policy or policies to provide coverage for persons who will become eligible for coverage under amendments made by this Act.

* Sec. 6. Sections 1 - 4 of this Act take effect on the date that the commissioner of administration has secured coverage under sec. 5 of this Act.

* Sec. 7. Section 5 of this Act takes effect immediately in accordance with AS 01.10.070(c).

STATE OF ALASKA 1986 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date: _____

REQUEST

Bill/Resolution No.: CSHB 589 (L&C)
Title: Relating to disability insurance.

Sponsor: Labor & Commerce Committee
Requester: _____
Date of Request: _____

FISCAL DETAIL

Agency Affected: Commerce & Economic Development
BRU: Insurance

Components: Public Protection

EXPENDITURES / REVENUES: (Thousands of Dollars)

OPERATING	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
PERSONAL SERVICES	-0-	-0-	-0-	-0-	-0-	-0-
TRAVEL	-0-	10.0	2.0	2.6	3.2	4.0
CONTRACTUAL	-0-	25.0	25.0	25.0	25.0	25.0
SUPPLIES	-0-	2.0	1.0	1.0	1.0	1.0
EQUIPMENT	-0-	-0-	-0-	-0-	-0-	-0-
LAND & STRUCTURES	-0-	-0-	-0-	-0-	-0-	-0-
GRANTS, CLAIMS	-0-	-0-	-0-	-0-	-0-	-0-
MISCELLANEOUS	-0-	-0-	-0-	-0-	-0-	-0-
TOTAL OPERATING	-0-	37.0	28.0	28.6	29.2	30.0
CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
REVENUE	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of dollars)

GENERAL FUND	-0-	37.0	28.0	28.6	29.2	30.0
FEDERAL FUNDS	-0-	-0-	-0-	-0-	-0-	-0-
OTHER	-0-	-0-	-0-	-0-	-0-	-0-
TOTAL	-0-	37.0	28.0	28.6	29.2	30.0

POSITIONS:

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

ANALYSIS: Attach a separate page if necessary.

While there is an increase of the duties of the Director in this legislation, additional positions will not be necessary. Start-up costs cause a higher fiscal impact than subsequent years. The formative needs require more attention by the Director in the form

Prepared by: John L. George, Director
Division: Division of Insurance
Phone: 465-2515
Date: April 7, 1986

Approved by Commissioner: [signature]
Agency: Commerce and Economic Development
Date: April 7, 1986

Distribution (by Agency preparing fiscal note):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

10/25/85

0274K

of increased travel to attend formation meetings and monitor activities of the Association. Most of the major insurers expected to be involved in the Association are in the east. The fiscal note contemplates that the formation meetings will occur in the east. After the first year the travel necessary for monitoring the Association will probably be on the order of one per year.

The contractual monies are primarily for the purpose of securing actuarial assistance for review of the rate structures that will be subject to review by the Director of Insurance.

The director has the duty to contract with the federal government or another unit of government to ensure coordination of the state plan with other governmental assistance programs and to undertake directly or through contracts with other persons, studies or demonstration programs to develop awareness of the benefits of the proposed legislation. The bulk of this activity is expected to be borne by the Association. The state share of this cost is included in the $25.0 shown for contractual. The amount needed for this specific area is really a guess, but we believe that, if anything, it is substantially understated.

The supplies amounts are needed to support mailings necessary to insurers when establishing the Association and for advising insurers of their ongoing role and requirements under this legislation.

It is possible that the division may find it necessary to promulgate regulations to facilitate the formation of the Association. If this is necessary, some of the travel will be moved over to the appropriate areas on the theory that it will reduce travel. Addition of a sum for that purpose would be duplicative.

STATE OF ALASKA 1986 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date: _____

REQUEST Attached draft of 3/28/86
Bill/Resolution No.: CSHB589 (L&C)
Title: "An Act Relating to Disability Insurance"

FISCAL DETAIL
Agency Affected: All State Agencies
BRU: Retirement & Benefits

Sponsor: Sund, et al
Requestor:
Date of Request:

Components: Retirement & Benefits (GHLB)

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
OPERATING						
PERSONAL SERVICES						
RTMNT & BNFTS						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
TRS MATCH						
TOTAL OPERATING		-0-	-0-	-0-	-0-	-0-
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL		-0-	-0-	-0-	-0-	-0-
POSITIONS:		-0-	-0-	-0-	-0-	-0-
FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS: Attach a separate page if necessary

See attached

Prepared By: J.K. Humphreys, Director
Phone: 465-4470
Division: Retirement & Benefits
Date: 4/7/86

Approved by Commissioner: Eleanor Andrews
Date: 4/8/86
Agency: Department of Administration

Distribution (by Agency preparing fiscal note):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

Rev. 11/15/85

Draft CSHB 589 (03/28/86)
Fiscal Note Analysis
Prepared by Division of Retirement & Benefits
Department of Administration

ANALYSIS: The work draft of CSHB 589 (L&C) dated March 28, 1986 creates a Comprehensive Disability Insurarce Commission to offer health coverage to residents of the State of Alaska. This proposed bill has no apparent effect on the group health plans offered by the State of Alaska to its employees.

STATE OF ALASKA 1986 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date: _____

REQUEST
Bill/Resolution No.: HB 589
Title: An Act relating to participation in state group life and health insurance
Sponsor: Sund
Requestor:
Date of Request:

FISCAL DETAIL
Agency Affected: All State Agencies
BRU: Retirement & Benefits
Components: Retirement & Benefits (GHLB)

EXPENDITURES/REVENUES: (Thousands of Dollars)

	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
OPERATING						
PERSONAL SERVICES		109.4	113.8	118.3	123.1	128.0
RTMNT & BNFTS		13310.0	14374.8	15524.8	16766.8	18108.1
TRAVEL						
CONTRACTUAL		3.9	4.1	4.2	4.4	4.6
SUPPLIES		.5	.5	.5	.6	.6
EQUIPMENT		15.8	16.4	17.1	17.8	18.5
LAND & STRUCTURES						
GRANTS, CLAIMS						
TRS MATCH						
TOTAL OPERATING		13440.6	14509.6	15664.9	16912.7	18259.8
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND		12150.3	13116.7	14161.1	15289.1	16506.9
FEDERAL FUNDS		618.3	667.4	720.6	778.0	839.9
OTHER		672.0	725.5	783.2	845.6	913.0
TOTAL		13440.6	14509.6	15664.9	16912.7	18259.8

POSITIONS:

		3	3	3	3	3
FULL-TIME		3	3	3	3	3
PART-TIME						
TEMPORARY						

ANALYSIS: Attach a separate page if necessary

See attached

Prepared By: D.K. Humphreys, Director
Division: Retirement & Benefits
Phone: 465-4470
Date: 3/4/86

Approved by Commissioner: Eleanor Andrews
Agency: Department of Administration
Date: 3/5/86

Distribution (by Agency preparing fiscal note):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

Rev. 11/15/85

House Bill 589
Fiscal Note Analysis
Prepared by Division of Retirement & Benefits
Department of Administration

March 4, 1986

Analysis:

Passage of this bill would allow all Alaskans to take advantage of group rates to obtain the health and life coverage as provided to State of Alaska employees.

The State of Alaska now provides health and life insurance coverage to all permanent employees at no cost to the employee. Permanent part-time employees must pay one-half the cost. This analysis does not address any cost increase due to residents enrolling in the life insurance plan. Without requiring evidence of insurability as a condition of enrollment, the cost could heavily impact premiums. It is therefore assumed that this requirement could be imposed or the bill would be amended to allow health coverage only.

We have identified two large groups in the state that would contain individuals likely to enroll in this coverage:

1) Uninsured residents of the state
2) Insured residents of the state other than employees who have equal or comparable levels of health coverage.

The uninsured residents would be considered a higher risk group than state employees or employees insured under other group plans. They could range from young, healthy individuals with no interest or need for insurance to older, chronically ill individuals who are unable to obtain insurance elsewhere. For purposes of this analysis we have assumed medical costs to be 100% higher for these individuals than that of state employees.

The insured residents would also be considered a higher risk group than state employees since those who would enroll would probably be after a higher level of benefits than the insurance plan they were covered by. For purposes of this analysis, we have assumed insurance costs for these individuals to be 25% higher than that of state employees.

We have assumed an equal number of each of the above groups would enroll in this coverage. The FY 87 cost to the state due to the resulting increase in premiums for employees is estimated to be $13.31 million.

House Bill 589
Fiscal Note Analysis
Prepared by Division of Retirement & Benefits
Department of Administration

March 4, 1986

In addition to this premium cost increase would be the necessity of adding three permanent full-time positions to collect premiums, administrative fees, report eligibility, and answer questions on plan coverage.

These FY 87 administrative costs are as follows:

Personal Services:	
1 permanent Retirement & Benefit Specialist for 12 months	$37.2
2 permanent retirement technicians for 12 months	$72.2
Contractual:	
Telephone and other contractual costs for 3 positions	3.9
Supplies:	
Supplies for 3 positions	1.5
Equipment:	
Equipment accommodations for 3 non-perr nent positions	15.8
Total FY 87 administrative costs	$130.6

The cost for these positions would be paid by participants as provided in the bill. The assumed enrollment of 16,400 would require an $8.00 enrollment fee for each participant. This fee could vary with enrollment.

Position Title	No. of Positions	Range/Step	Barg. Unit	Gov.	Approv.	Disapp
Retirement and Benefits Specialist I	1	13A	GGU			

Time Status	Staff Months	RP Number	Location	Election District	Leg.
1 (PE/FT)	12.0	5	Juneau	4	

Type of Expenditure		Amount
1	2	3
Salary	27.5	
Benefits	9.7	
Premium Pay		
Other		
Total Personal Services		37.2
Travel		.0
Contractual		1.3
Commodities		.5
Equipment		6.4
Other		
Total Cost		45.4

Receipt Code	Funding Source		Amount
	Federal Receipts	1002	
	G. F. Match	1003	
	General Funds	1004	
	I-A Receipts	1005	
	Program Receipts	1028	45.4
	CIP Receipts	1061	
	Other		

For B&M Use Only
Key Number __ __ - __ __ - __ __ - __ __ - __ __

Justification

The passage of HB 589 would necessitate the addition of three permanent full-time positions (2 Retirement and Benefits Technicians and 1 Specialist) to collect premiums, administrative fees, report eligibility and answer questions on plan coverage.

3/6R1/0305-01

Request For New Position

Agency: Department of Administration
BRU: Retirement and Benefits
Component: Retirement and Benefits

Revised Date

FY 87

Position Title	No. of Positions	Range/Step	Barg. Unit	Gov.	Approv.	Disapp
Retirement and Benefits Technician II	2	12B	GGU			

Time Status	Staff Months	RP Number	Location	Election District	Leg.		
1 (PE/FT)	12.0	5	Juneau	4			

Type of Expenditure		Amount
1	2	3
Salary	53.2	
Benefits	19.0	
Premium Pay		
Other		
Total Personal Services		72.2
Travel		.0
Contractual		2.6
Commodities		1.0
Equipment		9.4
Other		
Total Cost		85.2

Receipt Code	Funding Source		Amount
	Federal Receipts	1002	
	G. F. Match	1003	
	General Funds	1004	
	I-A Receipts	1005	
	Program Receipts	1028	85.2
	CIP Receipts	1061	
	Other		

Justification

The passage of HB 589 would necessitate the addition of three permanent full-time positions (2 Retirement and Benefits Technicians and 1 Specialist) to collect premiums, administrative fees, report eligibility and answer questions on plan coverage.

For B&M Use Only
Key Number __ __ - __ __ - __ __ - __ __ - __ __

3/6B1/0305-01/3

Request For New Position

Agency: Department of Administration
BRU: Retirement and Benefits
Component: Retirement and Benefits

Page 1 of 1
Revised Date

FY 87

REVISIONS TO CS HB 589 (Judiciary)
(From Version #2 dated April 17, 1986 to Version #2 dated April 21, 1986)

Prepared by Rep. John Sund's office -- April 21, 1986.

The major changes in the bill are:

1. The plan will be offered on an individual basis only. It will not include group or dependent coverage.

   See Sec. 21.55.100; Page 4, lines 4-7; subsection (a).

2. The expanded medicare supplement plan is deleted. The state plan will only offer the minimum medicare supplement plan. The expanded medicare supplement plan for high risk individuals probably would have been cost prohibitive to those on a fixed income.

   See Sec. 21.55.100; Page 4, lines 8-11; subsection (b). The former reference to the medicare plans was Sec. 21.55.120 which has been deleted.

3. Preexisting condition limitation has been lessened to three months back and six months in, meaning, a condition that has occurred or been treated within the three months prior to application will not be covered for the first six months of a plan. The previous limitation was six months back and one year in.

   See Sec. 21.55.130; Page 8, lines 1-10.

4. The provision for the association to adopt a plan for coordinating benefits with other insurance coverage has been deleted because other coverage would cause ineligibility for the state plan.

   The deleted section was Sec. 21.55.160.
   The revision that disallows additional coverage to the state plan is Sec. 21.55.300; Page 14, line 3, subsection (b).

5. Premium rates will be on scales of age and geographic location, which are common rating scales in the industry.

   See Sec. 21.55.150; Page 10, line 12, subsection (b).

6. The $50 referral fee for agents who refer an accepted person to the state plan has been deleted. The incentive

behind the fee could not justify the added administrative costs it would create. In addition, the bill mandates that agents tell those people who were rejected or restricted in a policy about the state plan.

See Sec. 21.55.340; Page 15, lines 21-26, subsection (d).

7. The definition of a high risk person has been changed and placed under the definitions at the end of the bill. A high risk person is now someone who has been rejected, for medical purposes, by at least two association members or has had a restrictive rider placed on a policy. The former criteria of involuntary termination for reasons other than nonpayment, a 50% increase in premium and the list of presumptive conditions have been deleted. This should ease the administrative burden and, therefore, lower the plan costs.

See Sec. 21.55.500; Page 18, lines 16-24.
Former reference was in Sec. 21.55.100; Page 4, lines 14-29 and Page 5, lines 1-12.

CS HB 589 (Judiciary)
Version #2 dated April 21, 1986

An Act relating to disability insurance; and providing for an effective date.

SECTIONAL ANALYSIS

Prepared by Rep. John Sund's office; April 21, 1986

Section 1
ARTICLE 1
Sec. 21.55.010. Page 1, line 12: creates the Comprehensive Disability Insurance Association, a nonprofit corporation with membership consisting of all licensed disability insurers and licensed hospital or medical service corporations in the state that write on an expense incurred basis. Insurers must be members of the association in order to do business in the state.

Sec. 21.55.020. Page 1, line 22: sets a seven-member board of directors selected by association members and approved by the director of the state Division of Insurance. The director or a designee will be a nonvoting, ex officio member of the board.

Sec. 21.55.030. Page 2, line 12: describes the association's general powers.

Sec. 21.55.040. Page 2, line 21: subjects association articles, bylaws and operating rules to the approval of the director of the Division of Insurance.

Sec. 21.55.050. Page 3, line 26: exempts the association from the Administrative Procedure Act.

Sec. 21.55.060. Page 3, line 28: exempts the association from taxes.

ARTICLE 2
Sec. 21.55.100. Page 4, line 4: offers the state plan, including the medicare supplement plan, on an individual basis to high-risk residents. The association may not deny coverage to any eligible resident.

The plans will be offered with three deductible options.

Sec. 21.55.110. Page 4, line 16: explains the minimum benefits of the state plan, which is a basic major medical plan. Lifetime maximum benefit is $1 million.

Sec. 21.55.120. Page 6, line 26: offers deductibles of $200, $500 or $1,000 per person. The maximum copayment by enrollees would be 20% once the deductible is met for all health care

and 50% for mental health care. Maximum annual payments of deductible and copayments cannot exceed $2,000 per insured. The plan would pay 100% once that limit is reached.

Sec. 21.55.130. Page 7, line 27: excludes coverage for preexisting conditions if the condition began within the three months just preceding the effective date of coverage. Preexisting conditions would not be covered for the first six months of a plan. The limitation can be waived if the insured's previous insurance was terminated and the state plan application is made within 31 days following termination.

Sec. 21.55.140. Page 8, line 22: describes care and services that are not covered by the plan.

Sec. 21.55.150. Page 10, line 9: sets separate scales of premium rates based on age and geographic location of the insured. It also caps the premiums at 150% of the average rate of the plan if it were offered to standard risk people as determined by the five largest disability insurers in the state.

ARTICLE 3

Sec. 21.55.200. Page 10, line 23: sets guidelines for the association's selection of a writing carrier through a bidding process.

Sec. 21.55.210. Page 11, line 1: explains the duties of the writing carrier which will be contracted for three-year terms unless earlier termination is approved by the director.

The carrier will perform the administrative and claims payment functions of the plan and report quarterly to the association. The carrier will be reimbursed for direct and indirect expenses of administering the plan.

Sec. 21.55.220. Page 12, line 11: requires that association members will be assessed to share the claim losses and administrative expenses that exceed premium payments. Each member will contribute to the association an amount based on that member's share of all disability insurance premiums paid in the state. Assessments will be made yearly, unless interim assessments are desired.

A member's failure to pay an assessment within 30 days could cease that member's certification to operate in the state.

Net gains will be held at interest to offset future losses.

ARTICLE 4

Sec. 21.55.300. Page 13, line 28: states that all high-risk residents are eligible for the state plan unless covered by another disability insurance policy. A person loses eligibility upon ceasing residency.

Sec. 21.55.310. Page 14, line 10: explains the enrollment procedure.

Sec. 21.55.320. Page 14, line 19: requires the state plan writer to respond to the applicant within 30 days of receiving the application.

Sec. 21.55.330. Page 14, line 24: sets the policy effective date at the day of application once the first premium is paid. It also permits 60 day retroactive coverage for those individuals whose previous insurance terminated, if premiums are paid for the retroactive period.

Sec. 21.55.340. Page 15, line 9: requires that the state plan be advertised to the public. An insurer who rejects or restricts a policy must tell the applicant about the state plan.

ARTICLE 5
Sec. 21.55.400. Page 15, line 28: explains the duties of the director of the Division of Insurance in regard to the state plan.

Sec. 21.55.410. Page 16, line 10: states the state is not liable for association actions.

Sec. 21.55.500. Page 16, line 14: offers chapter definitions.

Resident is defined as a person who has lived in the state at least six consecutive months prior to application and intends to remain. Absence from the state is permitted for medical and educational reasons.

A high risk resident is defined as someone who has been rejected for disability coverage by at least two association members or has had a restrictive rider placed on a policy.

Section 2. Page 19, line 14: requires that the state plan be available by July 1, 1987.

Section 3. Page 19, line 17: sets an immediate effective date.

MEMORANDUM

TO: House Judiciary Committee members

FROM: Rep. John Sund

DATE: April 1[illegible], 1986

RE: HB 589

I have attached two versions of a new CS for HB 589 along with a brief overview of the bill and sectional analyses.

The bill is scheduled in committee tomorrow (April 18).

The bill establishes an association of insurance writers in the state to offer health insurance to residents -- especially those considered to be high risks and unable to get standard insurance. It has undergone many revisions and technically is pretty clean. But we have a question of policy here -- which is the reason for the two versions of the bill.

Version #1 would permit groups and standard risk people to purchase insurance through the state plan, as well as high-risk people. It would also make premium rates actuarially sound.

Version #2 would limit enrollment in the state plan to high-risk individuals and would cap the premium that the association would charge for the coverage.

Testimony has shown that there is a need for high-risk health insurance in the state and that concept is unopposed -- even by the insurance industry. But the industry does oppose the inclusion of standard risk in the belief that it would be a duplication of services already provided and competition with private enterprise.

I believe that ethically the health insurance made available through this association should be offered to all residents. But that is the major decision we face with HB 589.

Thanks for your consideration.

CS HB 589
Version #1 dated 4/16/86 and Version #2 dated 4/17/86

Act relating to disability insurance; and providing for an ·tive date.

OVERVIEW
Prepared by Rep. John Sund's office; April 17, 1986

Objective

The primary purpose of HB 589 is to ensure medical insurance availability to those Alaskan residents who are considered too high of a health risk for standard insurance in the open marketplace.

What This Bill Does

HB 589 would establish a nonprofit, statewide association of all disability insurers in the state. Participation in the association would be mandatory in order to do business in the state.

The association would offer major medical insurance and medicare supplement insurance as described in the bill to any Alaskan who cannot get standard coverage or has excessive restrictions placed on his or her insurance. Certain eligibility requirements would be set.

The association members would share the cost of claim payments in excess of premium income through periodic assessments. The association would administer the plan under the monitoring of the director of the Division of Insurance. Little cost would be born by the state. (The bill carries a $37,000 fiscal note that reduces over subsequent years.)

Version #1 versus Version #2

There are two differences between the two versions of this bill. In addition to the high risk coverage, Version #1 would offer insurance to standard risk Alaskans and small groups of up to 25 residents. Version #1 also seeks actuarially sound premium rates and makes no attempt to cap any of the rates.

Version #2, on the other hand, would apply only to high-risk individuals and would cap the premium rate. The cap would be 150% of the average rate of the plan if it were offered to standard risk people as determined by the five largest disability insurers in the state.

Which version to use is a matter of policy. Should a state plan be available to all residents, or should some Alaskans be excluded? And should we risk (in the case of Version #2) that rates will be too high and unaffordable?

Why This Bill Is Needed

Standard disability insurance is often denied people who are considered high risks, such as older individuals and those who are suffering or have suffered from serious illnesses. Comprehensive insurance should be available to these people. Moreover, providing them insurance should eventually decrease costs to society.

CS HB 589 (Judiciary)
Version #1 dated April 17, 1986

An Act relating to disability insurance; and providing for an effective date.

SECTIONAL ANALYSIS

Prepared by Rep. John Sund's office; April 17, 1986

Section 1
ARTICLE 1
Sec. 21.55.010. Page 1, line 12: creates the Comprehensive Disability Insurance Association, a nonprofit corporation with membership consisting of all licensed disability insurers and licensed hospital or medical service corporations in the state that write on an expense incurred basis. Insurers must be members of the association in order to do business in the state.

Sec. 21.55.020. Page 1, line 21: sets a seven-member board of directors selected by association members and approved by the director of the state Division of Insurance. The director or a designee will be a nonvoting, ex officio member of the board.

Sec. 21.55.030. Page 2, line 11: describes the association's general powers.

Sec. 21.55.040. Page 2, line 20: subjects association articles, bylaws and operating rules to the approval of the director of the Division of Insurance.

Sec. 21.55.050. Page 3, line 25: exempts the association from the Administrative Procedure Act.

Sec. 21.55.060. Page 3, line 27: exempts the association from taxes.

ARTICLE 2
Sec. 21.55.100. Page 4, line 2: specifies the types of insurance plans that will be available through the association: group plan for up to 25 residents; individual plan for standard risks; individual plan for high risks; medicare supplement plan for those 65 years or older who are either standard or high-risk. Each plan will have an option of three deductibles.

Eligibility requirements for the high-risk plan are defined. The association may not deny coverage to any eligible state resident, but may determine whether the individual fits into the high-risk or standard risk group.

Sec. 21.55.110. Page 5, line 24: explains the minimum benefits of the state plan, which is a basic major medical plan. Lifetime maximum benefit is $1 million.

Sec. 21.55.120. Page 8, line 12: explains two types of medicare supplement plans: a minimum benefits plan which is defined in present regulation and an expanded coverage plan.

Sec. 21.55.130. Page 8, line 26: offers deductibles of $200, $500 or $1,000 per person The maximum copayment by enrollees would be 20% once the d cible is met for all health care and 50% for mental heal are. Maximum annual payments of deductible and copayments cannot exceed $2,000 for individuals and $4,000 for families. The plan would pay 100% once those limits are reached.

Sec. 21.55.140. Page 9, line 28: excludes coverage for preexisting conditions if the condition began within the six months just preceding the effective date of coverage. Preexisting conditions would not be covered for the first year of a plan. The limitation can be waived for a 10% additional premium payment, or if the insured's previous insurance was terminated and the state plan application is made within 31 days following termination.

Sec. 21.55.150. Page 11, line 3: describes care and services that are not covered by the plan.

Sec. 21.55.160. Page 12, line 20: requires the association to adopt a plan for coordinating benefits with other insurance coverage.

Sec. 21.55.170. Page 12, line 24: states that premiums must be rated on generally accepted actuarial principles and may not be excessive or discriminatory. The association may set separate scales of rates based on age, group or individual coverage and standard or high-risk coverage. A flat rate would be used for dependents.

ARTICLE 3

Sec. 21.55.200. Page 13, line 9: sets guidelines for the association's selection of a writing carrier through a bidding process.

Sec. 21.55.210. Page 13, line 16: explains the duties of the writing carrier which will be contracted for three-year terms unless earlier termination is approved by the director.

The carrier will perform the administrative and claims payment functions of the plan and report quarter to the association. The carrier will be reimbursed for direct nd indirect expenses of administering the plan.

Sec. 21.55.220. Page 14, line 26: allows enrollment in the state plan to all eligible people and requires that association members will share the claim losses and administrative expenses that exceed premium payments. Each member will contribute to the association an amount based on that member's share of all disability insurance premiums paid in the state. Assessments will be made yearly, unless interim assessments are desired.

A member's failure to pay an assessment within 30 days could cease that member's certification to operate in the state.

Net gains will be held at interest to offset future losses.

ARTICLE 4

Sec. 21.55.300. Page 16, line 14: states that all residents or groups of up to 25 residents are eligible for the state plan. An individual who has voluntarily ended coverage in the state plan, however, cannot reenter the plan for 12 months.

Sec. 21.55.310. Page 16, line 24: explains the enrollment procedure and disallows those people covered under another medical plan as the primary policyholder from enrolling in the state plan. A person loses eligibility upon ceasing residency.

Sec. 21.55.320. Page 17, line 13: requires the state plan writer to respond to the applicant within 30 days of receiving the application.

Sec. 21.55.330. Page 17, line 22: permits 60 day retroactive coverage for those high risk individuals whose previous insurance terminated, if premiums are paid.

Sec. 21.55.340. Page 18, line 1: requires that the high-risk portion of the plan be advertised to the public and that the plan writer pay a $50 referral fee to every insurance agent who refers an accepted applicant to the state plan. An insurer who rejects or restricts a policy must tell the applicant about the state plan.

ARTICLE 5

Sec. 21.55.400. Page 18, line 26: explains the duties of the director of the Division of Insurance in regard to the state plan.

Sec. 21.55.410. Page 19, line 8: states the state is not liable for association actions.

Sec. 21.55.500. Page 19, line 12: offers chapter definitions. Resident is defined as a person who has lived in the state at least six consecutive months prior to application and intends to remain. Absence from the state is permitted for medical reasons.

Section 2. Page 22, line 1: requires that the state plan be available by July 1, 1987.

Section 3. Page 22, line 4: sets an immediate effective date.

CS HB 589 (Judiciary)
Version #2 dated April 17, 1986

An Act relating to disability insurance; and providing for an effective date.

SECTIONAL ANALYSIS

Prepared by Rep. John Sund's office; April 17, 1986

(Note: This will only explain differences from Version #1 of the bill.)

Section 1
ARTICLE 2
Sec. 21.55.100. Page 4, line 2: offers the state plan, including the medicare supplement plan, only to those people who are high risks. Standard risks and groups would not be eligible.

Sec. 21.55.170. Page 12, line 7: caps the premium at 150% of the average rate of the plan if it were offered to standard risk people as determined by the five largest disability insurers in the state.

CS HB 589 (Judiciary)
Version #2 dated April 17, 1986

An Act relating to disability insurance; and providing for an effective date.

SECTIONAL ANALYSIS

Prepared by Rep. John Sund's office; April 17, 1986

Section 1
ARTICLE 1
Sec. 21.55.010. Page 1, line 12: creates the Comprehensive Disability Insurance Association, a nonprofit corporation with membership consisting of all licensed disability insurers and licensed hospital or medical service corporations in the state that write on an expense incurred basis. Insurers must be members of the association in order to do business in the state.

Sec. 21.55.020. Page 1, line 21: sets a seven-member board of directors selected by association members and approved by the director of the state Division of Insurance. The director or a designee will be a nonvoting, ex officio member of the board.

Sec. 21.55.030. Page 2, line 11: describes the association's general powers.

Sec. 21.55.040. Page 2, line 20: subjects association articles, bylaws and operating rules to the approval of the director of the Division of Insurance.

Sec. 21.55.050. Page 3, line 25: exempts the association from the Administrative Procedure Act.

Sec. 21.55.060. Page 3, line 27: exempts the association from taxes.

ARTICLE 2
Sec. 21.55.100. Page 4, line 2: offers the state plan, including the medicare supplement plan, only to those people who are high risks. Standard risks and groups would not be eligible. Each plan will have an option of three deductibles.

Eligibility requirements for the high-risk plan are defined. The association may not deny coverage to any eligible state resident.

Sec. 21.55.110. Page 5, line 13: explains the minimum benefits of the state plan, which is a basic major medical plan. Lifetime maximum benefit is $1 million.

Sec. 21.55.120. Page 8, line 12: explains two types of medicare supplement plans: a minimum benefits plan which is defined in present regulation and an expanded coverage plan.

Sec. 21.55.130. Page 8, line 15: offers deductibles of $200, $500 or $1,000 per person. The maximum copayment by enrollees would be 20% once the deductible is met for all health care and 50% for mental health care. Maximum annual payments of deductible and copayments cannot exceed $2,000 for individuals and $4,000 for families. The plan would pay 100% once those limits are reached.

Sec. 21.55.140. Page 9, line 17: excludes coverage for preexisting conditions if the condition began within the six months just preceding the effective date of coverage. Preexisting conditions would not be covered for the first year of a plan. The limitation can be waived for a 10% additional premium payment, or if the insured's previous insurance was terminated and the state plan application is made within 31 days following termination.

Sec. 21.55.150. Page 10, line 15: describes care and services that are not covered by the plan.

Sec. 21.55.160. Page 12, line 3: requires the association to adopt a plan for coordinating benefits with other insurance coverage.

Sec. 21.55.170. Page 12, line 7: caps the premium at 150% of the average rate of the plan if it were offered to standard risk people as determined by the five largest disability insurers in the state.

ARTICLE 3

Sec. 21.55.200. Page 12, line 19: sets guidelines for the association's selection of a writing carrier through a bidding process.

Sec. 21.55.210. Page 12, line 26: explains the duties of the writing carrier which will be contracted for three-year terms unless earlier termination is approved by the director.

The carrier will perform the administrative and claims payment functions of the plan and report quarterly to the association. The carrier will be reimbursed for direct and indirect expenses of administering the plan.

Sec. 21.55.220. Page 14, line 8: allows enrollment in the state plan to all eligible people and requires that association members will share the claim losses and administrative expenses that exceed premium payments. Each member will contribute to the association an amount based on that member's share of all disability insurance premiums paid

in the state. Assessments will be made yearly, unless interim assessments are desired.

A member's failure to pay an assessment within 30 days could cease that member's certification to operate in the state.

Net gains will be held at interest to offset future losses.

ARTICLE 4

Sec. 21.55.300. Page 15, line 25: states that all residents or groups of up to 25 residents are eligible for the state plan. An individual who has voluntarily ended coverage in the state plan, however, cannot reenter the plan for 12 months.

Sec. 21.55.310. Page 16, line 1: explains the enrollment procedure and disallows those people covered under another medical plan as the primary policyholder from enrolling in the state plan. A person loses eligibility upon ceasing residency.

Sec. 21.55.320. Page 16, line 18: requires the state plan writer to respond to the applicant within 30 days of receiving the application.

Sec. 21.55.330. Page 16, line 27: permits 60 day retroactive coverage for those high risk individuals whose previous insurance terminated, if premiums are paid.

Sec. 21.55.340. Page 17, line 5: requires that the high-risk portion of the plan be advertised to the public and that the plan writer pay a $50 referral fee to every insurance agent who refers an accepted applicant to the state plan. An insurer who rejects or restricts a policy must tell the applicant about the state plan.

ARTICLE 5

Sec. 21.55.400. Page 17, line 28: explains the duties of the director of the Division of Insurance in regard to the state plan.

Sec. 21.55.410. Page 18, line 10: states the state is not liable for association actions.

Sec. 21.55.500. Page 18, line 14: offers chapter definitions. Resident is defined as a person who has lived in the state at least six consecutive months prior to application and intends to remain. Absence from the state is permitted for medical reasons.

Section 2. Page 21, line 3: requires that the state plan be available by July 1, 1987.

Section 3. Page 21, line 6: sets an immediate effective date.

POSITION PAPER

House Bill 589

The apparent goal of HB 589, to make available high quality health insurance and basic life insurance coverage at attractive group rates to all Alaskans who are willing to pay for it themselves is hard to argue with. However, there appears to be an underlying misconception that somehow the fact that there are existing policies of group insurance being provided to state employees presents an opportunity for a "free lunch." In fact, when the number of people to be served is large, as it presumably is in this case, there is little if any advantage in combining groups and there are compelling reasons to separate the claims experience of the two groups (state employees and citizens who elect to participate).

Certainly the State of Alaska could make a group health policy available to citizens of the state but it would seem to make more sense to offer a basic, no frills major medical package and price it according to the claims experience of those who choose to enroll in the plan. Bids to provide the coverage could be solicited and a servicing carrier chosen who would collect premiums, pay claims and maintain records. This would provide the maximum advantage to citizens, ensuring a competitive, fair rate without any significant state subsidy and without getting the state

into the insurance business.

Our analysis and position on this bill is based on the assumption that residents would be required to furnish evidence of insurability as a requirement for enrollment in the life insurance coverage or that the bill would be amended to allow for resident participation in the health plan only. Without these requirements, the impact on life insurance premiums would be significant due to the high possibility of adverse selection from the new group.

The question that must be answered is, "What possible advantages does the plan in HB 589 have when compared with the scenario described above?" We think there are no real advantages and several serious disadvantages. One might ask if the rates the state enjoys because of a large group of relatively good risks couldn't be passed on to citizens who enroll. This could only be done at the expense of those rates; in other words, if the experience of those who signed up was worse than the state average (and we are reasonably certain it would be), the rate would be driven up for everyone and the state would be in the position of subsidizing coverage for those individuals. We have tried to show this effect in our Fiscal Note analysis. Also, the coverage provided to state employees, regardless of bargaining unit, is first rate and includes audio, visual and dental coverage; we do not feel it would be appropriate for a general offering in any event.

For these reasons the Department of Administration is opposed to HB 589. If the legislature feels that this issue must be addressed, we feel a

non-subsidized approach such as the one indicated above would be more appropriate.

J. K. Humphreys — 3/5/86

J.K. Humphreys, Director, Division of Retirement & Benefits — Date

Eleanor Andrews — 3/5/86

Eleanor Andrews, Commissioner, Department of Administration — Date

PROVIDENT
COMPANIES

CHATTANOOGA, TN 37402

April 11, 1986

Honorable M. Mike Miller
Room 122, State Capitol
P. O. Box V
Juneau, Alaska 99811

Re: Committee Substitute for House Bill No. 589 --
Comprehensive Disability Insurance Association

Dear Representative Miller:

We are very concerned with the Committee Substitute for House Bill 589 recently introduced to the Legislature, which would establish an assigned risk pool for uninsurables and would offer major medical insurance to all eligible residents of Alaska.

As we understand the bill, it would require all insurance companies licensed to write disability insurance in the State of Alaska (whether or not they are actively engaged in the health insurance market) and all licensed hospital or major medical service corporations in the state to maintain membership in the Comprehensive Disability Insurance Association as a condition of doing disability insurance business in Alaska. The Board of the Association would select a writing carrier to provide the coverage established by the bill, which appears to be a standard type major medical insurance policy with a choice of a $200, $500, or $750 deductible and which would provide for 20% coinsurance (50% for diagnosis or treatment of mental conditions), and a $2,000 limit per covered individual and $4,000 limit per covered family on out-of-pocket expenses.

The proposal would make available to Alaska residents (1) a group plan for groups of 3 to 25 residents, (2) an individual plan for residents who are standard risks, and (3) an individual plan for residents who are high risks. The plan would also include a Medicare supplement policy for residents age 65 and older. Premium rates would be based on whether or not it is an individual or group plan, and if an individual plan, whether or not it is a high risk or standard risk, as well as the age group and the choice of deductible. Rates would be determined by sound actuarial methods. The bill would further require that at least 85% of the collective premiums for the plan be used to pay claims, while a maximum of 15% could be used for administrative costs. All costs of the plan which are not paid out of premiums would be assessed against Association members in amounts based on the amount of business the member writes in Alaska to cover claim payments that exceed premium receipts. The act does not provide for an offset of any assessment against premium taxes.

First, let me state that I do not know why the State of Alaska would consider such a bill. To require all health insurance companies doing business in the State of Alaska to finance insurance for residents of your state over and above a reasonable cost, despite the experience of the state plan, and in competition with the private insurer, would have the net effect of most health carriers simply withdrawing from the state. Why do business in a state where the state is going to compete with you, and furthermore, is going to put you at a competitive disadvantage by requiring you to support their plan and not receive a premium tax offset for the assessments for the Association (which does not have to pay premium tax on their policy while insurance companies are paying premium taxes on the business they sell)? I do not believe any insurance company would remain in a state which enacted such a law, and we would certainly give serious consideration to withdrawing from the State of Alaska and would probably do so.

Law Department 615/755-1244
Provident Life and Accident Insurance Company

Furthermore, I believe other companies would also withdraw. Why would they stay when such a bill would put them at such a competitive disadvantage that everyone in Alaska would elect the state plan? The only thing a disability insurer would be doing if it were authorized to write disability insurance in Alaska would be to subsidize the state plan. This should be done by the taxpayers and not the insurance companies doing business in the state. I know of no better way to make certain that health insurance is unavailable to residents of your state than to enact a bill such as this one.

As one of the leading health insurance companies writing employee benefits, a suggestion that there might be a lack of competition in the small group health insurance market disturbs us. This has not been our experience. We believe the market is extremely competitive and that there are insurance companies offering coverage through this market which is both comprehensive in coverage and competitive in price with rates offered to larger groups. The problems in providing group health benefits at an affordable cost do not exist because insurance companies are not active and competitive in the marketplace; they exist because (1) there is not sufficient control on the providers of health care which would enable health care costs to be curbed, (2) the enactment of mandated benefits covering all aspects of health care, including some benefits which are not benefits for the treatment of an illness or injury, which has a substantial over-all impact on the premium rates of health insurance, and (3) the tendency of state legislatures and state governments to put the financial burden of social responsibility on the insurance buying public.

If you are concerned with the lack of insurance for some types of individuals such as uninsurables, then I would suggest that you enact a bill similar to the one recently enacted in Indiana providing comprehensive health insurance coverage for residents of that state who are uninsurable, with a full premium tax offset for assessments paid by health insurers doing business in Indiana. Providing coverage for the uninsurables is a social responsibility and not one that should be passed on to the insurance buying public in the form of higher premiums. I believe that other health insurance is available to most persons in the State of Alaska, as it is in other states, if they want to purchase it.

We urge you to take a serious look at this bill when it comes up for a vote in the Alaska Legislature, and would encourage you to oppose it unless you wish almost all of the health insurance in Alaska to be provided by the state at state expense. If you wish to discuss any of our comments further or if we can provide you with any additional information in support of our position, please let us know.

Sincerely yours,

Charles T. Cady

Charles T. Cady
Vice President, General Counsel
and Secretary

CTC:fd/2271z

DAVID T. WALKER
ATTORNEY AT LAW
MENDENHALL BUILDING
320 FOURTH STREET, SUITE B
JUNEAU, ALASKA 99801
(907) 586-3537

April 22, 1986

M. Mike Miller, Chairman
House Judiciary Committee
P.O. Box 1494
Juneau, Alaska 99802

RE: House Bill 589 (An act relating to disability insurance; and providing for an effective date.)

Dear Representative Miller:

I am the registered lobbyist for the Alaska Nurses Association. The Association has some concerns about the impact of HB 589 on the practice of nursing. If the bill is scheduled for a hearing I believe the Association will want to appear and present testimony. Specifically, the Association recommends:

1. Acquired Immune Deficiency Syndrome (A.I.D.S.) should be added to the list of high risk conditions under sec. 21.55.100 (e)(3);

2. the language "at the physician's direction" should be deleted form sec. 21.55.110 (2) - registered nurses frequently perform services that are within the area of nursing practice and those services should be covered by the plan;

3. sec. 21.55.150 (13) should be deleted - we believe it is poor policy to exclude services of a registered nurse from coverage simply because she resides in the covered individual's home - this makes no more sense than excluding the services of a physician who treats a member of his family.

Please do not hesitate to contact me if you have a

question about the Association's position on HB 589, nurses, the practice of nursing, or any other matter.

Very truly yours,

David T. Walker

DTW/dsm
cc: Kay Lahdenpera
Barbara Walker
Laura Rima
Alaska Nurses Association
Constance Trollan

CAI INC

COMMUNICATING FOR AGRICULTURE

Law Office Building
P.O. Box 677
Fergus Falls, Minnesota 56537-9990

Phone (218) 739-3241

MINNESOTA APRIL 1985

I. PLAN SUMMARY

1.	Minnesota Contact:	Mr. Dave Platt Manager, Underwriting Research and Contracts Dept. Blue Cross-Blue Shield P.O. Box 64560 St. Paul. MN 55164 (612) 456-8561
2.	Plan Administrator:	Blue Cross-Blue Shield
3.	Effective Date:	June 1976
4.	Board Composition:	7 members selected by members of the pool
5.	Benefit:	Regular Plan - $250,000 Lifetime Benefit Medicare Supplement - $100,000 Lifetime Benefit
6.	Deductible:	$500, $1,000
7.	Stop Loss:	Regular plans - $3,000/Individual Medicare Supplement - $1,000/Individual
8.	Premium Cap:	125% Maximum
9.	Waiting Period:	6 Months for pre-existing conditions
10.	Pre-existing conditions:	Not covered if diagnosed or treated within 90 days preceding the policy date until 6 months after the policy date.
11.	Eligibility Criteria:	Rejected by one carrier Rider by one carrier
12.	Agent fee:	Referral fee of $50
13.	Medicare qualified plan:	Yes

MINNESOTA

II. OPERATIONAL DATA

1. Total individuals covered by plan at end of:

1981	2,918
1982	4,25[illegible]
1983	6,669
1984	9,158
As of April 1, 1985	10,359

2. Total premiums collected by plan at end of:

1981	$ 1,305,245.00
1982	$ 2,325,060.00
1983	$ 4,[illegible]2,351.00
1984	$ 6,[illegible]13,829.00

3. Total claims paid by plan at end of:

1981	$ 2,852,845.00
1982	$ 4,514,172.00
1983	$ 6,981,967.00
1984	$ 9,761,835.00

4. Total assessment to members of plan for:

1981	$ 1,000,000.00
1982	$ 3,000,818.00
1983	$ 3,487,532.00
1984	$ 4,795,071.00

5. What was the total cost to administer the plan in:

1981	$ 163,156.00
1982	$ 298,823.00
1983	$ 383,741.00
1984	$ 665,100.00

6. Does your state allow for a premium tax credit on the assessment? X Yes ___ No

Comments _____

7. Is there a maximum percentage assessment allowed towards the companies (such as 1%)? ___ Yes X No

Comments _____

8. What was the percentage assessed to members (such as .8%) at the end of:

1981	-
1982	-
1983	-
1984	-

Each assessment is based on the ratio of the contributing members total amount of accident and health insurance premium received from or on behalf of Minnesota residents divided by the total cost of accident and health insurance premium received by all Association Contributing Members from or on behalf of Minnesota residents, as determined by the Commissioner of Commerce for the state of Minnesota.

9. What were the total premiums collected by all companies in your state at the end of:

1981	$	N/A
1982	$	N/A
1983	$	N/A
1984	$	N/A

10. What were the total premium taxes paid by all companies in your state at the end of:

1981	$	N/A
1982	$	N/A
1983	$	N/A
1984	$	N/A

11. Did the above taxes paid include all companies or were some exempt from paying taxes (such as self-insurers)?

Self-Insurers and non-profit service plan corporations do not pay premium tax.

12. What problems has your plan experienced?

13. Additional comments:

Individuals covered -

Plan 1	($1,000 deductible)	2,265
Plan 2	($500 deductible)	5,525
Plan 4	(Med Supplement - 65 & over)	622
Plan 5	(Med Supplement - Under 65)	123
		8,535

Minnesota feels that adjustments made to the plan since its inception have made for a very good program.

Minnesota also has a listing of eighteen conditions which allow for automatic acceptance into the pool without having to receive a rejection notice from an insurance carrier.

CAP INC

COMMUNICATING FOR AGRICULTURE

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P.O. Box 677
Fergus Falls, Minnesota 56537-9990

Phone (218) 739-3241

NORTH DAKOTA

APRIL 1985

I. PLAN SUMMARY

1. North Dakota Contact:	Mr. Bob Carlson 4510 - 13th Ave. SW Fargo, ND 58121-0001 (701) 282-1235
2. Plan Administrator:	Blue Cross-Blue Shield
3. Effective Date:	June 1981
4. Board Composition:	10 members - 1 from each member of the 10 insurers with the highest annual premium volumes
5. Benefit:	$250,000 Lifetime Benefit
6. Deductible:	$250 $500 $1,000
7. Stop Loss:	$3,000/Individual
8. Premium Cap:	135% Maximum
9. Waiting Period:	6 Months for pre-existing conditions
10. Pre-existing conditions:	Not covered if diagnosed or treated within 90 days preceding the policy date until 6 months after the policy date. Waiting period is waived if applicant has been covered under an insured health plan within past year. Pre-existing condition clause may also be waived upon payment of additional premium.
11. Eligibility Criteria:	Rejected by one carrier Riders by two carriers Resident for six months
12. Agent fee:	Referral fee of $25
13. Medicare qualified plan:	Yes

NORTH DAKOTA

II. OPERATIONAL DATA

1. Total individuals covered by plan at end of:

1981	-0-
1982	78
1983	245
1984	615
As of April 1, 1985	727

2. Total premiums collected by plan at end of:

1981	$ -0-
1982	$ 73,408.00
1983	$ 138,666.00
1984	$ 455,874.00

3. Total claims paid by plan at end of:

1981	$ -0-
1982	$ 103,400.00
1983	$ 345,918.00
1984	$ 1,058,694.00

4. Total assessment to members of plan for:

1981	$ -0-
1982	$ 49,862.00
1983	$ 229,483.00
1984	$ 605,367.00

5. What was the cost to administer the program in:

1981	$ -0-
1982	$ 33,111.00
1983	$ 25,306.00
1984	$ 35,904.00

6. Does your state allow for a premium tax credit on the assessment? X Yes ___ No

Comments _____

7. Is there a maximum percentage assessment allowed towards the companies (such as 1%)? ___ Yes X No

Comments _____

8. What was the percentage assessed to members (such as .8%) at the end of:

1981	-0-
1982	.03%
1983	.11%

9. What were the total premiums collected by all companies in your state at the end of:

1981	$ N/A
1982	$ N/A
1983	$73,667,853.0
1984	$ N/A

10. What were the total premium taxes paid by all companies in your state at the end of:

1981	$ N/A
1982	$ N/A
1983	$ N/A
1984	$ N/A

11. Did the above taxes paid include all companies or were some exempt from paying taxes (such as self-insurers)?

Self-Insurers do not report to the State Insurance Department, and are therefore exempt.

12. What problems has your plan experienced?

No major problems.

13. Additional comments:

Enrollment seems to be picking up. Approximately 30 individuals are signed up per month.

Assessments - Assessments are made to all companies doing more than $100,000 of accident and health insurance business in the state. Assessments are based on each company's premium volume as compared to the total for all companies. Assessments are a direct offset against premium taxes.

Lead carrier expenses are, by law, limited to 12.5% of premium.

COMMUNICATING FOR AGRICULTURE

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INDIANA

MAY 1985

I. PLAN SUMMARY

1.	Indiana Contact:	Ms. Helen Adrian Deputy Commissioner Indiana Dept. of Insurance 509 State Office Bldg. Indianapolis, IN 46204 (317) 232-2418
2.	Plan Administrator:	Mutual of Omaha
3.	Effective Date:	July 1982
4.	Board Composition:	5 to 9 members selected by members of the pool
5.	Benefit:	Plan I - No limit Plan II - No limit, $50,000 Lifetime Benefit for mental and nervous disorders
6.	Deductible:	Plan I - $200 Plan II - $200, $500, $1,000
7.	Stop Loss:	Plan I - $1,000/Individual; $2,000 Family Plan II - $1,000/Individual; $2,000/Family $1,500/Individual; $3,000/Family $2,000/Individual; $4,000/Family
8.	Premium Cap:	150% Maximum
9.	Waiting Period:	6 months for pre-existing conditions
10.	Eligibility Criteria:	Rejected by two carriers, notified of benefit reduction, premium increase or not eligible for medicare. Criteria may be waived under certain conditions.
11.	Pre-existing conditions:	Not covered if diagnosed or treated within 6 months preceding the policy date until 6 months after the policy date. May be waived under certain conditions.
12.	Agent fee:	$25.00
13.	Medicare qualified plan:	No

INDIANA

II. OPERATIONAL DATA

1. Total individuals covered by plan at end of:

1981	-0-
1982	41
1983	2,288
1984	3,510
As of April 1, 1985	3,428

2. Total premiums collected by plan at end of:

1981	$ -0-
1982	$ 34,479.69
1983	$ 2,352,179.23
1984	$ 6,356,995 39

3. Total claims paid by plan at end of:

1981	$ -0-
1982	$ -0-
1983	$ 217,877.60
1984	$ 6,843,690.79

4. Total assessment to members of plan for:

1981	$ -0-
1982	$ 53,300.00
1983	$ 10,601.00
1984	$ 134,077.00

5. What was the total cost to administer the plan in:

1981	$ -0-
1982	$ 28,936.61
1983	$ 56,511.63
1984	$ 256,462.35

6. Does your state allow for a premium tax credit on the assessment? X Yes ___ No

Comments _____

_____

7. Is there a maximum percentage assessment allowed towards the companies (such as 1%)? ___ Yes X No

Comments: _____

8. What was the percentage assessed to members (such as .8%) at the end of:

	1981 _____
	1982 _____
Does not use %	1983 _____
	1984 _____

9. What were the total premiums collected by all companies in your state at the end of:

1981 $_____
1982 $_____
1983 $_____
1984 $_____

10. What were the total premium taxes paid by all companies in your state at the end of:

1981 $_____
1982 $_____
1983 $_____
1984 $_____

11. Did the above taxes paid include all companies or were some exempt from paying taxes (such as self-insurers)?

_____

_____

12. What problems has your plan experienced? _____

_____

_____

13. Additional comments:

The Indiana plan has a provision whereby the pre-existing condition waiting period can be waived if the individual is willing to pay an additional premium of 10% over the life of the contract. This provision has worked very well. As of November 1, 1984, over 1,400 policy-holders were using this waiver.

Indiana also has a list of conditions whereby a rejection notice from an insurance carrier is not required to become eligible for the plan.

COMMUNICATING FOR AGRICULTURE

Law Office Building
P.O. Box 677
Fergus Falls, Minnesota 56537-9990

Phone (218) 739-3241

WISCONSIN APRIL 1985

I. PLAN SUMMARY

1. Wisconsin Contact:	Ms. Rosemary Van Susteren P.O. Box 7873 Madison, WI 53707 (608) 267-2305
2. Plan Administrator:	Mutual of Omaha
3. Effective Date:	June 1981
4. Board Composition:	9 members - Commissioner or his Rep., Rep. of Health Policy Council, Reps. of 2 nonprofit insurers appointed by Comm., Reps. of 2 other insurers, 3 public members appt. by Commissioner
5. Benefit:	$250,000 Lifetime Benefit
6. Deductible:	Plan I - $1,000 Plan II - Medicare Part A deductible
7. Stop Loss:	Plan I - $2,000/Individual $4,000/Family Plan II - $500
8. Premium Cap:	150% Maximum
9. Waiting Period:	6 months for pre-existing conditions
10. Pre-existing conditions:	Not covered if diagnosed or treated within 6 months preceding the policy date until 6 months after the policy date.
11. Eligibility Criteria:	Cancelled or rejected by two carriers, rider by one carrier 50% or greater premium increase by one carrier.
12. Agent fee:	Referral fee of $35
13. Medicare qualified plan:	Yes, for persons under 65

WISCONSIN

II. OPERATIONAL DATA

1. Total individuals covered by plan at end of:

1981	309
1982	977
1983	1,798
1984	1,916
As of April 1, 1985	1,940

2. Total premiums collected by plan at end of:

1981	$ 127,740.00
1982	$ 618,216.00
1983	$ 1,232,352.00
1984	$ 2,079,996.00

3. Total claims paid by plan at end of:

1981	$ 37,165.00
1982	$ 1,144,686.00
1983	$ 2,463,703.00
1984	$ 3,104,604.00

4. Total assessment to members of plan for:

1981	$ 100,000.00
1982	$ 1,300,000.00
1983	$ 2,000,000.00
1984	$ 1,683,925.00 (Collected)

5. What was the cost to administer the plan in:

1981	$ 28,212.00
1982	$ 85,206.00
1983	$ 156,964.00
1984	$ 196,338.00

6. Does your state allow for a premium tax credit on the assessment? ___ Yes X No

Comments

7. Is there a maximum percentage assessment allowed towards the companies (such as 1%)? ___ Yes X No

Comments:

8. What was the percentage assessed to members (such as .8%) at the end of:

1981	N/A
1982	N/A
1983	N/A
1984	N/A

9. What were the total premiums collected by all companies in your state at the end of:

1981	$	N/A
1982	$	N/A
1983	$	N/A
1984	$	N/A

10. What were the total premium taxes paid by all companies in your state at the end of:

1981	$	N/A
1982	$	N/A
1983	$	N/A
1984	$	N/A

11. Did the above taxes paid include all companies or were some exempt from paying taxes (such as self-insurers)?
N/A

12. What problems has your plan experienced? Coordinating benefits with other government programs. Cash flow problems experienced first two years.

13. Additional comments:

Experience for Wisconsin shows that for each $1.00 of premium received, paid claims are $2.00

Wisconsin will be considering legislation in 1985 to allow for the members of the pool to receive general program revenue relief against some of their assessment. Legislation will also be considered to allow premium subsidies for those individuals with a low income.

Richard BEAULIEU, Appellant,
v.
James V. ELLIOTT, Appellee.

James V. ELLIOTT, Appellant,
v.
Richard BEAULIEU, Appellee.
Nos. 765, 766.

Supreme Court of Alaska.
Dec. 5, 1967.

Action for damages for personal injuries sustained in automobile accident. The Superior Court, Third Judicial District, Hubert A. Gilbert, J., entered judgment for plaintiff and defendant appealed. The Supreme Court, Dimond, J., held that record which disclosed implicit finding that plaintiff's wage earning capacity had been impaired for remainder of his work life of 29 years and disclosing testimony that plaintiff's inability to work would only continue from one to five years did not set forth findings of fact to enable reviewing court to have clear understanding of basis of trial court's decision that plaintiff sustained permanent 50 percent impairment of earning capacity and case would be remanded for more detailed and explicit findings of fact.

Judgment set aside and case remanded with directions.

1. Administrative Law and Procedure ⇐501

Findings or judgment of quasi-judicial administrative agency in proceedings before it are not admissible in subsequent action against person not a party to such proceedings.

2. Attorney and Client ⇐85

Admissions of fact by counsel during course of trial are binding on his client if made with express purpose of dispensing with formal proof of some fact at trial and are thus used as substitute for legal evidence of the fact.

3. Evidence ⇐264

Even if statement in defendant's brief filed subsequent to close of trial suggesting award to be made plaintiff for damages from personal injuries and containing computation based on 50 percent disability rating for next five years did constitute admission of fact binding on defendant, it admitted only that plaintiff's earning capacity had been 50 percent impaired for period of five years and not for plaintiff's remaining work life.

4. Trial ⇐388(1)

Trial court must comply meticulously with requirements of rule with respect to making of findings of fact in order to give reviewing court clear understanding of basis of trial court's decision and to enable reviewing court properly to appraise elements which entered into award of damages. Rules of Civil Procedure, rule 52(a).

5. Appeal and Error ⇐1177(8)
Trial ⇐395(1)

Record which disclosed implicit finding that plaintiff's wage earning capacity had been impaired for remainder of his work life of 29 years and disclosing testimony that plaintiff's inability to work would only continue from one to five years did not set forth findings of fact to enable reviewing court to have clear understanding of basis of trial court's decision that plaintiff sustained permanent 50 percent impairment of earning capacity and case would be remanded for more detailed and explicit findings of fact. Rules of Civil Procedure, rule 52(a).

6. Appeal and Error ⇐1176(1)

Whether trial court improperly used Air Force physical evaluation board's findings to award plaintiff $16,088 for impaired earning potential caused by depressive reaction could not be determined where trial court in awarding total of $169,937.25 made no mention of award for $16,088 for depressive reaction and trial court would be directed to make more detailed and explicit findings of fact on remand. Rules of Civil Procedure, rule 52(a).

7. Damages ⇐15

General principle underlying assessment of damages in tort cases is that injured person is entitled to be replaced as nearly as possible in position he would have occupied had it not been for defendant's tort.

8. Damages ⇐226

Damages awarded for future loss of earnings should not be reduced to present value.

9. Damages ⇐60

Disability retirement pay which plaintiff became entitled to upon retirement from Air Force by reason of injuries sustained in automobile accident would not be used to mitigate damages and reduce award for loss of future earnings.

10. Damages ⇐100

Damage award for impairment of earning capacity should not be reduced by amount representing estimated income taxes that injured party would have to pay on future income.

11. Damages ⇐99

Amount of income taxes which injured party would have had to pay had he earned amount awarded prior to trial should be deducted from the award for past loss of wages.

12. Damages ⇐60

Damages in form of past loss of wages sustained by serviceman as result of automobile accident could not be diminished or mitigated on account of payments received by serviceman from Air Force by virtue of contractual arrangement between serviceman and government for payment during periods of physical incapacity from performing his duty.

13. Damages ⇐132.5

Evidence that osteomyelitis had developed in bone of plaintiff's ankle injured in automobile accident and testimony that it was reasonable medical probability that osteomyelitis would remain with plaintiff for rest of his life supported award of $71,241 for pain and suffering that plaintiff would experience for expected 29 years remaining of his life.

14. Damages ⇐97

In determining amount of award for pain and suffering, juror or judge should necessarily be guided by some reasonable and practical consideration and should endeavor to make reasonable or sane estimate.

15. Damages ⇐97

There is no fixed measure of compensation in awarding damages for pain and suffering.

16. Damages ⇐97

Assessing damages for future pain and suffering by using per diem formula was not manifestly unfair or unjust.

17. Appeal and Error ⇐1013

Ultimate question for decision on review of award for damages for pain and suffering is whether sum awarded is reasonable and not how it was arrived at.

18. Appeal and Error ⇐1013

Award of damages will not be set aside on claim of excessiveness unless it is so large as to appear manifestly unjust or result of passion or prejudice or disregard of evidence or rules of law.

19. Damages ⇐226

Amount awarded for future pain and suffering will not be reduced to present worth.

20. Damages ⇐185(1)

Record disclosing no testimony by plaintiff's physician that he told plaintiff to bear as much weight as possible on injured ankle and disclosing that physician prescribed that plaintiff use crutches to tolerance by testing how much weight he would be able to put on his foot would not substantiate defendant's claim that plaintiff's pain and suffering were attributable to plaintiff's failure to follow orders of his doctor in not bearing as much weight as possible on his ankle.

21. Appeal and Error ⇐1176(1)

Record which failed to disclose why trial court used plaintiff's military pay rather than civilian pay scales in computing plaintiff's impairment of future earning capacity as result of injury to ankle, where plaintiff indicated that he might have retired from military service if he had not received medical discharge because of injury, was insufficient to enable reviewing court to determine whether award for impairment of future earning capacity was inadequate and trial court would be directed to make further findings on remand.

22. Appeal and Error ⇐1177(8)

Findings disclosed by record were not sufficient for purpose of determining whether evidence established that impairment of plaintiff's earning capacity was total or near total rather than 50 percent as determined by trial court.

23. Appeal and Error ⇐984(5)

Where liability is admitted but amount of damages is contested, question of which category of rule pertaining to computation of attorney fees is applicable is matter within discretion of trial court. Rules of Civil Procedure, rule 82(a)(1).

24. Costs ⇐173(1)

Where liability for injury to plaintiff's ankle was admitted but question of damages was contested in four-day trial resulting in award of $169,937.25 compensatory damages, trial court's assessing attorney's fees at rate prescribed by rule for cases concluded without trial was not abuse of discretion. Rules of Civil Procedure, rule 82(a)(1).

25. Appeal and Error ⇐981(1)
Costs ⇐12

Taxing of costs rests largely in sound discretion of trial court and reviewing court will not interfere with exercise of that discretion except in cases of abuse.

26. Costs ⇐154

Refusal to include in costs assessed against defendant certain expenses incident to taking of depositions which allegedly were necessary to establish liability, where plaintiff did not point out what depositions were involved, how they related to liability, when they were taken, or when concession of liability was made by defendants, was not abuse of discretion.

James J. Delaney, Jr., and James K. Singleton, of Delaney, Wiles, Moore & Hayes, Anchorage, for appellant in No. 765 and appellee in 766.

Robert M. Libbey, of Kay, Miller, Jacobs & Libbey, Anchorage, for appellee in No. 765 and appellant in 766.

Before NESBETT, C. J., and DIMOND and RABINOWITZ, JJ.

OPINION

DIMOND, Justice.

As a result of an automobile accident on April 13, 1963, James Elliott suffered a fracture dislocation of his right ankle. He brought this action for damages against Richard Beaulieu. Liability was conceded by Beaulieu, and the issue of damages was tried by the court without a jury. The trial court filed findings of fact and conclusions of law and entered judgment awarding Elliott $169,937.25 compensatory damages, costs of $82.40, and attorney's fees in the amount of $13,870.29. Both parties have appealed. We shall consider first Beaulieu's appeal.

Beaulieu's Appeal

In his brief on appeal, Beaulieu states 21 specifications of error. These resolve themselves into six principal issues to be reviewed and determined by this court.

1. *Impairment of Earning Capacity.*

There is no question but that Elliott suffered a permanent injury. The fracture dislocation of his right ankle, after several unsuccessful operations, resulted in a lack of a true ankle joint per se. As Dr. Scholtens said: "There is simply a ragged margin of rather sclerotic bone." He also stated, "It's not a joint any more but it's just a couple of pieces of bone grating against each other." Dr. Wichman testified that the joint was such that Elliott's ankle could be used only as a "peg". In

addition, osteomyelitis developed in the ankle bone and both Shelton and ... testified that the reasonable medical probabilities were that such disease would continue for the remainder of Elliott's life.

In its third conclusion of law the trial court stated:

> That plaintiff will suffer a future wage loss in the amount of $80,110.40, after taking into consideration the fact that his wage earning capacity has been impaired to the extent of fifty (50%) per cent plus the further fact that his rate of pay at the time of discharge was $402.30 per month and plus the further fact that he has a remaining work life of twenty-nine (29) years.[1]

Beaulieu contends that there is no evidence to support the court's determination that Elliott suffered an impairment of earning capacity which would result in a loss of future wages.

On this point we must remand the case to the trial court for the making of more explicit findings of fact. The court's conclusion as to loss of future wages contains the implicit finding that Elliott's wage earning capacity had been impaired for the remainder of his work life of 29 years. The court gives no indication, however, of the factual basis for such an ultimate finding, nor does it indicate how it reconciles such a finding with the testimony of two physicians who spoke on the subject of Elliott's capacity to be gainfully employed. Dr. Foster testified that in his opinion, while Elliott was unable to work at the time of the trial in 1966, this inability would at the most only continue from one to five years, and that the condition of Elliott's ankle would steadily improve so that within that period of time he would be able to engage in a sedentary type of occupation that would not involve prolonged walking, running or ... lifting. It was Dr. Foster's opinion that Elliott's future earning capacity was impaired only to the extent that he must move to clerical work rather than truck driving which he had done prior to 1963. Dr. Wickman testified that the prognosis of the condition of Elliott's ankle was satisfactory, that he would be limited in daily activities because he would have to use his ankle as a peg and would be deprived of the movements that a normal ankle offers, that it would be possible for him to be gainfully employed in a sedentary type of occupation, but that he could not give an estimate as to when that might be because he did not know how much dead bone was present in the ankle.

As to the extent of impaired earning capacity, the court reached the conclusion that there was a 50% impairment. But the court does not say how it arrived at that figure. And we are unable to tell from our review of the record.

Conceivably, the court's determination of a percentage impairment was influenced by Elliott's testimony that he had received a medical discharge from the United States Air Force in January of 1966, and that he was receiving from the government a 60% disability compensation, 40% of which was attributable to his ankle, and the remaining 20% to other medical problems not related to the accident. That this may have influenced the court appears to be a possibility, because the court made Finding of Fact No. 19 which provided as follows:

> That on October 17, 1964, plaintiff was discharged from the hospital to "travel status"; that on January 14, 1966, plaintiff was given a medical discharge from the Air Force, as above mentioned; that the physical evaluation board, found plaintiff to be 60% disabled, assigning a 40% disability because of the injuries to plaintiff's right ankle, a 10% disability to a "depressive reaction" and a 10% disability due to an impairment of vision; that the latter disability is not related to the accident of April 13, 1963.[2]

[1] If the court based its conclusion as to degree of impairment of earning capacity upon certain findings of an Air Force physical evaluation board, this would have been error. The findings or judgment of a quasi-judicial administrative agency in proceedings before it are not admissible in a subsequent action against a person not a party to such proceedings.[3]

The trial court also may have been influenced in its determination of the existence of a 50% impairment of earning capacity by what Elliott characterizes as admissions made by Beaulieu's trial counsel. In his opening statement at the trial, counsel for Beaulieu admitted that Elliott had sustained a "permanent injury", that this did not render him 100% disabled, and that the question for determination was just how much "he will lose in the future because of the injury." In his brief filed subsequent to the close of the trial Beaulieu's counsel said this:

> In summary, it is suggested by the defense that the Court make its award to the Plaintiff on the basis of the figures set forth below. These figures take into consideration: The prognosis established by the medical experts; the 60% disability rating established by the Air Force, of which 50% is attributable to Plaintiff's ankle injury; and, the Plaintiff's ability to be gainfully employed in the future as a clerk or transportation specialist in the transportation industry, or as a travel agent.
>
> * * * [I]t is * * * suggested that the following award be made:

For past lost wages	$10,000.00
For future "lost wages", or diminution of earning capacity, based on 50% disability rating for the next five years ...	11,500.00
For past pain and suffering	7,000.00
For future pain and suffering	10,000.00
For permanent disability and injury to ankle	25,000.00
Total	$61,500.00

[2,3] It is true that admissions of fact by counsel during the course of the trial are binding on his client,[4] if they are made with the express purpose of dispensing with the formal proof of some fact at the trial, and are thus used as a substitute for legal evidence of the fact.[5] It does not appear that this was the purpose of counsel's statement in his brief filed subsequent to the trial. But even if it did constitute an admission of fact binding on Beaulieu, it is an admission only that Elli-

1. The pertinent part of Conclusion of Law No. 3 originally read:
   "That plaintiff will suffer a future wage loss in the amount of $80,110.40, after taking into consideration the *fact that his disability is 50%*. * * * [Emphasis added.]
   The italicized words were amended by the court on Elliott's motion to read: "That his wage earning capacity has been impaired to the extent of fifty (50%) per cent."

2. Apart from Elliott's testimony just mentioned, we do not know where the trial court obtained information regarding the findings of the Air Force physical evaluation board. Such findings were not introduced into evidence at the trial.

3. Cady v. Fraser, 122 Colo. 252, 222 P.2d 422, 425 (1950).

4. Ferrolino Corp. v. General Aniline & Film Corp., 207 F.2d 912, 916-917 (7th Cir. 1953), cert. denied, 347 U.S. 953, 74 S.Ct. 673, 98 L.Ed. 1098 (1954), reh. denied, 347 U.S. 979, 74 S.Ct. 784, 98 L.Ed. 1118 (1954), reh. denied, 348 U.S. 851, 75 S.Ct. 19, 99 L.Ed. 671 (1954).

5. Dallas v. Stovall, 48 Wash.2d 619, 296 P.2d 312, 313 (1956); Humble Oil & Refining Co. v. Sun Oil Co., 190 F.2d 705, 711 (4th Cir. 1951), cert. denied, 342 U.S. 820, 72 S.Ct. 367, 96 L.Ed. 617 (1952).

ott's earning capacity had been [illegible] impaired for a period of five years, and not for the remaining work life of [illegible] of 29 years as found by the trial court. Consequently, what Beaulieu's counsel said in his brief does not satisfactorily explain or establish the basis for the trial court's Conclusion of Law No. 3 which dealt with impairment of earning capacity.

[4, 5] It is most important that the trial court comply meticulously with the requirements of Civil Rule 52(a) [6] with respect to the making of findings of fact in order to give us a clear understanding of the basis of the trial court's decision, and to enable us to properly appraise the elements which entered into the court's award of damages.[7] This was not done in this case. Our review of the record leaves us with the conclusion that the trial court's findings with respect to damages for future impairment of earning capacity are not sufficiently detailed to afford us a clear understanding of the basis for the court's award.[8] We therefore will remand this case to the trial court for the purpose of making detailed and explicit findings as to Elliott's earning capacity and the degree of impairment in respect thereto.[9]

In his Finding of Fact No. 19 the trial court referred to the fact that the Air Force physical evaluation board had found Elliott to be 60% disabled, and that 10% of that disability was due to a "depressive reaction". In Finding of Fact No. 22 the court stated that a psychiatric evaluation of Elliott had been made, that the psychiatric findings were that Elliott had developed a depressive reaction attributable to permanent crippling, deformity of the lower extremity, semi-isolation, and a protracted period of surgery and recovery, and that such depressive reaction was proximately caused by the accident of April 15, 1963. Beaulieu contends that the judge used the Air Force physical evaluation board's findings to award Elliott $16,083.60 for that part of his impaired earning potential caused by a depressive reaction, and that this was error.

[6] We are unable to review this point because nowhere in the court's finding of fact or conclusions of law or judgment is there any mention of an award of $16,083.-00 for a depressive reaction as an element of Elliott's impaired earning capacity. It may be that the trial court intended that of the 50% impairment of earning capacity which is found to exist, 10% was due to a depressive reaction. However, we are unable to determine if that is the case from the record as it now exists. This point should be clarified on a remand of the case for more detailed and explicit findings of fact.

2. *Future Wage Loss—Present Value.*

The trial court did not reduce the amount it found as damages for future impairment of earning capacity to present value. Instead, the court stated that "The interest rate reduction and decline in purchasing power of the dollar is off-set by pay increases plaintiff could have expected in the future from his military service." Beaulieu contends that the failure to reduce the damages to present value was prejudicial error.

[7] The general principle underlying the assessment of damages in tort cases is that an injured person is entitled to be

6. Civ.R. 52(a) provides in part:
In all actions tried upon the facts without a jury or with an advisory jury, the court shall find the facts specially and state separately its conclusions of law thereon and direct the entry of the appropriate judgment • • •.

7. Patrick v. Sedwick, 413 P.2d 169, 174-176 (Alaska 1966); Hamilton v. Lotto, 391 P.2d 948, 949 (Alaska 1964); Spenard Plumbing & Heating Co. v. Wright Const. Co., 370 P.2d 519, 525-526 (Alaska 1962); Merrill v. Merrill, 368 P.2d 510, 518 (Alaska 1962); Dickerson v. Gebermann, 368 P.2d 217, 219 (Alaska 1962).

8. Patrick v. Sedwick, note 7 supra, 413 P.2d at 175.

9. Patrick v. Sedwick, note 7, supra, 413 P.2d at 176.

replaced as nearly as possible in the position he would have occupied had it not been for the defendant's tort.[10] In the case of impairment of future earning capacity, it is reasoned that a failure to reduce damages to present value would be to place the injured person in a better position than he would have occupied except for the defendant's tort, because the injured person would get all of his future wages long in advance and would be able to invest the lump sum and realize earnings on such investment during the intervening period.[11] For this reason—that money has the power to earn money—it has become the generally accepted rule that damages awarded for future loss of earnings should be reduced to present worth.[12]

[8] In applying the general rule, the Supreme Court of Washington has stated a formula for reducing awards of future earnings to present value which involves the "rate of interest (which) could fairly be expected from safe investments which a person of ordinary prudence, but without particular financial experience or skill, would make in that locality." [13] This formula, although empirical at best, is probably as definite as any that has been devised. But we believe that the rule for reducing awards, including the formula applied by the Washington court, ignores facts which should not be ignored. Annual inflation at a varying rate is and has been with us for many years. There is no reason to expect that it will not be with us in the future. This rate of depreciation offsets the interest that could be earned on government bonds and many other "safe" investments. As a result the plaintiff, who through no fault of his own is given his future earnings reduced to present value must, in order to realize his full earnings and not be penalized by reduction of future earnings to present value, invest his money in enterprises, other than those which are considered "safe" investments, which promise a return in interest or dividends greater than the offsetting rate of annual inflation. But ours is a competitive economy. By their very nature some enterprises backed by investors' money are going to fail with resulting loss to individuals. Thus, instead of being assured of earnings at rates greater than the annual rate of inflation, the injured plaintiff stands a chance of entirely losing his future earnings by unlucky or unwise investments. Since the plaintiff, through the defendant's fault and not his own, has been placed in the position of having no assurance that his award of future earnings, reduced to present value, can be utilized so that he will ultimately realize his full earnings, we believe that justice will best be served by permitting the trier of fact to compute loss of future earnings without reduction to present value. The plaintiff is more likely to be restored to his original condition under the rule we adopt than under the prevailing rule which calls for a discounting of the award for future earnings.

Our conclusion is fortified by another factor which also may not be ignored. This is the factor, relied upon by the trial judge, which involves wage increases that the injured plaintiff might have expected to receive in the future had he not been injured.

10. Hill v. Varner, 3 Utah 2d 166, 280 P.2d 448, 449 (1955); Restatement, Torts § 924 comment d, at 634-35 (1939); McCormick, Damages § 86, at 301 (1935). Accord United States v. Holbley, 257 F.2d 920, 923, 79 A.L.R.2d 668 (10th Cir. 1958); Hoghett v. Caldwell County, 313 Ky. 85, 90, 230 S.W.2d 92, 21 A.L.R.2d 373 (1950).

11. McCormick, Damages § 86, at 301 (1935).

12. Wentz v. T. E. Connolly, Inc., 45 Wash. 2d 127, 273 P.2d 485, 491 (1951); Borchelding v. Eklund, 156 Neb. 196, 55 N.W.2d 643, 650 (1952); Dunphy v. Cline, 221 N.C. 381, 20 S.E.2d 322, 324, 151 A.L.R. 789 (1944); Rigby v. Price, 290 Mo. 10, 233 S.W. 828, 832 (1921); Restatement, Torts § 924 comment d, at 634-35 (1939); McCormick, Damages § 86, at 301 (1935); Annots., 77 A.L.R. 1439, 1446 (1932) 151 A.L.R. 796, 797 (1944).

13. Wentz v. T. E. Connolly, Inc., supra note 12, 270 P.2d at 492.

It is a matter of common experience that as one progresses in his chosen occupation or profession he is likely to increase his earnings as the years pass by. In nearly any occupation a wage earner can reasonably expect to receive wage increases from time to time. This factor is generally not taken into account when loss of future wages is determined, because there is no definite way of determining at the time of trial what wage increases the plaintiff may expect to receive in the years to come. However, this factor may be taken into account to some extent when considered to be an offsetting factor to the result reached when future earnings are not reduced to present value. Thus, if there is any fear that failure to reduce the present value will give the plaintiff more than he is entitled to because of the possibility of his making successful investments of the sum awarded at returns greater than the annual rate of inflation, such fear is obviated by the fact that the award may well be deficient in that it does not take into account probable wage increases that the plaintiff would ordinarily be expected to receive in the future.

3. *Retirement Pay.*

Elliott testified that he would receive disability retirement pay from the Air Force in the amount of $191.00 a month for the remainder of his life. Beaulieu contends that the trial judge committed prejudicial error in refusing to deduct the net present value of future retirement pay from the award for future loss of earnings. Beaulieu's argument is that to allow Elliott damages for future wage loss, in addition to his retirement pay, is to unjustly enrich Elliott by allowing him double compensation for his injuries.

[9] The general principle underlying the assessment of damages in tort cases is that an injured person is entitled to be replaced as nearly as possible in the position he would have occupied had it not been for the defendant's tort.[14] Elliott had been in the Air Force for about 18 years at the time of his discharge and he testified that he had intended to remain in the service for at least 20 years. If he had not been injured, Elliott could have continued to earn to his full capacity and, in addition, after 20 years' service, would have been entitled to retire and draw retirement pay.[15] By reason of his injuries, Elliott was entitled under law to be retired early for disability and draw retirement pay in lieu of retirement on a regular basis after completion of 20 years' service.[16] The award of damages for impaired earning capacity has the effect of putting Elliott in the same position he would have occupied had it not been for the injury, because the damages represent what Elliott could have earned had he not been injured and the disability retirement pay represents that which Elliott had earned and become entitled to under law by reason of his years of service in the Air Force. In other words, Elliott now receives an amount representing wages he could have earned were it not for the injury, plus retirement pay; had he not been injured, he would have received the full wages he could have earned during his remaining work life, in addition to receiving the retirement pay to which he would become entitled by reason of his years of service in the Air Force. Thus, Elliott, under the court's award, is getting no more than he would have gotten had he not been injured. The disability retirement pay Elliott is receiving should not be used to mitigate damages and reduce the award for loss of future earnings.

4. *Income Taxes.*

Beaulieu argues that the trial judge erred in failing to deduct from the damages awarded for impairment of future earning capacity an amount representing income taxes that Elliott would have had to pay on future income.

The courts are divided on this question. It is the more general view, supported by a majority of American decisions, that an amount representing future income taxes should not be deducted from the award.[17] As was stated by the Supreme Court of Rhode Island:

> This view has been adopted by the various courts on diverse grounds but primarily on the ground that the quantum of such taxation is of necessity in the realm of conjecture.[18]

[10] We adopt the majority rule. Income tax rates, provisions relating to deductions and exemptions, and other aspects of income tax laws and regulations are so subject to change in the future that we believe that a court cannot predict with sufficient certainty just what amounts of money a plaintiff would be obliged to pay in federal and state income taxes on income that he would have earned in the future had it not been for a defendant's tortious conduct. We hold that a damage award for impairment of earning capacity should not be reduced by an estimated amount representing income taxes that the injured party may be required to pay on future income. In awarding damages to Elliott for impaired earning capacity, the court did not err in failing to take income tax consequences into consideration.

[11] The rule we adopt has no application, however, as to the court's award of past wages in the amount of over $10,000.00. The reason for the rule—inability to predict with sufficient certainty what taxes would have to be paid—does not exist here, because taxes on income earned prior to trial can be easily calculated based on income tax laws and regulations as they existed at the time the wages would have been earned. The court erred in failing to deduct from the award for past loss of wages the income taxes Elliott would have had to pay had he earned the amount awarded prior to the trial.

5. *Past Loss of Wages.*

Elliott testified that he had not lost any military pay or allowances between the date of the accident in April 1955 and the date of his military discharge in January 1956. During that period of time Elliott was either hospitalized or on leave, except for the period January to August, 1954, when he was on duty status. The trial court awarded $10,752.85 for a partial past wage loss covering the period from the date of the accident to the day of Elliott's discharge from the Air Force, but excepting the period between January and August, 1954, when Elliott was on duty status.

Beaulieu contends that this award for past wages was error. His argument in essence is that the general principle underlying the assessment of damages in tort cases is that the injured person is entitled to be replaced as nearly as possible in the position he would have occupied had it not been for the defendant's tort, and that since Elliott suffered no loss of wages during the period in which he should be awarded none.

[12] In arguing that the award should be sustained, Elliott urges the adoption of the collateral source rule, which provides that damages may not be diminished or mitigated on account of payments received by plaintiff from a source other than the defendant.[19] We applied this rule as to workmen's compensation benefits in Ridgeway v. North Star Terminal & Stevedoring Co.[20] We apply the rule in this instance. By entering the military service, Elliott in effect agreed to perform certain duties and func-

14. Note 10 supra.

15. 10 U.S.C.A. §§ 8914, 8880, 8991 (1959).

16. 10 U.S.C.A. §§ 1201, 1402 (1959).

17. Annot., 63 A.L.R.2d 1295, 1296 (1959).

18. Odin v. Cardi, 218 A.2d 370, 377 (R.I. 1966). See also Dixie Feed & Seed Co. v. Byrd, 52 Tenn.App. 619, 376 S.W.2d 715, 719 (1963); appeal dismissed, 379 U.S. 15, 85 S.Ct. 117, 13 L.Ed.2d 84 (1964); Cunningham v. Roderiet Vinedegen, 323 F.2d 308, 313-315 (2d Cir. 1963); Spencer v. Martin K. Eby Const. Co., 196 Kan. 315, 350 P.2d 18, 22-25 (1960); Kawamoto v. Yamatake, 49 Haw. 42, 410 P.2d 976, 981 (1966).

19. Bell v. Primeau, 101 N.H. 227, 138 A.2d 729, 730, 7 A.L.R.3d 512, 514 (1962). The collateral source rule is followed in most jurisdictions. Annot., 7 A.L.R.3d 516, 520 (1966).

20. 378 P.2d 617, 650 (Alaska 1963).

tions in exchange for certain benefits given him by the government. One of these benefits was that he was to receive military pay and allowances during periods of physical incapacity from performing his duties. This was in the nature of a contractual arrangement between Elliott and the government when he became a member of the armed forces, and which he may have paid for by accepting wages lower than those he might have obtained from the performance of like duties in civilian life. The income that Elliott received from the government is not the result of earnings, but of such previous contractual arrangement.[21] Such a contractual arrangement was made for Elliott's own benefit, and not for the benefit of a tort feasor, such as Beaulieu. The latter has no right to claim the benefit of such an arrangement by having the damages awarded against him reduced by the amount that Elliott was paid by the government during the period of his disability. The trial court did not err in awarding damages for loss of wages during the period of Elliott's disability while he was still in the military service.

5. Future Pain and Suffering.

The court awarded Elliott $71,211.00 for pain and suffering that he would experience for the remainder of his life. Beaulieu contends that the evidence does not justify such an award.

An infection, osteomyelitis, had developed in the bone of Elliott's injured ankle. Elliott testified that from the time of the onset of the osteomyelitis he was required to keep his ankle in an upright position for a period of from four to five days on an average of once a month to alleviate the pain he experienced, that he suffered pain of a sufficient intensity to keep him awake the better part of the night on an average of one night per week, and that there was an open, draining sinus on his ankle. Beaulieu concedes that Elliott's testimony was sufficient to justify an award for past pain and suffering.[22] However, Beaulieu contends that there is a lack of substantial medical evidence to justify an award for pain and suffering in the future.

Dr. Wichman testified that the osteomyelitis would cause the sinus tract in Elliott's ankle to become obliterated or plugged by bone particles in the drainage fluid—osteomyelitis being the type of infection caused by the healing process in draining away or discarding dead bone—and that this caused a pressure build-up and a swelling with resulting pain.

Dr. Foster testified that the probable source of Elliott's pain was the presence of injured tissues which, throughout the injury, operation and infection, became so altered that with use they became sore. It is true, as Beaulieu points out, that Dr. Foster said that within approximately five years from the time of trial, Elliott would be able to return to work and would no longer be limited by the infection. But the doctor also testified that at the end of the five-year period Elliott would still have some pain, and that it was a reasonable medical probability that the osteomyelitis would remain with Elliott the rest of his life.

Dr. Scholtens gave his opinion as to the reasonable medical probability of the infection in Elliott's ankle continuing for the remainder of his life. He said:

> Yes, I have an opinion, and my opinion is that the infection present, by all odds, will continue, there's an excellent possibility for the rest of his life, no matter what medical attempts are made to clear the infection in the ankle. Present—the experience with osteomyelitis indicates that it's very, very difficult to treat, that cures are relatively infrequent. Recurrences of those that appear to be cured are frequent. For those reasons, I would feel that he, at present, has a chronic infection. He has the fuel for the infection, dead bone, and I think that this will continue in the future for as far as I can see.

And as to the reasonable medical probability of the general condition of the ankle improving or remaining the same, Dr. Scholtens said:

> I'd say that the chances are that his ankle will stay very much the same as it is, with no appreciable change. This is by far the greatest probability. * * * There's- there's a slight chance that it could get worse. There's a slight chance that it could get better, but—and I'm not talking in terms that if he never sees a doctor again. I mean if he's treated, I think the chances of this appreciably improving are slim or really of getting a great deal worse, that's what I'm saying.

[13] The trial court found that it was a reasonable medical probability that Elliott's condition, including the infection in the ankle and the pain, would continue for the remainder of his life. The medical evidence supports such a finding; we cannot say that it is clearly erroneous. Such a finding, in turn, justifies the court's conclusion that Elliott should be awarded damages for pain and suffering for the remainder of his life. An award of such damages was not error.

The trial court used a per diem formula in assessing damages for future pain and suffering. In its Conclusion of Law No. 5 the court said:

> That plaintiff is entitled to recover from defendant the sum of $78,636.00 for past and future pain and suffering, for his general physical disability and permanent crippling and for the fact that he will no longer be able to lead that sort of life to which he had become accustomed. The past pain and suffering is set at the sum of $7,500.00. The future pain and suffering of $71,211.00 is based upon a finding of $20.00 per day for 52 days per year and an additional $3.00 per day for 313 days per year for a total sum of $1,979.00 per year multiplied by 36 years.

Beaulieu contends that such a method of ascertaining damages constituted prejudicial error.

A similar contention was made by a defendant in Imperial Oil, Ltd. v. Drlik, 234 F.2d 4 (6th Cir. 1956), cert. denied, 352 U.S. 941, 77 S.Ct. 261, 1 L.Ed.2d 236 (1956), where the trial court had used a per diem formula in awarding damages for pain and suffering. It was argued there that damages for pain and suffering cannot be properly computed by using a mathematical formula. In answer to this argument, the Court of Appeals said:

> It remains to be considered whether the method used by the District Judge in determining the total amount was error as a matter of law. It may be that it was a novel one but it does not follow that it invalidates the award. In determining the amount of an award for pain and suffering a juror or judge should necessarily be guided by some reasonable and practical considerations. It should not be a blind guess or the pulling of a figure out of the air. At the same time there is no exact or precise measuring stick. Exact compensation is impossible in the abstract but the juror or judge should endeavor to make a reasonable or sane estimate. The practical considerations influencing a particular juror or judge or the reasoning used by him may very well differ with the method used by another juror or judge, yet each of such different methods or modes of reasoning may be a reasonable method of reaching the desired result. We are more concerned with the result reached by a reasonable process of reasoning and consistent with the evidence, than we are with which one of several suitable formulas was actually used by the juror or judge. It is not necessary for us to adopt the method used by the District Judge as a rule of law for the proper disposition of such an issue, and we do not do so. In our opinion, it was not an arbitrary or unreasonable approach to the problem presented and its application was so adjusted in the present case as to be consistent

21. Restatement, Torts § 920 comment c (1939).

22. The trial judge awarded Elliott $7,500 for past pain and suffering.

with the evidence and to reach a result which does not appear to us to be manifestly unjust. United States v. Puscedu, 5 Cir., 224 F.2d 5; City of Knoxville, Tenn. v. Bailey, 4 Cir., 222 F.2d 529, 531.[23]

[14-17] We agree with the foregoing. As we stated in Patrick v. Sedwick,[24] there is no fixed measure of compensation in awarding damages for pain and suffering, and such an award necessarily rests in the good sense and deliberate judgment of the tribunal assigned by law to ascertain what is just compensation. We can see nothing manifestly unfair or unjust about the method used by the trial court in assessing damages for future pain and suffering. In fact, as was suggested in the dissenting opinion in the Kansas case of Caylor v. Atchison, Topeka & Santa Fe Ry. Co.,[25] it appears to be a fair argument and a rational approach to treat damages for pain the way it is endured—day by day, month by month, year by year. Ultimately, however, the question for decision is whether the total sum is reasonable or not, regardless of how it was arrived at. We find no error in the method used by the trial court in awarding damages for future pain and suffering.

[18] Beaulieu contends that the total sum awarded is unreasonable and is grossly excessive. We shall not set aside an award on a claim of excessiveness unless it is so large as to strike us that it is manifestly unjust, such as being the result of passion or prejudice or a disregard of the evidence or rules of law.[26] Considering the evidence of permanent damage to Elliott's ankle, the osteomyelitis, and the pain and suffering he is likely to endure for the remainder of his life, it is our opinion that the award for future pain and suffering was not manifestly unjust.[27] And Beaulieu has not contended in his brief or in oral argument that the trial court acted through passion or prejudice.

Beaulieu contends that the court erred in not reducing the future pain and suffering award to present value. He relies principally on the case of Affett v. Milwaukee & Suburban Transp. Corp.,[28] where the court, after disapproving of the use of a mathematical formula for computing damages for pain and suffering, said: Logically, if this method were followed, the gross amount arrived at should be discounted to its present worth." [29]

[19] If an award for future pain and suffering must be reduced to present value when a mathematical formula is used, it must be for the same reason that an award for future earnings is discounted under the prevailing rule—i. e., because the plaintiff receives his damages for the future long in advance and is able to invest the sum awarded and realize earnings during the intervening period. But we have held that as to impairment of future earning capacity, the award should not be reduced to present value. The same reasoning applies here as to an award for future pain and suffering. Because of the annual rate of inflation offsetting dividends or interest that may be expected on "safe" investments, and of the risk of loss involved in making other investments, a plaintiff is more likely to be restored to his original condition had defendant not committed his tort by allowing the plaintiff his award for future pain and suffering without reduction to present worth.

Finally, Beaulieu contends that the greater part of Elliott's pain and suffering was attributable to his failure to follow his doctor's orders in not bearing as much weight as possible on his ankle, and therefore that such pain and suffering cannot be the basis for the recovery of damages.

Dr. Wichman did state that if he were asked by Elliott for treatment, he would suggest as much ambulation as possible, and that it was his opinion that complete ambulation would be his suggestion or prescription. However, there is no evidence that Dr. Wichman ever told Elliott to bear as much weight as possible on his ankle. All that Wichman said was that this is what he would prescribe if he were to treat Elliot for his injury.

[20] There is also no testimony by Dr. Foster that he told Elliott to bear as much weight as possible on his ankle. The doctor stated that he prescribed crutches and advised Elliott to use them to tolerance by testing how much weight he would be able to put on his foot, absorbing the rest with the crutches. When Dr. Foster was asked what his suggested course of procedure would be, based on his examination of Elliott's ankle, he stated:

> My suggested course of procedure is for Sergeant Elliott to continue bearing what—weight he can on his foot, to treat it when it becomes inflamed and sore and red by warm soaks and elevation, to continue on the use of the crutches up to the limits of comfort, to maintain his brace on his ankle as he is.

There is nothing in the evidence to show that Elliott had not done what Dr. Foster suggested that he do. The record does not substantiate Beaulieu's claim that Elliott's pain and suffering was attributable to his failure to follow the orders of his doctor.

Elliott's Appeal

As a basis for computing Elliott's impairment of future earnings for the remainder of his work life of 29 years, the court used Elliott's wage scale in the Air Force at the time of his discharge in the amount of $162.50 a month. On his appeal, Elliott claims that his future wage loss was greater than that determined by the court. The basis for his claim is that, considering evidence of his experience in truck driving and traffic management, the court ought to have determined what earnings Elliott probably would and could have received in civilian life—the wage scale there being higher for the same type of work than in the military service.

[21] We have held that this case must be remanded to the trial court for the purpose of making detailed and explicit findings as to Elliott's earning capacity and the degree of impairment in respect thereto. Such findings may contain the answer to the question as to why the court used Elliott's military pay, rather than civilian pay scales for equivalent work, as a basis for computing future wage loss for the entire period of 29 years, when Elliott had indicated that he may have retired from the Air Force at the end of 20 years of service which would have been approximately two years after his discharge if he had not received a medical discharge. In the absence of adequate findings and a clear understanding of the basis for the court's award, we are unable to pass upon Elliott's contention that the award for impairment of future earning capacity was inadequate.

[22] Similarly, we are unable to pass upon Elliott's contention that the evidence established that the impairment of his earning capacity was total, or near total, rather than 50% as determined by the court. Adequate findings as to Elliott's degree of impairment of earning capacity may afford a clear understanding of the basis for the court's determination. The findings are not sufficient for that purpose now.

Elliott's next point has to do with attorney's fees allowed by the court. Civil Rule 82(a) (1) provides as follows:

> Unless the court, in its discretion, otherwise directs, the following schedule of attorney's fees will be allowed

23. 224 F.2d at 11. See Annot., Per Diem or similar mathematical basis for fixing damages for pain and suffering, 69 A.L.R.2d 1347 (1958).

24. 413 P.2d 169, 176 n. 21 (Alaska 1966).

25. 190 Kan. 261, 374 P.2d 52, 61 (1962).

26. Imperial Oil, Ltd. v. Drlik, 234 F.2d 1, 11 (6th Cir. 1956), cert. denied, 352 U.S. 941, 77 S.Ct. 261, 1 L.Ed.2d 236 (1956).

27. Accord, Peters v. Benson, 425 P.2d 149, 152 (Alaska 1967); National Bank of Alaska v. McHugh, 416 P.2d 239, 241 (Alaska 1966); Patrick v. Sedwick, 413 P.2d 169, 175 (Alaska 1966).

28. 11 Wis.2d 604, 106 N.W.2d 274, 279, 86 A.L.R.2d 927, 936 (1960).

29. See also Bigley v. Prior, 200 Mo. 10, 23, S.W. 828, 832 (1921); Comment, 60 Mich.L.Rev. 612, 629-30 (1962).

to in fixing such fees for the party recovering any money judgment therein, as part of the costs of the action allowed by law:

ATTORNEY'S FEES IN AVERAGE CASES

	Contested	Without Trial	Non-Contested
First $2,000	25%	20%	15%
Next $3,000	20%	15%	12.5%
Next $5,000	15%	12.5%	10%
Over $10,000	10%	7.5%	5%

Should no recovery be had, attorney's fees for the prevailing party may be fixed by the court as a part of the costs of the action, in its discretion, in a reasonable amount.

The court awarded Elliott $13,870.29 attorney's fees based on the percentages listed in the "without trial" category of the above rule. Elliott claims that this was an erroneous application of the rule, and that a correct computation of attorney's fees should have been under the "contested" category[30] because even though liability was admitted, the question of damages was in issue and was contested in a four-day trial.

[23] In a case like this where liability is admitted but the amount of damages is contested, the question of which category of Civil Rule 82(a) (1) is applicable in computing attorney's fees is a matter within the discretion of the trial court. We limit our review in matters of this type to the question of whether the court exceeded the bounds of such discretion—whether such discretionary authority has been abused.[31]

[24] The court's reasons for assessing attorney's fees as it did was that liability was admitted, that the total recovery of damages was large, and that the attorney's fees allowed were adequate. Considering the character of this litigation and the amount of recovery,[32] we cannot say that the court's reasoning was not sound and that the manner of applying the rule amounted to an abuse of discretion.[33]

Costs were assessed against Beaulieu in the amount of $82.40. Elliott claims that it was error to not include in the costs certain expenses incident to the taking of depositions necessary to establish liability.[34]

[25, 26] The taxing of costs rests largely in the sound discretion of the trial court, and we shall not interfere with the exercise of that discretion except in cases of abuse.[35] Elliott claims that the depositions taken were necessary to establish liability. But he does not point out what depositions were involved, how they related to liability, when they were taken, or when the concession of liability was made by Beaulieu. In these circumstances we cannot find any abuse of discretion in the court's refusal to allow as costs the expenses incident to the taking of said depositions.

The judgment is set aside. The case is remanded to the superior court for the purpose of making appropriate findings as to the damage issues referred to in this opinion and for the further purpose of entering an appropriate judgment thereon.

30. Attorney's fees computed under the "Contested" category of the rule would have amounted to $17,843.73.

31. McDonough v. Lee, 420 P.2d 459, 465 (Alaska 1966); Kenai Power Corp. v. Strandberg, 415 P.2d 659, 661 (Alaska 1966); Patrick v. Sedwick, 413 P.2d 169, 178-179 (Alaska 1966); Professional Gen. Agency v. Raffetto, 391 P.2d 951, 954 (Alaska 1964); Davidsen v. Kirkland, 362 P.2d 1068, 1070-1071 (Alaska 1961).

32. Elliott's total recovery, in addition to costs and attorney's fees, was $103,037.25.

33. McDonough v. Lee, 420 P.2d 459, 465 (Alaska 1966).

34. Civ.R. 79(b) provides that "A party entitled to costs may be allowed * * * the necessary expenses of taking depositions for use at trial * * *."

35. Euler v. Waller, 295 P.2d 765, 768, 97 A.L.R.2d 155, 157-158 (10th Cir. 1961).

Warren A. TAYLOR, Appellant,
v.
DISTRICT COURT FOR the FOURTH JUDICIAL DISTRICT, AT FAIRBANKS, Appellee.
No. 704.

Supreme Court of Alaska.
Dec. 8, 1967.

The Superior Court, Fourth Judicial District, Everett W. Hepp, J., affirmed judgment of the district court which held attorney in contempt for failure to appear for trial at time set. Upon the attorney's appeal, the Supreme Court, Dimond, J., held that action of the attorney in agreeing to a trial setting in the superior court two days before date previously set for trial of another case in the district court, with result that the attorney was unable to appear for the district court trial when the superior court trial extended longer than two days, did not give rise to an inference, which would support judgment of contempt, of a willful disregard or disobedience by the attorney of the district court order in setting the district court case for trial.

Reversed and remanded with directions.

1. Contempt ⇐2

In order for there to be contempt, it must appear that there has been a willful disregard or disobedience of the authority or orders of the court. Rules of Civil Procedure, rule 90.

2. Contempt ⇐20

Attorney's failure to appear in court at time specified by order of the court may amount to an indirect, but not a direct, contempt of court. Rules of Civil Procedure, rule 90.

3. Contempt ⇐5(1)

Purpose of civil rule relating to contempt in requiring a motion in indirect contempt proceedings to be supported by affidavits is to afford one charged with contempt the procedural due process requirement of notice of the charge against him. Rules of Civil Procedure, rule 90(b).

4. Contempt ⇐51(1)

In proceeding by district court judge to hold attorney in contempt of court for failure to appear for trial at time required, it was unnecessary under rule for judge to have filed in his own court his affidavit stating that the attorney had failed to appear at the time required, in view of fact that the attorney was duly apprised of the charge against him by the district court's order directing the attorney to show cause why he should not be punished for the alleged contempt. Rules of Civil Procedure, rule 90(b).

5. Contempt ⇐20

Action of attorney in agreeing to a trial setting in the superior court two days before date previously set for trial of another case in the district court, with result that the attorney was unable to appear for the district court trial when the superior court trial extended longer than two days, did not give rise to an inference, which would support a judgment of contempt, of a willful disregard or disobedience by the attorney of the district court order in setting the district court case for trial. Rules of Civil Procedure, rule 90.