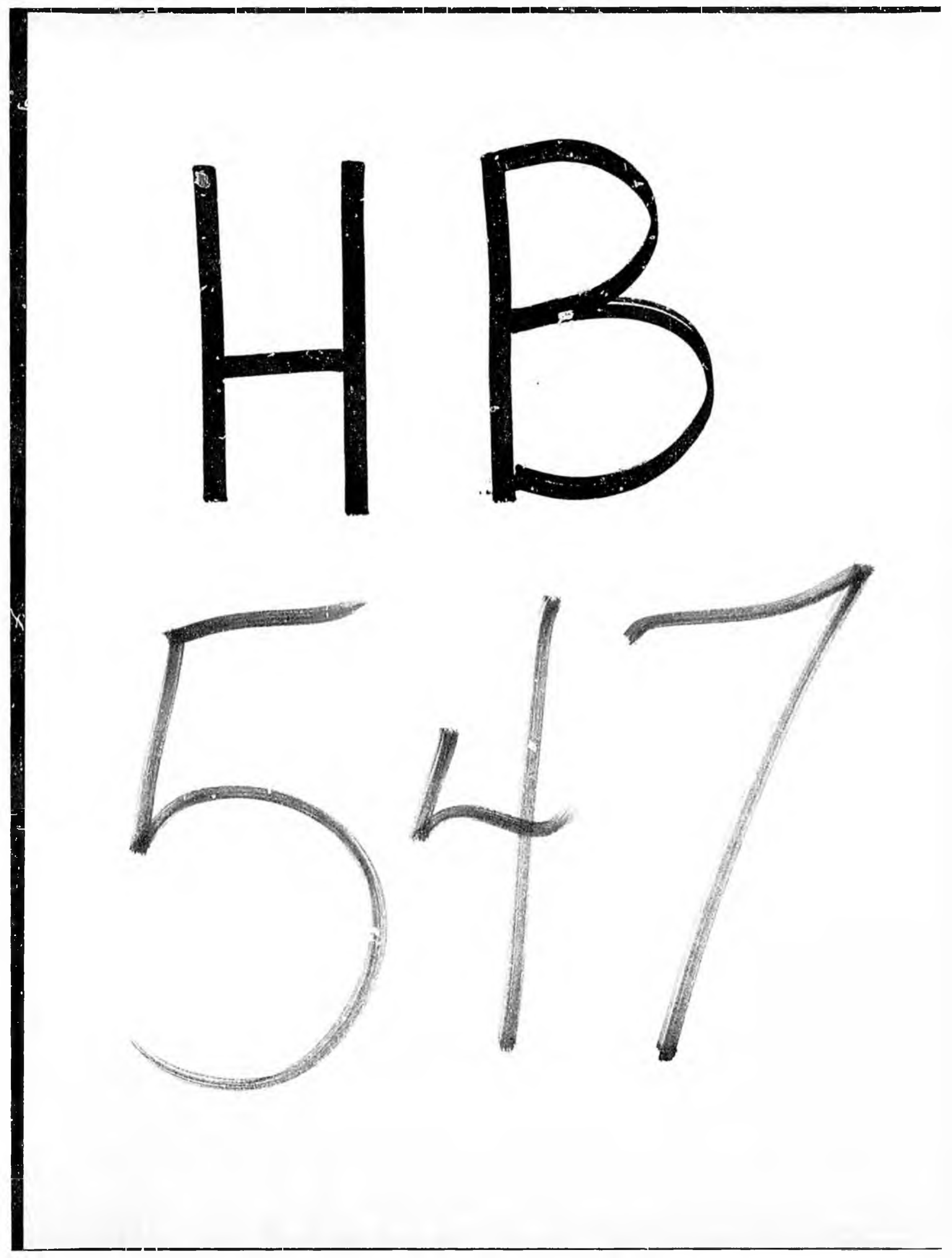
HB
547

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

Pouch Y, State Capitol
Juneau, Alaska 99811
(907) 465-3991

February 11, 1986

MEMORANDUM

TO: Representative John Sund

ATTN: Shari Kochman

FROM: Katherine Hazard KH
Legislative Analyst

RE: Group Insurance for Self-Employed Persons
Research Request 86-092

You asked whether it would be possible to change current Alaska Statutes so that individuals, such as persons who are self-employed, could form a group in order to obtain health insurance. In the United States, the federal government does not regulate insurance; state governments are the primary source of regulation for the insurance industry. Thus, there are no conflicts with federal laws. Two segments of Alaska Statutes would need revision to permit formation of groups for the purpose of obtaining health insurance: AS 21.54.060 and AS 21.48.010.

In the Alaska Statutes, health insurance is included as disability insurance. According to current statute (AS 21.54.060), disability insurance may cover groups under a policy issued to:

1) an employer of trustees of a fund, insuring employees;

2) an association (including a labor union) which has a constitution and bylaws, and which has been organized for purposes other than that of obtaining insurance, insuring members and employees;

3) the trustees of a fund established by two or more employers in a related industry, one or more labor unions, or by an association, insuring employees or members;

4) a person or organization to which group life insurance may be issued, or;

5) any other substantially similar group which the Director of Insurance (Department of Commerce and Economic Development) determines may be subject to the issuance of a group disability policy.

Pertinent to number four above, the statute governing issuance of group life insurance specifies that "a group life insurance policy may not be delivered in this state insuring the lives of more than one individual unless (1) the policyholder was formed for purposes other than obtaining insurance" [AS 21.48.010(a)].

According to Jim Jordan of the Division of Insurance, these Alaska statutes were modeled after the National Association of Insurance Commissioners' model group insurance law. The rationale behind prohibiting formation of a group for the purpose of obtaining insurance is to prevent groups of unhealthy individuals who are high insurance risks from forming a group. This rationale was offered as the basis for the statutory prohibitions by Jim Jordan, Greg Scandlen of the Blue Cross Blue Shield Association, and an attorney with the National Association of Insurance Commissioners.[1] Mr. Scandlen said he doubted that insurance companies would be flocking to cover unhealthy individuals who formed a group in order to obtain insurance.

Under present law, an insurance company is not required to issue policies to groups which meet the legal stipulations described above; it may issue a policy. The decision is left to the discretion of the insurance company. If the prohibitions in AS 21.54.060 and AS 21.48.010 were dropped, the same discretionary power could prevail with respect to groups formed for the purpose of obtaining insurance.

The following jurisdictions currently have group insurance laws which do not prohibit formation of groups for the purpose of obtaining insurance: Missouri, Rhode Island, North Dakota, Wisconsin, and the District of Columbia. Laws in these states do not specifically allow formation of a group, they simply fail to prohibit it.

Several advantages are afforded by group insurance policies. Group policies can frequently be offered at lower rates because there are economies of scale to administrative costs in handling the policy, running medical checks, billing, etc. In many instances, costs are also reduced because the risk of incurring costs is spread more broadly.

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[1] Jim Jordan, Division of Insurance, Department of Commerce and Economic Development, Anchorage, Alaska. (907) 562-3626

Greg Scandlen, Blue Cross Blue Shield Association, Washington, D.C. (202) 783-6222

Sandra Gilfillan, National Association of Insurance Commissioners, Kansas City, Missouri. (816) 842-3600.

Even low-risk individuals who are members of a group comprised in part of higher risk individuals may save money as a result of reduced administrative costs. Another advantage often afforded through group policies is that individuals covered by the policy are covered for pre-existing conditions. Pre-existing conditions are not usually covered as part of individual policies.

Although current laws restrict formation of a group for the purpose of obtaining insurance, the group size of which an individual must be a member is small enough that the statutory restrictions are not as prohibitive as they might at first seem to be. The current minimum size limit for a group policy with the two companies consulted (Blue Cross of Washington and Alaska and State Farm Insurance) is five. Thus, any association of at least five members which has a constitution and bylaws and was organized for a purpose other than to obtain insurance, could apply for group insurance. According to Mr. Scandlen, Blue Cross of Washington and Alaska offers open enrollment to groups as small as five; any group member could be covered by the policy, individuals would not be asked to write a health statement, and individuals would be covered for pre-existing conditions.

* * * *

Several states also have laws which provide opportunity for insurance coverage to individuals who are otherwise uninsurable. Your aide maintained interest in this subject also, although our agency was not requested to research this subject. In the course of researching the subject of group insurance for self-employed persons, I obtained the following information regarding this second topic.

At least eight states--Connecticut, Florida, Indiana, Minnesota, Montana, North Dakota, Rhode Island, and Wisconsin--currently have health insurance risk pooling laws, which enable persons otherwise uninsurable to obtain health insurance coverage.[2] According to Danny Albert of the Connecticut Department of Insurance, the Connecticut Comprehensive Health Care Plan has not resulted in added costs to the state; costs are shared by all insurance companies licensed in the state. Mr. Albert said this program has been operating since 1975, when it was

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[2]This list, excepting Montana, was provided by Kevin Osborn of the National Council on State Governments (NCSL). (606) 252-2291.

created by Connecticut Statutes 38-371 through 38-381. The Indiana Comprehensive Health Insurance Association provides similar coverage for otherwise uninsurable individuals (Indiana Statute 27-8-10). Attached is a memorandum discussing the Montana Health Insurance Pool.

Please let us know if you have further questions.

KH

Attachment

LEGISLATIVE RESEARCH

S-420 State Capitol, Salem, OR 97310-1316

(503) 378-8871

85:296

TO: Representative Tom Throop

FROM: Theresa McHugh, Research Analyst

SUBJECT: Louisiana and Montana Health Insurance Pools

DATE: September 25, 1985

You asked Legislative Research to compare bills introduced in Louisiana and Montana to establish health insurance pools. This memorandum provides information on these similar measures.

Legislative Purpose

The legislative purpose of both measures is to insure availability of health insurance coverage for residents who are otherwise uninsurable. All insurers in the state must participate in the program. The bills call for the programs to be governed by a board of directors, overseen by the state Commissioner of Insurance.

Eligibility Criteria

Eligibility criteria to purchase health insurance under both bills would include being a state resident for at least six months prior to application. The Louisiana bill also would require a person to have received health insurance coverage rejections, for health reasons, from three insurers during the same time period. Montana's HB 817 would only require rejection from two insurers in the six month period. Persons who can only buy insurance with a rider that limits coverage for a pre-existing medical condition would be eligible in both states.

Louisiana's measure would also give eligibility to persons who have been refused coverage similar to the comprehensive health insurance plan or who have been offered similar insurance plans at higher premium rates. The bill provides exceptions to the eligibility criteria for persons with certain medical conditions, which are to be specified by the board. Louisiana's bill also provides a list of persons ineligible for insurance coverage through the pool.

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Extent of Insurance Coverage

Under HB 817, the Montana comprehensive health association would be required to offer a policy that provides the benefits of a "qualified plan," which means that minimum benefits must cover at least 80 percent of the services specified in the bill, after an annual deductible fee, which may not be over $1,000 per person. Coverage would also include a $5,000 per person annual limit on "out-of-pocket" expenses for covered services and there would be a maximum lifetime benefit of at least $100,000.

Under Louisiana's pool, the board with the commissioner's approval, would be required to establish major medical expense coverage, including a schedule of benefits, exclusions, and other limitations which must be commensurate with individual health insurance provided by the five insurers writing the largest amount of individual health insurance coverage in the state. A high and low deductible option would be available to persons buying insurance through the pool. Factors which would be considered in establishing coverage are current levels of health care provided in Louisiana and appropriate medical economic factors.

Pool Insurer Selection Process

Louisiana's board would select an insurer through a competitive bidding process to administer the pool for a three year term. Criteria for selection and the administering insurer's responsibilities are specified in the bill.

Montana's association would select a lead carrier to perform administrative and claims payment functions for the association for three years. The board would prepare specifications and bid forms, solicit bids from insurers, and establish selection criteria for the lead carrier position. The measure specifies that the lead carrier is an independent contractor for the association and is individually liable for its actions.

Premium Rates

In Louisiana, initially, annual premium rates could not exceed 135 percent of rates established as appropriate for individual standard risks and they would never exceed 165 percent of such rates. Individual standard risk rates are based on the average individual rate charged by the five insurers writing the largest amount of health insurance coverage in the state. Montana's premiums would be calculated in the same way, but may not be less than 150 percent, or more than 40 percent, of the average premium rates of the five

bill requires a study of claims loss experience under the pool after the pool has been in operation for two years.

Status of Measures

Montana enacted HB 817, but SB 452 in Louisiana was in committee upon adjournment. The sponsor of SB 452 decided the issue warranted further study and introduced a study request on the subject. At this time, there is no specific date for initiation of the study.

2/7/86 Louisiana's bill died in committee. KH phone conversation with Louisiana Legislature Clerk.

TO: REP. NAVARRE, DAVIS, BOUCHER, COLLINS, HANLEY, KOPONEN, PEARCE, SUND AND TAYLOR.

FROM: M/M RICHARD BEAL, BOX 113, PETERSBURG 772-4206

RE: HB 547 HIGH RISK GROUP INSURANCE

ANY INSUANCE BROKER WILL TELL YOU, AS WE HAVE FOUND OUT, THAT MEDICAL INSURANCE FOR ANYONE THAT, IN THEIR PAST, HAS HAD A DIAGNOSIS OF CANCER, DIABETES, LEUKEMIA, AND EVEN HIGH BLOOD PRESSURE, IS PRACTICALLY UNAVAILABLE.

PLEASE WORK FOR THE PASSAGE OF THIS BILL.

****

TO: REP. NAVARRE, DAVIS, BOUCHER, COLLINS, HANLEY, KOPONEN, PEARCE, SUND, AND TAYLOR.

FROM: M/M LOUIS SEVERSON, BOX 507, PETERSBURG, 772-4413

RE: HB547 HIGH RISK INSURANCE

MEDICAL INSURANCE FOR ANYONE THAT, IN THEIR PAST, HAS HAD A DIAGNOSIS OF CANCER, DIABETES, LUEKEMIA AND EVEN HIGH BLOOD PRESSURE, IS PRACTICALLY NOT AVAILABLE. PLEASE VOTE FOR PASSAGE OF THIS BILL.

THANK YOU.

****

TO: REP. NAVARRE, DAVIS, BOUCHER, COLLINS, HANLEY, KOPONEN, PEARCE, SUND AND TAYLOR

FROM: MRS. DELORES LUND, BOX 723, PETERSBURG 772-3111

RE: HB547 HIGH RISK INSURANCE.

INSURANCE IS UNAVAILABLE TO THOSE WHO HAVE BEEN DIAGNOSED WITH CANCER, DIABETES, LEUKEMIA. PLEASE HELP THOSE WHO ARE UNABLE TO GET GROUP HEALTH INSURANCE BY VOTING FOR THE PASSAGE OF HB 547.

****

TO: REP. NAVARRE, DAVIS, BOUCHER, COLLINS, HANLEY, KOPONEN, PEARCE, SUND AND TAYLOR.
FROM: M/M LLOYD PEDERSEN, BOX 447, PETERSBURG 772-3242

RE: HB547

ANY INSURANCE BROKER WILL TELL YOU, AS WE HAVE DISCOVERED, THAT MEDICAL INSURANCE IS UNAVAILABLE FOR THOSE OF US WHO HAVE BEEN DIAGNOSED AS HAVING CANCER, DIABETES, LEUKEMIA AND EVEN HIGH BLOOD PRESSURE. PLEASE HELP US BY VOTING FOR PASSAGE OF HB 547.

THANK YOU.

10

DELIVER TO: JPOM

ORIGINAL
SENT: 02/18/86 TIME: 15:51
FROM: LIOPSG
SUBJECT: POM/HB 547
PRINT DATE: 02/18/86 TIME: 15:51

TO REP. NAVARRE, DAVIS, BOUCHER, COLLINS, HANLEY, KOPONEN, PEARCE, SUND, TAYLOR

FROM AUDREY SAMUELSON, BOX 858, PETERSBURG, AK 772-4851

RE: HB 547--HIGH RISK INSURANCE

MY HUSBAND IS A FISHERMAN AND I DON'T WORK, SO WE ARE UNABLE TO GET COVERAGE UNDER A GROUP HEALTH INSURANCE. WE CURRENTLY HAVE PERSONAL BLUE CROSS, BUT THEY HAVE EXEMPTED OUR DAUGHTER AS SHE HAS DIABETES. THEY REFUSE TO COVER HER FOR ANYTHING.

WE NEED HELP AND SUPPORT THE BILL.

State Health Legislation Report

Vol. 9, No. 2
July, 1981

- Guest Article—Medical Society Initiative to Improve "Health" Orientation in State Public Health System
- Recently Enacted Health Legislation

Public Affairs Group
Division of Legislative Activities
Department of State Legislation
American Medical Association
535 N. Dearborn Street
Chicago, Illinois 60610

3. Timetable

A state medical society should allow approximately one year for the study and implementation strategy, plus one to several years to put the recommendations into effect.

The project in Wisconsin involved many hours of hard work by society members, staff and others. The result, however, has been rewarding for SMS and promises to provide an improved public health system for the people of Wisconsin.

HEALTH INSURANCE LAWS

Risk Sharing Pools

An Indiana law creates the Indiana Comprehensive Health Insurance Association, a nonprofit legal entity composed of health insurance carriers, prepaid health care delivery plans, and self-insurers who are not exempt from state insurance regulation through action of federal law or who are political subdivision of the state.

The association is to issue policies of health insurance to eligible state residents. A person is eligible for an association policy when he has been rejected by two carriers for coverage substantially similar to the association plan coverage (without material underwriting restriction) at a rate equal to or less than the association plan rate.

The law provides that the rates for a given classification may not be more than 150% of the average premium rate for that class charged by the five carriers with the largest premium volume in the state during the preceding calendar year.

An association policy is to provide for a $200 deductible and a 20% copayment requirement for expenses in excess of the deductible, except that the maximum aggregate out-of-pocket payments for eligible expenses by the insured in the form of deductibles and coinsurance may not exceed $1,000 per person or $2,000 per family, per policy year.

An association policy may exclude coverage for preexisting conditions for the first 6 months of coverage for any condition manifesting itself within the 6 month period before the effective date of coverage. (S.B. 99)

North Dakota law establishes a comprehensive health association with participating membership consisting of insurers with an annual premium volume of accident and sickness insurance contracts, derived from or on behalf of state residents, of at least $100,000. The association is to offer a policy of comprehensive health insurance coverage to eligible persons.

A person is eligible and may enroll in the plan by showing he is a resident of the state and has been rejected for accident and sickness insurance or that restrictive riders or a preexisting conditions limitation (the effect of which is to reduce substantially coverage

from that received by a person considered a standard risk) was required by at least two insurers within the previous six months.

The association is to communicate to the public information regarding the existence of the comprehensive health insurance plan and the means of enrollment. Licensed accident and sickness insurance agents are to be paid $25 for each applicant referred to the association plan and accepted.

Insurers that reject an applicant or apply underwriting restrictions for accident and sickness insurance, are required to notify the applicant of the existence of the association plan, the requirements for being accepted in it, and the procedure for applying to it. (H.B. 1058)

Policy Provisions and Language

New Mexico legislation requires that insurance policies delivered in the state meet minimum standards of language simplification to make them easily readable. (S.B. 378) Another New Mexico law requires that health insurance policies contain certain provisions relating to: the policy as the entire contract, the time limit on certain defenses, grace period, reinstatement, notice of claim, claim forms, proof of loss, time of payment of claims, payment of claims, physical examinations and autopsy, legal actions, and change of beneficiary. (S.B. 359)

Breast Reconstruction

Arizona law requires that insurance contracts which provide coverage for surgical services for a mastectomy also provide coverage incidental to the patient's covered mastectomy for surgical services for breast reconstruction and for at least two external postoperative prostheses. (S.B. 1025)

Alcoholism

A New York law requires that every insurer issuing a group policy which provides coverage for inpatient hospital care must make available and, if requested by the contract holder, provide coverage for the diagnosis and treatment of alcoholism or alcohol abuse. (A.B. 1684) A Utah law requires insurance carriers offering group disability policies to make available a rider providing for alcoholism detoxification and treatment. (H.B. 257)

Mental Illness

Insurers and health service corporations transacting health insurance in Montana must make available certain benefits for the necessary care and treatment of mental illness. Mental illness is defined as neurosis, psychoneurosis, psychopathy, psychosis, or personality disorder. (S.B. 352)

February 10, 1986

Representative John Sund
Pouch V
Juneau, Alaska 99811

John:

I support your sponsorship of HB 547 creating insurance pools.

You will remember that on September 30 last year I was summarily dismissed as manager of Ketchikan Senior Services for the weakest of reasons, a subterfuge for the real reason in my opinion. This action was taken by Sharon Adelmeyer even though the enabling legislation gives employment priority to persons 60 years and older.

Being 61 years old I am having difficulties. In addition to no income, I have no health insurance. I've tried to buy Blue Cross and was turned down.

In that respect I am one of your "relatively large segment." I would be willing to organize support if that will help.

Sincerely,

Bert

BERT ROMO
Box 3095
Ketchikan

Department of Commerce
& Economic Development / POSITION PAPER

HB 547: See Attached Memo, 2-11-86

F. Gregory Baker
Deputy Commissioner

MEMORANDUM State of Alaska

TO: John Georg[illegible]
Director

DATE: February 11, 1986

FILE NO:

TELEPHONE NO:

FROM: Jim Jordan
Insurance Market Analyst

SUBJECT: Comments HB 547

I. General Comments

HB 547 provides for a third party medical care financing mechanism for individua[illegible] that are either marginally insurable or uninsurable with the financial ability to pay premiums at level deemed affordable. This proposal has a number of technical and practical flaws that, in my opinion, will result in opposition from the insurance industry.

II. Section by Section Analysis

A.S. 21.55.010

This section creates the Comprehensive Health Insurance Association (CHIA). Several technical problems exist with the membership criteria. First, Title 21 does not include any provisions to define or regulate "self-insurers" or "health maintenance organizations" (HMO). The Employee Retirement Income Security Act of 1974 (ERISA) also would appear to preclude the mandatory membership of "self-insurers" or any regulation at the state level. Additionally, it appears that membership does not include hospital or medical service corporation (e.g., Blue Cross). Currently, HMO's can only be licensed to do business as an insurer or as a hospital or medical service corporation. Therefore, references to HMO's should be deleted throughout this act.

Membership is a required condition for continued licensure in Alaska. HB 547 includes that term "doing accident and health insurance" which is not defined in this proposal or in Title 21. The term found in Title 21 which probably should be used is "disability insurance". Modification is needed throughout this proposal.

To be technically correct, the membership criteria should read "all insurers licensed to transact disability insurance and all licensed hospital or medical service service corporations". It should be noted that insurers that are principally property and casualty insurers may be included if their certificate of authority includes disability insurance.

A.S. 21.55.020

This section establishes the criteria for the selection of CHIA's board of directors. Again, technical amendments are necessary to remove "self-insurers", the term "accident and health", and the term, "health maintenance contract".

A.S. 21.55.030-060

These sections set out CHIA's general powers, oversight by the director, exemption from the Administrative Procedure Act, and exemption from state taxation of its premiums.

A.S. 21.55.100

The director is required to establish the configuration of benefits for the CHIA's plan by regulation. It should be noted that the state plan will also have to include a Medicare supplement plan.

A.S. 21.55.110

CHIA's plan is to be administered by a writing carrier selected for three year period by the competitive bid process. The writing carrier is to provide those administrative services normal to any health insurance plan. The CHIA is required to adopt cost accounting methods to substantiate the writing carrier's administrative expenses. A.S. 21.55.120 limits those expenses to 15% of the premiums with any excess administrative costs assessed to all members.

A.S. 21.55.120

Subsection (b) provides for an employer to make contributions to the state plan on behalf of its eligible employees directly to the writing carrier. This provision will tend to complicate the premium billing function.

As mentioned previously, subsection (c) limits the administrative expenses to 15% of premiums. My interpretation of this provision is that an expense factor not to exceed 15% may only be used in the promulgation of the rates. To the extent that that actual or normally anticipated administrative expenses exceed 15%, the actuarial integrity of the rate basis is in question. This subsection would appear to conflict with the rate basis criteria that the rates be self-supporting and based on sound actuarial principles as set in A.S. 21.55.250(d). The established ceiling level may also inhibit the competitive bidding process and may be insufficient to cover a writing carrier's fixed cost if there is minimal participation.

Assessments to all members on a proportionate basis for claims which exceed the premiums and administrative expenses which exceed the ceiling set in subsection (c) are provided for in subsections (d) and (e). However, these subsections do not stipulate whether the need for assessment is to be on an "incurred" or "paid" basis. Theoretically, the assessments should be based on an incurred basis, but practical consideration would probably dictate a cash basis. However, it must be recognized that on a cash basis a member insurer leaving the association may end up having been assessed either too little or too much dependent upon the development of those claims that were incurred while the insurer was a member.

Any excesses of premium over claims and expenses are required to be held at interest for future losses, or to reduce future premiums. The member insurers sustain all losses and do not participate in any of the gains. In essence, any assessments are another form of taxation which ultimately is paid by the member insurers' stockholders and/or policyholders.

A.S. 21.55.200-210

Eligibility for enrollment in the state plan is predicated on a person's inability to obtain similar coverage or to obtain it without restrictive riders, a more restrictive pre-existing conditions limitation, or rated above standard rates. The director may determine what evidence would prove meeting those requirements and would be embodied in the certificate of eligibility called for in A.S. 21.55.210.

A.S. 21.55.220

The writing carrier is required to determine eligibility and to accept or reject coverage within 30 days of receiving an application. Upon receipt of the first month's premium and determination of eligibility, coverage is retroactive to the date of the application. This section would indicate the monthly mode of premium payment as the required mode (as opposed to quarterly, semiannually, or annually).

A.S. 21.55.230

The plan will not provide coverage for a pre-existing medical condition for the first six months of coverage under the plan if the applicant was diagnosed or treated for that condition during the 90 days preceding the application date. This is a mechanism which will help prevent anti-selection against the plan. However, it is more liberal than most pre-existing conditions limitations and is more liberal than the NAIC Model. The NAIC Model contains longer time periods for non-coverage and for the treatment or diagnosis period (twice as long in both cases). Additionally, the NAIC Model also includes conditions for which an ordinarily prudent person would have sought treatment but did not.

A.S. 21.55.240

Marketing and awareness criteria and procedures are established in this section. The association is required to devise and implement a public awareness program. Each individual member that rejects standard coverage or applies restrictions to the coverage and/or rates-up for an applicant must notify the applicant of the state plan, eligibility requirements, and application procedures.

This section would allow all licensed agents to market the state plan. It might be advisable to limit this to only agents licensed to sell disability insurance and to brokers similarly qualified. This would provide some quality control, but would still provide for a sufficient number of persons to market the state plan.

A.S. 21.55.250

Standards for the establishment of the premium rates are established by this section. The rates are to be established on the basis of sound actuarial principles and are to be designed to be self-supporting. However, the maximum rates charged may not exceed 125% of the average of the standard rates charged by the five insurers with the largest number of Alaska residents covered by equivalent plans of insurance. The director needs to establish criteria to determine actuarially equivalent plans and collect data regarding the number of persons covered in each plan in order to determine the five whose rates are going to be used. (This would represent data that currently is not reported to the various states via the NAIC convention blank). Next, each of these five insurers' rates for their plan that is actuarially equivalent to the

state plan would have to be determined and be verified as being actuarially sound. This process would be very time-consuming, complex, and costly for both the insurance industry as well as the director. This process is undertaken to merely establish that amount of premium which is deemed affordable (i.e., a premium that is 25% higher than that for a standard insured). I suspect this to be the intent as I find it difficult to believe the excess morbidity for this target population does not greatly exceed 25% of standard. Therefore, it is my opinion that this subsection (d) conflicts with the other subsections. Actually, I would expect that the difference between rates set by sound actuarial principles and the maximum rate level established by this section would equal the amount of additional assessments made to the association members.

A less costly approach might be to select the five largest insurers on the basis of their total disability premium written in Alaska. Each of these insurers would then provide the director with their determination of the rate structure for a standard insured for the state plan benefit configurations. These five rate structures would then be averaged with the average then multiplied by a factor of 1.25 to arrive at the "affordable" rate to be charged. This approach would still require the director to contract with a qualified actuary, annually, to determine the structural compatibility and actuarial soundness of these five rate structures.

A.S. 21.55.300

The duties of the director are outlined in this section. Most of the duties are already inherent in the remainder of this act or in other sections of Title 21. The exceptions being appointment of advisory committees, ensure the coordination of the state plan with governmental medical assistance programs, and to undertake demonstration programs to develop awareness of the state plan. No doubt, if enacted, this proposal would require additional staff time as well as additional contractual expenditures.

A.S. 21.55.350

This section defines three terms - "association", "state plan", and "writing carrier".

III. Summary and Conclusion

Until all third party financers of medical care can be included in the association (e.g., self-insurers), I would recommend that this and similar proposals not be supported. Also, any such proposal that involves hidden or indirect taxation should not be supported. The provision of a third party financing mechanism for uninsurable individuals, in the classical sense, is an admirable goal and one in which we need to strive to achieve. However, the cost to society ought not be hidden and should be spread equitable and fairly across our entire population.

In my opinion, the insurance industry will vigorously oppose this proposed act.

HB 547

An Act relating to health insurance.

SECTIONAL ANALYSIS
Prepared by Rep. John Sund's office.

ARTICLE 1

Sec. 21.55.010 creates the Comprehensive Health Insurance Association, a nonprofit corporation with membership consisting of all insurers, self-insurers and health maintenance organizations operating in Alaska. Insurers and HMOs must be members of the association in order to do business in the state.

Sec. 21.55.020 sets a seven-member board of directors selected by association members and approved by the director of the state Division of Insurance.

Sec. 21.55.030 describes the association's general powers.

Sec. 21.55.040 subjects association articles, bylaws and operating rules to the approval of the director of the Division of Insurance.

Sec. 21.55.050 exempts the association from the Administrative Procedure Act.

Sec. 21.55.060 exempts the association from taxes.

ARTICLE 2

Sec. 21.55.100 establishes the minimum coverage the association must offer for the state accident and health insurance plan as required by the director of the Division of Insurance and offers HMO contracts in applicable areas.

Sec. 21.55.110 establishes a bidding procedure for selecting a writing carrier for the state plan for three-year terms. The carrier can be an association member and will perform the administrative and claims payment functions for the state plan. The carrier will report monthly to the association and the director and will be reimbursed from state plan premiums for administrative expenses incurred.

Sec.21.55.120 allows enrollment in the state plan to all eligible people and requires that at least 85% of the premiums must be used to pay claims.
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 accident and health insurance premiums paid in the state.
Assessments will be made yearly but the association, with the director's approval, may make interim assessments. Any net gains will be held at interest to

offset future losses.

ARTICLE 3

Sec. 21.55.200 sets eligibility requirements for the state plan as: rejection by at least one association member for a standard health insurance policy within the previous six months; or requirement of a restrictive rider; or a pre-existing condition limitation which substantially reduces the standard coverage.

Sec. 21.55.210 explains the procedure for enrollment in the state plan and requires that a person ceasing state residence would lose his or her eligibility.

Sec. 21.55.220 requires the state plan writer to respond to the applicant within 30 days of receiving the application.

Sec. 21.55.230 exempts coverage for pre-existing conditions during the first six months of the state plan coverage for conditions diagnosed in the 90 days preceding application.

Sec. 21.55.240 requires that the plan be advertised to the public and that the carrier 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.

Sec. 21.55.250 sets the maximum premium for the state plan at 125% of the average of rates charged for similar insurance by the five largest accident and health insurers in the state.

ARTICLE 4

Sec. 21.55.300 explains the duties of the director of the Division of Insurance in regard to the state plan.

Sec. 21.55.350 offers chapter definitions.

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

Bill/Resolution No.: HB 547
Title: An Act relating to Health Insurance
Sponsor: Sund
Requester:
Date of Request:

FISCAL DETAIL

Agency Affected: Commerce & Econ. Dev.
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-	86.8	86.8	86.8	86.8	86.8
TRAVEL	-0-	5.0	1.0	1.3	1.6	2.0
CONTRACTUAL	-0-	25.0	25.0	25.0	25.0	25.0
SUPPLIES	-0-	.5	.5	.5	.5	.5
EQUIPMENT	-0-	13.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	-0-	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	-0-	0.0	0.0	0.0	0.0	0.0
MISCELLANEOUS	-0-	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	-0-	130.3	114.3	114.6	114.9	115.3
CAPITAL						
REVENUE						

FUNDING: (Thousands of dollars)

GENERAL FUND	-0-	130.3	114.3	114.6	114.9	115.3
FEDERAL FUNDS						
OTHER						
TOTAL	-0-	130.3	114.3	114.6	114.9	115.3

POSITIONS:

FULL-TIME	0	2	2	2	2	2
PART-TIME						
TEMPORARY						

ANALYSIS: Attach a separate page if necessary.

Two positions are added to provide staff support for the duties of the director listed in Sec. 21.55.300. These would be a Range 21 professional and a Range 8 clerical position to be located in Anchorage.

Prepared by: John L. George, Director — Phone: 465-2515
Division: Insurance — Date: 2/24/86

Approved by Commissioner: — Date: 2/24/86
Agency: Commerce and Economic Development

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

10/25/85

3585W21986a

Position Title	No. of Positions	Range/Step	Barg. Unit	Gov.	Approv.	Disapp.
Market Analyst IV	1	21A	GGU			
Time Status	**Staff Months**	**RP Number**	**Location**	**Election District**	**Leg.**	
PFT	12		Anchorage			

Type of Expenditure		Amount
1	2	3
Salary	45.7	
Benefits	13.4	
Premium Pay		
Other		
Total Personal Services		59.1
Travel		1.0
Contractual		25.0
Commodities		.3
Equipment		6.5
Other		-
Total Cost		91.9

Receipt Code	Funding Source		Amount
	Federal Receipts	1002	
	G. F. Match	1003	
	General Funds	1004	91.9
	I-A Receipts	1005	
	Program Receipts	1028	
	CIP Receipts	1061	
	Other		

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

Justification

The duties of the director stated in the bill require the full-time attention of an analyst. The bill establishes a number of new duties that cannot be absorbed by current staff.

The director has a duty to formulate general policie to advance the purpose of the legislation. This requires research and a data base to underlie the policies advanced. This must include some identification of the numerous unknowns now existing, such a the scope of unavailability, impact on availability in the voluntary market, effect on surplus of affected insurers, expectation of the public, scope of coverage and others.

The director has the duty to supervise the operation of the State Comprehensive Health Association. This is a time-intensive activity which must be carefully monitored so that the purpose and intent o the Legislature is transformed into a mechanism that will meet those expectations.

The director has the duty to select the writing carrier, the Association's contract with that

Request For New Position

Agency: Commerce & Economic Development
BRU: Insurance
Component: Public Protection

FY 87

carrier, the State plan coverage and the premiums to be charged. This requires an effort to determine how the choice is to be made, and under what conditions. While it is not discussed in the legislation, it is implied that the director will have a duty to find a market to service the Association if none volunteers. The State does not currently have rate review of this kind of insurance, so it will be necessary to commence such an activity for the purpose of meeting the requirements of this bill.

The director has the duty to conduct periodic audits to assure general accuracy of the financial data submitted by the writing carrier and the Association.

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 assistant 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 $25.0 shown for this activity is really a guess but we believe that, if anything, it is substantially understated.

The director has the duty to contract with insurers and others for administrative services. The nature of these services have not been fully explored or determined.

The foregoing duties cannot be effectively quantified or maintained in an information vacuum. There is a substantial effort that will be necessary to flush out the data needs of the various duties and develop the procedures and approaches to obtain, collate, organize and analyze the information needed for that purpose. This must be a continuing effort due to the dynamics of the data.

Since the activities of this position are expected to concentrate in Anchorage, $1.0 have been allocated for the analyst position on the assumption that it would be necessary to attend meetings not held in Anchorage. It is felt that all functions of the created entity should be subject to monitoring by the division. In the start up year, additional travel by the director would be necessary as part of the organizational effort. $40.0 has been set for this purpose. This includes travel necessary for hearing of regulations under this proposal.

Equipment includes $6.5 for a P.C. minicomputer to be used for a data base, word processing, and spread sheet work. The P.C. would tie in with the P.C. for the clerical position, thus increasing efficiency for both positions. The commodities would cover the function costs of paper, copier, stamps, etc.

Position Title			No. of Positions	Range/Step	Barg. Unit	Gov.	Approv.	Disapp.
Clerk Typist			1	8B	GGU			
Time Status	Staff Months	RP Number	Location	Election District		Leg.		
PFT	12		Anchorage					

Type of Expenditure		Amount
1	2	3
Salary	20.1	
Benefits	7.6	
Premium Pay		
Other		
Total Personal Services		27.7
Travel		-
Contractual		-
Commodities		.2
Equipment		6.5
Other		-
Total Cost		34.4

Receipt Code	Funding Source		Amount
	Federal Receipts	1002	
	G. F. Match	1003	
	General Funds	1004	34.4
	I-A Receipts	1005	
	Program Receipts	1028	
	CIP Receipts	1061	
	Other		

For B&M Use Only
Key Number ___ . ___ . ___ . ___ . ___

Justification

Duties set forth in Sec. 21.55.300 necessitate additional staff. Work would require additional clerical support which cannot be absorbed by current clerical staff. To increase the efficiency of the proposed additional positions, the equipment includes a P.C. minicomputer to tie in with one for the analyst position. The clerks work on the computer would principally be word processing but would also include input for the data base. Work on the analyst's computer would be put in final form by the clerk.

Request For New Position

Agency: Commerce & Economic Development
BRU: Insurance
Component: Public Protection

Revised Date

FY 87

HB 547

An Act relating to health insurance.

OVERVIEW
Prepared by Rep. John Sund's office.

Standard accident and health insurance coverage is denied to people considered high risks, such as older individuals and those who have previously suffered from illnesses.

Even if coverage is offered, insurers often place restrictive riders or limitations on preexisting conditions.

HB 547 would establish a nonprofit, statewide association of all accident and health insurers and health maintenance organizations in the state. The association would offer accident and health insurance to those state residents unable to obtain standard coverage. Certain eligibility requirements would be set.

The association members would share the cost of claim payments in excess of premium income through periodic assessments. Bylaws, board of director selection, operation procedure and selection of a writing carrier would be subject to the approval of the State Division of Insurance.

HB 547 is modeled after 1976 Minnesota legislation. At least eight states have high-risk health insurance pool laws, according to the House Research Agency (see attached report, page 3).

The Minnesota program has "been working very well," according to John Ingrassia of the Minnesota Department of Commerce. He said that 10,400 people are now in the program. That number does not include those who were previously enrolled in the program.

Mr. Ingrassia also said that the insurers, by and large, did not act adversely to the pool upon its inception. Some 43 insurers of the 700 operating in Minnesota at the time left the state. But those companies represented less than 1% of the accident and health insurance business in the state. And most of those companies have tried to reenter the state, he said.

Since the legislation, Minnesota has chosen to partially subsidize the program which has prevented any real cost to the insurers. But the subsidy of $4 million has been minimal in terms of the state budget, according to Mr. Ingrassia.

Connecticut has had a similar program since 1975 and has continued the approach of assessing insurance companies for excess costs. The plan has not incurred costs to the state. (See research report).

PRESENTATION OF JOAN GAUMER

I am Joan Gaumer, representing Blue Cross of Washington and Alaska. Blue Cross recognizes the problems of high risk individuals and supports programs which provide an equitable method to provide coverage for persons who cannot obtain coverage through regular programs.

HB 547 seems to be directed toward this problem. It is, unfortunately, not drafted with sufficient understanding of the health care insurance industry to be able to offer a workable alternative. I'd like to address some particulars of the bill.

In AS 21.55.010 membership includes insurers, HMO's and "self insurers". I see three problems here.

1. I believe you meant to include Blue Cross of Washington and Alaska, but we are not an insurer, an HMO, or a self insurer and are not included in the bill.
2. HMO's are not licensed or authorized in this state.
3. You do include "self insurers". This term is not defined and seems to ignore the constraints of ERISA. ERISA, the Employees' Retirement Income Security Act, is federal legislation, passed in 1974, which precludes state insurance laws from impacting any employer which self funds its employee health benefit program. I believe you will find that this Association <u>cannot</u> include employers who self fund.

If that is so, this proposal will once again impact those

of us who are in the business of health care coverage and make self funding of benefits that much more attractive to the employer. The State of Alaska, when benefits are self funded, loses its control to require adequate reserves, reasonable benefit design, and consumer protection issues such as unfair claims practices.

In general powers, AS 21.55.030, you allow the association to sue and be sued. You do not specify to what limits the members of the association would be at risk. Is it limited to the assets of the association? Or would a suit be able to top the non-risk-pool assets of the carriers who participate? In our litigious society, that is not an idle question.

In AS 21.55.050 you exempt the Association from the APA. However, you create a non-profit incorporated legal entity which is not a state agency anyway. You place some (actuaries)(?) under the Division of Insurance. If they issue regulations, do they do that exempt from notice requirements of the APA? We question this exception and ask that you reconsider this provision. AS 10.20 governs non-profit corporations. How does this affect this Association?

You infer, on page 5 (subsection (b) of AS 21.55.120, that an employer may cover his "bad risk" employees through this program. That would abrogate the idea of group insurance as we know it. It will legalize dumping of poor risk employees. Some carriers will welcome that, since it will lay poor risk into the state pool and lower costs for coverage to the employer who can

eliminate from his group any employee with chronic or progressive conditions. We believe it will become a standard business decision and should not be encouraged.

Sub-section (c) of AS 21.55.120 sets an 85% loss ratio. You state that as a percent of "state plan premium" which is not defined. If that term means only the premium paid by enrollees at 125% of average premium, then the writing carrier will be, in our opinion, unable to meet that loss ratio. If "state plan premium" includes the subsidization funds from insurers in the state, you can probably expect to be barely able to reach the 85% figure.

Advertising and referral fees as required in AS 21.55.240, etc. will be high costs and our actuary estimates that claims paid can be expected to run at 200-300% of subscriber premium.

In AS 21.55.200, you make eligibility dependent on one rejection, a rider or a preexisting condition limitation for substantially similar coverage. How do you determine sub-similar if there are $200, $500, $1,000 deductible options and (different)(?) benefits? Most standard contracts have preexisting condition limits. This bill includes one for persons enrolling in this coverage. If you were diagnosed or treated for a condition within a set number of months before coverage, that preexisting condition is not covered for a set period of time at the beginning of the contract. That individual does not belong in a high risk pool. Eligibility based on preexisting limitation should be stricken.

Other states laws and NAIC model legislation in this area require rejection from two carriers before a person is eligible. That is not an onerous requirement and it is a much more realistic standard for eligibility into this program.

The eligibility based on <u>one rider</u> is also not realistic. It assures that this state program will cover persons who can receive standard coverage with reasonable restrictions.

AS 21.55.210(2) allows spouse and children to be covered in the high risk plan. It would make no sense economically for me to cover my son or daughter in a high risk plan at higher premium costs if they are an average person without medical problems. We believe it is a meaningless provision and should be stricken.

In AS 21.55.240, subsections (c) and (d) seem to unnecessarily increase costs. In (c) you require a $50 referral fee, as well as a requirement in (d) that a rejected applicant be notified of the plans by the insurer rejecting. There will be many cases where a rejection automatically triggers a $50 referral fee. That may be an unnecessary administrative cost.

AS 21.55.250 sets the maximum premium at 125% of the average of rates changed by five insurers covering the largest numbers of Alaskans. You must, if the premium is to be anywhere near realistic, make that determination based on the five insurers offering individual <u>non group</u> coverage. Our actuary also suggests that the premium be based on age-rated products and should be age-rated itself. There should also be a requirement in the law that the cap of 125% be reviewed annually

and raised as needed, as carriers refile their rates to assure that it remains reasonable. To effect this you may want to allow the Division of Insurance to establish and modify the cap through regulations.

The premium for an HMO is seemingly accepted per se on a per HMO basis. Since Medicare risk contracts with HMOs are based on a correlation to 95% of fee for service charges in the same area, you may want to revise this language to assure some compar bility between the HMO cost and the 125% premium for persons using traditional coverage.

In summary, Blue Cross of Washington and Alaska opposes this proposal in its present form. It will, due to the federal requirements of ERISA, make the provision of coverage more expensive for admitted carriers while allowing employers who self-fund their benefits to provide coverage over which the state Division of Insurance has no control.

It would, as drafted, allow employers to shift their chronic higher risk employees over to this pool, lowering their insurance costs at the expense of all other insured persons in the state, and if a self-funded employer did this, he/she would escape the cost entirely!

The eligibility requirements are not stringent enough and will create too large a pool, essentially putting the state pool in competition with private carriers who also have the "privilege" of subsidizing the costs of these persons.

Blue Cross of Washington and Alaska would be pleased to

assist you or your staff in any way we can as you work on this or similar legislation. We recognize the problem you are trying to solve, but we urge you to fashion a solution which does not unfairly impact those of us who are striving to provide affordable coverage for the citizens of this state.

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).

RECORDS CERTIFICATION

I, the undersigned, an employee of the State of Alaska, do hereby certify that the microfilm images on this microform are accurate reproductions of the original records of the State of Alaska as accumulated during the regular course of business, and that it is the established policy and practice of this State to microfilm its records and to dispose of the original records after microfilm reproductions have been made.

James O. Smith
Signature of Camera Operator

9/5/89
Date

02-519 (REV 8/78)