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# SENATE FINANCE COMMITTEE REPORT

DATE: 3/29/90

FURTHER:

DATE TURNED INTO OFFICE: \_\_\_\_\_

The Finance Committee considered

SSSB 304

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

and recommended:

- replace with \_\_\_\_\_ CS \_\_\_\_\_  same title  
 or adopt \_\_\_\_\_ CS \_\_\_\_\_  new title  
 attached amendment(s)  technical title change (HB only)  
 \_\_\_\_\_ letter of intent adopted
- do pass *Hearings 4-23-90*  
 do not pass *4-24-90*  
*4-25-90*
- no recommendation *Bill subsequently*  
 individual recommendations *died in committee.*  
 further referral to \_\_\_\_\_

ATTACHES NEW FISCAL NOTE(S):  
Dept/Date:  
 fiscal note(s) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

APPROVES PREVIOUS:  
Dept/Date:  
 fiscal note(s) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

zero fiscal note(s) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

zero fiscal note(s) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

appropriation-no fiscal note

SIGNING DO PASS:

OTHER RECOMMENDATIONS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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\_\_\_\_\_

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1. \_\_\_\_\_ 2. \_\_\_\_\_  
Co-Chairs: Signatures and Recommendations

SENATE COMMITTEE REPORT

DATE: 3/1/90

FURTHER: Finance

DATE TURNED INTO OFFICE: 3/29/90

H E S S

Committee considered

SSSB 304

SPONSOR SUBSTITUTE FOR SENATE BILL NO. 304

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

and recommends L+C CS be adopted and reports it back with no amendments

and recommended:

[ ] replace with \_\_\_\_\_ CS
[ ] or adopt L+C CS

for SSSB 304

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

[ ] attached amendment(s)

[ ] \_\_\_\_\_ letter of intent adopted

[ ] do pass

[ ] do not pass

[ ] no recommendation

[X] individual recommendations

[ ] further referral to \_\_\_\_\_

ATTACHES NEW FISCAL NOTE(S):

Dept/Date:

[X] fiscal note(s) Attached

APPROVES PREVIOUS:

Dept/Date:

[X] fiscal note(s) Attached. DCIEC

[ ] zero fiscal note(s)

[ ] zero fiscal note(s)

[ ] appropriation-no fiscal note

[ ] Governor's bill w/fiscal note

SIGNING DO PASS:

OTHER RECOMMENDATIONS:

Blank lines for signing do pass

1 L. Gardner (No Rec)
1 C. Adams (No Rec)
1 Tim Kelly (No Rec)
1 J. ... (No Rec)

1 Paul ... (No Rec)

Chair: Signature and Recommendation

SENATE COMMITTEE REPORT  
FIRST COMMITTEE OF REFERRAL

6-1231#19  
c

DATE: 1/25/90

FURTHER: HESS  
Finance

Date of 5-Day Notice: 2/22/90  
(in accordance with Uniform Rule 23)

DATE TURNED INTO OFFICE: 3/1/90

L & C Committee considered SSSB 304

Act relating to disability insurance; efd.

and recommended:

- replace with \_\_\_\_\_ CS SS SB 304 (L+C)  same title  new title
- attached amendment(s) + maj of 1 Cmte re dp
- \_\_\_\_\_ letter of intent adopted

do pass

do not pass

no recommendation

individual recommendations

further referral to \_\_\_\_\_

FN

ATTACHES NEW FISCAL NOTE(S):

Department(s)/Date:

Department(s)/Date:

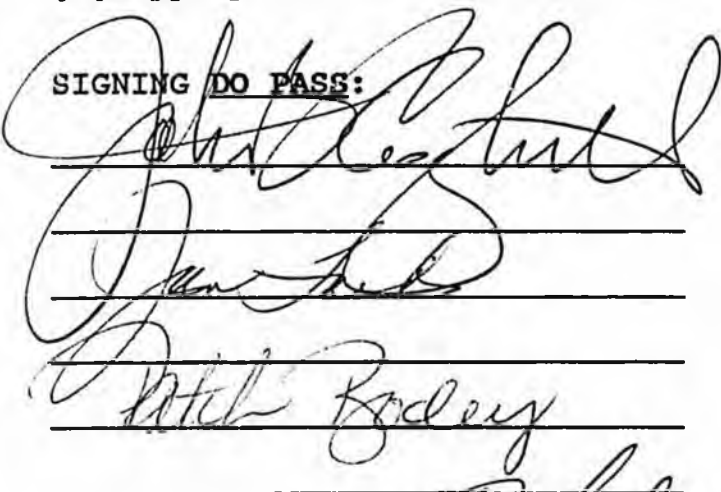
fiscal note(s) Dept of Commerce 2/23/90  
(for SSSB 304 + CS SSSB 304(L+C))

zero fiscal note(s) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

appropriation-no fiscal note

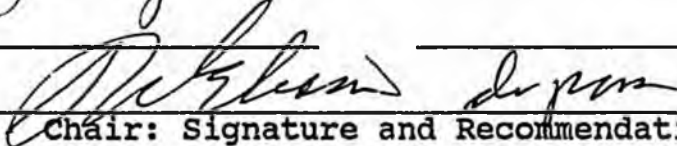
Governor's bill w/fiscal note

SIGNING DO PASS:



OTHER RECOMMENDATIONS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

  
Chair: Signature and Recommendation

SENATE COMMITTEE REPORT

FIRST COMMITTEE OF REFERRAL

Date of 5-DAY NOTICE \_\_\_\_\_  
IN ACCORDANCE WITH UNIFORM RULE 23

\*\*FISCAL NOTE(S) MUST BE ATTACHED  
IN ACCORDANCE WITH AS 24.08.035

4/25/89

FURTHER

HESS  
FIN

DATE TURNED INTO OFFICE \_\_\_\_\_

Mr. President:

L&C

Committee considered

SB 304

disability insurance; efd

and recommended:

replace with CS \_\_\_\_\_  same title

attached amendment(s) and  new title

\_\_\_\_\_ letter of intent adopted

do pass

do not pass

no recommendation

individual recommendations

further referral to \_\_\_\_\_

FISCAL NOTE(S) attached  zero

appropriation no FN attached

fiscal impact

Gov. FN introduced w/ bill

MEMBERS SIGNING DO PASS

OTHER RECOMMENDATIONS

\_\_\_\_\_  
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Chair: \_\_\_\_\_ signature and recommendation

Committee backup attached

FISCAL NOTE

*Attached to Bill*

REQUEST:

Revision Date: \_\_\_\_\_  
Title: An Act relating to disability insurance

Agency Affected: Commerce & Economic Development  
BRU: Insurance

Sponsor: Coghill  
Requestor: Senate Labor & Commerce

Components: Operations

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	65.4	65.4	65.4	65.4	65.4	65.4
TRAVEL	12.0	6.0	6.0	6.0	6.0	6.0
CONTRACTUAL	35.0	35.0	35.0	35.0	35.0	35.0
SUPPLIES	1.0	1.0	1.0	1.0	1.0	1.0
EQUIPMENT	10.0					
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	123.4	107.4	107.4	107.4	107.4	107.4
CAPITAL	0	0	0	0	0	0
REVENUE	(0-4,234.7)	(0-4,234.7)	(0-4,234.7)	(0-4,234.7)	(0-4,234.7)	(0-4,234.7)

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER PR/GF	123.4	107.4	107.4	107.4	107.4	107.4
TOTAL	123.4	107.4	107.4	107.4	107.4	107.4

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS : (Attach a separate page if necessary) No fiscal impact in FY 90.

Prepared by: David J. Walsh, Director Phone: 465-2515  
Division: Insurance Date: \_\_\_\_\_

Approved by Commissioner: Larry Mercurieff *Gary Bell for* Date: 2/23/90  
Agency: Department of Commerce & Economic Development

Distribution (by preparer):

- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

) Changes in CS SSSB<sup>304</sup> (LAC) have no fiscal impact. This fiscal note is appropriate.

**FISCAL NOTE ANALYSIS - SSSB 304**

**Personal Services:** Funding for a new PFT position, Chief of Operations, \$65.4, is included.

**Travel:** The director is an ex-officio board member of the Comprehensive Disability Insurance Association. The seven members of the board will be from out-of-state insurance companies and hospital or medical service corporations. The travel estimate is based on the director or the director's designee attending eight out-of-state board meetings in the first year of operation and four in each subsequent year at an estimated cost of \$1,500 for each.

**Contractual:** Each year, the division will have to contract with an actuary to verify that the rating structures of the association are actuarially sound. The estimate for the annual contract is \$25,000.

In addition, the director may undertake studies or demonstration projects to develop awareness of the benefits of the program. The annual estimate for this is \$8,000.

\$2,000 is also included for the new position's miscellaneous contractual expenditures.

**Supplies:** The new position's supplies are estimated at \$1,000.

**Equipment:** A work station and computer are included for the new position at \$10,000.

**Revenue:** The members of the Comprehensive Disability Insurance Association are entitled to receive a credit against taxes levied by the state on disability insurance premiums. The maximum potential loss of state revenue is equal to the total tax collected on disability insurance premiums. It is impossible to predict what the actual tax revenue loss will be. However, using 1987 premium data as a benchmark, the state could lose \$4.2 million.

\$144,444.0	1987 disability premiums of insurers
<u>    x 2.7%</u>	Tax rate
\$ 3,900.0	Tax revenue
\$ 61,189.0	1987 disability premiums of hospital and medical service corporations
<u>  [55,610.0]</u>	Less claims
\$ 5,579.0	Taxable premiums
<u>    x 6.0%</u>	Tax rate
\$ 334.7	Tax revenue
\$ 3,900.0	
<u>  + 334.7</u>	
\$ 4,234.7	1987 total disability insurance tax revenue

Furthermore, an insurer whose assessment exceeds their tax liability can carry forward the excess credit to be applied against future years' tax liabilities.



6-1231J

Ford

4/23/90

*Handwritten signature and date*  
4/23/90

Original sponsor(s): SEN. COGHILL

1 IN THE SENATE

2 CS FOR SPONSOR SUBSTITUTE FOR SENATE BILL NO. 304 *Finance*

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 SIXTEENTH LEGISLATURE - SECOND SESSION

5 A BILL

6 For an Act entitled: "An Act relating to disability insurance; and provid-  
7 ing for an effective date."

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

9 \* Section 1. LEGISLATIVE INTENT. It is the intent of the legislature  
10 to provide access to disability insurance coverage to all residents of the  
11 state who are denied adequate disability insurance coverage for any reason  
12 or who are otherwise considered uninsurable. It is the further intent of  
13 the legislature that AS 21.55 provide a mechanism to ensure the availabil-  
14 ity of comprehensive disability insurance to persons unable to obtain  
15 disability insurance coverage on either an individual or a group basis  
16 under any health plan.

17 \* Sec. 2. AS 21 is amended by adding a new chapter to read:

18 CHAPTER 55. STATE DISABILITY INSURANCE.

19 ARTICLE 1. COMPREHENSIVE DISABILITY INSURANCE ASSOCIATION.

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

1           Sec. 21.55.020. BOARD OF DIRECTORS; ORGANIZATION. The board of  
2 directors of the association consists of seven individuals selected by  
3 participating members, subject to approval by the director of the  
4 division of insurance. The director or the director's designee shall  
5 serve as a nonvoting ex officio member of the board. In determining  
6 voting rights at members' meetings, a member is entitled to vote in  
7 person or proxy. The vote must be a weighted vote based upon the  
8 member's premiums for disability insurance for major medical coverage  
9 on an expense incurred basis, or the member's subscriber fees, derived  
10 from or on behalf of state residents in the previous calendar year, as  
11 determined by the director. In approving members of the board, the  
12 director shall consider, among other things, whether all types of  
13 participating members are fairly represented. Members of the board  
14 other than the director or the director's designee may be reimbursed  
15 from the association for expenses incurred by them as board members,  
16 but may not otherwise be compensated by the association for their  
17 services. The costs of conducting meetings of the association and its  
18 board of directors shall be borne by members of the association.

19           Sec. 21.55.030. GENERAL POWERS. The association may

- 20           (1) exercise the powers granted to insurers under the laws  
21 of the state;
- 22           (2) sue or be sued;
- 23           (3) enter into contracts with insurers, similar associa-  
24 tions in other states, or with other persons for the performance of  
25 administrative functions;
- 26           (4) establish administrative and accounting procedures for  
27 the operation of the association.

28           Sec. 21.55.040. PLAN OF OPERATION. (a) The association shall  
29 submit to the director a plan of operation and any amendments

1 necessary or suitable to assure the fair, reasonable, and equitable  
2 administration of the association. The plan of operation and amend-  
3 ments become effective upon approval in writing by the director. If  
4 the plan submitted by the association has been twice disapproved by  
5 the director, or the association fails to submit a suitable plan of  
6 operation by a date that is 180 days after the effective date of this  
7 Act, or if at any subsequent time the association fails to submit  
8 suitable amendments to the plan, the director may, after notice and  
9 hearing, adopt reasonable regulations necessary or advisable to  
0 effectuate the provisions of this chapter. The regulations continue  
1 in force until modified by the director or superseded by a plan sub-  
2 mitted by the association and approved by the director.

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

5 (c) The plan of operation must

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

8 (2) establish procedures for handling assets of the asso-  
9 ciation;

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

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

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

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

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

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

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

7 Sec. 21.55.060. TAX EXEMPTION. (a) The association is exempt  
 8 from the payment of fees and taxes levied by the state or any of its  
 9 political subdivisions except taxes levied on real or personal proper-  
 10 ty.

11 (b) A member of the association is entitled to receive a credit  
 12 against taxes levied by the state on disability insurance premiums as  
 13 provided in AS 21.09.210(j).

14 ARTICLE 2. STATE DISABILITY INSURANCE PLANS.

15 Sec. 21.55.100. TYPES OF INSURANCE PLANS. (a) The association  
 16 shall make available to residents eligible under AS 21.55.300 an  
 17 individual state plan of disability insurance. The association shall  
 18 offer two alternatives related to deductibles as described in AS 21.-  
 19 55.120.

20 (b) The association may not deny coverage under a state plan to  
 21 a resident who satisfies the requirements of AS 21.55.300 - 21.55.310.

22 Sec. 21.55.110. MINIMUM BENEFITS OF STATE DISABILITY INSURANCE  
 23 PLAN. Except as provided in AS 21.55.120 - 21.55.140, the minimum  
 24 standard benefits of a disability insurance plan offered under AS 21.-  
 25 55.100(a) must include benefits required under AS 21.42.345 and  
 26 21.42.365, and must be benefits with a lifetime maximum of \$500,000  
 27 per individual for usual, customary, reasonable, or prevailing charges  
 28 for the following medical services performed for an individual covered  
 29 by the plan for the diagnosis or treatment of nonoccupational disease

1 or nonoccupational injury:

2 (1) hospital services, subject to the provisions of a  
3 preauthorization utilization program;

4 (2) subject to the limitations of AS 21.36.090(d), profes-  
5 sional services that are rendered by a physician or by a registered  
6 nurse at the physician's direction, other than services for mental or  
7 dental conditions;

8 (3) the diagnosis or treatment of mental conditions, as  
9 defined in regulations of the director, rendered during the year

10 (A) on an inpatient basis, up to a yearly maximum of  
11 30 days; and

12 (B) on an outpatient basis, up to a yearly maximum  
13 benefit of \$4,000;

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

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

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

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

29 (8) use of radium or other radioactive materials;

1 (9) outpatient chemotherapy;

2 (10) oxygen;

3 (11) anesthetics;

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

8 (13) rental, or purchase if purchase is more cost effective  
9 than rental, of durable medical equipment that has no personal use in  
10 the absence of the condition for which it was prescribed;

11 (14) diagnostic x-rays and laboratory tests;

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

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

17 (17) transportation by a local ambulance operated by licen-  
18 sed or certified personnel to the nearest health care institution for  
19 treatment of a life-threatening illness or injury and round trip  
20 transportation by air to the nearest health care institution for  
21 treatment of a life-threatening illness or injury if the treatment is  
22 not available locally; if the patient is a child under 12 years of  
23 age, the transportation charges of a parent or legal guardian accom-  
24 panying the child may be paid if the attending physician certifies the  
25 need for the accompaniment;

26 (18) confinement in a licensed or certified facility estab-  
27 lished primarily for the treatment of alcohol or drug abuse or in a  
28 part of a hospital used primarily for this treatment, for a period of  
29 at least 45 days within any calendar year, up to a yearly maximum

1 benefit of \$7,000 and with a lifetime maximum benefit of \$14,000;

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

4 (20) second surgical opinions;

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

8 Sec. 21.55.120. DEDUCTIBLES AND COPAYMENTS. (a) A state plan  
9 may require deductibles of \$1,000 a person or \$5,000 a person. The  
10 amount of the deductible may not be greater when a service is rendered  
11 on an outpatient basis than when that service is offered on an inpa-  
12 tient basis. Expenses incurred during the last three months of a  
13 calendar year and actually applied to an individual's deductible for  
14 that year shall also be applied to that individual's deductible in the  
15 following calendar year. The \$1,000 maximum and the \$5,000 maximum  
16 may be adjusted yearly to correspond with the change in the medical  
17 care component of the consumer price index, as adjusted by the direc-  
18 tor. The base year for the computation is the first full calendar  
19 year of operation of the association.

20 (b) A state plan must require a maximum copayment of \$2,000 plus  
21 the deductible for charges for all types of medical care.

22 (c) In this section, "consumer price index" means the consumer  
23 price index for all urban consumers for the Anchorage Metropolitan  
24 Area compiled by the Bureau of Labor Statistics, United States Depart-  
25 ment of Labor.

26 Sec. 21.55.130. PREEXISTING CONDITIONS. (a) A state plan may  
27 not exclude coverage for a loss due to a preexisting condition for a  
28 period greater than 12 months following the effective date of cover-  
29 age.

1 (b) A state plan issued to a person whose previous subscriber  
2 contract or insurance policy was involuntarily terminated must credit  
3 the time covered under the previous contract or policy toward an  
4 exclusion for preexisting conditions under the state plan if the  
5 previous contract or policy had a similar preexisting condition exclu-  
6 sion and the person applies for a state plan within 31 days after  
7 termination of the previous contract or policy. If a person covered  
8 by this subsection is accepted by the writing carrier and pays a  
9 specified premium for retroactive coverage, the state plan is effec-  
0 tive retroactively to the date that the person's previous contract or  
1 policy terminated.

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

4 (1) care for an injury or disease either

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

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

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

8 (3) travel, other than transportation covered under AS 21.-  
9 55.110(17);

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

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

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

9 (7) services or articles that are not within the scope of  
0 the license or certificate of the institution or individual rendering  
1 the services or articles;

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

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

7 (10) service charges that would not have been made if no  
8 insurance existed or that the covered individual is not legally ob-  
9 ligated to pay;

0 (11) eyeglasses, contact lenses, or hearing aids or the  
1 fitting of them;

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

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

6 (14) experimental procedures; and

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

9 Sec. 21.55.150. STATE PLAN PREMIUMS. (a) Except as provided in

1 (c) of this section, the association may not charge a rate for cover-  
2 age issued by or through the association that is excessive, inade-  
3 quate, or unfairly discriminatory.

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

6 (c) The five members of the association that insure, or have  
7 subscriber contracts with, the largest number of individuals in the  
8 state under plans with benefits substantially equivalent to the state  
9 plan benefits shall submit to the association an estimate of the rate  
10 that would be actuarially sound for a person who is a standard risk  
11 for coverage substantially equivalent to the state plan. The premium  
12 for a state plan may not exceed 200 percent of the average of those  
13 five estimates.

14 ARTICLE 3. ADMINISTRATION OF PLANS.

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

22 Sec. 21.55.210. DUTIES OF WRITING CARRIERS. (a) The writing  
23 carrier shall perform the administrative and claims payment functions  
24 required by this section. The writing carrier shall provide these  
25 services for a period of three years, unless a request to terminate is  
26 approved by the director. The director shall approve or deny a re-  
27 quest to terminate within 90 days of its receipt. A failure to make a  
28 final decision on a request to terminate within the specified period  
29 is considered an approval. Six months before the expiration of each

1 three-year period, the association shall invite submissions of policy  
2 forms from members of the association, including the writing carrier.  
3 The association shall follow the provisions of AS 21.55.200 in  
4 selecting a writing carrier for the subsequent three-year period.

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

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

15 (d) Claims shall be paid by the writing carrier. A claim pay-  
16 ment must indicate that the claim was paid under a state plan and  
17 include a telephone number that can be used for inquiries regarding  
18 the claim.

19 (e) The writing carrier shall be reimbursed from the state plan  
20 premiums received for its direct and indirect expenses for administer-  
21 ing the plan. Direct and indirect expenses must include a pro rata  
22 reimbursement for that portion of the writing carrier's administra-  
23 tive, printing, claims administration, and management and building  
24 overhead expenses that are assignable to the maintenance and adminis-  
25 tration of the state plans. The association shall approve cost ac-  
26 counting methods to substantiate the writing carrier's cost reports  
27 consistent with generally accepted accounting principles. Direct and  
28 indirect expenses may not include costs directly related to the origi-  
29 nal submission of policy forms before selection as the writing carri-

er.

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

(g) The writing carrier shall administer a billing system for premium payments and may bill for premiums on a monthly or quarterly basis.

Sec. 21.55.220. OPERATION OF THE PLAN. (a) Upon notification of eligibility 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 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 state residents, as divided by the total subscriber fees and 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

1 assessment if necessary. The association may also, subject to the  
2 approval of the director, provide for interim assessments against the  
3 members as may be necessary to assure the financial capability of the  
4 association in meeting the incurred or estimated claims expenses of  
5 the state plans and operating and administrative expenses of the  
6 association until the association's next annual fiscal year end as-  
7 sessment. Payment of an assessment is due within 30 days of receipt  
8 by a member of written notice of a fiscal year end or interim assess-  
9 ment. Failure by a member to tender to the association the assessment  
0 within 30 days shall be grounds for revocation of a member's certifi-  
1 cate of authority. A member that ceases to do disability insurance  
2 business in the state, or ceases to offer subscriber contracts in the  
3 state, due to revocation, suspension, or voluntary surrender of its  
4 certificate of authority remains liable for assessments through the  
5 calendar year that the disability insurance or subscriber contract  
6 business ceased. The association may decline to levy an assessment  
7 against a member if the assessment would not exceed \$10. Assessments  
8 paid by a member are a general expense of the member.

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

3 ARTICLE 4. ENROLLMENT IN THE STATE DISABILITY INSURANCE PLAN.

4 Sec. 21.55.300. ELIGIBILITY FOR STATE DISABILITY INSURANCE. (a)  
5 Except as provided in (b) of this section, a person who is a resident  
6 is eligible for coverage upon providing evidence of

7 (1) rejection for medical reasons, a requirement of re-  
8 strictive riders, an up-rated premium, or a preexisting conditions  
9 limitation on disability insurance, the effect of which is to substan-

1 tially reduce coverage from that received by a person considered a  
2 standard risk, by at least one member within six months of the date of  
3 application; or

4 (2) involuntary termination of disability insurance cover-  
5 age for any reason other than nonpayment of premium.

6 (b) The following persons are not eligible for coverage:

7 (i) a person who is at the time of application eligible for  
8 medical assistance;

9 (2) a person who terminated coverage under this chapter  
0 unless

1 (A) 12 months have elapsed since termination; or

2 (B) that person can show other continuous coverage  
3 that has been involuntarily terminated for any reason other than  
4 nonpayment of premiums;

5 (3) a person on whose behalf the state has paid out  
6 \$500,000 in benefits; and

7 (4) inmates of public institutions and persons whose bene-  
8 fits are duplicated under public programs.

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

11 Sec. 21.55.310. ENROLLMENT BY AN ELIGIBLE PERSON. A person may  
12 enroll in a state plan by applying to the writing carrier. The appli-  
13 cation must include the following:

14 (1) name, address, age, and length of residency of the  
15 applicant;

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

18 (3) proof of eligibility under the criteria established in  
19 AS 21.55.300.

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

6           Sec. 21.55.330.   EFFECTIVE DATE OF POLICIES.   (a) Except as  
7 provided in (b) of this section and AS 21.55.330(b), insurance under a  
8 state plan is effective immediately upon receipt of the first quar-  
9 terly premium, and is retroactive to the date of the application, if  
0 the applicant otherwise complies with the requirements of this chap-  
1 ter.

2           (b) Insurance under a state plan is effective retroactively to  
3 the date that the person's previous contract or policy was terminated  
4 if the person

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

7                   (2) is accepted by the writing carrier; and

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

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

6           (b) The association shall devise and implement means of main-  
7 taining public awareness of the provisions of this chapter regarding  
8 the state plans and shall administer this chapter in a manner that  
9 facilitates public participation in the state plans. The association

1 shall prepare a brochure outlining the benefits and exclusions of the  
2 state plan in plain language.

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

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

11 ARTICLE 5. GENERAL PROVISIONS.

12 Sec. 21.55.400. DUTIES OF DIRECTOR. The director may

13 (1) approve the selection of the writing carrier by the  
14 association and approve the association's contract with the writing  
15 carrier including the coverages and premiums to be charged;

16 (2) contract with the federal government or another unit of  
17 government to ensure coordination of the state plans with other gov-  
18 ernmental assistance programs; and

19 (3) adopt regulations necessary to administer this chapter.

20 Sec. 21.55.410. STATE NOT LIABLE. The state is not liable for  
21 acts or omissions of the association or a writing carrier under this  
22 chapter, or for payment of a claim under a state plan issued by a  
23 writing carrier.

24 Sec. 21.55.500. DEFINITIONS. In this chapter

25 (1) "association" means the Comprehensive Disability Insur-  
26 ance Association created in AS 21.55.010;

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

29 (3) "deductible" means the portion of eligible expenses for

1 which the insured is responsible in each calendar year under AS 21.-  
2 55.120(a);

3 (4) "disability insurance" means a group or individual  
4 disability insurance policy, health care service contract, or health  
5 maintenance agreement;

6 (5) "home health agency services" means any of the follow-  
7 ing services provided upon recommendation of a licensed physician as  
8 part of a treatment plan:

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

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

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

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

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

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

7 (7) "major medical coverage" means a disability insurance  
8 contract or subscriber contract that provides benefits for hospital  
9 and medical care with potential lifetime maximum benefits per insured  
10 of \$500,000;

11 (8) "medical social services" means services rendered the  
12 patient under the direction of a physician by a qualified social  
13 worker holding a master's degree from an accredited school of social  
14 work, including assessment of the social, psychological and family  
15 problems related to or arising out of the covered person's illness and  
16 treatment, appropriate action and utilization of community resources  
17 to assist in resolving the problems, and participation in the develop-  
18 ment of treatment for the covered person;

19 (9) "resident" means a person who is physically present in  
20 the state, has lived in the state for at least the six consecutive  
21 months immediately preceding application for a state plan, and intends  
22 to remain permanently in the state; "resident" also includes a person  
23 who is not physically present in the state if the person lived in the  
24 state for at least six of the nine months immediately preceding appli-  
25 cation for a state plan and the person's absence from the state is for  
26 medical treatment or education; a person ceases to be a resident if  
27 the person is absent from the state for more than 90 consecutive days  
28 for reasons other than for medical treatment or education;

29 (10) "state plan" means a policy of insurance offered by the

1 association through a writing carrier;

2 (11) "usual, customary, reasonable, or prevailing charge"  
3 means a charge that has been approved by the director for a medical  
4 care procedure, service, or supply item, and that is the lowest of the  
5 following amounts:

6 (A) the billed amount for the medical service pro-  
7 vider's actual charge;

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

1 (C) the customary charge, based on a profile of char-  
2 ges made for the same medical procedure, service, or supply item  
3 in the same geographical area by other providers that have per-  
4 formed the same procedure or service or can provide the same  
5 supply item; the customary charge may not exceed the 75th percen-  
6 tile of the profile of charges;

7 (12) "writing carrier" means the insurer or insurers select-  
8 ed by the association and approved by the director to administer a  
9 state plan.

\* Sec. 3. AS 21.09.210 is amended by adding a new subsection to read:

1 (j) A member of the Comprehensive Disability Insurance Asso-  
2 ciation created in AS 21.55.010 may credit against a premium tax  
3 imposed against disability insurance premiums under this section, an  
4 amount equal to an assessment against the member under AS 21.55.-  
5 220(d). Any portion of the credit allowed in this subsection that  
6 cannot be taken in a tax year without reducing taxable premiums below  
7 zero may be carried forward and credited in successive years until the  
8 credit is exhausted.

\* Sec. 4. The association established by sec. 2 of this Act shall make

1 available to residents the plans required by AS 21.55.100, enacted in  
2 sec. 2 of this Act, by January 1, 1991.

3 \* Sec. 5. This Act takes effect immediately under AS 01.10.070(c).  
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4/24/90

1 available to residents the plans required by AS 21.55.100, enacted in  
2 sec. 2 of this Act, by January 1, 1991.

3 \* Sec. 5. AS 21.09.210(j) and AS 21.55 are repealed.

4 \* Sec. 6. Section 5 of this Act takes effect July 1, 1995.

5 \* Sec. 7. Except for sec. 5 of this Act, this Act takes effect immedi-  
6 ately under AS 01.10.070(c).

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STATE OF ALASKA  
THE LEGISLATURE

POUCH V STATE CAPITOL  
JUNEAU ALASKA 99811  
907 465 3800

LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM

March 12, 1990

SUBJECT: Disability insurance - CSSSSB 304(L&C)  
TO: Senator Jack Coghill  
FROM: Michael F. Ford *M.F.*  
Legislative Counsel

The following is a sectional analysis of CSSSSB 304(L&C):

Section 1 - Legislative intent.

Section 2

Sec. 21.55.010 - Establishes the Comprehensive Disability Insurance Association and provides that the purpose of the association is to provide health insurance to eligible residents of the state.

Sec. 21.55.020 - Establishes the board of directors of the health insurance association, and requires the board to use a weighted voting system based on premium income.

Sec. 21.55.030 - Establishes the general powers of the authority.

Sec. 21.55.040 - Requires the association to develop a plan of operation. Provides specific items that must be included in the plan of operation.

Sec. 21.55.050 - Exempts the association from the Administrative Procedure Act (AS 44.62).

Sec. 21.55.060 - Exempts the association from all taxes except taxes on real or personal property. Allows a tax credit for members of the association.

Sec. 21.55.100 - Requires the authority to provide health care insurance to eligible residents of the state.

3/12/90 Sectional Analysis

Senator Jack Coghill  
Page 2  
March 12, 1990

Sec. 21.55.110 - Establishes minimum benefits that must be provided.

Sec. 21.55.120 - Establishes deductible and copayment amounts. Provides for annual adjustment of the deductible.

Sec. 21.55.130 - Establishes criteria for coverage of a pre-existing condition.

Sec. 21.55.140 - Provides that certain care and services are not covered by the state insurance plan.

Sec. 21.55.150 - Establishes limits on the premium charged for state insurance.

Sec. 21.55.200 - Establishes criteria for selection of an insurer to administer the state plan.

Sec. 21.55.210 - Establishes the duties of the insurer who administers the state plan.

Sec. 21.55.220 - Provides for enrollment in the state plan, and for assessment of claims expenses to members of the association.

Sec. 21.55.300 - Establishes eligibility requirements for enrollment in the state plan.

Sec. 21.55.310 - Provides for enrollment in the state plan.

Sec. 21.55.320 - Requires the writing carrier to act on an enrollment application within 30 days.

Sec. 21.55.330 - Establishes the effective date of insurance coverage.

Sec. 21.55.340 - Requires the association to solicit eligible residents for enrollment.

Sec. 21.55.400 - Duties of the director of the division of insurance.

Sec. 21.55.410 - Gives the state immunity for acts or omissions of the association, and for payment of claims.

Sec. 21.55.500 - Definitions.

Senator Jack Coghill  
Page 3  
March 12, 1990

Section 3 - Establishes a tax credit for members of the association.

Section 4 - Requires the association to make insurance available to residents by January 1, 1991.

Section 5 - Effective date.

MFF:pl  
WKP3/037



**STATE OF ALASKA  
OFFICE OF THE GOVERNOR  
BILL ANALYSIS**

DEPARTMENT Commerce & Econ. Dev.	DIVISION Insurance	BILL NUMBER CSSSSB 304(L&C)	SPONSOR Senator Coghill
SHORT TITLE OF BILL An Act Relating to Disability Insurance			
DEPARTMENT POSITION Neutral			
PREPARED BY Dave Walsh, Director	DATE 3/2/90	COMMISSIONER'S SIGNATURE <i>S. M. [Signature]</i>	DATE 3/5/90

**SUMMARY**

OTHER AGENCIES AFFECTED BY BILL Department of Health and Social Services	CONSTITUENT GROUP(S) AFFECTED BY BILL Uninsurable residents and residents who have involuntarily lost their health insurance coverage
ORGANIZATIONAL SUPPORT FOR BILL Insurance Industry	ORGANIZATIONAL OPPOSITION TO BILL Unknown

FISCAL IMPACT:     NONE     FISCAL NOTE ATTACHED

**BACKGROUND LEGISLATIVE INTENT**

SB 304 provides for a third party medical care financing mechanism for residents who are either marginally insurable or uninsurable or who have involuntarily lost their coverage with the financial ability to pay premiums at a level deemed affordable. This measure is similar to CSHB 589 of the Fourteenth Legislature, and HB 72 and HB 474 of the Fifteenth Legislature. There is the possibility of a substantial loss of premium tax revenues up to \$4.2 million.

**ANALYSIS OF BILL PROGRAM EFFECTS**

See Attached

**AMENDMENTS PROPOSED**

None

4076D-1/3290f

PLEASE ATTACH A SEPARATE SHEET FOR ADDITIONAL COMMENTS OR ANALYSIS

ANALYSIS OF BILL/PROGRAM EFFECTS

SECTION 2 AS 21.55.010 - .500

AS 21.55.010

This section creates the Comprehensive Disability Insurance Association (CDIA). Membership is mandatory as a condition of licensure for those insurers and hospital or medical service corporations that offer major medical coverage in Alaska. "Self-insurers" are not members and could not be forced to be members due to the preemption created by the Employee Retirement Income Security Act of 1974 (ERISA).

AS 21.55.020

Criteria for CDIA's seven-member board is established in this section. The director or director's designee is a nonvoting, ex-officio member of the board. The vote of a board member is weighted based upon that member's share of Alaska disability insurance premium for major medical coverage. The CDIA board members may be compensated only for their expenses incurred as board members. The costs incurred by the director for association related duties, such as travel expenses to attend board meetings, must be borne by the Division of Insurance's budget. FY 91 would be impacted the most as numerous meetings can be anticipated to implement this program. Four board meetings can be anticipated in future years. The board meetings could also be expected to take place outside of Alaska as board membership will be insurers domiciled outside of this state. It will be more cost effective for members to meet in a central location in the contiguous 48 states.

AS 21.55.030 - .060

These sections set out CDIA's general powers, an outline for a plan of operations, an exemption from the Administration Procedures Act, and an exemption from any taxes and fees levied by the state or any political subdivisions (other than those on real or personal property).

AS 21.55.100

Two plans of disability insurance are required to be made available to eligible residents. The two plans are differentiated by the deductible described in AS 21.55.120 (\$1,000 and \$5,000).

A resident is eligible (AS 21.55.300(a)) for coverage if the person provides evidence of:

1. rejection for medical reasons, a requirement of restrictive riders, an updated premiums or a preexisting condition limitation which has the effect of substantially reducing coverage as compared to a person considered to be a standard risk, by at least one member insurer within six months of the date of application; or
2. involuntary termination of disability insurance coverage for any reason other than nonpayment of premiums.

The following persons are not eligible (AS 21.55.300(b)):

1. a person who, at the time of application, is eligible for medical assistance;
2. a person who terminated coverage under this chapter unless 12 months have elapsed since termination, or that the person can show that other continuous coverage was involuntarily terminated for any reason other than for nonpayment of premium;
3. a person on whose behalf \$500,000 in benefits have been paid; and
4. inmates of public institutions and persons whose benefits are duplicated under public programs.

It should be noted that a person who previously has had double coverage and involuntarily loses one coverage plan would be eligible for this program. If it is not the sponsor's intent for this program to provide for double coverage, this section would need to be amended to accomplish this.

No other eligibility criteria may be applied other than that found in AS 21.55.300 and a person may not be denied coverage if those criteria are met and application is made in accordance with AS 21.55.310.

#### AS 21.55.110

Minimum benefit standards are established in this section. The benefit configuration is quite comprehensive and may provide for premium rates that may not be affordable even with a premium cap of 150% of a standard rate established under AS 21.55.150. A "no frills" catastrophic type of benefit configuration may wish to be considered in order to address the affordability issue.

#### AS 21.55.120

The two deductible amounts of \$1,000 and \$5,000 are established here. A deductible "carry-over" provision is established for expenses incurred in the last three months of any calendar year used to satisfy the deductible. Those expenses will be used to also satisfy the deductible in the following year.

A copayment maximum is established.

An insured's out-of-pocket costs are limited to \$2,000 as a result of responsibility for the deductible and copayment.

The deductible may be adjusted annually by the director based upon the change in the consumer price index for the Anchorage Metropolitan area.

#### AS 21.55.130

This section provides the allowable preexisting medical condition provision to be included in the state plans. No coverage is to be provided for the first twelve months of coverage for any preexistent medical conditions.

The state plan must credit time covered under a previous contract which was involuntarily terminated toward satisfaction of the time parameters in which coverage is not provided for a preexisting condition. In such a situation and if the person applies for state plan coverage within 31 days after involuntary termination, the state plan coverage is retroactive to the termination date.

#### AS 21.55.140

This section provides a list of care and services not to be covered by the state plans.

#### AS 21.55.150

Standards for the establishment of premium rates are found here. Age banded rates that vary by geographic location of the insured are required. The rates charged by the CDIA are not to be excessive, inadequate, or unfairly discriminatory. However, the maximum rates charged may not exceed 150% of the average of the rates charged for a standard risk by the five insurers with the largest member of Alaskan residents covered under equivalent plans of insurance coverage. The director would need 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 members whose rates are going to be solicited. (This data is not currently reported.) Furthermore, each of the five insurer's rates for its actuarially equivalent plans would have to be verified as being actuarially sound by the division. This activity will have a fiscal impact on the division as well as on the insurance industry. A less costly approach would be to determine the five insurers on the basis of total disability premiums written in Alaska. However, the division would still need to contract annually with a qualified actuary to determine the structural compatibility and actuarial soundness of the rate structures.

Testimony on CSHB 589 of the Fourteenth Legislature from the insurance industry indicated that actuarially sound rates for the uninsurable population might exceed standard rates by a factor of three.

#### AS 21.55.200

Criteria for the selection of the member to administer the state plans is found in this section. Essentially, the criteria entail the proven ability to administer large insurance contracts efficiently. An additional criteria that may wish to be considered would be to require that an administrative, claims payment facility be located in Alaska. However, cost/benefit justification would need to prevail.

#### AS 21.55.210

This section sets out the duties to be performed by the writing carrier. The duties include those usually performed by any insurer or hospital or medical service corporation.

#### AS 21.55.220

The material provisions of this section pertain to establishing each member's liability for its proportional share of the costs to operate the state plans and proportional share of claims that exceed the premiums collected. Each member's proportional share is determined by the relationship of its total disability insurance premiums or subscriber fees to the total of all members. Failure by a member to pay an assessment within 30 days from when it is due is grounds for revocation of that member's certificate of authority. Any gains from operations of the state plans are required to be held at interest and be used to offset future claims or to reduce premium rates.

Any assessments paid by a member are considered an expense item for statutory financial reporting purposes.

#### AS 21.55.300

Eligibility for participation in the state plans is outlined in this section as well as an outline for those persons not eligible. These criteria were discussed previously in the comments on AS 21.55.100.

#### AS 21.55.310

This section contains the procedure for application for state plan coverage, and a description of the personal information required to be provided. It should also be noted that no premium payment is required to accompany the application.

#### AS 21.55.320

This section requires the writing carrier to respond to each applicant within 30 days of request of an application. The application is either rejected for noncompliance with AS 21.55.300 and AS 21.55.310, or it is accepted and billing information is provided.

### AS 21.55.330

The effective date of coverage under the state plans is governed by this section. The primary criteria for coverage effectuation is the receipt of the appropriate premium by the writing carrier. Generally, coverage is retroactive to the date of the application. However, coverage may be retroactive to the date that a person's previous coverage was terminated if that person:

1. applies for state plan coverage within 60 days after the previous coverage was terminated;
2. is accepted by the writing carrier; and
3. pays a specified premium for the period of retroactive coverage.

One area in need of clarification is what date constitutes the "date of application". Basically, two possible dates could constitute that date:

1. the date the applicant signs the application (under the assumption the application form will have a signature space, and a space for the applicant to date his or her signature). If this is the intended date, it is recommended that each applicant's signature and date of signature be notarized;

OR

2. the date the writing carrier receives a completed application. This would be determined assumedly by a mechanically stamped day/date of receipt on the application itself.

This clarification can be accomplished with adoption of regulations under AS 21.55.400(3).

### AS 21.55.340

This section calls for the association to develop and implement a program of public awareness that encourages and facilitates participation in the state plans. Any member that rejects coverage or applies underwriting restrictions is required to inform that person of the existence of the state plans, eligibility requirements, and the application procedures.

The marketing of the state plans, other than by association members or the writing carrier on a direct basis, is limited to licensed disability insurance agents. No mention is made of any compensation for the agent that "sells" a state plan to an eligible person. The issue of compensation for agents may wish to be addressed.

### AS 21.55.400

The duties of the director are outlined in this section. One duty (AS 21.55.400(2)) entails the contracting with other governmental entities (state and federal) to coordinate this program with other medical assistance

programs. It is understood that such arrangements are typically accomplished not through contracts, per se, but through "memoranda of agreement".

#### AS 21.55.410

This section states the state is not liable for the acts of the association in operating this plan.

#### AS 21.55.500

This section contains the definitions of the operative terms used in this proposal.

The term "major medical" includes the lifetime maximum of \$500,000. It should be noted that an insurer could escape membership in the association by offering plans with maximum benefits of less than \$500,000.

#### SECTION 3

This section creates an offset equal to any assessment to premium taxes required to be paid by a member. Such credits may be carried forward if the offset in a given year would reduce a member's premium tax liability to less than zero.

This will result in less premium tax receipts for the state depending upon the state plans' financial performance. It should be noted that this credit can be applied against premium taxes associated only with disability insurance premiums.

There may be an inequitable result due to the different premium tax bases for insurers and hospital or medical service corporations.

#### SECTION 4

This section requires that state plans be available by January 1, 1991. This appears to be a quite short lead time to develop these plans. If this Act is enacted during the first session, it might be more realistic to have the implementation date set at July 1, 1991.

#### SECTION 5

This Act would take effect immediately.

HOE QS  
AK  
TERRA  
AND  
COMMUNITY  
DEVELOPMENT  
DIVISION  
P.O. BOX 1100  
NOME, AK 99565

## The Uninsurables

54304 Scheduled 2/26/90

# Coghill's bill would create high-risk pool

By IMRE NEMETH

Uninsurable is a label branded on more and more people. As health care costs rise, insurance providers are looking for ways to cover themselves in a very volatile business.

People with heart conditions, cancer, other serious illnesses or just an all-around broken-down body don't fit into the system.

foot of calamity. Thus, it's good for the rest but, due to economic concerns, cancels out anybody else.

A bill Sen. Jack Coghill (R-Nenana) introduced this session would give these uninsurables another option.

Senate bill No. 304 would create a risk pool for this group. It would provide "access to disability insurance

Rather than place high-risk individuals in the same group as others taking out plans or having them face exclusion, this would incorporate every individual into one pool. The risk for this wouldn't be the concentrated responsibility of a single insurer but spread evenly among all the insurance firms providing health coverage in the state.

"We as an industry would be picking up the tab," Moore said. "I think it's important that our industry do what it can to support this big problem. It's a very positive solution."

Under the bill, which according to Moore was written to include as many hypothetical situations as possible, those in the pool wouldn't pay any more than 50 percent more than the

average health insurance premium. The bill is modeled after a similar program in Washington state. So far 17 states have adopted legislation creating like programs.

The problem of the uninsurable is fairly large. There is the possibility that employers may refrain from hiring somebody who would cause their health plans problems in the future.

Moore said there seems to be quite a bit of support this time around for the high-risk pool.

"The concern is what if the losses become too high?" he said. "What if the 50 percent premium cap is not adequate?"

These are questions nobody yet knows the answers to. It isn't even known yet how many people are out there who would be eligible.



Lucky enough to fit under the umbrella of a corporate health plan, those who have had some major medical catastrophe in their past are able to get coverage. Unfortunately, a large group of castaways seems to fit in the individual category.

In this area, it's easy for an insurer to print "rejected" on an applicant's form. It enhances competitiveness and keeps costs down for people who don't get sick or trampled under the

coverage to all residents of the state who are denied adequate disability insurance coverage for any reason or who are otherwise considered uninsurable."

Insurance agent Bruce Moore, president of the Southern Alaska Life Underwriters, considers the bill one of his pet projects. He feels the issue is of grand importance not only to his industry but to clients of his that fall under this category.

## KIRA BROKERAGE AND AFFILIATES

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**COMPARISON OF CONVERSION RATES  
TO AETNA MANUAL RATES**

	<b>Aetna Conversion Rates</b>	<b>Aetna Manual Rates (50/50 m/f split)</b>	<b>Relativity</b>
<b>Under 25</b>	<b>758</b>	<b>394</b>	<b>193%</b>
<b>25-29</b>	<b>830</b>	<b>394</b>	<b>211%</b>
<b>30-34</b>	<b>871</b>	<b>448</b>	<b>194%</b>
<b>35-39</b>	<b>915</b>	<b>448</b>	<b>204%</b>
<b>40-44</b>	<b>966</b>	<b>491</b>	<b>197%</b>
<b>46-49</b>	<b>1093</b>	<b>565</b>	<b>193%</b>
<b>50-54</b>	<b>1221</b>	<b>650</b>	<b>168%</b>
<b>55-59</b>	<b>1391</b>	<b>746</b>	<b>187%</b>
<b>60-64</b>	<b>1548</b>	<b>867</b>	<b>179%</b>

## SUBURBAN PRINTING

February 6, 1990

Senator Coghill  
P.O. Box 55028  
North Pole, Alaska 99705

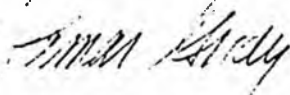
Dear Senator Coghill,

I have a medical condition which apparently makes me uninsurable. I have recently attempted to obtain adequate medical coverage and have been severely ridered because of my current medical condition. I know that there are many others that have the same fate as I.

I would like to express my support for Senate Bill 304 as written. I have recently reviewed the bill and feel that the creation of a "high risk pool" would be a benefit to all concerned. The State of Alaska, the insurance companies involved and certainly the Alaskan participants would be better off as a result of this bill.

Please contact me for any further support that you might need.

Sincerely,



H. Lamar Gray  
7703 Arlene  
Anchorage, Alaska 99502

HOMER MEDICAL CLINIC  
A PROFESSIONAL CORPORATION  
4136 BARTLETT STREET  
HOMER, ALASKA 99603  
TELEPHONE (907) 235-8586

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PAUL L. ENEBOE, M.D., A.B.F.P.  
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STEVE BECKER, M.D., A.B.F.P.  
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BETTY ENEBOE, R.N., M.P.H.

Senator John B. Coghill  
P.O. Box 55028  
North Pole AK 99705

RE: Support of Senate Bill 304 as written

Dear Senator Coghill:

We have employees and patients who have medical conditions which make them un-insurable. They have attempted to obtain adequate medical coverage and have either been rejected or severely ridered because of their circumstances. I understand that there are many Alaskans who share this situation.

I would like to express my support for Senate Bill 304 as written. I have recently reviewed the bill and feel that the creation of a "high risk pool" would be a benefit to all concerned. The State of Alaska, the insurance companies involved, and certainly the Alaskan participants would be better off as a result of this bill.

Please feel free to contact me for any further support that you may need.

Sincerely,

*William H. Bell*

Jan Maslyk  
2220 Tasha Drive  
Anchorage, AK 99502

NOV 27 1989

November 22, 1989

Senator Coghill  
P.O. Office Box 55028  
North Pole, AK 99705

Re: Support of Senate Bill 304 as written

Dear Senator Coghill,

My dependant child has a medical condition which apparently makes her uninsurable. I have recently attempted to obtain medical coverage for her from two insurance companies and have been rejected by both because of her current circumstance. I understand that there are many Alaskans whom share my situation.

I would like to express my support for Senate Bill 304 as written. I have recently reviewed the bill and feel that the creation of a "high risk pool" would be a benifit to all concerned. The State of Alaska, the insurance companies involved and certainly the Alaskan participants would be better off as a result of this bill.

Please feel free to contact me for any further support that you may need.

Sincerely,

*Jan Maslyk*

Jan Maslyk

March 27, 1989

To: Senator Jack Coghill  
Capital, Room 30  
Juneau

From: Jan H. Soloy  
P.O. Box 872801  
Wasilla, Alaska 99687  
376-3813

Subject: High Risk Health Insurance Coverage

I have been an Alaskan resident since 1981, prior to moving here I worked as a Registered Nurse in the speciality areas of Coronary|Intensive Care. The reason I relocated to Alaska was that I married a man that resided here. We have two sons, Matthew is seven and Sam is 3. We own and operate a helicopter company that is based in Wasilla. The past eight years we have built the company from the size of one machine and one employee to five machines and 25 full-time and seasonal employees. Chris and I are active in community youth activity programs and we sponsor youth sports in the area. We also have decided to donate a piece of needed equipment for one of the schools in this area each year that we can. We are firm believers in local business and individuals supporting the community.

For twelve years I have lived with a condition called Multiple Sclerosis. Although I am lucky and have been very stable, living and coping with a disease like MS has been a challenge in many ways. I have had the opportunity to be in large groups for health insurance coverage, that has changed now because of some changes in federal law and company policies of the group we are in. We have group benefits for 17 more months and if it weren't for the fact that our coverage is in Washington and not in Alaska, I would be out-of-luck and be without any comprehensive coverage. Because the Washington legislators saw fit to pass legislation that says that if you lose group coverage you must be guaranteed conversion to an individual plan, regardless of your health status. This goes beyond the COBRA law. Therefore I'm luckier than most with a high risk condition in a non-group situation. I have some basic coverage for general medical care. Nothing for Skilled Nursing Facilities, Hospice, Rehab., no catastrophic coverage at all. I'm grateful for the law in Wa. but I live in Alaska now. I have been turned down for insurance before but went back to work in a large hospital, I have been aware of health insurance problems, now that awareness is reality. I'm one of the 15 million in this country and thousands in this state alone, that because of a preexisting condition is underinsured. The numbers for uninsured are much greater.

I have copies of several pieces of legislation on this topic, that have been introduced in the Alaska legislature this year and one in 1986. Granted this is a national problem but experts agree that we are at least 20 years away from solving it at the national level. Indeed, the trend for solutions is at the State level of government. Twenty states have passed and put into effect laws which have created some version of a High Risk Health Insurance Pool. This number grows each year, fifteen more, including Alaska have introduced bills dealing with this issue. Yes, the states lose money but without this coverage another group of indigents are created. That has a fiscal impact on the state also. Only Multi-millionaires can afford to be without

page 2 of 2  
3-27-89  
High Risk Insurance

health insurance. One should not have to get a divorce or relinquish all assets to be eligible for medical benefits.

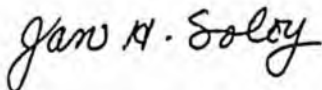
This is a problem that faces many people in Alaska. I have been in contact with the Heart, Diabetes, Lung and Epileptic Associations, MDA; Cancer Society and several Senior Citizens groups among a few. They are all in support of state health insurance for people that have been refused coverage for health reasons. We all realize that this insurance is costly, with large deductibles. I spoke with several that would be able to pay this, with some effort on my part and others you will be hearing from constituents on this. In the meantime, I believe it is time for Alaska to address this problem. I am aware of The Budget problems we face but if 20 going on more states can find ways to resolve this problem despite their varied problems, then I believe Alaska can too and will. Mike Losow of the National MS Society informed me that Alaska had introduced some of the best legislation ever designed to dissolve barriers to health insurance coverage for the chronic condition groups. This made me strangely proud. I told Mike that I felt we would do more than design and consider. The time is now to make this a legislative priority, even in the face of oil prices.

Furthermore, there is no sector of private business that can solve this, we have no one to turn to but our government. Government that was formed, among other things to protect and promote public health for everyone, not just the unfortunate but the middle-class group and upper middle-class.

I support state sponsored and created High Risk Health Insurance. Please consider introducing or supporting legislation that would allow access to health care for the ones who "fall through the cracks".

I would like to hear from you, your thoughts and how close you feel Alaska is to passing this type of legislation.

Respectfully,



Jan H. Soloy

cc: legislative offices

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# State Legislative Report



THE NATIONAL ASSOCIATION OF LIFE UNDERWRITERS 1922 FST, NW, WASHINGTON, D.C. 20006-4387

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SLR 87-16

June 4, 1987

\* \* SPECIAL \* \*

## RISK POOLS FOR UNINSURABLES

### ACKNOWLEDGEMENT

The charts and information provided with this SLR were in part compiled by an organization called Communicating for Agriculture which has been interested in the risk pool issue since 1975. We thank them and the other organizations who have provided information to NALU and who continue to provide information on this important issue.

### WHAT ARE RISK POOLS?

Among the uninsured are those who have been denied insurance coverage for reasons of poor health or who have been offered insurance policies with extremely high premiums or with restrictive exclusions for pre-existing conditions. For some of these people, money is not the barrier to health care until such time as large medical bills drain their resources.

In 13 states, high risk individuals now have access to health insurance risk pools. Under such programs, health status is in theory eliminated as a barrier to the availability of health insurance, since insurance is available through the pool.

Clearly, risk pools do not eliminate all barriers to the availability of health insurance, because the insurance obtainable through pools is expensive. Nevertheless, advocates argue that this availability of insurance helps to create a principle that everyone should have the opportunity to purchase health insurance. Second, they argue that health insurance for high risk individuals does address one small segment of the larger population of uninsured individuals.

**NALU POLICY**

NALU supports the passage of enabling legislation in all states to create reinsurance pools or other mechanisms to fully spread the risks associated with insuring those persons now denied access to adequate health insurance.

**RECENT NALU BOARD ACTION**

At their April 1987 meeting the NALU Board of Trustees adopted a recommendation to refer the issue of state pools for uninsurables to NALU's State Law and Legislation Committee as a high priority item with the exhortation that the Committee work toward the enactment of legislation creating such pools in all states.

**PURPOSE OF THIS SLR**

To provide information to all recipients of the State Legislative Report and to urge those states currently not providing a method or mechanism for uninsurables to obtain health insurance to consider taking steps toward the eventual enactment of legislation providing for such pools.

**BASIC DESIGN OF A RISK POOL**

The basic design of a risk pool is to guarantee availability of adequate health insurance to all individuals, regardless of their physical condition. Although the operation of pools varies considerably from state to state there is a basic pattern. The state generally forms an association of all health insurance companies doing business in the state (proposed federal legislation would permit inclusion of self-insuring business in this association). One organization is selected to administer the plan under the guidelines for benefits, premiums, deductibles, etc. as set forth in the state law. Individuals then are able to purchase insurance from the plan.

**COVERAGE**

Risk pool policies do provide a fairly comprehensive package of benefits. Unlike many private individual policies that do not cover physician fees, risk pools generally specify a minimum benefit package that includes in-patient hospital services and services rendered by or at the direction of a physician, as well as some skilled nursing care, home health care, and prescription drugs.

Normally a choice of deductibles is offered, ranging from as low as \$150 to as high as \$2000, resulting in substantially different premiums. Some form of pre-existing condition restriction has been deemed necessary, if only to prevent individuals from enrolling for insurance only after they need medical care. Most pools have a six to twelve month waiting period for pre-existing conditions. However, some sta-

tes allow a waiver of this waiting period through payment of a premium surcharge.

COST OF  
INSURANCE

Cost remains the biggest barrier to obtaining health insurance through risk pools, since insurance provided to high risk individuals must obviously be more expensive than that for standard risks.

While these premiums are high, they would be even higher in the absence of state imposed limits that cap premiums at no more than a fixed percentage (usually about 150%) of the standard individual premium in the state.

One state has taken an additional step to make risk pools more accessible to the poor. The Wisconsin legislature in 1985 passed legislation appropriating funds to assist low income policyholders in paying premiums.

PAYING FOR THE  
POOL

In theory, premiums are to cover the majority of claims paid by the pool. In practice, however, premiums are generally insufficient, because of the premium cap and the poor health status of the insured individuals. Accordingly, the losses incurred are compensated by assessing the members of the pooling association, in proportion to their share of the state health insurance market. In most states, these pool assessments are subsidized through rebates on premium taxes or other state taxes.

Experience in most states indicates that the plans lose money over the course of a year. While losses can at times be large, the cost has been in the range of 1% of the total amount of premiums collected from all health insurance policies sold in those states.

Three states, Illinois, New Mexico, Washington, enacted pooling laws in 1987. Illinois was a particularly interesting piece of legislation in that the law bases the subsidy on general revenues, not an assessment on insurers.

IN SUMMARY

No one can reasonably claim that risk pools will solve the entire problem of the insured, since the reasons for this lack of coverage are enormously varied. Some people are left vulnerable by limitations in Medicaid eligibility; others are employed by firms that do not offer health insurance; still others are left without insurance after becoming unemployed or losing dependent coverage through a spouse; some take the risk of not purchasing insurance although they can afford it.

Risk pools represent a small step in reducing the uninsured population, or at least that segment of the insured that is not poor but could become poor when faced with major medical expenses. These plans, however, provide no comprehensive solution to the indigent care problem. Risk pools simply encourage and assist individuals in purchasing health insurance. Those who cannot afford to purchase insurance will in most cases not benefit from the pools.

ADDITIONAL  
INFORMATION

The remainder of this SLR contains information on specific state programs showing the status of legislation creating comprehensive health insurance pools and describing the main aspects of a particular states pool.

NAIC MODEL  
LEGISLATION FOR  
CREATING A STATE  
HEALTH INSURANCE  
POOLING  
MECHANISM

The final attachment to this SLR is the Model Legislation adopted by the National Association of Insurance Commissioners. Immediately preceding the NAIC Model is a brief synopsis of the model bill.

\* \* \*

For further information contact: Roland L. Panneton, Counsel, National Association of Life Underwriters, 1922 F Street, N.W., Washington, D.C. 20006, (202)331-6023.

## STATUS OF LEGISLATION

### CREATING COMPREHENSIVE HEALTH INSURANCE POOLS

#### FOR HIGH-RISK INDIVIDUALS

<u>STATE</u>	<u>STATUS</u>
Alaska	Introduced in 1986 - Failed.
Arizona	Introduced in 1984 - Failed.
California	Introduced in 1984, 1985, 1986 - Failed.
Colorado	Introduced in 1985, 1986 - Failed.
* Connecticut	Program in effect - 1976.
* Florida	Program in effect - October, 1983.
* Illinois	Introduced in 1985, 1986 - Failed. <i>Passed in 1987</i>
* Indiana	Program in effect - July, 1982.
* Iowa	Passed and signed into law - April, 1986 - To become operational in 1987.
Kansas	Legislation passed and signed into law to further study the issue and draft legislation - March, 1986.
Kentucky	Introduced in 1984 - Failed.
Louisiana	Introduced in 1986.
Maine	To study the issue summer of 1986.
Maryland	To study the issue summer of 1986.
Massachusetts	Studying the issue.
* Minnesota	Program in effect - June, 1976.
Mississippi	Introduced in 1984, 1985, 1986 - Failed.
Missouri	Introduced in 1984, 1985, 1986 - Failed.
* Montana	Passed and signed into law - 1985 - To become operational July, 1987.
* Nebraska	Passed and signed into law - 1985 - To become operational late 1986 or early 1987.
* New Mexico	Introduced in 1986 - Failed. <i>Passed in 1987</i>
New York	Introduced in 1985, carried over to 1986 - Failed.
* North Dakota	Program in effect - June, 1981.

- Ohio Introduced in 1983-84 and 1985-86 - Failed.
- Oregon Introduced in 1985 - Failed.
- Rhode Island Catastrophic health plan in effect.
- South Carolina Introduced in 1985-86 - Failed.
- South Dakota Passed in 1984, but vetoed by Governor. Introduced in 1985 - Failed.
- \* Tennessee Passed and signed into law - April, 1986 - To become operational in 1987.
- Texas Introduced in 1977 - Failed.
- Utah Introduced in 1986 - Failed.
- Virginia Passed mandated enrollment for Blue Cross/Blue Shield in 1985. Studying pool issue in 1986.
- Washington To study issue the summer of 1986. *Passed in 1987*
- \* Wisconsin Program in effect - June, 1981.

\* Highlighted states have existing plans.

## MAXIMUM BENEFITS PROVIDED

<u>STATE</u>	<u>STATUS</u>
Alaska	No Limit In Legislation
Arizona	\$1,000,000 Lifetime Benefit
California	\$1,000,000 Lifetime Benefit
Colorado	\$500,000 Lifetime Benefit
* Connecticut	\$1,000,000 Lifetime Benefit
* Florida	\$500,000 Lifetime Benefit
Illinois	\$500,000 Lifetime Benefit
* Indiana	Plan I - No Limit Plan II - \$50,000 Lifetime Benefit
* Iowa	\$250,000 Lifetime Benefit
Kansas	No Limit in Legislation
Kentucky	\$1,000,000 Lifetime Benefit
Louisiana	\$500,000 Lifetime Benefit
* Minnesota	Regular Plan - \$250,000 Lifetime Benefit Medicare Plan - \$100,000 Lifetime Benefit
Mississippi	\$500,000 Lifetime Maximum
Missouri	\$1,000,000 Lifetime Benefit
* Montana	Not Less Than \$100,000 Lifetime Benefit
* Nebraska	\$500,000 Lifetime Benefit
New Mexico	To be Determined By The Board
New York	\$500,000 Lifetime Benefit
* North Dakota	\$250,000 Lifetime Benefit
Ohio	\$250,000 Lifetime Benefit
Oregon	\$250,000 Lifetime Benefit
South Carolina	\$1,000,000 Lifetime Benefit
South Dakota	\$50,000 Annual - \$250,000 Lifetime Benefit

- \* Tennessee \$500,000 Lifetime Benefit
- Texas No Limit in Legislation
- Utah \$250,000 Lifetime Benefit
- \* Wisconsin \$250,000 Lifetime Benefit

\* Highlighted states have existing plans.

July, 1986

## PREMIUM CAPS

### STATE

### RATE

Alaska

125% Maximum

Arizona

150% Maximum

California

To Be Determined By The Board

---

Colorado

150% Initial, 200% Maximum

\* Connecticut

125% Minimum, 150% Maximum

\* Florida

150% Initial, 200% Maximum

Illinois

135% Maximum

\* Indiana

150% Maximum

\* Iowa

150% Maximum

Kansas

To Be Determined By The Board

Kentucky

150% Initial, 200 Maximum

Louisiana

135% Initial, 165% Maximum

\* Minnesota

125% Maximum

Mississippi

150% Initial, 200% Maximum

Missouri

150% Initial, 200% Maximum

\* Montana

150% Initial, 400% Maximum

\* Nebraska

135% Initial, 165% Maximum

New Mexico

To Be Determined By The Board

New York

150% Maximum

\* North Dakota

135% Maximum

Ohio

130% Maximum For First Three Years

Oregon

130% Maximum For First Three Years

South Carolina

150% Initial, No Maximum

South Dakota

125% Initial, 200% Maximum

- \* Tennessee                    150% Maximum
- Texas                            To Be Determined By The Board
- Utah                              To Be Determined By The Board
- \* Wisconsin                    150% Maximum

\* Highlighted states have existing plans.

July 1, 1986

## DEDUCTIBLES

**NOTE:** Many states offer more than one plan. Unless stated, the amounts listed are all deductibles available.

<u>STATE</u>	<u>AMOUNT</u>
Alaska	To Be Determined By The Board
Arizona	\$200
California	\$1,000
Colorado	\$250; \$500; \$1,000 and any others Designated By The Board
* Connecticut	\$400; \$1,000; \$1,500
* Florida	\$1,000; \$1,500; \$2,000
Illinois	\$1,000; \$1,500; \$2,000
* Indiana	\$200; \$500; \$1,000
* Iowa	\$500; \$1,000 and any others Designated By The Board
Kansas	To Be Determined By The Board
Kentucky	To Be Determined By The Board
Louisiana	To Be Determined By The Board
* Minnesota	\$500; \$1,000
Mississippi	\$1,000; \$1,500; \$2,000
Missouri	To Be Determined By The Board
* Montana	Not to exceed \$1,000
* Nebraska	To Be Determined By The Board
New Mexico	To Be Determined By The Board
New York	\$500; \$1,000 and any others Designated By The Board
* North Dakota	\$150; \$500; \$1,000
Ohio	\$1,000
Oregon	\$1,000
South Carolina	To Be Determined By The Board
South Dakota	\$500; \$1,000 and any others Designated By The Board

- \* Tennessee            \$500; \$2,000 and any others Designated By The Board
- Texas                \$200
- Utah                 To Be Determined By The Board
- \* Wisconsin           \$1,000

\* Highlighted states have existing plans.

July, 1986

## STOP LOSS/OUT-OF-POCKET EXPENSE LIMITATION

NOTE: Out-of-Pocket expense is the amount each insured will pay each year before the plan begins to pay 100% of eligible expenses.

<u>STATE</u>	<u>AMOUNT</u>																																				
Alaska	To Be Determined By The Board																																				
Arizona	\$1,000/Individual; \$2,000/Family																																				
California	\$3,000/Individual; \$5,000/Family																																				
Colorado	\$1,500/Individual; \$3,000/Family																																				
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Ohio	\$1,500/Individual; \$3,000/Family		
Oregon	\$1,500/Individual; \$3,000/Family; \$500/Medicare		
South Carolina	To Be Determined By The Board		
South Dakota	\$3,000/Individual		
* Tennessee	A.	\$1,500/Individual;	\$2,500/Family
	B.	\$2,500/Individual;	\$3,500/Family
Texas	\$200 or 10% of insured's adjusted gross income, whichever is greater		
Utah	To Be Determined By The Board		
* Wisconsin	Plan I	\$2,000/Individual	\$4,000/Family
	Plan II	\$500	

\* Highlighted states have existing plans.

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## WAITING PERIOD FOR PRE-EXISTING CONDITION

**NOTE:** Most plans contain provisions under which coverage is excluded for a certain period of time following the effective date of coverage. This exclusion is based on a pre-existing condition which manifested itself within a certain period of time prior to coverage or medical advice or treatment was recommended or received.

<u>STATE</u>	<u>WAITING PERIOD</u>	<u>CONDITION PERIOD</u>
Alaska	6 Months	6 Months
Arizona	6 Months	6 Months
California	To Be Determined By The Board	
Colorado	6 Months	6 Months
* Connecticut	12 Months	6 Months
* Florida	12 Months	6 Months
Illinois	6 Months	6 Months
* Indiana	6 Months	6 Months
* Iowa	6 Months	6 Months
Kansas	To Be Determined By The Board	
Kentucky	12 Months	6 Months
Louisiana	6 Months	6 Months
* Minnesota	6 Months	90 Days
Mississippi	12 Months	90 Days
Missouri	12 Months	6 Months
* Montana	12 Months	5 Years
* Nebraska	6 Months	6 Months
New Mexico	To Be Determined By The Board	
New York	6 Months	6 Months
* North Dakota	6 Months	90 Days
Ohio	30 Days	6 Months
Oregon	30 Days	6 Months

South Carolina	6 Months	6 Months
South Dakota	12 Months	6 Months
* Tennessee	6 Months	6 Months
Texas	6 Months	6 Months
Utah	12 Months	6 Months
* Wisconsin	6 Months	6 Months

\* Highlighted states have existing plans.

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## POOL FUNDING

**NOTE:** Because of Federal Law (The Employee Retirement Income Security Act, known as ERISA) self-insurers are not required to become members of a state pool, therefore are not assessed any of the cost. In addition, all state pool legislation allows abatement of assessment if the payment of the assessment would endanger the ability of the member to fulfill his contractual obligations. Also, assessments that are less than an amount determined by the board to justify the cost of collection shall not be considered.

<u>STATE</u>	<u>SOURCE</u>
Alaska	Assessment of losses to participating insurers.
Arizona	Assessment with credit applied against premium tax and income tax. Use formula of approximately 20% per year.
California	The state has created a start-up fund of \$750,000.
Colorado	Assessment with credit applied against premium tax and income tax.
* Connecticut	Assessment of losses to participating insurers.
* Florida	Assessment with credit applied against premium tax and income tax. Maximum assessment of 1% per year on premiums or greater than premium tax. Use formula of approximately 20% per year for offset.
Illinois	Assessment with credit applied against premium tax and income tax. Also allowed to increase rates to offset assessment.
* Indiana	Assessment with credit applied against premium tax and income tax. Also allowed to increase rates to offset assessment.
* Iowa	Assessment with credit applied against premium tax and income tax.
Kansas	To Be Determined By The Board
Louisiana	Assessment with credit applied against premium tax.
* Minnesota	Assessment with credit applied against premium tax and income tax.
Mississippi	Assessment with credit applied against premium taxes, but only for the amount over 20% of total premiums collected by cash insurer.
Missouri	Assessment of losses to participating insurers.
* Montana	Assessment with credit applied against premium tax.
* Nebraska	Assessment with credit applied against premium tax.

New Mexico	To Be Determined.
New York	Assessment to insurers, although state has not determined if tax credit will be allowed.
* North Dakota	<b>Assessment with credit applied against premium tax and income tax.</b>
Ohio	Assessment of losses to participating insurers.
Oregon	Assessment of losses to participating insurers.
South Carolina	Assessment with credit applied against premium tax and income tax.
South Dakota	Assessment with credit applied against premium tax. Use formula of approximately 20% per year for write-off.
* Tennessee	<b>Assessment of losses to participating insurers with credit applied against premium tax.</b>
Texas	Assessment of losses to participating insurers.
Utah	To Be Determined.
* Wisconsin	<b>Assessment of losses to participating insurers plus special fund created by state to subsidize premiums for low-income policyholders.</b>

\* Highlighted states have existing plans.

## AGENT & ADMINISTRATOR FEES

**NOTE:** Those listed have fees set by statute. All others are to be determined by The Board.

Alaska	Agent Referral Fee - \$50 Administrator Fee - 12 1/2% Maximum
California	Agent Referral Fee - \$100
* Connecticut	Agent Referral Fee - \$20
* Florida	Agent Referral Fee - \$75
* Indiana	Agent Referral Fee - \$25
* Minnesota	Agent Referral Fee - \$50 Administrator Fee - 12 1/2% Maximum
* Montana	Agent Referral Fee - \$25 Administrator Fee - 12% Maximum
* North Dakota	Agent Referral Fee - \$25 Administrator Fee - 12 1/2% Maximum
Wisconsin	Agent Referral Fee - \$35

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## **ELIGIBILITY CRITERIA**

All states with comprehensive health insurance pools for high risk individuals, as well as those previously introducing legislation, have eligibility requirements for individuals wishing to take advantage of pool coverage.

The most common of these eligibility requirements are one or more of the following:

**1. STATE RESIDENCY.** All individuals applying for pool coverage must be state residents. This ranges from a residency requirement of 30 days up to six months before becoming eligible. Some states simply state "residency required" with no specific period listed.

**2. PROOF OF REJECTION.** Individuals must prove they have been rejected for insurance coverage by at least one insurance carrier. Some states require proof of rejection by at least two carriers, however the trend seems to be requiring only one proof of rejection. In addition, several states are adopting or considering guidelines which allow for automatic acceptance into a pool. The pool Board adopts a list of medical conditions to allow automatic acceptance into the pool without requiring a proof of rejection if the individual is afflicted with one of these conditions.

**3. PRESENTLY INSURED WITH A HIGHER PREMIUM.** An individual is eligible for pool coverage even though they are currently insured if their present insurance has a higher premium than that afforded under the pool.

**4. PRESENTLY INSURED WITH A RIDER OR RATED POLICY.** An individual is eligible for pool coverage even though they are currently insured if their present insurance has a rider attached or is rated.

**5.** Most states do not allow an individual to apply for pool coverage if that individual is eligible for Medicare or Medicaid. Several states do offer a Medicare supplement plan for these individuals.

## SYNOPSIS OF MODEL

The purpose of the NAIC Model Bill is to establish a mechanism through which adequate levels of health insurance coverages can be made available to residents of the state who are otherwise considered uninsurable. The bill would establish a state "association" or pool in which all health care financing mechanisms (insurers, non-profit service plan corporations and HMOs) would be members.

The pool coverage consists of very broad, comprehensive benefits with a choice of "high" and "low" deductible. Each state is cautioned that the scope of coverage may not be appropriate. In such case the benefit levels should be adjusted.

By definition, a pool consisting of uninsurable risks will necessitate premium rates substantially greater than applicable for standard risks. The bill establishes an initial maximum rate of 150% of applicable standard risk rates. Thereafter rates are expected to fluctuate according to experience, however, in no event shall rates exceed 200% of standard risk rates. The initial maximum rate of 150% is admittedly inadequate for the risks insured, and the 200% maximum will prevent the rates from becoming prohibitive. Pool losses in excess of the 200% maximum rate will be assessed to each member of the pool in proportion to the volume of business done in the state. Eligibility for pool coverage is not established by criteria such as the incurring of a catastrophic condition or the expenditure of a prescribed amount of earnings for health care. Such criteria may not apply equitably to all uninsurables and may neither be cost efficient nor practical to administer. Practical considerations of price will serve to discourage individuals from buying pool coverage when it is available to them in the standard marketplace at a lesser rate.

For obvious cost containment reasons, the pool coverage is the coverage of "last resort" and it does not duplicate coverages from any other source, private or public. The mechanics of the pool, its operations and functions must all be established under a plan approved by the Commissioner. The pool is subject to the requirements of the insurance code as has the general powers and authority of an insurer licensed to transact health insurance.

## MODEL HEALTH INSURANCE POOLING MECHANISM ACT

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**BE IT ENACTED BY THE STATE OF** (insert state).

(adapt caption and formal portions to local requirements and statutes)

### Statement of Principles

The State and Federal Health Insurance Legislative Programs (B6) Task Force was charged to develop model state legislation for the establishment of health insurance pooling mechanisms for uninsurables. The Task Force has developed the attached Model State Health Insurance Pooling Mechanism Bill and recommends its final adoption by NAIC subject to the following principles:

1. Adoption of the model bill does not constitute NAIC endorsement of the pooling concept, nor is it recommended for enactment in all states. Each state is urged to determine, through independent study, whether a pooling mechanism is needed and whether enactment of the model would be cost effective.
2. Enactment of the model bill by states is not recommended unless and until a viable solution is secured, through federal law or otherwise, under which pools for uninsurables can operate on a universal basis including all health care financing mechanisms. These recommendations and principles are consistent with NAIC strategy for alternatives to national health insurance which embrace the interrelated goals concerning the federal ERISA preemption problems, state pooling mechanisms, adequate health insurance availability and cost containment. The interrelationship of these initiatives is exemplified by the ERISA barrier to universal participation in such pools and overall concerns about health care cost containment.

Although much has been accomplished with the enactment of P.L. 97-473 subjecting multiple employer trusts to state jurisdiction, and by the adoption of the NAIC model "Jurisdiction to Determine Jurisdiction" bill, these measures will not, in and of themselves, establish universal participation in state pools for uninsurables.

Uninsurable pools may not be needed in every state, nor present the most effective answer to questions of availability of health insurance in every state. The establishment of such programs is costly and their cost effectiveness should be weighed in relation to whether there is a demonstrated need for a pool in a given state. Their cost effectiveness can be substantially impaired in the absence of universal participation, for without the inclusion of self-insured plans, the financial base necessary to support the pooling mechanism will tend to progressively diminish. The purpose of the attached model bill is to establish a mechanism through which adequate levels of health insurance coverages can be made available to residents of the state who are otherwise considered uninsurable. The bill would establish a state "association" or pool in which all health care financing mechanisms (insurers, nonprofit service plan corporations, HMO's and self-insurers) would be members.

The pool coverage consists of very broad comprehensive benefits with a choice of a "high" and a "low" deductible. Each state is cautioned that the scope of coverage may not be appropriate. In such case, the benefit levels should be adjusted, or the bill should include the Alternative Section 6. under which the Commissioner is authorized to establish by regulation actual pool benefits commensurate with the prevailing levels of group coverages provided in that state.

By definition, a pool consisting of uninsurable risks will necessitate premium rates substantially greater than applicable for standard risks. The bill establishes an initial minimum rate of 150% of applicable standard risk rates. Thereafter rates are expected to fluctuate according to experience, however, in no event shall rates exceed 200% of standard risk rates. The minimum rate of 150% is admittedly inadequate for the risks insured, and the 200% maximum will prevent the rates from becoming prohibitive. Pool losses in excess of the 200% maximum rate will be assessed to each member of the pool in proportion to the volume of business done in the state. Eligibility for pool coverage is not established by criteria such as the incurring of a catastrophic condition, the expenditure of a prescribed amount of earnings for health care, or the rejection of the applicant by any specified number of health insurance carriers. Such criteria may not apply equitably to all uninsurables and may neither be cost efficient nor practical to administer. Practical considerations of price will serve to discourage individuals from buying pool coverage when it is available to them in the standard marketplace at a lesser rate.

For the obvious cost containment reasons, the pool coverage is the coverage of "last resort" and it does not duplicate coverages from any other source, private or public. The mechanics of the pool, its operations and functions must all be established under a plan approved by the Commissioner. The pool is subject to the requirements of the insurance code and has the general powers and authority of an insurer licensed to transact health insurance.

#### Section 1. Definitions.

- (1) "Pool" means the State Health Insurance Pool as created in Section 2. of the Act.
- (2) "Board" means the Board of Directors of the pool.
- (3) "Insured" means any individual resident of this state who is eligible to receive benefits from any insurer or insurance arrangement as defined in this section.
- (4) "Insurer" means any insurance company authorized to transact health insurance business in this state, any (reference state nonprofit health care service plan act and, if appropriate, HMO law).
- (5) "Insurance arrangement" means any plan, program, contract or any other arrangement under which one or more employers, unions or other organizations provide to their employees or members, either directly or indirectly through a trust or third party administrator, health care services or benefits other than through an insurer.
- (6) "Health insurance" means any hospital and medical expense incurred policy, nonprofit health care service plan contract and health maintenance organization subscriber contract. The term does not include short term, accident, fixed indemnity, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

- (7) "Medicare" means coverage under both part A and B of Title XVIII of the Social Security Act, 42 USC 1395 et seq., as amended.
- (8) "Physician" (reference applicable state laws).
- (9) "Hospital" (reference applicable state laws).
- (10) "Health maintenance organization" (reference applicable state laws).
- (11) "Plan of operation" means the plan of operation of the pool, including articles, bylaws and operating rules, adopted by the board pursuant to Section 3. of this Act.
- (12) "Benefits plan" means the coverages to be offered by the pool to eligible persons pursuant to Section 6. of this Act.
- (13) "Department" means the Insurance Department.
- (14) "Commissioner" means the Insurance Commissioner.
- (15) "Member" means all insurers and insurance arrangements participating in the pool.

## **Section 2. Operation of the Pool.**

- (1) There is hereby created a nonprofit entity to be known as the (State) Health Insurance Pool. All insurers issuing health insurance in this state and insurance arrangements providing health plan benefits in this state on and after the effective date of this Act shall be members of the pool.
- (2) The Commissioner shall give notice to all insurers and insurance arrangements of the time and place for the initial organizational meetings. The pool members shall select the initial board of directors and appoint one or more insurers to serve as administrator. Both the selection of the board of directors and the administering insurer(s) shall be subject to approval by the Commissioner. The Board shall at all times, to the extent possible, include at least one domestic insurance company licensed to transact health insurance and one domestic nonprofit health care service plan.
- (3) If, within sixty (60) days of the organizational meeting, the board of directors is not selected or the administering insurer is not appointed, the Commissioner shall appoint the initial board and appoint an administering insurer.
- (4) The pool shall submit to the Commissioner a plan of operation for the pool and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the pool. The Commissioner shall, after notice and hearing, approve the plan of operation provided such is determined to be suitable to assure the fair, reasonable and equitable administration of the pool, and provides for the sharing of pool gains or losses on an equitable proportionate basis. The plan of operation shall become effective upon approval in writing by the Commissioner consistent with the date on which the coverage under this Act must be made available. If the pool fails to submit a suitable plan of operation within 180 days after the appointment of the board of directors, or at any time thereafter fails to submit suitable amendments to the plan, the Commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this section. Such rules shall continue in force until modified by the Commissioner or superseded by a plan submitted by the pool and approved by the Commissioner.

- (5) In its plan the pool shall,
- (a) Establish procedures for the handling and accounting of assets and monies of the pool.
  - (b) Select an administering insurer in accordance with Section 4. of this Act, and establish procedures for filling vacancies on the Board of Directors.
  - (c) Establish procedures for the collection of assessments from all members to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made. The level of payments shall be established by the board, pursuant to Section 5. of this Act. Assessment shall occur at the end of each calendar year. Assessments are due and payable within 30 days of receipt of the assessment notice.
  - (d) Develop and implement a program to publicize the existence of the plan, the eligibility requirements, and procedures for enrollment, and to maintain public awareness of the plan.
- (6) The pool shall have the general powers and authority granted under the laws of this state to insurance companies licensed to transact the kinds of insurance defined under Section 1. and in addition thereto, the specific authority to:
- (a) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Act, including the authority, with the approval of the Insurance Commissioner, to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;
  - (b) Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against pool members;
  - (c) Take such legal action as necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;
  - (d) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas and any other actuarial function appropriate to the operation of the pool. Rates shall not be unreasonable in relation to the coverage provided, the risk experience and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim cost and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices.
  - (e) Assess members of the pool in accordance with the provisions of this section, and to make advance interim assessments as may be reasonable and necessary for the organizational and interim operating expenses. Any such interim assessments to be credited as offsets against any regular assessments due following the close of the fiscal year.
  - (f) Issue policies of insurance in accordance with the requirements of this Act.
  - (g) Appoint from among members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design, and any other function within the authority of the pool.

**Drafting Note - Optional Paragraph**

A state may wish to provide members of the pool with the option of utilizing their existing distribution systems for the issuance of pool coverage. If so, such a provision should authorize the establishment of specific rules under which the pool would approve and serve as a reinsurer for coverage issued by members in their own names. Paragraph (h) is designed to allow states to implement this option.

- (h) Establish rules, conditions and procedures for reinsuring risks of pool members desiring to issue pool plan coverages in their own name. Such reinsurance facility shall not subject the pool to any of the capital or surplus requirements, if any, otherwise applicable to reinsurers.

**Section 3. Eligibility.**

- (1) Any individual person, who is a resident of this state shall be eligible for pool coverage, except the following:
  - (a) persons who have on the date of issue of coverage by the pool coverage under health insurance or an insurance arrangement;
  - (b) any person who is at the time of pool application eligible for health care benefits under (references state Medicaid law);
  - (c) any person having terminated coverage in the pool unless twelve months have lapsed since such termination;
  - (d) any person on whose behalf the pool has paid out \$1,000,000 in benefits;
  - (e) inmates of public institutions and persons eligible for public programs.
- (2) Any person who ceases to meet the eligibility requirements of this section may be terminated at the end of the policy period.
- (3) Any person whose health insurance coverage is involuntarily terminated for any reason other than nonpayment of premium and who is not eligible for conversion, may apply for coverage under the plan. If such coverage is applied for within 60 days after the involuntary termination and if premiums are paid for the entire coverage period, the effective date of the coverage shall be the date of termination of the previous coverage.

**Drafting Note - Section 3**

It is intended that only those unable to purchase health insurance coverage in the marketplace at a reasonable price will apply for pool coverage. The higher cost of pool coverage should accomplish this result. However, to assure that the pool coverage does not compete with available coverage in the marketplace, a state may desire to include as a criterion for pool coverage the requirement of rejection of coverage by a specified number of health insurance carriers. This question is discussed fully in the attached Synopsis.

**Section 4. Administering Insurer.**

- (1) The board shall select an insurer or insurers through a competitive bidding process to administer the pool. The board shall evaluate bids submitted based on criteria established by the board which shall include:
  - (a) The insurer's proven ability to handle individual accident and health insurance;
  - (b) The efficiency of the insurer's claim paying procedures;

- (c) An estimate of total charges for administering the plan;
  - (d) The insurer's ability to administer the pool in a cost efficient manner.
- (2)
- (a) The administering insurer shall serve for a period of 3 years subject to removal for cause.
  - (b) At least 1 year prior to the expiration of each 3-year period of service by an administering insurer, the board shall invite all insurers, including the current administering insurer to submit bids to serve as the administering insurer for the succeeding 3-year period. Selection of the administering insurer for the succeeding period shall be made at least 6 months prior to the end of the current 3-year period.
- (3)
- (a) The administering insurer shall perform all eligibility and administrative claims payment functions relating to the pool.
  - (b) The administering insurer shall establish a premium billing procedure for collection of premium from insured persons. Billings shall be made on a periodic basis as determined by the board.
  - (c) The administering insurer shall perform all necessary functions to assure timely payment of benefits to covered persons under the pool including:
    - 1. Making available information relating to the proper manner of submitting a claim for benefits to the pool and distributing forms upon which submission shall be made;
    - 2. Evaluating the eligibility of each claim for payment by the pool.
  - (d) The administering insurer shall submit regular reports to the board regarding the operation of the pool. The frequency, content, and form of the report shall be as determined by the board.
  - (e) Following the close of each calendar year, the administering insurer shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the Board and the Department on a form as prescribed by the Commissioner.
  - (f) The administering insurer shall be paid as provided in the plan of operation for its expenses incurred in the performance of its services.

#### Section 5. Assessments.

- (1) Following the close of each fiscal year, the pool administrator shall determine the net premiums (premiums less administrative expense allowances), the pool expenses of administration and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. Health insurance premiums and benefits paid by an insurance arrangement that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments.
- (a) Each insurer's assessment shall be determined by multiplying the total cost of pool operation by a fraction, the numerator of which equals that insurer's premium and subscriber contract charges for health insurance written in the state during the preceding calendar year and the denominator of which equals the total of all premiums, subscriber contract charges written in the state and 110% of all claims paid

by insurance arrangements in the state during the preceding calendar year.

- (b) Each insurance arrangement's assessment shall be determined by multiplying the total cost of pool operation by a fraction, the numerator of which equals 110% of the benefits paid by that insurance arrangement on behalf of insureds in this state during the preceding calendar year and the denominator of which equals the total of all premiums, subscriber contract charges and 110% of all benefits paid by insurance arrangements made on behalf of insured in this state during the preceding calendar year. Insurance arrangements shall report to the board claims payments made in this state on an annual basis on a form prescribed by the Commissioner.
- (2) If assessments exceed actual losses and administrative expenses of the pool, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" includes reserves for incurred but not reported claims.
- (3) (a) Each member's proportion of participation in the pool shall be determined annually by the board based on annual statements and other reports deemed necessary by the board and filed by the member with it.  
(b) Any deficit incurred by the pool shall be recouped by assessments apportioned under subsection (1) of this Section by the board among members.
- (4) The board may abate or defer, in whole or in part, the assessment of a member if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. In the event an assessment against a member is abated or deferred in whole or in part, the amount by which such assessment is abated or deferred may be assessed against the other members in a manner consistent with the basis for assessments set forth in subsection (1) of this Section. The member receiving such abatement or deferment shall remain liable to the pool for the deficiency for 4 years.

**Drafting Note - Section 6**

Section 6 deals with the coverage to be issued by the pool. The original draft bill established a comprehensive and specific plan of coverage. However, this plan may not be appropriate to the needs of all states. Thus, the model bill provides two alternative approaches to Section 6. Alternative 1 specifically establishes a broad, comprehensive plan of coverage in the form of a detailed schedule of benefits, exclusions, limits, deductibles and coinsurance factors.

Alternative 2 vests authority in the Commissioner to promulgate, with the advice and recommendations of the pool members, a level of pool coverage determined to be commensurate with those typically provided by a representational number of large employers in the state. It should be pointed out that most carriers will be members of the pools in more than one, and perhaps all, of the states that enacted pooling legislation. The administration of these pools will be greatly facilitated if those provisions of the model bill dealing with pool formation, operation and administration remain uniform. This uniformity will allow each state pool to benefit from the operational experience of the others and will facilitate monitoring of the efficiency of pooling mechanisms. There is not the same necessity, however, regarding the actual plan benefits or coverage and the scope of coverage could vary according to individual state needs.

**ALTERNATIVE 1**

**Section 6. Minimum Benefits - Availability.**

- (1) The pool shall offer major medical expense coverage to every eligible person who is not eligible for Medicare. Major medical expense coverage offered by the pool shall pay an eligible person's covered expenses, subject to limits on the deductible and coinsurance payments authorized under paragraph (4) (d) of this Section, up to a life time limit of \$1,000,000 per covered individual. The maximum limit under this paragraph shall not be altered by the Board, and no actuarial equivalent benefit may be substituted by the Board.

- (2) **Covered Expenses.** Covered expenses shall be the prevailing charge in the locality for the following services and articles when prescribed by a physician and determined by the pool to be medically necessary:
- (a) Hospital services;
  - (b) Professional services for the diagnosis or treatment of injuries, illnesses, or conditions, other than mental or dental, which are rendered by a physician, or by other licensed professionals at his direction;
  - (c) Drugs requiring a physician's prescription;
  - (d) Services of a licensed skilled nursing facility for not more than 120 days during a policy year;
  - (e) Services of a home health agency up to a maximum of 270 services per year;
  - (f) Use of radium or other radioactive materials;
  - (g) Oxygen;
  - (h) Anesthetics;
  - (i) Prostheses other than dental;
  - (j) Rental of durable medical equipment, other than eyeglasses and hearing aids, for which there is no personal use in the absence of the conditions for which is prescribed;
  - (k) Diagnostic x-rays and laboratory tests;
  - (l) Oral surgery for excision of partially or completely unerupted, impacted teeth or the gums and tissues of the mouth when not performed in connection with the extraction or repair of teeth;
  - (m) Services of a physical therapist;
  - (n) Transportation provided by a licensed ambulance service to the nearest facility qualified to treat the condition;
  - (o) Services for diagnosis and treatment of mental and nervous disorders, provided that an insured shall be required to make a 50 percent copayment, and that the payment of the pool shall not exceed \$4,000 for outpatient psychiatric treatment.
- (3) **Exclusions.** Covered expenses shall not include the following:
- (a) Any charge for treatment for cosmetic purposes other than surgery for the repair or treatment of an injury or a congenital bodily defect to restore normal bodily functions;
  - (b) Care which is primarily for custodial or domiciliary purposes;

- (c) Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semiprivate room, unless a private room is prescribed as medically necessary by a physician;
  - (d) That part of any charge for services rendered or articles prescribed by a physician, dentist, or other health care personnel which exceeds the prevailing charge in the locality or for any charge not medically necessary;
  - (e) Any charge for services or articles the provision of which is not within the scope of authorized practice of the institution or individual providing the services or articles;
  - (f) Any expense incurred prior to the effective date of coverage by the pool for the person on whose behalf the expense is incurred;
  - (g) Dental care except as provided in subsection (3) (1) of this section;
  - (h) Eyeglasses and hearing aids;
  - (i) Illness or injury due to acts of war;
  - (j) Services of blood donors and any fee for failure to replace the first 3 pints of blood provided to an eligible person each policy year;
  - (k) Personal supplies or services provided by a hospital or nursing home, or any other nonmedical or nonprescribed supply or service.
- (4) Premiums, Deductibles, and Coinsurance.
- (a) Premiums charged for coverages issued by the pool may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage.
  - (b) Separate schedules of premium rates based on age, sex, and geographical location may apply for individual risks.
  - (c) The pool shall determine the standard risk rate by calculating the average individual standard rate charged by the five largest insurers offering coverages in the state comparable to the pool coverage. In the event five insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Initial rates for pool coverage shall not be less than 150% of rates established as applicable for individual standard risks. Subsequent rates shall be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein. In no event shall pool rates exceed 200% of rates applicable to individual standard risks. All rates and rate schedules shall be submitted to the Commissioner for approval.
  - (d) The pool coverage defined in Section 6. shall provide optional deductibles of \$500 or \$1,500 per annum per individual, and coinsurance of 20%, such coinsurance and deductibles in the aggregate not to exceed \$3,500 per individual nor \$5,000 per family per annum. The deductibles and coinsurance factors may be adjusted annually according to the Medical Component of the Consumer Price Index.
- (5) Preexisting Conditions. Pool coverage shall exclude charges or expenses incurred during the first twelve months following the effective date of coverage as to any condition, which

during the six month period immediately preceding the effective date of coverage, (i) had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment or (ii) for which medical advice, care or treatment was recommended or received. Such preexisting condition exclusions shall be waived to the extent to which similar exclusions, if any, have been satisfied under any prior health insurance coverage which was involuntarily terminated; provided, that application for pool coverage is made not later than thirty-one (31) days following such involuntary termination and, in such case, coverage in the pool shall be effective from the date on which such prior coverage was terminated.

**(6) Nonduplication of Benefits.**

- (a) Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other health insurance, or insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or Federal law or program except Medicaid.**
- (b) The insurer or the pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not coverage expenses. Benefits due from the pool may be reduced or refused as a set-off against any amount recoverable under this paragraph.**

**ALTERNATIVE 2**

**Section 6. Minimum Benefits - Availability.**

- (1) The pool shall offer major medical expense coverage to every eligible person who is not eligible for Medicare. The coverage to be issued by the pool, its schedule of benefits, exclusions and other limitations, shall be established through regulations promulgated by the Commissioner taking into consideration the advice and recommendations of the pool members.**
- (2) In establishing the pool coverage, the Commissioner shall take into consideration the levels of health insurance provided in the state, medical economic factors as may be deemed appropriate and promulgate benefit levels, deductibles, coinsurance factors, exclusions and limitations determined to be generally reflective of and commensurate with health insurance provided through a representative number of large employers in the state.**
- (3) Pool coverage established under this Section shall provide both an appropriate "high" and a "low" deductible to be selected by the pool applicant. The deductibles and coinsurance factors may be adjusted annually according to the Medical Component of the Consumer Price Index.**
- (4) Premiums and Assessments.**
  - (a) Premiums charged for pool coverage may not be unreasonable in relation to the benefits provided, the risk experience and the reasonable expenses of providing the coverage. Separate schedules of premium rates based on age, sex and geographical location may apply for individual risks.**
  - (b) The pool shall determine the standard risk rate by calculating the average individual standard rate charged by the five largest insurers offering coverages in the**

state comparable to the pool coverage. In the event five insurers do not offer comparable coverage, the standard risk rate shall be established using reasonable actuarial techniques and shall reflect anticipated experience and expenses for such coverage. Initial rates for pool coverage shall not be less than 150% of rates established as applicable for individual standard risks. Subsequent rates shall be established to provide fully for the expected costs of claims including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations described herein. In no event shall pool rates exceed 200% of rates applicable to individual standard risks. All rates and rate schedules shall be submitted to the Commissioner for approval.

- (5) **Preexisting Conditions.** Pool coverage shall exclude charges or expenses incurred during the first twelve months following the effective date of coverage as to any condition, which during the six month period immediately preceding the effective date of coverage, (i) had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment or (ii) for which medical advice, care or treatment was recommended or received as to such condition. Such preexisting condition exclusions shall be waived to the extent to which similar exclusions, if any, have been satisfied under any prior health insurance coverage which was involuntarily terminated; provided, that application for pool coverage is made not later than thirty-one (31) days following such involuntary termination and, in such case, coverage in the pool shall be effective from the date on which such prior coverage was terminated.
- (6) **Nonduplication of Benefits.**
  - (a) Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other health insurance, or insurance arrangement, and by all hospital and medical expense benefits paid or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or Federal law or program except Medicaid.
  - (b) The insurer or the pool shall have a cause of action against an eligible person for the recovery of the amount of benefits paid which are not for covered expenses. Benefits due from the pool may be reduced or refused as a set-off against any amount recoverable under this paragraph.

#### **Section 7. Collective Action.**

Neither the participation in the pool as members, the establishment of rates, forms or procedures nor any other joint or collective action required by this Act shall be the basis of any legal action, criminal or civil liability or penalty against the pool or any of its members.

#### **Section 8. Taxation.**

The pool established pursuant to this Act shall be exempt from any and all taxes.

Model Health Insurance Pooling Mechanism Act

**Drafting Note - Optional Section**

A state may wish to provide for some form of offset against applicable taxes in the amount of the assessments incurred by the members of the pool. If so, such a provision should allow appropriate reductions in assessments as to pool members not subject to the taxes against which offsets are allowed.

**Section 9. Effective Date.**

The provisions of this Act shall become effective \_\_\_\_\_.

*Legislative History (all references are to the Proceedings of the NAIC).*

*1983 Proc. II 16, 22, 638, 693, 698-712 (adopted).*

*1984 Proc. I 6, 31, 576, 585, 590-592 (adopted The Health Insurance Act of 1983 as NAIC Policy).*

**FISCAL NOTE**

**REQUEST:**

Revision Date: April 26, 1990  
Title: An Act relating to disability insurance

Agency Affected: Commerce & Economic Development  
BRU: Insurance

Sponsor: Coghill  
Requestor: Senate Finance

Components: Operations

**EXPENDITURES/REVENUES: (Thousands of Dollars)**

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	65.4	65.4	65.4	65.4	65.4	
TRAVEL	12.0	6.0	6.0	6.0	6.0	
CONTRACTUAL	35.0	35.0	35.0	35.0	35.0	
SUPPLIES	1.0	1.0	1.0	1.0	1.0	
EQUIPMENT	10.0					
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
<b>TOTAL OPERATING</b>	<b>123.4</b>	<b>107.4</b>	<b>107.4</b>	<b>107.4</b>	<b>107.4</b>	

CAPITAL	0	0	0	0	0	
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REVENUE	0*	0*	0*	0*	0*	
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\*See revenue analysis on page 2.

**FUNDING: (Thousands of Dollars)**

GENERAL FUND	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
FEDERAL FUNDS						
OTHER PR/GF	123.4	107.4	107.4	107.4	107.4	
<b>TOTAL</b>	<b>123.4</b>	<b>107.4</b>	<b>107.4</b>	<b>107.4</b>	<b>107.4</b>	

**POSITIONS:**

POSITIONS	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
FULL-TIME	1	1	1	1	1	
PART-TIME						
TEMPORARY						

ANALYSIS : (Attach a separate page if necessary) No fiscal impact in FY 90.

Prepared by: David J. Walsh, Director Phone: 465-2515  
Division: Insurance Date: \_\_\_\_\_

Approved by Commissioner: Larry Mercutier Date: 4-26-90  
Agency: Department of Commerce & Economic Development

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

*Update of 4-24-90  
Fiscal Note*

## FISCAL NOTE ANALYSIS - CSSSSB 304 (FIN)

**Personal Services:** Funding for a new PFT position, Chief of Operations, \$65.4 is included.

**Travel:** The director is an ex officio board member of the Comprehensive Disability Insurance Association. The seven members of the board will be from out-of-state insurance companies and hospital or medical service corporations. The travel estimate is based on the director or the director's designee attending eight out-of-state board meetings in the first year of operation and four in each subsequent year at an estimated cost of \$1,500 for each.

**Contractual:** Each year, the division will have to contract with an actuary to verify that the rating structures of the association are actuarially sound. The estimate for the annual contract is \$25,000.

In addition, the director may undertake studies or demonstration projects to develop awareness of the benefits of the program. The annual estimate for this is \$8,000.

\$2,000 is also included for the new position's miscellaneous contractual expenditures.

**Supplies:** The new position's supplies are estimated at \$1,000.

**Revenue:** The members of the Comprehensive Disability Insurance Association are entitled to receive a credit against taxes levied by the state on disability insurance premiums. The maximum potential loss of state revenue is equal to the total tax collected on disability insurance premiums. It is impossible to predict what the actual tax revenue loss will be. However, using 1987 premium data as a benchmark, the state could lose \$2.5 million.

\$144,444.0	1987 disability premiums of insurers
<u>[62,898.6]</u>	Tax exempt health premiums
\$ 81,545.4	
<u>    x 2.7%</u>	Tax rate
\$2,201.7	Tax revenue
\$ 61,189.0	1987 disability premiums of hospital and medical service corporations
<u>[55,610.0]</u>	Less claims
\$ 5,579.0	Taxable premiums
<u>    x 6.0%</u>	Tax rate
\$ 334.7	Tax revenue
\$ 2,201.7	
<u>+ 334.7</u>	
\$ 2,536.4	1987 total disability insurance tax revenue

Furthermore, an insurer whose assessment exceeds their tax liability can carry forward the excess credit to be applied against future years' tax liabilities.



## FISCAL NOTE

**REQUEST:**

Revision Date: \_\_\_\_\_  
Title: An Act relating to disability insurance

Agency Affected: Commerce & Economic Development  
BRU: Insurance

Sponsor: Coghill  
Requestor: Senate Finance

Components: Operations

**EXPENDITURES/REVENUES:** (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	65.4	65.4	65.4	65.4	65.4	
TRAVEL	12.0	6.0	6.0	6.0	6.0	
CONTRACTUAL	35.0	35.0	35.0	35.0	35.0	
SUPPLIES	1.0	1.0	1.0	1.0	1.0	
EQUIPMENT	10.0					
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
<b>TOTAL OPERATING</b>	<b>123.4</b>	<b>107.4</b>	<b>107.4</b>	<b>107.4</b>	<b>107.4</b>	

CAPITAL	0	0	0	0	0	
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REVENUE	(0-2,536.4)	(0-2,536.4)	(0-2,536.4)	(0-2,536.4)	(0-2,536.4)	
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**FUNDING:** (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER PR/GF	123.4	107.4	107.4	107.4	107.4	
<b>TOTAL</b>	<b>123.4</b>	<b>107.4</b>	<b>107.4</b>	<b>107.4</b>	<b>107.4</b>	

**POSITIONS:**

FULL-TIME	1	1	1	1	1	
PART-TIME						
TEMPORARY						

**ANALYSIS :** (Attach a separate page if necessary) No fiscal impact in FY 90.

Prepared by: David J. Walsh, Director Phone: 465-2515  
Division: Insurance Date: \_\_\_\_\_

Approved by Commissioner: *Larry Morouloff* Date: 4/24/90  
Agency: Department of Commerce & Economic Development

Distribution (by preparer): *Fiscal note provided by Sen. Coghill. Copy sent to Sen. Dunbar's office 4-24-90*  
Legislative Finance  
Legislative Sponsor  
Requestor  
Office of Management and Budget  
Impacted Agency(ies)

page 1 of 3

FISCAL NOTE ANALYSIS - CSSSSB 304 (FIN)

Personal Services: Funding for a new PFT position, Chief of Operations, \$65.4 is included.

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In addition, the director may undertake studies or demonstration projects to develop awareness of the benefits of the program. The annual estimate for this is \$8,000.

\$2,000 is also included for the new position's miscellaneous contractual expenditures.

Supplies: The new position's supplies are estimated at \$1,000.

Revenue: The members of the Comprehensive Disability Insurance Association are entitled to receive a credit against taxes levied by the state on disability insurance premiums. The maximum potential loss of state revenue is equal to the total tax collected on disability insurance premiums. It is impossible to predict what the actual tax revenue loss will be. However, using 1987 premium data as a benchmark, the state could lose \$2.5 million.

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[62,898.6]	Tax exempt health premiums
\$ 81,545.4	
x 2.7%	Tax rate
<u>    \$2,201.7</u>	Tax revenue
\$ 61,189.0	1987 disability premiums of hospital and medical service corporations
[55,610.0]	Less claims
\$ 5,579.0	Taxable premiums
x 6.0%	Tax rate
<u>    \$ 334.7</u>	Tax revenue
\$ 2,201.7	
+ 334.7	
<u>\$ 2,536.4</u>	1987 total disability insurance tax revenue

Furthermore, an insurer whose assessment exceeds their tax liability can carry forward the excess credit to be applied against future years' tax liabilities.

1.	POSITION TITLE Chief of Operations				RANGE/STEP 23/A	BARG. UNIT S	PAGE/LINE	GOV.	APPROV.	DISAPP.
2.	TYPE OF POSITION PFT	STAFF MONTHS 12	RP NUMBER	PCH NUMBER	BRU PRIORITY	LOCATION Juneau	ELECTION DISTRICT 4	LEG.		
3.	CONTINUATION LEVEL				JUSTIFICATION:					
4.	TYPE OF EXPENDITURE			AMOUNT						
	1			2		3				
	PERSONAL SERVICES									
5.	Salary			49 2						
6.	Benefits			16 2						
7.	Supplemental Benefits									
8.	Fixed Benefits									
9.	TOTAL PERSONAL SERVICES			01		65 4				
10.	Travel			02						
11.	Contractual			03		2 0				
12.	Commodities			04		1 0				
13.	Equipment			05		10 0				
14.	Other									
15.	TOTAL COST			78 4						
	RECEIPT CODE			FUNDING SOURCE						
16.				Federal Receipts 1002						
17.				G.F. Match 1003						
18.				General Funds 1004						
19.				I-A Receipts 1005						
20.				Program Receipts 1028		78 4				
21.				Other						
FOR BAH USE ONLY										
KEY NUMBER										

JUSTIFICATION:

This position is necessary to work with the Comprehensive Disability Insurance Association's board members. The division anticipates that this program will take a great deal of staff time, which is unavailable. Another position is required if the division is to take on this additional responsibility.

Funds are included for a computer and workstation in the equipment line item.

REQUEST FOR  
NEW POSITION

(7/88)-13  
8129M

AGENCY Commerce & Economic Dev.

BRU Insurance

COMPONENT Operations

FY 91

Page 1 of 1

Revised Date

# FISCAL NOTE

**REQUEST:**

Revision Date: \_\_\_\_\_ Agency Affected: Health & Social Services  
 Title: An Act relating to disability insurance; BRU: \_\_\_\_\_  
and providing for an effective date  
 Sponsor: Senator Coghill Components: \_\_\_\_\_  
 Requestor: \_\_\_\_\_

**EXPENDITURES/REVENUES:** (Thousands of Dollars)

OPERATING	FY 91	FY92	FY93	FY94	FY 95	FY 96
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

**FUNDING:** (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

**POSITIONS:**

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

**ANALYSIS:** (Attach a separate page if necessary)

See attached analysis.

Prepared by: Bradley J. Whistler  
 Division: Administrative Services, DHSS  
 Approved by Commissioner: Maria M. Munson  
 Agency: Department of Health & Social Services

Phone: 465-3015  
 Date: 3/19/90  
 Date: 3/20/90

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

FISCAL NOTE Analysis (continued)

Committee Substitute for Sponsor Substitute for  
Senate Bill No. 304  
3-15-90

BY COGHILL

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

It is estimated that 43,000 Alaskan residents have no source of third party payment for financing their health care costs. This estimate is arrived at using the 1982 Alaska Comprehensive Health Care Financing Study (Battelle Study) for the current estimated population of Alaska (534,400).

The Battelle Study found that 0.9% of the Alaska population are "uninsurable" due to high risk medical condition(s). This compares favorably with the Blue Cross Insurance's national rate of uninsurable individuals (0.4-1%). It is estimated that 5000 Alaska residents are uninsurable due to their medical condition(s).

The department estimates about 50% of the uninsurable individuals in Alaska are covered by medical assistance. The group covered predominately have long term disabilities. It is unlikely that this group of Medicaid eligibles is seeking private insurance coverage, since they are generally not employed and do not have the income/resources to pay for private insurance. The department would not anticipate reduced expenditures for the medical assistance programs with the implementation of the insurance discussed in this bill.