

**S B**

**304**

# Senator John B. (Jack) Coghill

Alaska State Legislature

Box V  
Juneau, Alaska 99811  
(907) 465-4797

Box 55028  
North Pole, Alaska 99705  
(907) 488-0862



## MEMORANDUM

DATE: March 6, 1990

TO: Senator Paul Fischer, Chairman  
Senate HESS Committee

FROM: Senator Jack Coghill

SUBJECT: CSSSSB 304 (L&C) Sponsor Statement

Senate Bill 304, "An Act relating to disability insurance; and providing for an effective date" would establish a Comprehensive Disability Insurance Association. The purpose of the association would be to provide access to disability insurance coverage to all residents of the state who are denied adequate disability insurance coverage for any reason or who are otherwise considered uninsurable.

The availability of this insurance would be through a pool established by members of medical service corporations in the state that offer medical coverage through health insurance. It would be mandatory for those corporations offering any medical coverage to maintain membership in the association.

The Comprehensive Disability Insurance Corporation would be governed by a Board of Directors, which would include the Director of the Division of Insurance. They shall establish a plan of operation to provide disability insurance.

In order to make this system work, minimum and maximum benefits shall also be established.

The pool structure shall establish premium rates that must be fair. A ceiling would be established of 150% of the coverage of the five highest carriers offering health benefit plans in the state.

The bill also sets out the duties of the Director of the Division of Insurance, and establishes the eligibility of persons who may be covered under this program.

I ask that you give CSSSSB 304 (L&C) your most favorable consideration, as everyone should have the opportunity to purchase health insurance.

STATE OF ALASKA  
THE LEGISLATURE

POUCH Y STATE CAPITOL  
JUNEAU ALASKA 99811  
907 465 3800

LEGISLATIVE AFFAIRS AGENCY

M E M O R A N D U M

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.

*Who pays*

*Diabetic*

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  
THE LEGISLATURE

POUCH Y STATE CAPITOL  
BUREAU ALASKA 99811  
917 443 2800

LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM

February 20, 1990

SUBJECT: Disability insurance - SSSB 304  
TO: Senator Jack Coghill  
FROM: Michael F. Ford *m.f.*  
Legislative Counsel

The following is a sectional analysis of SSSB 304:

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.

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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.

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Senator Jack Coghill  
Page 3  
February 20, 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:mi  
wkmi6/046

**SUBURBAN  
PRINTING**

February 6, 1990

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

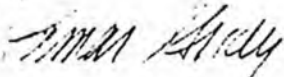
Dear Senator Coghill,

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

Jan Maslyk  
2220 Tasha Drive  
Anchorage, AK 99502

NOV 2 1989

November 22, 1989

Senator Coghill  
P.O. Office Box 55023  
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 Masiyk

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.

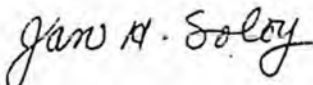
This is a problem that faces many people in Alaska. I have been in contact with the Heart, Diabetes, Lung and Epileptic Associations, MDA; Cancer Society and several Senior Citizens groups among a few. They are all in support of state health insurance for people that have been refused coverage for health 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

ANALYSIS OF BILL/PROGRAM EFFECTSSECTION 2 AS 21.55.010 - .500AS 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).

4076D/22390e

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.

## 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.

### AMENDMENTS PROPOSED

- Pg. 4  
line 25, 26
1. AS 21.55.110 needs to be amended to include those benefits mandated in AS 21.42.345 and AS 21.42.365.
- X
- AS 21.55.110(2) needs to be amended to define what constitutes "dental conditions" for which coverage is not to be provided.
- Pg. 9  
line 26, 27
3. AS 21.55.150 needs to be amended to eliminate the conflict between subsections (a) and (c). (See comments on AS 21.55.150.)
- Pg. 12  
line 1, 2, 3
4. AS 21.55.210 needs to be amended to require the writing carrier to perform billing functions and to stipulate that premiums be paid on a quarterly basis, if that is the sponsor's intent.
- Pg. 14  
line 25, 26
5. AS 21.55.310 needs to be amended to include a requirement that the applicant provide information proving eligibility for state plan coverage.
- Pg. 14
6. AS 21.55.400(3) should be deleted. (See comments on AS 21.55.400.)
- X
- AS 21.55.500 needs to be amended to include a definition of the term "date of the application". (See comments on AS 21.55.330.)
- Pg. 19  
line 12, 13
8. AS 21.55.500 (11) needs to be amended to include a percentile cutoff point in the customary charge profile of cha- s. (See comments on AS 21.55.500.)
- Pg. 19  
line 20
9. Section 3, AS 21.09.210(j) needs to be amended to make it clear that the premium tax credit only applies to disability insurance premiums. This can be accomplished by inserting the words "disability insurance premiums" between the words "imposed" and "under" on line 28 of page 19 of the Bill.

# SENATE COMMITTEE REPORT

DATE: 3/1/90

FURTHER: Finance

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

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 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

do not pass

no recommendation

individual recommendations

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

ATTACHES NEW FISCAL NOTE(S):

Dept/Date:

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

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

appropriation-no fiscal note

APPROVES PREVIOUS:

Dept/Date:

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

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

Governor's bill w/fiscal note

SIGNING DO PASS:

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

OTHER RECOMMENDATIONS:

*Lloyd Jones (No Rec)*  
*Al Adams No Rec*  
*Tim Kelly No Rec*  
*Janet ... No Rec*

*Paul ... (No Rec)*

Chair: Signature and Recommendation

## FISCAL NOTE

**REQUEST:**

Revision Date: March 12, 1990  
Title: An Act relating to disability insurance

Agency Affected: Commerce & Economic Development  
BRU: Insurance

Sponsor: Coghill  
Requestor: Senate HESS

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						
<b>TOTAL OPERATING</b>	<b>123.4</b>	<b>107.4</b>	<b>107.4</b>	<b>107.4</b>	<b>107.4</b>	<b>107.4</b>

CAPITAL	0	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)	(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	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>	<b>107.4</b>

**POSITIONS:**

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

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

Revised Fiscal Note

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

Approved by Commissioner: Larry Merculieff Date: 3/11/90  
Agency: Department of Commerce & Economic Development

Distribution (by preparer):

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

FISCAL NOTE ANALYSIS - C S S S B 304 (L&C)

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>[62,898.6]</u>	Tax exempt health premiums
\$ 81,545.40	
<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, insurers whose assessments exceed 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	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						
<b>TOTAL OPERATING</b>	<b>123.4</b>	<b>107.4</b>	<b>107.4</b>	<b>107.4</b>	<b>107.4</b>	<b>107.4</b>

CAPITAL	0	0	0	0	0	0
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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
<b>TOTAL</b>	<b>123.4</b>	<b>107.4</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	1
PART-TIME						
TEMPORARY						

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

Prepared by: David J. Walsh, Director  
Division: Insurance

Phone: 465-2515

Date: \_\_\_\_\_

Approved by Commissioner: Larry Merculieff  
Agency: Department of Commerce & Economic Development

Date: 3-2-90

Distribution (by preparer):

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

FISCAL NOTE ANALYSIS - CSSSSB 304 (L&C)

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<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.

1.	POSITION TITLE Chief of Operations				RANGE/STEP 23/A	BARG. UNIT S	PAGE/LINE	COV.	APPROV.	DISAPP
2.	TYPE OF POSITION PFT	STAFF MONTHS 12	RP NUMBER	PCN 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										

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

AGENCY Commerce & Economic Dev.  
BRU Insurance  
COMPONENT Operations

FY 91

Page 1 of 1  
Revised Date



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

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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 t'e 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. <i>Passed in 1987</i>
* 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

<u>STATE</u>	<u>RATE</u>
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																																				
* Connecticut	\$2,000/Individual; \$4,000/Family																																				
* Florida	<table border="0" style="margin-left: 20px;"> <tr> <td style="text-align: right;"><u>Regular</u></td> <td>Plan I</td> <td>\$2,500/Individual;</td> <td>\$4,000/Family</td> </tr> <tr> <td></td> <td>Plan II</td> <td>\$3,000/Individual;</td> <td>\$4,500/Family</td> </tr> <tr> <td></td> <td>Plan III</td> <td>\$3,500/Individual;</td> <td>\$5,000/Family</td> </tr> <tr> <td></td> <td><u>Medicare</u></td> <td>Plan I</td> <td>\$1,500/Individual;</td> </tr> <tr> <td></td> <td></td> <td>Plan II</td> <td>\$2,000/Individual;</td> </tr> <tr> <td></td> <td></td> <td>Plan III</td> <td>\$1,500/Individual;</td> </tr> <tr> <td></td> <td></td> <td></td> <td>\$4,000/Family</td> </tr> <tr> <td></td> <td></td> <td></td> <td>\$4,500/Family</td> </tr> <tr> <td></td> <td></td> <td></td> <td>\$5,000/Family</td> </tr> </table>	<u>Regular</u>	Plan I	\$2,500/Individual;	\$4,000/Family		Plan II	\$3,000/Individual;	\$4,500/Family		Plan III	\$3,500/Individual;	\$5,000/Family		<u>Medicare</u>	Plan I	\$1,500/Individual;			Plan II	\$2,000/Individual;			Plan III	\$1,500/Individual;				\$4,000/Family				\$4,500/Family				\$5,000/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.

July, 1986

## 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.

July, 1986

## 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.

## **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.

## 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

## SYNOPSIS OF MODEL

The purpose of the NAIC Model Bill is to establish a mechanism through which dequate 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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Section 8.	Taxation
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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. A. 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 by 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) (l) 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 standards 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.

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 NAJC).*

*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 NAJC Policy).*

54304 Schedule 2/26/90

## The Uninsurables

# 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.

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**SB 304**

25 Apr 1989

ORIGINAL COMMITTEE REFERRALS:  
Labor & Commerce, Health, Education & Social Services and Finance

ORIGINAL SPONSORS:  
Coghill

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

This bill would create a nonprofit, incorporated, legal entity known as the "Comprehensive Disability Insurance Association." Its membership would consist of all licensed hospital or medical service corporations in the state offering subscriber contracts for major medical coverage and all insurers licensed to transact disability insurance in the state that offer policies for major medical coverage on an expense-incurred basis. Membership in this association would be a condition of doing disability insurance business, or being able to offer subscriber contracts for major medical coverage in the state.

The stated purpose of this association is to provide a state plan of health and disability insurance for those who are denied adequate coverage for any reason or who are otherwise considered uninsurable. Maximum premiums for this insurance plan could not exceed 150 percent of the premiums that would be required for a similar actuarially sound plan for persons who are a standard risk. The losses due to claims expenses would be shared by each member of the association in proportion to the amount of business they transact in the state.

**SB 305**

27 Apr 1989

ORIGINAL COMMITTEE REFERRALS:  
Resources and Finance

ORIGINAL SPONSORS:  
Coghill

"An Act relating to utilization of fish caught by subsistence fishermen, waste of fish, and management of and planning for certain salmon stocks; and providing for an effective date."

According to this bill the state would develop plans and programs for rehabilitation and enhancement of salmon stocks that spawn in terminal

areas to meet the needs of subsistence, personal use, sport, and commercial fishermen who utilize those salmon stocks.

This bill would increase from 6 months to 1 year, the maximum term of imprisonment for those who intentionally, knowingly, or with reckless disregard waste not only salmon but fish in general.

This bill would allow the commercial utilization of fish parts from subsistence-caught fish.

**SB 306**

3 May 1989

ORIGINAL COMMITTEE REFERRALS:  
Finance

ORIGINAL SPONSORS:  
Finance Committee

"An Act making, amending, transferring, and repealing capital and operating appropriations; and providing for an effective date."

This bill makes 200 separate modifications in prior capital projects and operating expense appropriations.

**SB 307**

27 Apr 1989

ORIGINAL COMMITTEE REFERRALS:  
Community & Regional Affairs and Labor & Commerce

ORIGINAL SPONSORS:  
Pearce

"An Act relating to property foreclosed upon by a municipality."

Currently the owner at the time of a property tax foreclosure may within 10 years repurchase the property if it has not already been sold by the municipality. However, according to this bill, the repurchase price would have to include the "costs of maintaining and managing the property incurred by the municipality including insurance, repairs, association dues, and management fees, that exceed amounts received by the municipality for the use of the property."

Currently if the property is sold at a tax foreclosure sale, the former owner is entitled to the portion of the sale proceeds that exceeds the unpaid taxes, the accumulated taxes, penalties, interest, and the costs of foreclosing and selling the property. However, according to this bill, the "costs to the municipality of maintaining and

managing the property that exceed as received by the municipality for the use of property" would also be deducted from former owner's share of the proceeds.

**SB 308**

27 Apr

ORIGINAL COMMITTEE REFERRAL:  
Community & Regional Affairs and Labor & Commerce

ORIGINAL SPONSORS:  
Pearce

"An Act relating to taxation of certain property by municipalities; and providing for an effective date."

According to this bill the real property taxes of the following would be subject to municipal taxation:

- Teachers Retirement System
- Public Employees Retirement System
- Alaska Industrial Development Authority

**SB 309**

28 Apr

ORIGINAL COMMITTEE REFERRAL:  
Labor & Commerce

ORIGINAL SPONSORS:  
Frank, Duncan, Zharoff, Fischer, Binkley, Uehling and Faiks

"An Act relating to excluding a named person from a motor vehicle insurance policy providing for an effective date."

According to this bill, except for state automobile liability insurance policies:

"An insurer may not refuse to exclude a person from coverage under an automobile insurance policy if the claim experience or driving record of the person would have justified cancellation, nonrenewal, or an increase in the premium. A premium charge for a policy that excludes a person from coverage does not reflect the claims, experience, or driving record of the excluded person."

"An automobile insurance policy providing coverage for a named person is excluded from coverage may also exclude that the insurer is not liable for damages arising out of use or operation of the automobile by the excluded person."

**SENATE CONCURRENT RESOLUTIONS**

**SCR 29**

3 Apr 1989

ORIGINAL COMMITTEE REFERRALS:  
Labor & Commerce and Finance

ORIGINAL SPONSORS:  
Senate Special Committee on Banking & Economic Development

"Relating to the investment of the state's public trust funds."

This resolution encourages the managers of the state's public trust funds to consider placing a portion of their investment portfolios in sound, diversified venture capital funds and that all such investments be accompanied by appropriate

terms and conditions that encourage the venture capital fund managers to actively pursue investment opportunities in the state.

**SCR 30**

5 Apr 1989

ORIGINAL COMMITTEE REFERRALS:  
Oil & Gas and Resources

ORIGINAL SPONSORS:  
Rodey and Szymanski

"Urging coordinated research and development of technology and programs for prevention and cleanup of oil discharges."

This resolution requests the Governor to direct the Science and Engineering Advisory

Commission and the Alaska Science and Technology Foundation to explore additional ways to coordinate their activities and the activities of other state agencies in order to achieve development of better prevention and techniques related to oil discharges."

This resolution also requests the Governor to "consider the possibility of having Alaska participate in a future conference at which the attention of worldwide experts could be focused on prevention, consequences, and lessons learned from charge disasters like the one at Prince Sound."

**SCR 31**

ORIGINAL COMMITTEE REFERRAL:  
Rules