SB 304

SENATE COMMITTEE REPORT
FIRST COMMITTEE OF REFERRAL

DATE: 1/25/90

FURTHER: HESS
Finance

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

DATE TURNED INTO OFFICE: 3/1/90

L & C Committee considered SSSB 304

Act relating to disability insurance; efd.

and recommended:

[✓] replace with _____ CS SS SB 304 (L&C) [✓] same title
[ ] new title

[ ] attached amendment(s)

[ ] _____ letter of intent adopted

[✓] do pass

[ ] do not pass

[ ] no recommendation

[ ] individual recommendations

[ ] further referral to _____

ATTACHES NEW FISCAL NOTE(S):

Department(s)/Date:

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

[ ] appropriation-no fiscal note

Department(s)/Date:

[ ] zero fiscal note(s) _____

[ ] Governor's bill w/fiscal note

SIGNING DO PASS:

OTHER RECOMMENDATIONS:

Chair: Signature and Recommendation

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: February 23, 1990

TO: Senator Dick Eliason, Chairman
Senate Labor & Commerce Committee

FROM: Senator Jack Coghill

SUBJECT: Sena' Bill 304 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 eligibilty f persons who may be covered under this program.

I ask that you give Senate Bill 304 your most favorable consideration, as everyone should have the opportunity to purchase health insurance.

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

POUCH Y STATE CAPITOL
JUNEAU, ALASKA 99811
907 465-3800

M E M O R A N D U M February 20, 1990

SUBJECT: Disability insurance - SSSB 304

TO: Senator Jack Coghill

FROM: Michael F. Ford MF
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.

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.

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.

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

FEB 23 1990

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: SSSB 304
PUBLISH DATE:

FISCAL NOTE

REQUEST:

Revision Date:
Title: An Act relating to disability insurance

Sponsor: Coghill
Requestor: Senate Labor & Commerce

Agency Affected: Commerce & Economic Development
BRU: Insurance

Components: Operations

EXPENDITURES/REVENUES: (Thousands of Dollars)

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

FUNDING: (Thousands of Dollars)

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

POSITIONS:

FULL-TIME	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 (Gary Bell for)
Agency: Department of Commerce & Economic Development

Date: 2/23/90

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

4056D-1/22390c

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
x 2.7%	Tax rate
$ 3,900.0	Tax revenue
$ 61,189.0	1987 disability premiums of hospital and medical service corporations
[55,610.0]	Less claims
$ 5,579.0	Taxable premiums
x 6.0%	Tax rate
$ 334.7	Tax revenue
$ 3,900.0	
+ 334.7	
$ 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.

	POSITION TITLE				RANGE/STEP	BARG. UNIT	PAGE/LINE	GOV.	APPROV.	DISAPP
1.	Chief of Operations				23/A	S				
	TYPE OF POSITION	STAFF MONTHS	RP NUMBER	PCN NUMBER	BRU PRIORITY	LOCATION	ELECTION DISTRICT	LEG.		
2.	PFT	12				Juneau	4			
3.	CONTINUATION LEVEL		ADDITION							

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 B&M USE ONLY
KEY NUMBER - - - - -

JUSTIFICATION:

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

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

REQUEST FOR NEW POSITION

AGENCY Commerce & Economic Dev.

BRU Insurance

COMPONENT Operations

Page 1 of 1

Revised Date

FY 91

01-1137(7/88)-13

STATE OF ALASKA
OFFICE OF THE GOVENOR
BILL ANALYSIS

DEPARTMENT	DIVISION	BILL NUMBER	SPONSOR
Commerce & Econ. Dev.	Insurance	SSSB 304	Senator Coghill

SHORT TITLE OF BILL
An Act Relating to Disability Insurance

DEPARTMENT POSITION
Neutral

PREPARED BY	DATE	COMMISSIONER'S SIGNATURE	DATE
Don Koch, Acting Deputy Director	2/23/90		2/23/90

SUMMARY

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

See Attached

4076D-1/22390e PLEASE ATTACH A SEPARATE SHEET FOR ADDITIONAL COMMENTS OR ANALYSIS

(Rev. 11/89)

ANALYSIS OF BILL/PROGRAM EFFECTS

SECTION 2 AS 21.55.010 - .500

AS 21.55.010

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

AS 21.55.020

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

AS 21.55.030 - .060

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

AS 21.55.100

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

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

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

2. involuntary termination of disability insurance coverage for any reason other than nonpayment of premiums.

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

1. a person who, at the time of application, is eligible for medical assistance;

2. a person who terminated coverage under this chapter unless 12 months have elapsed since termination, or that the person can show that other continuous coverage was involuntarily terminated for any reason other than for nonpayment of premium;

3. a person on whose behalf $500,000 in benefits have been paid; and

4. inmates of public institutions and persons whose benefits are duplicated under public programs.

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

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

AS 21.55.110

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

AS 21.55.120

The two deductible amounts of $1,000 and $5,000 are established here. A deductible "carry-over" provision is established for expenses incurred in the last three months of a 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. Therefore, the mandatory cap at 150% of standard would provide for an inadequate rate basis which would seem to provide for a conflict between AS 21.55.150(a) and AS 21.55.150(c).

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. I would recommend this section be amended to include the function of premium billing. It would appear the intent is to have premiums paid on a quarterly basis (see AS 21.55.330(a)). If this is the intent, the frequency of billing and premium payments should be stipulated to be quarterly.

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. However, this section does not include a provision for an applicant to submit proof of eligibility such as a copy of a letter of rejection from a member, a copy of an insurance contract with a restrictive rider, or proof that previous coverage was involuntarily terminated for reasons other than nonpayment of premium. This section needs to be amended to include a requirement that such information be provided in the application for state plan coverage. 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.

Amendment is necessary to clarify this item. It is suggested that this be accomplished in the definitions section, AS 21.55.500.

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".

Another duty (AS 21.55.410(3)) requires the director to undertake studies and demonstration projects to develop awareness of this program. This appears to be duplicative of a similar duty imposed upon the association. It is recommended that this duty imposed upon the director be deleted.

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.

AS 21.55.500(11) defines the term "usual, customary, reasonable, or prevailing charge". This provision needs to be amended to evaluate at what cutoff point a charge no longer falls within the "customary charge" range of charges. This is typically set at some percentile such as the 75th or 90th percentile.

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. However, this is not clear from the reading of the Section; and AS 21.55.060 must be read as well.

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.

AMENDMENTS PROPOSED

1. AS 21.55.110 needs to be amended to include those benefits mandated in AS 21.42.345 and AS 21.42.365.

2. AS 21.55.110(2) needs to be amended to define what constitutes "dental conditions" for which coverage is not to be provided.

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.)

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.

5. AS 21.55.310 needs to be amended to include a requirement that the applicant provide information proving eligibility for state plan coverage.

6. AS 21.55.400(3) should be deleted. (See comments on AS 21.55.400.)

7. 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.)

8. AS 21.55.500 (11) needs to be amended to include a percentile cutoff point in the customary charge profile of charges. (See comments on AS 21.55.500.)

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.

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: SB 304
PUBLISH DATE:

FISCAL NOTE

REQUEST:

Revision Date:
Title: An Act relating to disability insurance

Agency Affected: Commerce & Economic Development
BRU: Insurance

Sponsor: Coghill
Requestor: Senate Labor & Commerce

Components: Operations

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES	0	0	65.4	65.4	65.4	65.4
TRAVEL	0	0	12.0	6.0	6.0	6.0
CONTRACTUAL	0	0	35.0	35.0	35.0	35.0
SUPPLIES	0	0	1.0	1.0	1.0	1.0
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GRANTS, CLAIMS						
MISCELLANEOUS						
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CAPITAL	0	0	0	0	0	0
REVENUE	0	0	(0-4,234.7)	(0-4,234.7)	(0-4,234.7)	(0-4,234.7)

FUNDING: (Thousands of Dollars)

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FEDERAL FUNDS						
OTHER PR/GF	0	0	123.4	107.4	107.4	107.4
TOTAL	0	0	123.4	107.4	107.4	107.4

POSITIONS:

FULL-TIME	0	0	1	1	1	1
PART-TIME						
TEMPORARY						

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

Prepared by: James J. Jordan, Deputy Director
Division: Insurance
Phone: 465-2515
Date: 2/2/90

Approved by Commissioner: Larry Merculieff
Agency: Department of Commerce & Economic Development
Date: 5/2

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

40560-1/011990b

ANALYSIS

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.

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STATE OF ALASKA
1989 LEGISLATIVE SESSION

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Revision Date:
Title: An Act relating to disability insurance

Agency Affected: Commerce & Economic Development
BRU: Insurance

Sponsor: Coghill
Requester: Senate Labor & Commerce

Components: Operations

EXPENDITURES / REVENUES : (Thousands of Dollars)

OPERATING	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
PERSONAL SERVICES	0	0	65.4	65.4	65.4	65.4
TRAVEL	0	0	12.0	6.0	6.0	6.0
CONTRACTUAL	0	0	35.0	35.0	35.0	35.0
SUPPLIES	0	0	1.0	1.0	1.0	1.0
EQUIPMENT	0	0	10.0			
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	123.4	107.4	107.4	107.4
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	(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	0	0	123.4	107.4	107.4	107.4
TOTAL	0	0	123.4	107.4	107.4	107.4

POSITIONS:

FULLTIME	0	0	1	1	1	1
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary.)

SEE ATTACHED PAGE

Prepared by: Jim Jordan, Deputy Director
Division: Insurance
Phone: 562-3626
Date: 5/16/89

Approved by Commissioner: Larry Merculieff
Agency: Department of Commerce & Economic Development
Phone: 465-2500
Date: 5/31/89

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

40560-2/051689c

ANALYSIS

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
x 2.7%	Tax rate
$ 3,900.0	Tax revenue
$ 61,189.0	1987 disability premiums of hospital and medical service corporations
[55,610.0]	Less claims
$ 5,579.0	Taxable premiums
x 6.0%	Tax rate
$ 334.7	Tax revenue
$ 3,900.0	
+ 334.7	
$ 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.

4056D

Position Title	No. of Positions	Range/Step	Barg. Unit
Chief of Operations	1	23/A	S
Time Status	**Staff Months**	**Location**	**Election District**
PFT	12	Juneau	4

Type of Expenditure		Amount
1	2	3
Salary	49.2	
Benefits	16.2	
Premium Pay		
Other		
Total Personal Services		65.4
Travel		
Contractual		2.0
Commodities		1.0
Equipment		10.0
Other		
Total Cost		78.4

Funding Source for Total Cost		
Federal Receipts	1002	
G. F. Match	1003	
General Fund	1004	
GF Program Receipts	1005	78.4
Other		

Justification

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

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

7135M

Request For New Position

Agency: Commerce & Economic Dev.

BRU: Insurance

Component: Operations

FY 89

STATE OF ALASKA

OFFICE OF THE GOVERNOR

BILL ANALYSIS

DEPARTMENT	DIVISION	BILL NUMBER	SPONSOR
Commerce & Econ. Dev.	Insurance	SB 304	Senator Coghill

SHORT TITLE OF BILL
An Act Relating to Disability Insurance

DEPARTMENT POSITION
Neutral

PREPARED BY	DATE	COMMISSIONER'S SIGNATURE	DATE
Jim Jordan, Deputy Director	5-4-89	[signature] for	5/21/89

SUMMARY

OTHER AGENCIES AFFECTED BY BILL	CONSTITUENT GROUP(S) AFFECTED BY BILL
Department of Health and Social Services	Uninsurable residents and residents who have involuntarily lost their health insurance coverage
ORGANIZATIONAL SUPPORT FOR BILL	**ORGANIZATIONAL OPPOSITION TO BILL**
Insurance Industry	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. Unless granted a waiver by the Authority, the state and each municipality or school district must have its health insurance benefits purchased through the Authority (Section 1). 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

See Attached

4076D-1/052489d

PLEASE ATTACH A SEPARATE SHEET FOR ADDITIONAL COMMENTS OR ANALYSIS

01-003 (Rev. 12/83)

ANALYSIS OF BILL/PROGRAM EFFECTS

SECTION 2 AS 21.55.010 - .500

AS 21.55.010

This section creates the Comprehensive Disability Insurance Association (CDIA). Membership is mandatory as a condition of licensure for those insurers and hospital or medical service corporations that offer major medical coverage in Alaska. "Self-insurers" are not members and could not be forced to be members due to the preexemption 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 under the age of 65. The two plans are differentiated by the deductible described in AS 21.55.120 ($500 and $1,000). Additionally, a Medicare supplement is required to be offered to those eligible residents 65 years of age and older.

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 $1,000,000 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 $500 and $1,000 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 of 20% is established. This copayment applies to all types of charges except those for the treatment of mental and nervous conditions which is 50%.

An insured's out-of-pocket costs are limited to $2,000 as a result of responsibility for the deductible and copayment. However, no cap is placed on out-of-pocket expenses for treatment of mental and nervous conditions.

The deductible may be adjusted annually by the director based upon the change in the consumer price index for the Anchorage Metropolitan area. The out-of-pocket limit must be adjusted annually by the same index.

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 six 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. Therefore, the mandatory cap at 150% of standard would provide for an inadequate rate basis which would seem to provide for a conflict between AS 21.55.150(a) and AS 21.55.150(c).

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. I would recommend this section be amended to include the function of premium billing. It would appear the intent is to have premiums paid on a quarterly basis (see AS 21.55.330(a)). If this is the intent, the frequency of billing and premium payments should be stipulated to be quarterly.

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. However, this section does not include a provision for an applicant to submit proof of eligibility such as a copy of a letter of rejection from a member, a copy of an insurance contract with a restrictive rider, or proof that previous coverage was involuntarily terminated for reasons other than nonpayment of premium. This section needs to be amended to include a requirement that such information be provided in the application for state plan coverage. 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.

Amendment is necessary to clarify this item. It is suggested that this be accomplished in the definitions section, AS 21.55.500.

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".

Another duty (AS 21.55.410(3)) requires the director to undertake studies and demonstration projects to develop awareness of this program. This appears to be duplicative of a similar duty imposed upon the association. It is recommended that this duty imposed upon the director be deleted.

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 $1,000,000. It should be noted that an insurer could escape membership in the association by offering plans with maximum benefits of less than $1,000,000.

AS 21.55.500(11) defines the term "usual, customary, reasonable, or prevailing charge". This provision needs to be amended to evaluate at what cutoff point a charge no longer falls within the "customary charge" range of charges. This is typically set at some percentile such as the 75th or 90th percentile.

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. However, this is not clear from the reading of the Section; and AS 21.55.060 must be read as well.

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, 1990. 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, 1990.

SECTION 5

This Act would take effect immediately.

AMENDMENTS PROPOSED

1. AS 21.55.110 needs to be amended to include those benefits mandated in AS 21.42.345 and AS 21.42.365.

2. AS 21.55.110(2) needs to be amended to define what constitutes "dental conditions" for which coverage is not to be provided.

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.)

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.

5. AS 21.55.310 needs to be amended to include a requirement that the applicant provide information proving eligibility for state plan coverage.

6. AS 21.55.400(3) should be deleted. (See comments on AS 21.55.400.)

7. 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.)

8. AS 21.55.500 (11) needs to be amended to include a percentile cutoff point in the customary charge profile of charges. (See comments on AS 21.55.500.)

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.

Senator John B. (Jack) Coghill

Alaska State Legislature

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(907) 465-4797

Box 55028
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(907) 488-0862

MEMORANDUM

To: Senator Dick Eliason
Senate Labor and Commerce Committee Chairman

From: Senator Jack Coghill

Re: State Disability Insurance.

Date: January 16, 1989

Attached you will find a legislative proposal and sectional analysis, I had prepared to solve a particular disability insurance problem.

The draft reflects an approach that other states have used to rectify similar problems.

Due to my senate minority status however, I would like to recommend this proposal for your consideration as a committee bill.

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

POUCH Y · STATE CAPITOL
JUNEAU, ALASKA 99811
907 465-3800

MEMORANDUM December 15, 1988

SUBJECT: State disability insurance (Work Order No. 6-0227)

TO: Senator Jack Coghill

FROM: Michael F. Ford
Legislative Counsel

The following is a sectional analysis of Work Order 6-0227A:

Section 1 -

Sec. 21.55.010 - Establishes the disability insurance association and requires that all disability insurers doing business in the state be members of the association.

Sec. 21.55.020 - Establishes the board of directors of the association and provides for organization of the board.

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

Sec. 21.55.040 - Requires the association to submit an operational plan to the director of the division of insurance and provides that the plan must contain certain provisions.

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

Sec. 21.55.060 - Provides that the association is exempt from state or local taxes, except for real or personal property taxes.

Sec. 21.55.100 - Requires the association to offer an individual plan of disability insurance to eligible state residents. Requires that the association offer a medicare supplement plan to residents who are 65 or older and provides

that the association may not deny coverage to eligible state residents.

Sec. 21.55.110 - Establishes the minimum benefits that the state disability insurance plan must offer for medical services.

Sec. 21.55.120 - Establishes the deductible and copayment amounts that the state may require in the insurance plan.

Sec. 21.55.130 - Provides that preexisting conditions may not be excluded from coverage for a period greater than six months.

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

Sec. 21.55.150 - Limits the premium amount that may be charged for state disability insurance, and requires that premiums not be excessive, inadequate or unfairly discriminatory.

Sec. 21.55.200 - Establishes criteria for selection of an insurer to provide the disability insurance policy and handle insurance claims under the state insurance plan.

Sec. 21.55.210 - Establishes specific duties of the insurer selected to provide the disability policy and claims service.

Sec. 21.55.220 - Provides that a person may enroll in the state plan by paying the appropriate premium to the insurer. Also provides that each member of the association is responsible for the costs of state disability insurance that exceed premium payments. Under Sec. 2 of this draft, an insurer that is required to pay an assessment under this section is entitled to a tax credit under AS 21.09.210.

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

Sec. 21.55.310 - Establishes procedures for enrolling in the state insurance plan.

Sec. 21.55.320 - Requires that an application for enrollment be accepted or rejected within 30 days of receipt by the insurer.

Sec. 21.55.330 - Establishes the effective date of insurance coverage under the state plan.

Sec. 21.55.340 - Requires that the disability insurance association devise and implement a public awareness program to encourage enrollment in the state insurance plan.

Sec. 21.55.400 - Establishes duties of the director of the division of insurance regarding the disability insurance association.

Sec. 21.55.410 - Establishes that the state is immune from liability for acts or omissions of the association.

Sec. 21.55.500 - Definitions section.

Section 2 - Provides that a member of the disability insurance association is entitled to a tax credit equal to any assessment under AS 21.55.220(d). This allows an offset against claims expenses in excess of premiums, charged for the state disability insurance.

Section 3 - Requires that the state disability insurance be available to residents by January 1, 1990.

Section 4 - Effective date.

MFF:mi
wkmi3/067

6-0227A
Ford
11/21/88

IN THE SENATE BY COGHILL

SENATE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - FIRST SESSION

A BILL

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

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

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

CHAPTER 55. STATE DISABILITY INSURANCE.

ARTICLE 1. COMPREHENSIVE DISABILITY INSURANCE ASSOCIATION.

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

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

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

Sec. 21.55.030. GENERAL POWERS. The association may

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

(2) sue or be sued;

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

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

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

regulations necessary to implement this chapter. These regulations continue in force until modified by the director or superseded by a plan submitted by the association and approved by the director.

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

(c) The plan of operation must

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

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

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

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

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

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

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

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

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

Sec. 21.55.060. TAX EXEMPTION. (a) The association is exempt from the payment of fees and taxes levied by the state or a political subdivision except taxes levied on real or personal property.

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

ARTICLE 2. STATE DISABILITY INSURANCE PLANS.

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

(b) The association shall make available to residents eligible under AS 21.55.300 who are 65 years of age or older a medicare supplement plan that meets the minimum policy standards and minimum benefit standards established by regulations adopted by the director under AS 21.89.060.

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

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

(1) hospital services;

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

dental conditions;

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

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

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

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

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

(8) use of radium or other radioactive materials;

(9) outpatient chemotherapy;

(10) oxygen;

(11) anesthetics;

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

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

than rental, of durable medical equipment that has no personal use in the absence of the condition for which it was prescribed;

(14) diagnostic x-rays and laboratory tests;

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

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

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

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

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

(20) second surgical opinions;

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

Sec. 21.55.120. DEDUCTIBLES AND COPAYMENTS. (a) A state plan other than a medicare supplement plan may require deductibles of $500 a person or $1,000 a person. The amount of the deductible may not be

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

(b) The copayment in a state plan other than a medicare supplement plan may not exceed 20 percent for charges for all types of medical care in excess of the deductible and 50 percent for services described in AS 21.55.110(3) in excess of the deductible.

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

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

Sec. 21.55.130. PREEXISTING CONDITIONS. (a) A policy may not exclude coverage for a loss due to a preexisting condition for a period greater than six months following the effective date of

coverage.

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

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

(1) care for an injury or disease either

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

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

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

(3) travel, other than transportation covered under

AS 21.55.110(17);

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

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

(6) services or articles that are determined not to be medically necessary, except for the fabrication or placement of the prosthesis as specified in (2) of this section and in AS 21.55.-110(12);

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

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

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

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

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

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

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

(14) experimental procedures; and

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

charged.

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

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

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

ARTICLE 3. ADMINISTRATION OF PLANS.

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

Sec. 21.55.210. DUTIES OF WRITING CARRIERS. (a) The writing carrier shall perform the administrative and claims payment functions required by this section. The writing carrier shall provide these services for a period of three years, unless a request to terminate is approved by the director. The director shall approve or deny a request to terminate within 90 days of its receipt. A failure to make a final decision on a request to terminate within the specified period

shall be considered an approval. Six months before the expiration of each three-year period, the association shall invite submissions of policy forms from members of the association, including the writing carrier. The association shall follow the provisions of AS 21.55.210 in selecting a writing carrier for the subsequent three-year period.

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

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

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

(e) The writing carrier shall be reimbursed from the state plan premiums received for its direct and indirect expenses for administering the plan. Direct and indirect expenses must include a pro rata reimbursement for that portion of the writing carrier's administrative, printing, claims administration, management and building overhead expenses that are assignable to the maintenance and administration of the state plans. The association shall approve cost accounting methods to substantiate the writing carrier's cost reports consistent with generally accepted accounting principles. Direct and indirect expenses may not include costs directly related to the original submission of policy forms before selection as the writing carrier.

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

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

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

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

(d) The association shall make an annual determination of each member's liability, if any, and may make an annual fiscal year end assessment if necessary. The association may also, subject to the approval of the director, provide for interim assessments against the members as may be necessary to assure the financial capability of the association in meeting the incurred or estimated claims expenses of the state plans and operating and administrative expenses of the

association until the association's next annual fiscal year end assessment. Payment of an assessment is due within 30 days after a member receives written notice of a fiscal year end or interim assessment. Failure by a member to tender to the association the assessment within 30 days is grounds for revocation of a member's certificate of authority. A member that ceases to do disability insurance business in the state, or ceases to offer subscriber contracts in the state, due to revocation, suspension, or voluntary surrender of its certificate of authority remains liable for assessments through the calendar year in which the disability insurance or subscriber contract business ceased. The association may decline to levy an assessment against a member if the assessment would not exceed $10. Assessments paid by a member are a general expense of the member.

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

ARTICLE 4. ENROLLMENT IN THE STATE DISABILITY INSURANCE PLAN.

Sec. 21.55.300. ELIGIBILITY FOR STATE DISABILITY INSURANCE. (a) Except as provided in (b) of this section, a person who is a resident of the state is eligible for disability insurance coverage under this chapter upon providing evidence of

(1) rejection for medical reasons, a requirement of restrictive riders, an up-rated premium, or a preexisting conditions limitation on disability insurance, the effect of which is to substantially reduce coverage from that received by a person considered a standard risk, by at least one member within the six months preceding the date of application; or

(2) involuntary termination of disability insurance

coverage for any reason other than nonpayment of premium.

(b) The following persons are not eligible for disability insurance coverage under this chapter:

(1) a person who is at the time of application eligible for medical assistance under AS 47.07.020;

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

(A) 12 months have lapsed since termination; or

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

(3) a person on whose behalf the state has paid out $1,000,000 in benefits under this chapter; and

(4) inmates of public institutions and persons whose benefits are duplicated under public programs.

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

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

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

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

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

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

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

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

(2) is accepted by the writing carrier; and

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

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

(b) The association shall devise and implement means of maintaining public awareness of the provisions of this chapter regarding the state plans and shall administer this chapter in a manner that facilitates public participation in the state plans. The association shall prepare a brochure outlining the benefits and exclusions of the state plan in plain language.

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

(d) An insurer or hospital or medical service corporation that

rejects or applies underwriting restrictions to an applicant for a subscriber contract, a disability insurance policy, or a medicare supplement plan in the state shall notify the applicant of the existence of the state plans, the requirements for being accepted, and the procedure for applying.

ARTICLE 5. GENERAL PROVISIONS.

Sec. 21.55.400. DUTIES OF DIRECTOR. The director may

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

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

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

(4) adopt regulations necessary to administer this chapter.

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

Sec. 21.55.500. DEFINITIONS. In this chapter

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

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

(3) "deductible" means the portion of eligible expenses for which the insured is responsible in each calendar year under AS 21.55.120(a);

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

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

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

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

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

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

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

(6) "hospice services" means services provided under a coordinated comprehensive program of palliative and supportive care on

a 24-hour, seven days per week basis for persons who have been diagnosed as terminally ill and their families by an interdisciplinary team of professionals or volunteers under an incorporated central administration that has a physician as medical director;

(7) "major medical coverage" means a disability insurance contract or subscriber contract that provides benefits for hospital and medical care with potential lifetime maximum benefits per insured of at least $1,000,000;

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

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

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

(11) "usual, customary, reasonable, or prevailing charge"

means the charge for a medical care procedure, service, or supply item that is the lowest of the following amounts:

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

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

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

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

* Sec. 2. AS 21.09.210 is amended by adding a new subsection to read:

(j) A member of the Comprehensive Disability Insurance Association created in AS 21.55.010 may credit against a premium tax imposed under this section, an amount equal to an assessment against the member under AS 21.55.220(d). The portion of the credit allowed in this subsection that cannot be taken in a tax year without reducing taxable premiums below zero may be carried forward and credited in successive years until the credit is exhausted.

* Sec. 3. The association established by sec. 1 of this Act shall make available to residents the plans required by AS 21.55.100, enacted in sec. 1 of this Act, by January 1, 1990.

* Sec. 4. This Act takes effect immediately under AS 01.10.070(c).

Analysis of States That have passed This type of legislation

"Comprehensive High Risk Health Study"

Write to:

Communicating for Agriculture
C.A. Support Services Offices
2001 Killebrew Dr, Suite 169
Minneapolis, MN 55420
(612) 854-9005

March 27, 1989

To: Senator Dick Eliason
Capital, Room 417
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 Registerd 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 preexsisting 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 Alaskan 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

health insurance. One should not have to get a divorce or relinguish 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 ng and Epileptic Associations,MDA¡Cancer Society and several Senior Citizens gr s 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 constiguents 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 <u>everyone</u>, 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

Jan H. Soloy

cc: legislative offices

89-470 E

CRS Report for Congress

Insurance Company Solvency

Edward B. Rappaport
Analyst in Industry Economics
Economics Division

July 13, 1989

CRS

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INSURANCE COMPANY SOLVENCY

SUMMARY

Insurance company failures have become more common in the last five years and, more importantly, have involved much larger companies than previously. Shortfalls of failed companies are still small relative to total industry revenues – less than one-half of 1 percent – but the consequences of poor business practice in this field sometimes take a long time to become manifest. It is important to look at industry practices and conditions with an eye toward ultimate results, especially with regard to possible adverse turns in the business environment.

The financial condition of the industry, viewed here in terms of the aggregate balance sheet, appears sound, with but two important reservations: (a) Loss reserves at property/casualty companies inevitably include a subjective element, leaving room for future surprises. And (b) life companies are increasingly selling annuities and other investment-oriented products funded by "separate accounts" that put the investment risk on the clients.

When the industry's condition is measured by the numbers of problem companies, there is no evident trend among the life/health segment of the industry (although there was a one-year slippage from 1984 to 1985 that has not been reversed). The property/casualty segment, though, has shown definite deterioration. The proportion of companies designated for "regulatory attention" increased from 8.4 percent in 1978 to 21.4 percent in 1987.

Looking at case studies of a few of the more prominent insolvencies of the 1980s, several generic problems are found to have played a role. Among these are fraud, uncollectible reinsurance, and under-pricing of insurance services. To some extent these problems have occurred because insurance companies have not adequately investigated or supervised their employees, agents, brokers, etc. And implicitly, State supervision failed in these cases, given the high priority the insurance commissioners themselves place on solvency regulation.

Finally, there are potential sources of future instability that may not be fully reflected in current financial reports. Prime among these are uncollectible reinsurance, potentially explosive claims areas (especially hurricanes, earthquakes, and AIDS) and innovations in business practice (such as cash flow underwriting and risk retention groups). Their financial impact may be impossible to quantify, but may nevertheless behoove State commissioners to take a conservative attitude in all aspects of solvency regulation.

CONTENTS

INSURANCE COMPANY SOLVENCY

Insolvencies of insurance companies have occurred with increasing frequency since 1983, and this has prompted public questioning from several quarters about the future stability of the industry. While the number of failures has been small relative to the industry's size, policymakers are understandably concerned that a seemingly adverse trend should not be allowed to get out of hand. When an insurer is unable to meet its obligations, its clients suffer a double hardship, because those who are making claims are precisely those who have already experienced a serious loss (such as fire, death of a breadwinner, etc.). Moreover, the industry plays an essential role in the U.S. financial system generally, by virtue of its large asset holdings (on the order of $1.5 trillion).

The first priority of public regulation of insurance, then, is preserving company solvency – the ability to meet all valid claims. In the United States, regulation is performed by insurance commissioners who are officers of the State governments. The Federal Government is not directly involved, but pressures for Federal involvement might grow if company failures become widespread.

The number of insolvencies – as defined and counted by the National Association of Insurance Commissioners (NAIC) – increased from four in 1983 to 21 in 1985. In retrospect, the rise appears to have been largely cyclical, as the industry then raised its premium rates sharply and the number of insolvencies fell to 13 by 1987. Still, the number was high by historical standards[1] and, more importantly, the failing companies were of increasingly large size. Thus the need for payments from State guaranty funds has continued to grow, despite the financial recovery of the industry as a whole. Guaranty fund assessments, just $82 million in 1984, grew to $917 million in 1987 and probably exceeded $1 billion in 1988. Even at these elevated levels, assessments amount to only about one-half percent of the property/casualty industry's total premiums. Nevertheless, the trend suggests that remedial action may be needed.

This report addresses several questions raised by the recent spate of large company failures. What do currently reported financial figures say about the condition of the industry? Is there any pattern among prominent failures already experienced? And what future developments, not reflected in current accounts, might plausibly threaten the industry's financial stability?

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[1] The average annual number between 1970 and 1983 was only six.

FINANCIAL CONDITION OF THE INDUSTRY

The insurance industry's financial condition can be analyzed quantitatively in at least three basic ways: by an aggregate balance sheet, by trends in the numbers of companies showing subnormal financial characteristics, and by the rate at which insolvencies occur. By custom (which is followed here) the two principal segments of the industry — property/casualty (P/C) and life/health (L/H) — are treated separately. As will be seen, the two segments differ fundamentally in their financial structures and functions.

INDUSTRY BALANCE SHEET, DECEMBER 31, 1987

Industry aggregate balance sheets in simplified form for the two segments are displayed in tables 1 and 2. These are derived by adding together the data for (nearly) all the firms licensed in the United States, as filed with regulators and using the industry's specialized accounting system known as "statutory accounting." Most of the data referred to in this section are derived from balance sheets rather than such other reports as the income statement, because this is where assets are compared to liabilities. The difference between these figures is net worth,[2] and firms are considered solvent as long as net worth is positive. That is to say, a solvent firm's assets, if liquidated, presumably can cover all of the firm's liabilities.

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[2] In the special accounting system used in the industry, "policyholders' surplus" is the concept corresponding to net worth. All figures quoted in this report are derived from this system of "statutory" accounting.

TABLE 1. Aggregate Balance Sheet of Life/Health Insurance Industry, December 31, 1987
(billion $)

Assets		Liabilities	
Bonds	557.1	Policy reserves a/	862.1
National gov'ts	75.8	Life	276.4
Agencies	67.0	Health	24.0
Municipal	10.7	Annuities & suppl. contracts	561.7
Corporate	405.7		
Stocks	96.5	Policy dividends payable	27.8
Mortgages	213.4	Other liabilities	87.1
Real Estate	34.2		
Total investments	901.2	**Total liabilities**	977.1
Policy loans	53.6	Capital & surplus	67.4
Receivables	32.1		
Other	57.5		
	1,044.5		1,044.5

a/ including 109.3 in separate accounts.

Source: American Council of Life Insurance, 1988 Life Insurance Fact Book.

TABLE 2. Aggregate Balance Sheet of Property/Casualty Insurance Industry, December 31, 1987
(billion $)

Assets		Liabilities	
Bonds	253.6	Loss reserves	188.2
National gov'ts	66.4	of which:	
Agencies	94.0	in process of adjust.	225.1
Muncipal	42.8	incurred, not reported	122.4
Corporate	50.4	less reinsur.recoverable	(159.4)
		Loss adjustment expenses	30.9
Stocks	65.0		
Mortgages	5.2	Unearned premiums	72.3
Real estate	4.4	Deposits on reins.treaties	4.4
Short-term & other	32.9	Other liabilities	26.9
Total investments	360.8	**Total liabilities**	322.7
Agents' balances	33.4	Capital & surplus	104.0
Reinsurance recoverable (on paid losses)	8.5		
Other assets	24.0		
	426.7		426.7

Source: Best's Aggregates and Averages (A.M. Best Co.)

Several features of the industry's operations and condition are illustrated by the tables.

- The industry acts largely as a financial intermediary, holding a "common pool" from which the clients' losses wil' be paid. In the L/H segment especially, not much else shows up on the balance sheet. Policy reser·es account for 82.5 percent of the liability side of the balance sheet, and investments (which are undertaken to fund the reserves) account for 86.3 percent of assets.[3]

[3] In addition, the $54 billion of policy loans and $28 billion of dividends left on deposit represent bank-like functions for the policyholder.

- The intermediary role is further illustrated by the relatively slow rate of asset turnover. Total assets of the L/H companies exceed annual premium revenues by a factor of 9.8 (a factor of 2.3 for the P/C companies) whereas, for the average manufacturing firm, the relationship is the other way around, with annual sales revenue usually exceeding the value of assets.

- The bulk of investments are of low risk and high liquidity: principally mortgages and investment-grade bonds. Nevertheless, relatively long maturities (an average 10.2 years to maturity among bonds held by P/C insurers) leaves the companies open to some interest rate risk. If funds are needed earlier than expected and at a time when interest rates have risen, the bonds will be worth less than face value.

- Capital is "leveraged" in that it is exceeded by loss reserves – by a factor of 13 in the case of the L/H segment. If reserves were considered in the nature of debt, this would be a rather high debt/equity ratio compared to other industries. The main concern here is that errors in setting the reserves, which are educated guesses about future payments, could have a disproportionate effect on capital. If, say, gross losses in P/C turn out to be 10 percent greater than estimated ($382 billion instead of $347 billion) the shortfall could reduce capital by 33 percent. (Although the loss reserve/capital ratio is higher in the L/H segment, these losses can be predicted much more reliably than can P/C losses.)

- Instead of comparing loss reserves to capital, one might model the life insurance companies, at least, analogously to depository institutions. Then capital would be measured first and foremost against total assets, and the L/H average ratio of 6.45 percent would compare favorably to the banking and thrift industries.

- The P/C segment relies extensively on reinsurance. Gross loss reserves of $347.5 billion are expected to be offset by reinsurance recoveries of $159.4 billion. Reinsurance performs important functions, particularly the spreading of risk, but it makes the estimation of ultimate net losses less certain if there is doubt about its collectibility. (This will be discussed further below.)

TEN YEAR RETROSPECTIVE

The foregoing figures provide a snapshot as of December 31, 1987. In order to see whether the industry's solvency is improving or deteriorating, it is useful to make some comparisons with a decade earlier in 1977. Following are some of the more noteworthy trends – or absence of trends – that are revealed by such a comparison (first for the L/H segment, then P/C).

- Growth was surprisingly rapid for a large, "mature" industry. Inflation-adjusted assets of the L/H segment (relative to the Gross National Product price deflator) grew by 69.8 percent over the decade, or a compound rate of 5.4 percent per year.

- Fundamental financial ratios of the L/H segment (such as capital/assets and premiums/assets) were quite stable.

- Annuities, rather than traditional life insurance, powered the growth. Reserves for annuities and supplemental contracts increased their share of assets from 32 to 54 percent over the decade, while the real value of life reserves was actually falling.

- Paralleling the shift in products was a growth in "separate accounts" investing, from 4.9 percent of assets to 10.7 percent. These funds are used especially in connection with pension plans and variable life insurance, and are not limited by the conservative restraints traditionally imposed on life insurance investing, e.g. 42 percent of the separate account assets in 1987 were in common stocks.

Essentially what happened in the life insurance industry in the 1980s was that rapid inflation induced the development of products emphasizing investment returns at least as much as mortality protection. This has not necessarily weakened the companies,[4] but it does put more investment risk on the client via uncertainty in the future cash value of his/her policy.

In the property/casualty industry, meanwhile,

- Growth was faster than with L/H companies. Real premiums grew by 92.7 percent over the decade, or a 6.8 percent compound annual rate.

- Total assets and capital grew even faster than premiums, so that key financial ratios improved, at least in the aggregate. For example, the average premium/surplus ratio improved from 2.35 to 1.82.

- Portfolios appear to have become more liquid. Long-term bonds were reduced from 65.4 percent of assets to 59.4, while cash, short-term and miscellaneous items increased from 1.9 to 7.7 percent.

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[4] A handful of companies have been induced by the emphasis on "performance" to either offer higher returns to the client than they were earning on their portfolio (e.g. Baldwin-United) or to invest heavily in junk bonds (e.g. Executive Life). Arguably, another destabilizing trend could be that the changed client relationship encourages early fund withdrawals and increases the companies' need for liquidity.

- The "tail" of unpaid claims lengthened. This is evidenced by the ratio of loss reserves (for future payments) to currently-paid claims, which rose from 1.50 years worth of paid claims to 1.91 years.

There were dramatic swings in the property/casualty business, marked by substantial losses bottoming in 1984, followed by very rapid increases in premium rates and a return to profitability. From the point of view of solvency, the most important *lasting* change appears to be the lengthening of the claims tail. Since more and more of the premium dollar is being set aside for future payments, uncertainty about the ultimate total of payments — and hence uncertainty about the adequacy of the premiums and reserves — is growing. Concommitantly, the ratio of loss reserves to capital has increased, from 1.99 to 2.11.

The stretching out of payments is probably the result of several trends. First, litigation seems to have become more common. Second, formal insurance coverage for some business lines has been supplanted by alternative mechanisms, such as risk retention groups and higher deductibles. This has left the formal insurance market to specialize increasingly on the larger losses, with their lengthier settlement procedures. Finally, and largely as a result of the foregoing, premiums are being concentrated on the "long tail" lines of business. Liability-type lines tend to be increasing. For example, the "other liability" category which includes commercial general liability, increased its share of P/C premiums over the decade from 7.8 percent to 10.6 percent.[5] These increases are overshadowing those of property-oriented lines. Fire and allied lines, for example, decreased from 6.4 to 4.0 percent of the total. As a consequence of these trends, the financial intermediary role of P/C insurers is becoming more pronounced.

NUMBERS OF COMPANIES WITH PROBLEMS

Even more important than the average health of the industry, as measured by aggregate statistics, is the number of companies near the lower limit of acceptable financial condition. Just as "near misses" in aviation can indicate deficiencies in the control system, subnormal companies may highlight emerging problems.

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[5] There are some exceptions to the general trend. Workers' compensation, which is one of longest of the long-tail lines, decreased its share of premiums from 13.2 to 12.2 percent. But, in view of the carriers' chronic poor profitability, this may simply reflect tighter State regulation of their rates than of other P/C rates.

Several organizations monitor the financial strength of insurance companies, the most widely consulted of which is the A. M. Best Co.[6] Although their methods vary in detail, certain quantitative aspects are universally recognized. About a dozen ratios are calculated to quantify key factors influencing or indicating a company's stability, including capital adequacy, liquidity, quality of investments, reliance on reinsurance, profitability, rates of change in business activity, and track record in forecasting ultimate losses. For example, one of the more important measures of capital adequacy for P/C companies is the ratio of premiums to surplus. "From a regulatory point of view, policyholders' surplus represents a cushion or margin for error, primarily to absorb above-average insurance claims. . . . The higher the premium to policyholders' surplus ratio, the more insurance risk the company bears in relation to the surplus available. . . ."[7] In 1987, the median of this ratio among all companies examined by the NAIC was 1.2, the mean was 1.3, and the maximum considered prudent was 3.0. After calculating a series of such ratios, the analyst will pay especial attention to companies with more than one or two falling outside the "usual" range. Further analysis leading to a final rating is then qualitative and subjective. For example, unusual ratios may result from rapid growth, which may or may not be considered prudent depending on the company's overall business plan, depth of management, and other factors.

Since there are no absolutes in this methodology, what is most useful for judging the industry as a whole is the *trend* of ratings over time. And by this standard, there has been a significant deterioration over the last decade in the P/C segment. In 1978, 8.4 percent of examined P/C companies were designated for "regulatory attention," in most cases due to having several abnormal ratios.[8] By 1987, that proportion had increased to 21.4 percent.[9] The NAIC has not completely disclosed how it makes these determinations; it is possible that the criteria for regulatory attention could have been narrowed

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[6] Others include Insurer Solvency International, Standard & Poors, Moody's Investors Service and Duff & Phelps. Although such services are widely recognized, recent court cases suggest that insurance agents have a duty to go beyond the ratings and use all available sources of information to check companies on behalf of their clients. Finnegan, Philip. Should Agents be Liable when Insurer Goes Bust? *Journal of Commerce*, January 24, 1989. p. 9A

[7] National Association of Insurance Commissioners. *Insurance Regulatory Information System Ratio Results*. Kansas City: the Association, 1988. Appendix, p. 7

[8] U.S. General Accounting Office. *Insurer failures*. Washington: G.A.O. (report no. 87-100), July 1987. pp. 13,18

[9] More on the NAIC's IRIS Ratios for 1988. *Insurance Forum*, v. 16, no. 1. January 1989, p. 4

as the number of abnormal cases increased, in recognition of the regulators' limited resources for follow-up. If so, the deterioration over time may actually have been greater than indicated by the raw numbers.

In the L/H segment, there was some deterioration around 1985, but otherwise no trend is evident over the last five years. In terms of the NAIC's 12 indicator ratios, the proportion of companies showing four or more "unusual" values increased from 21.1 percent on the basis of 1984 statements to 24.5 percent in 1985. It has since remained stable. Best's ratings paralleled this development: The proportion of companies receiving the top A+ rating declined from 32 percent in 1984 to 24 percent in 1985, while the group "not assigned" ratings (with presumably negative inference, categories NA-6 through NA-10) grew from 2 percent to 10. Since then the top rated companies have remained fairly constant, but the NA-6 to -10 group has fallen back to 4 percent.[10]

TREND IN INSOLVENCIES

Aside from a peak in 1975 (which apparently resulted from the recession and "stagflation" of the time), the number of insolvencies remained fairly low — generally fewer than eight per year — in the 1970s and early 1980s. Then the number spiked, to 21 in 1985. Again, macroeconomic forces (this time declining interest rates and a strong dollar vis-a-vis foreign currencies) seem to have produced a stressful environment.

Not just the numbers, but the qualitative character of the failing companies seems to have changed in the interim. Whereas they used to be "small companies handling mostly automobile insurance and operating in one state or on a regional basis,"[11] the failing companies have become more diverse, and now reflect more fully the whole range of operating companies. Most importantly, as noted in the introduction to this report, larger and larger companies have become involved. The GAO found that one third of the insolvent companies it studied in the post-1976 period operated in 20 or more States.[12] Nevertheless, the largest insurance group to fail in recent history (Mission, see below) ranked 55th in premiums among all P/C groups as of 1982. This is large compared to most of the thousands of companies in the market, but they, in turn, are relatively small. The 50 largest groups account for nearly 80 percent of the business, and insolvencies to date have not reached into their ranks.

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[10] Best's Property/Casualty Ratings: Distribution of 1988 Assignments. *Best's Insurance Management Reports* (release no. 11), August 15, 1988.

[11] General Accounting Office, *Insurer Failures*, p. 15

[12] ibid., p. 21

The numbers of insolvencies have not gotten any worse than the peak year of 1985, but the data are ambiguous as to whether there has been any real improvement. On the positive side, figures kept by the National Committee on Insurance Guaranty Funds (NCIGF) indicate a steady drop-off in insolvencies, to only eight in 1988. But the NAIC's tabulation diverged noticeably from the NCIGF numbers in 1988, going up from 13 to 20 and thus nearly matching the 1985 peak. These organizations use different criteria because of their differing missions, so neither series is categorically "right" for all purposes. It would seem, though, that the NAIC series comes closer to indicating industry-wide problems from a national, public policy viewpoint.[13] And in these terms, the insolvency wave of the mid-1980's has not yet been reversed.

FIVE NOTABLE CASES OF THE 1980s

Before 1980, the largest assessment for a failed insurer was $85 million (the American Reserve Group in 1979), less than one-twentieth the cost of the largest bank rescue up to then ($1.8 billion dollars of Government assistance for the Franklin National Bank in 1974).[14] But subsequent insurance failures have reached beyond the billion dollar range. What are the specific causes behind this new phenomenon? How does a company evolve from apparent health to a financially weakened condition and finally to forced closure? Several of the most notable cases are sketched here in order to illustrate the range of problems that have come to light.

BENEFICIAL CORP.[15]

Beneficial Corporation is primarily a consumer finance company that diversified into other financial services in the 1970s. Its principle insurance subsidiary, American Centennial (ACI), survived its problems, but only after leaving Beneficial with losses of at least $400 million, a divestiture without

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[13] The NAIC series counts companies when the State insurance commissioner takes control, whereas the NCIGF considers only liquidations, which usually come later. The NAIC counts reinsurers (often of national significance); the NCIGF excludes reinsurers but includes single-state insurers (usually small).

[14] Schmidt, Charlie. Failures: Banks Outdo Insurers. *Best's Insurance Management Reports*, Property/casualty release no. 12. April 11, 1988. Note that total assets of the banking industry were about twice as large as the insurance industry at the time.

[15] The following is gleaned largely from Kwitny, Jonathan. Beneficial's Cry of 'Swindle' is Heeded. *Wall Street Journal*, February 2, 1988. p. 6

any immediate cash compensation, and some complicated civil and criminal litigation. To our knowledge, no policyholders suffered losses.

ACI's difficulties centered on an accident policy with a group of electric and gas utilities. For the first two years claims were sparse, but after ACI signed a five year, non-cancellation agreement, a number of large claims were presented. ACI alleges that the utility group's manager, an agent hired by ACI, and an ACI vice-president defrauded the company by concealing the losses. The difficulties were compounded when ACI acquired reinsurance, i.e. distributed part of the risk to other companies in exchange for part of the premium. This process reportedly was riddled with hidden ownership ties, excessive brokerage fees and kickbacks. Reinsurers ended up taking on a goodly share of the disputed business. One of them (a unit of Home Group, Inc.) alleges that ACI was not just victim, but also perpetrator of fraud because it neglected for three years to tell Home Group of its suspicions of the original fraud.

Based on published accounts, the following factors appear to have caused or exacerbated the ACI case: (a) conflicts of interest amounting to self-dealing in reinsurance transactions, (b) use of intermediaries (brokers and managing general agents) who, it seems in hindsight, were inadequately supervised, (c) extensive reliance on reinsurance of questionable quality, and (d) a slow and uncertain arbitration process when fraud is alleged. The last factor greatly complicates resolution of the matter because fraud on the part of the primary insurer may excuse the reinsurers of their liability. While the case is pending, reinsurers withhold payments, and even fulfillment of letters of credit securing the reinsurance may be enjoined (as happened in this case) thus pushing the primary insurer into a liquidity crisis. Meanwhile, the primary insurer's investigative cooperation may be compromised because it has an interest in fraud not being proven.

MISSION/INTEGRITY[16]

Mission Insurance specialized in commercial casualty lines (workers compensation, general liability, etc.). The most prominent feature of this case is Mission's intensive involvement in reinsurance arrangements as both buyer and seller. One of the buyers of reinsurance, Integrity Insurance, failed when Mission was closed down and became unable to make payments to Integrity. These are two of the largest insolvencies on record, with Mission's negative net worth estimated at $1.5 billion and Integrity's at $300 million.

The facts of the case are the subject of sharp debate and litigation (and a criminal investigation by the U.S. Attorney in the Southern District of New

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[16] The following is based largely on testimony presented to the House of Representatives, Committee on Energy and Commerce, Subcommittee on Oversight, September 14, 1988.

York). It is clear in retrospect that the business Mission wrote since 1981 (and probably several years before) was very unprofitable. That was a time when the entire liability insurance industry was pricing its services at a low rate. Some hoped to come out ahead by earning high rates of interest on their investment of the premiums; others resigned themselves to losses but felt it important to retain their position in the market. Mission seems to have been of the latter category, growing rapidly by virtue of aggressive bidding for business. The losses were allowed to grow even larger than they might otherwise have due to continual underestimation of projected future claims.

Many of the assuming reinsurers (i.e. those who assumed risks originally written by Mission) started withholding payments around 1984, claiming that they had been defrauded. They allege that Mission had knowingly written poor business (including unauthorized classes of business) with the intention of making profits via fees (as manager of the reinsurance pool) and leaving the reinsurers to absorb the bulk of the losses. Moreover, they claim, Mission had prolonged the fraud by creative accounting that hid the growing losses. Whatever the merits of these claims, the reinsurers' withholding of payments (and banks' similar refusal to honor letters of credit) pushed Mission into liquidation in 1987.

The Mission case is similar to the Beneficial case in that reinsurers' allegations of fraud led to their nonpayment on claims, a liquidity crisis, and complex arbitration/litigation in which the question of fraud became a dollars-and-cents issue between the reinsurers and the liquidators.

TRANSIT CASUALTY

Like the companies just discussed, Transit expanded and diversified in the early 1980s. Headquartered in Los Angeles and "domiciled" (legally based) in Missouri, Transit moved from a niche in the transportation industry into workers compensation and general liability. And like Beneficial, Transit got into trouble when it used a managing general agent (MGA) to spearhead its expansion. An MGA is "an independent business firm that performs for one or more separate insurers some or all of the functions usually performed by company branch offices."[17] As these delegated functions may include sensitive ones such as underwriting, claims adjusting and accounting, it is important that the insurer seek MGA's with reliable personnel, draft an agreement that is clear and provides suitable incentives, and monitor performance. In retrospect, these tasks appear to have been done inadequately by Beneficial and Transit.

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[17] Webb, Bernard L. et al. *Insurance Company Operations*. Malvern PA: American Institute for Property and Liability Underwriters, 1984 (3rd ed.). p. 82

The particulars of the Transit case are the most complex and contentious of the cases reviewed here. It would hardly be an exaggeration to say that everyone at all connected with the disputed transactions has sued everyone else.[18] In essence, Transit (and its State-appointed liquidator) alleges that its MGA wrote unauthorized business at improper rates, failed to properly perform virtually all of its duties, and falsely reported on its activities. The MGA (Miro and Associates, of Dallas) responds that Transit gave little guidance, knew what the MGA was doing, and implicitly consented.[19] Miro further alleges that Transit was victimized by a conspiracy of its directors "to drain the insurer's surplus . . . and to conceal Transit's poor financial condition with [temporary] reinsurance contracts. . . . The alleged conspiracy was intended to allow Transit's parent, Beneficial Standard Corp. of Los Angeles, to complete a liquidation . . . unencumbered by any regulatory action against Transit."[20]

Since Transit failed in 1985, the estimates of losses have been revised radically upward. A realized deficit of less than $20 million as of May 1985 was superseded by a 1986 estimate of ultimate losses of $500 million and a September 1987 estimate of $1.1 billion. Most of these costs will be borne by State guaranty funds, but some policyholders (as illustrated by the Wal-Mart case) may find that they do not hold valid policies on the terms they thought.

NATIONAL COUNTY MUTUAL

The declaration on October 24, 1988 of the insolvency of National County Mutual Fire Insurance Co. precipitated an ongoing controversy over the quality of insurance regulation in Texas. National County, with 125,000 policyholders (mostly high-risk drivers) was the largest insurance failure in Texas experience, but there have been numerous smaller failures as well. The 134 companies currently in conservation or liquidation proceedings exceeds the

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[18] For example, in a dispute over whether a workers compensation policy covering Wal-Mart Stores was valid, both sides (Transit and Wal-Mart) asked the Federal court in Fayetteville, Ark. that, if they lost, the broker on the policy (Alexander and Alexander) be made to pay the damages. Alexander, for its part, sued Miro et al. in Federal court in New York to assure that Miro bear the costs if Alexander were found liable in the Arkansas case.

[19] McLeod, Douglas. Transit Casualty Sues MGA's and Reinsurers. *Business Insurance*, June 10, 1985. p. 1, 43.

[20] As summarized in McLeod, Douglas. Ex-Transit MGA Alleges Collusion. *Business Insurance*, July 20, 1987. p. 1. A Federal judge in Dallas subsequently dismissed Miro's pleadings as being without a reasonable basis. However, the allegations of improper dividend payments from Transit to Beneficial Standard were revived in a suit by the State-appointed receiver against Transit directors and officers.

number in any other State.[21] While certain factors reduce the significance of such a comparison,[22] the controversy has brought to light many potential weaknesses in the State regulatory system.

National County reportedly fell victim to wholesale embezzlement by its president. At least $25 million is unaccounted for, having been collected by an agency controlled by the president but never forwarded to National County.[23] The total extent of insolvency is in the range of 50 to 70 million dollars. Controversy has focussed, though, more on the role of the regulators. According to a study done for the Texas Senate, the insurance board knew about the problems at National County for more than a year before taking action. Allegedly the regulators have procrastinated about taking firm action in many other cases.

More generally, the Texas insurance regulatory system has been criticized for allowing undercapitalized firms into the business, not requiring audits of their books, and not yielding quick action when problems are found. The legislature instituted some reforms in 1987 (such as an increase in minimum initial capital from $800 thousand to $2 million), but these have not led to noticeable improvement yet. Indeed, a 62 percent increase in staffing of the insurance board over a two year period may have caused additional problems in the short run. The State Senate investigation alleges "wholesale hiring of unqualified . . . individuals" and "patronage and cronyism."[24]

BALDWIN UNITED

This case differs from the others in that Baldwin operated in the life insurance and annuity field, the economics of which are quite different from property/casualty insurance. The immediate cause of Baldwin's failure was an "uncontrollable" factor — a sharp drop in prevailing interest rates. But it can be argued that the company should not have gotten so exposed to that risk, and that other errors reduced the company's ability to weather the problem.

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[21] Getschow, George and Marj Charlier. Woes Envelope Texas Insurance Industry. *Wall Street Journal*, November 8, 1988. p. A8.

[22] Texas has more locally domiciled companies than almost any other State; its liquidation listing includes some companies domiciled elsewhere; the State handles the liquidation of agencies (while most States don't); etc.

[23] Hayes, Thomas C. Texas Insurance Regulator Quits, Calling System Lax. *New York Times*, January 17, 1989. p. D12.

[24] Quoted in Bradford, Michael. Report Assails Texas Regulators. *Business Insurance*, January 23, 1989. p. 1, 38.

D.H. Baldwin had been a piano manufacturer for over a century when it started building a diversified financial services operation in the 1970s. Rapid growth of its life insurance subsidiaries was fueled by sales of a relatively new product, the single premium deferred annuity, which offered clients a high rate of return with the added advantage of tax deferral. As noted, the company had difficulty meeting its commitments on the investment contracts when market rates of interest started falling in 1982. But there were several other problem areas, among them: (a) too rapid growth of annuity sales, spurred by overzealous (and allegedly fraudulent) brokers, which strained the company's capital base, (b) similarly over-ambitious corporate acquisitions, and (c) transactions with other subsidiaries in the holding company structure, in effect "funneling the premium dollars up to the parent" so that "the security of the policyholder was actually dependent on the strength of the parent holding company" – which was not directly regulated.[25]

After Baldwin was closed down in 1983, holders of 165,000 annuities with a face value of $3.4 billion were unable to withdraw their investment until a work-out plan was implemented in 1987; in the meantime the "crediting rate" of interest was reduced from 13.5 percent to 7.5 percent. The policyholders' loss thus consisted of a four year period of frozen assets and reduced interest. As of November 1, 1987 their Baldwin policy was converted into a deferred annuity policy from Metropolitan Life (which could be cashed out immediately if the policyholder desired).

The regulatory response to Baldwin's problems showed both strengths and weaknesses. It was actually the Arkansas regulators who precipitated the beginning of the end (a liquidity crisis in March 1983) by insisting on infusions of additional capital into Baldwin's annuity-selling subsidiaries. Their examination of the 1981 annual statement revealed that the insurance units had invested considerable sums in other Baldwin operations and that the value of the securities obtained was greatly overstated. Unfortunately, by the time the examination was completed, the holding company was so overextended that, in the words of the regulators, "the only assets that can be contributed as a [capital] subsidy are affiliated securities," i.e. more questionable paper.[26] In short, the regulators correctly identified a serious financial shortcoming and required a correction, but these actions came too late to prevent the company's failure.

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[25] Dunne, John R. Insurers and Holding Company Legislation: Public Trust vs. the Bottom Line. In Mackin, Robert, ed. *Insurance Legislative Fact Book and Almanac*. Brookfield, WI: Conference of Insurance Legislators, 1985. p. 50-51.

[26] Ingrassia, Paul and Daniel Hertzberg. How Baldwin-United Expanded from Pianos to Finance to Trouble. *Wall Street Journal*, March 28, 1983. p. 1, 10.

After the collapse, the "work out" process also manifested strengths and weaknesses. At their regular quarterly meeting in late March 1983 the NAIC decided to coordinate State efforts through the organization's Examination Oversight Task Force. Over the next year, behind-the-scenes negotiations by a host of public and private interests yielded the restoration plan. A key feature was the "voluntary" contribution of $200+ million by numerous life insurers and stock brokers. This was an alternative to (a) assessment of insurers under the guaranty plans and (b) litigation of suits against brokers who had allegedly sold the annuities without being properly licensed. The work-out process exhibited flexibility and cooperation by all concerned and eventually restored to the investors their funds. Yet it also showed that the *formal* process had to be bypassed because it was narrow, slow and fragmented.

COMMON THREADS

Several common threads can be seen running through these cases:

- Fraud, especially where there are financial ties among brokers, reinsurers and managing general agents.[27]

- Uncollectible reinsurance, caused by inability or unwillingness of the reinsurer to pay. Sometimes unwillingness stems from alleged fraud by the primary insurer; these disputes can take a long time to resolve.

- Bad business judgment, particularly under-pricing (over-promising in the case of investment products) and too rapid expansion or diversification.

- By implication from all of the above, inadequate State regulation.[28]

EMERGING SOURCES OF INSTABILITY

The available accounting data, as well as the case studies just reviewed, record what has already transpired, whereas solvency regulation is concerned with stability in the future. In part, financial statements do make use of

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[27] In response to these problems, the NAIC is developing a model act for the oversight of MGA's by insurers and regulators. Mulcahy, Colleen. NAIC to Discuss MGA Act. *National Underwriter* (P/C ed.), June 5, 1989. p. 3, 12.

[28] Recently the NAIC has started a program to define minimum standards of practice for State regulators with regard to solvency regulation. See Fletcher, Meg. Standards Set for State Insurance Departments. *Business Insurance*, June 19, 1989. p. 3, 27.

actuarial or judgmental methods to project future results, but the numbers are still subject to great uncertainty. As the focus of this report is solvency (rather than, say, profitability) this section describes emerging trends in the insurance industry that may cause results *more adverse* than suggested by the accounting-based data.

REINSURANCE RECOVERABLES

As noted in the discussion of P/C industry aggregate data, reported claim reserves assume substantial recoveries from reinsurance. This complicates the assessment of companies' balance sheets because they are so dependent on the condition of other companies — the reinsurers. Moreover, reinsurers themselves reinsure with others ("retrocessionaires"), and so forth through several tiers of coverage. In the normal case, this practice gives the industry greater capacity and stability because large losses are spread widely. But if an upstream reinsurer fails, this could cause cascading failures all the way back to the policyholders.[29] This is rare, but the consequences are potentially serious enough to warrant close attention to reinsurer reliability.

Unfortunately, reinsurer financial condition is not as accurately monitored as that of primary insurers, for several reasons:

- Much of the capacity is supplied from offshore by carriers who are not subject to State examination or enforcement (though special security measures such as letters of credit are usually required).

- Although the domestically licensed reinsurers are regularly examined, their business is arcane and their liabilities particularly hard to assess, since they tend to cover low probability, high consequence events, and with long reporting delays.

- Reinsurers are directly linked to the retrocession chain, the other end of which is often unknown even to them — until large claims are processed.

Despite the absence of conclusive figures (due to the above factors), there persists a widespread feeling in the P/C industry that recorded reinsurance recoverables are unduly optimistic, that the amounts eventually collected will fall short of the projections. Of particular concern are various liability coverages written in the early 1980s. As we move into the period of final resolution of the large, complex cases, it is feared that a wave of "cheap reinsurance" available ten years earlier will be shown to be no bargain. Estimates are sketchy; one prominent analyst guesstimates that one sixth of

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[29] Note, however, that an insurer's obligation to the policyholder is not excused by its reinsurers' inability or unwillingness to meet their obligations. Thus, upstream failures are not necessarily transmitted back down the chain.

reported recoverables will need to be written off, reducing the industry's net worth by 10 percent.[30]

EXPLOSIVE CLAIMS AREAS

Insurers are already paying substantial awards to large numbers of claimants for liabilities that were generally considered to be isolated and remote possibilities when the policies were written 30, 40 or more years ago. Asbestos is probably the most prominent example, but there are other "mass tort" situations that cause at least as much concern in the insurance industry. For example, courts have ruled that general liability policies can apply to seepage later occurring from a municipality's intentionally disposing of contaminants in a landfill, even though the policy specifically covers only "sudden and accidental" discharges.[31] Recent policy forms have been crafted to narrow or better define coverages or to enable insurers to more accurately estimate their costs (for example, by covering only claims made during the current year, rather than for retroactive occurrences). But there is still a large overhang of claims expected from coverages written, priced and reserved long before current judicial trends emerged. The cost of cleaning up toxic waste sites has been variously estimated at $150 billion to $700 billion.[32] If only a fraction of this is borne by insurers, the industry's capital base could be seriously impaired.

Another claims area that may not be adequately reserved against is natural disasters, particularly earthquakes and hurricanes. America's relatively benign experience in the last two decades may be inducing many – including insurance executives – to underestimate the possibility of a recurrence of earlier patterns. If Hurricane Betsy (1965) were to occur today,

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[30] Picoult, Myron. Recoverables Threaten Insurers. *Business Insurance*, July 25, 1988. p. 34-35.

[31] *Jackson Township Municipal Utilities Authority v. Hartford Accident and Indemnity*, cited in Levit, Victor B. Pollution, Clean-up Costs and Insurance Exposure. *Chartered Property and Casualty Underwriters Journal*, v. 40, June 1987. p. 99-100

[32] U.S. Library of Congress. Congressional Research Service. *Environmental Impairment Liability Insurance: Overview of Availability Issues*, by Rawle O. King. [Washington] 1989. p. 14 (CRS Report No. 89-269 E)

it would cause nearly $6 billion in insured losses.[33] Moreover, multiple storms could strike the mainland within one or two years.

Earthquakes can be even more destructive, with estimates of maximum losses on the order of $50 billion.[34] What insurers have only recently come to recognize is that only a fraction of the payments would come from explicit earthquake policies or riders. Probably three quarters of the losses would be paid on fire insurance policies, which do not exclude earthquake-induced fires. Many other coverages would be involved. For example, anyone injured at work would be eligible for workers compensation. And major earthquakes can occur in areas whose seismic dangers are not widely appreciated, such as the New Madrid fault in the region between Memphis and St. Louis. Many companies (and their regulators) may not fully understand the extent of their exposure and, even where they do, Federal tax law does not allow full deductibility of multi-year reserves.[35]

Life insurance is usually more predictable than property and liability, but the AIDS epidemic may change that in the coming decade. The most severe epidemic to strike the U.S. since the "Spanish" influenza of 1918, AIDS is estimated to have already infected from 1.0 to 1.5 million Americans. If past experience continues, the majority of them will die within 10 years of infection.[36] Such a mortality rate is radically higher than normal for young adults (which is where most cases occur). For life insurers, the consequences could be severe: It has been estimated that AIDS claims in the next decade could come to $50 billion just among clients *already on the books*.[37] Even if insurers are allowed to screen new cases by medical testing (unlimited use of which most states probably will not allow), long latency and spreading infection may well mean further losses on new policyholders.

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[33] Carpenter, C.A. Hurricane Losses Stir Debate. *Journal of Commerce*, December 30, 1986. p. 12A. According to the same study (by the All-Industry Research Advisory Council), foreign reinsurers would be responsible for 42 percent of the payments.

[34] Hofmann, Mark A. Federal Catastrophe Plan Needed. *Business Insurance*, October 24, 1988. p. 14-15.

[35] Haggerty, Alfred. Long-term California Quake Cover Outlined. *National Underwriter* (P/C ed.), June 5, 1989. p. 6, 52.

[36] Cowell, Michael and Walter Hoskins. *AIDS, HIV Mortality and Life Insurance*. Chicago: Society of Actuaries, 1987.

[37] ibid. In addition, the lifetime cost of medical treatment per AIDS case is on the order of $75,000, with private health insurance paying on average about half.

The losses contemplated here could eliminate a large fraction of the L/H industry's capital and endanger the existence of many firms. Fortunately, some maneuvering room has been built into the system. Reserves are calculated on a conservative basis, allowing for adverse experience in mortality without dipping into capital. Also, many life policies are sold on a "participating" basis, meaning that dividends (rebates) are paid to the policyholders each year depending on experience. Such dividends came to $10 billion in 1987, equivalent to about half as much as total paid death benefits. Dividends on older policies could be reduced or eliminated (besides raising premiums on new policies) if mortality were to deteriorate significantly.

INNOVATIVE METHODS AND COVERAGES

Contrary to conventional wisdom, the insurance industry does not run completely on the basis of routine. Continual innovation in products and methods has brought a stream of new services in recent years. While this has broadened the insurance purchaser's choices in many ways, it has also introduced instabilities. Pricing may be more volatile and regulation may not keep up with the pace of innovation, so that solvency may be less assured.

One of the most commonly remarked changes in insurance practice is "cash flow underwriting," which means a discounting of premium rates in the expectation of making up the difference through investment income. Traditionally, companies priced their services so as to earn a profit of 5 percent or so on underwriting, i.e. the core insurance activities. But with the coming of an era of high interest rates (1979 onward), competition to acquire investable funds has made 5 percent *losses* more like the achievable standard. Companies are counting on investment income to reach a positive bottom line.

There is nothing intrinsically unreasonable or unsustainable about cash flow underwriting, and the practice has moderated as interest rates eased. It should be realized, though, that with the more flexible pricing systems allowed now by many States, the combined result is lower net profits for the industry on average, and profits could be viewed as a margin for error. Moreover, the companies now must manage a substantial new source of uncertainty, the future course of interest rates. The uncertainty might be neutralized by carefully matching asset maturities to the expected timing of liabilities (claims), but claim timing is inherently not totally predictable. Alternatively, companies could hedge interest risk with "synthetic" investments such as futures and options, but this would lead into other practical and regulatory questions. In effect, at this point the industry seems to have taken on a new type of risk without offsetting protections or compensation.

Another changing mode of operation is the trend among commercial clients toward self-insurance. That is, businesses are retaining more of their own risks and buying insurance only to cover catastrophic losses. The trend accelerated during the "hard market" of the mid-1980s and also since passage of the Risk Retention Act amendments of 1986. This law simplifies

procedures under which businesses in an industry or profession can act as a group to purchase insurance or form their own insurance company. Although the market has softened in the last couple of years, making coverage more readily available, commercial clients are continuing to make greater use of alternative market mechanisms such as risk retention groups. It is expected that these could take as much as one-third of the potential market by 1992.[38]

The move toward alternatives may lead to instabilities of at least two kinds. First, the traditional companies are losing the predictable "working layer" of coverages and will probably have more volatile experience as they are forced to specialize more on the upper limits of potential losses. Second, the wider opportunity to form risk retention or purchasing groups was achieved by partially preempting state regulations. Many State commissioners and others active in the insurance field believe that important regulatory protections have thus been lost.[39]

Finally, financial guarantee insurance might be mentioned as exemplifying the new areas challenging regulators. This is insurance that promises creditors the timely performance of financial obligations, such as mortgages or municipal bonds. In form it resembles surety bonding, but economically it is more like title insurance because only negligible losses are expected. The premium goes primarily to do the research enabling the insurer to exclude cases that have any significant probability of loss.

The theory that risk is being identified and excluded rather than transferred and absorbed is *usually* valid in this field. But in the process the insurers become potentially liable for enormous sums, so even seemingly remote chances of loss might prudently require holding of significant reserves. And unlike title insurance, the probabilities of loss are neither fixed nor statistically independent. If macroeconomic variables deteriorate significantly, widespread losses could materialize. As cautiously concluded by the Best organization, in view of the "different methods of underwriting and actuarial technique, some regulators feel [financial guarantee] cannot be dealt with in the same manner as traditional lines of insurance."[40]

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[38] Kuffel, Frances. RRG's, Premium Volumes Growing. *Journal of Commerce*, March 21, 1989. p. 13A.

[39] Fletcher, Meg. Regulators Fear Insolvency of Purchasing Group Insurers. *Business Insurance*, October 31, 1988. p. 90-92.

[40] 1986 Financial Guarantee Insurance. *Best's Insurance Management Reports*. P/C release no. 12, June 22, 1987. The main regulatory action taken has been to require these insurers to be incorporated as specialist companies that are financially separated from other lines, essentially as a "firewall" between them and other policyholders.

OVERALL ASSESSMENT

The insurance industry has had an excellent record in that insolvencies have been rare and, in the cases that have occurred, regulators and guaranty funds have usually prevented loss to the policyholders. Moreover, the financial data do not indicate any industry-wide impairment of condition. This achievement is apparently attributable to the "culture" of the industry, which has long placed emphasis on financial conservatism. This attitude is partially embodied in regulations, e.g. the statutory accounting system, which is more conservative on most points than general business accounting, but mostly conservatism is traditional.

Although traditionalism has worked well as a safeguard through most of this century, forces weakening it have been at work more recently. High inflation and interest rates in the last decade have forced insurers in both the L/H and P/C lines to be more flexible in pricing. Combined with looser regulation of premium rates in many states, this has meant bigger swings in profitability over the course of the insurance business cycle. Meanwhile, deregulation of other financial institutions has given life insurers more vigorous competition, prompting new types of contracts and new modes of marketing them. Where established companies did not respond to these forces, new companies (or buyer groups) formed, dedicated to exploiting the new opportunities and giving consumers new choices. But the retreat from self-restraint may lead to solvency problems farther down the road.

Where inhibitions have dissolved, prohibitions may be called for. Presumably this would come in the form of closer surveillance and discipline by the State regulators. However, the resources devoted to insurance regulation have actually been declining as a percentage of industry revenue.

It must be emphasized that there are no signs of imminent crisis for this industry. Solvency, especially with insurance, is a long-term matter. Liquidity – the ability to promptly meet current cash claims – is more than adequate for the great majority of companies. And in contrast to deposit-taking institutions, public confidence is not the constant *sine qua non*: policyholders (at least in the P/C segment) cannot "run" because they have to experience the loss specified in the contract before collecting benefits.

But if solvency crises do not occur overnight, neither are they averted by quick fixes. Meeting the challenges mentioned in this report may require changes of attitude and finances in many companies and, most importantly, State insurance departments. These will take time, money, and political leadership to implement. Unfortunately, these will be difficult to marshall as long as insolvency is only a negative number on a balance sheet with tangible consequences somewhere in the future.

JUNK BONDS
THE CLEANUP BEGINS
PAGE 3

▶MARVIN DAVIS AND UAL ▶MONSANTO ▶RENAULT

BusinessWeek

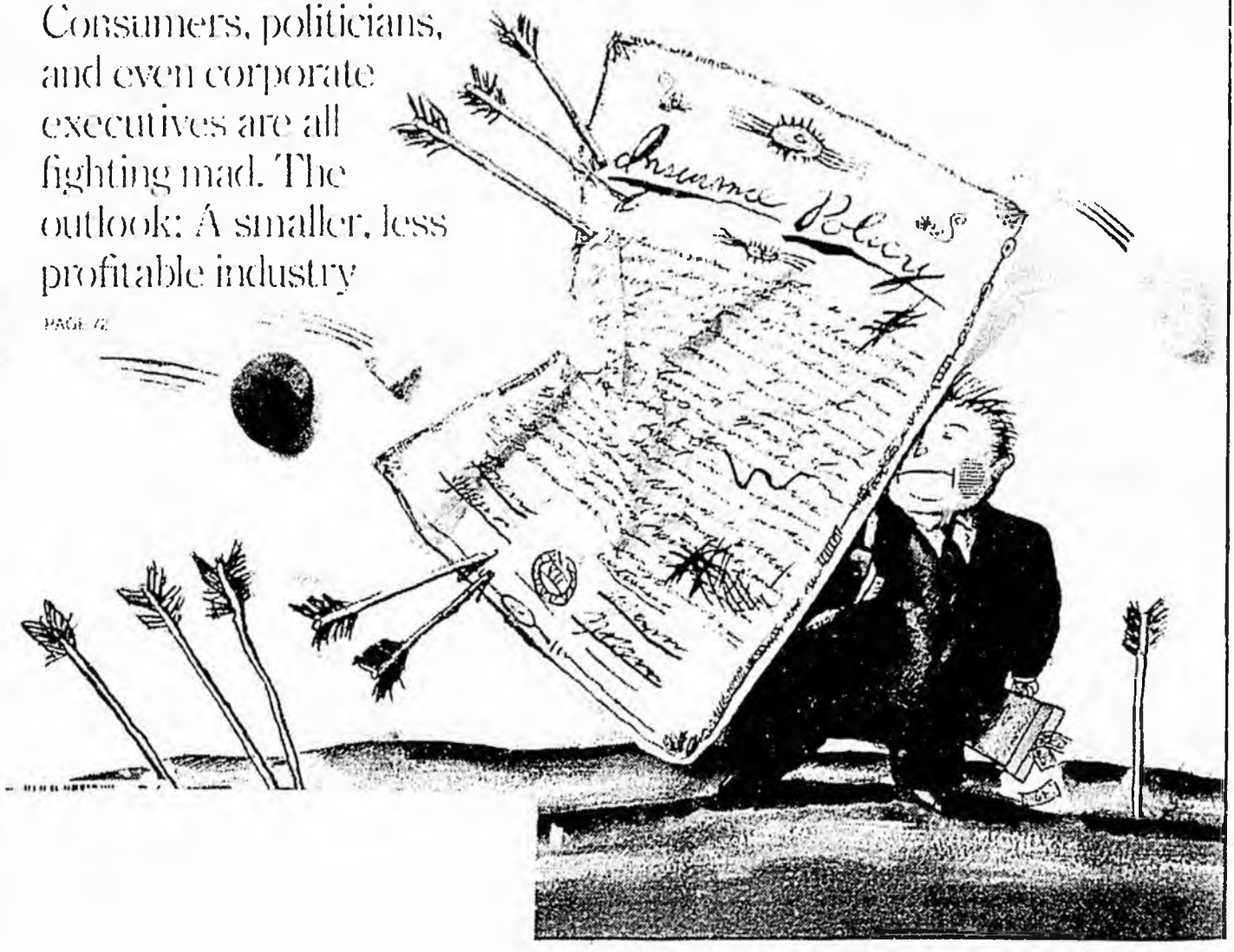
AUGUST 21, 1989 A McGRAW-HILL PUBLICATION $2.00

INSURANCE

AN INDUSTRY UNDER SIEGE

Consumers, politicians, and even corporate executives are all fighting mad. The outlook: A smaller, less profitable industry

PAGE 72



INSURERS UNDER SIEGE

LAWMAKERS, CONSUMERS, AND CORPORATE CUSTOMERS ARE FIGHTING MAD

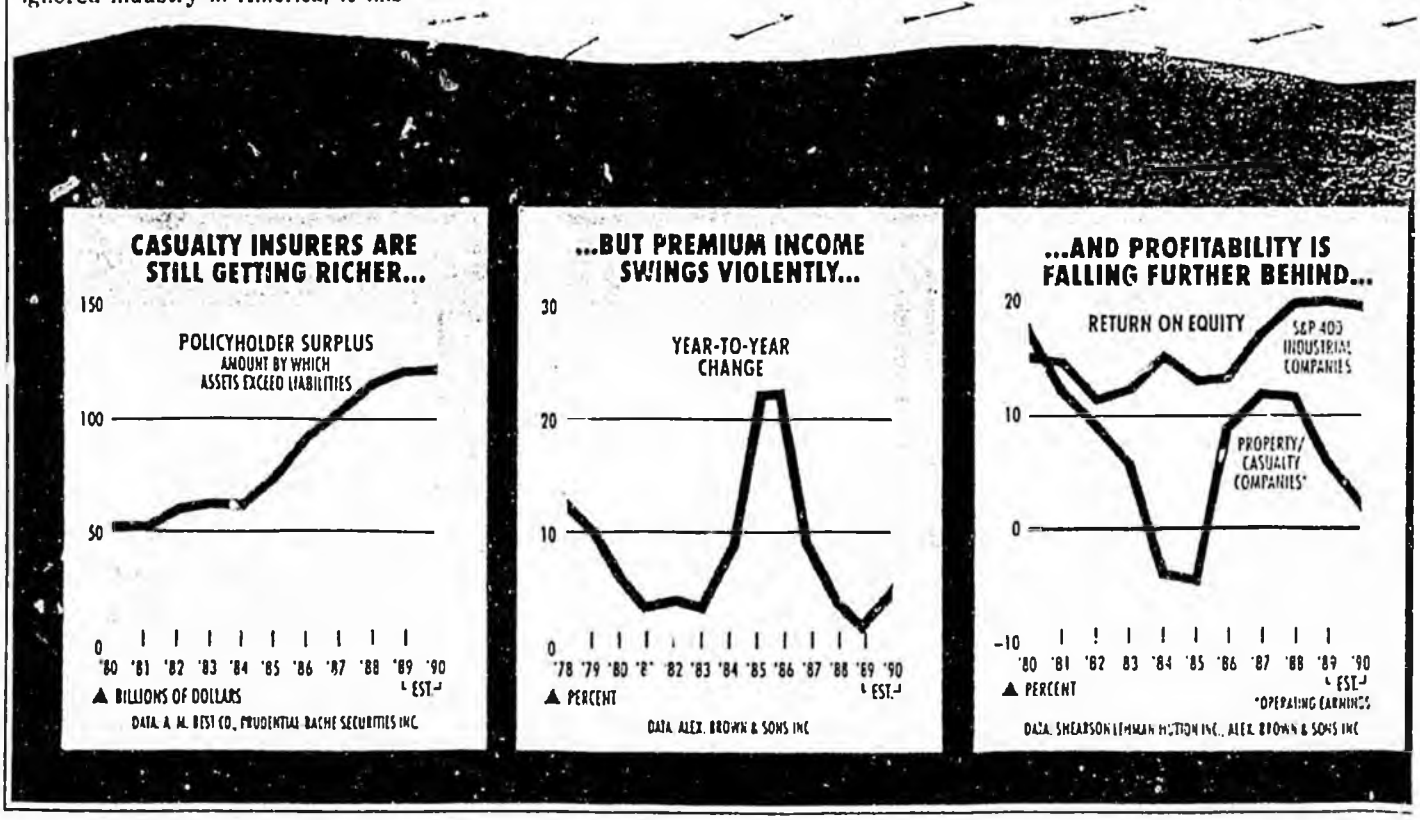
Obscure. Abstruse. Boring.

For years, that was the image most people had of the insurance industry, a remote monolith shrouded by a cloud of mystery. Everybody bought insurance, but few buyers gave much thought to those who produced it. The insurance business, as a result, operated free from public scrutiny. Exempt from federal regulation, including most antitrust laws, and subject only to feckless state regulation, the industry was a "private government," as Wyoming Senator Joseph C. O'Mahoney put it in 1945. As a legal cartel, it reaped bountiful profits and came to control enormous assets, now more than $1.8 trillion. Its premium income is 9% of the GNP. Few industries have ever enjoyed such unchecked political and economic power.

Now, the once-tranquil world of insurance is in turmoil. Instead of the most ignored industry in America, it has become perhaps the most reviled. Consumers, corporate executives, and lawmakers are lambasting insurers for everything from profiteering to an unseemly attitude of arrogance and insensitivity. "We're being besieged. It's a holocaust that's going on," complains Robert E. Vagley, president of the American Insurance Assn., the most prominent commercial-insurance trade group. Adds Chief Executive John J. Byrne of Fireman's Fund Insurance Co.: "We're at the bottom of everyone's list. Our name is mud."

'LONG DECLINE.' A muddy image is only the most obvious sign of a far-reaching deterioration in the industry's well-being. Everywhere they look today, insurance executives see their power eroding, their markets contracting, and their profits evaporating. "They're in a state of panic," says J. Robert Hunter, president of the National Insurance Consumer Organization and the industry's best-known critic. Consumers and other insurance buyers are benefiting from these developments, which are producing better insurance services at more competitive prices. The insurance industry, however, may end up losing its status as the chief provider of these services. It is threatened, says consultant Orin S. Kramer, "by a period of long-term decline"—a reversal of fortunes that would be among the most dramatic for a major industry in American business history.

Insurers are suffering from many forces beyond their control, notably surging liability damages that have beset property/casualty companies and high interest rates that have squeezed life insur-



ers. Yet, says Washington attorney T. Lawrence Jones, Vagley's predecessor at the ATA, "they've created a lot of their own problems."

Insurance executives have long been known for their obstinate resistance to change and new ideas—a not surprising shortcoming for individuals used to the stability of cartel life and whose business is predicting the future by extrapolating from the past. "They're the nicest, most honorable people in business," says Jones. "But they're not the most imaginative or creative."

They are, though, working on strategies to clean up their image and befriend their antagonists. "The industry's instinct is to say no, do nothing," says Vagley. "We're trying to develop affirmative responses." But the outlook is not propitious, for the industry faces many noxious changes:

■ Its customers are rebelling. The revolt by California consumers against soaring automobile-insurance rates last year culminated in voter approval of Proposition 103, whose sweeping reforms include a 20% rollback in auto and other insurance rates. The fever is spreading. As many as 10 similar voter initiatives are possible in 1990, and 300 insurance-reform bills have been introduced in dozens of state legislatures. Corporations are bypassing insurers in favor of do-it-yourself approaches, which are siphoning off a third of the property/casualty industry's premiums. "We have largely ignored and mistreated our customers," concedes Leslie Cheek III, head of Crum & Forster Insurance Cos.' Washington office.

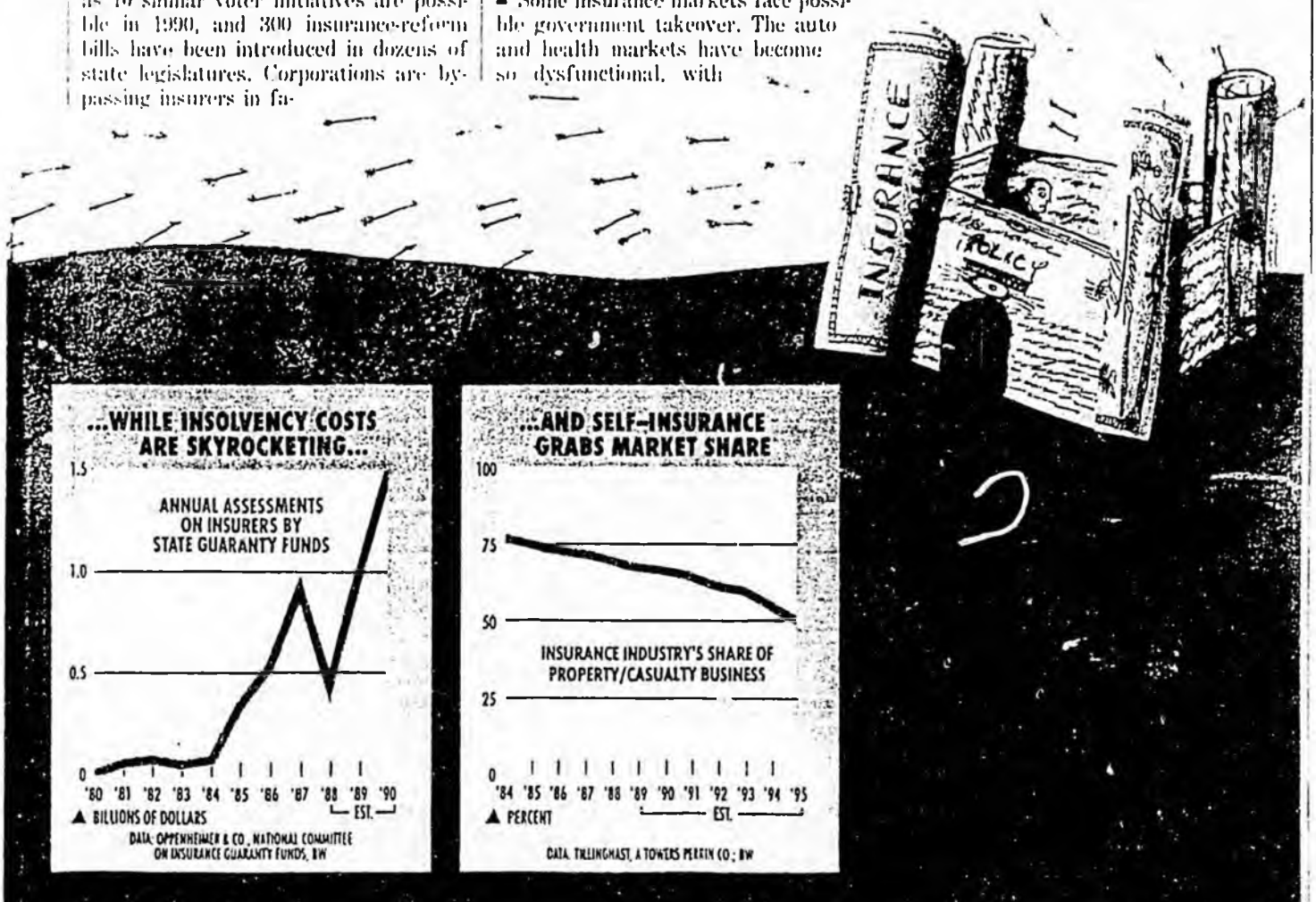
■ The industry's political clout is crumbling. State legislators and insurance commissioners, once comfortably in the industry's pocket, are now more independent, even adversarial. In Washington, the industry has suffered some embarrassing legislative defeats. "They're losing control of their destiny," says Bruce A. Bunner, a partner at accounting firm KPMG Peat Marwick and former California insurance commissioner.

> As markets shrink and profits evaporate, the industry seems headed for a fierce shakeout

■ Some insurance markets face possible government takeover. The auto and health markets have become so dysfunctional, with millions of people unable to get affordable coverage, that these markets may be increasingly assumed by state and federal insurance mechanisms. Insurance consultant Barbara J. Lautzenheiser sees "a real tendency toward socialization of all insurance."

■ The cartel is dying. Competition has become vicious. "Soft" markets, when insurers often lose money underpricing each other, are more protracted, while "hard" markets, when companies can raise prices and rebuild balance sheets, are briefer. Critics are seeking to abolish insurers' antitrust immunity, which could make competition even worse.

■ Insurers' financial health is deteriorating. "There will almost certainly be a major shakeout, major insolvencies, and financial dislocations," says Robert H. Moore, senior vice-president of Alexander & Alexander Services Inc., a large insurance broker. Morgan Stanley & Co. analyst Norman L. Rosenthal foresees "a fundamental downsizing of the property/casualty industry." Life insurers also face shrinkage. While they have mostly escaped serious image-tarnishing, their profits are also under



severe, perhaps irreversible, pressure.

The proximate cause of the property/casualty industry's traumas was the widely publicized liability-coverage crisis of 1984-86. After a six-year price war, insurers hiked some premiums severalfold. They refused to write or renew other coverage, which closed down facilities from jails to day-care centers. They blamed excessive liability litigation. But mainly, they had simply panicked, in typical herd-like fashion, when their profits sunk to new lows. Their actions set off a fierce public backlash—"retribution beyond the industry's wildest imaginings," according to Check.

JOLTING BLOW. Yet the roots of the industry's traumas extend back much further, to attitudes engendered by the insurance cartel, organized during the 1800s by fire insurers, forerunners of today's property/casualty companies. The temptation to slash prices has always been intense in insurance markets because insurance is sold primarily on price. To protect profits, insurers erected mechanisms to fix prices, standardize products, and share information.

In 1944, the cartel suffered a jolt—the Supreme Court held the industry subject to federal antitrust laws. But the industry flexed its political muscle and won passage in 1945 of the McCarran-Ferguson Act, which exempted it from antitrust laws so long as it was regulated by the states. McCarran left intact the cartel's price-fixing mechanism, a group of industry-controlled rating bureaus, most of which were consolidated in 1971 into the Insurance Services Office. The ISO issued "advisory" rates that were high enough to protect even the most inefficient concerns from insolvency.

The cartel began unraveling in the 1950s. Auto and homeowners insurance came to be dominated by large "direct writers" such as State Farm Mutual Automobile Insurance Co., with in-house sales forces. They underpriced other insurers that sold policies through vast networks of high-commission independent agents. The agency writers were forced to discount ISO rates.

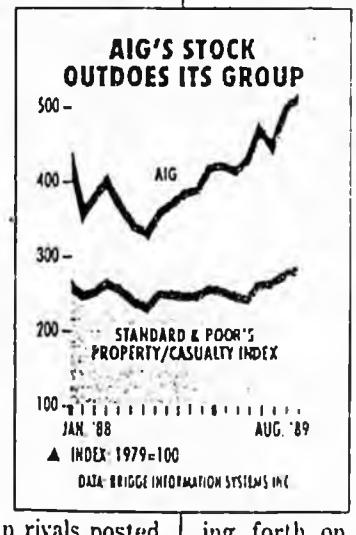
Commercial insurers followed ISO until the 1970s, when supply and demand became badly imbalanced. On the supply side, the cartel, like all cartels, had chronic excess capacity and excess cartel membership. Returns on equity of around 25% a year started enticing billions of dollars of new underwriting capacity, especially from the booming London market, where insurers lay off some of their risk with reinsurers.

Demand growth, meanwhile, was already slowing. Increasingly sophisticated corporate risk managers began insuring themselves. Companies, industry groups, even municipalities and nonprofits set up alternative facilities such as their own "captive" insurers. According to the Tillinghast division of Towers, Perrin, Forster & Crosby, a consulting firm, the alternative market now has a 35% market share, depriving insurers of $50 billion in annual premiums. By 1995, Tillinghast projects, the alternative share could reach 50%.

Insurers could not have forestalled the alternative market. But they are to blame for its rapid growth. In hard mar-

AIG THRIVES ON BUSINESS OTHER COMPANIES WON'T TOUCH

Shanghai's teeming port drew many a dreamer and adventurer at the century's turn. One enterprising American, 27-year-old Cornelius Vander Starr, founded an insurance company in a two-room office in 1919. Only in 1926, by which time he had offices throughout the Far East, did Starr open a New York branch. That's a circuitous origin for what evolved into American International Group Inc., the largest shareholder-owned commercial insurance company in America. But then again, AIG is unlike any other U.S. insurer.



'GENIUS.' While most ignore overseas markets, AIG operates in more than 130 countries. As many American rivals posted anemic returns, AIG earned an average return-on-equity of 18% this past decade by cannily exploiting less popular markets and keeping a tight check on costs. While its rivals mostly sell commodity products, AIG excels in exotic niche markets—all for a pretty penny.

The company's success clearly bears the stamp of Maurice R. "Hank" Greenberg, its tough, combative chairman, president, and CEO. A trim, fit New Yorker of legendary discipline, he took the helm from Starr in 1968, when AIG's net income was $17.2 million. Its stock market value the following year, after going public, was some $285 million. In 1988, AIG earned $1.2 billion, and the company's market value is now $15.5 billion. Says New York State Insurance Superintendent James P. Corcoran: "The guy's a genius."

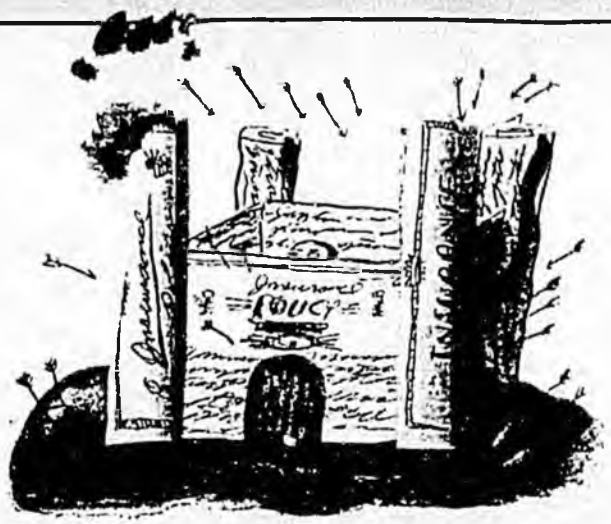
As with Michael R. Milken on junk bonds, when the 63-year-old Greenberg talks insurance, people listen—if uncomfortably. Charming and wryly humorous, Greenberg can turn acerbic when holding forth on common industry practices, such as lax underwriting standards. Indeed, says an insurance broker, he's "widely loathed" by his peers, regarded as a brilliant loner who refuses to join major industry trade groups or schmooze with competitors. Greenberg, often trotting the globe, runs an entrepreneurial, high-stress workplace. For executives who can hack it, the reward is a slice of management's 31% stake in AIG, with Greenberg alone owning or controlling stock worth $670 million. Says T. Lawrence Jones, former head of the American Insurance Assn.: "Greenberg is the only man to make an absolute fortune in insurance over the last 20 years."

He did it by taking risks others shun. Although AIG sells a broad range of insurance products, "we look for markets without a lot of competition," says Thomas R. Tizzio, vice-chairman of AIG's North American property/casualty business.

ONLY GAME IN TOWN. Among its specialty products are liability insurance for directors and officers, coverage it's flogging in Europe as deal mania sweeps the Continent, and for professionals, mostly lawyers and accountants. AIG's trademark is seizing opportunities, says Jones, recalling that during the difficult market of the late 1970s, AIG's directors and officers policy was the only one the trade group could buy. Currently, the company is among a handful selling tailor-made pollution liability policies.

For its multinational clients, AIG often underwrites worldwide coverage. Unlike other U.S. insurers, it has eagerly provided services and backup coverage to the offshore "captive" insurers since the movement's early

kets, they acted as if buyers had nowhere else to go, jacking up prices and walking away from lines that seemed unattractive. "Their heavy-handedness really turned off a lot of their clients," says Richard C. Heydinger, risk manager for Hallmark Cards Inc. Now, hundreds of major companies and large portions of industries such as pharmaceuticals and chemicals are self-insured. After the industry all but abandoned the medical-malpractice market in the 1970s, doctors and hospitals set up their own insurance vehicles. Insurers have made little headway trying to regain market share. ISO President Fred R. Marcon concedes that most of the business lost is "gone forever."



Insurers for years ignored the alternative market, refusing, for instance, to deal with captives. Insurance brokers, though, created a lucrative business by helping to set up and manage captives. Insurers' belated efforts to offer services to captives have not been very successful. "They could have been the leaders," says Charles L. Ruoff, head of strategic planning at Fred S. James & Co., a large insurance broker. "But by the time they got interested, the ship had left the dock."

The business that insurers are losing to alternative markets tends to be their best business. The reason is a pernicious process known as "adverse selection." Companies with low insurance risks tend to insure themselves, while risk-prone companies tend to buy insurance. And the risks that self-insurers retain tend to be their most predictable, such as workers' compensation. They go outside mainly for high-risk coverage, such as the catastrophic loss of an offshore oil rig. "The insurance industry is being left with a much worse book of business," says consultant Barbara D. Stewart. A few venturesome insurers, notably American International Group Inc. (box), developed the skills to handle new, tough risks, on which they make big profits. Most companies, though, chase the shrinking supply of routine low-risk business, exacerbating overcapacity and competition.

The alternative market and growing overcapacity have made insurance cycles hazardous. Hard and soft markets each used to last about three years. But the soft market that began in the late 1970s was the longest (six years) and deepest in history. And despite the sharp price hikes, the latest hard market was about the shortest (18 months). Aggravating

days. And AIG is comfortable creating markets. For instance, it plowed new ground starting in 1979 by entering joint ventures with East Bloc nations.

In a classic Greenberg move to take advantage of others' ineptitude, AIG is about to expand its minor presence in a troubled Main Street business—auto insurance. It aims to tap the latest marketing and servicing techniques to hold down expenses while reducing claims costs through other innovations—including possibly its own repair shops. "We expect to be a major underwriter of the business in the future," says Greenberg.

Financially, however, AIG is conservative. It tries to earn a buck the old-fashioned way in insurance—through underwriting profits. Its executives are almost cult-like in their insistence that premiums be high enough to reflect a policy's risk. "Expecting investment income to bail you out is a dangerous game," says Vice-Chairman Edward E. Matthews. AIG can also compete hard without lowballing rates since it's a tightwad company. It is a low-cost producer with an expense ratio of about 20%; most competitors have a ratio of around 30%.

GLOBAL ROOTS. The company's global network comes directly out of its foreign origins. AIG shifted headquarters from Shanghai to New York only in 1939. In sharp contrast to its U. S. competition, some 31% of its property/casualty operating profits and 93% of its life insurance operating income were generated overseas in 1988. About 65% of all pretax earnings came from foreign markets during the past 11 years. "We understand doing business globally," says Greenberg. "We feel comfortable in any part of the world."

AIG's foreign operations are a source of stable profits, with income from many less competitive markets, especially in fast-growing Southeast Asia, offsetting the earnings drag from vicious pricing cycles in the U. S. In Japan, AIG is a strong niche player, ranking third in personal accident insurance, for one, and is about to expand there through a new company closely tied to Japan Travel Bureau Inc. In anticipation of Europe 1992, AIG recently restructured its Continental operations by replacing 13 different national companies with a new one, Paris-based UNAT. AIG is expanding into financial services and is already a factor in such markets as international interest-rate swaps and overseas merchant banking.

GREENBERG IN BUENOS AIRES: AT HOME ABROAD

ONE-MAN SHOW. Although it's still able to turn a profit selling life policies in Beirut, some of AIG's foreign adventures do go sour. After years of struggle, AIG finally broke into the South Korean life market, but business is moribund with half its agents out on strike. And while it's still insuring foreign interests in China despite the Great Leap Backward, hopes for expanding into the domestic market of AIG's historic homeland have dimmed for now. Back in the U. S., even AIG's earnings machine will sputter if price-cutting in the commercial market continues. Wall Street is edgy, too, about the lack of an obvious corporate heir to the dominating Greenberg.

Still, Greenberg is confident that AIG is set to make the most of the upheaval he sees racking the property/casualty business these next few years. After all, in China, AIG's birthplace, the word crisis is made up of the characters for danger and opportunity.

By Christopher Farrell in New York, with bureau reports

"IT'S A HOLOCAUST," SAYS VAGLEY OF THE AMERICAN INSURANCE ASSN. "THEY'RE IN A PANIC," SAYS CONSUMER ACTIVIST HUNTER

the severity of recent cycles has been a big shift in the industry's business mix. Once it wrote mainly property coverage, where claims are made soon after an accident. Now it mainly sells liability coverage, where damages are less predictable and often do not surface until years after a policy is written. And while property loss costs have been dropping, liability costs keep rising. Still, with claims costs so far off and uncertain, many insurers feel less inhibited in cutting prices, often recklessly.

Life insurers for years avoided the competitive havoc of their property/casualty brethren. They had something of a cartel of their own. Everyone followed the pricing lead of the large Eastern mutual companies. They grew fat on the wondrous creation known as whole life, with its huge spread between the niggardly yield to policyholders and the lush return on insurers' investments.

Double-digit interest rates in the early 1980s wrecked the business. Customers bought cheap term insurance and defected to high-yield investments offered by banks and mutual funds. Insurers were forced to counter with market-rate products such as universal life. Their spreads are now so wafer-thin that some big players such as Cigna Corp. and Travelers Corp. are sharply reducing their life business.

COALITION FOR CHANGE. The already badly tattered property/casualty cartel, meanwhile, faces further damage. Last year, 19 states filed suits alleging that 32 insurance defendants conspired, starting in 1983, to restrict the availability of commercial-liability coverage, mainly by altering the terms of the industry's most widely used policy. The suits say the defendants used acts of "boycott, coercion" and "[illegible]," which are excluded [illegible]arran-Ferguson Act [illegible]ity. The alleged [illegible] of the price war by limiting [illegible]cording to the states, this was [illegible]portant contributing factor" to [illegible]ability crisis.

A federal judge recently said he intends to dismiss the litigation on the grounds that the defendants' actions were immune from prosecution under McCarran. Such a ruling, which will be appealed by the states, would likely intensify the already broad political assault being mounted against McCarran.

> National health insurance has always been a political long shot. But corporate backing could change that

Congress is considering several bills that, while allowing some joint activities, would sharply modify the act. To industry critics, McCarran symbolizes the industry's privileged status.

Consumerists, many of whom consider insurance reform their top priority, have put together a formidable coalition that includes groups representing women, minorities, labor, senior citizens, and small business. They have even enlisted the influential American Bar Assn., many of whose members resent being blamed by insurers for causing the liability crisis.

Once, such a coalition would have been no match for the insurance lobby. But now, says a Capitol Hill staffer, the insurers "don't have anybody on their side." State insurance commissioners and legislators are distancing themselves from the mud-splattered industry. Insurance brokers, once close to insurance executives, are now loyal to corporate risk managers.

WANING POWER. Insurers' most powerful allies have been the 150,000 independent insurance agents who, says a lobbyist, are "the industry's shock troops." Aided by fat eye budgets, they have intimate political connections at the state and federal level. Officially the agents back McCarran. However, says Dennis Jay, a spokesman for the National Association of Professional Insurance Agents, "we're no longer following with blind faith what the big carriers want."

Signs of the industry's waning political power are abundant. In what the AIA's Vagley calls "a major defeat," the industry failed to derail the 1986 Liability Risk Retention Act, which made it much easier for businesses to self-insure. Vagley has been quietly exploring a compromise on McCarran. "A number of our members feel its benefits are outweighed by the political mischief it creates," he says. The ISO, meanwhile, recently announced that next year it will stop issuing advisory rates and instead estimate future losses and related costs. Insurers will then have to factor in their own projections of profits and overhead. While critics claim that ISO figures will still facilitate price-fixing, the move is likely to heighten rate competition.

Some of the industry's most important markets face an even more serious threat: government takeover. The reason

is a big shift in society's view of certain kinds of insurance. Affordable auto and health insurance is now seen less as a voluntary option than as a necessity, even an entitlement. Insurers, though, don't want to sell affordable insurance to everyone. They deliberately discriminate. They charge people thought to be good risks relatively low rates. Bad risks, who are often poor, are charged high premiums, regardless of whether they can afford it, and they may be denied coverage altogether. The result: millions of Americans with little if any insurance.

James M. Stone, former Massachusetts insurance commissioner who now runs a small auto insurer, says the insurance industry "should have taken the initiative" and worked with the government to develop a mix of public and private mechanisms "to make sure its products were available and affordable to all." Instead, the industry ignored the problem. It paid little heed to loss prevention, and simply passed costs to customers. Now, the auto and health markets are in such disarray that demands are growing for government insurance covering everyone.

In auto insurance, which produces 42% of the property/casualty industry's volume, the impetus for socialized insurance stems from relentlessly rising claims costs and public pressure on state regulators to keep premiums low. Plagued by losses, some insurers are leaving the auto business. Others are turning down more bad risks. In large urban states with the highest costs and premiums, notably New Jersey and Massachusetts, drivers who can't afford or get insurance are relegated to "residual" markets of last resort subsidized by insurers and states. New Jersey's state-run residual market has half the state's autos and a $3 billion deficit.

Auto insurers are now pushing such measures as broader no-fault laws and cheap no-frills policies. But some observers feel these solutions do not go far enough. "If this situation continues," says Crum & Forster's Cheek, "I don't see any alternative to a government takeover." As states have to foot more of the bill for the bad risks, observers feel, some will want to insure all motorists. With monopoly power, they could control costs and subsidize poor risks with premiums from good ones. States that don't socialize will still likely continue to subject insurers to low-return, utility-type regulation.

The outlook for health insurers is also grim. Their market is already a patchwork of public and private systems. In theory, it makes sense: private insurers, mainly life companies, who get a third of their premiums from health, serve the good risks who can afford to pay. Through medicare and medicaid, the government subsidizes coverage for the old and poor. Nonprofit Blue Cross/Blue Shield helps the government by selling coverage to all comers.

MINIMUM STANDARDS. But this arrangement is breaking down. Government programs have become more restrictive and cover a declining portion of the needy. And the loss-plagued Blues are targeting better risks. This is raising the num-

VERMONT: LAND OF GREEN MOUNTAINS AND SELF-INSURANCE

Montpelier, Vt., with its gold-domed capitol and tall-spired churches, makes an unlikely headquarters for 163 "captive" insurers. These are paper vehicles created by corporations, industry groups, and nonprofits that have opted to finance their own risks. Instead of sending claims to an outside insurer, companies with Vermont captives route them here, usually to specialized claims-processing companies. No fuss, no muss, and no surprise premium hikes.

No fly-by-nighters either. Among the corporations with Vermont captives are AT&T, Hewlett-Packard, and Citicorp. Montpelier also hosts the largest number of risk-retention groups—insurance-buying pools enabled by Congress in 1986 for groups such as lawyers who find it tough to get coverage.

Why does Vermont, the state of maple syrup and ski bums, now rival Bermuda, the longtime home of corporate captives? Because image-conscious companies wanted a base free of any offshore, tax-ducking connotations. In 1979, Edward Meehan, director of captive insurance at the state Banking & Insurance Dept. in Montpelier, and insurance broker H. Lincoln Miller began transforming Vermont into a haven for captives. State legislation, in 1981, included low initial capital requirements, an annual audit, and a hefty dose of self-regulation. Result? Vermont is now home to twice as many captives as all other states combined.

TINY MONTPELIER IS HOME TO 163 CAPTIVE INSURANCE COMPANIES

A BOON. Vermonters benefit, too. Last year, the state collected some $4 million in taxes on premiums. And the business has created more than 100 jobs—not bad for a state with only 500,000 residents. But most significant, says Meehan, is the required annual board meeting, a boon to the tourist trade. "The boards of directors come for two or four days, they stay in the best hotel, do some skiing or the foliage thing in the fall. It really helps the local economy," he says.

Other states, jealous of Vermont's success, are trying to attract captives. But Vermont is staving off the competition with its telling combination of attractive laws, efficient insurance department, and plenty of skilled insurance professionals.

Meehan expects two new giant captives, with over $100 million in annual premiums each, to open this year. And "just wait until the next [insurance] crisis," says Charles Tagman, a principal with consultants Tillinghast in Boston. "The number of captives could triple. Vermont will be the mouse that roared."

By Laura Jereski in Montpelier, Vt.

ber of people without coverage, now 37 million. Many hospitals treat the uninsured but then inflate bills for clients who are able to pay, mainly employers. To arrest skyrocketing costs, which have resisted years of containment programs, 60% of all large employers self-insure. Most insurers serving the rest have been operating in the red. They've been unable to raise rates fast enough to keep up with cost inflation. They're losing market share to "managed care" facilities such as health maintenance organizations. And they're losing big money on their own HMOs.

Things could get even worse. Ohio and several other states are considering statewide health plans. In part to avoid picking up the tab for the uninsured, many large employers such as Chrysler Corp. and American Airlines Inc. now support a federal plan. National health insurance has always been a political long shot, but corporate backing could change that. A federal system would not necessarily threaten insurers. Their role, for instance, would be preserved under a bill sponsored by Senator Edward M. Kennedy (D-Mass.) that would impose minimum standards on employers and guarantee similar coverage to others through medicaid.

But critics, including many physicians, claim the best, maybe only, way to control costs and make sure everyone is

MORE COMPANIES ARE DOING WITHOUT COVERAGE—EXCEPT FOR CATASTROPHES

covered is to make the government the sole payer. They cite as a model Canada's tax-financed national health system, which is far less expensive than that of the U.S. Insurers claim its quality is inferior. Still, only 3% of Canadians favor a switch to a U.S.-style system, while 61% of Americans would prefer the Canadian system, according to Louis Harris and Gallup polls.

THIN MARGINS. Socialized health insurance would usurp insurers' underwriting business, except for excess coverage not provided by the government. Insurers could serve as administrators, much as they do today for corporate self-insurers. But they would face heavy competition from the Blues and noninsurance administrators. And they would lose the income from premium investment. Says David F. D'Alessandro, head of group health for John Hancock Mutual Life Insurance Co.: "Processing margins are very thin. It's not a very good business."

Over the next few years, companies with thin margins may consider themselves lucky, for they will at least be alive. That may not be the case for dozens, even hundreds, of their compatriots.

On the surface, the property/casualty business looks fit. The 1984-86 price hikes, coupled with investment gains from the booming stock and bond markets, boosted the industry's surplus, or net worth, to $117 billion. From a $3.0 billion loss in 1985, net income jumped to $12.8 billion in 1988.

But appearances are deceiving. The quality of the policies that the industry is writing is deteriorating. Price-cutting is rampant. To compensate, insurers are skimping on reserves for future claims. As a result, says Shearson Lehman Hutton Inc. insurance analyst Udayan D. Ghose, current earnings are "grossly exaggerated." Earnings, further, do not reflect the danger that insurers will never be able to collect on claims against

STATE FARM'S HUGE HARVEST IN AUTO INSURANCE

Edward B. Rust Jr. owns a soybean and cattle farm near Bloomington, Ill. But when a hail storm hits, he worries less about beans than about cars—millions of them. That's understandable: As CEO of State Farm Mutual Automobile Insurance Co., he covers more cars than anyone else. State Farm's 20% market share dwarfs arch-rival Allstate Insurance Co.'s 12% stake. Rust, the third generation of his family to head the company, runs a juggernaut that sells good service at a fair price.

RUST: SELLING LOW-PRICE POLICIES TO LOW-RISK DRIVERS

As a "direct writer," State Farm sells auto policies through its own 17,000 captive agents, who get 10% commissions, compared with the 15% rate for independent agents. That helps hold State Farm's expenses to 17% of premium income, against the 30% average for companies using independents. Lower expenses permit lower premiums, and direct writers now control 63% of the auto market.

The State Farm group, true to its Midwest farm roots in the 1920s, sticks to the basics. It supports its well-trained agents with a handful of carefully designed products, including auto, life, and health policies, a reputation for processing claims fairly and fast, and a "Good Neighbor" national advertising campaign. Agents, in turn, pay their own expenses. Although the company denies it, competitors say that State Farm "creams off" the best drivers.

Still, auto insurance is a tough slog these days, even for State Farm. Dragged down by $1 billion in underwriting losses, its auto earnings fell 31% last year, to $720.6 million. Rust says 1989 results will be worse. It also faces a policyholder lawsuit, backed by the Citizen Action consumer group, alleging that State Farm's conservatism has shortchanged policyholders on dividend payments by putting twice as much into reserves as the industry average. State Farm says this is only prudent. "When it comes to claim time," Rust fires back, "customers don't want an IOU."

Weep not for State Farm, however. As direct writers drive others out of the auto insurance business, the market could become more like an oligopoly—with State Farm ruling the roost.

By David Greising in Bloomington, Ill.

some fly-by-night reinsurers who popped up during the last price war. That bill, says Oppenheimer & Co. analyst Myron M. Picoult, could be $16 billion.

Losses from insurer insolvencies are already escalating. The eventual tab for recent liquidations could be as much as $20 billion, much of which will have to be picked up by state guaranty funds underwritten by solvent insurers. Former Colorado Insurance Commissioner John Kezer has called the problem "huge, growing, and . . . unchecked." A probe of three failed casualty companies by Representative John D. Dingell (D-Mich.) and his oversight and investigations subcommittee revealed, he says, "a deadly mix of incompetence, greed, self-dealing, and fraudulent activity." These practices, coupled with weak regulation, his staff said, "are disturbingly similar" to those that produced the S&L crisis.

Life insurers are not in much better shape. Many have been subsidizing losses on new universal-life products with profits from old whole-life policies. Some are precariously leveraged, and the quality of some of their investments is dubious. "There are many companies in deep, fundamental trouble," says Robert McDonald, chief executive officer of LifeUSA, a Minneapolis life company. "People would be scared if they knew what was happening."

AN EARTHQUAKE? A wave of insurance collapses could have a domino effect. It could overwhelm often weak and understaffed state regulators, drag down healthy companies, and ultimately bring on federal regulation. Many analysts think a hair-curling shakeout is inevitable, and would even be salutary, to wring out overcapacity and other inefficiencies still burdening the dying cartel. The industry would end up smaller but with a chance to rebuild its health.

But looming down the road may be some big hits for property/casualty insurers that could make overcapacity seem like a fender-bender claim. If court rulings turn decisively against them, they could get stuck with much of the $175 billion cost of cleaning up Superfund toxic-waste sites. A worst-case Los Angeles earthquake could sock insurers with a $60 billion bill. Says Tillinghast Vice-President H. Felix Kloman: "You're talking about a sequence of events that could topple the whole industry."

There isn't much insurers can do to prevent the quake but pray. There is a lot they can do to arrest their slow slide into a permanent eclipse. It would require a heavy dose of enterprise, imagination, and hustle—in short, a cultural revolution. But if insurers are to regain anything close to their former power and glory, they have no other choice.

By Chris Welles and Christopher Farrell in New York, with bureau reports

COMMONWEALTH OF VIRGINIA
HOUSE OF DELEGATES
RICHMOND

BERNARD S COHEN
221 S ALFRED STREET
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FORTY-SIXTH DISTRICT

April 30, 1986

COMMITTEE ASSIGNMENTS
COURTS OF JUSTICE
CORPORATIONS INSURANCE AND BANKING
LABOR AND COMMERCE

Mr. Bob Lembo
ATLA
1050 31st Street, N.W.
Washington, DC 20007-4499

Re: "The Truth About Insurance Company Losses"

Dear Bob:

Enclosed is a copy of a paper I have written called "The Truth About Insurance Company Losses." You may wish to duplicate this and send it out to state trial lawyer association presidents and executive directors and friends.

Please call me if you have any questions.

Sincerly,

BERNARD S. COHEN

BSC:ch

Enclosure

THE TRUTH ABOUT INSURANCE COMPANY LOSSES

BY

BERNARD S. COHEN

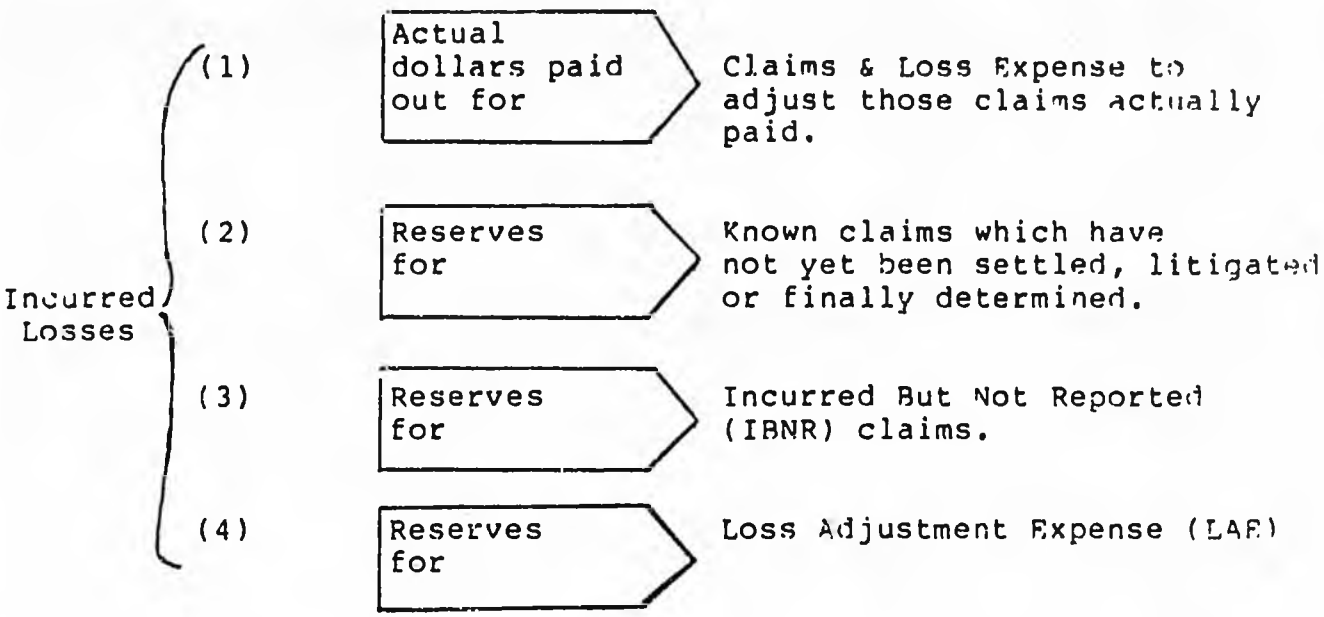
Insurance companies in recent years have charged that there is a crisis in the medical malpractice field, that there is a crisis in the product liability field and that they are losing money writing these lines of insurance. They have raised premiums dramatically for these and related types of coverage.

An examination and analysis of official insurance industry reports indicate that they are actually overcharging doctors and other professionals on their malpractice coverage and businesses on their product liability coverage. The analysis also indicates that there is no crisis except the one that the insurance industry has manufactured to scare doctors, businesses and consumers into paying higher rates while insurance companies take in billions of dollars and take in profits in the multi-millions of dollars.

In order to understand how they do this and hide the true facts from the public it is necessary to understand the accounting definitions of some terms commonly used by the insurance industry. The most important term to understand is "incurred losses". To the average person, incurred losses is thought to mean actual dollar losses paid out by the insurance companies. This is not so. The term is used to include possible future losses and report them as current losses. Incurred losses is a composite term and includes several components. The following equation

and diagram will be helpful in understanding how the term "incurred losses" is used by the industry.

Incurred losses = (Claims Paid + Loss Adjustment Expense) + (Known Claims) + (IBNR) + (LAE)[1]



As can be seen, only component (1) reflects actual dollars paid out by the insurance companies. Components (2), (3) and (4) are "reserves" which each insurance company sets for itself. Under the present system, if an insurance company wants to hide income or report high losses, all it has to do is artificially inflate the reserve components and report incurred losses which exceed premium income.

The A. M. Best Co. of Oldwick, New Jersey, collects voluminous

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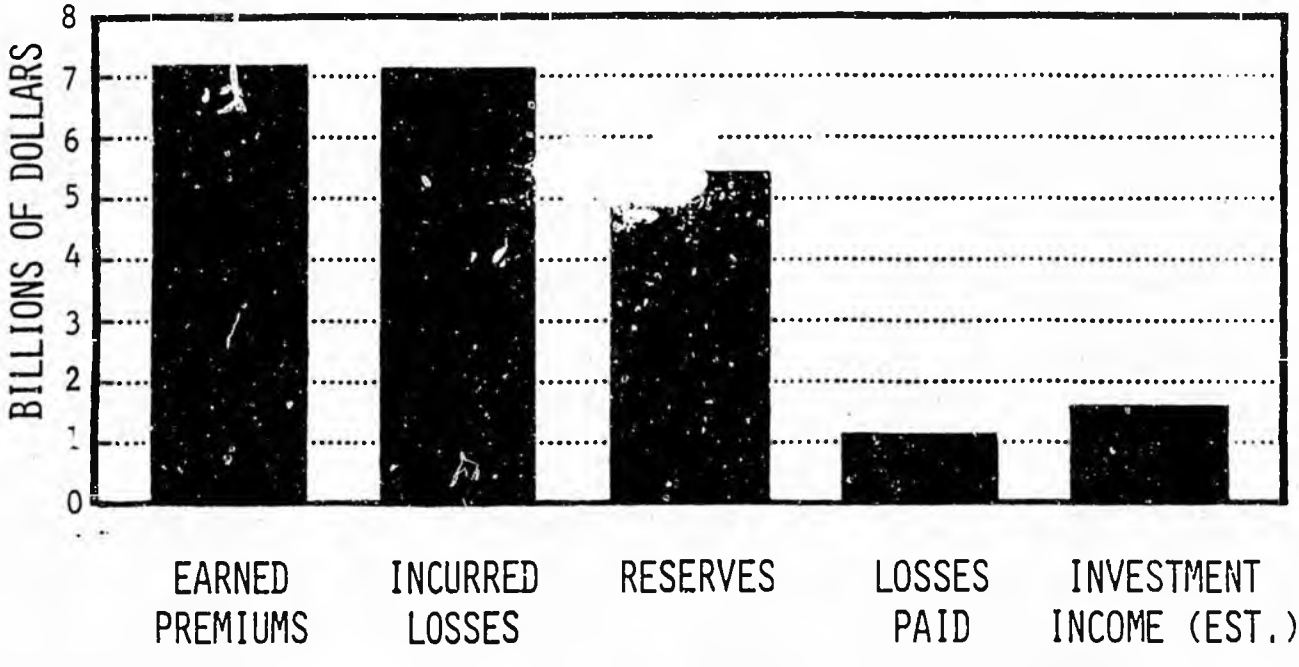
[1] It is technically more correct to state the formula as: Incurred Losses and Expenses = (Claims Paid + Loss Adjustment Expense Paid) + change in reserves for known claims, IBNR and LAE. However, for clarity, the abbreviated formula and diagram are shown.

data from insurance companies and state insurance commissions and publishes this data. But it takes a lot of work to examine, analyze and interpret this data and it is not available in the necessary detail for each line of insurance. The following data, however, was culled from the Best reports filed by the insurance companies with each state insurance commission and serves to show how reserves can be manipulated to allow over-charges by insurance companies. From 1977 through 1982, the 85 leading property/casualty insurance companies representing 94% of the total premiums written, took in over $7.1 billion in premiums and actually paid out only $1.1 billion. Assuming a conservative 10% return on investment for those six years, they earned more from the investment of the reserves than they had to pay out in claims.

Figure 1

SELECTED 85 COMPANIES - 1977 - 1982
(Representing 94% of Total Premiums Written)



An examination of the data received from St. Paul Fire and Marine Insurance Company, the largest writer of medical malpractice insurance is equally revealing. In 1977, they received $128.7 million in premiums and paid out $2.7 million in claims and expenses for occurrences in 1977, the year the premiums represent. For claims for all prior years plus 1977, plus all adjustment expenses, they paid out $5.1 million, just under 4 cents on the dollar. In 1978, they took in $131.3 million in premiums for 1978 occurrences alone and paid out $10.3 million for all claims and loss adjustment expenses, just under 8 cents on the dollar. (See Figure 2.)

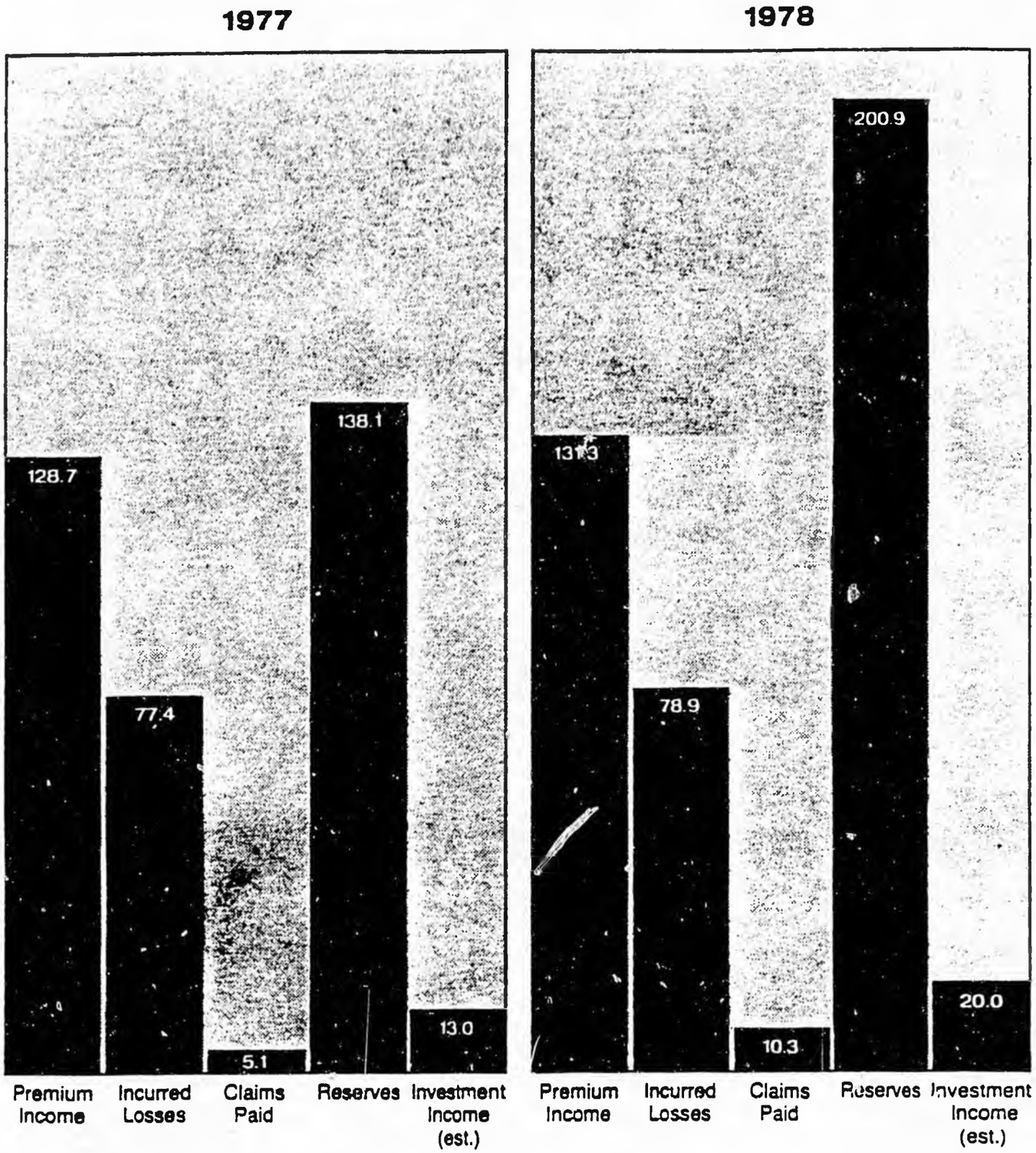
All this information is contained in their Convention Statements on file with each state insurance commissioner. The reserves for losses and loss adjustment expenses were $138.1 million in 1977 and $200.9 million in 1978. The investment income for these years on their loss reserves is better than twice the claims paid and the expense of paying those claims. (See Figure 2). It is important to note that when St. Paul first reported incurred losses for 1975 in the medical malpractice line they claimed they were $38.1 million. In their 1983 statement, their current estimate of incurred losses for 1975 has been reduced to $30.3 million. Their original claim for 1976 losses was $62.6 million; by 1983, they reduced their estimate of incurred losses for 1976 to $25.02 million, a reduction of more than $37.6 million.

Figure 2

St. Paul Fire and Marine Insurance Co.

Medical Malpractice

(All figures in Millions of Dollars)



The following table shows that they have similarly overstated their incurred losses by millions of dollars for every year from 1975 through 1982.

Change In Estimate of Incurred Losses and Expenses Between 1975 and 1982

YEAR	CHANGE
1975	-$ 7,744,000
1976	- 37,608,000
1977	- 43,010,000
1978	- 20,884,000
1979	- 47,518,000
1980	- 39,413,000
1981	- 40,531,000
1982	- 21,227,000
TOTAL	-$257,935,000

Shouldn't the doctors and hospitals who paid premiums based upon incurred losses which St. Paul now says is more accurately $257.9 million less than their previous estimates get a refund? And what of the consumers who had the increased charges passed on to them in the form of higher hospital and doctor bills? How will they get their refund?

An examination of the data for general liability, which includes product liability, is also very revealing. The figures for 200 selected companies writing general liability insurance show that for the eight years, 1977 through 1984, they had income of $44.676 billion; estimated incurred losses of $35.137 billion;

and claims paid, including loss adjustment expense of $17.416 billion. Reserves at the end of 1984 were $17.719 billion and investment income was $7.853 billion for those years. In 1984 alone, investment income was $1.708 billion. What a way to go broke!

Under the present system it is impossible or at least very difficult for anyone who wants to check on the fairness of rates charged by an insurance company for a particular type or line of insurance, because the insurance companies are not required to report the breakdowns of the component parts of "incurred losses" or other important details. Insurance companies should be required to report:

1. A breakdown of each of the reserve components and a rationale supporting the amount of reserves they set;

2. Premium income by type of insurance;

3. Number of claims actually made, paid or closed, specifying when the incident occurred and when the loss was actually paid or closed;

4. The dollar amount of the claims actually paid;

5. Reserve investment income.

Such truthful disclosure is the least we ought to require.

THE VIRGINIA EXPERIENCE

In November, 1975, the Bureau of Insurance prepared a report on the scope and severity of the medical malpractice insurance problem in Virginia. The report stated at pages 27-28:

> While extremely large verdicts or settlements may be a severe problem in other jurisdictions, available data indicates that verdict or settlement sizes has not yet reached crisis proportions in Virginia . . .

The report then documents the size of claims paid against physicians, surgeons, and hospitals from 1970 to 1975, indicating that of payments between $100,000 and $149,999 there were only five; between $150,000 and $249,999 there was only one; between $250,000 and $499,999 there was only one; and there were no payments over $500,000.

Although the November, 1975 data is now somewhat dated, later information has been made available from the Bureau of Insurance data on the disposition of all Virginia medical malpractice claims. The information covers the period from December, 1976 through November, 1981. The total indemnity paid out for medical malpractice by insurance companies during this period is as follows:

Amount	Frequency	Percent
Zero	2,002	73.4
$1 to $25,000	577	21.2
$25,001 to $100,000	115	4.2
$100,001 to $1,000,000	32	1.2
Totals	2,726	100.0

Since almost three-fourths of the dispositions result in

the claimant getting nothing, it can hardly be said that the insurance companies are waging a losing battle. Indeed, the zero result disposition plus settlements or verdicts up to $25,000 constitutes 95% of all claims. Conversely, only 5% of all claims result in $25,000 or more to the claimant. Only 1% of the claims result in a recovery of $100,000 or more.

Analyzing in more detail the 32 dispositions of $100,000 or more shows the following results:

Amount	Frequency
$105,000	1
$115,000	2
$120,000	2
$124,386	3
$125,000	3
$130,000	1
$154,549	1
$182,000	2
$200,000	5
$250,000	1
$275,000	1
$285,386	1
$340,000	2
$350,000	1
$475,000	1
$525,000	1
$724,000	2
$750,000	2
Total Claim	32

Thus, we see that there were only twelve dispositions over $200,000; only five were over $500,000. The total dollar amount for these claims is less than $8.8 million in this five-year period.

Additional figures available from the Bureau of Insurance for the period covering 1981 to 1983 are also very enlightening. While they indicate that the frequency of claims have gone up

(there are now more doctors), most of the claims (78.7%) still result in a zero recovery for the claimant. The figures for the largest claims actually paid (those falling between $100,000 and $1 million), show a total payout of less than $5.5 million during this three-year period.

The distribution of all 1981-1983 closed medical malpractice claims by size of payment is as follows:

AMOUNT	FREQUENCY	PERCENT
$0	3,275	78.7
$1.00 TO $25,000	678	16.3
$25,001 TO $100,000	180	4.3
$100,001 TO $1,000,000	27	.7
TOTAL:	4,160	100.0

The breakout of the 27 closed claims in the largest category total $5,489,953 and show a median value of $200,000 and a mean value of $203,332. The actual claims listed in ascending order are:

$100,083	$204,446
100,250	212,500
100,807	214,421
100,839	220,865
101,315	225,000
105,643	225,007
108,431	230,000
113,536	292,179
125,000	292,179
125,000	300,000
126,634	319,046
200,000	387,147
200,000	559,625
200,000	
Total:	$5,489,953

It is interesting to note that of the 4,160 closed claims, the St. Paul Insurance Company has 2299, or 55%; the Virginia Insurance Reciprocal has 1182, or 28%. Thus, the two largest medical malpractice insurance writers in the state had 83% of all the closed claims. Since only 16 companies reported any closed claims for the three-year period, it is apparent that there is very little competition in the medical malpractice underwriting business in Virginia. This enables St. Paul to control the market.

The figures in the largest category also show that capping claims at $1,000,000 is unjustified and has no effect on the insurance premiums paid by health care providers.

Remember, these figures are a census of all closed claims in Virginia for the periods shown; they are not samples or surveys. During this three-year period the carriers writing Medical Malpractice in Virginia earned premiums totaling in excess of $100 million. Even if we assume that the 885 cases in which something was paid were at the top dollar amount shown in each category range (we know it is actually less), their earned premiums are two and one-half to three times their payout. Examination of A. M. Best's Casualty Loss Reserve Development Tables shows that nationally the ratio of total claims paid to total premiums earned is only 24.7% for St. Paul in the medical malpractice line. Compare these reality figures with the premiums being charged by the carriers and you can readily see that they have

created the fiction of a malpractice crisis enabling them to overcharge health care providers and their patients.

THE 1986 "CRISIS"

In 1986 the casualty insurance industry is again claiming dramatic losses and they are demanding that claimants rights be limited and in some cases be abrogated. But close analyses show that they have used the same accounting methodology to manufacture the crisis and are attempting to mislead legislators into enacting unfair measures to curtail victims rights, so that they may move onto even greater profits. That is not to say that their profits did not go down in 1985. They went from years of astronomical profits to a year or two of ordinary profits which would be the envy of almost any other business.

But, the cause of the drop in profits was not excessive jury verdicts as they would have you believe. Rather, several factors combined to cause profits to decline. First, there was the dramatic decline in interest rates. The premium reserves which the insurance companies set aside to pay claims were able to earn enormous sums during the era of 15% to 21% interest rates. Now that yields on government securities and certificates of deposit are down to 7% to 9%, their investment income has been dropping dramatically. Second, during the high interest rate period the carriers were competing to get premium dollars quickly so that they could earn the unprecedented income available from high interest rates. Some carriers were not as careful

in selecting the risks they would write nor did they charge the premiums which their underwriting department said was necessary to cover the risks they were writing. As interest rates fell and as claims increased from the poorer risks they wrote, underwriting profits declined. Instead of responding with careful consideration, the industry over reacted, engaged in wholesale cancellations, refusals to renew and renewals with premium increases of 200% to 500% and even more.

Another factor also added to the crisis of unavailability. The London reinsurers put the squeeze on the American carriers by refusing to reinsure the risks they were writing. Reinsurance is an essential part of the insurance business whereby insurance companies spread the risk of their exposure by reinsuring part of the risks they have written with other carriers who specialize in reinsurance. Lloyds of London is the most well known of these reinsurers. The London reinsurers let it be known that they wanted the American tort system changed to curtail the principles of liability which we have carefully put in place in this country to give full access and real justice to persons injured by another person, company or product. The American companies, eager for ever-greater profits seized the opportunity to change the system to curtail the rights of injured persons. They joined together to cripple the tort system, blaming high verdicts, judges, juries and important principles in the American system of jurisprudence for their declining profits. To the uninitiated who do not understand that "incurred losses" is

a prediction shifting on the sands of time, this presented the insurance industry with a golden opportunity to again add insult to injury by attacking victims rights.

In January of 1986, a trade group for the insurance industry, the Insurance Information Institute, claimed that the industry would lose $5.5 billion in 1985. But an analysis made by Robert Hunter, former Federal Insurance Administrator in the Ford and Carter administrations, showed that the claim was "misleading and fraudulent" because the industry did not include $6.5 billion of realized and unrealized gain on its investments, nor did it include federal tax credits of $3.5 billion. With a straight face the industry even included in losses, $2.1 billion paid out in dividends.

Abba Eban once said that "propaganda is the art of persuading others of what one does not believe oneself." The insurance industry is a prime example of this. The sophisticated investor and the stock market evidence the industry's profitability while they shed crocodile tears over their "incurred losses." Investors are not fooled by this accounting system which counts the prophecy of tomorrow's "losses" as today's payout. During the last ten years the index of the leading property/casualty insurance stocks rose by almost 500%, while the Dow Jones Industrial average did not even double. In 1985 the index of insurance stocks rose more than 50%, twice as much as the Dow Jones Industrial average.

One of the most effective ways to combat these overcharges is to require the insurace carriers to report actual loss data on a closed claim basis. Also, health care providers should consider suing the carriers to recover the overcharges; in 1981 this strategy resulted in a recovery by California doctors from Travelers Insurance Company on a breach of contract basis. Recovery for one year was $6 million and a reasonable estimate is that eventually more than $50 million will be recovered.

Concerned health care providers and legislators should resist the impulse to tackle the problem of high insurance rates through legislation which would deny or limit recoveries by injured victims. Denying fair compensation to those who are the victims of malpractice merely adds insult to injury, nurtures ill will and hostility between professionals and their patients, and does not comport with any sense of fairness, justice and equity.

Doctors Who Maim and Kill . . .

NY Times 8/25/89

By Harvey F. Wachsman

GREAT NECK, L.I.

A doctor performs surgery on the sexual organs of women without their consent. The procedure, totally unnecessary and without any medical basis, ruins the lives of his patients. The hospital knows about it and other doctors in the community know about it. However, nobody acts on behalf of the patients. The doctor continues to perform this procedure on hundreds of women over two decades, both with and without consent, and nobody does anything.

Unfortunately, this astonishing and chilling story is true. Even more unfortunate, the inability or the unwillingness of the medical establishment to stop the doctor from engaging in immoral, unprofessional, unethical, illegal and life-threatening behavior is not uncommon.

HEALTH CARE: For No One

An Occasional Series

Dr. James C. Burt, a Dayton, Ohio, obstetrician-gynecologist who has come to be known as the "Love Surgeon," did experimental surgery on hundreds of women without their consent over 22 years. Presumably, his procedure was designed to enhance their sex lives through surgery on the clitoris and vagina. In fact, the surgery disfigured the women, causing extreme pain and many other significant, irreparable medical problems.

Perhaps worst of all, Dr. Burt performed this surgery on many women without their consent, and while they were under general anesthesia for entirely different reasons.

St. Elizabeth Medical Center, where he performed these procedures, knew what he was doing. The members of his surgical teams knew what he was doing. He even wrote a book about it in 1975, called "Surgery of Love," published by a vanity press. Dr. Burt gave copies to his patients, sold it through bookstores and sent it to some physicians. He hired a press agent and appeared on talk shows. He admitted in articles, and in his book, that in many cases he hadn't received consent from his patients.

Harvey F. Wachsman is a physician and practicing lawyer. He has represented patients and families of patients of the doctors he mentions.

What was the reaction in Dayton's medical community? Was it outrage? In fact, it was just the opposite.

Other doctors trivialized the problem and treated it as if it were a joke. There are reports of doctors who examined women who had been through this horrendous procedure, who laughed and said, "Oh, I see Jim Burt got hold of you." But they did nothing about it.

St. Elizabeth's aided and abetted a physician who used the sanctity of their hospital to maim women, concluding that what this physician had done was between him and his patients.

In 1975, the dean of the local medical school, in a report to the city medical society, said of the procedure that it was "medically unfounded and a rebuttal to the author would only add dignity to its existence." But, apparently under fear of a lawsuit, the medical society did nothing.

Other physicians, required by law to report improper conduct to the state, turned their backs, in obvious violation of every trust society has ever placed in doctors as a group.

It was not until some of Dr. Burt's victims brought lawsuits and the attendant publicity uncovered these scandalous events that anyone began to pay attention.

Dr. Burt was finally forced to resign his license to practice medicine, in 1989, under pressure from the Governor of Ohio and the Ohio Medical Board. His victims are scarred for life, and in many ways violated, abused and stripped of their human dignity while he is living a comfortable life, in Fort Meyers, Fla. He has never apologized to his victims.

While this story may seem shocking, it is not an uncommon.

In New York City, a physician has been using an unproved cancer cure and jeopardizing the lives of thousands of desperate cancer patients for about 40 years.

In 1945, and again in 1949, the Journal of the American Medical Association, referring to Dr. Emanuel Revici and his treatment of cancer patients, warned of its risks. In 1965, the Journal concluded that, "The Revici method of treatment of cancer is without value."

> Perhaps the Government should license physicians.

Cecilia Zyjewski, a 66-year-old Connecticut resident was diagnosed by her physician, in 1982, as having a walnut-sized rectal tumor, later confirmed as malignant. However, rather than obtaining treatment that would have had a 90 percent success rate, she visited Dr. Revici, whom she had heard on a radio program discussing his method of treatment. (His treatment relied on a mixture of selenium and other chemicals, none of which had approval from the Food and Drug Administration.)

In December 1982, Dr. Revici told Mrs. Zyjewski that the tumor had almost completely disappeared. She died in November 1983. An examination by another physician showed that the cancer had not shrunk; in fact, it had grown dramatically, spread to the liver, fractured her spine and caused her death.

Five years ago, the New York State Health Department charged Dr. Revici with fraudulent practice, gross incompetence and gross negligence.

What happened? Was Dr. Revici drummed out of the medical profession in shame? No.

The New York State Board of Regents, which licenses physicians in New York, placed the 93-year-old Dr. Revici on five years' probation and he is still practicing medicine. Although the Chancellor, alone, voted to revoke his license, other members of the board succumbed to the lobbying efforts of Dr. Revici's supporters. They offered no official explanation.

Dr. Revici has been allowed to put people's lives in jeopardy for years. But, again, it was not until he was sued for wrongful death by the family of one of his victims that he came under public scrutiny and his methods open for question. In July, the U.S. Court for the Southern District found Dr. Revici responsible for the death of Mrs. Zyjewski.

The medical profession is unable to police itself. In 1987, there were 1,700 complaints to the Office of Professional Medical Conduct, the authority that disciplines physicians in New York State. Of these, only five came from the medical societies of New York. The sad fact is that doctors don't report the misconduct of other doctors. And medical societies say it's not their job — or they don't have any power — to discipline physicians.

> . . . And get away with a wink and smile.

States have medical review boards, which license doctors and regulate and discipline them, but they just aren't doing the job properly. They are often understaffed, sometime subject to political pressures, sometimes reluctant to make waves. All too often, they err of the side of giving a fellow physician a break rather than protecting patients' lives.

There are currently about 600,000 physicians in the U.S. According to the American Medical Association, 7 percent to 9 percent of them are alcohol- or drug-impaired. This figure represents approximately 30,000 to 40,000 physicians. Last year, however, only about 200 physicians lost their licenses, including those who have committed criminal acts like fraud and felonies.

The only recourse is the legal system. The courts have become the true policing body for the medical profession. Malpractice lawyers have become the prosecutors.

If state governments won't make the commitment necessary in this area, then the Federal Government should. If Congress can investigate ethical lapses in Government, it can certainly investigate the kinds of morally reprehensible practices that took place in the cases I have described.

Perhaps the Government should license doctors. After all, standards of medical care should be the same from state to state and there should be a centralized authority to enforce those standards.

Most physicians are highly skilled, decent, honorable people who have dedicated their lives to helping others. However, the public should be outraged — and our Government should be outraged — by a system that allows even a few quacks and charlatans to practice medicine. Every one of us, including physicians and their families, is a potential patient, and we should all demand action. After all, everyone's life is at stake. □

The Uninsurables

SB304 Scheduled 2/26/90

Coghill's bill would create high-risk pool

By Imre Nemeth

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

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

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 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 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.

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 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 anymore 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.

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 Registerd 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 preexsisting 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 Alaskan 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

health insurance. One should not have to get a divorce or relinguish 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 constiguents 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

Jan H. Soloy

cc: legislative offices

N & S Texaco

FEB 2 0 1990

February 15, 1990
Anchorage, Alaska

Have A
Happy Day

Senator John B Coghill
P.O. Box V
Room 30 Captil Building
Juneau, Alaska, 99811

Re: Senate Bill #304
Uninsured and Catastrophic
Medical Coverage, Etc.

Dear Senator John Coghill:

We have just been advised that you are in suppost of Senate Bill #304 and we are in support one hundred per cent on this bill, and hoping that it passes the Senate as the unisured and catastrophic individuals have a very bleak existence having to contend their sickness along with worrying about medical coverage, we know full well on this issue as we carry a group policy at our business , but we are dropping employees all of the time and our group will not cover under 5 persons on their group plan and none of the other companies we talk to will cover either, consequently we have a fellow on the policy that will be unisurable when we drop the plan and he will be unable to convert to a single policy as they say he is uninsurable due to being a 30 year old diabetic and he will have no coverage, whereas everyone else will be able to be covered as they are HEALTHY individuals.

Certainly do appreciate your efforts in the aboveforesaid Bill and wishing you much success during this legislative session.

Sincerely,

Norman B & Shirley Presotn

Norman and Shirley Presotn
901 East 15th Avenue
Anchorage, Alaska 99501

SP:s
Encl:

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 7 1989

November 22, 1989

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

Re: Support of Senate Bill 304 as written

Dear Senator Coghill,

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

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

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

Sincerely,

Jan Maslyk

Jan Maslyk

State Legislative Report

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

SLR 88-20

June 1, 1988

* * SPECIAL * *

RISK POOLS FOR UNINSURABLES

ACKNOWLEDGEMENT

The charts and information provided with this SLR were in large part compiled by an organization called Communicating for Agriculture which has been very involved 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 15 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.

HIGH PRIORITY ISSUE

The issue of state pools for uninsurables is a high priority item of NALU's State Law and Legislation Committee. The Committee has been working 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 states 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.

Over the last couple of years, several other approaches to funding have become available. At least one state has decided to simply pay all losses directly out of state general funds, thereby foregoing the assessment totally. At least one other state has placed a tax on hospital patient revenues to raise the funds necessary to support operation of the program. There is no doubt that several other options will become available in the near future as more states consider the program.

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 state's pool.

NAIC MODEL LEGISLATION CREATING A STATE HEALTH INSURANCE POOLING MECHANISM

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

* * *

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

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

Table of Contents

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 alternative to national health insurance which embrace the interrelated goals concerning the federal ERISA preemption problems, state pooling mechanisms, adequate health insurance availability and cost containment. The interrelationship of these initiatives is exemplified by the ERISA barrier to universal participation in such pools and overall concerns about health care cost containment.

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

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

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

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

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

Section 1. Definitions.

(1) "Pool" means the State Health Insurance Pool as created in Section 2. of the Act.

(2) "Board" means the Board of Directors of the pool.

(3) "Insured" means any individual resident of this state who is eligible to receive benefits from any insurer or insurance arrangement as defined in this section.

(4) "Insurer" means any insurance company authorized to transact health insurance business in this state, any (reference state nonprofit health care service plan act and, if appropriate, HMO law).

(5) "Insurance arrangement" means any plan, program, contract or any other arrangement under which one or more employers, unions or other organizations provide to their employees or members, either directly or indirectly through a trust or third party administrator, health care services or benefits other than through an insurer.

(6) "Health insurance" means any hospital and medical expense incurred policy, nonprofit health care service plan contract and health maintenance organization subscriber contract. The term does not include short term, accident, fixed indemnity, limited benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, or insurance under which benefits are payable with or without regard to fault and which is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(7) "Medicare" means coverage under both part A and B of Title XVIII of the Social Security Act, 42 USC 1395 et seq., as amended.

(8) "Physician" (reference applicable state laws).

(9) "Hospital" (reference applicable state laws).

(10) "Health maintenance organization" (reference applicable state laws).

(11) "Plan of operation" means the plan of operation of the pool, including articles, bylaws and operating rules, adopted by the board pursuant to Section 3. of this Act.

(12) "Benefits plan" means the coverages to be offered by the pool to eligible persons pursuant to Section 6. of this Act.

(13) "Department" means the Insurance Department.

(14) "Commissioner" means the Insurance Commissioner.

(15) "Member" means all insurers and insurance arrangements participating in the pool.

Section 2. Operation of the Pool.

(1) There is hereby created a nonprofit entity to be known as the (State) Health Insurance Pool. All insurers issuing health insurance in this state and insurance arrangements providing health plan benefits in this state on and after the effective date of this Act shall be members of the pool.

(2) The Commissioner shall give notice to all insurers and insurance arrangements of the time and place for the initial organizational meetings. The pool members shall select the initial board of directors and appoint one or more insurers to serve as administrator. Both the selection of the board of directors and the administering insurer(s) shall be subject to approval by the Commissioner. The Board shall at all times, to the extent possible, include at least one domestic insurance company licensed to transact health insurance and one domestic nonprofit health care service plan.

(3) If, within sixty (60) days of the organizational meeting, the board of directors is not selected or the administering insurer is not appointed, the Commissioner shall appoint the initial board and appoint an administering insurer.

(4) The pool shall submit to the Commissioner a plan of operation for the pool and any amendments thereto necessary or suitable to assure the fair, reasonable and equitable administration of the pool. The Commissioner shall, after notice and hearing, approve the plan of operation provided such is determined to be suitable to assure the fair, reasonable and equitable administration of the pool, and provides for the sharing of pool gains or losses on an equitable proportionate basis. The plan of operation shall become effective upon approval in writing by the Commissioner consistent with the date on which the coverage under this Act must be made available. If the pool fails to submit a suitable plan of operation within 180 days after the appointment of the board of directors, or at any time thereafter fails to submit suitable amendments to the plan, the Commissioner shall, after notice and hearing, adopt and promulgate such reasonable rules as are necessary or advisable to effectuate the provisions of this section. Such rules shall continue in force until modified by the Commissioner or superseded by a plan submitted by the pool and approved by the Commissioner.

(5) In its plan the pool shall,

(a) Establish procedures for the handling and accounting of assets and monies of the pool.

(b) Select an administering insurer in accordance with Section 4. of this Act, and establish procedures for filling vacancies on the Board of Directors.

(c) Establish procedures for the collection of assessments from all members to provide for claims paid under the plan and for administrative expenses incurred or estimated to be incurred during the period for which the assessment is made. The level of payments shall be established by the board, pursuant to Section 5. of this Act. Assessment shall occur at the end of each calendar year. Assessments are due and payable within 30 days of receipt of the assessment notice.

(d) Develop and implement a program to publicize the existence of the plan, the eligibility requirements, and procedures for enrollment, and to maintain public awareness of the plan.

(6) The pool shall have the general powers and authority granted under the laws of this state to insurance companies licensed to transact the kinds of insurance defined under Section 1. and in addition thereto, the specific authority to:

(a) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this Act, including the authority, with the approval of the Insurance Commissioner, to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons or other organizations for the performance of administrative functions;

(b) Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against pool members;

(c) Take such legal action as necessary to avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

(d) Establish appropriate rates, rate schedules, rate adjustments, expense allowances, agents' referral fees, claim reserve formulas and any other actuarial function appropriate to the operation of the pool. Rates shall not be unreasonable in relation to the coverage provided, the risk experience and expenses of providing the coverage. Rates and rate schedules may be adjusted for appropriate risk factors such as age and area variation in claim cost and shall take into consideration appropriate risk factors in accordance with established actuarial and underwriting practices.

(e) Assess members of the pool in accordance with the provisions of this section, and to make advance interim assessments as may be reasonable and necessary for the organizational and interim operating expenses. Any such interim assessments to be credited as offsets against any regular assessments due following the close of the fiscal year.

(f) Issue policies of insurance in accordance with the requirements of this Act.

(g) Appoint from among members appropriate legal, actuarial and other committees as necessary to provide technical assistance in the operation of the pool, policy and other contract design, and any other function within the authority of the pool.

Drafting Note - Optional Paragraph

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

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

Section 3. Eligibility.

(1) Any individual person, who is a resident of this state shall be eligible for pool coverage, except the following:

(a) persons who have on the date of issue of coverage by the pool coverage under health insurance or an insurance arrangement;

(b) any person who is at the time of pool application eligible for health care benefits under (references state Medicaid law);

(c) any person having terminated coverage in the pool unless twelve months have lapsed since such termination;

(d) any person on whose behalf the pool has paid out $1,000,000 in benefits;

(e) inmates of public institutions and persons eligible for public programs.

(2) Any person who ceases to meet the eligibility requirements of this section may be terminated at the end of the policy period.

(3) Any person whose health insurance coverage is involuntarily terminated for any reason other than nonpayment of premium and who is not eligible for conversion, may apply for coverage under the plan. If such coverage is applied for within 60 days after the involuntary termination, and if premiums are paid for the entire coverage period, the effective date of the coverage shall be the date of termination of the previous coverage.

Drafting Note - Section 3

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

Section 4. Administering Insurer.

(1) The board shall select an insurer or insurers through a competitive bidding process to administer the pool. The board shall evaluate bids submitted based on criteria established by the board which shall include:

(a) The insurer's proven ability to handle individual accident and health insurance;

(b) The efficiency of the insurer's claim paying procedures;

(c) An estimate of total charges for administering the plan;

(d) The insurer's ability to administer the pool in a cost efficient manner.

(2) (a) The administering insurer shall serve for a period of 3 years subject to removal for cause.

(b) At least 1 year prior to the expiration of each 3-year period of service by an administering insurer, the board shall invite all insurers, including the current administering insurer to submit bids to serve as the administering insurer for the succeeding 3-year period. Selection of the administering insurer for the succeeding period shall be made at least 6 months prior to the end of the current 3-year period.

(3) (a) The administering insurer shall perform all eligibility and administrative claims payment functions relating to the pool.

(b) The administering insurer shall establish a premium billing procedure for collection of premium from insured persons. Billings shall be made on a periodic basis as determined by the board.

(c) The administering insurer shall perform all necessary functions to assure timely payment of benefits to covered persons under the pool including:

1. Making available information relating to the proper manner of submitting a claim for benefits to the pool and distributing forms upon which submission shall be made;

2. Evaluating the eligibility of each claim for payment by the pool.

(d) The administering insurer shall submit regular reports to the board regarding the operation of the pool. The frequency, content, and form of the report shall be as determined by the board.

(e) Following the close of each calendar year, the administering insurer shall determine net written and earned premiums, the expense of administration, and the paid and incurred losses for the year and report this information to the Board and the Department on a form as prescribed by the Commissioner.

(f) The administering insurer shall be paid as provided in the plan of operation for its expenses incurred in the performance of its services.

Section 5. Assessments.

(1) Following the close of each fiscal year, the pool administrator shall determine the net premiums (premiums less administrative expense allowances), the pool expenses of administration and the incurred losses for the year, taking into account investment income and other appropriate gains and losses. Health insurance premiums and benefits paid by an insurance arrangement that are less than an amount determined by the board to justify the cost of collection shall not be considered for purposes of determining assessments.

(a) Each insurer's assessment shall be determined by multiplying the total cost of pool operation by a fraction, the numerator of which equals that insurer's premium and subscriber contract charges for health insurance written in the state during the preceding calendar year and the denominator of which equals the total of all premiums, subscriber contract charges written in the state and 110% of all claims paid

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

(b) Each insurance arrangement's assessment shall be determined by multiplying the total cost of pool operation by a fraction, the numerator of which equals 110% of the benefits paid by that insurance arrangement on behalf of insureds in this state during the preceding calendar year and the denominator of which equals the total of all premiums, subscriber contract charges and 110% of all benefits paid by insurance arrangements made on behalf of insured in this state during the preceding calendar year. Insurance arrangements shall report to the board claims payments made in this state on an annual basis on a form prescribed by the Commissioner.

(2) If assessments exceed actual losses and administrative expenses of the pool, the excess shall be held at interest and used by the board to offset future losses or to reduce pool premiums. As used in this subsection, "future losses" includes reserves for incurred 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 domicilliary 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 termintated.

(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 NAIC).

1983 Proc. II 16, 22, 638, 693, 698-712 (adopted).
1984 Proc. I 6, 31, 576, 585, 590-592 (adopted The Health Insurance Act of 1983 as NAIC Policy).

STATUS OF LEGISLATION
CREATING COMPREHENSIVE HEALTH INSURANCE POOLS
FOR HIGH-RISK INDIVIDUALS

	STATE	STATUS
	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. Passed in 1987
*	**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. Passed in 1987
	New York	Introduced in 1985, carried over to 1986 - Failed.
*	North Dakota	Program in effect - June, 1981.

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

*** Highlighted states have existing plans.**

July, 1986

MAXIMUM BENEFITS PROVIDED

	STATE	STATUS
	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

PREMIUM CAPS

	STATE	RATE
	Alaska	125% Maximum
	Arizona	150% Maximum
	California	To Be Determined By The Board
	Colorado	150% Initial, 200% Maximum
*	Connecticut	125% Minimum, 150% Maximum
*	Florida	150% Initial, 200% Maximum
	Illinois	135% Maximum
*	Indiana	150% Maximum
*	Iowa	150% Maximum
	Kansas	To Be Determined By The Board
	Kentucky	150% Initial, 200 Maximum
	Louisiana	135% Initial, 165% Maximum
*	Minnesota	125% Maximum
	Mississippi	150% Initial, 200% Maximum
	Missouri	150% Initial, 200% Maximum
*	Montana	150% Initial, 400% Maximum
*	Nebraska	135% Initial, 165% Maximum
	New Mexico	To Be Determined By The Board
	New York	150% Maximum
*	North Dakota	135% Maximum
	Ohio	130% Maximum For First Three Years
	Oregon	130% Maximum For First Three Years
	South Carolina	150% Initial, No Maximum
	South Dakota	125% Initial, 200% Maximum

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

* Highlighted states have existing plans.

July 1, 1986

DEDUCTIBLES

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

	STATE	AMOUNT
	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.

	STATE	AMOUNT
	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	Regular Plan I $2,500/Individual; $4,000/Family Plan II $3,000/Individual; $4,500/Family Plan III $3,500/Individual; $5,000/Family Medicare Plan I $1,500/Individual; $4,000/Family Plan II $2,000/Individual; $4,500/Family Plan III $1,500/Individual; $5,000/Family
	Illinois	$1,500/Individual; $3,000/Family; $500/Medicare
*	Indiana	Plan I $1,000/Individual; $2,000 Family Plan II A. $1,000/Individual; $2,000 Family B. $1,500/Individual; $3,000 Family C. $2,000/Individual; $4,000/Family
*	Iowa	A. $1,500/Individual; $3,000/Family B. $2,000/Individual; $4,000/Family
	Kansas	To Be Determined By The Board
	Kentucky	To Be Determined By The Board
	Louisiana	To Be Determined By The Board
*	Minnesota	Regular Plan - $3,000/Individual Medicare Supplement - $1,000/Individual
	Mississippi	$1,500/Individual; $3,000/Family; $500/Medicare
	Missouri	To Be Determined By The Board
*	Montana	$5,000/Individual
*	Nebraska	To Be Determined By The Board
	New Mexico	To Be Determined By The Board
*	North Dakota	$3,000/Individual

	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.

	STATE	WAITING PERIOD	CONDITION PERIOD
	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.

	STATE	SOURCE
	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 an 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	**Assessment with credit applied against premium tax and income tax.**
	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	**Assessment of losses to participating insurers with credit applied against premium tax.**
	Texas	Assessment of losses to participating insurers.
	Utah	To Be Determined.
*	Wisconsin	**Assessment of losses to participating insurers plus special fund created by state to subsidize premiums for low-income policyholders.**

*** Highlighted states have existing plans.**

July, 1986

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

July, 1986

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.

Opinion

Another national health care issue that Congress must tac

By Bob Moos

After having its knuckles rapped for trying to protect the elderly against the expense of catastrophic illness, Congress may be wary of grabbing hold of another health care issue soon. Yet there is one that lawmakers cannot afford to avoid any more: how to make health insurance available to more than 30 million Americans who now have none.

The ranks of the uninsured have grown substantially in recent years. Employer-based insurance coverage has been scaled back in response to rising costs, while more workers have entered industries that do not offer health insurance. The result is that one in every six Americans does not have access to even the most basic protection today.

Lacking insurance, these people tend not to seek out health care except in an emergency. When they finally do stagger into a public hospital's emergency room, their condition often is far worse than might have been the case if they had obtained help early. In a nation as advanced and wealthy as ours, that is appalling.

Contrary to conventional wisdom, the uninsured are not necessarily the unemployed. Most work for employers who do not offer health insurance: In fact, almost 60 percent of the uninsured family heads are full-time employees. Another 20 percent are part-time employees. Only about one-fifth of the uninsured adults are jobless.

Some of the lower-income uninsured are covered by Medicaid, the federal-state health care program for the poor, but unfortunately most are not. Medicaid's financial eligibility ceilings are notoriously low — less than 50 percent of the federal poverty line in some states — so even many of the very poor do not qualify for benefits.

A commission of congressional members and presidential appointees began hearings on the problems of the uninsured last week and is expected to issue recommendations in the spring. As was true with providing catastrophic illness coverage for the elderly, the goal is a noble one. Where the disputes will arise is over how best to pursue it.

At the moment, many Americans are looking at Canada's privately run but government-funded health care system as a way of providing comprehensive coverage. Our interest is easy to understand. While we spend 12 percent of our economic output on a system that passes over millions, the Canadians spend only 8.6 percent to care for all their citizens.

Still, Canada's system has its flaws. Some advanced medical devices are not easily available, and some surgery requires long waits. What's more, such a system would be costly — about $180 billion yearly. The protest waged over the catastrophic illness surtax would pale in comparison to the public's resistance to a tax bill of that magnitude.

In all likelihood, then, the problem of the uninsured will be solved in narrower terms and through some kind of public-private partnership. One proposal that already has been put on the table deserves a close look. Offered by the insurance industry itself, it would combine public and private resources to make sure no one is uninsured.

To begin with, the plan suggested by the Health Insurance Association of America would expand Medicaid eligibility to anyone below the federal poverty line — roughly $10,000 for a family of four. Anyone with an income slightly higher — say, to $15,000 — would pay a small premium, or whatever he could afford, for coverage.

Next, the proposal seeks to encourage more employers to offer basic insurance. The industry believes that many smaller businesses could afford to help their workers with the cost of health coverage if states did not mandate so many benefits. To reduce premiums, the plan would allow smaller employers to offer stripped-down policies.

Third, the industry says the self-employed should receive a bigger tax break for the purchase of their health insurance. Under its proposal, people in business for themselves could increase their tax deduction from 25 percent of their premium costs to a full 100 percent, which is the same benefit now afforded corporations.

Finally, the plan would have all states set up high-risk insurance pools for people who have had difficulty obtaining protection because of special medical problems or particularly dangerous occupations. About 16 states currently operate such pools. The industry envisions a pool's losses being financed by a state's general revenue.

Whether the insurance associ-

Letters to the Editor

A fair reapportionment

Dear Editor:

One would conclude by your editorial of Friday, Sept. 22, that only the Democrats cheat when it comes to reapportionment.

You express fear of what the Democrats may do in the 1990 reapportionment because of what they did in 1983 with the creation of the doughnut district. Through this deception of equal representa-

Don't pay us anymore lip service . . . show us! Those of us who been beating on Juneau's door to deaf ears are real gun-shy. Minority special-interest groups seem to have a hold and have locked up Alaska.

I don't mean pave the whole state, but allow us to use some of it.

Marla Jean Adkins
Roadless in Cordova

naked attempt to apologize for a situation that logic and reason say should not exist. In his piece, Foster provides answers to the questions he asks.

The first and most important answer is that the people who wish the rules bent are American citizens, just like the rest of us. That prime fact removes most of the basis for special consideration.

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Whether the insurance association's plan would provide a broad enough safety net remains to be debated, as does the question of how to pay for it. However ,Congress eventually decides to cover the uninsured, new taxes likely will be needed. Even a modest federal-state program could total in the tens of billions of dollars annually.

Still, the public ought to remember that a hidden tax already exists to some extent. The cost of caring for the uninsured now is borne by hospitals, by private insurance carriers and by businesses with group insurance. The challenge facing lawmakers will be to design a system that more fairly apportions the expense.

Unfortunately, that could make the present wrangling over catastrophic illness coverage look like child's play.

Bob Moos is an editorial writer and columnist for the Dallas Morning News.

Letters to the Editor

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costs are so outrageous, who pays, and how do they do it?

What is the economic reason for the village seeking special rules allowing its residents privileges unavilable to the rest of Americans?

Even AFN's Janie Leask has indicated that villages without economic base might review their reason for existence. Considering rural Alaskans ". . . as much a part of the wilderness as the caribou