

SB

74

FISCAL NOTE

No. 3

STATE OF ALASKA
1992 LEGISLATIVE SESSION

J.A. Bill Version: SB 74

(S) Publish Date: 4-17-92

Revision Date: 12/27/91 1.3.92

Department Affected: Commerce & Econ. Dev.

Title: Relating to pooled health insurance who are uninsured or denied adequate coverage

BRU: Insurance

Sponsor: Senator Kerttula

Component: Operations

Requestor: Senator Kerttula

COMPONENT SERIAL NO.

0	3	5	4
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EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
PERSONAL SERVICES						
TRAVEL	1.9	.6	.6	.7	.7	.8
CONTRACTUAL	7.5					
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	9.4	.6	.6	.7	.7	.8
CAPITAL	0	0	0	0	0	0
REVENUE FUND RESOURCE:	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	9.4	.6	.6	.7	.7	.8
FEDERAL FUNDS						
OTHER FUND SOURCE:						
TOTAL	9.4	.6	.6	.7	.7	.8

POSITIONS:

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

Estimate of current year impact: _____

ANALYSIS (Attach a separate page if necessary.)

SEE ATTACHED

Changes in CSS374 (YES) have no fiscal impact. This fiscal note is appropriate.

15A12970 MA Fouse
date Comte Aide (initial)

Prepared By: Don Koch, Chief of Market Surveillance Phone: 465-2577

Division: Insurance Date: 1/2/92

Approved by Commissioner: Glenn A. Olds for [Signature] Asst. Comm.

Agency: Department of Commerce & Economic Development Date: 1.10.92

Distribution (by preparer): Leg. Fin., Legislative Sponsor, Requestor, OMS/DBR, Gov. Leg. Ofc., and Impacted Agency(ies).
Page 1 of 2

FISCAL NOTE - SB 74

ANALYSIS:

This legislation creates a health insurance pool for individuals who are uninsured or denied adequate coverage. It creates an association in which all insurers writing health insurance must participate as a condition to doing business. This fiscal note assumes that the full faith and credit will not be exposed by the association. It also assumes that the formation of the association will require the director's presence for three meetings. It also assumes that contractual assistance will be needed for the writing of any necessary regulations and review of plan of operation. Subsequent activity by the division should be contained by one annually after formation.

9052D

FISCAL NOTE

STATE OF ALASKA
1992 LEGISLATIVE SESSION

JAN 28 1992 LL NO. SB 74

Revision Date: 12/27/91

Department Affected: Commerce & Econ. Dev.

Title: Relating to pooled health insurance
who are uninsured or denied adequate coverage

BRU: Insurance

Sponsor: Senator Kerttula

Component: Operations

Requestor: Senator Kerttula

COMPONENT SERIAL NO.

0	3	5	4
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EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
PERSONAL SERVICES						
TRAVEL	1.9	.6	.6	.7	.7	.8
CONTRACTUAL	7.5					
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	9.4	.6	.6	.7	.7	.8
CAPITAL	0	0	0	0	0	0
REVENUE FUND RESOURCE:	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

GENERAL FUND	9.4	.6	.6	.7	.7	.8
FEDERAL FUNDS						
OTHER FUND SOURCE:						
TOTAL	9.4	.6	.6	.7	.7	.8

POSITIONS:

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

Estimate of current year impact: _____

ANALYSIS (Attach a separate page if necessary.)

SEE ATTACHED

Prepared By: Don Koch, Chief of Market Surveillance

Phone: 465-2577

Division: Insurance

Date: 1/2/92

Approved by Commissioner: Glenn A. Olds

Asst. Comm.

Agency: Department of Commerce & Economic Development

Date: 1.10.92

Distribution (by preparer): Leg. Fin., Legislative Sponsor, Requestor, OMB/DBR, Gov. Legis. Ofc., and Impacted Agency(ies).

JAN 28 1992

FISCAL NOTE - SB 74

ANALYSIS:

This legislation creates a health insurance pool for individuals who are uninsured or denied adequate coverage. It creates an association in which all insurers writing health insurance must participate as a condition to doing business. This fiscal note assumes that the full faith and credit will not be exposed by the association. It also assumes that the formation of the association will require the director's presence for three meetings. It also assumes that contractual assistance will be needed for the writing of any necessary regulations and review of plan of operation. Subsequent activity by the division should be contained by one meeting annually after formation.

9052D/122691c

FISCAL NOTE

BILL NO. SB 74

STATE OF ALASKA
1992 LEGISLATIVE SESSION

Revision Date: _____
Title: An Act relating to pooled health insurance for individuals who are uninsured;

Department Affected: All State
BRU: All State

Sponsor: Kerttula
Requestor: Senate Finance

Component: All State

COMPONENT SERIAL NO. _____

Expenditures/Revenues: (Thousands of Dollars)

OPERATING	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
PERSONAL SERVICES	116.6	270.5	2031.2	2031.2	2031.2	2031.2
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	116.6	270.5	2031.2	2031.2	2031.2	2031.2

CAPITAL	0	0	0	0	0	0
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REVENUE FUND SOURCE:	0	0	0	0	0	0
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FUNDING: (Thousands of dollars)

GENERAL FUND	116.6	270.5	2031.2	2031.2	2031.2	2031.2
FEDERAL FUNDS	0	0	0	0	0	0
OTHER FUND SOURCE	0	0	0	0	0	0
TOTAL	116.6	270.5	2031.2	2031.2	2031.2	2031.2

POSITIONS

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

Estimate of current year impact: none

ANALYSIS: (attach a separate page if necessary.) Passage of this bill will also increase personal services cost to political subdivisions and school districts by approximately \$1,640.1 in FY 95 and each year thereafter. See attached analysis for details.

Prepared By: Gary Bader *Nancy M. Bader*
Division: Retirement and Benefits

Phone: 465-4470
Date: April 27, 1992

Approved by Commissioner: Nancy Bear Usera
Agency: Department of Administration

Date: 4/20/92

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB & Impacted Agency(ies).
Rev 10/90 Page 1 of 5

Senate Bill 74
 Analysis of Financial Impact
 Prepared by the Division of Retirement and Benefits
 Department of Administration
 April 27, 1992
 Page 2 of 5

Passage of this bill would require operating losses incurred by the Comprehensive Health Insurance Association to be shared by members of the Association. The Association may provide for assessments against individual members to meet these losses. This analysis is based on estimates of operating losses and the resulting assessments to the State's plans. These estimates have been developed by the State's health insurance carrier, Aetna.

For purposes of this analysis it is assumed that annual losses in the first year of operation of the insurance pool (FY 93) would be \$187,000. The second and third year losses would be \$432,120 and \$826,316 respectively. It is assumed that losses would become level after the third year.

The costs on page 1 of this fiscal note consist of two components-- active employees and retirement system contributions. These components are discussed separately below:

State of Alaska Costs

Active Employees

These operating losses when allocated to the State's plan for active employees would result in a \$.72/employee/month increase in cost for health insurance in the first year, \$1.67/employee/month in the second year and \$3.18/employee/month in the third and following years. The costs for active employees are calculated as follows:

FY 93		
13,500 employees X 12 months X \$.72 increase=		\$116.6
FY 94		
13,500 employees X 12 months X \$1.67 increase=		\$270.5

FY 95 (and following fiscal years)
13,500 employee X 12 months X \$3.18 increase= \$515.2

Retirement System Contributions

The operating losses outlined above that are allocated to the State's retiree health plan will result in an increase to employer contributions to the Public Employees' (PERS) and Teachers' Retirement Systems (TRS). These increases will not become effective until FY 95. The increase in funding to both the Judicial Retirement System and the Elected Public Officers Retirement System is insignificant and not considered here.

The bill is estimated to increase the State's contributions by .20% of the Public Employees' Retirement System (PERS) payroll, and .16% of the Teachers' Retirement System (TRS) payroll. The FY 95 State PERS payroll, including the University of Alaska, is estimated to be \$707,802,127 (State \$626,535,254 and University of Alaska \$81,266,873). It is assumed payroll will remain level each year thereafter.

The FY 95 State TRS payroll, including the University of Alaska, is estimated to be \$482,697,507 (Department of Education/Legislature \$5,857,379 and the University of Alaska \$56,901,980). TRS salaries are also assumed to remain level each year thereafter.

The estimated FY 95 increase in contributions for the State of \$1,516.0 is calculated as follows:

Estimated State PERS FY 95 payroll	\$626,535,254	
PERS contribution rate increase	x <u>0.20%</u>	
State total PERS cost		\$1,253.1
Estimated University of Alaska PERS FY 95 payroll	\$81,266,873	
PERS contribution rate increase	x <u>0.20%</u>	
U of A total PERS cost		\$ 162.5
Estimated Department of Education/ Legislature TRS FY 95 payroll	\$5,857,379	
TRS contribution rate increase	x <u>0.16%</u>	
DOE/Leg total TRS cost.....		\$ 9.4
Estimated U of A TRS FY 95 payroll	\$56,901,980	
TRS contribution rate increase	x <u>0.16%</u>	
U of A total TRS cost		\$ 91.0

FY 95 increased retirement system costs..... \$1,516.0

TOTAL FY 95 STATE COSTS
INCLUDING ACTIVE HEALTH COSTS \$2,031.2

Political Subdivision and School District Costs

Political subdivisions throughout the state will also see their costs increase in the same manner as the State, that is in two components- active employees health costs and increased contributions to the retirement systems.

Political Subdivision/School District Active Employees

FY 93
1200 employees X 12 months X \$.72 increase= \$10.4

FY 94
1200 employees X 12 months X \$1.67 increase= \$24.0

FY 95 (and following fiscal years)
1200 employee X 12 months X \$3.18 increase= \$45.8

Political Subdivision/School District Retirement System Contributions

In addition to the State's costs above, political subdivision costs would increase by \$922.4 in FY 95 calculated as follows:

Estimated Political Subdivision		
PERS FY 95 payroll	\$461,219,955	
PERS contribution rate increase	<u>X</u> .20%	
Political Subdivision PERS cost.....		\$922.4

Estimated School District TRS		
FY 95 payroll	\$419,938,149	
TRS contribution rate increase	<u>X</u> .16%	
School District TRS cost.....		\$671.9

FY 95 increased retirement system costs for
political subdivisions..... \$1594.3

TOTAL FY 95 POLITICAL SUBDIVISIONS COSTS
INCLUDING ACTIVE EMPLOYEE HEALTH COSTS..... \$1,640.1

Passage of this bill would result in a .3% decrease in the PERS funding ratio and increase the present value of the unfunded liability of the PERS by \$9,532,000. The TRS funding ratio would decrease by .2% and the present value of its unfunded liability would increase by \$3,605,000.

FISCAL NOTE No. 4

Bill Version: SB 74

**STATE OF ALASKA
1992 LEGISLATIVE SESSION**

BILL NO. : (S) Publish Date: 4-17-92

Revision Date: 4/7/92

Department Affected: Health & Social Services

Title: An Act relating to pooled health insurance.....

BRU: Medicaid

Component: Medicaid Non-Facility

Sponsor: Kertulla

Requestor: Senate HESS

COMPONENT SERIAL NO.

2	2	9	
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EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE FUND SOURCE:	0	0	0	0	0	0

FUNDING (Thousands of Dollars)

GENERAL FUNDS	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER FUND SOURCE:	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

POSITIONS:

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

Estimate of current year impact:

ANALYSIS: (Attach a separate page if necessary.)

See attached note

Changes in CSSM 4 (HE) have no fiscal impact. This fiscal note is appropriate.
Kimberly B. Busch date April 7, 1992
Comte Aide (initial)

Prepared by: Kimberly B. Busch  Phone: 465-3355

Division: Medical Assistance Date: April 7, 1992

Approved by Commissioner: Theodore A. Mala, MD, MPH 

Agency: Health and Social Services Date: April 7, 1992

Distribution (by Preparer): Leg. Fin., Legislative Sponsor, Requestor, OMB/DBR, Gov. Legis. Ofc., & Impacted Agency(ies)

FISCAL NOTE

**STATE OF ALASKA
1992 LEGISLATIVE SESSION**

BILL NO. SB No. 74

Revision Date: 4/7/92

Department Affected: Health & Social Services

Title: An Act relating to pooled health

BRU: Medicaid

Insurance.....

Component: Medicaid Non-Facility

Sponsor: Kertulla

Requestor: Senate HESS

COMPONENT SERIAL NO.

2	2	9	
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EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 93	FY 94	FY 95	FY 96	FY 97	FY 98
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS, CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0	0	0	0	0	0

CAPITAL	0	0	0	0	0	0
REVENUE FUND SOURCE:	0	0	0	0	0	0

FUNDING (Thousands of Dollars)

GENERAL FUNDS	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER FUND SOURCE:	0	0	0	0	0	0
TOTAL	0	0	0	0	0	0

POSITIONS:

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

Estimate of current year impact:

ANALYSIS: (Attach a separate page if necessary.)

See attached note

Prepared by: Kimberly B. Busch

Phone: 465-3355

Division: Medical Assistance

Date: April 7, 1992

Approved by Commissioner: Theodore A. Mala, MD, MPH

Agency: Health and Social Services

Date: April 7, 1992

Distribution (by Preparer: Leg. Fin., Legislative Sponsor, Requestor, OMB/DBR, Gov. Legis. Ofc., & Impacted Agency(ies))

FISCAL NOTE ATTACHMENT

4/7/92

SB 74

We believe it is the intent of SB 74 in proposing 21.55.300(b) that coverage under the plan presented in this bill would cease when Medicaid eligibility was found to exist. We recommend, if this is correct, that this section be amended to specifically exclude Medicaid recipients from coverage in order to prevent confusion on this point. In our view, it would make little fiscal sense not to exclude the few Medicaid recipients who would qualify as "high risk" state plan eligibles, as each person who has, if even for a short period of time, overlapping dual coverage would result in the state plan making some payments in lieu of Medicaid payments. This would produce small Medicaid program savings, but would result in the loss of the 50% federal funds employed in the Medicaid program.

Even if this assumption is correct, there may be a very small number of persons, possibly fewer than 200 per year, for whom the plan may pay for medical expenses which could have been paid for by Medicaid. Medicaid provides for coverage of unpaid medical bills for a period of up to three months prior to the month of application, provided that the recipient would have been eligible in any of those months and that unpaid bills exist for covered services provided in that month. Anyone who had bills paid by the plan during this retroactive Medicaid period would not have Medicaid payment for these bills.

The Medicaid application provides none of the information that is necessary to determine whether a recipient would be a plan eligible, and even if it did, we would be unable to accurately assess the average costs such potential dual eligibles might shift from Medicaid to the plan. Therefore, this fiscal note presents no calculation of potential savings from this cost shift.

FISCAL NOTE

STATE OF ALASKA
1991 LEGISLATIVE SESSION

BILL NO. SB No. 74

JAN 28 1992

Revision Date: _____ Department Affected: Health and Social Services
 Title: An Act Relating to Pooled health Insurance for individuals who BRU: Medicaid
are uninsured or denied adequate coverage; and providing for an effective date. Component: Medicaid Non-Facility
 Sponsor: Kertulla
 Requestor: _____ COMPONENT SERIAL NO 2-2-9

Expenditures/Revenues: Thousands of Dollars

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES	0	0	0	0	0	0
TRAVEL	0	0	0	0	0	0
CONTRACTUAL	0	0	0	0	0	0
SUPPLIES	0	0	0	0	0	0
EQUIPMENT	0	0	0	0	0	0
LAND & STRUCTURES	0	0	0	0	0	0
GRANTS CLAIMS	0	0	0	0	0	0
MISCELLANEOUS	0	0	0	0	0	0
TOTAL OPERATING	0.00	0.00	0.00	0.00	0.00	0.00

CAPITAL	0	0	0	0	0	0
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REVENUE	0	0	0	0	0	0
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FUNDING: (Thousands of Dollars)

GENERAL FUND	0	0	0	0	0	0
FEDERAL FUNDS	0	0	0	0	0	0
OTHER	0	0	0	0	0	0
TOTAL	0.00	0.00	0.00	0.00	0.00	0.00

POSITIONS:

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

Estimate of current year impact: None

ANALYSIS: (Attach a separate page if necessary.)

See attached note

Prepared By: Kimberly B. Busch Phone: 465-3355
 Division: Medical Assistance Date: 2-25-91

Approved by Commissioner: [Signature] Date: _____
 Agency: Health and Social Services

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impact Agency(ie

SB 74

We believe it is the intent of SB 74 at Sec. 21.55.300(b) that coverage under the plan proposed by this bill would cease when Medicaid eligibility was found to exist. We recommend, if this is correct, that this section be amended to specifically exclude Medicaid recipients from coverage in order to prevent confusion on this point. In our view, it would make little fiscal sense not to exclude the few Medicaid recipients who would qualify as "high risk" state plan eligibles, as each person who has, if even for a short period of time, overlapping dual coverage would result in the state plan making some payments in lieu of Medicaid payments. This would produce small Medicaid program savings, but would result in the loss of the 50% federal funds employed in the Medicaid program.

Even if this assumption is correct, there may be a very small number of persons, possibly fewer than 200 per year, for whom the plan may pay for medical expenses which could have been paid for by Medicaid. Medicaid provides for coverage of unpaid medical bills for a period of up to three months prior to the month of application, provided that the recipient would have been eligible in any of those months and that unpaid bills exist for covered services provided in that month. Anyone who had bills paid by the plan during this retroactive Medicaid period would not have Medicaid payment for these bills.

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Alaska State Legislature

SENATE

Official Business


P.O. Box V
State Capitol
Juneau, Alaska 99811

TO: Senator Arliss Sturgulewski
Chair, Senate HESS Committee

FROM: Senator Jay Kerttula

SUBJECT: Senate Bill 74
High Risk Health Insurance Pool

DATE: January 28, 1992



I would appreciate your scheduling Senate Bill 74, relating to high-risk health insurance pools.

High risk pools are pools of **insurers**. States will ask insurance companies to share the costs of medical care for people with high risk medical problems - individuals whom insurance companies have rejected.

To create a high risk pool, a state generally forms an association of all health insurance companies doing business in the state. The enabling language creates a board of directors and the board is responsible for developing the authorizing legislation's intent about benefits, eligibility and pricing. The legislature sets the premium rate (somewhere between 125 to 150 percent of the standard individual premium in the state)

Senate Bill 74 is based on model legislation which has been approved by 24 states. Senate Bill 74 would require all health insurance companies, hospitals and medical service corporations (that offer subscriber contracts for major medical coverage) to join a high risk pool.

All state residents who are "high risk" would be eligible for insurance through this pool at a "reasonable rate." In addition, Senate Bill 74 also provides for a Medicare supplement plan for state residents who are high risks and 65 years of age or older.

With Assoc. of Health Ins.

Additionally, Alaskans who have had their health insurance terminated once they have become "high risk", would be eligible for this health insurance plan.

According to the 1988 GAO report, approximately 1% of the population was estimated to be medically uninsurable in 1986. Based on these "rough" figures, 5,000 plus Alaskans would qualify for high risk insurance.

Senate Bill 74 sets a cap on a premium of 125 percent of the average of five instate rate estimates.

In theory, premiums cover the majority of claims paid by the pool. In practice, however, premiums are generally insufficient because of a premium cap and because the high risk participants in the pool are likely to create more costs than the premium will cover.

A 1988 GAO study concluded that for every \$1.00 received in premiums by the current operating pools, \$1.60 is paid out in claims. Senate Bill 74 takes the approach taken in most states with pools; it assesses the pool members for the excess costs in proportion to their share of the state health insurance market.

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

High-risk pools may be the only way that individuals with severe or chronic health conditions can obtain adequate major medical coverage. While Senate Bill 74 in no way solves the problem of ensuring that all Alaskans have adequate health coverage, it is one piece of the puzzle and a most necessary one.

JK:pt
attachments

Alaska State Legislature



Sen. Jay Kerttula, Co-Chairman
Sen. Pat Pourchot, Co-Chairman

Sen. Al Adams
Sen. Jim Duncan
Sen. Lyman F. Hoffman
Sen. Dick Shultz
Sen. Rick Uehling

Senate Finance Committee

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CONTENTS OF SB 74 PACKET

SENATE HEALTH EDUCATION AND SOCIAL SERVICES COMMITTEE

- 1) SPONSOR STATEMENT
- 2) SECTIONAL ANALYSIS AND COPY OF BILL AND FISCAL NOTE
- 3) LEGISLATIVE RESEARCH ANALYSIS OF FINANCIAL IMPACT OF SENATE BILL 74 AND REDUCTION OF BAD DEBT
- 4) LETTER OF SUPPORT FROM SOUTHERN ALASKA LIFE UNDERWRITERS ASSOCIATION
- 5) NEWS ARTICLES
- 6) HEALTH BENEFITS LETTER ON HIGH RISK POOLS IN OTHER STATES

Alaska State Legislature



Sen. Jay Kerttula, Co-Chairman
Sen. Pat Pourchot, Co-Chairman

Sen. Al Adams
Sen. Jim Duncan
Sen. Lyman F. Hoffman
Sen. Dick Shultz
Sen. Rick Uehling

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Senate Finance Committee

Sponsor Statement

Senate Bill 74

SB 74 is a bill to establish a high risk insurance pool for those who are deemed medically uninsurable due to a preexisting condition which makes it impossible for them to buy insurance on the open market.

All state residents who are deemed "high risk" would be eligible for insurance through this pool at a "reasonable rate". In addition, Senate Bill 74 also provides for a Medicare supplement plan for state residents who are high risks and 65 years of age or older. Approximately 5,000 Alaskan residents would be eligible under this plan.

Senate Bill 74 does not require a subsidy from the general fund.

More and more Alaskans are finding they cannot get health insurance even if they can pay for it. Insurance company practices, in Alaska, and nationally, shifted away from health insurance plans that were open to all, to a practice

of selectively deinsuring individuals the company thinks have risks of experiencing claims.

The health insurance industry practice of skimming off the the low risk healthy populations and individuals has recently become significantly more aggressive.

Small employers cannot get health insurance if one employee, or the employee's child has asthma or another pre-existing condition. Nationally, commercial carriers do not sell policies to individuals that have heart disease, cancer, diabetes, stroke, adrenal disorders, epilepsy or ulcerative colitis. Even asthma and mild hypertension are now likely to cause a rejection. Treatment for depression or a visit to a marriage counselor or a psychiatrist are also likely to trigger a rejection.

If you are rejected or dropped from coverage, that fact is recorded at the Medical Information Bureau in Boston, an industry clearing house. The next company to which you apply is likely to check your file with the Bureau and also deny you coverage.

If individuals have a less serious condition, they may get coverage with an exclusion rider. The company may offer policies to exclude coverage for conditions such as

glaucoma, recent knee operation, migraine headaches, varicose veins, arthritis, a caesarian delivery, or even a chronic ear infection in a child.

Between 1/4 and 1/2 of all policies carry these exclusion riders. Even if your health is perfect, you may be denied coverage because you are in a profession that is more likely to file claims, switch jobs frequently, or because you do hazardous work. Those who fall into this category are barbers, florists, medical practitioners, miners, commercial fishermen, waiters, maids, railroad workers, lawyers, fry cooks, house painters, car wash operators, loggers, pilots - to name just a few.

Blue Cross and Blue Shield used to offer policies that anyone could buy. Today, because of the skimming practices of other carriers, even the Blues decline coverage of health problems and use exclusion riders and higher premiums.

26 other states have created risk pools known as comprehensive health insurance associations. Many other states are considering such legislation.

Senate Bill 74 reflects the model legislation created by the National Association of Insurance Commissioners.

In brief, SB 74 creates a nonprofit health insurance association made up of all health insurance carriers who write major health insurance in the state. The Association also includes hospital and medical services corporations that offer subscriber contracts. Members must participate as a condition of doing business in the state.

Subject to the approval of the Director of the Division of Insurance, DCED, the Association organizes itself, uses its Board of Directors and offers major medical insurance to those who have been rejected by two carriers in the previous six months, or who have had a restrictive rider placed on a subscriber contract. The association will contract with one of its members to administer the plan.

The premiums are capped at 125% of the rate charged for standard coverage for a similar plan in the state. For example, if the standard coverage for a similar plan were \$100, the premium under this plan would be \$125.

Senate Bill 74 complements other remedies and health care options which have been reviewed and recommended by the Health Cost Containment Task Force. It is one piece of the health insurance puzzle that the legislature is looking to resolve. It can stand alone and can be moved forward

without waiting for other legislation. It would provide relief for an important group of individuals who are presently unable to get insurance.

What happens when goals can't come
spreading health insurance of district

notary affect for

that in SB 83 - Should not be in Health Authority

Nationally 1% of premiums.

How much would standard policies increase

What will impact on bad debt.

SB 74

A HIGH RISK POOL FOR THE UNINSURABLE

SB 74 Creates a mechanism to make health insurance available to those who are unable to obtain health insurance on the open market.

COMPREHENSIVE HEALTH INSURANCE ASSOCIATION

The bill creates a Comprehensive Health Insurance Association which is a non-profit incorporated legal entity

MEMBERSHIP

Membership in this association is mandatory for all health insurers as a condition of doing business in Alaska.

BOARD OF DIRECTORS

A board of 7 directors is chosen by the members from the membership subject to the approval of the Director of the Division of Insurance. The Director of the Division of Insurance will serve as a non-voting ex-officio member of the board. (To be amended)

POWERS AND PROCEDURES

The association, exercising the powers granted to an insurer, establishes administrative and accounting procedures to administer the state high risk health insurance plan. These procedures will be used to contract with a carrier to administer the state plan. The association may sue or be sued.

PLAN OF OPERATION

The plan of operation is approved and may be modified by the Director of the Division of Insurance.

The association is exempt from the Administrative

Procedure Act and exempt from state taxes.

TYPES OF HIGH RISK INSURANCE:

Two types of plans must be offered;

1. an individual state plan of health insurance covering major medical for high risk individuals, or
2. medicare supplement policy for those over 65 years of age who are high risk

ELIGIBILITY

TO QUALIFY FOR HIGH RISK COVERAGE one must be able to show that the individuals have been state residents for six months who;

1. have been rejected by two health insurance carriers in the previous 6 months for medical reasons, or
2. have a policy but an exclusion rider has been placed on a medical condition.

BENEFITS

The high risk policy covers major medical services like that available to groups that are not high risk. There is a lifetime maximum of \$1,000,000 for usual, customary and prevailing charges. The covered services are detailed in SB 74. Coverage includes hospital services, professional services, laboratory and X-ray services, and prescription medications among others. Please see SB 74 for details.

COPAYMENT AND DEDUCTIBLE

The high risk plan other than the Medicare supplement plan may require deductibles of \$200, \$500, and \$1000 and copayments of 20% to a limit of \$2000 after which payment is at 100%. Mental Health services require a 50% copayment to a limit of \$4000 per year.

PREEXISTING CONDITIONS

Preexisting conditions can be excluded from coverage for a period of 6 months if the condition became evident within the previous three months.

However, there is a waiver of the preexisting condition waiting period if the preexisting condition waiting period has been satisfied while the person was covered by a policy from which they have been involuntarily terminated.

PREMIUMS

The premium charged the individual is capped at 125% of the average premium paid by those of standard risk. The premium will vary only on the basis of age and the geographical location of the insured.

ADMINISTRATION OF THE PLAN

The selection of the writing carrier to administer the state plan will be based on the carrier's efficiency, ability and estimate of total charges.

Members are assessed for losses in excess of premiums in proportion to the proportion of the premiums written in the state.

Each member insurer of the association shall share the losses due to claims and administrative costs and the costs of the administration of the association that are in excess of the income from premiums. The loss is shared among all insurers in proportion to the proportion of premiums written in the state by that insurer. (Experience in other states is that the assessment to insurers does not exceed 1% of the total premiums written. Thus premiums state-wide should not increase more than 1% as a result of this assessment.)

Net gains shall be held at interest and used by the association to offset future losses.

ENROLLMENT

Provides that a state resident at high risk is eligible to enroll in the state insurance plan. It prohibits enrollment if other coverage exists.

WRITING CARRIER'S RESPONSE

Requires the plan to accept or reject an application for enrollment within 30 days.

EFFECTIVE DATE OF POLICIES

The policy is effective from the date of the application if the first quarterly premium has been received and the applicant qualifies for the policy.

TRANSITION FROM PREVIOUS POLICY

If a person is involuntarily dropped from coverage, is denied coverage by one other carrier, and if the person applies to the plan within 60 days of termination and pays the premium, their coverage applies retroactively to the date they were terminated from coverage.

SOLICITATION OF ELIGIBLE PERSONS

Requires the association to solicit eligible persons for enrollment through use of the press, radio, and television. Insurers and HMOs that reject a person from coverage, or apply underwriting restrictions shall notify the applicant of the existence of the state plans, the requirements for being accepted, and the procedure for applying.

DUTIES OF THE DIRECTOR

The Director of the Division of Insurance must approve the association's plan, the association's contract with the writing carrier including the coverage and premiums to be charged, and pass regulations to administer the chapter.

STATE NOT LIABLE

Provides that the state is not liable for acts of the association.

**PROPOSAL BY SENATOR KERTTULA
FOR EXPANDED AVAILABILITY OF
HEALTH INSURANCE FOR ALASKANS**

**HIGH RISK POOL
SENATE BILL 74**

(Montana's plan is used to given an idea of potential impact in Alaska. Montana's plan is more restrictive than proposed in SB 74. Montana's 1990 population was 803,655 compared to Alaska's 1990 population of 551,947.

**EXISTING
PLAN**

\$1,000 Deductible

**SB 73/74
PLAN**

\$200, \$500 & \$1,000 deductibles. Premium Cap of 125%. \$1 million lifetime benefit.

**PROJECTED
STATE COST**

\$30,000 Admin. start-up costs

**PROJECTED
PREMIUMS**

(Montana's prem. schedule + 35 % added costs)

<17: 100.60
<24: 150.05
<29: 161.87
<34: 179.46
<39: 202.18
<44: 229.51
<49: 255.67
<54: 284.27

**PROJECTED
INS. IND. COST**

No more than 1 % of total health ins. premiums sold.

**PROJ.
HOSP/DR.**

0

SENATE BILL 73

(The SCOPE plan offered in Denver is used to give an idea of the potential impact in Alaska. The SCOPE plan does not have a public subsidy, the proposal in SB 73 would include a sliding scale for the low income. The cost projections are based on a pilot project in a community of 2,110 with 30% uninsured; an average premium cost of \$65 per month, an average state subsidy of \$20 per month, per participant.

\$250 Deductible for hospital care. 0 deductible for preventative care. 50% copay. of first \$5,000 for hospital care, 100% thereafter. \$15 copayment for Dr. visit, not a preventative visit. 0 copay. for Dr. preventative visit. Unlimited lifetime benefit for under 70, \$50,000 lifetime benefit for over 70.

Emphasize prev. care/ nominal copay. deemphasize hosp. care with a large deductible & copayment.

\$200,000

(Premiums based SCOPE premiums + 35 percent)

<30: 44.31
<34: 55.37
<39: 65.58
<44: 78.66
<49: 94.58
<54: 114.47
<59: 139.39
<64: 171.95

0

20 % discount

DIVISION OF LEGAL SERVICES

LEGISLATIVE AFFAIRS AGENCY STATE OF ALASKA

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Court Plaza, Room 500
Mail Stop 3101

MEMORANDUM

January 24, 1991

SUBJECT: Pooled Health insurance - SB 74

TO: Senator Jay Kerttula

FROM: Michael F. Ford *M.F.*
Legislative Counsel

The following is a sectional analysis of SB 74:

Section 1 - Purpose.

Section 2

Sec. 21.55.010 - Establishes the comprehensive health insurance association and provides that membership in the association consists of certain insurers.

Sec. 21.55.020 - Establishes the board of directors of the health insurance association and provides for voting rights of members.

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

Sec. 21.55.040 - Requires the association to submit a plan of operation. Establishes specific items that the plan of operation must include.

Sec. 21.55.050 - Exempts the association from the Administrative Procedure Act.

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

Sec. 21.55.100 - Requires the association to make insurance available to residents who are high risks. Specifies the type of deductible to be offered and requires that a medicare supplement plan also be provided to certain residents.

Senator Jay Kerttula
January 24, 1991
Page 3

Section 3 - Requires the association to make insurance available to eligible residents by January 1, 1992.

Section 4 - Effective date.

MFF:pl
91-024.plm

Alaska State Legislature

Legislative Research Agency



130 Seward Street, Suite 218
Juneau, Alaska 99801-2196

Phone: (907) 465-3991
Fax: (907) 463-3351

March 19, 1992

MEMORANDUM

TO: Senator Jay Kerttula

FROM: Paul Engelman *PE*
Legislative Analyst

RE: Financial Impact of Senate Bill 74: High Risk Insurance Pool
Research Request 92.179

As requested in your memorandum of February 14, 1992 we have estimated the financial impact of the high risk health insurance pool created by Senate Bill 74 (SB 74). In this memorandum we discuss the assumptions needed to make the estimates, estimate the impact of the legislation on bad debts incurred by medical providers, and estimate the effect the bill will have on Medicaid payments.

The approach taken in this analysis was to be as actuarially conservative as possible. As a result, the cost estimates may be higher than those developed previously. The alternative that would generate the highest rate was used wherever a choice was presented. The only exception to this was choosing between Alaska information and information from other regions. In these cases the Alaska data was used.

The analysis yielded a monthly rate of \$181 per insured for the "high risk" pool, a monthly rate increase of \$3.30 for the "main" pool members, and a maximum potential monthly savings of \$1.12 for the "main"-pool members because of bad debt reduction. The attached table shows how computations were made.

3.30
1.12
2.18

Assumptions

Rates: The Alaska rates are based on the experience of nine states with high risk pools that have been in existence for three or more years.¹ Since all but one of these states has a cap on participant premiums that is greater than the 25 percent cap proposed in SB 74, the premiums in each state are adjusted down to reflect the income they would earn with a 25 percent cap on premiums.

¹Health Benefits Letter, Scandlen Publishing, Inc. Alexandria, October 23, 1991. The original source is *Communicating for Agriculture*.

Senator Kerttula
March 19, 1992
Page 2

Pool Participants: Two insurance pools are associated with SB 74. A "main" pool consists of Alaskans who have private health insurance and are not in "ERISA" programs.² This pool is based on Alaska enrollments in Aetna (86,200 subscribers) and Blue Cross of Washington and Alaska (71,900 subscribers), who underwrite the bulk of this business (75 percent) according to Chris Ulmann of the Division of Insurance. The number qualified for the pool is adjusted to include other commercial health insurers in Alaska. The final estimate is 209,500.

The size of the second or "high risk" pool is based on the Minnesota experience and is estimated to have 3,180 participants in Alaska. The nine-state average could be used and would result in a lower estimate of 703 participants; however the higher number is used because it is the one that yields the maximum potential liability for the program.

Two estimates identifying the cost of the high risk insurance premiums were considered. The first estimate uses the premium revenue and enrollment from the nine-state "high risk" pool. The premiums are adjusted to reflect a 25 percent cap in each state then the average rate based on total enrollment is determined. This rate reflects costs in the "lower forty-eight" and was adjusted to reflect Alaska medical costs.³ This resulted in a capped rate of \$192.

The second approach uses an average rate for the "main" pool as identified by the Division of Insurance.⁴ This rate, \$145, was increased by 25 percent to reflect the cap on the high risk pool. This resulted in a rate of \$181 for the "high risk" pool. The lower rate of \$181 is used since it directly reflects the Alaska insurance experience.

Claims/Expenses: Because the claims figures are provided on a paid rather than an incurred basis resulting in an understatement of total liability, 3 percent

²"Self-insured firms are exempt under the Employee Retirement Income Security Act (ERISA)." Source :*Focus On*, Office of Intergovernmental Affairs, Health Care Financing Administration. DHHS, February, 1988

³Costs were adjusted using the ACCRA cost of living index for health expenditures produced by the American Chamber of Commerce Researchers Association.

⁴Personal communication with Chris Ulmann.

is added to the paid claims to adjust to an incurred claim amount.⁵ Another 5 percent is added to the loss ratio to cover the incremental administrative costs of claims payments. With these two adjustments, the "fully funded" loss ratio (the ratio of the sum of claims and administrative costs to premiums) is estimated to be 220 percent. That is, costs are estimated to be 120 percent higher than the premiums if the rate cap is 25 percent.

Estimating the Impact

Estimating the effects of SB 74 using this information is uncomplicated. The annual high risk premium is equal to the monthly premium multiplied by the number of high risk pool participants times 12 months. This yields premium income of \$6,916,500. Multiplying the premium income by the loss ratio of 220 percent yields claims and operating expenses of \$15,216,300. Subtracting the claims and operating expense from the premium income yields a loss of \$8,299,800. This is the amount that must be distributed among the "main" pool. Based on these calculations, each member of the "main" pool will be assessed an additional premium of \$3.30 per month or 1.82 percent of the base premium amount.

One of the effects of the pool is the reduction of bad debts incurred by doctors, hospitals, and other health care providers. The effect of the pool on bad debts is also uncomplicated once an amount of the high risk claims that would have been bad debts has been determined. Based on discussions with Larry Bartlett of Health Systems Research, Inc. of Washington, D.C., bad debts are assumed to be equal to 50 percent of the total high risk claims. Since the "main" pool of 209,500 constitutes 38 percent of the current population and assuming that the health care utilization rate by the "main" pool is the same as the total population, if all of the benefits of the bad debt reduction experienced by the providers were passed along to the pool members, the maximum benefit that the "main" pool could receive would be \$1.12 or 0.62 percent of the base premium. The balance of the benefits are distributed to other

⁵Paid claims usually understate the liability that corresponds to the premiums earned for two reasons. 1) there is a lag in the payment of claims: the claims paid at the beginning of the current period reflect claims incurred in the previous period (as much as 90 percent of the claims paid in January were incurred in December) and the claims paid at the end of the period do not reflect the full amount of claims incurred (these claims will be paid in the next period). Since costs are generally increasing the claims incurred at the end of the period will be more costly than those that are paid at the end. By estimating the amount of payment lag, an adjustment to the paid claims to reflect the difference in costs at the beginning of the period and the end of the period can be made. 2) If the insured group is increasing or decreasing in size the number of claims will increase or decrease, respectively. Adjusting to an incurred amount of claims will also reflect the change in claims due to changes in group size.

Senator Kerttula
March 19, 1992
Page 4

Alaskans not in the pool. If either the hospitals or insurance companies do not pass the full amount of the benefit to the public or members of the pool the benefit will be less.

The estimate of the effect of distributing the losses of the "high risk" pool to the "main" pool can change significantly depending on the size of the pools. For example, a decrease of 10 percent in the number of people in the "main" pool will result in a cost increase of \$0.37 per individual when the losses from the high risk pool are charged back.

The Effect on Medicaid Payments

After contacting several individuals in the agency that determines which individuals qualify for Medicaid, we were unable to develop an estimate of the impact of the high risk pool on Medicaid, although it is likely to be quite small. Those individuals contacted felt the number of people who "spend down" in order to qualify for these programs is very small (1 percent or less).⁶ In addition, it is highly unlikely anyone with sufficient discretionary cash income to be able to afford the premiums for this program would qualify for Medicaid benefits (a young mother living with someone was the only specific instance mentioned). If this is the case, the impact of the high risk pool on Medicaid recipients would be very small. Unfortunately none of the individuals who were contacted could do more than talk in broad generalizations; as a result, we did not feel comfortable developing a rate. None of the individuals contacted knew of any study of individuals "spending down" to qualify for Medicaid.

The agency staff indicated an interest in the pool as a way to insure some of their low income high risk individuals (Medicaid would pay the premiums). My understanding is Medicaid qualified individuals would not be eligible for the "high risk" pool the way it is now structured. However if they were determined to be eligible, these individuals would reduce the benefits to the State by shifting money away from federal Medicaid dollars to Alaska insurance dollars.

We hope this information is useful to you. If you have any questions or would like additional information, please contact this agency.

Attachment

⁶Most of the information was supplied by Chris Aschenbrenner, Gordon Landes and Curt Lomas.

Impact and Rating Information for SB 74

High Risk Health Insurance Pool Experience

Selected States - 1990 (From Health Benefits Letter)

<u>State</u>	<u>Enrollment</u>	<u>Premium Cap</u>	<u>Premiums Paid</u>	<u>Claims Paid</u>	<u>Loss Ratio</u>	<u>1990 Population</u>	<u>Enrollment % of Pop.</u>
Connecticut	2,200	150%	\$4,496	\$10,438	232%	3,296	0.07%
Florida	5,934	300%	\$12,444	\$17,425	140%	13,003	0.05%
Indiana	3,080	150%	\$8,377	\$16,978	203%	5,564	0.06%
Iowa	1,971	150%	\$4,574	\$5,054	110%	2,787	0.07%
Minnesota	25,272	125%	\$25,735	\$49,470	192%	4,387	0.58%
Montana	304	400%	\$629	\$570	91%	804	0.04%
Nebraska	2,904	165%	\$4,423	\$6,760	153%	1,585	0.18%
North Dakota	1,303	135%	\$2,571	\$4,312	168%	541	0.20%
Tennessee	4,121	150%	\$10,775	\$17,121	159%	4,897	0.08%
Total / Average	47,089	158%	\$74,024	\$128,128	173%	36,964	0.13%
Experience Adjusted to a 125 percent cap =			\$60,366	\$128,128	212%		

1) Average Monthly Premium Paid \$131
 Adjusted to a 125 percent Cap \$107
 Adjusted to Alaska Costs Using ACCURA Cost Index \$192

2) Average Monthly Premium Based on Division of Insurance Data \$145
 Adjusted to 125 percent Cap \$181

Alaska Enrollment in High Risk Pool

1) Based on Nine State Average 703
 2) Based on Minnesota Experience 3180

Estimating the Effects of SB 74

Assumptions.

Number of insured's in Main Pool*	209,500
Number of Insured's in High Risk Pool	3,180
Premium with a 125 Percent Cap	\$181
Paid Loss Ratio	212%
Factor to Adjust Paid Claims to Incurred	3%
Incremental Claims Payment Cost	5%
Fully Funded Loss Ratio	220%

Annual Income (Premium x pool x 12 months)	\$6,916,500
Annual Claims Expense (Income x Loss Ratio)	\$15,216,300
Losses to be Covered by Main Pool	\$8,299,800
Annual Cost per Main Pool Member	\$39.62
Monthly Cost per Main Pool Member	\$3.30

Effect on Bad Debts

Assume 50 percent of the estimated claims amount would have ended up as bad debt (probably would be less)

Estimated bad debt reduction \$7,435,238

Savings to insurance pool members (assumes that the insurance pool covers 38 percent of the population). \$2,825,390

Maximum possible reduction of premiums (insurance companies transfer full savings)
\$1.12 0.62%

*Based on 86,200 Aetna +71900 Blue Cross = 75% Main Pool
Source: Division of Insurance (Chris Ulmann)

Prepared by Legislative Research, March 1992 (92.179)

MEMORANDUM

14 April 1992

TO: Senate HESS Committee Members

FROM: Senator Arliss Sturgulewski, Chair

Following are recommendations regarding the amendments proposed by the division of insurance and others.

DO NOT RECOMMEND ADOPTION:

Pages 1-6 of amendments offered by div of insurance.
These amendments combine the associations of SB 74 & SB 242

RECOMMEND ADOPTION:

Page 7 of amendments offered by div of insurance.
Provides additional options for deductibles. Clarifies Medigap coverage available only to high risk residents covered by Medicare. Clarifies state plan coverage must be made available to eligible high risk residents.

DO NOT RECOMMEND ADOPTION:

Page 8-12 of amendment offered by division of insurance.
Establishes a benefit committee to decide benefits offered by pool rather than outlining benefits to be covered in statute.

DO NOT RECOMMEND ADOPTION:

Page 13 of amendments offered by division of insurance.
This amendment is a clarifying amendment following adoption of amendments on pages 8-13.

RECOMMEND ADOPTION:

Page 14 of amendments offered by division of insurance.
prohibits coverage where workers' compensation policy is available.

DO NOT RECOMMEND ADOPTION:

Page 15 of amendments offered by division of insurance.
This amendment is a clarifying amendment following adoption of
amendments on pages 8-13.

RECOMMEND ADOPTION

Pages 16 & 17 of amendments offered by division of insurance.
clarifies that persons eligible for other health benefits are ineligible
for this program.

Page 18 is a duplicate.

RECOMMEND ADOPTION

Page 19 of amendments offered by division of insurance.
Clarifying amendment regarding licensed persons.

RECOMMEND ADOPTION

Page 20 of amendments offered by division of insurance.
Clarifying amendment.

RECOMMEND ADOPTION

Page 21 of amendments offered by division of insurance
Provides guidance as to what may constitute a medical condition.

RECOMMEND ADOPTION

Page 22 of amendments offered by division of insurance.
Sets out requirements for legislative review of plan.

OTHER SUGGESTIONS:

RECOMMEND ADOPTION:

Page 2, Line 5.

after "division of Insurance, add: "at least two board members
shall be consumers appointed by the director of the division of
insurance"
(offered by Kerttula)

RECOMMEND ADOPTION:

Page 2, line 17 through 23:

The association should have the power to receive funds from other sources.

RECOMMEND ADOPTION

Page 8, Line 17:

HIAA, Aetna, and the division of insurance all agree that the percentage amount that can be charged for premiums should be higher than 125% and probably should be 150%. (HIAA - 200%)

MEMORANDUM

10 April 1992

TO: Senator Arliss Sturgulewski

FROM: Staff

Following is a list of suggested changes or amendments to Senate Bill 74:

Page 2, Line 5.

OK after "division of Insurance, add: "at least two board members shall be consumers appointed by the director of the division of insurance" amendment by Kerttula

OK Staff recommends that it be the commissioner of the department of commerce who appoints members.

Page 2, line 17 through 23:

the division of insurance feels that the association should have the power to receive funds from other sources

Staff concurs

OK Page 2, line 28:

OK this section provides that if the association fails to act on a plan of operation, the director may adopt regulations. This provision was in the original SB 242 and it was felt that it was not

the duty of the director to act if the association dropped the ball.

Staff recommends that the association be responsible for the plan of operations.

Page 3, lines 4 through 17:

the division of insurance recommends that language be added to provide that the association establish standards for cost containment.

Staff concurs.

Page 3, lines 27 through 29:

the division of insurance and the HIAA both recommended removal of this section, division of insurance says it is redundant, and probably ok to leave in.

Staff recommends it be left in.

Page 4, line 5:

HIAA recommends reduction of lifetime maximum from \$1,000,000 to \$500,000.

Staff recommends it be left at \$1,000,000

Page 4, Line 12:

this section excludes dental services from the services offered under this plan.

Staff recommends dental services be included.

Page 5, Line 25 through 31:

HIAA recommends that the amount of the deductible be raised from the current amount in the bill of \$200, \$500, & \$1000 to \$1000 and \$5000.

Staff has no recommendation, although \$1000 and \$5000 seems high.

Page 6, Lines 17 through 31;

HIAA and the division of insurance both feel that the 6 month preexisting condition exclusion is too short and recommend it be lengthened.

Page 8, line 15:

the division of insurance feels that the estimate of rates should be submitted annually

Staff concurs

Page 8, Line 17:

HIAA, Aetna, and the division of insurance all agree that the percentage amount that can be charged for premiums should be higher than 125% and probably should be 150%. (HIAA - 200%)

Page 9, line 26:

HIAA & Aetna both feel there should be a prohibition against employers taking an employee out of the regular insurance policy and putting that employee into this insurance pool ("dumping").

the insurance companies say that SB 242 will take care of the problem of high risk employees - this bill, however, is a much better deal for high risk persons, whether or not the employer is paying the premiums. The policy question is if the legislature feels that high risk persons should be subsidized, or run the risk of getting the boot from their employers because of the high insurance premiums an employer has to pay (SB 242 allows for 5x the premium base rate to be charged for high risk employees).

Page 10, Line 28 through 31:

the division of insurance believes that there should be an exclusion in this section for persons who are able to obtain insurance through COBRA or conversion policies

Page 11, Line 1 & 2:

the division of insurance suggests that the director, by regulation, be able to add eligibility requirements.¹

Page 12, Lines 6 through 14

here again, the director is responsible for duties that may be more appropriately assigned to the association itself.

Page 14, Line 5

Sen. Kerttula offered amendment deleting "for medical reasons" from this line. Both HIAA and Aetna object to this deletion on the grounds that the purpose of this legislation is to ensure that unhealthy individuals can get insurance. Sen. Kerttula's position is that persons are often denied insurance because of the class of persons they belong to.

Staff has no recommendation.

Page 14, Line 10:

add: (c) have been refused by two insurers to issue insurance except at a rate exceeding the state high risk plan rate (offered by Kerttula) HIAA objects to adoption of this amendment.

Staff has no recommendation.

¹ NOTE: the association itself is exempt from the administrative procedures act, but there are several references in the legislation to the ability of the director of the division of insurance to promulgate regulations affecting the operation of the association. There should be a policy decision made as to how much control the director has over the association.

SUMMARY OF COMMENTS BY MEISELS RE: SB 74

- 2000-01-10*
- ✓ Recommends the premium be 150 percent (rather than 125 percent) of average premium. Goes on further to suggest that it be 175-200 percent.
 - ✓ Recommends allowance of a credit against premium taxes (2.7%) *Policy discussion*
 - ✓ Recommends increase in deductibles (current bill = \$200, \$500, and \$1000)(recommendation=\$1000 & \$5000.)
 - ✓ Recommends removal of medicare eligible persons so that this will not act as medicaid supplement coverage.
- Recommends reduction of lifetime maximum from \$1,000,000 to \$500,000.
- Recommends extension of pre-existing condition exclusion from three months to 10 months.
- ✓ Recommends barring employers from paying premiums for that person so as to avoid "dumping" (goes on to say that SB 242 will eliminate the need)
- Recommends listing in the legislation of persons ineligible for coverage.
- Recommends deletion of section allowing persons to purchase insurance retroactively within 60 days of termination of previous coverage after making application.
- ✓ Recommends no adoption of amendment proposed by sponsor which deletes "for medical reasons" within the definition of high risk resident.
 - ✓ Recommends no adoption of amendment that would allow persons who have been refused by two insurers to issue insurance except at a rate exceeding the state high risk plan rate.

SUMMARY OF COMMENTS BY MFISELS RE: SB 74

✓ Recommends the premium be 150 percent (rather than 125 percent) of average premium. Goes on further to suggest that it be 175-200 percent. *could have a range 125-150%*

✓ Recommends allowance of a credit against premium taxes (2.7%)

Recommends increase in deductibles (current bill = \$200, \$500, and \$1000)(recommendation=\$1000 & \$5000.)

✓ Recommends removal of medicare eligible persons so that this will not act as medicaid supplement coverage. *Needs further discussion*

✓ Recommends reduction of lifetime maximum from \$1,000,000 to \$500,000.

✓ Recommends extension of pre-existing condition exclusion from three months to 10 months.

6 months is 3 mo "lookback" provision
Recommends barring employers from paying premiums for that person so as to avoid "dumping" (goes on to say that SB 242 will eliminate the need)

*pg 9
1/20*
Recommends listing in the legislation of persons ineligible for coverage.

Recommends deletion of section allowing persons to purchase insurance retroactively within 60 days of termination of previous coverage after making application. *There - actually = continuity*

Recommends no adoption of amendment proposed by sponsor which deletes "for medical reasons" within the definition of high risk resident. ~~Amendment~~

Recommends no adoption of amendment that would allow persons who have been refused by two insurers to issue insurance except at a rate exceeding the state high risk plan rate.

PROPOSED AMENDMENTS TO SB 74

*Drafted by
Senator [unclear]*

*Rec. on
[unclear] 7
[unclear]*

Page 2 line 5 after "division of insurance." Add:

"In addition at least 2 board members shall be consumers appointed by the Director of the Division of Insurance".

*amend [unclear]
[unclear]
model code
5*

Page 14 line 4 delete "[for medical reasons]"

Page 14 between line 10 and line 11 Add:

"(C) have been refused by two insurers to issue insurance except at a rate exceeding the state high risk plan rate".

NAAC model

Red steps

Proposed Amendments to S.B. 74 (Aetna)

CARVE-OUTS FROM EMPLOYER GROUPS

This amendment addresses the potential problem of insurers' carving out unhealthy employees and dependents from employer groups and "dumping" such individuals into the high-risk pool. It is taken from the Connecticut statute governing that state's individual high-risk plan (Conn. Gen. Stat. Ann. §38a-556(c) (West Supp. 1992).

Page 10, line 27 - Insert after the period:

"No member [of the association] shall be permitted to select out individual lives from an employer group to be insured by or through the association."

Page 9, lines 26-27 - Delete the entire subsection and re-letter the remaining subsections accordingly. This section contemplates employers' carving out unhealthy employees from the employer group and sending those risks to the high-risk plan. Such carve-outs by employers, as well as by insurers, are contrary to the purpose of the high-risk pool, will produce an excessively large pool, and should be illegal.

ELIGIBILITY FOR THE HIGH-RISK PLAN

This amendment clarifies that persons possessing or eligible for substantially similar coverage under other health plans are not eligible for the high-risk plan. It is taken from the NAIC's MODEL HEALTH INSURANCE POOLING MECHANISM ACT.

Page 10, lines 28-29 - Delete everything up to the period. Insert the following:

"A person shall not be eligible for coverage under the plan if the person has or obtains health insurance coverage substantially similar to or more comprehensive than a plan policy, or would be eligible to have coverage if the person elected to obtain it. Persons otherwise eligible for plan coverage may, however, solely for the purpose of having coverage for a preexisting condition, maintain other coverage only while satisfying any preexisting condition waiting period under a plan policy."

PREMIUM LEVEL

Page 8, line 17 - Delete "125" and insert "150". Setting the premiums as low as Minnesota's will push Alaska's pool into the same deficit situation as Minnesota is now facing (\$28 million). A low premium will unduly raise assessment levels for insurers and cause severe cost-shifting from the high-risk population to other insureds in Alaska.

REJECTION FOR MEDICAL REASONS

Page 14, line 4 - Reject the proposed amendment to delete "for medical reasons". The whole purpose of a high-risk plan is to enable unhealthy individuals who cannot get coverage to obtain it. Thus, the only rational basis for accepting otherwise rejected individuals under this plan is that they were rejected for medical reasons.

AMENDMENT #1

OFFERED IN THE SENATE
TO: CSSB 74 (HES)

BY SENATORS HALFORD, COLLINS, AND KERTTULA

Page 9, line 1:

Delete "150"

Insert "200"

Page 15, after line 9:

Insert a new bill section to read:

"* Sec. 3. AS 21.55 is repealed."

Failed

Renumber the following bill sections accordingly.

Page 15, after line 11:

Insert a new bill section to read:

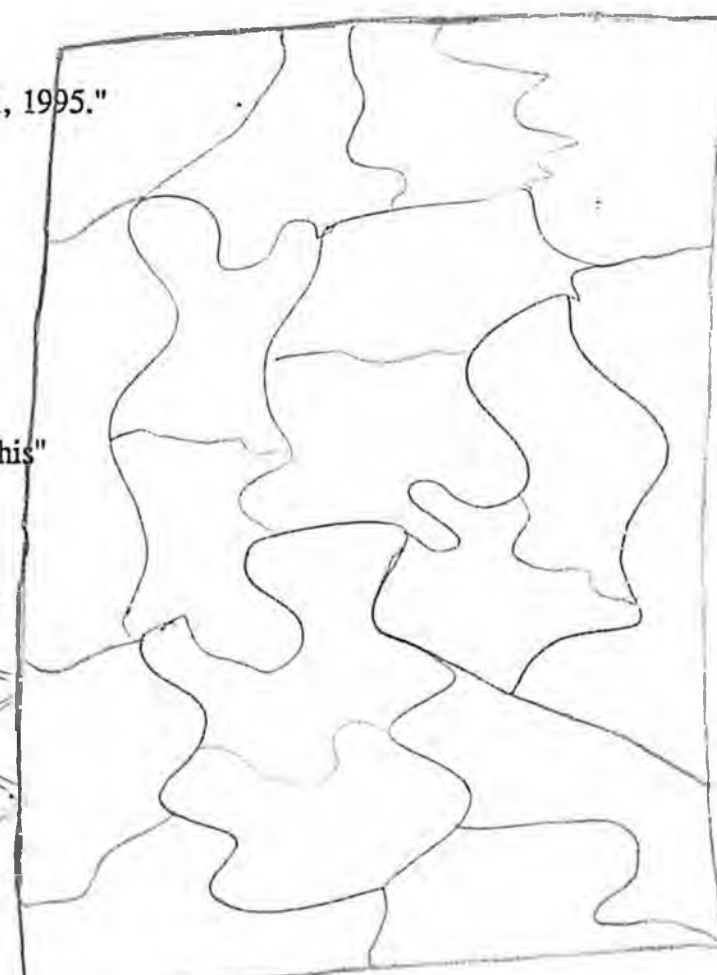
"* Sec. 5. Section 3 of this Act takes effect July 1, 1995."

Renumber the following bill section accordingly.

Page 15, line 12:

Delete "This"

Insert "Except as provided in sec. 5 of this Act, this"



SENATE AMENDMENT

BY: Division of Insurance

TO: Page 1, line 10

SENATE BILL NO. SB 74

TO: _____

HOUSE BILL NO. _____

After: "MEMBERSHIP"

Insert: "A nonprofit incorporated legal entity to be known as the Comprehensive Health Insurance Association is established."

Delete: "There is established a nonprofit incorporated legal entity to be known as the Comprehensive Health Insurance Association."

SPONSOR STATEMENT: Provides a consistent language with SB 242.

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 2, line 8

SENATE BILL NO. SB 74

TO: _____

HOUSE BILL NO. _____

After: "ORGANIZATION"

Insert: "(a) The board of directors of the association consists of nine individuals selected by the director. The director shall endeavor to appoint at least six board members who are also individual major medical insurers. If the director is unable to appoint six board members who are also individual major medical insurers, the director may fill the remaining seats with any insurer. In approving members of the board, the director shall consider, among other things, whether all types of participating members are fairly represented

(b) To the extent possible, one board member shall represent a health maintenance organization, one board member shall represent a hospital or medical service corporation, one board member's principal health insurance business shall be in the individual major medical market, and one board member's principal health insurance business shall be in the group major medical market. Members of the board 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 the association.

(c) A member of the board serves for a term of three years and may be reappointed to an unlimited number of terms. The term of a board member shall continue until a successor is appointed. A vacancy on the board shall be filled by the director. A board member may be removed by the director for cause."

Delete: "The board of directors of the association consists of seven individuals selected by participating members, subject to approval of the director. 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 by proxy. The vote shall be a weighted vote based upon the member's premiums for health 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 their services. The costs of conducting meetings of the association and its board of directors shall be borne by members of the association."

SPONSOR STATEMENT: Clarifies the terms of board members and provides a consistent board and organizational structure with SB 242.

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 2, line 23

SENATE BILL NO. SB 74

TO: _____

HOUSE BILL NO. _____

After: "association"

- Insert: " (5) take legal action as necessary to avoid the payment of improper claims against the state plan of health insurance;
- (6) design the array of health coverage products to be provided to high risk residents;
- (7) establish rules, conditions, and procedures pertaining to the insuring of high risk residents
- (8) establish actuarial functions appropriate to the operation of the association;
- (9) assess members under the provisions of this chapter and make advance interim assessments as may be reasonable and necessary for organizational and interim operating expenses; interim assessments shall be credited as offsets against regular assessments due following the close of the calendar year;
- (10) appoint appropriate legal, actuarial, and other committees as are necessary to provide technical assistance in the operation of the association, design of a policy or contract, or to assist in other functions of the association;
- (11) borrow money to accomplish the purposes of the association; notes or other evidence of indebtedness of the association that are not in default are investments for insurers and may be carried as admitted assets."

SPONSOR STATEMENT: Provides a consistent organizational structure with SB 242.

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 2, line 26

SENATE BILL NO. SB 74

TO: _____

HOUSE BILL NO. _____

After: "association"

Insert: "The director may, after notice and hearing, approve the plan of operation if the director determines it to be suitable to assure fair, reasonable and equitable administration of the state insurance plan, is fiscally sound, and does not shift program costs to other insured persons or the state. The plan of operation and amendments become effective upon approval in writing by the director.

Delete: "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 a subsequent time the association fails to submit suitable amendments to the plan, the director may, after notice and hearing, adopt reasonable regulations necessary or advisable to effectuate the provisions of this chapter. These regulations shall continue in force until modified by the director or superseded by a plan submitted by the association and approved by the director."

SPONSOR STATEMENT: Maintains the division of insurance as regulator and provides a consistent plan of operation process with SB 242.

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 3, line 3

SENATE BILL NO. SB 74

TO: _____

HOUSE BILL NO. _____

After: "operation"

Insert: "must establish procedures for

- (1) handling and accounting of program assets and money of the association and for an annual fiscal report to the director;
- (2) insuring risks under the provisions of this section;
- (3) collecting assessments from all members to provide for claims insured by the state insurance plan and for administrative expenses incurred or estimated to be incurred by the association;
- (4) selection of an administering insurer and establishment of the administering insurer's powers and duties; and
- (5) provisions necessary or proper for the execution of the powers and duties of the association."

Delete: "shall

- (1) establish procedures whereby all the powers and duties of the association under this chapter will be performed;
- (2) establish procedures for handling assets of the association;
- (3) establish the amount and method of reimbursing members of the board of directors under AS 21.55.020;
- (4) establish regular places and times for meetings of the board of directors;
- (5) establish procedures for records to be kept of all financial transactions of the association, its agent, 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 procedure whereby selections for the board of directors will be submitted to the director;
- (8) contain additional provisions necessary or proper for the execution of the powers and duties of the association."

SPONSOR STATEMENT: Provides a consistent plan of operation with SB 242.

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 3, line 26

SENATE BILL NO. SB 74

TO: _____

HOUSE BILL NO. _____

After: "AS 21.55.120"

Insert: "and may offer additional deductible alternatives.

(b) The association shall make available to residents who are high risks, eligible for and covered by Medicare, over 65 years of age, and eligible under this chapter at least one state Medicare supplement plan that meets the minimum policy standards and minimum benefit standards established by the director under AS 21.89.060

(c) The association may not refuse to offer coverage under a state plan to residents who are high risks who are eligible under this chapter, and may not refuse coverage under a state plan to residents who are high risks who are eligible under this chapter and apply for coverage and pay premiums for the coverage."

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

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

SPONSOR STATEMENT: Provides additional options for deductibles so that the association may provide high risk residents additional coverage and/or premium options. Clarifies that Medigap coverage is available only to high risk residents who are covered by Medicare. Clarifies that state plan coverage must be made available to eligible high risk residents.

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 4, line 2

SENATE BILL NO. SB 74

TO: _____

HOUSE BILL NO. _____

After: "Sec. 21.55.110 "

Insert: "STATE HEALTH INSURANCE PLAN BENEFIT COMMITTEE;
MINIMUM BENEFITS. (a) The individual state plan of health insurance
benefit committee is established in the association. The committee is
composed of the members selected by the director as follows:

(1) three members who are representatives of participating
insurers;

(2) two members who represent high risk residents;

(3) two members who represent health care providers;

(b) The committee shall recommend benefit levels, cost sharing
levels, exclusions and limitations for the individual state plan of health
insurance. The committee may design an individual state plan of health
insurance that

(1) contains benefit levels and cost sharing levels that are
consistent with the basic method of operation and the benefit plans of
health maintenance organizations, including restrictions imposed by
federal law; or

(2) includes cost containment features such as

(A) utilization review of health care services, including
review of the medical necessity of hospital, physician services, and
other health care providers;

(B) case management;

(C) selective contracting with hospitals, physicians, and
other health care providers;

(D) reasonable benefit differentials applicable to
providers that participate or do not participate in arrangements
using restricted network provisions; and

(E) other managed care provisions.

(c) The minimum standard benefits of the individual state plan of health insurance must include

- (1) benefits with a lifetime maximum of no less than \$500,000;
- (2) covered medical services performed for an individual covered by the plan for the treatment of nonoccupational disease or nonoccupational injury.

(d) The committee shall seek to maximize the coverage available to high risk residents consistent with a fiscally and actuarially sound individual state plan of health insurance. The committee shall consider the following medical services for high priority inclusion:

- (1) hospital services;
- (2) 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 by the committee, rendered during a benefit year on other than an inpatient basis, up to a benefit yearly maximum of \$4000;
- (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 benefit year if the services commence within seven days following confinement in a hospital or skilled nursing facility of at least three consecutive days for the same condition, except that in the case of an individual diagnosed by a physician as terminally ill with a prognosis of six months or less to live, the home health agency services may commence irrespective of whether the covered person was previously confined, or, if the covered person was confined, irrespective of the seven-day period, and the yearly benefit for medical social services may not exceed \$200;
- (7) hospice services for up to six months in a calendar year;
- (8) use of radium or other radioactive materials;
- (9) outpatient chemotherapy;
- (10) oxygen;
- (11) anesthetics;
- (12) nondental prosthesis and maxillo-facial prosthesis used to replace any anatomical structure lost during treatment for head and neck tumors or additional appliances essential for support of a covered 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 a covered 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 benefit year;

(19) alternatives to inpatient services; and

(20) second surgical opinions;

(d) The committee may establish advisory technical groups to assist the committee in evaluating alternative benefit levels, cost sharing levels, exclusions and limitations, cost containment features, priorities of medical services, and other appropriate issues. Members of the advisory technical groups will be appointed by the director. The committee or the board may recommend to the director persons to be considered for appointment.

Delete: "MINIMUM BENEFITS OF STATE HEALTH INSURANCE PLAN. Except as provided in AS 21.55.120 - 21.55.140, the minimum standard benefits of a health insurance plan offered under AS 21.55.100(a) shall be benefits with a maximum 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) 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 by the committee, rendered during a benefit year on other than an inpatient basis, up to a benefit yearly maximum of \$4000;

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

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

(8) use of radium or other radioactive materials;

(9) outpatient chemotherapy;

(10) oxygen;

(11) anesthetics;

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

(19) alternatives to inpatient services; and

(20) second surgical opinions;

SPONSOR STATEMENT: Provides a benefit committee similar to SB 242. Rather than mandate benefits which may make insurance unaffordable or fiscally or actuarially unsound and therefore defeat the purpose of this Act, a set of suggested priorities are provided. Advisory technical groups may provide expertise in evaluating the alternatives available to meet the goals of the Act.

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 6, line 6

SENATE BILL NO. SB 74

TO: _____

HOUSE BILL NO. _____

After: "for"

Insert: "the diagnosis or treatment of mental conditions rendered on an outpatient basis"

Delete: "services described in AS 21.55.110(3)"

SPONSOR STATEMENT: Change for clarity and consistency with other proposed changes.

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 7, line 7

SENATE BILL NO. SB 74

TO: _____

HOUSE BILL NO. _____

After: "is"

Insert: "available to be provided under a workers' compensation policy or equivalent self-insurance to a sole proprietor, business partner, or executive officer"

Delete: "required to be provided under a workers' compensation policy to a sole proprietor, business partner, or corporation officer"

SPONSOR STATEMENT: Where coverage is available to sole proprietors, partners, and executive officers through a workers' compensation policy or self-insurance program, care and services should not be provided under this Act. Therefore, it is not appropriate to shift the cost of employment related injuries to the individual state plan of health insurance.

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 7, line 16

SENATE BILL NO. SB 74

TO: _____

HOUSE BILL NO. _____

After: "travel"

Insert: "except as medically necessary as defined by the association or which it will, in the opinion of the association, reduce the overall cost of covered medical services."

Delete: "travel, other than transportation covered under AS 21.55.110(17)"

SPONSOR STATEMENT: Change for clarity and consistency with other proposed changes. Removes a mandated exclusion for travel that would reduce the overall costs of medical services.

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 7, line 3

SENATE BILL NO. SB 74

TO: _____

HOUSE BILL NO. _____

After: "Sec. 21.55.140"

Insert: "PERSONS, CARE, AND SERVICES NOT COVERED. (a)"

Delete: "CARE AND SERVICES NOT COVERED."

SPONSOR STATEMENT: Change needed to avoid shift of federal or state health care obligations to this program.

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 8, line 7

SENATE BILL NO. SB 74

TO: _____

HOUSE BILL NO. _____

After: "charged"

Insert: "AS 21.55.140 is amended by adding a new subsection to read:

(b) A state plan may not provide coverage for persons

(1) eligible for major medical coverage under any law of government including Veterans Administration benefits, native health care, or medicaid; or

"(2) eligible for major medical coverage under any health benefit program including a self-insurance plan, health care trust, or welfare trust.

SPONSOR STATEMENT: Change needed to avoid shift of government health care obligations or other noninsurance mechanisms to this program.

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 8, line 7

SENATE BILL NO. SB 74

TO: _____

HOUSE BILL NO. _____

After: "charged"

Insert: "AS 21.55.140 is amended by adding a new subsection to read:

(b) A state plan may not provide coverage for persons

(1) eligible for major medical coverage under any law of government including Veterans Administration benefits, native health care, or medicaid; or

"(2) eligible for major medical coverage under any health benefit program including a self-insurance plan, health care trust, or welfare trust.

SPONSOR STATEMENT: Change needed to avoid shift of government health care obligations or other noninsurance mechanisms to this program.

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 11, line 30

SENATE BILL NO. SB 74

TO: _____

HOUSE BILL NO. _____

After: "to"

Insert: "persons acting within the scope of a license issued in the state."

Delete: "licensed health insurance agents"

SPONSOR STATEMENT: Clarifies that all properly licensed persons may sell or market the plans."

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 14. line 9

SENATE BILL NO. SB 74

TO: _____

HOUSE BILL NO. _____

After: "rider"

Insert: "that substantially reduces coverage."

SPONSOR STATEMENT: The mere attachment of a rider may have no material effect upon the insureds coverage. This act is intended to provide coverage to persons who cannot get insurance. Therefore, only a rider that significantly reduces coverage should make a person eligible for this plan."

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 14, line 8

SENATE BILL NO. SB 74

TO: _____

HOUSE BILL NO. _____

After: "plan"

Insert: "; medical reasons may include preexisting medical conditions, a family medical history which predicts future medical conditions, or occupations which generate such frequency or severity of injury or disease that coverage is not generally available "

SPONSOR STATEMENT: Provides guidance as to what constitutes a medical condition."

SENATE AMENDMENT

BY: Division of Insurance

TO: Page 2, line 16

SENATE BILL NO. SB 74

TO: _____

HOUSE BILL NO. _____

After: "association."

Insert: "*Sec. _ . AS 21.55.020 is amended by adding a new subsection to read:

(b) The board shall study and report at least once every three years to the legislature on the effectiveness of this chapter. The report must analyze the effectiveness of the chapter in promoting rate stability, product availability, and coverage affordability. The report may contain recommendations for actions to improve the overall effectiveness, efficiency, and fairness of the ^{individual} ~~small-group~~ health insurance marketplace. The report may contain recommendations for legislative or other regulatory action.

(c) Upon receipt of a report from the board, the legislature must review the program to determine the effect of the program on its target market, the effect of the program on the overall health insurance market, and whether the program should be continued."

SPONSOR STATEMENT: Provides for legislative review of the program to determine if it should be continued."

CS FOR SENATE BILL NO. 74 (HES)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - SECOND SESSION

BY THE SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

Offered:

Referred:

Sponsor(s): SENATORS KERTTULA, Cotten, Menard

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to pooled health insurance for individuals who are uninsured or denied
2 adequate coverage; and providing for an effective date."

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

4 * Section 1. PURPOSE. It is the purpose of this Act to provide access to health insurance to all
5 residents of the state who are presently denied adequate health insurance or who are considered
6 uninsurable.

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

8 **CHAPTER 55. STATE HEALTH INSURANCE.**

9 **ARTICLE 1. COMPREHENSIVE HEALTH INSURANCE ASSOCIATION.**

10 **Sec. 21.55.010. CREATION; MEMBERSHIP.** There is established a nonprofit
11 incorporated legal entity to be known as the Comprehensive Health Insurance Association.
12 Membership consists of all licensed hospital or medical service corporations in the state that offer
13 subscriber contracts for major medical coverage and all insurers licensed to transact health
14 insurance in the state that offer policies for major medical coverage on an expense incurred basis.

1 All members shall maintain membership in the association as a condition of doing health
2 insurance business, or being able to offer subscriber contracts, in the state.

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

18 (b) The board shall study and report to the legislature at least once every three years on
19 the effectiveness of this chapter. The report must include an analysis of the effectiveness of this
20 chapter in promoting rate stability, product availability, and affordability of coverage. The report
21 may contain recommendations for legislative or other regulatory action. OK

22 Sec. 21.55.030. GENERAL POWERS. The association may

- 23 (1) exercise the powers granted to insurers under the laws of the state;
- 24 (2) sue or be sued;
- 25 (3) enter into contracts with insurers, similar associations in other states, or with
26 other persons for the performance of administrative functions;
- 27 (4) establish administrative and accounting procedures for the operation of the
28 association; and
- 29 (5) receive funds from sources other than members of the association. ?

30 Sec. 21.55.040. PLAN OF OPERATION. (a) The association shall submit to the
31 director a plan of operation and amendments necessary or suitable to assure the fair, reasonable,

1 and equitable administration of the association. The plan of operation and amendments become
2 effective upon approval in writing by the director. If the association fails to submit a suitable
3 plan of operation by a date that is 180 days after the effective date of this Act, or if at subsequent
4 time the association fails to submit suitable amendments to the plan, the director may, after notice
5 and hearing, adopt reasonable regulations necessary or advisable to effectuate the provisions of
6 this chapter. These regulations shall continue in force until modified by the director or
7 superseded by a plan submitted by the association and approved by the director.

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

9 (c) The plan of operation shall

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

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

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

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

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

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

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

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

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

26 Sec. 21.55.060. TAX EXEMPTION. The association is exempt from the payment of fees
27 and taxes levied by the state or any of its political subdivisions except taxes levied on real or
28 personal property.

29 ARTICLE 2. STATE HEALTH INSURANCE PLANS.

30 Sec. 21.55.100. TYPES OF INSURANCE PLANS. (a) The association shall make
31 available to residents who are high risks an individual state plan of health insurance. The

1 association shall offer three alternatives related to deductibles as described in AS 21.55.120 and
2 may offer additional deductible alternatives. ok

3 (b) The association shall make available to residents who are high risks, eligible for and
4 covered by Medicare, 65 years of age or older, and eligible under this chapter at least one ok
5 Medicare supplement plan that meets the minimum policy standards and minimum benefit
6 standards established by regulations adopted by the director under AS 21.89.060. Good

7 (c) The association may not refuse to offer coverage under a state plan to residents who
8 are high risks and who are eligible under this chapter. The association may not refuse coverage
9 under a state plan to residents who are high risks, are eligible under this chapter, apply for
10 coverage, and pay the required premium. Good

11 Sec. 21.55.110. MINIMUM BENEFITS OF STATE HEALTH INSURANCE PLAN.

12 Except as provided in AS 21.55.120 - 21.55.140, the minimum standard benefits of a health
13 insurance plan offered under AS 21.55.100(a) shall be benefits with a lifetime maximum of
14 \$1,000,000 per individual for usual, customary, reasonable, or prevailing charges or, when
15 applicable, the allowance agreed upon between a provider and the writing carrier for charges, for
16 the following medical services performed for an individual covered by the plan for the diagnosis
17 or treatment of nonoccupational disease or nonoccupational injury:

18 (1) hospital services;

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

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

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

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

28 (6) home health agency services up to a maximum of 270 visits in a calendar year
29 if the services commence within seven days following confinement in a hospital or skilled
30 nursing facility of at least three consecutive days for the same condition, except that in the case
31 of an individual diagnosed by a physician as terminally ill with a prognosis of six months or less

1 to live, the home health agency services may commence irrespective of whether the covered
2 person was previously confined or, if the covered person was confined, irrespective of the seven-
3 day period, and the yearly benefit for medical social services may not exceed \$200;

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

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

6 (9) outpatient chemotherapy;

7 (10) oxygen;

8 (11) anesthetics;

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

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

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

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

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

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

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

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

31 (20) second surgical opinions;

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

3 Sec. 21.55.120. DEDUCTIBLES AND COPAYMENTS. (a) A state plan other than a
4 Medicare supplement plan may require deductibles of \$200 a person, \$500 a person, or \$1,000
5 a person. The amount of the deductible may not be greater when a service is rendered on an
6 outpatient basis than when that service is offered on an inpatient basis. Expenses incurred during
7 the last three months of a calendar year and actually applied to an individual's deductible for that
8 year shall also be applied to that individual's deductible in the following calendar year. The
9 \$200 maximum, the \$500 maximum, and the \$1,000 maximum may be adjusted yearly to corre-
10 spond with the change in the medical care component of the Consumer Price Index, as adjusted
11 by the director. The base year for the computation shall be the first full calendar year of
12 operation of the association.

13 (b) A state plan other than a Medicare supplement plan shall require a maximum
14 copayment of 20 percent for charges for all types of health care in excess of the deductible and
15 50 percent for services described in AS 21.55.110(3) in excess of the deductible.

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

23 (d) In this section, "Consumer Price Index" means the Consumer Price Index for all
24 urban consumers for the Anchorage Metropolitan Area compiled by the Bureau of Labor
25 Statistics, United States Department of Labor.

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

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

31 (2) medical advice or treatment was recommended or received within the period

1 of three months immediately before the effective date of coverage.

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

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

12 Sec. 21.55.140. PERSONS, CARE, AND SERVICES NOT COVERED. (a) A state plan
13 may not provide benefits for charges for the following:

14 (1) care for an injury or disease either

15 (A) arising out of and in the course of an employment subject to a
16 workers' compensation or similar law or where the benefit is available to be provided
17 under a workers' compensation policy or equivalent self-insurance to a sole proprietor,
18 business partner, or corporation officer; or

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

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

25 (3) travel, other than transportation covered under AS 21.55.110(17);

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

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

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

1 section;

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

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

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6

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

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

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

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

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

16 (14) experimental procedures; and

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

18 (b) A state plan may not provide coverage for a person eligible for major medical
19 coverage under

20 (1) another state or federal law, including veterans' benefits. Native health care,
21 or Medicaid; or

22 (2) another health benefit program, including a self-insurance plan,* health care
23 trust, or welfare trust.

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

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

29 (c) The five members of the association that insure, or have subscriber contracts with,
30 the largest number of individuals in the state under plans with benefits substantially equivalent
31 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

1 state plan. The premium for a state plan may not exceed 150 percent of the average of those five
2 estimates. OK

3 ARTICLE 3. ADMINISTRATION OF PLANS.

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

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

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

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

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

28 (e) The writing carrier shall be reimbursed from the state plan premiums received for its
29 direct and indirect expenses for administering the plan. Direct and indirect expenses shall include
30 a pro rata reimbursement for that portion of the writing carrier's administrative, printing, claims
31 administration, management and building overhead expenses that are assignable to the

1 maintenance and administration of the state plans. The association shall approve cost accounting
2 methods to substantiate the writing carrier's cost reports consistent with generally accepted
3 accounting principles. Direct and indirect expenses may not include costs directly related to the
4 original submission of policy forms before selection as the writing carrier.

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

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

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

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

22 (d) The association shall make an annual determination of each member's liability, if any,
23 and may make an annual fiscal year end assessment if necessary. The association may also,
24 subject to the approval of the director, provide for interim assessments against the members as
25 may be necessary to assure the financial capability of the association in meeting the incurred or
26 estimated claims expenses of the state plans and operating and administrative expenses of the
27 association until the association's next annual fiscal year end assessment. Payment of an
28 assessment is due within 30 days of receipt by a member of written notice of a fiscal year end
29 or interim assessment. Failure by a member to tender to the association the assessment within
30 30 days shall be grounds for revocation of a member's certificate of authority. A member that
31 ceases to do health insurance business in the state, or ceases to offer subscriber contracts in the

1 state, due to revocation, suspension, or voluntary surrender of its certificate of authority remains
2 liable for assessments through the calendar year that the health insurance business ceased. The
3 association may decline to levy an assessment against a member if the assessment would not
4 exceed \$10. Assessments paid by a member are a general expense of the member.

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

8 ARTICLE 4. ENROLLMENT IN THE STATE HEALTH INSURANCE PLAN.

9 Sec. 21.55.300. ELIGIBILITY FOR STATE HEALTH INSURANCE. (a) Except as
10 provided in (b) of this section, a state resident who is a high risk is eligible to enroll in a state
11 plan described in AS 21.55.100.

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

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

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

- 20 (1) name, address, age, and length of residency of the applicant;
- 21 (2) a designation of the plan desired, including deductible option chosen;
- 22 (3) information relevant to whether the person is a high risk.

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

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

31 (b) Insurance under a state plan is effective retroactively to the date that the person's

1 previous contract or policy terminated if the person

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

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

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

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

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

14 (c) A person may not sell or market a qualified state plan unless the person is acting *
15 within the scope of a license issued in this state.

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

20 ARTICLE 5. GENERAL PROVISIONS.

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

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

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

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

29 (4) adopt regulations necessary to administer this chapter.

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

1 claim under a state plan issued by a writing carrier.

2 Sec. 21.55.500. DEFINITIONS. In this chapter

3 (1) "association" means the Comprehensive Health Insurance Association created
4 in AS 21.55.010;

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

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

9 (4) "health insurance" means an individual or group contract or other plan
10 providing coverage of health care services that is issued by a health insurance company, a
11 hospital service corporation, a medical service corporation, or a health maintenance organization;
12 "health insurance" includes disability insurance under AS 21.12.050;

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

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

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

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

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

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

29 (6) "hospice services" means services provided under a coordinated comprehensive
30 program of palliative and supportive care on a 24-hour, seven days per week basis for persons
31 who have been diagnosed as terminally ill and their families by an interdisciplinary team of

1 professionals or volunteers under an incorporated central administration that has a physician as
2 medical director;

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

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

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

19 (10) "residents who are high risks" means residents who

20 (A) have been rejected for medical reasons after applying for a subscriber
21 contract, a policy of health insurance, or a Medicare supplement policy by at least two
22 association members within the six months immediately preceding the date of application
23 for a state plan; medical reasons may include preexisting medical conditions, a family
24 history that predicts future medical conditions, or an occupation that generates a frequency
25 or severity of injury or disease that results in coverage not being generally available; or

26 (B) have had a restrictive rider placed on a subscriber contract, a health
27 insurance policy, or a Medicare supplement policy that substantially reduces coverage;

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

30 (12) "usual, customary, reasonable, or prevailing charge" means the charge for
31 a medical care procedure, service, or supply item that is the lowest of the following amounts:

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* may want to remove

- 1 (A) the billed amount for the medical service provider's actual charge;
2 (B) the charge usually made by that provider for performing that procedure
3 or service or for providing the supply item; or
4 (C) the customary charge, based on a profile of charges made for the same
5 medical procedure, service, or supply item in the same geographical area by other
6 providers that have performed the same procedure or service or can provide the same
7 supply item;

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

10 * Sec. 3. The association established by sec. 2 of this Act shall make available to residents the plans
11 required by AS 21.55.100, enacted in sec. 2 of this Act, by January 1, 1993.

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

SENATE BILL NO. 74

IN THE LEGISLATURE OF THE STATE OF ALASKA

SEVENTEENTH LEGISLATURE - FIRST SESSION

BY SENATOR KERTTULA

Introduced: 1/22/91
 Referred: I.&C and Finance

A BILL

FOR AN ACT ENTITLED

1 "An Act relating to pooled health insurance for individuals who are uninsured or denied
 2 adequate coverage; and providing for an effective date."

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

4 * Section 1. PURPOSE. It is the purpose of this Act to provide access to health insurance to all
 5 residents of the state who are presently denied adequate health insurance or who are considered
 6 uninsurable.

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

8 CHAPTER 55. STATE HEALTH INSURANCE.

9 ARTICLE 1. COMPREHENSIVE HEALTH INSURANCE ASSOCIATION.

10 Sec. 21.55.010. CREATION; MEMBERSHIP. There is established a nonprofit
 11 incorporated legal entity to be known as the Comprehensive Health Insurance Association.
 12 Membership consists of all licensed hospital or medical service corporations in the state that offer
 13 subscriber contracts for major medical coverage and all insurers licensed to transact health
 14 insurance in the state that offer policies for major medical coverage on an expense incurred basis.

1 All members shall maintain membership in the association as a condition of doing health
2 insurance business, or being able to offer subscriber contracts, in the state.

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

17 Sec. 21.55.030. GENERAL POWERS. The association may

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

24 Sec. 21.55.040. PLAN OF OPERATION. (a) The association shall submit to the
25 director a plan of operation and amendments necessary or suitable to assure the fair, reasonable,
26 and equitable administration of the association. The plan of operation and amendments become
27 effective upon approval in writing by the director. If the association fails to submit a suitable
28 plan of operation by a date that is 180 days after the effective date of this Act, or if at subsequent
29 time the association fails to submit suitable amendments to the plan, the director may, after notice
30 and hearing, adopt reasonable regulations necessary or advisable to effectuate the provisions of
31 this chapter. These regulations shall continue in force until modified by the director or

1 superseded by a plan submitted by the association and approved by the director.

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

3 (c) The plan of operation shall

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

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

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

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

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

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

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

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

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

20 Sec. 21.55.060. TAX EXEMPTION. The association is exempt from the payment of fees
21 and taxes levied by the state or any of its political subdivisions except taxes levied on real or
22 personal property.

23 ARTICLE 2. STATE HEALTH INSURANCE PLANS.

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

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

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

1 is a high risk in accordance with AS 21.55.500(9) and the director's regulations.

2 Sec. 21.55.110. MINIMUM BENEFITS OF STATE HEALTH INSURANCE PLAN.

3 Except as provided in AS 21.55.120 - 21.55.140, the minimum standard benefits of a health
4 insurance plan offered under AS 21.55.100(a) shall be benefits with a lifetime maximum of
5 \$1,000,000 per individual for usual, customary, reasonable, or prevailing charges or, when
6 applicable, the allowance agreed upon between a provider and the writing carrier for charges, for
7 the following medical services performed for an individual covered by the plan for the diagnosis
8 or treatment of nonoccupational disease or nonoccupational injury:

9 (1) hospital services;

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

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

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

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

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

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

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

28 (9) outpatient chemotherapy;

29 (10) oxygen;

30 (11) anesthetics;

31 (12) nondental prosthesis and maxillo-facial prosthesis used to replace any

1 anatomic structure lost during treatment for head and neck tumors or additional appliances
2 essential for the support of the prosthesis;

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

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

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

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

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

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

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

22 (20) second surgical opinions;

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

25 Sec. 21.55.120. DEDUCTIBLES AND COPAYMENTS. (a) A state plan other than a
26 Medicare supplement plan may require deductibles of \$200 a person, \$500 a person, or \$1,000
27 a person. The amount of the deductible may not be greater when a service is rendered on an
28 outpatient basis than when that service is offered on an inpatient basis. Expenses incurred during
29 the last three months of a calendar year and actually applied to an individual's deductible for that
30 year shall also be applied to that individual's deductible in the following calendar year. The
31 \$200 maximum, the \$500 maximum, and the \$1,000 maximum may be adjusted yearly to corre-

1 spond with the change in the medical care component of the Consumer Price Index, as adjusted
2 by the director. The base year for the computation shall be the first full calendar year of
3 operation of the association.

4 (b) A state plan other than a Medicare supplement plan shall require a maximum
5 copayment of 20 percent for charges for all types of health care in excess of the deductible and
6 50 percent for services described in AS 21.55.110(3) in excess of the deductible.

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

14 (d) In this section, "Consumer Price Index" means the Consumer Price Index for all
15 urban consumers for the Anchorage Metropolitan Area compiled by the Bureau of Labor
16 Statistics, United States Department of Labor.

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

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

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

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

26 (c) A state plan issued to a person whose previous subscriber contract, health policy, or
27 Medicare supplement policy was involuntarily terminated shall credit the time covered under the
28 previous contract or policy toward an exclusion for preexisting conditions under the state plan
29 if the previous contract or policy had a similar preexisting condition exclusion and the person
30 applies for a state plan within 31 days after termination of the previous contract or policy. If a
31 person covered by this subsection is accepted by the writing carrier and pays a specified premium

1 for retroactive coverage, the state plan is effective retroactively to the date that the person's
2 previous contract or policy terminated.

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

5 (1) care for an injury or disease either

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

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

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

16 (3) travel, other than transportation covered under AS 21.55.110(17);

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

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

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

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

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

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

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

- 1 (11) eyeglasses, contact lenses, or hearing aids or the fitting of them;
2 (12) dental care not specifically covered by this chapter;
3 (13) services of a registered nurse who ordinarily resides in the covered
4 individual's home, or who is a member of the covered individual's family or the family of the
5 covered individual's spouse;
6 (14) experimental procedures; and
7 (15) services and supplies for which the patient was not charged.

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

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

13 (c) The five members of the association that insure, or have subscriber contracts with,
14 the largest number of individuals in the state under plans with benefits substantially equivalent
15 to the state plan benefits shall submit to the association an estimate of the rate that would be
16 actuarially sound for a person who is a standard risk for coverage substantially equivalent to the
17 state plan. The premium for a state plan may not exceed 125 percent of the average of those five
18 estimates.

19 ARTICLE 3. ADMINISTRATION OF PLANS.

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

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

1 association, including the writing carrier. The association shall follow the provisions of
2 AS 21.55.210 in selecting a writing carrier for the subsequent three-year period.

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

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

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

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

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

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

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

28 (c) Each member of the association shall share the losses due to claims expenses of the
29 state plans issued or approved for issuance by the association, and shall share in the operating
30 and administrative expenses incurred or estimated to be incurred by the association incident to
31 the conduct of its affairs. Claims expenses of the state plan that exceed the premium payments

Open door to new funds - Red hat in hospital

1 allocated to the payment of benefits shall be the liability of the members. Each member shall
2 share in the claims expense of the state plans and operating and administrative expenses of the
3 association in an amount equal to the ratio of the member's total fees for subscriber contracts or
4 total health insurance premiums, received from or on behalf of state residents, as divided by the
5 total subscriber fees and health insurance premiums received by all members from or on behalf
6 of state residents, as determined by the director.

*Assessments
paid by
members*

7 (d) The association shall make an annual determination of each member's liability, if any,
8 and may make an annual fiscal year end assessment if necessary. The association may also,
9 subject to the approval of the director, provide for interim assessments against the members as
10 may be necessary to assure the financial capability of the association in meeting the incurred or
11 estimated claims expenses of the state plans and operating and administrative expenses of the
12 association until the association's next annual fiscal year end assessment. Payment of an
13 assessment is due within 30 days of receipt by a member of written notice of a fiscal year end
14 or interim assessment. Failure by a member to tender to the association the assessment within
15 30 days shall be grounds for revocation of a member's certificate of authority. A member that
16 ceases to do health insurance business in the state, or ceases to offer subscriber contracts in the
17 state, due to revocation, suspension, or voluntary surrender of its certificate of authority remains
18 liable for assessments through the calendar year that the health insurance business ceased. The
19 association may decline to levy an assessment against a member if the assessment would not
20 exceed \$10. Assessments paid by a member are a general expense of the member.

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

24 **ARTICLE 4. ENROLLMENT IN THE STATE HEALTH INSURANCE PLAN.**

25 **Sec. 21.55.300. ELIGIBILITY FOR STATE HEALTH INSURANCE.** (a) Except as
26 provided in (b) of this section, a state resident who is a high risk is eligible to enroll in a state
27 plan described in AS 21.55.100.

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

Chase

1 (c) Additional eligibility requirements may not be imposed by the director, the
2 association, or a writing carrier. *Requirements to apply it*

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

- 5 (1) name, address, age, and length of residency of the applicant;
6 (2) a designation of the plan desired, including deductible option chosen;
7 (3) information relevant to whether the person is a high risk.

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

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

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

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

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

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

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

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

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

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

5 ARTICLE 5. GENERAL PROVISIONS.

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

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

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

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

14 (4) adopt regulations necessary to administer this chapter.

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

18 Sec. 21.55.500. DEFINITIONS. In this chapter

19 (1) "association" means the Comprehensive Health Insurance Association created
20 in AS 21.55.010;

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

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

25 (4) "health insurance" means an individual or group contract or other plan
26 providing coverage of health care services that is issued by a health insurance company, a
27 hospital service corporation, a medical service corporation, or a health maintenance organization;
28 "health insurance" includes disability insurance under AS 21.12.050;

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

31 (A) intermittent or part-time nursing services of a registered professional

1 nurse or a licensed practical nurse, that are provided to a person under the continued
2 direction of the person's physician and within the limitation of the nurse's license;

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

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

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

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

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

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

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

28 (9) "resident" means a person who is physically present in the state, has lived in
29 the state for at least the six consecutive months immediately preceding application for a state
30 plan, and intends to remain permanently in the state; "resident" also includes a person who is not
31 physically present in the state if the person lived in the state for at least six of the nine months

1 immediately preceding application for a state plan and the person's absence from the state is for
2 medical treatment or education; a person ceases to be a resident if the person is absent from the
3 state for more than 90 consecutive days for reasons other than for medical treatment or education;

4 (10) "residents who are high risks" means residents who

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

9 (B) have had a restrictive rider placed on a subscriber contract, a health
10 insurance policy, or a Medicare supplement policy;

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

13 (12) "usual, customary, reasonable, or prevailing charge" means the charge for
14 a medical care procedure, service, or supply item that is the lowest of the following amounts:

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

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

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

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

24 * Sec. 3. The association established by sec. 2 of this Act shall make available to residents the plans
25 required by AS 21.55.100, enacted in sec. 2 of this Act, by January 1, 1992.

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

STATE OF ALASKA

DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT

DIVISION OF INSURANCE

WALTER J. HICKEL, GOVERNOR

P.O. BOX 110805
JUNEAU, ALASKA 99811-0805
PHONE (907) 465-2515

April 10, 1992

MS MELISSA FOUSE, STAFF AID
OFFICE OF SENATOR STURGULEWSKI
STATE CAPITOL
JUNEAU AK 99801-1182

Dear Ms. Fouse:

Re: Testimony for HSS Health
Committee on April 8, 1992

The Division of Insurance suggests the following changes in regard to SB 74.

1. Sec. 21.55.040. Plan of Operation. We suggest that language be added stating:
 - (a) Provide for and employ cost containment measures and requirements including, but not limited to, preadmission screening, second surgical opinion, concurrent utilization review, and individual case management for the purpose of making the benefit plan more cost effective.
 - (b) Design, utilize, contract or otherwise arrange for the delivery of cost effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations and other limited network provider arrangements.
 - (c) The board shall make an annual report to the director of Insurance which shall also be filed with the legislature. The report shall summarize the activities of the plan in the preceding calendar year, including the net written and earned premiums, plan enrollment, the expense of administration, and the paid and incurred losses.

2. Sec. 21.55.100. Types of Insurance Plans

Amend section (b) to read: The association shall make available to residents who are high risk and are obtaining Medicare, 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.

3. Sec. 21.55.130(1). Preexisting Condition

Line 19 and line 23, increase to six months.

4. Sec. 21.55.150. State Plan Premiums

Line 17, amended to read: The premium for a state plan may not exceed 150 percent of the average of those five estimates.

5. Sec. 21.55.220. Operation of Plan. Subsection (f) is added.

The association has the right to generate additional funds in the form of fundraisers, pull-tabs and to obtain private and public donations, etc.

6. Sec. 21.55.300. Eligibility for State Health Insurance. By extending subsection (b).

(b) The board shall promulgate a list of medical or health conditions for which a person shall be eligible for plan coverage without applying for health insurance pursuant to subsection (a). Persons who can demonstrate the existence or history of any medical or health conditions on the list promulgated by the board shall not be required to provide the evidence specified in subsection (a). The list shall be effective on the first day of the operation of the plan and may be amended from time-to-time as may be appropriate.

(c) Each resident dependent of a person who is eligible for plan coverage shall also be eligible for plan coverage.

(d) A person shall not be eligible for coverage under the plan if:

(1) the person has or obtains health insurance coverage substantially similar to or more comprehensive than a plan policy, or would be eligible to have coverage if the person elected to obtain it except that:

(A) A person may maintain other coverage while satisfying any preexisting condition waiting period under a plan policy; or

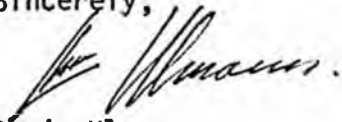
(B) A person may maintain plan coverage while satisfying a preexisting condition waiting period under another health insurance policy.

(2) the person is determined to be eligible for health care benefits under [reference state Medicaid law];

APRIL 10, 1992

- (3) the person has previously terminated plan coverage unless twelve (12) months have lapsed since such termination;
 - (4) the plan has paid out \$ (Lifetime maximum) in benefits on behalf of the person;
 - (5) the person is an inmate or resident of a public institution;
 - (6) the person's premiums are paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider.
- (e) coverage shall cease:
- (1) on the date a person is no longer a resident of this state;
 - (2) on the date a person requests coverage to end;
 - (3) upon the death of the covered person;
 - (4) on the date state law requires cancellation of the policy; or
 - (5) at the option of the plan, thirty (30) days after the plan makes any inquiry concerning the person's eligibility or place of residence to which the person does not reply.
- (f) Except under the circumstances described in subsection (d), a person who ceases to meet the eligibility requirements of this section may be terminated at the end of the policy period for which the necessary premiums have been paid.

Sincerely,



Chris Ulmann
Insurance Market Analyst

CU/ems6333W
041092c

Proposed Amendments to S.B. 74 (ActNA)

CARVE-OUTS FROM EMPLOYER GROUPS

This amendment addresses the potential problem of insurers' carving out unhealthy employees and dependents from employer groups and "dumping" such individuals into the high-risk pool. It is taken from the Connecticut statute governing that state's individual high-risk plan (Conn. Gen. Stat. Ann. §38a-556(c) (West Supp. 1992)).

Page 10, line 27 - Insert after the period:

"No member [of the association] shall be permitted to select out individual lives from an employer group to be insured by or through the association."

Page 9, lines 26-27 - Delete the entire subsection and re-letter the remaining subsections accordingly. This section contemplates employers' carving out unhealthy employees from the employer group and sending those risks to the high-risk plan. Such carve-outs by employers, as well as by insurers, are contrary to the purpose of the high-risk pool, will produce an excessively large pool, and should be illegal.

ELIGIBILITY FOR THE HIGH-RISK PLAN

This amendment clarifies that persons possessing or eligible for substantially similar coverage under other health plans are not eligible for the high-risk plan. It is taken from the NAIC's MODEL HEALTH INSURANCE POOLING MECHANISM ACT.

Page 10, lines 28-29 - Delete everything up to the period. Insert the following:

"A person shall not be eligible for coverage under the plan if the person has or obtains health insurance coverage substantially similar to or more comprehensive than a plan policy, or would be eligible to have coverage if the person elected to obtain it. Persons otherwise eligible for plan coverage may, however, solely for the purpose of having coverage for a preexisting condition, maintain other coverage only while satisfying any preexisting condition waiting period under a plan policy."

PREMIUM LEVEL

Page 8, line 17 - Delete "125" and insert "150". Setting the premiums as low as Minnesota's will push Alaska's pool into the same deficit situation as Minnesota is now facing (\$28 million). A low premium will unduly raise assessment levels for insurers and cause severe cost-shifting from the high-risk population to other insureds in Alaska.

REJECTION FOR MEDICAL REASONS

Page 14, line 4 - Reject the proposed amendment to delete "for medical reasons". The whole purpose of a high-risk plan is to enable unhealthy individuals who cannot get coverage to obtain it. Thus, the only rational basis for accepting otherwise rejected individuals under this plan is that they were rejected for medical reasons.



Health Insurance Association of America

April 8, 1992

The Honorable Arliss Sturgulewski
Chairperson, Senate Health, Education and Social Services
Committee
Alaska Legislature
P.O. Box V
Juneau, Alaska 99811

Dear Senator Sturgulewski:

Thank you very much for the privilege of testifying by telephone during the hearing on April 8 on SB74 and SB242.

Reflecting on some of the comments and questions that occurred during the testimony on SB74, I thought that you and other members of Senate Health, Education and Social Services Committee would find of interest the attached charts from the Comprehensive Health Insurance For High-Risk Individuals by Aaron Trippler (August 1991). Specifically, the following charts list the life time benefits, deductibles offered and preexisting waiting periods and condition periods for the 25 states that currently have uninsurable risk pools in operation. In addition, I have extrapolated from the state by state discussion included in the Trippler monograph, the percentage of average premium charged for individual coverage. I believe these charts and the extrapolation will indicate to the committee, that which was being proposed in SB74 is different from the vast majority of other uninsurable risk pools. For example, SB74 while suggesting a preexisting six month waiting period, only permits a three month condition for treatment or diagnosis prior to the beginning of coverage. In virtually all but four of the 25 states with pools, the condition periods are at least six months if not longer. In regard to the deductibles, no other state has a deductible as low as \$200, one state has a deductible at \$250 with most of the states offering the lowest deductible as \$500 and others with a \$1000 or \$1,500 deductible. Regarding the life time benefit of \$1 million as proposed in SB74, only three other states have that amount or greater, with the vast majority having life time benefits of between \$250,000 and \$500,000

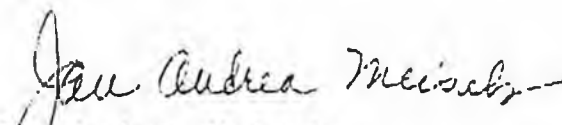
Senator Arliss Sturgulewski
April 8, 1992
Page 2

I am also including the pages that discuss the different state funding mechanisms for the expected pool losses. Please note, that a number of states do have some dedicated funding mechanism i.e. a hospital bed tax, an inclusion on the state income tax form, a dedicated funding from a tax on cigarettes, general revenue funds, etc. Other states do permit a premium tax offset recognizing that only the insured business, will be assessed in proportion to their premiums in the state. As Mr. Ullmann indicated during his testimony, the trend is away from insured business toward self insured business, and as a result, the resulting losses become a "tax" on a smaller and smaller insured base, raising the costs to the remaining insureds.

The attached compilation indicates for each state what the premium cap is for each of the states that currently have an uninsurable risk pool.

I hope the attached information helps the committee in its deliberations in determining whether SB74 should be amended as per suggestions by HIAA and others who testified during the April 8 hearing. Please feel free to contact me if I may be any additional assistance to you or other members of the committee in their deliberations. Again, I appreciate you permitting me to testify by phone.

Sincerely,


Jan Andrea Meisels
Legislative Director

JAM/ag

Attachment

cc: Senator Paul Fischer
Senator Samuel Cotten
Senator Lyman Hoffman
Senator Jay Kerttula
Senator Curt Menard

HIGH RISK POOL PREMIUM CAPS BY STATE

California	125 percent of the standard average individual rate
Colorado	150 percent initial - 175 percent maximum
Connecticut	125 percent initial - 150 percent maximum
Florida	After 1991: 200 percent - 300 percent
Georgia	125 percent initial - 150 percent maximum
Illinois	135 percent
Indiana	150 percent
Iowa	150 percent
Louisiana	Not less than 150 percent initial: 200 percent maximum
Maine	150 percent maximum
Minnesota	125 percent
Mississippi	150 percent initially; 175 percent maximum
Missouri	Not less than 150 percent initial - 200 percent maximum
Montana	Not less than 150 percent, not more than 400 percent
Nebraska	135 percent of rates established as applicable for individual risks
New Mexico	150 percent
North Dakota	135 percent
Oregon	150 percent
S. Carolina	200 percent initial, 300 percent maximum
Tennessee	150 percent maximum
Texas	Not less than 150 percent, not more than 200 percent
Utah	Premium cap 150 percent
Washington	150 percent maximum
Wisconsin	150 percent maximum
Wyoming	150 percent minimum, 200 percent maximum

Source: Comprehensive Health Insurance for High-Risk Individuals
by Aaron Trippler - August 1991

Comprehensive Health Insurance for High-risk Individuals

A STATE-BY-STATE ANALYSIS
(Fifth Edition)

- Operating statistics
- Model bill
- Program descriptions
- Premiums/Benefits
- Financing mechanisms

By:

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August 1991

BENEFITS AND CRITERIA FOR EXISTING PLANS

MAXIMUM LIFETIME BENEFITS PROVIDED

NOTE: The Maximum Lifetime Benefit Limitation is intended to limit the amount of coverage to be provided to the policyholder over the life of the policy. However, some states have incorporated a provision to deal with individuals reaching this limit. The wording on this provision states the plan may impose a premium surcharge and issue a new policy.

<u>STATE</u>	<u>BENEFIT</u>
CALIFORNIA	\$500,000 Lifetime Benefit — \$50,000 Annual
COLORADO	\$500,000 Lifetime Benefit
CONNECTICUT	\$1,000,000 Lifetime Benefit
FLORIDA	\$500,000 Lifetime Benefit
GEORGIA	\$500,000 Lifetime Benefit — \$100,000 Annual
ILLINOIS	\$500,000 Lifetime Benefit
INDIANA	No Maximum Lifetime Benefit
IOWA	\$250,000 Lifetime Benefit
LOUISIANA	\$500,000 Lifetime Benefit — \$100,000 Annual
MAINE	\$500,000 Lifetime Benefit
MINNESOTA	Regular Plan — \$500,000 Lifetime Benefit Medicare Plan -- \$100,000 Lifetime Benefit
MISSISSIPPI	\$250,000 Lifetime Benefit
MISSOURI	\$1,000,000 Lifetime Benefit
MONTANA	\$250,000 Lifetime Benefit

NEBRASKA	\$500,000 Lifetime Benefit
NEW MEXICO	No Maximum Lifetime Benefit
NORTH DAKOTA	\$250,000 Lifetime Benefit
OREGON	\$500,000 Lifetime Benefit
SOUTH CAROLINA	\$250,000 Lifetime Benefit
TENNESSEE	\$500,000 Lifetime Benefit
TEXAS	\$500,000 Lifetime Benefit
UTAH	\$500,000 Lifetime Benefit — \$100,000 Annual
WASHINGTON	\$500,000 Lifetime Benefit
WISCONSIN	\$500,000 Lifetime Benefit
WYOMING	\$250,000 Lifetime Benefit

DEDUCTIBLES

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

<u>STATE</u>	<u>DEDUCTIBLES OFFERED</u>
CALIFORNIA	\$500 for PPOs — None for HMOs
COLORADO	\$300; \$750; \$2,000
CONNECTICUT	\$500; \$1,250; \$2,000
FLORIDA	\$1,000; \$1,500; \$2,000
GEORGIA	\$500; \$1,500
ILLINOIS	\$500; \$1,000/Individual \$1,000; \$1,500/Family
INDIANA	\$500; \$1,000; \$1,500
IOWA	\$500; \$1,000; \$1,500; \$2,000
LOUISIANA	\$1,000; \$2,000
MAINE	\$500
MINNESOTA	\$500; \$1,000
MISSISSIPPI	To Be Determined
MISSOURI	\$500; \$1,000
MONTANA	\$1,000
NEBRASKA	\$250; \$500; \$1,000
NEW MEXICO	\$500; \$1,000
NORTH DAKOTA	\$500; \$1,000
OREGON	\$500
SOUTH CAROLINA	\$500
TENNESSEE	\$1,000
TEXAS	Not less than \$250/Individual and \$500/Family
UTAH	\$500; \$1,000
WASHINGTON	\$500; \$1,000
WISCONSIN	\$1,000
WYOMING	Varies according to plan chosen

WAITING PERIOD FOR PRE-EXISTING CONDITIONS

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.

Several states have expanded the pre-existing waiting period condition clause to cover other areas. One option being used by several drafts allows a waiver of this waiting period if the pre-existing condition exclusion has already been satisfied under any prior health insurance coverage which was involuntarily terminated and application for pool coverage is made not later than thirty days following the involuntary termination.

Also, one of the newest waivers allows an individual moving from one state plan to another first-day coverage if the waiting period had already been satisfied in the previous state and the maximum benefits have not been used up. This is known as the reciprocity agreement.

<u>STATE</u>	<u>WAITING PERIOD</u>	<u>CONDITION PERIOD</u>
CALIFORNIA	90 Days	6 Months
COLORADO	6 Months	6 and 12 Months
CONNECTICUT	12 Months	6 Months
FLORIDA	12 Months	6 Months
GEORGIA	6 Months	6 Months
ILLINOIS	6 Months	6 Months
INDIANA	180 Days	180 Days
IOWA	6 Months	6 Months
LOUISIANA	6 Months	Unlimited
MAINE	90 Days	90 Days
MINNESOTA	6 Months	90 Days

MISSISSIPPI	12 Months	6 Months
MISSOURI	12 Months	6 Months
MONTANA	12 Months	5 Years
NEBRASKA	6 Months	6 Months
NEW MEXICO	6 Months	6 Months
NORTH DAKOTA	180 Days	90 Days
OREGON	6 Months	6 Months
SOUTH CAROLINA	6 Months	6 Months
TENNESSEE	6 Months	6 Months
TEXAS	6 Months	6 Months
UTAH	6 Months	6 Months
WASHINGTON	6 Months	6 Months
WISCONSIN	6 Months	6 Months
WYOMING	6 Months	6 Months

FUNDING MECHANISMS

The following data pertains to the funding mechanism of the various state health insurance risk-sharing plans.

California

Major Risk Medical Insurance Fund. Funding for the California plan is provided directly by the state of California. \$30 million is deposited annually in the fund from the State Cigarette and Tobacco Products Surtax Fund. In order for the plan to remain financially solvent, the state has limited the enrollment to 10,000 individuals.

Note: The California legislation passed and was signed into law in 1989. The plan became operational on January 28, 1991.

Colorado

Losses associated with operation of the plan are to be paid by a state income tax surcharge. The law states that single filers with adjusted gross incomes of \$15,000 or more are assessed a \$2 tax when filing their Colorado income tax. Joint filers will be assessed \$4 if adjusted gross income is more than \$15,000. Colorado is the first state to directly place a tax on the citizens for support of the high-risk plan.

Note: The legislation passed and was signed into law in May of 1990. The plan became operational in April, 1991. The legislation also included a provision that this funding mechanism is only put in place for a period of three years.

Connecticut

Association members assessed for plan losses based on share of health insurance premium volume in the state. This funding mechanism has been in place since inception of the pool with one exception. Originally, Blue Cross and Blue Shield offered a separate pool for high risks. Because of this, Blue Cross and Blue Shield was not obligated to pay for losses incurred by the state plan. In 1984, Blue Cross and Blue Shield ended the offering of their plan. Between 1984 and 1988, the assessment to Blue Cross and Blue Shield only applied to those policies issued during this period. Since September of 1988 the two pools have merged and assessments for the combined pool include Blue Cross and Blue Shield.

Note: The legislation passed and was signed into law in 1975. The pool has been operational on a continuous basis since 1976.

Florida

Association members assessed for plan losses based on share of health insurance premium volume in state during the year. From the time of passage of this legislation in 1983 until 1989, these assessments were allowed as a tax credit offset. This credit could be applied towards premium taxes and income taxes payable to the state at the rate of 20% credit per year over a five-year period. 1989 legislation repealed this premium tax offset. If the state also provides an appropriation to the plan, these funds shall be used prior to the assessment.

Note: The legislation passed and was signed into law in 1983. The plan has been operational since this time. Legislation passed in 1989 repealed the entire law October 1, 1990, however an extension has been approved until October 1, 2000.

Georgia

General revenue. The General Assembly is not required to appropriate monies to the plan. The 1990 legislature did not appropriate any monies to fund the losses of the plan, but authorized a \$75,000 appropriation to study actuarial data for the plan. In 1991, the general assembly again failed to authorize any expenditure for the plan. The board, as well as other interested parties, are still attempting to find an adequate funding mechanism other than a state appropriation.

Note: The legislation passed and was signed into law in 1989. The plan is not yet operational.

Illinois

General Revenue. The first state to directly pay the costs of the risk plan through such an appropriation. However, the state placed a cap on the number of participants eligible to participate in the plan at any one time, thereby controlling the amount of dollars to be contributed to the plan. This cap has already been raised once (to 4,500 individuals) and the state may have to consider another increase, with approximately 1,000 individuals on a waiting list. The appropriation was \$12 million in 1990 and \$18.7 million for 1991.

Note: The legislation passed and was signed into law in 1987. The plan became operational in 1989 and is still operational.

Indiana

Association members assessed for net losses in proportion to share of total health insurance premiums received in state during the year. Assessments offset against income or premium taxes in year of assessment or following years. Insurers may also include in premium rates an amount to recoup assessments.

Note: The legislation passed and was signed into law in 1981. The plan became operational in 1982 and has operated since this time. No change has occurred in the funding of the plan.

Iowa

Association members assessed for losses in excess of those covered through premiums and the Health Insurance Trust Fund. Assessments allowed as offset against premium taxes or other forms of taxes payable to the state. These offsets are granted at the rate of 20% per year over a five-year period.

Note: The legislation passed and was signed into law in 1986 and the plan became operational in 1987 and has operated since this time. No change has occurred in the funding of the plan.

Louisiana

Each patient, except one covered by a program which is directly subsidized by the federal government or one covered by an insolvent insurer, admitted to a hospital for treatment other than psychiatric care or alcohol or substance abuse shall be assessed a service charge of \$2 for each day during which the patient is confined as an inpatient in that facility. Facilities operated by the state, United States, Veterans Administration or solely for psychiatric care or treatment of alcohol or substance abuse are not included.

Each patient, except one covered by a program which is directly subsidized by the federal government or one covered by an insolvent insurer, admitted to an ambulatory surgical center or to a hospital for outpatient ambulatory surgical care shall be assessed a service charge of \$1 for each admission to that facility.

These service charges are to be paid by the patient's insurer or insurance arrangement. In the event that no payment is made on behalf of the patient for services rendered, the fee is waived.

Note: The legislation passed and was signed into law in June of 1990. The plan is experiencing some logistical problems in the collection process. Latest word is this plan may not become operational until mid-1992.

Maine

Funding will be taken care of by a Reserve Fund established to pay any expenses and claims above premium income. This reserve shall be funded by an assessment on all revenues of all hospitals in the state. The amount of the assessment shall be determined and adjusted annually and shall not exceed .0015 times hospitals' gross patient services revenues. Original legislation stated this plan would cease operation in June of 1991 unless the legislature reauthorized the plan. The 1991 legislature did reauthorize the plan until June of 1992, and there is word that the 1992 legislature will recommend dropping the sunset provision. The 1992 legislature will also search for a new funding mechanism.

Note: The legislation passed and was signed into law in 1987. The plan became operational in 1988 and is still operational.

Minnesota

Health insurers assessed for net losses in proportion to share of total health insurance premium received in the state during the year. Until 1987, insurers were granted a 100% tax offset against assessments paid to the plan. At that time, this tax offset was removed.

Note: The legislation passed and was signed into law in 1976. The plan became operational in 1976 and has operated since that time. Other than removal of the tax offset, no other funding changes have taken place.

Mississippi

The plan uses a very unique approach to financing. First, they have defined "insurer" as any insurance company or any nonprofit health care services plan authorized in the state to write direct health insurance policies and contracts supplement to health insurance policies or any third party administrator. The plan then mandates that each insurer shall be assessed an amount not to exceed \$1 per covered person per month. Excluded are contracts insuring federal or state employees.

Note: The legislation passed and was signed into law in April of 1991. It is expected to become operational on January 1, 1992.

Missouri

Association members assessed for net losses in proportion to share of total health insurance premiums received in state during the year. Assessments offset against premium taxes paid to the state in the year such assessments are made.

For those members not paying premium taxes to the state, assessments are still made and such assessment is offset against any sales and use taxes paid to the state. However, no assessment to any member can be in excess of 1% of nongroup premium income, exclusive of Medicare supplement programs, received in the previous year.

Note: The legislation passed and was signed into law in June, 1990. The plan is expected to begin offering plans in November 1991, with an effective date of January, 1992.

Montana

Association members assessed for net losses in proportion to share of total health insurance premiums received in the state during the year. Assessments offset against premium taxes in year of assessment or following years.

Note: The legislation passed and was signed into law in 1985. The plan became operational in 1987. No change in the funding mechanism has taken place.

Nebraska

Association members assessed for net losses in proportion to share of total health insurance premiums received in the state during the year. Assessments offset against premium taxes in year of assessment or following years.

Note: The legislation passed and was signed into law in 1986 and the plan became operational that year. No change in the funding mechanism has taken place.

New Mexico

All insurers will be assessed for the losses of the pool and no credit on future taxes will be allowed until one member's assessment reaches \$75,000 per year. At that time, the member will receive a 30% tax credit for the amount paid over \$75,000. New Mexico was the first state to combine both government offsets and an assessment to participating insurers.

Note: The legislation passed and was signed into law in 1988 and became operational that year. No change in the funding mechanism has taken place.

North Dakota

Association members doing more than \$100,000 in accident and health insurance business within the state are assessed for net losses of the pool. These members are allowed a direct offset against premium taxes in year of assessment or following years. This funding mechanism was passed into law in 1983. Prior to this, the plan attempted to be a self-supporting one, with premiums adjusted to match total claims paid.

Note: The legislation passed and was signed into law in 1981. The plan became operational in 1982 and has operated since that time. No change in the funding mechanism has taken place since 1983.

Oregon

In the first year of operation (FY 1990/91) funding was provided with a combination of State General Funds, insured premiums and assessments of reinsurers and insurers. In addition, a one-time assessment of \$150,000 to offset start-up administrative costs was made of reinsurers and insurers.

The plan now operates under an expenditure limitation established by the Oregon State Legislature. For the 1990/91 FY, this limitation was \$2 million. For the 1991/93 biennium, the limitation has been established at \$12,409,792. Funding will be provided by premiums (58%) and assessments (42%). There are no State General Fund contributions for the 1991/93 biennium. Additional assessments may be made of reinsurers and insurers for plan operating losses above premiums collected.

Note: The legislation passed and was signed into law in 1987. The plan became operational in May, 1990.

South Carolina

Association members assessed for net losses in proportion to share of total health insurance premiums received in the state during the year. Assessments offset against premium or income taxes in year of assessment or following years. This offset is limited to a total statewide offset of \$5 million in any one year. If this cap is reached, premiums of the plan must be raised to keep losses and offset at \$5 million.

Note: The legislation passed and was signed into law in 1989. The plan became operational in 1990.

Tennessee

Until 1990, association members were assessed for net losses in proportion to share of total health insurance premiums received in the state during the year. These assessments were granted as a tax offset to a limit of \$3 million. In 1990 the entire funding mechanism was changed.

New funding has the state appropriating \$3 million towards operation of the pool. Association members are to be assessed an amount equal to their share of the number of participants in their health care program as compared to the total number in the state. The total assessments to the members cannot exceed \$3 million in any one year. In addition, the association membership was expanded to include HMOs and PPOs. No tax credit is allowed to assessed members.

Note: The legislation passed and was signed into law in 1986. The plan became operational in 1987. The initial cap by the state was \$2 million, then raised to \$3 million, and in 1990 the entire funding mechanism was restructured. However, this funding mechanism was only put in place for two years.

Texas

Association members assessed for net losses in proportion to share of total health insurance premiums received in the state during the year. The members will be granted reimbursement against this assessment, however the manner of the reimbursement has not yet been finalized. The 1991 state legislative session again attempted to provide an adequate mechanism to help the plan become operational. However, no mechanism was secured and the plan remains stalled.

Note: The legislation passed and was signed into law in 1989. The plan is not yet operational.

Utah

Comprehensive Health Insurance Pool Enterprise Fund. This fund will be credited with all pool policy premiums, interest and dividends earned on the fund's assets, and an initial \$75,000 appropriation from the State General Fund. All losses associated with operation of the Utah plan are to be paid from the assets of this fund. The 1991 Legislature appropriated \$2 million for 1991 operations of the plan.

Note: The legislation passed and was signed into law in March of 1990. Issuance of policies is to commence on August 1, 1991.

Washington

Association members assessed for net losses in proportion to share of total health insurance premiums received in the state during the year. Assessments offset against premium taxes in year of assessment or following years.

Note: The legislation passed and was signed into law in 1987. The plan became operational in 1988. No change in the funding mechanism has taken place since inception of the pool.

Wisconsin

Association members assessed for net losses in proportion to share of total health insurance premiums received in the state during the year. No offset of this assessment is allowed, despite several attempts to do so in previous years. However, the state legislature does appropriate a yearly sum of dollars to help reduce the premium charges and deductibles for low-income individuals in the plan.

Note: The legislation passed and was signed into law in 1980. The plan became operational in 1981. Despite several attempts, no change in the funding mechanism has taken place since the pool became operational.

Wyoming

Association members assessed for plan losses based on their share of health insurance premium volume in the state. Also to be assessed are any self insurers not governed by the ERISA law. The state will grant a credit against any premium tax owed to the state towards the assessment paid. However, the total credit allowed by all members cannot exceed \$1 million in any one year.

Note: The legislation passed and was signed into law in March, 1990. The plan became operational in January, 1991. Also included in the legislation is a "sunset" provision which terminates the plan on June 30, 1993.



Health Insurance Association of America

STATEMENT OF HIAA

ON

SENATE BILL 74

PRESENTED BY

JAN ANDREA MEISELS

LEGISLATIVE DIRECTOR

BEFORE THE

ALASKA SENATE HEALTH, EDUCATION AND SOCIAL SERVICES COMMITTEE

April 8, 1992

22111 Clarendon Street, Suite 220
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818-704-9274

I am Jan Andrea Meisels, Legislative Director, Health Insurance Association of America. The Health Insurance Association of America (HIAA) is a trade association of the nation's leading commercial insurance carriers that provide health insurance for approximately 95 million Americans.

HIAA has long-supported state uninsurable risk-pools. These risk pools are included as one of the components in our program of "Financing Health Care for All Americans." Uninsurable risk pools address accessible health coverage to those who are otherwise considered medically uninsurable. However, we have serious concerns with a number of the provisions contained in SB-74, which will result in underfunding of the program and inappropriate accessibility to the program. We strongly encourage the committee's consideration and adoption of proposed amendments reflecting the issues discussed below.

During the 1990 Alaska legislative session, then-Senator Coghill sponsored SB-304 and the Senate Labor and Commerce Committee agreed to a committee substitute for the original bill -- CSSSSB-304. The committee substitute was a result of an agreement emanating from negotiations between all interested parties. The only reason CSSSSB-304 was not enacted was that the amendments were provided too late for the bill to complete its journey through the legislative process. We encourage the committee to amend SB-~~304~~⁷⁴ to duplicate the agreed-upon version of CSSSSB-304.

Individuals with severe preexisting conditions may be ineligible to purchase insurance from the private insurance industry. A number of states have enacted uninsurable risk pools

to address this need. Historical data of the loss ratios of the "mature" (longest operating) risk pools are:

Connecticut - 200 percent

Florida - Exceeded 200 percent in 1990

Indiana - Close to 200 percent in the last several years

Minnesota - Exceeded 200 percent over the last four years and in 1991 experienced a \$26 million deficit.

North Dakota - Over 200 percent in 1986-87 and exceeded 175 percent in 1989

Wisconsin - Was the best controlled, but its loss ratio is now moving over 150 percent

The legislative analyst memo on SB74 made assumptions based on the Minnesota 125 percent average premium, and the current insured Alaska population base. It is my understanding there is currently pending legislation that would permit the Alaska state employee program to self-fund. If this is enacted, the cost for the losses of the pool that is to be borne by insurers -- which will be passed on to other insureds in Alaska -- will be dramatically affected. Currently, all insureds, including the state employees, will have to ~~be~~^{bear} the cost of the pool losses. We believe it will be more than the \$3.30 per month per employee -- the amount to which the author's consultant testified.

The population base and therefore, the extra rates charged to nonpool insureds on which the calculations are made should be revised upwards. Firstly, SB74 proposes a 125 percent premium, similar to Minnesota's -- the only other state with such a low and undercharged premium. Minnesota is running a higher percent-

age of losses than any other state, because the premium rate is closer to the standard rate. Thirty percent of the Minnesota population are in HMOs. Therefore, the high HMO penetration affects the numbers of people assumed not to have access to health insurance. Alaska has no HMOs to date. The presumption of the number of pool eligibles in Alaska, based on the Minnesota numbers we believe may be incorrect.

Alaska has many people covered by federal government programs -- Bureau of Indian Affairs, military, CHAMPUS, Medicare and the federal employees health benefits program. None of these programs are included in the assessment base, nor are self-funded employers. Therefore, the total cost of the pool losses will be spread across a reduced base of insured people. We suggest to the committee to increase the premium to at least 150 percent of the average premium so as not to burden the small insured employers with excessive pool losses. If the premium stays as proposed it will result in increased costs to the other insureds in Alaska which may result in some of them dropping the coverage, and increasing the amount of uninsureds in Alaska.

The above cited figures on pool loss ratios indicate the absolute requirement that additional funding is going to be required to cover the claim losses due to the adverse experience of the uninsurable risk pools. We strongly encourage general fund appropriations be allocated to cover these losses. However, if the committee keeps the current assessment on health insurance companies doing business in Alaska, on a pro rata earned premium basis, we strongly encourage the allowance of a credit against

premium taxes imposed against disability insurers. Suggested wording would include:

A member of the Comprehensive Disability Insurance Association created in AS21.55.010 may credit against a premium tax imposed against disability insurance premiums under this section, an amount equal to an assessment against the member under AS21.55.220(d). Any 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.

In addition, the following subparagraph should be added to Section 21.55.060, Subparagraph B:

(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 AS21.09.210(j).

The 1990 CSSSSB-304 legislation allowed for such a credit by the inclusion of the above-referenced language.

Most states with uninsurable risk pools either have the losses covered by a broad-based funding mechanism, i.e., general funding, dedicated taxes or allow a premium tax offset as mentioned above. Examples of dedicated taxes imposed by other state uninsurable risk pools include: California -- funding from cigarette and tobacco products surtax fund; Colorado -- funding by imposing a \$2.00-4.00 charge on state taxpayers whose federal

- 5 -

income tax return indicates an adjusted gross income in excess of \$15,000; Louisiana -- funded by a \$2.00 service charge on each admitted hospital day and \$1.00 charge for admittance to an ambulatory surgery center. Fees are paid by all private payers as a medical expense; Maine -- assessment on all revenues of hospitals in the state. We recognize Alaska's constitution does not permit dedicated funding, however, we thought the committee would find it of interest how other states are addressing this issue.

An adequate premium must be charged to the insured, reflecting the increased risk that will be borne due to their preexisting medical condition. SB-74, as proposed, permits a maximum premium of 125 percent of the average of five Association members' standard premiums for similar-type benefits. CSSSSB-304 (1990) included a 150 percent premium based on the average of an estimate of five Association members' standard premium for like-type benefits. It is our understanding that Senator Coghill and the group of interested parties had further agreed that the premium would be raised to 175-200 percent of standard risk. Most state insurance risk pool plans allow premiums greater than 125 percent. Therefore, we strongly encourage the committee to increase the premiums above the 125 percent of the average of five Association members' plans. Even with a 200 percent premium, the claims experience of these uninsurable individuals will be inadequate to cover all the claims losses.

Deductibles are a mechanism to reduce the cost of the insurance policy premium to the purchaser. CSSSSB-304 called for

two alternative deductibles: \$1,000 and \$5,000. SB-74 has substantially reduced deductibles -- \$200, \$500 and \$1,000. Today, the average private sector deductible for standard policies is considerably higher than \$200. In addition, many state uninsurable pools have deductibles substantially greater than those proposed in SB-74. We request the committee consider increasing the deductible to a more appropriate level such as those proposed in last year's CSSSSB-304.

Unlike CSSSSB-304, SB-74 includes Medicare-eligible persons within the uninsurable risk pool, allowing the pool to act as a Medicare supplement plan. We oppose this inclusion, as the purpose of the uninsurable risk pool is to provide coverage for those without any insurance. People covered under Medicare have coverage and are also eligible to purchase Medicare supplement insurance. Medicare supplement policies are available in Alaska. Congress included in the Omnibus Budget Reconciliation Act of 1990 -- P.L.101-508 -- that Medicare supplementary policies meet specific National Association of Insurance Commissioners (NAIC) standards. The Alaska Department of Insurance has proposed regulations which comply with the Congressionally required ten variations. Therefore, we do not see the need for inclusion of Medicare supplement coverage within the uninsurable risk pool and urge the committee to remove that provision. CSSSSB-304 did not include Medicare supplementary insurance within the uninsurable risk pool.

SB-74 requires a lifetime maximum of \$1 million per individual. This coverage is higher than many of the state

uninsurable risk pool programs. To further make the pool premium more affordable, we suggest reducing the policy lifetime maximum to \$500,000 similar to the amount contained within CSSSSB-304.

CSSSSB-304 allowed for a preexisting exclusion of 12 months. However, SB-74 allows only 3 months for such an exclusion. It is necessary to collect an adequate premium over a period of time in order to cover the losses for expected claims, as for people with preexisting conditions. Therefore, a three-month preexisting exclusion is an inadequate amount of time and will lead to further losses for the pool, especially as the premium charge will be inadequate to cover all claims incurred. Therefore, we strongly encourage the committee to amend the 3-month preexisting time limit to 12 months.

Section 21.55.220 allows an employer who has one or more eligible persons enrolled in a state plan to pay for the premiums of that person. We are concerned that such a provision will allow employers to "dump" higher risk employees into a state pool which is available only for individuals who are medically uninsurable, i.e., those who have been declined health insurance. The purpose of the uninsurable risk pool is not to reduce the cost of an employer's overall premium for their employees -- by their eliminating a higher risk employee from the group -- but to provide access to health insurance to medically uninsurable individuals. HIAA recognizes that some small employers have been declined insurance because one or more of the employees have proven to be uninsurable. However, SB-242 will preclude that from occurring, and all employees of an employer will be covered.

Therefore, provisions in SB-242 negate the need to find high-risk employees an alternative to their group plan. Employers should not be encouraged to nor given the opportunity to "dump" higher risk employees, into a state uninsurable risk pool.

Section 21.55.300 in SB-74 does not include a listing of persons who are ineligible for coverage, as does Section 21.55.300(b) in CSSSSB-304. It is imperative to list those persons who would not be eligible for coverage, i.e., a person who at the time of application is eligible for medical assistance; a person who terminated coverage under the chapter in the previous 12 months; or that the person on whose behalf the pool has paid out the maximum lifetime benefits; or for persons who are inmates of public institutions; or persons whose benefits are duplicated under public programs.

The purpose of insurance is to provide coverage for some unexpected, future event. Allowing applicants to pay retroactively for coverage back to when their previous contract was terminated is a violation of the principle of insurance. Coverage should be based on a prospective, not a retrospective basis. Therefore, we strongly encourage Section 21.55.330(b) to be deleted. We are also concerned with two of the author's proposed changes to SB74. (1) Section 21.55.500 (10) (A) currently includes the term "for medical reasons" within the definition of high risk resident. The proposal to delete the term "for medical reasons" would permit others who are not high risk to participate. With enactment of SB242 insurers would be required to provide coverage for any small group, regardless of occupa-

tion, risk or turnover, therefore, there is no reason for the deletion "for medical reasons".

(2) The author is also proposing to allow people with existing insurance, whose premium is higher to drop their private insurance in lieu of the uninsurable risk pool. This pool is for uninsurables who have been rejected for coverage not for the general public. Private insurance may be higher or lower cost depending upon the benefits covered, the duration of the policy, the premium tax required in private insurance, etc. One cannot compare the price of the "pool" with private insurance, due to differences in rating structure if the private insurance is in effect more than one year due to changes in durational rating.

The memo given by the legislative analyst to the committee cited a study by Scanlon. The correct historical experience should be based on the rates charged January 1, 1993 (presuming the legislation is enacted and becomes effective July 1, 1992) - the midpoint for an average issue is half-way between July 1, 1992 and June 30, 1993 i.e. July 1, 1992. This would have to be used for the average exposure for 1993-1994 i.e. January 1, 1993 rates rather than using 1990 and trending forward.

Therefore we request the committee not to adopt these proposed recommendations and to amend SB74 to more closely relate to the agreement in 1990 which was expressed in CSSSB-304. HIAA is very willing to work with the committee in developing a workable, affordable, uninsurable risk pool that will be to the benefit of Alaskan medically uninsurable residents. Participation by health insurers is required in the uninsurable risk pool,

as a privilege of doing business in Alaska. Insurance companies want to support and participate in the risk pool. However, the absence of a broad-based financing mechanism or a premium tax offset for the claims-incurred losses to pay the residual losses will result in a failed system with severe financial implications to the insurers licensed in Alaska.

HIAA

Health Insurance Association of America

STATEMENT OF HIAA

ON

SENATE BILL 74

PRESENTED BY

JAN ANDREA MEISELS

STATE AFFAIRS ASSOCIATE

BEFORE THE

ALASKA SENATE COMMITTEE ON LABOR AND COMMERCE

April 19, 1991

6052 Hackers Lane
Agoura, California 91301
818-991-6817

I am Jan Andrea Meisels, State Affairs Associate, Health Insurance Association of America. HIAA is a trade association of 300 private health insurance companies which provide health insurance for 95 million Americans.

HIAA has long-supported state uninsurable risk-pools. These risk pools are included as one of the components in our program of "Financing Health Care for All Americans." Uninsurable risk pools address accessible health coverage to those who are otherwise considered medically uninsurable. However, we have serious concerns with a number of the provisions contained in SB-74, which will result in underfunding of the program, inappropriate accessibility to the program. We strongly encourage the committee's consideration and adoption of proposed amendments reflecting the issues discussed below.

During the 1990 Alaska legislative session, then-Senator Coghill sponsored SB-304 and the Senate Labor and Commerce Committee agreed to a committee substitute for the original bill -- CSSSSB-304. The committee substitute was a result of an agreement emanating from negotiations between all interested parties. However, the amendments were provided too late for the bill to complete its journey through the legislative process last year. We encourage the committee to amend SB-74 to duplicate the previously agreed-upon version of CSSSSB-304.

Individuals with severe preexisting conditions may be ineligible to purchase insurance from the private insurance industry. A number of states have enacted uninsurable risk pools to address this need. Historical data of the loss ratios of the "mature" (longest operating) risk pools are:

Connecticut - 200 percent

Florida - Exceeded 200 percent in 1990

Indiana - Close to 200 percent in the last several years

Minnesota - Exceeded 200 percent over the last three years

North Dakota - Over 200 percent in 1986-87 and exceeded 175 percent in 1989

Wisconsin - Was the best controlled, but its loss ratio is now moving over 150 percent

These figures indicate the absolute requirement that additional funding is going to be required to cover the claim losses due to the adverse experience of the uninsurable risk pools. We strongly encourage general fund appropriations be allocated to cover these losses. However, if the committee keeps the current assessment on health insurance companies doing business in Alaska, on a pro rata earned premium basis, we strongly encourage the allowance of a credit against premium taxes imposed against disability insurers. Suggested wording of a new section of the bill to accomplish this purpose would include the following language as AS 21.09.210 (j):

A member of the Comprehensive Disability Insurance Association created in AS21.55.010 may credit against a premium tax imposed against disability insurance premiums under this section, an amount equal to an assessment against the member under AS21.55.220(d). Any 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.

A new subparagraph should be added to Section 21.55.060 on page 3. The present paragraph should be designated as sub paragraph (a). A new subparagraph (b) should be added to read:

A member of the Association is entitled to receive a credit against taxes levied by the state on disability insurance premiums as provided in AS21.09.210(j).

The 1990 CSSSSB-304 legislation allowed for such a credit by the inclusion of the above-referenced language.

Most states with uninsurable risk pools either have the losses covered by a broad-based funding mechanism, i.e., general funding, dedicated taxes or allow a premium tax offset as mentioned above. Examples of dedicated taxes imposed by other state uninsurable risk pools include: California -- funding from cigarette and tobacco products surtax fund; Colorado -- funding by imposing a \$2.00-4.00 charge on state taxpayers whose federal income tax return indicates an adjusted gross income in excess of \$15,000; Louisiana -- funded by a \$2.00 service charge on each admitted hospital day and \$1.00 charge for admittance to an ambulatory surgery center. Fees are paid by all private payers as a medical expense; Maine -- assessment on all revenues of hospitals in the state.

An adequate premium must be charged to the insured, reflecting the increased risk that will be borne due to their

preexisting medical condition. SB-74, as proposed, permits a maximum premium of 125 percent of the average of five Association members' standard premiums for similar-type benefits. CSSSSB-304 (1990) included a 150 percent premium based on the average of an estimate of five Association members' standard premium for like-type benefits. It is our understanding that Senator Coghill and the group of interested parties had further agreed that the premium would be raised to 175-200 percent of standard risk. Most state insurance risk pool plans allow premiums greater than 125 percent. Therefore, we strongly encourage the committee to increase the premiums to 200 percent of the average of five Association members' plans. Even with a 200 percent premium, the claims experience of these uninsurable individuals will be inadequate to cover all the claims losses.

Deductibles are a mechanism to reduce the cost of the insurance policy premium to the purchaser. CSSSSB-304 called for two alternative deductibles: \$1,000 and \$5,000. SB-74 has substantially reduced deductibles -- \$200, \$500 and \$1,000. Today, the average private sector deductible for standard policies is considerably higher than \$200. In addition, many state uninsurable pools have deductibles substantially greater than those proposed in SB-74. We request the committee consider increasing the deductible to a more appropriate level such as those proposed in last year's CSSSSB-304.

Unlike CSSSSB-304, SB-74 includes Medicare-eligible persons within the uninsurable risk pool, allowing the pool to act as a Medicare supplement plan. We oppose this inclusion, as the

purpose of the uninsurable risk pool is to provide coverage for those without any insurance. People covered under Medicare have coverage and are also eligible to purchase Medicare supplement insurance. Medicare supplement policies are available in Alaska. Congress included in the Omnibus Budget Reconciliation Act of 1990 -- P.L.101-508 -- that Medicare supplementary policies meet specific National Association of Insurance Commissioners (NAIC) standards. The NAIC is actively working on the development of the ten variations which will be before the NAIC for adoption later this year. Therefore, we do not see the need for inclusion of Medicare supplement coverage within the uninsurable risk pool and urge the committee to remove that provision which is 21.55.100(b) on page 3. CSSSSB-304 did not include Medicare supplementary insurance within the uninsurable risk pool.

SB-74 requires a lifetime maximum of \$1 million per individual. This coverage is higher than many of the state uninsurable risk pool programs. To further make the pool premium more affordable, we suggest reducing the policy lifetime maximum to \$500,000 similar to the amount contained within CSSSSB-304.

CSSSSB-304 allowed for a preexisting exclusion of 12 months. However, SB-74 allows only 3 months for such an exclusion. It is necessary to collect an adequate premium over a period of time in order to cover the losses for expected claims, as for people with preexisting conditions. Therefore, a three-month preexisting exclusion is an inadequate amount of time and will lead to further losses for the pool, especially as the premium charge will be inadequate to cover all claims incurred. Therefore, we

strongly encourage the committee to amend the 3-month preexisting time limit to 12 months.

Section 21.55.220 allows an employer who has one or more eligible persons enrolled in a state plan to pay for the premiums of that person. We are concerned that such a provision will allow employers to "dump" higher risk employees into a state pool which is available only for individuals who are medically uninsurable, i.e., those who have been declined health insurance. The purpose of the uninsurable risk pool is not to reduce the cost of an employer's overall premium for their employees -- by their eliminating a higher risk employee from the group -- but to provide access to health insurance to medically uninsurable individuals. HIAA recognizes that some small employers have been declined insurance because one or more of the employees have proven to be uninsurable. However, SB-242 will preclude that from occurring, and all employees of an employer will be covered. Therefore, provisions in SB-242 negate the need to find high-risk employees an alternative to their group plan. Employers should not be encouraged nor given the opportunity to "dump" higher risk employees into a state uninsurable risk pool.

Section 21.55.300 in SB-74 does not include a listing of persons who are ineligible for coverage, as does Section 21.55.300(b) in CSSSSB-304. It is imperative to list those persons who would not be eligible for coverage, i.e., a person who at the time of application is eligible for medical assistance; a person who terminated coverage under the chapter in the previous 12 months; or that a person on whose behalf the pool

has paid out the maximum lifetime benefits; or for persons who are inmates of public institutions; or persons whose benefits are duplicated under public programs.

The purpose of insurance is to provide coverage for some unexpected, future event. Allowing applicants to pay retroactively for coverage back to when their previous contract was terminated is a violation of the principle of insurance. Coverage should be based on a prospective, not a retrospective basis. Therefore, we strongly encourage Section 21.55.330(b) to be deleted. HIAA is very willing to work with the committee in developing a workable, affordable, uninsurable risk pool that will be to the benefit of Alaskan medically uninsurable residents. Participation by health insurers is required in the uninsurable risk pool, as a privilege of doing business in Alaska. Insurance companies want to support and participate in the risk pool. However, the absence of a broad-based financing mechanism or a premium tax offset for the claims-incurred losses to pay the residual losses will result in a failed system with severe financial implications to the insurers licensed in Alaska.

We thank the committee for its consideration of incorporating the provisions of CSSSSB-304 into SB-74.

THOMAS A. TURNER, CLU

INSURANCE AND EMPLOYEE BENEFITS

Senator J. Kerttula
P.O. Box V
Juneau, AK 99811

March 10, 1992

Re: SB 74

Dear Senator Kerttula:


MAR 10 1992

As the chairman of the Southern Alaska Life Underwriters Association Legislative Committee, I am writing to advise you of our strong support for your bill number 74. In reviewing all of the health insurance related submitted this session, yours offers the potential to benefit the greatest number of Alaskans. Unfortunately, most of these Alaskans do not have a well funded lobbying effort. Self employed individuals, small business owners and employees and their families make up this group. The one thing that they all have in common is one or more medical problems which deny them access to comprehensible medical coverage. These people fall through the cracks because they either make too much money or have too large a net worth to qualify for Medicaid.

We also support your legislation because it provides for a fiscally responsible mechanism to guarantee these Alaskans coverage. It is not a socialized all intrusive plan, as some have proposed, but a solid first step in meeting the needs of most Alaskans who desire adequate medical care.

Members of our organization will continue to be in contact with you throughout the session, and hope that we can assist you in getting this legislation passed.

Sincerely,



Thomas A. Turner, CLU
Chairman, Legislative Committee
Southern Alaska Life Underwriters
TT/jm

cc: Senator Virginia Collins

Ernest B. Meloche, MD
Fellow of the American Board of Emergency Physicians
Emergency Department Medical Director
Ketchikan General Hospital
3100 Tongass Avenue
Ketchikan, Alaska, 99901

March 27, 1992

Senator Jay Kerttula
PO Box V
Juneau, Alaska, 99811

Dear Senator Kerttula,

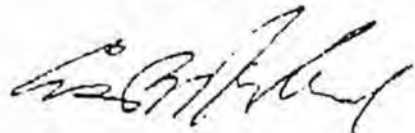
I strongly support Senate Bill 74, the bill which provides high risk health insurance for those people found to be uninsurable. I am a practicing emergency physician in Ketchikan, Alaska, as well as the medical director for Ketchikan General Hospital Emergency Department. In my practice I have witnessed again and again the tragic situation of people who have been denied health insurance.

Many people in this category are responsible, working individuals who are excellent neighbors and citizens of our state, yet who have been afflicted with any of a wide number of diseases which create claims on a health insurance policy. The unavailability of insurance for individuals with medical conditions within the state of Alaska has forced patients of mine to leave Alaska. Others have been driven into bankruptcy and are living well below the poverty line simply trying to keep up with the costs of their illnesses.

The insurance industry insists that they can not accept such high risk individuals. While such a decision makes financial sense for a profit making company, we must ask ourselves if this is how we wish to treat our neighbors when they fall into such unfortunate circumstances. Senate Bill 74 creates a mechanism whereby such people would be allowed to act responsibly and purchase their insurance like anyone else, admittedly at a slightly higher rate. This is fully acceptable.

It is not acceptable to deny health care protection to those who need it most. Senate Bill 74 is an excellent step toward a responsible Alaskan health care policy. It is important for Senate Bill 74 to pass as soon as possible, since more Alaskans are finding themselves affected by this problem daily. If I can be of any assistance in this matter please feel free to contact me directly. Thank you for your efforts on behalf of those to whom this legislation will be literally life-saving.

Sincerely,



Ernest B. Meloche, MD,

BALDWIN FINANCIAL CONCEPTS

2525 BLUEBERRY ROAD, SUITE 107
ANCHORAGE, ALASKA 99503
(907) 276-4849 FAX 279-4814



FAX COVER SHEET

SENT TO: Senator Arliss Sturgulewski

COMPANY: _____

FAX# 465-3810 DATE 4/3/92

FROM: Leona Baldwin

TOTAL NUMBER OF PAGES INCLUDING COVER _____

COMMENTS: There are currently thousands of
Alaskans who cannot obtain medical
insurance coverage at any cost due
to current or pre-existing medical
conditions. The ability to obtain
medical coverage is a right no one
should be denied.

Please report Senate Bill 74 out
of committee.

Sincerely,
Leona Baldwin, CU ChFC

If total number of pages received differ
from number sent, or if theres was a
transmission problem please call.
Thank You.

Consulting
Services,
Inc.

10-28
10-29

September 28, 1990

C. Keith Powell, ASA, MAAA
Consulting Actuary

Office of the Director
Department of Insurance
Juneau, Alaska 99811

Dear Sir:

I was recently asked to make a presentation to an actuarial meeting on the subject of state pools for people who are uninsurable for health coverages. The larger topic of the meeting was national health insurance, and I was asked specifically to examine the possibility that these state pools (now existing or in the process of implementation in 23 states) may be a backdoor approach to national health insurance.

The survey that I did in preparation for this presentation developed some interesting information on the financial results under those pools, different approaches to funding used by the various states, eligibility requirements, etc.

As the consulting actuary who reviews the pool rates for the Indiana DOI, I have often wished that I had such information available; so I thought you or a member of your staff might be interested in the financial results of these pools.

I am enclosing a summary of these financial results, as well as a copy of my presentation. If you or a member of your staff would like to discuss this material, feel free to contact me. I can usually be reached at 502-245-1459 on Monday through Thursday, or by mail at the address below.

Sincerely yours,

C. Keith Powell

C. Keith Powell, ASA, MAAA
Consulting Actuary

RECEIVED
OCT 09 1990
Department of Commerce
& Economic Development

STATE POOLS FOR THE UNINSURABLE.

As of 1989 thirteen states had in place relatively mature (operational for two years or more) state pools offering health insurance coverage for residents who can not otherwise get health insurance. Counting the states with newer programs, some authorized but still in the process of becoming active, the total is now 23 states whose populations represent over 50% of the people in this country. This is about four times the number of such pools in force five years ago - a very rapid and surprisingly little publicized development. The ongoing, and worsening, problem of the lack of availability of private sector coverage for large segments of the population seems to be a major force driving this growth of state sponsored pools.

I would like to share with you the results of a recent survey of these programs that I have completed. While I am rambling through the survey results, you might want to keep in mind the following radical thoughts, not original with me:

(i) With the growth of these pools, we might be seeing a form of national health insurance growing right before our eyes.

(ii) Of the approaches to national health insurance with any chance of implementation, this might be the one that is most favorable to the private insurance industry.

Now, to the results of the survey.

(1) Eligibility Requirements.

It is difficult to generalize about eligibility requirements, but the most common one is an individual's status as uninsurable for reasons of health. There are other requirements in several states, and the type of proof of eligibility based on the status of uninsurable for reasons of health varies considerably by state.

(2) Financial Results.

If you look at 1989 results for the thirteen relatively mature plans, there was \$68 million of collected premiums and \$112 million of paid claims, for a paid loss ratio of 165%. The administrative cost of \$9 million was about 8% of claims. If you take out two large states (Connecticut and Minnesota) that are atypical in certain important respects, the "loss ratio" drops from the 165% above to about 139%. Of the remaining eleven states, seven show loss ratios in the 125% to 150% range.

I think that this loss ratio range of 125% to 150% is about where

it should be. This is my conclusion based on looking at commutation functions for health insurance claims and making some guesses about antiselection in the bigger claims. It is also borne out as order of magnitude reasonable by conversion experience, experience on some Blue Cross plans that are not underwritten, and some social insurance experience.

When you look at details, results are, as you would expect, all over the place for reasons such as rate of growth, position in the rating cycle, etc. Within the eleven more normal plans, the paid loss ratios for 1989 range from a low of 72% to a high of 172%.

The low loss ratio of 72% was from Washington, a very fast growing plan that had \$122,000 of collected premium in 1988 and \$2,065,000 in 1989. Under these conditions a paid claims / collected premium loss ratio understates incurred claim / earned premium experience due to the claims reporting and processing lag and to the failure of collected premiums to reflect the fact that some of the collected premiums are not fully earned. The Washington plan also has a six month / six month preexisting condition exclusion. In the presence of such fast growth, a great deal of the experience will still be driven by the pre-ex period and as such the loss ratios will be considerably lower than ultimate experience should show.

The Iowa plan, with its loss ratio of 112%, is another very fast growth case.

The high loss ratio of 172% for 1989 comes from right here in Indiana. This resulted from some very special circumstances. The Indiana plan tried to get approval for an incredibly large rate increase to be effective 7/1/89. The DOI challenged the rate increase all over the place, and it was finally approved under the Indiana deemer provision effective 12/1/89. The effect of this delay contributed to the high loss ratio in Indiana for 1989. Just as a footnote to this story, as some of the Indiana participants might know, the incredibly high set of rates was rescinded in 1990 and the state plan agreed to make partial refunds of the excessive portion of the premiums.

Again, the purpose of this detail is to present an argument that most of the plans tend to have cash loss ratios in the range of 125% to 150%. As you might expect, the results by state are all over the place due to such factors as rate of growth, the pre-existing condition exclusion provisions, and the plan position in its rating cycle.

On additional thought bridging design and pricing is that there is surprisingly little exclusive provider design in these plans. This could be the one angle that could really contribute to bringing

down the loss ratios somewhat. It should be possible to get some excellent discounts from hospital and physician providers by promising them these very high using populations.

(3) Funding Mechanism.

Premiums are most often set at 125% to 150% of the some version of an average price for underwritten products in the state. This price reason pops up for many reasons.

At the low end of the 125% to 150% range, it is probably a friendly gesture to the insurance industry to try to keep the price above 125% of the average net selling underwritten rate. By keeping the rate 25% over the average selling rate for underwritten products, it is safe to assume that there will be little or no loss of private sector underwritten business to the pools. Notice that but for this point of wanting to protect the private sector you could logically justify holding the pool rate below 125% of the average selling rate for an underwritten product. Recall that the underwritten rates generally target 50% to 70% loss ratios, so a pool rate based on 125% of the average underwritten selling rate means that the pool is allocating twice as high a percent of premium to benefit costs as the private sector product does.

If you go much higher than this range of 125% to 150% of the average underwritten selling rate a look at claims distributions and almost any reasonable guesses about antiselection show that the product will be priced well above "reasonable" for a very large portion of the people needing the product. This would discourage purchase of pool products by not only a large number of the people who need it but also by the very people who do not tend to contribute large losses to the pool.

The linkage between this 125% to 150% and the emerging loss ratios of 125% to 150% mentioned earlier is very tenuous. There actually might be a little bit of a linkage, but it is pretty far out there and it is probably best to think of them as unrelated concepts.

Remaining costs (in addition to premiums) are usually paid by either (i) the insurance industry in the state or (ii) local health care providers, and there is often some kind of tax offset that ultimately brings it to rest on general revenues.

(4) National Health Insurance Implications.

In 1989, 13 states (representing roughly 20% of the U. S. population) paid \$112,000,000 in health benefit costs to providers, \$9,000,000 for administration mainly to the insurance industry, for a total cost of \$121,000,000. This was offset by \$68,000,000 in premiums collected, for a net cost of \$53,000,000. With all kinds

of caveats, extrapolating that to the entire U. S. would have cost less than \$300,000,000. These numbers relate to programs that are almost exclusively freedom of choice arrangements that have made very little effort to get the savings from exclusive provider arrangements; and proper use of exclusive provider arrangements could introduce an element of savings. Again, with still more caveats, it had no direct impact on the federal deficit.

Note how nicely these pools dovetail with existing public and private health insurance programs.

Medicare and Medicaid are the major social insurance programs in this country. Medicare people generally do not need the pool benefits because the Medicare program itself is so comprehensive. Medicaid people generally already have some kind of half way decent benefits. They are not as generous as those in the state pools, but then Medicaid people generally pay nothing for their benefits.

I am going to try to summarize the value of this concept of national health insurance to the insurance industry, at the risk of getting up on the soap box.

Over the last half century the private health insurance industry has proved itself totally incapable of providing significant medical expense benefits on an individual basis to people with serious health problems, in spite of the fact that these people beg for our products and are willing to pay almost anything asked for the benefits. At least for freedom of choice insurers there is no reason to believe that this is changing, and in fact the problem seems to be worsening each year health care costs grow faster than other costs. While this is a very serious indictment of our industry, it does point out that the people that we are losing to these pools are the very people that we could not handle anyway. In fact, the payments that the health insurance industry receives to administer the benefits for these people probably exceeds aggregate premiums that the industry could collect from them for meaningful medical expense benefits; and absent state legislation making the cost fall directly on insurers, it comes without underwriting losses or significant financial risks.

These pools leave with the health industry the very people that the health insurance most wants and takes the people that they do not want.

With caveats, I would like to suggest that this may be the feasible approach to national health that is kindest to the health insurance industry.

Uninsurable Pool Data

State	Premis. Col.	Claims Paid	Admin. Paid	Loss Ratio	Admin (% Claims)
Connecticut					
1983	3134889	3442223	272550	109.80%	7.92%
1984	3473145	4454451	315450	128.25%	7.08%
1985	3285762	4579461	276379	139.37%	6.04%
1986	3532941	4203833	246156	118.99%	5.86%
1987	3186476	6663081	337235	209.11%	5.06%
1988	3460337	7293434	412942	210.77%	5.66%
1989	4495872	10438000	567826	232.17%	5.44%

Comment - These results may not be typical due to the presence of a Blue Cross plan in the process of being phased out.

Florida					
1983	23759	0	0	0.00%	ERR
1984	505798	141430	69114	27.96%	48.87%
1985	1107581	774174	103946	69.90%	13.43%
1986	1770171	1686195	184389	95.26%	10.96%
1987	2858173	3963710	357017	138.68%	9.01%
1988	5294446	8581468	1134991	162.08%	13.23%
1989	12443960	17425025	2810723	140.03%	16.13%

Indiana					
1983	2352179	217878	56512	9.26%	25.94%
1984	6356995	6843691	256462	107.66%	3.75%
1985	7505144	9518759	253524	126.83%	2.66%
1986	7197774	11352494	443791	160.50%	3.84%
1987	6301707	11564602	459462	183.52%	3.97%
1988	5607908	9640519	500643	171.91%	5.19%
1989	6210701	10690610	670565	172.13%	6.27%

Comment -The Indiana loss ratios for the last few years are held artificially low due to the reluctance of the pool to raise rates.

Iowa					
1987	164995	56725	16560	34.38%	29.19%
1988	1008691	1249159	82560	123.84%	6.61%
1989	2876251	3232227	339660	112.38%	10.51%

Comment -The Indiana loss ratios for the last few years are held artificially low due to the reluctance of the pool to raise rates.

*Minnesota 1976
@ 15%*

Uninsurable Pool Data

2

State	Premis. Col.	Claims Paid	Admin. Paid	Loss Ratio	Admin (% Claims)
Maine					
1988	15179	0	33960	0.00%	ERR
1989	228189	290179	81265	127.17%	28.01%
Minnesota					
1983	4082351	6981967	383741	171.03%	5.50%
1984	6413829	9761835	665100	152.20%	6.81%
1985	9492438	13324992	984514	140.37%	7.39%
1986	10772454	18913879	904886	175.58%	4.78%
1987	11407281	21893358	928773	191.92%	4.24%
1988	14197219	27098596	1340562	190.87%	4.95%
1989	18459482	38373578	2115892	207.88%	5.51%
Montana					
1987	9870	0	9759	0.00%	ERR
1988	97026	65374	14675	67.38%	22.45%
1989	316276	395050	24523	124.91%	6.21%
Nebraska					
1986	8414	0	11558	0.00%	ERR
1987	458857	443238	14600	96.60%	3.29%
1988	1221792	1808813	57097	148.05%	3.16%
1989	2572213	4088816	128223	158.56%	3.14%
New Mexico					
1988	233053	127399	103475	54.67%	81.22%
1989	1222400	1565229	157945	128.05%	10.09%
North Dakota					
1983	138666	345918	25305	249.46%	7.32%
1984	455874	1058694	35904	232.23%	3.39%
1985	894701	1704988	56756	190.57%	3.33%
1986	1321991	2863886	108756	216.63%	3.80%
1987	1626970	3389229	174130	208.32%	5.14%
1988	1937903	3340441	234984	172.37%	7.03%
1989	2261638	3691487	278007	163.22%	7.53%
Tennessee					
1987	556763	17450	0	3.13%	0.00%
1988	3236204	2807338	317930	86.75%	11.32%
1989	8433944	10212644	623744	121.09%	6.11%

Uninsurable Pool Data

3

State	Premis. Col.	Claims Paid	Admin. Paid	Loss Ratio	Admin (% Claims)
Washington	Earned	Incurred			
1988	124260	74121	78575	59.65%	106.01%
1989	1940334	2543839	204221	131.10%	8.03%
Wisconsin					
1983	1232352	2463703	156964	199.92%	6.37%
1984	2079996	3104604	196338	149.26%	6.32%
1985	2600586	3265492	210646	125.57%	6.45%
1986	2856286	3336087	284500	116.80%	8.53%
1987	2959861	3956056	366245	133.66%	9.26%
1988	4056671	5518189	906550	126.03%	16.43%
1989	6676614	9754103	885383	146.09%	9.08%
Comment - Participating insurers are not permitted any kind of credit against premium or income taxes.					
Total					
1983	10964196	13451689	895072	122.69%	6.65%
1984	19285637	25364705	1538368	131.52%	6.06%
1985	24886212	33167866	1885765	133.28%	5.69%
1986	27460031	42556374	2184536	154.98%	5.13%
1987	29530953	51947449	2663781	175.91%	5.13%
1988	40490689	67604851	5218944	166.96%	7.72%
1989	68137874	112700787	8887977	165.40%	7.89%
Total - Minus Connecticut and Minnesota					
1983	3746956	3027499	238781	80.80%	7.89%
1984	9398663	11148419	557818	118.62%	5.00%
1985	12108012	15263413	624872	126.06%	4.09%
1986	13154636	19438662	1033494	147.77%	5.32%
1987	14937196	23391010	1397773	156.60%	5.98%
1988	22833133	33212821	3465440	145.46%	10.43%
1989	45182520	63889209	6204259	141.40%	9.71%

United States General Accounting Office

GAO

Briefing Report to the Committee on
Labor and Human Resources, U.S. Senate

April 1988

HEALTH INSURANCE

Risk Pools for the Medically Uninsurable



Sent To You By
Legislative Research Agency

HEALTH
004668



United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-230452

April 13, 1988

The Honorable Edward M. Kennedy, Chairman
The Honorable Orrin G. Hatch, Ranking Minority Member
Committee on Labor and Human Resources
United States Senate

This report responds to your March 23, 1987, request concerning state-administered health insurance risk pool programs. You asked that we determine the programs' characteristics, enrollment, and financial experience; the characteristics of the persons they insure; and their success in meeting expectations. We agreed with your offices to focus on the programs in Connecticut, Florida, Indiana, Minnesota, North Dakota, and Wisconsin. These six state programs had been in operation for 3 or more years and, therefore, had sufficient experience to permit analysis. We also obtained information on programs in the other nine states that have more recently enacted risk pool legislation. We obtained oral comments on this report from the Department of Health and Human Services and have incorporated them where appropriate.

Risk pool programs provide health insurance to individuals who cannot obtain it because their health conditions make them unacceptable risks to private insurers. The programs provide comprehensive insurance coverage similar to that of employer-sponsored group health plans. Costs to the insured are relatively high because of generally large deductibles and premiums that are usually 25 to 50 percent more than those paid by individuals with private health insurance.

Despite high premiums, the programs require a subsidy. Two states subsidize their risk pools directly from state revenue, while most of the 15 states that have enacted risk pool legislation assess risk pool deficits against insurers doing business in the state. In the majority of these states, however, insurers may credit their full share of risk pool deficits against state premium or corporate income taxes. Allowing a tax credit results in reduced tax collections and has much the same effect as financing the risk pool from general revenues.

The six programs we reviewed have consistently operated at a loss, paying an average of \$1.60 in claims for each dollar of premium income in 1986. According to estimates prepared by the Health Care Financing Administration (HCFA), private insurers nationally paid \$0.87 in claims per dollar of premium income during that year.

B-230452

The six programs insured about 20,000 individuals. Middle-aged individuals appear most likely to enroll in risk pools. Enrollees incur higher medical expenses than the general population. The data available indicate that their expenses are higher for treatment of heart conditions, cancer, and diabetes specifically. Insurance industry and advocacy group officials believe that risk pools can also help finance the cost of treating patients with acquired immunodeficiency syndrome (AIDS). State officials expressed concern that AIDS patients could increase program costs, but did not know the extent to which persons infected with the virus that causes AIDS have enrolled in risk pools.

The six states we reviewed have not determined the extent to which persons who cannot obtain insurance because of poor health are enrolling in risk pools. State officials generally believe, however, that their programs are not serving all eligible individuals.

As arranged with your offices, unless you publicly announce its contents earlier, we plan no further distribution of this report until 30 days after its issue date. At that time, we will send copies to other congressional committees having jurisdiction over the matters discussed in this report and other interested parties.

If you have any questions, please call me on (202) 275-6195.



MS Michael Zimmerman
Senior Associate Director

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ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome
BLS	Bureau of Labor Statistics
GAO	General Accounting Office
HCFA	Health Care Financing Administration

HEALTH INSURANCE: RISK POOLS
FOR THE MEDICALLY UNINSURABLE

INTRODUCTION

About 63 percent of the population is covered by health insurance that is related to employment, normally a group insurance plan. Persons not covered by a group plan may purchase an individual plan. When writing an individual policy, insurance companies normally obtain information on the individual's medical condition to assess the risks involved in providing coverage. Occasionally companies either refuse to provide coverage to, or limit coverage for, persons who have chronic medical conditions that are costly to treat. These persons are commonly referred to as the medically uninsurable.

An estimated 37 million Americans lack health insurance coverage. Researchers believe that from 1 to 2 million of these persons cannot obtain insurance because of medical conditions that make them unacceptable risks to private insurers. Researchers also believe that this group is growing because (1) an increasingly competitive insurance market has led insurers to adopt more restrictive health insurance standards; (2) increasing health care costs, and resulting increased insurance premiums, have discouraged some employers from providing group health insurance as an employee benefit; and (3) advances in diagnostic testing have enabled insurers to identify individuals who have potentially costly illnesses.

In the past, Blue Cross and Blue Shield Plans have been a source of insurance for the medically uninsurable. During the 1930s, when the plans pioneered health insurance, all group and individual subscribers paid a uniform rate regardless of their health status. Enrollment in the plans was open to all, and individuals who were at risk of incurring high medical costs benefited because their premiums were subsidized by lower risk individuals. Commercial companies entered the field in the 1940's, and a competitive for-profit health insurance industry developed.

In this competitive environment, Blue Cross and Blue Shield Plans began to base premiums for large group policies wholly or partly on the group's health experience, rather than on the experience of all their subscribers. Therefore, the plans had fewer lower risk individual subscribers to subsidize health care costs for high-risk individuals. Not all Blue Cross and Blue Shield Plans continue to offer individual insurance coverage without regard to health status, referred to as open enrollment. As of October 1987, Plans in 11 states and the District of Columbia offered open enrollment. Appendix I lists the states in which Plans offer open enrollment.

To help the medically uninsurable, 15 states have passed legislation establishing health insurance risk pool programs.¹ Typically, the states create associations to operate the programs and require all insurers doing business in the state to be members. The associations offer insurance to eligible individuals and establish premiums. If premiums do not cover expenses, deficits are generally shared among association members. Table 1 shows the states that have enacted legislation, and the effective dates.

**Table 1: Effective Dates of Risk Pool
Authorizing Legislation^a**

<u>State</u>	<u>Effective date</u>
Connecticut	Apr. 1976
Minnesota	July 1976
Wisconsin	Jan. 1981
North Dakota	July 1981
Indiana	Sept. 1981
Florida	July 1982
Montana	July 1985
Tennessee	July 1986
Nebraska	Sept. 1986
Iowa	Jan. 1987
New Mexico	Apr. 1987
Washington	May 1987
Illinois	Apr. 1987
Maine	Sept. 1987
Oregon	Sept. 1987

^aRhode Island established a risk pool in 1975. However, Blue Cross and Blue Shield of Rhode Island offers open enrollment. According to a state official, no more than 10 or 12 persons have been enrolled in the risk pool at any time. Because of its small size, we did not examine the Rhode Island program.

In addition, according to a study conducted by the Intergovernmental Health Policy Project, legislatures in 12 states considered, but did not enact, legislation authorizing a risk pool during 1987. Appendix II lists these states.

OBJECTIVES, SCOPE, AND METHODOLOGY

On March 23, 1987, the Chairman and the Ranking Minority Member of the Senate Committee on Labor and Human Resources asked us to obtain information on health insurance risk pools. In later discussions with their offices, we agreed to obtain information on

¹Blue Cross and Blue Shield Plans in the 15 states with risk pools we examined do not offer open enrollment.

- the programs' characteristics, including eligibility requirements, covered medical services, deductibles, and coinsurance requirements;
- the programs' experience concerning enrollment, premium income, claims expenses, and subsidy requirements;
- enrollees' characteristics, including age, gender, primary illness, and the types and costs of medical services they have received; and
- the extent to which the programs have met the expectations that led to their creation.

As agreed with the Senators' offices, our review focused on the programs in Connecticut, Florida, Indiana, Minnesota, North Dakota, and Wisconsin. These six state programs had been in operation for 3 or more years and, therefore, had sufficient experience to permit analysis. We also obtained information on programs in the nine other states that have more recently established risk pools.

In the six states, we spoke with and obtained and reviewed appropriate documentation from (1) risk pool program administrators, (2) officials of state insurance departments, and (3) representatives of private groups interested in the programs. For the other nine states, we interviewed and obtained documents from program administrators. We also interviewed representatives of national organizations interested in risk pools. Appendix III lists the groups and organizations we contacted.

To obtain information on program characteristics, we analyzed authorizing legislation, reviewed program administrative policies and procedures, and examined risk pool insurance policies. We compared program characteristics to data on employer-sponsored group insurance plans reported by the Bureau of Labor Statistics (BLS) in its June 1987 Survey of Employee Benefits in Large and Medium Firms, 1986. We discussed program characteristics with program administrators, state insurance department officials, and representatives of private groups interested in risk pools to obtain their views of how program characteristics affect program operations.

To obtain information on the programs' enrollment and financial experience, we analyzed program financial and operating reports prepared by program administrators and state insurance departments. We also discussed enrollment and financial trends with these officials.

To obtain information on the insured, we analyzed reports prepared by program administrators and state insurance departments,

and interviewed program administrators, risk pool association representatives, and state insurance officials. Except for Wisconsin, which surveyed risk pool enrollees in 1982, 1984, and 1986, limited information on the characteristics of the insured was available. Moreover, the results of Wisconsin's surveys may not accurately represent the characteristics of enrollees in that state's risk pool because many of those surveyed did not respond, and state officials did not analyze the characteristics of nonrespondents to determine whether differences existed between them and respondents.

To obtain information on how well the programs have met the expectations that led to their creation, we examined authorizing legislation and reviewed legislative histories and program evaluations where available. We also discussed the programs' effectiveness with program administrators, state insurance officials, and representatives of private groups interested in risk pools.

Our fieldwork was conducted between April and November 1987 in accordance with generally accepted government auditing standards. We obtained oral comments from the Department of Health and Human Services, and have revised the report to reflect these comments where appropriate.

RISK POOL PROGRAM CHARACTERISTICS

Risk pools provide health insurance that is comprehensive, but costly, to persons who can afford, but have difficulty obtaining, health insurance. Risk pool insurance covers a broad range of health services comparable to those covered through group health insurance plans offered by large and medium-sized employers.

Deductibles, or the covered medical expenses an enrollee pays before the plan pays, are usually higher under risk pool insurance than under typical group plans. Further, premiums charged for risk pool insurance are normally 25 to 50 percent higher than rates private insurers charge for individual policy. The premiums that risk pools charge do not cover claims expenses. Risk pool operating losses are generally shared among private insurers doing business in the state. Most states, however, allow insurers to offset these losses through state tax credits.

Risk Pool Management

The organizational structures of the 15 state risk pools are essentially the same. The risk pool is operated by an association consisting of health insurance providers doing business in the state, including commercial health insurance companies and Blue Cross and Blue Shield Plans. Twelve states also require health maintenance organizations to be association members. While

legislation in six states provides for self-insured organizations² to be association members, U.S. district courts have held that, under the provisions of the Employee Retirement Income Security Act of 1974, employers with self-insured health plans are exempt from state insurance regulation and therefore cannot be required to participate in a risk pool.

The risk pool association manages the program through its governing body, which generally includes health insurance industry officials, state government officials, and consumer representatives. The association recommends premium rates and changes in program benefits within the framework of authorizing legislation. The association contracts with an insurance company to administer the program, issue policies, collect premiums, process claims, and maintain financial records.

State insurance departments oversee program operations--they review and approve program operating plans, premium rates, and changes in program benefits. The departments also review program performance.

Eligibility Requirements

To be eligible for risk pool enrollment, individuals must normally have been rejected for health insurance by one or more insurers. Ten states also grant eligibility to persons who either hold or have been offered a policy with premiums higher than risk pool premiums. Eleven states permit enrollment if an individual was offered a policy that excluded coverage of specific medical conditions. Seven states allow applicants with specified diseases--such as cancer, acquired immunodeficiency syndrome (AIDS), or juvenile diabetes--that generally make it difficult to obtain insurance to enroll without meeting other requirements. Table 2 summarizes the eligibility requirements of the various state programs.

²Self-insured organizations directly bear the risk and cost of providing health care coverage rather than purchasing coverage from an insurance company.

Table 2: Eligibility Requirements for
State Risk Pool Programs^a

<u>State</u>	<u>Individuals are eligible if they</u>			
	<u>Are refused coverage by (number of insurers)</u>	<u>Are offered limited coverage by other insurers</u>	<u>Are offered high premiums by other insurers</u>	<u>Suffer from specified diseases</u>
Florida	Two	Yes	Yes	No
Illinois	One	No	Yes	Yes
Indiana	Two	Yes	Yes	Yes
Iowa	One	Yes	Yes	Yes
Minnesota	One	Yes	Yes	Yes
Montana	Two	Yes	No	No
Nebraska	One	Yes	Yes	Yes
New Mexico	One	Yes	Yes	No
North Dakota	One	Yes	No	No
Oregon	One	No	No	Yes
Tennessee	One	Yes	Yes	Yes
Washington	One	Yes	Yes	No
Wisconsin	One	Yes	Yes	No

^aConnecticut and Maine do not have these eligibility requirements.

Insurance Benefits

Risk pool insurance covers a comprehensive range of medical services and is comparable to the coverage that large and medium-sized employers make available through their group health plans. Table 3 provides examples of medical services typically covered or excluded under risk pool insurance policies.

Table 3: Medical Services Typically Covered
or Excluded Under Risk Pool Insurance Policies

<u>Covered</u>	<u>Excluded</u>
Hospital services	Experimental treatments
Physician services	Cosmetic treatments
in-hospital and	Eyeglasses and hearing aids
out-of-hospital	Dental care
Prostheses	Routine physical
Durable medical	examinations
equipment	Expenses payable under
Physical therapy	other insurance or under
Oral surgery	government programs
	Custodial care

The programs also protect enrollees from extraordinary medical costs by limiting the out-of-pocket expenses that they must pay during the year. Table 4 shows the out-of-pocket medical expense limits under the state risk pool programs.

Table 4: Out-of-Pocket Medical Expense Limits of State Risk Pool Programs

<u>State</u>	<u>Out-of-pocket limit</u>	
	<u>Individual</u>	<u>Family</u>
Connecticut	\$2,000	\$4,000
Florida ^a	2,500	5,000
Illinois	1,500	3,000
Indiana ^a	1,000	2,000
Iowa ^a	1,500	3,000
Maine	1,500	3,000
Minnesota	3,000	b
Montana	5,000	b
Nebraska	5,000	b
New Mexico ^a	1,500	2,500
North Dakota	3,000	b
Oregon	c	c
Tennessee ^a	1,500	2,000
Washington ^a	1,500	3,500
Wisconsin	2,000	4,000

^aThe program also offers a higher out-of-pocket limit at a reduced premium.

^bLimit on out-of-pocket medical expenses is applied "per covered person." No family limit is provided.

^cAs of January 1988, Oregon had not established an out-of-pocket expense limit for its program.

Cost-Sharing and Benefit Limitation Provisions

Risk pool insurance policies contain a number of cost sharing and benefit limitation provisions. These features, which are traditional mechanisms that have long been used in the insurance industry, include

- deductibles, or the amount of covered medical expenses, either for a calendar year or per hospital admission, an enrollee must pay before the plan provides coverage;
- coinsurance, or the fixed percentage or amount of covered medical expenses an enrollee must pay after satisfying deductible requirements;

- waiting periods during which expenses to treat medical conditions diagnosed before the policy was issued, referred to as preexisting conditions, are not covered; and
- limitations on the maximum amount of medical expenses that will be paid during the enrollee's lifetime.

Cost Sharing Provisions

Risk pool deductibles for medical expenses are generally higher than deductibles under the group health plans that large and medium-sized employers offer. According to risk pool officials, high deductibles discourage unnecessary use of medical services and help control costs. With one exception, Wisconsin, the programs allow enrollees to select from among two or more deductible amounts. BLS found that group health plans covering 78 percent of employees at large and medium-sized firms have medical expense deductibles of \$150 or less and that plans covering 93 percent of the employees have deductibles of \$200 or less. Table 5 shows the range of medical expense deductible amounts under state risk pool programs.

Table 5: Deductible Amounts for State Risk Pool Programs

<u>State</u>	<u>Medical expense deductibles for an individual</u>	
	<u>Lowest</u>	<u>Highest</u>
Connecticut	\$400	\$1,500
Florida	1,000	2,000
Illinois	250	1,000
Indiana	200	1,000
Iowa	500	1,000
Maine	500	1,000
Minnesota	500	1,000
Montana	500	1,000
Nebraska	250	1,000
New Mexico	500	1,000
North Dakota	150	1,000
Oregon	a	a
Tennessee	500	2,000
Washington	500	1,000
Wisconsin	1,000	1,000

^aAs of January 1988, Oregon had not established a deductible for its program.

Risk pool coinsurance requirements were generally comparable to those required under group health plans that large and medium-sized employers offer. Thirteen of the 15 states require enrollees to pay 20 percent of covered medical expenses after meeting

deductible requirements. Nebraska requires a 10-percent coinsurance payment, and, as of January 1988, Oregon had not established a coinsurance percentage. BLS found that group health plans covering 86 percent of employees at large and medium-sized firms also contained a 20-percent coinsurance feature.

Benefit Limitation Provisions

Risk pool insurance policies exclude preexisting medical conditions from coverage for a period of time. Preexisting conditions are those that have been diagnosed or treated during a specified period before the effective date of the policy--referred to as the condition period. Costs of treating preexisting conditions are not covered for a period after the effective date of the policy--referred to as the waiting period. Insurers have traditionally used waiting periods for preexisting conditions to prevent persons in poor health from purchasing insurance only when they plan to seek treatment.

Nine programs will waive or reduce the preexisting condition waiting period if the individual had other insurance in force before enrolling. Two of these states require enrollees requesting a waiver to pay a 10-percent premium surcharge. One state will also reduce the waiting period for enrollees who pay a surcharge, whether they had other insurance or not.

Thirteen state risk pool programs limit the maximum amount in benefits payable during an enrollee's lifetime. The limits were generally similar to those of the group health plans that large and medium-sized employers offer. BLS found that group health plans covering about 43 percent of the employees at large and medium-sized firms were covered by a plan that limited lifetime benefits to \$500,000 or less.

Table 6 shows the benefit limitation provisions of the state risk pool programs.

Table 6: Benefit Limitation Provisions of
State Risk Pool Programs

<u>State</u>	<u>Preexisting condition provisions</u>			<u>Maximum lifetime benefit</u>
	<u>Condition period (months)</u>	<u>Waiting period (months)</u>	<u>Waiver provision</u>	
Connecticut	6	12	a	\$1,000,000
Florida	6	6	None	500,000
Illinois	6	6	b, c	500,000
Indiana	6	6	None	None
Iowa	6	6	b	250,000
Maine	3	3	a, b	500,000
Minnesota	3	6	a	250,000
Montana	60	12	b	250,000
Nebraska	6	6	d	500,000
New Mexico	6	6	b	None
North Dakota	3	6	b	250,000
Oregon	6	6	d	1,000,000
Tennessee	6	6	None	500,000
Washington	6	6	b	500,000
Wisconsin	6	6	None	500,000

^aWaiting period may be waived or reduced under certain limited circumstances.

^bWaiting period will be waived if the applicant had other health insurance in force before enrolling in the risk pool.

^cWaiting period will be reduced if the applicant also pays a premium surcharge.

^dWaiting period will be waived if the applicant had other health insurance in force before enrolling in the risk pool and pays a 10-percent premium surcharge.

Cost-Containment Provisions

Private insurers have included a number of cost-containment features in their health insurance policies. In general, these features discourage individuals from seeking unnecessary medical treatment or encourage them to use less costly treatment alternatives. BLS surveyed large and medium-sized firms to determine whether their health plans included any of nine common

cost-containment measures.³ BLS found that 68 percent of the employees at large and medium-sized firms were covered by a plan that included at least one of the nine cost-containment features.

Like private insurers, risk pool programs include cost-containment features in their insurance policies. Eight of the state programs have implemented one or more of the provisions covered in the BLS survey. The most common provision, a requirement that decisions to hospitalize enrollees be reviewed by the program administrator, has been adopted by seven states. Three states require enrollees to obtain a second opinion before nonemergency surgery, three states require enrollees to use generic rather than more expensive brand-name drugs, and three states require that routine laboratory tests before hospitalization be performed on an outpatient basis.

Risk Pool Premiums

The basis for setting risk pool insurance premiums is normally prescribed in authorizing legislation. Premiums are usually established based on the rates charged for private health insurance in the state and vary based on age and, sometimes, sex and geographic area. The legislation generally provides for premiums to be adequate to cover anticipated claims expenses, but it limits rates to a multiple of the rates charged by private insurers. Legislation in 12 states provides for multiples between 125 and 150 percent. Three states provide for higher multiple limits, including Montana, which provides a 400-percent limit. Program administrators in the six states we reviewed survey private insurers to determine the average rates they charge for health insurance as a basis for setting risk pool rates. Table 7 shows the rate limits and examples of premiums charged in the six states reviewed.

³The cost containment measures covered in the BLS survey included (1) incentives to encourage a second surgical opinion before nonemergency surgery, (2) incentives to encourage use of outpatient surgery, (3) incentives to use generic rather than more expensive brand-name drugs, (4) limits on reimbursement for nonemergency weekend hospital admissions, (5) separate deductibles for hospital admissions, (6) incentives to have routine laboratory tests done on an outpatient basis before hospitalization, (7) higher payment for delivery at a birthing center, (8) incentives to audit the hospital's statement, and (9) preadmission certification requirements.

Table 7: Rate Limits and Examples of Annual Premium Rates Charged by State Risk Pool Programs

State	Rate limit ^a (percent)	1987 annual premium rates for coverage with a \$1,000 medical expense deductible for a			
		40-year-old		55-year-old	
		Male	Female	Male	Female
Connecticut	150	\$1,156	\$1,538	\$2,077	\$2,486
Florida	200	1,924	1,924	3,153	3,153
Indiana	150	1,162	1,597	2,130	2,363
Minnesota	125	641	641	999	999
North Dakota	135	945	945	1,383	1,383
Wisconsin	150	996	1,320	1,784	1,660

^aBased on rates charged for private health insurance in the state.

Financing Program Deficits

Risk pool authorizing legislation generally prescribes how program operating deficits will be financed. In 12 of the 15 states, deficits are shared among risk pool association members through assessments voted by the association's governing body. These states distribute assessments in proportion to each member's share of total premium income⁴ in the state except in Connecticut, which assesses members according to their share of total claims paid, and in Washington, which assesses members according to their share of total health insurance subscribers. Maine plans to finance deficits through a tax on hospital revenues, while Illinois will subsidize its risk pool from general revenues. Tennessee will provide up to \$2 million a year from general revenues to cover deficits, with any remaining deficits made up from assessments to association members. Oregon assessed association members for startup costs, but state legislation does not address how operating deficits will be financed.

Nine of the 12 states that assess deficits against association members allow them to credit the assessments against their state taxes. Allowing a tax credit results in reduced tax collections and has much the same effect as subsidizing risk pool losses from general revenues. In the other three states, assessments are considered a cost of doing business that the state insurance department may consider when approving rates the companies propose for their health insurance plans.

⁴Premium income is the revenue an insurer earns from the sale of insurance.

As stated earlier, legislation in six states provides for self-insured organizations to be risk pool association members. The courts, however, have held that because employers with self-insured health plans are exempt from state insurance regulation under the Employee Retirement Income Security Act of 1974, they cannot be required to participate in risk pools.

Insurance industry officials and program administrators in the states we reviewed believed that exempting self-insured organizations from risk pool participation can unfairly increase the burden on persons who obtain private insurance from risk pool association members. Even in states where tax credits relieve insurers from subsidizing risk pools, officials were concerned because of the possibility of the tax credit being repealed. Minnesota, for example, repealed its tax credit provision in 1987.

RISK POOL ENROLLMENT AND FINANCIAL EXPERIENCE

In five of the six programs we reviewed, enrollment has increased since 1983. For the six programs, total enrollment increased 48 percent to 20,545 persons. However, the Minnesota risk pool, with 10,842 insured, has 53 percent of the six-state total.

The risk pools in the six states have consistently operated at a loss. In 1986 the programs paid an average of \$1.60 in claims for each dollar of premium income. According to estimates prepared by HCFA, private insurers nationally paid about \$0.87 in claims per dollar of premium income during the same period. To date, however, assessments to risk pool association members in the three states that do not permit tax credits have been modest when compared to the total volume of insurance business in the states.

State officials have found that often a conflict exists between the objectives of (1) increasing enrollment by enhancing the attractiveness of the risk pool plan and (2) reducing deficits through higher premiums or reduced coverage.

Enrollment

Enrollment in risk pool programs has increased since 1983, but growth in the programs has not been uniform. Between the end of 1983 (the first year all six were offering policies) and the end of 1986, the number of insured grew from 13,842 to 20,545.⁵ About half of the insured at the end of 1986 were in Minnesota. Two newer programs, those in Florida and North Dakota, experienced

⁵The number of policies in force is virtually equivalent to the number of insured persons, according to program officials, since almost all risk pool policies are for individuals rather than families.

significant percentage growth, but from a low base. Table 8 summarizes the number of policies in force at the end of 1983 and 1986.

Table 8: Risk Pool Insurance Policies in Force as of December 31, 1983, and December 31, 1986

<u>State</u>	<u>Policies in force as of</u>		<u>Change (percent)</u>
	<u>December 31, 1983</u>	<u>December 31, 1986</u>	
Connecticut	3,419	2,315	-32
Florida	49	1,036	2,014
Indiana	2,288	2,998	31
Minnesota	6,043	10,842	79
North Dakota	245	1,279	422
Wisconsin	<u>1,798</u>	<u>2,075</u>	15
Total	<u>13,842</u>	<u>20,545</u>	48

Because of turnover in the enrollee population, the number insured through risk pools has been greater than indicated by the table. Excluding North Dakota, for which data were not readily available, there were about 23,000 policies written and in force during the 3-year period in addition to the 19,266 policies in force on December 31, 1986.

Wisconsin was the only state that has surveyed former enrollees to determine why they had canceled their policies. In 1982 Wisconsin surveyed 562 former enrollees and received responses from 208, or about 37 percent of those surveyed. About 23 percent canceled because they could not afford the insurance premiums. The other cancellations resulted from enrollees obtaining group health insurance coverage, becoming eligible for Medicare, dying, or moving out of the state.

Fiscal Experience

Risk pools in the six states we reviewed have consistently operated at a loss. The six programs incurred an aggregate net operating loss of about \$18.1 million in 1986--about three times the 1983 level. Minnesota, with by far the largest enrollment, experienced the greatest loss, \$9,024,228 in 1986. Table 9 compares program operating results for calendar years 1983 and 1986.

**Table 9: Comparison of Risk Pool Deficits
for Calendar Years 1983 and 1986**

<u>State</u>	<u>Deficit or (surplus)</u>		<u>Change (percent)</u>
	<u>1983</u>	<u>1986</u>	
Connecticut	\$508,721	\$885,375	74
Florida	(6,276) ^a	681,157	b
Indiana	177,657	5,160,982	2,805
Minnesota	3,972,634	9,024,228	127
North Dakota	230,896	1,633,219	607
Wisconsin	1,609,052	678,806	-58
Total	<u>\$6,492,684</u>	<u>\$18,063,767</u>	178

^aThe Florida risk pool was in operation only during the last 4 months of 1983 and, according to program officials, had a surplus primarily because of the 12-month waiting period for coverage of preexisting medical conditions.

^bPercentage change not calculated.

From calendar year 1983 to calendar year 1986, premium income for the six programs increased by 178 percent, while claims expense increased by 190 percent. Meanwhile, the loss ratio--the ratio of claims expenses to premium income--increased from \$1.54 in claims per dollar of income in 1983 to \$1.60 in 1986. In comparison, the loss ratio for health insurers nationally, according to HCFA estimates, was \$0.87 per dollar of premium income during 1986. Table 10 shows the loss ratios for the six states for calendar years 1983-86.

**Table 10: Risk Pool Loss Ratios for
Calendar Years 1983-86**

<u>State</u>	<u>Claims paid per dollar of premium income</u>			
	<u>1983</u>	<u>1984</u>	<u>1985</u>	<u>1986</u>
Connecticut	\$1.10	\$1.28	\$1.39	\$1.19
Florida	a	0.28	1.79	1.25
Indiana	0.83	1.56	1.30	1.70
Minnesota	1.87	1.65	1.49	1.76
North Dakota	2.49	2.32	1.91	2.17
Wisconsin	3.02	2.07	1.35	1.19

^aThe Florida risk pool was in operation only during the last 4 months of 1983 and, according to the pool's audited financial statements, did not incur claims expense during the period.

Administrative Expenses

Risk pools in the six states we reviewed reimburse the company that administers their programs for expenses incurred in issuing policies, processing claims, and paying benefits. This reimbursement, however, is generally subject to limits. Three states reimburse the program administrator for reasonable costs incurred, but Minnesota and North Dakota limit the reimbursement to 12.5 percent of claims expenses. Indiana and Wisconsin pay the administrator a basic monthly fee plus additional fees related to the volume of activities, such as processing insurance applications and insurance claims. Florida, which has the highest rate of administrative expenses, reimburses the administrator for all direct costs incurred, pays a monthly fee for indirect costs, and additional activity-related fees. Administrative expenses ranged from about 3.7 percent of claims expenses in Connecticut and Indiana to about 14.9 percent of claims in Florida.

Assessments

Risk pool association members share in operating losses through assessments voted by the association's governing board. Because the association normally maintains a cash reserve, assessments are not necessarily equal to operating losses for any given year. Table 11 shows the 1986 assessments in the six states.

Table 11: Assessments Levied on Members of State
Risk Pool Associations--1986

<u>State</u>	<u>Assessment</u>
Connecticut	\$1,490,387
Florida	0
Indiana	4,683,662
Minnesota	9,054,432
North Dakota	1,509,780
Wisconsin	<u>750,000</u>
Total	<u>\$17,488,261</u>

Despite concerns expressed that risk pool losses will significantly increase insurance costs, assessments to date have been modest compared to the total volume of insurance business in the states. For the three states that did not permit tax credits, risk pool assessments represented less than 1 percent of the total volume of premium income in those states.

Program Features That Have Affected Operations

Officials in the six states have adjusted program requirements and benefits to achieve two sometimes conflicting objectives-- increasing enrollment and controlling costs. Efforts to make the programs more attractive to potential enrollees, mainly involving improved benefits, tend to increase operating losses. Program officials have found that, in particular, reductions in and waivers of preexisting condition waiting periods contribute to increased program losses. However, when program administrators have attempted to control costs through premium increases and benefit restrictions, enrollment has either decreased or increased at a lower rate.

State program officials have not made a detailed analysis of how various changes have affected program operations. According to officials, many factors affect the operations of a risk pool, and it is difficult to isolate the impact of a change or event from the impact of the other factors. Nonetheless, program officials told us that the programs' enrollment history and fiscal experience can provide insight into the impact policy changes are likely to have on program operations.

Efforts to Increase Enrollment

Minnesota has the largest enrollment of the six risk pool programs reviewed, and that enrollment has grown steadily since 1983. Minnesota law limits risk pool premium rates to 125 percent of comparable private insurance rates. However, despite significant loss increases, the state insurance department has not authorized an increase in premium rates since 1985 even though the law would have permitted it. As a result, the program has the lowest premium rates of the six programs reviewed.

Wisconsin has taken several steps to boost enrollment. In 1985 it implemented a program, financed by state revenues, to subsidize risk pool premiums for low-income individuals. Persons with a household income of less than \$16,500 are eligible for the premium subsidy, which varies with income. Table 12 shows the percentage of premium subsidies and the number of policyholders assisted as of December 31, 1986.

Table 12: Subsidy Percentage by Income and Number of
Persons Assisted by the Wisconsin Program

<u>Household income</u>	<u>Subsidy as a percentage of premium</u>	<u>Number of policies</u>
Under \$9,000	33.3	253
\$9,000-\$11,999	29.7	151
\$12,000-\$14,999	23.0	138
\$15,000-\$16,499	17.0	<u>57</u>
Total		<u>599</u>

Participants in this program represented about 29 percent of risk pool enrollees as of December 31, 1986. Wisconsin officials estimated that \$433,000 was spent for premium subsidies in 1987. In 1988, the state will introduce a program to also subsidize deductibles for low-income individuals.

Provisions to waive the waiting period for coverage of preexisting medical conditions have proven costly. In 1983, Indiana authorized a waiver for enrollees who paid a 10-percent premium surcharge. Losses increased sharply during 1983 and 1984, and program officials attributed the increase to the waiver provision. Similarly, North Dakota introduced a waiver in 1985 to attract enrollment. According to North Dakota officials, the additional revenue gained from the 50-percent premium surcharge did not cover the sharp increase in claims expenses. The state has since terminated this waiver provision.

Efforts to Control Costs

The Connecticut program experienced sharply increased losses in part due to court action that required the program to provide unlimited coverage for mental and nervous conditions. To moderate losses, Connecticut increased premiums and doubled both deductibles and out-of-pocket expense limits for enrollees in 1985. Enrollment declined by about 20 percent between December 31, 1984, and December 31, 1985. Program officials identified the changes as a major factor in the enrollment decline. The state's robust economy and federal legislation extending health benefits to laid-off workers also contributed to the decline, according to the officials.

In 1983, Wisconsin took various steps to reduce risk pool losses. It raised the limit on risk pool premiums from 130 to 150 percent of comparable private premiums, extended the waiting period for coverage of preexisting medical conditions from 30 days to 6 months, and increased the enrollee's liability for out-of-pocket medical expenses from \$1,500 to \$2,000. Growth in program participation has been modest, despite the previously noted premium subsidies provided to low-income enrollees.

To reduce losses that occurred as a result of waiving the waiting period for coverage of preexisting medical conditions, Indiana increased base premiums significantly and, in January 1986, increased the waiver surcharge from 10 to 25 percent. Despite this action, losses continued to increase. Program officials believe that the higher premiums resulted in only those with the most costly health conditions enrolling or continuing their enrollment. Average claims paid per policyholder were \$3,713 in 1986, the highest of the six programs reviewed. Program officials believe that enrollees paid the higher premiums and the 25-percent waiver surcharge because they had an immediate need for medical care. Indiana has since eliminated the waiver provision.

ENROLLEE CHARACTERISTICS

Risk pool enrollees are most likely to be middle aged. The limited data available suggest that enrollees incur higher medical costs generally and incur higher costs for heart and circulatory diseases, cancer, and diabetes specifically than does the population at large. State officials are concerned about, but have little information on, the potential cost impact on their programs concerning the treatment of AIDS patients.

Researchers who have studied risk pools believe that from 0.5 to 1 percent of the population is medically uninsurable. Their estimates, however, are rough approximations, not supported by detailed research on the size and demographic makeup of this population.

Demographics of Risk
Pool Enrollees

Risk pool enrollees are more likely to be between the ages of 40 and 64 than the general population. Five of the six states reviewed maintained data on the age and sex of enrollees. Table 13 compares the age distribution of enrollees in the five states as of December 31, 1986, to that of the U.S. population in 1986. About 54 percent of the enrollees in these states were females, compared to about 52 percent of the national population.

Table 13: Comparison of Age Distribution of Risk Pool
Enrollees to the National Population
as of December 31, 1986^a

<u>Age</u> <u>category</u>	<u>Percent distribution</u>	
	<u>Risk pool</u> <u>enrollees</u>	<u>National</u> <u>population</u>
Under 30	22	47
30-39	14	16
40-49	15	11
50-59	26	9
60-64	19	5
Over 64	4	12

^aThe Census Bureau does not publish age distribution estimates for individual states for age categories comparable to those the risk pools maintain. Analysis of Census Bureau state-level data shows that differences between age distribution in the five states and the nation are not significant.

Insurance officials described various factors that influence the makeup of risk pool enrollment. First, women are less likely to participate in the labor force than men and are more likely to depend on their spouse for access to employer-sponsored group insurance plans; and as a result, women are at greater risk of losing access to group insurance because of divorce or death of a spouse. Second, middle-aged workers who lose coverage under group plans because of layoffs or terminations are more likely than younger workers to be in poor health and to experience difficulty in obtaining commercial health insurance. Finally, large numbers of persons 65 and older may not be enrolled because they are generally covered by Medicare.

Wisconsin has conducted periodic surveys to obtain demographic information on its program enrollees. In 1986, Wisconsin surveyed 1,919 enrollees and received responses from 1,101, or about 57 percent. The results of this survey may not accurately represent the characteristics of all enrollees in that state, but do provide information on the respondents. Wisconsin found that

- 61 percent were not employed, and 13 percent were employed part time; and
- 88 percent of those who were employed worked for firms employing 25 or fewer people--firms less likely to provide group health insurance.

Cost and Nature of
Medical Services Used

The six states we reviewed did not gather consistent data on the health care costs risk pool enrollees incur. Available information on medical expense reimbursements made to enrollees, however, indicates that the costs they incur are higher than those of the average person. Table 14 presents 1986 claims expenses per policyholder, based on the average number of policies outstanding for the year in the six states. The states did not maintain consistent data on claims expenses per insured person, and these figures may slightly overstate average annual expenses for an individual to the extent that more than one person was insured under a policy.

Table 14: Average 1986 Claims Expenses per Policyholder
for State Risk Pool Programs

<u>State</u>	<u>Average claims expense per policyholder</u>
Connecticut	\$1,742
Florida	2,504
Indiana	3,713
Minnesota	1,804
North Dakota	2,495
Wisconsin	1,555

As the table shows, average claims expense per policyholder, not including deductible and coinsurance expenses paid by the policyholder, varied considerably. The weighted average for the six states was \$2,140. In comparison, according to estimates prepared by the Department of Health and Human Services, per capita health care expenses, including deductible and coinsurance payments, averaged about \$1,620 nationally in 1986.

Three states have gathered information on the conditions that enrollees suffer from, and one state has gathered information on the conditions that made it difficult for them to obtain insurance in the private market. The company that administers the Florida, Indiana, and Wisconsin programs summarizes claims expenses by the health conditions that led enrollees to seek treatment. These data indicate that enrollees in these states incur more expenses for the

treatment of heart and circulatory diseases, cancer, and diabetes than national averages for all persons the company insures. Table 15 shows the data from the three states.

Table 15: Comparison of 1986 Claims Expenses Incurred, by Medical Condition, for Three State Risk Pool Programs, to Company's 1986 Average Claims Expense

<u>Medical condition</u>	<u>Percent of claims expenses paid</u>			
	<u>Company average</u>	<u>Florida</u>	<u>Indiana</u>	<u>Wisconsin</u>
Heart and circulatory diseases	12	12	15	23
Cancer	7	15	18	13
Abdominal conditions	10	18	10	7
Diabetes	1	5	3	6
Blood disease	1	5	1	5
All other	69	45	53	45

In its periodic surveys, Wisconsin asks enrollees about the health conditions that prevented them from obtaining private insurance. In 1986, about 22 percent of those who responded reported that heart-related diseases prevented them from obtaining insurance. About 11 percent cited hypertension; 14 percent, diabetes; and 9 percent, cancer.

Impact of AIDS on Risk Pool Programs

Both insurance industry and advocacy group officials have indicated that risk pools can help finance the cost of treating AIDS patients. The president of the Health Insurance Association of America, for example, has written that no institution by itself can bear the burden of "the alarming medical bill for AIDS." Likewise, the executive director of the Gay Men's Health Crisis, an organization interested in AIDS-related health care issues, has acknowledged that insurance companies have legitimate concerns about the catastrophic cost of treating AIDS patients. Both have endorsed risk pools as part of the solution to the problem of financing AIDS care.

Program officials in the six states reviewed expressed concern about the potential impact of AIDS-related costs on their risk pool program. None of the states limit coverage of AIDS, and four states--Indiana, Iowa, Minnesota, and Nebraska--specifically make individuals diagnosed with AIDS eligible for their programs. None of the states, however, had studied whether individuals likely to develop AIDS were enrolled in their programs or whether enrollees were being treated for the disease. In two states, officials noted that the types of medical services being provided certain enrollees appeared to be consistent with an AIDS diagnosis.

HAVE THE PROGRAMS MET EXPECTATIONS?

The six states we reviewed have not formally assessed risk pool program performance. Risk pool legislation emerged in response to a perception that opportunities to purchase health insurance were decreasing for persons with serious health problems. According to state officials and insurance industry representatives, the legislation generally was a compromise response to other approaches that would have required all insurers to offer open enrollment. Legislators concluded that the risk pool would distribute the burden of persons with chronic or costly medical conditions among insurers more equitably. Legislation authorizing the risk pools did not establish specific goals but rather contained general statements about assisting the medically uninsurable. Legislative histories of the programs generally offered limited insight into what legislators expected the programs to accomplish.

The information that would be needed to evaluate program performance generally has not been developed. Officials in the six states reviewed have not estimated the size of the medically uninsurable population in their states. Consequently, program officials do not know what portion of this population their programs serve. Further, the states generally do not compile information on the makeup of the enrollee population. As a result, program officials do not know which population segments find the programs most attractive or, more importantly, which segments to target in order to bring coverage to those in need. Officials in the six states reviewed generally believe that their programs are not serving all the medically uninsurable in their states.

SUMMARY

Risk pools provide subsidized health insurance to that segment of the uninsured population that cannot obtain it because of poor health. The six programs that we reviewed have assisted a limited number of persons. As of February 1988, conclusive evidence to show that risk pools are or are not effective, and data that would allow comparison of risk pools to other mechanisms for financing health care for the uninsured, had not been developed.

STATES IN WHICH BLUE CROSS AND BLUE SHIELD
PLANS OFFER OPEN ENROLLMENT

District of Columbia
Maryland
Massachusetts
Michigan
New Hampshire
New Jersey
New York
North Carolina
Pennsylvania
Rhode Island
Vermont
Virginia

STATES THAT CONSIDERED, BUT DID NOT ENACT,
LEGISLATION AUTHORIZING A RISK POOL DURING 1987

Alaska
California
Georgia
Mississippi
Missouri
New York
Ohio
South Carolina
South Dakota
Texas
Vermont
West Virginia

PRIVATE GROUPS AND ORGANIZATIONS
CONTACTED TO OBTAIN INFORMATION ON RISK POOLS

American Diabetes Association
Washington, D.C.

Blue Cross and Blue Shield Association
Washington, D.C.

Center for Health Affairs
Chevy Chase, Maryland

Communicating for Agriculture
Minneapolis, Minnesota

Employee Benefits Research Institute
Washington, D.C.

Health Insurance Association of America
Washington, D.C.

Intergovernmental Health Policy Project
Georgetown University
Washington, D.C.

National Association of Insurance Commissioners
Kansas City, Kansas

National Governors' Association
Washington, D.C.

National Health Policy Forum
George Washington University
Washington, D.C.

The Center for Study of Social Policy
Washington, D.C.

Urban Institute
Washington, D.C.

Washington Business Group on Health
Washington, D.C.

(101122)

Insurers Weeding Out the Sick

Even in large group plans, those with problems can lose coverage

By Gina Kolata
New York Times

New York

In a new practice, some health insurance companies are starting to divide the sick from the well, even in large groups that were once a bastion of security in a tumultuous industry.

Families in large groups had always felt that if they had been part of the group for at least six months or a year, their medical costs would be covered and their premiums would remain stable. But now, some insurance companies are drastically raising rates for sick people, and even for people they think may become sick.

The result, said Dr. Norman Daniels, an ethicist at Tufts University who is an expert on health insurance, is that "no one in this country with private health insurance coverage who is in any kind of group plan is free from the kind of uncertainty that competition is producing."

One Family's Story

No one knows how common it is for insurance companies to raise the rates for the sick in large groups, which usually consist of employees at big corporations or members of special-interest organizations. But the experience of Kathleen Renshaw of Leucadia, Calif., and others shows that the problem, once thought to be limited to small groups, is spreading to large groups as well.

Renshaw finally admitted defeat in her struggle to keep group health insurance for her family when the annual premium reached \$16,000 a year. Her problem is her 8-year-old daughter, Marisa, an exuberant child who swims on a team and takes singing lessons.

But Marisa has only one kidney, and it does not fully function. She needs regular checkups and may face kidney failure in the future. When the family's insurance company learned of the problem, which doctors discovered when Marisa was 3, it began doubling the family's health insurance premiums each year, the maximum increase allowed by California law.

Finally, the family could no longer pay, and no other company would insure them. Along with Marisa, Renshaw, her husband, William Harvey, and their 4-year-old daughter, Kirsten, who has no medical problems, were out in the cold.

Renshaw and Harvey never thought they would be without health insurance. They both have jobs, they bought group health insurance through the alumni association at the University of California at San Diego, and they always paid their premiums.

"I thought that when you pay insurance, the insurance companies will pay for you when you get sick," Renshaw said.

'Spiral of Exclusion'

Donald Light, a sociologist who is professor of health policy at the University of Medicine and Dentistry of New Jersey, said the family's experience is "a tragic example of the spiral of exclusion that is spreading through the entire health care industry."

Light said the practice of raising rates for people who are sick or have pre-existing conditions began in small groups, like self-insured small businesses, in the mid- to late 1980s. Although it is still most common in small groups, he said, it is spreading to larger and larger groups. The

group Renshaw and Harvey joined has thousands of families.

Donald B. White, a spokesman for the Health Insurance Association of America, which represents commercial insurance companies, said that what happened to Renshaw's family is unacceptable. He said it is because of cases like hers that "we and everyone else are proposing reforms that would change the laws so that could not happen again."

White said most problems are with small groups, so the insurance association has proposed legislation to change that market. It wants federal laws to guarantee that high-risk people in small groups can buy insurance at a cost that is no more than 50 percent more than the average premium.

Legislation

Senator Lloyd Bentsen, D-Texas, has introduced a bill in Congress that would prevent the exclusion of sicker people from health insurance coverage sold to small businesses and would prevent small groups from canceling policies of sicker people.

But these remedies do not address the situation Renshaw and Harvey faced because they were not insured with a small group.

Through a catastrophic health insurance plan of the California Children Services, Marisa is now covered for major problems with her kidney, but nothing else.

And Renshaw said this coverage is available only if a family of four has an income of \$40,000 or less. But if Renshaw, now a substitute teacher, gets a full-time teaching job, which she has been seeking, the family would be disqualified. In that case, she said, "our next option is a divorce."

STAYING AHEAD *Jane Bryant Quinn*

Having Health Insurance Is No Guarantee of Coverage

Americans who have health insurance may complacently ignore the terrors of the people without.

But there's a mounting risk your health insurer will fail, leaving you with unpayable bills. The toll is cutting across every kind of medical-payment group.

■ According to Standard & Poor's, 121 life and health insurance companies went broke in the past three years.

■ Blue Cross and Blue Shield of Charleston, W.Va., collapsed in 1990, leaving some \$41 million in unpaid bills.

■ At least 131 Health Maintenance Organizations failed between 1988 and 1990, says Jon Christianson, a professor in the School of Public Health, University of Minnesota.

■ Unknown numbers of multiple employer welfare arrangements have gone broke, often through fraud. MEWAs sign up small companies that can't afford coverage from the major insurers. Some MEWAs are legitimate, but others collect premiums and then skip.

So serious is the carnage that, in some states, doctors and hospitals require their patients to agree, in writing, to pay any bill that their insurer defaults on.

When looking for a sound insurance company, all you can go by is its safety rating. You want an A+ from A.M. Best and AAA from at least one of the other major rating firms — Moody's, Standard & Poor's or Duff and Phelps. S&P also passes out "q" ratings for insurers it hasn't examined in full — the highest being BBBq. Such a company might be an AAA had S&P examined its books.

No rating system covers HMOs. A.M. Best

doesn't rate the Blues, either, although a few are rated by S&P. To get the current financial statement of any Blue plan, call its public information department or your state's insurance commission. Look to see if it's making or losing money.

With MEWAs, the sign of a high-risk plan is lower monthly premiums than the competition offers. Employers shouldn't buy into a MEWA without asking their state insurance commis-

The sign of a high-risk plan is lower monthly premiums than the competition offers

sion if the plan is licensed for sale there and whether there have been any complaints. Avoid new MEWAs.

If your insurer fails, leaving you with unpaid bills, you might be caught by one of the following safety nets:

■ "Hold-harmless" clauses. These stop doctors and hospitals from dunning individuals for bills that should have been paid by their medical-service plans. All federally qualified HMOs have them, as do HMOs in 33 states. Some states also require them of the Blues and of regular insurance plans. Some doctors ignore hold-harmless clauses and bill their patients anyway (ask your state insurance department if you have to pay). If you sign an agreement to pay when you enter a hospital you might, in some states, lose the protection of a hold-harmless clause.

■ State guaranty funds. All the states — the only exception being the District of Columbia — now provide guaranty funds for individual policies. They cover up to \$100,000 of medical expenses (more in some states) for insurers licensed to sell in the state. Most group-health plans aren't included, however, nor are MEWAs. Eighteen funds now cover the Blues; seven cover HMOs.

In general, the funds guarantee (up to the dollar limits of state law) all your back bills, all your current bills, and all future bills until you find another insurer or your policy comes up for renewal, which may be anytime from tomorrow to 12 months. Starting from the time your insurer failed, you have to pay premiums to the guaranty fund, perhaps at a higher rate than you paid before.

■ Insurance-agent liability. If your agent sold you a policy from a company not licensed in your state, the agent may be liable for any bills the company defaults on. Pennsylvania, which is vigorously pursuing MEWA cases, has collected more than \$70,000 from agents on behalf of consumers, says Linda Wells, chief counsel for the state insurance department. Some states hold agents liable if they knew or should have known that the company was insolvent, says Washington, D.C., attorney Gregory Luce.

If you work for a big company whose insurer fails, the chances are good that your employer will cover your bills. Smaller companies, however, may not be able to afford it. Sometimes doctors and hospitals don't bill patients whose insurers collapse, but that's not a sure thing, either. You have to get lucky, which is no way to run a health-insurance system.

Blues Release New Health Insurance Reform Proposal

In testimony before the House Ways and Means Committee, Bernard Tresnowski, President of the Blue Cross Blue Shield Association, presented a new health reform proposal that, he said, had been unanimously approved by his board of directors just days before. He said, "we must create a new insurance environment — patterned on the Blue Cross and Blue Shield organization's historic practices."

The proposal would eliminate most existing health insurance companies by allowing tax deductions only for benefits purchased from "qualified carriers." To become qualified, an insurer would have to meet federally imposed standards that would include the use of participating provider arrangements and managed care techniques. "Under our approach, we would stop rewarding insurance companies that are principally claims processors and medical underwriters," Mr. Tresnowski told the committee.

He said qualified carriers, "must demonstrate proven records of managing health care costs effectively, including a capacity to perform utilization management, selective provider contracting and uniform billing and data collection."

Mr. Tresnowski said this emphasis on managed care, combined with with reform of the medical malpractice system would control health care costs better than regulatory approaches could.

For assuring universal coverage, Mr. Tresnowski proposed requiring small employers to offer, but not pay for, employee coverage. Those who do not fund coverage "would be subject to an assessment which would be significantly less than the cost of contributing to coverage."

Employees would be required to "accept" the coverage, and be re-

quired to pay for it unless their employer could be persuaded to pick up the tab.

Mr. Tresnowski does not directly discuss the cost impact on individual employees, except to say "substantial tax subsidies" would be made available to low income employees, and "most employees" would have most of their premium paid by their

(Please turn to page 2)

Twenty-five States Now Have Enacted High Risk Pools

Twenty-five states have enacted insurance pools for their high risk populations. According to information compiled by Communicating for Agriculture (CA) these pools (also known as "Comprehensive Health Insurance Plans" or CHIPs) enroll 76,873 people (see charts on pages 4 and 5).

The pools are intended to provide subsidized coverage to individuals with existing medical conditions who are unable to obtain insurance in the private market. They typically provide major medical benefits with substantial deductibles and copayments. They also charge from 125% to 400% of the standard premium for similar benefits within the state. At these rates the pools are clearly not intended to help people of limited means, but are aimed at those with financial resources who are otherwise uninsurable.

While the pools do not cover large numbers of people, they have an effect well in excess of raw enrollment figures because of the high use of services by those who are enrolled. According to the most recent available numbers, the seventeen state pools which have been active long enough to pay claims, pay over \$185 million per year for 67,972 enrollees - an average payment of \$2,726.30. For this coverage enrollees pay premiums averaging \$1,583.24 per person per year. The difference is made up for by any one of several subsidy approaches.

NAIC Model Revisions

How to subsidize the pools for losses in excess of premium income has been the biggest issue of contention for those states that have not yet adopted a pool. The National Association of Insurance Commissioners

(Please turn to page 4)

High Risk Pools in 25 States

(Continued from page 1)

(NAIC) has had a working group of regulators, chaired by South Dakota's Director of Insurance Mary Jane Cleary, looking into this and several other issues for the past two years. This working group is about to release a revised model act for public comment with the hope that it will be adopted at the December NAIC meeting in Houston.

Other issues considered by the NAIC group were benefit structure, pool administration, and whether group plans should be allowed to refer high-risk employees to the pool. Discussion of each of these issues follows.

Financing

States have adopted a wide range of financing mechanisms for their high-risk pools. Nearly all of the early ones were viewed as industry-based residual market mechanisms that were organized, operated and financed by the health insurance industry. The industry was assessed for any excess losses but could take the assessments as a credit against their premium tax obligation.

More recently pools have been seen as public programs, usually with broad-based boards of directors and broad-based funding. Several are now financed through general revenues, others use dedicated taxes on tobacco or hospital services. The new NAIC model act references all the available financing mechanisms without recommending reliance on any one of them. Director Cleary says the model lays out the following funding sources:

- Premiums from enrollees
- Health insurer assessments with full or partial tax offsets
- Per capita assessments on insurers and reinsurers

High Risk Pools - Financial Experience					
	Enrollment	Premiums Collected	Per Person Premium	Claims Paid	Per Person Claims
CA	8,901	n/a	n/a	n/a	n/a
CO	n/a	n/a	n/a	n/a	n/a
CT	2,200	\$ 4,495,872	\$ 2,043.58	\$ 10,438,000	\$ 4,744.55
FL	5,934	\$ 12,443,960	\$ 2,097.06	\$ 17,425,025	\$ 2,936.47
GA	n/a	n/a	n/a	n/a	n/a
IL	4,370	\$ 11,951,968	\$ 2,735.00	\$ 24,138,119	\$ 5,523.60
IN	3,080	\$ 8,376,736	\$ 2,719.72	\$ 16,978,462	\$ 5,512.49
IA	1,971	\$ 4,574,013	\$ 2,320.66	\$ 5,053,843	\$ 2,564.10
LA	n/a	n/a	n/a	n/a	n/a
ME	400	\$ 515,525	\$ 1,288.81	\$ 1,154,193	\$ 2,885.48
MN	25,272	\$ 25,734,981	\$ 1,018.32	\$ 49,469,692	\$ 1,957.49
MS	n/a	n/a	n/a	n/a	n/a
MO	n/a	n/a	n/a	n/a	n/a
MT	304	\$ 629,463	\$ 2,070.60	\$ 569,834	\$ 1,874.45
NE	2,904	\$ 4,422,717	\$ 1,522.97	\$ 6,760,239	\$ 2,327.91
ND	1,303	\$ 2,571,307	\$ 1,973.37	\$ 4,312,535	\$ 3,309.70
NM	1,656	\$ 2,854,825	\$ 1,723.93	\$ 4,205,865	\$ 2,539.77
OR	1,211	\$ 1,332,469	\$ 1,100.30	\$ 1,132,952	\$ 935.55
SC	1,072	\$ 1,636,144	\$ 1,526.25	\$ 1,794,927	\$ 1,674.37
TN	4,121	\$ 10,775,374	\$ 2,614.75	\$ 17,121,200	\$ 4,154.62
TX	n/a	n/a	n/a	n/a	n/a
UT	n/a	n/a	n/a	n/a	n/a
WA	2,793	\$ 4,718,231	\$ 1,689.31	\$ 7,186,956	\$ 2,573.20
WI	9,287	\$ 10,561,456	\$ 1,137.23	\$ 17,569,449	\$ 1,891.83
WY	94	\$ 20,690	\$ 220.11	\$ 548	\$ 5.83
	76,873	\$ 107,615,731	\$ 1,583.24	\$ 185,311,839	\$ 2,726.30

NOTES: All figures are year end 1990 except, CT and FI (1989), OR (6/90), and WY (4/91). Per capita averages exclude California enrollment. Source, Communicating for Agriculture

High Risk Pools - General Information

	Effective Date	Pre-X Waiting Period	Premium Cap	Funding Source	Tax Offset	Plan Administrator
CA	1991	90 Days	125%	Tobacco Tax	n/a	BCBS
CO	1991	6 Months	175%	Income Tax Surcharge	n/a	BCBS
CT	1976	12 Months	150%	Insurer Assessment	No	Travelers
FL	1983	12 Months	300%	Insurer Assessment	No	BCBS
GA	note 1	6 Months	150%	General Revenue	n/a	n/a
IL	1980	6 Months	135%	General Revenue	n/a	Mutual of Omaha
IN	1982	6 Months	150%	Insurer Assessment	Yes	ASGC, Inc.
IA	1987	6 Months	150%	Insurer Assessment	Partial	Mutual of Omaha
LA	1992	6 Months	200%	Lottery & Hospital Tax	n/a	n/a
ME	1988	90 Days	150%	Hospital Tax	n/a	Mutual of Omaha
MN	1976	6 Months	125%	Insurer Assessment	No	BCBS
MS	1992	12 Months	175%	note 2	No	n/a
MO	1991	12 Months	200%	Insurer Assessment	Yes	BCBS
MT	1987	12 Months	400%	Insurer Assessment	Yes	BCBS
NE	1986	6 Months	165%	Insurer Assessment	Yes	BCBS
NM	1988	6 Months	150%	Insurer Assessment	Partial	BCBS
ND	1981	6 Months	135%	Insurer Assessment	Yes	BCBS
OR	1990	6 Months	150%	note 2	No	BCBS
SC	1990	6 Months	300%	Insurer Assessment	Yes	BCBS
TN	1987	6 Months	150%	Gen'l Rev. & Insur. Assmt.	No	BCBS
TX	note 1	6 Months	200%	Insurer Assessment	Yes	BCBS
UT	1991	6 Months	200%	General Revenue	n/a	BCBS
WA	1988	6 Months	150%	Insurer Assessment	Yes	Mutual of Omaha
WI	1981	6 Months	150%	Insurer Assessment	No	Mutual of Omaha
WY	1991	6 Months	200%	Insurer Assessment	Partial	BCBS

NOTES: (1) Effective dates in GA and TX depend upon additional legislative action. (2) MS and OR both assess payers, including reinsurers and TPAs, on a per capita basis. Source, Communicating for Agriculture

High Risk Pools in 25 States

(Continued from previous page)

- Hospital fees on admissions or outpatient services when paid by a third party
- General revenues
- Dedicated revenues from alcohol and tobacco taxes, per-employee payroll taxes, income tax surcharges, and state lottery proceeds.

Each of these approaches is in effect somewhere. Which approach is most acceptable depends on the political and economic status of the particular state.

Administration

As public financing becomes more prevalent, so does public administration of the pool. The new model will suggest that board members be appointed by the insurance commissioner in those states where the commissioner is elected, or by the governor in states where the commissioner is appointed. In either case the board should have a majority of public members and should be chaired by the insurance commissioner.

The pool boards will continue to select an insurer or other entity to perform administrative services for the pool.

Benefits

Generally, covered benefits in the existing pools are very comprehensive. They are structured as major medical programs with high deductibles and copayments. Deductibles range from \$200 to \$2,000 for individuals and stop-loss levels may be as high as \$5,000.

Most pools give enrollees a choice of coverage options and set premiums according to the level of coverage

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High Risk Pools in 25 States

(Continued from page 5)

chosen. Maximum lifetime benefits may be as low as \$250,000 or as high as \$1 million.

The NAIC working group had two concerns about benefits. One was whether to include benefits that are mandated for inclusion in private insurance contracts, and the other concern was on how to encourage the use of managed care and other cost containment programs. The revised model continues to reference a major medical approach to benefits but suggests that the final decisions on benefit structure and cost controls should be left to the board.

Enrollment

Several states have had problems with employer groups "dumping"

their high-risk employees into the pool as a way of lowering the cost of coverage for the rest of the group, or of making the whole group insurable when it otherwise would not be.

Some people maintain that this use of a pool is a legitimate strategy for simultaneously covering people with medical conditions, and making small group coverage more affordable for standard-risk employer groups.

Most states enacted pools only for individuals, and did not anticipate this use by employers. The administrators in several of these states are alarmed that pool enrollment (and pool losses) has exceeded projections because of this use by employers.

Director Cleary said the new model will include language taken from the California legislation which prohibits dumping. The language calls it an unfair trade practice for insurers, employers or agents to refer someone to the pool for the purpose of separating them from employment-based coverage.

The adoption of the new NAIC model in December is likely to renew efforts to enact pools in those states that have come close to adopting them in the past. Notable among these states are Ohio, North Carolina, Oklahoma, New Hampshire and Arizona. Director Cleary said that in her own state of South Dakota a pool bill is likely to pass next year, but it will need to have funding other than straight general revenues or the governor will veto it.

The report from Communicating for Agriculture is available for \$24 by calling 612-854-9005

