

HB

195

ALASKA STATE LEGISLATURE
House of Representatives

COMMITTEE ASSIGNMENTS:

RULES COMMITTEE, CHAIRMAN
LABOR & COMMERCE COMMITTEE, MEMBER
LEGISLATIVE COUNCIL, MEMBER
SPECIAL COMMITTEE ON OIL & GAS, MEMBER
LEGISLATIVE ETHICS COMMITTEE, MEMBER

website: <http://www.akrepublicans.org/rokeberg/>



INTERIM:
716 WEST 4TH AVENUE, SUITE 300
ANCHORAGE, AK 99501
PHONE: (907) 269-0117
FAX: (907) 269-C119

SESSION:
ALASKA STATE CAPITOL
JUNEAU, AK 99801-1182
PHONE: (907) 465-4968
FAX: (907) 465-2040

Representative Norman Rokeberg

e-mail: Representative_Norman_Rokeberg@legis.state.ak.us

MEMORANDUM

TO: Representative Peggy Wilson
House HESS Committee

FROM: Representative Norman Rokeberg

DATE: April 15, 2003

RE: Request to hear HB 195

A handwritten signature in black ink, appearing to read "Norman Rokeberg".

I respectfully request that HB 195, Individual Health Care Insurance, be scheduled for a hearing. I have attached the following for your information: .

1. CS HB 195
2. Sponsor Statement
3. Sectional Analysis
4. Zero Fiscal Note
5. Relevant Statutes
6. Memo regarding mandates
7. E-mail from Division of Insurance on Individual Health Care
8. Letter w/attachments regarding TAA
9. Statistics from Anchorage Daily News
10. Article from Anchorage Daily News
11. Statistics and Information from Division of Insurance Annual Report
12. Letters of support

ALASKA STATE LEGISLATURE

House of Representatives

COMMITTEE ASSIGNMENTS:

RULES COMMITTEE, CHAIRMAN
LABOR & COMMERCE COMMITTEE, MEMBER
LEGISLATIVE COUNCIL, MEMBER
SPECIAL COMMITTEE ON OIL & GAS, MEMBER
LEGISLATIVE ETHICS COMMITTEE, MEMBER

website: <http://www.akRepublicans.org/rokeberg/>



INTERIM:
716 WEST 4TH AVENUE, SUITE 300
ANCHORAGE, AK 99501
PHONE: (907) 269-0117
FAX: (907) 269-0119

SESSION:
ALASKA STATE CAPITOL
JUNEAU, AK 99801-1182
PHONE: (907) 465-4968
FAX: (907) 465-2040

Representative Norman Rokeberg

e-mail: Representative_Norman_Rokeberg@legis.state.ak.us

SPONSOR STATEMENT FOR CSHB 195 (L&C)

BY: Representative Norman Rokeberg

TITLE: An Act relating to coverage offered under an individual policy of health care insurance; and providing for an effective date.

Alaska and the nation are in the midst of a health care financial crisis. Alaskans are being asked to contribute a greater percentage of their disposable income to the increasing costs of health care insurance. It is the legislature's responsibility to help contain these costs. This legislation is intended to lower the cost of insurance for individuals and families who are not part of a group health plan. In most group plans, employers typically contribute to the employee's cost of health insurance. Individuals seeking coverage do not have this benefit.

HB 195 allows a health insurance company to offer a new type of health insurance policy. This legislation gives insurance companies the authority to offer an individual health insurance plan that does not provide coverage for all of the insurance mandates currently required in state statute.

Alaska law requires insurance companies to provide for specific types of coverage; these are called "mandates." For example, some of the mandates required are coverage for services of midwives, substance abuse treatment, treatment of diabetes, and screening for prostate and cervical cancer. This legislation allows a health insurance company to offer an individual plan without covering these mandates, thus giving Alaskans a more affordable health insurance option.

In addition, sections 2-9 have been added to the bill at the request of the Division of Insurance. These sections relate to the Federal Trade Adjustment Assistance Reform Act of 2002 (TAA), which provides tax credits of 65% of the amount paid by an eligible individual for qualified health insurance coverage. Alaskans qualify for TAA assistance if they have lost their jobs to foreign imports, e.g. salmon and oil. These sections amend the Alaska Comprehensive Health Insurance Association (ACHIA) statutes to make Alaskans eligible under TAA, eligible for coverage under ACHIA. This will allow these Alaskans to get 65% of their premiums paid by the U.S. Department of Treasury.

HB 195 is a small step towards creating more affordable health care in Alaska. I encourage your support of this legislation.

Sponsor Statement For HB 195

“An Act relating to coverage offered under an individual policy of health care insurance; and providing for an effective date.”

Alaska and the nation are in the midst of a health care financial crisis. Alaskans are being asked to contribute a greater percentage of their disposable income to the increasing costs of health care insurance. It is the legislature's responsibility to help contain these costs. This legislation is intended to lower the cost of insurance for individuals and families who are not part of a group health plan. In most group plans, employers typically contribute to the employee's cost of health insurance. Individuals seeking coverage do not have this benefit.

HB 195 allows a health insurance company to offer a new type of health insurance policy. This legislation gives insurance companies the authority to offer an individual health insurance plan that does not provide coverage for all of the insurance mandates currently required in state statute.

Alaska law requires insurance companies to provide for specific types of coverage; these are called “mandates.” For example, some of the mandates required are coverage for services of midwives, substance abuse treatment, treatment of diabetes, and screening for prostate and cervical cancer. This legislation allows a health insurance company to offer an individual plan without covering these mandates, thus giving Alaskans a more affordable health insurance option.

In addition, the legislation calls for a change in public policy by granting an exemption from premium tax for individual/family policies. This small amount of waived tax is a recognition of the high cost of individual/family health care insurance.

HB 195 is a small step towards creating more affordable health care in Alaska. I encourage your support of this legislation.

By: Representative Norman Rokeberg

ED 1: 3/31/03

ALASKA STATE LEGISLATURE

House of Representatives

COMMITTEE ASSIGNMENTS:

RULES COMMITTEE, CHAIRMAN
LAPOR & COMMERCE COMMITTEE, MEMBER
LEGISLATIVE COUNCIL, MEMBER
SPECIAL COMMITTEE ON OIL & GAS, MEMBER
LEGISLATIVE ETHICS COMMITTEE, MEMBER

website: <http://www.akrepublicans.org/rokeberg/>



INTERIM
716 WEST 4TH AVENUE, SUITE 300
ANCHORAGE, AK 99501
PHONE: (907) 269-0117
FAX: (907) 269-0119

SESSION:
ALASKA STATE CAPITOL
JUNEAU, AK 99801-1102
PHONE: (907) 465-4968
FAX: (907) 465-2040

Representative Norman Rokeberg

e-mail: Representative_Norman_Rokeberg@legis.state.ak.us

SECTIONAL ANALYSIS FOR CSHB 195 (L&C)

BY: Representative Norman Rokeberg

TITLE: An Act relating to coverage offered under an individual policy of health care insurance; and providing for an effective date.

- Section 1:** Allows for individual health care insurance coverage without state mandated benefits.
- Section 2:** Amends AS 21.55.130 as required by the federal Trade Adjustment Assistance Act of 2002 (TAA), to prohibit a state plan issued to a qualified TAA eligible individual from imposing a preexisting condition exclusion.
- Section 3:** Amends the ACHIA statutes to conform to the TAA program requirement that a plan cannot exceed 150 percent of the standard risk premium rates.
- Section 4:** Amends the ACHIA statutes to allow for TAA eligible individuals to participate in ACHIA.
- Section 5:** Amends the ACHIA statutes to exempt TAA eligible individuals from restrictions on eligibility for participation in ACHIA, in order to conform to TAA requirements. Moves certain existing requirements for eligibility previously found in the exclusion statute to the eligibility section. See Section 9.
- Section 6:** Amends the ACHIA statutes to require that the ACHIA to notify the director that a TAA eligible individual is enrolled in ACHIA in order to allow the director to certify that a TAA eligible individual has qualified health coverage as required under the TAA.
- Section 7:** Amends the definition of "resident" to provide for TAA eligible individuals.
- Section 8:** Defines "qualified TAA eligible individual" and "TAA eligible individual."
- Section 9:** Repeals AS 21.55.140(b). The provisions were moved to AS 21.55.300 (b) (see section 5). They were moved to clarify that these are eligibility requirements, not exclusion provisions.
- Section 10:** This Act takes effect on July 1, 2003.

Sec. 21.55.140. Persons, care, and services not covered.

(a) A state plan may not provide benefits for charges for the following:

(1) care for an injury or disease either

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

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

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

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

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

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

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

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

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

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

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

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

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

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

who is a member of the covered individual's family or the family of the covered individual's spouse;

(14) experimental procedures; and

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

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

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

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

(§ 2 ch 126 SLA 1992)

Revisor's notes. In 1999, in (a)(6), "subsection" was substituted for "section" to correct a manifest error in ch. 126, SLA 1992.

ALASKA STATE LEGISLATURE

House of Representatives

COMMITTEE ASSIGNMENTS:

RULES COMMITTEE CHAIRMAN
LABOR & COMMERCE COMMITTEE, MEMBER
LEGISLATIVE COUNCIL, MEMBER
SPECIAL COMMITTEE ON OIL & GAS, MEMBER
LEGISLATIVE ETHICS COMMITTEE, MEMBER

website: <http://www.akrepublicans.org/rokeberg/>



INTERIM
716 WEST 4TH AVENUE, SUITE 300
ANCHORAGE, AK 99501
PHONE: (907) 269-0117
FAX: (907) 269-0115

SESSION
ALASKA STATE CAPITOL
JUNEAU, AK 99801-1182
PHONE: (907) 465-4968
FAX: (907) 465-2040

Representative Norman Rokeberg

e-mail: Representative_Norman_Rokeberg@legis.state.ak.us

MEMORANDUM

To: House HESS Committee

From: Representative Norman Rokeberg

Date: April 9, 2003

Re: Health Care Mandates

The health mandates are located in AS 21.42:

- 42.353: Acupuncture coverage (offer only, does not mandate coverage)
- 42.355: Coverage for services of midwives
- 42.363: Eye care (if plan provides for eye care, can use an optometrist)
- 42.365: Substance abuse treatment coverage
- 42.375: Mammography coverage
- 42.380: Phenylketonuria
- 42.385: Dental, Vision, Health coverage (offer only, does not mandate coverage)
- 42.390: Coverage for diabetes treatment
- 42.392: Requirements relating to dental (if coverage is provided)
- 42.395: Prostate and cervical cancer screening

Federal Mandates

- 42.345: Coverage of newly born children
- 42.347: Postpartum hospital stay coverage
- 42.400: Reconstructive surgery following mastectomies

Subject: Re: Quick Questions

Date: Wed, 09 Apr 2003 11:32:20 -0800

From: Katie Campbell <katie_campbell@dced.state.ak.us>

To: Heather Nobrega <Heather_Nobrega@legis.state.ak.us>

CC: Linda S Hall <linda_hall@dced.state.ak.us>, Sally A Saddler <sally_saddler@dced.state.ak.us>

Hi Heather,

According to the 2001 Health Insurance Survey the number of individual health policies in force at the end of 2001 was 5,843. The number of individuals covered under those policies (i.e. includes dependents) was 14,946. The premium collected during 2001 was about \$24 million.

Katie

Heather Nobrega wrote:

> Katie,

>

> Rep. Rokeberg would like to know the current number of individual health insurance policies currently issued in the state for today's meeting?

>

> Thanks Katie.

> Heather

The Honorable «Governor»
Governor of «State»
«Address»
«Address2»
«City_State_ZIP»

Dear Governor «Governor_Last_Name»:

The Trade Act of 2002, Public Law No. 107-210 ("the Act"), includes important provisions to assist certain workers who lose their jobs due to the effects of international trade in paying for qualified health insurance. The Act also provides such assistance to certain beneficiaries of the Pension Benefit Guaranty Corporation. The primary mechanism for assistance is a federal tax credit equal to 65 percent of the amount paid by eligible individuals for such health insurance. An additional interim mechanism to assist in paying for qualified health insurance is through National Emergency Grants (NEGs). We estimate these provisions could help over 500,000 Americans each year – many of whom may reside in your state – continue or obtain health insurance. To make the most of this opportunity, however, we need your assistance.

Under the law, the States play an important role in providing health insurance coverage options and assisting individuals to enroll. The Department of the Treasury administers the federal tax credit under the Act. NEG assistance, which is administered by the Department of Labor, is available without any cost to the State. Certain health insurance coverage options, such as continuation health coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (commonly known as COBRA coverage), are automatically available to all eligible individuals. Other options specified in the law are available only if the State elects them and certain conditions are met. Enclosed is more detailed guidance on how States may elect coverage options for eligible individuals under the Trade Act. Please note that funds are available to States through additional NEGs administered by the Department of Labor for start-up and administrative costs relating to the tax credit program. The Department of Health and Human Services will assist States in interpreting this guidance with respect to qualified health insurance.

We strongly encourage your state to take advantage of the benefits of these programs. We also encourage your state to elect options to increase the opportunities for eligible individuals to have health insurance.

We look forward to working with you. If you or your staff have any questions, please contact Ruben J. King-Shaw Jr., Senior Advisor to the Secretary of the Treasury for Health Insurance Initiatives, at 202-622-2336.

Sincerely,

John W. Snow
Secretary of the Treasury

Elaine L. Chao
Secretary of Labor

Tommy G. Thompson
Secretary of Health
and Human Services

Guidance for Elections of Qualified Health Insurance Under the Trade Act of 2002

I. Purpose and Background

On August 6, 2002, President Bush signed into law the Trade Act of 2002 ("the Act"), Public Law 107-210.¹ Title II of the Act contains provisions that provide assistance to certain individuals participating in the Trade Adjustment Assistance program (TAA) or receiving a payment from the Pension Benefit Guaranty Corporation (PBGC), to enable them to purchase health insurance. (A copy of Title II of the Act is available at http://www.doleta.gov/tradeact/2002act_index.asp). The primary mechanism for such assistance is a federal tax credit that is equal to 65 percent of the amount paid by the eligible individual for coverage for the individual and qualifying family members under qualified health insurance. The end of the year tax credit became available on December 1, 2002 for individuals who claim the credit on their subsequent income tax return. By August 1, 2003, the credit will also be available on a monthly basis as the premium is paid. The government's share (65 percent of the premium amount paid by the individual) will be combined with the eligible individual's payment of the 35 percent and paid on a monthly basis, in general to the qualified health plan in which the individual has enrolled. The Department of the Treasury (Treasury) is responsible for implementing this advance credit under its Health Coverage Tax Credit program (HCTC).

The Act also authorizes two types of National Emergency Grants (NEGs) for which States may apply under the Workforce Investment Act of 1998. One type of NEG is available to assist eligible TAA and PBGC recipients, on an interim basis, in paying up to 65 percent of the premiums for qualified health insurance (equivalent to the Federal share under the tax credit) until the advance tax credit mechanism becomes available in August. The second type of NEG is available to provide resources to assist the States with start-up and administrative costs relating to the tax credit. The Department of Labor (DOL) is responsible for administering both types of NEGs (see Section V below).

The Administration estimates that as many as 260,000 people nationwide may be able to claim this credit next year. When combined with qualifying dependents, this means more than a half million people could benefit from the credit. (Attachment A provides estimates of TAA and PBGC recipients eligible in each State).

The States play a critical role in the administration of this assistance. Particularly important to the success of this assistance are the States' efforts toward ensuring the availability of coverage for which the assistance can be used, making eligible individuals aware of the program, and increasing the options available to them. The purpose of this guidance is to inform the States of the program and to explain their role in making health insurance options available.

¹ The law is the Trade Act of 2002. Division A of the Trade Act contains its own title: The Trade Adjustment Assistance Reform Act of 2002. Title II of the Act (Division A) contains the health coverage assistance provisions.

II. Who Is Eligible

There are two basic categories of individuals who may be eligible for the tax credit and NEG assistance under the Act: (1) certain Trade Adjustment Assistance (TAA) recipients as described below, and (2) people who have attained age 55 but who are not on Medicare or other specified coverage who receive pension payments from the Pension Benefit Guaranty Corporation (PBGC).

A. TAA Recipients:

An eligible TAA recipient is defined as any individual who is receiving a trade readjustment allowance under the Trade Act of 1974 at any time during a month, or individuals who would be eligible for such an allowance except that they have not exhausted their regular unemployment insurance benefits. In addition, individuals receiving benefits under the alternative trade adjustment assistance program, established under section 246 of the Trade Act of 1974 (which commences on August 1, 2003) also will be eligible for assistance. All TAA recipients remain eligible for the tax credit for one month after the end of the month that their eligibility for TAA status ceases.

B. PBGC Pension Recipients:

A person who is receiving a benefit payment from PBGC and who has attained age 55 (but who is not eligible for Medicare) on the first of the month may be eligible for the tax credit.

C. Other factors:

An eligible individual is not entitled to the tax credit for any month if, on the first day of the month, the individual is covered by "other specified coverage".

The tax credit can be used to purchase qualified health insurance that also covers an eligible individual's spouse or dependent (i.e., anyone who qualifies as a dependent under the Internal Revenue Code), provided the spouse or dependent does not have "other specified coverage".

"Other specified coverage" includes:

- insurance coverage through the spouse's employer, and the spouse's employer contributes at least 50 percent of the cost of coverage for the spouse, the eligible individual and dependents (or the spouse receives coverage in lieu of an employer's cash or other benefits under a cafeteria plan);
- coverage under Medicare Part A or enrolled under Part B;
- a State's Medicaid program;
- a State's SCHIP program;
- a plan in the Federal Employees Health Benefit program; or
- a Defense Department health plan.

An individual who is imprisoned cannot be an eligible individual.

Individuals with questions about their TAA status or tax credit eligibility should contact their State workforce agency. PBGC beneficiaries with questions about their eligibility for the tax credit will be able to contact a toll free telephone number that we expect to establish in the near future.

III. Qualified Health Insurance

A. Types of Plans

The law identifies ten categories of health insurance that may be "qualified" as coverage for purposes of the tax credit and NEG assistance. The coverage must be for comprehensive health coverage.²

The ten categories are:

1. COBRA: any continuation coverage that the eligible individual has under the federal Consolidated Omnibus Budget and Reconciliation Act of 1985.
2. State COBRA or continuation coverage: any State-based continuation coverage in a group plan that is obtained under a State law that requires such coverage.
3. High risk pool: as defined in the Public Health Service Act section 2744(c)(2), coverage that is offered through a State high risk pool that is otherwise open to "HIPAA eligibles" without imposing a preexisting condition exclusion, and is consistent with the NAIC model act entitled "Health Plan for Uninsurables" that was in effect in August, 1996. (Attachment B is a list of the State high risk pools that are qualified based on the information currently available to the Department of Health and Human Services.³)
4. State employees' health plan: coverage under a State employees' health insurance program.
5. A State-based health insurance program that is comparable to the health insurance program offered to State employees.
6. A State arrangement: a State can enter into an arrangement with an issuer of health insurance coverage (including individual insurance) to offer coverage to eligible individuals. It can also enter into an arrangement with an administrator or an employer to offer coverage to the individual, or with a group health plan (including a multiemployer plan).
7. Purchasing pool: a State arrangement for coverage that is provided through a private sector purchasing pool.
8. Other State plans: coverage that is provided through a State operated health plan that does not receive any federal financial assistance.

² Examples of types of plans that are not eligible for the credit or NEG assistance are limited coverage plans such as dental or vision care; fixed dollar indemnity coverage; specific disease insurance; workers' compensation; health coverage under an automobile insurance policy; liability insurance; or coverage for on-site medical clinics.

³ The Act also provides a grant program that provides up to \$1 million to a State to establish a qualified high risk pool in FY 2003 or 2004, and a separate two year grant program that will provide a grant up to 50 percent of a qualified high risk pool's operating losses, up to a national total of \$40 million each year. The seed grant announcement can be found at www.cms.hhs.gov/riskpool. The grant announcement for the operating losses will be forthcoming.

9. Spouse's coverage: coverage under a group health plan that is available through the employment of the eligible individual's spouse, if the spouse's employer contributes less than 50 percent of the total cost of coverage for the spouse, the eligible recipient, and any dependents. (There is a distinction for Alternative TAA recipients—those aged 50 or older who are receiving income support. If these people are eligible for spousal coverage where the employer pays 50 percent or more, they are considered to have other specified coverage, even if they are not actually covered by the spouse's plan.)
10. Individual health insurance: coverage under individual health insurance if the eligible individual was covered under the insurance during the entire 30 day period that ended on the date that such individual became separated from the employment that qualifies the person as a TAA or PBGC recipient.

B. State Election

Coverage options 1, 9 and 10 above are automatically considered to meet the definition of "qualified health insurance" for all eligible individuals, without further state action. Options 2 through 8 only meet the definition if the State elects to have one or more of these options considered to be qualified health insurance. For individuals who have had at least three months of creditable coverage⁴ prior to seeking enrollment in any of these Options 2 through 8, the insurance will only be considered qualified health insurance if it meets the following four criteria:

1. Guaranteed issue: Qualifying individuals must be guaranteed enrollment regardless of their medical status and must be permitted to remain enrolled so long as they pay the premium.
2. No pre-existing condition restrictions: No pre-existing condition restriction may be imposed on qualifying individuals.
3. Nondiscriminatory premium: The premium charged for a qualifying individual may not be greater than the premium for a similarly situated person who is not receiving the credit.
4. Benefits are the same (or substantially the same) under coverage provided to similarly situated individuals who are not qualifying individuals.

Generally, periods of coverage prior to a break in coverage of 63 days or more do not count in determining whether an individual has three months of creditable coverage. However, individuals who do not have at least three months of creditable coverage may still use the tax

⁴ "Creditable coverage" is defined in section 9801(c) of the Internal Revenue Code, and includes most kinds of health coverage. (The identical definition also appears in section 2701(c) of the Public Health Service Act and section 701(c) of the Employee Retirement Income Security Act (ERISA). Periods of creditable coverage prior to a "significant break in coverage" do not count in determining whether an individual has three months of creditable coverage for purposes of the tax credit or NEG assistance. This also means that there can be a break in coverage between the loss of health plan coverage and applying for a new plan elected by the State. A significant break in coverage under federal law is a break in coverage of at least 63 consecutive days (days in a waiting period in which an individual has no other coverage are not considered creditable coverage nor are they taken into account when determining if there is a significant break in coverage). However, the length of time that passes before a significant break in coverage is reached may be longer under State law that applies to HMOs and health insurance carriers.

credit or NEG assistance in connection with enrollment in health insurance that the State has elected to have treated as qualified.

States may find that the four requirements can be met most easily by selecting as the State option(s) the coverage arrangements that now qualify as the State's alternative mechanism under section 2744 of the Public Health Service Act. These are typically either a high risk pool (#3) or individual coverage (#6).

The Department of Health and Human Services will assist States in interpreting this guidance with respect to qualified health insurance. Questions should be directed to:

Stephen Finan
Office of the Assistant Secretary for
Planning and Evaluation
Dept. of Health and Human Services
Room 442E
200 Independence Ave, SW
Washington, DC 20201
Telephone: 202.690.7387
E-mail: Stephen.Finan@hhs.gov

IV. State Elections

A. *Elections Letter*

Options 1, 9 and 10 are automatically considered to meet the definition of "qualified health insurance" for all eligible individuals without any further State action. However, under the law, the remaining options are available only if the State elects to provide one or more of them.

To facilitate implementation of the law, we request that the Governor, or the Governor's representative, send a letter indicating which options (2-8, above) the State is electing to make available to eligible recipients under the tax credit. (Note: DOL expects the coverage options for the interim assistance NEG to be identified in the application for the grant and will coordinate the review of these options with HHS). Please send the letter to:

John Hoff, Deputy Assistant Secretary
Office of the Assistant Secretary for
Planning and Evaluation
Dept. of Health and Human Services
Room 424E
200 Independence Ave, SW
Washington, DC 20201

B. Information Requested

The letter should:

1. Identify the State official responsible for implementing this decision, including address and telephone number.
2. State the option(s) chosen by the State (of options 2-8).
3. Provide the name, policy form number or other unique identifier for each qualifying plan under each option. Also, provide a name and contact number for the plan administrator or insurance carrier official who can provide additional information, if necessary.
4. Certify that the four requirements (III. B. above) are met for each plan under each option.
5. Certify that the benefits made available to tax credit recipients are the same or substantially the same as those in the plans who do not receive the tax credit.

C. Public Information

To assist eligible individuals, the State should take steps to publicize the options available to eligible individuals in their State. Such steps can include the listing of qualified plans on a website, providing lists at State TAA offices, unemployment offices, and other locations where eligible recipients may obtain information.

V. National Emergency Grant Assistance

As noted above, the Trade Adjustment Assistance Reform Act of 2002 authorizes two new NEG mechanisms relating to the provision of health insurance coverage assistance that are to be administered by the Department of Labor. The Department of Labor and the Department of Health and Human Services will work closely together to facilitate the provision of technical assistance to the States regarding these NEGs.

A. System Development Grants. These grants are intended to help States cover certain start-up and administrative costs. Guidance for applying for these grant funds have been issued in Training and Employment Guidance Letter (TEGL) 10-02. These grants may be used to establish and implement systems for:

- eligibility verification;
- certification of State-based health insurance coverage;
- notification to eligible individuals of available qualified health insurance options;
- providing assistance to individuals in enrolling in qualified health insurance;
- processing of certificates confirming eligibility of individuals for the advance payment of the tax credit;
- developing and installing necessary data management systems; and
- other expenses, as determined appropriate by the Secretary of Labor, including the start-up and ongoing administration of State-elected health-insurance coverage options.

B. Health Insurance Interim Assistance Grants. These grants are available to States to assist eligible TAA and PBGC recipients in paying up to 65 percent of the monthly premiums for

qualified health insurance coverage until the advance payment mechanism for the tax credit becomes available. The grants may also be used to provide additional support services to eligible individuals. Draft guidance was published in the Federal Register on December 4, 2002 (67 FR 72222-72234), and guidance for applying for Health Insurance Interim Assistance Grants will soon be issued through another TEGL .

C. Contact. For further assistance regarding these NEG's please contact:

Shirley M. Smith
Office of National Response
U.S. Department of Labor
Employment and Training Administration
Room N5420
200 Constitution Ave., NW
Washington DC 20210
202-693-3501

**Attachment A: Estimated Eligibles by State 2002 Level
Under The Trade Act of 2002**

	Estimated Population ⁵		
	Total	TAA	PBGC
Alabama	8,100	5,500	2,600
Alaska	200	100	100
Arizona	2,500	1,000	1,500
Arkansas	3,000	1,700	1,300
California	14,300	7,100	7,200
Colorado	1,800	500	1,300
Connecticut	2,600	1,100	1,500
Delaware	200	0	200
District of Columbia	100	0	100
Florida	13,000	1,700	11,300
Georgia	10,700	4,700	6,000
Hawaii	600	0	600
Idaho	1,100	800	300
Illinois	11,900	4,800	7,100
Indiana	9,700	5,100	4,600
Iowa	1,900	600	1,300
Kansas	3,600	2,600	1,000
Kentucky	4,200	2,900	1,300
Louisiana	1,400	400	1,000
Maine	1,600	1,300	300
Maryland	1,200	100	1,100
Massachusetts	3,900	2,000	1,900
Michigan	7,500	4,000	3,500
Minnesota	4,900	2,800	2,100
Mississippi	3,100	2,300	800
Missouri	6,500	1,300	5,200
Montana	100	0	100
Nebraska	500	200	300
Nevada	900	200	700
New Hampshire	1,300	800	500
New Jersey	5,900	1,200	4,700
New Mexico	600	300	300
New York	11,900	4,200	7,700
North Carolina	14,600	9,900	4,700

⁵ These estimates are intended to provide states with rough guidance as to the size of the eligible population at 2002 levels. States listed as having zero TAA eligibles may have a few participants. Actual enrollment will depend on many factors, including the size of the population currently eligible for TAA and PBGC benefits, the number and type of health plans available to the eligible population, and take-up rates. Moreover, in some states the number of workers eligible for Trade Adjustment Assistance varies significantly from year to year.

	Estimated Population		
	Total	TAA	PBGC
North Dakota	100	0	100
Ohio	19,600	5,200	14,400
Oklahoma	3,400	2,400	1,000
Oregon	5,100	4,500	600
Pennsylvania	20,000	8,400	11,600
Rhode Island	500	200	300
South Carolina	5,200	3,400	1,800
South Dakota	200	100	100
Tennessee	9,000	4,700	4,300
Texas	15,500	10,700	4,800
Utah	600	300	300
Vermont	500	300	200
Virginia	6,700	3,800	2,900
Washington	11,600	10,300	1,300
West Virginia	1,700	700	1000
Wisconsin	5,300	3,300	2,000
Wyoming	200	100	100

Source: TAA data are based on information from the Employment and Training Administration, U.S. Department of Labor. PBGC estimates are based on data provided by the Pension Benefit Guaranty Corporation.

Attachment B: Currently "Qualified" State High Risk Pools⁶

Alabama
Alaska
Arkansas
Colorado
Connecticut
Idaho
Illinois
Indiana
Iowa
Idaho
Kansas
Kentucky
Louisiana
Minnesota
Mississippi
Montana
Nebraska
New Hampshire
North Dakota
Oklahoma
South Carolina
Texas
Wisconsin
Wyoming

Note: To be "qualified," a high risk pool (as defined in the Public Health Service Act section 2744(c)(2)) must be open to "HIPAA eligibles" without imposing a preexisting condition exclusion and be consistent in its premium rates and benefits with the NAIC model act entitled "Health Plan for Uninsurables" that was in effect in August, 1996.

⁶ These States' risk pools meet the criteria set forth in section 2744(c)(2) of the Public Health Services Act. In addition, to be qualified health insurance under the credit or NEG assistance, the risk pools must meet the four conditions in III.B. above.

Trade Adjustment Assistance (TAA) Health Care Tax Credit (HCTC)

Trade Act of 2002, U.S. Public Law No. 107-210, includes important provisions to assist qualified TAA recipients purchase and pay for qualified health insurance.

The primary mechanism for the assistance is a federal tax credit equal to 65 percent of the amount paid by the eligible individual for qualified health coverage for the individual and qualifying family members.

Two tax credit options are available. An end of the year tax credit effective December 1, 2002 for the individual to claim on their subsequent income tax return or by August 1, 2003 an advance credit will be available on a monthly basis as the premium is paid. The U.S. Federal Government's share of 65 percent will be combined with the eligible individual's payment of 35 percent and paid on a monthly basis to the insurance provider.

The U.S. Department of the Treasury is responsible for implementing this advance credit under its Health Coverage Tax Credit Program (HCTC).

An HCTC office has been created within the Internal Revenue Service (IRS) to design the infrastructure for the advance tax credit options. The HCTC office will be responsible for the collection and verification of information related to eligibility, such as whether the individual is enrolled in qualified health coverage.

Each state has the responsibility to identify eligible Trade Adjustment Assistance (TAA) recipients and report those individuals to the HCTC office for its use in determining who qualifies for the credit. Each state will also be required to report the Alternative Trade Adjustment Assistance (ATAA) recipients when the ATAA program becomes operational later this year. The Interstate Connection (ICON) network currently used by each state for Unemployment Insurance purposes will be utilized as the communication vehicle for reporting the information to the HCTC office.

Each state plays a critical role in the administration of the assistance. Particularly important to the success of this assistance are the states' efforts toward ensuring the availability of coverage for which the assistance can be used, making eligible individuals aware of the program and increasing the options available to them.

The State of Alaska's role is to ensure that there is a health coverage plan available for all qualified TAA eligible individuals. Under proposed legislation, the high-risk insurance pool program will be able to accommodate TAA individuals, which will satisfy federal requirements established under the Trade Reform Act of 2002.

In the late 1990's there were thousands of Alaska workers who were eligible for TAA benefits. Since January 2003, over 1500 workers in Alaska have been approved for TAA benefits. While mostly timber and oil industry workers were eligible in the past, fishing industry workers have become eligible in recent months.

ALASKA TRADE ADJUSTMENT ASSISTANCE (TAA) ELIGIBLE WORKERS BY INDUSTRY

Year	Timber Industry		Oil Industry		Fishing Industry		Other	
	Company	Number of layoffs	Company	Number of layoffs	Company	Number of layoffs	Company	Number of layoffs
1992	Alaska Pulp Corp	260	BP Exploration	55			Micro Link	10
	Halliburton Logging	10	Western Atlas	30			Otis Engineering	25
	Wrangell Sawmill	190	Shell Oil Company	25			Eastman Teleco	12
			Camco	60				
			Doyon Drilling	80				
			Conoco Inc.	20				
			Alaska United Drilling	10				
1994			Baroid Corp.	45				
			Marathon Oil	15				
			Alaska Safety	15				
1997	Ketchikan Pulp Corp	535	Dresser Industries	45				
1999	Annette Hemlock Sawmill	62	BP Exploration	260				
			Veco Inc.	1101				
			Weatherford	3				
			Parker Drilling	99				
			Peak Oilfield Services	1461				
			Quadco	34				
			Schlumberger	75				
			Sperry Sun Drilling	30				
			MI Drilling	20				
			Nabors Alaska Drilling	508				
			Doyon Drilling	173				
			Fairweather E&P	30				
			Fairweather Inc.	32				
			ForceEnergy	4				
			Halliburton Energy Service	145				
			Baker Hughes Inteq	5				
			Baroid	33				
BJ Services	6							
Chevron	2							
ARCO	177							
ASCG Inspection	221							
Pool Arctic Alaska	205							
Baker Hughes Centrilift	3							
Inlet Drilling	51							
2000	Ketchikan Sawmill	226	Baker Atlas	6				
	Mellakalla Forest Products	15	Arctic Pipe Inspection	12				
2002			BP Exploration	120	Various Bristol Bay fishermen	150		
			ASCG Inspection	199				
2003 to date	Gateway Forest Products	70			Wards Cove Packing	1241		
					Cook Inlet Processing	204		
					Various fishermen	70		
TOTAL:	Timber Industry	1368	Oil Industry	5415	Fishing Industry	1665	Other	47

Trade Adjustment Assistance is a program that offers training benefits, job search allowances, relocation allowances and weekly benefits to workers who have lost their jobs due to competition from or a shift in production to a foreign country. Workers petition the United States Department of Labor for certification of eligibility for TAA benefits. Once a company is certified for TAA benefits, the certification is good for two years. Activity tends to follow general economic conditions in the State of Alaska. That is why there are breaks in years. This spreadsheet shows TAA activity in Alaska beginning 1992 through March 31, 2003. Source: Alaska Department of Labor and Workforce Development, Division of Employment Security



STATE OF ALASKA

Department of Community and
Economic Development



DIVISION OF INSURANCE 64th ANNUAL REPORT

Calendar Year 2001 ♦ Fiscal Year 2002



IX

**Statistical
& Financial
Data**



**2001 ALASKA HOSPITAL AND
MEDICAL SERVICE CORPORATIONS
(\$000)**

PREMIUMS WRITTEN

INSURER	COMPREHENSIVE		MEDICARE SUPPLEMENT	VISION ONLY	DENTAL ONLY	FEDERAL EMPLOYEES HEALTH PLAN	TOTAL
	Individual	Group					
PREMERA/ BLUE CROSS	15,353	183,269	1,597	0	0	48,535	248,754
ALASKA VISION	0	0	0	1,074	0	0	1,074

PREMIUMS EARNED

INSURER	COMPREHENSIVE		MEDICARE SUPPLEMENT	VISION ONLY	DENTAL ONLY	FEDERAL EMPLOYEES HEALTH PLAN	TOTAL
	Individual	Group					
PREMERA/ BLUE CROSS	15,269	184,247	1,573	0	0	48,965	250,055
ALASKA VISION	0	0	0	1,121	0	0	1,121

CLAIMS INCURRED

INSURER	COMPREHENSIVE		MEDICARE SUPPLEMENT	VISION ONLY	DENTAL ONLY	FEDERAL EMPLOYEES HEALTH PLAN	TOTAL	NUMBER OF SUBSCRIBERS*
	Individual	Group						
PREMERA/ BLUE CROSS	12,406	153,369	1,087	0	0	45,524	212,386	104,763
ALASKA VISION	0	0	0	919	0	0	919	19,187

*Numbers not rounded to the nearest thousand.

2001 ALASKA ACCIDENT & HEALTH MARKET SHARE

01 - GROUP (\$000)

COMPANY NAME	PERCENT OF MARKET	DIRECT PREMIUMS WRITTEN
Aetna Life Ins Co	15.43	18,188
Principal Life Ins Co	15.28	18,011
United Healthcare Ins Co	10.03	11,823
Great West Life & Annuity Ins Co	6.22	7,329
Golden Rule Ins Co	5.33	6,279
Unum Life Ins Co of Amer	5.23	6,166
United of Omaha Life Ins Co	4.34	5,115
Mega Life & Health Ins Co The	4.22	4,973
Guardian Life Ins Co of Amer	2.89	3,405
Hartford Life & Accident Ins Co	2.22	2,615
Safeco Life Ins Co	2.18	2,566
Stonebridge Life Ins Co	1.89	2,229
Standard Ins Co	1.79	2,104
States West Life Ins Co	1.48	1,748
Fortis Benefits Ins Co	1.47	1,733
Union Labor Life Ins Co	1.44	1,700
Metropolitan Life Ins Co	1.28	1,509
Life Ins Co of North Amer	1.23	1,451
Mutual of Omaha Ins Co	1.09	1,289
John Alden Life Ins Co	0.96	1,133
<hr/>		
TOTAL FOR TOP 20 RANKED INSURERS	86.01	101,367
TOTAL FOR ALL 151 INSURERS WRITING THIS LINE	100.00	117,859

02 - CREDIT (\$000)

COMPANY NAME	PERCENT OF MARKET	DIRECT PREMIUMS WRITTEN
Cuna Mut Ins Society	21.33	1,055
American Bankers Life Assur Co of FL	21.30	1,053
American Natl Ins Co	19.66	972
Union Security Life Ins Co	11.78	583
Minnesota Life Ins Co	9.82	486
North Central Life Ins Co	5.30	262
Resource Life Ins Co	4.77	236
Centurion Life Ins Co	2.25	111
Household Life Ins Co	1.01	50
Stonebridge Life Ins Co	0.73	36
Protective Life Ins Co	0.46	23
American Gen Assur Co	0.33	16
Life Investors Ins Co of Amer	0.31	15
Union Fidelity Life Ins Co	0.29	14
Associates Financial Life Ins Co	0.24	12
Allstate Life Ins Co	0.24	12
Balboa Life Ins Co	0.18	9
American Heritage Life Ins Co	0.11	5
USAA Life Ins Co	0.02	1
Central States H & L Co of Omaha	0.01	0
<hr/>		
TOTAL FOR TOP 20 RANKED INSURERS	100.14	4,952
TOTAL FOR ALL 30 INSURERS WRITING THIS LINE	100.00	4,945

2001 ALASKA ACCIDENT & HEALTH MARKET SHARE

9 - ALL OTHER (\$000)

COMPANY NAME	DIRECT PERCENT OF MARKET	PREMIUMS WRITTEN
American Family Life Assr Co Columbus	32.51	5,434
New York Life Ins Co	6.94	1,160
Physicians Mut Ins Co	4.49	750
Mutual of Omaha Ins Co	3.52	589
Unum Life Ins Co of Amer	3.31	553
Northwestern Mut Life Ins Co	3.17	530
Provident Life & Accident Ins Co	2.92	488
General Electric Capital Assur Co	2.87	481
Life Investors Ins Co of Amer	2.85	477
Golden Rule Ins Co	2.81	470
Paul Revere Life Ins Co	2.65	443
Colonial Life & Accident Ins Co	2.31	387
Guardian Life Ins Co of Amer	2.21	370
John Hancock Life Ins Co	1.77	296
Mony Life Ins Co	1.76	294
Equitable Life Assr Soc of The US	1.74	290
Continental General Ins Co	1.40	234
Conseco Senior Health Ins Co	1.38	230
USAA Life Ins Co	1.34	223
Bankers Life & Cas Co	0.89	149
<hr/>		
TOTAL FOR TOP 20 RANKED INSURERS	82.83	13,846
TOTAL FOR ALL 164 INSURERS WRITING THIS LINE	100.00	16,716

10 - TOTAL (\$000)

COMPANY NAME	DIRECT PERCENT OF MARKET	PREMIUMS WRITTEN
Aetna Life Ins Co	13.06	18,224
Principal Life Ins Co	12.98	18,104
United Healthcare Ins Co	8.44	11,823
Great West Life & Annuity Ins Co	5.26	7,342
Golden Rule Ins Co	4.84	6,749
Unum Life Ins Co of Amer	4.82	6,719
American Family Life Assr Co Columbus	3.90	5,438
United of Omaha Life Ins Co	3.67	5,115
Mega Life & Health Ins Co The	3.57	4,975
Guardian Life Ins Co of Amer	2.71	3,775
Hartford Life & Accident Ins Co	1.87	2,616
Safeco Life Ins Co	1.84	2,566
Stonebridge Life Ins Co	1.66	2,323
Standard Ins Co	1.51	2,112
Mutual of Omaha Ins Co	1.35	1,878
New York Life Ins Co	1.31	1,828
States West Life Ins Co	1.25	1,748
Fortis Benefits Ins Co	1.24	1,736
Union Labor Life Ins Co	1.22	1,704
Metropolitan Life Ins Co	1.14	1,590
<hr/>		
TOTAL FOR TOP 20 RANKED INSURERS	77.67	108,364
TOTAL FOR ALL 224 INSURERS WRITING THIS LINE	100.00	139,519

HEALTH INSURANCE BY PRODUCT LINE

INDIVIDUAL - CALENDAR YEAR 2001

PRODUCT	# POLICIES IN FORCE BEG OF YEAR	# INDIVIDUALS COVERED BEG OF YEAR	# NEW # INDIVIDUALS		# COVERED		# POLICIES IN FORCE END OF YEAR	# INDIVIDUALS COVERED END OF YEAR	EARNED PREMIUM*	INCURRED CLAIMS*
			POLICIES ISSUED DURING THE YEAR	NEWLY ISSUED COVERAGE DURING THE YEAR	POLICIES TERMINATED DURING THE YEAR	INDIVIDUALS TERMINATED DURING THE YEAR				
Accident	10,929	18,489	5,016	8,811	4,604	7,347	11,461	20,146	2,875,162	1,161,898
Comp MedPPO	5,163	9,308	725	1,320	461	991	5,427	9,637	15,268,979	12,405,798
Non-PPO	263	474	3	3	41	81	229	396	1,125,263	740,664
Dental PPO	0	0	0	0	0	0	0	0	0	0
Non-PPO	29	34	488	867	90	161	424	740	87,030	4,972
Disability Income	6,131	6,052	1,193	1,207	1,711	1,691	5,662	5,555	5,332,179	5,515,100
Hospital Expense	883	1,325	94	146	194	301	780	1,170	1,418,883	1,557,964
Hospital Indemnity	3,800	5,854	1,324	2,066	1,350	2,158	3,778	5,768	1,209,738	416,712
Limited Benefit	66	66	13	13	1	1	79	79	136,657	0
Long Term Care	1,072	1,103	578	533	55	61	1,593	1,648	2,196,447	509,619
Medical Expense	9	11	2	2	1	1	10	12	9,504	-8,426
Medicare Supplement	2,008	2,029	160	161	204	209	1,968	1,985	2,910,614	1,855,132
Specified Disease	4,658	9,053	2,341	4,103	1,320	2,500	5,703	10,690	1,823,060	693,468
Vision PPO	19	1,589	6	96	1	54	24	1,631	95,683	78,147
Non-PPO	0	0	0	0	0	0	0	0	0	0
Other	2,976	6,083	1,279	2,465	1,112	2,149	3,143	6,399	476,293	108,310
TOTAL	38,006	61,470	13,222	21,853	11,145	17,705	40,281	65,856	34,965,491	25,039,438

Note: This health survey report was compiled from data provided by the companies. The Division of Insurance does not warrant the accuracy of this information.



Alaska Insurance Consumer Guide

Health Insurance

Everyone runs the risk of becoming ill or suffering an accident that results in doctor or hospital bills, and sometimes in loss of income. Most Alaskans need protection from unexpected and sometimes devastating expenses associated with an illness or accident.

How do you choose from the hundreds of medical plans available? To wisely purchase medical care protection you must:

- Determine your family's needs
- Know the different types of protection available
- Choose a plan on the basis of coverage, costs, and services

Before buying a health insurance policy, know what insurance or other benefits you already have. This will help prevent duplicating coverage and will help you determine if you have enough coverage, inadequate coverage, or no coverage at all. Make sure you have up-to-date information on medical insurance, disability benefits, and sick leave benefits provided by your employer. Your first priority should be assuring that you have either a comprehensive major medical insurance policy or both basic medical insurance and supplemental major medical insurance.

How Health Insurance Policies are Sold

Individual Insurance

An individual insurance policy provides coverage to a specific individual or to an individual and their family under a policy issued to that individual. In order to be considered for individual insurance coverage, you will be asked to provide evidence of insurability that may require you to undergo a medical examination. This is called medical underwriting. The same requirements would apply to any dependents you may insure under the policy.

Group Insurance

A group insurance policy provides coverage to individuals under a single master policy issued to the group policy owner. Certificates of insurance are provided to the individuals. The policy owner may be an employer, an association, a labor union, or other entity. Unless the group is small, no individual medical underwriting is performed. Instead, insurers require minimum employee or member participation levels and minimum employer contribution levels in order to assure that there are sufficient individuals in the group in good health to balance those in the group in poor health.

[Back to Consumer Guide Index of Topics](#)

Thank you for visiting our web site. For help or information, please send an e-mail message to the Division of Insurance at: Insurance@dced.state.ak.us



Alaska Insurance Consumer Guide

Considerations in Purchasing Health Insurance

Whether you have individual or group health insurance coverage, it is important to understand what your coverage is and what charges you may be responsible for paying. Read your policy or certificate thoroughly and consider the following:

- What services and supplies are covered?
- What limits are set on the benefits for these services and supplies?
- What are the deductible, coinsurance and other charges you will be responsible for paying?
- How are benefit payments coordinated with other health coverage you may have?
- What are the managed care features and requirements of the plan?
- What level, type, and quality of service can be expected from the insurer?

[Back to Consumer Guide Index of Topics](#)

Thank you for visiting our web site. For help or information, please send an e-mail message to the Division of Insurance at: Insurance@dced.state.ak.us



Alaska Insurance Consumer Guide

Types of Health Insurance Plans

Following is a summary of several types of health insurance plans sold as group and individual health insurance. The actual health insurance benefits will vary from policy to policy. Therefore, it is important to read and understand your insurance contract. The term **provider** is commonly used in health insurance and in this guide to refer to physicians and other providers of medical care.

Basic Medical

A basic medical insurance policy provides coverage for basic hospital, provider and other services. There are limits placed on the benefits for covered services such as a limited number of hospital days, a maximum payment for each day of hospital confinement, or a surgical schedule where a specific payment maximum is established for each procedure. These benefits are provided without deductibles or coinsurance.

Supplemental Major Medical

Under a supplemental major medical policy, benefits are structured to supplement a basic medical insurance policy. The policy would pay for any covered services and supplies not covered by the basic medical insurance policy after the required deductible has been paid and subject to the coinsurance requirements. A basic medical policy in combination with a supplemental major medical policy results in coverage similar to a comprehensive major medical policy.

Comprehensive Major Medical

A comprehensive major medical policy provides coverage for almost all types of medical care services and supplies and has high benefit limits. These policies cover hospital, provider, and other services subject only to the required deductible, coinsurance, and benefit maximums. Unlike basic medical, individuals are required to share in the cost of their medical expenses. These policies have replaced most of the basic medical insurance policies.

Limited Benefit

Limited benefit plans are offered as independent, noncoordinated benefits provided under a separate policy and paid without regard to any other insurance plan. Examples of these types of plans include **hospital indemnity policies** that pay a fixed amount for each day of hospital confinement, and **specified or dread disease policies** that only pay for medical expenses associated with a specified disease (such as cancer or heart disease).

Long-Term Care

Long-term care insurance policies provide nursing home or home health care benefits for individuals with a prolonged physical illness, disability or mental disorder, medical condition, or a deficiency affecting activities of daily living or lifestyle. Benefits are provided as a reimbursement for services, but subject to a fixed dollar maximum per day. Usually a waiting period called an **elimination period** of 0, 30, 90, 180, or 360 days is required before the plan will pay benefits. Long-term care insurance may be available as a rider to a life insurance or annuity policy, as well as a separate health insurance policy.

Medicare Supplement

Medicare supplement (also called Medigap) insurance is sold to people age 65 and older and helps pay for medical costs that Medicare Parts A & B do not pay, such as the deductible and coinsurance amounts. Medicare supplement insurance is regulated by both state and federal laws. This coverage can only be provided through ten standard health plans that vary in the amount and type of coverage provided. Coverage is available to individuals without medical underwriting for six months following the date the individual first becomes eligible for Medicare Part B. The Division of Insurance produces, on an annual basis, a rate comparison guide that outlines the basic characteristics of Medicare supplement insurance, describes the ten standard health insurance plans, and shows the current premium rates charged by the insurers selling this insurance in Alaska. There is also a pamphlet entitled "Health Insurance for People with Medicare" produced by the 50 states and the federal government that summarizes the Medicare and Medicare supplement programs. Both publications are available from the Division of Senior Services, 3601 C Street, Suite 310, Anchorage, Alaska 99503, telephone number (907) 269-3680 or (800) 478-6065.

Dental Insurance

Dental insurance covers costs associated with the care of teeth. Benefits for preventive services, such as cleanings and exams are generally limited to once every six months. Most plans contain coinsurance and deductible cost-sharing requirements. The coinsurance provisions will vary based on the type of procedure.

Vision Coverage

Vision coverage provides benefits for glasses, contact lenses, and eye examinations up to a specified amount per year. Vision benefits are often subject to a set schedule of benefits and limits on the frequency of services. A typical vision plan covers the cost for one examination per year, with coverage for glasses and contact lenses limited to once every two years.

Back to Consumer Guide Index of Topics

Thank you for visiting our web site. For help or information, please send an e-mail message to the Division of Insurance at: Insurance@dced.state.ak.us



Alaska Insurance Consumer Guide

Things to be Aware of Regarding Health Insurance Policies

Benefit Limits

- Most health insurance plans set a maximum benefit amount that will be provided for all covered services and supplies over the lifetime of the covered individual. This is called a **lifetime maximum**. This maximum is often set at \$1,000,000.
- Most health insurance plans set a maximum benefit amount that provides for particular services and supplies, such as a maximum benefit of \$250,000 for organ transplants.
- Some health insurance plans limit the benefit that will be provided per day for a covered service. This is called a **daily maximum**. They may also limit the number of days that a service will be covered. These types of limits are generally used for services including mental and nervous disorders, skilled nursing facilities, and home health care.
- Many health insurance plans limit the total benefit that will be provided per year for covered services. This is called an **annual maximum**. These limits are generally used for those services where it is difficult to assess whether the service is medically necessary.
- Most health insurance plans exclude or limit coverage for a period of time for medical conditions that existed within a certain period, commonly six months, prior to the date coverage began for which medical advice, diagnosis, care or treatment was recommended or received. This is called a **preexisting condition waiting period**. The waiting period is commonly 12 months. In most cases, insurance companies must reduce this waiting period by the number of days you were covered under prior health insurance plans, as long as you had no more than a 90-day break in your health insurance coverage.

Deductibles, Coinsurance, and Other Charges

- A **deductible** is a specified dollar amount an individual must pay in each policy period before reimbursement for expenses begin. The primary purpose of the deductible is to encourage individuals to use health care services only when necessary. A separate deductible may be required for specified services such as hospital admissions or prescription drugs. Some health plans may include a provision that allows any claims incurred in the last quarter of the policy period to be carried over and applied to meet the deductible in the next quarter.
- **Coinsurance** is that percentage of covered services and supplies the insurer will pay for after the individual pays the deductible. The individual is responsible for the amount the insurer does not pay. A common coinsurance arrangement is for the insurer to pay 80% of charges for covered services and the individual 20%.
- **Out-of-pocket maximum** is the maximum dollar amount the individual pays for covered services and supplies during a specified period, generally a calendar year. This maximum may be defined to include or exclude the deductible. Once the out-of-pocket maximum is paid, benefits are paid at 100% of the costs incurred after that time.
- A **copayment** is the fixed dollar amount that the individual is required to pay at the time each covered service takes place. Copayments vary by type of service. They are commonly used with emergency services and prescription drugs.
- A **usual, customary and reasonable (UCR) charge** is an established maximum amount that an insurance company will reimburse for a medical expense covered under your health insurance policy. UCR charges are generally determined based on charges that are actually billed by providers for each medical procedure or service in a geographical area. In order to

determine a reasonable charge, UCR charges are commonly calculated as a percentile of the charges billed by providers. The percentile is generally set so that a large percentage, such as 80% or 90%, of charges actually billed by providers are reimbursable in full. Note that UCR charges are determined by each insurer and will vary.

- Under most health insurance plans, you will be responsible for paying any amount billed by a hospital or physician that is larger than the insurer's established UCR charges for the service or procedure. However, service corporations, such as Blue Cross, contract with various hospitals and providers who agree to accept the service corporation's payment as payment in full. Therefore you would not be responsible for paying any amount that exceeds their UCR charges, unless you chose to use a hospital or provider that does not have a contract with the service corporation.
- The following is an example of how the various charges described above impact the amount you may be responsible for paying for medical services:

The limits specified by your insurance policy:	
Deductible	\$ 500
Coinsurance	80%
Out-of-pocket maximum	\$1,000
Amount Insurer Owes:	
Charges billed by provider	\$4,200
Amount greater than the UCR for the procedure	-\$ 550
Amount you owe for your deductible	-\$ 500
Charges eligible for reimbursement by insurer	<u>\$3,150</u>
Insurer's coinsurance	80%
Amount insurer owes before out-of-pocket limit applied	\$2,520
Amount that is greater than your out-of-pocket limit	<u>\$ 130</u>
Total amount insurer owes after out-of-pocket limit applied	\$2,650
Amount You Owe:	
Deductible	\$ 500
Coinsurance amount (20% of \$3,150)	<u>\$ 630</u>
Amount of eligible charges before out-of-pocket limit applied	\$1,130
Amount greater than your out-of-pocket limit	<u>-\$ 130</u>
Amount of eligible charges after out-of-pocket limit applied	\$1,000
Amount greater than the UCR for the procedure	<u>\$ 550</u>
Total amount you owe	\$1,550

Covered Services and Supplies

There are two basic categories of services and supplies covered by health insurance policies.

- **Hospital Benefits** include expenses associated with stays at hospitals and other covered facilities, such as skilled nursing facilities, nursing homes and outpatient surgery centers. Benefits for hospital services often require that the individual or their physician contact the insurer or the employer to obtain prior approval for the number of days of hospital stay. Without this approval the benefits may be reduced.
- **Physician or Provider Benefits** include services provided by licensed physicians and other medical providers.

There are a number of other charges and services generally excluded from coverage under most health insurance plans. Following are examples of common exclusions:

- Services determined by the insurer to be medically unnecessary
- Services considered experimental by an accepted medical authority
- Services related to cosmetic surgery
- Services for mental or nervous disorders, vision, hearing
- Services that are provided without charge
- Services provided due to war
- Services provided as a result of a work-related injury
- Services provided by a relative
- Services related to normal pregnancy and routine well-baby care (these are generally excluded from individual policies and included in group policies).

Alaska law mandates that the following specific charges or services be covered in health insurance plans sold in Alaska. These requirements do not apply to employers with self-insured health plans.

- Coverage for newly born or adopted children for at least 30 days, if coverage includes dependents
- Coverage for treatment of alcoholism or drug abuse
- Low-dose mammography screening if the contract covers mastectomies and prosthetic devices and reconstructive surgery
- Treatment of phenylketonuria
- Coverage for not less than 48 hours after vaginal birth and 96 hours after a cesarean birth, if the contract covers the costs of childbirth
- Coverage for prostate cancer screening and cervical cancer screening

Coordination of Benefits

This provision applies to the situation where an individual is covered under two different health insurance plans. It is included in almost all group insurance plans. It requires that payments made under the two plans be coordinated so that the individual does not receive duplicate payments for a service, thereby being reimbursed more than what was spent. Duplicate coverage frequently occurs when an individual is covered under both their own and their spouse's insurance plans. Most coordination of benefits provisions require that the individual's own plan pay first on a claim, and the other plan only pay the amounts not covered by the first plan. It is important that this provision be reviewed so that misunderstandings can be avoided regarding the benefit payments each insurer will make.

[Back to Consumer Guide Index of Topics](#)

Thank you for visiting our web site. For help or information, please send an e-mail message to the Division of Insurance at: Insurance@dced.state.ak.us



Alaska Insurance Consumer Guide

Federal Laws Affecting Health Insurance

COBRA

COBRA is the federal law that requires employers to continue to provide their health insurance coverage to employees who have been laid off or terminated. The coverage may extend from 18 to 36 months. To obtain coverage under COBRA, the employee or their dependent must apply to the employer within 60 days of termination of their employment. The U.S. Department of Labor handles all inquiries regarding COBRA coverage. Inquiries should be sent to:

Office of Program Services
Pension and Welfare
Benefits Administration
U.S. Department of Labor
200 Constitution Ave., N.W.
Washington, DC 20210
(202) 219-8776

ERISA (Employee Retirement Income Security Act)

Many people who believe that they have a health insurance policy through their employer are actually covered under what is called a self-insured health plan. A self-insured health plan exists when an employer chooses to pay for medical bills directly, instead of purchasing insurance for that purpose. Most self-insured plans are regulated by the federal government through the Department of Labor under the authority of ERISA and are exempt from state regulation. Most large employers have self-insured health plans. The State of Alaska changed to a self-insured health plan for employees and retirees effective July 1, 1997.

Employers choosing to self-insure their health plans are not subject to state insurance laws such as benefit mandates, state premium taxes, capital and surplus requirements, and reserve requirements. They are also able to gain more control over their cash flow and have more freedom in determining benefits to be provided to their employees. Most employers with self-insured health plans purchase stop-loss insurance from insurance companies to protect themselves against large losses.

Employees who receive health coverage under a self-insured plan are not afforded the protections of state insurance laws and regulations. These protections include financial solvency requirements as well as requirements applying to the payment of claims. If a self-insured plan fails, Alaska benefits and managed care protections, such as standards for grievance procedures, fair disclosure of plan provisions, fair claims settlement practices and consumer services, are not available to employees. The federal laws governing these self-insured plans limit damages to actual costs and may not even cover attorney fees. Individuals covered under a self-insured plan must assume responsibility for all claims if the plan fails. Also, individual employees are required to obtain their own legal counsel to settle disputes, since the U.S. Department of Labor will not become involved in individual disputes over coverage. One other important consideration is that a self-insured employer may make material changes to the health plan (such as reducing or eliminating benefits) without providing advance notice.

HIPAA (Health Insurance Portability and Accountability Act of 1996)

This Act establishes federal standards for group and individual health insurance plans. The Act sets minimum standards for guaranteed renewability, preexisting condition waiting periods, and crediting for prior health insurance coverage. Alaska has enacted into law these federal standards which are

discussed in the health insurance sections of this guide.

Medical Savings Accounts

Under this federal law a bank, insurance company, or other federally approved entity may set up an individual savings account called a Medical Savings Account (MSA) where you can set money aside to pay for qualified medical expenses. The deposits (called contributions) in the account are tax deductible. Qualified medical expenses are those expenses paid by you for medical care including any deductible and coinsurance payments. Medical Savings Accounts are regulated by the federal government, not the Alaska Division of Insurance. One advantage to establishing an MSA is that contributions are not subject to tax and qualified medical expenses paid out of the account are not included in gross income for federal income tax purposes.

In order for a savings account to qualify as an MSA, you must be covered by a high deductible health plan offered by a small employer (2-50 employees) or be self-employed and have purchased a high deductible health plan. A high deductible health plan is an individual health insurance policy with deductibles between \$1,500 and \$2,250 and out-of-pocket limit of \$3,000, or a family health insurance policy with deductibles between \$3,000 and \$4,500 and out-of-pocket limit of \$5,500. These high deductible health plans are regulated by the Division of Insurance in the same manner as other health insurance policies.

If you are seeking information on setting up an MSA account, the best place to start is by contacting your financial advisor or producers selling health insurance in Alaska. Producers should have knowledge of the high deductible plans that are available in Alaska and any MSAs that may be offered in conjunction with those plans.

Back to Consumer Guide Index of Topics

Thank you for visiting our web site. For help or information, please send an e-mail message to the Division of Insurance at: Insurance@dced.state.ak.us

5-18-02

ALASKAALMANAC

Got health insurance? You're lucky



116,000 – Estimated number of Alaskans without health coverage

19 – Percentage of Alaskans without health coverage

3 – Number of states that have a higher percentage of uninsured residents than Alaska does

\$9,076 – Amount a typical 45-year-old Alaskan will pay each year for an individual health policy covering his family with a \$1,000 deductible

184 – Percentage increase in Alaska medical care

costs since 1983

3:1 – Ratio by which the increase in Alaska medical costs has exceeded overall inflation since 1983

\$297,500 – Minimum amount state health insurance will pay toward the \$300,000 of medical bills recently incurred by a state legislator (assuming no dispute over the price or necessity of the treatment)

Unknown – Number of Alaskans who will be able to afford health coverage if Alaska creates an unsubsidized insurance-buying pool for small businesses and non-profit groups

Source: Daily News files; state division of retirement and benefits.

5-18-02

ALASKA ALMANAC

Got health insurance? You're lucky



116,000 – Estimated number of Alaskans without health coverage

19 – Percentage of Alaskans without health coverage

3 – Number of states that have a higher percentage of uninsured residents than Alaska does

\$9,076 – Amount a typical 45-year-old Alaskan will pay each year for an individual health policy covering his family with a \$1,000 deductible

184 – Percentage increase in Alaska medical care

costs since 1983

3:1 – Ratio by which the increase in Alaska medical costs has exceeded overall inflation since 1983

\$297,500 – Minimum amount state health insurance will pay toward the \$300,000 of medical bills recently incurred by a state legislator (assuming no dispute over the price or necessity of the treatment)

Unknown – Number of Alaskans who will be able to afford health coverage if Alaska creates an unsubsidized insurance-buying pool for small businesses and non-profit groups

Source: Daily News files; state division of retirement and benefits.

In Alaska, health insurance depends on job



Falling Through the Cracks

ALASKA'S HEALTH INSURANCE CRISIS

■ **HEALTH INSURANCE:** This story and others in the Life section look at the health insurance problems facing Alaskans. The series continues Tuesdays in Life & Health through May.

■ **WITHOUT:** Small-business employees, self-employed, young can seldom afford it.

By ANN POTEPA
Anchorage Daily News

5/7/02

Studies show that the 116,000 Alaskans without health insurance aren't always whom you expect.

They're working people. They're self-employed. They're twentysomethings who assume youthful

good health will see them through. Often they work for small businesses that cannot afford to offer benefits.

They're your neighbors.

People like Steven Small. He has repaired cars in Anchorage for almost 20 years and has never had health insurance, even since he opened his own shop.

Doctors diagnosed liver cancer last fall. Small has been paying his medical bills out of pocket and with

the help of donations. With a family to support and employees who need work, Small can't stop. After his chemotherapy infusion last week, he worked an eight-hour-plus day.

Rep. Sharon Cissna, D-Anchorage, has met many families like the Smalls.

"It's not like they made all the wrong choices in life," she said. "It's not like they weren't hard workers."

See Back Page, INSURANCE

INSURANCE: 116,000 are not covered

Continued from A-1

Cissna has opened her office and invited the public in to talk about solutions to rising health care and insurance. She's not the only one paying attention. Local and state agencies have spent the past few years studying the problem and publishing data. They have discovered a disparity in who gets health insurance and who doesn't, and that difference often centers on one thing: where Alaskans work.

"Some folks get a Cadillac (plan)," Cissna said. "Some folks get bare bones."

And some folks get nothing at all. Well over 100,000 Alaskans, 19 percent of the state, lack health insurance. About 26,000 live in Anchorage.

Nancy Cornwell, the state's health policy analyst, said this total reflects Alaska's population in the late 1990s, but more recent data suggest that number is rising.

The U.S. Census Bureau and the Henry J. Kaiser Family Foundation, an independent agency tracking national health issues, have ranked all 50 states according to uninsured residents. In both studies, Alaska falls in the bottom five states.

New Mexico ranks lowest, with almost 24 percent uninsured; Rhode Island has the best performance, with only about 6 percent uninsured. The United States as a whole is almost in the middle, with 14 percent of Americans lacking health insurance.

Cornwell said some people wonder whether Alaska really has 116,000 residents without health insurance. They question whether Alaska Natives might have responded that they have no insurance, even though they receive health care through tribal programs like Indian Health Services, she said.

That issue aside, the deciding factor for whether Alaskans have benefits often comes down to whom they work for. The smaller the company, the less

likely its workers are to have health insurance, studies show.

Fewer than half of Anchorage companies offer health insurance to full-time employees, according to data collected by the Anchorage Access to Health Care Coalition. Companies with more than 250 employees are most likely to offer it. But the local marketplace is filled with companies of fewer than 10 employees. Only 35 percent of those offer health insurance to full-time workers.

Compare that to the nation, and Alaska falls short. Coast to coast, almost 60 percent of small businesses offer employees health insurance, according to the coalition.

Expensive premiums are the main reason employers give for not offering the benefit. Premiums escalate for many reasons, including rising health care costs.

Studies show Alaskans pay more for medical services than people in the Lower 48.

Last year, the state Department of Labor concluded that health care costs for Alaskans are increasing at a faster rate than any other cost-of-living category, including housing, food and transportation. The state Division of Medical Assistance studied the 300 most common dental, medical and surgical procedures performed nationwide. It reported that health care costs Alaskans 25 percent more than the average for all states.

As premiums climb, businesses make choices. They shop for a cheaper insurance provider, cut positions or ask employees to pick up more of the tab.

Jan MacClarence faced this choice just a few months ago. The executive director for Abused Women's Aid in Crisis learned that her health insurance provider would no longer serve the nonprofit organization in 2002. The best option she found more than doubled her premiums, jumping, per em-

How states rank

Percent of state population without health insurance, 1999-2000

Most Insured Rank	State	Percent not insured
1	Rhode Island	6%
2	Pennsylvania	8%
2	New Hampshire	8%
2	Minnesota	8%
2	Iowa	8%
2	Connecticut	8%
	U.S. average	14%
Least Insured		
46	California	19%
47	Alaska	19%
48	Louisiana	21%
49	Texas	22%
50	New Mexico	24%

Source: Henry J. Kaiser Family Foundation

RON ENGSTROM / Anchorage Daily News

ployee, from about \$300 to \$765 a month.

AWAIC pays all its employees' full premiums, but continuing to do so has meant sacrifices. MacClarence has had to leave positions unfilled to cover the expense.

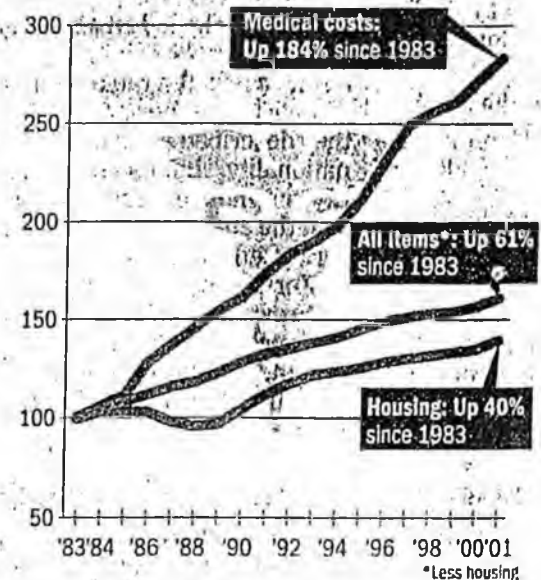
For the self-employed, the story is even more grim. They buy their own policies and pay all costs. Premera Blue Cross writes about 90 percent of all individual health insurance policies in Alaska, said Bob Lohr, director of the Division of Insurance. The average annual premium for a 35-year-old Alaskan with a \$1,000 deductible is \$2,484, Lohr said. The family rate is \$6,828.

And numbers climb with age. A 45-year-old will pay \$3,768 in premiums, \$9,096 if the whole family is covered, Lohr said.

People who cannot afford that kind of coverage often go without health care.

Medical costs have soared

Anchorage Consumer Price Index for selected costs; 1983-2001



Source: U.S. Bureau of Labor Statistics, Alaska Department of Labor

RON ENGSTROM / Anchorage Daily News

"I think there's a perception that not having health insurance is not a big deal," said Catherine Schumacher, chairwoman for the steering committee of the Anchorage Access to Health Care Coalition. "That people can just go to the emergency room and get the care they need."

The coalition's data show otherwise. Almost half of uninsured Anchorage residents couldn't see a doctor during the past year because of cost. Many have chronic conditions like high blood pressure but aren't able to pay for medications needed to manage them, Schumacher said. And forget about preventive checkups.

"They don't get their mammograms, their pap smears," she said. "They don't get their cholesterol checked."

So when they do end up in an emergency room, their conditions are often more serious — and more expensive.

Reporter Ann Potempa can be reached at apotempa@adn.com or 257-4581.



CFO GROWTH SOLUTIONS

April 9, 2003

Norman Rokeberg
State Capital, Room 214
Juneau, AK 99801-1182

RE: HB10 – Group Health Insurance

Dear Mr. Rokeberg:

We are a CPA/Consulting firm that provides business advice aimed at helping small businesses succeed. Based upon our twenty year business history we know that the cost of health insurance is a major impediment to furthering Alaskan business development. At this time there are few options, in an affordable way, for businesses to secure adequate health care coverage for their employees.

We are strongly in support of the state of Alaska pooling small business owners together for the purpose of obtaining health care coverage. We strongly believe that this will significantly improve the ability of owners to invest in Alaska.

Sincerely,


Robert Doughty
Founder/President



April 11, 2003

Jack C. McRae
Senior Vice President

Representative Norman Rokeberg
House of Representatives
State Capitol, Room 24
Juneau, AK 99801-1182

Re: Alaska House Bill 195

Dear Representative Rokeberg:

Blue Cross Blue Shield of Alaska is pleased to support the proposed Committee Substitute for House Bill 195 (version "Q"). We believe this bill represents an important step forward for Alaska in addressing increasing costs of health care coverage and the problem of the uninsured.

HB 195 gives health insurers the flexibility of offering a benefit plan to individuals that is not subject to state mandated health insurance benefits. We strongly believe that Alaska consumers should have choice in the insurance products available for purchase. The product allowed under HB 195 will be welcomed by many individual consumers looking for an alternate to plans currently available in the marketplace.

We are also pleased to see that version "Q" of HB 195 recognizes important new options available through the Federal Trade Act of 2002. The Trade Act contains important provisions for workers whose health coverage could be affected because of unemployment related to foreign trade agreements. Given that the Alaska Comprehensive Health Association is already a federally qualified HIPAA high-risk pool, the ACHIA amendments made by HB 195 are a fiscally responsible way to leverage federal dollars to assist in covering workers eligible under the Trade Act.

Blue Cross Blue Shield of Alaska congratulates Representative Rokeberg for introducing a bill that will benefit Alaskans seeking new alternatives for health insurance. We urge the committee to advance the bill to the next step in the legislative process.

Respectfully,

A handwritten signature in black ink, appearing to read "Jack C. McRae".

Jack C. McRae

Cc: Jerry Reinwand
Jeff Davis